REPUBLIC OF KENYA

Ministry of Health

NATIONAL REPRODUCTIVE HEALTH POLICY

2018 - 2030

Towards Attaining the Highest Reproductive Health Status for all Kenyans

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National Reproductive Health Policy
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Table of Contents

FOREWORD

This National Reproductive Health Policy aims to guide the country's investments in the health sector and beyond , so as to improve quality, efficiency, and harness synergies and economies of scale in the delivery of comprehensive universal reproductive health services for all Kenyans. Guided by the dictates of the Constitution of Kenya 2010, the Kenya Vison 20130 and the Kenya Health Policy 2014-2030, the drafting of this policy took a right based approach – with a universal access to comprehensive reproductive health services goal.

In line with the KHP 2014-30, this RH policy has been anchored around key policy principles that shall aim to guide investments, interpretation of targets, and performance of the RH programs towards attaining RH policy goals. These include:

I. Equity in the distribution of reproductive health service
II. People-centred approach to reproductive health interventions
III. Participatory approach to delivery of reproductive health interventions
IV. Multisectoral approach to realising reproductive health goals
V. Efficiency in the application of reproductive health technologies
VI. Social accountability

The overall goal of this policy is to attain the highest possible standard of reproductive health for all Kenyans. To attain this goal, strategic investments of RH services in the country shall be guided by the following strategic imperatives.

I. The need for progressive realization of the right to reproductive health services
II. The centrality of comprehensive universal RH services in the realisation of the KHP 2014-30 overall policy goals
III. The need for sustainable domestic funding for RH services in the country

Eight policy objectives have been identified. They will be regularly monitored to guide the interpretation of RH programs performance against targets by 2030. These objectives are:

1. Eliminate preventable maternal, and new-born morbidity and mortality
2. Eliminate unmet need for contraception including reversing the persistent inequities in access to family planning and infertility management
3. Promote Adolescent and youth sexual and reproductive health

4. Reverse the rising burden of HIV and RTIs
5. Reduce morbidity and mortality due to reproductive tract cancers and other complications
6. SRH for menopausal, andropause and the elderly persons and other special populations
7. Address sexual and gender-based violence, sexual exploitation, and harmful practices
8. RH in humanitarian settings and natural disasters or others such as industrial actions/strikes

It is envisaged that, with the appropriate political-will, and strategic economic investment, grounded on strong intra-sectoral leadership, the successful implementation of this RH policy will significantly contribute in the attainment of the KHP-2014-30 policy goals and lead to the economic development of the country in line with the Kenya Vision 2030 goals and Africa Union agenda 2063.

ACKNOWLEDGEMENTS

The development, and subsequent review of this RH policy was through a comprehensive consultative process involving many stakeholders, individuals and institutions. The Ministry Health (MoH) would like to thank all of those who participated in the development and review of this policy.

The ministry acknowledges the inputs made by the RH steering committee and other stakeholders who participated at the policy review retreat in Manzoni in October 2017. At this retreat, RH experts and practitioners from various health care delivery and training institutions, professional associations, faith-based organizations, and development partners as well as implementing partners made invaluable contributions to this document.

A special word of thanks goes to the MoH Division of Reproductive Health led by Dr Joel Gondi, for their effort in coordinating and steering the policy development process through the various consultative forums. In addition the ministry would wish to acknowledge the role played by both the United Nations Population Fund (UNFPA) and the ESHE family planning programme through UKAID and the Department for International Development or both technical and financial support during the development process of this policy.

Finally, the ministry would wish to acknowledge the roles played by Prof. Perter Gichangi and Dr. Benjamin Tsofa for their technical support in steering the policy development process and leadings the drafting of the policy.

ABBREVIATIONS

AIDS:	Acquired Immuno-Deficiency Syndrome
ARHD:	Adolescent Reproductive Health and Development
CDoH:	County Department of Health
CHMT:	County Health Management Team
CPR:	Contraceptive Prevalence Rate
CSO:	Civil Society Organisations
FBO:	Faith-Based Organisation
FGM:	Female Genital Mutilation
FP:	Family Planning
GoK:	Government of Kenya
HIV:	Human Immunodeficiency Virus
HPV:	Human Papilloma Virus
IGRF:	Intergovernmental relations forum
KDHS:	Kenya Demographic and Health Survey
KEPH:	Kenya Essential Package for Health
KHP:	Kenya Health Policy 2014-30
MERL:	Monitoring, Evaluation, Research and Learning
MoH:	Ministry of Health
NASCOP:	National AIDS and STD Control Programme
NGO:	Non-Governmental Organisation
PMTCT:	Prevention of mother to child transmission
RH:	Reproductive Health
RTIS:	Reproductive Tract Infections
SDGs:	Sustainable Development Goals
STIs:	Sexually Transmitted Infections
UHC	Universal Health Coverage
UNFPA:	United Nations Population Fund
WHO:	World Health Organisation

CHAPTER ONE: INTRODUCTION

This revised Reproductive Health Policy is anchored on The Constitution of Kenya 2010 and aligned to the Health Act 2017, Kenya Health Policy 2014 to 2030, and Vision 2030.

1.1.REPRODUCTIVE HEALTH POLICY AND THE CONSTITUTION OF KENYA

The Constitution of Kenya 2010 provides the overarching legal framework to ensure a comprehensive rights-based approach to health services delivery. It provides that every person has a right to the highest attainable standard of health, which includes reproductive health rights (Constitution 2010). The following articles address RH policy directly:

Article 26

Right to life

- Life begins at conception; abortion is not permitted unless, in the opinion of a trained health professional, there is need for emergency treatment, or the life or health of the mother is in danger, or if permitted by any other written law.

Article 43

Every person has the right

- To the highest attainable standard of health, which includes the right to healthcare services, including reproductive healthcare;
- To reasonable standards of sanitation;
- To be free from hunger and have adequate food of acceptable quality; and
- To clean and safe water in adequate quantities.
- A person shall not be denied emergency medical treatment.

1.2.REPRODUCTIVE HEALTH POLICY AND VISION 2030

In 2007, the GoK launched the national long-term economic blueprint, the Kenya Vision 2030 – aimed at transforming the country into a globally competitive middle-income economy by the year 2030. In this strategic policy document, the GoK underlined the role of the health sector under the 'Social Pilar' in ensuring a healthy productive population for the economic development of the country. In addition, the road-map underlined the importance and need for the country to undertake strategic management of its population

growth and development in order to achieve the national development agenda. This Was to be achieved through the adoption of appropriate health, and particularly reproductive health policies in the country to ensure a healthy population. The National Reproductive Health Policy 2007 -2017 was drafted in line with the long-term GoK development agenda articulated in the Kenya Vision 2030. This revised edition has in action incorporated the Constitution of Kenya 2010 imperatives into the police goals and objectives

1.3.REPRODUCTIVE HEALTH POLICY AND THE HEALTH ACT 2017

The policy is also aligned to The Health Act 2017 which has four objectives:

A. establish a national health system which encompasses public and private institutions and providers of health services at the national and county levels and facilitate in a progressive and equitable manner, the highest attainable standard of health services;
B. protect, respect, promote and fulfill the health rights of all persons in Kenya to the progressive realization of their right to the highest attainable standard of health, including reproductive health care and the right to emergency medical treatment;
C. protect, respect, promote and fulfill the rights of children to basic nutrition and health care services contemplated in Articles 43(1) (c) and 53(1) (c) of the Constitution;
D. protect, respect, promote and fulfill the rights of vulnerable groups as defined in Article 21 of the Constitution in all matters regarding health; and recognize the role of health regulatory bodies established under any written law and to distinguish their regulatory role from the policy making function of the national government.

1.4.THE KENYA HEALTH POLICY 2014-2030 AND OTHER INTERNATIONAL AND NATIONAL OBLIGATIONS

This policy is aligned to Kenya Health Policy 2014-2030; Reproductive maternal new-born, child and adolescent health investment framework 2016 (RMNCAH 2016) and the Kenya Health Act 2017. The Kenya Health Policy 2014-30, which was developed in line with the Constitution of Kenya 2010 and the Kenya Vision 2030, has highlighted six priority policy objectives that the health sector is going to focus its efforts on which address RH services. These are:

1. Eliminating communicable diseases

2. Reducing the burden of non-communicable diseases
3. Reducing the burden of injuries from violence and accidents
4. Providing essential health services
5. Reducing the health risk exposures
6. Strengthening health sector collaboration with other sectors

1.5. REPRODUCTIVE HEALTH POLICY AND THE NATIONAL DEVELOPMENT AGENDA

Over the years, Kenya has strived to overcome development obstacles and improve the socioeconomic status of her citizens, including reproductive health. Some of the initiatives include the development and implementation of the expired Reproductive Health Policy 2007-2017; Kenya Health Policy (KHP 2014-2030), Vision 2030, the promulgation of the Kenya Constitution 2010, and fast-tracking actions to achieve the Millennium Development Goals (MDGs) by 2015 and now Sustainable Development Goals (SDGs).

The implementation of RHP 2007-2017 led to improvement of reproductive health indicators such as increased modern contraceptive use prevalence rate. However, there are outstanding issues such as inequities and inequalities which persist. This policy aims at consolidating the gains attained so far, while guiding achievement of further gains in an equitable, responsive, and efficient manner.

It is envisioned that ongoing government projects including digitization of records and health information system; accelerating the process of equipping of health facilities including infrastructure development; human resources for health development; and initiating mechanisms towards universal health coverage will contribute to achievement of the RH policy goals. The goal of the Kenya Reproductive Health Policy 2018–2030 is attainment of the highest possible standard of reproductive health for all Kenyans.

1.6.THE PURPOSE OF POLICY REVISION

The RH policy was reviewed to ensure it aligns and addresses the following:

1. The devolved system of governance with distinct mandates between the national and county governments as per The Constitution of Kenya, 2010 (COK)
2. The devolved Health service delivery functions at the county level with policy formulation and capacity building to the county being left at the national level

3. Increased focus on health as a human right, quality and equity as enshrined in COK, 2010
4. Increased focus on evidence-based policy formulation and Adapt evidence-based practice
5. Broad overarching national priorities, including focus on NCDs, Kenya's commitment to the attainment of the Sustainable Development Goals (SDGs) and Universal Health Coverage (UHC)
6. Need to adapt to the changing RH environment including new CPR goal and emerging issues such need for infertility management, etc
7. Development of new health goals, including mCPR, MMR, NMR etc.

1.7.REVISION AND UPDATING PROCESS

The revision process was participatory and involved the formation of the technical working group and steering committee to make recommendations and review successive versions. There was also a wider call for submissions distributed through various electronic mailing lists. The deliberations and recommendations from these working groups, together with other submissions from individuals, organizations, and key informant interviews, form the main body of the revised policy.

1.8.GUIDING PRINCIPLES

In line with the KHP 2014-30, this revised RH policy shall be anchored around key policy principles that shall aim to guide investments, interpretation of targets, and performance of the RH programs towards attaining RH policy goals. These include:

Equity in the distribution of reproductive health services and interventions: There will be no exclusion or social disparities in the provision of reproductive healthcare services. Services shall be provided equitably to all individuals in a community, irrespective of their gender, age, caste, colour, geographical location, tribe/ethnicity, and socioeconomic status. The focus shall be on inclusiveness, non-discrimination, social accountability, and gender equality.

People-centred approach to reproductive health interventions: Reproductive Health (RH) services and RH interventions will be based on people's legitimate needs and expectations.

This necessitates community involvement and participation in deciding, implementing, and monitoring interventions.

Participatory approach to delivery of reproductive interventions: The different actors in health will be involved in the design and delivery of interventions in order to attain the best possible outcomes. A participatory approach should be applied when potential for improved outcomes exists. The private sector shall complement the public sector in terms of increasing geographical access to RH services and the scope and scale of services provided.

Multisectoral approach to realising reproductive health goals: The relevant sectors include, among others, education—secondary-level female education; agriculture—including nutrition/food security; roads—focusing on improving access among hard-to-reach populations; and environmental factors— focusing on a clean, healthy, unpolluted and safe environment.

Efficiency in the application of reproductive health technologies: This aims to maximise the use of existing resources. The RH programs will choose and apply technologies that are appropriate (accessible, affordable, feasible, and culturally acceptable to the community) in addressing RH challenges.

Social accountability: Reproductive Health service delivery systems will be reoriented towards the application of principles and practices of social accountability, including reporting on performance, creation of public awareness, fostering transparency, and public participation in decision making on RH-related matters. In addition, a rights-based approach to RH services underpins this Policy as outlined in Box 1 and The Health Act of 2017. Bridging the demand/supply gap through increasing the community "voice".

Box 1. A rights-based approach to RH services

- RH services are rendered (in relation to clients' rights) according to the Constitution of Kenya and other international related rights-based agreed documents and conventions.
- There is an enabling legislative environment for the provision of RH services.
- A rights-based approach is reflected in all aspects of service delivery. This is underpinned by the principle of informed voluntary contraception and people's right

to exercise their reproductive choices. This includes confidentiality and privacy, contraception choice, informed decision making and shared responsibility.

- All RH services are voluntary, unless the client is legally incapable of making such a decision.
- Services are rendered in an equitable and non-discriminatory manner in terms of sexual
- orientation, sexual preferences, sexual identity, race, gender, age and culture, with due regard for what is suitable and appropriate for individual clients' needs.
- No client requesting contraception should be sent away without a suitable method of their choice.
- Client empowerment and community participation and mobilisation are promoted as part of the overall RH service package.
- Cost is not a barrier to access and use FP/C services.

1.9.REPRODUCTIVE HEALTH CHALLENGES

The following gaps and obstacles to be addressed by the policy broadly include:

1. Quality and quantity of RH services.
2. Inequitable coverage with RH services among certain areas or population groups, including adolescents.
3. Demand side barriers that limit access and utilization of RH services such as long distances to health facilities, high costs, religious and sociocultural beliefs and practices and low status of women as well as lack of knowledge and information.
4. Supply side challenges due to suboptimal functioning of the health systems (infrastructure, human resources for health (HRH), supply chain, health financing, health Information, and leadership/governance).
5. Challenges of low middle-income status Kenya achieved recently.
6. Lack of clear mechanisms for accountability of the policy.
7. Inadequate coverage of priority emerging issues such as infertility and its management, vaccine preventable RH problems etc.

1.10. SCOPE OF THE POLICY

Perhaps the most crucial definition of the National RH policy rests on what is meant by

reproductive health, which defined below. Other definitions relevant to this policy are included in the glossary of terms.

Reproductive health is a subset of health which is defined as “a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity”. Reproductive health, therefore, implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.

The RH policy will address in principle four of the six lifecycles, with less emphasis on early childhood (28 days to 5 years) and late childhood (6 to 12 years). The six lifecycles (KHP 2014-2030) are: 1) Pregnancy and the newborn child (up to 28 days of age); 2) Early childhood (28 days to 5 years); 3) Late childhood (6 to 12 years); 4) Adolescence and youth (13 to 24 years); Adulthood (25 to 59 years) and 6) Elderly (60 years and over).

1.11. SCOPE FOR THE REPRODUCTIVE HEALTH POLICY

Reproductive health will address the reproductive processes, functions and system at all stages of life for men and women. By implementation of the RH policy, people will be able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implied in the foregoing is the right of both men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.

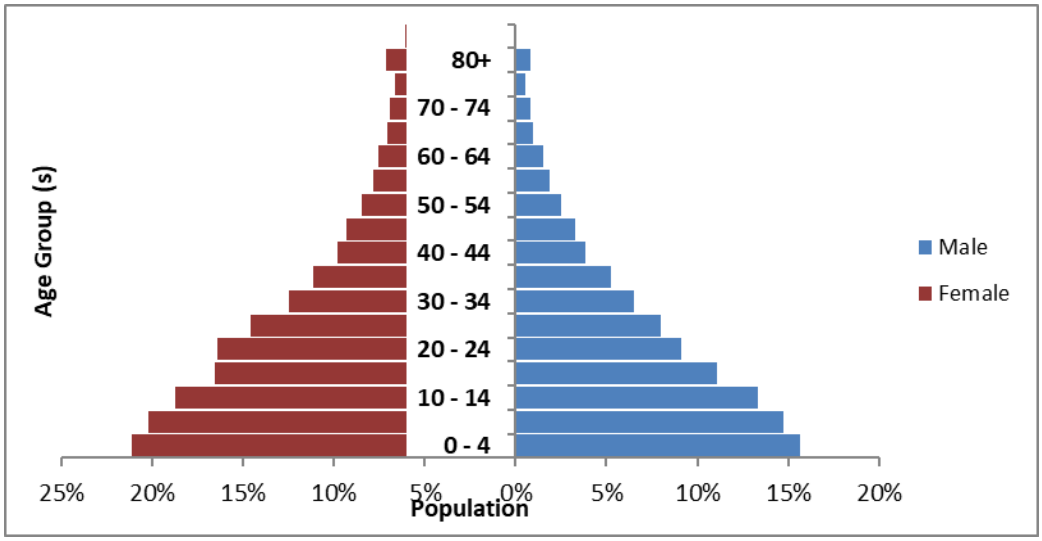
CHAPTER 2. COUNTRY CONTEXT

2.1. SOCIAL, DEMOGRAPHIC AND ECONOMIC SETTING

Kenya's population was estimated at 45.4 million people in 2016 in 10 million households, with an estimated household size of five persons. The country is in the middle of a demographic transition, with a still-high birth rate and a reducing mortality rate maintaining a high population growth rate (2.7% per year). The population distribution shown in the figure 1.

The Life expectancy in 2016 was estimated at 62.2 years, up from 51 years in 2004. The high child and youth population bulge present unique opportunities and challenges for health financing: opportunities of a large youth population able to contribute to health and financing, but challenges associated with their unique health needs of a dependent, increasingly urbanized population. The male to female population ratio stands at (1:1.04).

Figure 1: Kenya's population pyramid, 2016

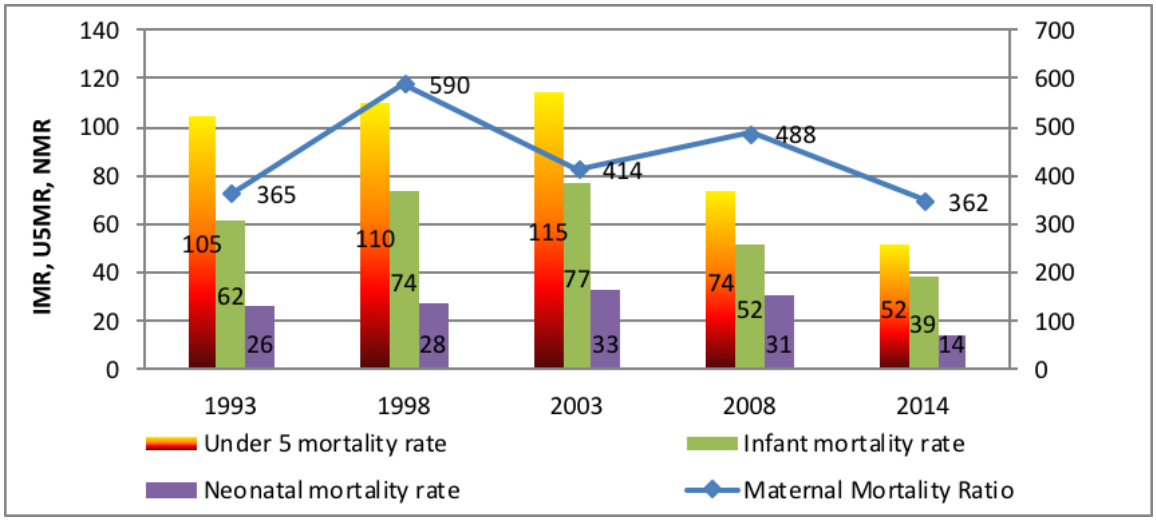


Source: *KNBS, Population census projections*

2.2. THE STATE OF HEALTH

The overall health of the people in Kenya has been on an improving trend in the past 10 years, following a period of stagnation/reduction in the 1990s/2000s. Adult, child and maternal health is showing improvements, though the trends are not at a rate expected for the level of development of the country, Figure 2.

Figure 2. Trends in health impact indicators, 1993 – 2014



Source: Kenya Health Policy 2014 – 2030 and MTP 2017 statistical report

The trend in improving health is driven by reductions in communicable conditions. However, the country is also witnessing an increase in non-communicable conditions including injuries, negating the gains made. As seen in the table below, the major causes of morbidity and mortality in the country are arising from both communicable and non-communicable events.

2.3. SITUATION ANALYSIS OF REPRODUCTIVE HEALTH AND RIGHTS IN THE COUNTRY

The RH 2007 to 2017 policy objectives were to: reduce maternal, perinatal and neonatal morbidity and mortality; reduce unmet family planning needs; improve sexual and reproductive health of adolescents and youth; promote gender equity and equality in matters of reproductive health, including access to appropriate services; contribute to reduction of the HIV/AIDS burden and improvement of the RH status of infected and affected persons; reduce the burden of reproductive tract infections (RTIs) and improve access to, and quality of, RTI services; reduce the magnitude of infertility and increase access to efficient and effective investigative services for enhanced management of infertile individuals and couples; reduce morbidity and mortality associated with the common cancers of the reproductive organs in men and women; address RH-related needs of the elderly; and address the special RH-related needs of people with disabilities. Some data was available to review performance of the RH policy 2007 to 2017 summarized below.

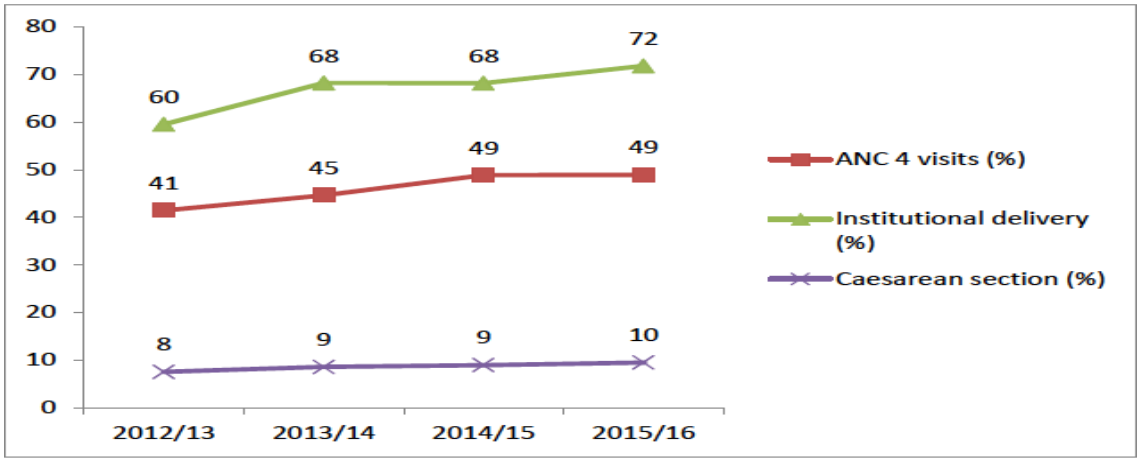
Safe motherhood, Maternal and Neonatal Health

Regarding Antenatal and delivery care, coverage of the first visit of antenatal care (ANC) was nearly universal. In the KDHS 2014 96% of women made at least one ANC visit, and in the DHIS ANC coverage rates also range from 95-97% during 2012/13-2015/16. The proportion of pregnant women who made 4 or more antenatal care visits was much lower but increased from 47% in the KDHS 2008/09 to 58% in 2014. In the DHIS2 there was also an increase from 42% in 2013/2014 to 49% 2015/2016.

Institutional delivery rates which are taken as a proxy for the skilled birth attendance increased from 43% (KDHS 2008/09) to 61% (KDHS 2014). This large increase also resulted in an increase of Caesarean section rates from 7.6% to 9.5%. This increase was almost entirely the result of more women delivering in health facilities, as the proportion of women with Caesarean section among those delivering in a health facility remained constant at 13%. This, like the continued decline of institutional maternal mortality ratios, also suggests that health facilities were able to keep up with the increased utilization, as Caesarean section rates did not go down (Figure 3).

Data from DHIS2 shows that the stillbirth rate in health institutions declined from 34 to 26 per 1,000 births during 2012/13 to 2015/16. Fresh stillbirth rates remained fairly constant at about 13-15 per 1,000 births. The overall stillbirth rate (macerated and fresh) was 26 per 1000 births in health facilities in 2015/16. The proportion of new-borns with low birth weight (<2500 grams) remained at 5% from 2012/13 to 2015/16. KDHS data suggests an increase in low birth weight (less than 2.5 kg) from 6% in 2008/9 to 8% in 2014 (KNBS 2010, 2015). Perinatal mortality rate for the five-year period preceding has decreased from 37 deaths per 1,000 pregnancies reported in the 2008-09 KDHS to 29 deaths per 1,000 pregnancies in KDHS 2014.

Figure 3. Trends in institutional delivery rates, coverage of four antenatal care visits and caesarean section rates, DHIS2, 2012/2013-2015/16



Source: MTP 2017 statistical report

Breastfeeding has remained nearly universal in Kenya (97.1% in 2008/9 and 98.7% in 2014 initiated breastfeeding). Exclusive breastfeeding for infants 0-3 months and 0-5 months has increased from 43% and 32% in 2008/9 to 72% and 61% in 2014 respectively.

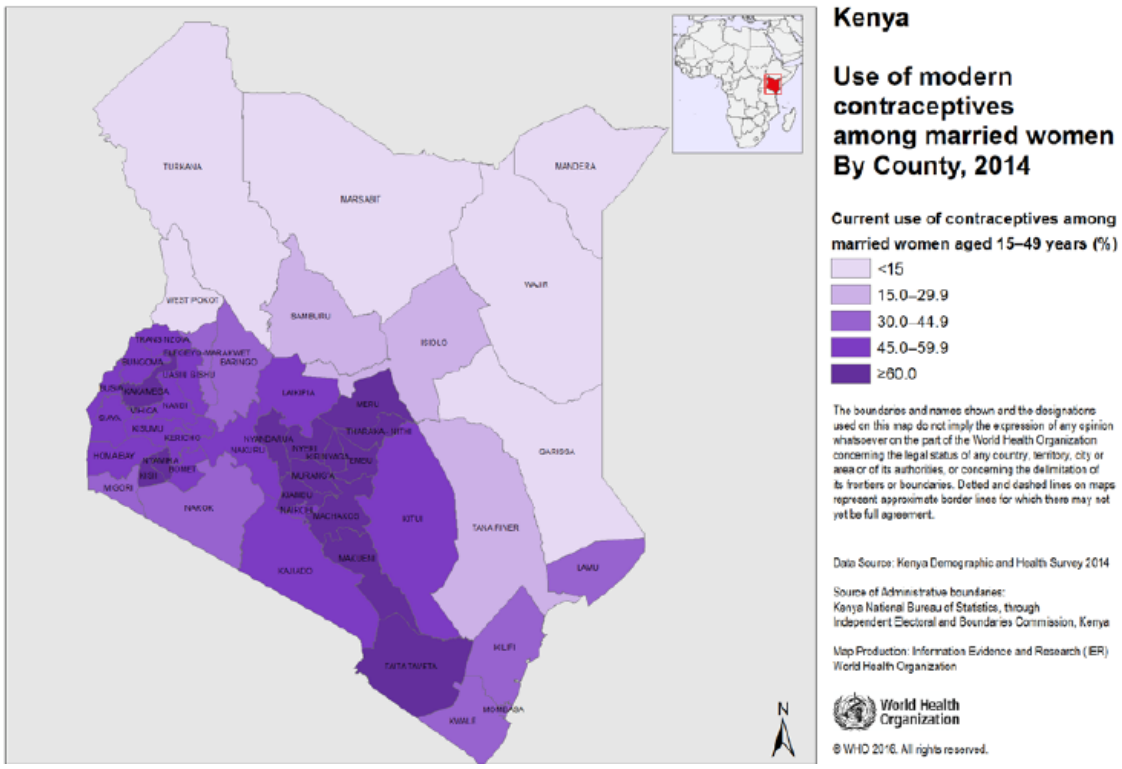
Regarding maternal mortality, the population level of maternal mortality in the KDHS 2014 was 362 per 100,000 live births for the period 2007-14, which was lower than 520 for the 7 years preceding the KDHS 2008/09 (although confidence intervals are overlapping). One in 7 deaths (14.1%) among women of reproductive ages were due to pregnancy related causes. The DHIS provides more recent information on maternal mortality in health facilities. There was a slight decline from 130 per 100,000 deliveries in 2012/13 to 118 in 2013/14, 103 in 2014/15 and 106 in 2015/16. This is close to the target of 100 per 100,000 deliveries, but still 1105 maternal deaths occurred in health facilities in 2015/16. Underreporting of maternal deaths is common and the DHIS2 data should be interpreted with caution.

Family planning

The KDHS data show a dramatic increase of use of modern contraceptives among currently married women 15-49 years during the 5 years, increasing from 32% in 2003 to 39% in 2008/09 and 53% in 2014 with significant disparities between counties, Figure 4. PMA 2020 data shows mCPR continues to increase now standing at 60% among MWRA. The percent of demand satisfied by modern methods, has increased from 64% in 2008/09 to 71% in 2014

among currently married women. Current modern contraceptive use by married women 15-49 was higher in urban than rural areas, but the difference was small: 57% and 51% respectively. Women in the poorest wealth quintile however had much lower contraceptive use (29%) than all other quintiles where use ranged from 54-60%. Similar results have been obtained from PMA 2020 data.

Figure 4. Use of modern contraceptives by currently married women 15-49 yeas



Source: KDHS 2014

Adolescent/Youth Sexual and Reproductive Health

Childbearing begins early in Kenya, with almost one-quarter of women giving birth by age 18 and nearly half by age 20. Age specific fertility for 15-19-year-old adolescents has decreased from 103 in 2008/9 to 96 in 2014. However, the percent of adolescent women age 15-19 already mothers or pregnant with their first child at the time of the survey has not changed from 18% in 2008/9 in the last five years KDHS 2014. Adolescents are least likely to have discussed family planning either with a fieldworker or at a health facility (KNBS 2015). Kenya AIDS response progress report of 2016 shows that young people significantly contribute to high HIV burden in the country. They constitute the largest proportion of

people living with HIV. Notably, they have contributed 51% of adult HIV new infections showing rapid rise from 29% in 2013. A number of factors have advanced this alarming rate of infection such as incorrect perception of their risks on HIV; limited knowledge on sexual behaviour that expose them to HIV such as failure to use condoms during the first sexual intercourse; failure to resist forced sex from partner; having sexual intercourse under influence of alcohol or drugs among others. This suggests a need to promote programmes that will reverse this pattern over time.

Gender issues, sexual and reproductive rights

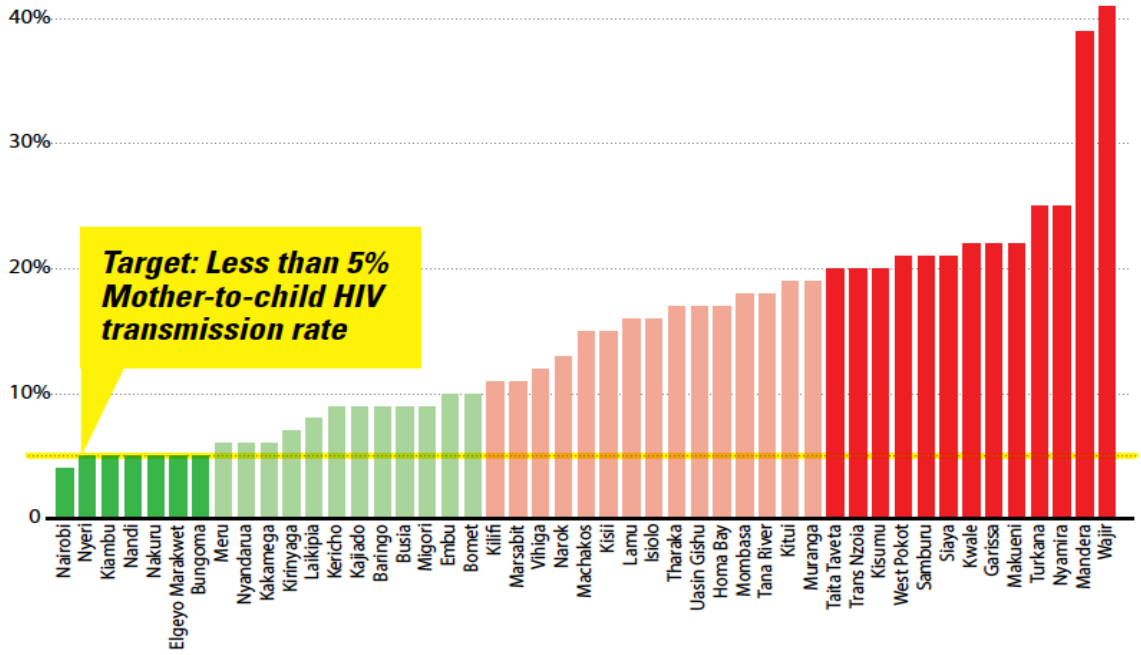
Gender-based violence is not rare in Kenya. Among women aged 15-49 years, reported rate of physical violence in the last 12 months has not changed from 24% in 2008/9 to 2014 (KNBS 2010, 2015). From KDHS of 2008/9, 5.5% reported physical violence was frequent while it was 5% in 2014. For men, the corresponding figures are lower: 11% and 1.4% respectively. Overall, 7.8% and 2.3% of women and men 15-49 years respectively reported to have been involved in a sexual assault incident in the past 12 months. The person committing the sexual violence against the women was the current husband or partner in 48% of cases, followed by the former husband or partner (25%). Female Genital Mutilation, a form of GBV is rampant in Kenya with national average prevalence of 21% nationally with some counties having a prevalence of over 90% (KDHS 2014).

HIV and AIDS

The country achieved 20% reduction on sexual transmission of HIV and 49% reduction of new infection among children. Good progress was made in addressing HIV in Kenya, however, targeted interventions are needed for adolescents 15-24 years in order to tackle increasing new HIV infections. Stigma and discrimination is the main barrier to achieving this goal.

HIV prevalence has remained stable at about 6% for the last 5 years with geographical variation ranging from a low of 0.4% in Wajir to a high of 26% in Homa Bay. New HIV infections in Kenya were reduced by 19% between 2013 and 2015. Kenya reduced number of new HIV infections among children by 49% between 2013 and 2015. More than half (24) of the 47 counties significantly reduced their new HIV infections among children, Figure 5.

Figure 5. Mother-to-Child HIV Transmission (MTCT) rates in 2015 by Counties



Source: Kenya progress report 2016

Because voluntary childlessness is rare in Kenya, it might be assumed that most married women with no births are unable to physiologically bear children. The percentage of women who are childless at the end of the reproductive period is an indirect measure of primary infertility (the proportion of women who are unable to bear children at all). Primary infertility is less than 2 percent (KDHS 2014). Primary infertility has changed little since 2003.

Cancers of reproductive organs

The recommended screening cycle for the cervical cancer in Kenya is every 5 years for women aged between 25-49 years with the exception for HIV positive women. Cervical cancer screening has remained quite low. In the KDHS 2014, only 18.8% of women 25-49 years had ever had cervical cancer screening. In STEPS 2015, cervical cancer screening coverage rates were similarly low, with 14.2% of women 25-49 years ever screened.

CHAPTER THREE: POLICY GOAL, OBJECTIVES, AND ORIENTATIONS

This section defines the goal of this policy, describes the eight key policy objectives that must be met to achieve that goal, and outlines the various orientations that will lead towards realisation of those objectives.

3.1. POLICY GOAL

The overall goal of the Policy is "to attain the highest possible standard of reproductive health for all Kenyans." To attain this goal, strategic investments in RH services in the country shall be guided by the following imperatives:

1. **Progressive realisation of the right to reproductive health:** The national and county governments will put in place measures to progressively realise the right to RH as outlined in Article 21 of the Constitution. The RH programs will employ a human rights-based approach in reproductive healthcare delivery and will integrate human rights norms and principles in the design, implementation, monitoring, and evaluation of RH interventions. This includes human dignity; attention to the needs and rights of all, with special emphasis on children, persons with disabilities, youth, minorities and marginalised groups, and older members of the society (Constitution of Kenya 2010 Article 53−57); and ensuring that RH services are made accessible to all.

To achieve this, a package of RH services shall be offered at different KEPH levels of care consisting of cost-effective priority RH interventions and services, addressing RH subcomponents, that are acceptable and affordable within the total resource envelop available. The package shall consist of the following clusters:

1. Maternal, and new-born health services;
2. Family planning/contraception and infertility services;
3. Adolescent sexual reproductive health services;
4. Sexual and reproductive health services appropriate to phases of the continuum of life (six life cycle cohorts – KHP 2014-2030) of all Kenyans;
5. Cross-cutting to address but not limited to: gender and RH; HIV&AIDS; RH for elderly and hard to reach populations {nomadic, key population, people with disabilities}.

The composition of the package shall be re-visited periodically depending on availability of new interventions based on evidence and changes in the cost-effectiveness of the interventions.

2. **Contribution to Health policy 2014-2030:** This National Reproductive health policy will contribute to the attainment of the country's Kenya Health Policy (KHP 2014-30) and the national development agenda outlined in Kenya's Vision 2030; through the provision of high-quality RH services to maintain a healthy and productive population able to deliver the agenda.

3. **Sustainable domestic funding for RH:** RH as part of health may be viewed as critical element needed to drive the economy. Thus, rather than health being an expenditure, it is an investment which has immediate and long term quantifiable outcomes. Given its strategic importance, this policy will advocate for total domestic funding which will eliminate some of the uncertainties the programs currently face which negatively impact on health indicators. RH funding sustainability and total domestic funding will be realized gradually with target date for attainment being the year 2030.

3.2. POLICY ORIENTATIONS

These define how the RH programs will be structured to facilitate the attainment of the policy objectives. This policy being subservient to the Health policy 2014-2030, it will support the eight orientations defined in KHP 2014-2030, or key action areas, where investments will need to be made to facilitate the attainment of the RH policy objectives as follows:

1. Organisation of Service Delivery: Organisational arrangements required for delivery of services;
2. Health Leadership and Governance: Oversight required for delivery of services;
3. Health Workforce: Human resources required for provision of services;
4. Health Financing: Financial arrangements required for provision of services;
5. Health Products and Technologies: Essential medicines, medical supplies, vaccines, health technologies, and public health commodities required for provision of services;

6. Health Information: Systems for generation, collation, analysis, dissemination, and utilisation of health-related information required for provision of services;
7. Health Infrastructure: Physical infrastructure, equipment, transport, and information communication technology (ICT) needed for provision of services; and
8. Research and Development: Creation of a culture in which research plays a significant role in guiding policy formulation and action to improve the health and development of the people of Kenya.

These policy orientations have informed policy objectives. The effects of investments in these eight key areas will be measured through attainment of desired RH outputs; which include and not limited to: improved access, quality of care, and demand for services. To see the light of the day, the following policy commitments are required:

3.3.POLICY COMMITMENTS

3.3.1. Policy commitments in relation to improving access to services:

1. All persons shall have adequate physical access to RH and related services, as defined in the Health policy 2014-2030;
2. Financial barriers hindering access to services will be minimised or removed for all persons requiring RH and related services; guided by the concepts of Universal Health Coverage and Social Health Protection; and
3. Sociocultural barriers hindering access to RH services shall be identified and directly addressed to ensure all persons requiring RH and related services are able to access them.

3.3.2. Policy commitments in relation to improving quality of care:

1. Clients/patients shall have positive experiences during utilisation of health and related services;
2. The available health and related services shall be provided in a manner that ensures patient/client safety—potential harm as a result of using services should be anticipated and mitigated against;
3. The health and related services provided shall be of the most effective as is feasibly possible;

4. Support implementation of the health sector quality management policy that act as a guide for quality management implementation and coordination; and
5. Establish mechanisms for a regular review of standards of care.

3.3.3. Policy commitments in relation to improving demand for health and related services:

1. Clients/patients shall have adequate awareness of the health actions needed to maximise their RH;
2. Support programs which promote appropriate clients/patients health-seeking behaviours when threats exist to their RH;
3. Support programs/groups which ensure clients are well-informed of available RH services;
4. Support programs to ensure sustainable health financing;
5. Support systems to ensure all players report health data;
6. Ensure there is provision of MNCH commodities.

3.3.4. Policy commitments in relation to stakeholders use and implementation of the policy:

1. Support counties to implement the policy implementation strategy based on their needs and priorities;
2. Support systems to ensure all players report health data to relevant reporting systems and tools;
3. Ensure there is provision of MNCH commodities;
4. Support initiatives to strengthen County Health Management Teams to ensure implementation of RH programs.

3.4. POLICY OBJECTIVES

The overall goal of the Policy is “to attain the highest possible standard of reproductive health for all Kenyans.” This policy addresses provision and progressive realisation of universal access for RH services for all. This overall objective shall be achieved through realization of the following policy objectives.

Policy objective 1: Eliminate preventable maternal, and new-born morbidity and mortality

Policy issue(s)

There is persistence of preventable maternal and new-born morbidity and mortality. Though there is under-reporting of data from DHIS2, in 2015/2016, 1,105 women died in hospitals, giving maternal mortality ratio of 106 per 100,000 deliveries (MTP 2017 statistical report). UN estimate infant mortality ratio of 21 per 1000 livebirths (MTP 2017 statistical report). MMR and IMR point to issue of quality of services during labour and immediate post-delivery. This policy aims to reduce the burden of morbidity and mortality during pre-pregnancy, pregnancy, childbirth and extended postpartum period.

The priority policy statements include the following:

1. Expand access to pre-pregnancy care including screening, counselling, and management.
2. Increase access to skilled continuum of care from antenatal, intrapartum and extended postpartum period.
3. Improve quality of care by ensuring adherence to clinical guidelines and quality improvement processes for maternal and new-born care as per the KQMH including respectful maternal and new-born care.
4. Strengthen accountability systems in provision of maternal and new-born services including MPDSR, and RMNCAH scorecard.
5. Ensure sustainable financing for MNH services, commodities and supply chain management.
6. Improve nutrition of mothers and adolescents during pre-pregnancy, pregnancy, and extended postpartum period.
7. Strengthen community MNH to achieve UHC.
8. Provide enabling environment for innovations to improve maternal and new-born health outcomes.
9. Develop necessary legislations and regulations to strengthen quality MNH services.

10. Promote referral to service units providing tertiary/highly specialised services, including high-level specialist medical care, reference laboratory support, and blood transfusion services.
11. Ensure there is provision of appropriate post abortion care services.
12. Promote community involvement to address the first and second delays in the pathway to maternal morbidity and mortality and use of postpartum services.
13. Strengthen referral networks across the service delivery points in both public and private facilities at national and county levels.

Policy objective 2: Eliminate unmet need for contraception including reversing the persistent inequities in access to family planning and infertility management.

Policy issue(s)

Though there is tremendous improvement in mCPR nationally, there are significant disparities among counties and also within counties and among different populations. About 2% of Kenyan couples have infertility (KDHS 2014). However, from a right perspective, these individuals and couples deserve infertility treatment and associated services. This objective will be achieved through sustaining current gains in contraceptive prevalence rate and implementing strategies to address inequalities and inequities between counties, within counties and among populations. The policy also prioritises infertility management.

The priority policy statements include the following:

1. Ensure universal access to full range of voluntary family planning services including integration, community FP service provision and total market approach.
2. Enhance quality of family planning services.
3. Scale up interventions addressing regional and population inequities and inequalities in accessing FP/C services.
4. Ensure sustainable financing for FP services, commodities and supply chain management.
5. Address socio-cultural, religious and other demand side barriers to uptake of FP services.

6. Put in place legislation to guide infertility management including sperm donation, in-vitro fertilization, sperm/ovum storage, surrogacy and establishment of infertility treatment centres.
7. Strengthening advocacy and health-promoting activities aimed at preventing causes of infertility, managing infertility and ensuring services are affordable.

Policy objective 3: Promote Adolescent and youth sexual and reproductive health

Policy issue(s)

Adolescents and youth in Kenya still lack access to quality, responsive and friendly sexual reproductive health information and services which this predisposes them various SRH risks. This challenge can be attributed to poor implementation of available policies, standards and guidelines largely due to inadequate dissemination and financing. Consequently, adolescents and youth continue to experience challenges in accessing and utilizing SRH services resulting in poor reproductive health indicators in comparison to older women. Notable is the persistent high pregnancy or parenthood rate of 18% among adolescents aged 15-19 years from 2008/9 to 2014 (KDHS 2014); high new HIV infections rates where over 50% of new HIV infections occur among adolescents and youth between the ages of 15-24 and the prevalence of sexual and gender-based violence estimated at 7% among adolescent girls and 3% among adolescent boys between the ages of 15 and 19 years (KDHS, 2014). In view of the highlighted concerns, the RH policy will support programs that address adolescent and youth sexual and reproductive health in a holistic manner as elaborated in the National ASYRH Policy of 2015.

The priority policy statements include the following:

1. Ensure increased access to Adolescent and youth friendly RH services.
2. Strengthen Collaboration with the Ministry of Education, Ministry of Public Service. Youth and Gender Affairs and other relevant ministries and stakeholders for implementation of existing policies, guidelines, SOPs, and standards that enhance delivery of SRH information and services to adolescents and youth and ensure their protection.

3. Promote Integration of AYF RH information and service delivery in the community strategy and other community approaches.
4. Support the integration of paediatric services with the RH services for the very younger adolescents (VYAs), 10-14 years.
5. Support programs aimed at turning around attitudes, practice and knowledge of health care providers, parents, care-givers, teachers, religious leaders and other key stakeholders for enhanced support of AYSRH needs.
6. Address social cultural barriers to address harmful practices such as child marriages, female genital mutilation (FGM), and sexual and Gender based violence among others.
7. Promote the use of innovations in promoting the SRH status of adolescents and youth.

Policy objective 4: Reverse the rising burden of HIV and RTIs

Policy issues

There is persistent high rate of Mother-to-child transmission of HIV (NASCOP) while adolescents contribute over 50% of new HIV infections in Kenya. Reproductive tract infections rates have either remained stagnant unchanged over time with notable increase in multidrug resistant gonorrhoea infections.

Priority policy statements include:

1. Promote abstinence among adolescence and youth.
2. Promote universal access to HIV prevention services including but not limited to HIV testing, dual protection, FP/contraception, treatment and retention in treatment programs and stigma reduction.
3. Promote integration of quality RH/HIV/RTI/SGBV services.
4. Coordinate RH/HIV/RTI/SGBV services with other relevant ministries and stakeholders.
5. Promote universal access to services addressing priority RTIs including but not limited to syphilis, gonococcal resistant bacteria and chlamydia.

6. Promote Advocacy Communication and social mobilization (ACSM) interventions aimed at strengthening community angagements and participationin RH/HIV/RTI/SGBV programs.
7. Increase access to HIV/RTI/SGBV services for marginalised and indigent populations.

Policy objective 5: Reduce morbidity and mortality due to reproductive tract cancers and other complications

Policy issue(s)

Reproductive tract cancers are now significant contributors to mortality among Kenyan. Services and facilities to address reproductive tract cancers are not universally accessible and also even where they exist, they are not optimally used. There are some complications such reproductive tract fistula which significant personal, family and even societal negative consequences which are not adequately addressed. This objective aims to reduce morbidity and mortality related to RT cancer and other complications.

Priority policy statements include:

1. Promote HPV vaccination, screening and treatment of RH related cancer including cervical cancer, prostate cancer and breast cancer among others as envisioned in the cancer control strategy 2017.
2. Promote community involvement to address female genital fistula.
3. Ensure multisectoral and multidisciplinary coordination of programs to address female genital fistula.
4. Strengthen programmes for prevention, treatment and reintegration of female genital fistula management.
5. Strengthen the health care system to support prevention and management of abortion and its complications.

Policy objective 6: SRH for menopausal, andropause and the elderly persons and other special populations

Policy issue(s)

SRH for menopausal, andropause, the elderly and special populations such as those living with disabilities is an overlooked field with inadequate focus on programs, services, and limited data. The elderly and women living with disabilities have limited access to RH services.

Priority policy statements include:

1. Integrate SRH in geriatric medicine and nursing.
2. Improve access to quality and comprehensive SRH services at all levels for menopausal, andropause, the elderly and special populations through peer programs, outreach, integration with NCDs, etc.
3. Support implementation of appropriate SRH service delivery models for special population groups including but not limited to: Key populations, Persons with disability (PWD), Refugees, Prisoners, Homeless/street families and Internally displaced people.
4. Ensure universal access to quality integrated SRHR for Persons with disability especially women and girls.

Policy objective 7: Address sexual and gender-based violence, sexual exploitation, and harmful practices

Policy issue(s)

Sexual violence and harmful cultural practices continue negatively impact RH indicators. This objective will be achieved by supporting programs that address GBV and gender-based bottlenecks which negatively influence RH outcomes.

Priority policy statements include:

1. Promote access to quality preventive, curative and rehabilitative Gender and SGBV services.

2. Collaborate with other relevant stakeholders to address factors that influence harmful practices in relation to gender in the community.
3. Collaborate with other ministries and stakeholders to address GBV, intimate Partner Violence (IPV) and Violence against Children (VAC).
4. Support public private partnership to establish and operationalize GBV rescue centres/safe houses for GBV clients.
5. Strengthen capacity of health care workers to eradicate medicalization of FGM.

Cross cutting objectives

Across all the objectives, there is need to support accountability systems to reduce recurrence of causes of morbidity and mortality as identified through MPDSR etc at County and National level and to advocate and create awareness in the community for healthy seeking behaviour, male participation and for the elimination of all forms of violence and discrimination against all people. Capacity of service providers to provide services; health infrastructure limitations; human resources for health, health financing; innovation as well as technologies application and monitoring, evaluation, research and learning (MERL) cuts across all objectives. There is need to support initiatives to streamline congruency of the existing laws and health practice/service delivery e.g. age of majority vis-à-vis mature minors, family planning policy allowing all who seek these services to access them including those below age of majority from rights perspective, etc. There need to ensure adherence to global reproductive health related commitments and support programs, initiatives that promote male involvement in RH matters. This policy will leverage other existing policies.

Policy objective 8: RH in humanitarian settings and natural disasters or others such as industrial actions/strikes

Policy issue(s)

Kenya has experienced recently humanitarian situations which have had negative impact on RH indicators. Some groups suffer more than others in these situations. Adolescents, especially those who are sexually active, encounter multiple constraints in accessing broad RH and specific family planning information and services during emergencies. The collapse of family and social support that happens in humanitarian settings and emergencies, compounded by inaccessible and overstretched health services, increases the vulnerability of adolescents who could engage in unprotected sex. Negative social and gender norms attendant to emergencies and livelihood conditions in humanitarian situations victimize adolescent girls. They may be forced to engage in sex and become pregnant in order to replenish decimated populations. Adolescent girls may also be forced to engage in survival sex in order to secure livelihood opportunities for their families. This objective is a response to such situations. This objective will be achieved by integration of RH in national disaster preparedness programs and sensitisation of national disaster response teams.

The priority policy statements include the following:

1. Integrate RH in the national and county disaster/management and response policies/plans.
2. Develop and implement a comprehensive adolescent focused family planning strategy for emergencies and humanitarian settings, including BCC interventions.
3. Expand medical, psychosocial and legal care for survivors of sexual violence and prevent and address other forms of GBV including FGM, child/forced marriage and trafficking.
4. Develop service delivery policy guidelines and protocols that strengthen adolescent access to ante natal and post natal care.
5. Deelop and implement a fast track plan for HIV and STIs for adolescents in emergencies and humanitarian settings.
6. Generate and disseminate population data on adolescent demographic patterns in emergencies.
7. Integrate RH service provision in humanitarian settings in the national disaster management and reponse teams trainings.
8. Ensure sustainable financing for RH interventions in humanitarian settings.

9. Strengthen RH and GBV coordination in humanitarian settings.

CHAPTER FIVE: IMPLEMENTATION AND GOVERNACE ARRANGEMENTS

The policy implementation process will adopt a multisectoral approach involving different stakeholders—state actors (relevant government ministries and agencies) at the national and county levels; clients/consumers (individuals, households, communities); regulatory bodies; professional associations; health workers unions; non-state actors (civil society organisations [CSOs], FBOs/nongovernmental organisations [NGOs], the private sector); and development partners. The implementation of this policy shall be guided by key institutional coordination and legal frameworks operating at different levels of the health care system in the country.

Governance and Coordination Structures for RH Policy Implementation

To effectively fulfil the aspirations of this National RH policy, the health sector, in line with te MoH Leadership and Governance Framework shall set up several key structures and Units to oversee and/or facilitate in its implementation. Some of the proposed key structures shall include:

- **The National RH Steering Committee**: This shall be chaired by the Director General for Health Services and will bring together all heads of departments in the MoH, The Head of the MoH RH Division/Unit, Heads of different relevant MoH Divisions/Units, including but not limited to NASACOP, Child and Adolescent Health, Nutrition, Health Promotion, etc; and several non-state actors providing technical, financial and other forms of Strategic support for RH issues to the MoH, Rep of the CoG/Intergovernmental Relations Forum (IGRF) for Health. The Head of the RH Division/Unit will be the secretary of the committee. It will be charged with the responsibility of overall policy and strategy development for RH services in the country.
- **The National RH Technical Working Group:** This will be comprised of selected technical players in academia, research, implementation and industry and will be charged with the responsibility of evidence gathering and synthesis to inform national RH policy and strategy. The MoH RH Division/Unit shall provide/undertake a secretariat coordinating role for this TWG
- **The MoH Division/Unit of Reproductive Health**: This will be charged with the overall responsibility for coordinating policy and guidelines development and implementation for

all for RH services in Kenya, and will serve as a coordinating organ for other national level coordinating structures. It will be housed in the MoH Directorate of Preventive Health

- **County RH Focal Person/Coordinator**: This will be charged with the overall coordination of all forms of RH services within the county. Will be the convener of the County RH Committee and committee, and will liaise with the overall County Health Stakeholders Forum to ensure a coordinated approach toward RH service delivery within the county.
- **County RH Committee**: Will be charged with the oversight and coordination of the operational implementation facilitation and monitoring of RH services at county level. It will be chaired by the County Director of Health, with the County RH Coordinator service as the convener/secretary.
- **Sub-County RH Committee:** This will be responsible for overseeing and facilitating the delivery of RH services at the sub-county level. It will ensure that health care providers obtain the appropriate RH service provision training and supervise the provision of RH services in health care facilities. The Sub-County Health Management Team (SCHMT) will appoint an RH focal person who will act as coordinator and secretary of this committee
- **Facility Level RH Committee:** Will be charged with the responsibility of planning, budgeting, implementation and monitoring of all RH interventions at the facility level. The Facility RH Coordinator will be the secretary of the committee
- **Facility Level RH Focal Person**: Appointed for every health care facility to coordinate the implementation of RH services at the facility.

Roles of Different Actors in the Policy Implementation

The RH policy shall be implemented progressively through development of five year strategic plans and annual work plans by the respective entities responsible for the realization of the various policy objectives.

It will also be dependent upon the collaborative efforts and synergies of all the stakeholders and actors through established partnership frameworks and existing institutional and management arrangements. This policy is also alive to the functional assignments between the two levels of government with respective accountability, reporting, and management responsibilities as follows:

- Ministry responsible for Health: The ministry shall take stewardship to ensure that the policy is launched, disseminated and rolled out to all relevant stakeholders.
- County departments responsible for Health: Shall manage the process of implementation of this policy.
- Inter-governmental coordination agencies: Shall be responsible for oversight of the process of implementation of this policy.
- Regulatory Bodies: Shall initiate review and harmonization of existing laws, regulations and policies to be in line with this policy where applicable.
- Public, Private and Faith based health facilities: will comply with this policy where applicable.
- Training and Research Institutions: Shall work in collaboration with health professional regulatory boards and councils and stakeholders at national and county levels to ensure quality healthcare through adequate pre-service, internship, in-service and continuing professional development training to equip health workforce with the necessary knowledge, skills and competencies. They shall revise their curricula and training syllabi to assure availability of a pool of Health Care Workers (HCWs) with adequate knowledge, skills and competency to provide quality RH services. Capacity building should be extended to faculty members of training institutions.
- Professional associations and societies: Shall support the dissemination and implementation of this policy.
- Development partners/External actors in health: Will provide technical and financial support to facilitate the roll out, monitoring and evaluation of the policy implementation.
- Community: Shall promote community health as well as sensitization for the uptake of quality health services at community level; management of minor ailments & injuries and facilitate referral to health facilities.

Structural arrangements for Policy implementation

The following strategies will facilitate the achievement of the overall goal of this policy:

- Health Leadership, Governance and Organization of service delivery: To the greatest extent possible, this policy shall be implemented through existing organizational and institutional structures, including structures established under the intergovernmental relations Act 2012.
- This policy shall be implemented within a Social Accountability framework that includes: - Appropriate service charters written in a language well understood by the clients; Established grievance redress arrangements, Stakeholder participation at all levels of decision making, Transparency and Information sharing.
- Financing the policy: In financing the RH Policy there will be need for resource mobilisation through budgetary provisions and off budget support for implementation and risk mitigation.

The following are the key health sector actors and their respective roles in implementing this policy:

Health Stakeholders in Reproductive Health Service Delivery

The policy implementation process will adopt a multisectoral approach involving different stakeholders—state actors (relevant government ministries and agencies) at the national and county levels; clients/consumers (individuals, households, communities); regulatory bodies; professional associations; health workers unions; non-state actors (civil society organisations [CSOs], FBOs/nongovernmental organisations [NGOs], the private sector); and development partners. The following are the key health sector actors and their respective roles in implementing this policy:

National government ministry and semi-autonomous government agencies (SAGAs) responsible for Reproductive health

The MOH and related SAGAs shall be responsible for the following functions:

1. Offering technical support, with emphasis on planning, development, and monitoring of health service delivery quality and standards throughout the country;

2. Conducting appropriate studies; and
3. Capacity building of county governments to effectively deliver high quality and culturally responsive RH services.

County government departments and entities responsible for reproductive health

The roles and responsibilities of the departments and entities shall be aligned to the following functions, as defined in the Fourth Schedule of the Constitution:

1. Provide RH services in the County health facilities and pharmacies;
2. Provide transportation to hospital and back home for pregnant women as part of the Ambulance services;
3. Promotion of primary healthcare with focus on RH.

Clients/consumers

Individual: This policy recognizes the role an individual play through adoption of appropriate health practices and healthcare-seeking behaviours as key in the realisation of the country's RH goals. The policy shall therefore seek to enhance the capacity of the individual to effectively play this role.

Household: The RH policy will support empowerment of household to take responsibility for their own RH and well-being.

Communities: This policy will continue to support community roles in matters pertaining to RH.

Non-state actors

They include the private sector, NGOs, FBOs, and CSOs. This policy will seek to work with non-state actors to use their unutilized capacity for RH services. The implementing partners have also been a critical source of human and monetary resources that would be critical in the implementation of this policy. Other non-state actors include firms involved in the manufacturing, importation, and distribution of HPT and health infrastructure, as well as health insurance companies. The RH policy will advocate for provision of RH services as part of the packages covered by insurance companies.

Development partners

Donors and international nongovernmental organisations have traditionally played a key role in providing resources for the health sector. This role has been structured around principles of aid effectiveness, which place emphasis on government ownership, alignment, harmonisation, mutual accountability, and managing for results of programmes in the health sector. The implementation of this policy will require the continued support of development partners in health, including support to the devolved system of government with ultimate goal of government covering all the financial requirements for RH by 2030.

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

As with the overall health sector coordination, RH matters will be dealt with under the Health Sector Intergovernmental Relations Forum (HSIRF established under the Intergovernmental Relations Act August 2012. For RH, the forum will do the following:

1. Identify RH issues for discussion during the intergovernmental consultative mechanisms and establish systems to address these issues;
2. Evaluate the performance of the national or county governments in realising health goals and recommending appropriate action;
3. Monitor the implementation of national and counties' plans for RH;
4. Produce annual reports on national health statistics pertaining to the RH status of the nation, RH services coverage, and utilisation;
5. Promote good governance and partnership principles across the RH programs; and
6. Consider issues on RH that may be referred to the forum by members of the public and other stakeholders, and recommend measures to be undertaken.

In addition, the CoG Health secretariat and the IGRF shall be represented within the National RH Steering Committee.

CHAPTER SIX: FINANCING, HUMAN RESOURCES AND MONITORING AND EVALUATION

7.1. Human resources for Reproductive Health

There has been a general increase in the number of healthcare personnel over the years to peak at an average of 20.7 doctors and 159.3 nurses for every 100,000 persons by 2013. This is below the WHO-recommended average of 21.7 doctors and 228 nurses per 100,000 people, which is the required standard for optimal delivery of services. There are prescribed staffing levels as per level of KEPH which are deemed necessary for optimal service delivery. Reproductive health service delivery depends on: medical officers/ specialists; clinical officers; nurses and specialist nurses; pharmaceutical technologists, medical laboratory technologists; community health workers and support staff (NHSSP – 2013-2017; KHP, 2014). Recent data extracted from the HRIS database shows poor population to health workforce ratios. The RH policy will benefit from other policy guidelines (MOH 2017 - 2017-2030 TASK SHARING POLICY GUIDELINES). To effectively deliver RH services, optimal staffing need to be availed as well as staff who have the knowledge, skills and required attitude.

To facilitate implementation of this policy, the MoH, County Departments of Health and partners shall work together to ensure progressive recruitment and deployment of relevant skilled health workers at all levels of the health service delivery systems as per the staffing norms and standards outlined in the KHP 2014-2030. In addition, the health sector will ensure continuous re-training of relevant health care workers at all levels of care through appropriate training to update their skills, and provision of appropriate tools to facilitate their ability to provide high quality RH services at all levels.

7.2. Financial Resources for RH services

This will be achieved by supporting a comprehensive national Health Financing program which address comprehensive health financing in Kenya. The priority policy strategies include the following:

1. Provide a list of comprehensive key budget elements to be included in planning
2. Address shared resource management
3. Address the challenges of lower middle-Income status of Kenya
4. Support initiatives to ear mark (ringfence) RH services budget line;

5. Support initiatives to ensure RH services are funded through local financing 100% by 2030.

7.3. BUDGETARY AND RESOURCE MOBILISATION

To implement this policy, the MoH together with is partners will have to re-strategize so as to achieve an increased funding allocation internally from government resources and externally from other innovative initiatives. Some of the proposed resource mobilization strategies will include but be not limited to:

- MoH budgetary allocation for the RH unit at central level;
- Increased government allocation for RH services at county level;
- Engage with private sector and industry stakeholders to develop co-financing strategies for some RH activities through PPP, e.g. the manufacture and production of RH consumables, provision of diagnostic services, advocacy initiatives, and HCWs capacity-building initiatives;
- Sensitize county-level and facility-level health managers to include RH budget line items during their regular planning and budgeting processes;
- Strengthen coordination of partner- and donor-supported RH initiatives to enhance resource maximization.

7.4. POLICY ISSUES PERTAINING TO MERL

Supervision: A process of guiding, helping, building capacities, and learning from staff at their places of work to ensure that services are managed and provided according to established leadership and service provision standards and shared objectives, while fostering an enabling working environment. It is therefore part of monitoring and called 'supportive supervision.' Supportive supervision is essential for continuous quality improvement and maintenance of highest standards of healthcare.

7.5. MONITORING, EVALUATION, LEARNING AND RESEARCH (MERL) FRAMEWORK

To continually monitor, evaluate, learn and undertake research, there are policy imperatives which need to be addressed.

Policy imperatives for MERL:

1. Support multisectoral systems to document and aggregate data on geriatrics to inform programs;
2. Support multisectoral systems to document and aggregate data on female genital fistula;
3. Strengthen the integrated surveillance system to monitor trends in infertility, including risk factors, to inform policy and planning;
4. Strengthening health information systems for complete and timely reporting of RH indicators.

7.5.1. PROGRESS INDICATORS

The implementation of this policy will be tracked using a set of select targets and indicators. These targets will contribute to attainment of Health policy 2014-2030. These plans will be implemented and monitored through annual work plans. This policy will undergo a mid-term review. The targets will be benchmarked against best practices from global initiative addressing reproductive health such maternal count down, every woman every child.

These are based on the policy objectives. Indicators that will be used are shown in Table 1. Targets are based on the KHP 2014-2030, SDG and other GOK targets to 2030. These targets shall be measured in absolute achievement at national level.

Table 1. Indicators for Measuring Kenya Reproductive Health Policy 2018-2028 Performance

Impact-level Indicators	2017 estimates	2028 target	KHP 2014-2030 target	KHP % Change
Neonatal mortality rate (per 1,000 births)			13	59% reduction
Infant mortality rate (per 1,000 births)	52		20	63% reduction

Maternal mortality rate (per 100,000 births)	488		113	77% reduction
FP mCPR for all women and for married women of reproductive age				
Teenage pregancy (AYSRH 2015)	18.0%			
Cervical cancer screening				
HPV vaccination coverage				
Legislation on infertility services				
Number of infertility management centres				

7.6. SOCIAL ACCOUNTABILITY AND ANNUAL PROGRESS REVIEW

This policy will the principles and practices of social accountability, including reporting on performance, creation of public awareness, fostering transparency, and public participation in decision making on health-related matters. An independent review group/body to assess RH policy achievements on an annual basis by triangulating service statistics and survey data is proposed. The duty bearer should produce a score card on yearly basis tracking progress as per the indicators and use of RH equipment.

Reproductive Health Research

To be populated in consultation with the research team at MOH

7.7. CONCLUSIONS

This policy represents a commitment towards improving the reproductive health of the people of Kenya by addressing key priority areas. The policy proposes a comprehensive and innovative approach to addressing the reproductive health agenda. It is based on the Constitution of Kenya 2010, Vision 2030, KHP 2014-2030 and Kenya's global health commitments.

This policy was developed through an inclusive and participatory process involving all stakeholders in the reproductive health sector and related sectors. Given that the expiring policy performance was not done, a desk review of key domains in the expired policy was undertaken to provide evidence of the challenges affecting the reproductive health.

The policy defines the reproductive health goal, objectives, principles, orientations, and policy statements aimed at achieving the highest standard of reproductive health in Kenya. It also outlines a comprehensive implementation framework to achieve the stated goal and objectives. It delineates the roles of the different stakeholders in the sector in delivering the reproductive health agenda and details the institutional management arrangements under the devolved system of government, taking into account the specific roles of the national and county levels of government. It therefore provides a structure that harnesses and gives synergy to health service delivery at all levels of government. Finally, the policy defines the monitoring, evaluation learning and research framework to enable tracking of the progress made in achieving its objectives.

GLOSSARY OF TERMS

Non-state Actors (NSA): Individuals or institutions whose primary purpose are provision of health services but are not part of the state. They include service providers (for profit and not for profit), health CSOs, NGOs, and their related management systems.

Post-delivery period: This represents the six weeks following delivery. It corresponds with the postpartum period.

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

Referral: The process by which a given level of health services that has inadequate capacity to manage a given health condition or event seeks the assistance of a higher level of healthcare delivery to guide or take over the management of the condition. It ensures establishment of efficient health service delivery system linkages across levels of care that ensure continuity of care for effective management of the health needs of the population in Kenya. It involves movement of clients, expertise, specimens, or client information.

Referral health services: The healthcare services whose function is specifically to manage or facilitate the referral process.

Reproductive Health: "Within the Framework Strategy the WHO's definition of health is defined as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, reproductive health addresses the reproductive processes, functions and system at all stages of life. Reproductive health, therefore, implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit to this are the right of both men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and the right of

access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant" (http://www.who.int/topics/reproductive_health/en/)

Supervision: A process of guiding, helping, building capacities, and learning from staff at their places of work to ensure that services are managed and provided according to established leadership and service provision standards and shared objectives, while fostering an enabling working environment. It is therefore part of monitoring and called 'supportive supervision.' Supportive supervision is essential for continuous quality improvement and maintenance of highest standards of healthcare.

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

Universal healthcare: A term referring to organised healthcare systems built around the principle of universal coverage for all members of society, combining mechanisms for health financing and service provision.

Universal Health Coverage (UHC): Ensuring that everyone who needs health services is able to get them without undue financial hardship.

Reproductive Rights: "Reproductive rights embrace certain human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. In the exercise of this right, they should take into account the needs of their living and future children and their responsibilities towards the community" (International Conference on Population and Development, Programme of Action 1994: 40, Para 7.3)

Sexual Health: According to the current working definition, sexual health is: "…a state of

physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled."
(http://www.who.int/reproductivehealth/topics/sexual_health/sh_definitions/en/)

Adolescence: United Nations Population Fund (UNFPA) along with the World Health Organization (WHO) and United Nations Children's Fund (UNICEF) defines adolescence between the ages of 10-19. The UNFPA breaks this age category down further by classifying early adolescence for the ages 10-14 years and late adolescence for the ages 15-19). Hence, this RH policy aligns itself with the above defined age category of 10-19 as well as embracing the breakdown of this category for age appropriate SRHR interventions and education.

Youth: Constitution of Kenya, 2010, "youth" means the collectivity of all individuals in the Republic Who - (a) have attained the age of eighteen years; but (b) have not attained the age of thirty-five years." This RH policy supports this definition of youth for the applicable ages that fall within the period of adolescence described above and the rest of the population.

Sex: Sex refers to the biological characteristics that define humans as female or male. While these sets of biological characteristics are not mutually exclusive, as there are individuals who possess both, they tend to differentiate humans as males and females. In general use in many languages, the term sex is often used to mean "sexual activity", but for technical purposes in the context of sexuality and sexual health discussions, the above definition is preferred.
(http://www.who.int/reproductivehealth/topics/sexual_health/sh_definitions/en/)

Gender: "Gender is a social construct 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".

Sexuality: Sexual health cannot be defined, understood or made operational without a broad consideration of sexuality, which underlies important behaviours and outcomes related to sexual health. The working definition of sexuality is: "…a central aspect of being human throughout life encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors."
(http://www.who.int/reproductivehealth/topics/sexual_health/sh_definitions/en/)

Gender Equality: It is the absence of discrimination on the basis of a person's sex in opportunities, the allocation of resources and benefits, or access to services. (http://www.euro.who.int/en/health-topics/health-determinants/gender/gender-definitions)

Gender Equity: It refers to the fairness and justice in the distribution of benefits and responsibilities between women and men. The concept recognizes that women and men have different needs and power, and that these differences should be identified and addressed in a manner that rectifies the imbalance between the sexes. (http://www.euro.who.int/en/health-topics/health-determinants/gender/gender-definitions)

Sexual and Gender Based Violence: Gender-based violence is defined as violence that which is directed against a person on the basis of gender. The inclusion of sexual violence as defined by WHO includes "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic women's sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the survivor, in any setting, including but not limited to home and work" (Population Council, 2008: 9).

The scope of the definition is also expanded to include forced sexual relations, sexual coercion and the rape of adult and adolescent boys and girls also including the sexual abuse of children.

Disability/Disabilities: "Disabilities are an umbrella term, covering impairments, activity limitations, and participation restrictions. An impairment is a problem in body function or structure; an activity limitation is a difficulty encountered by an individual in executing a task or action; while participation restriction is a problem experienced by an individual involvement in life situations. Thus, disability is a complex phenomenon, reflecting an interaction between features of a person's body and features of the society in which he or she lives" (WHO, www.who.int). This RH policy cites disabilities relating to limitations due to physical, visual, hearing, intellectual, mental impairments.