Purpose and process

It has been almost three years since the Commission on Information and Accountability for Women’s and Children’s Health (CoIA) delivered its ten recommendations to strengthen accountability for resources and results with special attention to women and children. Multi-stakeholder processes at regional and country level have resulted in country self-assessments and the translation of the recommendations into a country accountability roadmap which defines priority areas for strengthening birth and death registration, monitoring of results, use of eHealth, tracking resources, maternal death surveillance and response, national mechanisms for review and accountability, and advocacy/action.

The implementation of priority activities in Kenya’s Country Accountability Framework (CAF) is now well underway. At this midpoint in implementation of the activities, the purpose of this assessment, conducted by the World Health Organization (WHO) in close collaboration with national stakeholders and partners, is to review the progress to date, identify issues, challenges and lessons learnt and identify priorities for further work. The review contributes to an overall review conducted by Every Woman Every Child of the office of the UN Secretary-General.

The review was conducted by WHO and Family Care International and included a desk review (country self-assessment, accountability roadmap, country progress report, documents on monitoring and reviews) and a country visit by staff of both agencies. A workshop was held that brought together representatives working on the CAF; additional stakeholders were interviewed during the country visit (list available on request). Key discussion points during the interviews and the stakeholder meeting included:

- Progress on implementation of country roadmap and its elements;
- Progress in the last two years in terms of monitoring, review and action through domestic or external investments;
- Relevance of the CAF and new challenges;
- Alignment of partners with the national platform for information and accountability.

In Kenya, the major stakeholder groups include representatives from the Ministry of Health (RMNCAH, HIS/M&E, HMIS, national health accounts, health sector reviews), national statistical offices, those responsible for civil registration and vital statistics (CRVS), civil society representatives, media, in-country development partners and H4+ agencies.

Background and country context

There are indications of on-going improvements in the health status of infants and children under five years of age in Kenya. According to the latest Demographic Health Survey (DHS) 2009, from 2003 to 2008-09, infant mortality decreased from 77 to 52 per 1,000 live births, and under-5 mortality decreased from 115 to 74 per 1,000 live births. Maternal and neonatal mortality, on the other hand, has stagnated since 1993. As a result, the country is not on track to meet its health Millennium Development Goals (MDG) targets (4, 5 and 6). Furthermore, there are wide disparities in health status across the country, closely linked to underlying socio-economic, gender and geographical disparities.

In Kenya there has been great progress since 1990 in reducing child and infant mortality; however, maternal and neonatal mortality rates have declined at a much slower pace.

on the other hand, has shown some improvements, although morbidity remains high (e.g. reported diarrhoea episodes are still around 49%, up from 41% in 1993).  

In 2010, a new Constitution was signed into law that introduced a more decentralised (or devolved) political system. Instead of districts and provinces, Kenya now has 47 counties, each with its own assembly, governor and senators, elected in early 2013. Many of the government functions previously managed at the national level are now managed at the county level, including the development of annual budgets and work plans, and oversight of government employees. The devolution of certain government functions is an on-going process and there have been challenges in ensuring that the counties have the capacity to manage their new functions. During this transition, identifying the mechanisms for holding the government accountable, either at the national or county level, remains challenging. Although the policy documents state what each branch of government is expected to do, some of these functions are still in the process of being transferred.

High-level political commitment for RMNCH

In recent years, the Government of Kenya has endorsed a range of global initiatives for accelerating action to improve the health and well-being of women and children, including the Global Strategy for Women’s and Children’s Health, and has made specific commitments to achieve them. Kenya is in the process of finalizing an RMNCH implementation plan that brings together various aspects of RMNCH included in the national health plan.

At the regional level, Kenya has signed the Maputo Plan of Action for the Operationalization of the Continental Policy Framework for Sexual and Reproductive Health and Rights, The Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa (better known as the Maputo Protocol), and the Campaign on Accelerated Reduction of Maternal Mortality in Africa, among others.

Nationally, Kenya has a sufficient and strong legal and policy framework that governs RMNCH; the country has a number of supportive policies. In particular, the Constitution includes an explicit recognition of the right to health. The new government has announced support for women’s health and in June 2013, the President announced free maternity services including post-natal care across all government hospitals in Kenya. Additionally, the First Lady of Kenya launched the Beyond Zero campaign in December 2013, whose goal is to accelerate progress in HIV control and the promotion of maternal, newborn and child health.

As part of the Global Strategy for Women’s and Children’s Health, the previous Government of Kenya committed to the following objectives:

- recruit and deploy an additional 20,000 primary health care workers;
- expand community health care and decentralize resources;
- establish and operate 210 primary health care facilities of excellent quality to provide maternal and child health services to an additional 1.5 million women and 1.5 million children.

During a multi-country workshop on strengthening accountability for women’s and children’s health held in Tanzania in February 2012, Kenya’s delegation completed a self-assessment of the current situation on accountability for health, and developed a draft roadmap to implement the accountability framework according to country needs and priorities.

In February 2013, Kenya held a two-day national workshop in Nairobi with a total of 62 participants from the Government, development partners, and civil society organizations.

The high level of political commitment is a testament that this is an opportune moment for RMNCH and for the implementation of the Country Accountability Framework in Kenya. The CAF implementation should leverage the current positive political climate for RMNCH to drive forward its goals.

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2 Kenya National Health Sector Strategic and Investment Plan (KHSSP) 2013-2017
Progress and challenges

Accountability Framework well disseminated in all 47 Counties

The national accountability workshop, at which stakeholders validated the CAF, was followed by a similar process at county level. County meetings, held in September and October 2013 and attended by County Health Management Teams and Health Executives, line ministries (Education, Civil registration), CSOs, and media, resulted in the development of county plans on the CAF. There were five meetings that covered all 47 counties where participants were oriented and made plans focusing on two or three priority areas identified in the CAF for their county.

Responsibility for the implementation and oversight of the work plans remains to be clarified, and lack of funding has been a challenge.

Accountability framework brings together different partners that normally do not collaborate: A common theme was that the accountability framework brings together different departments within government that would not normally collaborate. According to one Ministry of Health (MoH) official, “It made people talk to each other. It has been a shift of paradigm. When you sit more with people, you learn to know their business.”

One of the aims of the CoIA recommendations is to build on existing structures and strengthen coordination among donors and government. The National eHealth/mHealth Forum, which brings together researchers, the private sector, government, donors and civil society, is an example of how the accountability work in Kenya has led to stronger collaboration and helped to bring partner efforts in line with government priorities.

Other examples include a forthcoming memorandum of understanding between the Ministry of the Interior and the Ministry of Health that will strengthen CRVS by leveraging the success of the vaccination programme. The increased focus on newborn health (stimulated through the CoIA framework) led to intense discussions between the units for Reproductive and Maternal Health and for Child Health within the Division of Family Health, as well as the Bureau of Statistics, over who should take the
lead responsibility for newborn health. Rather than duplicate efforts, the two departments are now collaborating and working well together to improve the situation for newborns.

**Distribution of catalytic funding:** As shown in the figure below, Kenya distributed the US$ 250,000 in catalytic funding fairly evenly across the various work streams, with the greatest proportion attributed to maternal death surveillance and response (MDSR).

![Figure 2: Distribution of US$ 250,000 of catalytic funding in Kenya (% distribution)](image)

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Advocacy &amp; Action</td>
<td>20%</td>
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<td>Reviews</td>
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<td>Ehealth &amp; Innovation</td>
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<tr>
<td>Resource Tracking</td>
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**Good political climate for modernizing the Civil Registration and Vital Statistics (CRVS) system**

There is a good political climate for civil registration in Kenya, and it has been recognized that a working CRVS system may replace future population censuses. There is a high degree of partner coordination for CRVS through a well-functioning mechanism. CRVS was a neglected area until the first CRVS Stakeholder Conference in late 2011, which attracted partner interest. Now there is active stakeholder participation in CRVS, providing technical and financial support to the Government. Partners support a common strategy that identifies key areas of focus; they bring their expertise and other resources to the table, and tasks are distributed among them.

The Civil Registration System is being updated, with the objective of producing a digitized register of all Kenyan residents by the end of 2014 or early 2015. Among other advantages, this will allow citizens to obtain a birth certificate outside of the area where they were born. An extensive birth registration campaign is scheduled to complete the current register; late registration will be outlawed after the campaign and citizens who were not registered within three months of birth will be required to prove in court that they have the right to register.

The Department for Civil Registration will be organized as a semi-autonomous government agency, giving it more flexibility than if it were part of the regular government structure. It is important to note that registration services have not been through the same decentralization process as the health sector.

According to the national annual vital statistics report, the coverage rate is now 60%. Training in International Classification of Diseases (ICD-10) coding has been conducted, and Ministry of Health staff report that this has led to an increased quality of reporting on causes of death. Some of the planned training, specifically for pre-service training institutions, has not yet been conducted.

Despite progress, the quality of data remains an important challenge. One of the main challenges is the linkage of information on births, deaths and causes of death from Chiefs in the community and from health workers to registrar offices. This will require:

- the adoption of standard guidelines in ICD-10 training;
- sufficient resources to roll out the ICD-10 trainings and verbal autopsy;
- registering deaths in the Civil Register;
- increased access to registration services.
**Maternal and Perinatal Death Surveillance and Review (MPDSR) revitalized through the Accountability Framework fostering strong partnership**

Through the accountability framework, MPDSR has been revitalized through a strong partnership between the Ministry of Health, DFID/Liverpool School of Tropical Medicine, UNICEF, UNFPA and WHO. The Government allocated US $40 000 of catalytic funding to this work stream. Both UNICEF and DFID (through the Liverpool School of Tropical Medicine) provided financial and technical support to the training.

Management teams and more than 1,000 health workers representing all 47 counties have been trained using a standardized training package that includes perinatal death reviews and near-misses. A phased approach is being used to focus first on the high-volume health facilities (hospitals); it is expected that selected health facilities in all 47 counties will be reached by the end of 2014.

A review of the system is being conducted in 15 counties that are assumed to be representative of the country. Data will inform national-level dialogue and advocacy.

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**Sub-county work to advance MPDSR**

36 out of 290 sub-counties are implementing mechanisms to review and respond to maternal deaths. Some of the results include:

- Higher motivation of staff, with the recognition that the review and response mechanism is about improving quality rather than being punitive;
- Health facility personnel more open to raising issues of quality with the management team and expecting to be supported; this should lead to less under-reporting of maternal deaths;
- Regular meetings of health facility management teams to review maternal deaths/near-misses and to come up with responses. This has led to suggestions for facility improvements including the availability of supplies, IV fluids, emergency preparedness for eclampsia, and integrating identified issues into Continuous Medical Education training;
- MPDSR is integrated into the Emergency Obstetric and Newborn Care (EmONC) training conducted by Liverpool School of Tropical Medicine;
- Audit form is included and uploaded in the District Health Information System (DHIS);
- Kenya weekly epidemiological bulletin now includes maternal death reporting. The bulletin is based on the Integrated Disease Surveillance and Response (IDSr) reporting system. 63% of facilities reported information through IDSR in mid-April 2013 (district average).

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**Scaling up is a challenge:** There is the intention to establish review teams at county and sub-county level in order to provide support to smaller health facilities. These review teams will also analyse aggregate data on maternal mortality to identify areas that need to be addressed. Management teams at the sub-county and county levels need strengthening in order to review county level data and institutionalize the response mechanism that is part of MPDSR. Lack of adequate funding and support is a serious obstacle.

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**Monitoring of results and use of 11 core indicators**

**Health Management Information System (HMIS):** The HMIS requires strengthening in order to improve data gaps, particularly from communities. Generally the collected information is neither analysed nor used for administrative or decision-making purposes.

Several parallel reporting systems exist, run by specific programmes. For example, facilities report more frequently to the HIV and TB programmes; this reporting is often a prerequisite for receiving necessary commodities. There are plans to integrate reporting on HIV with the HIMS.

The system for Integrated Disease Surveillance and Response (IDSr) reports some information through the HMIS, and hence contributes to increasing the information available through the DHIS2-based HMIS. IDSr does, however, also has a separate reporting system.

A comprehensive data quality assessment of HMIS that includes record review, conducted in at least three health facilities per sub-county, revealed substantial weaknesses in data reported through
the HMIS. For example, information in health facility registers or other sources was significantly different from information available through the HMIS.

**Services in health facilities:** The Service Availability and Readiness Assessment Mapping (SARAM) was conducted in mid-2013. All health facilities in Kenya were assessed.

**Measuring coverage in the population:** A standard Demographic and Health Survey is being implemented, with fieldwork ending in October 2014. The last survey of this kind was done in 2008/09, and a Multiple Indicator Cluster Survey was conducted in 2013.

**National eHealth/mHealth Forum a good coordination platform with broad partnership; eHealth Strategy needs revision**

The National eHealth/mHealth Forum is a technical working group that was established in February 2013 as a result of the accountability framework. This Forum is a successful partnership model, led by the Division of Family Health in the MoH and including representation from the private sector, government, NGOs, academic institutions, bilateral partners and the national tertiary teaching hospital. The group meets quarterly and has the clear tasks of reducing duplication, increasing sustainability and scaling up eHealth; it also serves to align projects with government priorities and policies.

The Forum is working to get an overview of eHealth projects, and has so far mapped 25. This may be only the tip of the iceberg, as there is reason to believe the number is much higher. The question remains as to the extent to which the Forum can achieve the needed coordination, and how it can contribute to the appropriate revision of the national eHealth strategy. The eHealth strategy, valid from 2011-17, is considered to be an outdated document that will be revised by the Forum and linked to the overall Government Plan for ICT.

**Joint Annual Health Strategic Plan Review process stalled due to Ministry of Health devolution**

Kenya has a National Health Sector Strategic Plan (July 2013 – June 2017). Over the last several years, the process of involving all units of the MoH in developing strategies and plans, as well as in reviewing results, has been improving. After each annual review meeting (Annual Health Summit), the relevant reports are made available online. The last Health Summit, scheduled for November 2013, was cancelled due to restructuring within the MoH and subsequent strikes by MoH staff.

**CSO engagement and coordination among CSOs need strengthening**

The accountability framework in Kenya has had limited CSO engagement. The CSOs that were invited to participate were primarily the larger cooperating agencies that provide technical assistance and funding to the MoH. Civil society is not always considered to be a partner of the government, and their comparative advantage and role in promoting accountability is not recognized. The perceived lack of collaboration between CSOs principally involved in advocacy and accountability seems to stem from a lack of mutual trust and collaboration between civil society and government. Decentralization offers an opportunity for advocacy at the county level, but there is a lack of relevant capacity among local CSOs; at the same time there may be a lack of information available to CSOs at the county level about various advocacy and accountability opportunities to track government commitments. The county plans that were developed through the CAF workshops need to be more widely shared to ensure that the CAF process can be moved forward in the newly devolved context. It may be useful to provide examples of how the CAF process has been made open for review by and engagement of additional partners and stakeholders at the national and devolved levels, and this broader participation should be fostered.
Advocacy efforts are hampered by competing priorities

In Kenya, there are many competing health priorities with respect to CSO engagement and advocacy. One of the advocacy activities in the CAF was a Country Countdown event, which would include the development of county health profiles/scorecards that may serve as key advocacy and accountability tools. However, there are currently several different scorecard methodologies under discussion or underway: county-level profiles developed by the Health Policy Project that provide a snapshot of selected health indicators, including for RMNCH; African Leaders Malaria Alliance (ALMA) Scorecards which primarily focus on malaria, but would include tracer metrics for maternal and child health; and the Amref Functionality Scorecards to track and manage community health workers through community units.

The catalytic funds allocated for advocacy activities (as with the other areas within the CAF) went to the Ministry of Health. No additional information was provided about the funding allocation or detailed budget process for allocation of CAF funds between streams.

There are numerous opportunities for improved advocacy efforts, including greater involvement of CSOs and ensuring coordination of efforts, both within the advocacy thematic group and in partnership with other thematic groups. This would include conducting a comprehensive mapping of CSOs and professional health associations and private sector providers. To ensure greater coordination of efforts, it has been suggested that organizations should work through existing MoH-led Technical Working Groups and Inter-Agency Coordination Committees. There are additional ongoing advocacy efforts that the CAF process should link up with, including the First Lady’s Beyond Zero Campaign. Other potential RMNCH champions, such as the County First-Ladies, should also be engaged.

Accountability seminar for Parliamentarians: After having participated in a multi-country seminar to identify actions that Parliaments can take to promote accountability for women’s and children’s health, Kenyan MPs have committed to a range of actions aimed at improving RMNCH. At a meeting in Nairobi in November 2013 supported by the Inter-Parliamentary Union (IPU), parliamentarians agreed on the need to build and enable a protective legislative framework with appropriate financing that addresses this issue effectively. Amongst the most urgent actions are working to push the national health budget up to 15 per cent of the State budget, finalizing a bill on maternal health and working towards developing a common legal instrument to ensure universal health coverage. MPs identified a series of pressing challenges relating to maternal and child health, including contradictions in legislation, labour-related laws with negative health implications, lack of clear definition on the sexual and reproductive health rights of women and girls as well as inadequate legal planning, budgeting, monitoring and evaluation.

To date, there is no evidence that the efforts of parliamentarians have been directly linked with the CAF activities. There should be efforts to work more closely with parliamentarians, and with the media, who have shown a willingness to highlight RMNCH news stories, as well as stories related to devolution and budget accountability.

Resource Tracking

Kenya has a history of tracking health expenditures. The MoH has been sensitized on the Systems of Health Accounts 2011 methodology (SHA 2011); data collection has started and is expected to be completed by the end of 2014. The Government plans to establish an official steering committee to support development and institutionalize health accounts production activities. It also plans to revamp the health financing technical working group to advocate and coordinate relevant issues.

It will be important for Kenya to hold orientation workshops for government, development partners, business representatives and civil society on the national health accounts. Kenya participated in a regional budget transparency workshop targeted to help civil society, media and parliamentarians better understand national budget information.
Examples of national (sub-national) accountability

Kenya has some interesting examples of national and sub-national accountability policies.

- **Health Summits.** The next health summit is planned for June 2014.
- **County level stakeholder forums.** These are currently being held at county level.
- **Social accountability.** The MoH is developing guidelines on social accountability, which supports active community participation in the oversight of health facilities. The draft guidelines suggest accountability methodologies (budget hearings, citizens’ report cards, service charters, etc.), as well as how social accountability should be rolled out at the county level. Community participation in accountability should be possible through Health Facility Management Committees, but these committees are not always in place or functional.
- **Budget transparency.** The budget is subjected to an annual public hearing process, where citizens are given an opportunity to provide views and inputs into the planned budget for the coming year. This is held in February before budgets are presented to parliament, to allow for these views to be incorporated into the priorities for the coming financial year.

Overall challenges and lessons learned

- The Kenyan Constitution devolution process stipulates that the national government focuses on policy development and strategic guidance, while the actual delivery of services is a function of country governments. The devolution process presents both an opportunity and a challenge.
  - It will provide increased local authority on health policy and direction; however, the process is not complete, and high staff turnover is causing instability.
  - It requires significant coordination amongst the various stakeholders and county health teams.
  - Information on spending and disaggregated county health budgets is not always available.
  - Structures are needed to improve communication to the counties.
  - Human resources for health are inadequate, particularly at the county level.

- Silos remain within the health sector. The resolution of this problem will require a high-level decisions and coordination.
  - Partners’/donors’ projects are not always aligned with government plans.
  - Coordination is needed among various global and national initiatives.
  - Parallel reporting systems are supported by different partners; there is some non-reporting, and a significant lack of capacity for analysis and use of data.

- There are multiple scorecard methodologies and approaches.

Moving Forward

The national Country Accountability Framework has been instrumental for Kenya. It has catalyzed a number of actions that contribute to women’s and children’s health. Despite challenges, Kenya has moved forward in implementing its CAF with many activities accomplished and in progress.

The key areas of action are CRVS and MPDSR thanks to the cooperation between the Kenyan government and partners. Future work should build on these early successes and leverage the existing political commitment.

The accountability work has been a platform for bringing together different sectors. This should be strengthened through engagement with more civil society actors as well as support to strengthen existing coordination mechanisms.

As the devolution process evolves and structures become clear, it is hoped that the Action Plans developed through the county accountability workshops will pick up momentum. It would be important to engage advocacy efforts to bring about a higher level of attention and political commitment to the accountability frameworks in order to help attract other partners, including civil society, as well as bilateral support to leverage additional funds for the various work streams.