

Independent Evaluation of the Reduction of Maternal and Neonatal Mortality in Kenya

Formative Evaluation Findings



Photo: Riccardo Gangale/USAID Kenya, 2013

Too many women in Kenya are dying in childbirth. Too many newborn babies don't survive the first month of their lives. The Government of Kenya is responding with support from international partners. Since 2013, maternity services have been provided free of charge by government hospitals and health centres. However, many challenges remain.

There is a strong tradition of home deliveries and hospitals or health centres are often far away. The roads to reach the health centres may not be safe at night, or the fare for the taxi may not be affordable. Throughout the country there is a severe shortage of trained doctors and midwives and many health centres are poorly equipped and may not even have electricity or running water.

The DFID-funded Reduction of Maternal and Neonatal Mortality Programme (MNH Programme) started to address these issues in 2014 with a grant of £75.3 million over five years. It is active in six counties, home of nearly one quarter of the Kenya's population of about 48 million.

The midterm evaluation in 2016 found that the MNH Programme addresses some key causes of maternal and newborn health with an appropriate mix of interventions to strengthen the Kenyan health system at all levels, including in the communities.

The implementation of some MNH Programme components started late. Training of doctors and midwives in emergency obstetric care was one of the first sets of activities to get underway, and it has started to show results. In 2016, it was, however, still too early for a robust assessment of the number of deaths averted by the programme. Nevertheless, the information collected and documented by the evaluation will serve as a valuable baseline on which such an assessment can be made in 2018 when the 5-year MNH Programme will be nearing its end.

Background

The hera consortium was appointed to undertake the evaluation of the DFID funded Reduction of Maternal and Neonatal Mortality Programme (MNH Programme) in Kenya. The evaluation will run over three years (2016 – 2018) and will assess the efficiency, effectiveness, relevance, equity and impact of support provided by DFID. This brief is a summary of the findings of the midterm evaluation, conducted in 2016 to review progress and recommend programme adjustments.

About the programme

The MNH Programme is funded by DFID with a total of £75.3 million over five years. It is delivered by three organisations, the Liverpool School of Tropical Medicine (LSTM), UNICEF Kenya and Marie Stopes International (MSI), each working in a separate field with differing numbers of subcontracted local and international partners. An additional component is the Community Innovation Challenge Fund (CICF) in which local organisations compete for grants to introduce innovation in maternity care through pilot projects and initiatives.

The MNH Programme aims to achieve a reduction of maternal and newborn deaths in Kenya by increasing the utilisation of quality maternity services in six counties. The main reasons why mothers and their newborn babies die in childbirth are delays in receiving good maternity care. The programme addresses the three main reasons for such delays.

- **Delay in the decision to seek care:** There are many reasons why women may not seek qualified assistance in a clinic or hospital for the birth of their baby. They may live in communities with strong traditions of home births and associated rituals, they may not know that assistance during birth is necessary or available, and their status in the family may not allow them to decide to deliver in a hospital. These, and other so-called demand-side reasons, are addressed through the community outreach activities of the programme.
- **Delay in reaching care:** Health centres and hospitals may be far away, especially in the northern savannah regions of Kenya. Money may not be available to pay for a motorcycle taxi. Or the roads in the city at night may be too insecure to attempt reaching a hospital. The programme includes several interventions to address these issues, including bringing obstetric services closer to communities, issuing transport vouchers to pay the motorcycle drivers, and establishing maternity waiting homes close to hospitals.

- **Delay in receiving care:** Health centres and hospitals that provide obstetric services need appropriate facilities with labour and delivery rooms, water and electricity, and the necessary equipment and medicines to respond to emergency situations. They also need well trained midwives and doctors that are available for 24 hours seven days a week. The programme aims to assure this through in-service training in emergency obstetric care and through support of national and county health administrations to strengthen health systems, including improvements in infrastructure, equipment, medicines supply, staffing levels and supervision of clinics and hospitals.

The midterm evaluation

The midterm evaluation was conducted in 2016 according to an evaluation plan which included four main components: a) detailed interviews with county administrations in six programme and two control counties to describe the status and context of providing maternity services in the county; b) a detailed study of maternity service provision and utilisation in a sample of 34 health facilities and their surrounding communities in programme and control areas; c) An overall programme analysis based on document reviews and interviews with a wide range of stakeholders at national level as well as a field visit to health facilities; and d) a Value for Money study to relate the expenditures by DFID to achievements in terms of lives saved.

The main findings

The programme context

The MNH Programme is complex because it includes many different types of supported interventions and many implementing partners. The programme, furthermore, is implemented in three distinct social and geographic environments. By working in counties with mainly pastoralist communities in the North, in primarily rural and agricultural counties in the East, and in high-density settlements in Nairobi, the programme will be able to generate lessons that will be applicable throughout the country and possibly in other countries of Africa.

Maternal health and service statistics prior to programme start-up in 2013 document that the six programme counties had generally poorer performance indicators than the national average and the two control counties. This indicates appropriate targeting of the MNH Programme to areas with the greatest needs.



Kenyan woman ensures her child's health

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The programming environment for maternal and neonatal health in Kenya is dynamic. In 2013, the Government of Kenya introduced the free maternal healthcare policy resulting in an increase in the use of clinics and hospitals for deliveries. In addition, many international organisations are actively supporting maternal and neonatal health initiatives throughout the country. Maternity care in Kenya is improving as documented by national indicators of service coverage and reduction in mortality rates. Attempts to identify the contribution of the MNH Programme to these changes are challenging. It will not be possible to document and measure all contributions because they cannot always be separated from the general trends.

There were many delays in the start-up of the programme. Some were beyond control due to requirements to revise programme plans, for instance due to the introduction of

the Kenyan free maternal healthcare policy or due to a decision by the UK government to stop all direct funding to state institutions in Kenya. Others were due to late contract assignments to MSI and to lengthy institutional processes for awarding sub-contracts by UNICEF.

Implementation started with the nation-wide roll-out of the training programme in emergency obstetric care by LSTM, and with UNICEF support to the Ministry of Health at national level. Programming at county level, other than LSTM training, did not start until late 2014, for some components until 2016. These start-up delays are likely to delay the achievement of the programme goals by 2018

Training

The midterm evaluation documented many positive changes in community attitudes, the use of health services, and in obstetric outcomes in the programme counties. Because of the late start of the MNH Programme, however, these changes could not be directly attributed to programme activities. The most likely contribution was achieved by the LSTM training activities because of their early start-up. These, however, are implemented in 32 counties and their effect in the six programme counties can therefore not be distinguished from overall national trends.

Not surprisingly, the training component of the MNH Programme received the highest rating of appreciation by the managers and senior staff at county and facility level. The main constraint they mentioned was the high mobility of staff. It is addressed by LSTM through the development of a pre-service training module to be introduced in the curricula of medical and nursing schools.

Care quality

The overall MNH Programme approach to improving the quality of maternity care by focusing on the health facilities that provide most of the deliveries is appropriate and efficient. However, it leaves out many smaller health centres that provide a major amount of ante-natal care. Quality ante-natal care is recognised as a key determinant in reducing the number of stillbirths. The evaluation therefore recommended to expand the programme scope by including these facilities at least in a training programme for ante-natal care.

Beyond the public sector

A further limitation of the MNH Programme has been its predominant focus on public sector health facilities. Depending on the county context, and especially in Nairobi, a large proportion of maternity care is provided by faith-based organisations and by the private sector. These providers are, until now, excluded from the national free

maternal healthcare policy. Until now, MNH Programme support to private and faith-based facilities has been timid. There is scope for greater involvement of these sectors in future programming.

Modes of delivery

Health system strengthening and community activities of the MNH Programme in Bungoma County are delivered by the Maternal and Newborn Initiative (MANI) under the contract to MSI. The mode of delivery differs significantly from that in counties under the UNICEF programme mandate. The two models of delivery face different challenges. The close contact of the MANI project with county authorities in Bungoma County has resulted in a cohesive operational programme with the ability to introduce interventions efficiently. This has led to a somewhat higher level of appreciation of the programme by local authorities than recorded in the UNICEF-supported counties. The project-type management of the programme by MANI, however, has its potential drawbacks in terms of generating sustained changes. Furthermore, the exclusion of infrastructure development and medicines supply from the mandate given to the project generated bottlenecks towards the achievement of objectives that were partially overcome by post-contract negotiations with DFID.

In the UNICEF-supported counties, health managers also expressed their appreciation of the programme. They are, however, dealing with many different sub-contracted partners as well as with projects funded from other sources. The MNH Programme is therefore less visible to them. Changes introduced by the county health management teams in the five UNICEF-supported counties may take longer and may be less successful than those managed by MANI in Bungoma, but they may have an advantage in terms of sustainability.

Challenge Fund

The third mode of MNH Programme delivery, the CICF will be formally evaluated in 2018. The midterm evaluation reviewed the portfolio of grants and met with some grant implementers. There are concerns that the challenge-funding approach tied up too many resources of the more than 500 applicants. A more targeted selection of interventions of known impact based on local identification of greatest need may have been a more efficient and effective way of spending MNH Programme funds. It would, of course, lack the 'innovation' dimension. Only the final evaluation will be able to assess whether this was a worthwhile trade-off.

Implications

The main needs for health systems strengthening identified by the midterm evaluation in all counties are the development, planning and mobilisation of human resources, the assurance of stable and adequate financing of maternity services, and the provision of appropriate infrastructure. The MNH Programme works in all these areas, however there is scope for improvement through greater consistency in identifying gaps and systematically working on their closure. For instance, assisting a county in developing a human resources for health plan is not sufficient if there is insufficient capacity to implement the plan.

Finally, the midterm evaluation found that the evaluation methodology of documenting changes at county and sub-county level was not appropriate for the programme in Nairobi. Hospitals and health centres are in close proximity, and clients do not seek care within the geographic and political boundaries of their communities. For further evaluation activities, a different approach for Nairobi will be proposed and negotiated.

This brief is a summary of the formative evaluation report of the programme for the reduction of maternal and neonatal mortality in Kenya, produced by heri in July 2017.

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