REVIEW OF ADVOCACY NEEDS

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POLICY GAP ANALYSIS

1.1 INTRODUCTION

The 2003 Kenya Adolescent Reproductive Health and Development (ARHD) Policy was a milestone for addressing the health and development concerns of Kenya's adolescents and youth. Prior to 2003, no policy document at the national level explicitly addressed adolescent sexual and reproductive health (ASRH). The progressive International Conference on Population and Development (ICPD) held in Cairo in 1994 had earlier stressed on the needs for governments to put human rights at the center of development. As part of the domestication of the ICPD Program of Action (PoA) and in response to the major reproductive and health development policy, the Government of Kenya developed and launched the ARHD Policy in 2003 and its plan of Action 2005-2015 through a national multi-sectoral approach.

The goal of the ARHD Policy was to contribute to improvement of the well-being and quality of life of Kenya's adolescents and youth; The ARHD Policy also sought to integrate the health and development concerns of adolescents and youth into the national development process, and to enhance their participation in that process. According to the ARHD Policy, adolescents are defined as persons ages 10 to 19, and youth are ages 10 to 24.

With the expiry of the Plan of Action in 2015, it became necessary to develop a new policy document that would provide policy directions for realizing the right to the highest standard of healthcare including reproductive healthcare. This was also necessitated by change in the local and international policy and legal environment. The most visible changes to this environment was the progressive constitution of Kenya, 2010, the devolution of healthcare and most recently transition from the Millennium Development Goals to the more ambitious seventeen Sustainable Development Goals.

As compared to the expired policy, the new Adolescent Sexual and Reproductive Policy focused on sexual and reproductive health as opposed to development and was developed by the Ministry of Health whereas the defunct one was developed by the National Council of Population and Development. There policy also laid more emphasis on evidence based intervention, Responsiveness to varying Sexual and Reproductive Health needs of adolescents in provision of care, insistence on multi-pronged and multi-sectoral approaches, Respect for human rights and fundamental freedoms and the meaningful involvement of adolescents in policy processes.

The constitution of Kenya in the The Bill of Rights Article 26 and Article 43 explicitly confer the right to health in general and to reproductive health in particular. Article 26 of the constitution provides that every person has the right to life and that life begins at conception. The Article 43 further provides that every person has the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care. Article 43(2) states that a person shall not be denied emergency medical treatment while Article 43(3) says that the State shall provide appropriate social security to persons who are unable to support themselves and their dependants.

The Constitution defines the role of the Ministry of Health Headquarters as providing national leadership and stewardship on health matters. The central level will be responsible and accountable for quality and quantity of health care to ensure physical access, affordability, acceptability and equity to all people. The County government provides county level leadership and stewardship on health matters. It is responsible and accountable for implementation of national policies, strategies and guidelines. (MOH 2011).

This would later be affirmed by the overarching National Health Policy 2014-2030 that has a goal of attaining the highest possible standard of health in a responsive manner. The policy further clarifies health in the devolved system and emphasizes on Public participation, multi-sectoral coordination, and efficiency in application of health technologies and most importantly mutual consultation and cooperation between the national and county governments and among county governments as key ingredients in realizing Constitutional rights.

Key gains with decentralization of health care services in the devolved system of government include:

- Increased local ownership and accountability;
- Improved community participation and responsiveness to local needs;
- Strengthened integration of services at the local level;
- Enhanced the streamlining of services; and
- Promoted innovation and experimentation.

On the other hand, devolved system has had a share of challenges including being accused of exacerbating inequities, weakening local commitment to some public health issues and decreasing the efficiency and effectiveness of service delivery by disrupting the referral chain. The most affected being reproductive health services since some (e.g. family planning) are controversial and thus susceptible to local pressures, and others (e.g. emergency obstetric care) are dependent on a functioning, integrated, health system.

To comprehend the impact of the reproductive health services in Kenya, the following key aspects need to be put in context:

- The implications of the constitution and devolved system of government in relation to RH;
- Health and specifically RH policy framework;
- Impact and distribution of Development Partners (DPs) support to the area of RH;

To help conceptualize the policy gaps the following parameters will be utilized:

- Health financing,
- Service delivery,
- Human resources for health (HRH),
- RH commodities,
- Policy Environment

1.2 POLICY GAP ANALYSIS

The right to health and RH as stipulated in the new Constitution creates an avenue for structural and systemic adjustment of the health system. With devolution a reality the impact and implications of health financing both by the government and development partners faces a new dynamism all together. Glaring gap in the National RH Strategy and the 2011 Acceleration Plan for the Attainment of Maternal and New-born Health (High Impact Interventions - HII) in particular has been lack of priority setting and costing, which makes it difficult to use them as a basis for planning strategic interventions and support.

Family planning and maternal & child health in general have some degree of coverage in the country– especially in the provision of free maternity services and RH commodities – such as family planning contraceptives. Adolescent sexual health and gender – both rights and more specifically, gender violence issues – are well articulated but the major gap so far lies with ASRH and GBV/HR both from the government and DPs.

The constraints in service delivery concerning ANC, MNC and FP show that a number of shortfalls in general service provision are causing poor outcomes. To reduce the morbidity and mortality as a result of complications during the antenatal period, labour and post-delivery, sustainable high impact interventions (HII) for both mothers and new-borns in particular should be emphasized. High Impact Interventions (HII) acceleration plan developed in Nakuru 2011 is a key milestone towards the attainment of improved RH services. But this alone is not sufficient there is need to invest in developing critical health systems components and to ensure solid linkages between the packages to deliver an effective continuum of care.

Key deliverables for High Impact Interventions (HII) includes capacity development for skilled birth attendance and emergency obstetric care; and making family planning accessible to all. While poor women of reproductive age are the general target group for improved RH services, special attention should be given to adolescents and young people. Trainings should be planned and carried out in close consultation with district / county health management in order to avoid vacancies and to

ensure that personnel with appropriate skills are posted to rural areas.

Reproductive Health commodities constant stock-outs hinder service provision. There is need to integrate RH commodities (including contraceptives) into the general supply chain management and the relevant policy document should be broadened to encompass an RH commodity security strategy hence the need to involve respective ICCs for RH and for Procurement. The other key concern is wastage and/or artificial shortages RH commodities.

The Health Policy Framework, 1994-2010 and successive 5-year National Health Sector Strategic Plans (NHSSP I /1999-2004 and NHSSP II / 2005-2010) set the targets and processes driving the health sector development as well as the healthcare service delivery. The aim of the policy was to introduce reforms specifically in the way the healthcare services are organized, financed, delivered and evaluated.

The goals of the health policy were:

- Ensure equitable allocation of Government of Kenya resources to reduce disparities in health status;
- Increase cost-effectiveness and efficiency of resource allocation and use;
- Manage population growth;
- Enhance the regulatory role of the government in health care provision;
- Create an enabling environment for increased private sector and community involvement in service provision and financing; and
- Increase and diversify per capita financial flows to the health sector.

These goals are still valid and have informed to a large extent both Vision 2030 and its Medium Term Plan (2008-2012).

Important approaches and innovations of the health policy and more so of NHSSP II were: the concept of the Kenya Essential Package for Health (KEPH), the Community Strategy, the Joint Framework of Work and Financing (JPWF) - an essential element for entrenching the Kenya Health Sector-Wide Approaches (KHSWAp) and finally the Annual Operational Planning (AOP) process. These approaches are increasingly becoming a feature of the health sector.

National Health Sector Strategic Plan II 2005-2010 (NHSSP II) objective was to reverse the downward trends in the health indicators to achieve the MDGs. RH is well reflected in the NHSSP II under cohort 1 (Pregnancy, delivery, new-born child), cohort 4 (Adolescence) and cohort 5(Adulthood). The system is struggling to adequately respond to the health needs of the population in general and to that of mothers and new-borns in particular. This contributes to the high morbidity and mortality due to complications during the antenatal period, during labour and in the post delivery period.

The Vision 2030 health sector flagship projects for 2012 are to:

- Revitalize Community Health Centers to promote preventive health care (as opposed to curative intervention) and by promoting health of individual lifestyles;
- Delink the Ministry of Health from service delivery in order to improve management of the country's health institutions;
- Create a National Health Insurance Scheme in order to promote equity in Kenya's health care financing;
- Channel funds directly to hospitals and Community Health Centers (as opposed to district headquarters),
- Scale up the output-based approach system to enable disadvantaged groups (e.g. the poor, orphans) to access health care from preferred institutions.

The key document summarizing the principles, policies and timetable for the specific measures around health financing is "Social Protection in Health: Policy and Financing Strategy, March 2009". The Strategy's genesis has been slow and difficult. A National Task Force for Health Financing was established in late 2006 to re-define a national strategy but was interrupted by the post-election crisis of 2007/8. A new strategy was finally agreed with major stakeholders in 2009 and endorsed by the National Social and Economic Council (NESC) in early 2010.
The aim of the Strategy is to achieve equity of access to, equity of finance for and financial risk protection as defined by the World Health Assembly (WHA) 2005 - "Resolution on Sustainable Health Financing" through:

- Expanding coverage of the National Health Insurance Fund (NHIF)
- Improving private health and other social health insurance systems
- Protecting the poor
- Increasing PPPs
- Improving health regulation and standards
- Improving capacity and quality in the public health system.

In Kenya, the area of reproductive health (RH) is regulated by a number of framework documents issued by the Ministry of Health. The National Reproductive Health Strategy 2009-2015 is based on the National Reproductive Health Policy 2007. The RH Strategy is a very broad document covering all areas of RH with over 65 strategies, 31 outputs and 10 thematic areas including cancers and the elderly but there is virtually no reference to commodity security.

RH Strategy envisaged the following areas as priorities:

- Safe motherhood;
- Maternal and neonatal health;
- Family planning;
- Adolescent/youth sexual and reproductive health;
- Gender issues, including sexual and reproductive rights.

However, the RH Strategy does not give advice or direction on what, and how, these areas could be supported. Whilst a strategy can be broad, it is important that some clear direction is given about focus.

The Road Map for Attainment of Maternal and New-born Health (MNH) was developed to try and agree on where to focus support for MNH. However, the Road Map does not represent a cost-effective evidence based package of care. There are also some technical gaps such as exclusive breastfeeding, maternal nutrition and it is not focused on evidence based cost–effective interventions. It remains too general and too unfocused. Although the MNH Road Map is costed, these are referred to as additional funding requirements and it is therefore very difficult to use this to assess resources required and any gaps there may be.

To achieve significant progress on morbidity and mortality in RH, there will have to be improvements in coverage of High Impact Interventions (HII) such as Focused Antenatal Care (FANC), Emergency Obstetric Care (EMOC), Post-partum Care (PPC) and Family Planning (FP).The plan was a fresh impetus to re-focus on HII and prioritizes the activities within HII, assigning specific tasks to national, provincial, district and community levels and commits all actors to timeliness.

The HII Acceleration Plan was the first step in developing an evidence-based cost effective package to guide the districts/counties towards achieving MDG 4 and 5. A particularly important point is that it recommended that maternal and perinatal audits take place routinely after a death, but it remains unclear how this information would be collated nationally to help inform policy and practice.

Another gap in the plan is where the plan identifies several key activities that would help to harmonize support for MNH at district/county level such as partner mapping to identify and target resources and coordinate supervision; many of these health systems activities should lead to better essential services, particularly for women and children but the plan failed to provide any indicative budget. Therefore, there is no understanding of the financial, personnel and logistic resources required to deliver the HII package, or what resources are available or the additional resources required for priority activities to achieve a reduction in MNM. It will require additional strategic planning in each district/county and together with IPs to identify what additional support is required.

In addition, if this HII plan is going to be an effective strategy to reduce MNM, there are other technical and strategic weaknesses: the current plan is limited in scope, particularly with regard to Adolescent RH with very specific needs that are often not dealt with through routine services.

It is acknowledged that maternal mortality is a health systems failure yet there is insufficient emphasis in the HII plan on improving critical health systems to help deliver the agreed interventions, particularly on how an effective continuum of care will be developed in each district/county. Successful implementation will require key aspects of the health system to work so that the health system provides a continuum of care from the community to the tertiary level when required which would also include: appropriately trained health workers to be in place; specific

equipment and sufficient supplies of essential medicines.

Youth Friendly Services (YFS) / Adolescent sexual and reproductive health (ASRH): Currently, there are four national policy documents that guide the provision of youth friendly SRH services in Kenya. Apart from the National Reproductive Health Policy 2007, the Adolescent Reproductive Health and Development Policy (NCAPD/DRH 2003), the Adolescent Reproductive Health and Development Policy-Plan of Action (2005-2010) (MOH/NCAPD 2005), and the National Guidelines for Provision of Youth-friendly Services (MOH/DRH 2005). Broadly, the ARH&D Policy addresses the following adolescent RH issues and challenges: adolescent sexual health and reproductive rights; harmful practices, including early marriage, female genital cutting, and gender-based violence; drug and substance abuse; socioeconomic factors; and the special needs of adolescents and young people with disabilities.

The National Guidelines for the Provision of YFS in Kenya identify two approaches to be used in the delivery of SRH to young people: the targeted and the integrated approaches. The targeted (or youth-only) approach is an arrangement where services are designed and planned for adolescents alone and are offered in youth-only settings. The services offered in such a set-up may be clinical, non-clinical or a combination of both. In the integrated approach, young people receive SRH services together with the general public but special arrangements are put in place to make the services more acceptable to young people such as the training of health care providers, youth corners, etc. The national guidelines recommend three models of youth friendly service provision each with an essential service package: youth centre based model, clinic based model and school based model.

In addition to these health sector related policy framework documents, there is a National School Health Policy and guidelines, which were jointly developed and published in 2009 by the MOPHS and the Ministry of Education (with assistance from GIZ). These documents cover a comprehensive range of health issues and life skills that are vital for supporting the health of young people. They are meant to guide school authorities in enhancing the quality of health in school communities by creating a healthy and child friendly environment for teaching and learning. The gap in the above well-articulated documents lies in the implementation and the impact elicited therein. Other challenges include lack of coordination among implementers; low stakeholder involvement, including low political will and youth involvement; limited leadership; lack of resources; poverty and unemployment among youth; and limited availability of high-quality ASRH services. Additionally, ASRH remains a contentious issue among some communities, and some cultural and religious practices are barriers for implementation. Adolescents and youth still face challenges, such as completing secondary school, finding employment, postponing marriage, and avoiding STIs and unintended pregnancies.

The MoH/DRH and its respective DPs have adopted a National Contraceptive Commodities Security Strategy 2007-2012. Forecasting and quantification exercise is led by the DRH/MOPHS and carried out annually with a semi-annual review in which the DPs are involved. The strategy does not cover the entire range of drugs and consumables needed for RH related services. The planning and procurement for other RH commodities other than contraceptives is included in the general drug supply system. Internationally, the priority focus is on providing comprehensive SRH and it has become standard that the whole range of commodities to ensure RH services is covered by one common RH Commodities Security Strategy. This corresponds with international initiatives like the RH Supplies Initiative and would support the comprehensive RH approach pursued by GOK.

1.3 Gaps

The Policy Gaps Assessment found out several gaps that hindered effective development and implementation of sexual and reproductive health and rights programs. Whereas different counties experience these gaps in different capacities, most of the gaps were cross cutting under the following major themes:

1. Limited Involvement of County Health Management Team in Policy Development.

With the promulgation of the constitution of Kenya, 2010 and the ensuing onset of devolution, health services become a key function of the county governments. The County Health Management Teams were tasked with the ominous onus of delivering the right to the highest attainable standard of healthcare including reproductive health care as enshrined in the constitution. However, for effective and efficient delivery of services, a strong anchoring policy and legal environment is equally important. This key function remained a task of the national government. Based in Nairobi, the Ministry of Health at the national level retained the core mandate of developing national policies, guidelines and implementation plans, and disseminating them to the counties for implementation. Whereas the spirit behind this was right and guided by a sense of commitment to realization of quality health for all, counties in South Western Kenya as other counties nationally have realized hiccups in implementation of policies and guidelines on sexual and reproductive health and rights because of limited involvement in development, trouble domesticating them into county realities and sometimes limited will by counties to adopt them.
This was a cross cutting gap for all the counties.

2. Insufficient Resources

Policy development requires resources throughout the cycle of conceptualization, designing, revision, development, dissemination, printing, monitoring and evaluation among others.

Kisii, Homa Bay, Migori, Siaya and Kisumu did not allocate sufficient resources for these crucial processes. In Homa Bay County, for example Policy was lumped together with Planning & Administrative Services and whereas the programme received the highest share of the health budget in the FY 2015/2016 at 64.2%, allocation to the sub programme Policy, Planning & Monitoring Services was less than 1% of the program budget.

But that's not unique to Homa Bay County. A quick analysis of the Migori, Kisii, Siaya and Kisumu budgets reveals that policy was allocated limited resources and mostly lumped together with other sub programs, making it difficult to deduce how much exactly was allocated, despite the obvious evidence based need to allocate resources to this sub program. Apart from Kisumu which has a county policy, research and strategy officer at the governor's office, these counties did not have specific functional county policy development units or dedicated policy staff within the county Health Management Team over and about, there was also insufficient budgetary allocation to health, with meagre or no budgetary allocation to reproductive health and key sub programs like family planning, youth friendly reproductive health services and staff capacity building.

3. Poor Dissemination.

A national assessment of the 2003 Adolescent Reproductive Health and Development Policy (ARHD) found out that one of the reasons the policy hadn't contributed significantly to the well-being of adolescents was poor dissemination of the policies. But this was not unique to the ARHD policy or even at the national level. Whereas Kenya is a country with a progressive policy and legal environment, this has not always translated into implementation, allocation of resources or even improved outcome for young people.

Most stakeholders, including health care workers were not aware of the existence of certain national policies on health including the Adolescent Sexual and Reproductive Health Policy. Other crucial documents like the Adolescent and Youth Friendly Services Guidelines, the Maternal, Neonatal and

Perinatal Surveillance Report Guidelines, the National Family Planning Guidelines, all launched at the national level, had not been disseminated already to the counties.

This gap proved a stumbling block to implementation of policies within the counties in South Western Kenya, especially because of the missed opportunity to allocate more resources to implementation and for implementing evidence based minimum resources maximum impact interventions.

But this was not restricted to the health department only. A huge proportion of County Education officials were not aware of the existence of the Education Sector Policy on HIV/AIDS as were most county officials of the public private partnership frameworks.

4. Amorphous policy and legal environment on provision of CAC Services

Whereas the constitution of Kenya provides for safe abortion under specific circumstances, this right is not translated into any policy guideline, policy or ACT. Instead, healthcare workers remain uncomfortable to provide this very important service due to fear of prosecution occasioned by an unclear environment. As if that was not enough, the government procedurally withdrew guidelines on reduction of maternal mortality through unsafe abortion and instead issued a circular stopping all abortion related trainings. After pressure from stakeholders, the government embarked on a process of developing policy standards on reduction of maternal mortality which provided for clinical guidelines on abortion. The said document has not been released despite the assurance of the government that it will. This has further created more confusion. Service providers at government and public facilities are thus afraid of providing safe and legal abortion as provided for in the constitution for fear of reprisals and harassments by state agencies.

This was a cross cutting challenge for all the counties where the policy gaps assessment was conducted.

5. Lack of Reproductive Health Care Bill

The Constitution of Kenya in the fourth schedule provided a period for parliament to enact acts of parliament that would help define and ensure the right of every Kenyan to the highest attainable standard of health including reproductive healthcare. The failure by the national legislature to pass a reproductive health act, or at the very least pass a health care act that has a strong component of reproductive healthcare, means that Kenyans are left without a legal framework on reproductive healthcare. Whereas the constitution does not bar county assemblies from enacting their own reproductive health acts, uniformity of service throughout the country is likely not to be standardized, and at the very best, only a few counties have the technical capacity to develop appropriate standards and acts that speak to the supremacy of the constitution.
This was a cross cutting challenge for all the counties where the policy gaps assessment was conducted.

6. Insufficient capacity of county to develop strategies, domesticate commitments and spearhead development of ACTS

As mentioned in the previous paragraph, the counties where the gaps assessment was done have limited technical experts to help them domesticate international and national commitments, develop ACTS and strategies to oversee the realization of sexual and reproductive health and rights. The national government needs to provide continuous technical assistance as per the devolution position paper on health, however, due to weak coordination mechanisms between national and county government, this has remained a mirage. As devolution continues to deepen its root, most counties are progressively able to develop appropriate strategies and road maps in line with their count integrated development plan and Kenya blue development print, the vision 2030. In this regard, Homa Bay County for example have developed HIV/AIDS plan to address the HIV/AIDS scourge in the county. Members of County Assembly, including MCA Champions, have also increasingly developed ACTS and motions on sexual and reproductive health and rights issues.

7. Weak coordination (between key departments e.g. Education, Youth and Health and between national and county governments)

Coordination is of central importance if the constitutional right to the highest attainable standard of healthcare including reproductive healthcare is to be realized. The coordination needs to be vertical (between the different tiers of government) and horizontal (among the different departments of a government). Key departments such as health, education, youth and technology must work together in sharing data, experiences, opportunities and best practices in order to realize high impact. However, multi-sectoral technical working groups targeting common reproductive health and adolescent and youth development issues remain non-existent in most counties, and at the very based just on paper without clear coordination mechanisms and resources.

Whereas Kisii, Migori, Homa Bay, Kisumu and Siaya all have Reproductive Maternal and Neonatal Technical Working Groups, these technical working groups mostly have officers from the ministry of health, thus excluding key people and departments like Gender and Youth, Education, Finance among others.

8. Expiry of Crucial National Policy Documents

Another cross cutting gap in the counties was elapse of crucial policies and guidelines. This was either due to ongoing revision or lapse in strategy time. The National Condom Policy and Strategy (2009-2014); The Contraceptive Policy and Strategy (2002-2006); The Contraceptive Commodities Procurement Plan (2003-2006); The Contraceptive Commodities Security Strategy (2007-2012) and the National Reproductive Health Strategy 2009-2015 are just but a few that were adversely mentioned by the respondents during the gaps assessment. The expiry of these crucial guidelines makes it difficult for organized service provision nationally, and specifically at the counties where provision of services takes place.

9. General opposition to SRHR

Sexual and Reproductive Health and Rights information and services remain one of the most misunderstood issues. The development and implementation of policies in south western Kenya have received lukewarm response at best and hostility at the very worst. Service providers in Siaya for example were forced to remove implants they had inserted into a school going children after a school organized an inspection and chased away the adolescent, her protests and desire for the services notwithstanding. Implementation of the Education Sector Policy on HIV/AIDS that provides for comprehensive sexuality education has also faced several challenges as stakeholders and implementers have misunderstood this for encouraging sexual debauchery.

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