REPUBLIC OF KENYA

MDG ACCELERATION FRAMEWORK

KENYA
MDG ACCELERATION FRAMEWORK AND ACTION PLAN

IMPROVING MATERNAL AND NEONATAL HEALTH

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Abbreviations and acronyms

AMREF	African Medical and Research Foundation
ANC	Antenatal care
BCC	Behaviour change communication
BEmOC	Basic emergency obstetric care
CAC	Comprehensive abortion care
CAP	Country Action Plan
CDF	Constituency Development Fund
CEmOC	Comprehensive emergency obstetric care
COMESA	Common Market for East and Southern Africa
CPR	Contraceptive prevalence rate
C-section	Caesarean section
DFH	Department of Family Health
DHS	Demographic and health survey
DRH	Division of Reproductive Health
EmOC	Emergency obstetric care
ENBC	Essential newborn care
ERS	Economic recovery strategy
ESP	Economic Stimulus Programme
FANC	Focused antenatal care
FBO	Faith-based organizations
GDP	Gross domestic product
HDU	High dependency unit
HII	High impact intervention
HMIS	Health Management Information System
HRD	Human resource development
HRM	Human resource management
ICT	Information and communications technology
ICU	Intensive care unit
IEC	Information, education and communication
IMR	Infant mortality ratio
KDHS	Kenya Demographic and Health Survey
KEMSA	Kenya Medical Supplies Agency
KMIS	Kenya Health Management Information Systems

KNBS	Kenya National Bureau of Statistics
KSPA	Kenya Service Provision Assessment
LAPM	Long acting permanent methods
MAF	MDG Acceleration Framework
MCH	Maternal and child health
MDG	Millennium Development Goal
MDN	Maternal death notification
MDR	Maternal death review
MMR	Maternal mortality ratio
MNH	Maternal and newborn health
MODP	Ministry of Devolution and Planning
MOF	Ministry of Finance
MOH	Ministry of Health
MOMS	Ministry of Medical Services
MOPHS	Ministry of Public Health and Sanitation
MOPW	Ministry of Public Works
MPDR	Maternal and perinatal death reviews
MTP	Medium term plan
NBTS	National Blood Transfusion Service
NHIF	National Hospital Insurance Fund
OBA	Output-based activity
PNC	Postnatal care
RH	Reproductive health
SBA	Skilled birth attendant
TB	Tuberculosis
TBA	Long acting permanent methods
TBD	To be determined
UN	United Nations
UNCT	United Nations Country Team
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development

Foreword

The Government of the Republic of Kenya is committed to achieving all the Millennium Development Goals (MDGs). The Kenya Vision 2030 and other government policy documents have mainstreamed the implementation of the MDGs in Kenya's policy, planning, budgeting and development processes. There has been progress, and in some cases substantial progress, towards realizing a number of the MDGs. In particular: universal primary education (MDG 2); promotion of gender equality and empowerment of women (MDG 3); reducing child mortality (MDG 4); combating HIV/AIDS, malaria and other diseases (MDG 6); and in exploiting information and communication technologies (ICTs) (MDG 8). However, progress towards realizing a number of other key MDGs – eradicating extreme poverty and hunger (MDG 1), achieving environmental sustainability (MDG 7) and improving maternal health (MDG 5) has been very slow. MDG 5 is of particular concern as it is the only area in which the key indicators show deterioration, and related indicators such as the neonatal mortality rate have not improved. At a maternal mortality ratio of 488 per 100,000 live births[1], over 8000 women die annually due to pregnancy and birth-related complications. Should this trend continue, and without drastic intervention, the country is unlikely to meet the MDG targets for improved maternal and neonatal health.

At the core of the problem is a poorly functioning health system with an inadequate number of skilled health workers; poor facilities; inadequate equipment and commodities; insufficient focus on quality of care; and low demand for health care for both mothers and their new-borns. The problem is compounded by significant disparities in both health care coverage and health seeking behaviour in different regions and for specific population groups. Solving these supply and demand side problems is at the core of the efforts proposed in this MDG Acceleration Framework (MAF) document.

This MAF was developed by the Government of Kenya under the leadership of the ministries of Health and that of Devolution and Planning. The effort was supported by the United Nations Development Programme (UNDP) and involved a variety of key actors in the health sector, and is designed to enhance efforts to overcome bottlenecks to interventions that have been proven to work in Kenya. It focuses on strengthening of the health system for the provision of maternal

[1] KDHS 2008/9

and new-born health, and raising the demand for maternal and new-born health (MNH) services from women, families and communities; the two most important cross-cutting intervention areas. The four specific intervention areas include: increasing access to skilled birth attendance; emergency obstetric and neonatal and post-abortion care; antenatal and postnatal services; and family planning. The MAF does not replace existing policies and strategies but is designed to complement them.

In conclusion, achieving MDG 5 by improving maternal and neonatal health is achievable within the remaining short timeframe; however, it requires a dramatic improvement in political will, decisive action and financial investment. Further, it requires government effort and significant support from partners.

The involvement of the United Nations Country Team (UNCT) and a number of key actors in this area is a good start. Focused and coordinated investment, and close and collaborative monitoring and management of the process are vital. The immediate attention to this critical issue is required from all relevant government agencies, and partners to collaborate and support implementation through technical, financial and logistical support. County governments are specifically requested to prioritize maternal and neonatal health in their budgets and programmes.

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The work on improving maternal and neonatal health to achieve MDG 5 by 2015 has just begun. You all appreciate the immensity and urgency of the commitment required to make the difference required in this area within the very short timeframes. You will be called upon for support and to actually implement the initiatives identified in this document to achieve the MDG 5 by 2015 and to establish the framework for continuous improvement in maternal, neonatal and child health in line with our Vision 2030 and the new constitution.

Executive Summary

RATIONALE FOR THE CHOICE OF THE LAGGING MDGS

Approximately 8000 women die annually due to pregnancy-related complications. The maternal mortality ratio (MMR) has remained unacceptably high in Kenya at 488 maternal deaths per 100,000 live births[2] which represents an increase from 414 in 2003. Despite the efforts of the Government and its partners, some regions (North Eastern and Western) report an MMR of over 1000.

The discussion on choosing maternal and neonatal health (MNH) as a focus area was taken in consideration of other lagging MDGs on Goals 1, 4 and 7c. While the deliberations noted the importance of reducing hunger and poverty (MDG 1), reducing infant mortality (MDG 4) and improving access to potable water, there was general agreement that a MAF focused on MNH is a more optimal choice and will have a greater impact due to a number of considerations. Namely: that there has been less emphasis on achieving MDG 5 in comparison to the other MDGs; achievements of the other MDGs do not necessarily result in a positive impact on MNH; and the role played by the mother in the family is crucial for child survival and the proper upbringing of the newborn and the entire family.

MDG ACCELERATION FRAMEWORK AND THE PROCESS

The MAF is not a substitute for existing government and health sector policies, strategies and plans. Rather it will complement these through a deeper assessment of the bottlenecks hindering progress on achieving improvements in maternal and neonatal health, and its exploration of high impact, feasible and monitorable solutions to accelerate progress. The MAF provides a coherent, consultative and harmonized framework elaborated by all key partners, and has the potential to foster buy-in from all stakeholders on improving maternal and neonatal health.

The MAF development process was a consultative one that went through four steps: identifying the off-track and poorest performing MDGs; identifying key country-specific interventions; identifying and prioritizing bottlenecks that impede the success of the interventions; and formulating an MAF Action Plan with a clear set of initiatives and responsibilities for all actors to collaboratively undertake, monitor and manage.

[2] (KDHS 2008, MDG Status Report 2009)

PROGRESS AND CHALLENGES IN IMPROVING MATERNAL AND NEONATAL HEALTH CARE

Although Kenya has achieved progress in the past 10 years of MDG implementation, challenges remain in achieving maternal and neonatal health. With only three years remaining to the MDG deadline of 2015, Kenya will have to accelerate its efforts – in collaboration and with the support of its partners – if it is to meet the MDG 5 targets and neonatal health. Although the maternal mortality ratio fell from 590 in 1998 to 414 in 2003, it rose to 488 in 2009 (KDHS: 1998, 2003, 2009). This shows that maternal mortality is not only not improving but is actually regressing. The MDG 5 target of reducing the MMR of 147 to 100,000 live births is unlikely to be achieved unless urgent and dramatic interventions are implemented.

Causes of maternal deaths

The direct causes of maternal deaths include haemorrhage, infection, eclampsia and others. The indirect causes include HIV/AIDS, anaemia, cardiovascular causes and malaria in that order. However, the majority of maternal deaths are largely preventable through the provision of proper and timely health care services. Yet, the maternal and neonatal health care indicators have not improved over the last 20 years, especially in the areas of: skilled attendance at delivery, antenatal and postnatal services; emergency obstetric and neonatal care; and family planning.

Progress made so far

The Constitution of Kenya recognizes high quality reproductive health services as a basic human right under a comprehensive bill of rights. The Kenya Vision 2030 goal for the health sector is, therefore, to provide equitable and affordable quality health services to all Kenyans. The MDGs have already been mainstreamed into the policy, planning and budgeting processes of the Government. Appropriate policies, strategies and guidelines are in place; the key amongst which being the National Road Map for the Achievement of MDGs related to maternal and neonatal health. The goal of the Road Map is to accelerate the reduction of maternal and newborn morbidity and mortality in order to the MDG targets.

All levels of health care now offer maternal and newborn health services. The pre-service curriculum for health worker training is being regularly updated, and capacity building of health workers in service provision is ongoing.

Additional health workers were employed under the Economic Stimulus Program (ESP) and are now serving in health facilities in the regions. A substantial number of health facilities have been built in all constituencies using Constituency Development Funds (CDF) which has, since inception, prioritized health and education in all regions.

To improve data on maternal health, maternal and perinatal death reviews (MPDR) are being institutionalized. Government policy is that reporting on maternal death is now mandatory and is treated in the same way as highly contagious diseases are reported under the Division of Disease Surveillance and Response in the Ministry of Public Health and Sanitation.

Other initiatives include: output-based activity (OBA), a voucher scheme system implemented as a pilot in specific districts which allows poor women to obtain reproductive health services including delivery. Maternal and Child Health (MCH) weeks are conducted in May and November; and there is a Mother/Baby booklet in use. Maternal and newborn health (MNH) High Impact Interventions (HII) have been identified and are being implemented.

IMPACT AND ROLE OF OTHER SECTORS

Other sectors have a significant impact on, and a role in, implementing solutions for improving MNH. These sectors include: water, energy, agriculture, gender and social services, and youth affairs. These are discussed in the main body of the report.

STRATEGIC INTERVENTIONS

The following strategic intervention areas are in line with current health sector policies and strategies and were agreed upon through a consultative process. They include:

1. Upgrade the functionality of the health system for the provision of maternal and neonatal health services by: increasing the numbers, skills and distribution of health personnel; increasing availability of appropriate facilities, equipment and commodities; and enhancing management of health services.

2. Increase demand for reproductive health services by using a variety of means, key amongst which is the full implementation of the Community Health Strategy and customer service training for health personnel.

3. Provide universal access to family planning services through increasing availability of skilled staff, family planning commodities, provision of services to the youth, and increasing service points.

4. Improve access to antenatal and postnatal care (ANC and PNC) for all pregnant women through improving service delivery and access, and improving knowledge of women on the benefits of ANC and PNC.

5. Provide access to skilled birth attendance through improving service delivery, raising awareness and knowledge of the need for skilled birth attendance, improving referral; and

6. Improve access to emergency care including: obstetric care (basic and comprehensive); comprehensive post-abortion care (CAC); and essential newborn care (ENBC). Specific interventions include increasing numbers and skills of staff able to handle emergencies; improving availability of appropriate facilities, equipment and commodities; and strengthening blood transfusion services.

BOTTLENECKS

Prioritized bottlenecks in each priority intervention areas include the following:

1. *Upgrade the functionality of the health care system for the provision of maternal health services:* inadequate government budget for maternal health, disjointed efforts and lack of synergies by both state and non-state actors; lack of basic capacities and resources; and weak management of the health system.

2. *Increase demand for reproductive health services:* resistance and low support for maternal and neonatal health services due to socio-cultural and religious reasons; low status of women; and inadequate knowledge on the benefits of maternal and reproductive health services.

3. *Provide universal access to family planning services:* inadequate numbers of health staff skilled in the provision of family planning services, especially long acting permanent methods (LAPM); inadequate number of health providers and service points; inadequate availability of reproductive health services for adolescents and youth; and family planning commodity insecurity.

4. *Improve access to antenatal and postnatal care:* human resource challenges and poor attitude of health personnel; poor access to and cost of lab services; inadequate availability of appropriate equipment and commodities; low level of awareness on the importance of ANC and PNC; and long distances to health facilities for some communities.

5. *Provide access to skilled birth attendance:* inadequate number of skilled midwives and nurses coupled with poor attitude of the existing staff; poor quality service delivery and environment to ensure the health, privacy, dignity and socio-cultural sensitivity of the mothers; and low demand for skilled birth attendance due to low value attached to skilled attendance, socio-cultural attitudes and preference for traditional birth attendants (TBAs). Other bottlenecks include long distances to health facilities for some communities; unaffordable cost of delivery; and poor referral system.

6. *Improve access to emergency obstetric and newborn care:* human resource challenges (inadequate number, skills and distribution of health staff able to handle emergencies); inadequate facilities, equipment and commodities; and non-availability of blood and transfusion services in time of need and insufficient stocks of blood especially for universal donors.

SOLUTIONS TO BOTTLENECKS

Short term high impact solutions to bottlenecks identified in each priority area include the following:

1. *Upgrade the functionality of the health system for the provision of maternal health services.* Specific solutions include:

    - Increase the proportion of the health budget available for maternal and neonatal health services, mobilizing additional funds from development partners and the private sector, and advocacy for the prioritization of maternal health with county governments; and improved coordination of efforts in this area. On managing health services, solutions include training health managers on management skills, support supervision and quality assurance; enforcing standards; and improving data quality;

    - Employ additional health personnel to provide maternal health services and provide incentives to retain them particularly in hardship areas. Systematically retrain all staff in maternal and neonatal care interventions along the continuum of care, upscale the training of nurses to provide anaesthesia services to bridge the gap; and allow for private practitioners to provide stop gap support in case of emergencies;

    - Strengthen the system for procurement, distribution and management of health commodities for maternal health and implement a system for regular monitoring;

    - Upgrade the sections of health facilities used to provide maternal and neonatal health services to provide a more conducive environment for mothers including ensuring their privacy, dignity and cultural sensitivity. These upgrades should be basic and cost effective. Provide reliable access to water, electricity and improved sanitation in all health facilities;

    - Work with roads authorities to lobby for all health facilities providing maternal health services to be connected via an all-weather road.

2. *Increase demand for reproductive health services:* use various means to raise awareness, educate the public and lobby for community support including fully implementing the Community Health Strategy.

3. *Provide universal access to family planning services:* adopt the solution for improving staff capacity; provide youth-friendly services; and provide means for expanding access to more service points. Increase demand for family planning and waive charges.

4. *Improve access to antenatal and postnatal care:* adopt the solution for improving staff capacity; provide free lab services; provide equipment and commodities; make it easier for women to access ANC and PNC including using mobile clinics in far to reach places.

5. *Provide access to skilled birth attendance at delivery:* provide an adequate number of midwives and train nurses in midwifery skills; train workers on customer service; upgrade the environment to ensure privacy and cleanliness; provide commodities; improve demand and specifically integrate the role of TBAs; improve geographical and cost access; and improve referral services.

6. *Improve access to emergency care:* implement solution for strengthening health services; ensure health facilities providing delivery services are able to provide essential newborn care; upgrade emergency preparedness at levels 4 and above with appropriate facilities, equipment and staff preparedness; ensure availability of blood and transfusion services at all times at health facilities levels 4 and above.

MDG ACCELERATION PLAN: BUILDING A COMPACT

Chapter IV sets out the Country Action Plan (CAP), the country compact based on mutual accountability, to support the country in its efforts to overcome the bottlenecks identified. It identifies the contribution and complimentary roles that the government and development partners agree to play in implementing identified solutions.

The CAP reflects the critical issues related to achieving maternal and neonatal health, prioritized interventions, prioritized bottlenecks, proposed solutions and their financing, and the parties responsible for the implementation of these solutions.

MONITORING AND EVALUATION FRAMEWORK

The MDGs can be achieved by 2015 if efforts are supported by the right policies, implementation strategies and actions, coupled with strong political commitment and adequate funding and institutional capacities. Central to the success of the CAP will be the implementation of a coordinated and collaborative approach to monitoring and evaluation that allows for timely feedback and proactive evidence-based decision making to achieve efficiency in the achievement of planned results.

Chapter I – Introduction

This MDG Acceleration Framework (MAF) has been formulated to address the MDGs related to maternal and neonatal health. These two areas have been identified as the most lagging MDGs and the least likely to be achieved by 2015.

This chapter provides the progress and challenges in achieving MDGs; the rationale for the choice of the most lagging MDGs; and the process used to develop the MAF.

OVERALL DEVELOPMENT CONTEXT

In 1963, during the first decade of Kenya's independence, the economy grew at an average of 7 percent, but this declined to an all-time low of 0.2 percent in 2000. This decline, which can be attributed to both adverse external and internal factors including poor commodity prices and climate volatility, contributed to the deterioration in the overall welfare of the Kenyan population.

Under the Economic Recovery Strategy (ERS), the economy grew steadily from 0.5 percent in 2002 to over 7 percent in 2007. In 2008, the Government launched the Kenya Vision 2030 and its first Medium Term Plan (MTP) of 5 years. The goal of Vision 2030 is to transform Kenya into an industrialized, middle income country by 2030.

The economy is predominantly agricultural with a strong industrial base. In 2012, agriculture contributed 25.9 percent of the GDP while the manufacturing sector contributed 9.2 percent; wholesale and trade, 10.2 percent; and transport and communications, 9.3 percent (KNBS 2013). Cash crops that form the main export commodities include tea, coffee and horticulture (flowers, fruits and vegetables) which jointly accounted for 42.7 percent of total export earnings in 2012 (KNBS, 2013).

The remarkable growth of the economy slowed dramatically to a real GDP growth of 1.7 percent in 2008 which was mainly attributed to the post-election crisis following the disputed 2007 General Elections. Since 2009, the country has experienced a modest economic recovery with the GDP growth rate forecast to be over 5 percent in 2012.

THE MILLENNIUM DEVELOPMENT GOALS IN KENYA

In 2010, an extensive review of Kenya's progress towards realizing the eight Millennium Development Goals by the 2015 deadline was undertaken. This section provides an overview of the major recent events globally and nationally which have had a direct impact on MDG progress and describes the need for MDG acceleration to enable Kenya to meet the MDGs by 2015.

OVERALL PROGRESS IN ACHIEVING THE MDGS IN KENYA

Kenya began institutionalizing the MDGs in September 2002. The Government conducted a MDG needs assessment resulting in the publication of the MDGs Needs Assessment and Costing Report of 2005. MDG sector specific assessment reports were also published in 2007. The Government's commitment to the MDGs is also manifested in the preparation of the consultative MDG Status Reports (2003, 2005, 2007 and 2009).

MDG-based planning started in Kenya in 2004. The focus of the MDG process in Kenya has been on mainstreaming the MDGs into policy, planning and budgeting and rallying all stakeholders to their implementation. MDGs are mainstreamed in the national development plans and strategies namely the Vision 2030 and its five years operational plan, the Medium Term Plan (2008-2012) as well as in the district and sector plans. The MDG-based planning has ensured that government planning and budgeting for resources is MDG-based. Similarly, budgetary allocation to sectors that are core to the MDGs has been increasing yearly since 2004.

As a result, there have been improvements in the performance of a number of key MDG indicators; in particular in the areas of education, child health, HIV/AIDS, Malaria, Tuberculosis. In addition, substantial progress has been made in the fight against hunger and poverty but this has been impacted by the recent global and domestic challenges of the financial crisis, high food and fuel prices, and drought. The current famine and refugee crises at the border with Somalia and at Northern Eastern Kenya will also impact Kenya's hunger indices. MDG 2, which focuses on universal primary education is the most likely goal to be met, although concerns remain on quality and the need to improve tertiary education. Other goals with substantive achievement relate to reducing infant mortality, the prevalence of HIV, AIDS, malaria and other diseases. There is significant evidence that greater ownership of intervention activities by the Government complemented by effective resource allocations, can improve the chances of meeting the MDGs by 2015.

Below is a summary of key achievements on the respective MDGs.

Goal 1: Eradication of extreme hunger and poverty

The Government has developed the draft National Policy on Irrigation and Drainage Development to increase the area of land under irrigation, and to reduce the dependence on rain fed agriculture. Other supportive policies and programmes, including the National Accelerated Agricultural Inputs Access Programme and the Economic Stimulus Programme, have succeeded in reducing the proportion of the Kenyan population living below the poverty line from 52.6 percent in 1997 to 45.9 percent in 2005/06. However, recent global and domestic challenges such as the economic and financial crisis, high fuel and food crises and unpredictable and lesser rains threaten to reverse these gains.

Goal 2: Achievement of universal primary education

Since the inception of the Free Primary Education programme in 2003, there has been an increase in primary school gross enrolment from 88.2 in 2002 to 110 in 2009. The goal of gender parity in primary school net enrolment is almost being achieved with the gender parity index reaching 0.958 in 2009.

Goal 3: Achievement of gender equality and empowering women

The country has put in place mechanisms to ensure the empowerment of women. These include the Women's Enterprise Development Fund and the entry into force in 2010 of Kenya's new constitution, which aims to enhance political participation of all genders in development by prescribing a representation of at least one third of either gender in the county assemblies.

Supported by a presidential directive to ensure that at least 30 percent of all jobs in the civil service are set aside for women, women now constitute about 30 percent of the labour force in the modern sectors.

Goal 4: Reduction of child mortality rates

The key interventions in reducing child and maternal mortality rates have been in the domain of policy such as reallocation of financial resources toward primary health care, with the Community health strategy being a prominent example. Towards the reduction of child and maternal mortality rates, there has been an increase in the immunisation coverage rates to 77.4 percent in 2009 from 56.8 percent in 2003 (KDHS 2009). Drugs for the prevention of mother to child transmission of HIV

as well as antiretroviral drugs are available at most health facilities. Infant mortality rates have fallen to 52 deaths per 1000 live births in 2009 from 77 in 2003, while the mortality rate for children aged five years and below has fallen from 115 per 1000 live births to 74 within the same period.

Goal 5: Reduction of maternal mortality rates

On June 1, 2013 The Government of Kenya introduced free (pre and postnatal) maternity services at all public health facilities. The proportion of births attended by skilled personnel has increased to 43.8 percent in 2009 from 42 percent in 2003. There has been an increase in the proportion of married women using contraception from 39 percent in 2003 to 46 percent in 2008/9. The maternal mortality ratio increased from 414 to 488 deaths per 100,000 live births between 2003 and 2009.

Goal 6: Combating HIV and AIDS, Malaria and other diseases

Supported by the successful implementation of the Kenya National HIV and AIDS Strategic Plans, the national rate of HIV prevalence fell to 6.3 percent in 2009 from 6.7 percent in 2003 for the age group 15-49 years. Drugs for the prevention of mother to child transmission of HIV as well as antiretroviral drugs are available at most health facilities.

Goal 7: Ensuring environmental sustainability

Overall, about 56 percent of Kenyans have access to clean water, while 84 percent have access to basic sanitation. Key areas of concern are the high proportion of urban populations living in informal settlements, poor land use planning, diminishing forest cover and low water-per-capita availability. A number of slum improvement and natural resource management programmes are in place such as the Kenya Slum Upgrading Project and the reclamation of the water towers. A draft policy on irrigation and drainage has also been developed.

Goal 8: Development of a global partnership for development

The proportion of developed country imports admitted duty free rose from 90.56 percent in 2000 to 98.67 in 2009, while the average tariff imposed on Kenya's agricultural products and clothing decreased from 4.71 percent in 2000 to 2.41 percent in 2009. The country has also achieved great improvements in the area of ICT especially mobile phone telephony and internet usage.

The Government of Kenya is also focused on increasing foreign direct investment and the volume of trade.

RATIONALE AND THE VALUE ADDED OF THE MAF ON IMPROVING MATERNAL AND NEONATAL HEALTH

Approximately 8,000 women die annually due to pregnancy-related complications. The maternal mortality ratio (MMR) has remained unacceptably high in Kenya at 488 maternal deaths per 100,000 live births[3] which represents an increase from 414 deaths per 100,000 live births in 2003 (KDHS 2009). Despite the efforts of the Government and its partners, some regions (North Eastern) report MMRs of over 1,000 deaths per 100,000 live births.

The discussion on choosing MDGs related to maternal and neonatal health was taken in consideration with other lagging MDGs on Goals 1, 4 and 7c. While the deliberations noted the importance in reducing hunger and poverty (Goal 1), reducing infant mortality (Goal 4) and improving access to potable water, there was general agreement that a MAF focused on maternal and neonatal health is a more optimal choice and will result in greater impact. Maternal health has significant impact on the health and wellbeing of the family, and improvement in this area is likely to have substantial benefits for the family and facilitate the achievement of other MDGs. Proven interventions along the continuum of care are well established, and alleviating bottlenecks through short term high impact solutions through a combined effort of the Government and its partners is likely to make a fundamental difference.

The MAF is not a substitute for existing government and health sector policies, strategies and plans. Rather it will complement these through a deeper analysis of the bottlenecks hindering progress in achieving improvements in maternal and neonatal health. It identifies and prioritizes bottlenecks thus avoiding the creation of a wish list of actions that is, regrettably, common in many government strategies and explores high impact, feasible and monitorable solutions for accelerating progress.

[3] (KDHS 2008, MDG Status Report 2009)

PURPOSE AND OBJECTIVES OF THE MAF IN KENYA

The purpose of this MAF is to provide a coherent, consultative and harmonized framework elaborated by all key partners, for action to accelerate implementation of the MDGs related to maternal and neonatal health. Through a consultative process, it has the potential to engender greater understanding of the real issues impacting maternal and neonatal health and foster buy-in by all stakeholders on how to engage and decrease maternal and neonatal mortality.

Specific objectives include: increased shared understanding by key actors on the lagging MDGs and why there is slow progress and regression; strengthened collaboration and buy-in by key actors; and enhanced coordinated action to ensure achievement of the relevant MDG targets.

THE MAF PROCESS

The MAF development process went through a number of stages. The first was the consultative process to identify the MDGs related to maternal and neonatal health as the most off track and the poorest performing MDGs that were unlikely to be achieved unless special attention and interventions were implemented to accelerate it. This was done in a workshop involving key stakeholders who including representatives from a number of government ministries and other stakeholders. This workshop was conducted in early 2011. Next, a systematic review of key policy and strategy documents of the health sector and specifically those focused on reproductive health was undertaken by a national consultant supporting the process.

This culminated in the development of background papers that were used in the MAF methodological workshop in December 2011, involving representatives from key stakeholders including key ministries, development partners and UN agencies. The workshop was facilitated by Dr Ayodele Adusola of the UNDP Regional Bureau for Africa in New York, who took workshop participants through the process of developing a MAF assisted by Eunice Kamwendo from the UNDP Regional Service Centre in Johannesburg. Amarakon Bandara of UNDP Tanzania, made a presentation on the development of the Tanzania MAF. The output of the workshop was a first draft of the MAF which was documented and then distributed.

The methodological workshop provided an opportunity to gather input from practitioners working in reproductive health in the public and private sector, and civil society organizations and development partners, on the key interventions, drivers and bottlenecks, as well as their potential solutions.

This workshop was followed by in-depth interviews and focus group discussions at the national and regional level. This extensive consultation involved senior management and officers of health sector ministries at the national and regional levels, and representatives of development partners and UN agencies.

These extensive consultations were used to refine the MAF draft document which was then distributed, and feedback was then received from the Government and its partners, the Regional Bureau for Africa and the Regional Service Centre.

These comments were incorporated into the document which was further subjected to a validation workshop involving representatives from the Government and key local and international partners. The validation workshop provided an opportunity to verify and take ownership of the identified interventions and solutions to the bottlenecks, fill the gaps where they existed, provide information on partner commitments and agree on the coordinated framework for implementation.

Chapter II – Progress and challenges in achieving maternal and neonatal health

Although Kenya has achieved progress in the past 10 years of MDG implementation, challenges remain in achieving MDG 5 on maternal and neonatal health. With only three years remaining to the MDG deadline of 2015, Kenya will have to accelerate its efforts – in collaboration with and support of its development partners – if it is to meet the MDG 5 targets. This section discusses the implementation gap to achieving MDG 5, progress made so far, current situation and challenges, and opportunities that can be exploited to achieve the targets.

The table below shows the significant gaps that still remain to achieve MDG 5 by 2015.

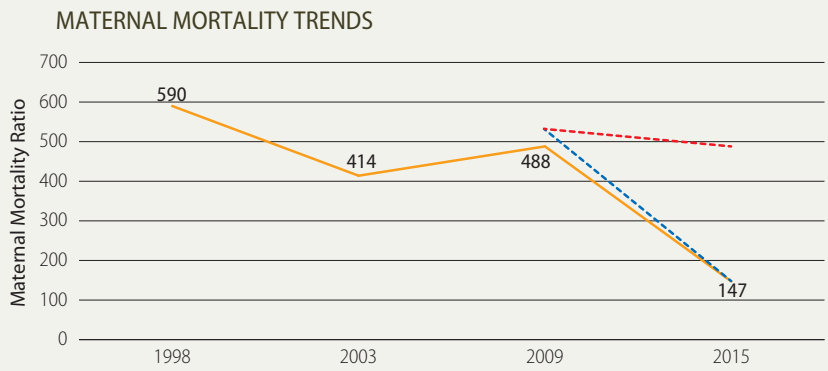
Table 1: MDG 5 status and targets in Kenya

MDG	Indicator	Baseline (2000)	2008/9	Target 2015
Goal 5: Improve maternal health				
Target 5A: Reduce by three quarters, maternal mortality ratio	Maternal mortality ratio	588	414	147
	Proportion of births attended by skilled health personnel	44	44	90
Target 5B: Achieve by 2015, universal access to reproductive health	Contraceptive prevalence rate	39 %	46%	
	Adolescent birth rate	21 %		
	Antenatal care coverage (at least one visit and at least 4 visits)	92 %	92 %, 47 %	100 %, 90 %
	Unmet need for family planning	26	26	0

Data sources: KDHS 2009 and National Road Map for Achieving MDG 5

As indicated in the figure below, although the maternal mortality ratio fell from 590 in 1998 to 414 in 2003, it rose to 488 in 2009 (KDHS: 1998, 2003, 2009). This shows that maternal mortality is not only not improving but is actually regressing. The target for MDG 5 is 147 which is, as shown in the following diagram, unlikely to be achieved unless urgent and dramatic interventions are implemented.

Figure 1: Trends in maternal mortality in Kenya



CAUSES OF MATERNAL DEATHS

The causes of maternal deaths include both direct and indirect causes. The direct causes include haemorrhage, infection, eclampsia and others. The indirect causes include HIV and AIDS, anaemia, cardiovascular causes and malaria in that order as depicted in the following diagram.

Figure 2: Direct causes of maternal death[4]

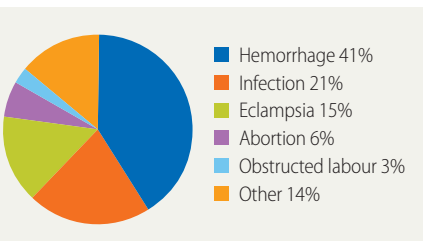
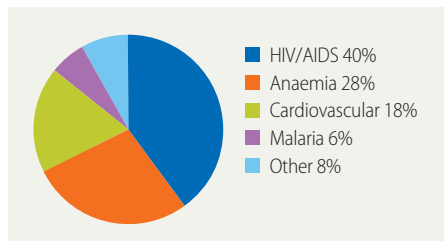


Figure 3: Indirect causes of maternal death[5]



All maternal deaths are largely preventable through proper and timely health care services. However, the maternal health care indicators to achieve MDG have not improved over the last 20 years. These include: skilled attendance during deliveries; antenatal and postnatal services; and emergency obstetric and neonatal care. The provision of family planning has not increased as fast as is needed to improve maternal health trends significantly.

[4] MPDR: Analysis of current reporting status (2009-2011), Yuki Yoshida, UNICEF Consultant

[5] MPDR: Analysis of current reporting status (2009-2011), Yuki Yoshida, UNICEF Consultant

PROGRESS MADE SO FAR

The Constitution of Kenya, promulgated in August 2010, now recognizes high quality reproductive health services as a basic human right under a comprehensive bill of rights. The Kenya Vision 2030 goal for the health sector is to provide equitable and affordable quality health services to all Kenyans. This is in recognition of the fact that good health and nutrition boosts the human capacity to be productive. The MDGs have already been mainstreamed into the policy, planning and budgeting processes of the Government of Kenya.

Appropriate policies, strategies and guidelines are in place, the key amongst which is the National Road Map for the Achievement of Maternal and Neonatal Health. The goal of the Road Map is to accelerate the reduction of maternal and newborn morbidity and mortality towards MDG targets. The three main objectives include: improve data management and utilization; improve availability, accessibility and utilization of skilled attendance; and enhance the capacities of individuals, households, communities and social networks to improve maternal and newborn health. The implementation of this Road Map is ongoing and is the basis for efforts being undertaken in the area of maternal and neonatal health.

All levels of health care now offer maternal and newborn health services. The pre-service curriculum for health worker training is being regularly updated and capacity building of health workers in service is ongoing.

Additional health workers were employed under the Economic Stimulus Program (ESP) and are now serving in health facilities in the regions. A substantial number of health facilities have been built in all constituencies using Constituency Development Funds (CDF) which has since inception, prioritized on health and education in all regions.

To improve data on maternal health, maternal and perinatal death reviews (MPDR) are being institutionalized. As a government policy, reporting on maternal death is becoming mandatory in the same way as that of highly contagious diseases under the Division of Disease Surveillance and Response in the Ministry of Public Health and Sanitation.

Other initiatives include: output based activity (OBA), a voucher scheme system implemented as a pilot in specific districts. This allows the women who obtain the voucher to obtain reproductive health services including delivery free of charge. Maternal and Child Health (MCH) weeks are conducted in May and November, and there is a mother/baby booklet in use.

Maternal and neonatal health (MNH) High Impact Interventions (HII) have been identified and are being implemented. These include: family planning; early ANC and emergency preparedness at the community level; basic and comprehensive emergency obstetric care (EmONC); skilled attendance during pregnancy, childbirth and the postnatal period; early and exclusive breastfeeding; and water, sanitation and hygiene.

As part of scaling up the HIIs, a meeting was held in February 2011 to discuss the major causes of maternal deaths and to identify high impact low cost interventions. Provinces and districts were requested to identify the barriers to rapidly scaling up these interventions and identify what can be done to eliminate them. They were also required to improve the monitoring of maternal and neonatal health.

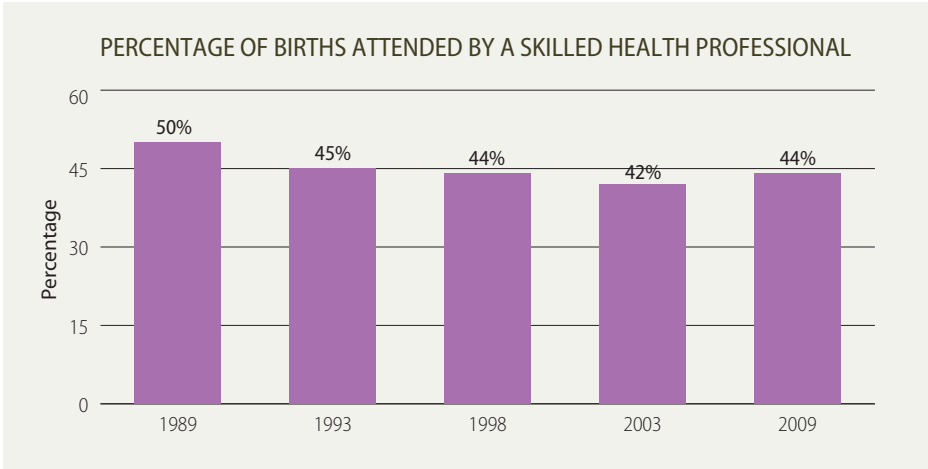
THE CURRENT SITUATION AND CHALLENGES

According to the National Road Map on Achieving MDGs Related to Maternal and Neonatal Health, the slow progress is attributed to: the limited availability, poor accessibility and low utilization of skilled attendants during pregnancy, childbirth and the postpartum period at all levels of health care delivery system; low emergency obstetric and newborn care coverage; poor involvement of communities in maternal and newborn health; and limited national commitment of resources to maternal and newborn care. The following paragraphs discuss the current situation of maternal health and neonatal health and challenges being experienced.

Skilled birth attendance

As shown by the experience of many countries, most maternal deaths can be avoided through the provision of skilled care during deliveries. Skilled birth attendance stands at 44 percent with significant regional disparities (DHS 2003). To achieve the MDG 5 target, skilled birth attendance needs to reach 90 percent according to the National Road Map. As shown in the following diagram, the proportion of mothers attended by a skilled professional during delivery has not improved and has actually fallen slightly over the last 20 years. This is despite increasing investments in health care and significant gains in the education and literacy levels of women.

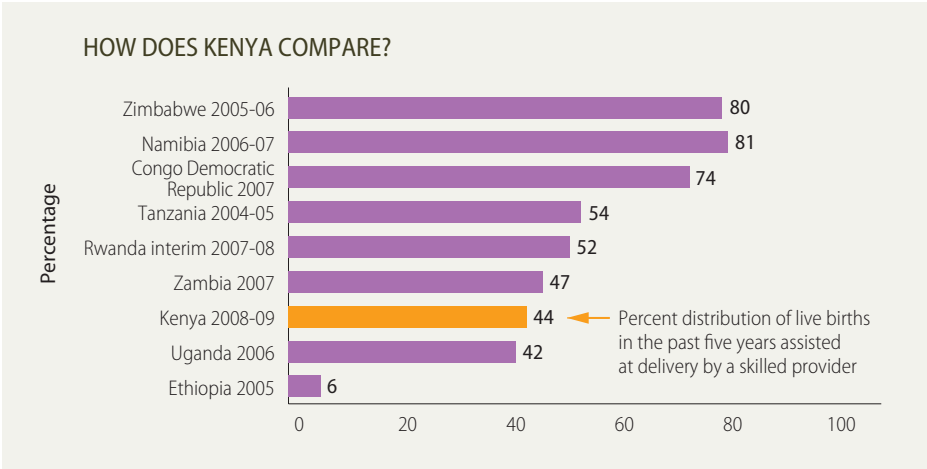
Figure 4: Trends in skilled birth attendance (KDHS 2009)



The majority of women in Kenya are attended by traditional birth attendants (28 percent), a relative or other unskilled person (21 percent) while 7 percent deliver on their own at home (KDHS 2003). The reasons women gave for not delivering at a health facility included: the facilities are at too great a distance; lack of transport; not necessary; abrupt delivery; and that it cost too much, in that order. Traditional birth attendants (TBAs) continue to play a significant role in deliveries especially in rural areas and surprisingly in areas where health facilities are within reach. Once embraced by the health system, TBAs are no longer integrated into the health system despite the continued reliance by women on the delivery services they provide. Interestingly, they charge as much if not more in some areas than what is charged in public hospitals for normal delivery.

Kenya has performed poorly in the region in the area of maternal health and specifically skilled birth attendance. Only Uganda at 42 percent and Ethiopia at 6 percent have a lower skilled birth attendance rate. For example, a mother in Zimbabwe or Namibia are nearly twice as likely to be attended by a health professional during deliveries than one in Kenya.

Figure 5: Comparing Kenya with countries in the region (DHS)



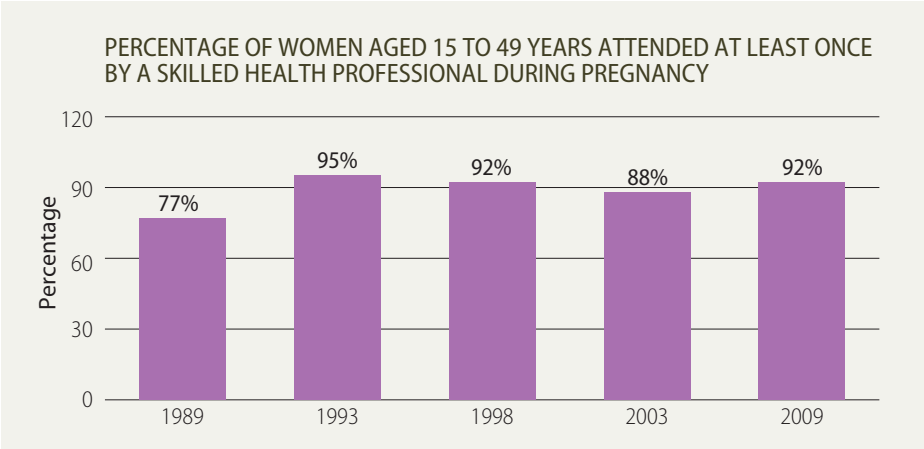
Emergency obstetric, post abortion and newborn care

Access to health facilities and emergency services during deliveries is vital to secure the health of the mother and the newborn and avoid maternal and neonatal deaths. However, most of the facilities, in particular lower level facilities, are unable to offer adequate EmOC, post-abortion and essential newborn care.

Antenatal care

The major objective of antenatal care during pregnancy is to identify and treat existing conditions and problems that may have an adverse impact on the health of the mother and the unborn baby. During antenatal care visits, screening for complications occurs and advice is given on a range of issues, including place of delivery and referral. Prevention of mother to child transmission of HIV is initiated at this point; neonatal tetanus which is a leading cause of neonatal deaths in developing countries is prevented through tetanus toxoid immunization; and major indirect causes of maternal deaths such as HIV and AIDS, anaemia and malaria are detected and managed. Antenatal care therefore has a major role in preventing maternal deaths and other pregnancy related complications while improving the health and living chances of the unborn baby. However, the level of antenatal care has not improved over the last 20 years as shown in the figure 6 on page 30.

Figure 6: Trends in antenatal care (DHS)



The above data shows that the majority of the women (over 90 percent) have the benefit of contact with a health professional at least once during pregnancy.

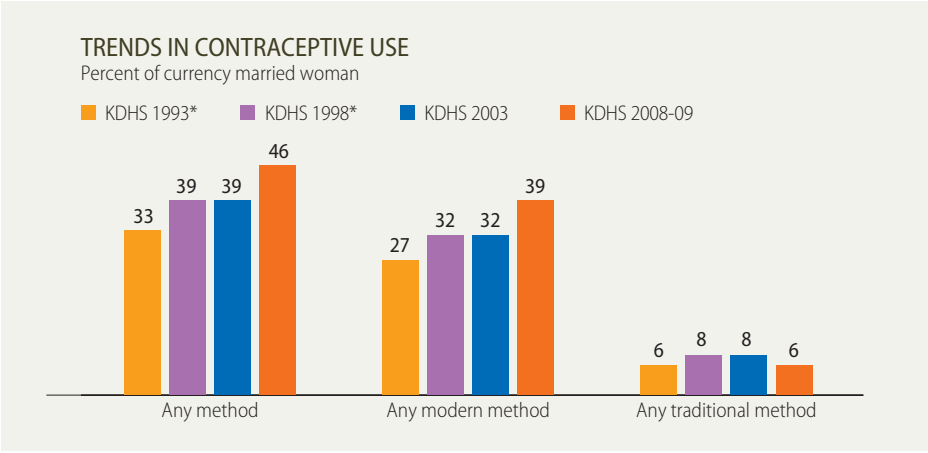
Postnatal care

Only a small proportion, 28 percent (KDHS 2008/9), of mothers had a postnatal check-up within 4 hours after delivery, while 42 percent of mothers had a postnatal check-up within 48 hours after delivery. Poor performance in this area points to lost opportunities by the health care system to prevent the deaths of both the mothers and their newborns, and therefore reduce maternal and neonatal mortality ratios.

Family planning

Family planning prevents unwanted pregnancies and reduces the risk of maternal deaths from pregnancy-related complications and unsafe abortions. Knowledge of family planning is near universal with 95 percent of women aware of at least one contraceptive method while 69 percent can name a traditional method of contraception. However, the modern contraceptive prevalence rate is still low: it is 39 percent among married women and 45 percent among sexually active, unmarried women (KDHS 2009). Women in urban areas are much more likely to use modern contraceptive methods, and use increases dramatically with the level of education. The figure 7 on page 31 shows the trends in contraceptive use in the last 20 years.

Figure 7: Trends in contraceptive use



The contraceptive prevalence rate has been rising steadily albeit not sufficiently to achieve MDG 5 by 2015. For those using contraceptive methods, there is greater preference for short term methods such as pills and injectables which are more expensive in the long run in comparison to the longer term, and less expensive methods. This is due in part to a lack of understanding of these longer term methods by women and a lack of skills by the health workers in administering them.

Fear of side effects, at 16 percent, is the most common reason for women not using family planning, followed by health concerns at 15 percent which point to a gap in the level of knowledge and/or choice of contraceptive methods.

Health personnel

There are inadequate numbers, skills and distribution of health personnel to provide the required level and quality of services to reverse the trends in the maternal mortality ratio. The greatest single weakness of the country's health system is the overworked, tired and resentful nurse who has to single-handedly attend to a huge number of patients including pregnant women in (particularly lower level) health facilities that are severely understaffed. In the hardship areas, few health personnel want to be posted there, and those who get posted find a way to get out to areas they consider more comfortable which are mainly in urban centres.

* The first two surveys excluded North Eastern province and several northern districts in Eastern and Rift Valley Provinces, while the data for 2003 and 2008-09 include the entire country.

The health personnel also lack adequate skills along the continuum of care in areas such as family planning, especially on LAPM, midwifery, emergency obstetric, post-abortion and newborn care. Systematic training of health personnel has not been carried out since the 1990s, leaving a large proportion of staff without updated skills.

Although there are many trained and qualified health personnel in the market, the Government officially stopped employing them in the late 1990s. This has led to a severe shortage of health personnel including nurses and midwives. The Government initiated a program in 2010 under the Economic Stimulus Program (ESP) to recruit 20 nurses for each constituency for a fixed monthly payment. This has assisted some parts of the country to obtain additional health personnel. However, the hardship areas that are the most in need did not get any nurses applying for the posts advertised and therefore did not benefit. For those constituencies that did get nurses employed under the program, no systematic training was provided to prepare them for maternal and newborn care.

There are therefore significant regional disparities in the availability of health personnel. There is no incentive provided by the government to retain health personnel in the hardship areas. The hardship allowance provided (Ksh1,200) has not been increased since the 1960s, and represents no incentive at all given the current value of the Kenyan Shilling. In fact, when health personnel are posted to these hardship areas, their overall earnings are adversely affected as the housing allowance is reduced in line with the value of housing in those areas. There are no housing facilities provided, no security and those areas lack vital facilities such as schools. The net effect is significantly lower levels of staffing for health facilities in rural and hard to reach areas.

Other areas of staff shortage include doctors who are affected by the same disincentives. For emergencies, there are not enough anaesthetists to support theatre operations, and a program to train nurses to take up the role and fill the gap has been affected by a lack of recognition by the relevant professional association.

Poor involvement of communities and households

According to health personnel interviewed as part of this exercise, there are three types of delay in maternal care, the first of which causes the greatest number of maternal deaths. This is the delay at home and in the community in seeking skilled care at an early stage. By the time the mother is seeking care, it is usually too late to save the mother or the newborn or prevent life threatening complications.

This delay is due to: socio-cultural barriers; lack of awareness of the benefits of skilled health care; reluctance to adopt good practices (including the preference for home delivery); limited male participation in maternal health issues in some areas; and a lack of community participation in maternal and newborn health.

Poor implementation of the community health strategy

At the moment, there exists a wide gap between the women and their communities (demand side) and the health system (supply side) as indicated in the previous paragraph. The Community Health Strategy is designed to bridge this gap by improving the participation of communities in the management of their own health and creating effective linkages with the health system. This strategy is being implemented on a limited scale through the establishment of community health units, with community health workers trained, supported and supervised by extension officers from the health system. It is one of the most effective ways of increasing community awareness on health issues including maternal and child health; thereby improving their participation and demand for health services. However, while there is anecdotal evidence that this strategy is achieving significant results within a short time and the costs involved are low, its implementation remains weak. The Government has not provided sufficient resources, and the efforts of non-state actors are uncoordinated, incomplete and insufficient to make a difference.

Even where the strategy has been implemented, health workers in public health facilities remain largely unclear on how the system works and how to interact with it. The motivation of community health workers remains an issue as even the small amount they are supposed to be paid on a monthly basis is usually not available.

Poor quality data on maternal health

The only available MMR indicator is in the KDHS and at the national level. Estimates of the MMR at the regional level are hard to come by, and there is no agreed method of arriving at comparable estimates. Problems occur when maternal deaths occur at home and/or are not reported. This difficulty in reasonably estimating the maternal mortality ratio undermines planning at sub-regional levels and needs to be resolved in the light of increasing devolution of health services to the county level.

For the other maternal and neonatal health indicators, data is only available at the provincial level in the KDHS and other relevant surveys such as the Kenya Service Provision Assessment (KSPA).

Because the provinces (now abolished under the new constitution) are very large with some of them spanning the length of the country, and varied, the data provided at the provincial level does not provide a good basis for planning and response.

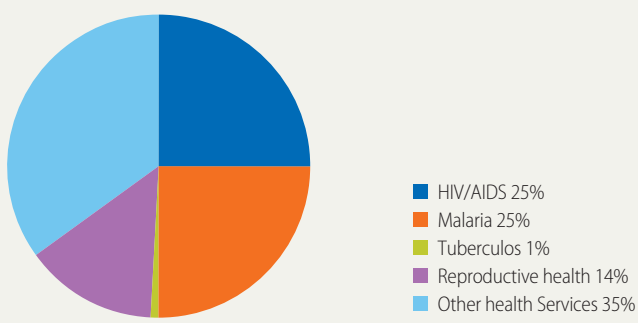
The quality of data on maternal health as reported by health facilities countrywide is low and incomplete according to Yuki Yoshida, a UNICEF consultant who has analyzed the current reporting status on Maternal and Perinatal Death Reviews (2009-2011) based on the Kenya Health Management Information System (KMIS). The overall reporting rate was found to be very low, with only a 30 percent response rate and significant disparities between the provinces. No reports were being received from some of the major maternity units such as Kenyatta National Hospital and Pumwani Hospital.

Inadequate expenditures on maternal health

Internationally maternal health costs is estimated at $41 per mother, while in comparison the total resource availability in the Kenyan health sector is $42 per capita according to National Health Accounts 2009/10 (NHA).

Priority areas in health have remained HIV/AIDS and Malaria each accounting for 25 percent of total health expenditure, while spending on reproductive health and Tuberculosis accounted for 14 percent and 1 percent respectively; the remaining 35 percent of total health expenditure was allocated to other health areas. Spending on child health services, which cut across the HIV/AIDS, TB, and malaria subaccounts and other general health spending, accounted for 7.5 percent of total health expenditure.

Figure 8: Total health expenditures by priority areas



In the RH sub account, the total reproductive health expenditure amounted to Ksh. 17 billion ($225 million), an increase from Ksh. 13 billion ($170 million) in 2005/06. The expenditure accounted for 13.9 percent of total health expenditure for the period. The total reproductive health expenditure accounted for 0.8 percent of GDP in 2009/10. However, on the positive side, the Government of Kenya met 80 percent of the cost of contraceptive commodities in 2010/11 for the first time.

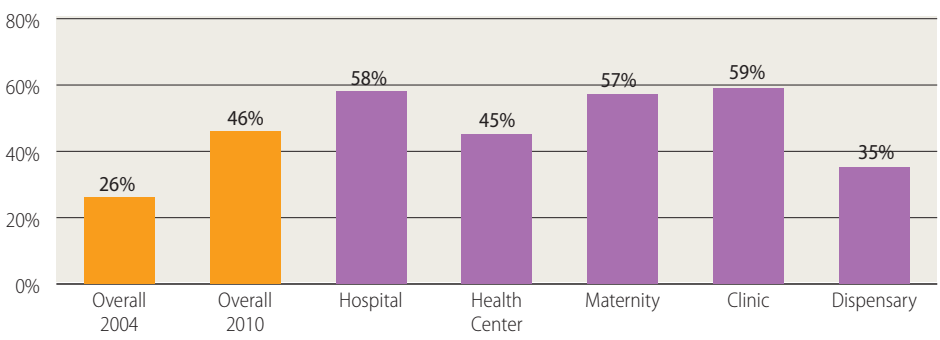
THE IMPACT AND ROLE OF OTHER SECTORS

Other sectors have a significant impact on and role in providing solutions for MNH. These are discussed below.

Water

Access to a regular supply of water from a protected source is critical to a well-functioning health facility. It is also critical to the wellbeing of the mother and the newborn at home. Although the overall availability of a regular supply of water to health facilities increased from 26 percent in 2004 to 46 percent in 2010, it still means that 54 percent of health facilities do not have regular supply of water with dispensaries leading with 65 percent (KSPA 2010). Without water, a health facility is unlikely to provide quality service.

WATER AVAILABILITY IN HEALTH FACILITIES



Source: KSPA 2010

In households, only 36 percent of them have water on the premises with the rural areas lagging behind at 26 percent. Of those without water on the premises, 39 percent of the rural households require a round trip of over 30 minutes to fetch water. Women are six times more likely to be the ones fetching the water (KDHS 2008/9). This situation is a major impediment to the health and wellbeing of the mother and her newborn at home.

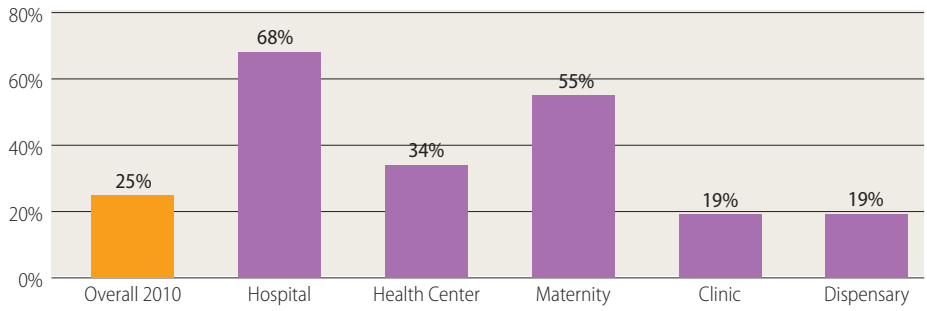
However, there have been widespread reforms in the water sector which include extensive institutional reforms. These reforms are aimed at reversing the declining trend in service provision, lack of pro-poor orientation and well as mismanagement of water resources. The reforms target achieving the relevant MDGs including halving the proportion of the population without sustainable access to safe drinking water.

Electricity supply

A reliable electricity supply is necessary for the proper functioning of a health facility. A facility is deemed to have a regular uninterrupted supply of electricity when it is connected to a central power grid or has solar or both, and power is routinely available during regular service hours or has a functioning generator with fuel (KSPA 2010).

Only a quarter of the facilities have a regular electricity supply. Even hospitals do not have a regular electricity supply a quarter of the time. For over 80 percent of the time, clinics and dispensaries do not have electricity. This is a major weakness in health facility infrastructure that has the potential to contribute significantly to poor service delivery and maternal and newborn health outcomes.

ELECTRICITY SUPPLY IN HEALTH FACILITIES

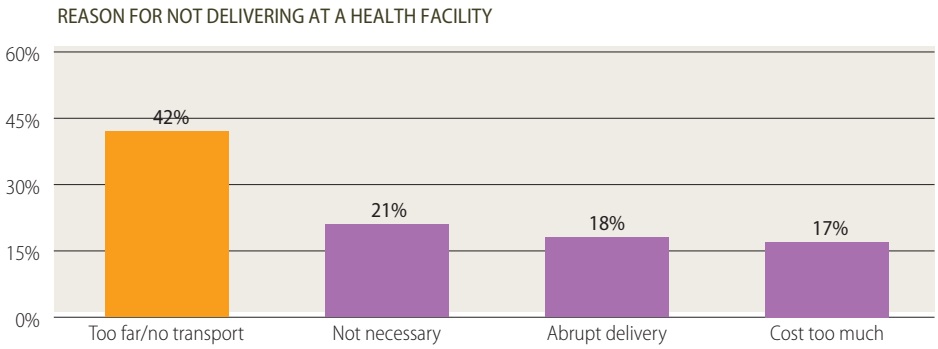


Source: KSPA 2010

However, the Government, through the Rural Electrification Programme has embarked on providing public facilities with electricity over the last few years. Lobbying with the energy ministry can help prioritize the availability of electricity to health facilities, but this needs to be supported by other actors as some facilities may need to be provided with an off-grid power supply.

Roads

The second delay that contributes to maternal and neonatal deaths is timely transport of the pregnant woman to a health facility. The major reason given by those who did not get to a health facility to receive skilled birth attendance was that the health facility was too far and/or there was no transport (42 percent, KDHS 2008/9).



Source: KDHS, 2008/9

According to the DRH, limited access to health facilities via poorly maintained roads, coupled with unavailability of transport at the time of need is a major cause of pregnant women not receiving medical care on a timely basis. In some instances, health facilities within slums are not accessible using a vehicle. This issue needs to be addressed as one component of improving MNH.

The roads sector has undergone significant reforms in the last few years. Four separate organizations have been formed: the Kenya Roads Board (KRB), the Kenya Rural Roads Authority (KERRA) the Kenya Urban Roads Authority (KURA), and the Kenya National Highways Authority (KENHA). In addition, the Government has prioritized the building of road infrastructure throughout the country in the last ten years. Under the Kenya Roads 2000 Programme, access roads in the rural areas are maintained through using local labour. In addition, constituency roads committees are in place in all constituencies to prioritize the maintenance of access roads throughout the country.

Through lobbying with these institutions, access to all health facilities can be achieved through the provision of all-weather roads.

Agriculture

Food insecurity and poor nutrition contribute significantly to poor MNH outcomes. Over 50 percent of pregnant women in Kenya are anaemic which, at 28 percent, is a major indirect cause of maternal death (KDHS 2008/9). It is also a major cause of pre-term and underweight newborns who at a higher risk of poor health and death.

Anaemia is caused by poor nutrition. Food insecurity in many parts of the country contributes significantly to this problem. The poor attendance at ANC clinics, especially in these hardship areas, makes it difficult for the health care system to intervene and reduce the risk to pregnant women and their newborns. Even when they access the health facilities, a lack of commodities (iron tablets) may undermine this intervention. In some cases, food supplements are provided.

The national Food and Nutrition Security Policy (FNSP 2011) recognizes this problem and its impact on MNH, and adopts a life cycle approach to improved nutrition that emphasizes the biological needs in terms of the different amounts, types and varieties of nutrients for population groups at different stages of life including pregnancy and for the newborn child. The Policy proposes specific measures to promote increased access to food and nutrition but also of meeting the specific objective of improving maternal and newborn nutrition.

Gender

Women continue to suffer from physical and sexual violence which adversely affects their health outcomes and those of their newborns. 21 percent of women have experienced sexual violence, with 12 percent having their first sexual intercourse against their will. 39 percent have experienced sexual or physical violence (KDHS 2008/9).

As stated elsewhere, women are six times as likely to be depended upon to fetch water (KDHS 2008/9) and do other household chores. Unfortunately at the same time, over 50 percent of the women aged between 15 and 49 believe that the husband has a right to beat them for at least one reason. In addition, women are also less likely to be gainfully employed or even to have health insurance (KDHS, 2008/9).

These statistics show the need to empower women and enable them to take care of themselves and their newborns. This is an area in which the Ministry of Gender must work harder in order to make a difference.

Youth affairs

Nearly two thirds of the Kenyan population is under the age of 24. One third is between the ages of 10 to 24 years. Nearly three quarters is under the age of 30 years. However, this population is highly underserved in terms of employment, empowerment and even reproductive health and family planning services. Clearly this youthful demographic profile and the consequent increased propensity for reproduction needs to be factored in when considering improving the reach of MNH.

The Government, through the Ministry of Youth Affairs, must provide avenues for the empowerment of the youth and ensure that this segment of the population is provided with youth-friendly services.

Education

MNH outcomes are directly related to the level of education of the mother. The higher her education level the greater the chances are of improving her health and that of her newborn. According to the health staff interviewed as part of this exercise, the low demand for health services is caused by the low level of awareness and poor understanding of the need for such services.

The Government implemented free primary education in 2003, which increased enrolment in primary schools by over one million children. However, although there are discussions on extending free education to secondary schools, there is a significant lack of resources available for this purpose; especially in terms of adequate numbers of teachers. This raises the question about the overall quality of education in Kenya.

The education system has an elaborate institutional infrastructure at all levels that can be used to influence the minds of the youth in order to raise awareness and ultimately improve reproductive health. The education system can also be used for providing services to the communities that live around these institutions.

Opportunities

The following are some of the opportunities that can be exploited to achieve MDG 5 within the time available.

- A well-established institutional framework and infrastructure for the provision of health services in all parts of the country. This has been further expanded by the construction of health centres and dispensaries (some of them with maternity wings) at constituency level using Constituency Development Funds (CDF).
- A professionally trained workforce including nurses, doctors and clinicians employed in the public and non-public sectors.
- A well educated population with a substantial number of unemployed health workers including nurses and midwives ready to work anywhere with the right incentives.
- A well-established institutional framework and extensive infrastructure for the training of health personnel run by government and other non-state actors.
- A Community Health Strategy is in place that is being implemented with success but on a limited basis in all regions of the country. The Strategy has great potential for improving maternal health and other health indicators by improving community participation and demand for health services. At the current state of implementation, scaling it up just requires resources and commitment.
- A vibrant private sector and faith based organizations involved in the delivery of health services and training.
- Substantial support from development partners for the health sector.
- Recent devolution of governance to the county level has the potential to direct resources to the most pressing areas. Sustained advocacy at that level from the beginning of the county governments in 2013 can have a significant beneficial impact on maternal health care provision. More devolved resources will be made available at the county level, which may serve to boost health services as has been demonstrated by the use of CDF funds so far.

Chapter III – Strategic interventions

This chapter presents the identified strategic interventions considered relevant, country-specific and high impact to achieve the relevant MDGs. The interventions are in line with the National Road Map for maternal and neonatal health (2010), national health sector strategies (2008-2012), reproductive health policy and strategy (2007); and input from extensive consultations with a wide variety of stakeholders.

The consultations that have been used to select the strategic interventions include: Accelerating Maternal, Newborn and Child Survival: Setting the National Agenda, held in January 17-19, 2011 involving heads of provincial and district medical and public health services; MAF Methodological Retreat, December 2011 involving representatives of relevant government ministries, development partners and NGOs; and the Reproductive Health Business Plan Development August 2012, involving provincial and district heads of medical and public health services.

There were also a number of interviews and focus group discussions held at the regional level that provided substantial input into this issue. Those chosen to provide input were from regions with the highest maternal mortality rates, those in hardship areas, those closest to the capital city and areas that have already achieved the MDG target. The areas included North Eastern, Eastern, Western, Central, Nairobi and Coast.

The National Road Map is the document that specifically focuses on this issue. Its goal is to accelerate the reduction of maternal and newborn morbidity and mortality ratios towards the achievement of the relevant MDGs. The objectives include: increasing skilled attendance and utilization; strengthening the capacity of individuals, households, communities and social networks to improve maternal and newborn health; and strengthening data management and utilization to improve maternal and newborn health.

Key strategies include: improving availability, access and utilization of quality maternal and newborn health services; reducing unmet demand for family planning through expanding access to quality reproductive health services; advocating for increased commitment and resources for maternal and newborn health, and family planning; and strengthening research and monitoring and evaluation.

Strategic intervention areas identified include:

1. Upgrade the functionality of the health system for the provision of maternal and neonatal health services
2. Increase demand for reproductive health services
3. Provide universal access to family planning services
4. Improve access to antenatal and postnatal care (ANC and PNC) for all pregnant women
5. Provide access to skilled birth attendance
6. Improve access to emergency care including: obstetric care (basic and comprehensive); comprehensive post abortion care (CAC); and Essential Newborn Care (ENBC)

The first two priority areas are cross-cutting and affect all the areas of improving service provision and utilization. These areas must be addressed if any improvement is to be realized in any of the other priority intervention areas identified. The interventions are elaborated below.

Upgrade the functionality of the health system for the provision of maternal and newborn health services

The weak health care system has been cited as one of the most significant impediments to improving health indicators and specifically maternal and newborn health.

Objectives include: increasing resources available for MNH; improving management of health services related to MNH; enhancing staff capacity for the provision of MNH services; improving availability of commodities and equipment to support MNH services; and improving the infrastructure and environment for the provision of MNH services.

The focus will be given to health facilities at levels 2 and 3 to upgrade their ability to provide quality MNH services and levels 4 and above in improving their emergency preparedness. Emphasis will be placed on hard to reach areas, urban slums and areas with high mortality rates. The target is to increase the availability of BEmOC per population of 500,000 from the current 0.4 to 4; and CEmOC from the current 1.3 to 1, taking total availability of both to 5 per the same population from the current 1.7.

In terms of infrastructure, significant progress has been made in constructing health facilities using devolved funds, but some of these are not open due to a lack of requisite staff, equipment and commodities. In terms of staff, each constituency was given resources to hire twenty nurses and clinical officers. However, hard to reach areas could not attract adequate number of new staff.

Key interventions include: achieving commitments of resources and reducing the financing gap for maternal health services; achieving better management of maternal health services including supervision, quality assurance and data; ensuring adequate number, skills and distribution of health personnel; providing adequate distribution of commodities for maternal health services to health facilities; providing conducive environment for the provision of health services in health facilities that ensures the privacy, dignity and cultural sensitivity of mothers; improving basic infrastructure of health facilities including access to water, reliable source of electricity and proper sanitation.

Increase demand for reproductive health services

Low demand for, and poor knowledge of, maternal and neonatal health services has been cited as a key impediment in the achievement of maternal and newborn health. In fact, the first delay at household and community level is considered as one of the greatest contributors to maternal and neonatal deaths.

The objective here is to raise women's and community awareness of the need to seek MNH services and the dangers of not doing so. The desired result will be increased demand and utilization of health services along the continuum of care, from family planning, antenatal, skilled birth attendance, newborn care and postnatal services.

While all areas will be targeted, emphasis will be on areas with low demand and poor health-seeking behaviour especially in the hard to reach and urban slum areas. Focus will be on the women and youth but also include men and community leaders.

Very little has been achieved here, and urgent and sustained effort is required to make a difference. However, the high percentage of women even in low demand areas who attend at least one antenatal clinic during pregnancy is a good basis for improvement.

This intervention is to encourage mothers to seek health services and increase support for and participation from men, families and the communities as a whole. It also seeks to improve knowledge of women (including men and adolescents) on maternal health services including family planning, antenatal, postnatal and neonatal care, and the need for access to skilled attendance and emergency care during delivery.

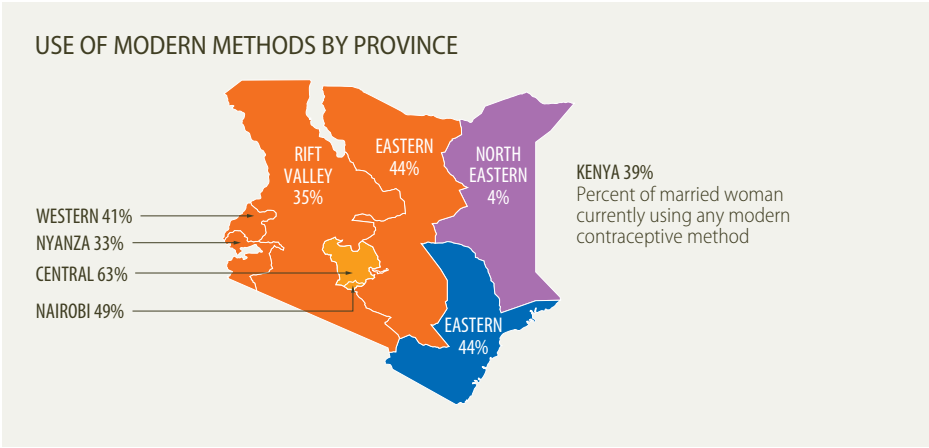
Provide universal access to family planning services

Improving access to family planning has significant returns as far as maternal and child health is concerned. It lowers the risk of unwanted pregnancies and those brought about by abortions, and allows for spacing of births which in turn lowers the risk to the mother and the newborn.

Unmet need for family planning remains high at a national average of 26 percent which is unchanged since 2003. The unmet need is evenly split between the women who want to wait for two or more years before having their next child (spacers) and those who want no more children (limiters). Unmet need for family planning is also higher in the rural areas at 27 percent compared to urban areas at around 20 percent.

There are significant regional disparities in the levels of contraceptive use. The following diagram presents the regional disparities in contraceptive use.

Figure 9: Regional disparities in contraceptive use



As indicated in the diagram figure 9 on page 44, contraceptive use ranges from 63 percent in the Central region to a low of 4 percent in North Eastern region. Therefore, Kenya is still very far from achieving the MDG 5 target at the current rate.

The objective here is to reduce the unmet need for family planning from 26 percent (KDHS 2008/9) to 0 percent; and increase the contraceptive prevalence rate among all women of reproductive age from 44 percent (KDHS 2008/9) to 60 percent by 2015. Focus will be on the youth, urban slums and areas with low contraceptive prevalence and high maternal mortality rates.

The key intervention is providing universal access to family planning services for women, men and the youth.

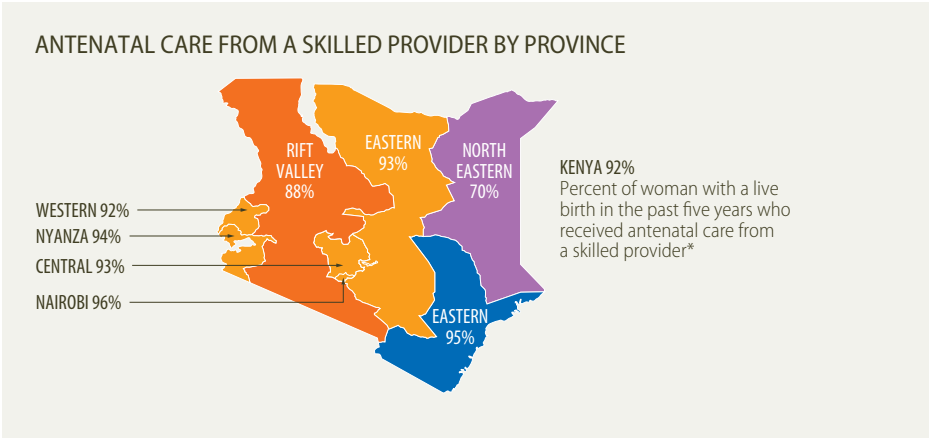
Improve access to antenatal and postnatal care

Improving access to antenatal care improves the chances of pre-existing conditions being detected earlier and managed in good time by health professionals thereby reducing the risk to the health of the mother and her newborn. Postnatal services provide the opportunity for the timely management of birth-related complications and thereby saving the life and improving the health of the mother and her newborn. It also presents the opportunity for a skilled health provider to educate the mother on the care of the newborn including promoting early and exclusive breast feeding.

92 percent of women have received antenatal care from a skilled provider (doctor, nurse, or midwife) at least once. This proportion decreases dramatically to 47 percent for those women who had four or more recommended visits. Many of the women visited the clinics to obtain a card for future health visits for the mother and the baby. As for the timing of the visits, only 15 percent of women followed the recommended guidelines and went to their first ANC visit during the first trimester of their pregnancy. Early initiation of ANC is necessary if a pregnant woman is to take full advantage of health care. 7 percent of women had no ANC visits.

There are significant regional disparities in ANC attendance as shown in the following diagram.

Figure 10: Antenatal care from a skilled provider by province (KDHS 2008/9)



The lowest is in North Eastern Province at 70 percent of pregnant women only undertaking one ANC visit. Nairobi has the highest at 96 percent. However this does not lead to improved skilled attendance at delivery or delivery at a health facility which stands at 44 percent and 43 percent respectively (KDHS 2003). This implies that the health workers do not or are unable to influence or encourage women to deliver under skilled health attendance.

A large proportion of maternal and neonatal deaths occur during the first 48 hours after delivery. Post neonatal and postnatal care is therefore important for both the mother and the child to treat complications arising from delivery, as well as to provide the mother with important information on how to care for herself and her child. It is recommended that all women are checked by a skilled health provider within 48 hours after delivery. However, only 28 percent of mothers had a postnatal check-up within 4 hours after delivery while 42 percent of mothers had a postnatal check-up within 48 hours after delivery. 53 percent of mothers had no postnatal check-up within 41 days of delivery (KDHS 2003). Poor performance in this area points to lost opportunities by the health care system to prevent deaths of both mothers and their newborns and therefore reduce maternal and neonatal mortality rates.

The objectives are to increase the proportion of pregnant women attending at least one antenatal visit from 92 percent (KDHS 2008/9) to 100 percent and at least four antenatal visits to 90 percent; and increase the proportion of women attending postnatal check-ups from at least one in two weeks after delivery to 90 percent. Other targets include increasing the proportion of women attending ANC tested for HIV/AIDS from 57 percent (KDHS 2008/9) to 80 percent; and those receiving IPT2 from 15 percent (KDHS 2008/9) to 80 percent.

Key interventions include providing quality focused antenatal (FANC) and postnatal care (PNC).

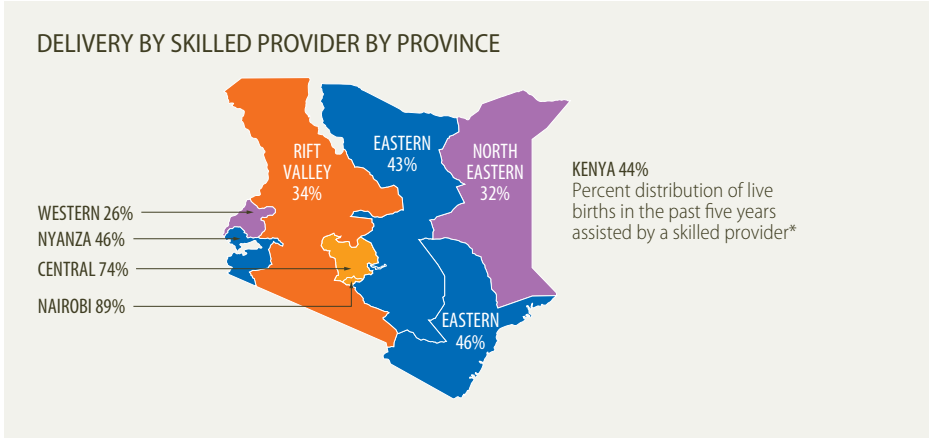
Provide access to skilled birth attendance

Access to skilled birth attendance is one of the most effective means of ensuring the safety of the mother and her newborn during delivery.

The objective is to increase the national proportion of births involving a skilled birth attendant from 44 percent (KDHS 2008/9) to 90 percent by 2015.

There are significant regional disparities in skilled birth attendance, as shown in the following diagram. Nairobi, the capital city has the highest rate at 89 percent, followed by Central Province at 74 percent. Western Province has the lowest rate at 26 percent, followed by North Eastern Province at 32 percent.

Figure 11: Regional disparities in skilled birth attendance (KDHS 2009)



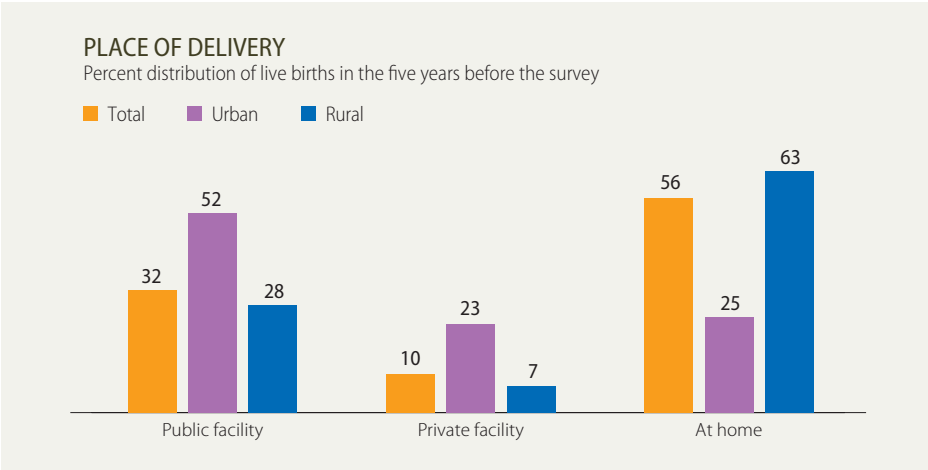
* Skilled provider includes doctor, nurse, or midwife.

There are also significant disparities between urban and rural populations as depicted in the following diagram. Urban mothers are much more likely to be delivered in a health facility attended by a skilled professional during delivery than rural mothers.

The focus is on the whole country but with an emphasis on the areas with low SBA and higher maternal mortality rates such as North Eastern, Upper Eastern, North Rift, Western and Coast regions. However, it is important that areas close to major towns receive attention to maximize skilled birth attendance. This is because some of these areas particularly in urban slums and some parts of the Central region also have high levels of births that are not attended by skilled professionals.

Interventions include providing quality delivery services; providing adequate commodities; increasing demand for skilled attendance during delivery; ensuring access to health services within reasonable distances; ensuring (cost) access to all women including the poor; and providing effective referral services including access to fully equipped and staffed ambulance services.

Figure 12: Disparities between rural and urban



* Skilled provider includes doctor, nurse, or midwife.

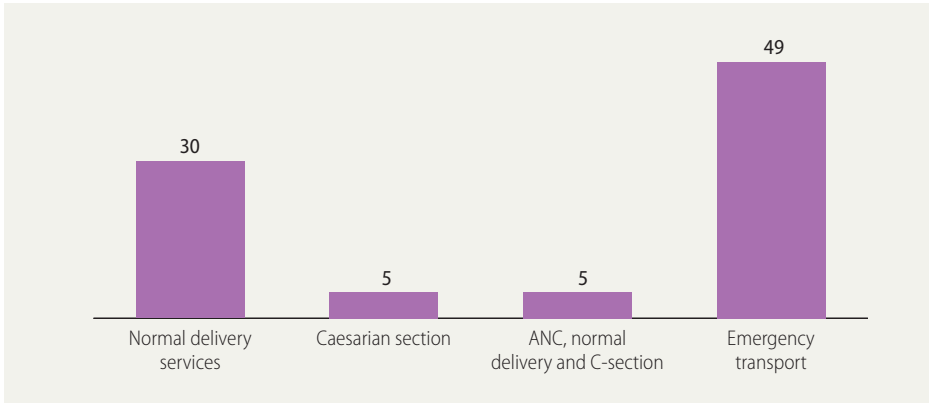
Improve access to emergency care

One in ten women delivering in a health facility will face complications which require emergency care. Also, management of complications resulting from abortions is critical in reducing maternal mortality, as is providing essential care for the newborns.

However, currently only 15 percent of health facilities are currently able to provide basic emergency obstetric care (BEmOC). To achieve the MDG 5 targets, the proportion of health facilities able to provide at least BEmOC needs to reach 100 percent (as outlined in the National Road Map). The Road Map also sets the target for the total availability of emergency obstetric care at a level of 5 to a population of 500,000 if MDG 5 targets are to be achieved. This ratio currently stands at 1.7 which is significantly below the target.

Not only are some areas far from and inaccessible to health facilities, the available facilities are not able to offer the full range of services required during delivery. The figure below shows that only 30 percent of all health facilities are able to provide delivery services; only 5 percent are able to perform a caesarean section in case of obstructed labour; only 5 percent are able to provide ANC, normal delivery and caesarean section; and 49 percent have access to emergency transport for referral to a higher level of care facility.

Figure 13: Availability of delivery services - all health care facilities (DRH)



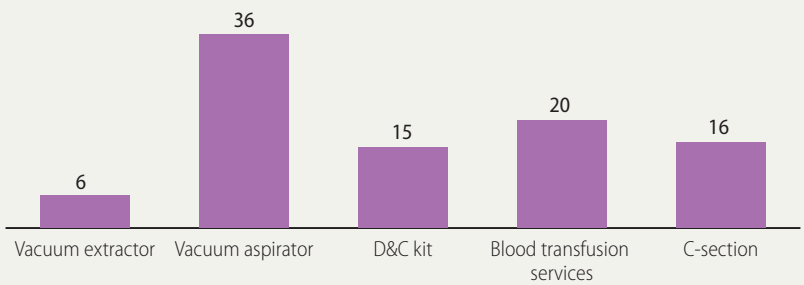
For the existing facilities offering delivery services, there is a serious lack of the requisite equipment and vital services. The following figure shows only 6 percent have a vacuum extractor; 36 percent have a vacuum aspirator; 15 percent have a D&C kit; only 20 percent are able to offer blood transfusion services to prevent death and complications from haemorrhage; and only 16 percent are able to offer a C-Section in the case of obstructed labour.

This shows a significant lack of capacity to handle emergencies at all levels of health care, a situation that needs to be addressed if the country is to make progress in achieving MDG 5.

On post-abortion care, health facilities, especially the lower level facilities do not have the requisite equipment and skills to handle cases.

In terms of newborn care, a there is a serious absence of the requisite equipment such as newborn resuscitation equipment and incubators for newborn care. There is also lack of basic skills for newborn care.

Figure 14: Availability of services in facilities offering deliveries (DRH)



The objective is to increase access to basic and comprehensive obstetric, post abortion and essential newborn care. The aim is for the lower level facilities offering delivery services to be able to provide basic obstetric emergency (BEmOC) care while all the higher level facilities (level 4 and above) be able to provide comprehensive emergency obstetric care (CEmOC). The target is to increase access to a total of 5 per population of 500,000; BEmOC to 4; and CEmOC to 1.

All facilities providing delivery services should be able to provide essential newborn care and post-abortion care. Higher level facilities should be able to provide comprehensive post abortion care (CAC).

The interventions here include improving access to basic and comprehensive emergency obstetric care, comprehensive post abortion care and essential newborn care.

The table below presents a summary of the interventions areas and key priority interventions.

Table 2: Key interventions

Intervention areas	Key interventions
A. Upgrade the functionality of the health system for the provision of maternal health services	A1. Reduce the financing gap for maternal health services
	A2. Improve the management of health services
	A3. Ensure adequate number, skills and distribution of health staff
	A4. Ensure adequate commodities for maternal and neonatal health services in all health facilities.
	A5. Ensure environment is conducive for the provision of maternal health services.
	A6. Ensure basic infrastructure exists at health facilities
	A7. Ensure that all health facilities providing maternal health services are easily accessible.
B. Increase demand for maternal health services	B1. Increase demand for maternal health services
C. Provide universal access to family planning services	C1. Provide family planning services for women, men and the youth
D. Improve access to FANC and PNC for all mothers and pregnant women	D1. Provide quality FANC and PNC services
E. Access to skilled birth attendance	E1. Provide access to quality skilled delivery services
F. Improve access to emergency and essential new born care	F1. Provide emergency obstetric and post abortion care
	F2. Provide essential newborn care

Chapter IV – Bottleneck analysis

This section presents the prioritized bottlenecks in policy and planning; budgeting and financing; service delivery (supply); and service utilization (demand) that impede the successful implementation of priority interventions that are not being fully or effectively realized.

Bottlenecks were identified in the key health sector policy and strategy documents, and through consultative fora as described in Chapter III on strategic interventions. The methodological retreat was particularly useful. The bottlenecks identified at the retreat were further refined through focused group discussions and in-depth interviews in Nairobi and in the regions which provided significant inputs.

The bottlenecks in the six strategic intervention areas are discussed below. As stated in the discussion on priority interventions, the first two areas are cross-cutting and affect all the other priority intervention areas. Removing bottlenecks in these two areas will have a significant impact on achieving the other priority interventions.

A. UPGRADE THE FUNCTIONALITY OF THE HEALTH SYSTEM FOR THE PROVISION OF MATERNAL HEALTH SERVICES

Prioritized bottlenecks that exist include the following:

Inadequate government budget for maternal health

Total health expenditure in absolute terms increased from Ksh82.2 billion (US$1,046 Million) in 2001/02 to Ksh122.9 billion (US$1,620 million), an increase of 49 percent. Total health expenditure per capita increased from Ksh2,636 (US$34) in 2001/02 to Ksh3,203 (US$42) in 2009/10, a 24 percent increase. Total RH expenditure amounted to Ksh17 billion ($225 million), an increase from Ksh13 billion ($170 million) in 2005/06. The budget line for FP commodities and the Government of Kenya met 80 percent of the cost of contraceptive commodities in 2010/11. The RH voucher scheme piloted by donors has been successful.

However, the international average spend on maternal health is estimated at $41 per mother (DRH) while the total resource availability in the Kenyan health sector is $42 per capita (NHA 2009/10). Total health expenditure as a percentage of gross domestic product (GDP) has remained nearly constant, at 5 percent since 2001/02; and government health expenditure as a percentage of total

government expenditure declined from 8 percent in 2001/02 to 4.6 percent in 2009/10. This is inconsistent with the Abuja Declaration (2001) which recommended an increase in the amount countries spend on health to 15 percent of their government budget.

Disjointed efforts and lack of synergies by both state and non-state actors

There are a number of public and non-state actors involved in the provision of health services in Kenya. For the public sector, there are the ministries of Medical Services and Public Health and Sanitation, and local governments. There is a disconnect and lack of synergy between these institutions in the provision of services and in the pursuit of health goals particularly between the local government health agencies and the government ministries. This is a major problem as the local governments have major roles to play in the provision of health services including MNH, particularly in the major towns. This area needs to be streamlined if the Government is to make significant progress in achieving MDGs in MNH.

Weak management of the health system

One of the weaknesses in government policy documents cited in the workshops conducted and in the focus group discussions and interviews, is weak management of the health system. There is pervasive poor oversight of health services throughout the country which needs to improve if quality is to be achieved and performance improved.

Inadequate data for planning; management and quality control

There is inadequate data for planning, management and quality control. To start with, there is only one figure for the maternal mortality ratio from KDHS and that is at national level. Estimates of the MMR at the regional level are hard to come by and there is no agreed method of arriving at comparable estimates. Problems occur when maternal deaths occur at home and/or are not reported. This difficulty in reasonably estimating the maternal mortality ratio undermines planning at sub regional levels and needs to be resolved as the country devolves to county levels.

Inadequate staff capacity

There are inadequate numbers, skills and distribution of health personnel to provide the required level and quality of services to reverse the trends in maternal mortality ratio. The greatest single weakness of the country's health system is the overworked, tired and resentful nurse who has to single-handedly attend to a huge number of patients including pregnant women in (particularly lower level) health facilities that are severely understaffed. In the hardship areas, few health personnel want to be posted there and those who get posted find a way to get out to areas they consider more comfortable mainly in urban centres.

Poor systems for the procurement, distribution and management of health commodities

A key complaint by health officers is a lack of essential commodities for the provision of health services in hospitals including drugs, other consumables and equipment. This commodity insecurity affects all services along the continuum of care. There are major weakness in the systems for procurement, distribution and management of these commodities at all levels from the central procurement agency, the Kenya Medical Supplies Agency, to the management of inventory at facility level. Health personnel managing health facilities lack the capacity to manage commodities efficiently and run poor systems of inventory control.

Poor environment for the provision of MNH services

According to health personnel and managers at regional and facility levels, the environment for the provision of MNH services is poor and a major disincentive for mothers. It does not, in many instances, provide a clean environment and ensure the privacy, dignity and cultural sensitivity of the mothers. On the whole, facilities are poor. For example, some of the delivery beds are very old and in disrepair, there are no curtains to ensure privacy and the sanitary conditions are very poor. Some health facilities do not have basic infrastructure such as water and a reliable source of electricity. This includes major maternity hospitals in the capital city such as Pumwani Maternity Hospital.

Poor road network

In some areas, the road network is poor and inaccessible, especially during the rainy season, and this prevents women from accessing health facilities on a timely basis.

B. INCREASE DEMAND FOR REPRODUCTIVE HEALTH SERVICES

Prioritized bottlenecks in this area include resistance and low support for maternal and neonatal health services due to socio-cultural and religious reasons. This is made worse by the low status of women and the lack of support at family and community levels.

In addition, inadequate knowledge on the benefits of maternal and reproductive health services for women, the men and communities is a major hindrance to seeking health services and a major contributor to maternal and neonatal deaths.

C. PROVIDE UNIVERSAL ACCESS TO FAMILY PLANNING SERVICES

Bottlenecks to providing universal access to family planning services include the following:

Inadequate staff capacity and providers for provision of FP services

There are inadequate numbers of health staff skilled in the provision of family planning services, especially LAPM and inadequate number of health providers and service points. The government no longer provides continuing training on family planning services to its health professionals including nurses and clinical officers. There is significant potential in using existing institutions to provide family planning services including the armed forces, universities and other institutions of learning, public sector institutions and the private sector.

There are substantial missed opportunities in the provision of family planning services. One of the key impediments to the success of family planning is the limited numbers and skills of health providers. Of the women who were not using family planning in the 12 months before the survey: only 5 percent were visited by a fieldworker who discussed family planning; only 9 percent visited a health facility and discussed family planning; and 88 percent of women neither discussed family planning with a fieldworker nor with staff at a health facility. For the adolescents and youth who represent 30 percent of the population, youth friendly services remain unavailable. These represent missed opportunities to educate women and youth and improve uptake of family planning services.

Poor access to RH by the youth and adolescents

There is inadequate availability of reproductive health services for the adolescents and youth. In fact, the unmet need is highest among adolescents and youth aged between 15 and 24 years at around 30 percent (KDHS 2008/9). This is significant taking into account that this segment of the population is 30 percent of the entire population of the country. 18 percent of young women aged 15 to 19 years have begun child bearing yet youth-friendly reproductive health services are nearly non-existent.

Family planning commodity insecurity

One of the key impediments to achieving progress in family planning is family planning commodity insecurity. According to health personnel interviewed, there were many women who sought family planning services but could not get them because there were no commodities available. Lack of family planning commodities presents missed opportunities to attend to those already seeking family planning services and to reduce the unmet need.

Low demand for family planning services

There is low demand for family planning services with significant variations between regions. This low demand is compounded by poor support from men and communities, and lack of information and misconceptions about family planning. Fear of side effects at 16 percent is the most common reason for women not using family planning, followed by health concerns at 15 percent which point to a gap in the level of knowledge and/or choice of contraceptive methods.

D. IMPROVE ACCESS TO ANTENATAL AND POSTNATAL CARE

Prioritized bottlenecks in this area include:

Inadequate staff capacity

Although this issue has been articulated in section A, it is mentioned here as it a major cause of poor performance in this area. Inadequate staffing of health facilities is a major cause of why women do not attend ANC and PNC clinics. The nurses are few and overworked and this may explain why although a significant proportion of women attend one ANC clinic during pregnancy, very few attend the required four visits. It may also explain why the high attendance of at least one ANC which provides contact with a trained health professional does not lead to SBA during delivery. Some training gaps and poor attitude of health personnel also presents some challenges.

Poor access to and cost of laboratory services

Lower level facilities that offer ANC services do not have lab services. Pregnant mothers are also required to pay for lab services and this affects the poor who cannot afford it.

Inadequate equipment and commodities

Inadequate availability of equipment and commodities were also cited as impediments to the provision of quality ANC and PNC services in the country.

Low level of awareness

There is a low level of awareness on the importance of ANC and PNC and poor support from men, families and communities.

92 percent of women received antenatal care from a skilled provider (doctor, nurse, or midwife) at least once. The proportion of women who had four or more recommended visits decreases dramatically to 47 percent. Many of the women visited the clinics to obtain a card for future health visits for the mother and the baby. As for the timing of the visits, only 15 percent of women went to their first ANC visit during the 1st trimester of pregnancy, as recommended. There is no appreciation that early initiation of ANC is necessary if a pregnant woman is to take full advantage of maternal health care. 7 percent of women did not visit a clinic to obtain ANC services.

The above data shows that the majority of the women (over 90 percent) have the benefit of contact with a health professional at least once during pregnancy. The lowest is in North Eastern Province which still has ANC visits of at least once at 70 percent. Nairobi has the highest at 96 percent.

Poor geographical access to ANC and PNC services

Distances to health facilities is a hindrance for some communities in hard to reach places.

E. PROVIDE ACCESS TO SKILLED BIRTH ATTENDANCE

Prioritized bottlenecks include the following:

Inadequate number of skilled midwives

Lack of an adequate number of skilled midwives, nurses and clinical officers leads to poor quality service delivery. Poor attitude of the existing staff discourages pregnant women from seeking professional help during delivery. Though an overall problem of the health care system, specific attention will be given to bridging this gap.

Poor environment for deliveries

Health professionals interviewed alluded to the poor environment and facilities for deliveries particularly at lower level facilities to guarantee the health, privacy, dignity and socio-cultural sensitivity of the mothers. Many of the facilities have old delivery beds, no curtains to ensure privacy, and have poor sanitation. Some do not adhere to adequate levels of cleanliness; have no access to adequate water and electricity supply.

Inadequate commodities and equipment

Lack of appropriate commodities and consumable supplies was cited as one of the key problems affecting deliveries in health facilities.

Low demand

There is low demand for skilled birth attendance due to the low value attached to skilled attendance, socio-cultural attitudes and preference for TBAs.

The following figure shows that a majority of women are attended by traditional birth attendants (28 percent), a relative or other unskilled person (21 percent) while 7 percent deliver on their own at home (KDHS 2003).

The reasons women gave for not delivering at a health facility included: the facilities are too far; no transport; not necessary; abrupt delivery; and that it cost too much, in that order. Traditional birth attendants continue to play a significant role in deliveries especially in rural areas and surprisingly in areas where health facilities are within reach. Once embraced by the health system, this group is now not integrated as part of the health system but continues being relied upon by women to provide delivery services. Interestingly, they charge as much if not more in some areas than what is charged in public hospitals for normal delivery.

The high proportion of women who have undertaken at least one ANC visit does not feed into an improved level of skilled attendance at delivery or delivery at a health facility which stands at 44 percent and 43 percent respectively (KDHS 2003). This implies that the health workers do not or are unable to influence or encourage women to deliver under skilled health attendance.

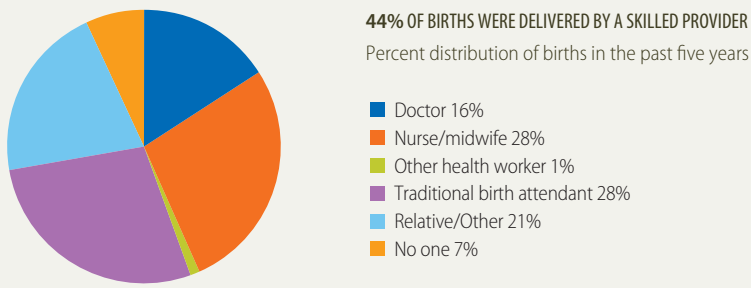
Distance for health facilities

Long distances to health facilities were cited as the single most important reason for not delivering at health facilities at 42 percent (KDHS 2008/9).

Cost of deliveries

Cost was cited as a reason for not delivering at a health facility by 17 percent (KDHS 2008/9) of the respondents who did not have a delivery at a health facility.

Figure 15: Assistance during delivery



Poor referral facilities

Inadequate access to equipment and staff ambulance services to provide effective referral in case of complications that need to be handled at higher level hospitals was one of the key weaknesses cited in the health system.

* Skilled provider includes doctor, nurse, or midwife.

IMPROVE ACCESS TO EMERGENCY OBSTETRIC AND NEWBORN CARE

Prioritized bottlenecks include the following:

Inadequate staff capacity

There are human resource challenges which include an inadequate number, skills and distribution of health staff able to handle emergencies. These include doctors, anaesthetists and nurses appropriately trained to handle emergencies.

Inadequate facilities

This bottleneck relates to inadequate facilities including theatres, intensive care units and high dependency unit facilities in higher level facilities for emergency preparedness; and inadequate equipment for the provision of quality basic and comprehensive EmOC, CAC and newborn care in lower level health facilities. (Equipment for newborn care includes newborn resuscitation equipment and incubators).

Poor access to blood and transfusion services

There are inadequate stocks of blood especially for universal donors in times of need. Access to blood transfusion services are inadequate especially in lower level health facilities. Blood banks and blood testing services are only available in limited locations in the country.

Inadequate commodities for EmOC, CAC and ENBC

There are inadequate supplies of commodities required for emergency services including EmOC, CAC and ENBC.

The following table summarizes prioritized bottlenecks to key interventions for achieving MNH targets. The last column categorizes these bottlenecks into policy and planning, finance and budgeting, supply and demand.

Table 3: Prioritized bottlenecks

Intervention areas	Key interventions	Prioritized bottlenecks	Bottleneck category
G. Upgrade the functionality of the health system for the provision of maternal health services	A1. Reduce the financing gap for maternal health services	A1.1 Inadequate government budget for maternal health	Policy and planning budgeting and finance
		A1.2 Disjointed efforts and lack of synergies by different actors, both state and non-state. This includes poor coordination and low synergy in the public sector, faith-based organizations (FBOs) and with development partner supported NGO initiatives.	Policy and planning
	A2. Improve the management of health services	A2.1 Weak management, supervision and quality assurance in health facilities	Supply
		A2.2 Inadequate data for planning, management and quality assurance	Supply
	A3. Ensure adequate number, skills and distribution of health staff	A3.1 Inadequate number of health staff. The number of health staff is inadequate to provide quality maternal and neonatal health services.	Supply
		A3.2 Inappropriate distribution of health staff. Although the government under Economic Stimulus Program allowed the employment of 20 nurses for each constituency, hardship areas were unable to recruit this number.	Supply
		A3.3 Inadequate technical skills and poor attitudes of health staff.	Supply
	A4. Ensure adequate commodities for maternal and neonatal health services in all health facilities.	A4.1 Poor system for the procurement, distribution and management of health commodities	Supply
	A5. Ensure environment is conducive for the provision of maternal health services.	A5.1 Poor facilities for the provision of maternal health services which does not ensure privacy, dignity and cultural sensitivity of mothers.	Supply
	A6. Ensure basic infrastructure exists at health facilities	A6.1 Some health facilities do not have a reliable source of clean water, reliable source of electricity and some have no proper sanitation facilities	Supply
	A7. Ensure that all health facilities providing maternal health services are easily accessible.	A7.1 Poor road network, especially rural access roads which prevent women from access health facilities in a timely manner	Supply and demand

Intervention areas	Key interventions	Prioritized bottlenecks	Bottleneck category
H. Increase demand for maternal health services	B1. Increase demand for maternal health services	B1.1 Resistance and low support for maternal health services due to socio-cultural and religious reasons. This is made worse by the low status of women and lack of support at household and community levels.	Demand
		B1.2 Inadequate knowledge on the benefits of maternal and reproductive health services	Demand
I. Provide universal access to family planning services	C1. Provide family planning services for women, men and the youth	C1.1 Inadequate numbers, skills and distribution of health staff (inadequate skills especially in LAPM)	Supply
		C1.2 Inadequate availability of family planning services for the youth with very little effort and understanding focused in this area	Supply
		C1.3 Inadequate number of health providers and service points	Supply
		C1.4 Poor distribution and frequent stock outs of family planning commodities	
		C1.5 Low demand for family planning services due to: resistance and low support for family planning due to socio-cultural and religious reasons. Low status of women and lack of support at family and community levels; and inadequate knowledge on the benefits of coupled with misconceptions and misinformation on family planning	Demand
		C1.6 Poor access for the poor due to cost especially for LAPM	Demand
J. Improve access to FANC and PNC for all mothers and pregnant women	D1. Provide quality FANC and PNC services	D1.1 Human resource challenges	Supply
		D1.2 Poor access to lab services for ANC profiling not available at lower level health facilities	Supply
		D1.3 Unaffordable cost of lab services for poor women	Demand
		D1.4 Inadequate equipment for ANC and PNC at health facilities	Supply
		D1.5 Poor availability of commodities at health facilities	Supply
		D1.6 Low level of awareness on the importance of ANC and PNC and poor support from men, families and communities	Demand
		D1.7 Distances to health facilities are significant for some communities (Access)	Demand

Intervention areas	Key interventions	Prioritized bottlenecks	Bottleneck category
K. Access to skilled birth attendance	E1. Provide access to quality skilled delivery services	E1.1 Human resource challenges: Inadequate numbers and distribution of skilled midwives and poor attitudes of health staff	Supply
		E1.2 Poor quality service delivery	Supply
		E1.3 Poor environment and facilities for deliveries especially lack of privacy with instances of a number of mothers delivering in the same room without curtains. This is especially the case for levels 2 & 3 hospitals	Supply
		E1.3 Lack of commodities e.g. delivery packs especially in level 2 & 3	Supply
		E1.4 Low demand due to: low value attached to skilled attendance at birth; and socio-cultural attitudes and preference for TBAs	Demand
		E1.5 Long distances to health facilities for some communities (geographical access)	Supply
		E1.6 Unaffordable cost of delivery services for poor women (cost access)	Demand
		E1.7 Poor referral services in terms of ambulances and access and emergency preparedness of higher level hospitals	Supply
L. Improve access to emergency and essential new born care	F1. Provide emergency obstetric and post abortion care	F1.1 Poor access to health facilities offering emergency services	
		F1.2 Human resources challenges: inadequate numbers, skills and distribution of health staff able to handle emergencies including EmOC and CAC especially at lower level facilities	Supply
		F1.3 Inadequate facilities including theatres, ICUs and HDUs in level 4 facilities and above to provide emergency services	Supply
		F1.4 Inadequate commodities for emergency care	Supply
		F1.5 Non-availability of blood at health facilities in time of need and insufficient stocks of blood especially for universal donors	Supply
	F2. Provide essential newborn care	F2.1 Inadequate skills in newborn care	Supply
		F2.2 Lack of and inadequate equipment for the provision of newborn care including newborn resuscitators and incubators	Supply


fc2
FEMALE CONDOM

Chapter V – Accelerating Progress: Solutions to Bottlenecks

To address the prioritized bottlenecks identified in Chapter IV, high impact, short term and cost-effective solutions for the six priority areas were proposed, based on impact (magnitude, speed and sustainability) and feasibility (governance, capacity and funding availability) to accelerate progress on the maternal and neonatal health-related MDGs. These are discussed below.

A. UPGRADE THE FUNCTIONALITY OF THE HEALTH SYSTEM FOR THE PROVISION OF MNH SERVICES

The following solutions will be pursued to upgrade the functionality of the health system for the provision of MNH services:

- To address the financing gap, the acceleration solutions include: increasing the proportion of the national health budget available for maternal and neonatal health services and commodities in line with the Abuja Declaration; introducing a budget line item for reproductive health services; mobilizing additional funds from development partners and the private sector; and advocacy for the prioritization of maternal health with county governments.

- To improve coordination of effort and create synergies between actors: the RH Business Plan and this MAF Action Plan will be implemented; and public sector institutional setup (including the local and county government's health management) will be harmonized.

- To improve management of health services, solutions include training health managers on management skills, support supervision and quality assurance; and enforcing standards for management, support supervision and quality assurance focused on MNH services. On improving data, more clerks will be employed, trained and deployed in health facilities; data collection and reporting on MNH will be enforced at all levels; maternal and perinatal death reviews will be made mandatory at all levels; and lobbying with legislators for legislation on maternal death notifications will be carried out.

- To address the issue of the inadequate number, skills and distribution of health personnel, additional health staff will be employed to provide MNH services; lobbying will be done for an immediate review of policy on hardship allowances, and health staff will be allowed to maintain full house allowance (to allow their families to remain in areas with adequate facilities such as schools) while allowing and encouraging county governments to give additional incentives to retain them especially in difficult areas. Such incentives include proper housing and additional allowances. On inadequate skills, a program will be drawn to systematically retrain all health staff on MNH interventions along the continuum of care, including family planning, midwifery, emergency responsiveness, post abortion and newborn care. Health staff will also be trained to improve customer care to support greater demand for health services. On lack of anaesthetists, nurses with high aptitude will be trained and allowed to practice to provide support in emergency situations; and policy will be reviewed to allow private practitioners to provide stop gap support in case of emergencies.

- On commodity insecurity, the system for procurement, distribution and management of health commodities for MNH services will be strengthened; lobbying will be done to obtain a high level directive to KEMSA for the procurement and timely distribution of MNH commodities and equipment to all health facilities providing services as a matter of priority and urgency; health facility managers will be trained in commodity management; and a system of regular monitoring of health commodities will be operationalized.

- To create a conducive environment, upgrade the sections of health facilities used to provide maternal and neonatal health services to provide a more conducive environment for mothers including ensuring their privacy, dignity and cultural sensitivity. These upgrades should be basic and cost effective.

- To address basic weaknesses in infrastructure, provide water harvesting facilities and boreholes for health facilities not connected to reliable piped water; install off grid power systems for facilities not connected to the national grid including solar, wind and diesel generators; and upgrade and maintain sanitation facilities.

- To improve the poor road network, roads authorities will be lobbied to ensure that all health facilities providing MNH services are connected via all-weather roads.

B. INCREASE DEMAND FOR REPRODUCTIVE HEALTH SERVICES

To address the low demand for reproductive health services, various means will be used to raise awareness, educate the public and lobby for community support. This will include: the Community Health Strategy which will be upscaled and fully implemented; conducting IEC/BCC media campaign at national and regional levels; community outreach through political and religious leaders; and through health workers who will be trained and supported to promote MNH services. Close collaboration will be sought with community, religious and political leaders at the national and county levels to leverage on their influence and community reach to help raise awareness and facilitate the availability of resources for MNH.

Close collaboration will also be sought with the media for them to support the creation of awareness and the education of the public. Mass media will be used in a sustained campaign to promote MNH services which include: radio, TV, road shows, bill boards in all major towns, posters and T-shirts. Local languages will be used to allow the message to reach all corners of the country.

Health staff will be trained to facilitate health facility-based education of women on an ongoing basis.

C. PROVIDE UNIVERSAL ACCESS TO FAMILY PLANNING SERVICES

The following are the solutions to identified bottlenecks in this area:

- For the lack of adequate staff capacity, in addition to the general upgrading of staff capacity discussed in section A, staff will be trained and some retrained on family planning methods especially on LAPM.
- On the issue of youth, establishment of youth friendly services in all constituencies will be upscaled through the support from devolved funds, NGOs and CBOs.
- In terms of inadequate health providers and service points, the private sector and institutions including those of higher learning and armed forces will be engaged to provide services and commodities. Community based distribution of commodities will also be implemented as part of the implementation of Community Health Strategy.

- On commodity insecurity, family planning commodities security will be improved by implementing the solution discussed in section A above.To address low demand for family planning services, create demand as suggested above.

- On poor access to family planning services, waive all charges for family planning services and commodities at all government health facilities especially for LAPM. The OBA voucher system will be upscaled to provide access to all women including the poor and the youth.

D. IMPROVE ACCESS TO ANTENATAL AND POSTNATAL CARE

The following are solutions identified for this area:

- To resolve human resource challenges, in addition to improving staff capacity discussed in Section A, health personnel will be trained/retrained in the provision of quality FANC and PNC services.

- In terms of lab services, provide lab facilities at all health centres (which should then be able to serve dispensaries) and provide lab technicians, equipment and consumables. In addition, as cost of lab services is cited as an obstacle, all charges for lab services will be waived for poor women to improve access. Where appropriate OBA voucher system will be upscaled to provide access to FANC and PNC services for all pregnant women and mothers.

- To address the inadequate level of equipment, provide and maintain equipment for FANC and PNC. The private sector and the county governments will be lobbied to provide this equipment.

- On commodities, implement solutions for strengthening the health system

- On the issue of distances to health facilities, equip, staff and operationalize facilities built through the CDF to allow for access to health facilities within reasonable distances. Mobile outreach services will be established for all counties which have hard to reach places. This will include purchasing, equipping and running mobile clinics to follow up and provide services to pregnant women, mothers and their newborn wherever they may be. Local and international institutions, partners and the private sector will be lobbied to donate and/or support such facilities.

E. PROVIDE ACCESS TO SKILLED BIRTH ATTENDANCE

The following are the solutions identified for this area.

- On low staff capacity on midwifery, as part of implementing the solution for strengthening the health system, the Government will ensure the provision of an adequate number of midwives in all areas. Appropriate incentives to retain midwives in hard to reach places will be put in place. Nurses and clinical officers will be trained on midwifery skills so that adequate numbers of properly skilled midwives are in place to provide skilled care during delivery. Health workers will also be trained on providing quality health services and to ensure proper attention is paid to the health, dignity and cultural sensitivity of the mothers.

- In addition to midwifery skills, health staff of lower level facilities offering maternity services will be trained to be able to handle most emergencies. District and sub district hospitals will be upgraded to improve their emergency preparedness to ensure that all emergency cases referred from lower level facilities are handled efficiently.

- On the issue of the poor environment for the provision of MNH services, resources will be provided to upgrade specific facilities used to provide MNH services to ensure cleanliness, privacy, and dignity of the mothers and their newborn. Specifically, new delivery beds will be provided and old ones will be renovated. The rooms will be provided with curtains and other amenities that will ensure privacy and dignity of mothers and pregnant women.

- On commodity insecurity, as a component of strengthening the health system for the provision of MNH services, emphasis will be placed on ensuring adequate commodities, consumables and equipment are available at all hospitals offering delivery services.

- To address the low demand for skilled birth attendance, as part of implementing solution in Sector B, awareness will be raised on the importance of seeking skilled attendance during delivery. All means explained in Section B will be used. However, staff will be educated to use the opportunity during the at least one ANC visit to encourage pregnant women to seek skilled support during delivery and promote other practices such as maintenance of individual birth plans. Integrating TBAs in the implementation of the Community Health Strategy in order to get their support for escorting pregnant women to health facilities will be an important component of this demand creation.

- To tackle the impact of long distances to health facilities for some communities, maternal shelters in all district hospitals in the hard to reach areas will be established and operationalized. Each district in the North Eastern, Upper Eastern, North Rift and parts of the Coast region will have a maternal shelter in the district hospital. This is to ensure that mothers assessed as being at greater risk during childbirth are accommodated closer to the availability of skilled care.

- On the issue of the cost of delivery for poor women, waive delivery charges in all public hospitals for poor women. Lobbying will also be done for the inclusion of maternal health services in health insurance schemes including the National Hospital Insurance Fund (NHIF). The up scaling of the OBA voucher system, where appropriate, will be implemented to ensure that all women have access to skilled birth attendance at all health facilities, both public and non-state facilities.

- On the inadequate number of ambulances, ambulances will be purchased and assigned ambulance teams in every district, so that every district has at least three ambulances. To ensure effective and efficient operation of the ambulance service, autonomous ambulance service units within the health sector ministries with their own management and budget will be created. Collaboration will also be sought with the private sector to provide services in case of emergencies that occur in areas where ambulance coverage is non-existent or unavailable.

F. IMPROVE ACCESS TO EMERGENCY CARE

The following are the solutions identified in this area.

- On the poor access to health facilities offering emergency services, the OBA voucher system will be upscaled to expand access to private and other non-state facilities which offer emergency services for all pregnant women including the poor and the youth.

- In terms of the staffing issue, as part of strengthening health services for MNH, health personnel will be trained to provide basic EmOC and post abortion care at facility levels 2&3. Multi-disciplinary teams will be established and trained to provide comprehensive EmOC at levels 4 and above. The relevant policy will be reviewed to allow for the engagement of private practitioners as a stop gap in emergencies in cases where there are no appropriate personnel or they are unavailable for any reason. All health facilities providing delivery services will be upgraded and the health staff appropriately trained to be able to provide essential newborn care.

- On the issue of the inadequate facilities and equipment, emergency preparedness at levels 4 and above will be upgraded with theatre and ICU facilities and equipment. These include that required for newborn and post abortion care.

- On blood transfusion services, availability of adequate stocks of blood and transfusion services will be ensured at all times at health facilities at level 4 and above. Also the number of blood banks and testing centres will be increased, with the goal of eventually all counties having these facilities. To increase blood stock, the number of donation centres and initiatives will be increased throughout the country in particular leveraging on existing institutions and churches. This will be achieved through increased support for the National Blood Transfusion Service (NBTS).

- On the inadequate commodities and consumable supplies for the provision of emergency services, priority will be given to ensuring that all level 4 and above hospitals have adequate supplies of these commodities and supplies at all times. This will be accomplished as part of improving commodity supply and management for all interventions along the continuum of care.

- On the lack of and inadequate equipment for the provision of newborn care including newborn resuscitators and incubators, this equipment will be provided to all health facilities offering maternity services and staff appropriately trained in their use. All such facilities should be able to save the newborns that are delivered.

- The following table summarizes the solutions to accelerating progress towards achieving the MDG targets on maternal health.

Table 4: Summary table for accelerating progress towards the MDGs on Maternal and Neonatal Health

Intervention areas	Key interventions	Prioritized bottlenecks	Acceleration solutions
A. Upgrade the functionality of the health system for the provision of maternal health services	A1. Reduce the financing gap for maternal health services	A1.1 Inadequate government budget for maternal health	A1.1.1 Lobby for political support to recognize maternal and neonatal health as a priority and increase government funding at national and county levels
		A1.2 Disjointed efforts and lack of synergies by different actors, both state and non-state. This includes poor coordination and low synergy in the public sector, faith-based organizations (FBOs) and with development partner supported NGO initiatives.	A1.1.2 Implement RH Business Plan
			A1.1.3 Mobilize additional support from development partners
			A1.1.4 Involve the private sector
	A2. Improve the management of health services	A2.1 Weak management, supervision and quality assurance in health facilities	A2.1.1 Train health professionals in charge of facilities on management skills, quality assurance and customer service
			A2.1.2 Enforce standards for management, support supervision and quality assurance focused on MNH
		A2.2 Inadequate data for planning, management and quality assurance	A2.2.2 Increase capacity for data collection at health facilities in terms of personnel, skills and resources
			A2.2.1 Enforce data collection on MNH including: maternal and perinatal death reviews and verbal autopsy at all levels. This includes lobbying for legislation on maternal death notifications
	A3. Ensure adequate number, skills and distribution of health staff	A3.1 Inadequate number of health staff. The number of health staff is inadequate to provide quality maternal and neonatal health services.	A3.1.1 Employ more health professionals in public hospitals for MNH. These include doctors, nurses, midwifes and anaesthetists
		A3.2 Inappropriate distribution of health staff. Although the government under Economic Stimulus Program allowed the employment of 20 nurses for each constituency, hardship areas were unable to recruit this number.	A3.2.1 Review the management of health staff to allow for a more flexible and responsive system that allows: improving salaries and allowances for health personnel in hardship and hard to reach areas which include reviewing policy to allow for a 30 percent hardship allowance on top of basic pay, full housing allowance to allow for families to remain in areas with facilities such as schools; county governments to implement additional measures to attract and retain health staff. Additional measures should include providing scholarships for health personnel who stay for three years in a hardship area.

Intervention areas	Key interventions	Prioritized bottlenecks	Acceleration solutions
		A3.3 Inadequate technical skills and poor attitudes of health staff.	A3.3.1 Systematically train and retrain all health personnel on specific skills related to interventions along the continuum of care. These include skills in family planning, ANC and PNC, midwifery, emergency obstetric, post abortion and new born care. Due to lack of adequate numbers of anaesthetists, upscale training of nurses with high aptitude to provide such services.
			A3.3.2 Train all health staff in customer care
			A3.3.3 Allow for the use of private practitioners to assist health teams in public hospitals as a stop gap measure.
	A4. Ensure adequate commodities for maternal and neonatal health services in all health facilities.	A4.1 Poor system for the procurement, distribution and management of health commodities	A4.1.1 Lobby for a high level directive to KEMSA to procure and distribute commodities for maternal and neonatal health to all health facilities as a matter of high priority
			A4.1.2 Strengthen the system of procurement, distribution and management of commodities for maternal and neonatal health.
	A5. Ensure environment is conducive for the provision of maternal health services.	A5.1 Poor facilities for the provision of maternal health services which does not ensure privacy, dignity and cultural sensitivity of mothers.	A5.1.1 Upgrade the sections of health facilities which provide maternal and neonatal services to provide a conducive environment that ensures privacy, dignity, cleanliness and cultural sensitivity of the mothers.
	A6. Ensure basic infrastructure exists at health facilities	A6.1 Some health facilities do not have a reliable source of clean water, reliable source of electricity and some have no proper sanitation facilities	A6.1.1 Provide water harvesting structures and boreholes for public health facilities not connected to piped water
			A6.1.2 Provide off grid power solutions to health facilities not connected to grid electricity such as diesel, solar and wind generators
			A6.1.3 Upgrade sanitation for health facilities ensuring cleanliness.
	A7. Ensure that all health facilities providing maternal health services are easily accessible.	A7.1 Poor road network, especially rural access roads which prevent women from access health facilities in a timely manner	A7.1.1 Lobby to ensure all health facilities providing maternal and newborn health are connected through an all-weather road.

Intervention areas	Key interventions	Prioritized bottlenecks	Acceleration solutions
B. Increase demand for maternal health services	B1. Increase demand for maternal health services	B1.1 Resistance and low support for maternal health services due to socio-cultural and religious reasons. This is made worse by the low status of women and lack of support at household and community levels.	B1.1.1 Engage communities through their religious and political leaders on the importance of seeking health services.
			B1.1.2 Upscale the implementation of Community Health Strategy
			B1.1.3 Use mass media in a sustained IEC campaign to promote MNH: radio, TV, road shows, bill boards, posters. Use indigenous languages to reach local communities.
			B1.1.4 Promote facility based education of women
C. Provide universal access to family planning services	C1. Provide family planning services for women, men and the youth	C1.1 Inadequate numbers, skills and distribution of health staff (inadequate skills especially in LAPM)	C1.1.1 Train health staff on family planning methods especially LAPM. Intervention A3 deals with adequacy of health professionals.
		C1.2 Inadequate availability of family planning services for the youth with very little effort and understanding focused in this area	C1.2.1 Upscale the establishment of youth friendly services in all constituencies through devolved funds, NGOs and CBOs
		C1.3 Inadequate number of health providers and service points	C1.3.1 Engage the private sector, institutions of higher learning, and uniformed forces for the provision of family planning services and commodities within their institutions and as part of their CSR
			C1.3.2 Implement community-based distribution of family planning commodities as part of Community Health Strategy
		C1.4 Poor distribution and frequent stock outs of family planning commodities	Articulated in Intervention A4
		C1.5 Low demand for family planning services due to: resistance and low support for family planning due to socio-cultural and religious reasons. Low status of women and lack of support at family and community levels; and inadequate knowledge on the benefits of coupled with misconceptions and misinformation on family planning	Articulated in Intervention area B
		C1.6 Poor access for the poor due to cost especially for LAPM	C1.6.1 Upscale OBA voucher system in all areas to provide access to all women including the poor and youth.

Intervention areas	Key interventions	Prioritized bottlenecks	Acceleration solutions
D. Improve access to FANC and PNC for all mothers and pregnant women	D1. Provide quality FANC and PNC services	D1.1 Human resource challenges	C1.6.1 Upscale OBA voucher system in all areas to provide access to all women including the poor and youth.
		D1.2 Poor access to lab services for ANC profiling not available at lower level health facilities	D1.1.1 Train health personnel in the provision of quality FANC and PNC services. Intervention A3 deals with adequacy of health professionals.
			D1.2.1 Establish lab services in health centres and above. These include lab technicians, equipment and commodities.
		D1.3 Unaffordable cost of lab services for poor women	D1.3.1 Waive the cost of lab services
			D1.3.2 Upscale ABA voucher system to access lab services
		D1.4 Inadequate equipment for ANC and PNC at health facilities	D1.4.1 Provide equipment in all health facilities. Lobby with county governments and private sector to provide these equipment
		D1.5 Poor availability of commodities at health facilities	Solution articulated in A4
		D1.6 Low level of awareness on the importance of ANC and PNC and poor support from men, families and communities	Solution articulated in intervention area B
		D1.7 Distances to health facilities are significant for some communities (Access)	D1.7.1 Operationalize health facilities built through CDF
			D1.7.2 Provide mobile FANC/PNC services. This involves purchasing, equipping, staffing and running mobile clinics to provide services for hard to reach places.

Intervention areas	Key interventions	Prioritized bottlenecks	Acceleration solutions
E. Access to skilled birth attendance	E1. Provide access to quality skilled delivery services	E1.1 Human resource challenges: Inadequate numbers and distribution of skilled midwives and poor attitudes of health staff	E1.1.1 Train midwives. Provide recommended numbers in all areas using solution articulated in intervention A3
		E1.2 Poor quality service delivery	E1.2.1 Train all health workers on improved service delivery and customer service. Cultural sensitivity should be a critical component of this training.
		E1.3 Poor environment and facilities for deliveries especially lack of privacy with instances of a number of mothers delivering in the same room without curtains in very old dilapidated delivery beds. This is especially the case for level 2 & 3 hospitals	E1.3.1 Upgrade environment and facilities for deliveries including ensuring privacy, dignity and cleanliness. This includes providing curtains, new delivery beds and renovating old ones. Solution articulated in area A4
		E1.3 Lack of commodities e.g. delivery packs especially in level 2 & 3	E1.3.1 Provide delivery packs in all health facilities providing delivery services. Solution articulated in A5
		E1.4 Low demand due to the low value attached to skilled attendance at birth, and socio-cultural attitudes and preference for TBAs	E1.4.1 As part of the solution articulated in intervention area B, integrate TBAs in the implementation of Community Health Strategy.
		E1.5 Long distances to health facilities for some communities (geographical access)	E1.5.1 Operationalize health facilities built through CDF with maternity facilities
			E1.5.2 Upscale the development of maternal shelters to house pregnant women at higher risk (Each district hospital in North Eastern, Upper Eastern and parts of the Coast regions should have a functional maternal shelter).
		E1.6 Unaffordable cost of delivery services for poor women (cost access)	E1.6.1 Upscale the use of OBA vouchers in all areas to support women to obtain delivery services in public and private hospitals.
			E1.6.2 Lobby for the inclusion of maternal and neonatal health services as a standard in health insurances including NHIF.

Intervention areas	Key interventions	Prioritized bottlenecks	Acceleration solutions
		E1.7 Poor referral services in terms of ambulances and access and emergency preparedness of higher level hospitals	E1.7.1 Upgrade ability of lower level health facilities to handle emergencies and upgrade the emergency preparedness of district hospitals.
			E1.7.2 Purchase ambulances and ambulance teams so that every district has at least 3 ambulances
			E1.7.3 Establish a fully functional autonomous ambulance unit within the Public Health Care system with its own budget and management.
			E1.7.4 Establish partnerships with the private sector for the provision of ambulance services.
F. Improve access to emergency and essential new born care	F1. Provide emergency obstetric and post abortion care	F1.1 Poor access to health facilities offering emergency services	F1.1.1 Upscale OBA voucher system to allow for access to private hospitals which for emergency services
		F1.2 Human resource challenges: inadequate numbers, skills and distribution of health staff able to handle emergencies including EmOC and CAC especially at lower level facilities	F1.2.1 Train health professionals (nurse/doctor teams) to provide emergency obstetric and post abortion care. Lower level facilities (L2 and L3) should be able to provide basic emergency care. Ensure adequate numbers of health staff exist through the solution articulated in A3.
		F1.3 Inadequate facilities including theatres, ICUs and HDUs in level 4 facilities and above to provide emergency services	F1.3.2 Upgrade emergency preparedness of health facilities level 4 and above providing adequate theatre, ICU and HDU facilities.
		F1.4 Inadequate commodities for emergency care	Provide commodities as articulated in intervention A5.
		F1.5 Non-availability of blood at health facilities in time of need and insufficient stocks of blood especially for universal donors	F1.5.1 Ensure availability of adequate stocks of blood at health facilities level 4 and above.
			F.1.5.2 Increase the number of blood banks and blood testing centres so that each county has one.
			F1.5.3 Increase the number of blood donation centres and campaigns to improve blood stocks
	F2. Provide essential newborn care	F2.1 Inadequate skills in newborn care	F2.1.1 Train health personnel in newborn care.
		F2.1 Lack of and inadequate equipment for the provision of newborn care including newborn resuscitators and incubators	F2.1.2 Provide neonatal resuscitators in all health facilities offering delivery services (they should be able to save the life of a newborn they have helped deliver). Also provide adequate numbers of incubators in health facilities levels 3 and above.

Chapter VI – MDG acceleration plan: Building a compact

This section provides a compact, a partnership based on mutual accountability, to support the country to overcome the bottlenecks in achieving MDGs related to MNH, and to implement the high impact solutions identified. It presents the contribution and complimentary roles that the Government, development partners, the private sector and other actors will play in implementing identified solutions and overcoming the bottlenecks to achieving MNH targets.

The section includes: priority actions to implement the MAF; Country Action Plan (CAP); financing the MAF; and a monitoring and evaluation framework.

PART I: PRIORITY ACTIONS TO IMPLEMENT THE MAF

The following are the priority actions necessary to implement the MAF.

Obtain high level political commitment

Political commitment is required from the highest levels of government. This will require lobbying through the ministers in charge of health sector ministries and ideally the commitment of the President himself. The output of this activity is an official declaration that maternal and neonatal health is a priority for Kenya. This is expected to provide a basis for an increased allocation of funds to MNH and the pooling of efforts by other government agencies and development partners in support of achieving the MDGs related to MNH.

Political commitment is also required at the county level. County governments will be key in implementing interventions related to achieving almost all the MDGs and in particular this MAF. Lobbying county governments will be necessary from the very beginning to promote the prioritization of MNH in their budget allocations and activities.

This effort will be spearheaded by the Ministry of Public Health and Sanitation and UNDP.

Develop partnerships

Implementing the MAF will require the efforts of government agencies, development partners, the private sector and other key actors. A strong partnership must be built from the outset to allow for coordinated action and synergies in implementing and monitoring solutions to achieve the priority MDGs.

Implement a governance structure and mechanism

The implementation of the MAF will require effective oversight and coordination at the highest levels. A committee involving senior government officers, development partners, the private sector and representatives of other key stakeholders will be formed to oversee the implementation for the next few years to 2015 and beyond. Ideally the committee will be supported at the highest levels of government, will have presidential backing and will meet on a regular basis.

Implement an institutional framework for implementation

There are many key tasks that are required for the implementation of this MAF. An institutional framework and structure will be agreed upon early and clear roles and responsibilities assigned to ensure efficient execution of activities.

Mobilize funds

Additional funds will be mobilized from the government, development partners and the private sector. Increase in funds from the Exchequer will be made possible through the political commitment to MNH and the process of the MTEF and budget for 2013/4. Mobilization of development partner funds will leverage efforts already in place to organize development partner support for MNH.

The private sector will be encouraged to contribute through close partnership and lobbying for their involvement at national and county levels.

Define a minimum package of quality health care

Stakeholders under the leadership of the health sector ministries will define a minimum package of health care services for maternal and newborn care along the continuum of care. This package will include family planning, ante and postnatal services, skilled birth attendance at delivery, essential newborn care, and emergency (including post abortion) care.

Agree on the cost of a minimum package of quality maternal and newborn care

Stakeholders, under the leadership of the health sector ministries, will agree on the cost for the package of quality maternal and newborn care. The cost reimbursed under the current OBA system is a good starting point. The reimbursable costs will differentiate between state and non-state actors. State actors will be supported by the Government and its development partners for the investments necessary to deliver quality services, and will be reimbursed only for the removal of user charges. Non-state actors on the other hand will be reimbursed for the amount necessary to cover running costs and the cost of investments to upgrade their facilities to the level necessary to provide the agreed quality of services.

Upgrade public sector health services

Investment in improving the health system to provide the basic package of quality health care for the mother and the newborn which will involve the following:

1. Agree on basic standards for health facilities to be achieved.
2. Upgrade infrastructure, facilities and equipment including delivery rooms, theatres, ICUs, HDUs, maternal shelters, newborn resuscitators, incubators, labs, ambulances, etc.
3. Providing commodities for all interventions along the continuum of care.
4. Increase staff capacity in terms of numbers, skills and distribution. This includes recruiting new staff, training all health workers with specific skills relevant to maternal and newborn care, and providing incentives to retain the health workers in difficult areas.
5. Improve management in terms of managerial skills, level of supervision, and information.

Raise awareness and educate the public

A critical component of this MAF is the raising of public awareness and educating the public on the need to seek health care and the options provided to access quality MNH care. This will be done through conducting a nationwide IEC campaign, engaging communities through their political and religious leaders, and upscaling the implementation of the Community Health Strategy.

Provide the poor with access to quality MNH care

A critical requirement in the achievement of MNH is the provision of quality services to the poor and marginalized. This will be done through: identifying beneficiaries for financial support; accrediting and contracting health care providers; and implementing an efficient reimbursement system.

To identify beneficiaries, stakeholders, under the leadership of the health sector ministries, will agree on the criteria to identify beneficiaries in need of subsidized or free services. Options include using the current identification tools being used for the OBA/voucher system. It also includes offering all maternal and neonatal services for free at point of use without incurring the cost of identifying and registering the beneficiaries. The role of identifying the poor will be agreed upon and relevant institutions contracted and facilitated to perform this role. The target beneficiaries will then be identified following agreed upon criteria and tools.

To implement an efficient reimbursement system, a number of management agencies will be recruited to implement and manage an efficient reimbursement system.

To accredit and contract health service providers, standards will be set that will determine which providers can qualify to be included in the OBA voucher program to provide health care services to the poor. Incentives will be provided to non-state actors to provide quality maternal and newborn care especially in hard to reach places.

PART II: COUNTRY ACTION PLAN (CAP)

The following table presents: the priority activities for implementing the MAF; indicators, baselines and targets to measure progress for the next three years; required financing; the financing mechanism and funding party; and the party responsible for the performance of the specific activity. As indicated in the table, the MAF will be implemented through a partnership comprising the Government, development partners, the private sector and other actors.

Table 5: MDG Country Action Plan

No.	Priority activity	Indicators	Baseline	Targets			Financing			Financing mechanism/ funding party	Responsible party
				2013	2014	2015	Required	Existing commitments	Gap		
	Obtain high level political commitment	• MNH declared a national priority		Feb						UNDP	MOH, UNDP
	Development partnerships	• Partnerships in place with DPs, private sector, others		Mar, April						UNDP	MOH
	Implement governance structure mechanism	Governance structure mechanisms in place		May						UNDP	MOH
	Implement institutional framework	Institutional framework in place		June						UNDP	MOH
	Mobilize funds	• Amount, % increase in budgetary allocation								UNDP	MOF
		• Amount, % increase in DP commitments									MOF/UNDP
		• Amount committed by private sector									OP
	Implement financing mechanism(s)	Financing mechanisms in place		July						UNDP	MOF
	Define minimum package of quality MNH care	Minimum package agreed		June						DP Basket funds	MOH/MOH
	Agree on cost of minimum package of quality health care	Cost of minimum package agreed		June						DP Basket funds	MOH
	Upgrade public health services									Central government	MOH
	• Agree on basic standards of HFs	Standards in place								County governments	MOH
	• Upgrade infrastructure and facilities	% of HFs with adequate infrastructure and facilities				100 %				DP basket funds DP basket funds	
	• Provide equipment	% of HFs with adequate equipment				100 %					
	• Ensure availability of commodities	% of HFs with adequate commodities				100 %					KEMSA

No.	Priority activity	Indicators	Baseline	Targets			Financing			Financing mechanism/ funding party	Responsible party
				2013	2014	2015	Required	Existing commitments	Gap		
	• Improve staff capacity	% of HFs with adequate staff				100 %					
	• Recruit and deploy staff	Number of staff recruited								Central government	MOH
		Number of doctors recruited									
		Number of anaesthetists									
		Number of nurses/midwifes									
		Number of lab technicians									
		Number of data clerks									
	• Train staff	% of staff trained on MNH interventions			100 %					DP basket funds Central government	MOH
		% of staff trained in customer care			100 %						
		% of HF managers trained in management			100 %						
	• Provide incentives	Conducive policies in place								Central government County government	MOH
		Incentives in place									
		% of staff in hardship areas housed				100 %					
		% increase in hardship allowance		30 %							
	• Improve management	% of HFs adhering to basic standards				100 %				Central government County government	MOH

No.	Priority activity	Indicators	Baseline	Targets			Financing			Financing mechanism/ funding party	Responsible party
				2013	2014	2015	Required	Existing commitments	Gap		
	Raise awareness and educate the public									DP basket funds	
	• Conduct nationwide IEC campaign	#of radio, TV programs #of bill boards #of pamphlets, posters Number of road shows								Central government County governments	MOH/MOI
	• Engage communities through leaders	Number of community outreach activities per county									MOH
	• Upscale implementation of Community Health Strategy	% of community units fully operational				100 %					MOH
		% of districts fully involving TBAs				100 %					
	Provide access to the poor	% access to MNH services				100 %					TBD
	• Identify beneficiaries	% poor reached				100 %				Central government County governments DP basket funds	
	• Accredit and contract non-state health care providers	Number of providers accredited									
	• Implement an efficient reimbursement system	Reimbursement system in place		DEC							
	Monitor and manage the MAF	Meetings of the committee Annual review and planning Midterm review End term review (2015 Dec)		4 1	4 1 1	4 1 1				Central government DP basket funds	TBD
	Totals										

FINANCING THE MAF

Financing the MAF will adhere to the following principles:

1. It is consistent, where possible, with the key elements of the draft National Health Sector Financing Strategy. This is to ensure alignment with the country's strategy on financing health care.

2. It adheres to the recommendations of the Joint Mission on Harmonizing Support to Reproductive Health in Kenya. This is to ensure synergies with key development partners.

3. It is in line with the MNCH Consensus of 2009 on policies and interventions necessary to accelerate progress on MDG 4 & 5 (www.pmnch.org). This is to ensure alignment with international thinking on the matter.

These are discussed in brief in the following paragraphs.

Draft National Health Financing Strategy

The implementation of the Strategy has been slow in commencing although some aspects of it have been approved by the National Economic and Social Council chaired by the President. Once approved, the Strategy will take centre stage in all health care financing decisions in the country. The draft Strategy takes into account the essential interrelationships of the key components of a financing system namely: (a) collection of funds, (b) pooling of funds, (c) purchasing of services, (d) provision of services, and (e) the individual or household. The relevant strategic pillars include: extending social health protection to all Kenyans in order to achieve universal coverage with a basic package of health services; eliminating, or at least minimizing, geographical, financial or cultural barriers to access; ensuring efficiency and equitable collection of sufficient funds; improving efficiency in purchasing quality healthcare services; and ensuring the availability of quality services, diversity of providers and user choice through contracted and accredited public and non-state health care providers.

Other key elements include: progressively engaging with the informal sector which has grown to an estimated 7.5 million people. Improved engagement with this sector would increase health coverage from the current 24 percent to 70 percent of the population, and would convert out of pocket expenditures (to the tune of Ksh38 billion) into health care savings; provision of incentives to health care providers to provide sufficiently high quality services; and a focus on the poor and vulnerable through elimination of user fees, better identification of the poor and provision of health insurance through tax revenues and from donors.

Joint Mission on Harmonizing Support to Reproductive Health in Kenya

In March 2011, the Joint Mission on Harmonizing Support to Reproductive Health in Kenya (mission partners being DANIDA, DFID, GDC, USAID together with MOH, MOMS, and BMGF) came up with the following findings and recommendations:

- There was no coherent strategy on prioritizing RH support. This has led to fragmented approaches and inefficient use of available resources. It identified the need for a more efficient allocation of RH resources.
- The implementation of the Health Financing Strategy for Kenya has stalled and may be unable to respond to the immediate need for meeting MDG targets;
- The vouchers/the OBA scheme is effective and popular with women and service providers. However, international evidence showed that voucher schemes are costly and unsustainable. The system could be used in the short term to direct DP and other resources to give more women decent, subsidized, urgently needed RH services, but the high administration costs should be reduced if the system is scaled up.

The mission called for the development of a strategic and costed RH business plan that: will be used by DRH to lead, coordinate and review support for RH; help ensure more efficient use of available resources; support mobilisation of resources with DPs, health sector ministries and MOH and MOF; covers both state and non-state actors; shows what is needed by highlighting and prioritizing gaps; and where and how support should be delivered. The mission recommended a more coordinated approach to supporting RH including: a single TA and a single commodity plan for RH; coordinated OR/knowledge management initiatives; support for the SWAPs process; joint planning and annual reviews; and use of funding baskets.

The MNCH Consensus

MNCH consensus of 2009 on policies and interventions necessary to accelerate progress on MDG 4&5 (www.pmnch.org) outlined a 5 point check list: political leadership and community engagement and mobilization; effective health systems with interventions in key areas; removing barriers to access, with services for women and children being free at the point of use; skilled and motivated health workers; and accountability for results at all levels.

Considerations

Financing the MAF will involve:

- the public sector, the private sector, FBOs and other non-state actors
- pooling of funds from the government, development partners, private sector sources and existing health insurance schemes;
- both the financing of inputs and outputs (OBA/voucher scheme);
- improving universal access to services along the continuum of care through subsidizing user fees for the poor and vulnerable groups at the point of service while improving services from pooled funds;
- defining the basic package of quality maternal and newborn health services; and
- ensuring the efficiency in the management of funds and the procurement and provision of services.

MOBILIZING FUNDS

Funds will be mobilized primarily from the following sources:

1. Increased allocation of budgetary resources from the Exchequer
2. Lobbying for increased resources focused on MNH from development partners
3. Lobbying with the private sector for funds and support of MNH activities

PART III: MONITORING AND EVALUATION FRAMEWORK

Central to the success of this Action Plan is the implementation of a coordinated and collaborative approach to monitoring and evaluation that allows for timely feedback and proactive evidence-based decision making to facilitate the achievement of the planned results. The ultimate responsibility for monitoring and evaluation will be with the Steering Committee, which as stated elsewhere, will be composed of representatives from the Government, development partners, the private sector and other key actors (faith-based organizations, etc). Different actors will have responsibility for collecting, analyzing and submitting monitoring reports to inform the Steering Committee on the progress of the various initiatives.

Surveys (such as the KDHS) will provide a critical input into the monitoring and evaluation of the outcomes and impact in this area. A mid-term evaluation will be carried out to assess the extent to which the initiatives are being effectively implemented, and determine the likelihood of achieving the expected results. A final evaluation will be conducted at the end of 2015 to determine the status of MNH and therefore the success or otherwise of the interventions implemented as part of this MAF. The evaluation will also form the baseline for future effort in this area.

REPORTING TO THE NATIONAL ECONOMIC AND SOCIAL COUNCIL (NESC)

The NESC is chaired by the President and has membership from the highest levels of government and strong representation from the private sector. The launching of the MAF by the President positions MNH as one of the most important items in the national agenda. It is desirable that the progress in the implementation of MNH initiatives and any challenges encountered along the way are reported on a regular basis as a key item in the NESC agenda. This will allow the issue to be discussed and supported by the highest levels of government and the private sector.

Table 6: Monitoring and evaluation framework – outcomes and impact

Result		Indicator	Baseline 2008/9	Target 2015	Data source	Frequency	Responsibility
Reduce neonatal mortality	1	Neonatal mortality rate	31	11	KDHS	5 years	KNBS
Reduce maternal mortality	2	Maternal mortality ratio	488	147	KDHS	5 years	KNBS
Improve access to skilled birth attendance	3	Proportion of births attended by skilled health personnel	43.6%	90%	KDHS	5 years	KNBS
Improve access to emergency care	4	Availability of CEONC/500,000	1.3	1	HMIS	Annually	Health ministries
	5	Availability of BEONC/500,000	0.4	4			
	6	Total availability of EmOC /500,000	1.7	5			
Provide universal access to family planning	7	Contraceptive prevalence rate	46%	60%	KDHS	5 years	KNBS
	8	Adolescent birth rate					
	9	Unmet need for FP	24%	0	KDHS	5 years	KNBS
Increase antenatal and postnatal care coverage	10	Proportion of pregnant women having at least 1 antenatal visits	91.5%	100%	KDHS	5 years	KNBS
	11	Proportion of pregnant women attending at least 4 antenatal visits	52%	90%	KDHS	5 years	KNBS
	12	Proportion of women attending ANC tested for HIV	57%	80%	KDHS	5 years	KNBS
	13	Proportion of antenatal women receiving IPT2	15%	80%	KDHS	5 years	KNBS
	14	Percentage of women attending postnatal care check-up at least once within 2 weeks	2%		KDHS	5 years	KNBS

Table 7: Monitoring and Evaluation Framework - CAP Activities and Outputs

No.	Priority activity	Indicators and targets	Data source	Frequency	Responsible party
	Organize and launch				
1	Obtain high level political commitment	MNH declared a national priority and program launched	Reports	Once	MOH
2	Develop partnerships	Partnerships in place with DPs, private sector, others	Reports	Quarterly	MOH
3	Implement governance structure and mechanism	Governance structure mechanisms in place	Reports	Quarterly	MOH
4	Implement institutional framework	Institutional framework in place	Reports	Quarterly	MOH
5	Mobilize funds	Amount, % increase in budgetary allocation	Annual budget	Annual	MOF
		Amount, % increase in DP commitments	Annual budget Reports	Annual	MOF DPs
		Amount committed by private sector	Reports	Quarterly	MOH
6	Implement financing mechanism(s)	Financing mechanisms in place	Reports	Quarterly	MOF
7	Define minimum package of quality MNH care	Minimum package agreed	Reports	Quarterly	MOH
8	Agree on cost of minimum package of quality health care	Cost of minimum package agreed	Reports	Quarterly	MOH
	Upgrade public health services				
9	Agree on basic standards of HFs	Standards in place	Reports	Quarterly	MOH
10	Upgrade infrastructure and facilities	% of HFs with adequate infrastructure and facilities	HMIS	Annually	MOH
11	Provide equipment	% of HFs with adequate equipment	HMIS	Annually	MOH
12	Ensure availability of commodities	% of HFs with adequate commodities	HMIS	Annually	MOH
13	Improve staff capacity	% of HFs with adequate staff	HMIS	Annually	MOH
14	• Recruit and deploy staff	Number of staff recruited	Reports	Quarterly	MOH
		Number of doctors recruited	Reports	Quarterly	MOH
		Number of anaesthetists recruited	Reports	Quarterly	MOH
		Number of nurses/midwifes recruited	Reports	Quarterly	MOH
		Number of lab technicians recruited	Reports	Quarterly	MOH
		Number of data clerks recruited	Reports	Quarterly	MOH
15	• Train staff	% of staff trained on MNH interventions	Reports	Quarterly	MOH
		% of staff trained in customer care	Reports	Quarterly	MOH
		% of HF managers trained in management	Reports	Quarterly	MOH

No.	Priority activity	Indicators and targets	Data source	Frequency	Responsible party
16	• Provide incentives	Conducive policies in place, (2013)	Policy documents	Quarterly	MOH
		Incentives in place, (2013)	Reports	Quarterly	MOH
		% of staff in hardship areas housed	Reports	Quarterly	MOH
		% increase in hardship allowance, (30 percent of basic salary)	Reports	Quarterly	MOH
17	Improve management	% of HFs adhering to basic standards	Reports	Quarterly	MOH
	Raise awareness and educate the public				
18	Conduct nationwide IEC campaign	Number of radio, TV programs, Number of bill boards Number of pamphlets, posters Number of road shows	Reports	Annual	MOF
19	Implement financing mechanism(s)	Number of community outreach activities per county	Reports	Quarterly	MOF
20	Upscale implementation of Community Health Strategy	% of community units fully operational	Reports	Quarterly	MOH
		% of districts fully involving TBAs	Reports	Quarterly	MOH
	Provide access to the poor	% access to MNH services	Reports	Quarterly	MOH
21	Identify beneficiaries	% poor reached	Reports	Quarterly	MOH
22	Accredit and contract non-state health care providers	Number of providers accredited	Reports	Quarterly	MOH
23	Implement an efficient reimbursement system	Reimbursement system in place, (2013)	Reports	Quarterly	MOH
24	**Monitor and manage the MAF**	Meetings of the committee, 12) Annual review and planning, (3) Report to the NESC, (12) Midterm review, (1) End term review (1)	Reports	Quarterly	MOH

ANNEXES

ANNEX 1: KENYA – COUNTRY CONTEXT

Background

Kenya is situated in the eastern part of Africa, lying between 5 degrees north and 5 degrees south latitude and between 24 and 31 degrees longitude. The Equator almost passes through the centre of the country. It is bordered by Ethiopia in the north, Somalia in the northeast, Tanzania in the south, Uganda and Lake Victoria in the west and Sudan in the northwest. It is bordered in the east by the Indian Ocean with a 536 km long coastline. The Port of Mombasa at the coast serves Kenya and a number of countries including Uganda, Rwanda, Burundi and Eastern Democratic Republic of Congo. The Capital City is Nairobi.

Under the new constitution promulgated in August 2010, Kenya is divided into 47 counties and over 250 districts and constituencies. The country is governed through an executive layer led by a President and a Deputy President; a bicameral legislature (the Senate and the National Assembly); and a newly revamped independent Judiciary.

The country has a total area of 582,646 square kilometres of which 571,466 square kilometres form the land area. 80 percent of the land area is either arid or semi-arid with only 20 percent being arable. Some of the major physical features include Mt Kenya , the second highest mountain in Africa; the Great Rift Valley which runs from the south to the north of the country; Lake Victoria which is the largest fresh water lake in Africa, and second largest lake in the world; and major rivers including Tana and Arthi. There are also a number of game parks that are the main tourist attraction in the country.

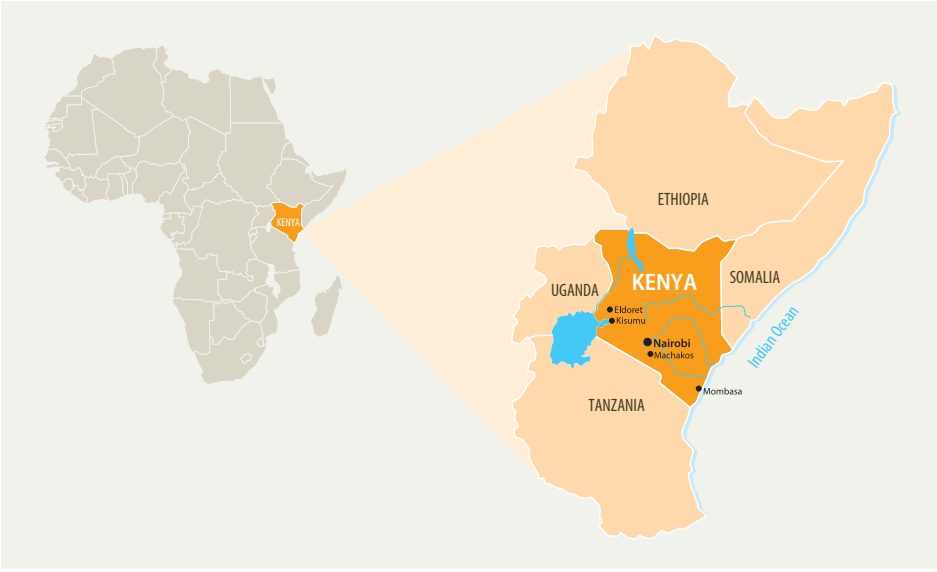
Major religions include Protestantism, Catholicism, Islam and others. The country has 42 tribes, among the main ones being Kalenjin, Kikuyu, Luo, Luhya, Kamba, Maasai, Meru, Kisii, Mijikenda, Somali and others.

The Economy and Society

The economy is predominantly agricultural with a strong industrial base. Agriculture contributed 22 and 23 percent of the GDP in 2007 and 2008 respectively. Cash crops that form the main export commodities include tea, coffee and horticulture (flowers, fruits and vegetables) which jointly accounted for 45 percent of the total export earnings (KNBS, 2009). The manufacturing sector contributes significantly to export earnings especially to the COMESA region.

In the first decade of Kenya's independence in 1963, the economy grew at an average of 7 percent, but this declined to an all-time low of 0.2 percent in 2000 attributed to both adverse

external and internal factors which included poor commodity prices, climate, world recession and mismanagement of the economy. This decline contributed to the deterioration in the overall welfare of the Kenyan population.



However, under the Economic Recovery Strategy (ERS), the economy grew steadily from 0.5 percent in 2002 to over 7 percent in 2007. In 2008, the Government launched the Kenya Vision 2030 and its first 5-year Medium Term Plan (MTP). The goal of Vision 2030 is to transform Kenya into a newly industrialized, middle income country by 2030.

The remarkable growth of the economy slowed dramatically to a real GDP growth of 1.7 percent in 2008 which was mainly attributed to the post-election crisis following the disputed 2007 General Election. Since 2009, the country has experienced a modest economic recovery with the GDP growth rate forecast to be over 5 percent in 2012.

The total population of the country is 40 million (Population Census 2009, KNBS). The population of women of child bearing age is 9.6 million. The population growth rate is estimated at 2.4 percent in 2012 and currently growing at 1 million per year. The current GDP per capita at current prices is estimated at US$680 (KNBS), while the proportion of the population living in absolute poverty is estimated to be 46 percent (KNBS) which, although an improvement from 2003 when it was over 55 percent, is still very high. The literacy rate for the population aged 15 years and above stands at 59 and 64 percent for men and women respectively (KDHS 2009).

ANNEX 2: REFERENCES

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UNFPA, Adding it Up: Costs and Benefits of Contraception Services – Estimates for 2012, June 2012

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ANNEX 3: LIST OF PEOPLE INTERVIEWED AND THOSE WHO PARTICIPATED IN FOCUS GROUP DISCUSSIONS

Name	Position	Organization
Mr Mark Bor	Former Permanent Secretary	Ministry of Public Health and Sanitation
Dr Wamae	Director , Department of Family Health	Ministry of Health
Dr Bashir M Isaak	Head, Division of Reproductive Health	Ministry of Health
Dr Tatu Kamau	Head, Division of Vaccinations and Immunizations	Ministry of Health
Dr Nakato Jumba	Programme Officer, Division of Reproductive Health	Ministry of Health
M/s Anne Kimemia	Human Resource Management	Ministry of Health
Mr Njoroge	Head, Human Resource Development	Ministry of Health
Dr Njeru	Head, Disease Surveillance and Response	Ministry of Health
Dr Khadija	Head, Child and Adolescent Health	Ministry of Health
Mr Thomas Maina	Economist	Ministry of Health
Mr Gideon Maillu	Head, MDGs Coordination Unit	Ministry of Devolution and Planning
M/s Batula Abdi	Program Officer	UNFPA
Dr Chris Ouma	Program officer	UNICEF
Dr Peter Simiyu	Provincial Director of Medical Services	Ministry of Health, Coast Province
Dr J M Othigo	Provincial Reproductive Health Coordinator	Ministry of Health, Coast Province
Mr Omari Tsuma	Provincial Health Information and Records Officer	Ministry of Health, Coast Province
M/s Tabitha Mburugu	Provincial Nursing Officer	Ministry of Health, Coast Province
M/s Carolyne Waluchio	Provincial Clinical Nutritionist	Ministry of Health, Coast Province
Mr Michael Ochieng	Public Health Administration Officer	Ministry of Health, Coast Province
Mr Michael Mwagamboga	Facility Management Officer (Nurse by profession)	Ministry of Health, Kwale District Hospital, Coast Province
Dr Mohamed Hassan	National Drought Management Authority	Kwale District, Coast Province
Mr Wilfred A Omari	Provincial Director of Planning	Ministry of Devolution and Planning
Dr Zakayo Kariuki	Provincial Director of Medical Services	Ministry of Health, Central Province
M/s Agnes Gichogo	Provincial Reproductive Health Coordinator	Ministry of Health, Central Province
M/s Angela Njiru	Provincial Reproductive Health Coordinator	Ministry of Health, Nairobi Province
Dr Evans Kiplagat	District Medical Officer of Health	Ministry of Health, Busia District
Dr Geoffrey Matete	Provincial Gynaecologist	Ministry of Health, Kakamega Provincial Hospital
Dr Mohamed Sheikh	Provincial Director of Public Health and Sanitation	Ministry of Health, North Eastern Province
Dr Peter Mongoi	District Medical Officer of Health	Ministry of Health, Fafi District, North Eastern Province
Mr Siyat Hassan	Reproductive Health Coordinator	Ministry of Health, Fafi District, North Eastern Province
Dr Thiongo	Provincial Director of Public Health and Sanitation	Ministry of Health, Eastern Province
M/s Doreen Manyara	Provincial Health Information and Records Officer	Ministry of Health, Eastern Province
Dr Mwangangi	District Medical Officer of Health	Ministry of Health, Meru South District, Eastern Province

ANNEX 4: MINUTES OF TASK FORCE MEETINGS

Minutes of MAF meeting held on 10th november 2011 at DFH conference room.

AGENDA

- Briefing on the Millennium Development Goal Acceleration Framework (MAF)
- Formalization of MAF committee
- Terms of reference
- Way forward
- AOB

MEMBERS PRESENT

Name	Organization	Email address
Assumpta Mureithi	WHO	muriithia@ke.afro.who.int
Dr Lavussa Joyce	WHO	lavussaj@ke.afro.who.int
Dr Bashir M. Izaak	DRH	drbashirim@yahoo.com
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Innocent Maloba	MODP	imaloba@planning.go.ke
Martin Wanjohi	Dicern Africa	Martinwanjohi@gmail.com
Nakato Jumba	DRH	jumbanakato@yahoo.com
Dr Gathari Ndirangu	DRH/Capacity Kenya	gndirangu@intrahealth.org
Dr Khadija Abdalla	DCAH	khdjahmed@yahoo.com
Fatou Leigh	UNDP	Fatou.leigh@undp.org
Nicholas Kipyego	UNDP	Nicholas.kipyego@undp.org

ABSENT WITH APOLOGIES:

- Dr Anne Wamae: Head Department of Family Health

- Dr Shiphrah Kuria: Deputy head- Division of Reproductive Health

The meeting started at 3:00 pm with welcoming remarks from the chair, followed by introductions.

BRIEF ON MAF

The MAF was launched during the MDG Summit in New York in 2010 as a tool for identifying the most lagging MDGs and for accelerating their implementation. The MAF was then piloted in four countries (Uganda, Tanzania, Niger, and Togo), to be rolled out to ten other countries in Africa.

In April 2011, UNDP Kenya facilitated a multisectoral retreat in Mombasa led by the Ministry of Planning, during which MDG 5 was identified as the most lagging MDG in the country. A MAF concept note, road map and a draft proposal were subsequently developed. The proposal was approved by the Regional Bureau for Africa (RBA).

Under MDG 5 and MDG 4 neonatal indicators are considered together, therefore MDG 4 has also been included in the process.

Considering that the MDG identified falls within the remit of the Ministry of Health (MOH), it is crucial that the MOH takes leadership of the process for optimal results. The MAF does not replace existing Government plans. Rather, it is an intervention designed to complement what is currently in place by:

- determining the strategic interventions required to achieve the MDGs by 2015
- identifying bottlenecks
- providing a coherent, consultative, and harmonized MAF framework elaborated by all key partners
- strengthening monitoring and evaluation

DISCUSSIONS

The lead consultant is Martin Wanjohi

There are MDG contact officers in other ministries and they will be involved in the process where necessary.

The Ministry of Health is ready and will take the lead in the MAF process.

The need to change from "Reducing maternal mortality" to "Reducing maternal and newborn mortality" as main Kenya MAF proposal.

Countdown to the MDGs- Is more on advocacy and there is need to incorporate this into MAF to avoid duplication and to gain more on the same.

FORMALIZATION OF MAF TECHNICAL COMMITTEE

This will include

- Head Department of Family Health- (chair)
- Division of reproductive health- MOH
- Division of child health- MOH
- Division of paediatrics- MOH
- Division of obstetrics and gynaecology- MOH
- Ministry of Devolution and Planning
- UNDP
- World Health Organization

TERMS OF REFERENCE

- The TORs for the committee
- The MAF technical committee will report to the health sector coordinating committee.- Add to TORs
- The consultant will report to the chair of the MAF technical committee and copy to UNDP.- Add to TORs
- The divisions to provide the consultant with relevant documents
- Revised TORs to be sent to members once finalized and comments from technical committee added-

WAY FORWARD

- Retreat to develop MAF work plan with key stakeholders

Date of retreat- 13th – 16th December 2011. (13th and 16th dates of travel)

Venue – Naivasha or Machakos - to be confirmed

Participants-

1. Director Ministry of Public Health and Sanitation
2. Director Ministry of Medical services
3. MAF Technical Committee
4. Department of primary health care
5. Technical planning
6. Division of Health Promotion
7. Division of Community strategy
8. Ministry of Finance
9. Ministry of Roads
10. Ministry of Water
11. Ministry of Devolution and Planning
12. UNFPA
13. UNICEF
14. DFID
15. USAID
16. Population Council
17. GIZ
18. FCI- Angela Mutunga

Invitations letters to be sent out by 14th November 2011. C.O.B

There being no other business, the meeting closed at 5:15 pm.

Next meeting - 5th December 2011 at 2:30 pm.

-DFH conference hall

ANNEX 5: LIST OF WORKSHOP PARTICIPANTS

MAF RETREAT TO SELECT THE MOST LAGGING MDGS, MOMBASA, 12TH – 16TH APRIL 2011 – LIST OF PARTICIPANTS

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CREDITS

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REPUBLIC OF KENYA

MDG ACCELERATION FRAMEWORK

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