



REPUBLIC OF KENYA

National Road Map



For
Accelerating the Attainment of the MDGs Related to
Maternal and Newborn Health in Kenya

August 2010

NATIONAL ROAD MAP

August 2010

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FOREWORD

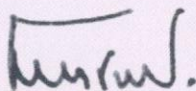
The high level of Maternal and Newborn morbidity and mortality has not changed substantially over the last decade as shown by the WHO 2007 report, with many women in Africa dying each year from complications of pregnancy and childbirth. The disability and death of a mother hinders child survival, destroys families, takes children out of school and lowers household and community economic productivity, thus posing a serious challenge to the broader social economic development. Improving Maternal Health (MDG 5) is often called the 'heart of MDGs' because if it fails, the other MDGs will also fail.

Addressing Safe Motherhood is human rights imperative. It is estimated that 7,700 Kenyan women die each year because of pregnancy-related causes. This translates to approximately 21 women each day or almost one Kenyan woman every hour. Further the Kenya Demographic Health Survey (2008/09) indicates that maternal mortality levels in Kenya have remained unacceptably high at 488 per 100,000 live births, with some regions reporting MMRs of over 1000 /100 000 live births. Notably, MDG 5 (Reduce maternal death to 147 per 100,000 by 2015) is doing poorly and there is need to redouble our efforts towards attaining this goal. In addition, around 1.12 million newborns die before they complete their first month of life and another one million babies are stillborn every year. Neonatal mortality rate in Kenya is estimated at 31 deaths per 1,000 live births (KDHS, 2008/09), a very marginal reduction when compared to the other child health indicators that have shown significant improvement.

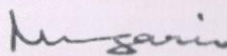
Vision 2030 aims to provide equitable and affordable health care of the highest affordable standard to all citizens, by restructuring health care delivery systems with a shift of emphasis to preventive and promotive health care. The emphasis is on access, equity, quality, capacity and institutional framework. The Health Ministries' core function is to support the attainment of the health goals of the people of Kenya by implementing priority interventions in health, based on their mandate and guided by the Strategic Framework for National Transformation 2008–2012 and the wider health sector. In pursuant of this, the Ministries of Health support the implementation of Vision 2030 and MTP 2008–2012, along with the broad goals of the National Health Sector Strategic Plans.

The National Maternal and Newborn Health (MNH) Road Map is adapted from the Africa Regional Road map following an agreement by all AU countries to accelerate the attainment of MDGs 4 and 5. The Implementation framework of the strategies adopted for the Road Map require concerted efforts by all stakeholders in the Health Sector from national level down to the community and across the political, social, and corporate divide.

It is envisioned that the implementation of this MNH Road Map will accelerate the attainment of MDG 5, thereby ensuring a vibrant and healthy Kenya. Let us all pull together in the national spirit of 'Harambee' and make this a reality.



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They include:

- Division of Health Promotion
- Division of Vaccines & Immunization
- Division of Nursing-MOMs
- Nursing Council of Kenya
- Health Information System
- Division of Nutrition
- The Midwives Chapter
- Nairobi Province-MOPHS
- Eastern Province-MOPHS/MOMs
- Western province MOPHS/MOMs
- Nyanza Province-MOPHS/MOMs
- Catholic Secretariat
- Family Health Options
- HSLP

Finally we appreciate the support given by the Head of Division of Reproductive Health, Dr. Bashir Issack, as we finalized the Document.

LIST OF ABBREVIATIONS

ANC	Antenatal Care
ASRH&DP	Adolescent Sexual Reproductive Health and Development Policy
BBI	Better Births Initiative
D&C	Dilation and Curettage
FCI	Family Care International
FP	Family Planning
HIV	Human Immunodeficiency Virus
ICPD	International Conference for Population and Development
IEC	Information Education Communication
KAIS	Kenya AIDS Indicator Survey
KDHS	Kenya Demographic Health Survey
KSPA	Kenya Service Provision Assessment Survey
LBW	Low Birth Weight
MDG	Millennium Development Goals
MMR	Maternal Mortality Rate
MNH	Maternal and Newborn Health
MOH	Ministry of Health
MTCT	Mother –to –Child Transmission
NASCOP	National AIDS and STI Control Program
NHSSP	National Health Sector Strategic Plan
OBA	Output-Based Aid
PEPFAR	US President's Emergency Plan for Aids Relief
PMTCT	Prevention of Mother to Child Transmission
PRHT	Provincial Reproductive Health Team
DRHT	District Reproductive Health Team
RH	Reproductive Health
RHICC	Reproductive Health Inter-agency Coordinating Committee
SWAPs	Sector Wide Approaches
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
WHO	World Health Organization

EXECUTIVE SUMMARY

Maternal and neonatal morbidity and mortality continue to be recognised internationally as public health priorities. More than 15 years since the launch of the Safe Motherhood Initiative (SMI), maternal and neonatal mortality levels in Africa have sadly continued to rise instead of decline. Of all maternal deaths occurring globally, 99 percent of them occur in developing countries with Sub-Saharan Africa having the highest maternal mortality ratio (MMR) of 900,000 maternal deaths per 100,000 live births and also the highest lifetime risk of maternal deaths of 1:26. Consequently, now more than ever before, the international community realises that unless greater investments are made, MDG 5 will not be attained in Africa.

Maternal mortality levels in Kenya have remained unacceptably high at 488 maternal deaths per 100,000 live births, (with some regions reporting MMRs of over 1000 /100 000 live births). Neonatal mortality rate is estimated at 31 deaths per 1,000 live births (KDHS, 2008/09) from 33 deaths per 1,000 live births (KDHS, 2003), a very marginal reduction when compared to the other child indicators that have shown significant improvement. Currently NMR is contributing 67% of IMR. This implies that reduction in newborn mortality would put Kenya on track for attainment of MDG 4.

The slow progress in attainment of Maternal and Newborn health targets in Kenya can be attributed to: i) Limited availability, poor accessibility and low utilization of skilled birth attendance during pregnancy, child birth and postnatal period, ii) low Basic Emergency Obstetric and Newborn Care coverage iii) Poor involvement of communities in maternal and newborn care iv) Limited national commitment of resources for maternal and newborn health.

The key strategies proposed to accelerate the attainment of MDG 4&5 include: improving availability of, access to, and utilisation of quality maternal and newborn health care; reducing unmet need through expanding access to good quality family planning options for men, women and sexually active adolescents; strengthening the referral system; advocating for increased commitment and resources for MNH and FP services; strengthening community based maternal and newborn health care approaches; and strengthening the monitoring and evaluation system and operations research.

The goal of the National MNH Road Map is to accelerate the reduction of maternal and newborn morbidity and mortality towards the achievement of the Millennium Development Goals (MDGs). The specific objectives are:

- i. to increase the availability, accessibility, acceptability and utilisation of skilled attendance during pregnancy, childbirth and the post partum period at all levels of the health care delivery system;
- ii. to strengthen the capacity of individuals, families, communities, and social networks to improve maternal and newborn health, and lastly.
- iii. to strengthen data management and utilisation for improved MNH.

The National MNH Road Map offers a new and revitalised dimension of efforts of all stakeholders. It provides a framework for building strategic partnerships for increased investment in maternal and newborn health at both institutional and programme levels. Implementation will take a phased approach and the final reporting year will be 2015.

INTRODUCTION

Maternal and newborn morbidity and mortality continue to be recognised internationally as public health priorities. The Global Safe Motherhood Initiative launched in Nairobi in 1987 aimed at reducing the burden of maternal deaths and ill health in developing countries. The 1994 ICPD Program of Action later called for a paradigm shift in strategies and policies in the provision of comprehensive and quality reproductive health services. These led to the Millennium Declaration in 2000 and development of goals with indicators.

A major contribution towards the achievement of the MDGs is the commitment of governments of developing countries and the international community, who have adopted the MDGs as their framework for development and cooperation. Two key MDGs relevant to maternal and newborn health are: MDG 4 – reduction in child mortality and MDG 5 - improved maternal health. These goals provide targets for countries in their efforts towards reducing maternal mortality, and increasing both skilled attendance and contraceptive prevalence rate. Other relevant MDGs include No. 3 - Gender equity and women's empowerment and No. 6 – Combat HIV/AIDS, malaria and other diseases.

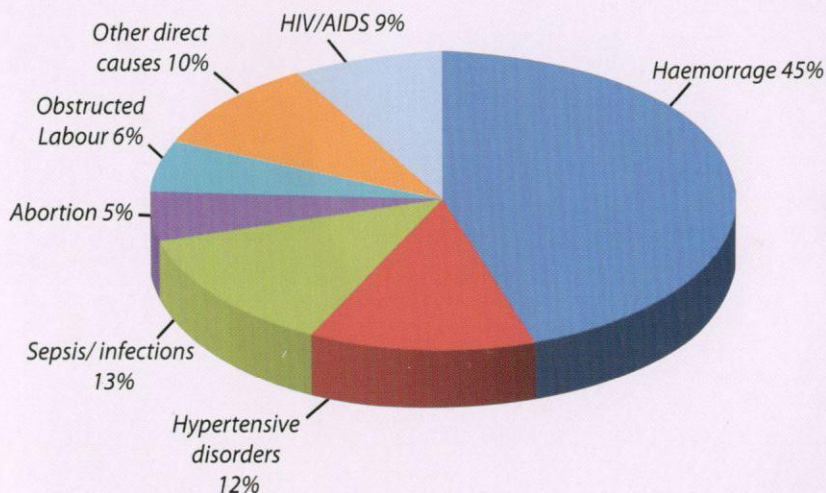
The UN recognises that MDGs cannot be achieved in low resource settings without attention to population issues and access to sexual and reproductive health information and services (UNDP, 2005). In order for the achievement of MDG 5 to be made a reality, MMR will have to decrease at a much faster rate, especially in Sub-Saharan Africa where the annual decline has so far been about 0.1 percent compared to the expected decline rate of 5.5 percent. The realization of this goal will require increased attention to improved health care for women, including: improved access to health services, reduced unmet need for family planning services, prevention of unsafe abortions, provision of high quality pregnancy and delivery care including essential obstetric care (WHO, 2007). Quick win interventions are therefore being recommended, among them expanding access to SRH information and services, including family planning, and closing the existing funding gap for supplies and logistics (UNDP, 2005). Efficient and effective skilled care during and after labour and delivery can make the difference between life and death for both women and their newborns, as complications are largely unpredictable and may rapidly become life threatening (WHO, 2005).

THE CURRENT SITUATION OF MNH

Maternal Health

Maternal and newborn conditions account for a substantial part of the health gap between the developed and developing countries. Of the estimated 536,000 maternal deaths that occurred in 2005 globally, 99 percent (533,000) occurred in developing countries with Sub-Saharan Africa having the highest MMR at 900 maternal deaths per 100,000 live births. The adult lifetime risk of maternal deaths is highest in Africa (1:26), followed by Oceania (1:62), and Asia (1:62); compared with developed countries, where the risk is 1: 7300 (WHO, 2007). Major causes of maternal mortality in SSA are depicted below.

Figure 1: Causes of Maternal Mortality in the African Region



Source: UNDP, WHO, UNFPA, World Bank (2006). *Causes of maternal death. A systematic review. The Lancet 2006;367:1066-74*

Approximately 13 percent of all maternal deaths occur among adolescents mainly as a result of complications of unsafe abortions (WHO 2008).

[†]These are members of the society who are at risk with respect to maternal and neonatal health and they include; persons with disabilities, youth and adolescents, the poor in urban, rural and hard to reach areas, people infected or affected by HIV/AIDS, Orphans and vulnerable children-homeless, refugees and abused persons (RH Policy, 2007)

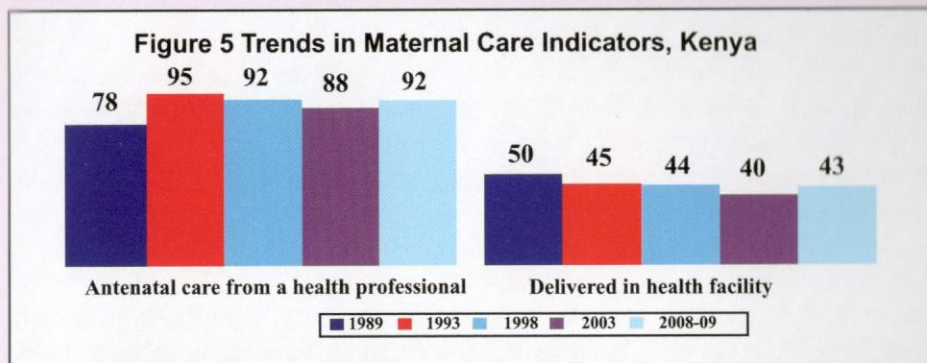
The most common causes of maternal morbidity and mortality (MOH-Kenya Annual Statistical Report, 2008) are: obstructed labour (29.5%), post partum haemorrhage (25%), ante partum hemorrhage (16.9%) and pre-eclampsia (16.9%).

The situation in Kenya with regards to MNH remains grim with the recently released KDHS 2008/9 basically showing very marginal improvements in the Maternal and Newborn care indicators. The Maternal Mortality Ratio (MMR) remains high at 488/100,000 (KDHS 2008/09). The proportion of mothers attending antenatal clinic at least once increased from 88% to 91.5%, deliveries by skilled attendants increased slightly from 40 to 42% and institutional deliveries increased slightly from 40.1 to 43.6% (KDHS, 2008/09). This means that over 50% of deliveries among Kenyan women are attended by unskilled persons; hence both mother and newborns are in danger should any complication arise during delivery or postnatal period. It is unlikely that the country will achieve the maternal mortality target of 147/100,000 by 2015 unless greater attention and efforts to increase skilled attendance are put in place.

Regional disparities within the country exist. Skilled birth attendance was found to be about 40% in Nyanza Province, 30% in North Eastern Province and 25% in Western Province. North Eastern Province has the highest MMR of 1,000-1,300/100,000 (KDHS, 2003). The urban poor also show very high levels of maternal mortality.

¹Kenya service Provision Assessment (KSPA) 2004.

Safe motherhood Programmes: Options and issues. Deborah Maine Prevention of Maternal Mortality, Centre for Population and family Health

Figure 2: Trends in Skilled Birth Attendance during Delivery

Among women who deliver outside the health facility, a vast majority (8 out of 10) do not receive postnatal care. Only 10 percent attend postnatal care within two days of delivery, while 2 percent get care three to six days after delivery (KDHS, 2003). This is despite the fact that majority of maternal deaths occur during the postpartum period.

Furthermore, nearly half (46%) of the population live below the poverty line and only 52% of Kenyans are within 5 kilometers of a functional health facility. Rural urban disparities in SBA are also prominent with urban areas showing skilled birth attendance of 72% (2003) and increasing to 75% (2008/09) while rural areas had SBA of 34% (2003) increasing to 37% (2008) (KDHS 2003; 2008/09). Equitable distribution of health facilities and services across the country is also lacking with urban areas having mainly CEOC while rural areas have mainly BEOC. The average recommended EOC facilities per 500 000 population remains low at 1.7 as compared to the recommended 5 EOC facilities/500 000 population.

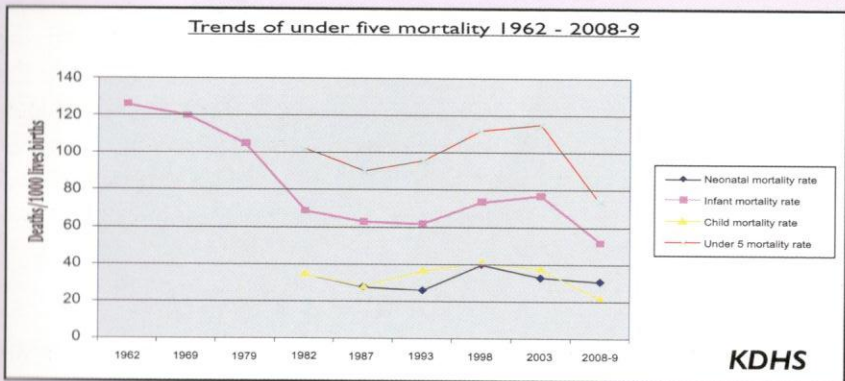
Newborn Health

Global data from vital statistics indicates that in 2004 there were 133 million live births, 3.7 million of whom died in the neonatal period and 5.9 million during the perinatal period. Ninety-eight per cent of these deaths took place in the developing world, where 90% of babies were born (WHO, 2007). The top three causes of newborn death in Africa are infections (29%), prematurity (25%), and asphyxia (24%). Neonatal tetanus, which accounts for 6% of all new born deaths in Africa is one of the most cost-effective conditions to prevent.

The non improvement of maternal indicators is even more significant for neonatal survival. According to the KDHS 2008/09 neonatal mortality rate only reduced marginally from 33 to 31 per 1000 live births contributing to 42% of the under five mortality and 60% of infant mortality. This is an increase when compared to 29 percent of under five mortality and 42% of infant mortality in 2003 (KDHS). Achieving the MDG 4 targets in under-five mortality (33/1000) and infant mortality (26/1000) by 2015 will be a challenge unless neonatal care, which is closely linked to maternal care, receives more attention (Lawn and Kerber, 2006).

The most common causes of neonatal morbidity and mortality (MOH-Kenya Annual Statistical Report, 2008) are pre-maturity and low birth weight (30%), neonatal infections (27%) and birth asphyxia. Despite overwhelming evidence that exclusive breastfeeding for the first six months of life significantly enhances child survival (Jones, G; Steketee, R; Black, R; Bhutta, Z; & Morris, S. 2003), Kenyan reports indicate that only 35% of infants are exclusively breastfed up to the age of 6 months (KDHS, 2008/09).

Figure 3: Trends in neonatal, infant and under-five mortality in Kenya



MNH Services

The Kenya Service Provision Assessment (2004) indicates that only 33 percent of health facilities offer ANC, TT immunisation and post natal care. Normal delivery services are provided by 38 percent of facilities while only 7 percent provide caesarean section. Emergency transport is available in only 27 percent of the facilities (KSPA, 2004).

Obstetric fistula is still a major problem in Kenya, and reflects on health systems failure in terms of early detection and management of complications of labour. The availability of post abortion care services are limited with only 16 percent and 14 percent of facilities offering delivery services having a manual vacuum aspirator and a D&C kit in place respectively (KSPA 2004). These findings demonstrate that Kenya still is far from attaining universal coverage of MNH care.

Results from the Kenya AIDS Indicator Survey 2007 show that the HIV prevalence rate among adults is 7.4% percent while that among pregnant women is higher at 9.0 percent. Although approximately 1.4 million people are currently living with HIV, the majority (83%) of HIV infected persons do not know their HIV status (KAIS, 2007).

Kenya's target for PMTCT services as outlined in the KNASP II was to increase coverage of PMTCT services to reach 80% of pregnant women by end of 2008, and reduce paediatric HIV infections by 50%. This is in line with the UNGASS 2001 recommendations. The percentage of ANC attendees tested for HIV significantly increased from 50.4% in 2003 to 78.6% in 2007 (KAIS 2007). More work is being done to ensure universal HCT for all pregnant women in Kenya.

Family Planning is known to be a cost effective strategy to enhance maternal and newborn health, reduce maternal and newborn mortality and is one of the prongs of PMTCT. However in Kenya, contraceptive prevalence stands at 46 percent, family planning unmet need among married women aged 15-49 stands at 45.6 percent and the total fertility rate is 4.7. Family planning utilisation is poorest among adolescents with a CPR of 19.6% for any modern method. FP unmet need is very high among HIV positive women with 57.9% of these women not using any contraception at all (KAIS, 2007; KDHS, 2008/09). This may be attributed to the fact that the PMTCT programme is managed as part of the HIV /AIDS programme which gives low prioritisation to the FP prong.

Reasons for Non Improvement of MNH Indicators in Kenya

The main reasons for the non improvement of MNH include: low BOEC coverage, poor access to skilled attendance along the continuum of care, lack of community involvement in MNH, high unmet need for family planning and the delays in seeking appropriate skilled care.

The first delay entails a delay in decision making at household level hence the importance of community awareness and participation in MNH programmes. In Kenya, many of these deliveries take place in the villages as a result of ignorance - poor knowledge of danger signs, cultural issues, and poor status of women. Women are not empowered to make decisions on skilled birth attendance, and majority of men still control use of resources at household level.

The second delay involves a delay in moving the woman to hospital. Some women may be willing to go to health facilities, but are not able to go due to various barriers. These include: cost - the cost of maternal care services remains very high for most women in Kenya; access - health facilities are few and sparsely located; the poor state of Kenyan roads and unavailability of transport in many areas makes it hard for many women to access health services at time of need; and poor status of women - most women are not empowered to make decisions on health care due to low education and low socio-economic status.

In the third delay, there is delayed intervention at the facility. This normally arises as a result of poor infrastructure, lack of equipment, and lack of knowledge and skills in EmONC. Poor distribution of health workers has left rural facilities with few or no health workers to provide services. Unfriendly attitude by health workers has also been shown to lower utilization of maternal and newborn Health services.

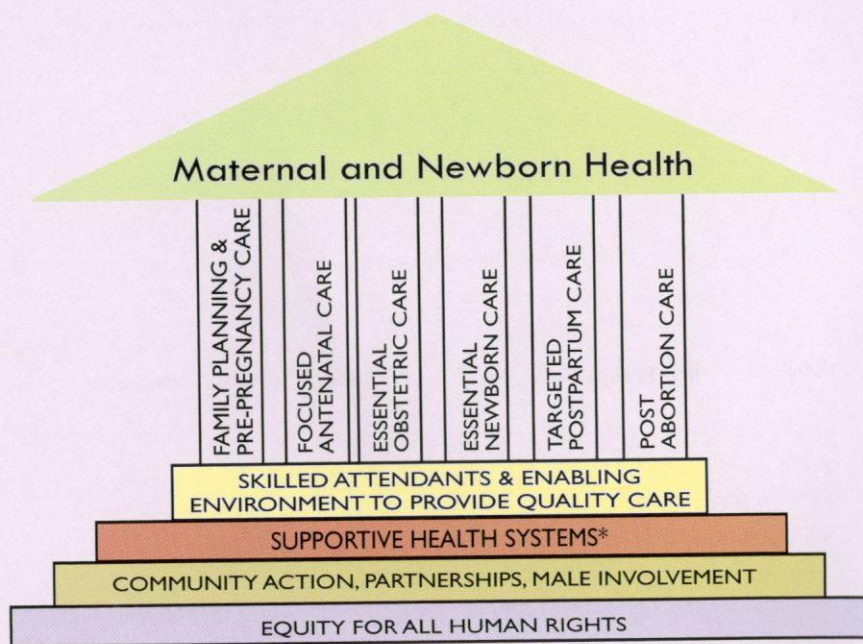
MNH Policy and Strategy Environment

- A National Reproductive Health Policy is in place.
- A National Reproductive Health Strategy is in place
- A Child Survival and Development Strategy (CSDS) has been developed.
- A Health Policy & Financing Strategy is being finalised - the health care financing strategy advocates for free health care for pregnant women and children under five years. Performance based financing has also been taken as an option in the draft financing strategy. Referral mechanism for community to be included as part of health care financing.
- Adolescent RH and Development Policy is in place.

THE KENYA MATERNAL AND NEWBORN HEALTH MODEL

The six pillars of Maternal and Newborn Health in Kenya include: pre-conceptual care and family planning, focused antenatal care, essential obstetric care, essential newborn care, targeted post-partum care, and lastly post-abortion care. These services are underpinned by the foundation of skilled attendance and a supportive and functional health system. The Kenya MNH model recognises the potential role communities have in the promotion of their own health, the importance of strengthening the interface between the community and health services, as well as promoting the human rights approach to health service delivery. These are also identified by the NHSSP II 2005-2010 (currently extended to 2012) as key areas of focus.

Figure 4: Kenya Maternal and Newborn Health Model



* M and E; health planning; financial & commodity supply management; functioning referral network; human resource management & development; quality assurance & standards; investment and maintenance; information, communication and technology; and performance monitoring

CHALLENGES IN THE IMPLEMENTATION OF MNH SERVICES

Since the launch of the Safe Motherhood Initiative, efforts invested in maternal and newborn health programmes have not yielded the expected results due to several challenges. A combination of structural and infrastructural problems has had a negative effect on the successful implementation of MNH programmes. These include:

Challenges

- Limited availability, poor accessibility and low utilization of skilled attendance during pregnancy, child birth and postpartum period at all levels of the health care delivery system.
- Socio cultural barriers contribute to delay in seeking care as well as reluctance to adopt good practices through behaviour change, thereby increasing the risk of obstetric and newborn complications (for example mother's preference to deliver at home with unskilled attendants), and lack of community based maternal and newborn care).
- Poor staffing and/or inappropriate staff deployment.
- Inadequate health provider competencies in Essential Obstetric and Newborn Care.
- Inadequately articulation of MNH issues in pre-service training curricular.
- Poor access to good quality MNH services including family planning.
- Inadequate access by adolescents and youth to reproductive health information and youth friendly services.
- Low uptake of PMTCT services.
- Inadequate integration of MNH and HIV/AIDS services.
- Limited skills in planning and management for use in MNH programming.
- Limited national commitment of resources for maternal and newborn health.
- A weak public-private partnership in service delivery.
- Limited participation of community, family and individuals in MNH.
- Lack of gender perspective and male involvement.
- Poor monitoring and evaluation.
- Poor utilisation of research findings for evidence-based service delivery.

Opportunities

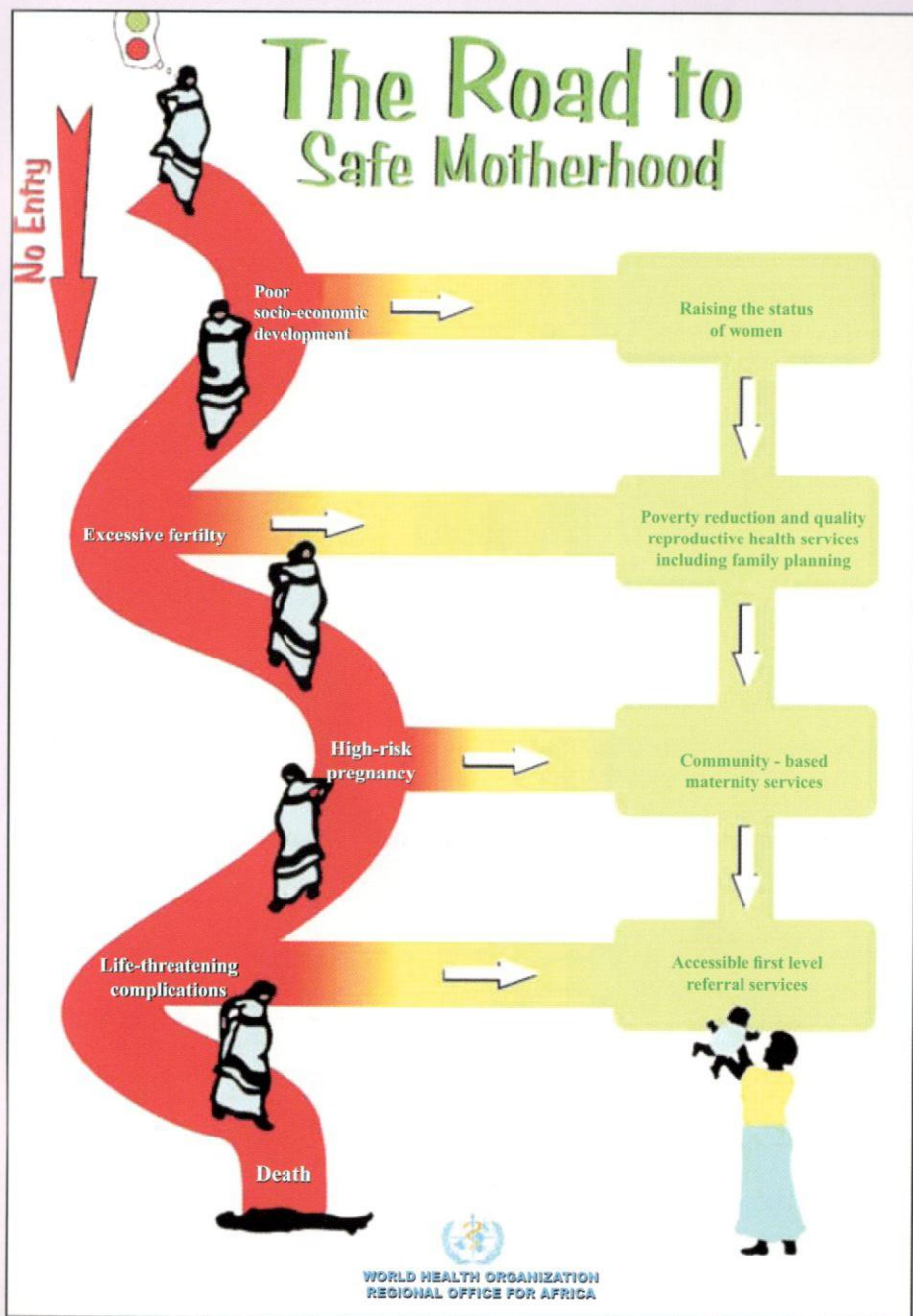
- Enabling policies, guidelines, strategies and training materials in place.
- Promising government and donor commitment.
- Existence of coordination mechanism for MNH.
- Promotion of the Better Births Initiative (BBI) and Baby Friendly Hospital Initiatives (BFHI).

- Adoption of appropriate approaches and best practices.
- The National Community Strategy is being rolled out.
- Men express readiness for involvement in MNH.
- Gender mainstreaming efforts in MNH are underway.
- Pre-service institutions showing interest in regular uptake and revision of curricular.

GUIDING PRINCIPLES OF THE ROAD MAP

The Kenya Road Map will be grounded on ten key principles.

1. **Evidence-based:** ensuring that the interventions are based on up-to-date evidence.
2. **Human rights approach, equity and accessibility:** human rights and freedom must be respected and reflected through scaling up of cost-effective interventions that promote equitable access to quality maternal and newborn care services with special attention to the poor and vulnerable groups.
3. **Health systems approach:** focus on the delivery of maternal and newborn health at all levels, more so, using primary health care as an entry point for engaging community resources and strengthening the referral system.
4. **Phased planning and implementation:** promoting implementation in clear phases with timelines and benchmarks that enable re-planning for best results.
5. **Complementarity:** leveraging on existing programmes and recognising the comparative advantage of the different partners in the planning, implementation and evaluation of maternal and newborn health programmes.
6. **Partnership:** promoting partnership, coordination and joint programming among stakeholders including the private sector, professional associations and councils at all levels in order to improve collaboration, maximise resources and avoid duplication.
7. **Clear definition of roles and responsibilities:** defining the roles and responsibilities of all stakeholders in the planning, implementation, monitoring and evaluation of the maternal and newborn program is essential for increased synergy.
8. **Promotion of gender equity and equality:** promotion of gender equity and equality, including the elimination of all forms of gender-based violence and related harmful practices must be addressed at all levels of service delivery.
9. **Male involvement:** involvement of men as responsible partners to increase access to and use of maternal and newborn health services.
10. **Governance, transparency and accountability:** promoting a sense of stewardship, accountability and transparency on the part of the government as well as other stakeholders for enhanced sustainability.



THE KENYA MNH ROAD MAP - STRATEGIC DIRECTION

Vision: Efficient and high quality MNH services that are accessible, equitable, acceptable, and affordable for all Kenyans.

Goal: To accelerate the reduction of maternal and newborn morbidity and mortality towards the achievement of the Millennium Development Goals (MDGs)

Specific objectives

1. To strengthen data management and utilisation for improved MNH.
2. To increase the availability, accessibility, acceptability and utilisation of skilled attendance during pregnancy, childbirth and the post partum period at all levels of the health care delivery system.
3. To strengthen the capacity of individuals, families, communities, and social networks to improve maternal and newborn health.

Objectives, Strategies and Appropriate Interventions

Objective 1

Improve data management for decision making and utilisation in health planning

Strategy 1: Strengthen monitoring and evaluation system for Maternal and Newborn Health

Priority Actions / interventions

1. Strengthen MNH data management and utilisation at all levels
2. Advocate for inclusion of MNH indicators in all the surveys and routine data collection tools

Strategy 2: Strengthen operations research in Maternal and Newborn Health

Priority Actions / interventions

1. Strengthen linkages between MNH stakeholders and research and training institutions
2. Promote the documentation, dissemination and utilisation of evidence-based practices

Objective 2

To increase the availability, accessibility, acceptability, and utilisation of skilled attendance during pregnancy, childbirth and the post partum period at all levels of the health care delivery system

Strategy 3: Strengthening national, provincial and district capacity for health planning and management of MNH care.

Priority Actions / interventions

1. Strengthen capacity of the national, provincial and district managers, in health planning, management and facilitative supervision.
2. Strengthen joint programming between MNH and related programmes to maximise resources.
3. Incorporate rights based approach and gender mainstreaming to advance MNH within planning processes at all levels

Strategy 4: Improving availability of, access to, and utilisation of quality Maternal and Newborn Health Care, including adolescents, youth, people with disabilities, and other vulnerable groups

Priority Actions / interventions

1. Increase skilled care at community level during pregnancy, childbirth, postpartum and the newborn period
2. Enhance the capacity of health facilities to provide Essential Maternal and Newborn Care
3. Strengthen human resources for Maternal and Newborn Health
4. Strengthen the integration of HIV/AIDS information and services into Maternal and Newborn Health services at all levels of health care.
5. Institutionalise quality of care approaches.
6. Scale up efficient healthcare financing mechanisms for Maternal and Newborn Health
7. Increase access to Maternal and Newborn Health information and services with special emphasis on adolescents, youth, and other vulnerable groups

Strategy 5: Reduce unmet need through expanding access to good quality family planning options for sexually active men, women, adolescents and persons with disabilities

Priority Actions / interventions

1. Increase access to postpartum family planning.
2. Advocate contraceptive commodity security.
3. Promote participation of communities and the private sector in provision of FP services.
4. Strengthen integration of FP and HIV services.

Strategy 6: Strengthening the referral system.

Priority Actions / interventions

1. Lobby for a strengthened transport and referral system.
2. Establish community-based mechanisms to promote timely referral.
3. Strengthen communication between different levels of care by use of modern technologies

Strategy 7: Advocating for increased commitment and resources for MNH and FP services

Priority Actions / interventions

1. Strengthen resource mobilisation for Maternal and Newborn Health.
2. Advocate for incorporation of MNH requirements in all National Policy and Strategy documents

Strategy 8: Fostering partnerships

1. Coordinate MNH stakeholders at national, provincial, district and community level
2. Strengthen and sustain Public Private Partnerships for MNH

Objective 3

To strengthen the capacity of individuals, families, communities, social networks to improve maternal and newborn health

Strategy 9: Strengthening community based maternal and newborn care approaches

Priority Actions / interventions

1. Promoting the household hospital continuum of care.
2. Operationalize the MNH aspects in line with the National Community Strategy principles.
3. Strengthening knowledge and awareness of communities on MNH services including family planning.
4. Support community based initiatives that promote MNH.

Monitoring and Evaluation of Maternal and Newborn Health

Monitoring and evaluation remains a key challenge of MNH programmes. The M&E system for maternal and newborn health will aim at generating information that will be used for evidence-based decision making and the planning process. The National MNH Road Map will endeavour to meet the targets outlined in the MDGs and the health sector strategic plans. The following are the key indicators and their targets.

No.	Indicators	Baseline	Target 2010	Target 2015	Source of data
1	Maternal Mortality Ratio/ 100 000 live births	488	280	147	KDHS 2008/09
2	Neonatal Mortality Rate/ 1 000 live births	31	21	11	KDHS 2008/09
3	Proportion of facilities providing BEONC	9%	50%	100%	KSPA 2004
4a	Availability of CEmOC / 500 000 population	1.3	1.3	1	KSPA 2004
4b	Availability of BEmOC / 500 000 population	0.4	2.2	4	KSPA 2004
4c	Total availability of EmOC/ 500 000 population	1.7	3.4	5	KSPA 2004
5	Proportion of (expected) deliveries in the population conducted by a skilled attendant	43.8%	67%	90%	HMIS KDHS 2008/09
6	Proportion of pregnant women having at least one antenatal visits during this pregnancy	91.5%	96%	100%	KDHS 2008/09
7	Proportion of pregnant women having at least four antenatal visits during this pregnancy	52%	71%	90%	HMIS KDHS 2003
8	Proportion of antenatal women receiving IPT2	15%	47.5%	80%	KDHS 2008/09
9	Percentage of women attending post-natal care check up at least once within 2 weeks	2%			HMIS KDHS 2003
10	Proportion of pregnant women attending ANC tested for HIV	57%	68.5%	80%	KAIS 2007
11	Unmet need for contraception	24%	12%	0%	KDHS 2003

Roles and Responsibilities

The successful implementation of this Road Map will be guided by the framework stipulated in the National Health Strategic Plans, National Reproductive Health Policy (2007) and Child Survival and Development Strategy (2008). This Road Map will be implemented at different levels as outlined in the RH policy - the National level through the DRH; at Provincial and District levels through the Provincial and District Management Teams and Boards; and at the Community level through the Village and Health Facility Committees.

Ministries of Public Health & Sanitation and Medical Services

The Ministries of Public Health & Sanitation (MOPHS) and Medical Services (MOMS) will oversee and facilitate the implementation of this Road map. The MOPHS/MOMS will:

- Ensure the creation of an enabling environment for the implementation of key activities.
- Ensure that health facilities have adequate capacity in terms of staffing, equipment and supplies to adequately provide quality services.
- Strengthen health systems to deliver quality maternal and newborn care.
- Allocate necessary resources using existing national initiatives for the implementation of the Road Map.
- Establish mechanisms for supervision and ensure regular monitoring and evaluation of progress made by Development partners.
- Mobilise and provide technical and financial support for the planning, implementation monitoring and evaluation.
- Advocate for increased national commitment to the reduction of maternal and newborn morbidity and mortality.

Roles of NGOs, CBOs, FBOs and Private sector

- These organisations will be encouraged to expand coverage and improve access to MNH services.
- Advocate for and promote the rights of women and children and the need to address their problems.
- Mobilise and allocate resources for MNH programmes.
- Implement community based strategies to promote healthy behaviour during pregnancy, childbirth and postpartum period.

Communities, Households and Individuals

- Communities will participate through the health facility committees, and village health committees as well as community health extension workers in resource mobilisation, planning, monitoring and evaluation of MNH services.
- Households and individuals will be encouraged to participate and contribute towards improvement of MNH.

Role of Training Institutions

- The approved university based medical and nursing schools, the Kenya Medical Training Colleges, and the private and mission medical training hospitals will be expected to regularly update and incorporate MNH into their curriculum.

Role of Research Institutions

- To regularly conduct MNH operations research and disseminate findings to all stakeholders.
- To assist the MOH to translate research findings into programming and service delivery.

Role of Parliamentarians

- Speak out in parliament and publicly for MDGs 4 & 5.
- Liaise regularly with constituents to educate them on MDGs 4 & 5 and seek training to do that effectively.
- Undertake a review of existing laws to eliminate legal obstacles that limit women's access to health care services.
- Liaise or work with the budget/finance committee in parliament, paying particular attention to health issues and MDGs 4 & 5.
- Raise awareness in constituencies and hold debates on harmful traditional practices

IMPLEMENTATION FRAMEWORK

Strategies	Priority Actions	Broad activities	Indicators	Targets			Estimated cost
				09/10	10/11	11/12	
Strategy 1: Strengthen Monitoring and Evaluation system for Maternal and Newborn Health	1.1 Strengthen MNH data management and utilisation at all levels	1.1.1 Operationalise National Reproductive Health M&E framework at all levels	No. of provincial dissemination meetings	4	4		
			No. of districts that submit monthly RH reports, including data from private sector	100	150	200	
		1.1.2 Conduct regular performance review meetings for MNH with stakeholders, at all levels	No. of review meetings at national, provincial and district level	quarterly	quarterly	quarterly	
	1.2 Advocate for inclusion of MNH indicators in all the surveys and routine data collection tools	1.1.3 Evaluate Road Map implementation in 2012 and 2015	Midterm evaluation conducted to measure implementation of the Road Map				midterm
		1.2.1 Participate in development of data collection tools for relevant surveys	No. of survey data collection tools with MNH indicators included	census, KSPA	KAIS	MIS	
		1.2.2. Conduct MNH surveys	No. of surveys conducted		1	2	
			No. of survey and HMIS reports with MNH data	2	2	2	
		1.2.3 Analyse, disseminate, and utilise data findings from surveys and routine service delivery	No. of meetings where MNH data is being disseminated	4	4	4	
	No. of documents that show translation of findings into decision making	2	4	8			
Strategy 2: Strengthen operations research in Maternal and Newborn Health	2.1 Strengthen linkages between MNH stakeholders and research and training institutions	2.1.1 Review and implement MNH research agenda	No. of MNH research topics being completed	4	6	8	
		2.1.2 Operationalise MNH research guidelines	No. of research proposals being reviewed by research TWG	2	4		
	2.2 Promote the documentation, dissemination and utilisation of evidence-based practices	2.2.1 Advocate for increased funding for MNH research.	Proportion of annual budget spend on MNH research	2%	3%	4%	
		2.2.2 Regularly document and share best practices in MNH	No. of fora where best practices in MNH are being shared	4	8	8	
		2.2.3 Disseminate research updates to promotetranslation of research findings into MNH policies and programming	No. of MNH policies and programmes that incorporate best practices / research findings	2	4	6	
Strategy 3: Strengthening national, provincial and district health planning and management of MNH care	3.1 Strengthen capacity of the national, provincial and district managers, in health planning, management and facilitative supervision	3.1.1 Conduct regular trainings /updates for managers in MNH planning and supervision	No. of managers trained and/or updated in MNH planning and programming	40	80	120	
			No. of facilitative supervision visits on MNH conducted by national level	2	4	6	
	3.2 Strengthen joint programming between MNH and related programmes to maximise resources	3.2.1 Participate in AOP planning guidelines and processes at all levels to ensure inclusion of MNH priorities	No. of district AOPs that have included comprehensive MNH activities	100	150	200	

			No. of service providers sensitised on Rn needs of PWD	4000	8000	12000	
	4.4 Strengthen the integration of HIV/AIDS information and services into Maternal and Newborn Health services at all levels of health care	4.4.1 Implement HIV/MNH integration protocols (PMTCT guidelines; RH /HIV Integration strategy, KNASP 3)	No of facilities implementing RH/HIV integrated services as recommended in the RH/HIV integration strategy	2000	3000	4000	
		4.4.2 Conduct RH/HIV integration programme evaluation	No of evaluations conducted	2	4	4	
	4.5 Institutionalise quality of care approaches	4.5.1 Review and update guidelines, standards and training materials for MNH	No. of updated documents finalized			MNH training package, guidelines	
		4.5.2 Strengthen/revitalise QA committees for MNH in all facilities	No of facilities with functional QA committees	1500	3000	5000	
			No of maternal deaths notified annually	400	1200	3000	
		4.5.3 Establish maternal and perinatal death reviews at all levels	No of districts submitting quarterly MDR reports	40	80	120	
			No of facilities conducting perinatal death reviews	100	200	400	
		4.5.4 Lobby for legislation of Maternal Death notification	MD notification gazetted			x	
	4.6 Scale up efficient healthcare financing mechanisms for Maternal and Newborn Health	4.6.1 Advocate for health financing mechanisms that increase access to and uptake of MNH services (NHIF, HSSF, Medical services funds, insurance industry, Demand side financing etc)	No of insurance companies that offer comprehensive MNH cover including FP	4	6	8	
			Proportion of HSSF funds that is used to strengthen MNH services	20%	30%	40%	
Creation of budget line for MNH				x			
		Proportion of partner funds committed to MNH	?	?	?		
4.6.2 Scale up demand side financing for MNH services	No of facilities that provide subsidised MNH services under demand side financing scheme	40	100	200			
4.7 Increase access to Maternal and Newborn Health information and services with special emphasis on adolescents & youth, and other vulnerable group	4.7.1 Develop and disseminate MNH IEC /BCC materials and messages	No. of IEC materials developed and disseminated	10	15	20		
	4.7.2. Sensitise service providers on MNH service provision to PWDs	No. of service providers that are competent to provide comprehensive MNH services to PWD	500	900	1500		
Strategy 5: Reduce unmet need through expanding access to good quality family planning options for sexually active men, women, adolescents and persons with	5.1 Increase access to postpartum Family Planning	5.1.1 Sensitise communities and health workers on Post Partum Care	Proportion of pregnant women receiving at least once postnatalcare	20%	40%	60%	
		5.1.2 Scale up post partum FP	No of women receiving FP during postpartum period	500,000	750,000	1,000,000	