REPUBLIC OF KENYA

IN THE HIGH COURT OF KENYA AT KIAMBU

CONSTITUTIONAL PETITION NO. OF 2022

IN THE MATTER OF ARTICLES 10(1) & 10 (2)(a), 19, 22, 23, 26 (1) & (4), 27, 33, 35, 43 (1(a)), 53 (1(c)) AND 232 (1(d)) OF THE CONSTITUTION OF KENYA, 2010

AND

I IN THE MATTER OF ARTICLES, 22, 23, 34 AND 35 OF THE EAST AFRICAN COMMUNITY HIV & AIDS PREVENTION AND MANAGEMENT ACT

AND

IN THE MATTER OF SECTIONS 5, 6, 7, 15 AND 68 OF THE HEALTH ACT, 2017

AND

IN THE MATTER OF SECTION 16(2), (3) & (4), 28(3), 146 AND THE FIRST SCHEDULE OF THE CHILDREN ACT NO. 29 OF 2022

AND

IN THE MATTER OF SECTION 6 AND 7 OF THE SCIENCE TECHNOLOGY AND INNOVATION ACT NO. 28 OF 2013

AND

IN THE MATTER OF SECTION 4 AND 5 OF THE ACCESS TO INFORMATION ACT NO. 31 OF 2016

AND

IN THE MATTER OF THE PUBLIC SERVICE COMMISSION GUIDELINES FOR PUBLIC PARTICIPATION IN POLICY MAKING (2015)

AND

IN THE MATTER OF THE NATIONAL REPRODUCTIVE HEALTH POLICY 2022-2032

BETWEEN

RACHAEL MWIKALI.....1ST PETITIONER

ESTHER AOKO.....2ND PETITIONER

AMBASSADOR FOR YOUTH & ADOLESCENT

REPRODUCTIVE HEALTH PROGRAMME (AYARHEP).....3RD PETITIONER

KENYA LEGAL AND ETHICAL

0-1

ISSUES NETWORK ON HIV & AIDS.....4TH PETITIONER

VERSUS

CABINET SECRETARY

MINISTRY OF HEALTH.....1ST RESPONDENT

THE ATTORNEY GENERAL.....2ND RESPONDENT

AND

KENYA OBSTETRICAL GYNAECOLOGICAL SOCIETY..... 1ST INTERESTED PARTY

KATIBA INSTITUTE .....2ND INTERESTED PARTY

CERTIFICATE OF URGENCY

We, **NYOKABI NJOGU** and **GAUDENCE WERE**, Advocates of the High Court of Kenya who have conduct of this matter on behalf of the Petitioners, certify that the Application and Petition herein are extremely urgent and should be heard at the earliest opportunity, and during the court vacation **ON THE GROUNDS THAT:**

1. On 5th July 2022, the 1st Respondent launched the National Reproductive Health Policy 2022-2023 (the Policy). The way the policy was passed is unconstitutional, and it contains provisions that when implemented, will violate the right to reproductive health.

2. The Petitioners seek conservatory orders suspending the implementation of the Policy pending the hearing of this petition to avert the violation of the right to life and the right to the highest attainable standard of health for the intended beneficiaries of the policy.

3. Unless the Application is certified urgent and admitted for hearing during the court vacation and the Application and Petition expedited, the Policy shall be implemented, which will endanger the health and life of millions of Kenyans, particularly for women and girls.

02

4. Should the Policy continue to be implemented in its current form, the lives of Kenyans, particularly women and girls continue to be threatened. Unless the Application and Petition are urgently heard and determined, the constitutional right to life and the highest attainable standard of health will be and continues to be violated and there will be a claw back to the constitutional guarantee of the right to the highest attainable standard of health for all Kenyans.

5. The adverse effects of the implementation of the Policy and the violations of the right to life and health will disproportionately affect women and girls, further compounding discrimination that they face in access to reproductive health services.

6. There is, therefore, a continuing violation of the Petitioners' constitutional rights, as well as Kenyans who will be affected by the implementation of the Policy by the 1st Respondent.

7. It is in the interest of justice that this Application is certified urgent and admitted for hearing on a priority basis during the current vacation of this Honourable Court, and the orders sought granted.

DATED at NAIROBI this .....8th.....day of .....September..... 2022

NYOKABI NJOGU AND GAUDENCE WERE

ADVOCATES FOR PETITIONERS

03

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04

REPUBLIC OF KENYA

IN THE HIGH COURT OF KENYA AT KIAMBU

CONSTITUTIONAL PETITION NO. OF 2022

IN THE MATTER OF ARTICLES 10(1) & 10 (2)(a), 19, 22, 23, 26 (1) & (4), 27, 33, 35, 43 (1(a)), 53 (1(c)) AND 232 (1(d)) OF THE CONSTITUTION OF KENYA, 2010

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AND

IN THE MATTER OF THE NATIONAL REPRODUCTIVE HEALTH POLICY 2022-2032

BETWEEN

RACHAEL MWIKALI.....1ST PETITIONER

ESTHER AOKO.....2ND PETITIONER

AMBASSADOR FOR YOUTH & ADOLESCENT

REPRODUCTIVE HEALTH PROGRAMME (AYARHEP).....3RD PETITIONER

KENYA LEGAL AND ETHICAL

05

ISSUES NETWORK ON HIV & AIDS.....4TH PETITIONER

VERSUS

CABINET SECRETARY

MINISTRY OF HEALTH.....1ST RESPONDENT

THE ATTORNEY GENERAL.....2ND RESPONDENT

AND

KENYA OBSTETRICAL GYNAECOLOGICAL SOCIETY..... 1ST INTERESTED PARTY

KATIBA INSTITUTE .....2ND INTERESTED PARTY

NOTICE OF MOTION

(Under Articles 10, 22 (1) & (2), 23, 26 (1) & (4), 27, 43 (1)(a),53 (1)(c), 165 (3)(b) and 232 (1)(d) of the Constitution of Kenya, 2010, and Rules 3, 4(1), 10(2)(a), 13 and 19 of the Constitution of Kenya (Protection of Rights and Fundamental Freedoms) Practice and Procedure Rules, 2013, Rule 17 of the High Court (Organization and Administration) Act, and all other enabling provisions of the law)

TAKE NOTICE that this Honourable Court shall be moved on the ..... day of ..... 2022 at 9:00 in the forenoon or soon thereafter as the Applicants may be heard on its application **FOR ORDERS THAT:**

1. This Application and the Petition be certified urgent and service be dispensed with in the first instance.
2. The Notice of Motion application and the Petition, both dated 8th September 2022 be admitted on a priority basis and heard during the court vacation.
3. Pending the hearing and determination of the Application, this Court issue a conservatory order suspending the implementation of the National Reproductive Health Policy 2022-2032.
4. In addition to or in the alternative to prayer 3, pending the hearing and determination of the Application, this Court issue a conservatory order suspending the implementation of clause 2.3.3, clause 2.3.7, clause 3.4.1 paragraph 12, clause 3.4.2, clause 3.4.4 paragraph 2, clause 3.4.8 paragraph 1, clause 3.4.8 paragraph 8, clause

06

3.4.11 paragraph 5 and 6, clause 3.4.12 paragraph 1,3 and 5, clause 3.4.13 paragraph 2, and clause 4.2.3.8 paragraph 5 of the Reproductive Health Policy 2022-2032.

5. Pending the hearing and determination of the Petition, this Court issue a conservatory order suspending the implementation of the National Reproductive Health Policy 2022-2032.
6. In addition to or in the alternative, pending the hearing and determination of the Petition, this Court issue a conservatory order suspending the implementation of of clause 2.3.3, clause 2.3.7, clause 3.4.1 paragraph 12, clause 3.4.2, clause 3.4.4 paragraph 2, clause 3.4.8 paragraph 1, clause 3.4.8 paragraph 8, clause 3.4.11 paragraph 5 and 6, clause 3.4.12 paragraph 1,3 and 5, clause 3.4.13 paragraph 2, and clause 4.2.3.8 paragraph 5 of the National Reproductive Health Policy 2022-2032.
7. Further to the prayers above, the Court issue such further directions and orders as may be necessary to give effect to its orders.
8. There be no order as to costs.

WHICH APPLICATION IS BASED ON THE GROUNDS THAT: -

1. On 5th July 2022, the 1st Respondent launched the National Reproductive Health Policy 2022-2023 (the Policy). The manner in which the policy was passed is unconstitutional as the 1st Respondent failed to conduct meaningful public participation, and it contains provisions that when implemented, will violate the right to life, and the right reproductive health for Kenyans, particularly for women and girls.

2. The petitioners challenge the 1st Respondent's failure to conduct meaningful public participation in developing the National Reproductive Health Policy 2022-2032. They also challenge the constitutionality of the National Reproductive Health Policy 2022-2032 in so far as it runs afoul of the right to life, the highest attainable standard of health for all persons. The Policy contains various provisions which claw back

07

on the constitutional rights to comprehensive sexual and reproductive health and rights for Kenyans.

3. The Application and Petition concern the right to health and life. Unless the Application and Petition are expedited, the Policy shall continue be implemented, which will endanger the health and life of millions of Kenyans. The constitutional right to health, particularly for reproductive health, will be and continues to be violated and there will be a claw back to the constitutional guarantee of the right to the highest attainable standard of health for all Kenyans.

4. There is, therefore, a continuing violation of the constitutional rights for Kenyans who are being affected by the implementation of the Policy by the 1st Respondent. Implementation of the policy will, in particular, cause untold harm to women and girls whose reproductive rights continue to be violated.

5. It is in the public interest and the interests of justice that the orders sought are granted as no parties will be prejudiced.

WHICH APPLICATION is further supported by the affidavits sworn by **NERIMA WERE and NELLY KWAMBOKA BOSIRE** as well as by the Petition and the supporting affidavits of **RACHAEL MWIKALI, ESTHER AOKO, JEROP LIMO** and **NERIMA WERE and NELLY KWAMBOKA BOSIRE** and on such other or further grounds as may be adduced at the hearing.

DATED at NAIROBI this.....8th..... **of** .....September..... **2022**

Ocl,

NYOKABI NJOGU AND GAUDENCE WERE

ADVOCATES FOR PETITIONERS

08

DRAWN & FILED BY:-

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09

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KENYA OBSTETRICAL GYNAECOLOGICAL

SOCIETY..... 1ST INTERESTED PARTY

KATIBA INSTITUTE .....2ND INTERESTED PARTY

AFFIDAVIT OF NERIMA WERE IN SUPPORT OF THE NOTICE OF MOTION

I, **NERIMA WERE**, of **P.O.BOX 112 – 00202, Nairobi**, a female Kenyan adult of sound mind residing and working for gain in Nairobi County within the Republic of Kenya do hereby make oath and state as follows;

1. I am an advocate of the High Court of Kenya and the Deputy Executive Director of the Kenya Legal and Ethical Issues Network on HIV and AIDS (KELIN), the 4th Petitioner herein and thus competent to swear this Affidavit. ***(A copy of the 4th Petitioner's registration certificate is attached and marked as NW-1)***

11

2. I have the authority of the Board of Directors to swear this Affidavit on behalf of the 4th Petitioner.

3. I am conversant with the contents of the Petition and I fully understand the issues in question and I further adopt the contents of the Petition filed herein as if the same were set out *seriatim*.

4. I swear this affidavit in support of the Application for orders as set out in the Notice of Motion dated 8th September 2022.

5. On 5th July 2022 the 1st Respondent launched the National Reproductive Health Policy 2022-2023 (the Policy) without facilitating a meaningful public participation process.

6. The 4th Petitioner considers the policy to be unconstitutional because it contains provisions that threaten the right to life and to reproductive health for women and girls. ***(A copy of the National Reproductive Health Policy 2022-2032 is attached and marked as NW-2)***

8. The Policy contains various provisions with claw back on the constitutional guarantee on the right to life and the right to reproductive health in the following manner addressed herein.

9. Specifically, the Policy uses exclusionary language that denies critical reproductive healthcare interventions to the majority of women and girls thereby intentionally excluding any person not in a marriage; providing contraceptive care alternatives to only couples that have had children.

10. The policy's situational analysis, for instance ***(2.3.3 Reduction in unmet family***

planning needs on page 11) draws data on the use of modern contraceptives from a population of married women instead of focusing on women of reproductive age. Further, ***the policy's preamble on family planning (3.4.2 To reduce unmet family planning needs on page 23)*** focuses on the provision of family planning for couples that have achieved their desired family sizes to the exclusion of the rest of the population of persons of reproductive age.

11. The bias towards families to the detriment of the rest of the population of reproductive age is further indicated at ***4.2.3 paragraph 6 of the policy (page 38)*** where it is indicated that the policy recognizes the central role of the family in reproductive health and that this shall be reflected in reproductive health interventions; as well as the description of the key components in service delivery and standards to include responsiveness to social values ***(page 39).***

12. The policy excludes adolescent women and young girls from benefiting from reproductive health services and commodities as it envisages the provision of cervical cancer screening services for women between 25 and 49 years to the exclusion of other age groups ***(2.3.7 on cancers of reproductive organs at page 15 of the policy).***

13. Additionally, the policy limits interventions from healthcare workers in regard to access to safe abortion by providing that termination of pregnancy shall be performed to ensure both the mother and unborn child receive the highest attainable standard of healthcare ***(policy thrust 3.4.1 to reduce maternal, perinatal and neonatal morbidity and mortality paragraph 12 at page 23 of the policy).***

14. To indicate that in abortion the health professional should ensure the highest standard of healthcare for an unborn child is to creates unnecessary fear and hesitation on the position on procurement of safe and legal abortions, thereby

contravening the right to life and to health of the mother. The position is further exacerbated by the lack of comprehensive provisions and guidelines on safe and legal abortion as well as post-abortion care.

9. Further, healthcare interventions under the policy exclude young women below 21 years as they are not guaranteed access to reproductive health services on the basis that they have "not attained full cognitive competence on matters of sexuality and reproduction." (***overarching policy statement at page 19 of the policy).*** Under ***3.4.8 paragraph 1 of the policy on page 25***, it is further indicated that a person attains complete full cognitive competence on matters of sexuality and reproduction at the age of 21 and that the government will prioritize abstinence and delayed sexual debut for persons yet to attain full cognitive competency.

10. The result of this policy direction is that it undermines the age of majority which is currently set at 18 years, and moves it to 21 years without any scientific or legal basis ***(Policy monitoring, evaluation, research and learning framework at page 50 of the policy).*** In the end, young adult women between the ages of 18-21 are now left with policy interventions that do not adequately meet their sexual and reproductive needs, yet they have the legal capacity to make informed decisions on their sexual and reproductive health; and to access those services and commodities.

11. By making a blanket intervention, the Ministry of Health fails to give regard to both facts and evidence on teenage pregnancies and HIV and AIDS infections. The policy therefore in requiring parental consent fails to provide a guideline for parental consent; and especially where parental and guardian consent cannot be achieved without undue hardship. ***(3.4.8 paragraph 8 of the policy on access to reproductive health services for children at page 26 of the policy)***

12. This provision further limits the ability of health care workers to provide services to adolescents based on their evolving capacities and needs by requiring parental consent for health care services.

13. Additionally, the policy excludes unmarried women from fertility treatment; thereby denying them access to reproductive rights and options that are unrestricted for married women. Under the policy's ***broad objective 2 on improving responsiveness to client's reproductive health needs (page 21 of the policy)***, it is indicated as a sub-objective (v) as to reduce the magnitude of infertility and increased access to management of infertile couples. Under ***3.4.11 paragraph 5 of the policy (page 28),*** it is expressly indicated that there shall be full financing of at least one cycle of assisted fertility treatment but the same is limited to "needy desirous couples," which term has not been qualified effectively. In the end, the provision is vague and further discriminatory as it is an option limited to couples only, yet government resources are in use.

14. The policy also introduces unconstitutional and unethical practices that would require all pregnant women and their families to be tested for HIV thereby creating a barrier to access to critical maternal healthcare and commodities as well as disregard for the right to privacy, dignity as well as the right to adequate health which includes the aspect of informed consent as well as freedom from forced medical procedures ***(3.4.4 paragraph 2 of the policy at page 24).***

15. Following the launch of the Policy, the 4th Petitioner together with other organisations working in the right to health, women's rights and human rights sectors; grassroots human rights defenders; individual citizens and residents of different counties by a letter dated 22nd July 2022 continued to express their concerns with the unconstitutional provisions of the Reproductive Health Policy 2022-2032 that would serve to exclude certain vulnerable and marginalized

populations from accessing critical services. ***(A copy of the letter dated 22nd July 22 is attached and marked as NW-3)***

16. The direction of this Policy fails to take into account the reality that is young women and girls need sexual and reproductive health services even before the age of 18, because they are engaging in sex early, and are victims of sexual violence and are most vulnerable to HIV infection. The Ministry has estimated that in 2021 alone, adolescents aged 10 – 19 years accounted for 5,294 new HIV infections (at the rate of 98 new infections every week), that over 20.4% of all pregnancies were among adolescents aged 10-19 years, and has conceded that currently, adolescents and young women face a triple threat of new HIV infection, sexual and gender-based violence and adolescent pregnancies. (***See an excerpt of End Triple Threat Campaign by the Ministry of Health and the National AIDS Control Council marked NW-4)***

17. The 1st respondent has completely refused to engage in any discussion with the Petitioners or other stakeholders with regard to amendment or staying the implementation of the Policy to ensure the right to the highest attainable standard of health.

18. If this Court does not stay the implementation of this Policy, the rights of women and girls will continue to be severely limited, and there will be no way to redress the violations.

19. Given the foregoing, and in the interest of safeguarding the constitutional rights of reproductive health and the lives of the people of Kenya, I pray that this Honourable Court to grant the orders set out in the Notice of Motion pending the hearing and determination of the Application and the Petition.

16

20. What is deponed to herein is true to the best of my knowledge, information and belief, save for information whereof sources of information have been disclosed.

SWORN at **NAIROBI** by the said)
NERIMA WERE)
)
)
This 8th day of September 2022)
BEFORE ME)
WICKLIFFE O. OYOO)
Advocate & Commissioner for Oaths)
KAPLAN & STRATTON)
P. O. Box 40111 - 00100)
NAIROBI)
COMMISSIONER OF OATHS)

DEPONENT

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Tel: +254 704 594962
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18

This is Exhibit marked "A.W.K-1" referred to in the Annexed affidavit/Declaration of [illegible]

Sworn/Declared before me on this [illegible] day of [illegible] 20[illegible]

at [illegible] in the Republic of Kenya

Commissioner for Oaths

REPUBLIC OF KENYA

OP.218/051/2002/0155/2233

OFFICE OF THE PRESIDENT

19

CERTIFICATE OF REGISTRATION

I, PROF. WILSON KIPNG'ENO KOECH, Chairman of the Non-Governmental Organizations Board, certify that the xxx KENYA LEGAL AND ETHICAL ISSUES NETWORK ON HIV/AIDS xxx has this day been registered under section 10 of the Non-Governmental Organizations Co-ordination Act as applied for.

W.K. KOECH
Chairman of the Board

Dated 20TH DECEMBER, 2001.

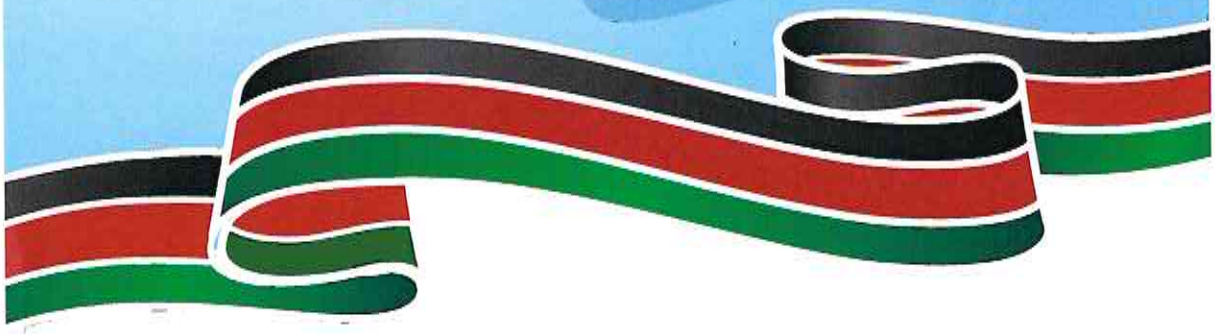
GPK 5004-500—1-2002

NM1

This is Exhibit marked "NW-2" referred to in the Annexed affidavit/Declaration of Nelima Wanyonyi
Sworn/Declared before me on this 5th day of October 2022 in the Republic of Kenya at Nairobi
Commissioner for Oaths

MINISTRY OF HEALTH

THE NATIONAL REPRODUCTIVE HEALTH POLICY 2022 - 2032



Towards the Highest Reproductive Health Status for all Kenyans

MINISTRY OF HEALTH

The National Reproductive Health Policy 2022 - 2032
is a publication of the Ministry of Health, Republic of Kenya

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TABLE OF CONTENTS

FOREWORD i

ACKNOWLEDGEMENTS ii

TECHNICAL NOTE iii

ABBREVIATIONS v

GLOSSARY OF TERMS viii

CHAPTER 1. PREAMBLE 1

1.1 Alignment to the constitution, policy and legal frameworks 3

1.2 Rationale for the Reproductive Health Policy 2020-2030 3

1.3 Methodology 4

CHAPTER 2. SITUATIONAL ANALYSIS 5

2.1 Introduction 5

2.2 SWOT & PESTEL analysis 5

2.3 Performance of Key Indicators on Reproductive Health 7

2.4 Policy Implementation Environment 16

CHAPTER 3. POLICY DIRECTION 19

3.1 Policy goal and overarching statement 19

3.2 RH policy objectives 20

3.3 Scope of the RH policy 21

3.4 Policy Thrust 22

CHAPTER 4. POLICY IMPLEMENTATION FRAMEWORK 31

4.1 Management and Coordination 31

4.2 Provision of RH services 34

4.3 Roles and Responsibilities 40

CHAPTER 5. MONITORING, EVALUATION, RESEARCH AND LEARNING (MERL) 47

LIST OF CONTRIBUTORS 48

FOREWORD

The National Reproductive Health Policy 2022 - 2032, herein referred to as "the Reproductive Health Policy" (RH Policy) reflects the commitment of the Government of Kenya to all persons in need and requiring reproductive services of the highest standard. Additionally, the policy guarantees achievement of universal Reproductive Health coverage to all persons in the country. This is consistent with the global call to action as espoused in the Sustainable Development Goals 3, 5 and 10, goals that if attained will ensure healthy lives and promotion of wellbeing through an entire life course, gender equality and significantly reduce inequality. The drafting of this policy took a multi-stakeholder consultative approach as informed by the Constitution of Kenya 2010, the Kenya Vision 2030 and the Kenya Health Policy 2014-2030. This is the first Reproductive Health policy to be developed within the context of a devolved system of governance in the country.

Since 2017, the Ministry of Health took lead in developing this Reproductive Health policy, reviewed the 2007 reproductive health implementation and factored in the current situation of Reproductive Health in the country. Overall some progress has been made on key indicators as per the initial policy objectives. However, there are pertinent areas that require urgent attention in order to accelerate progress in Reproductive Health gains in Kenya. Top on this urgent list is inequality in access to quality reproductive health interventions across the country; closely followed by gaps in addressing unique RH needs of specific populations (adolescents and young people; elderly persons; persons affected by reproductive tract cancers, persons with infertility; persons with disability; and persons in humanitarian settings and fragile contexts). Lastly on this list but by no means least, is inefficient operations of the health system building blocks (data systems; human resources; technology and products; research and infrastructure; and misaligned partnerships and collaborations) which hampered the optimal RH delivery of the previous Reproductive Health policy pronouncements.

This policy is timely, and will be a welcome enabler of **Universal Health Coverage** realisation in Kenya. The Government is committed to working closely with all players at the National and County levels in the execution of the pronouncement of this policy for the attainment of the highest standard of Reproductive Health for all Kenyans.

Sen. Mutahi Kagwe, EGH
Cabinet Secretary
Ministry of Health

ACKNOWLEDGEMENTS

The development of the National Reproductive Health Policy 2022 - 2032 was accomplished through the concerted efforts of many organizations, institutions, stakeholders and individuals.

Foremost, I acknowledge the Division of Reproductive and Maternal Health and the various techincal units of the MoH for spearheading this process.

Special acknowledgement goes to the County Governments, the Council of Governors, Constitutional Commissions & Independent Offices, Professional Bodies, Development Partners and Civil Society Organizations working in Reproductive Health Rights, who provided both technical and financial support for the development of this National Reproductive Health Policy.

I wish to acknowledge the Donor Community, Implementing Partners and Organizations who supported the Ministry to ensure that this document comes to pass. It is the Government's wish that this policy will be utilized by all stakeholders as a road map for providing quality reproductive and maternal health services across the nation as envisioned in the Constitution of Kenya 2010, Kenya Vision 2030, the Kenya Health Policy (2014 - 2030) and the relevant guiding international instruments.

Ms. Susan N. Mochache, CBS
Principal Secretary
Ministry of Health

TECHNICAL NOTE

This National Reproductive Health (RH) Policy is founded on the following key objectives:

1. To achieve universal Reproductive Health coverage through quality and comprehensive Reproductive Health interventions across the country

2. To improve responsiveness to client's reproductive health needs

3. To strengthen the enablers (Health Systems Building Blocks) for Reproductive Health, including aligning partnerships and collaboration.

Monitoring of this policy document, shall be as per the Kenya Health Sector Partnership and Coordination Framework MoH 2018 i.e through the Health Sector Inter Governmental Consultative Forum and the Inter Agency Coordination Committee for Reproductive Health, and will be guided by the following commitments:

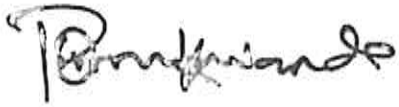
1. Reducing maternal, perinatal and neonatal morbidity and mortality
2. Reducing unmet family planning needs
3. Reducing the burden of Reproductive Tract Infections (RTIs) and improving access to, and quality of, RTI services
4. Reducing the HIV and AIDS burden and eliminating mother to child transmission (eMTCT) of HIV
5. Reducing morbidity and mortality associated with the common cancers of the reproductive organs in men and women
6. Mainstreaming special RH-related needs of people with disabilities, the elderly, people in humanitarian settings and fragile contexts.
7. Promotion of gender equity, elimination of medicalized FGM and eradication of all forms of gender-based violence and harmful reproductive health practices
8. Improving reproductive health outcomes among adolescents and young people
9. Reducing the magnitude of infertility and increased access to management of infertile couples

10. Promoting robust RH implementation environment especially data systems, research for development, innovation, collaborations, human resources for RH and RH partnerships

Qualifying Clause: The National Reproductive Health Policy is complementary to existing policies, and shall be the main reference policy on matters concerning Reproductive Health in Kenya.

Effective Clause: The National Reproductive Health Policy, becomes effective from the date of signature by the Cabinet Secretary for Health.

Review Date: This Policy should be reviewed as is deemed necessary in response to compelling new developments in the Reproductive Health environment in Kenya, preferably not later than the 10th year from the date herein when it comes to effect.



Dr. Patrick Amoth, EBS
Ag. Director General for Health

ABBREVIATIONS

AIDS: Acquired Immuno-Deficiency Syndrome

ANC: Antenatal Care

ARHD: Adolescent Reproductive Health and Development

ART: Antiretroviral treatment

CDoH: County Department of Health

CHMT: County Health Management Team

CPR: Contraceptive Prevalence Rate

CSO: Civil Society Organization

DFID: Department for International Development

DRMH: Division of Reproductive and Maternal Health

eMTCT: Elimination of Mother to Child Transmission

FBO: Faith-Based Organization

FGF: Female Genital Fistulae

FGM: Female Genital Mutilation

FP: Family Planning

HCW: Health Care Worker

HIV: Human Immunodeficiency Virus

HMIS: Health Management Information System

HPV: Human Papilloma Virus

HRH: Human Resources for Health

ICPD: International Conference on Population and Development

IDSR: Integrated Disease Surveillance and Response

IGRF: Intergovernmental relations forum

KDHS: Kenya Demographic and Health Survey

KEPH: Kenya Essential Package for Health

KHIS: Kenya Health Information System

KHP: Kenya Health Policy 2014-30

KMLTB: Kenya Medical Laboratory Technicians and Technologists Board

KNBS: Kenya National Bureau of Statistics

KOGs: Kenya Obstetrical and Gynecological Society

KHRC: Kenya Human Rights Commission

M&E: Monitoring and Evaluation

mCPR: Modern Contraceptive Prevalence Rate.

MDGs: Millennium Development Goals

MERL: Monitoring, Evaluation, Research and Learning

MNCH: Maternal Newborn Child Health

MOH: Ministry of Health

MPDSR: Maternal and Perinatal Surveillance and Response

MTCT: Mother to Child Transmission

NACADA: National Authority for the Campaign against Alcohol and Drug Abuse

NASCOP: National AIDS and STD Control Programme

NCK: Nursing Council of Kenya

NCPD: National Council for Population Development

NGO: Non-Governmental Organization

NHIF: National Hospital Insurance Fund

NMS: Nairobi Metropolitan Services

PEPFAR: President's Emergency Plan for AIDS Relief

PLWD: People Living with Disability

PMTCT: Prevention of mother to child transmission

RH: Reproductive Health

RTIs: Reproductive Tract Infections

SAGA: Semi-Autonomous Government Agencies

SDG: Sustainable Development Goals

SDGs: Sustainable Development Goals

SGBV: Sexual and Gender Based Violence

STIs: Sexually Transmitted Infections

UHC: Universal Health Coverage

UNFPA: United Nations Population Fund

UNICEF: United Nations International Children's Emergency Fund

VMMC: Voluntary Medical Male Circumcision

WHO: World Health Organization

WRA: Women of Reproductive Age

GLOSSARY OF TERMS

Abortion: Abortion means termination of pregnancy[1].

Adolescents: (from Latin adolescere 'to mature') is a person in the transitional stage of physical and psychological development that occurs during the period from puberty to adulthood. The WHO considers these persons to be aged 10-19 years , and the grouping includes children (persons below 18 years of age and young adults aged 18 and 19 years.

Adolescent-Friendly Services: Reproductive Health services delivered responsively and to specific needs of adolescents.

Age Appropriate: Suitability of information and services for people of a particular age.

Andropause: A gradual and highly variable decline in the production of androgenic hormones and especially testosterone in the human male together with its associated effects that is held to occur during and after middle age[2] – also called climacteric; male menopause.

Child: A person under the age of 18 years.

Child Abuse: Child maltreatment, all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development or dignity. Within this broad definition, five subtypes can be distinguished — physical abuse, sexual abuse, neglect and negligent treatment, emotional abuse and exploitation including sexualization of persons below 18 years of age[3].

Crisis: A time of intense difficulty or danger during pregnancy[4].

Female Genital Mutilation (FGM): Comprises all procedures involving partial or total removal of the female genitalia; or any other injury; or any harmful procedure to the female genital organs, for non-medical reasons which includes: - clitoridectomy, excision and infibulations, excluding a medical procedure done on the Female Genitalia by an expert for a medical therapeutic purpose[5].

Gender: Gender is a social construct about maleness or femaleness as it is determined by the socio-cultural attitudes, stereotypes, and norms in any

1 Britannica, T. Editors of Encyclopaedia (2022, January 18). abortion https //www.britannica.com/science/abortion-pregnancy)
2 Melmed, S., Polonsky, K. S., Larsen, P. R., & Kronenberg, H. M. (2015). WILLIAMS Textbook of. Endocrinology 13th.
3 Report of the Consultation on Child Abuse Prevention, 29–31 March 1999, WHO, Geneva. Geneva, World Health Organization, 1999 (document WHO/HSC/PVI/99.1)
4 https://www.merriam-webster.com/dictionary/crisis
5 World Health Organization. (1997). Female genital mutilation: a joint WHO/UNICEF/UNFPA statement. World Health Organization

given society. These constructs are learned and reinforced by the family structure, the educational system, the community, and the media.[6]

Gender Based Violence: Refers to any type of harm that is perpetrated against a person due to their gender.[7]

Gender Equality: The absence of discrimination based on a person's sex in opportunities, the allocation of resources and benefits, or access to services[8].

Gender Equity: The fairness and justice in the distribution of benefits and responsibilities between women and men. The concept recognizes that women and men have different needs and power, and that these differences should be identified and addressed in a manner that rectifies the imbalance between the sexes .[9]

Infertility: A medical diagnosis of the failure of a male and a female to achieve pregnancy after 12 months or more of regular sexual intercourse[10].

Intersex: A congenital condition of sex development in which the development of the chromosomal, gonadal or anatomic sex is atypical leading to ambiguous genitalia making it difficult to identify their sex at birth and before development of secondary sexual characteristics at puberty.[11]

Health: A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity

Life Skills Education: Education geared towards character development of individuals to equip them with values, appropriate knowledge on risk-taking behaviors and develop skills such as sexual risk avoidance, communication,assertiveness, self-awareness,decision-making, problem-solving,inter-personal relationships, critical and creative thinking to protect from and respond to abuse and exploitation and to help children to practice abstinence[12].

Maternal near-miss: A woman who nearly died but survived a complication that occurred during pregnancy, childbirth or within 42 days after the termination of pregnancy[13].

Marginalized groups: Means a group of people who are disadvantaged

6 Fast, I. (1984). Gender identity: A differentiation model (Vol. 2). Lawrence Erlbaum Assoc Incorporated.
7 UNHCR Policy on the Prevention of, Risk Mitigation and Response to Gender-based Violence, 2020
8 convention-on-the-elimination-of-all-forms-of-discrimination-against-women-cedaw-United Nations Treaty Collection UN.ORG archived Sept 2011, retrieved Feb 2021
9 http://www.euro.who.int/en/health-topics/health-determinants/gender/gender-definitions
10 World Health Organization (WHO). International Classification of Diseases, 11th Revision (ICD-11) Geneva: WHO 2018.
11 Lee, P. A., Houk, C. P., Ahmed, S. F., & Hughes, I. A. (2006). Consensus statement on management of intersex disorders. Pediatrics, 118(2), e488-e500
12 Conger, D. S., & Mullen, D. (1981). Life skills. International Journal for the Advancement of Counselling, 4(4), 305-319
13 Say, L., Souza, J. P., & Pattinson, R. C. (2009). Maternal near-miss–near-miss standard tool for monitoring quality of maternal health care. Best practice & research Clinical obstetrics & gynaecology, 23(3), 287-296.

by discrimination on one or more of the grounds in Article 27(4) in the Constitution of Kenya.[14]

Menopause: The time in a woman's life when she stops having a menstrual period and is no longer fertile. The time leading up to menopause is called the menopausal transition, or perimenopause. Often diagnosed after one has gone for 12 months without a menstrual period[15].

Non-State Actors: An entity that is not part of any state or a public institution. They range from grassroots community organizations to non-governmental organizations, philanthropic foundations, and academic institutions.

Opinion of a Trained Health Professional: The documented outcome after taking history of presenting illness, performing a physical examination, reviewing results of relevant tests, and treatment advised by a trained health professional.

Orphan: A child below 18 years of age whose mother (maternal orphans) or father (paternal orphans) or both (double orphans) are dead.

Persons with Disability: An individual with physical, sensory, mental, psychological or any other impairment, condition or illness that has, or is perceived by significant sectors of the community to have a substantial or long-term effect on their ability to carry out ordinary day-to-day activities[16].

Public health services: Healthcare services that are concerned with the science and art of preventing disease, prolonging life, and promoting health through organized efforts and informed choices of society, organizations (public and private), communities, individuals, and are concerned with threats to the overall health of a community.

Post Abortion Care (PAC): Consists of emergency treatment for complications related to spontaneous or induced abortion1, including evacuation of residual products of conception, treatment of attendant infections like sepsis, post-traumatic counselling, future conception planning and counselling, provision of contraceptives to prevent unplanned pregnancy and evaluation for STI and HIV/AIDS.

Reproductive Health: Reproductive health refers to the condition of male and female reproductive systems during all life stages[17]. WHO further qualifies reproductive health to include a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, in all

14 National Collaborating Centre for Determinants of Health, COCKERHAM, C. (1948). SOCIAL POLICIES AND HEALTH INEQUALITIES. Organization, 1.
15 Soules, M. R., Sherman, S., Parrott, E., Rebar, R., Santoro, N.,Utian, W., & Woods, N. (2001). Executive summary: stages of reproductive aging workshop (STRAW) Park City, Utah, July, 2001. Menopause, 8(6), 402-407.
16 The Persons with Disabilities Act, 2003, KLRC
17 Reproductive Health (nih.gov) accessed Feb 2022

matters relating to the reproductive system, its functions, and processes[18].

Reproductive Health Rights: The basic right of all couples and individuals to decide competently, freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of reproductive health. Includes the right to make decisions concerning reproduction free of discrimination, coercion and violence[19].

Sex: Biological state of being male or female.

Sexual Violence: Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic a person for sexual exploitation, using coercion, threats of harm or physical force, by any person. Includes: - forced sexual relations; sexual coercion; rape and sexual abuse of children.

Sexual Offence: This includes defilement, rape, incest, sodomy, bestiality and any other offense prescribed in the Sexual Offences Act[20].

State Actors: Government ministries, departments and agencies.

Supportive Supervision: A process of guiding, helping, building capacities, and learning from staff at their places of work.

Total market approach: When public and private players coordinate to jointly meet the healthcare needs of a population and leverage the strengths of each player to maximize the reach and quality of services[21].

Universal Access: The effective physical and financial access to health services by all.

Universal Healthcare: Organized healthcare systems built around the principle of universal coverage for all members of society, combining mechanisms for health financing and service provision.

Universal Health Coverage (UHC): Ensuring that everyone who needs health services can get them without undue financial hardship[22].

Vulnerable children and young persons: Children and young persons at high risk of lacking adequate care and protection14. The term includes orphans and street children as well as vulnerable adolescents: - living with HIV and AIDS; with disabilities; living in informal settlements; in the labor market;

18 Reproductive health (who.int) accessed Feb 2022
19 Freedman, Lynn P.; Isaacs, Stephen L. (1993). "Human Rights and Reproductive Choice". Studies in Family Planning. 24 (1): 18–30
20 The Sexual Offenses Act, No.3 of 2006, Laws of Kenya, Kenya Law Review Commission
21 Total market approach | FP Financing Roadmap, USAID, Accessed Feb 2022
22 Universal Health Coverage (who.int). World Health Organization, accessed Feb 2022)

who are sexually exploited; living below the poverty line and children affected by disaster, civil unrest or war as well as those living as refugees or dysfunctional family units.

Youth: The collectivity of all individuals in the Republic Who – (a) have attained the age of eighteen years; but (b) have not attained the age of thirty-five years[23]."

23 Constitution of Kenya, Cap 17 Article 260, Republic of Kenya, 2010

CHAPTER 1. PREAMBLE

This policy has been developed through a lengthy consultative process over several years involving multiple stakeholders to ensure everyone has a say, but retaining the people of Kenya in the driving seat to have their way on matters of Reproductive health within Kenya's progressive socio-cultural tenets.

Reproductive health is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity in all matters relating to the reproductive system and its functions and processes. Optimal reproductive health is core to the national development agenda as it is a key determinant of a nation's population health, the latter being a premier resource of any nation.

This policy is anchored on the philosophy of leaving no Kenyan behind on matters of reproductive health and seeks to cement responsible reproductive health rights enjoyed within bounded rationality as personal liberty prioritized for resource allocation.

Over the years, Kenya has made significant strides in improving the socioeconomic status of her citizens. Indeed this policy comes into effect at a time Kenya has transitioned to a Middle Income Economy[24] in which previous bilateral donors are seeking to trade with Kenya as she moves towards economic independence. Over the next decade, Kenya is projected to experience a significant increase in demand for reproductive health services as the nation continues to increase life expectancy while enjoying a modest annual growth rate of 2.2%, with close to a quarter of her population being adolescents. (Ref census 2019[25]). There is thus a need to consolidate the gains made so far, while concurrently addressing both the preexisting and the emerging gaps in reproductive health.

Previous investments in health including control of infectious diseases, maternal and child health services among others, have resulted in a significant decline in premature mortality and a gain of more than 10 years in life expectancy in the period 2004-2016[26]. In reproductive health, investment in family planning has seen a two-fold drop in unmet need for family planning in the past 10 years. Despite

24 Kenya becomes a middle-income economy - Business Today Kenya, NMG accessed 24 Feb 2022
25 Kenya Population and Housing Census: Volume III ISBN: 978-9966-102-11-9, Kenya National Bureau of Statistics, 2019
26 Kenya Population and Housing Census: Volume III ISBN: 978-9966-102-11-9, Kenya National Bureau of Statistics, 2019

Optimal reproductive health is at the core of national development because of its critical role in determining population dynamics.

these gains, more needs to be done to reduce the number of women dying due to pregnancy and childbirth complications currently standing at 352 women per 100,000 live births[27]. Additionally, public outcry about adverse reproductive health outcomes of adolescents and young people such as; teenage pregnancies, the resurgence of reproductive tract infections, HIV and AIDS, Female Genital Fistulae (FGF), Female Genital Mutilation (FGM), child marriages, sexual violence, drug and substance abuse, and negative social media influence, is getting ever louder. These unsettling reproductive health adversities have been partly driven by persisting inequalities in access to reproductive health services, suboptimal quality of services provided, limited information and capacity of populations to make informed demand of services, and challenges in aligning partnerships and collaborations in the reproductive health space with the Country priorities.

This reproductive health policy, being a public policy, generously borrows from the diverse policy typologies to apply the most feasible alternative to address the policy issue under consideration. One will thus see distributive, redistributive, facilitative, regulatory, and restrictive policy thrusts that seek to complement or guide the larger Kenya health policy space.

This Policy is informed by the Kenya Constitution 2010, the previous Reproductive Health Policy 2007; Kenya Health Policy 2014-2030; The Kenya Vision 2030, The Kenya Medium Term Expenditure Plans, The Kenya ICPD at 25 Nairobi Summit commitments, the Sustainable Development Goals (SDGs), domestic and domesticated global instruments, treaties as well as a growing body of research on best practices in reproductive health, to list but a few.

The National Reproductive Health policy 2022-2032 seeks to consolidate the gains achieved during the previous policy period and address the emerging challenges in reproductive health. This policy addresses the six RH operational life course cohorts[28]. Pregnancy and the newborn (up to 28 days of age); 2) Childhood (28 days to 9 years); 3) Adolescence (10 to <18 years); 4) Early youth (18 to 24 years); Adulthood (25 to 49 years) and 6) Elderly (50 years and over).

27 Kenya Demographic and Health Survey, 2014, KDHS 2016, Kenya National Bureau of Statistics
28 Mortimer, Jeylan T., and Michael J. Shanahan, eds. Handbook of the life course. Springer Science & Business Media, 2007

1.1 Alignment to the constitution, policy and legal frameworks

Reproductive health is addressed within various policy and legislative frameworks. The Constitution of Kenya 2010 provides for the right of every person to the highest attainable standard of health including reproductive health and the right to life. Other legal frameworks include the Sexual Offences Act (2006), Children's Act (2001), Counter Trafficking in Persons Act (2010), Prohibition of FGM Act (2011), Person With Disability Act (2003), HIV and AIDS Prevention and Control Act (2006), Marriage Act (2014), National Youth Policy (2007), Sessional Paper No. 3 on Population Policy for National Development (2012), Gender Policy in Education (2007), Kenya Health Policy (2014-2030), Kenya Health Sector Strategic and Investment Plan (2014-2018), Education Sector Policy on HIV and AIDS (2013), National School Health Policy (2009), National Gender-Based Violence (2014), , National policy on older persons and ageing 2014, Kenya Vision 2030 and the Health Act, 2017.

Achieving Universal Health Coverage within limited resources in the context of sustainable development goals further cements the urgency and need for this RH policy.

Kenya devolved governance through the Constitution of Kenya 2010 and adopted a National government and forty-seven (47) County governments. The RH policy takes cognizance of the specific distinct but complimentary functions of the two levels of governments, as outlined in the fourth schedule in which the National government mandate spans Health policy; national referral health facilities; capacity building, technical assistance, norms, standards and guidelines, while County Governments are mandated to take charge of County health services, including county health facilities and pharmacies; ambulance services; and promotion of primary health care; among other responsibilities as laid out in the fourth schedule[29].

1.2 Rationale for the Reproductive Health Policy 2022-2032

This policy is developed as a constitutional core mandate of the Ministry of Health to direct and guide the country on how to reduce the heavy burden of preventable reproductive health morbidity and mortality. Achieving

29 Fourth Schedule. Distribution of functions between National and the county governments

Universal Reproductive Health Coverage within limited resources in the context of sustainable development goals further cements the urgency and need for this RH policy.

This policy provides overall guidance for all stakeholders in the reproductive health sector and is the principal reference document in matters of RH. Prior to this RH policy, was the 2007 Reproductive health policy, which is now reviewed to ensure it addresses the following:

1. Alignment of RH programs with constitutional provisions which include the devolved system of governance with distinct mandates between the national and county governments and increased focus on quality and equitable health as a human right enshrined in the Constitution of Kenya, 2010;
2. Urgent need to formalise and mainstream overarching national RH priorities, including focus on Universal Health Coverage (UHC), NCDs, Kenya's commitment to the attainment of the Sustainable Development Goals (SDGs)
3. Dwindling financing – Kenya is now classified as a middle-income country and this has affected resource mobilization with more emphasis going to domestic financing of health programmes including RH;
4. Increased need for RH services with a high population of adolescents, large proportion of aging population, emerging conditions such as NCDs previously unforeseen existential threats like COVID19 Pandemic, all these in the canvas of persisting suboptimal RH outcomes in Kenya;
5. Challenges in partner coordination, alignment and stakeholder management in the context of RH.

1.3 Methodology

This RH policy was developed using a participatory mixed method approach. The policy development process employed both qualitative and quantitative methods that included but were not limited to: desk reviews, key informant interviews, focused group discussions, systematic review of research evidence and public participation. The consultative process involved both the public, private and non-state actors at both National and county level led by the Ministry of health through a nominated national steering committee operation as indicated in the 2015 national quality management system of the MOH.

CHAPTER 2. SITUATIONAL ANALYSIS

2.1 Introduction

Kenya's human population was estimated at 47.6 million in 2019 within 12 million households, with an estimated household size of 3.9 persons and a life expectancy of 66.4 years (KNBS). The high birth rate and declining mortality rate serves to maintain a population growth rate of 2.2% per year. The high child and youth population bulge present opportunities for reproductive health and economic development. Specifically, there are challenges for responsive reproductive health services to a largely dependent and increasingly young urbanized population in Kenya. Additionally, there is the emerging reality for older population reproductive health services requirement in Kenya with the increased life expectancy. The trend of improving health that is driven by reductions in communicable diseases is diminished by the emerging burden of non-communicable diseases and conditions such as violence, injuries, gender-based violence and cancers. The COVID-19 pandemic, caused by a novel corona virus SARS-CoV-2 has so far proven to be a health system wrecking ball across the world, and is a vivid testimony that new and unforeseen threats can be major setbacks to decades of health gains. Risk mitigation and disaster preparedness must be an integral part of health planning going into the future.

2.2 SWOT & PESTEL analysis

Review of the internal and external environment resulted in the identification of strengths, weaknesses, opportunities and threats with regard to RH in Kenya. These are highlighted in the tables in the next page;

2.3 Performance of Key Indicators on Reproductive Health

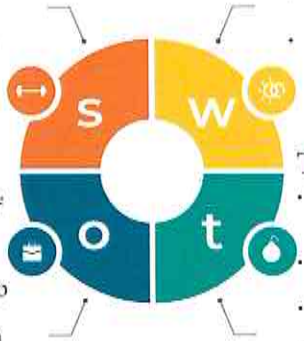
The elapsed reproductive health policy 2007 objectives were to: reduce maternal, perinatal and neonatal morbidity and mortality; reduce unmet family planning needs; improve the reproductive health of adolescents and youth; promote gender equity and equality in matters of reproductive health, including access to appropriate services; contribute to a reduction of the

Strengths

- Availability of data to inform strategies and interventions
- Well trained human resource
- Devolved health care services
- Partners committed to the delivery of RH services
- Literate populace who can be educated on importance of RH
- Health as a right in the Constitution and singling out of RH
- Existence of ongoing health programmes like UHC

Weakness

- Low level of prioritization of RH reflected in the resource allocation
- Weak structures for effective advocacy and coordination of RH issues at the county level
- Weak monitoring and evaluation mechanisms
- Inadequate allocation of funds



Opportunities

- Partnership with private sector in the delivery of heath
- Growing investment in the health sector
- Support from UN agencies like WHO
- Existing programmes like UHC: Beyond Zero provide a rich platform for RH mainstreaming in their core roles
- Pilot UHC experiences in county programmes to promote health like in Kitui, Nyeri, Isiolo, Kakamega, Kisumu & Makueni Counties
- High mobile telephone penetrance has created opportunities for digital UHC acceleration.
- Research and learning

Threats

- Competing development needs at the National and County level which affect the delivery of health
- Competition in the health programmes considering the
- Centrality of RH in other health Programme
- Reclassification of Kenya as a middle-income economy and changing donor priorities
- Management of HR in the health sector and the rising number of industrial relations which affects service delivery
- Emerging Pandemics like Covid-19
- Insecurity and tribal clashes

Figure 1: SWOT Analysis

42

PESTEL ANALYSIS	
Political factors	• Corruption • Legislative priorities • Government stability • Suboptimal Human resource for health (HRH)
Economic factors	• Economic growth inconsistency • Budgetary deficits at National and county levels • Growing National debt • Over-dependence on foreign support
Social factors	• Harmful socio-cultural practices (violence against children; FGM, Child marriage) • Inadequate distribution of social services (UHC) • Religious and cultural extremism.
Technological factors	• ICT advances with the possibility of developing and adopting technologies to advance and promote access to essential services.
Environmental factors	• Adverse environment negatively impacting RH • Climate change - fueling conflict • Vested interests in RH advocacy leading to a skewed environment.
Legal factors	• Law enforcement – e.g. on FGM • Contextual conflicts of international instruments

Figure 2: PESTEL Analysis

HIV and AIDS burden and improvement of the RH status of infected and affected persons; reduce the burden of reproductive tract infections (RTIs) and improve access to, and quality of, RTI services; reduce the magnitude of infertility and increase access to efficient and effective investigative services for enhanced management of infertile couples; reduce morbidity and mortality associated with the common cancers of the reproductive organs in men and women; address RH-related needs of the elderly; and address the special RH-related needs of people with disabilities. The following subsections provide a performance review of key indicators on reproductive health rights in Kenya.

2.3.1 Reduce maternal, perinatal and neonatal morbidity and mortality

Utilization of Antenatal Services:

Coverage of the first visit of antenatal care (ANC) was nearly universal with over 95% of pregnant women making at least one ANC visit (KDHS 2014, KNBS). The proportion of pregnant women who made 4 or more ANC visits was much lower but increased from 47% in the KDHS 2008/09 to 58% in

2014. In between the population-based periodic surveys, service statistics from the DHIS2 showed an increase from 32.6% in 2017 to 53% in 2021.

Skilled Delivery

Health facilities births which are taken as a proxy for the skilled birth attendance increased from 43% (KDHS, KNBS 2008/09) to 61% (KDHS2014 KNBS), this increase resulted in an attendant rise in Caesarean section rates from 7.6% to 9.5% almost entirely the result of more women delivering in health facilities. The KHIS data (Figure 4) supports a similar upward trend in skilled birth attendance and caesarian section rates since the last KDHS to date same trend as in Caesarean section deliveries from 14.5% in 2017 to 16.2% in 2021

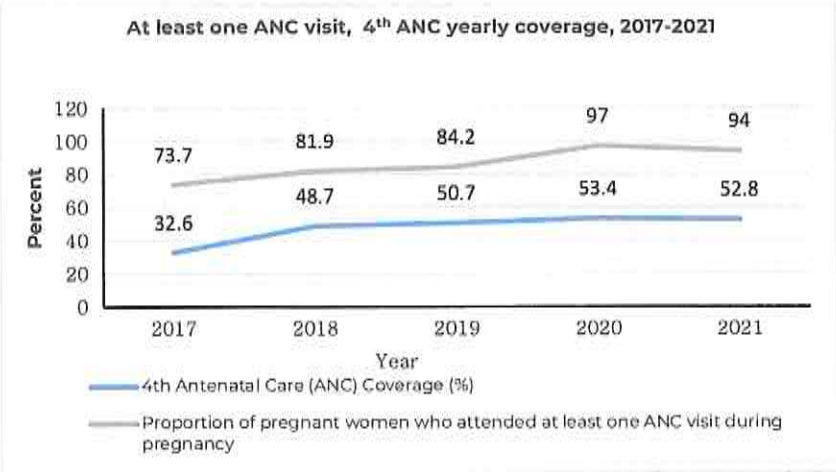


Figure 3: ANC Coverage

However, the changing trend is not homogeneous across the country when compared across the 47 counties. The continued decline of institutional maternal mortality ratios could suggest that health facilities were able to keep up with the increased utilization of these facilities for birthing services.

Post-natal care

Postpartum care is a key strategy to enhance maternal and newborn health and reduce deaths. However, utilization of postnatal care services in Kenya has remained low. The 2014 Kenya Demographic Health Survey reports that only 52% of women and 36% of newborns receive postnatal care. Low utilization of postnatal care leads to missed opportunities for early diagnosis and management of common puerperium and newborn complications or conditions, low rates of repeat maternal HIV testing and initiation of antiretroviral drugs for treatment and prophylaxis in HIV exposed infants as

44

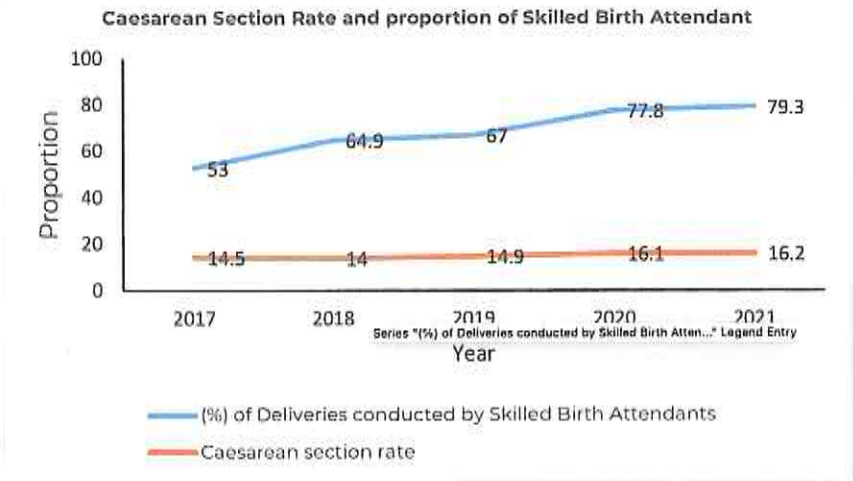


Figure 4: Skilled birth attendance

well as low uptake of contraceptives.

Maternal Mortality

The population-level maternal mortality ratio reduced from 520 per 100,000 live births (KDHS, 2008 -2014, KNBS) to 362 per 100,000 live births, maintaining a trend since 1993 as shown in figure 5.

In between the periodic population-level survey, service statistics from the KHIS data also showed a progressive decline in Health Facility Maternal Mortality ratios from 130 per 100,000 live births in 2013 to 95 per 100,000 live births in 2019. The continued decline in institutional maternal mortality ratios suggests that health facilities were able to cope with the increased utilization of skilled birth services. As a quality measure, maternal death audits in Health facilities have increased from 89.5% in 2018 to 96.9% in 2021 due to improved monitoring and reporting. The top five direct causes of maternal deaths were hemorrhage, hypertension in pregnancy, infections/ sepsis, obstructed labour and post abortion complications (CEMD, MOH, 2017[30]).

Pregnancies with abortive outcomes regardless of the cause, method or rationale, carry a significant risk of morbidity and mortality and thus this policy will strengthen health systems to mitigate morbidity and mortality from post-abortion complications while minimizing preventable causes of abortion. This policy expands the management of pregnancy to include holistic management, and psychosocial support for pregnancies compounded by a crisis. Specific guidelines mainstreaming pregnancy-

30 CEMD, MOH, 2017

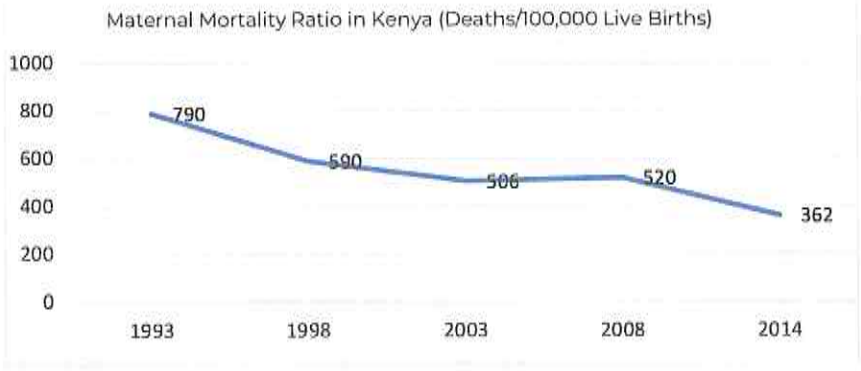


Figure 5: Maternal mortality Ratio in Kenya (Deaths/100,000 live births)

related crisis management and standardizing the practice of managing crisis in pregnancy shall be formulated to fully operationalize this policy direction.

In their conceptual framework, Thaddeus and Deborah articulated the three-delay model[31] of the causes of maternal deaths; 1st delay is the decision to seek care, 2nd delay is in reaching a health care facility and 3rd delay is receiving appropriate treatment and management. The Three Delays Model demonstrates that maternal mortality is not solely due to poor quality of health care but is a result of interwoven factors in the community, health care system, and other socio-economic variables, and this model continues to guide priority investments to address causes of maternal deaths.

Perinatal Mortality

Perinatal mortality rate had decreased from 37 deaths per 1,000 pregnancies reported in the 2008-09 KDHS to 29 deaths per 1,000 pregnancies in KDHS 2014. Data from KHIS showed overall institutional stillbirth rate declined from 23 to 21 per 1000 births in 2017 and 2018 respectively, and 20 to 19 per 1000 births in 2019 and 2020. The fresh stillbirth rates which is an indicator of quality-of-care also had a decline from 13 to 11 per 1000 births in 2017 and 2018 and 10 to 9 in 2019 and 2020. The main causes of perinatal mortality are prematurity, birth asphyxia, sepsis and respiratory distress syndrome.

2.3.2 Reduction of Teenage Pregnancy

The rate of teenage pregnancy has remained unchanged over the decades at a rate of about 18% and remains an ongoing concern for the nation.

31 Thaddeus, Sereen, and Deborah Maine. "Too far to walk: maternal mortality in context." Social science & medicine 38.8 (1994): 1091-1110

This policy recognizes the multiple players and prongs that intersect in teenage pregnancy as well as the social and cultural contributions to the same. This policy shall prioritize scientific effective interventions to reduce teenage pregnancy and motherhood in a multi-sectoral collaborative and enforcement approach.

2.3.3 Reduction in unmet family planning needs

Kenya Demographic Health Survey, 2014 reported a dramatic increase of use of modern contraceptives among currently married women 15-49 years during the 5 years, increasing from 32% in 2003 to 39% in 2008/09 and 53% in 2014 with significant disparities between counties. PMA 2020 data indicates mCPR continues to increase now standing at 60% among married women of reproductive age (MWRA). The percent of demand satisfied by modern method has increased from 64% in 2008/09 to 71% in 2014 among currently married women. There is minimal rural-urban variation in current modern contraceptive use by married women 15-49: 51% and 51% respectively. Women in the poorest wealth quintile however had much lower contraceptive use (29%) than all other quintiles where use ranged from 54-60%. Figure 6 below shows this trend.

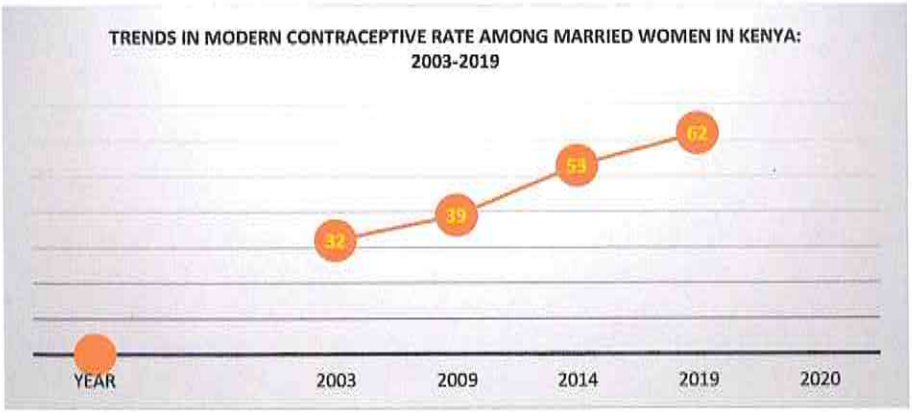


Figure 6: Trend in modern contraceptive rate among married women in Kenya: 2003-2019

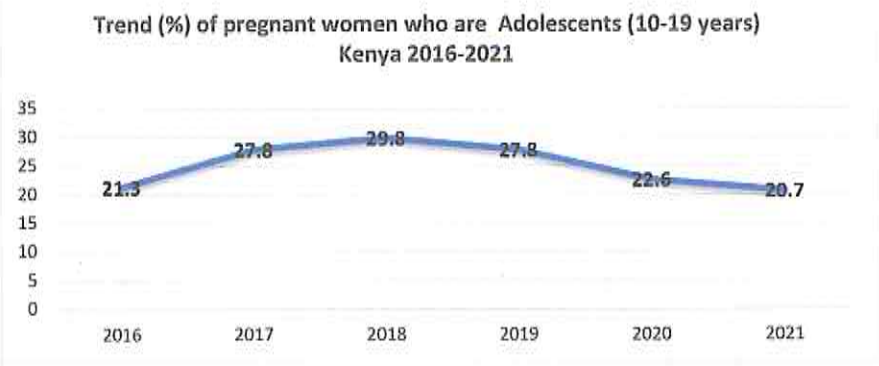


Figure 8: Trend of percentage of pregnancy women who are adolescent

2.3.4 Adolescent/Youth Reproductive Health

Adolescent health constitutes an ongoing challenge. Childbearing begins early in Kenya, with almost one-quarter of women having given birth by age 18 and nearly half had started childbearing by age 20 when asked at the KDHS. Age specific fertility rate for 15-19-year-old has decreased from 103 in 2008/9 to 96 in 2014[32]. However, the proportion of adolescent women age 15-19 already mothers or pregnant with their first child at the time of the KDHS survey remained unchanged from 18% reported in 2008/9.

A recurring challenge has been the failure to develop a dignified transition from childhood to adolescent and onto young adulthood including parenting and guardian support. The majority of reproductive health challenges facing adolescents and young women are related to this gap in programming. A significant proportion of young people continue to have incorrect perception or invisibility of their risks to early sexual debut; acquiring sexually transmitted infections, HIV, alcohol, drug and substance abuse as well as negative impact of social media. This suggests a need to promote programmes that will reverse this pattern over time including support during the transition of cognitive maturity and limited decision-making capacity as minors. Related to this is a need to clarify the age of consent for the various RH interventions in view of the varied provisions in different guidelines and lack of explicit legal pronouncements on the same. Structural prevention interventions such as protection from pornography, keeping children and young people in school or gainful engagement, free sanitary towel programs for girls, cash transfer social protection programs, physical protection corridors – after school transit programs, safe houses and justice for minors who are SGBV survivors are suboptimal.

32 KNBS 2010, 2015

2.3.5 Gender issues and reproductive health rights

Gender-based violence is prevalent in Kenya. According to KDHS 2014, 45 percent of women aged 15-49 had experienced physical violence and 20 percent had experienced physical violence within the 12 months prior to the survey compared to 39 percent and 24 percent respectively in 2008. KDHS 2014 further estimated that 44 percent of men age 15-49 experienced physical violence and 12 percent experienced physical violence within the 12 months prior to the survey. The main perpetrators of physical violence against women were husbands, whereas, the main perpetrators against men were parents, teachers, and others. 14 percent of women and 6 percent of men age 15-49 reported having experienced sexual violence at least once in their lifetime. Overall, 39 percent of ever-married women and 9 percent of men age 15-49 reported having experienced spousal physical or sexual violence. Among women and men who had ever experienced spousal violence (physical or sexual), 39 percent and 24 percent, respectively, reported experiencing physical injuries. 44 percent of women and 27 percent of men sought assistance from any source to stop the violence they experienced.

Female Genital Mutilation, a form of GBV is rampant in Kenya with a national average prevalence of 21% nationally with some counties having a prevalence of over 90%. Child marriage also persists in Kenya. The Kenya health information system (KHIS) has in the recent 5 years collected data on routine SGBV service in health facilities across the country. Only 1% of the sites report routinely and the quality of services based on reported data for cases seen is suboptimal going by the cases of emergency contraceptive, post-exposure prophylaxis (PEP) for HIV interventions given to those in need, mental health interventions and trauma support to survivors.

The violence against children national survey in 2019 in Kenya indicated that in the previous 12 months, 13.5% of females and 2.4% of males ages 13-17 experienced sexual violence often by persons known to them.14 56.7% of 13-17year-old females who experienced any incident of sexual violence in the past 12 months told someone about their experience. Only three in ten (31.8%) 13-17-year-old females who experienced sexual violence in the past 12 months knew of a place to seek help. Among 13-17-year-olds, about 36.8% females and 40.5% males experienced physical violence in the past 12 months. 42.4% of females and 31.4% of males were physically injured as a result of the violence. Only 6.0% of females and 5.7% of males sought help for an experience of physical violence, and 4.4% of females received help.

Children and adolescents (boys and girls) who suffer sexual abuse are more likely to be exposed to physical injury (including death) unintended pregnancy, post-abortion complications, sexually transmitted infections including HIV, and mental health complications (11). Child and Sexual abuse; Raising awareness and empathy is essential to promote a new public health response (3).

While health is the priority at the time of experiencing sexual and gender violence, access to justice after the ordeal is essential in ensuring survivors' recovery and integration into the community without stigma and discrimination. Significant work remains undone to ensure effective, well-coordinated integrated coordination and response mechanisms that ensure survivors receive the appropriate support

2.3.6 HIV and AIDS and Sexually transmitted infections

HIV prevalence has remained stable at about 5% for the last 5 years with geographical variation ranging from a low of 0.4% in Wajir to a high of 26% in Homa Bay. The country achieved 20% reduction on sexual transmission of HIV and 49% reduction of new infection among children. The advances in HIV treatment is manifested by an aging population of people living with HIV. There has been expansion of the prevention of new HIV interventions including expanded coverage of Voluntary Male medical circumcision (VMMC), Pre-exposure prophylaxis (Prep) and other combination prevention approaches. However, there is the continuing trend of high prevalence of new infections among young people. In 2016, adolescent girls and young women accounted for 51% of the new HIV infections among adults a sharp rise from 29% in 2013. This was both proportionate and absolute increase in number of new infections. Targeted interventions are needed for adolescents 15-24 years in order to tackle increasing new HIV infections. Additionally, a final push is needed to eliminate mother-to-child transmission and increase the proportion of pregnant women who receive anti -retroviral for HIV from 91% in 2018 to near or 100%.

Progress towards validation for elimination of MTCT of HIV

Kenya has committed to eliminate MTCT of HIV and is part of the global accountability target-based validation mechanisms for elimination of MTCT of HIV. In 2015 more than half (24) of the 47 counties significantly reduced their new HIV infections among children. The trend in declining MTCT transmission of HIV have reversed, with 2018 estimates at 12.8%, up from 6.7% in 2016. These worrying trends are not limited to MTCT of HIV. In the same review, an estimated 0.3 million women had not initiated antenatal care while only half of those who initiated achieved 4 visits, and 0.5 million women did not access an HIV test. Inadequate quality of health services was the biggest contributor to infant infections, identified positive women not given ART and poor ART adherence during pregnancy and breastfeeding and new infections during breastfeeding. Most of these infant infections could be averted with greater fidelity and rigor to implementing MNCH-PMTCT care package and HIV transmission prevention protocols.

2.3.7 Cancers of reproductive organs

The three cancers with the highest number of newly diagnosed cases in Kenya affect the breast, the cervix and the prostate. GLOBOCAN 2020, estimates show that cervical cancer causes the highest mortality at 12% and among the top 10 cancers in Kenya, slightly higher than breast cancer which was at 11.5 %. Screening for reproductive organ cancers for men and women has remained low. The recommended screening cycle for cervical cancer in Kenya is every 5 years for women aged between 25-49 years with the exception of HIV-positive women who should be screened annually. Cervical cancer screening has remained quite low. In the KDHS 2014, only 18.8% of women 25-49 years had ever had cervical cancer screening. In STEPS 2015, cervical cancer screening coverage rates were similarly low, with 14.2% of women 25-49 years ever screened. Kenya has rolled out universal school-age girls HPV vaccination program after a successful pilot phase.

2.3.8 Infertility and sexual dysfunction

In Kenya, it might be assumed that most married couples with no births are unable to physiologically bear children. The fulfillment of fertility desires is a fundamental human right relevant to the achievement of the International Conference on Population and Development (ICPD) call to action and sustainable development goals (SDGs). However, millions of people are unable to realize this right for a variety of reasons, including infertility. A majority of gynecological consultations are related to infertility. While the underlying challenge may half of the time be associated with the male or the female partner, due to the high level of stigma the data available is mostly among women. The percentage of women who are childless at the end of the reproductive period is an indirect measure of primary infertility (the proportion of women who are unable to bear children at all). Though primary infertility is less than 2 percent (KNBS, 2015), there is a burgeoning population of families affected by secondary infertility affecting close to a third of families, putting an urgent case for specific measures to assist couples to raise their desired family size. The prevalence of sexual dysfunction is not established and there is limited access to formal health services to address it. There is stigma and shame in society associated with sexual dysfunction. As a result, most Kenyans are exposed to over-the-counter drugs which are poorly monitored self-medication in an attempt to enhance sexual performance which exposes them to life-threatening adverse effects.

2.3.9 Menopause and andropause

While there has been an increase in life expectancy over the past decade, little has been achieved in terms of addressing geriatrics health including reproductive

health challenges. Men's health clinics and workplace health programs targeting men in their different cohorts have been suboptimal. Additionally, there is limited data on the needs and response landscape that hampers any investment in this area. With the increase in non-communicable disease burden, it is also critical that related issues in the context of reproductive health are well integrated and addressed to ensure healthy and dignified aging.

The National Government in consultation with County Governments shall establish Wellness Centres to serve elderly men and women's reproductive health needs and provide preventive services in a life-course approach.

2.4 Policy Implementation Environment

1. The ICPD25 commitment for Kenya by 2030 is zero maternal deaths, zero unmet needs for family planning and zero gender-based violence and harmful practices by 2022. This RH policy creates the enabling environment to realise these three zeroes by 2030.
2. There is a growing population of young people and therefore interventions need to be approached through this lens of scale. Inequitable coverage with RH services among certain areas or population groups, including adolescents need to be addressed.
3. Health governance structures - County RH data uploaded to a national health information management system allows for greater granularity in problem identification, but at the same time courts fragmentation which can be a barrier to rapid scale-up of evidence-based interventions given the many layers and players involved. Health services are provided for by the County Governments. Greater advocacy and capacity building are required at this level to facilitate prioritization of RH and the comprehension that RH is at the centre of human development, healthy individuals, families and communities. There is an opportunity for moving away from piece-meal partner driven implementation of skewed RH interventions to a composite comprehensive domestically funded RH intervention implementation model for the country.
4. Reduced external funding support due to re-classification as a lower middle-income Country. Donor funding of most of the RH commodity has supported the scale up of RH and many individuals, families and communities have benefitted. The lack of substantive government funding makes these programs very vulnerable as observed with the recent rapid downsizing of the PEPFAR funding. Further challenges are expected with reduced external funding support due to re-classification as a lower middle-income country.

5. Provision of health services requires human interaction and the quality of services finally boils down to skills and motivation of the frontline human resource. Greater attention will need to be made to address the perennial employer-worker disputes, strengthening the pipeline of pre-service and in-service training which will enable provision of high quality, evidence-based care. This will address the problems currently faced of poor quality of RH services; inequitable coverage with RH services among certain areas or population groups including adolescents; and supply side challenges due to suboptimal functioning of the health systems (infrastructure, human resources for health (HRH), supply chain, health financing, health Information, and leadership/governance).

6. Demand side barriers that limit access and utilization of RH services such as long distances to health facilities, high costs, religious and socio-cultural beliefs and practices need to be addressed. Stigma and shame surrounding sexual and gender-based violence compounded by challenges in accessing other non-health sector interventions derails progress in this area. The lack of clean toilet and safe running water, or even facilities for a warm bath, may deter women from delivering at a facility, increase risk of infections and sepsis within the health facilities and deter communities from using services at heath facilities.

7. It is noted that there is stagnation of critical health indicators specifically maternal and newborn deaths. The common causes of death require swift action at higher level health services and success is often dependent on whether one arrives to these able facilities on time. Most maternal complications arise after onset of labour and therefore every community maternity must have the means to safely transport a sick mother and her baby to a higher-level facility in a timely and professional manner. There is an opportunity to develop professional ambulance referral services and to move away from abhorrent practices of giving individuals in distress a referral note and asking the family to organize for referral transport.

8. Quality of care is increasingly emerging as a central pillar for and determinant of health outcomes. Kenya has joined global quality of care and patient safety networks to enhance peer review and accountability in the quality of care given to health service users. Majority of maternal and newborn deaths occurring within health facilities are directly linked to poor quality of care, therefore this policy operates in an environment where quality of care is a primary consideration in any health system design and health service delivery. Quality of RH services at prevention interventions at the community as well as at service delivery in the facility must be upheld and a culture of continuous quality improvement made the norm at every tier of health care. The nascent mechanisms for accounting for

maternal deaths and still births through MPDSR audit systems provide a tremendous opportunity for the health-system and communities to identify the gaps and opportunities for improvement. Quality of care has diverse parameters that also hold the potential to cure inadequate coverage and response to emerging priority issues including but not limited to fertility management, vaccine preventable RH problems, reemerging STI's and novel previously unfathomed pandemics like the currently health system ravaging communicable COVID19 global pandemic.

9. The country has joined the world in implementing Universal Health Coverage. UHC provides a new opportunity of expanding health care, not only with health insurance coverage but also with an expanded essential care benefit package. It is notable that each country must define its model of UHC for its citizens that would work best to protect and advance health of all, and Kenya has embraced the Primary Health Care model with great emphasis on promoting health and preventing disease. The government is revitalising the community health component through an elaborate network of community health units that make sure each of the 12 Million households in the country is accounted for. This hub and spoke model for operationalising UHC creates a tremendous opportunity for equity and rapid expansion of access to RH services to all. To guarantee quality of RH care in this ambitious and necessary era in health for our country, specific guidance on RH will be outlined in this policy, and more guidance will be issued from time to time by the division of reproductive and maternal health, with clear roles and expectations for each cadre of Human Resource involved in the Reproductive Health space in the country. The prevailing mantra of expecting more because one has paid more needs a reflective balance against the accrued harm to the larger population when part of the population is left out. The debate on individual benefit versus public good in access to RH needs to be more deliberate to enable us as a nation do the best possible within the resources that are available.

10. Innovation is a major piece of accelerating and contextualising RH interventions. The COVID19 pandemic, that started in Wuhan city of china and is tearing down health systems globally, has called for bold innovative measures to protect the gains made including for RH. Kenya has a high mobile phone penetrance and this policy will deliberately be tapping into this telemedicine platform to expand access to quality public literacy on RH, link the public to accredited health care providers and service delivery points and trigger coordinated emergency response as needed. It is important that even higher standards of expertise and professionalism be employed throughout the continuum of care on the telemedicine platform, with emphasis on data confidentiality and rigorous protection of the constitutional right to the highest standard of health care.

CHAPTER 3. POLICY DIRECTION

3.1 Policy goal and overarching statement

OVERARCHING POLICY STATEMENT

The Government of Kenya will guarantee universal Reproductive Health coverage and equitable access to all persons in need and requiring RH care in the country. The government will play its fiduciary role by ensuring this RH care and services are of the highest possible quality and standard. RH interventions will employ a life course approach that will be facilitated by a multisectoral collaboration and will pay close attention to social, cultural and religious competency, while exalting the central role of the family unit in all matters Reproductive Health that is inherent to the Kenyan people.

This policy is cognizant of the undisputed opportunity offered by the adolescence period to shape lifelong reproductive health trajectory of an individual and shall emphasize protecting adolescents from premature entry or retention into sexual and reproduction acts that often burden the individual with lasting health and socioeconomic sequelae. The policy shall emphasize delaying sexual debut, preventing sexual and reproduction abuse of minors and rehabilitating adolescents initiated into premature sexual and reproduction acts. Kenya shall promote competency based programming on matters of sexuality and reproductive health respecting the level of cognitive maturity and attainment of social competency on matters of sexuality and reproduction for adolescents. These complex developmental transitions are often not fully achieved until the age of 21 years. Recognizing that persons with Disability (PWD) have special RH needs, this Policy shall prioritize integration of RH services that are responsive to the needs of PWD.

OVERALL GOAL

To minimize the burden of preventable morbidity and mortality related to reproductive health

3.2 RH policy objectives

Broad objectives

1. To achieve universal coverage of quality and comprehensive Reproductive Health interventions across the country
2. To improve responsiveness to client's reproductive health needs
3. To strengthen the enablers (Health Systems Building Blocks) for Reproductive Health, including aligning partnerships and collaborations

Specific objectives

In keeping with the broad objectives of the policy, the specific sub-objectives to be addressed by this policy are detailed in this section.

Broad objective 1. To achieve universal coverage of quality and comprehensive Reproductive Health interventions across the country;

Sub objectives;

i. To reduce maternal morbidilty and mortality due to obstetric haemorrhage, sepsis, hypertensive disorders, obstructed labour and post-abortion complications.

ii. To reduce perinatal morbidity and mortality due to prematurity, birth asphyxia, sepsis and respiratory distress syndrome.

iii. To reduce unmet need for family planning.

iv. To reduce the burden of reproductive tract infections (RTIs) through improved access to quality Reproductive Tract Infection prevention and management services.

v. To reduce the burden of HIV and AIDS and eliminate mother to child transmission (eMTCT) of HIV.

vi. To reduce morbidity and mortality associated with the common cancers of the reproductive organs in women and men.

vii. To harness digital technology to integrate evidence-based platforms such as telemedicine and self-care to ensure access to RH care to all.

Broad objective 2.

To improve responsiveness to client's reproductive health needs:

Sub objectives;

i. To mainstream special RH needs of marginalized groups, persons living with disabilities, elderly persons, people in humanitarian settings, and correctional institutions.

ii. To promote gender equity, address Female Genital Fistula (FGF), eliminate FGM and eradicate all forms of gender-based violence and harmful reproductive health practices by 2030.

iii. To improve reproductive health outcomes among adolescents and young people

iv. To improve Menstrual Hygiene Management for girls and women.

v. To reduce the magnitude of infertility and increased access to management of infertile couples.

vi. To ensure that persons born intersex attain the highest standards of reproductive health.

Main objective 3.

To strengthen the enablers (Health Systems Building Blocks) for Reproductive Health:

Sub objectives;

To promote a robust RH implementation environment especially data systems, research for development, innovation, human resources for RH, partnerships and collaborations

3.3 Scope of the RH policy

The National Reproductive Health Policy is complementary to existing policies on Reproductive Health, and shall be the primary reference document on matters concerning Reproductive Health in Kenya. It includes all persons in Kenya including children, adolescents, young persons, adults and older persons in need and requiring RH interventions including children, adolescents, adults and older persons. It will serve as a guiding and organizational framework to promote RH and guide all RH-related policies, design of programmes and interventions across all actors by all stakeholders working in Kenya.

3.4 Policy Thrust

3.4.1 To reduce maternal, perinatal and neonatal morbidity and mortality

1. All women of reproductive age (WRA) shall have adequate access to quality reproductive health care that is respectful and provides a positive care experience for them and their families.
2. This policy seeks to ease financial barriers hindering access to basic Reproductive Health services through the Universal Health Coverage and other Social Health Protection frameworks for all Kenyans.
3. All mothers and their babies who require emergency treatment and /or referral shall be supported with the necessary requisite expertise and resources to access quality emergency care.
4. Every woman with pregnancy-related conditions must be clinically evaluated by a qualified, experienced and registered nurse-midwife, clinical officer, medical doctor or obstetrician-gynecologist within the shortest feasible time, as per the prevailing guidelines, of presenting to any health facility.
5. Essential reproductive health commodities and supplies including; uterotonics, uterine balloon tamponade and non-pneumatic anti-shock garment (NASG) devices, blood supplies, anti-hypertensive, ARVs, antibiotics, Family Planning commodities including contraceptives and fertility treatment medications shall be classified as national strategic commodities and adequately funded from domestic resources.
6. Every maternal and perinatal death shall be notified within 24 hours and audited within 7 days at the facility, while those occurring in the community shall be notified and audited within 30 days and the recommendations actioned within one calendar month of submitting a report to the primary duty bearer. Maternal and perinatal death Reports shall promptly be uploaded to the KHIS portal and a copy of action/no action on audited deaths securely delivered to the Director-General for Health not later than 60 days from the death incidence.
7. All maternity and MCH units shall have functional quality improvement teams and services audited annually as per the set norms and standards.
8. Expand access to preconception care including screening, counseling and management of pre-existing conditions.
9. Increase access to skilled post-partum care.
10. Integrate Maternal Mental health into all Maternal and Newborn Health services.

11. Accord access to quality and comprehensive diagnostic, curative and rehabilitative services without attendant financial burden to girls and women with Female Genital Fistula (FGF).
12. Termination of pregnancy shall be performed in an environment meeting the minimum medical standards and guided by the opinion of a trained health professional with the proficiency to ensure both the mother and her unborn child receive the highest attainable standard of healthcare.

3.4.2 To reduce unmet family planning needs;

Preamble on FP:

Family planning is a premier investment in reducing reproductive health morbidity and mortality. A couple that has achieved their desired family size is not only more likely to be a stable family unit but is also likely to be a better empowered socioeconomic pillar for the nation. Family planning is a national security issue and as such, every effort will be made to free the country from external dependency and undue influence on this crucial element of a nation's sovereignty.

1. Ensure appropriate costing and ring-fencing of allocated funds for RH programs in the national and county budgets including funding for FP commodities and services;
2. Rationalize the provision of FP method mix and services to ensure cost-effectiveness and align commodity quantification to the Kenya UHC model of PHC, and support the country's transition to full domestic financing of family planning
3. Decentralize FP service delivery at all levels of health care as per set norms and standards, specifically support informed initiation, correct use, refills and community distribution of self-care family planning methods including the pills, vaginal rings, patches, condoms, fertility awareness and to the extent systems have been established, self-injectable contraceptives.
4. To expand access and align with the Kenya UHC model, skill-intensive contraceptive methods including surgical methods and long-acting reversible methods, in addition to being offered in family planning clinics with the resources and expertise to initiate, offer and follow up on the users of these methods, the county governments will explore entering into contracts with and commissioning local medical practitioners to provide specified methods and volumes of contraceptives services in the respective communities.
5. Ensure the safety and positive care experience for women and men accessing FP interventions
6. Mainstream HIV and STI prevention in every FP intervention at all levels of healthcare and for all clients

3.4.3 To reduce the burden of reproductive tract infections (RTIs) and improved access to, and quality services;

1. Enhance community awareness of the impacts of RTIs, including non-sexually transmitted endogenous RTIs, on reproductive health;
2. Ensure integrated, high-quality RTI services at all levels, including strengthened capacity for screening services for all ages including neonates and old persons;
3. Encourage generation of information and research on RTIs;
4. Ensure that STI prevention and control approaches contribute to HIV prevention;
5. Ensure adoption of proven new modalities of prevention and treatment of reproductive tract infections when available, especially for viral infections.

3.4.4 To reduce the HIV and AIDS burden and accelerate reversal of mother to child transmission of HIV;

1. Integrate HIV and AIDS control in Reproductive health;
2. Ensure all pregnant women and their families are tested for HIV and those HIV infected access quality HIV care and treatment including ARVs

3.4.5 To reduce morbidity and mortality associated with the common cancers of the reproductive organs in men and women

1. Increase availability of high-quality services for the prevention, early detection and management of cancers of reproductive organs, as appropriate at all levels
2. Recognizing that cervical cancer is a leading cause of death among women, and is almost entirely preventable if detected early, all levels of government shall appropriate resources to guarantee each sexually active WRA aged 25 years or more is offered, or referred for, a free cervical cancer screening test linked to accredited pathology referral and reporting system, and specialist care as may be needed.
3. Enhance programmes that advocate for, create awareness of, and sensitize the community on cancers of reproductive organ including the voluntary national free HPV vaccination program
4. Promote research on all aspects of cancers of the reproductive organs
5. Promote the collection and utilization of data on cancers of reproductive organs in both men and women of all ages.
6. Promote screening for Prostate cancer for men of 40 years and above at all levels.

3.4.6: To harness digital technology to integrate evidence-based platforms such as telemedicine and self-care to ensure access to RH care to all;

Create enabling environment to utilize regulated telemedicine as a valid universal low-cost platform for expanding access to quality RH information services.

3.4.7: To mainstream special RH needs of marginalized populations [persons living with disabilities, elderly, people in humanitarian settings and correctional institutions].

1. Prioritize reproductive health educational programs that are responsive to the needs of the marginalized populations including the use of health education materials in BRAILLE and SIGN language and other appropriate means of communication.
2. Promote positive social-cultural values of recipient communities to inform the design and framing of reproductive health programs and initiatives for marginalized populations.
3. Ensure inclusivity of marginalized populations in reproductive health social accountability processes.
4. Encourage the generation of routine information and research on RH among marginalized populations.
5. Enhance programs that advocate for and target comprehensive RH interventions for marginalized populations.

3.4.8: To promote gender equity, address Female Genital Fistula (FGF), eliminate FGM and eradicate all forms of gender-based violence and harmful reproductive health practices;

1. Recognizing that a person attains complete full cognitive competence on matters of sexuality and reproduction at the age of 21, the government will prioritize abstinence and delayed sexual debut for persons yet to attain full cognitive competency.
2. The Ministry of Health is committed to ending Female Genital Mutilation (FGM) by 2022 in alignment with Kenya's National FGM policy and strategy for the Abandonment of Female Genital Mutilation. Further, the MOH upholds the "do no harm" principle and emphasizes provision of quality prevention and care services in a manner guaranteeing the highest quality of health care to all who seek health care services within the Republic. All Health care service providers in the country are expected to offer prevention of FGM as well as appropriate care of its complications, and any health care provider who practices FGM, within or without a

health facility, or facilitates cross border practice of FGM is liable to severe deterrent disciplinary and regulatory measures.

3. Resource and enhance generation and utilization of routine information and research on Female Genital Fistula, Female Genital Mutilation and Sexual Gender-Based Violence.
4. Integrate into RH interventions the laws and statutes that protect children's life, health, social welfare, dignity, physical and psychological development from harmful cultural practices and normalization of harmful antisocial habits.
5. Advocate for the enforcement of the law to protect the children against transactional sex as per the Children Act and Counter Trafficking in Persons Act.
6. Establishment of National RH dialogue day to create awareness on RH issues including reduction of harmful practices.
7. Ensure critical reproductive health services offered to SGBV clients, Female Genital Fistula clients, vulnerable populations including adolescents, people with disability and special groups of vulnerable children (street children, humanitarian situation) shall be offered free of charge across the country as a package in the Linda Mama program.
8. Enforce parental consent, and in the absence of both parents, consent from a guardian or the children's officer acting in the best interest of the child in the provision of RH services, with emphasis on rehabilitation of minors engaged in sexual or reproductive activities into protective safety corridors such as school re-entry, child rescue programs, or cash for transfer programmes to facilitate exit from the vicious cycle of child sexual abuse and repeat premature childbearing.

3.4.9: To improve sexual and reproductive health outcomes among adolescents and youths;

1. Establish a universal reproductive health literacy framework for the population, which will ensure adequate age-appropriate RH information and awareness for all persons including adolescents and young people.
2. Support sensitization and implementation of education re-entry policy that is supportive of teenage mothers and their infants.
3. Advocate for the implementation of the school health policy on revitalizing health services delivery in schools and youth-friendly services in health facilities to improve access to information and services

4. Strengthen and scale up social protection for poor and vulnerable groups among teenagers, the disabled, street teenagers, orphans, young people in humanitarian settings and informal settlements
5. Strengthen programs in schools and colleges through a multi-sectoral approach targeting sexual and gender-based violence
6. Advocate for the mainstreaming of child protection programs and sexual violence prevention programs into learning institutions, workplaces and religious settings to deter exploitation of children and young people.
7. Ensure that all RH interventions for children (under 18 years) including matters of consent and ascent shall be aligned to the provisions in the law of the land which places the responsibility to parents, guardians and government; and must be premised on the best interest of the child, of which continued sexual exploitation and sustained opportunity to premature parenting are not in the best interest of the child (Constitution of Kenya 2010 (Article 53 (2), Children's Act revised edition 2018 (2001), Section 9 and 4(2).
8. Advocate for multi-sectoral promotion of parenting skills in line with the provisions of Article 53(1) (d) and (e) Constitution of Kenya 2010, and the Children Act to minimise parental neglect of children. This will entail, but will not be limited to, supporting, resourcing and promoting objective parenting competency and parenting mentorship programs.

3.4.10: To improve Menstrual Hygiene Management for girls and women;

The MOH recognizes the need to improve women and girls' quality of life by not only ensuring safe, affordable, accessible and hygienic menstrual products but also clean and secure facilities in learning institutions, workplace and public spaces. In alignment with the National Menstrual Hygiene Management (MHM) Policy 2019-2030, menstrual hygiene shall be incorporated in the various Reproductive Health programmes. The RH Policy takes cognizance of the need for collaborative investment and efforts by multiple sectors under the coordination of MOH to ensure successful implementation of MHM programmes in the country.

3.4.11: To reduce infertility and increase access to effective management of infertile individuals and couples;

1. Improve access to quality infertility services at all levels;
2. Promote community awareness on infertility, especially among males;
3. Encourage research on all aspects of infertility

4. Recognizing the rising burden of Primary & Secondary infertility. Integrate fertility care into STI prevention and treatment.
5. Finance establishment, certification and regulation of fertility care centres in the country and fully finance at least one cycle of assisted fertility treatment (ART) per needy desirous couple through The National Treasury and The National Insurance Fund
6. Support couples of the opposite sex establishing or furthering a family, who for gynaecological reasons it has been established cannot conceive and sire normally, commission as parents a willing surrogate mother to bear them a child through assisted reproductive technology, without monetary inducement except for the costs agreed to cover the entire process from embryo transfer to birth of the baby or otherwise, and as guided by the applicable laws and policies on surrogacy. The Cabinet Secretary for Health shall establish specific guidelines to bring into effect this policy direction.

3.4.12: To ensure that persons born intersex attain the highest standards of reproductive health.

1. Sex definition in Kenya is retained as Female or Male, but with a recognition that intersex is a disabling developmental state presenting with ambiguous genitalia at birth. Intersex can manifest variously from true intersex to normal variants of either the Female or the Male sex marker, which is highly medically and socially disruptive to the individual and the family. This policy recognizes and protects the constitutional rights of persons born with intersex, specifically outlawing discrimination and inhumane treatment targeting such persons, including forced premature medical sex reassignment. This policy lays the groundwork for resourcing a national avenue for scientifically and professionally guided intersex transition to a definitive sex identity.
2. The government shall constitute a multi-disciplinary team to confirm diagnosis, treatment and rehabilitation for the intersex child. The government shall create awareness as to the condition of persons born with ambiguous genitalia (intersex) to the child, the parents and the community
3. The medical procedures of persons born intersex are highly specialized, multidisciplinary, medically complex and carry significant life-threatening risks. The benefiting person often needs lifelong care and support even after the corrective medical procedures. Therefore, caution before, during

and after surgery must be employed and these procedures be deferred to an opportune time after puberty and attaining the age of majority when a person born with intersex is counselled, grants informed consent and is facilitated to present before a professional body dedicated, and resourced by the state to facilitate medical– and social transition to the actual sex.

4. On developing secondary sexual characteristic post puberty that reveal a different sex than that determined by medical experts previously, an intersex person shall receive a medical report from the professional body mentioned in 3.4.11 (2) above indicating their correct sex. They shall then present the medical report before a registration officer for the purpose of changing their sex in all their formal registration documents.
5. The birth of a child with ambiguous genitalia shall be reported or notified to a government health facility.

3.4.13: To strengthen research development and innovation, and use of research evidence for RH interventions

1. Adopt the '3 ones' principal- one coordination structure, one strategic framework and one monitoring and evaluation platform for implementation of the RH interventions as articulated in this policy
2. The Director-General of Health shall be the custodian of RH research conducted in the Country.
3. The technical division responsible for matters Reproductive Health shall work with the National Health Research Committee as stipulated in the Health Act to develop a priority RH Research agenda, Coordinate research, create RH research registry and repository and support enjoyment of benefits accruing from intellectual property and RH research by all involved parties.
4. Strengthen County Health Management Teams capacity to implement evidence-based RH programs as articulated in this policy and provide contextual leadership
5. National and County governments should enhance prudent management of existing RH resources from exchequer and collaborate with partners to augment these resources;
6. Map National and County RH partners to harmonize their work with the support they offer in RH policy implementation
7. Leverage on research, technology and innovations.

f. Co-ordinate development partner's efforts in RH space and veto RH interventions by all actors to ensure efficiency, value for investment to the Kenyan People and relevance as aligns to the national RH agenda.

g. Mobilize and allocate resources for RH programs.

h. Facilitate RH data disaggregation through revision of existing data capture tools.

i. Guide the adaptation of technology in the RH diagnostics, communication (including media) and interventions (treatment).

j. Strengthen the multi-sectoral and cross border collaboration with relevant ministries and non-state agencies to delivery RH school health program.

The County Departments of Health shall in line with their constitutional mandate and health Act 2017

County governments are responsible for health service delivery at the county level. Within the devolved governance structure, the county governments shall;

a. Allocate resources towards implementation of the RH Policy through their established coordination and management structures.

b. The county health boards, county hospital boards, primary care facility management committees and community health committees shall play an oversight role on RH matters, including resource mobilization, ensuring high quality of services as well as monitoring and evaluation this policy spellings and RH interventions in the respective counties;

c. The county and sub-county health stakeholders' forums and the community dialogue days shall provide avenues for partnership and public participation in the context of social accountability framework;

d. The county governments will be responsible for ensuring representation and participation of vulnerable groups including; children, those in justice system, prisoners, older persons, people living with disabilities, and people displaced by crisis.

County Reproductive Health Coordinator (CRHC)

a. To fully operationalize this policy in view of the devolved structure of governance it is of importance that each county to identify a focal person qualified and competent on matters RH who will act as a technical link between County Department of Health and Division of Reproductive and Maternal Health.

b. County RH Coordinator; will be charged with the overall coordination of all forms of RH services within the county. Will be the convener of the County RH Committee and sub-committees, and will liaise with the overall County Health Stakeholders Forum to ensure a coordinated approach toward RH service delivery within the county.

The Roles of other Ministries and stakeholders

A multi-sectoral approach shall be promoted in the implementation of the Policy.

The following ministries agencies and stakeholders shall be involved.

Table 1. Roles of Other Ministries and State Agencies in the Implementation of the Policy

Agency	Role
Ministry of Education	Support utilization of ICT and other innovative approaches in delivery of RH information to adolescent and young people in learning institution. Ensure implementation of the Education Re-entry Policy for adolescents and young people Facilitate provision of information to parents and care givers to support the policy agenda for children and young people. Strengthen health referral system in coordination with the MOH. Support the setting up of safe spaces for children and adolescents.
The National Treasury	Mobilize domestic and external resources to finance this policy Allocate financial resources for implementation of the Policy Improve fiscal responsibility Avail resources to support policy advocacy, mobilization resources to mainstream RH financing with the budgetary cycle and MTEF Integrate RH into community empowerment programs. Finance KNBS to carry out the periodic KDHS which forms the back bone of RH data for the country
National Authority for the Campaign Against Alcohol and Drug Abuse (NACADA)	Ensure enforcement of laws that protect adolescents and young people with regards to alcohol and substance abuse. Create awareness on harmful effects of drugs and substance abuse and its impact on families and communities Provide geographical, age and sex disaggregated data for alcohol, drug and substance abuse for decision making.
National Human Rights Institutions (KNHRC, KHRC) and National Gender and Equality commission	Investigate violations of RH rights. Operationalize the platform for receiving complaints on violations of RH rights. Monitor implementation of RH commitments and obligations. Expand the utilization of modern technology and local community /social intelligence in SGBV Advocate for the expansion of safety nets and corridors for survivors of SGBV and their dependants

Ministry of ICT, Innovation and Youth Affairs.	Support utilization of ICT in delivery of RH information. Finance the SimuAfya RH telemedicine platform through the Universal Service Fund Work with partners in regulation of media content on reproductive health information. Support the actualization of the national reproductive health citizenry education platform. Protect communities against harmful cultural practices, child marriages and child labour. Protect adolescents and young people against child marriages and trafficking. Ensure greater livelihood opportunities for adolescents and young peoples in line with existing laws
Law Enforcement Agencies (National Police Service, Judiciary, Internal Security, HIV tribunal, Office of the Director of Public Prosecutions (ODPP)	Enforce laws and administer justice to protect communities against RH violations. Expand the utilization of modern technology and local community /social intelligence in administration of justice in the context of RH matters including SGBV. Incorporate alternative dispute resolution mechanisms in the justice system on RH matters including SGBV
Ministry of Public Service and Gender	Strengthen the support for family unit and setting up of structural interventions. Advocate for the reorganization of RH interventions to ensure the prioritization of needs of persons with disabilities (physical and mental), street children, institutionalised children and the aging. Support the MOH Human resource expansion agenda for the successful delivery of this RH policy aspiration. Support gender mainstreaming in all RH and related programs Ensure implementation of the Prohibition of FGM Act (2011) and other RH related acts. Support advocacy on elimination of SGBV. Monitor anti-FGM interventions. Support the setting up of safe spaces for children and adolescents.
Ministry of Tourism and Wildlife	Support and integrate RH in their programs. Mainstream RH in the social environmental impact assessment of tourism and partnerships.
Ministry of Sports and Heritage	Support and integrate RH in their sporting activities, social and cultural events.
Ministry of Transport, Infrastructure, Housing, Urban Development and Public Works	Improve physical accessibility to health facilities. Support and integrate RH in their programs. Mainstream RH in the environmental impact assessment and intervention of expanding infrastructure.
Ministry of Agriculture, Livestock, Fisheries and Cooperatives	Support and integrate RH in their programs.

Ministry of Water & Sanitation and Irrigation	Support and integrate RH in their programs.
Ministry of Mining and Petroleum	Support and integrate RH in their programs.
Parliament	Support allocation of resources for implementation of the Policy. Advocate and support implementation of the Policy in their areas of jurisdiction. Enactment of relevant Acts and other required legal instruments necessary for the successful delivery of this policy aspirations.
NGOs, CSOs, CBOs, FBOs and Private Sector	Support provision of RH information and services to communities. Support research and RH Policy formulation and dissemination. Educate and capacity build communities and individuals on RH interventions and programs. Meaningfully engage in social accountability processes including program design, implementation, research and M&E. Advocate and mobilize resources for policy implementation. Align program design and delivery to set legal and policy framework. Support representation of vulnerable groups e.g. People living with disabilities, adolescents, people affected by crisis or displacement.
Development Partners	Mobilize resources for policy implementation. Support technical expertise for the MOH to lead and realize the spellings of this RH policy and responsible programming. Align interventions and delivery of programs to set legal, policy framework and recipient community values.
Communities, families and individuals	Champion RH desired outcomes through existing relevant structures at all levels. Volunteer RH information. Support RH policy implementation and remove barriers to access. Mobilize resources. Meaningfully engage in social accountability processes including program design, implementation, research and M&E.

Training and research Institutions (Medical Schools and Colleges and other Training and Research Institutions)	Enhance RH content in nursing and medical curricula at both pre- and in-service levels. Conduct continuous research on RH and generate information for decision making Participate in policy revision and/or development processes. Periodic dissemination of evidence and RH research Resource mobilization for RH
Media	Advocate and create public awareness on matters related to RH Share responsible and accurate information and evidence Regulate media content in the context of RH. Meaningfully engage in social accountability processes including program design, implementation, research and M&E.
Professional associations	Advocate for RH agenda in the professional associations Motivate and support health providers to adhere to principles laid out in this policy. Undertake research and knowledge sharing on RH. Provide guidance on RH matters. Participate in policy revision and/or development processes.
Regulatory bodies	Advance the objectives of this policy as prescribed in their various constitutive Acts of Parliament and mandate directives

CHAPTER 5. MONITORING, EVALUATION, RESEARCH AND LEARNING (MERL)

The MOH shall provide overall strategic leadership in monitoring and evaluating implementation of the Policy with technical assistance from a multi-sectoral technical working group that includes development partners. An M&E framework for assessing implementation and impact shall be established based on the goals and objectives of the Policy and targets set in the plan of action. The MOH and partners shall mobilize sufficient resources to support M&E of the Policy and its Plan of Action.

The M&E framework for the Policy shall be linked to the National Health Management Information System (HMIS). The Policy shall advocate for integration of RH relevant indicators into the National Integrated Monitoring and Evaluation System and other relevant M&E frameworks. State and non-state actors shall be expected to align their project or program reporting to the MOH M&E framework.

At the national level, monitoring shall be done on a quarterly basis through the DRMH and MERL committee of experts. Evaluation will be conducted through base line and periodic surveys or other research to ensure programmes are implemented as expected. In this respect, monitoring of this policy document shall be done through the RH ICC and guided by indicators and targets as reflected in Table 1.

Table 2. Indicators for Measuring Kenya Reproductive Health Policy 2022-2032 Performance

Policy Area	Sub Objectives	Impact-level Indicators	Baseline-KDHS 2014	Proposed 2030 target	Frequency of Measurement
1. To achieve universal coverage of quality and comprehensive Reproductive Health interventions across the country	Reduction of maternal, perinatal and neonatal morbidity and mortality	Neonatal mortality rate (per 1,000 births)	22	13	Annually
		Neonatal mortality rate (per 1,000 births)-Facility	36.3	22.3	Annually
		Maternal mortality ratio (per 100,000 births)-Population	362	100	KDHS (Periodic)
		Maternal mortality rate (per 100,000 births)- Facility	103	70	Annually
		4th ANC	58%	70%	Annually
		8 or more ANC contacts	4%	30%	Annually
		Stillbirth rate (per 1,000 births) – National	23	12	Annually
		Skilled Birth Attendance	62.5	80%	Annually
		Postnatal Care	58%	70%	Annually
		Perinatal mortality rate	13.20%	7.80%	Annually
		Percentage of maternal deaths audited in the country	70%	100%	Annually (MPDSR reports)
	Reduction of unmet family planning needs	FP mCPR for all women	58%	64%	Annually

		Proportion of Women with Unmet Need for Family planning	18%	10%	Annually
	Reduce the burden of curable reproductive tract infections (RTIs)	Proportion of women presenting in ANC with any or all of the following: syphilis, chlamydia trachomatis , Bacterial Vaginosis, Neisseria gonorrhea , genital ulcer disease , cervical manifestation of HPV infection , Trichomoniasis	20%	10%	Annually
	Improved access to, and quality of, RTI services	Proportion of ANC clinics able to test and treat RH signal infections: C.Trachomatis and T.Pallidum	40%	60%	Annually
	Reduce the HIV and AIDS burden and eliminate mother to child transmission (eMTCT) of HIV	Comprehensive knowledge on HIV among adolescent girls 15- 19	49%	75%	KDHS (Periodic)
		Comprehensive knowledge on HIV among adolescent boys 15- 19	59%	80%	KDHS (Periodic)
	Reduction of morbidity and mortality associated with the common cancers of the reproductive organs in men and women	Cervical Cancer Screening	14%	75%	Annually
		Prostate cancer screening	7%	30%	Annually
		HPV Vaccination Coverage	10%	60%	Annually

2. To improve responsiveness to client's reproductive health needs	Mainstream special RH needs of people with disabilities, elderly and people in humanitarian settings	Existence of specific policies and resources for RH disability mainstreaming in RH service delivery points	0%	30%	Annually
	Promote of gender, equity eliminate FGM by 2022 and eradicate all forms of gender-based violence and harmful reproductive health practices by 2030	Prevalence of female genital mutilation among 15-19yrs	21%	10%	Annually
		Number of girls and WRA attending ANC screened for FGM	5%	50%	Annually
		Proportion of WRA who reported to have experienced intimate partner violence at first ANC screening	Data not available	50%	Annually
		Early marriages screening at ANC	Data not available	50%	Annually
		Proportion of girls married before 18th birthday	23%	10%	KDHS (Periodic)
	Improve reproductive health outcomes among adolescents and young people	Age of sexual debut	18 years	21 years	KDHS (Periodic)
	Reduce the magnitude of infertility and increase access to fertility care and treatment for individuals and couples with fertility challenges	Total fertility rate	3.9	2.5	5 years
		Legislation on fertility services (ART, Surrogacy and Organ and Tissue donation and transplant)	0	1	Annually
		Number of operational public fertility treatment and management centres	1	15	Annually

3. To strengthen the enablers (Health) Systems Building Blocks) for Reproductive Health	Promote robust RH implementation environment especially data systems, research for development, innovation, human resources for RH and partnerships and collaborations	Proportion of public facilities with a functional patient centered Telemedicine Platform	0	75%	Annually
		Establishment of a national RH research repository	0	1	Bi-annual
		National mapping and Publishing of RH partner interventions, shared with counties	0	1	Quarterly
M&E Inherent to the RH Policy	Launch of Policy	Policy signed and launched by MOH and disseminated	0	1	One off
	Dissemination to counties	Proportion of counties technically supported to interpret and operationalize this policy	0	100%	Annual

PARTICIPATING ORGANIZATIONS

- Options
- Kenya Obstetrics and Gynaecological Society (KOGS)
- Kenya Medical Association (KMA)
- Global Affairs Canada through World Vision (ENRICH)
- United Nations Population Fund (UNFPA)
- UKAID (ESHE)
- Council of Governors (CoG)
- County Governments

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County Executive Committee Members for Health	47 Counties

8. Develop and maintain a RH research repository for the country and publish its contents regularly to maximize research outputs and prioritization.
9. Facilitate issuance of letters of support and MOH collaborations in reproductive health research that clearly include a ring-fenced budget line for direct capacity building for MOH infrastructure, equipment and human resource for Reproductive Health Research and finding dissemination.

CHAPTER 4. POLICY IMPLEMENTATION FRAMEWORK

4.1 Management and Coordination

The Ministry of Health will take leadership in the implementation of this policy in collaboration with all stakeholders at national and county levels through a multisectoral approach. The county governments, other state actors, and non-state actors (NGOs, FBOs, Private Service Providers, private research Institutes and Professional Organizations such as KOGS, NNAK, MAK, KCOA, KMA, KPA, KPS, implementing partners, bilateral partners shall be governed and coordinate by this policy in their RH interventions. The RH policy shall be implemented progressively through development of five-year RH strategic frameworks and annual work plans by the National Government. Its implementation shall also be influenced by a series of documents and strategies, including the Universal Health Coverage Roadmap, the Kenya Essential Package for Health, Health sector Norms and Standards, Partnership framework, M&E framework, other operational documents including County Specific Reproductive Health Strategies, and SAGA specific strategies. An RH policy communication strategy to attain, strengthen and preserve a favorable opinion of the policy to ensure buy-in from all relevant partners and stakeholders will be facilitated.

At National level, management and coordination shall be done by;

a) Health sector intergovernmental consultative forum (HSICF)

As provided in the Health Act 2017. The composition includes Director-General for Health and the County Directors for Health. The forum has three main functions as outlined in Section 27(1) of the Health Act 2017. In this regard, the forum shall be used as a platform for mutual consultation, coordination and collaboration on all matters of this Policy.

b) RH Inter Agency Coordination Committee

This shall be chaired by the Director-General for Health Services and will bring together heads of department in the MOH: The Head of the MOH DRMH, Heads of different relevant MOH Divisions/Units, including but not limited to NASCOP, Child and Adolescent Health, Nutrition and Health Promotion and several non-state actors providing technical, financial and other forms of Strategic support for RH issues to the MOH, Representative of the Council of Governors

/ Intergovernmental Relations Forum (IGRF) for Health. The Head of the DRMH will be the secretary of the committee. It will be charged with the responsibility of overall policy and strategy development for RH services in the country.

c) The National RH Technical Working Group

This will comprise of selected technical players in academia, research, implementation and industry and will be charged with the responsibility of evidence gathering and synthesis to inform national RH policy and strategy. The MOH DRMH shall provide/undertake a secretariat coordinating role for this TWG and it shall be chaired by the MOH technical Head of Reproductive Health for the country.

d) The MOH RMH committees of experts

This will be charged with the overall responsibility for daily coordinating policy and guidelines development, technical assistance and implementation monitoring for the respective component programs in DRMH as per the organogram (figure 9). The MOH DRMH respective programs shall provide/undertake a secretariat coordinating role for this respective COEs, who shall be answerable to the Head Reproductive and Maternal Health and upon completion of their task, shall submit a report to the Head of the Division of Reproductive and Maternal Health for the necessary action.

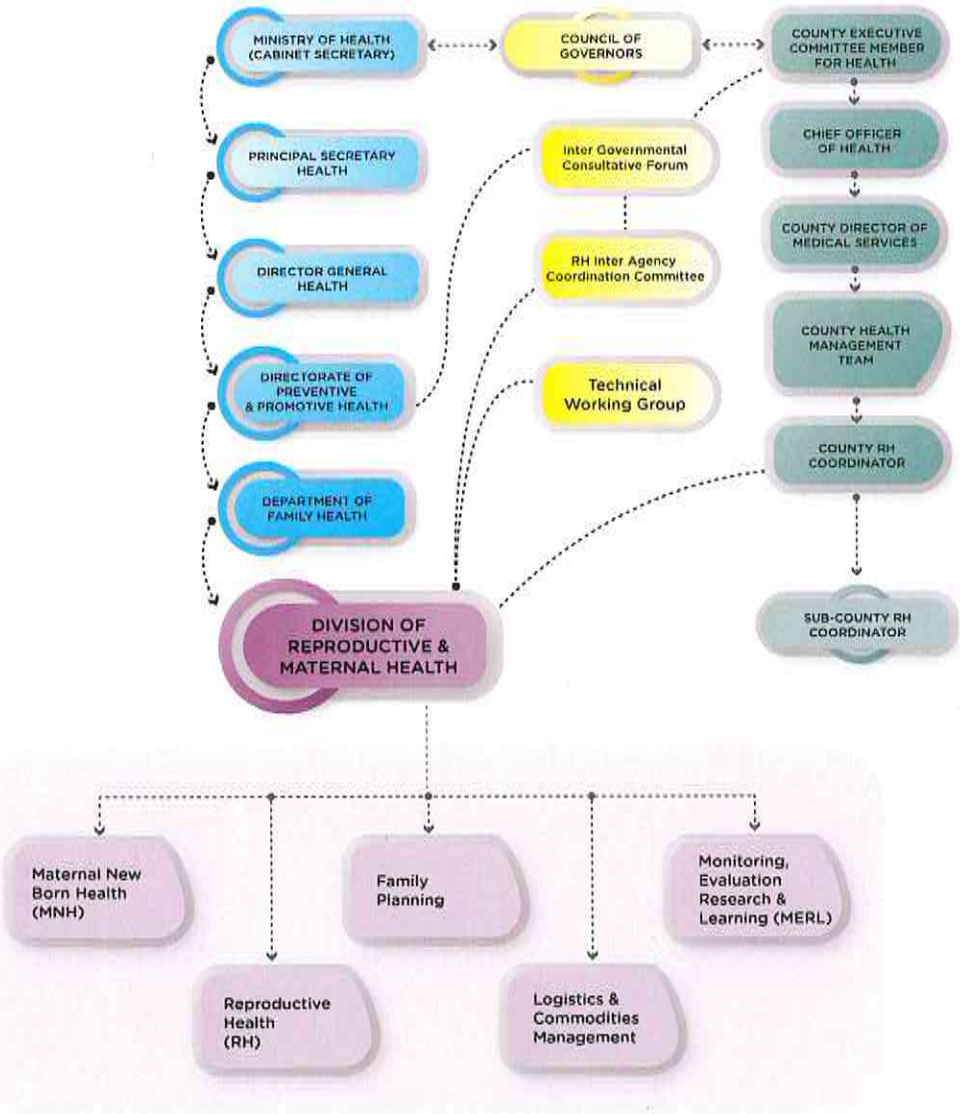
At the county level.

Management and coordination shall be done by the following teams within their prescribed terms of reference by the county governments:

- County Health Management Teams (CHMT)
- Sub-County Health Management Teams (SCHMT)
- Facility Management Teams
- Collaboration and partnerships shall be realized through the Joint County RH Stakeholders' Forum, Sub-County Stakeholders Forum and Community Health Committees.
- The Policy encourages formation of functional RH TWGs at the County level and community dialogue forums for RH in the community units.

Linkage and Coordination between National and County Levels of Government in Policy Implementation

As with the overall health sector coordination, RH matters will be dealt with under the Health Sector Intergovernmental Relations Forum (HSIRF established under



RH Coordination Organogram

the Intergovernmental Relations Act August 2012). For RH, the forum will do the following:

1. Establish systems to address thematic RH issues identified these;
2. Evaluate the performance of the national and county governments in realizing RH policy goals and recommending appropriate action;
3. Monitor the implementation of national and counties' plans for RH;
4. Produce annual reports on national health statistics pertaining to the RH status of the nation, RH services coverage, and utilization;
5. Promote good governance and partnership principles across the RH programs;
6. Consider issues on RH that may be referred to the forum by members of the public and other stakeholders, and recommend measures to be undertaken;
7. In addition, the CoG Health secretariat and the IGRF shall be represented within the National RH Steering Committee.

4.2 Provision of RH services

The Policy shall ensure provision of RH services for all in Kenya. It shall outline levels at which services shall be provided, applicable standards in service provision; and health system requirements for service provision.

4.2.1 Levels of Service provision

The Policy shall ensure the provision of RH services for all in Kenya. It shall outline levels at which services shall be provided; applicable standards in service provision; and health system requirements for service provision.

LEVEL 1: Community Health Services

LEVEL 2: Dispensary/Clinic

LEVEL 3: Health Centre

LEVEL 4: Primary Hospital

LEVEL 5: Secondary Hospital

LEVEL 6: Tertiary Hospital

Facilities operated by NGOs, FBOs and the private for-profit sector shall follow the same classification depending on their level of resources and capacity. The county governments shall be responsible for Level1 to Level 5 services while the national government shall be responsible for Level 6. The referral system will be strengthened to ensure that clients at all levels gain access to appropriate skilled care. The value and role of communities, including representatives from among marginalized groups, will be recognized and their involvement through community accountability mechanisms will be enabled. This will allow communities and citizens to be involved in the planning, delivery and monitoring of RH interventions at the point of use.

4.2.2 Standards for Provision of reproductive health services

In line with Article 43 (1) of the Constitution of Kenya (2010) which states that, 'every person has the right to the highest attainable standard of health, which includes the right to health care services, quality reproductive health care' is the right of every person in Kenya. The Policy shall support access to and provision of high quality and affordable RH services at all levels of health service provision by persons sufficiently trained, certified and competent to offer the respective RH service. The standards shall be described further in the intervention specific national guidelines where not spelled in this policy aligned to the national values and laws.

4.2.3 Health Systems Requirements

A functional health system is a key determinant of quality of services. In order to provide efficient, effective and sustainable RH services and deliver on the aspirations in this policy, the following health system building blocks as outlined in the Kenya Health Sector Strategic Plan (2018-2023) are essential and shall be addressed;

1. Health Financing and sustainability
2. Health Leadership
3. Health Products and Technologies
4. Health Information
5. Health Workforce
6. Service Delivery Systems
7. Health Infrastructure
8. Research and Development

4.2.3.1 Health Financing and Sustainability

The Policy recognizes the need to increase financial resources and to put in place sustainability mechanisms for effective and efficient provision of RH services. In this regard, the Ministry of Health shall:

a. Generate and avail evidence to justify resource allocation to RH programs;
b. Expand benefit package of existing insurance and financial protection mechanisms within NHIF, Linda mama programme to address urgent gaps in RH:
c. Require that each pregnancy be registered at the nearest accredited health facility at the earliest opportunity and be enrolled into the government free maternal, new-born and infant health National Hospital Insurance Fund scheme also known as Linda Mama which shall perpetually be financed through the exchequer.
d. Seek increased budgetary allocation for provision of RH information and services at national and county and community levels;
e. Coordinate and harmonize donor support for adolescent RH programs in line with the MOH partnership framework;
f. Expand resourcing avenues and platforms including Public Private Partnerships, research;
g. Improve efficiency and accountability in resource allocation and utilization;
h. Develop and advocate for necessary legal instruments to facilitate operational financing of service in the context of RH delivery at all levels including facilities and community level

4.2.3.2 Health Leadership

Leadership and governance are essential in the implementation of RH policy. This shall align with the defined roles of national and county governments. In this regard, The Ministry of Health shall:

a. Build capacity of health managers at all levels in strategic leadership, health systems and service management for Reproductive health;
b. Strengthen Reproductive Health Training and Supervision (RHT&S) system at all levels for effective provision of reproductive health interventions;
c. Advocate for prioritization of reproductive health in operational plans at all levels of health care system;
d. Continuously monitor the trends in RH at all levels;
e. Establish and strengthen partnerships and collaboration for successful RH.

4.2.3.3 Health Products and Technologies

Health products and technologies are essential in the provision and fast-tracking access to RH interventions. In this regard, the Ministry of Health shall:

a. Ensure equity in access to essential RH products and technologies in health facilities at all levels;

b. Ensure linkage with other policies on the procurement system and commodity supply chain;

c. Ensure linkage with institutions offering quality assurance of all medical RH commodities;

d. Expand and encourage innovation in the use of technology to bridge the gap in RH diagnostics, treatment, community empowerment and implementation to fast track the progress;

e. Mainstream use of technology in increasing efficiency at all levels of health service delivery for RH.

4.2.3.4 Health Information

The Kenya Health information includes health service delivery data (KHIS), and periodic survey data like KDHS. The Health Management Information System (HMIS) is critical in the implementation of the Policy. Towards this end, the Ministry of Health shall take the following actions:

a. Use the existing National platform for periodic surveys conducted by Kenya National Bureau of Statistics to collect, collate and analyze data for routine monitoring of the RH services as well as specialized studies;

b. Advance the rights to reproductive health by advocating for the revision and standardization of data collection tools to capture age and sex disaggregated data for different population cohort including adolescents, young people, the aging at all levels of data collection as underpinned by Article 35 of the Constitution of Kenya 2010;

c. Strengthen HMIS for RH and establish linkages with the National Integrated Monitoring and Evaluation System (NIMES) and IDSR systems for strengthened reporting of maternal and perinatal deaths and other vital events;

d. Reinforce the management of routine data collection, analysis and utilization to facilitate high-quality data and insights for reproductive health decision making at all levels;

e. Expand the use of appropriate modern technology (SimuAfya/mHealth/eHealth) to improve management of RH information at all levels;

f. Ensure health management information systems are reviewed and revised to report against commitments and specified in the M&E framework for this policy.

4.2.3.5 Health Workforce

A skilled health workforce and of adequate numbers is essential for the delivery of RH services. The Ministry of Health shall ensure effective recruitment, development, training and retention of the health workforce (nurse midwives, medical doctors and specialists, obstetrician gynecologists, and complementary medical/ operational expertise) for provision of RH services by:

a. Ensuring sustainable increase in health financing for human resources in health;

b. Expand the number and skill mix of human resources for the successful delivery of the policy;

c. Building capacity and motivation of health providers to deliver RH services through in-service, on-job training, mentorship and continuous medical education;

d. Supporting integration of RH training into the pre-service curriculum in all medical training institutions;

e. Strengthening quality assurance mechanisms through continuous support supervision and mentorship at all levels to provide adolescent and youth friendly RH services;

f. Advocate for enactment of necessary legal instruments to address barriers of an efficient and effective human resource for health in the context of RH at all levels

4.2.3.6 Service Delivery Systems and standards

Article 43 (1) of the Constitution of Kenya (2010) states that 'every person has the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care'. This policy recognizes the central role of the family in reproductive health as stipulated under Article 45(1) of the Constitution of Kenya 2010 and this shall be reflected in RH interventions. This Policy supports access to and provision of high quality and affordable RH services at all levels of health service provision and for all citizens, including vulnerable groups and that services are accessible and acceptable. The detailed standards shall be described in the national guidelines, protocols and standard operating procedures (SOPs) for various RH interventions. Key components to be considered in defining the standards for service delivery systems will be:

- Effective
- Efficient
- Universally accessible, acceptable and patient-centred, including being age-appropriate and respectful
- Equitable
- Safe
- Private and confidential
- Responsive to social values
- Alignment with legal framework in the country
- Reliable and consistent
- Evidence based.

4.2.3.7 Health Infrastructure

The MOH health infrastructure will be enhanced to support the reproductive health policy aspirations. This is especially important to meet the expanded needs of people living with disabilities and the emerging population cohorts such as elderly and children and address the suboptimal performance of key indicators in reproductive health. The health infrastructure changes will focus on ensuring:

a. Physical access to facilities
b. Equipment and tools for service delivery including specialized tools for delivery of services for people living with disabilities
c. Periodic Assessment of capacities and making necessary adjustment
d. Communication system to and within the facilities
e. Information systems for data collection and management infrastructure for RH interventions
f. Client-centeredness design and flow of intervention package with service delivery points
g. Safety in designs and set up of the infrastructure.

4.2.3.8 Research and Development

The ministry of health notes that research in health including reproductive health is currently not appropriately coordinated, leading to unwarranted duplication

and limiting optimal use of resources and findings, funding for research has remained very low and the sector has continued to rely on donors and funding from partners. Translation of research findings into sustainable improvements in health outcomes remains a substantial obstacle to improving the quality of care. Research is a critical pillar of evidence generation and quality assurance of RH interventions. No intervention or program in reproductive health shall be implemented unless it has been shown objectively to be effective in improving the target sexual reproductive health outcome or preventing the target adverse reproductive health outcome. In the absence of effectiveness evaluation of the intended intervention or program in Kenya, such an intervention or program shall be deemed experiemental and shall have an embedded elaborate effectiveness evaluation plan. The contextual effectiveness evaluation plan shall be shared at the beginning of the intervention, will include a mid-term effectiveness evaluation, and an independent end-term effectiveness evaluation policy brief. These reports (plan, mid-term and end-term effectiveness assessments) shall be submitted to the Director General for Health without exception. In this regard the focus shall be;

1. Mainstreaming of RH research and capacity building at national and county levels
2. Enhanced investment in RH research and evidence generation
3. Operationalize the data protection ACT no 24 of 2019 provisions in RH
4. Strengthened research links with other state actors, academic institutions and SAGAs in the RH
5. Vet RH research in the country and prioritise research that aligns with the pressing RH concerns for the MOH and the country.

4.3 Roles and Responsibilities

The Ministry of Health shall in line with the constitutional mandate and health Act 2017

a. Oversee and facilitate adaptation and implementation of the Policy at National and County levels;
b. Ensure that there is adequate capacity in terms of staffing, equipment and supplies as per MOH norms and standards.
c. Develop a comprehensive implementation framework for the delivery of this Policy.
d. Set standards and regulatory mechanisms.
e. Regulate and co-ordinate RH training, information sharing and service delivery.

f. Co-ordinate development partner's efforts in RH space and veto RH interventions by all actors to ensure efficiency, value for investment to the Kenyan People and relevance as aligns to the national RH agenda.

g. Mobilize and allocate resources for RH programs.

h. Facilitate RH data disaggregation through revision of existing data capture tools.

i. Guide the adaptation of technology in the RH diagnostics, communication (including media) and interventions (treatment).

j. Strengthen the multi-sectoral and cross border collaboration with relevant ministries and non-state agencies to delivery RH school health program.

The County Departments of Health shall in line with their constitutional mandate and health Act 2017

County governments are responsible for health service delivery at the county level. Within the devolved governance structure, the county governments shall;

a. Allocate resources towards implementation of the RH Policy through their established coordination and management structures.

b. The county health boards, county hospital boards, primary care facility management committees and community health committees shall play an oversight role on RH matters, including resource mobilization, ensuring high quality of services as well as monitoring and evaluation this policy spellings and RH interventions in the respective counties;

c. The county and sub-county health stakeholders' forums and the community dialogue days shall provide avenues for partnership and public participation in the context of social accountability framework;

d. The county governments will be responsible for ensuring representation and participation of vulnerable groups including; children, those in justice system, prisoners, older persons, people living with disabilities, and people displaced by crisis.

County Reproductive Health Coordinator (CRHC)

a. To fully operationalize this policy in view of the devolved structure of governance it is of importance that each county to identify a focal person qualified and competent on matters RH who will act as a technical link between County Department of Health and Division of Reproductive and Maternal Health.

b. County RH Coordinator; will be charged with the overall coordination of all forms of RH services within the county. Will be the convener of the County RH Committee and sub-committees, and will liaise with the overall County Health Stakeholders Forum to ensure a coordinated approach toward RH service delivery within the county.

The Roles of other Ministries and stakeholders

A multi-sectoral approach shall be promoted in the implementation of the Policy.

The following ministries agencies and stakeholders shall be involved.

Table 1. Roles of Other Ministries and State Agencies in the Implementation of the Policy

Agency	Role
Ministry of Education	Support utilization of ICT and other innovative approaches in delivery of RH information to adolescent and young people in learning institution. Ensure implementation of the Education Re-entry Policy for adolescents and young people Facilitate provision of information to parents and care givers to support the policy agenda for children and young people. Strengthen health referral system in coordination with the MOH. Support the setting up of safe spaces for children and adolescents.
The National Treasury	Mobilize domestic and external resources to finance this policy Allocate financial resources for implementation of the Policy Improve fiscal responsibility. Avail resources to support policy advocacy, mobilization resources to mainstream RH financing with the budgetary cycle and MTEF Integrate RH into community empowerment programs. Finance KNBS to carry out the periodic KDHS which forms the back bone of RH data for the country
National Authority for the Campaign Against Alcohol and Drug Abuse (NACADA)	Ensure enforcement of laws that protect adolescents and young people with regards to alcohol and substance abuse. Create awareness on harmful effects of drugs and substance abuse and its impact on families and communities. Provide geographical, age and sex disaggregated data for alcohol, drug and substance abuse for decision making.
National Human Rights Institutions (KNHRC, KHRC) and National Gender and Equality commission	Investigate violations of RH rights. Operationalize the platform for receiving complaints on violations of RH rights. Monitor implementation of RH commitments and obligations. Expand the utilization of modern technology and local community /social intelligence in SGBV Advocate for the expansion of safety nets and corridors for survivors of SGBV and their dependants

Ministry of ICT, Innovation and Youth Affairs.	Support utilization of ICT in delivery of RH information. Finance the SimuAfya RH telemedicine platform through the Universal Service Fund Work with partners in regulation of media content on reproductive health information. Support the actualization of the national reproductive health citizenry education platform. Protect communities against harmful cultural practices, child marriages and child labour. Protect adolescents and young people against child marriages and trafficking. Ensure greater livelihood opportunities for adolescents and young peoples in line with existing laws
Law Enforcement Agencies (National Police Service, Judiciary, Internal Security, HIV tribunal, Office of the Director of Public Prosecutions (ODPP)	Enforce laws and administer justice to protect communities against RH violations. Expand the utilization of modern technology and local community /social intelligence in administration of justice in the context of RH matters including SGBV. Incorporate alternative dispute resolution mechanisms in the justice system on RH matters including SGBV
Ministry of Public Service and Gender	Strengthen the support for family unit and setting up of structural interventions. Advocate for the reorganization of RH interventions to ensure the prioritization of needs of persons with disabilities (physical and mental), street children, institutionalised children and the aging. Support the MOH Human resource expansion agenda for the successful delivery of this RH policy aspiration. Support gender mainstreaming in all RH and related programs Ensure implementation of the Prohibition of FGM Act (2011) and other RH related acts. Support advocacy on elimination of SGBV Monitor anti-FGM interventions. Support the setting up of safe spaces for children and adolescents.
Ministry of Tourism and Wildlife	Support and integrate RH in their programs. Mainstream RH in the social environmental impact assessment of tourism and partnerships.
Ministry of Sports and Heritage	Support and integrate RH in their sporting activities, social and cultural events.
Ministry of Transport, Infrastructure, Housing, Urban Development and Public Works	Improve physical accessibility to health facilities. Support and integrate RH in their programs. Mainstream RH in the environmental impact assessment and intervention of expanding infrastructure.
Ministry of Agriculture, Livestock, Fisheries and Cooperatives	Support and integrate RH in their programs.

Ministry of Water & Sanitation and Irrigation	Support and integrate RH in their programs.
Ministry of Mining and Petroleum	Support and integrate RH in their programs.
Parliament	Support allocation of resources for implementation of the Policy. Advocate and support implementation of the Policy in their areas of jurisdiction. Enactment of relevant Acts and other required legal instruments necessary for the successful delivery of this policy aspirations.
NGOs, CSOs, CBOs, FBOs and Private Sector	Support provision of RH information and services to communities. Support research and RH Policy formulation and dissemination. Educate and capacity build communities and individuals on RH interventions and programs. Meaningfully engage in social accountability processes including program design, implementation, research and M&E. Advocate and mobilize resources for policy implementation. Align program design and delivery to set legal and policy framework. Support representation of vulnerable groups e.g. People living with disabilities, adolescents, people affected by crisis or displacement.
Development Partners	Mobilize resources for policy implementation. Support technical expertise for the MOH to lead and realize the spellings of this RH policy and responsible programming. Align interventions and delivery of programs to set legal, policy framework and recipient community values.
Communities, families and individuals	Champion RH desired outcomes through existing relevant structures at all levels. Volunteer RH information. Support RH policy implementation and remove barriers to access. Mobilize resources. Meaningfully engage in social accountability processes including program design, implementation, research and M&E.

Training and research Institutions (Medical Schools and Colleges and other Training and Research Institutions)	Enhance RH content in nursing and medical curricula at both pre- and in-service levels. Conduct continuous research on RH and generate information for decision making. Participate in policy revision and/or development processes. Periodic dissemination of evidence and RH research Resource mobilization for RH
Media	Advocate and create public awareness on matters related to RH. Share responsible and accurate information and evidence Regulate media content in the context of RH. Meaningfully engage in social accountability processes including program design, implementation, research and M&E.
Professional associations	Advocate for RH agenda in the professional associations Motivate and support health providers to adhere to principles laid out in this policy. Undertake research and knowledge sharing on RH. Provide guidance on RH matters. Participate in policy revision and/or development processes.
Regulatory bodies	Advance the objectives of this policy as prescribed in their various constitutive Acts of Parliament and mandate directives

CHAPTER 5. MONITORING, EVALUATION, RESEARCH AND LEARNING (MERL)

The MOH shall provide overall strategic leadership in monitoring and evaluating implementation of the Policy with technical assistance from a multi-sectoral technical working group that includes development partners. An M&E framework for assessing implementation and impact shall be established based on the goals and objectives of the Policy and targets set in the plan of action. The MOH and partners shall mobilize sufficient resources to support M&E of the Policy and its Plan of Action.

The M&E framework for the Policy shall be linked to the National Health Management Information System (HMIS). The Policy shall advocate for integration of RH relevant indicators into the National Integrated Monitoring and Evaluation System and other relevant M&E frameworks. State and non-state actors shall be expected to align their project or program reporting to the MOH M&E framework.

At the national level, monitoring shall be done on a quarterly basis through the DRMH and MERL committee of experts. Evaluation will be conducted through base line and periodic surveys or other research to ensure programmes are implemented as expected. In this respect, monitoring of this policy document shall be done through the RH ICC and guided by indicators and targets as reflected in Table 1.

Table 2. Indicators for Measuring Kenya Reproductive Health Policy 2022-2032 Performance

Policy Area	Sub Objectives	Impact-level Indicators	Baseline-KDHS 2014	Proposed 2030 target	Frequency of Measurement
1. To achieve universal coverage of quality and comprehensive Reproductive Health interventions across the country	Reduction of maternal, perinatal and neonatal morbidity and mortality	Neonatal mortality rate (per 1,000 births)	22	13	Annually
		Neonatal mortality rate (per 1,000 births)-Facility	36.3	22.3	Annually
		Maternal mortality ratio (per 100,000 births)-Population	362	100	KDHS (Periodic)
		Maternal mortality rate (per 100,000 births)- Facility	103	70	Annually
		4th ANC	58%	70%	Annually
		8 or more ANC contacts	4%	30%	Annually
		Stillbirth rate (per 1,000 births) – National	23	12	Annually
		Skilled Birth Attendance	62.5	80%	Annually
		Postnatal Care	58%	70%	Annually
		Perinatal mortality rate	13.20%	7.80%	Annually
		Percentage of maternal deaths audited in the country	70%	100%	Annually (MPDSR reports)
	Reduction of unmet family planning needs	FP mCPR for all women	58%	64%	Annually

		Proportion of Women with Unmet Need for Family planning	18%	10%	Annually
	Reduce the burden of curable reproductive tract infections (RTIs)	Proportion of women presenting in ANC with any or all of the following: syphilis, chlamydia trachomatis , Bacterial Vaginosis, Neisseria gonorrhea , genital ulcer disease , cervical manifestation of HPV infection , Trichomoniasis	20%	10%	Annually
	Improved access to, and quality of, RTI services	Proportion of ANC clinics able to test and treat RH signal infections: C.Trachomatis and T.Pallidum	40%	60%	Annually
	Reduce the HIV and AIDS burden and eliminate mother to child transmission (eMTCT) of HIV	Comprehensiveknowledge on HIV among adolescent girls 15-19	49%	75%	KDHS (Periodic)
		Comprehensiveknowledge on HIV among adolescent boys 15-19	58%	80%	KDHS (Periodic)
	Reduction of morbidity and mortality associated with the common cancers of the reproductive organs in men and women	Cervical Cancer Screening	14%	75%	Annually
		Prostate cancer screening	7%	30%	Annually
		HPV Vaccination Coverage	10%	60%	Annually

99

2. To improve responsiveness to client's reproductive health needs	Mainstream special RH needs of people with disabilities, elderly and people in humanitarian settings	Existence of specific policies and resources for RH disability mainstreaming in RH service delivery points	0%	30%	Annually
	Promote of gender, equity eliminate FGM by 2022 and eradicate all forms of gender-based violence and harmful reproductive health practices by 2030	Prevalence of female genital mutilation among 15-19yrs	21%	10%	Annually
		Number of girls and WRA attending ANC screened for FGM	5%	50%	Annually
		Proportion of WRA who reported to have experienced intimate partner violence at first ANC screening	Data not available	50%	Annually
		Early marriages screening at ANC	Data not available	50%	Annually
		Proportion of girls married before 18th birthday	23%	10%	KDHS (Periodic)
	Improve reproductive health outcomes among adolescents and young people	Age of sexual debut	18 years	21 years	KDHS (Periodic)
	Reduce the magnitude of infertility and increase access to fertility care and treatment for individuals and couples with fertility challenges	Total fertility rate	3.9	2.5	5 years
		Legislation on fertility services (ART, Surrogacy and Organ and Tissue donation and transplant)	0	1	Annually
		Number of operational public fertility treatment and management centres	1	15	Annually

3. To strengthen the enablers (Health Systems Building Blocks) for Reproductive Health	Promote robust RH implementation environment especially data systems, research for development, innovation, human resources for RH and partnerships and collaborations	Proportion of public facilities with a functional patient centered Telemedicine Platform	0	75%	Annually
		Establishment of a national RH research repository	0	1	Bi-annual
		National mapping and Publishing of RH partner interventions, shared with counties	0	1	Quarterly
M&E Inherent to the RH Policy	Launch of Policy	Policy signed and launched by MOH and disseminated	0	1	One off
	Dissemination to counties	Proportion of counties technically supported to interpret and operationalize this policy	0	100%	Annual

PARTICIPATING ORGANIZATIONS

- Options
- Kenya Obstetrics and Gynaecological Society (KOGS)
- Kenya Medical Association (KMA)
- Global Affairs Canada through World Vision (ENRICH)
- United Nations Population Fund (UNFPA)
- UKAID (ESHE)
- Council of Governors (CoG)
- County Governments

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Ms. Susan Ontiri	JHPIEGO
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County Executive Committee Members for Health	47 Counties

MINISTRY OF HEALTH

Division of Reproductive and Maternal Health
Every Life Counts

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Layout & Design
Crestwood

NM 3

This is Exhibit marked "NW-3" referred to in the Annexed affidavit/Declaration of Nelson Wesonga
Sworn/Declared before me on this 22nd day of July 20 22 at Nairobi in the Republic of Kenya
22nd July 2022
Commissioner for Oaths

Dr Stephen Kaliti, MD MPH

Head, Division of Reproductive and Maternal Health,

Ministry of Health.

Copy

Advance copy by email

RE: RAISING CONCERNS ON THE PROBLEMATIC, EXCLUSIONARY PROVISIONS OF THE NATIONAL REPRODUCTIVE HEALTH POLICY 2022 – 2032

We refer to the above-mentioned matter and the National Reproductive Health Policy 2022 – 2032 (RH Policy) launched on Tuesday, 5 July 2022 at the Windsor Hotel in Nairobi. We, the undersigned, write in our capacity as organisations working in the right to health, women's rights and human rights sectors; grassroots human rights defenders; individual citizens; and residents of different counties.

On various occasions since April 2021, we have raised legitimate concerns that the communities, civil society, council of governors and medical bodies have on the RH Policy. The Division of Maternal and Reproductive Health have either ignored requests for an open and fair policy development process, or adopting a 'participation by ambush' model that denies stakeholders adequate opportunity to engage. Dissatisfied by the continued show of bad faith, we formally registered our disengagement and withdrawal from the process on 4 July 2022.

We also note with grave concern the continued efforts to claw-back on gains made in sexual and reproductive health; ignore rights-based approaches; and create a perception of illegality around critical sexual and reproductive health issues. In an article published in the Nation on 23 April 2022 titled 'You risk being imprisoned for giving minors contraceptives' Dr. Kaliti stated that '…giving contraceptives to minors is an illegality punishable by a jail term of up to 20 years…such a move is against the Children Act…' effectively excluding an entire vulnerable and marginalized population from accessing critical health services.

We note that certain provisions of the RH Policy violate our national values, and the rights to reproductive health care, equality and non-discrimination, access to information, and the best interests of the child. We take issue with the following provisions of the RH Policy:

i. **The RH Policy excludes meaningful interventions to reduce maternal mortality and morbidity due to unsafe abortion.** Unsafe abortion is one of the five major causes of maternal mortality and morbidity in Kenya. The right to safe and legal abortion in exceptional circumstances is articulated in Article 26(4) of the Constitution and a guiding framework is necessary to ensure access to safe abortion services provided by trained medical personnel. By refusing to institute a comprehensive guiding framework on abortion care in Kenya, the Ministry of Health is endorsing the exploitation of women and girls by quacks, and the subsequent harm to their lives and health.

ii. **The RH Policy provision on the unborn child is legally unsound.** The Policy notes that termination of pregnancy shall be '...guided by the opinion of a trained health professional with the proficiency to ensure both the mother and her unborn child receive the highest attainable standard of care.' This provision is legally unsound and directly contravenes the High Court's judgement in Petition 266 of 2015 where the Court held that abortion under Article 26(4) is an intentional deprivation of the life of the unborn child.

iii. **The RH Policy violates the right to equality and freedom from discrimination in accessing assisted reproductive technology.** The Policy provides for support for 'couples of the opposite sex' in accessing surrogacy and assisted reproductive technology. This is blatantly discriminatory against people outside of a marital or sexual union from accessing a health service and the Policy has not shown why limiting the right of single people to access a reproductive health service is reasonable and justifiable in an open and democratic society as stated in Article 24(1) of the Constitution.

iv. **The RH Policy only includes interventions on adolescent sexual and reproductive health that are discriminatory and not based on evidence.** Throughout the document, the Policy does not take into account the best interest of the child principle protected under Article 53(2) of the Constitution. Adolescents are a vulnerable and marginalised population with regard to sexual and reproductive health facing the triple threat of rising HIV infections, vulnerability to sexual and gender-based violence, and teenage pregnancy. Despite this, the Policy solely prioritises delaying sexual debut and enforcing parental consent,

even within the key performance indicators. It excludes diverse aspects including access to information, commodities, dignified and quality services and facilities.

These are some of the reasons we object to the implementation of the RH Policy in Kenya. We remind the Division that the Constitution of Kenya, 2010 affirms the right of **every person** to the highest attainable standard of health including reproductive health care. We remind the Division that all state organs and officers are bound by the national values set out in Article 10(2) of the Constitution including participation of the people; social justice; inclusiveness; human rights; non-discrimination and protection of the marginalized; and transparency and accountability.

We therefore call upon your office to halt the implementation of the RH Policy until these unscientific, discriminatory and unconstitutional issues are addressed to ensure a supportive environment that facilitates access to reproductive for all.

We are confident of your commitment towards the full implementation of the Constitution, and the enjoyment of the right to the highest attainable standard of health, including reproductive health. We trust that you will urgently undertake the proposed step above.

Cc: Hon. Mutahi Kagwe, EGH

The Cabinet Secretary

Ministry of Health

Susan Mochache, CBS

Principal Secretary

Ministry of Health

Dr. Patrick Amoth, EBS

Ag. Director General for Health

Ministry of Health

Signed by the following organisations:

1. Youth Changers Kenya
2. Zamara Foundation
3. Youth Empowerment Movement
4. Positive Young Women Voices
5. Reproductive Health Champions Organisation
6. Grassroots Women Initiative Network – Kenya
7. Xhale Africa
8. Reproductive Health and Rights Alliance
9. Coalition of Grassroots Human Rights Defenders
10. Trust for Indigenous Culture and Health
11. Kenya Legal and Ethical Issues Network
12. Reproductive Health Network Africa
13. SRHR Alliance
14. Love Matters Africa
15. Women First Digital
16. Women Spaces Africa
17. Kisumu Medical and Education Trust
18. Network for Adolescent and Youth for Africa

Dr Stephen Kaliti, MD MPH

Head, Division of Reproductive and Maternal Health

Ministry of Health.

22nd July, 2022

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Hon. Justice (Rtd) Paul Kariuki Kihara, EGH

The Attorney General of the Republic of Kenya

Office of the Attorney General and Department of Justice

H.E Martin Wambora, EGH

The Chairperson,

Council of Governors.

Dr. Joyce Mwikali Mutinda, PHD

The Chairperson,

National Gender and Equality Commission.

Roseline Odede, HSC

The Chairperson,

Kenya National Commission on Human Rights

Hon. Florence Kajuju, MBS

The Chairperson,

Commission on Administrative Justice

Signed by the following organisations:

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Dr Stephen Kaliti, MD MPH

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22nd July, 2022

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Received by: HOSEA
Date: 25/7/2022
Sign:

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NM4

END TRIPLE THREAT CAMPAIGN

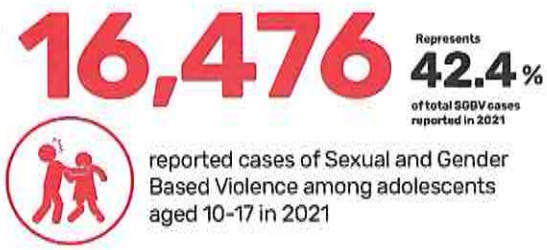
#EndTripletThreat #KomeshaMimbaZaUtotoni

END TRIPLE THREAT CAMPAIGN

1. New HIV Infections
2. GENDER-BASED VIOLENCE
3. ADOLESCENT PREGNANCIES

INTRODUCTION

Kenya is committed to ending AIDS as a public health threat and addressing all forms of Sexual and Gender- Based Violence (SGBV) by 2030. In addition, the country is determined to address the challenge of adolescent pregnancies. The National AIDS Control Council (NACC) and National Council for Population and Development (NCPD) have partnered with National Government Administration Officers (NGAO), other government entities, and implementing partners to develop and implement strategies for eliminating the triple threat; sexual gender-based violence, pregnancies and HIV among adolescents and young people.



Source: KHIS (MoH 711-SGBV)

1. HIV

HIV remains a major public health threat for adolescents and young people in Kenya. Globally, HIV is among the leading causes of death among adolescents. Moreso, an estimated 98 new HIV infections occur every week among adolescents aged 10-19 in Kenya.

2. SEXUAL AND GENDER-BASED VIOLENCE

Sexual and gender-based violence refers to any harmful act that is perpetrated against a person's will and is based on gender, norms, and unequal power relationships Of these, 5,890 (36%) were provided with Post Exposure Prophylaxis (PEP) to prevent HIV infection, out of whom 236 (4%) acquired HIV. Additionally, 1,665 of these adolescents reported being pregnant 4weeks after exposure to SGBV.

In 2021 **20.4%**
(316,187)
of all pregnancies were among adolescents aged **10-19**

Source: KHIS (MoH 711-ANC)

3. ADOLESCENT PREGNANCIES

In Kenya, almost 1 out of 4 women give birth by age 18 and nearly half by age 20. One in every five adolescents aged 15-19 are already mothers or pregnant with their first child. (KDHS,2014) In 2021, the country recorded a total of 316,187 adolescent pregnancies. Of these, 294,364 pregnancies were among girls aged 15-19 while those aged 10-14 contributed to 21,823 (7%) of the total adolescent pregnancies.

WHAT IS THE TRIPLE THREAT IN ADOLESCENTS?

Kenya has made significant investments to ensure adolescents and

IMPACT OF THE TRIPLE THREAT ON POPULATION AND DEVELOPMENT

young people are educated, enjoy a healthy life, and attain their aspirations. New HIV Infections, adolescent pregnancies and sexual and gender-based violence threaten this progress.

Adolescent pregnancy infringes on a young person's fundamental rights to education Increasing new HIV infections among adolescents impedes ending AIDS as a public health threat in the country. Sexual violence increases the risk of both HIV infection and pregnancy Sexual violence threatens a young woman's agency to negotiate for sex and safer sex, increasing her risk of HIV infection, unintended pregnancy, and other negative health and socioeconomic outcomes Adolescent pregnancy may be an indication of harmful cultural practices such as Female Genital Mutilation (FGM) and child marriage which infringe on basic human and child rights

1. Girls who do not complete secondary school education have higher vulnerabilities to HIV and other sexually transmitted infections and related complications, poor health outcomes such as the risks of
2. Adolescent mothers diagnosed with HIV must cope with the mistimed pregnancy, HIV diagnosis, and initiation to lifetime treatment during antenatal care.
3. Young mothers living with HIV also have poor outcomes in preventing the mother-to-child transmission continuum of services.
4. Perpetuate poverty at family, societal, and national levels with an increased burden on social services, such as healthcare and education.
5. Adolescent pregnancy leads to interrupted educational attainment and opportunities leading to loss of economic opportunities.
6. Violence infringes on child and human rights while narrowing opportunities for women and girls to participate in the country's development meaningfully.

CS Kagwe Calls for Sustained Efforts to End Teenage Pregnancies

About NACC

The overriding mandate of National AIDS Control Council (NACC) is to provide leadership in policy and strategy

News and Updates

> CS Kagwe Calls for Sustained Efforts to End Teenage Pregnancies

> Why we need to safeguard our youthful population

Contact Us

Landmark Plaza, 9th Floor,
Argwings Kodhek Road

P.O. Box 61307 – 00200
Nairobi, Kenya

formulation, resource mobilization and coordination of stakeholders in implementing and monitoring of the HIV response.

> My guardian turned against me, a personal life experience of sexual gender based violence

> Let's join hands to end the Triple Threat among teenagers, young women, urges PS Mochache

> A toast to fathers contributing to HIV prevention

Phone: +254 20 2715109, 2715144
Email: communication@nacc.or.ke
Mon to Fri – 8:00 am to 5:00 pm

REPUBLIC OF KENYA

IN THE HIGH COURT OF KENYA AT KIAMBU

CONSTITUTIONAL PETITION NO. OF 2022

IN THE MATTER OF ARTICLES 10(1) & 10 (2)(a), 19, 22, 23, 26 (1) & (4), 27, 33, 35, 43 (1(a)), 53 (1(c)) AND 232 (1(d)) OF THE CONSTITUTION OF KENYA, 2010

AND

I IN THE MATTER OF ARTICLES, 22, 23, 34 AND 35 OF THE EAST AFRICAN COMMUNITY HIV & AIDS PREVENTION AND MANAGEMENT ACT

AND

IN THE MATTER OF SECTIONS 5, 6, 7, 15 AND 68 OF THE HEALTH ACT, 2017

AND

IN THE MATTER OF SECTION 16(2), (3) & (4), 28(3), 146 AND THE FIRST SCHEDULE OF THE CHILDREN ACT NO. 29 OF 2022

AND

IN THE MATTER OF SECTION 6 AND 7 OF THE SCIENCE TECHNOLOGY AND INNOVATION ACT NO. 28 OF 2013

AND

IN THE MATTER OF SECTION 4 AND 5 OF THE ACCESS TO INFORMATION ACT NO. 31 OF 2016

AND

IN THE MATTER OF THE PUBLIC SERVICE COMMISSION GUIDELINES FOR PUBLIC PARTICIPATION IN POLICY MAKING (2015)

AND

IN THE MATTER OF THE NATIONAL REPRODUCTIVE HEALTH POLICY 2022-2032

BETWEEN

RACHAEL MWIKALI.....1ST PETITIONER

ESTHER AOKO.....2ND PETITIONER

AMBASSADOR FOR YOUTH & ADOLESCENT

REPRODUCTIVE HEALTH PROGRAMME (AYARHEP).....3RD PETITIONER

KENYA LEGAL AND ETHICAL

ISSUES NETWORK ON HIV & AIDS.....4TH PETITIONER

VERSUS

CABINET SECRETARY

MINISTRY OF HEALTH.....1ST RESPONDENT

THE ATTORNEY GENERAL.....2ND RESPONDENT

AND

KENYA OBSTETRICAL GYNAECOLOGICAL SOCIETY..... 1ST INTERESTED PARTY

KATIBA INSTITUTE .....2ND INTERESTED PARTY

AFFIDAVIT OF NELLY BOSIRE IN SUPPORT OF THE APPLICATION AND THE PETITION

I, **NELLY KWAMBOKA BOSIRE,** a female Kenyan adult of sound mind residing and working for gain in Nairobi County within the Republic of Kenya do hereby make oath and state as follows;

1. I am a qualified, registered and practicing specialist obstetrician and gynecologist with 15 years of experience in the field of medicine. I currently operate a clinic at the Kenya Medical Centre where I offer my services as a consultant obstetrician and gynecologist. I am also a director at Glissan Medical Services, an institution that provides medical services in Nairobi. (***Annexed hereto and marked NKB1 is a copy of my current practicing certificate from the Kenya Medical Practitioners and Dentists Council, my registration certificate as well as a copy of my curriculum vitae.***)

2. I hold a medical degree from the Moi University (MBCHB) and pursued my specialization in Obstetrics and Gynaecology (MMED OBS/GYN) at the University of Nairobi. I have various certifications in Leadership and Management, Reproductive health, and Early Pregnancy and Emergency Gynaecology from the University of Washington and the Royal College of Physicians.

3. Since qualifying as a medical doctor, I have served in various capacities in the field contributing to policy and curriculum development and medical research. In particular,
    a. I am presently a Technical Consultant for the Kenya Paediatric Research Consortium overseeing the implementation of a Bill and Melinda Gates Foundation (BMGF) funded project for Championing Evidence Based Advocacy for Primary Health Care (PHC) and Reproductive, Maternal, Neonatal, Child, Adolescent Health and Nutrition (RMNCAH+N) in 15 selected counties in Kenya.
    b. I have ten years' experience in medical education curriculum development and implementation as a member of the Kenya Medical Practitioners and Dentists' Council, developing the core curricula for the Undergraduate MBChB (Medical) and BDS (Dental) Degree Programmes and the Core Curricula for Post-graduate

MMeD and MDS Degree programmes in Surgery, Obstetrics and Gynaecology and Family Medicine and the COSECSA Fellowship Programmes

c. I have consulted for the Ministry of Health as a Specialist Obstetrician and Gynaecologist in the development of the Kenya Covid-19 Reproductive and Maternal Health Guidelines, April 2020; Health Systems Strengthening for Post-Abortion Care Services 2020 to 2022

d. I served as a Board Member in the Medical Practitioners and Dentists' Council from 2014 to 2019 and continue to serve as a Co-opted member to date. I have also served as a chair of the Nairobi Branch of the Kenya Medical Practitioners, Pharmacists and Dentists' Union (KMPDU) from 2011 to 2016

e. I chaired the Health Advisory Board of St. Francis Community Hospital.

4. I have read the Application and the Petition herein and the contents thereof have been explained to me by my counsel and I swear this affidavit in support of the orders sought in the Application and the Petition.

5. I am aware that the 1st Respondent has been in the process of development of the National Reproductive Health Policy 2022 - 2032 which was launched in July 2022. However, this Policy is fraught with various policy directions that hinder the provision of comprehensive reproductive health services.

6. It is indicated that the overall goal of the policy is to reduce the heavy burden of preventable reproductive health morbidity and mortality. The policy should focus on more than just reduction of death and mortality by wholesomely looking to improve the quality of reproductive health service delivery in order to facilitate the provision of the highest standard of reproductive health.

7. The policy conflicts with various existing guidelines that currently health care providers rely on to guide them as they provide services. Moreover, it contains clauses that will serve as barriers to reproductive health service provision for all Kenyans, and particularly for women, children, intersex persons and other vulnerable communities.

Provision of Reproductive Health Care Services to Women

8. The 1st Respondent indicates at ***policy thrust 3.4.8 paragraph 7*** that critical reproductive health services to vulnerable populations shall be offered free of charge as a package in under the Linda Mama Programme.

9. As currently implemented, the Linda Mama programme is not anchored in law despite being fully funded by the exchequer. It remains vulnerable to inadequate implementation and its financing remains subject to political goodwill. As it stands, it faces significant challenges in providing for the most vulnerable populations, throughout the range of services required in provision of maternity care. This policy document needs to address the Linda Mama Programme wholesomely, giving it an anchor on which the service is provided.

10. To benefit from Linda Mama, women or girls need to first register through the National Health Insurance Fund. The registration requires an identity card for all adults; an antenatal clinic card and a guardian's identity card for those under the age of 18; and an antenatal clinic card for all other citizens without an identity card. These requirements lock out those who are unable to prove citizenship, especially those who reside in marginalised and remote areas. It also locks out adolescents who may require critical reproductive health services but not have access to a guardian in a timely fashion.

11. Further, being a benefit accessible for registration only during pregnancy, it means that those who require emergency service as a first contact with a health facility may be unable to access the benefit. ***Annexed hereto and marked NKB2 is a copy of Policy Brief by the KEMRI Wellness Trust indicating some of the gaps in care in the Linda Mama Programme.***

12. Provision of reproductive health services related to termination of pregnancy, such as abortion and post abortion care is unclear. The policy uses a non-medical and non-scientific and inaccurate definition of abortion. Keeping in mind that this is a service

that is offered by a trained health professional, there should be no ambiguity in the definition of the terminology at all.

13. At ***policy thrust 3.4.1 at paragraph 12***, the Policy requires medical practitioners to terminate a pregnancy after taking into account the health of both the mother and the unborn child. This policy direction is confusing and is unclear, with regard to the already confusing definition of the terminology abortion.
14. The effect of the ambiguity created in the Policy may easily result in unwarranted barriers in access to services for women in need of abortion and post-abortion care, through creating an environment of fear and ambiguity.
15. The direction taken by the 1st Respondent in the Policy at ***policy thrust 3.4.2*** in provision of contraceptive services is exclusionary at and will mean that health care practitioners shall only provide services to women who are in family unions. This will exclude services to all persons in need of the service, who cannot show that they are in unions.
16. The ***Policy at policy 3.4.2 paragraph 4*** also provides that county governments should enter contracts with local medical practitioners to provide specified methods and volumes of contraceptive services in their respective communities. The Policy uses ambiguous language and does not specify what contracts these are. It assumes that medical practitioners in private practice require special contracts to provide contraceptives yet the same is not required for provision of other medical services.
17. At ***policy thrust 3.4.4 at page 24,*** the Policy requires that all pregnant women and their families are tested for HIV; whereas it should speak to ensuring access to HIV testing and treatment for those in need. The policy direction comes across as making testing mandatory while taking away the right of a pregnant woman to opt in or out of testing. This may present a barrier to access to comprehensive antenatal care services for patients who may shun seeking services out of fear of coercion.

18. There is no mention of what reproductive health interventions that children living with HIV should be afforded, particularly as they transition into adolescence and through to adulthood despite this being the most difficult phase for them.

19. The Policy at policy thrust 3.4.5 recognises that cervical cancer is preventable if detected early and in addition to that it also acknowledges that there have been efforts to vaccinate children aged 10 years in Kenya. Further, the Policy recognizes the existing cervical cancer screening guidelines for women 25 years and above. However, with evidence of sexual debut below the age of 19, as demonstrated by the rate of adolescent pregnancies and documented cases of cervical cancer in women as young as 22, there is need for the policy to promote patient-centered, individualized screening for younger women with a higher risk profile.

20. At clause ***3.4.11 paragraphs 5 and 6***, there is a clear exclusion of some women and girls from fertility treatment thereby denying them access to reproductive rights and options that are unrestricted for women in a union.

21. It is unclear who the intended beneficiaries of the fertility treatment are, and in particular who the "needy desirous couples" are, since there are no parameters for determining who is considered a needy desirous couple.

22. This policy direction at paragraph 6 further restricts provision of fertility services with regards to surrogacy to those couples who cannot conceive because of gynecological reasons. The limitation to gynecological reasons is not inclusive of other medical reasons and social reasons for which people seek fertility services. Further, it intimates that uncoupled persons are not considered in access to surrogacy services.

23. Moreover, the period under which a surrogate mother remains the responsibility of the commissioning parents should not end at the birth of the baby but extend to the postnatal period because a surrogate mother would still require maternity care even after the birth of the child.

The Requirement of Parental Consent

24. The Policy at clause 3.4.8 at paragraph 8 speaks to enforcement of parental consent in provision of reproduce health services in children and adolescents, requiring that in the absence of the parents, a guardian or a children's officer should give consent prior to treatment. This however, may create bottlenecks and fails to take into account that in emergency situations neither a parent, or guardian, or children's officer may be available.

25. The Policy as currently framed does not make room for minors who are already already mothers, and who are of sufficient maturity to be included in the decision-making process and who can then consent with regard to their reproductive health needs.

26. Where the parent, guardian or children's officer is not available or where a vulnerable adolescent seeks emergency care discreetly because of fear of retribution, it is the responsibility of the healthcare worker to provide comprehensive emergency care to protect the adolescent, in line with the provisions for emergency consent.

27. Moreover, there are many instances where an adolescent is fully aware of the situation they are in and competent to decide about the care they need. The policy does not envision the scenario where the opinion of the minor and the parent differ, and where the intervention would be in the best interests of the child.

28. In practice, children's officers are not stationed in health care facilities. The Policy has not demonstrated how this bottleneck shall be overcome without undue delay in service delivery.

29. Adolescents are diverse in abilities, with different cognitive ability and psychosocial development. This means that there is need to recognize that different sets of adolescents have potential to participate in decision-making regarding their reproductive health. The Policy does not give room to recognize this.

30. The reality is that due to the various vulnerabilities that adolescents face, they require various health care services to ensure both their reproductive health and sexual health. Adolescence is a transitionary period and one marked by continuing sexual development.

Adolescents require appropriate support in the form of health care information, education, counselling and where necessary, contraception during this period.

31. Many adolescents are involved in consensual and nonexploitative sexual acts amongst themselves. These adolescents require comprehensive reproductive health services to safeguard their health.

32. Moreover, reproductive health services especially on contraceptives encompasses provision of condoms. Condoms are widely used as a measure of HIV and STI prevention as well as a contraceptive. Under this policy, health care providers are not allowed to provide even condoms to high-risk adolescents without the consent of a parent.

33. Adolescents also continue to be vulnerable to sexual violence. They require reproductive health interventions such as treatment for physical injury, emergency medication to reduce chances of contracting sexually transmitted infections (STI) and HIV as well as the provision of emergency contraception to prevent unwanted pregnancy.

34. When supportive reproductive health care services and information is not given, this is manifested in a rise in teenage pregnancies, sexually transmitted infections and HIV infection which are currently evident in most parts of Kenya, with the highest number of new HIV infections being among the 15 to 24 year age group. Currently there are no structures that have been placed to ensure that there is comprehensive reproductive health education among the youth and adolescents.

Self-Care Reproductive Health Interventions and Telemedicine

35. The Policy at ***policy thrust 3.4.2 paragraph 3*** promotes self-care whereas guidelines for the same, as currently stands, have not been established. Many reproductive health interventions need evaluation by a health care provider to ensure that the correct course of action is followed. This policy direction may pose a risk to persons seeking reproductive health services, particularly those who are vulnerable or of poor socio-economic status who may not have adequate access to health care providers for an initial assessment.

Reproductive Health Interventions for Intersex Persons

36. Intersex persons have long faced challenges when seeking health care services. It is now accepted in both medical and other policy frameworks that there is need for the 1st Respondent to ensure that comprehensive health care services, including reproductive health services are provided to intersex persons. ***Annexed hereto and marked NBK3 is the Abridged report of the Taskforce On Policy, Legal, Institutional And Administrative Reforms Regarding The Intersex Persons In Kenya*** which details the legal and policy framework that the 1st Respondent ought to follow in ensuring service provision for intersex persons.

37. the procedure set out at ***policy thrust 3.4.12 at paragraph 3***, intersex persons are required to present themselves before a professional body to facilitate transition to the actual sex. This intervention by the Policy is ambiguous and unclear as it is not specified what professional body this is.

38. Further, the Policy direction does not envision a situation where an intersex person may have no desire to undergo transition and chooses to live as intersex throughout their lives. To this end, no provisions have been made to cater for the intersex persons' reproductive health needs in their intersex state.

39. The reproductive health interventions for an intersex person should be made with their fully informed consent and in consultation with their doctor. The need for multidisciplinary care in the event transition care is desired cannot be underscored. However, this does not call for the bureaucracy of having a standing professional body to address the care. The highly skilled healthcare providers are adequately qualified to assemble the team required for evaluation, treatment and follow-up care of the intersex persons. Creation of such a 'professional body' and requiring attendance before it subjects the intersex person to undue hardship and bureaucracy and further enhances stigmatization of the condition, which should otherwise be treated as any other congenital medical condition.

40. Furthermore, the Policy at ***policy thrust 3.4.12 paragraph 3*** introduces more bureaucracy into the registration of children born with ambiguous genitalia by providing that these

births be reported or notified to a government health facility. This is despite the fact that all medical institutions in Kenya licensed to provide maternity care, whether public or private, are fully bestowed upon the responsibility of registering all newborn babies. There is no rationale for this differential treatment of registration of intersex babies. It is does not provide a solution to the systemic discrimination in registration of intersex persons at birth and creates further differentiation without justification. The expectation of Policy is that it should advocate for review of the registration of intersex babies as such.

Barriers to Research, Development and Innovation, and Gaps in Implementation of the Policy

41. Research on reproductive health care is done by a variety of actors, including students in training, health care practitioners as well as governmental and non-governmental actors. County governments also contribute to the body of research that aids reproductive health developments.

42. In its bid to provide for the implementation of research and development, the Policy shuns the role that county governments play in promoting diversity by providing for the mainstreaming of reproductive health research. This stems from clause 3.4.13 at paragraph 2 that directs that the Director General for Health as the sole custodian of reproductive health research the country, yet all other research institutions have the autonomy to carry out research and may be even better resourced to do the same. This undermines efforts put in training and development of knowledge. Clause 4.2.3.8 at paragraph 5 demonstrates continued undermining where it provides that the Director General shall vet all reproductive health research in the country. There is no reasonable justification as to why only the Director General should vet research.

43. Given the foregoing, and in the interest of safeguarding the constitutional rights of reproductive health and the lives of the people of Kenya, I pray that this Honourable Court to grant the orders set out in the Notice of Motion pending the hearing and determination of the Application and the Petition. I also pray that the prayers in the Petition be granted.

44. What is deponed to herein is true to the best of my knowledge, information and belief, save for information whereof sources of information have been disclosed.

SWORN at **NAIROBI** by the said)
NELLY KWAMBOKA BOSIRE)
)
)
This 8th day of September 2022)
BEFORE ME)
)
)
COMMISSIONER OF OATHS)

DEPONENT

WYCKLIFE O. OYOO
Advocate & Commissioner for Oaths
KAPLAN & STRATTON
P.O. Box 40111 - 00100
NAIROBI

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NKB-1

Issue Date: 12-11-2021 **No. SP/2022/593490**

KENYA MEDICAL PRACTITIONERS AND DENTISTS COUNCIL

SPECIALIST PRACTICE LICENSE

Pursuant to Section 12 of the Medical Practitioners and Dentists Act, Cap 253 Laws of Kenya, this is to certify that:

DR. NELLY KWAMBOKA BOSIRE

of

Registration No: **A6160** duly registered on **11th April, 2008**

Whose qualification(s) are:

MBChB(Moi) 2007; M.Med(Obs & Gyna)(Nairobi) 2015

This is Exhibit marked "NKB-1" referred to in the Annexed affidavit/Declaration of Nelly Kwamboka Bosire
Sworn/Declared before me on this 20th day of December 2022 at Nairobi in the Republic of Kenya
Commissioner for Oaths

Type of Practice: **CLINICAL PRACTICE**

Discipline: **SPECIALIST PRACTICE (OBSTETRICS AND GYNAECOLOGY)**

and whose registered address is **P.O. BOX 4153 00506 NAIROBI**
is licensed to practice for the year **2022**

This license is valid up to **31st December, 2022**

Dated this **12th** day of **November, 2021**

The Doctor is duly licensed to Practice in the Republic of Kenya.

Daniel M. Yumbya, MBS
Chief Executive Officer/Registrar
Kenya Medical Practitioners and Dentists Council

FORM III

REPUBLIC OF KENYA

(Rule 4)

REGISTRATION A No. .....

THE MEDICAL PRACTITIONERS AND DENTISTS BOARD

(THE MEDICAL PRACTITIONERS AND DENTISTS ACT, CAP. 253)

CERTIFICATE OF REGISTRATION AS A MEDICAL PRACTITIONER

Dr./~~Mr./Mrs./Miss~~ Nelly Kwamboka Bosire
(*Full Names*—BLOCK LETTERS)

of P.O. Box 4153 Nairobi

Qualifications MB; Ch.B (Mak) 2007;

has been registered as a Medical Practitioner in accordance with the provisions of section 6 of the Medical Practitioners and Dentists Act (CAP. 253)

Dated this 11th day of April, 2008

Seal of the Board.

CHAIRMAN
MEDICAL PRACTITIONERS AND DENTISTS BOARD

REGISTRAR
MEDICAL PRACTITIONERS AND DENTISTS BOARD

FOOTNOTES:
(a) It shall be the duty of the holder of this certificate to inform the Registrar within 14 days of any change in his registered address (s. 9).
(b) Reference should be made to the current published list in the Kenya Gazette for evidence of continued registration of the practitioner (s 10).

155

CURRICULUM VITAE

Name: Dr. Nelly Kwamboka Bosire
Profession: Specialist Obstetrician and Gynaecologist
Years of Practice: 15
Nationality: Kenyan
Membership in Professional Societies:

- East, Central and South African College of Obstetrics and Gynaecology (ECSACOG)
- Kenya Obstetrical and Gynaecological Society
- Kenya Medical Association
- Kenya Hospital Association
- Reproductive and Maternal Health Consortium

Key Qualifications, Competencies and Experience:

1. **Master of Medicine in Obstetrics and Gynaecology (M.MED, Obs/Gyn),** University of Nairobi; **Bachelor of Medicine and Surgery (M.B.Ch.B.)** Moi University; **Certificate in Global Mental Health**, University of Washington; **Certificate in Leadership and Management in Health**, University of Washington; **Certificate in Policy Development and Advocacy for Global Health**, University of Washington; **Certificate in Economic Evaluation for Global Health**, University of Washington; **Certificate in Project Management**, University of Washington; **Certificate in Early Pregnancy and Emergency Gynaecology**, Royal College of Physicians; **Certificate in Basic Training in Minimal Access Surgery**, International Centre for Minimal Access Surgery (ICMAS); **Certificate in Basic Training in Hysteroscopy**, International Centre for Minimal Access Surgery (ICMAS)

2. Fifteen years' experience as a practising doctor in the field of obstetrics and gynaecology, with eight as a **Consultant Specialist Obstetrician and Gynaecologist** in full-time private practice, partnering with top level six facilities in Kenya; four years as a **Registrar, Obstetrics and Gynaecology**, at Kenyatta National Hospital; two years as a **Medical Officer** in Pumwani Maternity Hospital and a year as a **Medical Officer Intern** at Kenyatta National Hospital.

3. Ten years of experience in medical education curriculum development, implementation oversight and supportive supervision. I have been part of, and chaired various technical working groups responsible for the development of the **Kenya Medical Practitioners and Dentists' Council** core curricula for the **Undergraduate MBChB (Medical) and BDS (Dental) Degree Programmes** and the Core Curricula for **Post-graduate MMeD and MDS Degree programmes in Surgery, Obstetrics and Gynaecology and Family Medicine and the COSECSA Fellowship Programmes.**

4. I have consulted for the **Ministry of Health** as a **Specialist Obstetrician and Gynaecologist in the development of the Kenya Covid-19 Reproductive and Maternal Health Guidelines, April 2020; Health Systems Strengthening for Post-Abortion Care Services 2020 to 2022**

5. I have four years' experience, serving as the **Chair of the Hospital Board** of **St. Francis Community Hospital**

6. I have consulted for **Mount Kenya University** as the Lead Consultant, the **Graduate Specialist Medical Education Programme**

7. I am the **Director, Glissan Medical Services**, Overseeing the daily operations of the medical service; Managing rosters for consulting specialist doctors and non-medical staff; Overseeing financing of the practice; Development of standard operating procedures for clinical and non-clinical operations; and I also Participate in patient care.

Education

Institution [Date from - Date to]	**Degree(s) or Diploma(s) obtained:**
2015, University of Nairobi	Master of Medicine in Obstetrics and Gynaecology (M.MED, Obs/Gyn)
2007, Moi University	Bachelor of Medicine and Surgery (M.B.Ch.B.)
Other Training	
2021, University of Washington	Certificate in Global Mental Health
2020, University of Washington	Certificate in Leadership and Management in Health
2020, University of Washington	Certificate in Policy Development and Advocacy for Global Health
2020, University of Washington	Certificate in Economic Evaluation for Global Health
2020, University of Washington	Certificate in Project Management
2019, FIGO	Advocacy and Communication Training
2018, Royal College of Physicians	Early Pregnancy and Emergency Gynaecology
2017, Kenya School of Government	Corporate Governance

2014, ICMAS	Basic Training in Hysteroscopy, International Centre for Minimal Access Surgery
2013, ICMAS	Basic Training in Minimal Access Surgery, International Centre for Minimal Access Surgery
2012, Ministry of Public Health and Sanitation	Training of VIA/VILI for Screening and Prevention of Cervical Cancer

Employment Record

Year, Title and Company/Organization	Roles
2022 January to Present: Technical consultant, Kenya Paediatric Research Consortium	**Role:** To oversee the implementation of Bill and Melinda Gates Foundation (BMGF) funded project for Championing Evidence Based Advocacy for Primary Health Care (PHC) and Reproductive, Maternal, Neonatal, Child, Adolescent Health and Nutrition (RMNCAH+N) in 15 selected counties in Kenya.
2018 to Present: Health and Science Writer, Nation Media Group	**Role:** Writing weekly articles for the "Healthy Nation" pull-out magazine for the Tuesday Daily Nation Newspaper as a health care professional.
2016 to Present: Director and CEO, Glissan Medical Services	**Roles:** Overseeing the daily operations of the medical service; Managing rosters for consulting specialist doctors and non-medical staff; Overseeing financing of the practice; Development of standard operating procedures for clinical and non-clinical operations; Participating in patient care.
2015 to Present Specialist Obstetrician and Gynaecology in Private practice	**Roles:** Provision of specialized clinical services to patients in the ambulatory and outpatient setting in my clinic. Provision of specialized clinical and surgical care of patients requiring inpatient care in various hospitals in Nairobi including The Nairobi Hospital, MP Shah Hospital, The Mater Hospital and Coptic Hospital; Overseeing the daily operations of the clinic; Development of a wellness programme for patients seeking services; Development of youth-friendly services especially for the adolescents and university students; Providing comprehensive care for victims of sexual and gender-based violence as part of the healthcare team, Running a special subsidized reproductive health service for sickle cell female patients of reproductive age in conjunction with Children Sickle Cell Foundation – Kenya; Running a special free reproductive health clinic for disadvantaged youth living with HIV.
2014 to 2016: Director, Health and Medical Advocacy, Swiftmed Solutions.	**Roles:** Provided oversight over the daily operations of the company, Developed project proposals and oversaw their implementation; Marketing of the company services to potential clients; Oversaw financing of the company and implementation of budgetary controls; Implemented health advocacy campaigns in line with the company's protocols

2010-2015: Resident, University of Nairobi, Department of Obstetrics and Gynaecology.	**Roles:** Provided clinical care to patients at Kenyatta National hospital in the department of Obstetrics and Gynaecology; conducting maternal mortality and morbidity audits; running sub-specialty units within the department, including the sexual and gender-based violence unit, the youth centre, the fistula clinic and the colposcopy units.
2008-2010: Medical Officer, Pumwani Maternity Hospital	**Roles:** Provided clinical care to patients in the wards, theatres and the outpatient clinics. Also conducted neonatal and maternal mortality and morbidity audits.
2007-2008: Medical Officer Intern, Kenyatta National Hospital	**Roles:** Provided clinical care to patients under supervision in various departments in the hospital.

Professional Experience

Date from - to	Location	Company	Position	Description
August 2021- Ongoing	Kenya	Kenya Medical Practitioners and Dentists Council (KMPDC)	Technical Advisor	Provide technical guidance in the review of the Professional Code of Conduct and Ethics for Medical Practitioners and Dentists
July 2021- Ongoing	Kenya	Kenya Medical Practitioners and Dentists Council (KMPDC)	Chair, Technical Working Group	Development of the Scope of Practice for Medical Practitioners, Dentists and Community Oral Health Officers in Kenya
2020	Kenya	FIDA-Kenya	Technical Expert	Technical advisory services in the development of the Reproductive Health Bill; conducting public awareness about the bill and its contents and appearing as a technical expert in both the National Assembly and the Senate on behalf of FIDA-Kenya, to lobby for the Bill.
March to April 2020	Kenya	Ministry of Health, Reproductive and Maternal Health Division	Technical expert	Technical advisory services in the •Development of the KENYA COVID-19 RMNH GUIDELINES: A Kenya Practical Guide for Continuity of Reproductive, Maternal, Newborn and Family Planning Care and Services in the Background of COVID19 Pandemic, MOH, April 2020.
April 2020- Ongoing	Kenya	Ministry of Health, Reproductive and Maternal Health Division	Technical expert	Technical services in the implementation of the Health Systems Strengthening in Post-Abortion Care (PAC) services Project. This includes: • Development and publication of the: o National Post-Abortion Care Standards

				○ Post-Abortion Care: A Facilitator's Manual For Healthcare Providers (Oct 2020) ○ Post-Abortion Care: A Participant's Manual For Healthcare Providers (Oct 2020) ○ Post-Abortion Care: A Log Book For Healthcare Providers (Oct 2020) ○ Post-Abortion Care: Daily Activity Register; MoH No. 522 ○ National Post-Abortion Care Costed Implementation Plan 2021-2025 • Conducting County Entry Meetings across 47 counties with regard to project implementation. • Conducting training of trainers and focal persons for PAC services • Conducting training for clinical service providers
March 2020	Kenya	Kenya Healthcare Convention hosted by Express Communications Limited, Amref Health Africa and Glissan Medical Services	Co-Host	Hosting the first ever Kenya Healthcare Convention, organizing the opening ceremony presided over by the President of the Republic of Kenya, identifying and inviting speakers for the conference sessions.
April-September 2019	Kenya	Tell-Em Public Relations East Africa on behalf of Procter and Gamble Company Limited	Technical consultant	Writing and publishing of health articles for menstrual health and hygiene, television and radio appearances to provide education on the same and hosting of round-table sessions as an expert speaker on the subject matter.
2019	Kenya	Kenya Medical Practitioners and Dentists Council (KMPDC)	Technical Lead, Chair of the Training, Assessment and Registratio	Provision of technical guidance in the development of the KMPDC Core Curricula and Guidelines for Specialist Training in Kenya; General Surgery, Obstetrics and Gynaecology and Family Medicine specialties

			n Committee	
2019	Kenya	Kenya Medical Practitioners and Dentists Council (KMPDC)	Technical lead	Provision of technical guidance in the review of the Internship Training Guidelines for Medical Officers and Dentists in Kenya.
2018-2019	Kenya	Kenya Medical Practitioners and Dentists Council (KMPDC)	Technical Advisor	Provision of technical guidance in the Review and amendment of Cap. 253 of the Constitution of Kenya, Medical Practitioners and Dentists Board act 2019
2018	Kenya	Mount Kenya University	Lead Consultant	Prepared the draft zero curriculum for the Master of Medicine, Obstetrics and Gynaecology, for Mount Kenya University. Development of a Memorandum of Association between Mount Kenya University and Thika Teaching and Referral Hospital for purposes of graduate medical specialist training.
2018 - Present	Kenya	Hospital Advisory Board, St. Francis Community Hospital	Chair	Leading the Board in providing oversight to the hospital CEO and management as they execute the hospital's strategic and operational plans; Ensuring integrity and implementing budgetary controls to ensure the hospital operates within its budgetary thresholds.
2018 - Present	Kenya	Nation Media Group	Guest writer, Health and Science Desk	Authored over 250 articles on various topics regarding healthcare, published in the Healthy Nation pull-out of the Tuesday Daily Nation
2017	Kenya	Ministry of Health; National Cross Cadre Continuing Professional Development Committee	Technical Specialist	Providing technical advice during the development of the National Guidelines for Cross-cadre Continuous Professional Development activities for medical practitioners, dentists, nurses, midwives, clinical officers, laboratory technicians, pharmacists, pharmacy technologists, radiographers and sonographers.
2016	Kenya	Ministry of Health; National Telemedicine Initiative Technical Working group in	Technical Consultant	Technical advisory role in the establishment of the National Telemedicine Initiative pilot in Machakos County Referral Hospital, linking it to Kenyatta National Hospital for the provision of remote highly specialized patient consultations.

		collaboration with Merck Company Limited		
2016	Kenya	Swiftmed Solutions in collaboration with Smilewoman CBO and Nation Media Group	Organizer	Successful planning, execution and evaluation of a 34-day, 1000km walk by 5 cervical cancer champions across Kenya, to raise awareness about cervical cancer and raise funds to support the care of cervical cancer patients in Migori County by provision of NHIF cards valid for three years to cover for treatment. 36 patients benefitted from the activity.
2014 - 2019	Kenya	Kenya Medical Practitioners and Dentists Board	Board member	Role included Development of policy guidelines for regulation of medical practitioners, dentists and health facilities in Kenya; Development of policy guidelines for regulation of teaching institutions involved in training of medical practitioners and dentists in Kenya; Provision of oversight in the implementation of the developed policies; Identification of gaps in the legal framework of regulatory mandate of the Council and development of appropriate legislation to address them; Provided guidance and oversight to the chief executive officer and the management team as they drove the Council's strategic plan; Ensured integrity and implementation of budgetary controls to ensure the Council operated within its budgetary thresholds; Developed the Council's Strategic plan 2018 to 2022; Represented the Council at the Ministry of Health as a key stakeholder in the development of various policy documents; I was involvement in advisory role of the Council to the Ministry of Health
2014 to Present	Kenya	Kenya Medical Practitioners and Dentists Board (now Council)	Member, Disciplinary and Ethics Committee	Receive complaints from the public, institutions or media regarding medical practitioners, dentists and health institutions, conduct hearings, deliberate and give judgement regarding the same. This is a quasi-judicial body established under Cap. 253 of the Constitution that deals with matters of medical malpractice.

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NKB-2

THINKWELL

This is Exhibit marked "NKB-2" referred to in the Annexed affidavit/Declaration of Nelly Amanya Sworn/Declared before me on this 8th day of September 2023 in the Republic of Kenya Commissioner for Oaths

Examining the implementation of the Linda Mama free maternity program in Kenya

Policy Brief - November 2021

Introduction

Maternal mortality is still unacceptably high in Kenya where 362 mothers die out of 100,000 live births, partly because of inadequate access to skilled care during delivery. A key access barrier to skilled delivery care is out-of-pocket (OOP) payment paid by women to healthcare providers to access services. Kenya has introduced several health financing reforms aimed at reducing financing barriers of access to maternal services for women that need them. In 2013, a free maternity policy that removed user fees for maternity services in all public healthcare facilities was introduced. In October 2016, the free maternity policy was revised to include private providers, and its management was transferred from the Ministry of Health (MOH) to the National Hospital Insurance Fund (NHIF) and branded the "Linda Mama program".

In 2019, researchers from KEMRI-Wellcome Trust, in collaboration with ThinkWell and NHIF, carried out a process evaluation of the implementation of the Linda Mama program in five selected counties in Kenya. Of the five counties, one was one of the country's universal health coverage (UHC) pilot county and the other had a local county-run UHC program.

Findings

In some counties, newborns were excluded from benefiting from Linda Mama

The program was intended to cover all Kenyan pregnant women and their newborns for a period of one year. However, in some counties, newborns were not considered to be beneficiaries of the program, reflecting some misunderstanding about their inclusion and how to make a claim reimbursement for these services.

Key Messages

- In 2013, Kenya introduced a free maternal care program abolishing all user-fees for deliveries at public healthcare facilities and the Ministry of Health (MOH) started reimbursing health facilities for these costs. The program was transferred to the National Hospital Insurance Fund (NHIF) in 2016, thereafter renamed as the Linda Mama program

- The Linda Mama program offered an expanded benefit package compared to the original free maternity program. However, the package excluded some important services including ultrasounds, family planning, and immunization, and others services like care for the newborn and outpatient complications for the mother were covered on paper but not in practice.

- While the program intended to eliminate out-of-pocket (OOP) payments for maternal services, some healthcare facilities continued to charge fees which represent a financial barrier to access

- Public health facilities in some counties could not use Linda Mama funds because they had to send these funds to the county revenue account. This had a negative influence on service delivery

- The Linda Mama reimbursement to healthcare facilities by the NHIF was associated with delays. Additionally, facilities reported that the set payment rates for Linda Mama services were not enough to cover the costs incurred during service delivery

- Facilities faced challenges with submitting claims such as a lack of adequate training, lack of computers and photocopy machines, claim system hang-ups, lack of IDs, and the lack of focal persons to make Linda Mama claims.. These resulted in facilities losing out on some reimbursements

- There was poor communication to key stakeholders of the program. For instance, the UHC pilot county was not receiving reimbursements for the program however, there was no clear communication on whether the program should continue or not after UHC roll out. Furthermore, there was a lack of information among mothers in the counties about the program

Linda Mama beneficiaries could not access some services that were part of the Linda Mama benefit package

The services that the mothers were entitled to according to the Linda Mama implementation manual were antenatal care, delivery services, postnatal care, emergency referrals, complications, and newborn care, see Table 1. In practice some services such as care for the newborn, outpatient complications, referral costs were not being covered. Additionally, some essential services such as ultrasounds, family planning, immunization, medical abortions, and Anti-D medications were not included in the services that mothers were entitled to.

Linda Mama beneficiaries incurred some OOP payments to access maternal services

The Linda Mama program intended to eliminate OOP payments for accessing maternal services. However, there were some patients who had to incur medical costs outside the facility due to the unavailability of drugs and other supplies.

The mean reported OOP costs during an ANC visit ranged from $0.3 (median=$0) in public hospitals to $1.94 (median=$0.12) in faith-based facilities; items paid for included ultrasounds, drugs, and photocopy costs. For PNC visits, no OOP costs were incurred at the public facilities, however, the mean OOP cost in faith-based facilities was $0.75 (median=$0) and was mainly drug costs. Lastly, mean OOP costs for deliveries ranged from $0.04 (median=$0) in public health centre to $7.13 (median=$1.8) in faith-based facilities. Items paid for during delivery visits included drugs for the newborn, basins, cotton wool, tissues, photocopy, chlorhexidine, cannula, NG-tube costs, registration costs, and for mama kits (care packages). Details of OOP medical costs incurred at the facilities are listed in figure 1.

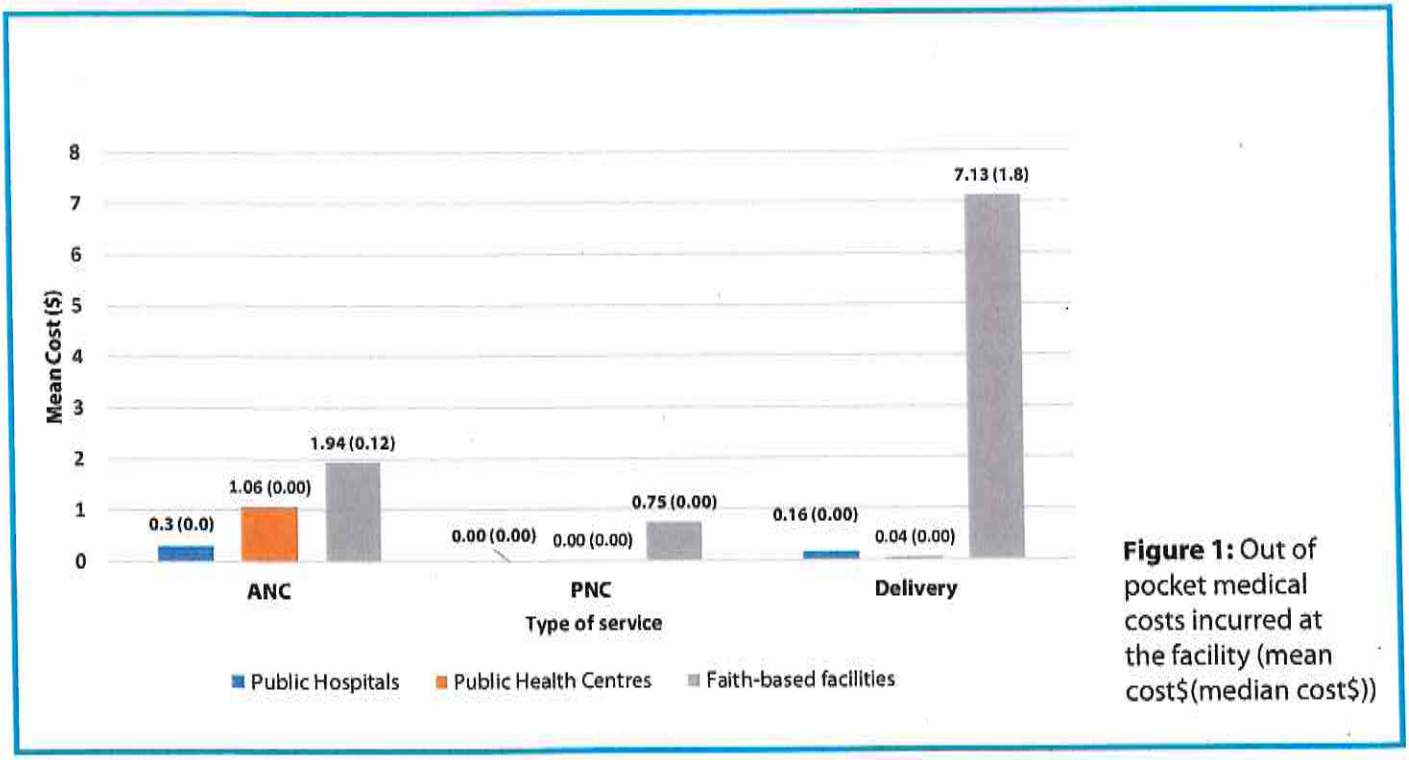

Figure 1: Out of pocket medical costs incurred at the facility (mean cost$(median cost$))

Public healthcare facilities did not access Linda Mama reimbursements in some counties

In some of the counties, Linda mama reimbursements by the NHIF were deposited directly into the public facilities' bank accounts and they had access to the funds after workplans and budgets were drawn, and approvals sought. On the other hand, in some counties the public facilities were required to either redirect the Linda Mama funds from their account to the County Revenue Fund (CRF) account, or NHIF would directly deposit to the CRF account. These funds would not be remitted back to the health facilities and this would as a result influence service delivery. This is illustrated in Figure 2.

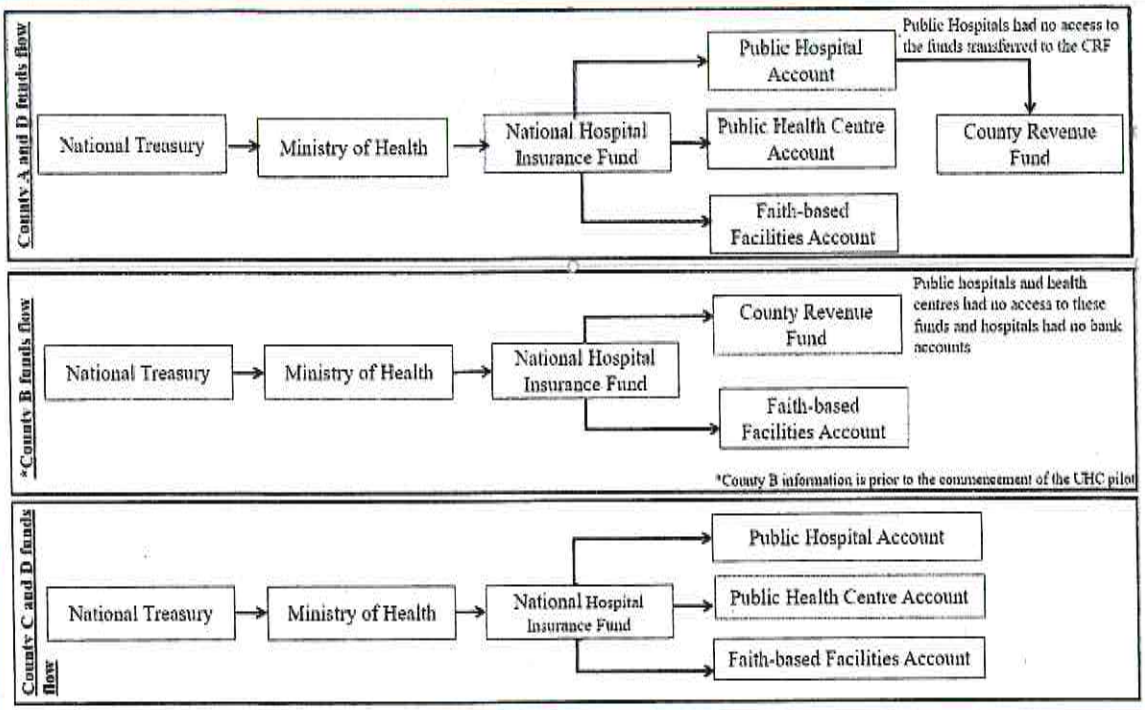

Figure 2: Funding flows of Linda Mama funds to facilities (de facto)

Funding disbursement by the NHIF to healthcare facilities was associated with delays

According to the Linda Mama implementation manual, NHIF was to ensure that there was a timely payment to the providers of within 30 days of receiving the invoices. The health facilities reported delays in receiving the payments and that the timing and amount that was to be reimbursed was unpredictable. This had resulted in pending claims to the facilities that ranged between 1% to 16% across all the facilities in the sampled counties for a period of 9 months. These pending claims are shown in Figure 3. On the other hand, the NHIF also reported delays in receiving funds from the Ministry of Health.

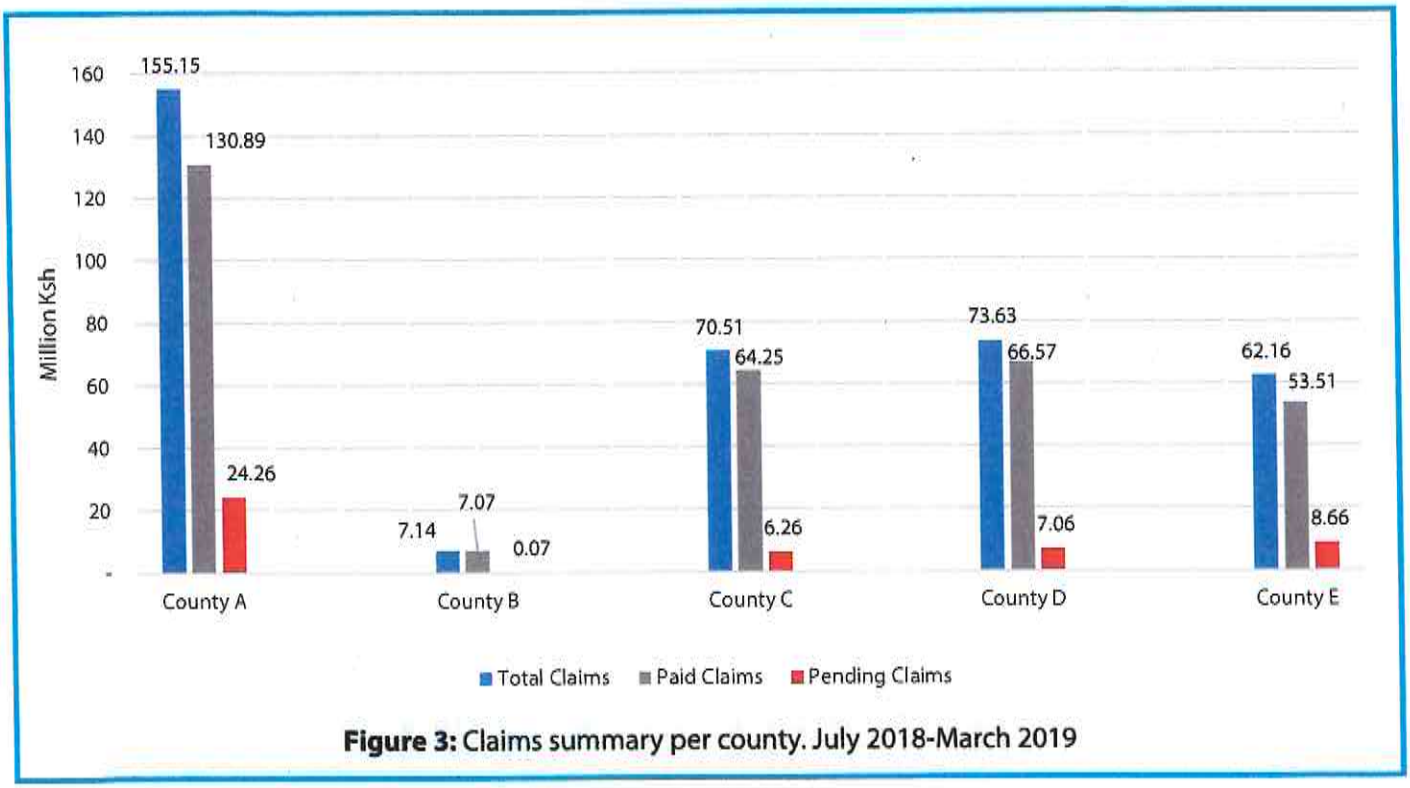

Figure 3: Claims summary per county. July 2018-March 2019

Linda Mama reimbursement rates were deemed insufficient to cover the incurred costs

Table 3 outlines the facility reimbursement rates under the Linda Mama program. Health facilities reported that the amounts reimbursed were not enough to cater for the costs incurred to offer the service. For instance, they pointed out that normal deliveries and caesarean sections were reimbursed at the same rate in public facilities. Further, the NHIF reimbursed facilities using higher rates under the national scheme. The facilities also reported that they were not to be reimbursed for referral services.

Table 1: Benefit package and reimbursement rates (de jure)

		Reimbursement rates according to the *Linda Mama* implementation manual					
Services	**Benefit package according to the *Linda Mama* implementation manual**	**Public primary care facilities (Tier 2)**	**Public primary and secondary referral facilities (Tier 3)**	**Public tertiary referral facilities (Tier 4)**	**Private/Faith based primary care facilities (Tier 2)**	**Private/Faith based primary and secondary referral facilities (Tier 3)**	Notes
Antenatal care	ANC profile, preventive services, prevention of mother to child transmission of HIV	KES 600 (USD 6)	KES 1000 (USD 10)	KES 1000 (USD 10)	KES 1000 (USD 10)	KES 1000 (USD 10)	Reimbursement for ANC-1st visit
		KES 300 (USD 3)	KES 300 (USD 3)	KES 500 (USD 5)	KES 500 (USD 5)	KES 500 (USD 5)	Reimbursement for ANC-subsequent 3 visits
Delivery	Skilled delivery (including caesarean section), neonatal care including costs related to preterm births	KES 2,500 (USD 25)	KES 5,000 (USD 50)	KES 17,000 (USD 170)	KES 2,500 (USD 25)	KES 6,000 (USD 60)	Reimbursement for normal delivery
		—	KES 5,000 (USD 50)	KES 17,000 (USD 170)	—	KES 17,000 (USD 170)	Reimbursement for caesarean section delivery
Postnatal care	Vitamins, family planning services, screening, immunization, and early infant diagnosis of HIV	KES 250 (USD 2.5)	KES 250 (USD 2.5)	KES 250 (USD 2.5)	KES 250 (USD 2.5)	KES 250 (USD 2.5)	Reimbursement for PNC and new-born care (each of the 4 visits)
Emergency referrals	Ambulance services						
Conditions and complications during pregnancy	Outpatient and inpatient treatment						
†Care for the infant	Outpatient services including treatment and child welfare clinics, and inpatient services						

Note: Source: Linda Mama implementation manual and circulars sent to facilities from the NHIF
† Care of the infant is within the 1-year period that the mother is in the program

The claims process was faced with several challenges

Facilities reported that there was inadequate training on how to make claims, especially for the lower level facilities who had previously not interacted with the NHIF on lodging claims. The sub county teams were also not trained on lodging of claims and could not adequately support the facilities in this regard. This was further compounded by a high staff turnover rate and a shortage of a focal person to lodge claims.

Some facilities also lacked computers, modems, and photocopy machines to lodge claims and the online e-claim system had several hang ups. The lack of patient identification documents (ID) posed a challenge in processing claims.

In some of the health facilities it was identified that having a focal NHIF clerk for processing Linda Mama claims specifically and ensuring all health care workers had the knowledge of the claim process was instrumental in making the claims process easier.

There was varying availability of essential medical supplies in the sampled healthcare facilities

NHIF was expected to contract healthcare facilities with the structural capacity to provide the services in the Linda Mama benefit package. However, there was varying availability of essential medical supplies across the facilities. This is reported in table 2.

Table 2: Structural quality: availability of essential medicines and supplies

Essential medicines and supplies	Available today	Available in the last 90days
Penicillin	95% (n=19)	90% (n=18)
Metronidazole	95% (n=19)	90% (n=18)
Gentamicin	95% (n=19)	85% (n=17)
Oxytocin	95% (n=19)	95% (n=19)
Misoprostol	55% (n=11)	55% (n=11)
Functional blood pressure machine	100% (n=20)	
Functional bag and mask (two neonatal mask sizes)	100% (n=20)	
Uninterrupted oxygen supply in childbirth	65% (n=13)	
Uninterrupted oxygen supply in neonatal ward (10 facilities)	60% (n=6)	
Uninterrupted oxygen supply in paediatric ward (10 facilities)	60% (n=6)	
Soap and running water/alcohol rub in childbirth	95% (n=19)	
Soap and running water/alcohol rub in neonatal ward (10 facilities)	90% (n=9)	
Soap and running water/alcohol rub in paediatric ward (10 facilities)	100% (n=10)	

168

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169

There were communication challenges in the program

NHIF branch offices communicated to facilities and counties through circulars and verbal communication. However, in 2 of the 5 counties, there was inadequate sensitization and a lack of proper cascade of information to county and sub-county health officials.

In the UHC pilot county, public healthcare facilities had not been receiving reimbursements for Linda Mama since UHC pilot rollout began. There was a lack of clarity at a county level, in the public and private facilities on whether the program should continue or not. MOH and NHIF reported that the program should be halted in public facilities during the UHC pilot however, these counties did not receive official communication.

There was a lack of information among the mothers on the availability of Linda mama, and unlike the previous free maternity policy, mothers had to register to access Linda Mama services.

Distance and associated transport costs were a barrier to access

Some of the counties were vast and the distance to facilities and transport costs was reported to be a barrier of access to care.

Conclusion

The process evaluation of the Linda Mama program reveals that there are barriers in access to maternal care, inefficiencies in the funding flow, claims process and reimbursement processes, and gaps in quality of care. Addressing these implementation challenges would contribute towards reducing the maternal mortality further and informative to the UHC reforms in Kenya.

Recommendations

Ministry of Health

- The Government of Kenya should consider making amendments to the public finance management act to ensure that health facilities have the autonomy to spend the Linda Mama funds according to their priorities.
- There needs to be better communication of the policy from the Ministry of Health. Specifically, more investments in improving community awareness of the program (possibly consider use of community health workers) and clear communication to the counties on the implications of the UHC scale up on the Linda Mama program in both the public and private sector.
- Costing of maternal and child health services should be done by the Ministry of Health to ensure that reimbursements are adequate to cater for the costs incurred.

NHIF

- NHIF should consider ensuring a stable and functioning e-platform system for lodging claims to allow for efficiency when registering and lodging claims. Training of subcounty teams by the NHIF should also be done to supplement the training that they offer to facilities, given the high staff turnovers in some of the public facilities.
- The NHIF should consider addressing bottle necks that cause delays in reimbursing the facilities and the Ministry of Health should also ensure timely transfers of funds to NHIF, without any variances. This would ensure that facilities are able to have essential drugs and supplies.
- The NHIF should consider addressing document challenges. Keeping in mind that the NHIF is trying to mitigate fraud, other exemptions should be explored in the absence of an ID/ANC book/next of kin document during delivery and in the absence of birth notifications in cases of abortions.
- The Ministry of Health and the NHIF should consider improving awareness on the service entitlements to health care providers and beneficiaries. Additionally, they should review and expand the service entitlements to include essential maternal health services that are currently excluded such as ultrasounds, family planning, immunization, and newborn care.
- The NHIF, as a strategic purchaser, should consider the active use of Linda Mama data as well as monitor quality of care under the program

Counties Department of Health

- Counties department of health should consider ensuring that the health facilities have the necessary hardware to facilitate claims. They should also ensure that there is an adequate capacity of human resources, regular support visits to ensure quality maternal and childcare.
- Providers should stop collection of OOP payments from women seeking maternal and childcare and invest in adolescent and youth friendly maternal services to minimize barriers to access of care and that the mothers are protected from financial hardships.
- Counties should strengthen engagement between county health managers and participating health facilities

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References

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NKB-3

This is Exhibit marked "NKB-3" referred to in the Annexed affidavit/Declaration of Kelly Kwamboka
Sworn/Declared before me on this 25th day of July 20 19 in the Republic of Kenya
Commissioner for Oaths

REPUBLIC OF KENYA

REPORT OF THE TASKFORCE ON POLICY, LEGAL, INSTITUTIONAL AND ADMINISTRATIVE REFORMS REGARDING THE INTERSEX PERSONS IN KENYA

ABRIDGED VERSION

NAIROBI

DECEMBER, 2018

Disclaimer

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FOREWORD BY THE CHAIRPERSON

I am very pleased to be associated with the work and publication of this report of the Taskforce on Legal, Policy, Institutional and Administrative Reforms regarding Intersex Persons in Kenya. The Taskforce was constituted by the Hon. Attorney-General in May 2017, with its membership drawn from various State and non-State institutions from the governance, medical and religious sectors as well as representation from the Intersex community. Primarily, the Taskforce was to investigate and make recommendations aimed at addressing the plight of Intersex Persons in Kenya. Indeed, this is the first time the country is undertaking such a bold step of documenting the number and distribution of intersex persons for policy interventions.

The Taskforce adopted various strategies in pursuit of its goals. Key among them were: a comprehensive and comparative desk review; stakeholder consultation; targeted awareness fora; a field survey; key informant interviews; field visits and use of ICTs. The approaches were also supported by a functional Secretariat, co-option of new members, hiring of a research consultant and partnership with relevant agencies and Development Partners. The Taskforce observed with keenness the nature and sensitivity of the subject matter. It was also confronted firsthand with the realities and stigma associated with the Intersex condition as meted out on the intersex persons, especially the children. It is evident that intersex persons as a "marginalised", "minority" and "vulnerable" group face a multitude of challenges and human rights violations from birth that includes: stigmatisation, ridicule, discrimination and inadequate medical attention. There is also a general lack of awareness about the intersex condition and the appropriate ways of supporting an intersex child and the immediate family. This report documents these challenges based on a first person encounter with intersex persons and families.

It was noteworthy that an inadequate policy and legislative framework has hampered development of supportive systems for intersex persons in the country. This had led to whatever advocacy efforts which may have been made to go unnoticed and ultimately fail to make the intended gains. However, the growing demonstration on the human aspects and appreciation of the need for integration of intersex persons has summoned society`s attention. In recent times, the country has witnessed positive legislative, judicial and administrative pronouncements that partially informed the work of the

Taskforce. Specifically, the court decisions in the RM Case of 2010 and the Baby 'A' Case prompted the establishment of the Taskforce.

In spite of challenges encountered due to the nature of work required by discharge of the Taskforce's mandate, there was remarkable progress and poignant success stories. The Taskforce findings further outline a number of recommendations that need to be implemented in order to guarantee that intersex persons achieve equality in law, human dignity and legal protection. Beyond meeting all the set goals, the Taskforce opened up the space for constant dialogue and engagement with intersex persons. This was achieved by working closely with the Intersex Persons Society of Kenya (IPSK). The Taskforce also developed a comprehensive and broad-based definition of the intersex status. This definition will no doubt inform the recognition debate and the response to the challenges associated with the intersex status. These and other milestones are detailed in this report.

These achievements, realised amid the obvious inherent and encountered challenges, were a product of collaboration, consultation and cooperation with many agencies and persons. The priceless input of all Taskforce Members, the Secretariat and the various experts and agencies is deeply appreciated. The Taskforce is further grateful to our partners particularly, the Office of the Attorney- General and Department of Justice (OAG&DOJ), International Law Development Organisation (IDLO) and the Open Society Initiative of Eastern Africa (OSIEA).

Mbage Njuguna Ng'ang'a

Chairperson of the Taskforce

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TABLE OF CONTENTS

1.0 INTRODUCTION AND BACKGROUND.	**10**
1.1 Contemporary Definitions of Intersex.	12
1.2 Legal Definitions of Intersex.	12
1.3 Medical Definitions of Intersex.	13
1.4 Religious Definition of Intersex.	13
1.4.1 The Biblical Perspective.	13
1.4.2 The Quranic Perspective .	14
1.5. Manifestations of Intersex.	16
1.5.1 Congenital Adrenal Hyperplasia (CAH) .	16
1.5.2 Clitoromegaly .	16
1.5.3 Ovo-testes (formerly called "true hermaphroditism")	16
1.5.4 Androgen Insensitivity Syndrome (AIS)	16
1.5.6 Partial Androgen Insensitivity Syndrome	17
1.5.7 Hypospadias	17
1.5.8 Progestin Induced Virilisation (PIV)	17
1.5.9 Aphalia	17
1.5.10 Klinefelter Syndrome	18
1.5.11 Micropenis	18
1.5.12 Mosaicism involving "sex" chromosomes	18
1.5.13 Swyer Syndrome	18
1.5.14 Turner Syndrome	19
1.5.15 Mosaic Turner Syndrome	19
1.5.16 Mayer, Rokitansky, Kuster, Hauser Syndrome	19
1.6 The Difference between Intersex, Sex, Gender and Transgender	19
1.7 Taskforce Definition of an Intersex	19

2.0 INTERNATIONAL LEGISLATIVE AND HUMAN RIGHTS FRAMEWORK **21**

2.1 International Human Rights Frameworks 21

2.1.1 Recognition and Freedom from Discrimination 21

2.1.2 Treatment of Intersex Persons Amounting to Torture, Cruel, Inhuman or Degrading Treatment 14

2.1.3 Concept of 'Informed, Free and Voluntary Consent' in Medical Procedures 23

2.1.4 Principle of 'Best Interests of the Child' in Care and Treatment of Intersex Children 23

2.1.5 The Intersex and Sports 23

2.1.6 Right to a Legal Remedy 25

2.1.7 Data Privacy and Protection 25

2.1.8 Education and Training 26

2.2 Regional Human Rights Systems on Protection of Intersex Persons 26

2.2.1 The Inter-American Human Rights Framework 26

2.2.2 The European Human Rights Framework 27

2.3 A Comparative Review of International Practices 28

2.3.1 Germany 28

2.3.1.1 Legal Framework 28

2.3.1.2 Policy Recommendations 29

2.3.2 Switzerland 30

2.3.2.1 Informed Consent and Recognition/Documentation 30

2.3.2.2 Corrective Surgeries 30

2.3.3 France 31

2.3.1 Principal Directions 31
2.4 The African Human Rights Framework 31
2.4.1 Overview and Key Provisions 31
2.4.2 Comparative African Practices 32

3.0 KENYA LEGAL AND POLICY FRAMEWORK 34
3.1 Introduction 34
3.2 Kenyan Case Law 34
3.2.1 RM's Case 35
3.2.2 Baby 'A' (Suing through the Mother E A) & another v Attorney General & 6 others [2014] 36

4.0 NUMBERS, DISTRIBUTION AND CHALLENGES OF INTERSEX PERSONS IN KENYA 38
4.1 Introduction 38
4.2 Findings 38

5.0 RECOMMENDATIONS 43
5.1 Introduction 43
5.2 Recommendations 43
5.2.1 Recognition 43
5.2.2 Documentation 43
5.2.3 Criminal Justice Sector 44
5.2.4 Health 44
5.2.5 Education and awareness 44
5.2.6 Statistics 45
5.2.7 Social, Economic and Legal Protection 45

1.0 INTRODUCTION AND BACKGROUND

The recognition of a person on the basis of sex is often pegged on the binary categorisation of one being either male or female at childbirth. This, however, is not the case for all births. In some cases, a child's sex cannot be clearly ascertained at birth due to marked differences in their sex characteristics, therefore they are referred to as intersex. Worldwide an estimated 0.05 to 1.7% of new born babies are born intersex . In Kenya, the current population of intersex persons are estimated at between 23,925 and 813,425 nationally.

Within the UN framework, the Convention on the Rights of the Child (CRC) proposes the establishment of a comprehensive data collection system to facilitate analysis of vulnerable children with a focus on disaggregated data on, among other things, sex. The Bill of Rights (Chapter 4 of CoK, 2010) provides an array of fundamental freedoms and human rights every person, including intersex persons is entitled to. Judicial decisions in Kenya have upheld and promoted the realisation of the rights of intersex persons with specific focus on protection against discrimination and from torture, cruel, inhumane and degrading treatment (See both R.M v Attorney General & 4 others [2010], eKLR and Baby 'A' (Suing through the Mother E A) & another v Attorney General & 6 others[2014], eKLR). The cases also outline the need for empirical data on intersex persons in Kenya to inform relevant reforms to address challenges faced by intersex persons as a marginalized group. The Kenyan Parliament has similarly formulated safeguards for intersex persons stemming from the Persons Deprived of Liberty Act (2014), which recognises the need for recognition before the law through introduction of an Intersex (I) marker, public awareness, generation of statistics, access to healthcare and redress for human rights violations. Following its own study, KNCHR wrote an advisory to the Kenya National Bureau of Statistics (KNBS) on 9th March 2018, which highlighted the recommendations directed to the Registrar of Persons, Kenya National Bureau of Statistics and Ministry of Health to provide statistics of all intersex persons and ensure they are captured in the national census or other socio-economic surveys to facilitate planning. In that regard, the Office of the Attorney-General and Department of Justice (OAG&DOJ) established the Taskforce on Policy, Legal, Institutional and Administrative Reforms regarding the Intersex Persons in Kenya on 26th May, 2017 vide Gazette Notice No. 4904.

The Taskforce was mandated to:

i. Compile comprehensive data regarding the number, distribution and challenges of Intersex persons;

ii. Provide a comparative analysis of approaches to care, treatment and protection of intersex persons;

iii. Conduct an analysis of the policy, legal, medical, administrative and institutional frameworks governing structures and systems with regard to Intersex persons;

iv. Recommend reforms to safeguard the interests of intersex persons;

v. Present a prioritized implementation matrix based on the immediate, medium and long term reforms governing the intersex persons; and

vi. Undertake any other activities required for effective discharge of the mandate.

The Taskforce was constituted on May 2017 with an initial term of 6 months and subsequent extensions to facilitate comprehensive fulfilment of its mandate, which expired on 30th November 2018. Its membership was drawn from various MDAs, the CRADLE and Intersex Persons Society of Kenya (IPSK). It was headed by the Chairperson of the Kenya Law Reform Commission (KLRC) with a designated Secretariat based at the KNCHR led by two joint secretaries drawn from KNCHR and OAG/DOJ. In order to fulfil its objectives, the Taskforce adopted strategies and interventions that included: consultative fora; advocacy and awareness raising (using print and broadcast media; digital and online communication platforms, opinion leaders, drama, public lectures, Social Media and local language community and international radio stations for public awareness and sensitisation); comparative studies and surveys, including through a benchmarking mission to Uganda; partnership-building, especially with Development Partners, notably IDLO and OSIEA, which supported the Taskforce with both financial and technical expertise; planning, monitoring and evaluation; feedback mechanisms and reporting, and regional validation meetings between 8th and 11th October 2018 in Nairobi City, Mombasa and Kisumu; five retreats to interrogate its findings, and; development of its final Taskforce Report, including reform proposals and an implementation matrix.

Fact Sheet, Intersex. Online: https://unfe.org/system/unfe-65-Intersex_Factsheet_ENGLISH.pdf/ (accessed on 13th June, 2018).

1.1 Contemporary Definitions of Intersex

The intersex is:

"... people who are born with sex characteristics (including genitals, gonads and chromosomal patterns) that do not fit typical binary notions of male or female bodies." (UN Human Rights Office of the High Commissioner)

"... a variety of conditions in which individuals are born with (or develop later in life) ambiguous external genitalia and/or a combination of chromosomes, gonads, external genitalia and hormones that do not align as typical male or typical female." (Sociologists for Women Society)

"... genetic conditions identifiable at birth that result in the birth of a child with anatomical or biological sex differentiation which varies from that most commonly found in male and female births." (The Androgen Insensitivity Support Group Australia, AISSGA)

"... a person born with sexual anatomy, reproductive organs and/or chromosome patterns that do not fit the typical definition of male or female." (Joint dialogue of the African Commission on Human and Peoples Rights, the Inter-American Commission on Human Rights and the United Nations)

1.2 Legal Definitions of Intersex

The international human rights framework safeguarding the protection against discrimination on the basis of sex characteristics defines the intersex as:

"... each person's physical features relating to sex and including genitalia, as well as other sexual and reproductive anatomy, chromosomes, hormones and secondary features that emerge from puberty." (Yogyakarta Principles + 10)

"a congenital sexual differentiation which is atypical to whatever degree." (South Africa's Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000)

"the chromosomal, gonadal and anatomical features of a person which include primary characteristics such as reproductive organs and genitalia and/or in chromosomal structures and hormones; and secondary characteristics such as muscle mass, hair distribution, breasts and/or structure." (Gender Identity, Gender Expression and Sex Characteristics Act, 2015 of Malta)

"the status of having physical, hormonal or genetic features that are neither wholly female nor wholly male or a combination of female and male or

neither female nor male. (Australia's Sex Discrimination Amendment (Sexual Orientation, Gender Identity and Intersex Status Act, 2013).

"an abnormal condition of varying degrees with regard to the sex constitution of a person." (R.M v Attorney General & 4 others [2010] eKLR).

"a person certified by a competent medical practitioner to have both male and female reproductive organs." (Section 2, the Persons Deprived of Liberty Act, 2014)

1.3 Medical Definitions of Intersex

In 2006, the European and American Society for Paediatric Endocrinology arrived at a consensus term, "disorders of sex development" (DSD), denoting congenital conditions with chromosomal, gonadal and anatomical sex development that is atypical. The Intersex Society of North America defines it as conditions involving the following elements: congenital development of ambiguous genitalia; congenital disjunction of internal and external sex anatomy; incomplete development of sex anatomy; sex chromosome anomalies, and; disorders of gonadal development. The different elements are indicative of the variety of manifestations of DSD /intersex which include anomalies of the sex chromosomes, the gonads, the reproductive ducts and the genitalia.

1.4 Religious Definition of Intersex

1.4.1 The Biblical Perspective

In the Christian faith, the Scripture speaks to creation of human beings as the works of God. For instance, in the story of creation, it provides that: "So God created man in his own image, in the image of God created he him; male and female created he them."(Genesis 1: 27, KJV). In the Gospels, the Bible alludes to sex characteristics when it says:

"For there are eunuchs who were born that way, and there are eunuchs who have been made eunuchs by others—and there are those who choose to live like eunuchs for the sake of the kingdom of heaven. The one who can accept this should accept it." (Mathew 19:12, NIV)

Lastly, in addressing the question of congenital guilt or curse from God, parents or other sources as a possible reason for children born intersex, Jesus gives an emphatic and enlightened answer on the matter thus:

"And his disciples asked him, saying, Master who did sin, this man, or his parents, that he was born blind? Jesus answered, 'neither hath this man sinned, nor his parents: but that the works of God should be made manifest in him'." (John 9:2-3, KJV)

In summary therefore, the Bible recognises and expresses respect for all creation which, after all, was created by God Himself, who at the end of His divine labours, pronounced it all good: "God saw all that he had made, and it was very good..." (Genesis 1:31, NIV) It is important to note that this summation came after the creation of humanity as the epitome of all creation that had proceeded in the first five days. In fact, in placing man as the regent of the earth and all creation, God seems to put all issues of judgement, including acceptance or otherwise of the intersex, squarely on us, humanity:

Then God said, "Let us make man in our image, in our likeness, and let them rule over the fish of the sea and the birds of the air, over the livestock, over all the earth, and over all the creatures that move along the ground." (Genesis 1:26, NIV)

God blessed them and said to them, "Be fruitful and increase in number; fill the earth and subdue it. Rule over the fish of the sea and the birds of the air and over every living creature that moves on the ground." (Genesis 1:28, NIV)

From the above context, it is clear that God does not discriminate among His creations, which are all good. It is thus incumbent upon us, humanity, to bring out the good in each creation, even the seemingly 'not good', and to 'avoid judging, that we be not judged". Intersex is a birth status, and not a choice made by the parents or the innocent children. It simply is, and we need to recognise it for itself and make room for it, just like for every other creature.

1.4.2 The Quranic Perspective

The Holy Quran unequivocally states that Allah has dominion over all creatures:

"To Allah belongs the dominion of the heavens and the earth; He creates what he wills. He gives to whom He wills female [children], and He gives to whom He wills males. Or He makes them [both] males and females, and He renders whom He wills barren. Indeed, He is Knowing and Competent. (Qur'an 42:49-50)

Classical Islam recognises four genders among human beings: male, female, Khusna, **and the effeminate male. Khusna is a person who has somatic sex ambiguity due to a disorder of sex development.** Khusna **has been described**

as a person with both male and female sex organs or with an opening in place of a sexual organ from which they urinate. This is further categorised into two types: wadhih (discernible) and musykil (intractable). In summary, it can be argued that, in the Islamic perspective everything is made by Allah, who is Al-`Aleem – the All-Knowing:

"They said, 'Exalted are You; we have no knowledge except what You have taught us. Indeed, it is You who is the Knowing, the Wise.' " (Surah al Baqarah, 2:32)

Since He is All-Knowing, Allah has complete knowledge of all the heights and depths of the visible and invisible worlds, the known and the unknown, the understood and the baffling. He knows what is and what could be, what was and what could have been.

"And with Him are the keys of the unseen; none knows them except Him. And He knows what is on the land and in the sea. Not a leaf falls but that He knows it." (al-An`aam 6: 59)

Since Allah surely knows every leaf that falls, He also knows the deepest longings of our souls, our feelings, struggles and situations. Allah does not forget either, but some things need patience and Allah subhanahu wa ta`ala teaches us with time:

"And most certainly shall We try you by means of danger, and hunger, and loss of worldly goods, of lives and of [labor's] fruits. But give glad tidings unto those who are patient in adversity – who, when calamity befalls them, say, 'Verily, unto God do we belong and, verily, unto Him we shall return." It is they upon whom their Sustainer's blessings and grace are bestowed.'" (Surah Al Baqarah, 2:155-157)

Allah knows the most intimate details of all things hidden and manifest, every generality and every particular, while humanity's knowledge is but like a speck in comparison: "What you (O humanity) have been given of knowledge is but little." (Al-Isra' 17: 85) In conclusion, to help us understand the deeper things which otherwise baffle us, the Quran teaches us to make du`a (prayer) in this manner: "Say: 'My Lord! Increase me in knowledge'." (Ta-Ha 20:114)

The Islamic Perspectives of Gender-Related Issues in the Management of Patients with Disorders of Sex Development https://link.springer.com/content/pdf/10.1007%2Fs10508-016-0784-y.pdf accessed on 29th September, 2019.

1.5 Manifestations of Intersex

1.5.1 Congenital Adrenal Hyperplasia (CAH)

The Congenital Adrenal Hyperplasia (CAH) is a variation that occurs in both males and females (XY and XX), characterised by virilisation of the external genitalia in females and hence ambiguous genitalia at birth. As a result, the female embryos may have larger than average clitorises, or a clitoris that looks rather like a penis, or labia that look like a scrotum.

1.5.2 Clitoromegaly

Clitoromegaly, also referred to as large clitoris, occurs when the clitoris is larger than expected.

1.5.3 Ovo-testes (formerly called "true hermaphroditism")

Ovo-testes are not evident through a visual examination at birth. It occurs when gonads (sex glands) contain both ovarian and testicular tissue. As a result, a person might be born with two ovo-testes, or one ovary and one ovo-testis, or some other combination. Some people with ovo-testes look fairly typically female, some fairly typically male, and some look fairly in-between in terms of genital development.

1.5.4 Androgen Insensitivity Syndrome (AIS)

Androgen Insensitivity Syndrome (AIS) is a variation where individual tissues fails to respond to hormones hence lack of virilisation of the external genitalia. An infant with Complete Androgen Insensitivity Syndrome (CAIS) has external genitalia of normal female appearance with un-descended or partially descended testes and, in most cases, a short vagina with no cervix. Often-times, it is not easily identified at birth or childhood. During puberty, most women suffering from CAIS may not have pubic or underarm hair. The variation occurs in approximately 1 in every 20,000 individuals. Its cause has been linked to a genetic condition except for occasional spontaneous mutations.

1.5.5 Partial Androgen Insensitivity Syndrome

Partial Androgen Insensitivity Syndrome (PAIS) results in "ambiguous genitalia" that presents itself as a large clitoris or a small penis and hypospadias. It may be quite common, and has been suggested as the cause of infertility in many men whose genitals are of typically male appearance.

Ibid.

1.5.6 Hypospadias

Hypospadias occur when a urethral meatus ('pee-hole') is located along the underside of the penis rather than at the tip. In some hypospadias, the meatus may be located on the underside of the penis i.e. sub-coronal, mid-shaft and peno-scrotal. In more pronounced hypospadias, the urethra may be open from mid-shaft out to the glans, while in some cases the urethra may even be entirely absent, with the urine exiting the bladder from behind the penis. Early correction of hypospadias is associated with higher success rates.

1.5.7 Progestin Induced Virilisation (PIV)

Progestin Induced Virilisation (PIV) occurs when XX people (female) affected in-utero by virilising hormones are born into a continuum of sex phenotype that ranges from "female with larger clitoris" to "male with no testes". Occasionally, a female neonate will have an excess of male hormones that she is given a male identity at birth and raised as a boy. This may result from maternal use of male hormones (androgens) during early pregnancy.

1.5.8 Aphalia

Aphalia occurs when a person is born without a penis yet they have an otherwise typical male anatomy.

1.5.9 Klinefelter Syndrome

This an intersex variation is quite common in male births with an occurrence rate of approximately1/500 to 1/1,000. Whereas most men inherit a single X chromosome from their mother and a single Y chromosome from their father, men with Klinefelter syndrome inherit an extra X chromosome from either their father or mother thus their karyotype is 47 XXY. It presents itself through small testes, about half the typical size, which are quite firm. However, after puberty, the ejaculate contains no sperm. As a result, boys with Klinefelter syndrome may not virilise very strongly at puberty (they may not develop much body hair, or they may experience breast development).

1.5.10 Micropenis

The Micropenis condition occurs when a person has a penis that is completely differentiated, that is, it has developed like a typical penis with the urethral meatus ('pee-hole') at the tip, but it is very small. Micropenis is apparent when a person has a 46, XY karyotype which is a typical male karyotype and testes

that are either descended or un-descended with a urethral meatus ('pee-hole') at the tip of the glans penis, unlike in hypospadias. It may also include a stretched penis length at or below 2.5cm standard deviation for age and stage of development.

1.5.11 Mosaicism involving "sex" chromosomes

This occurs when a person has one kind of karyotype in some of his or her cells, and a different karyotype in other cells. For instance, when a person is said to have a 45, X/46, XX karyotype, it indicates that he or she has 46, X in some cells, and 46, XX in other cells.

1.5.12 Swyer Syndrome

Also known as XY gonadal dysgenesis, Swyer syndrome occurs when a person is born without functional gonads (sex glands), but they have gonadal streaks, which are minimally developed gonad tissue in place of testes or in the ovaries. A child born with Swyer syndrome looks like a typical female, but will not develop most secondary sex characteristics without hormone replacement. This is because streak gonads are incapable of producing the sex hormones that bring about puberty.

1.5.13 Turner Syndrome

Turner syndrome occurs when a person has only one X fully functional chromosome as opposed to what a typical female karyotype would have, that is, 46, XX. When a person has Turner syndrome, the female sex characteristics are usually present but underdeveloped compared to the typical female. Turner syndrome presents as: short stature, lymphodema, broad chest and widely spaced nipples, low hairline, low-set ears, and infertility. However, the presentation varies in different people, thus some signs associated with the syndrome may be more obvious in one woman than in the next.

1.5.14 Mosaic Turner Syndrome

This type of variation occurs when the person usually doesn't have all the associated signs of Turner syndrome but may have other signs of being intersex. It can also occur where some cells have two "sex" chromosomes (XX)

[1] A karyotype is a picture of the chromosomes in a cell. A person is said to have a "mosaic karyotype" when sometimes cells divide incorrectly early in the life of an embryo. For instance, a woman with Mosaic Turner Syndrome may have some cells that are XO (typical Turner Syndrome karyotype) and some cells that are XX (typical female karyotype). Mosaicism also occurs in milder forms of Klinefelter Syndrome called 46/47 XY/XXY mosaic. In this case, the XY cells would have 46 chromosomes (a typical number of chromosomes) and the XXY cells would have 47 chromosomes.

[2] Both oestrogens and androgens.

while others only have one X, or when a person has 46, XY/45X. Other mosaic types are also possible.

1.5.15 Mayer, Rokitansky, Kuster, Hauser Syndrome

The Mayer, Rokitansky, Kuster, Hauser Syndrome (MRKH) (also known as Mullerian agenesis, vaginal agenesis or congenital absence of vagina) occurs when the ovaries are present but with an absent, misshapen, or small uterus. MRKH is associated with kidney and spine anomalies in a minority of individuals.

1.6 The Difference between Intersex, Sex, Gender and Transgender

In its various manifestations, intersex has been with humanity since the dawn of history and is so recognised in various religions and communities over the ages. Usually, the sex of a child (as the primary biological characteristic in respect to ones physical genital organ, hormones and the gonads) is determined and recorded at birth as either female or male. However, later on in life, due to environmental, religious, cultural or political socialisation or conditioning, these two sexes are allocated certain behavioural traits and roles that ideally affirm the gender. An intersex person and a transgender person are different in terms of their sex characteristics. An intersex person has no clear female or male sex characteristics due to the mix either of their physical genitalia (fe/male), hormones, chromosome (X or Y) or gonads (ovary and testes). In contrast, a transgender person is biologically born either female or male, but their feelings are not congruent with their body. Crucially, therefore, intersex is linked to in-born biological sex characteristics, not gender identity. Intersex status is now universally recognised as a human rights issue that requires recognition and protection by all state and non-state parties.

1.7 Taskforce Definition of an Intersex

The Taskforce examined the above definitions, variations, and the relevant social, medical and legal developments. The Taskforce further noted the evolving and increasingly informed understanding as well as the emerging consensus that persons born intersex are human beings with inherent rights

and dignity. Therefore, the Taskforce adopts this definition to inform and guide the policy, legal and administrative structures and systems in Kenya. An intersex person is:

"A person who is conceived or born with a biological sex characteristic that cannot be exclusively categorised in the common binary of female or male due to their inherent and mixed anatomical, hormonal, gonadal (ovaries and testes) or chromosomal (X and Y) patterns, which could be apparent prior to, at birth, in childhood, puberty or adulthood."

2.0 INTERNATIONAL LEGISLATIVE AND HUMAN RIGHTS FRAMEWORK

2.1 International Human Rights Frameworks

Kenya is a state party to all the nine core international human rights instruments. All the treaties and conventions ratified by Kenya as well as the general rules of international law form part of the law of Kenya by dint of Article 2(5)(6) of the Constitution of Kenya, 2010. The following rights and principles are recognised and developed in the international UN framework as well as in regional human rights systems on protection of intersex persons, including the inter-American human rights framework and the European human rights framework.

2.1.1 Recognition and Freedom from Discrimination

- The Universal Declaration of Human Rights (UDHR) of 1948 provides for the inherent dignity and worth of all persons. The Declaration underscores that: "All human beings are born free and equal in dignity and rights."
- The International Covenant on Civil and Political Rights (ICCPR) ratified by Kenya in 1972, provides that, "Every child shall be registered immediately after birth and shall have a name" (Article 24(2)). Article 7 of the ICCPR is categorical that, "No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation."
- The provisions of the International Covenant on Economic, Social and Cultural Rights (ICESCR) ratified by Kenya in 1972 guarantees the right to self-determination (Article 1) and the enjoyment of all other rights in the ICESCR to all without discrimination on the basis of, inter alia, sex, birth or other status (Article 2(2)).
- The Sustainable Development Goals (SDGs) under SGD 16 are to, 'provide legal identity for all, including birth registration' and to 'promote and enforce non-discriminatory laws and policies for sustainable development' by 2030.

- The Principles on the Application of International Human Rights Law in Relation to Sexual Orientation and Gender Identity (The 'Yogyakarta Principles') 2007 affirm binding international legal standards with which all States must comply. The Principles are endorsed by the African Commission on Human and Peoples' Rights.

2.1.2 Treatment of Intersex Persons Amounting to Torture, Cruel, Inhuman or Degrading Treatment

- Article 16 of the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment prohibits "other acts of cruel, inhuman or degrading treatment or punishment which do not amount to torture" likewise committed by any person acting in an official capacity. Torture is a non-derogable right under both national and international law that cannot be waived even in times of state emergencies that threaten the life of a nation and constitutes one of the crimes of jus cogens.
- In his report to the Human Rights Council in February 2013, Juan E Mendez, the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment observed that special attention should be paid to vulnerable groups".
- The World Health Organisation (WHO) in a 2014 'interagency statement' on behalf of the Office of the High Commissioner for Human Rights, UN Women, the Joint United Nations Programme on HIV/AIDS (UNAIDS), UN Development Program (UNDP), United Nations Population Fund (UNFPA), UNICEF and the WHO entitled Eliminating Forced, Coercive and Otherwise Involuntary Sterilisation cautions against involuntary sterilisation of intersex persons and other non-medically necessary surgery on intersex children.
- Principle 10 of The YP+10 secures the Right to be Free from Torture or other Cruel, Inhuman or Degrading Treatment. The Committee on the Rights of the Child (CRC) has repeatedly recognised Intersex Genital Mutilation (IGM) as a 'harmful practice'.

* The Universal Declaration of Human Rights was adopted by resolution of the United Nations General Assembly on 10 December 1948, and was ratified by Kenya on 31 July 1990.

2.1.3 Concept of 'Informed, Free and Voluntary Consent' in Medical Procedures

- Principle 32 of The YP+10 on The Right to Bodily Integrity stipulates that:
- "Everyone has the right to bodily and mental integrity, autonomy and self-determination ... No one shall be subjected to invasive or irreversible medical procedures that modify sex characteristics without their free, prior and informed consent, unless necessary to avoid serious, urgent and irreparable harm to the concerned person."
- The WHO recommends that, in the absence of medical necessity, treatments that result in sterilisation should be postponed until the "person is sufficiently mature to participate in informed decision-making and consent".

2.1.4 Principle of 'Best Interests of the Child' in Care and Treatment of Intersex Children

- The UN Committee on the Rights of the Child General comment No. 14 (2013) on the right of the child to have his or her best interests taken as a primary consideration (art. 3, para. 1 of the Convention on the Rights of the Child) adjoins all member States to, ensure that the requirement to consider the child's best interests is reflected and implemented in all national laws and regulations. The CRC has clarified that: "...the right of the child to have his or her best interests taken as a primary consideration means that the child's interests have high priority and [is] not just one of several considerations."

2.1.5 The Intersex and Sports

- Various international Conventions recognise the right of every person to leisure and creative activity. In April 2016, the UN Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health issued a report that notes that intersex persons experience multiple human rights violations including, for example, 'sex testing'.

[7]Article 24, Constitution of Kenya, 2010. [8]Article 4, ICCPR.
[9]A term coined to refer to cosmetic, un-consented and unnecessary surgical intervention carried out by doctors on infants and/or older children born with ambiguous genitalia with the aim of assigning them a gender that fits within the binary notion of male and female sex.
[10]Ibid. at 10.
[11]UN CRC, General comment No. 14 (2013) on the right of the child to have his or her best interests taken as a primary consideration (art. 3, para. 1), UN Doc. CRC/C/GC/14 (29 May 2013), online: <http://www2.ohchr.org/English/bodies/crc/docs/GC/CRC_C_GC_14_ENG.pdf> (accessed 18th October, 2017).

- The Yogakarta +10 Principles require sporting organisations to integrate the Yogakarta Principles (2006) and the Additional Principles (2017), as well as all relevant human rights norms and standards in their policies and practices.
- Article 7 of the ICCPR expressly provides that, "...no one shall be subjected without his free consent to medical or scientific experimentation."
- The Taskforce notes that requirements such as the controversial International Association of Athletics Federations (IAAF) 'Hyperandrogenism Regulations, which require women athletes with specific differences in sex development to medically reduce their blood testosterone levels are punitive, disproportionate and intrusive. Indeed, these Regulations have been challenged by the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health; the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment; and the Working Group on the issue of Discrimination Against Women in Law and in Practice. In a joint Communique to the President of the IAAF, Mr Sebastian Coe, the Special Rapporteurs are categorical that the IAAF eligibility criteria:
- "...appear to contravene international human rights norms and standards including the right to equality and non-discrimination, the right to the highest attainable standard of physical and mental health, the right to physical and bodily integrity and the right to freedom from torture, and other cruel, inhuman or degrading treatment and harmful practices."
- The Taskforce notes that sporting activities are an expression of culture, which serves as an important means of self and cultural expression as well as of employment and livelihood for an individual. For Kenya, athletics has for a long time remained an important source of national pride. There is need to amend the Kenya Sports Act, which is silent regarding participation and protection of the rights of athletes, to come up with appropriate regulations that prohibit discrimination and intrusive medical procedures.

2.1.6 Right to a Legal Remedy

- It is a general principle of international law that every wrong must attract a remedy. The Yogyakarta Principles task states to, "ensure that victims of human rights violations have access to full redress through restitution, compensation, rehabilitation, satisfaction, guarantee of non-repetition, and/or any other means as appropriate."
- Further, the Special Rapporteur on Health also notes the responsibility of States to provide victims with effective remedy and redress, including measures of reparation, satisfaction and guarantees of non-repetition as well as restitution, compensation and rehabilitation, including all acts of ill-treatment in a healthcare setting whether they meet the definition of torture or not.
- The WHO Interagency Statement report on Eliminating Forced, Coercive and Otherwise Involuntary Sterilization emphasizes that:
- "Accountability ... rests with states, to prevent coerced sterilisation, to explicitly prohibit such practices, to respond to the consequences of these practices, to hold the perpetrators responsible, and to provide redress and compensation in cases of abuse."

2.1.7 Data Privacy and Protection

- Data regarding intersex persons must be safeguarded and handled in an ethical manner and with confidentiality. Article 12 of the UDHR provides that, 'No one shall be subjected to arbitrary interference with his privacy, family, home or correspondence, or to attacks upon his honour and reputation' and that, 'Everyone has the right to the protection of the law against such interference or attacks.' Similar provisions are reiterated under Article 17 of the ICCPR.
- The United Nations High Commissioner for Human Rights 'Guidance Note to Data Collection and Disaggregation: A Human Rights Based Approach to Data Leaving No One Behind in the 2030 Agenda for Sustainable Development' sets out six principles which are key towards ensuring data collection, that is: lawfulness, transparency, fairness, confidentiality, data minimization, purpose limitation.

[9]Joint Communiqué by UN Mandates of the Special Rapporteur and the Working Group on the issue of Discrimination Against Women in Law and in Practice dated 18th September 2018. Online: https://www.ohchr.org/Documents/Issues/Health/Letter_IAAF_Sept2018.pdf/ (accessed 17th November, 2018).

- Chapter II of The Convention on Cyber Security and Personal Data Protection of the African Union (May 2014) provides for protection of personal data and calls upon State parties to establish a legal framework "aimed at strengthening fundamental rights and public freedoms, particularly the protection of physical data, and punish any violation of privacy."
- Closer home, Article 31 (c) of the CoK 2010 guarantees the right not to have information relating to family or private affairs unnecessarily revealed. At the time of publishing this report, Kenya's Draft Privacy and Data Protection Policy 2018 and the Data Protection Bill, 2018 were under discussion. The Draft Policy defines sensitive personal data to include information relating to the racial, ethnic or social origin, political opinions, religious belief or matters of conscience, culture, dress, language or birth of the data subject, gender, disability, sexual life or orientation, pregnancy, health status, etc.

2.1.8 Education and Training

- Article 2 of Principle 23 of the United Nations Guidelines on IDPs as incorporated in the Act provides that every human being has the right to education.
- Principle 16 of the YP+10 Principles on The Right to Education provide that states shall: "Ensure inclusion of comprehensive, affirmative and accurate material on sexual, biological, physical and psychological diversity".

2.2 Regional Human Rights Systems on Protection of Intersex Persons

2.2.1 The Inter-American Human Rights Framework

Despite the absence of laws expressly protecting the rights of the intersex at the regional level, various states in the Americas have made policy progress with regard to care, treatment and protection of intersex persons. In Colombia, for instance, the courts have defined the extent of 'informed consent' with specific reference to intersex persons. In Sentencia SU 337/99, Constitutional Court of Colombia (12 May 1999) , the Court found that constitutionally, consent could not be substituted if a child had achieved full cognitive, social, and emotional

[9] Ibid. at 13.

understanding of their body and had a gender identity firmly in place. The Court therefore required that:

1. A medical team be established to help support both the plaintiff and the child and ensure that they were both completely informed of all treatment options;
2. If the medical team then found the child to be sufficiently autonomous to provide informed consent, she could have surgery before the age of majority, and;
3. In the alternative, the ability for informed consent could be approached on a sliding scale, with less invasive procedures taking place first and the rest following as the child matured.

Similarly, in Sentencia T-912/08, Pedro v. Social Security et al., Constitutional Court of Colombia, Chamber of Revision (18 December 2008) , the Court in assessing the right to autonomy vis a vis the rights of the beneficiary in intersex cases involving surgery found that the decision of the child was paramount, while the right of the parent to make decisions in a protective capacity was secondary. The Court therefore stated that if the child was five years or older, it became the right of that child to make the decision subject to the considerations set out. As a consequence, when they are not met, the surgery is deferred.

2.2.2 The European Human Rights Framework

The EU provides general protection of human rights through its various instruments. Foremost among these is the Charter of Fundamental Rights of the European Union, which affirms the rights that arise from the national and international obligations that are common to the Member States of the EU, including the European Court of Human Rights (ECHR).

- Article 1 of the EU Charter provides that human dignity is inviolable and must be respected and protected. Article 3 provides for the right to physical integrity, expressly including the right to 'free and informed consent of the person concerned' in the field of medicine. Article 7 provides for the right to respect for one's private life, and Article 21 prohibits discrimination on any ground including, among others, sex, 'genetic features' and birth.

[14]Ibid. [15]See Sentencia SU 337/99, Constitutional Court of Colombia (12 May 1999). Online: https://www.icj.org/sogicasebook/sentencia-su-33799-constitutional-court-of-colombia-12-may-1999/ accessed on 29th September, 2018.
[16]Online: https://www.icj.org/sogicasebook/sentencia-t-91208-pedro-v-social-security-et-al-constitutional-court-of-colombia-chamber-of-revision-18-december-2008/ accessed on 29th September, 2018. [17]EU Charter, supra note 8 at Preamble.

- Further, the Court of Justice of the European Union (CJEU) has held that the principle of free and informed consent is an element of the right to physical integrity.

2.3 A Comparative Review of International Practices

2.3.1 Germany

Different studies in Germany have highlighted the challenges and complications arising from corrective procedures often performed on intersex persons. In a 2013 report entitled "Children's right to physical integrity" to the Committee on Social Affairs, Health and Sustainable Development of the Parliamentary Assembly of the Council of Europe, Rapporteur Marlene Rupprecht noted in part that,

"[m]any had been submitted to a series of operations and were confronted with post-operative complications. Relevant treatment was traumatising for them and often involved humiliating procedures such as being exposed to large groups of medical professionals and students studying this curious phenomenon. For many, the interventions linked to their syndrome had long-term effects on their mental health and well-being."

2.3.1.1 Legal Framework

Intersex persons have been recognised in German canon law since the late 18th century . Section 19 (I) 1 of the Prussian General Land Law of 1794 provided that parents could choose the sex of their hermaphrodite child, but section 20 (I)1 provided that the child could change their sex upon reaching the age of 18. The 2013 Regulation on the Implementation of the Civil Status Act (PStV) provides that the sex indication on a birth certificate may be left blank if the child has been diagnosed as being "affected by [Disorders of Sex Development]". Section 47(2) of the Act provides that a child's registered sex could be changed if it turns out that the sex had been wrongly registered, proof of which is required. However, the only options remained male and female, and once changed it cannot be changed again.

[39] EU Network of Independent Experts on Fundamental Rights, Commentary of the Charter of Fundamental Rights of the European Union (June 2006), online: <ec.europa.eu/justice/fundamental-rights/files/networkcommentaryfinal_en.pdf> (accessed 2nd February 2018) [Expert Commentary] at 24-25.
[40] Ibid. at 39.
[41] M. Rupprecht (2013), "Children's right to physical integrity", report, Committee on Social Affairs, Health and Sustainable Development, PACE (Doc. 13297), online: <http://assembly.coe.int/nw/xml/XRef/Xref-DocDetails-EN.asp?FileID=20057&lang=EN> (accessed 30th October, 2018).
[42] DeutscherEthikrat (German Ethics Council), Opinion – Intersexuality (23 February 2012), online: <http://www.ethikrat.org/files/opinion-intersexuality.pdf> (accessed 18th October, 2017) [GEC Opinion] at 109.
[43] GEC Opinion, supra note 82 at 109.
[44] CECHR Issue Paper, supra note 68 at 38.

2.3.1.2 Policy Recommendations

The German Ethics Council made a number of policy recommendations with respect to the civil status and medical treatment of intersex persons (referred to by the Ethics Council as "persons with DSD") as follows:

1. Diagnosis and treatment, along with medical and psychological counselling, should be provided to intersex persons by relevant experts and medical practitioners at specialised interdisciplinary centres distributed throughout the country;
2. The basic and continuing training of doctors, midwives, psychotherapists and other medical staff should include the avoidance of discrimination and insensitivity towards intersex persons;
3. Any decision to undergo corrective surgery should only be made by the intersex person, at a time when that person is competent to decide. Where the wishes of the child conflict with the wishes of those who have the right to care for the child, the law should require a ruling to be made by the Family Court;
4. An intersex person and their parent/guardians must be provided complete information on all options for treatment, including no treatment, and must be given a reasonable amount of time in which to weigh those options and make a decision;
5. Comprehensive documentation of all treatment options and measures must be taken and retained for a minimum period of 40 years, with a right of access for the intersex person;
6. A fund should be established to provide relief and assistance to intersex persons for both current treatment (such as hormone therapy) and long term effects on their quality of life;
7. The law should be amended to provide for intersex persons to register as 'female', 'male' or 'other' once they have reached an age whereby they are capable of making the decision for themselves.

Following the release of this report, in 2013 Germany became the first European nation to allow babies with characteristics of both sexes to be registered as indeterminate gender on birth certificates. In this respect, on 31st January 2013, the Deutscher Bundestag (German Federal Parliament) amended section 22 of the PStG to include a new subsection (3), which now provides that "[i]f the child can be assigned to neither the female nor the male sex, then the child has to be entered into the register of births without such a specification." Further, in a famous case on the intersex (Re: Volling) the majority of the Constitutional Court acknowledged the submission of the German Society for Psychology's statement that an "assumption that a person's gender can only be male or female is neither psychologically nor biologically and sexually sound."

2.3.2 Switzerland

2.3.2.1 Informed Consent and Recognition/Documentation

The Swiss National Advisory Commission on Biomedical Ethics (NEK-CNE) in a 2012 opinion recommends that any irreversible sex assignment treatment should be deferred until "the person to be treated can decide for him/herself", so long as no urgent intervention was necessary. In the NEK-CNE's opinion, children reach decision-making capacity between the ages of 10-14, but should nevertheless participate in decision-making even before they have attained full capacity, and parents should never be allowed to veto a child's decision if that child can understand the purpose, appropriateness and effects of surgery.

2.3.2.2 Corrective Surgeries

The United Nations Committee Against Torture in its concluding observations on Switzerland's periodic report welcomed the NEK-CNE's recommendations as outlined above. In its concluding observations on the State party report, the CRC urged Switzerland to,

"[i]n line with the recommendations of the National Advisory Commission on Biomedical Ethics on ethical issues relating to intersexuality, ensure that no one is subjected to unnecessary medical or surgical treatment during infancy or childhood, guarantee bodily integrity, autonomy and self-determination to the children concerned, and provide families with intersex children with adequate counselling and support."

[84]GEC Opinion, supra note 82 at 118.
[85]See ibid. at 163-167.
[86]Zwischengeschlecht.org, Intersex: Third Gender in Germany (22 August 2013), online: <http://blog.zwischengeschlecht.info/post/2013/01/31/Deutschland-staatliches-Zwangscouting-Intersex> (accessed 16 October 2017).

Finally, in its November 2016 concluding observations on Switzerland's report, the UN Committee on the Elimination of Discrimination Against Women (CEDAW) welcomed Switzerland's introduction of measures to combat intersex genital mutilation, but further urged the country to combat involuntary and medically unnecessary and disfiguring surgical procedures especially on intersex babies and children. Finally, the Committee recommended that intersex persons be included in national surveys and registers in order to address disparities in local access to health services for this vulnerable group.

2.3.3 France

2.3.3.1 Principal Directions

In France, the Women's Rights and Equal Opportunities for Women and Men Committee of the Senate released a report entitled Variations in Sexual Development: lifting a taboo, combating stigma and exclusions in February 2017. The report's recommendations include: the need to refrain from using terms that pathologise and therefore "unnecessarily stigmatises" the intersex status; amend the law to extend the period within which births must be registered and birth certificates issued, and provide for changes of sex registration to be made easily; collecting accurate, scientifically based statistics on intersex persons; creation of a dedicated fund for compensation of persons who have suffered the consequences of corrective surgeries; training of medical professionals and development of a protocol for the treatment of variations in sexual development, and; raising awareness on the difficulties experienced by those affected by variations in sexual development, in order to break taboos and to prevent exclusion and marginalisation.

2.4 The African Human Rights Framework

2.4.1 Overview and Key Provisions

- The African Charter on Human and Peoples' Rights (ratified by Kenya on 23 January 1992) safeguards all people against discrimination and sets out the right to equal treatment and protection before the law for all individuals and inviolability of a person's physical integrity. In addition, Article 5 states that human dignity is inherent and that every individual is entitled to recognition of his [their] legal status.

[47]Ibid. at 14. [48]Ibid. at 12 and 13. [49]Ibid. at para. 43.
[50]UN Committee on the Elimination of Discrimination against Women, Concluding observations on the combined fourth and fifth periodic reports of Switzerland, UN Doc. CEDAW/C/CHE/CO/4-5 (25 November 2016), online: <https://documents-dds-ny.un.org/doc/UNDOC/GEN/N16/402/99/PDF/N1640299.pdf?OpenElement>(accessed 1st February 2018) at para. 24(e).
[51]Ibid. at paras. 38(c) and 39(c).

- The African Charter on the Rights and Welfare of the Child (ACRWC) commits member states to the protection of all children against discrimination, child abuse and torture, harmful social and cultural practices and sexual exploitation among others. A child is defined as a human being below the age of eighteen .
- The African Commission on Human and Peoples' Rights Principles and Guidelines on the Implementation of Economic, Social and Cultural Rights in the African Charter on Human and Peoples' Rights guidelines explicitly recognise intersex people as a vulnerable and disadvantaged group of people, who face or continue to face significant impediments to their enjoyment of economic, social and cultural rights.
- A panel discussion: 'Intersex human rights: Challenges and opportunities' convened in Banjul, the Gambia on the sidelines of the 61st Ordinary Session of the African Commission on Human and Peoples' Rights noted that:

"Intersex persons in Africa continue to face human rights violations which include non-consensual medically unnecessary genital normalising surgeries and genital mutilation on minors; infanticide and baby abandoning; lack of appropriate legal recognition and administrative processes allowing intersex persons to acquire or amend identity documents; and unfair discrimination in schools, health care facilities, competitive sports, work, access to public services, detention and many other spheres of life."

2.4.2 Comparative African Practices

South Africa, Zimbabwe, Kenya and Uganda are the only African countries that have made attempts to explicitly recognise the existence of intersex persons within their societies, while Zimbabwe's Constitution indirectly underscores the need for consent in medical procedures generally. In South Africa, the Promotion of Equality and Prevention of Unfair Discrimination Act (2000) provides a broad categorisation of grounds for non-discrimination and, as amended by the Judicial Matters Amendments Act, 2005, includes a definition of intersex and the provision that sex shall include intersex. The Act defines

[11]rapport d'information fait au nom de la délégation aux droits des femmes et à l'égalite des chances entre les hommes et les femmes sur les variations du développementsexuel:lever un tabou, luttercontre la stigmatisation et les exclusions par Mmes MaryvonneBlondin et Corinne Bouchoux, Sénatrices (Enregistré à la Présidence du Sénat le 23 février 2017), online: «https://www.senat.fr/rap/r16-441/r16-441-syn.pdf» (accessed 18th October 2017) [note: translated from French using Google Translate].
[12]Ibid. (recommendation 1)
[13]CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982), (entered into force 21 October 1986) [African Charter].
[14]African Charter on the Rights and Welfare of the Child, CAB/LEG/24.9/49 (1990), entered into force 29 November 1999 [ACRWC].
[15]Article 2
[16]Ibid. at 8 (para. 1(e)).

intersex as "a congenital sexual differentiation which is atypical to whatever degree." The Alteration of Sex Description and Sex Status (ASDSS) Act (2003) similarly provides for the alteration of the sexual description of individuals in certain circumstances.

While Zimbabwe does not have any laws specific to intersex persons, the Zimbabwean Constitution of 2013 addresses informed consent for medical procedures that apply to all persons, including intersex. With respect to 'medical treatment for therapeutic purposes' undertaken to "cure or alleviate any disease or disability", Article 247 provides that a patient must consent or, if the patient is unable, then consent of a person capable in law of doing so on behalf of the patient must be given. Such consent must comply with the requirements set out in Article 52 and the treatment must be "carried out competently in accordance with recognised medical procedures."

According to a baseline survey on intersex persons in East Africa (2015), it is estimated that at least two intersex children are born every week in East Africa. Even so, the report notes that it is impossible to get accurate figures due to the stigma and "cultural practice of concealment". The survey report makes the following recommendations: end Intersex Genital Mutilation, and document other sex- and gender-based violence against intersex persons; include information regarding the intersex in health and social development education, service access and employment policies to prevent harassment, abuse and discrimination; and include intersex in health and human rights initiatives.

[46]University of Pretoria, Faculty of Law – News, Centre for Human Rights, Iranti-org and SIPD-Uganda host panel discussion on intersex human rights in Africa (7 November 2017), online: <http://www.up.ac.za/en/faculty-of-law/news/post_2592184-centre-for-human-rights-iranti-org-and-sipd-uganda-host-panel-discussion-on-intersex-human-rights-in-africa> (accessed 6th February, 2018).

[47] Ibid.

[48]Support Initiative for People With Congenital Disorders, Baseline Survey on Intersex Realities in East Africa – Specific Focus on Uganda, Kenya and Rwanda (2015-2016), online: http://sipduganda.org/baseline-survey-on-intersex-realities-in-east-africa-specific-focus-on-uganda-kenya-and-rwanda/ (accessed 9th February, 2018) [SIPD Baseline Survey] [note: page references below are to the print version].

3.0 KENYA LEGAL AND POLICY FRAMEWORK

3.1 Introduction

In Kenya, the legal and human rights framework comprises the Constitution and other statutes. The Constitution of Kenya, 2010 (Part Four, the Bill of Rights) and Article 19 clarifies that the purpose of "recognising and protecting human rights and fundamental freedoms is to preserve the dignity of individuals and communities and to promote social justice and the realisation of the potential of all human beings." The Constitution is categorical that the rights secured under the Bill of Rights are inherent in every individual and are not given by the State (Article 19(3)(a)).Article 28 provides that, "every person has inherent dignity and the right to have that dignity respected and protected." This position has been upheld in the Baby 'A' Case, which highlighted the need to interpret Article 27(4) as broadly as possible in order to include intersex persons. In the Court's words:

An inclusive provision is not exhaustive of all the grounds specifically mentioned therein, including sex. That finding will therefore have to mean that intersexuals (sic) ought not to be discriminated against in anyway including in the issuance of registration documents such as a birth certificate. [Emphasis added]

The Report reviewed the current state of sectoral laws within Kenya that are likely to impact directly or indirectly on the rights of intersex persons in Kenya. The specific recommendations for reform in each sector are given in the relevant part of the Report.

3.2 Kenyan Case Law

In Kenya, two cases particularly stand out with regard to the judicial interpretation of the rights of intersex persons. One such case is Richard Muasya v Hon. Attorney General, High Court of Kenya (Nairobi High Court Petition No. 705 of 2007), and the other is **Baby 'A'** (Suing through the Mother E A) & another v Attorney General & 6 others [2014] eKLR (Petition 266 of 2013). Notably, in the **RM Case**, the cause of action arose prior to the 2010 Constitution and the Court was guided by the repealed Constitution. On the other hand, the **Baby A Case** was decided post-the 2010 promulgation. This is apparent in the interpretation of the two cases.

[1] Ibid. at 9.

3.2.1 Richard Muasya v Hon. Attorney General High Court of Kenya (Nairobi High Court Petition No. 705 of 2007)

The petitioner ("RM") was born with both male and female genitalia and was given a male name by his parents at birth. Due to his ambiguous genitalia, RM was unable to secure a birth certificate, identity card, or any travel documents. The petitioner dropped out of school at Class 3. He later attempted to marry but could not live with the wife, nor could his attempted marriage be given legal recognition. RM ended up in conflict with the law and was charged with an offence of robbery with violence in Kitui Chief Magistrate Court Criminal Case No.144 of 2005. While RM was in prison remand awaiting determination of his case, he was subjected to the usual statutory search at the prisons. It was realised during the search that he had both male and female genital organs. At a loss as to where to confine RM, prison officers referred the matter to the Kitui Magistrate's Court. The Court ordered that RM be taken to Kitui District Hospital for sex verification. The doctor's report confirmed that the petitioner had ambiguous genitalia.

An order was therefore made for the RM to be remanded at Kitui Police Station during the pendency of his trial. After trial, RM was convicted and sentenced to death for robbery with violence and committed to Kamiti Maximum Prison, which is reserved for male death row convicts. The petitioner was made to share cells, beddings and sanitary facilities with male inmates, and was exposed to constant abuse, mockery and ridicule. RM told the Court that he was also sexually molested by curious male inmates. RM then petitioned the High Court to seek redress for infringement of several rights including the right to dignity, freedom against inhuman treatment, discrimination on grounds of sex, and rights to freedom of association, freedom of movement and right to fair hearing and protection under the law.

In the ruling of 2nd December, 2010, a three judge bench of the High Court (Okwengu, Dulu and Sitati JJ) defined the term 'intersex' as "an abnormal condition of varying degrees with regard to the sex constitution of a person" (para. 109), but noted that the Court was not presented with any evidence of the existence of an "identified class or body of persons known as intersex in [Kenya]" (para.112) and therefore the Court was not persuaded that RM could bring a constitutional challenge in the public interest. They determined that RM's ambiguous genitalia did not negate the fact that "his" biological sexual constitution had already been fixed at birth (i.e. male) (para.128).

The Court further ruled that, "an intersex person falls within one of the two categories of male and female gender included in the term sex. To introduce intersex as a third category of gender would be a fallacy" (para. 130), and accordingly, with respect to RM specifically, "the petitioner as an intersex person is adequately covered by the law and has suffered no discrimination or lack of legal recognition" (para.133). The Court did however find that the strip searches RM had been subjected to during incarceration were "cruel and brought ridicule and contempt" and as a result constituted inhuman and degrading treatment in violation of the constitution (paras.167-168). The Court made the following statement in (para.145):

"...Few seem to appreciate the fact that the issue of gender definition for an intersex person, unlike a transsexual or a homosexual, is a matter of necessity and not choice. Tolerance and acceptance in this area will come with dissemination of appropriate information ..." [Emphasis added]

3.2.2 Baby 'A' (Suing through the Mother E A) & another v Attorney General & 6 others [2014], eKLR (Petition 266 of 2013)

This case was brought pursuant to the CoK, 2010 and in particular the fundamental rights and freedoms in the Bill of Rights. Baby A was born with both male and female genitalia. Hospital records indicated the baby's sex by a question mark and as a result, the child could not be issued a birth certificate or, concomitantly, an identity card (para.1). The petition alleged that this offends the child's rights to legal recognition, erodes its dignity and violates the right of the child not to be subjected to inhuman and degrading treatment as guaranteed in both the CoK, 2010, and the Children Act (para.1). In a progressive move away from the **RM Case**, the High Court (Lenaola J.) in **Baby A** case opined that Article 27(4) of the CoK, 2010 is an,

"... inclusive provision [that] is not exhaustive of all the grounds specifically mentioned therein, including sex. That finding will therefore have to mean that intersex persons ought not to be discriminated against in any way including in the issuance of registration documents such as a birth certificate." (para.61)

Similar to the **RM Case**, the High Court however left the specific addition of a third category of sex up to the legislature (para. 62). The Judge noted that he was not presented with any evidence upon which he could make a finding that Baby A was specifically subjected to discrimination on the basis of intersex

status (para.63). That notwithstanding, the Court made a note that there is "clear evidence that there is an urgent need to address the plight of intersex persons," including "an obvious lack of appropriate guidelines and regulations on how medical examinations and eventual corrective surgery, if needed, would be carried out" **(para.65). Accordingly, The High Court directed the government to consider developing an appropriate legal framework governing issues related to intersex children:**

"[T]here is currently no legal framework on intersex persons or any policies in place for them. It is the duty of the State to protect children born as intersexuals by providing a legal framework to govern issues such as their registration under the Births and Deaths Registration Act, examinations and tests by doctors, corrective surgeries, etc. It is on this basis that it behoves upon me to direct the Government towards an appropriate legal framework governing issues related to intersex children based on internationally acceptable guidelines. These guidelines would inform those minded to carry out medical examinations and corrective surgeries on intersex persons of the procedures and guidelines to follow so as to act within the law and in line with the best interests of the child. I would therefore strongly urge Parliament to consider enacting legislation in that regard. This in my view ought to be done in close consultation with various interested stakeholders ... in recognition of the principle of public participation." (Para.67)

Further, the High Court urged the government to consider the issue of collecting data relating to intersex persons with a view to designing policies to protect them as a marginalised group in society (para.68). It is pursuant to this Court's ruling that the Hon. Attorney-General constituted the Taskforce on Policy, Legal, Institutional and Administrative Reforms Regarding Intersex Persons in Kenya. **The above two cases are evident of the jurisprudential milestones that the country has made with regard to the recognition and protection of the intersex persons. The Taskforce is optimistic that, a decade after the RM Case, the full recognition and protection of the rights of intersex persons has gained momentum and will be realised sooner rather than later.**

4.0 NUMBERS, DISTRIBUTION AND CHALLENGES OF INTERSEX PERSONS IN KENYA

4.1 Introduction

Based on Kenya's population of 45.9 million (KNBS Statistical Abstract, 2017) the number of intersex persons in Kenya was estimated at 779,414 using the upper limit of 1.7% of the population as per the UN guideline, which approximates the population of intersex persons at 0.05-1.7% of global births. To help develop specific statistics for the country, the Taskforce commissioned a field survey to establish their present status in Kenya. Based on the nature of the target population and the stigma surrounding the intersex conversation, the study applied the non-probability sampling technique, Snowball Sampling, which yielded a study sample through referrals. To compliment data from the Key Informant Interviews, the survey reached out to various institutions across the country through purposive sampling using the following categories: Professional Regulatory Officers; National Government Administrative Offices; County Government Offices; Ministry of Labour and Social Protection; National Police Service; Correctional Facilities; Health Facilities; Educational Institutions; Religious Institutions, and; Civil Society Organisations. Wananchi were reached through by random sampling using online and face-to-face questionnaires.

4.2 Findings

- 16.3% of respondents had no/not completed any formal education, 4.1 % had attained university (undergraduate) education, while 3.1% of them had garnered various levels of technical education. These low levels of education and low transition rates among the intersex can be attributed to, among others, the presence of systematic biases in the population as well as in key institutions of society such as the educational system.
- The majority (77%) of intersex persons are in the youth category (ages 18-35). Nearly all the adult intersex persons interviewed (90%) were either in secondary (36%), primary (23%) or had never completed any level of formal education (31%). Only 10% of the adult intersex sampled had attained college or university education. Thus, many intersex people may drop out of school much earlier due to negative

peer pressure and societal stereotyping: they find no place to belong as they can neither fit in the boys' or girls' schools, and there are no dedicated intersex educational facilities in Kenya.

- **Most key informants (71%) became aware of the intersex status of their children at birth and/or during the early days of childhood; 23% of them discovered it at puberty/teenage, while 6% of them realised it in adulthood. This bears out the Taskforce's definition of the intersex, which argues that the intersex status,** "...can become apparent prior to, at birth, in childhood, puberty or adulthood."
- **Self-cognition or awareness of intersex status by the intersex also came at various times in their lives. In all cases encountered, the respondents admitted to being confused and not clearly understanding the intersex status and its causes, with many relating it to a curse or a punishment for some sins committed either by them or their parents/forefathers.** During such times, as indeed throughout their life, non-judgmental community perceptions and attitudes, psychosocial support, and overall facilitation through the legal, educational and vocational systems is critical in helping them adjust and settle down as productive adults and citizens.
- **The common belief and feeling patterns shared by the parents/ caregivers include: thoughts and regrets, blaming birth of the intersex child on a curse or a taboo broken; family break-up or abandonment of the mother by the husband and their relatives, seeing her accursed; resort to traditional healers, priests and herbalists, many of whom may prescribe various 'purification' rituals or downright infanticide. Others may seek help from various medical facilities, where the intersex may run the risk of misdiagnosis and suspect surgical interventions to 'normalise' the child.** In all this, dedicated psychosocial support, publicly-funded medical aid schemes, multidisciplinary medical support teams, the existence of accessible medical centres of excellence with the right mix of skills and attitudes for handling intersex-related cases, as well as a generally enlightened legal and administrative regime could greatly help.

- 63% of the intersex persons sampled self-identified themselves as male and actively cultivated a male gender, while 20% recognised themselves as female; 5% as of these respondents recognised themselves as intersex and sought to make the best of their lives, while a further 12% were not ready to self-recognise as male/female/intersex. It is important to note that this self-recognition is not always in accord with that of the parent, or even the assigned sex as recorded at birth in the civil registration documents. Where the self-recognised status of the child varies from that of the parents or the assigned status, the law and society must be willing to facilitate readjustment of the affected person in all ways, including through non-bureaucratic procedures for amending birth and other official civil documents.
- 34 (29%) of all the key informants indicated that they/their intersex charges had undergone surgery. Out of this, 30% were happy with the outcomes, 24% were unhappy with the surgical interventions, while 43% did not provide comprehensive feedback on the status of the surgery. In addition, many intersex persons reported feeling that they were treated as "specimens" of curiosity due to too much exposure to the doctors, nurses, student interns, who often posed many unnecessary, intrusive and embarrassing questions. Thus, there is need for systematic reform of the healthcare sector to better take care of the needs of the intersex, including through identification and operationalisation of intersex centres of excellence in the Level 5 and Level 6 hospitals across the country.
- Parents and caregivers who had their children undergo corrective surgeries reported having mixed feelings on the decision to have surgery, the procedures and the outcomes thereof. Some felt that medical intervention had to be done urgently when the child is young in order to 'fix' the sex of the child and thus 'normalise' them into the accepted binary of male/female. Others felt all non-emergency surgeries should wait until the child is of age. There is need for sensitisation on the concept of 'the best interest of the child' among all segments of the population.
- Presently, most of the diagnostic and therapeutic interventions related to the intersex persons in Kenya are carried out at a few

leading hospitals clustered around the major cities of Kenya. These are: Kenyatta National Hospital; Moi Teaching & Referral Hospital; Jaramogi Oginga Odinga Teaching & Referral Hospital; Wajir County Referral Hospital; the Agha Khan Hospital; Kijabe Mission Hospital; St. Mary's Hospital in Langata, Nairobi; and Gertrude's Children's Hospital.

- **On access to education, school teachers and administrators, as role models, can help to recognise, facilitate, promote and affirm the status and rights of the intersex in the school environment.** Thus, there is an urgent need to re-examine all facets of the educational system as presently constituted to remove all stigmatising and problematic statutes, rules and procedures, and to replace these with progressive alternatives that better recognise, support and promote the diversity of the Kenyan population.
- **On legal recognition and documentation of intersex persons, 44% of Key Informants ranked their access to key civil documents as generally good, 45% found them poor, while 15% did not express a clear opinion on the matter.** This points to the need for legal, policy and administrative reforms to institute more flexible and friendly processes for the intersex to both acquire and change their particulars in all civil registration documents.
- **On employment, a majority (57%) of intersex persons and their parents/caregivers expressed dissatisfaction with access to employment opportunities.** This suggests the need for reforms to equalise the employment space and to remove any lingering cultural and social biases and other systematic impediments that render the intersex uncompetitive.
- **On access to institutions for administration of justice, intersex people find themselves exposed to intrusive and unnecessary searches and placed in mixed remand with other male and female inmates, exposing them to sexual harassment and other dangers. Therefore,** there is a clear case for the reform of the prison and remand system, all the way from admission through search and registration, to assignment in specific prisons with appropriate intersex-friendly facilities, the training of at least some key personnel in each such

facility in the handling of intersex persons, and consideration where possible, of preferring non-custodial sentences for intersex persons, among other measures.

- **societal/customary/religious awareness challenges facing intersex persons in Kenya, these primarily emanate from low public awareness levels and unenlightened religious and customary beliefs and practises.** These findings corroborate the concern about the role of backward religious beliefs and practices in contributing to the plight of the intersex in Kenya. Thus, religious and faith-based organisations must be specifically engaged and reached with approved intersex-friendly messages.
- **The study found the highest levels of professional awareness among government officers (72%), and the lowest among religious and faith-based institutions at only 6%.** This gap can be bridged through targeted IEC materials and advocacy. The role of professional societies in this effort could be crucial.
- **94% of respondents from the Mwananchi questionnaire survey (both online and face to face) expressed their feeling that intersex children were a taboo, a curse on their parents and community and not 'normal'. Such widespread ignorance and mistaken beliefs suggest the need for a comprehensive and systematic public awareness campaign in partnership with key institutions and stakeholders.**
- **The majority of respondents (51%) reported their source of information on intersex persons and their related issues as the media; 36% got their information from the surrounding community/ society, while only 13% had encountered intersex persons and learnt firsthand from them. These findings indicate** the vital role played by the mass media in shaping public perceptions and attitudes about a myriad of issues in society, including on the treatment and perception of minorities and the marginalised such as the intersex. Any solution must thus have a robust media component to help drive the behaviour and culture change required to bring effective improvement in the lot of the intersex and other marginalised segments of the population in Kenya.

5.0 RECOMMENDATIONS

5.1 Introduction

- In view of the status (number, distribution and challenges) of intersex persons in Kenya; taking into account the lessons and milestones gleaned from a comparative analysis of international, regional, and selected States' approaches to the care, treatment and protection of intersex persons, and arising from an analysis of the policy, legal, medical, administrative and institutional frameworks governing structures and systems with regard to intersex persons in Kenya, the Taskforce identified and puts forward the following thematic reforms:

5.2 Recommendations

5.2.1 RECOGNITION

- 1. The Legislature in consultation with stakeholders to facilitate recognition of intersex persons in the law. This could be realised through the introduction of an Intersex (I) marker in all official documents that require identification of sex. This will involve amendment and introduction of a comprehensive definition of who an intersex person is:

  "Intersex" means a person who is conceived and born with a biological sex characteristic that cannot be exclusively categorised in the common binary of female or male due to their inherent and mixed anatomical, hormonal, gonadal (ovaries and testes) or chromosomal (X and Y) patterns, which could be apparent prior to, at birth, in childhood, puberty or adulthood.

5.2.2 DOCUMENTATION

- 2. Effecting expeditious provision of birth certificates, identification documents, passports and other official personal documentation by including provisions for the intersex (I) marker. This should include flexible legislative and administrative procedures for amending sex markers in official documents and correcting the original official documentation.

5.2.3 CRIMINAL JUSTICE SECTOR

3. The Legislature to facilitate review of laws to ensure equal treatment, respect and protection of the dignity of intersex persons within the criminal justice sector.

5.2.4 PUBLIC HEALTH

4. The Ministry of Health in consultation with relevant agencies to formulate specialised programmes to provide for intersex persons' care and protection in health facilities to facilitate their access to the highest attainable standard of health.
5. Surgical and hormonal interventions for children in relation to their intersex status should only be carried out in case of medical emergency based on informed consent. The Director of Medical Services in consultation with the relevant regulatory body (Kenya Medical Practitioners and Dentists Board, KMPDB) to develop a protocol on surgical and hormonal interventions that constitute medical emergencies.
6. The Ministry of Health to work with other regulatory agencies towards the protection against involuntary medical intervention and ensure effective remedy for persons otherwise affected.
7. The Ministry of Health in consultation with the KMPDB to formulate a harmonised and comprehensive treatment guideline focusing on a child- and human rights-based approach for the medical care and protection of intersex children.
8. The State to establish a fund to cater for all medical-related interventions for intersex persons due to the high cost implications of specialised intersex medical care. The State to give a free/ subsidised medical insurance health cover under the NHIF or any other scheme for intersex persons.

5.2.5 EDUCATION AND AWARENESS

9. Roll out awareness and sensitisation initiatives. This will be carried out through: Promotion of continuous and targeted awareness to the general public and all stakeholders to combat stigma and promote societal acceptance, and; review of the education curriculum in

primary, secondary and tertiary education institutions with the aim of recognising and infusing specific training in the syllabuses and training modules on sex development and categories.

5.2.6 STATISTICAL DATA

10. Collection of accurate and verifiable statistics on intersex persons. This will be achieved through: Kenya National Bureau of Statistics, the principal government agency for collecting, analysing and disseminating statistical data to include intersex as a third sex code/category. And inclusion of intersex (code 3) in the Kenya Population Housing Census scheduled for August, 2019.

5.2.7 SOCIAL, ECONOMIC AND LEGAL PROTECTION

11. Development and review of social protection mechanisms to ensure realisation of social, economic and legal protections for intersex persons and safeguarding against violations on the basis of their 'I' marker. This will be achieved through formulation of special protection mechanisms by State agencies to monitor violations of the enjoyment and realisation of human rights on the basis of a sex marker 'I'.

REPUBLIC OF KENYA

IN THE HIGH COURT OF KENYA AT KIAMBU

CONSTITUTIONAL PETITION NO. OF 2022

IN THE MATTER OF ARTICLES 10(1) & 10 (2)(a), 19, 22, 23, 26 (1) & (4), 27, 33, 35, 43 (1(a)), 53 (1(c)) AND 232 (1(d)) OF THE CONSTITUTION OF KENYA, 2010

AND

I IN THE MATTER OF ARTICLES, 22, 23, 34 AND 35 OF THE EAST AFRICAN COMMUNITY HIV & AIDS PREVENTION AND MANAGEMENT ACT

AND

IN THE MATTER OF SECTIONS 5, 6, 7, 15 AND 68 OF THE HEALTH ACT, 2017

AND

IN THE MATTER OF SECTION 16(2), (3) & (4), 28(3), 146 AND THE FIRST SCHEDULE OF THE CHILDREN ACT NO. 29 OF 2022

AND

IN THE MATTER OF SECTION 6 AND 7 OF THE SCIENCE TECHNOLOGY AND INNOVATION ACT NO. 28 OF 2013

AND

IN THE MATTER OF SECTION 4 AND 5 OF THE ACCESS TO INFORMATION ACT NO. 31 OF 2016

AND

IN THE MATTER OF THE PUBLIC SERVICE COMMISSION GUIDELINES FOR PUBLIC PARTICIPATION IN POLICY MAKING (2015)

AND

IN THE MATTER OF THE NATIONAL REPRODUCTIVE HEALTH POLICY 2022-2032

BETWEEN

RACHAEL MWIKALI.....1ST PETITIONER

ESTHER AOKO.....2ND PETITIONER

AMBASSADOR FOR YOUTH & ADOLESCENT

REPRODUCTIVE HEALTH PROGRAMME (AYARHEP).....3RD PETITIONER

KENYA LEGAL AND ETHICAL

217

ISSUES NETWORK ON HIV & AIDS.....4TH PETITIONER

VERSUS

CABINET SECRETARY

MINISTRY OF HEALTH.....1ST RESPONDENT

THE ATTORNEY GENERAL.....2ND RESPONDENT

AND

KENYA OBSTETRICAL GYNAECOLOGICAL SOCIETY..... 1ST INTERESTED PARTY

KATIBA INSTITUTE .....2ND INTERESTED PARTY

PETITION

The humble petition of **RACHAEL MWIKALI** (the 1st Petitioner), **ESTHER AOKO** (the 2nd Petitioner), **AMBASSADOR FOR YOUTH & ADOLESCENT REPRODUCTIVE HEALTH PROGRAMME** (the 3rd Petitioner) and **KENYA LEGAL AND ETHICAL ISSUES NETWORK ON HIV & AIDS** (the 4th Petitioner) is as follows: -

A. DESCRIPTION OF THE PARTIES

The Petitioners

1. The 1st Petitioner is a community organizer, sexual and reproductive health and rights activist and human rights defender. The 1st Petitioner supports and works with grassroots men and women; advocating for the recognition and protection of human rights, promoting public participation in law and policy development and implementation, and in public decision-making and mobilizing community support for social change.
2. The 2nd Petitioner is a community organizer, sexual and reproductive health and rights activist and comprehensive sexuality education trainer.
3. The 3rd Petitioner is a Non-Governmental Organization (NGO) registered in Kenya working to mitigate the impact of HIV and AIDS and promote healthcare, reproductive health and human rights.

4. The 4th Petitioner is a Non-Governmental Organization (NGO) registered in Kenya working to promote and protect health-related human rights in Kenya. It works to ensure that transparent and accountable governance in health is enhanced for the implementation of quality, accessible and comprehensive health and health-related services.

5. The address for service for the 1st – 4th petitioners for the purpose of these proceedings shall be care of Nyokabi Njogu and Gaudence Were, Advocates, C/O KELIN, Kuwinda Lane, off Langata Road, Karen C, P. O Box 112 - 00202 KNH Nairobi; litigation@kelinkenya.org.

The Respondents

6. The 1st Respondent is the Cabinet Secretary in charge of the Ministry of Health responsible for the development of health policies, laws and administrative procedures and programmes in consultation with county governments and health sector stakeholders and the public for the progressive realization of the highest attainable standards of health including reproductive health care.

7. The 1st Respondent, in consultation through the established intergovernmental relations mechanisms has a duty to make regulations on any matter where it is necessary or expedient in order to implement the provisions of the Health Act as well as to implement within Kenya measures agreed upon within the framework of any treaty, international convention or regional intergovernmental agreement to which Kenya is a party.

8. The 2nd respondent is the Principal Legal Adviser to the Government and the person authorized by Article 156(4)(b) of the Constitution of Kenya to represent the Government in proceedings to which it is a party and named in that capacity.

9. Service shall be effected through the Petitioners' advocate.

The Interested Party

10. The 1st Interested Party is a non-governmental organisation registered in Kenya working to promote a high standard of practice in the art and science of obstetrics and gynaecology in Kenya.

11. The 2nd Interested Party is a non-governmental organization registered in Kenya working to promote knowledge and understanding of the constitution and constitutionalism in Kenya.

B. FACTS CONSTITUTING THE PETITIONERS' CASE

12. In 2017, the Ministry of Health through its Division of Reproductive and Maternal Health (DRMH) (hereinafter referred to as the 1st Respondent) commenced a national process of redrafting the National Reproductive Health Policy with the goal of achieving "universal reproductive health coverage to all persons in the country."

13. The 1st Respondent consequently drafted a Reproductive Health Policy without involving key stakeholders in the health sector and the public; there was neither information provided on the process nor published and publicized invitations for participation of stakeholders or even the general public in the process.

14. On 10th September 2021, the 4th Petitioner received an invitation from the Council of Governors for a stakeholder consultation to review the draft policy and attend a virtual stakeholders engagement meeting.

15. The concept note sent out together with the invitation specifically indicated that the Ministry of Health drafted the policy without the involvement of the county governments and that they had requested that the policy not be launched before the counties' review and input.

16. The 4th Petitioner attended the virtual stakeholder consultation alongside other stakeholders on 17th September 2021 and gave oral submissions. Stakeholder views

were captured within the matrix under the Council of Governors with feedback generally concerning the lack of policy direction on access to comprehensive sexual and reproductive health as well as several limitation within the draft policy document; and providing an evidence base for twenty-one years.

17. The virtual workshop attended by the 4th Petitioner and other stakeholders was an engagement by the Council of Governors and not the 1st Respondent; up until this point, there had been no engagement between any of the Petitioners and the Ministry of Health regarding the draft policy.

18. Subsequently, by a letter dated 5th October 2021, the 4th Petitioner together with other organisations working on the right to health, women's rights and human rights sectors wrote to the head of the Division of Reproductive and Maternal Health of the 1st Respondent seeking the inclusion of civil society input to align the proposed National Reproductive Health Policy 2020-2032 with the Constitution of Kenya, 2010. In particular, the 4th Petitioner indicated that:

    i. The Ministry of Health has the constitutional mandate in designing health-related policies.
    ii. The National Reproductive Health policy 2020-2032 was in draft form and yet to be launched.
    iii. The Ministry of Health had had little engagement with civil society actors on the draft policy that ought to have been reflective of critical matters on reproductive health.
    iv. Non-governmental organisations offer more than 40% of the sexual and reproductive health care services in the Kenyan communities. There was therefore a need for civil society inclusion in the drafting and validation processes prior to the roll-out of the policy.
    v. There was also attached in an appendix (1) key issues that needed to be addressed in the draft policy including: -

a. The ministry's ignoring its own existing policies on: menstrual hygiene (completely absent from the proposed policy), sexual reproductive health for adolescents and young people, as well as measures to ensure provision of post-abortion care services (completely absent from the document);
b. The ministry equally ignored existing commitments that the government has made on sexual and reproductive health and rights. Beyond a single mention of the International Conference on Population Development 25 (ICPD25), the document had no cross-reference to regional and international commitments such as the Protocol to the African Charter On Human and Peoples' Rights on the Rights of Women (Maputo Protocol), Convention on the Elimination of Discrimination Against Women or the East African Community HIV & AIDS Prevention and Management Act which all speak towards Kenya's obligations in sexual and reproductive health provision.
c. The draft policy was selective and exclusionary. The draft policy had no policy direction on key issues connected to sexual and reproductive health such as mental health (post-partum depression), exclusion of sex workers as critical vulnerable population, post-abortion care and menstrual hygiene yet the policy was to override all existing policies on sexual and reproductive health. This would be fatal given the absence of so many aspects of sexual and reproductive health from the draft policy.
d. The draft had problematic, stigmatizing language that:
    i. blamed survivors of sexual violence;
    ii. indicated that adolescents have increased HIV infections due to failure to resist forced sex from partners;
    iii. encouraged out-of-court settlement for gender violence;

iv. Stigmatized people not planning family as it insisted on the role of families in advancing reproductive health; and

v. deliberately excluded those outside the union of marriage by the use of the term family planning instead of contraceptives.

e. The writing of the draft policy was driven by moral and religious sentiments that placed a focus on family with little regard to those outside marriage unions.

f. The draft policy was contrary to the constitutional principles of devolution as it purported to override county laws; yet counties and the national government are equal partners.

19. Despite the organisations' requests to be consulted beforehand and their input meaningfully reflected in the draft policy, no such action was taken by the 1st Respondent. In fact the 1st Respondent has to date not issued a response to the letter of 5th October 2021.

20. Later, through a letter dated 1st March 2022, the Ministry of Health indicated that its Division of Reproductive and Maternal Health had in collaboration with partners revised several reproductive health documents and the next steps would be to print, launch and disseminate the documents at the national and county levels to facilitate subsequent implementation within various reproductive health programmes. It did not mention who in particular these partners were. The letter further indicated that the national launch was tentatively scheduled for 23rd March 2022.

21. The 4th Petitioner and other organisations became aware of this letter and responded on 18th March 2022 expressing concern at the manner in which the policy had been developed and indicating the need for public participation in the draft reproductive healthcare policy.

22. The letter was a call for urgent steps to ensure adequate and meaningful public participation before launching and operationalising the policy. The request was based on the following key reasons: -

i. Public participation is a constitutional obligation. There is an obligation to consider the needs and interests of the public, particularly women and girls, who would be affected by the proposed policy, before the policy is launched and operationalised.

ii. Critical stakeholders were not adequately and meaningfully engaged in the development of the reproductive health policy. The 1st Respondent had not responded to the letter of 5th October 2021 on the inclusion of civil society in the drafting and validation process prior to the roll-out of the draft policy.

iii. The reproductive health policy being launched had not been made readily available. The draft Policy was not readily available online, on the 1st Respondent's website, and neither had it provided a copy to stakeholders. Moreover, the Ministry had not provided the public with information on the proposed policy and how they could access the draft Policy. It was therefore impossible for people to comment on the crucial document as it was not readily available.

iv. The reproductive health policy being launched excluded key sexual and reproductive health issues. It completely ignored any interventions on unsafe abortion despite unsafe abortion being a major cause of maternal mortality and morbidity in Kenya. It also failed to give policy direction on the availability of safe abortion as required under Article 43(1)(a) and Article 26(4) of the Constitution.

v. The reproductive health policy being launched contradicted the 1st Respondent's obligations under international human rights law as well as its own Adolescent Package of care by classifying sex for persons under the age of 21 years as a harmful reproductive health practice, and enforcing consent from parents, guardians or government medical specialists when providing

reproductive health services to minors. This also contradicted certain county-specific reproductive health policies that allow minors to consent to their own reproductive health services, as well as the HIV and AIDS Prevention and Control Act which also recognises that children may seek sexual and reproductive health services.

vi. This also amounts to supervision of adults as they seek and receive sexual and reproductive health services.

vii. The reproductive health policy being launched was a fundamental policy for the health sector as it provided a framework for actualising the right to the highest attainable standard of health including reproductive health as articulated in Article 43(1)(a) of the Constitution of Kenya. The Policy was intended to provide a much-needed foundation for ensuring quality reproductive health services are available and accessible, and therefore all stakeholders should have been given ample time to interact with it.

23. The organisations therefore called upon the Ministry of Health through the Head of the Division of Reproductive and Maternal Health to undertake the following actions to ensure the intended reproductive health policy meets the constitutional threshold and takes into account the views of the public: -

i. Stop the launch of the Reproductive Health Policy 2020 – 2030.

ii. Make the most recent draft of the reproductive health policy readily available by making it available online and publishing the full copy in the leading dailies.

iii. Issue a request for submission of memoranda on the reproductive health policy that would allow stakeholders at least 30 working days to make written submissions.

iv. Organise public hearings to directly receive oral submissions from stakeholders.

24. Further to the above, on 22nd March 2022, the Coalition for Grassroots Human Rights Defenders, a civil society organisation led by the 1st Petitioner, delivered a petition demanding community involvement, particularly from women from informal settlements in the formulation and validation process of the policy to the offices of the 1st Respondent.

25. Due to pressure received from stakeholders on the lack of adequate meaningful participation as well as the substantive flaws of the policy, on 31st March 2022, the Ministry of Health issued an invitation to a deliberation meeting on the draft reproductive health policy on 6th April 2022.

26. The 4th Petitioner attended the meeting of 6th April 2022 and highlighted the following key issues: -

    i. Lack of a guiding framework for safe abortion care.
    ii. The concept of attaining cognitive competency at the age of 21; priority interventions being delayed sexual debut and abstinence.
    iii. Requirements for parental consent for adolescents to access sexual and reproductive health services and commodities.
    iv. One of the participants in the meeting being the Kenya National Commission on Human Rights noted that they were unaware of the policy and asked to be included to aid the Ministry of Health in knitting a rights-based approach in the policy, particularly including global and regional conventions, treaties and commitments in the guiding framework and aligning definitions.

27. After this, the 4th Petitioner was thereafter invited by the 1st Respondent on 18th April 2022 to attend a reproductive health policy drafting workshop on 25th April 2022 during which the 1st Respondent was informed of the need to ensure that the intended policy was rights-compliant.

28. During that drafting workshop, the 1st Respondent indicated that it would take into account the submissions made by participants and share the updated draft reproductive health policy version together with the matrix of comments and responses and host a validation meeting prior to launching the Policy document.

29. Contrary to the above, the 1st Respondent did not share the updated draft reproductive health policy nor the matrix of comments for the 4th Petitioner and other participant's review, records and comments.

30. Instead, and in blatant violation of the earlier discussion and agreement, the 1st Respondent decided to move to launch the policy document. On 28th June 2022, the 1st Respondent sent out an invitation for a validation meeting that was to be held on 1st July 2022. This was just two working days to the validation meeting and the invite was without the 4th Petitioner or any other person at the drafting workshop having received the updated draft reproductive health policy nor the matrix of comments.

31. Due to the short notice given, and considering that the 1st Respondent refused to provide the policy that was to be validated, various stakeholders, including the 1st Petitioner and the 4th Petitioner were unable to attend the validation workshop of 1st July 2022. However, stakeholders including the 3rd Petitioner herein indicated that the validation meeting of 1st July 2022 was not participatory and was a simple dress-down from Dr. Stephen Kaliti, the Head of the Division of Maternal and Reproductive Health who refused to share the draft policy and harshly criticized the civil society for demanding an open and fair process.

32. It became clear that the 1st Respondent had not intended to facilitate meaningful public participation in development of the policy. Therefore, 4th Petitioner wrote a letter of protest to the 1st Respondent formally and officially disengaged itself from the process citing the following reasons: -

a. Despite involvement in the process, the 4th Petitioner was yet to receive the draft text of the reproductive health policy. Requests to have a meaningful process either went unanswered or were responded to through participation by ambush. All invitations were sent on short notice a day or two before meetings were held, and the documents to be discussed were not provided.
b. There was a lack of transparency by the 1st Respondent who refused to share any documentation even where requests and demands were made.
c. There was a blatant exclusion of professional views. Despite consistent submission on views from medical experts from the Kenya Obstetrical Gynaecological Society, the Interested Party herein, these views were disregarded completely on areas such as surrogacy, the exclusion of adolescents and young people in access to sexual and reproductive health, and the needs of gender minorities.
d. Disregard to science, data and facts – On various occasions, Dr Stephen Kaliti disregarded rising data on teen pregnancies, rising HIV infections, sexual and gender-based violence and unsafe abortion, and the need for policy interventions to address this. Moral and religious bias by the Director of the Division was evident and he, therefore, had clouded views thus compromising the quality of engagement.

33. On 5th July 2022 just one working day after the validation meeting, the 1st Respondent launched the National Reproductive Health Policy 2022-2023 (the Policy). At paragraph 3.3, it is noted that s complementary to existing policies on Reproductive Health, and shall be the primary reference document on matters concerning Reproductive Health in Kenya.

34. The Petitioners consider the policy to be unconstitutional because of the procedure involved in its development and as the policy provisions undermine the right to life and to reproductive health.

35. The process of development of the policy was fraught with irregularities. The 1st Respondent failed to undertake meaningful public participation. It also contains various provisions which claw back on the constitutional guarantee on the right to life and the right to reproductive health.

36. Specifically, the Policy uses exclusionary language that denies critical reproductive healthcare interventions to the majority of women and girls thereby intentionally excluding any person not in a marriage; providing contraceptive care alternatives to only couples that have had children.

37. ***The policy's situational analysis, for instance (2.3.3 Reduction in unmet family planning needs on page 11)*** draws data on the use of modern contraceptives from a population of married women instead of focusing on women of reproductive age. Further, ***the policy's preamble on family planning (3.4.2 To reduce unmet family planning needs on page 23)*** focuses on the provision of family planning for couples that have achieved their desired family sizes to the exclusion of family planning services of the rest of the population of persons of reproductive age.

38. The bias towards families to the detriment of the rest of the population of reproductive age is further indicated at ***4.2.3 paragraph 6 of the policy (page 38)*** where it is indicated that the policy recognizes the central role of the family in reproductive health and that this shall be reflected in reproductive health interventions; as well as the description of the key components in service delivery and standards to include responsiveness to social values ***(page 39).***

39. The policy further excludes adolescent women and young girls from benefiting from reproductive health services and commodities as it envisages the provision of cervical cancer screening services for women between 25-49 years to the exclusion of other age groups ***(2.3.7 on cancers of reproductive organs at page 15 of the policy).***

40. Additionally, the policy limits interventions from healthcare workers in regard to access to safe abortion. This is especially so as the policy provides that termination of pregnancy shall be performed guided by the opinion of a trained health professional with the proficiency to ensure both the mother and unborn child receive the highest attainable standard of healthcare ***(policy thrust 3.4.1 to reduce maternal, perinatal and neonatal morbidity and mortality paragraph 12 at page 23 of the policy).***

41. To indicate that in abortion the health professional should ensure the highest standard of healthcare for an unborn child is to give with one hand and take with the other. In the circumstances, the policy creates unnecessary fear and hesitation on the position on procurement of safe and legal abortions, thereby contravening the right to life and to health of the mother. This clause only exacerbates alarm and fear for health care professionals with respect to provision of safe abortions services and creates additional barriers with an unfeasible requirement to balance the pregnant woman health with the foetus' standard of health. The position is further exacerbated by the lack of comprehensive provisions and guidelines on safe and legal abortion as well as post-abortion care.

42. Further, healthcare interventions under the policy exclude young women below 21 years as they are not guaranteed access to reproductive health services on the basis that they have "not attained full cognitive competence on matters of sexuality and reproduction." (***overarching policy statement at page 19 of the policy).*** Under ***3.4.8 paragraph 1 of the policy on page 25***, it is further indicated that a person attains complete full cognitive competence on matters of sexuality and reproduction at the age of 21 and that the government will prioritize abstinence and delayed sexual debut for persons yet to attain full cognitive competency.

43. By making a blanket intervention, the Ministry of Health fails to give regard to both facts and evidence on teenage pregnancies and HIV and AIDS infections.

44. It also unreasonably requires parental consent prior to provision of services but fails to provide a guidelines for instances where parental or a guardian's consent cannot be achieved without undue hardship. ***(3.4.8 paragraph 8 of the policy on access to reproductive health services for children at page 26 of the policy).*** It also fails to take into account that there instances where adolescents have the capacity to make decisions about their health.

45. The Policy also fails to take into account the legal age of majority and seeks to unconstitutionally limit an adult's ability to consent to their own healthcare services.

46. Additionally, the policy excludes unmarried women from fertility treatment; thereby denying them access to reproductive rights and options that are unrestricted for married women. Under the policy's **broad objective 2 on improving responsiveness to client's reproductive health needs (page 21 of the policy),** it is indicated as a sub-objective (v) as to reduce the magnitude of infertility and increased access to management of infertile couples. Under ***3.4.11 paragraph 5 of the policy (page 28),*** it is expressly indicated that there shall be full financing of at least one cycle of assisted fertility treatment but the same is limited to "needy desirous couples," which term has not been defined effectively.

47. The policy also introduces unconstitutional and unethical practices that would require all pregnant women and their families to be tested for HIV thereby creating a barrier to access to critical maternal healthcare and commodities as well as disregard for the right to privacy, dignity as well as the right to adequate health which includes the aspect of informed consent as well as freedom from forced medical procedures ***(3.4.4 paragraph 2 of the policy at page 24).***

48. Following the launch of the Reproductive Health Policy 2022-2032, the 4th Petitioner together with other organisations working in the right to health, women's rights and human rights sectors; grassroots human rights defenders; individual citizens and residents of different countries by a letter dated 22nd July 2022 continued to express their concerns with the problematic provisions of the Reproductive Health Policy 2022-2032 that would serve to exclude certain vulnerable and marginalized populations from accessing critical services.

C. CONSTITUTIONAL AND STATUTORY BASIS OF THE PETITION

49. Article 10 establishes the national values and principles of governance and which bind all state organs and anyone when interpreting or applying the Constitution. These values include the rule of law, sharing and devolution of power, participation of the people, democracy, human rights, good governance, transparency and accountability.

50. Article 232 outlines the following values and principles of public service: responsive provision of services; involvement of the people in the process of policymaking; and transparency and provision to the public of timely, accurate information.

51. The Petitioners, as actors and practitioners within the sexual and reproductive health and rights sphere, as well as members of the public have a right to be involved under Article 10 and 232 of the Constitution in consultative processes and their views considered before decision-making by virtue of the principle of public participation.

52. Article 22(1) of the Constitution gives persons in Kenya the power to institute court proceedings claiming that a right or fundamental freedom in the Bill of Rights has been denied, violated or infringed, or is threatened. By virtue of Article 22(2) persons bringing claims of such nature before the Honourable Court may do so

either in their own interest or acting in public interest. Article 165(3)(b) of the Constitution gives this Court original jurisdiction to consider whether a right contained in the Bill of Rights has been violated.

53. Article 23 of the Constitution grants the High Court jurisdiction to hear and determine applications for redress of a denial, violation or infringement of, or threat to, a right or fundamental freedom in the Bill of Rights. The court has jurisdiction to grant appropriate reliefs including those set out at Article 23(3) thereof.

54. The Policy also contains various provisions that contravenes the Constitution.

Contravention of Article 10 and 232 (1(d)) of the Constitution, the Health Act and the Public Service Commission Guidelines for Public Participation in Policy Making on adequate and meaningful public participation, and sharing and devolution of power

55. Article 10 of the Constitution outlines the national values and principles of governance which bind all state organs, state officers, public officers and all persons whenever any of them makes or implements public policy decisions.

56. Article 10(2)(a) specifically provides that the national values and principles of governance include patriotism, national unity, sharing and devolution of power, the rule of law, democracy and participation of the people.

57. Article 232(1)(d) in a similar fashion provides that the values and principles of public service include the involvement of the people in policy making. Per Article 232(2), the values and principles of public service apply to public service in all state organs at both levels of government and all state corporations.

58. Despite the Petitioners and other organisations' efforts to ensure that the policy-making process of the reproductive health policy was inclusive and involved public

participation, the Ministry of Health proceeded without due consideration for the views of the public and major stakeholders.

59. The formulation and implementation of the Reproductive Health Policy 2022-2032 fails to meet the constitutional threshold on adequate and meaningful public participation to the extent that: -

i. There was inadequate community and stakeholder consultation in the formulation and review of the policy;

ii. Even where engagement was sought, it was through ambush as all invitations were sent on short notice. The policy in draft form was never shared prior to the meetings called by the 1st Respondent despite their mandate to proactively disclose the document for consideration of members of the public and stakeholders;

iii. The Ministry of Health was not responsive to protests by key stakeholders on the provisions that were in contravention of the law and Kenya's international sexual and reproductive health obligations and eventually passed the policy with those retrogressive provisions;

iv. The validation meeting of 1st July 2022 was not participatory as it was on short notice, with none of the attendees having access to the policy being validated or the matrix developed during the reproductive health drafting workshop held on 25th April 2022 and was merely an address by Dr. Stephen Kaliti, the head of the Division of Reproductive and Maternal Health;

v. The draft Reproductive Health policy was not made readily and reasonably available to the public;

60. The Reproductive Health Policy as is, contravenes Section 15 of the Health Act, 2017 which provides that one of the duties of the national government shall be to develop health policies, laws and administrative procedures and programmes in consultation with county governments and the health sector stakeholders and the

public for the progressive realisation of the highest attainable standards of health including reproductive health care and the right to emergency treatment.

61. The Reproductive Health Policy contravenes Section 15 of the Health Act in so far as: -

i. The Ministry of Health drafted the Reproductive Health Policy without involving members of the public who are affected by reproductive health issues and would in fact be the beneficiaries of the policy.

ii. The Ministry of Health failed to meaningfully engage actors, or even the county government, and practitioners within the sexual and reproductive health and rights sphere who have a right to be considered stakeholders for purposes of public participation as their input is critical; with non-governmental organizations offering substantial sexual and reproductive health services and programs to the citizens of Kenya.

iii. The draft reproductive health policy was, before its launch, not readily available. The draft Policy was not readily available online, on the Ministry of Health's website. Moreover, the Ministry had not provided the public with information on where and how they could access the draft Policy. It was therefore impossible for the public to comment on the crucial document as they had no access to it.

62. The entire formulation of the Reproductive Health Policy is contrary to the provisions of the Public Service Commission Guidelines for Public Participation in Policy Making, 2015 (Policy guideline 2.0) in so far as it provides guidelines to the effect that in the public participation process a public office shall: -

i. Adhere to the provisions of Articles 10(2)(a), 35 and 232(1)(d) of the Constitution.

ii. Consider legislation specific to the organ and the legislation applicable to service delivery in the sector.

iii. Provide adequate opportunities and notice to stakeholders to voice their opinions.

iv. Ensure proper logistical arrangements including the recording of stakeholder inputs.

v. Ensure the purpose of the session is clearly explained to stakeholders.

63. As none of the steps above were demonstrably taken, the formulation of the Reproductive Health Policy 2022-2032 and intended implementation is devoid of the fundamental constitutional principle of reasonable public participation.

64. Promotion of primary health care and other county health services fall under county health services. However, the Policy undermines various county processes by creating an incoherent policy environment in its policy implementation framework. It creates unnecessary and bureaucratic processes that will hinder the provision of reproductive health care services by county governments.

Breach of the right to the highest attainable standard of health contrary to Article 43 (1)(a), 53(1)(c) and 26(4) of the Constitution as read with Article 14 of the Maputo Protocol

65. Under Article 43(1)(a) of the Constitution, every person has the right to the highest attainable standard of health, which includes the right to healthcare services, including reproductive health care. The right to the highest attainable standard of health is to be enjoyed by **every person.** This is further outlined in the Health Act, where Section 5 provides that every person has the right to the highest standard of health attainable while Section 6 provides that every person has the right to reproductive health care.

66. The right to the highest attainable standard of health, is an immediate right for all children; as espoused under Article 53(1)(e) of the Constitution. The standards of health are elaborated to include healthcare for children as Article 53 (1)(c) provides that every child has the right to basic nutrition, shelter and healthcare.

67. By limiting the reproductive health care interventions to various people such as adolescents, the policy is therefore unconstitutional to the extent that it does not provide for access to reproductive healthcare for **all persons of reproductive age.**

68. Abortion is an element of reproductive health. Article 26(4) of the Constitution provides for the right to procure an abortion where in the opinion of a trained health professional, or there is a need for emergency treatment or the life or health of the mother is in danger, or where it is permitted by any other written law. The 1st Respondent through the Ministry of Health, as the national government ministry in charge of health, has a duty to give guidance to medical professionals on the interventions beforehand when the life or health of the mother is in danger, in emergency situations as well as on post abortion care.

69. As currently drafted, the policy limits interventions from healthcare workers on safe abortion and even post abortion care. By providing that termination of pregnancy be guided by the opinion of a trained health professional to ensure both the mother and unborn child receive the highest attainable standard of healthcare ***(policy thrust 3.4.1 to reduce maternal, perinatal and neonatal morbidity and mortality paragraph 12 at page 23 of the policy).***

70. To indicate that in abortion the health professional should ensure the highest standard of healthcare for an unborn child is to goes contrary to Article 26(4). Article 26(4) requires the trained health care provider to consider the life or health of the mother, and this Policy direction and will only serve to create unnecessary confusion on the position on procurement of safe and legal abortions, thereby

contravening the right to the highest attainable standard of health for the mother. The requirement in the policy is not feasible and only serves to create additional barriers for women to access abortion as provided in law, including post abortion care, which is a matter of safeguarding the life of the pregnant woman.

71. Moreover, the inclusion of the term 'unborn child' in this policy direction amounts to amending the substance of Article 26(4) of the Constitution of Kenya, 2010 without any legal basis.

72. The position is further exacerbated by the lack of comprehensive provisions and guidelines on safe and legal abortion as well as post-abortion care.

Violations of the right to freedom from discrimination contrary to Article 27 of the Constitution and the right of access to reproductive health services and information by all contrary to Sections 22, 23 and 34 and 35 of the East African Community HIV and AIDS Prevention and Management Act, the Children Act 2022 and Section 68 of the Health Act

73. Article 27 of the Constitution provides that every person is equal before the law and has the right to equal protection and equal benefit before the law and that equality includes the full and equal enjoyment of all rights and fundamental freedoms.

74. Section 34(1)(a) of the East African Community HIV Act provides that the government shall ensure that women and girls regardless of their marital status have access to adequate and gender-sensitive HIV-related information and health services including women-specific and youth-friendly sexual and reproductive health services for all women of reproductive age and women living with HIV.

75. Contrary to the above provisions, the Policy uses exclusionary language that denies critical reproductive healthcare interventions to the majority of women and girls

thereby intentionally excluding any person not in a marriage and providing contraceptive care alternatives to only couples that have had children.

76. ***The policy's situational analysis, for instance (2.3.3 Reduction in unmet family planning needs on page 11)*** draws data on the use of modern contraceptives from a population of married women instead of focusing on women of reproductive age. Further, ***the policy's preamble on family planning (3.4.2 To reduce unmet family planning needs on page 23)*** focuses on the provision of family planning for couples that have achieved their desired family sizes to the exclusion of the rest of the population of persons of reproductive age. The use of the term "family planning" by itself is discriminatory as it denies access to contraceptives to persons who are not in unions.

77. Additionally, the policy excludes unmarried women from fertility treatment; thereby denying them access to reproductive rights and options that are unrestricted for married women. Under the policy's **broad objective 2 on improving responsiveness to client's reproductive health needs (page 21 of the policy),** it is indicated as a sub-objective (v) as to reduce the magnitude of infertility and increased access to management of infertile couples. Under ***3.4.11 paragraph 5 of the policy (page 28),*** it is expressly indicated that there shall be full financing of at least one cycle of assisted fertility treatment but the same is limited to "needy desirous couples," which term has not been defined effectively. In the end, the provision is vague and further discriminatory as it is an option limited to couples only yet government resources are in use.

78. The bias towards families to the detriment of the rest of the population of reproductive age is further indicated at ***4.2.3 paragraph 6 of the policy (page 38)*** where it is indicated that the policy recognizes the central role of the family in reproductive health and that this shall be reflected in reproductive health

interventions; as well as the description of the key components in service delivery and standards to include responsiveness to social values ***(page 39).***

79. The policy also introduces unconstitutional and unethical practices that would require all pregnant women and their families to be tested for HIV thereby creating a barrier to access to critical maternal healthcare and commodities as well as disregard for the right to privacy, dignity as well as the right to adequate health which includes the aspect of informed consent as well as freedom from forced medical procedures ***(3.4.4 paragraph 2 of the policy at page 24).***

80. The policy limits the rights of intersex persons and discriminates against intersex persons who do not wish to have their assignment of sex into what the Policy terms as "the correct sex". ***(Policy thrust 3.4.12 paragraph 1 to ensure that persons born intersex attain the highest standards of reproductive health at pg. 28)***

81. This policy direction fails to recognize that intersex persons can choose to recognized as such, as it forces them to be assigned either a male or female sex, and to present themselves before a 'professional body for the purpose of being assigned the 'correct sex.' This deprives intersex persons the right to seek reproductive health services as intersex persons. It also fails to take into account past discrimination that intersex persons have faced in the past.

82. Section 35 of the East African Community HIV and AIDS Management Act recognizes that the government has a responsibility to ensure access by youth and adolescents to information and education about sexual and reproductive health in general. However, the Policy excludes adolescent girls and young women from benefiting from reproductive health services and commodities as it envisages the provision of cervical cancer screening services for women between 25 and 49 years to the exclusion of other age groups ***(2.3.7 on cancers of reproductive organs at page 15 of the policy).***

83. Further, healthcare interventions under the policy exclude young women below 21 years as they are not guaranteed access to reproductive health services on the basis that they have "not attained full cognitive competence on matters of sexuality and reproduction." (***overarching policy statement at page 19 of the policy).*** Under ***3.4.8 paragraph 1 of the policy on page 25***, it is further indicated that a person attains complete full cognitive competence on matters of sexuality and reproduction at the age of 21 and that the government will prioritize abstinence and delayed sexual debut for persons yet to attain full cognitive competency.

84. The Ministry of Health in this case contradicts its previous guidelines by emphasising abstinence and delayed sexual debut. This fails to take into account that many adolescents make their sexual debut well before the age of 18 years.

85. This provision is also contrary to county laws and policies, (for instance Mombasa and Makueni) that allow minors to consent to their own reproductive health services. Moreover, it directly contradicts section 16(2), (3) and 16(4) all of which underscore the right of children to receive the highest attainable standard of health, to receive health care services while having their right to privacy safeguarded and to receive age appropriate information on reproductive health.

86. This provision further limits the ability of health care workers to provide services to adolescents based on their evolving capacities and needs by requiring parental consent for health care services.

87. Under the Children Act, 2022

    i. Under Section 28 (3), every child has the right to express their views in all matters affecting them and have these views considered in accordance with the child's age and maturity.

ii. Section 146 of the allows for children in need of care and protection to access healthcare without the prerequisite for prior parental consent.

iii. The first schedule identifies one of the best interest of the child considerations to include the age, maturity, stage of development, gender, background and any other characteristic of the child.

88. The push to exclude adolescents below the age of 21 years is without any scientific basis or evidence. There is no legal basis for limiting the age of consent past the age of 18 years. In the end, young adult women between the ages of 18 and 21 are left with policy interventions that do not adequately meet their sexual and reproductive needs yet they have the legal capacity to make informed decisions on their sexual and reproductive health; and to access those services and commodities.

89. The above violations are also contrary to Section 68 of the Health Act, 2017 which provides that the national health system shall devise and implement measures to promote health and to counter health influences having an adverse effect on the health of specific people including a comprehensive programme to advance reproductive health including effective family planning services; implementation of means to reduce unsafe sexual practices; adolescence and youth sexual and reproductive health.

90. The provisions of the Policy are also contrary to Section 34(2)(b) of the East African Community HIV and AIDS Prevention and Management Act, which provides that the Ministry responsible for matters relating to gender and health and HIV (the Ministry of Health) in collaboration with key stakeholders shall implement strategies, policies and programmes that promote the rights of women and girls specifically the sexual and reproductive rights and responsibilities of men and women and the right to access health and reproductive services independently.

91. Despite the Ministry of Health recognising, in the Kenya AIDS Strategic Framework II (2020/1-2024/25) that the risk of infection for HIV and AIDS is most significant in at least 12 counties in Kenya, there policy makes no mention of reproductive health interventions for the key populations who at the highest risk for infection, such as sex workers, men who have sex with men and transgender persons.

Contravention of Article 35 of the Constitution and the Access to Information Act on the right to access information

92. Article 35 of the Constitution of Kenya and section 4 of the Access to Information Act provides for a citizen's right to information to information that is held by the state, or that is held by any other person and is required for the exercise or protection of a fundamental right or freedom.

93. Article 35(3) and Section 5 of the Access to Information Act also requires public entities to proactively disclose information. Section 5(3) obliges public entities to publish all relevant facts while formulating important policies or announcing the decisions which affect the public, prior to formulating any policy, scheme, programme or law, a public entity is required to publish or communicate to the public in general or to the persons likely to be affected thereby in particular, the facts available to it or to which it has reasonable access which in its opinion should be known to them in the best interests of natural justice and promotion of democratic principles.

94. The Ministry of Health contravened the right to access information by refusing to make the draft Reproductive Health Policy available to the Petitioners and the general public in order to facilitate a meaningful and transparent public participation process in its development.

95. Further the Reproductive Health Policy that was eventually passed denies adolescents and young people information on sexual and reproductive health by precluding anyone under 21 years old from accessing sexual and reproductive health information, in so far as limitations on sexual and reproductive health information to adolescents and young women are imposed by the policy; especially with the policy recognizing that a person attains complete full cognitive competence on matters of sexuality and reproduction at the age of 21. This automatically excludes adolescents from receiving or benefitting from crucial reproductive health information.

Contravention of Article 33 on the right to freedom of expression, including academic freedom and freedom of scientific research as read with Sections 6 and 7 of the Science Technology and Innovation Act, 2013

96. Article 33(1)(c) of the Constitution of Kenya guarantees the freedom of expression which includes academic freedom and freedom of scientific research. Sections 6 of the Science and Technology Act places the responsibility encouraging innovation and research on the National Commission on Science and Technology. Section 7 requires the Commission to be guided by various principles including the promotion of knowledge creation, and the promotion of development of manpower and skills.

97. In Chapter 4 at the Policy Implementation Framework, the policy direction 4.2.3 paragraph 8, the 1st Respondent purports to decry the manner in which research in reproductive health is coordinated, and therefore puts in place a policy framework that limits freedom of scientific research. This is done by making the Director General for Health the custodian of all reproductive health research and arrogating to him broad unchecked power to vet such research.

98. There is no reasonable justification why the 1st Respondent should have sole discretion to approve and vet all research on reproductive health.

99. The manner in which the 1st Respondent intends to implement clause 4.2.3 paragraph 8 of the Policy is irrational is a barrier on academic freedom and will deprive Kenyans on access to scientific progress.

Contravention of the right to life

100. Article 26(1) of the Constitution provides that every person has the right to life. A person's right to life can only be sufficiently enjoyed if such a person's physical, mental and emotional well-being is secured.

101. The Reproductive Health Policy 2022-2032 and the actions of the Respondent in its formulation and intended implementation run afoul the provision of Article 26 (1) on the right to life for the following reasons: -

i. The lack of public participation by the immediate beneficiaries of the policy means that the policy document does not recognize the needs and interests of the community. The document is not a sustainable and responsive document and therefore not promotive and protective of the communities' right to the highest attainable standard of health and in specific the right to reproductive health.

ii. The Reproductive Health policy is in substance derogative of and limiting to the realisation of the highest attainable standard of health. This derogation reduces the quality of life of the beneficiaries of the policy document thereby compromising the promotion and protection of their right to life.

iii. The Reproductive Health Policy is, in particular, a threat to the lives of women and girls in Kenya, as it is predominantly set out to deny women and girls access to sexual and reproductive health and services which would in the end ensure that they do not have complete and adequate access to the

highest attainable standard of health; which in turn affects their physical, mental and emotional well-being.

iv. The policy direction in terms of parental consent are a threat to the right life as many reproductive health interventions require emergency treatment.

No reasonable justification for limitation of rights

102. As provided in Article 24 of the Constitution, a right or fundamental freedom in the Bill of Rights shall not be limited except by law, and then only to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, considering all relevant factors. There is no reasonable justification for the limitation of rights as has been outlined in the Policy.

D. RELIEFS

103. The Petitioners therefore humbly pray for the following reliefs: -

i. A declaration do hereby issue that the process arrived at in developing the National Reproductive Health Policy 2022-2032 violated the right to meaningful public participation guaranteed in Articles 10(1) & 10 (2)(a), 35 and 232(1(d)) of the Constitution as read together with Section 15 of the Health Act and the Public Service Commission Guidelines for Public Participation in Policy Making, 2015.

ii. A declaration do hereby issue that the fundamental right to life and the right to the highest attainable standard of health including reproductive healthcare as envisaged by Articles 26(1) and (4), 27, 35, 43 (1)(a), 53 (1)(c) of the Constitution as read together with Section 34 (1)(a), 34(2)(b) and 35 of the East African Community HIV Prevention and Management Act,2012 and Sections 5, 6, 7 and 68 of the Health Act, 2017 and Section 5 of the Access to Information Act encompass access to sexual and reproductive health services, information and commodities for all Kenyans.

iii. A declaration that the Reproductive Health Policy 2022-2032 violates the right to reproductive health as provided under Articles 26(4), 27, 35, 43(1)(a), 53(1)(c) of the Constitution as read together with Section 21, 22, 34 (1)(a), 34(2)(b) and 35 of the East African Community HIV Prevention and Management Act,2012 and Sections 5, 6, 7 and 68 of the Health Act, 2017 and Section 5 of the Access to Information Act.

iv. A declaration that the Reproductive Health Policy 2022-2023 violates the rights of children under Article 53(1)(c) and (2), as read with section 16(2)(3) and (4) of the Children Act in the manner it limits the provision of reproductive health interventions to adolescents.

v. A declaration do issue that the Reproductive Health Policy 2022-2032 violates Article 33 on the right to freedom of expression, including academic freedom and freedom of scientific research as read with Sections 6 and 7 of the Science and Technology Act, 2013.

vi. A mandatory order do issue barring the Respondents from implementing the Reproductive Health Policy 2022-2032 in so far as the same is contrary to the constitutional principle of public participation and a violation of Article 10 (1) & 10 (2)(a), 35 and 232 (1)(d) and restricts the right to health under Article 43 (1(a)), 26(4) and 53 (1)(c) of the Constitution.

vii. In addition to or in the alternative to prayer (vi), a mandatory order do issue suspending the implementation of of clause 2.3.3, clause 2.3.7, clause 3.4.1 paragraph 12, clause 3.4.2, clause 3.4.4 paragraph 2, clause 3.4.8 paragraph 1, clause 3.4.8 paragraph 8, clause 3.4.11 paragraph 5 and 6, clause 3.4.12 paragraph 1,3 and 5, clause 3.4.13 paragraph 2, and clause 4.2.3.8 paragraph

5 of the Reproductive Health Policy 2022-2032 in so far those provisions violate the right to the highest attainable standard of health under Article 43(1)(a), 26(4) and 53(1)(c) of the Constitution.

viii. A mandatory order do issue compelling the Respondent to within 30 days of this order, review the National Reproductive Health Policy 2022-2032 and conduct this review together with the Petitioners, relevant stakeholders and members of the public in order to consider all views of interested and affected parties.

ix. A structural interdict do issue compelling the 1st Respondent to report back to this Honourable Court every 45 days to confirm compliance with order (viii) above.

x. The Honourable Court do issue any further orders, directions and remedies as it may deem fit and just in the circumstances.

xi. There be no orders as to costs.

DATED at NAIROBI this ....5th....day of ....September..... 2022

NYOKABI NJOGU AND GAUDENCE WERE

ADVOCATES FOR PETITIONERS

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REPUBLIC OF KENYA

IN THE HIGH COURT OF KENYA AT KIAMBU

CONSTITUTIONAL PETITION NO. OF 2022

IN THE MATTER OF ARTICLES 10(1) & 10 (2)(a), 19, 22, 23, 26 (1) & (4), 27, 33, 35, 43 (1(a)), 53 (1(c)) AND 232 (1(d)) OF THE CONSTITUTION OF KENYA, 2010

AND

I IN THE MATTER OF ARTICLES, 22, 23, 34 AND 35 OF THE EAST AFRICAN COMMUNITY HIV & AIDS PREVENTION AND MANAGEMENT ACT

AND

IN THE MATTER OF SECTIONS 5, 6, 7, 15 AND 68 OF THE HEALTH ACT, 2017

AND

IN THE MATTER OF SECTION 16(2), (3) & (4), 28(3), 146 AND THE FIRST SCHEDULE OF THE CHILDREN ACT NO. 29 OF 2022

AND

IN THE MATTER OF SECTION 6 AND 7 OF THE SCIENCE TECHNOLOGY AND INNOVATION ACT NO. 28 OF 2013

AND

IN THE MATTER OF SECTION 4 AND 5 OF THE ACCESS TO INFORMATION ACT NO. 31 OF 2016

AND

IN THE MATTER OF THE PUBLIC SERVICE COMMISSION GUIDELINES FOR PUBLIC PARTICIPATION IN POLICY MAKING (2015)

AND

IN THE MATTER OF THE NATIONAL REPRODUCTIVE HEALTH POLICY 2022-2032

BETWEEN

RACHAEL MWIKALI.....1ST PETITIONER

ESTHER AOKO.....2ND PETITIONER

AMBASSADOR FOR YOUTH & ADOLESCENT

REPRODUCTIVE HEALTH PROGRAMME (AYARHEP).....3RD PETITIONER

KENYA LEGAL AND ETHICAL

ISSUES NETWORK ON HIV & AIDS.....4TH PETITIONER

VERSUS

CABINET SECRETARY

MINISTRY OF HEALTH.....1ST RESPONDENT

THE ATTORNEY GENERAL.....2ND RESPONDENT

AND

KENYA OBSTETRICAL GYNAECOLOGICAL SOCIETY..... 1ST INTERESTED PARTY

KATIBA INSTITUTE .....2ND INTERESTED PARTY

1ST PETITIONER'S AFFIDAVIT IN SUPPORT OF THE PETITION

I, **RACHAEL MWIKALI** a female adult Kenyan of sound mind residing and working for gain in Nairobi County within the Republic of Kenya do hereby make oath and state as follows;

1. I am a community organizer, sexual and reproductive health and rights activist and human rights defender working with the Coalition for Grassroots Human Rights Defenders and the 1st Petitioner herein and thus competent to swear this affidavit. I fully understand the issues in question and I further adopt the contents of the Petition filed herein as if the same were set out *seriatim.*

2. I am a resident of Mathari Mabatini in Nairobi County, and support and work with grassroots men and women and human rights defenders; advocating for the recognition and protection of human rights, promoting public participation in law and policy development and implementation and in public decision-making and mobilizing community support for social change. The areas I work include Kiambu county and Nairobi County.

3. As a human rights defender working with marginalised communities, I undertake work to ensure the realisation of various rights for women and girls, particularly in relation to sexual and reproductive health and rights and ensuring that women and girls enjoy bodily autonomy.

4. In the course of my work, I engage closely with other actors and civil society actors to advocate for a rights-based approach in policy making, particularly an approach that ensures that the needs of marginalised women and girls are met.

5. In March 2022, I learnt from the 4th Petitioner that the Ministry of Health intended to launch several reproductive health documents, including a reproductive health policy, and had invited some civil society actors to a meeting for the purposes of the launch by a letter dated 1st March 2022. The letter further indicated that the national launch was tentatively scheduled for 23rd March 2022. ***Annexed hereto and marked RM-1 is a copy of the letter dated 1st March 2022).***

6. I had never heard of the development of the said policy, neither was I invited as a human rights defender and member of the public to take part in the process of the formulation, development and launch of the policy.

7. I was very concerned about the contents of the proposed policy because in my work as a community activist, I have noted that in areas such as Mathare where I reside and work, women and girls are often denied sexual and reproductive health services because of a lack of proper policy direction from the Ministry of Health. Some of these services include access to safe abortion where the law allows it, access to contraception, access to testing for HIV and access to pre and post exposure prophylaxis.

8. In fact, the gaps and barriers, including economic barriers, in provision of safe and accessible health services lead to young and girls seeking reproductive health services in unsafe environments. The 1st Respondent has noted that half of the incidences girls and women seeking post abortion care due to unsafe abortion were predominantly under 25 years of age due to a lack of access to safe abortion services. Of these, 17% were adolescent girls. ***Annexed hereto and marked RM-2 is a copy of a report by the 1st Respondent demonstrating the incidences of unsafe abortion in Kenya)***

9. I am aware that in informal settlements like Mathare, there is an extremely high level of sexual violence and teenage pregnancies which lead to unsafe abortion and many other negative outcomes for women. As such, all women and girls must have services that responds to this reality and have access to sexual and reproductive health services.

10. Due to my work as a community activist and the realities of the community I work with, together with the 4th Petitioner, I tried to engage with the Ministry to suspend the intended launch and to allow stakeholders engage with the document.

11. When it became apparent that the Ministry of Health was intent on launching the said, policy, On 22nd March 2022, I led the Coalition for Grassroots Human Rights Defenders, and many young women and girls from informal settlements, alongside other civil society organisations to conduct a peaceful protest against and deliver a petition to the Ministry of Health demanding community involvement, particularly of women and girls from informal settlements, in the formulation and validation process of the policy to the Ministry of Health offices.

12. On arrival at the Ministry of Health offices, at Afya House where we were denied access by the police officers at the gate. I tried to negotiate with the police officers to allow us in to deliver our petition to the Ministry offices for over an hour. It was only when the protest started gaining media coverage did the police officers agree to grant us access. ***(Annexed hereto is a flash disk with the video clip showing the demonstrations marked as RM-3)***

13. The police officers eventually informed us that only a few of us could enter the building. The group nominated me together with two other representatives to deliver the petition to the Ministry of Health. The three of us were escorted to Room 716 by a police officer where we met a man who introduced himself as Mr. Steven Sangolo.

14. After explaining the purpose of our visit, which was to deliver a petition to the 1st Respondent urging it to ensure that the policy being developed was responsive to the needs of women and girls in informal settlements, Mr. Sangolo refused to acknowledge receipt of the petition and stated that there was no Reproductive Health Policy being launched by the Ministry of Health. He proceeded to insult and intimidate us, asking us whether we were in our right senses. I knew that this unbecoming conduct of a public official constitutionally mandated to serve all Kenyan expeditiously and without discrimination.

15. We stood our ground, articulated to Mr Sangolo the need for the 1st Respondent to consider the women and girls, particularly of lower socio-economic status as we had outlined in our petition. We asked him to acknowledge receipt of our petition which he adamantly refused. This exchange lasted for about an hour before another senior police officer who was witnessing the whole exchange intervened after which our petition was time stamped as received. ***(Annexed hereto and Marked RM4 is a copy of the Petition)***

16. In that petition, we raised the following concerns with regards to the intended launch of the National Reproductive Health Policy:

    a. The Policy was being launched devoid of meaningful public participation especially by grassroot communities thus excluding their sexual and reproductive health priorities.
    b. The Policy used stigmatizing language whose implication was to discriminate against adolescents in pursuit of sexual reproductive health facilities, people outside the traditional family unit and survivors of sexual violence.
    c. That as grassroot communities, we were aware that the Ministry had a constitutional mandate to facilitate the right to public participation, which guarantees citizens the right to be consulted in all decisions that affect them.

d. Women and girls who are socio-economically challenged or who live in informal settlements are routinely denied reproductive health services such as access to safe abortion, but there was a lack of policy direction from the Ministry meant that they were unable to receive those services from health care facilities.
e. We urged the Ministry to stop the launch of the Policy and restart the validation process to include the voices of the grassroot communities.
f. We also urged the Ministry to include all the critical and sexual reproductive health needs of the most vulnerable and marginalised.

17. Despite leaving our contact details in the Petition, we received no response from the Ministry of Health and were not at any point invited to be part of the policy making process.

18. On 6th April 2022, the Ministry of Health held a deliberation meeting on the reproductive health policy at the Emory Hotel in Kileleshwa. I had not been sent an invitation to this meeting despite leaving my contact details in the petition. I only became aware of it through the 4th Petitioner which I work closely with.

19. Despite the lack of invitation, I nonetheless attended the deliberation meeting in order to ensure the voice of the community, particularly from the standpoint of vulnerable and economically disenfranchised women and girls was heard. Dr. Stephen Kaliti, who was the moderator, was tasked with choosing who would present their views that day.

20. I had to demand for an opportunity to speak on behalf of individual community members seeing that he had only selected representatives from other organizations. I made the following contributions during the meeting:

a. Lack of meaningful engagement: The Ministry had failed to engage the grassroot community which was directly be affected by the Policy. The petition tabled to the Ministry on 22nd March 2022 had elicited no response

from the Ministry. Despite leaving my contact details in the said petition, I had not received an invite to the deliberations meeting.

b. Exclusion of community views. The meeting was held in a high-end hotel in opulent neighbourhood such as Kileleshwa which made it difficult for me and the persons from the grassroot communities which I represent to access without incurring undue financial strain. No other modalities had been made to ensure that all communities could participate, and there had been no provision for meetings outside Nairobi.

c. Disregard of scientific data and facts. Making the issues surrounding sexual reproductive health as a religious rather than a health rights issue. The moral and religious undertones were explicit from Dr Kaliti's submissions on sexual reproductive health issues such as abortion, teen pregnancies, non-marital sex among others. It was evident that engagement towards procuring access to sexual reproductive health services surrounding these issues would not objective.

21. Dr. Andrew Mulwa, a Director in the Ministry later made a statement recognizing and admitting the shortcoming of the Ministry in undertaking meaningful public participation. He also made an undertaking that the Ministry would ensure that at least forty-five (45) days were set aside to undertake community engagement. I left my contacts with the Ministry in order to be informed of any upcoming engagement.

22. However, the Ministry did not undertake any community engagement and on 18th April 2022 just twelve (12) days later, the Ministry sent an invitation to partners to attend a Reproductive Health Policy Drafting Workshop on 25th April 2022 in Mombasa. This meant that participants had eight (8) days to prepare for the workshop. The invite included a logistics financed package for participants who were not affiliated to sponsoring institutions. However, there was no further information on how one was to apply for the package. As an individual who was not sponsored, I found it financially challenging to travel to Mombasa at such short

notice, and without funds. I therefore did not attend. ***(Annexed hereto and marked RM5 is a copy of the invitation)***

23. On 1st July 2022, I was informed by the 4th Petitioner that the Ministry was holding a validation meeting at Emory Hotel in Kileleshwa. I had not received any invitation but sent a representative to attend the meeting on my behalf. I instead tried in vain to join the alternative online meeting that the Ministry was hosting through Zoom. I tweeted on the Ministry page requesting for admission to the virtual meeting which elicited no response. ***(Annexed hereto and marked RM6 is a copy of the screen shot of the tweet)***

24. On 5th July 2022, the 1st Respondent launched the National Reproductive Health Policy 2022-2023. I did not receive an invitation from the Ministry to witness the launch. I am of the view that the entire process of development of the policy was done without any inclusion of community voices or addressing the factors that lead to lack of access for sexual and reproductive health services for communities

25. After the launch, I managed to get a copy of the Policy and after reviewing I see that it has provisions which will make access to sexual and reproductive health services very difficult of women and girls to access. This includes language that denies critical reproductive healthcare interventions to the majority of women and girls thereby excluding any person not in a marriage. These interventions include contraception to only couples that have had children which fails to take into account people engaged on consensual sex even when not married, and those who engage in transactional sex.

26. The bias towards families to the detriment of the rest of the population of reproductive age is further indicated at ***4.2.3 paragraph 6 of the policy (page 38)*** where it is indicated that the policy recognizes the central role of the family in reproductive health and that this shall be reflected in reproductive health

interventions; as well as the description of the key components in service delivery and standards to include responsiveness to social values ***(page 39).***

27. Additionally, unsafe abortion has been recognized as one of the major causes of high maternal mortality and morbidity in Kenya, particularly within informal settlements. Part of the reason for this is because of a lack of clarity about where one can seek safe abortion services including post abortion care.

28. The policy further excludes adolescent women and young girls from benefiting from reproductive health services and commodities as it envisages the provision of cervical cancer screening services for women between 25 and 49 years to the exclusion of other age groups.

29. Further, reproductive healthcare interventions under the policy exclude young women below 21 years.

30. This policy direction fails to take into account the reality that is young women and girls need sexual and reproductive health services even before the age of 18, because they are engaging in sex early, and are victims of sexual violence and are most vulnerable to HIV infection. ***(See an excerpt of the End Triple Threat Campaign by the National AIDS Control Council marked RM-7)***

31. In addition, it is indicated that parental consent should be enforced prior to provision of services to adolescents. There are no guidelines for what should happen where parental consent cannot be achieved without undue hardship. ***(3.4.8 paragraph 8 of the policy on access to reproductive health services for children at page 26 of the policy)***

32. Additionally, the policy excludes unmarried women from fertility treatment; thereby denying them access to reproductive rights and options that are unrestricted for married women.

33. Currently, it is very difficult for women and girls who attend health care facilities to access HIV testing services. I have been turned away and denied testing for HIV due to the fact that I did not present the name of my sexual partner or a spouse. To require testing only where the woman's family is present is effectively to deny that woman testing because it is not always possible to bring one's partner to the facility and have them consent to testing.

34. Through my personal experience and my activism work in Mathare, I have witnessed how many women suffer from lack of access to reproductive health facilities due to the lack of policies to guide health service providers especially in public hospitals. Victims of sexual violence die when procuring unsafe abortions having been denied these services in public hospitals.

35. The Policy will directly affect the lives of these women and that is why it was imperative for the Ministry of Health to include their views in the making of this Policy. The Ministry instead made it difficult for this to be fulfilled by not inviting these women or their representatives to the Policy deliberation meetings; by not creating spaces where such women would be heard and by not incorporating the views of such women and that of partner organisations in the final draft of the Policy.

36. In the circumstances, it is highly likely that the community, and particularly women and girls shall be negatively affected by the implementation of the Reproductive Health Policy 2022-2032 based on the lack of public participation and as the document does not recognise the needs and interests of the women and girls, particularly those who already have challenges in accessing sexual and reproductive health.

37. Given the foregoing and in the interest of safeguarding the constitutional rights of reproductive health and the lives of the people of Kenya, I pray that this Honourable Court grant the orders as set out in the Petition.

29. What is deponed to herein is true to the best of my knowledge, information and belief, save for information whereof sources have been disclosed.

SWORN at **NAIROBI** by the said)
RACHAEL MWIKALI)
)
)
This 7th day of September 2022)
BEFORE ME)
)
)
)
COMMISSIONER OF OATHS)

Rachael
DEPONENT

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261

KNI 1

This is Exhibit marked "KNI - 1" referred to in the Annexed affidavit/Declaration of Richard Kiwi Kali
Sworn/Declared before me on this 8th day of September 20 22 at Nairobi in the Republic of Kenya
Commissioner for Oaths

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Ref: MOH/DRMH/RH GEN/8/VOL 1(22) **1st March 2022**

Dear RH partner

RE: REQUEST TO SUPPORT THE LAUNCH OF REPRODUCTIVE HEALTH DOCUMENTS

The Division of Reproductive and Maternal Health (DRMH) is responsible for formulation of reproductive health policies, guidelines and standards, as well as providing technical support to counties on matters RH, to promote operationalization of the policies and standards of care.

The Division in collaboration with partners has revised several reproductive health documents. The next steps will be to print, launch and disseminate these documents at the national and county levels to facilitate subsequent implementation within various RH programs.

The National launch is **tentatively scheduled on 23rd March 2022.** The planning team has put together a plan with areas of support and budget estimates to ease decision making and execution. **The purpose of this letter is to request for your support on areas convenient to you as per the attached budget.**

Kindly confirm your support to the following officers;

1. **Mary Magubo, 0722885199** - **for Communication and Conference package**
2. **Mary Gathitu, 0720929059** - **for National and County Support**
3. **Hellen Mutsi, 0722778013** - **for Printing of the MNH documents**
4. **Clarice Okumu, 0722466583** - **for printing of FP documents**

Thank you for your continued support.

Dr. Stephen Kaliti, M.B.Ch.B, MMED (OBSGYN), MPH, FCOG (ECSA), HIA.
Head, Division of Reproductive Maternal Health

Encls.

RM-2

REPUBLIC OF KENYA

MINISTRY OF HEALTH

"RM-2"
This is Exhibit marked
referred to in the Annexed affidavit/Declaration
of
Sworn/Declared before me on this 5th
day of November 20 22
at Nairobi in the Republic of Kenya
Commissioner for Oaths

Quality of Post-Abortion Care in Kenya

Findings from a national survey

November 2020

REPUBLIC OF KENYA

MINISTRY OF HEALTH

Quality of Post-Abortion Care in Kenya

Findings from a national survey

November 2020

Contents

Acknowledgments	vi
Foreword	vii
List of Acronyms	viii
Executive Summary	ix
Background	1
Methods	2
Findings	6
▪ Preparedness of health facilities to deliver PAC	6
▪ Patients' experiences with post-abortion care	21
Discussion	36
Study Limitations	38
Policy Recommendations	38
References	39

List of Tables

Table 1:	Characteristics of PAC providers and policy makers (qualitative survey)	4
Table 2:	PAC patient's socio-demographic characteristics (qualitative survey)	4
Table 3:	Capacity to provide PAC services at primary and referral facilities	5
Table 4:	Distribution of health facilities in the survey	6
Table 5:	Availability and distribution of medical staff by facility level and cadre	7
Table 6:	Operation days and hours for general services and contraceptive services	7
Table 7:	Proportion of health facilities with staff trained for PAC	8
Table 8:	Equipment and supplies for PAC in facilities (reported available)	9
Table 9:	Medicines and commodities available	10
Table 10:	PAC supplies by NGOs	10
Table 11:	Availability of Laboratory services	11
Table 12:	Patients' socio-demographic characteristics	22
Table 13:	Summarizes patients experiences with post-abortion care by facility level	24

List of Figures

Figure 1:	Health facilities with staff trained on PAC by county	8
Figure 2:	Proportion of facilities providing surgical and medical PAC for 1st and 2nd trimester pregnancies by facility level	11
Figure 3:	Contraceptives available after PAC across facility levels	14
Figure 4:	Primary level facilities capacity for basic PAC provision	16
Figure 5:	Proportion of primary level facilities with specific PAC services	16
Figure 6:	Availability of PAC services in referral facilities	17
Figure 7:	Proportion of referral level facilities with specific PAC services	18
Figure 8:	Main reasons for non-provision of medical/surgical PAC, blood transfusion and surgical procedures to manage abortion complications	18
Figure 9:	PAC patients' distribution by age categories across counties	21
Figure 10:	Pregnancy desirability among PAC patients by marital status	22
Figure 11:	Pregnancy desirability by county	23
Figure 12:	Dignity and respect by county	24
Figure 13:	Lack of privacy and confidentiality by county	27
Figure 14:	Autonomy by county	28
Figure 15:	Communication by county	29
Figure 16:	Supportive care by county	30
Figure 17:	Trust by county	31
Figure 18:	Predictability and transparency of payments by county	32
Figure 19:	Stigma and discrimination by county	32
Figure 20:	Facility environment by county	33
Figure 21:	Provision of post-abortion counselling by county	34
Figure 22:	Contraceptive methods offered (by counties)	35

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- Ministry of Health Kenya
- African Population and Health Research Center

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REPUBLIC OF KENYA

MINISTRY OF HEALTH

APHRC

African Population and Health Research Center

Foreword

In the past few decades, the Kenyan government has increasingly invested in efforts to address maternal mortality and morbidity. A considerable proportion of these illnesses and deaths result from complications of unsafe abortion. A nationwide study on the incidence of abortion in Kenya conducted by the African Population and Health Research Center (APHRC), in collaboration with the Ministry of Health (MoH) and other partners in 2012, revealed that most abortions in Kenya were unsafe and resulted in various complications that were treated in public health facilities.

This follow-up study conducted by APHRC, examined the preparedness of public health facilities in Kenya to deliver post-abortion care to patients. In addition, the study sought to obtain an overview of patient experiences while seeking post-abortion care services within facilities. This report presents critical evidence and highlights gaps to guide programming towards the improvement of women's access to quality post-abortion care in the country.

Evidence presented in this report shows that the capacity to deliver essential elements of post-abortion care among primary and referral level facilities is relatively low because of the absence of staff trained on post-abortion care (PAC), as well as lack of post-abortion care equipment and supplies. Patients arriving in primary facilities are not fully guaranteed the recommended level of post-abortion care services, and due in part to weak referral mechanisms, they may experience delays in obtaining care with implications on health outcomes. Experiences of post-abortion care patients at health facilities may influence patients' uptake of PAC services. Drawing from these findings, this report offers guidance to collaboratively push for reforms that strengthen health facility capabilities for PAC through training of health providers and provision of post-abortion care equipment and supplies across all facility levels. These efforts should include addressing unsafe abortions and improving access to family planning for all women.

Dr. Patrick Amoth
Ag. Director General for Health
Ministry of Health

List of Acronyms

APHRC	African Population and Health Research Center
CCC	Comprehensive Care Centers
EmOC	Emergency Obstetric Care
ERC	Ethics Review Committee
ERPC	Evacuation of retained products of conception
ESRC	Ethics and Scientific Research Committee
FP	Family planning
HIV	Human Immunodeficiency Virus
HTS	HIV Testing Services
IUD	Intrauterine Device
IV	Intravenous
KEMSA	Kenya Medical Supplies Authority
KNH	Kenyatta National Hospital
MA	Medical Abortion
MoH	Ministry of Health
MUE	Medical Uterine Evacuation
MVA	Manual Vacuum Aspiration
NACOSTI	National Commission for Science, Technology & Innovation
NGO	Non-Governmental Organization
PAC	Post-Abortion Care
PDT	Pregnancy Determination Test
SRH	Sexual and reproductive health
SSA	Sub-Saharan Africa
STIs	Sexually Transmitted Infections
VCAT	Values Clarification and Attitude Transformation

Executive Summary

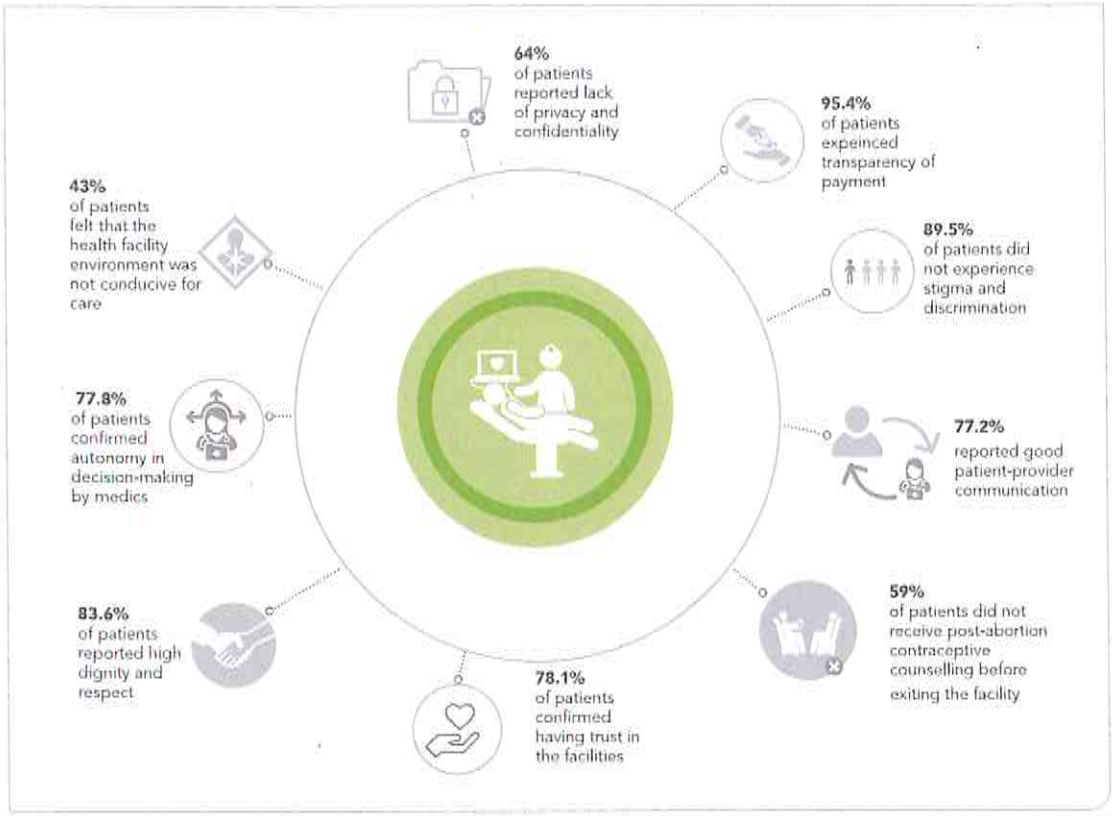
Research indicates that nearly 464,690 induced abortions occur annually in Kenya. Majority of these are unsafe, resulting in a large variety of medical complications and about one in ten maternal deaths. Further, a considerable proportion of these complications require treatment and long-term admissions, in the absence of which, many women may experience permanent disabilities and/or death. Post-abortion care (PAC) services offer treatment for incomplete abortions and provision of post-abortion contraceptive services. Provision of quality PAC is therefore essential for the reduction of unsafe abortion-related illnesses and deaths. A cross-sectional nationally representative survey was conducted in 253 primary, secondary and tertiary health facilities in Kenya. We collected data using a facility assessment questionnaire in all the sampled health facilities and complemented this with 819 patient-exit interviews. One-hundred and twenty-six (126) in-depth interviews were also conducted with women treated for post-abortion complications, PAC providers and policy makers.

In the last 15 years, the Kenyan government and its partners have pursued policies aimed at reducing maternal mortality, including those cases related to unsafe abortions. Currently, there is a paucity of data on the quality of PAC available to women and girls in public health facilities. This study contributes to addressing this gap through provision of evidence.

Findings showed a low capacity of primary and referral health facilities for provision of a range of PAC services. Barely 3% of primary facilities could deliver all designated PAC services consistent with this level, while just 29% of referral health facilities could provide the entire package of PAC services. Only 24% of primary facilities could deliver medical uterine evacuation and 27% could do the same surgically for first trimester pregnancies. The limited capacity to treat PAC cases among primary facilities was mainly due to the absence of trained providers and limited availability of necessary equipment and commodities for PAC services. As a result, most primary facilities refer PAC patients to higher level facilities, even though the capacity for timely and effective referrals is limited due to lack of fueled vehicles or ambulances stationed at the facility. Further, over two-thirds of referral facilities lacked the capacity to deliver the full range of PAC services. For instance, only 64% and 62% respectively of Level 4 facilities reported capacity to deliver medical and surgical PAC for first trimester pregnancies. Similarly, blood transfusions and surgical procedures could only be done by 55% and 36% of Level 4 facilities respectively. The absence of trained providers, lack of equipment and PAC supplies and commodities were the main reasons for insufficient capacity to deliver PAC services within referral facilities in the country.

The majority of patients reported lack of privacy and confidentiality (64%), and a considerable proportion of these patients (43%) felt that the health facility environment was not conducive for care. Specifically, referral facilities often lacked dedicated MVA procedure rooms and had crowded wards or open spaces where examinations and treatment were conducted. More than half of PAC patients interviewed (59%) did not receive post-abortion contraceptive counselling before exiting the facility. However, transparency of payment (95.4%), lack of stigma and discrimination (89.5%), dignity and respect (83.6%), trust (78.1%), autonomy in decision-making (77.8%), and patient-provider communication (77.2%) were rated highly across all facilities.

In a few cases, patients reported instances of hostile providers, limited involvement in care decisions, sexual harassment, long waiting hours and complex referral processes. Findings also revealed several multi-level barriers impeding access to and provision of quality PAC services. The initial withdrawal of the *Standards and Guidelines for Reducing Morbidity and Mortality from Unsafe Abortion in Kenya* left most PAC providers unsure of the full extent of care they are allowed to offer. Further, it disrupted training of providers on PAC and hindered supply of medical equipment and commodities. The limited dissemination of the standards and guidelines has created key gaps in quality of clinical care and staff capacity. In certain instances, lack of PAC guidelines created room for poor patient-provider interactions, with some providers denying services to patients, especially those suspected of inducing abortions. Addressing the gaps and barriers reported in the provision of PAC could improve access as well as the quality of service delivered. To achieve this, there is need for reforms that strengthen PAC infrastructure, improve PAC service processes within the facility through training and ensuring access to PAC supplies. These reforms should also include updating PAC guidelines and wider dissemination of the same in addition to improving collaboration with communities and partners to reduce unintended pregnancies and unsafe abortions.



Background

Over 93% of women of childbearing age in Africa live in countries with restrictive abortion laws [1]. In Kenya, abortion is legally restricted and is permitted only to save a pregnant woman's life or to preserve her physical health [2]. As such, the vast majority of women in need of abortion in these contexts resort to clandestine, often unsafe interventions to terminate unwanted pregnancies [3]. These unsafe abortions often result in complications, severe disabilities and mortality [4]. Although complications arising from unsafe abortions vary in severity, a considerable proportion require treatment, long hospital stays, intensive care, and attendance by highly skilled - but often scarce - healthcare personnel [5]. Further, approximately 10% of maternal mortality cases in Kenya are linked to unsafe abortions [6].

While abortion is restricted in much of Africa, most countries in sub-Saharan Africa (SSA) are increasingly devoting significant resources to addressing abortion-related morbidity and mortality through post-abortion care (PAC) [7]. PAC focuses on treatment of incomplete abortion and provision of post-abortion contraceptive services [8]. The WHO definition of comprehensive PAC includes: treating complications, providing counseling and responding to emotional and physical concerns, providing contraceptive counselling and services, referrals to other sexual and reproductive health (SRH) services, and partnering with the community for prevention. One of the key interventions being introduced by countries in the region to enhance women's access to PAC is upgrading the capacity of mid-level providers and health facilities to provide emergency treatment as well as implementing misoprostol as a treatment strategy for complications of unsafe abortion [9].

Despite these efforts, many women in SSA lack timely access to critical PAC services within health facilities [10]. Several studies have interrogated the various barriers that impede access to PAC services. Most prominent among these barriers are structural and health system factors such as the existing legal restrictions on abortion, the lack of guidelines on PAC service provision, lack of trained staff within health facilities, limited in-service training, and inadequate medical equipment and supplies. In Kenya, for example, in 2013 the Ministry of Health withdrew the *Standards and Guidelines for Reducing Morbidity and Mortality from Unsafe Abortion* [11], which are intended to guide the provision of appropriate PAC, with detrimental effects on women's access to PAC [12]. Equally important is abortion-related stigma, health providers' negative attitudes and behavior [13], as well as low levels of awareness and knowledge among women [14]. In the absence of quality PAC services, women are likely to have repeated unplanned pregnancies and unsafe abortions [15].

There is increasing interest in the quality of healthcare — the extent to which healthcare services advance patients' desired health outcomes [16] — as a core pillar of health systems reforms [17]. Prior research outlines three core, connected ingredients for assessing quality of care: (i) structure (facility infrastructure, management and staffing), (ii) process (technical/technical quality and patient experience), and (iii) outcomes (patient satisfaction, return visits and health outcomes) [17-19]. So far, studies in Kenya have attempted to examine the general status of PAC such as its availability and access within the health system [10]. However none of these studies have quantitatively assessed the preparedness of facilities to deliver quality PAC services as well as patient experiences seeking PAC with a nationally representative sample [20, 21]. The scarcity of such evidence has continued to curtail attempts to increase investment and improve quality maternal health services to Kenyan women, a gap that this study seeks to address.

We examined the state of preparedness of public health facilities to deliver the full spectrum of PAC services in Kenya using key PAC indicators for health service delivery, such as staffing (including training), medical supplies and equipment, and reproductive health and abortion services provided. We also gathered data on patients' experiences through exit interviews conducted in selected health facilities and in-depth interviews with both PAC patients and care providers. The study's findings are expected to generate relevant evidence to inform programs and interventions.

Methods

Study design and population

We conducted a cross-sectional, mixed methods study involving service provision assessments and patient-exit surveys. Data were collected across a nationally representative sample of primary, secondary and tertiary health facilities in Kenya between November 2018 and February 2019, with each facility observed for 30 days. We also conducted qualitative interviews with purposively selected PAC patients, healthcare providers and policy makers.

Sampling and recruitment

The sampling of facilities was stratified by the different administrative jurisdictions (i.e. counties) as well as by facility levels of care. A master list of all public health facilities in the country was obtained from the Ministry of Health as at December, 2017. Sampling was conducted in two stages. In the first stage, a random sample of six counties was drawn from a list of all counties excluding Nairobi, the country's capital. Nairobi was purposively added to the list of already selected counties: Garissa, Kajiado, Kiambu, Laikipia, Mandera, and Migori. Nairobi was included to account for its strategic role in the provision of public healthcare services as it hosts the largest and oldest teaching and referral hospital in the country. Further, as the seat of the national government, it would provide a benchmark for comparing quality of PAC in other randomly sampled counties. At the second stage, a requisite sample of public health facilities was determined using the sample size formula for known populations using known estimates as shown below: $\Delta = z\sqrt{\frac{p(1-p)}{n}}$

In this case, the known estimate (p) used as a sampling proportion was the proportion of facilities that could offer counselling and information on how to avoid contraceptive method failure, which was the lowest measure of quality of care from a recent survey [10]. Accounting for a response rate of 93%, which is based on the APHRC, MoH and partners 2012 abortion incidence study [4], the requisite sample size of facilities was determined as 259. Facilities eligible for this study were Levels 2, 3, 4, 5 and 6 facilities that could conduct deliveries. Psychiatric hospitals, rehabilitation facilities, and other facilities that offer specialized care as well as military and prison hospitals that do not offer services to the general public were excluded from the sample.

During the survey implementation, certain facilities were dropped from the study due to insecurity and/or complete inaccessibility and replaced with similar facilities within the same locality. Except for facilities that declined to participate, all other sampled facilities that could not participate in the study were replaced with facilities of similar characteristics from the sampling frame. In total, 253 level 2, 3, 4, 5 and 6 health facilities were ultimately reached during the study with about 35 having been replaced for various reasons while six were not replaced. Four of the six facilities that did not participate in the study were in insecure locations or inaccessible due to flooding, while two declined to participate and it was not possible to replace any of these facilities because the data collection period had elapsed. In one case, there was no alternative replacement facility of the same level.

Based on the above 2012 study, about 7.6% of women treated with post-abortion complications were treated using medical uterine evacuation. The current study therefore drew a sample of PAC patients from the above facilities, with sufficient power for a stable estimation of 7.6% medical abortion cases to detect statistical difference in estimates with a 5% error. A sample of 108 women was thus needed for this study. Accounting for a patient-level response rate of 93.1% from the 2012 study, a sample of 117 patients was required per stratum. Given that we had seven (7) regions (counties), the final sample of patients required in the study was 117 (stratum sample) multiplied by the 7 counties resulting in 819 patients from all of the eligible facilities.

Data collection tools

Trained healthcare providers and research assistants collected data on PAC service indicators (signal functions) and conducted patient-exit interviews in sampled facilities in Kenya using structured survey tools. The facility survey tool was drawn from Healy and colleagues (2006) model [18] and updated to address country specificities (level, cadre of staff, equipment, supplies, etc.). This tool captured facility level data on staffing, reproductive health and post-abortion care services provided, hours of operation and available equipment and commodities. The patient exit tool was adopted from the frameworks developed to advance person-centered care for reproductive health equity by Sudhinaraset and colleagues [22]. Both tools were programmed in SurveyCTO and data collected using tablets. Qualitative interviews were guided by a semi-structured interview guide focusing on patients and providers experiences in seeking and providing PAC services.

Health facility survey for PAC services

This was a health facility assessment of all sampled facilities. Upon verifying eligibility of health facilities for participation, trained healthcare providers visited each facility and administered the signal function questionnaire. At large health facilities such as referral hospitals, the respondents were the heads of the obstetrics and gynecology department, or a key obstetrician-gynecologist working in the facility. Within lower level facilities, a nurse, midwife or clinical officer who was in a position to provide information on abortion care offered in that facility was interviewed. The data collection combined both interviews with relevant staff in the selected facilities and observation to confirm availability/functionality of identified items.

Patient-exit survey

To understand women's experiences while seeking or obtaining PAC, and to assess the quality of care received, we interviewed 820 women at discharge following receipt of PAC. All women treated for incomplete and/or spontaneous abortion in the selected health facilities and who agreed to participate were included in the study until the desired sample size was achieved for each county. Prior to discharge, PAC providers introduced the women to the study and research assistants stationed at the facilities, with only those who consented to participate being interviewed. Data collection took place in facilities over a period of 30 consecutive days. Women were interviewed about their reproductive history, nature of post-abortion care received and perceived quality, post-abortion contraception and their wellbeing after clinical management.

Qualitative survey

Trained and experienced qualitative research assistants conducted in-depth interviews with PAC service providers (e.g. nurses, midwives, clinical officers, medical officers, obstetricians and gynecologists), policy makers and PAC patients. The interviews with policy makers aimed to document national-level efforts to improve PAC services and their perceptions of facility preparedness to offer PAC as well as the quality of the services provided. The interviews with PAC providers aimed to explore their experiences delivering PAC services, their perceptions of PAC and to understand how these perceptions influenced PAC provision. Providers and policy makers were purposively selected to capture variation by position and roles, experience in PAC provision, and location. Providers' and policy makers' socio-demographic characteristics are summarized in Table 1.

Table 1: Characteristics of PAC providers and policy makers (qualitative survey)

Characteristics		Frequency (N=56)
Facility level	**Primary**	**29**
	Referral	20
	Missing	7
Health provider cadres	Nurse/Midwife	36
	Clinical Officer/ Gynaecology/ Obstetrician	20
Location	Urban	29
	Rural	25
	Missing	2
Policy makers*		**4**

*Policy Makers- Two were practicing/consultant obstetrician and gynecologists who are involved in national PAC policy making processes, while another two were county coordinators of health

The interviews with PAC patients aimed to explore their experiences during PAC, their perceptions of PAC and how it informs their care seeking pathways and interactions with PAC providers. Patients were purposively selected to include women of varying ages, marital status, education level, occupation, and level of facility where they were treated. PAC patients' socio-demographic characteristics are summarized in Table 2.

Table 2: PAC patient's socio-demographic characteristics (qualitative survey)

Characteristic		Frequency (N=66)
Age (Years)	15-19	6
	20-29	33
	30 and above	26
	Missing	1
Area of Resident	Urban	55
	Rural	11
Marital Status	Married/cohabiting	43
	Separated/divorced/widowed	2
	Single	15
	Missing	6
Occupation	Employed	44
	Unemployed	11
	Missing	11

In-depth interviews were supplemented with observations of PAC services provision in the targeted health facilities. While waiting to meet and interview the patients, the field workers observed interactions happening between PAC patients and healthcare providers, as well as the facility environments. These observations took place in waiting rooms, and during the patient's admission process.

Data analysis and management

Analysis was performed using Stata Statistical Software, Version 15. Exploratory analysis was done to summarize response rates of PAC patients and health facilities by levels and regions. We computed cross-tabulations to examine differences in key indicators (e.g., stigma and discrimination, autonomy, privacy and confidentiality, predictability of costs, communication, supportive care, trust, health facility environment and post-abortion counselling) by facility level and region. Based on the classification of facility levels, we generated proportions of facilities capable of delivering various components of post-abortion care.

Qualitative interviews were transcribed and translated into English (where needed). Researchers then developed a code-book from the interview guide and also by reviewing a few interviews. The code-book was applied to code a set of transcripts to ensure accuracy and capture missing codes. The code-book was then updated and the comprehensive version applied to all the transcripts using Nvivo version 12. Key emerging themes were identified and discussed with a focus on providers' perceptions of their capacity, and that of health facilities to provide PAC services, including reasons for not providing PAC, their interactions with PAC patients and their coping strategies. We focused equally on patients' experiences with PAC including decision-making processes, access to service, and perceptions of the quality of care received.

Table 3: Capacity to provide PAC services at primary and referral facilities

Expected functions for all levels of facilities	
1. Remove retained products of conception*	
2. Administer parenteral antibiotics*	
3. Administer parenteral uterotonics*	
4. Administer intravenous fluids†	
5. Provide at least one modern, short-acting family planning method at time of survey†	
Capaacity to provide PAC functions expected of primary facilities	**Capacity to provide PAC functions expected of referral facilities**
6. Has vehicle with fuel to transport patients needing referral†	6. Administer a blood transfusion*
7. Has staff trained on PAC on duty or who are on call for 24/7	7. Undertake major abdominal surgery (proxied by provision of caesarean section) *
	8. Provided at least one long-acting, reversible family planning method† or permanent method
	9. Has staff trained on PAC on duty or who are on call 24/7

*Assessed on the basis of facility reporting if they had ever provided the service
†Assessed on the basis of the availability and validity or functionality of a given item (drug or equipment) at the time of survey

Ethical Considerations

The study protocol was reviewed and approved by the AMREF Ethics and Scientific Research Committee (ESRC) (AMREF-ESRC P429/2018), and the University of Nairobi/Kenyatta National Hospital Ethics and Research Committee (KNH-ERC/A/384) in Kenya. Permits to conduct the study were also obtained from the Kenyan National Commission for Science, Technology and Innovation (NACOSTI) and from each participating health facility. All participants provided signed informed consent before being interviewed by the data collectors. Girls below the age of 18 years were considered emancipated minors because of their pregnancy status [23]. Confidentiality, anonymity and privacy of all participants were maintained at all levels of this study by excluding all unique identifiers from all datasets and by limiting data access to the research team.

Findings

Preparedness of health facilities to deliver PAC

Distribution of health facilities and response rate

Of the 259 sampled health facilities across the seven counties, 253 responded to the PAC service assessment tool, giving an overall response rate of 97.7%. Study facilities mainly consisted of Level 2 (65%), Levels 3 and 4 (18.6% and 15.8% respectively) facilities (Table 4).

Table 4: Distribution of health facilities in the survey

County	Level 2	Level 3	Level 4	Level 5 & 6	Total (%)
Garissa	10	6	8	1	25 (9.9)
Kajiado	27	6	3	0	36 (14.2)
Kiambu	27	8	9	0	44 (17.4)
Laikipia	21	5	3	1	30 (11.9)
Mandera	15	7	3	1	26 (10.3)
Migori	38	5	9	0	52 (20.6)
Nairobi	26	10	3	1	40 (15.8)
Total n (%)	**164 (64.8)**	**47 (18.6)**	**38 (15.8)**	**4 (0.8)**	**253 (100.0)**

Description of the health system levels in Kenya: Level 2 and 3 facilities - Primary healthcare facilities; Level 4-6- Referral level facilities

Staffing in health facilities and operating hours

Forty-four percent of the facilities had midwives present every day for 24 hours (Table 5). Close to one in five (19.4%) facilities and about one in eight (12.3%) facilities had clinical officers and doctors respectively, present daily. In addition, 9.1% of the facilities had anesthetists and 6.2% had obstetrician/gynecologists present at the facilities daily. The Level 6 facility had all cadres of health staff, excluding clinical officers, while two of three Level 5 hospitals had all cadres of staff. One Level 5 hospital lacked doctor(s), clinical officer(s) and an anesthetist present for 24 hours daily.

Among Level 4 facilities, only one in four (28.2%) had an obstetrician/gynecologist present daily, while about half (48.7%) had an anesthetist present daily. More than 64% of Level 4 facilities had doctors and clinical officers (66.7%) every day, and almost all facilities at this level had midwives present daily (97.4%).

Fewer Level 2 (1.2%) facilities had doctors on a daily basis compared to Level 3 (4.3%) facilities. Just 4.9% of Level 2 facilities had clinical officers present daily, compared to more than a quarter (27.8%) of Level 3 facilities. While three in every four (78.7%) Level 3 facilities had midwives present every day, only one in five (20.7%) of Level 2 facilities had midwives.

Table 5: Availability and distribution of medical staff by facility level and cadre

Staff availability by Cadre					
Facility levels* **	**Present daily*, n (%)**				
	Obstetrician & Gynecologists**	**Doctors****	**Clinical Officers**	**Midwives**	**Anesthetist****
Level 2 (N=164)	2 (1.2)	2 (1.2)	8 (4.9)	34 (20.7)	1 (0.6)
Level 3 (N=47)	-	2 (4.3)	14 (27.8)	37 (78.7)	1 (2.1)
Level 4 (N=38)	11 (28.2)	25 (64.1)	26 (66.7)	38 (97.4)	19 (48.7)
Total (N=253)	**16 (6.2)**	**31 (12.3)**	**49 (19.4)**	**112 (44.3)**	**23 (9.1)**

***Level 6 had all cadres of staff, except clinical officers.
Two level 5 hospitals had all cadres of staff. One level 5 hospital lacked doctor(s), clinical officer (s) and anesthetist present 24/7
*Present for 24 hours 7 days a week, as at the time of study.
**We understand that these cadres are not usually deployed at dispensaries. However, these may have been visiting healthcare providers that might have been reported as regular staff

In terms of operating hours and days, only a third (36%) of facilities were open 7 days a week for 24 hours. While all Level 5 and 6 facilities were open around the clock, just about 76% of Level 3 and 87% of Level 4 hospitals were open at all hours. Most Level 2 facilities (76.2%) were open for five days and for less than 24 hours. Overall, except for Level 5 and 6 facilities, less than 6% of the other facility levels were open around the clock to deliver contraceptive services with about one-quarter of Level 4 facilities (23.1%) open all the time to deliver this service. (Table 6).

Table 6: Operation days and hours for general services and contraceptive services

	Level 2 (N=164)	**Level 3 (N=47)**	**Level 4 (N=38)**	**Total (N=253)**
Operational days/time, n (%)				
7 days for 24 hours	17 (10.4)	36 (76.6)	33 (87.2)*	90 (35.6)
5 days, Less than 24 hours daily	125 (76.2)	5 (10.6)	1 (2.6)	131 (51.8)
Others	22 (13.4)	6 (12.8)	4 (10.3)	32 (12.7)
Days and time when contraceptive services are provided, n (%)				
7 days for 24 hours daily	3 (1.8)	3 (6.4)	9 (23.1)	15 (5.9)
5 days, Less than 24 hours daily	151 (92.1)	38 (80.9)	20 (53.9)	213 (84.2)
Others	**10 (6.1)**	**6 (12.8)**	**9 (23.1)**	**25 (9.9)**

*All Level 5 and 6 were open 7 days for 24 hours daily
*Level 4 facilities (hospitals) ~13% not open 24-7, were Level 3 facilities recently upgraded to Level 4 and were mostly in Migori County

Qualitative data highlighted information on facilities' staffing and operations. Providers interviewed were involved in a broad array of reproductive health services (including delivery, antenatal care, family planning, and PAC) within their respective health facilities. The providers (medical officers, clinical officers, nurses or midwives) worked in a rotation system. In this case, they rotated in different wards (antenatal care, gynecology, labor, etc.) following a particular schedule (on a weekly or monthly basis), based on the level of facility and management strategy. This allowed them to get familiar with all types of clients, including PAC patients.

> *Well, you know we rotate, so I would say that out of the two years, I have spent maybe one year in maternity, another six months in pediatrics. In any case, since we still cover the hospital on calls, we tend to cover the whole hospital. (Medical Officer, primary healthcare facility, Kajiado)*

Health facilities have a shift system in place to reduce the risk of staff burn-out. Because of the staff rotations and shifts, the providers recognized that some PAC services may be unavailable at certain times, especially when trained service providers are off duty when a patient has been admitted. Such scenarios were reported in primary healthcare facilities as one of the reasons for referrals of PAC patients. Another consequence of the shifting and rotation is delay in care provision when only one provider is available and has to handle PAC patients together with other patients not seeking PAC services.

Staff training and availability of PAC equipment and supplies

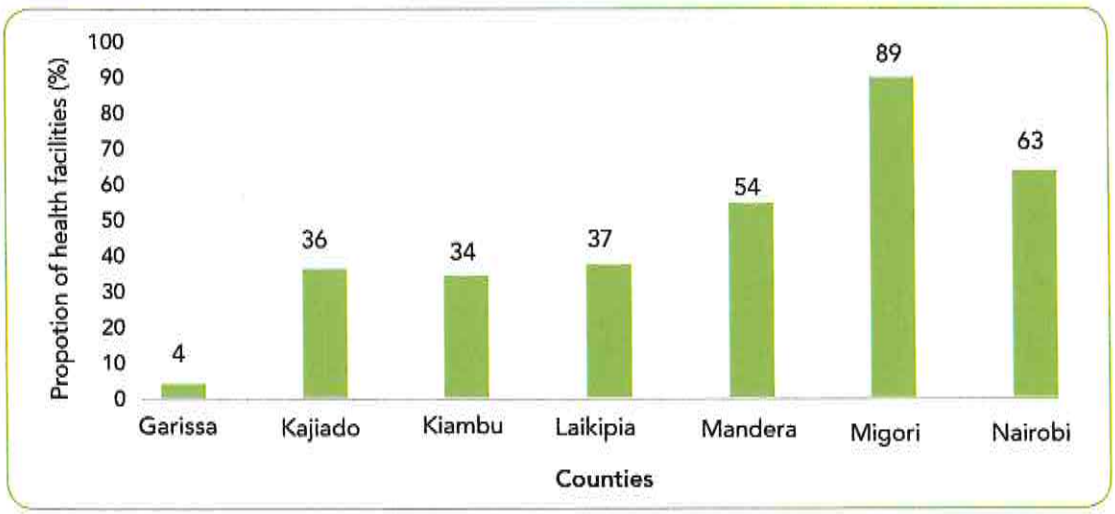
Slightly less than half of all facilities (49.4%) had staff trained on all the five components of PAC. Fewer Level 2 facilities (43%) had providers trained on PAC compared to about 60%, 64% and 75% of Levels 3, 4, 5 and 6 respectively. Nurses accounted for the majority of trained providers (49.0%) across all the facility levels, compared to clinical officers (18.6%) and doctors (6.3%) (Table 7). Generally, non-governmental organizations (NGOs) provided considerable support in training of health providers on PAC, and payment of salaries for some staff stationed in facilities on full time or part time basis, in addition to provision of various supplies and commodities.

Table 7: Proportion of health facilities with staff trained for PAC

Indicators	Level 2 (N=164) (%)	Level 3 (N=47) (%)	Level 4 (N=38) (%)	Total (N=253) (%)
Staff stationed at facility trained on PAC	70(42.7)	28(59.6)	24(64.1)	125(49.4)
Doctor	0.0	2(4.3)	12(30.8)	16(6.3)
Clinical Officers	15(9.2)	15(31.9)	16(41.0)	47(18.6)
Nurses	69(42.1)	28(59.6)	24(64.1)	124(49.0)

Looking at counties, most facilities in Migori (88.5%), Nairobi (62.5%) and Mandera (53.8%) had staff trained on all components of PAC, while Garissa had the fewest facilities (less than 5%) with trained staff, whereas the rest had about one third of facilities with staff trained on comprehensive PAC (Figure 1). Of those trained, the majority were nurses, with very few doctors and clinical officers. In Migori County, the high number of staff trained was attributed to the high presence of international NGOs who have partnered with public health facilities to train service providers on PAC and provide the facilities with the relevant commodities and supplies.

Figure 1: Health facilities with staff trained on PAC by county



Regarding essential PAC supplies and equipment, less than one fifth of health facilities had a functional operating theatre or an MVA room (16.6%). Only 3.7% of Level 2 facilities, one-quarter (23.4%) of Level 3, and half of Level 4 facilities (55.3%) reported having functional theatres or MVA rooms. Slightly less than one-third (28.5%) of facilities had backup generators in case of power blackouts (10.4% of Level 2 and 36.2% of Level 3), nonetheless a great proportion (90.5%) of the referral facilities had backup generators. Slightly more than half of the facilities (56.9%) had a functional landline or mobile phone for calls in case of emergency. Within the PAC treatment room, less than half of all facilities had specific suction tubes (20%), vacuum aspirator kits or syringes (36.4%), or a manual vacuum aspiration pack on hand (53.8%). Even so, majority of facilities (≥98%) indicated having a private room for examining/counselling women and performing reproductive health procedures, an examination or procedure bed and clean running water source (Table 8).

Table 8: Equipment and supplies for PAC in facilities (reported available)

PAC supplies and equipment	Level 2; (N= 164)	Level 3 (N= 47)	Level 4 (N=38)	Total (N=253)
The following instruments, equipment, and supplies are needed for PAC, n (%)				
Vorsellum/Tenaculum	118 (72.0)	39 (83.0)	38 (100)	199 (78.7)
Sponge (ring) forceps	132 (80.5)	45 (95.7)	37 (97.4)	218 (86.2)
Vaginal speculums (Sims, Cusco, Auvard, Graves)	153 (93.3)	47 (100)	38 (100)	242 (95.7)
Needles and syringes	158 (96.3)	45 (95.7)	38 (100)	245 (96.8)
Manual vacuum aspiration pack	60 (36.6)	37 (78.7)	35 (92.1)	136 (53.8)
Examination light/ Light source or flashlight	92 (56.1)	39 (83.0)	35 (92.1)	170 (67.2)
Disposable latex gloves (surgical)	161 (98.2)	45 (95.7)	36 (94.7)	246 (97.2)
Hand-washing soap/liquid soap	147 (89.6)	47 (100)	35 (92.1)	233 (92.1)
The health facility or the treatment room should have the following furniture and equipment in working order, n (%)				
Functional operating theatre/MVA room	6 (3.7)	11 (23.4)	21 (55.3)	42 (16.6)
Examination/Procedure bed	160 (97.6)	47 (100)	38 (100)	249 (98.4)
Clean water Source	159 (97.0)	47 (100)	38 (100)	248 (98.0)
Electric/non-electric autoclave/dry heat sterilizer	143 (87.2)	45 (95.7)	38 (100)	230 (90.9)
Functional Landline/Mobile phone in the facility	78 (47.6)	32 (68.1)	31 (81.6)	144 (56.9)
Electricity (e.g. electricity grid, generator, solar)	137 (83.5)	47 (100)	38 (100)	226 (89.3)
Backup generator (in case of power outage)	17 (10.4)	17 (36.2)	34 (89.5)	72 (28.5)
A toilet (latrine) on premises (functioning)	152 (92.7)	45 (95.7)	38 (100)	239 (94.5)
Stethoscope	161 (98.2)	46 (97.9)	38 (100)	249 (98.4)
Blood pressure machines (sphygmomanometer)	162 (98.8)	47 (100)	37 (97.4)	250 (98.8)
IV fluid giving set (adult)	153 (93.3)	46 (97.9)	37 (97.4)	240 (94.9)
Ambu (ventilatory) bag	141 (86.0)	46 (97.9)	35 (92.1)	226 (89.3)
Suction catheter, 10, 12 Ch	91 (55.5)	39 (83.0)	37 (97.4)	171 (67.6)
Suction aspirator operated by foot or electronically	94 (57.3)	39 (83.0)	35 (92.1)	172 (68.0)
Vacuum aspirator kit/syringes	31 (18.9)	26 (55.3)	31 (81.6)	92 (36.4)
Private room for examining/treating/counselling	162 (98.8)	47 (100)	37 (97.4)	250 (98.8)
Suction tube, 22.5cm, 23 French gauge	8 (4.9)	11 (23.4)	28 (73.7)	51 (20.2)

All (100%) Level 5 and 6 facilities (n=4) reported having all the listed items

Virtually all referral facilities had all medicines available while relatively fewer Level 2 facilities had uterotonics (76.3%) and anticonvulsants (60.3%). Fewer Level 2 (44.5%) and 3 (68.1%) facilities had antiretroviral medicines on hand. Considering other non-pharmaceuticals, just about three quarters of Level 2 facilities (78.1% and 64.6%) could give IV fluids and plasma expanders compared to (87.2% and 83%) of Level 3 facilities respectively (Table 9).

Table 9: Medicines and commodities available

Medicines and commodities available today	Level 2 (N=164) (%)	Level 3 (N=47) (%)	Level 4 (N=38) (%)	Total
Drugs				
Antibiotics	158 (96.3)	46(97.9)	38(100.0)	246(97.2)
Uterotonics*	125 (76.2)	42(89.3)	37(97.4)	208(82.2)
Anticonvulsants**	99(60.3)	39(83.0)	33(87.2)	175(69.2)
Antiretrovirals	73(44.5)	32(68.1)	36(94.9)	145(57.3)
Anesthetics***	163(99.4)	46(97.9)	38(100.0)	251(99.2)
Non-pharmaceuticals				
IV fluids****	128(78.1)	41(87.2)	34(89.7)	207(81.8)
Colloids/Plasma expanders	106(64.6)	39(83.0)	37(97.4)	186(73.5)

All (100%) Level 5 and 6 facilities (n=4) reported having all the medicines and commodities available
*Mifepristone & misoprostol combination, Misoprostol alone, other abortifacient, injectable uterotonic
** Magnesium sulphate injection, other anticonvulsants
*** Halothane, Ketamine, Lignocaine/Lidocaine 2% or 1%|
**** IV fluids Dextrose 5%, 10%, 50%, Dextran 70%, Glucose Infusion 5%

As reported previously, NGOs play a central role in availing essential PAC equipment and supplies. About one-quarter of health facilities (22%) reported receiving relevant equipment (such as manual vacuum aspiration (MVA) kits) and/or medical commodities as donations from NGOs supporting PAC provision in public health facilities. This was mainly to supplement government supplies and to address the challenge of stock-out. Facilities that benefited from such donations were Levels 4, 5 and 6, while very few Level 2 facilities had benefited. (Table 10)

Table 10: PAC supplies by NGOs

Indicators	Level 2 (N=164) (%)	Level 3 (N=47) (%)	Level 4 (N=38) (%)	Total (N=253) (%)
Facilities with PAC equipment/commodities provided by NGOs	26(15.9)	11(23.4)	16(41)	55(21.7)
Manual Vacuum Aspiration Kit	18(11.0)	11(23.4)	13(33.3)	44(17.4)
Delivery set & beds	3(1.8)	0	3(7.7)	6(2.4)
Family planning supplies*	9(5.5)	0	2(5.1)	11(4.4)
Other equipment and drugs**	**3(1.8)**	**1(2.1)**	**2(5.1)**	**6(2.4)**

Three of four level 5 and 6 facilities received PAC equipment/commodities from NGOs
*IUCD, Implanon, Emergency contraceptive pills
*Examination lamps, Doppler's, autoclave, speculum, forceps, cytotec;

Provision of Other Reproductive Health Services

More than half (58.5%) of the health facilities had laboratory services present. Level 2 facilities had the least number of laboratories (37.8%) while all the referral level facilities (Levels 4, 5 and 6) had laboratory services present. A greater proportion of facilities 99.6% offer HIV counselling and testing, whereas 90.5% could provide STI screening. Hepatitis B screening was the least provided service (32.4%) and also the least provided across all the facility levels except in Level 5 and 6 facilities (Table 11).

Table 11: Availability of Laboratory services

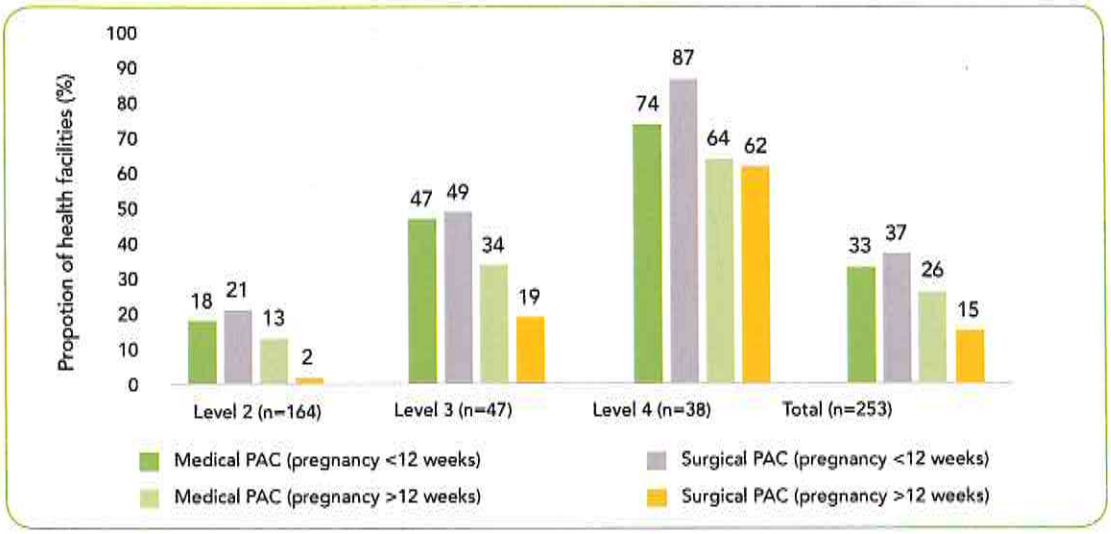
Laboratory procedures	Level 2 (N=164)	Level 3 (N=47)	Level 4 (N=38)	Total (N=253)
Laboratory present in the facility	62(37.8)	44(93.6)	38(100.0)	148(58.5)
HIV counselling and testing services	163(99.4)	47(100.0)	38(100.0)	252(99.6)
Hepatitis B screening	25(15.2)	21(44.7)	32(84.6)	82(32.4)
STI screening**	140(85.4)	47(100.0)	38(100.0)	229(90.5)

*All level 5 and 6 facilities had all the laboratory procedures
**STIs including Chlamydia, Gonorrhea, Trichomonas's, Candidiasis, and Genital herpes

Evacuation of retained products of conception (ERPC) by facility levels

Overall, 32.8% and 37.2% of the all the health facilities could perform medical and surgical PAC for first trimester pregnancies respectively. The lowest capability was recorded in primary level facilities as only 17.7% and 20.7% Level 2 facilities could provide medical and surgical PAC for first trimester pregnancies respectively. About half of Level 3 facilities could provide medical (47%) and surgical PAC (49%) services. Most referral facilities had capacities to deliver both medical and surgical PAC for first-trimester pregnancies. About 74.4% and 87.2% of Level 4 facilities could provide medical and surgical PAC procedures for first trimester pregnancies (Figure 2).

Figure 2: Proportion of facilities providing surgical and medical PAC for 1st and 2nd trimester pregnancies by facility level



*All Level 5 & 6 facilities were capable of providing surgical and medical PAC for pregnancies below and above 12 weeks.

Drawing from the perceptions of providers and policy makers, the capacity to provide PAC was dependent on both personal skills and facility resources (PAC equipment and medical supplies). Participants considered the presence of well-trained providers and well-equipped facilities as complementary to providing quality PAC. The absence of either was viewed as lack of capacity. According to them, for facilities to be described as capable of providing PAC, they must have both the equipment and the personnel to utilize and manage them. Some of the narratives obtained highlight this.

> *The question of capacity comes with the knowledge and skills and then it also comes with equipment. If one is missing, you will definitely not be able to take care of patients. (Nurse, primary healthcare facility, Migori). Basically, we usually face a lot of challenges because as for me actually, I am very equipped. You know I've gone to school, where I was working actually, I was practicing a*

lot of it [PAC] because it was a level five facility, (...); but when I came to this facility, which is a level three, you find there are so many constraints in terms of the infrastructure. We don't have the tools to do even MVA, we don't even have a ward to keep a patient for observation as much as possible, we would love to... Majority of us we have the knowledge, a lot of it from school or from where we have worked and practiced ... but now we can't be able to deliver the quality that we expect. (Clinician, primary healthcare facility, Kiambu).

According to healthcare providers, training allows them to assess the clinical condition of PAC patients, make a diagnosis, and decide on which treatment protocol to administer. Policy makers also indicated that training would enhance health providers' attitudes by enabling them to understand how their personal values may influence their actions (values clarification) and improve how they relate with and handle PAC patients.

It all depends on trainings, if these people are not trained so that they can be able to clarify their values, they are not able to differentiate their own values from professionals. (Senior MoH official, County level, Nairobi).

However, there are assorted challenges linked to training and facility resourcing. The question of training centered on pre-service and in-service training. Some participants also discussed the lack of training on performing certain key PAC services including MVA and prescription of medical abortion (MA) drugs. Pre-service training (i.e. basic emergency obstetric care (EmOC) training) was cited by providers as inadequate and in-service training was seen as infrequent, even though the situation was more pronounced in primary health facilities. These views are illustrated in the following quotes from two providers in Kajiado and Kiambu counties:

I think I'm not that good at offering PAC because I'm not able to do the MVA, I haven't undergone that training. (Nurse, primary healthcare facility, Kajiado). Personally I'm not trained on PAC, post-abortion care and I believe that it involves MVA and the rest, so, and I believe also...we are three nurses and we are not trained on that so it's almost...I cannot say zero because we can give some treatment but we cannot do much. Sometimes we need an MVA (so we) refer and sometimes we want the persons who are trained and were given MVA kits... I don't know whether it [MVA] can be effectively done here. (Nurse, primary healthcare facility, Kiambu)

The frequency of the training opportunities was also reported to be irregular and far between. Most participants reported that a long time had elapsed since they were trained on PAC, insisting on the need for refresher training to ensure that they were up to date on evolving technologies and protocols used to treat PAC such as medical abortion drugs. Refresher training was noted to be particularly important in contexts where providers have limited opportunities to perform PAC because of a low caseload or lack of equipment as this would ensure that they updated their skills. As highlighted in the foregoing quote, healthcare providers who are only able to offer basic care, including examining the patients to make a diagnosis, have to refer all patients whose conditions require uterine evacuation using MVA or MA to another facility. Some facilities did not have a trained provider while others had a limited number of trained personnel relative to the caseload in the facility. In such situations where a limited number of providers had training, the participants reported delays in care provision or referral in those instances when patients were admitted and the trained staff were not available.

Both policy makers and healthcare providers noted that staff transfers impede PAC services. A healthcare provider in Migori County, for example, explained that they had a colleague who was trained to provide PAC but the person was transferred to another facility. As a result, they had to refer their PAC patients although they had the equipment to offer the services:

We have the facilities but the staff is an issue, of late the staff is not there. There was a time we used to do that strictly here without a problem. But now we refer because that person is no longer here. (Nurse, primary healthcare facility, Migori).

Policy makers also cited frequent staff turnover within facilities, with trained and experienced PAC providers exiting as new ones joined the service. Coupled with restrictions on the training of providers that emanate

from controversies surrounding abortion, staff turnover was noted to pose a major challenge on the provision of PAC services as the remaining staff may not be trained and may be unable to offer the services or provide poor quality services.

> *Yes, that I've already explained to you earlier, we are not at zero. Already, we have people who were trained, but there are not many because some have already exited. Therefore, if this person who was trained ... is the one who is on duty today, and they are offering the services, this person will offer the quality service, but come tomorrow if this person is not in, and the person who is there is not trained, that is where you hear things like maybe the attitude, that judgment and such. (Senior MoH official, County level, Nairobi).*

The lack of training for PAC providers was also blamed on inconsistent policies or unclear implementation frameworks. One of the participants reported, for instance, that the withdrawal of the *Standards and Guidelines for Reducing Morbidity and Mortality from Unsafe Abortion* had consequences on providers' training:

> *You know initially we used to have the guidelines on the post-abortion care but somewhere from twenty twelve (2012), there was a circular that came from the DMS [Directorate of Medical Services] that cancelled all those things such that we cannot even train the healthcare providers. (Senior MoH official, County level, Nairobi).*

The changes and inconsistencies with PAC guidelines as reported above were also noted to have affected supply of equipment. Kenya Medical Supplies Authority (KEMSA), which equips the facilities with MVA kits, stopped stocking kits and supplying facilities due to the withdrawal of the guidelines in 2013, as explained by one of the policy makers interviewed:

> *Yes, and no. No in the sense that if a client comes who requires the services, for example in a public facility and they have the commodities, the equipment that are required to do so, they will offer the services but now you will notice that with this [withdrawal of guidelines in 2013], even the kits are no longer with the KEMSA. So they have skills to do so but we don't have the equipment. (Senior MoH official, County level, Nairobi).*

Participants emphasized that the concern around equipment or commodities was more pronounced in primary level facilities, where providers lacked MVA kits or rooms, ultra-sonographers, observation rooms, blood banks and other equipment. In some facilities, MVA kits were never supplied, while in others restocking was delayed leaving such facilities in "a sorry state", as described by one provider in Migori:

> *I don't know when it was supplied, because there are those cannulas [tubing inserted into a vein or body cavity to aid in administering medication or fluids, drain fluid, or insert surgical instruments], they are color- coded, the smallest being the yellow one. It is not here, so it means you have to use the larger ones. So sometimes I have challenges. Actually, I've never used it from the time I reported here. (Clinician, primary healthcare facility, Migori).*

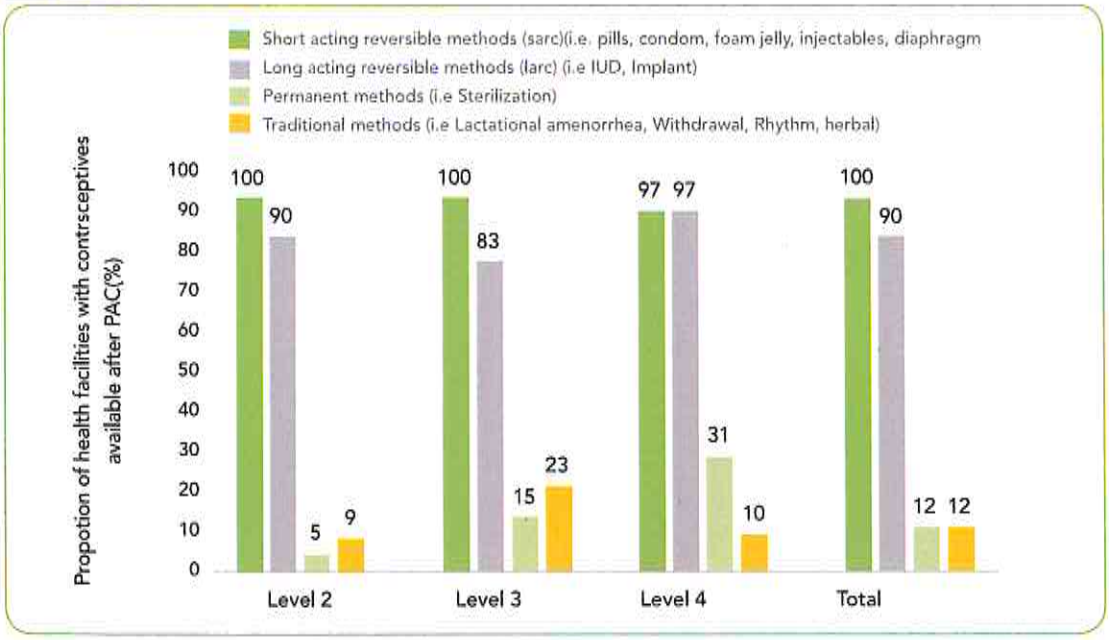
Observations in health facilities revealed cases of referral level hospitals being unable to deliver PAC for prolonged periods (up to two weeks) because of broken MVA kits (such as cannula loss, broken syringes, etc.). Therefore, although they had well-trained providers, they had to refer their patients to other facilities resulting in delays in care and additional costs for patients.

Availability of contraceptive services after PAC

All primary level facilities (Level 2 and 3) could provide at least one short-acting contraceptive. Similarly, a high proportion of Level 2 (90%) and 3 (83%) could provide at least one long-acting reversible contraceptive method. As for the referral facilities, nearly all (97%) could provide short- and long-acting contraceptives following PAC. Just 50% of Level 5 and 6, and 31% of Level 4 facilities could provide permanent contraceptives (Figure 3). Various contraceptives are typically available to women after PAC. Most facilities had combined oral contraceptive pills (91.3%), progestin-only contraceptive pills (84.6%),

progestin-only injectable contraceptives (79.5%), implants (77.1%) and male condoms (75.5%). Overall, the least available contraceptives were combined injectable (1.6%), vasectomy (8.7%), and bilateral tubal ligation (BTL) (10.3%).

Figure 3: Contraceptives available after PAC across facility levels



Healthcare providers interviewed in the qualitative survey indicated that post-PAC counseling is a requirement before discharge of a patient. Post-PAC counselling was noted to include educating patients about the need for contraception, what contraceptive methods were available and how they work, the causes of spontaneous abortion, the consequences of induced abortion, and sexually transmitted infections (STIs), among other topics. PAC providers were noted to tailor their counselling to the identified cause(s) of abortion (induced or spontaneous), personal circumstances (married or single) or sexual activities (for instance those who are abstaining from sexual intercourse either as a choice or because their partners were unavailable). Participants also reported a few facilities that have comprehensive care centers (CCC) or HIV testing services (HTS) with dedicated counselors to whom patients are referred for counselling on contraceptives and other SRH needs. These services were either offered within or outside the facility.

Counselling is mainly provided after treatment, when the patient's condition is stable and/or when being discharged. However, providers acknowledged that not all patients receive counselling. As explained by one of the providers in Laikipia county, one reason why some patients did not receive counseling was because the patient was treated when the counselor was unavailable (e.g., at night or over the weekends):

> *Yeah, sometimes because we get these clients at night and maybe he [counsellor] is not available and maybe he is gone; maybe sometimes on the weekend he is not also available so most of these services they don't get, the counseling part. (Clinician, referral healthcare facility, Laikipia).*

Heavy caseloads and understaffing were also noted to hinder providers' ability to provide counselling to all PAC patients. Indeed, one of the participants pointed out that their caseload is often high which makes it difficult to offer counselling to all PAC patients.

> *Mostly, time need is the major constraint because as I told you, we really receive a lot of patients so we have very minimal time to have adequate interactions with specific patients... But in a scenario where we have time to ourselves, and the patient also has time to themselves, we do provide the ultimate care of the counseling and also provision of the family planning methods. (Nurse, referral healthcare facility, Nairobi).*

Sending patients to CCC counsellors was described as a solution given provider's inability to provide the counselling. However, some providers noted that CCC counselors could also be busy, and patients may decide not to follow through with the referral. As some providers further indicated, in cases of induced abortions, police officers were sometimes called when the treatment was completed to "threaten" patients. This was the case where a particular facility was recording a high number of induced abortions, and involving the police was thought to be a useful measure (despite implications on the code of medical ethics) to reduce the number of cases by interrogating the patients to identify the clandestine abortion providers while threatening the patients.

> *And we transfuse them and then discharge and then we send most of them for family planning and then also we involve the police. Since (we) started involving the police, we noticed that the number of cases has reduced. (Clinician, referral healthcare facility, Kajiado).*

Regarding the availability of and access to contraceptives, most of the providers interviewed in referral facilities reported the availability of all types of methods that patients may need. This is explained by one of the providers:

> *Almost ... not even almost, we have all the methods; we have the implant, the injection for three months, we have the Norplant, we have the NST [injectable] that is, all the methods that are supposed to be there are always available at any particular time. (Nurse, primary healthcare facility, Garissa).*

Participants also indicated that contraceptives are provided for free in line with government subsidized fees for gynecologic and obstetric conditions.

> *The fortunate thing in our facility is maternity PAC services, all (gynecological), obstetric conditions are free, so at one point we don't go to cash for that. The government supplements for that amount as long as it's in the report, it's supplemented for. (Nurse, primary healthcare facility, Kajiado).*

In a few facilities, patients were able to access contraceptive methods in the patient treatment wards. In most cases, however, patients had to be referred to a different unit, such as a family planning clinic, for contraceptive counseling and products. Even so, the respondents recognized that not all patients follow through with the referral to the family planning clinic as the majority exit the facilities without any method. In the particular case of induced abortion, one provider explained that patients *"don't get there- they disappear. It's downstairs, it's not like it's in a different place, (it) is a part of the hospital, it's like (the) pharmacy. It's just that I think the stigma [brings about] the desire to just disappear" (Clinician, primary healthcare facility, Kajiado).* Though this provider did not link such situations with the element of police presence to threaten PAC patients, it is possible that these practices may have instilled fear that pushes patients to escape from the health facility.

Overall capacity to provide post-abortion care in Kenya

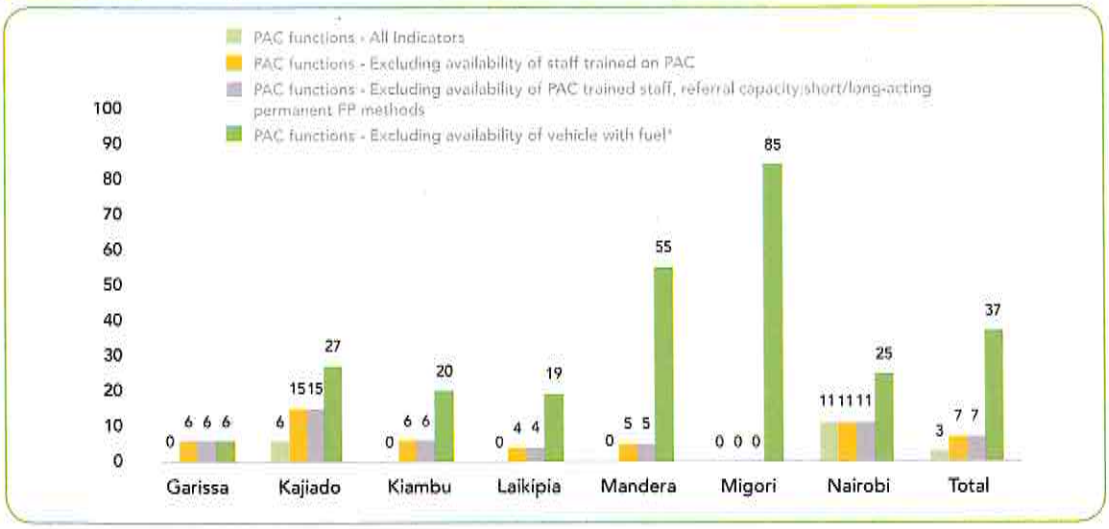
Capacity to provide PAC in primary-level facilities

Only 2.8% of primary health facilities had the capacity to deliver all the essential elements of PAC services, which include: treatment of complications, family planning counselling and contraceptive services, ability to refer (through availability of vehicle with fuel to transport patients needing referral), and staff trained on PAC (Figure 4). Few facilities in Nairobi (11.1%) and Kajiado (6.1%) counties could deliver all PAC services expected of primary facilities. None of the primary facilities in Garissa, Kiambu, Laikipia, Mandera and Migori counties could deliver on all essential indicators for PAC service package.

While applying less restrictive criteria (that is excluding the availability of staff trained on PAC), only 6.6% of primary facilities across all study counties could deliver the whole package of PAC services. Similarly, excluding availability of staff trained on PAC as well as availability of short/long acting and permanent family planning methods slightly improved the proportion of primary level facilities with capacity to provide

PAC services across counties to about 6% in Garissa and Kiambu counties, 11% in Nairobi and 15% in Kajiado. Further, when excluding availability of a vehicle with fuel (for transporting patients during referral) from the criteria, close to two in five (37%) primary facilities could deliver all other essential PAC services, with 84% of facilities in Migori, 55% in Mandera, 27% in Kajiado and 25% in Nairobi showing capacity for PAC provision. Notably, excluding the vehicle with fuel for referrals did not change the proportion of primary facilities that could deliver PAC in Garissa County (Figure 4).

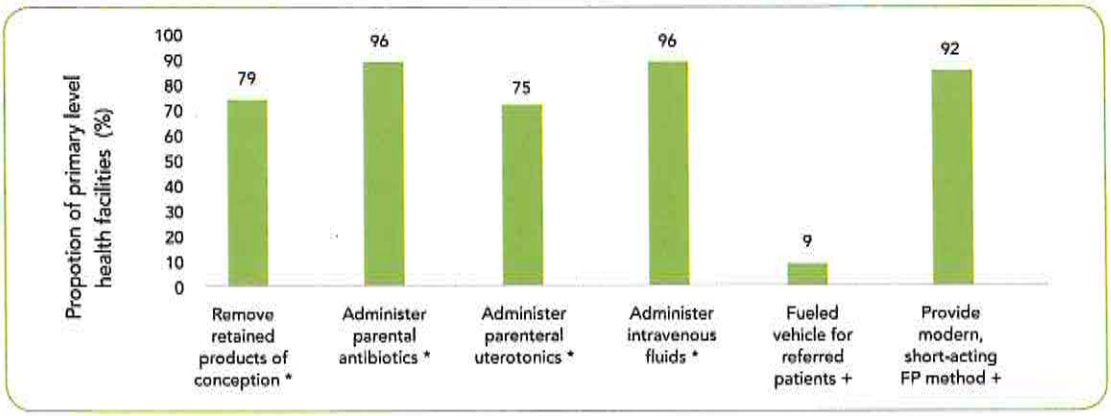
Figure 4: Primary level facilities capacity for basic PAC provision



Capacity to provide specific PAC services among primary-level facilities

More than three-quarters of primary level facilities (78.7%) could remove retained products of conception while nearly all facilities could administer parenteral antibiotics as well as intravenous fluids (96.2%). Similarly, three in four primary facilities (76.3%) could administer parenteral uterotonics with most facilities capable of providing at least one modern, short-acting contraceptive method (91.5%). Only 8.5% of the facilities had fueled vehicles to facilitate referral of patients (Figure 5).

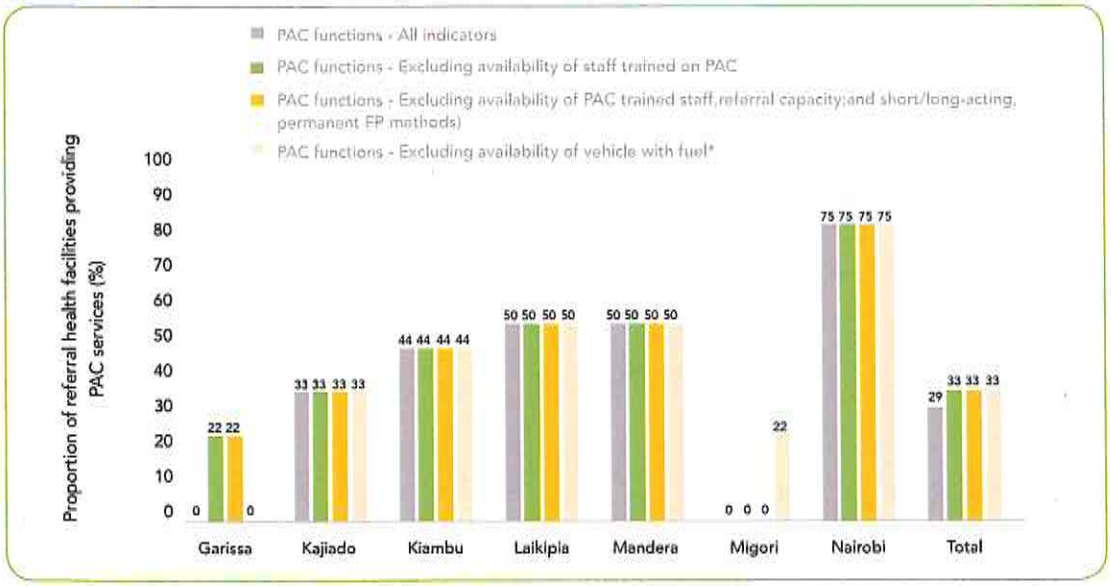
Figure 5: Proportion of primary level facilities with specific PAC services



Capacity to provide PAC services in referral facilities

Barely one in three referral facilities (28.6%) was capable of providing the entire package of essential PAC services, which include: treatment of complications, family planning counselling, short- and long-acting contraceptive services, blood transfusion, major abdominal surgery (proxied by provision of caesarean section), vehicle with fuel to transport patients needing referral and staff trained on PAC. Among these facilities, most were in Nairobi (75%), compared to 50% in Laikipia and Mandera counties, and none in Garissa and Migori Counties (Figure 6). While using a less restrictive criteria for PAC services in referral facilities (that is excluding availability of staff trained on PAC and availability of short and long-acting or permanent family planning methods), the capacity to deliver all essential elements of PAC services for this levels of health facilities did not considerably change the proportion of referral facilities, except in Garissa county. Once the requirement of having a fueled vehicle at the facility is excluded, 33.3% of referral facilities could deliver PAC services, with the highest change in capacity observed in Migori County (22.2%).

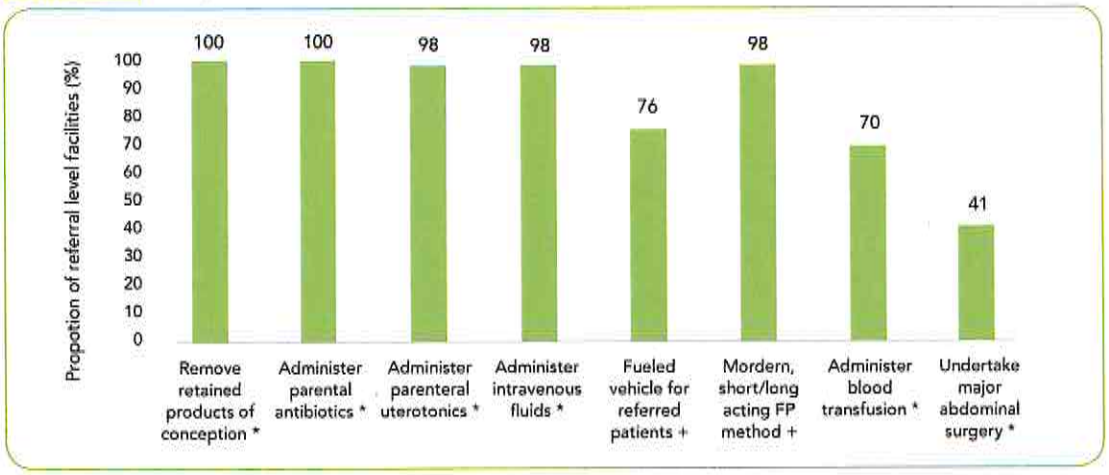
Figure 6: Availability of PAC services in referral facilities



Capacity to provide specific PAC services for referral level facilities

All referral level facilities (100%) had the capacity to remove retained products of conception and administration of parenteral antibiotics to women. Virtually all (97.6%) had the capacity to administer parenteral uterotonics, intravenous fluids as well as provide modern short- or long-acting family planning methods. Barely three in four referral facilities (76.2%) had fueled vehicles to facilitate the referral of patients to or from the facility, and about seven in ten (70%) could administer blood transfusions. Only two in five (40.5%) referral facilities could undertake major abdominal surgeries (i.e., exploratory laparotomy) (Figure 7).

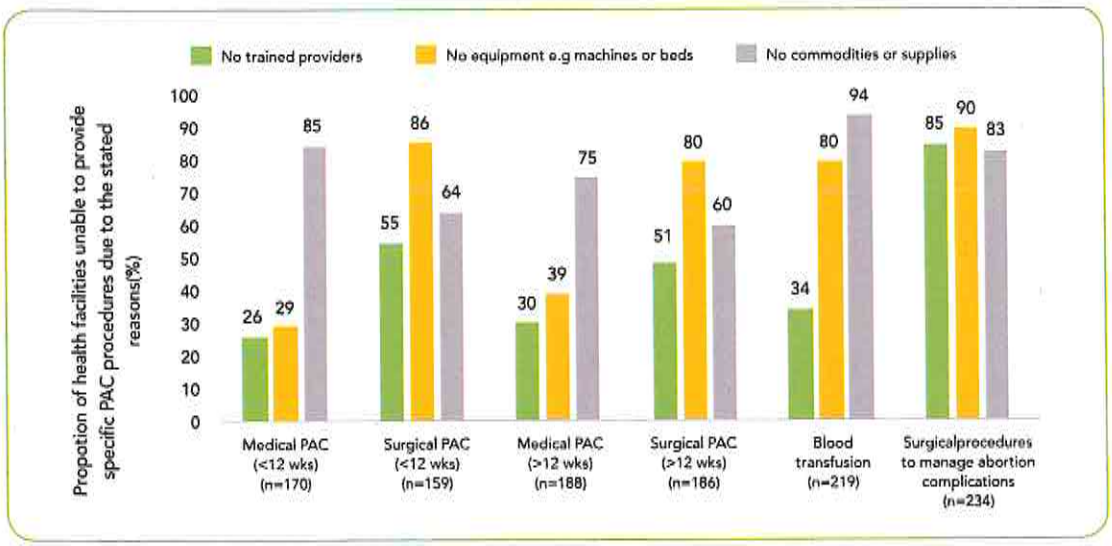
Figure 7: Proportion of referral level facilities with specific PAC services



Reasons for lack of PAC services

The lack of trained providers, equipment and commodities or supplies were cited as the most common reasons for the absence of basic and comprehensive PAC services in public health facilities. The main reasons cited for not providing surgical procedures to manage abortion complications included: lack of trained providers (85%), lack of equipment (89.7%) and absence of commodities and supplies (82.9%). The greatest gap was reported in Levels 2, 3 and 4 in that order (Figure 8). Similarly, performing blood transfusion was prevented by the lack of blood supplies in 94% of health facilities, while 79.5% were due to lack of equipment such as blood banks (Figure 8). Surprisingly, some facilities that were unable to administer IV fluids indicated that it was against their hospital policies. Several respondents also cited some services as against the providers' moral and ethical standing such as delivering medical PAC.

Figure 8: Main reasons for non-provision of medical/surgical PAC, blood transfusion and surgical procedures to manage abortion complications



More specific PAC services were also largely impeded by lack of training for providers, as well as absence of equipment/supplies. Though rare, providers from primary health facilities reported the absence of PAC patients as a reason for not providing PAC services, even though they had been trained and facilities were well equipped. One of the providers in a dispensary explained:

I think I can do post- abortion. I think I can treat them, I can give them antibiotics, we even have some disposable MVA kits but the cases are not there, unfortunately we don't have clients for now (Clinician, primary healthcare facility, Kajiado).

Provider-related personal choices and values were also raised as a hindrance to the provision of PAC services. As illustrated in the following quote, respondents described cases of their colleagues not offering PAC for reasons related to their religious beliefs. In these situations, these providers opted to refer their patients to colleagues or other facilities, thus delaying care and increasing the risk of complications. Some facilities resolved such challenges by relocating those specific staff to other wards where they would not need to handle PAC patients.

... except one or two staff who have a religious issue, relating to general FP and PAC issues, generally the others are okay. It affects in one way because, one she will not be able to provide the PAC service meaning it becomes a problem to the client because that client will be told wait for so and so to come so that (they) are able to (receive) the service and remember in PAC that delay would also not be good for the patient. (Nurse, primary healthcare facility, Kajiado).

Referral of PAC patients

Given the limited capacity of most primary level facilities to deliver PAC, the majority of these facilities tend to refer PAC patients to other facilities. There are existing guidelines for the referral process. These guidelines emphasize task shifting, which involves the delegation of duties from highly skilled doctors down to the clinical officers, nurses and community nurses. The guidelines also describe how a service provider evaluates a patient's condition and refers the patient in cases that cannot be managed at a lower level facility.

It is very clear in the guidelines that if you cannot do it either because of lack of equipment, lack of a facility to do it then of course you refer to the next facility where what you are lacking [exists]. (Senior MoH official, national level, Nairobi).

There was consensus among participants that an ambulance is the appropriate means of transport during referral, especially where the patient is in critical condition. Therefore, most facilities reported regular use of an ambulance whenever it was available on site and operational. However, participants noted that most primary level facilities have no ambulance and relied on "satellite ambulances" which are often managed by the sub-county administration. As such, ambulances are not always available or may take a long time to come to facilities located in distant areas.

About the referral system, previously it was like good because we had our own ambulance in the sub-county but right now we still don't strain so much because now we liaise with the sub-counties with the ambulances, we also have the number of emergency services in Kiambu... but if you have to source from the other sub-counties at times it takes long and during that time maybe the client is bleeding much, you have to give the fluids and you see you might reach a certain level that you do not give any more fluids. (Clinician, primary healthcare, Kiambu).

Providers explained that when the patient's condition allows it, they ask or allow them to use private means of transport when the patients are referred. However, providers noted that some patients had to use private transportation even when their condition was severe because the ambulance was delayed or unavailable and access to care was urgent to avoid deterioration of the patient's condition.

....we call the ambulance and in the meantime we also work together with the relatives, you know a patient cannot die because you are waiting for the ambulance to come from the sub-county hospital. If the relatives are able to get a vehicle to the hospital, well and good. (Nurse, primary healthcare, Kiambu).

According to providers, PAC referrals were primarily linked to facilities' limited capacity to deliver services, especially due to lack of training, commodities, and supplies, and providers' personal values. They also noted that a patient's condition plays a key role in the decision to refer. For example, providers pointed

out cases where the referral was due to delay in care seeking by the patient resulting in complications that could not be managed in the facility.

> *No, what happens is, most of the referrals we get from the community and mostly it's let's say self-referral or from our community health workers, so they come to the facility after trying one or two [remedies] at home... and when they are defeated at home is when they come to the facility. So at most times if you get them at an early stage, you are able to deal with them. Sometimes you get them when it's complicated, a lot of bleeding has taken place, and you are forced to refer because we don't offer transfusion services. So when it's a little late we refer. (Nurse, primary healthcare facility, Kajiado).*

After making the diagnosis, some facilities immediately refer the patients because they lack the competencies to provide the care needed per the Ministry of Health guidelines. Nurses, for instance, reported that they are trained to, and allowed to manage or handle abortions that occur within the first trimester. One of the nurses interviewed explained that she always immediately refers later term cases:

> *So basically any miscarriage that's below three months, we can handle or, personally, I handle. But something like intrauterine fetal death or inevitable abortion above three, four months, which is supposed to be inducted, we don't do it here so we refer. From the ministry's referral system, you only refer to a level three or four hospital. (Nurse, primary healthcare facility, Nairobi).*

Policy makers also asserted that complications are classified in guidelines as either acute or chronic. Therefore, service providers at lower level facilities are to evaluate and refer clients based on the severity of each case.

> *Based on the background that this service is supposed to be task shifted, task shared to the level of a nurse, we know that a good proportion of these cases are becoming complicated and so the nurse cannot handle them. So part of the guideline is to prepare the nurse to pick out patients who may have near misses or whose complications are such that the nurse cannot manage and [must] refer to the next level who is a doctor working in a hospital. For example, if one [patient] has bled so much and would require blood transfusion, we know we don't transfuse blood in a health center or dispensary, so she has to refer for correction in a hospital set up... In addition, nurses are not supposed to manage [sepsis]. (Senior MoH Official, National level, Nairobi).*

Some facilities, especially the lower level with trained personnel and some equipment such as MVA, would still opt to refer because of the uncertainty surrounding PAC cases. Providers explained that PAC requires many resources that go beyond simple MVA such as the availability of blood for transfusion, surgery, and in-patient services. They noted that a seemingly simple case can quickly become complicated thereby requiring unavailable resources. To avoid any risk of last-minute surprises, they referred PAC patients to higher level facilities.

> *If the cases are not complicated, sometimes we do the minor procedures and then give them the drugs and if it's complicated we refer them because we can't afford to have them. We don't have inpatients and also beds and maternity as well...so we refer them to referral hospitals for further management. (Nurse, primary healthcare facility, Mandera).*

Providers' descriptions of cases that were "not complicated" differed considerably from one provider to another. To some providers, these cases included conditions where the evacuation could be done manually, or cases without heavy bleeding after uterine evacuation, anemia, infections, or cases not requiring surgery. According to some providers, mostly in rural areas, there were instances where they resorted to manage patients' even when they lacked the capacity to do so because the patient could not afford care in a higher level facility.

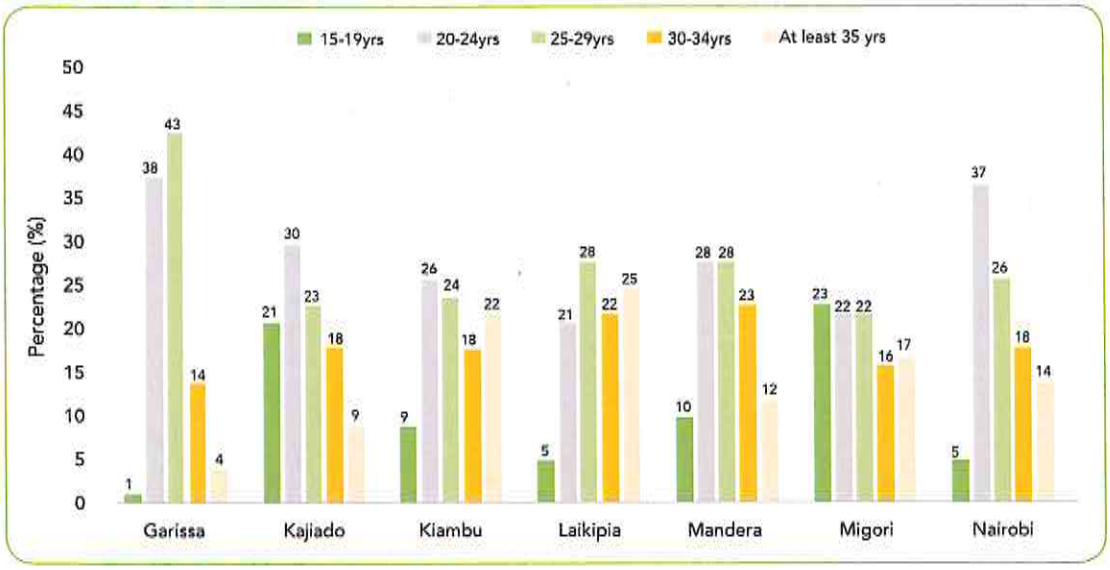
> *... The equipment is not effective but you have to do it, and you have to do it because even if you refer, they may not go; they tell you if there is something you can do, do it. We work in a community where the economic state is also low therefore referring somebody either to the county referral hospital or to a private hospital of their choice is like you are exposing them to expenses which they would have not been ready for. (Clinician, primary healthcare facility, Migori).*

Patients' experiences with post-abortion care

Socio-demographic characteristics of study participants

More than half (56%) of the patients who participated in the exit interviews was between 20 and 29 years, while one in every three (33.9%) was 30 years and older. Thirty-nine percent were younger than 25 years. There were differences in age across counties with about one in five patients interviewed in Kajiado and Migori counties being between 15-19 years compared to other counties where fewer than 10% of women were in this age group (Figure 9). Moreover, nearly half of these teenagers (44%) were seen at the primary level facilities.

Figure 9: PAC patients' distribution by age categories across counties



Exit interview participants' sociodemographic characteristics are summarized in Table 12. Although just a slight majority indicated they were residing in an urban setting (53.8%), most of those seen at the primary level facilities were rural residents (77.3%) while close to a third of those seen at referral facilities were urban residents. Majority of the PAC patients had attended school (83%) with at least two in five (40.9%) having completed primary level education, while 40.6% had reached secondary level education. Close to one in five women (17.8%) had achieved tertiary level education. More than half of the patients treated for post-abortion complications (57.9%) were unemployed. Among those employed, about one in four (26.8%) was earning KES 5000 (approximately 50 US dollars) or less per month, while a third (33.8%) earned between KES 5,000 to KES 10,000 per month and another one in three earned above KES 10,000. Unemployment or lack of income among PAC patients was greatest in Mandera County (92.9%), Garissa (87.5%), Kajiado (61.2%) and Migori (56.5%). A slight majority of PAC patients in Kiambu (58.8%), Laikipia (59.8%) and Nairobi (56.7%) were employed.

Most of the PAC patients were Christians (74.5%) with Protestants comprising 36.9% of the total sample and Catholics, 18.3%. Twenty-five percent of the patients were Muslims. Majority of PAC patients were married or cohabiting (72.8%), while 16.5% were single (Table 12).

Table 12: Patients' socio-demographic characteristics

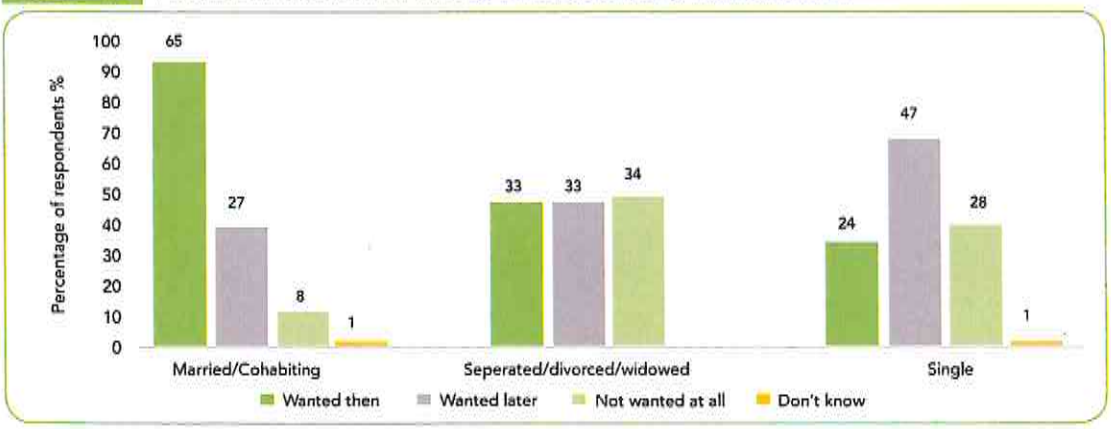
Characteristic		Primary level: N=172; n (%)	Referral level: N=647; n (%)	Total: N=819; n (%)
Age (years)	15-19	32 (18.6)	47 (7.3)	79 (9.7)
	20-24	38 (22.1)	199 (30.8)	236 (28.9)
	25-29	42 (24.4)	184 (28.4)	226 (27.6)
	30-34	33 (19.2)	119 (18.4)	152 (18.6)
	At least 35	27 (15.7)	98 (15.2)	125 (15.3)
Area of residence	Rural	133 (77.3)	245 (37.9)	378 (46.2)
	Urban	39 (22.7)	402 (62.1)	441 (53.8)
Ever attended school		**111 (64.5)**	**569 (87.9)**	**680 (83)**
Highest level of education*	Primary	62 (55.9)	216 (38.0)	278 (40.9)
	Secondary	33 (29.7)	243 (42.7)	276 (40.6)
	Tertiary	15 (13.5)	106 (18.6)	121 (17.8)
Main economic activity	Employed	45 (26.2)	300 (46.4)	345 (42.1)
	Unemployed	127 (73.8)	347 (53.6)	474 (57.9)
Monthly income (KES)	≤5000	23 (52.3)	69 (23.1)	92 (26.8)
	5000-10000	11 (25.0)	105 (35.1)	116 (33.8)
	10001-15000	1 (2.3)	39 (13.0)	40 (11.7)
	>15000	9 (20.5)	86 (28.8)	95 (27.7)
Religion*	Catholic	21 (12.2)	129 (19.9)	150 (18.3)
	Protestant	37 (21.5)	265 (19.8)	302 (36.9)
	Other Christian	30 (17.4)	128 (19.8)	158 (19.3)
	Islam	84 (48.8)	121 (18.7)	205 (25.0)
Marital status	Married/cohabiting	140 (81.4)	456 (70.5)	596 (72.8)
	Separated/divorced	10 (5.8)	78 (12.1)	88 (10.7)
	Single	22 (12.8)	(7.5)	135 (6.5)

*These indicators had an additional category of "others" with less than 1%

Pregnancy desirability

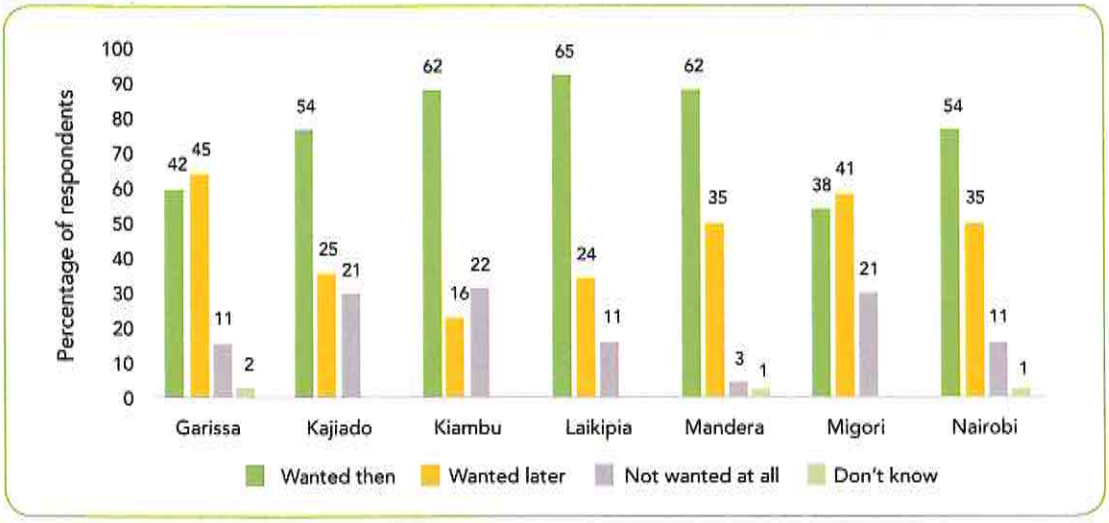
The index pregnancy of close to half of PAC patients (45%) was unintended. About one in three married patients (34.6%) did not want the pregnancies then. Moreover, majority of those who were single (75.5%), divorced or widowed or separated (67.1%) did not want their pregnancies (Figure 10). Close to one in every five patients (17.1%) treated for their abortion-related complications had considered terminating the pregnancy.

Figure 10: Pregnancy desirability among PAC patients by marital status



Considering preference for pregnancy by county, the vast majority of patients in all counties reported that they wanted the pregnancies then, except for Migori and Garissa counties where the proportion of women who indicated that the pregnancy was unwanted exceeded that of women who indicated that the pregnancy was wanted (Figure 11).

Figure 11: Pregnancy desirability by county



Reasons given for pregnancy being unintended included contraceptive failures (29%), financial constraints (26%), and concerns about school and/or career progression (14%). A greater proportion of women in in Mandera (76.7%) and Garissa (45%) reported that the unwanted pregnancy resulted from contraceptive failure, while among women in Kiambu (26.6%), Laikipia (35.3%) and Nairobi (39.5%) counties, financial constraints dominated. School and career progression concerns were most common in Migori (29.3%) and Kajiado (27%) counties.

Quality of PAC services received

Qualitative interviews described patients' perceptions of what they considered as "good care" and/or "bad care" based on their previous experiences in health facilities. In their description of "good care", we noticed the recurrence of expressions such as friendliness, lack of harassment, respect and empathy in the context of their interactions with service providers, as well as absence of queues (or presence of short queues) and low cost of care. Some patients considered receiving the right treatment or feeling better when leaving the facility as good care. As one woman explained, "bad care", on the other hand, was associated with harsh or rude providers, long queues, and lack of empathy:

> *For bad care... the doctors and nurses are harsh [when] they talk to people. That is why I don't go to a hospital. They are so rude. They can shout at you, they can even beat you because you did something, they don't care how you feel. In good care, you feel your patients' pain as your pain. (25 years old, single, business, urban, Nairobi).*

Patient's decision to seek PAC services in a particular facility was guided by perceived good experiences of previous care, the cost of service and their resources. This is explained by one of the patients:

> *I wanted to come here because it is cheap, it's not the same with the other hospitals because it depends on your earnings, and you can go to an expensive one or a cheap one. So I decided according to my means, I should be brought here. (23 years old, single, unemployed, urban, Kajiado).*

However, many of those who opted for primary level facilities based on their previous experiences of good care while seeking treatment for a different medical issue, ended up being referred because the facility chosen could not offer the service needed. Patients expressed their PAC experiences using several key constructs including dignity and respect, autonomy, stigma and discrimination, communication, privacy and confidentiality, trust, predictability of costs and supportive care. These constructs are summarized in Table 13.

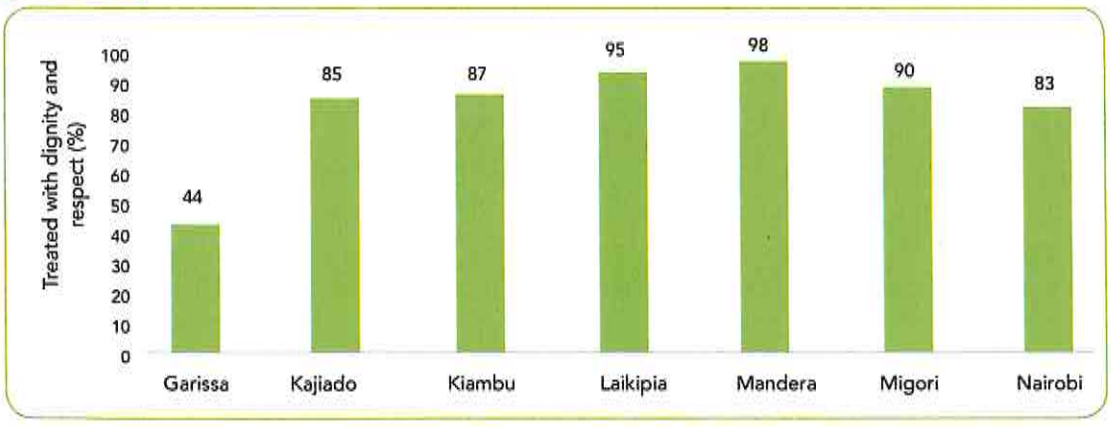
Table 13: Summarizes patients experiences with post-abortion care by facility level

Construct	Proportion of patients who rated their experience as good		
	Primary level: N=172, n (%)	Referral level: N=647, n (%)	Total: N=819 n (%)
Dignity and respect	164 (95.4)	521 (80.5)	685 (83.6)
Privacy and confidentiality	110 (64.0)	182 (28.1)	292 (35.7)
Post-abortion counselling	117(68.0)	217(33.5)	334(40.8)
Health facility environment	106 (61.6)	360 (55.6)	466 (56.9)
Autonomy	149 (86.6)	488 (75.4)	637 (77.8)
Communication	151(87.7)	481(74.4)	632 (77.2)
Supportive care	131 (76.6)	453 (70.0)	584 (71.3)
Trust	147 (85.5)	493 (76.2)	640 (78.1)
Predictability/transparency of payments	153 (89.0)	628 (97.1)	781 (95.4)
Stigma and discrimination	168 (97.7)	565 (87.3)	733 (89.5)

Dignity and respect

Patients rated dignity and respect highly with 83.6% of them indicating that they felt respected and their dignity preserved while seeking PAC services. Close to one in five PAC patients (16.4%) reported poor experiences. Of those who reported poor quality, 30% felt that the waiting time was long, and this was especially so among patients in referral level facilities. Similarly, half of the patients (49%) reported that health providers failed to introduce themselves during their first interaction (primary facility: 33%; referral facility: 53%). Notably, some patients (10%) reported being scolded, insulted, threatened, or spoken to rudely by health providers. Two percent of the women reported that they had been pushed, beaten, pinched, physically restrained or gagged. In general, the majority of patients felt more dignified and respected within primary level facilities (95.3%) compared to those in referral facilities (80.4%) (Table 13). Across the counties, the majority of PAC patients in Garissa (55.8%) felt that dignity and respect was poor. However, patients in the rest of the counties reported good scores for dignity and respect, with Mandera County leading (98.2%) (See Figure 12).

Figure 12: Dignity and respect by county



In-depth interviews with patients illustrated how women experience dignity and respect when seeking PAC services especially in terms of waiting time and friendliness of providers.

Perception of waiting time

Nearly half of qualitative participants mentioned that they experienced a delay of at least one hour. Most patients treated immediately on arrival were often cases of emergency such as those with heavy bleeding or severe pain or those referred from other facilities. A patient from Laikipia described how fast she was attended to once she arrived:

> *Actually it was an emergency so they started it on the stop and they were so nice to me, that I must say because, even if they didn't know what happened because, maybe I might even have done something like abortion or something, but they didn't take it that way because it was an emergency and later on that is when they asked me if I did anything or something. But even after realizing that I did not do abortion or something, they did treat me well. (31 years old, married, teacher, urban, Laikipia).*

Unlike this patient, others who reported delays felt that their condition was an emergency since they were bleeding heavily, and in severe pain. However, they were forced to wait for long hours, because of the caseload and few care providers. One patient who bled excessively and ended up having a spontaneous abortion while still queuing, reported feeling embarrassed. For this patient, the providers should have assessed her condition before allowing her to queue as narrated:

> *They should at least look at the state of the patient when they get here, observe them instead of making them queue and maybe they don't know what their situation is.[Had] they have checked my situation, I wouldn't have had the problem. I bled while I was just sitting and had the abortion there. So had they attended to me fast when I came, because I was in pain, you know I would at least have bled there and I wouldn't have bled in front of everyone else. (35 years old, single, employed, urban, Kiambu).*

A 23-year-old patient from Kajiado, who *"was told the child had died in the womb"*, felt that this was an emergency situation that should have been handled immediately. Instead, she was kept waiting for long hours, a situation she felt could have worsened her condition and exposed her to more pain.

As illustrated in the following quotes, patients' assessment of the appropriateness of the waiting time was also influenced by the number of patients on the queue, the number of service providers available, and the number of patients needing emergency care. As one patient (33 years old, married, employed, urban Kajiado) explained, *"...there was a patient being attended to so I could not blame the doctor because she was alone and the patients were many."* This patient and many others felt that most health providers would prefer to offer immediate care to all patients in emergency situations but could not because of their heavy workload or the high number of patients.

Cases of provider burnout were also reported as a reason for delays in services, especially for patients who arrived at the facility in the evening. In one of the referral facilities, a service provider was found taking a nap while patients were still on the queue waiting to be attended to. As a result, patients piled up and new emergencies developed on account of long waiting hours. This is common in facilities with high volumes of patients and few providers.

In some cases, patients were initially taken in, but were then referred for other services such as ultrasound scan, further prolonging the wait time to receive treatment. As illustrated in the following narratives, patients who were instructed to take an ultrasound scan and other tests not only had to queue at the scanning room or lab and pay the approved fees before they received the services, they also had to cover some distance within the facility, a situation that further delayed their care process.

> *...So when I got there I started bleeding, then I was told to go for an ultrasound. I took the stairs and went for that. I was then sent to go for a rhesus test to know my blood group, I went and got*

tested. Then I was sent again to test for PDT [Pregnancy Diagnostic Test] again I was tested (...). So when I was there I kept using stairs and coming down, so I started feeling my abdomen being painful like I am in labor. So that's when...because I had also drunk a lot of water, I went down to the toilet and I was bleeding profusely and could see clots coming out; then I would go and wait for results then go back to the toilet and bleed. So when I was given the results, I took them to the doctor down there and that's where there was a problem; I waited for long ... to give him the results because people were so many and the doctors were very few. I waited for long and the abdomen pain continued like labor, like labor pain. (36 years old, married, casual laborer, urban, Nairobi).

In other facilities, women simply could not get the scan because the ultrasound machine was broken, while others were sent elsewhere because the person in charge of performing the scans was unavailable. Some facilities provided ultrasound services at specific times and days of the week, hence patients who presented past working hours were referred for ultrasound services elsewhere. Even in cases where the ultrasound scan services were immediately available, some patients were unable to afford the service charge. They therefore had to postpone treatment.

Patients also noted that delays in receiving care resulted from inadequate equipment and medical supplies. A participant from Nairobi, for example, reported that she had to wait for more than four days before undergoing MVA treatment because of the lack of MVA equipment in the referral facility:

I came on Thursday evening and I was admitted, I was here on Friday, Saturday. On Sunday, the doctor who did the rounds told me that there was no MVA equipment and that I could go to a different hospital. I told him whoever will come here on Monday... so I relaxed and decided to wait for the equipment. They were brought on Monday ... I was "washed" in the evening. (30 years old, married, employed, urban, Nairobi).

PAC providers' friendliness

Patients judged providers as friendly if they were welcoming, checked on them, used encouraging words, shared life experiences or soothed patients to ease their pain. Other patients simply pegged provider friendliness in the way providers greeted them, gave them medication at the right time, and answered questions freely and openly. Most PAC patients across the counties felt that service providers were friendly to them, as explained by one of the participants in Kajiado.

A female tall and dark nurse, she really attended to me well. Even after she brought me here, she came back to check if I had been attended to. Yes, even the one we were with here attended to me well. You know some can attend to you, when you tell them to stop and that you are in pain, they tell you are disturbing and so on; but this one was saying sorry to me and attending to me well. I could tell her, wait a minute I feel sweaty and he could open the windows for me and attend to me well. (34 years old, married, business lady, urban, Kajiado).

However, some patients reported cases of physical, verbal and sexual abuse, especially when they were suspected to have had an induced abortion or were considered stubborn. These patients often felt vulnerable, they could not speak and chose to suffer in silence even when they were uncomfortable about how they were being treated:

You know... not that they weren't answering me alone, there were some who called them, and they just came and answered them rudely. Some doctors are grumpy. There was one you called him, he asked, 'what are you calling me for, stop disturbing me', he just comes at his own time. So how he answers me I just feel bad. We just kept quiet, we are sick we have been brought here... (25 years old, married, unemployed, urban, Kajiado)

Some PAC patients narrated how they were sexually abused while at a particular health facility. According to several patients, cases of sexual abuse in the health facility remained unaddressed even after the facility administration had been informed. During our facility observation, we encountered patients complaining

among themselves and describing how a particular provider harassed and threatened some of them, requesting that they "hug him". According to the patients, this situation seemed to have persisted for some time with different women experiencing it. During the interviews, one of the patients recounted what she went through when one of the providers was evacuating her uterus:

> *When I was going to be washed, I came and removed my pants...so I assumed that position, he came and saw no remains coming out but he started throwing hands at me. He asked me, 'you don't feel well when you are touched to be ready for sex'...he touched my clit, and asked me, 'don't you feel good to receive a man'...asked me whether I didn't feel ready to have sex...You know if the doctor tells you something, you just relax, I felt very bad because still that morning the lady there came to my bed and told me she was also mistreated, the man touched her breasts or [hugged] her. (28 years old, married, unemployed, urban, Kiambu).*

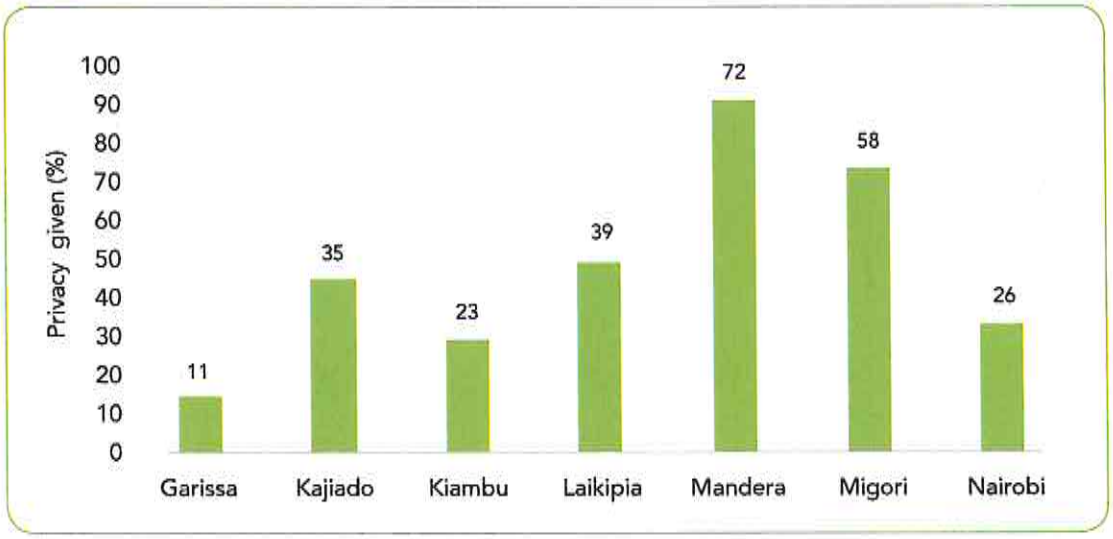
Such situations depressed patients as they trusted the providers with their care. Patients noted that whenever they refused the providers' sexual advances, they would be neglected during treatment in retaliation. As such, some PAC patients felt insecure and uncomfortable around male service providers, and wished male providers were transferred to male sections or other departments where there were no women.

> *After I was "washed", he came in and I didn't feel secure because we were just the two of us...I didn't fear a woman but when he came in, I didn't like it. I was not impressed by him being in a woman's job yet he is a man. He fondled my breast and I was not impressed...; I wouldn't prefer being (in) the ward, his character (is) not good, what he wanted to do to me yesterday night wasn't good to me. He tried to seduce me...he wanted to hold me but I moved away. I didn't see his reason for having such a habit. In fact, I preferred he be taken to the men's section or maybe to a different department with no women. (20 years old, separated, casual laborer, urban, Kiambu).*

Privacy and confidentiality

In general, over 64% of the patients felt that their privacy was compromised. A higher proportion of women treated in referral level facilities (71.9%) than in primary level facilities (36.7%) felt that their privacy was compromised (Table 13). Across the counties, the majority of PAC patients in Garissa (89.4%), Kiambu (77.1%), Nairobi (74.4%), Kajiado (65%) and Laikipia (60.8%) felt that there was no privacy during PAC service provision. However, in Mandera County, the majority of PAC patients (72.3%) felt that they were accorded privacy (Figure 13).

Figure 13: Privacy and confidentiality by county



The qualitative findings provide insights on the issues of privacy and confidentiality. For instance, in Kajiado and Garissa, patients reported occasions where the treatment rooms were not isolated, thereby leading to situations where other patients or people could eavesdrop on the conversations between providers and patients or even enter the room when the patient was naked on the surgical table. Other patients felt very uncomfortable or embarrassed when certain procedures like MVA were done with many healthcare providers in the treatment room.

> *...Because of course when you go to the theatre you remove all clothes so I was naked and there... the door was not closed, even those who were passing by could see you when you are being washed and there isn't a curtain. In fact, that guy who came to clean just got me there naked. (25 years old, married, unemployed, urban, Kajiado).*

> *Sometimes like MVA, because it's more of you showing part of your body a lot, at some point, you feel they are too much in the room, I never loved that. You find that they are like eight people and like six of them are just storytelling, the students are not necessary there. (23 years old, single, beautician, urban, Kiambu).*

There were a few reported instances where providers spoke so loudly that others were able to hear their conversation with patients. Breach of privacy was aggravated when such interactions happened while the consultation or procedure rooms were close to intake or waiting areas, or close to the washing rooms. In some cases, the interactions with the provider happened in overcrowded places such as treatment or hospitalization rooms with many patients. Patients who felt that their privacy was breached described feeling embarrassed.

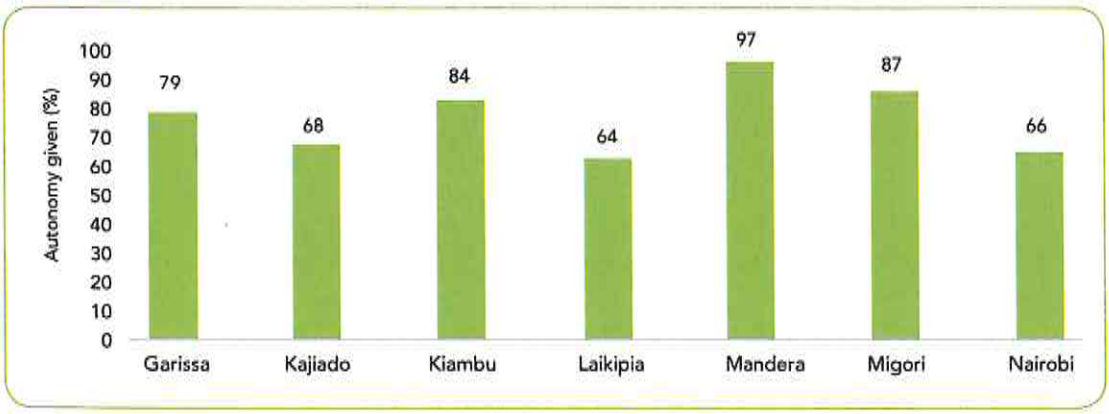
> *He asked me, 'Do you want to heal or what?' and they [other patients] all heard. It's not good because you expect to tell the doctor your problems but not for others to hear. It embarrassed me. (23 years' old, single, urban, Kajiado).*

Although such privacy concerns were reported by various patients, they were more common among young and single women, some of whom had induced abortion. According to these patients, the breach of confidentiality would put them at risk of stigmatization in their communities.

Autonomy

Autonomy was meant to capture patients' involvement in the decisions around their care. The overall score on autonomy was fairly high, with patients from primary facilities reporting higher scores (87.1%) compared to referral level facilities (75.5%) (Table 13). About one in every five PAC patients (22%) felt that their autonomy was not respected. Autonomy during PAC service provision was also highly rated across the counties, with the highest figures seen in Mandera (97.3%), Migori (87%) and Kiambu (84.1%). However, in Laikipia, Nairobi and Kajiado, about one in three patients (36.1%, 34.1% and 32.5% respectively), reported that autonomy was not provided (Figure 14).

Figure 14: Autonomy by county



While data from the quantitative findings indicated that most PAC patients were consulted during treatment, IDIs depicted a completely different picture regarding their autonomy and involvement in decisions regarding their care. Most PAC patients indicated they were not involved in making decisions regarding their treatment. According to patients, providers made decisions about the kind of treatment (i.e. choice between MVA and MA for the uterine evacuation) without consulting them or their caregivers. Even in situations where some patients felt they could refuse certain procedures, they did not make any objections as they feared providers' reactions.

> *As I have told you, we are never in a position to tell the doctors that we want to be treated, you just come and you see them come to give you drugs. (23 years, single, urban, Kajiado).*

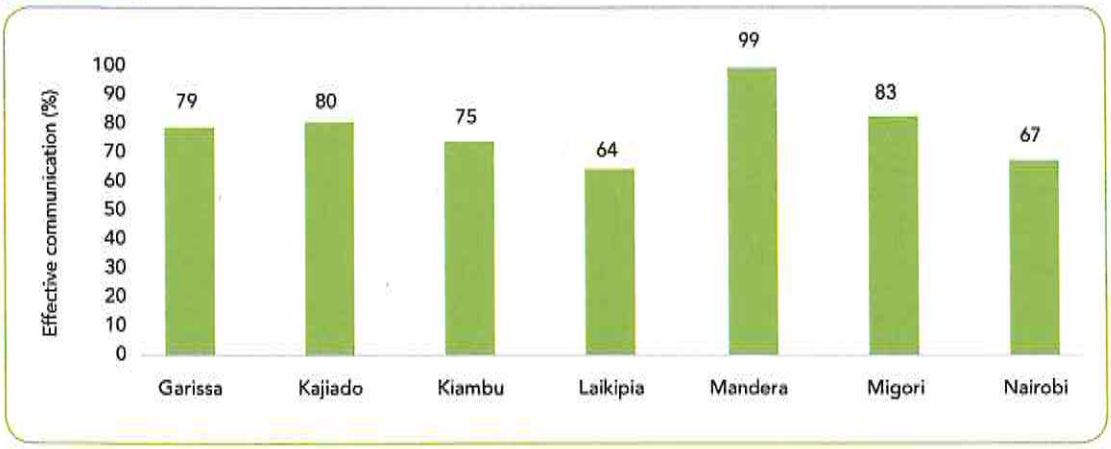
Some patients were even surprised when the question about their involvement was asked, because to them, patients' non-involvement has always been the practice. Moreover, some patients felt that the healthcare providers were more knowledgeable, therefore, they would accept whichever treatment is provided to them as long as they got well. A participant noted:

> *Mostly they do say that you cannot argue with the doctor, because he is the one who knows the medication to give you so that's why you cannot always ask a question even when you have. (33 years old, married, employed, urban, Kajiado).*

Communication

Most PAC patients (77.2%) reported that communication between them and healthcare providers was good or effective, with 87.7% in primary level facilities and 74.4% in referral level facilities stating that this was the case (Table 13). Overall, fewer patients reported understanding the language used by healthcare providers (65.1%), reasons why they could not be accompanied by other family members or friends during treatment (56.2%), and reasons for giving medicines (66.3%). At county level, the majority of PAC patients in Mandera (99.1%) reported good communication. Even so, it is worth noting that over 32% and about 35% of PAC patients in Nairobi and Laikipia respectively felt that there was poor communication between them and the healthcare providers (Figure 15).

Figure 15: Communication by county



Although most of the qualitative survey participants were not involved in decision making regarding their treatment, many of them were reportedly informed about the providers' choices, the reasons underlying those choices, and what the PAC procedures (e.g. MVA) entailed. Some respondents also applauded service providers for giving them a chance to ask questions. Women reported that the information helped them to prepare psychologically. For instance, a participating patient explained how her discussion with the provider helped her psychologically before her womb "washing":

He told me how he would "wash" me, and prepared me psychologically, and told me it's a bit uncomfortable, that I would feel some pain, so I felt okay. So before I got in, I was prepared. (29 years old, married, sales and marketing, urban, Laikipia).

Those who reported that they lacked information explained that they could not ask questions because they were afraid that the providers would respond rudely or even stop the procedure. In most cases, the fear and the reluctance around asking questions was driven by previous experiences with providers who did not encourage positive provider-patient interactions. The few who were courageous enough to ask questions or requested to know the reasons for certain medications, were threatened with dire consequences. Many were left with the impression that providers are not people who entertain questions from patients. Some of these concerns are illustrated below:

You know I feared them, I didn't ask them. There was just one sister whom I asked and told me that you will just get pregnant and then I just kept quiet because I was satisfied with what she told me. (22 years old, married, business woman, urban, Nairobi).

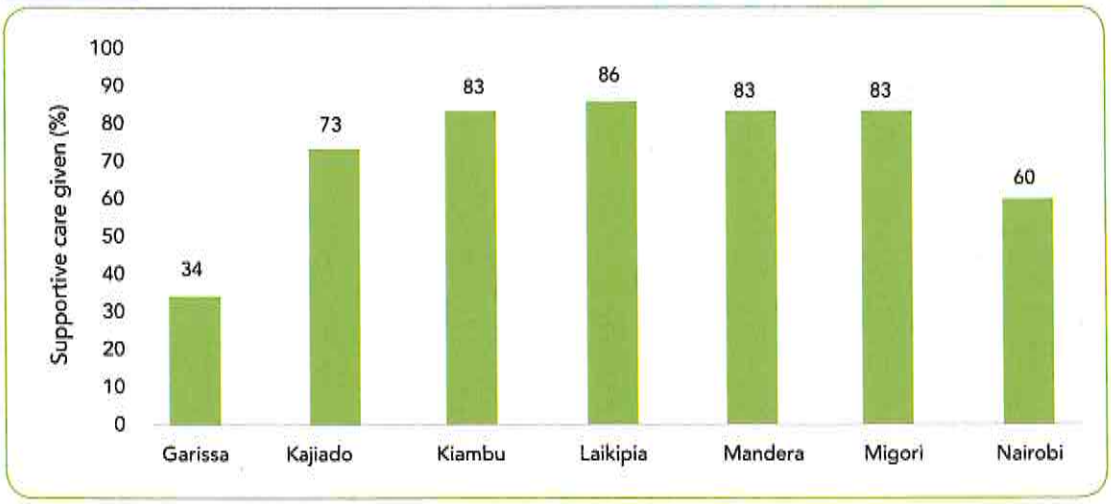
I told her that the injection was [causing] more pain. She told me 'either you accept these drugs or go there'. I asked her where? 'Won't you die', she said. I felt bad, yes, because she didn't want to tell me the reason for that medication. (28 years old, separated, business woman, urban, Laikipia).

Supportive care

Seventy-seven percent of PAC patients in primary facilities and 69.9% of patients in referral level facilities indicated that they received supportive care (Table 13). Specifically, almost all patients, irrespective of facility level reported that health providers took measures to control their pain. A fairly high proportion of patients in primary (86.1%) and referral level (76.9%) facilities also confirmed that health providers paid attention to their requests for help.

At county level, the majority of PAC patients (at least 70%) reported receiving supportive care, with the exception of Garissa and Nairobi counties where only 33.7% and 59.8%, respectively, reported that they had received supportive care (Figure 16).

Figure 16: Supportive care by county



In the qualitative interviews, patients confirmed that they received supportive care. They described supportive care as empathetic care from providers and being given pain management drugs. Some patients, particularly those who had miscarriages and experienced psychological distress, described how providers took time to listen to their stories and advised them. Such counselling helped the patients to

overcome the pain of pregnancy loss. In some cases, the psychological support reportedly received was detailed information on pain associated with procedures such as MVA, which helped calm their fears. One patient explained how the information she received helped her prepare psychologically for the MVA, and overcome her fears and misconceptions.

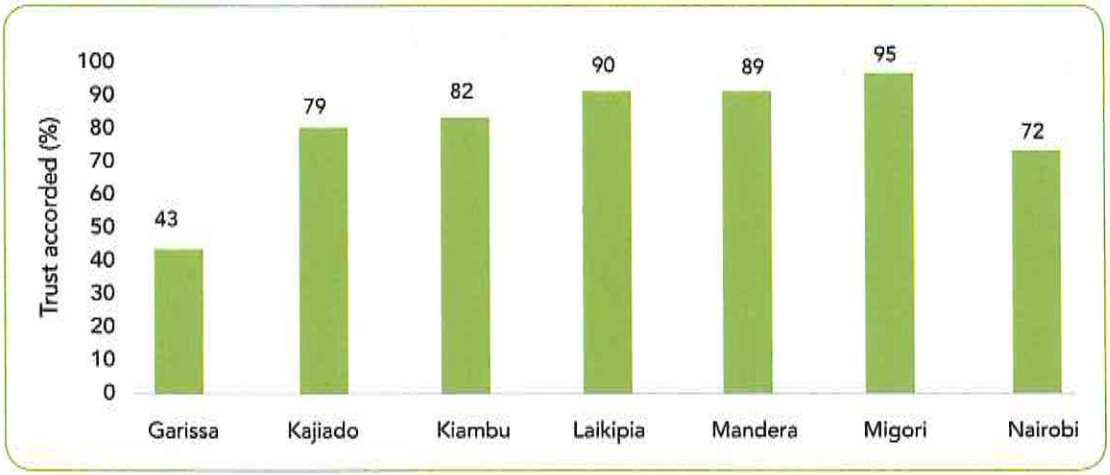
> *They gave me enough information and they would prepare me. Like the MVA, I really feared, because I had heard stories plus I was Googling when I was in the ward because you are scared, you have been told it's an incomplete abortion, you don't even know what it is. So, when they realized I was scared, they first told me what it entails and everything. So, I think they helped me overcome it by giving me information, like trying to teach me what treatment they were giving me. (23 years old, single, beautician, urban, Kiambu).*

It is worth noting that patients who received such counselling were mostly those who reported that they received respectful and friendly care. For patients who were suspected to have induced their abortions, their interactions with providers were largely characterized by tension and rudeness, devoid of supportive counselling.

Trust

Majority of PAC patients (78.1%) felt that they could trust the healthcare providers and expressed confidence in the care they received. This was more common among patients at primary level facilities (90.7%) compared to those in referral facilities (83.2%). By implication, the majority of patients who expressed lack of trust were from referral level facilities (Table 13). At county level, with the exception of Garissa, where only 43% of patients indicated that they trusted their providers, over 70% of PAC patients in the other counties felt that they could trust their providers (Figure 17).

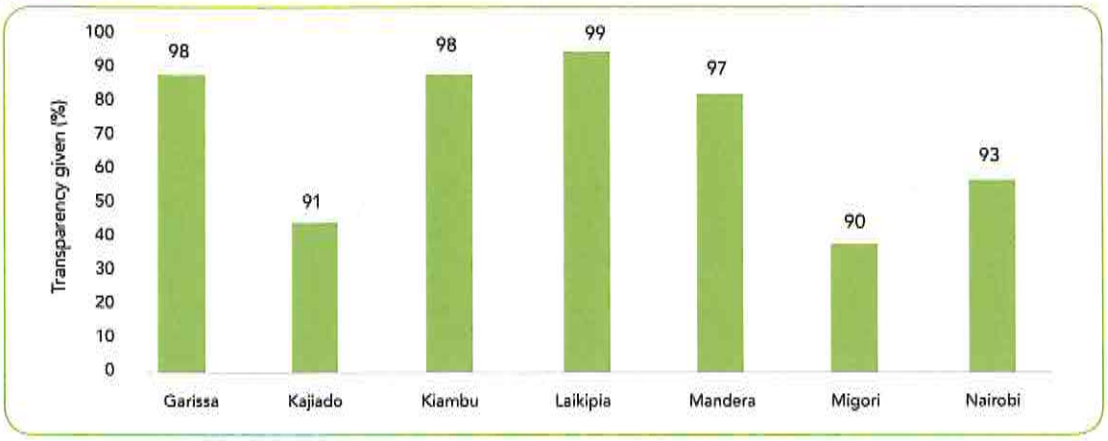
Figure 17: Trust by county



Predictability and transparency of payments

The vast majority of the patients in primary (89.5%) and referral (97.2%) level facilities stated that payments for PAC were transparent (Table 13). Most PAC patients (91.9%) in primary level and nearly all (97.8%) in referral level facilities reported that they had never been asked for a bribe to facilitate the care process. Considering the counties, most PAC patients felt the payments were transparent and predictable with less than one in every ten patients reporting lack of transparency and accountability (Figure 18).

Figure 18: Predictability and transparency of payments by county

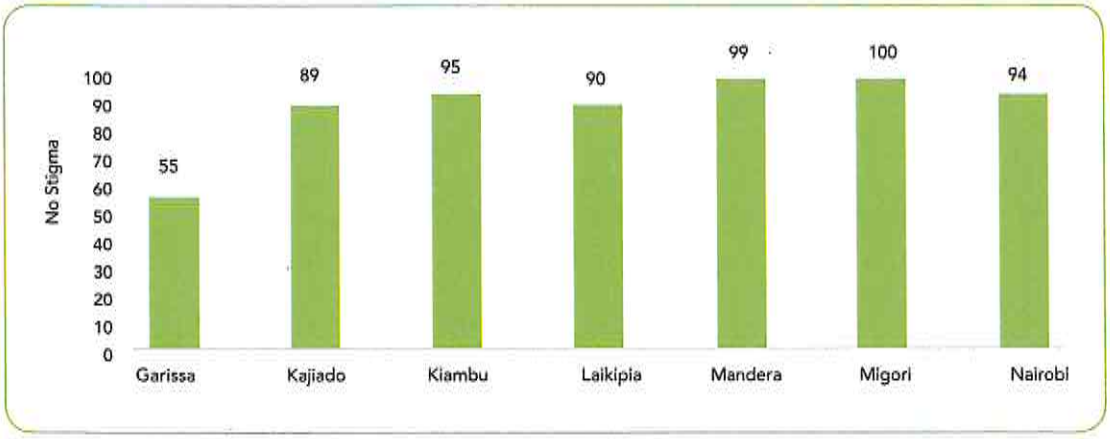


Stigma and discrimination

While the majority of PAC patients (89.5%) did not experience stigma and discrimination by health providers or other personnel during their stay in the facility, about 12.8% of patients in referral facilities experienced some form of stigma (i.e. being treated differently because of the type of abortion, or their personal attributes such as age and marital status), compared to only 1.8% in primary health facilities (Table 8).

The highest proportion of patients reporting that they had experienced stigma and discrimination cases was in Garissa, where 45.2% of reported that they experienced stigma (Figure 19).

Figure 19: Stigma and discrimination by county



Women reported experiences of being treated in a demeaning manner such as being shouted at or spoken to rudely, abused and threatened based on their personal attributes.This was aptly reflected when some PAC patients reported being sexually harassed. Patients felt that providers were intentionally acting or behaving in certain disparaging ways because of their conditions. A 19-year-old single PAC patient from one of the referral facilities in Nairobi County explained how she was mistreated right from the consultation to the treatment area:

> *When I got in there and was talking to the doctor, one of them was on Facebook just pressing the phone, another one was saying 'I cannot do that is difficult'; and then a young doctor came and gave me this injection. Though when he said he would help me, I waited for long. I was in so much pain and had to go to the bed all by myself. I cried but there was no doctor in sight. So I just had to*

cry there and hang on and fortunately the baby came and I pushed, so when the baby came, that lady shouted 'nurse come and help this girl'. That's when she came and told me to push, and she went back and she came and checked if I had pushed...You know, I waited for long. I do see that when a patient comes here, they are attended to fast but here when you come you are just made to wait out there and feel the pain. People were just...yes, people were many but not very many, and the person who was to help me was only with me and when I asked he told me that I am with you. So I don't know why he took so long. (19 years old, single house help, urban, Nairobi).

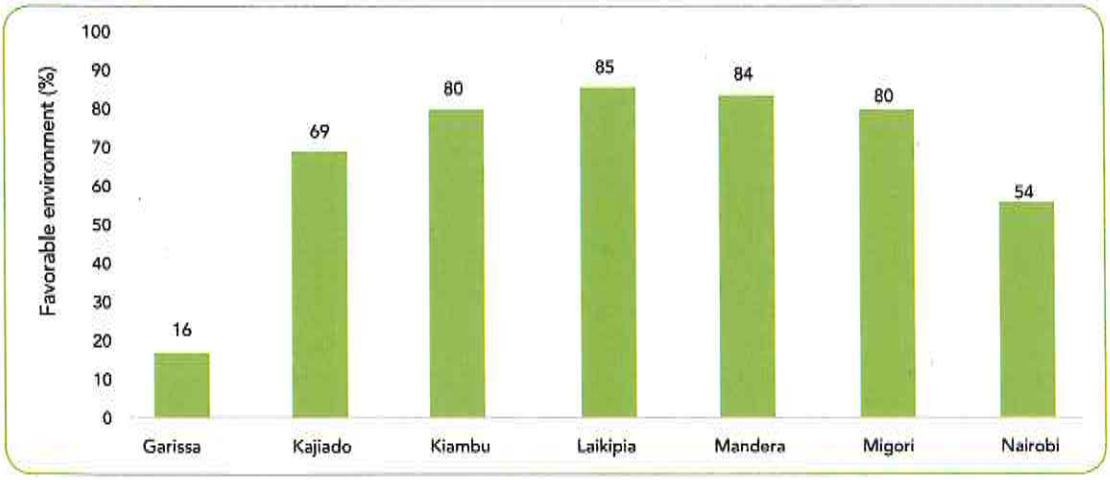
Nevertheless, there were reported instances where providers protected PAC patients from community driven stigma. During our health facility observations in Kajiado County, for example, a service provider tried to hide a PAC patient to protect both of them from community attack and humiliation arising from the perception about their having participated in an abortion procedure. In the follow-up discussion with that provider, he lamented about the extreme levels of stigma around abortion in the county, including against PAC providers. As a result, patients were reported to seek secret abortions and hiding any complications, resulting in delays in seeking care. Providers were also noted to be afraid of handling PAC patients because community members (in most cases women) could raid the facility and attack or shame the patients and providers. According to one provider, high levels of stigma forced many women who could afford it to cross into Tanzania (across the border) to procure an abortion or seek treatment for post-abortion complications.

Health facility environment

Over 60% of the patients in the primary level facilities and 55.6% in referral facilities felt that the health facility environment was favorable (Table 13). Across all primary level facilities, 72.7% of women felt that there was enough space in the ward in which they were treated, whereas in referral level facilities only 58.3% stated the same. However, only 8.7% of patients in primary facilities considered the general environment to be clean compared to 25.8% in referral level facilities. About the same proportion of patients at both levels (primary: 80.2% and referral: 81.6%) reported that the facilities had electricity. Also, 71.5% and 68.8% of patients in primary and referral levels respectively indicated that the facility had a tap and running water.

Across the counties, the majority of PAC patients felt that the health facility environment was favorable. However, four in five (83.7%) PAC patients in Garissa indicated that the facility environment was unfavorable. In Nairobi County, (45.7%) of the patients considered the environment unclean (Figure 20).

Figure 20: Facility environment by county



Overall, qualitative interviews and observations suggested that the physical environment of most health facilities was favorable. Nevertheless, patients recalled certain cases where wards were crowded, especially in referral facilities, and where patients had to share hospital beds. They also spoke about facilities without specific MVA rooms and where patients were treated together with others.

Observations also highlighted instances where patients' histories were collected in open spaces where other patients could listen in. In such situations, PAC patients requiring emergency care (especially those having induced abortion) could omit abortion complications from their histories or go into hiding in the facility until some confidentiality could be assured. This increased waiting times with potentially detrimental effects on outcomes.

Some patients also complained about the poor state of hospital sanitation especially toilets and bathrooms. In most cases, the toilets were very dirty especially in crowded facilities, while others were blocked. In certain facilities with dirty toilets some patients opted to use bathrooms to urinate, pushing others to avoid bathing there for fear of potential infections. A respondent from Kiambu County narrated:

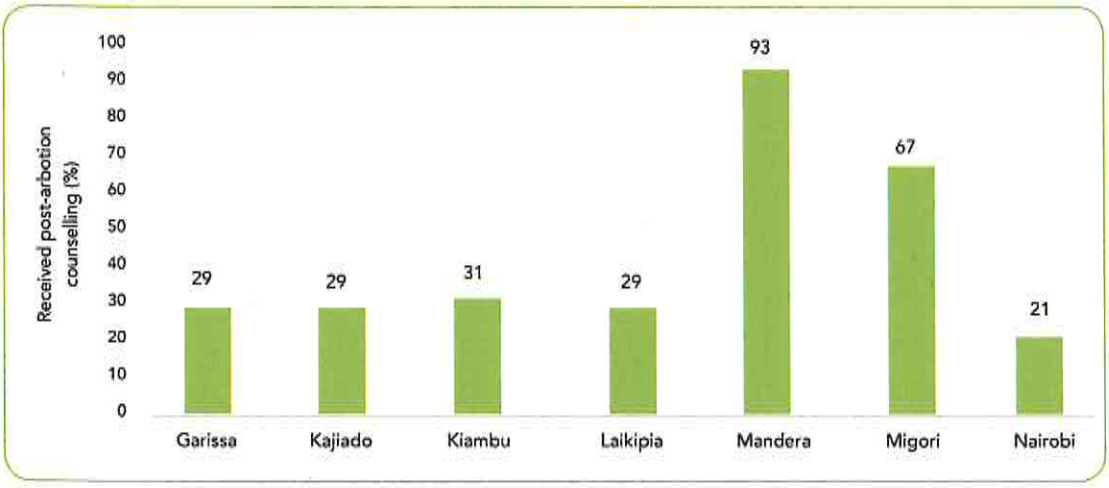
> *Wards are clean but the toilets are not clean and even the bathrooms. Since I came here I haven't gone to the toilets, they are dirty, they don't scrub the floor and you know there are patients who urinate there (bathrooms). It's because the toilets are dirty, they urinate in the bathroom to avoid infections from the toilet and you avoid taking bath in the bathroom to avoid infections. (28 years old, married, unemployed, Kiambu).*

Post-abortion contraceptive counselling

About three in every five patients (60%) were not offered post-abortion contraceptive counselling as part of PAC services. A greater proportion of patients in referral hospitals (66.5%) than in primary level facilities (31.6%) did not receive post-abortion counseling (Table 13).

At county level, contraceptive counselling was very low in five of the seven counties: Nairobi (21.3%), Garissa (28.8%), Kajiado (28.8%) and Laikipia (28.9%) and Kiambu (31%). Mandera county had the highest contraceptive counselling provision with nine in ten (92.9%) patients receiving counselling before exiting the facility, followed by Migori where two in every three (67.4%) patients were counselled (Figure 21).

Figure 21: Provision of post-abortion counselling by county

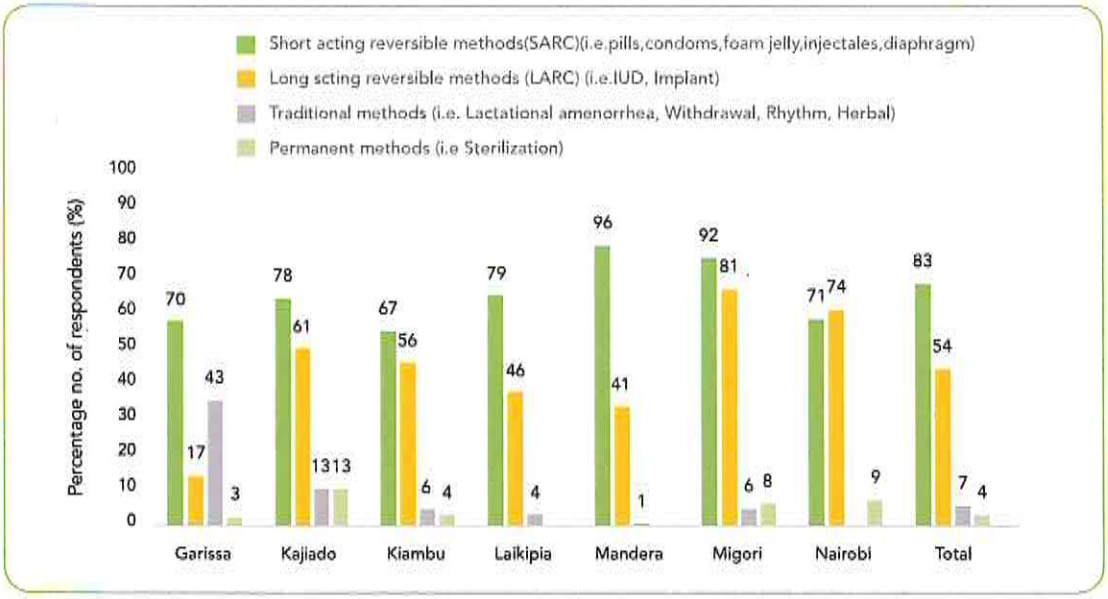


Among patients who received post-abortion contraceptive counselling, majority (83.2%) were informed about and/or offered short acting family planning methods (such as pills, condom, foam jelly, injectable, and diaphragm), while about half (53.9%) were informed about and/or offered long acting reversible methods (such as IUDs and implants). Less than 10% of women were informed about traditional (lactational

amenorrhea, withdrawal, rhythm and herbal) family planning methods (7.5%); and far less about long acting permanent methods (i.e., sterilization or tubal ligation) (4.2%).

Majority of PAC patients across all counties were offered short-term contraceptive methods, as opposed to long-acting methods, even though these were offered at high levels in Migori (81%), Nairobi (74.3%) and Kajiado (60.9%) (Figure 22).

Figure 22: Contraceptive methods offered (by counties)



Few patients who participated in the in-depth interviews reported that they had received post-abortion counselling before discharge. This is consistent with reports from the healthcare providers who indicated counselling was limited due to the unavailability of counsellors or lack of time. Moreover, patients who received counselling explained that healthcare providers mentioned family planning and the need to prevent future pregnancies without offering enough information on the type of methods available, their advantages and possible side effects depending on patients' future aspirations for parenthood. As a result, patients were unable to choose a method, because they had reservations about the side effects (e.g. infertility) and they left the facilities without a contraceptive method. Some patients also left the facilities without a contraceptive method because they were not accessible (either because the unit was closed or far from the ward where they were treated, patients did not have money to pay for it, or wanted to avoid stigma etc.).

In the case of participants treated using medical uterine evacuation, the counselling was done when they received the medical uterine evacuation (MUE) drugs, and they were supposed to receive contraceptives during the ensuing checkup visit (usually after one week). Two participants from Kiambu and Migori were given appointments to allow them to finish their medication:

> *They have told me that since they have given me drugs, I should come and join family planning on Monday. (24 years old, married, casual worker, urban, Kiambu).*

> *I didn't receive it but I was planning that when I heal I will come back. (22 years old, married, business-maize, rural, Migori).*

However, we followed up and it seems that none of them went back to the facility for subsequent check-ups and the contraceptives. Indeed, in the cases where abortion was induced and the patient went through difficult interactions with providers (i.e., police being called to threaten them), patients were reluctant to return for check-ups (including counselling).

Discussion

Capacity of public health facilities to offer quality PAC services

The study findings reveal that majority of primary and referral health facilities had relatively low capacity to deliver essential elements of PAC consistent with their respective level [20]. The greatest weaknesses were reported in Level 2, 3 and 4 facilities [9]. The main reasons for the limited capacity to deliver PAC services included unavailability of staff trained on PAC and the absence of functional PAC equipment, supplies and commodities. While referral facilities receive emergency cases from primary facilities, a considerable proportion of them lacked the essential equipment, commodities and supplies for the provision of PAC services. Moreover, primary facilities did not have adequate referral capabilities - in the form of ready transportation (vehicle with fuel or ambulance) for critical patients - which often compelled patients to arrange their own transport or self-refer themselves to higher level facilities. Such weaknesses in the referral system translate to delays in reaching and obtaining PAC, and creates gaps in key services such as post-PAC contraceptive counselling with implications for health outcomes. The few primary or referral facilities that reported having capabilities to deliver all PAC services are often overwhelmed and overcrowded with emergency cases, translating into long hours of work for providers, staff burnout and diminished quality of care to patients, and ultimately poor health outcomes [24].

Regarding staff availability and training, our findings showed that few facilities at the primary level had medical staff present for 24 hours daily. Further, the shift system also affected the continuous presence of trained staff. Consequently, various services such as MVA procedures, ultrasound scans, and contraceptives were not offered 24/7 across all levels of facilities. Limited operating hours means that patients may only be able to access such services on certain days or times per week, exposing them to delayed care, unnecessary referrals, severe complications, as well as a significant risk for unplanned pregnancies and repeat abortions due to lack of access to contraceptives.

Patients' experiences with post-abortion care

PAC patients' experiences revealed significant variations in the quality of care across the counties, and across health facility levels. Whereas most patients reported being treated with dignity and respect, a number of them felt the opposite. Cases of long waiting hours, complex referral chains, provider hostilities, and sexual harassment were highlighted by several participants. Patients who reported disrespectful care and abuse felt that they were stigmatized because of their age or assumptions that they had induced the abortion.

These concerns were particularly prevalent in Garissa and Kiambu counties and may create mistrust and perpetuate feelings of stigma and discrimination among PAC patients. Patients confirmed that supportive care offered psychological healing to them, especially for those who experienced miscarriages. Concerns about privacy during examination and treatment as well as worries about the confidentiality of patients' health information were also highlighted. These concerns seemed more pronounced in referral facilities. The lack of privacy and confidentiality was compounded by the environment where services were delivered (crowded wards or open spaces, shared hospital beds, lack of specific MVA rooms leading to PAC patients being treated alongside others). Such situations increased the risk of abortion disclosure, pushing patients to hide their conditions and delay access to care. Consistent with prior evidence, the lack of privacy and confidentiality degrades the dignity of women and exposes them to the risk of stigma. The result is that some women shy away from health facilities, even when faced with severe abortion-related complications.

Based on in-depth interviews, some patients reported that decisions about treatment were made solely by providers, and patients were only informed about the treatment procedure to be undertaken with

no consideration for their concerns. This approach to care assumes providers have all the knowledge, and always have the best interests of patients. Drawing from studies on abortion stigma, the choice of treatment including technologies for uterine evacuations (i.e. medical abortion versus MVA) may perpetuate or mitigate the risks of stigma for patients. On the other hand, strengthening patients' roles in care decision making could potentially improve in-facility experiences for patients, influencing PAC health seeking behavior and reducing risks of obstetric violence [25].

The findings also revealed critical gaps in communication between PAC patients and providers. These gaps were more pronounced in referral facilities, perhaps because of the high patient volumes and limited number of providers. In such facilities, providers sometimes expressed negative and hostile attitudes and behavior towards PAC patients, especially those thought to have induced abortions. This in effect hindered communication. Some patients never understood the reasons why certain treatments or procedures were undertaken, and did not dare to ask questions because they feared the provider's reaction. Poor patient-provider communication is problematic, and limits patient's education regarding risks of unsafe abortion, PAC and contraceptive use. Poor patient-provider communication may translate into suboptimal adherence to treatment (especially where there are side effects) and other self-care measures.

The majority of PAC patients across the counties and facility levels did not receive post-abortion counseling and contraceptive methods before discharge. A core component of PAC services is counseling women on abortion, risks of abortion and contraception methods as well as guiding them to a preferred choice with the aim of preventing further unplanned pregnancies and repeat unsafe abortions. This gap may be blamed on stigma, involvement of police in the care process, lack of awareness, provider behavior, disintegration of services and patient flow arrangements in each facility that earmarks PAC counselling as the last stage of care before discharge, even as it is not compulsory and is somewhat detached from the treatment wards. There were significant missed opportunities among patients treated with MA drugs, who were discharged to complete their drugs at home, but failed to return for subsequent appointments during which counselling and contraceptives were supposed to have been provided. Considering that 45% of PAC patients had unplanned pregnancies, the lack of post-abortion counselling curtails opportunities to foster patients' awareness, promote uptake and use of contraceptives and prevent unsafe abortions.

Barriers to the provision of quality PAC services

Despite commitments made to ensure availability of PAC services, there are numerous impediments to provision of quality care. Using data drawn from multiple sources, three main categories of barriers to quality PAC services were apparent: structural challenges, facility-related factors and patients' experiences with care.

Structural-related challenges

The overall legal, political and cultural context of abortion in Kenya, makes availability and access to PAC controversial. While the Kenyan Constitution permits abortion to protect the health or life of a pregnant woman, abortion remains criminalized in the penal code. This inconsistency instils fear and confusion among providers and patients. The lack of clear policy guidelines from the Ministry of Health and the sudden withdrawal of PAC guidelines in 2013 (even though these have now been reinstated) further exacerbates the confusion, influencing provider behavior and practices (i.e. police involvement or prioritization of personal values). As such, without clear policies and guidelines, training of providers on PAC is inhibited, distribution of PAC supplies, commodities and equipment are not streamlined and facilities experience frequent stock outs as they are largely dependent on NGOs to fill these gaps.

Facility-related challenges

Facilities had very low capacity to deliver all or comprehensive PAC services or even some basic ones. The overall weak health system preparedness to address PAC complications was largely attributable to

an inadequate number of providers due to the low numbers who are trained on PAC as well as high staff turnover, lack of equipment, inadequate supply of commodities, and inadequate spaces for treatment that guarantee privacy. Also noted was the lack of PAC clinical protocols and patient flow charts to guide patients especially in obtaining services that have not been mainstreamed in delivery of PAC, such as post-abortion counselling. Improved clarity through PAC protocols may also spell out if and when an ultrasound scan is necessary during PAC, and establish the necessary infrastructure. Finally, a PAC service protocol would outline a clear referral process for PAC patients thus eliminating delays in care. Other challenges include high patient volumes and the disintegration of services in various facility departments and units.

Individual related barriers

At the individual level, stigma and personal values appear to be key barriers to both the delivery of and access to quality PAC services. Study findings revealed instances where providers' personal values made them deny care to patients and/or treat them differently especially those with induced abortions, which in turn prevented patients from seeking care or to delay doing so because of fear of stigma and confidentiality breaches. Negative provider attitudes have direct effects on the quality of care and can result in negative health outcomes. Efforts to improve provider attitudes through values clarifications training and other approaches could have long term benefits on patients' health and satisfaction.

Study Limitations

The study combines perspectives from both the health system and patients to examine the quality of post abortion care available in Kenya, and effectively including the structure and process components of healthcare provision. However, this study does not include the examination of patient health outcomes in assessing the quality of post-abortion care.

This study addresses three of the five essential components of post-abortion care , including treatment of incomplete and unsafe abortion complications, contraceptive and family planning services, and availability of reproductive and other health services. Also, the signal function component on the preparedness of health facilities did not assess counselling to identify and respond to women's emotional and physical health needs and concerns as well as community and service provider partnerships for prevention, mobilization of resources and ensuring that health services reflect and meet community expectations and needs. Nevertheless, the qualitative findings provide some insights on the type and content of counselling provided and forms of partnership for prevention of unsafe abortion and unintended pregnancies.

Policy Recommendations

The current analysis demonstrates that access to quality PAC is not fully guaranteed across all levels of public health facilities in Kenya. Further, a good number patients face varied experiences while seeking PAC, such as stigma and provider-hostility. To address the multiple gaps in PAC services – at the health system and facility levels – there is need for strong political will, strategic investment and research aimed at:

1. Upgrading the capacity of primary facilities to provide all essential PAC service components through training, availing infrastructure, equipment and supplies needed for PAC. This ensures access to PAC services for majority of women and girls who mostly visit primary healthcare facilities due to their proximity. This will limit PAC referrals to only the most severe cases and reduce delays in care, additional costs, risks of disclosure among others.

2. Updating PAC Clinical Guidelines, the PAC training curriculum, manual, and logbook for training and mentoring of healthcare providers. Increasing awareness of PAC guidelines among sexual and reproductive health actors nationwide is also critical.
3. Strengthening the supply chain of medical supplies for PAC, especially medical uterine evacuation (MUE) drugs and contraceptives
4. Establishing and strengthening resilient referral systems for post-abortion patients
5. Establishing distinct units for PAC services and improving PAC service organization within health facilities, with a focus on integration of various PAC services such as other reproductive health services and contraceptives into PAC services
6. Promoting task shifting and task sharing policies in the context of post-abortion care to address staff capacity and burn-outs
7. Ensuring full implementation of various policies and guidelines including the reinstated *'Standards and guidelines for reducing morbidity & mortality from unsafe abortion in Kenya'* among others
8. Strengthening community education about contraception and prevention of unsafe abortion as well improving access to PAC
9. Investing in values clarification and attitude transformation (VCAT) of healthcare providers

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RM-3

achael Mwikali on Twitter: ".@MOH_Kenya & Team .@Stephen_Kaliti,you have decided to deny me access to this meeting that we had been resisting.We Grassroots women protested against the Launch o...

https://twitter.com/rachaelmwiks/status/1534093254383349760/photo/1

1 2 10

Rachael Mwikali
@rachaelmwiks

.@MOH_Kenya & Tea
@Stephen_Kaliti,you
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women & problematic
Reproductive Health I
2020-2032...
@AmnestyKenya .
@UNFPAKen .
@mutahikagwe_cs

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2 Retweets 10 Likes

Tweet your reply

314

NW3

mai ha! National AIDS Control Council

HOME ABOUT NACC

END TRIPLE THREAT CAMPAIGN

#EndTripletThreat #KomeshaMimbazaUtotoni

This is Exhibit marked "RM-4" referred to in the Annexed affidavit/Declaration of Rachael Mumbi Sworn/Declared before me on this 8th day of September 2022 at Nairobi in the Republic of Kenya

Commissioner for Oaths

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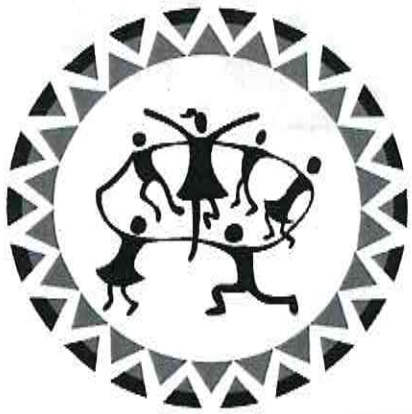


END TRIPLE THREAT CAMPAIGN

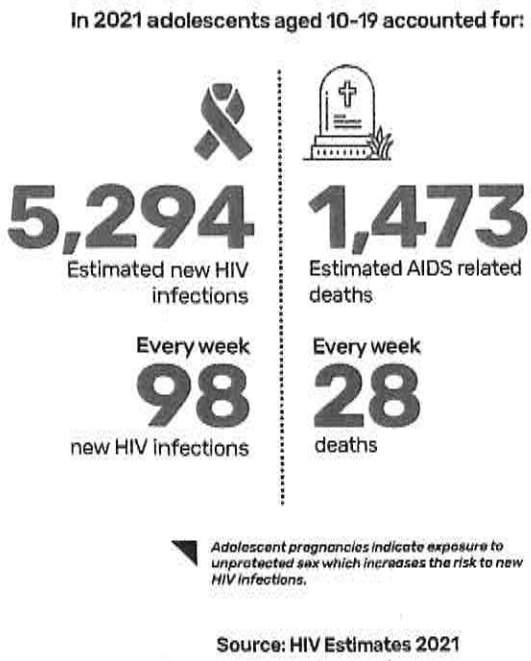
1. New HIV Infections

2. GENDER-BASED VIOLENCE

3. ADOLESCENT PREGNANCIES

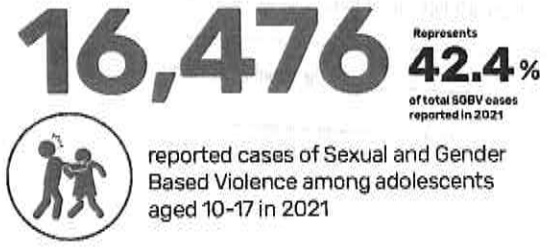
INTRODUCTION

(NCPD) have partnered with National Government Administration Officers (NGAO), other government entities, and implementing partners to develop and implement strategies for eliminating the triple threat; sexual gender-based violence, pregnancies and HIV among adolescents and young people.



1. HIV

HIV remains a major public health threat for adolescents and young people in Kenya. Globally, HIV is among the leading causes of death among adolescents. Moreso, an estimated 98 new HIV infections occur every week among adolescents aged 10-19 in Kenya.



2. SEXUAL AND GENDER-BASED VIOLENCE

Sexual and gender-based violence refers to any harmful act that is perpetrated against a person's will and is based on gender, norms, and unequal power relationships Of these, 5,890 (36%) were provided with Post Exposure Prophylaxis (PEP) to prevent HI infection, out of whom 236 (4%) acquired HIV. Additionally, 1,665 of these adolescents reported being pregnant 4weeks after exposure to SGBV.

of all pregnancies were among adolescents aged **10-19**

Source: KHIS (MoH 711-ANC)

3. ADOLESCENT PREGNANCIES

In Kenya, almost 1 out of 4 women give birth by age 18 and nearly half by age 20. One in every five adolescents aged 15-19 are already mothers or pregnant with their first child. (KDHS,2014) In 2021, the country recorded a total of 316,187 adolescent pregnancies. Of these, 294,364 pregnancies were among girls aged 15-19 while those aged 10-14 contributed to 21,823 (7%) of the total adolescent pregnancies.

WHAT IS THE TRIPLE THREAT IN ADOLESCENTS?

Kenya has made significant investments to ensure adolescents and

IMPACT OF THE TRIPLE THREAT ON POPULATION AND DEVELOPMENT

based violence threaten this progress.

Adolescent pregnancy infringes on a young person's fundamental rights to education Increasing new HIV infections among adolescents impedes ending AIDS as a public health threat in the country. Sexual violence increases the risk of both HIV infection and pregnancy Sexual violence threatens a young woman's agency to negotiate for sex and safer sex, increasing her risk of HIV infection, unintended pregnancy, and other negative health and socioeconomic outcomes Adolescent pregnancy may be an indication of harmful cultural practices such as Female Genital Mutilation (FGM) and child marriage which infringe on basic human and child rights

infections and related complications, poor health outcomes such as the risks of

2. Adolescent mothers diagnosed with HIV must cope with the mistimed pregnancy, HIV diagnosis, and initiation to lifetime treatment during antenatal care.
3. Young mothers living with HIV also have poor outcomes in preventing the mother-to-child transmissior continuum of services.
4. Perpetuate poverty at famil societal, and national levels with a increased burden on socic services, such as healthcare and education.
5. Adolescent pregnancy leads to interrupted educational attainment and opportunities leading to loss of economic opportunities.
6. Violence infringes on child an human rights while narrowing opportunities for women and girls to participate in the country's development meaningfully.

TRIPLE THREAT COUNTY EDITIONS

Let's join hands to end the Triple Threat among teenagers, young women, urges PS Mochache

KM4

NOTHING FOR US WITHOUT US! STOP THE LAUNCH OF THE REPRODUCTIVE HEALTH POLICY 2022

PETITION TO DR. STEPHEN KALITI, HEAD OF DIVISION OF REPRODUCTIVE HEALTH IN THE MINISTRY OF HEALTH

This is Exhibit marked KM4 referred to in the Annexed affidavit/Declaration of Rachael Mwikali
Sworn/Declared before me on this 21st day of March 2022
at Nairobi in the Republic of Kenya
Commissioner for Oaths

We, the undersigned individuals:

Concerned about the upcoming launch of the Reproductive Health Policy 2022 – 2032 without the input of grassroots communities, and excluding our sexual and reproductive health priorities;

Angered by the stigmatizing language used against adolescent sexual and reproductive health, people outside the traditional family unit and survivors of sexual violence;

Aware of the Constitution of Kenya that provide the right to public participation, thereby guaranteeing the right of citizens to be consulted in any and all decisions that affect them;

Informed about our right to the highest attainable standard of health including reproductive health, and the circumstances when we can access lawful abortions;

Demand that the Ministry of Health urgently stops the launch of the Reproductive Health Policy 2022 – 2032

Call on the general public to come together and demand for meaningful and adequate public engagement in the development of the Reproductive Health Policy

Call on the Ministry to restart the validation of the Reproductive Health Policy to include the voices of grassroots communities

Urge the Ministry of Health to ensure that all critical sexual and reproductive health needs, including for the most vulnerable and marginalized, are covered under the Reproductive Health Policy.

Coalition for Grassroots Human Rights Defenders CBO.
- Rachael Mwikali - chairperson.
Mwikali. mwikali@gmail.com
+254723764748.

MINISTRY OF HEALTH RECEIVED 21 MAR 2022 ADMINISTRATION P.O. Box 30016 - 00100, NAIROBI

Marylize Biubwa
Bi Kind Initiative
0718 294 276
candylize@gmail.com

MINISTRY OF HEALTH RECEIVED 22 MAR 2022 ADMINISTRATION P.O. Box 30016 - 00100, NAIROBI

Ruth Mumbi
0722 354-195
Mumbiruth@gmail.com

RM 5

This is Exhibit marked "KM-5" referred to in the Annexed affidavit/Declaration of Rachael Mukami Kaliti
Sworn/Declared before me on this 23 day of March 2022 at Nairobi in the Republic of Kenya
Commissioner for Oaths

MINISTRY OF HEALTH

Telegrams: "RMHEALTH", Nairobi
Telephone: 725105/6/7/8
All correspondence to: Head DRMH, MOH,
Email: dr.kaliti@gmail.com/ headrmhke.moh@gmail.com .

DIVISION OF REPRODUCTIVE & MATERNAL HEALTH
OLD MBAGATHI ROAD, MTC GROUNDS
P.O.BOX 43319
NAIROBI

18th April 2022

Dear Valued Reproductive Health Policy: Stakeholder/ Duty bearer/Advocate

REF: INVITATION TO THE REPRODUCTIVE HEALTH POLICY DRAFTING WORKSHOP ON 25TH APRIL TO 29TH APRIL 2022 AT PRIDE-INN FLAMINGO RESORT IN SHANZU MOMBASA

Easter greetings from the MOH,

Kenya has been in the process of developing a National Reproductive Health Policy since 2015. This policy making process has spanned multiple years and a broad array of stakeholder engagements across the country in an effort to reflect the aspirations of Kenyans on matters Reproductive health in compliance with the Constitutional requirement for public participation in public policy making.

The last such event in this process was an inclusive participatory public engagement meeting held on 06th April 2022 at The Emory Hotel in Nairobi, during which public submissions to improve the policy were made. In this this meeting, additionally ,you were identified as possessing the requisite expertise and mandate to represent your constituency of ideals in considering the various submissions made with respect to this policy for technical inclusion into the final draft policy. The sole motivation of this activity is to give Kenyans a befitting policy direction that will guide investments on matters reproductive health for the next decade without leaving no one behind.

It is thus my pleasure to invite you to this policy writing workshop to be held at the Pride-Inn **Flamingo resort** in Shanzu **Mombasa** from **25th April 2022 to 29th April 2022**, with travel dates of 24th April 2022 and 30th April 2022.

If you are not affiliated to a sponsoring organization, a Nairobi-Mombasa return flight and reasonable accommodation on half-board near the workshop venue will be provided. In addition to flights, Government officers will be on DSA as per Government policy. A conference package that includes lunch and two beverage snack breaks will be provided for all. Please note that this is an individual **invitation** and **not transferable**.

Sincerely,

Dr Stephen Kaliti, HEAD DRMH -MOH.

REPUBLIC OF KENYA

IN THE HIGH COURT OF KENYA AT KIAMBU

CONSTITUTIONAL PETITION NO. OF 2022

IN THE MATTER OF ARTICLES 10(1) & 10 (2)(a), 19, 22, 23, 26 (1) & (4), 27, 33, 35, 43 (1(a)), 53 (1(c)) AND 232 (1(d)) OF THE CONSTITUTION OF KENYA, 2010

AND

I IN THE MATTER OF ARTICLES, 22, 23, 34 AND 35 OF THE EAST AFRICAN COMMUNITY HIV & AIDS PREVENTION AND MANAGEMENT ACT

AND

IN THE MATTER OF SECTIONS 5, 6, 7, 15 AND 68 OF THE HEALTH ACT, 2017

AND

IN THE MATTER OF SECTION 16(2), (3) & (4), 28(3), 146 AND THE FIRST SCHEDULE OF THE CHILDREN ACT NO. 29 OF 2022

AND

IN THE MATTER OF SECTION 6 AND 7 OF THE SCIENCE TECHNOLOGY AND INNOVATION ACT NO. 28 OF 2013

AND

IN THE MATTER OF SECTION 4 AND 5 OF THE ACCESS TO INFORMATION ACT NO. 31 OF 2016

AND

IN THE MATTER OF THE PUBLIC SERVICE COMMISSION GUIDELINES FOR PUBLIC PARTICIPATION IN POLICY MAKING (2015)

AND

IN THE MATTER OF THE NATIONAL REPRODUCTIVE HEALTH POLICY 2022-2032

BETWEEN

RACHAEL MWIKALI.....1ST PETITIONER

ESTHER AOKO.....2ND PETITIONER

AMBASSADOR FOR YOUTH & ADOLESCENT

REPRODUCTIVE HEALTH PROGRAMME (AYARHEP).....3RD PETITIONER

KENYA LEGAL AND ETHICAL

322

ISSUES NETWORK ON HIV & AIDS.....4TH PETITIONER

VERSUS

CABINET SECRETARY

MINISTRY OF HEALTH.....1ST RESPONDENT

THE ATTORNEY GENERAL.....2ND RESPONDENT

AND

KENYA OBSTETRICAL GYNAECOLOGICAL SOCIETY..... 1ST INTERESTED PARTY

KATIBA INSTITUTE .....2ND INTERESTED PARTY

CERTIFICATE OF AUTHENTICITY

(Under Section 78 and 106B of the Evidence Act Cap. 80 of the Laws of Kenya)

I, **NYOKABI NJOGU**, of **P.O.BOX 112 – 00202, Nairobi**, a female Kenyan adult of sound mind residing and working for gain in Nairobi County within the Republic of Kenya, who has conduct of this matter on behalf of the petitioners herein do hereby make a solemn oath and state as follows;

1. I am an advocate of the High Court of Kenya practicing as such at the Kenya Legal and Ethical Issues Network on HIV and AIDS (KELIN), the 4th Petitioner herein and thus competent to swear this affidavit.

2. On 7th September 2022 while drawing the affidavit of the 1st Petitioner herein, I used my laptop to take a screen shot of a tweet by the 1st Petitioner dated 7th June 2022 from the 1st Petitioner's twitter page at 14:37 pm. This screen shot is annexed to the affidavit of the 1st Petitioner and marked "**RM6**".

3. I took the screenshot using my laptop (Model-MAC BOOK PRO and serial number C02T856SFVH3) which was in good working condition and operated and performed the actions described above seamlessly and without any technical difficulties.

4. At the time of my use, the laptop and printer which I used to access and print the information were both functioning correctly to the best of my knowledge.

5. I also used my laptop to download a video of the protest that took place on the 22nd March 2022 from the National Television Kenya (NTV) YouTube page. I stored the video on my laptop and later transferred it to the flash disk which is annexed to the 1st Petitioner's Affidavit and marked **"RM-3".**

6. I dowloaded, stored and transfered the video using my laptop which was working in good condition and operated and performed the actions described above seamlessly and without any technical difficulties.

7. I therefore certify that the video and video link I have produced before this court are authentic.

CERTIFIED at **NAIROBI** this ....8th..... day of ...September.....2022

By the said

NYOKABI NJOGU

DRAWN & FILED BY:-

Nyokabi Njogu and Gaudence Were, Advocates,
C/O KELIN
Kuwinda Lane, off Langata Road, Karen C
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REPUBLIC OF KENYA

IN THE HIGH COURT OF KENYA AT KIAMBU

CONSTITUTIONAL PETITION NO. OF 2022

IN THE MATTER OF ARTICLES 10(1) & 10 (2)(a), 19, 22, 23, 26 (1) & (4), 27, 33, 35, 43 (1(a)), 53 (1(c)) AND 232 (1(d)) OF THE CONSTITUTION OF KENYA, 2010

AND

I IN THE MATTER OF ARTICLES, 22, 23, 34 AND 35 OF THE EAST AFRICAN COMMUNITY HIV & AIDS PREVENTION AND MANAGEMENT ACT

AND

IN THE MATTER OF SECTIONS 5, 6, 7, 15 AND 68 OF THE HEALTH ACT, 2017

AND

IN THE MATTER OF SECTION 16(2), (3) & (4), 28(3), 146 AND THE FIRST SCHEDULE OF THE CHILDREN ACT NO. 29 OF 2022

AND

IN THE MATTER OF SECTION 6 AND 7 OF THE SCIENCE TECHNOLOGY AND INNOVATION ACT NO. 28 OF 2013

AND

IN THE MATTER OF SECTION 4 AND 5 OF THE ACCESS TO INFORMATION ACT NO. 31 OF 2016

AND

IN THE MATTER OF THE PUBLIC SERVICE COMMISSION GUIDELINES FOR PUBLIC PARTICIPATION IN POLICY MAKING (2015)

AND

IN THE MATTER OF THE NATIONAL REPRODUCTIVE HEALTH POLICY 2022-2032

BETWEEN

RACHAEL MWIKALI.....1ST PETITIONER

ESTHER AOKO.....2ND PETITIONER

AMBASSADOR FOR YOUTH & ADOLESCENT

REPRODUCTIVE HEALTH PROGRAMME (AYARHEP).....3RD PETITIONER

KENYA LEGAL AND ETHICAL

ISSUES NETWORK ON HIV & AIDS.....4TH PETITIONER

VERSUS

CABINET SECRETARY

MINISTRY OF HEALTH.....1ST RESPONDENT

THE ATTORNEY GENERAL.....2ND RESPONDENT

AND

KENYA OBSTETRICAL GYNAECOLOGICAL

SOCIETY..... 1ST INTERESTED PARTY

KATIBA INSTITUTE .....2ND INTERESTED PARTY

2ND PETITIONER'S AFFIDAVIT IN SUPPORT OF THE PETITION

I, **ESTHER AOKO,** a female adult Kenyan of sound mind residing and working for gain in Nairobi County within the Republic of Kenya do hereby make oath and state as follows;

1. I am a twenty one year old community organizer based in Dandora, sexual and reproductive health and rights advocate and comprehensive sexuality education trainer. I am the 2nd Petitioner herein.

2. I fully understand the issues in question and I further adopt the contents of the Petition filed herein as if the same were set out *seriatim.*

3. By virtue of the work that I am engaged in, I interact with many young girls and young women seeking various sexual and reproductive health services. I am

aware and have been part of civil society engagement in advocating for provision of sexual and reproductive health and services, particularly for young girls and young women.

4. I am aware that since 2021, the Ministry of Health has been engaged in a process to review its policies, but it has done so without engaging any members of the community. By a letter dated 1st March 2022, the Ministry of Health indicated that its Division of Reproductive and Maternal Health had in collaboration with partners revised several reproductive health documents and the next steps would be to print, launch and disseminate the documents at the national and county levels to facilitate subsequent implementation within various reproductive health programmes. It did not mention who these partners were. ***(A copy of the letter dated 1st March 2022 is attached and marked as EA-1)***

5. The letter further indicated that the national launch was tentatively scheduled for 23rd March 2022.

6. I had to the best of my knowledge never heard of the development of the said policy, neither was I invited as a human rights defender and member of the public to take part in a meaningful public participation process on the formulation, development and launch of the policy.

7. I was concerned about the lack of community involvement on development of the policy, and efforts to get a draft of the policy that was intended to be launched on the 23rd March 2022 were not fruitful.

8. On 22nd March 2022, I attended a protest led by the 1st Petitioner and attended by other community members. During that protest, we headed to the offices of the Ministry of Health at Afya House to deliver a petition to the Ministry of Health

demanding community involvement in the formulation and validation process of the policy to the Ministry of Health offices.

9. On 31st March 2022, the Ministry of Health later issued an invitation to a deliberation meeting on the reproductive health policy on 6th April 2022. ***(A copy of the invitation is attached herein and marked EA2)***

10. I attended the meeting of 6th April 2022 which was held at Emory Hotel in Kileleshwa in Nairobi. During that meeting various participants, including one from the Kenya National Commission on Human Rights noted that they were unaware of the policy and asked to be included to aid the Ministry of Health in knitting a rights-based approach in the policy, particularly including global and regional conventions, treaties and commitments in the guiding framework and aligning definitions.

11. During that meeting, various participants from civil society highlighted that the draft policy had various missing interventions which would be detrimental to health care provision for women and girls.

12. The persons presiding over the meeting from the Ministry of Health indicated that they would invite all stakeholders for a drafting workshop where all views would be considered.

13. I later received an invitation from the Ministry of Health on 18th April 2022 to attend a reproductive health policy drafting workshop on 25th April 2022. ***(A copy of the invitation is attached and marked as EA3)***

14. I attended the drafting workshop that was held between 25th April and 29th April 2022 at Pride Inn Flamingo Resort in Mombasa. During this workshop, participants made various contributions on the retrogressive policy direction that the draft policy

contained. I personally made contributions on the complete lack of adequate policy direction on access to contraceptives for young women, the lack of access to reproductive health services for adolescents and young women as well as the unjustified increase of age during which adults could access contraception.

15. Various other civil society actors made contributions that if adopted, would ensure that the Ministry would be facilitating access to sexual and reproductive health for all women and girls. ***A copy of the recommendations made by civil society actors is annexed hereto and marked EA4)***

16. The drafting process concluded on 28th April 2022 and the representatives from the Ministry of Health and the participants agreed that the Ministry would consider and incorporate the suggestions given and share the updated draft reproductive health policy version together with the matrix of comments and responses and host a validation meeting. The draft policy was to be shared with participants as they left on 29th April 2022.

17. To my surprise the Ministry of Health neither shared the updated draft reproductive health policy nor the matrix of comments for the participant's review, records, and comments.

18. Instead, the next communication that I received from the Ministry of Health was, on 28th June 2022, when an invitation for a validation meeting on the policy which was scheduled to be held on 1st July 2022. This was just two working days to the validation meeting and the invite was without me or any other person at the drafting workshop having received the updated draft reproductive health policy nor the matrix of comments. ***(A copy of the invitation is annexed hereto and marked as EA5).***

19. I attended the meeting of 1st July 2022. Due to the short notice given by the ministry and considering that the ministry had not provided the policy that was to be validated, I was unable to meaningfully and interactively participate in the validation workshop of 1st July 2022.

20. The validation meeting of 1st July 2022 was not participatory and was simply a dress-down from one Dr. Stephen Kaliti head of the Division of Maternal and Reproductive Health who refused to share the draft policy and harshly criticized the civil society for demanding an open and fair process.

21. Those of us present tried to reason with Dr Kaliti to no avail, which forced us to walk out of the meeting as he would not listen to our concerns or even give us a copy of the draft as it was then.

22. On 5th July 2022, the 1st Respondent launched the National Reproductive Health Policy 2022-2023. I did not attend this launch.

23. After receiving a copy of the Policy, I am concerned that the Policy uses language that results in denying health care interventions to women and girls by excluding any person not in a marriage and providing contraceptive care alternatives to only couples that have had children.

24. Further the policy only focuses on provision of contraception services only for married women. ***The policy's preamble on family planning (3.4.2 To reduce unmet family planning needs on page 23)*** focuses on the provision of family planning for couples that have achieved their desired family sizes to the exclusion of the rest of the population of persons of reproductive age.

25. The bias towards families to the detriment of the rest of the population of

reproductive age is further indicated at ***4.2.3 paragraph 6 of the policy (page 38)*** where it is indicated that the policy recognizes the central role of the family in reproductive health and that this shall be reflected in reproductive health interventions; as well as the description of the key components in service delivery and standards to include responsiveness to social values ***(page 39).***

26. The policy further excludes adolescent women and young girls from benefiting from reproductive health services and commodities as it envisages the provision of cervical cancer screening services for women between 25-49 years to the exclusion of other age groups ***(2.3.7 on cancers of reproductive organs at page 15 of the policy).***

27. Additionally, the policy limits interventions from healthcare workers in regard to access to safe abortion. This is especially so as the policy provides that termination of pregnancy shall be performed guided by the opinion of a trained health professional with the proficiency to ensure both the mother and unborn child receive the highest attainable standard of healthcare ***(policy thrust 3.4.1 to reduce maternal, perinatal and neonatal morbidity and mortality paragraph 12 at page 23 of the policy).***

28. Further, healthcare interventions under the policy exclude young women below 21 years as they are not guaranteed access to reproductive health services on the basis that they have "not attained full cognitive competence on matters of sexuality and reproduction." ***(overarching policy statement at page 19 of the policy).*** Under ***3.4.8 paragraph 1 of the policy on page 25***, it is further indicated that a person attains complete full cognitive competence on matters of sexuality and reproduction at the age of 21 and that the government will prioritize abstinence and delayed sexual debut for persons yet to attain full cognitive competency.

29. The policy direction in provision of services or the push to move the age of majority from 18 to 21 years is without any scientific basis or evidence leaving young adult women between the ages of 18 and 21 with policy interventions that do not adequately meet their sexual and reproductive needs yet they have the legal capacity to make informed decisions on their sexual and reproductive health; and to access those services and commodities
30. It also fails to consider that by requiring parental consent, adolescents and young persons may face hardships in getting parental or guardian's consent. ***(3.4.8 paragraph 8 of the policy on access to reproductive health services for children at page 26 of the policy)***

31. This provision further limits the ability of health care workers to provide services to adolescents based on their evolving capacities and needs by requiring parental consent for health care services.

32. This policy direction does not reflect the reality of women and girls in Kenya, where the Ministry of Health has stated that between January and February 2022, they handled 45,724 cases of pregnant adolescents aged between 10 and 19 years. It has further revealed that 2,196 cases of Sexual and Gender Based Violence were registered among adolescents aged between 12 and 17 years. This is an indication that there is need to ensure that adolescents and young people receive adequate reproductive health interventions to reduce the rate of teenage pregnancies. The 1st Respondent through the National Aids Control Council has indicated that in 2021, the country recorded a total of 316,187 adolescent pregnancies. Of these, 294,364 pregnancies were among girls aged 15-19 while those aged 10-14 contributed to 21,823 (7%) of the total adolescent pregnancies. In fact, even in the Reproductive Health Policy at clause 2.3.4 on page 12, the 1st Respondent acknowledges that at least 25% of girls give birth before the age of 18, and that there has been a failure to develop a dignified transition which has caused reproductive health challenges.

(Annexed hereto and marked EA6 are bundle of newspaper reports with as well as the statistics from the National AIDS Control Council demonstrating this.)

33. This demonstrates that adolescents and young girls continue to be vulnerable to violence and there is a complete lack of access of sexual and reproductive health services including information and services to ensure that further harm does not occur.

34. Additionally, the policy excludes unmarried women from fertility treatment; thereby denying them access to reproductive rights and options that are unrestricted for married women. Under the policy's **broad objective 2 on improving responsiveness to client's reproductive health needs (page 21 of the policy),** it is indicated as a sub-objective (v) as to reduce the magnitude of infertility and increased access to management of infertile couples. Under ***3.4.11 paragraph 5 of the policy (page 28),*** it is expressly indicated that there shall be full financing of at least one cycle of assisted fertility treatment but the same is limited to "needy desirous couples," thus limiting the treatment for couples only.

35. The need for alignment of laws and policies on sexual and reproductive health services to the Constitution is one of the ways through which the rights of women and girls can be respected. The continued implementation of the Policy will stand in the way of reproductive health care for women and girls.

36. Given the foregoing, and in the interest of safeguarding the constitutional rights of reproductive health and the lives of the people of Kenya, I pray that this Honourable Court to grant the orders set out in Petition.

31. What is deponed to herein is true to the best of my knowledge, information and belief, save for information whereof sources of information have been disclosed.

SWORN at **NAIROBI** by the said)
This 8th day of September 2022)
ESTHER AOKO) _____
) DEPONENT

BEFORE ME)
WYCKLIFE O. OYOO
Advocate & Commissioner for Oaths
KAPLAN & STRATTON
P.O. Box 40111 - 00100
NAIROBI)
COMMISSIONER OF OATHS)

DRAWN & FILED BY:-

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The Honourable Attorney General
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Kenya Obstetrical Gynaecological Society
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Katiba Institute,
The Crescent, House No. 5
Off Parklands Road
P.O. Box 26586 -00100
Tel: +254 704 594962
Email: info@katibainsitute.org

This is Exhibit marked "Esther EA-1"
referred to in the Annexed affidavit/Declaration
of Esther Anko
Sworn/Declared before me on this 8th
day of September 2022
at Nairobi in the Republic of Kenya
Commissioner for Oaths

MINISTRY OF HEALTH

Telegrams:"FAMHEALTH",Nairobi
Telephone:Nairobi 725105/6/7/8
All correspondence should be addressed to the Head.
E-mail: headrmhke.moh@gmail.com
When replying please quote

DIVISION OF REPRODUCTIVE & MATERNAL HEALTH
MBAGATHI ROAD (OLD)
P. O. Box 43319
NAIROBI.

Ref: MOH/DRMH/RH GEN/8/VOL 1(22) 1st March 2022

Dear RH partner

RE: **REQUEST TO SUPPORT THE LAUNCH OF REPRODUCTIVE HEALTH DOCUMENTS**

The Division of Reproductive and Maternal Health (DRMH) is responsible for formulation of reproductive health policies, guidelines and standards, as well as providing technical support to counties on matters RH, to promote operationalization of the policies and standards of care.

The Division in collaboration with partners has revised several reproductive health documents. The next steps will be to print, launch and disseminate these documents at the national and county levels to facilitate subsequent implementation within various RH programs.

The National launch is **tentatively scheduled on 23rd March 2022.** The planning team has put together a plan with areas of support and budget estimates to ease decision making and execution. **The purpose of this letter is to request for your support on areas convenient to you as per the attached budget.**

Kindly confirm your support to the following officers;

1. **Mary Magubo, 0722885199** - **for Communication and Conference package**
2. **Mary Gathitu, 0720929059** - **for National and County Support**
3. **Hellen Mutsi, 0722778013** - **for Printing of the MNH documents**
4. **Clarice Okumu, 0722466583** - **for printing of FP documents**

Thank you for your continued support.

Dr. Stephen Kaliti, M.B.Ch.B, MMED (OBSGYN), MPH, FCOG (ECSA), HIA.
Head, Division of Reproductive Maternal Health

Encls.

This is Exhibit marked "
referred to in the Annexed affidavit/Declaration
of
Sworn/Declared before me on this
day of 20
at in the Republic of Kenya
Commissioner for Oaths

EA - 2

This is Exhibit marked "EA - 2" referred to in the Annexed affidavit/Declaration of Esther ASK Sworn/Declared before me on this 15 day of September 2022 at Nairobi in the Republic of Kenya
Commissioner for Oaths

MINISTRY OF HEALTH

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Telephone: Nairobi 729105/6/7/8
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To the Head,DRMH
E-mail:theadrmhke.moh@gmail.com
When replying please quote
When replying please quote

DIVISION OF REPRODUCTIVE & MATERNAL HEALTH
MBAGATHI ROAD (OLD)
P. O. Box 43319
NAIROBI

Ref: MOH/DRMH/RH GEN./8/VOL. 1 (42)

31st March 2022

Dear Reproductive Health Stakeholder/
Lead - Civil Society Organisation in Reproductive Health

RE: INCLUSION OF CIVIL SOCIETY INPUT, PUBLIC PARTICIPATION AND ALIGNMENT OF THE DRAFT KENYA REPRODUCTIVE HEALTH POLICY

Reference is made to the group civil society letters dated **05th October 2021** and **17th March 2022, as well as various communications** to the Ministry of Health (MOH) requesting for further inclusion of civil societies and more public participation in the drafting of the Reproductive Health Policy for the country. Your letter and concerns are noted and well received.

The Ministry of Health, in discharge of its constitutional mandate of spearheading policy formulation in matters health, has led the national formulation of a revised Kenya Reproductive Health Policy **since 2015.** This was necessitated by the lapse of the previous Reproductive Health Policy and a need to align with the Constitution of Kenya 2010 while assimilating new evidence on matters sexual reproductive health.

This Policy seeks to guide collective investments in key directions that scientifically and competently hold a promise to promote a healthy sexual and reproductive health for the Nation, while mitigating known and emerging challenges burdening the sexual and reproductive health of Kenyans.

While the policy formulation process has been extensively consultative and deliberate in ensuring **public participation across the country from 2018 through 2020**, it is commendable that you, an integral non-state actor in the Kenya Reproductive Health space, seek to further enrichen this participation by your considered inputs submitted variously to improve the policy.

With this level of fervor in holding the process accountable, Kenyans stand to gain immensely through robust informed culturally competent policies that will accelerate the country's attainment of the highest standard of reproductive health care. It is in the interest of the MOH to be as accommodative as possible, and to promote as wide ownership of this Policy as is feasible to facilitate smooth implementation by all stakeholders including the Civil Society.

To this end, the MOH grants your request to put on hold the launch of this Policy, and further invite you to publicly share and engage on the content of the draft Reproductive Health Policy, with an intention to deliberate on the submissions you have shared with a view to improving this Policy.

The purpose of this letter is thus to re-share with you the **enclosed draft National Reproductive Health Policy**, and specifically to invite you to this additional public iteration on this draft Reproductive Health Policy. The agenda of this meeting is to deliberate on the issues you have raised as well as make further oral submissions with a view to bringing this policy to a progressive common ground centered on the best reproductive health interests of the Kenyan citizenry.

Kindly avail yourself on **Wednesday 06th April 2022** at **The Emory Hotel** on Kandara Road, **Kileleshwa, opposite Kileleshwa Police Station** starting **07:30am Nairobi time.** Breakfast will be served and your conferencing will be catered for.

Get directions here: (https://goo.gl/maps/W6tNHZET9dHWuaQN7)

Sincerely,

Dr. Stephen Kaliti, M.B.Ch.B. MMED (OBSGYN), MPH, FCOG (ECSA), HIA.
Head, Division of Reproductive & Maternal Health

Encls

CC:

1. CS Health
2. PS Ministry of Health
3. Ag. Director General for Health
4. Ag. DMS/PPH
5. Head, Dept. of Family Health
6. H.E Martin Wambora, EGH, Chairperson, Council of Governors
7. Dr. Joyce Mwikali Mutinda, PHD, Chairperson National Gender And Equality Commission
8. Roseline Odede, HSC, Chairperson, Kenya National Commision For Human Rights
9. Hon. Florence Kajuju, MBS, Chairperson, Commission for Administrative Justice

EA'3

RMS

This is Exhibit marked "EA-3" referred to in the Annexed affidavit/Declaration of Esther ASIRO Sworn/Declared before me on this 8th day of August 2022 at Nairobi in the Republic of Kenya

Commissioner for Oaths

MINISTRY OF HEALTH

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DIVISION OF REPRODUCTIVE & MATERNAL HEALTH
OLD MBAGATHI ROAD, MTC GROUNDS
P.O.BOX 43319
NAIROBI

18th April 2022

Dear Valued Reproductive Health Policy; Stakeholder/ Duty bearer/Advocate

REF: INVITATION TO THE REPRODUCTIVE HEALTH POLICY DRAFTING WORKSHOP ON 25TH APRIL TO 29TH APRIL 2022 AT PRIDE-INN FLAMINGO RESORT IN SHANZU MOMBASA

Easter greetings from the MOH,

Kenya has been in the process of developing a National Reproductive Health Policy since 2015. This policy making process has spanned multiple years and a broad array of stakeholder engagements across the country in an effort to reflect the aspirations of Kenyans on matters Reproductive health in compliance with the Constitutional requirement for public participation in public policy making.

The last such event in this process was an inclusive participatory public engagement meeting held on 06th April 2022 at The Emory Hotel in Nairobi, during which public submissions to improve the policy were made. In this this meeting, additionally ,you were identified as possessing the requisite expertise and mandate to represent your constituency of ideals in considering the various submissions made with respect to this policy for technical inclusion into the final draft policy. The sole motivation of this activity is to give Kenyans a befitting policy direction that will guide investments on matters reproductive health for the next decade without leaving no one behind.

It is thus my pleasure to invite you to this policy writing workshop to be held at the Pride-Inn **Flamingo resort** in Shanzu **Mombasa** from **25th April 2022 to 29th April 2022**, with travel dates of 24th April 2022 and 30th April 2022.

If you are not affiliated to a sponsoring organization, a Nairobi-Mombasa return flight and reasonable accommodation on half-board near the workshop venue will be provided. In addition to flights, Government officers will be on DSA as per Government policy. A conference package that includes lunch and two beverage snack breaks will be provided for all. Please note that this is an individual **invitation** and **not transferable**.

Sincerely,

Dr Stephen Kaliti, HEAD DRMH -MOH.

ISO 9001:2015
Certified

KA-4

This is Exhibit marked "KA-4" referred to in the Annexed affidavit/Declaration of Kelvin Kiptoo
Sworn/Declared before me on this 8th day of September 2022 at Nairobi in the Republic of Kenya
Commissioner for Oaths

REPORT ON THE REPRODUCTIVE HEALTH POLICY DRAFTING WORKSHOP THAT TOOK PLACE FROM THE 25TH OF APRIL TO THE 29TH OF APRIL AT PRIDE INN FLAMINGO RESORT IN SHANZU MOMBASA

EXECUTIVE SUMMARY

The Ministry on 6 April 2022 met with stakeholders from the reproductive health and human rights sector to discuss key reproductive healthcare interventions in the Reproductive Health Policy that members of civil society highlighted as missing or problematic.

The protest culminated in the submission of a petition to Afya House highlighting reasons why the current policy was not inclusive of women in all their diverse reproductive health needs. 'The Policy must include interventions on adolescent sexual and reproductive health that respect the best interests of the child. Adolescents have the poorest sexual and reproductive health outcomes nationally. 14.4% of adolescent girls aged 13 to17 experience sexual violence. There are an estimated 345,000 pregnancies among adolescents annually, the majority of them being unintended. Adolescent girls and young women account for 51% of new HIV infections. Any policy must take into account the evolving capacities of children to consent to their own treatment, and respect their right to health including their right to access health-related information.'

After these discussions,the Ministry of Health suspended the launch of the Reproductive Health Policy 2022-2032 and agreed to go back to the drawing board.

INTRODUCTION

Kenya has been in the process of developing a National Reproductive Health Policy since 2015. This policy making process has spanned multiple years and a broad array of stakeholder engagements across the country in an effort to reflect the aspirations of Kenyans on matters Reproductive health in compliance with the Constitutional requirement for public participation in public policy making.

The last such event in this process was an inclusive participatory public engagement meeting held on 06th April 2022 at The Emory Hotel in Nairobi, during which public

submissions to improve the policy were made. From the meeting, the Ministry of Health chose representatives who had shared their submissions to attend a Reproductive Health Policy Drafting workshop that took place from the 25th of April to the 29th of April 2022 at Pride-Inn Flamingo Resort in Shanzu Mombasa. The people chosen were tasked with representing their constituency of ideals in considering the various submissions made with respect to the policy for technical inclusion into the final draft policy. The sole motivation for this activity was to give Kenyans a befitting policy direction that will guide investments on matters reproductive health for the next decade without leaving no one behind.

SUMMARY OF DISCUSSION

During the workshop,the participants were taken through the various submissions that were made by different groups in order to give their inputs on whether these submissions should be included in the Reproductive Health Policy.

The table below shows the name of the group,the submissions made and the comments/decisions arrived at regarding the specific submission.

EMPOWERED YOUTH NETWORK SUBMISSIONS

GROUP	SUBMISSIONS	COMMENTS/DECISIONS
Empowered Youth Network	1.Support for pregnant mothers by providing prenatal vitamins, sufficient food and proper nutrition for optimal development of the child in the womb. 2. In the case of unexpected or crisis pregnancies, referrals shall be made to a crisis pregnancy center that can provide mothers with social, financial, and emotional support to continue with the Pregnancy. 3. Mothers who express a desire to end their pregnancy through abortion should be counseled and encouraged to	1,2 and 5 are addressed in MNH guidelines 3 and 4 Notifiability of the death of a person in PAC? Gap - care given after abortion is not supportive enough to address the complications both physical and mental (Is it a policy gap or can it be addressed in the guidelines?) The post abortion complications affect women regardless of the cause for the pregnancy termination.

	consider the life-affirming option of adoption for their baby—a win/win option that can provide infertile couples with a child. 4. Should medical or mental health issues arise that 1,2 and 5 are addressed in MNH guidelines 3 and 4 Notifiability of the death of a person in PAC? Gap - care given after abortion is not supportive enough to address the complications both physical and mental (Is it a policy gap or can it be addressed in the guidelines?) SPOKEN TO IN HEALTH ACT SECTION 6 The post abortion complications affect women regardless of the cause for the pregnancy termination. Pregnancy crisis centers give support to help women cope with situations that may lead to the decision to terminate a pregnancy. Need for a policy direction to address crisis pregnancy Definition of abortion (abortion has been defined by law and should be adopted as is) Suggestion that a write up to articulate the steps in the provision of legally permitted pregnancy Termination seriously endanger the life of the mother and require removal of the child from the	Pregnancy crisis centers give support to help women cope with situations that may lead to the decision to terminate a pregnancy Need for a policy direction to address crisis pregnancy Definition of abortion (abortion has been defined by law and should be adopted as is) Suggestion that a write up to articulate the steps in the provision of legally permitted pregnancy Termination Regulation of counseling of 'crisis pregnancies' to reduce misinformation Provision for the training of 'healthcare professionals' to form opinion on the circumstances warranting pregnancy termination. There is no universality in morality and moral responsibilities may mean different things to different people

	womb, every effort must be made to save the life of both mother and child while extracting the child. Should the baby be born alive, every effort shall be made to provide the child with needed medical care. 5. After the birth, mothers should be encouraged to breastfeed their babies for the first six months exclusively where possible and young child feeding programmes should be scaled up.	

CIVIL SOCIETY SUBMISSIONS

Term/Section	Submission	Comments/Decisions.
Adolescence	**Adolescence:** Phase of life between childhood and adulthood, from ages 10 to 19.	Definition was adopted
Intersex	**Intersex:** "A person who is conceived or born with a biological sex characteristic that cannot be exclusively categorised in the common binary of female or male due	Definition was not adopted. The definition settled on was the one presented by the pro-family group and was modified.

	to their inherent and mixed anatomical, hormonal, gonadal (ovaries and testes) or chromosomal (X and Y) patterns, which could be apparent prior to, at birth, in childhood, puberty or adulthood	
Addition od terms	**"Key Populations"** Groups who, due to specific higher-risk behaviors, are at increased risk of HIV irrespective of the epidemic type or local context. Also, they often have legal and social issues related to their behaviors that increase their vulnerability to HIV. These include Sex workers and Men who have sex with men **"Gender"** refers to the characteristics of women, men, girls, and boys that are socially constructed. This includes norms, behaviors and roles associated with	The definitions were denied and the ones that currently exist in the policy were retained.

	being a woman, man, girl or boy, as well as relationships with each other. As a social construct, gender varies from society to society and can change over time.[1] **"Gender-based violence"** refers to any type of harm that is perpetrated against a person or group of people because of their factual or perceived sex, gender, sexual orientation and/or gender identity.[2] **"Marginalised group"** means a group of people who, because of laws or practices before, on, or after the effective date, were or are disadvantaged by discrimination on one or more of the grounds in Article 27(4) in alignment with the Constitution.	

1
2

	(Article 260 of the Constitution) **"Sexuality"** is a central aspect of being human throughout life encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy, and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviors, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious, and spiritual factors."[3]	

[3]

Additions to RH policy objectives	Sub objective i. To mainstream special RH needs of marginalized populations [persons living with disabilities, elderly people in humanitarian settings ~~and~~ correctional institutions, **[intersex persons, and sexual and gender minorities**	Suggestion was denied
Scope of the RH Policy	As a result it is recommended that this part: "It supersedes all other previous policies that have pronounced themselves on reproductive health matters in Kenya."of the Clause on Scope of the Policy is deleted.	This suggestion was accepted and the section was removed in the policy section was removed in the policy
Policy Thrust **To reduce unmet family planning needs**	Under Bullet no.5, replace [Ensure the safety and positive care experience for women and men accessing FP interventions] to [Ensure the dignity, safety, and positive care experience to all persons of reproductive age accessing contraceptive information, products and services]	Suggestion was accepted but with changes on the term contraceptives to family planning

Policy Thrust **To ensure that persons born intersex attain the highest standards of reproductive health.**	2. On the medical procedures for correction of persons born intersex; Add: [Intersex persons who undergo corrective surgery must be offered mental and psychological support, including counselling services to ensure wholesome recovery from the medical procedure.] 3. On registration of sexual identity upon corrective surgery; Add before paragraph: [Every intersex child has a right to be registered immediately after birth and the right to a legal identity.]	
Policy Thrust To reduce the burden of reproductive tract infections and improved access to quality services	Under Bullet no.1, replace reference to ' women and men'' to 'people of reproductive age'	The suggestion was accepted but the use of the term reproductive age was denied.

		The term used instead was the age of majority
Policy Thrust **To reduce the HIV and AIDS burden and accelerate reversal of mother to child transmission of HIV**	Inclusion of a specific policy thrust that aims to reduce the HIV/AIDS burden among Key Populations.	The ministry of health noted this and said they would have conversations around it.
Policy Thrust **To promote gender equity, address Female Genital Fistula (FGF), eliminate FGM and eradicate all forms of gender-based violence and harmful reproductive health practices by 2030.**	Integrate comprehensive sexual education and reproductive health knowledge programmes as a mitigation measure. At paragraph 8 amend as follows: - [8. Enforce parental consent, and in the absence of both parents, and/or where parental consent cannot be reasonable obtained, ensure the minor has reasonably been informed of and fully comprehends the nature, consequences and risks of the proposed action ~~without inducement whatsoever, consent from a guardian or government medical~~	The suggestion of integrating comprehensive sexuality education was denied and life skills education was given as an alternative. This age was changed to 18 as per the Kenyan laws. The term government medical specialist was replaced by children's officer and healthcare provider . These two will only come in cases of emergency.

	~~specialist~~, in the provision of RH services including contraception to children and minors, with emphasis on rehabilitation of emancipated minors into protective safety corridors such as school re-entry, child rescue programs, or cash for transfer programmes to facilitate exit from the vicious cycle of child sexual abuse and repeat premature childbearing among minors.]	
Policy Thrust **To reduce infertility and increase access to effective management of infertile individuals and couples**	Access to surrogacy and assisted reproductive technologies should be guaranteed for all adult Kenyans who wish to bear children without the imposition of undue barriers and bureaucracies imposed by the Church or State.	This suggestion was denied as the Ministry of Health stated that the use of couple was intentional to prevent malicious activities by people when it comes to surrogacy.

PRO-LIFE. PRO-FAMILY SUBMISSIONS

TERM	SUBMISSIONS	COMMENTS/DECISIONS
Abortion	"Abortion is deiberately terminating a pregnancy"	Definition was denied and it was agreed that the definition of Babortion in the RH policy should be in line with the definition in the Health Act
Adolescent Friendly Services	Replace the term adolescent friendly services with child-friendly health services	Suggestion was not accepted
Consent (Not defined in the policy)	"Agreement by a person who has freedom and capacity to make that choice"	Definition was accepted.
Child Marriage	Definition should be removed in the policy	• Cannot be deleted since it is a reality and it is happening. • The definition should align with the definition in the Children's Act.
Female Genital Mutilation	Should be changed to "Genital Mutilation" instead of Female Genital mutilation because there are people who intentionally remove their genitalia because they want to transition to a particular gender.	The Prohibition of FGM Act defines terms it as FGM and it cannot be changed. Additionally the Act also defines FGM and it is that definition that has been adopted in the policy.
Infertility	"A medical diagnosis of the failure of a male and female to achieve a pregnancy after 12 months or more of regular sexual intercourse.	It will be defined as a reproductive health service

Sexual Intercourse(has not been defined in the policy)	"The consensual gratifying and reproductive act in which the male reproductive organ enters the female reproductive tract and sperm are passed and deposited in the female tract.	The only condition as to why the definition will be discussed and retained is if it is mentioned in the RH policy which is it is not. Therefore addition of the definition was denied
Intersex definition	No specific definition was given,the ones provided were guidelines.	The definition was denied since it was already discussed and approved during the previous presentation by Civil Society
Life Skills Education	Education for which parents or guardians are the primary provider,Geared towards character development of individuals to equip them with values,appropriate knowledge on risk-taking behaviors and develop skills such as sezual risk avoidance,communication,assertiveness,self-awareness, decision making, problem solving,critical and creative thinking to protect them from abuse and exploitation and to help children to practice abstinence before marriage and fidelity in marriage.	• The definition was denied. • The definition pf life skills will remain as it was in the RH policy. • Life skills will be included in a policy thrust and the content will encompass the curriculum by the Ministry of Education.
Unborn Child Definition(has not been defined in the policy)	"Is a person from conception till birth"	Suggestion was not accepted.

CONCLUSION AND WAY FORWARD

The participants requested the Ministry of Health to include all the suggestions that were agreed upon in the policy. The Ministry of Health committed to inviting the participants for a

validation process so that they could confirm that the content of the policy included what was discussed.

REPORT WRITTEN BY : ESTHER AOKO

KA-5

This is Exhibit marked "KA-5" referred to in the Annexed affidavit/Declaration of Kethemiah Kimathi Sworn/Declared before me on this 8th day of September 2022 at the Republic of Kenya
Commissioner for Oaths

Geraldine Moraa

From: MOH-DIRECTORATE OF MEDICAL SERVICES/PREVENTIVE & PROMOTIVE HEALTH <directordpphs.moh@gmail.com>

Sent: Tuesday, 28 June 2022 10:34

To: nehemiahkimathi@gmail.com; fridah@rhnk.org; carrumm@knchr.org; hakimala@livinggoods.org; j_nyamu@yahoo.com; mwikali@srhralliance.or.ke; monyango@reprorights.org; wesongamasirivai@gmail.com; kirekiomanwa@gmail.com; e.fundi@ombudsman.go.ke; essieaoko@gmail.com; wngare@hotmail.com; msolomon@fhi360.org; rkakeelo@cuea.edu; gusterkakeelo@gmail.com; cynthia@wya.net; jmaina@ticahealth.org; aketch@pearlsandtreasures.org; pm_remigeo@yahoo.com; tatueda995@gmail.com; edabeauttah@gmail.com; lowino@kelinkenya.org; Mnjames.Karanja@gmail.com; candylize@gmail.com; womenspacesafrica@gmail.com; majanis@ipas.org; gochieng@ticahealth.org; lkahuko86@gmail.com; ngogae@ipas.org; jsoki@path.org; peteroiba@gmail.com; wamaer@hotmail.com; wangari.ireri@kma.co.ke; shantal.onyango@gmail.com; joymdivo@gmail.com; KOduol@livinggoods.org; andrewmulwa@ymail.com; drbashirm@gmail.com; dr.kaliti@gmail.com; headrmhke.moh@gmail.com; ndwigaal@gmail.com; nitahjp@yahoo.com; Winfredwanjiku69@gmail.com; Wakoli2ken@gmail.com; waiguru.scsu@gmail.com; Wabwire789@gmail.com; mwangangialice@yahoo.com; owendeka2010@gmail.com; skmuleshe@gmail.com; mmagubo@gmail.com; hmutsi@yahoo.com; lekoreremerina@gmail.com; gathitumaRy54@gmail.com; gideonmut@gmail.com; okumuclarice62@yahoo.com; mwangajob1@gmail.com; floireri58@gmail.com; mmburulamu@yahoo.com; martinmburu2014.mm@gmail.com; menganyicate83@gmail.com; amadivakibisu@gmail.com; janetmogire15@gmail.com; annwangui863@gmail.com; simonkigondu@gmail.com

Cc: wereian12@gmail.com; cshealth2015@gmail.com; dghealth2019@gmail.com; drbashirim@gmail.com

Subject: Invitation to the Reproductive Health Policy Validation Meeting on 1st July 2022 at Emory Hotel, Nairobi

Dear all,

Trusting you have been well since our drafting session of this policy in **Mombasa 20th -25th April 2022,** the MOH is delighted to inform you that a final draft incorporating our deliberations and guidance of **THE CS Health** as agreed during this meeting is now available for our appraisal and validation.

The purpose of this email is to invite you to this important validation meeting on **1st July 2022 at the EMORY Hotel Nairobi starting at 7: 00 AM.**

Thank you for your continued support

Regards,

Dr. Mulwa A. M.
Ag. Director of Medical Services, Preventive & Promotive Health
Ministry of Health
Afya House | 6th Floor | Room 621

P. O. Box 30016 - 00100
NAIROBI
Alternate email: andrewmulwa@ymail.com

356

NAIROBI, Kenya, April 12 – The Ministry of Health says 45,724 cases of teenage pregnancies were recorded bbetween January and February this year.

According to Principal Secretary Susan Mochache, among those registered, 2,196 were as a result of Sexual and Gender Based Violence aged between 12 and 17 years.

Mochache stated that although the numbers were still high, teenage pregnancies have reduced by 26 percent to 317,644 in 2021 from where 427,135 in 2018.

"This encouraging performance reflects an increase of 83% in the number of people living with HIV that are on life-saving antiretroviral treatment, from 600,000 people in2013 to 1.2 million people in 2021," she said.

She noted that Kilifi, Taita-Taveta and Siaya counties had registered reduced number of teenage pregnancies by more than 50 percent in the same period with poverty and hunger termed as the main attributes.

She further highlighted that for adolescent girls, in 2015, every week, more than 343 girls aged 10-19 were newly infected with HIV.

In 2021 these numbers albeit still high had been reduced by 71% to about 98 cases in a week.

Interior Cabinet Secretary Fred Matiangi directed that County Commissioners will now be expected to organize engagements programmes and create a conducive environment where young people thrive without discrimination, stigma and violence.

"Most importantly, we must ensure that perpetrators of teenage pregnancies and Gender-Based Violence face the full force of the law and ensure that any girl who gets pregnant goes back to school," he said.

Popular

1. Chebukati Kept Lt. Gen. Ogolla, Team Waiting For 4 Hours Despite Kinyua's Call: AG
2. Piki Piki Ponki...Lawyer Willis Otieno Sings Nursery Rhymes In Supreme Court
3. Dr. KALUA GREEN: 3 Key Issues Supreme Court Must Consider In Petition Verdict
4. Kisii Governor Arati Unearths Ghost Workers Scam In Various Depts
5. Mahat Somane: KIEMS Kits Wired For JPEG To PDF Conversions Using Onboard Scanners
6. Duale Alleges Mischief By Uhuru Over Delayed Convening Of The House
7. Are You Sure You Want A Solomonic Verdict, Justice Wanjala Asks Ruto Lawyers
8. HESBON OWILA: Supreme Court Verdict Will Define Our True Destiny
9. Raila: Venezuelan Jose Carmago Was Uploading Forms On IEBC Portal
10. PHOTOS: Governor Arati Parades Kisii County Drivers For A Headcount

The Standard
SINCE 1902

Kenya recorded 45,724 cases of teen pregnancies in January, February - Health Ministry

By Joackim Bwana | 4mos ago

Interior CS, Dr. Fred Matiang'i, Health PS Susan Mochache, National Aids Control Council's Dr Ruth Masha and other officials during the National Aids Control Council, National Council for Population and Development National dialogue at English Point Marina in Mombasa County on April 7, 2022.

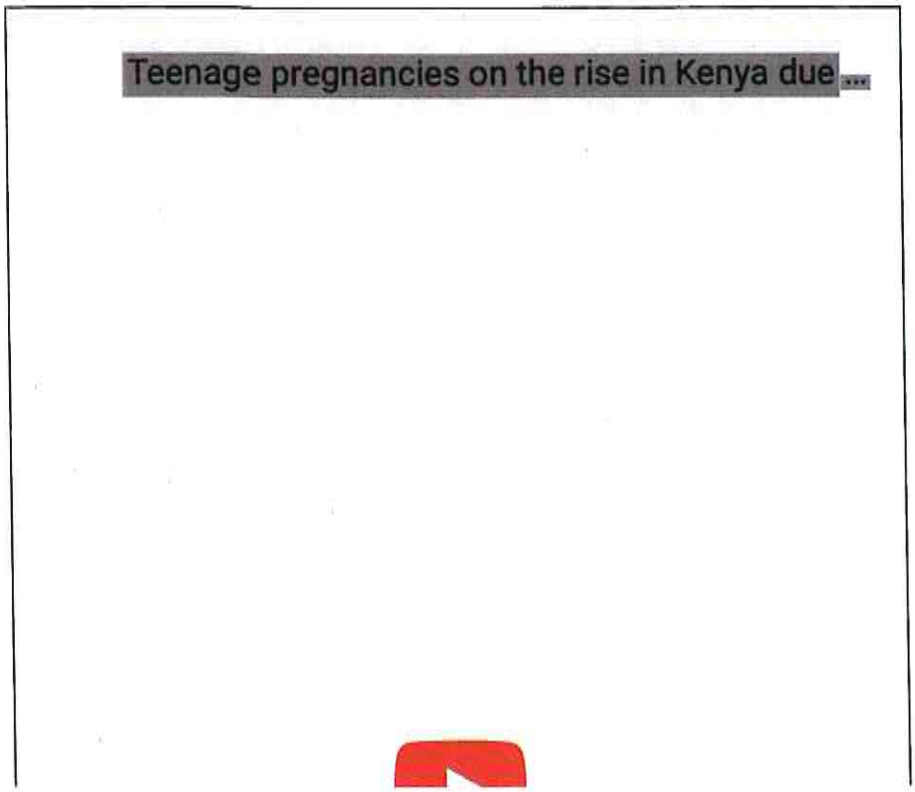
[Kelvin Karani, Standard]

358

The Ministry of Health has revealed that between January and February 2022, they handled 45,724 cases of pregnant adolescents aged between 10 and 19 years.

Health Permanent Secretary Susan Mochache Thursday said that 2,196 cases of Sexual and Gender-Based Violence (SGBV) were registered among those aged 12 and 17 years.

Mochache further said every week 98 girls aged between 10 and 19 years are infected with HIV due to SGBV.



359

Keep Reading

- **157 cases of gender-based violence reported during election period**
- **Polls: Report reveals counties where women were assaulted**
- **Women making positive strides towards equality at highest levels**
- **The rise of Kenyan women: History says they are good political leaders**

She spoke in Mombasa during the National Dialogue with Regional and County Commissioners against HIV, teen pregnancies and GBV in Kenya that was graced by Interior Cabinet Secretary Fred Matiang'i.

Mochache said in 2021, the ministry received 12,520 cases of SGBV and were able to provide HIV preventive services to 4,664 young survivors but unfortunately, 53 of the survivors had contracted HIV.

The PS however noted there had been a drop of HIV infections from 343 recorded among adolescent girls in 2015 to 98 per week representing a 71 percent decrease in HIV infections.

"For adolescent girls, in 2015, every week, more than 343 girls aged 10-19 were newly infected with HIV. In 2021 these numbers albeit still high had been reduced by 71 percent to about 98 cases in a week," said Mochache.

360

She said in 2021 of all antenatal care attendances, 21 percent were adolescent mothers aged 10-19 compared to 2018, where 427,135 cases of teenage pregnancies were reported at antenatal clinics.

The PS said that although the numbers were still high, they had reduced by 26 percent to 317,644 in 2021.

"Worse still, a total of 23,279 of girls aged 10 and 14 were recorded in the health facilities as presenting with pregnancies," said Mochache.

Poverty fuelling teen pregnancies

She said Kilifi, Taita-Taveta and Siaya counties had registered reduced number of teenage pregnancies by more than 50 percent in the same period.

According to SGBV victim Purity Chengo from Kilifi County, a teen mother who already has three children at the age of 20, poverty and hunger contributed to her being a teen mother.

361

REPUBLIC OF KENYA

IN THE HIGH COURT OF KENYA AT KIAMBU

CONSTITUTIONAL PETITION NO. OF 2022

IN THE MATTER OF ARTICLES 10(1) & 10 (2)(a), 19, 22, 23, 26 (1) & (4), 27, 33, 35, 43 (1(a)), 53 (1(c)) AND 232 (1(d)) OF THE CONSTITUTION OF KENYA, 2010

AND

I IN THE MATTER OF ARTICLES, 22, 23, 34 AND 35 OF THE EAST AFRICAN COMMUNITY HIV & AIDS PREVENTION AND MANAGEMENT ACT

AND

IN THE MATTER OF SECTIONS 5, 6, 7, 15 AND 68 OF THE HEALTH ACT, 2017

AND

IN THE MATTER OF SECTION 16(2), (3) & (4), 28(3), 146 AND THE FIRST SCHEDULE OF THE CHILDREN ACT NO. 29 OF 2022

AND

IN THE MATTER OF SECTION 6 AND 7 OF THE SCIENCE TECHNOLOGY AND INNOVATION ACT NO. 28 OF 2013

AND

IN THE MATTER OF SECTION 4 AND 5 OF THE ACCESS TO INFORMATION ACT NO. 31 OF 2016

AND

IN THE MATTER OF THE PUBLIC SERVICE COMMISSION GUIDELINES FOR PUBLIC PARTICIPATION IN POLICY MAKING (2015)

AND

IN THE MATTER OF THE NATIONAL REPRODUCTIVE HEALTH POLICY 2022-2032

BETWEEN

RACHAEL MWIKALI.....1ST PETITIONER

ESTHER AOKO.....2ND PETITIONER

AMBASSADOR FOR YOUTH & ADOLESCENT REPRODUCTIVE HEALTH PROGRAMME (AYARHEP).....3RD PETITIONER

KENYA LEGAL AND ETHICAL

ISSUES NETWORK ON HIV & AIDS.....4TH PETITIONER

VERSUS

CABINET SECRETARY

MINISTRY OF HEALTH.....1ST RESPONDENT

THE ATTORNEY GENERAL.....2ND RESPONDENT

AND

KENYA OBSTETRICAL GYNAECOLOGICAL SOCIETY..... 1ST INTERESTED PARTY

KATIBA INSTITUTE .....2ND INTERESTED PARTY

3RD PETITIONER'S AFFIDAVIT IN SUPPORT OF THE PETITION

I, **JEROP LIMO,** a female Kenyan adult of sound mind residing and working for gain in Nairobi County within the Republic of Kenya do hereby make oath and state as follows:

1. I am the Executive Director of the Ambassador for Youth and Adolescent Reproductive Health Programme (AYARHEP), the 3rd Petitioner herein and thus competent to swear this affidavit.

2. I am conversant with the contents of the Petition and I fully understand the issues in question and I further adopt the contents of the Petition filed herein as if the same were set out *seriatim.*

3. The 3rd Petitioner is a non-governmental organisation registered in Kenya working to mitigate the impact of HIV and AIDS and promote healthcare, reproductive health and human rights. ***(A copy of the 3rd Petitioner's registration certificate is attached and marked as JL-1)***

4. On 5th July 2022, the 1st Respondent launched the National Reproductive Health Policy 2022-2032 (the policy) which has provisions that if implemented, will constitute a barrier for adolescents and young people. In addition, the Policy does not responds to persons living with HIV, as well as those who are most at risk of HIV infection.

5. A suitable policy document ought to recognize the needs and interests of the community. In relation to persons living with HIV, access to comprehensive sexual and reproductive health is a key priority need.

6. I am aware that the country has made specific commitments towards eliminating HIV with a view to eliminating new infections and ensuring that persons living with HIV are receiving appropriate health care services. One key intervention area that needs to be made is to ensure access to comprehensive sexual and reproductive health services.

7. I am also aware that HIV continues to be a public health threat for adolescents and young people, and that the National Aids Control Council has stated that an estimated 98 new HIV infections occur every week among adolescents aged 10-19 in Kenya. ***(Annexed hereto and marked JL2 is an extract of the NACC's End Triple Threat' Campaign' outlining the vulnerabilities that adolescents living with HIV face as a result of poor access to sexual and reproductive health and services.)***

8. Adolescent girls and young women face obstacles when accessing sexual and reproductive health services and commodities and are less likely to access those services compared to older or married women in the society. The Policy direction that has been taken completely ignores this fact by creating barriers that prevent adolescents and young people from accessing services. ***(Annexed hereto and marked as JL3 Is an exract of the National Guidelines for HIV/STI Programming with Key Populations showing the risk and vulnerability of adolescents and young people at page 14)***

9. The healthcare interventions under the policy are discriminatory and exclude young women below 21 years as they are not guaranteed access to reproductive health services on the basis that they have "not attained full cognitive competence on matters of sexuality and reproduction." (***overarching policy statement at page 19***

of the policy). This policy direction is in direct contradiction of the 1st Respondent's own evidence that that adolescents and young people aged 15 -29 years account for 61.2% of new HIV infections, and that they are priority population in with regard to the HIV response.

10. Moreover, the push to move the age of sexual debut from 18 to 21 years is without any scientific basis and evidence. ***(Policy monitoring, evaluation, research and learning framework at page 50 of the policy).*** There is particularly no legal basis for limiting sexual debut past the age of 18 years. It is important to note that the reliance on the age of 18 is based on data collected from the Kenya Demographic Health Survey that attributes teenage pregnancies to early sexual debut. ***(Annexed hereto and marked JL4 is an extract of the Kenya Demographic Health Survey, 2014 at pg. 55 and 78).***

11. In the end, young adult women between the ages of 18 and 21 are left with policy interventions that do not adequately meet their sexual and reproductive needs yet they have the legal capacity to make informed decisions on their sexual and reproductive health; and to access those services and commodities. This will only lead to an ineffective HIV response, particularly given that a lack of access to comprehensive sexual and reproductive health services makes young people (and particularly young women even more vulnerable to HIV infection.
(Annexed hereto and marked JL5 is an extract of the Kenya AIDS Strategic Framework (KASF II) (2020/2021 - 2024/2025) showing Prevention and management of HIV among children aged 0-14 at page 10)

12. The policy direction requiring parental consent prior to adolescents under 18 years will only impede access to reproductive health, more so because there are no guidelines to accessing reproductive health fails to provide guidelines as to how to adolescents will access services in cases of emergencies, or where it is impossible to get parental or consent of a guardian or children officer. ***(3.4.8.8 of the policy on access to reproductive health services for children at page 26 of the policy)***

13. The policy further excludes adolescent women and young girls from benefiting from reproductive health services and commodities as it envisages the provision of cervical cancer screening services for women between 25 and 49 years to the exclusion of other age groups ***(2.3.7 on cancers of reproductive organs at page 15 of the policy).*** This policy direction if implemented will detrimentally affect adolescents who live with HIV as Women living with HIV have a substantially increased risk for cervical cancer when compared with women without HIV. ***(Annexed hereto and marked JL5 is an extract of the Kenya AIDS Strategic Framework (KASF II) (2020/2021 - 2024/2025) outlining cervical cancer screening as a means to reduce AIDS-related deaths and improve health outcomes at page 41)***

14. This provision is also contrary to county laws and policies, (for instance Mombasa and Makueni) that allow minors to consent to their own reproductive health services. This provision further limits the ability of healthcare workers to provide services to adolescents based on their evolving capacities and needs by requiring parental consent for healthcare services. ***(Annexed hereto and marked JL6 is the Mombasa County Adolescent and Yong People Strategy on HIV and Sexual Reproductive Health, 2018 on reducing incidence of STI, teen pregnancies at page 14 and marked as JL7 is the Makueni County Reproductive Health and Family Planning Act, 2019, section 31)***

15. Access to health is not just inclusive of the right to access health facilities and services, but also the right to be subjected to treatment with one's consent. Therefore, a person can only be subjected to a HIV test with their prior informed consent. I am also aware that no person may be denied a benefit (including access to healthcare facilities, services and commodities) based on their HIV status and neither should people be subjected to mandatory HIV testing to accrue such benefits without their consent.

16. In the context of HIV testing, subjecting a woman's family to HIV testing can open up avenues for gender-based violence for the woman. Therefore, requiring all pregnant women and their families to be tested for HIV only creates a barrier to access to critical maternal healthcare and commodities as well as disregard for the right to privacy, dignity as well as the right to adequate health which includes the aspect of informed consent as well as freedom from forced medical procedures ***(3.4.4 paragraph 2 of the policy at page 24).***

17. The need for alignment of laws and policies on sexual and reproductive health services to the Constitution is one of the ways through which the rights of women and girls can be respected. In the end, the policy is not suitable and sustainable as it does not recognise the needs and interests of adolescent girls and young women as well as of persons living with HIV.

18. The Policy is silent on the reproductive health interventions that should be in place for persons living with HIV, particularly during transition from adolescents living with HIV to adulthood. There are also no reproductive health interventions for key populations or others who are at high risk for HIV such as sex workers, men who have sex with men who the 1st Respondent has noted have a higher HIV prevalence and who require comprehensive sexual and reproductive health services.

19. Given the foregoing, and in the interest of safeguarding the constitutional rights of reproductive health and the lives of the people of Kenya, I pray that this Honourable Court grant the orders set out in the Petition.

20. What is deponed herein is true to the best of my knowledge, information and belief, save for information whereof sources have been disclosed.

SWORN at **NAIROBI** by the said)
JEROP LIMO)
)
)
This 18th day of September 2022)
BEFORE ME)
WYCKLIFE O. OYOO)
Advocate & Commissioner for Oaths)
KAPLAN & STRATTON)
P.O. Box 40111 - 00100)
NAIROBI)
COMMISSIONER OF OATHS)

DEPONENT

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Katiba Institute,
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Off Parklands Road
P.O. Box 26586 -00100
Tel: +254 704 594962
Email: info@katibainsitute.org

369

JK-1

Form 5

REPUBLIC OF KENYA

THE PRESIDENCY

This is Exhibit marked "JK-1" referred to in the Annexed affidavit/Declaration of Sworn/Declared before me on this 8th day of May 2016 at Nairobi in the Republic of Kenya
Commissioner for Oaths

OP.218/051/16-058/10205

(r.11)

MINISTRY OF DEVOLUTION AND PLANNING

CERTIFICATE OF REGISTRATION

I, FAZUL YUSUF MAHAMED, Executive Director of the Non-Governmental Organizations Board, certify that xxx AMBASSADOR FOR YOUTH AND ADOLESCENT REPRODUCTIVE HEALTH PROGRAM xxx has this day been registered under section 10 of the Non-Governmental Organizations Co-ordination Act as applied for.

Dated 4TH MAY, 2016

FAZUL Y. MAHAMED
Executive Director of the Board

370

NB3
JK - 2

END TRIPLE THREAT CAMPAIGN

#EndTripletThreat #KomeshaMimbazaUt

This is Exhibit marked "JK-2" referred to in the Annexed affidavit/Declaration of KNBS Kimo SK
Sworn/Declared before me on this 15th day of October 2020
at Nairobi in the Republic of Kenya
Commissioner for Oaths

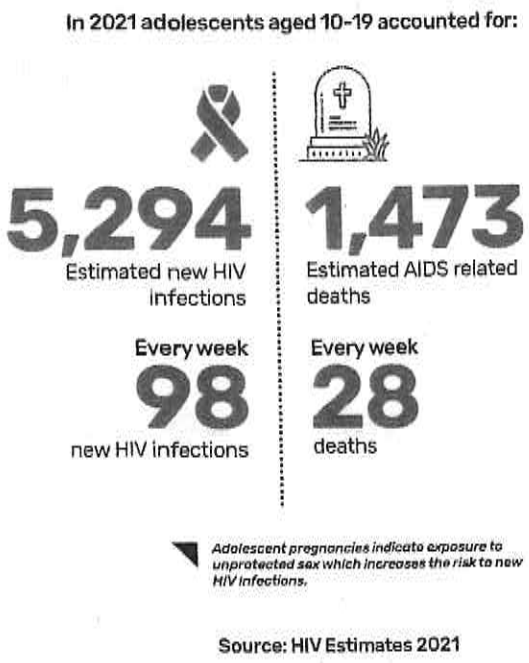
Previous

END TRIPLE THREAT CAMPAIGN

1. New HIV Infections
2. GENDER-BASED VIOLENCE
3. ADOLESCENT PREGNANCIES

INTRODUCTION

(NCPD) have partnered with National Government Administration Officers (NGAO), other government entities, and implementing partners to develop and implement strategies for eliminating the triple threat; sexual gender-based violence, pregnancies and HIV among adolescents and young people.



1. HIV

HIV remains a major public health threat for adolescents and young people in Kenya. Globally, HIV is among the leading causes of death among adolescents. Moreso, an estimated 98 new HIV infections occur every week among adolescents aged 10-19 in Kenya.

2. SEXUAL AND GENDER-BASED VIOLENCE

Sexual and gender-based violence refers to any harmful act that is perpetrated against a person's will and is based on gender, norms, and unequal power relationships Of these, 5,890 (36%) were provided with Post Exposure Prophylaxis (PEP) to prevent HI infection, out of whom 236 (4%) acquired HIV. Additionally, 1,665 of these adolescents reported being pregnant 4weeks after exposure to SGBV.

of all pregnancies were among adolescents aged **10-19**

Source: KHIS (MoH 711-ANC)

3. ADOLESCENT PREGNANCIES

In Kenya, almost 1 out of 4 women give birth by age 18 and nearly half by age 20. One in every five adolescents aged 15-19 are already mothers or pregnant with their first child. (KDHS,2014) In 2021, the country recorded a total of 316,187 adolescent pregnancies. Of these, 294,364 pregnancies were among girls aged 15-19 while those aged 10-14 contributed to 21,823 (7%) of the total adolescent pregnancies.

WHAT IS THE TRIPLE THREAT IN ADOLESCENTS?

Kenya has made significant investments to ensure adolescents and

IMPACT OF THE TRIPLE THREAT ON POPULATION AND DEVELOPMENT

based violence threaten this progress.

Adolescent pregnancy infringes on a young person's fundamental rights to education Increasing new HIV infections among adolescents impedes ending AIDS as a public health threat in the country. Sexual violence increases the risk of both HIV infection and pregnancy Sexual violence threatens a young woman's agency to negotiate for sex and safer sex, increasing her risk of HIV infection, unintended pregnancy, and other negative health and socioeconomic outcomes Adolescent pregnancy may be an indication of harmful cultural practices such as Female Genital Mutilation (FGM) and child marriage which infringe on basic human and child rights

infections and related complications, poor health outcomes such as the risks of

2. Adolescent mothers diagnosed with HIV must cope with the mistimed pregnancy, HIV diagnosis, and initiation to lifetime treatment during antenatal care.
3. Young mothers living with HIV also have poor outcomes in preventing the mother-to-child transmissior continuum of services.
4. Perpetuate poverty at famil societal, and national levels with a increased burden on socic services, such as healthcare and education.
5. Adolescent pregnancy leads to interrupted educational attainment and opportunities leading to loss of economic opportunities.
6. Violence infringes on child an human rights while narrowing opportunities for women and girls to participate in the country's development meaningfully.

TRIPLE THREAT COUNTY EDITIONS

JL-3

Ministry of Health

This is Exhibit marked "JL-3" referred to in the Annexed affidavit/Declaration of [illegible] Sworn/Declared before me on this [illegible] day of [illegible] 20[illegible] at [illegible] in the Republic of Kenya

Commissioner for Oaths

NATIONAL GUIDELINES FOR HIV/STI PROGRAMMING WITH KEY POPULATIONS

National AIDS and STI Control Programme

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National Guidelines for HIV/STI Programming with Key Populations

National AIDS and STI Control Programme

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CHAPTER 01

HIV Epidemiology and Key Populations in Kenya

CONTENTS

Chapter 1 presents the contextual 'who' and 'why' driving the Kenya's HIV epidemic.

1.1 Introduction
1.2 HIV in Kenya—A Mixed Epidemic
  1.2.1 HIV in Key Populations
  1.2.2 Estimates of Key Populations
1.3 Risk and Vulnerability
  1.3.1 Risk and Vulnerability among Sex Workers
  1.3.2 Risk and Vulnerability among Men Who Have Sex with Men
  1.3.3 Risk and Vulnerability among People Who Inject Drugs
  1.3.4 Overlapping Risks and Vulnerabilities
  1.3.5 Adolescents and Young People from Key Populations
1.4 Typologies
  1.4.1 Typologies of Female Sex Workers
  1.4.2 Typologies of Male Sex Workers
  1.4.3 Typologies of Men Who Have Sex with Men

1.1 INTRODUCTION

The recent move toward more strategic use of HIV resources draws attention to the value of addressing HIV in key populations. In both concentrated and generalized epidemics, greater investment in a country's key populations is likely to improve the cost-effectiveness of the response to HIV. In Kenya's mixed epidemic, key populations account for 33% of all new infections.

Investment in key populations is cost-effective because of the central role of key populations in the dynamics of epidemics. People from key populations can transmit HIV to other populations—for example, sex workers' clients and the sexual partners of people who inject drugs. Thus, infections in people from key populations can have a multiplier effect. A modelling exercise undertaken in Kenya showed that when a community-empowerment-based comprehensive HIV-prevention intervention[29] is brought to scale from a baseline coverage level of 5% to 100% in five years, it can show a range of impacts on HIV: 10,800 infections in Kenya were averted in five years among female sex workers. Impacts of the intervention for female sex workers extend to the adult population, cumulatively averting 20,700 adult infections in Kenya.[30]

1.2 HIV IN KENYA—A MIXED EPIDEMIC

Since Kenya recorded its first case of HIV in 1984, the AIDS epidemic has evolved to become one of the central impediments to national health, well-being, and development. In the 1990s, HIV spread rapidly in Kenya, reaching prevalence rates of 30% in some antenatal care sites—with major social and economic consequences throughout society.[31] In 1999, the Government of Kenya declared HIV a national disaster and established the National AIDS Control Council to coordinate a multisectoral national response.

Kenya has the third-largest population of people living with HIV in sub-Saharan Africa and the highest national HIV prevalence of any country outside of Southern Africa. Within its counties, there are important variations in HIV burden.[32] Findings of the Kenya AIDS Indicator Survey (2012) indicated that approximately 5.6% of the adult population aged 15–64 years is HIV-infected.[33] However, rates of HIV prevalence vary by demographic groups and geographic areas. HIV prevalence is higher among women (6.9%) than men (4.4%). The highest HIV prevalence rates in the country are in Nyanza region (15.1%), followed by Nairobi (4.9%), Western (4.7%), and Coastal (4.3%) regions. Adults in Kenya's urban areas have been found to have higher HIV prevalence (6.5%) than adults in rural areas (5.1%).

Kenya's HIV epidemic is classified as a mixed epidemic, meaning that it is generalized among the general population and concentrated among key populations that are especially at risk of infection.[34] The generalized epidemic is driven by sero-discordance, unprotected sex, multiple and concurrent partnerships, low rates of male circumcision among some cultural groups, and unawareness of HIV status. The concentrated epidemic is driven by high-risk sexual behaviour, such as unprotected anal or vaginal sex, drug-related HIV-risk behaviour, such as unsafe injection practices, and structural factors that heighten the vulnerability of key populations.

1.2.1 HIV in Key Populations

According to the Kenya HIV Prevention Responses and Modes of Transmission Analysis (2008), conducted by NACC, approximately 33% of all new infections in the country are attributed to key populations, as shown in Figure 2. A meta-analysis conducted by Baral et al. found that the

29 This approach to HIV prevention includes sex worker organization, mobilization, and collective action to address social and structural factors related to sex worker rights, health and HIV risk. It also considers more traditional programmatic elements, including community-led peer education, condom distribution, and STI/ HIV screening and treatment.

30 Wirtz AL et al. Epidemic impacts of a community empowerment intervention for HIV prevention among female sex workers in generalised and concentrated epidemics. PLoS ONE. 2014; 9(2). e88047. doi:10.1371/journal.pone.0088047. http://www.plosone.org/article/fetchObject.action?uri=info%3Adoi%2F10.1371%2Fjournal.pone.0088047&representation=PDF

31 *The Kenya National AIDS Strategic Plan II (KNASP)*, 2005/06–2009/10. http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/legaldocument/wcms_127530.pdf

32 NACC and NASCOP. 2014. Kenya HIV Estimates

33 NASCOP. 2014. *Kenya AIDS Indicator Survey 2012*. Final Report. Nairobi: NASCOP http://www.nacc.or.ke/attachments/article/403/KAIS_II_2014_Final_Report.pdf

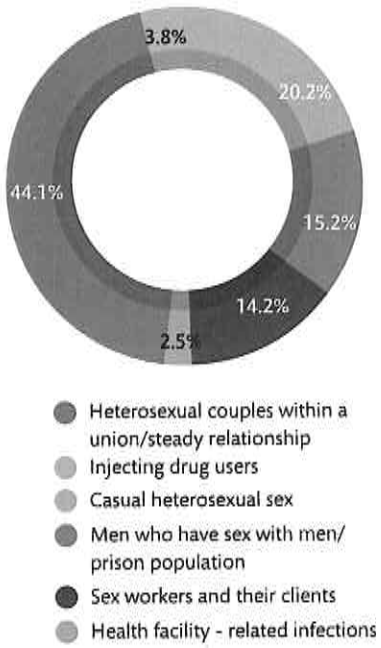
34 See Annex 1 for more information about HIV epidemiology.

HIV prevalence among FSWs in Kenya was around six times greater than among adult women in the general population (45% vs. 7.7%).35 In a meta-analysis of HIV prevalence among MSM and adults of reproductive age, Baral and his team found that HIV prevalence among MSM in Kenya is higher (11%) compared to adults of reproductive age (7%).36 In 2007 in Mombasa, HIV prevalence among MSM/MSWs with exclusively male partners was 41%.37 The Kenya AIDS Indicator Survey in 2007 revealed that HIV prevalence in Nairobi was 18.2% among MSM, 29.3% among FSWs, and 18.7% among PWID.[38] When further disaggregated by sex, it was established that 49% of female injecting drug users were HIV-positive, whereas only 16% of male injecting drug users were HIV-positive. A recent rapid situational analysis of PWID in Nairobi and Coast provinces highlighted the high HIV prevalence among PWID, ranging from 17% to 47% among male and female PWID, respectively.

More recently, in a Nairobi-based prospective cohort study with MSM conducted during 2009-12, the baseline HIV prevalence was 40%. HIV incidence was found to be 10.9 per 100 person-years.[39] Another recent study found that overall HIV-1 incidence among 449 MSM in coastal Kenya was 8.6 per 100 person-years. Incidence was 5.8 per 100 person-years among men who reported sex with men and women, but *35.2 per 100 person-years* among men who have sex with men exclusively.[40]

In the context of mixed epidemics, there is an urgent need for HIV-prevention interventions to first target key populations at greatest risk for HIV, then bridge populations who frequent high-risk venues and are involved with high-risk networks, and, finally, the general population.

Figure 2: **Prevalence Rate for New Infections (NACC, 2008)**



Programmatic focus on key populations in Kenya is based on the rationale that these populations are most vulnerable, experience the greatest burden of HIV, and are currently underserved in the country. In the KNASP III, Kenya acknowledged that without addressing the needs of key populations, a sustainable HIV response will not be achieved.

1.2.2 Estimates of Key Populations

Kenya has large populations of sex workers, MSM, and PWID. These populations have many connections to the general population, including sexual and drug injecting relationships, which act to bridge HIV transmission between key populations and members of the general population.

Recent mapping estimated that there are 133,675 female sex workers throughout the country, with significant regional variations, ranging from 29,494 FSWs in Nairobi Province to 2,030 in North Eastern Province. It is estimated that there are 19,175 men

35 Baral S et al. Burden of HIV among female sex workers in low-income and middle-income countries: a systematic review and meta-analysis. *Lancet Infectious Diseases*. 2012;12(7):538 - 549 doi:10.1016/S1473-3099(12)70066-X

36 Baral S et al. Elevated risk for HIV infection among men who have sex with men in low- and middle-income countries 2000–2006: A systematic review. *PLoS Med*. 2007;4(12):e339. doi:10.1371/journal.pmed.0040339 http://www.plosmedicine.org/article/fetchObject.action?uri=info%3Adoi%2F10.1371%2Fjournal.pmed.0040339&representation=PDF

37 Sanders EJ et al. High HIV-1 incidence, correlates of HIV-1 acquisition, and high viral loads following seroconversion among MSM. *AIDS*. 2013;28;27(3):437–46. doi: 10.1097/QAD.0b013e32835b0f81. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3929859/pdf/nihms544598.pdf

38 NACC. 2009. *Kenya AIDS Indicator Survey 2007*. Nairobi: NACC. http://www.nacc.or.ke/nacc%20downloads/official_kais_report_2009.pdf.

39 McKinnon LR et al. High HIV risk in a cohort of male sex workers from Nairobi, Kenya, *Sex Transm Infect* 2013;90(3):237–42. doi: 10.1136/sextrans-2013-051310.

40 Sanders EJ et al. High HIV-1 incidence, correlates of HIV-1 acquisition, and high viral loads following seroconversion among MSM. *AIDS*. 2013;28;27(3):437–46. doi: 10.1097/QAD.0b013e32835b0f81. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3929859/pdf/nihms544598.pdf

who have sex with men and/or male sex workers, and 18,327 people who inject drugs in Kenya.41 In some cities, the percentage of FSWs is as high as 15% of the adult female population. Counties with a high HIV prevalence tend to have more sex workers.

1.3
RISK AND VULNERABILITY

UNAIDS defines 'risk' as 'the probability that a person may acquire HIV infection', usually as a result of specific behaviours that enable HIV transmission to occur.[42] An individual is 'vulnerable' to HIV when his or her ability to avoid infection is diminished by inadequate personal knowledge or skills, by cultural norms that validate risky behaviours, or by circumstances that make risk reduction difficult or impossible.[43],[44],[45] For key populations, many of the factors that cause vulnerability are beyond their control.

HIV prevention among key populations requires reducing their risk *and* their vulnerability. While access to condoms and access to quality treatment for STIs reduce people's HIV risk, interventions need to also address cultural, legal, economic, and other contextual factors that affect vulnerability. By influencing access to income, information, prevention services and commodities, and care and treatment, structural factors affect how well individuals or populations can protect themselves from and cope with HIV infection. Structural factors include punitive legislation and policing practices, stigma and discrimination, education, poverty, and violence.

Violence and Vulnerability

Violence is so common that many key populations consider violence 'normal' or 'part of the job', and do not know that violence violates their rights. As a result, they are often reluctant to report incidents of rape, attempted or actual murders, beatings, molestation, or sexual assault to the authorities. When they do report, their claims are often disregarded.[46] Key populations face various forms of violence:

- **Physical violence:** Being subjected to physical force which can potentially cause death, injury, or harm. It includes, but is not limited to, having an object thrown at one, being slapped, pushed, shoved, hit with the fist or with something else that could hurt, being kicked, dragged, beaten up, choked, deliberately burnt, threatened with a weapon or having a weapon used against one (e.g., gun or knife).

- **Sexual violence**: Rape, gang rape (i.e., by more than one person), sexual harassment, being physically forced or psychologically intimidated to engage in sex or subjected to sex acts against one's will (e.g., undesired touching, oral, anal, or vaginal penetration with penis or with an object) or that one finds degrading or humiliating.

- **Emotional or psychological violence**: Includes, but is not limited to, being insulted (e.g., called derogatory names) or made to feel bad about oneself, being humiliated or belittled in front of other people, being threatened with loss of custody of one's children, being confined or isolated from family or friends, being threatened with harm to oneself or someone one cares about, repeated shouting, inducing fear through intimidating words or gestures, controlling behavior, and the destruction of possessions.

There are several contexts, dynamics, and factors that put key populations at risk for violence.

Violence at the place of work, cruising, or drug use: This may include violence from managers, support staff, clients, or co-workers in establishments where sex work takes place (e.g., brothels, bars, hotels), or by other power structures at cruising sites for MSM, or violence from drug peddlers and pushers at drug sites for PWIDs.

Violence from intimate partners and family members: Stigmatization of key populations

41 NASCOP mapping estimates, 2013

42 UNAIDS. 2007. *Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access*. Geneva: UNAIDS. http://data.unaids.org/pub/Manual/2007/20070306_Prevention_Guidelines_Towards_Universal_Access_en.pdf

43 Bates I et al. Vulnerability to malaria, tuberculosis, and HIV/AIDS infection and disease. Part 1: determinants operating at individual and household level. *Lancet Infectious Diseases* 2004; 4(5):267–277. doi:10.1016/S1473-3099(04)01002-3

44 Bates I et al. Vulnerability to malaria, tuberculosis, and HIV/AIDS infection and disease. Part II: determinants operating at environmental and institutional level. *Lancet Infectious Diseases*. 2004 ;4(6):368–75. doi:10.1016/S1473-3099(04)01047-3

45 UNAIDS. 2007. *Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access*. Geneva: UNAIDS. http://data.unaids.org/pub/Manual/2007/20070306_Prevention_Guidelines_Towards_Universal_Access_en.pdf

46 WHO. 2005. Violence against sex workers and HIV prevention. Violence against Women and HIV/AIDS: Critical Intersections Information Bulletin Series, no. 3. WHO. http://www.who.int/gender/documents/sexworkers.pdf?ua=1

may lead partners or family members to think it acceptable to use violence to 'punish' a key population member who is engaged in sex work or in a same-sex relationship or takes drugs.

Violence by perpetrators at large or in public spaces: In most contexts, as the behaviors of key populations are not necessarily socially accepted and people use moral grounds to stigmatize, members of the general public often persecute key populations in the name of upholding moral values. Key populations may experience violence from landlords, boda boda drivers, religious leaders, etc.

Organized non-state violence: Key populations may face violence from extortion groups, gangs, and chokoras.

State violence: Key populations may face violence from law enforcement officers, like police or county askaris. Criminalization or punitive laws against key populations may provide cover for violence. Violence by representatives of the state compromises key populations' access to justice and police protection, and sends a message that such violence is not only acceptable but socially desirable.

1.3.1 Risk and Vulnerability among Sex Workers

HIV transmission risks faced by SWs include high volume of high-risk partners, inconsistent condom and lubricant use, and high prevalence of sexually transmitted infections and HIV positivity.[47] Common causes of vulnerability among SWs are poverty, stigma, harassment, violence, ignorance or misconceptions about HIV and STIs, and social and gender inequities. Such factors often weaken SWs' ability or determination to avoid coercive working environments, negotiate condom use, refuse sex with dangerous clients, and use health, social, and legal services, and thereby prevent or discourage SWs from protecting their health.

FSWs' risk and vulnerability are evident in findings of surveys among female sex workers in Kenya conducted by NASCOP in 2014.[48] Although most FSW survey participants reported condom use during their most recent sex with a paying client (88%), about 36% reported at least one episode of unprotected sex with a paying client in the preceding one month. The most common reason for not using a condom, given by about a third of FSWs, was client refusal to use a condom, while about one in four FSWs reported that they had engaged in unprotected sex in the past month because of alcohol consumption or because of unavailability of condoms.

In the same survey, 22% of the FSW respondents reported being beaten or physically forced to have sexual intercourse in the past six months, and 44% of the respondents reported being arrested or beaten up by police/ askaris in last six months. The experience of violence increases an individual's risk and vulnerability to HIV.[49] Rape, coercion to have sex without condoms with law-enforcement personnel, and coercion to have sex without condoms in intimate relationships put sex workers at risk. In addition, fear of violence discourages sex workers from coming to places where commodities (condoms/needles) or preventive services are available, or forces them to disregard their safety during sex. Constant experience of violence also leads to anxiety, depression, loss of self-esteem, and neglect of their health, thus making sex workers vulnerable to HIV.[50]

Counterproductive legislation and policies increase FSWs' vulnerability by driving sex work underground, often into unsafe locations, thereby reducing the ability of law enforcement officers and health workers to protect sex workers' health and safety, and introducing the potential for police harassment. In the NASCOP Polling Booth Surveys in 2014, 32% FSW from Eldoret, 20% from Kisumu, , 17% in Mombasa, 27% in Nairobi, 11% in Nakuru, 34% in Nyeri and 28% in Thika reported experiencing physical and sexual violence in the last 6 months. 44% of the FSW (aggregated across 7 sites) reported experiencing arrest or beatings by law enforcement in the last 6 months.

As illustrated in Figure 3, the risks and vulnerabilities faced by FSWs are influenced at the levels of society, community, and the individual.

47 Karnataka Health Promotion Trust. 2012. *A Systematic Approach to the Design and Scale-Up of Targeted Interventions for HIV Prevention among Urban Female Sex Workers*. Bangalore: KHPT. http://www.khpt.org/reports%20pdf/A%20Systematic%20Approach%20to%20the%20Design%20and%20Scale-Up%20of%20Targeted%20Interventions%20for%20HIV%20Prevention,%20full%20version.pdf

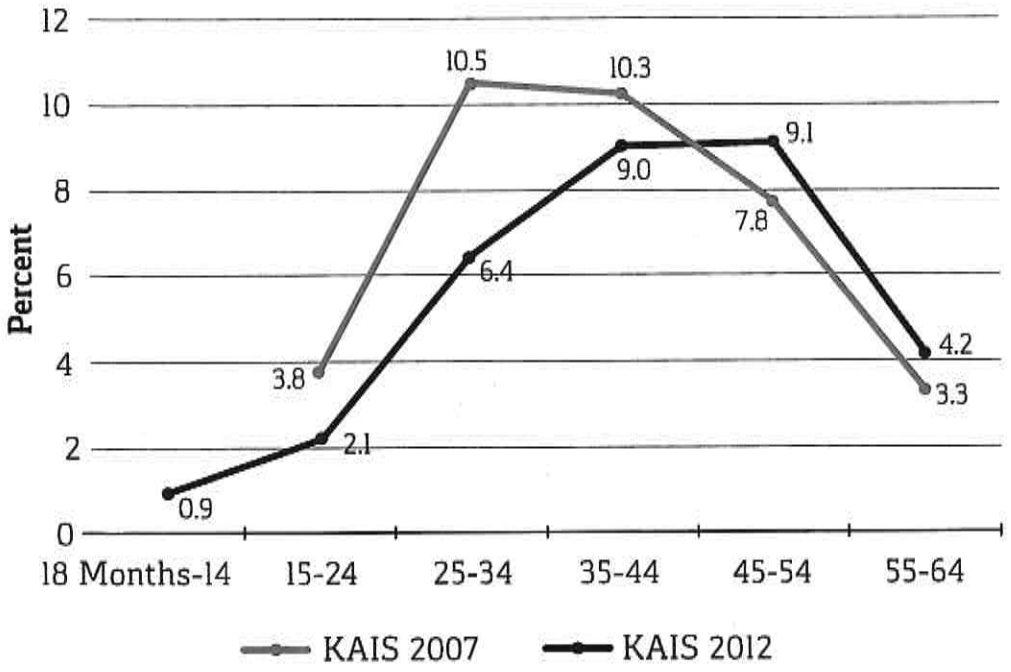
48 Odek W et al. 2014. *Baseline Polling Booth Surveys among Male and Female Sex Workers in Nairobi and Mombasa NASCOP Learning Sites*. Nairobi: NASCOP.

49 See Annex 2.11

50 WHO. 2005. *Violence against Sex Workers and HIV Prevention*. Violence against Women and HIV/AIDS: Critical Intersections Information Bulletin Series, no. 3. WHO. http://www.who.int/gender/documents/sexworkers.pdf?ua=1

Societal factors, including cultural norms, the economy, mass media, government policy, legal frameworks, women's rights, migration, trafficking, and stigmatization, set the context within which risk and vulnerability are formed. At the community level, factors include self-stigma, educational and employment opportunities, religion, alcohol and drug use, violence and crime, social services, and attitudes about sex work and HIV/AIDS. At the individual level, contributing factors include demographics, length of time in sex work, knowledge and beliefs about HIV/AIDS, substance use, and expectations and aspirations for the future. The social organisation of sex work, including the solicitation process, work patterns, and venues, is influenced by the interaction of societal factors, the local sex work environment, and FSW characteristics.

Figure 3: **Risks and Vulnerabilities of FSWs**



The current paucity of local research on vulnerabilities specifically faced by transgender women (male-to-female transgender) hampers HIV-prevention programmes. A study of Hispanic and African American transgender women in the United States found that a key vulnerability for HIV/STIs was the social expression of transgender identity (measured as gender identity disclosure and dressing in female attire). Androphillic (*Androphiles - a subset of transgender women sexually attracted only to men*) sexual orientation, commercial sex partners (sex work), and the social expression of transgender identity were consistently associated with HIV infection.[51]

The study found that transgender women who live out their social lives in the female gender role from an early age and dress accordingly were more likely to become infected with HIV or some other STI. Because of dispositional factors or early socialization, some transgender women may have a greater need than others to express their gender identity at an early age. Once they are 'out' to others and live their lives in the female gender role they may become increasingly marginalized to a social realm where transgenderism is condoned and often desired (sex work). The study found that more than one-half of the transgender women among these populations reported a history of commercial sex clients. Further, due to difficulties in maintaining employment in the legitimate economy, transgender women may be financially compelled to pursue sex work, which then puts them at risk for HIV/STIs.[52]

Other studies have associated HIV/STI vulnerabilities with the following factors:

- Bi-gendered norms can complicate social integration. This complication combines with the effects of transphobia, including internalized transphobia, on access to employment, housing, healthcare, and social and economic inclusion. Social expressions of transgender identity may be psychologically beneficial in important respects, but 'coming out' to others may also expose gender-variant individuals to increased abuse and discrimination and ultimately increase their odds of HIV/STI infections.
- Because of their failure to conform to conventional gender roles, transgender women may experience psychological and physical abuse, which is proclaimed to be a fundamental cause underlying many of the issues confronting gender variant individuals, including HIV infection.
- Lack of access to quality services by well-trained primary and allied health care providers who are knowledgeable about transgendered health and wellness
- Lack of access to affordable and accessible gender reassignment surgery or other surgeries
- Lack of access to unused needles that are the appropriate size for hormone injections

1.3.2 Risk and Vulnerability among Men Who Have Sex with Men

Men who have sex with men are another key population who experience risk and vulnerability to HIV and are therefore a strategically important group on which to focus HIV-prevention programming. High rates of HIV and STIs, low knowledge of HIV status, network risk, survivor guilt, low perception of risk, inconsistent and incorrect condom and lubricant use, unprotected sex with multiple concurrent partners of unknown HIV status, and poor health-seeking behaviour comprise the HIV transmission risks faced by MSM.

Surveys conducted by NASCOP in 2014 in five sites in Kenya found that

- 77% of MSM used a condom and only 54% of the MSM used lubricants in last anal sex
- 60% of the MSM penetrated/inserted into the partner during their most recent anal sex
- 61% of the MSM respondents also exchanged sex for money or goods with other men
- 57% of the respondents had a female regular partner and 64% of the MSM respondents also

51 Nuttbrock L et al. Lifetime risk factors for HIV/STI infections among male-to-female transgender persons. *J Acquir Immune Defic Syndr*. 2009;52(3): 417–421. doi:10.1097/QAI.0b013e3181ab6ed8. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2784264/pdf/nihms-139784.pdf

52 Ibid.

had a regular male partner (who does not pay for sex)

- 31% of MSM had one occasion of unprotected sex in the past month
- 23% and 30% of the MSM respondents did not use a condom because the sexual partner did not want to use a condom or the partner had been drinking, respectively.

Stigma towards MSM, criminalization of anal sex, and the 'heteronormativity' of sexual health services discourage MSM from seeking medical services and disclosing their sexual behaviour and sexual health problems to health workers. Religious intolerance and homophobia—the fear of or antipathy against homosexuals—lead to social disapproval, marginalization, and persecution of MSM, increasing their vulnerability to HIV transmission. There have been numerous reports of hate crimes, including murder, against MSM. Studies of MSM in other African countries indicate that many MSM (43% among MSM surveyed in Senegal) have experienced at least one instance of rape.[53] Social rejection can exacerbate internalized homophobia and create psychological stress among MSM.[54] The NASCOP Polling Booth Survey study reported that 17% of MSM experienced beating and sexual harassment, while 24% of the respondents were arrested or beaten by police/ askaris in the last six months.

1.3.3 Risk and Vulnerability among People Who Inject Drugs

A 2012 rapid situation assessment of the status of drug and substance abuse in Kenya revealed an increase in lifetime use of heroin among persons aged 15–65 years from 0.4% in 2007 to 0.7% in 2012.[55] Both the UNODC/ICHIRA RSA of PWID in Nairobi and Mombasa and the Population Council's Integrated Bio-Behavioural Survey (IBBS) conducted in 2011 revealed that 90% of PWID are male. Almost all PWID inject drugs daily, with 75% injecting at least thrice per day. Between 33% and 50% of them have shared injecting equipment with close friends or primary sex partners.

Among PWID, HIV and other blood-borne infections, such as hepatitis B (HBV) and hepatitis C (HCV), are spread primarily through sharing of contaminated syringes and drug injection equipment. Although needles and syringes are sold by pharmacies, some pharmacy staff refuse to sell injecting equipment to people they suspect of abusing drugs.[56] Sharing of injecting equipment is common among drug users in Kenya, and evidence suggests that awareness is low regarding the risks associated with injecting.[57] The NASCOP PBS done with PWID found that 36% of PWID reported having an occasion in the past one month when they could not find a new needle. Seventeen per cent shared a needle with another person when they injected drugs the last time. Half the PWID had experienced a drug overdose. The survey also found overlapping risk. Nineteen per cent of female injecting drug users had sex with a paying client in the last one month. Similarly, 35% of the male PWID paid for sex in the last one month. Only 67% of the PWID used a condom when they bought or sold sex last time.

PWID serve as a potential epidemiological bridge for HIV transmission to other populations through unprotected sex with non-drug-using sexual partners, and through perinatal transmission to newborns.[58]

Of additional concern are the levels of violence and harassment experienced by PWID. On average, 31% of respondents in the UNODC/ICHIRA Rapid Situational Assessment (2012) had been confronted by police or other authorities in the past six months, and an assessment of female drug users in Malindi by the OMARI Project highlights widespread police extortion and non-existent legal representation. In the PBS conducted by NASCOP, 57% of the PWID report being arrested or beaten by police or askaris in the last six months.

53 NACC and Population Council. 2009. *The Overlooked Epidemic: Addressing HIV Prevention and Treatment among Men Who Have Sex with Men in sub-Saharan Africa.* Report of a consultation, Nairobi, Kenya, 14–15 May 2008. Nairobi: Population Council. http://www.popcouncil.org/uploads/pdfs/HIV_KenyaMSMMeetingReport.pdf

54 Sharma A et al. Sexual identity and risk of HIV/STI among men who have sex with men in Nairobi. *Sex Transm Dis.* 2008;35(4):352–4. doi: 10.1097/OLQ.0b013e31815e6320. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2929353/pdf/dyq057.pdf

55 National Authority for the Campaign against Alcohol and Drug Abuse (NACADA). 2012. *Rapid Situation Assessment of the Status of Drug and Substance Abuse in Kenya, 2012.* Nairobi: NACADA.

56 Beckerleg S, Telfer M, and Hundt GL. The rise of injecting drug use in east Africa: a case study from Kenya. *Harm Reduction Journal.* 2005; 2(12) doi:10.1186/1477-7517-2-12. http://www.harmreductionjournal.com/content/pdf/1477-7517-2-12.pdf

57 Beckerleg S, Telfer M, and Hundt GL. The rise of injecting drug use in east Africa: a case study from Kenya. *Harm Reduction Journal.* 2005; 2(12) doi:10.1186/1477-7517-2-12. http://www.harmreductionjournal.com/content/pdf/1477-7517-2-12.pdf

58 PEPFAR (The U.S. President's Emergency Plan for AIDS Relief). 2010. *Comprehensive HIV Prevention for People Who Inject Drugs, Revised Guidance.* http://www.pepfar.gov/documents/organization/144970.pdf

1.3.4 Overlapping Risks and Vulnerabilities

Many people from key populations compound their risk by engaging in more than one high-risk behaviour (e.g., injecting drugs and engaging in sex work, or a man who has sex with other men who also injects drugs). Thus, they are likely to have higher HIV prevalence rates than those with only one type of risk. Subgroups of key populations may have especially high risk for HIV infection.[59]

1.3.5 Adolescents and Young People from Key Populations

Studies are limited, but they consistently show that adolescents and young people from key populations are more vulnerable than older cohorts to STIs, HIV, and other sexual and reproductive health problems.[60] Rapid physical, emotional, and mental development; complex psychosocial and socio-economic factors; and poor access to and uptake of services increase their vulnerability and risk.[61] Particularly for those under 18 years of age, policy and legal barriers related to age of consent often prevent access to a range of health services, including HIV testing and counselling, and harm reduction and other services provided specifically for key populations. Such barriers also limit adolescents' ability to exercise their right to informed and independent decision making. Adolescents from key populations may face stigma, discrimination, and violence even greater than that faced by older people from key populations. Fearing discrimination and/or legal trouble, many adolescents from key populations are reluctant to attend diagnostic and treatment services. Consequently, they remain hidden from many essential health interventions, further perpetuating their exclusion.[62]

59 WHO. 2004. Evidence for Action: *Effectiveness of Community-Based Outreach in Preventing HIV/AIDS among Injecting Drug Users*. Geneva: WHO. http://www.who.int/hiv/pub/prev_care/evidenceforactionreprint2004.pdf.

60 Interagency Working Group on Key Populations. 2014. A background review of the global epidemiology among young people from key populations. Geneva: Interagency Working Group on Key Populations. Unpublished.

61 FHI. 2010. *Young People Most at Risk of HIV: A Meeting Report and Discussion Paper from the Interagency Youth Working Group, U.S. Agency for International Development, the Joint United Nations Programme on HIV/AIDS (UNAIDS) Inter-Agency Task Team on HIV and Young People, and FHI*. Research Triangle Park, North Carolina: FHI. http://www.unfpa.org/webdav/site/global/shared/iattyp/docs/Young%20People%20Most%20at%20Risk%20of%20HIV.pdf

62 WHO. 2014. *Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations*. Geneva: WHO. http://apps.who.int/iris/bitstream/10665/128048/1/9789241507431_eng.pdf?ua=1&ua=1

1.4
TYPOLOGIES

To guide HIV prevention efforts, programmers define typologies within each key population on the basis of common traits that present distinct levels of risk and vulnerability. These typologies are used by programmes to tailor prevention and outreach strategies specifically and appropriately for the risks and vulnerabilities associated with each typology, and to give priority to typologies that are most at risk and most vulnerable.[63]

1.4.1 Typologies of Female Sex Workers

In the past, female sex workers have been categorised according to various criteria, including practice, mode of operation, mode of organisation, nature of the sex work network, place of sex, primary place of solicitation, earnings, and level of autonomy from brothel owners. However, a categorization system should be clearly specified, with mutually exclusive and exhaustive categories that use directly measurable criteria and generally recognized definitions of FSW category. For the purposes of mapping and programme design, sex workers must be categorized according to their primary identity and terms of engagement in the sex trade.

One categorization system for sex workers is based on the types of places where they solicit clients, either directly or indirectly. By categorising sex work according to the place of solicitation, three key typologies have been identified that are applicable to FSWs in Kenyan urban and rural settings: 1) public/street-based sex work, 2) home-based sex work, and 3) venue-based sex work.

Public/Street-Based Sex Work

Public/street-based sex workers tend to work in the evenings and solicit and pick up clients in streets and public places /parks, whereas beach-based sex workers tend to ply lake/ sea shores during the day. Solicitation generally occurs directly by the sex

63 Karnataka Health Promotion Trust. 2012. *A Systematic Approach to the Design and Scale-Up of Targeted Interventions for HIV Prevention among Urban Female Sex Workers*. Bangalore: KHPT. http://www.khpt.org/reports%20pdf/A%20Systematic%20Approach%20to%20the%20Design%20and%20Scale-Up%20of%20Targeted%20Interventions%20for%20HIV%20Prevention,%20full%20version.pdf

worker, though in some instances it occurs through pimps and brokers in the same public spaces. Taxi drivers or bar owners may facilitate access to such sex workers, but most operate independently. Sexual services typically occur in places that are known to the sex worker or client, such as lodges, brothels, uninhabited buildings, the home of the client, on the streets, in car parks, and other public spaces. After venue-based sex work, public/street-based sex work constitutes the second most common typology of sex work in Kenya.[64] Public/street-based sex workers are highly vulnerable to assault and crime.

Home-Based Sex Work

Home-based sex workers typically operate from their homes. They can directly control how they perform sex work, including the choice of clients and payments. Clients are contacted through word of mouth, middle men and through referrals from other sex workers. Sex typically occurs in the home when co-habiting partners are away or in the home or lodge of the client's choice. Emerging trends indicate that home-based sex work is prevalent in rural settings while in urban settings this type of sex work takes place predominantly in slum areas. Home based sex workers are considered the most hidden and may be the most difficult to reach through outreach.

Venue-Based Sex Work

Venue-based sex work is the primary type of sex work in Kenya. Venue-based sex workers solicit in brothels, bars, bars with attached lodging, strip clubs / night clubs, and massage parlours.

Brothel-based sex workers operate from brothels (recognized or hidden) or **sex dens** (similar to brothels but un-regulated) and clients are arranged through the brothel managers or madams who receive a portion of the earnings. Typically, a small group of sex workers will work out of one brothel and have little or no control over the choice of clients. Sex occurs in the brothel or at an alternative location of the client's choice, such as a lodge or at his home.

Other venues in which sex is exchanged for money may be further classified as follows:

Bars (without lodging) where men go to drink and pick up sex workers. These venues include registered/licensed facilities and drinking dens in commercial, urban, peri-urban, rural, and slum settings.

Bars with lodging (bars which have adjacent boarding facilities) are establishments where men will go to drink and pick up either bar hostesses who may also trade in sex or sex workers who ply the location, with whom they will retire to an adjoining room for sex. Taxi drivers and bar and hotel owners usually facilitate the sex worker-client interaction and may or may not receive a portion of the sex worker's earnings. In **the rural context**, bars may translate to local brew dens where the proprietors and staff facilitate the sex worker-client interaction and may or may not receive a portion of the sex workers' earnings.

Strip clubs / night clubs are where men may pick up strippers who also trade in sex or sex workers who frequent the clubs, and retreat to an alternative location for sex. These are clubs or bars where close, erotic dance occurs. Although management discourages physical contact, it is possible that sex may be negotiated in some lap dancing bars.

Massage parlours whose range of services may include paid sexual services. In rural settings these may translate into hair and beauty salons and barber shops. Proprietors or personnel may facilitate the sex worker-client interaction and may or may not receive a portion of the sex workers' earnings.

Others - Online Networks

In addition to the specific sex work typologies noted above, there are a number of others that can be found in different settings, such as **escort services**. This is the most discreet type of sex work. The client usually contacts an escort (i.e., sex worker) by calling a listed phone number through a contact, hotel staff, or online. Services are provided at the clients home or hotel room. Escort services are usually run by a management team that requires a certain percentage of the money sex workers receive from clients.

The typologies used here are often overlapping and fluid. For example, a sex worker may be street

64 Odek WO et al. Estimating the size of the female sex worker population in Kenya to inform HIV prevention programming. *PLoS ONE 2014*: 9(3): e89180. doi:10.1371/journal.pone.0089180. http://www.plosone.org/article/fetchObject.action?uri=info%3Adoi%2F10.1371%2Fjournal.pone.0089180&representation=PDF

based for some time and then go into a contract with a lodge owner to become lodge based. Or a brothel-based sex worker may move to another town or city temporarily and work as a street based sex worker.

1.4.2 Typologies of Male Sex Workers

In a mapping exercise carried out by NASCOP, MSM and male sex workers (MSWs) were grouped according to their location of congregation (including popular venues, the streets, home-based, and escort services). However, like MSM, MSWs are typologised according to their sexual behaviour. More research is needed in Kenya to identify and profile MSM typologies and to learn the proportions of MSM who are at higher risk and those among the group who are MSW.

Typologies of Men Who Have Sex with Men
For operational and programming purposes, the following typologies* will apply:
Top - Refers to men who penetrate their partner during penile anal sex.
Bottom - Refers to men who are penetrated during penile anal sex.
Versatile - Refers to males who are both insertive and receptive during penile anal sex.

NB *While it is important to know whether men prefer to be bottoms or tops or versatile, health service providers should make sure that men understand the risk of unprotected receptive anal intercourse and avoid asking private questions about which sexual roles people prefer.

Identities, Contexts, and Practices

Men with non-heterosexual identity (gay, homosexual, bisexual, or other culture-specific concepts that equate with attraction to other men)

Men who consider themselves heterosexual but who engage in sex with other males for reasons like isolation, economic compensation, sexual desire, and gender scripts.

Settings with forced gender segregation, such as prisons and military establishments, are important contexts for male-to-male sexual activity not linked to homosexual identity.

Sex between men includes anal sex, oral sex, mutual masturbation, or any combination of these practices.

Many MSM conceal their sexual preference because of societal expectations, and publicly conform to patriarchal norms due to fear of discrimination, arrest, or violence.

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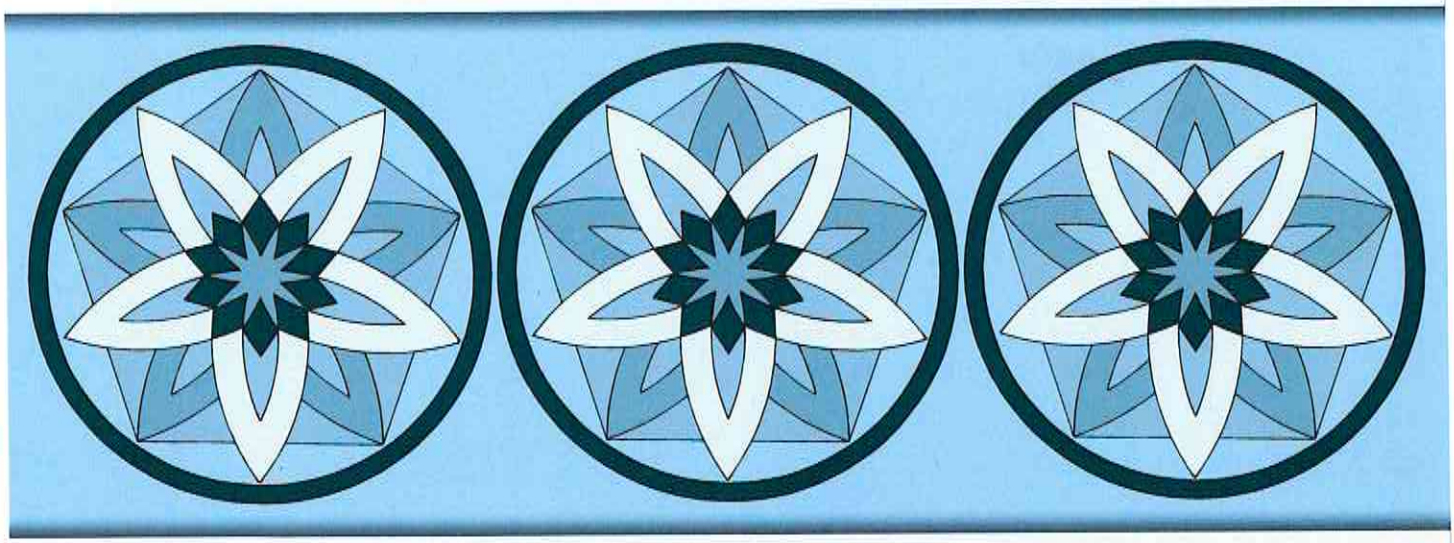
referred to in the Annexed affidavit/Declaration
of [illegible]
Sworn/Declared before me on this [illegible]
day of [illegible] 20[illegible]
at [illegible] in the Republic of Kenya

Commissioner for Oaths

Kenya



Demographic and Health Survey

2014

Table 4.2.2 Number of men's wives

Percent distribution of currently married men age 15-49 by number of wives, according to background characteristics, Kenya 2014

Background characteristic	Number of wives		Total	Number of men
	1	2+		
Age				
15-19	*	*	100.0	16
20-24	98.7	1.3	100.0	377
25-29	97.8	2.2	100.0	1,201
30-34	96.3	3.7	100.0	1,398
35-39	92.9	7.1	100.0	1,277
40-44	92.7	7.3	100.0	1,100
45-49	89.1	10.9	100.0	727
Residence				
Urban	95.6	4.4	100.0	2,894
Rural	93.6	6.4	100.0	3,201
Region				
Coast	91.9	8.1	100.0	617
North Eastern	81.9	18.1	100.0	103
Eastern	97.0	3.0	100.0	835
Central	97.6	2.4	100.0	773
Rift Valley	94.5	5.5	100.0	1,523
Western	94.1	5.9	100.0	561
Nyanza	88.2	11.8	100.0	767
Nairobi	98.5	1.5	100.0	916
Education				
No education	83.6	16.4	100.0	234
Primary incomplete	93.7	6.3	100.0	1,370
Primary complete	94.4	5.6	100.0	1,677
Secondary+	96.0	4.0	100.0	2,814
Wealth quintile				
Lowest	88.9	11.1	100.0	813
Second	93.7	6.3	100.0	1,036
Middle	95.5	4.5	100.0	1,110
Fourth	95.4	4.6	100.0	1,481
Highest	96.5	3.5	100.0	1,655
Total 15-49	94.5	5.5	100.0	6,095
50-54	89.0	11.0	100.0	667
Total 15-54	94.0	6.0	100.0	6,762

Note: An asterisk denotes a figure based on fewer than 25 unweighted cases that has been suppressed.

4.3 AGE AT FIRST MARRIAGE

The start of marriage is an important social and demographic indicator and, in most societies, represents the point in a person's life when childbearing first becomes acceptable. The duration of exposure to the risk of pregnancy depends primarily on the age at which women first marry. Women who marry early, on average, are more likely to have their first child at a young age and give birth to more children overall, contributing to higher fertility. Age at first marriage is defined as the age at which the respondent began living with her or his first spouse/partner.

Table 4.3 shows the percentage of women and men age 15-49 who were first married by specific ages, according to current age. Marriage occurs relatively early in Kenya; among women age 25-49, 29 percent were married by age 18, and 48 percent were married by age 20. The median age at first marriage among women age 25-49 is 20.2 years.

The median age at first marriage does not vary much across the age cohorts from 25-29 to 45-49, hovering around age 20. However, the proportion of women married by age 15 increases with age from about 2 percent among those currently age 15-19 to 9 percent among those currently age 40-49. This is an indication of rising age at first marriage.

Men tend to marry later than women. The median age at first marriage among men age 30-49 is 25.3 years. Eleven percent of men age 25-49 were married by age 20, and less than half (48 percent) were married before age 25. The median age at first marriage for men is almost constant across the age cohorts, reflecting stability over time.

Table 4.3 Age at first marriage

Percentage of women and men age 15-49 who were first married by specific exact ages and median age at first marriage, according to current age, Kenya 2014

Current age	Percentage first married by exact age: 15	18	20	22	25	Percentage never married	Number of respondents	Median age at first marriage
				WOMEN				
15-19	1.6	na	na	na	na	86.8	5,820	a
20-24	4.4	22.9	40.7	na	na	38.8	5,735	a
25-29	8.4	28.4	45.9	62.3	79.1	14.0	6,100	20.5
30-34	6.3	28.6	48.2	63.9	78.5	8.0	4,510	20.2
35-39	6.6	25.5	46.0	64.2	79.8	6.7	3,773	20.4
40-44	8.9	30.5	51.1	67.6	80.3	5.0	2,885	19.9
45-49	9.3	32.5	52.2	68.4	82.2	4.8	2,257	19.8
20-49	7.0	27.4	46.3	na	na	15.6	25,259	a
25-49	7.8	28.7	48.0	64.5	79.6	6.8	19,524	20.2
				MEN				
15-19	0.1	na	na	na	na	99.3	2,540	a
20-24	0.3	2.5	7.9	na	na	79.6	2,125	a
25-29	0.1	3.9	12.2	24.0	48.1	37.0	2,104	a
30-34	0.2	4.0	11.3	24.5	49.5	12.6	1,785	25.1
35-39	0.2	3.5	9.6	24.1	51.0	4.8	1,483	24.9
40-44	0.3	3.3	9.5	21.3	43.1	3.2	1,224	25.6
45-49	0.1	2.9	9.3	21.1	44.3	2.7	800	25.8
20-49	0.2	3.4	10.1	na	na	29.7	9,522	a
25-49	0.2	3.6	10.7	23.4	47.8	15.4	7,397	a
30-49	0.2	3.5	10.1	23.1	47.7	6.8	5,293	25.3
20-54	0.2	3.3	10.0	na	na	27.6	10,279	a
25-54	0.2	3.6	10.6	23.1	47.6	14.1	8,153	a
30-54	0.2	3.4	10.0	22.8	47.5	6.1	6,049	25.3

Note: The age at first marriage is defined as the age at which the respondent began living with her/his first spouse/partner.
na = Not applicable due to censoring
a = Omitted because less than 50 percent of the women or men began living with their spouse or partner for the first time before reaching the beginning of the age group

Table 4.4 shows the median age at first marriage among women age 25-49 and men age 30-54, according to background characteristics. Urban women marry two years later than rural women (21.5 years and 19.5 years, respectively). Women from Nairobi, the region with the highest median at 22.1 years, marry about three years later than women from the North Eastern, Nyanza, and Western regions. Median age at first marriage increases with increasing education. Women with at least some secondary education marry about five years later than those with no education (22.7 years and 17.9 years, respectively). Also, women from the highest wealth quintile marry more than four years later than those from the lowest quintile.

Although some variation exists in the median age at first marriage for men, the range in age at marriage is not as broad by background characteristics as it is for women. Urban men marry one year later than rural men. Men from the Nairobi, Coast, and Central regions have the highest median age at first marriage (26.0 years or greater), while those from the Nyanza and Western regions have the lowest median age (23.8 and 24.1 years, respectively). Wealth quintile has a positive association with men's age at first marriage, as it does for women, but the age range is only 2 years for men, whereas it is 5 years for women.

Table 4.4 Median age at first marriage by background characteristics

Median age at first marriage among women age 25-49, and median age at first marriage among men age 30-54, according to background characteristics, Kenya 2014

Background characteristic	Women age 25-49	Men age 30-54
Residence		
Urban	21.5	25.9
Rural	19.5	24.8
Region		
Coast	19.7	26.4
North Eastern	18.6	24.9
Eastern	20.5	25.5
Central	21.4	26.0
Rift Valley	20.0	25.3
Western	19.2	24.1
Nyanza	18.6	23.8
Nairobi	22.1	26.1
Education		
No education	17.9	24.5
Primary incomplete	18.3	24.0
Primary complete	19.7	24.5
Secondary+	22.7	26.3
Wealth quintile		
Lowest	18.3	24.3
Second	19.1	24.6
Middle	19.6	25.0
Fourth	20.6	25.1
Highest	22.6	26.6
Total	20.2	25.3

Note: The age at first marriage is defined as the age at which the respondent began living with her/his first spouse/partner.

At the county level, median age at first marriage for women is highest in Nairobi (22.1 years), Nyeri (21.8), Kiambu and Embu (21.6 each), and Mombasa (21.5) and lowest in Migori (17.1), Tana River (17.3), Homa Bay (17.5), Wajir (18.1), and Marsabit (18.3). The median age at first marriage for men is highest in Mombasa (27.7 years) and Marsabit (27.6), and lowest in Migori (22.2) and Busia (22.3) (Table 4.4C).

Table 4.4C Median age at first marriage by county

Median age at first marriage among women age 25-49, and median age at first marriage among men age 30-54, according to county, Kenya 2014

County	Women age 25-49	Men age 30-54
Coast	**19.7**	**26.4**
Mombasa	21.5	27.7
Kwale	19.1	25.3
Kilifi	18.9	24.8
Tana River	17.3	24.5
Lamu	19.4	25.1
Taita Taveta	21.4	26.7
North Eastern	**18.6**	**24.9**
Garissa	18.7	24.8
Wajir	18.1	24.0
Mandera	19.0	26.6
Eastern	**20.5**	**25.5**
Marsabit	18.3	27.6
Isiolo	18.5	25.3
Meru	20.3	25.4
Tharaka-Nithi	21.0	25.1
Embu	21.6	26.5
Kitui	19.8	24.3
Machakos	21.0	26.4
Makueni	20.4	24.5
Central	**21.4**	**26.0**
Nyandarua	20.7	25.6
Nyeri	21.8	25.3
Kirinyaga	21.1	25.3
Murang'a	21.3	26.6
Kiambu	21.6	26.3
Rift Valley	**20.0**	**25.3**
Turkana	18.9	24.2
West Pokot	19.0	24.5
Samburu	18.4	26.2
Trans-Nzoia	19.6	24.6
Uasin Gishu	20.9	25.9
Elgeyo Marakwet	20.5	24.2
Nandi	20.7	25.4
Baringo	20.7	26.1
Laikipia	20.6	26.0
Nakuru	20.6	25.6
Narok	18.6	24.9
Kajiado	21.3	26.7
Kericho	19.5	25.0
Bomet	18.9	24.8
Western	**19.2**	**24.1**
Kakamega	19.2	24.7
Vihiga	20.6	24.6
Bungoma	19.2	23.9
Busia	18.4	22.3
Nyanza	**18.6**	**23.8**
Siaya	19.1	24.3
Kisumu	19.1	24.5
Homa Bay	17.5	23.8
Migori	17.1	22.2
Kisii	19.3	23.4
Nyamira	19.7	24.5
Nairobi	**22.1**	**26.1**
Total	20.2	25.3

Note: The age at first marriage is defined as the age at which the respondent began living with her/his first spouse/partner.

4.4 Age at First Sexual Intercourse

Age at first marriage is often used as a proxy for first exposure to sexual intercourse, but the two events do not necessarily occur at the same time. In the 2014 KDHS, women and men were asked how old they were when they first had sexual intercourse. Table 4.5 shows the percentage of women and men who had first sexual intercourse by specific ages and the median age at first intercourse, irrespective of marital status. This information allows an assessment of the age at which women and men start having sexual intercourse and the trends across age cohorts.

Fifteen percent of women age 20-49 had first sexual intercourse by age 15, 50 percent by age 18, and 71 percent by age 20. Older women are slightly more likely to have had their first sexual encounter at an earlier age. Men have an earlier sexual debut than women, a pattern that holds true for most age groups. For example, 22 percent of men age 20-49 had first sexual intercourse by age 15, 56 percent by age 18, and 76 percent by age 20. The median age at first sexual intercourse among men age 20-49 (17.4 years) is also slightly lower than that among women (18.0 years).

Three percent of both women and men age 20-49 have never had sexual intercourse, while 37 percent of women and 38 percent of men age 15-24 have never had sexual intercourse. There does not appear to be a change in age at first sex compared with the 2008-09 KDHS.

Table 4.5 Age at first sexual intercourse

Percentage of women and men age 15-49 who had first sexual intercourse by specific exact ages, percentage who never had sexual intercourse, and median age at first sexual intercourse, according to current age, Kenya 2014

Current age	Percentage who had first sexual intercourse by exact age: 15	18	20	22	25	Percentage who never had intercourse	Number	Median age at first intercourse
				WOMEN				
15-19	10.7	na	na	na	na	62.7	5,820	a
20-24	13.6	46.7	71.1	na	na	10.7	5,735	18.2
25-29	14.9	49.0	69.8	81.8	90.6	1.7	6,100	18.1
30-34	13.8	49.1	69.4	80.8	88.6	0.7	4,510	18.1
35-39	14.7	50.1	69.6	81.8	89.1	0.4	3,773	18.0
40-44	17.0	52.2	72.2	83.7	89.6	0.4	2,885	17.8
45-49	16.4	54.3	73.4	83.0	90.7	0.3	2,257	17.6
20-49	14.7	49.5	70.6	na	na	3.1	25,259	18.0
25-49	15.1	50.3	70.4	82.0	89.7	0.9	19,524	18.0
15-24	12.1	na	na	na	na	36.9	11,555	a
				MEN				
15-19	19.6	na	na	na	na	59.4	2,540	a
20-24	22.6	57.2	78.6	na	na	11.5	2,125	17.3
25-29	25.0	60.3	78.5	88.3	93.9	2.8	2,104	17.0
30-34	23.1	55.7	76.1	88.3	93.9	0.6	1,785	17.4
35-39	17.3	54.4	73.6	86.7	92.2	0.3	1,483	17.6
40-44	20.7	52.9	74.5	85.6	90.3	0.3	1,224	17.7
45-49	16.2	54.0	74.1	84.7	91.9	0.3	800	17.6
20-49	21.6	56.3	76.4	na	na	3.4	9,522	17.4
25-49	21.3	56.1	75.8	87.2	92.8	1.1	7,397	17.4
15-24	21.0	na	na	na	na	37.6	4,666	a
20-54	21.3	56.0	76.1	na	na	3.2	10,279	17.4
25-54	20.9	55.7	75.5	86.8	92.6	1.0	8,153	17.4

na = Not applicable due to censoring
a = Omitted because less than 50 percent of the respondents had sexual intercourse for the first time before reaching the beginning of the age group

Table 4.6 shows the median age at first sexual intercourse among women age 20-49 and 25-49 and men age 20-54 and 25-54 by background characteristics. Women in rural areas initiate sexual activity slightly earlier than their urban counterparts. Among women age 20-49, sexual activity begins earliest in the Nyanza region (16.4 years) and latest in Nairobi (19.3 years). With respect to education, women with at least some secondary education begin sexual activity three years later than those with no education. Similarly, women in the highest wealth quintile tend to initiate sexual activity three years later than those in the lowest.

The data for men age 25-54 show fewer and less dramatic patterns than those seen among women. There are minimal differences in median age by residence, education, and wealth. By region, however, differences in median age at first sex are more substantial. The median age at first sex for men in the Eastern region is 16.1 years, as compared with 24.1 years for men in the North Eastern region.

Table 4.6 Median age at first sexual intercourse by background characteristics

Median age at first sexual intercourse among women age 20-49 and age 25-49, and median age at first sexual intercourse among men age 20-54 and age 25-54, according to background characteristics, Kenya 2014

Background characteristic	Women age 20-49	Women age 25-49	Men age 20-54	Men age 25-54
Residence				
Urban	18.8	18.8	17.6	17.6
Rural	17.4	17.3	17.3	17.3
Region				
Coast	18.3	18.2	18.2	18.3
North Eastern	19.0	18.9	a	24.1
Eastern	18.0	17.9	16.2	16.1
Central	19.1	19.0	18.3	18.4
Rift Valley	17.7	17.7	16.9	16.9
Western	17.1	16.9	17.1	17.1
Nyanza	16.4	16.3	17.1	17.2
Nairobi	19.3	19.6	17.8	17.9
Education				
No education	16.4	16.5	18.2	18.3
Primary incomplete	16.2	16.2	16.5	16.6
Primary complete	17.5	17.6	17.2	17.3
Secondary+	19.5	19.7	17.8	17.9
Wealth quintile				
Lowest	16.6	16.6	17.3	17.3
Second	16.9	16.9	16.9	16.9
Middle	17.4	17.3	17.1	17.2
Fourth	18.2	18.1	17.4	17.4
Highest	19.6	19.7	18.0	18.1
Total	18.0	18.0	17.4	17.4

a = Omitted because less than 50 percent of the respondents had intercourse for the first time before reaching the beginning of the age group

At the county level, the five counties with the highest median age at first sexual intercourse for women are Mandera (19.4 years), Tharaka-Nithi (19.4), Kiambu (19.4), Mombasa (19.3), and Nairobi (19.3). The counties with the lowest median age include Migori (15.5), Homa Bay (15.7), Samburu (15.7), Kisumu (16.4), and Siaya (16.6). For men, Garissa (23.6) and Wajir (22.7) counties recorded the highest median age at first sexual intercourse, while Meru (14.4) and Samburu (15.0) had the lowest median age at first sexual intercourse (Table 4.6C).

Table 4.6C Median age at first sexual intercourse by county

Median age at first sexual intercourse among women age 20-49 and age 25-49, and median age at first sexual intercourse among men age 20-54 and age 25-54, according to county, Kenya 2014

	Women age		Men age	
County	20-49	25-49	20-54	25-54
Coast	**18.3**	**18.2**	**18.2**	**18.3**
Mombasa	19.3	19.3	18.1	18.1
Kwale	16.6	16.3	18.5	18.5
Kilifi	18.4	18.3	17.7	17.8
Tana River	17.0	17.0	18.9	19.6
Lamu	18.8	18.6	18.8	18.9
Taita Taveta	19.0	19.0	17.8	17.8
North Eastern	**19.0**	**18.9**	**a**	**24.1**
Garissa	19.1	18.9	a	23.6
Wajir	18.5	18.5	a	22.7
Mandera	19.4	19.3	a	a
Eastern	**18.0**	**17.9**	**16.2**	**16.1**
Marsabit	17.5	17.5	17.9	17.9
Isiolo	18.2	18.5	17.1	17.1
Meru	17.1	17.0	14.6	14.4
Tharaka-Nithi	19.4	19.5	16.3	16.0
Embu	19.1	18.9	18.0	18.3
Kitui	17.7	17.6	16.9	17.0
Machakos	18.3	18.2	15.8	15.6
Makueni	18.1	18.0	17.9	17.8
Central	**19.1**	**19.0**	**18.3**	**18.4**
Nyandarua	18.9	18.8	18.3	18.4
Nyeri	18.7	18.6	19.0	18.9
Kirinyaga	18.9	18.9	17.5	17.3
Murang'a	19.1	19.0	19.0	19.2
Kiambu	19.4	19.3	18.0	18.2
Rift Valley	**17.7**	**17.7**	**16.9**	**16.9**
Turkana	17.6	18.1	18.0	18.0
West Pokot	17.0	17.2	15.8	15.9
Samburu	15.7	15.7	14.9	15.0
Trans-Nzoia	17.8	17.7	17.5	17.6
Uasin Gishu	17.3	17.2	16.1	16.2
Elgeyo Marakwet	17.9	17.8	16.3	16.4
Nandi	16.9	16.7	16.7	16.7
Baringo	17.6	17.7	16.6	16.6
Laikipia	18.1	18.1	18.2	18.3
Nakuru	18.7	18.6	17.2	16.9
Narok	16.7	16.7	17.8	17.6
Kajiado	18.3	18.3	16.6	16.3
Kericho	17.4	17.5	17.0	17.0
Bomet	17.5	17.5	16.6	16.7
Western	**17.1**	**16.9**	**17.1**	**17.1**
Kakamega	17.0	16.8	16.7	16.5
Vihiga	18.1	18.0	17.7	17.5
Bungoma	17.1	16.9	17.1	17.3
Busia	16.6	16.5	17.4	17.4
Nyanza	**16.4**	**16.3**	**17.1**	**17.2**
Siaya	16.6	16.5	16.6	16.7
Kisumu	16.4	16.2	17.9	18.0
Homa Bay	15.7	15.6	15.6	15.8
Migori	15.5	15.4	17.0	17.2
Kisii	17.2	17.3	17.7	17.8
Nyamira	17.1	17.1	18.1	18.1
Nairobi	**19.3**	**19.6**	**17.8**	**17.9**
Total	18.0	18.0	17.4	17.4

a = Omitted because less than 50 percent of the respondents had intercourse for the first time before reaching the beginning of the age group

4.5 Recent Sexual Activity

In the absence of contraception, the probability of pregnancy is related to the regularity of sexual intercourse. Thus, information on sexual activity can give added perspective to measurement of exposure to pregnancy. The 2014 KDHS asked all women and men how long ago their last sexual intercourse occurred. Tables 4.7.1 and 4.7.2 show the percent distribution of women and men age 15-49 by the timing of their last sexual intercourse, according to background characteristics.

Fourteen percent of women and 15 percent of men age 15-49 have never had sexual intercourse. Twelve percent of women and 10 percent of men report that their last sexual encounter occurred more than one year before the survey. Slightly more than half of women (51 percent) and men (54 percent) reported that they had a recent sexual encounter (within the last four weeks). The proportion of both women and men who reported having a recent sexual encounter is similar to that observed in the 2008-09 KDHS.

The proportion of women who were sexually active within the last four weeks is lowest among those in the youngest age group of 15-19 (11 percent) and highest among those age 30-34 (69 percent). Similarly, the proportion of men sexually active in the last four weeks ranges from 10 percent among those age 15-19 to 80 percent among those age 40-44. By marital status, recent sexual activity is most common among those currently married or living together, with 80 percent of married women and 84 percent of married men having had sex in the four weeks before the survey. Male-female differences are greatest among those who have never been married and those who were formerly married. The proportion of never-married men who reported having a recent sexual encounter is about three times that of women (20 percent and 7 percent, respectively), and the proportion among formerly married men is more than twice that among women (37 percent and 17 percent, respectively). These patterns are similar to patterns in the 2003 and 2008-09 KDHS surveys.

Recent sexual activity for both women and men differed by rural-urban residence, with women and men in urban areas somewhat more likely than those in rural areas to report being sexually active in the four weeks preceding the survey. By region, women in Nairobi and Central are most likely to have been sexually active in the four weeks before the survey (55 percent), although regional differences are minimal. Regional variations are wider for men, with Nairobi having the highest proportion of men with recent sexual activity (61 percent) and North Eastern having the lowest (37 percent). There are no patterns evident in recent sexual activity by educational level or wealth among women and no evident pattern for education among men. The proportion of men with recent sexual activity is higher among those in the highest wealth quintile (61 percent) than among those in the other quintiles (50-53 percent).

Table 4.7.1 Recent sexual activity: Women

Percent distribution of women age 15-49 by timing of last sexual intercourse, according to background characteristics, Kenya 2014

Background characteristic	Timing of last sexual intercourse			Never had sexual intercourse	Total	Number of women
	Within the past 4 weeks	Within 1 year[1]	One or more years			
Age						
15-19	11.4	15.3	9.6	63.7	100.0	2,717
20-24	49.2	28.0	12.3	10.5	100.0	2,691
25-29	63.0	25.9	9.0	1.9	100.0	2,932
30-34	69.0	22.3	7.8	0.8	100.0	2,162
35-39	64.9	20.3	14.2	0.6	100.0	1,780
40-44	60.3	20.0	19.1	0.4	100.0	1,292
45-49	57.1	17.4	25.0	0.4	100.0	1,052
Marital status						
Never married	6.8	24.7	18.8	49.5	100.0	4,255
Married or living together	79.5	18.1	2.3	0.0	100.0	8,710
Divorced/separated/widowed	17.3	35.3	47.3	0.0	100.0	1,660
Marital duration[2]						
0-4 years	79.7	18.9	1.3	0.0	100.0	1,992
5-9 years	80.5	18.3	1.1	0.0	100.0	1,747
10-14 years	79.5	18.6	1.8	0.0	100.0	1,593
15-19 years	81.9	15.1	2.8	0.0	100.0	1,260
20-24 years	76.0	20.1	3.9	0.0	100.0	807
25+ years	72.6	20.3	6.9	0.0	100.0	700
Married more than once	83.7	14.1	2.2	0.0	100.0	612
Residence						
Urban	53.9	22.4	11.8	11.7	100.0	5,929
Rural	49.5	21.6	12.5	16.3	100.0	8,696
Region						
Coast	52.5	21.1	10.3	16.1	100.0	1,421
North Eastern	48.7	19.0	9.0	22.4	100.0	299
Eastern	52.8	20.3	10.2	16.7	100.0	2,066
Central	54.8	18.3	13.0	13.8	100.0	1,905
Rift Valley	49.2	23.4	14.1	13.2	100.0	3,714
Western	46.5	23.1	11.8	18.6	100.0	1,571
Nyanza	50.6	23.2	12.9	13.2	100.0	1,908
Nairobi	55.0	23.7	11.5	9.4	100.0	1,742
Education						
No education	55.0	25.4	14.8	4.3	100.0	1,015
Primary incomplete	51.2	19.6	11.3	17.8	100.0	3,793
Primary complete	59.6	21.5	12.4	6.5	100.0	3,543
Secondary+	46.1	23.1	12.3	18.4	100.0	6,274
Wealth quintile						
Lowest	48.0	24.6	13.7	13.4	100.0	2,236
Second	50.7	20.4	12.5	16.3	100.0	2,590
Middle	49.3	22.3	12.2	16.2	100.0	2,859
Fourth	53.9	21.5	11.6	13.1	100.0	3,113
Highest	53.0	21.7	11.6	13.5	100.0	3,827
Total	51.3	22.0	12.2	14.4	100.0	14,625

Note: Totals may not add up to 100 percent because women with missing information are not shown separately.
[1] Excludes women who had sexual intercourse within the last 4 weeks
[2] Excludes women who are not currently married

Table 4.7.2 Recent sexual activity: Men

Percent distribution of men age 15-49 by timing of last sexual intercourse, according to background characteristics, Kenya 2014

Background characteristic	Timing of last sexual intercourse: Within the past 4 weeks	Within 1 year[1]	One or more years	Never had sexual intercourse	Total	Number of men
Age						
15-19	9.6	15.8	15.0	59.4	100.0	2,540
20-24	38.0	34.8	15.6	11.5	100.0	2,125
25-29	62.2	26.6	7.9	2.8	100.0	2,104
30-34	75.2	19.0	5.1	0.6	100.0	1,785
35-39	77.8	16.4	5.4	0.3	100.0	1,483
40-44	79.6	15.7	4.2	0.3	100.0	1,224
45-49	77.2	16.5	5.8	0.3	100.0	800
Marital status						
Never married	20.1	27.7	17.7	34.3	100.0	5,350
Married or living together	84.4	14.5	0.9	0.0	100.0	6,095
Divorced/separated/widowed	37.3	38.9	23.8	0.0	100.0	618
Marital duration[2]						
0-4 years	84.6	13.7	0.8	0.0	100.0	1,483
5-9 years	82.7	16.7	0.5	0.0	100.0	1,282
10-14 years	85.2	13.5	1.2	0.0	100.0	1,089
15-19 years	84.1	14.7	1.1	0.0	100.0	735
20-24 years	82.4	15.9	1.7	0.0	100.0	358
25+ years	87.4	12.2	0.4	0.0	100.0	127
Married more than once	85.7	13.5	0.7	0.0	100.0	1,021
Residence						
Urban	56.7	24.1	8.4	10.4	100.0	5,300
Rural	51.0	19.6	10.4	19.0	100.0	6,762
Region						
Coast	48.8	23.1	11.0	16.7	100.0	1,260
North Eastern	37.1	9.9	9.8	43.1	100.0	227
Eastern	51.7	20.6	11.9	15.9	100.0	1,825
Central	54.4	20.4	9.5	15.5	100.0	1,564
Rift Valley	54.0	22.1	9.6	14.3	100.0	3,050
Western	48.3	19.1	11.1	21.4	100.0	1,164
Nyanza	56.1	20.6	7.5	15.6	100.0	1,405
Nairobi	61.0	26.3	6.2	5.9	100.0	1,568
Education						
No education	58.4	21.0	9.4	11.1	100.0	345
Primary incomplete	48.6	17.9	9.4	24.1	100.0	3,071
Primary complete	64.0	21.1	8.2	6.4	100.0	2,734
Secondary+	50.8	23.8	10.2	14.9	100.0	5,913
Wealth quintile						
Lowest	49.6	18.3	11.5	20.4	100.0	1,691
Second	50.9	21.4	10.0	17.7	100.0	2,145
Middle	50.1	21.3	10.8	17.6	100.0	2,370
Fourth	52.7	24.0	8.8	14.4	100.0	2,959
Highest	61.1	21.5	7.6	9.3	100.0	2,897
Total 15-49	53.5	21.6	9.5	15.2	100.0	12,063
50-54	75.1	17.0	7.2	0.1	100.0	756
Total 15-54	54.7	21.3	9.4	14.3	100.0	12,819

Note: Totals may not add up to 100 percent because men with missing information are not shown separately.
[1] Excludes men who had sexual intercourse within the last 4 weeks
[2] Excludes men who are not currently married

FERTILITY 5

Andrew Kyalo Mutuku, Samwel Ogola, Michael Musyoka

Key Findings

- The total fertility rate for the three years preceding the survey is 3.9 births per woman, with rural women having at least one child more than urban women.
- Fertility has decreased from 4.9 births per woman in 2003 to 3.9 births per woman in 2014, a one-child decline in the past 10 years.
- Half of births occur within three years of a previous birth, with 18 percent occurring within 24 months.
- Childbearing begins early in Kenya, with almost one-quarter of women giving birth by age 18 and nearly half by age 20.
- Eighteen percent of adolescent women age 15-19 are already mothers or pregnant with their first child. In the last five years, teenage pregnancy has remained unchanged.

One of the major objectives of the 2014 KDHS was to examine fertility levels, trends, and differentials in Kenya. Fertility is a principal component of population change that contributes to the size, structure, and composition of the population in a country. This chapter focuses on a number of fertility indicators including levels, patterns, and trends in both current and cumulative fertility; the length of birth intervals; and the age at which women begin childbearing. Birth intervals are important because short intervals are associated with high childhood mortality. The age at which childbearing begins can have a major impact on the health and well-being of both the mother and the child.

To generate data on fertility, a birth history was collected from each woman interviewed in the 2014 KDHS. Women were asked to report on the total number of sons and daughters to whom they had given birth in their lifetime. To ensure that all information was reported, women were asked separately about children still living at home, those living elsewhere, and those who had died. The sex, date of birth, and survival status of each child were obtained, and age at death for deceased children was recorded.

5.1 CURRENT FERTILITY

Measures of current fertility are presented in Table 5.1 for the three-year period preceding the survey, corresponding to the calendar period 2011-2014. A three-year period was used for calculating these rates to provide the most current information while also allowing the rates to be calculated for a sufficient number of cases so as not to compromise the statistical precision of the estimate. Age-specific fertility rates (ASFRs), expressed as the number of births per thousand women in a specified age group, show the age pattern of fertility.[1] The total fertility rate (TFR) is the number of live births a woman would have if she were subject to the current age-specific fertility rates throughout her reproductive period (age 15-49). More generalised indicators of fertility include the general fertility rate (GFR), expressed as the annual number of live births per 1,000 women age 15-44, and the crude birth rate (CBR), expressed as the annual number of live births per 1,000 population.

[1] Numerators for ASFRs are calculated by summing the live births that occurred in the three-year period preceding the survey classified according to the age of the mother (in five-year age groups) at the time of the child's birth. The denominators of the rates represent the number of woman-years lived by the survey respondents in each of the five-year age groups during the specified period.

5.9 TEENAGE PREGNANCY AND MOTHERHOOD

Teenage pregnancy and motherhood has remained a major health and social concern because of its association with higher morbidity and mortality for both the mother and the child. Childbearing during the teenage years also frequently has other adverse social consequences, particularly for female educational attainment, as women who become mothers in their teens are more likely to curtail education.

Table 5.11 presents the percentage of women age 15-19 who have had a live birth or who are pregnant with their first child and the percentage of women who have begun childbearing by selected background characteristics. Fifteen percent of women age 15-19 have already had a birth, and 3 percent are pregnant with their first child. The percentage of women who have begun childbearing increases rapidly with age, from about 3 percent among those age 15 to 40 percent among those age 19.

Table 5.11 Teenage pregnancy and motherhood

Percentage of women age 15-19 who have had a live birth or who are pregnant with their first child, and percentage who have begun childbearing, by background characteristics, Kenya 2014

Background characteristic	Percentage of women age 15-19 who: Have had a live birth	Are pregnant with first child	Percentage who have begun childbearing	Number of women
Age				
15	1.7	1.6	3.2	1,226
16	5.9	2.0	8.0	1,206
17	10.3	4.7	15.0	1,078
18	21.5	4.4	25.9	1,185
19	35.3	4.6	39.9	1,125
Residence				
Urban	14.0	3.3	17.3	1,859
Rural	15.0	3.5	18.5	3,961
Region				
Coast	16.6	4.3	20.8	604
North Eastern	8.7	3.5	12.2	143
Eastern	12.1	2.3	14.4	849
Central	7.7	2.7	10.4	600
Rift Valley	17.0	4.3	21.2	1,492
Western	14.1	2.7	16.8	790
Nyanza	19.2	3.0	22.2	874
Nairobi	13.1	4.3	17.4	467
Education				
No education	29.2	4.1	33.2	133
Primary incomplete	15.7	3.2	18.9	2,102
Primary complete	30.0	6.2	36.2	801
Secondary+	8.8	2.7	11.5	2,783
Wealth quintile				
Lowest	22.3	3.9	26.2	1,040
Second	14.5	3.9	18.4	1,220
Middle	15.8	3.4	19.1	1,331
Fourth	13.1	3.7	16.8	1,113
Highest	8.1	2.1	10.2	1,116
Total	14.7	3.4	18.1	5,820

While rural-urban differences are small, the prevalence of early childbearing varies by region, ranging from 10 percent in Central region to 21 percent in Rift Valley and Coast and 22 percent in Nyanza. One-third of women age 15-19 with no education (33 percent) have begun childbearing, as compared with only 12 percent among those who have a secondary or higher education (Table 5.11). Similarly, teenagers from the poorest households are more likely to have begun childbearing (26 percent) than teenagers from the wealthiest households (10 percent). The proportion of teenagers who have begun childbearing has not changed since the 2008-09 KDHS.

At the county level (Table 5.11C), early childbearing is lowest in Murang'a, Nyeri, Embu, and Elgeyo Marakwet (less than 10 percent each) and highest in Samburu, Nyamira, Tana River, West Pokot, Homa Bay, and Narok (more than 25 percent each).

Table 5.11C Teenage pregnancy and motherhood

Percentage of women age 15-19 who have had a live birth or who are pregnant with their first child, and percentage who have begun childbearing, by county, Kenya 2014

County	Percentage of women age 15-19 who:		Percentage who have begun childbearing	Number of women
	Have had a live birth	Are pregnant with first child		
Coast	**16.6**	**4.3**	**20.8**	**604**
Mombasa	11.6	5.0	16.6	123
Kwale	18.9	5.3	24.2	132
Kilifi	18.8	3.0	21.8	252
Tana River	20.4	7.8	28.2	41
Lamu	8.2	1.9	10.0	20
Taita Taveta	10.0	3.4	13.4	36
North Eastern	**8.7**	**3.5**	**12.2**	**143**
Garissa	8.5	1.7	10.2	67
Wajir	13.8	3.5	17.4	41
Mandera	3.3	6.8	10.1	36
Eastern	**12.1**	**2.3**	**14.4**	**849**
Marsabit	11.9	4.8	16.6	25
Isiolo	18.0	0.9	18.9	18
Meru	18.3	1.5	19.9	185
Tharaka-Nithi	10.4	3.2	13.7	50
Embu	4.7	3.3	8.0	91
Kitui	11.8	3.0	14.8	169
Machakos	12.2	1.7	14.0	143
Makueni	9.3	1.8	11.1	168
Central	**7.7**	**2.7**	**10.4**	**600**
Nyandarua	4.0	5.7	9.7	67
Nyeri	4.2	2.7	6.9	101
Kirinyaga	9.2	2.1	11.3	54
Murang'a	2.6	3.8	6.3	137
Kiambu	12.7	1.4	14.1	242
Rift Valley	**17.0**	**4.3**	**21.2**	**1,492**
Turkana	17.6	2.6	20.2	51
West Pokot	22.8	5.9	28.6	38
Samburu	19.7	6.0	25.7	21
Trans-Nzoia	18.9	4.3	23.3	185
Uasin Gishu	16.4	5.9	22.2	137
Elgeyo Marakwet	7.4	1.2	8.7	51
Nandi	13.8	1.8	15.6	133
Baringo	10.5	2.7	13.2	83
Laikipia	14.8	3.9	18.7	65
Nakuru	13.4	5.0	18.4	295
Narok	33.0	7.4	40.4	107
Kajiado	16.2	4.0	20.2	106
Kericho	17.6	2.9	20.5	91
Bomet	19.6	4.5	24.0	129
Western	**14.1**	**2.7**	**16.8**	**790**
Kakamega	13.5	6.0	19.4	242
Vihiga	10.8	2.0	12.7	98
Bungoma	13.8	0.7	14.4	319
Busia	18.4	2.3	20.8	131
Nyanza	**19.2**	**3.0**	**22.2**	**874**
Siaya	13.6	3.6	17.2	130
Kisumu	12.4	3.1	15.4	179
Homa Bay	31.2	2.1	33.3	177
Migori	20.9	3.4	24.3	140
Kisii	15.9	2.5	18.4	191
Nyamira	23.5	4.3	27.8	58
Nairobi	**13.1**	**4.3**	**17.4**	**467**
Total	14.7	3.4	18.1	5,820

2020/21-2024/25

Ministry of Health

Kenya AIDS Strategic Framework II

Sustain Gains, Bridge Gaps and Accelerate Progress

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2020/21-2024/25

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401

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Introduction

The Kenya AIDS Strategic Framework II is the 5th agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners involved in the HIV response in Kenya. KASF II will be operationalised through 47 County AIDS Implementation Plans in line with principles of devolved governance and reported through agreed country level Monitoring and Evaluation System. The National AIDS Control Council will coordinate the broad based multi-sector partners involved in implementation.

1.1 Addressing HIV is critical to achieving the right to health

The Kenyan Health Policy 2014-2030 prioritises the elimination of communicable diseases including HIV and AIDS in line with the right to the highest attainable standard of health mandated by the Constitution of Kenya (2010). Despite the tremendous progress made in more than three decades of the HIV and AIDS response, the epidemic continues to be a significant contributor to the national disease burden. In 2017, HIV accounted for 19% of all years of life lost in that year. Since the first case was officially reported in 1984 in Kenya, about 2 million people have lost their lives due to AIDS-related deaths (Kenya HIV Estimates, 2020). At the peak of the epidemic in the mid-1990s, HIV caused a decline in life expectancy by about 12 years and led to an increase in child mortality by 20%. Fortunately, there has been a reversal of this trend in the last two decades, spurred by significant progress in preventing new infections, increasing access to life-saving antiretroviral therapies (ART) and scaling up of care and support services for the PLHIV. By the end of 2019, at least, 1.5 million Kenyans were found to be living with HIV while 41,416 new infections were reported and 20,997 AIDS-related deaths had occurred.

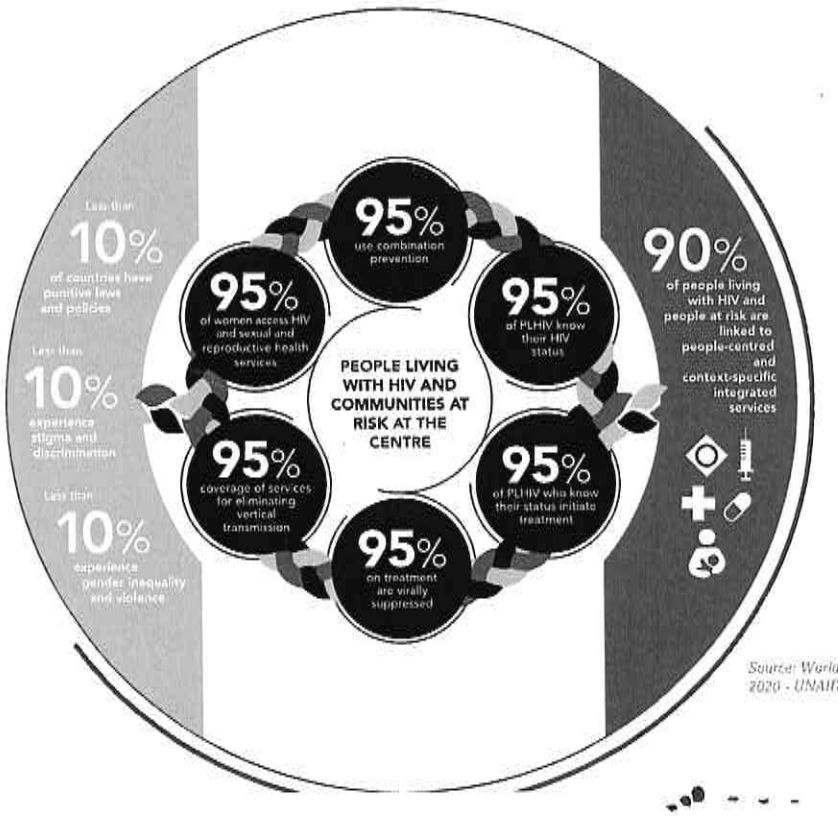
This strategic framework maps out priority areas, strategic interventions, population groups, geographical areas and identifies critical social and programmatic enablers to effectively respond to the HIV challenge. It also provides implementation and management arrangements that will promote effective coordination for programme coherence. KASF II emphasis on the need to consolidate the gains made over the years by identifying programmatic gaps and appropriate interventions that will ensure high impact interventions and approaches are strengthened and scaled up.

1.2 Global, regional and national commitments guiding KASF II implementation

Kenya has made several global, regional and national commitments that will guide the implementation of KASF II:

- **Sustainable Development Goals (SDGs) commitment to end AIDS by 2030:** KASF II is aligned to the SDGs including the goal to end the AIDS epidemic by 2030, inspired by a global vision to progress towards *'zero new HIV infections, zero AIDS-related deaths and zero discrimination'*.

People-Centred 2025 targets



Source: World AIDS Day Report 2020 - UNAIDS

- The **African Union Agenda 2063:** KASF II is aligned to the African Union Agenda 2063 under Goal 3 for a prosperous Africa, focusing on healthy and well-nourished citizens. Ending the AIDS epidemic by 2030 is also a part of the African Union Agenda 2063.

- **East African Community HIV and AIDS Prevention and Management Bill (2012):** This Bill directs governments in the East African Community to ensure that persons living with or are affected by HIV and AIDS are protected from all forms of abuse, discrimination and are provided with appropriate support, care and treatment services.

- **The Constitution of Kenya (2010)**: KASF II is aligned to the Constitution of Kenya in its commitment to provide the highest attainable standard of health to its citizens. In line with the constitution, KASF II will adopt a devolved and participatory planning and service delivery approach by counties, sectors and the people of Kenya through CASPs and sector-specific plans. These plans will be aligned with the KASF II based on county and sector-specific needs.

- The **Kenya Vision 2030:** Kenya Vision 2030 is the long-term development blueprint for the country. The aim of the Vision is to create 'a globally competitive and prosperous country with a high quality of life by 2030'. As a part of its long-term development objectives, it identifies HIV and AIDS as a challenge that needs to be addressed. The Vision is divided into 5-year plans and KASF II is aligned with the current MTP III (2018 - 2020).

- **The Kenya Health Sector Strategic and Investment Plan (KHSSP) of 2018/2019 - 2022/2023:** The KHSSP recognises the contribution of the HIV response to the achievement of targets under the President's 'Big-Four' agenda related to affordable health care for all. This therefore means that KASF II is well-placed to support the KHSSP by prioritising activities to reach the most vulnerable and marginalised population. It aims to achieve the health aspirations of all Kenyan citizens.

1.3 KASF II in Relation to Devolution

Kenya has a decentralised system of governance made up of two levels of government namely: the national government and the 47 county governments as established by the Constitution of Kenya (2010). Devolution of power, resources and representation of citizens facilitate Counties to address HIV related challenges within their local context. KASF II will continue to entrench citizen participation in formulating and implementing AIDS strategies that respond to local needs. To facilitate this process, granulation and dissemination of strategic information will be done at various levels of governance to provide evidence for localised decision-making.

Under the devolved system of governance, county governments have the primary mandate of establishing relevant structures, and prioritising interventions and investments in the provision of HIV and AIDS and other health services. The county governments, in collaboration with stakeholders and partners, are the principal implementers of KASF II. In line with devolved governance, county governments have an obligation to coordinate resource allocation for priority HIV and AIDS and other health interventions so as to fully address priority areas identified. The second generation of County AIDS Implementation Plans will be aligned to country Roadmap to achieve Unversal Health Coverage. NACC will provide technical support to County governments to provide quality HIV services that meet localised needs and context across all health, education and community level implementation platforms. Greater attention will be the need to address to social determinates of health and HIV, building of strong community responses, puttig in place effective governance and coordination structures and domestic allocation of resources to sustain the HIV response.

1.4 KASF II and multi-sectoral perspectives

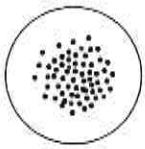
In order to ensure maximum participation of stakeholders and partners, HIV prevention, treatment, care and support interventions need synergy and unified coordination across all sectors, including non-health sectors at the county. KASF II lays emphasis on a multi-sectoral approach to AIDS response that aligns with the globally *"Three Ones Principles of one One agreed HIV and AIDS Action Framework that provides the basis for coordinating the work of all partners; One National AIDS Coordinating Authority, with a broad based multi-sector mandate and One agreed country level Monitoring and Evaluation System"*. It calls out for re-energised platforms for engagement of the public and private sectors, CSOs, FBOs, networks of PLHIV, PwDs, Key Populations and AYPs, research institutions, among other stakeholders in decision-making, implementation of programmes and tracking of results at both levels.

I.5 Progress and trends in the HIV response against global and country commitments

New HIV infections

New HIV infections declined from 75,000 in 2010 to 41,416 in 2019. This amounts to a 44% reduction of cases, which is indicative of substantial progress, but short off the reduction by 75% envisioned by 2020.

New HIV infections among children declined from 18,000 to 6,806, while new HIV infections among adults declined from 56,000 to 34,610. Kenya needs to accerelate progress in the reduction of new HIV infections in a new context: an HIV epidemic that has evolved, the global COVID-19 pandemic, the increasing role of new technologies and a rapidly changing society. Altogether, this requires an HIV prevention response that is persistent in its drive towards core objectives but reflecting innovation. The existing high impact and quality interventions including condom programming, Voluntary Medical Male Circumcision (VMMC), prevention and treatment of Sexually Transmitted Infections, Pre-Exposure Prophylaxis (PrEP), HIV testing and treatment, elimination of Mother-to-Child Transmission (eMTCT), keeping girls in schools, elimination of all forms of gender related violence, ending HIV related stigma and discrimination will need to be expanded to scale.



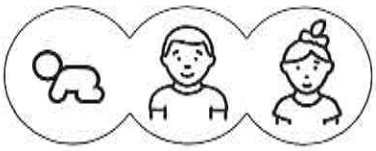
HIV prevalence

Kenya has made commendable progress in the HIV response as evidenced by the progressive decline in HIV prevalence among adults (15-49 years) in the general population, from a peak of about 10% in the mid-1990s to 4.5% in 2020. The HIV epidemic in Kenya continues to be disproportionately higher among females than males. The burden of HIV remains highest for the age category of 15-49 years. The epidemic shows a pattern of generalisation across the country, concentrated among sub-populations, and a mix of both in some geographical locations. The geographical diversity of HIV prevalence ranges from a high of 20.1% in Homa Bay County to a low of 0.2% in Mandera and Wajir counties (Kenya HIV Estimates 2020).

Kenya has made commendable progress in the HIV response noted through progressive decline in HIV prevalence among adults (15-49 years) in the general population, from a peak of about 10% in the mid-1990s down to 4.5% in 2020 and reduction of new HIV infections and AIDS related deaths

Table 2: **Progress In Reduction of HIV Incidence Across 47 Counties 2018-2020**

Increased Infections Reverse Gear		**Minimal Decline <50%** Parking		**Large Improvement >50%** Forward Gear	
Nandi	Baringo	Mombasa	Meru	Kwale	Kirinyaga
Narok	Samburu	Busia	Machakos	Makueni	Murang'a
Nakuru	Uasin Gishu	Kakamega	Kericho	Nyeri	Kilifi
Elgeyo-Marakwet	Kisii	Siaya	Nairobi	Bungoma	Taita-Taveta
Laikipia	Kisumu	Migori	Lamu	Vihiga	Tana River
Kajiado	Turkana	Homa Bay	Tharaka-Nithi	Nyandarua	Isiolo
Bomet	Trans-Nzoia	Nyamira	West Pokot	Kiambu	Kitui
Marsabit		Garissa	Wajir		
		Mandera	Embu		



Prevention and management of HIV among children aged 0-14

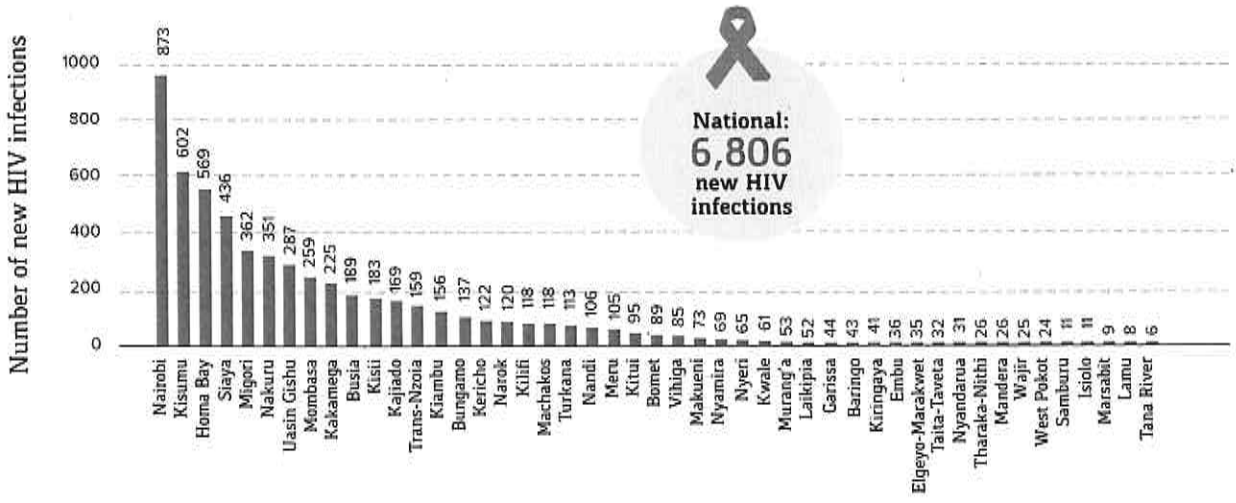
The main mode of HIV transmission among children aged 0-14 is from mother to child during pregnancy, birth and breastfeeding. In 2019, a total of 59,304 (94%) of women living with HIV received ARV prophylaxis to prevent HIV transmission during pregnancy and breastfeeding period. Despite the annual decline of the number of women in need for prevention of mother to child transmission services from about 85,400 in 2010 to approximately 63,000 in 2019, an estimated 6,696 HIV positive pregnant women did not access treatment for their health and that of their unborn and newborns in 2019. The situation demands increased focus to minimise the missed opportunities to provide HIV testing and treatment services for HIV positive women.

Estimates models shows that by end of 2019, Kenya has averted 118,300 mother to child HIV infections due to scale up of Prevention of transmission of HIV from mother to child during pregnancy and breastfeeding since 2004

HIV transmission among children due to early sexual debut and defilement cases are worrying. In 2019, proramme data showed that 20,362 children aged 10-14 were pregnant. Factors such as high number of orphans (656,300) who require social protection services, low retention, and low transition rates from primary to secondary school - 18% of girls who do not complete primary education (KDHS 2014) and elimination of all forms of violence against children must be addressed. There is need to target locations with high teenage pregancies as a proxy-indicator of heightened risk to HIV infections among girls. Kenya Health Information System (KHIS) shows 28% (399,028) of all pregnancies registered were among adolescents aged 10-19. In 2019 a third of these teenage pregnancies occurred in nine counties, namely, Nairobi (26,545), Kakamega (17,555), Nakuru (16,502), Meru (15826), Narok (14,962), Bungoma (14,512), Kiambu (13,562) Homabay (13,644) and Kwale (11,251).

The success of ART treatment programmes among children (0-14yrs) is largely dependent on early diagnosis and prompt ART initiation. Some 34,337 (32%) children living with HIV were not on ART treatment by the end of 2019. Among those on treatment, only 51% were virally suppressed leaving a large cohort of children prone to HIV related co-morbidities and ill health.

Figure 1: **Annual new HIV Infections among Children aged 0-14 years across Counties, 2019**

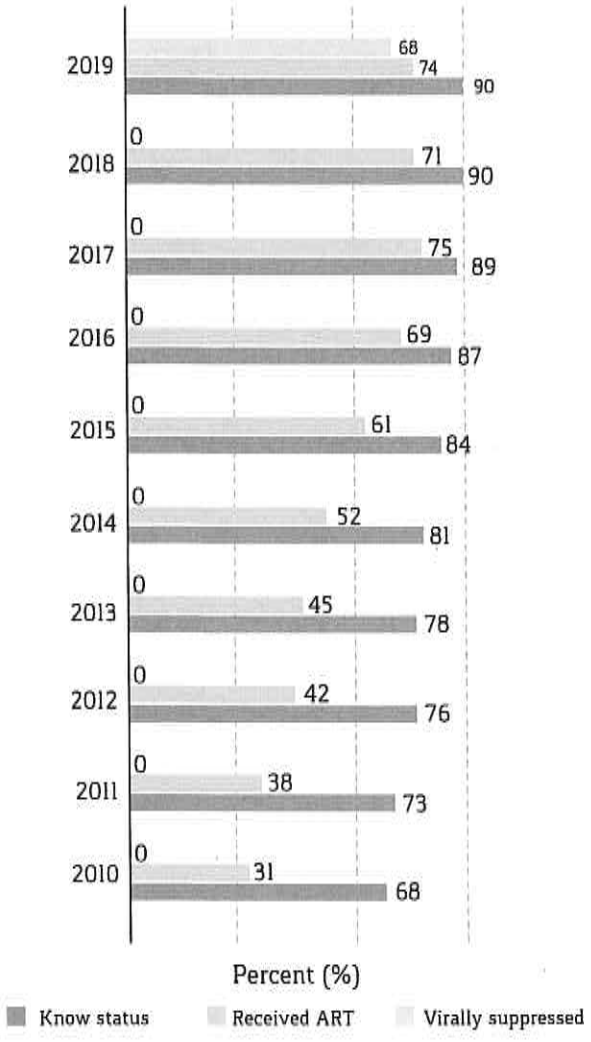


Source: Kenya HIV Estimates 2020

Access to Treatment

The number of people living with HIV on treatment increased dramatically since 2010. The increase is largely attributed to the evolution and rapid adoption of global guidelines for HIV treatment. By the end of 2019, a total of 1,160,479 (1,087,511 adults and 72,968 children) were on antiretroviral therapy, representing an estimated treatment coverage of 80% among adults (68% among children). Positive health outcomes attributed to ART still remain elusive for close to half a million Kenyans who are not aware of HIV status.

Figure 2: **Trends in HIV Knowledge Status, Treatment and Viral Suppression Cascade**



Source: Kenya HIV Estimates 2020

HIV-related stigma and discrimination

Progress in elimination of HIV related stigma and discrimination is off track. According to the KDHS 2014 the percentage of women reporting accepting attitudes towards PLHIV reduced from 33% in 2010 to 26% in 2014. Similarly, the same indicator showed a decrease from 48% to 44% among men who reported accepting attitudes. Programmatic reports show that specific groups, such as key populations, continue to face stigma and discrimination even in health care settings. There is need to address policy and legal barriers that impact negatively on access to HIV services.

HIV and Gender issues

In recent decades, incremental gains towards gender equality have fallen short of improving educational and economic opportunities for women and girls. For this reason, women and girls remain disproportionately affected by poverty, violence and injustice that make them vulnerable to HIV. Unequal gender norms deny women and girls the ability to make their own choices about health care. Domestic work along with caregiving responsibilities curtail their freedom to enter and remain in the labour force on terms that suit their needs. This ultimately impacts women's economic independence, security, decision making and control. KASF II will prioritize efforts that build synergies with other development agendas that seek to empower women and girls thus reducing their vulnerability to HIV.

AIDS Related Deaths

AIDS related deaths declined rapidly from 51,000 in 2010 to 20,997 in 2019, representing a 59% reduction. AIDS related deaths declined more significantly among children - from 16,000 in 2010 to 4,300 in 2019. AIDS related deaths among women also declined from 22,000 to 7,300, while the deaths among men only declined moderately from

13,000 in 2010 to 9,400 in 2013. In 2019, 90% of all Kenyans living with HIV knew of their HIV status, which means that the 2020 target of achieving 90 percent across the cascade was achieved. Some 74% of people living with HIV were on treatment against a target of 81% and 68% had a suppressed viral load against a target of 73%. Progress varies by age and sex, as 74% of adult women had a suppressed viral load, achieving the 2020 targets was however only 61% of adult men and 51% of children had a suppressed viral load. The lower levels of viral suppression among men contribute to higher mortality rates among men and impact negatively on increased number of new HIV infections among their sexual partners. The low level of viral suppression among men and children points to continued service gaps and barriers that need to be urgently addressed.

1.6 HIV and non-communicable diseases

The Kenya Non-Communicable Diseases (NCDs) 2019 Estimates mathematical model showed that an estimated 33% of Kenyan adults suffered from one NCD in 2018 with 29% suffering from two or more NCDs. Adults living with HIV are more likely to suffer (one 36%) or (two 46%) forms of NCDs as compared to people without HIV diagnosis at 28% suffering from one or two NCDs. The model showed that the prevalence of people living with HIV suffering from two NCDs would increase to 55% by 2035 compared to 33 percent among those with negative HIV diagnosis. Prevention and management of NCDs among PLHIV should remain a key priority.

1.7 End term review of KASF I performance against key target indicators

Table 3: **Key Achievements of KASF I 2014/2015-2018/2019**

Objective	Achievement
Reduce new HIV infections by 75%	44%
Reduce AIDS-related mortality by 25%	64%
Reduce HIV-related stigma and discrimination by 50%	*
Increase domestic financing of HIV response to 50%	32%

*There was no new HIV stigma index available to assess progress on this indicator.

Table 4: **Impact level indicators achievements of KASF I**

HIV prevalence	**Overall**	Baseline **2013** 6.0% Target **2019** 4.8% Performance **2019** 4.5%	***1.5%** reduction in prevalence rate*
	Female	Baseline **2013** 7.6% Target **2019** 5.2% Performance **2019** 5.8%	***1.8%** reduction in prevalence*
	Male	Baseline **2013** 5.6% Target **2019** 4.5% Performance **2019** 3.1%	***2.5%** reduction in prevalence*
Incidence per 1,000	**Adults (15-49)**	Baseline **2013** 3.2% Target **2019** 0.97% Performance **2019** 1.2%	***2.0%** reduction in incidence since*
New HIV Infections	**Overall**	Baseline **2013** 101,488 Target **2019** 25,362 Performance **2019** 41,416	***59%** reduction in new HIV infections*
	Children (0-14)	Baseline **2013** 12,826 Target **2019** 3,207 Performance **2019** 6,806	***47%** reduction in children new infections*

New HIV Infections (continued)	**Adolescents (10-19)**	Baseline **2013** 18,004 Target **2019** 4,501 Performance **2019** 6,166	***66%** reduction in new HIV infections*
	Young Adults (15-24)	Baseline **2013** 35,776 Target **2019** 8,944 Performance **2019** 14,410	***25%** reduction of new Young Adult infections*
	Adults (15+)	Baseline **2013** 88,622 Target **2019** 22,156 Performance **2019** 34,610	***61%** reduction in new infections*
	MTCT rate	Baseline **2013** 13.9% Target **2019** Less than 5% Performance **2019** 10.8%	***3.1%** reduction in MTCT rate*
People living with HIV	**Overall**	Baseline **2013** 1,599,358 Target **2019** 1,493,382 Performance **2019** 1,508,405	*Number reduced by **90,963***
	Children (0-14)	Baseline **2013** 191,743 Target **2019** 105,213 Performance **2019** 106,807	*Number reduced by **84,936***
	Adolescents (10-19)	Baseline **2013** 133,455 Target **2019** 105,230 Performance **2019** 91,634	*Number reduced by **41,821***
	Young Adults (15-24)	Baseline **2013** 268,586 Target **2019** 184,719 Performance **2019** 145,471	*Number reduced by **46%***
	Adults (15+)	Baseline **2013** 1,407,615 Target **2019** 1,388,169 Performance **2019** 1,401,598	*Number reduced by **6,017***
Treatment	**Children on ART**	Baseline **2013** 60,141 Target **2019** 86,325 Performance **2019** 72,968	***21%** increase on ART Coverage among children*
	Adults on ART	Baseline **2013** 596,228 Target **2019** 1,035,618 Performance **2019** 1,087,511	***82%** increase in ART Coverage among Adults*
	On PMTCT	Baseline **2013** 55,543 Target **2019** 53,067 Performance **2019** 59,304	***7%** increase in PMTCT Coverage*
HIV Related Deaths	**Total**	Baseline **2013** 58,446 Target **2019** 43,835 Performance **2019** 20,897	***64%** reduction in total AIDS related deaths*
	Children (0-14)	Baseline **2013** 10,374 Target **2019** 7,781 Performance **2019** 4,333	***58%** reduction in AIDS related deaths*
	Adolescents (10-19)	Baseline **2013** 2,793 Target **2019** 2,095 Performance **2019** 2,275	***19%** reduction in AIDS related deaths*
	Young Adults (15-24)	Baseline **2013** 3,853 Target **2019** 2,890 Performance **2019** 2,621	***32%** reduction in AIDS related deaths*
	Adults (15+)	Baseline **2013** 48,072 Target **2019** 36,054 Performance **2019** 16,664	***65%** reduction in AIDS related deaths*

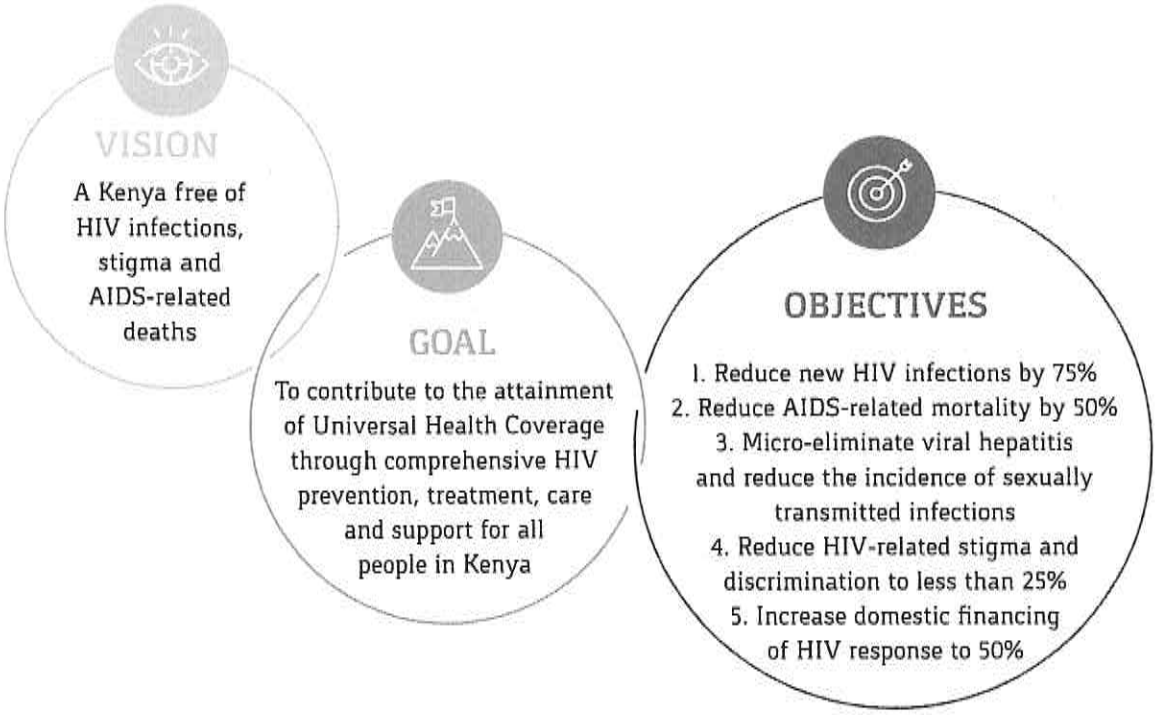
Lessons from implementation of the first Kenya AIDS Strategic Framework 2014/2015 - 2018/2019

Lessons from implementation of KASF I	Recommendations for KASF II
A multi-sectoral approach to the HIV response remains highly relevant considering the multisectoral action needed to address structural drivers and unequal access to services.	Strengthen partnerships across key sectors and communities, including the private sector to bridge gaps in programmes and improve quality. There is need for skill transfer, capacity building and quality assurance interventions; promote programmatic reporting and accountability across sectors.
Community-led programming serves as a catalyst to expand HIV services.	Enhance community-led and based interventions such as use of trusted access platforms to improve coverage, quality and outcomes of HIV programmes.
Decline in external funding without increase in domestic resources affects uniform progress towards achievement of ambitious programme targets to end AIDS.	Develop alternative models for HIV investment to bridge funding gaps at the county and national level.
HIV programme resilience is critical to sustain gains during emergencies and interruptions such as those witnessed during COVID-19 pandemic.	Create contingency plans that are regularly reviewed and updated to sustain HIV services at the time of emergencies including the ongoing COVID-19 pandemic.
Programmatic gaps in elimination of HIV among children and adolescents, combination HIV prevention and HIV testing and treatment among men remain a major challenge.	Promote high level political and technical leadership for the HIV response especially for fragile programmes and areas with large gaps for sub-populations. Bring to scale combination HIV prevention to reach all sub-populations and expand coverage of elimination of mother to child transmission of HIV interventions; Swiftly translate programme data and research into policies and programmes as key priorities.
County level leadership and ownership for the HIV response is a key factor for programme success.	Enhance county-level HIV programme implementation and management capacities through training, mentoring, sharing, harmonisation and peer-accountability.
The persistence of human rights and legal barriers continues to hinder access to HIV services for key and vulnerable populations.	Scale up interventions to address human rights violations, access to justice against HIV related stigma and discrimination.
Integration and linkage of HIV programme with other disease management through a system wide strengthening approach should be prioritised.	Integrate and link HIV prevention and treatment with programmes addressing sexual and reproductive health and rights (SRHR) including sexually transmitted infections (STIs) and contraceptive services, viral hepatitis, cancers, non-communicable diseases (NCDs), other chronic diseases and nutrition
Fragile gains - such as in the elimination of mother to child transmission of HIV and syphilis programme - depends on resilient health systems.	Strengthen the health workforce, commodity security and laboratory infrastructure.

02

The Framework

Despite the tremendous progress made in more than three decades, HIV continues to be a significant contributor to national disease burden. Kenya AIDS Strategic Framework II will focus on bridging the gaps in programme coverage through differentiated approaches that meet the needs of citizens within their geographical locations.



Guiding principles

This framework is guided by the following key principles:

i. **Respect for and promotion of human rights** as well as principles of social justice, equality and equity in access to HIV and AIDS services in line with the provisions embedded in the Constitution of Kenya (2010)

ii. **Universal Health Coverage and access** to quality and integrated HIV prevention, treatment, care and support services, embracing the principle of *'leave no one behind'*

iii. **Inclusion and participation** of all stakeholders at national and county levels, including and not limited to, community representatives of networks of PLHIV, AYPs, KPs including sex workers, men who have sex with men (MSM), people who use drugs (PWUDs), transgender people, PwDs, representation from the public and private sectors, faiths sector, CSOs and development partners

iv. **People-centred service delivery** placing people at the centre of the decision making, planning and implementation process towards achieving desired outcomes

v. **Evidence-informed planning, prioritisation and investments** through use of evidence and strategic information for decision making

vi. **Multi-sectoral partnership and accountability for collective responsibility,** coordination and shared accountability for results.

vii. **Responsiveness to emergencies and humanitarian crisis such as calamities or pandemics through strengthening** of resilient health, education and community systems

2.1 Thematic Areas

Nine thematic areas are outlined whose implementation will accelerate the achievement of the overall goal:

Thematic Area 1:
Universal access to comprehensive, quality, and integrated prevention of HIV and Sexually Transmitted Infections

Thematic Area 2:
Revitalise shared fast-track commitment to achieve treatment targets

Thematic Area 3:
Protect the rights of people to live a life free of violence, stigma and discrimination

Thematic Area 4:
Invest in resilient systems for Health to improve HIV response and other health outcomes

Thematic Area 5:
Leverage on communities led programmes for an effective HIV response

Thematic Area 6:
Integrate HIV in humanitarian and emergency responses

Thematic Area 7:
Swift translation of innovations, strategic information, research, surveillance, and implementation of science into programmes

Thematic Area 8:
Invest in longer-term HIV investments and efficiency in use of resources

Thematic Area 9:
Promote Leadership, Communication and Advocacy

2.2 Overall Implementation Approach

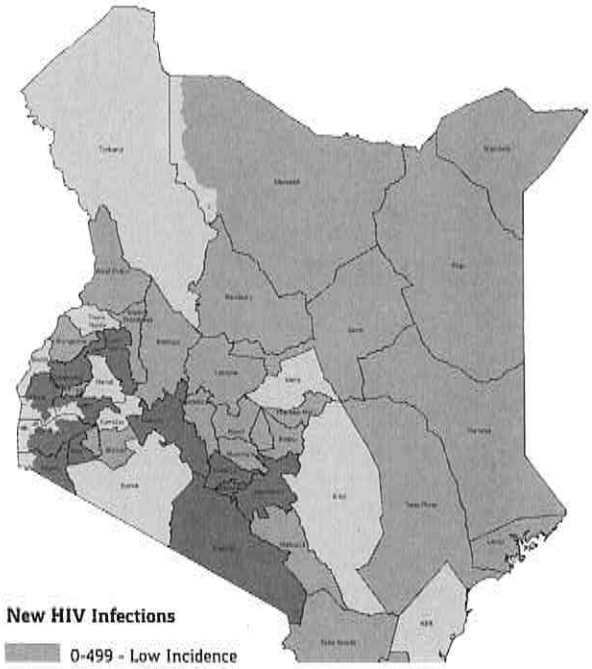
The following considerations will be key to guide implementation of KASF II:

- Coordinated county level operational plans and strategies in line with the devolved system of governance and local contexts
- Promotion of leadership for a coherent, synergised, and accountable multi-sectoral response
- Evidence-based prioritisation of population groups and geographic locations to address heterogeneity of the Kenyan epidemic
- Integration and layering of interventions for efficiency gains and maximal impact
- Differentiated approach to service delivery in respect to population needs and geographic context
- Enhanced community engagement in demand creation and monitoring of quality of services
- Scale up high impact interventions and continuous monitoring to measure outcomes and impact of the interventions
- Prioritisation of combination prevention interventions with equal emphasis on structural, biomedical and behavioural interventions

Status of HIV Epidemic in Kenya, 2020

	Children (0-14)	Adolescent Girls and Young Women	Female (15+)	Male (15+)	Adults (15+)
Prevalence	0.57%	1.96%	6.12%	3.53%	4.76%
New HIV infections	6,806	10,422	21,502	13,108	34,610
Treatment coverage	70%	76%	85%	73%	80%
AIDS Related deaths	4,333	2,604	7,255	9,317	6,572

Geographical distribution of new HIV infections in Kenya



13 counties had more than 1,000 new HIV infections, accounting for 72% of all new infections in the country

Table 6: **HIV prevalence (15-49 years) by County**

County	Prevalence
Homa Bay	20.2
Kisumu	18.6
Siaya	17.8
Migori	12.8
Busia	7.2
Mombasa	6.9
Uasin Gishu	6.0
Kisii	5.4
Nairobi	5.4
Vihiga	5.1
Trans Nzoia	4.5
Nyeri	4.3
Nyamira	4.2
Kitui	4.2
Nakuru	4.0
Kakamega	3.95
Kericho	3.8
Taita Taveta	3.8
Kilifi	3.7

County	Prevalence
Kajiado	3.6
Machakos	3.6
Makueni	3.5
Turkana	3.3
Nandi	3.3
Kwale	3.2
Kirinyaga	3.2
Bomet	3.0
Kiambu	2.97
Narok	2.97
Tharaka-Nithi	2.9
Meru	2.9
Bungoma	2.8
Murang'a	2.8
Nyandarua	2.7
Laikipia	2.7
Embu	2.5
Lamu	2.4
Elgeyo Marakwet	2.2

County	Prevalence
Baringo	1.7
Isiolo	1.8
West Pokot	1.2
Samburu	1.1
Marsabit	0.96
Tana River	0.9
Garissa	0.4
Mandera	0.3
Wajir	0.2

HIV prevalence

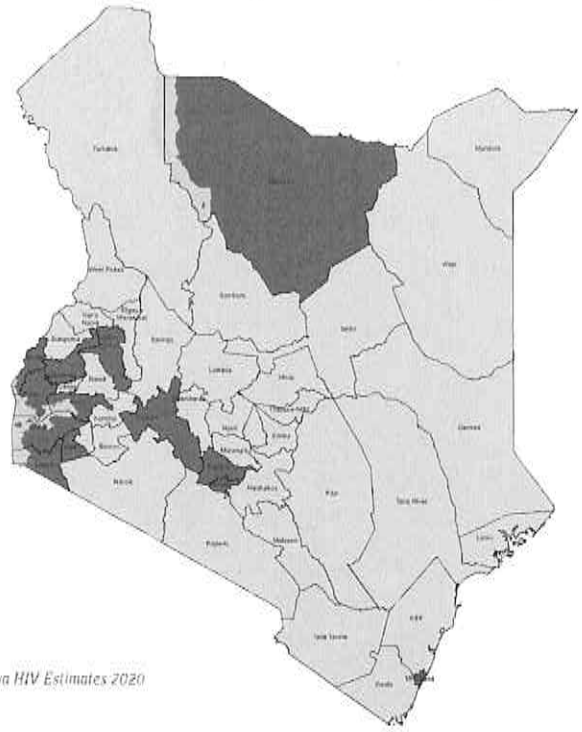
- 11.1% and above
- 5% - 11%
- 2.1% - 4.9%
- 0% - 2%

Homa Bay, Kisumu, Siaya and Migori counties have HIV prevalence at hyper epidemic levels

This framework will be implemented through partnership from multiple sectors including and not limited to Ministry of Health and its departments/agencies such as National AIDS and STIs Control Programme, Division of Nutrition and dietetics, Division of Non communicable diseases, department of Family and Reproductive Health, Tuberculosis programme, Pharmacy and Poisons Board, National HIV reference Laboratory, Kenya Medical Laboratory Technicians and Technologists Board, Kenya National Blood and Safety, Kenya Medical Training College. Ministries, Departments and Agencies such as Ministry of Education and related State Department of Technical and Vocational Training, State Department of University Education, Research institutions, Department of Children Services, State Department of Gender, Ministry of Interior, Judiciary, HIV Tribunal, National Council for Legal Aid, Kenya Law Reform Commission, National Council for Persons with Disability, People with Disability Associations, National Treasury, Council of Governors, County Governments, County Health Departments, among others.

Non-State Actors include, but are not limited to, representation of National Network of People Living with HIV (NEPHAK) and other networks of PLHIV, civil society organisations, community led organisations, Faith-based organisations, women rights organisations, Private Sector, Mission for Essential Drugs and Supplies, Trade Unions, Key population networks, Adolescent and young people networks, other Community led groups, Development Partners and Implementing Partners.

12 counties that require intensified focus



Source: Kenya HIV Estimates 2020

Key HIV epidemic and programme coverage indicators show gaps in Mombasa, Kisumu, Siaya, Nairobi, Kisii, Homa Bay, Migori, Busia, Kakamega, Nakuru, Kiambu and Uasin Gishu Counties that require intensified focus to stem new HIV infections. Marsabit County has an emerging HIV epidemic that needs to be mitigated

Settings with high risk and vulnerability

Worldwide, the levels of HIV infection among prison populations tend to be much higher than in the population outside prisons. This situation is often accompanied and exacerbated by high rates of hepatitis C (HCV), tuberculosis (TB), sexually transmitted infections (STIs), drug dependence, and mental health problems in prison populations. Inside prisons, the primary risk behaviours for the transmission of HIV are the sharing of injecting equipment and unprotected sex. Prisons present a good opportunity to provide health-care access to those who may not otherwise have regular access, and to improve the health of vulnerable groups and the communities they associate with. Health care settings are critical to reducing the risk of the potential spread of disease. These settings should follow infection prevention and control practices and maintain a safe environment. Other priority settings in Kenya include the refugee and migrant camps, long distance truck routes, army barracks and other concentrated work places like flower farms.

II. Prioritise populations for comprehensive preventive interventions based on epidemic typology in the geographies

To address long-term prevention goals, epidemic typology needs to be defined to differentiate epidemics based on their underlying transmission dynamics and epidemic potential. The epidemic typology in Kenya can be defined as:

a) **Concentrated epidemic** where ongoing transmission is within sub-populations who are at a higher risk due to sexual practices or needle-sharing networks.
b) **Generalising epidemic** where HIV transmission is largely sustained by high risk sexual behaviour in the general population, without any substantial contribution by defined sub population at risk.
c) **Mixed epidemic** where there is substantial contribution from both the general population sexual behavioural patterns and defined sub populations at risk due to shared networks of higher risk sexual behaviour practices. Based on epidemic typology, specific sub-population needs to be prioritised.

Priority populations

Adolescent and young people

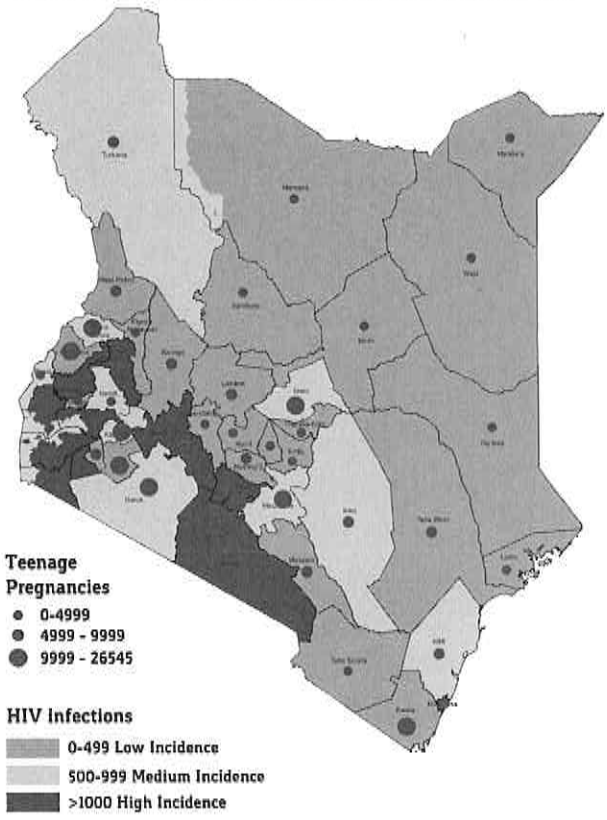
Adolescent and young people contribute to 42% of the new HIV infections in the country and hence are a priority population. However, within this group, the focus of programming will be on adolescents and young girls and boys, and young men in priority geographies for high impact.

- **Adolescent girls and young women (10-24 years).** Adolescent girls and young women (AGYW) aged 15-24 years contribute to a third (30%) of the 41,728 new HIV infections in the country (HIV Estimates 2020). Factors such as intergenerational sex, teenage pregnancies, sexual and other forms of gender-based

violence (GBV), discontinuation of school specially during transition from primary to secondary school, prevailing gender norms, poor access to comprehensive sexuality education, limited access to HIV, STI, SRHR services and low socio-economic status have largely been attributed to the high HIV incidence among AGYW compared to boys and young men of the same age group. KASF II will adopt a multi-sectoral approach to address the HIV and STI, risk and vulnerability of AGYW with special focus on at risk AGYW in priority counties. It will address multi-faceted vulnerabilities and reduce teenage pregnancies and gender-based inequalities.

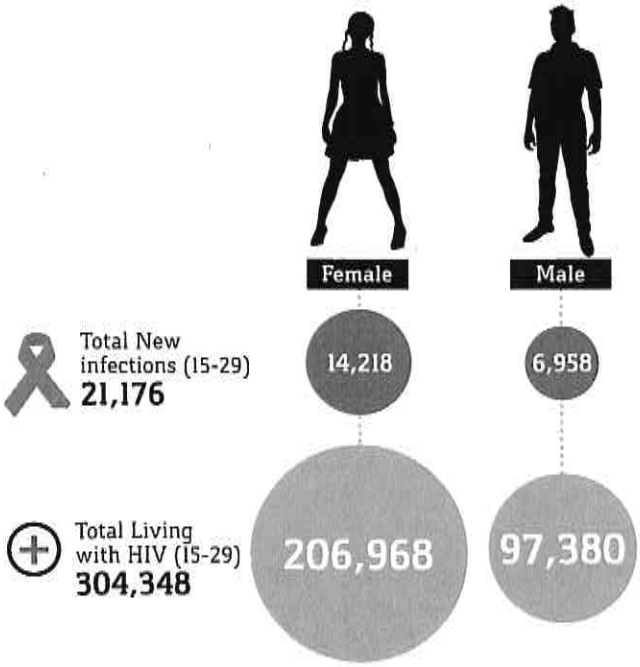
6 Counties, Mombasa, Siaya, Kisii, Migori, Kisumu and Homabay have extremely high HIV incidence per 1,000 among adolescent girls and young women aged 15-24

Teenage Pregnancy and New HIV Infections



- **Boys and young men in priority geographies and settings.** Boys and young men aged 15-34 years account for 53% of the 13,320 new HIV infections that occurred among male adults in 2019. The peak of new HIV infections is among young men aged 20-34 years. Evidence from KENPHIA 2018 also shows that compared to women, awareness of HIV status is low among men. Delay in awareness of HIV status also delays entry into prevention and treatment services. KENPHIA 2018 also reveals that in traditionally non-circumcising counties (many of the counties with high incidence are traditionally non-circumcising), coverage of VMMC among boys and young men was lower than 60%. KASF II will prioritise reaching boys and young men in priority geographies and settings with HIV prevention interventions. Engaging men more extensively in HIV prevention can also potentially reduce girls and women's risk considering power imbalances in the circumstances of sex and safety considerations.

Adolescents and young people aged 15-29 account for 61.2% of the total adult new HIV infections



Source: Kenya HIV Estimates 2020

Key populations

Members of Key Populations (KPs), including Men who have Sex with Men (MSM), Female Sex Workers (FSWs), People Who Inject and Use Drugs (PWI/UDs) and transgender people, have higher HIV prevalence compared to the general population. They experience stigma, discrimination, criminalisation and violence which further increases their HIV and STI risk and vulnerability. The KP mapping and estimation exercise conducted in 2018 estimated that there are 206,000 FSWs, 50,000 MSM, 19,000 PWID, and 5,000 transgender people. The KP mapping and estimation exercise also reported that 9-11% of the KPs in the hotspots were below the age of 18, confirming the need for inclusion of younger KPs in programming. There is gender disparity among key populations in the way service provision is done. KASF II will continue with the prioritisation of KPs and scale up interventions to ensure complete coverage of the estimated populations and those left behind like women who inject or use drugs, young KP and KPs in migrant settings and prisons, through trusted access platforms.

People in HIV sero-discordant sexual partnerships

In Kenya, it is estimated that at least two thirds of infected couples are discordant, meaning only one of the partners is HIV-infected[1]. While discordant couples are at high risk of HIV transmission, use of HIV prevention methods in such partnerships is low as majority of such couples are in cohabiting relationships where condom use is generally low. Targeted HIV prevention programmes among sero-discordant couples with focus on ART for the positive partner, PrEP and consistent use of condoms (where applicable and feasible) for the negative partner, can reduce new infections. KASF II will prioritise these sero-discordant partnerships with comprehensive prevention interventions through strengthening community led structures and organisations.

Other priority and vulnerable populations

Priority and vulnerable populations include people living in closed settings such as people in prisons, internally displaced persons (IDPs), fisher folk, long distance truckers, refugees and migrant populations, people living in large scale agricultural plantations, people with disabilities and members of uniformed services. These populations have much higher HIV prevalence due to low condom use, unsafe sexual partnerships and heighted vulnerabilities to sexual violence and other forms of sexual exploitation. Limited access to education and healthcare along with the lack of information

1 Florence Chizi et al. Challenges Facing HIV Discordant Couples in Kenya. International Journal of Business and Social Science Vol. 5, No. 10(1); September 2014

and resources needed to facilitate effective prevention interventions also expose these populations to HIV infections. KASFII will define a standard service package and differentiated service models to optimize reach and coverage among these populations.

III. Scale up comprehensive packages of interventions to address coverage and effectiveness gaps

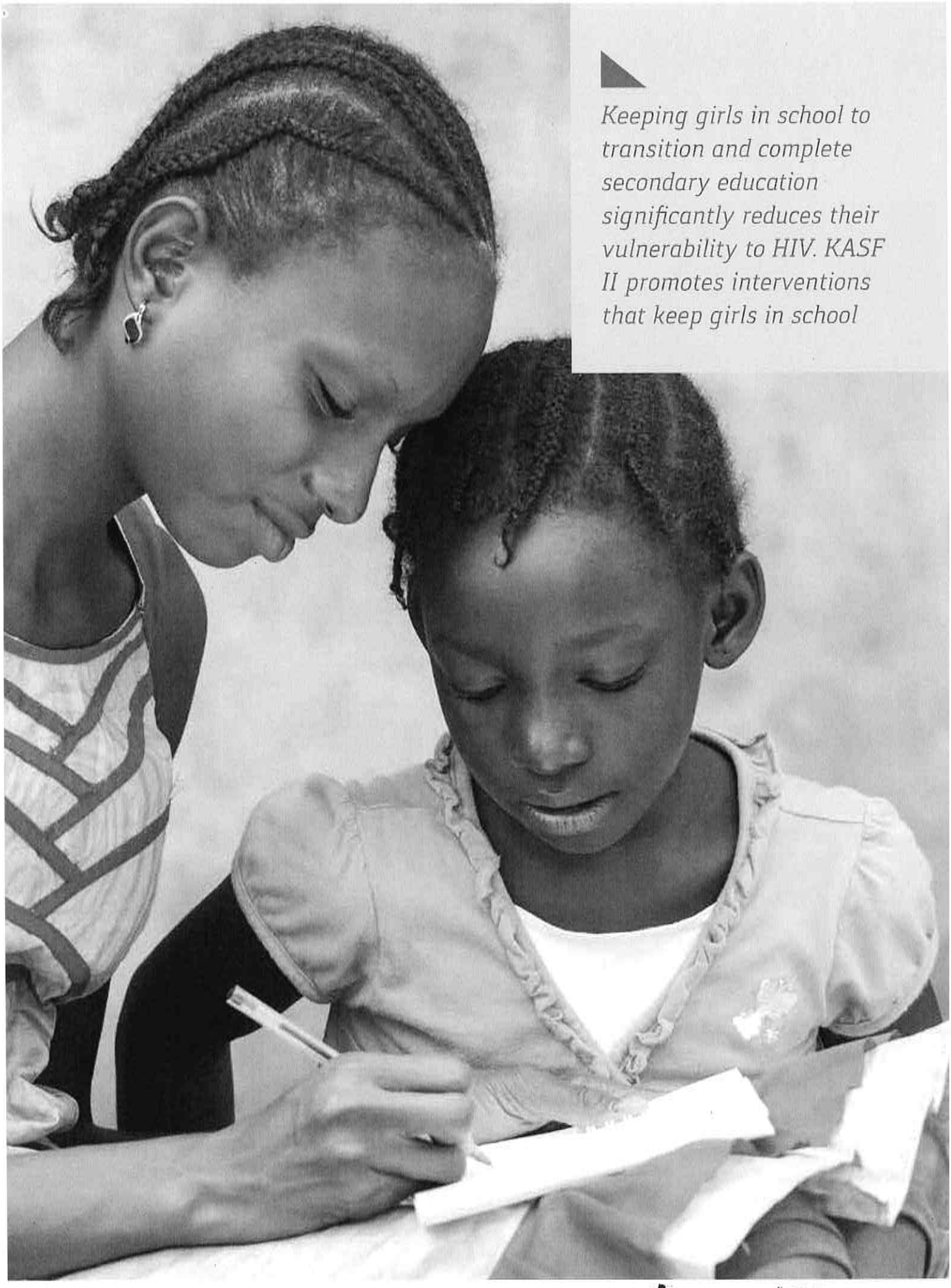
Development of a standard package of intervention for each priority sub population is critical. Standardisation of packages ensures that a minimum programme package is received by all sub populations which has been developed based on their needs and priorities. Kenya has developed standard package of interventions for most of the priority sub populations. KASF II will prioritise development of costed minimum programme packages through community centred approaches and adaptation of available global guidance for sub-populations to suit local context. Service delivery channels will be contextualised to meet local needs.

KASF II outlines the need for a systematic approach to scale up the provision of comprehensive packages of services for all priority populations based on the epidemic typology in a geography. Gaps in coverage will be monitored on a regular basis to address supply barriers to address both availability and utilisation. Active investments in community led assessment and utilisation of the packages will be enhanced. There will be need for adoption of surveys, surveillance, evaluation, reviews and analysis to regularly measure and monitor progress towards prevention outcomes. Integration of HIV prevention services across HIV testing facilities, family planning, antenatal, post-natal services, and other health services will be promoted. HIV prevention interventions will be layered within broader development agenda including UHC.

Table 8: **Examples of Comprehensive HIV prevention packages for sub-populations**

Priority Population	Recommended Prevention Packages
Adolescent Girls and Young Women (10-24 years)	▪ Condom and lubricant programming ▪ Behaviour change interventions ▪ Comprehensive Sexuality Education ▪ Pre-exposure prophylaxis ▪ Comprehensive sexual and reproductive health services ▪ Differentiated HIV testing ▪ Gender-based violence prevention and post violence care ▪ Addressing stigma, discrimination and violence ▪ Social protection interventions that address ▪ Interventions to keep girls in school and to transition to and complete secondary school. ▪ Menstrual health and hygiene ▪ Integration into national multi-sectoral responses of AGYW programmes ▪ Community empowerment and outreach including peer education ▪ Integration of HIV prevention in contraception clinics.
High risk boys and young men in high priority geographies	▪ Voluntary Medical Male Circumcision ▪ Condom and lubricant programming ▪ Behaviour change interventions ▪ Pre-exposure prophylaxis ▪ Sexual and reproductive health services, including STIs ▪ Differentiated HIV testing - facility, community and self-test
Key Populations (FSW, MSM, PWID, Transgender People)	▪ Behaviour change interventions including peer education ▪ Condom and lubricant programming ▪ Pre-exposure prophylaxis ▪ Comprehensive sexual and reproductive health services, including STIs ▪ Harm reduction interventions for drug use ▪ Addressing stigma, discrimination and violence ▪ Interventions for young Key Populations ▪ Community empowerment ▪ Prevention and management of co-infections and co-morbidities ▪ Differentiated HIV testing - facility, community and self-test

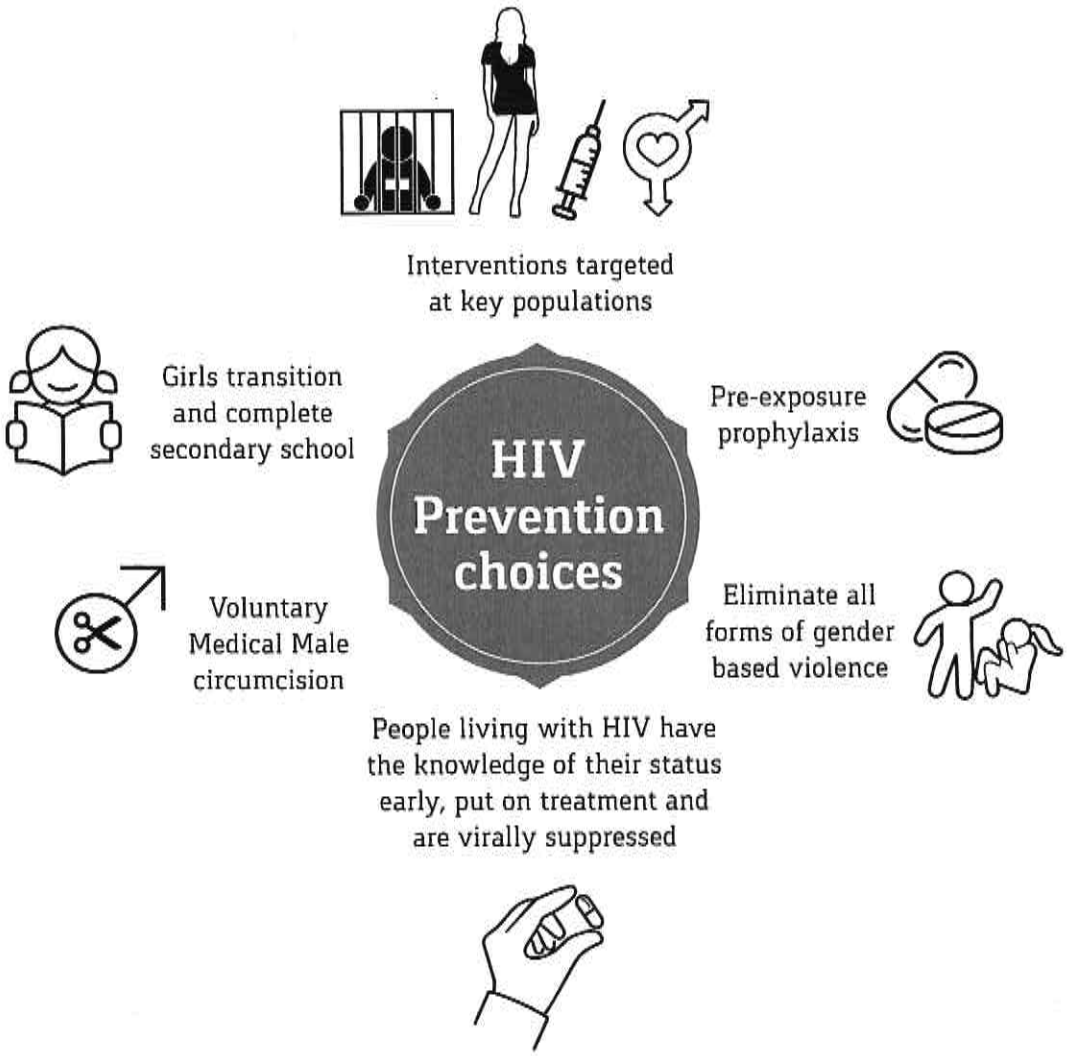
Priority Population	Recommended Prevention Packages
	Additional services for People who Inject Drugs: ▪ Needle and syringe programmes ▪ Opioid substitution therapy and other medically assisted drug dependence treatment ▪ Overdose prevention and management ▪ Sustainable livelihood support programmes
Sero discordant couples	▪ Behaviour change interventions including peer education ▪ Condom and lubricant programming: ▪ Pre-exposure prophylaxis ▪ Sexual and reproductive health services, including STIs ▪ Addressing stigma, discrimination and violence ▪ Community empowerment ▪ Prevention and management of co-infections and co-morbidities ▪ Differentiated HIV testing - facility, community and self-test
People in prison settings	▪ Condom and lubricant programming ▪ Pre-Exposure Prophylaxis ▪ Behaviour change interventions ▪ Community empowerment including vocational training and social integration programmes ▪ Sexual and reproductive health services, including STIs ▪ Harm reduction interventions for drug use ▪ Prevention and management of co-infections and co-morbidities ▪ Addressing stigma, discrimination and violence
Health care settings	▪ Expand and prioritise access to vaccination programme (Hepatitis) ▪ Personal protection equipment ▪ Universal precaution trainings ▪ HIV testing ▪ Availability and utilisation of Post Exposure Prophylaxis
Other vulnerable population	▪ Condom and lubricant programming ▪ Behaviour change interventions ▪ Sexual and reproductive health services, including STIs ▪ Addressing stigma, discrimination and violence ▪ Community empowerment ▪ Prevention and management of co-infections and co-morbidities ▪ Differentiated HIV testing - facility, community and self-test



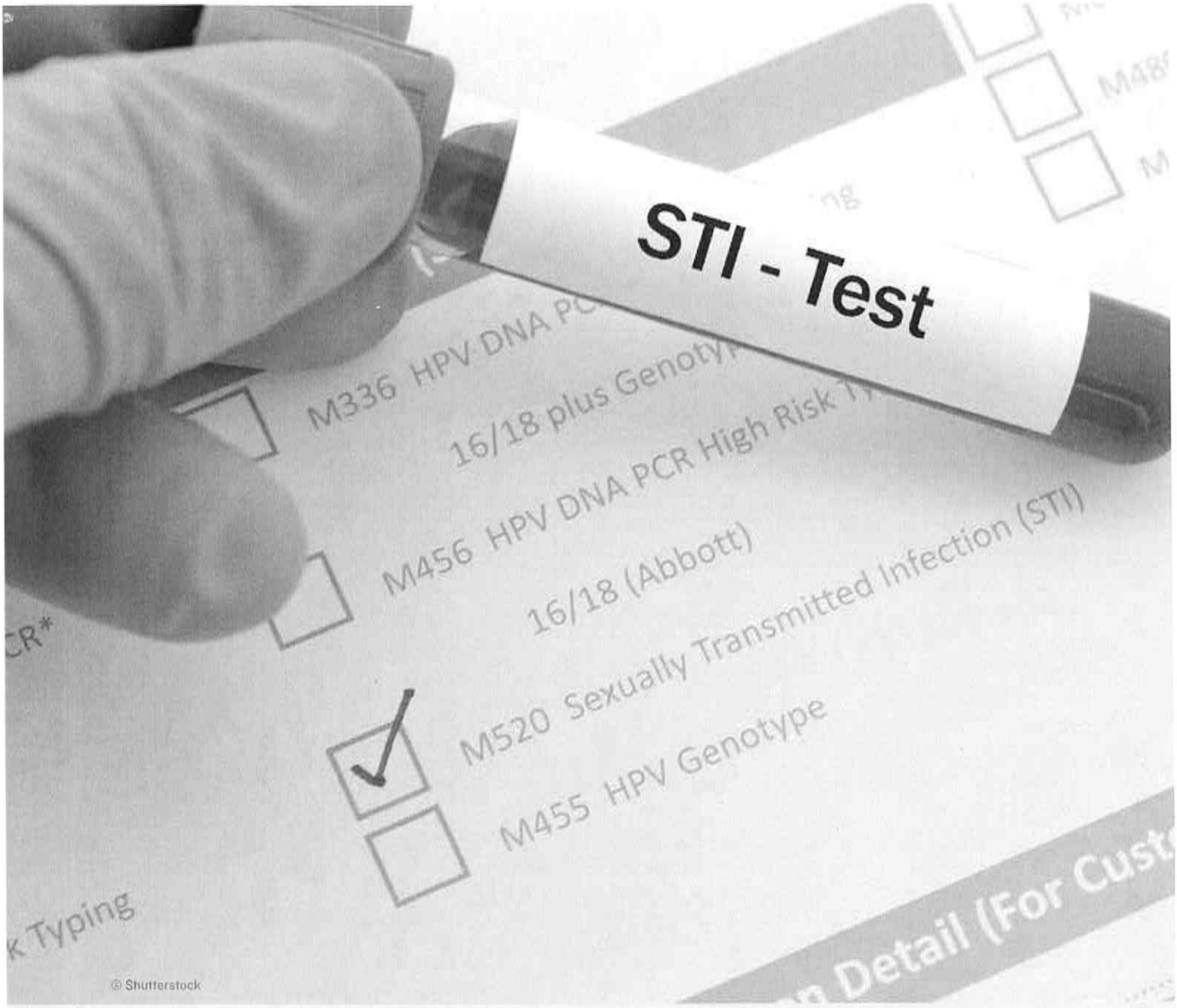
Keeping girls in school to transition and complete secondary education significantly reduces their vulnerability to HIV. KASF II promotes interventions that keep girls in school

IV. Adopt and expand HIV prevention choices and technology to make the response effective

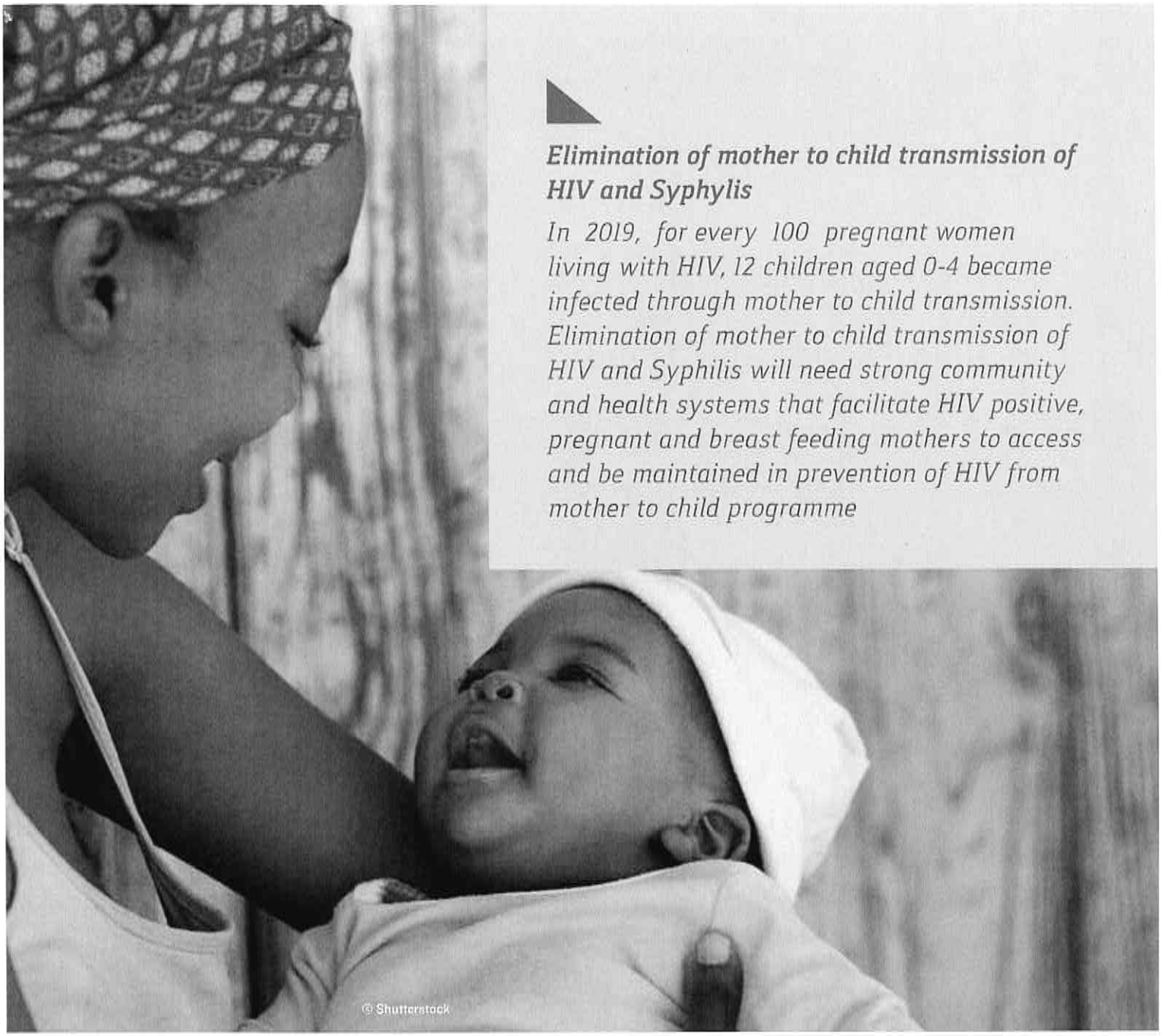
KASF II will prioritise expanding choices and options for available HIV prevention interventions. The country will assess effectiveness of emerging HIV prevention technologies through rigorous evaluation. Pilot interventions and learning sites will be put in place to conduct action research related to new prevention technologies such as those related to PrEP, Medication Assisted Therapy, voluntary medical male circumcision among others. Innovative and successful strategies will be adopted and scaled up to expand HIV prevention choices. KASF II recommends the use of mixed models of service delivery and use of strategic information generated from programmes to improve intervention outcomes.



KASF II promotes adoption of new technology to expand effective HIV prevention choices



The burden of Sexually Transmitted Infections (STIs) and Viral Hepatitis (VH) has been on the increase despite availability of effective preventive vaccines. There is need to target population at higher risk with effective prevention and treatment interventions



Elimination of mother to child transmission of HIV and Syphylis

In 2019, for every 100 pregnant women living with HIV, 12 children aged 0-4 became infected through mother to child transmission. Elimination of mother to child transmission of HIV and Syphilis will need strong community and health systems that facilitate HIV positive, pregnant and breast feeding mothers to access and be maintained in prevention of HIV from mother to child programme

6%
(102,000)of pregnant women do not attend at least one ANC visit

8%
(136,000) pregnant women do not know their HIV status

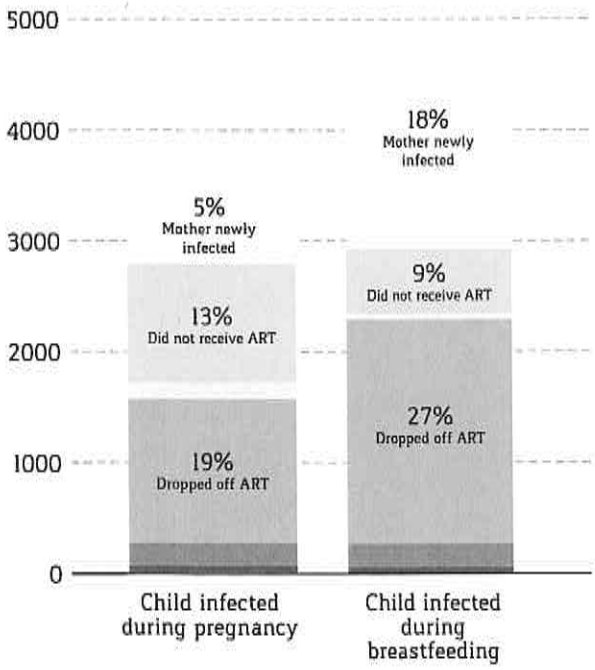
6%
of pregnant women living with HIV do not receive lifelong ART

33%
of HIV-exposed infants do not get tested within two months of birth

2.3.3 Accelerate efforts towards elimination of HIV mother to child transmission of HIV and Syphilis

Though the number of children (0-14 years) newly infected with HIV has dropped over the years, in 2020, 10.8% of new infections among children were estimated to be infected with HIV vertically from mother-to-child (HIV Estimates 2020). MTCT rates are relatively high in low-medium prevalence areas, of the 29 counties, collectively contributing to 25% of the new HIV infections among children. Elimination of mother-to-child transmission of HIV, syphilis and viral hepatitis will be a critical marker of universal access. For this reason, pregnant and breast-feeding women (PBFW) will continue to be a priority for HIV and STI prevention in KASF II.

Figure 3: **Causes of HIV Transmission from Mother to Child**



Source: UNAIDS Global Estimates and Mashavi Kenya 2020

23 percent of the cases of transmission of HIV from mother to child during pregnancy and breastfeeding occur among mothers newly infected with HIV

Strategic Focus Areas

1. Sustain leadership, advocacy and coordination of the eMTCT programme.
2. Expand equitable and quality testing, prevention and treatment services for HIV and Syphilis to all pregnant women and children.
3. Strengthen partnerships between communities, private and public health systems.
4. Ensure routine monitoring of progress and accountability at all levels.

Implementation Approach

New HIV infections amongst children occur when major interventions are missed - primary prevention of HIV amongst the HIV-negative pregnant and breastfeeding women, delayed initiation to antiretroviral therapy, poor linkage and retention of positive mothers in ART, low re-testing rates and discordant partnership as a result of low partner testing. Strategic efforts should therefore be aimed at addressing these gaps during the antenatal and post-natal period. eMTCT interventions in the first 1,000 days of a child at risk of HIV infection should be ingrained within the tenets of primary health care. The window of opportunity to eliminate infections is dependent on strong and sustained leadership, resilient community and health systems that protect the programme from disruptions such as industrial strikes for health care workers, commodity stock-outs and displacement of population during emergencies. The implementation of eMTCT will include a four-pronged approach of 1) primary prevention of HIV infection among women of child bearing age 2) preventing unintended pregnancies among women living with HIV 3) preventing vertical HIV prevention, and 4) treatment care and support for mothers living with HIV, their children and families. While prioritising counties with high mother to child transmission rates, the programme will promote universal access to triple elimination of mother to child transmission of HIV, hepatitis B virus and syphilis.

Table 10: **Proposed interventions to scale up elimination of mother to child transmission of HIV and Syphilis**

Strategic Focus area	Recommended Interventions
Sustain leadership, advocacy and coordination of eMTCT programme.	▪ Nurture championship for eMTCT among eminent persons at all levels (political, faith based, community and technocrats). ▪ Strengthen linkages between health and non-health leadership at national, county, sub county and community levels.
Expand equitable and quality testing, prevention and treatment services for HIV and Syphilis to all pregnant women and children.	▪ Assess the gaps in reach of the eMTCT programme and identify priority geography and populations. ▪ Strengthen the community structures to ensure that all pregnant and breast-feeding women are identified and linked to primary care for ante-natal care, post-natal care and immunisation programme. ▪ Strengthen the facilities to ensure that all pregnant women have access to HIV testing and are aware of their HIV status. ▪ Expand linkages to contraception and family planning services to all HIV positive women to avoid unintended pregnancies.
Strengthening integration of HIV prevention and treatment services with all reproductive, maternal, child and adolescent health programmes	▪ Expand the facility and community linkage to ensure all HIV positive pregnant women or mother and baby pair initiate treatment and are retained on treatment. ▪ Adapt the programme to address the unique needs of AGYW who are pregnant or are mothers. ▪ Ensure linkage of the facility with HIV positive mother to provide access to early infant diagnosis within the immunisation programme. ▪ Expand access to the eMTCT of HIV and syphilis for different sub populations through different service delivery models. ▪ Reduce missed opportunities for linkage to treatment through expansion of point of care services. ▪ Strengthening integration of HIV prevention and treatment services with all reproductive, maternal, child and adolescent health programmes.
Strengthen partnerships between communities, private and public health systems	▪ Create demand and a norm among the AGYW (women in child bearing age) to be aware of their HIV status. ▪ Promote community-led eMTCT education strategies. ▪ Strengthen health facilities and community linkages by expanding the Kenya mentor mother programme. ▪ Strengthen community structures to increase demand generation for ante-natal, post-natal and immunisation
Ensure routine monitoring of progress and accountability at all levels	▪ Promote system wide quality reporting and accountability. ▪ Provide platforms to regularly take stock of progress at all levels. ▪ Sustain positive service delivery and outcome data from both the public and private health sectors.

KASF II, will implement innovative and differentiated HIV testing models to reach sub-populations and geographical locations

2.3.4 Enhance identification and linkages to prevention, treatment, care and support services for HIV

In 2019, approximately 79% of Kenyans were aware of their HIV status. The country missed the opportunity to provide life saving medication to 11% (158,000) of people living with HIV who were not aware of their status. The knowlege of HIV status among men and boys is 88% much lower than that of women and girls at 94 %. Delay in awareness of HIV status results to poor health outcomes at an individual level and low levels of viral load suppression desired for interrupting HIV transmission at the population level.

Strategic Focus Areas

1. Scale up the use of evidence, innovative and differentiated HIV diagnostic services to increase access and meet diverse population needs.
2. Expand voluntary, client-centred and confidential partner and sexual/social network testing services through facility and community led interventions.
3. Promote integration of HIV testing with sexual and reproductive health services and the diagnosis of other co-infections including TB and viral hepatitis.

Implementation Approach

KASF II, will implement innovative and differentiated HIV testing models to reach sub-populations and geographical locations with highest gaps of HIV knowledge. Human rights based, voluntary, client-centred and confidential social and sexual network based HIV testing services will be expanded. This strategy will be implemented through effective partnerships with people living with HIV and key population network to provide opportunity to test people at risk of HIV, link them to treatment and care programmes if positive or offer risk reduction options such as the use of condoms and PrEP when they test negative. The HIV testing programme will utilise data from surveys and programmes to identify and prioritise geographical locations and sub-populations.

Human rights based, voluntary, client-centred and confidential HIV testing services will be promoted

Table 11: **Recommended Interventions to Scale Up Differentiated HIV Testing Services**

Strategic Focus Areas	Recommended Interventions
Scale up the use of evidence, innovative and differentiated HIV diagnostic services to increase access and meet diverse population needs.	▪ Use evidence to expand HIV testing services to priority geography, settings and population. ▪ Support community-led HIV stigma free demand creation initiatives for testing among men and boys, children, key populations and other priority sub populations ▪ Promote options for testing by expanding access to testing products like HIV self-testing kits including using vending machines for distribution.
Expand voluntary, client-centred and confidential partner and sexual/ social network testing services through facility and community led interventions	▪ Develop a community-led framework to expand testing in sexual/ social/injecting networks. ▪ Promote capacity building of service providers at facilities to provide HIV testing through sexual, social and injecting networks. ▪ Engage community in implementing and monitoring these testing strategies to identify adverse events and refine the service delivery model and approach.
Promote integration of HIV testing with sexual and reproductive health services and the diagnosis of other co-infections including TB and viral hepatitis	▪ Develop and implement a framework to integrate HIV testing in other service delivery platforms including contraception, nutrition clinics, vaccination centres, TB clinics ▪ Establish systems of linkage to prevention and treatment services in these integrated platforms

The Kenya AIDS Strategic Framework II (2020/21- 2024/25) provides strategic direction for the country's HIV response for the next four years. The health sector platform remains a key pillar of the AIDS response. In the next five years, the National AIDS and STI Control Programme will scale up biomedical interventions focused on narrowing the gaps in diagnosis, HIV prevention, the commitment towards eliminating mother to child transmission of HIV and Syphilis, and universal ART for improved health outcomes for people living with HIV across all sub- populations. To improve, retain and achieve sustained viral suppression of People Living with HIV on treatment, the programme will spearhead ART optimisation through differentiated service delivery and the adoption of novel safe, and efficacious treatment regimens. Innovative differentiated models for test and treat will be scaled up with intesified focus on priority populations including key populations, adolescent and young people, pregnant and breast feeding mothers, among others. Effective HIV prevention interventions such as Voluntary Male Medical Circumcision, Pre-Exposure Prophylaxis and condoms distribution will be implemented to scale. Intergration of management of HIV across other disease management platforms will be promoted for efficiency gains and to improve the effectiveness of interventions. NASCOP will promote a coordinated approach to monitoring the HIV response for all health sector stakeholders while promoting national and county governmen strong leadership and management. NASCOP is committed to the goals of the KASF II, which underscore the importance of multi-sectoral response to HIV in Kenya.

Dr. Catherine Ngugi,
Head, National AIDS and STI Control Programme

HIV Treatment Programme Coverage Gaps in 2019

		Achieved	90 90 90 Target	Gap
Overall (All ages)	Total Number of people living with HIV	1,508,405	0	0
	Knowledge of Status among all people living with HIV	1,350,447	1,357,565	(7,118)
	ART access among people who know their HIV status	1,112,254	1,221,808	(109,554)
	Number of people virally suppressed among people on ART	1,024,795	1,099,627.25	(74,832)
Adults 15+ (Male & Females)	Total Number of people living with HIV	1,401,761	0	0
	Knowledge of Status among all people living with HIV	1,280,357	1,261,585	18,772
	ART access among people who know their HIV status	1,042,164	1,135,426	(93,262)
	Number of people virally suppressed among people on ART	967,769	1,021,884	(54,115)
Female 15+	Total Number of people living with HIV	889,627	0	0
	Knowledge of Status among all people living with HIV	829,700	800,664	29,036
	ART access among people who know their HIV status	710,993	720,598	(9,605)
	Number of people virally suppressed among people on ART	657,866	648,538	9,328
Male 15+	Total Number of people living with HIV	512,135	0	0
	Knowledge of Status among all people living with HIV	450,657	460,922	(10,265)
	ART access among people who know their HIV status	331,171	414,829	(83,658)
	Number of people virally suppressed among people on ART	309,904	373,346	(63,442)
Children	Total Number of people living with HIV	106,807	0	0
	Knowledge of Status among all people living with HIV	70,090	96,126	(26,036)
	ART access among people who know their HIV status	70,090	86,514	(16,424)
	Number of people virally suppressed among people on ART	57,026	77,862	(20,836)

Achieved **Gap (below target)** **Achieved (above target)** **Total Number of people living with HIV**

KASF II will intensify focus on differentiated testing and treatment models to bridge gaps across sub-populations

2.4 Thematic Area 2: **Revitalise shared fast-track commitment towards achieving of treatment Targets**

Goal: To reduce AIDS-related deaths and improve health outcomes

Kenya HIV programme provides comprehensive treatment and care interventions for improved health outcomes among people living with HIV. Evidently, data shows significant improvement in viral suppression rates and reduction in mortality rates over the years. Estimates models demonstrate the scale up of ART treatment initiated scale since 2004, has averted over 733,600 AIDS related deaths by the end of 2019. With the adoption of the universal test and start policy, retention on ART at 12 months has declined from 92.4% in 2013 to 83% in 2019.

To sustain the gains and accelerate progress, KASF II will strengthen the treatment programme by focusing on early HIV diagnosis, screening and management of co-morbidities including cervical cancers, TB-HIV co-infection, Non-communicable diseases and severe malnutrition. Mental health and psycho-social interventions for people living with HIV. The programme will strengthen treatment preparation and adherence support to improve health and holistic wellness.

It is estimated that by the end of 2019 Kenya had averted over 733,600 AIDS related deaths as a result of the scale up of ART since 2004

Strategic Focus Areas

To achieve and sustain progress in line with global targets, KASF II will prioritise the following strategies:

1. Optimise ART treatment for all sub-populations to improve patient health outcomes.
2. Strengthen differentiated service delivery models to improve access
3. Strengthen screening and management of TB, cervical cancers and other NCD's and comorbidities among PLHIV
4. Strengthen multisectoral engagement including private sector in HIV service delivery to expand coverage and enhance effectiveness of interventions
5. Prioritise mental health, substance and alcohol control interventions in HIV programmes.

Expected Outcomes

- Increased ART coverage towards universal access to Care and Treatment
- Achieve population level sustained viral suppression
- Reduce comorbidity and mortality among PLHIV.

Implementation Approach

KASF II promotes implementation of high quality, integrated HIV treatment programme. It calls out for the integrated HIV treatment with sexual and reproductive health services, maternal and newborn health services, mental health and management of NCDs. Innovative

differentiated models of service delivery at both facility and community level will be promoted to accelerate progress on timely linkage, ART initiation, enhanced retention and retention in HIV care and treatment programmes. Strategic partnerships at national and county, private sector, developing and implementing partners with communities will be enhanced.

In order to manage donor transition, KASF II promotes the inclusion of HIV treatment and care within essential benefits package of universal coverage. Efforts to strengthen capacity of health providers with knowledge and skills to deliver optimal treatment services will enhanced. People centred behaviour change and peer to peer communication strategies will be implemented to empower and stimulate positive actions among treatment to clients.

Table 12: **Recommended interventions to improve treatment, care and support for people living with HIV**

Strategic Focus Areas	Recommended Interventions
Optimise ART treatment for all sub-populations to improve patient health outcomes.	▪ Optimise test and start policy for all sub-populations. ▪ Strengthen community and facility-based systems for treatment preparation. ▪ Strengthen the capacity of service providers at all levels, including care givers, guardians, parents/relatives and teachers on treatment support. ▪ Focus on addressing barriers to treatment access for key and vulnerable populations, including persons with disability and geographies with low treatment coverage ▪ Sustained engagement of the PLHIV communities. ▪ Timely adoption of novel treatment regimens.
Strengthen differentiated service delivery models to improve access	▪ Adopt, implement and scale up comprehensive Differentiated Service Delivery (DSD) Models. ▪ Promote knowledge management to inform DSD implementation. ▪ Strengthen documentation and monitoring and evaluation of DSD.
Strengthen management of comorbidities among PLHIV	▪ Support utilisation and coverage of UHC Essential Health Packages among PLHIV. ▪ Increase efficiency in management of NCDs e.g. Diabetes, Hypertension and cancers ▪ Mentorship of healthcare workers on NCDs/HIV management ▪ Facilitate mechanisms to improve treatment outcomes among TB-HIV co-infected ▪ Improve management of STI's and Viral Hepatitis.
Strengthen multisectoral engagement including private sector in HIV service delivery to enhance coverage and effectiveness	▪ Expand access to treatment, care and support in the private sector ▪ Improve reporting and quality of data on HIV treatment data among private sector providers in Kenya Health information System
Prioritise mental health, substance and alcohol control interventions in HIV programmes.	▪ Support development and dissemination of technical tools for prevention, identification, diagnosis, treatment and management of health conditions due to alcohol and substance use ▪ Scale up services for mental, neurological and substance use disorders among PLHIV

Mombasa County Adolescents and Young People Strategy on HIV and Sexual Reproductive Health

Foreward

The Kenya AIDS Strategic Framework (2014 – 2019), identifies adolescents and young people (AYP) as a priority population for the HIV response. Since AYP were identified as a priority populations, the country has continued to invest in policies and programmes that address the gaps identified in this population. Despite the investments, AYP are yet to demonstrate the benefits drawn from improved services.

The African Union has recognized the harnessing of the demographic dividend as an opportunity for African countries to address its development challenges and this has been anchored on Kenya Vision 2030. Harnessing the potential of AYP for the demographic dividend is essential. Developing programmes that identify and develop the potential of AYP is a key factor in achieving the development milestones in a country. The Mombasa County Integrated Development Plan (2018 – 2022) prioritizes the need to empower AYP through development of skills and talents.

A majority of AYP spend most of their time in learning institutions at different levels. The County Department of Education plays a key role in achieving the social outcomes as stipulated in Vision 2030, CIDP and this strategy. Creating opportunities and spaces for AYP to be engaged in responding to the negative outcomes on HIV, SRH and other related illnesses. Strengthening the capacities of stakeholders in education will be of paramount importance in addressing stigma and discrimination while improving access to information and treatment.

The writing team took into consideration the different policies and initiatives implemented in the country. Documents such as Global Accelerated Approach to the Health of Adolescents (WHO), Fast Track Plan to end HIV and AIDS among Adolescents and Young people (NACC), Acceleration plan for children and adolescent treatment scale up (NASCOP), Education Sector Policy on HIV and AIDS (MOEST), National ASRH policy, Adolescent Package of Care among others were instrumental in the development of this strategy.

This 5-year plan requires stakeholders across all sectors to work together in ensuring the needs of AYPs are addressed and their rights upheld. A combined and comprehensive approach in tackling the challenges facing AYP will be critical in realizing the objectives of this strategy.

Hon. Hazel Koitaba,
County Executive Committee Member,
DEPARTMENT OF HEALTH SERVICES
COUNTY GOVERNMENT OF MOMBASA.

Preface

The Mombasa County Adolescent and young people (AYP) strategy on HIV and sexual reproductive health marks a milestone in the County's investment plan in young people. The strategy will be implemented over a period of 5 years (2018 – 2023). It is a first of its kind in Kenya that has boldly attempted to provide a holistic approach to addressing the needs of adolescents and young people in Mombasa County.

In developing this strategy, the County is cognizant of the critical role of adolescents and young people in achieving the county development priorities. Despite attempts to address the health challenges of AYP, the county is still lagging behind in achieving the set milestones. Over the years, the county continues to record a high number of child marriages, gender based violence, teenage pregnancies and STIs. Other information in the county reveals low employment rates, high rates of school drop-outs and more AYP getting involved in sex tourism.

In the era of universal health coverage (UHC), the county has put in place bold steps to increase awareness and access to quality and affordable health services for all citizens in the county including AYP. To achieve this, the county recognizes the need for a multi-pronged and multi-layered approach in programming for AYP requiring input from stakeholders across all sectors.

This strategy has been developed to provide guidance to stakeholders who want to invest in and implement high impact programmes with AYP in the county. It seeks to boldly tackle the socioeconomic, behavioural and healthcare system-based determinants of health with an emphasis on multi-sectoral collaboration while meaningfully engaging AYPs. This document has four key strategic objectives:

1. To improve HIV/SRH outcomes for adolescents and young people
2. To improve the social and economic status of adolescents and young people
3. To strengthen AYP participation and leadership in HIV/SRH planning and programming at all levels
4. To strengthen county leadership and coordination of multi-sectoral partners engagement for AYP health and well-being.

All sectors (public and private) are invited to join us by creating opportunities for AYP, mainstreaming AYP in their policies and investing in the implementation of this strategy.

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List of Abbreviations

ANC	Ante natal Care
ARV	Anti-Retro Viral
AGYW	Adolescent Girls and Young Women
AYP	Adolescents and Young People
AYPLHIV	Adolescents and Young People Living with HIV
ASRH	Adolescent Sexual Reproductive Health
AYPKP	Adolescent and Young people Key Population
ATWG	Adolescent Technical Working Groups
CQI	Continuous Quality Improvement
CHMT	County Health Management Team
CHAs	Community Health Assistants
CHEWs	Community Health Extension Workers
CHVs	Community Health Volunteers
DHIS	District Health Information System
DDIU	Data Demand and Information Use
EBIs	Evidence Based Interventions
EMTCT	Elimination of Mother to Child Transmission
CASCO	County AIDS and STI Coordinator
CBO	Community Based Organization
CDH	County Department of Health
CEC Health	County Executive Committee member for Health
CIDP	County Integrated Development Plan
CO	Chief Officer
ECP	Emergency Contraceptive Pill
FBO	Faith Based Organization
GBV	Gender Based Violence
HCW	Health Care Workers
IEC	Information Education Communication
PrEP	Pre-exposure Prophylaxis

PEP	Post Exposure Prophylaxis
PNS	Partner Notification Services
MoE	Ministry of Education
MAT	Medically Assisted Therapy
HIV	Human Immunodeficiency Virus
HTS	HIV Testing Services
IDU	Intravenous Drug users
KASF	Kenya AIDS Strategic Framework
KEPH	Kenya Essential Package for Health
KENPHIA	Kenya Population-based HIV Impact Assessment
KDHS	Kenya Demographic Health Survey
NACC	National AIDS Control Council
NASCOP	National AIDS and STI Control Programme
KICD	Kenya Institute of Curriculum Development
WHO	World Health Organization
MoH	Ministry of Health
OSS	Organizational Systems Strengthening
NCD	Non-Communicable Diseases
NGO	Non-Governmental Organization
NSP	Needles and Syringes Programme
OTZ	Operation Triple Zero
PAC	Post Abortive Care
PVC	Post Violence Care
SDG	Sustainable Development Goals
SGBV	Sexual Gender Based Violence
SRH	Sexual Reproductive Health
STIs	Sexually Transmitted Infections

Table of Contents

Definition of working terms and relevant definitions	IX
INTRODUCTION	1
Rationale and Scope	5
VISION, GOAL AND OBJECTIVES	7
Guiding principles	7
Standards for quality adolescents and youth friendly services	8
STRATEGIC INTERVENTIONS	
Strategic Objective 1: Improved HIV/SRH outcomes for adolescents and young people	11
Strategic Objective 2: To improve the social and economic status of adolescents and young people	21
Strategic Objective 3: To strengthen AYP participation and leadership in HIV/SRH planning and programming at all levels	23
Strategic Objective 4: To strengthen county leadership and coordination of multi-sectoral partners engagement for AYP health and well-being	24
FINANCING AND RESOURCE MOBILIZATION	29
COMMUNICATIONS AND ADVOCACY	31
IMPLEMENTATION STRUCTURE	34
ANNEXES	39
REFERENCES	43

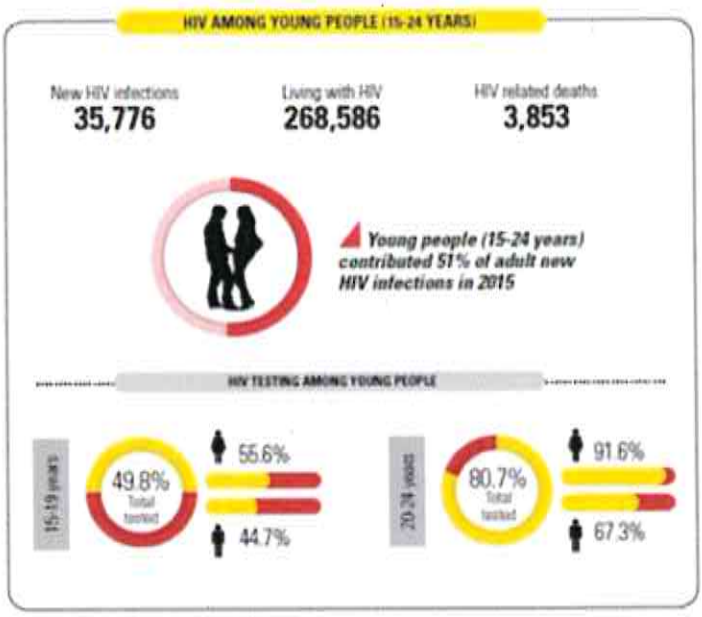
Definition of working terms and relevant definitions

- "Adolescents" are defined as persons between the ages of 10-19 year while Young people are persons between the ages of 15 – 24 years (UNAIDS, 2013). The Kenya youth policy defines youth as 15 – 30years. For the purpose of this strategy, adolescents and young people shall be between 10 – 30 years.
- Sexual reproductive health (SRH): It is a state of complete physical, mental and social well-being in all matters relating to the reproductive system. This means that adolescents and young people can have a satisfying and safe sex life, be able to reproduce and have the freedom to decide if, when and how often to do so. This requires access to accurate information and safe, effective, affordable and acceptable contraception method of their choice. They must be informed and empowered to protect themselves from sexually transmitted infections. (UNFPA)
- Mental Health: Mental health is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community. (WHO)
- Health systems; the people, institutions and resources, arranged together in accordance with established policies, to improve the health of the population they serve, while responding to people's legitimate expectations and protecting them against the cost of ill-health through a variety of activities whose primary intent is to improve health. (WHO, 2000)
- Community systems; are community-led structures and mechanisms used by communities through which community members and community-based organizations and groups interact, coordinate and deliver their responses to the challenges and needs affecting their communities. (The Global Fund)

INTRODUCTION

The Global Accelerated Action for the Health of Adolescents (AA-HA!), (WHO, 2017) highlights the key changes in adolescents. The importance of knowing that adolescents are not young adults, they are experiencing rapid physical, cognitive, social, emotions and sexual development, widening gap between biological , maturity and social transition to adulthood and balance between protection and authority.

Globally, 30 teenagers aged 15 – 19 were newly infected with HIV per hour (UNICEF, 2018) while the burden of HIV is greater among the 15 – 24 age group, with 4 million of them living with HIV (UNAIDS, 2014). AIDS is the leading cause of morbidity and mortality among adolescents in the world (WHO, 2014) with Sub-Saharan Africa contributing more than two thirds of all HIV related adolescent deaths. Young women are disproportionately affected by HIV and bear the brunt of the epidemic; they are twice as likely to acquire HIV as young men their age. Kenya has the fourth largest HIV epidemic in the world with 1.6 million people living with HIV. According to Kenya AIDS Response Progress Report (2016), young people aged 15-24 years contributed 55% of adult new infections with adolescent girls and young women contributing 33%. On the other hand however, Kenya is a global trendsetter in HIV prevention with adoption of new interventions and technologies such as PrEP and HIV self-testing. Access to treatment for people living with HIV continues to rise, with 75% of adults living with HIV accessing treatment in 2018 (UNAIDS, 2018). However, in 2014, only 24% of adolescents (aged 10-19) with a known HIV positive status were on ART (NACC, 2015) and a multifaceted approach is critical for the attainment of the 90-90-90 fast track targets in the country.



Kenya AIDS Response Progress Report, 2016

Each year, 16 million girls (15-19yrs) give birth representing 11% of all births worldwide (UNFPA, 2015) of which 2.5 million are girls under the age of 16 years from developing regions (Neal S, Matthews Z, Frost M et al, 2015). 3.9 million adolescents undergo unsafe abortion each year (Daroch J, 2016). Complications during pregnancy and child birth are the leading cause of death for 15 – 19 year old girls globally (WHO, 2016). An estimated 5% to 33% of girls ages 15 to 24 years who drop out of school in some countries do so because of early pregnancy or marriage (World Bank, 2017). In Kenya, the Total Fertility Rate, or the average number of children per woman over the course of her lifetime, had declined from 6.1 children in 1990 to 4.4 children per woman in 2015. Teenage pregnancy has stagnated at 18% among 15-19 year olds since 2009. Unmet need for FP among adolescent girls is at 23%. Contraceptive prevalence rate (CPR) among married adolescents 15 – 19 years is at 37% while CPR rate for any contraceptive method among adolescents this age group is 40.2%. The average age of sexual debut among 12-14 is 10 years, with condom use at sexual debut for 15-24 years old reported at 67% (women), 58% (men). Among adolescent girls aged 15 - 19 years, 4.2% have experienced sexual gender based violence (KDHS, 2014).

There is a global direction towards integration of services that ensures holistic approach to individuals. In Kenya, certain health services including TB, HIV, SRH and mental health services have been provided in isolation. The same individuals who access HIV services have other sexual reproductive health needs that remain unmet due to parallel programming. Sexually transmitted infections are an indicator of risk of contracting HIV, providing an opportunity to tackle the same within HIV services settings. In addition, the responses to HIV/AIDS and non-communicable diseases (NCDs) have many commonalities. Timely identification, long-term treatment, regular monitoring, adherence to treatment, lifestyle modifications, prevention of complications, psychosocial support are some of the essential elements of management of both disease conditions. Data collection and appropriate disaggregation of the data remains a major challenge in the provision of sexual reproductive health services. The discussion of sex and sexuality continues to be a taboo in most parts of Sub-Saharan Africa including Kenya despite the high rates of teenage pregnancies and HIV infections. Cultural practices such as childhood marriages are contextual contributors to this situation. Coupled with this, there is low comprehensive knowledge on HIV/SRH among adolescents and young people at 17.4% (10-14 years for both girls and boys), 49% and 57.7% among girls and boys aged 15-19 years respectively (KDHS,2014). There is increase in teenage pregnancies in Kenya, low access to contraceptives and lack of access to post abortion care services among other sexual and reproductive health challenges. Low economic capabilities of adolescents and young people in Kenya impedes their access to health services as they are not able to afford some of the costs associated with treatment and other medical procedures.

Demographic dividend, which is defined as the temporary opportunity to achieve rapid socio-economic development occasioned by a decline in fertility levels and strategic investments in key sectors, has been fronted as a solution to the myriad of problems being experienced by developing countries. This is drawn from the experience of the "Asian Tigers" and the newly industrialized countries in Asia that have successfully achieved high levels of income and a much better quality of life for their citizens. In response to these experiences, the African Union has recognized the harnessing of the demographic dividend as an opportunity for African countries to address its development challenges which include high unemployment levels, high incidence of poverty, forced migration by inhabitants of the continent in search for better opportunities abroad, low education levels, high mortality and morbidity incidences, and criminal activities among the youth (NCPD). This strategy will borrow from Kenyan demographic dividend roadmap anchored under vision 2030.

The Kenya Health Act No 21 of 2017 enshrines the right to access to health as outlined below:

4. "It is a fundamental duty of the State to observe, respect, protect, promote and fulfill the right to the highest attainable standard of health including reproductive health care and emergency medical treatment..."

(c) "ensuring the realization of the health related rights and interests of vulnerable groups within society, including women, older members of society, persons with disabilities, children, youth, members of minority or marginalized communities and members of particular ethnic, religious or cultural communities;"

6. (1)" Every person has a right to reproductive health care which includes—the right of men and women of reproductive age to be informed about, and to have access to reproductive health services including safe, effective, affordable and acceptable family planning services;"

The Situational analysis for most at risk adolescents conducted in 2014 provided evidence of existence of young Key populations (those injecting drugs, practicing same sex and exploited through sex work) in Kenya. There lacks global data on estimates of young key populations, as well as their risks and needs. Often times, health care systems are unresponsive, with health care providers lacking adequate skills on providing services to young KP (WHO, 2014).

Children Act Chapter 141 Revised Edition 2012 [2010]

9. Right to health care: Every child shall have a right to health and medical care the provision of which shall be the responsibility of the parents and the Government.

14. Protection from harmful cultural rites, etc. No person shall subject a child to female circumcision, early marriage or other cultural rites, customs or traditional practices that are likely to negatively affect the child's life, health, social welfare, dignity or physical or psychological development.

15. Protection from sexual exploitation: A child shall be protected from sexual exploitation and use in prostitution, inducement or coercion to engage in any sexual activity, and exposure to obscene materials.

16. Protection from drugs: Every child shall be entitled to protection from the use of hallucinogens, narcotics, alcohol, tobacco products or psychotropic drugs and any other drugs that may be declared harmful by the Minister responsible for health and from being involved in their production, trafficking or distribution.

HIV prevalence in Mombasa is 1.2 times higher than the national prevalence at 7.5%

There are a number of health issues that affect young people in Mombasa County. The Mombasa County Adolescent and Youth Survey (NAYS, 2017) confirmed that the main health issues include; STIs or HIV/AIDS, Drug and Substance Abuse as well as Teenage Pregnancy. Sexual and Gender based Violence was also mentioned to be an issue affecting the young people especially in form of rape and domestic violence. Mombasa County is one of the priority counties in the HIV response in Kenya. HIV prevalence in Mombasa is 1.2 times higher than the national prevalence at 7.5% (Kenya HIV Estimates 2015). The county contributed 3.6% of the total number of people living with HIV in Kenya, and is ranked the seventh nationally (County profiles 2015) with 54,310 people living with HIV; with 19% being young people aged 15-24 years (County profiles 2015). Adolescents and young people (10-19) and (15-24) years contributed to 25% and 47% of all new HIV infections in the County respectively (County profiles 2015). Mombasa is one of the counties reported to be on a reverse gear in the HIV response, with an 87% increase in the number of new HIV infections among children aged below 15 years and 51% among adults aged 15 years and above. About 1 in 5 (17%) girls aged 15-19 years in Mombasa County have begun childbearing; about the same as the national level (Figure 2). Specifically, 5% are pregnant with their first child and 11.6% have ever given birth

compared to 3.4% and 14.7%, respectively, at the national level (AFIDEP, 2017). Among married adolescent girls, use of modern contraceptive methods has risen from 13% in 2003 to 37% in 2014 and unmet need for family planning for this age group has declined from 30% in 2003 to 23% in 2014.

The Mombasa County AYP HIV and SRH strategy aims to provide guidance on standardization, implementation and monitoring and evaluation of HIV and SRH information and services provided to AYP. The national youth policy (2006), "visualizes a society where youth have an equal opportunity as other citizens to realize their fullest potential, productively participating in economic, social, political, cultural and religious life without fear or favour. Multi-sectoral approaches, whole-of-government involvement and whole-of-society efforts are critical to the responses to both HIV and NCDs. Strong and robust health and community systems are an integral part of achieving universal health coverage.

Rationale and Scope

Adolescents and young people (10 – 24 years) account for 29% (346,916) of the population of Mombasa County (MCASP, 2016). Their health and well-being is therefore an asset in the development of the county. Evidence has demonstrated that this population also contributes greatly to new HIV infections and STIs. AYP present a myriad of challenges including high rates of teen pregnancies, drugs and substance abuse, sexual and gender based violence, high rates of unemployment among others. Underneath these challenges are harmful cultural and religious practices that impede efforts to address them.

Reproductive health is an essential priority in the Kenya Essential Package for Health (KEPH) system. This strategy captures the spirit of the Constitution of Kenya, National Adolescent sexual reproductive health policy, Kenya SRH policy, KASF (2014 – 2019) and County Integrated Development Plan (2018 – 2022).

This strategy addresses HIV response on testing, care and treatment and viral suppression and services for sexual reproductive health needs including STIs, GBV and Contraceptives. In addition, it proposes possible interventions to be implemented and stipulates the roles of different stakeholders in the county. There is great emphasis of county leadership to achieve the success of this strategy.

The AYP strategy will be useful for the county government in planning, budgeting and implementing AYP responsive HIV/SRH services. AYP will be able to hold the county government responsible for the execution of the strategy. There is a greater call for a multi-sectoral and multi-pronged approach to holistically respond to the needs of adolescents and young people while addressing the social determinants like job and business opportunities, retention in school among other.

VISION, GOAL AND OBJECTIVES

Vision: Healthy, empowered and productive adolescents and young people

Goal: To contribute to improved health and well-being of adolescent and young people in Mombasa County

Objectives:

1. To improve HIV/SRH outcomes for adolescents and young people
    - To improve access to comprehensive HIV/SRH and related services among AYP
    - To strengthen health and community systems for improved HIV & SRH services for AYP
2. To improve the social and economic status of adolescents and young people
3. To strengthen AYP participation and leadership in HIV/SRH planning and programming at all levels
4. To strengthen county leadership and coordination of multi-sectoral partners engagement for AYP health and well-being

Guiding principles

1. **Rights-based approach –** every human being has rights and freedoms that they enjoy. These include right to life, equality, human dignity and freedom from discrimination on the basis of gender, sex, age, health status, disability, religious beliefs and practices, tribe, culture, geographic location, social status among others. These rights and freedoms must be respected by all. Sexual and reproductive health rights within the context of the Law, are components of human rights should be upheld and adhered to by all stakeholders involved. Adolescents and young people have a right to decide freely and responsibly on their health on aspects of SRH and HIV.
2. **Meaningful engagement –** AYPs must be involved in designing, planning, implementation, monitoring and evaluation of SRH and HIV interventions at all levels. Promotion of partnerships, collaborations and creation of open channels of communication are essential for achievement of the goals of this strategy. All the AYP sub-populations including those who are: living

with HIV, disabilities, using and injecting drugs, orphans and vulnerable, exploited through sex and engaging in same sex. Their representation and involvement are critical to attain the vision of healthy and productive AYP.

3. **Responsiveness of services and information –** interventions provided to AYP must be responsive to the needs presented at the point of service delivery, or based on information collected through research or feedback mechanisms.
4. **Holistic and integrated information and services –** through multi-layered and multi-sectoral approaches that are effective and efficient in reaching AYP with information and services.
5. **Multi-sectoral –** through clarification on the roles of each sector in achieving a healthy generation of AYP who are free to make choice regarding their health.
6. **Involvement of caregivers and communities –** acknowledging that AYP have family ties and the involvement of their caregivers is critical in promotion of SRH and well-being irrespective of HIV status.
7. **Evidence based programming –** services and information targeting AYP should be informed by evidence generated at all levels.

Standards for quality adolescents and youth friendly services

The eight standards outlined below define the required level of quality in the delivery of services for adolescents and youth. Each standard reflects an important facet of quality services and in order to meet the needs of adolescents and youth all standards need to be met. These standards are defined under the National standards and guidelines on delivery of Youth Friendly services.

Standard 1. Adolescents and youth health literacy: The service delivery point implements systems to ensure that adolescents and youth are knowledgeable about their own health, and they know where and when to obtain health services.

Standard 2. Stakeholder support: The service delivery point implements systems to ensure that stakeholders recognize the value of providing health services to adolescents and support such provision and the utilization of services by adolescents and youth Adolescents' and youth health literacy Stakeholder support.

Standard 3. Appropriate package of services: The service delivery point provides a package of information, counselling, diagnostic, treatment and care services that fulfil the needs of all adolescents and youth. Services are provided in the facility,

through referral linkages, networks and outreach including in humanitarian settings.

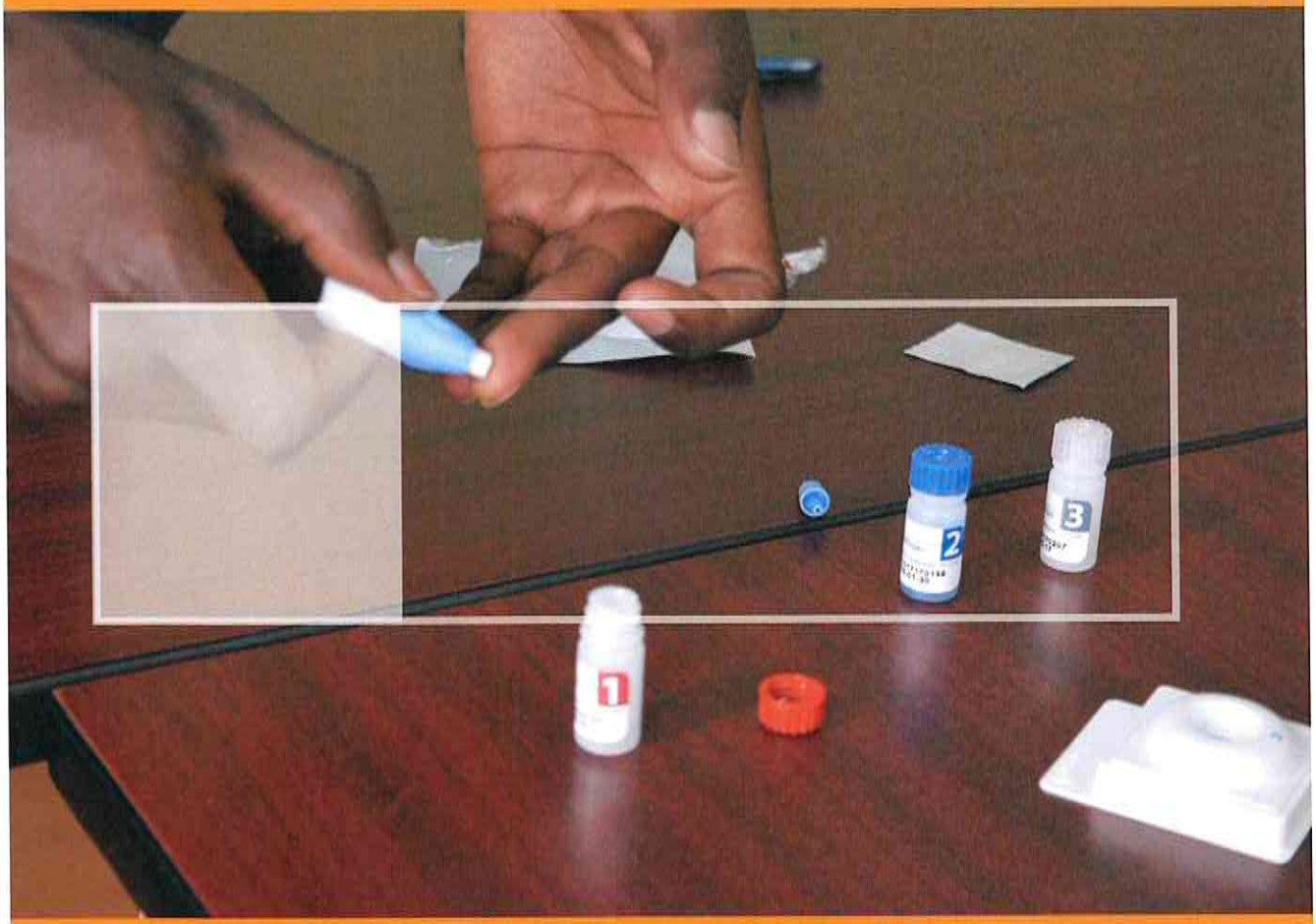
Standard 4. Providers competencies: Health-care providers demonstrate the technical competence required to provide effective health services to adolescents and youth. Both healthcare providers and support staff respect, protect and fulfil adolescents' and youth rights to information, privacy, confidentiality, non-discrimination, and non-judgmental attitude Providers' competencies.

Standard 5. Refers to facility characteristics: The service delivery point has convenient operating hours, a welcoming and clean environment and maintains privacy and confidentiality. It has the appropriate and relevant equipment, medicines, supplies and technology needed to ensure effective service provision to adolescents and youth.

Standard 6. Refers to Equity and nondiscrimination: The health service providers and delivery point provides quality services to all adolescents and youth irrespective of their ability to pay, age, sex, marital status, education level, ethnic origin, social status, cultural background, sexual orientation, gender identity, disabilities or other characteristics. The service providers and points of service shall ensure human rights of adolescent and youth are upheld.

Standard 7. Data and quality improvement: The service delivery point collects, analyses and uses data on service utilization and quality of care, disaggregated by age and sex, to support quality improvement. The service providers are supported to participate in continuous quality improvement. This data should be captured in the MoH Health information system/tools including uploading data into DHIS as is appropriate.

Standard 8. Refers to Adolescents' participation: Adolescents and youth are involved in the planning, monitoring and evaluation of health services and in decisions regarding their own care, as well as in certain appropriate aspects of service provision.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STRATEGIC INTERVENTIONS

Strategic Objective 1: Improved HIV/SRH outcomes for adolescents and young people

Many adolescents and young people do not have access to quality HIV and SRH services. Poor sexual reproductive health and HIV have shared drivers such as lack of correct and comprehensive HIV/SRH information, gender based violence, harmful cultural and religious practices, gender and economic inequalities among others. Integrating HIV and SRH services is a health and community systems response that can improve access and uptake of services, increase coverage and reduce costs to users and services that can ultimately improve the health outcomes of AYPs. Strong and robust health and community systems are an integral part of achieving universal health coverage. The Kenya Health Sector Strategic and Investment Plan 2014 – 2030 (KHSSP) documented that the Kenya health care system is characterized by lack of adequate and trained personnel, uneven distribution of health care workers, poor leadership, low staff morale, uncoordinated linkages and referrals, weak collaboration between and across public and private sector health systems, data analysis, monitoring, data demand for decision making, unclear indicators, lack of M&E tools at community level and inadequate financing. This strategy aims to build robust and sustainable health and community systems to enable effectiveness and efficiency in delivery of HIV/SRH information and services.

This section describes strategies for improving HIV & SRH outcomes for the different sub-categories of the AYP. By utilizing an ecological model, the focus is on high impact strategies that can be employed at individual, family and community levels to support the affected individuals realize improved health.

a. **To improve access to comprehensive HIV/SRH and related services among AYP**

Expected outcomes:

- Reduced new HIV infections among AYP in Mombasa County
- Reduced AIDS-related mortality among AYP in Mombasa County
- Reduced unplanned and early pregnancies among AYP in Mombasa County
- Reduced STIs incidence among AYP in Mombasa County

- Increased access to quality and comprehensive adolescent and youth-friendly HIV/SRH services
- Increased access to correct and comprehensive information on HIV/SRH by AYP in Mombasa County

Cross-cutting issues:

1. Provision of age appropriate Information to increase awareness on HIV/SRH and related services. Use appropriate channels for delivery of information by use of technology: social media, small group discussions in and out of school settings, audiovisual materials.
2. Delivering HIV/SRH services in conducive and responsive settings such as Youth Friendly Centers, safe spaces or days/hours favorable to AYP.
3. Integration of NCDs, nutrition, TB, mental health and alcohol and substance abuse services into HIV/SRH interventions.
4. Sensitization of the education sector stakeholders in HIV/SRH interventions for the AYP for integration in school programmes.
5. Incorporating of HIV/SRH messages and activities during ministry of education calendar events e.g. drama and music festivals, sports.
6. Leveraging on out of school sports and creative arts activities, national days to promote HIV/SRH interventions among AYP in various geographical /administrative zones.
7. Scale up training and sensitization of AYP mentors and champions for in and out of school HIV/SRH interventions.
8. Promote use of technologies like self-testing, PrEP and other innovative interventions for HIV prevention.
9. Empowerment of AYP on abstinence (delayed sexual debut or secondary virginity) until they are able to make healthy choices on sexual activities.
10. Conduct rapid assessments on the knowledge, attitudes and practices of health care providers and address the gaps to improve provision of HIV/SRH services to adolescents and young key populations, AGYW, AYPLHIV and other emerging vulnerable AYP.

Intervention area	Proposed actions	
	Target populations	
Reducing new HIV infections	**AYP in general population**	• Provision of appropriate key essential health package for AYP that includes : • Biomedical - HTS services both facility and community based settings, Condoms demonstration and distribution, PrEP, PEP, VMMC, Behavioural - comprehensive sexual education and comprehensive behavior change interventions using EBI's (Shuga, My health My choice, Family Matters!)
	AYP Key populations	• Provision of appropriate key essential health package for AYP that includes : • Biomedical - HTS services both facility and community based settings, Condoms demonstration and distribution, PrEP, PEP, VMMC, Behavioural - comprehensive sexual education and comprehensive behavior change interventions using EBI's (Shuga, My health My choice, Family Matters!) • Provision of Psychosocial support to address issues of sex, sexuality, sex exploitation, etc. • Sensitization of law enforcement agencies and other stakeholders on AYPKP issues. • Conduct PNS for AYPKP with recurrent STIs and those testing positive • Implement interventions targeting children of KPs
	AYPLHIV	• Psychosocial support on relationships, sex, future career, family and social integration. • Provision of Condoms (demonstration and distribution). • Behavioural interventions comprehensive sexual education and comprehensive behavior change interventions using EBI's (Shuga, My health my choice, Family Matters!) • In-school support structures for AYPLHIV • Provision information about EMTCT and services to AYPLHIV • Educate on treatment as prevention • Scale up partner notification services to identify positives

Improving referrals, linkage and retention to HIV/SRH services	• Develop referral systems e.g. county referral directory • Train and engage peer mentors and champions to link AYP to services at community and facility level • Strengthen facility and community inter and intra linkages • Use technology to provide information on benefits of early access to HIV/SRH services e.g. enrollment and initiation to ART • Establish defaulter tracing mechanisms • Scale up retention strategies for AYP to enhance prevention and treatment outcomes • Scale up integrated HIV/SRH services in AYP responsive centres
Increasing viral suppression among AYPLHIV	• Provision of age appropriate HIV treatment literacy • Timely initiation on ART (test and treat) • Timely viral load monitoring for viral suppression. • Innovative interventions for addressing high viremia cases, including parental/caregiver support. Real time identification and reporting of high viremia. Viremia case management. • Psychosocial support on adherence, including Peer–led support groups. • Structural interventions to address barriers to adherence including nutritional support, parental care & support, school based support systems, • Scale up differentiated care models e.g. Operation Triple Zero plus (OTZ+) • Home visits and follow up by HCW /peers for AYPLHIV • Use of Technology for appointment reminders e.g. SMS
Reducing incidence of STI, teen pregnancies	• Provision of age appropriate Information on SRH using different channels that including audio-visual and digital platforms especially for the out-of-school AYPS, • Age appropriate SRH content in the school curriculum for the in-school AYPs in collaboration with MoE. • Provision of services , including condoms, modern contraceptives methods, STI screening & treatment, cervical cancer screening and vaccinations, Ante & post-natal care (ANC), quality obstetric care for all pregnant adolescents and young girls, post-abortion care (PAC), in conducive settings such as integrated or stand-alone Youth Friendly Centers, • Appropriate referrals and linkages for SRH services. • Psychosocial support programs for in and out of school AYP with child • Leveraging on multi-sectoral stakeholders (religious leaders, parents associations, legislative leaders; for policy change) in the curbing early teenage pregnancies.

Optimise Tuberculosis (TB) case finding and treatment outcomes	• Routine TB screening within HIV/SRH service delivery • Scale-up of active case finding at community and facility level • Education campaigns on TB symptoms to increase self-referrals to health facilities • Strengthen specimen transportation to increase testing coverage • TB lab networking to enhance universal DST target • Chest x-ray to be availed free of charge or at affordable fee • Scale-up use of GeneXpert for diagnosis
Reducing Drugs and substance abuse	• Sensitization of AYP on harmful consequences of drugs and substance abuse for both in and out of school. (Age appropriate messages for AYP) • Sensitization of county askaris law enforcement agencies on the necessary interventions for AYP using and injecting drugs • Enrollment into rehabilitation and reintegration to school and communities. • Provision of MAT to young people injecting drugs • Linkage to livelihood interventions e.g. entrepreneurship, employment, back to school, vocational training. • NSP programme. • Training of peer educators on drugs and substance abuse to cascade the information to their peers (Engage the recovering drug users) • Harm reduction package to include HIV prevention interventions, hygiene packs, and contraceptives. • Expand rehabilitation services for young girls. • Demand creation for rehabilitation services for AYP IDU's. • Address mental and psychological health issues among AYPs. • Develop interventions targeting children of IDUs

Gender based violence prevention and response (including SGBV)	• Age appropriate Information on what GBV entails and prevention options using different channels, including digital platforms, especially for the out-of-school • Standardize content taught in school based curriculum (lobby M.O.E and KICD for content development) • Empowerment to recognize GBV when it occurs, seek health care and report to the relevant authorities. • Provision of services including post violence care (PVC), emergency contraceptives (ECP), psychosocial support and referrals /access to justice system. • Training of health care workers to deliver quality GBV services • Sensitization of programmers to integrate GBV interventions in AYP targeted programs. • Awareness creation targeting the public through different channels such as community groups, religious gatherings, chief's barazas, IEC materials in public places including health facilities. • Sensitization of law enforcers to facilitate justice for survivors of sexual and gender based violence. • Training of peer educators on GBV to cascade the information to their peers. • Sensitizing parents and caregivers on GBV issues affecting AYPs. • Community level engagement to mitigate harmful cultural practices that affect AYP. • Establishing and equipping of safe houses (one) in every sub-county. • Set up intervention s to address issues emanating from AYP witnessing and or experiencing GBV. • Strengthen GBV reporting structures and interconnectivity of agencies/ stakeholders in the incidence-reporting cascade. • Establishing and operationalizing the GBV desks within the health facilities and communities e.g. Integrating GBV within Homebased care desk in facilities • Capacity building stakeholders in GBV issues. For example HCW, teachers, police, parents and community members • Identify and build capacities of GBV champions within the community settings. • Training and continuous sensitization of paralegals to address GBV issues affecting the AYP's. • Leveraging and linkages with the legal department, human rights activists and institutions to address GBV issues affecting the AYPs.

Improved programming for Menstrual hygiene management	• Provision of menstrual hygiene information in and out of school targeting AGYW • Put systems in place to ensure provision of sustainable and cost effective sanitary pads to AGYW unable to access sanitary pads • Sensitize parents on menstrual hygiene information. • Male and parents involvement meetings • County government of Mombasa to support menstrual Hygiene programs for AYPs in and out of school. • Multi sectoral approach in county ministries to support menstrual programs. • Training of mentors to cascade information on menstrual health. • Involvement of individual and corporate institutions to support menstrual hygiene program. • Engagement of the county women leaders to support menstrual hygiene program.
Prevention, early diagnosis and management of Non-communicable diseases	• Awareness creation on NCDs • Screening for NCDs to be integrated in routing HIV/SRH services for early diagnosis • Prioritization of cardiovascular diseases, Cancers, Diabetes and Chronic obstructive pulmonary disease, obesity, hypertension • Lab commodities and supplies for screening
Mental Health awareness and response	• Conduct campaigns to sensitize communities of mental health issues • Map and engage mental health experts to provide interventions • Develop mental health assessment tools for early diagnosis • Introduction of psychosocial and psychological support

b. **To strengthen health and community systems for improved HIV & SRH service delivery to AYP**

Expected Outcomes:

- Improved availability and use of quality essential commodities and technologies for HIV and SRH interventions
- Competent and adequate human resources to deliver quality, comprehensive and responsive AYP HIV and SRH services
- Enhanced community and in-school interventions for integrated HIV/SRH information and services
- Improved infrastructure for provision of quality, comprehensive and responsive AYP SRH/HIV services
- Increased availability and access to quality and comprehensive adolescent and youth-friendly SRH/HIV services

Areas of interventions	Proposed actions
Capacity building of Health Care Providers and other support staff to provide quality, comprehensive and responsive AYP services.	• Conduct a capacity assessment for Health Care Providers and support staff on AYP SRH/HIV. • Recruit and motivate skilled staff • Develop/Review/adopt training materials, practice guidelines/job aids on responsive AYP service delivery • Conduct trainings for the Health Care Providers and support staff on AYP SRH/HIV based on the needs assessment • Develop a Health Care Providers' mentorship and skills transfer plan for AYP SRH/HIV services (This is important to close the gaps left with attrition) • Develop a skill-set database for HealthCare provides trained on responsive AYP SRH/HIV service delivery • Training young people to provide comprehensive services at youth centres
Quality assurance for HIV/SRH AYP services	• Supportive supervision and feedback at community and facility level • Establish CQI teams • Implement Guidelines and standards • Debriefing of staff serving AYPKP to ensure quality of services is maintained • Client satisfaction through exit interviews, suggestion boxes,

Strengthen systems for effective commodity management and security	• Establish/strengthen logistics management information systems for essential SRH/HIV services for AYP • Train focal county and facility health staff on commodity forecasting, quantification and management of SRH/HIV commodities • Procure and distribute essential AYP SRH/HIV commodities to all service delivery points based on individual facility's need as per forecasting and quantification • Strengthen reporting
Integration of AYP SRH/HIV information and services into community structures	• Train and sensitize CHEWs/CHVs/CHAs, Mentor mothers and peer mentors/navigators on responsive AYP information delivery and service referral. • Strengthen the quality assurance structures at the community level that responds to AYP needs. • Hold bi-annual sensitization stakeholders forum • Integrate HIV/SRH services for AYP in existing structures e.g. Likoni youth empowerment center. • Develop/Review Community Strategy tools to include AYP SRH/HIV linked to DHIS • Out of school interventions at community level e.g. EBI , AYP dialogues e.tc. • Parents/caregivers interventions e.g. FMP, Structured dialogues in social places e.g. churches, mosques, Chama • Interventions targeting Teachers e.g. Beacons, champions of HIV prevention and treatment • Use of AYP as peer navigators to strengthen follow-up and linkage to services • Conduct media engagement • Social media campaigns/activations led by AYP to inform dialogues e.g. use of one2one social media platforms, hotlines like 1190
Improvement of infrastructure for provision of quality, comprehensive and responsive AYP SRH/HIV services	• Conduct infrastructural needs assessment in all public health facilities/YFCs/Youth corners in line with the National Guidelines and standards for provision of Youth Friendly Services. • Undertake need-based facility renovations or improvement to enhance provision of integrated, quality and comprehensive AYP SRH/HIV services. • Upgrade existing Youth Centers in sub-counties and establish more adolescent and youth responsive model centers • Integrate AYP responsive services in existing health facilities and establish where there are none • Set up school based AYP clinics

AYP HIV/SRH information systems	• Define/adopt indicators for service delivery and community interventions • Disseminate the reporting tools to facilities and community health units • Include AYP HIV/SRH indicators in reporting tools • Capacity building for reporting entities (health facilities, CBOs, Youth groups, NGOs) • Conduct routine data quality assurance • Strengthen data flow processes and reporting to DHIS2 • Develop data feedback mechanism. • Improve inter-operability of M&E systems EMIS, IHRIS, DHIS, CAPR • Establish and operationalize forums for use of data to inform interventions at facility and community level

Strategic Objective 2: To improve the social and economic status of adolescents and young people

Social and economic status of AYP has a direct impact on their HIV/SRH outcomes. High levels of poverty, unemployment, and low literacy level hinder access to HIV/SRH information and services. The inequalities and inequities that are brought about by the social and economic status of AYP contribute disproportionately to high incidences of preventable diseases, premature deaths especially among the poor, adolescent girls and young women and displaced AYP. As these determinants exist outside the health domain, multi-sectoral and interdisciplinary approaches are required. This section seeks to reduce the health equity gaps through addressing the social and economic determinants of health.

Expected outcomes:

- Improved economic status of AYP
- Reduced school drop outs
- Increased access to legal and justice processes
- Adequate, affordable and safe housing

Intervention areas	Proposed actions
Access to education	• Implement national education policy to enhance enrollment into school • Implement basic education amendment act • Put interventions to retain AYP in schools e.g. sustainable education support like bursary, scholarships, hygiene packs for AGYW • Reintegrate AYP into schools e.g. pregnant teenagers to be integrated into school after delivery, friendly programs for teenage mothers • Education for AYP to include motivational, skills building, communication skills and personal development
Economic empowerment and working conditions	• Training on economic empowerment for AYP to encourage entrepreneurship • Timely provision of seed grants/business start-up funds to AYP to set up business • Develop and implement safe working conditions for AYP to address HIV/SRH in the work place • Create meaningful employment opportunities for AYP • Internship opportunities created for AYP
Family and social support	• Address harmful cultural and religious practices e.g. child marriages • Sensitization of families and communities on AYP needs and available HIV/SRH policies for support • Develop innovative approaches to enhancing male involvement in HIV/SRH services • Establish support mechanism to support AYP as they transition from childhood to adolescence to adulthood
Community safety	• Scale-up Nyumba kumi initiative • Sensitize community gatekeepers on enhancing security in their units • Establishment and maintenance of safe spaces for AYP at community level • Facilitate community dialogues on safety including the impact of safety on health and well-being of AYP
Access to legal services	• Train paralegals to work in communities and link AYP to legal services • Civic education on available legal services • Strengthen facility, community and legal linkages • Enact and enforce laws that ban child marriages
Housing	• Build adequate housing that meets set standards e.g. with toilets, safe water • Make housing affordable and safe
Enrollment into national medical plans	• Civic education on the importance of NHIF • Enroll AYP on NHIF

Strategic Objective 3: To strengthen AYP participation and leadership in HIV/SRH planning and programming at all levels

Nothing for us without us has become a common slogan for ensuring no one is left behind in population specific response.

Expected outcomes:

1. Improved capacity of AYP to engage in policy, programming and research
2. Adoption of AYP contributions in interventions
3. Defined mentorship programme for AYP

Intervention Areas	Proposed Actions
Capacity building for AYP	• Conduct capacity needs assessments in relation to meaningful participation of AYP in advocacy • Conduct trainings/sensitization on involvement in policy influencing, programme life cycle and research • Implement creative mentorship approaches to sharpen AYP engagement skills • Train AYP on documentation of advocacy milestones, best practices
Creation of Advocacy spaces	• Identify advocacy forums at local, county and national levels • Conduct community dialogues to tap on the voice of AYP at community level using peer led approach • Establish and operationalize AYP technical working group at county level • Build capacity of policy makers to engage AYP in policy forums • Build capacities of non-state actors and service delivery entities to involve AYP in planning, implementation and M&E • Facilitate establishment and functionality of Youth advisory councils
Linking AYP to advocacy platforms	• Facilitate participation of AYP in advocacy forums at all levels from community to international level • Facilitate development of advocacy agenda and messages to support AYP to engage
Organisational systems strengthening (OSS) for AYP groups	• Conduct group capacity assessments • Conduct OSS training to respond to capacity gaps identified • Develop and track growth milestones • Strengthen the roles of AYP led CBOs in programming, research, and policy, resource mobilisation

Strategic Objective 4: To strengthen county leadership and coordination of multi-sectoral partners engagement for AYP health and well-being

The health and well-being of AYP cannot be achieved through the department of health alone. Deliberate efforts must be put in place to enhance collaboration between and among various sectors in addressing multiple factors that affect the health outcomes of AYP. Multi- sectoral collaborations can result in a number of benefits including enhance accountability, more efficient use of resources and holistic approach in responding to the needs of AYP.

The success of this strategy will greatly depend on the leadership and ownership of the county. Thus counties are responsible for implementation of HIV and SRH services and programmes across different sectors. The county government Act 2012, requires that county governors submit the county plans and policies to the county assembly for approval together with an annual report on the implementation status.

Expected outcomes:

- Enhanced coordination of multiple sectors in responding to HIV/SRH among AYP
- Increased access to resources
- Enhanced accountability of stakeholders at all levels
- Sustainability of interventions for HIV/SRH and other related services

Intervention Area	Proposed Actions
Promote accountable leadership and political goodwill	• Capacity building of county departments for buy-in and political goodwill • Allocate adequate resources for AYP HIV/SRH response • Capacity building of CHMT to effectively manage and coordinate responsive AYP SRH/HIV services in the county • Promote gender mainstreaming and people with different abilities
Coordination of partners	• Undertake development and implementing partners mapping exercise and develop a functional database • Convene quarterly AYP TWG meeting • Develop partner reporting and accountability frameworks for AYP SRH/HIV services/response
Institutionalize multi-sectoral engagement	• Identification of relevant sectors to be involved in implementation of the HIV/SRH strategy for AYP • Define and implement multi-sectoral coordination mechanism e.g. Multi-sectoral TWG with clear TORs • Facilitate annual stakeholders forum (community, implementing partners, donors) • Development and implementation of AYP advocacy agenda across sectors • Facilitate joint supervision of services with stakeholders • Establish quarterly multi-sectoral forum to discuss sector contribution to the achievements of this strategy • Integrate HIV/SRH interventions targeting AYP across sectors
Joint planning	• Development of sector specific M&E frameworks with inclusion of HIV/SRH among AYP • Joint M&E frameworks across sectors • Multi-sectoral joint supervision • Sector specific budget allocations for AYP interventions
Policy (re)formulation	• Identification of policy gaps in relation to HIV/SRH outcomes for AYP • Review of existing policies to respond to AYP needs • Facilitate dissemination of relevant policies at all levels • Development of progressive and responsive policies e.g. policies that govern sex tourism • Monitor implementation of policies e.g. children Act, institutionalization of Child protection policies

Data utilization and Research

Generation of quality data in a timely manner and use of evidence to inform decisions remains a major challenge in addressing HIV/SRH gaps. Monitoring of multi-sectoral data requires interconnectivity of various systems before such data can be utilized to inform interventions. Routine data collection and collation, analysis and collective use requires the efforts of multiple sectors to achieve a combined approach to responding to HIV/SRH challenges among AYP. There are currently separate systems that are used to collect and collate HIV and SRH service delivery data; this leaves out interventions that are not direct services and those done at community level. Research agenda for AYP at national and county level is unclear, yet there are myriads of challenges that remain unresolved in the efforts to ensure comprehensive services are provided.

Expected outcomes

- Improved data for HIV and SRH AYP services disaggregated by age and sex
- Functional reporting system
- Structured DDIU forums to inform interventions
- Clearly defined research agenda for AYP
- Functional repository for AYP research

Intervention Areas	Proposed Actions
Data Demand and Information Use forums (remove forum).	• Convene quarterly DDIU meetings to include all relevant sectors e.g. education, tourism, mining, agriculture etc • Document best practices through abstracts, manuscripts • Conduct Mombasa County annual AYP scientific conferences.
Piloting of new strategies for AYP	• Develop research protocols with relevant partners • Conduct research observing ethical standards • Involve AYP in research • Establish AYP centres of excellence in the county where benchmarking can be done.
Evidence for AYP HIV/SRH needs	• Develop annual survey systems for HIV/SRH services and needs • Develop feedback mechanisms for AYP • Establish and operationalize repository for AYP research and linked to the national repository • Evidence presented to ATWG on biannually
Access to strategic information	• Conduct assessment on data needs/gaps/reporting systems • Revise and standardize data collection tools to address data gaps (based on the needs assessment) and aligning them to national guidelines/systems • Train relevant Health personnel on data analysis and presentation • Train focal county Health personnel on data management and use of evidence-based decision making • Accelerate inclusion of AYP data in the Kenya HIV and Health Situation room • Strengthen reporting to existing data management systems-KDHS, DHIS, KENPHIA • Development and use AYP SRH/HIV dashboard/s for Mombasa County


FINANCE
funding
saving
benefit

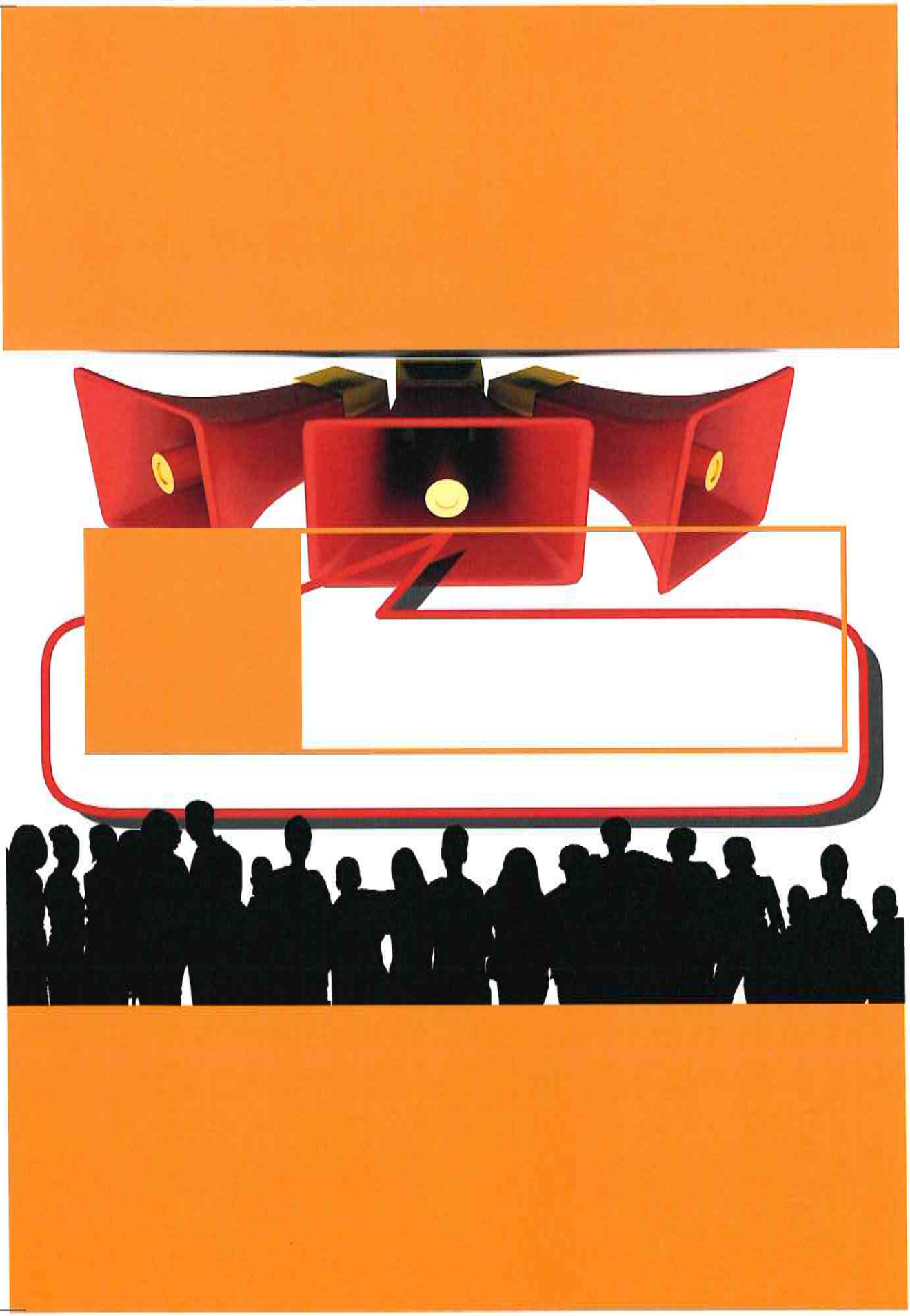
Financing and resource mobilization

Health is critical to the welfare and prosperity of a people and health service provision is a fundamental right enshrined in Kenya's constitution, which asserts that every citizen has a right to the highest attainable standard of health. These highest standards cannot be attained without financial investment in health resources that include human resources, infrastructure, medical supplies and commodities among others.

Kenya runs a devolved government structure where counties are mandated to plan, prioritize, implement, monitor, and allocate resources and budgets for programmes and interventions. In 2018, most counties allocated 25% of their budgets to health. About 70% of the health budget in counties goes to recurrent expenditures leaving just 30% for direct service provision. Mobilising more domestic funds is key in helping to ensure sustainability of health programmes in the wake of reduced donor funding. Resource mobilization becomes an active role of all sectors in ensuring this strategy is adequately funded.

The county government will develop a costed plan for this strategy that will inform development partners, implementing partners and other investors on areas of investment. Annually, the county will review the resources allocated and used to implement activities under each strategic objective and review the costed plan for the following year.

Intervention areas	Proposed actions
Implement robust and sustainable resource allocation plan	• Generate and provide evidence to justify resource allocation to AYP HIV/SRH programmes • Develop county and sub-county level resource gap analysis to inform resource needs • Engage county health and finance committees to prioritize and allocate funds for HIV/SRH interventions • Establish mechanisms for resource mobilisation including Public Private Partnerships • Enhance efficiency and accountability in resource allocation and utilisation • Monitor utilization of funds allocated for AYP interventions • Coordinate and harmonize donor support for AYP HIV and SRH programmes



Communications and Advocacy

This section emphasizes the need for meaningful engagement of stakeholders for the successful implementation of this strategy. The communication of this strategy to the relevant stakeholders will be key in getting buy in and support for HIV/SRH services for AYP. Dissemination will help increase the knowledge of the county citizens on the needs of AYP and their roles in implementation of the strategy. In addition, communication will help enhance positive attitudes towards AYP seeking HIV/SRH services and information thus addressing stigma and discrimination that can impede uptake of services.

Key components in communicating this strategy will include:

1. HIV and SRH statistics of AYP from ward, sub-county to county level
2. Gaps in service delivery and information
3. Approaches in responding to HIV/SRH needs of AYP
4. Use of ICT in reaching AYP e.g. social media platforms, hotlines
5. Role of different stakeholders in responding to the needs of AYP including youth advisory council, youth groups and organisations
6. County leadership in HIV/SRH response for AYP
7. Role of research in informing policy and practice

Audience	Communication needs
CHMT, county government departments	Awareness of AYP health needs, proposed interventions and strategies, roles of each department, funding gaps, accountability system
Health care workers, researchers, implementing partners	Awareness of AYP health needs, proposed interventions and strategies, roles stakeholders, funding gaps, engagement and accountability frameworks
Youth groups and organisations	Proposed interventions and strategies, roles of AYPs, engagement channels,
Donors	Proposed interventions and strategies, funding gaps
National government	Update on progress and technical support required to implement the strategy

Documentation of success stories is key in communicating the impact of this strategy. The communications team at county level will be responsible for training stakeholders on how to document stories of change and establish a mechanism for disseminating the stories using different platforms like blogging, social media engagements among others. In addition, all

communication efforts will be linked to county ICT systems for accountability and visibility. The ICT team at county level will also support AYP to develop and implement digital and innovative communication approaches.

The success or failure of this strategy will be determined by advocacy work undertaken at community, facility, county and national level. AYP individuals, youth groups and organisations will be instrumental in aggressively advocating at grass root level with opinion leaders, MCAs, religious groups, facilities among others to reduce stigma and discrimination towards AYP demanding for HIV/SRH services. In addition, they will be able to influence resource allocation and investment in AYP wellbeing. Concerted advocacy through youth advisory council and other organized groups will amplify the voice of AYP in the relevant advocacy platforms. Channels for advocacy by AYP should be created at all levels to ensure feedback is provided on services and information received.

Innovative approaches will be engaged by AYP in advocacy at different levels. The use of art and talents will be engaged at grass root level to garner support at that level. Community dialogues will be conducted through a peer-led approach. The community dialogues will be used to create demand and improve uptake of HIV/SRH information and services. The county department of health will be able to advocate for allocation of funds for HIV/SRH services and information for AYP. The county will be able to use this strategy to approach donors for funding support. Implementing partners will use this strategy to advocate for provision of quality services and improved service standards across board.

DRAG
YOUR
SCREEN
HERE
filmbee
INFOGRAPHIC
UI DESIGN

Implementation Structure

Sexual reproductive health and HIV services will be implemented in line with the National Adolescent Sexual Reproductive Health policy (2016) and the National Health Sector Strategic Plan through a multi-sectoral approach including collaboration with private sector and civil society groups. The goal is to improve access to HIV and SRH services by all sub-populations of AYP irrespective of their socio-economic status. All health facilities (government or non-government owned) from community level to county level have a role to play in provision of comprehensive, equitable, affordable, accessible and high quality HIV and SRH services. All stakeholders must ensure that the services provided are responsive to the needs of AYP and are in the best interest of each individual. The county through the department of health will develop an implementation framework for this strategy to inform sector specific actions.

Management and coordination

This strategy will be managed and coordinated by the County Director for Health with support from CASCO at county level, SCASCOs at sub-county level, Facility in-charges at facility level and community leaders at community level.

a. Roles and responsibilities

1. Department of Health

- Provide oversight and facilitate implementation of this strategy at county and sub-county level
- Disseminate AYP HIV/SRH strategy
- Develop and share a comprehensive implementation plan
- Ensure adherence to standards and regulations on HIV/SRH service provision
- Coordinate implementing partners and activities
- Facilitate involvement of other sectors in HIV/SRH response for AYP
- Mobilise and allocate resources for HIV/SRH programmes
- Ensure adequate skilled staff in facilities
- Ensure availability of equipment, commodities and supplies for provision of HIV/SRH services including condoms, contraceptives
- Strengthen school health programme

- Conduct supervision of services in facilities at all levels
- Facilitate data management and utilization of data to inform HIV/SRH programmes for AYP
- NACC and NASCOP at regional level

2. Other departments

Department	Roles
Education, ICT and Vision 2035	• Support implementation of school health programmes • Implement age appropriate comprehensive sexuality education in line with Education sector policy of HIV and AIDS 2013 • Facilitate involvement of parents and guardians of AYP through provision of HIV/SRH information within school settings • Strengthen referrals to health systems and structural interventions like bursaries • Facilitate a supportive environment for AYP living with HIV, pregnant adolescents • Ensure implementation of the Education re-entry policy for AYP • Strengthen partnership with department of health at county level to provide AYP-specific information and services on HIV/SRH • Support generation of data on school retention
Trade, Tourism and Investment	• Create a conducive environment for young people to engage in trade • Incorporate HIV/SRH policies in work places and tourism industry • Include a requirement in licensing for hotels, restaurants and bars to provide condoms • Put strict regulations against exploitation of children (under 18years) through sex work • Support generation of data to inform HIV/SRH programmes • Implementation of entrepreneurship development fund • Single business permit to be issued to AYPLHIV, AYP with disabilities

Youth, gender and social services	• Roll-out entrepreneurship plan for young people • Ensure equity in accessing youth empowerment funds • Train young people on entrepreneurship • Support advocacy on elimination of sexual and gender based violence • Support gender mainstreaming in all HIV/SRH and related programmes • Integrate HIV/SRH into youth empowerment programmes • Support policy advocacy, resource mobilization and generation of data • Protect adolescents against harmful cultural practices, child marriages, child labour and child trafficking
Transport and infrastructure	• Improve physical accessibility to health facilities • Set regulations that protect adolescents from being exploited by actors in the transport sector e.g. bodaboda and tuktuk riders, conductors in matatus, drivers • Ensure cases of sexual harassment especially involving adolescents do not go unreported • Support integration of HIV/SRH in the sector
Agriculture, livestock and fisheries	• Support integration of HIV/SRH in the sector • Work with beach management units to create a safe environment for AYPs
Environment, waste management and energy	• Support integration of HIV/SRH in the sector • Involvement of AYP in environmental management
Law enforcement agencies (Legal, police, county commissioner)	• Investigate violations of HIV/SRH rights according to the laws of Kenya • Enforce laws and administer justice to protect AYP
NACADA (County level)	• Create awareness on harmful effects of drugs and substance abuse • Ensure enforcement of laws that protect adolescents from alcohol, drugs and substance abuse • Provide age and sex disaggregated data for alcohol, drugs and substance abuse for decision making

3. Adolescents and young people

Adolescents and young people are the primary beneficiaries of this strategy. The AYP will champion HIV/SRH interventions among their peers through peer to peer approach and other AYP responsive approaches at all levels. AYP will participate in research, policy, planning, design, implementation and monitoring and evaluation. Additional effort will be put to ensure inclusion of vulnerable AYP including AGYW, most at risk adolescents and young people, orphaned and vulnerable children.

4. Development partners

Development partners will be encouraged to support HIV/SRH programmes targeting AYPs in line with this strategy. Development partners will seek approval from the department of health on HIV/SRH interventions to be implemented.

5. NGOs, CBOs, FBOs, and private sector

The Civil Society is instrumental in provision of HIV/SRH services and information. These non-state actors will work with the department of health to improve access and uptake of HIV/SRH services. The department of health encourages the non-state actors to increase access to HIH/SRH services at all levels in the design, financing, implementation, monitoring and evaluation of interventions. Non-state actors will be required to provide technical support to enhance skills of county staff, allocate resources to under funded programme areas, document and share best practices with stakeholders through forums organized by the department of health. In addition, non-state actors will be expected to ensure there is equity in the provision of services.

6. Youth groups

Youth groups/organizations will be responsible for advocating for implementation of the strategy. They will inform innovative ways of reaching AYP and increase uptake of HIV/SRH information and services. They will champion the use of art, social media platforms and other innovative ways to reach AYP with information and services.

7. Communities, families and individuals

Communities and families will be responsible for providing HIV/SRH information and support implementation of this strategy. They will participate in planning, implementation and M&E, and mobilizing resources e.g. allocation of safe spaces.

8. Communications and mass media

The communication and mass media entities at county level will advocate and create public awareness on HIV/SRH.

9. National government – NACC, NASCOP, MOH, NCPD, MoE, KNBS

NACC	• Provide guidance to regional team on coordination and implementation of national strategies and frameworks
NASCOP	• Provide guidance on biomedical approaches to HIV/SRH services and support regional team to streamline county data systems with national systems
Ministry of Health	• Provide guidance and support to county department of health on implementation of this strategy • Provide national guidance on standard indicators and SRH service delivery improvements.
Ministry of health	• Support county department of education to implement HIV/SRH interventions in learning institutions as per national standards
NCPD	• Provide AYP specific population guidelines to improve quality of life of AYP in Mombasa
KNBS	• Spearhead collection , analysis and dissemination of AYP statistical data in Mombasa through AYP specific surveys

10. Parastatals and corporates

Parastatals and corporates will support in resource mobilization, social corporate responsibility and integration of AYP responsive HIV/SRH policies in the work place will be required. Parastatals and corporates will also create employment and other gainful opportunities like scholarships to be accessed by AYP.

ANNEXES

Indicators

Focus Area	Indicators
Improved HIV/SRH Outcomes	• New HIV infection among the AYP • Incidence rate of STIs among AYP • Teenage pregnancy rates among AGYW (10-24years) / Percentage of women aged 20-24 that have given birth by age 18 • Contraceptive Prevalence Rate (CPR) among young people (15-19, 20-24) • HIV mortality and morbidity among AYPs • Maternal mortality among young women (15-19, 20-24) • % of AYPLHIV retained in care and treatment • % viral suppression among AYPLHIV • GBV incidences reported • % reporting rates by AYP implementing entities. • # of AYP accessing youth friendly services • # of rehabilitation centres service AYP using drugs
Social and economic determinants	• # of AYP engaged in meaningful employment (self or employed) • # of community level dialogues held • % AYP school retention • % of AYP school transition and completion. • % AYP reintegrated in school • % of women age 20-24 that report being married by age 18
Meaningful engagement of AYP	• # of AYP participating in policy forums • # of AYP organisations/groups trained on OSS • # of AYP active/vibrant youth groups in the county.
County leadership and support	• % resources allocated for AYP interventions • # of AYP advocacy forums at county level • # of funded AYP programmes in the County

Annex 2: List of Contributors

The Mombasa County Adolescent and Young People Strategy on HIV and Sexual Reproductive Health was supported by a team of young people, implementing partners, development partners who formed the technical review team, technical writing team and validation team.

2. Technical Review Team

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Make Dubi	County Gov't of Mombasa
Jackline Tsuma	County Gov't of Mombasa
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Juliet Kanuni	County Gov't of Mombasa
Alfred Mwakio	County Gov't of Mombasa
Aziza Katsutsu	County Gov't of Mombasa

Name	Organisation
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Margaret Mnyanzi	County Gov't of Mombasa
Everline Mbuche	County Gov't of Mombasa
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Nelly Egehiza	NACC
Rashid Gakucha	NACC
Rebecca Nyakieya	NACC
Sarah Wachira	NASCOP
Zachary Keyaa	NASCOP
Patriciah Jeckonia	LVCT Health, Facilitator
Joseph Gatimu	LVCT Health
Jane Thiomi	LVCT Health
Felix Murira	LVCT Health
Robert Kimathi	LVCT Health
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Sophie Safari	WOFAK
Juliet Akumu	YAC
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SPECIAL ISSUE

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REPUBLIC OF KENYA

KENYA GAZETTE SUPPLEMENT

MAKUENI COUNTY ACTS, 2019

NAIROBI, 19th November, 2019

CONTENT

Act—

PAGE

The Makueni County Reproductive Health and Family Planning Act, 2019.. 1

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THE MAKUENI COUNTY REPRODUCTIVE HEALTH AND FAMILY PLANNING ACT, 2019

No. 5 of 2019

Date of Assent: 14th August, 2019

Date of Commencement: See Section 1

ARRANGEMENT OF SECTIONS

Section

PART I—PRELIMINARY

1—Short title and commencement.

2—Interpretation.

3—Purpose of the Act.

4—Objects of the Act.

5—Guiding principles.

PART II—ESTABLISHMENT OF THE MAKUENI COUNTY REPRODUCTIVE HEALTH AND FAMILY PLANNING PROGRAM

6—Establishment of the Makueni County Reproductive Health and Family Planning Program.

7—Composition of the program.

8—Functions of the Program.

9—Powers of the Program.

PART III — ADMINISTRATION OF THE MAKUENI COUNTY REPRODUCTIVE HEALTH AND FAMILY PLANNING PROGRAM

10—Role of the County Department of Health.

11—Innovative strategies.

12—STIs HIV Aids and Reproductive Health diseases.

13—Unique needs of youth and adolescents.

14—Mentorship.

15—Counselling services.

16—Menstrual hygiene management.

17—Male involvement.

PART IV— ACCESS TO REPRODUCTIVE HEALTH AND FAMILY PLANNING SERVICES

18—Eligibility.

19—Right to Information.

PART V— DEVELOPMENT OF APPROPRIATE REPRODUCTIVE HEALTH EDUCATION AND PUBLIC AWARENESS

20—Age Appropriate education.

21—Role of the County Department of Education.

PART VI —REPRODUCTIVE HEALTH AND FAMILY PLANNING PROGRAMS FOR PERSONS WITH DISABILITIES

22—Abolition of barriers to reproductive health for persons with disabilities.

23—Prohibition of any form of discrimination.

PART VII —FINANCIAL PROVISIONS

24—Source of Funds.

25—Resource Mobilization Strategy.

26—Reporting.

PART VIII—MISCELLANEOUS PROVISIONS

27—Confidentiality.

28—Protection from liability.

29—Monitoring, Evaluation and Learning Framework.

30—Prohibited Acts.

31—Consents'.

32—Redress.

33—Regulations.

THE MAKUENI COUNTY REPRODUCTIVE HEALTH AND FAMILY PLANNING ACT, 2019

AN ACT of the County Assembly of Makueni to provide for the establishment of the Makueni County Reproductive Health and Family Planning Program; the management and coordination of reproductive health and family planning initiatives in the County through strategic innovations and for connected purposes

ENACTED by the County Assembly of Makueni as follows—

PART I—PRELIMINARY

Short title and commencement

1. This Act may be cited as the Makueni County Reproductive Health and Family Planning Act, 2019, and shall come into force on the date the Executive Member may, by notice in the *Gazette*, appoint.

Interpretation.

2. (1) In this Act, unless the context otherwise requires—

"abortifacient" means any drug or device that induces abortion or the destruction of a foetus inside the mother's womb or the prevention of the fertilized ovum to reach and be implanted in the mother's womb;

"actors" mean "parents, guardians, care giver, teachers, peers, religious leaders, media, health care professionals, non-governmental organizations, counsellors, academia, and civil society"

"adolescent "means young people between the ages of ten to nineteen years who are in transition from childhood to adulthood;

"age appropriate sexuality education" means sexual education that may be deemed appropriate or inappropriate to a person's stage or level of development

"confidentiality" means to be assured that any personal information shall not be made public and shall remain confidential;

"counselling services" means services offered to the individual who is undergoing a problem and needs professional help to overcome it;

"county departments" means the departments of the County Government of Makueni

"Executive Committee Member" means the County Executive Committee Member for the time being responsible for matters of reproductive health and family planning;

"Department" means the department established by the County Government which is responsible for reproductive health and family planning;

"dignity" means to be treated with respect, consideration and attentiveness;

"discrimination" includes any distinction, exclusion or restriction made on the basis of any ground including sex, race, pregnancy, marital status, health status, ethnic or social origin, colour, age, disability, religion, conscience, belief, culture, dress, language or birth which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by any person, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field;

"family planning "means a program which enables couples and individuals to decide freely and responsibly the number and spacing of their children and to have the information and means to do so, and to have access to a full range of safe, affordable, effective, non-abortifacient modern natural and artificial methods of planning pregnancy;

"health care professionals" includes any person who has obtained health professional qualifications and licensed by the relevant regulatory body.

"health facilities" means the whole or part of public or private institutions, buildings or places, whether for profit or not, that are operated or designed to provide in- patient or out-patient treatment, diagnostic or therapeutic interventions, nursing, rehabilitative, palliative, convalescent, preventive or other health services;

"innovative strategies" means plans used by the department of health to encourage better and unique ways of service delivery;

"male involvement" refers to the inclusion, commitment, accountability and responsibility of males in all areas of sexual health and reproductive health, as well as the care of reproductive health concerns specific to men;

"menstrual hygiene management" means of women and adolescent girls to be able to manage menstruation hygienically and with dignity;

"modern methods of family planning" refers to safe, effective, non-abortifacient and legal methods, whether natural or artificial, that are registered with the Department, to plan pregnancy;

"natural family planning" refers to a variety of methods used to plan or prevent pregnancy based on identifying the woman's fertile days;

"privacy" means to have a confidential environment during counselling and services;

"public health care service provider" refers to—

(a) public health care institution, which is duly licensed and accredited and devoted primarily to the maintenance and operation of facilities for health promotion, disease prevention, diagnosis, treatment and care of individuals suffering from illness, disease, injury, disabilityor deformity, or in need of obstetrical or other medical and nursing care;

(b) public health care professional, who is a doctor of medicine, a clinical officer, a nurse or a midwife;

(c) public health worker engaged in the delivery of health care services; or

(d) health worker who has undergone training programs under any accredited government and non-governmental organization and who voluntarily renders primarily health care services in the community after having been accredited to function as such by the local health board in accordance with the guideline's promulgated by the Department of Health;

"poor" means member of a household identified as poor through any relevant system used by the national government in identifying the poor;

"reproductive health" means the state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes: this implies—

(a) that people are able to have a responsible, safe, consensual and satisfying sex life, that they have the capability to reproduce and the freedom to decide if, when, and how often to do so; and

(b) that women and men attain equal relationships in matters related to sexual relations and reproduction.

"reproductive health and family planning stakeholders" means any actor, individual, interest group or organization who participates in Reproductive Health and Family Planning;

"reproductive health care" means the access to a full range of methods, facilities, services and supplies that contribute to reproductive health and well-being by addressing reproductive health-related problems and includes sexual health, the purpose of which is the enhancement of life and personal relations.

"reproductive health care program" means the systematic and integrated provision of reproductive health care to all citizens prioritizing women, the poor, marginalized and those invulnerable or crisis situations;

"reproductive health tract diseases" means diseases, disorders and conditions that affect the functioning of the male and female reproductive systems during all stages of life;

"reproductive health rights" means the rights of individuals and couples, to decide freely and responsibly whether or not to have children; the number, spacing and timing of their children; to make other decisions concerning reproduction, free of discrimination, coercion and violence; to have the information and means to do so; and to attain the highest standard of sexual health and reproductive health:

"reproductive health and sexuality education" means a lifelong learning process of providing and acquiring complete, accurate and relevant age- and development-appropriate information and education on reproductive health and sexuality through life skills education and other approaches;

"responsible parenthood" means the will and ability of a parent to respond to the needs and aspirations of the family and children. It is likewise a shared responsibility between parents to determine and achieve the desired number of children, spacing and timing of their children according to their own family life aspirations, taking into account psychological preparedness, health status, sociocultural and economic concerns consistent with their religious convictions;

"sexual health" means a state of physical, mental and social well-being in relation to sexuality. It requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free from coercion, discrimination and violence;

"sexually transmitted infection" means any infection that may be acquired or passed on through sexual contact, use of IV, intravenous drug needles, childbirth and breastfeeding;

"sustainable human development" means the bringing of people, particularly the poor and vulnerable, to the centre of development process, the central purpose of which is the creation of an enabling environment in which all can enjoy long, healthy and productive lives, done in the manner that promotes their rights and protects the life opportunities of future generations and the natural ecosystem on which all life depends;

"user of the Program" means any person who accesses the Makueni County reproductive health and family planning services.

Purpose of the Act

3. The purpose of this Act is to provide a framework for the advancement of reproductive health and family planning services in Makueni County.

Objects of the Act

4. The objects of this Act are to—

(a) establish and manage the Makueni County Reproductive Health and Family Planning program;

(b) identify and enhance innovative strategies to increase family planning uptake and reproductive health services;

(c) support the implementation of age appropriate and comprehensive sexuality education; ensure specific tailor made interventions to address the unique needs of the youth and adolescents in family planning and reproductive health including mentorship for youth;

(d) build linkages with the reproductive health and family;

(e) mainstream reproductive health and family planning.

Guiding principles

5. This Act shall be guided by the following principles —

(a) every person has the right to the highest attainable standards of health;

(b) every person has inherent dignity and the right to have that dignity respected and protected;

(c) rights to reproductive and sexual health including the autonomy, privacy and confidentiality in making sexual and reproductive decisions;

(d) every person has the right to relevant reproductive and family planning information without bias, to all methods of family planning, including effective natural and modern methods which have been proven medically safe;

(e) human resource is among the principal assets of the county, as such the County shall ensure adequate, well trained, knowledgeable, and competent and equitably distributed human resource for reproductive health and family planning with the right cadre mix;

(f) to facilitate access to services for all eligible to accessing reproductive health and family planning services by ensuring social and financial risk protection through adequate mobilization, allocation and efficient utilization of financial resources for reproductive health services and family planning;

(g) ensure effective partnership with national government, development partners, non-state actors including the religious sector and the private sector in the design, implementation, coordination, integration, monitoring and evaluation of people-centered programs to enhance the quality of reproductive health and access to family planning;

PART II—ESTABLISHMENT OF THE MAKUENI COUNTY REPRODUCTIVE HEALTH AND FAMILY PLANNING PROGRAM

Establishment of the Makueni County Reproductive Health and Family Planning Program

6. (1) There is established the Makueni County Reproductive Health and Family Planning Program.

(2) The primary focus of the Program shall be to improve the health and well-being of the users of the program through providing high-quality, reproductive health care and right- based family planning information and services.

Composition of the Program

7. (1) There shall be a steering committee which shall oversee the implementation of the program.

(2) The Committee in sub section (1) above shall comprise of—

(a) a Patron;

(b) the Executive Committee Member;

(c) the Director in charge of medical services;

(d) the County reproductive health coordinator;

(e) a representative of religious organization;

(f) a representative of development partners in the County;

(g) a representative of the youth;

(h) a representative of women and;

(i) a representative of persons with disabilities .

(3) The Roles of the Steering Committee shall be to—

(a) give technical support to the department in external resource mobilization;

(b) develop guidelines for operationalization of various aspects of the Act;

(c) engage relevant personnel for implementation of the program;

(d) conduct stakeholder engagement forums whose aim shall be to—

(i) increase the accuracy and value of reproductive health and family planning services by providing an avenue for multiple perspectives;

(ii) incorporate and collect information on reproductive health and family planning which is not readily available;

(iii) collaboratively identify priority reproductive health and family planning issues;

(iv) disseminate information in lay terms;

(v) identify and facilitate continuous interaction between the county and the stakeholders; and

(vi) incorporate learning between the stakeholders and the department.

(4) The Patron in consultation with the Executive Committee Member may co-opt such other member as may be necessary for the performance of the duties of the Program.

(5) The Executive Committee Member shall nominate and appoint the Patron of the Program upon the approval of the County Assembly.

(6) The Patron shall be the Chairperson while the Director in charge of medical services shall be the secretary to the Steering Committee.

(7) The Executive Committee Member shall appoint the persons in Clause 7(2) (e) (f) (g) (h) & (i) of this Act from persons ordinarily residents in the County.

(8) The duties of the Patron shall be to—

(a) Champion reproductive health and family planning in the County;

(b) mobilize resources for the implementation of the program;

(c) contribute to the implementation of the program by providing insights, experiences and other enriching leadership perspectives; and

(d) leverage their networks to steer and encourage the involvement of reproductive health and family planning stakeholders.

(9)The Department shall support the Patron in the execution of their duties.

(10) The Patron shall serve for a term of five years renewable once.

(11) The representatives listed in 7(2) (e) (f) (g) (h) and (i) shall serve for a non-renewable term of three years.

(12) A person qualifies for appointment as the Patron of the Program if the person—

(a) possesses a degree from a recognized university;

(b) demonstrate the capability to champion for rights for minority;

(c) has ability to mobilize resources;

(d) is a Kenyan citizen;

(e) satisfies the requirement of Chapter 6 of the Constitution.

(13) A person qualifies for appointment as a representative in Clause 7(2) (e) (f) (g) (h) & (i) if the person—

(a) possesses a minimum in diploma from a recognized institution

(b) is aged 18 years and above

(c) is a resident of the County

(d) satisfies the requirements of Chapter 6 of the Constitution

(e) proof of engagement in social issues

Functions of the Program

8. The functions of the Program shall be to ensure access to quality, safe and affordable reproductive health and family planning information and services and for the avoidance of doubt the program shall—

(a) ensure the availability of services that meet minimum quality standards;

(b) ensure human resources for reproductive health and family planning are competent, responsive, productive, available in adequate numbers and are equitably distributed;

(c) improve leadership and strengthen governance structures and functions to ensure county readiness;

(d) timely, relevant and quality data from health and relevant sectors and analyse the data into information for related decision making;

(e) secure equitable access to quality, safe and cost-effective family planning commodities, essential medical products, vaccines and technologies;

(f) undertake continuous research and adopt evidence based practices to influence decision making;

(g) strengthen the reproductive health and family planning advocacy framework to achieve better health outcomes for the broader community;

(h) perform any other function that may be conferred by this Act or any other written law; and

(i) continuous expand health infrastructure to remove access barriers to family planning.

Powers of the Program

9. The Program may—

(a) partner with public and private sector, Civil Society Organizations (CSOs), Faith Based Organizations (FBOs) and Non-governmental Organizations (NGOs) in the realization of the objects of this Act;

(b) receive or administer funds donated or entrusted to the Program by any agency or organization for any purpose relating to the objects of this Act;

(c) engage with key stakeholders to ensure the proper performance of its functions.

PART III—ADMINISTRATION OF THE MAKUENI COUNTY REPRODUCTIVE HEALTH AND FAMILY PLANNING PROGRAM

Role of the County Department of Health

10. (1) The County Government department of health shall serve as the lead agency for the implementation of this Act and shall integrate in their regular operations the following functions—

(a) fully and efficiently implement the program;

(b) ensure access to quality and affordable reproductive health and family planning information and services; and

(c) perform such other functions necessary to attain the purposes of this Act.

(2) The Department, shall ensure—

(a) comprehensive range of appropriate and inclusive services is provided to the needs of the public;

(b) services are directly and permanently accessible with no undue barriers to cost or culture;

(c) services are timely, effective, safe, people centred and of high quality;

(d) maintain a comprehensive human resource information system;

(e) train and integrate community health volunteers into the program;

(f) promote stakeholder and civic engagement and demand side accountability;

(g) ensure access to information within constitutional parameters;

(h) ensure continuous delivery of age appropriate education;

(i) raise and ring fence sufficient funds from internal and external sources for effective and efficient services;

(j) access to safe, quality and affordable essential medical products, vaccines and technologies;

(k) utilize digital platform to raise awareness on reproductive health and family planning;

(l) create a reproductive health and family planning repository for enhanced knowledge management;

(m) develop data driven reproductive health and family planning strategies linked to the county needs and priorities;

(n) integrate family planning and reproductive health within and without the county government; and

(o) perform any other function that may be conferred by this Act or any other written law.

(3) For purposes of this section "services" means "reproductive health and family planning information and services."

Innovative strategies

11. (1) The Department shall—

(a) establish youth friendly spaces as an effective strategy to provide young people with youth friendly Reproductive health and family planning information and services;

(b) conduct tailor made on-the-job training to build the capacity of health care professionals;

(c) develop an output based perfomance system;

(d) safeguard family planning and reproductive health commodity security.

STI's, HIV-Aids and Reproductive Health diseases

12. (1) The Department shall—

(a) develop and disseminate information, education and communication material on reproductive health diseases;

(b) utilize print, electronic, traditional and social media and mobile marketing platforms to create awareness on transmission prevention and control of STI's, HIV-Aids and Reproductive Health diseases; and

(c) strengthen peer to peer awareness mechanisms.

Unique needs of youth and adolescents

13. (1) The Department shall—

(a) strengthen the capacity of health care professionals to provide adolescent and youth friendly services;

(b) create avenues to engage the youth in family planning and reproductive health.

Mentorship

14. The Department shall develop a mentorship framework and mainstream it in school health programmes and adolescent and youth interventions.

Counselling Services

15. The Department shall integrate counselling services in reproductive health and family planning.

Menstrual Hygiene Management

16. The Department shall —

(a) supplement provision of commodities for menstrual hygiene management;

(b) create awareness and educate the public on proper menstrual hygiene management; and

(c) provide facilities for the disposal of menstrual hygiene waste.

Male Involvement

17. The Department shall promote male involvement in reproductive health and family planning and shall—

(a) etablish safe spaces for men as an effective strategy to increase male involvement in reproductive health and family planning;

(b) design and undertake outreach activities to increase male involvement;

(c) sensitize and educate the public on male involvement;

(d) develop and disseminate content on male involvement.

PART IV— ACCESS TO REPRODUCTIVE HEALTH AND FAMILY PLANNING SERVICES

Eligibility

18. (1) Every person who is of reproductive age should have access to reproductive health and family planning education; and every adult person regardless of race, sex, pregnancy, marital status, health status, ethnic or social origin, colour, disability, religion, conscience, belief, culture, dress, language, birth or ability to pay is eligible to access reproductive health and family planning services.

(2) The Department shall make available reproductive health and family planning services, including contraceptive options, counselling, information and education.

(3) The Department shall employ the Medical eligibility criteria for contraceptive use to guarantee the safety of each contraceptive method.

Right to Information

19. Every health care professional prescribing a contraceptive method shall provide information to the person to whom the prescription is being given as to its advantages and disadvantages and ensure informed consent.

PART V— THE IMPLEMENTATION OF AGE APPROPRIATE REPRODUCTIVE HEALTH EDUCATION AND PUBLIC AWARENESS

Education and implementation of age appropriate reproductive health education

20. (1) The Department shall—

(a) ensure the institutionalization of the Life Skills Curriculum or its equivalent'.

(b) strengthen the capacity of the school health program.

(c) provide continuous education for the actors

The Role of the County Department of Education

21. The Department of Education in the County shall lead in the Institutionalization of the Life Skills curriculum.

PART VI—REPRODUCTIVE HEALTH AND FAMILY PLANNING PROGRAMS FOR PERSONS WITH DISABILITIES

Abolition of barriers to Reproductive Health and Family Planning Programmes for Persons with Disabilities

22. The Department shall abolish barriers to reproductive health and family planning services for persons with disabilities by—

(a) providing physical access, and resolving transportation and proximity issues to clinics, hospitals and places where public health education is provided, contraceptives are sold or distributed or other places where reproductive health services are provide

(b) adapting examination tables and other laboratory procedures to the needs and conditions of persons with disabilities;

(c) increasing access to information and communication materials on reproductive health and family planning in braille, large print, simple language, sign language and pictures;

(d) providing continuing education and inclusion of rights of persons with disabilities among health care providers; and

(e) undertaking activities to raise awareness and address misconceptions among the general public on the stigma and their lack of knowledge on reproductive health and family planning needs and rights of persons with disabilities.

Prohibition of any form of discrimination

23. (1) A person shall not, in offering services or assistance, where reproductive health or family planning matters are concerned, discriminate, in any form or manner, against any person with disability.

PART VII—FINANCIAL PROVISIONS

Source of Funds

24. (1) The funds of the Program shall consist of—

(a) monies appropriated by the County Assembly for the Department for purposes of the Program;

(b) grants from National Government;

(c) any other grants, gifts, donations or other endowments given to the Program; and

(d) such funds as may vest in or accrue to the Program in the performance of its functions under this Act or any other written law.

(2) The County Government shall ensure that it reserves one and a half percent of the annual budget of the Department for the program.

(3) The functions of the Program shall be financed through a vote in the estimates of revenue and expenditure of the Department

(4) The funds of the program shall be utilized for the Realization of the objects of this Act.

Resource Mobilization strategy

25. (1) The Executive Member in consultation with the Steering committee and other relevant stakeholders shall, within six months of the Act coming into force, develop a resource mobilization strategy to identify sources of support, material or financial, to facilitate the realization of the objects of this Act.

(2) The strategy in sub-section (1) shall be reviewed after every Financial Year.

Reporting

26. (1) Before the end of each financial year, the Department shall submit to the Governor an annual consolidated report, which shall provide a definitive and comprehensive assessment of the implementation of the Program.

(2) The report referred to in sub section (1) shall recommend priorities for executive and legislative actions.

(3) The annual report shall evaluate the content, implementation, and impact of all policies related to reproductive health and family planning to ensure that such policies promote, protect and fulfill reproductive health rights and the freedom to choose

(4) The department shall submit Quarterly Financial Reports to the County Assembly.

PART VIII—MISCELLANEOUS PROVISIONS

Confidentiality

27. A person who possesses information by virtue of this Act shall not divulge such information to any person unless as provided for under this Act.

Protection from liability

28. (1) No matter or thing done by any employee or agent of the Department or any community health volunteer, shall, if the matter or thing is done bona fide for executing the functions, powers or duties of the Program under this Act, render the employee or agent of the Department or any community health volunteer personally liable to any action, claim or demand whatsoever.

(2) The provisions of subsection (1) shall not relieve the employee or agent of the Department or any community health volunteer of the liability to pay compensation or damages to any person for any injury to them, their property or any of their interests caused by the exercise of any power conferred by this Act or any other written law or by the failure, wholly or partially, of any works.

Monitoring, Evaluation, Assessment and Learning Framework

29. (1) The Executive Member shall within six months of the Act coming into force develop a monitoring, evaluation, assessment and learning framework for the program

(2) The framework in sub-section (1) shall be reviewed after every three years.

Prohibited Acts

30. (1) Any health care professional, whether public or private, who—

(a) Knowingly withholds information, restricts the dissemination thereof;

(b) intentionally provides incorrect information regarding programs and services on reproductive health, including the right to informed choice and access to a full range of legal, medically-safe, non-abortifacient and effective family planning methods;

Consents

31. For purposes of this Act consent includes—

(a) spousal consent in case of married persons: provided that, in case of disagreement, the decision of the one undergoing the procedure shall prevail; and

(b) parental consent or that of the person exercising parental authority in the case of abused minors,

(c) In the case of minors, the written consent of parents or legal guardian or, in their absence, persons exercising parental authority or next-of-kin shall be required only in elective surgical procedures

(d) In the case of persons with mental or psychosocial disabilities, the written consent of the personal exercising authority or next of kin shall be required for emergency and elective procedures.

Redress

32. (1) If any user of the Program thinks he or she has been wronged in any way by any employee or agent of the County Government or any community health volunteer, he or she may complain in writing to the Executive Member and seek redress for the wrong.

(2) The executive member shall, on receiving a complaint under subsection (1), form an Ad-hoc committee to look into the complaints registered and give proposals on how the issue(s) is/are to be addressed.

(3) This section shall be implemented within the parameters of fair administrative action.

Regulations

33. (1) The Executive Member may, make such regulations as are necessary or expedient to give full effect to or for the carrying out of the provisions of this Act including—

(a) the employment of Medical eligibility criteria for contraceptive use;

(b) access to information;

(c) stakeholder engagement;

(d) resource Mobilization;

(e) mentoring strategies;

(f) monitoring, Evaluation and learning framework;

(g) grant of consents;

(h) exercising Redress;

(i) any other matter necessary for the implementation of this Act.

REPUBLIC OF KENYA

IN THE HIGH COURT OF KENYA AT KIAMBU

CONSTITUTIONAL PETITION NO. OF 2022

IN THE MATTER OF ARTICLES 10(1) & 10 (2)(a), 19, 22, 23, 26 (1) & (4), 27, 33, 35, 43 (1(a)), 53 (1(c)) AND 232 (1(d)) OF THE CONSTITUTION OF KENYA, 2010

AND

I IN THE MATTER OF ARTICLES, 22, 23, 34 AND 35 OF THE EAST AFRICAN COMMUNITY HIV & AIDS PREVENTION AND MANAGEMENT ACT

AND

IN THE MATTER OF SECTIONS 5, 6, 7, 15 AND 68 OF THE HEALTH ACT, 2017

AND

IN THE MATTER OF SECTION 16(2), (3) & (4), 28(3), 146 AND THE FIRST SCHEDULE OF THE CHILDREN ACT NO. 29 OF 2022

AND

IN THE MATTER OF SECTION 6 AND 7 OF THE SCIENCE TECHNOLOGY AND INNOVATION ACT NO. 28 OF 2013

AND

IN THE MATTER OF SECTION 4 AND 5 OF THE ACCESS TO INFORMATION ACT NO. 31 OF 2016

AND

IN THE MATTER OF THE PUBLIC SERVICE COMMISSION GUIDELINES FOR PUBLIC PARTICIPATION IN POLICY MAKING (2015)

AND

IN THE MATTER OF THE NATIONAL REPRODUCTIVE HEALTH POLICY 2022-2032

BETWEEN

RACHAEL MWIKALI.....1ST PETITIONER

ESTHER AOKO.....2ND PETITIONER

AMBASSADOR FOR YOUTH & ADOLESCENT

REPRODUCTIVE HEALTH PROGRAMME (AYARHEP).....3RD PETITIONER

KENYA LEGAL AND ETHICAL
ISSUES NETWORK ON HIV & AIDS.....4TH PETITIONER

VERSUS

CABINET SECRETARY
MINISTRY OF HEALTH.....1ST RESPONDENT
THE ATTORNEY GENERAL.....2ND RESPONDENT

AND

KENYA OBSTETRICAL GYNAECOLOGICAL SOCIETY..... 1ST INTERESTED PARTY
KATIBA INSTITUTE .....2ND INTERESTED PARTY

4TH PETITIONER'S AFFIDAVIT IN SUPPORT OF THE PETITION

I, **NERIMA WERE**, of **P.O.BOX 112 – 00202, Nairobi**, a female Kenyan adult of sound mind residing and working for gain in Nairobi County within the Republic of Kenya do hereby make oath and state as follows;

1. I am an advocate of the High Court of Kenya and the Deputy Executive Director of the Kenya Legal and Ethical Issues Network on HIV and AIDS (KELIN), the 4th Petitioner herein and thus competent to swear this Affidavit. ***(Annexed hereto and marked NW1 is a copy of the registration certificate for the 4th Petitioner)***

2. I have the authority of the Board of Directors to swear this Affidavit on behalf of the 4th Petitioner.

3. I am conversant with the contents of the Petition and I fully understand the issues in question and I further adopt the contents of the Petition filed herein as if the same were set out *seriatim*.

4. In 2017, the Ministry of Health through its Division of Reproductive and Maternal Health (DRMH) commenced a national process of redrafting the National

Reproductive Health Policy with the goal of achieving "universal reproductive health coverage to all persons in the country."

5. The Ministry of Health consequently drafted a Reproductive Health Policy without involving key stakeholders in the health sector and the public; as there was neither information provided on the process nor published and publicized invitations for participation in the process.
6. Despite numerous requests by various stakeholders that the ministry considers public participation as an integral part of the policy-making process, such efforts were not considered by the 1st Respondent.

7. On 8th September 2021, the 4th Petitioner received an invitation from the Council of Governors for stakeholder consultation to review the draft policy and attend a virtual stakeholders engagement meeting. ***(A copy of the invitation is attached hereto and marked as NW2)***

8. The concept note sent out together with the invitation specifically indicated that the Ministry of Health drafted the policy without the involvement of the county governments and that they had requested that the policy not be launched before the counties' review and input. ***(A copy of the concept note is attached hereto and marked as NW3)***

9. The 4th Petitioner attended the virtual stakeholder consultation on 17th September 2021 and gave oral considerations. Stakeholder views were captured within the matrix under the Council of Governors with feedback generally concerning the lack of abortion within the document; and providing an evidence base for twenty-one years. ***(A copy of the matrix is attached hereto and marked as NW4)***

10. The virtual workshop attended by the 4th Petitioner and other stakeholders was an engagement by the Council of Governors and not the Ministry of Health and therefore up until that point, there was no engagement between the 4th Petitioner and the Ministry of Health regarding the draft policy.

11. Subsequently, by a letter dated 5th October 2021, the 4th Petitioner together with other organisations working on the right to health, women's rights and human rights sectors wrote to the head of the Division of Reproductive and Maternal Health seeking the "inclusion of civil society input and aligning problematic national reproductive health care policy 2020-2032." The letter raised the following issues: -

    i. The Ministry of Health has the constitutional mandate in designing health-related policies.
    ii. The Reproductive Health policy 2020-2030 was in draft form and yet to be launched.
    iii. The Ministry of Health had had little engagement with civil society actors on the draft policy that ought to have been reflective of critical matters on reproductive health.
    iv. Non-governmental organisations offer more than 40% of the sexual and reproductive health care services in the Kenyan communities. There was therefore a need for civil society inclusion in the drafting and validation processes prior to the roll-out of the policy.
    v. There was also attached in appendix (1) key issues that needed to be addressed in the draft policy including: -
        a. The ministry's ignorance of its existing policies on menstrual hygiene (completely absent from the document), post-abortal care (completely absent from the document), adolescents' package of care, Kenya AIDS strategic framework, the National Family Planning Guidelines etc.;

b. The ministry equally ignored existing commitments that the government has made on sexual and reproductive health and rights. Beyond a single mention of International Conference for Population Development 25 (ICPD25), the document had no cross-reference to regional and international commitments such as the Maputo Protocol, Convention on the Elimination of Discrimination Against Women or the East African Community HIV Prevention and Management Act which all speak towards Kenya's obligations in sexual and reproductive health provision.

c. The draft policy was selective and exclusionary. The draft policy invisibilized key issues connected to sexual and reproductive health such as mental health (post-partum depression), exclusion of sex workers as a critical vulnerable population, post-abortal care and menstrual hygiene yet the policy was to override all existing policies on sexual and reproductive health. This would be fatal given the absence of so many aspects of sexual and reproductive health from the draft policy.

d. The draft had problematic, stigmatizing language that blamed survivors of sexual violence, indicated that adolescents have increased HIV infections due to failure to resist forced sex from partners, encouraged out-of-court settlement for gender violence and stigmatized people not planning family as it insisted on the role of families in advancing reproductive health. Further, the use of the term family planning instead of contraceptives was deliberately isolating those outside the union of marriage.

e. The writing of the draft policy was driven by moral and religious sentiments that placed a focus on family with little regard for those outside marriage unions.

f. The draft policy was resistant to devolution as it purported to oversee counties, yet counties and the national government are equal partners.

(A copy of the letter dated 5th October 2021 is attached hereto and marked as NW-5)

12. Despite the organisations' requests to be consulted beforehand and their input meaningfully reflected in the draft policy, no such action was taken by the 1st Respondent, especially in regard to issuing a response to the letter of 5th October 2021.

13. By a letter dated 1st March 2022, the Ministry of Health indicated that its Division of Reproductive and Maternal Health had in collaboration with partners revised several reproductive health documents and the next steps would be to print, launch and disseminate the documents at the national and county levels to facilitate subsequent implementation within various reproductive health programmes. It did not mention who in particular these partners were.

14. The letter further indicated that the national launch was tentatively scheduled for 23rd March 2022. ***(A copy of the letter dated 1st March 2022 is attached hereto and marked as NW-6)***

15. The 5th Petitioner and other organisations became aware of this letter, and responded to the letter dated 1st March 2022 by a letter dated 18th March 2022 expressing concern at the manner in which the policy had been developed and indicating the need for public participation in the draft reproductive healthcare policy. ***(A copy of the letter dated 18th March 2022 is attached hereto and marked as NW-7)***

16. The letter was a call for urgent steps to ensure adequate and meaningful public participation before launching and operationalising the policy. The request was based on the following key reasons: -

    i. Public participation is a constitutional obligation. There is an obligation to consider the needs and interests of the public who are likely to be adversely affected by the proposed policy, before the policy is launched and operationalised.

    ii. Critical stakeholders were not adequately and meaningfully engaged in the development of the reproductive health policy. The Ministry of Health had not responded to the letter of 5th October 2021 on the inclusion of civil society in the drafting and validation process prior to the roll-out of the draft policy.

    iii. The reproductive health policy being launched had not been made readily available. The draft Policy was not readily available online, on the Ministry of Health's website. Moreover, the Ministry had not provided the public with information on where and how they could access the draft Policy. It was therefore impossible for people to comment on the crucial document as it was not readily available.

    iv. The reproductive health policy being launched excluded key sexual and reproductive health issues. It completely ignored any interventions on unsafe abortion despite unsafe abortion being a major cause of maternal mortality and morbidity in Kenya. The right to access abortion is found under Article 43(1)(a) and Article 26(4) of the Constitution. A guiding framework on Article 26(4) is necessary to ensure access to safe abortion services provided by trained medical personnel.

    v. The reproductive health policy being launched contradicted the Convention on the Rights of the Child and the Ministry's own adolescent Package of care by classifying sex for persons under the age of 21 years as a harmful reproductive health practice, and enforcing consent from parents, guardians or government medical specialists when providing reproductive health

services to minors. This also contradicted certain county-specific reproductive health policies that allow minors to consent to their own reproductive health services.

vi. The reproductive health policy being launched was a fundamental policy for the health sector as it provided a framework for actualising the right to the highest attainable standard of health including reproductive health as articulated in Article 43(1)(a) of the Constitution of Kenya. The Policy provided a much-needed foundation for ensuring quality reproductive health services are available and accessible and should have been given ample opportunity to receive all the relevant feedback from stakeholders.

17. The organisations therefore called upon the Ministry of Health through the head of the Division of Reproductive and Maternal Health to undertake the following actions to ensure the reproductive health policy meets the constitutional threshold and takes into account the views of the public: -

    i. Stop the launch of the National Reproductive Health Policy 2020 – 2032.

    ii. Make the most recent draft of the reproductive health policy readily available by making it available online and publishing the full copy in the leading dailies.

    iii. Issue a request for submission of memoranda on the reproductive health policy that would allow stakeholders at least 30 working days to make written submissions.

    iv. Organise public hearings to directly receive oral submissions from stakeholders.

18. Further to the above, I am reasonably aware that on 22nd March 2022, the Grassroots for Human Rights Defenders, a civil society organisation led by the 1st Petitioner herein, delivered a petition demanding community involvement in the formulation and validation process of the policy to the Ministry of Health offices.

19. In a bid to respond to the petition and pressure received from stakeholders on the lack of adequate meaningful participation as well as the substantive flaws of the policy, on 31st March 2022, the Ministry of Health issued an invitation to a deliberation meeting on the reproductive health policy on 6th April 2022. ***(A copy of the invitation is attached hereto and marked as NW-8)***

20. The 5th Petitioner attended the meeting of 6th April 2022 and highlighted the following key issues: -

    i. Lack of a guiding framework for safe abortion care.

    ii. The concept of attaining cognitive competency at the age of 21; priority interventions being delayed sexual debut and abstinence.

    iii. Requirements for parental consent for adolescents to access sexual and reproductive health services and commodities.

    iv. One of the participants in the meeting being the Kenya National Commission on Human Rights noted that they were unaware of the policy and asked to be included to aid the Ministry of Health in knitting a rights-based approach in the policy, particularly including global and regional conventions, treaties and commitments in the guiding framework and aligning definitions.

    The livestream to the meeting can be accessed here: https://m.facebook.com/aKtiveCitizen/videos/?ref=page_internal&mt_nav=0 ***(Annexed hereto is a flash disk with the video clip of the meeting marked as NW-9)***

21. The 5th Petitioner further received an invitation from the Ministry of Health on 18th April 2022 to attend a reproductive health policy drafting workshop on 25th April 2022. ***(A copy of the invitation is attached hereto and marked as NW-10)***

22. The Ministry of Health and the participants agreed on the following at the drafting workshop: -

i. The Ministry would share the updated draft reproductive health policy version together with the matrix of comments and responses and host a validation meeting.

23. Contrary to the above, the Ministry of Health shared neither the updated draft reproductive health policy nor the matrix of comments for the 4th Petitioner and other participant's review, records and comments.

24. Surprisingly, on 28th June 2022, the Ministry of Health sent out an invitation for a validation meeting on 1st July 2022. This was just two working days to the validation meeting and the invite was without the 4th Petitioner or any other person at the drafting workshop having received the updated draft reproductive health policy nor the matrix of comments. ***(A copy of the invitation is attached hereto and marked as NW-11)***

25. Due to the short notice given by the ministry and considering that the ministry had not provided the policy that was to be validated, the 4th Petitioner was unfortunately unable to attend the validation workshop of 1st July 2022.

26. Seeing no good faith on the part of the Ministry of Health regarding meaningful engagement in so far as the development of the policy was concerned, the 5th Petitioner formally and officially disengaged itself from the process citing the following reasons: -

i. Despite involvement in the process, the 4th Petitioner was yet to receive the draft text of the reproductive health policy. Requests to have a meaningful process either went answered or were responded to through participation by ambush.

ii. The validation meeting of 1st July 2022 was not participatory and was simple a dress-down from one Dr. Stephen Kaliti head of the Division of Maternal and Reproductive Health who refused to share the draft policy and harshly criticized the civil society for demanding an open and fair process.

iii. In the circumstances, the 4th Petitioner formally withdrew and disengaged itself from the Division of Reproductive Health on the following specific reasons: -

a. Lack of meaningful engagement – Engagement had been through ambush. All invitations were sent on short notice a day or two before meetings were held.

b. Lack of transparency – At no point were drafts shared even when the 5th Petitioner demanded for the same ahead of a meeting and as a result, no prior preparations were made.

c. Exclusion of professional views- Despite consistent submission on views from medical experts from the Kenya Obstetrical Gynaecological Society, the Interested Party herein, these views were disregarded completely on areas such as surrogacy, intersex persons etc.

d. Disregard to science, data and facts – On various occasions, Dr Stephen Kaliti disregarded rising data on teen pregnancies, unsafe abortion etc. Moral and religious bias by the Director of the Division was clearly evident and he, therefore, had clouded views thus compromising the quality of engagement.

(A copy of the letter of 4th July 2022 is attached hereto and marked as NW-12)

27. On 5th July 2022 just one working day after the validation meeting, the 1st Respondent launched the National Reproductive Health Policy 2022-2023. The 4th Petitioner considers the policy to be unconstitutional because of the procedure involved in its development and as the policy provisions threaten the right to life and to reproductive health for women. ***(A copy of the reproductive health policy 2022-2032 is attached and marked as NW-13)***

28. The process of development of the policy was fraught with irregularities. The 1st Respondent failed to undertake meaningful public participation.

29. Further, the Policy is constitutionally deficient in substance. It contains various provisions with claw back on the constitutional guarantee on the right to life and the right to reproductive health.

30. Specifically, the Policy uses exclusionary language that denies critical reproductive healthcare interventions to the majority of women and girls thereby intentionally excluding any person not in a marriage; providing contraceptive care alternatives to only couples that have had children.

31. ***The policy's situational analysis, for instance (2.3.3 Reduction in unmet family planning needs on page 11)*** draws data on the use of modern contraceptives from a population of married women instead of focusing on women of reproductive age. Further, ***the policy's preamble on family planning (3.4.2 To reduce unmet family planning needs on page 23)*** focuses on the provision of family planning for couples that have achieved their desired family sizes to the exclusion of the rest of the population of persons of reproductive age.

32. The bias towards families to the detriment of the rest of the population of reproductive age is further indicated at ***4.2.3 paragraph 6 of the policy (page 38)*** where it is indicated that the policy recognizes the central role of the family in reproductive health and that this shall be reflected in reproductive health interventions; as well as the description of the key components in service delivery and standards to include responsiveness to social values ***(page 39).***

33. The policy further excludes adolescent women and young girls from benefiting from reproductive health services and commodities as it envisages the provision of cervical cancer screening services for women between 25-49 years to the exclusion of other age groups ***(2.3.7 on cancers of reproductive organs at page 15 of the policy).***

34. Additionally, the policy limits interventions from healthcare workers in regard to access to safe abortion. This is especially so as the policy provides that termination of pregnancy shall be performed guided by the opinion of a trained health professional with the proficiency to ensure both the mother and unborn child receive the highest attainable standard of healthcare ***(policy thrust 3.4.1 to reduce maternal, perinatal and neonatal morbidity and mortality paragraph 12 at page 23 of the policy).***

35. To indicate that in abortion the health professional should ensure the highest standard of healthcare for an unborn child is to give with one hand and take with the other. In the circumstances, the policy creates unnecessary fear and hesitation on the position on procurement of safe and legal abortions, thereby contravening the right to life and to health of the mother. The position is further exacerbated by the lack of comprehensive provisions and guidelines on safe and legal abortion as well as post-abortion care.

36. Further, healthcare interventions under the policy exclude young women below 21 years as they are not guaranteed access to reproductive health services on the basis that they have "not attained full cognitive competence on matters of sexuality and reproduction." ***(overarching policy statement at page 19 of the policy).*** Under ***3.4.8 paragraph 1 of the policy on page 25***, it is further indicated that a person attains complete full cognitive competence on matters of sexuality and reproduction at the age of 21 and that the government will prioritize abstinence and delayed sexual debut for persons yet to attain full cognitive competency.

37. The push to move the age of sexual debut from 18 to 21 years is without any scientific basis/evidence. There is particularly no legal basis for limiting sexual debut past the age of 18 years. It is important to note that the reliance on the age

of 18 is based on data collected from the Kenya Demographic Health Survey that attributes teenage pregnancies to early sexual debut. ***(Policy monitoring, evaluation, research and learning framework at page 50 of the policy).*** In the end, young adult women between the ages of 18-21 are left with policy interventions that do not adequately meet their sexual and reproductive needs yet they have the legal capacity to make informed decisions on their sexual and reproductive health; and to access those services and commodities.

38. By making a blanket intervention, the Ministry of Health fails to give regard to both facts and evidence on the top teenage nuances being teenage pregnancies and HIV/AIDS infections. The policy therefore in requiring parental consent fails to provide a guideline for parental consent; and especially where parental/guardian consent cannot be achieved without undue hardship. ***(3.4.8 paragraph 8 of the policy on access to reproductive health services for children at page 26 of the policy)***

39. This provision is also contrary to county laws and policies, (for instance Mombasa and Makueni) that allow minors to consent to their own reproductive health services.

40. This provision further limits the ability of health care workers to provide services to adolescents based on their evolving capacities and needs by requiring parental consent for health care services. ***(Annexed hereto and marked as NW-14 is a copy of an extract of the National Guidelines for Provision of Adolescent and Youth Friendly Services, 2016 that outlines parental consent as one of the structural barriers to access to reproductive health by adolescents at pg. 12)***

41. Additionally, the policy excludes unmarried women from fertility treatment; thereby denying them access to reproductive rights and options that are unrestricted for married women. Under the policy's ***broad objective 2 on***

improving responsiveness to client's reproductive health needs (page 21 of the policy), it is indicated as a sub-objective (v) as to reduce the magnitude of infertility and increased access to management of infertile couples. Under ***3.4.11 paragraph 5 of the policy (page 28),*** it is expressly indicated that there shall be full financing of at least one cycle of assisted fertility treatment but the same is limited to "needy desirous couples," which term has not been qualified effectively. In the end, the provision is vague and further discriminatory as it is an option limited to couples only yet government resources are in use.

42. The policy also introduces unconstitutional and unethical practices that would require all pregnant women and their families to be tested for HIV thereby creating a barrier to access to critical maternal healthcare and commodities as well as disregard for the right to privacy, dignity as well as the right to adequate health which includes the aspect of informed consent as well as freedom from forced medical procedures ***(3.4.4 paragraph 2 of the policy at page 24).***

43. Following the launch of the Reproductive Health Policy 2022-2032, the 4th Petitioner together with other organisations working in the right to health, women's rights and human rights sectors; grassroots human rights defenders; individual citizens and residents of different countries by a letter dated 22nd July 2022 continued to express their concerns with the problematic provisions of the National Reproductive Health Policy 2022-2032 that would serve to exclude certain vulnerable and marginalized populations from accessing critical services. ***(A copy of the letter dated 22nd July 22 is attached and marked as NW-15)***

44. The need for alignment of laws and policies on sexual and reproductive health services to the Constitution is one of the ways through which the rights of women and girls can be respected.

45. Given the foregoing, and in the interest of safeguarding the constitutional rights of reproductive health and the lives of the people of Kenya, I pray that this Honourable Court to grant the orders set out in the Petition.

What is deponed to herein is true to the best of my knowledge, information and belief, save for information whereof sources of information have been disclosed.

SWORN at **NAIROBI** by the said)
NERIMA WERE)
)
)
This 8th day of September 2022)
BEFORE ME)
WYCKLIFE O. OYOO)
Advocate & Commissioner for Oths)
KAPLAN & STRATTON)
P. O. Box 40111 - 00100)
COMMISSIONER OF OATHS)

DEPONENT

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523

This is Exhibit marked "KLW - 1"
referred to in the Annexed affidavit/Declaration
of Kevin Wolf Sth
Sworn/Declared before me on this
day of 20th July 2022
at Nairobi in the Republic of Kenya
Commissioner for Oaths

FORM 5

REPUBLIC OF KENYA

OP.218/051/2002/0155/2233

OFFICE OF THE PRESIDENT

CERTIFICATE OF REGISTRATION

I, PROF. WILSON KIPNG'ENO KOECH, Chairman of the Non-Governmental Organizations Board, certify that the xxx KENYA LEGAL AND ETHICAL ISSUES NETWORK ON HIV/AIDS xxx has this day been registered under section 10 of the Non-Governmental Organizations Co-ordination Act as applied for.

Dated 20TH DECEMBER, 2001.

W. K. KOECH,
Chairman of the Board.

GPK 5004—200—1/2002

527

NW-1

This is Exhibit marked "NW-2"
referred to in the Annexed affidavit/Declaration
of Nerima Were
Sworn/Declared before me on this 8th
day of September 2021
at Nairobi in the Republic of Kenya
Commissioner for Oaths

COUNCIL OF GOVERNORS

Westlands Delta House 2nd Floor, Waiyaki Way.
P.O. BOX 40401-00100,
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Our Ref. COG/6/40 Vol. 67 (60) 8th September, 2021

Ms. Nerima Were
Kenya Ethical & Legal Issues Network on HIV & AIDS (KELIN Kenya)
Karen C, Kuwinda Lane, Off Langata Rd
Nairobi.

Dear Ms. Were,

REVIEW OF THE REPRODUCTIVE HEALTH POLICY 2020-2030

The above matter refers.

The Ministry of Health has developed the National Reproductive Health Policy 2020-2030. The Council of Governors would like to have wider consultation with its partners and stakeholders to review the draft policy with a view to make recommendations and proposals to enrich it and make it more responsive to the needs of the people.

The purpose of this letter is therefore, to request you to review the entire draft policy content in terms of whether it addresses the key components of Reproductive Health holistically and adequately. The main components of reproductive health are elaborated in the attached concept note.

Kindly, prepare and submit your inputs and suggestions which will be presented and discussed at the stakeholders engagement meeting on Friday 17th September 2021. The Meeting will be held virtually on the zoom platform, log in details are attached hereto. This will be followed by a joint physical meeting between the stakeholders and Counties on Monday 20th September 2021 in Nairobi at a venue to be communicated for validation of the report.

Please submit your comments to the COG via Email: RHPreview@cog.go.ke call Dr. Nehemiah Kimathi on Telephone 0722529755 for any clarifications.

We look forward to your participation and feedback.

Yours sincerely,

Mary Mwiti
Ag. Chief Executive Officer

Encl: Reproductive Health Policy 2020-2030
Concept Note
Policy Review Matrix

XW-2

This is Exhibit marked "XW-8" referred to in the Annexed Affidavit/Declaration of ... Sworn/Declared before me on this ... day of ... 20... at ... in the Republic of Kenya ... Commissioner for Oaths

KENYA MEDICAL ASSOCIATION NATIONAL EXECUTIVE RECEIVED 7 MAR 2022

MINISTRY OF HEALTH

Directorate of Medical Services/Preventive and Promotive Health

Division of Reproductive and Maternal Health

THE REPRODUCTIVE HEALTH POLICY REVIEW MATRIX

	CHAPTER	SUGGESTED INPUT/AMENDMENT	S/HOLDER	ACCEPT	COMMENT
1	Technical Notes	Repealing policy renamed Qualifying Clause	COG	Yes	This National Reproductive Health Policy is Complementary to existing RH Policies. If a policy document is contradictory to this policy in matters of RH, that policy is inconsistent to the extent of the contradiction Repealing policy renamed Qualifying Clause as it qualifies the context in which the policy will operate
2	Glossary of terms	Addition of definition of abortion	COG	Yes	
3		Definition of andropause added	COG	Yes	
4		Comprehensive Abortion care definition	COG	No	
5		Definition of infertility added	COG	Yes	Edited to remove "affects millions of people" as is not part of the definition

526

6		Definition of menopause added	COG	Yes	Edited to remove the age of menopause as it does not add value to the definition
7		Definition of "near-miss" added	COG	Yes	
8		Definition of "Post Abortion Care"	COG	Yes	
9		Modification of Adolescent-Friendly Services to include "these services should be offered in a non-judgmental and confidential way that fully respects human dignity and status".	COG	Yes	
	CHAPTER 1 – PREAMBLE				
10		The general spirit of the document does not recognize the role of the county governments	CECM	Yes	The document was edited to capture comprehensively the role of the devolved units
		ORGANOGRAM changes inserted	COG	YES	
11	Paragraph one	WHO definition of health not the definition of reproductive health	CECM	No	The definition in the policy is the WHO definition of Reproductive Health
12		"Rights to reproductive and sexual health include the right to life..." Added	COG	Yes	"Of central importance ..." excluded as it is redundant
13		Rearrange and add content to chapter 1 to ensure the proper flow of information. Revise to include, background, vision, mission, principles, and objectives. The Preamble should not be properly placedNeed a page for the preamble. The object of the policy should be in this chapter. Acknowledge the source of information. Each County should set its population growth rate targets to use to determine the national average. Need for consistency	CECM	No	The vision, Mission, and objectives of the document are mainly tied to the policy directions. Comprehensive literature review and review of relevant databases was done in the development of the policy KHIS is a database and it is updated regularly and therefore always current

		The Policy should make reference to the most recent baseline data KDHS			
14	Paragraph 2	Acknowledge the source of the 2.2% growth rate	CECM	Yes	Census 2019 quoted as the source
15	1.1	Alignment of the policy to the legal framework	CECM	Yes	Added a clause to recognize both levels of government
16	1.1	Include adolescent and youth	COG	No	SRH Policy is under review in alignment with the RH Policy
17	1.3	The methodology does not depict the true scenario	CECM	No	To date, all the stakeholders have been consulted
	CHAPTER 2				
18	2.2 (SWOT AND PESTEL ANALYSIS)	The policy sees the devolution as a threat	CECM	Yes	The SWOT analysis has been comprehensively reviewed
19	2.2 (SWOT AND PESTEL ANALYSIS)	PESTEL analysis to be done	CECM	Yes	Pestel analysis developed
20	2.3	Include mental health as an indicator	COG	Yes	Screening for maternal health will be done routinely as prescribed by the National Obstetric and Perinatal guidelines, and it is comprehensively addressed in Chapter 3 of the policy. The proportion of Mothers screened for mental health is one of the indicators that will be monitored in the implementation of this policy.
21	2.3	MMR- The three delays should be captured. Referral strategy	CECM	Yes	Added under "Maternal Mortality"
22	2.3.1	The year of DHIS 2	CECM	Yes	The quoted text was from KDHS 2014. DHIS 2 deleted

23	2.3.1	Skilled delivery line 2 to 6...hanging, Maternal Mortality Ratio; reference-678- 6&7 are the same Graph showing trends to be included	CECM	Yes	Errors in the reference fixed, the graph included showing trends
24	2.3.1	Inclusion of safe abortion as a policy to mitigate maternal deaths from unsafe abortion	COG	No	Abortion is not permitted by law. However, this policy recognizes that causes of maternal death include complications arising from unsafe abortion. Therefore, guidelines on post-abortion care have been implemented to mitigate this cause of maternal death.
25	2.3.1	The main causes of perinatal mortality are prematurity, birth asphyxia, sepsis, and respiratory distress syndrome	COGS	Yes	Added
26	2.3.3	Menstrual Hygiene Management			The MOH recognizes the need to improve women and girls' quality of life by not only ensuring safe, affordable, accessible, and hygienic menstrual products but also clean and secure facilities in learning institutions, workplaces, and public spaces. In alignment with the National Menstrual Hygiene Management (MHM) Policy 2019-2030, menstrual hygiene shall be incorporated in the various Reproductive Health programmes. The RH Policy takes cognizance of the need for collaborative investment and efforts by multiple sectors under the coordination of MOH to ensure the successful

23	2.3.1	Skilled delivery line 2 to 6...hanging, Maternal Mortality Ratio; reference-678- 6&7 are the same Graph showing trends to be included	CECM	Yes	Errors in the reference fixed, the graph included showing trends
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25	2.3.1	The main causes of perinatal mortality are prematurity, birth asphyxia, sepsis, and respiratory distress syndrome	COGS	Yes	Added
26	2.3.3	Menstrual Hygiene Management			The MOH recognizes the need to improve women and girls' quality of life by not only ensuring safe, affordable, accessible, and hygienic menstrual products but also clean and secure facilities in learning institutions, workplaces, and public spaces. In alignment with the National Menstrual Hygiene Management (MHM) Policy 2019-2030, menstrual hygiene shall be incorporated in the various Reproductive Health programmes. The RH Policy takes cognizance of the need for collaborative investment and efforts by multiple sectors under the coordination of MOH to ensure the successful

					implementation of MHM programmes in the country.
27	2.3.4	Replace "experience" with "ordeal" regarding the survivors of GBV	COGS	Yes	
28	2.3.5	HIH typo changed to HIV	COGS	Yes	
29	2.3.6	CA screening 5years is long	COGS	No	CA Guidelines emphasizes on 5years if negative but doesn't prevent a woman to seek services if need the arise Global statistics 2018 replaced with global statistics of 2020
30	2.3.7	Infertility and sexual dysfunction	COGS	Yes	
31	2.3.9	Mental health be added as an indicator	COG	Yes	But a sentence added to policy direction on mental health because tracking of indicators will be done by the relevant department
32	Broad objective 1	No 6 edited	COGS	yes	To read as suggested
33	Broad objective 2	No 4	COGS	yes	Bullet on menstrual cycle inserted
34	Objective 3	No 2	COGS	yes	HRH capacity building added
35	3.3	Scope of RH policy	COGS	Yes	Supersede statement repiaced
36	3.4	Policy thrust-sentence no 4 and inclusion of (Registered HC provider define in the definition of terms)	CECS/COGS		Mothers seen and evaluated by a specialist within 30min for quality care is in order. CEMD report informs policy directive - Clinical officer included
37		No 5 – including	COGS	Yes	Deleted not limited to
38		No 8	COGS		Role Preconception care added
39		No 9-- CAC	COGS	No	Abortion is not permitted by law. However, this policy recognizes that causes of maternal death include complications arising from unsafe abortion. Therefore, guidelines on post-abortion care have been implemented to mitigate this cause of maternal death

40	3.4.2	The preamble assumes that FP is only for couples	COGS	NO	No such an assumption
41	3.4.2	Embrace the view that we are no longer planning for families but is more of access to contraception	COGS	NO	The policy addresses itself to FP and contraceptive is only part of FP
42	3.4.2	The statement is only political but irrelevant in policy	COGS	NO	The statement being addressed is not identified for review purposes
43	3.4.2(1)	"Ring-fencing" should be replaced by "budgeting"	CECM	NO	Ring-fencing is the process of protecting resources for a specified course
44	3.4.1	Postnatal care was missing	RHC	Yes	Postnatal care and obstetric fistula included
45	3.4.5(6)	Add prostate cancer screening	COGS	Yes	Added
46	3.4.6	Correctional institution added	COGS	Yes	Added(people in lawful custody)
47	3.4.6(6)(7)	True intersex deleted and replaced with persons born intersex 6,7,8 potion moved correct section (3.4.11)	COGS	Yes	It's government policy to recognize persons born intersex to protect them against violation of their reproductive health rights
48	3.4.11	New section created for intersex section	COG	Yes	A new section was created for intersex under the new title
49	3.4.7	FGF meaning in health	COG		Put in full(female genital fistula)
	3.4.7	The statement has nothing to do with the age of consent, it's about voluntarily delaying sex debut until the age of social maturation	COG/CEC	NO	The government emphasizes abstinence And delay sexual debut
50	3.4.7(4)	Delete this part	COGS	NO	The statement is in line with the children's Act. Radicalization replaced with normalization
51	3.4.7(7)	Neighbourhood dialogue replaced by National dialogue		YES	
52	3.4.8(2)	Interchange	COGS	YES	

40	3.4.2	The preamble assumes that FP is only for couples	COGS	NO	No such an assumption
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	3.4.7	The statement has nothing to do with the age of consent, it's about voluntarily delaying sex debut until the age of social maturation	COG/CEC	NO	The government emphasizes abstinence And delay sexual debut
50	3.4.7(4)	Delete this part	COGS	NO	The statement is in line with the children's Act. Radicalization replaced with normalization
51	3.4.7(7)	Neighbourhood dialogue replaced by National dialogue		YES	
52	3.4.8(2)	Interchange	COGS	YES	

PMT 1 NW-5

This is Exhibit marked "NW-5" referred to in the Annexed affidavit/Declaration of Kenna Were Sworn/Declared before me on this 25 day of September 2022 in The Republic of Kenya Commissioner for Oaths

MINISTRY OF HEALTH

Telegrams:"FAMHEALTH",Nairobi
Telephone:Nairobi 725105/6/7/8
All correspondence should be addressed to the Head.
E-mail: headrmhke.moh@gmail.com
When replying please quote

DIVISION OF REPRODUCTIVE & MATERNAL HEALTH
MBAGATHI ROAD (OLD)
P. O. Box 43319
NAIROBI.

Ref: MOH/DRMH/RH GEN/8/VOL 1(22) **1st March 2022**

Dear RH partner

RE: REQUEST TO SUPPORT THE LAUNCH OF REPRODUCTIVE HEALTH DOCUMENTS

The Division of Reproductive and Maternal Health (DRMH) is responsible for formulation of reproductive health policies, guidelines and standards, as well as providing technical support to counties on matters RH, to promote operationalization of the policies and standards of care.

The Division in collaboration with partners has revised several reproductive health documents. The next steps will be to print, launch and disseminate these documents at the national and county levels to facilitate subsequent implementation within various RH programs.

The National launch is **tentatively scheduled on 23rd March 2022.** The planning team has put together a plan with areas of support and budget estimates to ease decision making and execution. **The purpose of this letter is to request for your support on areas convenient to you as per the attached budget.**

Kindly confirm your support to the following officers;

1. **Mary Magubo, 0722885199** - **for Communication and Conference package**
2. **Mary Gathitu, 0720929059** - **for National and County Support**
3. **Hellen Mutsi, 0722778013** - **for Printing of the MNH documents**
4. **Clarice Okumu, 0722466583** - **for printing of FP documents**

Thank you for your continued support.

Dr. Stephen Kaliti, M.B.Ch.B, MMED (OBSGYN), MPH, FCOG (ECSA), HIA.
Head, Division of Reproductive Maternal Health

Encls.

ISO 9001:2015
Certified

534

N.W-3

This is Exhibit marked "N.W-3" referred to in the Annexed affidavit/Declaration of Nduma Wendo
Sworn/Declared before me on this 25th day of September 2020
at Nairobi in the Republic of Kenya
Commissioner for Oaths

COUNCIL OF GOVERNORS

REVIEW OF THE DRAFT NATIONAL REPRODUCTIVE HEALTH POLICY 2020-2030 BY COG

CONCEPT NOTE

BACKGROUD

The Constitution of Kenya 2010 provides the overarching legal framework to ensure a comprehensive rights-based approach to health services delivery. It provides that every person has a right to the highest attainable standard of health, which includes reproductive health rights

The World Health Organization (WHO) defines health as "a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity

The ICPD Programme of Action (Cairo 1994) broadly defines ***reproductive health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes***. Reproductive health implies that people are able to have a safe and satisfying sex life; the ability to reproduce; and the right to decide if, when, and how frequently to reproduce.

Globally Governments recognize the inherent link between sustainable development, the eradication of poverty, and gender equality, and are committed to address these issues in tandem. Furthermore, states agree that coercive laws, policies, and practices that do not respect individuals' autonomy and decision making must be eliminated. In adopting the ICPD Programme of Action, states committed to take legal, policy, budgetary, and other measures to effectuate the principles and rights enshrined in the document.

His Excellency Uhuru Kenyatta, President, Republic of Kenya: in his address at the 2019 ICPD25 in Nairobi promised Increased budgetary allocations and integration of population issues into all national and subnational policies, increase in HIV and social protection allocations, elimination of female genital mutilation in Kenya by 2022 and all forms of gender-based violence and harmful practices by 2030

It is against this backdrop that the Ministry of Health Kenya has formulated the draft Reproductive Health Policy

REPORODUCTIVE HEALTH has a wide range of components targeting women, children, the youth and men, which would be the basis for the draft RH policy

1. **WOMEN'S HEALTH COMPONENT** which includes the following programmes

- Safe Motherhood - pre-conception consultations, pregnancy surveillance, supervision of labour and delivery, post-partum, post-abortion and post-natal surveillance and emergency obstetrical acre
- Gynaecological Care -functional disorders, genital and breast cancers, menopause and treatment of sexual disorders

2. **CHILD HEALTH COMPONENT**

The child health component is the largest, with such programs as
Neonatology. – Common hereditary diseases and malformations. – Control and promotion of growth (CPG): breastfeeding, nutrition, vaccination (EPI). – Integrated management of diseases (IMD): diarrhoea/diseases, acute respiratory infections, malaria and malnutrition. – Promotion of the health of school children.

3. **THE YOUTH HEALTH COMPONENT (ADOLESCENCE)**

Programs relating to this component include: – Family life education. – Management of youth health, including such risk behaviours as alcohol and drug addiction, delinquency and prostitution. prenuptial consultations and counselling during marriage. fight against unwanted pregnancies, self-induced abortions and early motherhood. Promotion of a physical, political, legal, social and economic environment conducive for youth development. Promotion of the gender approach, promotion of college and university students' health and promotion of youth literacy.

4. **MEN HEALTH COMPONENT**

• This component is often forgotten. It generally consists of: – Responsible sexual life, management of men's sexual dysfunction and pathologies, control of genital cancers. And management of andropause.

CONSTITUENTS COMMON TO THE FOUR COMPONENTS.

These are programs involving all 4 components. These are mainly: – Family planning: contraception, STD/ AIDS control, Infertility prevention and treatment, Protection against disease caused by the administration of health care, Prevention of infections, IEC in reproductive health with special emphasis on the gender approach, fight against harmful traditional practices and sexual violence, such as: – Female genital mutilation/cutting, nutritional taboos girl child and forced marriages.

THE MINISTRY OF HEALTH DRAFT REPRODUCTIVE HEALTH POLICY

The Ministry of Health has drafted a Reproductive Health Policy without the involvement of the County Governments. Accordingly, the Council wrote to the Cabinet Secretary about the matter and requested that the policy is not launched before Counties review and give their input as required under Article 189 of the Constitution. This is because health is a devolved function and requires adequate intergovernmental consultation and cooperation.

The Council of Governors seeks to improve the policy and then with the Ministry of Health subject it for wider stakeholder consultations. The counties have been recently involved in the review of the policy with the ***objective to obtain contributions from multiple stake holders to make the policy fit for purpose functionality for the country.*** To achieve the objective a series of workshops will be organized with the county governments, to obtain and document their inputs and feedback and collate these into a report to inform the next activity.

Multi-stakeholder workshops will be organized to further review the draft policy alongside the counties' inputs and feedback report and provide inputs to improve the content and quality of the policy to the required standard.

NW – 4

Dr Stephen Kaliti, MD MPH
Head, Division of Reproductive and Maternal Health,
Ministry of Health.

5th October 2021

RE: INCLUSION OF CIVIL SOCIETY INPUT AND ALIGNING PROBLEMATIC REPRODUCTIVE HEALTH CARE POLICY 2020- 2030

We, the undersigned, being service providers, representatives of institutions drawn from the health, women's rights and human rights sectors, individual citizens and residents of different counties write to you regarding the above-mentioned matter.

Our attention is drawn to the consultative exercise conducted by the Council of Governors on 22nd September 2021 in an effort to review and align the Ministry of Health Reproductive Health Policy 2020-2030.

We collectively recognize that the Ministry of Health has the constitutional mandate in designing health related policies. We are equally cognizant that the Reproductive Health Policy 2020-2030 is currently in draft form and yet to be launched. We however note with particular concern that the Ministry has had little engagement with civil society actors on this particular draft that is reflective of critical matters on reproductive health.

As service providers, Non-Governmental Organizations offer more than 40% of the sexual and reproductive health services and programs in the Kenyan communities. Joint programs between many civil society partners and the Ministry exist to date. Civil Society partners have remained critical in the roll out of numerous joint projects with Global Fund, USAID and PEPFAR funded initiatives on sexual and reproductive health matters contributing to the reduction of maternal and infant mortality nationwide.

We wish to indicate at the earliest chance the need for civil society inclusion in the drafting and validation processes prior to roll-out of this particular policy. Acknowledging that we have a constitutional mandate enshrined under Articles 3, 10 and 43 to defend and protect the Constitution, the right to participate in matters concerning us and the right to the highest attainable standard of health respectively. It remains critical that civil society input be meaningfully sought at the drafting stages.

This is Exhibit marked "NW-4" referred to in the Annexed affidavit/Declaration of Nimo Ward
Sworn/Declared before me on this 22 day of October 20 22
at Nairobi in the Republic of Kenya
Commissioner for Oaths

538

As the Ministry now receives the input of the Council of Governors, we wish to share the attached memorandum shared with the Council of Governors that articulates all the areas that we deem problematic. We await communication from your office towards ensuring that civil society partners are consulted before hand and their input meaningfully reflected in the current draft.

We are confident in your commitment to uphold the right to the highest attainable standard of reproductive health care. We trust that the steps above will urgently be actioned to deliver these rights.

Cc: *Mutahi Kagwe,*
The Cabinet Secretary,
Ministry of Health,

Susan Mochache,
Principal Secretary
Ministry of Health

The Chairperson,
Council of Governors
Delta Corner, 2nd Floor,

Embassy of Netherlands,

United States Agency for International Development (USAID)

PEPFAR

Dr Ademola Olajide,
United Nations Population Fund's (UNFPA) Representative
UNFPA Kenya

Signed by the following organisations.

1. Youth Changers Kenya(YCK)
2. Zamara Foundation
3. Youth Empowerment Movement Kenya (YEM Kenya)
4. Trust for Indigenous Culture and Health
5. Kenya Legal and Ethical Issues Network on HIV and Aids

6. Ipas
7. NAYA
8. Grassroots Women Initiative Network - Kenya
9. Reproductive Health and Rights Alliance
10. Xhale Africa
11. Positive Young Women Voices
12. Mariestopes Kenya
13. RHYFE
14. Zamara Foundation
15. SRHR Alliance
16. Reproductive Health Network Kenya
17. Women Spaces Africa
18. Love Matters Africa
19. Women First Digital

6. Resistance to devolution and insistence by MoH that it oversights counties under clause 4.3. Counties and the national government are equal partners.

NW-6

This is Exhibit marked "NW-6" referred to in the Annexed affidavit/Declaration of Nemwel Wekesa Sworn/Declared before me on this 22nd day of March 2022 at Nairobi in the Republic of Kenya Commissioner for Oaths

Positive Young Women Voices

RHCO

RHN

RHRA Reproductive Health and Rights Alliance

TICAH Trust for Indigenous Culture and Health

RURAL TO GLOBAL ORGANIZATION

WOMEN SPACE AFRICA

XHALE AFRICA

LOVE MATTERS

NATIONAL GENDER AND EQUALITY COMMISSION
RECEIVED
18 MAR 2022
TEL: 2727770
FAX: 2727776
P.O Box 27512-00506, NAIROBI

Dr Stephen Kaliti, MD MPH
Head, Division of Reproductive and Maternal Health,
Ministry of Health.

17th March 2022

RE: NEED FOR PUBLIC PARTICIPATION IN THE DRAFT REPRODUCTIVE HEALTH CARE POLICY 2020 – 2030

We refer to the above-mentioned matter and your intention to the launch the National Reproductive Health Policy 2020 – 2030. We, the undersigned, write in our capacity as service providers; organisations working in the right to health, women's rights and human rights sectors; individual citizens; and residents of different counties.

We write to request that you take urgent steps to ensure adequate and meaningful public participation before launching and operationalising the RH Policy 2020 – 2030. This request is based on the following key reasons:

i. **Public participation is a Constitutional obligation.** Under Articles 1(1), 1(2), 10, and 38 of the Constitution of Kenya, there is an obligation to consider the needs and interests of the public who are likely to be adversely affected by the proposed policy, before the policy is launched and operationalised.

ii. **Critical stakeholders were not adequately and meaningfully engaged in the development of the RH Policy.** On 5th October 2021, non-governmental organisations wrote to the Ministry requesting inclusion of civil society in the

drafting and validation processes prior to roll-out of the draft Policy. To date, the Ministry has neither responded to the request for inclusion nor made any direct efforts to include civil society in the policy development process despite the fact that the Ministry held validation meetings on 2nd February 2022, and 17th March 2022.

iii. **The RH Policy being launched has not been made readily available.** The draft Policy is not readily available online, on the Ministry of Health's website. Moreover, the Ministry has not provided the public with information on where and how they can access the draft Policy. It is therefore impossible for people to comment on this crucial document as it is not readily available.

iv. **The RH Policy excludes key sexual and reproductive health issues.** It completely ignores any interventions on unsafe abortion despite unsafe abortion being a major cause of maternal mortality and morbidity in Kenya. The right to safe and legal abortion in exceptional circumstances is articulated in Article 26(4) of the Constitution. A guiding framework on Article 26(4) is necessary to ensure access to safe abortion services provided by trained medical personnel.

v. **The RH Policy contradicts the Convention on the Rights of the Child and the Ministry's own Adolescent Package of Care** by classifying sex for persons under the age of 21 years as a harmful reproductive health practice, and enforcing consent from parents, guardians or government medical specialists when providing reproductive health services to minors. This also contradicts certain county-specific reproductive health policies that allow minors to consent to their own reproductive health services.

vi. **The RH Policy is unconstitutional** as it requires single parents to be vetted by a professional committee to have children through surrogacy. This violates the right to reproductive health under Article 43(1) of the Constitution, which includes the right to decide if, when and how often to have children; and the right to equality and freedom from discrimination under Article 27 of the Constitution.

vii. **The RH Policy is a fundamental policy for the health sector** as it provides a framework for actualising the right to the highest attainable standard of health including reproductive health as articulated in Article 43(1) of the Constitution of Kenya. This Policy provides a much-needed foundation for ensuring quality reproductive health services are available, and accessible. The RH Policy should be given ample opportunity to receive all the relevant feedback from stakeholders.

Dr. Joyce Mwikali Mutinda, PHD

The Chairperson,

National Gender and Equality Commission.

Roseline Odede, HSC

The Chairperson,

Kenya National Commission on Human Rights

Hon. Florence Kajuju, MBS

The Chairperson,

Commission on Administrative Justice

Signed by the following organisations:

1. Youth Changers Kenya
2. Zamara Foundation
3. Youth Empowerment Movement
4. Positive Young Women Voices
5. Reproductive Health Champions Organisation
6. Grassroots Women Initiative Network – Kenya
7. Xhale Africa
8. Reproductive Health and Rights Alliance
9. Coalition of Grassroots Human Rights Defenders
10. Trust for Indigenous Culture and Health
11. Kenya Legal and Ethical Issues Network
12. Reproductive Health Network Africa
13. SRHR Alliance
14. Love Matters Africa
15. Women First Digital
16. Women Spaces Africa
17. Kisumu Medical and Education Trust
18. Network for Adolescent and Youth for Africa

Dr. Joyce Mwikali Mutinda, PHD

The Chairperson,

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Roseline Odede, HSC

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11. Kenya Legal and Ethical Issues Network
12. Reproductive Health Network Africa
13. SRHR Alliance
14. Love Matters Africa
15. Women First Digital
16. Women Spaces Africa
17. Kisumu Medical and Education Trust
18. Network for Adolescent and Youth for Africa

~~EXH~~ - 2

This is Exhibit ... referred to in the Annexed affidavit of Nonna Wolf
Sworn/Declared before me on this ... day of ... 2022 at Nairobi in the Republic of Kenya
Commissioner for Oaths

MINISTRY OF HEALTH

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Telephone: Nairobi /2719054/6/7/8
All correspondence should be addressed
To the Head, DRMH
E-mail:headrmnhe.moh@gmail.com
When replying please quote

DIVISION OF REPRODUCTIVE & MATERNAL HEALTH
MBAGATHI ROAD (DLN)
P. O. Box 43319
NAIROBI.

When replying please quote

Ref: MOH/DRMH/RH GEN./8/VOL. 1 (42)

31st March 2022

Dear Reproductive Health Stakeholder/
Lead - Civil Society Organisation in Reproductive Health

RE: INCLUSION OF CIVIL SOCIETY INPUT, PUBLIC PARTICIPATION AND ALIGNMENT OF THE DRAFT KENYA REPRODUCTIVE HEALTH POLICY

Reference is made to the group civil society letters dated 05th October 2021 and 17th March 2022, as well as various communications to the Ministry of Health (MOH) requesting for further inclusion of civil societies and more public participation in the drafting of the Reproductive Health Policy for the country. Your letter and concerns are noted and well received.

The Ministry of Health, in discharge of its constitutional mandate of spearheading policy formulation in matters health, has led the national formulation of a revised Kenya Reproductive Health Policy since 2015. This was necessitated by the lapse of the previous Reproductive Health Policy and a need to align with the Constitution of Kenya 2010 while assimilating new evidence on matters sexual reproductive health.

This Policy seeks to guide collective investments in key directions that scientifically and competently hold a promise to promote a healthy sexual and reproductive health for the Nation, while mitigating known and emerging challenges burdening the sexual and reproductive health of Kenyans.

While the policy formulation process has been extensively consultative and deliberate in ensuring public participation across the country from 2018 through 2020, it is commendable that you, an integral non-state actor in the Kenya Reproductive Health space, seek to further enrichen this participation by your considered inputs submitted variously to improve the policy.

With this level of fervor in holding the process accountable, Kenyans stand to gain immensely through robust informed culturally competent policies that will accelerate the country's attainment of the highest standard of reproductive health care. It is in the interest of the MOH to be as accommodative as possible, and to promote as wide ownership of this Policy as is feasible to facilitate smooth implementation by all stakeholders including the Civil Society.

To this end, the MOH grants your request to put on hold the launch of this Policy, and further invite you to publicly share and engage on the content of the draft Reproductive Health Policy, with an intention to deliberate on the submissions you have shared with a view to improving this Policy.

The purpose of this letter is thus to re-share with you the **enclosed draft National Reproductive Health Policy**, and specifically to invite you to this additional public iteration on this draft Reproductive Health Policy. The agenda of this meeting is to deliberate on the issues you have raised as well as make further oral submissions with a view to bringing this policy to a progressive common ground centered on the best reproductive health interests of the Kenyan citizenry.

Kindly avail yourself on **Wednesday 06th April 2022** at **The Emory Hotel** on Kandara Road, **Kileleshwa, opposite Kileleshwa Police Station** starting **07:30am Nairobi time.** Breakfast will be served and your conferencing will be catered for.

Get directions here: (https://goo.gl/maps/W6tNHZET9dHWuaQN7)

Sincerely,

Dr. Stephen Kaliti, M.B.Ch.B. MMED (OBSGYN), MPH, FCOG (ECSA), HIA.
Head, Division of Reproductive & Maternal Health

Encls

CC:

1. CS Health
2. PS Ministry of Health
3. Ag. Director General for Health
4. Ag. DMS/PPH
5. Head, Dept. of Family Health
6. H.E Martin Wambora, EGH, Chairperson, Council of Governors
7. Dr. Joyce Mwikali Mutinda, PHD, Chairperson National Gender And Equality Commission
8. Roseline Odede, HSC, Chairperson, Kenya National Commision For Human Rights
9. Hon. Florence Kajuju, MBS, Chairperson, Commission for Administrative Justice

This is Exhibit marked "NW-5" referred to in the Annexed affidavit/Declaration of Kenya Nairobi
Sworn/Declared before me on this 5th day of September 2022 at Nairobi in the Republic of Kenya
Commissioner for Oaths

MINISTRY OF HEALTH

Telegrams: "RMHEALTH", Nairobi
Telephone: 725105/6/7/8
All correspondence to: Head DRMH, MOH,
Email: dr.kaliti@gmail.com/ headrmhke.moh@gmail.com .

DIVISION OF REPRODUCTIVE & MATERNAL HEALTH
OLD MBAGATHI ROAD, MTC GROUNDS
P.O.BOX 43319
NAIROBI

18th April 2022

Dear Valued Reproductive Health Policy: Stakeholder/ Duty bearer/Advocate

REF: INVITATION TO THE REPRODUCTIVE HEALTH POLICY DRAFTING WORKSHOP ON 25TH APRIL TO 29TH APRIL 2022 AT PRIDE-INN FLAMINGO RESORT IN SHANZU MOMBASA

Easter greetings from the MOH,

Kenya has been in the process of developing a National Reproductive Health Policy since 2015. This policy making process has spanned multiple years and a broad array of stakeholder engagements across the country in an effort to reflect the aspirations of Kenyans on matters Reproductive health in compliance with the Constitutional requirement for public participation in public policy making.

The last such event in this process was an inclusive participatory public engagement meeting held on 06th April 2022 at The Emory Hotel in Nairobi, during which public submissions to improve the policy were made. In this this meeting, additionally ,you were identified as possessing the requisite expertise and mandate to represent your constituency of ideals in considering the various submissions made with respect to this policy for technical inclusion into the final draft policy. The sole motivation of this activity is to give Kenyans a befitting policy direction that will guide investments on matters reproductive health for the next decade without leaving no one behind.

It is thus my pleasure to invite you to this policy writing workshop to be held at the Pride-Inn **Flamingo resort** in Shanzu **Mombasa** from **25th April 2022 to 29th April 2022**, with travel dates of 24th April 2022 and 30th April 2022.

If you are not affiliated to a sponsoring organization, a Nairobi-Mombasa return flight and reasonable accommodation on half-board near the workshop venue will be provided. In addition to flights, Government officers will be on DSA as per Government policy. A conference package that includes lunch and two beverage snack breaks will be provided for all. Please note that this is an individual **invitation** and **not transferable**.

Sincerely,

Dr Stephen Kaliti, HEAD DRMH -MOH.

548

NW-9

This is Exhibit marked "NW-9" referred to in the Annexed affidavit/Declaration of Neima Wako Sworn/Declared before me on this 8th day of September 2022 at Nairobi in the Republic of Kenya
Commissioner for Oaths

Geraldine Moraa

From: Marylize Biubwa <candylize@gmail.com>
Sent: Tuesday, 28 June 2022 13:34
To: Mwikali Kivuvani
Cc: Albert Ndwiga; Alice Mwangangi; Bashir Issak; Clarice Okumu; Estella Waiguru; Florence Ireri; Gordon Ochieng; HEADRMHKE MOH; Hellen Mutsi; Howard Akimala; Jade Maina; James Soki; John Nyamu; Karen Aura; Kezia K'Oduol; Lisa Owino; Martin Mburu; Martin Mburu; Martin Onyango; Mary Gathitu; Mary Magubo; Mnjames.Karanja@gmail.com; Scola Wabwire; Stephen Kaliti; Suzanne Majani; Wakoli2ken@gmail.com; Wangari Ireri; Winfredwanjiku69@gmail.com; aketch@pearlsandtreasures.org; amadivakibisu@gmail.com; andrewmulwa@ymail.com; annwangui863@gmail.com; carrumm@knchr.org; cshealth2015@gmail.com; cynthia@wya.net; dghealth2019 @gmail.com; directordpphs.moh@gmail.com; drbashirm@gmail.com; e.fundi@ombudsman.go.ke; edabeauttah@gmail.com; essieaoko@gmail.com; fridah@rhnk.org; gideonmut@gmail.com; gusterkakeelo@gmail.com; janetmogire15 @gmail.com; joymdivo@gmail.com; kirekiomanwa@gmail.com; lekoreremerina@gmail.com; lkahuko86@gmail.com; menganyicate83@gmail.com; msolomon@fhi360.org; mwangajob1@gmail.com; nehemiahkimathi@gmail.com; ngogae@ipas.org; nitahjp; peteroiba@gmail.com; pm_remigeo@yahoo.com; rkakeelo@cuea.edu; shantal.onyango@gmail.com; simonkigondu@gmail.com; skmuleshe@gmail.com; tatueda995@gmail.com; wamaer@hotmail.com; wereian12 @gmail.com; wesongamasirivai@gmail.com; wngare@hotmail.com; womenspacesafrica@gmail.com
Subject: Re: Invitation to the Reproductive Health Policy Validation Meeting on 1st July 2022 at Emory Hotel, Nairobi

Hello Dr. Mulwa,

Thank you for the invite and I am excited and looking forward to the meeting. It is however paramount that I, we all get the copy of the policy, given how vast it is, before tomorrow so that we can show up ready to rubber stamp a document that we know what it Carries.

It's also part of due diligence as we had agreed on 29th April 2022 that when the document is ready for public consumption, it will be shared with us for perusal but also in the spirit of the full transparency commitment made.

Sincerely,
Marylize Biubwa.
For the sexual and gender minorities in Kenya.

On Tue, Jun 28, 2022 at 12:27 Mwikali Kivuvani <mwikali@srhralliance.or.ke> wrote:

> Dear Dr. Mulwa,
> Thank you very much for your email and invitation to the validation meeting. The SRHR Alliance will be in attendance.
>
> Best wishes
> Mwikali

On Tue, Jun 28, 2022 at 10:38 AM MOH-DIRECTORATE OF MEDICAL SERVICES/PREVENTIVE & PROMOTIVE HEALTH <directordpphs.moh@gmail.com> wrote:

Dear all,
Trusting you have been well since our drafting session of this policy in **Mombasa 20th -25th April 2022,** the MOH is delighted to inform you that a final draft incorporating our deliberations and guidance of **THE CS Health** as agreed during this meeting is now available for our appraisal and validation.

The purpose of this email is to invite you to this important validation meeting on **1st July 2022 at the EMORY Hotel Nairobi starting at 7: 00 AM.**

Thank you for your continued support

Regards,

Dr. Mulwa A. M.
Ag. Director of Medical Services, Preventive & Promotive Health
Ministry of Health
Afya House | 6th Floor | Room 621
P. O. Box 30016 - 00100
NAIROBI
Alternate email: andrewmulwa@ymail.com

--
Human Rights Defender and Black Queer Angry Radical Intersectional Feminist
Queer Republic

~Communication Expert, Gender Expert, Healer, Content Creator, Human Rights and Feminism ToT Trainer and Consultant.
They/Them
+254718294276
candylize@gmail.com

550

NW-10

This is Exhibit marked "NW-10" referred to in the Annexed affidavit/Declaration of ... Sworn/Declared before me on this ... day of ... 20... in the Republic of Kenya ... Commissioner for Oaths

Geraldine Moraa

From:	lowino@kelinkenya.org
Sent:	Monday, 4 July 2022 20:29
To:	'directordpphs.moh@gmail.com'; 'Andrew Mulwa'; 'cshealth2015@gmail.com'; 'dghealth2019@gmail.com'; 'HEADRMHKE MOH'; 'Stephen Kaliti'
Cc:	'haki@knchr.org'; 'info@ombudsman.go.ke'
Subject:	DISENGAEMENT AND WITHDRAWAL OF KELIN FROM THE LAUNCH OF REPRODUCTIVE HEALTH POLICY 2022 - 2032

Dear Hon Mutahi Kagwe,

We refer to your invitation to the launch of the National Reproductive Health Policy tomorrow, 5th July 2022 at Windsor Gold Hotel.

On behalf of KELIN - a health rights organization - we are deeply concerned that the Division of Reproductive Health continues to be a human rights violator, with a persistent disregard of our concerns over how flawed the above process has been.

On various occasions since April 2021, we have raised legitimate concerns that the communities, civil society, council of governors and medical bodies have on this draft policy. To date, none of us is yet to access the revised text of the RH policy. Our requests to have meaningful processes that are not by ambush have gone unanswered. Friday's validation meeting held on 1st July 2022 was simply a dress down from Dr Stephen Kaliti who yet again, refused to share the draft document while harshly criticizing us for demanding an open and fair process. There has been a continued show of bad faith that reeks of a dishonest process.

As an organization advocating for a rights-based entity providing services, information and advocacy on sexual and reproductive rights at national and county processes, **we now wish to formally withdraw and disengage with the Division of Reproductive Health on this particular policy for the following reasons:**

1. Lack of meaningful engagement – Engagement has been through ambush. All invitations were sent on short notice a day or two before meetings were held.
2. Lack of transparency – At no point were drafts shared even when we demanded for the same ahead of a meeting and as a result, no prior preparations were made.
3. Exclusion of professional views- Despite consistent submission on views from medical experts from KOGS, these views were disregarded completely on areas such as surrogacy, intersex persons etc.
4. Disregard to science, data and facts – On various occasions, Dr Kaliti disregarding rising data on teen pregnancies, unsafe abortion etc. Moral & Religious bias by the Director of the Division was clearly evident. His clouded views have thus compromised the quality of engagement.

The Division of Reproductive Health led by Dr Stephen Kaliti no longer has our support, trust, resources and goodwill for this process. As such, this is a formal request to remove any indication of our name, organization and individual representation from the document. We do not in any way endorse the views and text therein which we have not had any opportunity to see beforehand.

Yours faithfully,

Lisa Achieng Owino | *Sexual and Reproductive Health and Rights*
(she/her/hers)

Programme Officer,

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P.O. Box 112 - 00202 KNH Nairobi
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Fax: 020 386 1390

E-mail: lowino@kelinkenya.org
Website: www.kelinkenya.org

552

NMA NW-11

This is Exhibit marked "NW-8" referred to in the Annexed affidavit/Declaration of Nduma Nderi
Sworn/Declared before me on this 8th day of July 2025 in the Republic of Kenya at Nairobi
Commissioner for Oaths

MINISTRY OF HEALTH

THE NATIONAL REPRODUCTIVE HEALTH POLICY 2022 - 2032

Towards the Highest Reproductive Health Status for all Kenyans

MINISTRY OF HEALTH

The National Reproductive Health Policy 2022 - 2032
is a publication of the Ministry of Health, Republic of Kenya

Suggested Citation

Ministry of Health, The National Reproductive Health Policy 2022 - 2032, Government of Kenya, July 2022.

Enquiries and Feedback:
Direct all correspondence to:
Principal Secretary
Ministry of Health
P.O. Box 30016 GPO Nairobi - 00100.
Email: ps@health.go.ke
Web site: www.health.go.ke

TABLE OF CONTENTS

FOREWORD i

ACKNOWLEDGEMENTS ii

TECHNICAL NOTE iii

ABBREVIATIONS v

GLOSSARY OF TERMS viii

CHAPTER 1. PREAMBLE 1

1.1 Alignment to the constitution, policy and legal frameworks 3

1.2 Rationale for the Reproductive Health Policy 2020-2030 3

1.3 Methodology 4

CHAPTER 2. SITUATIONAL ANALYSIS 5

2.1 Introduction 5

2.2 SWOT & PESTEL analysis 5

2.3 Performance of Key Indicators on Reproductive Health 7

2.4 Policy Implementation Environment 16

CHAPTER 3. POLICY DIRECTION 19

3.1 Policy goal and overarching statement 19

3.2 RH policy objectives 20

3.3 Scope of the RH policy 21

3.4 Policy Thrust 22

CHAPTER 4. POLICY IMPLEMENTATION FRAMEWORK 31

4.1 Management and Coordination 31

4.2 Provision of RH services 34

4.3 Roles and Responsibilities 40

CHAPTER 5. MONITORING, EVALUATION, RESEARCH AND LEARNING (MERL) 47

LIST OF CONTRIBUTORS 48

FOREWORD

The National Reproductive Health Policy 2022 - 2032, herein referred to as "the Reproductive Health Policy" (RH Policy) reflects the commitment of the Government of Kenya to all persons in need and requiring reproductive services of the highest standard. Additionally, the policy guarantees achievement of universal Reproductive Health coverage to all persons in the country. This is consistent with the global call to action as espoused in the Sustainable Development Goals 3, 5 and 10, goals that if attained will ensure healthy lives and promotion of wellbeing through an entire life course, gender equality and significantly reduce inequality. The drafting of this policy took a multi-stakeholder consultative approach as informed by the Constitution of Kenya 2010, the Kenya Vision 2030 and the Kenya Health Policy 2014-2030. This is the first Reproductive Health policy to be developed within the context of a devolved system of governance in the country.

Since 2017, the Ministry of Health took lead in developing this Reproductive Health policy, reviewed the 2007 reproductive health implementation and factored in the current situation of Reproductive Health in the country. Overall some progress has been made on key indicators as per the initial policy objectives. However, there are pertinent areas that require urgent attention in order to accelerate progress in Reproductive Health gains in Kenya. Top on this urgent list is inequality in access to quality reproductive health interventions across the country; closely followed by gaps in addressing unique RH needs of specific populations (adolescents and young people; elderly persons; persons affected by reproductive tract cancers, persons with infertility; persons with disability; and persons in humanitarian settings and fragile contexts). Lastly on this list but by no means least, is inefficient operations of the health system building blocks (data systems; human resources; technology and products; research and infrastructure, and misaligned partnerships and collaborations) which hampered the optimal RH delivery of the previous Reproductive Health policy pronouncements.

This policy is timely, and will be a welcome enabler of **Universal Health Coverage** realisation in Kenya. The Government is committed to working closely with all players at the National and County levels in the execution of the pronouncement of this policy for the attainment of the highest standard of Reproductive Health for all Kenyans.

Sen. Mutahi Kagwe, EGH
Cabinet Secretary
Ministry of Health

ACKNOWLEDGEMENTS

The development of the National Reproductive Health Policy 2022 - 2032 was accomplished through the concerted efforts of many organizations, institutions, stakeholders and individuals.

Foremost, I acknowledge the Division of Reproductive and Maternal Health and the various techincal units of the MoH for spearheading this process.

Special acknowledgement goes to the County Governments, the Council of Governors, Constitutional Commissions & Independent Offices, Professional Bodies, Development Partners and Civil Society Organizations working in Reproductive Health Rights, who provided both technical and financial support for the development of this National Reproductive Health Policy.

I wish to acknowledge the Donor Community, Implementing Partners and Organizations who supported the Ministry to ensure that this document comes to pass. It is the Government's wish that this policy will be utilized by all stakeholders as a road map for providing quality reproductive and maternal health services across the nation as envisioned in the Constitution of Kenya 2010, Kenya Vision 2030, the Kenya Health Policy (2014 - 2030) and the relevant guiding international instruments.

Ms. Susan N. Mochache, CBS
Principal Secretary
Ministry of Health

TECHNICAL NOTE

This National Reproductive Health (RH) Policy is founded on the following key objectives:

1. To achieve universal Reproductive Health coverage through quality and comprehensive Reproductive Health interventions across the country
2. To improve responsiveness to client's reproductive health needs
3. To strengthen the enablers (Health Systems Building Blocks) for Reproductive Health, including aligning partnerships and collaboration.

Monitoring of this policy document, shall be as per the Kenya Health Sector Partnership and Coordination Framework MoH 2018 i.e through the Health Sector Inter Governmental Consultative Forum and the Inter Agency Coordination Committee for Reproductive Health, and will be guided by the following commitments:

1. Reducing maternal, perinatal and neonatal morbidity and mortality
2. Reducing unmet family planning needs
3. Reducing the burden of Reproductive Tract Infections (RTIs) and improving access to, and quality of, RTI services
4. Reducing the HIV and AIDS burden and eliminating mother to child transmission (eMTCT) of HIV
5. Reducing morbidity and mortality associated with the common cancers of the reproductive organs in men and women
6. Mainstreaming special RH-related needs of people with disabilities, the elderly, people in humanitarian settings and fragile contexts.
7. Promotion of gender equity, elimination of medicalized FGM and eradication of all forms of gender-based violence and harmful reproductive health practices
8. Improving reproductive health outcomes among adolescents and young people
9. Reducing the magnitude of infertility and increased access to management of infertile couples

10. Promoting robust RH implementation environment especially data systems, research for development, innovation, collaborations, human resources for RH and RH partnerships

Qualifying Clause: The National Reproductive Health Policy is complementary to existing policies, and shall be the main reference policy on matters concerning Reproductive Health in Kenya.

Effective Clause: The National Reproductive Health Policy, becomes effective from the date of signature by the Cabinet Secretary for Health.

Review Date: This Policy should be reviewed as is deemed necessary in response to compelling new developments in the Reproductive Health environment in Kenya, preferably not later than the 10th year from the date herein when it comes to effect.

Dr. Patrick Amoth, EBS
Ag. Director General for Health

ABBREVIATIONS

AIDS: Acquired Immuno-Deficiency Syndrome

ANC: Antenatal Care

ARHD: Adolescent Reproductive Health and Development

ART: Antiretroviral treatment

CDoH: County Department of Health

CHMT: County Health Management Team

CPR: Contraceptive Prevalence Rate

CSO: Civil Society Organization

DFID: Department for International Development

DRMH: Division of Reproductive and Maternal Health

eMTCT: Elimination of Mother to Child Transmission

FBO: Faith-Based Organization

FGF: Female Genital Fistulae

FGM: Female Genital Mutilation

FP: Family Planning

HCW: Health Care Worker

HIV: Human Immunodeficiency Virus

HMIS: Health Management Information System

HPV: Human Papilloma Virus

HRH: Human Resources for Health

ICPD: International Conference on Population and Development

IDSR: Integrated Disease Surveillance and Response

IGRF: Intergovernmental relations forum

KDHS: Kenya Demographic and Health Survey

KEPH: Kenya Essential Package for Health

KHIS: Kenya Health Information System

KHP: Kenya Health Policy 2014-30

KMLTB: Kenya Medical Laboratory Technicians and Technologists Board

KNBS: Kenya National Bureau of Statistics

KOGs: Kenya Obstetrical and Gynecological Society

KHRC: Kenya Human Rights Commission

M&E: Monitoring and Evaluation

mCPR: Modern Contraceptive Prevalence Rate.

MDGs: Millennium Development Goals

MERL: Monitoring, Evaluation, Research and Learning

MNCH: Maternal Newborn Child Health

MOH: Ministry of Health

MPDSR: Maternal and Perinatal Surveillance and Response

MTCT: Mother to Child Transmission

NACADA: National Authority for the Campaign against Alcohol and Drug Abuse

NASCOP: National AIDS and STD Control Programme

NCK: Nursing Council of Kenya

NCPD: National Council for Population Development

NGO: Non-Governmental Organization

NHIF: National Hospital Insurance Fund

NMS: Nairobi Metropolitan Services

PEPFAR: President's Emergency Plan for AIDS Relief

PLWD: People Living with Disability

PMTCT: Prevention of mother to child transmission

RH: Reproductive Health

RTIs: Reproductive Tract Infections

SAGA: Semi-Autonomous Government Agencies

SDG: Sustainable Development Goals

SDGs: Sustainable Development Goals

SGBV: Sexual and Gender Based Violence

STIs: Sexually Transmitted Infections

UHC: Universal Health Coverage

UNFPA: United Nations Population Fund

UNICEF: United Nations International Children's Emergency Fund

VMMC: Voluntary Medical Male Circumcision

WHO: World Health Organization

WRA: Women of Reproductive Age

GLOSSARY OF TERMS

Abortion: Abortion means termination of pregnancy[1].

Adolescents: (from Latin adolescere 'to mature') is a person in the transitional stage of physical and psychological development that occurs during the period from puberty to adulthood. The WHO considers these persons to be aged 10-19 years , and the grouping includes children (persons below 18 years of age and young adults aged 18 and 19 years.

Adolescent-Friendly Services: Reproductive Health services delivered responsively and to specific needs of adolescents.

Age Appropriate: Suitability of information and services for people of a particular age.

Andropause: A gradual and highly variable decline in the production of androgenic hormones and especially testosterone in the human male together with its associated effects that is held to occur during and after middle age[2] – also called climacteric; male menopause.

Child: A person under the age of 18 years.

Child Abuse: Child maltreatment, all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development or dignity. Within this broad definition, five subtypes can be distinguished — physical abuse, sexual abuse, neglect and negligent treatment, emotional abuse and exploitation including sexualization of persons below 18 years of age[3].

Crisis: A time of intense difficulty or danger during pregnancy[4].

Female Genital Mutilation (FGM): Comprises all procedures involving partial or total removal of the female genitalia; or any other injury; or any harmful procedure to the female genital organs, for non-medical reasons which includes: - clitoridectomy, excision and infibulations, excluding a medical procedure done on the Female Genitalia by an expert for a medical therapeutic purpose[5].

Gender: Gender is a social construct about maleness or femaleness as it is determined by the socio-cultural attitudes, stereotypes, and norms in any

1 Britannica, T. Editors of Encyclopaedia (2022, January 18). abortion.https://www.britannica.com/science/abortion-pregnancy)
2 Melmed, S., Polonsky, K. S., Larsen, P. R., & Kronenberg, H. M. (2015). WILLIAMS Textbook of. Endocrinology 13th.
3 Report of the Consultation on Child Abuse Prevention, 29–31 March 1999, WHO, Geneva. Geneva, World Health Organization, 1999 (document WHO/HSC/PVI/99.1)
4 https://www.merriam-webster.com/dictionary/crisis
5 World Health Organization. (1997). Female genital mutilation: a joint WHO/UNICEF/UNFPA statement. World Health Organization

given society. These constructs are learned and reinforced by the family structure, the educational system, the community, and the media.[6]

Gender Based Violence: Refers to any type of harm that is perpetrated against a person due to their gender.[7]

Gender Equality: The absence of discrimination based on a person's sex in opportunities, the allocation of resources and benefits, or access to services[8].

Gender Equity: The fairness and justice in the distribution of benefits and responsibilities between women and men. The concept recognizes that women and men have different needs and power, and that these differences should be identified and addressed in a manner that rectifies the imbalance between the sexes .[9]

Infertility: A medical diagnosis of the failure of a male and a female to achieve pregnancy after 12 months or more of regular sexual intercourse[10].

Intersex: A congenital condition of sex development in which the development of the chromosomal, gonadal or anatomic sex is atypical leading to ambiguous genitalia making it difficult to identify their sex at birth and before development of secondary sexual characteristics at puberty.[11]

Health: A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity

Life Skills Education: Education geared towards character development of individuals to equip them with values, appropriate knowledge on risk-taking behaviors and develop skills such as sexual risk avoidance, communication,assertiveness, self-awareness,decision-making, problem-solving,inter-personal relationships, critical and creative thinking to protect from and respond to abuse and exploitation and to help children to practice abstinence[12].

Maternal near-miss: A woman who nearly died but survived a complication that occurred during pregnancy, childbirth or within 42 days after the termination of pregnancy[13].

Marginalized groups: Means a group of people who are disadvantaged

6 Fast, I. (1984). Gender identity: A differentiation model (Vol. 2). Lawrence Erlbaum Assoc Incorporated.
7 UNHCR Policy on the Prevention of, Risk Mitigation and Response to Gender-based Violence, 2020
8 convention-on-the-elimination-of-all-forms-of-discrimination-against-women-cedaw-United Nations Treaty Collection UN.ORG archived Sept 2011, retrieved Feb 2021
9 http://www.euro.who.int/en/health-topics/health-determinants/gender/gender-definitions
10 World Health Organization (WHO). International Classification of Diseases, 11th Revision (ICD-11) Geneva: WHO 2018.
11 Lee, P. A., Houk, C. P., Ahmed, S. F., & Hughes, I. A. (2006). Consensus statement on management of intersex disorders. Pediatrics, 118(2), e488-e500
12 Conger, D. S., & Mullen, D. (1981). Life skills. International Journal for the Advancement of Counselling, 4(4), 305-319
13 Say, L., Souza, J. P., & Pattinson, R. C. (2009). Maternal near-miss—near-miss standard tool for monitoring quality of maternal health care. Best practice & research Clinical obstetrics & gynaecology, 23(3), 287-296.

by discrimination on one or more of the grounds in Article 27(4) in the Constitution of Kenya.[14]

Menopause: The time in a woman's life when she stops having a menstrual period and is no longer fertile. The time leading up to menopause is called the menopausal transition, or perimenopause. Often diagnosed after one has gone for 12 months without a menstrual period[15].

Non-State Actors: An entity that is not part of any state or a public institution. They range from grassroots community organizations to non-governmental organizations, philanthropic foundations, and academic institutions.

Opinion of a Trained Health Professional: The documented outcome after taking history of presenting illness, performing a physical examination, reviewing results of relevant tests, and treatment advised by a trained health professional.

Orphan: A child below 18 years of age whose mother (maternal orphans) or father (paternal orphans) or both (double orphans) are dead.

Persons with Disability: An individual with physical, sensory, mental, psychological or any other impairment, condition or illness that has, or is perceived by significant sectors of the community to have a substantial or long-term effect on their ability to carry out ordinary day-to-day activities[16].

Public health services: Healthcare services that are concerned with the science and art of preventing disease, prolonging life, and promoting health through organized efforts and informed choices of society, organizations (public and private), communities, individuals, and are concerned with threats to the overall health of a community.

Post Abortion Care (PAC): Consists of emergency treatment for complications related to spontaneous or induced abortion1, including evacuation of residual products of conception, treatment of attendant infections like sepsis, post-traumatic counselling, future conception planning and counselling, provision of contraceptives to prevent unplanned pregnancy and evaluation for STI and HIV/AIDS.

Reproductive Health: Reproductive health refers to the condition of male and female reproductive systems during all life stages[17]. WHO further qualifies reproductive health to include a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, in all

14 National Collaborating Centre for Determinants of Health, COCKERHAM, C. (1948). SOCIAL POLICIES AND HEALTH INEQUALITIES. Organization, 1.
15 Soules, M. R., Sherman, S., Parrott, E., Rebar, R., Santoro, N.,Utian, W., & Woods, N. (2001). Executive summary: stages of reproductive aging workshop (STRAW) Park City, Utah, July, 2001. Menopause, 8(6), 402-407.
16 The Persons with Disabilities Act, 2003, KLRC
17 Reproductive Health (nih.gov) accessed Feb 2022

matters relating to the reproductive system, its functions, and processes[18].

Reproductive Health Rights: The basic right of all couples and individuals to decide competently, freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of reproductive health. Includes the right to make decisions concerning reproduction free of discrimination, coercion and violence[19].

Sex: Biological state of being male or female.

Sexual Violence: Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic a person for sexual exploitation, using coercion, threats of harm or physical force, by any person. Includes: - forced sexual relations; sexual coercion; rape and sexual abuse of children.

Sexual Offence: This includes defilement, rape, incest, sodomy, bestiality and any other offense prescribed in the Sexual Offences Act[20].

State Actors: Government ministries, departments and agencies.

Supportive Supervision: A process of guiding, helping, building capacities, and learning from staff at their places of work.

Total market approach: When public and private players coordinate to jointly meet the healthcare needs of a population and leverage the strengths of each player to maximize the reach and quality of services[21].

Universal Access: The effective physical and financial access to health services by all.

Universal Healthcare: Organized healthcare systems built around the principle of universal coverage for all members of society, combining mechanisms for health financing and service provision.

Universal Health Coverage (UHC): Ensuring that everyone who needs health services can get them without undue financial hardship[22].

Vulnerable children and young persons: Children and young persons at high risk of lacking adequate care and protection14. The term includes orphans and street children as well as vulnerable adolescents: - living with HIV and AIDS; with disabilities; living in informal settlements; in the labor market;

18 Reproductive health (who.int) accessed Feb 2022
19 Freedman, Lynn P.; Isaacs, Stephen L. (1993). "Human Rights and Reproductive Choice". Studies in Family Planning. 24 (1): 18–30
20 The Sexual Offenses Act, No.3 of 2006, Laws of Kenya, Kenya Law Review Commission
21 Total market approach | FP Financing Roadmap, USAID, Accessed Feb 2022
22 Universal Health Coverage (who.int). World Health Organization, accessed Feb 2022)

who are sexually exploited; living below the poverty line and children affected by disaster, civil unrest or war as well as those living as refugees or dysfunctional family units.

Youth: The collectivity of all individuals in the Republic Who – (a) have attained the age of eighteen years; but (b) have not attained the age of thirty-five years[23]."

23 Constitution of Kenya, Cap 17 Article 260, Republic of Kenya, 2010

CHAPTER 1. PREAMBLE

This policy has been developed through a lengthy consultative process over several years involving multiple stakeholders to ensure everyone has a say, but retaining the people of Kenya in the driving seat to have their way on matters of Reproductive health within Kenya's progressive socio-cultural tenets.

Reproductive health is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity in all matters relating to the reproductive system and its functions and processes. Optimal reproductive health is core to the national development agenda as it is a key determinant of a nation's population health, the latter being a premier resource of any nation.

This policy is anchored on the philosophy of leaving no Kenyan behind on matters of reproductive health and seeks to cement responsible reproductive health rights enjoyed within bounded rationality as personal liberty prioritized for resource allocation.

Over the years, Kenya has made significant strides in improving the socioeconomic status of her citizens. Indeed this policy comes into effect at a time Kenya has transitioned to a Middle Income Economy[24] in which previous bilateral donors are seeking to trade with Kenya as she moves towards economic independence. Over the next decade, Kenya is projected to experience a significant increase in demand for reproductive health services as the nation continues to increase life expectancy while enjoying a modest annual growth rate of 2.2%, with close to a quarter of her population being adolescents. (Ref census 2019[25]). There is thus a need to consolidate the gains made so far, while concurrently addressing both the preexisting and the emerging gaps in reproductive health.

Previous investments in health including control of infectious diseases, maternal and child health services among others, have resulted in a significant decline in premature mortality and a gain of more than 10 years in life expectancy in the period 2004-2016[26]. In reproductive health, investment in family planning has seen a two-fold drop in unmet need for family planning in the past 10 years. Despite

24 Kenya becomes a middle-income economy - Business Today Kenya, NMG accessed 24 Feb 2022
25 Kenya Population and Housing Census: Volume III ISBN: 978-9966-102-11-9, Kenya National Bureau of Statistics, 2019
26 Kenya Population and Housing Census: Volume III ISBN: 978-9966-102-11-9, Kenya National Bureau of Statistics, 2019

Optimal reproductive health is at the core of national development because of its critical role in determining population dynamics.

these gains, more needs to be done to reduce the number of women dying due to pregnancy and childbirth complications currently standing at 352 women per 100,000 live births[27]. Additionally, public outcry about adverse reproductive health outcomes of adolescents and young people such as; teenage pregnancies, the resurgence of reproductive tract infections, HIV and AIDS, Female Genital Fistulae (FGF), Female Genital Mutilation (FGM), child marriages, sexual violence, drug and substance abuse, and negative social media influence, is getting ever louder. These unsettling reproductive health adversities have been partly driven by persisting inequalities in access to reproductive health services, suboptimal quality of services provided, limited information and capacity of populations to make informed demand of services, and challenges in aligning partnerships and collaborations in the reproductive health space with the Country priorities.

This reproductive health policy, being a public policy, generously borrows from the diverse policy typologies to apply the most feasible alternative to address the policy issue under consideration. One will thus see distributive, redistributive, facilitative, regulatory, and restrictive policy thrusts that seek to complement or guide the larger Kenya health policy space.

This Policy is informed by the Kenya Constitution 2010, the previous Reproductive Health Policy 2007; Kenya Health Policy 2014-2030; The Kenya Vision 2030, The Kenya Medium Term Expenditure Plans, The Kenya ICPD at 25 Nairobi Summit commitments, the Sustainable Development Goals (SDGs), domestic and domesticated global instruments, treaties as well as a growing body of research on best practices in reproductive health, to list but a few.

The National Reproductive Health policy 2022-2032 seeks to consolidate the gains achieved during the previous policy period and address the emerging challenges in reproductive health. This policy addresses the six RH operational life course cohorts[28]. Pregnancy and the newborn (up to 28 days of age); 2) Childhood (28 days to 9 years); 3) Adolescence (10 to <18 years); 4) Early youth (18 to 24 years); Adulthood (25 to 49 years) and 6) Elderly (50 years and over).

27 Kenya Demographic and Health Survey, 2014, KDHS 2016, Kenya National Bureau of Statistics
28 Mortimer, Jeylan T., and Michael J. Shanahan, eds. Handbook of the life course. Springer Science & Business Media, 2007

1.1 Alignment to the constitution, policy and legal frameworks

Reproductive health is addressed within various policy and legislative frameworks. The Constitution of Kenya 2010 provides for the right of every person to the highest attainable standard of health including reproductive health and the right to life. Other legal frameworks include the Sexual Offences Act (2006), Children's Act (2001), Counter Trafficking in Persons Act (2010), Prohibition of FGM Act (2011), Person With Disability Act (2003), HIV and AIDS Prevention and Control Act (2006), Marriage Act (2014), National Youth Policy (2007), Sessional Paper No. 3 on Population Policy for National Development (2012), Gender Policy in Education (2007), Kenya Health Policy (2014-2030), Kenya Health Sector Strategic and Investment Plan (2014-2018), Education Sector Policy on HIV and AIDS (2013), National School Health Policy (2009), National Gender-Based Violence (2014), , National policy on older persons and ageing 2014, Kenya Vision 2030 and the Health Act, 2017.

Achieving Universal Health Coverage within limited resources in the context of sustainable development goals further cements the urgency and need for this RH policy.

Kenya devolved governance through the Constitution of Kenya 2010 and adopted a National government and forty-seven (47) County governments. The RH policy takes cognizance of the specific distinct but complimentary functions of the two levels of governments, as outlined in the fourth schedule in which the National government mandate spans Health policy; national referral health facilities; capacity building, technical assistance, norms, standards and guidelines, while County Governments are mandated to take charge of County health services, including county health facilities and pharmacies; ambulance services; and promotion of primary health care; among other responsibilities as laid out in the fourth schedule[29].

1.2 Rationale for the Reproductive Health Policy 2022-2032

This policy is developed as a constitutional core mandate of the Ministry of Health to direct and guide the country on how to reduce the heavy burden of preventable reproductive health morbidity and mortality. Achieving

29 Fourth Schedule Distribution of functions between National and the county governments

Universal Reproductive Health Coverage within limited resources in the context of sustainable development goals further cements the urgency and need for this RH policy.

This policy provides overall guidance for all stakeholders in the reproductive health sector and is the principal reference document in matters of RH. Prior to this RH policy, was the 2007 Reproductive health policy, which is now reviewed to ensure it addresses the following:

1. Alignment of RH programs with constitutional provisions which include the devolved system of governance with distinct mandates between the national and county governments and increased focus on quality and equitable health as a human right enshrined in the Constitution of Kenya, 2010;
2. Urgent need to formalise and mainstream overarching national RH priorities, including focus on Universal Health Coverage (UHC), NCDs, Kenya's commitment to the attainment of the Sustainable Development Goals (SDGs)
3. Dwindling financing – Kenya is now classified as a middle-income country and this has affected resource mobilization with more emphasis going to domestic financing of health programmes including RH;
4. Increased need for RH services with a high population of adolescents, large proportion of aging population, emerging conditions such as NCDs previously unforeseen existential threats like COVID19 Pandemic, all these in the canvas of persisting suboptimal RH outcomes in Kenya;
5. Challenges in partner coordination, alignment and stakeholder management in the context of RH.

1.3 Methodology

This RH policy was developed using a participatory mixed method approach. The policy development process employed both qualitative and quantitative methods that included but were not limited to: desk reviews, key informant interviews, focused group discussions, systematic review of research evidence and public participation. The consultative process involved both the public, private and non-state actors at both National and county level led by the Ministry of health through a nominated national steering committee operation as indicated in the 2015 national quality management system of the MOH.

CHAPTER 2. SITUATIONAL ANALYSIS

2.1 Introduction

Kenya's human population was estimated at 47.6 million in 2019 within 12 million households, with an estimated household size of 3.9 persons and a life expectancy of 66.4 years (KNBS). The high birth rate and declining mortality rate serves to maintain a population growth rate of 2.2% per year. The high child and youth population bulge present opportunities for reproductive health and economic development. Specifically, there are challenges for responsive reproductive health services to a largely dependent and increasingly young urbanized population in Kenya. Additionally, there is the emerging reality for older population reproductive health services requirement in Kenya with the increased life expectancy. The trend of improving health that is driven by reductions in communicable diseases is diminished by the emerging burden of non-communicable diseases and conditions such as violence, injuries, gender-based violence and cancers. The COVID-19 pandemic, caused by a novel corona virus SARS-CoV-2 has so far proven to be a health system wrecking ball across the world, and is a vivid testimony that new and unforeseen threats can be major setbacks to decades of health gains. Risk mitigation and disaster preparedness must be an integral part of health planning going into the future.

2.2 SWOT & PESTEL analysis

Review of the internal and external environment resulted in the identification of strengths, weaknesses, opportunities and threats with regard to RH in Kenya. These are highlighted in the tables in the next page;

2.3 Performance of Key Indicators on Reproductive Health

The elapsed reproductive health policy 2007 objectives were to: reduce maternal, perinatal and neonatal morbidity and mortality; reduce unmet family planning needs; improve the reproductive health of adolescents and youth; promote gender equity and equality in matters of reproductive health, including access to appropriate services; contribute to a reduction of the

Strengths

- Availability of data to inform strategies and interventions
- Well trained human resource
- Devolved health care services
- Partners committed to the delivery of RH services
- Literate populace who can be educated on importance of RH
- Health as a right in the Constitution and singling out of RH
- Existence of ongoing health programmes like UHC

Weakness

- Low level of prioritization of RH reflected in the resource allocation
- Weak structures for effective advocacy and coordination of RH issues at the county level
- Weak monitoring and evaluation mechanisms
- Inadequate allocation of funds

Opportunities

- Partnership with private sector in the delivery of heath
- Growing investment in the health sector
- Support from UN agencies like WHO
- Existing programmes like UHC; Beyond Zero provide a rich platform for RH mainstreaming in their core roles
- Pilot UHC experiences in county programmes to promote health like in Kitui, Nyeri, Isiolo, Kakamega, Kisumu & Makueni Counties
- High mobile telephone penetrance has created opportunities for digital UHC acceleration.
- Research and learning

Threats

- Competing development needs at the National and County level which affect the delivery of health
- Competition in the health programmes considering the
- Centrality of RH in other health Programme
- Reclassification of Kenya as a middle-income economy and changing donor priorities
- Management of HR in the health sector and the rising number of industrial relations which affects service delivery
- Emerging Pandemics like Covid-19
- Insecurity and tribal clashes

Figure 1: SWOT Analysis

PESTEL ANALYSIS	
Political factors	• Corruption • Legislative priorities • Government stability • Suboptimal Human resource for health (HRH)
Economic factors	• Economic growth inconsistency • Budgetary deficits at National and county levels • Growing National debt • Over-dependence on foreign support
Social factors	• Harmful socio-cultural practices (violence against children; FGM, Child marriage) • Inadequate distribution of social services (UHC) • Religious and cultural extremism.
Technological factors	• ICT advances with the possibility of developing and adopting technologies to advance and promote access to essential services.
Environmental factors	• Adverse environment negatively impacting RH • Climate change - fueling conflict • Vested interests in RH advocacy leading to a skewed environment.
Legal factors	• Law enforcement – e.g. on FGM • Contextual conflicts of international instruments

Figure 2: PESTEL Analysis

HIV and AIDS burden and improvement of the RH status of infected and affected persons; reduce the burden of reproductive tract infections (RTIs) and improve access to, and quality of, RTI services; reduce the magnitude of infertility and increase access to efficient and effective investigative services for enhanced management of infertile couples; reduce morbidity and mortality associated with the common cancers of the reproductive organs in men and women; address RH-related needs of the elderly; and address the special RH-related needs of people with disabilities. The following subsections provide a performance review of key indicators on reproductive health rights in Kenya.

2.3.1 Reduce maternal, perinatal and neonatal morbidity and mortality

Utilization of Antenatal Services:

Coverage of the first visit of antenatal care (ANC) was nearly universal with over 95% of pregnant women making at least one ANC visit (KDHS 2014, KNBS). The proportion of pregnant women who made 4 or more ANC visits was much lower but increased from 47% in the KDHS 2008/09 to 58% in

2014. In between the population-based periodic surveys, service statistics from the DHIS2 showed an increase from 32.6% in 2017 to 53% in 2021.

Skilled Delivery

Health facilities births which are taken as a proxy for the skilled birth attendance increased from 43% (KDHS, KNBS 2008/09) to 61% (KDHS2014 KNBS), this increase resulted in an attendant rise in Caesarean section rates from 7.6% to 9.5% almost entirely the result of more women delivering in health facilities. The KHIS data (Figure 4) supports a similar upward trend in skilled birth attendance and caesarian section rates since the last KDHS to date same trend as in Caesarean section deliveries from 14.5% in 2017 to 16.2% in 2021

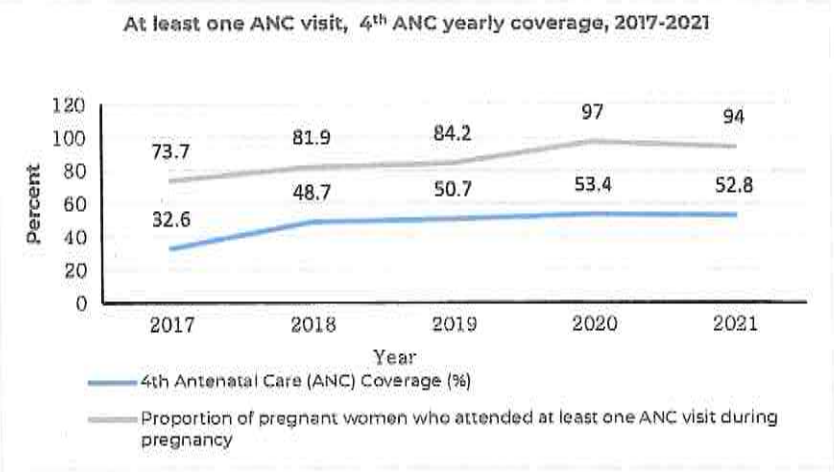


Figure 3: ANC Coverage

However, the changing trend is not homogeneous across the country when compared across the 47 counties. The continued decline of institutional maternal mortality ratios could suggest that health facilities were able to keep up with the increased utilization of these facilities for birthing services.

Post-natal care

Postpartum care is a key strategy to enhance maternal and newborn health and reduce deaths. However, utilization of postnatal care services in Kenya has remained low. The 2014 Kenya Demographic Health Survey reports that only 52% of women and 36% of newborns receive postnatal care. Low utilization of postnatal care leads to missed opportunities for early diagnosis and management of common puerperium and newborn complications or conditions, low rates of repeat maternal HIV testing and initiation of antiretroviral drugs for treatment and prophylaxis in HIV exposed infants as

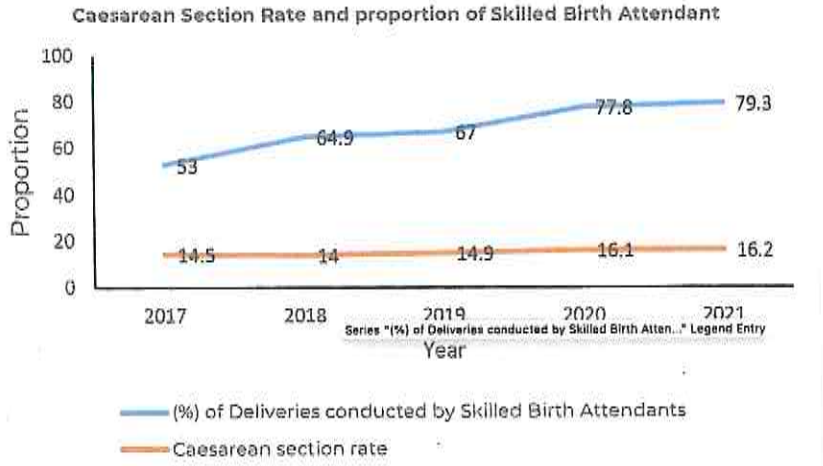


Figure 4: Skilled birth attendance

well as low uptake of contraceptives.

Maternal Mortality

The population-level maternal mortality ratio reduced from 520 per 100,000 live births (KDHS, 2008 -2014, KNBS) to 362 per 100,000 live births, maintaining a trend since 1993 as shown in figure 5.

In between the periodic population-level survey, service statistics from the KHIS data also showed a progressive decline in Health Facility Maternal Mortality ratios from 130 per 100,000 live births in 2013 to 95 per 100,000 live births in 2019. The continued decline in institutional maternal mortality ratios suggests that health facilities were able to cope with the increased utilization of skilled birth services. As a quality measure, maternal death audits in Health facilities have increased from 89.5% in 2018 to 96.9% in 2021 due to improved monitoring and reporting. The top five direct causes of maternal deaths were hemorrhage, hypertension in pregnancy, infections/ sepsis, obstructed labour and post abortion complications (CEMD, MOH, 2017[30]).

Pregnancies with abortive outcomes regardless of the cause, method or rationale, carry a significant risk of morbidity and mortality and thus this policy will strengthen health systems to mitigate morbidity and mortality from post-abortion complications while minimizing preventable causes of abortion. This policy expands the management of pregnancy to include holistic management, and psychosocial support for pregnancies compounded by a crisis. Specific guidelines mainstreaming pregnancy-

30 CEMD, MOH, 2017

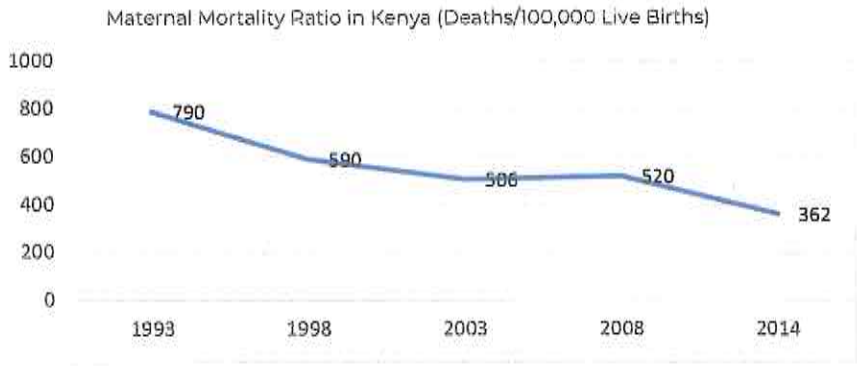


Figure 5: Maternal mortality Ratio in Kenya (Deaths/100,000 live births)

related crisis management and standardizing the practice of managing crisis in pregnancy shall be formulated to fully operationalize this policy direction.

In their conceptual framework, Thaddeus and Deborah articulated the three-delay model[31] of the causes of maternal deaths; 1st delay is the decision to seek care, 2nd delay is in reaching a health care facility and 3rd delay is receiving appropriate treatment and management. The Three Delays Model demonstrates that maternal mortality is not solely due to poor quality of health care but is a result of interwoven factors in the community, health care system, and other socio-economic variables, and this model continues to guide priority investments to address causes of maternal deaths.

Perinatal Mortality

Perinatal mortality rate had decreased from 37 deaths per 1,000 pregnancies reported in the 2008-09 KDHS to 29 deaths per 1,000 pregnancies in KDHS 2014. Data from KHIS showed overall institutional stillbirth rate declined from 23 to 21 per 1000 births in 2017 and 2018 respectively, and 20 to 19 per 1000 births in 2019 and 2020. The fresh stillbirth rates which is an indicator of quality-of-care also had a decline from 13 to 11 per 1000 births in 2017 and 2018 and 10 to 9 in 2019 and 2020. The main causes of perinatal mortality are prematurity, birth asphyxia, sepsis and respiratory distress syndrome.

2.3.2 Reduction of Teenage Pregnancy

The rate of teenage pregnancy has remained unchanged over the decades at a rate of about 18% and remains an ongoing concern for the nation.

31 Thaddeus, Sereen, and Deborah Maine. "Too far to walk: maternal mortality in context." Social science & medicine 38.8 (1994): 1091-1110

This policy recognizes the multiple players and prongs that intersect in teenage pregnancy as well as the social and cultural contributions to the same. This policy shall prioritize scientific effective interventions to reduce teenage pregnancy and motherhood in a multi-sectoral collaborative and enforcement approach.

2.3.3 Reduction in unmet family planning needs

Kenya Demographic Health Survey, 2014 reported a dramatic increase of use of modern contraceptives among currently married women 15-49 years during the 5 years, increasing from 32% in 2003 to 39% in 2008/09 and 53% in 2014 with significant disparities between counties. PMA 2020 data indicates mCPR continues to increase now standing at 60% among married women of reproductive age (MWRA). The percent of demand satisfied by modern method has increased from 64% in 2008/09 to 71% in 2014 among currently married women. There is minimal rural-urban variation in current modern contraceptive use by married women 15-49: 51% and 51% respectively. Women in the poorest wealth quintile however had much lower contraceptive use (29%) than all other quintiles where use ranged from 54-60%. Figure 6 below shows this trend.

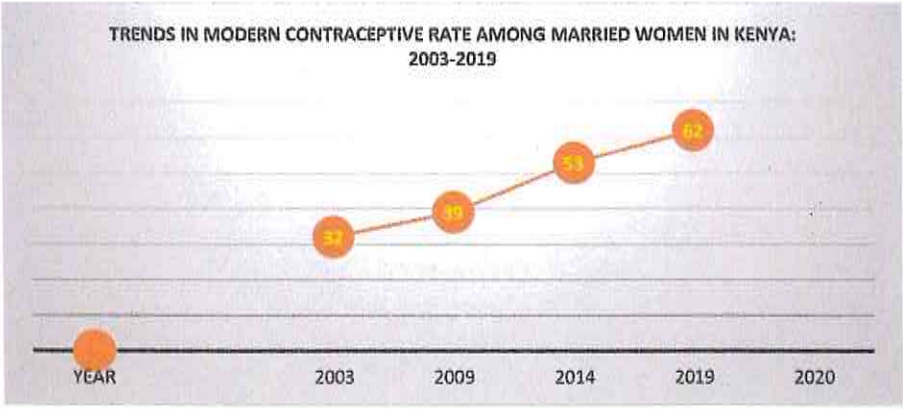


Figure 6: Trend in modern contraceptive rate among married women in Kenya: 2003-2019

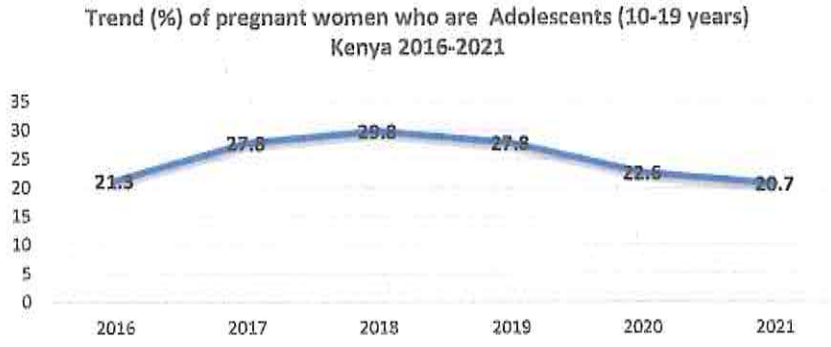


Figure 8: Trend of percentage of pregnancy women who are adolescent

2.3.4 Adolescent/Youth Reproductive Health

Adolescent health constitutes an ongoing challenge. Childbearing begins early in Kenya, with almost one-quarter of women having given birth by age 18 and nearly half had started childbearing by age 20 when asked at the KDHS. Age specific fertility rate for 15-19-year-old has decreased from 103 in 2008/9 to 96 in 2014[32]. However, the proportion of adolescent women age 15-19 already mothers or pregnant with their first child at the time of the KDHS survey remained unchanged from 18% reported in 2008/9.

A recurring challenge has been the failure to develop a dignified transition from childhood to adolescent and onto young adulthood including parenting and guardian support. The majority of reproductive health challenges facing adolescents and young women are related to this gap in programming. A significant proportion of young people continue to have incorrect perception or invisibility of their risks to early sexual debut; acquiring sexually transmitted infections, HIV, alcohol, drug and substance abuse as well as negative impact of social media. This suggests a need to promote programmes that will reverse this pattern over time including support during the transition of cognitive maturity and limited decision-making capacity as minors. Related to this is a need to clarify the age of consent for the various RH interventions in view of the varied provisions in different guidelines and lack of explicit legal pronouncements on the same. Structural prevention interventions such as protection from pornography, keeping children and young people in school or gainful engagement, free sanitary towel programs for girls, cash transfer social protection programs, physical protection corridors – after school transit programs, safe houses and justice for minors who are SGBV survivors are suboptimal.

32 KNBS 2010, 2015

2.3.5 Gender issues and reproductive health rights

Gender-based violence is prevalent in Kenya. According to KDHS 2014, 45 percent of women aged 15-49 had experienced physical violence and 20 percent had experienced physical violence within the 12 months prior to the survey compared to 39 percent and 24 percent respectively in 2008. KDHS 2014 further estimated that 44 percent of men age 15-49 experienced physical violence and 12 percent experienced physical violence within the 12 months prior to the survey. The main perpetrators of physical violence against women were husbands; whereas, the main perpetrators against men were parents, teachers, and others. 14 percent of women and 6 percent of men age 15-49 reported having experienced sexual violence at least once in their lifetime. Overall, 39 percent of ever-married women and 9 percent of men age 15-49 reported having experienced spousal physical or sexual violence. Among women and men who had ever experienced spousal violence (physical or sexual), 39 percent and 24 percent, respectively, reported experiencing physical injuries. 44 percent of women and 27 percent of men sought assistance from any source to stop the violence they experienced.

Female Genital Mutilation, a form of GBV is rampant in Kenya with a national average prevalence of 21% nationally with some counties having a prevalence of over 90%. Child marriage also persists in Kenya. The Kenya health information system (KHIS) has in the recent 5 years collected data on routine SGBV service in health facilities across the country. Only 1% of the sites report routinely and the quality of services based on reported data for cases seen is suboptimal going by the cases of emergency contraceptive, post-exposure prophylaxis (PEP) for HIV interventions given to those in need, mental health interventions and trauma support to survivors.

The violence against children national survey in 2019 in Kenya indicated that in the previous 12 months, 13.5% of females and 2.4% of males ages 13-17 experienced sexual violence often by persons known to them.14 56.7% of 13-17year-old females who experienced any incident of sexual violence in the past 12 months told someone about their experience. Only three in ten (31.8%) 13-17-year-old females who experienced sexual violence in the past 12 months knew of a place to seek help. Among 13-17-year-olds, about 36.8% females and 40.5% males experienced physical violence in the past 12 months. 42.4% of females and 31.4% of males were physically injured as a result of the violence. Only 6.0% of females and 5.7% of males sought help for an experience of physical violence, and 4.4% of females received help.

Children and adolescents (boys and girls) who suffer sexual abuse are more likely to be exposed to physical injury (including death) unintended pregnancy, post-abortion complications, sexually transmitted infections including HIV, and mental health complications (11). Child and Sexual abuse; Raising awareness and empathy is essential to promote a new public health response (3).

While health is the priority at the time of experiencing sexual and gender violence, access to justice after the ordeal is essential in ensuring survivors' recovery and integration into the community without stigma and discrimination. Significant work remains undone to ensure effective, well-coordinated integrated coordination and response mechanisms that ensure survivors receive the appropriate support

2.3.6 HIV and AIDS and Sexually transmitted infections

HIV prevalence has remained stable at about 5% for the last 5 years with geographical variation ranging from a low of 0.4% in Wajir to a high of 26% in Homa Bay. The country achieved 20% reduction on sexual transmission of HIV and 49% reduction of new infection among children. The advances in HIV treatment is manifested by an aging population of people living with HIV. There has been expansion of the prevention of new HIV interventions including expanded coverage of Voluntary Male medical circumcision (VMMC), Pre-exposure prophylaxis (Prep) and other combination prevention approaches. However, there is the continuing trend of high prevalence of new infections among young people. In 2016, adolescent girls and young women accounted for 51% of the new HIV infections among adults a sharp rise from 29% in 2013. This was both proportionate and absolute increase in number of new infections. Targeted interventions are needed for adolescents 15-24 years in order to tackle increasing new HIV infections. Additionally, a final push is needed to eliminate mother-to-child transmission and increase the proportion of pregnant women who receive anti -retroviral for HIV from 91% in 2018 to near or 100%.

Progress towards validation for elimination of MTCT of HIV

Kenya has committed to eliminate MTCT of HIV and is part of the global accountability target-based validation mechanisms for elimination of MTCT of HIV. In 2015 more than half (24) of the 47 counties significantly reduced their new HIV infections among children. The trend in declining MTCT transmission of HIV have reversed, with 2018 estimates at 12.8%, up from 6.7% in 2016. These worrying trends are not limited to MTCT of HIV. In the same review, an estimated 0.3 million women had not initiated antenatal care while only half of those who initiated achieved 4 visits, and 0.5 million women did not access an HIV test. Inadequate quality of health services was the biggest contributor to infant infections, identified positive women not given ART and poor ART adherence during pregnancy and breastfeeding and new infections during breastfeeding. Most of these infant infections could be averted with greater fidelity and rigor to implementing MNCH-PMTCT care package and HIV transmission prevention protocols.

2.3.7 Cancers of reproductive organs

The three cancers with the highest number of newly diagnosed cases in Kenya affect the breast, the cervix and the prostate. GLOBOCAN 2020, estimates show that cervical cancer causes the highest mortality at 12% and among the top 10 cancers in Kenya, slightly higher than breast cancer which was at 11.5 %. Screening for reproductive organ cancers for men and women has remained low. The recommended screening cycle for cervical cancer in Kenya is every 5 years for women aged between 25-49 years with the exception of HIV-positive women who should be screened annually. Cervical cancer screening has remained quite low. In the KDHS 2014, only 18.8% of women 25-49 years had ever had cervical cancer screening. In STEPS 2015, cervical cancer screening coverage rates were similarly low, with 14.2% of women 25-49 years ever screened. Kenya has rolled out universal school-age girls HPV vaccination program after a successful pilot phase.

2.3.8 Infertility and sexual dysfunction

In Kenya, it might be assumed that most married couples with no births are unable to physiologically bear children. The fulfillment of fertility desires is a fundamental human right relevant to the achievement of the International Conference on Population and Development (ICPD) call to action and sustainable development goals (SDGs). However, millions of people are unable to realize this right for a variety of reasons, including infertility. A majority of gynecological consultations are related to infertility. While the underlying challenge may half of the time be associated with the male or the female partner, due to the high level of stigma the data available is mostly among women. The percentage of women who are childless at the end of the reproductive period is an indirect measure of primary infertility (the proportion of women who are unable to bear children at all). Though primary infertility is less than 2 percent (KNBS, 2015), there is a burgeoning population of families affected by secondary infertility affecting close to a third of families, putting an urgent case for specific measures to assist couples to raise their desired family size. The prevalence of sexual dysfunction is not established and there is limited access to formal health services to address it. There is stigma and shame in society associated with sexual dysfunction. As a result, most Kenyans are exposed to over-the-counter drugs which are poorly monitored self-medication in an attempt to enhance sexual performance which exposes them to life-threatening adverse effects.

2.3.9 Menopause and andropause

While there has been an increase in life expectancy over the past decade, little has been achieved in terms of addressing geriatrics health including reproductive

health challenges. Men's health clinics and workplace health programs targeting men in their different cohorts have been suboptimal. Additionally, there is limited data on the needs and response landscape that hampers any investment in this area. With the increase in non-communicable disease burden, it is also critical that related issues in the context of reproductive health are well integrated and addressed to ensure healthy and dignified aging.

The National Government in consultation with County Governments shall establish Wellness Centres to serve elderly men and women's reproductive health needs and provide preventive services in a life-course approach.

2.4 Policy Implementation Environment

1. The ICPD25 commitment for Kenya by 2030 is zero maternal deaths, zero unmet needs for family planning and zero gender-based violence and harmful practices by 2022. This RH policy creates the enabling environment to realise these three zeroes by 2030.
2. There is a growing population of young people and therefore interventions need to be approached through this lens of scale. Inequitable coverage with RH services among certain areas or population groups, including adolescents need to be addressed.
3. Health governance structures - County RH data uploaded to a national health information management system allows for greater granularity in problem identification, but at the same time courts fragmentation which can be a barrier to rapid scale-up of evidence-based interventions given the many layers and players involved. Health services are provided for by the County Governments. Greater advocacy and capacity building are required at this level to facilitate prioritization of RH and the comprehension that RH is at the centre of human development, healthy individuals, families and communities. There is an opportunity for moving away from piece-meal partner driven implementation of skewed RH interventions to a composite comprehensive domestically funded RH intervention implementation model for the country.
4. Reduced external funding support due to re-classification as a lower middle-income Country. Donor funding of most of the RH commodity has supported the scale up of RH and many individuals, families and communities have benefitted. The lack of substantive government funding makes these programs very vulnerable as observed with the recent rapid downsizing of the PEPFAR funding. Further challenges are expected with reduced external funding support due to re-classification as a lower middle-income country.

5. Provision of health services requires human interaction and the quality of services finally boils down to skills and motivation of the frontline human resource. Greater attention will need to be made to address the perennial employer-worker disputes, strengthening the pipeline of pre-service and in-service training which will enable provision of high quality, evidence-based care. This will address the problems currently faced of poor quality of RH services; inequitable coverage with RH services among certain areas or population groups including adolescents; and supply side challenges due to suboptimal functioning of the health systems (infrastructure, human resources for health (HRH), supply chain, health financing, health Information, and leadership/governance).

6. Demand side barriers that limit access and utilization of RH services such as long distances to health facilities, high costs, religious and socio-cultural beliefs and practices need to be addressed. Stigma and shame surrounding sexual and gender-based violence compounded by challenges in accessing other non-health sector interventions derails progress in this area. The lack of clean toilet and safe running water, or even facilities for a warm bath, may deter women from delivering at a facility, increase risk of infections and sepsis within the health facilities and deter communities from using services at heath facilities.

7. It is noted that there is stagnation of critical health indicators specifically maternal and newborn deaths. The common causes of death require swift action at higher level health services and success is often dependent on whether one arrives to these able facilities on time. Most maternal complications arise after onset of labour and therefore every community maternity must have the means to safely transport a sick mother and her baby to a higher-level facility in a timely and professional manner. There is an opportunity to develop professional ambulance referral services and to move away from abhorrent practices of giving individuals in distress a referral note and asking the family to organize for referral transport.

8. Quality of care is increasingly emerging as a central pillar for and determinant of health outcomes. Kenya has joined global quality of care and patient safety networks to enhance peer review and accountability in the quality of care given to health service users. Majority of maternal and newborn deaths occurring within health facilities are directly linked to poor quality of care, therefore this policy operates in an environment where quality of care is a primary consideration in any health system design and health service delivery. Quality of RH services at prevention interventions at the community as well as at service delivery in the facility must be upheld and a culture of continuous quality improvement made the norm at every tier of health care. The nascent mechanisms for accounting for

maternal deaths and still births through MPDSR audit systems provide a tremendous opportunity for the health-system and communities to identify the gaps and opportunities for improvement. Quality of care has diverse parameters that also hold the potential to cure inadequate coverage and response to emerging priority issues including but not limited to fertility management, vaccine preventable RH problems, reemerging STI's and novel previously unfathomed pandemics like the currently health system ravaging communicable COVID19 global pandemic.

9. The country has joined the world in implementing Universal Health Coverage. UHC provides a new opportunity of expanding health care, not only with health insurance coverage but also with an expanded essential care benefit package. It is notable that each country must define its model of UHC for its citizens that would work best to protect and advance health of all, and Kenya has embraced the Primary Health Care model with great emphasis on promoting health and preventing disease. The government is revitalising the community health component through an elaborate network of community health units that make sure each of the 12 Million households in the country is accounted for. This hub and spoke model for operationalising UHC creates a tremendous opportunity for equity and rapid expansion of access to RH services to all. To guarantee quality of RH care in this ambitious and necessary era in health for our country, specific guidance on RH will be outlined in this policy, and more guidance will be issued from time to time by the division of reproductive and maternal health, with clear roles and expectations for each cadre of Human Resource involved in the Reproductive Health space in the country. The prevailing mantra of expecting more because one has paid more needs a reflective balance against the accrued harm to the larger population when part of the population is left out. The debate on individual benefit versus public good in access to RH needs to be more deliberate to enable us as a nation do the best possible within the resources that are available.

10. Innovation is a major piece of accelerating and contextualising RH interventions. The COVID19 pandemic, that started in Wuhan city of china and is tearing down health systems globally, has called for bold innovative measures to protect the gains made including for RH. Kenya has a high mobile phone penetrance and this policy will deliberately be tapping into this telemedicine platform to expand access to quality public literacy on RH, link the public to accredited health care providers and service delivery points and trigger coordinated emergency response as needed. It is important that even higher standards of expertise and professionalism be employed throughout the continuum of care on the telemedicine platform, with emphasis on data confidentiality and rigorous protection of the constitutional right to the highest standard of health care.

CHAPTER 3. POLICY DIRECTION

3.1 Policy goal and overarching statement

OVERARCHING POLICY STATEMENT

The Government of Kenya will guarantee universal Reproductive Health coverage and equitable access to all persons in need and requiring RH care in the country. The government will play its fiduciary role by ensuring this RH care and services are of the highest possible quality and standard. RH interventions will employ a life course approach that will be facilitated by a multisectoral collaboration and will pay close attention to social, cultural and religious competency, while exalting the central role of the family unit in all matters Reproductive Health that is inherent to the Kenyan people.

This policy is cognizant of the undisputed opportunity offered by the adolescence period to shape lifelong reproductive health trajectory of an individual and shall emphasize protecting adolescents from premature entry or retention into sexual and reproduction acts that often burden the individual with lasting health and socioeconomic sequelae. The policy shall emphasize delaying sexual debut, preventing sexual and reproduction abuse of minors and rehabilitating adolescents initiated into premature sexual and reproduction acts. Kenya shall promote competency based programming on matters of sexuality and reproductive health respecting the level of cognitive maturity and attainment of social competency on matters of sexuality and reproduction for adolescents. These complex developmental transitions are often not fully achieved until the age of 21 years. Recognizing that persons with Disability (PWD) have special RH needs, this Policy shall prioritize integration of RH services that are responsive to the needs of PWD.

OVERALL GOAL

To minimize the burden of preventable morbidity and mortality related to reproductive health

3.2 RH policy objectives

Broad objectives

1. To achieve universal coverage of quality and comprehensive Reproductive Health interventions across the country
2. To improve responsiveness to client's reproductive health needs
3. To strengthen the enablers (Health Systems Building Blocks) for Reproductive Health, including aligning partnerships and collaborations

Specific objectives

In keeping with the broad objectives of the policy, the specific sub-objectives to be addressed by this policy are detailed in this section.

Broad objective 1. To achieve universal coverage of quality and comprehensive Reproductive Health interventions across the country;

Sub objectives;

i. To reduce maternal morbidity and mortality due to obstetric haemorrhage, sepsis, hypertensive disorders, obstructed labour and post-abortion complications.

ii. To reduce perinatal morbidity and mortality due to prematurity, birth asphyxia, sepsis and respiratory distress syndrome.

iii. To reduce unmet need for family planning.

iv. To reduce the burden of reproductive tract infections (RTIs) through improved access to quality Reproductive Tract Infection prevention and management services.

v. To reduce the burden of HIV and AIDS and eliminate mother to child transmission (eMTCT) of HIV.

vi. To reduce morbidity and mortality associated with the common cancers of the reproductive organs in women and men.

vii. To harness digital technology to integrate evidence-based platforms such as telemedicine and self-care to ensure access to RH care to all.

Broad objective 2.

To improve responsiveness to client's reproductive health needs:

Sub objectives;

i. To mainstream special RH needs of marginalized groups, persons living with disabilities, elderly persons, people in humanitarian settings, and correctional institutions.

ii. To promote gender equity, address Female Genital Fistula (FGF), eliminate FGM and eradicate all forms of gender-based violence and harmful reproductive health practices by 2030.

iii. To improve reproductive health outcomes among adolescents and young people

iv. To improve Menstrual Hygiene Management for girls and women.

v. To reduce the magnitude of infertility and increased access to management of infertile couples.

vi. To ensure that persons born intersex attain the highest standards of reproductive health.

Main objective 3.

To strengthen the enablers (Health Systems Building Blocks) for Reproductive Health:

Sub objectives;

To promote a robust RH implementation environment especially data systems, research for development, innovation, human resources for RH, partnerships and collaborations

3.3 Scope of the RH policy

The National Reproductive Health Policy is complementary to existing policies on Reproductive Health, and shall be the primary reference document on matters concerning Reproductive Health in Kenya. It includes all persons in Kenya including children, adolescents, young persons, adults and older persons in need and requiring RH interventions including children, adolescents, adults and older persons. It will serve as a guiding and organizational framework to promote RH and guide all RH-related policies, design of programmes and interventions across all actors by all stakeholders working in Kenya.

3.4 Policy Thrust

3.4.1 To reduce maternal, perinatal and neonatal morbidity and mortality

1. All women of reproductive age (WRA) shall have adequate access to quality reproductive health care that is respectful and provides a positive care experience for them and their families.
2. This policy seeks to ease financial barriers hindering access to basic Reproductive Health services through the Universal Health Coverage and other Social Health Protection frameworks for all Kenyans.
3. All mothers and their babies who require emergency treatment and /or referral shall be supported with the necessary requisite expertise and resources to access quality emergency care.
4. Every woman with pregnancy-related conditions must be clinically evaluated by a qualified, experienced and registered nurse-midwife, clinical officer, medical doctor or obstetrician-gynecologist within the shortest feasible time, as per the prevailing guidelines, of presenting to any health facility.
5. Essential reproductive health commodities and supplies including; uterotonics, uterine balloon tamponade and non-pneumatic anti-shock garment (NASG) devices, blood supplies, anti-hypertensive, ARVs, antibiotics, Family Planning commodities including contraceptives and fertility treatment medications shall be classified as national strategic commodities and adequately funded from domestic resources.
6. Every maternal and perinatal death shall be notified within 24 hours and audited within 7 days at the facility, while those occurring in the community shall be notified and audited within 30 days and the recommendations actioned within one calendar month of submitting a report to the primary duty bearer. Maternal and perinatal death Reports shall promptly be uploaded to the KHIS portal and a copy of action/no action on audited deaths securely delivered to the Director-General for Health not later than 60 days from the death incidence.
7. All maternity and MCH units shall have functional quality improvement teams and services audited annually as per the set norms and standards.
8. Expand access to preconception care including screening, counseling and management of pre-existing conditions.
9. Increase access to skilled post-partum care.
10. Integrate Maternal Mental health into all Maternal and Newborn Health services.

11. Accord access to quality and comprehensive diagnostic, curative and rehabilitative services without attendant financial burden to girls and women with Female Genital Fistula (FGF).

12. Termination of pregnancy shall be performed in an environment meeting the minimum medical standards and guided by the opinion of a trained health professional with the proficiency to ensure both the mother and her unborn child receive the highest attainable standard of healthcare.

3.4.2 To reduce unmet family planning needs;

Preamble on FP:

Family planning is a premier investment in reducing reproductive health morbidity and mortality. A couple that has achieved their desired family size is not only more likely to be a stable family unit but is also likely to be a better empowered socioeconomic pillar for the nation. Family planning is a national security issue and as such, every effort will be made to free the country from external dependency and undue influence on this crucial element of a nation's sovereignty.

1. Ensure appropriate costing and ring-fencing of allocated funds for RH programs in the national and county budgets including funding for FP commodities and services;
2. Rationalize the provision of FP method mix and services to ensure cost-effectiveness and align commodity quantification to the Kenya UHC model of PHC, and support the country's transition to full domestic financing of family planning
3. Decentralize FP service delivery at all levels of health care as per set norms and standards, specifically support informed initiation, correct use, refills and community distribution of self-care family planning methods including the pills, vaginal rings, patches, condoms, fertility awareness and to the extent systems have been established, self-injectable contraceptives.
4. To expand access and align with the Kenya UHC model, skill-intensive contraceptive methods including surgical methods and long-acting reversible methods, in addition to being offered in family planning clinics with the resources and expertise to initiate, offer and follow up on the users of these methods, the county governments will explore entering into contracts with and commissioning local medical practitioners to provide specified methods and volumes of contraceptives services in the respective communities.
5. Ensure the safety and positive care experience for women and men accessing FP interventions
6. Mainstream HIV and STI prevention in every FP intervention at all levels of healthcare and for all clients

3.4.3 To reduce the burden of reproductive tract infections (RTIs) and improved access to, and quality services;

1. Enhance community awareness of the impacts of RTIs, including non-sexually transmitted endogenous RTIs, on reproductive health,
2. Ensure integrated, high-quality RTI services at all levels, including strengthened capacity for screening services for all ages including neonates and old persons;
3. Encourage generation of information and research on RTIs;
4. Ensure that STI prevention and control approaches contribute to HIV prevention;
5. Ensure adoption of proven new modalities of prevention and treatment of reproductive tract infections when available, especially for viral infections.

3.4.4 To reduce the HIV and AIDS burden and accelerate reversal of mother to child transmission of HIV;

1. Integrate HIV and AIDS control in Reproductive health;
2. Ensure all pregnant women and their families are tested for HIV and those HIV infected access quality HIV care and treatment including ARVs

3.4.5 To reduce morbidity and mortality associated with the common cancers of the reproductive organs in men and women

1. Increase availability of high-quality services for the prevention, early detection and management of cancers of reproductive organs, as appropriate at all levels
2. Recognizing that cervical cancer is a leading cause of death among women, and is almost entirely preventable if detected early, all levels of government shall appropriate resources to guarantee each sexually active WRA aged 25 years or more is offered, or referred for, a free cervical cancer screening test linked to accredited pathology referral and reporting system, and specialist care as may be needed.
3. Enhance programmes that advocate for, create awareness of, and sensitize the community on cancers of reproductive organ including the voluntary national free HPV vaccination program
4. Promote research on all aspects of cancers of the reproductive organs
5. Promote the collection and utilization of data on cancers of reproductive organs in both men and women of all ages.
6. Promote screening for Prostate cancer for men of 40 years and above at all levels.

3.4.6: To harness digital technology to integrate evidence-based platforms such as telemedicine and self-care to ensure access to RH care to all;

Create enabling environment to utilize regulated telemedicine as a valid universal low-cost platform for expanding access to quality RH information services.

3.4.7: To mainstream special RH needs of marginalized populations [persons living with disabilities, elderly, people in humanitarian settings and correctional institutions].

1. Prioritize reproductive health educational programs that are responsive to the needs of the marginalized populations including the use of health education materials in BRAILLE and SIGN language and other appropriate means of communication.
2. Promote positive social-cultural values of recipient communities to inform the design and framing of reproductive health programs and initiatives for marginalized populations.
3. Ensure inclusivity of marginalized populations in reproductive health social accountability processes.
4. Encourage the generation of routine information and research on RH among marginalized populations.
5. Enhance programs that advocate for and target comprehensive RH interventions for marginalized populations.

3.4.8: To promote gender equity, address Female Genital Fistula (FGF), eliminate FGM and eradicate all forms of gender-based violence and harmful reproductive health practices;

1. Recognizing that a person attains complete full cognitive competence on matters of sexuality and reproduction at the age of 21, the government will prioritize abstinence and delayed sexual debut for persons yet to attain full cognitive competency.
2. The Ministry of Health is committed to ending Female Genital Mutilation (FGM) by 2022 in alignment with Kenya's National FGM policy and strategy for the Abandonment of Female Genital Mutilation. Further, the MOH upholds the "do no harm" principle and emphasizes provision of quality prevention and care services in a manner guaranteeing the highest quality of health care to all who seek health care services within the Republic. All Health care service providers in the country are expected to offer prevention of FGM as well as appropriate care of its complications, and any health care provider who practices FGM, within or without a

health facility, or facilitates cross border practice of FGM is liable to severe deterrent disciplinary and regulatory measures.

3. Resource and enhance generation and utilization of routine information and research on Female Genital Fistula, Female Genital Mutilation and Sexual Gender-Based Violence.
4. Integrate into RH interventions the laws and statutes that protect children's life, health, social welfare, dignity, physical and psychological development from harmful cultural practices and normalization of harmful antisocial habits.
5. Advocate for the enforcement of the law to protect the children against transactional sex as per the Children Act and Counter Trafficking in Persons Act.
6. Establishment of National RH dialogue day to create awareness on RH issues including reduction of harmful practices.
7. Ensure critical reproductive health services offered to SGBV clients, Female Genital Fistula clients, vulnerable populations including adolescents, people with disability and special groups of vulnerable children (street children, humanitarian situation) shall be offered free of charge across the country as a package in the Linda Mama program.
8. Enforce parental consent, and in the absence of both parents, consent from a guardian or the children's officer acting in the best interest of the child in the provision of RH services, with emphasis on rehabilitation of minors engaged in sexual or reproductive activities into protective safety corridors such as school re-entry, child rescue programs, or cash for transfer programmes to facilitate exit from the vicious cycle of child sexual abuse and repeat premature childbearing.

3.4.9: To improve sexual and reproductive health outcomes among adolescents and youths;

1. Establish a universal reproductive health literacy framework for the population, which will ensure adequate age-appropriate RH information and awareness for all persons including adolescents and young people.
2. Support sensitization and implementation of education re-entry policy that is supportive of teenage mothers and their infants.
3. Advocate for the implementation of the school health policy on revitalizing health services delivery in schools and youth-friendly services in health facilities to improve access to information and services.

4. Strengthen and scale up social protection for poor and vulnerable groups among teenagers, the disabled, street teenagers, orphans, young people in humanitarian settings and informal settlements
5. Strengthen programs in schools and colleges through a multi-sectoral approach targeting sexual and gender-based violence
6. Advocate for the mainstreaming of child protection programs and sexual violence prevention programs into learning institutions, workplaces and religious settings to deter exploitation of children and young people.
7. Ensure that all RH interventions for children (under 18 years) including matters of consent and ascent shall be aligned to the provisions in the law of the land which places the responsibility to parents, guardians and government; and must be premised on the best interest of the child, of which continued sexual exploitation and sustained opportunity to premature parenting are not in the best interest of the child (Constitution of Kenya 2010 (Article 53 (2), Children's Act revised edition 2018 (2001), Section 9 and 4(2).
8. Advocate for multi-sectoral promotion of parenting skills in line with the provisions of Article 53(1) (d) and (e) Constitution of Kenya 2010, and the Children Act to minimise parental neglect of children. This will entail, but will not be limited to, supporting, resourcing and promoting objective parenting competency and parenting mentorship programs.

3.4.10: To improve Menstrual Hygiene Management for girls and women;

The MOH recognizes the need to improve women and girls' quality of life by not only ensuring safe, affordable, accessible and hygienic menstrual products but also clean and secure facilities in learning institutions, workplace and public spaces. In alignment with the National Menstrual Hygiene Management (MHM) Policy 2019-2030, menstrual hygiene shall be incorporated in the various Reproductive Health programmes. The RH Policy takes cognizance of the need for collaborative investment and efforts by multiple sectors under the coordination of MOH to ensure successful implementation of MHM programmes in the country.

3.4.11: To reduce infertility and increase access to effective management of infertile individuals and couples;

1. Improve access to quality infertility services at all levels;
2. Promote community awareness on infertility, especially among males;
3. Encourage research on all aspects of infertility

4. Recognizing the rising burden of Primary & Secondary infertility. Integrate fertility care into STI prevention and treatment.
5. Finance establishment, certification and regulation of fertility care centres in the country and fully finance at least one cycle of assisted fertility treatment (ART) per needy desirous couple through The National Treasury and The National Insurance Fund
6. Support couples of the opposite sex establishing or furthering a family, who for gynaecological reasons it has been established cannot conceive and sire normally, commission as parents a willing surrogate mother to bear them a child through assisted reproductive technology, without monetary inducement except for the costs agreed to cover the entire process from embryo transfer to birth of the baby or otherwise, and as guided by the applicable laws and policies on surrogacy. The Cabinet Secretary for Health shall establish specific guidelines to bring into effect this policy direction.

3.4.12: To ensure that persons born intersex attain the highest standards of reproductive health.

1. Sex definition in Kenya is retained as Female or Male, but with a recognition that intersex is a disabling developmental state presenting with ambiguous genitalia at birth. Intersex can manifest variously from true intersex to normal variants of either the Female or the Male sex marker, which is highly medically and socially disruptive to the individual and the family. This policy recognizes and protects the constitutional rights of persons born with intersex, specifically outlawing discrimination and inhumane treatment targeting such persons, including forced premature medical sex reassignment. This policy lays the groundwork for resourcing a national avenue for scientifically and professionally guided intersex transition to a definitive sex identity.
2. The government shall constitute a multi-disciplinary team to confirm diagnosis, treatment and rehabilitation for the intersex child. The government shall create awareness as to the condition of persons born with ambiguous genitalia (intersex) to the child, the parents and the community
3. The medical procedures of persons born intersex are highly specialized, multidisciplinary, medically complex and carry significant life-threatening risks. The benefiting person often needs lifelong care and support even after the corrective medical procedures. Therefore, caution before, during

and after surgery must be employed and these procedures be deferred to an opportune time after puberty and attaining the age of majority when a person born with intersex is counselled, grants informed consent and is facilitated to present before a professional body dedicated, and resourced by the state to facilitate medical– and social transition to the actual sex.

4. On developing secondary sexual characteristic post puberty that reveal a different sex than that determined by medical experts previously, an intersex person shall receive a medical report from the professional body mentioned in 3.4.11 (2) above indicating their correct sex. They shall then present the medical report before a registration officer for the purpose of changing their sex in all their formal registration documents.
5. The birth of a child with ambiguous genitalia shall be reported or notified to a government health facility.

3.4.13: To strengthen research development and innovation, and use of research evidence for RH interventions

1. Adopt the '3 ones' principal- one coordination structure, one strategic framework and one monitoring and evaluation platform for implementation of the RH interventions as articulated in this policy
2. The Director-General of Health shall be the custodian of RH research conducted in the Country.
3. The technical division responsible for matters Reproductive Health shall work with the National Health Research Committee as stipulated in the Health Act to develop a priority RH Research agenda, Coordinate research, create RH research registry and repository and support enjoyment of benefits accruing from intellectual property and RH research by all involved parties.
4. Strengthen County Health Management Teams capacity to implement evidence-based RH programs as articulated in this policy and provide contextual leadership
5. National and County governments should enhance prudent management of existing RH resources from exchequer and collaborate with partners to augment these resources;
6. Map National and County RH partners to harmonize their work with the support they offer in RH policy implementation
7. Leverage on research, technology and innovations.

8. Develop and maintain a RH research repository for the country and publish its contents regularly to maximize research outputs and prioritization.
9. Facilitate issuance of letters of support and MOH collaborations in reproductive health research that clearly include a ring-fenced budget line for direct capacity building for MOH infrastructure, equipment and human resource for Reproductive Health Research and finding dissemination.

CHAPTER 4. POLICY IMPLEMENTATION FRAMEWORK

4.1 Management and Coordination

The Ministry of Health will take leadership in the implementation of this policy in collaboration with all stakeholders at national and county levels through a multisectoral approach. The county governments, other state actors, and non-state actors (NGOs, FBOs, Private Service Providers, private research Institutes and Professional Organizations such as KOGS, NNAK, MAK, KCOA, KMA, KPA, KPS, implementing partners, bilateral partners shall be governed and coordinate by this policy in their RH interventions. The RH policy shall be implemented progressively through development of five-year RH strategic frameworks and annual work plans by the National Government. Its implementation shall also be influenced by a series of documents and strategies, including the Universal Health Coverage Roadmap, the Kenya Essential Package for Health, Health sector Norms and Standards, Partnership framework, M&E framework, other operational documents including County Specific Reproductive Health Strategies, and SAGA specific strategies. An RH policy communication strategy to attain, strengthen and preserve a favorable opinion of the policy to ensure buy-in from all relevant partners and stakeholders will be facilitated.

At National level, management and coordination shall be done by;

a) **Health sector intergovernmental consultative forum (HSICF)**

As provided in the Health Act 2017. The composition includes Director-General for Health and the County Directors for Health. The forum has three main functions as outlined in Section 27(1) of the Health Act 2017. In this regard, the forum shall be used as a platform for mutual consultation, coordination and collaboration on all matters of this Policy.

b) **RH Inter Agency Coordination Committee**

This shall be chaired by the Director-General for Health Services and will bring together heads of department in the MOH: The Head of the MOH DRMH, Heads of different relevant MOH Divisions/Units, including but not limited to NASCOP, Child and Adolescent Health, Nutrition and Health Promotion and several non-state actors providing technical, financial and other forms of Strategic support for RH issues to the MOH, Representative of the Council of Governors

/ Intergovernmental Relations Forum (IGRF) for Health. The Head of the DRMH will be the secretary of the committee. It will be charged with the responsibility of overall policy and strategy development for RH services in the country.

c) The National RH Technical Working Group

This will comprise of selected technical players in academia, research, implementation and industry and will be charged with the responsibility of evidence gathering and synthesis to inform national RH policy and strategy. The MOH DRMH shall provide/undertake a secretariat coordinating role for this TWG and it shall be chaired by the MOH technical Head of Reproductive Health for the country.

d) The MOH RMH committees of experts

This will be charged with the overall responsibility for daily coordinating policy and guidelines development, technical assistance and implementation monitoring for the respective component programs in DRMH as per the organogram (figure 9). The MOH DRMH respective programs shall provide/undertake a secretariat coordinating role for this respective COEs, who shall be answerable to the Head Reproductive and Maternal Health and upon completion of their task, shall submit a report to the Head of the Division of Reproductive and Maternal Health for the necessary action.

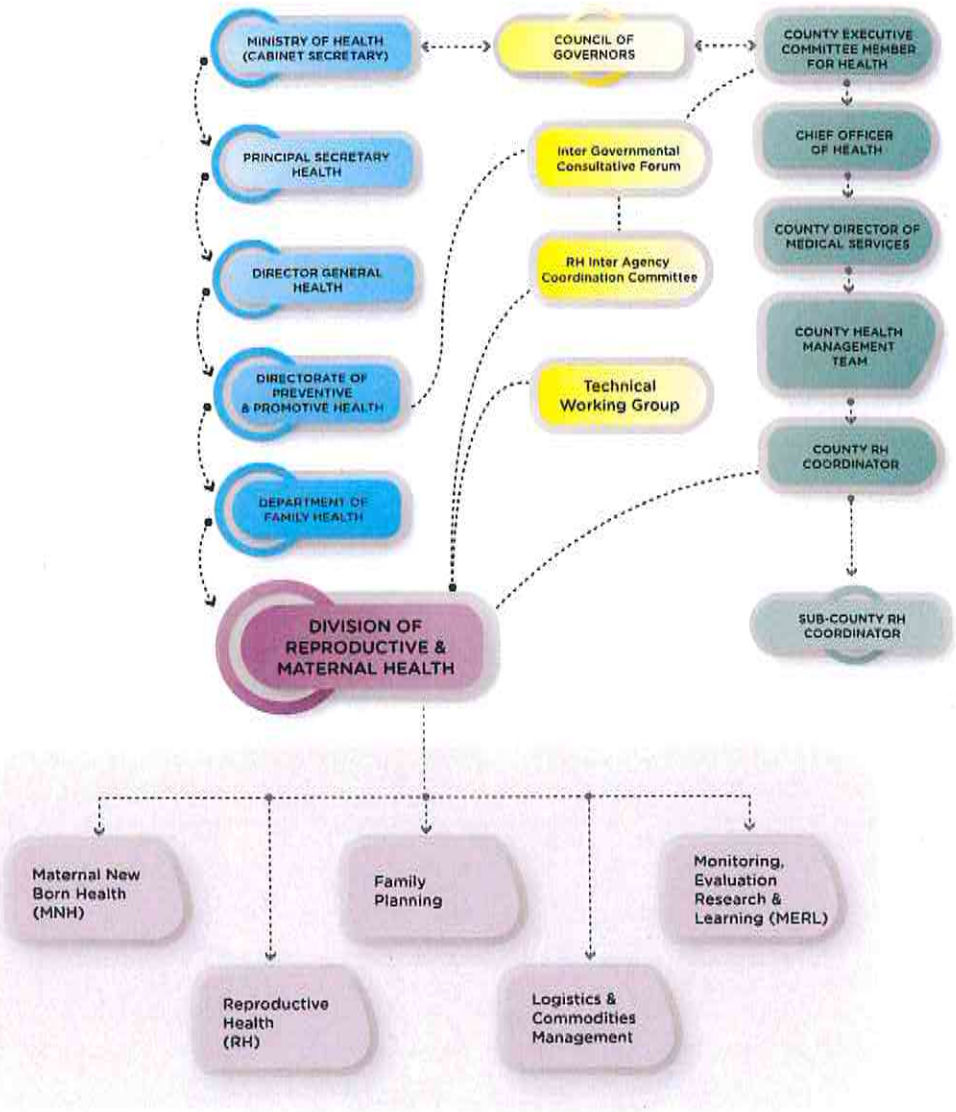
At the county level.

Management and coordination shall be done by the following teams within their prescribed terms of reference by the county governments:

- County Health Management Teams (CHMT)
- Sub-County Health Management Teams (SCHMT)
- Facility Management Teams
- Collaboration and partnerships shall be realized through the Joint County RH Stakeholders' Forum, Sub-County Stakeholders Forum and Community Health Committees.
- The Policy encourages formation of functional RH TWGs at the County level and community dialogue forums for RH in the community units.

Linkage and Coordination between National and County Levels of Government in Policy Implementation

As with the overall health sector coordination, RH matters will be dealt with under the Health Sector Intergovernmental Relations Forum (HSIRF established under



RH Coordination Organogram

the Intergovernmental Relations Act August 2012). For RH, the forum will do the following:

1. Establish systems to address thematic RH issues identified these;
2. Evaluate the performance of the national and county governments in realizing RH policy goals and recommending appropriate action;
3. Monitor the implementation of national and counties' plans for RH;
4. Produce annual reports on national health statistics pertaining to the RH status of the nation, RH services coverage, and utilization;
5. Promote good governance and partnership principles across the RH programs;
6. Consider issues on RH that may be referred to the forum by members of the public and other stakeholders, and recommend measures to be undertaken;
7. In addition, the CoG Health secretariat and the IGRF shall be represented within the National RH Steering Committee.

4.2 Provision of RH services

The Policy shall ensure provision of RH services for all in Kenya. It shall outline levels at which services shall be provided; applicable standards in service provision; and health system requirements for service provision.

4.2.1 Levels of Service provision

The Policy shall ensure the provision of RH services for all in Kenya. It shall outline levels at which services shall be provided; applicable standards in service provision; and health system requirements for service provision.

LEVEL 1: Community Health Services

LEVEL 2: Dispensary/Clinic

LEVEL 3: Health Centre

LEVEL 4: Primary Hospital

LEVEL 5: Secondary Hospital

LEVEL 6: Tertiary Hospital

Facilities operated by NGOs, FBOs and the private for-profit sector shall follow the same classification depending on their level of resources and capacity. The county governments shall be responsible for Level1 to Level 5 services while the national government shall be responsible for Level 6. The referral system will be strengthened to ensure that clients at all levels gain access to appropriate skilled care. The value and role of communities, including representatives from among marginalized groups, will be recognized and their involvement through community accountability mechanisms will be enabled. This will allow communities and citizens to be involved in the planning, delivery and monitoring of RH interventions at the point of use.

4.2.2 Standards for Provision of reproductive health services

In line with Article 43 (1) of the Constitution of Kenya (2010) which states that 'every person has the right to the highest attainable standard of health, which includes the right to health care services, quality reproductive health care' is the right of every person in Kenya. The Policy shall support access to and provision of high quality and affordable RH services at all levels of health service provision by persons sufficiently trained, certified and competent to offer the respective RH service. The standards shall be described further in the intervention specific national guidelines where not spelled in this policy aligned to the national values and laws.

4.2.3 Health Systems Requirements

A functional health system is a key determinant of quality of services. In order to provide efficient, effective and sustainable RH services and deliver on the aspirations in this policy, the following health system building blocks as outlined in the Kenya Health Sector Strategic Plan (2018-2023) are essential and shall be addressed;

1. Health Financing and sustainability
2. Health Leadership
3. Health Products and Technologies
4. Health Information
5. Health Workforce
6. Service Delivery Systems
7. Health Infrastructure
8. Research and Development

4.2.3.1 Health Financing and Sustainability

The Policy recognizes the need to increase financial resources and to put in place sustainability mechanisms for effective and efficient provision of RH services. In this regard, the Ministry of Health shall:

a. Generate and avail evidence to justify resource allocation to RH programs;
b. Expand benefit package of existing insurance and financial protection mechanisms within NHIF, Linda mama programme to address urgent gaps in RH:
c. Require that each pregnancy be registered at the nearest accredited health facility at the earliest opportunity and be enrolled into the government free maternal, new-born and infant health National Hospital Insurance Fund scheme also known as Linda Mama which shall perpetually be financed through the exchequer.
d. Seek increased budgetary allocation for provision of RH information and services at national and county and community levels;
e. Coordinate and harmonize donor support for adolescent RH programs in line with the MOH partnership framework;
f. Expand resourcing avenues and platforms including Public Private Partnerships, research;
g. Improve efficiency and accountability in resource allocation and utilization;
h. Develop and advocate for necessary legal instruments to facilitate operational financing of service in the context of RH delivery at all levels including facilities and community level

4.2.3.2 Health Leadership

Leadership and governance are essential in the implementation of RH policy. This shall align with the defined roles of national and county governments. In this regard, The Ministry of Health shall:

a. Build capacity of health managers at all levels in strategic leadership, health systems and service management for Reproductive health;
b. Strengthen Reproductive Health Training and Supervision (RHT&S) system at all levels for effective provision of reproductive health interventions;
c. Advocate for prioritization of reproductive health in operational plans at all levels of health care system;
d. Continuously monitor the trends in RH at all levels;
e. Establish and strengthen partnerships and collaboration for successful RH.

4.2.3.3 Health Products and Technologies

Health products and technologies are essential in the provision and fast-tracking access to RH interventions. In this regard, the Ministry of Health shall:

a. Ensure equity in access to essential RH products and technologies in health facilities at all levels;

b. Ensure linkage with other policies on the procurement system and commodity supply chain;

c. Ensure linkage with institutions offering quality assurance of all medical RH commodities;

d. Expand and encourage innovation in the use of technology to bridge the gap in RH diagnostics, treatment, community empowerment and implementation to fast track the progress;

e. Mainstream use of technology in increasing efficiency at all levels of health service delivery for RH.

4.2.3.4 Health Information

The Kenya Health information includes health service delivery data (KHIS), and periodic survey data like KDHS. The Health Management Information System (HMIS) is critical in the implementation of the Policy. Towards this end, the Ministry of Health shall take the following actions:

a. Use the existing National platform for periodic surveys conducted by Kenya National Bureau of Statistics to collect, collate and analyze data for routine monitoring of the RH services as well as specialized studies;

b. Advance the rights to reproductive health by advocating for the revision and standardization of data collection tools to capture age and sex disaggregated data for different population cohort including adolescents, young people, the aging at all levels of data collection as underpinned by Article 35 of the Constitution of Kenya 2010;

c. Strengthen HMIS for RH and establish linkages with the National Integrated Monitoring and Evaluation System (NIMES) and IDSR systems for strengthened reporting of maternal and perinatal deaths and other vital events;

d. Reinforce the management of routine data collection, analysis and utilization to facilitate high-quality data and insights for reproductive health decision making at all levels;

e. Expand the use of appropriate modern technology (SimuAfya/mHealth/eHealth) to improve management of RH information at all levels;

f. Ensure health management information systems are reviewed and revised to report against commitments and specified in the M&E framework for this policy.

4.2.3.5 Health Workforce

A skilled health workforce and of adequate numbers is essential for the delivery of RH services. The Ministry of Health shall ensure effective recruitment, development, training and retention of the health workforce (nurse midwives, medical doctors and specialists, obstetrician gynecologists, and complementary medical/ operational expertise) for provision of RH services by:

a. Ensuring sustainable increase in health financing for human resources in health;

b. Expand the number and skill mix of human resources for the successful delivery of the policy;

c. Building capacity and motivation of health providers to deliver RH services through in-service, on-job training, mentorship and continuous medical education;

d. Supporting integration of RH training into the pre-service curriculum in all medical training institutions;

e. Strengthening quality assurance mechanisms through continuous support supervision and mentorship at all levels to provide adolescent and youth friendly RH services;

f. Advocate for enactment of necessary legal instruments to address barriers of an efficient and effective human resource for health in the context of RH at all levels

4.2.3.6 Service Delivery Systems and standards

Article 43 (1) of the Constitution of Kenya (2010) states that 'every person has the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care'. This policy recognizes the central role of the family in reproductive health as stipulated under Article 45(1) of the Constitution of Kenya 2010 and this shall be reflected in RH interventions. This Policy supports access to and provision of high quality and affordable RH services at all levels of health service provision and for all citizens, including vulnerable groups and that services are accessible and acceptable. The detailed standards shall be described in the national guidelines, protocols and standard operating procedures (SOPs) for various RH interventions. Key components to be considered in defining the standards for service delivery systems will be:

- Effective
- Efficient
- Universally accessible, acceptable and patient-centred, including being age-appropriate and respectful
- Equitable
- Safe
- Private and confidential
- Responsive to social values
- Alignment with legal framework in the country
- Reliable and consistent
- Evidence based.

4.2.3.7 Health Infrastructure

The MOH health infrastructure will be enhanced to support the reproductive health policy aspirations. This is especially important to meet the expanded needs of people living with disabilities and the emerging population cohorts such as elderly and children and address the suboptimal performance of key indicators in reproductive health. The health infrastructure changes will focus on ensuring:

a. Physical access to facilities
b. Equipment and tools for service delivery including specialized tools for delivery of services for people living with disabilities
c. Periodic Assessment of capacities and making necessary adjustment
d. Communication system to and within the facilities
e. Information systems for data collection and management infrastructure for RH interventions
f. Client-centeredness design and flow of intervention package with service delivery points
g. Safety in designs and set up of the infrastructure.

4.2.3.8 Research and Development

The ministry of health notes that research in health including reproductive health is currently not appropriately coordinated, leading to unwarranted duplication

and limiting optimal use of resources and findings, funding for research has remained very low and the sector has continued to rely on donors and funding from partners. Translation of research findings into sustainable improvements in health outcomes remains a substantial obstacle to improving the quality of care. Research is a critical pillar of evidence generation and quality assurance of RH interventions. No intervention or program in reproductive health shall be implemented unless it has been shown objectively to be effective in improving the target sexual reproductive health outcome or preventing the target adverse reproductive health outcome. In the absence of effectiveness evaluation of the intended intervention or program in Kenya, such an intervention or program shall be deemed experiemental and shall have an embedded elaborate effectiveness evaluation plan. The contextual effectiveness evaluation plan shall be shared at the beginning of the intervention, will include a mid-term effectiveness evaluation, and an independent end-term effectiveness evaluation policy brief. These reports (plan, mid-term and end-term effectiveness assessments) shall be submitted to the Director General for Health without exception. In this regard the focus shall be;

1. Mainstreaming of RH research and capacity building at national and county levels
2. Enhanced investment in RH research and evidence generation
3. Operationalize the data protection ACT no 24 of 2019 provisions in RH
4. Strengthened research links with other state actors, academic institutions and SAGAs in the RH
5. Vet RH research in the country and prioritise research that aligns with the pressing RH concerns for the MOH and the country.

4.3 Roles and Responsibilities

The Ministry of Health shall in line with the constitutional mandate and health Act 2017

a. Oversee and facilitate adaptation and implementation of the Policy at National and County levels;

b. Ensure that there is adequate capacity in terms of staffing, equipment and supplies as per MOH norms and standards.

c. Develop a comprehensive implementation framework for the delivery of this Policy.

d. Set standards and regulatory mechanisms.

e. Regulate and co-ordinate RH training, information sharing and service delivery.

f. Co-ordinate developrnent partner's efforts in RH space and veto RH interventions by all actors to ensure efficiency, value for investment to the Kenyan People and relevance as aligns to the national RH agenda.

g. Mobilize and allocate resources for RH programs.

h. Facilitate RH data disaggregation through revision of existing data capture tools.

i. Guide the adaptation of technology in the RH diagnostics, communication (including media) and interventions (treatment).

j. Strengthen the multi-sectoral and cross border collaboration with relevant ministries and non-state agencies to delivery RH school health program.

The County Departments of Health shall in line with their constitutional mandate and health Act 2017

County governments are responsible for health service delivery at the county level. Within the devolved governance structure, the county governments shall;

a. Allocate resources towards implementation of the RH Policy through their established coordination and management structures.

b. The county health boards, county hospital boards, primary care facility management committees and community health committees shall play an oversight role on RH matters, including resource mobilization, ensuring high quality of services as well as monitoring and evaluation this policy spellings and RH interventions in the respective counties;

c. The county and sub-county health stakeholders' forums and the community dialogue days shall provide avenues for partnership and public participation in the context of social accountability framework;

d. The county governments will be responsible for ensuring representation and participation of vulnerable groups including; children, those in justice system, prisoners, older persons, people living with disabilities, and people displaced by crisis.

County Reproductive Health Coordinator (CRHC)

a. To fully operationalize this policy in view of the devolved structure of governance it is of importance that each county to identify a focal person qualified and competent on matters RH who will act as a technical link between County Department of Health and Division of Reproductive and Maternal Health.

b. County RH Coordinator; will be charged with the overall coordination of all forms of RH services within the county. Will be the convener of the County RH Committee and sub-committees, and will liaise with the overall County Health Stakeholders Forum to ensure a coordinated approach toward RH service delivery within the county.

The Roles of other Ministries and stakeholders

A multi-sectoral approach shall be promoted in the implementation of the Policy.

The following ministries agencies and stakeholders shall be involved.

611

Table 1. Roles of Other Ministries and State Agencies in the Implementation of the Policy

Agency	Role
Ministry of Education	Support utilization of ICT and other innovative approaches in delivery of RH information to adolescent and young people in learning institution. Ensure implementation of the Education Re-entry Policy for adolescents and young people Facilitate provision of information to parents and care givers to support the policy agenda for children and young people. Strengthen health referral system in coordination with the MOH. Support the setting up of safe spaces for children and adolescents.
The National Treasury	Mobilize domestic and external resources to finance this policy Allocate financial resources for implementation of the Policy Improve fiscal responsibility. Avail resources to support policy advocacy, mobilization resources to mainstream RH financing with the budgetary cycle and MTEF Integrate RH into community empowerment programs. Finance KNBS to carry out the periodic KDHS which forms the back bone of RH data for the country
National Authority for the Campaign Against Alcohol and Drug Abuse (NACADA)	Ensure enforcement of laws that protect adolescents and young people with regards to alcohol and substance abuse. Create awareness on harmful effects of drugs and substance abuse and its impact on families and communities. Provide geographical, age and sex disaggregated data for alcohol, drug and substance abuse for decision making.
National Human Rights Institutions (KNHRC, KHRC) and National Gender and Equality commission	Investigate violations of RH rights. Operationalize the platform for receiving complaints on violations of RH rights. Monitor implementation of RH commitments and obligations. Expand the utilization of modern technology and local community /social intelligence in SGBV Advocate for the expansion of safety nets and corridors for survivors of SGBV and their dependants

Ministry of ICT, Innovation and Youth Affairs.	Support utilization of ICT in delivery of RH information. Finance the SimuAfya RH telemedicine platform through the Universal Service Fund Work with partners in regulation of media content on reproductive health information. Support the actualization of the national reproductive health citizenry education platform. Protect communities against harmful cultural practices, child marriages and child labour. Protect adolescents and young people against child marriages and trafficking. Ensure greater livelihood opportunities for adolescents and young peoples in line with existing laws
Law Enforcement Agencies (National Police Service, Judiciary, Internal Security, HIV tribunal, Office of the Director of Public Prosecutions (ODPP)	Enforce laws and administer justice to protect communities against RH violations. Expand the utilization of modern technology and local community /social intelligence in administration of justice in the context of RH matters including SGBV. Incorporate alternative dispute resolution mechanisms in the justice system on RH matters including SGBV
Ministry of Public Service and Gender	Strengthen the support for family unit and setting up of structural interventions. Advocate for the reorganization of RH interventions to ensure the prioritization of needs of persons with disabilities (physical and mental), street children, institutionalised children and the aging. Support the MOH Human resource expansion agenda for the successful delivery of this RH policy aspiration. Support gender mainstreaming in all RH and related programs Ensure implementation of the Prohibition of FGM Act (2011) and other RH related acts. Support advocacy on elimination of SGBV. Monitor anti-FGM interventions. Support the setting up of safe spaces for children and adolescents.
Ministry of Tourism and Wildlife	Support and integrate RH in their programs. Mainstream RH in the social environmental impact assessment of tourism and partnerships.
Ministry of Sports and Heritage	Support and integrate RH in their sporting activities, social and cultural events.
Ministry of Transport, Infrastructure, Housing, Urban Development and Public Works	Improve physical accessibility to health facilities. Support and integrate RH in their programs. Mainstream RH in the environmental impact assessment and intervention of expanding infrastructure.
Ministry of Agriculture, Livestock, Fisheries and Cooperatives	Support and integrate RH in their programs.

Ministry of Water & Sanitation and Irrigation	Support and integrate RH in their programs.
Ministry of Mining and Petroleum	Support and integrate RH in their programs.
Parliament	Support allocation of resources for implementation of the Policy. Advocate and support implementation of the Policy in their areas of jurisdiction. Enactment of relevant Acts and other required legal instruments necessary for the successful delivery of this policy aspirations.
NGOs, CSOs, CBOs, FBOs and Private Sector	Support provision of RH information and services to communities. Support research and RH Policy formulation and dissemination. Educate and capacity build communities and individuals on RH interventions and programs. Meaningfully engage in social accountability processes including program design, implementation, research and M&E. Advocate and mobilize resources for policy implementation. Align program design and delivery to set legal and policy framework. Support representation of vulnerable groups e.g. People living with disabilities, adolescents, people affected by crisis or displacement.
Development Partners	Mobilize resources for policy implementation. Support technical expertise for the MOH to lead and realize the spellings of this RH policy and responsible programming. Align interventions and delivery of programs to set legal, policy framework and recipient community values.
Communities, families and individuals	Champion RH desired outcomes through existing relevant structures at all levels. Volunteer RH information. Support RH policy implementation and remove barriers to access. Mobilize resources. Meaningfully engage in social accountability processes including program design, implementation, research and M&E.

Training and research Institutions (Medical Schools and Colleges and other Training and Research Institutions)	Enhance RH content in nursing and medical curricula at both pre- and in-service levels. Conduct continuous research on RH and generate information for decision making. Participate in policy revision and/or development processes. Periodic dissemination of evidence and RH research Resource mobilization for RH
Media	Advocate and create public awareness on matters related to RH. Share responsible and accurate information and evidence Regulate media content in the context of RH. Meaningfully engage in social accountability processes including program design, implementation, research and M&E.
Professional associations	Advocate for RH agenda in the professional associations Motivate and support health providers to adhere to principles laid out in this policy. Undertake research and knowledge sharing on RH. Provide guidance on RH matters. Participate in policy revision and/or development processes.
Regulatory bodies	Advance the objectives of this policy as prescribed in their various constitutive Acts of Parliament and mandate directives

CHAPTER 5. MONITORING, EVALUATION, RESEARCH AND LEARNING (MERL)

The MOH shall provide overall strategic leadership in monitoring and evaluating implementation of the Policy with technical assistance from a multi-sectoral technical working group that includes development partners. An M&E framework for assessing implementation and impact shall be established based on the goals and objectives of the Policy and targets set in the plan of action. The MOH and partners shall mobilize sufficient resources to support M&E of the Policy and its Plan of Action.

The M&E framework for the Policy shall be linked to the National Health Management Information System (HMIS). The Policy shall advocate for integration of RH relevant indicators into the National Integrated Monitoring and Evaluation System and other relevant M&E frameworks. State and non-state actors shall be expected to align their project or program reporting to the MOH M&E framework.

At the national level, monitoring shall be done on a quarterly basis through the DRMH and MERL committee of experts. Evaluation will be conducted through base line and periodic surveys or other research to ensure programmes are implemented as expected. In this respect, monitoring of this policy document shall be done through the RH ICC and guided by indicators and targets as reflected in Table 1.

Table 2. Indicators for Measuring Kenya Reproductive Health Policy 2022-2032 Performance

Policy Area	Sub Objectives	Impact-level Indicators	Baseline-KDHS 2014	Proposed 2030 target	Frequency of Measurement
1. To achieve universal coverage of quality and comprehensive Reproductive Health interventions across the country	Reduction of maternal, perinatal and neonatal morbidity and mortality	Neonatal mortality rate (per 1,000 births)	22	13	Annually
		Neonatal mortality rate (per 1,000 births)-Facility	36.3	22.3	Annually
		Maternal mortality ratio (per 100,000 births)-Population	362	100	KDHS (Periodic)
		Maternal mortality rate (per 100,000 births)- Facility	103	70	Annually
		4th ANC	58%	70%	Annually
		8 or more ANC contacts	4%	30%	Annually
		Stillbirth rate (per 1,000 births) – National	23	12	Annually
		Skilled Birth Attendance	62.5	80%	Annually
		Postnatal Care	58%	70%	Annually
		Perinatal mortality rate	13.20%	7.80%	Annually
		Percentage of maternal deaths audited in the country	70%	100%	Annually (MPDSR reports)
	Reduction of unmet family planning needs	FP mCPR for all women	58%	64%	Annually

		Proportion of Women with Unmet Need for Family planning	18%	10%	Annually
	Reduce the burden of curable reproductive tract infections (RTIs)	Proportion of women presenting in ANC with any or all of the following: syphilis, chlamydia trachomatis , Bacterial Vaginosis, Neisseria gonorrhea , genital ulcer disease , cervical manifestation of HPV infection , Trichomoniasis	20%	10%	Annually
	Improved access to, and quality of, RTI services	Proportion of ANC clinics able to test and treat RH signal infections: C.Trachomatis and T.Pallidum	40%	60%	Annually
	Reduce the HIV and AIDS burden and eliminate mother to child transmission (eMTCT) of HIV	Comprehensive knowledge on HIV among adolescent girls 15- 19	49%	75%	KDHS (Periodic)
		Comprehensive knowledge on HIV among adolescent boys 15- 19	58%	80%	KDHS (Periodic)
	Reduction of morbidity and mortality associated with the common cancers of the reproductive organs in men and women	Cervical Cancer Screening	14%	75%	Annually
		Prostate cancer screening	7%	30%	Annually
		HPV Vaccination Coverage	10%	60%	Annually

618

2. To improve responsiveness to client's reproductive health needs	Mainstream special RH needs of people with disabilities, elderly and people in humanitarian settings	Existence of specific policies and resources for RH disability mainstreaming in RH service delivery points	0%	30%	Annually
	Promote of gender, equity eliminate FGM by 2022 and eradicate all forms of gender-based violence and harmful reproductive health practices by 2030	Prevalence of female genital mutilation among 15-19yrs	21%	10%	Annually
		Number of girls and WRA attending ANC screened for FGM	5%	50%	Annually
		Proportion of WRA who reported to have experienced intimate partner violence at first ANC screening	Data not available	50%	Annually
		Early marriages screening at ANC	Data not available	50%	Annually
		Proportion of girls married before 18th birthday	23%	10%	KDHS (Periodic)
	Improve reproductive health outcomes among adolescents and young people	Age of sexual debut	18 years	21 years	KDHS (Periodic)
	Reduce the magnitude of infertility and increase access to fertility care and treatment for individuals and couples with fertility challenges	Total fertility rate	3.9	2.5	5 years
		Legislation on fertility services (ART, Surrogacy and Organ and Tissue donation and transplant)	0	1	Annually
		Number of operational public fertility treatment and management centres	1	15	Annually

3. To strengthen the enablers (Health Systems Building Blocks) for Reproductive Health	Promote robust RH implementation environment especially data systems, research for development, innovation, human resources for RH and partnerships and collaborations	Proportion of public facilities with a functional patient centered Telemedicine Platform	0	75%	Annually
		Establishment of a national RH research repository	0	1	Bi-annual
		National mapping and Publishing of RH partner interventions, shared with counties	0	1	Quarterly
M&E Inherent to the RH Policy	Launch of Policy	Policy signed and launched by MOH and disseminated	0	1	One off
	Dissemination to counties	Proportion of counties technically supported to interpret and operationalize this policy	0	100%	Annual

620

PARTICIPATING ORGANIZATIONS

- Options
- Kenya Obstetrics and Gynaecological Society (KOGS)
- Kenya Medical Association (KMA)
- Global Affairs Canada through World Vision (ENRICH)
- United Nations Population Fund (UNFPA)
- UKAID (ESHE)
- Council of Governors (CoG)
- County Governments

LIST OF CONTRIBUTORS

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47 County Governments	Counties
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Dr. Geoffrey Okumu	DFID, OPTIONS
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County Executive Committee Members for Health	47 Counties

MINISTRY OF HEALTH

Division of Reproductive and Maternal Health
Every Life Counts

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Website: www.familyhealth.go.ke
Email: headrmhke.moh@gmail.com

Crestwood

NW-12

This is Exhibit marked "NW-12" referred to in the Annexed affidavit/Declaration of Nduma Wendo
Sworn/Declared before me on this 22nd day of September 2022 at Nairobi in the Republic of Kenya
Commissioner for Oaths

Dr Stephen Kaliti, MD MPH

Head, Division of Reproductive and Maternal Health,

Ministry of Health.

MINISTRY OF HEALTH Received 23 JUL 2022 MAIL OFFICE P. O. Box 30016, NAIROBI

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Advance copy by email

RE: RAISING CONCERNS ON THE PROBLEMATIC, EXCLUSIONARY PROVISIONS OF THE NATIONAL REPRODUCTIVE HEALTH POLICY 2022 – 2032

We refer to the above-mentioned matter and the National Reproductive Health Policy 2022 – 2032 (RH Policy) launched on Tuesday, 5 July 2022 at the Windsor Hotel in Nairobi. We, the undersigned, write in our capacity as organisations working in the right to health, women's rights and human rights sectors; grassroots human rights defenders; individual citizens; and residents of different counties.

On various occasions since April 2021, we have raised legitimate concerns that the communities, civil society, council of governors and medical bodies have on the RH Policy. The Division of Maternal and Reproductive Health have either ignored requests for an open and fair policy development process, or adopting a 'participation by ambush' model that denies stakeholders adequate opportunity to engage. Dissatisfied by the continued show of bad faith, we formally registered our disengagement and withdrawal from the process on 4 July 2022.

We also note with grave concern the continued efforts to claw-back on gains made in sexual and reproductive health; ignore rights-based approaches; and create a perception of illegality around critical sexual and reproductive health issues. In an article published in the Nation on 23 April 2022 titled 'You risk being imprisoned for giving minors contraceptives' Dr. Kaliti stated that '…giving contraceptives to minors is an illegality punishable by a jail term of up to 20 years…such a move is against the Children Act…' effectively excluding an entire vulnerable and marginalized population from accessing critical health services.

We note that certain provisions of the RH Policy violate our national values, and the rights to reproductive health care, equality and non-discrimination, access to information, and the best interests of the child. We take issue with the following provisions of the RH Policy:

i. **The RH Policy excludes meaningful interventions to reduce maternal mortality and morbidity due to unsafe abortion.** Unsafe abortion is one of the five major causes of maternal mortality and morbidity in Kenya. The right to safe and legal abortion in exceptional circumstances is articulated in Article 26(4) of the Constitution and a guiding framework is necessary to ensure access to safe abortion services provided by trained medical personnel. By refusing to institute a comprehensive guiding framework on abortion care in Kenya, the Ministry of Health is endorsing the exploitation of women and girls by quacks, and the subsequent harm to their lives and health.

ii. **The RH Policy provision on the unborn child is legally unsound.** The Policy notes that termination of pregnancy shall be '...guided by the opinion of a trained health professional with the proficiency to ensure both the mother and her unborn child receive the highest attainable standard of care.' This provision is legally unsound and directly contravenes the High Court's judgement in Petition 266 of 2015 where the Court held that abortion under Article 26(4) is an intentional deprivation of the life of the unborn child.

iii. **The RH Policy violates the right to equality and freedom from discrimination in accessing assisted reproductive technology.** The Policy provides for support for 'couples of the opposite sex' in accessing surrogacy and assisted reproductive technology. This is blatantly discriminatory against people outside of a marital or sexual union from accessing a health service and the Policy has not shown why limiting the right of single people to access a reproductive health service is reasonable and justifiable in an open and democratic society as stated in Article 24(1) of the Constitution.

iv. **The RH Policy only includes interventions on adolescent sexual and reproductive health that are discriminatory and not based on evidence.** Throughout the document, the Policy does not take into account the best interest of the child principle protected under Article 53(2) of the Constitution. Adolescents are a vulnerable and marginalised population with regard to sexual and reproductive health facing the triple threat of rising HIV infections, vulnerability to sexual and gender-based violence, and teenage pregnancy. Despite this, the Policy solely prioritises delaying sexual debut and enforcing parental consent,

even within the key performance indicators. It excludes diverse aspects including access to information, commodities, dignified and quality services and facilities.

These are some of the reasons we object to the implementation of the RH Policy in Kenya. We remind the Division that the Constitution of Kenya, 2010 affirms the right of **every person** to the highest attainable standard of health including reproductive health care. We remind the Division that all state organs and officers are bound by the national values set out in Article 10(2) of the Constitution including participation of the people; social justice; inclusiveness; human rights; non-discrimination and protection of the marginalized; and transparency and accountability.

We therefore call upon your office to halt the implementation of the RH Policy until these unscientific, discriminatory and unconstitutional issues are addressed to ensure a supportive environment that facilitates access to reproductive for all.

We are confident of your commitment towards the full implementation of the Constitution, and the enjoyment of the right to the highest attainable standard of health, including reproductive health. We trust that you will urgently undertake the proposed step above.

Cc: Hon. Mutahi Kagwe, EGH

The Cabinet Secretary

Ministry of Health

Susan Mochache, CBS

Principal Secretary

Ministry of Health

Dr. Patrick Amoth, EBS

Ag. Director General for Health

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Hon. Justice (Rtd) Paul Kariuki Kihara, EGH

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H.E Martin Wambora, EGH

The Chairperson,

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The Chairperson,

National Gender and Equality Commission.

Roseline Odede, HSC

The Chairperson,

Kenya National Commission on Human Rights

Hon. Florence Kajuju, MBS

The Chairperson,

Commission on Administrative Justice

Signed by the following organisations:

1. Youth Changers Kenya
2. Zamara Foundation
3. Youth Empowerment Movement
4. Positive Young Women Voices
5. Reproductive Health Champions Organisation
6. Grassroots Women Initiative Network – Kenya
7. Xhale Africa
8. Reproductive Health and Rights Alliance
9. Coalition of Grassroots Human Rights Defenders
10. Trust for Indigenous Culture and Health
11. Kenya Legal and Ethical Issues Network
12. Reproductive Health Network Africa
13. SRHR Alliance
14. Love Matters Africa
15. Women First Digital
16. Women Spaces Africa
17. Kisumu Medical and Education Trust
18. Network for Adolescent and Youth for Africa

Dr Stephen Kaliti, MD MPH

Head, Division of Reproductive and Maternal Health,

Ministry of Health.

22nd July, 2022

Received by : HOSEA
Date : 25/7/2022
Sign:

Advance copy by email

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NW-13

This is Exhibit marked "NW-13" referred to in the Annexed affidavit/Declaration of Nonno Hare
Sworn/Declared before me on this 8th day of September 2022 at Nairobi in the Republic of Kenya
Commissioner for Oaths

REPUBLIC OF KENYA

MINISTRY OF HEALTH

NATIONAL GUIDELINES FOR PROVISION OF ADOLESCENT AND YOUTH FRIENDLY SERVICES IN KENYA

Second Edition

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656

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NAIROBI

TABLE OF CONTENTS

i.	**Acknowledgements**	**3**
ii.	**Foreword**	**4**
1.0	**Introduction**	**10**
1.1	Background	10
1.1.1	Situation analysis	10
1.1.2	Legal and Policy context	12
1.1.3	Rationale for Revision	12
1.2	Purpose of the guidelines	14
1.2.1	Goal	14
1.2.2	Objectives	14
1.3	The Intended Audiences and Targeted Beneficiaries	15
1.3.1	Intended Audiences	15
1.3.2	Targeted Beneficiaries	15
1.4	The Guiding Principles	16
2.0	**Characteristics and Standards of Adolescent and Youth Friendly Services**	**17**
2.1	Characteristics of adolescent and youth friendly services	17
2.2	Standards for quality adolescents and youth friendly services	19
3.0	**Strategies, Approaches And Service Delivery For Adolescent And Youth Friendly Services**	**21**
3.1	Strategies and Actions	21
3.2	Approaches for service delivery	27
3.3	Service delivery for adolescents and youth	27
3.3.1	Essential package	27
3.3.2	Service delivery models	28
3.3.3	Service delivery points	33
3.3.4	Recommendations for reaching vulnerable sub-population of young people	33
4.0	**Implementation framework**	**39**
4.1	Introduction	39
4.2	Stakeholders	37
4.3	Roles and Responsibilities of the stakeholders	40
4.4	Monitoring and Evaluation	46
	Annexes	**49**
	References	**54**

ACKNOWLEDGEMENTS

The review of the National Guidelines for Provision of Adolescents and Youth Friendly Services in Kenya (2005) involved consultations with a wide range of stakeholders through consultative meetings, literature review, and reviews of the various drafts of the guidelines.

The Ministry of Health through the Division of Family Health feels greatly indebted to individuals and organizations who contributed in one way or another to this elaborate review process. We particularly thank the Reproductive Maternal Health Services Unit for overseeing and guiding the review process.

Specifically the Division of Family Health would like to thank Ms. Leah Rotich, Director General, Ministry of Education , Science and Technology, Dr Josephine Kibaru-Mbae, Director General, National Council for Population & Development and Dr. Kigen Bartilol, Head of the Reproductive and Maternal Health Services Unit, who gave invaluable inputs and guided the process to successful completion.

Special thanks to Dr. Jeanne Patrick, ASRH Programme Manager and programme officers Anne Njeru, Mary Magubo and Clifton Katama for coordinating and spearheading the review process.

We also wish to acknowledge contributions of the taskforce members who worked together with the ASRH Technical Working Group and adolescent and youth sexual and reproductive health stakeholders throughout the review process. The taskforce team included representatives from the Reproductive and Maternal Health Services Unit (RMHSU), Neonatal and Child Health Unit (NCAHU), Health Promotion Unit (HPU) and NASCOP and partner institutions.

We also thank GOAL-Kenya, CSA and UNFPA for their technical and financial support to the review process.

FOREWORD

Adolescents and youth comprise 24% of Kenya's population. This youthful population has implications on the social, economic and political agenda of the country. A young population provides opportunities for the country's development if the right investments are made towards attainment of educational and health goals, including all round preparation for responsible adulthood. At the same time, a youthful population puts great demands on provision of health services, education, water and sanitation, housing and employment. The Government of Kenya recognises that the provision of comprehensive and high-quality reproductive health services to adolescents and youth requires a multi-sectoral integrated approach from all sectors of government, development partners and other stakeholders for the country to attain the Vision 2030, African Youth Charter (2006) and Post-2015 Development Agenda through Sustainable Development Goals (SDGs).

The first edition of the National Guidelines for provision of Youth friendly services in Kenya was developed in 2005. The review of these national guidelines was necessitated by significant changes that have been observed in the provision of adolescents and youth sexual reproductive health at the national and international levels. The Guideline were reviewed to align with the emerging SRHR realities including the National Adolescent and Sexual Reproductive Health (ASRH) Policy (2015), The World Health Organisation's Global Standards for Quality Health Care Services for Adolescents, the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030), Sustainable Development Goals (SDGs) and the Constitution of Kenya (2010) with its attendant devolved governance structure.

The transformational changes in the Kenyan Health System with the devolved governance structure provide a unique window of opportunity to address long standing inequalities and inefficiencies in the provision of adolescent and youth friendly services in the health sector. These guidelines provide a useful guidance for counties to set priorities relevant to their context and mobilize collective effort involving both levels of government, development partners, civil society and private sector to improve adolescent and youth health outcomes.

The development of this second edition of AYFS Guidelines together with the 2015 National Adolescent Sexual and Reproductive Health Policy, are clear proof of the Kenya government's desire and commitment to bring adolescent and youth sexual and reproductive health and rights issues into the country's mainstream health and development agenda. However, more focused effort is required to increase access to SRH information and services among adolescents and youth and improve health outcomes.

These AYFS guidelines, evolved through an extensive consultative process involving key adolescent and youth SRH stakeholders, Counties' Departments of Health, Ministry of Education, Science and Technology, Youth Serving Organisations among others. It outlines the standards for service provision of AYSRH services, the essential package of services, service delivery models and service delivery points that should be

implemented and scaled up at the counties to improve the health outcomes of adolescents and youth. All government sectors including education, law enforcement and protection agencies, transport and agriculture among others have an important role in planning and delivering sexual and reproductive health services to adolescents and youth. AYSRH needs are best met through involving adolescents and youth in every phase of action: from assessing their needs to designing programmes, to launching and implementing programmes and evaluating their impact

The Ministry of Health will enhance intergovernmental coordination mechanisms that ensure collective response from both levels of Government and development partners to rapidly improve the health status of adolescents and youth in Kenya.

Dr. Kigen Bartilol

Head, Reproductive Maternal Health Services Unit

ACRONYMS AND ABBREVIATIONS

AACSE	Age Appropriate Comprehensive Sexuality Education
AYFS	Adolescent and Youth Friendly Services
AYSRH	Adolescent and Youth friendly Sexual Reproductive Health Services
CHMT	County Health Management Teams
CPR	Contraceptive Prevalence Rate
CSE	Comprehensive Sexuality Education
FGM	Female Genital Mutilation
HIV	Human Immuno-deficiency Virus
HTC	HIV Testing and Counselling
HTS	HIV Testing Services Kits
ICPD	International Conference on Population and Development
IEC	Information, Education and Communication
JICC	Joint Interagency Coordinating Committee
KAIS	Kenya AIDS Indicator Survey
KDHS	Kenya Demographic and Health Survey
KSPA	Kenya Service Provision Assessment
MOEST	Ministry of Education, Science and Technology
MOH	Ministry of Health
NACADA	National Campaign against Alcohol and Drugs Abuse
NCPD	National Council for Population and Development
PAC	Post-Abortion Care
RMHSU	eproductive and Maternal Health Services Unit
RH-ICC	Reproductive Health – Inter Agency Coordinating Committee
SARAM	Service Availability and Readiness Assessment Mapping
SCHMT	Sub-county Health Management Team
SDG	Sustainable Development Goals
SGBV	Sexual and Gender-Based Violence
SRHR	Sexual Reproductive Health and Rights
TWG	Technical Working Group
WHO	World Health Organisation

DEFINITION OF TERMS

Abortion: The termination of pregnancy by the removal or expulsion from the uterus of a foetus or embryo before viability. An abortion can occur spontaneously, in which case it is often called a miscarriage; or it can be purposely induced. The term abortion most commonly refers to the induced abortion of a human pregnancy.

Adolescent: Any person aged between 10 and 19 years.

Adolescent and youth friendly services: Are Sexual and Reproductive Health services that are accessible, acceptable appropriate, effective and equitable for adolescents and youth.

Age appropriate: It is the suitability of information and services for people of a particular age, particularly in relation to adolescent development

Age Appropriate Comprehensive Sexuality Education (AACSE): An age-appropriate, culturally relevant approach to teaching about sexuality and relationships by providing scientifically accurate, realistic and non-judgmental information. Sexuality education provides opportunities to explore one's own values and attitudes and to build decision-making communication and risk reduction skills about many aspects of sexuality.

Child: An individual who has not attained the age of eighteen years as per the Kenya constitution 2010.

Child Abuse: Child maltreatment, sometimes referred to as child abuse and neglect, includes all forms of physical and emotional ill-treatment, sexual abuse, neglect and exploitation that results in actual or potential harm to the child's health, development or dignity. Within this broad definition, five sub-types can be distinguished — physical abuse, sexual abuse, neglect and negligent treatment, emotional abuse and exploitation

Child marriage: This is a situation where marriage, cohabitation or any arrangement is made for such marriage or cohabitation with someone below the age of 18 years.

Confidentiality: The right of an individual to privacy of personal information, including health-care records. This means that access to personal data and information is restricted to individuals who have a reason and permission for such access. The requirement to maintain confidentiality governs not only how data and information are collected (e.g. a private space in which to conduct a consultation), but also how the data are stored (e.g. without names and other identifiers) and how, if at all, the data are shared.

Female genital mutilation (FGM): Comprises all procedures involving partial or total removal of the female genitalia or any other injury to the female genital organs or any harmful procedure to the female genitalia, for non-medical reasons and includes: clitoridectomy, excision and infibulations; but does not include a sexual reassignment procedure or a medical procedure that has a genuine therapeutic purpose.

Health: A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

Humanitarian setting: A humanitarian setting is one in which an event or series of events has resulted in a critical threat to the health, safety, security or well-being of a community or other large group of people. The coping capacity of the affected community is overwhelmed and external assistance is required. This can be the result of events such as armed conflicts, natural disasters, epidemics or famine, and often involves population displacement. In these guidelines, the terms "humanitarian settings", "crisis settings" and "emergency settings" are used interchangeably.

Life Skills Education: A structured programme of needs- and outcomes-based participatory learning that aims to increase positive and adaptive behaviour by assisting individuals to develop and practice psycho – social skills that minimize risk factors and maximize protective factors. Life skills education programmes are theory and evidence-based, learner-focused, delivered by competent facilitators and appropriately evaluated to ensure continuous improvement of documented results.

Marginalized and Vulnerable adolescents and youth: These are adolescents and youth at high risk of lacking adequate care and protection. For the purpose of the Policy, the term includes orphans and street children as well as adolescents and youth with disabilities; adolescents and youth living with HIV and AIDS; adolescents and youth living in informal settlements; adolescents and youth in the labor market; adolescents and youth who are sexually exploited; adolescents and youth living below poverty line and children affected by disaster, civil unrest or war as well as those living as refugees.

Non State Actors: A non-state actors are entities that are not part of any state or a public institution. Non-state actors range from grassroots community organizations to non-governmental organizations, philanthropic foundations and academic institutions

Peer Education: The process whereby specially trained adolescents undertake informal or organized educational activities with their peers (those similar to themselves in age, background or interests). These activities, occurring over an extended period of time, are aimed at developing adolescents' knowledge, attitudes, beliefs and skills and at enabling them to be responsible for and to protect their own health.

Peer Educator: An adolescent or youth who was specially trained to perform or reach their peers with targeted information/behavioural messages/ education.

Post-Abortion Care: The physical, social and psychological care and support given to a person after an abortion

Reproductive Health: A state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system, its functions and processes.

Service delivery points: The designated place where the essential adolescents and youth friendly service package can be offered

Sexual, reproductive health and rights: The exercise of control over one's sexual and reproductive health linked to human rights and includes the right to:

- Reproductive health as a component of overall health, throughout the life cycle, for both men and women;
- Reproductive decision-making, including voluntary choice in marriage, family formation and determination of the number, timing and spacing of one's children and the right to have access to the information and means needed to exercise voluntary choice;
- Equality and equity for men and women, to enable individuals to make free and informed choices in all spheres of life, free from discrimination based on gender; and
- Sexual and reproductive security, including freedom from sexual violence and coercion, and the right to privacy.

Sexual health: A state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.

Sexual Offence: This violation of an individual's sexual health rights which includes defilement, rape, incest, sodomy, bestiality and any other offence prescribed in the Sexual Offences Act (2006).

Sexuality: A central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors.

State Actors: These include government ministries, departments and agencies.

Young People: Any persons aged 10 – 24 years as defined by WHO

Youth: Any person aged between 15 – 24 years as defined by WHO

For the purposes of this guideline, the terms will be used according to these definitions, with the terms "adolescents and youth" and "young people" being used interchangeably

1. INTRODUCTION

1.1 BACKGROUND

According to the 2009 Kenya Population and Housing Census (KPHC), young people below the age of 25 constitute 66% of the total population in Kenya. Adolescents on the other hand make up 24% of the country's total population (9.2 million). Nonetheless, they experience some of the poorest reproductive health outcomes in the country.

Data from KDHS (2014) indicates that, one in every five teenage girls between the ages of 15-19 have begun child bearing; contraceptive prevalence rate among sexually active unmarried girls aged 15-19 years is 49% and 64% among those aged 20-24 years; the age of sexual debut has dropped with 12% of young women and 21% of young men aged between 15-24 years having had sexual intercourse before age 15, while 47% of young women and 55% of young men between the ages of 18-24 years have had sexual intercourse before age 18 years; comprehensive knowledge of HIV among youth stands at 57% for young women and 64% for young men. The rate of condom use is 61% and 75% among young men and young women respectively.

Additionally, about 20,000 girls seek care for abortion related complications each year, while unsafe abortion remains the leading cause of maternal mortality and morbidity especially among girls below 20 years. The National AIDS Control Council (NACC) further estimates that 29,000 youth aged between 15-24 years get infected with HIV every year while17% of all AIDS related deaths occur among adolescents and youth.

The negative health outcomes among adolescents and youth can be attributed to early sexual debut; risky sexual behaviors such as unprotected sex and multiple sexual partners; sexual and gender based violence; poverty; and harmful retrogressive cultural practices. Moreover, many young people lack comprehensive and correct information on their sexuality largely because of the embarrassment, silence and disapproval of open discussion of sexual matters by adults, including parents and teachers. Consequently, many are unlikely to seek health services and when they do, they don't get the required services either due to the judgmental nature of health care providers, concerns around privacy and confidentiality, or low capacities of the health care system.

1.1.1 Situation Analysis

Investing in adolescents and youth presents significant development and economic gains. The World Health Organization report, Health for the world's adolescents: A second chance in the second decade reiterates the need to transform how countries' health sectors respond to the health needs of adolescents. It emphasizes the development and implementation of quality standards and monitoring systems as a key action to achieve this transformation.

Adolescents and Youth-friendly services (AYFS) are meant to help young people overcome barriers to access to quality sexual and reproductive health care services. AYFS providers should be able to respond to the

needs of young people, remove their fears, respect their concerns, confidentiality and provide the services within an environment that suit their preferences.

While access and use of high-quality and comprehensive SRH services could prevent or mitigate many of the poor health outcomes experienced among adolescents and youth, a wide range of barriers prevent young people from accessing these services.

These include:

- **Structural barriers**, such as laws and policies requiring parental or partner consent, distance from facilities, costs of services and/or transportation, long wait times for services, inconvenient hours, lack of necessary commodities at health facilities, and lack of privacy and confidentiality.
- **Socio cultural barriers**, such as restrictive norms and stigma around adolescent and youth sexuality; inequitable or harmful gender norms; and discrimination and judgment of adolescents by communities, families, partners, and providers.
- **Individual barriers**, such as young people's limited or incorrect knowledge of SRH, including myths and misconceptions around contraception; limited self-efficacy and individual agency; limited ability to navigate internalized social and gender norms; and limited information about what SRH services are available and where to seek services.

According to the Kenya Service Provision Assessment Survey (KASP, 2010), only 7 percent of all health facilities provide youth-friendly services. The limited coverage of AYFS can be attributed to: limited number of trained service providers on adolescents and youth friendly service provision; shortage of health personnel; inadequate infrastructure for provision of AYFS; and limited resources to support the establishment of adolescents and youth friendly facilities.

Provision of reproductive health services to young people continues to remain sensitive to a cross-section of the public; staff remains ambivalent about providing RH services to young people. Additionally, making reproductive health services adolescent and youth friendly requires additional training, staff time, and funds. Studies have shown that Adolescent and youth friendly services can increase young people's use of SRH services when they include three major components: (1) training for health care providers on youth-friendly service provision and core competencies for delivering adolescent reproductive health services (2) improvements in facilities to increase access and quality of services for young people e.g. lowering user fees, organizing services to improve client flow, and increasing privacy, (3) and community-based activities to cultivate an enabling environment and increase demand. Furthermore, young people themselves consistently prioritize privacy, confidentiality, and respectful treatment by providers as the most important attributes of quality health services.

1.1.2 Legal and Policy Context

These Adolescent and Youth friendly Services Guidelines are in line with national, regional and international legal instruments and commitments. Kenya is signatory to a number of regional and global commitments including Maputo Plan of Action 2007-2010, Programme of action of the International Conference on Population and Development (ICPD, 1994) and Ministerial Commitment on Comprehensive Sexuality Education and SRH services for Adolescents and Young People in Eastern and Southern Africa (ESA, 2013). The ICPD program of action makes emphasis on human rights based approach to the access of sexual and reproductive health especially among women and girls.

The Constitution of Kenya (2010) expressly recognises in article 43 (1) that, "every person has the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care. In addition the country has enacted Children's Act 2001, Prohibition of FGM Act (2011) Person with Disability Act (2003), HIV and AIDS Prevention and Control Act (2006), Marriage Act (2014) all which provide the legal framework to support provision of AYFS.

The National Adolescent Sexual and Reproductive Health Policy (2015) policy provides a framework to enhance the SRH status of adolescents in Kenya towards realization of their full potential in national development. Other policies that support AYFS include: Kenya Vision 2030, National Reproductive Health Policy (2007), National Youth Policy (2007), Gender Policy in Education (2007), Kenya Health Policy (2012-2030), Kenya Health Sector Strategic and Investment Plan (2013-2017), The Education Sector Policy on HIV and AIDS (2013), and the National School Health Policy (2009).

Finally, the Sustainable Development Goals (SDGs) provides the impetus the country needs towards realization of AYFS over the next 15 years. The SDGs' transformative agenda positions the adolescents and youth at the centre of development as envisaged in goals 3, 4, and 5. These goals express good health and well-being; quality education and Gender equality respectively. In addition, the updated Global Strategy for Women's, Children's and Adolescent health (2016-2030) whose 3 main objectives are to survive, thrive and transform, does recognize adolescents' right to health, education, well-being and their full and equal participation in the society.

1.1.3 Rationale for Revision

Despite the existence of the National Guidelines for Provision of Adolescent Youth-Friendly Services (2005), coverage of AYFS has remained unacceptably low at 7% which has led to poor AYSRH indicators. This has been attributed to a number of factors including inadequate investment in: health infrastructure, training service providers on youth friendly service provision, deployment of service providers, commodities and supplies, awareness creation, monitoring and evaluation, as well as coordination.

These gaps, coupled with new developments brought about by the SDGs, Constitution of Kenya (2010), Vision 2030, Education Sector policy on HIV and AIDS (2013) and National ASRH Policy (2015) among others

informed the revision of the National guidelines for provision of Adolescent and Youth Friendly Services (2005).

The revised guidelines aim to provide a framework for the provision of comprehensive adolescents and youth friendly sexual and reproductive health services including services related to issues that impact on adolescents and youth have been included. It also outlines an implementation framework for coordination, monitoring and evaluation. It is envisaged that these guidelines will reach every institution with the mandate to facilitate or provide AYFS.

1.2 PURPOSE OF THE GUIDELINES

1.2.1 Goal

The goal of the guidelines is to improve availability, accessibility, acceptability and use of quality sexual and reproductive health services by adolescents and youth seeking services.

1.2.2 Objectives

1. To define the essential package of health services to be provided to adolescents and youth at service delivery points;
2. To standardize the provision of quality AYSRH Services at all levels;
3. To increase access to comprehensive sexual and reproductive health information and services among adolescents and youth;
4. To strengthen collection and utilization of age and sex disaggregated data on sexual and reproductive health among adolescents and youth.

1.3 THE INTENDED AUDIENCES AND TARGETED BENEFICIARIES

1.3.1 The Intended Audiences

The National AYFS guidelines have been developed to provide information and guidelines on youth sexual and reproductive health related services to those working for the betterment of the health and well being of youth in the country. These groups include:

- Policy makers
- Service providers
- Program managers
- Educators
- State Actors
- Non state actors including local and international NGO's, religious and community based organizations
- Young people.

1.3.2 Targeted beneficiaries

In principle, all adolescents and youth in Kenya, living both in rural and urban areas, in and out of school should benefit from any Sexual and Reproductive Health (SRH) programs and interventions. However, as described in the National ASRH Policy (2015), there are certain groups of adolescents and youth that are hard to reach, vulnerable and marginalised and may require special attention or considerations while providing AYFS, and these include:

- Rural adolescents and youth
- Out of school adolescents and youth
- Orphans and street children
- Young people with disability
- Young people living with HIV
- The very young adolescents 10-14 years of age
- Married adolescent girls
- Young first-time mothers
- Young people who have migrated to the urban centres to escape early marriage and/or seek employment i.e. including housemaids, houseboys
- Young people in humanitarian/emergency settings

1.4 THE GUIDING PRINCIPLES

The implementation of the National Adolescent and Youth Friendly Services Guidelines shall be guided by the following principles:

- Every young person is unique and belongs to a heterogeneous group with different needs, for health information and services based on a range of factors that include their age, race, sex, gender, culture, life experiences, social situation, religion etc;
- Reproductive health services are the basic human rights for all people and adolescents and youth have inherent sexual and reproductive rights, including the right to a full range of reproductive health information and services;
- Gender inequities and differences that characterize the social, cultural and economic lives of the young people influence their health and development. Thus, adolescents and youth friendly reproductive and sexual health services must promote gender equality and equity;
- The health needs of the young people are best addressed by a holistic approach that takes into consideration their physical, mental and social well being;
- The management of the needs of young people SRH includes the promotion of healthy sexual development, the prevention and treatment of SRH problems, as well as the response to specific SRH needs;
- The participation of parents, community members and other stakeholders is crucial to sustainable adolescents and youth SRH services and programs;
- The meaningful participation of adolescents and youth in the Planning, Implementation, Monitoring and Evaluation of SRH services and programs meant to address their SRH needs is essential to ensure that their needs are addressed fully and in an appropriate manner.

REPUBLIC OF KENYA

IN THE HIGH COURT OF KENYA AT KIAMBU

CONSTITUTIONAL PETITION NO. OF 2022

IN THE MATTER OF ARTICLES 10(1) & 10 (2)(a), 19, 22, 23, 26 (1) & (4), 27, 33, 35, 43 (1(a)), 53 (1(c)) AND 232 (1(d)) OF THE CONSTITUTION OF KENYA, 2010

AND

I IN THE MATTER OF ARTICLES, 22, 23, 34 AND 35 OF THE EAST AFRICAN COMMUNITY HIV & AIDS PREVENTION AND MANAGEMENT ACT

AND

IN THE MATTER OF SECTIONS 5, 6, 7, 15 AND 68 OF THE HEALTH ACT, 2017

AND

IN THE MATTER OF SECTION 16(2), (3) & (4), 28(3), 146 AND THE FIRST SCHEDULE OF THE CHILDREN ACT NO. 29 OF 2022

AND

IN THE MATTER OF SECTION 6 AND 7 OF THE SCIENCE TECHNOLOGY AND INNOVATION ACT NO. 28 OF 2013

AND

IN THE MATTER OF SECTION 4 AND 5 OF THE ACCESS TO INFORMATION ACT NO. 31 OF 2016

AND

IN THE MATTER OF THE PUBLIC SERVICE COMMISSION GUIDELINES FOR PUBLIC PARTICIPATION IN POLICY MAKING (2015)

AND

IN THE MATTER OF THE NATIONAL REPRODUCTIVE HEALTH POLICY 2022-2032

BETWEEN

RACHAEL MWIKALI.....1ST PETITIONER

ESTHER AOKO.....2ND PETITIONER

AMBASSADOR FOR YOUTH & ADOLESCENT REPRODUCTIVE HEALTH PROGRAMME (AYARHEP).....3RD PETITIONER

KENYA LEGAL AND ETHICAL ISSUES NETWORK ON HIV & AIDS.....4TH PETITIONER

VERSUS

CABINET SECRETARY MINISTRY OF HEALTH.....1ST RESPONDENT

673

THE ATTORNEY GENERAL.....2ND RESPONDENT

AND

KENYA OBSTETRICAL GYNAECOLOGICAL SOCIETY..... 1ST INTERESTED PARTY

KATIBA INSTITUTE .....2ND INTERESTED PARTY

CERTIFICATE OF AUTHENTICITY

(Under Section 78 and 106B of the Evidence Act Cap. 80 of the Laws of Kenya)

I, **NERIMA WERE**, of **P.O.BOX 112 – 00202, Nairobi**, a female Kenyan adult of sound mind residing and working for gain in Nairobi County within the Republic of Kenya, ,and the Deputy Executive Director of the 4th Petitioner and whose address for the purposes of petition is care of KENYA LEGAL AID ETHICAL ISSUES NETWORK ON HIV AND AIDS, Kuwinda Lane, off Langata Road, Karen C, P.O. Box 112-002, Nairobi do hereby make a solemn oath and state as follows;

1. I am an advocate of the High Court of Kenya and the Deputy Executive Director of the Kenya Legal and Ethical Issues Network on HIV and AIDS (KELIN), the 4th Petitioner herein and thus competent to swear this affidavit.

2. On 7th September 2022 while preparing an affidavit by KELIN I used my laptop to download the live stream video of the deliberation meeting convened by the Ministry of Health on 6th April 2022 from the aKtive Citizen Facebook page.

3. I stored the video on my laptop and later transferred it to the flash disk which is annexed to my affidavit and marked **"NW-9"**.

4. I dowloaded, stored and transfered the video using my laptop (Model-MAC BOOK PRO A2338 and serial number C02FP43ZQ05G) which was working in good condition and operated and performed the actions described above seamlessly and without any technical difficulties.

5. At the time of my use, the laptop I used to access, download, store and transfer the video was functioning correctly to the best of my knowledge.

I therefore certify that the video and video link I have produced before this court are authentic.

CERTIFIED at **NAIROBI** this ..... day of 2022

By the said

NERIMA WERE

DRAWN & FILED BY:-

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