



Ministry of Health

National Social and Behavior Change Strategy for Adolescents and Young People Sexual Reproductive Health



2024 - 2030



Republic of Kenya

**The National Social and Behavior Change Strategy for Adolescents and Young People
Sexual Reproductive Health 2024 – 2030**

is a publication of the Ministry of Health, Republic of Kenya



Every life counts

Suggested Citation

Ministry of Health, The National Social and Behavior Change Strategy for Adolescents and Young People
Sexual Reproductive Health 2024 – 2030, Government of Kenya, May 2024.
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Contents

List of Figures	5
Foreword	6
Acknowledgements	7
List of Abbreviations	8
Definition of Terms	9
Executive Summary	11
1 Introduction	13
1.1 Sexual Reproductive Health Overview	15
1.2 Problem statement	16
1.3 Vision	17
1.4 The SBC Broad Strategic Objectives	17
1.5 Guiding Principles	17
1.6 The Strategy Development Process	18
1.7 The Social Ecological Model	19
1.8 Conceptual Framework for the National SBC Strategy for AYPSRH	20
2 Sexual Reproductive Health Status of Adolescents and Young People in Kenya	23
2.1 Individual-level Barriers to Uptake of AYPSRH Services	24
2.1.1 Inadequate Knowledge of Sexual Reproductive Health	24
2.1.2 Inadequate Knowledge on Sexually Transmitted Infections	25
2.1.3 Inadequate Knowledge on HIV Prevention	26
2.1.4 Low Self-Efficacy and Individual Agency	26
2.1.5 Limited Access to Education	26
2.2 Community-level barriers	27
2.2.1 Fears about Stigma Related to SRH Matters	27
2.2.2 Social-cultural Norms	27
2.2.3 Religious Beliefs	27
2.2.4 Gender-based Violence	28
2.2.5 Female Genital Mutilation	28
2.3 Institutional (Organization) – level barriers	29
2.3.1 Limited Access to SRH Services	29

2.4	Policy level barriers	29
2.4.1	Legal and Policy Landscape	29
3	Social Behavior Change Approaches	31
3.1	Strategic Approach	31
3.2	Audience Segmentation	32
3.3	The SBC Approaches for Reaching Primary Audience	33
3.3.1	Adolescents aged 10 – 14 years	33
3.3.2	Adolescents aged 15 – 17 Years	37
3.3.3	Young Adults Aged 18 – 24 Years	39
3.3.4	Adolescent Parents Aged 10 – 19 years	43
3.3.5	Young Parents aged 20 – 24 years	46
3.4	The SBC Approaches for Reaching Secondary Audiences	49
3.4.1	Parents and caregivers of adolescents and young people	49
3.4.2	Health care workers	51
3.4.3	Religious Leaders	53
3.5	The SBC Approaches for Reaching Tertiary Audiences	55
3.5.1	Media: Traditional/New Media	55
3.5.2	Policymakers	57
4	Costed Implementation Plan	59
5	Monitoring and Evaluation Plan	63
6	List of Contributors	69

List of Figures

Figure 1: Strategy Development Process	18
Figure 2: Illustration of the Social-Ecological Model	19
Figure 3: Ideation Model of Strategic Communication and Behavior Change	20
Figure 4: Illustration of Audience Segments	32

Foreword



Kenya is faced with a rapidly growing population; adolescents and young people (AYP) aged 10– 24 years constitute about 33% of the country's total population. The wellbeing of this nearly ten million strong demographic is pivotal for the nation's trajectory, however the population surge strains healthcare, education, housing, employment, and sanitation sectors.

Acknowledging AYP as vital to society, embodying its aspirations, it's imperative to equip them with accurate age appropriate sexual reproductive health (SRH) information and services. This is a strategic investment, backed by the Kenyan Constitution's guarantee of the highest standards of health, including reproductive healthcare.

The Ministry of Health aims to strengthen strategies for preventive and promote SRH services through Social and Behavior Change (SBC) approaches. The SBC approach is recognized as pivotal for fostering sustained changes in social norms and behaviors, overcoming barriers to accessing SRH services and generating demand for them.

Since 2023, the Ministry has led the development of this The National Social and Behavior Change Strategy for Adolescents and Young People Sexual Reproductive Health, incorporating insights from the Reproductive Health Communication Strategy 2012 and addressing current challenges faced by AYP. While progress has been made, urgent attention is required for issues like high teenage pregnancies, sexual gender based violence and increased prevalence of sexually transmitted infections (STIs) and HIV among others.

The National Social and Behavior Change Strategy for Sexual Reproductive Health underscores the Government's commitment to ensuring AYP receive the highest standard of reproductive services, aligning with global mandates of Sustainable Development Goals 3, 5, and 10 for healthy lives, gender equality, and reduced inequality.

This timely strategy serves as a key tool in realizing Universal Health Coverage in Kenya. The Government is fully committed to collaborating with stakeholders at both the national and county levels to execute the SBC strategy and achieve the highest standard of Reproductive Health for AYP.

DR. Patrick Amoth

Director General

Ministry of Health

Executive Summary



The World Health Organization (WHO) defines an adolescent as an individual in the 10 – 19 years age group and usually uses the term young people to denote those between 10 and 24 years. According to world population dashboard Kenya 2023, adolescents and young people (AYP) aged 10 – 24 years constitute about 33% of the country's total population. Rapid population growth, particularly among AYP aged 10 – 24 years, poses challenges to healthcare, education, housing and employment. Some young people miss out on opportunities to develop life skills hence result in engaging in risky behaviors, including drug and substance abuse, dropping out of school and involvement in crime, which may lead to unintended pregnancies, unemployment and life-threatening sexually transmitted diseases and infections.⁶

The Kenya Demographic and Health Survey (KDHS, 2022) indicates elevated levels of teenage pregnancies at 15%, prevalent gender-based violence (16%) and a relatively low awareness of HIV prevention methods, particularly among adolescents aged 15 – 17 years, with slightly more than half (54% of women and 55% of men) being knowledgeable about it.⁷

The Ministry of Health Sexual Reproductive Health Program focuses on reducing adverse reproductive health outcomes of AYP such as; teenage pregnancies, reproductive tract infections, HIV and AIDS, Female Genital Fistulae (FGF), Female Genital Mutilation (FGM), child marriages, sexual and gender-based violence, reproductive tract cancers, drug and substance abuse, and negative social media influence. Despite comprehensive programming, Kenya faces teenage pregnancies at 15% and prevalent gender-based violence (16%), high HIV infection rates among AYP in 15 – 24 years cohort; accounting for 35% of new infections,⁸ and 9.6% prevalence of STIs.⁹ Hence, there is a need to re-evaluate the approaches currently adopted to deliver AYP sexual reproductive health (SRH) and support them through the continuum of change.

Creative and consistent interventions are needed to influence positive behavior change and address deeply rooted myths and misconceptions AYP have about SRH services.¹⁰ Therefore, the Ministry of Health has developed the *National Social and Behavior Change (SBC) strategy for Adolescents and Young People Sexual Reproductive Health (AYPSRH)*, to guide implementation. The strategy envisions a country where AYP adopt healthy SRH behavior and transition to responsible productive adulthood.

The National SBC strategy for AYPSRH objective is to promote positive sexual reproductive health behavior among the AYP in Kenya by the year 2030, through integrated SBC approaches. It deploys behavior change theories to create lasting positive behavior change, contributing to improved AYPSRH outcomes. It is informed by the *National Guidelines for Provision of Adolescent and AYPSRH friendly services in Kenya, 2016*, that outlines the essential package of services.

The strategy is also informed by existing literature; a section of desk review is included that provides a comprehensive understanding of the SRH landscape in Kenya, particularly among AYP. Utilizing the social-ecological framework, the strategy categorizes barriers and enablers to AYPSRH services at individual, community, institutional, and policy levels.

Acknowledgments



The development of the ‘National Social and Behavior Change Strategy for Adolescent and Young People Sexual Reproductive Health’ involved extensive consultations with diverse stakeholders, facilitated through co-design workshops, consultative meetings, and rigorous reviews of multiple strategy drafts.

First and foremost, I express profound gratitude to the Division of Reproductive and Maternal Health (DRMH) team for their exemplary coordination led by Mary Magubo the ACSM/SBC Manager and supported by the SRH team Dr. Jackie Kisua (SRH Manager), alongside Mary Gathitu, Merina Lekorere, and Martin Mburu for their invaluable support and guidance. The Division of Health Promotion, guided by Grace Wasike (Head DIEC), Samson Thuo (NVIP ACSM/SBC Manager), and Dr. Christine Wambugu (Head,DASH),Alice Mwangangi(FP) Dr Estella Waiguru(FP) and Janet Mogire(MNH) Dr.Rose Misati, Nicholas Kigondou(KBC) Steve Gitau(Children’s Department) Florence Musalia(MOE) and Dr.Bob Agwata as well as the various technical units of the Ministry of Health, provided indispensable support to this initiative.

Special appreciation goes to Dr. Grace Miheso (ED) and Alphayo Wamburi from Breakthrough for their critical technical and financial assistance. We extend our thanks to the Ministry of Education, the Children's Department, the State Department for Youth Affairs, Creative Economy and Sports, and the County Governments for their invaluable contributions. Gratitude is also due to USAID and Breakthrough ACTION for their generous financial and technical support.

The active involvement of the Adolescent and Young People ; The Gen z representatives Keegan Gichovi,Cosmas Kolum, Vennessa Mokeira, Hodkan Kento, Talia Wanjiru(Designer) and Wycliffe Biwott for offering invaluable insights into content and design, which has been pivotal in shaping the vision of this strategy. We extend special thanks to our partner Non-Governmental Organizations (NGOs) for their guidance, expertise, and support during the validation process.

Acknowledgment is also extended to the media, policymakers, and politicians for their advocacy and efforts in creating an enabling environment for AYPSRH programs. Religious leaders are recognized for their engagement, guidance, and commitment to promoting positive cultural and religious values related to sexual reproductive health.

This strategy stands as a testament to the collective dedication of all stakeholders involved, and we eagerly anticipate its successful implementation for the benefit of AYP health and future in Kenya.

Dr. Edward Serem

Head, Division Reproductive and Maternal Health

Ministry of Health

List of Abbreviations

ACE	Adverse Childhood Experiences
ACSM	Advocacy Communication and social mobilization
ANC	Antenatal Care
AYP	Adolescent and Young People
AYPSRH	Adolescents and young people Sexual Reproductive Health
CHPs	Community Health Promoters
CHWs	Community Health Workers
FGF	Female Genital Fistulae
FGM	Female Genital Mutilation
FP	Family Planning
HPV	Human Papillomavirus
HCPs	Healthcare Providers
HCWs	Health Care Workers
ICPD POA	International Conference for Population and Development Programme of Action
IEC	Information, Education, and Communication
IUD	Intrauterine Device
KASF	Kenya AIDS Strategic Framework
KDHS	Kenya Demographic and Health Survey
MCA	Member of County Assembly
MOE	Ministry of Education
MOH	Ministry of Health
MOU	Memorandum of Understanding
NSDCC	National Syndemic Disease Control Council
NASCOP	National AIDS and STI Control Programme
NGO	Non-Governmental Organization
PAC	Post-abortion Care
PWD	Persons with disabilities
SDGs	Sustainable Development Goals
SBC	Social and Behavior Change
SEM	Social Ecological Model
SGBV	Sexual and Gender-Based Violence
SRH	Sexual Reproductive Health
STIs	Sexually Transmitted Infections
UHC	Universal Health Coverage

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ICPD PoA	International Conference for Population and Development Programme of Action
IEC	Information, Education, and Communication
IUD	Intrauterine Device
KASF	Kenya AIDS Strategic Framework
KDHS	Kenya Demographic and Health Survey
MCA	Member of County Assembly
MOE	Ministry of Education
MOH	Ministry of Health
MOU	Memorandum of Understanding
NSDCC	National Syndemic Disease Control Council
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SEM	Social Ecological Model
SGBV	Sexual and Gender-Based Violence
SRH	Sexual Reproductive Health
STIs	Sexually Transmitted Infections
UHC	Universal Health Coverage

UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization
WRA	Women of Reproductive Age
GENZ	Generation of people born between 1997 and 2012 characterized by their digital fluency, social media use, and cultural perspective shaped by the internet age.

Definition of Terms

Term	Definition
Adolescents	A person between 10 and 19 years of age.
Adolescent-Friendly Services	Reproductive Health services delivered responsively and to specific needs of adolescents.
Adolescent parents	Women and men between the ages of 10 and 19 who become pregnant and parent their children.
Adolescents and Young people friendly services	Reproductive Health services delivered responsively and to specific needs of adolescents and young people.
Age-appropriate	Suitability of information and services for people of a particular age.
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. ¹
Children in crisis	Children experiencing various adversities like natural disasters, conflict, abuse, poverty, health emergencies, family breakdowns, or trauma, requiring immediate interventions to safeguard their safety, well-being, and development.
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. ²
Gender	Gender is a social construct about maleness or femaleness as it is determined by the socio-cultural attitudes, stereotypes, and norms in any given society. These constructs are learned and reinforced by the family structure, the educational system, the community, and the media.
Gender-based Violence	Refers to any type of harm that is perpetrated against a person due to their gender. ³
Health	A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.
Health Care provider	A licensed person that provides health care services.
Health Care Worker	Anyone who works in a healthcare or social care setting.
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.

¹ The National Reproductive Health Policy 2022 – 2032.

² World Health Organization. (2024). Female genital mutilation: Fact sheet

³ UNHCR Policy on the Prevention of, Risk Mitigation and Response to Gender-based Violence, 2020

Term	Definition
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 ⁴ .
Parents of AYP	A father or mother; one who begets or one who gives birth to or nurtures and raises a child.
Post Abortion Care (PAC)	Consists of emergency treatment for complications related to spontaneous or induced abortion, 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 and treatment of STI, HIV and AIDS.
Persons with disabilities	All persons who have long-term physical, mental, intellectual or sensory impairments which, in interaction with various attitudinal and environmental barriers, hinders their full and effective participation in society on an equal basis with others.
Reproductive Health	Reproductive health refers to the condition of male and female reproductive systems during all life stages. 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 matters relating to the reproductive system, its functions, and processes ⁵ .
Risky behaviors	Acts that increase the risk of disease or injury, which can subsequently lead to disability, death, or social problems e.g. unprotected sex, having multiple sexual partner, early sexual debut, drug and substance use.
Self-efficacy	Refers to an individual's belief in his or her capacity to execute behaviors necessary to produce specific performance attainments.
Sex	Biological state of being male or female.
Sexual reproductive health (SRH)	It is a state of complete physical, mental and social well-being in all matters relating to the reproductive system.
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. Includes: forced sexual relations; sexual coercion; rape and sexual abuse of children.
Social and Behavior Change (SBC)	A set of processes, approaches, tools, strategies, and tactics that promote positive and measurable changes in people's environments, societies, and behaviors. It encompasses; A Human Centered Design (HCD) approach to deepen understanding of the barriers to change among targeted audiences and develop new SBC interventions; Community Engagement to strengthen community capacity and agency to address the determinants of key behaviors by designing their own and Social and Behavior Change Communication (SBCC) , approach that emphasizes the use of communication techniques to bring about social and behavioral change.
Supportive Supervision	A process of guiding, helping, building capacities, and learning from staff at their places of work.
Universal Health Coverage (UHC)	Ensuring that everyone who needs health services can get them without undue financial hardship.
Youth	The collectivity of all individuals in the republic of Kenya who have attained the age of eighteen years but have not attained the age of thirty-five years.

⁴ The National Reproductive Health Policy 2022 – 2032

⁵ Reproductive health (who.int) accessed Feb 2022



1

Introduction

Adolescence is a period of transition from childhood to adulthood during which, boys and girls undergo physical, behavioral, cognitive, social, intellectual and emotional growth. An adolescent is a person between 10 and 19 years of age.¹¹ It is estimated that there are 1.2 billion young people aged 15 – 24 years, accounting for 16% of the global population.¹² Young people make up the largest and fastest growing proportion of the general population in East and Southern Africa; in 2022, 32% of the population were adolescents and young people (AYP) aged 10 – 24 years.¹³

Kenya is faced with a rapidly growing population. According to world population dashboard Kenya 2023, AYP aged 10 – 24 years constitute about 33% of the country's total population. The wellbeing of this fast-growing, almost ten-million-strong AYP is vital to the country's future.¹⁴ The rapid increase in population has created substantial demands on healthcare, education, housing, employment, water and sanitation.

Studies show that adolescents across Sub-Saharan Africa face vast unmet needs for sexual reproductive health (SRH).¹⁵ Moreover, there are glaring inequalities in the levels and trends of key SRH priorities like harmful practices including female genital mutilation (FGM), child marriage, sexual and gender-based violence (SGBV) and healthy behaviors like having protected sex and the uptake of SRH services. Adolescents and young people in Kenya go through a myriad of challenges; for instance, the KDHS 2022 indicates high teenage pregnancies at 15% and prevalent gender-based violence (16%). According to NASCOP report 2022, young women 20 – 24 years were more than five times likely to be infected with HIV than their male counterparts; 3.4% among women versus 0.6% among men.¹⁶ For Kenya to achieve Vision 2030, there is need to adopt innovative strategies to meet the SRH needs of AYP.

Ensuring universal access to health services is one of the focus targets of the SDG (target 3.7 and target 5.6). Kenya is a state party to various international and regional human rights instruments that guarantee the right to sexual reproductive healthcare. The Constitution of Kenya guarantees the right to the highest attainable standards of health including reproductive healthcare. The *National Guidelines for Provision of Adolescent and AYPSRH friendly services in Kenya*, outlines the package of services as: Counselling on SRH; pregnancy testing; Sexually Transmitted Infections

¹¹ Ministry of Health, DRMH; Understanding Adolescence: A Guide for Adolescents 2021 Edition

¹² United Nations; Peace, dignity and equality on healthy planet.

¹³ UPFA East and Southern Africa; Young People; 2022

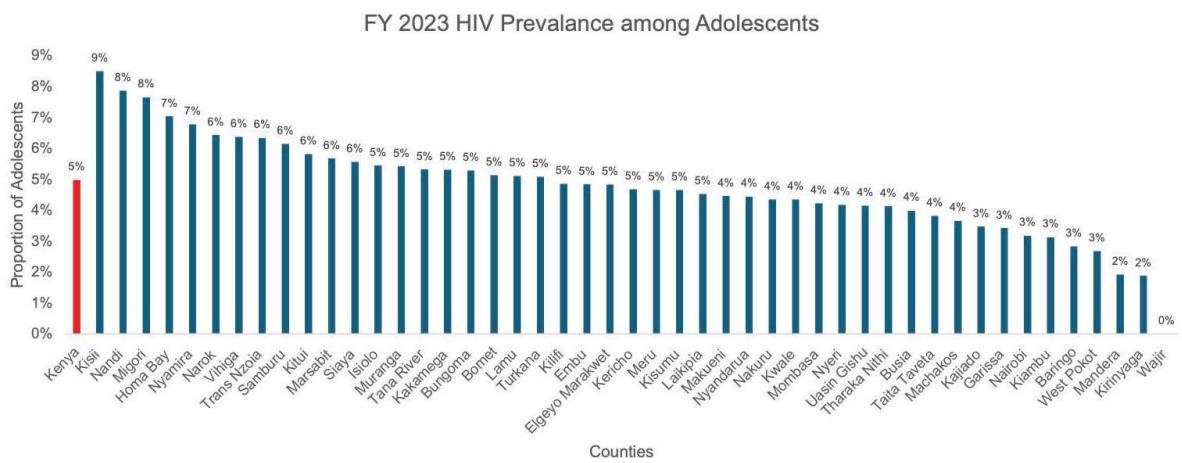
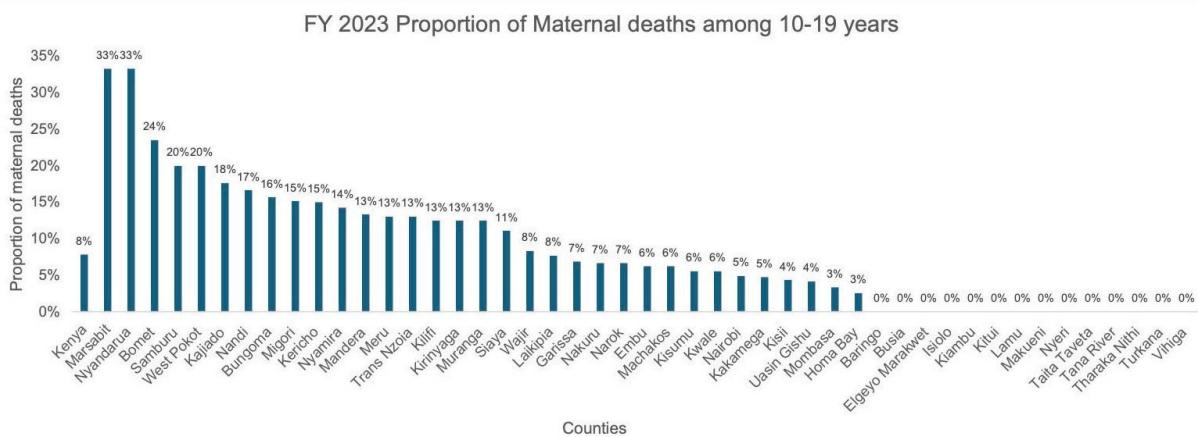
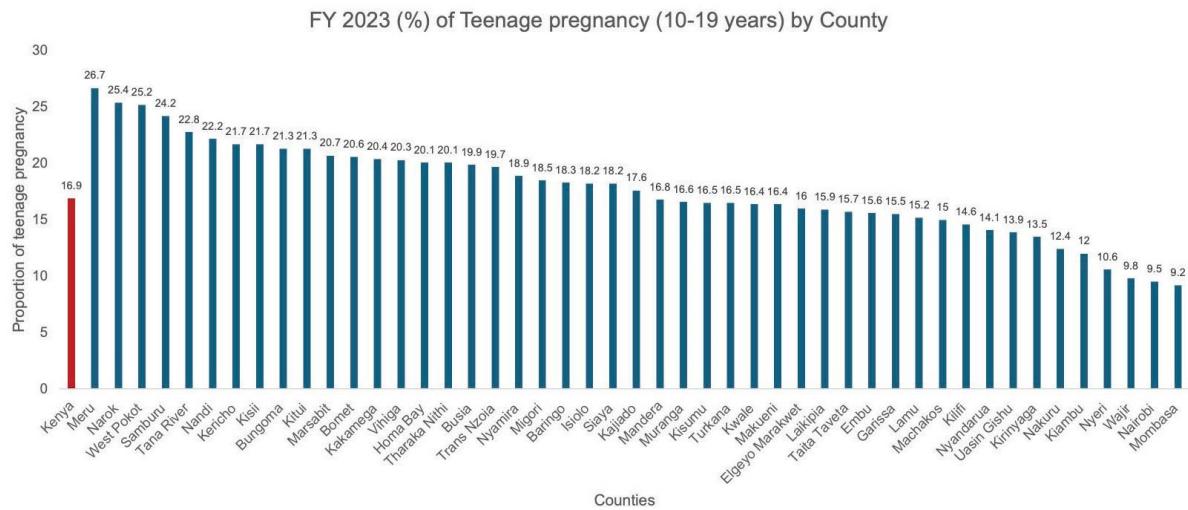
¹⁴ Next Generation Kenya, 2018: British Council; Listening to the voices of young people

¹⁵ Chandra-Mouli, V., Neal, S. & Moller, AB. Adolescent sexual reproductive health for all in sub-Saharan Africa: a spotlight on inequalities. *Reprod Health* 18 (Suppl 1), 118 (2021).

¹⁶ Kenya Population-based HIV Impact Assessment (KENPHIA) 2018: NASCOP; August 2022.

(STIs) counselling, screening and treatment; reproductive and urinary tract infection testing and treatment; Post Abortion Care (PAC); SGBV counselling, services and referrals; antenatal and post-natal care; HPV screening and vaccination; life skills; HIV services e.g. prevention of mother to child transmission services, Voluntary Medical Male Circumcision (VMMC); counselling on drugs and substance abuse including alcohol and tobacco use. The Nairobi Summit (ICPD+25) also emphasized the importance of the essential package of SRH services that should be provided to ensure choices, access and utilization of AYPSRH services.

The following data charts indicate some key statistics for AYPSRH in Kenya:



1.1 Sexual Reproductive Health Overview

The Ministry of Health (MoH) Sexual Reproductive Health Program is responsible for overseeing the execution of AYPSRH. The *National Adolescent Sexual Reproductive Health Policy 2015*, aims to enhance the SRH status of adolescents and young people (AYP) in Kenya through promoting the provision of accurate information and SRH services. This could be achieved by complementing existing service provision channels to capture the diverse needs of the target population.

The roadmap for implementation is guided by the *National Reproductive Health Policy 2022 – 2032*, *National Guidelines for Provision of Adolescent and AYPSRH friendly services in Kenya, 2016*, *Kenya Community Health Strategy 2020 – 2025*, the *Kenya Universal Health Coverage Policy 2020 – 2030*, among other national, regional, and international strategies. The program involves a multi-stakeholder collaboration, engaging organizations from the civil society, education, and youth affairs sectors.

One of the goals of the MoH is **to improve reproductive health outcomes among adolescents and young people (AYP) 10 – 24 years**. The specific goals include improving the following:

1. Access to age appropriate SRH information and reproductive health services;
2. Prevention and treatment of all STIs including HPV and HIV;
3. Prevention of unintended pregnancies;
4. Protection from harmful practices;
5. Sexual and gender-based violence awareness, prevention and response.

The ministry recognizes that health outcomes of individuals, families, and communities are significantly influenced by the social determinants of health that include both structural determinants and intermediary determinants, that shape human interaction and the ability to act or change behaviors.

Mental health problems and in particular depression is one of the causes of the burden of disease among AYP: poor mental health is associated with several health and social outcomes such as; alcohol and substance abuse, adolescent pregnancies and school dropouts.¹⁷ The *Kenya Mental Health policy 2015 – 2030* seeks to destigmatize, decriminalize and offer guidance on handling mental health concerns. In addition, the MOH has developed a guide for adolescents – *Understanding Adolescence* – that incorporates messages on SRH and mental health; causes of stress, stress management and how to avoid it.

Kenya is committed to ensuring the highest standard of health for its citizens by the year 2030, through provision of age-appropriate health information, protection of children, elimination of preventable maternal and newborn morbidity and mortality, prevention mother to child transmission of HIV, and reduction of teenage pregnancies, as well as new HIV infections among AYP.¹⁸

The ministry aims to implement strategies for preventive and promotive services for SRH through social and behavior change (SBC). The SBC interventions aim to influence key behaviors, social norms, and barriers that influence AYP by addressing individual, social, or structural determinants of desired changes.¹⁹

Further, the program aims to create a comprehensive '*National SBC strategy for AYPSRH*' that will serve as a guiding framework for implementation. Secondary data review findings played a key role in pinpointing strengths, identifying gaps, recognizing best practices, and emerging issues, that informed the focus of the SBC strategy. The insights gathered empowered the SRH program to tailor SBC interventions specifically for AYP, maximizing the effectiveness of efforts to increase demand and uptake of SRH services.

¹⁷ National AIDS and STI Control Program (NASCOP), Adolescents package of care in Kenya: A health care provider guide to adolescent care: 2014

¹⁸ The African Women's Development and Communications Network; Sexual reproductive health and rights at a glance, Kenya Factsheet: 2022

¹⁹ USAID, Social and behavior change and health system strengthening; 2022

1.2 Problem statement

Adolescents and young people (AYP) encounter formidable challenges in adopting behaviors conducive to healthy Sexual Reproductive Health (SRH), thereby exposing themselves to significant risks that impact their overall well-being. The Kenya Demographic and Health Survey indicates elevated levels of teenage pregnancies at 15%, prevalent gender-based violence (16%) among young women, and a relatively low awareness of HIV prevention methods, particularly among adolescents aged 15 – 17 years, with slightly more than half (54% of women and 55% of men) being knowledgeable about it.²⁰ Further, the young people 15 – 24 years account for 35% of new HIV infections in Kenya,²¹ and an STI prevalence of 9.6%.²²

The challenges faced by AYP in Kenya are compounded by unhealthy explorative sexual behavior, such as early sexual debut which is at the mean age of 16 years.²³ Other factors include: engaging in unsafe sex practices, and having multiple sexual partners.²⁴ These challenges are attributed to individual level barriers like school dropouts, drug and substance abuse, low self-efficacy in SRH, inadequate age-appropriate information in SRH, HIV and STIs.

Community level barriers to AYPSRH include stigma, socio-cultural norms, religious beliefs, gender-based violence (GBV), FGM and child marriages, which are major public health concerns.²⁵ The KDHS shows that the prevalence of sexual violence is 7.2% for women and 4.8% for men in the 15 – 19 years age group, and for those aged 20 – 24 years, it is 11.3% for women and 8.1% for men; while the prevalence of FGM is 15%.²⁶ Further, poor health-seeking behavior is prevalent, influenced by the inadequacy of facilities offering youth-friendly services and the attitudes of healthcare providers.²⁷

Studies have documented that adolescent pregnancy, increases the risk of maternal morbidity and mortality, including complications of unsafe abortion, prolonged labor, and sepsis during the postnatal period.²⁸

Despite the comprehensive SRH programming, there is still an unmet need for AYPSRH services. This strategy provides a tactical approach and activities that will address the problems affecting AYP health-seeking behaviors and will reverse the trend.

²⁰ Kenya Demographic Health Survey (KDHS) Report 2022

²¹ UNICEF Report, 2022: Protecting children and adolescents from HIV and AIDS and providing care

²² Hong-Ha M. Truong et al. Prevalence of chlamydia and gonorrhea among adolescents in Kisumu, Kenya: 2023

²³ Sing'oei, V. et al. Early sexual debut is associated with drug use and decreased educational attainment among males and females in Kisumu County, Kenya. Reprod Health 20, 111 (2023)

²⁴ Odo AN, Samuel ES, Nwagu EN, Nnamani PO, Atama CS. Sexual reproductive health services (SRHS) for adolescents in Enugu state, Nigeria: a mixed methods approach. BMC Health Serv Res. 2018

²⁵ Habte, A., Dessu, S. The uptake of key elements of sexual reproductive health services and its predictors among rural adolescents in Southern Ethiopia, 2020

²⁶ Kenya Demographic Health Survey (KDHS) Report 2022

²⁷ Masaba BB, et al.: Devolution of healthcare system in Kenya: progress and challenges. 2020.

²⁸ Nove A, Matthews Z, Neal S, Camacho AV. Maternal mortality in adolescents compared with women of other ages: evidence from 144 countries. The Lancet Global Health. 2014

1.3 Vision

A country where adolescents and young people (AYP) adopt healthy sexual reproductive health (SRH) behavior and transition to responsible productive adulthood.

1.4 The SBC Broad Strategic Objectives

Promotion of positive sexual reproductive health behavior among the AYP through integrated SBC approaches by the year 2030.

Strategic Objectives:

1. Promote SRH knowledge and skills among the AYP;
2. Create demand and acceptability, for age-appropriate SRH services among the AYP;
3. Strengthen the health care system to be responsive to AYPSRH needs;
4. Foster an enabling environment through a multi-sectorial collaboration for the implementation of the National SBC strategy for AYPSRH.

1.5 Guiding Principles

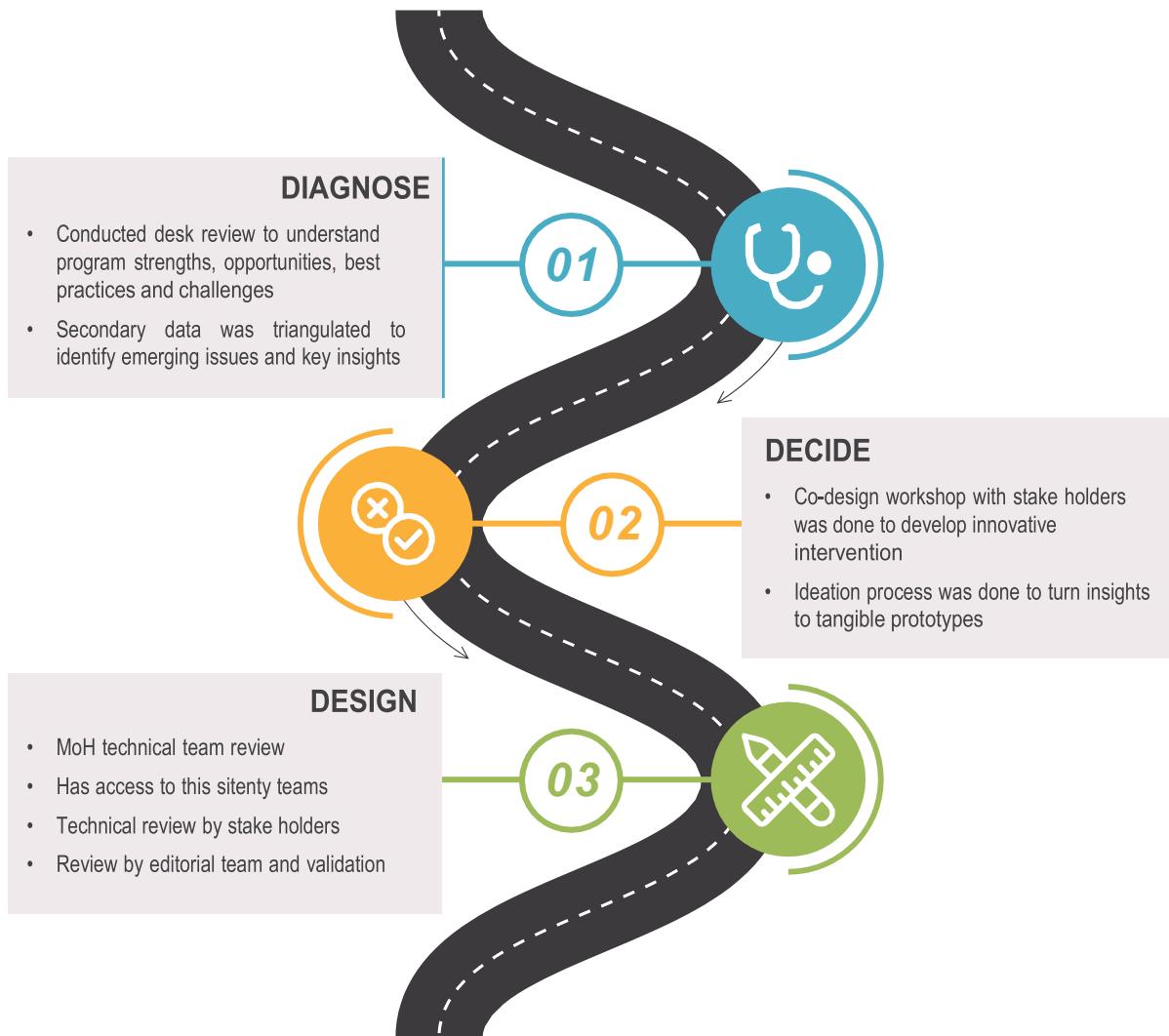
These are informed by basic principles of communication and the SRH goals:

- **Right to Health** as provided in the constitution of Kenya.
- **Do no harm:** All Interventions will be dignified and respectful of beneficiaries without causing harm such as intimidation, stigmatization or abuse.
- **Consistency:** Interventions will always be in line with the policies, plans, programs, and objectives of SRH, MoH and not in conflict with them.
- **Results-oriented:** Effective interventions will be evidenced by improved SRH outcomes among AYP.
- **Audience-centered:** All interventions will be adapted to the local context, age, language and respond to the changing needs and preferences of the target audience.
- **Participatory:** The involvement of key stakeholders in planning, implementation, monitoring and evaluation.
- **Multi-pronged approach:** A mix of strategies will be implemented complementarily, targeting different levels of influence depending on resource availability.
- **Equity:** This strategy will embrace fairness and impartial treatment to all stakeholders.
- **Innovation:** The strategy will utilize cutting-edge technologies, tailored age-appropriate and culturally sensitive interventions to effectively engage and empower AYP in making informed decisions about their SRH.

1.6 The Strategy Development Process

The National SBC strategy for AYPSRH development process adopted a consultative and multisectoral approach, engaging a diverse array of stakeholders. The process deployed both human-centered design and public health approach to ensure the relevance of proposed strategies within the specific context. The *Figure 1* below illustrates the process:

Figure 1: Strategy Development process



Diagnose:

An extensive literature review was conducted to comprehend the program strengths, best practices, opportunities and challenges. Analysis of secondary data was done to pinpoint emerging issues, providing crucial insights that informed strategies for different target groups.

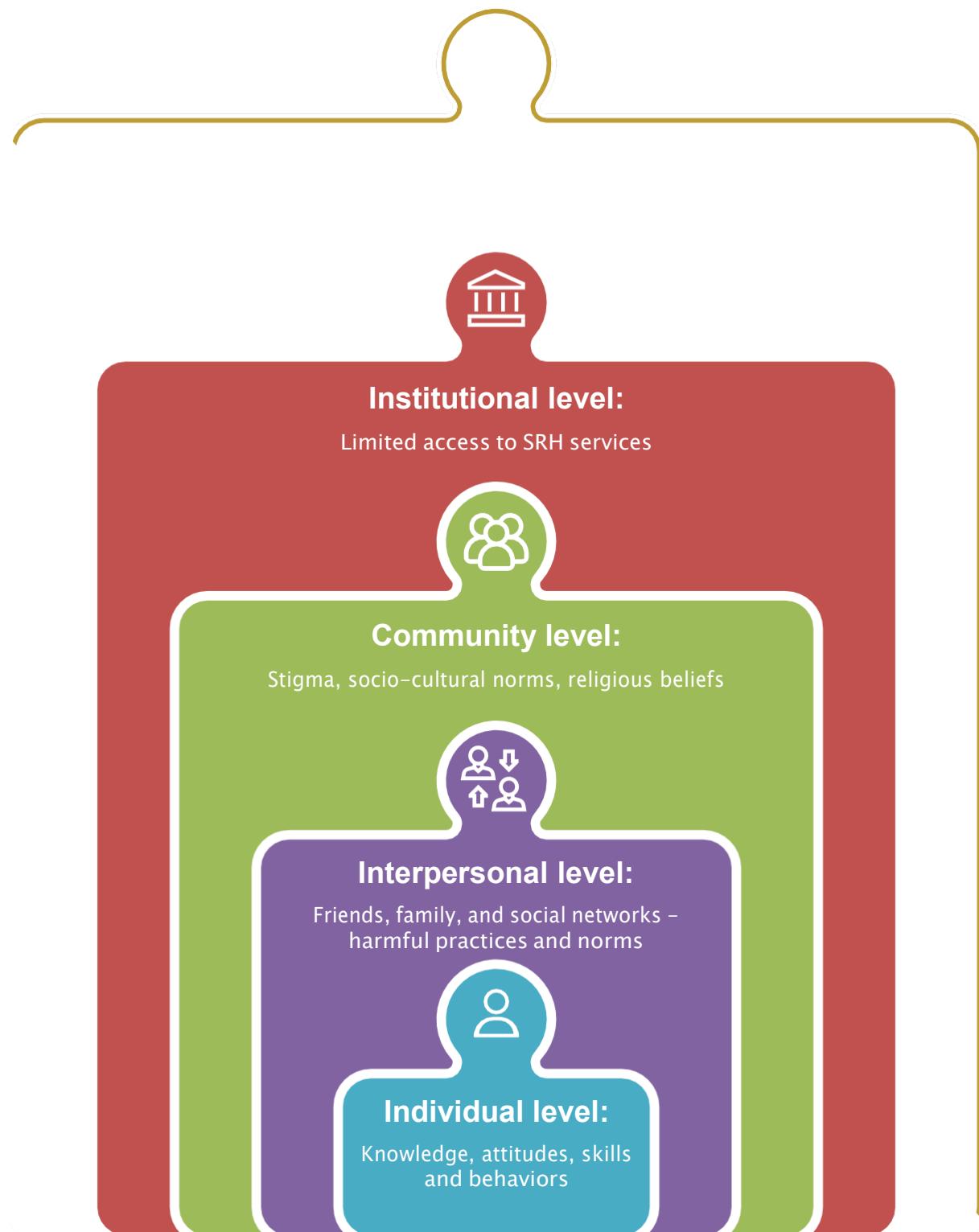
Decide and Design:

A collaborative co-design workshop involving key stakeholders was convened to develop innovative SBC approaches for primary, secondary and tertiary audiences. Following an ideation process, insights were refined into tangible prototypes. The finalized prototypes underwent presentation and review by the MoH technical team, county teams, stakeholders and the editorial team, culminating in the validation of the final strategy.

1.7 The Social Ecological Model

This SBC strategy is anchored on the social ecological model (SEM) which recognizes that behaviors take place within a complex web of social and cultural influences at individual, interpersonal, community, institutional and policy levels. Within the SEM, individuals' decisions and behaviors are understood to depend on their own characteristics, as well as the social and environmental contexts in which they live. The following is an illustration of the SEM:

Figure 2: Illustration oF the social-ecological model



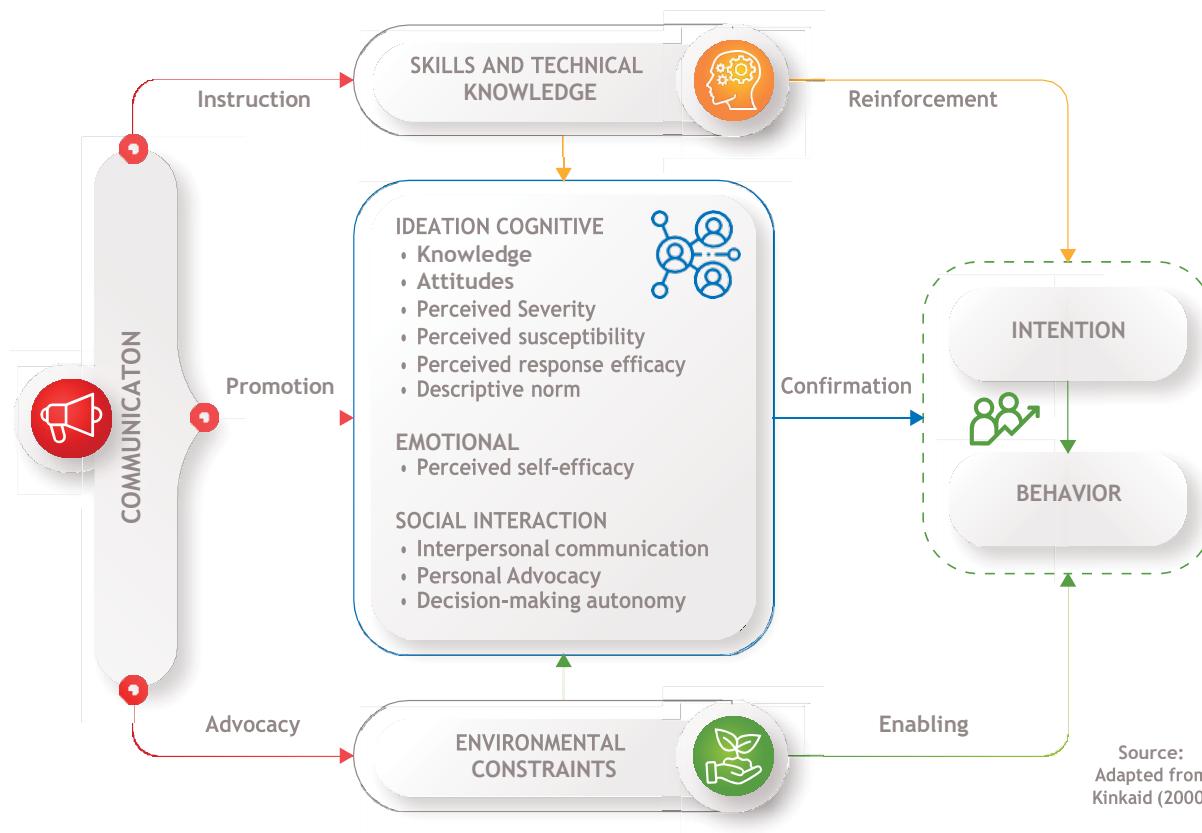
1.8 Conceptual Framework for the National SBC Strategy for AYPSRH

The conceptual framework underlying this strategy is the ideation model for strategic communication and behavior change. This model of behavior change focuses on the multiple, inter-related psychosocial variables that commonly influence individual behavior. As shown in *Figure 3*, the ideation model recognizes most behavioral decisions as driven by multiple (often simultaneous) psychosocial factors. The model has three components, each comprising several variables:

1. Cognitive elements such as knowledge, attitudes, beliefs, values, perceived risk, descriptive norms, and self-image;
2. Emotional elements such as response, empathy, and self-efficacy; and
3. Social elements such as Interpersonal communication, personal advocacy, and decision-making autonomy.

The component variables function like risk factors for disease but in a positive way: the more ideational variables that apply to a person, the more likely that individual is to adopt the behavior. Ideational variables are also influenced by communication, (e.g. social interaction, mass media, or interpersonal. Research has demonstrated a relationship between ideation and protective SRH behavior, including delay of sexual debut, SRH services uptake, and prevention of HIV and STIs. The model also includes environmental constraints, which are often under-emphasized in social and behavior change communication programming. Social determinants of health, such as social class, income, race, ethnicity, education, occupation, gender, and access to health care, are recognized as important according to the World Health Organization (WHO).²⁹

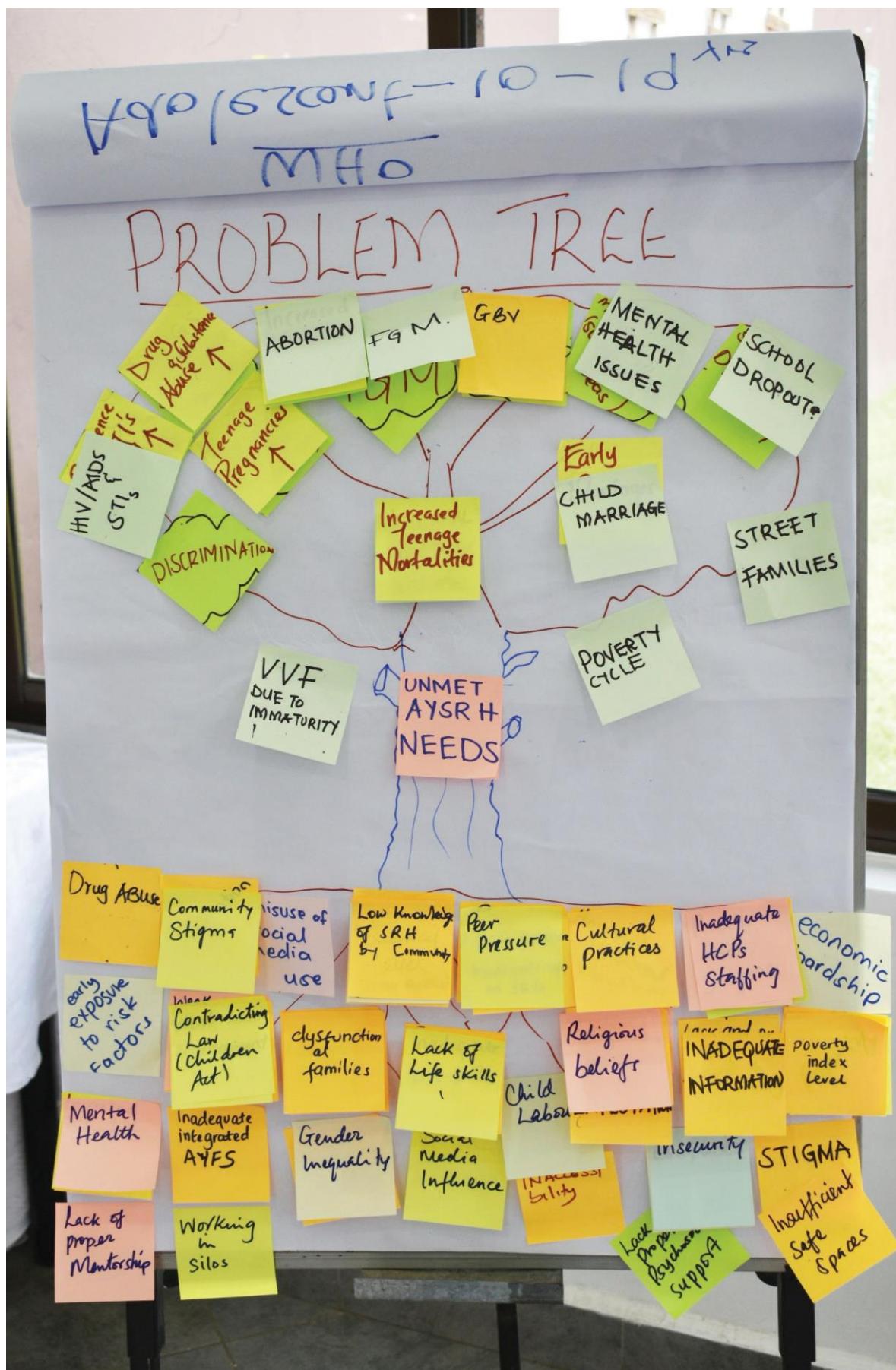
Figure 3: Ideation Model of Strategic Communication and Behavior Change



²⁹ World Health Organization; Social determinants of health

Illustrative SRH ideational indicators

- Perceived susceptibility is the belief that an adolescent or young person is likely to be affected for instance, by an unplanned pregnancy, HIV, and/or STIs.
- Perceived severity is the belief that the consequences of an unplanned pregnancy, HIV transmission, and/or STIs would be severe.
- Perceived response-efficacy is the belief that recommended actions (e.g., delay of sexual debut, safe sex, SRH services) will help AYP to minimize these threats.
- Perceived self-efficacy is a belief in an adolescent or young person's ability to take actions related to preventing unwanted SRH-related consequences.
- Descriptive norms are the perceptions of what other people do, and injunctive norms are the perceptions of what is approved or disapproved of by others.
- Interpersonal communication is the discussion with AYP about SRH topics (e.g., delay of sexual debut, safe sex).
- Decision-making autonomy is an adolescent or young person's active involvement in decisions related to SRH.



2

Sexual Reproductive Health Status of Adolescents and Young People in Kenya

A comprehensive literature review was conducted, encompassing an exhaustive search and examination of existing policies, national guidelines on reproductive health services, as well as publications in the realm of AYPSRH. The exercise was conducted between October and December 2023. The data analysis was done to generate valuable insights that informed this National SBC strategy for AYPSRH.

While there is no universal agreement on which healthcare services are needed to enable people to attain the highest standard of sexual reproductive health, in 1994 the International Conference for Population and Development Programme of Action (ICPD PoA) identified many of the services that are today considered essential.³⁰ The *Kenya National Guidelines for Provision of Adolescent and AYPSRH friendly services in Kenya, 2016* outlines the following as the recommended package of services:

The essential package of Sexual Reproductive Health interventions:

- Counselling on Sexual Reproductive Health, including growth, development, and relationships
- Accurate age-appropriate information on SRH
- Pregnancy testing
- Sexually Transmitted Infections (STIs) counselling, screening and treatment
- Reproductive and urinary tract infection testing and treatment
- Contraception counselling and provision of contraceptive methods as guide by RH policies and legal frameworks
- Counselling and treatment of irregular or painful menstruation, screening for anaemia

³⁰ Critical considerations and actions for achieving universal access to sexual reproductive health in the context of universal health coverage through a primary health care approach. Geneva: World Health Organization; 2022.

- Post Abortion Care (PAC)
- Screening services e.g. breast, cervical cancer screening
- Other Reproductive Health services e.g. prenatal counselling; HPV screening and vaccination; HIV services e.g. prevention of mother to child transmission services, Voluntary Medical Male Circumcision (VMMC) etc.
- HIV counselling and testing, linkages to care and support and initiation of ART for eligible adolescents and young people
- Nutritional counselling and screening services including advice on physical activity
- Personal hygiene and sanitation
- Life skills, values clarification, goal setting, communication skills, decision making skills, and financial literacy
- Mental health services as appropriate
- Counselling on drugs and substance abuse including alcohol and tobacco use and abuse
- Stress management
- Referral, linkages and follow-up.

According to *ICPD+25 Nairobi Summit Commitments analysis report*, progress in SRH programming has been made, which has enhanced public knowledge about adolescents and young people (AYP), their needs, concerns and ways to help them overcome barriers to SRH information and services.³¹

This strategy applies the Social Ecological Model (SEM) to organize barriers and enablers to AYPSRH information and services. The subtopics for the literature review section were informed by the social determinants under the various levels as indicated in the SEM.

2.1 Individual-level Barriers to Uptake of AYPSRH Services

These refer to factors that would hinder primary audience, that is AYP, behavior change and subsequent uptake of SRH services. They include knowledge, attitudes and skills – self efficacy.

2.1.1 Inadequate Knowledge of Sexual Reproductive Health

Adolescents need complete and correct knowledge on AYPSRH including:

2.1.1.1 Age-appropriate culturally sensitive sexual reproductive health information

Age-appropriate sexual reproductive health information is necessary to ensure healthy sexual and reproductive lives for AYP. It should include accurate information on a range of age-appropriate topics; should be participatory; and should foster knowledge, attitudes, values and skills in SRH.³²

³¹ ICPD+25 Nairobi Summit Commitment Analysis Report; 2020: A roadmap for fulfilling the promise

³² United Nations Population Fund (UNFPA), Operational Guidance for Age-appropriate sexuality education: A Focus on Human Rights and Gender, New York: UNFPA, 2014, s

The SRH education equips AYP with knowledge and skills to help them make informed decisions to prevent sexual and reproductive infections including HIV, other sexually transmitted infections (STIs) and unplanned pregnancy.³³ In numerous Kenyan communities, discussing sex is considered a taboo and the family's reputation and status take precedence.³⁴

Parents are often in denial about their children being sexually active, or are hesitant to discuss SRH with their AYP, yet their responsibility in SRH education is critical. Some of the topics of discussion may include: abstinence, STIs, HIV and preferred age-appropriate sexual reproductive information. Some of the best practices for delivery of SRH information to AYP include; school-based teaching, use of online resources and social media, community-based elements or trusted individuals.³⁵

This document is anchored on the existing legal frameworks including the Children Act which states that, “exposure to age-inappropriate content, information and dissemination to a child of any material, information, education or health services that promotes, induces, condones, or normalizes sexual activity or behavior among children or with children or any other similar acts calculate to cause physical, emotional, economic or psychological injury to a child” is Child Abuse.³⁶

2.1.1.2 Early Sexual Debut and Unintended Pregnancies

The Kenya Demographic and Health Survey 2022 shows that, the mean age of sexual debut in Kenya is 16 years; for females being 16 years, while for males is 15.4 years. The same study indicated that teenage pregnancy rates declined to 15% in 2022, from 18% in 2014; the rate is still significant. The early childbearing poses increased health risks to adolescent and young mothers, as well as hampering their access to education.³⁷ It is also important to note that maternal conditions are a cause of death among adolescent girls globally.

Research has proven that trends in delayed marriages do not indicate a decrease in the age of onset of sexual activity among young people, but rather highlights the need to improve access to SRH information, skills and services to prevent unintended pregnancies and sexually transmitted infections.³⁸

2.12 Inadequate Knowledge on Sexually Transmitted Infections

Sexually transmitted infections (STIs) are a major global cause of infertility, acute illness, long-term disability and mortality, with severe medical and psychological consequences.³⁹ Each year, there are an estimated 374 million new infections globally, with 1 of 4 curable STIs (chlamydia, gonorrhea, syphilis and trichomoniasis); with the highest reported rates being among young people aged 15 – 24.⁴⁰ A study conducted in Kenya, showed an STI prevalence of 9.6% overall and was higher among girls than boys (12.5% vs. 6.3%). Additionally, the study showed STI prevalence was higher among adolescents who had engaged in transactional sex (13.0%) and those who had experienced forced sex (12.2%).⁴¹ The high prevalence of STIs observed among

³³ Leekuan, P., Kane, R., Sukwong, P. et al. Understanding sexual reproductive health from the perspective of late adolescents in Northern Thailand: a phenomenological study. *Reprod Health* 19, (2022).

³⁴ Mutea L, Ontiri S, Kadiri F, Michielesen K, Gichangi P. Access to information and use of adolescent sexual reproductive health services: Kenya. 2020.

³⁵ Miranda Håkansson, et al.: Unmet Needs for Age-appropriate sexuality education: A Qualitative Study Among Secondary School Students in Western Kenya, *American Journal of Sexuality Education*, (2023)

³⁶ Children's Act 2022

³⁷ World health statistics 2023 – Monitoring health for the SDGs

³⁸ Ninsiima, L.R., Chiumia, I.K. & Ndejjo, R. Factors influencing access to and utilization of youth-friendly sexual reproductive health services in Sub-Saharan Africa: *Reprod Health* 18, 135 (2021).

³⁹ Louis Kobina Dadzie, et al.: Self-reported sexually transmitted infections among adolescent girls and young women in sub-Saharan Africa, *International Health*, Volume 14, Issue 6, November 2022, Pages 545–553,

⁴⁰ World Health Organization, fact sheet: Sexually transmitted infections (STIs): 2023

⁴¹ Hong-Ha M. Truong et al. Prevalence of chlamydia and gonorrhea among adolescents in Kisumu, Kenya: 2023

adolescent girls and young women (AGYW) compared to their male counterparts may be related to; increased biological susceptibility, decreased educational and economic opportunities, older sexual partners, increased risk for sexual coercion, and cultural norms and gender inequalities that reduce access to sexual health resources.⁴²

213 Inadequate Knowledge on HIV Prevention

There is inadequate HIV prevention knowledge among the AYP; the KDHS 2022 indicates that slightly more than half of young people in Kenya know about HIV prevention (54% of women and 55% of men). The survey also showed knowledge of prevention was lowest among young people aged 15–17 years (44% each of women and men). The same study states that knowledge about HIV prevention increases with higher levels of education, from 13% among young women with no education to 69% among those with above secondary education and from 14% among young men with no education to 80% among those with more than a secondary education.⁴³

214 Low Self-Efficacy and Individual Agency

Self-efficacy is defined as one's perceived ability to deal with a task or situation while individual agency is one's actual ability to deal with a task or situation. Self-efficacy, individual agency coupled with SRH knowledge about the availability and type of services offered may act as barriers or facilitators to SRH utilization among adolescent girls.⁴⁴ In order to enhance self-efficacy and individual agency among adolescent girls regarding SRH, targeted interventions should focus on skill-building programs and peer support networks. Empowering girls with SRH education, communication skills, and decision-making abilities can effectively address these factors, promoting informed decision-making and utilization of SRH services.⁴⁵

215 Limited Access to Education

Most countries in the world have included the right to education in their constitutions. Kenya has followed suit to ensure AYP do not fall out of the education system. At the same time, attending school may reduce the likelihood of adolescent girls entering age-disparate relationships, delay their sexual debut and first pregnancy, and protect them from acquiring STIs.⁴⁶ Curiosity, peer pressure, coercion, expectation of gifts/ money and forced intercourse are the most common reasons for early sexual activity. Moreover, Out-of-school adolescent girls are highly vulnerable to adverse SRH outcomes and interventions are needed to support keeping them enrolled in and attending primary and secondary education.⁴⁷ The same study reveals that school represents an important avenue to disseminate age-appropriate SRH information, which may in turn improve SRH outcomes for adolescents.

⁴² Yuh T, et. al. Sexually Transmitted Infections Among Kenyan Adolescent Girls and Young Women with Limited Sexual Experience. *Front Public Health*. 2020 Jul 14:8:303. doi: 10.3389/fpubh.2020.00303. PMID: 32766197; PMCID: PMC7381162.

⁴³ Kenya Demographic Health Survey: 2022

⁴⁴ Republic of Kenya Ministry of Health. National guidelines for provision of adolescent and youth-friendly services in Kenya. Second Edition. Nairobi, Kenya: 2016.

⁴⁵ Candice Groenewald, Nazeema Isaacs, Phiwokazi Qoza; Hope, agency, and adolescents' sexual reproductive health: A mini review: 2023

⁴⁶ De Neve JW, et al.: Are out-of-school adolescents at higher risk of adverse health outcomes? Evidence from 9 diverse settings in sub-Saharan Africa. *Tropical Med Int Health*; 2020

⁴⁷ Thirugnanasampanthar, S.S., Embleton, L., Di Ruggiero, E. et al. School attendance and sexual reproductive health outcomes among adolescent girls in Kenya; 2023

2.2 Community-level barriers

These barriers involve people who are around and influence the AYP directly, such as parents, teachers and health care workers (HCWs). Family members, media, and social networks have a role to play in teaching AYP appropriate behaviors⁴⁸ and norms for interacting, forming relationships, and engaging in social and sexual behaviors. The same study also states the barriers to SRH among AYP as: restrictive norms and stigma around adolescent and young people SRH; inequitable or harmful gender norms; discrimination and judgment by communities, families, partners, and healthcare providers.

221 Fears about Stigma Related to SRH Matters

In Kenya stigma, fear of parental judgment, family dishonor, and shame related to SRH issues are key factors hindering uptake of services among AYP.⁴⁹ Interventions to destigmatize AYPSRH services uptake in the community and to improve communication about sensitive topics between parents and adolescents are vital to improving SRH among AYP. Parents can be an important source of SRH information for very young adolescents and are likely to have a significant influence on adolescents' sexual health attitudes, values, and risk-related beliefs.⁵⁰ Adolescents do not want to be seen by friends or community members at the health facility receiving SRH services due to association of AYPSRH services with sexual activities.⁵¹

222 Social-cultural Norms

In Kenya, some of social norms often construct adolescent SRH as a taboo, preventing AYP from utilizing SRH services for fear of judgment and discrimination from parents, peers, and other community members.³⁶ For example, SRH services use is considered as inappropriate for unmarried adolescents hence they are less likely to use them.³⁴

223 Religious Beliefs

Studies have shown that religious institutions play a role in delivering SRH information to AYP, which influences knowledge, beliefs and their behaviors. For instance, some religions are reluctant to teach SRH because they regard it as a sin.⁵² Some faith-based institutions believe that providing SRH education promotes immorality and violates God's commandment to abstain from premarital sex. Religious leaders reiterate this idea to the followers, emphasizing that young people should be nurtured to grow within this belief.⁵³ A study conducted in Western Kenya revealed that religious leaders held the belief that the uptake of SRH services by young girls would have detrimental effects on their future reproductive abilities.⁵⁴ It is therefore imperative to address religious barriers and leverage on the religions' structures to reach AYP and their parents.

⁴⁸ Kågesten AE, et al. Sexual wellbeing in early adolescence: a cross-sectional assessment among girls and boys in urban Indonesia; 2021

⁴⁹ Harrington EK, et al.: "Spoiled" girls: Understanding social influences on adolescent contraceptive decision-making in Kenya. PLoS ONE; 2021

⁵⁰ Maina BW, Ushie BA, Kabiru CW. Parent-child sexual reproductive health communication among very young adolescents in Korogocho informal settlement in Nairobi, Kenya; 2020

⁵¹ Sidamo NB, Kerbo AA, Gidebo KD, Wado YD. Socio-Ecological Analysis of Barriers to Access and Utilization of Adolescent Sexual Reproductive Health Services in Sub-Saharan Africa: 2023.

⁵² Mbarushimana, V., Conco, D.N. & Goldstein, S. "Such conversations are not had in the families": a qualitative study of the determinants of young adolescents' access to sexual reproductive health and rights information in Rwanda.

⁵³ Munea, A.M., Alene, G.D., Debelew, G.T. et al. Socio-cultural context of adolescent sexuality and youth friendly service intervention in West Gojjam Zone, Northwest Ethiopia: a qualitative study.

⁵⁴ Mutea L, et al. Access to information and use of adolescent sexual reproductive health services: Qualitative exploration of barriers and facilitators in Kisumu and Kakamega, Kenya. PLoS One. 2020

224 Gender-Based Violence

The United Nations defines violence against women as "any act of gender-based violence that results in, or is likely to result in, physical, sexual, or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life." Studies indicate that adolescent girls and young women in particular, are disproportionately affected by gender-based violence (GBV), such as dating violence/intimate partner violence (IPV) (inclusive of physical, emotional, sexual, economic and controlling behaviors). Intimate partner violence and GBV also includes childhood sexual abuse, child marriage, FGM and marital rape.⁵⁵ Further, GBV can be perpetrated by intimate partners, family members, peers, and authority figures, and is underscored by a gender power hierarchy, wherein "masculinity" is privileged over "femininity".⁵⁶

Worldwide, almost one third (27%) of women aged 15 – 49 years who have been in a relationship have been subjected to some form of physical and/or sexual violence by their intimate partner.⁵⁷ Studies have shown that multiple adverse childhood experiences (ACEs) are strongly related to a wide range of mental health, violence and substance use histories.⁵⁸

The *KDHS 2022* indicates that the percentage of women who experienced physical violence declined from 20% in 2014 to 16% in 2022. Over the same period, the percentage among men declined slightly from 12% to 10%.⁵⁹ This could be attributed to the existing government programs; however, there is still a need to close the gap. Gender-based violence can affect short-term and long-term physical and mental health, and social well-being of a survivor. Studies show that survivors of sexual and gender-based violence (SGBV) have an increased likelihood of having reproductive health problems, HIV, other sexually transmitted infections, unintended pregnancies, depression, anxiety, and developing unhealthy coping strategies, such as drug and substance abuse.⁶⁰

225 Female Genital Mutilation

The WHO defines female genital mutilation (FGM), also known as female circumcision, as any procedure that involves partial or total removal of the external genitalia and/or injury to the female genital organs, whether for cultural or any other non-therapeutic reasons. It is widely recognized as a violation of human rights and is deeply rooted in beliefs and perceptions over generations. The *KDHS 2022* indicates that the prevalence of FGM among women aged 15 – 49 years is 15%; declined from 38% in 1998 to 15% in 2022. Girls exposed to FGM are at risk of immediate physical consequences, such as severe pain, bleeding, shock, difficulty in passing urine and feces, and infections. Long-term consequences can include pain, sexual/orgasmic dysfunction, infections and mental trauma.⁶¹

The *Constitution of Kenya 2010* protects children and women from abuse, harmful practices, and all forms of violence.⁶² The Government of Kenya has enacted legislation prohibiting FGM, including the *Prohibition of Female Genital Mutilation Act, 2011* and the *Children's Act, 2022*.

⁵⁵ IASC. The Inter-Agency Minimum Standards for Gender-Based Violence in Emergencies Programming. Gender-Based Violence Area of Responsibility. 2019.

⁵⁶ Vahedi L, et al. Childhood and adolescent nutrition outcomes among girls exposed to gender-based violence: 2023

⁵⁷ World Health Organization report: Violence against women: 2021

⁵⁸ Meeker EC, O'Connor BC, Kelly LM, Hodgeman DD, Scheel-Jones AH, Berbary C. The impact of adverse childhood experiences on adolescent health risk indicators in a community sample. *Psychol Trauma*. 2021

⁵⁹ Kenya Demographic Health Survey: 2022

⁶⁰ Lindsay Stark, Ilana Seff, Chen Reis: Gender-based violence against adolescent girls in humanitarian settings: a review of the evidence *Lancet Child Adolesc Health* 2021; 5: 210–22

⁶¹ Salam RA, Faqqah A, Sajjad N, Lassi ZS, Das JK, Kaufman M, Bhutta ZA. Improving Adolescent Sexual Reproductive Health: A Systematic Review of Potential Interventions. *J Adolesc Health*. 2016.

⁶² The Constitution of Kenya, 2010

2.3 Institutional (Organization) - Level Barriers

These are challenges related to health facilities and schools e.g. distance from facilities, costs of services and/or transportation, long wait times for services, inconvenient working hours, lack of necessary commodities at health facilities, lack of privacy and confidentiality and inadequate youth-friendly services provision/environment.

2.3.1 Limited Access to SRH Services

High-performing and resilient health systems built on strong primary health care are essential for Universal Health Coverage. Health facilities may lack dedicated adolescent-friendly spaces or have staff that stigmatize and discriminate against AYP.⁶³ This can discourage AYP from getting to facilities for services even when they are well informed and desire SRH services. Also, availability of SRH services/ commodities and capacity to deliver can influence uptake among AYP.⁶⁴ Studies have proven that healthcare provider behavior, poor provider competency, judgmental attitude of the health care provider and breaking privacy and confidentiality of client information are barriers that further discourage AYP from accessing and utilizing SRH services.⁶⁵ Other barriers include unsupportive environment (inconvenient operating hours, long waiting times, long distances to reach healthcare facilities) and if preferred commodities are out-of-stock.⁶⁶

2.4 Policy level barriers

In Kenya, there are laws and policies that may promote while others may hinder uptake of SRH services among AYP. For instance, the Government of Kenya protects children from all forms of abuse and harmful practices including child marriage, FGM among others and the Act provides for the right to health and medical care.⁶⁷ Regarding provision of reproductive health services to children, express consent must be given by parents and guardians which at times acts as a barrier. The Sexual Offences Act enforces stringent measures to protect adolescents from abusive behavior and spells out stiff penalties for perpetrators. On the other hand, some services like HIV testing among adolescents require parental consent. Also, lack of knowledge of the *Adolescent Sexual Reproductive Health Policy 2015*, among AYP, the secondary and tertiary audience is a barrier to services uptake.⁶⁸ Sometimes, health service providers and teachers are not fully aware of what information and services adolescents are entitled to.⁶⁹

2.4.1 Legal and Policy Landscape

The Government of Kenya also recognizes that while adolescents generally experience health challenges, some have worse SRH outcomes than others, therefore the need for additional protection.⁷⁰ The *Adolescent Sexual Reproductive Health Policy 2015* outlines several objectives and targets, including identifying the SRH needs of adolescents and providing clear guidelines to deal with their health concerns. Topics covered include: harmful practices like child marriage, FGM and GBV; drug and substance abuse; socio-economic factors; and the special needs of AYP

⁶³ Masaba BB, et al.: Devolution of healthcare system in Kenya: progress and challenges. 2020.

⁶⁴ Gebremariam FA, et al.: Health facilities readiness to provide comprehensive abortion care and factors associated with client satisfaction in Central Oromia Region, Ethiopia: a multilevel modeling approach. Reprod Health. 2023

⁶⁵ Garney W, Wilson K, Ajayi KV, et al. Social-ecological barriers to access to healthcare for adolescents: 2021

⁶⁶ Sidamo NB, Kerbo AA, Gidebo KD, Wado YD. Socio-Ecological Analysis of Barriers to Access and Utilization of Adolescent Sexual Reproductive Health Services in Sub-Saharan Africa: 2023

⁶⁷ Children Act 2022

⁶⁸ Ninsiima LR, Chiumia IK, Ndejjo R. Factors influencing access to and utilisation of youth-friendly sexual reproductive health services in sub-Saharan Africa: a systematic review. 2021.

⁶⁹ Ninsiima LR, Chiumia IK, Ndejjo R. Factors influencing access to and utilisation of youth-friendly Sexual Reproductive Health services in sub-Saharan Africa: a systematic review. 2021.

⁷⁰ National Adolescent Sexual Reproductive Health Policy (Ministry of Health, 2015

with disabilities. The adolescent SRH policy is currently being revised to include the specific needs of adolescents who are most-at-risk, which are not explicitly catered for in the current policy.

The Government of Kenya, identifies ‘most-at-risk adolescents’ as those who are pregnant, married or parents, and those engaging in any behavior that puts them at risk of contracting HIV.⁷¹ The presence of a relatively broad policy framework that guides provision of SRH services in Kenya has, however, not led to an improvement in service delivery and evidence indicates that there is still unmet need for such services. Implementation of the policies at service delivery level has been weak resulting in inadequate provision and access, especially for the hard to reach and most vulnerable populations.⁷²

In addition to the *Adolescent Sexual Reproductive Health Policy 2015*, there are other policies and guidelines for AYPSRH service implementation in Kenya, which aim to both protect and respond to AYP specific health needs and vulnerabilities.

The following table outlines some of the policy and legal documents and guidelines for AYPSRH service implementation in Kenya, which aim to both protect and respond to AYP specific health needs and vulnerabilities:

Policy/guideline document	Content summary
The Constitution of Kenya	Article 43 of the Constitution guarantees every person the right to the highest attainable standard of health, which includes the right to reproductive health care. Additionally, Article 53 specifically addresses the rights of children, including access to healthcare, education, and protection from harmful practices.
The Childrens' Act 2022	It advances the concept of the child's best interest as the primary consideration in every decision touching on a child. Contains provisions for the protection and care of children such as prioritization of family-based care, as opposed to institutionalization of children.
The National Reproductive Health Policy 2022 - 2032	This policy provides overall guidance for all stakeholders in the reproductive health sector and is the principal reference document in matters of RH.
Adolescents and Young People Reproductive Health Policy 2024	Promotes the provision of SRH services for adolescents in Kenya by mainstreaming their SRH rights in all health activities, including services and planning.
Sessional Paper No. 3 of 2012 on Population Policy for National Development (NCPD)	Recommends critical policy measures that can respond to most- at-risk adolescent programming e.g., enforcement of rights and legal frameworks for protection of young people and multi-sectoral approach in responding to youth-friendly SRH services.
School Health Policy 2018 (MOH, Ministry of Education (MOE))	Kenya is committed to ensuring healthy lives and promote the well-being for all ages. This means upholding the rights of all learners to basic, compulsory and quality education as well as their highest attainable health standards.
Kenya AIDS Strategic Framework (KASF) II (2020/21-2024/25)	Regards AYP as a priority population and recommends combined interventions approach – focuses on changes in underlying structures through biomedical interventions.
The Kenya HIV Prevention and Treatment Guidelines 2022 (National AIDS and STI Control Programme (NASCOP))	Lowered the age of consent for HIV testing services to 15 years to enable access to services without parental consent for minors engaging in HIV- risk behavior.
The Kenya HIV Prevention Revolution Road Map: Countdown to 2030 (Ministry of Health)	Identifies adolescents and young people as a priority population for HIV services and recommends a location-based approach to service provision. Interventions identified include protection and provision of SRH services.

⁷¹ HIV and AIDS Prevention and Control Act (Government of Kenya, 2006a)

⁷² Mutea L, Ontiri S, Kadiri F, Michielesen K, Gichangi P (2020) Access to information and use of adolescent sexual reproductive health services: Qualitative exploration of barriers and facilitators in Kisumu and Kakamega, Kenya.

3

Social and Behavior Change Approaches

A multifaceted approach will be employed to reach target audiences with tailored social and behavior change interventions. The following section describes the strategic approach.

3.1 Strategic Approach

Three broad approaches have been identified:

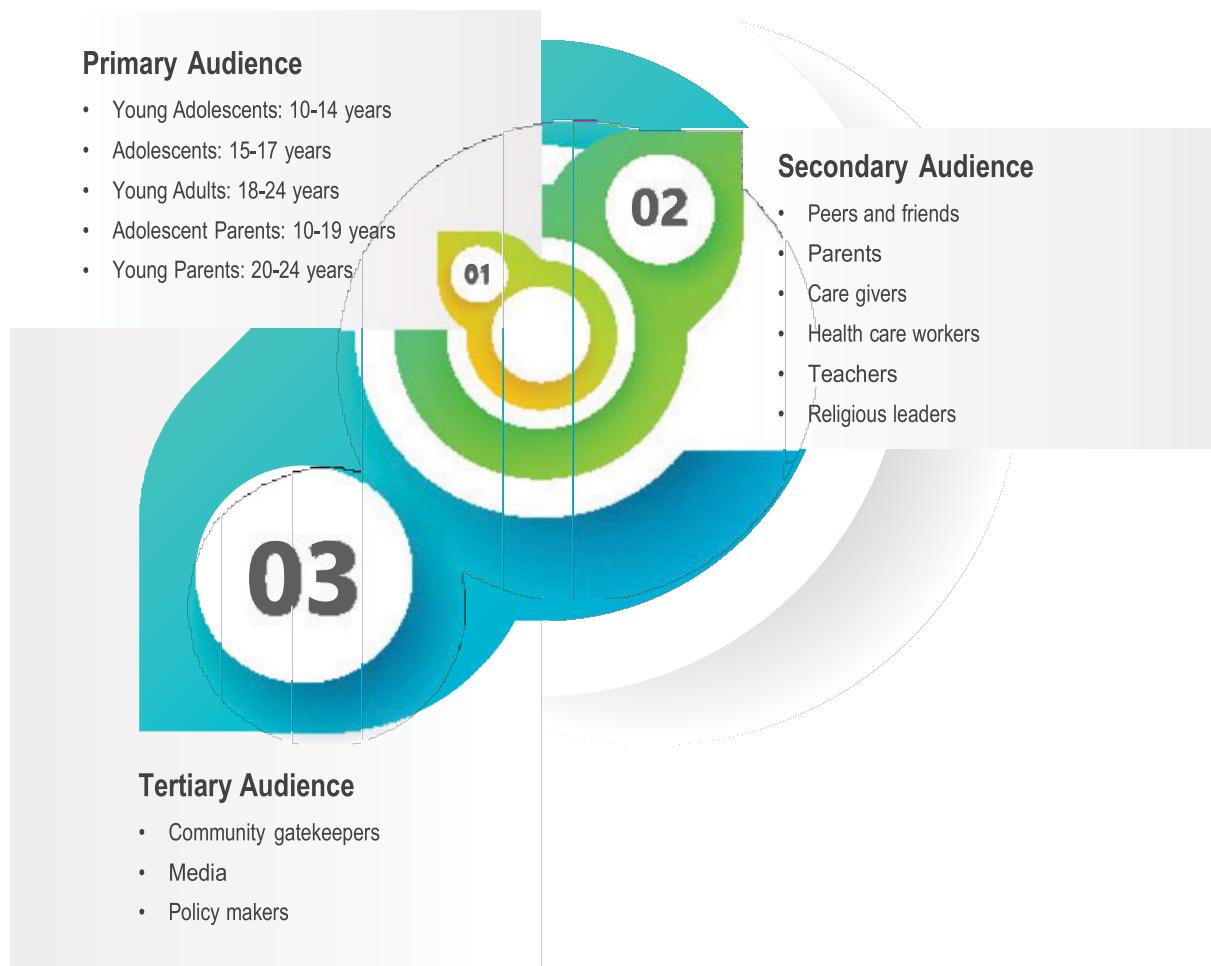
1. **Diverse communication channels and techniques:** The strategy embraces a range of methods and media that extend beyond information delivery. It encompasses skill-building, modeling, on-going positive support and other active behavior change approaches. Successful social and behavior change interventions often incorporate three or more categories of techniques, engaging participants at behavioral, social, sensory, and cognitive levels. Studies indicate that interventions relying on a single channel or technique tend to be less effective.⁷³
2. **Community-centric approaches:** Social norms and societal pressures play a crucial role in influencing behavior, not only in initiating but also in reinforcing the behavior through visible successes and ongoing support. The strategy emphasizes community engagement and AYP involvement, aiming to address socio-cultural issues related to SRH across the communities.
3. **Psycho-social appeals:** The messages and communication channels within the strategy are designed to appeal to both the emotional and intellectual capacity of the AYP. The progression moves seamlessly from providing information with substantial content to creative, entertaining, and emotional elements. These activities delve into deeper socio-cultural issues without causing harm or discomfort to the audience and complement the other approaches described here to form a holistic, multi-layered approach.

⁷³ Tanya Agurs-Collins et al. "Designing and Assessing Multilevel Interventions to Improve Minority Health and Reduce Health Disparities", American Journal of Public Health 109, no. S1 (January 1, 2019): pp. S86-S93.

3.2 Audience Segmentation

Segmentation recognizes that different groups will respond differently to social and behavior change activities and support materials. The following is an illustration of the three audience segments:

Figure 4: Illustration of Audience Segments



3.3 The SBC Approaches for Reaching Primary Audience

Primary audiences for the National SBC strategy for AYPSRH are adolescents and young people aged 10 to 24 years. They are categorized into: adolescents 10 – 14 years old; adolescents 15 – 17 years old, young adults 18 – 24 years old, adolescent parents 10 – 19 years old, and young parents 20 – 24 years old. This section describes strategies for reaching each of the categories.

3.3.1 Adolescents Aged 10-14 Years

Characteristics	<p>Physical and sexual maturation:</p> <ul style="list-style-type: none">• Physical and sexual development starts at this stage• Develop interest in sexual matters and are anxious about changing body features. <p>Brain Development and Cognition:</p> <ul style="list-style-type: none">• Stage associated with imaginative thinking with limited ability to anticipate long term consequences to their actions. <p>Relationship with peers:</p> <ul style="list-style-type: none">• Seek the same sex relationships to counter feelings of instability; girls play with girls and boys with boys. <p>Emotional development:</p> <ul style="list-style-type: none">• Characterized by very wide mood swings, intense feelings, and low impulse control. <p>Self-concept</p> <ul style="list-style-type: none">• Self-consciousness about appearance and attractiveness due to changing body features. <p>Ability to choose between right and wrong:</p> <ul style="list-style-type: none">• View relationships with adults in terms of power and fear of punishment• Can be sexually exploited for a long time before they have the courage to report to a responsible adult. <p>Relationship with peers:</p> <ul style="list-style-type: none">• Experience a growing separation from the family• Develop a sense of being a different person from the mother• about changing body features.• Increased need for privacy. <p>Other characteristics:</p> <ul style="list-style-type: none">• Desire for attention and care• Some adolescents trust their caregivers/parents• May not want to be associated with SRH issues due to fear of judgment and embarrassment talking about AYPSRH• Some may be socially excluded e.g. persons with disabilities or intersex persons• Some may be living in controlled environments e.g. refugee camps or correctional facilities• Some are born with both female and male reproductive organs.
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Barriers to healthy sexual reproductive behavior	<ul style="list-style-type: none"> • Fear of being judged • Parental communication barrier - lack of open communication • Inadequate age-appropriate SRH information • Inadequate life skills • Societal stigma surrounding AYPSRH e.g. information sharing, teenage pregnancy, HIV and AIDS, SGBV • Cultural and religious beliefs • Inadequate mechanisms for reporting and addressing concerns • Negative effects of unregulated use of social media • Limited access to SRH services due to medical and transport cost • Those with disability may have difficulty accessing information and services • Limited access to intersex friendly services.
Enablers to healthy SRH behaviors	<ul style="list-style-type: none"> • Availability of appropriate support systems at family and community levels • Availability of age-appropriate and timely SRH information • Existing school health clubs and counselors • Enforcement of Values and Life skills in the school curriculum and in appropriate environments such as functional youth friendly centres and religious institutions • Existence of <i>Kenya School Health Policy 2018</i> • Availability of AYPSRH skilled HCPs • The operationalization of <i>AYPRH policy</i> • Existence of age-appropriate SBC materials • High literacy level • Existence of youth groups and youth-led organizations • Access to controlled spaces e.g. refugee camps and rehabilitation centres by HCWs.
Key concerns	<ol style="list-style-type: none"> 1. Inadequate parental guidance 2. Negative media influence 3. Lack of accurate information on and access to AYPSRH.
Prioritize these key barriers	<ul style="list-style-type: none"> • Inadequate age-appropriate SRH information and life skills • Societal stigma, cultural taboos and fear of being judged.

Develop a message tool kit (to be used in the different regions in accordance with prevailing concerns and consider PWD)

- Age-appropriate information on SRH
- Abstinence till marriage
- STIs including HIV, HPV; information on prevention screening and management and referrals
- GBV (e.g. bullying, child sexual abuse, physical violence, psychological violence) awareness, prevention and reporting
- Parental consent
- Personal hygiene
- Use of online content
- Mental health wellness
- Nutrition
- Communication skills and Life Skills
- Child rights protection messages.

NOTE:

When it comes to SRH services for this age group, it's important to consider their developmental stage and provide age-appropriate information. Addressing topics like puberty, hygiene, healthy relationships, and self-care can contribute to their overall well-being. Creating a supportive and non-judgmental environment is crucial for adolescents to feel comfortable seeking information and assistance related to SRH.

Channels of reaching adolescents 10-14 years

The adolescents aged 10 – 14 years will be reached through:

1. Family-based appropriate AYPSRH guidance

Parental/guardian/caregiver involvement in guidance and counseling of the adolescent on age-appropriate AYPSRH information.

2. School-based programs

Age-appropriate SRH education will be conducted through schools. The following activities will be implemented:

1. Interpersonal Communication

(Murals) with cartoon content and messages will be developed within primary schools. The students will be involved in the development process.

2. Interpersonal Communication

They will entail:

- a. **Storytelling and narrative approaches:** Will be applied to convey SRH messages. Personal experiences and relatable scenarios will be utilized as tools for conveying information and influencing behavior.

- b. **Debate sessions:** Led by the guidance and counselling teachers, the students will engage in SRH- themed debate sessions in class or school clubs. Winners will be rewarded with appropriate gifts.
- c. **Singing games, drama and poems:** The SRH program at county level will work with music and drama teachers to develop AYPSRH scripts to guide student performances during competitions and winners shall be rewarded.
- d. **School clubs and extracurricular activities:**
 - i. **School clubs:** The SRH program will leverage on existing clubs as a platform for adolescents to engage in discussions and activities related to AYPSRH.
 - ii. **Sporting activities and events:** SRH-themed sporting activities will be conducted to create a positive and supportive atmosphere for adolescents to absorb important information about AYPSRH.

3. Rites of passage events

The AYPSRH information package will be delivered by healthcare providers during the occasions.

4. Sessions in places of worship

The AYPSRH information package will be delivered by religious leaders during worship sessions/activities with adolescents.

5. The SBC materials

The materials including posters, Adolescent booklet guide billboards and fact sheets will be produced and disseminated through areas frequented by the adolescents. The SRH materials will be done in braille and audio to enable accessibility to adolescents with disabilities.

6. Digital platforms

Digital platforms, such as websites, apps, and social media, will be utilized to share age-appropriate SRH information. This will allow adolescents to access information anonymously and conveniently.

7. Adolescents' social events

Social events such as birthdays, often serve as important milestones in their social development and personal growth. These events are marked by a mix of excitement, social interaction, and individual expression. They will be a good opportunity for sharing the SRH information package.

8. Interpersonal communication

This will entail one-on-one sessions or small group sessions among peers or with a health care worker. It will allow personalized messaging, trust-building, behavior modeling, and ongoing support tailored to the needs of adolescents.

9. Road shows

This will entail one-on-one sessions or small group sessions among peers or with a health care worker. It will allow personalized messaging, trust-building, behavior modeling, and ongoing support tailored to the needs of adolescents.

3.3.2 Adolescents Aged 15-17 Years

Characteristics	
	<p>Physical and sexual maturation: Characterized by further maturation of secondary sexual characteristics.</p> <p>Brain development and development of cognition:</p> <ul style="list-style-type: none">• Concrete operational thought and abstract ideas develop e.g. love• Questions more which may be interpreted as disobedience• Perceives future implications but may not apply them in decision making• Applies operational thought to school work but not to dilemmas• Regress to operational and magical thinking under stressful situations• Some may have had adverse childhood experiences e.g. death or separation of parents, which may lead to mental disorders• Some may be socially excluded e.g. persons with disabilities and intersex persons. <p>Relation with peers: Characterized by peer group relationships</p> <ul style="list-style-type: none">• Preoccupation with peer culture and peers provide the behavioral example. Confide with friends on sensitive issues• Emotional Development: Dominated by feelings of invincibility• Risk taking behavior peaks based on environment.• Self-concept: This stage is the face of the classic adolescent, concerned with attractiveness• There is increasing introspection. <p>Ability to choose between right and wrong: Perception of right and wrong as absolute and unquestionable</p> <ul style="list-style-type: none">• Experience a moral crisis when they see adults in their lives doing the wrong thing.• Relationship with parents: The peak of parental conflict - feeling that parents don't understand or value their opinion• There is rejection of parental values• Often believe his/her views are different from the parents'• Academic and career considerations gain importance.• Reluctance to correction – they don't like to be corrected <p>Other characteristics:</p> <ul style="list-style-type: none">• May experience harmful practices e.g. child marriages and FGM• Developing their identities• They develop interest in the opposite sex• Some may be sexually active, putting them at risk for unintended pregnancies and STIs like HIV• Lack of trust in authority figures e.g. teachers and matrons• Some face pressure at home, whether to get married or drop out of school to help bring in income• Some may be living in controlled environments e.g. refugee camps or correctional facilities.

Barriers to healthy sexual reproductive behavior	<ul style="list-style-type: none"> • Stigma and shame – fear of judgment and societal stigma around AYPSRH • Inadequate SRH knowledge • Peer pressure • Discomfort in discussing AYPSRH matters • Confidentiality concerns • Cultural and religious beliefs • Drug and substance abuse • Mental health issues • Healthcare workers' attitudes and biases • Some may have difficulty accessing AYPSRH information and services arising from special needs or placement like those in conflict with the law, street families, those in refugee camps and those in war zones.
Enablers to healthy sexual reproductive behavior	<ul style="list-style-type: none"> • Education and awareness among influencers • Availability of AYP friendly services • Availability of a supportive environment; community/family • Availability of SRH services • Social network for peer support • Access of controlled spaces e.g. refugee camps and rehabilitation centres by HCWs • Availability of rescue centres for the street AYP.
Key concerns	<ol style="list-style-type: none"> 1. Fitting in the social network 2. Academic pressure and future uncertainties 3. Negative social media influence 4. Gender-based violence.
Prioritize these key barriers	<ul style="list-style-type: none"> • Fear of stigma and shame related to SRH • Inadequate SRH knowledge • Peer pressure to engage in risky behaviors.

NOTE:

The channels of reach and message tool kit is similar to the 10-14 years cohort.

3.3.3 Young Adults Aged 18-24 Years

Characteristics	
	Physical and sexual maturation: They are undergoing physical, mental, and social development. Weight and height increases.
	Brain development and development of cognition: Have achieved formal logical thought; able to relate today's actions to the future; have abstract thoughts reasoning from known principles and points of view; weigh consequences of decisions, prioritize and strategize; are characterized by idealism and absolutism; understand others' thoughts, feelings and set limits. However, the brain is not yet fully developed at this time. The brain finishes developing and maturing in the mid to late 20s.
	Relation with peers: There is formation of long-term relationships. They are at greater risk of peer pressure to engage in high-risk behavior.
	Emotional development: Dominated by realization of one's vulnerability; characterized by delayed gratification; less risk-taking behavior.
	Self-concept: There is a more stable body image; concerned about attractiveness; growing sense of independence and also a firmer identity of who they are.
	Ability to choose between right and wrong: Characterized by a distillation of one's moral values.
	Relationship with parents: Improved communication and acceptance of parental values; begin seeking advice from the parents.
	Other characteristics:
	<ul style="list-style-type: none">• Includes older adolescents (18-19) years old and young adults (20-24) years old• Care about fun and entertainment• Are concerned about career development and education pursuit• Some may be sexually active, putting them at risk for pregnancy and STIs including HIV• Desire power, leadership, social and civic engagement• Strive for financial independence• Tech-savvy• Believe they don't need SRH services (services meant for older generations)• Some may be in conflict with the law, others in refugee camps and war zones.• Some may be PWDs or living as street families.

Barriers to healthy SRH behavior	<ul style="list-style-type: none"> • Inadequate SRH knowledge • Stigma and judgement • Inaccessibility of AYPSRH services • Healthcare workers' attitudes and biases • Social-cultural norms, beliefs and practices • Religious beliefs • Drug and substance abuse • Negative peer influence • Gender inequality • Poverty and economic hardship • Inadequate parental mentorship • Policy restrictions on access to AYPSRH • Conflicts and insecurity • Confidentiality concerns • Mental Health concerns.
Enablers to healthy SRH behavior	<ul style="list-style-type: none"> • Self-efficacy among young adults • High literacy levels • Parental / caregiver / family support • Existence of youth social networks and youth-led organizations implementing age-appropriate SRH interventions • Availability of youth-friendly health services • Availability of youth-friendly HCWs • Accessibility to age-appropriate SBC materials • Access to age-appropriate information through digital platforms • Accessibility to social club activities • Supportive policy environment.
Key concerns	<ol style="list-style-type: none"> 1. Career development and education pursuit 2. Money, fun and entertainment 3. Relationships and social connections.
Prioritize these key barriers	<ul style="list-style-type: none"> • Inadequate SRH knowledge • Social-cultural/religious beliefs & practices • Inadequate life skills.

<p>Develop a message tool kit (to be used in the different regions in accordance with prevailing concerns)</p>	<ul style="list-style-type: none">• Definition of SRH• STIs including HIV, HPV - information on prevention screening and management and referrals• Drugs and substance abuse - prevention and treatment, referrals & support groups• Contraceptive methods and where they can access• Abstinence till marriage, being faithful to one partner, condom use (ABC)• Information on FGM - Reporting, management and referral• Information on GBV (e.g. sexual, physical violence, IPV, reproductive coercion, psychological) – prevention and intervention strategies• Psychosocial support – information on where to get counseling services• Hotlines, help desk, and referrals• Encouragement to register for social health insurance fund• Sensitization of existing economic opportunities e.g. youth funds, <i>uwezo</i> fund, access to government procurement opportunity.
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Channels of reaching young adults 18-24 years

Reaching young adults aged 18–24 years effectively involves utilizing diverse communication channels and strategies that appeal to their age and promote healthy behavior. These include:

1. Digital media

- Social media platforms such as Instagram, Facebook, WhatsApp, X, Snapchat, and TikTok will be utilized to post age-appropriate SRH content for the targeted group engaging with positive trends and using relevant hashtags.
- Establish and utilize regulated strong online presence through websites, blogs, and forums that address topics promoting SRH. Mobile apps like chatbots containing SRH information will be developed, ensuring ease of access and user-friendly interfaces.

2. Youth events, forums and experiences

- Will entail hosting physical events or virtual experiences like webinars that offer value, including but not limited to age-appropriate educational insights, career guidance, or entertainment that incorporates AYPSRH messaging.
- Sports events e.g. football tournaments will be conducted as an avenue of communication; SRH branded materials will be distributed and educational sessions conducted.

3. Text messaging

Bulk SMS will be sent to the target audience respecting privacy preferences and providing opt-in options.

4. Help lines and toll-free lines

This will entail utilizing existing help lines and toll-free lines, call centers for reporting and support.

5. Health events at learning institutions

Health events will be organized in colleges/universities to disseminate SBC materials, conduct AYPSRH sessions, and offer services/commodities.

6. National SBC Campaigns and Influencer collaborations

National campaigns like Tujulishane campaign focusing on different target audiences with SRH information including reduction of teenage pregnancy, Self-care, SGBV, FP, PAC and Continuum of care for preconception, antenatal and postnatal care. The messages need to be standardized as per the existing policies to avoid misconcepts.

Influencers or individuals who have been Vetted by the MOH and with significant following by the 18-24 years' age group will be engaged to amplify AYPSRH messages and increase visibility.

7. Peer education trainings and Youth led initiatives

The program will use the National AYPSRH peer educator training Manual to train peer educators across the country in different settings including tertiary institutions.

Young people attach value to their networks and their decisions are highly influenced by peers as they share information in relatable ways. Youth champions will be recruited and have their capacity built, to work as advocates for SRH services. This approach will foster a sense of trust and openness, creating a supportive environment for discussions about AYPSRH.

8. Places of worship

Age-appropriate SRH messages will be developed and delivered at places of worship in close collaboration with religious leaders. The sessions will be done during specific youth sessions and events organized by the religious leaders.

9. Youth-friendly centers and services

With the guidance of the HCPs and the youth peer leaders, these centers will offer a convenient and non-judgmental environment for young individuals to access SRH information and services. Accessibility to the centers will be enhanced by including ramps in buildings where youth-friendly services are offered.

10. Use of SBC materials

The SBC materials will be developed for dissemination during various activities and online platforms, The adolescent booklet guide. The same will be customized to enable access by the young people with disabilities
e.g. record audio messages.

11. Outreaches and in-reaches

Activities will be organized to reach vulnerable young adults within refugee camps, prisons, street families and migrants to enhance knowledge and access to SRH services and commodities.

12. Art and theatre

Comedy, plays, music, poetry, drama, storytelling and art and design will be utilized to disseminate SRH information.

3.34 Adolescent Parents Aged 10-19 Years

Characteristics	<ul style="list-style-type: none">• Has a child• May be a school drop-out• Faces financial constraints• Some engage in casual jobs or transactional sex to meet their needs and those of the child• Some don't have access to a health facility hence child was vaccinated during mobile clinic• May be at risk of getting pregnant again• May have limited health information• Have higher risk of health issues for both mother and child• May be emotionally unstable and mentally drained• May feel like a victim of circumstances - frustrated• Needs reintegration into social circles and school• May have limited support system from friends and family• May be children in crisis (homeless, living in the street, refugee camps or in war zones)• May be in conflict with the law (Borstal institution)• May be living with disability and in special schools.
Barriers to healthy SRH behavior	<ul style="list-style-type: none">• Stigma and judgment• Social norms• Inadequate SRH knowledge• Mental health issues• Healthcare workers' attitudes and biases• Inadequate AYPSRH services• Financial constraints• Inadequate AYPSRH services• Confidentiality concerns• Poor support system by family and friends• Harmful practices• Religious beliefs• Gender inequality• Low levels of literacy• Inadequate parenting skills and lack of proper role modeling• Policy-related issues• Sexual and Gender Based Violence• Lack of inclusion of vulnerable populations like PWDs, children in crisis, those living in streets and those in refugee camps to AYPSRH interventions.

Enablers to healthy SRH behavior	<ul style="list-style-type: none"> • Existing school health clubs and counselors • Life skills in the school curriculum • Existing AYPSRH friendly services • Existence of youth groups and youth-led organizations • Social support • Existence of school health policy • Existence of trained HCPs • Availability of services and commodities • Existence of AYPSRH SBC materials • Favorable legal and policy framework.
Key concerns	<ol style="list-style-type: none"> 1. Stigma and judgment 2. Vulnerability of the adolescent's baby 3. Harmful practices; child marriages and FGM 4. Inadequate social inclusion.
Prioritize these key barriers	<ul style="list-style-type: none"> • Inadequate SRH knowledge • Harmful practices self/community Stigma and discrimination • Inadequate adolescent and youth friendly services.
Develop a message tool kit (to be used in the different regions in accordance with prevailing concerns)	<ul style="list-style-type: none"> • Maternal and child nutrition • Importance of breastfeeding • STIs including HIV, HPV - information on prevention screening and management and referrals • Health insurance • Immunization for babies • Mental health awareness, psychosocial support and information on where to get counseling services • Drugs and substance abuse; prevention and treatment, referrals and support groups • Information on GBV (bullying, physical, psychological and sexual violence); prevention, referral, and reporting • Information on harmful practices (child marriages, FGM) Prevention, referral, reporting and management • Policies that protect the rights of adolescent parents, including access to confidential SRH services and parental rights • Legal redress where minors are involved • Rights to child support • Importance of education; school re-integration • Hotline, help desk, and referrals • Support for children in crisis • Social inclusion; PWD and intersex.

Channels of reaching adolescent parents aged 10-19 years

1. Social networks

Family-based interventions will be incorporated into SBC strategies to harness the power of information exchange, social norm shaping, conflict resolution, and solidarity building within peer networks in families. This integration will capitalize on existing support structures for SRH discussions, enhancing the well-being of both young parents and their children.

2. Use of SBC materials

Materials like posters, fact sheets/pamphlets with AYPSRH messages will be produced and disseminated. Braille, audio and sign language will be used to reach adolescent parents with disabilities.

3. Peer education sessions

In liaison with HCWs, peer educators/champions will be recruited and trained. They will conduct sessions adolescent parents with parenting knowledge and skills covering SRH and various aspects of child development, health, and well-being, empowering adolescent parents with practical parenting knowledge.

4. Places of worship

Religious leaders will conduct one-on-one or group sessions with adolescent parents at places of worship or at home and deliver the SRH package of information, ensuring linkage to the facilities for services. They will also hold discussions with the adolescents' parents to promote a supportive system for the adolescent parent and child. They will work in liaison with CHPs to ensure correct and factual AYPSRH messaging.

5. Digital Media campaigns

Mass media campaigns will be conducted using various channels (TV, radio) and social media (Tiktok, Instagram,x and snapchat)and other digital platforms to challenge stereotypes, break stigma, and promote positive narratives about adolescent parents and SRH.

6. Mental health support programs

Programs that address the mental health needs of adolescent parents, including counseling services, support groups, and awareness campaigns will be developed and implemented.

3.3.5 Young Parents Aged 20-24 Years

Characteristics	<ul style="list-style-type: none"> • Consist of young people aged 20-24 years who have a child/children • Educated and have career aspirations • Active in community development • Desire power and money • Feel their youthful life is interrupted • Some are happy and satisfied, especially on getting a child • Positive about SRH, requiring more information • Receive misleading information from different sources • Have conflicted roles about the transition to parenthood • Care about body changes/image • Want to feel loved, given attention and care from partners/spouses • Tech-savvy • May face financial challenges • May face substantial peer influence • Some are married • May be homeless, living in the street, refugee camps or migrants • Some may have disability and in special schools.
Barriers to healthy SRH behavior	<ul style="list-style-type: none"> • Stigma and judgment • Social norms • Inadequate SRH knowledge • Privacy and confidentiality concerns • Cultural and religious beliefs • Inaccessibility of AYPSRH services • Healthcare workers' attitudes and biases • Inadequate AYPSRH friendly services • Financial constraints • Poor support system by family and friends • Gender inequality • Inadequate parenting skills and lack of proper role modeling.
Enablers to healthy SRH behavior	<ul style="list-style-type: none"> • Availability of friendly-youth services • Existence of trained HCWs • Availability of SRH services and commodities • Existence of AYPSRH SBC materials • Existence of youth groups and youth-led organizations • Availability of social media platforms • Availability of counseling services • Responsive policies • Literacy levels.

Key concerns	<ol style="list-style-type: none"> 1. Financial constraints 2. Education and career development 3. Social isolation 4. Mental health issues.
Prioritize these key barriers	<ul style="list-style-type: none"> • Stigma, judgment, and social norms • Inadequate SRH knowledge • Privacy and confidentiality concerns • Lack of health insurance for self and baby.
Develop a message tool kit (to be used in the different regions in accordance with prevailing concerns)	<ul style="list-style-type: none"> • Maternal, newborn and child care • Career development • Importance of breastfeeding • STIs, HIV, HPV information on prevention screening and Management, and referrals • Family planning, contraception, including methods available and where to access • Immunization for babies • Health insurance for self and baby • Mental health awareness and psychosocial support • Information on where to get counseling services • Drugs and substance abuse; prevention and treatment, referrals and support groups • Information on GBV (bullying, intimate partner violence, physical, psychological and sexual violence); prevention, referral, and reporting • Policies that protect the rights of young parents, including access to confidential SRH services • Rights to child support • Importance of education; going back to school • Hotlines, help desk, and referrals • Social inclusion for PWDs and intersex.

Channels of reaching young parents aged 20-24 years

1. Social support

Family-based interventions will be incorporated into SBC strategies to harness the power of information exchange, social norm shaping, conflict resolution, and solidarity building within peer networks.

2. Community-based health programs

These will provide support services and resources such as reproductive health education, parenting classes, and mental health counseling, fostering a sense of belonging and empowerment within their communities.

3. Use of SBC materials

The AYPSRH SBC materials including, e-posters and fact sheets with SRH messages that will be disseminated through online interactive platforms. Audio visual messages, sign language and braille will be used to reach persons with disabilities.

4. Peer education programs

The programs will utilize interpersonal communication to reach the young parents through their peers and friends. It will also be an effective channel of reaching those in the correctional and the rehabilitation institutions and street families.

5. Youth-friendly services and centers

Youth-friendly centers will be established to offer friendly services in a welcoming environment by non-judgmental staff. They will also offer flexible clinic hours to accommodate the schedules of young parents. Educational materials will also be provided in waiting areas and consultation rooms.

6. Digital media

Text messages will be sent to young parents in addition to mobile apps that will be developed or adapted to disseminate SRH information. Social media ,Mobile apps like chatbots with AYPSRH information will ensure ease of access and user-friendly interfaces. The interactions will be confidential and content will be accessible, culturally sensitive, and will address diverse needs.

7. Places of worship

Religious leaders will conduct one-on-one sessions with young parents at places of worship or at home and deliver the SRH package of information, ensuring linkage to the facilities for services. They will also hold discussions with their parents to promote a supportive system for the young parent and child. They will work in liaison with CHPs to deliver the package of information.

8. Interpersonal communication

For those in correctional, rehabilitation institutions and street families.

NOTE:

SGBV survivors could be influential advocates for AYPSRH, particularly for the boychild. Through their firsthand experiences, they can empower others, offer peer support, and raise awareness about SGBV and SRH issues.

Their advocacy can extend to policy change and promote gender equality, while also facilitating access to essential services.

3.4 The SBC Approaches for Reaching Secondary Audiences

The secondary audience has a direct social influence on the behavior of the primary audience at interpersonal, organizational, and community levels. They are trusted, and respected and can provide support and guidance to the primary audience.

They include HCWs, parents and/or caregivers.

3.4.1 Parents and Caregivers of Adolescents and Young People

Facts and Characteristics	<ul style="list-style-type: none"> • Consider adolescents too young to be sexually active • Some have AYPSRH knowledge gap and could be unaware of adolescents' needs • May have AYPSRH information but have challenges communicating with AYP • Believe AYP should follow their instructions • Responsible for providing for the needs of AYP • Some may feel they have lost authority over AYP • Some feel unable to influence decisions of AYP • Some feel powerless in the face of negative influence • Feel frustrated and let down when AYP impregnate/ get pregnant • Have a different approach to handling SRH matters based on culture and beliefs • Attempt to provide guidance to AYP • Ensure AYP's safety • Responsible for AYP's health • Some don't discuss SRH matters, they are not approachable.
Barriers to supporting AYP healthy SRH behavior	<ul style="list-style-type: none"> • Poor communication between parents and children • Inadequate parenting skills • Illiteracy levels • Social-cultural practices and religious beliefs • Gender inequality • Poverty and economic hardship • Policy related issues e.g. Inadequate information on policy • Conflicts and insecurity.
Enablers to supporting AYP healthy SRH behavior	<ul style="list-style-type: none"> • Existence of SRH education and awareness programs • Existence of communication platforms for SRH information including digital media • Mentorship initiatives (e.g. boys' rites of passage/ alternative rites of passage for girls) • Learning institutions • Existence of parents' teachers' associations • Accessibility of SRH services information and education • Existence of community forums, dialogue and social groups • Existence of enabling AYSRH Policy environment.

Key concerns	<ol style="list-style-type: none"> 1. Communication barrier that exists between parents and AYP 2. Re-integration of AYP to school 3. Early sexual debut among AYP 4. Preventing early and unintended pregnancies among AYP 5. Drug and substance abuse.
Prioritize these key Barriers	<ul style="list-style-type: none"> • Knowledge gap on AYPSRH • Cultural practices and beliefs • Poor communication between parents and AYP.
Develop a message tool kit (to be used in the different regions in accordance with prevailing concerns)	<ul style="list-style-type: none"> • Introduction to AYPSRH • STIs including HIV, HPV, information on prevention screening, management and referrals • Drugs and substance abuse, prevention and treatment, referrals and support groups • Age-appropriate SRH services and points of access • Abstinence till marriage, being faithful to one partner and condom use • Information on FGM reporting, management and referral • Information on GBV (bullying, intimate partner violence, physical, psychological and sexual violence); prevention, referral, and reporting • Information on where to find psychosocial support • Legal framework • Effective child support systems • Importance of education; back to school reintegration policy • Hotlines, help desk, and referrals.

Channels of reaching parents and caregivers of adolescents and young people

1. Community engagement activities

In collaboration with CHPs the local administration leaders will work with local community organizations, schools, marketplaces, and healthcare providers to reach parents with the SRH information package.

The CHPs will attend social events, community events, and gatherings to distribute SBC materials and engage in face-to-face conversations.

2. Health facility education

Stakeholders will collaborate with HCWs to conduct health education sessions and to disseminate SBC materials in healthcare settings. This will ensure that waiting areas have informative SBC materials.

3. Organized school health events

Stakeholders will engage with HCWs, schools and educational institutions to conduct health education sessions and distribute SRH SBC materials through parent– teacher associations during organized school events.

4. Mass Media and Local media partnerships

The SRH program and stakeholders will partner with local radio stations, newspapers, digital media, influencers and TV channels to feature SRH messages during programs or segments targeting parents.

5. Use of SBC materials

Various SBC communication channels like posters, flyers, videos, audio clips, and vignettes will be utilized to engage parents and caregivers of AYP, conveying essential messages and promoting behavior change. These materials will cover topics ranging from adolescent health to communication strategies, aiming to empower parents with the knowledge and skills necessary to support the well-being of their children.

6. Community Outreaches

The CHPs will visit neighborhoods and public spaces to engage directly with parents for SBC sessions, distribution of SBC materials and address any SRH concerns raised.

3.4.2 Health Care Workers

They include healthcare providers (HCPs), community health promoters (CHPs) and all individuals working in health care settings.

Characteristics	<ul style="list-style-type: none">• They are knowledgeable on SRH matters• Some are adequately equipped to offer youth-friendly services• Some are tech-savvy and active on social media• They are accessible at healthcare facilities.
Barriers to offering AYP friendly SRH services	<ul style="list-style-type: none">• Attitudes and biases• Stigma and judgement to AYP• SRH services that are not responsive to AYP needs• Social-cultural and religious beliefs• Inadequate policy and guidelines dissemination and implementation• Lack of proper psychosocial support• Mental health issues• Inadequate supply of SRH commodities• Inadequate awareness and information on intersex AYP• Heavy workload at health facilities• Conflict and insecurity.
Enablers to offering AYP friendly SRH services	<ul style="list-style-type: none">• Availability of health facilities offering SRH services• Availability of a training package (youth-friendly services) for healthcare providers• Existence of communication platforms for SRH information• On job training and/ or mentorship initiatives• Existence of community/public forums and social groups• Social media and mass media• Enabling policy environment.

Key concerns	<ol style="list-style-type: none"> 1. Limited access to AYPSRH information and commodities 2. Inadequate capacity among healthcare providers on AYPSRH 3. Unethical practices by the HCP; breach of confidentiality 4. The law is limiting to offering some SRH services e.g. PAC 5. Staff attrition like transfers and resignation 6. Inadequate infrastructure. 7. Unfriendly environment with little activities
Prioritize these key barriers	<ul style="list-style-type: none"> • Healthcare providers' attitudes and biases • Inadequate communication skills.
Develop a message tool kit (to be used in the different regions in accordance with prevailing concerns)	<ul style="list-style-type: none"> • Introduction of AYPSRH • SRH age-specific information, services and where to access • Communication skills • Value clarification and attitude transformation process • STIs including HIV, HPV; information on prevention screening, management and referral • Information on FGM reporting, referral and management • Information on GBV (bullying, intimate partner violence, physical, psychological and sexual violence); prevention, referral, and reporting • Psychosocial support - information on where to get psychosocial support for AYP • Hotlines, help desk, and referrals.

Channels of reaching healthcare workers (HCWs)

1. Comprehensive training programs

AYSRH Training programs for healthcare workers will be conducted to enhance their knowledge, skills and improve attitudes towards AYPSRH.

2. Addressing stigma and bias

Continued awareness campaigns and discussions will be held to foster a culture of respect and inclusivity among HCWs. In order to ensure quality services provision, ongoing learning will be encouraged, coupled with dialogue to promote culturally sensitive SRH services provision.

3. Psychological debriefing/team building session for HCWs

This will help with relieving health care workers from the stresses of work in a healthy way that allows them to become better at providing AYPSRH services.

4. Partnerships and community engagement

Community engagement and dialogue activities will be done to strengthen the connection between healthcare workers and the communities.

5. Use of technology

Digital platforms will be utilized to enhance behavior change campaigns among the healthcare workers.

6. Use of SBC materials

Branded SBC materials like laboratory coats, nurse uprons and job aids like handbooks will be developed, produced and disseminated.

7. Values clarification and attitude transformation

Workshops and reflective exercises for HCWs will be conducted. The HCWs will be led to assess their values and beliefs regarding healthcare practices. The process entails challenging and reshaping existing attitudes.

3.4.3 Religious Leaders

They include spiritual leaders or leaders of faith institutions.

Characteristics of religious leaders	<ul style="list-style-type: none">• They aspire to be the moral authority on matters of SRH, marriage and social behavior• Believe youth are the future of the faith and should be protected from premarital sex• Capitalize social influence over the AYP• Can be found in sectarian organizations and places of worship• Serves a captive audience that hold their messages with high credibility.
Enablers to supporting AYPSRH	<ul style="list-style-type: none">• Advocacy pack• SDG 3.7• Doctrine in various religions that support taking care of the body• Existing policy and legal framework• Existing structure and platform for reaching AYP and the other audiences.
Key concerns	<ol style="list-style-type: none">1. Moral and ethical dilemmas2. Inadequate knowledge of AYPSRH3. Community backlash about religious beliefs and SRH.
Key barriers to supporting AYPSRH	<ul style="list-style-type: none">• Cultural and religious beliefs• Stigma and judgment by the community if they support or oppose AYPSRH• Inadequate knowledge on SRH matters• Fear of losing credibility from followers.

Develop a message tool kit (to be used in the different regions in accordance with prevailing concerns)

- SRH awareness
- Communication skills to facilitate engagement with AYP
- Cultural sensitivity; alignment with community values and norms
- Community engagement and collective responsibility
- Stigma and misconceptions on AYPSRH
- STIs including HIV, HPV; information on prevention screening, referrals and management
- Information on SRH services
- Harmful practices (e.g. child marriages, FGM); prevention reporting and referral
- Information on GBV (bullying, intimate partner violence, physical, psychological and sexual violence); prevention, referral, and reporting
- Psychosocial support; information on where AYP can get counseling services
- Policies that protect the rights of adolescent parents, including access to confidential SRH services and parental rights
- Feedback mechanisms e.g. hotlines, help desk, and referrals
- Support for children in crisis
- Social inclusion for PWDs and intersex.

Channels of reaching religious leaders

1. Interfaith dialogues

Religious leaders from different faiths will be brought together to discuss shared concerns about AYPSRH. The coordination will be done through the umbrella religious bodies such as National Council of Churches of Kenya (NCCK), Kenya Conference of Catholic Bishops (KCCB), Inter–Religious Council of Kenya (IRCK), The Supreme Council of Kenya Muslims (SUPKEM). This will promote mutual understanding, buy-in and goodwill to enhance collaboration.

2. Conduct sensitization sessions with religious leaders

- Sensitization sessions tailored for religious leaders will be conducted providing them with accurate information about SRH services and addressing any misconceptions or concerns they may have.
- Storytelling and testimonials; sharing experiences and success stories of AYPSRH with religious leaders during sensitization sessions.
- Religious leaders will be provided with an information pack containing scriptural references that support SRH as a reference tool.
- The SRH program will build partnerships with religious institutions and utilize existing channels e.g. letters by the leaders to introduce the SRH info-packs to their network branches.

3. Incorporate religious values

Messages tailored for religious leaders will be developed integrating religious values into SRH education programs, ensuring that the information provided aligns with the teachings of various faiths. This approach will help religious leaders feel more comfortable endorsing and supporting these services.

4. Using SBC materials

SBC materials such as pamphlets, Parents and caregiver guide, and multimedia presentations, that align SRH information with religious teachings will be developed, produced and disseminated. These resources will be distributed to religious leaders for them to share within their communities.

3.5 The SBC Approaches for Reaching Tertiary Audiences

Tertiary audiences are stakeholders at the national, regional, community, and organizational levels with higher influence on both the secondary and primary audiences. They include media personalities, religious leaders and political class. Their support is crucial in ensuring a conducive and enabling environment for AYPSRH, including the development or change of laws, policies, increased awareness and resource mobilization. The following are barriers and enablers to the support of SRH among tertiary audiences:

3.5.1 Media: Traditional/New Media

Traditional media includes newspapers, radio and television while new media is the digital media which includes social media

Media personalities' characteristics	<ul style="list-style-type: none">• Have an appetite for new information as guided by news value• Ready to amplify health related issues (e.g. teenage pregnancy)• Intention is to highlight matters of public interest that can elicit debate and action• Help uncover challenges about access to AYPSRH• Easily accessible through media houses, websites, and social media platforms• Serve as powerful tools for advocacy, influencing public opinion, and policy changes• Broad reach.
Enablers to supporting AYPSRH	<ul style="list-style-type: none">• Advocacy and Media Kits• Training of media personnel on AYSRH issues• SDG 3.7• Goodwill from mainstream/social media• Existing policy and legal framework• Existing commitments made by the government on AYPSRH.
Key concerns	<ol style="list-style-type: none">1. Inadequate understanding of AYPSRH issues that often leads to misreporting2. Propensity for sensational information at the expense of facts3. Health experts not comfortable to honor media interviews.
Key barriers to supporting AYPSRH	<ul style="list-style-type: none">• Inadequate SRH knowledge: Lack of specialized training of media personnel on AYPSRH to avoid instances of misreporting• Lack of trust between healthcare providers and the media• Instances of bias on reporting certain health topics• Limited access to aggregated data on AYPSRH.• Misuse of social media• Conflicts and insecurity.

Develop a message tool kit (to be used in the different regions in accordance with prevailing concerns)

- Training media package on age-appropriate information and services
- Capacity building of health professionals on media engagement
- Information on where AYP can get SRH services
- Hotlines, help desk, and referrals should be availed to the media
- Policies and guidelines that address AYPSRH.

Channels of reaching the media personalities

1. Engagement meetings

- The program will identify and train health reporters and editors within media houses on AYSRH
- Media personalities' ambassadors will participate in TWG meetings for regular updates
- Stakeholder engagement meetings with health journalists will be conducted e.g. breakfast meeting before major events
- Media team will be invited to participate in field activities or celebration of thematic days.

2. Print Media

- Informative articles, infographics, and success stories will be published in local newspapers and magazines
- A media kit will be developed and provided to the media team to ensure correctness and consistency in messaging.

3. Media sensitization

- Sensitization meetings and webinars with media teams will be conducted through professional bodies for journalists and editors (e.g. Union (KUJ), Kenya Editors Guild, Kenya Media Council) on AYPSRH.

4. Digital media

- The MOH and stakeholders will identify social media influencers and content creators and empower them to utilize digital resources available to amplify AYPSRH messages. They will produce podcasts that share personal stories, providing a platform for individuals to express their experiences and challenges.

Important consideration:

- Ensure information contained in the media reports is accurate and in line with existing legal framework including the Kenya Constitution 2010, policies and guidelines.
- The media will collaborate with government agencies, partners, and community leaders to ensure a coordinated campaign with correct information sharing.

3.52 Policymakers

They include government officials, members of parliament, women representatives, members of county assembly, senators and governors.

Characteristics	<ul style="list-style-type: none"> • They can be found at the national, county and community level health, caucuses and parliamentary house health committees • They have a strong youthful following that is a political asset • Some politicians support AYPSRH initiatives. • They enjoy a large following in the community • Have AYPSRH knowledge gaps • Work with community gatekeepers and community development committees • Have advocacy skills and competency • Are empathetic to the welfare of their people; supporters.
Enablers to supporting AYPSRH	<ul style="list-style-type: none"> • Funding commitments • Advocacy pack • SDG 3.7 • Goodwill from mainstream/social media • Commitment and goodwill from development partners • Existing policy and legal framework • Existing champions for girl child and SRH in parliament.
Key concerns	<ol style="list-style-type: none"> 1. Political future and/or follow-on elections 2. Political narrative of their political affiliation 3. Policy integration.
Key Barriers to supporting AYPSRH	<ul style="list-style-type: none"> • Limited knowledge of the SRH program and services to the AYP • Socio-cultural and religious sensitivities • Lack of prioritization for AYPSRH issues • Lack of budget or funding for AYPSRH strategy • May lose political following due to supporting SRH initiatives such as anti-FGM. • Conflict and insecurity; may not access some areas.
Develop a message tool kit (to be used in the different regions in accordance with prevailing concerns)	<ul style="list-style-type: none"> • Overview of SRH • Communication skills • STIs including HIV, HPV; information on prevention screening and management and referrals • Contraceptive methods available and where to access • Information on harmful practices such as FGM and child marriage • Information on GBV (bullying, intimate partner violence, physical, psychological and sexual violence); prevention, reporting, management and policies • Policies that protect the rights of adolescent parents, including access to confidential SRH services and parental rights • Hotlines, help desk, and referrals.

Channels of reach for policymakers

1. Advocacy

a. Evidence-based advocacy meetings

The program will present well-researched and evidence-based information on the positive impact of AYPSRH services to policy makers and demonstrate how SRH contributes to healthy communities. This will help to obtain their buy-in and persuade them to support AYPSRH.

b. Advocacy campaigns

- Political leaders will be invited to collaborate with stakeholders, including healthcare professionals, CSOs, youth organizations, and community leaders. The political leader will be mandated to steer the AYPSRH dialogue and paint a positive image to SRH and address the possible barriers.
- Advocacy campaigns will be designed and implemented to raise awareness among the public and garner political support for improved AYPSRH services.
- The AYP will be actively involved in advocacy efforts encouraging their participation in civic engagement, politics, meetings, forums, and decision-making processes. Youth voices are powerful, and political leaders, may be more receptive when they hear directly from the AYP.

2. Policy briefs and recommendations

Targeted policy briefs will be developed outlining the specific needs, challenges, and recommended interventions for AYP in the realm of SRH.

The information on AYSRH shall be updates frequently on the MOH and RMNCAH website and social media handles

3. Media engagement

Existing social media platforms like facebook and Twitter (Xspace) will be utilized to reach the political class withAYPSRH messages.

4. Lobbying and policy dialogue

Regular meetings will be held with house committees (county and national) and council of governors, to provide them with opportunities to learn SRH and influence policy decisions.

4

Costed Implementation Plan



4.0 Costed Implementation Plan

60

National Social and Behavior Change
Strategy for Adolescents and Young
People Sexual Reproductive Health

No	Strategic priorities	Timeline					Amount	Responsibility
		2024/ 2025	2025/ 2026	2027/ 2028	2028/ 2029	2029/ 2030		
1.0.	Objective 1: Promote SRH knowledge and skills among AYP							
Capacity building and Sensitization								
1.1.	Provide orientation sessions to stakeholders including partners, counties, and private sectors						15,000,000	Head, DRMH
1.2.	Conduct National Social behavior change communications campaigns						97,200,000	Head, DRMH/HP ACSM/SBC Manager
1.3.	Development and distribution of messages and IEC materials						20,000,000	Head, DRMH/HP ACSM/SBC Manager
1.4.	Training of media stakeholders on AYPSRH						8,000,000	Head, DRMH/HP ACSM/SBC Manager
1.5.	Establish peer education programs in counties and learning institutions						70,000,000	MOH-DRMH / MOE
2.0.	Objective 2: To create demand and acceptability for age-appropriate SRH services among the AYP							
A Community Mobilization and Engagement								
2.1.	Conduct Sub-County advocacy meetings with community leaders						25,000,000	MOH County /CSOs
2.2.	Conduct community dialogue days focused on AYPSRH						20,000,000	AYPSRH Coordinator
2.3.	Dissemination of AYP messages through digital platforms						16,040,000	ACSM/SBC Manager Communication Officer

No	Strategic priorities	Timeline				Amount	Responsibility
		2025/ 2026	2026/ 2027	2027/ 2028	2028/ 2029	2029/ 2030	KSH
B	Advocacy and policy support						
2.4.	Track the inclusion of AYPSRH concerns in relevant policies (highlight specific sections)/ Conduct a policy advocacy campaign.						
2.5.	Conduct regular meetings to discuss and plan advocacy efforts and regular advocacy materials (e.g., reports, infographics) to support policy advocacy efforts.					10,000,000	Head , DRMH ACSM/SBC manager Advocacy officer
2.6.	Develop advocacy materials (e.g., reports, infographics) to support policy advocacy efforts.					10,000,000	DRMH /SRH /ACSM AYP Coordinators
2.7.	Develop an AYSRH interactive platform and updating of the MOH and updating the RMNCAH website and DRMH social media platforms					5,000,000	Advocacy and Communication team
						8,000,000	ACSM/SBC Manager Communications officer
3.0.	Objective 3: To strengthen the healthcare system to be responsive to AYPSRH needs.						
A	Service Delivery						
3.1.	Conduct training for HCPs on AYP friendly services					20,000,000	Head DRMH SRH Rgnl
3.2.	Increase and improve number of health facilities offering AYPSRH friendly services in 47 counties					100,000,000	DRMH /SRH Program County AYP Coordinators
B	Resource Mobilization						
3.3.	Develop resource mobilization strategies for the SBC strategy and document funding needs, fundraising approaches, and AYPSRH implementation plan.					10,000,000	Head DRMH SRH Manager ACSM/SBC Manager
C	Monitoring Evaluation Learning and Research						
3.4.	Develop and revise existing data collection tools for integration into KHS					10,000,000	Head DRMH/ MERL Manager

3.5.	Conduct DQA in health facilities			20,000,000	DRMH/MERL
3.6.	Develop and monitor AYPSRH mobile applications			16,000,000	DRMH/ICT Health promotion officer
3.7.	Conduct baseline, mid-term, end line surveys			15,000,000	DRMH- SRH/M&E

No	Strategic priorities	Timeline					Amount	Responsibility
		2025/ 2026	2026/ 2027	2027/ 2028	2028/ 2029	2029/ 2030		
4.0.	Objective 4: To foster an enabling environment through multi-sectoral collaboration for AYPSRH							
	Stakeholder engagement and partnerships							
4.1.	Conduct Annual Reviews on the effectiveness of the SBC strategy for AYPSRH						20,000,000	MOH/ TWG
4.2.	Strengthen the multi-stakeholder AYPSRH and SBC coordination committee/ TWG at the national and county level.						14,100,000	Head, DRH County Reproductive Health Coordinator
							Total	332,340,000

5

Monitoring and Evaluation Plan

Monitoring is an essential part of the strategy; it is the routine assessment of program resources, activities, and outputs and is done throughout the implementation period of the strategy. Monitoring of work plans will be done on an annual basis, as well as quarterly reviews conducted at the division level within SBC structures, both at national and county levels. These quarterly and annual reviews will bring together key stakeholders to discuss achievements and challenges, and they will provide an opportunity to document learnings and synthesize and document best practices.

Evaluation helps determine whether planned activities have achieved their expected results or outcomes. Ideally, to lay the groundwork for the program evaluation(s), a baseline study is conducted to gather data before the program starts to provide benchmarks against which to measure change as well as to gather data to inform program design and implementation. Evaluations are often conducted at several critical junctures of the program lifecycle, including (i) a midterm evaluation to assess activity implementation, including whether any population groups are underserved, and to adjust program implementation, if necessary, and (ii). A end-term evaluation is necessary to evaluate the overall performance of the strategy, and identify new challenges, and lessons learned to develop the subsequent SBC strategy. The national team, in coordination with the county program officers, will provide oversight for the M&E activities at their respective levels.

The strategy shall advocate for the integration of AYPSRH-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.

Limitations in implementing monitoring and evaluation plan

Successful execution of activities as identified in this strategy could be hindered by different factors that are within or beyond the control of the program officers. Some of these limitations may include, but are not limited to:

- Insufficient data tools and methods.
- Fragmented reporting structures.
- Inequity in advocacy capacity across counties and between different actors.
- Unforeseen emerging and re-emerging issues (COVID-19, drought, flooding, conflicts, etc.).
- Inadequate financing and budgetary realignments.

While these limitations may be unforeseen, efforts to mitigate their effects toward the achievement of desired results will be made.

The following table outlines the activities to be conducted, indicators for measuring progress, identifies data sources, specifies the frequencies of data collection, and designates the responsible person for ensuring accurate, timely execution and evaluation of the initiatives.



Objective/ Thematic Areas and Activities	Indicators	Numerator/ Denominator	Data Source	Frequency of data collection	Responsibility
Objective 1: Promote SRH knowledge and skills among AYP.					
Capacity building and Sensitization					
1.1. Provide orientation sessions to stakeholders including partners, counties, and private sectors	The proportion of key implementers oriented. Sensitization packaged developed	Numerator: Number of implementors who have been sensitized Denominator: Number of Key implementors approached for sensitization	Orientation records	Annual	Head, DRH and RH Unit manager
1.2. Conduct SBC communication campaigns	The proportion of SRH SBCC National and county campaigns conducted bi-annual	Numerator: Number of SRH SBCC campaigns conducted nationally and counties Denominator: 94 campaigns	Campaigns launched	Bi-annual	Health promotion/ DRH
1.3. Development and distribution of messages and IEC materials	Proportion of Health facilities provided with IEC materials	Numerator: Number of health facilities provided with IEC materials Denominator: Total health facilities	Printed IEC materials developed Radio mentions, social media posts Distribution list	Bi-annual	Head, DRH
1.4. Training of media partners on AYPSRH	The proportion of media partners trained	Numerator: Number of media partners trained Denominator: Media partners	Partnership agreements Reports / Minutes	Routine	Communication Officer
1.5. Establish peer education programs	Proportion of Sub counties with established peer education programs Number of peer educator groups were established	Numerator: Active peer educator programs established Denominator: All the 352 sub-counties	Program reports	Routine	MOH/ MOE/ Partners

Strategic Objective Areas and Activities	Indicators		Data source/ means of verification	Frequency of data collection	Responsibility
Objective 2: To create demand and acceptability, for age-appropriate SRH services among the AYP					
Community Mobilization and Engagement					
2.1. Conduct Sub-County advocacy meetings with community leaders	The proportion of Sub-county community advocacy meetings held	Numerator: Total sub-county holding advocacy meetings with community leaders Denominator: 352 sub-counties	Advocacy reports Activity Reports	Bi-Monthly	MOH / Partner
2.2. Conduct community dialogue days focused on AYP	Proportion of community units that held a dialogue day focused on AYP	Numerator: Total number of community units holding dialogue days with a focus on AYP Denominator: Total CHUs	Event reports Survey reports	Activity based	Community Mobilizer AYPSRH Coordinator
2.3. Dissemination of AYP messages through digital platforms	The proportion of digital platforms where AYP messaging has been disseminated. Number of AYP reached with AYP messaging through the digital platforms.	Numerator: Total number of digital platforms with AYP messages Denominator: Total number of existing potential digital platforms Numerator: Number of AYP accessing messages on the digital platform Denominator: total population of AYP	Analytics and platform reports	Monthly	Technology / Communication Officer
Advocacy and policy support					
2.4.	Track the inclusion of AYPSRH concerns in relevant policies (highlight specific sections)/ Conduct a policy advocacy campaign.	Number of policies influenced by the AYPSRH SBC strategy	Policy documents	Annually	Advocacy Officer

Strategic Objective Areas and Activities	Indicators	Data source/ means of verification	Frequency of data collection	Responsibility
2.5. Conduct regular meetings to discuss and plan advocacy efforts.	Number of meetings held to discuss policy advocacy	Numerator: Total advocacy meetings held Denominator: 20 meetings	Minutes of meetings	Quarterly AYP Coordinators
2.6. Develop advocacy materials (e.g., reports, infographics) to support policy advocacy efforts.	Number Communication materials developed	IEC materials	Annually Communication team	
Objective 3: To strengthen the healthcare system to be responsive to AYPSRH needs.				
Service Delivery				
3.1. Conduct training for HCPs on AYP friendly services	The proportion of HCPS trained on AYP friendly services Number of counties that have conducted AYP training	Numerator: Number of HCPS trained on AYP services Denominator: Total number of HCPS Numerator: number of trainings Denominator: 47 counties	Training reports Annualy	CSOs DRH
3.2. Increase number of health facilities offering AYPSRH friendly services	Number of spaces created and utilization rates Proportion of facilities offering AYPSRH friendly services	Numerator: Number of health facilities offering AYPSRH friendly services Denominator: Total number of Health facilities	Reports Annual	AYP Coordinators
Resource Mobilization				
3.3. Develop resource mobilization strategies for the SBC strategy and document funding needs, fundraising approaches, and AYPSRH implementation plan.	Resource mobilization strategy developed including execution plan Number of proposals submitted	Numerator: Total national/county level resource mobilization plans Denominator: 48 (47 counties and one national)	Resource Mobilization strategy RM reports Proposals Quarterly	Resource Mobilization Officer

Strategic Objective Areas and Activities	Indicators	Data source/ means of verification	Frequency of data collection	Responsibility
Monitoring Evaluation Learning and Research				
3.4. Develop and revise existing data collection tools for integration into KHSIS	Proportion of facilities reporting using the revised tool	Numerator: Number of health facilities reporting with the revised tools Denominator: Total health facilities reporting AYP services	Meeting minutes/ M&E tools	Annual
3.5. Conduct DQA in health facilities	The proportion of health facilities routinely collecting AYPSRH data Develop a dashboard	KHSIS	Routine	DRH/ Division of M&E
3.6. Develop AYPSRH mobile applications	Number of application downloads and usage	App analytics	Quarterly	HIS/ Communication Officer/ DRH
3.7. Conduct baseline, mid-term, end line surveys	Number of surveys conducted	Survey questionnaires & reports	Biennial	M&E
Objective 4: To foster an enabling environment through multi-sectoral collaboration for AYPSRH				
Stakeholder engagement and partnerships				
4.1. Conduct Annual Reviews on the effectiveness of the SBC strategy for AYPSRH	Number of annual reviews conducted	Numerator: Total reviews conducted Denominator: 47 counties	Review reports and feedback	Annual
4.2. Strengthen the multi-stakeholder AYSRH and SBC coordination committee/ TWG at the national and county level.	The proportion of national/County/ Sub- County TWG carrying out Quarterly meetings	Numerator: Number of active national/county/Sub counties holding quarterly TWGs Denominator: Number of TWGs held	Committee meeting minutes	Quarterly
				Head, DRH County Reproductive Health Coordinator
				MOH/ TWG

6

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2024 - 2030