UNITED NATIONS JOINT PROGRAMME *on* REPRODUCTIVE, MATERNAL, NEWBORN, CHILD, AND ADOLESCENT HEALTH *2016–2020*

REDUCING PREVENTABLE MATERNAL, NEWBORN, AND CHILD DEATHS IN TEN HIGH-BURDEN COUNTIES IN KENYA

UNFPA · World Health Organization · unicef · The World Bank · UNAIDS · UN WOMEN United Nations Entity for Gender Equality and the Empowerment of Women

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REDUCING PREVENTABLE MATERNAL, NEWBORN, AND CHILD DEATHS IN TEN HIGH-BURDEN COUNTIES IN KENYA

CONTENTS

Country: Kenya

Programme Title:

United Nations Joint Programme on Reproductive, Maternal, Newborn, Child, and Adolescent Health in Ten High-burden Counties in Kenya 2016–2020

Joint Programme Outcome: By 2020, ten counties with a high maternal mortality burden enjoy increased utilization of integrated quality reproductive, maternal, newborn, child, and adolescent health, HIV, and gender-based violence services, which contribute to the reduction of maternal, newborn, and child mortality in Kenya.

Programme Duration: 2016–2020

Anticipated Start: October 2016
End Date: December 2020

Fund Management Option(s): Combination

Managing or Administrative Agent: UNFPA

Total estimated budget*:
USD 40,840,833

Out of which:
1. **Committed budget:** USD 20,450,433
2. **Unfunded budget:** USD 20,390,400

* Total estimated budget includes both programme costs and indirect support costs

Sources of budget:
- Government: in kind
- H6 agencies: USD 14,408,049
- Danida: USD 6,042,384
- Donors
- NGOs

Joint Programme Signatories

UN/H6 Agencies
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Ms. Zebib Kavuma *UN Women, Country Director* 
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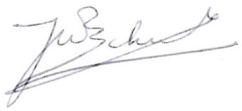
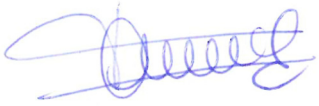
Mr. Werner Schultink *UNICEF, Representative* 
Ms. Diarietou Gaye *World Bank, Country Director for Eritrea, Kenya, Rwanda, and Uganda* 

ACRONYMS AND ABBREVIATIONS

AIDS	acquired immune deficiency syndrome
ART	antiretroviral therapy
GBV	gender-based violence
H6	partnership among UNAIDS, UNICEF, UNFPA, UN Women, WHO, and World Bank
HIV	human immunodeficiency virus
HPV	human papilloma virus
MMR	Maternal Mortality Ratio
RMNCAH	reproductive, maternal, newborn, child, and adolescent health
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization

EXECUTIVE SUMMARY

This document outlines the Joint Programme on Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) of the Government of Kenya and United Nations H6 partners (UNAIDS, UNFPA, UNICEF, WHO, UN Women, and the World Bank), working together towards the reduction of preventable maternal, newborn, and child deaths in ten high-burden counties in Kenya during the period October 2016 to December 2020. The H6 partnership is a global initiative of the United Nations to support the implementation of maternal, newborn, child, and adolescent health programmes at the country level following the UN Secretary-General's Global Strategy for Women's and Children's Health in September 2010.[1]

In March 2016, the six United Nations (UN) agencies previously known as H4+ recommitted at the global level to operationalizing the global strategy and rebranded themselves as H6, committing to further align and strengthen coordination among themselves to achieve the ambitious targets set under Goal 3[2] of the Sustainable Development Goals. It is within this framework that the H6 agencies in Kenya have developed a joint programme to demonstrate their commitment and renewed focus.

The Kenya Joint Programme on RMNCAH brings together the wealth of expertise located within the government and H6 partners and makes use of the lessons learned during the implementation of the first round of the RMNCAH programme, implemented in six high-burden counties (Mandera, Marsabit, Wajir, Isiolo, Lamu, Migori)[3] in Kenya between March 2015 and September 2016, with funding from the Reproductive, Maternal, Newborn, and Child Health (RMNCH) Trust Fund. The trust fund was established in 2013 by UNICEF, UNFPA, WHO, and development partners[4] as a global-level funding mechanism designed to finance high-impact, priority interventions that countries have already included in their reproductive, maternal, neonatal, and child health plans, in order to accelerate the reduction of maternal and child deaths.

The Department for International Development of the United Kingdom and the Government of Norway have been pooling resources in the trust fund. Towards the end of 2016, the RMNCH Trust Fund ended.

1 Every Woman Every Child (2016): 'UN Secretary-General Announces Members of the High-Level Advisory Group for Every Woman Every Child' [Press release]. Retrieved from http://www.everywomaneverychild.org.
2 Ensure healthy lives and promote well-being for all at all ages.
3 UN H4+ agencies (2014): *Improving Maternal and Newborn Outcomes in Six High Burden Maternal Mortality Counties in Kenya: Isiolo, Lamu, Mandera, Marsabit, Migori, and Wajir*, December 2014.
4 The Department for International Development of the United Kingdom and the Government of Norway.

Unspent resources at the country level have been re-programmed towards RMNCAH investment cases. In 2015, the Global Financing Facility, which is a multi-stakeholder partnership that supports country-led efforts to improve the health of women, children, and adolescents, was launched, with the H6 partners as the technical advisers. Kenya's national Ministry of Health has developed a national RMNCAH Investment Framework, which presents Kenya's RMNCAH vision and prioritizes areas for investment and action at national and/or county levels to ensure that affordable, evidence-based, high-impact interventions are delivered to improve RMNCAH results.[5]

In 2016, the H6 agencies applied to various sources for funding of the second phase of the UN Joint Programme on RMNCAH (which was scheduled to start in October 2016) in the same six counties. During the midterm review of the joint programme in 2018, the Government of Kenya and H6 partners will identify four additional counties to benefit from the joint programme, in order to further maximize the potential for success in the reduction of maternal, newborn, and child mortality in Kenya.

The Joint Programme on RMNCAH is aligned to Kenya's National Reproductive Health Strategy and contributes to the country's national development plans and goals on reproductive health and child health, as well as HIV and gender. It further supports the country in its efforts to adhere to international commitments on protecting reproductive health rights and child rights. The joint programme will be implemented within the framework of the 2014–2018 United Nations Development Assistance Framework in Kenya and its successor. The programme will leverage the support of other programmes implemented by UN and other agencies – with funding from UN core resources or development partners – and also of public–private partnerships such as the Private Sector Health Partnership Kenya. The joint programme is results based and ensures the integration of gender equality and human rights considerations throughout implementation, thereby ensuring a rights- and equity-based approach to addressing the identified disparities.

The overall outcome of the UN Joint Programme on RMNCAH is that, by 2020, ten counties with high maternal mortality burden (Mandera, Marsabit, Wajir, Isiolo, Lamu, Migori, plus four additional counties to be selected) will enjoy increased utilization of integrated, quality reproductive, maternal, newborn, child, and adolescent health, HIV, and gender-based violence (GBV) services, to contribute to the reduction of maternal and newborn mortality in Kenya. While long-term investments in all the building blocks for health systems are required to address these issues, the joint programme will work on implementing evidence-based, equitable, and efficient high-impact interventions that will contribute to the long-term sustainability of the results achieved.

5 Kenya Ministry of Health (2014): *Transforming Health: Accelerating Attainment of Universal Health Coverage,* Kenya Health Sector Strategic and Investment Plan, July 2014–June 2018.

Specifically, the UN Joint Programme on RMNCAH will focus on three intermediate outcomes:

1. Improved access to, and quality of, integrated RMNCAH, HIV, and GBV services
2. Increased demand for quality RMNCAH, HIV, and GBV services
3. Strengthened institutional capacity at county and national levels for planning and budgeting, coordination, supportive supervision, and monitoring and evaluation of RMNCAH, HIV, and GBV services

The joint programme will be coordinated through an inclusive coordination and management structure, with overall oversight and accountability provided by a high-level steering committee comprised of UN heads of agencies and senior national government representatives. A technical working group and county coordination mechanism will be established for the implementation and monitoring, while a secretariat managed by UNFPA and led by a programme coordinator will be responsible for the day-to-day management of the joint programme. A joint resource mobilization committee will be established for filling the budget gap.

The total budget of the Joint Programme on RMNCAH is estimated to amount to USD 40.81 million, of which over USD 14.4 million will be contributed by the UN H6 agencies from their own resources. The Government of Denmark has committed an additional DKK 40 million, equivalent to USD 6 million. The remaining gap required to implement the proposed interventions is USD 20.36 million. The H6 partners will continue leveraging their core funding to sustain the gains made in the first phase of implementation, while at the same time supporting counties to forge new partnerships for the mobilization of additional resources.

1. SITUATION ANALYSIS

1.1 Introduction

By the end of 2015, Kenya had made modest progress towards achieving the eight Millennium Development Goals. Through the implementation of Vision 2030 and subsequent medium-term plans, the Government of Kenya has demonstrated its commitment to achieving its long-term goal of a "globally competitive and prosperous nation with a high quality of life by 2030, that aims to transform Kenya into a newly industrializing, middle-income country providing a high quality of life to all its citizens by 2030 in a clean and secure environment".[1]

Kenya retains its position as the largest of the three East African economies by prioritizing and investing in large-scale infrastructure development and further attracting foreign investment. Economic growth continues to increase slowly at 5.6 percent in 2015, up from 5.3 percent in 2014.[2] Despite this, nearly half (42 percent) of Kenya's population of 44 million live below the poverty line, and access to the most basic social services – education, health, water, and sanitation – remains elusive to a large proportion of citizens. Under the new constitution, enacted in 2010, power was devolved from the national government to 47 county governments with the aim of bringing services closer to the people.

1.2 Health Status

1.2.1 Maternal Health

Kenya's Maternal Mortality Ratio (MMR) stands at about 362 deaths per 100,000 live births.[3] In other words, for every 1,000 live births in Kenya in the seven years preceding the 2014 Kenya Demographic and Health Survey, approximately four women died during pregnancy, during childbirth, or within two months of childbirth. Estimates suggest that more than 5,000 women and girls die each year as a result of pregnancy-related complications. Additionally, close to 250,000 women are estimated to suffer from disabilities caused by complications during pregnancy and childbirth each year.[4] Overall between 1990 and 2010, despite the global MMR reducing by close to 50 percent, Kenya recorded no significant change in MMR, which highlights insufficient

1 Kenya Ministry of Planning and National Development and National Economic and Social Council (2007): *Kenya Vision 2030: A Globally Competitive and Prosperous Kenya*, Nairobi.
2 Kenya Economic Survey 2016.
3 Kenya National Bureau of Statistics and ICF Macro (2010): *Kenya Demographic and Health Survey 2008-09*, Calverton, Maryland.
4 http://www.policyproject.com/pubs/MNPI/Kenya_MNPI.pdf.

progress in reducing maternal mortality in Kenya. This national MMR estimate however obscures disparities between counties, with the MMR ranging from 187 deaths per 100,000 live births in Elgeyo Marakwet County to 3,795 deaths per 100,000 live births in Mandera County.[5]

The high MMR in selected counties is a reflection of major supply and demand gaps and challenges in health service coverage, which result in continued disparities among counties, between urban and rural residents, and among different population groups. Coverage and utilization indicators show some improvement, but much more needs to be done to address inequities and to reach universal health care.

The *Kenya Demographic and Health Survey 2014* showed that the total fertility rate in Kenya declined from 4.6 in 2008/2009 to 3.9 in 2014. Again, there are significant differences in county fertility rates, with rates particularly high in Wajir (7.8) and relatively high in other counties (Migori 5.3; Mandera 5.1; Marsabit 5.0; Isiolo 4.9; and Lamu 4.3). However, there has been no change in teen pregnancy, with one in five (18 percent) adolescents in the 15–19 age group having started childbearing (see the section on adolescent health below).

According to the *2013 Service Availability and Readiness Assessment Mapping Report*, the average availability of services defined within the Kenya Essential Package for Health levels stands at 41 percent, with only 7 percent of facilities being able to offer all the services.[6] A major hindrance to the provision of basic lifesaving obstetric and newborn care is lack of necessary supplies and equipment, as well as regular stock-outs of the essential commodities needed to provide emergency obstetric and neonatal care services. Aside from limited equipment and supplies, a lack of technical know-how among health care workers, especially in lower-level facilities (health centres and dispensaries), hinders the provision of quality services.

In the current six selected counties, female genital mutilation/cutting is prevalent. In the four counties of Mandera, Wajir, Marsabit, and Isiolo, more than 90 percent of pregnant women may have undergone female genital mutilation/cutting, with a fair proportion having undergone the severe forms (Type III).[7] This often leads to complications that the available staff are ill equipped to address. Further, long-term morbidity related to these complications often results in a greater number of mothers who experience severe long-term complications resulting from pregnancy and childbirth than those who die. Such complications include debilitating obstetric fistula. Estimates indicate that family planning may contribute indirectly to the prevention of up to 40 percent of maternal and newborn deaths.[8] Contraceptive prevalence rate estimates in four of the target counties (Mandera, Marsabit, Isiolo, and Wajir) are less than 10 percent, with a total fertility rate of close to seven.

5 UNFPA/University of Nairobi Population Studies and Research Institute (2014): *Situational Analysis Report on Ending Preventable Maternal Mortality in Kenya*.

6 Kenya Ministry of Health (2014): *Kenya Service Availability and Readiness Assessment Mapping Report*.

7 http://www.childinfo.org/files/Marsabit_Report.pdf.

8 Byrne et al. (2012): 'Context-specific, Evidence-based Planning for Scale-up of Family Planning Services to Increase Progress to MDG 5: Health Systems Research', *Reproductive Health*, Vol. 9, p. 27.

1.2.2 Neonatal Health

Of the eight million deaths occurring globally on a yearly basis among children under five years, the major causes are preventable. The neonatal (newborn) mortality rate in Kenya has declined. Recent estimates from the *Kenya Demographic and Health Survey 2014* suggest that infant and under-five mortality in the country dropped to 52 per 1,000 live births in 2014 from 74 in 2008. According to the RMNCAH Investment Framework, these declines have been driven mainly by the enhanced use of mosquito nets, increases in antenatal care, skilled attendance at childbirth, postnatal care, contraceptive use, exclusive breastfeeding practices, and a decrease in unmet family planning needs, as well as overall improvements in other social indicators such as education and access to water.[1]

The neonatal mortality rate declined from 31 deaths per 1,000 births to 22 between 2008 and 2014. However, during the past decade, this rate exhibited the slowest decline. It is notable that more than 56 percent of infant deaths may be occurring within the neonatal period.[2] Further reductions in infant and child mortality require a steeper decline in the neonatal mortality rate, which is closely linked to improvements in maternal health services, including intrapartum care. Many newborns are left with long-term disabilities that impact negatively on their quality of life.

Therefore, there is an urgent need to ensure that mothers and their children are provided with comprehensive services to prevent mother-to-child transmission of HIV, primary health care, and social support. More investment is required to ensure that fewer infections occur in children as a result of mother-to-child transmission of HIV.

Kenya has just developed its Newborn Action Plan (Maternal and Newborn Health Scale-up Plan) under the umbrella of the 'Every Newborn Every Mother' initiative, in which the Kangaroo Mother Care and Community Health Strategy features heavily, together with emergency obstetric and neonatal care.

1.2.3 Child Health

As mentioned above, the eight million deaths among children under five around the world are largely preventable. Presently, HIV accounts for 2 to 10 percent of global childhood mortality, translating to more than 200,000 deaths per year. This proportion is as high as 27–42 percent in countries with a high HIV burden.[3]

In Kenya, it is estimated that 74,000 children die each year before their fifth birthday. Under-five mortality in Kenya dropped from 74 deaths per 1,000 live births to 52 between 2003 and 2014. Regional disparities exist, with higher under-five mortality rates in western Kenya. Migori reported a rate of 130 (*Multiple Indicator Cluster Survey*

1 Kenya Ministry of Health (2015): Kenya RMNCAH Investment Framework.
2 Mwaniki et al. (October 2010): 'An Increase in the Burden of Neonatal Admissions to a Rural District Hospital in Kenya over 19 Years', *BMC Public Health*, DOI: 10.1186/1471-2458-10-591.

3 Black, Robert E. et al. (2013): 'Maternal and Child Undernutrition and Overweight in Low-income and Middle-income Countries', *The Lancet*, Vol. 382, No. 9890, pp. 427–451.

A group of women on Pate Island, Lamu County, during an awareness creation campaign on maternal health.

2011), whereas Marsabit reported 70 (*Multiple Indicator Cluster Survey 2008*). In the north-eastern region (Garissa, Wajir, and Mandera Counties), an under-five mortality rate of 44 per 1,000 live births was reported (*Kenya Demographic and Health Survey 2014*). Forty-five percent of under-five deaths occur during the neonatal period.

Under-five mortality remains very high in the six counties targeted in the previous RMNCAH project, with the majority of deaths caused by pneumonia and diarrhoea (in some localities, malaria remains the number one child killer). Kenya is currently contributing a high number of under-vaccinated children (400,000); of these children, the six counties contribute 13 percent. The six counties report that fewer than 50 percent of children have access to preventive and timely recommended treatment against the major killers of children along the continuum of care.

There is therefore a need to invest in interventions that will address health system challenges that hinder access to preventive and curative actions

against major killers. It is crucial to maintain and consolidate existing highly effective and high-impact child health interventions. These include the introduction of Amox DT for the treatment of paediatric pneumonia, and Zinc and oral rehydration solutions for diarrhoea. It is also important to build on Global Fund investments for malaria case management. If these are reduced at the expense of investing only in maternal and neonatal health, one may see an under-five mortality increase. Strategies to improve child health include Integrated Management of Childhood Illnesses, integrated Community Case Management of Childhood Illnesses, and demand generation, as well as supplementing anti-malaria activities, including through the use of social mobilization platforms.

1.2.4 Adolescent Health

Kenya is a youthful nation where children below the age of 18 years make up 49 percent of the population. Adolescent needs are quite diverse, depending on age, sex, marital status, residence, education attainment, etc., and are confronted by different risks and challenges – biological, emotional, and social. Adolescents aged 10 to 19 years constitute a sizeable 24 percent of the population. Except for data related to sexual and reproductive health, which is measured through the Kenya Demographic and Health Surveys, there is inadequate information in Kenya on the situation of adolescent health. There is scarcity of data on the leading causes of morbidity and mortality among adolescents, their mental health, the status and impact of accidents among adolescents, as well as indicators on the national status of drug and substance abuse among adolescents. The government has developed the National Adolescent Sexual Reproductive Health Policy, 2015.

Some of the health-related issues affecting adolescents include barriers in accessing information on sexual and reproductive health, which result in a lack of knowledge and skills to prevent unwanted pregnancy and HIV infection. In addition, adolescent girls and young women are disproportionately affected by sexual and gender-based violence, including harmful cultural practices such as early and forced child marriage and female genital mutilation. In 2015, 30 percent of all new HIV infections occurred among adolescent girls and young women. In combination with a high rate of teenage pregnancies, there is also an increased risk of HIV transmission from mother to child (Kenya HIV Estimates 2016). Therefore, HIV testing during antenatal care is a critical entry point for access to antiretroviral treatment and preventing mother-to-child transmission of HIV.

Community support is also important to ensure that those who have power over young girls support the interventions being promoted, ensuring that girls profit from the programme efforts. Strategies to support adolescent mothers must take cognizance of the broader overall agenda of supporting the rights of girl children and adolescent girls as a vital component of fostering sustainable development.

Purity Bahati and Naomi Kitsao, teen mothers.

Although the Constitution of Kenya highlights the importance of investing in this age group, adolescent sexual and reproductive health still remains a low priority, and existing legal frameworks are not effectively implemented to address harmful cultural practices such as early and forced child marriage, female genital mutilation, and GBV. With limited access to contraception, teen pregnancy remains high and has not changed since 2008 (*Kenya Demographic and Health Survey 2014*); the teenage pregnancy rate in Kenya stands at 18 percent.[1] This implies that about one in every five girls between the age of 15 and 19 has either had a live birth or is pregnant with their first child. The rate increases rapidly with age, from 3 percent among girls aged 15 to 40 percent among girls aged 19. This implies that many girls continue to experience health-related

1 Kenya National Bureau of Statistics (2014): Kenya National Housing and Population Census.

challenges, including mortality and morbidity due to birth-related complications and unsafe abortion; in some instances, they are forced into early marriages.

Only half of adolescents transition to secondary school, with high dropout rates, particularly for girls.

The net effect of this is that the prospects for girls securing decent economic opportunities are greatly compromised; this in turn jeopardizes the country's potential for reaping the demographic dividend.

The RMNCAH Investment Framework estimates that the high teenage pregnancy rates are due to early marriage, a high unmet need for contraception, and poor access to family planning services. Existing adolescent programmes are fragmented, with low coverage, and many are not effectively implemented or adequately evaluated to build evidence on their efficacy or cost effectiveness. Additionally, issues such as substance/alcohol abuse, mental health, self-harm, injuries, and violence are growing problems. Addressing and mitigating the risks and vulnerabilities adolescents – particularly adolescent girls – face requires an effective and integrated multisectoral response that addresses the needs of adolescents, both within and outside schools, and provides appropriate safety nets.

1.2.5 Gender-based Violence

Women and young girls in Kenya are particularly vulnerable to gender-based violence. The *Kenya Demographic and Health Survey 2014* found that 41 percent of ever-married women aged 15–49 years have experienced physical or sexual violence. Among ever-married women, the most commonly reported perpetrators of sexual violence are current spouses/partners (55 percent). The survey also found that 21 percent of Kenyan women have undergone female genital mutilation. The survey notes variations in the experience of sexual violence across the country. In the north-eastern region, which includes five of the six counties currently covered by the RMNCAH project, sexual violence reports are among the lowest, accounting for less than 1 percent of cases. However, anecdotal evidence would suggest that this is a gross under-representation of the magnitude of the problem.

GBV is fuelled by a number of factors, including socio-cultural dynamics that contribute to socialization that normalizes and condones GBV, as well as slow and uneven enforcement of anti-GBV laws and policies. These factors often contribute to or fuel the spread of harmful cultural practices such as female genital mutilation/cutting, early and forced marriage, sexual violence, and other forms of gender-based violence. Gaps exist in providing comprehensive services to survivors of GBV.

There are only a few locations where GBV survivors can access services from key sectors (e.g.

health, security, psychosocial, and legal) through a single referral. Translating the known linkages between gender inequality and sexual reproductive health rights concerns, including GBV and HIV, into practical programming in support of survivors and people living with HIV and AIDS remains a challenge in Kenya. Empirical evidence shows that living with HIV/AIDS may constitute a risk factor for experiencing GBV, with an increase in violence following a disclosure of HIV status, or even following a disclosure that HIV testing has been sought.[2] Among women, the fear of experiencing violence may potentially delay an individual's decision to disclose her HIV status and seek treatment when necessary and when most important for survival.

In line with the provisions of the national guidelines for the management of survivors of sexual violence (revised 2012), the Government of Kenya has made significant progress in addressing the needs of survivors of violence. There are a small number of health facilities in Kenya where survivors can get free and immediate HIV testing and counselling, post-exposure prophylaxis, emergency contraceptive pills, and prophylaxis and treatment for sexually transmitted infections. The facilities also collect samples for medico-legal interventions, which includes the filling in of the Post-rape Care Form. These facilities thus promote a holistic approach to service delivery for survivors of sexual violence, tailored to their needs and underpinned by principles of dignity and respect.

2 Amuyunzu-Nyamongo, M. and K. Kiragu (2005): 'Gender Roles and Sexual Behaviour in Africa', *AIDS in Africa: Scenarios for the Future*, UNAIDS.

However, gaps related to health worker capacity to manage sexual and gender-based violence and poor linkages among sexual violence and GBV service providers still exist, especially in the public sector. Under-reporting of GBV cases, inefficient data collection and management, and inadequate case management and service provision for survivors make it difficult to collect accurate information on the prevalence of the problem. Without accurate data, the proper costing and budgeting of services for GBV survivors continues to be underestimated, and this situation reduces the possibility of services reaching all those in need.

1.2.6 HIV and AIDS

With 1.5 million people currently living with HIV out of a population of approximately 44 million, Kenya has the second largest epidemic in east and southern Africa and the fourth largest globally. The epidemic is deeply rooted among the general population, though there is high geographical variability of the HIV burden – ranging from less than 1 percent prevalence in the northern arid and semi-arid areas to a prevalence of over 20 percent in some counties in the former Nyanza Province. At the same time, the epidemic is also characterized by very high prevalence among key populations (sex workers, men who have sex with men, and people who inject drugs).

Women in Kenya are more vulnerable to getting HIV infection than men, with a national HIV prevalence of 6.3 percent against 5.5 percent. The high burden of HIV and AIDS in Kenya accounts

for 30,800 annual adult deaths. Furthermore, AIDS-related deaths account for one-fifth of maternal mortality, and one-sixth of deaths among children under the age of five, with 5,000 annual deaths. HIV infection in pregnancy increases the risk of miscarriage, anaemia, post-partum haemorrhage, puerperal sepsis, and post-surgical complications, as well as the risk of tuberculosis and malaria infection. Among young people (aged 15–24), AIDS is the leading cause of death, resulting in 3,850 deaths in 2015. A total of 35,776 young people acquired HIV in 2015 (51 percent of all new adult infections), with 23,300 infections in young women and 12,500 infections in young men.

People living with HIV have been shown to have higher rates of human papilloma virus (HPV) infection and to be more likely to be infected with high-risk HPV and multiple HPV types than HIV-negative individuals. Studies have shown that the prevalence of HPV 6 or 11 was nearly four to six times higher among women living with HIV than it was among HIV-negative women. As such, cervical cancer is considered to be an AIDS-defining illness.[3]

While still high, AIDS-related deaths have decreased in the past few years. This decrease is directly attributed to the wider and easier access to antiretroviral therapy (ART). The ART programme has scaled up tremendously since 2008: the number of adults living with HIV on ART has increased from 238,000 to almost 900,000 in 2015. Impressive gains have also been made on biomedical interventions, particularly the prevention of mother-to-child transmission of HIV. This coverage has increased to 75 percent, contributing to a decrease in mother-to-child transmission of HIV to 8.3 percent and 6,600 new infections among children, as compared to a transmission rate of 16 percent and 12,800 new infections in 2012 (*Kenya Framework for Elimination of Mother to-Child Transmission of HIV and Syphilis 2016–2021*). More intensified efforts are however necessary to eliminate mother-to-child transmission.

Kenya has been a pioneer in the integration of services. It is currently implementing the minimum package of reproductive health and HIV/AIDS services on a limited scale, and this now needs to be scaled up. Opportunities exist for the integration of HIV and RMNCAH services and the promotion of better linkages. These relate to prevention of mother-to-child transmission, antiretroviral therapy, and strengthening linkages between HIV and reproductive cancer screening.

HIV prevalence is low in five of the six counties that the Joint Programme on RMNCAH is focusing on. The exception is Migori, where prevalence is around 14 percent; 5.5 percent of all people living with HIV in Kenya live in Migori (*Kenya HIV Estimates 2016*). While the prevalence is low in the five other counties, the mother-to-child transmission rate is notably higher, especially in Mandera and Wajir. ART coverage is also low, resulting in a high number of HIV-related deaths relative to the number of people living with HIV.

3 UNAIDS (2016): *HPV, HIV and Cervical Cancer: Leveraging Synergies to Save Women's Lives*, Geneva.

Table 1: HIV-related Indicators for the Six Current Counties of the Joint Programme on RMNCAH

Indicator	Migori	Lamu	Mandera	Wajir	Isiolo	Marsabit
HIV prevalence	14.3%	3.5%	0.8%	0.4%	3.8%	1.4%
Mother-to-child transmission rate	9%	16%	39%	41%	16%	11%
Prevention of mother-to-child transmission coverage	90%	70%	6%	3%	70%	85%
ART coverage (15+)	88%	48%	2%	2%	53%	57%
New infections total	5,619	117	121	46	208	163
People living with HIV (15+)	78,621	2,149	2,884	1,089	3,385	2,659
Young people (15–24) living with HIV	18,411	432	653	246	719	565
Young people (15–24) newly infected	2,895	55	43	16	102	80
Young people (15–24) AIDS-related deaths	219	7	28	10	79	8
Children living with HIV	4,982	170	501	189	231	181
HIV-related deaths	1,749	62	258	97	98	77

Source: Kenya HIV Estimates 2016

1.3 Policy Context

Improving coverage for RMNCAH services is a priority for the Government of Kenya, as reflected in its Vision 2030, the 2010 Constitution of Kenya, and the Health Sector Strategic and Investment Plan 2014–2018.[1] The government has introduced new policies as well as initiatives such as free maternity services, the elimination of user fees for primary care, and the Beyond Zero campaign to address critical barriers to accessing basic care.

At the county level, there is a strong commitment to advance the rights and health of women and girls, as shown by the communiqué signed in May 2014 by the 15 governors of those counties contributing close to 98.7 percent of all maternal deaths. Finally, there is also strong commitment

1 Kenya Ministry of Health (2014): *Transforming Health: Accelerating Attainment of Universal Health Coverage*, Kenya Health Sector Strategic and Investment Plan, July 2014–June 2018.

from civil society and the private sector to support the cause, clearly demonstrated by initiatives such as the Private Sector Health Partnership Kenya.

Globally, there also is renewed momentum and support for RMNCAH as part of the Sustainable Development Goals and the updated Global Strategy for Women's, Children's, and Adolescents' Health (2016–2030), which aims to achieve the highest attainable standard of health for all women, children, and adolescents, and ensures that every newborn, mother, and child not only survives, but thrives. The Global Financing Facility for RMNCAH creates a new platform for collective action at the country level, and the Global Financing Facility Trust Fund is one of the main funding streams for the Every Woman Every Child movement. Such growing national and international commitments provide an opportune time to enhance both domestic and external support for RMNCAH in Kenya to ensure smart, scaled-up, and sustained financing.

Kenya has recently finalized its RMNCAH Investment Framework.[2] The framework focuses on translating political commitment into sustainable results. It recommends approaches and innovations relevant to the Kenyan context to address prioritized bottlenecks. It is further informed by the guiding principles of respecting human and reproductive health rights (as enshrined in the Kenyan constitution), promoting equity and gender equality, ensuring a health system responsive to client needs, and promoting leadership and ownership at both national and county levels. Emphasis is on achieving results by enhancing accountability through effectively leveraging performance incentives, optimizing efficiency through improved productivity, and integrating RMNCAH service delivery with other vertical programmes while ensuring the continuum of care.

The Kenyan constitution binds the government to provide 'the highest possible standard of health'.[3] In addition, devolution and the creation of semi-autonomous regions further offer an opportunity for the established counties to direct more investments towards the health sector. A transformative Vision 2030 development blueprint clearly stipulates strategies to strengthen the health care system so that it can deliver better and more accessible services.

Specific to RMNCAH, the President of Kenya has made a direct commitment to supporting the UN Secretary-General's Global Strategy for Women's and Children's Health, specifically to:

1. Progressively increase government allocation to health, with a greater focus on women, children, adolescents, and HIV, and ensure sustainable financing of the RMNCAH Investment Framework
2. Continue to provide free maternal and child health care services and remove user fees at government primary health care facilities
3. Implement policies, strategies, and laws that support gender equality and women's empowerment
4. Support and strengthen efforts in the implementation of strategies that ensure access to information on sexual and reproductive health services for adolescents

2 Kenya Ministry of Health (2015): Kenya RMNCAH Investment Framework.

3 http://www.cmd-kenya.org/index.php/new-constitution.

Finally, progressive political interest in maternal health and the elimination of mother-to-child transmission of HIV – spearheaded by the country's First Lady (the Beyond Zero campaign) and with overwhelming support of the spouses of all the county governors – has put a spotlight on maternal and newborn health as a national agenda item, in contrast to the past decade.[4] Some of the priority investment areas articulated include the following: rehabilitation of rural health facilities to offer comprehensive services; revamping of human resources for health, and implementing output-based approaches in health financing; and fast-tracking the implementation of the national community health strategy.[5]

Relevant national policy documents developed recently include the following:

1. **Kenya Health Policy 2014–2030:**[6] The policy aims to support equitable, affordable, high-quality health and related services, as well as the progressive realization of the right to health by employing a human rights–based approach in health care delivery.
2. **Kenyan Health Sector Strategic and Investment Plan 2014–2018:**[7] The plan places importance on investments relating to maternal and newborn health. Its impact targets include the reduction (by at least half) of infant, neonatal, and maternal deaths.
3. **Kenya Reproductive Health Strategy of 2009–2015:**[8] The strategy seeks to enhance the reproductive health status of all Kenyans by increasing equitable access to reproductive health services; improving the quality, efficiency, and effectiveness of service delivery at all levels; and improving responsiveness to client needs. Specifically, the strategy seeks to address the special reproductive health needs of the poor, 'hard to reach', and other vulnerable populations.
4. **Kenya RMNCAH Investment Framework:**[9] Kenya recently developed the RMNCAH Investment Framework, which presents the RMNCAH vision and prioritizes areas for investment and action to be taken at national and/or county level to ensure that affordable evidence-based and high-impact interventions are delivered to improve RMNCAH results.
5. **The National Policy for Prevention and Response to Gender-based Violence:**[10] The overall goal of this policy is to accelerate efforts towards the elimination of all forms of GBV in Kenya. It provides an implementation framework that spells out the roles and responsibilities of all stakeholders, and further recognizes the functions of the two levels of government along accountability, reporting, and management lines.
6. **The Kenya AIDS Strategic Framework 2014/15–2018/19:**[11] This is the strategic guide for the country's response to HIV at

4 http://www.emtct-iatt.org/wp-content/uploads/2013/12/Strategic-Framework-for-Engagement-of-the-First-Lady-in-HIV-Control-and-Promotion-of-MNCH-in-Kenya.pdf.
5 http://www.vision2030.go.ke/index.php/pillars/index/social.
6 Republic of Kenya, Ministry of Health (2014): *Kenya Health Policy 2014–2030: Towards Attaining the Highest Standard of Health*.
7 Kenya Ministry of Health (2014): *Transforming Health: Accelerating Attainment of Universal Health Coverage, Kenya Health Sector Strategic and Investment Plan, July 2014–June 2018*.
8 Kenya Ministry of Health (2009): *National Reproductive Health Strategy: 2009–2015*.
9 Kenya Ministry of Health (2015): Kenya RMNCAH Investment Framework.
10 Kenya Ministry of Devolution and Planning (2014): National Policy for Prevention and Response to Gender-Based Violence.
11 National AIDS Control Council/Ministry of Health (2014): Kenya AIDS Strategic Framework 2014/2015–2018/2019.

A happy mother after undergoing a Caesarean section at the newly upgraded Wajir Hospital in Wajir County.

national and county levels. The framework addresses the drivers of the HIV epidemic and builds on the achievements of previous country strategic plans to achieve its goal of contributing to the country's Vision 2030 through universal access to comprehensive HIV prevention, treatment, and care. All 47 counties also developed a County AIDS Strategic Plan in 2016, which will guide the AIDS response in each county in line with the framework.

7. **The Kenya National Adolescent Sexual and Reproductive Health Policy 2015:**[12] The policy seeks to enhance the sexual and reproductive health status of adolescents in Kenya and contribute towards the realization of their full potential in national development. The policy intends to bring adolescent sexual and reproductive health and rights issues into the mainstream of health and development.
8. **Kenya's Fast-track Plan to End HIV and AIDS among Adolescents and Young People of 2015**[13] aims to accelerate the response to end new infections and AIDS-related deaths among adolescents and young people.

12 Kenya Ministry of Health (2015): National Adolescent Sexual and Reproductive Health Policy.

13 Kenya Ministry of Health, National AIDS Control Council (2015): *Kenya's Fast-track Plan to End HIV and AIDS among Adolescents and Young People*.

9. **The Kenya Framework for Elimination of Mother-to-Child Transmission of HIV and Syphilis 2016–2021**[14] aims to facilitate Kenya's validation for the pre-elimination of mother-to-child transmission of HIV and syphilis by 2011, as per WHO guidelines.

1.4 Health Systems Challenges

The remaining gaps and obstacles are numerous and were grouped into four main areas by the RMNCAH Investment Framework for Kenya:

- **Inequitable health service coverage**, which results in continued disparities among counties, between urban and rural residents, and among different population groups, including adolescents.
- **Demand-side barriers** that limit access and utilization of proven high-impact interventions to realize Kenya's RMNCAH vision. These include long distances to health facilities, high costs, religious and sociocultural beliefs and practices, and low status of women, as well as lack of knowledge and information. The demand-side barriers are further compounded by provider attitudes and poor quality and limited integration of services, which hamper and discourage the utilization of services.
- **Supply-side challenges** due to suboptimal functioning of the health system (infrastructure, human resources for health, supply chain, health financing, health information, and leadership/governance). The main health system challenges include poor workforce distribution and productivity, coupled with funding gaps and weak supply chain management for the provision of essential RMNCAH commodities. This results in missing inputs critical to service delivery; incomplete and poor quality data and poor utilization of data from routine health information systems, which hamper evidence-based decision making and accountability for results; insufficient financing; and an inability to optimize the devolution dividend and make effective use of resources from both domestic and foreign partners due to capacity challenges and weak coordination at national and county levels.
- **High burden of HIV** and AIDS and related mortality and morbidity.

The RMNCAH Investment Framework focuses on strategies to address these major gaps.

1.5 RMNCAH Response

The Government of Kenya is supporting the RMNCAH response through the provision of public sector staff at facility, county, and national levels, as well as public sector infrastructure, equipment, and commodities.

14 Kenya Ministry of Health (2015): *Kenya Framework for Elimination of Mother-to-Child Transmission of HIV and Syphilis*, Every Mother and Child Counts, 2016–2021, National AIDS and STI Control Programme (final draft).

An aggressive policy environment conducive to stronger impact may make interventions targeting drastic reductions in maternal, neonatal, and child mortality more feasible in the country moving forward. First, the country's constitution binds the government to provide 'the highest possible standard of health'. In addition, devolution further offers an opportunity for counties to direct more investments towards the health sector.

Several development partners are currently supporting sexual and reproductive health and maternal and neonatal health interventions in Kenya, mostly focusing on the 15 counties where more than 98 percent of Kenya's maternal mortality occurs. They implement large programmes that involve training of health workers, strengthening of the referral system, undertaking community mobilization for demand creation, addressing harmful cultural practices, and ensuring an enabling and protective environment, in particular for girls and young women, including those from key populations and living with HIV. Development partner support for child health interventions in Kenya is limited, except for the Global Fund for AIDS, Tuberculosis, and Malaria and the Global Alliance for Vaccines Initiative. Most affected by this lack of support are interventions that address diarrhoea, pneumonia, broader adolescent health issues, and early childhood development, especially early stimulation.

Development partner support for RMNCAH programming in Kenya includes:

- Department for International Development: Maternal and newborn health and nutrition programmes in five counties (Turkana, Garissa, Homa Bay, Kakamega, and Nairobi); emergency obstetric and newborn care training through the Liverpool School of Tropical Medicine in 32 counties, including the H6 counties; national initiative to build midwifery skills implemented through the Liverpool School of Tropical Medicine.
- Government of USA: RMNCAH/HIV/nutrition programmes in four counties, including Nairobi and Turkana; provision of maternal and newborn health equipment nationally in 2015–2016; support to the Kenya Medical Supplies Authority for efficient forecasting, acquisition, warehousing, and distribution for US government–supported commodities and quality assurance for HIV commodities.
- Denmark: Contribution to the Joint Programme on RMNCAH in six counties; operational funds to all public Level 2 and Level 3 health facilities in all 47 counties in the country; support to the institutional development of County Departments of Health in all 47 counties, as well as the national Ministry of Health; support to the Gender Violence Recovery Centre in Nairobi.
- UNFPA: Delivery of comprehensive integrated maternal and newborn health/HIV prevention services; generating demand and providing family planning services; delivering integrated adolescent sexual and reproductive health services and supporting comprehensive sexuality education; coordinating and implementing compliance on GBV, reproductive health rights, and harmful cultural practices; and supporting population data systems in

three counties (Homa Bay, Kilifi, and Kasarani sub-county of Nairobi County).

- UNICEF: Child health, nutrition, and water and sanitation programmes in five counties (Turkana, Garissa, Homa Bay, Kakamega, and Nairobi); maternal and neonatal health programme funded by the Department for International Development from 2014 to 2019 in six counties, with 50 percent allocated for the strengthening of health systems. In addition, a maternal and newborn health programme in Bungoma through MANI/Options. Large-scale support in nutrition includes scaling of high-impact nutrition interventions in 23 arid and semi-arid counties, through the provision of technical, financial, and commodity assistance. This includes the six ongoing joint programme counties. In addition, general health system strengthening support to counties.
- WHO: Health systems strengthening for RMNCAH in four counties; overall health system strengthening support to the national Ministry of Health.
- World Bank: Health Sector Support Project, which focuses on scaling up results-based financing in 20 arid and semi-arid counties plus Migori County, the Health Insurance Subsidy Programme for the poor in all 47 counties, and building capacity in midwifery targeting arid and semi-arid counties; the new project Transforming Health Systems for Universal Care, which focuses on improving primary health care results, with a focus on RMNCAH, using a results-based approach in all 47 counties, strengthening institutional capacity at both national and county levels and promoting cross-county and intergovernmental collaboration. Transforming Health Systems for Universal Care is partially funded through the Global Financing Facility Trust Fund.
- UNAIDS: Undertaking political advocacy and provision of strategic guidance to the AIDS response to address the impact of HIV on RMNCAH, in consultation with national and county governments; monitoring of progress for identification of programmatic gaps and catalysing actions accordingly; mobilization of communities for service demand creation and engagement.
- The County Innovation Challenge Fund: Bungoma, Garissa, Homa Bay, Kakamega, Nairobi (Embakasi and Kamukunji Sub-counties), and Turkana Counties. Applications targeting Garissa.
- Japan: Support to national Ministry of Health and counties in the implementation of a universal health care road map, through budget support and capacity building of County Health Management Teams.

It would be useful to take into account lessons learned from all this work. Results directly attributable to Department for International Development investments include new comprehensive/basic emergency obstetric and newborn care centres, integration at centres of excellence, substantial scale-up of community units, and full buy-in at the national Ministry of Health and at the county level.

Finally, the private sector – through its corporate philanthropy as well as through innovations – is also making important strides to support the health sector. For example, private sector partners established the Private Sector Health Partnership Kenya. Safaricom, Huawei, Philips, Merck Sharp & Dohme, and GlaxoSmithKline pledged support to complement ongoing efforts to significantly improve maternal health in the six counties targeted through the H6 RMNCAH programme. UNFPA and the Kenya Healthcare Federation were mandated to convene and coordinate partners in meeting their commitment.

A number of public–private partnership initiatives have taken off, and promising new models that offer the best of both the public and private sectors are being tested, with the potential for scaling up the delivery of care for vulnerable and poor populations in low-resource settings. Total current investment commitments of Private Sector Health Partnership Kenya partners are around USD 2 million. Initiatives include the following:

- The UNICEF/Philips/Maker/Concern Worldwide Maternal and Newborn Health Innovations Project, through which the Philips Foundation invested over USD 1 million to support Kenya to design and manufacture medical devices, equipment, and innovations domestically, especially for maternal and newborn health. This project started in August 2016.
- A Community Life Centre model, which will be inaugurated later this year in Mandera County in collaboration with Philips. The objective is to demonstrate that maternal and new-born health can be improved through innovation, even in the most difficult conditions and in places no one has yet succeeded.
- Safaricom and Huawei have started to pool their unique expertise and services in information technology and mobile connectivity to design and test transformational digital health solutions. A project is currently being designed with Lamu County Government and Mombasa Referral Hospital for the testing of telemedicine between Lamu district and main hospitals and Mombasa Referral Hospital. Partners will also support the introduction of a comprehensive electronic management system for health facilities to improve tracking of patients, availability of medical commodities, data gathering and reporting, and facility management.
- Merck Sharp & Dohme recently announced a USD 1.5 million grant, through its MSD for Mothers initiative, to a new project by Jhpiego that will engage with the Kenya Red Cross Society in Mandera and Migori Counties to explore and document innovative approaches to adolescent and youth sexual and reproductive health service delivery to inform the national roll-out of Kenya's policy on this issue. The project will seek innovative partnerships with businesses in the two counties, including the Philips Community Life Centre in Mandera.

1.6 Gaps in the RMNCAH Response

Whereas the 15 counties in Kenya with the highest maternal mortality are located mainly in the north and east of the country, they are also generally the counties with the lowest coverage of services and investment.

Sections 2.1 and 3.3 of this document set out the justification for the selection of the six counties that will be targeted in this Joint Programme on RMNCAH. Annex 2 contains an in-depth analysis of the maternal mortality burden per county in Kenya, and a recent multi-dimensional ranking with sensitivity analysis that was undertaken during the development of the RMNCAH Investment Framework.

Newly upgraded maternity wing courtesy of UNFPA's support at the Mpeketoni Sub-county Hospital in Lamu County.

2. PROGRAMME CONTEXT

2.1 Description of the Previous UN H6 RMNCAH Programme

This Joint Programme on Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCAH) for 2016–2020 builds on the experience of the United Nations H6 agencies in implementing the RMNCAH activities in six high-burden counties[1] in Kenya between March 2015 and September 2016 with a grant of USD 14.9 million from the global RMNCH Trust Fund.

Target Counties

In order to identify the six target counties of the RMNCAH project during 2015 and 2016, UNFPA, in conjunction with the University of Nairobi Population Studies and Research Institute, carried out a rapid situational analysis on the burden of maternal mortality and its distribution in 2014 based on the 2009 Population and Housing Census.[2] This analysis ranked all 47 counties in Kenya based on their maternal mortality rate, and counties with the highest rate were identified.

These high-mortality counties were then further prioritized based on donor project presence. Six counties with the least project presence were then selected to benefit from the RMNCAH project: Mandera, Wajir, Marsabit, Isiolo, Lamu, and Migori. The six target counties were also identified as priority counties in the RMNCAH Investment Framework, which ranked counties based on the modern contraceptive prevalence rate, number of skilled birth attendants, number of antenatal care visits (ANC4+), vaccination, and HIV prevalence among females using data from the Kenya Demographic and Health Survey 2014 and the Kenya National AIDS and STI Control Programme. Annex 2 of this document contains more information on both of these ranking methodologies.

Catalytic Nature of the Project

The high maternal mortality rate in the selected counties is a reflection of many factors, the key among them being poor health infrastructure. While long-term investments in all the building blocks for health are required to address the high maternal mortality rate, this project has utilized RMNCH Trust Fund resources for critical gap filling in the selected counties.

1 *Improving Maternal and Newborn Outcomes in Six High-burden Maternal Mortality Counties in Kenya: Isiolo, Lamu, Mandera, Marsabit, Migori, and Wajir.*
2 UNFPA/University of Nairobi Population Studies and Research Institute (2014): *Situational Analysis Report on Ending Preventable Maternal Mortality in Kenya.*

The project has specifically focused on four outcome areas:

1. Increasing access to and improving quality of RMNCAH services
2. Generating community demand for RMNCAH services
3. Capacity building at county and national levels
4. Strengthening monitoring and evaluation systems

Key Interventions

Key interventions of the RMNCAH project for 2015–2016 included the following:

1. Increasing access and improving delivery of quality RMNCAH services:

- Rapid assessment of capacity of existing facilities to offer emergency obstetric and newborn care services.
- Equipping health facilities to provide emergency obstetric and newborn care services appropriate for each level.
- Training of health service providers on comprehensive/basic emergency obstetric and newborn care lifesaving competencies.
- Building capacity of health care workers in identification and management of long-term pregnancy and labour-related morbidity, e.g. obstetric fistula.
- Application of quality improvement methodology at the point of service delivery; institutionalization of the Kenya Quality Model for Health.
- Operationalized county plans for a functional referral system.
- Establishment of innovative maternity waiting homes using new approaches.
- Renovation of dilapidated maternity and newborn units.

2. Demand generation for RMNCAH services:

- Demand-side financing innovations such as referral and transport vouchers and incentives for traditional birth attendants and community volunteers in order to generate demand.
- Working with religious leaders to address sociocultural and religious barriers to reproductive health service uptake.
- Working with county governments, facilities, and the community to focus on the needs of adolescents and young first mothers, e.g. follow-up for teenage mothers and establishment of youth peer groups.

3. Strengthening health systems at county and national levels:

- Supporting the development of integrated operational plans (annual work plans) at the county level.
- Strengthening county monitoring and evaluation systems.
- Strengthening county collection, analysis, and utilization of data.
- Improving vital registration.
- Supporting the finalization of the National RMNCAH Investment Framework.
- Supporting the drafting and finalization of the national training package against the medicalization of female genital mutilation.

4. Partnerships:
Partnerships with private companies to provide cost-effective solutions at the system level, such as the Private Sector Health Partnership Kenya.

5. Documentation of innovation, knowledge management, and advocacy:
Across all the interventions, information sharing and exchange platforms were supported to contribute to the generation of evidence for decision making.

Project Funding

Funds were channelled through UNFPA, UNICEF, and WHO. The main implementers were the County Health Management Teams, the National Council for Population and Development, the Liverpool School of Tropical Medicine, the Kenya Red Cross Society, Amref Health Africa, and the three UN agencies concerned.

Project Management and Coordination

A project steering committee was established with representatives from the H6 partners to oversee the implementation of the project. Among the H6 partners, UNFPA was the lead agency and provided overall stewardship for the project.

2.2 Achievements, Challenges, Lessons Learned, and Recommendations of the Previous RMNCAH Programme

During a planning retreat held in May 2016 to develop this joint programme, the UN H6 agencies identified successes and achievements, weaknesses and challenges, and lessons learned related to the management and coordination of the first phase of implementation in the six counties between early 2015 and March 2016. Further successes, challenges, and lessons learned were identified during the RMNCAH project review meeting held in October 2016.[3]

Main Project Successes and Achievements

- Demonstrated high-level political goodwill and leadership by the county governments, which has contributed to the successful roll-out of the project: direct involvement of Governors, County Executives for Health, and Chief Officers of Health, and County Health Management Teams actively engaged.

3 H6/Government of Kenya (2016): a workshop report; *Improving Maternal and Newborn Outcomes in Six High-burden Maternal Mortality Counties in Kenya*; a final project review and validation of the draft UN Joint Programme on RMNCAH (2016–2020), October 17–19, 2016. Report draft, 23 October 2016.

Trained community health volunteers in Mpeketoni, Lamu County.

- Strengthened capacity of County Health Management Teams to undertake annual priority setting and planning for priority interventions, as well as to undertake continuous programme monitoring and reviews and partner coordination.
- Increase in use of data such as the quarterly RMNCAH scorecards and the HIV Situation Room for county decision making.
- Evident increase of county budget allocation to health sector – hiring of additional staff, training of health care workers (postgraduate and higher diploma levels), infrastructure, and health commodity security.
- Strengthening of supply of services by increasing the proportion of public health facilities that provide quality comprehensive/basic emergency obstetric and newborn care, through the rehabilitation of 24 health facilities (mainly maternity units) in the six counties, plus capacity building of health workers and procurement of equipment worth

USD 3.5 million, with the first consignment having been distributed to over 300 health facilities. Through this support, the capacity of the counties to provide basic emergency obstetric and newborn care has increased. The upgrading of seven health facilities that now provided full comprehensive emergency obstetric and newborn care in Wajir, Isiolo, and Migori Counties is not only saving the lives of mothers and newborns but has also reduced the cost of referral.

- Increases in demand for services: many counties have reported almost twice the demand for RMNCAH services. These can partly be attributed to the innovative demand-side financing initiatives, community health strategy, and use of mass media such as radio spots.
- Religious leaders are actively engaged in the promotion of maternal health and advocacy against harmful practices.
- Improvements in coordination and partnership structures.
- Quality improvement measures are in place.
- Through reprogramming, the establishment of HIV Situation Rooms in each of the six counties was included, as well as scale-up of the HeForShe Campaign targeting Isiolo County.
- The roll-out of the results-based financing support to health facilities in the six counties also contributed to providing much-needed funding to health facilities, in addition to the basic operational funding already provided through the Health Sector Services Fund (provided by the Government of Kenya with support from the Government of Denmark).
- The project has provided a platform to revamp the Private Sector Health Partnership. This support has resulted in the Mandera Community Life Centre spearheaded by Philips, the Lamu Telemedicine Project spearheaded by Huawei Technologies, and youth-friendly family planning information and services supported by Merck Sharp & Dohme. By engaging with the private sector, it has become possible to harness the strength, resources, and expertise of the private sector to design, test, and scale innovations for improving access, availability, and quality of care.

Main Project Weaknesses

- Short project implementation period.
- Constraints in the provision of technical support by the project due to delayed recruitment of the RMNCAH project coordinators in the six counties.
- Delayed implementation of some key project activities.
- Delays in identification of some of implementing partners.
- Utilization of maternal and newborn health and sexual and reproductive health services remains low in spite of investment.
- Missed opportunity of integrated RMNCAH, HIV, and GBV service delivery at point of care.

Main External Challenges

- Development planning is affected by insecurity and the poor road network in most programme counties.
- High government staff turnover, coupled with a lack of specialists.
- Sociocultural and religious barriers limiting the uptake of services.
- Twin outbreaks of chikungunya and cholera in Mandera negatively impacted programme implementation.
- Competing tasks for health workers, who are overworked and have low morale, particularly in lower-level facilities.
- Few utility vehicles available for supportive supervision, particularly in the vast counties.
- Sociocultural and religious barriers hamper efforts to increase demand for services.
- Reduced (President's Emergency Plan for AIDS Relief or PEPFAR) HIV funding in the five low-prevalence counties, while all these counties demonstrate an increase in HIV infant infection rates between 2013 and 2015 (*Kenya Framework for Elimination of Mother-to-Child Transmission of HIV and Syphilis*), against a background of high levels of HIV-related stigma and discrimination.

Recommendations

- Consolidate the gains of the current project.
- Intensify efforts to reach unreached and marginalized groups.
- Use data for decision making.
- Plan an exit strategy and develop a long-term plan for each county.
- Advocate for increased domestic financing of RMNCAH services.
- Increase integrated RMNCAH, HIV, and GBV point of care service delivery.

Documented Best Practices and Lessons Learned

1. High-level political goodwill contributed to successful roll-out of project in the counties, particularly through the direct involvement and active engagement of County Governors, County Executives for Health, Chief Officers of Health, and County Health Management Teams.
2. Establishment of project implementation teams at the county level enabled implementation progress.
3. Dissemination of programme progress at the national Maternal and Newborn Health Technical Working Group and other county forums.
4. Continuous monitoring by the County Health Management Team and using the observed findings for decision making was crucial and allowed, for example, the reprogramming of activities and funds to match county priorities on RMNCAH.
5. Clear partner coordination structures at the county level were helpful and contributed to the integration of activities supported

with related activities and to avoidance of duplication.

6. Religious leaders played a key role in the promotion of maternal health prevention and care and in advocacy against harmful practices, using specific and clear references to Quranic verses and texts.

Recommendations for Guiding Principles for the Next Project Phase for 2016–2020

Planning and Programme Design

- To optimize joint programme planning and design among the H6 partners, the Ministry of Health, and counties, this should be aligned to the national and county planning cycle, ensuring participation and adequate consultation of all key stakeholders to identify synergies and reduce the potential for duplication of activities.
- The H6 joint programme should emphasize high-level strategic interventions that address structural issues/capacity bottlenecks at the county level and minimize focus on direct service delivery.

Coordination

- At the national level, a programme steering committee should be established, comprised of heads of agencies, for decision making and strategic guidance.
- A Joint Programme Technical Working Group should also be established, comprised of technical officers from the UN H6 partners, to monitor implementation progress.
- A resource mobilization (partnership) and communication task force should be established.
- The county-level programme coordination mechanisms should comprise county government representatives, implementing partners, and H6 agencies to facilitate the coordination and visibility of the joint programme at the county level.
- Regular Joint Programme Steering Committee meetings should be convened by the chair (currently UNAIDS, as the global chair of the H6). The steering committee secretariat will be managed by UNFPA.
- The joint programme division of labour and the roles and responsibilities of the agencies should be clearly articulated.

Financial Management

- Timely communication should be provided to all H6 agencies on funds disbursement.
- Comprehensive programme budgeting should be undertaken that makes provisions for the technical assistance required to support the implementation of activities, e.g. training workshops where one agency plans for the activity, with technical assistance provided by a different agency or another government department.

Partner Identification and Selection
Joint identification should be conducted of county-level implementing partners based on clearly defined criteria for selection, while ensuring that county authorities are involved in the selection process.

Monitoring and Reporting
- A comprehensive monitoring and evaluation plan should be developed for the joint programme, with a common reporting framework for all H6 partners and a dedicated monitoring and evaluation expert to support the monitoring of the programme.
- The joint programme county coordinators and other relevant stakeholders will need to be oriented on the joint programme monitoring and evaluation plan.
- Joint monitoring visits should be conducted throughout the programme period to establish the status of activity implementation on the ground, and to identify issues.

Communication, Advocacy, and Visibility
- Joint orientation/sensitization should be conducted for the county coordinators regarding their programmatic roles.
- Options should be identified to enhance the visibility of the joint programme, e.g. newsletters, updates, and H6 logo/branding.

Resource Mobilization and Partnerships
- A joint programme resource mobilization and partnership strategy should be developed and implemented, targeting a mix of traditional and emerging donors, as well as philanthropic donors and those from the private sector.
- Capacity of county managers should be strengthened in resource mobilization and advocacy, to enable them to effectively discharge their new roles.

2.3 Lessons Learned from Other Maternal and Newborn Health Programmes

UNICEF has reported the following lessons learned from maternal and neonatal health programme implementation in Kenya:

1. Social accountability and respectful maternity care is important as cross-cutting work.
2. Modelled strategic approaches for pastoralists, including birthing positions, CHS restricting, uterine balloon tamponade, Mama Packs, etc., increased skilled birth attendance. South–south cooperation in Karamoja, Ethiopia, and Malawi (Kangaroo Mother Care) made this possible.
3. Community maternal and newborn health policy and guidelines are now available in Kenya. There is therefore a need to include a community maternal and newborn health component alongside integrated community case management to save children from dying from pneumonia, diarrhoea, and malaria.

A pregnant woman in Marsabit County accessing maternal and newborn health services.

4. Lessons from the renovation of maternity centres by UNICEF and UNOPS and from mainstreaming green technology in facilities to mitigate adverse climate change.
5. Vouchers to support demand creation work well in some locations but less well in other locations. Another method is to provide cash transfers to women at the first and fourth antenatal clinic visit, at delivery/birth registration, and at postnatal visits, especially in counties and areas where private transport does not exist or is very limited. This cash transfer system is working well in Kakamega and was fully established and funded by the County Health Management Team using domestic funds.
6. Human resources for health are extremely important, as insufficient quality and quantity of health workers is one of the main bottlenecks in the H6 counties. UNICEF developed five-year human resources for health plans for the five counties of the maternal and newborn health project, based on situational analysis, and supported the counties to develop training staff databases.

3. THE UN JOINT PROGRAMME ON RMNCAH

3.1 Justification

3.1.1 Relevance

The UN Joint Programme on RMNCAH aims to assist the Kenyan government implement the constitution, which binds the government to provide 'the highest possible standard of health'.[1] The joint programme is aligned to the Kenya national policies and frameworks described in the policy context section above that aspire to increase access and improve the quality of reproductive, maternal, neonatal, and child health services, including HIV and GBV services, as defined in the RMNCAH Investment Framework of 2015.

The joint programme responds to the UN Secretary-General's Global Strategy for Women's and Children's Health (2010) and supports the direct commitment made by the President of Kenya to support this strategy and the efforts to reduce maternal and child mortality and new HIV infections among children, spearheaded by the country's First Lady (Beyond Zero campaign).

The recommitment of the H6 agencies in March 2016 increased the focus on HIV and gender and on strengthened coordination and alignment of the H6 agencies' interventions. The joint programme is further anchored on the United Nations Delivering as One modality. It also contributes directly to Strategic Result Area 2 of the 2014–2018 Kenya UN Development Assistance Framework's Outcome 2.3, which seeks to contribute to improved maternal, neonatal, and child survival, reduced malnutrition and incidence of major endemic diseases (malaria, tuberculosis), and stabilized population growth, underpinned by a universally accessible, quality, and responsive health system.

1 http://www.cmd-kenya.org/index.php/new-constitution.

3.1.2 Comparative Advantage of the United Nations and the Joint Programme Modality

The added value of the United Nations agencies to coordinate the implementation of the RMNCAH programme in the target counties is that – as intergovernmental bodies – UN agencies have direct and access to national and county governments. They also have the convening power to fulfil the UN mandate for advocacy and policy development, and to provide technical support to government institutions. UN agencies are in a unique position to provide holistic support by harnessing the technical competencies of agencies, drawing on their particular mandates. Furthermore, the UN has a comparative advantage over other development partners due its unique neutral role as a broker, convener, and partner to the Government of Kenya. UN agencies are trusted partners of government and are seen as neutral agencies without a political agenda. In addition, UN agencies leverage their global mandates and expertise, and at the national level support the Kenyan government in policy development.

A joint programme is one of the available implementation tools used within the common United Nations country programming process to promote the objective of Delivering as One in order to increase coherence among approaches and optimize the effectiveness and efficiency of resource use. National joint programmes are vehicles through which the UN organizations deliver at national level in different geographic regions. The establishment of the Joint Programme on RMNCAH is driven by the Kenya country situation and context, building upon country analyses and the United Nations Development Framework.

3.2 Programme Strategy

In partnership with the Ministry of Health, County Health Departments, and other implementing partners, the H6 partners will support the identification of RMNCAH strategy and policy gaps at the county level and focus primarily on implementing high-level, strategic, catalytic, and sustainable interventions by operationalizing **three core strategies**:

1. Scaling up access to and quality of integrated RMNCAH, HIV, and GBV services, i.e. by conducting an assessment of the capacity of health facilities to provide basic emergency obstetric and newborn care and HIV-related services and, where applicable, comprehensive emergency obstetric and newborn care services; integration in delivery of RMNCAH services, including integrated management of childhood illnesses/integrated community case management/emergency triage assessment and treatment, trainings in basic emergency obstetric and newborn care; introducing community maternal, newborn, and child health care; establishing maternity waiting

homes; strengthening the supply chain, especially the logistics management information system that is currently very weak, for the 13 lifesaving commodities (except the HIV, malaria, and tuberculosis medicines); and implementing results-based financing that takes into account priority RMNCAH indicators.

2. Generating community demand for uptake of lifesaving RMNCAH, HIV, and GBV services, i.e. by introducing vouchers and other demand-side financing; working with political, religious, and other community leaders; and strengthening the community health strategy.

3. Strengthening county health systems for coordination, planning, supervision, and monitoring and evaluation of RMNCAH, HIV, and GBV services, i.e. by providing embedded technical assistance to RMNCAH and HIV service delivery; developing and disseminating core strategic planning documents; building capacity in the development of core strategic planning documents; building capacity in leadership and governance; and improving health information systems.

3.3 Geographic Scope and County Focus

To address equity and increase service coverage, the Joint Programme on RMNCAH considers data on coverage indicators and burden and prioritizes investments in counties with a high burden of poor maternal and child health outcomes, low coverage rates, and large underserved populations. The joint programme seeks to address disparities and increase equitable coverage through prioritized investments in these underserved counties and accelerate action for underserved and marginalized populations. Roll-out and effective use of the RMNCAH Scorecard will promote accountability at all levels.

The six programme counties identified for the initial phase of the RMNCAH project (2015–2016) were: Mandera, Wajir, Marsabit, Isiolo, Lamu, and Migori. These six counties have a combined population of 3,257,229 (less than 10 percent of the national Kenyan population), but contribute close to 50 percent of the prevailing maternal deaths in the country. Except for Migori and Lamu, the counties are in the northern arid land region and have faced poverty, infrastructural challenges, inequity, and marginalization, leading to poor maternal and newborn health statistics.

For the Joint Programme on RMNCAH for 2016–2020, it is proposed to continue working in the six counties of the previous RMNCAH project (Mandera, Wajir, Marsabit, Isiolo, Lamu, and Migori) in order to consolidate the achievements of the previous project. These are among the 20 priority counties identified by the RMNCAH Investment Framework.[2]

In the second phase of the joint programme from the second half of 2018 onwards, four additional counties will be selected to benefit from joint

2 Kenya Ministry of Health (2015): Kenya RMNCAH Investment Framework.

programme resources. The selection is likely to be based on the joint programme midterm review and a donor mapping exercise to be carried out in 2018.

A joint assessment will be undertaken in 2018, in consultation with the Ministry of Health Division of Reproductive Health, to identify the four additional counties and to select the priority interventions from which they will benefit. The additional counties will be high maternal mortality burden counties not covered by large development partner initiatives, where strategic support by the RMNCAH and HIV programme can make a difference and impact on maternal, newborn, child, and adolescent health. Key criteria for selecting the additional counties will include the following:

- High maternal, newborn, and child mortality (based on the ranking of counties undertaken recently during the development of the Kenyan National RMNCAH Investment Framework)
- Presence or absence of other large development partner initiatives providing strategic countywide support to RMNCAH
- Demonstrated commitment by the county authority to reducing maternal, newborn, and child mortality (e.g. county funding allocation to health)
- Expectations that the H6 joint programme initiative will be able to make a difference

The UN Joint Programme on RMNCAH will therefore expand coverage from the current six counties to a total of ten high-burden counties by 2018, using a phased approach that will build on the progress made in the original six counties while addressing the challenges/gaps identified in the 2014–2016 project.

3.4 Strategic Framework

3.4.1 Programme Outcome

The UN Joint Programme on RMNCAH 2016–2020 seeks to ensure that, **by 2020, ten counties with a high maternal mortality burden enjoy increased utilization of integrated quality reproductive, maternal, newborn, child, and adolescent health services, including HIV and GBV services, which contribute to the reduction of maternal and newborn mortality in Kenya.**

The programme will strengthen support to high-impact priority interventions to ensure the sustained provision of a comprehensive package of services, accompanied by quality assurance and monitoring of selected indicators, adopting a life cycle approach. These interventions will be delivered both through health facilities and community health interventions and outreach, and should contribute to saving maternal and newborn lives. The joint programme will work on achieving this outcome through three intermediate outcomes and outputs described in the Theory of Change diagram below.

3.4.2 Theory of Change

Ensuring that health facilities have the requisite and consistent inputs necessary for the provision of quality services will contribute to improved access to and quality of integrated RMNCAH, HIV, and GBV services. The programme will strengthen the provision by the Kenya public health service of a comprehensive package of services, accompanied by quality assurance and monitoring of selected indicators, adopting a life cycle approach.

Support to high-impact priority interventions will include improving access to and quality of family planning services, which is the single most effective method to decrease maternal and neonatal mortality. These interventions will be delivered both through health facilities and community health interventions and outreach, and should contribute to saving maternal and newborn lives. The programme will furthermore support child and adolescent health and HIV services in an integrated approach at both facility and community level, including important preventive measures such as strengthening family planning, antenatal care, eradication of mother-to-child transmission of HIV, assisted delivery, and services for survivors of gender-based violence, as well as improving the quality of emergency obstetric and newborn care and post-abortion care. Assisting County Health Management Teams to accelerate the in-service training and mentorship of key facility staff and community health workers, and to provide essential equipment and supplies, in combination with the establishment of quality improvement teams, should contribute to improving the quality of care provided.

The programme will increase focus on adolescent girls and young women. Tackling adolescent pregnancies is a complex issue that requires targeted, evidence-based, girl-centered interventions in multiple sectors, and also involves working with boys and men. Therefore, the programme will address the drivers for early sexual debut among adolescent girls and boys and improve access to correct information and comprehensive reproductive health and HIV services for those who are sexually active. The programme will also focus on preventing early childbearing and helping married adolescents space their births. It will also address early marriage through various strategies, such as community dialogue and advocating (within communities and political leadership) for keeping girls in school, given the high prevalence of early marriage in high-burden counties and its contribution to high maternal mortality.

While ensuring sexual and reproductive health and HIV literacy among girls, boys, and young women, as well as building skills to prevent unwanted pregnancy, HIV infection, and sexual violence, there is an equal need to strengthen community support. Addressing unmet contraceptive needs to prevent untimely pregnancy must be accompanied by focused counselling on family planning. With the high rate of new HIV infections among girls and young women, and the likely transmission of HIV from mothers to children in view of their high viral load, HIV testing at the antenatal care stage is a critical

entry point for access to antiretroviral treatment to contribute to the elimination of mother-to-child transmission of HIV and the reduction of maternal and child mortality. Community support is also important to ensure that those who have power over young girls support the interventions promoted, to ensure that the girls can profit from the programme efforts.

Furthermore, in the area of service delivery, basic lifesaving obstetric and newborn care will be strengthened not only through trainings, but also through contributing to addressing the lack of necessary supplies and equipment where needs persist following the support provided in the previous RMNCAH project, while taking into consideration resources allocated by the counties and support provided by other development partner initiatives. In consultation with County Departments of Health, based on a gap analysis, the programme will continue to promote the purchase of the essential equipment and commodities needed to provide basic emergency obstetric and newborn care services. The programme wil explore the feasbility of establishing basic/comprehensive emergency obstetric and newborn care centres of excellence. Each centre consists of referral hospitals, their link facilities, and community units covering a population catchment area. This programme will also institute a framework for monitoring and restocking basic commodities across the high-burden counties as part of building capacity for a sound logistics management information system in order to minimize stock-outs, especially in primary health facilities.

Elements of results-based financing are currently being introduced by the H6 partners to promote key reproductive and health services. Innovative public–private partnerships will be supported to strengthen referral services in the counties supported (e.g. Kenya Red Cross Society), increase mobile technology for personal messaging and commodity tracking (e.g. Safaricom), and improve access to power and lighting for facilities (e.g. Philips). This will be in the context of the new Public–Private Partnership for Health Strategy currently being developed by the national Ministry of Health and its partners.

Community outreach and behaviour change communication interventions will contribute to increased demand by adolescents and young women for RMNCAH, HIV, and GBV services. This should promote improved utilization of reproductive, sexual, and HIV services by adolescents and young women, which in turn will contribute to decreasing mortality and increasing maternal, newborn, child, and adolescent health.

Barriers that stop adolescents, women, and children from accessing critical health products and quality services need to be overcome, so that the utilization of services increases. Community outreach to prevent untimely pregnancy, HIV infection, and sexual violence, and to create demand for service (in case of need) will be a critical element of the programme. In addition, the programme will address structural and socio-cultural barriers that hinder girls, young women, and adult women from seeking health care, with

specific attention to key populations such as female sex workers, women who inject drugs, and girls and women living with HIV.

Community health initiatives need to be sustainable and proposed interventions need to avoid being stand-alone, otherwise perpetuating the current confusion in service implementation at the community level. Therefore, the programme will support the roll-out and operationalization of the community units linked to public health facilities in the selected counties, as defined in the new national community health strategy.

In order to support the return of pregnant girls to school, the programme will work with county governments, Ministries of Health and Education, and other stakeholders to set up strategies to address the education needs of young adolescent mothers and how they can be reintegrated into formal or vocational schooling. This initiative is aligned with the All In campaign, which aims to end AIDS among adolescents and keep them in school, free from stigma and discrimination. Strategies to support adolescent mothers must take cognizance of the broader overall agenda of supporting the rights of the girl child and adolescent girls as a vital component to fostering sustainable development. Therefore, in leading the implementation of the outlined strategies, the programme will aim at gradually developing the capacity of these counties to operationalize the various policies that address the health, education, economic, and protection needs of the girl child, especially the Adolescent Reproductive Health and Development Policy and the Fast-track Plan to End HIV and AIDS among Adolescents and Young People.

Stronger county and national capacity for coordination, planning, supervision, and monitoring and evaluation for RMNCAH, HIV, and GBV services will facilitate better planning and decision making for quality improvement. A strong planning and monitoring and evaluation system in the country should therefore contribute to reducing maternal and child mortality in the respective counties. In this regard, the programme will continue to build the capacity of county health teams in developing their annual work plans for the health sector, with key RMNCAH and HIV interventions integrated into the plans. County and sub-county health teams will also be supported to generate evidence for planning – for example, through operational research, maintaining data quality, and having functional maternal and perinatal death surveillance and response committees.

At the national level, the UN H6 agencies will continue to work on supporting the national Ministry of Health in improving the generation of data for planning and monitoring implementation. It will also help in improving the quality of data and enhancing the utilization of the district health information system, as well as supporting the roll-out of the maternal and perinatal death surveillance and response system. These efforts will link with the capacity strengthening of the national Ministry of Health, supported by Denmark

and other partners. There will also be support to the institutionalization of the RMNCAH Scorecard, an accountability tool for monitoring programming and interventions on RMNCAH by the counties, as well as capacity building of counties on the use of the HIV Situation Room for early warning of underperformance.

Furthermore, county health teams will be supported to improve their plans related to human resources for health. At the national level, the H6 agencies and their RMNCAH programme partners will continue to assist the national Ministry of Health in finalizing the various policies, operational plans, and tools. They will also coordinate closely with the national Ministry of Health and other development partners in the implementation of the RMNCAH programme, and where possible assist in strengthening coordination mechanisms at county and national levels.

3.4.3 Intermediate Outcomes

The **Joint Programme Intermediate Outcomes** are defined as follows:

1. Intermediate Outcome 1: Improved access to and quality of integrated RMNCAH, HIV, and GBV services.
2. Intermediate Outcome 2: Increased demand for RMNCAH, HIV, and GBV services.
3. Intermediate Outcome 3: Strengthened county and national capacity for coordination, planning, supervision, and monitoring and evaluation of RMNCAH, HIV, and GBV services.

Graph 1 gives a graphic overview of the strategic and results framework of the Joint Programme on RMNCAH.

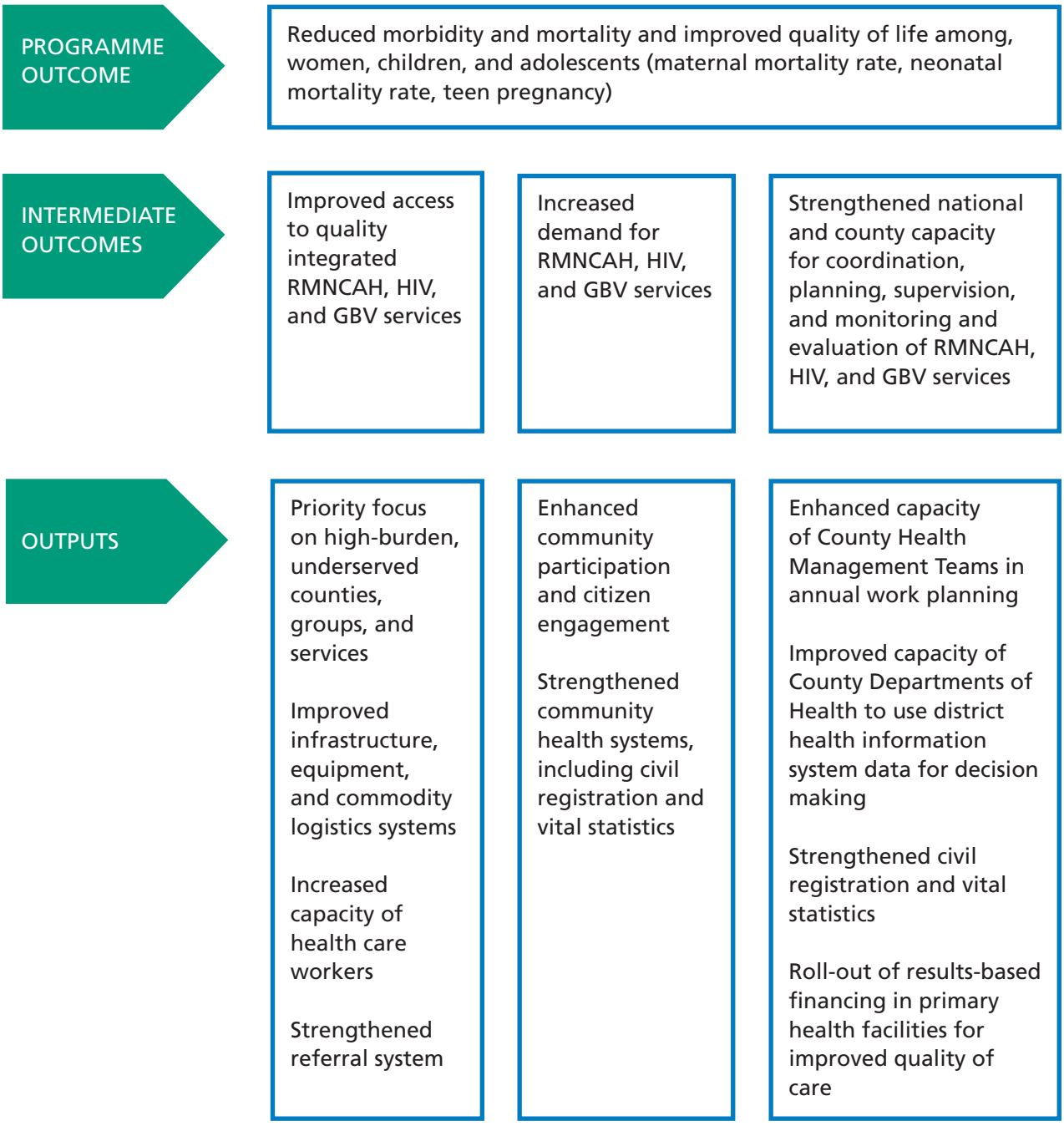
Intermediate Outcome 1: Improved access to and quality of integrated RMNCAH, HIV, and GBV service

For Outcome 1, five outputs were defined for the ten target counties. These contribute to the achievement of this intermediate outcome by ensuring that health facilities consistently have the requisite inputs necessary for the provision of quality services.

Output 1.1: Health facilities in ten counties strengthened with key commodities and equipment and improved supply chain monitoring mechanisms in order to deliver quality RMNCAH, HIV, and GBV services

Addressing the major gaps identified regarding supplies and equipment will strengthen the delivery of quality RMNCAH, HIV, and GBV services. Over the past years, the previous RMNCAH project procured essential equipment and commodities for the six counties. In addition, the counties mobilized their own resources for the procurement of such equipment and supplies. Based on an updated gap analysis and in consultation with County Departments of Health,

Graph 1: Schematic Overview of the Strategic and Results Framework of the UN Joint Programme on RMNCAH for 2017–2020



the programme will support – particularly in the four new counties – the procurement, where necessary, of the essential (delivery and laboratory) equipment and commodities needed to provide integrated RMNCAH, HIV, and GBV services. The project will further specifically strengthen access to youth- and adolescent-friendly health facilities to increase the uptake of services in order to prevent teenage pregnancies and sexually transmitted and HIV infections.

The programme will also strengthen the systems for monitoring and restocking basic commodities across the additional high-burden counties as part of strengthening capacity in the utilization of the logistics management information system (linked to the national commodity management system). This will minimize stock-outs, especially in the primary health facilities, and will strengthen county commodity security working groups.

Advocacy and policy dialogue activities supported by the programme will continue to focus on promoting increased domestic financial investment by the counties in the health sector to address infrastructural and other challenges.

Output 1.2: Improved skills, competences, and knowledge among health care workers, community health volunteers, and County Health Management Teams regarding RMNCAH, HIV, and GBV services in ten counties

The joint programme will use a number of strategies to improve the skills, competencies, and knowledge of County Health Management Teams, facility health workers, and community health volunteers through regular training and mentorship activities, specifically in the areas of leadership and management, including analytics, advocacy, child health (including integrated management of childhood illnesses), basic and comprehensive emergency obstetric and newborn care, and provision of HIV- and GBV-related services. Capacity-building efforts will be closely coordinated with efforts supported by the Government of Kenya and other development partners (including the emergency obstetric and newborn care training provided nationally by the Liverpool School of Tropical Medicine, funded by the Department for International Development, World Bank projects, etc.) to optimize the efficient use of resources and to avoid duplication.

In addition, specific awareness raising among county health and gender executives will be conducted on the link between GBV and RMNCAH. To ensure a more sustainable programme outcome, the joint programme will focus on strengthening pre-service training institutions through curriculum review to improve service delivery capacity as well as on-the-job training and supportive supervision for health care workers. Assisting County Health Management Teams to accelerate the training and mentorship of key facility staff, community health workers, and the joint verification teams supporting the results-based financing initiative should contribute to improving the quality of care provided.

Aisha Tiro Bahero meeting Nurse Alice Cheptoo at Kiwayuu Dispensary after her delivery.

Output 1.3: Strengthened and integrated RMNCAH, HIV, and GBV service provision ten counties

The programme will strengthen the delivery of maternal, neonatal, child, and adolescent health and HIV and GBV services in an integrated approach at both facility and community level through prioritized interventions. These will focus on strengthening family planning; antenatal care; the elimination of mother-to-child transmission of HIV and syphilis; assisted delivery; access to treatment of common childhood diseases and immunization services by marginalized population groups such as migrants, nomads, and the urban poor; and services for survivors of gender-based violence.

Effective integration of RMNCAH and vertical programmes is required to prevent, diagnose, and treat indirect causes of maternal death such as AIDS, tuberculosis, sexually transmitted infections, malaria, and reproductive system cancers. At present, fragmented funding, planning, and reporting relating to vertical programmes create inefficiencies, and there are many missed opportunities to provide services across the continuum of RMNCAH services. Service integration will

optimize the available resources and facilitate the leveraging of vertical programme resources, especially from HIV/AIDS, malaria, tuberculosis, nutrition, and immunization programmes.

Interventions under this output will see the H6 partners support the roll-out of key policies at the county level (where this has yet to take place) and support existing county platforms (e.g. the County Health Stakeholder Forum) to monitor and fast-track RMNCAH, HIV, and GBV integrated programming.

Output 1.4: Strengthened RMNCAH, HIV, and GBV referral services in ten counties

Towards the achievement of this output, the joint programme will work with the County Health Management Teams to conduct mapping exercises to assess and determine those areas that are vital to strengthening the capacity for providing outreach services. The mapping will also determine where to strengthen the linkages between RMNCAH/HIV testing/HIV treatment and care referral services to attain the 90/90/90 treatment targets as per the fast-track approach and the HIV differentiated care model, as well as where to strengthen referral mechanisms for GBV (legal and psychosocial) services at the county level.

Innovative public–private partnerships will be supported to strengthen referral services in the counties supported (e.g. Kenya Red Cross Society), to leverage mobile technology for health initiatives and supply chain management, and to improve access to power and lighting in facilities. This will be in the context of the new Public–Private Partnership for Health Strategy, which is currently being developed by the Ministry of Health and its partners.

Output 1.5: Strengthened roll-out of results-based financing in health facilities in ten counties

In order to improve the quality of care and the performance of primary care health facilities, the joint programme will also support results-based financing at the facility level, which the Ministry of Health and county governments are currently implementing through the Kenya Health Sector Support Project supported by the World Bank. Results-based financing is a health financing mechanism that shifts the focus from inputs to results and focuses on improving the utilization and quality of RMNCAH services at Level 2 and Level 3 government and faith-based organization health facilities. Currently, the results-based financing programme is being scaled up in 20 arid and semi-arid counties, and in Migori.

Intermediate Outcome 2: Increased demand for RMNCAH, HIV, and GBV services

For this outcome, two outputs were identified. The outcome focuses on community demand creation through community mobilization interventions to influence social norms, cultural practices, and local traditions. Targeted activities will promote health-seeking behaviours, improve awareness about available health and social services, provide education about GBV, HIV, and other health issues, encourage uptake of antenatal and postnatal

services, and address HIV stigma and discrimination to increase demand for and adherence to HIV testing and/or treatment, including through HIV mentor-mothers and community health volunteers.

Community outreach and behaviour change communication interventions will contribute to increased demand by adolescents and young women of RMNCAH and HIV services. Community outreach to prevent untimely pregnancy, HIV infection, and sexual violence, as well as create demand for service – in case of need – will be a critical element of the programme. In addition, the programme will address structural and sociocultural barriers that hinder the health-seeking behaviour of girls, young women, and adult women. Specific attention will be given to those belonging to key populations, including female sex workers, women who inject drugs, and girls and women living with HIV.

Output 2.1: Enhanced community engagement and citizen's participation in ten counties

The joint programme will seek to address prioritized demand-side barriers to increase the utilization, coverage, and affordability of RMNCAH, HIV, and GBV services. Interventions to improve health-seeking behaviour may include providing incentives for community health workers and traditional birth attendants (in their new role redefined in national policy) to identify pregnant girls and women in the community, and generating demand by promoting attendance at facilities with antenatal care and delivery services. In addition, voucher schemes may be used for referral transport services and for emergency care to make it easier for pregnant adolescents and young women to access antenatal and delivery services.

The programme will improve access to correct information and culturally sensitive, comprehensive reproductive and HIV services for those who are sexually active. The programme will also focus on preventing early childbearing and promoting birth spacing, especially among married adolescents. It will also address early marriage through various strategies such as community dialogue, advocating within communities to keep girls in school, and engaging HeForShe champions to lead dialogues on positive masculinity and to challenge gender norms that contribute to the incidence of GBV. Thus the programme will support the return to school of adolescent girls after pregnancy. It will also work with the political leadership of the counties to get their support for measures to address the high prevalence of early marriage and its contribution to high maternal mortality.

Links with religious and community leaders will be strengthened to address misconceptions about family planning and other reproductive health issues, including female genital mutilation, broader gender-based violence issues, and promoting attendance of priority services, while creating an enabling environment for zero stigma and discrimination and addressing harmful practices and sexual violence.

Community-based care and support for people living with and affected by HIV will also be

strengthened, especially for HIV-positive expectant mothers, in order to stimulate treatment adherence. The programme will explore how to leverage campaigns to improve male involvement in advancing gender equality, such as the UN Women HeForShe Campaign launched by President Kenyatta in November 2014.

Output 2.2: Strengthened community health systems to deliver responsive RMNCAH and HIV services, including birth registration, in ten counties

Community health initiatives need to be sustainable, avoiding stand-alone interventions and not perpetuating the current confusion in service implementation at the community level. Therefore, the programme will support the rolling out and operationalization of the community units linked to public health facilities in the selected counties, as defined in the new national community health strategy.[3] The community units will also be engaged to provide support for (networks of) people living with HIV to stimulate adherence to protocols and to decrease HIV-related stigma and discrimination.

In leading the implementation of the outlined strategies, the programme will aim at gradually developing the capacity of the counties to operationalize the various policies that address the health, education, economic, and protection needs of the girl child. It will focus on key policies such as the adolescent reproductive health and development policy, as well as the operational plan for accelerated action to end new HIV Infections and AIDS-related deaths among adolescents and young women[4] and the renewed framework for the elimination of mother-to-child transmission (to be launched later this year).

Intermediate Outcome 3: Strengthened county and national capacity

For Outcome 3, four outputs were identified. Stronger county and national capacity for coordination, planning, supervision, and monitoring and evaluation of RMNCAH, HIV, and GBV services will facilitate better planning and decision making for quality improvement, and will contribute to reducing maternal and child mortality in the respective counties. In this regard, the programme will continue to build the capacity of county health teams in developing their annual work plans for the health sector, with RMNCAH, HIV, and GBV key interventions integrated into the plans. County and subcounty health teams will also be supported to generate evidence for planning by making sure that a robust monitoring and evaluation system is in place, and to have functional Maternal and Perinatal Death Review, Surveillance, and Response Committees, and to build capacity on the International Statistical Classification of Diseases and Related Health Problems (ICD-10) for certifiers and coders. Furthermore, the programme will build the capacity of county teams to advocate with county

3 Kenya Ministry of Health (2014): *Strategy for Community Health 2014–2019: Transforming Health – Accelerating the Attainment of Health Goals.*

4 Kenya Ministry of Health, National AIDS Control Council (2015): *Kenya's Fast-track Plan to End HIV and AIDS among Adolescents and Young People.*

authorities for continued political commitment to the RMNCAH response and for increased resource allocations to the health sector.

Output 3.1: Strengthened capacity of County Health Management Teams for the development of comprehensive integrated annual work plans and for mobilizing continued commitment and resources in ten counties

The county-level capacity-building work supported through the joint programme will be closely coordinated with other efforts undertaken by the national government, development partners, and other institutions through the national coordination framework, which includes the Maternal, Newborn, and Child Health Technical Working Group and the Inter-Governmental Coordination Framework. This should ensure that joint programme institutional strengthening efforts will work in synergy with the general capacity strengthening of County Departments of Health, which is currently ongoing with support from several development partners and institutions.

Furthermore, the programme will build the capacity of county teams to advocate with county authorities for continued political commitment to the RMNCAH response and for increased resource allocations to the health sector. The programme will also support the organization of **high-level meetings with county leadership** in order to hold the counties to account for performance related to the implementation of RMNCAH interventions and the allocation of resources to the health sector in their counties.

The H6 agencies will also coordinate closely with the Ministry of Health and other development partners in the implementation of the RMNCAH programme, and where possible assist in strengthening overall coordination mechanisms at county and national levels. As part of their other programmes, the H6 agencies and their RMNCAH programme partners will continue to assist the national Ministry of Health in finalizing the various RMNCAH policies, operational plans, and tools.

Output 3.2: Increased capacity of county-level staff in ten counties to collect and analyse data and use the district health information system

The programme will support improving the quality of data and enhancing the utilization of the district health information system (DHIS 2) as needed. This will be achieved through on-the-job training and mentorship for the different users of the system. The programme will also roll out capacity building for the RMNCAH/HIV situation room in the counties: an internet-based dashboard that works as a data visualization, analysis, and accountability tool. It incorporates district health information system data with Kenya Medical Supplies Authority logistics management information system data and HIV estimates for quick identification of trends, bottlenecks, and stock-outs, thereby enabling advocacy and quick decision making. As part of the validation of pre-elimination of mother-to-child transmission of HIV and syphilis, the counties will be encouraged to undertake quarterly reviews of progress towards targets, either combined with other audits and reviews or as dedicated reviews.

Jumwa Kabibu, 77, can afford a smile after undergoing fistula repair.

In addition, the project will support the institutionalization of the RMNCAH Scorecard, an accountability tool for monitoring RMNCAH programming and interventions by the counties.

Output 3.3: Strengthened Civil Registration and Vital Statistics Systems in ten counties

The joint programme will support the institutionalization of maternal and perinatal death surveillance and response at county and subcounty levels. This will include quarterly review/audit meetings of the County Health Management Teams with representatives of key health facilities to review the underlying reasons for the following: maternal deaths; perinatal and neonatal deaths; mothers lost to follow-up in the prevention of mother-to-child transmission programme; and children born with HIV. In addition, it will include support for the roll-out of the birth registration component of the maternal and child health strategy at county level, in collaboration with the World Bank–supported

Transforming Health Systems for Universal Care Project. It will also strengthen linkages with the national Department of Civil Registration Services. Furthermore, the joint programme will support the implementation and institutionalization of International Statistical Classification of Diseases and Related Health Problems (ICD-10) capacity building among health care workers.

Output 3.4: Strengthened capacity of ten counties to address human resources for health challenges

The joint programme will support the monitoring of the implementation of the human resources for health norms and standards, in addition to supporting the counties to develop human resources for health strategies with national government guidance. Situational analyses, human resources for health five-year plans, and staff training databases will be produced.

Output 3.5: Management and coordination of the UN Joint Programme on RMNCAH

This output focuses on the operational and coordination aspects of the UN Joint Programme on RMNCAH and provides an opportunity to articulate the specific activities that will be undertaken to ensure that the programme has both the technical and financial resources to achieve the overall results. The activities will relate to the joint advocacy, resource mobilization, public–private partnership, communication, visibility, knowledge management, and monitoring and evaluation activities of the joint programme.

Monitoring will include quarterly review/audit meetings of the County Health Management Teams with representatives of key health facilities (building on maternal and perinatal death surveillance and response) to review the underlying reasons for the following: maternal deaths; perinatal and neonatal deaths; mothers lost to follow-up in the prevention of mother-to-child transmission programme; children born with HIV; and people living with HIV on treatment without viral suppression. Public–private partnerships will be monitored by the Aga Khan Centre of Excellence in Women and Child Health,[5] which was involved in the design of the various public–private partnerships.

Overall monitoring will be carried out through joint monitoring missions by the H6 agencies, in combination with monitoring by the respective agencies.

UNFPA and UNAIDS will be responsible for coordinating this output.

3.5 Results Framework

The results framework of the joint programme is included in Annex 1. It includes proposed indicators at Overall Outcome level and at Intermediate Outcome level.

5 This centre is currently led by Prof. Marleen Temmerman, founder of the International Centre for Reproductive Health of the University of Ghent in Belgium. She is also the Chair of the OB/GYN Department at the Aga Khan University Hospital in Nairobi, OB/GYN Professor at Ghent University, and Senior WHO Advisor on Women, Child, and Adolescent Health.

Baseline, milestone, and target values for each county will be confirmed during the joint programme inception phase. National indicators from the district health information system (DHIS 2) and national surveys have been used as much as possible.

3.6 Partnerships and Synergies

The UN Joint Programme on RMNCAH will be implemented by the United Nations H6 agencies in partnership with:

- The Government of Kenya health sector authorities at national and county levels
- Health care workers in the public sector
- Implementing partners (to be confirmed)
- Local and religious leaders, as well as communities
- Private sector partners (to be confirmed)

Implementing and other partners will be confirmed during the programme inception phase.

Furthermore, the Joint Programme on RMNCAH will work in synergy with a number of other programmes and projects supported by the Government of Kenya and development partners. Thus the joint programme will coordinate with programmes such as the World Bank–supported Health Sector Support Project, the Transforming Health Systems for Universal Care Project, and the efforts supported by Denmark towards strengthening the capacity of County Departments of Health and Health Management Teams for the planning, management, and monitoring of health interventions in their counties.

Denmark's health sector support funding initiative and the results-based financing initiative supported by the World Bank will contribute to the financing of health facilities, which will contribute to improving the quality of services and the motivation of health workers. The programme will also closely coordinate with projects funded by the World Bank, the Government of USA, and the Department for International Development that support the training of health workers and the renovation and equipping of health facilities, so as to optimize the use of resources and avoid duplication. The joint programme will also have synergies with efforts by development partners supporting the HIV response and GBV services in the counties.

3.7 Sustainability of Results

3.7.1 Documentation

The Joint Programme on RMNCAH will focus on documenting best practices and lessons learned during the previous RMNCAH project and during this joint programme, on disseminating these in formats suitable for influencing policy (e.g. policy briefs), and on ensuring that these feed into policy development at both county and central levels.

3.7.2 Sustainability

Programme principles contributing to the sustainability of the interventions supported include the following:

- Promotion of a county-led, county-owned systems approach
- Use of existing institutional infrastructure (the public health system) for programme implementation (rather than establishing parallel systems)
- Focus in the six counties on system-strengthening efforts, since most equipment and infrastructure inputs were already provided during the previous RMNCAH project (2015–2016)
- Modelling of best approaches, so that counties can scale up these approaches beyond the programme period
- Development of costed county health plans based on evidence, and prioritizing interventions for greatest value for money impact
- Investment in advocacy with governments and communities to sustain the achievements
- Leveraging other existing initiatives, such as the Transforming Health Systems for Universal Care Project in all 47 counties; the UNICEF/Department for International Development Maternal and Newborn Health Programme in five high-burden counties; the regional sexual and reproductive health/HIV linkages integration programme (UNFPA managed, Department for International Development funded); and the Private Sector Health Partnership

The joint programme seeks to contribute to the institutional sustainability of county health systems by focusing on the provision of high-impact interventions that are centred on building structural capacity at the county level.

Increased capacity of the County Health Management Teams will enhance their ability to design, manage, and monitor programmes within their geographic areas, irrespective of the funding source. These programmes will be integrated into the county work plans and systems, and the county governments will be encouraged to progressively absorb them and develop sustainable financing mechanisms for the interventions. County governments will be capacitated to improve their health planning cycles, include evidenced-based costed health interventions in the County Integrated Development Plans and Health Sector Strategic Plans, and especially leverage domestic funding through evidence-based annual work plans.

The joint programme will enhance county health sector capacity to lobby their own county and national governments for increased resources and to mobilize resources from other sources, such as the private sector and development partners. Thus the joint programme will contribute to the increased financial sustainability of county health systems.

3.8 Joint Programme Budget Summary

3.8.1 Programme Budget

As Table 2 shows, the overall joint programme budget for the period October 2016 to December 2020 amounts to USD 44.3 million, of which USD 10.5 million of external funding is required for Intermediate Outcome 1, USD 8.1 million for Intermediate Outcome 2, and USD 7.3 for Intermediate Outcome 3.

Annex 3 of this programme document contains a detailed overview of the joint programme work plan and budget.

3.8.2 Funding Commitments

Funding committed to the joint programme so far includes the following:

- **Contributions in kind by the Government of Kenya**, by making available human resources, infrastructure, equipment, and commodities to the public health system.
- **Co-financing by the H6 agencies** amounting to USD 14.4 million, through contributions to programme staff, operational costs, and administrative costs, and contributions for equipment, supplies, and activities.
- **Contribution from the Government of Denmark** of DKK 40 million (equivalent to USD 6 million).

Table 3 gives an overview of the amounts contributed by the H6 agencies.

Section 6.6 sets out the resource mobilization strategy and efforts of the H6 agencies to mobilize additional resources for the joint programme.

3.8.3 Funding Gap

As of 31 October 2016, the total funding gap for the UN Joint Programme on RMNCAH amounts to USD 20.4 million. Table 4 gives an overview of how this gap is calculated.

Table 4: Joint Programme Funding Gap for 2017–2020 as of October 2016

Description	Amount (USD)	Percent
Total budget for the UN Joint Programme on RMNCAH	40,840,833	100%
Total co-financing by H6 agencies	14,408,049	35%
Total contribution by Denmark	6,042,384	15%
Subtotal committed funding	20,450,433	50%
TOTAL FUNDING GAP	20,390,400	50%

Table 2:UN Joint Programme RMNCAH Budget over 2017–2020

Budget for the UN Joint Programme on RMNCAH 2017 to 2020 (USD)					
RESULTS	**2017**	**2018**	**2019**	**2020**	**TOTAL**
External Funding Requirement					
Intermediate Outcome 1: Improved access to and quality of integrated RMNCAH, HIV, and GBV services	2,020,000	1,810,000	3,085,000	2,715,000	**9,630,000**
Intermediate Outcome 2: Increased demand for RMNCAH, HIV, and GBV services	1,030,000	1,280,000	1,580,000	1,470,000	**5,360,000**
Intermediate Outcome 3: Strengthened county and national capacity	2,095,400	2,105,400	2,677,000	2,607,000	**9,484,800**
Subtotal outcomes	5,145,400	5,195,400	7,342,000	6,792,000	**24,474,800**
Overhead (7%)	360,178	363,678	513,940	475,440	**1,713,236**
Agency fee (1%)	51,454	51,954	73,420	67,920	**244,748**
Subtotal overhead/fee	411,632	415,632	587,360	543,360	**1,957,984**
Subtotal (USD)	5,557,032	5,611,032	7,929,360	7,335,360	**26,432,784**
Co-financing by H6 agencies	3,602,012	3,602,012	3,602,012	3,602,012	**14,408,049**
TOTAL (USD)	**9,159,044**	**9,213,044**	**11,531,372**	**10,937,372**	**40,840,833**

Table 3: Joint Programme Commitments by H6 Agencies 2017–2020

UN H6 Agency	Projected contribution to UN Joint Programme on RMNCAH during 2017–2020 (four years) USD	Percent
UNFPA	4,294,151	30%
WHO	1,898,920	13%
UNICEF	1,248,611	9%
World Bank	5,995,667	42%
UN Women	681,600	5%
UNAIDS	289,100	2%
TOTAL	14,408,049	100%

4. RISK ANALYSIS AND RISK RESPONSES

Table 5: Risk Analysis and Responses

Risk factor	Likelihood	Background to assessment of likelihood	Impact	Background to assessment of potential impact	Risk response	Residual risk
Shifting national priorities result in the joint programme no longer being relevant.	**Unlikely**	Rapidly evolving context due to deepening of devolution.	**Medium**	The national and county levels could come up with different strategies as they learn to work with devolution. However, RMNCAH priorities are not likely to change, as they are linked to global commitments Kenya has signed up to.	Continue to liaise with government and other development partners. Conduct annual review of the joint programme and reorient the programme where required to adapt to changing priorities.	**Minor**
2017 election could slow down programme implementation due to a shift in the attention of policymakers and the possibility of election violence.	**Likely**	Some political analysts say that election violence is most likely within counties due to fierce political competition. Politically appointed administrators may also have their attention diverted to campaign activities.	**Medium**	Change in leadership sometimes leads to change in management within the sector, which can slow the implementation of programmes that began under previous regimes.	The programme has built its interventions around national policies that outlast political leadership changes.	**Medium**
Weakness of data collection and processing for joint programme monitoring and evaluation, meaning that monitoring is inadequate to judge programme performance effectiveness.	**Likely**	Following devolution, national monitoring and evaluation systems, including health information systems, have been disrupted.	**Medium**	Will impact on the ability of the joint programme to monitor the effectiveness of programme implementation when using national indicators.	The H6 agencies will work actively with counterparts at all levels to strengthen monitoring and evaluation systems and capacity. Also, H6 agencies will ensure the monitoring of the few programme-specific indicators.	**Minor**

Risk factor	Likelihood	Background to assessment of likelihood	Impact	Background to assessment of potential impact	Risk response	Residual risk
Inadequate support from the Government of Kenya and county governments to county health sector budgets.	**Likely**	Economic crisis has led to a reduction in available donor funding.	**High**	The joint programme depends largely on external support. If support is not continued, the H6 agencies may have to reduce activities. However, RMNCAH is likely to remain a priority, and new financing modalities are being established.	Advocacy by H6 agencies with development partners to live up to their commitments. Continued resource mobilization. Continued publication of evidence.	**Minor**
Deteriorating security situation will hamper the implementation of programme activities.	**Likely**	The security situation in northern and eastern counties has been volatile	**High**	Decreased access to northern or eastern counties will hamper access by programme staff, technical assistance, and deliveries of equipment and supplies, as well as supervision and monitoring by county health authorities.	UN agencies have put security measures in place. H6 agencies will allow for realistic planning of joint programme implementation timelines. Outsource the monitoring of implementation progress to non-UN organizations/ individuals.	**Medium**
Management changes in the H6 agencies could result in sound developments in managerial efficiency not being sustained.	**Possible**	History has shown that sound management and a high level of integrity are key to maintaining efficiency.	**High**	Managerial efficiency and financial credibility are essential in order to maintain donor support. Consequences of failure are described above.	Development by the H6 agencies of a risk management system.	**Minor**
Use of resources for unintended purposes, particularly by subcontractors.	**Likely**	Counties or implementing partners may use joint programme resources for other priorities when they face financial constraints.	**Medium (only for one quarter)**	Will delay the implementation of the joint programme until the revenue budget replaces the resources.	UN has a harmonized approach to cash transfers system to ensure sound financial management practices. Ensure monitoring of the Integrated Financial Management Information System and counterpart fund allocation quarterly, and suspend further disbursements to such implementing partners in the following quarter.	**Minor**

Table 5 summarizes the main risks related to the UN Joint Programme on RMNCAH, and suggests the risk management responses that the H6 agencies should take to mitigate the risks.

5. PROGRAMME IMPLEMENTATION

5.1 Inception Phase

The UN Joint Programme on RMNCAH 2016–2020 will commence with an Inception Phase of a total duration of six months (December 2016 to May 2017).

The first months of the Inception Phase will focus on taking stock of the current programme. The basis for this will be the evaluation of the current H6 RMNCAH programme, which is planned for March–April 2017. The results are expected to be available in May 2017. In addition, a rapid gap analysis and mapping will be done, focusing on the RMNCAH context and the interventions that are underway or are being planned by the Government of Kenya and other partners.

Based on these assessments, the H6 agencies will work with national and county-level authorities on jointly developing a detailed work plan and results framework for the Joint Programme on RMNCAH for the period 2017 to 2020. H6 agencies and relevant national and county-level authorities will also jointly agree on the description of the specific programme output indicators, quantify the targets, and agree on baseline values.

The H6 agencies will do their best to ensure a smooth transition from the previous RMNCAH project to the new Joint Programme on RMNCAH. The commencement of the joint programme's implementation is expected to be swift and will not require the recruitment of new staff, the procurement of additional equipment, etc.

5.2 Phased Implementation

During its first phase from October 2016 to mid-2018, the Joint Programme on RMNCAH will focus on consolidating the achievements of the previous H6 RMNCAH project, implemented during 2015 and 2016 in the six programme counties. The good and evidence-based practices generated and adopted during the current programme will need to be synthesized and scaled up.

It is expected that in the second half of 2018, the Joint Programme on RMNCAH will be expanded to four additional counties, as described in Section 3.3. Implementation in the additional counties will focus on bringing RMNCAH services and capacity up to the level of the other six counties.

5.3 Implementation Structure

Similar to what took place during the previous RMNCAH six-county project, the joint programme will initially second County Project Coordinators to the counties to provide direct technical support for the planning, coordination, and management of activities. These tasks will however be progressively handed over to the County Health Management Teams. For increased efficiency in the use of scarce resources, the H6 agencies will explore the option of using the regional field offices of the H6 agencies in assisting to coordinate programme implementation for all H6 agencies at the local level. UNICEF currently has a field office in Garissa of 12 staff, which also covers the counties of Mandera, Marsabit, Wajir, and Isiolo, and an office in Kisumu (15 staff), which also covers Migori.

5.4 Division of Tasks and Responsibilities

The division of tasks and responsibilities among the H6 agencies will be as follows:

UNFPA:

- Reproductive, maternal, newborn, and adolescent health services
- Procurement of commodities and equipment, as well as infrastructure support
- In-service training of health workers, including midwives
- Strengthening of commodity security management systems
- Capacity building of county health management teams
- Integration of HIV and RMNCAH services
- Public–private partnerships

UNICEF:

- Child health services, including integrated management of childhood illnesses, immunization, and nutrition
- Community health strategy
- Demand-side financing
- Mama Packs/maternity kits
- Outreach programmes

UNAIDS:

- Support improved integration of RMNCAH and HIV services
- Technical support to inform strategies for HIV prevention, including the elimination of mother-to-child transmission of HIV and syphilis, achievement of 90-90-90 treatment targets, and elimination of HIV stigma and discrimination, as part of the fast-track approach
- Support the utilization of timely, reliable strategic information on HIV and RMNCAH to inform resource allocation and adjust and inform responses specifically through the scale up of HIV and RMNCAH Situation Rooms
- Advocacy for and facilitation of meaningful inclusion and involvement of people living with HIV and key populations in RMNCAH/HIV/GBV initiatives
- Convening of partners to address HIV infection/teenage pregnancy among young people

UN Women:
- HeForShe Campaign
- Support for strengthening services to GBV survivors
- Support for measures to address gender norms that fuel GBV, including harmful cultural practices

WHO:
- Strengthening of quality of care
- Strengthening of referral systems
- Health systems strengthening
- Capacity building of counties on health planning and monitoring
- Strengthening of civil registration systems, including capacity building on cause of death reporting

World Bank:
- Results-based financing
- Strengthening the quality of care through the results-based financing initiative

6. MANAGEMENT AND COORDINATION ARRANGEMENTS

6.1 Overall Oversight and Accountability

Overall programmatic and financial oversight, accountability, and strategic guidance for the Joint Programme on RMNCAH will be provided by the Joint Programme Steering Committee, co-chaired by the National Ministry of Health and UNAIDS, to ensure national ownership of the programme.

The existing Maternal and Newborn Health Steering Committee at the Ministry of Health will be strengthened and expanded to an RMNCAH Steering Committee to provide technical monitoring and oversight of the implementation of the programme. The inter-governmental coordination mechanism for the health sector, comprising representatives of both the national Ministry of Health and the County Departments of Health, will also be engaged for guidance and support.

6.2 National Coordination

UNFPA is the convening agency of the Joint Programme on RMNCAH and has the responsibility to coordinate the development and implementation of the UN Joint Programme on RMNCAH, working with the Joint Programme Steering Committee, the H6 RMNCAH Technical Working Group, and intermediate outcome leads. The tasks of the convening agency will also include convening and reporting on steering committee meetings, coordinating the preparation of the work plans, commissioning midterm and final evaluations, and other planning of joint processes. The UNFPA senior RMNCAH coordinator (Joint Programme coordinator) will be responsible for soliciting, supporting, and coordinating inputs on the development, implementation, and achievements of the joint programme. They will document lessons learned and oversee the county-level coordinators, ensuring constant communication and feedback among the various mechanisms described above.

H6 Technical Working Group

A technical working group comprised of senior technical staff from each of the six H6 agencies will be responsible for the day-to-day planning, implementation, and monitoring of the joint programme activities. The H6 Technical Working Group will have a revolving chair agency, to be decided on an annual basis. WHO and UNICEF will chair the group initially and will meet monthly to discuss joint programme progress. The programme partners will coordinate closely with the national Ministry of Health and programme counties to ensure effective implementation of the prioritized interventions.

6.3 County Coordination

At the county level, a county coordination team (chaired by the chief health officer) that brings together all the implementing partners will be constituted to monitor the implementation of activities, identify challenges, and report to the technical working group for guidance and action.

6.4 Communication

The UN Joint Programme on RMNCAH will work on presenting a coherent communication strategy for the programme and the expected results. This will entail maximizing the use of in-house communication expertise to develop joint messaging around the progress and expected results of the joint programme. While acknowledging their individual agency contributions, each of the joint programme partners will be expected to publicize the programme and acknowledge and credit the other participating agencies. Communications and publicity on the joint programme must acknowledge the national and county government participating agencies and donor partners.

For internal communication, all participating partners are encouraged to share, in a timely manner, information related to the joint programme with all other H6 partners.

6.5 Fund Management Arrangements

6.5.1 UN Development Group Guidance on Joint Programme Fund Management

The United Nations Development Group guidance on joint programming provides a number of fund management options based on the country

context and capacities. UN agencies are recipients of two types of funding: (i) core resources that are already mobilized by each UN agency and allocated for programmes, and (ii) non-core resources that are to be mobilized by the H6 partners and the government during the country programme period.

The UN Joint Programme on RMNCAH will utilize a combination of parallel and pass-through fund management modalities, as illustrated in Graph 2.

Parallel Funding
Under this option, each organization manages its own activities within the common work plan and the related budget, whether from core or non-core Resources. Funding arrangements under this option follow each agency's regulations and rules for individual programming and project processes. Each participating UN organization will prepare a separate budget consistent with its procedures and covering the mutually agreed components of the programme it will manage.

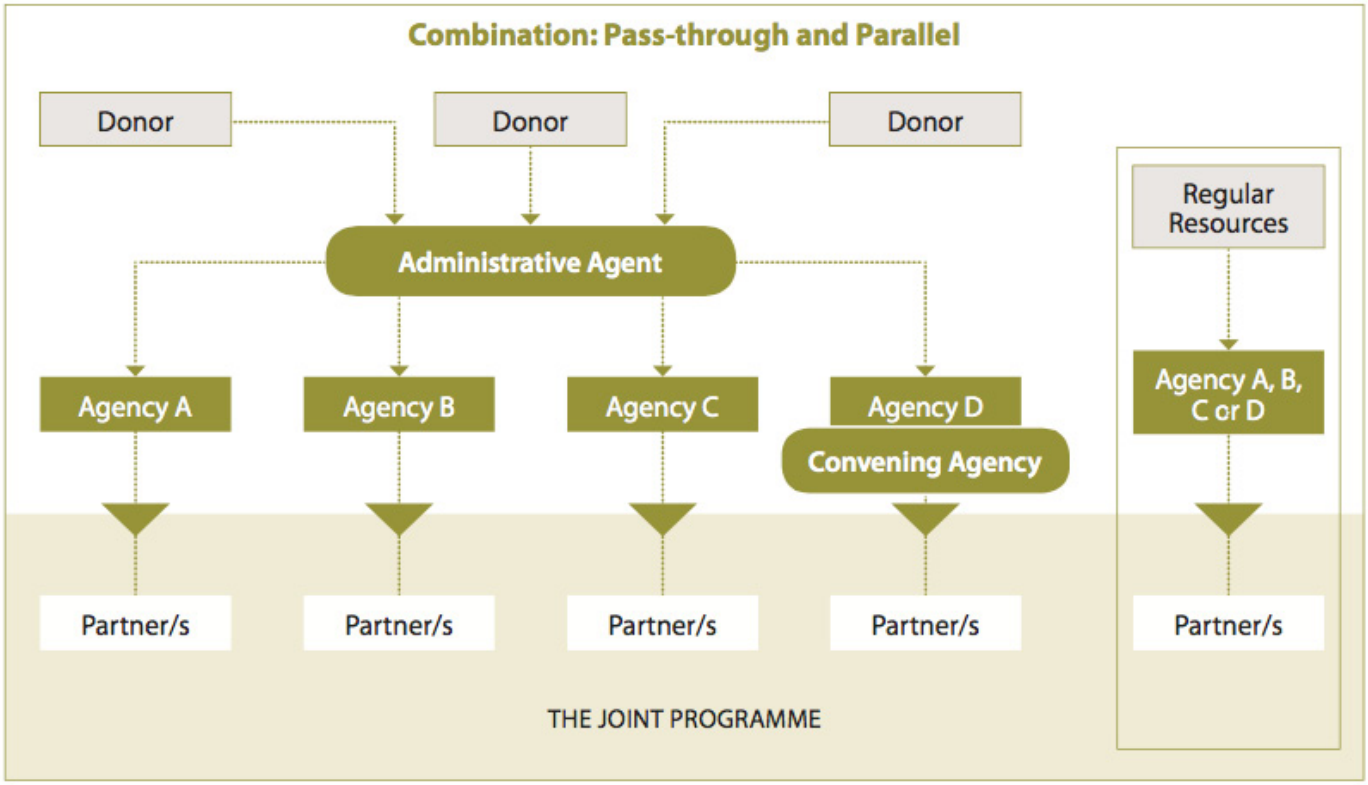
Pass-through Funding
The pass-through modality will be used for resources that are to be obtained from donors through resource mobilization initiatives at UN Country Team level (One Fund). Details of procedures, processes, and requirements for pass-through funding of the UN Joint Programme on RMNCAH are contained in the Standard Memorandum of Understanding for Joint Programmes Using Pass-through Fund Management and Standard Administrative Arrangements for Joint Programmes Using Pass-through Fund Management.

6.5.2 Administrative Agent

In accordance with the agreed modality, the administrative agent has the accounting responsibility, but not the management responsibility, for the joint programme. The principle functions of the administrative agent, as set out in the Standard Memorandum of Understanding for Joint Programmes Using Pass-through Fund Management, are as follows:

- Receive contributions from donors that wish to provide financial support to the joint programme
- Administer such funds received, in accordance with this memorandum of understanding, including the provisions relating to winding up the joint programme account and related matters
- Subject to availability of funds, disburse such funds to each of the H6 agencies in accordance with instructions from the UN Country Team/steering committee, taking into account the budget set out in the UN Joint Programme on RMNCAH Programme Document, as amended in writing from time to time by the steering committee
- Consolidate statements and reports, based on submissions provided to the administrative agent by each of the H6 agencies, as set forth in the joint programme document, and provide these to each donor that has contributed to the joint programme account and to the UN Country Team

Graph 2: Joint Programme Fund Management Modalities



- Provide final reporting, including notification that the joint programme has been operationally completed, in accordance with Section IV of the memorandum of understanding
- Disburse funds to any H6 agency for any additional costs for the task that the UN Country Team may decide to allocate (as referred to in Section I, Paragraph 3 of the memorandum of understanding) in accordance with the UN Joint Programme on RMNCAH Programme Document

The administrative agent will be entitled to an administrative fee of 1 percent of the amount contributed by each donor to the joint programme to meet the administrative agent's costs of performing the administrative agent's functions described in the memorandum of understanding. The administrative agent will establish a separate ledger account under its financial regulations and rules for the receipt and administration of the funds received pursuant to the administrative arrangement (hereinafter, the "H6 RMNCAH

Joint Programme Account"). The account will be administered by the administrative agent in accordance with the regulations, rules, directives, and procedures applicable to it, including those relating to interest.

For the UN Joint Programme on RMNCAH, UNFPA will be the administrative agent.

6.5.3 Transfer of Cash to Implementing Partners

All cash transfers to an implementing partner are based on the annual work plans agreed between the implementing partner and the H6 agencies. Pursuant to the harmonized approach to cash transfers procedures, all agencies will assess risks associated with transactions to an implementing partner before initiating cash transfer procedures. In both the parallel and pass-through funding arrangements, implementing partners will prepare a fund request and report form (Funding Authorization and Certificate of Expenditures or FACE), which is submitted to the respective H6 agency for any fund request and reporting. The release of funds to the implementing partner will be done by each of the H6 agencies. They will disburse funds to the county government treasury, which will then transfer the funds, on request, to the county government department of health.

6.6 Resource Mobilization

Participating UN agencies are collectively responsible for raising funds for the joint programme, promotion of the One Fund, effective monitoring of results, and support to joint communication on the joint programme's achievements. UNAIDS will continue to coordinate UN Country Team actions to promote the joint programme and direct donor contributions through the One Fund (pass-through funding).

In order to efficiently and effectively mobilize the additional USD 20 million to bridge the funding gap, the joint programme will establish a joint resource mobilization task force to develop and implement a resource mobilization strategy for the programme. The H6 partners, the Office of the UN Resident Coordinator, the Ministry of Health, and respective county governments are expected to support the development and implementation of the strategy.

The joint resource mobilization strategy will target a mix of traditional and emerging donors, as well as philanthropic donors and those from the private sector.

The programme will aim to optimize coordination for leveraging RMNCAH investments in the joint programme's target counties. Through the Private Sector Health Partnership Kenya, UNFPA will also seek to further leverage the investments for improvements in RMNCAH services through

public–private partnerships. The programme team will collaborate with the Kenya Sustainable Development Goal Philanthropy Platform to mobilize and leverage philanthropic resources for the programme.

Quarterly reporting on resource mobilization progress will be provided to the UN Joint Programme on RMNCAH Steering Committee by the chair of the resource mobilization task-force.

7. PROGRAMME PLANNING, MONITORING, EVALUATION, AND REPORTING

7.1 Planning and Budgeting

H6 agencies will conduct joint assessment and planning sessions with the county government department staff (County Health Management Team, etc.) and identified implementing partners to integrate the supported RMNCAH interventions into the county work plans and budgets.

From the county work plans, the H6 agencies will develop an overall national joint programme work plan and budget.

7.2 Monitoring

As the convening agency, UNFPA is responsible for overseeing the development and implementation of a monitoring and evaluation system/framework for the entire joint programme that will track indicators at the different levels of results (outcome and output), as well as process monitoring of the activities and budgets.

During the programme inception phase, UNFPA, the H6 agencies, the relevant national- and county-level authorities, and development partners will jointly agree on the exact description of the specific programme output indicators, as well as quantify and agree on the baselines at the county level. Indicators will be aligned to national and county scorecards.

The monitoring and evaluation framework will include county-specific baselines and targets. The district health information system (DHIS 2) and Kenya Demographic and Health Survey will be supported to track progress at outcome and impact levels. Currently, systems may not be adequate to track progress.

Progress on the implementation of the project will be monitored against the UN Joint Programme on RMNCAH Results Framework through bi-monthly monitoring meetings by the H6 agencies at national and county levels.

As part of the monitoring and evaluation framework, the H6 agencies will be expected to plan and undertake joint monitoring visits to assess joint programme progress.

7.3 Reporting

7.3.1 Narrative Reporting

Reporting will take place through the production of quarterly programme reports as well as semi-annual narrative and financial reports by the H6 agencies, which will be shared with the H6 heads of agencies, the Government of Kenya, relevant county governments, and joint programme donors. The report template will be used. In addition, the H6 agencies/UNFPA will make progress reports to the Joint Programme Technical Working Group on a regular basis.

Additional tools for monitoring and reporting are available:

- Annual work plan and budget
- Quarterly progress reports
- Semi-annual financial and programme progress reports
- Annual progress report
- Midterm review
- Joint field visits

H6 agencies will be expected to report to UNFPA (the designated joint programme coordinator) on all activities planned under the joint programme, whether funded through the parallel or pass-through funds modality. The reporting will use formats specific to the joint programme.

In addition to the financial reports prepared by the participating UN organizations, where pass-through funding is being used, the administrative agent also prepares consolidated financial reports for submittal to the UN Coordinating Agency. These different reports and inputs are consolidated by the UNFPA Programme Coordinator and discussed with the H6 Technical Working Group to highlight key issues, achievements, lessons learned, and recommendations for future action. The report will then be submitted to the Joint Programme Steering Committee and UN Country Team for review and approval.

The convening agency, UNFPA, will submit the final annual report to the donors, the UN Joint Programme on RMNCAH Steering Committee, and the national Ministry of Health Maternal and Newborn Health Steering Committee for review, approval, and onward transmission to concerned partners and stakeholders. At the county level, the engagement will be monitored by the county government through the County Executive for Health and the County Health Management Team.

7.3.2 Financial Reporting

County-level implementing partners shall send their reports to the respective participating H6 agency using the Funding Authorization and Certificate of Expenditures or FACE forms. UNFPA, the convening agency, will be responsible for consolidating financial reporting across both parallel and pass-through modalities unless the Joint Programme Steering Committee agrees to an alternative arrangement. Intermediate outcome lead agencies will support this coordination effort by consolidating reports at the outcome level.

Financial audits of contracted implementing partners will be jointly undertaken by the H6 agencies implementing the joint programme. Under the current harmonized approach to cash transfers framework, audits will take a risk-based approach. Depending on the risk rating of the implementing partner and the amount of funds transferred to them, an audit or another assurance activity (e.g. a spot check) will be undertaken. The total cost of audits or other assurance activities of the joint programme will be covered directly by the joint programme, and a budgetary provision for these costs will be included from the onset. The H6 agencies will not be subject to specific financial audits for the UN Joint Programme on RMNCAH. The portion of joint programme activities implemented by the individual H6 agencies will be audited in accordance with each agency's financial rules and regulations.

7.4 Programme Review and Evaluations

7.4.1 Programme Reviews

In collaboration with the county governments and implementing partners, the H6 agencies will conduct both mid-year and end-of-year reviews, with the participation of national and county governments and donors, to examine programme performance over the past year. The reviews will highlight achievements, lessons learned, and recommendations for the way forward, and discuss the programme plans for the following year.

7.4.2 Programme Evaluation

Midterm Review
A midterm review of the joint programme will be conducted in the second half of 2018 by the H6 agencies, with the participation of the Ministry of Health, counties, and implementing partners, to coincide with the overall review and development of the 2018–2022 UN Development Assistance Framework. The midterm review is essential to highlight the progress of the joint programme and to make recommendations for solidifying positive results and taking corrective action to ensure that the joint programme achieves its results by the end of 2020. The terms of reference

for this will be shared with donors, the UN Joint Programme on RMNCAH Steering Committee, the Technical Working Group on Maternal and Newborn Health, and other partners. Involvement of beneficiaries in the evaluation process will be emphasized, including in the development of the terms of reference.

Evaluation

An end-of-term evaluation will be undertaken by an independent consultancy team to evaluate programme performance. The terms of reference for this will be shared with donors, the UN Joint Programme on RMNCAH Steering Committee, the Technical Working Group on Maternal and Newborn Health, and other partners. Involvement of beneficiaries in the evaluation process will be emphasized, including in the development of the terms of reference.

UNICEF and the Department for International Development have contracted the Belgian company Health Research for Action (HERA) to conduct an evaluation (covering 2015 to 2019) for the USD 95 million maternal and newborn health programme implemented in six counties. It is suggested that the H6 evaluation terms of reference and evaluation contractor align as much as possible with the work HERA is undertaking in order to provide reference points and make it easier to compare results across all 12 counties (the 6 counties covered by the UN Joint Programme on RMNCAH and the 6 counties covered by the maternal and newborn health programme).

8. LEGAL CONTEXT OR BASIS OF RELATIONSHIP

Table 6: Basis of Relationship

Participating UN organization	Agreement
UNAIDS	This Joint Programme Document shall be the instrument referred to as the Project Document in Article I of the Standard Basic Assistance Agreement between the Government of Kenya and the United Nations Development Programme, signed by the parties on 17 January 1991.
UNFPA	This Joint Programme Document shall be the instrument referred to as the Project Document in Article I of the Standard Basic Assistance Agreement between the Government of Kenya and the United Nations Development Programme, signed by the parties on 17 January 1991.
UNICEF	The Basic Cooperation Agreement, concluded between the Government of Kenya and UNICEF on 24 June 1970 (and revised on 29 January 1993), provides the basis of the relationship between the government and UNICEF. The Country Programme Action Plan is to be interpreted and implemented in conformity with the Basic Cooperation Agreement. UNICEF also has biannual rolling work plans with the Ministry of Health.
UN Women	This Joint Programme Document shall be the instrument referred to as the Project Document in Article I of the Standard Basic Assistance Agreement between the Government of Kenya and the United Nations Development Programme, signed by the parties on 17 January 1991.
WHO	The Basic Agreement for the provision of technical advisory assistance with the Government of Kenya was concluded on 23 June 1964 and has been in force since that date. The Country Cooperation Strategy for WHO/Kenya elaborates how the country office will support the implementation of the organization's strategic agenda in the context of the country's priorities and WHO capabilities to make the greatest possible contribution to health in Kenya.
World Bank	The World Bank relationship with the Government of Kenya is guided by the Country Partnership Strategy. The current strategy covers the period of 2014 to 2018 and includes three domains: (a) Competitiveness and sustainability – growth to eradicate poverty; (b) Protection and potential – human resource development for shared prosperity; and (c) Building consistency and equity – delivering a devolution dividend.

Table 6 specifies what cooperation or assistance agreements[1] form the legal basis for the relationships between the Government of Kenya and each of the UN organizations participating[2] in this joint programme.

1 Such as the Basic Cooperation Agreement for UNICEF; Standard Basic Assistance Agreement for UNDP, which also applies to UNFPA; the Basic Agreement for WFP; the Country Programme Action Plan(s) where they exist; and other applicable agreements for other participating UN organizations.
2 Including specialized agencies and nonresident agencies participating in the Joint Programme.

The implementing partners/executing agency[3] agree to undertake all reasonable efforts to ensure that none of the funds received pursuant to this joint programme are used to provide support to individuals or entities associated with terrorism and that the recipients of any amounts provided by participating UN organizations do not appear on the list maintained by the Security Council Committee established pursuant to resolution 1267 (1999).[4]

3 Executing agency in the case of UNDP in countries with no signed Country Programme Action Plans.
4 The list can be accessed via http://www.un.org/Docs/sc/committees/1267/1267ListEng.htm.

ANNEX 1: RMNCAH RESULTS FRAMEWORK

This results framework includes proposed indicators at Overall Outcome level and at Intermediate Outcome level. Baseline, milestone, and target values for each county will be confirmed during the joint programme inception phase.

RMNCAH Results Framework

UN Development Assistance Framework Outcome

By 2018, morbidity and mortality in Kenya are sustainably reduced, with improved maternal, neonatal, and child survival, reduced malnutrition and incidence of major endemic diseases (malaria, tuberculosis), and stabilized population growth underpinned by a universally accessible, quality, and responsive health system.

Kenya UN Joint Programme on RMNCAH Overall Outcome

By 2020, ten counties with high maternal mortality burden enjoy increased utilization of integrated quality reproductive, maternal, newborn, child, and adolescent health (RMNCAH), HIV, and GBV services to contribute to the reduction of maternal and newborn mortality in Kenya.

Joint Programme Indicator Name	Indicator Description	Data Source/ Methodology	Responsibility for Data Collection	Baseline 2016	Milestone 2018	Target 2020
Overall Joint Programme Outcome Indicators						
Overall Outcome Indicator (OOI) 1: Pregnant women attending at least four ANC visits (percentage)	Proportion of women between the ages of 15-49 years who had at least 4 ANC visits attended by trained health personnel	District Health Information System (DHIS2)	County Department of Health (CDOH)	ISI: 45% LAM: 61% MAN: 33% MAR: 37.3% MIG: 38% WAJ: 18	ISI: 55% LAM: 70% MAN: 43% MAR: 43.3% MIG: 45% WAJ: 28	ISI: 66% LAM: 80% MAN: 53% MAR: 49.3% MIG: 60% WAJ: 38
OOI.2: Births attended by skilled health personnel (percentage)	Proportion of births attended by skilled health personnel	DHIS2	CDOH	ISI: 67% LAM: 64% MAN: 28% MAR: 48.7% MIG: 65% WAJ: 31	ISI: 77% LAM: 80% MAN: 41% MAR: 58.7% MIG: 72% WAJ: 41	ISI: 87% LAM: 90% MAN: 51% MAR: 68.7% MIG: 80% WAJ: 51

Joint Programme Indicator Name	Indicator Description	Data Source/ Methodology	Responsibility for Data Collection	Baseline 2016	Milestone 2018	Target 2020
OOI.3: Women of reproductive age living with HIV who are on antiretroviral treatment (percentage)	Proportion of women of reproductive age living with HIV who are enrolled in antiretroviral treatment (ART)	DHIS2	CDOH	ISI: 60% LAM: 1,415 MAN: 5% MAR: 57% MIG: 99% WAJ: 8.3	ISI: 70% LAM: 1,486 MAN: 5% MAR: 67% MIG: 100% WAJ: 10	ISI: 80% LAM: 1,557 MAN: 5% MAR: 77% MIG: 100% WAJ: 14
OOI.4: Births registered (percentage)	Proportion of births which are registered through the proper channels	Civil Registration and Statistics Department	Civil Registration and Statistics Department at county level	ISI: 43% LAM: 60% MAN: 60% MAR: Unavailable MIG: Unavailable WAJ: 18.4%	ISI: 62% LAM: tbc MAN: 65% MAR: Unavailable MIG: 85% WAJ: 20%	ISI: 70% LAM: tbc MAN: 70% MAR: Unavailable MIG: 100% WAJ: 24%
Intermediate Outcome 1: Improved access to and quality of integrated RMNCAH services, including HIV and GBV services						
Intermediate Outcome Indicator (IOI) 1.1: Facilities (L2-L4) providing basic emergency obstetric and newborn care (BEMONC) (percentage)	Proportion of L2 to L4 health facilities that provide the entire package of BEMONC services	Service Availability and Readiness Assessment Mapping Report	CDOH	ISI: 54% LAM: 84% MAN: 38% MAR: 92% MIG: 61% WAJ: 79%	ISI: 70% LAM: 100% MAN: 48% MAR: 100% MIG: 72% WAJ: 84%	ISI: 77% LAM: 100% MAN: 58% MAR: 100% MIG: 80% WAJ: 94%
IOI.1.2: Percentage of pregnant women who were tested for HIV and received their results – during pregnancy, during labour and delivery, and during the post-partum period	Proportion of ANC clients tested for HIV among new ANC clients coverage (shown in bracket, highlighted yellow)	DHIS2 Kenya AIDS Indicator Survey	CDOH	ISI: 18% LAM: 42.5% MAN: 80% MAR: 12% MIG: 72% WAJ: 28.3%	ISI: 50% LAM: 52.5% MAN: 80% MAR: 50% MIG: 80% WAJ: 38%	ISI: 80% LAM: 57.5% MAN: 80% MAR: 80% MIG: 90% WAJ: 48%
IOI.1.3: Number of GBV survivors treated in health facilities (number)	Number of survivors of GBV who attend health facilities where they have received the full package of GBV health sector services	DHIS2	CDOH	ISI: 0% LAM: Unavailable MAN: Unavailable MAR: 0% MIG: 0% WAJ: 0%	ISI: 30% LAM: Unavailable MAN: Unavailable MAR: 20% MIG: 25% WAJ: 5%	ISI: 50% LAM: Unavailable MAN: Unavailable MAR: 40% MIG: 50% WAJ: 15%

Joint Programme Indicator Name	Indicator Description	Data Source/ Methodology	Responsibility for Data Collection	Baseline 2016	Milestone 2018	Target 2020
Intermediate Outcome 2: Increased demand for RMNCAH services, including HIV and GBV services						
IOI.2.1: Women of reproductive age receiving modern family planning (new users) (number)	Number of women aged 15–49 who receive modern family planning	DHIS2	CDOH	140,890 (aggregate in six counties) ISI: 3,832 LAM: 4,126 MAN: tbc MAR: 5,738 MIG: 125,927 WAJ: 8,113	ISI: 3,932 LAM: 70% MAN: tbc MAR: 6,138 MIG:129,726 WAJ: 8,713	170,000 (20% increase) (aggregate in ten counties) ISI: 4,132 LAM: 80% MAN: tbc MAR: 65,38 MIG: 134,813 WAJ: 9,613
IOI.2.2: Adolescent girls supported to return to school after pregnancy (number)	Number of girls aged 14 to 19 who return to school after pregnancy	Adolescent Survey	National Council for Population and Development	ISI: Unavailable LAM: Unavailable MAN: Unavailable MAR: Unavailable MIG: 2 WAJ: Unavailable	ISI: Unavailable LAM: 50 MAN: Unavailable MAR: Unavailable MIG: 10 WAJ: tbc	ISI: Unavailable LAM: 150 MAN: Unavailable MAR: Unavailable MIG: 20 WAJ: tbc
IOI.2.3: Women and men aged 15 years and older who received HIV testing and counselling in the last 12 months and know their results (number)	Number of women and men aged 15 years and above who received HIV testing and counselling in the last year and know their results	Kenya AIDS Indicator Survey	National AIDS and STI Control Programme	ISI: 8,444 LAM: 17,141 MAN: 41% MAR: 9,828 MIG: 247,805 WAJ: tbc	ISI: 9,444 LAM: 50% MAN: 50% MAR: 11,828 MIG: 260,196 WAJ: tbc	ISI: 10,994 LAM: 90% MAN: 55% MAR: 13,828 MIG: 273,205 WAJ: tbc
IOI.2.4: Counties that launched the HeForShe Campaign, identified local champions as trainers of trainers, and supported the mentorship programme for young people (e.g. health sector, male youth leaders, prominent business people, local media personalities, county executives, religious leaders)	Number of counties with HeForShe RMNCAH Champions, who have launched the campaign and organized trainers and trainers of trainers to influence the reproductive health services uptake by women of childbearing age in the county.		UN Women	ISI: 0 LAM: 0 MAN: 0 MAR: 0 MIG: 0 WAJ: 0	ISI: 20 LAM: 20 MAN: 20 MAR: 20 MIG: 20 WAJ: 20	ISI: 100 LAM: 100 MAN: 100 MAR: 100 MIG: 100 WAJ: 100

Joint Programme Indicator Name	Indicator Description	Data Source/ Methodology	Responsibility for Data Collection	Baseline 2016	Milestone 2018	Target 2020
Intermediate Outcome 3: Strengthened county and national capacity for coordination, planning, supervision, monitoring, and evaluation of RMNCAH services, including HIV and GBV services						
IOI.3.1: Counties with RMNCAH, HIV, and GBV interventions integrated into the county annual work plans for the health sector (number)	Proportion of overall county expenditure that is allocated to the health sector	Programme data	County Programme Coordinators	0	6	10
IOI.3.2: County health expenditure on health (percentage)	Proportion of overall county expenditure that is allocated to the health sector	Integrated Financial Management Information System	County Programme Coordinators	ISI: 21.8% LAM: 30% MAN: tbc MAR: 30% MIG: 25% WAJ: 16	ISI: 25% LAM: 35% MAN: tbc MAR: 30% MIG: 27% WAJ: 20	ISI: 25% LAM: 35% MAN: tbc MAR: 30% MIG: 30% WAJ: 24
IOI.3.3: Counties with a functional maternal and perinatal death surveillance and response (MPDSR) system and that have used the results to take policy decisions (number)	Number of counties with a functional MPDSR system that have actually used the results to influence policies and activities in the county. Functional is defined as: -Existence of MPDSR committees at community facility, subcounty, and county level -Regular committee meetings -Implementation of the audits -Audit data reviewed -Use of audit data for decision making	Programme data	County RMNCAH Coordinators	ISI: 1 LAM: 1 MAN: 1 MAR: 1 MIG: 1 WAJ: 1	ISI: 1 LAM: 1 MAN: 1 MAR: 1 MIG: 1 WAJ: 1	ISI: 1 LAM: 1 MAN: 1 MAR: 1 MIG: 1 WAJ: 1

RESULTS FRAMEWORK ABBREVIATIONS

ISI: Isiolo
LAM: Lamu
MAN: Mandera
MAR: Marsabit
MIG: Migori
tbc: to be confirmed
WAJ: Wajir

ANNEX 2: COUNTIES WITH THE HIGHEST BURDEN OF MATERNAL MORTALITY

Maternal mortality is one of the indicators of the reproductive health status of the population. Efforts to reduce maternal deaths have for decades been a focal point of international agreements and a priority for women's rights and health groups throughout the world because a maternal death is one of life's most tragic outcomes. The irony is that almost all maternal deaths are entirely preventable given proper medical surveillance and intervention.

Ranking of Counties in 2014 for the Previous RMNCAH Project

In the last round of censuses, the United Nations Statistical Division encouraged many developing countries to include questions on pregnancy-related deaths as a way of helping to improve the quantity and quality of data needed for the estimation of maternal mortality in the world. This was subsequently adopted in the 2009 Kenya Population and Housing Census. Respondents were asked to report any death in the household in the 12 months prior to enumeration. These were subsequently named the recent deaths in the household. Among the deceased females aged 12 to 49, subsequent questions were asked on whether the female deaths were pregnancy related (i.e. during pregnancy, during delivery, or within two months after delivery).

Measurement of Maternal Mortality

Several indicators are used to measure maternal mortality in order to display the sources of different risks as well as interventions. The first definition is **pregnancy-related death**, which is the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective

of the cause of death. When information on the cause of death is available, then we have **maternal death**, which is the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.

However, for comparison purposes between different contexts, due to differences in the risk of pregnancy, the **Maternal Mortality Ratio** (MMR) is often used. Maternal Mortality Ratio is thus the number of maternal deaths during a given time period per 100,000 live births during the same period. MMR captures the risk of death in a single pregnancy or a single live birth. In technical terms, it measures the extent of obstetric risk.

In the entire country, a total of about 32,021 women of reproductive age were reported to have died in the five years previous to the 2009 census, out of which 6,632 or 21 percent died of pregnancy-related causes.[1] Table 7 shows the ranking of the top 15 counties by number of maternal deaths and maternal mortality ratio. Columns 1 to 3 are the ranks by number of maternal deaths. It indicates that only 15 out of 47 counties account for 98.7 percent of the total maternal deaths in the country. However, the number of deaths masks important considerations, such as the size of the population of women in the region, as well as the frequency of pregnancies. An alternative ranking is by maternal mortality ratio, which takes into account the obstetric risk. This is provided from column 4 to 6. Mandera and Wajir still rank highest in terms of absolute number of maternal deaths as well as increased obstetric risk.

Although Nairobi, Nakuru, Kakamega, Kilifi, Nandi, Bungoma, and Kwale rank higher in terms of number of deaths, in terms of MMR they do not rank higher. With regard to maternal mortality burden, it is therefore important to include risks in number of deaths as well as obstetric risk. This is shown in Table 8. At the national level, nearly half of deaths (48 percent) occur during delivery. In five counties (Lamu, Garissa, Wajir, Mandera, and Turkana), over half of deaths occur during delivery. The county with the highest proportion of deaths during pregnancy is Marsabit. Siaya, Kisumu, and Taita Taveta have the highest proportion of deaths in the post-partum period. The implication here is that different factors influence the risk of maternal death in different counties. Kenya is among the top ten countries with the highest number of HIV-associated maternal deaths, and about 20 percent of maternal deaths are indirectly related to HIV. Thus HIV may be important in Nyanza region counties, which have the highest prevalence of HIV, while other factors may be important in Mandera, Wajir, and Garissa, which have a low prevalence of HIV.

1 UNFPA/University of Nairobi Population Studies and Research Institute (2014): *Situational Analysis Report on Ending Preventable Maternal Mortality in Kenya*.

Table 7: Ranking of Counties by Number of Maternal Deaths and Maternal Mortality Ratio

Rank	Region	Maternal deaths	Rank	Region	Maternal Mortality Ratio (deaths per 100,000 live births)
	KENYA	**6,623**		**KENYA**	**495**
1	Mandera	2,136	1	Mandera	3,795
2	Wajir	581	2	Wajir	1,683
3	Nairobi	533	3	Turkana	1,594
4	Nakuru	444	4	Marsabit	1,127
5	Kakamega	364	5	Isiolo	790
6	Kilifi	289	6	Siaya	691
7	Nandi	266	7	Lamu	676
8	Bungoma	266	8	Migori	673
9	Homa Bay	262	9	Garissa	646
10	Migori	257	10	Taita Taveta	603
11	Kisumu	249	11	Kisumu	597
12	Siaya	246	12	Homa Bay	583
13	Trans-Nzoia	234	13	Vihiga	531
14	Garissa	208	14	Samburu	472
15	Kwale	203	15	West Pokot	434
	Other counties	85			
	TOTAL	6,538			
Percentage of the total number of deaths		98.7			

Source: Kenya National Population and Housing Census 2009 (Population Studies and Research Institute, University of Nairobi Sub-analysis)

Ranking of Counties According to the 2015 RMNCAH Investment Framework

The RMNCAH Investment Framework used a multidimensional ranking with sensitivity analysis to identify its 20 priority counties. Within each dimension, more than one indicator was considered, and the sensitivity of the ranking to the choice of a particular indicator was assessed. For some indicators, no sensitivity analysis was done, as the indicators had no rivals (e.g. modern contraceptive prevalence rate in the reproductive health dimension, antenatal care and skilled birth attendance in the maternal and newborn health dimension). Three child health indicators were considered, but were ultimately not included because they combined need and access. All variables were ranked to denote monotonically improving performance (e.g. pregnancy was ranked in descending order, and all others were ranked in increasing order). In order to arrive at the final ranking, a simple average across the ranked indicators was calculated.

Using the above methodology, the first ten counties were ranked based on the proportions of the key demographics satisfying the indicator in question, e.g. percentage of women aged 15–49 years using modern contraceptives, or percentage of pregnant women aged 15–49 delivered by a skilled attendant, etc. To avoid disadvantaging counties with large population sizes in deriving the top 15 high-burden county rankings, the remaining five counties were added based on the absolute rankings of the indicators considered. An alternative scenario ranks the top ten counties based on absolute figures, and the remaining five based on percentage versions of the indicators in question.

The 20 priority counties identified by the RMNCAH Investment Framework are as follows:

- The six counties covered by the previous RMNCAH project: Isiolo, Lamu, Mandera, Marsabit, Migori and Wajir
- Plus Bungoma, Garissa, Homa Bay, Kakamega, Kilifi, Kitui, Nairobi, Nakuru, Narok, Samburu, Tana River, Trans-Nzoia, Turkana, and West Pokot

Table 8: Ranking of Counties by Burden of Maternal Mortality

County	Maternal deaths	Maternal Mortality Rate	Percentage of deaths during		
			Pregnancy	Delivery	Two months after delivery
Mandera	2,136	3,795	28	56	16
Turkana	175	1,594	24	54	22
Wajir	581	1,683	28	60	12
Migori	257	673	24	45	30
Nakuru	444	374	28	40	31
Siaya	246	691	22	28	50
Kisumu	249	597	18	33	48
Nairobi	533	212	25	38	38
Homa Bay	262	583	22	34	43
Kakamega	364	316	20	44	36
Garissa	208	646	25	61	13
Marsabit	97	1,127	30	47	23
Taita Taveta	129	603	16	36	48
Isiolo	32	790	25	56	19
Lamu	52	676	10	65	25
Kenya	**6,623**	**495**	**26**	**48**	**26**

This document outlines the Joint Programme on Reproductive, Maternal, Newborn, Child and Adolescent Health of the Government of Kenya and United Nations H6 partners (UNAIDS, UNFPA, UNICEF, WHO, UN Women, and the World Bank), working together towards the reduction of preventable maternal, newborn, and child deaths in ten high-burden counties in Kenya from October 2016 to December 2020. The H6 partnership is a global initiative of the United Nations to support the implementation of maternal, newborn, child, and adolescent health programmes at the country level following the launch of the UN Secretary-General's Global Strategy for Women's and Children's Health in September 2010.