Global Health Initiative

Kenya Strategy
2011-2014

In Partnership with the Government of Kenya

Revision: January 18, 2011

I. EXECUTIVE SUMMARY

Building upon five decades of strong partnership with Kenya, four cornerstone United States government (USG) agencies have designed a strategy aiming to address the principles of the USG Global Health Initiative (GHI) as outlined by President Barack Obama. The USG health investment in Kenya is one of the largest globally, and joint USG-Kenya bilateral priorities under the new GHI are carefully and closely aligned to maximize impact. They are designed to move the country towards a sustainably independent, healthy and thriving African future. In order to achieve this we have incorporated governance activities into the GHI strategy.

As GHI unfolds, so does a new Kenya. On August 4, 2010, the vast majority of Kenyans peacefully voted for a new constitution. Critical changes in the country's democratic governance structure include an independent judiciary, greater political accountability and new regional authorities. What this means for the health sector is still unclear, but Kenyans and the international community agree that the change will enable progress, growth and stability. Brilliantly timed, GHI implementation will be greatly shaped by –and will be in a position to influence- the hopeful signs of August 4.

All of the seven key principles outlined in GHI are relevant at this landmark time in Kenya's blossoming democracy. Each principle has its place, all fitting naturally into a single, robust, tightly integrated health plan.

Under GHI, USG-Kenya partnership will aim to address the principles by:

- Intensifying USG-Kenya efforts and investment focus on **women and girls**, supporting the goal of reducing maternal, neonatal and child mortality in Kenya, where progress on Millennium Development Goals (MDGs) 4 and 5 lags far behind other sector successes;
- Intensifying USG-Kenya efforts to determine best integrated management and control strategies for **neglected tropical diseases** (NTDs);
- Working to **increase impact** through strategic efficiencies with the approximate annual $700 million in nation-wide USG health investments, and harmonizing priorities with other key stakeholders;
- **Leveraging non-USG health funding** to achieve national objectives, working with partners such as GAVI, GFATM, the Bill and Melinda Gates Foundation, as well as established bilateral and multilateral partners;

What is being proposed for GHI in Kenya?

To achieve GHI goals, GHI Kenya proposes three priority areas:

1) Health systems strengthening
2) Integrated service provision
3) Demand creation

Through the implementation of these areas, GHI Kenya will:

- Intensify program integration across agencies and with host government and will impact and measure health outcomes related to maternal, neonatal and child health (MNCH).
- Accelerate impact and learning related to integrated management and control of selected neglected tropical diseases (NTDs) and their impact on morbidity and mortality.

In Kenya, this approach assumes that program efficiencies will be gained around the USG's extensive health portfolio.

- Beginning an exciting new phase of development assistance in Kenya, one that **invests in sound country-led plans** and reliably measures their associated performance outcomes-while focusing on good governance and accountability;
- Boosting Kenya's own capacity to deliver quality health services throughout the country by launching an ambitious five-year Sustainability Strategy to **strengthen health systems** and to achieve important health outcomes;
- Aligning USG's expectation of rigorous **monitoring and evaluation** with Kenya's growing and impressive leadership in this field, ultimately eliminating the need for costly parallel systems; and,
- Supporting all investment areas with locally respected, credible and rigorous **research and innovation** that provides Kenya with solid answers to relevant questions that will help achieve joint priorities.

II. BACKGROUND

The GHI Strategy in Kenya identifies three broad focus areas: (1) health systems strengthening; (2) integrated service provision; and (3) creating awareness to create demand for available services. Applying these broad areas will potentially have their greatest measurable health benefits in substantially reducing unacceptably high rates of: (1) maternal, neonatal and child mortality and (2) morbidity and mortality from neglected tropical diseases.

The strategy recognizes the opportunities that exist within USG programs to ensure more integrated planning and coordination without duplication of efforts. The strategy builds on the existing interagency governance system on which USG agencies have successfully planned, implemented and reported for many years. It seeks to utilize existing activities and platforms of each of the agencies to create efficient and functional cross-agency synergies.

Kenya's ability to deliver improved health services is inherently linked to progress on its broad-based political reform and economic growth agenda. Kenya is at a critical juncture; its new constitution contains new institutions and a more robust system of checks and balances to assure improved governance and fiscal accountability. In tandem with the implementation of the GHI strategy, USG will join and support the Government of Kenya (GOK) in its vigorous pursuit of improved governance to reduce corruption, boost business confidence, increase trade and investment, and support broad-based economic growth. Quality governance and investments are necessary to generating livelihood, especially for youth, and deliver economic growth that will make GHI sustainable as we move into the future. Kenya has the robust technical expertise to address health issues, but must translate this strength more consistently to advance and implement key political, economic and social reforms.

The GHI Strategy presents a Learning Agenda with a focus on reducing maternal, neonatal and child mortality and reducing morbidity and mortality from neglected tropical diseases (see Appendix 1). The focus of the Learning Agenda is the implementation of a comprehensive package of services in selected geographic areas, utilizing resources from USG agencies, the GOK and other development partners. The Learning Agenda will focus on five geographic areas: three areas where USG agencies are currently working at different levels of coverage and intensity and two areas

where intensified focused planning and programming will be implemented together. In these areas, we will utilize existing USG agency and country platforms and linkages with partners to implement a comprehensive cross-cutting evaluation exploring the effectiveness and feasibility of current and intensified integrated planning that cuts across policy, health systems and services.

While previous implementation by USG agencies has tended to be vertical, focusing on specific disease or program areas, the proposed strategy identifies areas of synergy and emphasizes cross-program and cross-agency integration.

The proposed Learning Agenda will be implemented within a context of country leadership and ownership. The strategy recognizes that the GOK prioritizes, and already has in place, policies and strategies for improving maternal, neonatal and child health and for reducing morbidity and mortality from neglected tropical diseases. This will form the basis for the integrated services which will utilize existing GOK health structures through investing in existing country plans.

III. MATERNAL, NEONATAL AND CHILD HEALTH

Maternal mortality levels in Kenya remain unacceptably high at 488 per 100,000 live births[1]. The United Nations estimated in 2005 that 1 in every 39 Kenyan women die in childbirth; while major progress has been made in reducing infant and child mortality rates, one in every 19 babies born in Kenya this year will die before their first birthday. 60% of these deaths will occur in the neonatal period. While poverty and high rates of HIV, TB, malaria and other infectious diseases provide underlying substantial challenges, the appalling mortality statistics implicate dysfunctional health systems as being the principal obstacle for addressing these challenges and preventing pre-mature mortality.

What will we do to improve MNCH health outcomes in Kenya?

Through health systems strengthening, integrated service delivery, and demand creation, GHI in Kenya is determined to strategically and intensively coordinate integrated programming and use all relevant and appropriate funding streams to produce a comprehensive public health effect for women, children and their families. GHI will leverage all potential funding sources (e.g. malaria, TB, HIV) to ensure that programs benefit the needs of women and girls. By combining effective program efforts at the facility/community level, GHI aims to boost MNCH performance and reduce mortality rates which have been at plateau for many years.

The Government of Kenya's March 2009 *National Road Map for Accelerating the Attainment of the MDGs Related to Maternal and Newborn Health in Kenya*[2] and the *Child Survival and Development Strategy 2008-15*[3] identified several barriers for program improvement, including: lack of recognition of danger signs in pregnancy; poor accessibility and low utilization of skilled attendance during pregnancy, child birth and postpartum period; limited access to essential and emergency obstetric care due to limited health provider competencies and inadequate staffing, equipment and supplies; socio-cultural barriers leading to delays in seeking care; and limited national commitment of resources for maternal and newborn health.

[1] Kenya National Bureau of Statistics and ICF Macro (2010). *2008-2009 Kenya Demographic Health Survey*.
[2] Ministry of Public Health and Sanitation and Ministry of Medical Services, GOK (2010). *National Roadmap for Accelerating the Attainment of the MDGs related to Maternal and Newborn Health in Kenya*.

Recognizing that the GOK cannot scale-up and implement all essential maternal, neonatal and child health (MNCH) interventions with currently available, limited resources, the *National Road Map for Accelerating the Attainment of the MDGs related to Maternal and Newborn Health*[1], the *Child Survival and Development Strategy 2008-15*[3] and the *National Health Sector Strategic Plan*[4] have each declared that improvement of health systems and promotion of high impact service provision interventions will require partnership between communities, health care providers, civil society, development partners, private sector, policy makers, leaders and government. This approach is consistent with GHI principles of country ownership and a whole-of-government approach, strengthening and leveraging partnerships and increasing impact through strategic coordination and integration.

Approach

To maintain and promote the health of young women, mothers, girls, infants and children, GHI Kenya will utilize existing resources and build upon a variety of agency programs to increase health systems strengthening, to integrate health service provision and to create demand for services. The strengthening of these three areas will facilitate the building of effective health systems which will deliver a package of high quality integrated maternal and child health interventions along a continuum of care from household to community to health facility. This will include: (1) improving the coverage and quality of services including skilled birth attendance and (2) specific health promotion for families, aimed at improving health seeking behavior. These interventions will contribute to safer pregnancy and deliveries. In addition, they will provide essential newborn, infancy and child care including immunizations for vaccine-preventable diseases; prevention, early diagnosis and treatment of childhood illnesses; and appropriate infant and young child nutrition to promote health, growth and development.

What would integration of services mean for mothers and children?

- One stop shopping offering services to mothers and children in the same place;
- Allows a mother/infant pair to receive routine HIV monitoring, malaria screening, and follow-up care with other services;
- Saves time and money for the patient as they travel fewer times for health services and spend less transit time for referrals.

Health Systems Strengthening

The renewed global attention to MNCH fits well in Kenya where government health ministries have prioritized and focused health programs on mothers and young children and have supported MNCH with appropriate policies and strategies. However, weaknesses of the health system such as human resource capacity, health facility infrastructure, supply chain systems, financial resources, national health management and information system and district level management negatively impact on efforts aimed at strengthening MNCH services. In response, the GOK has defined an economic stimulus package which includes resource allocation for health facility infrastructure to help meet the national target of increasing the coverage of basic emergency

[3] Ministry of Public Health and Sanitation, GOK (2008). *Child Survival and Development Strategy 2008-2015.*

[4] Ministry of Public Health and Sanitation and Ministry of Medical Services, GOK (2009). *National Health Sector Strategic Plan II, 2009-12.*

obstetric care from 24% to 100% by 2015. In addition, government resources will be targeted to the employment of additional nurses and support for the community strategy.

GHI will contribute to the strengthening of the Kenyan health system by accelerating support for the following areas currently being implemented by one or most USG partners: (1) *Leadership and Management*: promoting broad partnerships in building capacity for delivery of quality health services at national, county and district levels; (2) *Policy*: developing local capacity for effective advocacy to sustain broad political will required for allocation of greater GOK resources for health and implementation of relevant policies and guidelines; (3) *Human Resources for Health*: improving human resource planning and information systems, building skills among community health workers and health facility providers; (4) *Health facility infrastructure improvement*: defining and achieving progress toward national standards for clean, functional, safe and user friendly clinical settings and laboratories; (5) *Supply chain systems*: improving the national coordination systems for supply chains, including procurement, distribution, information and monitoring and evaluation systems; and, (6) *Cost-effectiveness*: evaluating the costing, quality and impact of health care services.

In the area of human resources for health, the specialization of several key health services in Kenya has led to inequitable staff distribution at the facility level. Once provided in out-patient clinics, some services-including family planning, HIV testing care and support, TB treatment - have been moved to specialized sites in the health facility. In addition to meeting needs of patients, the appropriate re-integration of these services allows for more efficient use of health workers time. For example, one specialized staff may see 10 patients a day while 3 out-patient clinic staff working together may see up to 200 patients per day.

Integrated Service Provision

What could an integrated package of services include?

- Health education on safe motherhood practices
- HIV/AIDS care including assessment of eligibility for treatment, routine monitoring, treatment of opportunistic infections
- Food supplementation, immunization, and provision of vitamin A and zinc supplementation
- Growth monitoring and infant feeding counselling
- ORS corners and WASH education
- TB screening and treatment
- Malaria screening and LLIN distribution
- Family planning services
- Cervical cancer screening and referral
- Psychosocial support groups and peer counsellors

(*See Appendix 3 for additional services*)

In Kenya, service delivery has been based traditionally on a combination of vertical and integrated approaches. GHI will integrate all USG partners in Kenya with GOK and will engage bilateral, multilateral and non-governmental organizations to bridge the artificial divide between vertical approaches. It will use integrated approaches to address a variety of specific disease priorities and interventions, resulting in strengthened health systems providing comprehensive services with improved efficiency. To support rapid expansion of high impact interventions pertinent to MNCH, as defined by the GOK's safe motherhood, malaria, child health and HIV programs, better alignment of programs will be required, including specific agency activities within

PEPFAR, PMI, and other USG programs.

Demand Creation

Improvements in health status of mothers, newborns, and children are inextricably linked to changes in health behavior and practice in the household. Using a multipronged approach to health communication under GHI, health promotion programs will support the GOK's own demand creation mechanisms—its Community Strategy and its health communication programs- to amplify their impact and increase uptake of needed services. Specifically: 1) the HIV prevention program will use a combination prevention approach to ensure increased knowledge of HIV status, prevention amongst most at risk populations and linkages to care and support, with an emphasis on high impact prevention interventions; 2) to reduce unmet needs for family planning, programs will focus on youth, poorer and lesser educated girls and women; 3) the malaria program will prioritize increased utilization of key malaria interventions such as usage of Long Lasting Insecticide Treated Nets (LLINs) and prompt and effective treatment in endemic districts; and 4) maternal and child health activities will encourage pregnant mothers to utilize health services for care and delivery as well as prevention and prompt treatment of illnesses in children.

Key Strategic Components

- **Family Planning**: Family planning (FP) can potentially eliminate 32% of maternal deaths and 10% of newborn, infant and child deaths by reducing high risk births.[5] GHI will support the GOK's strategy to achieve a contraceptive prevalence rate increase from 46% to 56% by 2015 and meet 70% of unmet need through: (1) demand creation by developing and disseminating communication tools focused on service providers, community health workers and messages for youth and married couples; (2) increased demand for and availability of modern contraceptives, including long acting and permanent methods; (3) expanded coverage of integrated FP, PMTCT, MNCH and other HIV prevention and treatment services; and (4) improved contraceptive commodity security.
- **Making pregnancy and childbirth safer**: Pregnancy poses a substantial risk for many mothers in Kenya. Although 92% of pregnant women attend antenatal care at some point during their pregnancy, only half receive the recommended four or more visits and in some areas, over 80% of mothers deliver at home. Through improved coordination of the PMTCT, PMI and MNCH programs, GHI will support interventions at community and facility level, including (1) improved quality, access and utilization of focused antenatal care; (2) improved skills in PMTCT, HIV treatment, emergency obstetric care and essential newborn care for service providers and appropriate skills for community health workers; and (3) through community strategies, health promotion for families to improve pregnancy outcomes including birth preparedness plans, recognition of danger signs, prevention of malaria in pregnancy through use of LLINs and Intermittent Preventive Treatment in Pregnancy (IPT) and appropriate case management of malaria.

  Neonatal deaths contribute to 60% of Kenya's infant mortality rate (52/1000 live births). To address this and reduce IMR to 25/1000 by 2015, GOK aims to increase Skilled Birth Attendance (SBA) to 90%. GHI will support interventions towards this goal, in a variety of

[5] World Health Organization (2010). *Sexual and Reproductive Health Package of Interventions for Family Planning, Safe Abortion Care, Newborn and Child Health*.

ways, including: (1) improved skills of health providers in emergency obstetric care, essential newborn care including neonatal resuscitation, postpartum and post natal care; (2) limited procurement of delivery kits for critical districts; (3) early detection and appropriate management of complications of the mother and newborn; (4) family planning for birth spacing; (5) care and counseling for HIV infected mothers; (6) increased home visits by community health workers during the early hours of birth to complement facility-based post-natal care and improve neonatal survival; (7) effective support for breastfeeding and appropriate management by HIV infected mothers; (8) identification and follow up of HIV exposed and/or infected infants including early infant diagnosis, care of HIV infected infants with cotrimoxazole and ARVs and appropriate treatment of opportunistic infections; and (9) prevention and optimal management of neonatal infections.

- **Infancy, child and mother care**: Improved care during infancy includes attention to a variety of home and community interventions aimed at preventing common childhood infections and ensuring better health for the mother. Specific interventions which GHI will support are as outlined in the *Kenya National Child Survival and Development Strategy*[6], which include: (1) promoting improved infant nutrition with particular attention to exclusive breast feeding, as appropriate, and the weaning period/treatment for HIV infected babies; (2) promoting safer breastfeeding for HIV infected mothers by using highly active antiretroviral therapy (HAART); (3) promoting immunization (existing and new vaccines against high impact diseases) and micronutrient supplementation; (4) promoting the prompt and effective treatment of malaria and prevention using LLINs; (5) strengthening household water sanitation and hygiene (WASH) practices to reduce and control diarrheal diseases, including point-of-use water treatment and provision and use of soap; (6) improving household air quality, including the use of smokeless cooking and lighting systems; and (7) scaling up the use of oral rehydration therapy (ORT) and zinc for diarrhea prevention and management.

  For a more detailed discussion of these interventions, please refer to Appendix 3.

IV. NEGLECTED TROPICAL DISEASES

The Kenya GHI strategy will also employ health systems strengthening, integrated service provision and demand creation to focus on the GHI target of reducing the prevalence of seven neglected tropical diseases (NTDs) by 50% among 70% of the affected population. The Kenya GHI strategy will bolster GOK's own prioritization of reducing morbidity and mortality from NTDs. NTDs are a group of 14 parasitic and bacterial infections that, according to the World Health Organization (WHO), currently affect over 1 billion people, representing one sixth of the world's population,

> *What will we do to improve child and maternal health outcomes in the context of NTDs in Kenya?*
>
> GHI Kenya will utilize existing resources and build upon GOK's own priorities and a variety of interagency programs and strengths to utilize health systems strengthening, integrated service provision, and demand creation to integrate NTD prevention and management into the broader maternal, child, and adolescent health platforms, and thereby reduce the impact of NTDs. We will assist GOK in the development of a successfully integrated NTD management and control program.

[6] Ministry of Public Health and Sanitation, GOK (2008). *Child Survival and Development Strategy 2008-2015*.

killing more than 500,000 people annually. The estimated global burden of NTDs is roughly one-third that of the health impact of HIV/AIDS, TB and malaria combined.[7]

NTDs contribute to anemia, vomiting, diarrhea, malnutrition and organ damage. Growth and cognitive development are also affected in children, who are highest risk for infection. Contributing to maternal and neonatal mortality, NTDs can complicate pregnancy by causing severe anemia. Recent research indicates that chronic parasitic infections can impair protective immune responses against many unrelated infections (including malaria, TB, and HIV) and can cause impaired responses to vaccines.[8] Direct costs of treatment for NTDs, combined with the indirect costs of productive labor time lost due to morbidity and mortality, have severe negative impact on the economies of afflicted communities.[9]

Broad management of NTDs contributes towards enhanced cognitive and physical development and to the reduction in number of underweight, malnourished and stunted children under the nutrition and child health targets, as well as to improved maternal health. Reduction of worm burden can also lead to improved health outcomes for individuals suffering from HIV/AIDS, TB and malaria. The GOK considers integrated management and control of NTDs both attainable and a high priority.

Approach

GHI Kenya will assist GOK to utilize existing resources and build upon a variety of interagency programs and strengths to employ health systems strengthening, integrated service provision, and demand creation to integrate NTD management into the broader maternal, child, and adolescent health platforms, and thereby reduce the impact of NTDs. We will assist the GOK in the development of a successfully integrated NTD management and control program.

Little is known about how MNCH and adolescent health platforms can be optimally used to reduce the morbidity and mortality associated with NTDs. As the GOK addresses control of NTDs, operational research is increasingly needed for effective program implementation. On-going activities in western Kenya are helping to determine best approaches for improving access and increasing uptake of treatment for schistosomiasis and STHs within larger programmatic activities which target maternal, child, and adolescent health and could serve as a foundation for such research. Through the GHI approach, GOK efforts to address NTDs can be coordinated as part of an integrated service provision approach involving malaria, HIV/AIDS, and MNCH.

Health Systems Strengthening

Successful management and control of NTDs relies on strong health systems. GHI will provide technical assistance to the GOK in the development of an integrated and cross-program NTD prevention and control program in Kenya, focused on strengthening and integrating the multi-sectoral response to NTDs through systematic inclusion of the education and health sectors,

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[7] Hotez PJ, Molyneux DH, Fenwick A, Ottesen E, Ehrlich Sachs S, et al. (2006). Incorporating a Rapid-Impact Package for Neglected Tropical Diseases with Programs for HIV/AIDS, Tuberculosis, and Malaria. *PLoS Med* **3**(5): e102. doi:10.1371/journal.pmed.0030102

[8] Malhotra, P. Mungai, A. Wamachi, J. Kioko, J.H. Ouma, J.W. Kazura and C.L. King (1999). Helminth- and Bacillus Calmette-Guerin-induced immunity in children sensitized in utero to filariasis and schistosomiasis. *J. Immunol.* **162**: pp. 6843–6848.

[9] Chitsulo, L., Engels, D., Montresor, A. and Savioli, L. (2000). The global status of schistosomiasis and its control. *Acta Tropica*. **77**: 41-51.

supporting a community centered approach for strengthening the primary health care system, and implementing drug administration together with community outreach programs.

GHI will also contribute to the strengthening of NTD integrated management and control through assisting GOK with the evaluation of the best prevention and management delivery systems. This includes whether a given integrated prevention or management approach can impact transmission of NTDs and which approach yields the largest effect on prevalence, morbidity, and mortality per unit of cost. The GHI NTD efforts will also support GOK leadership and management, policy, human resources for health, and supply chain systems.

To assure country ownership, USG will provide technical assistance to the GOK in ensuring appropriate budgetary allocation for planned activities within GOK's annual budgets and to include planned NTD control activities in MOH annual operation plans at district and national levels.

Integrated Service Provision

Service delivery for NTD control in Kenya and most African countries has primarily been through a vertical approach and has not fully leveraged the contribution of other sectors. GHI in Kenya will provide technical assistance to GOK's health sector in facilitating the incorporation of NTD prevention and management into maternal and child health platforms, and into the educational system to reach adolescents. GHI will work with the GOK Ministries of Education, Medical Services and Public Health and Sanitation on the implementation of the interventions. Prevention and management of NTDs will also occur through integration into community outreach, including albendazole and praziquantel distribution in home-based VCT, LLIN distribution, immunization days, and water and sanitation programs as a method for reducing NTD transmission and disease burden.

In coordination with the MNCH component of the GHI strategy, prevention of NTDs will also include the promotion of WASH practices in households, the provision of safe water and construction of sanitation facilities. Since lymphatic filariasis (LF) can be prevented through the use of bednets, efforts in this arena can be more tightly integrated with PMI to emphasize bednet distribution in areas with LF, even if malaria is not highly prevalent. Face washing and other prevention activities are a proven part of the trachoma control strategy and will be implemented in coordination with other behavioral intervention strategies. Ultimately, GHI in Kenya will facilitate the development of an integrated management and control program for all NTDs, providing a critical learning opportunity for integration of NTD prevention and management into the larger public health context.

Demand Creation

The health impacts of NTDs are under-recognized by both public health officials and infected people. Information on burden, control activities and improvements in both child and adult health will be disseminated by building on existing GOK health communication programs, in line with the GOK community strategy.

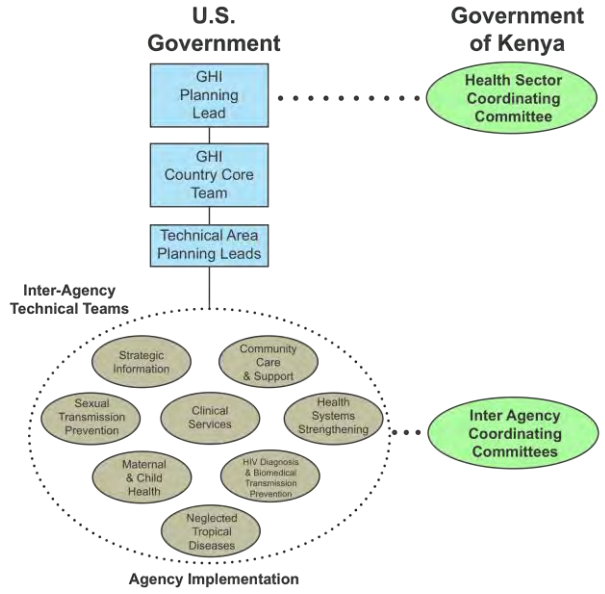
The GOK NTD prevention program will use a combination prevention approach to ensure knowledge of NTDs and their impact, to disseminate prevention messages amongst at risk populations, and to create linkages to all community outreach programs. Increased awareness of

NTDs and their impact will stimulate demand for prevention and treatment programs at both the community and school level and should ensure that community members initiate and undertake preventive measures.

V. GHI KENYA MANAGEMENT STRATEGY

Building on a solid interagency governance system, GHI Kenya will make appropriate modifications to the structure already functioning in country. US Peace Corps, DoD, CDC, USAID and PEPFAR have jointly planned, implemented and reported on a large program base for several years. This tight, multi-tiered governance structure allows for full participation across agencies, at all levels, and across technical areas – resulting in well-conceived programs that are responsive to country needs.

Figure 1: Proposed GHI Management Structure



GHI adds new dimensions to the existing disease-focused structure, for example, a co-chaired MCH interagency committee in which USAID and CDC will jointly plan the MCH component of GHI, with input from other agencies. As such, GHI Kenya will embrace this strong management base and expand into broader public health areas relevant to the GHI Strategy. During initial phases, GHI Kenya will emphasize the development of programs that leverage unique capacities of each of the agencies, utilizing existing activities and platforms to create efficient and functional cross-agency synergies. Over time, this model will mature into expanded inter-agency work to achieve GHI objectives and targets (see Figure 1).

This is a welcome and natural development. A key principle of this expansion will be to ensure inclusion of all parties, irrespective of direct agency-specific resource allocation. Another key element will be to monitor transaction costs, cognizant of staff time as it relates to practical public health outcomes.

External relations with host country government and other stakeholders (e.g. development partners, private sector and civil society) are critically important to the successful implementation of GHI in Kenya. Once again, GHI Kenya will build on close and effective bilateral relations led by the Chief of Mission. Meaningful engagement at the right time in Kenya's budget and planning cycle will enable GHI to accelerate improvements to strategic interventions. With country ownership serving as the centerpiece of the GHI foundation, GHI Kenya will redouble its efforts to respect and work within existing host country management and coordination structures in place, in line with the PEPFAR/GOK Partnership Framework, the principles of the Three Ones, and the Kenya Code of Conduct.

The Management Strategy will be headed by the designated planning lead, the PEPFAR Coordinator, with support from all agencies.

VI. GHI KENYA COMMUNICATIONS STRATEGY

GHI Kenya will establish a robust whole-of-government, multi-layer Communication Strategy, reflecting all fundamental principles of the President's initiative. This will benefit the full complement of the USG health portfolio in Kenya. As with the Management Strategy above, GHI Kenya will build upon the existing interagency management platform. Proposed are *four components* of the strategy, with all aiming to enhance dialogue, learning, and recognition of the USG's partnership in Kenya:

1. Internal USG Communications
    a. Tighten internal communications within GHI Kenya to ensure a commitment to inclusiveness, and enhance participation at all levels.
    b. Engage proactively with US Embassy's Public Diplomacy staff to develop a clear Mission-wide communication/outreach strategy (maximizing use of innovative media in and out of Kenya).
2. Support Interagency HQ-Field communications
    a. Produce informative communications planning between GHI Kenya and GHI US. Evaluate effectiveness as needed.
    b. Prepare protocols to manage any/all anticipated visitors to maximize benefit of in-country missions and minimize impact on technical staff.
3. Bilateral USG-Kenya Communications
    a. Using a calendar of key events, work with GOK counterparts to plan and prepare for key engagements (at all levels of government) to ensure inclusive dialogue, and encourage two-way feedback loops on GHI plans and programs. Reduce any additive burden to all parties by mainstreaming GHI into existing schedules.
    b. Provide support to and strengthen the capacity of the GOK to develop and execute targeted communication strategies (i.e. with the Kenyan public and relevant stakeholders) that enhance and promote the Kenyan government's initiatives to improve health service and health outcomes.
4. External Outreach
    a. Develop a whole-of-government media management strategy that centralizes function with dedicated staff, while ensuring that agency-specific technical contributions and support to the GOK are recognized.
    b. Engage local and international media to enhance coverage and reporting of GHI Kenya initiatives.
    c. Collaborate with GHI Kenya partners, health sector stakeholders, and other donors to identify joint opportunities to promote health sector investment among both public and private sectors.

This component would require budget support, estimated at $300,000 per year.

VII. LEARNING AGENDA

The existing USG investments in health in Kenya support a combination of vertical planning with integrated programming. GHI provides the opportunity to establish a more deliberate approach to integrated planning, coordination and measurement across the PEPFAR, PMI, and other USG programs to ensure a comprehensive package of services without unnecessary duplication of effort (see Appendix 1). In order to evaluate the potential to achieve many of the GHI targets, Kenya will chose approximately five geographic areas to evaluate: three areas where USG agencies are currently working at different levels of coverage and intensity, and two areas where intensified focused planning and programming will be implemented together. Kenya will share the lessons learned from the process.

Criteria for the specific geographic areas chosen will include: 1) already existing health activities and programs being implemented by USG agencies, 2) area(s) with the infrastructure to precisely measure input, uptake and impact towards GHI targets, 3) areas where substantial progress is needed to reduce morbidity and mortality rates and to improve function of health systems.

In brief, the constellation of national service coverage varies from location to location. Within the USG, there are essentially four key categories of integrated service delivery, each aiming to respond to the population size and epidemiology. These categories are:

1. Project level integration of different public health priorities (and different funding accounts), e.g., APHIA plus platform combining all sub-accounts, at facility and community levels;
2. Interagency coordination among different implementers to ensure a complete package of essential services in a specific geographic location, e.g., family planning services injected into a location where others are not supporting;
3. USG and stakeholder coordination (including GOK), e.g., UNICEF which has maintained a presence in Northeast Province, allowing others to complement; and,
4. Same as #3, but where stakeholders do not provide the full complement of services.

What will we do to measure improved health outcomes in Kenya?

As part of our learning agenda, GHI Kenya will chose approximately five geographic areas to evaluate how strengthening health systems, integrating service provision, and creating demand for services can reduce MNCH and NTD morbidity and mortality: three areas where USG agencies are currently working at different levels of coverage and intensity, and two areas where intensified focused planning and programming will be implemented together. We will conduct a comprehensive cross-cutting evaluation exploring the effectiveness and feasibility of current and intensified integrated planning that cuts across policy, health systems and service delivery.

In the area of NTDs, we will also work to determine the burden of disease and improve integrated management and control of NTDs by evaluating the effectiveness of various integrated prevention and treatment delivery systems.

The focus of the Learning Agenda will be a comprehensive cross-cutting evaluation exploring the effectiveness and feasibility and costs of current and intensified integrated planning that cuts across policy, health systems and service delivery. Consultations were held with the GOK and other

stakeholders on November 29-30, 2010. The purpose of this and other future meetings will be to refine the focus, methodology and implementation of the GHI strategy and Learning Agenda.

Within specific geographic areas, GHI Kenya will identify existing activities and programmatic gaps and, in the intensified areas, new potential synergies between USG agencies/programs and the GOK towards maternal, neonatal and child mortality and NTD morbidity and mortality reduction. Illustrative activities described in Appendix 1 are part of standard care and management practices. The Learning Agenda approach allows the USG agencies and GOK to work together to measure current synergies and program effectiveness, to share resources, to create new efficiencies, and to intensify activities, ensuring these activities are comprehensively implemented following rigorous, yet practical, guidelines. The GHI Kenya will design the best way to use the existing platforms in the chosen geographic areas to facilitate the precise, relevant metrics needed to measure implementation and impact on GHI targets. Areas which could be utilized include (but are not limited to): areas throughout Kenya with DHS data; DoD areas of focus such as Kombewa/Kericho; USAID's APHIA plus platforms; CDC's on-going population-based surveillance such as the western Kenya Health and Demographic Surveillance System (HDSS) and the Kibera-based population-based surveillance site; and the Dadaab and Kakuma refugee camps (of note, refugees are often excluded from national policies and programs, to the detriment of the health of refugees and their host communities). These platforms, in particular the population-based surveillance platforms, offer the capacity to precisely measure inputs and outcomes, including interim and proxy indicators. Through the Learning Agenda, Kenya will be able to measure impact on GHI targets, or interim targets, across a spectrum of implementation activities, resource allocations, and USG/GOK synergies. The use of 5 distinct geographic areas, versus the entire country, enables GHI to achieve success and find the most appropriate models for scale up and dissemination.

Appendix 1 represents current activities in maternal, neonatal and child mortality reduction implemented by CDC, USAID, DOD and Peace Corps. The measurements from the different geographical area(s) will demonstrate the impact and cost-effectiveness of implementation of routine and intensified activities on achieving GHI targets. Feasible and effective approaches can then be scaled in Kenya with lessons learned and best practices shared with other GHI countries. As one of the largest international USG health platforms, Kenya is uniquely positioned to demonstrate an integrated approach to health programming within the context of all USG agencies.

Also within GHI, we have the opportunity in Kenya to contribute significantly to a Learning Agenda that will determine the burden of disease and improve integrated delivery of NTD prevention and management. In contrast with the well-defined, ready for implementation programmatic components for MNCH, reduction of the impact of NTDs in developing countries will require additional knowledge before effective programs can be implemented. In Kenya, GHI has a unique opportunity to look to the future by supporting the development of evidence-based programs for integrated control of NTDs. Many tools and treatments for NTD control are available, but unlike the status of MNCH, the most effective and efficient methods of comprehensive program integration and implementation remain undefined.

Maternal, neonatal and child mortality learning focus

1) *Current and enhanced integrated implementation of a comprehensive package of cross-disease health interventions will reduce maternal mortality by 30%*
    a. Example intervention: Antiretroviral treatment (ART) uptake
        i. Measure the percent uptake of ART by women at risk (CD4≤350) in the selected geographical areas
            - Using infrastructure, such as the HDSS, identify the number of women in the population, the number of women tested for HIV, the proportion of these who are HIV+ with CD4≤350, and the proportion of these who have initiated an ART program at baseline (now) and after intensive inter-agency/GOK planning and maximization of efficiencies
        ii. Measure/describe specific USG/GOK activities contributing to this intervention
    b. All interventions described in Appendix 1 can be detailed in this way
    c. Using the existing baseline maternal mortality as a comparator (obtained from DHS or HDSS data), assess impact of the strategy on maternal mortality
    d. Measure the cost of implementing this package, effectiveness on GHI targets, and cost-effectiveness of maximizing synergies across agencies/program areas

2) *Current and enhanced integrated implementation of a comprehensive package of cross-disease health interventions will reduce child mortality by 35%*
    a. Example intervention: Immunizations
        i. Measure the percent uptake of the full EPI series of vaccinations by infants in the selected geographical area
            - Using existing surveillance infrastructures, identify the birth cohort in the populations, the number of infants receiving each vaccination (now) and after intensive inter-agency/GOK planning and maximization of efficiencies
        ii. Measure/describe specific USG/GOK activities contributing to this intervention
    b. All interventions described in Appendix 1 can be detailed in this way
    c. Use the existing baseline infant mortality as a comparator (obtained from DHS or HDSS data) to assess impact on infant and child mortality
    d. Measure the cost of implementing this package, effectiveness on GHI targets, and cost-effectiveness of maximizing synergies across agencies/program areas

<u>NTD learning focus</u>

1. *What is the optimal integration of NTD prevention and treatment into existing maternal, child and adolescent public health platforms?*
    a. *What is the impact on health outcomes of integration of NTD management and control, including evaluation of impact on anemia, physical growth and development, and cognitive indicators?*

b. *What are the costs and cost-effectiveness of an integrated platform which strengthens health systems, integrates services and creates demand to reduce morbidity and mortality from NTDs?*

2. *What is the burden of disease due to NTDs across Kenya?*

ILLUSTRATIVE TIMELINE AND BUDGET

The expected timeframe of the strategy is 2011–2014, with implementation already begun in 2010 for much of this work. As such, no additional funds are expected from GHI outside of the usual USG budgeting processes (i.e. OP, MOP, and COP). However, additional GHI funds would be needed to support the Learning Agenda.
In addition, end-line targets/objectives correspond to those set at national level with government and health partners as part of national strategy development and annual operational planning. As such, USG activities are expected to contribute to the achievement of these country-defined national level targets as part of joint planning and coordination together with government, donor, NGO and other key stakeholders. Limited seed funding may be necessary to begin momentum on these new ventures. After consultation with government and development partners and GHI headquarters, funding requests will be forthcoming. Recognizing current budgetary constraints and the need for further discussion on such issues, a notional draft budget follows.

Table 1: Illustrative Timelines and Budgets for the Learning Agenda

Activity	Timeline	Budget
1. Define geographical areas for evaluation	4Q 2010	N/A
2. Planning meetings for USG/GOK	4Q 2010 - ongoing	Part of regular core team meetings
3. Determination of additional activities, etc for enhanced areas	4Q 2010	Part of regular core team meetings
4.Determine specific metrics and data collection procedures	4Q 2010	Part of regular core team meetings
5.Hire additional implementation and data collection staff	1Q 2012	$400,000
6.Collect/collate baseline data	1Q 2012	$200,000
7.Implement new activities in enhanced areas	2Q 2012-ongoing for 1-2 years	$500,000-$1,000,000/year
8. Data collection	2Q 2012-ongoing for at least 2 years	$500,000-$1,000,000/year
9. Initial analysis	1Q 2013	$300,000

APPENDIX 1: TABLE OF EXAMPLE ACTIVITIES FOR THE LEARNING AGENDA

The activities listed below form the basis of the indicators Kenya will measure as part of GHI as a whole and the Learning Agenda specifically; e.g., indicator 1 = the number of pregnant women attending ANC during the course of pregnancy/ the total number of pregnant women in that time/area. Note we will use Kenya's existing health indicators where possible.

Maternal mortality reduction: in order to reduce maternal mortality, the following activities should be comprehensively implemented. The platform chosen for measurement will measure specific activities implemented, uptake, and overall impact on morbidity and mortality.

Antenatal Care	Birth

• All women should come for at least 4 ANC visits
• All women should receive PMTCT in first and 3rd trimester
  o All HIV+ women should start cotrimoxazole
  o All HIV+ women should have a CD4 performed; all with CD4 equal to or less than 350 or WHO Stage 3 or 4 should start HAART
  ▪ Adherence should be monitored and peer educators engaged
  ▪ New Kenya National Guidelines for HIV management in pregnancy and postpartum should be followed
• All women in malarious areas should receive intermittent preventive therapy during pregnancy (IPTp) (if not HIV+) for malaria at 3-4 ANC visits after quickening; should be sleeping under a LLIN
• All women should be screened for TB, more frequently (every 3 months) if HIV+
• All women should be tested for the presence of NTDs and managed
• All women should receive tetanus toxoid vaccine if not yet vaccinated
• All women should be assessed for malnutrition/anemia and managed
• All women should be assessed for syphilis/other STD's and managed
• Improve diagnosis and treatment of ascending reproductive tract infections in pregnant women, including syphilis, gonorrhea and Chlamydia; improve screening for and management of cervical cancer (consider HPV vaccine)
• Safe water should be ensured for all pregnant women
	• All women should be educated and encouraged to deliver in an equipped health facility with skilled providers
	  o HF in the specific area chosen should be evaluated and equipped, and the presence of skilled providers ensured
	  o Training programs of birth attendants should be scaled up and high coverage ensured
	  ▪ Training should include management of obstructed labor/other complications
	  o Need to evaluate/scale ways to combat barriers to HF attendance, including transportation of mothers and care of other children and quality of treatment of women
	  o Cleanliness/friendliness/cultural appropriateness of environment and treatment should be evaluated
	• All women should be re-tested for HIV at delivery if missed during 3rd trimester
	  o HIV management accordingly
	• All women should be counseled on, and offered, family planning

Neonatal and Child Mortality Reduction: in order to reduce neonatal and child mortality, the following activities should be comprehensively implemented. The platform chosen for measurement will measure specific activities implemented, uptake, and overall impact on morbidity and mortality.			
Post-partum	**Infants – neonatal**	**Infants - 6 week**	**Infants- 1st year of life/ up to 5 years**
• All women should be educated and encouraged to attend a HF for any post-partum complication and 6 week evaluation; need to encourage early identification of infection • Safe water should be ensured for all mothers and infants; smokeless stoves should be implemented	• All women should be educated and encouraged to come to a HF for any post-partum complication, especially in the first 28 days (neonatal period) • Encourage immediate and exclusive breastfeeding for all children • Ensure infant sleeping under a bed net • Increase home visits by community health workers during the early hours of birth to complement facility-based post-natal care and improve neonatal survival • Train community health workers to use the algorithms to identify acutely infected neonates • Use surveillance platform to identify the principal bacterial and viral agents of neonatal infections and their drug resistance profiles, and assessment of the consequences of sexually transmitted diseases to fetuses and newborns • Ensure BCG vaccination	• Infants should receive HIV PCR test if known HIV exposed; antibody to determine exposure if mother status unknown ○ Follow new Kenya National Guidelines for testing and treating- all babies HIV+ or HIV exposed should receive cotrimoxazole from 6 weeks of age • Infants should start immunizations series- 6/10/14 weeks; 9 months. New vaccines should be targeted to these areas: pneumococcal vaccine, rotavirus vaccine, other new vaccines	• Malnutrition/ anemia should be assessed throughout and managed; vitamin A supplementation • ORS/zinc: mothers should be educated and ORS/zinc made available in all health facilities • Full uptake of immunization series, including new vaccines • General health management should occur- mothers should be educated about danger signs (severe diarrhea/dehydration, etc) and encouraged to bring their children in to health facilities for management • All infants should be tested for NTDs and properly managed

APPENDIX 2: KENYA GHI MATRIX

Area 1: Maternal Health					
Baseline Information: MMR: 488/100,000 CPR 46 percent					
Objectives supporting Key National priorities by 2015	**Key Challenges and Gaps Addressed**	**Current efforts by GOK and USG**	**Key priority actions likely to have largest impact (contributions)**	**Support by other partners**	**GHI Principles**
1.1 Increase Skilled Birth Attendance (SBA) from 44 % to 90 %	Inadequate Government of Kenya (GOK) resources devoted to reducing maternal mortality interventions Slow disbursement of GOK funds to facilities resulting in activity delays Shortage of skilled birth attendants namely doctors, clinical officers and nurses. Poor referral services Limited demand for facility deliveries in some regions Integration of MNCH components into new Community Strategy not yet completed Lack of Community Health Worker (CHW) kits Lack of timely and accurate data for facility and community efforts. Antenatal care (ANC) attendance is poor—only 47% of women receive at least four visits and only 43% deliver in a health facility.	**GOK** : Launched an economic stimulus package for 2010-2011--includes hiring 4,000 nurses and 3,000 CHWs annually; a Road Map for Safe Motherhood and Newborn Health with high impact activities for community and health facility services; ongoing development of community strategy to include an MNCH component **USG**: Supports an emergency hire program and human resources for health (HRH) within the GOK Supports skills-building for health workers and limited improvement of health facility infrastructure Procures some essential reproductive health (RH) equipment like delivery kits Supports GOK in the development and roll out the community strategy—a continuum of household, community and health facility care for MNCH	Advocate for increased GOK resources for maternal, newborn and child health (MNCH) services Advocate for and increase access to safe and appropriate health facility births Increase availability, acceptability and utilization of antenatal care, delivery and postpartum services in health facilities Develop a functional referral system. Scale up Focused Antenatal Care (FANC). Strengthen training program for nurses, doctors and clinical officers on improving skills in birth attendance, Essential Newborn Care, Post-Partum Care, Postnatal Care, and leadership and management Strengthen and facilitate scale up of community MNCH with a focus on birth preparedness plans and community support for transportation of the mother Expand FP/MNCH/HIV integrated services in health facilities (PFIP). Improve evaluation and management of reproductive health issues, cervical	*DANIDA*: Supports nurses for health services in specific districts *EU*: Provides support to NGOs for primary health care and reproductive health in urban slum areas *GDC*: Supports an output-based voucher scheme in some urban and rural areas for maternity and FP services—expected to expand to include MCH and FGM services *World Bank and DfID*: Total War on AIDS (TOWA) program to provide US$28.5M for 2009-2011 in support grant awards to NGOs for advocacy (PFIP) *DfID*: May provide direct support to GOK for MNCH services in 2011 *Population Council*: Supports a community midwifery model in a few rural areas, utilizing retired nurses *Family Care International, International Center for Research on Women, MacArthur Foundation and DfID*: Support evaluation of	*Country ownership*: Transition of emergency hire staff to GOK supported staff. Fully supports GOK priority areas. *Women and girl centered approach*: Focus on demand creation and more efficient and accessible quality integrated services for women. Women are focus of client-centered approach. *Strategic Coordination and Integration*: Coordination with existing programs and partners and integration of services in the community and health facilities. *Strengthen and leverage partner engagement*: USG and GOK will work to integrate partner contributions and increase efficiency *Health Systems Strengthening*: Building systems to support the entire continuum of care from before pregnancy to delivery to after birth *Metrics, monitoring and evaluation*: Evaluation of social and financial costs (and causes) of maternal mortality

Area 1: Maternal Health					
Baseline Information: MMR: 488/100,000 CPR 46 percent					
Objectives supporting Key National priorities by 2015	**Key Challenges and Gaps Addressed**	**Current efforts by GOK and USG**	**Key priority actions likely to have largest impact (contributions)**	**Support by other partners**	**GHI Principles**
		Supports advocacy efforts for effective policies on women's reproductive health issues	cancer screening, and other cancer screenings. Provide HPV vaccine starting in 2015 Strengthen national health management information system (HMIS) to facilitate timely and accurate information. Develop and implement interventions aimed specifically at men as partners.	financial and social costs of maternal mortality	*Research and innovation*: Learning agenda will measure integrated approaches and best practices/use of population-based platforms to measure impact on GHI targets. Evaluation of routine surveillance data to learn best practices, e.g. HIV care and treatment; operations research on pregnancy and NTDs/treatment delivery
1.2 Increase availability of emergency obstetric care (EOC) from 24% to 100%.	Lack of a critical mass of service providers Shortage of delivery kits and other reproductive health equipment and supplies. Only 16% of health facilities conduct Caesarean sections; only 15% are completely equipped for Basic Emergency Obstetric Care; and only 9% are equipped for Comprehensive Emergency Obstetric Care Lack of new born and lab equipment for hematology and chemistry Stock outs of essential supplies, including hematinics, antimalarials and drugs to treat delivery complications. High costs of maternity	**GOK**: Launched an economic stimulus package for 2010-2011—includes infrastructure improvements providing a model health center and maternity ward **USG:** Supports equipment service maintenance and lab networking through PEPFAR Will provide delivery kits for health centers in some priority districts identified by GOK Procures lab supplies Provides training for health care staff on blood safety	Improve comprehensive package for PMTCT, implement new WHO guidelines, support integrated and increased HIV care and treatment for women. Strengthen training program to improve skills for nurses on emergency obstetric care, essential newborn care, neonatal resuscitation, post-partum care and postnatal care Establish links with the U.S based "Helping Babies Breathe" initiative to create access to newborn resuscitation equipment Procure and distribute delivery kits Support infrastructure improvement Advocate for increased GOK resources for MNCH services.		*Women and girl centered approach*: Women are focus of client-centered approach *Health Systems Strengthening*: Improving infrastructures, provider skills, and supply chain systems for emergency obstetric care

Area 1: Maternal Health					
Baseline Information: MMR: 488/100,000 CPR 46 percent					
Objectives supporting Key National priorities by 2015	**Key Challenges and Gaps Addressed**	**Current efforts by GOK and USG**	**Key priority actions likely to have largest impact (contributions)**	**Support by other partners**	**GHI Principles**
	services and comprehensive emergency obstetric care Poor referral systems from health center to hospitals.				
1.3 Family Planning increase from 46% to 56%, meet 70% of unmet need for family planning services	Current GOK supply chain agency has inefficient distribution and reporting systems	**GOK:** Procure contraceptive commodities worth $6,000,000 per year, about 40% of annual national requirement Kenya Medical Supplies Agency (KEMSA) currently undergoing reform process to improve effectiveness **USG:** Support distribution of FP commodities, long lasting insecticide treated nets (LLINS) and malaria drugs through KEMSA. Due to KEMSA weaknesses and at the request of GOK, USG currently supports a separate supply chain system Provide technical assistance to KEMSA to strengthen overall warehousing and distribution systems with a five year plan to phase in USG commodity management Procure contraceptive commodities(intrauterine contraceptive devices,	Support a new robust family planning communication strategy with multimedia messages for youth, adults, communities, service providers, leaders and consumers Increase access to family planning services in communities and facilities Expand private sector involvement in providing FP services Expand FP/MNCH/HIV integrated services in health facilities Strengthen and facilitate scale-up of community strategy components on family planning services Promote long acting and permanent contraceptive methods Support improvement of contraceptive commodity security through improved planning, quantification, procurement and distribution systems Continue support for national advocacy activities targeting parliamentarians and policy makers for more attention and resources for family planning	*DfID and UNFPA*: Provide family planning commodities *KfW*: Provide family planning commodities and TA on distribution to KEMSA, 10 million Euros over 2009-2011 *GDC*: Provide family planning commodities and vouchers to access maternity and family planning services *World Bank*: provide $100 million to focus on strengthening KEMSA's procurement systems, commodity procurement of essential medicines and financial management *DANIDA*: Provides support to KEMSA to strengthen supply chain system	*Women and girls centered approach*: FP communication strategy targets women and girls Health system strengthening: Supporting FP commodity security through improved supply chain systems *Strategic Coordination and Integration/Leveraging Partnerships*: Working with GOK and partners to improve resources for and access to FP services

Area 1: Maternal Health					
Baseline Information: MMR: 488/100,000 CPR 46 percent					
Objectives supporting Key National priorities by 2015	**Key Challenges and Gaps Addressed**	**Current efforts by GOK and USG**	**Key priority actions likely to have largest impact (contributions)**	**Support by other partners**	**GHI Principles**
		injectables and implants) in the amount of $2,000,000 per year Support social marketing of family planning commodities, including male and female condoms in partnership with DfID	Seek to provide increased funding to fast-track improvements in health commodities procurement; storage and distribution; improve governance of the public sector supply chain, including expanded use of information technology to automate critical functions (PFIP, Millennium Challenge Corporation Threshold Program; recommendations of the Task Force to reform KEMSA) Seek increased resources to support implementation of a mutually-agreed and sustainable application of private sector services to improve the health commodities supply chain (PFIP)		
1.4 Increase coverage to 80% for pregnant women with malaria preventive interventions in endemic districts	Stock outs of long lasting insecticide-treated nets (LLINs) and drugs for intermittent preventive treatment in pregnancy (IPTp).	**USG**: Procure malaria commodities—LLINs and drugs for IPTp Support the revision of training curriculums on Malaria in Pregnancy (MIP) Support the development and dissemination of IEC/BCC on malaria in pregnancy Evaluate pregnant women and uptake of malaria drugs for adverse events	Support the distribution of MIP guidelines to health facilities Support the distribution of LLINs, and provision of IPTp Evaluate new drugs for IPTp (e.g. mefloquine) and new control strategies in the face of increasing resistance and decreasing transmission (e.g. Intermittent Screening & Treatment in pregnancy)	*DfID and UNICEF*: Support the procurement of LLINs *DfID*: Supports monitoring and supervision DfID: Supports the development of technical guidelines for malaria control *EDCTP*: Providing support for MIP evaluations	*Health Systems Strengthening*: Strengthening the distribution, information and supply systems. *Women and girls centered approach*: Demand creation for women to increase access to malaria control tools *Innovation and Research*: Evaluation of malaria control tools (new drugs, new vaccines,LLINs)
1.5 Sustain high quality DOTS expansion and enhancement through case finding, case	Operational guidelines for Infection Control, MDR-TB, and Childhood TB not fully disseminated MDR-Surveillance among	**GOK:** Developed the DLTLD strategic plan 2011-2015 **USG**: Strengthen the health system	Increase access to TB screening and improve diagnosis Support central TB program management to support coordination of implementation of activities	*GFATM Round 6 &9*: Support to the national TB surveillance, infection prevention and control program and support to M&E systems	*Health Systems Strengthening*: Supporting laboratory capacity for diagnosis and supporting the strengthening of Kenya's national program in TB, Leprosy and Lung Disease

Area 1: Maternal Health					
Baseline Information: MMR: 488/100,000 CPR 46 percent					
Objectives supporting Key National priorities by 2015	**Key Challenges and Gaps Addressed**	**Current efforts by GOK and USG**	**Key priority actions likely to have largest impact (contributions)**	**Support by other partners**	**GHI Principles**
notification and case holding modalities to ensure all TB patients have access to optimal TB diagnosis, care and treatment Ensure TB/HIV co-infected patients receive quality and comprehensive TB HIV care and treatment	retreatment cases is still low Scale up of TB/HIV collaborative activities is good at TB service points but there are no guidelines and M&E formats for ICF and Screening for TB among HIV clients	to improve TB, leprosy and lung disease service delivery Procure TB diagnostic commodities Provide cotrimoxazole to TB/HIV patients Support lab TB diagnosis and external quality assurance Support evaluation of intensified case finding strategies in HF, infection control and IPT in limited settings.	Strengthen MDR TB diagnosis, prevention, care, treatment and support Support community based TB Care to increase the level of community involvement in provision of quality TB, leprosy and lung health services		
1.6 4.3 million women (80% of expected pregnancies) benefit from PMTCT interventions (PFIP)		**USG**: Support lab networking; equipment procurement, service and maintenance; ARVs; CT; care and support Support evaluation of PMTCT practices and barriers to PMTCT uptake	Endeavor to support 100% coverage of PMTCT interventions in ANC settings by 2010 and maintain coverage throughout period of the Partnership Framework (PFIP) Expand PMTCT to reach women who do not attend ANC and/or deliver outside facilities (PFIP) Work with Kenya Division of Reproductive Health (KDRH) to develop community interventions to reach 50% of pregnant HIV+ women who do not attend ANC with PMTCT services (PFIP) Ensure implementation of National RH/HIV Integration Strategy (PFIP) Advocate for strengthening of the community strategy to include follow	*JICA*: Provides test kits that are used for PMTCT *UNICEF*: Supports training in PMTCT settings University of Nairobi/University of Washington: supports evaluation of PMTCT	*Health Systems Strengthening*: Supporting stronger lab systems and integrated service provision *Innovation and Research*: Examination of ways to improve the reach and effectiveness of PMTCT services

Area 1: Maternal Health					
Baseline Information: MMR: 488/100,000 CPR 46 percent					
Objectives supporting Key National priorities by 2015	**Key Challenges and Gaps Addressed**	**Current efforts by GOK and USG**	**Key priority actions likely to have largest impact (contributions)**	**Support by other partners**	**GHI Principles**
			up of HIV infected pregnant women at the community level (PFIP)		
1.7 HIV testing and counseling in health settings for 25-50% of 18 million to be newly tested by 2013 (PFIP)		**USG**: Support lab networking, equipment procurement, service and maintenance	Seek to increase support for women targeted HIV testing and counselling (HTC) through multiple mutually-reinforcing and non-redundant methodologies to assist in achieving GOK target of 80 percent knowledge of HIV status among adults, including enhanced HIV testing at delivery/postpartum Seek to procure up to 4 million HIV rapid test kits annually for use in PMTCT/ANC settings	*JICA*: Provides 2.5 million HIV rapid test kits (2009-2011) and technical assistance to NASCOP for HCT quality assurance *GFATM*: Provides 1.5 million HIV rapid test kits annually *Clinton Foundation*: Provide US $13 million (2009-2011) in HIV test kits and lab supplies *Joint UN* : Support for social mobilization during annual testing week	*Women and Girls Centered Approach*: Targeting women for HIV counseling and testing *Health Systems Strengthening*: Supporting stronger lab systems and integrated service provision
1.8 Increase coverage and quality of ART provision for women living with HIV to reach at least 80% of those in need (PFIP)	New HIV infections are growing in rural areas, according the Kenya AIDS Indicator Survey (KAIS) 2007 Lack of access to HIV counseling and testing (CT) in rural areas.	**USG**: Support lab networking, equipment procurement, service and maintenance; ARVs; CT (including door to door testing); and care and support Evaluate of use of early ART to prevent transmission in sero-discordant couples and increase survival (HPTN052)	Treat all HIV+ women at or below CD4=350. Maintain support for full treatment costs based on GOK regimens for women on USG-procured ARVs (PFIP) Endeavor—through increased efficiencies and economies of scale—to expand ART coverage annually commensurate with increased need, decreased cost of ARVs, and changing treatment guidelines as available resources allow Manage future treatment procurements in a way that optimizes the likelihood of transition to local partners	*GFATM Round 10*: Application includes $131.5 million (2009-2013) for ARV drug procurement *Clinton Foundation*: Provide $45 million (2009-2011) for pediatric ARVs and $24 million (2009-2011) for adult 2nd line ARVs *NIH*: Provides support for HPTN052	*Women and Girls Centered Approach*: Targeting women for HIV counseling and testing and ART treatment *Country-Ownership/Leverage Partnerships*: Working with GOK, GFATM, and other partners to create shared investment in ART treatment for Kenyans

Area 1: Maternal Health					
Baseline Information: MMR: 488/100,000 CPR 46 percent					
Objectives supporting Key National priorities by 2015	**Key Challenges and Gaps Addressed**	**Current efforts by GOK and USG**	**Key priority actions likely to have largest impact (contributions)**	**Support by other partners**	**GHI Principles**
			Endeavor to increase direct budget support by GOK through recurrent expenditure for procurement of ARVs by a minimum of 10% annually (PFIP) Work toward achieving and maintaining steady state buffer stock of at least six months of essential treatment commodities, especially ARVs, in public sector stores based on five-year projections (PFIP) Seek to enact policy changes for critical treatment task-shifting (e.g., enhanced roles for lower cadres in monitoring treatment, prescribing ARVs) Seek to enact policy changes to enhance the role of private and FBO / mission health facility sectors in provision of treatment and care		

Area 2: Neonatal and Child Health					
Baseline Information: IMR: 52/1,000 live births					
Objectives supporting Key National priorities by 2015	**Key Challenges and Gaps Addressed**	**Current efforts by GOK and USG**	**Key priority actions likely to have largest impact (contributions)**	**Support by other partners**	**GHI Principles**
2.1 Reduce IMR to 25/1,000 live births by 2015	Shortage of service providers Service providers lack adequate knowledge and skills in infant and child care and health issues Weak supply chain that leads to infrequent supply of vaccines, oral rehydration therapy (ORT), zinc, LLINs, early infant diagnosis supplies (EID), vitamin A, antibiotics, and equipment Weak lab networks Lack of timely and accurate data for facility and community efforts Lack of community MNCH strategy Inadequate GOK resources devoted to infant and child health programs Lack of strong GOK leadership and management at National, Provincial and District levels Lack of quality health facilities and infrastructure	**GOK**: Launched an economic stimulus package for 2010-2011—Includes hiring 4,000 nurses and 3,000 CHWs annually and providing infrastructure improvements for health centers and maternity wards Supply equipment for all 6,000 plus health facilities Procure and supply essential medicines and program commodities through KEMSA **USG**: Support skills building for health workers in child health , promotion of breastfeeding, immunization and Vitamin A, blood safety Support integrated outreach services to communities, including the rollout of the community strategy Support community activities for prevention and management of diarrhea through community Support water and sanitation activities and scale up of ORT and zinc Support to scale up integrated disease surveillance focusing on polio through a WHO mechanism Strengthen the professional regulatory bodies and the Continuing Professional Department in the Ministries of Health	Increase access to, use of, and supplies in health facilities for births and new born care Skill building for providers in essential newborn care and child health Support scale up of essential newborn care and immunization in facilities Support early and appropriate health seeking behavior for mothers and infants through the community strategy Early identification and management of infections and use of algorithms Support for the "Reach every district (RED)" approach in 6 districts to scale up immunization coverage Support for roll out of new pneumococcal vaccine from Jan 2011 and rotavirus from 2013 Diarrhea prevention and management, ORT and Zinc scale up, promotion and provision of Vitamin A , iron and zinc NTD assessment and management Leadership and management	*GAVI*: Co-finances vaccines *UNICEF*: Supports vaccine procurement and logistics as well as social mobilization of communities for supplementary immunization activities. *WHO*: Supports surveillance of immunization practices and rotavirus, and training on best practices for pneumococcal vaccine introduction *JICA*: Supports cold chain procurement Glaxo-Smith Kline: Will supports studies on adverse effects for the new pneumococcal vaccine *Areas Global TB Foundation*: Supporting TB vaccine evaluations Malaria Vaccine Initiative (Gates Foundation): Supports malaria vaccine evaluations	*Country ownership*: Supporting the operationalization of the National Child Survival and Development Strategy 2008-12 and the National Malaria Strategy *Coordination/integration*: Further integrating efforts and coordinating with GOK and partner efforts *Strengthen and leverage partner engagement*: Integrating partner contributions to increase efficiency *Health Systems Strengthening*: Building systems to support the entire continuum of care from birth to the end of the first 5 years of life *Mertrics, monitoring and evaluation*: Evaluation of neonatal and childhood mortality -causes and social and financial costs and support baseline surveys in all provinces to provide information which Districts can use to prioritize and budget for MNCH services *Coordination*: Working with partners on the roll-out of

Area 2: Neonatal and Child Health					
Baseline Information: IMR: 52/1,000 live births					
Objectives supporting Key National priorities by 2015	**Key Challenges and Gaps Addressed**	**Current efforts by GOK and USG**	**Key priority actions likely to have largest impact (contributions)**	**Support by other partners**	**GHI Principles**
		Strengthen lab networks and supply chain Support improvement of TB screening and diagnosis in infants and children Support evaluation of new infant TB vaccine and rollout of new pneumococcal vaccine (Jan 2011) and rotovirus vaccine (2013) Supply LLINs to households with children under 1 years of age Conduct evaluations and surveillance activities on neonatal infant and child infections, morbidity and mortality Support advocacy, policy change raising awareness on availability and need for services	training		vaccinations to maximize impact *Research and innovation*: Measuring the impact on GHI targets from integrated approaches and best practices/use of population-based platforms as part of Learning Agenda
2.2 Reduce the proportion of under five children who are stunted to 16.2% by 2015	35% of children under five are stunted, an indicator of chronic malnutrition Only 32% of babies under 6 months are exclusively breastfed Only 30% Children 6-59 months receiving a full dose of vitamin A About 16 % of under five children are underweight Inadequate capacity to assess and address	**GOK** Support skills building for health workers in infant and young child feeding and integrated management of acute malnutrition Adopted and prioritized High Impact interventions comprising a set of Essential Nutrition Actions (ENA's) approach as indicated in the 'Framework for action' **USG** Commodities/education for nutrition and OVC nutritional support. Support coordination of nutrition	Promotion of exclusive breastfeeding, Vitamin A and infant and young child feeding practices and "food by prescription' program for HIV+ babies Feed the Future Initiative: conduct baseline nutritional surveillance Improved coordination – under the Food and Nutrition Inter agency coordinating committee Scale up of High impact nutrition interventions Building capacity in management	*UNICEF:* Advocacy in uptake of new proven interventions and frameworks as well as use of PROFILES in high level positioning of nutrition in the national developmental agenda Supports advocacy with GOK during budgeting and provision of therapeutic food and non food commodities *Micronutrient initiative* Support national and	*Integration*: Along with the Feed the Future Initiative , conduct national surveillance *Coordination/integration*: Further integrating and coordinating with GOK and partner efforts *Strengthen and leverage partner engagement*: Integrating partner contributions to increase efficiency

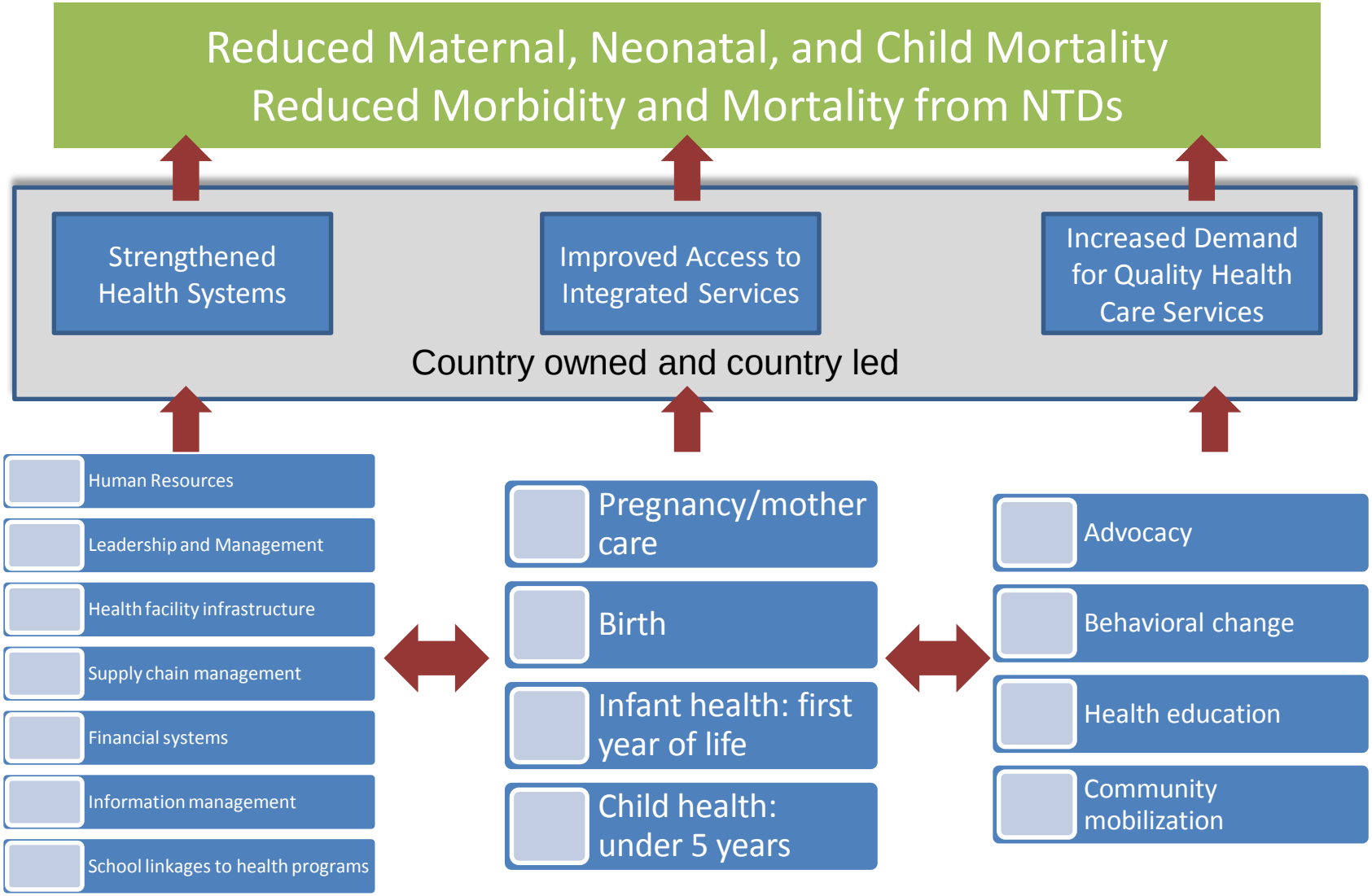
Area 2: Neonatal and Child Health					
Baseline Information: IMR: 52/1,000 live births					
Objectives supporting Key National priorities by 2015	**Key Challenges and Gaps Addressed**	**Current efforts by GOK and USG**	**Key priority actions likely to have largest impact (contributions)**	**Support by other partners**	**GHI Principles**
	malnutrition at facilities and community levels.	activities at the Food and Nutrition ICC level and development of a nutrition M&E framework Support facility and community based nutrition interventions – Vitamin A, Iron supplementation, deworming, Infant and young child feeding practices including consumption of diversified diets and fortified foods. Support capacity building of Health workers and community health workers in BCC and IEC on positive nutrition messages Support management of acute malnutrition at facility and community level	of acute malnutrition at facility and community level	countrywide program implementation in micronutrients supplementations. Partly supporting implementation of the micronutrient survey. *GAIN:* New in Kenya and will be supporting food fortification. *WHO*: Provides technical assistance on nutrition at national level. Current focus is on impacts of aflatoxins on health and nutrition.	
2.3 Increase the proportion of people with access to safe water to 80% and improved sanitation to 90% by 2015	Poor access to clean water and sanitation. Water supply coverage is estimated 62%, Sanitation coverage at 48% (13 million Kenyans lack access to improved water supply and 19 million to improved sanitation) Poor water, sanitation and hygiene (WASH) community practices Lack of a comprehensive BCC approach to addressing hygiene and sanitation practices	**GOK** Developed a 'total sanitation plan' to lay basis for scale up of community led total sanitation Leading the development of a country hygiene and sanitation strategy – to implement the national environmental sanitation and hygiene policy Support community activities for hand washing with soap at critical times and use of latrines under the community health strategy **USG** Provide TA to national level to support scale up of community and household WASH practices	Improving access to safe water including point of use water treatment Scale up of safe hygiene and sanitation practices at schools and households (hand washing at critical times, use of latrines) Scale up of behavior change and communication on safe water, hygiene and sanitation through the community health strategy Coordination of the Water and Sanitation stakeholders for improved synergy	*EU:* support Water Governance in various water boards, hygiene and sanitation in informal Settlements and Rural Water and Sanitation Improvement through the Trust Fund. *UNICEF:* Rural water supply and sanitation in the ASAL regions *World Bank:* support to water and sewerage improvement *ADB*: support to water and sewerage improvement	*Coordination/integration*: coordination with GOK and partner efforts at the WASH interagency coordinating committee Supporting the integration of WASH component s into diarrhea prevention, control and management *Strengthen and leverage partner engagement*: Integrating partner contributions to increase efficiency

Area 2: Neonatal and Child Health					
Baseline Information: IMR: 52/1,000 live births					
Objectives supporting Key National priorities by 2015	**Key Challenges and Gaps Addressed**	**Current efforts by GOK and USG**	**Key priority actions likely to have largest impact (contributions)**	**Support by other partners**	**GHI Principles**
		Support point of use water treatment, prompt diarrhea treatment with ORT and zinc and community led total sanitation Support hygiene and sanitation promotion at the community level, as well as through schools and health clinics Support to development of national communication guidelines on diarrhea prevention, control and management		*DANIDA*: support to community water schemes *JICA* : increasing water supply through community projects *AfD*: support to access to safe water and sanitation in major towns	
2.4 Increase infant HIV-free survival through universal access to PMTCT	Low coverage for early infant diagnosis (EID) and follow up Lack of awareness on safer breast feeding practices for HIV exposed babies	**USG**: Support expansion of EID Support ART, PMTCT and care and treatment for HIV	HIV diagnosis through EID, care and treatment.	*CHAI*: provides pediatric ARVs.	
2.5 Increase coverage to 80% of children under five getting prompt and effective treatment and other malaria prevention interventions	Inadequate diagnostic skills Lack of diagnostic equipment (microscopes and RDTs) Stock outs of LLINs and drugs in health facilities	**USG**: Support the training of clinical and laboratory personnel Support the development and production of laboratory diagnostic guidelines Support the procurement of diagnostic supplies and equipment (RDTs and microscopes) Support the procurement of anti-malarials (ACTs)	Support the distribution and monitoring of the use of diagnostic equipment (microscopes & RDTs) Support the distribution of LLINs Support the development and dissemination of key messages on malaria prevention in children under five years	*DfID and UNICEF*: Support the procurement of LLINs *DfID*: Supports monitoring and supervision and supports the development of technical guidelines for malaria control	*Health Systems Strengthening*: Improving the diagnostic capacities of health providers and facilities, building capacity for LLIN distribution *Women and Girl Centered Approach*: creating demand for children and girls to increase access to malaria control tools Innovation and research: Evaluating effectiveness of malaria control tools (drugs, new vaccines, LLINS)

Area 3: Neglected Tropical Diseases

Baseline Information:

- Mass Drug Administration will contribute towards the reduction in number of underweight, malnourished and stunted children under the Nutrition and Child Health targets, as well as to improved maternal health
- In the 2008 Kenya DHS, 35 percent of children under 5 were stunted, 16 percent were underweight, and 7 percent were wasted. In addition, 12 percent of women demonstrated malnutrition.
- WHO estimates more than 16 million pre-school and school aged children are at risk for soil transmitted helminth infection.
- One nationwide MDA has been conducted with donated mebendaazole; the coverage estimate from this MDA was only 34.9 percent of the targeted population. In Kenya, it is estimated that more than 9 million individuals are infected with schistosomes and 32 million people are eligible for MDAs.

Objectives supporting Key National priorities by 2015	Key Challenges and Gaps Addressed	Current efforts by GOK and USG	Key priority actions likely to have largest impact (contributions)	Support by other partners	GHI Principles
3.1 There is currently no national schistosomiasis control program, or NTD control program, although the need for one is recognized by the GOK	No national schistosomiasis/NTD control program	Current USG/GOK activities will contribute to the collection of the necessary data to design the appropriate control program.		*International Trachoma Initiative (ITI):* Mapping trachoma burden in Kenya.	
3.2 All primary school children be treated for soil-transmitted helminths (STH) once a year	Mass drug administration, (MDA) programs can be resource intensive and drug availability can be limited Because of the reliance on partners for MDA drugs such as albendazole, treatment of school children has only been carried out one time Inadequate GOK resources devoted to MDAs for program and coordination	**USG** and **GOK** are determining best approaches for improving access and increasing uptake of treatment for schistosomiasis, STHs, lymphatic filarasis (LF) and trachoma. Increased diagnosis and treatment capacity, including evaluation of rapid diagnostic tests Leadership and management training Increased human resources for health Improved supply chain systems	Optimal MDA program-optimal delivery system and frequency for greatest health impact to improve efficiency and minimize resource needs Improved tools for monitoring and evaluation to assess impact in ways that translate well for policy- and decision-makers Identifying synergistic impact of NTD control on other health programs, including diarrheal and respiratory illness incidence, improved vaccine efficacy, and decreased susceptibility to malaria and HIV	*WHO*: Provides support for operational research. *Schistosomiasis Consortium for Operational Research and Evaluation (SCORE):* Provides support for operational research on best treatment practices. *Deworm the World/Innovations for Poverty Action (IPA)*: Works with the Ministry of Education on School Health Programs *Glaxo-Smith Kline (GSK) and Merck*: Donate treatment doses	*Country ownership*: supporting GOK as they design and implement the appropriate control program *Strengthen and leverage partner engagement*: Working with donors and NGOs to maximize impact of NTD strategy *Health Systems Strengthening*: Supporting supply chains for MDA *Metrics, monitoring and evaluation:* Evaluating the impact of NTDs on maternal, neonatal and child morbidity and mortality *Research and Innovation*: Supporting examination of NTD burden in Kenya, development of better diagnostic tools, and lessons learned for program implementation

APPENDIX 3: RESULTS FRAMEWORK