



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

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## 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.

A handwritten signature in black ink, appearing to read "Mutahi Kagwe".

*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 technical 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.

A handwritten signature in black ink, appearing to read "Susan N. Mochache".

*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:

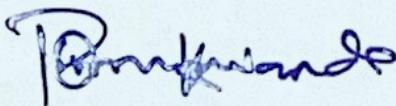
1. Reducing maternal, perinatal and neonatal morbidity and mortality
2. Reducing unmet family planning needs
3. Reducing the burden of Reproductive Tract Infections (RTIs) and improving access to, and quality of, RTI services
4. Reducing the HIV and AIDS burden and eliminating mother to child transmission (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.

A handwritten signature in blue ink, appearing to read "Patrick Amoth".

*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<sup>1</sup>.

**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<sup>2</sup> – 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<sup>3</sup>.

**Crisis:** A time of intense difficulty or danger during pregnancy<sup>4</sup>.

**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<sup>5</sup>.

**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.<sup>6</sup>

**Gender Based Violence:** Refers to any type of harm that is perpetrated against a person due to their gender.<sup>7</sup>

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

**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.<sup>9</sup>

**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<sup>10</sup>.

**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.<sup>11</sup>

**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<sup>12</sup>.

**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<sup>13</sup>.

**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.<sup>14</sup>

**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<sup>15</sup>.

**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<sup>16</sup>.

**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 abortion<sup>1</sup>, 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<sup>17</sup>. 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

<sup>14</sup> National Collaborating Centre for Determinants of Health, COCKERHAM, C. (1948). SOCIAL POLICIES AND HEALTH INEQUALITIES. Organization, 1.

<sup>15</sup> 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.

<sup>16</sup> The Persons with Disabilities Act, 2003, KLRC

<sup>17</sup> Reproductive Health (nih.gov) accessed Feb 2022



matters relating to the reproductive system, its functions, and processes<sup>18</sup>.

**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<sup>19</sup>.

**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<sup>20</sup>.

**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<sup>21</sup>.

**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<sup>22</sup>.

**Vulnerable children and young persons:** Children and young persons at high risk of lacking adequate care and protection<sup>14</sup>. 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;

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<sup>18</sup> Reproductive health (who.int) accessed Feb 2022

<sup>19</sup> Freedman, Lynn P.; Isaacs, Stephen L. (1993). "Human Rights and Reproductive Choice". *Studies in Family Planning*. 24 (1): 18–30

<sup>20</sup> The Sexual Offenses Act, No.3 of 2006, Laws of Kenya, Kenya Law Review Commission

<sup>21</sup> Total market approach | [FP Financing Roadmap](#), USAID, Accessed Feb 2022

<sup>22</sup> [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<sup>23</sup>.”

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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<sup>24</sup> 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<sup>25</sup>). 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<sup>26</sup>. 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

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<sup>24</sup> [Kenya becomes a middle-income economy](#) - Business Today Kenya, NMG accessed 24 Feb 2022

<sup>25</sup> Kenya Population and Housing Census: Volume III ISBN: 978-9966-102-11-9, Kenya National Bureau of Statistics, 2019

<sup>26</sup> 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<sup>27</sup>. 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<sup>28</sup>. 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

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

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.

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<sup>29</sup>.

## **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

<sup>29</sup> 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

## Opportunities

- Partnership with private sector in the delivery of health
- 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 penetration has created opportunities for digital UHC acceleration.
- Research and learning

## 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

## 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

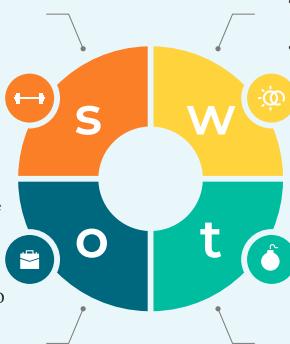


Figure 1: SWOT Analysis

PESTEL ANALYSIS	
Political factors	<ul style="list-style-type: none"> <li>• Corruption</li> <li>• Legislative priorities</li> <li>• Government stability</li> <li>• Suboptimal Human resource for health (HRH)</li> </ul>
Economic factors	<ul style="list-style-type: none"> <li>• Economic growth inconsistency</li> <li>• Budgetary deficits at National and county levels</li> <li>• Growing National debt</li> <li>• Over-dependence on foreign support</li> </ul>
Social factors	<ul style="list-style-type: none"> <li>• Harmful socio-cultural practices (violence against children; FGM, Child marriage)</li> <li>• Inadequate distribution of social services (UHC)</li> <li>• Religious and cultural extremism.</li> </ul>
Technological factors	<ul style="list-style-type: none"> <li>• ICT advances with the possibility of developing and adopting technologies to advance and promote access to essential services.</li> </ul>
Environmental factors	<ul style="list-style-type: none"> <li>• Adverse environment negatively impacting RH</li> <li>• Climate change - fueling conflict</li> <li>• Vested interests in RH advocacy leading to a skewed environment.</li> </ul>
Legal factors	<ul style="list-style-type: none"> <li>• Law enforcement – e.g. on FGM</li> <li>• Contextual conflicts of international instruments</li> </ul>

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

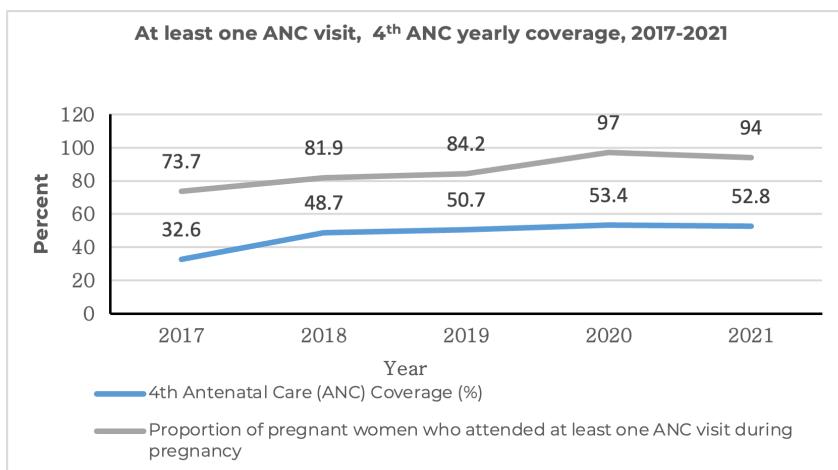


Figure 3: ANC Coverage

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

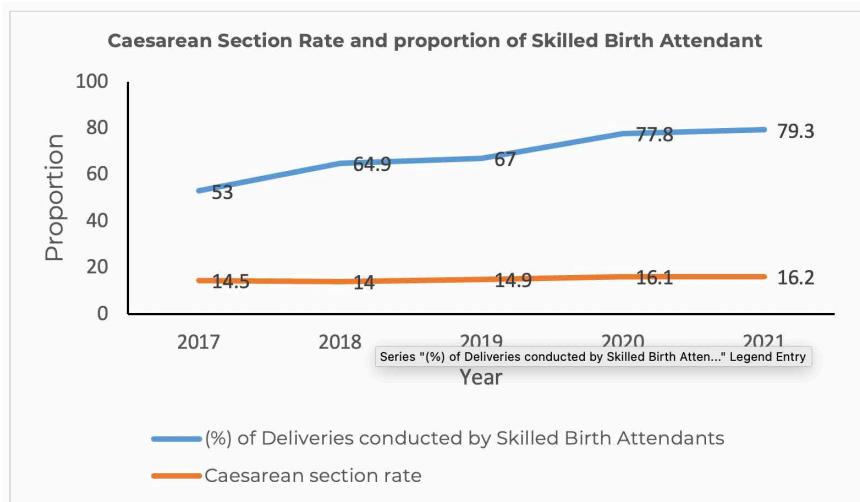


Figure 4: Skilled birth attendance

well as low uptake of contraceptives.

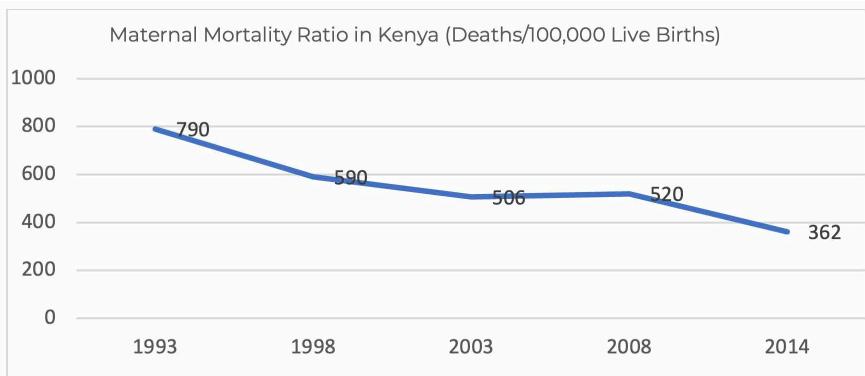
### **Maternal Mortality**

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<sup>30</sup>).

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-

<sup>30</sup> 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<sup>31</sup> 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.

<sup>31</sup> 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.

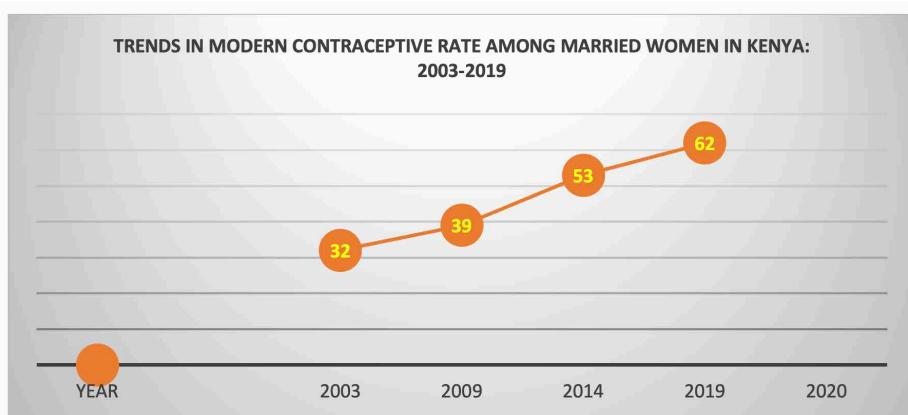


Figure 6: Trend in modern contraceptive rate among married women in Kenya: 2003-2019

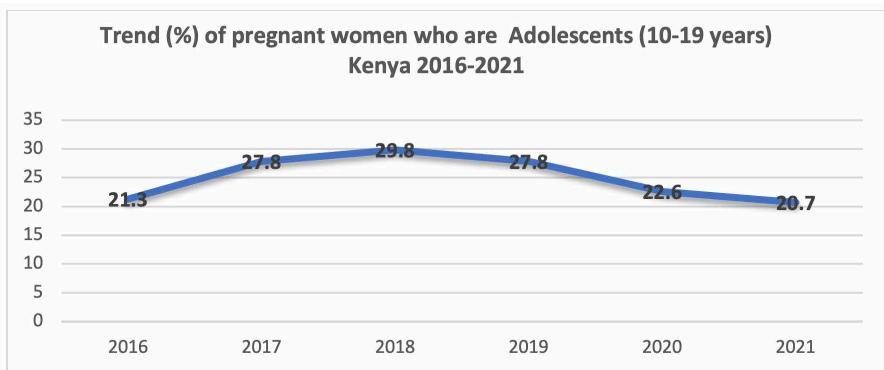


Figure 8: Trend of percentage of pregnancy women who are adolescent

#### **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<sup>32</sup>. 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.

<sup>32</sup> 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.<sup>14</sup> 56.7% of 13-17-year-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; uterotronics, 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. Integrate into RH programming HCW and community empowerment on the utilization of alternative forms of dispute resolutions mechanisms as stipulated in Article 159(2)(c) and (3) of the Constitution of Kenya 2010 to reduce inter-personal violence including SGBV.
7. Establishment of National RH dialogue day to create awareness on RH issues including reduction of harmful practices.
8. 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.
9. 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.

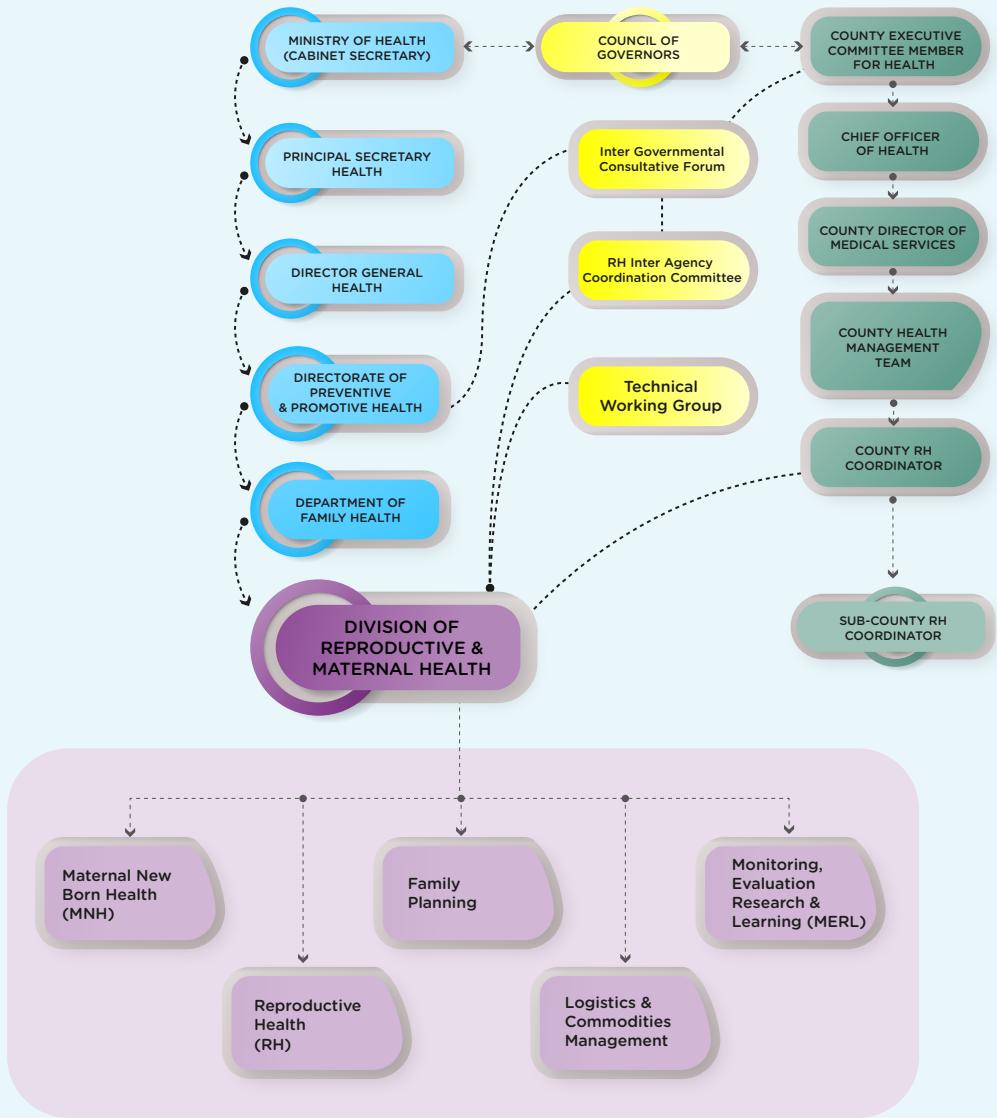
**At the county level.**

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 Level 1 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 experimental 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	<p>Support utilization of ICT and other innovative approaches in delivery of RH information to adolescent and young people in learning institution.</p> <p>Ensure implementation of the Education Re-entry Policy for adolescents and young people</p> <p>Facilitate provision of information to parents and care givers to support the policy agenda for children and young people.</p> <p>Strengthen health referral system in coordination with the MOH.</p> <p>Support the setting up of safe spaces for children and adolescents.</p>
The National Treasury	<p>Mobilize domestic and external resources to finance this policy</p> <p>Allocate financial resources for implementation of the Policy</p> <p>Improve fiscal responsibility.</p> <p>Avail resources to support policy advocacy, mobilization resources to mainstream RH financing with the budgetary cycle and MTEF</p> <p>Integrate RH into community empowerment programs.</p> <p>Finance KNBS to carry out the periodic KDHS which forms the back bone of RH data for the country</p>
National Authority for the Campaign Against Alcohol and Drug Abuse (NACADA)	<p>Ensure enforcement of laws that protect adolescents and young people with regards to alcohol and substance abuse.</p> <p>Create awareness on harmful effects of drugs and substance abuse and its impact on families and communities.</p> <p>Provide geographical, age and sex disaggregated data for alcohol, drug and substance abuse for decision making.</p>
National Human Rights Institutions (KNHRC, KHRC) and National Gender and Equality commission	<p>Investigate violations of RH rights.</p> <p>Operationalize the platform for receiving complaints on violations of RH rights.</p> <p>Monitor implementation of RH commitments and obligations.</p> <p>Expand the utilization of modern technology and local community/social intelligence in SGBV</p> <p>Advocate for the expansion of safety nets and corridors for survivors of SGBV and their dependants</p>

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

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

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
	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

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