REPUBLIC OF KENYA

Ministry of Public Health and Sanitation

Ministry of Medical Services

NATIONAL REPRODUCTIVE HEALTH STRATEGY

2009-2015

August 2009

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Foreword

This National Reproductive Health Strategy covering the period 2009 to 2015, is a revision of the National Reproductive Health Strategy 1997-2010. The need for revision was to address several issues and challenges most of which were not factored in during the time of its development. This was necessary to provide clear guidance and alignment with implementation of the National Reproductive Health Policy which was launched in 2007. This policy states Kenya's commitment to the achievement of the ICPD and MDG goals, as well as other international development goals and targets, and identifies priority actions through which the adverse reproductive health outcomes, including those related to the impacts of the HIV and AIDS pandemic, will be reversed. The Vision 2030[1] acknowledges the growing concern of reversals in reproductive health gains made in the 1980s and the early part of 1990s. This is reflected in many other national policies and strategies that have been developed to guide response and focus programme efforts to the myriad of current and emerging issues in health and development[2].

In addition, the revision of the strategy is made necessary by the significant change in recent years in government approaches to conducting business, which recognises the need for strategic planning across all sectors and ministries; the need for evidence-based management; as well as the need for enhanced citizens' participation in planning and implementing development programmes in a devolved manner. Thus, the revised Strategy seeks to ensure that the inter-linkages between reproductive health and all other sectors of development are properly identified and effectively addressed through a multisectoral approach. This strategy is a product of extensive consultations and collaboration with stakeholders including the provincial and district level RH coordinators. Other key stakeholders who were involved in this process include development partners, non-governmental and faith-based organizations, and the private health sector.

The overall goal of this strategy is to facilitate the operationalization of the National Reproductive Health Policy through a national multisectoral approach. The goal echoes the overall goal of the National Reproductive Health Policy that is "to enhance the reproductive

[1]First Medium Term Plan (MTP) of Vision 2030

[2]These include the Economic Recovery and Wealth Creation Strategy, the National Health Sector Strategic Plan II (2005-2010), the Kenya National HIV and AIDS Strategy (2005-2010), the Vision 2030 and the respective strategic plans for the period 2008-2012 of Ministry of Public Health and Sanitation and Ministry of Medical Services.

health status of all Kenyans by increasing equitable access to reproductive health services; improving quality, efficiency and effectiveness of service delivery at all levels; and improving responsiveness to the client needs"

It will also aid the Division of Reproductive Health in advocating for increased resources and partnership involvement in its implementation.

Reproductive health is a development issue as it contributes to death and disability that affect many families. Access to reproductive health is crucial to achieving the eight Millennium Development Goals, population, development and health goals as well as realizing vision 2030.

The strategy calls for enhanced multisectoral participation at all levels and we are confident that it will provide the necessary framework for the requisite multisectoral approach towards enhanced reproductive health status of all Kenyans.

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List of Acronyms and Abrreviations

AIDS	Acquired Immune Deficiency Syndrome
ARH	Adolescent Reproductive Health
ART	Anti retroviral therapy
ARV	Antiretroviral
BCC	Behaviour Change Communication
CCC	Comprehensive Care Centre
CHEWS	Community Health Extension Workers
CHW	Community Health Worker
CSO	Civil Society Organizations
CT	Counselling and Testing
DRH	Division of Reproductive Health
FBO	Faith Based Organization
FHI	Family Health International
FP	Family Planning
HBC	Home Based Care
HIV	Human Immuno-Deficiency Virus
HPI	Health Policy Initiative
IEC	Information Education and Communication
IUCD	Intra-Uterine Contraceptive Device
KSPA	Kenya Service Provision Assessment
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDG	Millennium Development Goals
MOMS	Ministry of Medical Services
MOPHS	Ministry of Public Health and Sanitation
NASCOP	National AIDS and STD Control Programme
OVC	Orphaned and Vulnerable Children
PAC	Post Abortion Care
PEP	Post Exposure Prophylaxis
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
RH	Reproductive Health
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infections
TB	Tuberculosis
TOT	Training of Trainers
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
VSC	Voluntary Surgical Contraception
WHO	World Health Organization

CHAPTER 1

Introduction

1.1 Background

The population of Kenya currently is estimated at 37.4 million and is projected to reach 42 million by 2012. The current annual growth rate of about 2.9 percent per annum is still considered to be high. Owing to the past growth rates the population is still youthful with nearly half aged 18 years or below.

Kenya's history of population change has been characterized by a rapid rise in fertility levels in the early 1970s that reached one of the highest recorded fertility rates (TFR of 8.1), followed by a rapid decline in the 1980s reaching a TFR of 4.7 in 1998. However, the results of the 2003 Kenya Demographic and Health Survey (KDHS) showed that further fertility decline had stalled at a high total fertility rate (TFR) of about five children per woman. The 2008 DHS has reported that fertility rate has since declined to 4.6. Despite the impressive declines in fertility rate in the 1990s compared to other sub Saharan African countries, nearly one in four women between age 15 and 19 has had a first child.

Kenya similarly experienced rapid declines in mortality rates in the 1970s and 1980s. In particular, the infant mortality rate declined from 119 deaths per 1000 live births in 1969 to 88 and 66 in 1979 and 1989 respectively. However, as a result of several factors mortality levels have continued to rise since 1993. The life expectancy at birth has declined from 58 years to 54 years for males and 61 years to 57 years for females in the last decade. The neonatal mortality rate was estimated at 33 per 1,000 live births in 2003 and 45 per 1,000 live births in 1998 respectively.

The preliminary results of the Kenya Aids Indicator Survey (KAIS) 2007 show that HIV prevalence rate among adults age 15-49 is about 7.8 percent compared to 6.7 from the 2003 KDHS. Women are more disproportionately infected (8.7%) compared to men (5.6%) in the age group 15-64 years. Approximately 1.33 million people are currently living with HIV and AIDS.

Despite the continued commitment to the promotion and provision of adequate reproductive health services, several factors such as social and cultural beliefs and practices, lack of women's empowerment, lack of male involvement, poverty, and weak health management systems impede the demand for and utilization of reproductive health care. The proportion of women making the recommended number of antenatal care visits of 4 and above declined from 64 per cent in 1993 to only 52 per cent in 2003, while the proportion receiving skilled care during delivery declined from 51% in 1989 to 45 per cent in 1993 and 1998 and to 42 per cent in 2003. The contraceptive prevalence rate (CPR) among married women for all methods that rose from 27 to 39 per cent between 1989 and 1998 has also stalled since 1998 with wide regional differentials. Unmet need for family planning has stagnated at about 24 percent with the poorer women more disadvantaged. This has been largely due

to inadequate service provision and poor access to family planning commodities and lack of support for contraceptive security. The unmet need for RH services translate into unacceptably high maternal mortality ratio of about 414 per 100,000 live births since 1998, and high morbidity levels. The neonatal mortality rate was estimated at 33 per 1,000 live births in 2003 and 45 per 1,000 live births in 1998. The lack of access to a rapid means of referral in case of emergency compounds the situation.

According to KAIS, 2007 preliminary results about 83 per cent of HIV infected persons do not know their HIV status, while 26 per cent of those who reported themselves uninfected tested positive. The unmet need for ART is about 18 percent among adult Kenyans who are HIV, while between 20-40% of HIV-infected pregnant women that needed ART for PMTCT in 2007 were not receiving it[3]. Nearly half of the women who are HIV positive have unmet need for family planning services. The great majority of unmet need is attributed to low level of awareness of HIV status among those infected. Nearly 1 out of 10 pregnant women in Kenya are infected with HIV (9.6 percent) up from 7.3 percent in 2003 with minimal differences by urban and rural residence.

The high unmet need for reproductive health services has been compounded by the poor growth of the economy in the 1990s that led to deterioration of the welfare of the majority of the population. This resulted into slightly more than half of the population living below the poverty line. However, the economic and structural reforms established in 2003 led to growth in real gross domestic product from 2.8 per cent in 2003 to 7 per cent in 2007. Positive change in the economic growth resulted in the proportion under the poverty line to decline from 56 per cent to 46 per cent in the 2003-2007 period. However, due to a number of factors such as the global rise in fuel cost and food prices, the GDP growth rate is expected to decline to 4.5 per cent by end of 2008 but projected to reach 10 per cent by 2012. Such negative outcomes cannot only compound the state of poor reproductive health outcomes but also limit the adequate provision of the services.

1.2 The National Reproductive Health Strategy 1997-2010:

Achievements and Challenges

The National Reproductive Health Strategy (NRHS) 1997-2010 was a national response to the Programme of Action of ICPD (1994), which defined the focus and prioritised the reproductive health components for implementation by the National Reproductive Health Programme in Kenya. The Strategy recognised the importance of multi-sectoral approach and collaboration in the

[3](WHO/UNICEF, 2008).

implementation of the full range of RH components, even though the health sector had a crucial role to play in the prevention and management of most of the reproductive health problems. The NRHS (1997-2010) has over the years provided a common point of reference for all RH stakeholders in Kenya, thereby focusing efforts and resources towards the achievement of the goal and objectives of the one Strategy. The strategy, along with other national policy documents, formed the basis for the development of the mandate of the Division of Reproductive Health (DRH) of the Ministry of Public Health and Sanitation, and guides the development and execution of its work programme. In this regard it can be observed that most of the components of RH as included in the Strategy have been addressed to varying degrees. Several significant achievements have been made, including the following:

- Maternal and Newborn Health- strengthening of maternal death review by development of guidelines, increased access to obstetric fistula services, and increased access to skilled attendance at delivery through the community midwifery programme;
- Family Planning- development of Family Planning Guidelines for Service Providers (2005), and a revised edition in 2009. Contraceptive Policy and Strategy 2002-2006, Contraceptive Commodities Procurement Plan 2003-2006 and Contraceptive Commodities Security Strategy 2007-2012, which have sought to ensure uninterrupted supply of contraceptive commodities;
- ASRH- development of the Adolescent Reproductive Health and Development Policy (2003) and Adolescent Reproductive Health and Development Policy Plan of Action 2005-2015, and the development of Guidelines for the provision of Youth Friendly Services. Also important to ASRH are the Child Survival and Development Strategy 2008-2015, and the School Health Policy and Guidelines;
- Gender Issues, Sexual and Reproductive Rights - development of gender mainstreaming guidelines;
- HIV&AIDS and RTIs- The NRHP (2007) identifies as a priority action the integration of HIV and AIDS and RTIs information and services in RH programmes. In this respect several guidelines have been developed to guide integration including: The National Guidelines for Voluntary Counselling and Testing and the National Guidelines on Prevention of Mother-to-Child Transmission of HIV. A specific strategy, The National Reproductive Health and HIV&AIDS Integration Strategy (May 2009), has been developed.
- Infertility- The National Reproductive Health Policy (2007) recognizes infertility as a public health concern in Kenya, and the Infertility Survey in Kenya (March 2008) which was commissioned by DRH, has shed some light on the magnitude of the problem and availability of facilities for the diagnosis and management of the problem.

- Cancer of Reproductive Organs- Guidelines for prevention and management of reproductive organ cancers have been developed.

At the same time, the implementation of the NRHS (1997-2010) has continued to face numerous serious challenges. The achievement by 2015 of the Millennium Development Goals (MDGs), especially MDG 4 (Reduce child mortality) and MDG 5 (Improve maternal health) is a key challenge, which requires strengthening of health systems in order that every pregnancy will be wanted; all pregnant women and their infants have access to skilled care; that every woman has access to a functioning health facility to obtain appropriate care when complications arise; and that every newborn has access to appropriate care. Other related challenges include the following:

- The National Reproductive Health Policy (2007) has brought about a paradigm shift towards a focus on skilled attendance for all pregnant women, thus necessitating a policy change regarding the TBA as provider of delivery services;
- The continuing manifestation of the impacts of the HIV and AIDS epidemic on provision of reproductive health services, especially the general shift of focus for international assistance from population issues to HIV and AIDS;
- Worsening national economy, inadequate funding of the health sector, and disparities in health resource allocation have constrained design and implementation of effective RH interventions, including efficient referral systems, that are accessible to the poor, hard-to-reach and vulnerable populations;

1.3 Justification of the Strategy

A revision of the National Reproductive Health Strategy 1997-2010 is justified by the need to address several issues and challenges most of which were not factored in during the time of its development. First and foremost is the need for clear guidance on the implementation of the National Reproductive Health Policy which was launched in 2007. This policy states Kenya's commitment to the achievement of the ICPD and MDG goals, as well as other international development goals and targets, and identifies priority actions through which the adverse reproductive health outcomes, including those related to the impacts of the HIV and AIDS pandemic, will be reversed. The Vision 2030[4] acknowledges the growing concern of reversals in reproductive health gains made in the 1980s and the early part of 1990s. This is reflected in many other national policies and strategies that have been developed to guide response and focus programme efforts to the myriad of current and emerging issues in health and development[5].

[4]First Medium Term Plan (MTP) of Vision 2030

[5]These include the Economic Recovery and Wealth Creation Strategy, the National Health Sector Strategic Plan II (2005-2010), the Kenya National HIV and AIDS Strategy (2005-2010), the Vision 2030 and the respective strategic plans for the period 2008-2012 of Ministry of Public Health and Sanitation and Ministry of Medical Services.

In addition, the revision of the strategy is made necessary by the significant change in recent years in government approaches to conducting business, which recognises the need for strategic planning across all sectors and ministries; the need for evidence-based management; as well as the need for enhanced citizens' participation in planning and implementing development programmes in a devolved manner. Thus, the revised Strategy seeks to ensure that the inter-linkages between reproductive health and all other sectors of development are properly identified and effectively addressed through a multi-sectoral approach.

1.4 Goal and Objectives

Goal

The overall goal of this strategy is to facilitate the operationalization of the National Reproductive Health Policy through a national multisectoral approach. The goal echoes the overall goal of the National Reproductive Health Policy that is: "To enhance the reproductive health status of all Kenyans by increasing equitable access to reproductive health services; improving quality, efficiency and effectiveness of service delivery at all levels; and improving responsiveness to the client needs"

Objectives

The objectives of the strategy are to:

- Formulate strategies that will enable the achievement of the goal and objectives of the national reproductive health policy.
- Identify priority activities and major implementers of the national RH programme
- Identify resource mobilization strategies
- Facilitate/enhance effective management of a sustainable national reproductive health programme.

1.5 The Process of Developing This Strategy

The development of this strategy involved several steps, key of which were: literature review; drafting the status report that informed its development; writing of narratives based on the agreed upon strategies; holding consultative sessions with the key stakeholders. The specific activities involved in these processes were:

1. Reviewing available relevant documents on national policies, strategies, and implementation plans to inform the development of the health policy framework. The review yielded the necessary information that was used to develop the strategy. The review exercise was used to gain insight into the existing relevant national policies, strategies and implementation plans to allow for harmonization and linkages between this strategy and on-going efforts in addressing the reproductive health needs of people in the country.
2. The development of this strategy was highly consultative and involved various stakeholders at different levels. Advantage was taken of the dissemination workshops for NRHP (2007) that were attended by district level health teams, to obtain their inputs on what the NRHS 2009-2015 ought to address. Through consultations with key stakeholders, areas of focus for the strategy were agreed upon. The first draft was reviewed and the resultant inputs shared through a consultative meeting with Reproductive Health task force members for information exchange, suggestions of ways of improving existing strategies, raising the level of understanding of the reproductive health Policy, gaining clarity on roles and responsibilities of stakeholders, building consensus on outputs and mapping out specific activities to be undertaken together with their respective strategies.

1.6 Outline of the Strategy

This strategy document is organized into four chapters. This first Chapter on introduction provides the background, status of reproductive health in the country, emerging issues and challenges, justification of the strategy, goal and objectives, the process of developing the Plan, and finally the outline of the strategies. Chapter 2 outlines the implementation strategies in main areas: cross cutting components and strategies; core reproductive health components as outlined in the 2007 RH policy document. Chapter 3 presents the implementation mechanisms that includes how policy and the strategies will be coordinated, roles of the key institutions in the management of the reproductive health care services and programs. Chapter 4 concludes by highlighting key aspects of the resources required and the gaps that exists in the full implementation of the strategies.

CHAPTER 2

Implementation Strategies

2.1 Introduction

This chapter describes the strategies and key activities that will ensure the realization of the policy commitment of enhancing the reproductive health status of all Kenyans. Implementation of this Strategy will be guided by the Principles contained in the National Reproductive Health Policy 2007, in particular:

- Respect for human rights and freedoms regardless of religion, culture and socio-economic status;
- Respect for reproductive and sexual health rights, and responsiveness to client needs;
- Promotion of gender equity and equality including involvement of men as RH consumers and partners;
- Integrated approach to provision of reproductive health services; and
- Adoption of evidence-based practices, quality improvement, standard setting and audit, and application of appropriate and cost-effective technologies.

Effective implementation of this National Reproductive Health Strategy will require a multi-sectoral approach, and the contribution of all actors in the health sector is essential. The National Health Sector Strategic Plan 2008-2010 (NHSSP II), and the respective strategic plans of MOPHS and MOMS provide the overriding framework guiding this strategy. In addition, other national strategic plans, policies and guidelines provide supportive elements; these include the National Reproductive Health Policy (NRHP), 2007), Norms and Standards for Health Service Delivery (2006), and the Kenya Essential Package for Health (KEPH).

A number of cross-cutting strategies are needed for effective implementation of specific interventions targeting the various components of Reproductive Health. These include: strengthening the health systems; improving efficiency, effectiveness and quality of RH services; implementing the Community Strategy as proposed in NHSSP II; and targeting groups with special needs (people with disabilities, "hard to reach" and other vulnerable groups.

2.2. Cross Cutting Strategies

2.2.1 Health Systems strengthening

Introduction

Achievement of the goal of the National Reproductive Health Policy 2007 requires that the scope of coverage of sexual and reproductive health services is expanded. This in turn will require sustainable financing mechanisms, human resources, quality in service provision and use of services. There is need to understand and address the factors which limit the scope of coverage, and impede the demand for and utilization of reproductive health services in Kenya. These include weak management and governance systems; inadequate skilled attendants; lack of needed equipment and maintenance, drugs and supplies; and poor referral and linkage systems. In addition, there will be need to support research activities to enhance and support decision making mechanisms at all levels of management and provision of reproductive health services.

OBJECTIVE: *To enhance the provision of a comprehensive range of essential sexual and reproductive health services.*

OUTPUT 1: *Increased availability of reproductive health services*

Strategies and Key Activities

STRATEGY 1: Develop and Support Sustainable Financing Mechanisms for RH Services

Efficient and effective delivery of RH services will require availability of adequate financial resources to support:- infrastructure development and maintenance; sustainable procurement system for drugs, commodities and other medical supplies; and a well-motivated and committed health workforce, with relevant skills and competencies, in the right numbers, at all levels of care. The Government has remained the major source of funding to the health sector. However, over the past decade, real financial allocations to the public sector have declined or remained constant.

Key Activities:

1. Advocate for reproductive and sexual health to be central to national planning and strategy development processes,
2. Enhance the capacity of RH programme managers to engage relevant individuals and institutions during national development planning including, MTEF and poverty reduction strategies.

3. Mobilize political will to support equitable provision of reproductive health services
4. Engage parliamentarians and other policymakers (e.g. local authority policy makers) for higher budgetary allocation for reproductive health services
5. Design ways to facilitate access to services by adolescents, poor people and other disadvantaged groups,
6. Monitor the effects of policies and programs on the underserved, poor and hard to reach populations
7. Investigate and develop mechanisms towards increasing the scope of health care financing, including approaches such as performance-based financing mechanisms, and strengthened public-private partnerships for both funding and provision of reproductive health services.

STRATEGY 2: Ensure Availability of Adequate Human Resource

Training, recruiting, deploying and retaining skilled health personnel are central elements in improving health and health care generally. Many core reproductive and sexual health interventions can be made by mid-level professionals and paramedical workers. The challenge is to determine the cadres of health workers, skills and forms of training that are most necessary to provide the prioritized reproductive and sexual health services. Enabling conditions will have to be created for health workers to realize their full potential and to motivate them to work with all population groups, including the poorest.

Key Activities:

1. Regularly review and update staffing norms
2. Advocate for appropriate deployment and retention of skilled service providers at all levels, according to the Norms and Standards for Health Service Delivery (2006).
3. Regularly assess work environments, conditions of employment and supervision with a view to ensure proper motivation and appropriate retention of the required staff;
4. Develop and implement appropriate policies and regulations that promote and enable service delivery personnel to use their skills to the full, including Continuous Professional Development opportunities.
5. Ensure optimal workload for health workers at all levels,
6. Build managerial and organizational capacity of health workers to ensure quality work output within available resources
7. Review and improve basic (pre-service) and in-service training of reproductive health service providers in order to improve their skills in both clinical care and service management.

8. Review and evaluate experience to date with task-shifting and establish mechanisms for scaling up the system as a means of increasing access to RH services at all levels,.

STRATEGY 3: Improvement of Basic Infrastructure and Strengthening Logistics and Management Systems

The basic infrastructure of a health facility is an important determinant of the quality of the services that the facility can provide. The KSPA 2004 reported that the majority of health facilities lacked adequate infrastructure, equipment and general maintenance. Some facilities lack adequate premises for priority interventions (such as delivery rooms, maternity, laboratories and operating theatres, etc.) while equipment has not been replaced for a long period, compromising the quality of care. In addition, quality of care and expansion of services will require adequate logistics management for the provision of relevant supplies. Therefore there will be need to strengthen logistics system to enable adequate supply of commodities in the respective sites. It will also involve capacity building of the various stakeholders to be able to forecast the supply of commodities to accommodate provision of relevant supplies at each service provision site.

Key Activities:

1. Conduct periodic facility assessment to identify the infrastructure and maintenance requirements and supply needs for the provision of essential comprehensive RH services at all levels. This may involve establishment of new infrastructure or improving existing ones.
2. Review and update the logistics management systems
3. Train relevant staff on logistics management
4. Advocate for improvement and regular maintenance of health facilities infrastructure to provide comprehensive RH services at all levels
5. Improve procurement and distribution of good quality equipment, supplies, pharmaceuticals (including contraceptive commodities) at all levels
6. Provide work-friendly environment to permit efficiency and quality.

OUTPUT 2: *Strengthened Monitoring, Evaluation and Accountability*

STRATEGY 1: Strengthening Monitoring and Evaluation Systems

Improving access, quality and equity of reproductive health services require strengthened management and coordination mechanisms at all levels. It also calls for adoption of evidence-based and cost effective ways to deliver services amid limited resources. In addition it will require accountability to both those who support the services as well as to the communities. It will require

strengthening the monitoring and evaluation systems at all levels of service delivery and management. Monitoring and evaluation of this reproductive health strategy will use the existing National Reproductive Health M&E Framework, with linkage to the National Health Sector M&E Framework.

Key Activities:

1. Periodically assess the status of RH M&E system at all levels
2. Develop and implement annual budgets for the M&E processes at all levels
3. Establish and regularly update monitoring and evaluation infrastructure at all levels
4. Develop, implement and regularly update monitoring and evaluation plans at all levels
5. Build capacity of relevant staff on M&E at all levels
6. Facilitate the implementation of national M&E frameworks.

STRATEGY 2: Improving M&E Information Use for Priority Setting

Collection, processing, analysis and utilization of accurate data at the facility and district levels is of utmost importance in the provision of quality care. The development of an effective HMIS will therefore improve the efficiency of health service delivery at all levels. To ensure RH data is adequately captured in the national HMIS there will be need to develop and design minimum data collection tools for each level of care, including tools for supervision, monitoring and evaluation of programme activities, at all levels.

Key Activities:

1. Support timely reporting of data at all levels
2. Strengthen Routine Reproductive Health Management Information System
3. Develop data use manuals
4. Train relevant staff on analysis and interpretation of routine RH data
5. Improve accessibility of Routine Reproductive Health Management data by relevant stakeholders
6. Regularly provide feedback to RH sub system service providers and managers
7. Regularly produce and disseminate M&E products to relevant stakeholders

OUTPUT 3: *Increased availability of research information for evidence-based decision making, planning and programme interventions*

Among the principles[6] to guide the implementation of this Strategy are the adoption of evidence-based practices and application of appropriate and cost-effective technologies. Research is a powerful tool for providing evidence-based information for standards setting and audit. The DRH has a National Reproductive Health Agenda, and has produced an Annotated Bibliography on RH Research. The goal of the National Research Programme is to enhance operational and other researches for evidence-based decision making, planning and programme interventions. The aim is to promote operational and other researches for evidence based decision making, planning and programme interventions.

STRATEGY 1: Encourage and Support Research on Priority RH Issues

Key Activities:

1. Review and operationalize National RH Research Agenda
2. Disseminate regularly to relevant stakeholders the National RH Research Agenda
3. Advocate for funding of RH research from GOK, development partners, private sector, etc
4. Support relevant researches on reproductive health

OUTPUT 4: *Increased utilization of information from research, monitoring and evaluation system, routine health information system and health surveys*

Although research identifies critical issues that both inform the process and help establish priorities and strategies, however research and all other sources of information needs to be supported by the development of networks and dissemination of knowledge and information at all levels. Two strategies are envisaged to support utilization of data and information from various sources.

STRATEGY 1: Creating Data and Information Demand and Use

Key Activities:

1. Establish and regularly update resource centre at DRH
2. Support repackaging of information from the different sources (research, routine health information, M&E systems etc) to various audiences
3. Support dissemination of information from the different sources (research, routine health information, M&E systems etc)

[6]National Reproductive Health Policy 2007

4. Train service providers, relevant policy audiences and partners on data and information use
5. Facilitate analysis and use of existing data from surveys and routine health information systems
6. Support partnerships and collaboration on the utilization of existing data and information
7. Regularly assess data use constraints and needs at all levels

2.2.2 Improving Efficiency, Effectiveness and Quality of RH Services

OBJECTIVE: *To ensure cost-effective quality RH services at all levels of care*

OUTPUT 1: *Improved quality RH services*

Strategies and Key activities

STRATEGY 1: Improving Service Quality

Factors related to the achievement of this objective include the performance of health workers on the supply side, and public awareness of client rights on the demand side. The identified strategies to address these include improving health worker performance at all levels, including developing incentive schemes to motivate better performance. The competence of service providers will be addressed through a series of training and performance management initiatives that will include the following:

Key Activities:

1. Review and strengthen basic and in-service training of medical and para-medical staff in both clinical care and service management;
2. Provide supportive supervision and management at all levels through strengthening of the decentralized RH training and supervision system.
3. Initiate and enhance regular clinical audits (in particular mortality review- including maternal and perinatal death reviews) and building these into the performance management systems.

STRATEGY 2: Improving Responsiveness to Client Needs

Improving responsiveness to client needs is a strategy to increase the demand for services, by attracting clients to make use of the health services.

Key Activities:

1. Develop and regularly update reproductive health service charter
2. Support mechanisms for protecting client rights through the development and promulgation of a Citizens Health Charter.
3. Develop and disseminate essential information (like fee schedules in health facilities, exemption schemes, etc.,) and ensure that this is posted publicly and visibly at all facilities.
4. Promote client/provider interaction dialogue and feedback.
5. Develop mechanisms for encouraging the participation of males in reproductive health services.

STRATEGY 3: Integration and Standardization of Training of RH Service Providers:

A bold step in linkage of pre-service and in-service training was the development of the National Reproductive Health Curriculum (2004) which harmonized and standardized the various curricula hitherto used in RH pre-service and in-service training. The content and training approaches used in the curriculum form the minimum package necessary for training in comprehensive RH in order to prepare service providers to deliver standardized, high quality services. Pre-service training is based at university medical and nursing schools, the Kenya Medical Training Colleges (KMTC), and in private and faith-based hospitals.

Key Activities:

1. Regularly review and revise existing training plans and curricula
2. Strengthen in-service training approaches for service providers
3. Promote adoption of National RH Curriculum in training institutions
4. Develop and disseminate national RH training guidelines

STRATEGY 4: Strengthening the Referral System and Linkages

One of the strategies for improving the quality and credibility of the health services at all levels is to ensure the timely access to the appropriate level of services in case of life-threatening complications. Accomplishing this strategy is expected to result in more clients/patients making more use of lower level facilities as opposed to higher level facilities. To promote efficiency in health service utilization the system must facilitate supportive supervision of lower levels of care by higher levels. Effective referrals also make it possible for an acceptable quality of care to be provided at the different levels. Once patients are diagnosed and medication is prescribed, they can be referred back to lower levels for actual follow up and treatments. The expected result is the reduction of congestion at higher levels of

service, thereby improving quality of care. A functioning referral system will also reduce the financial barriers for the general public, and the poor in particular, in relation to transaction costs, transport and accommodation, as they seek to access higher levels of care. Expansion of communication technologies, especially mobile telephony opens opportunity for improved referral and feedback, especially for the remote facilities.

Key Activities:

The mechanisms for achieving this result include the following[7]:

1. Developing the capacity of service providers to conduct proper referrals at each level of the health system; and
2. Improving the system's ability to transfer clients between the different levels of the health care system.
3. Establishing appropriate linkages across levels of care in order to ensure efficiency in referrals.
4. Build capacity at the community level (Level 1) for early recognition of complications and early referral (transfer).
5. Develop the capacity of referral centres to receive and promptly manage the referrals.
6. Support the utilization of new and emerging technologies, including e-health and telemedicine in the provision of reproductive health services in all parts of the country.

OUTPUT 2: *Cost effectiveness of RH Services Improved*

Because of limited resources, there is need to not only make services available but also attempt to target services to those who need particular services and also to prioritize between specific kinds of services for specific situations. It is therefore necessary to determine and provide relevant and quality services to those who need, with lesser resources.

STRATEGY 1: Improving Knowledge base on RH Service Costing and Allocations

1. Conduct/review relevant studies on cost effectiveness of RH service delivery
2. Disseminate the results of review and studies
3. Develop and disseminate policy briefs on cost effectiveness of service delivery

[7]See also the Joint Programme of Work and Funding for the Kenya Health Sector 2006/07–2009/10 (KPWF)

4. Develop and disseminate strategies for cost effective service delivery
5. Build the capacity of relevant staff on cost effective service delivery principles

STRATEGY 2: Advocacy among Policy Makers

1. Advocate for cost effective methods in service delivery
2. Regularly review the effectiveness of service delivery at all levels

2.2.3 Increasing access to RH services through the Community Strategy

Introduction

The overall thrust of NHSSP II is to involve the communities in reversing the decline in the health status of Kenyans. The goal of reducing health inequities can only be achieved effectively by involving the population in decisions and in mobilization, devolving and allocation of resources, and thereby promoting community ownership and control in the context in which they live their lives. The Community Strategy[8] is crucial to attainment of this goal. "The overall goal of the community strategy is to enhance community access to health care in order to improve productivity and thus reduce poverty, hunger, and child and maternal deaths, as well as to improve education performance across all the stages of the life cycle…" (NHSSP II). The Community Strategy has a component of Community-Based Communication which is designed to facilitate behaviour change of individuals at family/household level supported through advocacy, social mobilization and interactive communication.

OBJECTIVE: *Improve the health status of Kenyan communities through the initiation and implementation of life-cycle focused health actions at Level 1 (community level).*

OUTPUT 1: *Increase coverage of reproductive health services and communication at community level*

Strategies and Key Activities

These initiatives target the major priority health issues (including RH) that affect all cohorts of life at the community and household levels. They aim to build the capacity of communities to assess, analyze, plan, implement and manage health and health related development issues.

[8]The Community Strategy is described in "A Strategy for the Delivery of Level One Services" (MOH, June 2006)

STRATEGY 1: Capacity Building of Community Health Workers and Community-Level Institutions

Key Activities:

1. Recruit and Train community health extension workers- CHEWs (e.g. retrained Public Health Technicians- PHT or Nurse/ Midwives); as well as community-owned resource persons (Community Health Workers- CHWs) to provide RH services at Level 1.
2. Strengthen community level institutions such as Village Health Committees to increase demand for RH services at Level 1.
3. Build capacity of community-based service providers for effective interface between Level 1 and Levels 2 and 3.
4. Recruit, train and support community midwives to provide skilled attendance at Level 1 as the TBA is phased out.

STRATEGY 2: Promote Linkages and Referrals

Emphasis will be on strengthening the interface between the community (Level 1) and Levels 2 and 3, thereby enhancing the functional effectiveness of the CHW in screening and as appropriate, referring cases that require clinical attention without undue delays. This will include ensuring there are means of rapid communication such as a mobile phone, and transport that can be readily summoned to transfer patients when needed.

Key Activities:

1. Strengthen linkages (interface) between health facility and community through effective decentralization and partnership.
2. Develop appropriate strategies to enhance transport and communication between communities and the relevant facilities

OUTPUT 2: *Increased knowledge and awareness of sexual and reproductive health rights and services*

Strategies and key activities

The Community Strategy mandates the CHWs to be fully part of the community-based system, and partially part of the formal health system, while the CHEWs would be fully part of the formal health system but partially community-based. The key role of CHWs, is to involve and support households and communities as Partners in RH service delivery at Level 1, and at all stages in the life cycle. The

other major intended impact of the approach is that the communities will thereby be empowered to demand their rights and seek accountability from the formal health system for the efficiency and effectiveness of health and other services.

STRATEGY 1: Support Health Promotion Mechanisms at the Community Level

Key Activities:

1. Promote community-driven research to inform creation of appropriate messages
2. Carry out BCC activities to promote early pregnancy identification, ANC, preparedness for delivery, skilled delivery attendance, family planning, and where appropriate use of ITNs by pregnant women and newborns
3. Sensitize communities on care seeking and compliance with treatment and advice on services such as TB therapy, ARVs, FP commodities

OUTPUT 3: *Improved quality of care and services at the community level*

The Ministry of Health's Norms and Standards for Health Service Delivery (2006) sets out the specific services that should be offered at different levels (including Level 1), as well as the minimum human resources, infrastructure and commodity requirements. Accordingly, the implications of Norms and Standards for the community services are as follows:

- One CHW will serve 20 households or 100 people.
- One CHEW will supervise and support 25 CHWs.
- One Level 1 unit will serve 5,000 people and will require 50 CHWs and 2 CHEWs.

Strategies and Key Activities

STRATEGY 1: Capacity Building (Training) to Enhance Effectiveness of CHW and CHEW

Effective community health services require well structured theoretical and practical training of community-based health workers, (CHEWs and CHW). Most training activities for the latter should take place in the community but with periods of practice at various facilities up to level 3.

Key Activities:

1. Hold training workshops for CHWS on community organization, the community information system, behaviour change communication, and first aid

2. Conduct training on specific service delivery programmes including sexual and reproductive health

STRATEGY 2: Supportive Supervision

Supervision is an integral part of quality assurance that is critical to maintenance of standards of care as laid down in the guidelines. In addition, supervision provides channels for dissemination of policies and guidelines, improving the knowledge and skills of service providers, assessment of institutional needs including training and maintenance needs. The district health system (Levels 2-4) should provide supportive supervision to the Level 1 services frontline personnel through trained multidisciplinary supervisory teams. These will ensure that standards of quantity and quality of work are met during service delivery. In creating supervisory systems at various levels multi-sector coordination, collaboration and team work will be encouraged.

In order for CHWs to be effective they need the support of trained CHEWs, whose main roles include training and continued support for the CHWs according to the felt needs of the community. The CHEWs are based at a health facility (usually Level 2) but assigned to work within a specific sub-location to ensure acceptable standards of care at Level 1. They provide continuing training to CHWs through demonstration and instruction based on immediate learning needs.

Key Activities:

1. Build capacity of community-based service providers for effective interface between Level 1 and Levels 2 and 3.
2. Support relevant staff to supervise service delivery at the community level
3. Mobilize resources to enhance community level supervision

STRATEGY 3: Strengthen Record Keeping, Reporting and Feedback Systems at the Community Levels

The participation of the community will be required in planning of RH intervention programmes so as to promote their relevance and effectiveness. In addition, through the village and facility health committees, the community members will be involved in monitoring and evaluation of the quality of RH services provided by the various implementing agencies serving the community and hence enabling the community to take stock of what is happening regarding reproductive health.

Key Activities:

1. Strengthen mechanisms for record keeping and reporting at the community levels
2. Support mechanisms for enhancing record keeping at community level
3. Provide regular feedbacks to community service providers based on their reporting

STRATEGY 4: Promote Establishment of Community-Based Audit Systems including Maternal Death Review

Key Activities:

1. Create awareness within the community of the importance of maternal mortality reviews
2. Build capacity of community based institutions (e.g. VHC) to implement maternal mortality reviews and reporting at community level

STRATEGY 5: Promote Establishment of Community-Based Mobilization of Resources for Reproductive Health

Key Activities:

1. Create awareness within the community of the importance of contributing local resources in support of reproductive health services
2. Build capacity of community based institutions (e.g. VHC) to undertake resource mobilization at community level in support of reproductive health services

2.2.4. Targeting Groups with Special Needs

Reduction of reproductive health inequalities is one of the goals of NRHP. A key policy objective of the NHSSP II is to increase equitable access to health services for all through addressing equity and by expanding access to basic services with special focus on the community level. Certain vulnerable groups have inadequate access to health services, including sexual and reproductive health services; these include People with Disabilities (PWDs), the Poor, and "hard to reach" groups.

(a) RH services for People with Disabilities

World Health Organization (WHO) has estimated that disability affects 10% of every population. An estimated 650 million people world-wide, of whom 200 million are children, experience some form of disability. However, wide disparities exist; for example, surveys conducted by the Disability Statistics Compendium in 55 countries show prevalence rates ranging from 0.2% to 21%. In Kenya, the

Preliminary Report of the Kenya National Survey for Persons with Disabilities (March 2008) indicates that 4.6% of Kenyans experience some form of disability (being 4.5% for rural and 4.6% for urban areas). The survey also shows that the most common forms of disability are physical (35%), visual (30%), hearing (11%), mental (7%) and speech (4%).

According to the People With Disabilities ACT of 2003, the lack of access for PWDs to health/HIV/AIDS facilities amounts not only to discrimination on the basis of disability but also denial of access. Persons with disabilities (PWDs) are disadvantaged depending on the extent of their disability. They are confronted with multiple discriminatory practices, including stigma, within the society, as well as within health facilities, which constitute a denial of human rights. Access to infrastructure and services is a big challenge. Various interventions by Government and other PWD-serving organisations have proved that it is possible to minimize the degree of handicap and enhance the performance of PWDs, e.g. education policy on integration of PWDs into regular learning institutions.

OBJECTIVE: *To address the special RH needs of people with disabilities*

The NRHP has the objective of addressing the special RH needs of people with disabilities. The challenges for doing this include the following: insufficient information on the full extent of the problem and the varied needs of PWDs; inadequate capacity to provide quality services; knowledge gaps among individuals, communities and providers; and stigma.

OUTPUT 1: *Increased access to sexual and reproductive health services for People with Disabilities*

STRATEGY 1: Raise Awareness on Reproductive Health Needs of People with Disabilities, and Roles of Families with Children with Disabilities

Key ***Activities:***

1. Advocate for policy support and initiatives for the provision (or to enhance provision) of disability-friendly reproductive health care services
2. Increase awareness within the community on prevention of certain disabilities
3. Increase awareness within the community on special needs and rights of PWDs.
4. Sensitizing law enforcement forces on special needs and rights of PWDs.
5. Encourage research on reproductive health needs of PWDs
6. Educate PWDs on their rights including the right to make decisions

STRATEGY 2: Strengthen Capacity of the Health System to Provide Quality RH Services for People with Disabilities; Improving Access to Services; and Addressing Issues of Stigma.

Key Activities:

1. Ensure both basic and post-basic health training curricula address health needs of People with Disabilities
2. Improve facility infrastructure to respond adequately to the reproductive needs of People with Disabilities, including health workers with disabilities
3. Train service providers on specialized skills to effectively address RH needs of PWDs
4. Sensitize service providers including DHMTs and other health management committees, on the special needs and rights of PWDs

(b) RH services for the "hard to reach" and other vulnerable populations

Communities that live pastoralist or nomadic lives in arid or semi-arid regions of Kenya, are "hard to reach" with health services, and this has far-reaching implications to the coverage of RH services. Other hard to reach groups include persons with disability (see above), migrant workers in industries and farms, internally displaced persons (IDPs) and refugees. Generally, these sections of the population are under-served by health services, mainly because of difficulties in accessing static health institutions, also because their peculiar health needs have not in the past been adequately addressed in the planning of health services. Current data on indicators of access to RH services indicate that access is lowest among the poor, and the "hard to reach". For example, in the North Eastern Province, the 2003 KDHS revealed several serious gaps regarding access to various components of RH care including Safe Motherhood, Family Planning, and Gender-Based Violence. Current data on indicators of access to RH services indicate that access is lowest among the poor, and the "hard to reach".

The 'poor' include urban and rural poor, as well as the increasing population of orphans and other vulnerable children, many of them adolescents that are confronted by multiple and varied problems, among them inadequate access to health care. In addition, and especially for adolescent girls, they may be subjected to physical and sexual abuse, forced early marriages, prostitution, which expose them to STIs (including HIV), and to unwanted pregnancy. UNAIDS/WHO (2008)[9] estimates show that in 2007 Kenya had between 990,000 and 1,400,000 orphans due to AIDS, close to 40% being dual (total) orphans.

[9]UNAIDS/WHO Epidemiological Fact Sheets on HIV and AIDS, 2008 Update

OBJECTIVE: *To address the special RH needs of the poor, "hard to reach" and other vulnerable populations*

OUTPUT 1: *Increased access to sexual and reproductive health services for Poor and Hard to Reach Populations*

STRATEGY 1: Increase Access to and Utilization of RH Services by the Poor, 'hard to reach' and Vulnerable Groups

Key Activities:

1. Carry out an assessment of RH needs and service availability for hard to reach populations
2. Design strategies for improving equity in access to reproductive health care for hard to reach population; these may include establishment of innovative outreach services compatible with their lifestyles, and employment of e-health technologies
3. Advocate for strategies to reduce inequities in access to reproductive health care

2.3 STRATEGIES FOR SPECIFIC REPRODUCTIVE HEALTH COMPONENTS

The National Reproductive Health Policy has prioritized the following components of RH based on both magnitude and significance of the problem: maternal and newborn health; family planning unmet need; adolescent/youth sexual and reproductive health; and gender issues, including sexual and reproductive rights. Other components of RH addressed in the policy are: HIV/AIDS, reproductive tract infections, infertility, cancers of reproductive organs and RH for the elderly. The implementation of interventions targeting these components will be guided by the goal of the national Reproductive Health Programme viz- the provision of a comprehensive and integrated system of reproductive health care that offers a full range of services by the Government, FBOs, NGOs and the Private sector[10]. In this regard MOPHS through the Division of Reproductive Health will continue to play supervisory, supportive and monitoring roles, towards ensuring the above components of RH are addressed in a sustainable manner. The sections that follow describe the strategies for implementation of the individual RH components.

[10]National Reproductive Health Strategy 1997-2010

2.3.1 Maternal and Neonatal Health

Introduction

The Road Map for accelerating the attainment of the MDGs related to Maternal and Newborn Health in Kenya[11] has adopted six pillars of maternal and newborn Health that include pre-conceptual care and family planning; focused antenatal care; essential obstetric care; essential newborn care; targeted post-partum care; and post-abortion care. The foundation on which these pillars stand consists of: Skilled attendants and enabling environment to provide quality (skilled) care; supportive health systems that involve effective systems of referral, management, procurement, training, supervision, and health management information system; community action, partnerships and male involvement; and grounded on the principle of equity for all and respect for reproductive rights. These elements of MNH are recognised by the NRHP and are addressed within the following components of Reproductive Health: SM/MNH, Family Planning, HIV/AIDS, Adolescent SRH, and Gender issues Sexual and Reproductive Rights.

In Kenya levels of maternal and neonatal mortality remain high; a Kenyan woman faces a 1 in 35 lifetime risk of maternal death. Maternal mortality ratio has been estimated at over 400 per 100,000 live births since 1998, while perinatal and neonatal mortality rates were respectively estimated at 40 and 33 per 1,000 live births in KDHS 2003. For women who survive severe complications, maternal disability can have long-term consequences such as obstetric fistulae and infertility. The most critical time for the mother and her baby is during childbirth and in the first 24 hours postpartum, yet this is the time when coverage of care is lowest for mothers and babies. About 75% of maternal deaths occur during the process of childbirth or in the first week thereafter. Nearly two-thirds of neonatal deaths take place during the perinatal period (first week of life), and of these, two-thirds take place in the first 24 hours of life. Most maternal deaths are known to result from one or more of five "direct" obstetric complications: postpartum haemorrhage, obstructed labour/ ruptured uterus, preeclampsia/ eclampsia, puerperal sepsis, and complications of unsafe abortion. Among the "indirect" causes of maternal death are severe anaemia, malaria, HIV/AIDS and tuberculosis. The majority of neonatal deaths are due to infections, birth asphyxia, birth trauma, and complications of prematurity or birth defects. It is known that the majority of the maternal and perinatal deaths can be prevented if women received timely and appropriate care.

It is generally recognised that at least 15% of all pregnant women are at risk of a serious obstetric complication that usually cannot be predicted or prevented in advance. The implication of this is that all pregnant women require access to skilled care throughout the continuum of pregnancy- delivery-

[11] Ministry of Public Health and Sanitation, Road Map for accelerating the attainment of the MDGs related to Maternal and Newborn health in Kenya. Division of Reproductive Health December 2008

postnatal period. In addition, rapid access to quality basic or comprehensive emergency obstetric care is necessary for all women that experience an obstetric complication. The key challenges for effective provision of maternal and neonatal health services are weaknesses in the health sector that negatively affect access to, quality of, demand for and utilization of RH services; the various access barriers (cultural and socio-economic) to skilled care throughout the continuum of pregnancy, delivery, post-partum and post-natal periods; and inadequate access to improved care of the newborn. Access is an imperative for achievement of MDG 5 target which requires that Kenya reduces MMR from 414 per 100,000 live births in 2003 to 147 per 100,000 live births by 2015, a monumental task. Achievement of these targets requires strengthening the health systems in order to improve and increase access to emergency obstetric care, by ensuring that for every 500,000 people, there should be at least four Basic Emergency Obstetric Care facilities and one Comprehensive Emergency Obstetric Care facility (WHO/AFRO 2003).

OBJECTIVE:	*The main objective is to reduce rates of maternal, perinatal and neonatal morbidity and mortality in Kenya. This will be achieved by "increasing equitable access to maternal and newborn services; improving quality, efficiency and effectiveness of service delivery at all levels; and improving responsiveness to the client needs"*
OUTPUT 1:	*Increased 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*

Strategies and Key Activities:

STRATEGY 1: Strengthening Systems and Building Capacity at all Levels for Efficient and Effective Delivery of Maternal and Neonatal Health Services.

Weaknesses in the health systems, also discussed in Cross-cutting Strategies (2.2), result in inadequate responses to the health needs of women and newborns, mainly due to inadequate skilled attendants; lack of needed equipment, drugs and supplies; and poor referral systems. For example, studies have shown that the higher the proportion of deliveries with a skilled attendant in a country, the lower the country's maternal mortality ratio. In addition, full implementation of the Integrated Management of Childhood Illness (IMCI), will address key causes of newborn deaths.

The Cross-cutting strategies 2.2.1: Reproductive Health Systems Strengthening and 2.2.2: Improving efficiency, effectiveness and quality of RH services, address the critical issues of financing, human resources and infrastructure strengthening, which are crucial to achieving Output 1.

Other specific key activities are:

1. Advocate for increased allocation for MNH services within the reproductive health budget line, in the national budget, and build capacity for management and optimization of resources for MNH services
2. Improve effectiveness of supervision with emphasis on facilitative supervision; and sharing of resources e.g. transport
3. Improve communication and referral systems through mechanisms such as maternity shelters; mobile phone and radio; boats, motorbikes, and camel ambulances
4. Strengthen health information systems, including registration of births and deaths by cause.
5. Promote partnerships and coordination with other actors(NGOs FBOs)

STRATEGY 2: Improve Responsiveness to Client Needs (Equitable Access)

Key Activities:

1. Carry out an assessment of RH needs and service availability for populations with special needs (especially women and newborns), and address the gaps
2. Strengthen system to incorporate the requirements for women with special needs, for example, special training of staff on how to handle these clients, development of specialized IEC materials, etc
3. Participate in the support for service charters for health service delivery at ministerial and facility levels and client satisfaction tools at the facility level

STRATEGY 3: Increase availability of Integrated Maternal and Neonatal Health Services, at all Levels

Key Activities:

1. Integrate provision of maternal and neonatal health services at all levels
2. Strengthen provision of Post-Abortion Care (PAC) as an integral component of comprehensive reproductive health services
3. Scale up OBA voucher and other subsidy schemes, as approaches to increasing proportion of facilities providing integrated MNH services; other approaches may involve opening of new facilities (e.g. CDF projects), outreach services and improved communication (mobile phones, radio, etc)

4. Provide health facilities with appropriate equipment and supplies for effective provision of integrated MNH services
5. Regularly review and update service delivery guidelines, procedure manuals, job aids, etc.

STRATEGY 4: Increase Community Engagement in Promotion and Delivery of Maternal and Neonatal Health Services (demand creation, birth preparedness, early referral)

Community participation is critical to increasing timely and appropriate utilization of health services.

Key Activities

1. Increase community awareness of MNH issues through the implementation of the RH communication strategy.
2. Strengthen RH component in Community Strategy
3. Engage CHWs in demand creation activities, support birth preparedness, and early referrals.
4. Provide technical support to institutional bodies: village health committees, DHC, HCMC, etc, etc.

OUTPUT 2: *Increased access to quality Maternal and Neonatal Health services at all levels*

Strategies and Key Activities:

STRATEGY 5: Increase Access to Skilled Attendance for all Women During Pregnancy, Delivery and Postpartum Periods and for the Newborn.

This strategy focuses on activities towards increased access to skilled care for all women during pregnancy, delivery and postpartum periods and for the newborn, and on availability of prompt and efficient management (including referral) of complications of pregnancy, delivery and newborn.

Key Activities:

1. Scale up provision of BEOC at Levels 2 and 3, and CEOC at Level 4 and above
2. Scale up Community Midwife recruitment, update training and support

STRATEGY 6: Improve Quality of Integrated Maternal and Neonatal Health Services

Key Activities:

1. Identify training needs and provide update training in integrated Maternal and Neonatal Health services: focused ANC, skilled labour and delivery care, essential newborn care and early postnatal care; and in functional referral systems, post-abortion care (PAC), BEOC, CEOC, care of the sick/ LBW baby
2. Strengthen the decentralized RH training and supervision system
3. Support the implementation of quality assurance models such as KQM, ISO and other quality improvement tools, at all levels

STRATEGY 7: Support and Facilitate Maternal and Neonatal Mortality Review Mechanisms

Implementation of an effective Maternal Death Audit and Review (MDR) is a key strategy for improvement of the quality of maternal health services and lowering of both maternal and perinatal mortality. MDR permits timely qualitative in-depth investigation of causes and circumstances surrounding maternal deaths which can form the basis for formulation of relevant standards and protocols, towards improved quality of maternal care. An important step in implementing maternal death audit and reviews is advocacy towards making maternal death a legally notifiable event (see also Cross-cutting strategies for the role of community in mortality audits).

Key Activity:

1. Advocacy for legal notification of maternal and neonatal deaths
2. Implement mortality review mechanisms at all levels.
3. Disseminate results of mortality reviews
4. Implement recommendations of mortality review reports

2.3.2 Family Planning

Introduction

Family Planning programmes are an essential part of services to reduce maternal and perinatal morbidity and mortality because they enable women to postpone space and limit pregnancies. These services are also directly concerned with the outcomes of sexual relationships and have great potential for leading the way in promoting sexual health and efforts to prevent sexually transmitted infections

and HIV transmission. Kenya was one of the pioneer countries in Africa to initiate family a planning programme and its success is extensively acknowledged. The contraceptive prevalence rate among married women (CPR) rose from 7 percent in the late 1970s to 17 percent in 1984, 27 percent in 1989, and 33 percent in 1993 but leveled off at 39 percent in the period 1998-2003 with wide regional as well as social strata differentials. The unmet need for family planning is estimated at 24 per cent, largely due to inadequate service provision and poor access especially among the poor and other socially disadvantaged groups. The number of facilities providing family planning services dropped from 88% to about 75%. The national reproductive health policy (2007) recognizes that despite the stall, the number of couples and other sexually active unmarried individuals who need family planning will grow by 200,000 per annum between 2005 and 2015. A major challenge is the trend in the patterns of use of modern contraceptives which shows a general increase in the use of short-acting methods and a decline in the use of long acting and permanent methods (LAPMs). According to 1993, 1998 and 2003 KDHSs, injectable methods (mainly DMPA) had the greatest increase in use, rising from 7% in 1993 to 15% in 2003. Over the same period the use of female sterilisation (bilateral tubal ligation) decreased from 5.5% to 4.5%, while IUCD use declined from 4.2% to 2.5%, among currently married women ages 15-49 years. However, LAPMs have the proven advantages of being more effective in preventing pregnancy, more convenient to use, as well as being more cost-effective over time[12]. Among the factors contributing to the decline in choice of LAPMs are limitations in health facilities to offer these methods, provider biases as well as lack of, or deteriorating skills among service providers[13]. Another challenge for provision of FP services is the large unmet need for these services among HIV infected persons[14]. This is being addressed through the National Reproductive Health and HIV&AIDS Integration Strategy 2009, which aims at ensuring improved coordination and collaboration among key agencies and organisations offering RH and HIV/AIDS services in order to meet the needs of clients.

OBJECTIVE: *The main objective is to reduce unmet need for family planning, unplanned births as well as socio-economic disparities in Contraceptive Prevalence Rate (CPR).*

OUTPUT 1: *Improved Policy environment for the delivery of family planning services*

[12]Family Health International. Addressing the unmet need for family planning in Africa: Long-acting and permanent Methods; Briefs, (Research Triangle Park, NC, Family Health International, 2007b)

[13]Ministry of Health, Kenya. Kenya Comparative Assessment of LAPM Activities: Final Report. (Nairobi, Kenya, 2008)

[14]Reynolds HW, Liku J, Maggwa BN (2003), Assessment of Voluntary Counseling and Testing Centers in Kenya. FHI Institute for Family Health; Family Health International (2005) Country Assessments (Kenya): Family Planning Needs in the Context of the HIV/AIDS Epidemic

Strategies and Key Activities

STRATEGY 1: Advocacy and Policy Dialogue

Advocacy is critical to gaining both institutional and public support for legal and policy changes at various levels, including national laws, policies and regulations affecting standards of practice, and community customs and practices. In addition, non-governmental organizations and the private sector must also be acknowledged and involved as partners in national policies and programmes. Such efforts need to be supplemented by continuous policy dialogue and learning, including sensitization on key issues and challenges to help achieve positive societal change and increased resource allocation for programmes on the same issues. The main objectives of advocacy and continued policy dialogue are to foster active involvement of elected representatives of people, concerned groups and individuals, especially at the grass-roots level, and to build the capacity and self-reliance to undertake concerted national actions.

Key Activities

1. Review/update policies and regulatory mechanisms in order to ensure that they facilitate universal and equitable access to family planning education, information and services;
2. Strengthen integration of family planning into other RH programmes
3. Advocate for increased resource allocation for family planning services
4. Build public–private sector partnership to support the financing of FP commodities and services
5. Support the engagement of communities, civil society organizations and private sector in implementation of family planning programmes;

STRATEGY 2: Community Engagement in Promotion and Delivery of Family Planning Services

In order to achieve desired results and reach the expected targets the necessary actions and activities will include continuous engagement of communities to pass positive messages about family planning at community level while at the same time understanding the potential barriers to sustained uptake. In addition community based providers and mobilizers work as good advocates and providers of information.

Key Activities

1. Intensifying awareness campaigns among communities on the benefits of FP and to collaborate with community-based groups and opinion leaders to understand and address underlying cultural values and practices that could contribute to non-use of FP and/or unmet need for FP
2. Use participatory approaches to work with communities, public and private sector institutions, and non governmental organizations to overcome barriers and promote appropriate use of available services;
3. Mobilize civil society to advocate for family planning in disadvantaged communities
4. Engage key community leaders to become champions and advocates for FP within the communities

STRATEGY 3: Building Knowledge Base and Supporting Knowledge Sharing among Practitioners for Priority Setting

Even where family planning services exist, there are many reasons (social, economic and cultural) why people nevertheless do not use them. Identifying and overcoming obstacles require working with women and men, young people, and other community groups to understand better their needs, analyze problems and find acceptable solutions.

Key Activities

1. Support research that seeks to understand social and cultural determinants of non use and unmet need for family planning among various social and economic groups to advocate for and promote evidence-based interventions
2. Share lessons learnt from researches and innovative programs and projects and use the results to Intensify awareness campaigns to address operational barriers to create sustained demand for family planning
3. support initiatives for mass media campaigns and education on family planning

OUTPUT 2: *Increased availability of family planning services*

STRATEGY 1: Strengthening Commodity Logistics and Management

There are concerns on stock-outs of contraceptives and other reproductive health supplies in Kenya. In addition, growing numbers of people of reproductive age will create high future demand for contraceptives. It is therefore necessary to match supplies with the demand. Such action will

require efficiency and a well coordinated logistics capacity and contraceptive security at levels. At all levels, a sound logistics system ensures the smooth distribution of contraceptive commodities and other supplies so that each service delivery point has sufficient stock to meet clients' needs. In addition to preventing stock-outs, a well-run logistics system assures that all supplies are in good condition and controls costs by eliminating overstocks, spoilage, pilferage, and other kinds of waste. The above concerns are addressed in the National Contraceptive Commodities Security Strategy 2007-2012, the development of which involved the consensus and participation of the partners and major stakeholders of reproductive health in Kenya. The Strategy has the objective of ensuring "uninterrupted and affordable supply of contraceptives to all people that need them".

Key Activities:

1. Support the implementation of Contraceptive Commodity Security Strategy
2. Strengthen the contraceptive management unit and logistics management information system at all levels
3. Ensure sustained supplies of commodities at all levels
4. Train relevant staff on commodity logistics and management

STRATEGY 2: Increase Coverage of Facilities Providing FP Especially in the Disadvantaged Areas and Groups

Key Activities:

1. Support partnerships that provide services and information in hard to reach areas
2. Support community-based distribution to overcome social and geographic barriers to family planning particularly in rural and remote areas
3. Scale up social marketing campaigns

OUTPUT 3: *Increased utilization of family planning services*

STRATEGY 1: Improving Quality of Care

Over the past decade, international family planning programs have shifted priorities to focus not only on meeting the demand for services but also on the quality of the services. Quality of care contributes to both contraceptive adoption and continuation rate and hence creates demand for service utilization. In addition, the close linkages between family planning and other RH and STI/HIV &AIDS require that these services be provided in an integrated way so as to maximize synergies. These approaches can be built on and improved in order to expand coverage and outreach to men, youth

and other groups not previously the focus of family planning. The recent widespread advertisement campaigns of herbal medicines and unregulated influx of drugs including contraceptives, has raised concerns of safety in the use of some of the products.

Key Activities:

1. Support the enforcement of regulations and standards that are in place for the provision of quality family planning services, including approved commodities.
2. Regularly update and monitor standards for practice in both private and public sectors;
3. Support effective and sustained training (pre-service and in-service) and supervision for high-quality service delivery.

STRATEGY 2: Building Knowledge Base for Priority Setting

Understanding the operational barriers to sustained use of services is an important aspect in the provision of quality services, expansion of coverage and utilization of services.

Key Activities:

1. Support research to identify and address barriers to family planning use among the underserved groups
2. Use results of studies to intensify awareness campaigns to address operational barriers
3. Develop strategies to create sustained demand for family planning

STRATEGY 3: Promoting Complete Method-mix of Contraceptive Methods

Emphasis will be on revitalizing the use of LAPMs in Kenya, thereby changing the current pattern which favours short-acting methods predominantly. This will be achieved through addressing the factors contributing to the decline in the utilisation of LAPMs

Key Activities:

1. Implement the LAPM strategy
2. Build the capacity of service providers to provide appropriate methods
3. Strengthen the health infrastructure in order to increase access and quality in the provision of a balanced method mix

2.3.3 Sexual And Reproductive Health For Adolescents and Youth

Introduction

Adolescents and youth, who are defined as persons in the age groups 10-19 and 10-24 years respectively, constitute 36 percent of the total Kenyan population. In addition, all persons under the age of 18 years in Kenya are defined as children under the Children Act of 2001. This large proportion of young people has major demographic, social and economic implications. It has an in-built population growth momentum due to increase in young potential mothers entering reproductive ages. Currently, adolescent fertility in Kenya is still high. The KDHS-2003 reported that the proportion of women age 15-19 that had begun childbearing rose from 21% in 1998 to 23% in 2003. Children of teenage mothers are also at a higher risk of dying. Among population age 15-24, women are 4 times more likely to be infected by HIV &AIDS to than men (6.1 % compared to 1.5 %).

The Adolescent Reproductive Health and Development Policy (2003) recognises that the optimal health of the adolescent population of Kenya will increase their productive capacity to contribute to the nation's development. The Policy identifies; adolescent sexual and reproductive health and rights, harmful practices, drug and substance abuse, socio-economic factors, and adolescents and youths with disabilities as priority concerns. In order to address these concerns the Adolescent Reproductive Health and Development Policy Plan of Action 2005-2015 focuses on the following strategic areas: advocacy; health awareness and behaviour change communication; improved access to and utilization of youth friendly services. Despite existence of the ASR&D Plan of Action, there still is inadequate access by adolescents and youths to RH information and services. The focus of current RH programmes also leaves out a substantial group of adolescents and youth in need- out of school, the very young adolescents (10-14 years), adolescents in marriage, and adolescents living on the streets. Only 12% of health facilities provide youth-friendly services (KASP-2004). This strategy recognizes that full implementation of the actions stipulated in ASR&D Plan of Action will ensure that the challenges outlined in the national reproductive health policy are overcome.

OBJECTIVE:	*To improve the sexual and reproductive health of Kenya's adolescents and youth*
OUTPUT 1:	*Legal and policy environment for effective implementation of adolescent and youth reproductive health programmes improved*

Strategies and key activities

STRATEGY 1: Advocacy and Policy Dialogue

Key Activities:

1. Advocate for the enforcement of relevant legislation on reproductive health and rights protecting young people
2. Advocate for elimination of legal and socio-cultural barriers that limit access to reproductive health information, counselling and services for adolescents and youth
3. Mainstream ASRH issues into relevant national and sectoral development plans
4. Advocate for the full implementation of ASRH&D Plan of action and the national plan of action for implementing the health component of the youth policy

STRATEGY 2: Support Networks and Partnerships

Key Activities:

1. Support coalitions and networks of youth health advocates at various levels
2. Strengthen existing partnerships of NGOs and FBOs working with the youth
3. Participate in lobbying for the private – public sector support for youth reproductive health
4. Engage communities to support sustainable youth health programmes

OUTPUT 2: *Increased utilization of quality youth friendly RH services*

Strategies and key activities

STRATEGY 1: Reproductive Health Awareness Creation among the Youth

Key Activities:

1. Develop relevant IEC and BCC materials
2. Promote and support school based health education programmes
3. Promote initiatives reaching out to out-of-school youths with IEC and BCC interventions
4. Support mass media campaigns for reproductive health among young people
5. Support initiatives aimed at creating reproductive health awareness among youth in difficult circumstances (youth in street, pastoral communities, youth with disabilities etc)

STRATEGY 2: Integration of Adolescent and Youth Health Information and Services in other Youth Programmes

Key Activities:

1. Mainstream youth reproductive health services into other development programs targeting young people
2. Scale up projects that integrate youth health information, and life skills into existing livelihood programmes.

STRATEGY 3: Expanding Scope and Coverage of Youth Friendly Services

Key Activities:

1. Support expansion of the number of facilities offering youth friendly reproductive health services
2. Develop strategies to reach adolescents, and youth involved in risky behaviours, and the hard to reach e.g., the very young (10-14 years), married, out of school, young people living with HIV and adolescents living on the streets.
3. Train staff to provide quality reproductive health services to adolescents and youth with disabilities
4. Develop protocols, guidelines and/or job aid cards for quality of reproductive health care for young people with disabilities

2.3.5 Gender Issues, Sexual And Reproductive Rights

Introduction

The three key issues in the spheres of gender equality, sexual and reproductive rights in Kenya can be summarized as a lack of empowerment for women to exercise decision on their own reproductive health and rights, including decisions regarding seeking health care for themselves and children; gender-specific harmful cultural practices including early or child marriages and female genital mutilation (FGM); and sexual and gender based violence (SGBV) including rape. In addition, lack of male involvement in reproductive health programmes has been an important barrier to implementation of reproductive health interventions. In Kenya, harmful traditional practices of major concern are early or child marriages and female genital mutilation (FGM). About 8 percent of women aged 20-49 years in 2003 KDHS data reported that they were first married by age 15 years, i.e. when they were still children (Children Act (2001) Cap 586 of the Laws of Kenya). Female genital cmutilation contravenes several basic rights of women and girls, including right to liberty and security of person,

and the right to be free from inhuman and degrading treatment. The 2003 KDHS estimated FGM prevalence at about 32 percent, with one third of all circumcised women reporting having had the operation carried out by health workers.

Gender based violence affects both women and men, and in both situations these are violations of right to be free from inhuman and degrading treatment, besides having severe psychological, emotional and medical consequences- increase risk of unintended pregnancy and sexually transmitted infections including HIV/AIDS. The 2003 KDHS reported that nearly 43 percent of women aged 15-49 years had experienced some form of gender based violence in their lifetime with 29 percent reporting having been violated in the year preceding the survey. The survey results also revealed that the prevalence rate of sexual abuse was 13 percent among females aged 15-49 years. The main challenges for addressing gender based violence are poor reporting and limited access to services for the victims. Other challenges include impunity of the perpetrators, societal perceptions of sexual violence and stigma.

Other emerging challenges include sexual orientation practices, and inadequate preparation of health service providers to address the needs of such clients. There is paucity of data on the various types of sexual orientation practices in Kenya, and poor understanding of associated reproductive health problems, if any.

OBJECTIVE: *Promote gender equity and equality in decision making in matter of sexual and reproductive health and contribute to the elimination of harmful practices and gender-based violence within a multisectoral and legal framework*

OUTPUT 1: *Improved Policy environment for mainstreaming gender and reproductive rights*

Strategies and Activities

STRATEGY 1: Advocacy and Policy Dialogue

Key Activities:

1. Promote gender mainstreaming in reproductive health service delivery
2. Advocate for legislation and enforcement of relevant laws touching on reproductive health and rights
3. Advocate for elimination of harmful practices

4. Solicit the support of health professionals in the elimination of harmful traditional practices such as FGM
5. Advocate for the full implementation of Gender Policy and plan of action
6. Support the generation of RH data that is dis-aggregated by sex where appropriate
7. Regularly review, laws and policies in order to ensure that they facilitate universal and equitable access to reproductive and sexual health education, information and services

STRATEGY 2: Awareness Creation of Sexual and Reproductive Health Needs and Rights

Key Activities:

1. Support the dissemination of the natiuonal Gender Policy
2. Develop culturally gender-sensitive reproductive health messages
3. Inform, and educate individuals and communities on reproductive health issues and rights.
4. Engage communities to change negative socio-cultural norms and practices affecting sexual and reproductive health and rights
5. Promote research on various sexual orientation practices so as to establish the extent and magnitude, and associated reproductive health issues that may be addressed within the mandate of reproductive health services.
6. Build capacity of service providers in the provision of counseling services on various problems associated with sexuality including sexual orientation and sexual dysfunction.

OUTPUT 2: *Improving access to quality treatment and rehabilitative reproductive health services for individuals who experience gender-based violence and harmful practices.*

STRATEGY 1: Providing Supportive Services to Survivors of Gender Based Violence and Harmful Practices:

Key Activities:

1. Enhance community knowledge on sexual and gender based violence and services
2. Inform, and educate health service providers on need to observe reproductive rights in health service delivery.
3. Strengthen capacities of relevant institutions to provide quality treatment and rehabilitative reproductive health services for survivors of gender based violence and harmful practices, including comprehensive post-rape care services.

OUTPUT 3: *Improving equitable access to reproductive health services*

STRATEGY 1: Empowerment of Men and Women, Boys and Girls to Increase Utilisation of RH Services

Key Activities:

1. Increasing male involvement in reproductive health programmes.
2. Empowering women in RH decision making and participation

2.3.5 Integration Of Hiv and Aids In Reproductive Health

Introduction

HIV & AIDS remains a major challenge in Kenya. According to the 2007 Kenya AIDS Indicator Survey (KAIS), Preliminary Report roughly 1.4 million Kenyan adults were estimated to be living with HIV, with substantial gender and regional variations in HIV prevalence, and in levels of HIV testing. The overall prevalence of HIV was reported as 7.4% among persons age 15-64, being 8.7% among women and 5.6% among men. In the case of those aged 15-49, the prevalence was 9.2% among women and 5.8 among men. Comparison of 2007 KAIS and 2003 KDHS data shows that whereas urban areas showed slight reduction from 10% in 2003 to 9.2% in 2007, rural areas have witnessed a significant increase in HIV prevalence, increasing from 5.6% in 2003 to 7.4% in 2007. Despite a growing proportion of Kenyans being aware of their HIV status, as many as 4 out of 5 HIV-infected persons do not know their status. According to KAIS 2007, nearly 1 out of 10 pregnant women in Kenya are infected with HIV (9.6 percent) with minimal differences by urban and rural residence. According to KSPA 2004, only 24% of health facilities were offering any form of PMTCT services (74% of hospitals and <40% of Levels 2-3 facilities). Of pregnant women that tested HIV+ only 58% received ARV prophylaxis (89% in hospitals, <60% in levels 2,3).

Reproductive health services are important entry points for most HIV/AIDS services, however, integration of HIV/AIDS interventions in RH services remains inadequate. Among the key challenges for integration are stigma, negative attitudes of service providers, and knowledge gaps regarding reproductive health needs of people living with HIV and how to address them. The Priority Actions identified in NRHP 2007 for the reduction of HIV/AIDS burden and improvement of reproductive health status of the infected and affected are: to ensure integration of HIV/AIDS information and services into RH services at all levels of health care, including integration of HIV testing and counselling as part of a comprehensive antenatal care package; and to ensure adequate capacity at all levels for the provision of integrated, high-quality RH services in the context of HIV/AIDS. The National Reproductive Health and HIV&AIDS Integration Strategy seeks to address this need.

OBJECTIVE: *The main objective is to contribute to the reduction of HIV & AIDS burden and to improve reproductive health status of the infected and affected*

OUTPUT 1: *Increased availability of integrated HIV & AIDS information and services at all levels of health care.*

STRATEGY 1: Strengthen Integration of RH and HIV & AIDS Services at all Levels of Health Care

Key Activities:

1. Strengthen inter-departmental collaboration between DRH and NASCOP, and other governmental arms including NACC
2. Promote joint planning, training, and resource mobilization for integrated RH and HIV/AIDS services
3. Develop/strengthen coordination (strategies) to monitor and evaluate the efficient allocation of resources and implementation of regulatory instruments (policies, strategies, guidelines and laws) for quality integrated HIV & AIDS /RH services
4. Strengthen training programmes in integrated RH and HIV/AIDS service
5. Strengthen the logistics and supplies system to take into account the integrated services
6. Strengthen M & E system to capture integrated service provision at all levels

STRATEGY 2: Build the Capacity of Health Facilities to provide Quality Level-Appropriate integrated RH and HIV/AIDS Services

Key Activities:

1. Ensure adequate capacity at all levels for the provision of integrated quality RH services in the context of HIV&AIDS and vice versa:
2. Provide appropriate training (including update) of service providers at all levels on integrated RH and HIV&AIDS services
3. Advocate and Mobilize resources to support integrated RH/HIV services, including physical facilities, equipment, drugs and commodities.

OUTPUT 2: *Increased utilisation of integrated HIV and AIDS and RH information and services at all levels of health care*

STRATEGY 1: Increase Availability of PMTCT Plus services for Pregnant Women

Key Activities:

1. Sensitize communities and individuals to create demand for integrated RH and HIV services
2. Ensure availability of commodities and supplies for integrated RH and HIV services at all levels of health care
3. Support the full implementation of the PMTCT Strategy

STRATEGY 2: Promotion of Access to Appropriate RH services for HIV infected Individuals and Couples

Key Activities:

1. Provide appropriate (pre- and in-service) training (including update) of service providers at all levels on integrated RH and HIV&AIDS services
2. Provide appropriate reproductive health services for HIV infected persons at all levels of care
3. Increase awareness within the community of availability of and importance of utilising RH services, including contraceptive services

2.3.6 Reproductive Tract Infections (RTIs)

Reproductive tract infections (RTIs) have serious impacts on health, and are important contributors to poor RH outcomes. Indeed, the impact of RTIs can manifest in all other components of RH. However, it needs to be appreciated that most available data is on sexually transmitted infections (STIs) including HIV, and that there is scarcity of data on endogenous infections and their implication to the social and reproductive health of women. On the other hand, the KDHS 2003 showed that 1.6% of the women interviewed reported to have had an STI over the previous 12 months, 2.4% of them reporting a genital ulcer or sore. In the case of men, 2.1% and 1.5% respectively reported an STI and genital ulcer or sore, respectively. The 2007 Kenya AIDS Indicator Survey (KAIS) Report has shown that as much as 35 percent of people age 15-64 are infected with genital herpes virus (HSV-2), and that infection rates are higher in women compared with men (42 versus 26 percent). Sexually transmitted infections may amplify the transmission of HIV. In both men and women, those that reported having had an STI or related symptoms, or those diagnosed with genital herpes, have all been shown to have higher rates of HIV infection when compared to those that neither reported or were not diagnosed with an STI (KDHS 2003; KAIS 2007). In women, RTIs are often asymptomatic, making it more difficult to diagnose than in men, and as a result treatment is frequently delayed, increasing the risk of ascending pelvic infection. The KDHS 2003 showed that among the women reporting previous infections more than a third (32%) had not sought advice or treatment (from anywhere) compared with only 11% of the men.

Effective treatment of RTIs is a key prevention strategy both for HIV and for complications of RTIs (e.g. infertility, cancers etc). Including RTI screening and treatment as a component of RH services increases early detection and treatment, as well as follow-up. However, KSPA 2004 found that availability of RTI services was lacking in 33% of FP clinics and in 47% of ANCs.

OBJECTIVE: *Reduce transmission of RTIs and improve access to RTI services within RH programmes.*

OUTPUT 1: *Improved knowledge base among the communities on the incidence, prevalence and prevention of RTIs*

Strategies and Activities

Strategy 1: Create awareness among communities and individuals on the magnitude and impacts of RTIs and the role communities can play in RTI prevention

Key Activities:

1. Implement the RH Communication strategy
2. Develop appropriate messages on RTIs
3. Carry out community educational campaigns on RTIs
4. Engage mass media to provide information and education on RTIs

OUTPUT 2: *Strengthened health information system to capture incidence and prevalence of RTIs*

STRATEGY 1: Capacity Building of the Relevant Infrastructure for Generating Information on RTIs

Key Activities:

1. Developing routine and regular surveillance system for RTIs
2. Developing data base on incidence and prevalence of RTIs

STRATEGY 2: Promoting use of Data from Information System for Service Improvement

Key Activities:

1. Support the dissemination of data and information from routine and regular surveillance system on RTIs
2. Support social, epidemiological, and clinical research on RTIs

OUTPUT 3: *Strengthened quality of provision of RTI services within RH programmes*

STRATEGY 1: Mainstreaming of RTI Services into RH Services at all Levels

Key Activities:

1. Build capacity at all levels of service delivery for effective integration of RTI into RH services
2. Strengthen syndromic management (as appropriate) and laboratory services to support early diagnosis and effective treatment of RTIs
3. Strengthen the RTI treatment kit supply chain management and carry out periodic review of the drugs used in syndromic management in order to ensure their effectiveness in curing RTIs
4. Strengthen RTI prevention activities, and early detection and treatment, at all levels.

2.3.7 Infertility and Sexual Dysfunction

The National Reproductive Health Policy (2007) recognises infertility as an important public health concern in Kenya. The actual magnitude of infertility in Kenya remains inadequately determined. The 2003 KDHS reported that 2.2 per cent of women aged 40-49 years had not given birth to a child, which may be interpreted as primary infertility. However, secondary infertility may exist in a much larger proportion of women depending on the desired family size norms and the extent of pregnancy wastage. A DRH commissioned infertility survey[16] has established that in Kenya infertility cases comprise approximately 30% of all gynaecological consultations at Levels 5 and 6 hospitals. In Kenya, as it is in most sub-Saharan African countries, RTIs are the leading contributors to infertility in both women and men, contributing to tubal occlusion and other tubal pathology in women, and accessory gland infection in men. This implies that prevention and effective treatment of RTIs are key strategies for addressing the problem of infertility. In Kenya there is limited access to infertility services, few

[16]Machoki et al. (2008), Magnitude, causes, management and challenges of infertility in Kenya: Infertility survey in Kenya – 2nd draft report to DRH, 11th March 2008.

health facilities are equipped with adequate resources to provide the services, and very few service providers possess the knowledge and skills needed to cater for the needs of infertile couples[17]. Other challenges for provision of effective infertility services are failure to seek health care early on the part of affected individuals and couples, and negative attitudes towards infertility both at the service provider and community levels. The infertility survey quoted above established that communities had poor knowledge on infertility which was shrouded with misconceptions and myths. The National Reproductive Health Policy (2007) identified the following as priority actions for reduction of the magnitude of infertility and for increasing access to proper investigation and management of infertility: improving access to quality infertility services at all levels; promoting community awareness on infertility, especially among males; and encouraging research on all aspects of infertility.

An emerging reproductive health challenge is sexual dysfunction. Sexual dysfunction can be an underlying factor in infertility, at the same time infertility can precipitate sexual dysfunction. In Kenya there is paucity of data on the various types of sexual dysfunction, as well as inadequate understanding of any associated reproductive health problems. In addition, there is inadequate preparation of health service providers to address the needs of such clients.

OBJECTIVE: *The main objective is to reduce the magnitude of infertility and increase access to proper investigation and quality management of infertile individuals and couples in Kenya*

OUTPUT 1: *Increased access to services for prevention, investigation and management of infertility and sexual dysfunction*

STRATEGY 1: Promoting Community Awareness on Infertility and Sexual Dysfunction

Key Activity:

1. Carry out community education and awareness creation on infertility
2. Educate communities on their roles in the prevention of infertility and in support for the affected individuals and couples.

[17]Machoki et al. (2008), Magnitude, causes, management and challenges of infertility in Kenya: Infertility survey in Kenya – 2nd draft report to DRH, 11th March 2008.

STRATEGY 2: Ensure Availability of Services for Prevention of Infertility at all Levels, as Appropriate

Prevention of factors responsible for tubal occlusion and other pelvic pathology in women, and accessory gland infection in men, is a key strategy to address the problem of infertility in Kenya. These factors include RTIs, postpartum and post-abortion infections.

Key Activities:

1. Strengthen integration of infertility prevention services in RH services at all levels.
2. Support infertility prevention measures including improved postpartum and post-abortion care, and early diagnosis and effective treatment of RTIs

STRATEGY 3: Ensure Availability of Appropriate Services for Investigation and Management of Infertility at all Levels

In Kenya there is limited access to infertility services, few health facilities are equipped with resources to provide the services, and very few service providers possess the knowledge and skills needed to cater for the needs of infertile couples.

Key Activities:

1. Build capacity at all levels for appropriate management of infertile individuals and couples, including facilities for early diagnosis and management.
2. Develop regulatory and service delivery guidelines showing what can be done and by whom at different levels and provision of appropriate training in infertility counselling, management, and prevention.
3. Build capacity of tertiary level facilities to provide specialised infertility management including Assisted Reproductive Technologies (ART) services
4. Support referral centres of excellence for specialised training and advanced management of infertility in Kenya.
5. Promote and support research on all aspects of infertility

STRATEGY 4: Strengthening Services for the Management of Sexual Dysfunction at all Levels

Key Activities:

1. Promote research on sexual dysfunction to establish the extent, magnitude, and associated reproductive health issues

2. Build capacity at all levels for appropriate management of individuals and couples, with sexual dysfunction
3. Develop service delivery guidelines on the management of sexual dysfunction at all levels, including appropriate training.
4. Create community awareness on the problem of sexual dysfunction and availability of services

2.3.8 Cancers Of Reproductive Organs

Introduction

Cancers of reproductive organs are important causes of morbidity and mortality among women and men in Kenya. Cancers of the cervix and breast are the leading malignant diseases among women in Kenya while cancers of the prostate and testis are common in men. Both cervical and breast cancers present opportunities for their early detection since both develop on organs which are easily accessible by inspection or palpation. Similarly, prostate cancer can be detected early by careful clinical examination aided by biochemical markers. Given that it takes up to 10 years for progression from pre-cancerous lesions to cancer, screening for early detection and effective treatment of pre-malignant lesions is critical for reduction of mortality and morbidity associated with these cancers. The high prevalence of HIV infection in Kenya has implications for cervical cancer prevention and management, since HIV-positive women are more likely to have HPV infection and cervical dysplasia than HIV-negative women[18]. The International Agency for Research on Cancer (IARC) has estimated that nearly 3000 cervical cancer cases occur each year in Kenya, resulting in an estimated 1524 annual deaths[19]. Hospital-based cancer registries in Kenya indicated that cervical cancer accounted for 70-80% of all cancers of the genital tract and 8-20% of all cancer cases recorded during the 10-year period 1981-1990[20]. On the whole there is substantial delay in seeking health care; the mean duration of symptoms is over 8 months and close to 90% of the cases are seen in advanced disease, Stage 2B and above[21]. Majority of women in Kenya have very limited access to cervical cancer services; less than 1% of the women were screened in the previous 5 years between 2000 and 2005 (MOH/DRH, 2005). However, a few demonstration projects suggest it is feasible to expand screening for cervical cancer down to Level

[18]Hawes SE, Critchlow CW, Faye Niang MA, Diof MB, Diop A, Toure P et al. Increased risk of high-grade cervical squamous intraepithelial lesions and invasive cervical cancer among African women with human immunodeficiency virus type 1 and 2 infections. J Infect Dis. 2003; 188 (4): 555-63; Ferency A, Coutlee F, Franco E, Hankins C. Human papillomavirus and HIV co-infection and the risk of neoplasias of the lower genital tract: a review of recent developments. CMAJ. 2003; 169(5): 431-4.

[19]Ferlay J, Bray F, Pisani P, Parkin DM, Globocan 2000: Cancer incidence, mortality and prevalence worldwide, Version 1.0. Lyon: IARCPress, 2001

[20]Rogo KO, Omany J, Onyango JN, Ojwang SB, Stendah U: Carcinoma of the cervix in an African setting. International Journal of Gynecology and Obstetrics 1990, 33: 249-255

[21]Were EO, Buziba NG. Presentation and health care seeking behaviour of patients with cervical cancer seen at Moi Teaching and Referral Hospital, Eldoret, Kenya, East Afr Med J 2001; 78 (2): 55-59

2 utilising visual inspection methods, and treating dysplasia with cryotherapy at Level 4. Given the age profile of cancer cases and considering the prolonged pre-cancerous stage, screening in the ages 30-49 years will reach women at the highest risk of persistent high-grade disease, who would benefit most from treatment. Surgical treatment of invasive cervical cancer is available at Level 4 upwards, however, curative radiotherapy is only available in Nairobi. The recent availability of vaccines against some oncogenic strains of HPV provides new opportunity for primary prevention of cervical cancer.

Objective:	*To reduce morbidity and mortality associated with the common cancers of the reproductive organs in men and women.*
Output 1:	*Improved information base on cancers of the reproduction organs*

STRATEGY 1: Establish Mechanisms for Improved Data Collection on Cancers of the Reproductive Organs

Key Activities:

1) Develop cancer registers at appropriate levels and integrate into national cancer registry.
2) Strengthen the collection and analysis of routine data and information at relevant levels of service delivery
3) Strengthen the documentation and dissemination of information related to cancers of reproductive organs
4) Support reproductive health research

Output 2:	*Improved access to services for prevention and management of cancers of reproductive organs*

STRATEGY 1: Advocacy and Awareness Creation

Key Activities:

1. Promote positive health seeking behaviour in the community, including awareness of regular screening for early signs of cancer
2. Promote community awareness of symptoms of reproductive organ cancers towards elimination of delay in seeking health services
3. Promote information exchange among practitioners

STRATEGY 2: Capacity Building for Integrated Service Provision

Key Activities:

1. Scale up integrated reproductive organ cancer services (prevention, early detection and treatment) in RH services –including provision of routine cervical, breast and prostate cancer screening services as appropriate, at all RH clinics, including Comprehensive Care Centres for HIV/AIDS.,.
2. Strengthen RH services at all levels to provide prevention, screening and early diagnosis, and management, of cancers of reproductive organs
3. Strengthen oncology services at appropriate levels in order to cater for the needs of prevention, early diagnosis and treatment of cancers of reproductive organs, including HPV vaccines and other emerging technologies.
4. Develop and/or regularly review guideline and procedure manuals for early detection and management of reproductive tract cancers

2.3.9 Reproductive Health of Elderly Persons

The demographic transition towards lower fertility levels is expected to produce slight changes in the age structure of Kenya's population notably slight increase in the proportion and number of elderly persons. People aged 65+ years made up 4% of the Kenyan population in 1999, and were projected to increase to slightly over 5% by the year 2015[22]. The number of people aged 50+ years is projected to reach 3.7 million by 2015. The increasing breakdown in societal structures that used to cushion them, and the absence of comprehensive support programmes, the elderly are highly vulnerable to poverty and have limited access to health care including SRH services. Women, because they live longer relative to men, constitute the majority of the elderly population. Elderly people, particularly older women, are sometimes victims of violence and discrimination. The NHSSP II has identified the Elderly (60+ yrs) among the six KEPH Life-Cycle Cohorts, and lists some of the services needed by the Elderly both promotive/preventive and curative to be: annual screening and medical examinations; promotion of exercise and general hygiene; social/emotional/community support; and access to drugs for degenerative illnesses. Reproductive health problems of elderly persons relate mainly to the higher incidence of chronic illnesses, cancer and degenerative diseases, and to complications of menopause in women and andropause in men, which negatively affect their quality of life. The lack of comprehensive and integrated SRH services that target elderly persons, as well as paucity of data on SRH needs and indicators to guide programming and monitoring services for elderly persons, are important challenges for addressing RH needs of the elderly.

[22]National Population Policy for Sustainable Development: Sessional Paper No 1 of 1997 and No 5 of 1999 (GOK/NCPD)

OBJECTIVE: *To address RH- related needs of the elderly*

OUTPUT 1: *Increased awareness of SRH needs of the elderly*

STRATEGY 1: Create Awareness at all Levels of the Sexual and Reproductive Health Needs of Elderly Persons

Key Activities:

1. Promote research on SRH needs for the elderly
2. Advocate for the elimination of all forms of violence and discrimination against elderly persons
3. Promote awareness among service providers at all levels of the sexual and reproductive health needs of elderly persons.
4. Promote healthy lifestyles and good nutrition throughout the life cycle.

OUTPUT 2: *Increased availability and utilization of acceptable and affordable RH services for elderly persons*

STRATEGY 1: Promote Integration of RH Services for the Elderly in Routine RH Services at all Levels of Health Care

Key Activities:

1. Promote awareness within the Community of the availability of RH services for the elderly.
2. Build capacity within health facilities at all levels to provide integrated. elderly-friendly services, including management of menopausal problems and cancer screening, as appropriate
3. Integrate counselling and appropriate health services for elderly persons in current RH programmes and services, including outreach activities.

STRATEGY 2: Improve Access to Appropriate Facilities for Management of SRH Problems among the Elderly

Key Activities:

1. Support the provision of cost-effective screening programmes for malignancy, cardiovascular and musculoskeletal diseases in the elderly persons.
2. Improve access to appropriate facilities for screening, early diagnosis and treatment of reproductive organ cancers (especially cervical, breast and prostate cancers) and complications associated with menopause and andropause.
3. Improve access to services for medical and emotional problems associated with old age (especially menopause and andropause), including counselling and hormone replacement therapy (HRT), as necessary.

CHAPTER 3

Implementation Mechanisms

3.1 Introduction

This strategy will be implemented in accordance with the overall national health sector management and coordination framework contained in NHSSP II, the respective strategic plans of MOPHS and MOMS, the National Reproductive Health Policy, Adolescent Reproductive Health and Development Policy and its Plan of Action 2005-2015, and the national plan of action for the health component of the youth policy. It will therefore entail relevant coordinating agencies to seek collaboration with a wide range of partners within the government, civil society and the donor community as each fulfils its roles and responsibilities. Effective coordination and collaboration will facilitate the best use of available resources by minimizing duplication of efforts, aligning quality assurance standards, and ensuring that the efforts of all stakeholders are harmonized towards the achievement of the common goal and objectives and the expected targets. To this end, the sector-wide approach (SWAp), which has the main focus to coordinate effectively the development of the health sector, will provide the framework for collaboration in the design, financing, and execution of the RH interventions, through platforms such as the Joint Inter-agency Coordinating Committees (JICC) and Inter-agency Coordinating Committees (ICCs) which are essential elements to build and strengthen the existing partnerships between the public sector, the private sector and development partners. The Health Sector Stakeholders' Forums both at the provincial and district levels are key structures for exchange and coordination of programmes. The Health Sector Stakeholders fall in three constituencies: Government of Kenya, led by the Ministry of Public Health and Sanitation (MOPH&S) together with the Ministry of Medical Services (MOMS), but including other line ministries and institutions[23]; Implementing partners, broadly categorized as: Private-for-profit organizations (private facilities and practitioners including traditional practitioners) and Private not-for-profit organizations (like faith-based organizations- (FBO), non-governmental organizations- (NGOs) and civil society organizations- CSOs); and Development Partners, broadly categorized as: Technical partners and Funding partners. The Joint Programme of Work and Funding (JPWF) and the Annual Operation Plans (AOP) which have been adopted since 2005/2006 will continue to be the mechanisms for outlining priority health interventions including reproductive health, to be implemented over specified period, their resource implications and financing situation. The Plans emphasize stewardship and partnerships for good governance, efficiency, effectiveness, improved coordination and better management in the Health Sector.

[23]These include: the Ministry of Finance, Ministry of Planning and National Development, Office of the President (DPM) Cabinet Office (Public Service Reform and Development Secretariat), Ministry of Local Government (responsible for City Council health services), Public Service Commission, Ministry of Education, Science and Technology, and other relevant ministries; the six parastatal organizations (state corporations) under MOH that are governed by a Board of Management; regulatory bodies (like Pharmacy and Poison Board, the Medical Practitioner and Dentist Board) and various other professional associations.

3.2 Management And Coordination

3.2.1 Introduction

Following the signing of the National Accord and Reconciliation Act, and as part of Government's re-organisation process, the Ministry of Health split into two entities: the Ministry of Public Health and Sanitation (MOPHS) and the Ministry of Medical Services (MOMS). Their respective roles and functions are stipulated in the presidential circular No.1/2008 which gives the mandate for Reproductive Health to MOPHS. Thus the Division of Reproductive Health (DRH) which is responsible for the national Reproductive Health Programme[24] administratively falls under the Department of Family Health within MOPHS. According to the same circular the mandate of MOPHS encompasses primary care functions at the community, dispensary and health center (i.e. Levels 1-3), while MOMS has mandate over hospitals (Levels 4-6). The implication of this for DRH is that the Division must work closely with MOMS considering that many RH interventions do require hospital level facilities, e.g. comprehensive emergency obstetric care (CEOC), care of survivors of gender based violence, and investigation and treatment of infertility and cancers of reproductive organs.

The DRH has several Technical Working Groups (TWGs) including the RH-ICC and at the provincial and district levels there are the "RH coordinators", which though not being official structures, but nevertheless are implementation monitoring and supervisory agencies used by DRH and PMOs.

3.2.2 Roles and Responsibilities

The following institutions have roles and responsibilities in the implementation of this Strategy:

- Ministry of Public Health and Sanitation
- Ministry of Medical Services
- Division of Reproductive Health
- Other relevant MOH divisions
- Other line ministries
- Stakeholder standing committees
- FBO, NGO and Private sectors
- Development Partners

[24] Adolescent Health has been moved to the Division of Child Health

- **Role of Ministry of Public Health and Sanitation**

The management of the reproductive programmes will be undertaken within the framework of the ongoing decentralisation in the Civil Service Reform Programme. The Ministry of Public Health and Sanitation through the Division of Reproductive Health (DRH) will be responsible for providing reproductive health services and co-ordinating all reproductive health activities being implemented by other line ministries, NGOs and private sector. The reforms and restructuring in the Ministry of Public Health and Sanitation will ensure transferring and increasing responsibility for planning and resource allocation to the districts and facilities in the periphery; strengthening provincial, district, and community levels; having more effective co-ordination of health services throughout the country; and, involving more stakeholders in programme design, planning and implementation. In this regard, the role of the Ministry of Public Health and Sanitation headquarters will be to oversee reproductive health policy formulation and development, strategic planning, setting standards and regulatory mechanisms, regulating and co-ordinating reproductive health training, co-ordinating donor activities, and ensuring adequate allocation of national reproductive health resources.

- **Role of Ministry of Medical Services**

The Ministry of Medical Services has key roles to play in the implementation of this Strategy through facilitation of the provision of hospital-based reproductive health services and coordination of training for human resources for health.

- **Division of Reproductive Health**

The responsibilities of the Division of Reproductive Health will include providing guidance to the implementation of the National Reproductive Health Programme, including monitoring of performance and assuring quality of services. In addition, the Division will provide leadership in RH policy development, standardise and review protocols, guidelines and procedures, and in ensuring these are adequately disseminated at all appropriate levels of care. Other responsibilities will be as follows:

- providing inputs and technical backstopping to lower levels of RH managers and service providers at provincial, district, and sub-district levels;
- advising Ministry of Public Health and Sanitation headquarters on all issues that require attention, for example, changing demands for contraceptive commodities, procurement and distribution;

- ensuring equitable distribution of reproductive health services throughout the country;
- assisting in curriculum development for basic and in-service training and provide technical support for implementation of RH programmes at all levels;
- guiding the prioritisation processes for reproductive health research agenda in the country and advocating for increased financial allocation for the research; and
- establishing an accessible national database of reproductive health research

The Provincial and District Health Management Teams

These will play a central role in supervising the planning and implementation of all reproductive health programmes and activities in the provinces and the districts. This will include: enforcement of reproductive health standards; setting reproductive health priorities; and, collaboration with other sectors, development partners, FBOs, NGOs and other partners in RH and related activities in their respective regions.

Other Relevant MOPHS Divisions

Since reproductive health services are part of the essential health packages, their management and implementation will involve other Ministry of Public Health and Sanitation Divisions providing relevant packages such as KEPI, HIV and AIDS and TB, IMCI, and malaria.

Roles of other Line Ministries

Addressing reproductive health issues requires a multi-sectoral approach hence several government ministries and agencies will be involved in the implementation of this Strategy. These ministries will collaborate with the Ministry of Public Health and Sanitation to plan and implement aspects of reproductive health relevant to their ministries. The Ministry of Public Health and Sanitation will encourage, and provide technical support, to these ministries to mainstream reproductive health issues in their core functions.

The following line ministries are envisaged to be actively involved, as indicated:

- The Office of the President- support advocacy initiatives for RH
- Ministry of Finance- Financial resources allocation
- Ministry of Home Affairs and National Heritage- RH issues for vulnerable groups
- Ministry of Gender, Sports, Culture and Social services- support the Gender component of the RH Programme

- Ministry of Justice and Constitutional Affairs and Reconciliation- legislation in support of RH issues
- Ministry of Planning and National Development and Vision 2030- Policy advocacy, resource mobilization, data/information
- Ministry of Education Science and Technology- implementation of ARH&D Policy and Research
- Ministry of Information and Broadcasting- IEC of RH messages, communication infrastructure
- Ministry of Water- Community and facility water supply
- Ministry of Agriculture- Food security
- Ministry of Roads- Road networks

Roles of FBOs, NGOs, CBOs and Private sector

Supplement government effort in the formulation, financing of reproductive and implementation of reproductive health projects. They are also expected to assist in the monitoring and evaluation of RH programme.

Role of Stakeholder Standing Committees

The central role of the various stakeholder-standing committees such as RH-ICC and RH Technical Working Group (TWG) will be to facilitate their greater participation and involvement in planning and implementation within the reproductive health programmes. They are expected to assist in the identification of critical problems and provision of solutions to all aspects including technical issues affecting the implementation of reproductive health programmes at all levels.

Role of Development Partners

Development Partners will be actively involved at the levels of priority setting, planning and financing, and monitoring and evaluation of reproductive health interventions under this Strategy. They will play these roles in their representation at the various RH Stakeholder Forums and Technical Working Groups.

Role of Communities, Households and Individuals

Communities will participate through the Health Facility Committees (HFC) and Village Health Committees (VHC) as well as through CHWs, in resource mobilisation, planning, and

monitoring and evaluation of RH services. Households and individuals will be encouraged to participate and contribute towards improvement of their own RH status.

- **Role of Training Institutions**

  Training Institutions are key to availability of human resources for health. The university-based medical and nursing schools, the Kenya Medical Training Colleges (KMTC) and the private and mission medical training hospitals will be expected to conform to the standardised national RH curriculum in addition to other national and international standards that contribute to delivery of high-quality RH care.

- **Role of Research Institutions**

  Research institutions will play a key role in providing researched evidence for the development of evidence-based reproductive health policies and interventions. These institutions include, among others, the Kenya Medical Research Institute (KEMRI); Population Studies and Research Institute (PSRI); Department of Obstetrics and Gynaecology, University of Nairobi; and Department of Reproductive Health, Moi University.

- **Role of Mass Media**

  The mass media will be expected to play a key role in advocacy and creation of public awareness on matters related to reproductive health in line with existing reproductive health communication strategy.

- **Roles of Other Stakeholders**

  Other stakeholders are expected to facilitate greater public participation and involvement in planning and implementation of reproductive health programmes. These other stakeholders include women's organisations, professional associations, regulatory bodies and political parties.

3.3 Reproductive Health Research

Among the principles (see 2.1 above) to guide the implementation of this Strategy are the adoption of evidence-based practices and application of appropriate and cost-effective technologies. Research is a powerful tool for providing evidence-based information for standards setting and audit. The DRH has a National Reproductive Health Agenda, and has produced an Annotated Bibliography on Research. The goal of the National Research Programme is to enhance operational and other researches for evidence based decision-making, planning and programme interventions

OBJECTIVE: *To promote operational and other researches for evidence based decision making, planning and programme interventions.*

OUTPUT 1: *Increased availability of research information for evidence based decision making, planning and programme interventions.*

STRATEGY 1: Increase Access to Research Information by Creating a Resource Centre at DRH

Key Activities:

1. Establish a resource centre at DRH which is accessible to RH researchers and programme managers
2. Ensure ongoing updating of the Annotated Bibliography
3. Promote evidence based decision making, planning and programme interventions

STRATEGY 2: Encourage and Support Research on Priority RH Issues

Key Activities:

1. Advocacy towards funding for RH research from GOK, development partners, private sector, etc
2. Support mechanisms for sharing of research information and dissemination of RH research results e.g. conferences, publications, etc

3.4 Monitoring and Evaluation

Monitoring and evaluation (M&E) is the measurement and assessment of progress towards and achievement of expected results. The M&E system will be expected to promote evidence-based decision making at all levels involving several stakeholders. Therefore the M&E system is expected to meet information needs of various stakeholders at all levels. It is, therefore, imperative that the developed system should:

- encourage efficient use of data and resources and avoid duplication of efforts;
- ensure data generated by the M&E system serve the needs of many constituents;
- encourage communication between different groups involved in the national as well as sub national response.

In addition to meeting the information needs of the various stakeholders, the M&E system for this strategy must fit within the national monitoring and evaluation system. The Division of Reproductive Health in partnership with other implementing partners, will therefore, define and develop further, the scope and focus of monitoring and evaluation framework and plans. This section describes in general terms the core components of the national monitoring and evaluation of the strategy.

Institutional Framework and Implementation Mechanisms

The implementation of the M&E strategy will entail DRH seeking close collaboration with a wide range of partners within the government, civil society and the donor community as each fulfils its roles and responsibilities. The successful implementation of the M&E system will depend on the coordinated action of the Ministry of Public health and Sanitation, Ministry of Medical Services Health (MOH), Ministry of Planning and National Development and Vision 2030, (particularly the Kenya National Bureau of Statistics and the National Coordinating Agency for Population and Development) and the Ministry of Gender, Culture and Social Services. The Division of Reproductive Health, as the coordinating body, will be responsible for the overall coordination of the M&E programme. Some of the suggested outcome and impact indicators for the strategy are outlined in the annex. It will be expected that the implementing agencies develop further their own frameworks and plans to monitor the strategies and activities they will be implementing.

National Programme for Monitoring and Evaluation

The implementation of the strategy will be monitored periodically at all levels. Standardized formats that ensure continuous and harmonized assessment will be developed and used for routine monitoring. An integrated Monitoring and Evaluation Plan will be developed with clearly defined indicators for programme progress monitoring and evaluation. This M&E Plan will prescribe the frequency of the different monitoring activities at each level of interventions; identify the responsible actors for each respective activity and core information products for the different audiences. In addition, the M&E Plan will further specify the feedback systems. The M&E mechanisms will also include, where necessary, commissioned studies, special surveys, and reviews. The overall mechanism for monitoring and evaluation will be further elaborated within the annual planning documents.

Data collection and management: Strategies for data collection, analysis and management will be developed and included in the monitoring and evaluation plans. All implementing partners will be expected to collect information on process indicators relevant to the activities they implement. It is expected that this information will be reported as per the time schedule and in a format as provided in the tools, which will be standardized for purposes of uniformity in data capture, analysis and

management. Levels of programme performance will determine responsibility for data collection, in which case methods of data collection may vary according to the type of indicators and data needs.

The implementing partners may undertake studies on particular themes for purposes of establishing benchmarks and targets to be achieved. Such studies are important in determining the different information needs, reviewing policies and programmes and also for determining best practices and lessons learnt. However, there are circumstances where there will be need for ad hoc information that may not have been planned for.

Evaluation: Evaluation is an important component of any programme implementation and management. For effective evaluation to take place adequate planning is essential and every aspect of evaluation will be indicated and described in the monitoring and evaluation plans. There will be need for baseline, mid-term and end-term evaluations to assess the effectiveness of the strategy. These evaluations will inform and guide implementation and review of the strategy by various coordination committees and agencies. The evaluation strategy will pay particular attention to linkages with other national monitoring and evaluation systems to ensure harmonization of information. In particular, efforts will be made to ascertain that evaluation activities are harmonized with those of the National Monitoring and Evaluation Division in the Ministry of Planning, National Development and Vision 2030.

Outputs of the M&E system: Details of the frequency of production of information and reporting are expected to be included in the Monitoring and Evaluation plans. However, key information products will include annual progress reports, in-depth analytical reports utilizing data generated from the M&E system, and/or commissioned researches and other evaluations relevant to this strategy.

OBJECTIVE:	*To generate information that is used in evidence-based decision making and planning to improve the reproductive health of Kenyans.*
OUTPUT:	*Functional National Reproductive Health M&E systems implemented at all levels.*

STRATEGY: Establish Mechanisms for Implementation of the National Reproductive Health M&E Systems at all Levels

Key Activities:

- Build capacity of staff to ensure implementation of M&E systems at all levels
- Review regularly the M&E plans

CHAPTER 4

Resources For Reproductive Health Service Delivery

4.1 Introduction

The availability of adequate resources is critical to efficient and effective implementation of the integrated RH services. A number of government policy documents still indicate that the health sector is still under-funded, however modest improvements in budgetary allocations in recent years has been made. To address the resource gap, substantial financial and non-financial resources are required to support the implementation of RH interventions. This chapter identifies various sources of financial and non-financial resources and different ways of maximising use of the available resources. However, one of the core activities that will be made is to estimate the cost of providing comprehensive RH services at all levels.

4.2 FINANCIAL RESOURCES

Sources of funds for the Health Sector derive from GOK (through taxes), development partners (external aid and borrowing), households and individuals (through out-of pocket contributions and pre-payment schemes), and employers (though contribution to cover cost of care of their employees).

Recurrent and development funding for health services has increased from 7 percent in 2003/2004, to 7.9 per cent in 2006/07. The actual government expenditures on health increased from Kshs 16 billion (2003/04), to Kshs 27 billion in 2006/07 and further, to an estimated Kshs. 32 billion in 2007/08[25]. The per capita expenditure on health also rose from USD 6.4 in 2003/04, to USD 10.9 in 2006/07. However, the health budget allocation continues to be skewed in favour of tertiary and secondary care facilities (Levels 5 and above), which absorb 70% of the health expenditure. For instance, in 2006/07, curative services accounted for 52 per cent of the recurrent expenditure, while preventive and promotive care accounted for 5 per cent.

The Health Sector's expenditure accounts for 9 per cent of the total government expenditure, constituting 1.7 per cent of the GDP, and USD 10.9 per capita. However, this amount remains inadequate when compared with the WHO recommendation that developing countries spend an average of USD 34 per capita on health care, and the 15% target set by the Abuja Declaration of African heads of state in 2000.

[25]Ministry of Public Health and Sanitation Strategic Plan 2008-2012

Under-financing of the Health Sector remains a pervasive challenge for health service delivery, considering that it reduces the health sector's ability to ensure an adequate level of service provision to the population. The three options for health funding in the public sector are tax revenue, cost-sharing and insurance. The revenue from the cost-sharing programme has continued to grow in absolute terms and as a percentage of the recurrent government budget. In 2003/04, cost sharing contributed over 8% of the recurrent expenditure and about 21% of the non-wage recurrent budget of the MOH. However, against the background of worsening poverty situation in the country and limitations in implementing the waivers and exemptions systems, cost-sharing has become a barrier to service utilization by the poor. In response, the MOH replaced its cost-sharing policy at Levels 2 and 3 with the "10/20 policy". In addition, charges for RH and child health services at those levels have been abolished. Other pro-poor plans include the eventual implementation of the National Social Health Insurance Bill of 2004, and introduction of other pre-payment arrangements including voucher schemes, e.g. the Output Based Assistance (OBA) Project (2005-2011). In terms of policy health sector financing will take into consideration the important differences in regional health indicators in Kenya, such as the geographical disparities in RH indicators depicted in the 2003 KDHS. Other measures proposed in NHSSP II that will be undertaken towards improved and equitable financing of the health sector include the following:

- Improve resource allocation, utilization and accountability of funds to attract additional funding.
- Rationalize resource allocation to services with significant impact.
- Negotiate with Treasury and advocate for increased resource allocation.
- Mobilize resources from development partners and other agencies.
- Prepare the phased introduction of the planned National Social Health Insurance Fund (NSHIF) and develop appropriate regulatory and policy tools.
- Diversify resources, for example by initiating prepayment schemes to support cost recovery systems in both the formal and the informal sectors (e.g. OBA voucher scheme).
- Shift resource allocations from higher levels of service delivery (hospitals) to lower levels (health centres and dispensaries). This will include the introduction of a system to channel funds directly to health sector facilities at Levels 2 and 3 through the Health Sector Services Fund (HSSF)[26],
- Shift resources from relatively well served areas to areas of extreme poverty (poverty mapping) like North Eastern Province, Nyanza Province, and the dry (and poor) northern

[26](The Government Financial Management (Health Sector Services Fund) (amendment) Regulations, 2008)

parts of the country. Similarly, shift resources to arid areas and to areas with pastoralist populations and to urban slums in major cities.

- Elaborate and implement mechanisms of common fund arrangements.

4.3 Human Resources

The human resources that are needed for effective implementation of KEPH are rationalized in Norms and Standards for Health Service Delivery (2006) which defined the need for the different levels of the health care system in order to ensure an adequate and appropriate work force for the workload. The norms for human resources for health (HRH) were derived according to expected types and cadres of staff, the expected standards with regard to service delivery for the different staff cadres at each level, and the numbers of the different identified staff cadres, needed at every level of care.

Availability of skilled health workers, in adequate numbers, is key to achieving improved service quality and responsiveness in reproductive health service delivery. The MOPHS Strategic Plan 2008-2012 has recognised that in order to improve quality and responsiveness there must be adequate health workers at Levels 1, 2 and 3 through reduction of the staff vacancy rate by 40% between 2008-2012. In addition, training (capacity building) will be intensified during the plan period so as to ensure that by 2012, every health worker receives at least a 5-day training every year, as is the policy.

Staff rationalization has been worked out as follows:

- Nursing staff: an estimate of one RCN for each 5,000 population (i.e. two at each level 2 facility). This is to be modified for higher levels according to the functional requirements of the particular level. Nursing staff will provide the backbone of first contact services at the outpatients in Level 2 (e.g. ANC, FP, immunization, etc) as well as in-patient services in Level 3 facilities (e.g. BEOC). Trained midwives provide normal delivery services at all levels of care in Kenya, referring complications to Medical Officers and Specialists from Level 4 upwards.
- Clinical officers posted at Level 3 will provide the first referral level for outpatients, managing the clients as referred by the nurses. Subject to training Clinical officers will provide simple surgical procedures such as Post-Abortion Care and manual removal of placenta.
- Medical Officers are posted from Level 4 upwards. The Medical Officer at Level 4 they receives referrals from nurses and clinical officers at lower levels, and should handle most of the RH services at that level. Complications and cases requiring more specialized attention are referred to specialists.

- Level 4 facilities are expected over time to have a complement of specialties in Medicine, Surgery, Obstetrics and Gynaecology, and Paediatrics. In this case a Level 4 facility will be capable of providing almost all RH services, except for complex investigations and treatments requiring a higher level of care, e.g. advanced treatment of infertility and cancers of reproductive organs.
- Level 5 facilities will have more Medical specialists posted there in order to ensure they provide specialized care not only at this level, but also operate outreach visits to Level 4 facilities in their catchment area; they should make at least 1 outreach per month in each Level 4 facility. Such visits will provide more specialized care to patients in Level 4 facilities, as well as creating opportunity for on-the-job training of the Medical Officers towards improvement of their skills.

ANNEX 1

Indicators for Impact and Outcome Monitoring and Evalaution

Maternal and Newborn Health

OBJECTIVE: *To reduce rates of maternal, perinatal and neonatal morbidity and mortality in Kenya.*

RESULT LEVEL	INDICATOR	MEASUREMENT	DATA SOURCE	TARGET(S)
Impact	Maternal mortality ratio	Deaths per 100,000 live births	DHS	147 by 2015
	Perinatal mortality rate	(# of still births +# early neonatal neonatal deaths) divided by (Total # of still births +live births) per 1000	DHS	
	Neonatal mortality rate	# of neonatal deaths per 1000 live births	DHS	
Increased 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				
	skilled care during delivery	Percent pregnant women using skilled care during delivery	DHS	90% by 2015
	Pregnant women making recommended ANC visits	Percent pregnant women making recommended ANC visits	DHS	80% by 2015
		Caesarean sections as percentage of all live births		
Increased access to quality Maternal and Neonatal Health services at all levels				
	Met need for essential obstetric care	Proportion of women with major obstetric complication treated at EOC facilities disaggregated by region		
	Emergency obstetric care	No of Facilities providing BOEC per 1000 population	KSPA	100% by 2015
	Comprehensive Emergency Obstetric Care facility	No of Facilities providing COEC per 1000 population		70% by 2010 (Level 4 to 6)
		Average distance to the nearest BOEC facility		
	Case review audits	# of facilities providing case review/ audits into maternal deaths/near miss	Facility reports	
		Percentage of facilities with communication and transport for referrals disaggregated by geographical region	KSPA	

Family Planning

OBJECTIVE: *To reduce unmet need for family planning, unplanned births as well as socio-economic disparities in Contraceptive Prevalence Rate*

RESULT LEVEL	INDICATOR	MEASUREMENT	DATA SOURCE	TARGET(S)
Impact	Total fertility rate			Reduced to 2.1 by 2015
	Wanted total fertility rate			
Improved Policy environment for the delivery of family planning services				
Outcome				
	Resources available for family planning by source			
Increased availability of family planning services				
	Percent of facilities with full range of family planning services			Facilities with full range of family planning services increased from 60 percent of health care facilities to 80 percent in 2010 to 100 percent in 2015
Impact	Number of contraceptive users by method (method mix) disaggregated by age and geographical area			
	# of acceptors new to modern contraceptive methods (first time users) disaggregated by age and geographical area			
Increased utilization of family planning services				
	Contraceptive prevalence rate		DHS	CPR among the poor increased by 20 percentage points form 12 % by 2015
	Unmet need for contraception			Unmet need reduced by 75% by 2015 from the current 24%

Adolescents and Youth

OBJECTIVE: *To improve the sexual and reproductive health of Kenya's Adolescents and youth*

RESULT LEVEL	INDICATOR	MEASUREMENT	DATA SOURCE	TARGET(S)
Impact	HIV prevalence among those aged 15-24 disaggregated by sex		Routine	
Legal and policy environment for effective implementation of adolescent and youth reproductive health programmes improved				
	Number of implementing partners mainstreaming and integrating youth RH issues in their programmes		Survey	
Utilization of quality youth friendly RH services increased				
	Proportion of facilities providing YFS by geographical area		Master Facility List	
	Proportion of youth accessing youth friendly services		Routine	
	Number of staff trained in YFS		Training database	

Gender Issues, Sexual and Reproductive Rights

OBJECTIVE: *Promote gender equity and equality in decision making in matter of sexual and reproductive health and contribute to the elimination of harmful practices and gender-based violence within a multisectoral and legal framework*

RESULT LEVEL	INDICATOR	MEASUREMENT	DATA SOURCE	TARGET(S)
Outcome				
	1. Supportive policies on gender and reproductive rights index[27]		Routine	
	2. Health system responsiveness to gender and reproductive rights index			
	3. Percent of facilities by type that provide quality treatment and rehabilitative reproductive health services for individuals who experience gender-based violence and / or harmful		Master Facility List	
	4. Percent of male clients receiving RH services		Routine	

[27]Define an index to measure items in the policies that are supportive of gender and reproductive rights

HIV AND AIDS

OBJECTIVE: *To contribute to the reduction of HIV & AIDS burden and to improve reproductive health status of the infected and affected*

RESULT LEVEL	INDICATOR	MEASUREMENT	DATA SOURCE	TARGET(S)
Outcome				
	1. Percent of facilities where a given proportion of clients receive integrated services that meets the expected standards		Master Facility List or/ and CCC	
	2. Percent of clients receiving services at the integrated service delivery sites		Survey	

REPRODUCTIVE TRACT INFECTIONS (RTIS)

OBJECTIVE: *Reduce transmission of RTIs and improve access to RTI services within RH programmes.*

RESULT LEVEL	INDICATOR	MEASUREMENT	DATA SOURCE	TARGET(S)
Impact				
	Incidence of endogenous and iatrogenic reproductive tract infections		Routine	
	Prevalence of curable STIs		Survey	

INFERTILITY

OBJECTIVE: *To reduce the magnitude of infertility and increase access to proper investigation and quality management of infertile individuals and couples in Kenya.*

RESULT LEVEL	INDICATOR	MEASUREMENT	DATA SOURCE	TARGET(S)
	Reduced prevalence of infertility		Survey	

Cancers of Reproductive Organs

OBJECTIVE: *Reduced morbidity and mortality associated with the common cancers of the reproductive organs in men and women.*

RESULT LEVEL	INDICATOR	MEASUREMENT	DATA SOURCE	TARGET(S)
	Reduced case fatality rate from cancers of reproductive organs		Routine	
	# of Facilities offering RT cancers screening		Master Facility List	
	# of women aged 30-49 years (high-risk) screened annually		Survey	
	#referral facilities for basic management of cancer patients established and maintained		Master Facility List	

Reproductive Health of Elderly Persons

OBJECTIVE: *To address RH- related needs of the elderly*

RESULT LEVEL	INDICATOR	MEASUREMENT	DATA SOURCE	TARGET(S)
	proportion of health facilities providing elderly-friendly services		Master Facility List	
	proportion of health facilities providing integrated services for elderly- e.g. cancer screening, health monitoring		Master Facility List	

N/B – Most of the indicators require baseline data to enable the setting of the targets

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