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# *Harmonizing support to Reproductive Health in Kenya*

Joint Mission

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# List of Abbreviations

| | |
|---|---|
| AFDB | African Development Bank |
| ANC | Ante-Natal Care |
| AOP | Annual Operational Plan |
| APHIA | AIDS, Population, Health Integrated Assistance |
| ART | Antiretroviral Therapy |
| ASRH | Adolescent Sexual and Reproductive Health |
| BCC | Behaviour Change Communication |
| BMGF | Bill and Melinda Gates Foundation |
| BP | Business Plan |
| CBO | Community Based Organisation |
| CDTF | Community Development Trust Fund |
| CEmOC | Comprehensive Emergency Obstetric Care |
| CHEW | Community Health Extension Worker |
| CHW | Community Health Worker |
| CMR | Child Mortality Rate |
| CoC | Code of Conduct |
| CoC | Continuum of Care |
| CPR | Contraceptive Prevalence Rate |
| CS | Community Strategy |
| CSO | Civil Society Organisation |
| CYP | Couple Years Protection |
| DANIDA | Danish International Development Agency |
| DCAH | Division of Child and Adolescent Health |
| DFH | Department of Family Health |
| DfID | Department for International Development |
| DP | Development Partner |
| DPHK | Development Partners in Health Kenya |
| DRH | Division of Reproductive Health |
| DSW | Deutsche Stiftung Weltbevölkerung |
| EAC | East African Community |
| EHS | Support to Essential Health Services |
| EMMS | Essential Medicines and Medical Supplies |
| EmOC | Emergency Obstetric Care |
| EOC | Essential Obstetric Care |
| EU | European Union |
| FANC | Focused Antenatal Care |
| FB | Facility Based |
| FBO | Faith-Based Organisation |
| FHI | Family Health International |
| FP | Family Planning |
| FP/RH | Family Planning and Reproductive Health |
| GBV | Gender-based Violence |
| GDP | Gross Domestic Product |
| GFATM | Global Fund to fight AIDS, Tuberculosis and Malaria |
| GIZ | German International Cooperation |
| GJLOS | Governance, Judiciary, Law, Order and Security |
| GOK | Government of Kenya |
| GTZ | German Technical Cooperation |
| HAKI | Health for All Kenyans through Innovation |
| HCT | HIV Counselling and Testing |
| HENNET | Health NGOs Network |

| | |
|---|---|
| HII | High Impact Interventions |
| HIV | Human Immune deficiency Virus |
| HMIS | Health Management Information System |
| HRH | Human Resources for Health |
| HSPS II | Health Sector Programme Support II |
| HSS | Health System Strengthening |
| HSSF | Health Sector Services Fund |
| ICC | Inter - Agency Coordinating Committee |
| ICPD | International Conference on Population and Development |
| IFC | International Finance Corporation (part of World Bank) |
| IFMIS | Integrated Financial Management Information System |
| IMCI | Integrated Management of Childhood Illnesses |
| IMF | International Monetary Fund |
| IMR | Infant Mortality Rate |
| IP | Implementing Partner |
| IPSAS | International Public Sector Accounting Standards |
| IUD | Intra Uterine Device |
| JICA | Japan International Cooperation Agency |
| JPWF | Joint Programme of Work and Funding |
| KDHS | Kenya Demographic Health Survey |
| KEMSA | Kenya Medical Supplies Agency |
| KEPH | Kenya Essential Package for Health |
| KfW | KfW Development Bank |
| KHWIS | Kenya Health Workforce Information System |
| KJAS | Kenya Joint Assistance Strategy |
| KNASA | Kenya National Aids Spending Assessment |
| KSPA | Kenya Service Provision Assessment Survey |
| LAPM | Long Acting and Permanent Methods |
| LSS | Life Saving Skills |
| LSTM | Liverpool School of Tropical Medicine |
| M&E | Monitoring and Evaluation |
| MCH | Maternal and Child Health |
| MDG | Millennium Development Goals |
| MMR | Maternal Mortality Ratio |
| MNC | Maternal and Newborn Care |
| MNCH | Maternal, Newborn and Child Health |
| MNH | Maternal and Newborn Health |
| MOH | Ministry of Health |
| MOMS | Ministry of Medical Services |
| MOPHS | Ministry of Public Health and Sanitation |
| MOU | Memorandum of Understanding |
| MPER | Ministerial Performance Expenditure Review |
| MPHS | Ministry of Public Health and Sanitation |
| MPND | Ministry of Planning and National Development |
| MSH | Management Sciences for Health |
| MSIK | Marie Stopes International Kenya |
| MTEF | Medium Term Expenditure Framework |
| MTP | Medium Term Plan |
| MVA | Manual Vacuum Aspiration |
| NASCOP | Kenya National AIDS/STI Control Programme |
| NCAPD | National Coordinating Agency for Population and Development |
| NGO | Non-Governmental Organization |
| NHIF | National Health Insurance Fund |
| NHSSP | National Health Sector Strategic Plan |
| NIMES | National Integrated Monitoring and Evaluation System |

| | |
|---|---|
| NMR | Neonatal Mortality Rate |
| NRHS | National Reproductive Health Strategy |
| OBA | Output-Based Aid |
| PAC | Public Accounts Committee |
| PEFA | Public Expenditure & Financial Accountability |
| PETS | Public Expenditure Tracking Survey |
| PFM | Public Financial Management |
| PFMR | Public Financial Management Reform |
| PIC | Public Investment Committee |
| PIU | Project Implementation Unit |
| PLWA | People Living with HIV and AIDS |
| PMTCT | Prevention of Mother To Child Transmission |
| PMU | Project Management Unit |
| PNC | Post-natal Care |
| PPC | Post-Partum Care |
| PPD | Public Procurement Directorate |
| PPOA | Public Procurement Oversight Authority |
| PPP | Public Private Partnership |
| PS | Permanent Secretary |
| PSD | Private Sector Development |
| PSI | Population Services International |
| PSR | Public Sector Reform |
| PSRDS | Public Service Reform and Development Secretariat |
| RCOG | Royal College of Obs and Gyn |
| RDE | Royal Danish Embassy |
| SBA | Skilled Birth Attendance |
| SBCC | Social and Behavioural Change Communication |
| SGBV | Sexual and Gender-based Violence |
| SIDA | Swedish International Development Agency |
| SMNH | Safe Motherhood and Neonatal Health |
| SPS | Strengthening Pharmaceutical Systems |
| STI | Sexually Transmitted Infections |
| SWAp | Sector Wide Approach |
| SWG | Sector Working Groups |
| TA | Technical Assistance |
| TFR | Total Fertility Rate |
| TOR | Terms of Reference |
| TWG | Technical Working Group |
| UNDP | United Nations Development Programme |
| UNFPA | United Nations Fund for Population Activities |
| UNICEF | United Nations Children's Fund |
| USAID | United States Agency for International Development |
| USG | United States Government |
| VfM | Value for Money |
| WB | World Bank |
| WHO | World Health Organization |
| WRA | Women of Reproductive Age |
| YFS | Youth-Friendly Services |

Exchange rates used:
US$ 1 = KSh 85
EUR 1 = KSh 120
EUR 1 = US$ 0.71
£ 1 = US$ 1.60
US$1 = DKK 5

# Executive summary

In the context of Kenya's challenges in the area of *Reproductive Health* (RH) and the persistent high *maternal mortality* (MM) in particular, a group of five Development partners (DPs) in RH has commissioned this report together with the Ministry of Public Health and Sanitation (MOPHS, DFH and DRH in particular), and the Ministry of Medical Services (MOMS). The commissioning DPs include DANIDA, DFID - Department for International Development, GDC - German Development Cooperation (GIZ and KfW Development Bank), USAID, and the BMGF - Bill and Melinda Gates Foundation.

The ToRs specify three *objectives*, namely (1) recommend/define prioritised appropriate and cost-effective support to RH by participating DPs, (2) define priority support gaps, and (3) recommend support modalities that are as aligned and harmonised as is feasible.

The *mission team* comprised five consultants from several different countries: Marilyn McDonagh, Harmonisation, Rachel Phillipson, Health economics, Dhimn Nzoya, Health economics, Kawaye Kamanga, Health systems strengthening, and Luise Lehmann, Reproductive health and Team leader. The mission was carried out from 13th February to 4th March, 2011.

Maternal mortality is generally acknowledged as a failure of overall health systems. Health services more broadly, and RH specifically, are fundamentally *systems* - i.e. a group of interacting and interdependent elements forming a complex whole. Action is needed on a range of fronts simultaneously. Thus, the relative strengths of the health system components dictate the speed, efficiency and effectiveness at which an effective continuum of care for RH can be delivered and scaled up. It is well documented that the most effective way to improve Maternal and Newborn Health (MNH), is through the delivery of evidence-based packages of integrated care that provide a *Continuum of Care (CoC).* This includes the reliable provision of a wide range of modern *Family Planning* methods which is the most effective intervention to avoid (unintended) pregnancy and consequently maternal mortality.

The consultants assessed the current situation in Kenya through studying international and national documents and visiting a number of Kenyan regions with DP supported programmes. An assessment was made of a number of key areas of concern including: (1) the implications of the new Constitution and the upcoming devolution of government responsibilities for RH; (2) health and RH policy framework documents; (3) the distribution of DP support to the area of RH (mapping); and (4) RH as integral part of the six health systems building blocks defined by WHO. Based on these assessments, a number of recommendations were identified with regard to the areas of health financing, aspects of service delivery, human resources for health (HRH), health information (HMIS and operational research), RH commodities, infrastructure, governance and harmonization.

RH is a key aspect of GoK policies and has been given a high priority in all framework documents. The right to health and RH as well as social equity stipulated in the new Constitution pose an important challenge for the future structure of the health system. As the devolution process and the design of the future systems unfold, the consultants have highlighted the implications

that devolution may have on health financing, DP support and also the risks for RH in a devolved system. DPs are recommended to respond to these challenges by providing immediate technical assistance to the MoHs in this process and to review their own agreed code of conduct in the context of the SWAp.

Revisions of policy documents that are due in the near future should take the RH focus of the new constitution into consideration. With regard to policy documents governing RH implementation there is a general lack of priority setting and costing, which makes it difficult to use them as a basis for planning strategic interventions and support. This applies particularly to the national RH Strategy, the 2011 Acceleration Plan for the Attainment of Maternal and Newborn Health (High Impact Interventions - HII), and to the Community Strategy.

The *mapping* exercise to show DPs' intervention areas in RH in Kenya in order to identify gaps or over-emphasis was a time consuming exercise as the information was not readily available in the existing reference documents. The consultants sought to include information from some of the other major DPs in the RH sector, (the UN and the World Bank) to ensure the completeness of the mapping exercise.

From the information gathered, it can be concluded that family planning and maternal & child health – both the provision of TA and of commodities – is well covered by DP inputs. Adolescent sexual health and gender – both rights and more specifically, gender violence issues – are addressed directly much less often by the major DPs. ASRH and GBV/HR are the most important gaps in DP support to RH.

It is noted that of the *committed or allocated DP funds,* over 60% is to be spent on procurement. A further 10% each is to be spent on human resources, M&E and various efficiency measures and support for non-state actors. Only 4% is committed to providing support to financing (either actual financial support or TA for financial planning) and 2.5% to governance and leadership. The *geographical mapping* exercise shows that DPs are present in some form in practically every district of Kenya – mainly due to the comprehensive coverage of APHIAplus. Danida and the World Bank, through their financial support to the nationwide roll-out of the HSSF will also theoretically be in every district - though this has yet to be fully implemented.

DPs tend to be clustered in Coast Province – due to the presence of Danida – and Nyanza and Western provinces – due to DFID. Mapping of thematic areas and DP harmonization demonstrate that the indicators of DP supported programmes are generally in line with framework documents and the RH strategy in particular. However, they are quite diverse in their formulation.

The conclusion from mapping existing DP support to RH is that the current DP reporting mechanisms for the allocation of funding, TA and monitoring spend are too broad to allow a gap analysis or to develop recommendations for priority interventions and support. It is therefore recommended that the MOPHS should develop an evidence-based and costed RH-Business Plan (BP) with core indicators which can be used to prioritize and report against. DPs should be asked to provide TA for developing the RH BP.

With regard to *health financing*, the main recommendations are to continue the revision of the Health Financing Strategy; promising pilot PPPs, demand side approaches and financing mechanisms (such as social franchising, OBA voucher schemes, community health insurance) should be continued and carefully expanded in order to demonstrate working innovations. The impact of such innovative interventions on user fees and cost of access should be monitored.

The constraints in *service delivery* concerning ANC, MNC and FP show that a number of shortfalls in general service provision are causing poor outcomes. To achieve significant progress in reducing the morbidity and mortality attributable to complications during the antenatal period, labour and post delivery, there will have to be substantial improvements in service delivery in general and in the coverage of sustainable high impact interventions (HII) for both mothers and newborns in particular. The consultants see the HII acceleration plan developed in Nakuru 2011 as an important first step to improve RH services. The next step should be to define and agree on the minimum packages identified in the continuum of care, including critical health systems components and to ensure solid linkages between the packages to deliver an effective continuum of care. It is recommended that this ***expanded HII acceleration plan*** should form the basis for an ***RH Business Plan***.

The focus for joint DP commitment in RH should be: ***(1) to scale up skilled birth attendance and (2) emergency obstetric care; and (3) to make family planning more reliable and address unmet need.*** This will require joint planning and up-scaled support of training in CEmOC, including Life Saving Skills (LSS) also for normal deliveries. For Family Planning, a whole range of improvements in procurement and logistics needs to be implemented. The focus should be on long-acting and permanent methods (LAPM) and outreach particularly to rural areas.

While poor women of reproductive age are the general target group for improved RH services, special attention should be given to adolescents and young people. Youth-friendly corners in health facilities and multisectoral comprehensive ASRH programmes should be supported. Information about services and demand creation should be addressed by jointly supported RH communication for which relevant costed policies and implementation guides exist and are ready to implement. Overall, the health system in Kenya relies on different sectors and *non-state service provision* (PPP) contributes highly to RH. It is recommended to create a forum for dialogue to ensure stewardship of the MoH at all levels. With regard to social franchising, a special area of DP support, there is a need to harmonize the existing approaches.

*Human resources for health (HRH*) is an area of great concern in Kenya as RH services experience particular problems regarding the availability of trained and specialized personnel for skilled birth attendance and emergency obstetric care. There is a need to accelerate the application of incentive packages for working in hardship areas and to contribute to pooled efforts for TA or HRH recruitment. Trainings should be planned and carried out in close consultation with district / county health management in order to avoid vacancies and to ensure that staff with appropriate skills are posted to rural areas.

*RH commodities* are a constant concern in the Kenyan health system and multiple stock-outs of essential commodities hinder service availability. It is recommended that all RH commodities (including contraceptives) are integrated into the general supply chain management and the relevant policy document should be broadened to encompass an RH commodity security strategy. The respective ICCs for RH and for Procurement should be mutually involved. It is also urgent to streamline the "Pull" and "Push" system where possible to avoid waste and/or artificial shortages. A remedy could also be to factor RH commodities into the health facility drawing rights for the EMMS.

In regard to *infrastructure*, it is noted that even at current levels of service demand, many facilities can hardly cope with customer demand. It is therefore recommended that the rehabilitation and expansion of existing facilities should be accelerated. DPs should allocate additional funds for infrastructure and equipment in level 2 and 3 facilities, especially in high need areas like Nyanza, Western, Coast and North Eastern Provinces.

*Governance and harmonization* have been reviewed looking at both the general SWAp environment and the specific RH domain. As has been stated above, the MOPHS (together with MOMS) should be supported to build on the HII acceleration plan to develop an effective continuum of care and an evidence-based and costed RH Business Plan. It should include an agreed set of core indicators that can be used to harmonize and coordinate all support to RH in Kenya and help Kenya achieve MDG4 & 5. With regard to managing the RH area, it is recommended that the MOPHS strengthens public health management skills at the DRH and provides more coherent management of ASRH. It is proposed to strengthen the capacity of the DRH through TA provided by a *Health Systems Advisor*.

Regarding the *modalities* of future harmonized DP support to RH, it is recommended that the following mechanisms are established:

- *A RH Business plan* to be the core document against which to allocate and report funding and TA;
- One *RH TA plan* supported through pooled funding - at minimum one TA plan reflecting all support (virtual pooling) being provided to RH for the implementation of the RH plan;
- Pooled funding, where possible: DPs should support existing *SWAp baskets* such as HSSF, EMMS and HRH, at a minimum it is suggested to support them through joint planning ("virtual pooling");
- One RH commodity plan, including contraceptives *and* essential MNH commodities;
- Regular review of the Code of Conduct at central level;
- New Code of Conduct at district / county level.

In addition to harmonizing and eventually scaling up ongoing and planned support, the following areas are suggested for new joint DP support:

- *Strengthen the capacity of the DRH.* Additional TA should be provided to DRH in the form of a *health systems adviser* either embedded in the DRH or placed in WHO (e.g. as part of the Health Systems Strengthening currently funded by DFID).

- *A joint programme to scale up the coverage of Skilled Birth Attendance (SBA):* Immediately support a joint programme to accelerate the training of LSS – EONC through the pooled RH TA plan and RH commodity plan country – wide.
- *Strengthen the DP/IP harmonization at district/county level.* It is recommended that TA to DHMTs /County HMTs should be provided in order to develop and implement a coordination mechanism that allows proactive and results-based implementation of the CoCs (e.g. a new component of GIZ TA eventually co-financed by DPs).
- *Joint support of RH Communication:* All DPs should ensure in their respective areas that the planned campaigns are carried out in a coordinated way. There is a need for co-financing, which could be done through funding from Danida or the KfW Development Bank (IEC Fund).
- *Joint support to the OBA voucher scheme*: It would be important to scale up this pilot scheme and also test new options and technologies in managing the vouchers, the type of services to be covered, etc.
- *Joint support to enhance comprehensive interventions for ASRH, including YFS:* As the most promising approach is a combined multisectoral strategy, strategic planning of a joint up-scale of interventions in various sectors based on the new information about youth's needs in Kenya and best practice analysis is justified in view of the magnitude of ASRH needs.

# 1 Introduction

## 1.1 Terms of reference and mission team

In the context of Kenya's challenges in the area of Reproductive health (RH) and the persistent high maternal mortality ratio in particular, a group of five Development partners in RH commissioned this report together with the Ministry of Public Health and Sanitation (MOPHS, DFH and DRH), and the Ministry of Medical Services (MOMS). The commissioning DPs include DANIDA, DFID - Department for International Development, GDC - German Development Cooperation (GIZ and KfW Development Bank), USAID, and the BMGF - Bill and Melinda Gates Foundation.

The ToRs specify three objectives: (1) recommend/define prioritised appropriate and cost-effective support to RH by participating DPs; (2) define priority support gaps; and (3) recommend support modalities that are as aligned and harmonised as is feasible (ToRs included in annex 8.1). The ToRs stipulate that while the focus is on RH, the overview should be holistic, assessing inequity, health systems, institutional arrangements/capacity (DPs, implementing partners as well as GOK), including a forward look related to the challenges around decentralisation in accordance with the new Kenya Constitution. The shape of future DP support should be presented holistically, incorporating a programme approach, including all areas supported by key stakeholders, rather than lists of individual DP priorities. Modalities should attempt to incorporate optimally harmonised approaches within the limitations and constraints of individual DPs. Transaction costs should be minimised.

The mission team comprised five consultants from several different countries: Marilyn McDonagh, Harmonisation, Rachel Phillipson, Health economics, Dhimn Nzoya, Health economics, Kawaye Kamanga, Health systems strengthening, and Luise Lehmann, Reproductive health and Team leader. The total duration of the mission was from 13th February to 4th March, 2011, but only the two experts on HSS and RH worked in-country during this time while the other three joined the mission from 20th March onwards.

## 1.2 Methodology

In response to the ToRs that call for holistic analyses that take account of the complexity and interconnectedness of the various issues to be analyzed in this report, the consultant team grouped the issues in line with the WHO Health Systems Framework (Building blocks). This WHO Framework conceptualizes the health system as comprising of six main domains, i.e. Service Delivery, Human Resources for Health (HRH), Health Management Information System (HMIS), Medicines and Technology, Health Financing, and Leadership and Governance. This was justified on the grounds that maternal mortality is generally acknowledged as a failure of overall health systems and not only related to RH specific constraints.

The consultants carried out field visits to Nyanza, Western, Eastern, and Coast Provinces, as well as to low-income areas in Nairobi: Korogocho, Dondera, and Stahere districts. The following DP supported projects and

implementing partners (IPs) were visited: DFID supported EHS in Rongo district / Nyanza and a community unit in Nyakuru, USAID supported APHIAplus projects in Kakamega for Western and Nyanza province and in Embu for Eastern and Central province, GIZ in Vihiga district, Danida supported facilities at Vipingo and Mtwapa, Kilifi District in Coast province, PSI and a Tunza clinic in Dondera, KfW supported OBA / voucher scheme with EPOS and PROVIDE NGO clinic in Korogocho, Jhpiego with various projects including Tupane (BMGF), FHI, MSH with SPS, Population Council, Liverpool VCT, and EU supported DSW Safe Motherhood Project in Stahere.

At national level, a number of official representatives were met from a number of departments and divisions of MOPHS and MOMS, Ministry of Education, Ministry of Youth Affairs, NCAPD, and the SWAp Secretariat. At decentralised level, the team met PHMTs, DHMTs, as well as a CHEW and CHWs. The team also consulted some other resource people in the fields of health economics and legal support of the devolution process.

Various Steering Committee meetings were held with representatives of the MOPHS, DPs and other stakeholders, and individual and/or small group meetings with DANIDA, DFID, GDC (GIZ and KfW), USAID, World Bank, UNICEF, UNFPA, and WHO.

An important limiting factor was that the mission took place at a time when many key informants, particularly government representatives, were often unavailable due to consultative meetings on the devolution process, the development of the new health policy framework in the country and AOP planning sessions. Overall, time constraints reduced the time for common analysis among the team and led to the need to continue research after the in-country mission had ended. Consequently, the dates for submission of the report were changed.

# 2 Background

## 2.1 Reproductive Health in Kenya

The First Medium Term Plan (MTP) of Kenya's Vision 2030 acknowledged the growing concern of reversals in Reproductive health (RH) gains made in the 1980s and early 1990s.The Government of Kenya is committed to achieving the Millennium Development Goals (MDG) to ensure, inter alia, that adverse RH outcomes are reversed.

With regard to RH, MDG 5 stipulates to "Improve maternal health". Two major targets shall be achieved:

- Target 5a: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio.
- Target 5b: Achieve, by 2015, universal access to reproductive health.

The national MDG targets to be achieved by 2015 have been quantified in Kenya's Second National Health Sector Strategic Plan 2005-2010 (NHSSP II). Currently there is particular concern that, in contrast to other MDGs, progress towards MDG 5 is very slow.

The results of the Kenya Demographic and Health Survey (KDHS) 2008-09 show that the maternal mortality ratio (MMR) is estimated at 488 per 100,000 live births, while the MDG target has been set at 147. The fact that the maternal mortality ratio (MMR) was at 488 per 100,000 live births in 2008-09, is particularly alarming as the KDHS 2003 had reported an MMR of 414. Though statistically not significant, it implies that the MMR has not improved. Recent WHO estimates (2010) show an MMR of 530 with a lifetime risk of maternal death of 1:38. The KDHS 2008-09 estimates a fertility rate (TFR) of 4.7 children per woman. Neonatal mortality in Kenya was estimated at 31 per 1,000 live births. These indicators have geographic variations, with North Eastern, Nyanza, Western and Coastal Provinces having the worst statistics.

The second indicator refers to the proportion of births attended by a skilled provider (doctor, nurse or midwife), which was 44% in 2008-09 and is supposed to increase to 90% by 2015.

Indicators for target 5b also include the contraceptive prevalence rate (CPR) for any FP method, aiming at 70% of married women of reproductive age in 2015, but having reached only 46% in 2008-09. While KDHS 2008-09 shows a CPR (any method) of about 46%, the CPR of modern methods is only 39%. As family planning is the most cost-efficient strategy to reduce maternal mortality, it is important to recognise that despite this relatively high CPR, there is a persisting high unmet need for contraception of 26% among Kenyan women of reproductive age.

Adolescent fertility in Kenya is high. The adolescent birth rate is estimated at 103 per 1,000 women 15-19 years (KDHS 2008-09). The differential in teenage fertility between urban and rural women is 92 to 107. The levels of teenage childbearing are highest in Nyanza (27 percent) and Coast (26 percent) provinces and lowest in Central province (10 percent). This conforms

to other social indicators of development such as education that influence a delay in the onset of childbearing. 32 per cent of uneducated teenage girls have begun childbearing, compared with only one-tenth of those with some secondary education and above. Similarly, teenagers from poorer households are more likely to have begun childbearing (24 percent) than are teenagers from wealthier households (16 percent). (KDHS p. 56) Generally, the percentage of teenagers 15-19 years who have begun childbearing declined from 23 percent in the 2003 KDHS to 18 percent in the 2008-09 KDHS and is below the 21% stated in 1998.

However, compared to the average in the Sub-Sahara African (SSA) region, Kenya's indicators are among the more advanced. The SSA region has the highest maternal mortality ratio in the world, estimated at an average of about 640 per 100,000[1]. This high maternal mortality (MM) combined with the low contraceptive prevalence rate of about 22% (2007)[2] and the high fertility rate estimated at 5.6 children per woman (WHO 2005), increases the lifetime risk of a woman dying of pregnancy related complications to 1:31 in SSA, compared to 1:4,300 in developed countries (WHO 2010). The average adolescent birth rate in SSA is estimated at 121 per 1,000 women 15-19 years (WHO).

## 2.2 Critical issues in reproductive health

It is well documented that maternal mortality is a failure of the health system. It is recommended that strategies to reduce maternal mortality should focus on building a functioning health care system from at least first-referral facilities to the community level[3].

International evidence shows that maternal mortality can be significantly reduced by **three critical interventions** that make the following accessible to all women of reproductive age:

- a wide range of contraceptives to avoid pregnancy;
- skilled attendance at each delivery;
- basic and comprehensive emergency obstetric care (BEmOC and CEmOC).

With regard to giving birth, timing is critical in preventing maternal death as most women in Africa die in pregnancy and during labour mainly because of **three major delays**[4]. The 'three delays' model (see below) has proved to be a useful tool to identify the points at which delays can occur in the management of obstetric complications, and to design measures and structure the health system to address these delays.

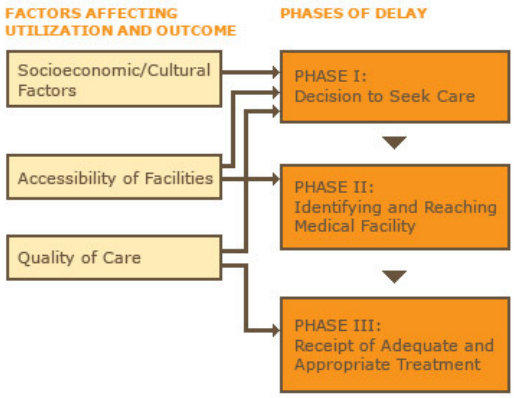
The first two "delays" (delay in deciding to seek care and delay in reaching appropriate care) relate directly to the issue of access to care, encompassing factors in the family and the community, including transportation. The third

[1] WHO, 2010, *Trends in maternal mortality: 1990 to* 2008
[2] United Nations, 2010, *The Millennium Development Goals Report 2010*
[3] Freedman, Lynn et al. Who's got the power? Transforming health systems for women and children. UN Millennium Project 2005

[4] The Safe Motherhood Initiative launched in 1987, the Making Pregnancy Safer Initiative launched in 2000 (both by WHO) and the World Health Report 2005 "Make Every Mother and Child Count". The UNICEF presentation made at the Nakuru Meeting in January 2011 and discussions with FHI also gave a similar picture for Kenya.

"delay" (delay in receiving care at health facilities) relates to factors in the health facility, including quality of care. Unless the three delays are addressed, no safe motherhood programme can succeed. In practice, it is crucial to address the third delay first, for it would be useless to facilitate access to a health facility if it was not available, well-staffed, well equipped and providing good quality care. [5]

Figure 1 Three phases of delay




Source: UNFPA website http://www.unfpa.org/public/home/mothers/pid/4383

Regarding Maternal and Newborn Health (MNH), it is well documented that the most effective way to reduce maternal mortality is through the delivery of evidence-based packages of integrated care and coverage of targeted interventions that provide a **Continuum of Care (CoC).** Science in Action[6] defines a continuum of care for MNH as

> *"a core organising principle for health systems that emphasises seamless linkages between health care packages across time and through various service delivery strategies".*

They recommend that a CoC for MNH is made up of 4 critical areas with a defined basic package of care; pre-pregnancy; pregnancy, birth; newborn/ post-natal care within 2 days covering clinical, outpatient and community. A functioning continuum of care for MNH relies on these integrated health packages to deliver a range of high impact interventions (HII). It is recognised that each country is at different stages in delivering the packages and therefore each country needs to define the critical components that should make up the minimum basic package to be delivered and this can and should be expanded as resources become available.

Science in Action analysed the situation in Kenya and calculates that 80% of maternal, newborn and child (MNC) deaths could be avoided if Kenya were to scale up the coverage of high impact essential MNCH services to 90%. It recognises that at the moment most countries are not at the coverage levels required but has further analysed the data looking for intermediate actions that could make a difference whilst coverage is increasing. For Kenya they are proposing that a critical component – and therefore the priority intervention - is the availability and access to **Comprehensive Emergency**

[5] UNFPA website http://www.unfpa.org/public/home/mothers/pid/4383
[6] Science in Action: Saving lives of Africa's mothers, newborns, and children. 2009

**Obstetric Care (CEmOC).** It estimates 19% of maternal deaths could be avoided per year if all mothers currently giving birth in health facilities had access to CEmOC.

The study estimated the per capita cost to be $0.30 for drugs, equipment and personnel time. This means that the total recurrent budget cost would be around US$12 million per year. There would be additional costs of increasing the number and skills of the health professionals and for ensuring access through some form of health financing covering the costs of transport etc. The former has been separately estimated[7] to require a doubling of staff, the training cost of which could be in the region of US$ 2 million. Other costs of access would be marginal.

[7] Rising to the Challenges of Human Resources for Health in Kenya. Developing Empirical Evidence for Policy Making, July 2006. The estimate refers to "delivery care".

# 3 Implications of the devolution under the new Constitution for Kenya's health system and RH

## 3.1 Background

The promulgation of the new Constitution in August, 2010 has profound implications for the health system in Kenya in three ways:

1. The new Constitution includes a Bill of Rights which states that every citizen has the right to life, quality healthcare including reproductive health care, emergency care, clean, safe & adequate water, reasonable standards of sanitation, food of acceptable quality and a clean & healthy environment.[8]
2. The devolution to new county governments of responsibility for (*a*) county health facilities and pharmacies; (*b*) ambulance services; (*c*) promotion of primary health care;
3. The fiscal devolution context in which government resources for these responsibilities will be allocated.

County governments will come into being at the December 2012 elections. County governors and assembly members will be elected at this time – as will the next President and Parliament.

Before then, an Act of Parliament transferring functions to the counties must be passed, infrastructure for the county governments set up and staff identified. The Act must set out the ways in which the national government will help new county governments to build their capacity to fulfil their new responsibilities. According to the Constitution, this Act may establish criteria that must be met before particular functions are devolved; and it may permit the asymmetrical devolution of powers to ensure that functions are devolved promptly to counties that have the capacity to perform them but that no county is given functions it cannot perform;

The Constitution allows for a transition period of three years starting from the creation of the counties in 2012 over which this transfer of functions shall take place. This means that the Ministries of Health and DPs have four and a half years from now in which to plan for, and implement, a smooth transition of responsibilities. Other key points of the Constitution to note are:

- Counties are to receive "not less than" 15% of total government revenues every year;
- The exact share received by counties is to be determined on criteria devised by a Commission on Revenue Allocation and approved by the Senate. The criteria will be reviewed every three years for the first two "determinations", then every five years.
- An Equalisation Fund, worth 0.5% of annual total government revenues, is to be set up and used to fund measures aimed at disadvantaged groups and areas.

[8] The Bill of Rights Article 26 and Article 43 explicitly confer the right to health in general and to reproductive health in particular. Article 26 of the constitution provides that every person has the right to life and that life begins at conception. The Article 43 further provides that every person has the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care. Article 43(2) states that a person shall not be denied emergency medical treatment while Article 43(3) says that the State shall provide appropriate social security to persons who are unable to support themselves and their dependants.

- Representative bodies, including commissions and elected assemblies, must maintain a gender balance, in that "not more than two-thirds of the members ...shall be of the same gender."
- Provincial administrations must be "restructured to accord with and respect" the new system of devolved government within five years. All local governments will continue in existence, unless it is chosen to abolish them by Act of Parliament.

## 3.2 MoH documents and actions to date relating to devolution

The Constitution defines the role of the Ministry of Health Headquarters as providing national leadership and stewardship on health matters. The central level will be responsible and accountable for quality and quantity of health care to ensure physical access, affordability, acceptability and equity to all people. Emphasis will be placed on preventive and promotive health services where the impact on health will be greatest.

The Ministries of Health (MoH) will lead the process to develop a new policy framework that will take into account the Vision 2030, the Constitution and other public reforms. The County government will provide county leadership and stewardship on health matters. It will be responsible and accountable for implementation of national policies, strategies and guidelines. (MOH 2011)

Both Ministries of Health have already embarked on a process of implementation of the Constitution, setting up various commissions and task forces to guide the elaboration of the necessary legal framework. A position paper aimed at guiding the Task Force on Devolution on key issues relating to health is in advanced draft. It identifies the decisions around definitions, timing, criteria, transfer of ownership and divisions of responsibility which must be made in each of the key areas in order to make progress towards effective devolution.

## 3.3 Assessment

Devolution which includes the decentralisation of health care can have positive effects through:

(a) increasing local ownership and accountability;
(b) improving community participation and responsiveness to local needs;
(c) strengthening integration of services at the local level;
(d) enhancing the streamlining of services; and
(e) promoting innovation and experimentation.

On the other hand, it can also exacerbate inequities, weaken local commitment to some public health issues and decrease the efficiency and effectiveness of service delivery by disrupting the referral chain.

Reproductive health services are particularly prone to these negative effects, since some (e.g. family planning) are controversial and thus susceptible to local pressures, and others (e.g. emergency obstetric care) are dependent on a functioning, integrated, health system. Experience from other parts of the world suggests that these negative unintended consequences do arise in RH, and we summarise them in the table 1 below.

Table 1. Reproductive Health implications of devolution

| Aspects of health system | Unintended consequences of devolution | Implications for RH services |
|---|---|---|
| Delivery of services | Fragmentation of referral care<br>National government unable to influence local decision-making | Safe motherhood services adversely affected<br>Provision of family planning services may be a national priority but not implemented by some local governments |
| Financing of services | Non-earmarked transfer of funds<br>Resource allocation not based on revenue-generating capacity at local level<br>Curative care bias of government spending not addressed. | Some local governments do not invest in priority health areas such as family planning<br>Income inequities exacerbated; access to reproductive health services of those in greatest need suffered<br>Under-funding of preventive reproductive health care. |
| Institutional capacity | Reorganisation of roles & responsibilities between central and local<br>Speed and scale of devolution may exacerbate institutional constraints at local level. | Centre does not provide vision for comprehensive reproductive care to local levels<br>Local level unable to effectively manage reproductive health services. |
| Health personnel | Cash-strapped local govts fail to honour national pay awards for public employees<br>Local integration of services creases workload of front-line workers | Staff morale and quality of reproductive care adversely affected<br>Midwives unable to meet the reproductive health care needs of the population they serve |
| Quality of care | Loss of integrity of referral care; under-funding of preventive care; low personnel morale; increase in workload of midwives<br>Budget constraints lead to cuts in in travel, training, supervision | Negative implications for quality of care<br>Reproductive health skills eroded<br>No technical support or quality guidance for devolved workers |
| Local representation | Local level susceptible to strong conservative pressures<br>Local representation of women in decision-making capacities low<br>Large number of local governments units responsible for service delivery. | Traditionally controversial areas such as family planning and STDs targeted for cuts<br>Limited voice for women in decisions on RH<br>Efforts needed to build support for RH services |

The consultants believe that many of these risks are present in Kenya. Awareness of the potential pitfalls, early planning and early engagement with the devolution process – in order to lobby with the commissions and lead ministries - will reduce them. The

[9] Taken from: Lakshminarayanan, R. Decentralisation and its Implications for Reproductive Health. Reproductive Health Matters, 2003.

Ministries of Health, with their position paper are clearly already taking steps to rise to the challenge.

DPs should do likewise, noting that the institutional changes set out in the Constitution present a new set of incentives and imperatives into which future support will feed. The main new incentives appear to be:

- the clear and immutable timelines and deadlines set out in the Constitution.
- the opportunity to ensure that new resource allocation criteria for the counties take into account the costs of their health responsibilities (and the pretty clear consequences if they don't);
- the threat of the discontinuity in some of the health services that the new counties represent;
- prospect of a new local democratic element (with more self-governance and new participation) in decision-making processes;
- the new gender quotas.

The new Kenyan Constitution has brought with it new challenges and also new opportunities. The current provincial and district structures and boundaries will be replaced by County structures and boundaries. The County Health Management Teams that will be constituted require orientation on health planning and management. The teams will also need to be supported in developing health management competences in general and competences in health programs management in particular. This is critical because there is need to ensure that programs like RH do not suffer reverses as a result of these governance reforms. With the advent of devolution, strengthening of the regulatory framework becomes paramount.

## 3.4 Recommendations

DPs should urgently provide TA to MoH to support the Ministries in being proactive in navigating in the new constitution and the implications of the devolution on the RH sub-sector. This support should be provided at national and sub-national level.

DPs need to review their Code of Conduct especially as to how it would operate at County Level.

# 4 Appraisal of framework documents related to Health and RH in Kenya

## 4.1 General health policy frameworks

**The Health Policy Framework, 1994-2010** and successive 5-year National Health Sector Strategic Plans (NHSSP I /1999-2004 and NHSSP II / 2005-2010) set the targets and processes driving the health sector development as well as the healthcare service delivery. The aim of the policy was to introduce reforms specifically in the way the healthcare services are organized, financed, delivered and evaluated. The goals of the health policy were:

- Ensure equitable allocation of Government of Kenya resources to reduce disparities in health status;
- Increase cost-effectiveness and efficiency of resource allocation and use;
- Manage population growth;
- Enhance the regulatory role of the government in health care provision;
- Create an enabling environment for increased private sector and community involvement in service provision and financing; and
- Increase and diversify per capita financial flows to the health sector.

These goals are still valid and have informed to a large extent both Vision 2030 and its Medium Term Plan (2008-2012). Important approaches and innovations of the health policy and more so of NHSSP II were: the concept of the Kenya Essential Package for Health (KEPH), the Community Strategy, the Joint Framework of Work and Financing (JPWF) - an essential element for entrenching the Kenya Health Sector-Wide Approaches (KHSWAp) and finally the Annual Operational Planning (AOP) process. These approaches are increasingly becoming a feature of the health sector. The evaluation of the implementation and the impact of the Health Policy Framework has been concluded and the results are currently being used to inform the development of the next round of policies for the health sector.

**National Health Sector Strategic Plan II 2005-2010 (NHSSP II):** The objective of the broad NHSSP II strategy is to reverse the downward trends in the health indicators to achieve the MDGs. RH is well reflected in the NHSSP II under cohort 1, 4 and 5 [10]. The system is struggling to adequately respond to the health needs of the population in general and to that of mothers and newborns in particular. This contributes to the high morbidity and mortality due to complications during the antenatal period, during labour and in the post delivery period.

Preparations will soon be under way to develop NHSSP III. Concerns were expressed to the mission about a lack of participation when NHSSP II was being developed leaving many partners feeling excluded. This has resulted in limited ownership by some partners of what should be the leading strategy for the health sector and it is hoped that this will be different when preparing for NHSSP III.

The finalization of the development of the next health sector policy beyond 2012 may have to wait for some clarity on the architecture of the sector in the devolved governance of functions and structure. And since most DPs align their support to the Sector Plan, it follows that the DPs be prepared for a scenario where the thrusts of

[10] Cohort 1: Pregnancy, delivery, newborn child; Cohort 4: Adolescence; Cohort 5 Adulthood

the Sector Plan may vary to reflect County peculiarities and where their main partners at lower levels may change in name, functions (mandates) and structures. The reporting and communications channels may also change correspondingly.

**Vision 2030**: This key framework document was adopted in 2007. It provides guidance to develop Kenya towards prosperity and involves the building of a just and cohesive society, enjoying equitable social development in a clean and secure environment. This goal is the basis of transformation in eight key social sectors, including the health sector.

To improve the overall livelihoods of Kenyans, the country aims to provide an *efficient and high quality health care system with the best standards.* This will reduce health inequalities and improve key areas where Kenya is lagging, especially in lowering infant and maternal mortality. Specific strategies will involve: provision of a robust health infrastructure network; improving the quality of health service delivery to the highest standards and promotion of partnerships with the private sector. In addition the Government will provide access to those excluded from health care by financial reasons. The Vision 2030 health sector flagship projects for 2012 are to:

- Revitalise Community Health Centres to promote preventive health care (as opposed to curative intervention ) and by promoting health of individual lifestyles;
- Delink the Ministry of Health from service delivery in order to improve management of the country's health institutions;
- Create a National Health Insurance Scheme in order to promote equity in Kenya's health care financing;
- Channel funds directly to hospitals and Community Health Centres (as opposed to district headquarters),
- Scale up the output-based approach system to enable disadvantaged groups (e.g. the poor, orphans) to access health care from preferred institutions.

## 4.2 Health financing

The GoK and DP documents relating to financing in the health sector are:

- The Second National Health Sector Strategic Plan (NHSSP II) 2005-10: Reversing the Trends, 2004.
- The Second NHSSP Midterm Review, November 2007.
- Social Protection in Health: Policy and Financing Strategy, March 2009.
- 2008 Public Expenditure Tracking Survey, GoK March 2009.
- Kenya Health Sector Programme Support Phase iii (2012 – 2016), DANIDA Jan 2011.
- Health Sector Support Project Appraisal Document, World Bank June 2010.
- Reproductive Health Voucher Scheme (Output Based Approach), Design Mission Report, EPOS/KfW/NCAPD July 2010.

The key document summarizing the principles, policies and timetable for the specific measures around health financing is "Social Protection in Health: Policy and Financing Strategy, March 2009". The Strategy's genesis has been slow and difficult. A National Task Force for Health Financing was established in late 2006 to re-define a national strategy but was interrupted by the post-election crisis of 2007/8. A new strategy was finally agreed with major stakeholders in 2009 and endorsed by the National Social and Economic Council (NESC) only in early 2010. The aim of the

Strategy is to achieve equity of access to, equity of finance for and financial risk protection [11] through:

- Expanding coverage of the National Health Insurance Fund (NHIF)
- Improving private health and other social health insurance systems
- Protecting the poor
- Increasing PPPs
- Improving health regulation and standards
- Improving capacity and quality in the public health system.

The Strategy's key institutional reforms relate to the NHIF – splitting it into separate revenue collecting and purchasing agencies and creating a new Access and Equity Fund. These changes have not yet happened, the NHIF proving a difficult institution to open up and reform.

With the central pillar of institutional reform effectively stalled, GoK has concentrated on other elements of the strategy, most prominently a range of pilots of demand-side and PPP approaches and improving capacity and quality in public sector through a national roll-out of the HSSF All are predominantly funded and led by development partners, with little obvious leadership from GoK. At the same time, the passing of the new Kenyan Constitution is changing some important features of the institutional context for public sector finance which the current Health Financing Strategy does not capture.

## 4.3 RH implementation

In Kenya, the area of reproductive health (RH) is regulated by a number of framework documents issued by the Ministry of Health. (since 2008 the Ministry of Public Health and Sanitation and the Ministry of Medical Services).

The **National Reproductive Health Strategy** 2009-2015 is based on the **National Reproductive Health Policy 2007**. The RH Strategy is a very broad document covering all areas of RH with over 65 strategies, 31 outputs and 10 thematic areas including cancers and the elderly but there is virtually no reference to commodity security. As it stands the RH Strategy states that the following areas will be priorities:

- safe motherhood;
- maternal and neonatal health;
- family planning;
- adolescent/youth sexual and reproductive health;
- gender issues, including sexual and reproductive rights.

However, the RH Strategy does not give advice or direction on what, and how, these areas could be supported. Whilst a strategy can be broad, it is important that some clear direction is given about focus.

The **Road Map for Attainment of Maternal and Newborn Health (MNH)** was developed to try and agree on where to focus support for MNH. However, the Road Map does not represent a cost-effective evidence based package of care. There are also some technical gaps such as exclusive breastfeeding, maternal nutrition and it is not focused on evidence based cost–effective interventions. It remains too general and too unfocused. Although the MNH Road Map is costed, these are referred to as

[11] as defined by the 2005 WHA (World Health Assembly) resolution on sustainable health financing

additional funding requirements and it is therefore very difficult to use this to assess resources required and any gaps there may be.

**Acceleration of Maternal, Newborn and Child Survival in Kenya using High Impact Interventions (HII)**[12] is often referred to as the **Nakuru** meeting of January 2011, where participants from the districts and implementing partners came together to agree on a package of evidence based and high impact interventions. This was supported by the MOPHS. The plan is a fresh impetus to re-focus on HII and prioritizes the activities within HII, assigns specific tasks to national, provincial, district and community levels and commits all actors to timelines. Districts have been asked to ensure that these key activities are represented in the AOP 7 (2011-12) and that resources for its implementation are mobilized.

The HII Acceleration Plan is an excellent first step in developing an evidence-based cost effective package to guide the districts towards achieving MDG 4 and 5. A particularly important point is that it is recommending that maternal and perinatal audits take place routinely after a death, but it remains unclear how this information will be collated nationally to help inform policy and practice. In addition, there are several key activities that will help to harmonize support for MNH at district level such as partner mapping to identify and target resources and coordinate supervision; many of these health systems activities should lead to better essential services, particularly for women and children.

However, the HII plan as such does not provide any indicative budget. Therefore, there is no understanding of the financial, personnel and logistic resources required to deliver the HII package, or what resources are available or the additional resources required for priority activities to achieve a reduction in MNM. It will require additional strategic planning in each district/county and together with IPs to identify what additional support is required.

In addition, if this HII plan is going to be an effective strategy to reduce MNM, there are other technical and strategic weaknesses that will need to be addressed in order that it can be used to mobilise additional support and resources from DPs. The main weaknesses identified (from the available documentation) are: the current plan is limited in scope, particularly with regard to Adolescent RH with very specific needs that are often not dealt with through routine services.

It is acknowledged that maternal mortality is a health systems failure yet there is insufficient emphasis in the HII plan on improving critical health systems to help deliver the agreed interventions, particularly on how an effective continuum of care will be developed in each district/county. Successful implementation will require key aspects of the health system to work so that the health system provides a continuum of care from the community to the tertiary level when required which would also include: appropriately trained health workers to be in place; specific equipment and sufficient supplies of essential medicines.

## 4.4 Community Strategy

**Community Strategy (CS):** The expansion of the CS is a key element of Vision 2030 and a very important political commitment of the GOK to demonstrate its commitment to the citizens of the country. The initial expansion was not fully supported by the DPs

[12] To achieve significant progress on morbidity and mortality in RH, there will have to be improvements in coverage of *High Impact Interventions (HII)* such as Focused Antenatal Care (FANC), Emergency Obstetric Care (EMOC), Post Partum Care (PPC) and Family Planning (FP).

as there were concerns around the cost and cost–benefit of such support. There was also a sense that it has been rushed through the approval process with limited involvement of the DPs and hence very few were fully on board with its implementation. Initially, 6,000 community units had been planned in which voluntary CHWs would work under the supervision of a CHEW. To date 1,300 units have been established.

In 2010, the evaluation[13] of the CS showed that there was increased FANC attendance, assisted deliveries, neonatal care and uptake of FP in areas where the strategy was being applied, as against comparison areas. But it also stated that community services do not entirely address the needs of all age groups as outlined in the KEPH (so called life cycle cohorts). For instance, the adolescent's reproductive health and psychological health issues are not effectively addressed.

Based on the 2010 evaluation, a revision of the CS has taken place with the support from UNICEF with visits to different countries with different community models of care in order for the MOPHS to agree on the model that best represents the needs of Kenya. Based upon the evaluation of the CS, GoK and DPs are undertaking consultations for the introduction of a results based remuneration system for CHW and CHEWs (up to 2,000 KES per month). The mission has taken note of the evaluation and the proposed CHW training curriculum and the proposed composition of the CHW kit.

The International evidence is positive about the potential contributions of a CHW programme to help achieve MDGs 4 and 5 (Haines A 2007) but the evidence comes mainly from small CHW projects and Haines et al recommend that "the implementation of a large scale programme should be accompanied by research to show that the anticipated effect and value for money are achieved". Abatt (2005) found that the impact was often less than hoped for. It is also clear that CHWs cannot substitute for a weak health system as to be effective they need to be linked to an effective health system (Abatt F 2005) and the cost of this additional service is not insignificant. The literature also shows that CHWs are better at targeted and focused interventions and from an RH perspective they cannot replace the need to train health professionals to provide skilled attendance at birth..

The unavailability of the revised Community Strategy or of any costing with which to carry out a cost–benefit analysis means that the consultants are not in a position to provide more specific advice. However, it does look to be a relatively high-cost approach to CHW, raising questions of affordability for the new Counties. It is recommended that an options appraisal comparing the cost-benefit of this approach with: (a) lower cost approaches; and (b) expanding the training of skilled birth attendants should be undertaken before proceeding.

## 4.5 RH communication

**RH Communication - Social and Behavioural Communication Change (SBCC):** The **Reproductive Health Communication Strategy 2010-2012** of the MOPHS/MOMS (with assistance from GTZ) provides a broad framework within which communication should be used to serve as a strategic input to attain the RH goals articulated in the National RH Policy and Strategy. RH Communication is supposed to work in three complementary domains, namely the policy, institutional and programmatic domains. The communication approaches or methodologies used in this strategy range from those targeting individuals to those concerned with broad

[13] MOPHS / Division of Community Health Services, July 2010, Evaluation of the Community Health Strategy Implementation in Kenya

social and environmental factors for change and can be summarized as: behaviour change communication, social marketing, health education and promotion, policy advocacy, participatory development communication, social change and human rights based communication, social mobilization, enabling health communications environments.

For a 3 year period, the indicative budget for implementing the RH Communication Strategy is 555.6 million KES (about 3.995 million EUR), the first year 160 million KES (about 1.151 million EUR).

With reference to and based on the **RH Communication Strategy**, an **SBCC Implementation Guide 2010-2012** has been developed (with assistance from USAID), which prioritizes three key thematic areas ("campaigns") that include family planning, adolescent and youth sexual and reproductive health and rights (AYRHR), and maternal, neonatal and child health (MNCH). Clear overarching themes and key messages have been developed. The indicative budget for implementing the measures included in the implementation guide is 144.3 million KES (about 1.888 million EUR) covering a two year period.

## 4.6 Adolescent sexual and reproductive health (ASRH) and YFS

**Youth Friendly Services (YFS)** / Adolescent sexual and reproductive health (**ASRH):** Currently, there are four national policy documents that guide the provision of youth friendly SRH services in Kenya. Apart from the National Reproductive Health Policy 2007, the **Adolescent Reproductive Health and Development Policy** (NCAPD/DRH 2003), the Adolescent Reproductive Health and Development Policy - **Plan of Action (2005-2010)** (MOH/NCAPD 2005), and the **National Guidelines for Provision of Youth-friendly Services** (MOH/DRH 2005). Broadly, the ARH&D Policy addresses the following adolescent RH issues and challenges: adolescent sexual health and reproductive rights; harmful practices, including early marriage, female genital cutting, and gender-based violence; drug and substance abuse; socioeconomic factors; and the special needs of adolescents and young people with disabilities.

The **National Guidelines for the Provision of YFS** in Kenya identify two approaches to be used in the delivery of SRH to young people: the targeted and the integrated approaches. The targeted (or youth-only) approach is an arrangement where services are designed and planned for adolescents alone and are offered in youth-only settings. The services offered in such a set-up may be clinical, non-clinical or a combination of both. In the integrated approach, young people receive SRH services together with the general public but special arrangements are put in place to make the services more acceptable to young people such as the training of health care providers, youth corners, etc. The national guidelines recommend three models of youth friendly service provision each with an essential service package: youth centre based model, clinic based model and school based model.

In addition to these health sector related policy framework documents, there is a **National School Health Policy and guidelines**, which were jointly developed and published in 2009 by the MOPHS and the Ministry of Education (with assistance from GIZ). These documents cover a comprehensive range of health issues and life skills that are vital for supporting the health of young people. They are meant to guide school authorities in enhancing the quality of health in school communities by creating a healthy and child friendly environment for teaching and learning. Currently, NCAPD and DRH are in the process of reviewing the Youth Policy to be reviewed

after development of a comprehensive Youth Strategy involving all stakeholders concerned.

## 4.7 Operational research

**Operational Research (OR):** In 2010, the MOPHS/DRH has published a review of RH research that also includes a list of RH priority research areas for the years 2010 to 2014[14]. About 115 topics have been identified as priority research areas covering the important issues, particularly in the RH domain, but provide no guidance on prioritising funding and support.

## 4.8 Human resources for health

The **National Human Resources for Health Strategic Plan** 2009-2012 intends to support the NHSSP II goal of reducing health inequities and reversing the decline in key health indicators by providing a framework to guide and direct interventions, investments and decision making in the planning, management and development of Human Resources for Health. The acute shortage, inequitable distribution and inadequate skills of human resources have had a particularly negative impact on efforts to expand access and improve the quality of health services. The Strategic Plan details outcomes with corresponding indicators for progress. The Plan includes an itemized budget and recommends the establishment of a HRH leadership group to guide the implementation, monitoring and evaluation of the proposed strategies.

## 4.9 RH commodities

The MoH/DRH and its respective DPs have adopted a **National Contraceptive Commodities Security Strategy 2007-2012**. Forecasting and quantification exercise is led by the DRH/MOPHS and carried out annually with a semi-annual review in which the DPs are involved. The strategy does not cover the entire range of drugs and consumables needed for RH related services. The planning and procurement for other RH commodities other than contraceptives is included in the general drug supply system. Internationally, the priority focus is on providing comprehensive SRH and it has become standard that the whole range of commodities to ensure RH services is covered by one common RH Commodities Security Strategy. This corresponds with international initiatives like the RH Supplies Initiative[15] and would support the comprehensive RH approach pursued by GOK.

## 4.10 Public-private partnerships

**Non-state RH service provision / Public-Private Partnership (PPP):** The Kenya Vision 2030 envisages strengthening of health service delivery through development of a policy on public-private partnerships (PPP). In line with this, the MOH has identified a number of priority policy actions to foster PPP, such as: **Policy reforms to support PPP** (Accelerate the update and review of the National Health Policy framework, Review & harmonize appropriate health Acts to integrate a PPP perspective, with a focus on reforming healthcare professions, facilities and medical education licensing); **Policy dialogue to engage the private sector** (Institutionalize the PPP Health Unit into a formal entity that represents key groups in the health sector in all policy health forums; Strengthen government's stewardship capacity to engage and interact with the private sector); **Partnerships to improve availability and accessibility of heath care** (Establish a PPP Framework to guide initiatives; Analyze the service gaps (geographic, economic) to identify PPP opportunities;

[14] MOPHS/DRH, January 2010, Review of the 2004-2008 RH Research Agenda and the proposed 2010-2014 Research Agenda
[15] http://www.rhsupplies.org/

Integrate private sector into NHIF pilot financing of out-patient services and introduce low-cost insurance products through a PPP with private health insurance).

An important issue is that there is no legal framework compelling private sector facilities to submit data and reports regularly to the MoH.

## 4.11 Conclusions and recommendations on RH related policy framework

The MOH has numerous policy documents on RH which clearly articulate the problems however what is **lacking is a clear strategic RH framework** which lays out the priority areas requiring support by partners to achieve MDG 4 and 5. Therefore **the mission recommends** that the MOPHS to build on existing RH strategies and initiatives, in particular on the 2011 Acceleration plan for HII. The continuum of care model could be used to take the HII analysis a step further by defining minimum packages of care of the four CoC areas and linkages, including critical health systems components.

Based on this, the MOHPS should develop an **evidence–based prioritised and costed RH Business plan (RH-BP)** that can be used for direct support (MOH and DPs) to key areas in RH that will help Kenya achieve MDG 4 & 5.

These documents should provide the basis for the **districts/counties** to assess their own situation, to identify key gaps taking into consideration local needs and available capacity needed to be able to deliver the packages of care and develop an action plan. This in turn should be part of the local stakeholder coordination and be finally part of the AOP.

With regard to the **Community Strategy**, an options appraisal comparing the cost-benefit with (a) lower cost approaches and (b) expanding the training of skilled birth attendants should be undertaken before proceeding with up-scaling. There are several community units functioning and several supported by UNICEF, which could be used to carry out the VfM analysis.

As the **Contraceptive Security Strategy** is due to expire in 2012, it should be replaced by a broader strategy encompassing all commodities necessary to assure RH services more generally (**RH Commodity Security Strategy**). The revised strategy should also ensure that the full range of RH commodities is integrated into overall procurement and distribution systems that respond to the actual needs of health service providers and facilities in the most effective way.

For any **revision of Kenyan health policies** in the near future, the new Constitution provides fundamental guiding principles which need to be applied: i.e. the right to RH care services and appropriate social security are clearly stipulated. The restructured health system will need appropriate guidance on how to assure equity and quality of care in RH.

# 5 Mapping of DP support to RH

As part of the TORs, the Mission was asked to map the DPs' interventions in reproductive health in Kenya, in order to identify gaps or areas of over-emphasis.

## 5.1 Financial and geographical mapping

The DPHK/SWAp Secretariat, which reports donor financing intentions, was able to provide only a very partial picture of RH spending. Selecting the budget lines that it could identify as RH, it provided 6 (RH commodities, condoms, RH O&M, MCH commodities, MCH O&M and nutrition O&M): a group of budget lines which reflected neither what the DPs themselves considered to be their RH spending, nor a more comprehensive set of health systems spending.

The Mission therefore set about compiling its own set of data, collated from DPs' documentation, interviews and internet searches. For greater comprehensiveness, we sought to include some of the other major DPs in the RH sector; the UN and the World Bank. The usual challenges of collating expenditure data which is defined differently by different donors and covers different spending periods were present and the usual caveats of incompleteness and misallocation apply.

We looked at how donors thought they were spending in the different intervention areas for RH, which we defined as: family planning, maternal & neonatal health, adolescent sexual and reproductive health and gender rights and violence. We were unable to break down total DP spending into these areas with sufficient accuracy, so for RH intervention areas we have simply indicated presence in the area.

We were able to conclude that family planning and maternal & child health – both the provision of TA and of commodities – is covered by most DPs. Adolescent sexual health and gender – both broader rights and more specifically, gender violence, issues – are addressed directly much less often by the major DPs (see Table 2 below).

Table 2. Reproductive Health Interventions: DPs' Current areas of Activity

| | | GIZ | KfW | DANIDA | DFID | USAID | BMG | WB | UN |
|---|---|---|---|---|---|---|---|---|---|
| 1. Family Planning | Commodities | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | |
| | TA | ✓ | | ✓ | ✓ | ✓ | ✓ | | ✓ |
| 2. Maternal & Neonatal Health | Commodities | ✓ | | ✓ | | | | ✓ | ✓ |
| | TA | ✓ | | ✓ | ✓ | | | ✓ | ✓ |
| 3. Adolescent Sexual & Reproductive Health | | ✓ | | | | ✓ | ✓ | | ✓ |
| 4. Gender Violence & Rights | | ✓ | ✓ | ✓ | | | | | |

In acknowledgement of the general agreement that RH is a systems issue, and that RH can (and should) be addressed through wider health systems interventions, we attempted to quantify how much donors are spending on this. Definition of health

systems was guided by the WHO health systems framework[16]. Using DPs' own figures, where these were available, or imputing a spread of spend where this was not available or not clear, we found (see table 3 below) almost $3 billion currently or expected to be committed by eight major DPs: equivalent to a donor spend of $600 million per year or $15 per person per year for the next 5 years[17].

Of this, over 60% is to be spent on procurement (either actual commodities or strengthening of procurement systems - largely support to KEMSA and USAID's HIV/AIDS spending). A further 10% each is to be spent on human resources, M&E and efficiency measures and support for non-state actors. Only 4% is committed to providing support to the specific issues of health financing (either actual financial support or TA for financial planning) and 2.5% to governance and leadership.

Table 3. Health Systems (not RH specific) Current & future likely commitments, US$ Million

| | GIZ | KfW | DANIDA | DFID | USAID[18] | BMG | WB | UN | TOTAL | % |
|---|---|---|---|---|---|---|---|---|---|---|
| Finance[19] | 3 | 28 | 28 | | | | 34 | | 93 | 4 |
| Procurement[20] | 0.5 | 25 | 16 | 36 | 1,325 | | 48 | | 1,450.5 | 63 |
| HRH[21] | 1 | | 22 | | 200 | 12 | | 20 | 255 | 11 |
| Governance [22]& Leadership | 2 | | 8 | 20 | | | 18 | 5 | 53 | 3 |
| M&E (& efficiency)[23] | 2.5 | | 6 | 4 | 200 | | | | 212.5 | 9 |
| Non-state[24] | | 7 | | 10 | 200 | 11 | | | 228 | 10 |
| TOTAL | 9 | 60 | 80 | 70 | 1,925 | 23 | 100 | 25 | 2,292 | 100 |

Is this an adequate overall level of resources? There are few sound benchmarks against which to judge. However, we do have a handful of estimates with which to attempt a ballpark figure: WHO estimate[25] an average cost per head for scaling up maternal health (not quite the same as RH, but similar) in developing countries of $1.40, implying Kenya would need to increase spending by about[26] $60 million per year. In addition, we found that GoK's two costed strategies – the National Road Map for MNH (2010) and the Child Survival and Development Strategy (2008) – have family planning and RH components which are estimated at $50 and $380 million per year respectively. The average of these three different estimates is $165 million. If we take this as an indicator of the sort of level of spending required, it suggests that with current levels of donor assistance, an effective RH system is, in simple monetary terms, attainable.

[16] Measuring Health Systems Strengthening & Trends: A Toolkit for Countries. World Health Organisation, 2008
[17] Assuming commitments are for the next 5 years (the planning horizon for the largest donor, USAID).
[18] USAID/Kenya intends to provide approximately $385 million (via APHIAplus) annually over 5 years(2010-2015) for the four activities :-HIV and AIDS, Malaria, Family Planning and Tuberculosis. At this point USAID are not able to show how much would be allocated to which district and for what activity. Since most of USAID funds are known however to go on procurement of commodities, especially for HIV/AIDS, we assume a split of 70% procurement; 10% HRH; 10% M&E (HMIS); 10% non-state.
[19] This includes actual financial resources for health facilities as well as TA for financial systems.
[20] Includes funds and TA for procurement of drugs and equipment.
[21] Includes TA, training of clinical staff, financing, eg for contracting of nurses.
[22] TA and training for management systems
[23] Includes HMIS, operational research and other interventions aimed at improving overall efficiency.
[24] Includes PPPs, social marketing and demand side approaches
[25] The World Health Report 2005 – Make Every Mother and Child Count.
[26] The WHO estimate is explicitly based on the experience of scaling up MH in a sample of developing countries. It assumes there is an average level of existing spend and suggests the kind of additional spending that would be needed to achieve a minimum acceptable level of service.

There are even fewer useful benchmarks against which to judge whether the current allocation of resources *across* the various systems areas is appropriate. WHO concludes that effective RH systems spend about 50% on commodities and 22% on staff salaries, suggesting DPs may be over-supporting the former and under-supporting the latter in Kenya, but since our figures are for all health – not just RH – this is only a tentative conclusion based on the figures alone. Similarly, the areas of finance and governance & leadership would appear to be under-assisted relative to their importance overall. We go on to discuss whether this can be confirmed by a more qualitative assessment in other sections of the report.

We have also looked at where, geographically, DPs are spending on RH. We have identified which districts they are operating in, comparing this to measures of poverty, modern contraceptive prevalence and presence of skilled birth attendance. Where we have been able to find district level measures, we have shown these, though often only provincial level data are available. See table 4 and maps in annex 8.2.

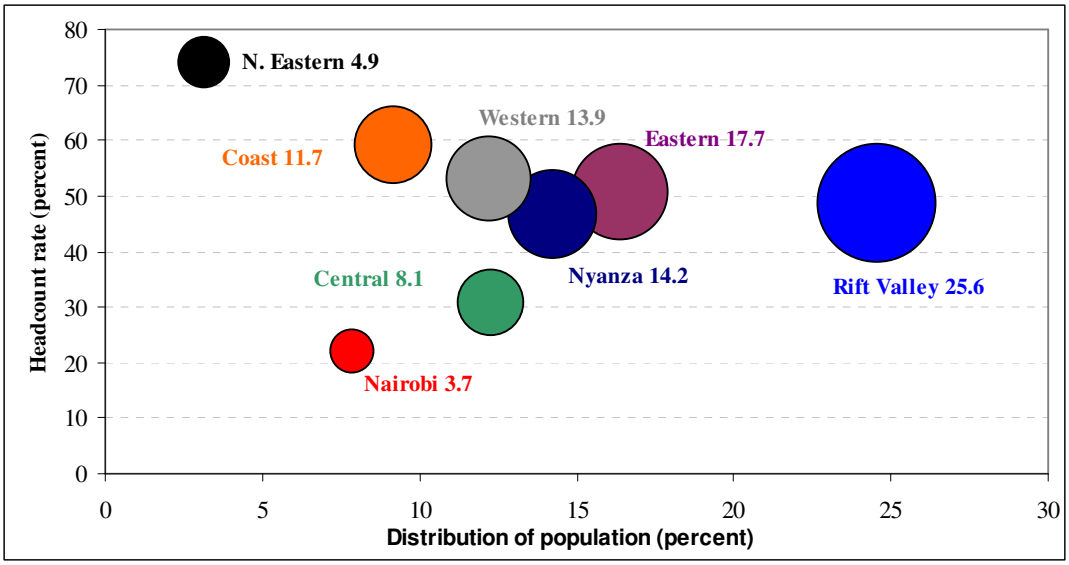
This geographical mapping exercise shows that DPs[27] are present in some form in practically every district of Kenya – mainly due to the comprehensive coverage of APHIAplus (funded by USAID) and HSSF (funded by Danida and the World Bank). The nationwide roll-out of the HSSF has already been started and will cover practically every district/county in the next four years.

We also found that DPs tend to be clustered in Coast Province – due to the presence of Danida – and Nyanza and Western provinces – due to DFID. Note that Coast and Nyanza have higher than national average CPR and SBA rates, suggesting (as we would hope) that donor presence on the ground at district level does indeed have a positive effect on the proxy indicators for RH[28].

An examination of the distribution of population and poverty by province in Kenya (figure 2 below) shows that although Rift Valley (25.6%) and Eastern (17.7%) provinces have the largest shares of total poverty in the country, donor presence is minimal compared to Coast and Nairobi provinces with shares of 8.1% and 3.7% respectively.

Figure 2: Distribution of Population and Poverty by Province, 2005-2006

[27] Note that this does not cover NGOs not supported by the DPs, or FBOs.
[28] This is of course only a suggestion – testing against baselines and correlations would be necessary to conclude this definitively.




Note: the size of the bubble represents province's share of total poverty in the country.

A general simple principle for prioritising RH interventions geographically would be to identify districts which combine high levels of poverty (which correlates with low RH indicators) and high rates of population growth. Thus, absolute levels of need (the poverty measure) would be matched with numbers of women reached and facilities under pressure (the population growth measure) - and therefore cost effectiveness. In terms of actual districts this would seem to indicate several districts in Nyanza, Coast and Rift (Turkana).

## 5.2 Technical mapping, harmonization and alignment

The technical mapping initially attempted to look at DPs commitment against MOPHS priorities as requested in the TOR. This process hit several bottle-necks: the first was that the MOPHS does not have one document clearly laying out its priorities in RH, and secondly the DPs reflect their funding to RH under 4 rather broad categories of: (1) MCH commodities, (2) MCH O&M, (3) RH commodities and (4) RH O&M. Nevertheless we looked at DPs' support against the outputs of the RH strategy and the Road Map to MNH and found a clustering of activities against MNH and FP with seemingly very little support for RH more broadly and adolescents.

A second exercise was looking at the indicators used by DPs to monitor and evaluate their support programmes against indicators of the RH Strategy 2009-2015 (see annex 8.2-2). With the exception of DFID for which the indicators will be defined for the new programme, it is obvious that there is a match between the indicators of high priority components of the broad RH Strategy and the indicators selected in line with priority interventions of the respective DP. However, the formulation of most indicators differs from the RH strategy. It is hoped that this mapping will provide guidance for future programme indicators. It could also be instrumental when defining a set of core indicators to be a common basis for assessment as proposed (see chapter 6.6.3).

As discussed above, it is impossible to carry out a mapping exercise that provides a basis for assessing how well DP's commitments are harmonized and aligned in support of MOPHS priorities as there is no prioritised RH framework by which to assess DP's commitments. The RH strategy is very broad and unfocused and the Road Map to MNH as well as the Acceleration HII plan are not comprehensive

enough to fully represent support to RH, although they are very useful to show where funds are allocated, largely in those key thematic areas.

A broad strategy with no clear priorities agreed upon can lead to a situation where DPs and IPs can legitimately feel they are supporting the MOPHS but the support could be unfocused, fragmented and possibly duplicating the efforts of other DPs.

## 5.3 Conclusions and recommendations

In conclusion, it should be stated that the mapping exercises do not give the necessary information for a meaningful gap analysis. Without a prioritized RH strategy and a breakdown of funding, TA allocations and actual spending, it will be impossible to gain this information.

The time is right for the MOPHS to take leadership and for the DPs to work together (Global RMNH Alliance) and support initiatives coming from the Ministry. What is needed is a framework which the MOPHS and DPs can "rally around" and that the MOPHS/ DRH can use to manage and coordinate the funding and implementation of an evidence–based and costed RH package.

- Therefore, an RH Business Plan is recommended to provide a framework to manage and galvanize support. (see Chapter 6.6)
- It is recommended that TA should be provided immediately to support the MOPHS/DRH to develop an RH-Business Plan.
- The MOPHS, in conjunction with the DPHK/SWAp Secretariat, should build on the Mission's mapping work to create an inventory of the geographical and thematic distribution of DP investments in the RH sub-sector. This could be linked to the on-going support to HMIS, including GPS mapping of individual facilities. This would be useful for planning and directing future investments in the sector.

# 6 Appraisal of RH in the context of the WHO health system building blocks

Maternal mortality is generally acknowledged as a failure of overall health systems. Thus, the relative strengths of the health system components dictate the speed, efficiency and effectiveness at which districts / counties can scale up and deliver an effective continuum of care for reproductive health. The following assessment is based on the WHO Framework which shows the health system as comprising of six main domains, i.e. Health Financing, Service Delivery, Human Resources for Health (HRH), Health Management Information System (HMIS), Medicines and Technology, and Leadership and Governance.

## 6.1 Health financing

**Health as a percentage of total GoK expenditure has suffered a progressive decline** from a peak of 6.3% in 2004/05 to an estimated 4.2% in 2008/9[29]. The decline began in the middle of the decade but was exacerbated by the domestic events of 2007, followed by the global financial crisis in 2008 and 2009.

**Prospects for a sustained improvement in the medium term are poor**. Although there has been a recovery in growth and tax revenues, and a boost to spending which enabled Government to increase the allocation to the overall health budget in 2009/10 [and 2010/11] by 20%, medium-term prospects for this to be sustained are poor: not only is inflation high – so cutting the real value of any nominal increase - but the World Bank predicts a slow recovery in tax revenues. In addition, the 2007 HSSP mid-term review revealed a decline in budget execution – the difference in the amounts allocated and actually spent – since 2004, which has not yet been shown to have been reversed[30].

**Fiscal Devolution enshrined in the Constitution will intensify already strong competition for limited domestic resources.** Under the new Constitution, public health is to become the responsibility of the new Counties, which are to receive ["not less than"] 15% of total government revenue to discharge their new legal obligations. A further 0.5% is to be distributed to the poorest counties via a national Equalisation Fund. In light of the Abuja Declaration, which recommends that a target 15% of a country's national budget is necessary for health *alone*, it is clear that the squeeze on public health financing is going to get worse. Currently, central Government allocations to health stand at approximately 6.3% (MPER 2009/10) which falls well below the Abuja target and the Economic Recovery Strategy for Wealth and Employment creation (ERS) of 12 percent. This implies that the country is not on target to meet its health financing obligations.

**DPs' resources for health are rising.** DP inputs to health rose sharply from 16% of total spending in 2001/02 to over 30% in 2005/6. They have continued to rise to about 50% in recent years (commitments for 2011-2012 and 2012-2013 amount respectively to KES 44.2 and 40.6 billion, of which KES 30 billion each year is from US Government (USG)[31]. This may turn out to be a peak; US Government commitments risk being cut by one-third as a result of Congressional decisions, and Germany has pulled out the GFATM in response to GoK corruption claims. On the other hand, new global commitments to maternal health will compensate for at least

[29] World Bank Health Sector Support Programme for Health, Project Appraisal Document, June 2010.
[30] The 2008 Public Expenditure Tracking Survey (published in March 2009) does not identify any improvement.
[31] DANIDA HSSP II, January 2011.

some of any decline in these sources: RH spending in Kenya by development partners reported to the DPHK rose by over 70% between 2009/10 and 20010/11[32].

In the light of devolution, the dominance of DP resources heightens the risk to sustainable domestic financing of health services in Kenya. Not only are DP funds susceptible to being turned off at short notice, but the current practice of funding off-budget risks undermining the negotiating position of the Ministry of Health in the forthcoming fiscal devolution process. Funding is provided by more than 15 bilateral and multilateral Development Partners (DPs), mainly through vertical projects and programs. Almost three-quarters of total external inputs for AOP 6 (2010-11)[33] are off-budget – a fact not likely to be missed by other Ministries battling for scarce domestic resources at the county level.

Despite the dominance of DP funding overall, two-thirds of identifiable funding *at the facility level* is received directly from households. Moreover, these resources are largely unbanked and disbursed directly by facility staff. The 2008 Public Expenditure Tracking Survey (PETS) found that out of the identifiable funding at facility level, one-quarter came from GOK, two-thirds from cost-sharing, 3% from other sources (mainly NGOs and local community funds) and only 1% from Development partners. The PETS also found that only 20% of cost-sharing revenues were banked by the facilities as legally required.

**The abolition of user fees has failed to increase access to *quality* services and has generated informal charging policies.** The abolition of locally-determined user fees in 2004 and the introduction of the "10/20" policy – a one-off charge of KES 10/- at dispensaries and KES 20/- at clinics – was intended to increase access by the poor. Studies show that utilisation of public health facilities did rise immediately after fee abolition, but quickly fell back as failure to provide the extra staff and drugs to meet the higher demand discouraged new users. Revenue at the facility level also fell – by over a half, in some areas[34]. These crucial *quality* determinants of access remain poor. Low income women demonstrate that they are prepared to pay for quality through their use of more expensive (though still subsidised) FBO services and in practice they are often required by government facilities to pay for their drugs, blood tests and other incidentals (though exemptions for poor women are often applied at the discretion of staff). Charging for extras has become a (limited) source of revenue for cash-starved facilities, the income used to purchase essential out-of-stock pharmaceuticals and to pay for casual workers[35]. At the same time, other non-clinical costs for patients - particularly transport to and from the facility – are high. There is a particularly steep rise in the cost of treatment for complications at district hospitals. This financial barrier to level 4 facilities and the emergency element of the "continuum of care" is a critical factor in maternal mortality and remains unaddressed.

**Spending on HIV/AIDS from all sources is equivalent to over three-quarters of total Government expenditures on health.** The Kenya National Aids Spending Assessment (KNASA 2009) shows that overall Kenya spent $300 million on HIV and AIDS response in 2006/07. This increased to over $350m in 2007/08, a growth of 18%. Spending on HIV/AIDS from all sources over the two years accounted for approximately 80% (2006/07) and 75% (2007/08) of the total Government expenditures on health.

[32] This is the difference between *actual* AOP5 spend in 2009/10 and *planned* AOP6 inputs in 2010/11. Even assuming a significant proportion of planned expenditure does not occur, the rise is likely to be substantial.
[33] DANIDA Kenya HSPS Draft 2, January 2011.
[34] GoK Planning Department, May 2005, *Cost Sharing Review Study & The Impact of the 10:20 Policy*
[35] The issue of stock outs of RH commodities seems to be the main driver of fees being charged to patients at point of use.

**Less than 4% of all health funds is subject to risk pooling** (by the NHIF or private health insurance). As a result, there is insufficient cross-subsidy from among the different socio-economic groups in the country. User-fees as a mechanism for demand-side financing are reduced by this lack of third party payment for waivers and exemptions to guarantee access by the poor.

**Some improvements in KNHIF have been achieved, but progress is very slow**: the Fund is becoming more open. Administrative expenses are reported to have dropped from a high of over 60 percent to about 40 percent, for example[36]. DPs consider reform of the KNHIF to be slow but perceptible. On the other hand, KNHIF remains a national scandal amongst Kenyan workers obliged to pay expensive premiums for limited cover. It is currently locked in a high court case with employers and workers associations fighting the prospect of further increased premiums.

**A range of promising PPPs and demand-side approaches are being piloted**, with scope for careful, evaluated, scale-up. Social franchising models, such as Tunza and Amua clinics, are promoting RH services through private facilities. They help reduce the social/cultural barriers to accessing to RH services and may help to keep down the price to users by supplying subsidised commodities through the facility. Their best prospect for replication and sustainability lies in urban areas and amongst groups who can afford subsidized fees to use private providers. Similarly, the OBA voucher system is proving successful and highly popular, particularly for antenatal and delivery services and amongst providers (especially public sector providers). DRH has recently taken the lead in this programme from NCAPD. Issues have been identified around cost-effectiveness, FP services, reimbursement rates, and accreditation but the vouchers are clearly effective at putting purchasing power into the hands of women[37] and enabling choice in poor urban areas. The Health for All Kenyans through Innovation (HAKI) community health insurance pilots are still being established. There are no results as yet to assess but the careful and rigorous approach by GIZ and DFID is a model for GoK and other DPs, for whom there is an opportunity to combine and take forward a sound, evidence-based, approach to health financing options.

**The new Constitution is changing the institutional context for public sector financing of health**. Devolution aims to give significant responsibility for implementation into the hands of the new counties, providing each of them with a Revenue Fund "into which will be paid all money raised or received by or on behalf of the county government" and an elected Assembly. The two Ministries have already begun to consider the implications of the Constitution and have recently proposed a split between the Centre and the Counties for responsibilities on a broader range of health financing issues[38]. The central Ministries propose to take on:

- Advocacy to increase government's share of public health spending.
- Formulating a health financing policy.
- Transforming the NHIF to play a greater role in social health insurance
- Advising on tax changes relevant to public health, service delivery, pharmaceuticals.

[36] This is still high compared to other countries' social health insurance schemes, where costs range from 3 to 6 percent.

[37] User fees – cf. chapter 2.1

[38] Implementation of the Constitution and Vision 2030 in the Health Sector. Draft Policy Directions, March 2011.

While it is proposed that the counties:

- Strengthen and develop a clear policy on use and collection of cost-sharing revenue.
- Develop mechanisms for supporting those who cannot afford health care fees, by strengthening the waivers systems.
- Develop financial allocations criteria for equitable disbursement of funds at in county health facilities (currently the Health Sector Service Fund and the Hospital Management Service Fund)
- Develop Plans to attract partners to invest in health at the county level.
- Encourage community financing schemes.

The Health Ministries now need to consider how these changes are likely to impact on the overall financing needs and prospects of the public health system, and to review the current health financing strategy. The fundamental question to be answered by a health financing strategy remains unchanged - whether the Government can sustain a free health care system, given the high level of public expectations, the excessive leakages in the system and the rising cost of running the health care system.

However, the new Bill of Rights and the new fiscal structures set out in the Constitution give the question added force, as well as introducing new institutional requirements which the current Health Sector Financing Strategy does not address as explicitly as it should; nor does it take into account the timetable for change over the next four and a half years. Strategic emphasis for the short and medium term needs to shift from KNHIF (though still retain pressure on this important institution) to defining and operationalising relationships and responsibilities between the new fiscal structures and the health sector (especially the purchasing function), estimating the cost implications of the health rights set out in the Constitution, exploring how the necessary resources will be mobilized, pooled and sustained including extending voucher schemes and risk-pooling mechanisms as pathways to genuinely universal coverage.

**Recommendations**
DPs – particularly those already involved in the various health financing initiatives - should work with GoK to **revise the Health Financing Strategy** along the dual lines proposed and in the light of the experience with KNHIF, the various demand side pilots and the implications of fiscal devolution for the health sector. While developing the new Strategy, existing pilots should be continued and expanded, carefully emphasising the demonstration of innovations actually working in practice so that GoK have confidence in moving forward in this important area. VfM analyses should be regularly conducted for any innovative interventions with policy implications.

With particular reference to reproductive health, the first challenge for the health financing strategy is determining which element(s) of the continuum of care should be included in a (free, tax funded) essential health package and which can be included in a social or community insurance scheme – and how the two financing systems should interface. Complications arise through the fact that a (normal) pregnancy is not an insurable risk and that some significant costs (mainly transport) arise outside the health system. DPs should ensure that these questions are addressed more explicitly in the health financing strategy. They can be tested by using multiple financing mechanisms at the same time but they should be coordinated within an overarching financing strategy with a longer term vision aimed at ensuring financial sustainability over time.

**The impact of various GoK and DP interventions on user fees and cost of access should be regularly monitored:** Interventions such as commodity support to KEMSA and HSSF should be reducing the incentives facilities have to employ informal charging policies – still an important barrier to access. The Mission found no systematic monitoring of this, however. It is recommended that this is rectified, possibly by inclusion in HSSF monitoring.

**Joint support to the OBA voucher scheme**: It would be important to scale up the pilot OBA voucher scheme supported by KfW as one of the promising demand-side approaches and also test new options and technologies in managing the vouchers, the type of services to be covered, etc.

## 6.2 Service Delivery

### 6.2.1 RH services: Maternal and newborn care (MNC) and Family planning (FP)

**Antenatal Care (ANC)** is a critical service in reducing maternal and newborn morbidity and mortality in that it enables women and caregivers to recognize early the danger signs of life-threatening complications; know when and where to seek appropriate care if complications arise and to develop a birth preparedness plan, including emergency transport. According to the preliminary Kenya Service Provision Assessment Survey 2010 (KSPA), most health centres (level 3) and hospitals (levels 4 & above) offer ANC, 99% and 95% respectively, against only 41% of clinics (level 2), which should be the most accessible facilities. Overall, 72% of the health facilities offer ANC, Postnatal Care (PNC) and Tetanus Toxoid vaccine (TT). Facilities in Nyanza Province (88%) are most likely to offer these services and facilities in Rift Valley are least likely (57%). ANC clients visiting dispensaries are least likely to be screened for syphilis as only 38% of facilities offer this service. Altogether 45% of facilities offer ANC, PNC and TT vaccine and also routinely screen ANC clients for syphilis.

**Maternal and Newborn Care (MNC):** According to KSPA 2010, normal delivery services are currently available in 41 percent of the health facilities. Comprehensive emergency obstetric care (CEmOC) is available only in a very limited number: caesarean sections in 16 percent and blood transfusion in 20% of the facilities with delivery services. The low proportion of deliveries assisted by skilled attendants (44% - KDHS) contributes significantly to maternal mortality. Essential newborn care practices (cleaning and drying of the newborn, cutting of the umbilical cord, and initiation of breastfeeding) were done for 46 percent of the newborns in observed deliveries. Health centres (58 percent) were more likely to adhere to the three practices than hospitals (46 percent) and maternity facilities (29 percent). The three elements of essential newborn care were observed in over half of the deliveries conducted in privately managed health facilities and in less than half of the deliveries in facilities managed by other non-state providers.

Two items are considered important for emergency support of the newborn, respiratory support (infant sized ambu bag) and an external heat source (an incubator or heated light source). Yet the KSPA 2010 showed that newborn respiratory support is available in 73 percent of facilities offering delivery services, but an external heat source is found in less than a third of the facilities. The two items are however each widely available in levels 4 and above (92 percent and 67 percent respectively).

Most of the RH services in Kenya are provided by the public sector. But in vast hardship areas which are also hard to reach (e.g. North Eastern provinces), the Faith Based Organizations and other non state/ private service providers give considerable amount of essential RH care.

**Family Planning** (FP) services in Kenya are provided in public and non-state facilities, are well established and have considerable DP support. 85% of facilities in Kenya offer temporary modern family planning methods. 90% of facilities that offer FP methods have both visual and auditory privacy for family planning consultations (KSPA 2010). However, the preliminary 2010 KSPA results do not report on availability of FP commodities in the facilities, where stock-outs are often an issue[39]. Injectables (DMPA) seem to be the preferred method among married women and shows the lowest discontinuation rate (KDHS 2008-09). Oral contraceptives are the preferred choice for younger women and youths. Efforts are being made to provide non-state social franchising, and integrating FP into HIV and AIDS related services and IMCI (e.g. PMTCT).

Despite the availability of FP services, the 2003 KDHS and 2008-09 KDHS estimated the unmet need for family planning at 25% and 26% respectively. Data show that 49% of currently married women did not want more children in 2008 compared to 44% in 2003. The high unmet need is largely due to inadequate FP service provision, stock-outs of contraceptives, lack of sustained demand creation for FP services, low community and private sector participation in FP, low involvement of males and poor access, especially among the poor and other socially disadvantaged groups (National RH Strategy, 2009-2015).

With regard to FP, Kenya has long experience in utilizing specialized CBD volunteers at community level. In this respect, there seems to be uncertainty among stakeholders as to whether or not CBDs will continue to work alongside CHWs. For expanding access to family planning, a recent operational research project in Kenya provided excellent evidence on the value of task-shifting to CBDs for injecting DMPA and not only distributing male condoms and oral contraceptives. According to the MOPHS, it is not planned to expand the CHW kit to provide this very popular FP method. Furthermore, social franchising programmes are successfully using paid community mobilizers to motivate clients for using e.g. LAPM and referring to private franchise service providers.

**Conclusions and recommendations**

The available data show that the RH service delivery needs to increase the coverage of skilled birth attendance in general and CEmOC in particular. This includes sustainable high impact interventions for both mothers and newborns as laid out in the HII Acceleration plan. In addition, the offer of FP methods needs to become reliable and constant. The evidence is clear that to reduce maternal mortality, increasing the coverage of a combined package of skilled birth attendance supported by a functioning health system delivering a continuum of care is required.

Whilst there is no one solution, evidence suggests that the training of health professionals to provide CEmOC is one aspect of the continuum of care that could make a difference and reduce MNM whilst systems are strengthened. DFID has been funding a programme called “Making it Happen“ implemented by LSTM and RCOG which is developing a model to roll out a training in Life–Saving Skills (LSS) for Emergency Obstetric and Newborn Care (EONC) through training of trainers approaches.

[39] Cf. Chapter 3.5.1# for supply chain management

The following steps are recommended:

- Building on the HII acceleration plan, MOPHS should **define a minimum package** for each of the 4 critical areas, including the critical health systems components and ensure linkages between the packages and therefore the scaling up of an effective continuum of care (i.e. pre-pregnancy, pregnancy, birth, newborn/post-natal care).
- DPs should immediately support a joint programme to accelerate the **training of LSS** – EONC and up-scaling of CEmOC through the pooled RH TA plan and RH commodity plan country–wide. This could be done through the existing LATH programme or a redesigned national programme. Simultaneously linking trainees where possible to DP projects on the ground (APHIA plus, UNICEF, WB, DANIDA) to provide the trained health professionals with the supplies, equipment and support required once back in the health facility so they are able to deliver CEmOC services.
- Accelerate **PPPs with FBO** service providers particularly in hardship regions of Kenya to increase coverage of RH services.
- The coverage of underserved populations with **FP services** needs to be addressed based on data analysis of preferred methods and unmet need for particular FP methods and geographic regions where CPR is lowest among poor rural women with low education levels. The coverage with **LAPM** needs to be further expanded.

### 6.2.2 Youth-friendly services

**Youth-friendly services (YFS) and Adolescent sexual and reproductive health (ASRH):** It is noted that there is inadequate access to services by adolescents and youths and that in 2004 only 12% of health facilities provide youth-friendly services (YFS)[40] The preliminary results of KSPA 2010 do not show improvement in this area as only 7% of the health facilities offer youth friendly (HIV) counselling services and only about 1/3 of surveyed health facilities have at least one health worker who provides YFS. The situation in Nyanza, Western, and Nairobi is the most advanced as slightly over half of the facilities have at least one health worker providing YFS, but only 16% of facilities in North Eastern province provide these services.

The area of ASRH and YFS is currently under review and results of the various consultation processes are not yet available. A notable effort has been undertaken to explore particularly the perspectives of young people themselves on which services they would need, which are enabling factors for YFS and what barriers do exist[41]. In addition, service providers and community members were equally requested to contribute their views. The preliminary results are utilized to propose a comprehensive YFS model for the health sector. As YFS are also offered in non-health settings, such as in schools, Youth Empowerment Centres, among youth organisations, there is need to further investigate the particular opportunities and challenges in these settings.

[40] Kenya Service Provision Assessment Survey 2004
[41] NN, December 2010, *Sexual and Reproductive Health Service Provision to Young People in Kenya: What is the best model? Perceptions of young people, health service providers and community members - Preliminary Report - Summary*

The accumulated international evidence suggests that a combination of complementary strategies is more effective than any single strategy to reduce risky behaviour among adolescents and youth. This means multi-component programmes, including (1) school-based comprehensive sexuality education; (2) Use of mass media to provide comprehensive messages to in and out-of-school youth; and (3) the provision of youth friendly health services. To be most effective, these strategies should be responsive to the local cultural and environmental contexts and should involve the community in which they operate.[42]

A multisectoral approach calls for strong ownership of the concept, which is not easy to attain as there are a number of stakeholders involved, i.e. DRH, DCAH[43] of DFH and the Department of Primary Health Service at the MOPHS, as well as relevant departments of the Ministry of Education (schools) and the Ministry of Youth Affairs and Sports (e.g. youth empowerment centres). The key players are finally at the district/county level, where coordinated efforts are crucial for any YFS programme to have impact.

**Conclusions and recommendations**
As the mapping of DP support shows (see chapter 4.1), RH interventions for adolescents get much less support than other RH areas and yet are crucial to avoiding unwanted teenage pregnancies, unsafe abortions and the like. As the most promising approach is a combined multisectoral strategy, strategic planning of a joint scale-up of interventions in various sectors based on the on going needs assessments of young people's ASRH needs in Kenya and best practice analysis would be justified in view of the magnitude of ASRH needs.

It is recommended that:

- IPs support particularly YFS in health, e.g. by establishing adolescent friendly corners in health facilities.
- DHMTs (or County HMTs) should be technically and financially supported through DPs/IPs to coordinate comprehensive ASRH programmes in partnership with other sectors.
- At central level, DPs should support the development of implementation plans for the respective policies.
- DPs should take advantage of the RH Communication Strategy to jointly address adolescents and youth.
- Within the RH ICC, strengthen the link between the TWGs on FP and on ASRH, to which partners from non-health sectors should be co-opted.

### 6.2.3 Demand creation for RH and FP services

Support to create demand for and access to RH and FP services is conducted through strategies like social marketing, targeted BCC including the use of ICT to address knowledge and cultural barriers. CHWs and other community based mobilizers are instrumental at the grass-root level, but the roll-out of the Community strategy has not been implemented as planned. Moreover, demand creation has not been matched with corresponding expansion for and increase in infrastructure, in predictable and regular supply of the labour ward and with FP commodities, and in the number and skills of health workers, especially at levels 2

[42] Petroni, Suzanne, 2007, *Improving Youth Sexual and Reproductive Health in the Developing World: An Evidence-Based Approach.* The Summit Foundation.
Boonstra, Heather. *Learning from Adolescents to Prevent HIV and Unintended Pregnancy. In Brief.* Guttmacher Institute 09/2007.
[43] Constraints of split responsibility among DRH and DCAH – cf. chapter 3.6.2

and 3 of health care. Hence the uptake of FP services remains low. There is consequently a risk that BCC, despite its good intentions, may heighten dissatisfaction with the health service in the community and undermine and reverse some gains achieved by the community health strategy.

The persisting high level (26 %) of unmet need regarding FP is a major concern. International evidence shows that a broad range of contraceptives that offer a choice to all women is key to overcoming barriers like fear of side effects. On the other hand, the unmet need of poor women with low level of education particularly in rural areas needs to be responded to with both demand creation and appropriate reliable offers. LAPM are the methods that propose the highest impact on CPR.

Both the RH Communication Strategy and its SBCC Implementation Guide have been developed in highly participatory processes with stakeholders from various sectors, including also many DPs and IPs. The Implementation Guide clearly identifies responsibilities at the various levels with the national lead being the RH/FP IEC/BCC Technical Working Group of the MOPHS/DRH. While the implementation focus is at provincial and district SBCC task forces with numerous APHIAplus partners, there is ample opportunity for other partners to join in planning, co-financing and/or implementation. The Implementation Guide calls for joint efforts to harmonize key communication messages for specific target groups with high RH information needs. ASRH in particular - such a larger area offers the potential to harmonize support through a pooled fund or at least through one plan reflecting all support. Each DP has partners which bring their comparative advantages to the table and provides an opportunity to provide coherence.

**Recommendations**

- All DPs should consider joint investment in the RH Communication Strategy and its SBCC Implementation Guide. All DPs should assure in their respective areas that the planned campaigns are carried out in a coordinated way. There is need for co-financing, which could be done through funding from Danida or the KfW Development Bank (IEC Fund).
- Ongoing Social marketing programmes should participate with harmonized key messages.
- Where Community Units are established, community mobilization could address particularly the 1st delay factors, CHWs and CHEWs to promote survival of both mothers and newborns.
- Demand creation for modern FP should focus on poor women with low level of education particularly in rural areas. The promotion of LAPM should be further enhanced.

### 6.2.4 Non-state service provision

**Non-state RH service provision (PPP):** In Kenya, the private health sector plays an important role and is yet not fully recognized by the public health sector. There is an urgent need to further develop the capacity of the MoH to effectively provide the leadership and oversight necessary for successful overall stewardship of the entire health sector. Effective health governance entails establishing strong PPP arrangements which make use of a **total market approach**, through country-led and country-managed processes. All the partners have to participate in discussing and agreeing on the functions, structures and procedures for the RH health sub sector. It has been shown[44] that the public health sector is sometimes skewed towards wealthier population segments: in the case of deliveries, 37 percent of the wealthiest women compared with 8 percent of the poorest women benefit from public

[44] O'Hanlon, Barbara, Nelson Gitonga, Jeff Barnes / World Bank, 2009, *2009 Kenya Private Health Sector Assessment - Summary Report*

subsidies. FP methods are obtained from private medical sources by about 36% of users and more than 6% from other sources, including shops and friends (KDHS 2008-09).

The MoH has an interest in enhancing the cooperation with the private sector and in RH there is innovative DP support for private sector initiatives including PPPs. More efficient use could be made of public sector funding for poorer population groups by segmenting the overall health sector and through targeting specific income groups. Taking advantage of such a *Total Market Approach* is expected to lead to choice, competition, better quality and lower prices.

There are several subsidized models in social franchising (e.g. Tunza and Amua clinics) supported by DPs. The demand side financing approach of the OBA / voucher scheme embraces the private and non-state sector as well as the public sector. Contracting out of services on the basis of comparative advantages of service providers is being developed. An MoU has been signed already with FBOs, particularly in hardship areas.

Another area of PPP is partnering with the general private commercial sector for resource mobilization under the aspect of Corporate Social Responsibility (CSR). The sponsored use of telecommunication and IT appliances is just one example.

Recommendations

- Create a forum for dialogue at all levels to engage stakeholders in RH at all levels of the health system and thus ensure stewardship of the MoH.
- Franchising public private partnerships in key health markets such as FP commodities and other RH services should be upscaled.
- Harmonize urgently different social franchising approaches and regulate issues such as accreditation and licensing, quality control, coverage, etc.
- Include private sector providers in RH training programmes that are financed through DPs.

## 6.3 Human resources for health (HRH)

Kenya is experiencing health worker shortages particularly in skills, competences and in distribution. Between 2004 and 2008, the number of registered nurses employed by the MOH fell by 17%. The MOH currently has an overall vacancy rate of 29% of the approved establishment (National Human Resources for Health Strategic Plan, 2009-2012). The current HRH plan proposes an increase on the 2008 staff levels by 101% and 176% for clinical officers and for nursing officers respectively. However, in many cases the problem is less the absolute lack of available staff to fill the vacancies and more a mal distribution of staff, resulting from the difficulties in posting and retaining skilled staff in remoter and more difficult regions[45]. If this is not addressed, the proposal to increase staffing levels will serve only to increase reported vacancy levels. The irrational deployment of the HRH aggravates the shortage in rural areas, especially in the north east arid regions with nomadic populations. The deployment of trained staff to departments where the staff's RH skills are not utilized poses an additional challenge. High quality and accessible RH services require sufficient numbers of well-skilled, well distributed and well managed RH professionals and other health workers. This workforce requires supportive supervision for motivation, continued education and adherence to guidelines for service provision. The WHO recommends a minimum of 2.3 doctors and nurses per 1000 population. The current figure for Kenya is 1.5 per 1000 population or 53% lower than the WHO recommended minimum.

[45] Kenya Health System Assessment 2010, Abt

In Kenya, statistics show that overall skilled attendance is provided in about 43% of the deliveries. The DRH will provide technical support, build national capacity and introduce task sharing/task shifting for managed care to ensure universal coverage of skilled care for every birth within the context of a continuum of care. Generally the higher the proportion of deliveries with a skilled attendant in a country, the lower that country's maternal mortality.

In 2006, Kenya adopted and began to roll out the Community Strategy to mitigate the shortage of HRH and to improve assisted deliveries at levels 1 and 2. Under this plan, it was envisaged that 2,550 Community Units would be formed. An evaluation of this strategy in 2010, showed that the strategy increased FANC attendance, assisted deliveries, neonatal care and uptake of FP in areas where the strategy was being applied, as against comparison areas. However, the inadequacies in incentive packages were the major challenges faced.

Consequent upon the evaluation of the Community Strategy, the GoK and the DPs are undertaking consultations for the introduction of a results based remuneration for CHW and CHEWs.

Since most nursing officers and clinical officers are reluctant to serve in hardship areas, the Community strategy proposes to identify and train from the local communities CHW/CHEWs and to establish working stations for CHEWs at level 1 (Community Units). This approach will be complemented by appropriate task sharing/task shifting policies and guidelines and appropriate training to support task sharing/task shifting.

In 2008, the Kenya Health Workforce Information System (KHWIS) was expanded in order to develop a comprehensive health workforce surveillance system to provide regulatory and staffing data on Kenya's nurses, midwives, doctors, clinical officers, dentists, laboratory technicians and technologists. The project is an on-going collaboration between the Government of Kenya's Ministry of Medical Services (MoMS) and Ministry of Public Health and Sanitation (MoPHS), and their professional staff groups .The KHWIS links the 'supply data' retained by the regulatory boards to the 'deployment data' retained by the Government of Kenya.

Evidence from the database has helped the MoMS to improve payroll efficiency through the elimination of payments to 'ghost workers'. It has also helped improve human resource planning by identifying impending workforce shortages and hence providing evidence to justify an upward revision of the mandatory retirement age for civil servants in the health sector.

However, the numbers of health workers are not growing in tandem with the growth in demand for services and population. Skills and competences gap remain. For example, the KSPA 2010 showed that there is a skills gap for anaesthesia to support the provision of Comprehensive EOC. The skills and competences of staff are not quickly catching up with advances in technology and expectations from the populations. There is a retention problem of skilled staff, particularly in rural hardship areas. The remote, rural and hardship areas are shunned by the highly mobile cadres such as doctors and nursing staff, and consequently many health facilities in such areas have high vacancy levels. The current incentive packages do not seem to be adequately addressing this problem. The staff shortages, the gaps in skills and competence are further aggravated by poor health worker distribution. Generally, skilled health workers tend to concentrate in urban areas and along the main communication routes (road and rail).

We were told of plans to increase some allowances in order to increase the incentives to serve in difficult areas. However, we stress that such incentives are not only financial - a number of non-financial incentives are also highly valued:

- improved working conditions;
- training and supervision; and
- good living conditions, communications, health care and educational opportunities for staff and their families.

Trainings for RH staff have to be aligned to national priorities. Mentorship and on-the –job training are being considered to supplement residential training. The post-training support and supervision has to be enhanced to see whether the trainees have gone back to the facilities and whether the services are being provided as per guidelines.

The devolution that is advocated in the new constitution will empower counties to employ health staff locally. This has the potential to address some of the problems of deployment, e.g. by speeding up recruitment, addressing some local constraints to recruitment and, recruiting local people. However there will still need to be a national-level strategy to address the continuing challenge of deployment to difficult posts. In the meantime, some staff distribution problems would be addressed through a Deployment Policy in which it would be mandatory to budget HRH numbers by districts and provinces, rather than by aggregate national figures as is the case currently.

Recommendations

- Accelerate the application of an incentive package that clearly favours rural hardship areas.
- Institute a staff rotation system so that staff can be moved around from facilities in ”soft” areas to facilities in “hardship” areas, and vice versa, at regular intervals.
- Eligibility for MoH scholarships for in-service training should be tied to service in a hardship area for a minimum stipulated period of time
- To address skills and competences gaps and to improve staff attitudes to customers, MoH to institute on-the-job training and mentoring to augment residential trainings
- KHWIS should be used to monitor implementation and assess the impact of the proposed incentives package
- DPs should immediately support the development of a Deployment Policy, before any further staff recruitment, in which policy it would be mandatory to budget numbers of HWs by districts and provinces, rather than by aggregate national figures as is the case currently. This policy may later on be reviewed in light of the new constitution which confers the powers of staff employment to Counties.
- Immediately contribute to pooled TA or to a pooled fund for HRH recruitment and incentives, especially for HRH at levels 1, 2 & 3;
- MoH Staff trainings by DP projects should be conducted in consultations with District/County and Provincial MoH offices and in accordance with MoH priorities.
- Support the roll out of the Community Strategy in hardship areas.
- Formally permit the CHW and the CHEWs to perform some tasks which currently can only be provided by Nursing Officers. This task sharing or shifting should be accompanied by appropriate training and compensation.

## 6.4 Health information

### 6.4.1 Health Management Information System (HMIS)

The health sector is challenged by **data management** problems, including those of data availability, data retrieval and data quality. It is faced with difficulties in getting accurate and up to date data for RH programme management, including on FP, MM, NMR, IMR, and CMR

and in analyzing the same data as source for decision making. E.g. maternal death audits are not collated at central level in order to inform priority setting.

The **community health information system (CHIS)** at level 1 and 2 is not well developed as it is very voluminous and requires a lot of staff time. It is manual based and there is no link between community tools and those used at district level. This makes it difficult for the data to be stored, analysed and transmitted to higher levels. This was shown in the evaluation of the Community Strategy in 2010. The data management tools at levels 1 and 2 have not been formally approved and have no obvious link to data tools at higher levels. There did not seem to be a formal structured way of feedback on data from higher levels to the community level. In addition, the CHIS requires a lot of facility staff time, which is difficult due to time constraints. The district officers themselves lacked transport and so were not mobile.
Recommendations

- DPs should assist the MOPHS at central level to collate and analyze individual or a sample of maternal death audits to help set health systems priorities.
- Revise and approve data management tools at levels 1&2 to make them more user friendly and in line with those data tools at higher levels.
- Support the districts with Community Units to provide more and regular support supervision to Community Units to improve data quality and timely reporting and ensure that districts provide feedback to levels 1&2.
- DPs should support the revision of data tools for levels 1 and 2.
- Align DPs project reporting forms to those of GoK reporting forms.

The consultants were informed that only about 30% of **private sector facilities** submit any health information reports to MoH. The absence of a legal framework to compel private providers to submit reports regularly to MoH seems to be the excuse for this situation. If private facilities are to be included in the OBA scheme, then they have to be obliged to report to MoH.

**Recommendation:**

- Enact legislation to compel private providers to submit reports to MoH regularly and timely.

### 6.4.2 Operational research

**Operational research** (OR) helps making informed and/or evidence-based decisions and is vital for the development of the health system and the adaptation of new approaches for particular programmes. However, the amount of research undertaken in Kenya and the number of research institutions is quite substantial and exceeds the capacity of the DRH to take action and disseminate the results.

As mentioned above, the most recent MOPHS/DRH list has identified about 115 topics as priority research areas, far too many to be supported in a focussed way. On the other hand, OR is often funded globally through large grants looking at experience of different countries. This is surely valuable for lesson learning, but there is a sense that the host country is not always aware of the agenda and opportunities are being lost to use the results most effectively to influence policy and practice. It was felt that DRH had a particular problem around managing OR. Various management options could be considered.

An area of concern is the lack of information about the cost-effectiveness of particular approaches, most often those providing innovative solutions, e.g. community level interventions, social marketing, OBA voucher schemes. It would be helpful if VfM assessments would be available to inform strategic decision making.

**Recommendations**

- MOPHS should consider appointing a **Knowledge Management Adviser** in **DRH** and DPs supporting.
- The RH-ICC should take responsibility in reviewing all OR proposals to ensure alignment with the RH-BP and priorities for Kenya, and that information thus obtained is used to inform policy and planning.
- DPs should support MOPHS to conduct VFM analyses of particular intervention approaches in order to inform strategic decision making in RH.

## 6.5 RH commodities and infrastructure

### 6.5.1 RH commodities

**Supply chain for RH commodities**: The "Pull" or "Push" commodity supply systems, wherever they are being applied in the districts, do not seem to be working satisfactorily. RH does not have a parallel procurement and supply system for RH commodities. Though the procurement and supply chain is supported by a number of DPs, allocation to and coordination of this remains inadequate and erratic. It was said that supplies to levels 4 and above are on "pull" while those to lower levels are on "push" system. During the mission's visits to districts and health facilities, it was noted that neither seems to be working satisfactorily. Some facilities have drugs on their shelves which they do not need, while at the same time others were out of stock for the same drugs. The regular supply of essential drugs like syntocinon and magnesium sulphate is not assured. The system seems to be plagued with faulty forecasting due to inadequate data on anticipated consumption, irregular procurements of drugs /commodities and low and irregular supplies to points of use and sometimes by delays at ports of entry.

The issue of stock outs of RH commodities seems to be the main driver of user fees being charged to patients at point of demand of service. It is therefore an issue of access and equity.

**National forecasting** and procurement planning for contraceptive commodities is done annually among the DRH and the respective DPs supporting the procurement of contraceptives. However, this planning mechanism does not cover other essential RH commodities. These are planned for under the normal EMMS procedures. In addition, DRH and the provincial RH coordinators are not professionals in supply chain management and thus are not the best skilled health staff to do this.

The distribution "push" system of FP commodities to lower level health facilities is based on consumption data from the districts. The distribution is done quarterly by KEMSA and all RH commodities, irrespective of their source, are included in a standard kit that is delivered to the health facilities. The weakness of the systems lies in many factors, among them inadequate data management, untimely arrival of commodities, etc. Among the staff there are knowledge and skills gaps, compounded by poor staff attitudes regarding management of commodities. The infrastructure and storage facilities (e.g. fridges and cold rooms) are insufficient and poorly maintained.

Despite ample analysis and technical assistance of DPs and IPs to support the improvement of the supply chain management[46], the system does not show the expected results. In view of the devolution of the health system new challenges lie ahead to sort out these weaknesses.

**Recommendations**

[46] Current TA, inter alia, from the USAID supported SPS project – Strengthening Pharmaceutical Systems

Commodity security for RH services has to be vigorously addressed. It is recommended:

- All RH commodities (including contraceptives) should be integrated into general supply chain management.
- The DRH at central level as well as RH coordinators at provincial level should not be the drivers of the actual supply chain and data management. Their role should be in forecasting as well as M&E in coordination with the DPs involved. The respective ICCs for RH and for Procurement should be mutually involved.
- It is urgent to streamline the "Pull" and "Push" system where applicable to avoid waste and/or artificial shortages. This recommendation is given although the mission does not have sufficient insight in the various suggestions concerning the improvement or change of KEMSA distribution.
- DP support to the supply chain should cover all commodities essential for scaling up the High Impact Interventions.
- MOH should factor in RH commodities in the facility drawing rights for EMMS.

### 6.5.2 Infrastructure

**Infrastructure**: Health facilities are inadequate, and where they are available, many lack essential equipment and space for service provision. Although effective interventions to prevent mortality are known, for many women and newborns appropriate care remains unavailable, unused, and inaccessible or of poor quality due to lack or inadequate infrastructure and equipment .In general, for every 500,000 population there should be 4 Basic EmOC facilities and one Comprehensive EmOC facility. Only a small proportion of facilities (mostly hospitals) have equipment and supplies to manage complications of labour and delivery. It is of concern that only about 30% of facilities offer 24 hours delivery services.

Many health facilities especially in the arid North Eastern are few and far between and communities have to travel across difficult terrain and long distances to access health services. Complications of labour and delivery can sometimes occur unpredictably. It is therefore important for facilities offering delivery services to have the necessary equipment and supplies readily available for managing complications. Vacuum extractors for assisted labour are available in only 6 percent of the health facilities overall, while vacuum aspirators and D&C kits for the removal of retained products of conception are available in 35 percent and 16 percent of health facilities, respectively (KSPA 2010). This means most facilities are unable to provide Basic as well as Comprehensive EmOC, both of which are essential components of the High Impact Interventions.

Even at current levels of service demand, many facilities can hardly cope and are therefore unlikely to march any increases in customer demand. The MNH/FP services require running water, privacy for counselling and administration and some reliable source of power to light the facilities. Yet many of them do not have these basic essentials.

**Recommendations**

- Accelerate the rehabilitation and expansion of current facilities to accommodate current and rising demand for MNH/FP services and to enable the facilities to provide additional services and safe deliveries
- DPs should allocate additional funds in AOP 7 for infrastructure and equipment in level 2 and 3 facilities, especially in high need areas like Nyanza, Western, Coastal and North Eastern Provinces.
- Develop national policy to guide investments in physical facilities. Among the guidelines to be provided by this policy, include those on establishment of the different levels of facilities.

- Review the health facility infrastructure norms and standards to address emerging considerations such as distance from facility (enforcement of norms and standards) and achievement of equity in distribution of facilities.
- Integrate into the mainstream health facilities network all facilities constructed through different initiatives, including those under CDF (especially on human resources, drugs, etc), to ensure efficient, equitable, effective and sustainable delivery of health care services.

## 6.6 Governance and harmonization

### 6.6.1 General health sector

**Sector Wide Approach (SWAp):** The SWAp moved forward relatively quickly from 2005 to 2008 but since then progress has been slow. There are several understandable reasons for this, the unrest that followed the 2008 elections and the division of the ministry into 2 parts diverted attention from focusing on one sector approach, with one strategy, one M&E system and one co ordination system. As part of the Sector Wide Approach (SWAp), the Ministries constituted Health Sector Coordinating Committees (HSCC), Steering Committees and Interagency Coordinating Committees (ICCs) to facilitate MoH sector leadership and donor coordination.

Despite the challenges the MOH and DPs should be congratulated as the SWAp continues however, several key components such as the Joint Programme of Work and Funding (JPWF) and shadow budget have not been updated. A JFA was developed and signed by GOK and the WB and DANIDA in October 2010. In the JFA it is agreed that 5 baskets would be established in the MOH. To date 3 baskets have been set up: Health Sector Service Fund (HSSF), Essential Medicines and Medical Supplies (EMMS) and Human Resources for Health (HRH). In addition to WB and DANIDA, USAID is supporting EMMS and HRH through the joint planning process where their funds are reflected on the plan in a form of “virtual pooling“ so that total resources to the basket can be assessed to identify the gaps and help with efficient planning and predictable support.

Whilst the mission has been asked to look at the RH sub–sector, it was emphasised that any support should strengthen health systems and the SWAp and the consultants concur fully with this principle. Therefore we think the commissioning DPs should support where possible the existing central baskets of EMMS and HRH, at a minimum through joint planning (“virtual pooling”) of EMMS and HRH activities. These are two critical areas for RH where joint planning is essential to avoid duplication and ensure the right people are in the right place have the equipment they need to do the job.

HSSF is a means of by-passing the middle levels of district level financial management, reducing opportunities for leakage, getting funds directly to the facilities and enabling facility-level autonomy over part of their resources. This is commendable, and in line with practice elsewhere. It is popular with the facilities and the Mission did not come across evidence of extensive misuse. After piloting in Coast Province, the DPs who are supporting the roll-out of the HSSF – the World Bank and Danida – are introducing a scorecard to encourage facility management committees to use the HSSF better to improve service delivery Other partners should ensure that any projects they have working at lower level are aware of this and work with the HSSF to ensure effective use of available resources.

In the medium and longer term the HSSF risks being inconsistent with the new Constitution which devolves spending responsibilities to the Counties and their elected Assemblies, who are likely to want to have oversight and control of this flow of funds.

**Development Partners for Health in Kenya (DPHK)**: The DPs renamed the health donor group as DPHK in 2005 and at the same time established a Secretariat to provide support to the DPs to liaise with one voice with the MOH. This seems to have worked well in bringing more coherence within the DPs and certainly is welcomed by the MOPHS and the SWAp secretariat as it has minimised transaction costs for the MOH. The DPHK offers the opportunity for the DPs to discuss and agree the focus of their strategic support to MOH and to harmonize and align their support to MOH. To examine whether this group is being used as effectively as possible was not in the mission's scope of work. However, as the mission was not commissioned by the entire group of DPHK, there is a risk that this mission and its findings will be seen as only for the commissioning DPs and could exacerbate any existing divisions rather than seeking to increase harmonization within the DPHK for a joint approach to RH.

A **Code of Conduct** (CoC) was developed in 2005 which was also used as the International Health Partnership (IHP) compact. The CoC covers 10 areas, i.e. all the important aspects of the Paris Declaration and lays out a clear set of defined objectives. Yet it is not clear how often this is reviewed by the DPs and MOH to assess adherence and progress. The assessment of adherence to the CoC showed that there is: good adherence in the area of national ownership and leadership. The common development framework was developed but has not been updated. DPs are trying to align their support to GOK systems and are interested and exploring how to develop common working arrangements although few are working. Reporting on aid funds was good for overall general funding.

However, as the mission found out - it is very difficult to use the current spend figures to assess support to programmes and areas within programmes. Our assessment shows that the DPs could make more effort in actually developing more common working arrangements, harmonized support to capacity building and being more open and transparent about expenditure against programmes, not just allocations. To maintain the focus on the CoC, a six monthly review of progress between DPs and MOH would help to improve adherence by both parties.

**Harmonization at District Level:** Visits to the districts highlighted that the adherence to harmonization and DPs/IPs working with the District Medical Officers (DMO) is very patchy. There are examples of good practice where IPs worked closely with the DMO in developing the AOPs but in many cases the DMO feel by-passed. With the new Constitution it will be important that all DPs and their IPs are aligned and harmonized with the new counties as they will in future hold the budgets with full responsibility for implementation at this level. **It would be useful and help in generating good practice particularly for the future if a Code of Conduct (CoC) was developed** for the districts/counties to help them in managing and implementing the AOPs in close and constant coordination with the stakeholder forum. DPs should ensure that any MOU with IPs includes a clause that ensures adherence to this CoC and working closely with the respective technical authorities.

### 6.6.2 Reproductive health

The **Division of Reproductive Health (DRH)** - The increased commitment of both MOPHS and DPs offers a great opportunity to move forward with an effective RH programme. But over the last 3 years there has been a number of different heads of DRH which has affected the strength of the leadership provided for RH. The tendency to recruit replacements directly from clinical posts has not helped. The area where DRH would most benefit from more proactive and strategic management is health systems when maternal mortality is a systems failure. The transfer from a clinical position to a management role without the acquisition of skills required to manage a coordinated and effective response risks continual undermining of RH leadership. In view of the shortage of qualified obstetricians in the country to carry out emergency obstetric care, an element of work force HRH planning should be to match

professionals with the right jobs to make the most efficient use of available human resources to deliver health services for women and children. It would be desirable to use professionals with a public health background to manage central programmes rather than clinicians.

**DRH and DCAH:** Support to **Adolescents** ASRH is divided between the Division for Child and Adolescent Health (DCAH) and DRH, where the DCAH is responsible for Adolescent health and DRH for sexual health and rights. Although both these divisions are under the Department for Family Health (DFH) this division does make it more difficult to coordinate a comprehensive coherent approach to Adolescence.

The **RH ICC** meets on a regular basis supported by 5 technical working groups (TWGs on FP, MNH, ASRH, RH Cancers, Gender and the Elderly). There is a recognition by DRH that the RH ICC is not working strategically and is more a "talk shop" so they are in the process of streamlining membership. This is an opportunity for DPs to become more strategically involved with the DRH and help review the TOR of the RH ICC to ensure that it set up to provide the necessary strategic leadership, management and coordination. To do this effectively the DPs will need to commit to sending sufficiently high level staff who can provide strategic inputs to the RH ICC and who will participate on a regular basis. Support to a reformed and revitalised RH ICC would go a long way in demonstrating DPs' commitment and in maintaining the momentum of this mission and the current interest.

**Technical Assistance (TA)** is a major part of assistance to RH. However, for the most part the DRH is not always fully aware of who is providing what TA as there is a tendency for DPs to provide TA without full consultation or discussion. TA to the DRH would benefit from better and more harmonized planning that would help to ensure more efficient use of existing resources and better value for money. The most effective and most harmonized way to handle TA is to have one common TA plan for RH that reflects all significant support from DPs. This should be updated and monitored regularly to ensure TA provision is effective in delivering the agreed outputs, whether discrete activities or skills transfer.

Pooled funding is a stated ambition of the JFA and the COC mentions developing common working arrangements. DRH and Partners could agree to use one TA plan with "virtual" or pooled funding and lessons could be learnt from the management to inform the wider health sector. Due to the concerns around fiduciary risks we would recommend that initially the TA pooled funding should be managed externally by a DP contractor working closely with DRH on the TA planning process. If possible, this support would be better harmonized and more effective if it was aligned with our recommendation that TA is provided to DRH from a health systems adviser.

The **Acceleration** of Maternal, Newborn and Child Survival in Kenya using High Impact Interventions (HII). We feel this HII acceleration plan is the first step in developing an evidence-based costed RH strategy. As discussed previously it will require further analysis of the key health systems components required to ensure effective operationalisation of the plan. These will include: a broadened technical vision, costing and presentation as **RH Business Plan** (RH-BP). There is a considerable amount of information available - significant work has been done on costing the MNBRM, Child Survival Strategy (CSS), KEPI, and FP requirements to achieve a 56% CPR. Therefore much of the costing information already exists to help develop the costed elements of a RH package that presents an evidence based cost- effective framework which will reduce MNM.

It is acknowledged that Business Plans have been developed for DRH in the past and they have not brought about a coordinated approach; why should this one be different? When the previous plans were developed there was not the same interest in RH, the focus was on HIV/AIDS and little attention was paid to MNH. We feel that the time is now right for the

MOPHS/DRH to once again try and take control and leadership of the RH programme. One of the ways to do this is through a costed and cost–effective Business Plan.

There are now examples where BPs are being successfully used to help MOPHS divisions manage their programme (malaria and HIV). But it is essential that the BP it is kept simple and focused and is used as a tool to regularly monitor performance and funding. If the BP is perceived to have value it will be used.

The essence of an open and transparent relationship between MOPHS and DPs/ IPs is an agreed strategic RH framework based on strategic priorities that will help Kenya achieve MDG 4 and 5, laid out in a costed Business Plan. The RH-BP would allow DRH to manage and coordinate a coherent, comprehensive approach to RH; ensure more efficient and transparent use of available resources through DPs allocating and reporting against the key areas in the plan; and be used to mobilise additional resources, particularly if the RH-BP is based on results.

DPs should then be asked to allocate and report against the thematic areas in the agreed BP which will help guide the allocation and prioritisation of resources. The RH-BP should be used to hold all partners (MOPHS, DRH, MOMS, DPs, IPs) accountable for their spending and performance.

The **Alliance** for Reproductive Health, Maternal and Newborn Health (RMNH) launched in September 2010 by UN Secretary General and supported by DFID, USG, AUSAID and Bill and Melinda Gates Foundation (**Global Alliance**) has given extra momentum and impetus to efforts to reduce Maternal and Newborn Mortality (MNM). This group has agreed to focus on evidence based strategies (e.g. scale up skilled birth attendance & family planning) and to do this through “supporting country strategies to scale up proven high impact interventions“ and not to introduce new initiatives. Many of these DPs are in process of developing their new programmes of support for the next 5 years. The signed CoC and the new programming is an opportunity for the MOPHS to take the leadership and request increased and harmonized and aligned support from the DPs to help reduce MNM and help achieve MDG 4 and 5.

Joint Planning and Programming: There are many opportunities for better harmonization, coordination and complementary working nationally and at district level through the AOP, particularly with the APHIAplus programmes as they are working throughout the country. In looking for opportunities for joint programming, we were aware of balancing the benefits of a joint approach with ensuring the delivery of results. Therefore, any future design of what is being proposed would need to review that the joint approach is the best mechanism to deliver the programme and achieve results, and will add value.

**Criteria for Joint Planning and Programming**

Possible areas of joint programming include:

- Where one DP working alone would not be able to provide sufficient funds to scale up evidence – based interventions to achieve an impact;
- the programme requires a mix of skills and partnerships that cannot be provided by one DP alone;
- Those areas where individual DPs support the same area/ activity e.g. procurement, training which could result in fragmented coverage, duplication and inequity resulting in inefficient use of available resources;
- reduced transaction costs for MOH.

### 6.6.3 Recommendations

The following recommendations refer to the previous two sub-chapters. In addition, recommendations with regard to the policy framework need to be taken into consideration as they are part of governance.

**Recommendations to the MoPHS**

- Building on the HII acceleration plan develop an effective continuum of care and an evidence based costed RH strategy with an agreed set of core indicators presented as a RH Business Plan (BP) that can be used to harmonize and coordinate all support to RH in Kenya and help Kenya achieve MDG 4 and 5.
- One TA plan should be developed to support the RH-BP. The MOPHS/ RH ICC should take leadership of RH using the RHICC and the RH-BP and one TA plan to prioritise support and hold all partners accountable
- Carry out a Joint Annual Reviews of the RH-BP which should feed into the annual health summit thus ensuring alignment with the SWAp
- Future vacancies for the head of DRH and senior staff should be open to applications, with public health training, and management and health systems skills heavily weighted among the selection criteria.
- Support to the ASRH should be managed by one division to help ensure a coherent comprehensive approach.

**Recommendations to DPs**

- Immediately provide support to the MOPHS to build on the HII acceleration plan to deliver an effective continuum of care and develop an evidence-based costed RH strategy presented as an RH Business Plan (BP). DPs should then allocate existing resources and report against the thematic areas in the agreed BP which will help guide the allocation and prioritization of additional resources.
- DPs to help to make the RH ICC and TWGs operate more strategically by appointing sufficiently senior staff to participate to enable them to function more effectively as the strategic coordinating structure for RH.
- Provide additional TA to DRH in the form of a health systems adviser either embedded in DRH or placed in WHO (e.g. as part of the Health Systems Strengthening programme currently funded by DFID). This person could support DRH management and coordination of the BP through strengthening existing systems in RH, particularly the RH ICC. In addition, this person could ensure that DRH is playing its role in the wider sector planning (SWAp) and the changes required as Kenya moves to a devolved system of government.
- The TA plan - where possible - should be supported through pooled funding or at minimum “virtual pooling” from the commissioning DPs and all other interested DPs as this would reduce fragmentation and help to ensure harmonized support. Due to the concerns around fiduciary risks we would recommend that initially the TA pooled funding should be managed externally by a DP contractor working closely with the DRH on the TA planning process. If possible, this support would be better harmonized if it was linked to the TA from the health systems adviser.
- The consultants do not recommend that the RMNH Alliance Kenya develops a separate set of principles. But as a group the concerned, DPs should lead by example and maintain the momentum from this mission by supporting the development of the RH Business Plan and also the implementation of the recommendations from this mission’s report relating to harmonized and aligned support to RH. They should involve all DPs through DPHK to strengthen existing health sector systems and coordination structures.
- The Code of Conduct (CoC) should be reviewed six monthly between DPs and MOH to help to improve adherence by both parties.

- All DPs should participate in the Joint Annual Review of the RH BP and should not be holding separate reviews of their own projects.
- DPs to harmonize per diems for RH - this is acknowledged as a difficult area but the practice is resulting in internal competition between IPs and therefore inefficient use of resources and poor value for money.

# 7 Conclusions and recommendations

## 7.1 Major conclusions and recommendations

The expectations expressed in the ToRs that the mission on harmonizing support to RH in Kenya would present a prioritized and cost-effective plan for quick-win solutions with joint DP support cannot be met. Health services more broadly, and RH specifically, are fundamentally *systems* - i.e. a group of interacting and interdependent elements forming a complex whole - where defining a clear and simple set of priorities is not possible. Action is needed on a range of fronts simultaneously. We have however, attempted to identify a *set of actions* that are most urgent and most feasible, and a further set of interventions which are necessary but of lower priority or are likely to take longer to implement.

The analysis of the available information does not allow robust recommendations for immediate action to be proposed. In particular, the search for priority support gaps through mapping of MOPHS RH priorities against existing DPs commitment hit several bottle-necks: the first was that the MOPHS does not have one document clearly laying out its priorities in RH, and second, the DPs reflect their funding to RH under 4 rather broad categories of (1) MCH commodities, (2) MCH O&M, (3) RH commodities and (4) RH O&M. These broad categories make it difficult to provide clear recommendations on what components of MNH require increased support. Reviewing DPs' support against the technical outputs of the national RH strategy and the MNH Road Map, the consultants found a clustering of activities against MNH and FP with seemingly very little support for RH more broadly and particularly for adolescents.

The consultants see the **HII acceleration plan** as an important first step to improve RH services. The next step should be to define and agree on the minimum packages identified in the continuum of care, including critical health systems components to ensure linkages between the packages to deliver an effective continuum of care. Implications and costed requirements in all health systems components need to be looked at with regard to policy modifications, human resources, skills development, RH commodities and equipment, logistics, responsibilities of different levels, demand creation, equity measures, contributions from different health sectors, infrastructure, M&E and OR, etc. It is recommended that this **expanded HII acceleration plan** should form the basis for developing an **RH Business Plan** and that **TA should be provided immediately** to support the MOPHS/DRH.

International evidence and specific analysis of the Kenyan situation regarding MNH confirm the priorities set in the 2011 HII acceleration plan. Thus, MOPHS, DPs and IPs should agree to focus on areas for which immediate measures seem to promise positive results that are achievable provided they are accessible for the targeted population, reliable, scaled up and rolled out as far as possible. The impact would largely depend on the scale of contributions and the reallocation of human and financial resources.

The following RH specific areas are suggested to be addressed as priority joint undertakings:

- Scale up skilled birth attendance;
- Scale up comprehensive emergency obstetric care;
- Make family planning more reliable and address unmet need.
- While poor women of reproductive age with low level of education particularly in rural areas are the general target group of these measures, special attention needs to be given to adolescents and young people.

In view of the upcoming devolution of Kenya's political system and the restructuring of the health sector, a major focus should be placed on assisting all levels of the health system to manage the implications of devolution regarding responsibilities, technical, financial and personnel management, priority setting and the coordination of national and international partners. Responding effectively to the demands of devolution may require considerable flexibility in plans, budgets and in the location of project sites.

Although the individual DPs have different support mechanisms, these should be used to complement each other. It is critical that funding allocations and reporting are as transparent as possible.

Whilst the mission has been asked to look at the RH sub–sector, it was emphasized that any support should strengthen health systems and the SWAp and the consultants concur fully with this principle. Where possible, DPs should support the existing central baskets of EMMS and HRH, at a minimum through joint planning ("virtual pooling") and eventually pooled funding of EMMS and HRH measures. These are two critical areas for RH where joint planning is essential to avoid duplication and to ensure the right people are in the right place and there is a scale up in the provision of equipment and supplies needed to increase the coverage of skilled birth attendance.

The cost of access to RH services is a major access barrier and creates inequities in the health sector. A number of DPs are addressing this problem through a variety of pilot schemes. Although not RH specific, these pilots should be continued and utilized to inform the revision of relevant policies.

The **modalities** of a harmonized support to RH in Kenya should be based on the following framework and agreements:

- RH Business Plan
- One common Technical Assistance plan
- Pooled funding, where possible
- One RH commodity plan
- Regular review of Code of Conduct at central level
- New Code of conduct at district / county level
- Global RH Alliance in line with Code of Conduct

## 7.2 Specific recommendations

The mission's recommendations derived from observations and analysis are presented in the following according to the six HSS building blocks used in the report. As the fundamental issue is harmonization, the presentation starts with recommendations in this key area.

**Governance and harmonization**
**Recommendations to MOPHS**

- Building on the HII acceleration plan develop an effective continuum of care and an **evidence – based costed RH Business Plan (RH-BP)** with an agreed set of core indicators hat can be used to harmonize and coordinate all support to RH in Kenya and help Kenya achieve MDG 4 and 5.
- One TA plan should be developed to support the RH BP.
- These documents shall provide the basis for the **districts/counties** to assess their own situation to identify key gaps taking into consideration local needs and available

capacity needed to be able to deliver the packages of care and develop an action plan.

- The MOPHS/ RH ICC should take leadership of RH, using the RH-ICC and the RH-BP and one TA plan to prioritize support and hold all partners accountable.
- Carry out Joint Annual Reviews of the RH BP which should feed into the annual health summit so ensuring alignment with the SWAp.
- Future **vacancies** for the **head of DRH and senior staff** should be open to applications, with public health training, and management and health systems skills heavily weighted among the selection criteria.
- Support to the **ASRH** should be managed by **one division** to help ensure a coherent comprehensive approach.
- Revise the **Contraceptive Security Strategy** towards a comprehensive strategy encompassing all commodities necessary to assure RH services more generally (**RH Commodity Security Strategy**).
- With regard to the **Community Strategy**, an options appraisal comparing the cost-benefit with (a) lower cost approaches and (b) expanding the training of skilled birth attendants should be undertaken before proceeding with up-scaling.
- MOPHS, in conjunction with the DPHK/SWAp Secretariat, should create a **mapping inventory** of the geographical and thematic distribution of DP investments in the RH sub-sector.

**Recommendations to DPs**

- Immediately provide support to the MOPHS to build on the HII acceleration plan to deliver an effective continuum of care and develop an evidence-based costed **RH Business Plan (RH-BP**). DPs should then allocate existing resources and report against the thematic areas in the agreed BP which will help guide the allocation and prioritization of additional resources.
- DPs should urgently provide **TA** to MoH to support the Ministries in being proactive in navigating in the new constitution and the implications of the **devolution** on the RH sub-sector. This support should be provided **at national and sub-national level**.
- DPs help to make the **RH ICC and TWGs operate more strategically** by appointing sufficiently senior staff to participate so it is able to function as the coordinating strategic structure for RH.
- Provide additional TA to DRH in the form of a **health systems adviser**.
- The **TA plan** - where possible - should be supported through **pooled funding** or at minimum “virtual pooling” from the commissioning DPs and all other interested DPs in order to reduce fragmentation and ensure harmonized support.
- **The Code of Conduct (CoC)** should be reviewed six monthly between DPs and MOH to help to improve adherence by both parties. It also needs to be reviewed as to how it would operate at County level.
- All DPs should participate in the Joint Annual Review of the RH BP and should not be holding separate reviews of their own projects.
- DPs should harmonize **per diems for RH** - this is acknowledged as a difficult area but the practice is resulting in internal competition between IPs and therefore inefficient use of resources and poor value for money.

**Health financing**

**Specific recommendations**

- DPs – particularly those already involved in the various health financing initiatives - should work with GoK to revise the Health Financing Strategy along the dual lines proposed and in the light of the experience with KNHIF, the various demand side pilots and the implications of fiscal devolution for the health sector. VfM analyses

should be regularly conducted for any innovative interventions with policy implications.

- Joint support to the OBA voucher scheme: It would be important to scale up the pilot OBA voucher scheme supported by KfW as one of the promising demand-side approaches and also test new options and technologies

**Further recommendations**

- The impact of various GoK and DP interventions on user fees and cost of access should be regularly monitored: Interventions such as commodity support to KEMSA and HSSF should be reducing the drivers on facilities to implement informal charging policies – still an important barrier to access. The Mission found no systematic monitoring of this, however. It is recommended that this is rectified, possibly by inclusion in HSSF monitoring.

**Service delivery**
**Specific recommendations**

- Building on the HII acceleration plan, MOPHS should define a minimum package for each of the 4 critical areas, including the critical health systems components and ensure linkages between the packages and therefore the **scaling up of an effective continuum of care** (i.e. pre-pregnancy, pregnancy, birth, newborn/post-natal care).
- DPs should immediately support a joint programme to accelerate the **training of LSS** – EONC and up-scaling of CEmOC through the pooled RH TA plan and RH commodity plan country–wide. This could be done through the existing LSTM programme or a redesigned national programme.
- **FP services** need to be strengthened addressing unmet need for particular FP methods and in geographic regions where CPR is lowest among poor rural women with low education levels. The coverage with **LAPM** needs to be further expanded.
- All DPs should consider **joint** investment in the **RH Communication** Strategy and its SBCC Implementation Guide.
- Ongoing Social marketing programmes should participate with harmonized key messages.
- It is recommended that IPs support particularly **YFS in health facilities**, e.g. by establishing adolescent friendly corners in health facilities.
- At central level, DPs should support the development of implementation plans for the ASRH policies.
- Harmonize urgently different social franchising approaches and regulate issues such as accreditation and licensing, quality control, coverage, etc.

**Further recommendations**

- Accelerate PPPs with FBO service providers particularly in hardship regions of Kenya to increase coverage of RH services.
- DHMTs (or County HMTs) should be technically and financially supported through DPs/IPs to coordinate comprehensive ASRH programmes in partnership with other sectors.
- Within the RH ICC, strengthen the link between the TWGs on FP and on ASRH, to which partners from non-health sectors should be co-opted.
- DPs should take advantage of the RH Communication Strategy to jointly address **adolescents and youth**.
- Where **Community Units** are established, community mobilization could address particularly the 1st delay factors, CHWs and CHEWs to promote survival of both mothers and newborns.

- Create a **forum for dialogue** at all levels to engage stakeholders in RH at all levels of the health system and thus ensure stewardship of the MoH, including **non-state service providers**.
- **Franchising public private partnerships** in key health markets such as FP commodities and other RH services should be upscaled.
- Include **private sector** providers in RH **training** programmes that are financed through DPs.

**Human Resources for Health**
**Recommendations**

- Immediately contribute to pooled TA or to a pooled fund for HRH recruitment and incentives, especially for HRH at levels 1, 2 & 3;
- Accelerate the application of an incentive package that clearly favours rural hardship areas.
- MoH Staff trainings by DP projects should be conducted in consultation with District/County and Provincial MoH offices and in accordance with MoH priorities.
- Address skills and competency gaps and improve staff attitudes to customers, MoH to institute on-the-job training and mentoring to augment residential trainings.
- KHWIS should be used to monitor implementation and assess the impact of the proposed incentives package

**Health Management Information System / Operational Research**
**Recommendations**

- DPs should assist the MOPHS at central level to collate and analyze individual or a sample of maternal death audits to help set health systems priorities.
- Align DPs project reporting forms to those of GoK reporting forms
- MOPHS should consider appointing a Knowledge Management Adviser in DRH and DPs supporting.
- The RH-ICC should take responsibility in reviewing all OR proposals to ensure alignment with the RH-BP and priorities for Kenya, and that information thus obtained is used to inform policy and planning.
- DPs should support MOPHS to conduct VFM analyses of particular intervention approaches in order to inform strategic decision making in RH.

**Further recommendations**

- Revise and approve data management tools at levels 1&2 to make them more user friendly and in line with those data tools at higher levels.
- Support the districts with Community Units to provide more and regular support supervision to Community Units to improve data quality and timely reporting and ensure that districts provide feedback to levels 1&2.
- DPs should support the revision of data tools for levels 1 and 2.
- Enact legislation to compel private providers to submit reports to MoH regularly and timely.

**RH commodities and infrastructure**

**Recommendations**

- It is recommended that all RH commodities (including contraceptives) are integrated into the general supply chain management.
- DP support to the supply chain should cover all commodities essential for scaling up the High Impact Interventions.
- MOH should factor in RH commodities in the facility drawing rights for EMMS.

- It is urgent to streamline the "Pull" and "Push" system where applicable to avoid waste and/or artificial shortages.
- DPs should allocate additional funds in AOP 7 for infrastructure and equipment in level 2 and 3 facilities, especially in high need areas like Nyanza, Western, Coastal and North Eastern Provinces.

**Further recommendations**

- Accelerate the rehabilitation and expansion of current facilities to accommodate current and rising demand for MNH/FP services and to enable the facilities to provide additional services and safe deliveries
- Develop national policy to guide investments in physical facilities. Among the guidelines to be provided by this policy include those on establishment of the different levels of facilities.
- Review the health facility infrastructure norms and standards to address emerging considerations such as distance from facility and achievement of equity in distribution.
- Integrate into the mainstream health facilities network all facilities constructed through different initiatives, including those under CDF.

## 7.3 Proposed areas of new DP support

In addition to harmonizing and eventually scaling up currently planned support, the following areas are suggested for new joint support:

**Strengthen the capacity of DRH**. Additional TA should be provided to DRH in the form of a **health systems adviser** either embedded in DRH or placed in WHO (e.g. as part of the Health Systems Strengthening currently funded by DFID).

**Joint programme to scale up the coverage of CEmOC:** Immediately support a joint programme to accelerate the training of LSS – EONC through the pooled RH TA plan and RH commodity plan country – wide

**Strengthen the DP/IP harmonization at district/county level.** It is recommended to provide TA to DHMTs /County HMTs in order to develop and implement a coordination mechanism that allows proactive and results-based implementation of the Code of Conducts (e.g. a new component of GIZ TA eventually co-financed by DPs).

**Joint support of RH Communication:** All DPs should ensure in their respective areas that the planned campaigns are carried out in a coordinated way. There is need for co-financing, which could be done through funding from Danida or the KfW Development Bank (IEC Fund).

**Joint support to the OBA voucher scheme**: It would be important to scale up this pilot scheme and also test new options and technologies in managing the vouchers, the type of services to be covered, etc.

**Joint support to enhance comprehensive interventions for ASRH, including YFS**: As the most promising approach is a combined multisectoral strategy, strategic planning of a joint up-scale of interventions in various sectors based on the new information about youth's needs in Kenya and best practice analysis is recommended in view of the magnitude of ASRH needs.

# 8 Attachments

## 8.1 Terms of reference

**Terms of Reference: Harmonising Support to RH in Kenya**

**Background**

With the current pace of progress, Kenya will not reach the Maternal Mortality related MDG 5. While there has been some progress towards MDG 4 and MDG 6 during recent years, maternal and newborn health indicators have almost stagnated with only marginal improvement. The Kenya Demographic and Health Survey (KDHS) 2008 shows the neonatal mortality rate has, during the past five years, reduced insignificantly from 33 to 31/1000 and the estimate for the maternal mortality ratio has risen to 488/100,000 live births.

There are major access barriers for poor women and families who attend maternal and child health services. Disparities in the use of health services and of professionals for delivery by the status of education persist and widen despite substantial investments in the past.

Use of Health Care Facilities and Professionals for Delivery
Data from the KDHS 1993, 1998, 2003 and 2008

| KDHS Indicator | Education | 1993 | 1998 | 2003 | 2008 |
|---|---|---|---|---|---|
| **Delivery by a health professional in % of all deliveries** | No education | 23 | 24 | 15 | 19 |
| | Secondary and above | 73 | 71 | 72 | 72 |
| **Delivery in a health facility in % of all deliveries** | No education | 23 | 27 | 14 | 15 |
| | Secondary and above | 71 | 72 | 70 | 72 |

The Public Expenditure Tracking Survey 2007 reveals, more than 50% of women pay for deliveries which in principle should be for free for all. Data from the 2008 DHS suggest that free services are not working as intended. Waivers and exemption policies are implemented at the health facility's discretion, often arbitrarily. There is ample significant evidence the current system excludes many poor people from access to care.

There are a number of development partners (DPs) who are providing substantive support to reproductive health (RH) in Kenya. A number of bilateral DPs are in the process of designing new support or developing detailed work plans and would like to coordinate this programming to ensure optimal coordination and to maximise the opportunity for complementarity and synergy.

DFID Kenya's current support to RH includes social marketing condoms and hormonal contraceptives, and a maternal health project, Essential Health Services (EHS), in Nyanza Province. Over the next 4 years DFID Kenya has £X over 4 years for maternal health and £X over 4 years for family planning support. Initial scoping suggested that the MH funds should expand the coverage of DFID's current EHS project and FP funds would help to scale up a) long acting and permanent methods through outreach and b) short term methods through

community based distribution. However, this is not set in stone and DFID is willing to respond to the priority needs of RH in Kenya.

USAID Kenya has a new implementation framework for health assistance to Kenya for the period 2010 to 2015. It is called APHIAPlus and represents an integrated program in HIV/AIDS, TB, Malaria, FP/RH, MNCH, Nutrition and water and sanitation with a focus on health system strengthening, improvement in quality of health services, with attention to the social determinants of health through a country led country owned process for sustainability. The support to GOK is given at national and district level. In FP/RH USAID support includes supply chain, procurement of contraceptive commodities, advocacy and behaviour change, leadership and management and improvement in access to and quality of FP services. An important component is the integration of RH and HIV services with MNCH. Support to MNCH focuses on improvement of service quality and support at the national level for better coordination and planning of the national MNCH program. Currently USAID has five new regional integrated service delivery projects in all eight provinces and over the next two years will be designing national level projects.

German Development Cooperation is supporting Kenyan health reforms within the framework of NHSSP, especially in the fields of sexual and reproductive health, gender-based violence and health financing. GDC supported programs seek to ensure access to qualified health services for the poor by demand-side financing projects (OBA Voucher), social franchising networks, pilots of health care insurance, supply of commodities and by capacity building at governmental and provider level. GDC programs are implemented by GOK in close cooperation with the private sector. Vision 2030 is to facilitate the establishment of a social health insurance for all Kenyans covering amongst others reproductive health and GBV services.

Danida is currently formulating the phase three of support to health sector, with an appraisal mission scheduled for end of March beginning April 2011. The support will scale up support to the KEPH by pooling funds through JFA into three baskets namely HSSF, EMMS and additional Human Resources. In addition, Danida will support Sexual Reproductive health and rights with a communication strategy to increase demand for RH, support systems leading to increased delivery by skilled attendant, and referral systems in order to reduce maternal and new born mortality and maternal audits. Support to SWAp to improve coordination mechanism is also envisaged.

Bill and Melinda Gates Foundation is supporting a five year urban reproductive health initiative. The Initiative, 2010-2014 will focus on meeting the unmet need of the poor in the slums of Nairobi, Mombasa, Kisumu, Kakemega and Machakos. Harnessing the private sector and demand creation will be part of the implementation. Various approaches will be tested and validated for cost-effectiveness and replicability.

**Objectives**

- To recommend/define prioritised appropriate and cost effective support to RH by participating DPs (USAID, GDC, BMGF, Danida, DFID) and reflect this in as much detail as is needed, according to individual DP programming/design needs.
- To define priority support gaps (institutional/health systems, as well as service delivery) and scoping future support including developing and appraising options
- To recommend support modalities that are as aligned and harmonised as is feasible, according to their comparative advantage and based on jointly agreed priorities. This should also align with support by other major supporters of SRH apart from the commissioning DPs.

*Underlying all the above is an emphasis on integration and strengthening health systems.*

**Recipient**

The recipients are the above named 5 DPs together with the Ministry of Public Health and Sanitation and Ministry of Medical Services.

**Scope:**
The consultants will produce a report that includes:

- An appraisal of policies and plans for RH, including current draft Annual Operation Plans (including reports on prioritization of High Impact Interventions and addressing bottlenecks to their achievement), as well sector and RH strategic plans and other relevant framework documents
- Recommended changes to any framework documents and recommendations for the next health sector policy
- A mapping of support for RH against priorities and plans that leads to recommendations on areas of cost effective, priority support to improve maternal and newborn health (MDG 4 and 5). This should include specifics on approaches, geographical focus, delivery mechanisms, target beneficiaries, indicative budgets, etc. This should be justified by sound analysis of the situation in RH in its broadest terms including institutional development, structure and capacity, equity etc. Priorities for health system strengthening as well as service delivery should all be considered.
- Modalities of future support – specifying a) how development partners and implementing partners can more effectively and appropriately support RH, and b) how DPs and IPs can work better together, including mechanisms that could be improved and/or should be created to improve alignment and harmonisation, and reduce transaction costs.
- Recommendations that address SRH through demand side approaches in view of the intended health financing strategy including HSSF.
- A review of current and proposed community strategies for RH and MNH and recommendations on feasible/cost effective modalities of implementation which includes budgetary support within the health financing strategy.
- Role of a communication strategy in demand creation for SRH intervention with specifications on behaviour change and advocacy priority messages, channels, and approaches appropriate for different partners considering funding this area.
- Recommendations on the cooperation with the private sector as service provider, health insurer, third party administrator, innovative agent (e.g. by introducing new technologies), implementing partner and co-financer (e.g. by PPP)
- Recommended areas of operations research needed to further inform approaches and strategies, giving brief specifics on reason needed and study design
- Annexes that contain text which each individual agency needs to facilitate approval of funds in the future and which are specified by each agency below
- Recommendations on how the RH Alliance (an informal group of DPs committed to a) accelerating progress to MDG 5, and b) working better together) can best be implemented in Kenya given the existing coordination structures, variable coordination effectiveness at different levels, and the contents of the sector MOU. If a set of guiding principles or undertakings for DPs and their partners is considered useful, the team will help to develop these.

In considering priority support and appropriate and feasible modalities, the team should ensure that all identified support should be integrated, strengthen capacity at all levels, strengthen health systems and help to develop the SWAp. The implications of the new Constitution should be incorporated.

**Specific needs by individual DPs**

It may be preferable to deliver some sections of the report as annexes, particularly draft text for individual DPs to facilitate work-planning/design completion and approval/release of

funds. These specific DP requests will be clarified further during the in-country phase of the mission. In this context, DP-specific deliverables are as follows:

**DFID:**
DFID is assuming it will fund family planning, maternal health and innovative approaches to private sector delivery. These could be packaged as three separate programmes or a combination (including with other DPs). The consultants should advise (in consultation with DFID and others) on how they should be packaged. For each programme, the following parts of the business case are needed: draft project summary, stage 1, the appraisal case of stage 2, theory of change and log frame. The selected set of interventions should be based, among other things, on value for money and the feasibility of increasing demand for and accessibility to RH services by poor women.

**GDC:**
GIZ is in the process of planning for its new programme phase and the KfW is concluding its programme proposal. Both processes will benefit from the results of the joint mission. The mission report should therefore include recommendations on innovative approaches that require scaling up and support. This is especially in the area of demand side interventions as well as increasing access to adolescent sexual reproductive health and quality maternal health.

**Danida**
A report with prioritised areas of intervention with proposals on modality of implementation.

**USAID**
This will provide a reference framework for USAID useful for the development of the agencies national level assistance for FP/RH and to help focus the support for MNCH over the next five years given the limited USAID funding for this programmatic area.

**Methodology:**

The consultants will conduct a literature review, undertake a field trip, and conduct interviews with key stakeholders. They will identify the key needs of the Ministries of Health; the lessons learned from approaches and projects to date; the parameters, ongoing support, and comparative advantage of the DPs involved; and the findings of sector and programme annual reviews. These will all be factored into the proposed priorities for support and the recommended approaches.

Ownership by all key stakeholders is crucial. Briefing, interim report back, and final debrief should be an opportunity to obtain feedback from all those involved, which should be reflected in the final report.

If possible and appropriate, the mission should contribute to RH planning. For example, detailed programming for year 1 support should be presented in a format that can be easily incorporated into the AOP 7 (2011-12). All products should be developed in close collaboration with the Division of Reproductive Health and the RH Interagency Coordinating Committee and DRH technical working groups. It is essential that this exercise builds on what is already agreed.

Much is known about RH in Kenya. The team should add value by building on what is known and taking thinking forward, rather than confirming existing consensus/knowledge.

The team will comprise:
- RH specialist
- Health economist /health financing specialist

- Institutional specialist/health systems strengthening
- Harmonisation specialist

Team members should have substantial experience in programme design and, between them, be familiar with formats and requirements to satisfy the specific needs of the abovementioned development partners.

**Reporting**

The consultants will report to a joint steering committee comprising Ministry of Public Health, Ministry of Medical Services, DFID, USAID, GDC, Danida and BMGF and selected stakeholders.

**Timeframe and Deliverables:**

The consultancy mission will be undertaken in country for 3 weeks, mid February - early March 2011. The specific deliverables with timelines are outlined in the table below:

| Deliverables | Due By | Responsible |
|---|---|---|
| 1. Consultancy team in-country | 13th February – 4th March | Team leader |
| 2. Draft report outline (with Annexes) | 4th March | Team leader |
| 3. Comments on draft report submitted | 25th March | Steering Committee |
| 4. Final report (with Annexes) | 8th April (Tentative) | Team leader |

**Notes for the final report:**
***See also draft reporting framework***

- Future support should be presented holistically, incorporating a programme approach, including all areas supported by key stakeholders, rather than lists of individual DP priorities.
- Ideally, future support should be presented in a way that corresponds to Government of Kenya RH plans, or in a way that could be easily transformed into an RH business or implementation plan.
- Modalities should attempt to incorporate optimal harmonized approaches within the limitations of individual DPs. Transaction costs should be minimized**.**

***The team leader is accountable for the deliverables of the consultancy to the steering committee and will assign tasks to team members based on the scope of work and relevant specialized experience.***

**Coordination**
The focal point in organising the mission is Patricia Odero, GIZ.
Feedback on the report will be consolidated and coordinated through a focal point- Tony Daly (DFID)

**Annexes:**

1. Draft Division of Labour chart
2. Draft reporting framework

## 8.2 Mapping of DP presence

**Annex 8.2.-1**

Table 4: Development Partner (DP) Presence in Districts, 2011

| PROVINCE | OLD DISTRICT | NEW DISTRICT | POPULATION (2009, KNBS) | Poverty (old districts) Economic Survey 2005 | DPs | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | GIZ | KfW | DANIDA | DFID | USAID APHIA+ | BMGF |
| Kenya | | | 38,616,097 | 45.9 | | | | | | |
| 1. NAIROBI | 1. Nairobi | | 3,138,369 | 43.9 | | | | | | |
| | | 1. Nairobi West | 684,765 | | | | | | | |
| | | 2. Nairobi East | 1,144,416 | | | | | | | |
| | | 3. Nairobi North | 1,062,086 | | | | | | | |
| | | 4. West Lands | 247,102 | | | | | | | |
| 2. COAST | | | 3,325,307 | | | | | | | |
| | 2. Mombasa | Mombasa | 523,183 | 42.6 | | | | | | |
| | | Kilindini | 416,187 | | | | | | | |
| | 3. Kwale | Kwale | 151,978 | 63.0 | | | | | | |
| | | Kinango | 209,560 | | | | | | | |
| | | Msambweni | 288,393 | | | | | | | |
| | 4. Kilifi | Kilifi | 456,297 | 73.6 | | | | | | |
| | | Kaloleni | 252,924 | | | | | | | |
| | 5. Malindi | Malindi | 400,514 | 64.9 | | | | | | |
| | 6. Tana River | Tana River | 143,411 | 38.3 | | | | | | |
| | | Tana Delta | 96,664 | | | | | | | |
| | 7. Lamu | Lamu | 101,539 | 49.0 | | | | | | |
| | 8. Taita Taveta | Taita | 216,992 | 58.8 | | | | | | |
| | | Taveta | 67,665 | | | | | | | |
| 3. | | | | | | | | | | |

| PROVINCE | OLD DISTRICT | NEW DISTRICT | POPULATION (2009, KNBS) | Poverty (old districts) Economic Survey 2005 | DPs | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | GIZ | KfW | DANIDA | DFID | USAID APHIA+ | BMGF |
| NORTH EASTERN | | | 2,316,757 | | | | | | | |
| | 9. Garissa | Garissa | 196,062 | 62.9 | | | | | | |
| | | Lagdera | 245,123 | | | | | | | |
| | | Fafi | 95,212 | | | | | | | |
| | 10. Ijara | Ijara | 92,663 | 62.9 | | | | | | |
| | 11. Wajir | Wajir South | 130,070 | 66.1 | | | | | | |
| | | Wajir North | 135,505 | | | | | | | |
| | | Wajir East | 224,418 | | | | | | | |
| | | Wajir West | 171,948 | | | | | | | |
| | 12. Mandera | Mandera Central | 417,294 | 64.5 | | | | | | |
| | | Mandera East | 288,687 | | | | | | | |
| | | Mandera West | 319,775 | | | | | | | |
| | | Mandera North | | | | | | | | |
| 4. EASTERN | | | 5,668,123 | | | | | | | |
| | 13. Moyale | Moyale | 103,799 | 62.0 | | | | | | |
| | 14. Marsabit | Marsabit | 46,502 | 62.2 | | | | | | |
| | | Chalbi | 75,196 | | | | | | | |
| | | Laisamis | 65,669 | | | | | | | |
| | 15. Isiolo | Isiolo | 100,176 | 50.7 | | | | | | |
| | | Garbatula | 43,118 | | | | | | | |
| | 16. Meru Central | Meru Central | 141,768 | 43.6 | | | | | | |
| | | Imenti North | 258,947 | | | | | | | |
| | | Imenti South | 179,604 | | | | | | | |
| | 17. Meru North | Igembe | 482,756 | 59.5 | | | | | | |

| PROVINCE | OLD DISTRICT | NEW DISTRICT | POPULATION (2009, KNBS) | Poverty (old districts) Economic Survey 2005 | DPs | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | GIZ | KfW | DANIDA | DFID | USAID APHIA+ | BMGF |
| | | Tigania | 293,226 | | | | | | | |
| | 18. Meru South (Nithi) | Meru South | 128,107 | 58.3 | | | | | | |
| | | Maara | 107,125 | | | | | | | |
| | 19. Tharaka | Tharaka | 130,098 | 63.1 | | | | | | |
| | 20. Embu | Embu | 296,992 | 58.3 | | | | | | |
| | 21. Mbeere | Mbeere | 219,220 | 64.3 | | | | | | |
| | 22. Kitui | Kitui | 447,613 | 69.9 | | | | | | |
| | | Mutomo | 180,148 | | | | | | | |
| | 23. Mwingi | Mwingi | 244,981 | 62.4 | | | | | | |
| | | Kyuso | 139,967 | | | | | | | |
| | 24. Machakos | Machakos | 442,930 | 60.1 | | | | | | |
| | | Mwala | 163,032 | | | | | | | |
| | | Yatta | 273,519 | | | | | | | |
| | | Kangundo | 219,103 | | | | | | | |
| | 25. Makueni | Makueni | 253,316 | 62.0 | | | | | | |
| | | Mbooni | 177,832 | | | | | | | |
| | | Kibwezi | 248,704 | | | | | | | |
| | | Nzaui | 204,675 | | | | | | | |
| 5. CENTRAL | | | 4,383,743 | | | | | | | |
| | 26 Nyandarua | Nyandarua North | 308,551 | 37.2 | | | | | | |
| | | Nyandarua South | 287,717 | | | | | | | |
| | 27. Nyeri | Nyeri North | 324,659 | 31.0 | | | | | | |
| | | Nyeri South | 368,899 | | | | | | | |
| | 28. | Kiriyanga | | | | | | | | |

| PROVINCE | OLD DISTRICT | NEW DISTRICT | POPULATION (2009, KNBS) | Poverty (old districts) Economic Survey 2005 | DPs | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | GIZ | KfW | DANIDA | DFID | USAID APHIA+ | BMGF |
| | Kirinyaga | | 528,054 | 32.9 | | | | | | |
| | 29. Murang'a | Muranga North | 346,283 | 29.6 | | | | | | |
| | 30. Maragwa | Murang'a South | 432,701 | 34.5 | | | | | | |
| | 31. Kiambu | Kiambu East | 253,751 | 22.7 | | | | | | |
| | | Kikuyu | 265,829 | | | | | | | |
| | | Kiambu West | 131,132 | | | | | | | |
| | | Lari | 123,895 | | | | | | | |
| | | Githunguri | 147,763 | | | | | | | |
| | 32. Thika | Thika East | 77,073 | 35.3 | | | | | | |
| | | Thika West | 218,544 | | | | | | | |
| | | Ruiru | 241,007 | | | | | | | |
| | | Gatanga | 113,094 | | | | | | | |
| | | Gatundu | 214,791 | | | | | | | |
| 6. RIFT VALLEY | | | 10,006,805 | | | | | | | |
| | 33. Turkana | Turkana North | 374,414 | 59.3 | | | | | | |
| | | Turkana Central | 254,606 | | | | | | | |
| | | Turkana South | 226,379 | | | | | | | |
| | 34. West Pokot | Kacheliba | 156,011 | 53.0 | | | | | | |
| | | Kapenguria | 181,063 | | | | | | | |
| | | Singor | 175,616 | | | | | | | |
| | 35. Samburu | Samburu West | 164,853 | 39.8 | | | | | | |
| | | Samburu East | 59,094 | | | | | | | |
| | 36. Trans Nzoia | Kwanza | 236,218 | 51.1 | | | | | | |
| | | Sabot | 387,366 | | | | | | | |

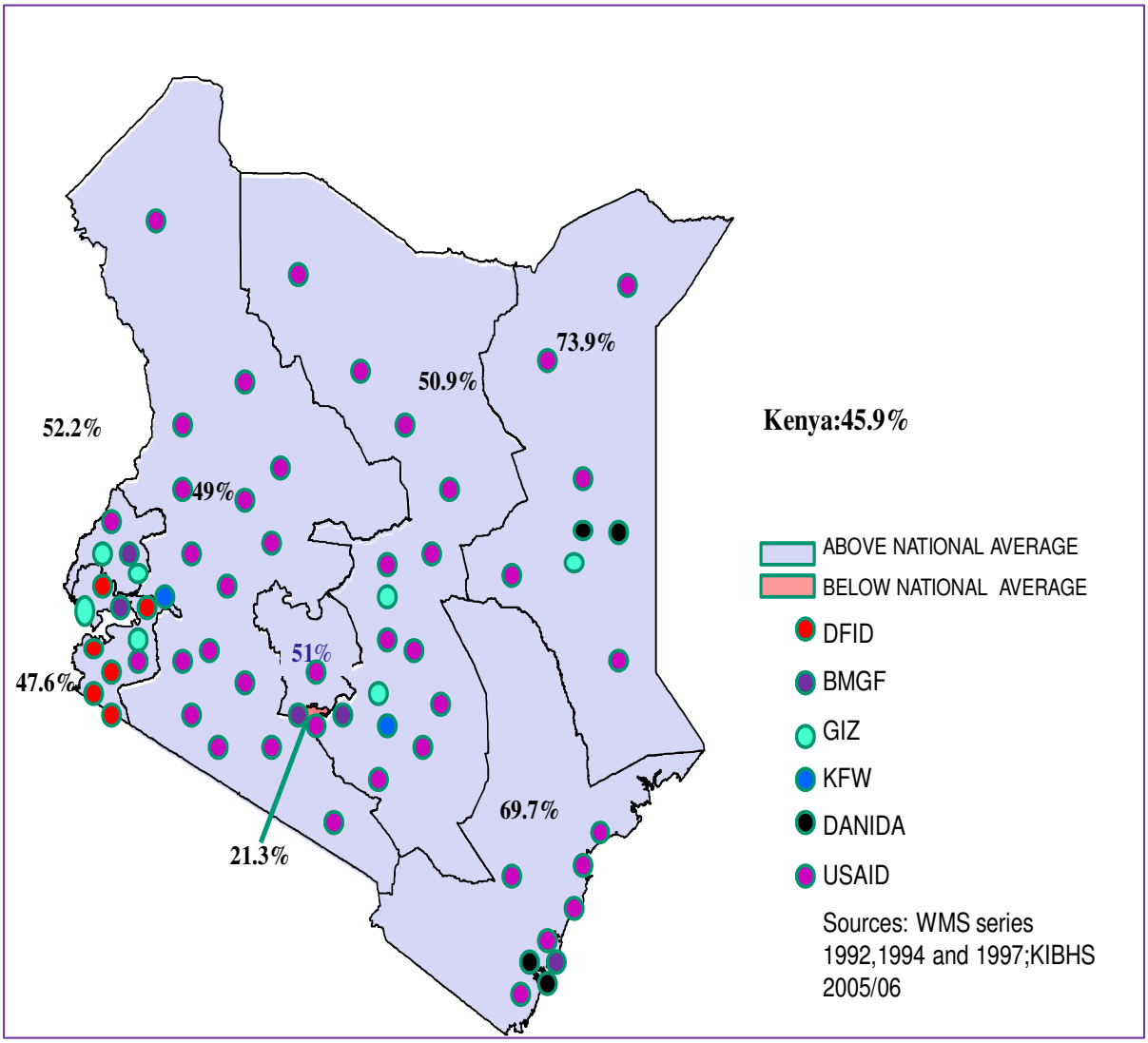
| PROVINCE | OLD DISTRICT | NEW DISTRICT | POPULATION (2009, KNBS) | Poverty (old districts) Economic Survey 2005 | DPs | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | GIZ | KfW | DANIDA | DFID | USAID APHIA+ | BMGF |
| | | Chereganyi | 195,173 | | | | | | | |
| | 37. Uasin Gishu | Eldoret North | 391,655 | 48.3 | | | | | | |
| | | Eldoret East | 241,451 | | | | | | | |
| | | Eldoret South | 261,073 | | | | | | | |
| | 38. Marakwet | Marakwet East | 78,749 | 41.5 | | | | | | |
| | | Marakwet West | 108,374 | | | | | | | |
| | 39. Keiyo | Keiyo North | 73,715 | 39.4 | | | | | | |
| | | Keiyo South | 109,160 | | | | | | | |
| | 40. Nandi North | Mosop | 164,430 | 45.2 | | | | | | |
| | | Aldai | 157,967 | | | | | | | |
| | 41. Nandi South | Emgwen | 231,054 | 56.4 | | | | | | |
| | | Tinderet | 199,514 | | | | | | | |
| | 42. Baringo | Baringo East | 133,189 | 42.8 | | | | | | |
| | | Baringo North | 93,789 | | | | | | | |
| | | Central Central | 162,351 | | | | | | | |
| | 43. Koibatek | Mogotio | 60,959 | 49.1 | | | | | | |
| | | Eldama Ravine | 105,273 | | | | | | | |
| | 44. Laikipia | Laikipia West | 224,431 | 43.8 | | | | | | |
| | | Laikipia East | 174,796 | | | | | | | |
| | 45. Nakuru | Naivasha | 376,243 | 41.0 | | | | | | |
| | | Nakuru Town | 309,424 | | | | | | | |
| | | Kuresoi | 239,485 | | | | | | | |
| | | Molo | 302,618 | | | | | | | |
| | | Rongai | | | | | | | | |

| PROVINCE | OLD DISTRICT | NEW DISTRICT | POPULATION (2009, KNBS) | Poverty (old districts) Economic Survey 2005 | DPs | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | GIZ | KfW | DANIDA | DFID | USAID APHIA+ | BMGF |
| | | | 163,864 | | | | | | | |
| | | Subukia | 211,691 | | | | | | | |
| | 46. Narok | Kilgoris | 274,532 | 51.8 | | | | | | |
| | | Narok South | 258,544 | | | | | | | |
| | 47. Transmara | Narok North | 317,844 | 58.9 | | | | | | |
| | 48. Kajiado | Kajiado North | 387,538 | 43.6 | | | | | | |
| | | CentralNorth | 162,278 | | | | | | | |
| | | Kajiado South | 137,496 | | | | | | | |
| | 49. Kericho | Bomet | 233,271 | 47.6 | | | | | | |
| | | Chepalungu | 163,833 | | | | | | | |
| | | Sotik | 187,968 | | | | | | | |
| | | Konoin | 139,114 | | | | | | | |
| | | Buret | 167,649 | | | | | | | |
| | | Belgut | 202,591 | | | | | | | |
| | | Ainamoi | 181,509 | | | | | | | |
| | | Kipkelion | 206,590 | | | | | | | |
| 7. WESTERN | | | 4,334,282 | | | | | | | |
| | 50. Lugari | Malava | 205,166 | 63.7 | | | | | | |
| | | Lugari | 292,151 | | | | | | | |
| | 51. Butere-Mumias | Mumias | 212,818 | 62.2 | | | | | | |
| | | Matungu | 146,563 | | | | | | | |
| | | Lurambi | 297,394 | | | | | | | |
| | | Shinyalu | 159,475 | | | | | | | |
| | | Ikolomani | 104,669 | | | | | | | |
| | | Butere | 139,780 | | | | | | | |
| | | Khwisero | 102,635 | | | | | | | |
| | | Emuhaya | 185,069 | | | | | | | |

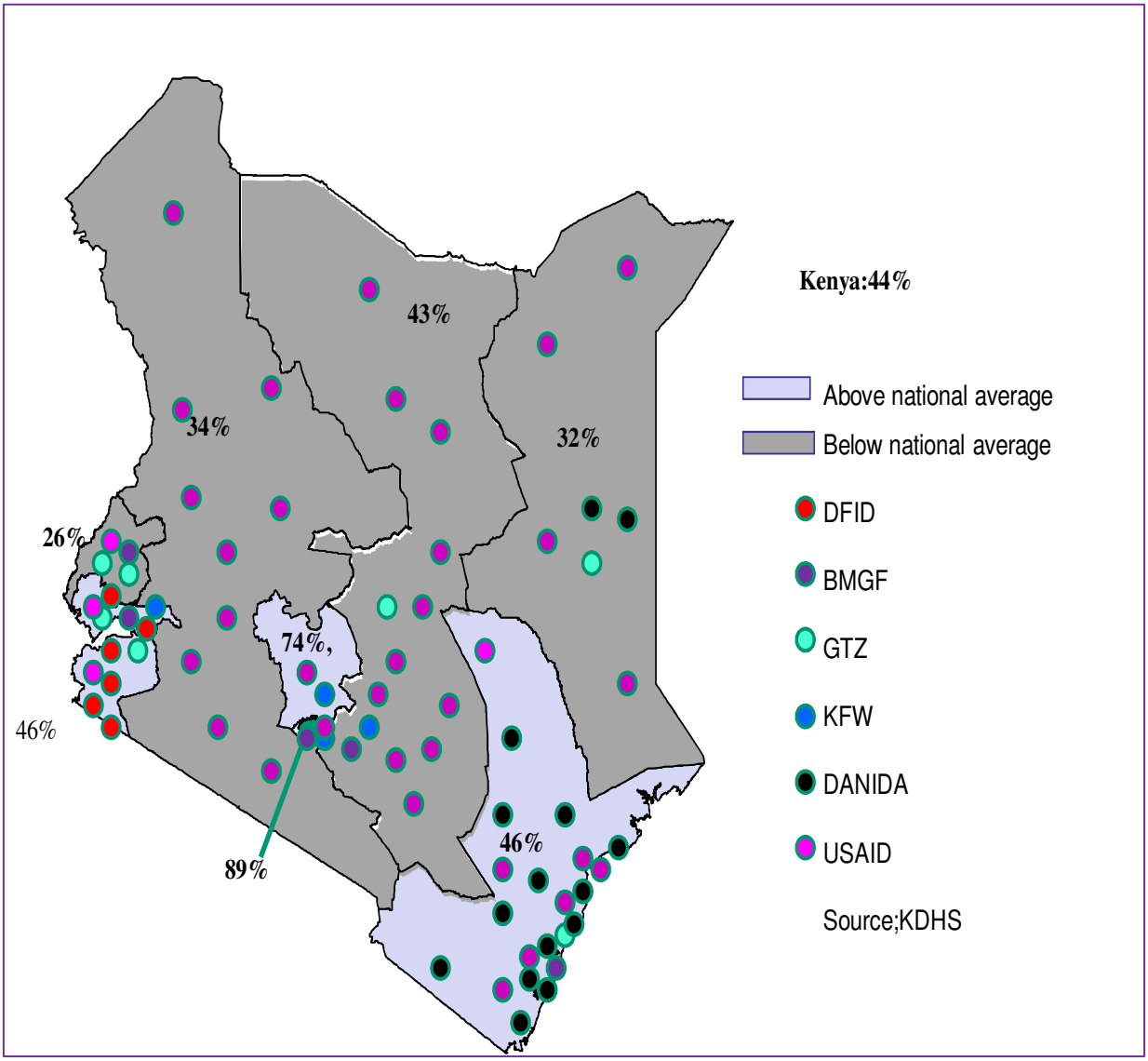
| PROVINCE | OLD DISTRICT | NEW DISTRICT | POPULATION (2009, KNBS) | Poverty (old districts) Economic Survey 2005 | DPs | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | GIZ | KfW | DANIDA | DFID | USAID APHIA+ | BMGF |
| | 52. Kakamega | Sabatia | 129,678 | 64.4 | | | | | | |
| | | Vihiga | 91,616 | | | | | | | |
| | | Hamisi | 148,259 | | | | | | | |
| | 53. Mt. Elgon | Mt Elgon | 172,377 | 55.0 | | | | | | |
| | 54. Bungoma | Kimilili | 320,300 | 59.2 | | | | | | |
| | | Webuye | 230,253 | | | | | | | |
| | | Silisia | 243,535 | | | | | | | |
| | | Kanduyi | 229,701 | | | | | | | |
| | | Bumula | 178,897 | | | | | | | |
| | 55. Busia | Amagolo | 255,871 | 69.4 | | | | | | |
| | | Nambale | 205,982 | | | | | | | |
| | | Butula | 121,870 | | | | | | | |
| | | Funyula | 93,500 | | | | | | | |
| | | Budalagi | 66,723 | | | | | | | |
| 8. NYANZA | | | 5,442,711 | | | | | | | |
| | 60. Siaya | Ugenya | 202,306 | 64.6 | | | | | | |
| | | Alego | 187,243 | | | | | | | |
| | | Gem | 160,675 | | | | | | | |
| | 61. Bondo | Bondo | 157,522 | 71.9 | | | | | | |
| | | Rarieda | 134,558 | | | | | | | |
| | 62. Kisumu | Kisumu Town East | 264,227 | 65.8 | | | | | | |
| | | Kisumu Town West | 139,933 | | | | | | | |
| | | Kisumu Rural | 144,907 | | | | | | | |
| | 63. Nyando | Nyando | 141,037 | 62.3 | | | | | | |
| | | Muhoroni | 145,764 | | | | | | | |
| | | Nyakach | 133,041 | | | | | | | |
| | 64. Rachuonyo | Kasipul kabondo | 220,666 | 71.7 | | | | | | |
| | | Karachuonyo | | | | | | | | |

| PROVINCE | OLD DISTRICT | NEW DISTRICT | POPULATION (2009, KNBS) | Poverty (old districts) Economic Survey 2005 | DPs | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | GIZ | KfW | DANIDA | DFID | USAID APHIA+ | BMGF |
| | | | 162,045 | | | | | | | |
| | 65. Homa Bay | Rangwe | 194,408 | 72.6 | | | | | | |
| | | Ndhiwa | 172,212 | | | | | | | |
| | 66. Migori | Rongo | 209,460 | 47.0 | | | | | | |
| | | Migori | 191,248 | | | | | | | |
| | | Uriri | 115,751 | | | | | | | |
| | | Nyatike | 144,625 | | | | | | | |
| | 67. Suba | Mbita | 111,409 | 68.4 | | | | | | |
| | | Gwasi | 103,054 | | | | | | | |
| | 68. Kuria | Kuria | 256,086 | 80.8 | | | | | | |
| | 69. Kisii | Kisii Central | 114,615 | 64.6 | | | | | | |
| | | south Mugirango | 159,049 | | | | | | | |
| | | Bomachoge | 200,729 | | | | | | | |
| | | Bobasi | 190,074 | | | | | | | |
| | | Nyaribari Masaba | 122,070 | | | | | | | |
| | | Nyaribari Chache | 142,389 | | | | | | | |
| | 70. Gucha | Kitutu chache | 223,356 | 68.0 | | | | | | |
| | | Kitutu Masaba | 199,136 | | | | | | | |
| | 71. Nyamira | West Mugirago | 159,673 | 71.0 | | | | | | |
| | | North Mugirago | 239,443 | | | | | | | |

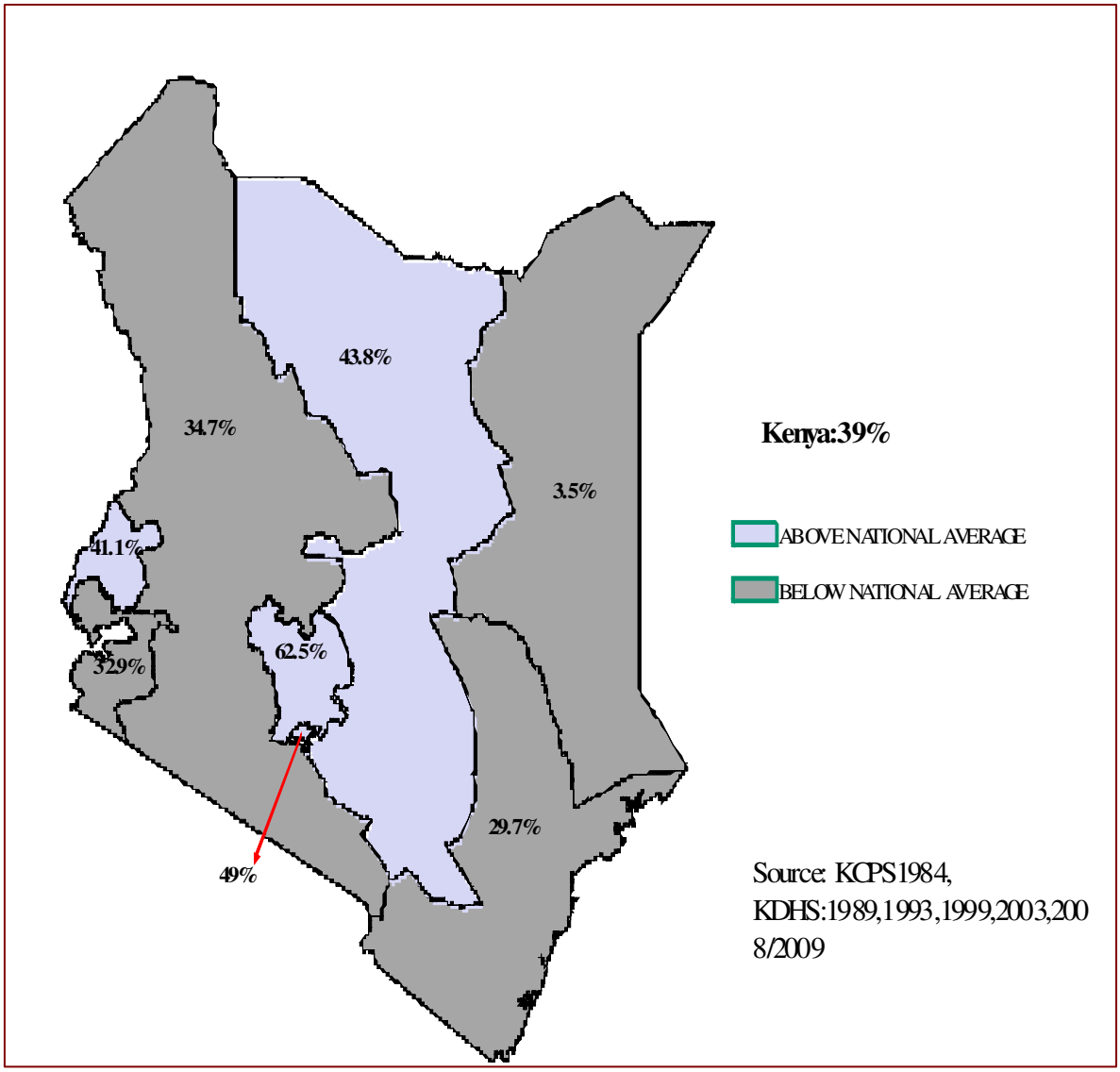
Map 1. Incidences of Overall Poverty (%) 2005/2006 versus Donors Support



Map 2. Births Assistance by Skilled Personnel (%) - 2008/09 Versus Donor Support.



Map 3. Current Use of Contraceptive (CPR) by married women 15-49, Any Modern Method-2008-2009



**Annex 8.2-2**
**Indicators of DP projects versus MOPHS RH Strategy 2009-2015**

| RH Strategy 2009-2015 Objectives | RH Strategy indicators | Danida | DFID | GDC | USAID |
|---|---|---|---|---|---|
| *High priority components:* | | | | | |
| Reduce maternal, perinatal and neonatal morbidity and mortality | (1) Increased aaa[47] and utilisation of SBA during pregnancy, CN and PPartum:<br>1. Skilled care during delivery<br>2. Pregnant women making recommended ANC visits<br>3. Cesarean sections as % of all live births<br>(2) Increased access to quality MNH services at all levels:<br>1. Met need for obstetric care<br>2. Emergency obstetric care<br>3. COEC: N° of facilities with COEC, Average distance to BOEC facility<br>4. Case review audits<br>5. % of facilities with communication and transport for referrals | Maternal Health: % Delivery by skilled staff.<br>Infant mortality.<br>Under 5 child mortality rate.<br>% Full immunization coverage of children below one year.<br>% of pregnant mother/children sleeping under LLITN. | To be determined | GIZ:<br>(1) Increase in SBA<br>(2) Increase in n° of pregnant women who receive complete ANC<br>(3) An outpatient quality management concept, incl. treatment of GBV, implemented in 20 designated HF<br>(4) Increase in the % of the poor using basic services (vaccinations and ANC)<br>KfW:<br>(1) Deliveries by skilled staff<br>(2) Ante natal care (ANC) coverage | 1) Training/mentoring of SBA and CHW to educate the community.<br>2)Train health providers in maternal/newborn health care<br>3) Increase ANC attendance<br>4) Increase the pregnant women sleeping under treated nets |
| Reduce unmet need for family planning, unplanned | (1) Improved policy environment for the delivery of | | | (1) Increase in the use of modern FP (selected | 1) Continue for advocating for |

[47] aaa = Availability, Accessibility, Acceptability

| RH Strategy 2009-2015 Objectives | RH Strategy indicators | Danida | DFID | GDC | USAID |
|---|---|---|---|---|---|
| births as well as socio-economic disparities in CPR | FP services: Resources available for FP<br>(2) Increased availability of FP services:<br>1. % of facilities with full FP range<br>2. N° of contraceptive users, age & geography<br>3. N° of new acceptors of modern FP<br>Increased utilization of FP services :<br>1. CPR<br>2. Unmet need for contraception | | | districts)<br>(2) Increase in the use of modern FP methods of women of child-bearing age from 28% (KDHS 2008) to 40%.<br>KfW:<br>Contraceptive Prevalence Rate (CPR) among MWRA | more RH/FP resources<br>2)Increase the use of modern FP uptake<br>3) Reduce unmet need.<br>4)Train/mentor providers on FP/RH<br>5)Increase facilities with FP method mix<br>6)Work with CU to deliver correct FP/MCH messages and counsel and refer |
| Improve sexual and RH needs of adolescents and youth | (1) HIV prevalence among 15-24 yrs<br>(2) Legal & policy environment:<br>N° of implementing partners mainstreaming / integrating youth RH<br>(3) Utilization of quality youth friendly RH services:<br>1. Proportion of facilities with YFS | | | GIZ: Implementation of the amended *ASRH Policy* by government partner in at least 10 healthcare facilities in the designated districts. | 1)Work with GOK and other stakeholders to develop a comprehensive Youth Strategy<br>2.Review current Youth Policy |

| RH Strategy 2009-2015 Objectives | RH Strategy indicators | Danida | DFID | GDC | USAID |
|---|---|---|---|---|---|
| | 2. Proportion of youth accessing YFS<br>3. N° of staff trained in YFS | | | | |
| Promote gender equity and equality in matters of RH, incl. access to appropriate services | 1. Supportive policies on gender and reproductive rights index<br>2. Health system responsiveness to gender & RR index<br>3. % facilities by type providing quality treatment and rehabilitative RH services for GBV<br>4. % of male clients receiving RH services | | | GIZ:<br>(1) Increase in the use of GBV-specific healthcare services accessed by survivors of GBV in the 2 selected Districts<br>(2) Development of an accreditation and referral system based on national guidelines for healthcare facilities with GBV-specific healthcare services.<br>(3) Cost of the healthcare of SGBV survivors paid by a joint government and NG finance mechanism.<br>KfW:<br>Increase of medical & psycho-social treatment of GBV victims | |
| *Further priority components:* | | | | | |
| Contribute to reduction of | | HIV AIDS prevalence | | | 1)Integration of |

| RH Strategy 2009-2015 Objectives | RH Strategy indicators | Danida | DFID | GDC | USAID |
|---|---|---|---|---|---|
| the HIV/AIDS burden and improvement of RH status of infected and affected persons | | among 15-64 yr olds. HIV/AIDS prevalence among pregnant Mothers (15-24 year).<br>% ART coverage to HIV positive pregnant mothers. | | | RH/HIV services in facilities<br>2)National coverage of PMTCT services and integration of FP/RH services<br>3)Register HIV+ mothers for ART services |
| Reduce the burden of reproductive tract infections (RTIs) and improve access to, and quality of, RTI services | | | | | |
| Reduce the magnitude of infertility and increase access to efficient and effective investigative services for enhanced management of infertile individuals and couples | | | | | |
| Reduce morbidity and mortality associated with the common cancers of the reproductive organs in men and women | | | | | |
| Address RH-related needs of the elderly | | | | | |

| RH Strategy 2009-2015 Objectives | RH Strategy indicators | Danida | DFID | GDC | USAID |
|---|---|---|---|---|---|
| Address the special RH-related needs of people with disabilities | | | | | |
| | | | | | |

## 8.3 Presentation of preliminary mission results, 3rd March 2011

C:\Documents and Settings\wyn54633\D

## 8.4 List of persons consulted

**Nairobi**

| Organisation/Agency | Name | Position |
|---|---|---|
| DANIDA | Rhodah Njuguna | Health Adviser |
| | Anne Hansen | Health Intern |
| DFID | Tony Daly | Regional Maternal Health Adviser |
| | Jean –Marion Aitken tel. | Health Adviser |
| GIZ Health Sector Programme Kenya | Dr. Klaus Hornetz | Sector Coordinator GDC in Health Care, GIZ Program Leader |
| | Dr. Patricia Odero | Component Head- Sexual and Reproductive Health |
| | Stephanie Sealy | HAKI Co-ordinator |
| KfW Development Bank Kenya | Piet Kleffman | Director KfW/DEG Office Nairobi |
| | Cynthia Macharia | Programme Coordinator |
| UNFPA | Dr Alexander Ilyin | Deputy Representative |
| | KL Bordvik | Programme Analyst |
| UNICEF | Ketema Aschenaki Bizuneh | Chief, Health |
| | Loise Oyugi | |
| USAID/KENYA | Lynn Adrian | |
| | Dr Sheila Macharia | |
| WORLD BANK | Wacuka Ikua | |
| WHO | Dr Joyce A Lavussa | National Professional Officer, Family & RH |
| | Dr Humphrey Karamagi | |
| MOPHS - Ministry of Public Health and Sanitation | Dr S.K. Shariff | Director Programmes |
| | Dr Annah Wamae | Director, Dept Family Health |
| | Dr Shiprah Kuria | DRH |
| | Dr Maina Isabel | Dept Family Health |
| | Dr Ruth Kitetu | Planning |
| | Dr P. Santau Migiro | Programme Manager |
| | Dr John O. Odondi | Head, Dept of Primary Health Service |
| | Mr Nyanchoba | |
| | Mr Kimunya | |
| | Peter Waithaka | |
| MOMS – Ministry of Medical Services | Dr Kimani | Director |
| | Dr Kiambati | Head of technical planning |

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|---|---|---|
| | Elkena Onguti | Head of planning |
| | Dr Masasabi | Head of OBs |
| NCAPD - National Co-ordinating Agency for Population and Development | Dr Boniface O K'Oyugi | Chief Executive Officer |
| | Patricia Lasoi | Senior Programme Officer |
| Ministry of Youth Affairs and Sports | Josephine W Mwangi | Assistant Director of Youth Development |
| | Et al. | |
| Ministry of Education | Kiragu Wa Magochi | Director Policy & Partnerships, EAC Affairs |
| | Onesmus Kiminza | SDDE |
| | Elizabeth Kaloki | |
| | Jane Mwereru | |
| | John Kiunjuri | |
| SWAp Secretariat | Dr Were | |
| DPHK Secretariat | Sandra Erickson | Consultant |
| Kenya National Commission on Human Rights (KNCHR) | Winfried Lichuma | Commisisoner |
| JHPIEGO Kenya | Dr Isaac M Malonza | Country Director |
| | Dr Nancy A Kidula | RH/FP Adviser |
| | Rosemary Kamunya | Senior Technical Advisor |
| | Nelson Keyonzo | Project Director Tupange |
| MSH - Management Sciences for Health | Dr Boniface K Njenga | Senior Programme Associate |
| | Dr Cecilia M Muiva | Senior Programme Associate |
| PSI – Population Services International Kenya | Daun Fest | Country Director |
| | Veronica W Musembi | Deputy Director/Social Marketing Director |
| | Joyce Wanderi-Maina | Deputy Director Reproductive Health Marketing |
| | Edna Ogada | Deputy Director Research and Metrics |
| Population Council | Harriet Birungi | Senior Associate |
| | Chi-Chi Undie | Associate |
| | Benjamin W Bellows | Associate |
| | Ian Askew | Director, Reproductive Health Services and Research |
| | Timothy Abuya | Senior Analyst |
| | Charlotte Warren | |
| | Ben Bellows | |
| FHI - Family Health International | Erika Martin | Deputy Director |
| | Dr Marsden Solomon | |
| | Et al. | |
| PATH | Dr Ambrose Misore | |
| PHP Consortium | John Maliti | |
| HENNET | Beatrice Okundi | |
| KEPSA | Dr Amid Thaker | |
| Liverpool VCT | Richard Pendame | |

| | | |
|---|---|---|
| EPOS Health Management | Robinson Kahuthu | National Programme Co-ordinator |
| PROVIDE International – Clinic in Korogocho | Jonah Kitheka | Executive Director |
| | Et al. | |
| German Foundation for World Population | Zabedee Mkala | Programme Manager |
| | Peter Nderitu | Country Representative |
| Kenyatta University | Prof. Julius Korir | Professor of Health Economics |
| KEMSA | Dr John M Munyu | CEO |
| | Joshua H. Obell | Operations Director |
| HMIS | Dr Nzioka | Head of Health Information System |

| **Visit to Huruma Lions Health Centre, Stahere District, Nairobi** | | |
|---|---|---|
| MOH City of Nairobi | Dr Robert Ayisi | |
| DMOH | Dr Musili F.K | DMO |
| | Elisabeth Zuma | Nursing Officer |
| | Mr Muoki | Community Strategy Coordinator |
| | Angela Njiru | Provincial RH Coordinator |
| | Henry | District Clinical Officer |
| German Foundation for World Population (DSW) | Peter Ndiritu | Country Representative |
| | Zeebede Mukala | Programme Manager |
| GIZ at DSW | Myriam B Sikaala | Technical Advisor HIV/AIDS and Organisational Development for Youth |
| Mathare Youth Sports Association (MYSA) | NN | |
| St John Kenya | John Mwalagho | Program Manager |

**Nyanza Province (Kisumu)**

| **DFID** | **Paul Dielemans** | **Maternal and Neonatal Health Adviser** |
|---|---|---|
| Rongo District | Dr Patricia Makokha | DMO |
| Nyanza Provincial Health Management | Dr Kioko Jackson | Provincial Director Public Health and Sanitation |
| | Dr Peter Okoth | Provincial Disease Prevention and Control Officer (Epidemiologist) |
| | Ms Clementine Gwoswar | Provincial Public Health Nurse |
| | Ms Norah Bett | Provincial RH Coordinator |

**Western Province (Kakamega)**

| **PHMT MOPHS MOMS** | **Dr Quido Ahindukia** | **PDPHS** |
|---|---|---|
| | Dr G.W. Onyango | PDMS |
| | And PHMT members | |
| USAID Aphia II Western | Cornelius Kondo | |
| | Hudson Inyangata | |

| | | |
|---|---|---|
| | Masibo Wamalda | Strategic Behaviour Change Communication |
| | Stephen Ingabo | |
| | Beatrice Misoga | HIV integration |
| | Celestina Asena | Food Security and Nutrition |
| | Benedict Abwas | |
| | Beth Barasa | |

**Eastern Province (Embu)**

| Provincial Health Management | Dr Kennedy Manyonyi |
|---|---|
| USAID Aphia II North-Eastern and Central | Dr Chebet |
| | Dr Jahonga |
| | Dr Thion'o |
| | Dr Mburu |
| | Dr Muli |
| | Dr Njagi |
| | Rita Njiru |
| | Juma Mwatsefu |
| | Anastacia Mutuku |
| | Dr Kamau |

**Coast Province (Mombasa)**

| DANIDA | Dr Linda Tindi Misiko | DANIDA Provincial Advisor, Coast |
|---|---|---|
| PHMT | Dr Anisa Omar | Provincial Director Public Health & Sanitation |
| | Francis Gwama | Deputy Provincial Nursing Officer |

## 8.5 References

Abbat, F., 2005, Scaling up Health and Education Workers: Community Health Workers. A Literature Review

African Science Academy Development Initiative (ASADI), hosted by the Ghana Academy of Arts and Sciences, Ghana November 2009, SCIENCE IN ACTION. Saving the lives of Africa's mothers, newborns, and children

Boonstra, Heather, Guttmacher Institute 09/2007, Learning from Adolescents to Prevent HIV and Unintended Pregnancy. In Brief http://www.guttmacher.org/pubs/2007/09/19/IB_PNG2007.pdf

Borghi, Jo, Ensor, Tim, Somanathan, Aparnaa, Lissner, Craig, Mills, Anne, on behalf of The Lancet Maternal Survival Series steering group, Maternal Survival 4 - Mobilising financial resources for maternal health

Campbell, Oona M R, Graham, Wendy J, on behalf of The Lancet Maternal Survival Series steering group 10/2006, Maternal Survival 2 – Strategies for Reducing Maternal Mortality: Getting on with What Works

Center for Reproductive Rights, 2010, In Harm's Way: The Impact of Kenya's Restrictive Abortion Law, New York, United States of America

DANIDA – Danish International Development Assistance, 2009, Alignment Study of Donor Assistance to Government Systems, Nairobi, Kenya

DANIDA – Danish International Development Assistance, 2009, Health Sector Programme Support to Kenya Phase II (2007 – 2011), Nairobi, Kenya

DANIDA – Danish International Development Assistance, 2009, Nomadic Clinics and Healthcare Provision to the Nomadic Population of North-Eastern Province, Kenya, Nairobi, Kenya

DANIDA – Danish International Development Assistance, 2010, Evaluation of the Pull System for Essential Medicines and Medical Supplies in Kenya, Nairobi, Kenya

DANIDA – Danish International Development Assistance, 2010, Health Sector Programme Support to Kenya Phase 3 (HSPS III) 2012 - 2017, Nairobi, Kenya

DANIDA – Danish International Development Assistance, 2011, Consultancy Services for TA to the Kenya Health Sector Programme Support II, (HSPS) 2008 -2011, Nairobi, Kenya

DANIDA – Danish International Development Assistance, 2011, Health Sector Programme Support to Kenya Phase III (2012 – 2016) DRAFT 2, Nairobi, Kenya

Darmstadt, Gary, Susan Rich, Monica Kerrigan / Bill and Melinda Gates Foundation, 2011, Overview: Family Health in Kenya. unpublished

DFID and WHO/Kenya, 2009, Proposal: Programme on Health Systems Strengthening & Malaria Control 2009 – 2014, 2009, PSI Proposal: DFID Malaria Program 2010/2014

DFID, 2004, Support to the Delivery of Essential Health Services

DFID, 2009, Family Care International Research Proposal – A Price too High to Bear: The Costs of Poor Maternal Health to Women, Families, and Societies

DFID, 2009, Programme Memorandum: Kenya Health Programme

DFID, 2010, Improving Reproductive, Maternal and Newborn Health: Burden, Determinants and Health Systems. Evidence Overview. A working Paper (Version 1.0)

DFID, 2010, Institutional Capacity Strengthening of the Health Non-Governmental Network (HENNET) for accelerating the attainment of Health MDGs, Nairobi, Kenya

DFID, 2010, Third Annual Output to Purpose Review (OPR) of DFID Support to the Delivery of Essential Health Services (EHS), Kenya

DFID, December 2010, Choices for women: planned pregnancies, safe birth and health newborns

DFID, Development Media International: Project Design Report – Improving Maternal and Child Health in Kenya Through Media

DFID, Further Business Case guidance: "Theory of Change"

DFID, Kenya Ministry of Health Proposal: Assessment of the impact of a structured 5-day training programme about mental health knowledge , skills and competencies on mental health for primary care staff in Kenya

Ensor, T. OPM, July 2003, Consumer-led Demand Side Financing for Health and Education: An international Review

EPOS Health Management – NCAPD & KfW Development of the Health Sector (SWAp) Programme. July 2010, Reproductive Health Voucher Scheme (Output based Approach) Design Mission Report

Freedman, Lynn P. et. Al. / Task Force on Child Health and Maternal health Un Millennium Project. Who's got the power? Transforming health systems for women and children. 2005

GOK – Ministry of Public Health and Sanitation, 2009, Social Protection in Health: Policy and Financing Strategy, Nairobi, Kenya

GOK and UNFPA, 2009, GOK/UNFPA 7th Country Programme Action Plan 2009-2013

GoK, 2008, Kenya Vision 2030, Sector Plan for Health 2008-2012, Ministry of Health, Nairobi, Kenya.

GOK, 2010, Framework for Health System Strengthening: Current Orientations, Nairobi, Kenya

GOK, 2010, KSPA: Preliminary Results presentation for MNCH retreat, Nairobi, Kenya

GOK, 2010, National Baseline Indicators for HINI, Kenya

GOK, 2011, Accelerating Maternal and Neonatal Survival in Kenya, Nairobi, Kenya

GOK, 2011, Acceleration of Maternal, Newborn and Child Survival in Kenya, Nairobi, Kenya

GOK, 2011, Potential for scaling up Maternal, Newborn Health, High Impact Interventions at Family and Community AMREF Experiences in Health Care, Kenya

GOK, 2011, Strengthening Human Resource for Health to Accelerate Implementation of MNCH HIIs, Nairobi, Kenya

GOK, 2011, The Second Retreat On Accelerated Maternal And Newborn Care: GoK Support for Logistics for MNH, Nairobi, Kenya

GOK, Situation Analysis and Lessons from Scaling-up High Impact Maternal and Newborn Health Interventions in Limited Resource Settings, Kenya

GTZ - Deutsche Gesellschaft für Technische Zusammenarbeit, 2009, Status Report – Center for the Cooperation with the Private Sector/PPP: Support District Government to Increase Knowledge and Use of Modern Contraceptives

GTZ - Deutsche Gesellschaft für Technische Zusammenarbeit, 2009, Are We Reaching the Poor and Vulnerable?, Kenya

GTZ - Deutsche Gesellschaft für Technische Zusammenarbeit, 2009, PPR Report: reviewing the current phase of the entire GTZ-HSP from 01/2008 to 12/2010. Kenya

GTZ - Deutsche Gesellschaft für Technische Zusammenarbeit, 2009, National Guidelines on Management of Sexual Violence in Kenya, Kenya

GTZ - Deutsche Gesellschaft für Technische Zusammenarbeit, 2009, Progress Report for PPP Measures: Support District Government to Increase Knowledge of Modern Contraceptives

GTZ - Deutsche Gesellschaft für Technische Zusammenarbeit, 2009, Reproductive Health Communication Strategy 2010 – 2012, Kenya

GTZ - Deutsche Gesellschaft für Technische Zusammenarbeit, 2009, Contribution of German Development Cooperation to the Kenyan Health Sector and the SWAp Process in the Areas of Reproductive Health and Health Financing, Kenya

GTZ - Deutsche Gesellschaft für Technische Zusammenarbeit, 2010, Programm Entwicklung des Gesundheitssektors (Reproduktive Gesundheit und Gesundheitsfinanzierung)“, Kenia, Kenya

GTZ - Deutsche Gesellschaft für Technische Zusammenarbeit, 2010, Anlage 1: Ziele und Indikatoren Beitrag der Deutschen Entwicklungszusammenarbeit zur Entwicklung des Gesundheitssektors Kenia (2010-2015)

Haines, Andrew et al., June 2007, Achieving child survival goals: potential contribution of community health workers. The Lancet Vol. 369 www.thelancet.com

Hulton, Louise, Susan Murray, Deborah Thomas, Options Consultancy Services Ltd. for DFID and NORAD, February 2010, The Evidence Towards MDG 5: A Working Paper

Inter-Agency Working Group (IAWG) on the Role of Community Involvement in ASRH, December 2007, Community Pathways to Improved Adolescent Sexual and Reproductive Health: A Conceptual Framework and Suggested Outcome Indicators. Washington, DC and New York http://www.pathfind.org/site/DocServer/IAWG_CI_Working_Paper_FINAL_WEB_6_17_08_key.pdf?docID=12161

KEMSA – Kenya Medical Supplies Agency, 2008, Driving Service Improvements through Supply Chain Excellence, Nairobi, Kenya

KEMSA – Kenya Medical Supplies Agency, 2008, Report of the Kenya Task Force, Nairobi, Kenya

Kenya National Bureau of Statistics (Kenya), National Aids Control Council (Kenya), National AIDS/STD Control Program (Kenya), National Publish Health

Laboratory Services (Kenya), Kenya Medical Research Institute (Kenya), National Coordinating Agency for Population and Development (Kenya), Measure DHS (USA), ICF Macro (USA), 2009, Kenya Demographic and Health Survey (KDHS) 2008-09, Kenya National Bureau of Statistics, Nairobi

Kenya National Bureau of Statistics, 2005, Geographic dimensions of well-being in Kenya: Who and where are the poor? A constituency level- Volume II, ISBN 9966-767-01-0, The Legal Press Kenya Limited, Nairobi

Kenya National Bureau of Statistics, 2008, Basic Report on Well-Being in Kenya based on the Kenya integrated household budget survey 2005-2006, ISBN 9966-767-08-08, The Legal Press Kenya Limited, Nairobi.

Kenya National Bureau of Statistics, 2008, Well-Being in Kenya: A Socio-Economic Profile, ISBN 9966-767-13-3, English Press Limited, Nairobi

Kenya National Bureau of Statistics, 2010, Statistical Abstract 2010, Government Printer, Nairobi

KfW Development Bank, 2009, Evaluating the impact of a maternal health voucher program on facility-based deliveries among residents of informal settlements in Nairobi, Kenya

KfW Development Bank, 2010, Reproductive Health - Output Based Approach Pilot Project, Nairobi, Kenya

KfW Development Bank,, 2009, Gates Foundation and Population Council collaborate on a multi-country evaluation of Voucher Programs, RH Vouchers Project Newsletter

Koblinsky, Marge, Matthews, Zoë, Hussein, Julia, Mavalankar, Dileep, Mridha, Malay K, Anwar, Iqbal, Achadi, Endang, Adjei, Sam, Padmanabhan, P, van Lerberghe, Wim, on behalf of The Lancet Maternal Survival Series steering group 10/2006, Maternal Survival 3 - Going to scale with professional skilled care

Lakshminararayan, R. Decentralization and its Implications for Reproductive Health: Reproductive Health Matters. 2003

Lichuma, Winnie, 2010, The Role Of National Human Rights Institutions in Reduction of Maternal Mortality. A Case Study of the Kenya National Commission on Human Rights (KNCHR). Presented during the International Roundtable on Maternal Mortality, Human Rights and Accountability, 2nd September 2010 in Geneva.

Ministries of Health, 2010, Annual Operation plans 5 and 6 (AOP 5, 6), Ministries of Health, Nairobi, Kenya

Ministries of Health, 2010, Review of Annual Operation plan 5 (AOP5), Ministries of Health, Nairobi, Kenya

Ministry of Health, 2004, Child Survival and Development Strategy 2008-2015, Ministry of Health, Nairobi

Ministry of Health, 2004, Kenya Health Policy Framework 2004, Ministry of Health, Nairobi

Ministry of Health, 2005, Adolescent Reproductive Health and Development Policy & Plan of Action 2005 - 2015, Ministry of Health, Nairobi

Ministry of Health, 2005, Millenium Development Goals in Kenya: Needs and Costs, Ministry of Health, Nairobi

Ministry of Health, 2006, Joint Programme of Work and Funding for the Kenya Health Sector 2006/07–2009/10, Ministry of Health, Nairobi

Ministry of Health, 2006, Monitoring and Evaluation of Health Sector Performance: Framework and Action Plan 2006/2007 – 2009/2010, Ministry of Health, Nairobi

Ministry of Health, 2006, Taking the Kenya Essential Package for Health to the Community: A Strategy for the Delivery of Level One Services, Ministry of Health, Nairobi

Ministry of Health, 2007, Cost of providing the Kenya Essential Package for Health, GTZ Health Sector Program, Nairobi

Ministry of Health, 2007, National Reproductive Health Policy: Enhancing Reproductive Health Status for all Kenyans, Ministry of Health, Nairobi

Ministry of Health, 2008, Annual Health Sector Statistics Report 2008, Ministry of Health, Nairobi

Ministry of Health, 2008, Ministry of Medical Services Strategic Plan 2008–2012, Ministry of Health, Nairobi

Ministry of Health, 2008, Ministry of Public Health and Sanitation Strateic Plan 2008–2012, Ministry of Health, Nairobi

Ministry of Health, 2008, Strategy for Improving the Uptake of Long-acting and Permanent Methods of Contraception in the Family Planning Program, Ministry of Health, Nairobi

Ministry of Health, 2009, Child Health Services in Kenya, Ministry of Health, Nairobi

Ministry of Health, 2009, Influence of Provider Training on Quality of Emergency Obstetric Care in Kenya, Ministry of Health, Nairobi

Ministry of Health, 2009, National Human Resources for Health Strategic Plan 2009–2012, Ministry of Health, Nairobi

Ministry of Health, 2009, National Road Map for Accelerating the Attainment of the MDGs Related to Maternal and Newborn Health in Kenya, Ministry of Health, Nairobi

Ministry of Health, 2009, Towards a Health Financing Strategy for Kenya**,** Ministry of Health, Nairobi

Ministry of Health, 2010, Facts and Figures, Nairobi, Kenya

Ministry of Health, 2010, Kenya Health System Assessment 2010, Ministry of Health, Nairobi

Ministry of Health, 2010, Reversing the trends: The Second NATIONAL HEALTH SECTOR Strategic Plan of Kenya - NHSSP II – 2005–2010, Ministry of Health, Nairobi

Ministry of Health, 2010, Reversing the trends: The Second NATIONAL HEALTH SECTOR Strategic Plan of Kenya – Norms and Standards for Health Service Delivery, Ministry of Health, Nairobi

Ministry of Medical Services / Ministry of Public Health and Sanitation, August 2010, Kenya Service Provision Assessment Survey 2010 – Preliminary Report

Ministry of Medical Services / Ministry of Public Health and Sanitation, 2010, Kenya Health facilities listing – Summary, Health Management Information System, Nairobi

Ministry of Medical Services / Ministry of Public Health and Sanitation, 2010, Accessible affordable and quality health care services in Kenya: Financing Options for universal coverage, Nairobi (unpublished)

Ministry of Medical Services, 2008, Ministry of Medical Services: Strategic Plan 2008-2012. Ministry of Medical Services, Nairobi

Ministry of Public Health and Sanitation / Ministry of Education, 2009, National School Health Guidelines

Ministry of Public Health and Sanitation / Ministry of Education, 2009, National School Health Policy

Ministry of Public Health and Sanitation, 2008, Ministry of Public Health and Sanitation: Strategic Plan 2008-2012. Ministry of public health and sanitation, Nairobi

Ministry of Public Health and Sanitation, 2008, Output Based Aid/Demand Side Financing of Safe Motherhood in Kenya: A position Paper for scale up, Ministry of Public Health, Nairobi

Ministry of Public Health and Sanitation, 2009, Estimates of Recurrent Expenditure 2009-2010 Volume I, Government printer, Nairobi

Ministry of Public Health and Sanitation, December 2010, Sexual and Reproductive Health Service Provision to Young People in Kenya: What is the best model? Preliminary Report - Summary

Ministry of Public Health and Sanitation, January 2010, Review of the 2004-2008 RH Research Agenda and the proposed 2010-2014 Research Agenda. Nairobi

MOH / NCAPD, 2005, Adolescent Reproductive Health and Development Policy - Plan of Action (2005-2010)

MOH-DRH, 2005, National Guidelines for Provision of Youth-friendly Services

MoH-DRH, 2007, National Contraceptive Commodities Security Strategy 2007-2012, Nairobi

MOH-DRH, 2007, National Reproductive Health Policy

MOPHS-DRH / KfW Development Bank, 2009, Best Practices in Reproductive Health in Kenya

MOPHS-DRH / USAID, 2010, RH Communication Strategy Implementation Guide 2010-2012

MOPHS-DRH, 23 March 2011, Priority Interventions to Improve RH Services in the Districts: AOP 7

NCAPD / DRH, 2003, Adolescent Reproductive Health and Development Policy

O'Hanlon, Barbara, Nelson Gitonga, Jeff Barnes / World Bank, 2009, 2009 Kenya Private Health Sector Assessment - Summary Report

OECD-DAC, 2005, The Paris Declaration on Aid Effectiveness.

Petroni, Suzanne, The Summit Foundation, 2007, Improving Youth Sexual and Reproductive Health in the Developing World: An Evidence-Based Approach. http://www.summitfdn.org/foundation/pdfs/ASRH-findings.pdf

Ronsmans, Carine, Graham, Wendy J, on behalf of The Lancet Maternal Survival Series steering group 09/2006, Maternal Survival 1 – Maternal Mortality: Who, When, Where and Why

SECTOR, 2010, Joint Financing Agreement between the Government of Kenya and Pooling Partners in Support of the Health Sector, Kenya

UNFPA – United Nations Population Fund, 2008, Final country programme document for Kenya,

UNICEF/Government of Kenya, 2009, Country Programme Action Plan 2009 – 2013

United Nations, 2010, The Millennium Development Goals Report 2010. New York

United Nations, September 201, Global Strategy for Women's and Children's Health.

USAID – United States Agency for International Development, 2008, Initial Environmental Examination & Request for Categorical Exclusion: Reduced Transmission & Impact of HIV/AIDS and Improved Reproductive, Maternal and Child Health

USAID – United States Agency for International Development, 2010, USAID/Kenya Five-year Implementation Framework for the Health Sector (2010 – 2015)

USAID – United States Agency for International Development, 2010, Request for Applications (RFA) Number 623-10-000009, USAID/KENYA APHIAplus, Health Service Delivery Projects

USAID, 2009, National Reproductive Health and HIV/AIDS Integrations Strategy, Kenya

USAID/Kenya Government, 2009, Support to Implementation of the Kenya National HIV Response, as articulated in 'The Kenya National Aids Strategic Plan III (KNASP III) 2009/10 – 2012/13

WHO - World Health Organisation, 2008, Measuring Health Systems Strengthening & Trends: A Toolkit for Countries

WHO – World Health Organization, 2007, Everybody's Business. Strengthening Health Systems to Improve Health Outcomes. WHO's Framework for Action http://www.who.int/healthsystems/strategy/everybodys_business.pdf

WHO - World Health Organization, 2010, Trends in maternal mortality: 1990 to 2008. ISBN 978 92 4 150026 5

WHO, World Health Report 2005 – Make Every Woman and Child Count.

World Bank, 2005, A Guide to Competitive Vouchers in Health

World Bank, June 2, 2010, Project Appraisal Document on a Proposed $100m Credit to the Republic of Kenya for a Health Sector Support Project

## 8.6 Proposals to individual DPs

Please note:
It has been convened that the DFID Business Case will be submitted in a separate document.

### 8.6.1 DANIDA

**1. Background**
Danida in Kenya promotes primary health care for the poor and vulnerable. It has traditionally concentrated support on the Coast region, although more recently the sparsely populated North-Eastern regions have been supported with nomadic primary health clinics/outreach. In 2005, with the Health Sector Programme Support (HSPS I), Danida began to shift towards a sector-wide approach by aligning with implementation of the National Health Sector Strategic Plan II (NHSSPII), increasing engagement in the policy dialogue and focussing on issues of strategic importance.

A second phase (HSPS II 2007-2011) along the same lines suffered setbacks due to the post-election violence, the split of the ministry of health into two and a general abandonment of DP support for the sector wide approach and a reversion to project mode.

As a result, HSPS II overall targets are unlikely to be reached. Nevertheless, GoK and Danida have agreed to a third phase (HSPS III) which will run from January 2012 to December 2016 (5 years). HSPS III will consolidate the areas supported under the current phase, taking forward the SWAp approach and terminating the current Project Implementation Unit, which currently exists within the two ministries.

HSPS III will focus on two main areas:

1) Support to primary health care through -
    i) Funding for the national roll-out of the HSSF (Health Sector Services Fund),
    ii) Funding for supply of essential medicines (EMMS),
    iii) Funding to improve staffing for health centres and dispensaries.
2) Health systems strengthening and support to SWAP.

The grant for HSPS III is DKK 430 million over 5 years (about US$ 85m) - an increase of 20% over the current phase. A final appraisal of HSPS III is to be undertaken in late March 2011, when the findings and recommendations of this joint donor mission will be taken into account by the Danida appraisal team.

**2. Summary of proposed DANIDA Support**

a) **HSSF** - Danida will provide DKK 140 million (US $ 28m) to the HSSF basket, ring-fenced for direct funding of levels 2 and 3 (therefore excluding the funding of DHMTs, of the HSSF Secretariat and of the National Health Service Committee). The HSSF is an important step towards effective decentralised service delivery at the lowest level, avoiding points of leakage and empowering communities to address specific local constraints to delivering services. Piloting of the HSSF in Coast Province with the support of Danida provides a sound platform from which to take forward national roll-out, which is reported to have already begun (in November

2010) with a first allocation of funds to about 600 health centres. In addition, 235 District Health Management Teams were provided funds by GoK for the same period. This first allocation will serve as a test of the accounting and financial systems which have been set up and which other DPs are watching closely.

b) **EMMS** -Danida will provide DKK 80 million (US $ 16m) ring-fenced for Essential Medicines and Medical Supplies (EMMS). It is proposed that funding will be performance-based, provided on evidence of the delivery of medicines at the facilities in the previous quarter. Danida funds will be pooled together with GOK funds from the drugs budget lines. It is assumed that funds from other DPs and IPs will also be pooled, or at least tightly co-ordinated. There are more than ten DPs and many others (NGOs, private suppliers) active in the provision of health commodities including EMMS. It is also assumed that following Danida training of facility staff during HSPS II, the pull system is working effectively.

c**) HRH -** Danida will provide DKK 110 million (US $22 m) to fund HRH recruitment. In the past, funds for recruitment were often released too late in the fiscal year to make appointments, resulting in the funds and positions then being 'lost', and the practice of budgeting on existing posts only led to vacant positions losing funding. This contributed to the problem of there being many unemployed health professionals who could not be taken on board due to the late or non-release of funding. To help overcome this, Danida funding will be targeted on recruitment of staff to difficult areas with the GOK gradually taking over responsibility on an incremental basis.

d) **Health System Strengthening and SWAP Support -** Danida will provide DKK 65 million (US $ 13m) in TA to strengthen systems in the three financed areas in particular (HSSF, EMMS, HRH) and to enhance leadership and management by the Ministry of Health more generally. This latter "support to SWAp" will consist of TA for planning, budgeting, performance monitoring and sector co-ordination.

**3. Implicationsof Findings of the Mission for Danida**

The Joint Donor Mission is recommending (broadly) that:

- the DPs strengthen their co-ordination by going forward with a pooled TA fund. (Pooling of other DP "baskets" of resources is not recommended at this stage, nor is it proposed that the World Bank's and Danida's intention to put funds through GoK systems is more widely followed.)

- DPs concentrate on supporting district level delivery. A first step is to rationalise, coordinate and organise DP interventions at the district level under a DP's District level Code of Conduct.

- DPs need to anticipate the major planning, funding and governance changes at District/County level required by the Constitution and expected to begin 2012 after the next general elections.

- DPs should support GoK to accelerate the development of a revised Health Financing Strategy which takes into account (i) the new fiscal devolution implications of the Constitution and (ii) the expected continued inability of GoK to provide adequate public finances for health.

- In order to achieve RH goals, DPs should provide more support to fill policy gaps in (i) youth ASRH and (ii) gender violence programmes.

- The RH Communication Strategy and Implementation Guide are well developed and clearly identify responsibilities at the various levels. While the implementation focus is at provincial and district SBCC task force level with numerous APHIAplus partners, there is ample opportunity for other partners to join in planning, co-financing and/or implementation.

An important implication for Danida is that their hope that other DPs will follow suit and provide ring-fenced budget support to elements of the GoK health budget is unlikely to materialise. This is identified as a key assumption in Danida's January 2011 draft HSPS Phase III (2012 – 2016) project document.

The Joint Donor Mission confirms Danida's view that RH is essentially a health systems issue, with district-level implementation the key. Co-ordination of DPs and IPs at the district level will be an important advance in achieving Danida's desire to promote aid effectiveness in Kenya's health sector.

At the same time, strengthening the Centre's capacity to plan for the imminent, major, institutional changes required by the Constitution is urgently needed; the Joint Mission endorses Danida's proposal to provide SWAp support.

RH gaps identified in support to youth and gender points to areas where Danida's small unallocated funds might be usefully spent.

**4. Recommendations**

1. Currently, only Danida (US $ 28 m over 5 years through HSPS III) and The World Bank (US $ 34 million over 4 years through the KHSSP) have concrete plans to contribute to the HSSF fund. Other donors will consider participating only if outstanding questions around fiduciary risk – the security and use of the funds – and reports that the facilities receiving HSSF are not fully adhering to the 10/20 policy (including laboratory services) are answered. WB/Danida advocacy amongst DPs to promote alignment around joint financing arrangements will be given greater force if their support to creating a robust HSSF financial system is accompanied with regular reporting on (i) timely disbursement of HSSF funds, (ii) production of timely financial returns and (iii) timely and accurate accounts for the sector. Improved tracking of funds and transparency about capacity strengthening of accounting and audit, including clear evaluated evidence that apparent risks are contained, will be an important contribution to reducing the perceived risk of corruption in the health sector. The forthcoming Appraisal Mission should be asked to ensure that this will be the case.

2. The HSSF pre-dates the Constitution's intentions to devolve spending responsibilities to the new Counties and to have County-level spending overseen by elected County Assemblies. It will be important that Danida-supported nation-wide roll-out of the HSSF does not neglect, and thereby undermine, the bigger issue of effective implementation of public health under the new devolved regime. The forthcoming Appraisal Mission should assess whether the current plans for HSSF are sufficiently alert to, and consistent with, the financial management support needs of the new counties.

3. The provisions of the new Constitution require major institutional changes at national and sub-national levels which are still unclear to many. The forthcoming Appraisal Mission should make specific detailed proposals for the US $ 13 million allocated for SWAp support so that the Ministries' urgent needs to develop plans for the division of responsibilities between the centre and the counties are met.

4. Danida's HSPS III document states that "it is expected that HSSF funds will be used by the facilities to carry out outreach services systematically. During outreach visits to communities, health education and awareness raising activities will emphasise key messages….". Both GoK Community and Communication Strategies - still to be fully costed - will influence whether this expectation is feasible or desirable. They will also determine whether the Danida contribution to HSSF is sufficient. The forthcoming Appraisal Mission should explore the implications of the new strategies for HSSF in more detail, and take a position.

5.Proposed resource allocation criteria for the HSSF should be reviewed to take into account the actual needs of health facility, including any intentions regarding the implementation and financing of the Community and Communication Strategies.

6. Consideration should be given to any currently unallocated funds under HSPS III being used to promote the piloting of youth ASRH and gender violence programmes.

7. The forthcoming Appraisal mission should confirm that the latest Essential Medical list (2010) includes all necessary RH and FP commodities.

### 8.6.2 USG - USAID Kenya

**BACKGROUND**

The Ministry of Public Health and Sanitation and the Ministry of Medical Services in Kenya in conjunction with five development partners (DPs), namely, The Department for International Development (DFID), United States Agency for International Development (USAID), German Development Cooperation (GDC), DANIDA and Bill and Melinda Gates Foundation agreed to field a team of consultants to review the DPs support to Reproductive Health(RH) and to propose how such support could be optimally harmonized. As part of the final report, the terms of reference stipulated that some sections of the report be submitted as an Annex for each DP and be attached to the final report.

This Annex relates to USAID/Kenya support, especially as it relates to current assistance and is intended as one of the references in the development of RH support, in the context of APHIAplus framework, given the large and flexible USAID/Kenya assistance for the Reproductive Health (RH) program.

**APHIAplus**

For the past 15 years, USAID/Kenya's Office of Population and Health (OPH), has provided support in collaboration with the Government of Kenya (GoK) under the umbrella of the AIDS Population and Health Integrated Assistance (APHIA I and II) program. Under the new assistance program (APHIAplus), USAID/Kenya intends to provide approximately $385 million annually over 5 years (2010-2015). The APHIAPlus (AIDS, Population and Health Implementation Assistance - Patient focussed, Leadership, Universal Access, Sustainability) will primarily support technical areas of HIV and AIDS, malaria, family planning and tuberculosis and, to the extent that funds are available, MNCH and nutrition, food security, water and sanitation, and selected interventions related to the social determinants of health. The inclusion for support in APHIAplus of Family Planning, HIV and AIDS provides a window of opportunity for channelling assistance to aspects of MNH which are amenable to integration into FP and HIV/AIDS activities.

For the purposes of this program, Kenya has been demarcated into 5 Zones: Northern Kenya Zone (North Eastern); High Needs Zone (Nyanza & Western); Moderate Need with Urban Areas Zone (Nairobi &Coast); Moderate Need Zone (Rift Valley) and Transitioning Zone (Central & Eastern). The districts that will be covered in each Zone are given in the Table below.

| Zone | Provinces/Districts Included |
|---|---|
| High Needs Zone | All districts in Nyanza Province and Western Province. |
| Moderate Need with Urban Areas Zone | All districts in Nairobi Province and only the following districts from Coastal Province: Kilifi, Kwale, Lamu, Mombasa, Taita Taveta, Malindi. |
| Moderate Need - Rift Valley Zone | Only the following districts of Rift Valley: Baringo, Bomet, Keiyo, Kajiado, Kericho, Koibatek, Laikipia, Marakwet, Nakuru, Nandi, Narok, Trans Mara, Trans Nzoia, Uasin Gishu, West Pokot, Buret. |
| Transitioning Zone | All districts in Central Province and only the following districts from Eastern Province: Embu, Kitui, Makueni, Machakos, Mbeere, Meru Central, Mwingi, Meru North, |

| Zone | Provinces/Districts Included |
|---|---|
| | Tharaka, Nithi. |
| "Northern Arid Lands" Zone | All districts in Northeastern Province and only the following districts from other provinces - Rift Valley Province: Turkana, Samburu; Eastern Province: Marsabit, Isiolo, Moyale; Coast Province: Tana River. |

Source: Request For Application (RFA) Number 623-10-000009, USAID/Kenya APHIAplus Health Service Delivery Project

The range of funding anticipated for each of the resulting awards for the five year period is as follows:

Zone 1 $100 to $150 million
Zone 2 $45 to $55 million
Zone 3 $75 to $100 million
Zone 4 $75 to $100 million

At the moment, it is not possible to show how much would be allocated to which district and for what activity.

**Alignment of APHIAplus**

The APHIAplus Implementation Framework is based on the Government of Kenya's (GOK) recent health policy and strategy frameworks, and builds on the successes of and lessons learned from USAID/Kenya's prior assistance. These documents include, but are not limited to, Vision 2030, National Health Sector Strategic Plan II, Reproductive Health Policy, MNH Road Map, HII acceleration plan Nakuru 2011, and Annual Operational Plans. Also, for the first time, USAID/Kenya will seek to operationalize strong linkages to other sectors in order to address contextual factors that impact on health, but have conventionally been perceived as outside of the control of the health sector. Referred to as the "social determinants of health" these include such factors as educational level, literacy, environment, and social-cultural norms and structures which generally impact negatively on the poor, marginalized and underserved populations

**Implementation**

USAID/Kenya has contracted Implementing Partners (IPs) for the Zones to provide oversight for the implementation of APHIAplus program activities (FHI, JHPIEGO, PATH, Pathfinder International). The budgets for the activities to be undertaken by the IPs will be detailed in the individual contracts, but would mainly cover HIV and AIDS, Malaria, Family Planning and Tuberculosis. But depending on the discussions the IP will have with the provincial, district and community teams, the APHIAplus support could be utilized to include integrated activities covering MNH. The USAID/Kenya Implementation Framework states that "In order to harmonize this work at the project level, especially in the provincial, districts and community levels, USAID/K will require its implementing partners to fully support agreed-upon country priorities and programs and to establish seamless mechanisms for coordination and communication with the GOK and other local organizations, donors and development partners, and with USAID's implementing partners in the designated program areas."

In addition to the support to the 5 Zones, USAID/Kenya would provide support to national level. This programme shall specifically seek to achieve four major results: 1) strengthened leadership, management and governance for sustain health

programs; 2) strengthened health systems for the sustainable delivery of quality services; 3) increased use of quality health services and information; and 4) enhanced social determinants of health (SDH) to improve well-being of targeted communities and populations. USAID/Kenya will support interventions that address the social determinants of health primarily through linkages and integration with the USG's broader development portfolio.

The guiding principles in the implementation for APHIAplus include: Assuring country-led, country-owned, and country-managed; Aligning Kenyan, USG and development partner strategies; Investing in leadership, capacity and systems for long-term sustainability; maximizing a client-centred approach through integration of services and systems; Increasing involvement of the private sector in health care delivery; ensuring strategic collaboration and coordination; Managing for results with mutual accountability.

**Maternal and Newborn/Family Planning Priorities**

The MoH in its Reproductive Health Policy and Strategy documents has prioritized maternal and neonatal health, family planning, adolescent/youth sexual and reproductive health, and gender issues, including sexual and reproductive rights. The main components of these priorities are Antenatal Care; Basic and Comprehensive Essential Obstetric Care; Essential New Born Care; targeted Post partum Care; Post abortion Care and Family Planning. The pillars for these priorities have been listed as skilled birth attendance, an enabling environment, supportive health systems, community action and male involvement and equity.

In light of the unchanging MN mortality despite the considerable investments in that area, in January 2011, the MoH convened a stakeholders workshop in Nakuru to re-look at the Maternal, Newborn, Child Health and Family Planning priorities. The Nakuru workshop more or less reaffirmed the above priorities but also called for accelerated action to achieve reductions in MNH mortality through high impact interventions. It detailed cardinal actions, commitments and timelines to be taken immediately by all stakeholders at national down to community level, with the MOPHS in the lead.

**Challenges**

The strategic plans of both MOMS and MOPHS have indicated that the funding partners have not adhered to good partnership principles of harmonization, alignment, predictability of funding and respect for government ownership.

USAID/Kenya support is usually off budget, and this complicates estimates in the AOPs.

HIV and AIDS is a health priority in Kenya and impacts negatively on the performance of all other sectors. It is therefore not surprising that the APHIAplus assistance is skewed to HIV and AIDS. However, the high degree of skewing relative to other health priorities in Kenya is a concern which is recognized even in the APHIAplus documents themselves. Fortunately, APHIAplus is a flexible framework and, through consultations, can accommodate deserving modifications.

There are implications of the new constitution which introduces new planning, budgeting, management and implementation modalities across all government sectors. The health sector, like other sectors, has to adapt to the new political dispensation. The DPs and the MoH have to be proactive and ready themselves to deal with new authorities at County levels. In addition, some of the senior managers

at County level may not have the requisite skills, expertise and experience to quickly appreciate the fine intricacies in planning, budgeting, management and implementation. This may cause some delays in project implementation and hence necessitating extensions of the end-dates of the APHIAplus program and the need to supporting some TA to the new health sector governance processes and structures.

Under APHIAplus, support to MNH is contingent upon additional funds being available. But the in-built flexibility of APHIAplus is a window of opportunity for channelling support to some components of MNH through integration into HIV and AIDS and FP. The DPs and the GoK all agreed at the Nakuru Workshop to accelerate the implementation of MNH HII (High Impact Interventions). From the discussions we had with USAID/Kenya officials, the USG is committed to the Nakuru Document and may be willing to including support in the AOP7 for the implementation of the HII at all levels.

Even though the USG is not unique in this, the APHIAplus excludes support to cervical cancer, breast cancer and fistulae management and repair, despite these conditions being of grave concern to women health and rights. It would be preferable that this matter be reviewed by all DPs so that support can be extended to the implementation of these services.

RH indicators of USAID/Kenya include CYP, service providers trained, stock-out rates at health facilities, and OMTCT. In addition, each IP is encouraged to develop own indicators to track progress.

Despite USAID's active participation and support to commodity supply to SPS and to FP and, the commodity insecurity is still a challenge in many facilities. Stock outs of commodities have been cited as the main driver of user fees in health facilities.

**Recommendations**

Keeping in mind some of the major challenges listed above, the fresh vigour with which GoK is addressing its MNH priorities, the huge financial support APHIAplus is making available to Kenya and the opportunities available to DPs and GoK brought about by the devolution and the flexibilities in donor support, we consider it within the realm of possibilities that the recommendations being proposed below could receive favourable consideration by the DPs in general and the USAID/Kenya in particular. More importantly, we consider it critically important that the additional DPs support to RH start to be committed as from AOP7, if Kenya were to have a reasonable chance to achieving the MDGs 4 & 5.

1. It was intimated to the mission during discussions with different stakeholders that where a TA had a fund with which to push his/her program priorities, that TA tended to achieve much more than if that was not the case. It is therefore recommended that TA in AOP 7 be provided with a dedicated fund at provincial and district levels which would be utilized to ensure that there is no stock out of commodities and supplies for attaining the HIIs at point of use

2. All APHIAplus IPs to abide by the Code of Conduct(rules of engagements) at all levels of care to avoid the development of parallel service delivery programs and systems and to minimise competition(e.g . through uniform perdiems)

3. USAID/Kenya being the largest donor to the health sector, is encouraged to participate in the development of and contribution to a national TA Plan for the health sector.

4. In view of the fact that HRH constraints are a critical challenge in the provision of accessible ,quality and equitable RH service, the USAID/Kenya be part of the national HRH pot, so it can have the same reporting requirements and incentives (redistribution plan, recruitment, incentives and trainings)

5. Noting that health facility infrastructure is a major impediment to access and quality, USAID consider providing support to HSSF to improve access, quality and utilization at district and community levels.

6. USAID/Kenya to cover HMIS rollout and capacity building up to community level and to take over HMIS from DANIDA who may be stepping out of this support.

### 8.6.3 GDC – GIZ and KfW

German Development Cooperation (GDC), comprising

- GIZ – German International Cooperation (Technical Cooperation)
- KfW Development Bank (Financial Cooperation)

**Background**

The health sector is one of the priority areas of Kenyan-German Development Cooperation (GDC). In a coherent overall approach combining financial and technical cooperation, GDC supports the health sector through GIZ (German International Cooperation[48]) and KfW Development Bank (KfW). GIZ is providing direct technical assistance (TA) to GoK at various levels of the health sector including policy advisory services, technical and organisational advisory services, and local subsidies. KfW is funding the procurement of commodities, consultancy services for GoK to implement particular RH programmes (OBA vouchers, social franchising) and the set-up of funds for special interventions.

The overall objective of the GDC programme is to improve access among poor and disadvantaged population groups to affordable and adequate health care services, particularly in the area of sexual and reproductive health. This objective corresponds with the national planning and is derived from the Second National Health Sector Strategic Plan (NHSSP II). The GDC documents emphasize that it can only be achieved jointly with other organizations, DPs and IPs. The achievement of GDC's overall objective shall be measured with the following indicators:

(1) A twofold increase in the percentage of the population with access to social security systems, from 10% to 20%.

(2) The access of women to modern family planning is increased to 40% (starting level 28%).

(3) The number of women who give birth with medical assistance is increased by 15% to 69,000 women per year.

(4) The percentage of victims of gender-specific violence who have access to medical and therapeutic services is substantially improved (from 2% to 10%).

It should be noted that special emphasis is placed on supporting the decentralisation of the health sector in view of the implementation of Kenya's new constitution. Furthermore, GDC support is in line with all major policy documents, such as Vision 2030, RH Policy, MNH Road Map and Annual Operational Plans (AOPs). An important challenge is GDC's commitment to help GoK develop sustainable health financing mechanisms through either supply or demand side models.

**Summary of current and planned GDC support**

***GIZ***

The ***GIZ technical cooperation programme*** has a multilevel approach, working on macro, meso, and micro levels of the health system. It consists of four inter-related components: (1) Policy advice, (2) Health financing, (3) Reproductive health, and (4) Gender-based violence (GBV) including female genital mutilation (FGM). The political executing agencies are the Ministry of Public Health and Sanitation (MOPHS) and

[48] Since January 2011, GIZ is the merger of three German TA development organisations, namely the former GTZ, DED and InWENT.

the Ministry of Medical Services (MOMS). The current third programme phase runs from January 2011 to December 2013. TA funds in the amount of EUR 6.5 million are provided for policy advisory services, technical and organisational advisory services, and local subsidies.

GIZ assists in a number of intervention areas that are directly or indirectly related to reproductive health.

(1) Policy advice on strengthening the steering and coordinating capacity of the health sector at the central level: With regard to RH, TA is given to the Department of Family Health (DFH) and in particular to the divisions DRH and DCAH. Special emphasis is placed on the development of youth-friendly services as part of the overall ASRH policy as well as RH communication. In addition, GIZ supports the further development of the national Health Sector Policy (NHSSP III) and envisages strengthening GoK's efforts to cooperate with non-state health care providers, such as FBOs and the private sector (PPP). GIZ continues to give support to the SWAp process and to harmonizing the DPHK group.

(2) Pilot approach to health financing options: The Health for All Kenyans through Innovation (HAKI) community health insurance pilots will be continued, most probably again in cooperation with DFID. Micro- and macro-economic analytical studies will be carried out.

(3) Sexual and reproductive health (SRH) and improvement of the quality of care: GIZ concentrates the TA on district level where DHMTs are supported to strengthen their capacity as managers of district health resources, including public and non-state health care providers. The training "Management Basics for Effective Health (MBEH)" is piloted in cooperation with the DRH. Six focal districts are covered, namely Bondo, Butere, Gucha, Tharaka, Wajir, and Vihiga. Quality improvement at facility level is supported in model facilities driven by the demand of the facilities themselves and using a coaching and mentoring approaches. This includes capacity building in comprehensive RH and GBV as well as equipping the facilities.

    Another area is the implementation of the amended *Adolescent Sexual and Reproductive Health Policy* and support for age-specific ASRH and YFS programmes and increasing use of such services in programme districts.

(4) Reduction in gender-specific violence: In cooperation with other actors, among which KfW Development Bank, GIZ will support GBV interventions at the national reference centres in Nairobi, Eldoret, Kisumu, and Mombasa.

***KfW Development Bank***

***KfW financial cooperation*** consists of funding for up to six components:

1) OBA voucher scheme: This component is ongoing in its second phase until 10/2011 and will be followed by a third phase over three years until 10/2014. EUR 13.7 mio have been allocated to this OBA III component.
2) Health financing pilots towards social health insurance will be financed from 11/2011 over a 3 year period amounting to EUR 6.3 mio.
3) A fund for GBV recovery services in national GBV reference centres will be financed for which EUR 3 mio have been allocated from 10/2011 over a 3 year period.
4) A fund amounting to EUR 1 mio had been allocated for IEC/BCC measures some time ago, but it has not been used for the purpose. Its availability for IEC needs to be confirmed.

5) Details of the following two components are subject to a feasibility study that is due to be carried out in the near future.
6) Procurement of commodities, mainly FP methods, is an ongoing commitment of German financial cooperation. Additional EUR 6 mio are earmarked to follow the current allocation of EUR 12.2 mio.
7) Social franchising of RH services in non-state AMUA clinics, a network of about 180 clinics in Rift Valley, Nyanza and Western provinces currently managed by MSI/Kenya. Special attention is given to promoting clinical FP methods. About EUR 2 mio are earmarked for the subsequent phase 11/2011 to 10/2014.

**Implications of mission findings for GDC**

The joint DP mission is broadly recommending the following, which should be considered by all DPs and likewise by GIZ and KfW where relevant.

- The focus for joint DP commitment in RH should be: (1) scaling up skilled birth attendance; (2) emergency obstetric care; and (3) to make family planning more reliable and address unmet need. This will require joint planning and up-scaled support of training in CEmOC, including Life Saving Skills (LSS) also for normal deliveries. For Family Planning, a whole range of improvements in procurement and logistics needs to be implemented. The focus should be on long-acting and permanent methods (LAPM) and outreach particularly to rural areas.
- Immediately provide support to the MOPHS to build on the HII acceleration plan to deliver an effective continuum of care and develop an evidence-based costed **RH Business Plan (BP**). DPs should then allocate existing resources and report against the thematic areas in the agreed BP which will help guide the allocation and prioritization of additional resources.
- DPs should concentrate on supporting district level delivery of health care services, i.e. rationalise, coordinate and organise DP/IP interventions at the district level under a district level Code of Conduct.
- DPs should anticipate the major planning, funding and governance changes at district / county level required by the Constitution and expected to begin in 2012 after the next general elections.
- DPs should urgently provide **TA** to MoH to support the Ministries in being proactive in navigating in the new constitution and the implications of the **devolution** on the RH sub-sector. This support should be provided **at national and sub-national level**.
- DPs – particularly those already involved in the various health financing initiatives - should work with GoK to revise the Health Financing Strategy along the dual lines proposed and in the light of the experience with KNHIF, the various demand side pilots and the implications of fiscal devolution for the health sector. VfM analyses should be regularly conducted for any innovative interventions with policy implications.
- DPs should consider joint programming in the area of ASRH – YFS, SBA training, RH Communications, and OBA vouchers.
- DPs should strengthen their coordination by going forward with a TA plan with pooled funding or at least virtual TA pooling. Reference is made to the main report (cf. chapter 6.6 in particular) with regard to other aspects of DP harmonization, such as joint annual AOP reviews, definition of a common set of core indicators, funding report against RH-BP priorities, harmonization of per diems.

- DPs should insist on strengthening the DRH in public health and general management skills as well as on a more efficient division of labour concerning ASRH within the Department for Family Health.

**Specific recommendations *for GIZ***

***District-level harmonization:*** As a DP specialized in technical cooperation and supporting the different levels and actors of the health system, GIZ has always had a special role in coordination and harmonization. It is recommended that this expertise is made available for further DP harmonization. GIZ should consider offering its TA services to strengthen district level harmonization of stakeholders, such as IPs, NGOs, FBOs and private sector, not only in those partner districts that are covered by the programme. It would be essential to establish a common agreement with all interested DPs/IPs. This should entail co-financing from different funding sources. This TA should be in line with the devolution process. Measures would include development of an appropriate district / county level Code of conduct, development of a district monitoring system for stakeholders and roll-out to a large number of districts in coordination with other DPs/IPs.

***ASRH and YFS***: As stated in the main report (cf. chapters 6.2.2 and 4.6), ASRH and YFS are seemingly neglected areas of RH in DP support to Kenya and should get more attention. Currently, adolescent SRH issues and services are under review. Results of this research should be taken into consideration for decisions on ASRH&D policy review and the like. International evidence suggests that complementary strategies of different sectors and types of service offers are more effective than single sector strategies.

This calls for intersectoral cooperation in which MOPHS should play a key role in setting standards and expanding the offer of YFS. GIZ is recommended to assist in the policy review against recent study results and the planning of future activities. The mission also recommends reviewing the division of labour among DRH and DCAH, both partly in charge of adolescents' health issues. GIZ may give advice how best to cover all ASRH aspects in the MOPHS.

GIZ has a lot of experience in the area of ASRH. In Kenya, GIZ's support of the development of the School health policy in cooperation with MOPHS and Ministry of Education has brought a lot of progress. Nonetheless, GIZ cannot assure the continued support of this endeavour. There is need to implement the School health policy including curriculum development and teacher training for which other DPs (not only in RH or Health) should be interested.

In the GIZ focal districts, GIZ should be instrumental in supporting DHMTs to coordinate comprehensive intersectoral ASRH programmes. Cooperation should be strengthened with IPs, NGOs and with institutions targeting youth, such as the Ministry of Education and the Ministry of Youth Affairs and Sports. YFS in health facilities should be a key area for service delivery and MBEH principles should be applied to improve ASRH in the districts.

In the framework of RH communication, ASRH should get utmost attention. GIZ could introduce the development and production of Youth fact books (Q&A books) on various pressing health issues, a highly participatory model successfully developed with GIZ assistance in several countries. The innovative use of media channels popular among youth (e.g. ICT, cell phones) should be supported.

***Health financing***: In view of the severe financial access barriers to RH services, the search for demand-side financing schemes that are feasible on a large scale, is a key contribution. Therefore, it is recommended to continue and accelerate, if possible, the research on the community health insurance pilots (HAKI - Health for All Kenyans through Innovation) and disseminate results regularly to the GoK and DP community. Reference is made to the main report chapters 3, 4.2 and 6.1.

***Gender-based Violence***[49]: With regard to the envisaged interventions concerning GBV victims, it is recommended to liaise not only with KfW and the national institutions, but to include other actors in this field (mostly NGOs).

**Specific recommendations for KfW Development Bank**

RH programmes funded by KfW are in part co-financed by other DPs (commodities), have helped introducing innovative approaches that would be interesting for other DPs (OBA voucher scheme), or could be better harmonized with competing approaches (social franchising).

***Harmonization at district level***: As a general rule, MOPHS and KfW together should oblige contractors in the various programmes to adhere to the district (County) Code of Conduct that is proposed to be established as a means to establish improved coordination among all stakeholders in health provision.

***OBA voucher scheme***: This demand side financing scheme has proven to be very popular not only among poor women, but also among service providers. Since 2005, it has been piloted in five low-income urban areas in partnership with NCAPD. The overall management of the programme has recently been handed over to MOPHS/DRH. Beside OBA's impact on numbers of skilled attended birth, the programme has a direct impact on service quality (including skills, staff, equipment, and infrastructure). OBA can be targeted very sharply on the most vulnerable population (poor, young, uneducated). Incentives for youth friendly services can be easily integrated.

For the next phase, it is planned to review certain features of the programme, e.g. offering comprehensive RH vouchers covering deliveries and FP as well as GBV recovery services. It is also planned to cooperate with youth clubs to make youth friendly services a competitive advantage for clinics. As the acceptance of different RH services varies obviously it might be wise to combine less preferred, but very important options with those that women opt for in the first place, i.e. deliveries. It is also intended to utilize innovative technologies (e.g. cell phones in partnership with telephone companies) like in other areas of Kenyan daily life. Transport to reach a clinic or for referrals is an important issue for reasons of cost and security particularly in informal settlements. It is recommended to encourage clinics to invest in partnerships with local transport providers or humanitarian organisations that are running ambulances.

During the mission it was discussed whether the administrative costs of currently about 20% could be reduced. So far, the poverty targeting is organized in a meticulous way in order to avoid misuse of funds. This might be done in a lighter way without loosing the focus. On the other hand, the reimbursement rates for health service providers are much more interesting for public health facilities than for private medical facilities and may have to be adjusted in view of assuring choice.

[49] Please note: The mission did not conduct an in-depth analysis of GBV interventions.

The mission recommends that other DPs join these OBA pilots in order to experiment other options and to create some scope for economies of scale. It is important to disseminate results widely and to assure that this voucher scheme is not seen as an end in itself but rather a step towards other forms of reimbursement of OBA to health providers such as a social health insurance.

***Supply chain for RH commodities:*** As described in the main report (cf. chapter 4.9 and 6.5.1), the erratic availability of MNH and FP commodities in health facilities is of major concern. Despite TA and investment in this area from various DPs, the supply chain management is far from being satisfactory. Together with USAID and other DPHK members, KfW should insist that RH commodity security is addressed as vigorously as possible. A number of recommendations have been given that affect all DPs, but KfW in particular. A major change should be considered as to integrate contraceptives into the general supply chain management together with other RH (MNH) commodities. Further examination of the feasibility will be necessary. The mission recommends as one option that DRH hands over the actual management of commodities and data to the specialized pharmaceutical units at all levels of the MoHs. DRH and RH coordinator roles should rather be to supervise and do the forecasting. Alternative options for transport and data gathering may be worthwhile experimenting. It will also be necessary to review the whole system in view of the responsibility shifts to counties as from 2012 onwards.

***Social franchising***: In Kenya, there are at least two NGO social franchising networks, namely the AMUA clinics managed by MSI-K financed by KfW and the TUNZA clinic network supported by PSI-K and funded through DFID and USAID. Both franchising networks show successful results in promoting quality services in private or NGO clinics based in low-income areas. However, there seems to be a certain geographic overlapping that could be avoided if there was better coordination. Moreover, social franchising is totally lacking a unified regulatory framework, e.g. accreditation and licensing as well as quality control. This should be taken up as soon as possible and be part of the tender for the next phase to be funded by GDC-KfW.

***Community-based RH mobilizers:*** It can be stated that there is a certain proliferation of grass root mobilizers not only in the area of HIV/AIDS, but also in RH, e.g. AMUA field officers, TUNZA mobilizers, voucher distributors, CHWs, CBDs. They all play an important in creating demand, and orienting potential clients towards the particular health services and even providing essential drugs (e.g. condoms and oral contraceptives). While their service is surely key for the success of the respective RH programmes, there is a need to clarify the specific roles and reduce duplication or mutual interference. KfW should engage the dialogue on this using the RH ICC.

***RH communication***: GDC funds have been made available to fund IEC/BCC projects in order to increase demand for RH services with a focus on FP and reduce GBV. Proposals were meant to be submitted from implementers. So far, the problem seems to be the missing quality of the proposals as only 6 applications met the criteria of the IEC/BCC Fund from initially 121 applications out of which only 16 met the prequalification criteria. The mission was not in a position to examine this in more detail. However, it is recommended to consider using remaining funds for co-financing certain interventions based on the RH Communication Strategy and the SBCC Implementation Guide (cf. main report chapter 3.2.3). In our view, there is an excellent opportunity for joint programming and co-funding. In view of the generally underfunded area of ASRH, it should be considered to support interventions targeting youth.

***Gender-based Violence***[50]: With regard to the envisaged GBV Fund, it is recommended to liaise not only with GIZ and the national institutions, but to include other actors in this field (mostly NGOs).

[50] Please note: The mission did not conduct an in-depth analysis of GBV interventions.

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