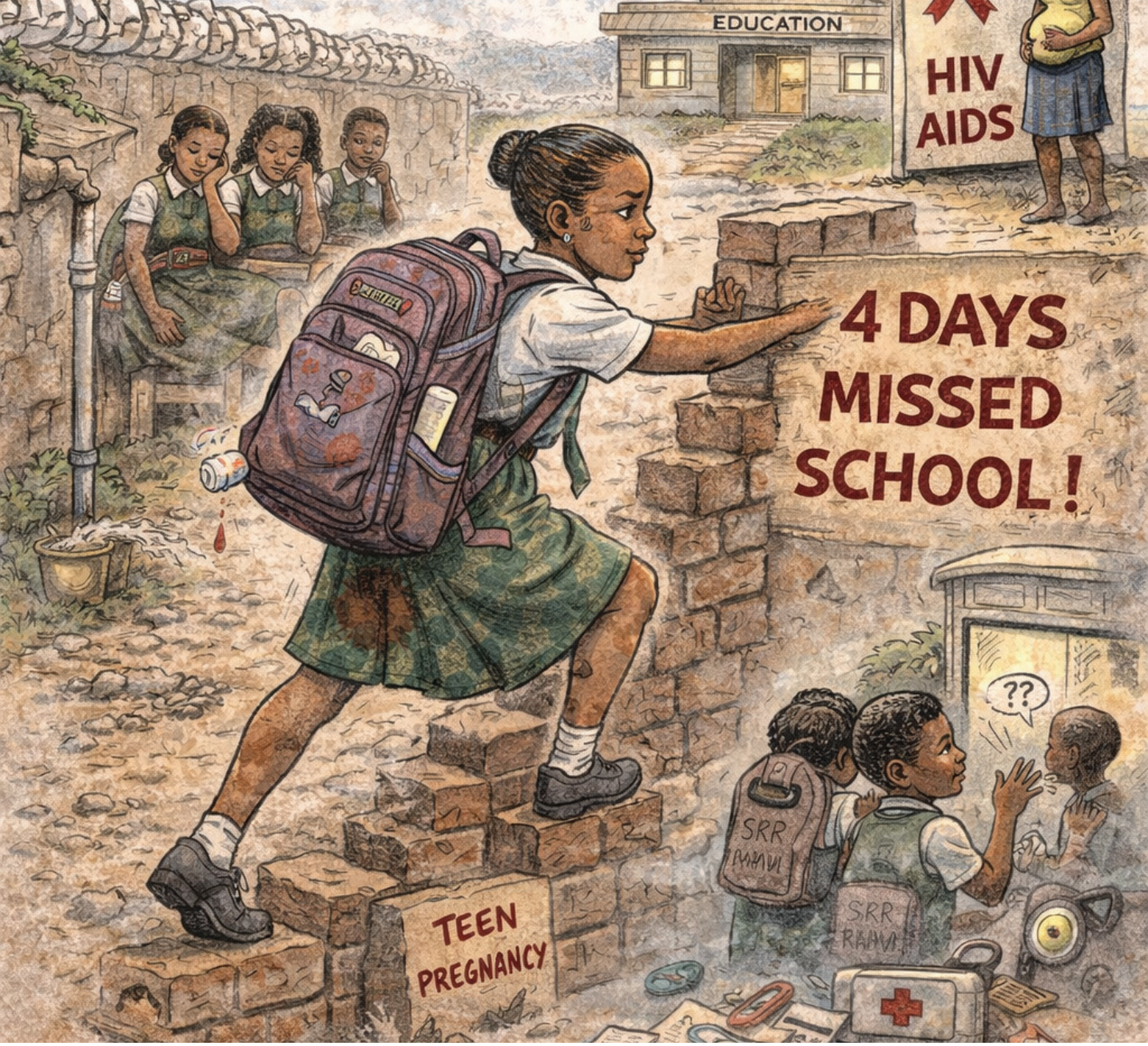

NAVIGATING BARRIERS IN KENYAN SECONDARY SCHOOLS

Sexual Reproductive Health and Menstrual Hygiene Management

giem
Gender in Education Movement
Towards a Gender Equal Society

Dedication

This report is dedicated to the **resilient girls and young women of Kenya** who continue to strive for a better future despite the challenges they face in accessing adequate Sexual and Reproductive Health (SRH) and Menstrual Hygiene Management (MHM) services. Your courage, strength, and perseverance inspire us to work tirelessly toward ensuring that every girl has the right to education, dignity, and health.

We also dedicate this report to the **teachers, parents, healthcare providers, and community leaders** who champion the cause of girls' education and health, and to the **policymakers and organizations** committed to advancing SRH and MHM initiatives across Kenya. Your dedication and efforts are paving the way for a brighter, more equitable future for all.

May this report serve as a beacon of hope and a call to action for everyone working towards a world where every girl can learn, thrive, and achieve her full potential!

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Definition of Terms and Abbreviations

UN	United Nations
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
EFA	Education For All
GER	Gross Enrolment Ratio - total enrolment in a specific level of education, regardless of age, expressed as a percentage of the eligible official school-age population corresponding to the same level of education in a given school year.
NER	Net Enrolment Ratio - the ratio of children of official school age who are enrolled in school to the population of the corresponding official school age.
SRH	Sexual and Reproductive Health
MHM	Menstrual Hygiene Management
CSE	Comprehensive Sexuality Education
JSS	Junior Secondary School
CBC	Competence Based Curriculum
GBV	Gender Based Violence
VACS	Violence Against Children Survey
CSE	Comprehensive sexuality education
STIs	Sexually transmitted infections

NGOs	Non-governmental organisations
FIDA	Federation of Women Lawyers
KNCHR	Kenya National Commission for Human Rights
UNFPA	United Nations Population Fund
WHO	World Health Organisation
MoH	Ministry of Health
MoE	Ministry of Education
ASRH	Adolescent Sexual Reproductive Health
UNESCO	United Nations Educational Scientific and Cultural Organisation
KISE	Kenya Institute of Special Education
UNICEF	United Nations International Children's Fund
USAID	United States Agency for International Development
WASH	Water Sanitation and Hygiene
P&G	Proctor and Gamble
KDHS	Kenya Demographic and Health Survey
KICD	Kenya Institute of Curriculum Development
AYSRH	Adolescent and Youth Sexual and Reproductive Health Policy
KNBS	Kenya National Bureau of Statistics
AFHS	Adolescent-friendly health services
FGM/C	Female Genital Mutilation/Cutting
ASAL	Arid and Semi-Arid Lands
LMICs	Low- and middle-income countries
NGAAF	National Government Affirmative Action Fund

Executive Summary

The report provides an in-depth analysis of the current status, challenges, and gaps in addressing Sexual and Reproductive Health (SRH) and Menstrual Hygiene Management (MHM) in Kenyan schools, highlighting key areas where improvements are needed.

In Kenya, SRH and MHM education have been integrated into the school curriculum under the Competency-Based Curriculum (CBC), but implementation remains inconsistent. While some progress has been made in providing girls with menstrual hygiene products and SRH education, significant gaps persist in rural and underserved areas.

— SRH Issues: Teenage pregnancies, gender-based violence, and limited access to contraception are prevalent among adolescents in Kenyan schools. Nearly 1 in 5 girls aged 15-19 have begun childbearing. A lack of contraceptive use among adolescents contributes to high rates of unintended pregnancies.

— MHM Issues: Only 46.1% of women in Kenya have access to adequate menstrual hygiene products, and schools often lack the necessary sanitation facilities to manage menstrual health effectively. Despite government initiatives, only 30% of schools have adequate sanitation infrastructure for MHM.

The report identifies systemic and cultural barriers hindering the effective implementation of SRH and MHM services in schools, particularly in rural and marginalized areas:

1. Cultural and Social Barriers: Cultural norms and taboos surrounding menstruation and SRH often result in stigma and misinformation. In conservative communities, discussions around sexuality are considered inappropriate, making it difficult for girls to access SRH education and services. Menstruation is stigmatized, leading to absenteeism and poor educational outcomes for girls.

2. Patriarchy and Gender Inequality: Patriarchal structures further limit women's autonomy over their reproductive health. Menstruation and SRH issues are often de-prioritized by decision-makers, leading to underfunding and poor infrastructure for girls' health needs.
3. Inconsistent Policy Implementation: National policies aimed at improving SRH and MHM are not uniformly applied across the country, with resource allocation often falling short, especially in remote and arid regions. Many schools lack proper WASH (Water, Sanitation, and Hygiene) facilities, which are crucial for managing menstruation in a dignified way.
4. Economic Barriers: In low-income areas, girls struggle to afford sanitary products, and despite government efforts, access remains uneven, particularly in informal settlements. This leads to high rates of absenteeism, as girls miss school during menstruation.

The intersectionality of cultural norms, stigma, patriarchy, and resource allocation creates a complex web of factors that exacerbate the challenges in providing adequate SRH and MHM services. Cultural taboos around menstruation and sexual health silence critical discussions, while patriarchal systems often dismiss these issues as irrelevant, leading to insufficient funding and infrastructure. Resource allocation is often skewed toward more visible issues like maternal and child health, leaving adolescent reproductive health underfunded.

This intersectionality highlights the compounded disadvantages faced by adolescent girls, particularly those with disabilities or from marginalized communities, who are doubly affected by societal stigma and infrastructural inadequacies. Addressing these interconnected challenges requires a culturally sensitive approach that includes community engagement, gender-sensitive policy planning, and increased investment in SRH and MHM infrastructure.

Key Recommendations:

1. **Increase Funding:** Allocate more resources toward SRH and MHM programs, particularly in rural areas, to ensure consistent access to sanitary products and adolescent-friendly health services.

2. **Improve School Infrastructure:** Enhance WASH facilities in schools to provide girls with safe, private spaces to manage their menstrual health.
3. **Community Sensitization:** Work with local leaders, faith-based organizations, and parents to reduce stigma around menstruation and sexual health, promoting open discussions.
4. **Policy Enforcement:** Strengthen the implementation of existing SRH and MHM policies to ensure that all schools, especially in marginalized regions, have access to necessary resources.
5. **Inclusive SRH Education:** Expand comprehensive sexuality education (CSE) that is culturally sensitive and integrates faith-based approaches to increase acceptance and effectiveness.

Addressing the barriers to SRH and MHM service provision in Kenyan schools requires a holistic approach that combines improved funding, better infrastructure, comprehensive education, and community engagement. Reducing stigma, particularly around menstruation and sexual health, is critical to improving school attendance and educational outcomes for girls across Kenya.

1. Introduction

The purpose of this review is to collate and synthesize evidence on the relationship between Sexual Reproductive Health (SRH), Menstrual Hygiene (MH), and the provision of sanitary towels for high school girls in Kenya, with a focus on how these factors impact girls' education. The review aims to understand the role SRH and MH services, particularly the provision of sanitary towels, play in improving or hindering school attendance, retention, and overall educational outcomes for girls. In Kenya, many adolescent girls face challenges related to menstrual health, stigma, and inadequate SRH services, all of which contribute to absenteeism, dropping out of school, or poor academic performance. These issues disproportionately affect girls from vulnerable and marginalized regions, further entrenching gender disparities in education.

The scope of this review is focused on junior and senior high school girls, analysing the availability of SRH services, including sexual education and reproductive health support, as well as the provision of sanitary towels. The review explores regional disparities in access to these services, particularly in rural, arid, and semi-arid regions, where cultural norms, poverty, and infrastructure challenges exacerbate the problem. By examining both national and regional data, this review seeks to provide a comprehensive understanding of how menstrual hygiene management and SRH interventions impact girls' educational attainment in Kenya.

The methodology of this review includes a desk-based analysis of existing academic literature, government policies, and reports from organizations working on SRH and MH issues in Kenya. Data was sourced from a variety of stakeholders, including NGOs, government agencies, and international bodies that have implemented programs

aimed at improving access to sanitary towels and SRH education for high school girls. The stakeholders were identified through desk review of available literature, policies and reports accessed through Gender and Education Dialogue members and online searches using Google. This review synthesizes existing evidence, map out key interventions, and identify gaps in service provision that need to be addressed to improve educational outcomes for girls.

1.1 Definition of terms

Sexual and Reproductive Health (SRH): According to the World Health Organization (WHO), SRH refers to a state of complete physical, mental, and social well-being in all matters relating to the reproductive system. It involves the ability to have a responsible, satisfying, and safe sex life, the capability to reproduce, and the freedom to decide if, when, and how often to do so. It also includes access to information and services related to contraception, maternal health, and the prevention and treatment of sexually transmitted infections (STIs), including HIV. The United Nations Population Fund (UNFPA) defines SRH as encompassing several interrelated issues, including adolescent reproductive health, family planning, gender-based violence, and access to reproductive health services. Reproductive Health includes the overall well-being in relation to the reproductive system. It involves ensuring access to a range of reproductive health services, including family planning, maternal health services, and prevention of STIs. It includes addressing infertility and reproductive health-related diseases such as cervical cancer.

Menstrual Hygiene Management (MHM): The Kenya Ministry of Health (MoH) and WHO define MHM as the practice of ensuring that women and adolescent girls can manage their menstruation safely, hygienically, and with dignity. This includes having access to the appropriate resources, such as sanitary products, clean water, and private sanitation facilities, and having accurate information about menstruation. The Kenya Ministry of Education emphasizes the need for schools to provide adequate facilities and education about menstruation, ensuring that girls do not miss school during their periods.

Adolescent Sexual Reproductive Health (ASRH) focuses on providing young people with the information and services they need to make informed decisions about their sexual and reproductive health. This includes education about puberty, contraception, prevention of STIs, and safe sexual practices.

SRH and MHM are closely interconnected. Menstrual health is a critical component of reproductive health, particularly for adolescents, as it marks the beginning of a girl's reproductive life. Ensuring that girls have access to proper MHM directly impacts their adolescent reproductive health, influencing their well-being, self-esteem, and educational attainment.

1.2 Education System in Kenya

The education system in Kenya follows a 2-6-3-3-3 structure, implemented under the Competency-Based Curriculum (CBC) introduced in 2017 to replace the 8-4-4 system. It consists of 2 years of pre-primary education, 6 years of primary education, 3 years of lower secondary, 3 years of upper secondary, and 3 years of tertiary education. The CBC emphasizes hands-on learning, creativity, and skills development, shifting away from rote memorization.

- Pre-primary education caters to children aged 4-5 years.
- Primary education is free and compulsory, and includes children aged 6-12 years. The Kenya Certificate of Primary Education (KCPE) exam is phased out in favour of continuous assessment under CBC.
- Secondary education includes junior and senior secondary school for learners aged 13-18 years. After completion, students pursue tertiary education or technical and vocational education and training (TVET).

To support the transition to this new system, the Ministry of Education's Strategic Plan 2023-2027 has set a goal of constructing 16,000 new classrooms for junior secondary schools by 2024 and hiring 111,870 teachers to address staffing shortages. These reforms require significant investment, estimated at KSh 5.2 trillion over five years.

Moreover, the government is rolling out the School Meals Programme, which benefits 2.6 million children in marginalized areas, helping improve retention rates in schools affected by food insecurity.

The government provides free primary and day secondary education in public schools. This is the policy but the costs of education remain unaffordable for many from poor backgrounds even in Nairobi.

1.3 Education Attainment for Girls in Kenya

In 2023, the Gross Enrolment Ratio (GER) and Net Enrolment Ratio (NER) for primary education in Kenya have continued to reflect the country's strong focus on achieving universal education. According to available data, the GER for primary school has been reported at around 104%. This high GER indicates that Kenya has made significant progress in ensuring access to primary education, though the figure may include over-aged and under-aged students. Meanwhile, the Net Enrolment Rate (NER) for primary education was approximately 87%, reflecting the proportion of school-age children enrolled in primary school (World Bank Data). This demonstrates a high level of participation, though there remain challenges related to retention and completion, particularly in marginalized areas.

Recent statistics on girls' education in Kenya reveal progress, particularly in enrolment rates, though challenges in retention and completion remain. As of 2023, primary school NER for girls was at 95%, nearly achieving universal access. However, the transition to secondary school sees a drop, with a 53% NER.

The dropout rate is particularly concerning, especially at the secondary level. Approximately 23% of girls drop out of secondary school, many due to unintended pregnancies or cultural practices like child marriage (Guttmacher Institute, 2020)[1]. Government and NGO programs have made efforts to counteract this, but more targeted interventions are needed.

1 Adolescent Pregnancy and School Dropout in Kenya: Guttmacher Institute, (2020)

Moreover, only 55% of girls complete secondary education, with challenges such as inadequate menstrual hygiene management (MHM) facilities and lack of access to sanitary products cited as significant barriers. UNESCO (2023)[2] emphasizes the impact of such factors, particularly in rural regions, leading to increased absenteeism rates for adolescent girls.

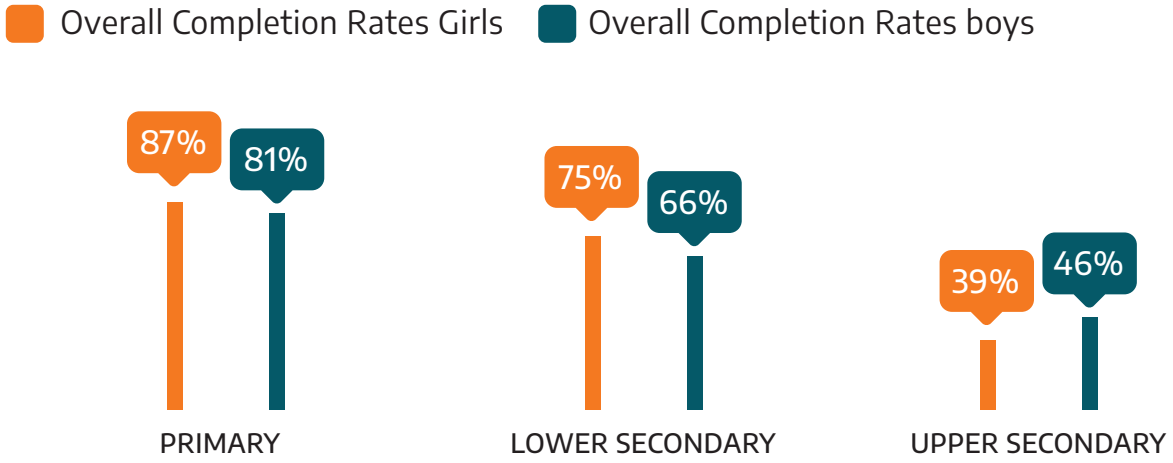
A report by Jaslika (2024)[3] highlights statistics on education completion rates for girls and boys in Kenya revealing some important trends, especially regarding gender disparities at different levels of education:

- The completion rate for girls in primary school is 87%, which is higher than that for boys, at 81%
- At the lower secondary level, the completion rate for girls drops to 75%, with boys' completion also lower at 66%
- The most significant shift occurs in upper secondary education, where the completion rate for girls drops sharply to 39%, compared to 46% for boys

2 Progress on Girls' Access to Education: UNESCO, 2023

3 Full Report on Creating Impact at the Local Level for Girls: Learning from Girls' Education Interventions in Kenya, Tanzania and Uganda. Nairobi: Wamahiu, S.P. with Ng'ang'a, W., Onguko E. and Mbithi, S.N. 2024, Jaslika.

Competion Rates in Kenya



Source: Booth, R. (2022). Computed from https://www.education-inequalities.org

Extracted from the Jaslika website: https://jaslika.com/articles/creating-impact-at-the-local-level-for-girls-learning-from-girls-education-interventions-in-kenya-tanzania-and-uganda

The dramatic decrease in completion rates from lower to upper secondary for girls points to structural and societal challenges. While girls outperform boys at both the primary and lower secondary levels, their lower completion rates in upper secondary suggest that external factors increasingly influence their education as they grow older.

The Kenya Institute of Special Education (KISE) reports that about 83.6% of girls with disabilities are enrolled in schools compared to 76.7% for boys with disabilities (KISE, 2018)[4]. Further, the Gender Report 2024 by Usawa Agenda[5] highlights the status of access to education for children with disabilities in Kenya. The report found that nationally 79.8% of children with disabilities were in school – the proportion of girls in school was higher (83.6%) as compared to 76.7% for boys. The report highlights that 20.2% of children with any form of disability reported they were out of school – 14.8% had dropped out while, 5.3% had never enrolled in school.

4 National Survey on Children with Disabilities and Special Needs in Education, Kenya Institute of Special Education, (2018)

5 Gender Report, Usawa Agenda (2024)

Kenya's Ministry of Education has acknowledged these disparities and is working to address gaps through various policy frameworks, though further support and funding are necessary to achieve gender parity in education.

1.4 Curriculum Placement for SRH and MHM in Kenya

In Kenya, Sexual and Reproductive Health (SRH) and Menstrual Hygiene Management (MHM) are incorporated into the curriculum primarily through Comprehensive Sexuality Education (CSE). The government recognizes the importance of educating young people on SRH and MHM to improve health outcomes, reduce teenage pregnancies, and address gender inequalities.

Curriculum Placement of SRH and MHM in Kenya

- **Life Skills Education**: SRH and MHM are integrated into the **Life Skills Education** curriculum, which is taught in both primary and secondary schools. This curriculum includes topics such as puberty, menstrual hygiene, reproductive health, relationships, and responsible behaviour. Life Skills Education aims to equip students with the knowledge and skills necessary to make informed decisions about their health and well-being.
- **Science and Biology Subjects**: SRH and MHM are also addressed in **science and biology lessons**, particularly in upper primary and secondary school. Topics such as human anatomy, reproduction, and the menstrual cycle are taught as part of the broader biology curriculum.
- **Guidance and Counselling Programs**: Many schools include SRH and MHM topics within their **guidance and counselling programs**, where teachers and health professionals provide additional support and education to students.
- **Basic Education Curriculum Framework (2017)**: As part of Kenya's new competency-based curriculum (CBC), SRH and MHM topics are integrated into the **Personal and Social Competency** strand, which aims to foster knowledge and skills related to health, hygiene, and personal development.

— In Kenya, schools have utilized clubs as platforms to teach SRH and MHM, aiming to fill gaps left by formal education and to provide a supportive environment for adolescents. These clubs, which often operate outside regular class time, play a crucial role in offering comprehensive SRH and MHM education, helping to reduce stigma, and improving overall health outcomes for girls

1.5 SRH and MHM Policy in Kenya

The Kenyan government has implemented several policies and guidelines to ensure that SRH and MHM are addressed in the education system. Key policies include:

National Adolescent Sexual and Reproductive Health Policy (2015): This policy emphasizes the need to provide adolescents with age-appropriate sexual and reproductive health information, including MHM. It advocates for the integration of SRH education into school curricula to empower young people with the knowledge to make informed decisions about their reproductive health.

— **National School Health Policy (2009)**: This policy, developed by the Ministry of Health and the Ministry of Education, provides a framework for addressing health issues in schools, including MHM and SRH. It recommends that schools provide safe and hygienic facilities for girls during menstruation and offer education on menstrual health as part of life skills education.

— **Menstrual Hygiene Management Policy (2019)**: The MHM Policy is designed to ensure that all girls and women have access to safe and hygienic menstrual products, education, and sanitation facilities. The policy includes specific guidelines for schools to ensure that girls are not disadvantaged by a lack of menstrual health education or inadequate facilities.

Key Objectives of SRH and MHM Policies in Kenya

— **Improving Access to Information**: Ensure that all students, especially girls, have access to accurate and age-appropriate information on reproductive health and menstrual hygiene.

- **Reducing Stigma**: Encourage open discussions about menstruation and reproductive health to reduce stigma and discrimination, particularly towards girls.
- **Promoting Hygiene and Access to Facilities**: Provide adequate sanitation facilities and access to menstrual products in schools to ensure that girls are not disadvantaged during their menstruation.
- **Empowering Adolescents**: Equip adolescents with the knowledge and skills to make informed decisions about their reproductive health, avoid teenage pregnancies, and reduce the spread of sexually transmitted infections (STIs).

2. SRH, MHM and Girls' Education in Kenya

According to the Ministry of Education (MoE) in 2023[6], nearly 2 million girls were enrolled in secondary education in Kenya. In 2023, approximately 1.29 million students transitioned into Junior Secondary School (JSS), marking the first year of the Competency-Based Curriculum (CBC) transition. According to statistics reported by the Ministry of Interior in May 2023 there were 641,270 boys and 625,518 girls who transitioned to JSS.

2.1 SRH in Secondary Schools in Kenya

2.1.1 Current status of SRH issues in secondary schools

— Teenage Pregnancy Rates: According to a report by UNFPA Kenya (2022), nearly 1 in 5 adolescent girls (ages 15-19) in Kenya has begun childbearing. According to The Gender Report 2024 by Usawa Agenda – an estimated 19,230 teenage girls were reported pregnant in 2022 and only 8,168 (42.5%) returned to school

— Sexual Activity and Contraception: A study by the Guttmacher Institute (2020) found that 48% of sexually active adolescent girls in Kenya are not using any form of contraception, leading to high rates of unintended pregnancies.

— Knowledge of HIV and STIs: The Kenya Demographic and Health Survey (KDHS) (2022)[7] indicates that 67% of adolescents are aware of HIV/AIDS and understand how it is transmitted. However, only 45% of these adolescents have a clear understanding of how to protect themselves from STIs

6 Secondary school enrolment in Kenya 2015-2022, Natalie Cowling, (2024)

7 Kenya Demographic and Health Survey 2022: Key Indicators Report, KNBS and ICF (2023)

— Gender-based violence (GBV) in Kenyan schools remains a critical issue. Data from the 2019 Kenya Violence against Children Survey (VACS)[8] indicates that 49% of girls and 48% of boys aged 13-17 have experienced physical violence in schools. Sexual violence is also prevalent, with 11% of girls and 4% of boys reporting incidents of sexual violence during their school years. A United Disabled Persons of Kenya (UDPK) report highlights alarming statistics, with 34% of women and 27% of men in Kenya reporting experiences of physical gender-based violence before the age of 15.[9]

2.1.2 Provision of SRH Education and Services in Kenya

Sexual and Reproductive Health (SRH) services, including sexual education, counselling, access to contraceptives, and reproductive health facilities, are provided through both schools and external providers in Kenya. The government, NGOs, and international organizations have made strides in improving access, but significant gaps remain, especially in marginalized areas.

1. Comprehensive Sexuality Education (CSE) in Schools

Kenya's withdrawal from the East and Southern Africa (ESA) commitment has affected the delivery of Comprehensive Sexuality Education (CSE) in schools, leading to modifications in how SRH information is presented. Instead of CSE, the current term used to describe SRH education in schools is "Age-Appropriate Life Skills and Values-Based Education" or "Reproductive Health and Life Skills Education." These terms align with the Ministry of Education's approach, which focuses on abstinence, values, and culturally accepted information while limiting discussions on contraception and lesbian, gay, bisexual, transgender and queer (LGBTQ+) topics.[10]

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8 Violence against Children in Kenya: Findings from a National Survey, Ministry of Labour and Social Protection of Kenya, Department of Children's Services,(2019)

9 Policy Brief: Inclusive Policy Planning and Implementation on Gender-Based Violence in Nairobi City County, Kenya, United Disabled Persons of Kenya (UDPK) Enhancing Disability, (2024)

10 From Paper to Practice: Sexuality Education Policies and Their Implementation in Kenya, Sidze EM et al., Guttmacher Institute, 2017, https://www.guttmacher.org/report/sexuality-education-kenya.

According to the Kenya Institute of Curriculum Development (KICD) (2021), sexual education is taught at both the primary and secondary levels. It is introduced at the upper primary school level and continues through secondary school.

- **Upper Primary (Grade 4 to 8):** Topics related to puberty, reproductive anatomy, menstrual hygiene, and responsible behaviour are introduced in life skills education and science classes. The aim is to provide learners with age-appropriate information about their bodies and personal health.
- **Secondary School:** In biology and life skills classes, students receive more detailed education on topics such as sexual health, contraception, sexually transmitted infections (STIs), and responsible relationships. This is where sexuality education becomes more in-depth, addressing issues like reproductive health, consent, and gender-based violence.

SRH Education Implementation: As of 2023, Kenya has made progress in integrating SRH education into the school curriculum, but challenges remain. According to UNESCO (2022)[11], only 47% of schools in Kenya are actively teaching the full SRH curriculum. This leaves many adolescents, especially in rural and marginalized areas, without accurate SRH information.

Life Skills Education Implementation: LSE is part of the Competency-Based Curriculum (CBC) in Kenya, but implementation is uneven. A report by the Kenya Institute of Curriculum Development (2023)[12] highlights that while, LSE is included in the curriculum, teacher training and resource allocation remain inadequate, particularly in public schools.

Disparities in Access: Data from UNFPA Kenya (2022)[13] indicates that less than 30% of girls with disabilities receive adequate SRH education. This is attributed to a lack of disability-inclusive teaching materials and trained educators.

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11 Comprehensive Sexuality Education in Sub-Saharan Africa: A Review of Implementation in Kenya, UNESCO Regional Office for Eastern Africa, 2022

12 Status of Life Skills Education Implementation in Kenyan Schools, Kenya Institute of Curriculum Development (KICD), 2023

13 Leaving No One Behind: Sexual and Reproductive Health and Rights for Persons with Disabilities in Kenya, UNFPA Kenya ,2022

2. Guidance and Counselling Services

Policy Framework: The Kenyan government has institutionalized Guidance and Counselling (G&C) programs in schools through the Basic Education Act (2013) and the National Policy on Guidance and Counselling (2015)[14]. These frameworks mandate the provision of G&C services to address learners' academic, social, and psychological needs.

Impact on Learners: A study by Zizi Afrique Foundation (2022)[15] found that schools with active G&C programs report lower dropout rates and improved academic performance. However, only 40% of schools have functional G&C programs, with rural schools being the most underserved.

Focus on Mental Health: The Kenya National Commission on Human Rights (KNCHR) (2023)[16] reports a growing need for G&C programs to address mental health issues among students, particularly in the wake of the COVID-19 pandemic. Many schools lack the resources to provide psychosocial support.

3. Access to Contraceptives

Contraceptive access for adolescents is governed by Kenya's National Family Planning Program, led by the Ministry of Health. However, cultural and religious resistance to providing contraceptives to teenagers is significant, particularly in rural and conservative areas.

A report by Kenya National Bureau of Statistics (KNBS) (2021)[17] found that while contraceptive use among married women is relatively high (over 60%), contraceptive access for adolescents remains low. Only 10% of sexually active adolescents in rural areas report using contraceptives, compared to 35% in urban areas.

14 National Policy on Guidance and Counselling for Schools, Ministry of Education, Kenya (2015).

15 The Role of Guidance and Counselling in Reducing School Dropouts in Kenya, Zizi Afrique Foundation (2022).

16 Mental Health and Well-being in Kenyan Schools: The Role of Guidance and Counselling, KNCHR (2023)

17 "Family Planning and Contraceptive Use Report." Kenya National Bureau of Statistics (KNBS). (2021).

4. Adolescent-Friendly Reproductive Health Services

Policy Framework: Kenya has made significant strides in promoting adolescent-friendly reproductive health services through policies such as the Adolescent Sexual and Reproductive Health Policy (2015)[18] and the School Health Policy (2018). These frameworks aim to ensure that adolescents have access to accurate SRH information and services.

Service Availability: A report by UNFPA Kenya (2023)[19] indicates that only 35% of schools in Kenya have access to adolescent-friendly reproductive health services. These services are often concentrated in urban areas, leaving rural and marginalized communities underserved.

2.1.3 Challenges in Implementing SRH Programmes in Kenyan Schools

The Sexual Reproductive Health (SRH) needs of junior and senior high school girls in Kenya face significant challenges, particularly in terms of access to sexual reproductive health education and services. Many girls experience limited access to accurate information, leading to issues such as unintended pregnancies, sexually transmitted infections (STIs), and unsafe abortions. These challenges are listed below:

1. **Cultural Barriers:** Many communities in Kenya are still resistant to discussions about sexuality, leading to reluctance among parents and educators to openly address SRH topics in schools. This resistance can result in the exclusion or superficial treatment of critical SRH issues. A study by **Population Council Kenya** (2023)[20] found that cultural taboos and stigma around SRH topics hinder effective delivery of SRH education. Teachers often feel uncomfortable discussing sensitive topics, and parents sometimes resist the inclusion of SRH in the curriculum.
2. **Inconsistent Delivery:** While SRH is part of the curriculum, the quality and depth of SRH education vary significantly between urban and rural schools.

18 National Adolescent Sexual and Reproductive Health Policy, Ministry of Health, Kenya (2015).

19 Access to Adolescent-Friendly Reproductive Health Services in Kenya, UNFPA Kenya (2023). UNFPA Kenya (2023).

20 Barriers to Effective SRH Education in Kenyan Schools, Population Council Kenya (2023).

Many teachers lack adequate training in delivering SRH content, which affects the effectiveness of the lessons. A report by the **Kenya Institute of Curriculum Development (KICD)** (2023)[21] highlights that while G&C programs are part of the school curriculum, their implementation is inconsistent. Many schools lack trained counsellors, and teachers assigned to G&C roles often lack the necessary skills.

3. **Access to Contraceptives:** Despite government policies promoting adolescent access to contraceptives, there remains a stigma around providing these services to adolescents, limiting their availability. While the majority of girls and boys know where to access SRH services, few use contraception such as condoms during sexual activity (G Manguro, et al, 2021)[22]
4. **Limited Availability of Accessible SRH Materials:** Many schools and healthcare facilities lack the resources to provide SRH materials in accessible formats. For instance, only a small percentage of institutions provide information in braille or sign language, leaving many individuals with disabilities without the necessary information to make informed decisions about their SRH. While Kenya is making strides in digitalization, digital platforms often lack accessibility features for people with disabilities. This limits their access to online SRH resources and information.[23]
5. **Lack of Trained Teachers:** Teachers are often not adequately trained to address the specific SRH needs of girls with disabilities. The Ministry of Education (2021) has acknowledged that there are insufficient specialized educators trained in delivering SRH content to students with disabilities. A report by **UNESCO Kenya** (2022)[24] notes that only **30% of teachers** handling G&C programs have received formal training. This limits the effectiveness of the programs in addressing issues such as drug abuse, teenage pregnancies, and career guidance.

21 Status of Guidance and Counselling Implementation in Kenyan Schools, KICD (2023).

22 Failing the rights: sexual vulnerability, access to services and barriers to contraceptives among adolescents in Narok County, Kenya, G Manguro, J Mwaisaka, D Okoro, K Korir, P Owira, G Githinji, A Olajide, M Temmerman, International Journal of Human Rights in Healthcare, 2021

23 Kenya's Disability Inclusion Report Reveals Progress and Gaps, National Council for Persons with Disabilities (NCPWD), 2024-04-22: https://ncpwd.go.ke/kenyas-disability-inclusion-report-reveals-progress-and-gaps/

24 Teacher Preparedness for Guidance and Counselling in Kenyan Schools, UNESCO Kenya (2022).

6. Stigma and Discrimination: Stigma and discrimination against people with disabilities persist, particularly in healthcare settings. Many healthcare providers lack the training to communicate effectively with individuals with disabilities, leading to inadequate SRH service delivery. Physical barriers, such as the absence of ramps and modified examination beds, further hinder access to SRH services and materials for people with disabilities.[25] Stigmatization of unwed pregnant teenage girls (Wamahiu, S.P. et al. 2024)[26]

2.2 MHM in Secondary Schools in Kenya

2.2.1 Current status of MHM issues in secondary schools

— **Affordability and Availability**: A 2022 study by the **World Bank Group** and **Global Water Security & Sanitation Partnership (GWSP)** found that **65% of girls and women in Kenya cannot afford sanitary pads** due to their high cost. This financial barrier significantly impacts school attendance and performance.[27]

— According to a report from the Ministry of Health, since the launch of Kenya's Menstrual Hygiene Management Policy (2019-2030), many schools still lack proper WASH (Water, Sanitation, and Hygiene) facilities, which are crucial for girls to manage their periods.

— The Kenyan Government Sanitary Towels Program under the Ministry of Education only reaches about 60% of targeted girls who received the sanitary towels regularly.

— Only 10% of schools consistently provide sanitary pads, and disposal systems for menstrual waste are not always available (Ministry of Health Kenya, 2019-2030 MHM Strategy)

25 Delivering inclusive access to sexual and reproductive health and family planning information and services for marginalised communities in Kenya, Hezron Ochieng, 2022-08-02, https://cscuk.fcdo.gov.uk/development-theme/delivering-inclusive-access-to-sexual-and-reproductive-health-and-family-planning-information-and-services-for-marginalised-communities-in-kenya/

26 Creating Impact at the Local Level for Girls' Education in East Africa: Learning from Girls' Education Interventions in Kenya, Tanzania and Uganda, Wamahiu, S.P., Ng'ang'a, W., Onguko, E., & Mbithi, S. N. (2024).

27 Breaking Barriers: Addressing Menstrual Health and Wellbeing as Human Rights, Trevor Mwangi, 2024-05-28, https://www.kelinkenya.org/breaking-barriers-addressing-menstrual-health-and-wellbeing-as-human-rights

- The Kenya Ministry of Education (2022) notes that schools with proper menstrual hygiene facilities report a 17% reduction in absenteeism for girls.
- As of 2023, only 30% of schools in Kenya are equipped to provide comprehensive Menstrual Hygiene Management (MHM) education and resources (UNICEF Kenya, 2023)
- Kenya's Menstrual Hygiene Management Strategy (2019-2024) sets guidelines for educating girls and ensuring they have access to sanitary products in schools

2.2.2 Provision of Sanitary Towels in Schools

The Kenyan Government launched a Sanitary Towels Program in 2011 under the Ministry of Education to address the challenge of school absenteeism among girls due to lack of access to sanitary products. The program provides sanitary towels to girls in public schools, particularly in marginalized areas. The Kenyan government has allocated an annual budget to this program, with the aim of distributing sanitary towels to over 3.7 million girls in primary and secondary schools annually.

Funding and Reach: According to a report by the National Treasury (2022), the government allocated Ksh 470 million to the program in the 2021/2022 fiscal year. However, a report by Kenya National Bureau of Statistics (KNBS) (2022) found that only about 60% of targeted girls received the sanitary towels regularly.

2.2.3 Challenges in Implementing MHM in Kenyan Schools

- **Lack of Sanitary Products:** Many schools, especially in rural areas, struggle to provide sufficient sanitary pads, leading to high absenteeism among girls during their menstruation.
- **Inadequate Facilities:** Most schools lack waste disposal bins for menstrual materials, leading to challenges in managing menstrual hygiene.
- **Cultural Stigma:** Menstrual stigma (period shaming) remains widespread, making it difficult for girls to discuss or manage their periods openly, affecting their confidence and attendance.

— **Barriers for Girls with Disabilities:** Schools are often not equipped to meet the specific needs of girls with disabilities, who may require additional support and facilities to manage menstruation.
— **Inconsistent Distribution:** gaps in the consistent distribution of sanitary towels, particularly in remote areas like Turkana, Garissa, and Mandera. Logistical issues and poor infrastructure in these regions limit regular access.
— **Sustainability Challenges:** there are barriers to adoption of reusable sanitary pads due to cultural perceptions and the need for access to clean water for proper hygiene. These challenges hinder widespread adoption in rural areas.
— **Private Sector Limitations:** The focus tends to be on urban and semi-urban areas, with less emphasis on the most rural, hard-to-reach populations.

2.3 Gaps in SRH and MHM Service Provision in Kenya

The provision of Sexual and Reproductive Health (SRH) and Menstrual Hygiene (MH) services across Kenya remains uneven, with significant gaps in availability, affordability, and distribution, particularly in marginalized regions such as arid and semi-arid lands (ASALs), informal settlements, and remote rural areas. These gaps are driven by multiple factors, including logistical challenges, socio-economic disparities, cultural barriers, and insufficient infrastructure.

1. Irregular Supply

a. **Menstrual Hygiene Products**: The government's **Sanitary Towels Program** and NGO initiatives have improved access, but the supply of menstrual hygiene products remains **irregular**, particularly in remote regions.

Contributing Factors:

— **Logistical Issues**: In ASALs like Turkana and Garissa, poor road networks and inadequate infrastructure delay the distribution of sanitary towels.
— **Limited Government Funding**: According to the **Kenya National Bureau of Statistics (2022)**[28], government funding for menstrual hygiene products is often delayed or insufficient, leading to inconsistent supply in schools.

28 Status Report on Sanitary Towels Program in Kenya: Kenya National Bureau of Statistics (KNBS). (2022).

Impact: Girls in remote regions may miss school during their menstrual periods due to irregular access to sanitary towels.

b. **SRH Services: Access to contraceptives and reproductive health services is often disrupted in rural and marginalized areas.**

Contributing Factors:

— **Supply Chain Disruptions**: A **UNFPA (2020)**[29] report highlights that many health centres in rural areas experience frequent stock-outs of contraceptives and essential SRH supplies.

— **Inadequate Training**: Many health workers in these regions lack the proper training to provide consistent and quality SRH services, compounding the irregularity in service provision.

2. **Unaffordability**

Menstrual Hygiene Products: Many girls and women in low-income areas, especially in informal settlements like **Kibera** and **Mathare**, struggle to afford sanitary products, despite free government distribution programs.

Contributing Factors:

— **Economic Hardship**: In areas with high poverty rates, families prioritize basic needs over sanitary products, which are considered a luxury.

— **Private Sector Pricing**: While corporate partners like P&G's **Always** brand provide some free products, these efforts are limited, and the cost of commercially available sanitary products remains too high for many.

SRH Services: For many women and girls in rural and marginalized communities, access to SRH services is limited by cost.

Contributing Factors:

— **Lack of Affordable Healthcare**: Many women in ASAL regions cannot afford basic reproductive healthcare services, including contraceptives and maternal care.

29 The State of World Population: Unfinished Business – The Pursuit of Rights and Choices for All: United Nations Population Fund (UNFPA), 2023

— **Out-of-Pocket Costs**: Public health services may not be free or are inadequately funded, leading to out-of-pocket costs that are prohibitive for low-income families.

3. Unequal Distribution across Regions

SRH Services: SRH services, including contraceptive access, sexual education, and maternal health, are disproportionately available in urban areas compared to rural and remote regions.

Contributing Factors:

— **Urban-Rural Divide**: Urban centres like **Nairobi** and **Mombasa** have better access to health infrastructure and external service providers, while rural and ASAL regions are underserved.

— **Health Workforce Shortage**: According to the **Ministry of Health (2021)**[30], rural health facilities are understaffed, with fewer trained personnel capable of delivering specialized SRH services.

Menstrual Hygiene Management (MHM): The unequal distribution of sanitary towels is most acute in marginalized regions.

Contributing Factors:

— **Geographic Disparities**: Rural and ASAL areas like **Mandera** and **Wajir** receive fewer menstrual hygiene supplies compared to schools in more central regions, such as **Nairobi** and **Kiambu**.

— **Focus on Urban Schools**: Government and NGO distribution efforts often prioritize urban schools due to easier access, leaving rural schools under-resourced.

4. Cultural Barriers

SRH Services: In many rural and conservative communities, particularly in ASALs, cultural and religious beliefs hinder access to SRH services and education.

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30 Adolescent and Youth Reproductive Health Progress Report: Ministry of Health. (2021).

Contributing Factors:

- **Stigma and Taboos**: Cultural stigma around contraceptive use and discussions on reproductive health often prevent adolescent girls from seeking services. This is particularly prevalent in regions such as **West Pokot** and **Samburu**.
- **Gender Inequality**: In patriarchal societies, decisions about reproductive health are often controlled by men, limiting women's access to services.

Menstrual Hygiene: Taboos around menstruation persist in many regions, leading to shame and misinformation.

Contributing Factors:

- Lack of Education: In rural areas, many girls receive limited or no education on menstrual health due to cultural taboos. Menstruation is still a highly stigmatized topic in many communities, leading to poor menstrual hygiene practices.

5. **Inadequate Infrastructure**

Water, Sanitation, and Hygiene (WASH) Facilities: Inadequate WASH facilities in schools, particularly in rural areas, make it difficult for girls to manage their menstruation effectively.

Contributing Factors:

- **Lack of Sanitation Facilities**: Many schools in ASAL and rural regions lack private toilets and water facilities, limiting girls' ability to maintain menstrual hygiene during school hours.
- **Poor Maintenance of Existing Facilities**: Even where WASH facilities exist, they are often poorly maintained, and access to clean water is inconsistent, particularly in areas prone to drought.

In addition to the gaps already identified, there are several other gaps in SRH (Sexual and Reproductive Health) services in Kenya, particularly in marginalized regions. These gaps limit access to comprehensive SRH care for women and adolescents, exacerbating issues related to reproductive health, family planning, and adolescent sexual health.

6. Limited Access to Family Planning and Contraceptives for Adolescents

Adolescent girls, particularly in rural and ASAL areas, face significant barriers in accessing family planning and contraceptive services.

Contributing Factors:

— **Cultural Resistance**: Many communities in in Kenya view the use of contraceptives by unmarried girls as taboo. Cultural stigma leads to low contraceptive use among adolescents in these areas.

— **Lack of Youth-Friendly Services**: Few health centers are equipped to offer youth-friendly services. According to **Pathfinder International (2020)**[31], **only 40%** of public health facilities in Kenya have staff trained to handle adolescent SRH needs, creating a barrier to contraceptive access for young people.

Impact: This leads to high rates of teenage pregnancy, especially in rural and ASAL areas, where adolescents are less likely to seek family planning services due to fear of judgment or lack of information.

7. Inadequate Post-Abortion Care

Access to post-abortion care (PAC) is limited, especially in rural and conservative regions where unsafe abortions are more common due to restricted access to legal abortion services.

Contributing Factors:

— **Legal and Policy Barriers**: The restrictive legal environment around abortion in Kenya often prevents women from seeking safe abortion services, leading to complications that require urgent post-abortion care. A **Guttmacher Institute (2020)** study revealed that many health facilities in rural areas do not provide PAC services, further limiting access.

— **Shortage of Skilled Providers**: Health facilities, especially in **rural** and **remote areas**, often lack trained personnel who can provide PAC services, leading to **increased maternal morbidity and mortality** from unsafe abortions.

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31 Adolescent-Friendly Health Services in Kenya: Status Report: Pathfinder International. (2020).

Impact: Women and girls who experience complications from unsafe abortions in remote areas are often unable to access the care they need, increasing the risk of death and long-term health consequences.

8. Lack of Mental Health and Psychosocial Support for SRH Issues

Mental health services related to SRH, such as psychosocial support for sexual violence survivors, pregnant adolescents, and young mothers, are severely lacking in many regions.

Contributing Factors:

— **Underdeveloped Mental Health Services**: A **World Health Organization (2021)**[32] report found that mental health services in Kenya are underfunded, with only a few healthcare providers trained to offer mental health support, particularly related to SRH issues.

— **Stigma**: Cultural attitudes surrounding mental health, especially in rural areas like **Turkana** and **Samburu**, discourage people from seeking help for SRH-related trauma, such as sexual abuse or unplanned pregnancies.

Impact: Lack of mental health services for SRH issues leads to untreated psychological trauma, with long-term effects on emotional well-being and physical health, particularly for survivors of sexual violence.

32 Barriers to Accessing Sexual and Reproductive Health Services in Low-Income Countries: World Health Organization (WHO), 2023

9. Sexual Violence and Inadequate Support Services

Sexual violence, particularly against girls, remains a significant issue in many parts of Kenya, but access to post-rape care and support services is limited, especially in ASAL regions and informal settlements.

Contributing Factors:

— **Inadequate Post-Rape Care**: Many rural health centres do not have **post-exposure prophylaxis (PEP)** or trained staff to handle cases of sexual violence. According to **UNFPA (2020)**[33], **less than 30%** of health facilities in ASAL regions offer adequate post-rape care.

— **Weak Legal Support**: Survivors often face barriers in accessing justice, with **limited legal aid** and slow response times from law enforcement in rural areas. Cultural stigmas around reporting sexual violence also lead to underreporting and lack of support for victims.

Impact: Sexual violence survivors, particularly in marginalized regions, are left without proper medical treatment, counselling, or legal recourse, perpetuating a cycle of abuse and poor health outcomes.

10. Inconsistent Access to Maternal Health Services

Maternal health services, including prenatal care, safe delivery, and postnatal care, are inconsistent across regions, with rural and marginalized areas experiencing the greatest service gaps.

Contributing Factors:

— **Infrastructural Barriers**: In **remote rural areas**, many pregnant women have to travel long distances to reach health facilities, and the available facilities are often **under-resourced** or **understaffed**. The **Kenya Health Demographic Survey (2022)** revealed that maternal mortality remains high in rural regions like **Turkana** and **Marsabit**, largely due to lack of access to skilled birth attendants and emergency care.

33 The State of World Population: Unfinished Business – The Pursuit of Rights and Choices for All: United Nations Population Fund (UNFPA), 2023

— **Poverty**: The high cost of transportation and healthcare deters many women from seeking prenatal and postnatal care, especially in areas with no **free or subsidized maternal health services**.

Impact: Women in these areas are at higher risk of maternal mortality and complications during childbirth due to inadequate access to skilled care and emergency obstetric services.

11. Limited Sexual Health Services for Men

SRH services targeting men, particularly for issues such as contraceptive use, STI prevention, and HIV testing, are limited in scope, with most programs focusing on women.

Contributing Factors:

— **Cultural Norms**: In many communities, reproductive health is seen as the woman's responsibility, leading to low uptake of male-centred SRH services such as vasectomy or condom use.

— **Lack of Male Engagement**: Few SRH campaigns focus on male engagement in family planning and sexual health, limiting awareness and utilization of services.

Impact: The lack of targeted SRH services for men perpetuates gender imbalances in family planning and contributes to the spread of STIs, as well as higher rates of unintended pregnancies.

12. Inadequate Integration of SRH Services with HIV/AIDS Programs

While Kenya has a strong HIV/AIDS prevention and treatment program, integration of SRH services with HIV care is still limited in many regions, particularly in rural areas.

Contributing Factors:

— **Separate Health Services**: Many health facilities offer **HIV services** separately from **SRH services**, making it difficult for patients to access comprehensive care that addresses both their sexual health and HIV status.

— **Resource Constraints**: Limited funding and staffing prevent the effective integration of SRH and HIV services, especially in resource-poor regions.

Impact: The lack of integrated care results in fragmented services, where individuals with HIV may not receive the SRH support they need, such as family planning, STI screening, or maternal care for HIV-positive women.

In addition to the irregular supply of services, unaffordability, and unequal distribution of SRH and MH services across regions, other critical gaps persist. These include limited access to family planning for adolescents, inadequate post-abortion and maternal care, lack of mental health support, and insufficient services for survivors of sexual violence, poor engagement of men in SRH programs, and weak integration of HIV/AIDS care with SRH services. Addressing these gaps will require comprehensive, multi-sectoral strategies that prioritize marginalized communities and focus on building a robust, inclusive SRH system.

2.4 Impact of Unmet SRH and MHM Needs on Girls' Education in Kenya

1. School Absenteeism

— Absenteeism due to MHM: According to UNICEF Kenya (2023), many girls miss up to 4-5 days of school each month due to a lack of access to menstrual products, inadequate sanitation facilities, and the stigma surrounding menstruation. Over the course of a year, this can add up to 20% of school days missed, severely affecting their academic performance.

2. Dropout Rates

— Teenage Pregnancies: According to the Kenya Demographic and Health Survey (2022), 13,000 girls drop out of school every year due to pregnancy-related issues. Without access to SRH services, many girls are unable to continue their education.

— Child Marriages: Girls who lack access to SRH education are at higher risk of child marriage, which is a leading cause of school dropouts. These marriages are prevalent in regions like Turkana and Samburu, where cultural practices further limit access to education.

— Teen parenthood: after delivery teen parents are burdened with the responsibility of parenting

3. Academic Performance

Poor Concentration: Even when girls attend school during their periods, the lack of proper menstrual hygiene management can lead to discomfort and distraction, affecting their ability to concentrate and perform well academically.

4. Gender Based Violence (GBV)

Unmet Sexual and Reproductive Health (SRH) and Menstrual Hygiene Management (MHM) needs are closely linked to the prevalence of gender-based violence (GBV) in Kenyan schools, affecting girls' safety, health, and educational outcomes. Here's how these issues interrelate:

- Increased Vulnerability to GBV Due to Lack of MHM Resources: When girls lack access to adequate menstrual hygiene products and facilities, they are more likely to experience embarrassment, harassment, and stigma from peers and even educators. In some cases, girls who seek support from male counterparts for funds to buy sanitary products may become vulnerable to exploitation.
- Absenteeism and Its Link to GBV: The absence from school due to unmet MHM needs increases girls' risk of sexual violence when they are out of the school environment, particularly in unsafe areas. This absenteeism can also result in poorer educational outcomes, which indirectly increases the risk of early marriage and GBV.
- SRH Ignorance and Exploitation: The lack of comprehensive SRH education leaves girls uninformed about bodily autonomy and consent, making them vulnerable to abuse and exploitation, often by those in positions of authority within schools.
- Stigmatization and Peer Violence: Unmet MHM needs and SRH ignorance contribute to social stigma. Girls who are perceived as "unclean" or who lack understanding about reproductive health are often targets of bullying and other forms of psychological GBV from peers, impacting their mental health and school attendance.

5. Mental Health and Confidence

— Stigma and misconceptions surrounding menstruation also impact girls' self-esteem and mental health, leading to disengagement from school.

— Period shaming: Many girls feel ashamed and embarrassed, particularly in environments where menstrual health is taboo, affecting their participation in class and school activities.

— Teen parenthood and the stigma associated with it also impacts girls mental health negatively

3. Mapping Vulnerable Regions

Research on sexual and reproductive health (SRH) outcomes and menstrual hygiene management (MHM) in Kenya highlights several regions where girls are most vulnerable to poor SRH and lack of menstrual hygiene products. These regions include arid and semi-arid lands (ASALs), informal settlements, and marginalized communities. The barriers faced by girls in these areas are compounded by limited access to services, infrastructure, and education, as well as cultural practices.

3.1 Regions with poor access to SRH and MHM Education and Services

1. **Arid and Semi-Arid Lands (ASALs):** Counties like Turkana and Garissa face high dropout rates due to early marriage, pregnancy, and lack of MHM resources. The ASAL regions of Kenya, including areas such as Turkana, Garissa, and Wajir, are known for extreme poverty, poor infrastructure, and traditional practices that negatively affect girls' SRH and MHM outcomes. A study by Omondi et al. (2020) identified that girls in ASAL regions are particularly vulnerable due to limited access to SRH services and menstrual hygiene products. These areas often lack adequate healthcare facilities, making it difficult for adolescent girls to receive the necessary care.

   In ASALs, cultural practices like child marriages and female genital mutilation (FGM) also contribute to poor SRH outcomes, with many girls dropping out of school due to these factors. Furthermore, water scarcity and inadequate sanitation facilities exacerbate the challenges of managing menstruation in a hygienic and dignified manner.

2. **Informal Settlements:** Girls in Kibera and Mathare lack access to SRH services and proper MHM products (KNBS & UNFPA, 2020). Informal settlements in

urban centers, such as Kibera and Mathare in Nairobi, also have high rates of poor SRH and MHM outcomes among girls. Lack of adequate sanitation, privacy, and access to affordable menstrual hygiene products as major issues in these densely populated areas. Girls in informal settlements are often forced to use improvised materials such as cloth or tissue, which are inadequate and unhygienic.

The stigma and shame associated with menstruation in these areas further limit girls' ability to seek help or access proper products. Additionally, the high levels of poverty in informal settlements prevent families from purchasing sanitary towels regularly, which has been shown to directly impact school attendance and performance.

3. **Coastal Regions:** Kwale and Kilifi counties are particularly affected by poor SRH and MHM services, leading to high absenteeism rates among girls (UNICEF, 2020). In the coastal counties of Kwale, Kilifi, and Mombasa, school absenteeism due to lack of menstrual products and SRH services is also a significant issue.

Table 1: Reported teenage pregnancy cases and school return rate by region in 2022

Region	Cases of Pregnancies Reported	Contribution to National Burden	Pregnant girls return to school after delivery	Percentage returned
Coast	1,600	8.3%	899	56.2%
North Eastern	13	0.07%	13	100.0%
Eastern	2,203	11.5%	605	27.5%
Central	324	1.7%	117	36.0%
Rift Valley	6,888	35.8%	2,690	39.1%
Western	2,164	11.3%	1,010	46.7%
Nyanza	4,117	21.4%	2,160	52.5%
Nairobi	1,922	10%	676	35.2
National	19,230	100%	8,168	42.5%

Source: Extracted from the Gender Report, 2024 published by Usawa Agenda

The table using statistics on teenage pregnancy demonstrates the Kenyan regions where girls' access to SRH and MHM education and services is poor. It is noteworthy that Rift valley (35.8%), followed by Nyanza (21.4%) and Eastern (11.5%) have the highest cases of teenage pregnancies reported.

4. Stakeholders and Partners in SRH and MHM

4.1. Triple Threats

Kenya has committed to end HIV and AIDS as a public health threat and teenage pregnancies by 2030 and gender-based violence (GBV), including sexual violence, by 2026. However, the overlapping challenge of new HIV infections, adolescent pregnancies, and sexual and gender-based violence among young people, known as the "Triple Threat," impedes progress towards achievement of the goals. Additionally, these challenges presents a complex web of vulnerabilities and profoundly impact health, population, and development, including education, economic opportunities, and the overall well-being of adolescent girls.

In February 2024 has unveiled a comprehensive Commitment Plan aimed at eradicating the 'Triple Threat' of new HIV infections, gender-based violence (GBV), and teenage pregnancy by the year 2027.

The "Triple Threats Strategy" in Kenya focuses on tackling three critical challenges affecting young people—HIV/AIDS, teenage pregnancy, and gender-based violence (GBV). This strategy is especially pertinent to the educational sector, as these issues directly impact girls' school attendance, engagement, and completion rates. Effectively applying the Triple Threats Strategy within the education system can significantly advance educational goals for girls by providing safer learning environments, improving health outcomes, and fostering long-term educational achievements.

Key Components of the Triple Threats Strategy and Applications in Education

1. **Awareness and Prevention Education**: Schools can implement targeted health and life skills programs to educate girls on reproductive health, GBV prevention, and HIV awareness. By incorporating these topics into the curriculum, students gain essential knowledge and become more empowered to make informed decisions. This approach aligns with Kenya's Competency-Based Curriculum (CBC) goals of holistic and life-ready learning.
2. **Provision of Health and Counselling Services**: Schools should provide on-site or partnered health services, including HIV testing, sexual health education, and counselling for students affected by GBV or at risk of early pregnancy. Access to these services in a supportive, safe school setting can prevent dropouts and improve the health and well-being of students, ultimately supporting higher attendance and academic achievement.
3. **Strengthening Protection Policies and Safe Reporting Mechanisms**: Integrating the Triple Threats Strategy within school policies involves creating a framework for child protection, which includes safe reporting channels for GBV incidents and safeguards against stigmatization for students dealing with HIV or pregnancy. Teachers and staff need training on handling these issues sensitively, allowing schools to become safer spaces for girls, which can reduce absenteeism and improve retention rates.

To maximize the strategy's effectiveness, it is recommended that the Ministry of Education collaborates with healthcare providers, NGOs, and community organizations focused on child protection. Such partnerships can help fund necessary resources, train teachers, and raise awareness within communities, ensuring comprehensive support for girls both in and out of school settings.

By implementing these aspects of the Triple Threats Strategy within schools, Kenya can work toward creating a safer, healthier, and more inclusive educational environment that supports girls in overcoming barriers and achieving their academic and life goals.

4.2. Government Agencies

1. **Ministry of Health (MOH):** Oversees SRH policy formulation and implementation. Provides guidelines for health service provision and manages public health programs, including menstrual hygiene awareness campaigns. Leads national SRH and MHM programs, including health education in schools. Provides training for healthcare providers and supports school-based health programs. Works with NGOs, international bodies, and county governments. Funded by the national government and international partners like the World Health Organization (WHO).
2. **Ministry of Education (MOE):** Implements programs on menstrual hygiene management and SRH education in schools. Distributes free sanitary towels to schoolgirls through the Sanitary Towels Program and ensures SRH education is incorporated into the school curriculum. Partners with the MOH, UNICEF, and NGOs to enhance access to menstrual products. National budget allocation and support from development partners.
3. **National Gender and Equality Commission (NGEC):** Advocates for gender equality and empowerment of women and girls, including ensuring access to SRH and MHM services. Drives advocacy for SRH and menstrual health rights, particularly for marginalized girls. Collaborates with civil society organizations and international agencies. Government funds and support from UN agencies.

4.3. Non-Governmental Organizations (NGOs)

1. **Amref Health Africa:** Focuses on ASAL regions, rural and marginalized areas. Offers comprehensive SRH services, including menstrual hygiene education, product distribution, and training for healthcare workers. AMREF implements the Youth in Action program, which educates adolescents in schools on SRH topics, including safe sex practices, menstrual hygiene, and addressing myths around reproductive health. AMREF's work also includes teacher training to ensure CSE content is delivered effectively. Amref also leads community sensitization programs to combat SRH stigma.

2. **Plan International Kenya:** Focuses on ASAL regions, rural and coastal areas. Provides SRH and menstrual hygiene education, product distribution, and promotes gender equality. Plan International Kenya works with schools to provide CSE through peer educators and teacher training. Their focus is on empowering young people with knowledge about reproductive health, preventing early pregnancies, and improving access to menstrual hygiene products. They focus on girls' education, health services, and breaking taboos around menstruation.
3. **Girl Child Network (GCN):** Advocates for girls' education and health rights. Conducts SRH education and distributes sanitary towels in schools. Engages in community sensitization to reduce stigma around menstruation.
4. **Akili Dada:** Focuses on Nairobi's informal settlements, rural areas. Offers leadership and SRH education for girls, including menstrual hygiene support, mentoring programs, and reproductive health workshops.
5. **The Dignity Project:** Focuses on urban slums and ASAL regions. Distributes menstrual hygiene products and provides education on reproductive health. They focus on dignity kits for schoolgirls and offer community health workshops.
6. **Kenya Red Cross Society:** Focuses on ASAL regions (e.g., Turkana, Wajir), marginalized rural areas. Provides menstrual hygiene products, SRH services, and water and sanitation facilities in schools and community centres. Through their Youth Peer Education Program (YPEP), the Kenya Red Cross focuses on teaching reproductive health and HIV prevention. The program is run by peer educators who provide CSE to fellow students, with an emphasis on building life skills and promoting responsible behaviour. They also run health and education campaigns on SRH.
7. **Well Told Story (Shujaaz):** Focuses on informal settlements, rural areas. Through their Shujaaz platforms, they offer SRH education and menstrual hygiene awareness for young people via multimedia campaigns and peer-led community programs.
8. **Marie Stopes Kenya:** Focuses on urban slums, rural areas. Delivers SRH services, including family planning, menstrual health management, and education on reproductive health. They also run youth-focused clinics and outreach programs in vulnerable communities.

9. **Days for Girls International:** Focus areas include rural areas, informal settlements. Focuses on providing menstrual hygiene products and education. They distribute reusable menstrual kits and offer training on menstrual health management to empower girls and break menstrual stigma.
10. **Save the Children Kenya:** Focuses on ASAL regions, rural and coastal areas. Works on improving access to SRH services for girls, focusing on adolescent health, menstrual hygiene education, and providing sanitary products to vulnerable schoolgirls.
11. **Faith to Action Network:** Work with religious schools to deliver CSE that is aligned with cultural and religious values. They focus on integrating SRH education into existing curricula while addressing myths and cultural taboos around reproductive health.
12. **World Vision Kenya:** World Vision works with schools in rural areas, providing both CSE and MHM education. Their efforts include building WASH facilities and supplying girls with sanitary pads, helping to reduce absenteeism during menstruation.

4.4. Private Sector Players

1. **Safaricom Foundation:** Corporate social responsibility (CSR) arm of Safaricom, focused on education and health. Provides funding for SRH and menstrual hygiene projects, including the distribution of sanitary towels to schoolgirls. Supports construction of WASH facilities in schools. Partners with NGOs like Plan International and Amref to implement health and education programs. Funded by corporate funds allocated for CSR projects.
2. **Procter & Gamble (P&G) – Always Brand:** Manufacturer of sanitary products, engaged in menstrual hygiene awareness campaigns. Provides free sanitary towels to schoolgirls through partnerships with NGOs. Runs educational programs that teach menstrual health and hygiene in schools. Partners with the Ministry of Education and NGOs to distribute products and conduct hygiene campaigns. Funded by P&G's CSR initiatives.

4.5. International Bodies

1. **United Nations Population Fund (UNFPA):** Leads international efforts to improve reproductive health and rights. Provides technical and financial support for SRH and MHM initiatives in Kenya. Facilitates the distribution of menstrual hygiene products and runs awareness campaigns in schools. Works with the Kenyan government, NGOs, and other UN agencies like UNICEF.
2. **UNICEF Kenya:** Promotes children's rights, health, and education, including access to SRH and MHM services. Supplies sanitary towels, improves WASH facilities in schools, and runs SRH education programs. Provides policy support and advocacy to ensure MHM is addressed in national strategies. Collaborates with the Ministry of Education, NGOs, and private sector players like P&G.
3. **USAID Kenya:** Provides development assistance, with a focus on health and education. Supports programs that distribute sanitary towels and provide SRH education to adolescents. Invests in school-based health initiatives and infrastructure development. Works with local NGOs, government agencies, and health institutions.

4.6. Research Institutions

1. **Jaslika Consulting:** Specializes in research related to **education**, **child rights**, and **gender equality**. They conduct studies on how societal structures and systems affect access to quality education for marginalized groups, especially girls. Jaslika focuses on creating localized impacts through evidence-based research on barriers to girls' education, including challenges in accessing SRH and MHM services.
2. **Usawa Agenda:** Conducts extensive research on **education equity** and learning outcomes in Kenya. Their research is primarily focused on improving access to quality education for all children, especially in rural and underserved areas. Usawa Agenda publishes reports on literacy and numeracy, learning assessments, and evaluates the barriers to girls' education, including SRH and MHM issues.

3. **African Population and Health Research Center (APHRC):** A leading institution in Kenya conducting research on SRH, MHM, and gender issues, with a focus on marginalized populations. It produces comprehensive data on health barriers for adolescent girls, including the impact of poor menstrual health on education.
4. **Kenya Medical Research Institute (KEMRI):** Conducts extensive research on reproductive health, including adolescent SRH and MHM, contributing to national health policies and strategies. They collaborate with international organizations to generate data on girls' health and education.
5. **Population Council – Kenya:** Works on reproductive health and rights, with a special focus on improving adolescent girls' access to SRH services. They provide data on barriers to girls' education, including those related to MHM and SRH.
6. **Guttmacher Institute:** Conducts SRH research, particularly focused on access to contraception and reducing unsafe abortions among adolescents in Kenya. It also studies the socio-cultural barriers to MHM and how they impact girls' education.
7. **FHI 360:** Conducts research on SRH and MHM as part of their global health initiatives. They focus on addressing educational barriers for girls, such as menstrual health and access to youth-friendly SRH services.
8. **Well Told Story:** This consultancy firm focuses on social change through storytelling and research. They have worked on projects related to SRH and girls' empowerment, providing data on barriers to education caused by poor access to SRH and MHM services.
9. **Centre for Reproductive Rights – Kenya:** Conducts research on legal and policy frameworks around SRH and MHM. They advocate for improved access to reproductive health services and address the legal barriers that impact girls' education.
10. **Innovations for Poverty Action (IPA):** Runs randomized controlled trials and research studies on education, health, and gender. Their work often includes data on how MHM and SRH access barriers affect school attendance and educational outcomes for girls.

4.7 Faith based organisations

In Kenya, several faith-based organizations (FBOs) are actively involved in implementing comprehensive sexuality education (CSE) and menstrual hygiene management (MHM) programs in partnership with the Ministry of Education. These initiatives aim to align with cultural and religious values while addressing the critical need for SRH and MHM education in schools. Here are some notable programs:

1. Faith to Action Network

Program: Interfaith Engagement on Sexual and Reproductive Health and Rights (SRHR)

— **Focus**: This program works across multiple faith groups (Christian, Muslim, and Hindu) to promote SRHR, including comprehensive sexuality education. It emphasizes culturally sensitive and faith-aligned approaches to educating young people on sexual health.
— Partnership: The organization collaborates with the Ministry of Education to integrate CSE that is both respectful of religious values and informative. The program also includes MHM education, particularly in faith-based schools.
— Key Activities: The curriculum addresses reproductive health, life skills, and gender equity, while promoting dialogue between religious leaders, educators, and parents.

2. 2. The Adventist Development and Relief Agency (ADRA)

Program: Girls' Education and Empowerment Project (GEEP)

— **Focus**: ADRA Kenya implements the Girls' Education and Empowerment Project, which includes components of menstrual hygiene management (MHM) and life skills education in primary and secondary schools, particularly in underserved regions. The program promotes education on SRH and MHM, helping girls manage menstruation with dignity and stay in school.
— **Partnership**: ADRA collaborates with local schools and the Ministry of Education to provide MHM materials, sanitary products, and training for teachers to integrate menstrual health education into the curriculum.

— Key Activities: The program provides both education on menstrual health and physical hygiene resources, including the distribution of reusable sanitary pads, hygiene kits, and access to safe, girl-friendly latrines in schools.

3. World Vision Kenya

Program: Channels of Hope (CoH) for Gender and SRHR

— Focus: World Vision Kenya's Channels of Hope is an interfaith initiative designed to address SRH through faith-based advocacy. The program trains faith leaders, teachers, and community members to discuss CSE and MHM while integrating religious teachings that support gender equity and child protection.
— Partnership: The Ministry of Education supports World Vision in scaling up CSE in public and private schools, especially those affiliated with religious organizations. The initiative also incorporates MHM by providing hygiene products and infrastructure improvements in schools.
— Key Activities: Besides CSE, the program promotes MHM by ensuring access to menstrual hygiene products and facilities for girls. It also creates a supportive environment for girls to manage menstruation and SRH without fear of stigma.

4. Christian Health Association of Kenya (CHAK)

Program: Reproductive Health Education for Adolescents

— Focus: CHAK's program integrates SRHR and MHM education within Christian-affiliated schools, focusing on age-appropriate CSE. It uses a faith-based approach to address sensitive topics such as reproductive health, menstruation, and adolescent rights.
— Partnership: CHAK collaborates with the Ministry of Education to implement CSE within Christian schools while ensuring that the content is respectful of religious values. Teachers are trained to deliver SRHR education in a faith-affirming manner.
— Key Activities: The program includes life skills training, awareness on menstrual hygiene, and sessions on reproductive health. It also works with communities to raise awareness on the importance of CSE and MHM.

5. Islamic Relief Kenya

Program: Gender Justice and SRHR Program

- **Focus**: Islamic Relief Kenya works in Muslim-majority regions, promoting gender justice and SRHR within an Islamic framework. The program addresses MHM and CSE while ensuring that the curriculum is aligned with Islamic teachings. It targets girls in schools, providing education on menstrual hygiene and reproductive health.
- Partnership: In partnership with the Ministry of Education, Islamic Relief implements MHM programs that also provide menstrual hygiene products and improve access to water, sanitation, and hygiene (WASH) facilities in schools.
- Key Activities: Activities include teacher training, community outreach, and awareness campaigns on SRHR and MHM. The program emphasizes the role of religious leaders in dispelling myths and promoting open discussions around menstrual and reproductive health.

4.8 Collaborations and Funding Mechanisms

Many of these stakeholders work together to achieve shared goals. For example, the Ministry of Health collaborates with UNICEF and USAID on SRH and MHM programs, while NGOs like Amref partner with corporate players like Safaricom to reach vulnerable populations. Schools serve as key implementation sites for these programs.

Funding Mechanisms:

- Government agencies rely on national budgets, donor funding, and international grants.
- NGOs are often funded through international development agencies like USAID, the Global Fund, and individual donor contributions.
- Private sector players fund SRH and MHM initiatives through CSR programs and product donations.

4.9 Scope of Services Provided

Sanitary Towels Distribution: The Ministry of Education, UNICEF, and corporate partners like P&G focus on the large-scale distribution of sanitary towels to schoolgirls.

SRH Education: Amref, Plan International, and UNFPA provide SRH education through school programs, workshops, and community sensitization efforts.

WASH Facilities: Organizations like UNICEF, Safaricom Foundation, and Plan International focus on improving sanitation infrastructure in schools to ensure privacy and hygiene for girls.

5. National and County Plans to Address SRH and MHM

5.1 Review of National Policies and Plans

1. National Adolescent Sexual and Reproductive Health Policy (2015)

Author: Ministry of Health, Kenya
Date of publication: 2015

Summary: This policy aims to enhance access to **sexual and reproductive health (SRH)** services for adolescents in Kenya. It addresses key SRH challenges such as teenage pregnancies, sexually transmitted infections (STIs), and early marriages. It also includes provisions for **menstrual hygiene management (MHM)** in schools, recognizing the need for girls to access sanitary products and proper facilities to ensure they remain in school during menstruation.

Key Elements:

— Promotion of comprehensive SRH education in schools.
— Integration of MHM into school health programs.
— Provision of adolescent-friendly health services across Kenya.

2. Kenya School Health Policy (2018)

Author: Ministry of Education and Ministry of Health
Date of Publication: 2018

Summary: This policy outlines a comprehensive approach to school health, covering various aspects of physical and mental well-being for students. It includes a focus on **SRH and MHM**, ensuring that schools provide appropriate facilities and sanitary products to manage menstruation and promote reproductive health education. The policy also emphasizes improving sanitation facilities in schools to promote better MHM practices.

Key Elements:

— Development of safe, gender-segregated sanitation facilities in schools.
— Ensuring access to menstrual hygiene products for girls.
— Incorporating SRH topics into the national curriculum.

3. Basic Education Act (2013)

Author: Ministry of Education, Government of Kenya
Date of publication: 2013

Summary: The Basic Education Act guarantees the right to free and compulsory education for all children in Kenya. It indirectly supports SRH and MHM by mandating that schools provide a safe learning environment that includes basic health services and access to sanitation facilities. This is critical for girls, who are more likely to miss school during their menstrual cycles if proper MHM facilities are not available.

Key Elements:

— Protection of the right to education for all children.
— Creation of gender-sensitive learning environments, including access to MHM facilities.

4. State Department for Gender and Affirmative Action Strategic Plan (2023-2027)

The **State Department for Gender and Affirmative Action** launched its **2023-2027 Strategic Plan**, aligning with **Kenya Vision 2030** and focusing on gender equality, reducing gender-based violence (GBV), and empowering vulnerable groups, including girls. One of the key goals of this plan is to reduce **gender disparities in education** and ensure that girls have access to SRH and MHM services. It includes capacity

building for gender-sensitive interventions and emphasizes reducing harmful cultural practices like Female Genital Mutilation (FGM), which directly affect girls' education.

Source: State Department for Gender and Affirmative Action, 2023.

5. National Education Sector Strategic Plan (2023-2027)

The **National Education Sector Strategic Plan** provides a roadmap for improving access to education, with a focus on enhancing **WASH (Water, Sanitation, and Hygiene)** infrastructure to support MHM in schools. The plan highlights the need for **menstrual hygiene facilities** and ensuring that schools are equipped with proper sanitation for girls to stay in school during menstruation. It also focuses on comprehensive sexuality education (CSE) to address SRH needs in the educational curriculum.

Source: Ministry of Education, 2023.

6. Menstrual Hygiene Management Strategy (2019-2024)

Although nearing the end of its timeline, the Menstrual Hygiene Management (MHM) Strategy from 2019 remains integral to ongoing county-level planning. This strategy addresses the need for accessible sanitary products, clean water, and private sanitation facilities in schools. The focus is on transforming MHM practices across the country by aligning with Kenya Vision 2030, ensuring that girls and women have access to MHM resources to prevent school absenteeism and improve academic outcomes.

Source: Ministry of Health, 2020.

5.1.1 Programs under Key Government Ministries

1. National Menstrual Hygiene Management (MHM) Program

Author: Ministry of Education, Government of Kenya
Date of Publication: 2017

Summary: Launched to improve access to **menstrual hygiene products** for girls in public schools. The program aims to distribute sanitary pads to schoolgirls, reduce absenteeism related to menstruation, and improve girls' retention rates in schools.

Key Elements:

— Distribution of free sanitary pads to schoolgirls.
— Training teachers on MHM to provide support to students.
— Incorporation of MHM education into the school curriculum.

2. Uwezo Fund and National Government Affirmative Action Fund (NGAAF)

Summary: The Uwezo Fund and NGAAF aim to empower women and youth through education, training, and entrepreneurship opportunities. Part of the fund is used to support SRH services and MHM initiatives, ensuring that girls and young women in marginalized regions have access to both economic opportunities and essential health services.

Key Components:

— Distribution of **MHM kits** to schools and communities.
— Support for local production of affordable **sanitary towels** through women-led enterprises.
— **SRH education** programs targeting adolescents and young women in marginalized regions.

Source: Ministry of Public Service, Youth, and Gender Affairs, **Uwezo Fund and NGAAF**, 2018.

3. Kenya Women's Empowerment Program (KWEP)

Summary: This program focuses on the empowerment of women and girls through education, health, and economic initiatives. A significant component of KWEP is improving access to **MHM products** and **SRH education** in underserved areas.

Key Components:

— **SRH and MHM education** workshops for young women.
— Collaboration with NGOs to improve **sanitation facilities** in schools.
— Distribution of **reusable sanitary pads** to girls in low-income regions.

Source: Ministry of Public Service, Youth, and Gender Affairs, **Kenya Women's Empowerment Program**, 2019.

5.2 Review of County-Level Policies and Plans

1. Nairobi County Integrated Development Plan (CIDP) 2023-2027

Author: Nairobi County Government

Date of publication: 2023

Summary: Nairobi County's CIDP includes provisions for improving health services, including **SRH** and **MHM**, for school-aged children. The plan focuses on building gender-sensitive schools with adequate sanitation facilities and access to menstrual products. It also includes SRH education as part of broader efforts to improve health outcomes for adolescents.

Key Elements:

— Implementation of SRH programs in schools.

— Construction and maintenance of sanitary facilities in schools to support MHM.

2. Kilifi County Adolescent Sexual and Reproductive Health Strategic Plan (2019-2023)

Author: Kilifi County Government

Date of publication: 2019

Summary: Kilifi County's strategic plan addresses the high rates of teenage pregnancies and school dropouts, focusing on improving **SRH** services and **MHM** for adolescents. The plan emphasizes improving school health programs, including providing menstrual hygiene products to girls and upgrading sanitation infrastructure to ensure girls remain in school during menstruation.

Key Elements:

— Comprehensive SRH education in schools.

— Provision of free sanitary products to adolescent girls in school.

— Upgrading of school sanitation facilities to be gender-sensitive.

3. Turkana County Integrated Development Plan (CIDP) 2023-2027

Source: Turkana County Government
Date of Publication: 2023

Summary: Turkana County, located in an **ASAL region** prone to drought and poverty, has a CIDP that prioritizes **girls' education** and **SRH services** as a way to address gender disparities. The plan outlines the need for improved **sanitation facilities** in schools and the provision of **menstrual hygiene products** to prevent absenteeism and dropouts among girls. There is also a focus on creating **adolescent-friendly health centers** that provide SRH education and services.

Key Interventions:

— Investment in adolescent-friendly health centers.
— Distribution of sanitary towels and improvement of MHM infrastructure.
— Initiatives to reduce child marriages and support girls' education.

4. Garissa County Adolescent Health Policy (2020-2024)

Source: Garissa County Government
Date of Publication: 2020

Summary: Garissa County's policy aims to tackle high rates of **adolescent pregnancies** and **school dropouts**, particularly among girls. The policy emphasizes the importance of providing **SRH education** in schools, equipping teachers with the necessary skills, and improving **access to MHM**. It also seeks to engage community leaders in reducing cultural practices that hinder girls' education.

Key Interventions:

— SRH training for teachers and health workers.
— Community engagement programs targeting the reduction of early marriages and female genital mutilation (FGM).
— Expansion of access to menstrual hygiene products.

5. Narok County Strategic Plan on Adolescent SRH and MHM

Author: Narok County Government
Date of publication: 2020

Overview: Narok County has developed a strategic plan to address the **high rates of teenage pregnancies** and school dropouts due to **MHM challenges** and **lack of SRH services**. The county focuses on providing **SRH education**, expanding **MHM** infrastructure, and engaging communities to reduce stigma.

Key Interventions:

- Regular supply of sanitary towels to all public schools.
- Strengthening partnerships with NGOs to deliver SRH services.
- Creation of safe spaces in schools where girls can access hygiene products and SRH counselling.

6. Mandera County CIDP 2018-2022

Author: Mandera County Government
Date of publication: 2018

Overview: Mandera County's plan focuses on reducing **high teenage pregnancy rates** and addressing **poor menstrual hygiene management** in schools. The county aims to increase access to **SRH services** and ensure that girls have the resources they need to manage their menstrual health effectively.

Key Interventions:

- Integration of SRH and MHM services within health and education systems.
- Distribution of free sanitary products in collaboration with NGOs.
- Expansion of school health programs to cover MHM and reproductive health.

County-level policies in Kenya, such as those from **Nairobi**, **Kilifi**, **Turkana**, and **Garissa**, prioritize **SRH services**, **MHM**, and **girls' education**, aligning with national policies while addressing specific local challenges. These policies focus on improving access to **sanitary products**, upgrading **sanitation facilities**, and providing **SRH education** to reduce dropout rates and promote girls' empowerment.

5.3. Resource Allocation and Implementation

1. National Menstrual Hygiene Management (MHM) Program

Funding: The Government of Kenya launched the **National Menstrual Hygiene Management Program** in 2017, aimed at distributing **free sanitary pads to schoolgirls**. The program has received significant public funding, with a commitment of **KES 470 million (approximately USD 4.5 million)** annually from the national government to support the distribution of sanitary products in public schools.

Impact on Girls' Education: The provision of sanitary products has been shown to reduce school absenteeism among girls, especially in rural areas where access to such products is limited. Studies show a **10-15% improvement in school attendance** for girls in schools that receive sanitary pads under this program.

Source: Ministry of Education, **National Menstrual Hygiene Management Program**, 2017.

2. Kenya Adolescent Sexual and Reproductive Health Policy (2015)

Funding: The policy's implementation, particularly regarding **SRH services** for adolescents, has been largely donor-funded. Key contributors include **UNICEF**, **UNFPA**, and **The Global Fund**, which have collectively provided funding to improve access to adolescent-friendly health services in schools and health centers. However, there are reported funding gaps, particularly at the county level, leading to inconsistent service delivery across regions.

Impact on Girls' Education: In regions where SRH services have been well-funded and implemented, there has been a **reduction in teenage pregnancies** and **early marriages**, both of which are key factors contributing to girls dropping out of school. Access to SRH education in schools has also increased knowledge and reduced stigma around reproductive health, further supporting girls' retention in education.

Source: Ministry of Health, **Kenya Adolescent Sexual and Reproductive Health Policy**, 2015.

3. Donor Contributions and Gaps

UNICEF and UNFPA: Both agencies have provided substantial funding for **SRH and MHM programs** in Kenya. UNICEF has specifically allocated funds for the distribution of sanitary pads, education on menstrual hygiene, and the construction of **gender-sensitive sanitation facilities** in schools. UNFPA has focused on **SRH services**, supporting the setup of youth-friendly reproductive health centers in schools and communities.

Funding Impact: Despite these efforts, reports indicate that **funding gaps remain**, particularly in rural and marginalized regions. For example, in **ASAL areas**, fewer schools benefit from these programs due to logistical and financial constraints, leaving many girls without access to MHM resources or SRH services.

Source: UNICEF Kenya, "SRH and MHM Programs," 2020; UNFPA Kenya, "SRH for Adolescents," 2019.

4. Private Sector Contributions

Corporate Partnerships: Companies such as **Procter & Gamble** and **Always** have been involved in corporate social responsibility (CSR) programs that contribute to **MHM** by providing free sanitary pads to schoolgirls. These programs have supplemented government efforts, particularly in urban areas.

Impact: While these contributions are valuable, they often reach a limited number of schools and are not sustainable long-term solutions. There is a need for more systemic resource allocation to ensure that MHM services are available to all girls, particularly in rural areas.

Source: Procter & Gamble, "Always Keeping Girls in School," 2021.

5. Challenges in Resource Allocation

Underfunding: According to a review by **ActionAid Kenya**, the **SRH and MHM sectors** are significantly underfunded, especially at the **county level**. Counties face difficulties in raising funds to support MHM and SRH services due to competing priorities, leaving many schools without the necessary resources to support girls during menstruation or provide comprehensive SRH education.

Source: ActionAid Kenya, "Funding Gaps in MHM and SRH," 2021.

Conclusion

While there has been commendable progress in funding SRH and MHM programs in Kenya, particularly through government and donor partnerships, significant funding gaps remain, especially in rural and marginalized areas. These gaps limit the reach and effectiveness of programs designed to keep girls in school by addressing their reproductive health and hygiene needs. To ensure equitable access, increased investment and sustained funding mechanisms are necessary across all regions.

6. Systemic Barriers and Gaps

6.1 Barriers in Policy and Implementation

Despite the existence of several policies and programs aimed at addressing Sexual and Reproductive Health (SRH) and Menstrual Hygiene Management (MHM) for girls in Kenya, various gaps in policy formulation and implementation hinder their effectiveness. These barriers include inadequate funding, poor infrastructure, lack of coordination, and cultural resistance.

1. **Inconsistent Implementation of MHM and SRH Policies**: While Kenya's **National Menstrual Hygiene Management Policy** (2017) outlines comprehensive plans for the distribution of sanitary pads and improved sanitation in schools, implementation at the county level is inconsistent. Many schools, particularly in rural and ASAL regions, do not receive adequate supplies of menstrual products or have appropriate sanitation facilities.

   This is partly due to insufficient coordination between the national and county governments, leading to disparities in resource distribution.

Source: Ministry of Education, **National Menstrual Hygiene Management Policy**, 2017.

2. **Funding Gaps and Resource Allocation**: Many policies related to SRH and MHM are **underfunded**, especially at the county level. Although donor

agencies and non-state actors contribute significantly to these sectors, the reliance on external funding creates an unstable financial base, which limits the sustainability of these programs.

Limited national and county budget allocations for SRH and MHM, and competing priorities in other sectors, result in inadequate financial support for education and health programs related to SRH and MHM.

Source: ActionAid Kenya, **Funding Gaps in SRH and MHM**, 2021.

3. **Lack of Gender-Sensitive Policy Integration**: SRH and MHM are often treated as separate from broader **gender and education policies**. This lack of integration means that while efforts may be made to improve educational access for girls, they often fail to address the specific barriers posed by poor SRH and MHM services.

   Policies like the **Basic Education Act (2013)** and the **Kenya Vision 2030** do not sufficiently integrate gender-responsive and health-based interventions into the national education framework.

Source: Ministry of Education, **Basic Education Act**, 2013.

4. **Cultural Resistance and Stigma**: Despite the existence of progressive policies, cultural stigma surrounding menstruation and sexual health persists, particularly in rural areas. This stigma prevents girls from accessing SRH services or discussing menstrual hygiene openly, undermining the effectiveness of MHM initiatives.

   Cultural barriers are not adequately addressed in the implementation strategies of many SRH and MHM policies, leading to persistent negative attitudes towards menstruation and reproductive health.

Source: Ministry of Health, **Kenya Adolescent Sexual and Reproductive Health Policy**, 2015.

5. **Lack of Comprehensive SRH Education**: SRH education in schools is **not uniformly implemented**. Although the **Kenya School Health Policy (2018)** mandates SRH education, many schools fail to provide adequate information due to a lack of trained teachers, insufficient materials, or resistance from communities.

SRH education is often seen as controversial, leading to push-back from conservative communities, teachers, and parents. This results in patchy implementation across different regions.

Source: Ministry of Education, **Kenya School Health Policy**, 2018.

6. **Inadequate Infrastructure for MHM**: Many schools, especially in rural areas, lack adequate **sanitation infrastructure** to support girls during menstruation. The absence of safe, gender-sensitive facilities prevents girls from managing their menstrual hygiene in a dignified manner, leading to increased absenteeism.

   Despite the **National MHM Program**, infrastructure improvements are slow due to insufficient funding, poor planning, and logistical challenges in rural regions.

Source: Ministry of Education, **National Menstrual Hygiene Management Program**, 2017.

Although Kenya has made significant progress in formulating policies related to **SRH**, **MHM**, and **girls' education**, several barriers in policy implementation continue to affect the efficacy of these programs. Addressing these gaps will require a **multi-sectoral approach** that integrates gender-sensitive planning, increased funding, cultural sensitization, and better coordination between national and county governments.

6.2 Cultural and Social Barriers

Kenya faces significant socio-cultural barriers that hinder the implementation and effectiveness of **Sexual and Reproductive Health (SRH)** and **Menstrual Hygiene Management (MHM)** programs, particularly impacting girls' education. These challenges are deeply rooted in traditional practices, gender norms, and societal expectations that shape attitudes towards reproductive health and menstruation.

1. **Stigma Surrounding Menstruation**: In many Kenyan communities, menstruation is considered **taboo** and surrounded by shame and secrecy. Girls often face embarrassment, social exclusion, and discrimination when menstruating, which prevents them from attending school during their periods.

This stigma leads to **absenteeism**, with girls missing several days of school each month, which negatively impacts their educational performance and retention rates. The lack of **MHM education** and awareness among both boys and girls exacerbates these issues.

Source: UNICEF Kenya, "Menstrual Hygiene and Education Programs," 2020.

2. **Patriarchal Norms and Gender Inequality**: Traditional gender roles in Kenya place greater value on boys' education compared to girls'. In patriarchal households, boys are seen as future providers, while girls are often prepared for domestic roles and early marriage. This mind-set leads families to prioritize the education of boys over girls, particularly during times of economic hardship or crises.

   Girls are more likely to drop out of school due to the compounded pressures of domestic work, child marriage, and the belief that their education is less important. Early marriages are often viewed as a strategy to reduce family burdens or secure financial stability through dowries.

Source: ActionAid Kenya, "Girls' Education and Cultural Norms," 2021.

3. **Child Marriages and Teenage Pregnancies**: are prevalent in several rural regions in Kenya, particularly in **ASAL areas**. Cultural practices and poverty drive families to marry off girls at a young age, often in exchange for dowries. Once married or pregnant, girls are expected to drop out of school and assume the role of wife and mother.

   Teenage pregnancies and child marriages are two of the leading causes of girls leaving school prematurely. Studies show that in regions where early marriage is common, **up to 30% of school-aged girls** leave education before completing secondary school.

Source: Ministry of Health, **Kenya Adolescent Sexual and Reproductive Health Policy**, 2015.

4. **Cultural Practices and Female Genital Mutilation/Cutting (FGM/C)**: In some communities, **FGM/C** is still practiced, despite being illegal in Kenya. FGM/C is often seen as a rite of passage into womanhood, after which girls are considered ready for marriage. FGM not only impacts girls' physical health but also disrupts their education, as many girls leave school during or after undergoing the procedure.

FGM/C is a major barrier to education for girls in regions where the practice persists. Girls who undergo FGM/C are at a higher risk of being married off early, which drastically reduces their chances of continuing their education.

Source: UNICEF Kenya, "End FGM Program in Kenya," 2020.

5. **Lack of Parental Support and Awareness**: In many rural communities, parents lack awareness of the importance of **SRH education** and **MHM** for their daughters. Many parents do not openly discuss issues of menstruation or reproductive health with their children, considering them culturally inappropriate topics. This lack of communication contributes to the stigmatization of menstruation and reinforces harmful gender norms.

   Without parental support, girls are less likely to seek out SRH services or use menstrual hygiene products, further exacerbating the issues of absenteeism and poor educational outcomes. Community resistance to SRH education in schools also limits the effectiveness of programs aimed at improving girls' health and educational attainment.

Source: Ministry of Education, **Kenya School Health Policy**, 2018.

6. **Poverty and Economic Challenges**: Economic hardship exacerbates socio-cultural barriers to girls' education. In impoverished households, families often cannot afford menstrual hygiene products, leading to absenteeism among girls during their menstrual cycles. Additionally, poverty drives early marriages and child labor, further reducing girls' chances of completing their education.

   Girls from low-income families are disproportionately affected by these challenges, with **higher dropout rates** compared to their male counterparts. The **lack of affordability** of sanitary products remains a critical issue, even with government and NGO interventions aimed at addressing MHM barriers.

Source: World Bank, **Gender Equality in Education Report**, 2019.

6.3 Infrastructure and Supply Chain Issues

Kenya faces significant infrastructure and supply chain challenges that hinder effective implementation of Sexual and Reproductive Health (SRH) and Menstrual

Hygiene Management (MHM) programs, particularly in rural and underserved areas. These challenges affect girls' access to necessary SRH services and hygiene products, which in turn impacts their educational outcomes.

1. **Lack of Adequate Sanitation Facilities in Schools**: Many schools in rural and marginalized areas lack proper sanitation facilities, including separate toilets for girls and boys. The absence of privacy, clean water, and appropriate waste disposal options discourages girls from attending school, particularly during menstruation.

   The lack of **MHM infrastructure** contributes to **high absenteeism** among girls during menstruation. Research shows that girls who lack access to clean and private sanitation facilities miss several school days each month, leading to poor academic performance and increased dropout rates.

Source: Ministry of Education, **Kenya School Health Policy**, 2018.

2. **Inconsistent Supply of Menstrual Hygiene Products**: There are significant **supply chain challenges** related to the distribution of sanitary products in remote and rural areas. While government programs and NGOs provide sanitary pads, the distribution is often irregular and insufficient to meet demand, particularly in **ASAL regions**.

   Girls in rural areas often resort to using improvised and unsafe materials during menstruation, which affects their confidence and health. The inconsistent supply of products, along with poor MHM facilities, exacerbates absenteeism and educational inequality.

Source: UNICEF Kenya, "Menstrual Hygiene and Education Programs," 2020.

3. **Inadequate Health Infrastructure for SRH Services**: In rural regions, healthcare facilities are often understaffed and lack the necessary resources to provide comprehensive **SRH services** for adolescents. Many health centres do not have the equipment or trained personnel to offer youth-friendly SRH services, including family planning, STI prevention, or reproductive health counselling.

   The lack of accessible **SRH services** in schools and communities contributes to high rates of **teenage pregnancies** and **early marriages**, both of which lead to school dropout among girls. Adolescents in underserved areas are left without

critical information or resources to manage their reproductive health.

Source: Ministry of Health, **Kenya Adolescent Sexual and Reproductive Health Policy**, 2015.

4. **Transportation and Logistical Barriers**: Poor infrastructure in remote areas affects the distribution of **MHM supplies** and the provision of **SRH services**. Many rural schools and health facilities are located far from main transport routes, making it difficult for girls to access health services or receive regular deliveries of sanitary products.

   Long distances and poor road conditions hinder access to both **healthcare facilities** and **educational institutions**. Girls in these regions are often forced to walk long distances to attend school or visit health centres, which increases the likelihood of **school absenteeism** and discourages consistent healthcare visits.

Source: World Bank, **Infrastructure and Education in Rural Africa Report**, 2019.

5. **Inefficient Supply Chains for Educational Materials**: Alongside MHM products, schools often experience delays in receiving **educational materials** and **SRH educational resources**. Supply chain inefficiencies, particularly in remote counties, mean that schools are often under-resourced when it comes to delivering effective SRH education and health services.

   This lack of resources hampers efforts to provide comprehensive **SRH education**, leaving students uninformed about critical health issues and limiting the success of national SRH and MHM initiatives.

Source: ActionAid Kenya, "Challenges in Delivering Educational Resources," 2020.

6.4. Emerging issues/gaps

6.4.1 Intersex Learners

Intersex children in Kenya face significant challenges within the education system, especially at the high school level, due to societal stigma, lack of legal recognition, and administrative gaps. Although Kenya became the first African country to include intersex individuals in its 2019 census, allowing for greater visibility and potential policy inclusion, structural barriers remain substantial.

One key issue is the lack of documentation and legal recognition. Kenyan law currently recognizes only male and female gender categories. As a result, intersex children often struggle to obtain birth certificates, which are necessary for school enrollment and national exams. Without these documents, intersex students may face exclusion from the education system, leading to poor academic and career prospects. Additionally, intersex students in high schools frequently encounter social stigma and bullying, often due to a general lack of awareness and acceptance of intersex individuals within communities and school environments (Chigiti, 2019; KLRC, 2017).

Efforts to support intersex students in Kenyan schools would benefit from policies that include gender sensitivity training for educators, anti-bullying initiatives, and the creation of safe, inclusive spaces. Legal reforms, such as amendments to the Registration of Births and Deaths Act, are underway to formally recognize intersex persons, which may improve access to documentation and secure their educational rights (Kenya Law Reform Commission, 2017; Ushie, 2019). To ensure that intersex children have equitable educational opportunities, both societal attitudes and policy frameworks will need significant development.

6.4.2. Online Gender Based Violence

Recent studies reveal a significant prevalence of OGBV among youth in Kenya. For example, a 2024 study by UNFPA and the Collaborative Center for Gender and Development found that nearly 90% of young adults in Nairobi's tertiary institutions have witnessed or experienced technology-facilitated GBV, with higher rates among females (64.4%) than males (39%) (UNFPA, 2024). Additionally, KICTANet's 2023 report highlighted that adolescent girls are especially susceptible to cyberbullying, online harassment, and sexual exploitation, which can lead to decreased self-esteem, anxiety, depression, and a negative impact on academic performance (KICTANet, 2023).

The most common forms of OGBV against children and youth in Kenya include:

— Cyberbullying: Persistent harassment on platforms like Facebook, WhatsApp, and Instagram that leads to emotional distress and fear.

- Cyber Crime and Exploitation: Cases of online grooming, blackmail, and unauthorized use of personal data for financial exploitation or coercion.
- Non-Consensual Content Sharing: Instances of sharing images or information without consent, particularly affecting girls (The Youth Cafe, 2023).

Teachers in Kenya currently lack adequate training to address OGBV and ensure a safe online environment for students. While some schools have implemented cyber-safety policies, gaps in teacher training and limited access to child protection tools have made it challenging to protect students effectively (UN Women, 2023).

While Kenya has established some online protection guidelines, enforcement remains a challenge. The existing policies are not fully equipped to handle the rapidly evolving nature of digital violence, and resources for law enforcement and education on OGBV prevention are limited. Key gaps include insufficient regulatory oversight of social media platforms and a lack of resources to support victims effectively (UNFPA, 2024; KICTANet, 2023).

6.5. Inter-sectionality of barriers to accessing SRH and MHM

The intersectionality between cultural norms, taboos, stigma, patriarchy, and the allocation of resources towards Sexual and Reproductive Health (SRH) and Menstrual Health Management (MHM) education and services reveals a complex web of factors that exacerbate inequalities and hinder access to essential health services. These factors influence how SRH and MHM services are prioritized, funded, and accessed, particularly in low- and middle-income countries (LMICs).

1. Cultural Norms and Taboos

Cultural beliefs often shape perceptions of menstruation and sexual health, perpetuating myths and stigmas. Menstruation is frequently seen as dirty or shameful, which can limit open discussions about menstrual health and deter the allocation of resources for MHM education and services. In many communities, SRH is considered a private matter, making it difficult for adolescents, particularly girls, to seek information or care.

— **Research Evidence**: A 2020 study published in BMC Women's Health found that cultural taboos surrounding menstruation were a major barrier to MHM, with girls in rural India reporting that they were not allowed to participate in household activities or religious ceremonies during menstruation due to perceptions of impurity. These taboos restricted their mobility, access to sanitary products, and willingness to engage in discussions about their menstrual health.

2. Stigma and Silence around SRH

Stigma associated with SRH, especially for adolescents and unmarried women, often results in limited access to information and services. Young people are often denied comprehensive SRH education because of concerns that it may promote promiscuity. This stigma contributes to misinformation, unwanted pregnancies, unsafe abortions, and an increased risk of sexually transmitted infections (STIs).

— **Research Evidence**: According to a 2021 report by the Guttmacher Institute, in many African countries, stigma around adolescent sexual activity has led to poor access to SRH services, with young girls feeling shame and fear of judgment when seeking contraception. This results in high rates of teenage pregnancy and unsafe abortions in these regions.

3. Patriarchy and Gender Inequality

Patriarchal structures reinforce gender inequalities, limiting women's autonomy over their bodies and reproductive choices. In many societies, men hold decision-making power over reproductive health matters, which impacts the allocation of resources to SRH services. Menstruation is often dismissed as a "woman's issue," resulting in limited investment in MHM infrastructure and education.

— **Research Evidence**: A 2022 study in The Lancet Global Health indicated that gender power imbalances in households in sub-Saharan Africa significantly affected women's ability to access SRH services. Men, who control household finances, were less likely to prioritize spending on SRH services for their partners. Additionally, MHM was not seen as an urgent issue by male decision-makers, further reducing resource allocation.

4. Resource Allocation and Policy Gaps

The interplay between cultural norms, stigma, and patriarchy influences government policies and how resources are allocated to SRH and MHM services. Often, national health budgets prioritize maternal and child health but neglect comprehensive SRH services for adolescents or fail to provide adequate resources for menstrual hygiene management.

— **Research Evidence**: A 2023 study conducted in East Africa found that although national policies supported adolescent reproductive health, the implementation was weak due to limited funding and cultural resistance. Only 15% of the health budget was allocated to SRH programs, with MHM receiving even less attention, reflecting deep-rooted patriarchal beliefs that devalue adolescent girls' and young women's specific health needs.

5. Access to Education and Misinformation

Cultural norms, stigma, and patriarchy also affect education systems, with many schools either not offering comprehensive SRH education or only teaching it from a moralistic or abstinence-only perspective. This leaves students with insufficient knowledge to make informed decisions about their reproductive health.

— **Research Evidence**: The UNESCO 2022 report on Comprehensive Sexuality Education (CSE) highlights that fewer than 40% of adolescents worldwide receive accurate and complete SRH education. The report cites cultural resistance and misconceptions about CSE as key barriers, resulting in poor reproductive health outcomes among adolescents, including high rates of STIs and early pregnancy.

Conclusion

Cultural norms, stigma, and patriarchy play significant roles in shaping the availability, prioritization, and effectiveness of SRH and MHM education and services. The lack of resources allocated to these areas is often rooted in the social and gender dynamics that diminish the importance of women's health, particularly adolescent girls. Addressing these issues requires culturally sensitive approaches that challenge patriarchal structures, reduce stigma, and advocate for the increased funding of comprehensive SRH and MHM services.

7. Recommendations and Conclusions

7.1 Addressing Gaps and Systemic Barriers

To overcome the challenges hindering access to **Sexual and Reproductive Health (SRH)** services, **Menstrual Hygiene Management (MHM)**, and **girls' education** in Kenya, a multi-sectoral approach is necessary. Below are key recommendations to address the gaps and systemic barriers:

1. **Increase Funding and Resource Allocation**: The government, in collaboration with donors, should increase **funding for SRH and MHM programs**, especially in rural and underserved areas where the need is greatest.

   Action: National and county governments should allocate a higher percentage of the budget to **SRH services** and ensure consistent supply of **MHM products** in schools. Partnerships with **NGOs** and **private sector actors** can further scale up resource distribution.

2. **Improve Infrastructure in Schools**: Invest in the **construction of gender-segregated toilets** and improve access to clean water in schools to ensure that girls have safe and private facilities during menstruation.

   Action: The Ministry of Education should work with county governments to ensure that all schools have adequate sanitation facilities that include clean water, waste disposal systems, and safe spaces for girls to manage menstruation.

3. **Expand Human Sexuality Education**: Implement **comprehensive SRH education by rebranding it to Human Sexuality Education which is acceptable among religious and cultural leaders** as part of the national curriculum, ensuring that both boys and girls receive age-appropriate and culturally sensitive information about reproductive health, menstruation, and sexual rights. Faith-based comprehensive sexuality education (CSE) and menstrual hygiene management (MHM) programs in schools have been increasingly recognized for their potential to address the sexual and reproductive health (SRH) needs of adolescent girls in culturally and religiously sensitive environments.

   Action: The Ministry of Education, in collaboration with faith based organisations, **UNICEF** and other partners to leverage religious education subjects and pastoral programs to provide human sexuality education to learners in school. Further there should be **teacher training programs** to ensure that SRH education is effectively delivered in schools. Additionally, include religious and cultural leaders in community engagement to address cultural and religious stigma around SRH topics.

4. **Strengthen Community Awareness and Sensitization**: Promote **community - level sensitization** campaigns to reduce the stigma surrounding **menstruation** and **SRH services** and involve parents and community leaders in these efforts.

   Action: Partner with local **NGOs**, **faith-based organizations**, and **community leaders** to deliver **awareness campaigns** that address harmful cultural practices, such as **early marriage** and **FGM**, and encourage girls' education.

5. **Address Policy Implementation Gaps**: The **full implementation** of existing policies, such as the **Kenya Adolescent Sexual and Reproductive Health Policy** and the **National Menstrual Hygiene Management Program**.

   Action: Strengthen coordination between the **national government** and **county governments** to monitor the implementation of these policies and address challenges at the local level.

6. **Engage Men and Boys in SRH and MHM Programs**: Develop programs that involve **men and boys** in conversations about SRH and MHM to foster a supportive environment for girls.

Action: Implement school-based programs and community outreach efforts that encourage **male participation** in MHM education, breaking down taboos and fostering understanding.

7. **Expand Access to Youth-Friendly SRH Services**: Ensure that **youth-friendly SRH clinics** are accessible in all counties, with a special focus on rural and marginalized areas.

   Action: Scale up the establishment of **adolescent-friendly SRH services** within health facilities and schools, ensuring that girls can access contraception, counselling, and health information in a safe and non-judgmental setting.

8. **Provide Sustainable Menstrual Hygiene Solutions**: Promote the production and distribution of **affordable, sustainable menstrual products** such as **reusable sanitary pads** in rural and low-income communities.

   Action: Support local **women's cooperatives** and small businesses to produce and distribute reusable sanitary products, and collaborate with **NGOs** to provide training on how to use and maintain these products.

7.2 Areas for further Research

To support **girls' education** through improved **Sexual and Reproductive Health (SRH)** and **Menstrual Hygiene (MH) services**, further research, policy advocacy, and program development should focus on the following areas:

1. **Long-Term Impact of SRH and MHM on Academic Performance**

   Research Gap: While studies have established a link between access to SRH and MHM services and improved school attendance, there is limited research on the **long-term academic performance** and socio-economic outcomes for girls benefiting from these programs.

   Further Research: Longitudinal studies should assess the **academic performance** of girls over time in regions where SRH and MHM interventions have been implemented, comparing outcomes to areas with no or fewer services.

2. SRH Education for Boys and Community Engagement

Research Gap: There is limited evidence on the effectiveness of involving **boys** and **communities** in SRH and MHM education. In many areas, boys' engagement in these issues remains underexplored.

Further Research: Investigate the impact of **SRH and MHM education for boys**, alongside community-led initiatives that address cultural taboos. This research could assess how involving boys reduces the stigma girls' face and increases school retention rates.

3. Digital Platforms and Innovation in SRH Education

Research Gap: The role of **digital platforms** and innovative technologies in delivering SRH services to adolescents, especially in marginalized areas, is underexplored.

Further Research: Investigate the use of **mobile apps**, **e-learning platforms**, and **SMS-based SRH education** to provide accurate and timely health information to adolescents, particularly in remote and rural regions.

7.3 Areas for further Policy Advocacy

1. Integration of SRH and MHM into National Education Policies

Advocacy Focus: Ensure that **SRH and MHM services** are mainstreamed into **national education policies**. This includes incorporating **MHM education** into the national curriculum and ensuring that both boys and girls receive **SRH education**.

Policy Action: Advocate for the **full implementation** of Kenya's **School Health Policy** and ensure that **MHM programs** are funded and implemented at the county level in all public schools.

2. Address Cultural Barriers to SRH and MHM

Advocacy Focus: Advocate for national policies that actively work to break down **cultural barriers** and **stigma** surrounding menstruation and reproductive health.

Policy Action: Partner with **community leaders** and **faith-based organizations** to advocate for policy changes at the local level. Cultural sensitivity should be integrated into advocacy programs to address **taboos** and harmful practices, such as **FGM** and **child marriage**, which affect girls' education.

3. Gender-Responsive Budgeting

Advocacy Focus: Advocate for **gender-responsive budgeting** to ensure that national and county governments allocate sufficient resources to **MHM services**, **sanitation infrastructure**, and **SRH education** in schools.

Policy Action: Engage with government stakeholders to ensure that a significant portion of education and health budgets is directed toward **gender-sensitive interventions**, particularly in marginalized regions.

4. Online Child Protection

Policy Strengthening and Enforcement: Developing stricter guidelines for social media platforms to report and manage OGBV cases.

5. Policy and Curriculum Reform:

The 2023 Taskforce on Policy, Legal, Institutional, and Administrative Reforms Regarding Intersex Persons in Kenya recommends inclusive SRH and MHM curricula in schools to address the specific needs of intersex students, ensuring comprehensive information and resources are available.

7.4 Areas for further Program Development

1. Scaling Up SRH and MHM Programs in Rural and ASAL Areas

Program Focus: Programs should prioritize expanding **SRH** and **MHM services** in rural and **ASAL (Arid and Semi-Arid Lands)** regions where infrastructure is weak and girls are at higher risk of dropping out of school.

Program Action: Develop partnerships with **NGOs**, **private sector** actors, and **government agencies** to implement **sanitation projects** and provide **MHM products** in these regions. Programs should also focus on improving **access to water** and **sanitation** in schools.

2. Sustainable and Locally Made Menstrual Products

Program Focus: Support the local production and distribution of **reusable** and **sustainable menstrual products**. Programs should encourage **women-led enterprises** that produce affordable menstrual hygiene products.

Program Action: Partner with **local businesses** and **women's cooperatives** to distribute **reusable pads** and train girls and women on how to use and maintain them. These programs will provide both economic opportunities and health benefits for girls and women in low-income areas.

3. Strengthen Community-Based Support Networks

Program Focus: Establish **community-based support networks** that engage parents, teachers, and health workers to ensure that girls receive the emotional, educational, and health support needed to stay in school.

Program Action: Develop **peer mentorship** programs where older girls or women act as **mentors** to younger girls, providing them with education on **menstruation**, **reproductive health**, and school-related issues. These networks should also work to reduce **gender-based violence** and early marriages.

4. Online child protection

Enhanced Education on Cyber Safety: Training programs for teachers on OGBV identification and response should be expanded

Mental Health Support: Providing psychological support to affected students to mitigate the impact on their education and well-being.

Capacity Building for Educators: Teachers and school administrators are trained to recognize signs of online abuse and manage incidents effectively. This is part of an effort to build a supportive environment within educational institutions.

5. Intersex Learners Protection

— Legal and Institutional Safeguards: Strengthen protections against discrimination and harassment for intersex individuals within educational institutions
— MHM Infrastructure: Create MHM facilities that accommodate the needs of intersex students, promoting privacy and accessibility.
— Psychosocial Support: Implement counselling services and peer support groups to address mental health impacts, providing a safe environment for intersex learners to discuss their concerns.
— Educator Training: Equip teachers with the knowledge and skills to support intersex learners sensitively and proactively, including anti-bullying strategies and SRH guidance tailored to diverse needs.

Conclusion

Addressing the gaps and barriers to **SRH**, **MHM**, and **girls' education** in Kenya requires a **holistic approach** that combines improved funding, better infrastructure, comprehensive education, community engagement, and policy implementation. By adopting these recommendations, Kenya can create a more supportive environment for girls, ensuring that they have the resources and opportunities to thrive in school and beyond.

Further research, policy advocacy, and program development can significantly improve **SRH and MHM services** and ensure that girls in Kenya have the opportunity to complete their education. Addressing the **systemic barriers** and filling the existing gaps will require collaborative efforts from **government bodies**, **non-state actors**, and **community leaders** to create an enabling environment for girls' education and health.

Appendices

Appendix 1: List of impact studies

Below is a list of related to **Sexual and Reproductive Health (SRH)**, **Menstrual Hygiene Management (MHM)**, and **girls' education** in Kenya or similar contexts:

1. **Impact of Menstrual Hygiene on Girls' School Attendance in Kenya**

   Study Overview: This study assessed the impact of providing **free sanitary products** on school attendance for girls in Kenya. The study, conducted by **UNICEF** and **Kenya's Ministry of Education**, found that the distribution of sanitary pads significantly reduced absenteeism rates among adolescent girls.

   Key Findings: Schools that received sanitary products recorded a **15% increase in school attendance**, with girls attending school more consistently during their menstrual cycles.

Source: **UNICEF Kenya**, "Impact of MHM on Girls' School Attendance," 2020.

2. **Adolescent Sexual and Reproductive Health Program Impact Evaluation (Kenya)**

   Study Overview: This evaluation, conducted by the **Ministry of Health** and **UNFPA**, explored the effects of **adolescent-friendly SRH services** in rural and urban areas of Kenya. The study evaluated the effectiveness of SRH education, counselling, and contraceptive services provided to adolescents in lowering the rates of teenage pregnancies.

Key Findings: The study found that access to youth-friendly SRH services reduced the rate of teenage pregnancies by **20%** in intervention areas, leading to higher school retention rates for girls.

Source: **UNFPA**, "Adolescent SRH Program Impact in Kenya," 2019.

3. **Impact of School-Based Health Interventions on Girls' Education in Sub-Saharan Africa**

   Study Overview: This regional study, conducted by the **Global Partnership for Education**, examined the impact of comprehensive **school health programs**—including SRH education and menstrual hygiene support—on girls' educational outcomes in several African countries, including Kenya.

   Key Findings: Schools that incorporated **SRH education** and provided **sanitary pads** saw a **50% reduction in dropout rates** among girls, particularly in rural areas. The study concluded that integrated health and education programs have a positive long-term impact on girls' education.

Source: **Global Partnership for Education**, "School Health Programs and Girls' Education in Sub-Saharan Africa," 2021.

4. **Economic Impact of Menstrual Hygiene Management in East Africa**

   Study Overview: This **World Bank** study explored the economic impact of poor menstrual hygiene management on girls' education and future employment in **East African countries**, including Kenya. It evaluated how menstrual-related absenteeism contributes to lost education and employment opportunities for girls.

   Key Findings: The study estimated that **girls lose up to 5% of potential income** due to absenteeism caused by lack of menstrual hygiene products and proper sanitation facilities. Access to MHM products in schools was found to reduce absenteeism and improve educational and economic prospects for girls.

Source: **World Bank**, "Economic Impact of MHM on Girls' Education and Employment in East Africa," 2020.

5. The Impact of Community-Led SRH Programs on Reducing Child Marriage in Kenya

   Study Overview: Conducted by Plan International and Kenya's Ministry of Youth and Gender, this study evaluated community-based programs that aimed to reduce child marriages and improve SRH outcomes for girls in rural Kenya. The programs included education for girls, advocacy against child marriage, and improved access to SRH services.

   Key Findings: Communities that implemented the program saw a 30% reduction in child marriage rates, contributing to higher secondary school completion rates for girls.

Source: Plan International, "Impact of SRH Programs on Reducing Child Marriage in Kenya," 2019.

6. Menstrual Hygiene Education and Health Outcomes for Adolescent Girls in Western Kenya

   Study Overview: This study by the Population Council examined the health and educational outcomes of adolescent girls in Western Kenya who participated in menstrual hygiene education programs. The study focused on how education about proper MHM practices and the distribution of sanitary products influenced school attendance and general well-being.

   Key Findings: Girls who received MHM education and sanitary products reported a 30% decrease in infections related to poor menstrual hygiene and a 10% improvement in mental health, which contributed to increased school attendance and engagement.

Source: Population Council, "Menstrual Hygiene Education and Health Outcomes in Western Kenya," 2019.

7. Sustainable Menstrual Hygiene Solutions and Educational Outcomes: The Case of Reusable Pads

   Study Overview: Conducted by AfriPads and Plan International, this study analysed the impact of providing reusable menstrual pads to girls in rural Kenya and Uganda. The program aimed to address both the environmental and financial barriers associated with disposable sanitary products.

Key Findings: The use of **reusable pads** led to a **15% reduction in absenteeism** during menstruation. Girls who used these pads also reported feeling more confident and were better able to participate in school activities during their menstrual cycles.

Source: **AfriPads and Plan International**, "Sustainable Menstrual Hygiene Solutions in Kenya," 2021.

8. **Menstrual Hygiene Management and the Impact on Girls' Educational Attainment in Uganda and Kenya**

   Study Overview: This impact evaluation study, funded by **WaterAid** and the **Bill & Melinda Gates Foundation**, examined the effects of menstrual hygiene education programs and the provision of sanitary pads in schools across **Kenya** and **Uganda**.

   Key Findings: The introduction of menstrual hygiene education programs, combined with the provision of sanitary pads, led to a **12% improvement** in girls' **classroom participation** and a **15% increase** in academic performance.

Source: **WaterAid and Gates Foundation**, "Menstrual Hygiene Management and Girls' Educational Attainment in East Africa," 2020.

9. **Menstrual Hygiene and Girls' Education in Kenya: A Randomized Controlled Trial"**

   Study Overview: This **randomized controlled trial** conducted by **Emory University** and **UNICEF** assessed the impact of providing **sanitary pads** and **MHM education** on girls' attendance and performance in rural Kenyan schools.

   Key Findings: Girls who received both **pads and MHM education** showed a **significant increase in school attendance** and improved educational performance compared to the control group. The intervention also positively affected girls' self-esteem and reduced the stigma surrounding menstruation in schools.

Source: **Emory University**, "Menstrual Hygiene and Girls' Education," 2019.

10. **The Role of Water, Sanitation, and Hygiene (WASH) in Menstrual Hygiene Management in Schools**

    Study Overview: This **UNICEF** and **Global Water Initiative** report focuses on how improved **WASH infrastructure** in schools, such as access to clean

water, separate toilets for girls, and menstrual hygiene facilities, can reduce absenteeism and improve school retention rates for girls.

Key Findings: Schools with adequate WASH facilities saw a **20% reduction** in absenteeism among girls during menstruation. The study found that girls were more likely to attend school consistently when they had access to private, clean toilets and clean water.

Source: **UNICEF**, "The Role of WASH in MHM in Schools," 2018.

11. Impact of Menstrual Hygiene Products on School Absenteeism: A Randomized Controlled Trial in Kenya

Study Overview: This randomized controlled trial, conducted by researchers from the **London School of Hygiene and Tropical Medicine**, and assessed the impact of providing **menstrual cups** and **sanitary pads** on school attendance among adolescent girls in rural Kenya. The study involved 644 girls across 30 schools.

Key Findings: Girls who received menstrual cups or sanitary pads had **fewer days of school absenteeism** compared to those who did not receive any MHM products. Over the course of a year, girls who used menstrual cups missed an average of **1.5 fewer days** of school during menstruation compared to their peers.

Source: **Phillips-Howard et al., 2016**, "Impact of Menstrual Hygiene Products on School Absenteeism: A Randomized Controlled Trial in Kenya."

12. The Effectiveness of MHM Interventions in Sub-Saharan Africa: A Review

Study Overview: This review, published in **BMC Public Health**, analyzed multiple studies on MHM interventions across Sub-Saharan Africa, including Kenya. It focused on the distribution of sanitary products and MHM education and their effects on education outcomes.

Key Findings: The review concluded that MHM interventions significantly reduced school absenteeism, improved **academic performance**, and **reduced stigma** around menstruation in schools where these interventions were implemented.

Source: **BMC Public Health**, "MHM and Educational Outcomes in Sub-Saharan Africa," 2019.

13. Impact of Menstrual Hygiene Education on Gender Equality in Schools

Study Overview: This study, funded by **UNICEF** and **Kenya's Ministry of Education**, examined the integration of **MHM education** into the school curriculum and how it influenced gender equality and student performance.

Key Findings: The study found that **gender equality improved** as both boys and girls participated in MHM education. Boys gained a better understanding of menstruation, reducing the stigma faced by girls, which, in turn, improved girls' participation in school.

Source: **UNICEF Kenya**, "MHM Education and Gender Equality," 2020.

14. The Long-Term Impact of MHM Programs on Girls' Education in Rural Kenya

Study Overview: Conducted by **WASH United**, this longitudinal study followed the implementation of **MHM programs** in rural Kenyan schools over five years. It measured the impact of improved sanitation, MHM education, and access to sanitary pads.

Key Findings: The study highlighted a **30% increase in retention rates** for girls, reduced stigma around menstruation, and improved teacher attitudes towards discussing menstrual health with students.

Source: **WASH United**, "Long-Term Impact of MHM on Girls' Education in Kenya," 2021.

1. **Author**: Cochrane, C., VanderEnde, K., and Mang'eni, R.

Title: Faith-Based Sexuality Education Programs in Kenya: Impact on Knowledge and Attitudes towards Sexual and Reproductive Health among Adolescents

Date of Publication: 2022 **Source**: Journal of Adolescent Health

Key Findings: This study evaluated the impact of faith-based CSE programs in Kenyan Christian and Muslim schools. It found that students who participated in these programs showed significant improvements in SRH knowledge, particularly regarding HIV prevention, contraceptive use, and understanding of gender roles. The integration of faith-based values helped reduce resistance to topics traditionally seen as taboo, such as contraception and premarital sex. In terms of MHM, girls reported increased confidence in managing menstruation, improved access to hygiene products, and reduced absenteeism due to menstrual challenges.

Conclusion: Faith-based CSE programs were effective in changing attitudes and improving health-seeking behaviours among adolescents, as they aligned SRH education with religious teachings, fostering community acceptance.

2. **Author**: Mbugua, J., Wekesa, E., and Ombasa, M.

   Title: Evaluating the Effectiveness of Menstrual Hygiene Management Programs in Kenyan Faith-Based Schools **Date of Publication**: 2023 **Source**: International Journal of Environmental Research and Public Health

   Key Findings: This study assessed the impact of MHM interventions in faith-based schools in rural Kenya. It found that girls attending schools where MHM programs were delivered within a religious framework had higher levels of menstrual knowledge, better hygiene practices, and improved school attendance compared to those in schools without such programs. The inclusion of religious leaders in MHM education helped to address cultural stigmas and taboos surrounding menstruation, fostering an environment of acceptance and support.

   Conclusion: Faith-based MHM programs contributed significantly to reducing absenteeism and improving menstrual management practices, highlighting the importance of culturally and religiously sensitive approaches to MHM education.

3. **Author**: Hebert, L., Hassan, S., and Njoroge, C.

   Title: Interfaith Approaches to Comprehensive Sexuality Education: A Case Study from Kenyan Schools **Date of Publication**: 2021 **Source**: African Journal of Reproductive Health

   Key Findings: This case study explored the effectiveness of interfaith CSE programs that integrate Christian and Islamic perspectives on SRH. The study showed that the programs had a significant impact on improving adolescents' knowledge of reproductive health and reducing risky behaviours such as early sexual debut. The faith-based approach, which involved religious leaders in curriculum development and delivery, was crucial in gaining community support, particularly in conservative regions.

   Conclusion: Faith-based CSE programs were successful in addressing SRH needs while maintaining cultural and religious sensitivity, resulting in high community engagement and improved health outcomes for adolescent girls.

4. **Author**: Munyiva, A., and Kimathi, P.

   Title: The Role of Faith-Based Organizations in Addressing Menstrual Hygiene and Reproductive Health in Kenyan Schools: An Evaluation Study **Date of Publication**: 2020 **Source**: BMC Public Health

   Key Findings: This study analyzed the role of faith-based organizations (FBOs) in MHM and SRH education in rural Kenyan schools. It found that schools implementing FBO-led programs had better menstrual health management, with more girls reporting access to hygiene products, clean water, and sanitation facilities. Additionally, the integration of SRH education within a religious framework led to greater community acceptance and support for discussing topics traditionally considered taboo, such as menstruation and contraception.

   Conclusion: FBOs played a critical role in addressing MHM and SRH needs by providing resources, education, and community engagement that helped to reduce stigma and improve girls' access to necessary health services.

5. **Author**: Ndirangu, G., and Wambui, M.

   Title: Religious Approaches to Sexual and Reproductive Health Education in Kenyan Schools: An Impact Evaluation **Date of Publication**: 2022 **Source**: Sexuality Research and Social Policy

   Key Findings: The study evaluated the impact of faith-based sexual and reproductive health education programs on adolescent girls in Christian and Muslim schools across Kenya. It demonstrated that such programs increased students' understanding of SRH issues, reduced misconceptions about contraception, and promoted safer sexual practices. Additionally, the faith-based MHM education significantly improved menstrual hygiene practices among girls, contributing to better school attendance and academic performance.

   Conclusion: Faith-based SRH and MHM programs effectively addressed the needs of adolescent girls by integrating religious teachings into the curriculum, leading to positive health outcomes and broader community acceptance of sensitive topics.

Hennegan et al. (2021) "Menstrual Health: A Definition for Policy, Practice, and Research."

This study provides a comprehensive definition of menstrual health and its impact on achieving health, education, and gender equality goals, emphasizing the importance of proper menstrual health management in both policy and practice contexts.

A world where gender equality shapes every learner's opportunity to thrive.