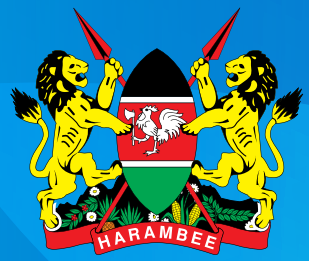

MINISTRY OF HEALTH

NATIONAL ADOLESCENT SEXUAL REPRODUCTIVE HEALTH POLICY IMPLEMENTATION FRAMEWORK

2017-2021

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LIST OF ABBREVIATIONS

AIDS	Acquired Immune-Deficiency Syndrome
ARHD/ARH&D	Adolescent Reproductive Health and Development
ASRH	Adolescent Sexual and Reproductive Health
ASRHR	Adolescent Sexual and Reproductive Health and Rights
AYFS	Adolescent and Youth Friendly Services
CDH	County Department of Health
CHAs	Community Health Assistants
CHMTs	County Health Management Teams
CIDP	County Integrated Development Plan
CIMES	County Integrated Monitoring and Evaluation System
CSO	Civil Society Organization
DHIS	District Health Information System
DSA	Drug and Substance Abuse
FBO	Faith Based Organization
FGM	Female Genital Mutilation
HIV	Human Immune-Deficiency Virus
HMIS	Health Management Information System
HMTs	Hospital Management Teams
HPV	Human Papilloma Virus
HTPs	Harmful Traditional Practices
KAIS	Kenya AIDS Indicator Survey
KDHS	Kenya Demographic and Health Survey
M&E	Monitoring and Evaluation
MLSSS	Ministry of Labor Social Security and Services
MOIS	Ministry of Internal Security
MOH	Ministry of Health
NCPD	National Council for Population and Development
NGO	Non-Governmental Organization
NIMES	National Integrated Monitoring and Evaluation System
PAC	Post-Abortion Care
RH	Reproductive Health
RH/ICC	Reproductive Health Inter-agency Coordination Committee
RTI	Reproductive Tract Infection
SGBV	Sexual and Gender-based Violence
SRH	Sexual Reproductive Health
STI	Sexually Transmitted Infection
TWG	Technical Working Group
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization
YSO	Youth Serving Organization

ACKNOWLEDGEMENT

The development of this ASRH Policy Implementation Framework 2017-2021 was extensively consultative. It was guided by a multi-sectoral technical working group, led by a task force comprised of national and county governments, international and local NGOs, development partners and adolescent and youth representatives.

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Head, Department of Preventive and Promotive Health Services

FOREWORD

According to the Kenya Population Situation Analysis (2013), the country has a rapidly growing youthful population with the majority (53.7%) being below 20 years. This young population has implications for the social, economic and political agenda of the country. A young population puts great demands on provision of health services, education, water and sanitation, housing and employment. At the same time, it provides opportunities for the development of the country if young people, especially the adolescents, get opportunities to attain educational goals and receive all round development in preparation for responsible adulthood. This segment of the population therefore requires the close attention of all sectors of government, development partners and other stakeholders for the country to attain the Vision 20301, the African Youth Charter (2006) and the Post-2015 Development Agenda through Sustainable Development Goals (SDGs).

The government of Kenya has made progress in creating an enabling policy environment to address some of the sexual and reproductive health concerns of adolescents. This commitment is evident in the national policies, legislations and guidelines that the government has put in place, including the National Adolescent Sexual Reproductive Health Policy, which is the subject of this Implementation Framework.

The National ASRH Policy (2015) was developed to provide guidance to the national and county governments, development partners and civil society organizations on how to respond to adolescents' SRH needs. The implementation of the Policy calls for substantial operational changes to respond to county-specific ASRH needs.

This Implementation Framework will therefore operationalize National ASRH Policy by outlining the: 1) strategies and key interventions for the achievement of the specific objectives stated within the policy; 2) resource requirements for the specific interventions; and 3) a monitoring and evaluation framework to track progress in implementation of the Policy.

It is my sincere hope that this framework will provide sufficient guidance to all actors working in adolescent sexual reproductive health at National and County level and thereby contribute to improved health and wellbeing of adolescents in the country.

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Director, Medical Services

1.0 INTRODUCTION

1.1 Background

Adolescents comprise about 24% of Kenya's population.[2] Nonetheless, they experience some of the poorest reproductive health outcomes in the country. Recent estimates show that one in every five adolescent girls between the ages of 15-19 have begun child bearing (KDHS 2014). Among the adolescent girls who had begun child bearing, 29% reported that the previous birth or current pregnancy was unintended[3]. According to the 2014 KDHS, contraceptive prevalence rate among sexually active unmarried girls aged 15-19 years is 49% while unmet need for contraceptives for married adolescents 15 – 19 years is 23%[4]. The median age at first sex in Kenya is about 18 years for women and 17 years for men. Though the median age at first sexual intercourse has remained stable over time, about 12% of young women and 21% of young men aged between 15-24 years have had sexual intercourse before age 15, while 47% of young women and 55% of young men between the ages of 18-24 years have had sexual intercourse before age 18 years. Additionally, of 71,034 new HIV infections that occurred in 2015, 51% (35,776) were among young people aged 15 – 24 years. This is further compounded by the fact that comprehensive knowledge of HIV among adolescents stands at 52% for girls and 58% for boys, while the rate of condom use among sexually active adolescent girls and boys is 56% and 66%, respectively.

According to a national study on unsafe abortion in Kenya, 120,000 women sought care for abortion-related complications in health facilities in 2012, with women below age 19 years accounting for 17% of all women seeking post-abortion care services. Additionally, women below age 19 years accounted for about 45% of severe abortion-related admissions in Kenyan hospitals[5]. Evidence also shows that adolescents living in marginalized communities such as informal settlements have poorer sexual and reproductive health (SRH) outcomes compared with their counterparts living in other urban settlements[6]. Similarly, adolescents living with disabilities tend to face heightened vulnerability to SRH risks due to inadequate information and services targeting their specific needs[7].

Sexual and Gender Based Violence remains a key issue of concern among adolescents in Kenya. According to 2014 KDHS, about 7% girls and 3% of boys aged 15-19 years have ever experienced sexual violence, while 32% of girls and 42% of boys reported ever experiencing physical violence since age 15. The capacity of the adolescents to report violence remains limited with only 33% of girls and 20% of boys aged 15 – 19 years demonstrating capacity to seek help[8]. The national prevalence of female genital mutilation (FGM) on the other hand stands at 11% among adolescent girls aged 15-19 years, with disparities ranging from 1% in Western to 98% in North Eastern region[9].

The government of Kenya has made progress in creating an enabling policy environment to address some of the sexual and reproductive health concerns of adolescents. This commitment is evident in the national policies, legislations and guidelines that the government has put in place, including the National Adolescent Sexual Reproductive Health Policy which is the subject of this Implementation Framework 2017 – 2021.

1.2 Principles

The implementation of interventions spelt out in this framework shall be guided by the following principles as stated in the National Adolescent Sexual Reproductive Health (ASRH) policy:

a) Respect for human rights and fundamental freedoms including the right to life, human dignity, equality and freedom from discrimination on the basis of gender, sex, age, disability, health status, geographical location or social, cultural and religious beliefs and practices.

b) Responsiveness to varying sexual and reproductive health needs of adolescents in provision of care.

c) Provision of holistic and integrated ASRH information and services through multi-pronged and multi-sectoral approaches that are effective and efficient in reaching adolescents with information and services.

d) Recognition of the critical role parents, guardians and communities play in the promotion of SRH of adolescents.

e) Meaningful involvement of adolescents in the planning, implementation, monitoring and evaluation of ASRH programs.

f) Utilization of evidence-based interventions and programming.

1.3 Rationale

The National ASRH Policy (2015) was developed to provide guidance to the national and county governments, development partners and civil society organizations on how to respond to adolescents' SRH needs. The implementation of the Policy calls for substantial operational changes to respond to county-specific ASRH needs. This

Implementation Framework therefore outlines: 1) strategies and key interventions for the achievement of the specific objectives stated within the policy; 2) resource requirements for the specific interventions; and 3) a monitoring and evaluation framework to track progress in implementation of the policy.

1.4 The Process of developing the Implementation Framework

The development of this implementation framework was extensively consultative. It was guided by a multi-sectoral technical working group, led by a task force comprised of national and county governments, international and local NGOs, development partners and adolescent and youth representatives. Various documents were reviewed in the drafting of the implementation framework, and in the formulation and design of the strategies and interventions outlined in the document. National and County stakeholders including RH inter-agency coordination committee (RH/ICC), county directors of health and county RH coordinators among others were engaged in the drafting and validation of this implementation framework.

1.4 Goal and Objectives of National ASRH Policy Implementation Framework

1.4.1 Goal

The overall goal of this National ASRH Policy Implementation Framework is to facilitate the operationalization of the National ASRH Policy.

1.4.2 Objectives

The objectives of the Implementation Framework are to:

1. Outline key intervention areas, strategies, and actions to enhance the sexual and reproductive health of adolescents in Kenya
2. Provide guidance for costing or estimating resource requirements for implementation of the policy
3. Outline the institutional arrangements for management and coordination of ASRH programs at national and county levels.
4. Provide a monitoring and evaluation framework for tracking implementation of the Policy at national and county levels

2.0 INTERVENTION AREAS, STRATEGIES AND PRIORITY ACTIONS

This section describes the intervention areas, strategies and priority actions that will be undertaken to ensure the realization of the stated ASRH Policy goals and objectives.

The nine intervention areas include:

1. Health systems strengthening
2. ASRH and rights
3. ASRH information and sexuality education
4. STIs, HPV and HIV
5. Early and unintended pregnancy
6. Harmful traditional practices
7. Drug and substance abuse
8. Sexual and gender-based violence and response
9. Marginalized and vulnerable adolescents.

Sections 2.1 – 2.9 provide brief description of the intervention areas, objectives, strategies, and the expected outcomes. A matrix is also provided for each intervention area highlighting strategies, indicators, lead activities, actors and a proposed time frame.

2.1 Intervention area *One*: Health systems strengthening for quality ASRH

A functional health system is key in addressing adolescent SRH service needs. According to WHO, programs and services for adolescents are highly fragmented, poorly coordinated and uneven in quality.1011 The development and implementation of national quality standards and monitoring systems is therefore critical in transforming how health systems respond to the SRH needs of adolescents.

The ASRH Policy identified several health systems requirements for effective management and coordination of ASRH programs and services. These requirements include: health financing and sustainability, health leadership, management and governance, health products and technologies, health information, health work force, service delivery systems and health infrastructure.

Objectives

1. To strengthen leadership, management and governance for effective coordination of ASRH programs at national and county levels.
2. To enhance service delivery systems, supply chain management, health infrastructure and human resources for effective provision of quality adolescent-friendly SRH services
3. To promote the development of sustainable financing mechanisms for ASRH programs and services
4. To strengthen health management information systems at national and county levels for effective collection, analysis and utilization of age and sex disaggregated data

Expected outcomes:

1. Increased availability and access to quality adolescent-friendly sexual and reproductive health services including information
2. Increased availability of age and sex disaggregated data for evidence-based decision making in ASRH

Intervention Area 1 : Health System Strengthening for quality ASRH									
Strategies	**Indicators**	**Lead Activities**	**Actors**	**Timeframe**					
				2017	**2018**	**2019**	**2020**	**2021**
1.Health financing and sustainability									
a. Development of a sustainable financing mechanism for ASRH programs and services	Budgets/resources allocated for ASRH programs in the public and private sectors – both at national and county levels	Develop a resource mobilization strategy for ASRH programs and services	MOH – RMHSU National treasury NCPD County departments of health (CDH) County treasury/Dept. of Finance County Planning Dept. County Assembly Committee for Health and Budget/Finance Development and Implementing Partners Communities	X	X	X	X	X
		Conduct evidence-based advocacy for creation of budget lines or increased budget allocation for ASRH programs and services		X	X			
		Coordinate and harmonize donor and partner support • Undertake donor and partner mapping • Establish donor and partner coordination forums		X	X	X	X	X
		Integrate ASRH programs into County Integrated Development Plans (CIDP)		X	X			
		Develop costed annual work plans for ASRH programs and services		X	X	X	X	X
b. Establishment and Strengthening mechanisms for accountability	Functional financial tracking systems for accountability at all levels	Establish and/or strengthen a functional reporting and feedback mechanism	MOH – RMHSU, Healthcare financing dept. (national) CHMT/ Chief officer of health (COH) Development and Implementing Partners Adolescents Communities	X	X	X	X	X
		Establish and/or strengthen programme based budgeting and allocation of funds for ASRH programme and services.		X	X	X	X	X

Intervention Area 1 : Health System Strengthening for quality ASRH								
Strategies	**Indicators**	**Lead Activities**	**Actors**	**2017**	**2018**	**2019**	**2020**	**2021**
2. Health Leadership, Management and Governance								
a. Capacity building of health management teams to effectively manage and coordinate ASRH programs and services	Competent health management teams (HMT) and focal persons for ASRH programs	Conduct training needs assessment on ASRH	MOH- RMHSU CHMT,SCHMT,HMT Development and Implementing Partners	X	X	X	X	
		Conduct trainings for the HMTs to address the gaps identified in the training needs assessment		X	X	X	X	X
b. Strengthening support supervision for ASRH programs and services	Support supervision mechanisms/systems in place and implemented	Integrate indicators on ASRH into routine health management supervision tools		X	X			
c. Advocacy for mainstreaming or integration of ASRH in other sectoral plans	Evidence that ASRH programs are mainstreamed in other Sectoral Plans	Educate other sectoral teams on the national ASRH policy and other relevant policies, standards and guidelines		X	X	X	X	X
d. Strengthening coordination and partnerships	Functional multi-sectoral ASRH TWGs at both national and county levels Existence of county focal persons or point for ASRH	Identify a county focal coordination point for ASRH programs	MOH- RMHSU CHMT,SCHMT,HMT Development and Implementing Partners	X	X			
		Map out and develop a database of ASRH partners		X	X			
		Establish and/or strengthen multi-sectoral ASRH TWGs		X	X	X		
3. Health Products and Technologies								
a. Strengthening the supply chain management to ensure commodity security	Stock outs of essential RH commodities	Establish and/or strengthen logistics and management information systems for essential RH commodities	MOH- RMHSU CDH/CHMT Development and Implementing Partners	X	X	X	X	X
		Train county teams on forecasting and quantification of essential RH commodities		X	X			
		Procure and distribute essential RH commodities to service delivery points based on need		X	X	X	X	X

Intervention Area 1 : Health System Strengthening for quality ASRH									
Strategies	**Indicators**	**Lead Activities**	**Actors**	**2017**	**2018**	**2019**	**2020**	**2021**
4. Health Information									
a. Strengthening of HMIS for ASRH programs and services	Functional M&E system to track ASRH interventions	Revise and standardize data collection tools to address data gaps, including age and sex disaggregation for adolescents	MOH- RMHSU, HMIS CDH/CHMT	X	X			
		Train health personnel, including frontline health care workers at county levels on newly developed data collection tools and HMIS	Development and Implementing Partners	X	X	X	X	X
		Develop/introduce and implement dashboards for ASRH indicators	Ministry of Planning	X	X			
		Conduct quarterly data quality audits		X	X	X	X	X
		Train Health Personnel on ASRH data management and use for evidence-based decision making		X	X	X	X	X
		Integrate ASRH indicators into National Integrated Monitoring and Evaluation System (NIMES)		X	X			
5.Human Resource and Service Delivery Systems									
a. Capacity strengthening of human resources for health on provision of adolescent friendly SRH services	Human resource for health recruited and deployed to support ASRH services	Conduct training needs assessment on provision of adolescent-friendly SRH services among health care providers	MOH- RMHSU	X	X			
		Conduct trainings for the health service providers to address the gaps identified in the training needs assessment		X		X		
		Develop a training database of health care providers with skills on adolescent friendly service provision	CDH/CHMT	X	X			
	Health care providers trained on provision of adolescent and youth friendly services	Develop and/or review training materials, practice guidelines/job aids on adolescent-friendly SRH services.		X	X	X	X	X
		Advocate for integration of adolescent-friendly SRH modules and guidelines into pre-service training of healthcare trainees	Development and Implementing Partners	X	X	X	X	X
b. Integration of ASRH information and services into Community health strategy and its implementation	ASRH issues are incorporated in Community Health Strategy Number of adolescents referred to health facilities by the community	Train CHEWs, CHAs CHVs and Peer mentors to provide ASRH information and referrals	Training Institutions (KMTC, Universities)	X	X	X	X	X
		Develop /review CHV referral tools to include ASRH						

Intervention Area 1 : Health System Strengthening for quality ASRH									
Strategies	**Indicators**	**Lead Activities**	**Actors**	**2017**	**2018**	**2019**	**2020**	**2021**
6.Health Infrastructure									
Improvement of infrastructure for provision of quality integrated and comprehensive adolescent-friendly SRH services	Health facilities offering quality and comprehensive AFS Number of adolescents accessing ASRH services	Conduct infrastructural needs assessment to assess gaps in the provision of quality integrated adolescent-friendly services	MOH- RMHSU	X	X			
		Undertake need-based health facility renovations to enhance the provision integrated adolescent-friendly service delivery	CDH/CHMT	X	X	X	X	X
		Establish county level model centres of excellence for adolescent-friendly Services	Development and Implementing Partners	X	X			

2.2 Intervention area *Two*: Promote Adolescent Sexual and Reproductive Health and Rights (ASRHR)

The right to health is enshrined in Kenya's constitution 2010 in article 43:1(a), which states; ''every person has the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care''.

The onset of adolescence brings about body changes as well as vulnerabilities to human rights abuses especially in the areas of sexuality, marriage and child bearing. Many adolescents, in particular adolescent girls, are coerced into unwanted sex or marriage putting them at risk of unwanted pregnancies, unsafe abortions, sexually transmitted infections (STIs) including HIV and dangerous childbirth. Despite these challenges, many adolescents face barriers in accessing sexual reproductive health information and services.

Objectives

1. To create an enabling legal, political and socio-cultural environment for the realization of sexual reproductive health and rights among adolescents

Expected Outcome

1. Improved legal, political and socio-cultural environment for the realization of sexual reproductive health and rights among adolescents

Intervention Area 2: Promote Adolescent Sexual and Reproductive Health and Rights								
Strategies	**Strategies**	**Strategies**	**Strategies**	2017	2018	2019	2020	2021
1. Advocacy for multi-sectoral and multi-pronged approaches to address SRHR issues of the adolescents	Sectoral plans integrating rights-based approaches for promotion of ASRH	Disseminate the ASRH policy and relevant legislations to national and county stakeholders – e.g. • Map relevant national and county stakeholders who can support the implementation of the policy • Identify and collaborate with different sectors to disseminate policy and legislation • Develop and disseminate -user-friendly policy briefs	MOH- RMHSU CDH/CHMT Adolescents County Department of Finance MOE Ministry responsible for Youth and Gender Religious leaders Development and Implementing Partners Department of Law enforcement agencies	X	X	X	X	X
		Convene quarterly meetings with multi-sectorial TWGs at national and county level on ASRHR	Department of Children Affairs Community leaders Children Affairs Community leaders Media	X	X	X	X	X

Intervention Area 2: Promote Adolescent Sexual and Reproductive Health and Rights								
Strategies	**Strategies**	**Strategies**	**Strategies**	2017	2018	2019	2020	2021
2. Empowerment of adolescents to participate in decision making processes for improvement of adolescent SRH and rights	Adolescents with comprehensive knowledge about ASRH and rights	Educate adolescents and peers on ASRH policy and relevant legal instruments including dissemination and use of existing youth empowerment manuals, tools and materials	MOH- RMHSU MoE CDH/CHMT Development and Implementing Partners Private sector Ministry responsible for Youth and Gender Ministry of labour social security and services Community leaders; CHAs	X	X	X	X	X
		Support and involve adolescents in existing decision making structures e.g. through community health committees or establishment of a council of adolescents at county level for advisory purposes		X	X	X	X	X
	Adolescents meaningfully participating in decision making process for improvement of ASRH and rights	Strengthen adolescent-adult partnership, engagement and dialogue on ASRHR		X	X	X	X	X
		Support integration of ASRHR into existing/on-going adolescent youth groups initiatives		X	X	X	X	X
		Develop age appropriate, culturally acceptable Information Education Communication (IEC) materials on sexual reproductive health and rights for the Adolescents		X	X	X	X	X

Intervention Area 2: Promote Adolescent Sexual and Reproductive Health and Rights								
Strategies	**Strategies**	**Strategies**	**Strategies**	2017	2018	2019	2020	2021
3. Parental and community education on ASRHR	Level of knowledge about ASRH and rights in the community	Educate gatekeepers, parents and communities on ASRHR • Develop and disseminate -user-friendly policy briefs for parents and communities • Hold community-level policy dialogues with community gatekeepers and opinion leaders	MOH- RMHSU MOE CDH/CHMT Communities Development and Implementing Partners Private sector	X	X	X	X	X
		Develop IEC materials on ASRHR for parents and communities		X	X	X	X	X
		Conduct media campaigns on ASRH • Engage with mainstream electronic and print media programs including opinion editorials and social media platforms		X	X	X	X	X
		Conduct advocacy activities targeting religious leaders, and community gatekeepers		X	X	X	X	X
4.Promote gender mainstreaming in all ASRHR programs	ASRHR programs that have mainstreamed gender	Support gender responsiveness in all ASRH programs • Conduct gender analysis on ASRH Programs. • Conduct sector-specific education on importance of gender mainstreaming in ASRHR	MOH- RMHSU MoE CDH/CHMT Development and Implementing Partners Human Rights institutions	X	X	X	X	X
		Train the community leaders and services providers on gender mainstreaming in ASRHR		X	X	X	X	X

2.3 Intervention area *Three*: Increase access to ASRH information and sexuality education

Every adolescent will at one point have life-changing decisions to make about their sexual and reproductive health. Research however shows that the majority of adolescents lack the knowledge required to make those decisions responsibly, leaving them vulnerable to coercion, STIs including HIV and unintended pregnancy. The KDHS (2014) for instance indicates that only 52% of adolescent girls and 58% of adolescent boys between 15-19 years have comprehensive knowledge of HIV.

The National ASRH Policy (2015) and the Education Sector Policy on HIV and AIDS (2013) call for the provision of SRH information and sexuality education including life skills to adolescents in and out of school. This is further emphasized in the Eastern and Southern Africa Ministerial Commitments (2013). Empowering adolescents with the right information on their sexual reproductive health and rights enables them to protect their health, wellbeing and dignity.

Objectives

1. To equip adolescents with the right knowledge, attitudes and skills to make informed decisions about their sexual reproductive health and to protect themselves against SRH risks
2. To strengthen inter-sectoral coordination, networking, partnerships and community participation in the provision of ASRH information and sexuality education to adolescents

Expected Outcome

1. Improved capacity of adolescents to make informed decisions about their SRH and to protect themselves against SRH risks

Intervention Area 3: Increase access to ASRH information and sexuality education by adolescents								
Strategies	**Indicators**	**Lead Activities**	**Actors**	**2017**	**2018**	**2019**	**2020**	**2021**
1. Strengthening sexuality education and ASRH information for in-school adolescents.	Existence of SRH information/ sexuality education in the school curriculum comprehensive knowledge about SRHR among in-school adolescents	Establish joint programs between MOH, MoE and other relevant partners for the provision of SRH information/sexuality education to adolescents. • Provide technical support to review ASRH related policies, strategies and/or curriculum to embrace sexuality education • Advocate for the training of teachers (pre-service and in-service) on delivery of sexual reproductive health and life skills education in schools • Strengthen guidance and counselling departments in schools to mentor and support adolescents on SRHR matters • Strengthen school health programs to facilitate access to SRH information by learners • Strengthen linkages with MOE for development and dissemination of IEC on ASRH/ sexuality education • Strengthen referral system between MoE and MoH facilities for effective ASRH service delivery • Identify and train champions to advocate for integration / strengthening of ASRH in school health clubs • Develop and disseminate appropriate ASRH messages in school calendar events such as national games, music and drama festivals, students' council meetings	MoH CDH/CHMT MoE Adolescents Development Partners Implementing partners Kenya Primary School Sports Association Kenya Secondary School Sports Association Kenya Secondary School Head Association (KESSHA) Kenya Primary Schools Heads Association (KEPSHA)	X	X	X	X	X
		Educate teachers, tutors and other relevant personnel on emerging ASRH issues and how to integrate them in school health programs.		X	X	X	X	X

Intervention Area 3: Increase access to ASRH information and sexuality education by adolescents								
Strategies	**Indicators**	**Lead Activities**	**Actors**	**2017**	**2018**	**2019**	**2020**	**2021**
2. Support provision of ASRH information and sexuality education - for out of school adolescents.	Comprehensive knowledge about SRHR among out-of-school adolescents	Work with adolescents to develop and disseminate age appropriate ASRH messages using a variety of innovative channels	MoH MoE CDH/CHMT Adolescents Ministry responsible for youth and Gender affairs, Ministry of ICT, MLSSS Media Development Partners/ NGOs/FBOs/CBOs Sports Federations and Associations	X	X	X	X	X
		Establish partnerships with community structures and initiatives for provision of ASRH information and sexuality education to out-of-school adolescents. • Conduct targeted community dialogues using various channels and forums • Develop a national standardized manual to train parents on provision of accurate ASRH information and sexuality education • Build the capacity of religious leaders to support the provision of SRH information /sexuality education to adolescents, parents and communities using their platforms • Develop simple ASRH information modules for use by CHVs • Educate CHVs to support the provision of ASRH information to adolescents, parents and communities • Disseminate ASRH messages through sporting events in partnership with the Ministry responsible for Sports, sports associations and sports federations • Disseminate ASRH information through established youth empowerment structures like Youth Empowerment Centers, in partnership with the Ministry responsible for youth		X	X	X	X	X
		Support provision and utilization of technological advances and innovations to enhance access to SRH information/sexuality education • Develop an inventory of best practices in mhealth and social media approaches to ASRH programming and service delivery • Support scale up of evidence-based technological innovations and best practices in ASRH programming and service delivery	MoH, MoE, CDH/ CHMT Ministry of ICT Development Partners/ NGOs/FBOs/CBOs	X	X	X	X	X

2.4 Intervention Area *Four:* Reduce STIs, including HPV and HIV among adolescents

In Kenya, AIDS remains the leading cause of mortality and morbidity among adolescents and young people, with approximately 29% of all new HIV infections are among adolescents and youth. Young women aged 15 – 24 years post the highest number of HIV infections and contribute 21% of all new infections in Kenya[1]. In addition, STIs and reproductive tract infections (RTIs) are also a serious health problem in developing countries like Kenya, particularly among women[2]. Consequences of untreated STIs and RTIs include maternal complications, such as ectopic pregnancy, pelvic inflammatory disease and infertility, cancer, neonatal complications and death. STIs and other RTIs have also been proven to increase the likelihood of contracting or transmitting HIV.[12]

There is therefore a need for targeted and appropriate interventions for adolescents and particularly adolescent key populations, who are at a greater risk of HIV infections with little or no appropriate interventions targeting them. This plan specifies key strategies that will prioritize interventions to address HIV, STI, and HPV among adolescents.

Objectives

1. To enhance equitable access to high quality, efficient and effective adolescent friendly ASRH information and services aimed at reducing STIs, HPV and HIV infection among adolescents
2. To minimize the burden of STIs including HPV and HIV, on adolescents

Expected Outcome(s):

1. Increased availability and accessibility of HIV, STI/RTIs and HPV -related information and services by the adolescents
2. Increased uptake of HIV, STI/RTIs and HPV services among adolescents
3. Increased availability of SRH tailored services and interventions for marginalized and vulnerable populations including adolescent key populations on HIV STIs and RTIs prevention and treatment research.
4. Reduced incidence of STIs including HPV and HIV among adolescents
5. Reduced mortality and morbidity from STIs including HPV and HIV, among adolescents

1 Republic of Kenya (2015): Kenya Fast Track Plan to End HIV&AIDS among Adolescents and Young People
2 Republic of Kenya (2013): Kenya Population Situation Analysis

Intervention Area *Four*: Reduce STIs, including HPV and HIV among adolescents								
Strategies	**Indicators**	**Activities**	**Actors**	**2017**	**2018**	**2019**	**2020**	**2021**
1. Promoting or enhancing access to accurate information on STIs/RTIs, HPV and HIV&AIDS to all adolescents including marginalized, vulnerable and key population adolescents	Comprehensive knowledge on STIs/RTIs/ HPV &HIV&AIDS among adolescents including marginalized, vulnerable & key population adolescents and communities	Develop and disseminate age- appropriate ASRH information on STIs, HIV and HPV using a variety of innovative channels	Ministry of Health (MoH) – NASCOP, NACC, CDH/CHMT,	X	X	X	X	X
		Train and provide regular updates to service providers on provision of HIV, STIs HPV information to adolescents	Relevant County government departments	X	X	X	X	X
		Provide adolescents including marginalized, vulnerable adolescents and adolescent key populations, with tailored information on STIs, RTIs, HIV and AIDS prevention including New Prevention Technologies (NPTs)		X	X	X	X	X
		Engage adolescents meaningfully in education on transmission and prevention of STIs/RTIs, HPV and HIV&AIDS	Partners including those working with key populations	X	X	X	X	X
		Establish and strengthen appropriate forums for engagement with parents, religious leaders etc. on the provision of SRH, HIV, STI, HPV information and services	Peer mentors and adolescents	X	X	X	X	X
		Conduct demand creation activities e.g. Campaigns, media talks, outreaches to sensitize adolescents on STIs/RTIs/HPV &HIV&AIDS	Media	X	X	X	X	X

Intervention Area *Four*: Reduce STIs, including HPV and HIV among adolescents								
Strategies	**Indicators**	**Activities**	**Actors**	**2017**	**2018**	**2019**	**2020**	**2021**
2. Promotion of screening, testing and treatment of HIV, STIs/ RTIs and HPV among marginalized, vulnerable and key population adolescents.	- Facilities offering Adolescent friendly HIV/STIs/ HPV services - Adolescents accessing HIV, STI/RTI and HPV services - Prevalence of HIV, STIs/ RTIs and HPV among adolescents	Organize service delivery points and health facilities to provide adolescent tailored SRH services	MoH-RMHSU /NASCOP, NVIP,	X	X	X	X	X
		Conduct trainings for health care providers on provision of adolescent friendly health services	CDH, CHMT,	X	X	X	X	X
		Integrate STI/RTI and HIV screening and treatment in RH services and other health care services		X	X	X	X	X
		Involve adolescents in the development of HIV/ STI/RTI/HPV IEC materials and dissemination using a variety of innovative channels	Partners	X	X	X	X	X
		Provide targeted HIV, STI, RTI and HPV treatment and prevention options specific to marginalized, vulnerable and key population adolescents e.g. PrEP and HPV vaccines according to approved guidelines	Adolescents	X	X	X	X	X
3. Promotion of Voluntary Medical Male Circumcision (VMMC) for all adolescent boys including marginalized and vulnerable adolescent boys	- Adolescents accessing VMMC services - VMMC rates among adolescents	Provide relevant VMMC information, services and referral pathways for adolescents	MOH/NASCOP, CDH/CHMT and partners	X	X	X	X	X
		Develop and disseminate VMMC IEC materials using a variety of innovative channels		X	X	X	X	X

Intervention Area *Four*: Reduce STIs, including HPV and HIV among adolescents								
Strategies	**Indicators**	**Activities**	**Actors**	**2017**	**2018**	**2019**	**2020**	**2021**
4. Scaling up HPV vaccination for adolescents	Adolescents accessing HPV vaccination HPV vaccination rates among adolescents Level of knowledge about HPV vaccine among the adolescents and communities	Procure and provide HPV vaccines at all levels	MOH, KEMSA, CDH/CHMT and partners	X	X	X	X	X
		Educate the community and adolescents on the importance of HPV vaccinations		X	X	X	X	X
		Train health workers on HPV vaccine provision		X	X	X	X	X
5. Promote generation and utilization of adolescent age and sex disaggregated data on STIs/RTIs/HPV &HIV&AIDS	Existence of a functional HMIS system that tracks adolescent specific data on STIs/RTIs/HPV &HIV&AIDS	Review, develop and disseminate data collection and reporting tools for ASRH programs	MOH – RMHSU/NASCOP/ CDH/CHMT Partners	X	X	X		
		Train health care providers on DHIS including ASRH data tools		X	X	X	X	X
		Train health service providers on data management for decision making		X	X	X	X	X
		Educate providers on the importance of capturing and reporting adolescent specific data and strengthen data collection systems		X	X	X	X	X

Intervention Area *Four*: Reduce STIs, including HPV and HIV among adolescents								
Strategies	**Indicators**	**Activities**	**Actors**	**2017**	**2018**	**2019**	**2020**	**2021**
6. Support research on HIV & STI/RTIs prevention and treatment among all adolescents, including marginalized, vulnerable and key population adolescents	Utilization of research products in ASRH-related policy formulation and interventions	Educate stakeholders about all research guidelines including Guidelines for Conducting HIV Sexual and Reproductive Health Research in Kenya[1]	MoH, RMHSU/NASCOP	X	X	X	X	X
		Conduct, document and disseminate tailored operational, implementation science and basic research on prevention and treatment of HIV, HPV, STIs and RTIs among marginalized, vulnerable and adolescent Key population	KEMRI CDH/CHMT,	X	X	X	X	X
		Include HIV, STI and RTI tailored prevention and treatment research in national and county research agenda specifically for marginalized, vulnerable and key populations adolescents	partners	X	X	X		
		Include New Prevention Technologies (NPTs) research for HIV prevention tailored for adolescents in national and county plans	other tertiary research institutions	X	X	X	X	X

2.5 Intervention Area: *Five*: Early and unintended pregnancy

The 2014 KDHS shows that by age 15, 21% of boys and 12% of girls had initiated sex[3]. The unmet need for contraception was higher among married adolescent girls (23%) compared with married women (18%), while the teenage pregnancy rate stands at 18%.

Early and unintended pregnancies pose major long term health and socio-economic implications to adolescent girls and limits their future lifetime opportunities. Studies show that adolescents aged 15 – 19 years are twice as likely to die during pregnancy and childbirth as those aged over 20 years[4].

Objectives

1. To enhance equitable access to high quality, efficient and effective adolescent friendly SRH information and services to reduce early and unintended pregnancy among adolescents
2. To strengthen inter-sectoral coordination, networking, partnerships and community participation in reducing early and unintended pregnancy among adolescents.

Expected Outcomes:

1. Reduced early and unintended pregnancy among the adolescents.
2. Increased access and uptake of ASRH information and services among adolescents.
3. Improved inter-sectoral coordination for the reduction of early and unintended pregnancy among the adolescents.
4. Increased school retention, transition and completion rates among adolescent girls
5. Reduced mortality and morbidity arising from early and unintended pregnancy among adolescent girls

3 Republic of Kenya (2014): Kenya Demographic and Health Survey
4 Republic of Kenya (2013): Kenya Population Situation Analysis

Intervention Area: *Five*: Early and unintended pregnancy								
Strategies	**Indicators**	**Activities**	**Actors**	**2017**	**2018**	**2019**	**2020**	**2021**
1. Promoting the provision of accurate information to prevent early and unintended pregnancies among adolescents	Comprehensive knowledge among adolescents on pregnancy prevention	Work with adolescents to develop and disseminate accurate ASRH information on pregnancy prevention including abstinence and contraception using conventional and digital platforms	RMHSU-MOH, CDH/CHMT	X	X	x	X	X
	Contraceptive Prevalence Rate (CPR) among adolescents	Integrate ASRH information within the school health programme framework and through other existing education sector forums.		X	X	X	X	X
		Train teachers, tutors, wardens and other relevant personnel to offer ASRH information and referral services	partners including private sector	X	X	X	X	X
	Adolescent fertility rate	Educate community leaders, religious leaders, parents, local administration, CHAs, CHVs, peer mentors for provision of ASRH information on pregnancy prevention including contraception.	MoE, Peer champions, Community, Parents, Adolescents	X	X	X	X	X
2. Strengthening existing service delivery points for provision of accurate adolescent friendly information and services on pregnancy prevention.	Functional AYFS facilities	Integrate AYFS into existing structures and systems	MoH, CDH/CHMT and partners	X	X	X		
		Procure & provide equipment and commodities to enhance provision of comprehensive ASRH services	Adolescents	X	X	X	X	X
	CPR among adolescents	Conduct Values Clarification and Attitudes Transformation (VCAT) on AYFS for service providers and health managers		X	X	X	X	X
	Adolescent fertility rate	Train/update service providers on provision of comprehensive ASRH services		X	X		X	

Intervention Area: *Five*: Early and unintended pregnancy								
Strategies	**Indicators**	**Activities**	**Actors**	**2017**	**2018**	**2019**	**2020**	**2021**
3. Strengthening the provision of maternal health services to all pregnant and lactating adolescents, including the marginalized and vulnerable adolescents	Facility readiness[2] to provide adolescent-youth friendly services	Establish/strengthen parental and community support structures/systems for all pregnant adolescents.	MoH, CDH/CHMT and partners Adolescents	X	X	X		
		Provide free adolescent-friendly maternal and child health services.		X	X	X	X	X
		Strengthen linkages and effective referral systems for pregnant and lactating adolescents to appropriate and relevant services		X	X	X	X	X
	Adolescents using ANC, skilled birth delivery, PAC and PNC services	Provide age-disaggregated data on maternal and perinatal death reporting and reviews at all levels.		X	X	X	X	X
		Strengthen the health systems/structures to provide adolescent-friendly MNH, ANC,PNC and PAC		X	X	X	X	X
4. Promotion of male engagement in prevention of early and unintended pregnancy	Adolescent CPR Adolescent fertility rate Age at first sex among males aged 10-19	Educate, mobilize and engage male community members on prevention of early and unintended pregnancies and child marriages using various platforms and fora	MoH, CDH/CHMT and partners Male Community Initiatives	X	X	X	X	X
		Identify and train male champions on prevention of early and unintended pregnancies		X	X	X	X	X
5. Promotion of School Re-entry of adolescent mothers	School enrolment and transition rate among girls	Support the implementation of the return to school policy by MOE for adolescent mothers	MoE, MoH, CDH/CHMT political and community leaders and partners	X	X	X	X	X
		Educate parents/ guardians and community at large on MOE's school re-entry policy		X	X	X	X	X
		Educate in and out of school pregnant adolescents on school re-entry policy.		X	X	X	X	X
		Conduct education campaigns on anti-stigmatization of pregnant and adolescent mothers		X	X	X	X	X
		Support MOE in sensitizing teachers and head teachers on return to school policy						

Intervention Area: *Five*: Early and unintended pregnancy								
Strategies	**Indicators**	**Activities**	**Actors**	**2017**	**2018**	**2019**	**2020**	**2021**
6.Strengthening inter-sectorial coordination for effective prevention of early and unintended pregnancy	Functional multi-sectorial ASRH TWGs at national and county levels	Establish/strengthen multi-sectorial ASRH TWGs at national and county level	MoH, CDH/CHMT Other relevant sectors	X	X	X	X	
		Convene quarterly meetings with multi-sectorial ASRH TWGs at national and county level to coordinate teenage pregnancy prevention efforts		X	X	X	X	X
		Coordinate the development of multi-sectorial strategies and action plans to address teenage pregnancy at the county level		X	X	X		

2.6 Intervention area *Six*: Addressing Harmful Traditional Practices (HTPs)

The ASRH Policy (2015) identifies Female Genital Mutilation (FGM) and child marriage as the main HTPs within the Kenyan context. Indeed, there's need for more concerted efforts by stakeholders to ensure that laws concerning FGM, child marriage and return to school for teenage mothers, are enforced/implemented. In addition, there is need to build the capacity of communities on HTPs and their implications. The 2013 Adolescent Reproductive Health and Development (ARHD) policy assessment noted that cultural practices and gender norms can hinder implementation of ASRH interventions because of the influence they have on behavioral expectations.

Objectives

1. To strengthen partnerships and community participation in eliminating HTPs among adolescents
2. To increase gender equity and equality in SRH among adolescents
3. To minimize the burden of harmful traditional practices on adolescents

Expected outcomes

1. Improved legal and policy environment for protection of adolescents against HTPs
2. Increased access to quality reproductive health services that are responsive to HTPs for adolescents
3. Reduced incidence of child marriage
4. Reduced incidence of FGM among adolescents
5. Increased school retention, transition and completion rates among adolescent girls and adolescent mothers
6. Reduction in health related complications arising from HTPs

Intervention area *Six*: Addressing Harmful Traditional Practices (HTP)								
Strategies	**Indicators**	**Activities**	**Actors**	**2017**	**2018**	**2019**	**2020**	**2021**
1.Strengthening the capacity of institutions, communities, families and individuals to prevent and respond to HTPs affecting adolescents	Prevalence of HTPs among adolescents Communities with comprehensive knowledge about effects of HTPs on ASRH	Disseminate the ASRH policy and AYFS guidelines, and other relevant policies and laws addressing girl child education, child labor, child marriage, and FGM	MoH, CDH/CHMT, MoE, NCPD, Ministry responsible for Gender and Youth, human rights organizations, National Police Service, Judiciary, National Council for Children Services, Directorate of Children Services Media,	X	X	X	X	X
		Develop partnerships with relevant agencies that advocate for implementation and enforcement of anti-HTP policies and laws		X	X	X	X	X
		Develop partnerships with relevant institutions that enforce anti-HTPs legislations and policies		X	X	X	X	X
		Develop and disseminate IEC materials on harmful traditional practices and identify innovative channels of dissemination.		X	X			
		Identify and train Anti HTPs champions and change agents including adolescents		X	X	X		
		Conduct community campaigns on the Negative effects of HTPs - Hold sensitization and training events on HTPs		X	X	X	X	
		Document and share success stories and best practices on prevention and response to adolescents affected by HTPs		X	X	X	X	X
2. Promote Male involvement in prevention of HTPs	Males (10-19 years) with comprehensive knowledge about HTPs	Support and partner with community leaders to address HTPs	MoH, Community Leaders, County leadership, peer support groups, Male community initiatives Development and Implementing Partners Media,	X	X	X	X	X
		Identify, train and engage male champions in the existing anti HTP structures		X	X			
		Document and share of success stories and best practices on male involvement				X		X

Intervention area *Six*: Addressing Harmful Traditional Practices (HTP)								
Strategies	**Indicators**	**Activities**	**Actors**	**2017**	**2018**	**2019**	**2020**	**2021**
3. Support management of health consequences of HTPs	Adolescents accessing psycho-social support, treatment and rehabilitation services for HTPs	Establish and strengthen psycho-social support and treatment mechanisms and facilities for HTPs	MoH, CDH/CHMTs, CHAs/CHVs, communities, Development and Implementing partners	X	X	X	X	X
		Build capacity of service providers on psycho-social counselling		X	X			
		Incorporate communities into the rehabilitative mechanisms		X	X	X	X	X
4. Support implementation and enforcement of appropriate policies and laws to reduce prevalence of HTPs	Prevalence of HTPs among adolescents	Work with partners to educate law enforcers / agencies/health workers on HTPs	MoH, CDH/CHMTs, Ministry of Interior and Coordination of National Government, Directorate of Children Services, Dev. partners Judiciary, Dev. partners, Community leaders	X	X	X	X	X
	Adolescent HTP survivors obtain re-dress from the justice system	Hold community level education forums on justice and re-dress- seeking procedures		X	X	X	X	X
5. Support programs and research on HTPs for promotion of evidence based interventions	Interventions addressing HTPs among adolescents informed by research products	Partner with research organizations to generate and disseminate evidence on interventions and response to HTPs	NCPD, KNBS, and Research Institutions	X	X	X	X	X

Intervention area *Six*: Addressing Harmful Traditional Practices (HTP)								
Strategies	**Indicators**	**Activities**	**Actors**	**2017**	**2018**	**2019**	**2020**	**2021**
6. Support Community and institutional education on re-integration of adolescents affected by HTPs in school	Adolescents being re-integrated back into the school system - School enrolment rate among adolescents who have experienced HTPs - Education transition rate among adolescents who have experienced HTPs	Partner with the MOE to educate communities and school staff on reintegration of adolescents affected by HTPs in School.	MoH, MoE, FAWE, County administration, Development partners Adolescents HTP survivors	X	X	X	X	X
		Work with MOE to enforce the re-entry policy to school		X	X	X	X	X
		Work with partners and relevant agencies to develop rescue and rehabilitation mechanisms and interventions for adolescents affected by HTPs		X	X	X	X	X

2.7 Intervention Area *Seven*: Drug and substance abuse (DSA)

Adolescence is a time when the influence of peers and parents, as well experimentation and exploration with tobacco, alcohol and illicit drugs is significant.[5]. A study conducted by NCPD in 2015 indicated that, all the counties in Kenya reported that DSA is a rising concern and the practice is increasingly becoming common among both in-and out-of-school adolescents and youth[6]. A survey conducted by APHRC in a Nairobi urban slum in 2012, indicated that age 14 is a threshold where use of alcohol increases from about 7% to 40% in boys and about 4% to 17% in girls.

These are risky behaviors that can cause negative impact on adolescent health and well-being with negative life-long consequences. Substance use and abuse compromises decision making and is associated with increased risk for early sexual debut, multiple sexual partners and early childbearing. The need for active partnerships, community and adolescent participation to address the use and abuse of drugs and other substances cannot therefore be over-emphasized. Interventions to be put in place must aim to strengthen multisector approaches and actively involve the adolescents to help reduce the problem.

Objectives

1. To strengthen the health and community systems and structures to provide counselling, treatment and rehabilitation of adolescents affected by drugs and substance abuse.
2. To strengthen inter-sectoral coordination, networking, partnerships, community, parents/guardians and adolescents participation and leadership in prevention of drugs and substance abuse among adolescent.

To minimize the burden of drugs and substance use and abuse on the health and well-being of adolescents

Expected Outcome(s):

1. Improved coordination in prevention and response to drug and substance abuse among adolescents
2. Improved access to quality treatment and rehabilitative services for adolescents who have been exposed to drugs and substance abuse

5 Republic of Kenya (2013): Kenya Population Situation Analysis
6 Republic of Kenya (2015): National Adolescent and Youth Survey – *Preliminary report*

Intervention Area *Seven:* Drug and substance abuse (DSA)								
Strategies	**Indicators**	**Activities**	**Actors**	**2017**	**2018**	**2019**	**2020**	**2021**
1. Ensure provision of quality and effective treatment and rehabilitation services for adolescents affected by drugs and substance abuse.	- Functional drugs and substance use/abuse counselling facilities and/ or services - Adolescents accessing counselling services	Provide counselling services for adolescent drugs and substances users.	MOH, RMHSU CHMT, KEMSA, MOH- Mental Health Unit NACADA, Faith leaders, adolescents, Partners	X	X	X	X	X
		Procure and provide commodities for provision of treatment services for drugs and substance users.		X	X	X	X	X
	- Adolescents accessing treatment and rehabilitation services	Train Health care workers/ counsellors on identification, management and rehabilitation services to adolescent drugs and substance users.		X	X	X		X
		Strengthen referrals and linkages in the management of drugs and substance users.		X	X	X	x	x
	- Prevalence of drug and substance use among adolescents	Improve the available Rehabilitation Centres to provide appropriate services to the adolescents.		x	X	X	X	

Intervention Area *Seven:* Drug and substance abuse (DSA)								
Strategies	**Indicators**	**Activities**	**Actors**	**2017**	**2018**	**2019**	**2020**	**2021**
2. Establishment/ Strengthening of multi-sectoral linkages for prevention and control of drug and substance abuse	Functional referral systems	Institute mechanisms for involvement of adolescents, families and communities in the prevention and management of drug and substance abuse among adolescents	MOH, CHMT, MOE Partners parents, communities MOH- RMHSU/Mental Health Unit NACADA, adolescents Ministry of internal security (MOIS)	X	X	X	X	X
	- Adolescents being re-integrated back into the school system	Engage the MOE to encourage re-admission into school of adolescents after successful rehabilitation		X	X			
	- School enrolment rate among adolescents	Formation of TWGs to spearhead the coordination for prevention, control and management of drugs and substance abuse		X				
	- Education transition rate among adolescents							
	Prevalence of drug and substance use and abuse among adolescents	Support enforcement of relevant supportive policies and laws on drug, alcohol and other substances by adolescents		X	X	X	X	X
3. Ensure provision of accurate information on dynamics and dangers of drug and substance abuse through in-/out-of- school programs	Prevalence of drug and substance use and abuse among adolescents Comprehensive knowledge of the dynamics and dangers of drugs and substance abuse among adolescents	Integrate DSA messages into ASRH information delivery packages and channels.	MOH, CDH/CHMT, NACADA partners Ministry of ICT, adolescents	X	X			
		Provide technical support to MOE to integrate drug and SA messages into the education curriculum		X	X	X	X	X
		Develop and integrate information and messages on dangers of drug and SA into existing digital platforms, including adolescent friendly social media		X	X		X	

2.8 Intervention area *Eight*: Reduction of Sexual and gender-based violence (SGBV) and response

Adolescent girls in Kenya are more likely to experience sexual violence compared to adolescent boys. According to the 2014 KDHS, about 7% adolescent girls and 3 % adolescent boys have ever experienced sexual violence. The National Adolescent and Youth Survey (NAYS) 2015, indicated that SGBV is a major public health problem among the young people, therefore interventions must aim to increase gender equity in provision of SRH information and services to adolescents.

Objectives

1. To strengthen inter-sectoral coordination, networking, partnerships and community participation to reduce sexual and gender based violence being experienced by adolescents
2. To strengthen prevention and response to SGBV among adolescents.
3. To minimize the burden of SGBV on adolescents

Expected Outcomes:

1. Improved legal and policy environment for protection of adolescents against SGBV and response
2. Improved access to quality treatment and rehabilitative services for adolescents who experience SGBV
3. Reduced prevalence of SGBV among adolescents
4. Reduced vulnerability of adolescents to SRH risks arising from SGBV

Intervention area *Eight:* Sexual and gender-based violence and response								
Strategies	**Indicators**	**Activities**	**Actors**	**2017**	**2018**	**2019**	**2020**	**2021**
1. Community empowerment on SGBV prevention and response	Accurate and comprehensive knowledge levels in the community about SGBV prevention and response services Adolescents accessing SGBV information and response services	Undertake mapping of existing SGBV response programs and services	MoH, MoE, CDH/CHMT Ministry of Public service, Youth, Gender and Social Services, Judiciary, Kenya police service Human rights agencies, CHAs, CHVs and youth groups/organizations; Development partners Implementing partners	X	X			
		Educate adolescents, families and communities about various forms of SGBV and existing SGBV prevention and response services • Work with youth-led organizations and initiatives to educate adolescents on SGBV and existing prevention and response services • Conduct community anti-SGBV campaigns • Partner with MoE to develop SGBV educational materials to compliment content in the current school curriculum • Partner with relevant agencies to develop anti-SGBV messages and IEC materials		X	X	X	X	X

Intervention area *Eight:* Sexual and gender-based violence and response								
Strategies	**Indicators**	**Activities**	**Actors**	**2017**	**2018**	**2019**	**2020**	**2021**
1. Community empowerment on SGBV prevention and response	Accurate and comprehensive knowledge levels in the community about SGBV prevention and response services Adolescents accessing SGBV information and response services	Undertake mapping of existing SGBV response programs and services	MoH, MoE, CDH/CHMT Ministry of Public service, Youth, Gender and Social Services, Judiciary, Kenya police service Human rights agencies, CHAs, CHVs and youth groups/organizations; Development partners Implementing partners	X	X			
		Educate adolescents, families and communities about various forms of SGBV and existing SGBV prevention and response services • Work with youth-led organizations and initiatives to educate adolescents on SGBV and existing prevention and response services • Conduct community anti-SGBV campaigns • Partner with MoE to develop SGBV educational materials to compliment content in the current school curriculum • Partner with relevant agencies to develop anti-SGBV messages and IEC materials		X	X	X	X	X

Intervention area *Eight:* Sexual and gender-based violence and response								
Strategies	**Indicators**	**Activities**	**Actors**	**2017**	**2018**	**2019**	**2020**	**2021**
2. Promotion of male engagement in prevention of SGBV	Males with comprehensive knowledge about various forms of SGBV and prevention of SGBV	Support and partner with community leaders to address SGBV Hold workshops for community leaders on SGBV prevention and response services Involve men in the existing community structures/ institutions Identify and train male champions on SGBV prevention and response	MoH, CDH/CHMT, Ministry of Public service, Youth, Gender and Social Services, Youth groups/organizations Judiciary,	X	X	X	X	X
3. Strengthening provision of medical, legal & psychological support for adolescent survivors of SGBV	Functional psycho-social support system Functional community supported safe houses Functional recovery/rehabilitation centres Existence of systems of re-integration of adolescent survivors of SGBV in the community Adolescent SGBV survivors accessing safe houses and recovery centres Adolescent SGBV survivors accessing treatment and legal services	Establish and strengthen psycho-social support services for adolescents • Train service providers on psycho-social counselling and post rape care • Partner with the communities in the development of safe houses and recovery centres for rehabilitation and integration of adolescent survivors of SGBV • Integrate SGBV management, treatment and prevention SGBV in AYF services Partner with legal aid organizations for the provision of legal services to adolescent survivors of SGBV	the Kenya Police Service, Community leadership, Development and Implementing partners Adolescents	X	X	X	X	X

Intervention area *Eight:* Sexual and gender-based violence and response								
Strategies	**Indicators**	**Activities**	**Actors**	**2017**	**2018**	**2019**	**2020**	**2021**
4. Capacity building of health service providers and stakeholders on prevention, response and management of SGBV	Prevalence of SGBV among adolescents Adolescent SGBV survivors accessing protection services	Disseminate relevant policies, law and strategies addressing SGBV	MoH, CDH/CHMT, Ministry of Interior and Coordination, National Council for Children, Directorate of Children Services, Youth organizations, religious leaders, Development and Implementing partners SGBV Survivors, Ministry of Public Service, Youth, Gender and Social Services, Advocacy CBOs, youth organizations, law enforcement agencies, Development and Implementing partners	X	X	X	X	
		Train law enforcers including members of the national administration on SGBV prevention and response services Training of health care workers on SGBV		X	X			
5. Support advocacy for enforcement of laws that protect the rights of adolescents	Adolescent SGBV survivors accessing justice and protection services Prevalence of SGBV among adolescents Number of SGBV Cases reported to law enforcers	Conduct situation analysis on SGBV	MoH, CDH/CHMT Community leadership, Ministry of Public Service, Youth, Gender and Social Services, law enforcement agencies, Advocacy CBOs, youth organizations, Development partners	X	X			
		Work with community-led initiatives and partners to educate communities on anti-SGBV laws and their rights in seeking justice		X	X	X	X	X
		Advocate for establishment and/or strengthening of community structures for prevention and response to SGBV		X	X	X	X	X
	SGBV perpetrators brought to justice	Advocate for full enforcement of laws relating to SGBV by law enforcement agencies to ensure that perpetrators are brought to justice		X	X	X	X	X

Intervention area *Eight:* Sexual and gender-based violence and response								
Strategies	**Indicators**	**Activities**	**Actors**	**2017**	**2018**	**2019**	**2020**	**2021**
6. Strengthening inter-sectorial coordination for effective SGBV prevention and response among adolescents	Functional multi-sectorial ASRH TWGs at national and county levels	Establish/strengthen multi-sectorial ASRH TWGs at national and county level	MoH, CDH/CHMT	X	X	X	X	
		Convene quarterly meetings with multi-sectorial ASRH TWGs at national and county level to coordinate SGBV prevention and response	All the relevant sectors	X	X	X	X	X
		Coordinate the development of multi-sectorial strategies and action plans to address SGBV among adolescents at the county level		X	X	X		

2.9 Intervention Area Nine: Address the SRHR of Marginalized and vulnerable adolescents

The 2010 Kenya Constitution article 43 (1) (A) articulates and guarantees every person the right to the highest attainable standard of health, which includes the right to health care services including reproductive health care. The ASRH Policy 2015 identifies the marginalized and vulnerable adolescents who have unique ASRH needs that call for a targeted response. Marginalized and vulnerable adolescents have limited access to SRH information and services and opportunities for self-advancement. In addition, data capture in service areas for this group of adolescents is often too weak to inform decision making for appropriate response to their needs. The mental health policy (2015-2020) also identifies adolescents with mental health disorder as vulnerable. This intervention area aspires to address the unique SRH needs of the marginalized and vulnerable adolescents

Objectives

1. To enhance equitable access to high quality, efficient and responsive adolescent friendly SRH information and services to address the unique needs of the marginalized and vulnerable adolescents
2. To strengthen inter-sectoral coordination, networking, partnerships and community participation in adolescent SRH
3. To generate and utilize age disaggregated data on marginalized and vulnerable adolescents to guide ASRH programming
4. To improve the sexual reproductive health outcomes among marginalized and vulnerable adolescents

Expected Outcomes:

1. Improved equitable access to SRH information and services by marginalized and vulnerable adolescents
2. Improved coordination and partnership efforts for provision of ASRH information and services to marginalized and vulnerable adolescents
3. Increased number of marginalized and vulnerable adolescents accessing SRH information and services
4. Improved sexual reproductive health outcomes among marginalized and vulnerable adolescents

Intervention Area Nine: Address the SRHR of Marginalized and vulnerable adolescents								
Strategies	**Indicators**	**Activities**	**Actors**	**2017**	**2018**	**2019**	**2020**	**2021**
1.Provision of friendly ASRHR information and services to marginalized and vulnerable adolescents	Marginalized and vulnerable adolescents accessing ASRH information and services Knowledge levels about ASRH rights among marginalized and vulnerable adolescents Functional disability friendly infrastructure in AYFS areas/health facilities Service providers trained in provision of disability-friendly ASRH information and services Adolescents with disabilities accessing ASRH services	Conduct mapping to identify the marginalized and vulnerable adolescents	MOH, CDH/CHMT, MOE, Children Department, Ministry of Interior, Vulnerable adolescents, Prisons Department Ministry of Public Service, Youth Gender, and Social Services, Local Administration,	X	X			
		Establish and strengthen partnerships for promotion and protection of provision of ASRH and health rights of marginalized and vulnerable adolescents		X	X	X	X	X
		Work with relevant programs to provide ASRHR information and services to marginalized/ vulnerable adolescents		X	X	X	X	X
		Educate families and communities to care and protect the marginalized and vulnerable adolescents		X	X	X	X	X
		Develop and disseminate Vulnerability-specific ASRH information materials and services for all groups of marginalized and vulnerable adolescents.		X		X	X	X
		Install disability-friendly infrastructure in AYFS areas/health facilities		X	X	X	X	X
		Train service providers on provision of disability friendly ASRH information and services		X	X	X	X	X
		Establish community level linkages for vulnerable adolescents		X	X	X	X	X
		Establish referral systems and mechanisms for ASRH information and services for marginalized and vulnerable adolescents		X	X	X	X	X
		Establish safe spaces and centers to shelter and protect marginalized and vulnerable adolescents		X	X	X	X	X
		Conduct targeted outreach services to adolescents in labor market, informal settlements, streets, married adolescents, orphaned adolescents and adolescents in humanitarian and emergency situations		X	X	X	X	X

Intervention Area Nine: Address the SRHR of Marginalized and vulnerable adolescents								
Strategies	**Indicators**	**Activities**	**Actors**	**2017**	**2018**	**2019**	**2020**	**2021**
2. **Support evidence generation and utilization of data on marginalized and vulnerable adolescents to guide ASRHR programming**	Availability of data on vulnerable and marginalized adolescents to guide ASRHR programming and policy development	Conduct quarterly data audits on adolescent with disability/vulnerability and marginalized.	MOH, CDH/ CHMT and partners	X	X	X	X	X
		Train health workers on revised data capture tools and data utilization for decision-making		X	X	X	X	X

3.0 MONITORING AND EVALUATION FRAMEWORK

According to the ASRH Policy for which this implementation framework has been developed, the national Ministry of Health will provide overall strategic leadership and technical assistance to the counties in monitoring and evaluating the implementation of the Policy. To this extent, the MOH will provide guidance to the county governments/CHMTs on the formation of ASRH technical working groups and provision of M&E tools and guidance in using the same. It ought also to be noted that the focus for M&E for implementation of the ASRH Policy is on the beneficiary – i.e. the changes that will occur among the adolescents when the policy is effectively implemented.

The monitoring and evaluation framework is therefore a critical component to guide tracking of the ASRH Policy implementation based on the goals, objectives and targets that will have been set by the respective counties. Each county health department will have to develop its own Monitoring and evaluation plan. It is expected that the MOH will provide technical assistance on how this should be done. It is further expected that each county will choose areas to prioritize and emphasize depending on their needs. At the national level, the MOH shall mobilize sufficient resources to technically support the CHMTs to develop their M&E plans which in turn will be linked to the Ministry's institutional M&E framework, HMIS and other key sectoral M&E frameworks.

The main objective of the M&E system is to promote evidence-based decision-making on ASRH at all levels. To achieve this objective, the County Health Management Teams – with technical guidance from the MOH – shall:

- Undertake to develop costed annual work plans to operationalize the ASRH Policy as guided by this implementation framework
- Ensure continuous monitoring of the ASRH programs and service provision through routine data collection using HMIS tools and support supervision.
- Promote and insist on collection, analysis and utilization of age and sex disaggregated data on adolescents.
- Support capacity building of programme managers, planners, implementers and service providers on data utilization for decision-making on matters affecting ASRH in their respective counties.
- Ensure proper storage, reliable access and easy retrieval of data by different users
- Encourage operations research at service delivery and programme/ project implementation sites

Be guided by other research and survey results to evaluate changes towards desired ASRH outcomes

3.1 Institutional Arrangements and M&E Implementation Mechanisms

At the national level, monitoring and evaluation of the ASRH Policy implementation framework will be undertaken through a functional multi-sectoral ASRH Technical Working Group under the direction of RMHSU/ MOH. This arrangement will be replicated in the counties with the County RH Coordinators or County adolescent health focal persons taking leadership, under the guidance of the County Health Management Teams. They will put together multi-sectoral County ASRH TWGs and ensure that the TWGs are functional.

At the national level, the responsibilities of the ASRHTWG will include, but not limited to:

1. Providing technical assistance and guidance to the CHMTs to ensuring a rationalized, harmonized and functional system of ASRH data collection vis in place and functional
2. Ensuring capacity development at all levels for data collection, analysis, reporting and use
3. Ensuring that dissemination plans on ASRH-related policies and relevant laws targeted at key stakeholders including policy/decision makers are developed and implemented
4. Ensuring institutional capacity building for the coordinating structures to be able to deliver on the expected outputs and ensure sustainability of the monitoring and evaluation system
5. Ensuring that special measures are put in place to build capacities in areas where performance in ASRH information and service delivery is observed to be weak
6. Providing technical support to Kenya National Bureau of Statistics, Directorate of M&E and other relevant research institutions at the national level, to ensure inclusion of ASRH indicators in periodic population-based surveys and research.
7. Advising on and commissioning periodic evaluation of the ASRH Policy implementation – i.e. mid- and end-line of the policy implementation
8. Undertaking the regular/periodic review and revision of ASRH policies and service provision guidelines
9. Determine national level activities and prepare costed annual work plans to reflect those activities, including M&E plans

At the county level, the ASRH TWG will be responsible for:

1. Ensuring the functionality and use of a rationalized, harmonized and functional system of ASRH data collection in county health and related facilities
2. Ensuring capacity development for data collection, analysis, reporting and use at all levels (i.e. county, sub-county, health facility);
3. Ensuring development and implementation of costed 5-year and annual M&E work plans to domesticate the ASRH Policy
4. Reporting the status of implementation, the ASRH Policy;
5. Putting in place systems and mechanisms for tracking and reporting on the implementation of the annual work plans for ASRH programs and service provision
6. Putting in place functional data dissemination and feedback mechanisms
7. Developing their own resource requirements and mobilize resources for sustainable implementation of identified county-specific ASRHR focus areas
8. Ensuring institutional capacity building for the health management structures to be able to deliver on the expected outputs and ensure sustainability of the monitoring and evaluation system
9. Ensuring capacity building in areas where performance in ASRH information and service delivery is observed to be weak.

3.2 Monitoring

For effectiveness, monitoring requires the routine collection of data according to established performance indicators, together with the analysis and dissemination of the findings. This is especially important to enable programme managers and implementers to monitor progress and make evidence-based decisions about any adjustments that need to be made in the implementation of programs and provision of ASRH information and services. The following will be the main considerations for the successful implementation of the ASRH Policy: Indicators (and indicator tracking); data collection, analysis, storage and use; and, data dissemination and feedback channels.

3.3 Evaluation

This implementation framework has an in-built call for periodic external evaluation of the Policy implementation. Three points of evaluation are suggested – i.e. baseline, mid-line (2019) and end-line (2021) to implementation of the Policy. However, baseline evaluation has been taken care of by using the 2014 KDHS and other most recent national surveys and county estimates to benchmark the implementation starting point and set targets for 2021. At both mid- and end-points, the evaluations will consist of:

- Comprehensive reviews of periodic progress reports (quarterly, annual) produced under national and county level consultative processes;
- In-depth analytical reports using data generated by/from the M&E system, commissioned research and other evaluations relevant to ASRH;

Interviewing direct ASRH programme coordinators, managers and implementers at all levels.

4.0 COSTING FINANCIAL REQUIREMENTS AND ALLOCATIONS

The estimation of the financial requirement for the implementation of this framework was based on activity-based costing approach. In this approach, cost of each lead activity as spelt out in the framework was estimated, taking into consideration all the inputs required for that activity. The inputs were quantified and cost calculated by multiplying the quantities of the units by their respective cost prices. The total cost of any activities was obtained by summing the cost of all the inputs for the activity.

Overall cost of the framework is shown in Table 4.1 and Table 4.2. As shown, the estimated total cost for the period are KSh. 6,956 million (US$ 69 million) in 2017, KSh. 9,365 million (US$ 93 million) in 2018, KSh. 8,866 million in (US$ 88 million) in 2019, KSh. 8,420 million (US$ 83 million) in 2020 and KSh. 7,967 million (US$ 79 million) in 2021. The overall cost for the five-year period is estimated at KSh. 41.6 billion (US$ 412 million).

Table 4.1 and Table 4.2 provide summary costs for the different intervention areas.

4.1 Total Financial Requirements

Table 4.1: Estimated total cost (Kshs million)

Thematic Area	2017	2018	2019	2020	2021	Total
Health System Strengthening	694	971	955	590	452	3,661
Promote Adolescent Sexual and Reproductive Health and Rights (ASRHR)	529	617	634	659	602	3,041
ASRH information and sexuality education	1,483	1,546	1,601	1,664	1,729	8,023
Reduce STIs, including HPV and HIV among adolescents	1,031	1,630	1,464	1,336	1,267	6,727
Early and unintended pregnancy	751	910	568	981	614	3,825
Addressing Harmful Traditional Practices (HTP)	424	492	366	351	405	2,038
Drug and substance abuse (DSA)	384	986	1,021	430	446	3,266
Sexual and gender-based violence and response	591	766	757	778	808	3,700
Address the SRHR of Marginalized and vulnerable adolescents	1,069	1,447	1,500	1,632	1,645	7,294
Total	**6,956**	**9,365**	**8,866**	**8,420**	**7,967**	**41,575**

Table 4.2: Estimated total cost (US$ million[7])

Thematic Areas	2017	2018	2019	2020	2021	Total
Health System Strengthening	6.87	9.61	9.45	5.84	4.47	36
Promote Adolescent Sexual and Reproductive Health and Rights (ASRHR)	5.24	6.11	6.28	6.52	5.96	30
ASRH information and sexuality education	14.69	15.31	15.86	16.47	17.12	79
Reduce STIs, including HPV and HIV among adolescents	10.21	16.14	14.49	13.22	12.55	67
Early and unintended pregnancy	7.44	9.01	5.63	9.72	6.08	38
Addressing Harmful Traditional Practices (HTP)	4.20	4.87	3.62	3.48	4.01	20
Drug and substance abuse (DSA)	3.80	9.76	10.11	4.25	4.41	32
Sexual and gender-based violence and response	5.85	7.58	7.50	7.70	8.00	37
Address the SRHR of Marginalized and vulnerable adolescents	10.59	14.33	14.85	16.16	16.29	72
Total	**69**	**93**	**88**	**83**	**79**	**412**

7 Exchange rate of US$ 1 = KSh 101.

4.2 Detailed Costs per Intervention Areas

Table 4.3: Estimated cost of health system strengthening activities (KSh)

	Activity	2017	2018	2019	2020	2021	Total
1	Develop a resource mobilization strategy for ASRH programmes and services	5,383,300	-	-	-	-	5,383,300
2	Conduct evidence-based advocacy for creation of budget lines or increased budget allocation for ASRH programmes and services	14,483,400	15,048,253	15,635,134	16,244,905	16,878,456	78,290,148
3	Coordinate and harmonize donor and partner support	-	587,658	610,577	-	-	1,198,235
4	Integrate ASRH programmes into County Integrated Development Plans (CIDP)	-	3,082,583	-	-	-	3,082,583
5	Develop costed annual work plans for ASRH programmes and services	44,775,825	46,522,082	48,336,443	50,221,565	51,862,410	241,718,326
6	Establish and/or strengthen a functional reporting and feedback mechanism	-	619,140	-	-	-	619,140
7	Establish and/or strengthen programme based budgeting and allocation of funds for ASRH programme and services.	-	46,238,747	-	-	-	46,238,747
8	Conduct training needs assessment on ASRH among HMTs	-	103,574,793	-	111,811,164	-	215,385,957
9	Conduct trainings for the HMTs to address the gaps identified in the training needs assessment	-	39,161,136	-	42,275,269	-	81,436,405
10	Integrate indicators on ASRH into routine health management supervision tools	-	-	-	-	-	-
11	Educate other sectoral teams on the national ASRH policy and other relevant policies, standards and guidelines	303,000	314,817	327,095	339,852	-	1,284,763
12	Identify a county focal coordination point for ASRH programmes	-	-	-	-	-	-
13	Map out and develop a database of ASRH partners	141,400	-	-	-	-	141,400
14	Establish and/or strengthen multi-sectoral ASRH TWGs	99,929,400	103,826,647	107,875,886	112,083,045	116,454,284	540,169,262
15	Establish and/or strengthen logistics and management information systems for essential RH commodities	2,000,000	2,078,000	2,159,042	2,243,245	2,330,731	10,811,018
16	Train county teams on forecasting and quantification of essential RH commodities	74,480,430	77,385,167	-	-	-	151,865,597
17	Procure and distribute essential RH commodities to service delivery points based on need (under general health services)	-	-	-	-	-	-
18	Revise and standardize data collection tools to address data gaps, including age and sex disaggregation for adolescents	1,265,530	-	-	-	-	1,265,530
19	Train health personnel, including frontline health care workers at county levels on newly developed data collection tools and HMIS	99,402,180	103,278,865	107,306,741	111,491,704	115,839,880	537,319,370
20	Develop/introduce and implement dashboards for ASRH indicators	-	682,104	-	-	-	682,104
21	Conduct quarterly data quality audits	44,775,825	46,522,082	48,336,443	50,221,565	51,862,410	241,718,326
22	Train of the Health Personnel on ASRH data management and use for evidence-based decision making	44,503,125	46,238,747	48,042,058	49,915,698	51,862,410	240,562,039
23	Integrate ASRH indicators into National Integrated Monitoring and Evaluation System (NIMES)	151,500	157,409	-	-	-	308,909
24	Establish and/or strengthen logistics and management information systems for essential RH commodities	-	15,678,510	2,283,940	2,373,014	2,465,561	22,801,024
25	Carry out needs assessment	-	-	-	-	-	-
26	Conduct trainings for the health service providers to address the gaps identified in the training needs assessment	223,441,290	-	241,209,565	-	-	464,650,855
27	Develop a training database of health care providers with skills on adolescent friendly service provision	-	-	-	-	-	-

	Activity	2017	2018	2019	2020	2021	Total
28	Develop and/or review training materials, practice guidelines/job aids on adolescent-friendly SRH services.		95,445		105,228		200,673
29	Advocate for integration of adolescent-friendly SRH modules and guidelines into pre-service training of healthcare trainees						
30	Train CHEWs, CHAs CHVs and Peer mentors to provide ASRH information and referrals	25,254,040	26,238,948	27,262,267	28,325,495	29,430,189	136,510,938
31	Develop /review CHV referral tools to include ASRH	90,900	-	-	-	-	90,900
32	Conduct infrastructural needs assessment to assess gaps in the provision of quality integrated adolescent-friendly services	12,473,500	-	-	11,328,385	11,770,192	35,572,078
33	Undertake need-based health facility renovations to enhance the provision integrated adolescent-friendly service delivery	700,000	727,300	755,665	785,136	815,756	3,783,856
34	Establish county level model centres of excellence for adolescent-friendly Services	-	292,998,000	304,424,922	-	-	597,422,922
	Total	**693,554,645**	**971,056,431**	**954,565,778**	**589,765,268**	**451,572,282**	**3,660,514,403**

Table 4.4: Cost of Adolescent Sexual and Reproductive Health and Rights activities (KSh.)

	Activity	2017	2018	2019	2020	2021	Total
1	Disseminate the ASRH policy and relevant legislations to national and county stakeholders	29,639,460	30,795,399	31,996,419	33,244,280	34,540,807	160,216,365
2	Convene quarterly meetings with multi-sectorial TWGs at national and county level on ASRHR	125,341,000	130,229,299	135,308,242	140,585,263	146,068,088	677,531,892
3	Educate adolescents and peers on ASRH policy and relevant legal instruments including dissemination and use of existing youth empowerment manuals, tools and materials	57,913,400	60,172,023	62,518,731	64,956,962	67,490,284	313,051,400
4	Support and involve adolescents in existing decision making structures e.g. through community health committees or establishment of a council of adolescents at county level for advisory purposes	67,407,400	70,036,289	72,767,704	75,605,644	78,554,264	364,371,301
5	Strengthen adolescent-adult partnership, engagement and dialogue on ASRHR	-	19,728,532	20,497,945	21,297,365	22,127,962	83,651,803
6	Support integration of ASRHR into existing/on-going adolescent youth groups initiatives	-	9,864,266	10,248,972	10,648,682	11,063,981	41,825,902
7	Develop age appropriate, culturally acceptable Information Education Communication (IEC) materials on sexual reproductive health and rights for the Adolescents	-	2,424,091	-	-	-	2,424,091
8	Educate gatekeepers, parents and communities on ASRHR	26,108,500	39,415,088	38,433,646	39,932,559	41,489,928	185,379,722
9	Develop IEC materials on ASRHR for parents and communities	-	22,152,623	20,497,945	21,297,365	22,127,962	86,075,894
10	Conduct media campaigns on ASRH	73,463,360	76,328,431	79,305,240	82,398,144	85,611,672	397,106,847
11	Conduct advocacy activities targeting religious leaders, and community gatekeepers	6,827,600	7,093,876	7,370,538	7,657,989	7,956,650	36,906,653
12	Support gender responsiveness in all ASRH programs	71,162,580	75,564,475	78,511,490	81,573,438	2,106,864	308,918,847
13	Train the community leaders and services providers on gender mainstreaming in ASRHR	70,920,180	73,686,067	76,559,824	79,545,657	82,647,937	383,359,665
	Total	**528,783,480**	**617,490,459**	**634,016,695**	**658,743,347**	**601,786,400**	**3,040,820,381**

Table 4.5: Cost of ASRH information and sexuality education activities (KSh)

	Activity	2017	2018	2019	2020	2021	Total
1	Establish joint programs between MOH, MoE and other relevant partners for the provision of SRH information/ sexuality education to adolescents	671,373,260	699,948,377	724,761,533	753,027,233	782,395,295	3,631,505,698
2	Educate teachers, tutors and other relevant personnel on emerging ASRH issues and how to integrate them in school health programs.	39,874,800	41,429,917	43,045,684	44,724,466	46,468,720	215,543,587
3	Work with adolescents to develop and disseminate age appropriate ASRH messages using a variety of innovative channels	667,618,080	693,655,185	720,707,737	748,815,339	778,019,137	3,608,815,479
4	Establish partnerships with community structures and initiatives for provision of ASRH information and sexuality education to out-of-school adolescents.	102,962,430	109,369,525	111,150,105	115,484,960	119,988,873	558,955,892
5	Support provision and utilization of technological advances and innovations to enhance access to sexuality education	1,575,600	1,637,048	1,700,893	1,767,228	1,836,150	8,516,920
	Total	**1,483,404,170**	**1,546,040,052**	**1,601,365,953**	**1,663,819,225**	**1,728,708,175**	**8,023,337,575**

Table 4.6: Cost of activities for Reduction of STIs, including HPV and HIV among adolescence

	Activity	2017	2018	2019	2020	2021	Total
1	Develop and disseminate age- appropriate ASRH information on STIs, HIV and HPV using a variety of innovative channels	13,602,680	15,702,023	14,684,379	15,257,069	15,852,095	75,098,246
2	Train service providers on provision of HIV, STIs HPV information and provide regular updates on current information	120,194,040	124,881,608	129,751,990	134,812,318	140,069,998	649,709,954
3	Provide adolescents including marginalized, vulnerable adolescents and adolescent key populations, with tailored information on STIs, RTIs, HIV and AIDS prevention including New Prevention Technologies (NPTs)	134,445,140	217,931,858	206,138,236	214,177,627	222,530,554	995,223,415
4	Engage adolescents meaningfully in education on transmission of STIs/RTIs, HPV and HIV&AIDS and prevention	-	-	-	-	-	
5	Establish and strengthen appropriate forums for engagement with parents, religious leaders etc. on the provision of SRH, HIV, STI, HPV information and services	-	17,755,679	18,448,150	19,167,628	19,915,166	75,286,623
6	Conduct demand creation activities e.g. Campaigns, media talks, outreaches to sensitize adolescents on STIs/RTIs/ HPV &HIV&AIDS	283,900,160	294,972,266	306,476,185	318,428,756	330,847,477	1,534,624,844
7	Organize service delivery points and health facilities to provide adolescent tailored SRH services	-	-	-	-	-	
8	Conduct trainings for health care providers on provision of adolescent friendly health services	232,128,300	241,181,304	250,587,375	260,360,282	270,514,333	1,254,771,594
9	Integrate STI/RTI and HIV screening and treatment in RH services and other health care services	-	109,296,067	-	-	-	109,296,067
10	Involve adolescents in the development of HIV/STI/RTI/ HPV IEC materials and dissemination using a variety of innovative channels	-	5,280,530	2,640,265	-	-	5,280,530
11	Provide targeted HIV, STI, RTI and HPV treatment and prevention options specific to marginalized, vulnerable and key population adolescents e.g. PrEP and HPV vaccines according to approved guidelines	14,000,000	140,000,000	140,000,000	14,000,000	14,000,000	308,000,000

	Activity	2017	2018	2019	2020	2021	Total
12	Provide relevant VMMC information, services and referral pathways for adolescents	13,671,360	14,204,543	14,758,520	15,334,103	15,932,133	73,900,659
13	Develop and disseminate VMMC IEC materials using a variety of innovative channels	-	1,568,838	-	-	-	1,568,838
14	Procure and provide HPV testing and vaccines at all levels (*under general health services commodity procurement)*	-	-	-	-	-	
15	Educate the community and adolescents on the importance of HPV vaccinations	-	-	-	-	-	
16	Train health workers on HPV vaccine provision	-	124,881,608	129,751,990	-	-	254,633,598
17	Review, develop, print, disseminate and distribute data collection and reporting tools for ASRH programs	2,500,000	2,500,000	15,000,000	-	-	20,000,000
18	Train health care providers on DHIS including ASRH data tools	177,158,040	184,067,204	191,245,824	198,704,412	206,453,884	957,629,364
19	Train health service providers on data management for decision making	-	90,060,749	-	97,222,469	-	187,283,218
20	Educate providers on the importance of capturing and reporting adolescent specific data and strengthen data collection systems	23,735,000	24,660,665	25,622,431	26,621,706	27,659,952	128,299,754
21	Educate stakeholders about all research guidelines including Guidelines for Conducting HIV Sexual and Reproductive Health Research in Kenya	-	4,932,133	5,124,486	5,324,341	5,531,990	20,912,950
22	Conduct, document and disseminate tailored operational, implementation science and basic research on prevention and treatment of HIV, HPV, STIs and RTIs among marginalized, vulnerable and adolescent Key population	15,790,000	15,947,560	16,111,265	16,281,354	11,750,000	75,880,179
23	Include HIV, STI and RTI tailored prevention and treatment research in national and county research agenda specifically for marginalized, vulnerable and key populations adolescents	-	-	-	-	-	-
24	Include New Prevention Technologies (NPTs) research for HIV prevention tailored for adolescents in national and county plans	-	-	-	-	-	-
	Total	**1,031,124,720**	**1,629,824,635**	**1,463,700,831**	**1,335,692,065**	**1,267,057,582**	**6,727,399,833**

Table 4.7: Cost of activities for early and unintended pregnancy interventions (KSh)

	Activity	2017	2018	2019	2020	2021	Total
1	Work with adolescents to develop and disseminate accurate ASRH information on pregnancy prevention including abstinence and contraception using conventional and digital platforms	12,709,840	14,774,362	13,720,539	14,255,640	14,811,610	70,271,991
2	Integrate ASRH information within the school health programme framework and through other existing education sector forums.	20,507,040	21,306,815	22,137,780	23,001,154	23,898,199	110,850,987
3	Train teachers, tutors, wardens and other relevant personnel to offer ASRH information and referral services	117,820,540	122,415,541	127,189,747	132,150,147	137,304,003	636,879,979
4	Educate community leaders, religious leaders, parents, local administration, CHAs, CHVs, peer mentors for provision of ASRH information on pregnancy prevention including contraception	46,757,950	48,581,510	50,476,189	52,444,760	54,490,106	252,750,515
5	Integrate AYFS into existing structures and systems	-	-	-	-	-	-
6	Procure & provide equipment and commodities to enhance provision of comprehensive ASRH services	-	-	-	-	-	-
7	Conduct Values Clarification and Attitudes Transformation (VCAT) on AYFS for service providers and health managers	48,917,835	50,825,631	52,807,830	54,867,336	57,007,162	264,425,793
8	Train/update service providers on provision of comprehensive ASRH services	348,050,040	361,623,992	-	390,380,693	-	1,100,054,725
9	Establish/strengthen parental and community support structures/systems for all pregnant adolescents.	23,735,000	24,660,665	25,622,431	26,621,706	27,659,952	128,299,754
10	Provide free adolescent-friendly maternal and child health services.	-	-	-	-	-	-
11	Strengthen linkages and effective referral systems for pregnant and lactating adolescents to appropriate and relevant services	-	-	-	-	-	-
12	Provide age-disaggregated data on maternal and perinatal death reporting and reviews at all levels	-	-	-	-	-	-
13	Strengthen the health systems/structures to provide adolescent-friendly MNH, ANC, PNC and PAC	-	-	-	-	-	-

	Activity	2017	2018	2019	2020	2021	Total
14	Educate, mobilize and engage male community members on prevention of early and unintended pregnancies and child marriages using various platforms and fora	14,241,000	99,343,023	103,217,401	107,242,879	111,425,352	435,469,655
15	Identify and train male champions on prevention of early and unintended pregnancies	11,962,440	12,428,975	12,913,705	13,417,340	13,940,616	64,663,076
16	Support the implementation of the return to school policy by MOE for adolescent mothers	-	-	-	-	-	-
17	Educate parents/ guardians and community at large on MOE's school re-entry policy	18,988,000	19,728,532	20,497,945	21,297,365	22,127,962	102,639,803
18	Educate in and out of school pregnant adolescents on school re-entry policy.	47,470,000	49,321,330	51,244,862	53,243,411	55,319,905	256,599,508
19	Conduct education campaigns on anti-stigmatization of pregnant and adolescent mothers	-	43,056,300	45,209,115	47,469,571	49,843,049	185,578,035
20	Support MOE in sensitizing teachers and head teachers on return to school policy	1,898,800	1,972,853	2,049,794	2,129,736	2,212,796	10,263,980
21	Establish/strengthen multi-sectorial ASRH TWGs at national and county level	-	-	-	-	-	
22	Convene quarterly meetings with multi-sectorial ASRH TWGs at national and county level to coordinate teenage pregnancy prevention efforts	35,883,280	37,282,728	38,736,754	40,247,488	41,817,140	193,967,390
23	Coordinate the development of multi-sectorial strategies and action plans to address teenage pregnancy at the county level	2,232,100	2,319,152	2,409,599	2,503,573	2,601,213	12,065,637
	Total	**751,173,865**	**909,641,408**	**568,233,692**	**981,272,799**	**614,459,064**	**3,824,780,828**

Table 4.8: Cost of activities for addressing Harmful Traditional Practices (HTP) (KSh)

	Activity	2017	2018	2019	2020	2021	Total
1	Disseminate the ASRH policy and AYFS guidelines, other relevant policies and laws addressing girl child education, child labour, child marriage, and FGM	127,272,953	132,236,598	30,746,917	31,946,047	33,191,943	355,394,458
2	Develop partnerships with relevant agencies that advocate for implementation and enforcement of anti-HTP policies and laws	4,666,025	4,848,000	5,037,072	5,233,518	5,437,625	25,222,240
3	Develop partnerships with relevant institutions that enforce anti-HTPs legislations and policies	6,999,038	7,272,000	7,555,608	7,850,277	8,156,438	37,833,360
4	Develop and disseminate IEC materials on harmful traditional practices and identify innovative channels of dissemination.	-	15,702,023	14,684,379	-	-	30,386,401
5	Identify and train Anti HTPs champions and change agents including adolescents	11,962,440	12,428,975	12,913,705	-	-	37,305,120
6	Conduct community campaigns on the Negative effects of HTPs	40,235,678	41,804,869	43,435,259	45,129,234	46,889,275	217,494,316
7	Document and share success stories and best practices on prevention and response to adolescents affected by HTPs	3,091,242	3,211,800	3,337,060	3,467,206	3,602,427	16,709,734
8	Establish and strengthen psycho-social support and treatment mechanisms and facilities for HTPs	-	-	-	-	-	-
9	Build capacity of service providers on psycho-social counselling	-	36,103,214	-	-	40,494,170	76,597,384
10	Incorporate communities into the rehabilitative mechanisms	-	-	-	-	-	-
11	Work with partners to educate law enforcers /agencies/ health workers on HTPs	177,158,040	184,067,204	191,245,824	198,704,412	206,453,884	957,629,363

	Activity	2017	2018	2019	2020	2021	Total
12	Hold community level education forums on justice and re-dress- seeking procedures	24,921,750	25,893,698	26,903,552	27,952,791	29,042,950	134,714,742
13	Partner with research organizations to generate and disseminate evidence on interventions and response to HTPs	20,200,000	20,987,800	21,806,324	22,656,771	23,540,385	109,191,280
14	Partner with the MOE to educate communities on reintegration of adolescents affected by HTPs in School.	-	-	-	-	-	-
15	Work with MOE to enforce the re-entry policy to school	-	-	-	-	-	-
16	Work with partners and relevant agencies to develop rescue and rehabilitation mechanisms and interventions for adolescents affected by HTPs	7,302,300	7,587,090	7,882,986	8,190,423	8,509,849	39,472,648
	Total	**423,809,465**	**492,143,270**	**365,548,688**	**351,130,678**	**405,318,944**	**2,037,951,045**

Table 4.9: Cost of drug and substance abuse (DSA) activities (KSh)

	Activity	2017	2018	2019	2020	2021	Total
1	Provide counselling services for adolescent drugs and substances users.	-	-	-	-	-	-
2	Procure and provide commodities for provision of treatment services for drugs and substance users	-	-	-	-	-	-
3	Train Health care workers/ counsellors on identification, management and rehabilitation services to adolescent drugs and substance users.	354,316,080	368,134,407	382,491,649	397,408,823	412,907,767	1,915,258,727
4	Strengthen referrals and linkages in the management of drugs and substance users.	2,676,500	2,780,884	2,889,338	3,002,022	3,119,101	14,467,845
5	Improve the available Rehabilitation Centres to provide appropriate services to the adolescents.	-	585,996,000	608,849,844	-	-	1,194,845,844
6	Institute mechanisms for involvement of adolescents, families and communities in the prevention and management of drug and substance abuse among adolescents	-	-	-	-	-	-
7	Engage the MOE to encourage re-admission into school of adolescents after successful rehabilitation	1,247,350	1,295,997	-	-	-	2,543,347
8	Formation of TWGs to spearhead the coordination for prevention, control and management of drugs and substance abuse	24,775,300	25,741,537	26,745,457	27,788,529	28,872,282	133,923,105
9	Support enforcement of relevant supportive policies and laws on drug, alcohol and other substance abuse among adolescents	-	-	-	-	-	-
10	Integrate DSA messages into ASRH information delivery packages and channels.	-	650,622	-	-	729,752	1,380,374
11	Provide technical support to MOE to integrate drug and SA messages into the education curriculum	-	-	-	-	-	-
12	Develop and integrate information and messages on dangers of drug and SA into existing digital platforms, including adolescent friendly social media	1,242,300	1,290,750	-	1,393,391	-	3,926,441
	Total	**384,257,530**	**985,890,195**	**1,020,976,288**	**429,592,766**	**445,628,902**	**3,266,345,682**

Table 4.10: Cost of sexual and gender-based violence and response (KSh)

	Activity	2017	2018	2019	2020	2021	Total
1	Undertake mapping of existing SGBV response programmes and services	2,848,200	2,959,280	-	-	-	5,807,480
2	Work with youth-led organizations and initiatives to educate adolescents on SGBV and existing prevention and response services	134,445,140	217,931,858	206,138,236	214,177,627	222,530,554	995,223,415
3	Conduct community anti-SGBV campaigns	40,903,485	43,056,300	44,347,989	45,678,429	47,048,782	221,034,984
4	Partner with MoE to develop SGBV educational materials to compliment content in the current school curriculum	-	2,093,533	-	-	-	2,093,533
5	Partner with relevant agencies to develop anti-SGBV messages and IEC materials	-	-	-	-	-	-
6	Hold workshops for community leaders on SGBV prevention and response services	25,396,450	26,386,912	27,416,001	28,485,225	29,596,149	137,280,737
7	Involve men in the existing community structures/ institutions	-	-	-	-	-	-
8	Identify and train male champions on SGBV prevention and response	7,690,140	7,990,055	8,301,668	-	-	23,981,863
9	Train service providers on psycho-social counselling and post rape care	227,001,540	235,854,600	245,052,929	254,609,994	264,539,783	1,227,058,847
10	Partner with the communities in the development of safe houses and recovery centres for rehabilitation and integration of adolescent survivors of SGBV	-	68,366,200	71,032,482	73,802,749	76,681,056	289,882,486
11	Integrate SGBV management, treatment and prevention SGBV in AYF services	-	-	-	-	-	-
12	Disseminate relevant policies, law and strategies addressing SGBV	2,020,000	2,098,780	2,180,632	2,265,677	2,354,038	10,919,128
13	Train law enforcers including members of the national administration on SGBV prevention and response services	9,090,000	9,444,510	-	-	-	18,534,510
14	Conduct situation analysis on SGBV	-	2,403,103	-	-	-	2,403,103
15	Work with community-led initiatives and partners to educate communities on anti-SGBV laws and their rights in seeking justice	-	-	-	-	-	-
16	Advocate for establishment and/or strengthening of community structures for prevention and response to SGBV	606,000	629,634	654,190	679,703	706,212	3,275,738
17	Advocate for full enforcement of laws relating to SGBV by law enforcement agencies to ensure that perpetrators are brought to justice	1,212,000	1,259,268	1,308,379	1,359,406	1,412,423	6,551,477
18	Establish/strengthen multi-sectorial ASRH TWGs at national and county level	-	-	-	-	-	-
19	Convene quarterly meetings with multi-sectorial ASRH TWGs at national and county level to coordinate SGBV prevention and response	104,539,040	108,616,063	112,852,089	117,253,320	121,826,200	565,086,712
20	Coordinate the development of multi-sectorial strategies and action plans to address SGBV among adolescents at the county level	35,301,520	36,678,279	38,108,732	39,594,973	41,139,177	190,822,681
	Total	**591,053,515**	**765,768,375**	**757,393,327**	**777,907,103**	**807,834,374**	**3,699,956,694**

Table 4.11: Cost of activities to address the SRHR of Marginalized and vulnerable adolescents (KSh.)

	Activity	2017	2018	2019	2020	2021	Total
1	Conduct mapping to identify the marginalized and vulnerable adolescents	2,848,200	2,959,280	-	-	-	5,807,480
2	Establish and strengthen partnerships for promotion and protection of provision of ASRH and health rights of marginalized and vulnerable adolescents	303,000	314,817	327,095	339,852	353,106	1,637,869
3	Work with relevant programmes to provide ASRHR information and services to marginalized/ vulnerable adolescents	-	-	-	-	-	-
4	Educate families and communities to care and protect the marginalized and vulnerable adolescents	-	43,056,300	44,459,415	70,023,579	73,524,758	231,064,051
5	Develop and disseminate Vulnerability-specific ASRH information materials and services for all groups of marginalized and vulnerable adolescents.	3,848,100	3,998,176	4,154,105	4,316,115	4,484,443	20,800,939
6	Install disability-friendly infrastructure in AYFS areas/ health facilities	600,000,000	623,400,000	647,712,600	672,973,391	699,219,354	3,243,305,345
7	Train service providers on provision of disability friendly ASRH information and services	-	-	-	49,622,860	-	49,622,860
8	Establish community level linkages for vulnerable adolescents	-	-	-	-	-	-
9	Establish referral systems and mechanisms for ASRH information and services for marginalized and vulnerable adolescents	2,434,100	2,529,030	2,627,662	2,730,141	2,836,616	13,157,549
10	Establish safe spaces and centers to shelter and protect marginalized and vulnerable adolescents	-	292,998,000	304,424,922	316,297,494	328,633,096	1,242,353,512
11	Conduct targeted outreach services to adolescents in labor market, informal settlements, streets, married adolescents, orphaned adolescents and adolescents in humanitarian and emergency situations	272,976,000	283,622,064	294,683,324	306,175,974	318,116,837	1,475,574,200
12	Conduct quarterly data audits on adolescent with disability.	9,736,400	10,116,120	10,510,648	10,920,564	11,346,466	52,630,197
13	Train health workers on revised data capture tools and data utilization for decision-making	177,158,040	184,067,204	191,245,824	198,704,412	206,453,884	957,629,363
	Total	**1,069,303,840**	**1,447,060,990**	**1,500,145,596**	**1,632,104,380**	**1,644,968,559**	**7,293,583,365**

APPENDIX 1: ASRH indicators to be tracked at the national level

Kenya	Key ASRH Indicators										
	Teenage pregnancy in 15-19 yr old girls (%)	CPR for any method for 15-19 yr old girls (%)	Condom use at first sex in 15 – 24 yr olds (%)	% facilities offering YFS	FGM prevalence in 15-19 yr olds (%)	Knowledge of HIV prevention in 15-19 yr old girls (%)	Knowledge of HIV prevention in 15-19 yr old boys (%)	HIV incidence in 15-19 yr. olds (%)	HIV prevalence in 15-24 yr old males (%)	HIV prevalence in 15-24 yr old females (%)	SGBV among 15-19 yr old girls
Baseline (2016)	18.0	40.2	67 (female) 58 (male)	10.0	11.4	49.0	57.7	0.9	1.7	2.8	4.2
Target by 2021	12.0	50.0	75 (F) 65(M)	30.0	8.0	60.0	65.0	0.7	1.3	2.4	2.0

Note: National CPR for any method among 15 – 19 yr olds (all = 10.1%; Married = 40.2%; sexually active unmarried = 50.1)

APPENDIX 2: Indicators to be tracked by counties for improving SRH among adolescents

1. No. of adolescents (10-14 years) presenting with pregnancy
2. No. of adolescents (15-19 years) presenting with pregnancy
3. No. of adolescents (10-19YRS) Maternal Deaths
4. Total adolescent clients (10-14YRS) receiving FP Services
5. Total adolescent clients (15-19YRS) receiving FP Services
6. Total youth clients (20-24YRS) receiving FP Services
7. Adolescent (10-19YRS) Accessing PAC Services
8. Percent facilities offering AYFS

Indicators to be tracked by counties benchmarked from July 2016 - June 2017 data***											
County	# 10-14 yr olds presenting with pregnancy	# 15-19 yr olds presenting with pregnancy	# 10-19 yrs maternal deaths+++	New ANC Clients	# 10-14 yrs receiving FP services+++	# 15-19 yrs receiving FP services	# 20-24 yrs receiving FP services	Adolescents (10-19 yrs) accessing PAC services	Women accessing PAC services	Teenage pregnancy in 15-19 yr. old girls (%)	% facilities offering AYFS (county primary care facilities)*
1. Baringo	949	4031	13	17273	370	1323	2157	7	37	23.3	2
2. Bomet	446	8769	10	23338	2251	6023	18396	14	54	37.6	9
3. Bungoma	2291	15094	2	45953	358	6833	6329	164	618	32.8	12
4. Busia	331	11983	13	23895	991	7565	19698	287	860	50.1	12
5. Elgeyo Marakwet	149	3258	1	12121	369	2219	8049	43	111	26.9	3
6. Embu	435	3755	12	12436	675	2409	10607	18	106	30.2	4
7. Garissa	571	3518	4	16350	29	1620	775	0	20	21.5	6
8. Homa Bay	1225	14503	1	32931	2638	15973	31694	200	780	44.0	25
9. Isiolo	27	1952		5636	184	600	2117	5	7	34.6	0
10. Kajiado	1344	8303	6	33033	601	3268	11890	99	546	25.1	14
11. Kakamega	1080	6602	4	51630	138	794	1907	237	621	12.8	12
12. Kericho	205	6917	38	20784	1084	2898	12138	46	188	33.3	8
13. Kiambu	434	12847	4	62186	4821	7802	40204	261	1210	20.7	13
14. Kilifi	855	14290	7	42606	1682	10428	31876	114	673	33.5	11
15. Kirinyaga	326	3643	3	11481	1046	3011	12232	109	351	31.7	7
16. Kisii	912	13001	22	30995	2879	11539	29070	163	434	41.9	25
17. Kisumu	506	15897	2	34262	1417	15490	39969	154	827	46.4	39
18. Kitui	531	9059	13	26685	1279	5385	22524	46	311	33.9	6
19. Kwale	1372	11758	59	28211	647	5632	13298	140	216	41.7	18
20. Laikipia	175	4064	9	13799	444	2352	8691	135	296	29.5	6
21. Lamu	112	1936	1	4317	23	882	3632	3	5	44.8	8
22. Machakos	355	8124	31	29266	1505	6080	30926	18	231	27.8	7
23. Makueni	274	6233	4	20191	1363	3670	18503	84	252	30.9	9
24. Mandera	223	613	5	15342	109	179	531	4	109	4.0	6
25. Marsabit	369	1860	7	10883	287	1431	4859	8	19	17.1	7
26. Meru	541	12662	43	33690	3318	9921	25488	127	433	37.6	3
27. Migori	750	14074	12	37910	2256	19631	39163	678	1554	37.1	21

Indicators to be tracked by counties benchmarked from July 2016 - June 2017 data***											
County	# 10-14 yr olds presenting with pregnancy	# 15-19 yr olds presenting with pregnancy	# 10-19 yrs maternal deaths+++	New ANC Clients	# 10-14 yrs receiving FP services+++	# 15-19 yrs receiving FP services	# 20-24 yrs receiving FP services	Adolescents (10-19 yrs) accessing PAC services	Women accessing PAC services	Teenage pregnancy in 15-19 yr. old girls (%)	% facilities offering AYFS (county primary care facilities)*
28. Mombasa	649	6984	15	37287	281	3227	5220	70	131	18.7	9
29. Muranga	84	5589	1	19069	247	3011	14262	44	567	29.3	6
30. Nairobi	4399	19776	42	177501	1990	11219	10833	166	639	11.1	10
31. Nakuru	1148	14164	28	56723	2340	10084	41396	195	899	25.0	10
32. Nandi	844	5333	3	18226	1134	3797	8124	12	31	29.3	4
33. Narok	635	11037	28	32118	392	3825	11668	44	234	34.4	13
34. Nyamira	327	5699	11	16824	1171	8740	21891	100	247	33.9	21
35. Nyandarua	97	2942	21	12981	243	2391	11179	100	231	22.7	10
36. Nyeri	261	2199		14482	728	2135	13463	20	356	15.2	6
37. Samburu	116	2662	7	8225	2140	1386	3644	55	92	32.4	3
38. Siaya	508	12462	9	25244	774	11775	30405	520	1207	49.4	25
39. Taita Taveta	56	2640	7	7698	575	1456	5978	11	63	34.3	12
40. Tana River	166	4177	45	9438	188	1604	3812	3	18	44.3	6
41. Tharaka-Nithi	217	2218	22	8537	202	1556	6527	25	78	26.0	2
42. Trans Nzoia	372	5429	1	21874	470	5819	11695	238	861	24.8	10
43. Turkana	662	5898	7	29415	919	1608	4503	99	111	20.1	4
44. Uasin Gishu	895	7933	115	31331	1524	5939	23596	141	593	25.3	5
45. Vihiga	102	4420	43	13436	680	2501	6381	403	653	32.9	16
46. Wajir	309	2735	19	14518	801	661	1958	27	129	18.8	5
47. West Pokot	297	6422	20	21580	520	2813	5432	27	59	29.8	2

+ Source: SARAM Report

*** Source: DHIS,

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