REPUBLIC OF KENYA

MINISTRY OF HEALTH

POLICY BRIEF

The National Adolescent Sexual and Reproductive Health Policy 2015

Reaffirming support for adolescent sexual and reproductive health in Kenya

Background

About 9.2 million Kenyans are adolescents aged 10-19, constituting 1 out of every 4 in the population (24%) [1]. As in other parts of Sub-Saharan Africa, adolescents in Kenya face severe challenges to their lives and general well-being particularly in relation to their sexual and reproductive health (SRH). Poor SRH outcomes in adolescence has long-term adverse effects on health, wellness and productivity.

The Ministry of Health launched a new National Adolescent Sexual and Reproductive Health (ASRH) policy on 3rd September, 2015, reaffirming commitment to ensure adolescents have access to comprehensive SRH information and services [2]. The 2015 ASRH policy replaces the 2003 Adolescent Reproductive Health and Development (ARHD) policy [3]. Development of the new policy was informed by evolution of the international, regional and national legislative and policy context for ASRH including a change in the Constitution supporting reproductive health as a right for all citizens and the Vision 2030, which prioritises young people's health and development [2, 4, 5].

The 2015 ASRH policy has 8 strategic objectives as follows:

- Promote Adolescent Sexual and Reproductive Health and Rights
- Increase Access to ASRH Information and Age Appropriate Comprehensive Sexuality Education
- Reduce STIs including HPV and HIV
- Reduce Early and Unintended Pregnancies
- Reduce Harmful Traditional Practices
- Reduce Drug and Substance Abuse
- Reduce Sexual and Gender-Based Violence (SGBV) and Improve Response
- Address SRHR needs of Marginalised and Vulnerable Adolescents

The policy also prioritises health systems strengthening as a crosscutting thematic area.

This policy brief aims to provide guidance to policymakers, planners and implementers involved in ASRH on priority areas for resource allocation and implementation. The brief first highlights the evidence supporting the 2015 ASRH policy priority areas and then recommends priority policy actions identified from the 2015 ASRH policy.

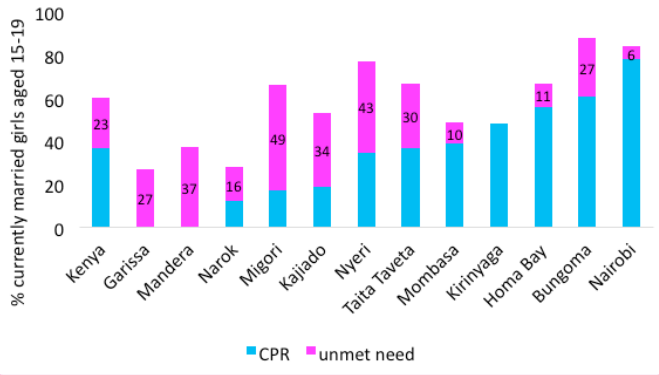
The evidence-base supporting the 2015 ASRH policy priorities

Adolescent SRH status in Kenya

Adolescents in Kenya face many SRH challenges including early pregnancy, STIs and HIV and related adverse health, social and economic consequences. This is mainly because a considerable proportion of adolescents begin engaging in sex during adolescence and lack access to comprehensive SRH information and services. The 2014 Kenya Demographic and Health Survey (KDHS) found that on average half of men and women start engaging in sex at age 17 and 18, respectively [6]. In addition, 11% girls and 20% of boys aged 15-19 start engaging in sex by age 15. One in five (23%) girls age 15-19 has an unmet need for contraceptives. Consequently, 1 in 5 girls aged 15-19 has begun childbearing and about half (47%) of these births are unwanted [6]. The STI prevalence among girls aged 15-19 is 3 times the rate in boys of the same age group [7]. Knowledge of comprehensive HIV prevention, HIV testing and condom use are also low among adolescents relative to other age groups [7]. There is also low uptake of the Human Papilloma Virus (HPV) vaccine, recommended for administration in preteen girls aged 11 and 12 to prevent infection with the cervical cancer causing HPV, as well as low adherence to HIV treatment among adolescents [8, 9].

There are large variations in early pregnancy rates at subnational level. The 2014 Kenya Demographic and Health Survey (KDHS) found that Narok and Homa Bay Counties recorded more than 30% of girls having begun childbearing and Embu, Nyandarua, Nyeri, Murang'a and Elgeyo Marakwet Counties recorded less than 5% of girls having begun childbearing [6]. Likewise, there are large variations in in contraceptive use and unmet need for contraceptives at sub-national level. However, Counties with high contraceptive use tend to have lower unmet need for contraceptives than Counties with low contraceptive use (Figure 1).

Figure 1. Current modern contraceptives use and unmet need for contraceptives among currently married girls aged 15-19 (%)



Source: 2014 KDHS

Factors linked to poorer adolescents SRH

A number of factors predispose adolescents to poor SRH including socio-economic status, harmful traditional practices, SGBV, alcohol and drug abuse and other structural factors that marginalise adolescents.

i. Socio-economic factors

The 2014 KDHS found that women from the poorest households and those with little or without education start engaging in sex 3 years earlier, marry 5 years earlier and are 2 to 3 times more likely to have begun childbearing, respectively, compared to girls with secondary and higher education.

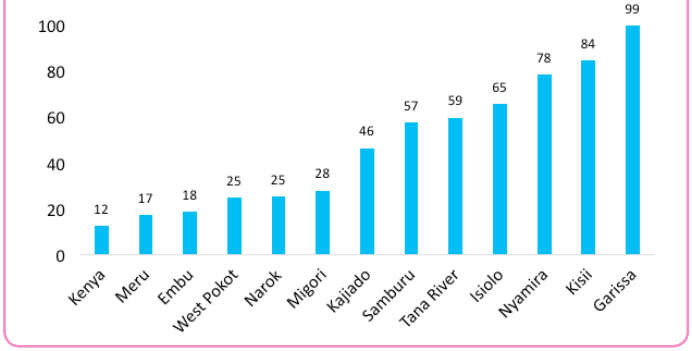
Staying in school through secondary education and higher is therefore protective against early sexual debut, early pregnancy and other related SRH issues among girls and women. An estimated 57% of Kenyan children transition from primary school to secondary school [10]. Early pregnancy is one of the reasons for school dropout among girls with an estimated 13,000 Kenyan girls leaving school every year due to pregnancy [11]. Many other issues are implicated in school dropout including early marriage, poverty and inequality [12, 13].

ii. High prevalence of harmful traditional practices in some communities

The main cultural practices in Kenya that are linked to poor adolescent SRH are early marriage and female genital mutilation (FGM). These practices often result in early marriage and related SRH problems. Early marriage has declined over the past 2 decades. Between 1993 and 2014, the proportion of women who married at age 15 declined from 13 to 8% and those who married at age 18 declined from 41 to 29%, however, in a few Counties, marriage below age 18 is still common [6, 14].

Similarly, despite a decline in FGM over the past 2 decades, still 1 in 10 (12%) girls aged 15-19 in Kenya have undergone circumcision with significant variations at sub-national level [6, 15]. FGM is rampant in some Counties while it is not practiced in others. Twelve Counties have FGM rates above the national average of 12% among which FGM is near universal in 3 Counties (Figure 2).

Figure 2. Percent women aged 15-19 self-reporting as circumcised



Source: 2014 KDHS

iii.Sexual and gender-based violence (SGBV)

SGBV is linked to high rates of unintended pregnancy, STIs including HIV and psychosocial problems. The 2014 KDHS found that 6.5% of girls aged 15-19 and 2.7% of boys aged 15-19 have ever experienced sexual violence. Whereas, 32% of girls aged 15-19 and 42% of boys have ever experienced physical violence since age 15 years. The prevalence of SGBV has been reducing but at a slow pace and girls continue to be disproportionately at risk of sexual violence. In addition, young women and women who are married, have low education levels and are from poor households tend to experience sexual violence more than women who are older, unmarried, more educated and from richer households [6, 16].

iv. Underage drinking and drug use

Alcohol and drug use are linked to risky sexual behavior particularly among men, and as a result predispose both men and women to unintended pregnancy and STIs including HIV. Latest national statistics show that boys are more likely to engage in underage drinking than girls. One percent of girls aged 15-19 and 6% of boys aged 15-19 currently drink alcohol [6]. Up to 8% of adolescents aged 10-14 and 19% adolescents aged 15-17 have ever used alcohol and 13% of adolescents aged 10-14 and 17% of adolescents aged 15-17 have ever used a drug other than alcohol[6, 17]. Reported levels of use of alcohol and drugs among adolescents are likely underestimates considering that underage drinking is illegal and the available statistics are based on self-reported data.

v. Marginalised and vulnerable adolescents

The ASRH policy defines marginalised and vulnerable adolescents as those at high risk of lacking adequate care and protection including: orphans and street children; adolescents with disabilities; adolescents living with HIV and AIDS; adolescents living in informal settlements; adolescents in the labor market; adolescents who are sexually exploited; adolescents living below poverty line and children affected by disaster, civil unrest or war as well as those living as refugees [2].

Marginalised and vulnerable adolescents generally face severe socio-cultural, economic and structural barriers to accessing SRH information and services. For instance, SRH information, education and communication materials are often not translated to formats appropriate for adolescents with disabilities and healthcare providers are not equipped with the skills to offer services to adolescents with disabilities [3].

Limited access to SRH education

Healthy behavior is preceded by knowledge on what characterises healthy and unhealthy behaviour, however, Kenya has limited access to age-appropriate comprehensive SRH information and education at all levels – education and health systems and at family and community levels [18].

i. Education sector challenges and constraints

A large proportion of adolescents spend their time in school and this provides a great avenue to disseminate information and education on SRH. Nearly all (84%) primary school- age children are in school and about half (47%) of secondary school-age children are in school [10]. However, the education system offers limited information on sexuality. The National Lifeskills curriculum focuses on HIV and has experienced implementation

challenges including inadequate capacity of teachers to deliver the curriculum [18]. The MoH and Ministry of Education, Science and Technology (MoEST) signed onto the East and Southern Africa committement to implement age-appropriate comprehensive sexuality education but efforts to integrate it into primary and secondary school education curriculum have been slow [19]. Therefore, there is uncoordinated implementation of different institutional and individual policies by development partners with limited geographical coverage and impact [18].

ii. Health sector challenges and constraints

At health sector level, Information, Education and Communication (IEC) materials are not yet standardised or tailored for adolescents and the community due in large part to limited and fragmented investments in the health sector [3]. Development partners often develop and use their own IEC materials which have not been accredited by the Ministry of Health and have limited geographical coverage and impact.

iii. Family- and community-level challenges and constraints

Modernisation has resulted in the disintegration of traditional structures that were used to educate young people on sexuality [20]. As a result, parents have been left with responsibility of talking to their children about sex but many regard this topic as taboo, are ill-equipped to have these discussions with their children and in most cases preoccupied with work [11, 18].

These challenges and constraints to adolescents accessing accurate SRH information have resulted in use of alternative and sometimes dangerous sources of information. Adolescents often seek advice from their peers, social media and the internet, where they are likely to get varying and sometimes conflicting information [21].

Limited access to SRH services

Kenya's health system has inadequate capacity to offer comprehensive SRH services to adolescents [3]. Only 10% of health facilities countrywide were offering youth friendly health services [22].

An assessment of the implementation of the 2003 ARHD found that the policy faced implementation challenges due to a range of supply and demand-side factors including: lack of a costed implementation plan for the ARHD policy; inadequate investments to adolescent SRH particularly in the public sector; inadequate mechanism for ensuring efficiency and accountability in resource allocation and utilization; lack of a clear coordination framework for stakeholders; low levels of political will and limited leadership for adolescent SRH; low awareness of the ARHD policy and action plan; low stakeholder and youth involvement in the formulation and implementation of the ARHD policy; commodity stock-outs at health facilities; inadequate monitoring and evaluation framework; inadequate data collection and reporting tools for adolescent SRH; and lack of capacity of service providers to provide adolescent friendly health services; limited number of facilities offering youth friendly health services; marginalised and vulnerably adolescents not being reached with services; the impact of poverty on demand-side access to services; regressive cultural practices and gender norms and religious beliefs and practices resulting in supply- and demand-side barriers to accessing services [3]. A persistent broad health systems challenge has been the inadequate engagement of private sector in provision of youth friendly SRH services despite evidence that a considerable proportion of young people seek services from the private sector [23, 24].

Furthermore, a national comprehensive school health policy which includes SRH services exists but has faced implementation challenges including inadequate funding and a weak coordination mechanisms [25].

Policy recommendations

The ASRH policy has 8 strategic objectives, each with 5-20 policy actions. This brief seeks to guide policymakers, planners and implementers on which aspects of the policy should be prioritised to ensure its effective implementation. From the evidence in the brief, there are seven emergent themes that support the prioritisation of the following ASRH policy actions:

1. **Develop and disseminate a costed implementation plan for the national ARSH policy and costed County ASRH strategies.** To support implementation of the policy, at both national and county levels, advocacy, coordination of partners, capacity building and monitoring and evaluation activities should be costed.
2. **Increase funding to adolescent SRH from government and development partners.** Both national and county governments should contribute and increase resources for advocacy, coordination of partners, capacity building and monitoring and evaluation.
3. **Strengthen inter-sectoral coordination and networking, partnership and community participation in adolescent SRH** including: developing a coordination mechanism and monitoring and evaluation framework for national and county levels; ensuring adolescent participation in key decision making around policy, advocacy, budgeting, planning, research and implementation processes; and strengthening coordination of development partners and collaboration with key departments in the Ministry of Health including those in charge of neonatal, child and adolescent health and HIV.
4. **Promote a multi-sectoral and multi-pronged approaches to addressing SRHR issues among adolescents** including: enhancing the linkage between government ministries in charge of education and health (MoEST and MoH) and other key agencies responsible for population and development, youth and sports, gender, the judiciary and law enforcement agencies, and community structures and the media.
5. **Strengthen capacities of institutions, service providers and communities to provide appropriate information and services to adolescents** who require them. This includes:
   - **In the health sector:** improving the capacity of the health system to provide adolescent friendly SRH services including a wide range of contraceptive products; strengthen the monitoring and evaluation system to capture and report ASRH indicators including training health workers on data collection and reporting and providing supportive supervision; and supporting law enforcement to deal with rape and other SGBV cases.
   - **In the education sector:** advocating for improved access to comprehensive sexuality education; supporting implementation of the SRH components of the School Health Policy including rolling out the HPV vaccination; supporting monitoring and evaluation of the delivery of Life skills education and comprehensive sexuality education in schools; and support the development and implementation of the return to school guidelines.

- **In the community:** ssensitizing parents and the community including Faith-based organisations on Sexual and Reproductive Health and Rights of adolescents and training them to disseminate information about sexuality and SRH to adolescents in the home and the community.

6. **Promote educational opportunities to the highest levels for girls through formal and non-formal channels** including advocating for reduction of economic and structural barriers to school attendance.
7. **Promote the enforcement of laws and policies prohibiting marriage of girls below 18 years, female circumcision and sexual offences** including sensitization of communities on existing legislation and policies; sensitization of reintegration to school of adolescents in early marriage and FGM situations; supporting efforts to strengthen capacities of institutions, communities, families and individuals to prevent and respond to harmful traditional practices to adolescents; and supporting management of health consequences of harmful traditional practices.

Conclusion

Kenya has made considerable progress on many fronts to improve adolescent SRH. However, significant challenges remain and threaten to reverse the progress so far if not addressed. The 2015 ASRH policy has been formulated to address these challenges. However, its success is hinged upon support from all stakeholders including policymakers from various sectors of government, politicians, parents, adolescents, and development partners including faith based organizations and private sector.

References

1. Kenya National Bureau of Statistics (KNBS), *The 2009 Kenya Population and Housing Census.* 2010: Nairobi, Kenya.
2. Ministry of Health (MoH), N*ational Adolescent Sexual and Reproductive Health Policy 2015.* 2015: Nairobi, Kenya.
3. National Council for Population and Development (NCPD), Division of Reproductive Health (DRH), and Population Reference Bureau (PRB), *Kenya Adolescent Reproductive Health and Development Policy Implementation Assessment Report.* 2013: Nairobi, Kenya.
4. Government of Kenya, *Kenya Vision 2030.* 2007: Nairobi, Kenya.
5. Laws of Kenya, *The Constitution of Kenya.* 2010: Nairobi, Kenya.
6. Kenya National Bureau of Statistics (KNBS), et al., *Kenya Demographic and Health Survey 2014.* 2015: Nairobi, Kenya.
7. National AIDS and STI Control Programme (NASCOP), *Kenya AIDS Indicator Survey 2012: Final Report.* 2014: Nairobi, Kenya.
8. Friedman, A.L., et al., *Preparing for human papillomavirus vaccine introduction in Kenya: implications from focus-group and interview discussions with caregivers and opinion leaders in Western Kenya.* BMC public health, 2014. **14**(1): p. 1.
9. Haberer, J. and C. Mellins, *Pediatric adherence to HIV antiretroviral therapy.* Current HIV/AIDS Reports, 2009. **6**(4): p. 194-200.
10. Ministry of Education, S.a.T.M., 2014 *Basic Education Statistical Booklet.* 2015: Nairobi, Kenya.
11. Ikamari, L., C. Izugbara, and R. Ochako, *Prevalence and determinants of unintended pregnancy among women in Nairobi, Kenya.* BMC pregnancy and childbirth, 2013. **13**(1): p. 1.
12. Melhado, L., *Pregnancy and miscarriage are not the main reasons for leaving school in Africa.* International Family Planning Perspectives, 2008. **34**(3): p. 147-148.
13. Odejimi, O. and D. Bellingham-Young, *A policy pathway to reducing teenage pregnancy in Africa.* Revista brasileira de crescimento e desenvolvimento humano, 2014. **24**(2): p. 135-141.
14. National Council for Population and Development (NCPD) and Macro International Inc., *Kenya Demographic and Health Survey 1993.* 1994: Nairobi, Kenya.
15. National Council for Population and Development (NCPD) and Macro International Inc., *Kenya Demographic and Health Survey 1998.* 1999: Nairobi, Kenya.
16. Hindin, M.J., *Adolescent childbearing and women's attitudes towards wife beating in 25 Sub-Saharan African countries.* Maternal and child health journal, 2014. **18**(6): p. 1488-1495.
17. National Authority for the Campaign Against Alcohol and Drug Abuse (NACADA), *Rapid Situation Assessment of the Status of Drug and Substance Abuse in Kenya, 2012.* 2012: Nairobi, Kenya.
18. Wanyonyi, H.S., *Youth Sexual Behaviour and Sex Education.* International Journal of Education and Research, 2014. **2**(3).
19. Ministry of Education, S.a.T.M. and Ministry of Health (MoH), *Ministerial Committment on Comprehensive Sexuality Education and Sexual and Reproductive Health Services for Adolescents and Young People in Eastern and Southern African (ESA).* 2013.
20. Oronje, R.N., *Understanding the drivers of change in sexual and reproductive health policy and legislation in Kenya.* 2013, University of Sussex.
21. Bleakley, A., et al., *How sources of sexual information relate to adolescents' beliefs about sex.* American Journal of Health Behavior, 2009. **33**(1): p. 37.
22. Chen, A., A. Dutta, and T. Maina, *Assessing the quality of primary healthcare services in Kenya.* 2014.
23. Bellows, N.M., B.W. Bellows, and C. Warren, *Systematic Review: the use of vouchers for reproductive health services in developing countries: systematic review.* Tropical Medicine & International Health, 2011. **16**(1): p. 84-96.
24. Decker, M. and D. Montagu, *Reaching youth through franchise clinics: assessment of Kenyan private sector involvement in youth services.* Journal of adolescent health, 2007. **40**(3): p. 280-282.
25. Wasonga, J., et al., *Kenya comprehensive school health policy: lessons from a pilot program.* Journal of Public Health in Africa, 2014. **5**(1).

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