WOMEN'S COMMISSION
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Reproductive Health Coordination Gap, Services Ad hoc:

Minimum Initial Service Package (MISP) Assessment in Kenya

Women's Commission for Refugee Women and Children

September 2008

Cover photograph: Firewood distribution, Eldoret Showground IDP camp.

All photographs: Women's Commission for Refugee Women and Children/Sandra Krause

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Executive Summary

The post-election violence in Kenya in the early months of 2008 displaced more than 500,000 people. In any humanitarian crisis, certain priority reproductive health (RH) services must be put in place from the earliest stages of an emergency. These essential activities are defined in the Minimum Initial Services Package (MISP)—the established international standard for providing RH care in emergencies. They include activities to prevent sexual violence and treat survivors; protect against the transmission of HIV; ensure delivery supplies and emergency care for pregnant women and newborns; and lay the groundwork for comprehensive RH services once conditions allow. The Women's Commission for Refugee Women and Children (Women's Commission) undertook a mission to Kenya in April 2008 to assess the progress the humanitarian community has made in the institutionalization of the MISP in emergency response operations. The assessment took place four months after the crisis erupted and included visits to camp settings in the Nairobi, Kisumu, Kitale, Eldoret and Nakuru regions.

Key Findings

1) Despite the ongoing and urgent needs of large numbers of displaced persons, the Women's Commission found that funding was clearly inadequate to meet the unaddressed health needs of the displaced. UN emergency appeals to address humanitarian needs related to the post-election violence remained significantly underfunded at the time of the assessment, and organizations that could have continued to respond were bringing their emergency response operations to a close.

2) The most significant and overarching gap in the implementation of the MISP was the absence of RH coordination at all levels.

3) Awareness of the MISP among humanitarian workers in Kenya was higher than awareness levels registered in two earlier MISP assessments conducted by the Women's Commission. However, the MISP was not guiding action in Kenya which meant there were still unacceptable gaps in protection and key RH services.

4) Planning to prevent high levels of sexual violence, inlcuding sexual exploitation and abuse, were strong at the national level but still inadequate at the field level. Poor security measures were noted at all but one camp and the assessment team received numerous disturbing reports of sexual exploitation and abuse by humanitarian workers, police and others.

5) Mechanisms to respond to sexual violence, inlcuding sexual exploitation and abuse, were also weak at the field level. Displaced persons and representatives of humanitarian organizations reported a general atmosphere of impunity toward perpetrators of sexual violence. Health workers also suggested that many of the displaced did not know the importance of seeking treatment for sexual assault or where it was offered. Many displaced women were only slowly seeking care months after the height of the violence.

6) In terms of priority activities taken to protect against HIV transmission, the findings were mostly positive. It was encouraging that health care providers were concerned from the start of the crisis about the need to prevent the transmission of HIV and to ensure people living with AIDS had continuing access to antiretroviral medicines. By all accounts,

Components of the MISP

- Coordination of the MISP
- Prevent and manage the consequences of sexual violence
- Reduce the transmission of HIV
- Prevent excess maternal and newborn morbidity and mortality
- Plan for comprehensive reproductive health services

there were sufficient supplies of male condoms; however, some displaced persons reported that they were still not freely available or easy to obtain.

7) The Women's Commission found that referral systems to care for pregnancy-related emergencies were not uniformly in place, and transportation for women and girls suffering from complications of their pregnancy or delivery was highly problematic in some places. While clean delivery kits were available in some settings, they were not consistently distributed to visibly pregnant women and there were shortages in some settings. In addition, no displaced women we spoke with were aware of or had heard of clean delivery kits.

8) Young people appeared to be the most severely affected, with many reporting idleness due to a lack of jobs and opportunities to attend secondary school and university. In addition, young people noted that the sudden movement from their busy lives in rural areas to overcrowded urban camps where they were now idle created more exposure to the opposite sex. A sudden increase in sexual activity enhanced their vulnerability to sexually transmitted infections, including HIV, and unwanted pregnancies.

Although the Kenya crisis has disappeared from the headlines, daily life remains a crisis for people who are still displaced from their homes and communities. The Kenyan government and international aid agencies must take immediate and coordinated action to address the priority RH needs of the displaced populations. In particular, the needs of young people should be prioritized considering their vulnerability to sexual exploitation and abuse and heightened risk of unsafe sex as they remain displaced or return to their homes.

More broadly, this assessment highlights the need for a deeper commitment on the part of donors and the humanitarian community to the institutionalization of the MISP in humanitarian crises, particularly to ensure RH coordination from the beginning of an emergency. Adequate funding for MISP activities must be provided at the onset of an emergency, and more humanitarian workers must be trained and skilled in MISP implementation.

KEY RECOMMENDATIONS

- The United Nations Population Fund (UNFPA) and the Ministry of Health's Division of Reproductive Health should initiate reproductive health coordination, as people continue to be displaced in camps, transit camps and communities, and those returning can also benefit from such services.
- All agencies working to prevent sexual violence and provide care to survivors should enforce rules and procedures to prevent and manage sexual violence, address the issue of impunity, and inform communities of where and how to report incidents and the importance of seeking medical care.
- All agencies working in or funding the health sector should strengthen the health care system to provide care for pregnancy-related problems, especially as international agencies hand over their projects to the government and local organizations.
- All organizations should better engage young people in the recovery process, enhance their educational and job opportunities, and address their specific reproductive health needs.

Introduction

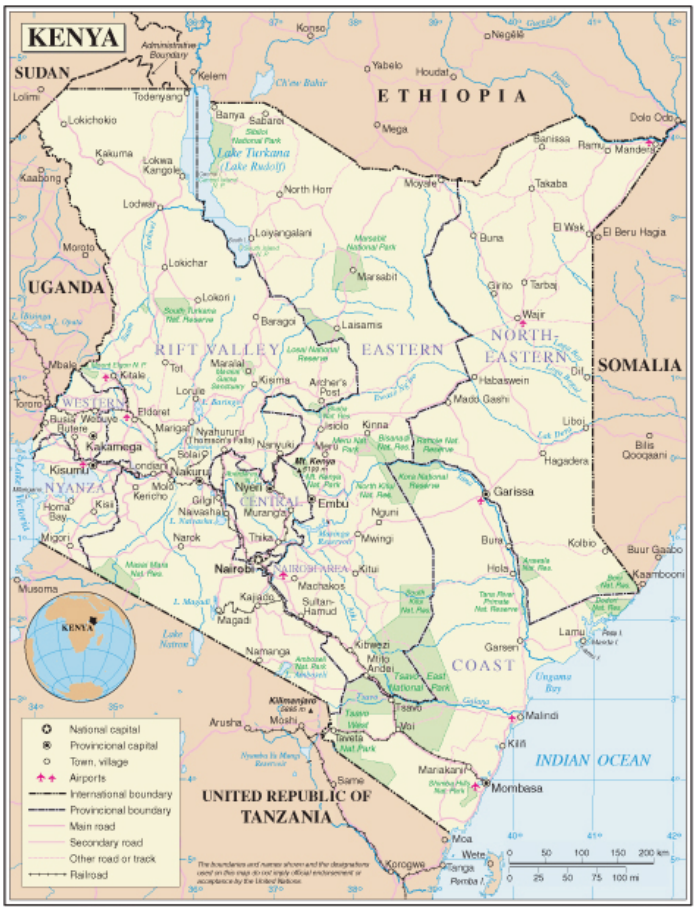
On December 30, 2007, the results of Kenya's general elections were announced with President Mwai Kibaki's Party of National Unity (PNU) declaring victory. In response, the opposition Orange Democratic Movement (ODM) led by Raila Odinga claimed widespread irregularities and fraud, sparking violence that escalated to result in more than 1,000 deaths and 500,000 people displaced in camps and other host communities.[1] Displacement in camps peaked in early February, with those in the Rift Valley comprising close to 85 percent of the total number displaced.[2]

At the time of the assessment, approximately 153,000 displaced persons resided in 157 camps,[3] although according to Kenya's National Disaster Operations Center, many more—approximately 196,000—were seen to be displaced in communities.[4] President Kibaki and Odinga signed a power-sharing arrangement on February 28, establishing a coalition government and identifying steps designed to restore peace in the country. While the political situation appeared to be gradually calming, the humanitarian crisis continued. The MISP assessment was undertaken at a time of uncertainty for both service providers and IDPs. The Kenyan Government had begun to initiate and facilitate IDP returns, and it was unclear whether returns would be forced and how many would remain displaced.

Region	IDP Camp	IDP Population
North Rift	41	77,588
South Rift	70	51,981
Nyanza	15	4,294
Western	16	14,648
Central	9	1,958
Nairobi	6	2,608
Total	**157**	**153,077**

Figures as of April 22, 2008, Kenya Red Cross [5]

In conjunction with calling for IDP returns, the Kenyan government has led the humanitarian response through the Ministry of Special Programmes (MoSP), which has a National Disaster Operations Centre that acts as the coordinating agent. The Kenya Red Cross Society is the government's official implementing partner. The United Nations cluster system[6] has been activated, and a flash appeal was launched on January 16, 2008, with an original appeal of close to $42 million that was later revised to $191 million.[7] The health appeal at $5.7 million was revised to over $12 million, and



Map No. 4187 Rev. 1 UNITED NATIONS. January 2004.
Department of Peacekeeping Operations. Cartographic Section.

at the time of the assessment, 26 percent had been funded.[8] Gender-based violence (GBV) fell under the Protection appeal, which was revised to $7.7 million from $3.6 million. This appeal was funded at 19 percent at the time of the assessment.[9]

Objectives

The purpose of the assessment was to examine the degree of implementation of the Minimum Initial Service Package (MISP) for RH as a response to the post-election violence in Kenya. The MISP is a coordinated set of priority activities designed to prevent and manage the consequences of sexual violence, reduce HIV transmission, prevent excess maternal and newborn morbidity and mortality, and plan for comprehensive RH services. The MISP was first articulated in the 1997 *Reproductive Health in Refugee Situations: An Inter-agency Field Manual* and recognized as a Sphere standard[10] in 2004 as a priority intervention to be implemented at the onset of every new emergency.

Methodology

The assessment methodology consisted of observational checklists based on the MISP objectives, facilities assessments, key informant interviews and focus group discussions and communications with displaced populations. In-depth interviews were conducted with 52 service providers and policymakers from 20 institutions, including UN agencies, local and international NGOs, the Kenya Red Cross and the Ministry of Health. Eight focus group discussions with 139 displaced men, women and adolescents were convened in Kisumu and Kitale. For more detail on the methodology and study limitations, see Annex 1.

Reproductive Health in Kenya: Background

Kenya has a long history of strong commitment towards RH, with a Division of Reproductive Health within the Ministry of Health specifically devoted to addressing this area. The government also has a National Commission on Gender and Development and a National AIDS Commission that are responsible for GBV issues and HIV/AIDS, respectively. With the notable exception of guidelines to address RH in emergencies, the Ministry of Health provides comprehensive RH policies, guidelines and strategic plans to meet the RH needs of men, women and young people (see Annex 2).

Key national RH indicators reflect significant opportunities for improvement, with a maternal mortality ratio of 560 maternal deaths[11] per 100,000 live births and an infant mortality rate of 79 infant deaths[12] per 1,000 live births. Further, the total fertility rate is 5.0 and the contraceptive prevalence rate of modern methods is 30.5 percent. Twenty-five percent of Kenya's population is not practicing a method although they wish to limit or space their children.[13] To review a breakdown of RH indicators by region, see Annex 2.

General Situation

The level of humanitarian response varied per site. While key decisions had been made and action taken to respond to the immediate survival needs of IDPs, there was a general air of uncertainty regarding the provision of aid past June. Agencies had begun pulling out their operations due to lack of funding and dwindling international attention to the plight of the internally displaced. Against this backdrop, the situation did not appear to be improving for IDPs, given strained living circumstances, fear of returning home, the advent of the rainy season and loss of future prospects.

Education

In addition to concerns about common illnesses, such as pneumonia, diarrhea and malaria, IDPs in all focus groups mentioned their concerns over children's education, especially older children of secondary school age and above. While the UN Children's Fund (UNICEF) and other agencies were providing educational opportunities for primary school children in the camps, they were not always accessible for later arrivals, and even fewer opportunities were available for out-of-school youth. Whether IDP children could be accommodated in local schools depended on the district, as did the level of the educational intervention. Young people themselves were requesting continued educational opportunities.

"Now schools are closed [for the holiday], but when they open, I need 500 [Kenyan] Shillings to return. It may not be possible for me to go back."

Adolescent female focus group discussion participant, Kitale Showground

Sexual activity among young people

Sexual activity among young people was reportedly on the rise, with the possibility of an increase in unsafe sex that could lead to sexually transmitted infections, including HIV/AIDS, and unwanted pregnancies. Young people self-reported the changes that came about as a result of displacement from their homes in rural settings to urban areas. They specifically cited the lack of opportunities to work or go to school and engage in meaningful activity, congestion in the camps and tents and changes in relationship patterns with the opposite sex. Young men in focus group discussions noted that boys and girls were meeting each

other more regularly post-displacement; in the past, such encounters were limited to church, ceremonies or weddings. Older women also expressed concern over young people's sexual behavior, as many youth were forced to sleep outside due to limited space in the tents, and cultural inappropriateness for older children to sleep in the same tent as their parents. Adults were aware that children who slept outside would find a space where boys and girls could sleep together, generating opportunities for increased and possibly unsafe sexual activity.

"Now they have much more interaction because they share a common problem—they have all lost their past. Anytime you share a common problem, it brings people together."

Young male focus group discussion participant, Eldoret Showground

Organizations such as the Catholic Diocese of Nakuru and Family Health Options Kenya catered towards youth; both organizations were operating youth centers with peer educators. The latter noted that it was able to employ its networks and contacts to reach young people, which enabled it to target the specific population.

RECOMMENDATIONS

- All organizations should ensure that young people are better engaged in the recovery process and that their educational and job opportunities are enhanced.
- Health care providers should immediately identify and work with young people to establish RH information, education and behavioral change communication strategies such as peer education, youth groups and clubs as well as youth-friendly RH services.

Youth at a youth center, Nakuru Showground IDP Camp.

Menstrual hygiene

Menstrual hygiene materials posed ongoing challenges although organizations such as World Vision were providing supplies. The UN Population Fund (UNFPA) reported that it had purchased bulk quantities of sanitary pads; however, logbooks from a Kenya Medical Supplies Agency (KEMSA) warehouse in Eldoret showed that a consignment to Kitale contained 800 pads, which was not enough to provide the number of women and girls requiring such supplies. Moreover, some service providers questioned the cultural appropriateness of what was distributed, although the team also saw that sanitary towels were distributed in addition to pads.

"This [menstrual hygiene] is a huge problem. People would use whatever they have."

Young female focus group discussion participant, Kitale Showground IDP camp

Disposal of soiled materials was raised as a problem, especially in Eldoret and Kitale. In Endebbes camp, where the government had refused to grant additional land for the camp, septic tank trucks were used to remove waste and blockage—including soiled pads and used condoms—which became a biological hazard. In Nakuru Showground, pit latrines were deep enough to accommodate biological waste.

MISP awareness and understanding

Compared to previous MISP assessments undertaken by the Women's Commission,[14] there was more—albeit limited—awareness among humanitarian practitioners about the MISP. At a GBV sub-cluster meeting, six out of 28 people in attendance had heard of the MISP, and among the 52 service providers interviewed, two had completed the MISP distance learning module,[15] a self-learning course developed by the Women's Commission that enables certification in the MISP module once an online post-test is successfully completed. The extent to which those familiar with the MISP actually understood its components was unclear, however.

Most staff interviewed did not know that the MISP was a Sphere standard. Awareness of the Sphere standards themselves was evident in one setting among Kenya Red Cross staff at the district level who appeared to be referencing it on a regular basis. However, the staff were not aware of the MISP standard, highlighting a need for continuing emergency preparedness training in the Sphere standards and the MISP.

Coordination of the MISP

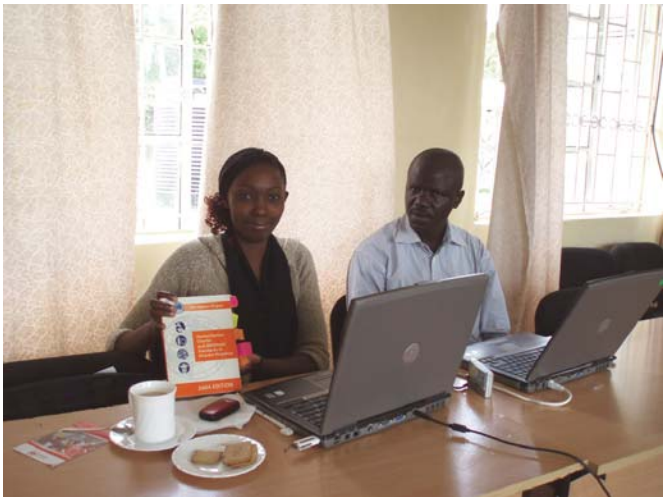
PRIORITY ACTIVITY:

- *Identifying an organization(s) and individual(s) to facilitate the coordination and implementation of the MISP*

The cluster system was activated in the Kenya post-election violence, and as a result, the humanitarian response centered on cluster coordination, with the Kenya Red Cross as the agency responsible for overall coordination. In line with the cluster approach, each cluster was designated its own leadership, although some were co-chaired by different agencies.

Given the Kenyan government's concerns over the spread of HIV and continued care for AIDS patients, the government established national-level HIV coordination. The strongest humanitarian coordination at the national level, however, appeared to be GBV, under the Protection Cluster. GBV coordination was chaired by UNFPA, with the Kenya Red Cross as co-chair, and numerous organizations were involved from the beginning. The GBV sub-cluster working group was highly active and inclusive, with its own terms of reference. Collective work was being conducted for advocacy, information- and tool-sharing and standardizing response.

RH coordination, on the other hand, was lacking at all levels. While Health and Nutrition Cluster meetings were instituted in the inter-agency response, at the time of the assessment, Health Cluster coordination appeared to be less prioritized at the national level, with meetings postponed and cancelled without warning. At the field level where such meetings took place, a District RH Coordinator lamented that RH was peripheral.



Kenya Red Cross staff with the Sphere Handbook, Nyanza/Western Region

Although staff of the Ministry of Health Division of Reproductive Health had been previously trained by UNFPA on the MISP and humanitarian response, the Director noted the lack of capacity within the Ministry to spearhead RH coordination in an acute emergency. Challenges existed within the Ministry of Health for RH to be recognized as a higher priority in emergency response.

In terms of coordination overall, a few interviewees expressed meeting fatigue, especially as the same people were represented at different meetings within the cluster system. Lack of monetary resources for transportation, human resources and office supplies was also raised as a challenge for Ministry staff participation. On the other hand, where no coordination mechanism was in place, such as in Kitale, agencies were required to travel to Eldoret to attend Protection Cluster meetings. GBV staff emphasized the need to establish local coordination and stated that a satellite presence of designated UN agencies was inadequate for the gravity of the problem.

RECOMMENDATIONS

- UNFPA and the Ministry of Health Division of Reproductive Health should establish RH coordination, which is still timely, given the continued existence of camps, the emergence of transit camps, and the need to address RH in a holistic manner. The Provincial District Health authorities can fill in gaps as relief agencies pull out.
- All health and protection service providers should understand that RH coordination can help identify and facilitate linkages between vertical interventions in GBV and HIV. RH coordination can also raise the profile of RH issues while addressing integration and synergies within the Health Cluster response.
- RH coordination should encompass the needs of non-registered IDPs in communities.

Prevent and Manage the Consequences of Sexual Violence

PRIORITY ACTIVITIES:

- *Ensuring systems are in place to protect displaced populations, particularly women and girls, from sexual violence*
- *Ensuring medical services, including psychosocial support, are available for survivors of sexual violence*

Sexual violence, including sexual exploitation and abuse, was a significant issue, as documented in depth by the Inter-agency GBV Assessment Report.[16] Incidents of rape were reported as a result of the crisis: among the 653 patients examined and treated between December 27, 2007 and March 31, 2008 at the Nairobi Woman's Hospital, which served as the referral center for Nairobi and the surrounding areas, 524 (80 percent) were classified as rape/defilement[17] cases and 22 (3 percent) as sexual assault.[18] For child defilement cases, more cases were seen in March (78) than in February (64), while with adult rape cases, similar numbers were seen in January (102) and February (105), with a slight decrease in March (90). The majority of survivors seen were female, although 16 percent of defilement cases were of boys.[19] In one focus group in Kisumu alone, 11 out of 20 women knew of someone who had experienced sexual violence in the post-election crisis.

Sexual exploitation and abuse was also a major issue and one that did not appear to be diminishing. Service providers and focus group participants raised concern over this issue, as those in positions of power were demanding sexual favors in exchange for commodities, even from younger girls. Young women in a focus group discussion in Kitale Showground noted that girls as young as 12 and 14 were engaging in sex for services; moreover, bribery was widespread. The common response was that personal items, including oil, undergarments, soap, lotion and perfume, were prompting women and girls to engage in sex. Perpetrators included police, businessmen and doctors outside of the camp, camp leaders and, most importantly, humanitarian volunteers who were overseeing sections of the camps.

"Last night around 10 pm, I heard a scream. I went outside to see what was happening and a man was pulling a girl from a bus. A group of young men began interrogating her, and then took her away. I am sure she was raped."

Female focus group discussion participant, Kisumu

Ensuring systems are in place to protect displaced populations, particularly women and girls, from sexual violence

While systems to support the protection of displaced populations were well underway at the national level, they were yet to be sufficiently established at the camp and community levels to be able to effectively enforce prevention measures. The GBV sub-cluster employed the Inter-agency Standing Committee *Guidelines for Gender-based Violence Interventions in Humanitarian Settings* (IASC GBV Guidelines, 2005) and other pre-existing guidelines, including the UN High Commissioner for Refugees' (UNHCR) *Guidelines on Gender-based Violence Prevention and Response among Displaced Populations* (2003), although awareness of such guidelines was limited at the district and camp levels. The assessment showed that where a UNFPA presence was lacking at the field level, more gaps existed in efforts to prevent and respond to sexual violence.

Camp management was primarily the responsibility of the Kenya Red Cross. Security measures were limited and among Noigam camp, Kitale, Eldoret and Nakuru Showgrounds, Nakuru Showground was the only camp with adequate gate security, but only as a result of a noted incident of girls being taken from the camp to work as domestic laborers. Latrines could not always be locked from the inside and lighting at night was problematic in all but Eldoret Showground. Some camps such as Noigam camp had torches distributed to families, although these were not available to everyone. In Nakuru Showground, where the government had spent 37,000 KES (roughly 610 USD) for electricity, lighting was not in place four months into the post-election crisis.

Firewood distribution, Eldoret Showground Camp

In Nakuru Showground alone, the following cases were documented by clinic staff:

- A 17-year-old girl was raped by a humanitarian worker in January. The person was convicted, but is now walking free.
- A pregnant woman from Kisumu was raped outside of the camp.
- A man posing as a "Dr. Azar" was luring girls into his tent. The man was caught and taken to the police, but he was released soon after. He now works for another humanitarian organization in the camp.
- Eight unaccompanied girls requested a tent, apparently to lure boys. The girls have been arrested, but the boys have walked free.
- A young woman agreed to work for an older woman who visited the camp claiming to need domestic help so that she could pay her college fees. The older woman gave her to a man, who raped her in early January. The young woman was left on the railroad until morning, when she followed school children and made her way back to the Showground. She was given post-exposure prophylactics (PEP), emergency contraception (EC), etc. and was counseled, but did not want to report the rapist since she was not sure who he was. The girl is now in school.
- A girl was placed in a tent with an older woman, who brought men to rape her for money. When this issue was discovered at the camp youth center, the girl was relocated to another tent.
- One boy was reportedly sodomized. The offender is in prison.
- A 36-year-old woman was raped by 10 people in the camp in February. She complained of physical ailments on numerous visits until she admitted that she was gang-raped. Her HIV test result came out negative but she is experiencing a pseudo-pregnancy.
- A 17-year-old girl was raped by a man. She is HIV positive but her husband is negative. She is now pregnant and will only talk to her counselor; otherwise she becomes hysterical.
- A woman and a group of men were sharing a large tent divided in the middle. When the 56-year-old woman was sleeping, the men would open the zipper and rape her. She was treated for sexually transmitted infections.

"If the woman screams in her tent, the neighbors come to help."

Young female focus group participant noting that men unzipped the tents at night, Kitale Showground

Firewood collection is often a risk factor for sexual violence,[20] and in the sites visited, wood for cooking was being provided. While the assessment team learned that one international NGO was exploring the procurement of fuel-efficient stoves, a systemic effort did not appear to be in place to engage communities in the development of mud stoves which would save energy and financial resources. There were also reports that insufficient firewood distribution forced women to leave camps in search of wood,[21] increasing their vulnerability to sexual violence.

Most traditional international humanitarian agencies had codes of conduct against sexual exploitation and abuse, although one prominent NGO did not. The Kenya Red Cross had not instituted a code of conduct against sexual exploitation and abuse, and although awareness was high at the national level, recognition of the gravity of the problem depended on the local representative or camp manager. Volunteers were reportedly briefed on sexual exploitation and abuse but were not held to any rules in writing. The overall climate of impunity exacerbated the problem. Clinic staff at Nakuru Showground noted that apprehended sexual offenders were released, citing one perpetrator who continued to work for a different humanitarian organization upon being discharged. In Eldoret, UNHCR and partners were piloting the placement of postboxes in various camp locations to enable reporting of sexual offenses. The GBV sub-cluster working group also developed standard operating procedures, which were to be rolled out in key field sites between May and July.

Ensuring medical services, including psychosocial support, are available for survivors of sexual violence

As the Inter-agency GBV Assessment Report noted, clinical care for rape survivors appeared to be available in larger health facilities and hospitals.[22] However, not all NGOs that launched a health response had medical care for survivors of sexual assault as standard protocol; one international NGO had post-exposure prophylaxis (PEP) for staff, but not for clients, noting a shortage of PEP kits and the costs to have it routinely stocked. Another organization in Kisumu mentioned that while PEP could be provided for free between January and March, funding for the post-election violence response had finished, raising challenges to appropriately respond to those presenting with evidence of sexual assault.

Health care providers expressed surprise that they had not seen a large increase in the number of survivors seeking care following the post-election violence. One local clinic in Eldoret, for example, saw an average of 20-30 sexual assault cases per month, and while on some days staff saw three cases in a day, no surge ocurred as anticipated. Clinic staff attributed this to the lack of awareness among IDPs on the importance of seeking care, in addition to the existence of stigma at the community level and lack of transportation to facilities. Cases were only slowly emerging, months after the height of the violence.

The International Organization for Migration (IOM) received funding to provide psychosocial support, and this component of response was heavily emphasized by the humanitarian community, including local organizations in Kenya. Quality control, however, was raised as a challenge.

RECOMMENDATIONS

- Humanitarian actors should apply existing GBV guidelines and standards, implement the recommendations of the January-February 2008 Inter-agency GBV Assessment Report,[23] and immediately put standard operating procedures for GBV into action in every site with appropriate technical/human resource support in the field.
- Health care providers should make clinical care for survivors of sexual assault standard protocol and thus not be dependent on the cost of PEP, which should be available for free to survivors. The Kenyan government should also make police forms to document rape readily available in health facilities so that survivors are not required to make two trips to the police and the health facility to receive care and report the incident.
- UN agencies should work collaboratively at the highest levels to address impunity of perpetrators of sexual exploitation and abuse and bring multi-agency influence over the Kenya Red Cross, the Kenyan government and other humanitarian actors. The National Commission on Gender and its partners should also continue code of conduct orientation for police and others.
- All agencies addressing GBV should make significant efforts to inform communities of their rights, where and how to report incidents of sexual exploitation and abuse, why medical care for survivors of sexual assault is important and where to access care.
- Donors should increase their commitment to ensuring comprehensive GBV services are available, and should also support GBV focal points at the field level.
- UNHCR, as lead agency for the Camp Coordination and Camp Management Cluster should ensure that a coordinated, multi-sectoral fuel strategy is established for IDPs in Kenya.

Reduce the Transmission of HIV

PRIORITY ACTIVITIES:

- *Ensuring safe blood transfusions*
- *Enforcing standard (universal) precautions*
- *Guaranteeing the availability of free condoms*

It is essential to implement the three priority activities to reduce the transmission of HIV at the start of an emergency. HIV transmission was seen by both service providers and displaced persons as a risk in the post-election violence. Knowledge levels among focus group participants on the modes of transmission and methods of prevention were high, although cultural biases, such as that women who carry condoms are promiscuous, were prevalent, especially among men. The real impact of the post-election violence on the rate of new infections is yet to be seen.

An opportunity did not present itself to determine whether Kenya's strong protocol and practices of ensuring safe blood transfusion were upheld in referral facilities throughout the crisis. Some camp clinics recognized standard precautions; for example, Nakuru Showground clinic had a disposer for sharps and was taking instruments to the provincial general hospital for sterilization. Alcohol was available for decontamination, and soiled materials were placed in garbage bags and taken to the same hospital for incineration.

Condoms were one of the commodities that service providers were keen to ensure, although community members felt they were not always readily accessible and more attention was needed to make female condoms available. The emphasis by the Kenyan government, UN agencies and international NGOs to make condoms available was reflected by the abundance of male condoms in warehouses, camp clinics and even in condom dispensers. Even so, focus group discussion participants in all locations commented that condoms were not freely available or easily accessible. Residents in Eldoret Showground, which had a functioning condom dispenser, mentioned that the distance to the sole dispenser posed access challenges. Moreover, some locations limited condom access points once service providers discovered that children and youth were taking them and found this inappropriate. Some clinics displayed female condoms; yet, only Medecins Sans Frontieres (MSF)-France's clinic in the Westlands had stocks for distribution, four months after the initial outbreak of the violence.

Condom dispenser by the Kenya Red Cross office, Eldoret Showground IDP Camp.

Innovative Practice

The Academic Model for the Prevention and Treatment of HIV (AMPATH) provided assistance in 11 camps in five districts in western Kenya. To reach displaced clients on ARVs, AMPATH initially placed notices in the media and created a telephone hotline. Through "snowball" communications, AMPATH identified those on ARVs in the camps, and provided information and referrals to nearby service providers for persons displaced outside of the catchment areas. AMPATH also offered psychological and trauma counseling and joint trainings in disaster management, sexual violence and the Sphere standards. As the situation stabilized, it undertook Voluntary Counseling and Testing (VCT) for IDPs.

"More than enough condoms are available—cartons and cartons—uptake has been good, around 500 per day."

International NGO worker, Nakuru

Although the provision of anti-retroviral (ARV) medication is not an articulated priority activity of the MISP, the government and international and local institutions responded robustly to ensure that AIDS clients did not miss their doses and develop drug resistance. The assessment team learned of creative ways that organizations coordinated and responded to reach clients and others displaced. Telephone hotlines and cell phone networks enabled agencies such as MSF-France and the Academic Model for the Prevention and Treatment of HIV (AMPATH) to spread the word and locate clients. Moreover, many agencies appeared to make linkages between HIV and GBV.

RECOMMENDATIONS

- All agencies should work with the IDP communities to identify creative ways to ensure IDPs, including youth, can access male condoms and improve women's and girls' access to female condoms.
- Health care providers should ensure adequate supplies are available to practice standard precautions to minimize HIV transmission.

Prevent Excess Maternal and Newborn Morbidity and Mortality

PRIORITY ACTIVITIES:

- *Providing clean delivery kits to visibly pregnant women or birth attendants to promote clean deliveries*
- *Providing midwife delivery kits to facilitate clean and safe deliveries at health facilities*
- *Initiating the establishment of a referral system to manage obstetric emergencies*

The rationale for providing clean delivery kits to visibly pregnant women in the early days and weeks of an emergency was evident from the reports shared with the assessment team. The Women's Commission heard stories of women delivering on buses, out in the open and in the rain in camps at the height of the crisis. Both service providers and IDPs also verified that it was not uncommon for women to deliver at home rather than in a health facility.

"I delivered eight children at home so my ninth child will also be delivered at home."

Quoted by an international NGO worker who encountered a woman who did not wish to deliver at a hospital

Clean delivery kits were available in the camps visited, although the majority of service providers noted supply shortages. While UNFPA and UNICEF had requisitioned clean delivery kits, shortages were reported by health providers in Kisumu and Kitale at the time of the assessment. One international NGO staff noted that while they received clean delivery kits for their work in the Western region, they had not received them for Nairobi given the assumptions that pregnant women would be taken to hospitals. Even where the agency received 500 kits for two locations in Kisumu, the supply was insufficient as the agency also wanted to service the slum areas with comparable need. Inadequate supply was echoed by another agency working in Eldoret. Moreover, none of the focus group participants and other interviewed internally displaced women had seen or were aware of the availability of or the right to such kits for pregnant women, even those who had given birth at the camp or in a nearby hospital following the December elections.

Fewer midwife delivery kits were seen onsite by the assessment team, and a clinical officer at the Nakuru Showground clinic noted that her team used clean delivery kits for births at the clinic, as midwife delivery kits required sterilization at the provincial general hospital, which was an added task.

A referral system that includes communications and transport to manage complications of pregnancy and delivery must be available 24 hours a day, seven days a week to avert preventable maternal and newborn deaths. Maternal mortality was not reported by district health staff or service providers in the sites visited by the assessment team, although conditions were ripe for referral failures. A functioning referral system was seen in Eldoret Showground where the international NGO operating a clinic teamed with the District Ministry of Health to coordinate transportation; all other sites were hampered with constraints such as the need to obtain a referral letter from the Kenya Red Cross, lack of a vehicle and fuel, time taken to locate a driver, or locked gates at night. A curfew also posed additional challenges in Kitale. While Noigam camp had a delivery center and a 24-hour clinic onsite, referral facilitation was the responsibility of the Kenya Red Cross, which was only present during the day. Focus group discussion participants mentioned the need for a referral form from the Kenya Red Cross, although it could take up to two days to obtain such a letter. One man reported losing two children because of such delays, although not from pregnancy-related causes. When the Kenya Red Cross is not available to provide transport, participants noted that they would sell food or contribute money to access a vehicle. Transport must also be arranged before 6.00 p.m.; if anything occurred at night, little could be done except to remain with the patient until morning.

Case Study

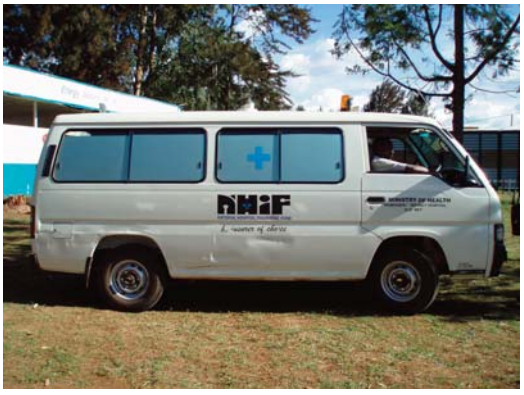
A young woman had given birth in early April in her tent at Nakuru Showground. She had delivered the baby on her own since it had come out too quickly for her to seek care. The child was her fourth, and she had not received a clean delivery kit. She had cut the umbilical cord herself, noting: "Any pregnant woman worth her weight in salt would carry a razor blade and tie." The woman said she followed the steps of delivery as taught in primary school. She developed no complications but had not seen a health care provider, whose clinic tent was less than 100 meters from her own. She was therefore not aware of the services she was entitled to, such as a clean delivery kit and supplemental foods for post-partum women. The woman was interested in family planning since she had practiced the lactational amenorrhea method but became pregnant six months after she delivered her third child. She wanted to have a tubal ligation, which Marie Stopes Kenya could provide.

Likewise in Kitale Showground, young women mentioned that if an emergency occurs at night, help is not available until morning. Participants were not aware of any telephone number they could call in case of emergencies.

In Nakuru Showground, the camp clinic operated by the Ministry of Health was forced to close in the evenings after angry men threatened to rape clinic staff. During clinic operating hours, referrals were made to the provincial general hospital. While an international NGO had previously provided fuel for referral transport, the organization recently withdrew. The Kenya Red Cross is responsible for providing transportation, but efforts to make this available were insufficient. The Ministry of Health owned an ambulance that serviced the provincial general hospital and the municipal council; a stationary vehicle was not available for the camp. According to the deputy clinic manager, it sometimes took two hours for a patient to be taken to the hospital, and two deaths were reported as a result of a lack of transport, although not pregnancy-related. In fact, while the assessment team was conducting the interview, a boy who had poisoned himself was rushed to the clinic. He needed to be taken to the hospital, and although a vehicle was present and a driver located, there was no money for fuel. The assessment team ultimately paid for fuel so that the child could be taken to the hospital.

"There were no means of transport and so they [neighbors] prepared a bicycle. She lost a lot of blood and when she arrived at the district hospital, she wasn't paid much attention. Around 6.00 a.m., both the mother and baby died. I witnessed it. The woman was 38 years old."

Male focus group discussion participant, Kisumu



Ambulance with a driver on standby, IMC Clinic, Eldoret Showground camp

Good Practice

The International Medical Corps (IMC) was working closely with the District Ministry of Health in Eldoret Showground camp, which provided the vehicle and driver. The Ministry of Health vehicle was stationed in front of the IMC clinic, making routine rounds for patients and also transporting emergency cases to the Moi Teaching and Referral Hospital. IMC has established a communications system so that if there is an emergency, staff, including volunteer health workers, can call one of the doctor's cell phones.

In Kisumu, where many IDP camps had been closed at the time of the assessment, focus group discussion participants reported pregnancy-related deaths they had witnessed in their communities. These women and girls appeared to be missed by authorities in camps and health facilities, raising concerns over non-registered IDPs residing in the community.

The assessment team was not able to assess the extent to which tertiary care facilities were equipped to address referral cases both during the height of and following the immediate violence, although the reported lack of supplies and drugs in the initial weeks of the crisis is believed to have had an impact on the level of care that could be provided.

RECOMMENDATIONS

- Health care providers should employ sustainable strategies that strengthen the health system to replace clean delivery and midwife delivery kits.
- Health care providers should identify and support or establish and properly maintain emergency referral systems where they are unavailable or are malfunctioning.
- Suggestions received on improving the clean delivery kits include adding cotton wool or sterile gauze to squeeze the umbilical cord and to clean the baby's nose and mouth (if a bulb syringe is not available), sanitary towels and clothes for the baby since s/he could be at risk of hypothermia.

Plan for Comprehensive Reproductive Health Services

PRIORITY ACTIVITIES:

- *Collecting basic background data on maternal and neonatal mortality, sexually transmitted infection and HIV prevalence, contraceptive prevalence and preferred methods, and RH knowledge, attitudes and practices, if available*
- *Identifying sites where RH services can be delivered in the future*
- *Assessing staff capacity and planning for staff training/retraining*
- *Identifying where/how RH supplies are bought and assessing monthly drug consumption*

The MISP objective to plan for comprehensive RH services encompasses activities that must be undertaken to expand such services when a crisis situation stabilizes. Unfortunately, due to a lack of RH coordination in this setting, inter-agency planning for comprehensive RH was only evident to address GBV.

Gender-based violence

While the MISP focuses on preventing and responding to sexual violence, planning for more comprehensive services includes being prepared to address broader GBV issues once the situation allows. More comprehensive GBV findings included reports of domestic violence from focus group discussion participants. In addition, service providers and displaced women reported breakdowns in marriages, with some men leaving their wives or taking new wives as a result of trauma leading to irrational behavior or economic challenges.

"There is no cash flow here so people turn to the wife and beat her or chase her away. There is a lot of violence."

Focus group discussion participant, Kisumu

Other GBV findings include reports of young girls in Kitale Showground quitting school to become married, which posed additional RH risks where services are not in place to support safe sex practices and the prevention of unwanted pregnancies.

In addition, UNHCR, in collaboration with the Kenya Red Cross, rolled out a series of trainings in all of the major sites on the IASC GBV Guidelines and the *Gender Handbook* in February. UNICEF also organized a sexual exploitation and abuse training of trainers with support from UNFPA, UNHCR and the UN Office for the Coordination of Humanitarian Affairs (OCHA). Other trainings held in March included a "Caring for Survivors" workshop, which comprised both psychosocial and medical components. UNICEF/UNFPA trainings for GBV sub-cluster members focused on the Kenya-specific GBV standard operating procedures and numerous trainings were also organized by local organizations.

Family planning

Although establishing a family planning program is not a part of the MISP, meeting existing need and planning for a family planning program are. Contraceptive supplies must be made available to meet demand for continued use and the additional needs of those who request birth control to prevent or space pregnancy as a result of displacement. Some agencies reported a lack of supplies in the initial weeks due to insecurity. However, by the time of the assessment, government and international NGO clinics had stocks of some method, presumably due to the existing family planning logistics system. Marie Stopes Kenya (MSK), a traditional development organization, was also conducting mobile outreach among displaced populations, so that IDPs could access long-term and permanent methods of birth control. Communication appeared to be good among service delivery agencies to coordinate mobile clinic visits. Following the post-election violence, MSK reported an increase in the sale of family planning vouchers that reduced the cost of contraceptives for clients, as well as an increase in the number of clients coming for family planning services, including men requesting vasectomies. Similarly, even for service providers working with populations that had limited experience with modern methods, after awareness-raising, uptake increased from six people in January to more than 400 by April, as reported by the Nakuru Showground clinic. Despite the increase however, a noticeable number of IDPs was not aware that contraceptives were available to them.

"The demand for family planning is increasing because people do not know their fate."

Female focus group discussion participant, Noigam Camp, Kitale

Service providers reported seeing an increase in pregnancies after the post-election violence, although this was unverified. Focus

group discussion participants also thought that many women had become pregnant after the violence, with some wanting contraceptives because of sexual exploitation and abuse. Kenya is the first country in Africa to make emergency contraception (EC) available without a prescription, but the men and women who were aware of the drug and service providers with whom the Women's Commission spoke only associated emergency contraception with post-rape care. As a result of high demand from the IDPs however, the Nairobi Women's Hospital, for example, distributed EC as a means of contraception.

The consequences of unwanted pregnancies were also beginning to be seen in camps at the time of the assessment. Cases of women and girls suffering from unsafe abortion had been reported in camps. Nakuru Showground clinic reported that in the week preceding the interview alone, there were two patients, one a 16-year-old who had used a pen and the other a 20-year-old who had used a coat hanger. The two women had come to the clinic for infection treatment.

"Today, I saw a 25 year old woman with four children less than five years—if you can imagine the degree of poverty. It was raining—just pouring, and you could see the stress on her face. Women want birth control—I have had five women [recently] asking."

International NGO staff, Kitale

Supplies

Commodity security was reported as a significant issue, especially during the height of the crisis when insecurity prevented routine operations. In Kisumu, for example, UNICEF reported that when road blocks were in place, only Kenya Red Cross trucks could pass. Many agencies, including government hospitals and facilities, relied on KEMSA for the delivery of medical products. Some agencies were able to fly chartered planes, but the post-election violence coincided with KEMSA's quarterly supply distribution, which contributed to the shortage of drugs and supplies such as malaria treatment, antibiotics and pain killers that were in high demand.

The centralization of medical supplies for the relief effort was viewed with mixed success. Responses showed that those in Nairobi were more positive than field staff about the role of KEMSA, the former appreciating the uniform security clearance process and single requests for convoys. UN agencies and larger NGOs appeared to be able to support KEMSA and the Kenya Red Cross for non-food items by providing courier options, although staff working at the field level were more aware of delays and complications in supplies reaching their intended destinations.

Innovative Practice

In early February when medical supplies were in short supply, Liverpool VCT, Care and Treatment, a Kenyan NGO, obtained commodities directly from Kenya Red Cross's office in Nairobi and delivered them using its own logistics system to the government hospital in Kiambu.

Treatment of sexually transmitted infections is also encompassed under comprehensive RH programming, although these interventions were not examined in this assessment.

RECOMMENDATIONS

- Donors should provide robust support as agencies hand over activities and ensure that government and locally operated services are sustainable for IDPs in camps, transit camps, communities and areas of return.
- Service providers, including community-based workers, should inform IDPs about the availability of contraception.
- Service providers should make emergency contraception readily available as a contraceptive method, especially to youth.

Notes

[1] United States Agency for International Development, *Kenya: Complex Emergency Fact Sheet #7* (FY 2008), Feb. 27, 2008.
[2] United Nations Office for the Coordination of Humanitarian Affairs, *Humanitarian Update Vol. 16*, April 17-23, 2008.
[3] As of April 22, 2008. Kenya Red Cross Society. "Kenya: Electoral Violence," *Kenya Red Cross Operations Update,* April 22, 2008.
[4] As of March 26, 2008. Cited in USAID, "Kenya—Complex Emergency," April 23, 2008.
[5] Ibid.
[6] The cluster approach was introduced in 2005 as part of the Humanitarian Reform Agenda to create a greater "spirit" of working together. The aim is to enhance humanitarian response capacity, predictability, accountability and partnership. There are nine clusters and each cluster has a designated lead, responsible to the Emergency Relief Coordinator (global) or Humanitarian Coordinator (country level). See http://www.allindiary.org/uploads/C4-UN_cluster_approach.pdf.
[7] United Nations, Kenya: *Emergency Humanitarian Response Plan,* April 2008.
[8] As of April 14, 2008. UN OCHA Financial Tracking System, "Table D: Requirements, Commitments/Contributions and Pledges per Sector," *Flash Appeal: Kenya Emergency Humanitarian Response Plan 2008.* Accessed April 14, 2008. http://www.reliefweb.int/fts.
[9] Ibid.
[10] The Sphere Project sets out the *Humanitarian Charter and Minimum Standards in Disaster Response* in a *Sphere Handbook* (Revised 2004). The project and standards are designed to improve the quality of assistance provided to people affected by disasters, and to enhance the accountability of the humanitarian system in disaster response.
[11] For 2005, United Nations Children's Fund Statistics, retrieved on July 18, 2008, from http://www.unicef.org/infobycountry/kenya_statistics.html.
[12] For 2006, UNICEF Statistics, retrieved on July 18, 2008, from http://www.unicef.org/infobycountry/kenya_statistics.html.
[13] Kenya National Bureau of Statistics, *Kenya Demographic and Health Survey 2003.* Retrieved on July 18, 2008, from http://www.cbs.go.ke/.
[14] Chad, April 2004 http://www.womenscommission.org/pdf/cd_misp%20final.pdf, and Indonesia, after the tsunami , February 2005, http://www.womenscommission.org/pdf/id_misp_eng.pdf.
[15] Women's Commission for Refugee Women and Children, *Minimum Initial Service Package (MISP) for Reproductive Health in Crisis Situations, A Distance Learning Module,* September 2006. http://misp.rhrc.org/
[16] Myrum, J., Ward, J. and Marsh, M. *A Rapid Assessment of Gender-based Violence during the Post-election Violence in Kenya,* conducted January – February 2008, (Nairobi: UNICEF, UNFPA, UNIFEM, CCF, 2008). Accessible from: http://www.humanitarianreform.org/humanitarianreform/Portals/1/cluster%20approach%20page/Kenya/GBV/GBVreportfinalMar7.pdf.
[17] According to the 2006 Sexual Offences Act, "defilement" is an act of penetration with a child below 18 years of age.
[18] Gender Violence Recovery Centre. "Support to the Gender Violence Recovery Centre—Post-election Conflict Emergency Intervention: Quarterly Report" (Nairobi: Nairobi Women's Hospital, 2008).
[19] Ibid.
[20] Patrick, E. Beyond Firewood: Fuel Alternatives and Protection Strategies for Displaced Women and Girls, (New York: Women's Commission for Refugee Women and Children, 2006).
[21] Myrum, J., et al. *A Rapid Assessment of Gender-based Violence during the Post-election Violence in Kenya.*
[22] See Myrum, J., et al for more information.
[23] Ibid.

ANNEX 1: METHODOLOGY

The assessment methodology consisted of observational checklists based on the MISP objectives, facilities assessments, key informant interviews and focus group discussions and communications with displaced populations. In-depth interviews were conducted with 52 service providers and policymakers from 20 institutions constituting UN agencies, local and international NGOs, the Kenya Red Cross and the Ministry of Health. Eight focus group discussions with 139 displaced men, women and adolescents were convened in Kisumu and Kitale.

Purposeful sampling was used to select participants, with the help of NGOs and their community health workers servicing each location. Explicit considerations were made to ensure that displaced women, men and youth came from different localities, resided in various locations if in a camp and represented various vulnerabilities. Separate focus group discussions were held with women and with men to the extent possible. Some discussions were conducted in English, others with Kiswahili translation by an experienced midwife who translated the focus group discussion guides adapted from pre-existing Reproductive Health Response in Conflict Consortium tools. Participants were informed of the purpose, process and use of information; the assessment team's commitment to respect confidentiality; the importance of participants' respect for confidentiality among the group; and their right to refuse to participate, to leave or to remain silent. Oral consent was obtained and, where possible, English and Kiswahili translations of the Women's Commission's work and contact details were provided to participants. All data were analyzed through triangulating the information and verifying findings with other available data.

Limitations

This assessment had several limitations in regards to focus group discussions including: non-representative sampling, translation error and the possible lack of consistency, and limited number of sessions per site resulting in potential lack of saturation. Moreover, while the majority of groups were separated by participant age and sex, this could not always be guaranteed given the logistics of organizing the groups. Nevertheless, women and younger people were contributing sensitive information to mixed discussions; it is unknown to what extent, if indeed, the mixing of sex and age ranges compromised quality. The facilitators were also female and it was unclear whether that had any repercussions on data quality of the focus group discussions with men. Lastly, with the exception of Kisumu where many camps had been dissolved, the team was not able to meet with persons displaced within communities; hence, the data do not capture the situation of IDPs outside of the camps, which was presumed to be worse, given the lack of targeted services for non-registered IDPs.

Time was an issue regarding interviews, as not all relevant staff were present and available for meetings at the time of the assessment. Some agencies had just withdrawn, which limited access to retrospective questioning of services provided.

ANNEX 2: REPODUCTIVE HEALTH POLICIES

General Reproductive Health

- Second National Health Sector Strategic Plan 2005-2010 (August 2005)
- Adolescent Reproductive Health and Development Policy Plan of Action 2005-2015 (August 2005)
- National Guidelines for Provision of Adolescent Youth-Friendly Services (YES) in Kenya (July 2005)
- National Guidelines for the Control of Reproductive Tract Infections (2005)
- Adolescent Reproductive Health and Development Policy (May 2003)
- National Plan of Action for the Elimination of Female Genital Mutilation in Kenya (June 1999)
- National Reproductive Health Strategy 1997-2010 (1996)

Gender-based Violence

- Sexual Offenses Act, 2006
- National Guidelines on Medical Management of Rape/Sexual Violence (November 2004)

HIV/AIDS

- HIV and AIDS Prevention and Control Act, 2006
- Guidelines for Antiretroviral Drug Therapy in Kenya (2001, revised December 2005)
- Guidelines for the Appropriate Use of Blood and Blood Products (April 2004)
- National Strategy on Blood Donor Mobilisation (2003)
- Clinical Guidelines for the Management of Human Immunodeficiency Virus (HIV) Infected Pregnant Women and Prevention of Mother to Child Transmission (MTCT) of HIV in Kenya (2001)
- National Guidelines for Voluntary Counseling and Testing (2001)
- National Guidelines on Home-based Care for HIV/AIDS (2001)

Maternal and Neonatal Health

- Standards for Maternal Care in Kenya (December 2002)

Family Planning

- Family Planning Guidelines for Service Providers (revised March 2005)

Reproductive Health Indicators

	National	Nairobi	Central	Coast	Eastern	North Eastern	Nyanza	Rift Valley	Western	Source
Maternal Mortality Ratio: maternal deaths per 100,000 live births	560									UNICEF, 2005
Infant Mortality Rate per 1,000 live births	79	67	44	78	56	91	133	61	80	UNICEF, 2006 (national); KDHS 2003
Total Fertility Rate	5.0	2.7	3.4	4.9	4.8	7.0	5.6	5.8	5.8	KDHS, 2003
Births per 1,000 women aged 15-19	113									KDHS, 2003
Contraceptive Prevalence (modern method) (percent)	30.5	45.6	58.3	18.8	37.0	0.3	21.2	22.9	26.2	KDHS, 2003
Unmet need for family planning (percent of currently married women, 15-49)	25	16	11	25	22	10	35	28	32	KDHS, 2003
Births attended by trained personnel (percent)	40.8	78.5	68.8	34.7	35.7	8.0	40.7	36.1	29.0	KDHS, 2003
Adult HIV Prevalence (percent)	5.2-7.0 (6.1)	9.1	5.9	6.0	4.1	--	14.0	5.2	5.0	WHO 2005 (range, national); KDHS, 2003

Sources: UNICEF Statistics; WHO Reproductive Health Indicators Database; Kenya National Bureau of Statistics Kenya Demographic and Health Survey (KDHS) 2003; National AIDS Control Council and the National AIDS and STD Control Programme National HIV Prevalence in Kenya 2006; UNAIDS Kenya Country Situation Analysis 2006. All accessed July 18, 2008.

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