

MCHIP Country Brief: Kenya



| Selected Health and Demographic Data for Kenya | |
|---|-------|
| Maternal mortality ratio (deaths/100,000 live births) | 488 |
| Neonatal mortality rate (deaths/1,000 live births) | 31 |
| Under-5 mortality rate (deaths/1,000 live births) | 74 |
| Infant mortality rate (deaths/1,000 live births) | 52 |
| Contraceptive prevalence rate | 45.5 |
| Total fertility rate | 4.6 |
| Skilled birth attendant coverage | 43.8% |
| Antenatal care, 4+ visits | 47.1% |
| Sources: *World Bank; **Kenya Population and Household Census, 2009; ***Kenya Demographic Health Survey, 2008-09. | |

Health Areas

- Nutrition
- Immunization
- Child health
- Maternal Health
- Newborn Health
- HIV/AIDS
- Malaria



| | | | | | | |
|--------------------------------|--|----|----------------------------|---|--------------------------|----|
| Program Dates | October 2009–September 2014 | | | | | |
| Total Mission Funding | Redacted | | | | | |
| Geographic Coverage | No. (%) of Counties | 6% | No. of Sub-counties | 3 | No. of facilities | 80 |
| Country and HQ Contacts | Dr. Isaac Malonza, Kenya Country Director; Dr. Muthoni Magu-Kariuki, MCHIP Program Director; Nancy Koskei, Senior Program Advisor; Patricia Taylor, Country Support Team Leader; Natalie Hendler, Senior Program Officer; Lena Mutui, Senior Program Coordinator | | | | | |

INTRODUCTION

Kenya has experienced tremendous development since 2000, including advancements in the economic, educational, and health sectors. Because of its strategic importance and motivated population, Kenya is a priority country for USAID's investments.

The most recent Kenya Demographic and Health Survey (KDHS), from 2008–09, saw some significant improvements in infant and child health but stagnation in the areas of maternal health and family planning as compared to the previous survey in 2003–04. For example, in 2003, the under-five mortality rate was 115/1,000 live births and the infant mortality rate (IMR) was 77/1,000 live births. By 2008, these figures had dropped to an under-five mortality rate of 74/1,000 and IMR of 52/1,000. Matching this were gains in coverage of key child health interventions such as treatment for acute respiratory infections (45.5% coverage in 2003 vs. 55.9% in 2008), use of oral rehydration therapy for treatment of diarrhea (50.6% in 2003 vs. 72% in 2008), and vaccination coverage of 3+ doses for diphtheria-pertussis-tetanus (72% in 2003 vs. 86% in 2008).

However, in maternal health there was little progress, as the maternal mortality ratio was measured at 414 per 100,000 live births in 2003 and 488 per 100,000 live births in 2008; this was not a statistically significant difference. In addition, skilled birth attendance increased minimally from 42% coverage in 2003 to 44% coverage in 2008, and antenatal care coverage for four or more visits actually decreased from 52.3% in 2003 to 47.1% in 2008. Family planning indicators saw similar sluggishness with the total fertility rate declining only from 4.9 in 2003 to 4.6 in 2008. Finally, the neonatal mortality rate—which is closely linked to maternal health—reduced slightly from 33/1,000 live births in 2003 to 31/1,000 in 2008. The next KDHS survey is currently under way in Kenya and the expectation is that there will be improvements in all areas.

Around the time that these data were emerging, the U.S. Agency for International Development (USAID)/Kenya began investing in large-scale, integrated health and HIV programs in different zones across the country, known as APHIAs (AIDS, Population and Health Integrated Assistance Programs). While these programs support service delivery and local governance within their respective zones, there was a need for national coordination and technical guidance. The Division of Family Health (DFH) under the Ministry of Health (MOH) made this request for support to USAID in 2009, and as a result, the MCHIP program was engaged to assist the DFH, and its divisions, to provide management, coordination, and technical leadership in maternal, newborn, and child health (MNCH) across the country.

Since 2009, MCHIP has built the management, supervision, information technology, monitoring and evaluation (M&E), institutional, and technical capacity of the divisions and strengthened the DFH's overall capacity to lead effective health programs countrywide. An element of technical leadership has also included supporting the DFH to demonstrate innovations and high-impact interventions in MNCH and develop strategies for scale-up. These demonstrations were implemented in selected districts of Bondo, Igembe North, and East Pokot. In 2012, MCHIP's role expanded to implementing activities in reproductive health (RH), malaria in pregnancy (MIP), infection prevention, maternal and newborn health, and HIV-related areas such as Prevention with Positives and



Nyamonye community unit: A CHW uses the FP/MIYCN counseling flip chart to counsel a young mother on family planning and MIYCN.

prevention of mother-to-child transmission (PMTCT). All strategies are geared to attaining four main objectives:

Objective 1: To strengthen the technical leadership, coordination, and management capacity of the DFH and its principal divisions.

Objective 2: To promote the scale-up of high-impact MNCH, family planning, nutrition, malaria, and HIV interventions and best practices through implementing partners.

Objective 3: To develop, test, and share promising innovations and best practices in scaling up high-impact MNCH, family planning, nutrition, malaria, and HIV-related interventions.

Objective 4: To improve RH, MNCH, FP, and FP indicators through implementation of the Community Strategy in the MCHIP demonstration districts.

Within these four main objectives, the MCHIP program has been working to attain 10 separate sub-objectives, which have guided and focused the program.

MCHIP Kenya Sub-Objectives

1. Strengthen technical and management capacity of the DFH
2. Address maternal, infant, and young child nutrition in high-priority areas
3. Increase immunization coverage for low-performing districts; introduce rotavirus vaccine
4. Address diarrhea and pneumonia in children
5. Improve the quality of maternal and newborn health and family planning services
6. Improve quality and uptake of PMTCT using an adapted Reaching Every District (RED) approach
7. Plan, coordinate, monitor, and implement malaria in pregnancy (MIP) interventions in Nyanza, Western, and Coast
8. Roll out Community Prevention with Positives (cPwP)
9. Promote infection prevention and control, including injection safety and medical waste management in the community
10. Scale up cervical cancer prevention and control (CECAP) interventions

KEY ACHIEVEMENTS

Organizational Capacity Building

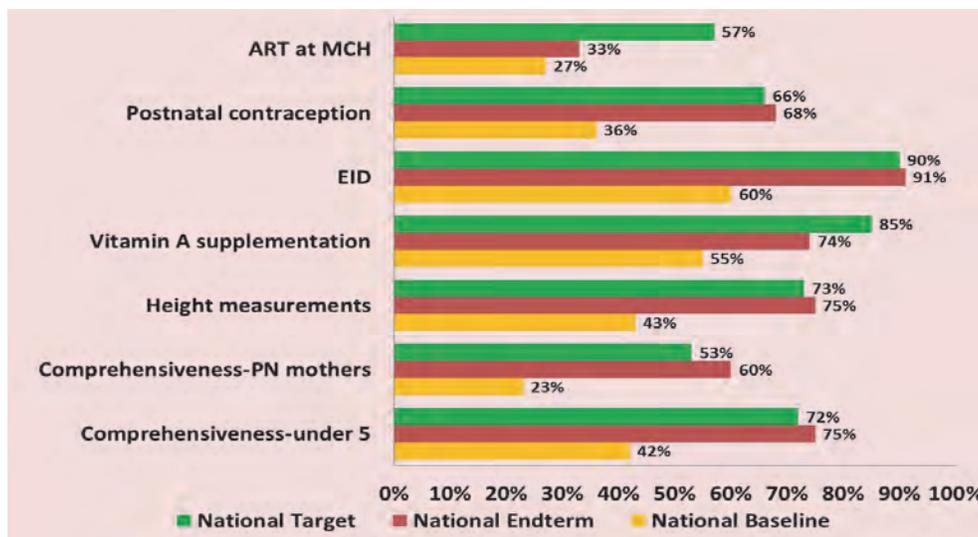
One of the key roles of the MCHIP program was to build the skills and capacity of the national-level MOH managers. MCHIP worked with the MOH to institute essential management strategies such as setting up regular, effectively run meetings; coordinating partners; and creating a more streamlined process for developing and reviewing policies, guidelines, and strategies. In particular, MCHIP was able to assist the DFH to functionalize Inter-Agency Coordinating Committees (ICCs) that led the process of endorsing and approving national documents such as the iCCM (integrated community case management) Operational Guide and the Maternal and Newborn Health Roadmap. In addition, MCHIP worked closely with Program Officers within DFH to improve their supportive supervision and training skills so that policies are implemented effectively. In collaboration with the Division of Child and Adolescent Health, MCHIP supported the revision, adoption, and launch of a new national vaccination policy that had stagnated for more than 10 years. This policy was complemented by the introduction of three new vaccines in Kenya—PCV-10 (Ten Valent Pneumococcal Conjugate Vaccine) to address pneumococcal disease; rotavirus vaccine, to prevent one of the leading causes of childhood diarrhea; and HPV vaccine, to eliminate one of the causes of cervical cancer. Furthermore, MCHIP supported the Division of Nutrition (DON) to develop an M&E framework for key nutrition indicators. After approval by the ICC, the M&E Framework was launched, resulting in tracking of exclusive breastfeeding until six months of age, tracking of fortification of maize flour and baby food, and tracking of management of breastfeeding complications, among others. MCHIP facilitated the compilation of evidence on community use of zinc, which led to a policy change moving zinc from prescription to over-the-counter availability. This means that

Community Health Workers (CHWs) are now able to provide zinc to children with diarrhea at the household level and scale up this evidence-based intervention. With MCHIP’s technical assistance, the MOH now has an effective structure for managing health interventions at a national level.

Demonstrating Success in Service Delivery

MCHIP supported selected aspects of service delivery, mainly in its target districts of Bondo, Igembe North, and East Pokot, but also in other areas of the country as needs arose. For example, MCHIP worked in the 64 districts with high malaria endemicity to address MIP through intermittent preventive treatment in pregnancy (IPTp) with sulfadoxine-pyrimethamine (SP). MCHIP supported the Division of Malaria Control and the Division of Reproductive Health to update 5,759 service providers in IPT-SP—exceeding targets, with 117% coverage—from 1,165 facilities (94% of target). The facility work was complemented by updating CHWs on community MIP where pregnant women were registered and referred to antenatal care services. These inputs led to increased coverage of two doses of IPTp, measured as rising from 25% to 63% in one independently evaluated district. Another example of successful service delivery was supporting the MOH to use the rapid result initiative (RRI) approach to integrate HIV services at maternal and child health (MCH) clinics in 40 facilities. The RRI approach was focused on reducing missed opportunities for linking HIV and MCH services. Targets were set for indicators such as postnatal contraception, early infant diagnosis (EID) of HIV, vitamin A supplementation for newborns, and others. During the RRI interventions, MCHIP measured baseline provision of these services and endline provision. The facilities surpassed the targets for five out of the seven indicators, as shown below. For example, at baseline EID was being provided at a level of 60%. After the RRI, EID coverage was 91%, higher than the 90% target.

National Achievements on the MNCH RRI Indicators among 40 Health Facilities



Key: EID – Early Infant Diagnosis; ART – Antiretroviral Therapy; PN – Postnatal

Scaling Up through Partners

MCHIP developed strong relationships with all USAID-funded partners—including the APHIAPlus partnerships—as well as non-USAID partners. MCHIP linked the MOH with APHIAPlus programs to scale up selected interventions. In Eastern and North Eastern regions, MCHIP worked with APHIAPlus Kamili and Imarisha, respectively, to roll out essential newborn care (ENC) training. MCHIP supported the training of 45 APHIAPlus staff as mentors in ENC. These mentors then scaled up ENC training to more than 300 health workers. In addition to providing technical assistance, MCHIP also led the process of bringing partners together to tackle challenges. Seven districts were identified by the Division of Vaccines and Immunization as low-performing districts in terms of immunization coverage, with high numbers of unvaccinated children. MCHIP coordinated efforts with the United Nations Children’s Fund (UNICEF) and APHIAPlus to address these gaps. MCHIP supported the training on Reaching Every District (RED)¹ in each district while UNICEF and APHIAPlus provided the funds to implement the micro-plans developed. MCHIP then also provided technical support to follow up these plans. Due to these joint efforts, the seven districts recorded significant reductions in the numbers of unvaccinated children and, in 2012, five of the districts were weaned off of donor support.

Innovative Implementation Approaches

Finally, in the target districts, MCHIP demonstrated successful, innovative approaches to addressing MNCH, which included adapting strategies from one technical area to another, piloting and testing different models, and sharing its lessons learned with partners. The RED approach, which was so successful for vaccination coverage, was also adapted and applied to increase PMTCT coverage. Between 2010 and 2012, there was an increase in coverage of the district with CHW interventions from 38% to 100%. This led to marked improvements in the proportion of HIV-exposed infants getting tested at six weeks of age: 27% to 78%. MCHIP also tested a client referral model using HIV support groups in Bondo and Igembe East districts increase the numbers of people living with HIV/AIDS (PLWH) coming in for HIV care and treatment services.

This approach connected the support groups to the facilities and enabled PLWH peer educators to do referrals as well. To elevate levels of family planning use, MCHIP supported the Bondo Sub-County Health Management Team to roll out distribution of family planning commodities through CHWs. This was measured in April 2014, and preliminary findings show impressively high contraceptive prevalence rates of 64% among all women and 72% among married women. MCHIP worked with the DON to demonstrate the Baby Friendly Community Initiative (BFCI) in Bondo and Igembe North. The BFCI package implements interventions at primary care facilities and in the community to improve maternal nutrition, breastfeeding rates, and complementary feeding. Following the training, supervision, and support group activities in Bondo, new mothers had improved knowledge and skills in infant feeding practices. To address infection prevention and control (IPC) at health facilities, MCHIP pioneered the on-site, whole-site training approach. This approach facilitates practical exposure to IPC for everyone at the facility, which resulted in the development of plans and allocated collective responsibility for IPC at the facility. MCHIP shared

“There has been a threefold increase in enrolment into our HIV services in this health facility; we are seeing mothers referred by their partners to the PMTCT and MCH for HIV testing. We are also seeing index clients referring their sexual partners for testing and HIV care at our HIV comprehensive clinic.”

– HIV clinic nurse in-charge at Bondo district hospital, Siaya County

¹ RED is an operational strategy for reaching every child with vaccinations by: addressing planning and management of financial and human resources; extending services to target population; creating community links with the health facility; providing supportive supervision; and monitoring data.

these and other innovative approaches with APHIAPlus Kamili, APHIAPlus Nuru Ya Bonde, FHI 360, and African Medical Research Foundation partners during several learning field visits to Bondo over the course of the program.

WAY FORWARD

- Counties should scale up proven approaches and best practices: community strategy (stipends, outreaches, dialogue days), RED, and SBM-R.
- Counties should institutionalize proven community innovations.
- Adequate preparation of service providers to meet high demand for services is needed to:
 - Avoid frustrations to caregivers who come for the newly introduced vaccines and other vaccines but are turned away due to stock-outs or miscommunication (e.g., child too old); and
 - Enable catch-up with other vaccines and thereby reduce missed opportunities.
- There is a need for appropriate and well-scripted communication on target ages for vaccination when introducing a new vaccine.
- To benefit more children, donors such as GAVI should consider funding vaccines for the entire under-one year-old catch-up cohort.
- To advance equity in vaccination, there is a need to deliberately target populations not normally reached by immunization services.
- The RED approach is practical and effective in reducing the numbers of unvaccinated children but continued advocacy for and implementation of the RED approach at district level is important for sustainability.
- Community engagement, such as the use of village elders to create demand and track defaulters, is essential for success of fully immunized child (FIC) coverage.
- Innovations such as the use of tickler files, immunization diaries, and cell phone contacts complement CHVs' responsibilities of creating demand and following up on defaulting children.
- There is a need to maintain adequate vaccine supplies in order for the RED approach to succeed.
- New vaccine introduction provides an excellent opportunity to refresh health worker knowledge on vaccine management and to reach populations previously underserved by immunization services.
- Initial external funds to jumpstart the RED approach and local funds to sustain it are essential for its success.
- Effective MOH leadership and management are key at all stages of the planning and implementation of immunization to encourage ownership and sustainability.
- Continued updates to health workers through job aids, on-the-job training, refresher courses, and supportive supervision are essential, especially when a new vaccine is introduced.

National-Level Recommendations

- The National iCCM task force's M&E team must spearhead the achievement of the M&E plan's objectives in order to have meaningful measurement of progress in iCCM moving forward.
- A proper iCCM policy landscape analysis, which incorporates existing and new initiatives/thinking, is important to inform current and future debates/programming in iCCM and to identify new opportunities for future engagements.
- It is important to convene a national learning symposium to share the outcomes of the various researches that were done to provide evidence and guide future scale-up of ICCM.
- A national and sub-national iCCM scale-up plan is one of the key ingredients for Kenya as it plans for scale-up.

Sub-National Recommendations

- An environment where IMCI at facility level is strengthened among HCWs alongside community case management ensures that coverage of lifesaving interventions is improved.
- Mentorship for IMCI and iCCM are critical to skills and knowledge retention and hence quality of service delivery among the HCWs and CHWs.
- Kenya must embrace the community health strategy in order to make significant improvements in reducing serious morbidity.