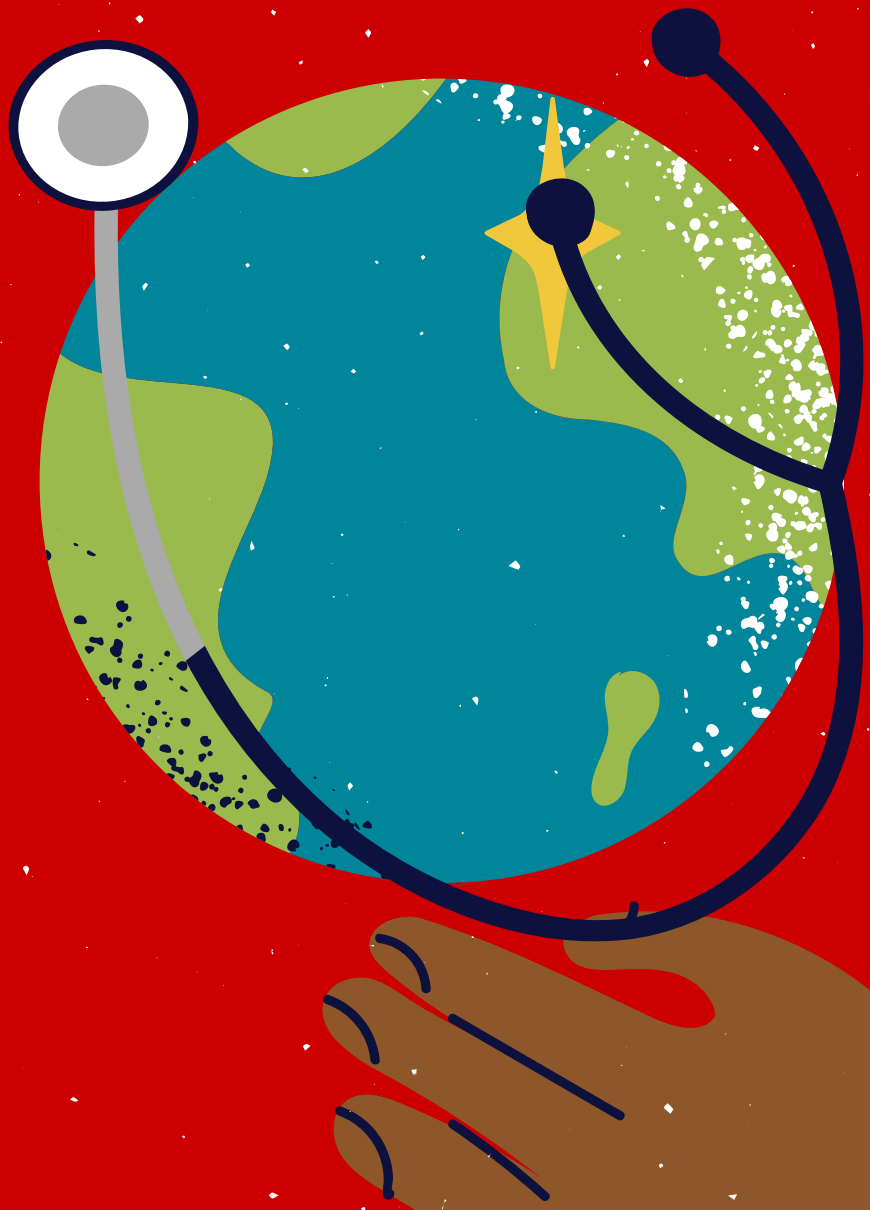
April 2023



Achieving universal health coverage for young people in Kenya

through realising their sexual and reproductive health and rights, and scaling up selfcare for health

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GLOBAL NETWORK OF YOUNG PEOPLE LIVING WITH HIV

Developed by African Alliance

Universal health coverage and self-care: Kenya

April 2023

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Introduction

In September 2023, governments will meet in New York during the second United Nations High-Level Meeting (HLM) on Universal Health Coverage (UHC) to agree on new commitments to realise UHC by 2030. In 2019, during the first-ever HLM on UHC, an ambitious Political Declaration was adopted to guide countries in their efforts to reform health systems, increase funding for health, and address barriers that prevent people from receiving the health services they need.

The world has fundamentally changed since 2019, with the COVID-19 pandemic demonstrating the devastating impact of weak health systems, underinvestment, and harmful policies and laws that prevent vulnerable, marginalised and stigmatised populations from taking care of their health.

This new HLM is critical to get world leaders back on track and agree on the need to invest in long-term, sustainable responses to ensure life-saving health services are guaranteed for everyone, particularly in the face of the ongoing effects of the COVID-19 pandemic – and the potential impacts of future pandemics. In addition, there needs to be a continued push for sociocultural and economic change; intersectional, human-rights based and gender-inclusive approaches to health; inclusive engagement of civil society in the development, implementation and monitoring of health policies and funding; and empowering and equipping people to meet their own health needs, including through scaling up self-care interventions for realising sexual and reproductive health and rights (SRHR).

Self-care has never been more relevant than during the COVID-19 pandemic, where, globally, public health systems failed to meet the demands and needs of citizens. Governments increasingly stepped up self-care and digital health interventions to reduce the burden on public health systems and give people choices to access the services they need despite COVID-19-related service restrictions related to the emergency response measures, including movement restrictions, total lockdowns and social distancing – affecting people's ability to reach clinics, but also – with the demand on emergency health services – resulting in increasing shortages of healthcare workers.

Solutions such as HIV self-testing, self-sampling for sexually transmitted diseases (STIs) and digital health information offer new options for people who are unable or willing to access clinic-based services. This is not just due to COVID-19-related limitations but also poverty, gender-based violence (GBV), (dis)ability and other vulnerabilities, as well as a lack of privacy and the related fear of stigma and discrimination that prevent adolescents and young people (AYP) in particular from accessing sexual and reproductive health (SRH) services in public clinics.

Thus, self-care provides a crucial contribution to realising UHC, where UHC is defined by the World Health Organization (WHO) as all people having access to the health services they need, when and where they need them, without falling into financial hardship. The "*where and when they need them*" is the very essence of self-care, where this approach means people are not dependent on the availability of doctors, nurses or the capacity or accessibility of health clinics for all of their health needs. It also increases people's autonomy, choice, and power in relation to their health.

For this reason, the partner organisations implementing the YouthWise and YouthCare projects in Malawi, Uganda, Kenya, Tanzania and Zambia are advocating for governments to commit to scaling up self-care in the 2023 UHC Political Declaration as a crucial component of health systems strengthening; self-care services and commodities must be included in national UHC plans and budgets.

Purpose of this Document:

To inform this advocacy, the African Alliance ('the Alliance'), funded by Aidsfonds, conducted a series of policy analyses for the five countries above to understand better why self-care is critical to improve the SRHR needs of AYP and achieve UHC. The analyses assessed the policy landscape; lived experiences around UHC, SRHR and self-care; and the current limitations AYP face in accessing the services they need – and used this process to develop a set of country-specific advocacy messages for partners in the five countries to take forward in the run-up to the HLM.

Country Snapshot: Kenya

KILE KILE HLM JUU YA UHC INAHITAJI KUSIKIA -NA KUFANYA!

Mazingira ya sheria na sera nchini Kenya yanaonyesha tena kwamba kuwa na mifumo, na sheria zilizopo zinazotangaza haki za raia ni nzuri tu kama muktadha wa kimuundo na kijamii ambao unaruhusu raia kutambua haki hizo. Ingawa haijumuishi kabisa au hata kuleta mabadiliko ya kijinsia, mazingira yanatoa fursa ya kuharakisha utambuzi na upatikanaji wa haki na uhuru unaozingatiwa katika katiba ya nchi. Hili linaweza kutokea iwapo tu uongozi utachukua jukumu la rasilimali, kutekeleza na kuwajibishwa kwa kuleta hati hizi kuwa hai na sehemu muhimu ya uwajibikaji huo ni kuwaweka vijana katikati katika nafasi za uongozi zinazokuja na nguvu ya maan.

WHAT THE HLM ON UHC NEEDS TO HEAR –AND DO!

The legislative and policy landscape in Kenya demonstrates yet again that having frameworks and laws in place that proclaim the rights of citizens are only as good as the structural and social context that allows citizens to realise those rights. Whilst not wholly inclusive or even gender transformative, the landscape presents an opportunity to urgently accelerate the recognition of and access to the rights and freedoms espoused in the country's Constitution. This can only happen if leadership takes on the responsibility to resource, implement and be held accountable for bringing these documents to life, and a vital part of that accountability is centring young people in leadership positions that come with meaningful power.

Kenya's *Constitution* provides a framework for many marginalised groups to claim their rights; however, adolescent girls and young women (AGYW) are particularly vulnerable and unable to participate effectively in decision-making and leadership. The intersection between poverty, gender-based violence (GBV), harmful cultural attitudes and beliefs around gender roles, norms and female empowerment means AGYW experience significant obstacles towards achieving their ambitions; they are more likely to be unemployed and uneducated, contributing to an ever-increasing gender gap.

In terms of the **HIV landscape**, in 2020, AYP contributed to 42% of new HIV infections, while AGYW aged 15-24 contributed to a third (30%) of new HIV infections[1]. Factors such as intergenerational sex, teenage pregnancies, sexual and other forms of GBV, discontinuation of school (especially during the transition from primary to secondary school), prevailing gender norms, poor access to CSE, limited access to HIV, STI, SRHR services and low socioeconomic status have largely been attributed to the higher HIV incidence compared to boys and young men of the same age group. Boys and young men aged 15-34 years account for 53% of the 13,320 new HIV infections that occurred among male adults in 2019. Evidence also shows that compared to women; awareness of HIV status is low among men[2]. Delay in awareness of HIV status also delays entry into prevention and treatment services. Additionally, in traditionally non-circumcising counties (many counties with high incidence are traditionally non-circumcising), coverage of voluntary male medical circumcision (VMMC) among boys and young men was lower than 60%. Engaging men more extensively in HIV prevention can potentially reduce girls' and women's risk considering power imbalances in the circumstances of sex and safety considerations.

Kenya has a very young population, with about 80% aged below 35 years and a median age estimated at 19 years[3]. These young people will ultimately determine the country's future; however, a key challenge for them is their high risk of SRH service access challenges and rights violations. They often lack access to relevant information and services, and policies are not well aligned to, or in many cases, totally disregard their reality. In addition, those with multiple identities, for example, living with HIV, a disability, identifying as LGBIQ+ or transgender, face elevated risks of violence, discrimination and stigma, compounding the risks of HIV. Some of the specific realities for young people that impede their health service access are outlined below.

1 Elizabeth Glaser Pediatric Aids Foundation (2016)
2 Ministry of Health Kenya (2018).
3 East Africa Institute (2017).

Young People's Experiences Of SRHR Service Access

KILE KILE HLM JUU YA UHC INAHITAJI KUSIKIA -NA KUFANYA!

Upatikanaji wa huduma za afya umekita mizizi - kwa viwango mbalimbali - katika sera na mikakati nchini Kenya. Hata hivyo, ukweli ambao ufikiaji huu unafikiwa - au la - ni ngumu na unahitaji viongozi wenye ujasiri ambao wanaweza na tayari, kuelewa ushahidi, kuwa wazi juu ya mantiki na manufaa ya uongozi wa vijana na wakala. Kenya ina idadi ya sheria zinazolenga vijana iliyoundwa kulinda watoto na kuhakikisha utimilifu wa haki zao nyingi na wakati Kenya imetathminiwa kama moja ya serikali za Kiafrika ambazo ni rafiki kwa vijana, hii haijasababisha utoaji wa huduma kwa Kenya. vijana, wala kutilia maanani udhaifu wao, hasa kuhusiana na haki zao za ngono. Tunahitaji kuhakikisha kwamba tunaondoka kwenye haki zinazopuuzwa kivitendo, huku zikikubaliwa katika sera na kulinda ushirikishwaji wa makundi yote yaliyotengwa kimakusudi na kihistoria.

WHAT THE HLM ON UHC NEEDS TO HEAR –AND DO!

Access to health services is entrenched – to various degrees – in policies and strategies in Kenya. However, the reality within which this access is realised – or not – is complex and requires courageous leaders who are able and willing to understand the evidence to be clear on the logic and benefits of young people's leadership and agency. On the surface, Kenya has several youth-focused legislation designed to protect children and ensure the realisation of their myriad rights, and while Kenya has been evaluated as one of the most youth-friendly African governments, this has not necessarily led to the provision of services for Kenya's youth, nor taken into consideration their vulnerability, especially in regards to their sexual rights. We need to ensure that we move from rights being ignored in practice while acknowledged in policy and safeguard the inclusion of all intentionally and historically marginalised groups.

Some of the specific realities for AYP that impede their health service access are outlined below.

Age of consent to sex and marriage:

The age of consent for both sex and marriage is 18. It is important to note that even with a stated age of consent for sexual activity, the reality may be lower for girls than boys, which creates further barriers to accessing SRH services.

Access to contraception:

Unmet contraception needs (both accessing contraception in the first instance as well as accessing different types of contraception) were as high as 74% for those aged 15–19 and 39% for those aged 20–24 of sexually active, never married, young women[4].

4 Wilson et al, (2020) p 2.

Access to abortion:

Abortion is permitted only under limited circumstances. Examples include a pregnancy that puts the woman's life at risk or results from rape, defilement or incest, or if there are foetal abnormalities[5]. However, even where abortion is partially decriminalised, women struggle to obtain accurate information about when it is legally available. The social, religious and legal stigma of abortion, particularly where a majority of the country identifies as Christian, cannot be underestimated. This, coupled with the unclear and often confusing abortion laws and policies, means that many people are not aware that abortions can be legally obtained in these circumstances, and, as a result, many women turn to unsafe, clandestine abortions with devastating consequences. However, there has been progress in Kenya, with the High Court ruling in 2019 that the Ministry of Health's 2014 withdrawal of the *Standards and Guidelines for Reducing Morbidity and Mortality from Unsafe Abortion in Kenya* and its subsequent ban on abortion training for healthcare professionals was arbitrary and unlawful. This reaffirmed constitutional protections for legal abortions when the life and health of pregnant women are threatened, including for survivors of sexual violence or in cases of emergency, creates an opportunity for further advocacy around Kenya's ratification of various international instruments regarding SRHR.

Age of consent to health services:

In Kenya, this is 18 and supported by the recently revised *National Adolescent Sexual and Reproductive Health Policy* (2022) and *National guidelines for the provision of adolescent and youth-friendly services in Kenya* (2016). The revised guidelines, in particular, sought to provide an updated framework for providing comprehensive AYP-friendly SRH services. In a 2010 review, coverage of AYP-friendly SRH was found to be unacceptably low at 7%, leading to poor AYP SRH indicators. This was attributed to factors including inadequate investment in health infrastructure, training service providers on youth-friendly service provision, deployment of service providers, commodities and supplies, awareness creation, monitoring and evaluation, as well as coordination[6].

Comprehensive sexuality education (CSE):

This is supported by the *Policy Framework for Education and Training* (2004) and the *Education Sector Policy on HIV and AIDS* (2013); however, these have been criticised for an emphasis on life skills and HIV education, and thus are limited in scope[7]. In 2013, Ministries of Education from the East and Southern Africa region, including Kenya, signed a declaration committing to scaling up comprehensive, rights-based sexuality education beginning in primary school; however, this has not translated into significant action, with education sector policies largely promoting an abstinence-only approach, resulting in a limited range of topics being offered in the CSE curricula. In addition, messages conveyed to students tended towards fear-inducing and judgmental or focused on abstinence, emphasising that sex is dangerous and immoral for young people.[8]

Criminalisation:

While notable progress has been made in recognition of the human rights of LGBTIQ+ people in Kenya over the past decade, largely through court victories, in 2019, the High Court upheld a colonial law criminalising same-sex, sexual relations between consenting adults, claiming that the law is not discriminatory and would if abolished, open the door to same-sex marriage, which is unconstitutional in Kenya. Despite this, forced anal examinations to 'prove' same-sex sexual conduct (a method often used by authorities in the region to degrade LGBTIQ+ activists) has been ruled unconstitutional, and in 2019, Kenya became the first African country to collect data on intersex populations in the national census[9]. While sex work is not criminalised per se, activities associated with sex work, such as living on the earnings of sex work, are criminalised, making it difficult for sex workers to engage in their work safely. The criminalisation also hinders sex workers' access to health services and makes them vulnerable to violence[10].

5 See: Constitution of Kenya, Article 26(4).
6 Ministry of Health Kenya (2016) p 13
7 Sidze, EM, Stilman, M, Keogh, S, et al. (2017).
8 Sidze, EM, Stilman, M, Keogh, S, et al. (2017).
9 Human Rights Watch (2020)
10 ARASA (2019)

In practice, lack of access to correct information and youth-friendly services are considered by many civil society organisations working in SRHR and HIV as the most pressing issues in the country. Consequently, young people are exposed to unwanted pregnancies, leading them to resort to harmful responses and mitigation measures due to a lack of options. This emanates from a lack of legislation on reproductive health which continues to operate in a statute-law vacuum.

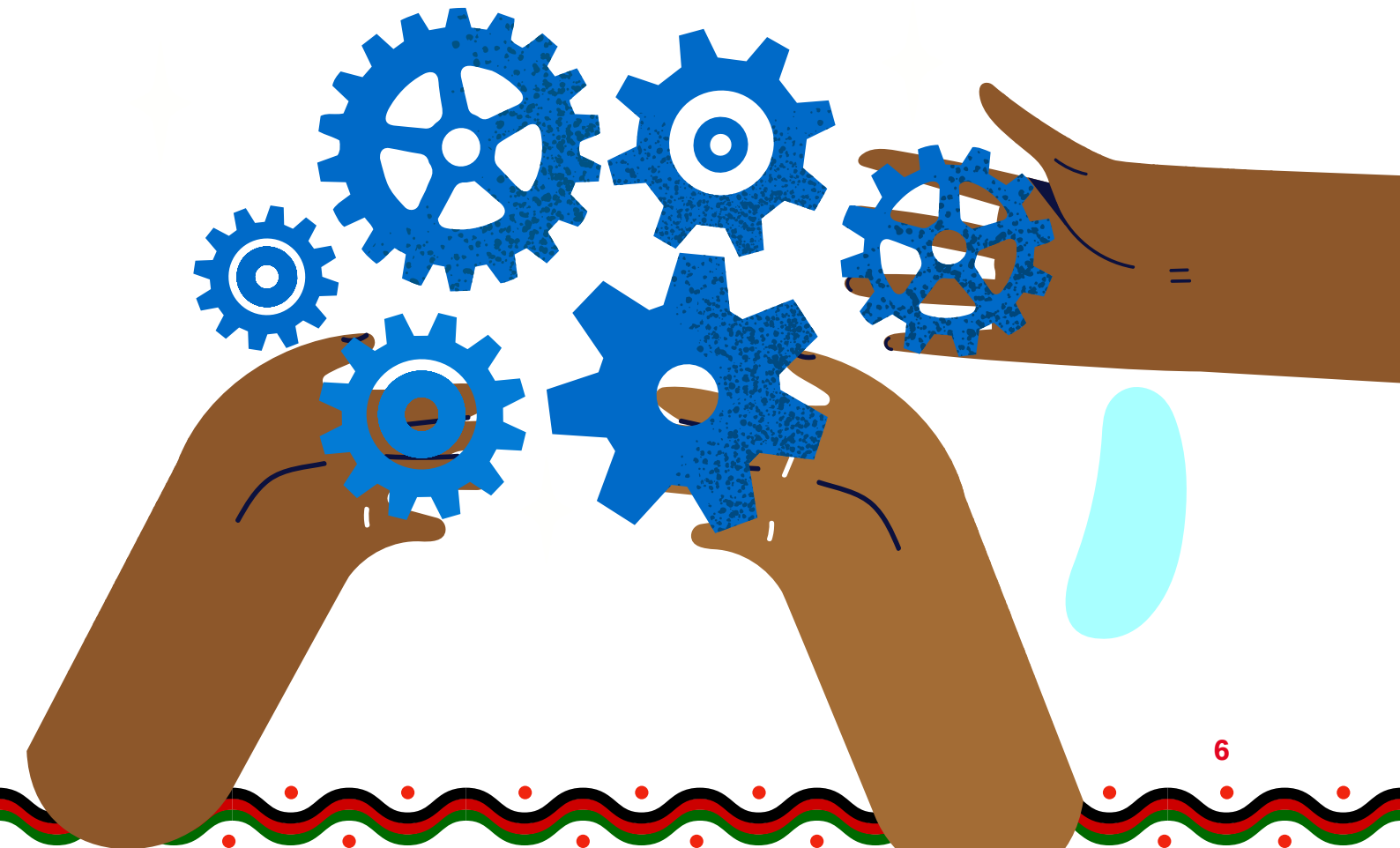
It was also noted that there are insufficient linkages between SRHR and HIV, yet, for the first time in the last decade, new infections are on the rise, with a majority of the cases being among AGYW. Therefore, a need exists to ensure that the spectrum of understanding sexuality and reproductive health is appreciated at all levels.

Young people shared their concerns about the lack of information and access to services on SRHR and GBV. While public health facilities provide free services or services at a subsidised fee, the demand is often higher than the supply, resulting in compromised quality of services and lengthy wait times.

People with disabilities (PWDs) are also often excluded from accessing SRHR services (including maternity services) in a dignified manner, as health providers do not consider them capable of being sexually active. Those with speech and/or hearing limitations are particularly disadvantaged as they are expected to communicate at par with people with no disabilities.

There is also discrimination against LGBTQ+ (Lesbian, Gay, Bisexual, Transgender, Queer or Questioning and others) persons and 'key populations', i.e. people with HIV and people using drugs in accessing services based on the service providers' biases.

To address these challenges, despite the high cost, some young people opt to get their SRH and GBV services from private health facilities as these tend to be of higher quality, with more sensitised health workers, i.e. who are patient and non-judgmental. However, the majority of young people cannot afford this option.



Health Policies and funding

KILE KILE HLM JUU YA UHC INAHITAJI

Kenya, kama wenzao wengi wa Afrika, wanategemea sana ufadhili wa wafadhili kwa huduma zake za afya. Kando na kutokuwa endelevu, ufadhili duni wa ndani wa mambo ya afya kwa hitaji la dharura la kuhamasisha mashirikiano na kuunga mkono Mkakati wa Ufadhili wa Afya wa Kenya na vile vile kuchukua fursa ya nafasi yake ya kipekee ya kikanda kuendeleza na kuhamasisha zaidi uzalishaji wa ndani wa dawa na uchunguzi. Vijana lazima pia watekeleze jukumu muhimu la uangalizi na kuwa waangalifu linapokuja suala la jukumu la mwekezaji binafsi katika afya ya umma ili kuhakikisha kuwa maisha yanawekwa mbele ya faida na wale walio katika ofisi za umma wanawajibika kwa ufadhili na utoaji wa huduma. na upatikanaji wa haki ya afya - kwa wote.

WHAT THE HLM ON UHC NEEDS TO HEAR –AND DO!

Kenya, like many of her African counterparts, relies heavily on donor funding for her health services. Apart from being unsustainable, inadequate domestic financing of health points to the urgent need to mobilise engagement with and support for the Kenyan Health Financing Strategy as well as take advantage of its unique regional positioning to advance and further incentivise local production of medicines and diagnostics. Young people must also play a critical oversight role and be on guard when it comes to the role of the private sector in public health to ensure that lives are put before profits and those in public office are held to account for the inclusive financing and delivery of and access to health justice – for all.

Policy landscape

Kenya was among the first African countries to formulate a population policy (in 1967) and established a national family planning programme under the Ministry of Health[11]. In 1982, the National Council for Population and Development (NCPD) was formed to coordinate all population and development research activities and information, education and communication programmes. In 1994, Kenya became a signatory to the ICPD Programme of Action, which included pledges to achieve the goal of universal access to reproductive health services by 2015. The *Kenyan Health Policy Framework* drew heavily on the 1994 ICPD and identified population growth management as a strategic imperative that was emphasised in subsequent National Health Sector Strategic Plans. A *National Reproductive Health Strategy* (2015) was also developed to provide a comprehensive, integrated system of reproductive healthcare through Government, CSOs and private sector facilities, and the *National Adolescent SRH Policy* has also recently been reviewed. In addition, in January 2023, the Ministry of Health approved the *National Guideline for Self-Care in Reproductive Health*[12], while in the latter half of 2022, the National Syndemic Diseases Control Council (NSDCC, successor to the National Aids Control Council) launched a nationwide campaign towards ending the "triple threat" of early pregnancies, new HIV infections and sexual and GBV cases among adolescents and young people[13].

There is a strong focus on UHC in Kenya's national health policies and strategies; however, the potential for linkages between UHC and SRHR and HIV services is not well articulated. While the Kenya Community Health Policy (2020-2030) has as its primary goal the 'attainment of Universal Health Coverage and access to essential health services that positively contribute to improved health', none of its priority areas directly mention SRH or HIV; however, there is an apparent attempt to integrate HIV prevention and treatment services into a broader UHC framework in *The National HIV-AIDS Strategic Framework 2021/22-2024/25.* The *National Adolescent SRH Policy* also recognises the need to increase financial resources and implement

11 Mumah et al., 2014.

12 See: https://saafund.org/kenyan-government-approves-self-care-guidance-for-reproductive-health/

13 See: https://nsdcc.go.ke/end-tripple-threat/

sustainability mechanisms to effectively and efficiently provide SRH services to adolescents. In the last section of *The National Adolescent Sexual and Reproductive Health Policy Implementation Framework (2017-21),* the Ministry lays out the financial requirements and allocations for Adolescent SRH implementation for the period 2017–2021. It breaks down the costs for nine thematic areas, yet self-care doesn't feature at all.

The *Kenya Health Policy 2014-2030* mentions UHC specifically and commits to progressively facilitating access to services for all 'by ensuring social and financial risk protection through adequate mobilisation, allocation, and efficient utilisation of financial resources for health service delivery'. National and county governments will bear the primary responsibility of providing the financing required to meet the right to health, and 'efforts will be made to progressively build a sustainable political, national, and community commitment with a view towards achieving and maintaining universal health coverage through increased and diversified domestic financing options'. Kenya's *Vision 2030 (2007)* also discusses Government plans to provide access to those excluded from healthcare due to financial reasons through a national health insurance scheme. This includes the devolution of health funds and management of healthcare to communities and district medical officers, leaving the Ministry to deal with policy and research issues.

The Kenya Community Health Strategy (2020-25) builds off the *Kenya Community Health Policy and* defines UHC as the situation where all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship. The KCHS aims to improve service delivery to all Kenyans through integrated, participatory and sustainable community health services towards attaining UHC. The Ministry acknowledges that government spending is lagging in allocating adequate funds to UHC; general government health expenditure (government funds from tax revenue only) was only at 2% of GDP, whereas intended target was 5%.

Financing for health

Overall, while Kenya has made strides in advancing community health, a lot more remains to be done, especially in terms of institutionalising and scaling community health as a critical driver of UHC in Kenya. The country's health system itself is split between national and county levels, with the health function devolved to counties. Health funding is a significant challenge that needs to be addressed to provide scalable, integrated health services at all levels[14]. In Kenya in 2019, 1.48% of the population was impoverished by out-of-pocket healthcare payments.[15] The devolution of the health system to county level also means there is varying consistency in services availability, quality, affordability, etc., so AYP, and those more vulnerable in particular, may travel further to access appropriate, youth friendly SRHR services rather than dealing with stigma and discrimination at mainstream health facilities. In addition, during the COVID-19 pandemic, health funding and services were re-routed to essential services, which amplified existing challenges by halting or reversing hard-won HIV and SRHR-related gains. AYP with multiple diversities, for example, living with HIV and/or a disability or identifying as LGBIQ+ or transgender, were at higher risk at this time, with access to medicines and services interrupted by economies and transport shutdowns, as well as medicine stock-outs[16].

14 AVERT (2019).
15 AHAIC (2021). p 29.
16 Alice, F. (2020) and Mutiso, P (2020).

Inclusion of SRHR and self-care in policies and funding

While significant policies are guiding AYP SRH services, and related funding allocations, it is essential to note that the term 'self-care' is in of itself not often used. Instead, language such as 'youth friendly' and 'adolescent friendly services' was prevalent. A prominent example of the use of the term 'self-care' in the Kenyan documentation was found in the National AIDS and STI Control Programme's (NASCOP) *Adolescent's Package of Care in Kenya: Health Care Provider Guide* (2015) in the contexts of managing personal self-care when depressed; discussions around disclosure of illness; managing alcohol and substance abuse; and transitioning adolescent patients from pediatric to adult services where they would need to be carefully managed in order to "boost the adolescent's capacity for self-care and self-advocacy."[17]

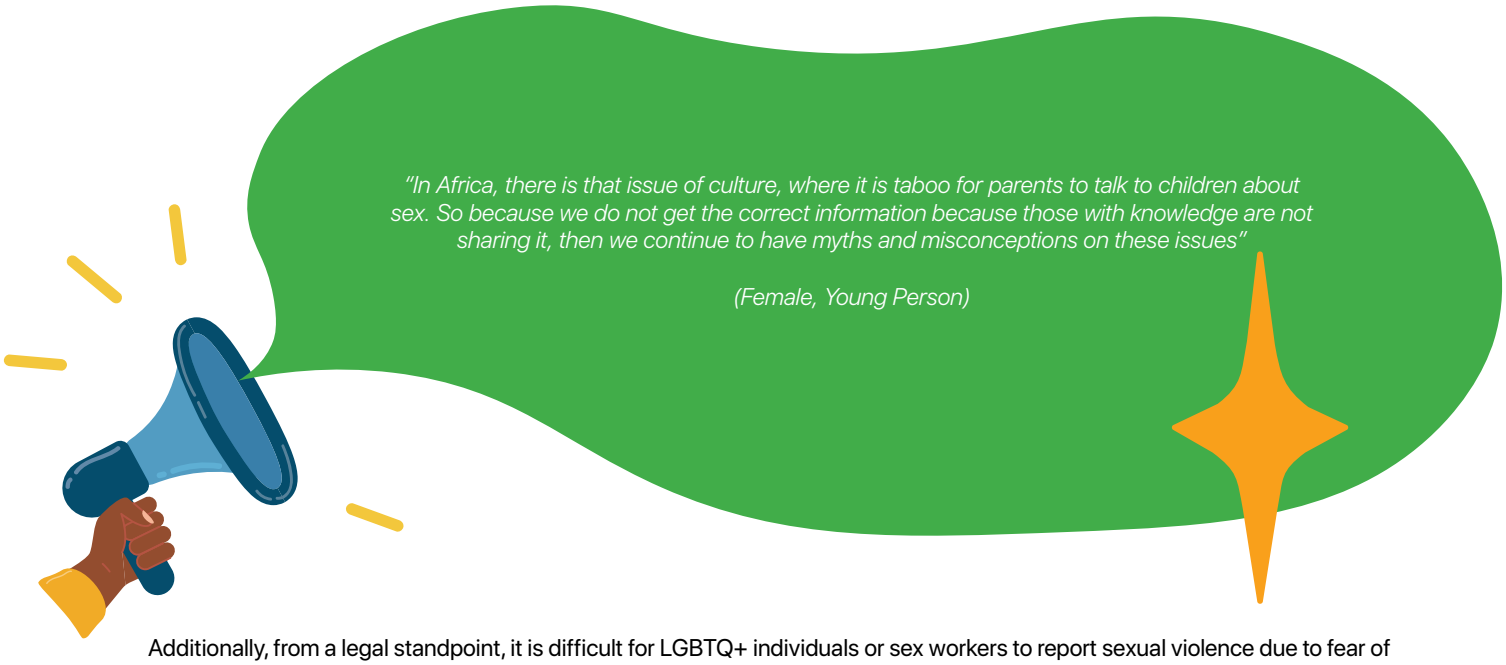
In addition, the term' family planning' is extensively used in the policy documentation, which is problematic in that it often replaces terms such as 'reproductive health', 'reproductive rights', 'sexual and reproductive health and rights', and 'reproductive justice', and assumes the individual is using contraception to plan a family, as opposed to people who want to use contraception solely to exercise their right to choice; it also assumes a very heteronormative version of a nuclear family and procreative path. The term' family planning' also does not include access to safe and legal abortion, yet family planning is often used for all pregnancy prevention.

17 NASCOP (2014). p 22, 56, 60, 77.

Voices of Young Advocates

Some of the **key barriers and challenges** identified by young people include the restrictive policy frameworks that exclude young people from accessing contraception and information, citing the Reproductive Health Policy (2022–2032).

Another barrier is the regressive culture that carries the stigma associated with aspects of SRHR. It is taboo in African culture for adults to discuss sex with children; therefore, those with correct information are not passing it on. This culture also makes it difficult to buy condoms or to get parental consent to access SRHR services as required by law. Young people are therefore exposed to myths and misconceptions (without credible sources for correct information) and are unable to make good sexual and reproductive choices due to fear:



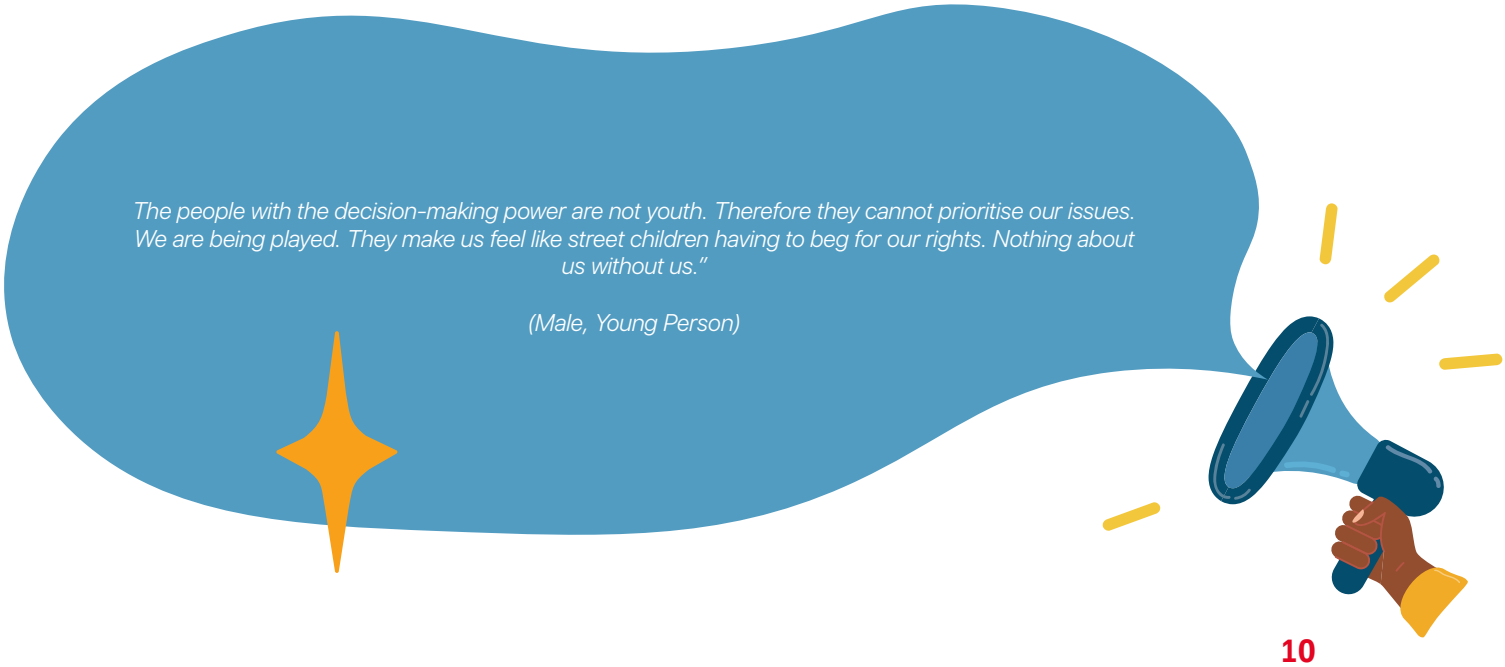
"In Africa, there is that issue of culture, where it is taboo for parents to talk to children about sex. So because we do not get the correct information because those with knowledge are not sharing it, then we continue to have myths and misconceptions on these issues"

(Female, Young Person)

Additionally, from a legal standpoint, it is difficult for LGBTQ+ individuals or sex workers to report sexual violence due to fear of arrest due to the criminalisation of same-sex, sexual conduct, drug use and/or sex work. This discourages them from speaking out and emboldens the perpetrators.

To achieve better health outcomes, intersectionality, i.e., embracing the diversity that young people come with as "we are not homogenous", must be a key advocacy priority.

Additionally, young people must be consulted in making these linkages:



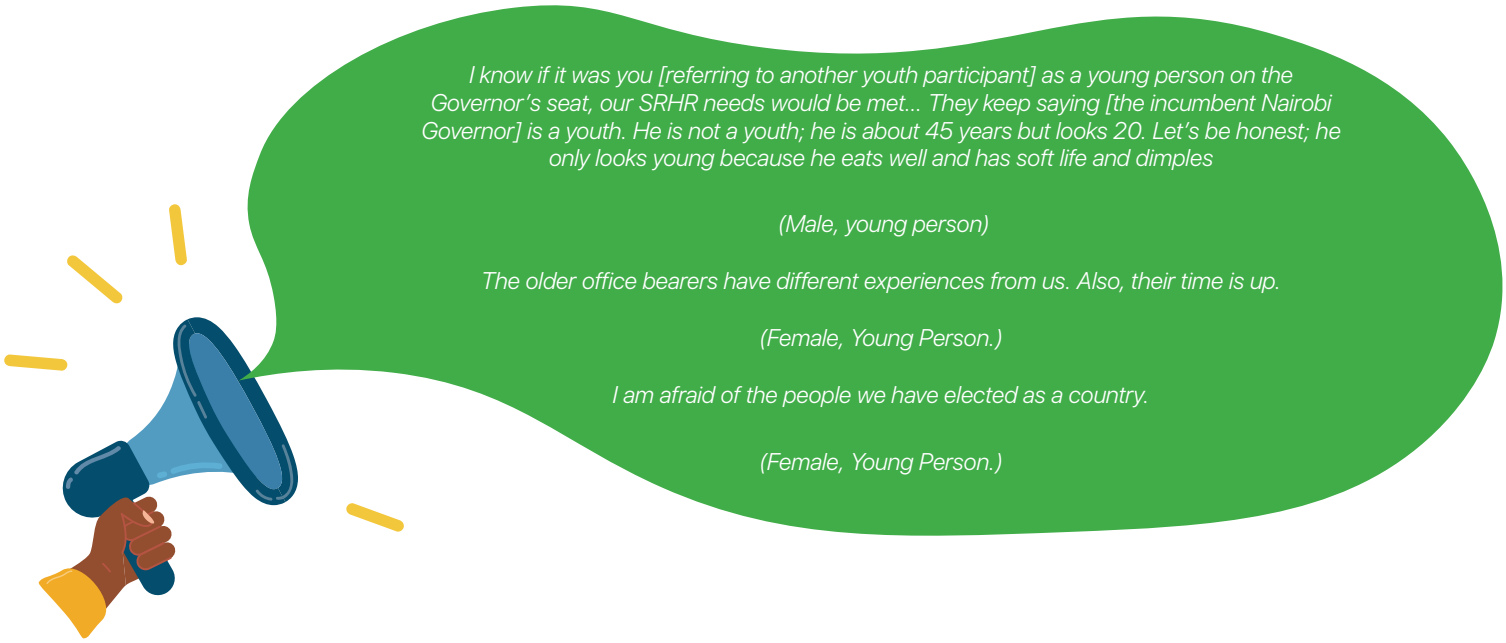
The people with the decision-making power are not youth. Therefore they cannot prioritise our issues. We are being played. They make us feel like street children having to beg for our rights. Nothing about us without us."

(Male, Young Person)

There is a sense that advocacy on SRHR issues can be tokenistic, where young people's value is not appreciated. Organisations are seemingly more interested in reporting (i.e., taking and posting pictures with young people) rather than in impactful programmatic interventions.

Additionally, much of the advocacy work on these issues is not evidence-driven. Documenting interventions better is needed to ensure continuity, accountability, and growth.

Young people also do not trust their leaders and are instead seeking opportunities to be engaged as equal partners in the fight to secure their SRHR as those directly affected by the gaps in the sector. Young people want to be supported to hold decision-making positions in civil society and in political office at all levels, where they will mainstream SRHR issues.



I know if it was you [referring to another youth participant] as a young person on the Governor's seat, our SRHR needs would be met... They keep saying [the incumbent Nairobi Governor] is a youth. He is not a youth; he is about 45 years but looks 20. Let's be honest; he only looks young because he eats well and has soft life and dimples

(Male, young person)

The older office bearers have different experiences from us. Also, their time is up.

(Female, Young Person.)

I am afraid of the people we have elected as a country.

(Female, Young Person.)

This ideally would be through breaking the barriers tied to seeking elective office, such as costs involved in registering with political parties and/or the electoral commission as part of implementing affirmative action.

Key Advocacy Messages

A clear set of recommendations emerged through this process:

YOUNG LEADERS ARE LEADERS!

Young people must be involved in making these linkages between SRHR, HIV and UHC – and how self-care can effectively strengthen health systems. This was resounded in the youth discussions where they advanced the clarion call of "nothing about us without us". And there are good practice examples of this in some counties already:

"In Kiambu County, the Government is boosting youth because everywhere you go, there are public youth-friendly centres. Now, we do not fear seeking information and services because there is no judgement in these centres, even if I have a sexually transmitted infection (STI). Those working in the centres are youth just like me – not like before, when it was older people. Therefore other counties should do the same."

(Female, Young Person)

LEADERS MUST LEAD!

Despite significant UHC policies and strategies, there is a clear gap in terms of implementation – as well as integration with HIV and SRHR policies - with the need for:

- Regularly updated standards and guidelines to reflect current realities, linked to regular review and update cycles for SRHR-related policies.
- Accessible standards and guidelines (at key levels of the health system) that translate the policy into tangible practice for service providers and users;
- Processes to ensure that civil society (CSOs) and community-based organisations (CBOs) are adequately involved at design and implementation stages;
- Greater inclusion of AYP, their communities and service providers through human rights literacy training (with a specific focus on health rights and how these can be realised within the context of the SRHR and HIV response in each country), tailored to how AYP best receive information (online, via Apps, via peers, and so on).

LEADERS MUST ACCOUNT!

There are many opportunities for communities to hold leaders accountable practically; however, the mechanisms can be very opaque. Some examples of how to hold leaders to account at different levels include:

- Leveraging the regional and international instruments Kenya has signed onto and their inbuilt accountability mechanisms. CSOs can check the status of these various treaties online18 to identify important advocacy opportunities, for example, submitting Shadow Reports to supplement periodic Government reporting on women's rights.
- Similarly, understanding the national policy frameworks – and the gaps – provides a foundation for influencing through national bodies, such as national HIV and AIDS councils' review cycles for their National Strategic Plans or Technical Working Groups' reviews of key strategies and guidelines for AYP SRHR services.
- Ensuring all SRHR-related policies and any associated strategies, plans and guidelines have regular review cycles and a schedule that can be accessed by civil society to influence policy updates by ensuring they reflect current realities on the ground.
- Influencing through targeted information campaigns catering to key audiences' information preferences, e.g., hardcopy posters, dialogues, and activations in communities, or online (via Apps and social media) or via peers for AYP.

LEADERS MUST INVOLVE!

Despite the absence of self care language and approaches, young people who engaged in this process have a good understanding of the concept of self-care and SRH, with one defining "health [broadly, as] the complete well-being of a person, but does not mean the absence of disease SRH was then agreed to entail HIV and STIs; female genital mutilation (FGM); GBV; use of contraceptives; and safe abortions. There was agreement that the SRHR of young people, especially young women and girls, are violated, with restricted or no access to comprehensive, non-judgmental information and commodities to support them to protect themselves.

In terms of self-care specifically, the discussions with young people in Kenya, many of whom were openly living with HIV, with some identifying as LGBQ+ elucidated key themes around love and happiness; mental health; costs of services and treatment; reproductive health and fertility:

18 See: https://www.ohchr.org/en/countries/kenya

While also not necessarily using the term, 'self-care', they had a good understanding of the concept, in terms of the use of condoms, seeking psychosocial support, taking their medication appropriately, when to withdraw (when being with people gets overwhelming), and when to lean into their support networks. Conversely, there was a strong sense from both young people and SRHR organisations engaged in the process that the sector itself has a simplistic or narrow perspective - only considering self-care from a mental health perspective. There is therefore a need for sensitisation before seeking to integrate it into existing legal and policy frameworks – and the best way to achieve this is to involve young people who are already engaging in and advocating for the practice.

LEADERS MUST UNITE!

Kenya has a strong network of stakeholders engaged in different ways in the SRHR and HIV landscape. There is, however, a clearly articulated need to meaningfully involve and – as part of that - better resource local CSO networks – particularly youth-focused and youth-led - to support a critical and representative mass of stakeholders who can support and drive the rights agenda. This can include:

- catalysing around a shared issue to leverage different expertise and resources
- making available joint funding for shared action (campaigns, movement strengthening)
- making available unrestricted funding for non-traditional forms of advocacy that local groups can implement without 'sign off' from a donor.
- leveraging off the significant work already being done by CSOs in Kenya, for example Women First Digital leverages technology to curate accurate information disseminated by their panel of social media influencers and across three digital platforms that direct users to hotlines to access information for youth friendly SRHR services (including access to contraception and safe abortion); the Centre for the Study of Adolescence has their own CSE curriculum which they train local champions in to ensure this information reaches young people in communities. They also develop alternative forms of online CSE; the Kenya Ethical and Legal Issues Network (KELIN) has programmes creating ties between SRHR and HIV at the county level (i.e., Kisumu and HomaBay counties). These include sensitisation campaigns targeted at AGYW as well as police and other stakeholders in an attempt to dismantle societal bias. They are also in the process of analysing the Children's Act 2022 to identify elements to challenge through strategic litigation, particularly around consent and reproductive health services, including the ability of children with evolving capacities to give consent when necessary.

LEADERS MUST EVOLVE!

While significant policies are guiding AYP SRH services in Kenya, the term 'self-care' was only introduced in January 2023. Predominantly, language such as 'youth friendly' and 'adolescent friendly services' is used, and written from a top-down perspective. Similarly, the policy documentation extensively uses the term family planning. This is problematic where it often replaces terms such as 'reproductive health', 'reproductive rights', 'sexual and reproductive health and rights', and 'reproductive justice' and assumes the individual is using contraception to plan a family, as opposed to people who want to use contraception solely to exercise their right to choose and to be safe; it also assumes a very heteronormative version of a nuclear family and procreative path. The term' family planning' does not include access to safe and legal abortion, yet family planning is often used for all pregnancy prevention. The concept is best placed within a broader SRHR framework founded on the understanding of choice.

These language issues present significant opportunities for advocacy, where partners and communities can influence at different levels (policy influencing and community-based activism) around more inclusive, rights-based language that, in the You(th) Care project context, prioritises AYP's agency in accessing services and making decisions about their SRHR – and that also reflects that we do not live in a heteronormative paradigm of identities, orientations or choices.

YOUNG PEOPLE ARE DIVERSE!

A strong theme in the discussions was that young people are not a homogenous group, and the pre-existing policy frameworks are restrictive in catering to their lived experiences and current realities:

"The biggest challenge we face in our diversities is the negative attitudes of health providers, whether you are a PWD, LGBTQ+ or heterosexual young people are facing the same judgments from them. We lack an action plan to eradicate this. Since I joined my first organisation three years ago - now, and those I found there who have been in the field for years, we still talk about the attitudes of health providers. It is time we move from the action stage. We know this is the issue, so what do we do about it? [...]If this health provider attitude is not changed, we will still be in the same place"

(Non-conforming, Young person)

"We will be united the day you'll find me as a queer person at the frontline fighting for the rights of PWDs, or when a straight man will be in the frontline advocating for us. Even if we have youth-friendly services but amongst ourselves, if we aren't accepting of each other, then we are doing nothing. We must fight for each other."

(Non-conforming, Young Person)

TAKE SRHR INFORMATION ONLINE!

There is a need to use technology in innovative ways given the many examples of the use and access of the internet through mobile phones (or other online channels) by young people in the country to access health information/self-care as a potential mechanism to enact different advocacy and influencing initiatives, alongside the provision of comprehensive, accessible SRHR information and referral information for key health services.

ANNEX 1: Research Methodology

In August 2022, following reflections from You(th)Care consortium partners meeting about gaps in knowledge of the policy landscape for SRHR and HIV in each programme country, Aidsfonds commissioned the African Alliance ('the Alliance') to undertake an initial country-specific (Kenya, Tanzania and Zambia) policy analysis to provide the consortium with insights into each country's policy environment to support partners to better promote and realise AYP's SRHR and HIV self-care needs, including AYP access to self-care services and commodities.

This first phase of work focused on mapping policies, strategies and guidelines related to AYP aged 10–25, identifying key stakeholders, and the specific barriers or enablers to progress in improving SRHR and the practice of self-care. To that end, the Alliance engaged stakeholders from the You(th) Care consortium cohort (partners and young people) alongside a small sample of thought leaders working regionally, continentally and globally on SRHR and self-care to better understand the policy landscape and what opportunities may exist for You(th) Care to inform its adaptation and future implementation. The policy analysis process sought to understand the state of the national adolescent and young people's SRHR and HIV response in each country and the possibilities to practice self-care; key policies and guidelines that influence adolescent and young people's SRHR and HIV vulnerability and access to self-care; barriers and opportunities for improving adolescent and young people's SRHR, the practice of self-care; the main stakeholders; recommendations to impact on adolescent and young people's SRHR, the practice of self-care and HIV/AIDS in the country.

The process was phased, consisting of an initial briefing with You(th)Care colleagues from Aidsfonds, a desk review, and country-based semi-structured discussions with consortium partners and the young people (aged 18-25) they work with. A second phase was commissioned in September 2022 to add an analysis of Malawi and Uganda and build on the initial process with an adjusted focus to consider what commitments or policies on UHC each country has in place and how they are being implemented.

In Kenya, the following stakeholders were engaged in this process:

- Network for Adolescent and Youth in Africa *(NAYA, staff and young people)*
- Ambassador for Youth and Adolescent Reproductive Health Program *(AYARHEP, staff and young people)*
- Reproductive Health Network Kenya *(RHNK, staff and young people)*
- Centre for the Study of Adolescence *(staff)*
- Kenya Ethical and Legal Issues Network *(KELIN, staff)*
- Sitiri Dada Kenya *(staff)*
- Woman First Digital *(staff)*
- Xhale Africa *(staff)*
- Network for Youth Empowerment Kenya *(staff)*
- Zamara Foundation *(staff)*

Through this approach, the Alliance sought to draw from the base set of findings from the desk review and build on these through the in-country processes, ensuring that the data collected is meaningful and nuanced rather than repetitive to draw a clearer picture of what is happening in each country from multiple perspectives. The Alliance used thematic analysis to group and compare the findings in each country and draw out country-specific advocacy recommendations. Where possible, useful examples of good practice are identified in the narrative. Findings are presented as individual country snapshots, with a summary' global brief' that also considers the profile of self-care in regional and global debates. Illustrative quotes are used throughout this document, extracted from the in-country conversations with partners and AYP.

Limitations

- Any instance of participants not feeling comfortable using English was largely mitigated by conducting face-to-face conversations in local languages (Kiswahili or Shen with young people). The recordings were transcribed and translated into English and used to generate synthesis reports of the conversations.
- The sample of young people (aged 18-24) who participated in the conversations was limited due to i) insufficient time to organise discussions with adolescents (age 10-17) due to the lead-in time required to coordinate informed consent processes with their parents and guardians; and ii) the time of year the second phase conversations took place (November-December) where stakeholders had competing deadlines before the end of year break; iii) consultations were held in urban centres (Nairobi in Kenya) which meant that only those young people who could reasonably travel to the meeting locations (i.e. those living in proximal urban or peri-urban areas) participated.

ANNEX 2: Key policies and guidelines

National policy landscape

In addition to the Constitution, a sample of current or most recently available policies, strategies, and guidelines include, but are not limited to:

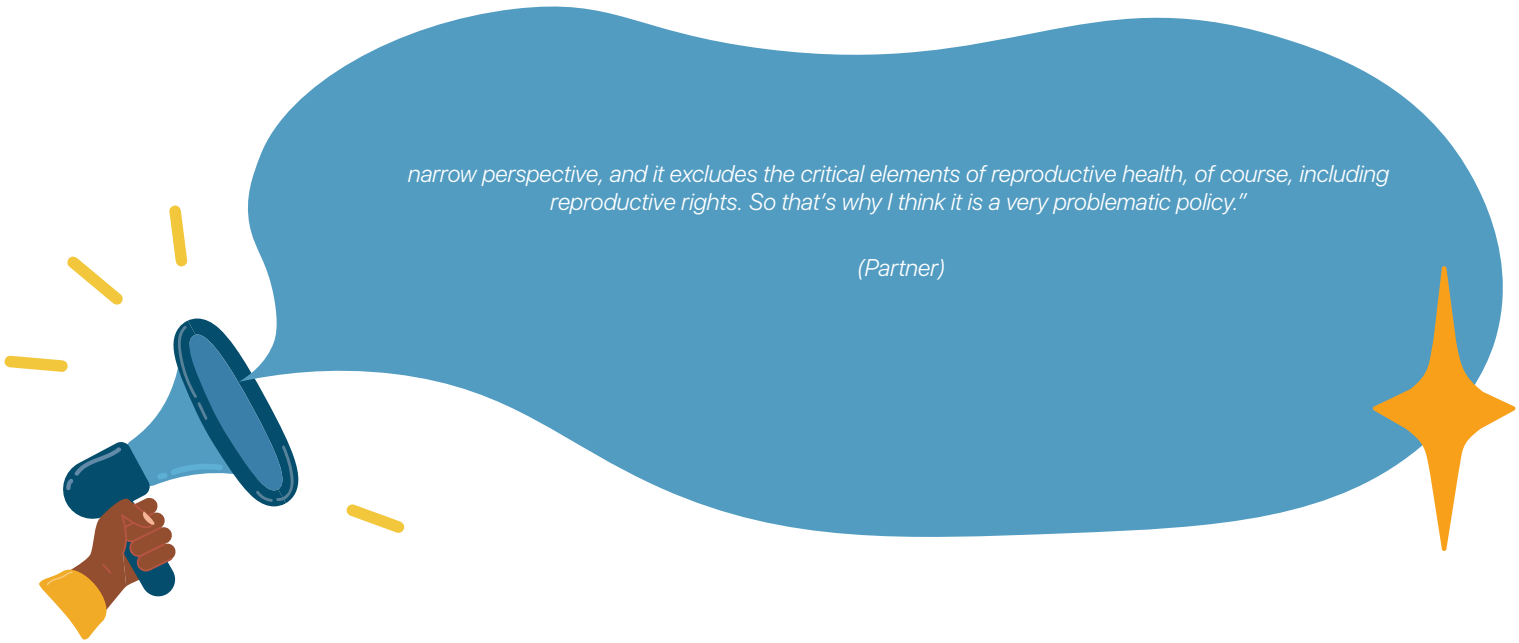
Policies

- National Youth Policy (2006)
- Prohibition of Female Genital Mutilation (2011)
- Marriage Act (2014)
- Health Policy (2014-2030)
- National Adolescent Sexual and Reproductive Health Policy (2015)
- Kenya School Health Policy (2018)
- National Reproductive Health Policy (2022-2032)

Strategies and guidelines

- Guidelines for Conducting Adolescent HIV SRH Research in Kenya (2015)
- Adolescent's Package of Care in Kenya: Health Care Provider Guide (2015)
- National Guidelines for Provision of Adolescent and Youth-Friendly Services in Kenya (2016)
- Vision 2030 (2007)
- National Adolescent Sexual and Reproductive Health Policy Implementation Framework (2017-21)
- National Family Planning Guidelines for Service Providers (2018)
- Kenya Community Health Strategy (2020-2030)
- Kenya AIDS Strategic Framework II (2020/21-2024/25)
- National Guideline for Self-Care in Reproductive Health (2023)

It is well recognised, and particularly noted by partners who participated in the initial phase of this review, that while Kenya has a solid legal and policy framework on SRHR and HIV, a key issue is implementation, particularly for SRHR. The recent *National Reproductive Health Policy* (2022-2032), for example, was viewed as problematic because it was enacted in an exclusive and opaque manner, i.e., without taking into consideration the input from CSOs and other stakeholders on contentious issues such as access to CSE and contraceptives for adolescents:



narrow perspective, and it excludes the critical elements of reproductive health, of course, including reproductive rights. So that's why I think it is a very problematic policy."

(Partner)

Regional and international policy landscape

Significant international and regional law, through treaties, conventions, protocols, covenants and declarations, exists to interpret human rights within the health framework and specifically to apply those rights to respect, protect and defend human sexuality and human reproduction. These resound with the rights to freedom, equality, non-discrimination, privacy, and human dignity and confer on states that are party to each treaty the obligation to provide, domestically, for the highest attainable standard of health. Kenya is obligated under several international and regional treaties to provide access to healthcare, including to promote and protect SRHR, and this is reflected to varying extents in the suite of policies, strategies and guidelines developed to realise these promises. A snapshot of some of these international and regional treaties is provided below.

- Universal Declaration of Human Rights (1948)
- International Covenant on Civil and Political Rights (1976)
- Convention on the Elimination of All Forms of Discrimination against Women (CEDAW, 1979)
    - Joint General Recommendation No 31 of the CEDAW
- International Covenant on Economic, Social and Cultural Rights (ICESCR)
- Convention of the Rights of the Child (1989)
    - General Comment No 4 on Adolescent health and development in the context of the Convention on the Rights of the Child (2003); General Comment No 18 of the Committee on the Rights of the Child on harmful practices (2014); and General Comment No 20 on the Implementation of the Rights of the Child during Adolescence (2016)
- Fast Track Commitments to end AIDS by 2030
- International Conference on Population and Development Programme of Action (1994)
    - Framework of actions for the Follow-up to the Programme of Action of the International Conference on Population and Development Beyond 2014
- The 2030 Agenda for Sustainable Development
- Political Declaration on HIV and AIDS: On the Fast Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030
- UNAIDS Agenda for Zero Discrimination in healthcare settings

Regional treaties and guidance

- African Charter on Human and People's Rights (1981)
- African Charter on the Rights and Welfare of the Child (1990)
- African Women's Protocol to the African Charter on Human and People's Rights (2003)
    - General Comments on Article 14 (1) (d) and (e)of the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (2012); and General Comment No 2 on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c) of the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (2014)
- African Youth Charter (2006)
- Continental Policy Framework for Sexual and Reproductive Health and Rights (2005)
- Maputo Plan of Action on Sexual and Reproductive Health and Rights (2006)
- Model Law on HIV in Southern Africa (2008)
- The ESA commitment made by ministers of health and education in 21 ESA countries to scale up comprehensive sexuality education (CSE) and SRH services for AYP (2013)
- Model Law on Eradicating Child Marriage and Protecting Children Already in Marriage (2016)
- Southern African Development Community (SADC) Gender Protocol
- AU 2063 Agenda
- SADC Minimum Standards for the Integration of HIV and Sexual and Reproductive Health in the SADC Region
- SADC Regional Strategy for HIV Prevention, Treatment and Care and Sexual and Reproductive Health and Rights among Key Populations (2018)
- AU Catalytic Framework to end AIDS, TB and Malaria in Africa by 2030
- Organisation of African Unity, Abuja Declaration on HIV/AIDS, TB and Other Related Infectious Diseases (2001)
- AU Addis Ababa Declaration on Population and Development in Africa beyond 2014 (2013)
- SADC SRHR Strategy and Scorecard (2019-2030) (2018)

This is not a comprehensive list, but the examples shared give some sense of the extensive international and regional relationships between states and the shared values of the international and regional communities. This provides a basis for engagement of civil society at a national level, as well as within and between states, for shared international and regional accountability, recognising that, while it can be difficult to 'enforce' the implementation of the content of these documents, they are important to be aware of as each comes with its own set of review mechanisms that can provide a point of advocacy and influencing for civil society engagement.

For example, the African Union (AU) Summits (for the Maputo Protocol) and the CEDAW country reviews, among others.

ANNEX 3: Key UHC Stakeholders

In terms of state actors, the Ministry of Health is the leading state actor responsible for the general health and well-being of Kenyan citizens at both national and county levels; the Ministry of Education provides (limited) age-appropriate SRH information in schools; and the Ministry of Public Service and Gender, Children and Social Development is responsible for children's welfare. The National Aids Control Council (NACC) works with people living with HIV, and young people have been identified as a priority group due to their particular vulnerabilities to HIV infection alongside key populations[19]. The National Gender and Equality Commission and Kenya National Commission on Human Rights and Adolescent Sexual Reproductive Health Technical Working Group (TWG) also work with AYP. In addition, most counties have County TWGs on Teenage Pregnancy and have expanded their mandate to cover adolescent SRH and GBV.

In terms of civil society actors, several organisations are working with AYP, including (but not limited to): the Young Women's Leadership Institute (YWLI); Trust for Indigenous Culture and Health; African Gender and Media Trust; Women Empowerment Link; the Center for Rights Awareness and Education of Women, LVCT Health; AMREF; IchooseLife Africa; National Organisation of Peer Educators (NOPE); Kenya Aids NGOs Consortium (KANCO); Population Services Kenya and the Center for the Study of Adolescents. In terms of youth-led civil society, there are a large number of actors (youth and otherwise) working with young people in Kenya, who are quite active, with a number of youth empowerment initiatives established at different levels and funded by the Government, local and international organisations. Examples include the Young Women's Christian Association, the YWLI mentioned above, Fortress of Hope, and Resource Center for Women and Girls.

In addition to a number of international NGOs (INGOs) who provide capacity building and institutional support to national organisations in the delivery of HIV services and programmes (e.g. FHI 360, Action Aid, and Aidsfonds), Kenya is also a hub for international coordination in East Africa, with a number of specific SRHR consortiums working from the country: Rutgers (Right Here Right Now - young people in all their diversity); Amref (Power to Youth - young people); Wemos (The Intersectionality Consortium - marginalised youth, people living with disabilities and women); Plan International Nederland (Break Free! - adolescent girls); and Hivos (Free To Be Me - LGBTIQ+ and We Lead - young women living with HIV, a disability, who are displaced, and/or LBTQIA+).

Partners who participated in this process included:

1. Network for Adolescent and Youth in Africa (NAYA, staff and young people)
2. Ambassador for Youth and Adolescent Reproductive Health Program (AYARHEP, staff and young people)
3. Reproductive Health Network Kenya (RHNK, staff and young people)
4. Centre for the Study of Adolescence (staff)
5. Kenya Ethical and Legal Issues Network (KELIN, staff)
6. Sitiri Dada Kenya (staff)
7. Woman First Digital (staff)
8. Xhale Africa (staff)
9. Network for Youth Empowerment Kenya (staff)
10. Zamara Foundation (staff, CSEM member)

19 Defined in the Kenya AIDS Strategic Framework II as: men who have sex with men, female sex workers, people who inject and use drugs, and transgender people.

In addition, Kenyan members of the Civil Society Engagement Mechanism (CSEM) for UHC 2030 include:

- Abrassa Mentorship and Empowerment Network (AMEN)
- Adventure Youth Group
- Advocacy Network Africa
- African Alliance for Health Research Economic Development
- African Family Health
- African Institute for Health and Development (AIHD)
- Aga Khan Foundation
- Amref Health Africa
- Arise and Shine Women's Integrated Project
- Bar Hostess Empowerment and Support Program
- Blessed Community Engagement Organization
- Cancer Awareness Centre of Kenya
- Centre for Health Research Advocacy
- Change Ambassadors Kenya (CHAKE)
- CheHerma Wellness and Knowledge
- Christian Aid
- Coalition Action for Preventive Mental Health
- Community Action for Sustainable Development
- Community Initiative Action Group Kenya
- Community Forum for Advanced and Sustainable Development
- Confraternity of Patients Kenya (Cofpak)
- Consumer Grassroots Association
- Dreams Alive Africa
- Eagle Neema
- Emonyo Yefwe International
- Evidence for Action (E4A) MamaYe
- Evidence Action – Kenya
- Family Care Foundation Agency – Kenya
- Family Health Options Kenya
- Femcorner Community-Based Organization
- Fred Kiserem Epileptic Foundation
- Good Health Community Programmes
- Great Minds Mentorship
- GreenLife Support International
- Health Dimensions Africa
- Health NGO's Network (HENNET)
- Health Users Alliance (HUA)
- Humanity for Orphans, Youth and Widows Initiatives Kenya (HOYWIK)
- Impact HHealthcareInternational
- Impart Change
- Interchurch Medical Assistance World Health
- Inuka Success Youth Group
- Jamii Shwari
- Jhpiego – Kenya
- KELIN
- Key Affected Population Health and Legal Rights Alliance
- Kenya AIDS NGOs Consortium
- Kenya Association for Maternal & Neonatal Health (KAMANEH)
- Kenya Cancer Association
- Kenya Female Advisory Organization
- Kenya Hospices and Palliative Care Association (KEHPCA)
- Kenya Legal and Ethical Issues Network
- Kenya Medical Association
- Kenyan Aged People Require Information, Knowledge and Advancement (KARIKA)
- Kisumu Male Sex Workers Organization (KIMASWO)
- Kisumu CSOs for UHC
- Kisumu Medical and Education Trust
- KMET Kenya
- KNEAD
- Kuza Upeo Africa
- Lake Region Public Benefit Network
- Lean on Me Foundation
- Living Goods – Kenya
- Madhira Institute
- Men against AIDS Youth Group (MAAYGO)
- Mumbo International
- NNAK Midwifery & Reproductive Health Chapter
- National Organization of Peer Educators
- NCD Alliance of Kenya
- NEPHAK
- Organisation of African Youth
- Options – Kenya
- Partnership for Universal Healthcare
- Pathfinder International Kenya
- PHM Kenya
- Positive Young Women Voices
- RaHa Solutions
- RESPEKT
- Ryculture Health and Social Innovation
- Safari Doctors
- Safe Water and AIDS Project
- Seeds of Peace Africa (SOPA) International
- Serene Haven Rescue Centre
- Solidarity Creations
- Soweto Youths Initiative
- St Hemmingways Community-Based Organisation
- St Joseph Community Education Centre
- Strategic Poverty Alleviation Systems-SPAS
- Stretchers Youth Organization
- Strengthening People's Engagement & Advocacy in Kenya (SPEAK)
- Support For Tropical Initiatives in Poverty Alleviation
- Surgical Systems Research Group
- Tinada Youth Organization (TIYO)
- Triple-K Live
- Tropical Institute of Community Health & Development
- Ugenya Youth and Community Development Project
- Ugunja Development Initiative
- WACI Health
- Wellness Approach Mentors
- Wezesha Health Services
- Women Working with Women
- Wote Youth Development Projects
- Y-ACT Youth in Action
- Young Advocate Community Project (YACOP)

Partners also spoke extensively on the increasingly growing and organised opposition that seeks to negate gains made in SRHR. This includes government officials, religious leaders and the media, who have made the operational environment for SRHR-related work difficult; for example, while many organisations work on HIV and/or SRHR, they may also hold a position where, because of their personal beliefs, they are against safe abortion, won't provide access to contraception, or won't support CSE in schools. This internal opposition within the movement is a significant obstacle to progress where there is no unified position on key issues affecting AYP's SRHR.

ANNEX 4: ADVOCACY ROADMAP

Timeline - UHC Negotiation Schedule

The UN Language Compendium is a useful tool for high-level United Nations negotiations and can be used for community advocacy to advance human rights commitments — particularly regarding access to healthcare and sexual and reproductive health and rights: https://hivlanguagecompendium.org

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aidsfonds

ARASA AIDS Rights Alliance for Southern Africa

AYARHEP

CHILDREN'S DIGNITY FORUM CDF UTU WA MTOTO

COPPER ROSE ZAMBIA
Beautiful | Valuable | Empowered

Network for Adolescent and Youth of Africa NAYA

NYP+ Network of Young People Living With HIV and AIDS

PATA PATA

GLOBAL NETWORK OF YOUNG PEOPLE LIVING WITH HIV

Developed by African Alliance