



Inside

4 Community Intervention Key to Improved Service Delivery

New UNFPA Country Rep Tours Western Province

5 KSPA 2004 Kicks Off

6 Africa Re-affirms commitment to implementing the MDGs and ICPD POA

7 State of the World Population Report 2004

Kenpop Launched

8 KDHS (2003) Fact Sheet on Maternal Health

9-16 Center Spread Saving Women's Lives

17 The Net Culture in Kenya

18 Expanding Community Contraceptive Choice

19 Pioneering "Child to Child" initiative

20 District Briefs

23 CAFS Courses Strengthened KENWA

24 Beyond the Numbers: WHO Guide for Safe Delivery

Improving the Quality of our Population ICPD+ 10: Lessons Learnt



In 1994 the ICPD Conference pledged to work towards improving women's lives but much still need to be done to ensure the resolutions are achieved by 2015

By Prof. Peter Anyang' Nyong'o - Minister for planning

Ten years ago, 179 countries from the developing world converged in Cairo to discuss population and development issues.

They committed themselves to certain principles and actions that would see mothers give birth in safer conditions, babies brought up with better chances of survival and fathers adopting an equal attitude towards both the girl and boy child.

Ten years later, a meeting in China looked at what has been achieved in 10 years through the South- to-South collaboration, a spirit of Cairo. Was there anything to celebrate? Had any records been broken? And were there any inspirations to urge our actions in the future?

I have seen and heard, I have held candid discussions with the young university women looking after us about their families and facilities at the university; about taxes people pay and what they experience when they go to the clinic to be treated; and to the park to relax and walk about. Those who have ears let them hear; those who have eyes let them see; that is a verse I learnt from Sunday school and that now finds its meaning appropriately as we take stock of ICPD ten years on.

The chances that a woman, walking in the park alone in Nairobi today could be raped is much higher than it was 10 years ago; that is not development. The chance that a child born out of wedlock in South Africa will not live past

continued on page 3

The NCPD Becomes Semi Autonomous

The National Council for Population and Development has become a Semi Autonomous Government Agency (SAGA) and will now be called the National Coordinating Agency for Population and Development (NCAPD). The NCAPD will act as a secretariat and will be headed by a Chief Executive.

The Council will be headed by a Chairman with a 13 member council called the National Council for Population and Development. The Council members have been nominated to serve for a period of three years.

Director's Statement



Dr. Richard Muga
Director - NCPD

We are pleased to welcome you to the second issue of Kenpop News after the successful launch of the inaugural issue in April-June this year. The feedback has been encouraging and we are delighted to note that this is serving as a useful reference and information medium for stakeholders in population and development.

Population policy issues are driven by evidence based information drawn from both what government departments are doing and the work of stakeholders in various sectors and areas. Our challenge is to creatively gather, analyse and translate these findings into strategies that will alleviate poverty, bring essential services closer to the people and ultimately improve the general quality of life.

NCPD continues in its commitment to be supportive and work closely with all agencies and partners to ensure that the results of their work in population and development flows into mainstream policy frameworks and contributes to the objectives of providing needed information and quality services.

From the Editorial Suite

In this issue the challenge of keeping our women alive in order that they may have a healthy normal existence and contribute positively to national development has taken centre stage. Ten years after the ICPD in Cairo, we have made some progress but statistics from the recent KDHS 2003 and the global report card on the achievement of ICPD indicate that African countries have yet a long road ahead. Kenya continues to register high maternal morbidity and mortality and unmet needs for reproductive health services further compounded by poverty and poor economic growth. Contrary to the WHO guidelines, a great number of women are delivering at home and in the absence of a trained medical officer. This is because they can not get access to a health provider when they need to. Saving women's lives is a major priority and should be viewed as a package of accurate and available information on family planning, access to a comprehensive contraceptive method mix and efficient access to a health provider. This is what confronts us today. Your feedback through the attached form and contributions are welcome.

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continued from page 1

Improving the Quality of our Population ICPD+10: Lessons Learnt

nine months because it will not have been immunized or the mother might have transmitted HIV in utero is also higher than it was 10 years ago. That does not show much improvement following the end of apartheid.

I say all these because as we reflect on ICPD + 10 and what our partnership is all about, let us remember that we are partners in population and development, and that sometimes we seem to speak more about population and pay scant attention to development under the assumption that the subject development is too wide, too complex and perhaps too difficult to deal with. Development is complex with too many experts and many power structures to deal with. Population, on the other hand, is easier to grapple with when the IPPF is around, UNAIDS comes to our help, and a whole host of NGOs dealing with safe motherhood, HIV/AIDS and gender issues are always at our service.

The South-South partnership is very specific. Its mission is confined to expanding and improving South-South collaboration in the field of family planning and reproductive health, with each member country strengthening institutional capacity to undertake South - South exchange activities and rapidly expanding to a number of South - South training and consultative programs. It is this capacity building aspect of our partnership that makes development so key to achieving our population Millennium Development Goals (MDGs), and that now makes China – the most successful in our midst – an important example to emulate.

HIV/AIDS and STDs are both a challenge and an opportunity. They challenge us with behavioural changes but they also provide us with the opportunity to produce the technology for safe and more enjoyable sexual intercourse through the use of user-friendly contraceptives not known to humankind before. This requires the advancement of knowledge and use of science and technology to transform raw materials



Hon. Anyang' Nyong'o (front row 2nd left) and NCPD Officer Mr. Charles Oisebe (back row 2nd right) with their working group during the Partners meeting in Wuhan, China

into contraceptives. Once these contraceptives are produced, they must be marketed to reward the entrepreneur and to motivate him/her to undertake more advanced interventions.

Chinese researchers and industrialists have produced both male and female condoms that are affordable and user-friendly. But when I asked them whether they could produce these in Kenya, their response was that they have tried but they find the market too small to warrant the setting up of a whole industry. We in Kenya are only 33 million people; perhaps 10% of these may need condoms in any one-day at best. The Chinese are over one billion; if 10% use condoms in any one-day, that market is worth the investment.

What is the moral of this story? We need functional markets to undertake the kind of development that will provide access to the kind of technology and tools needed to improve the quality of our population at prices we can afford. In our case, developing the Common Market for Eastern and Southern African states (COMESA) is as important to economic development as it is to fulfilling our mission of expanding and improving South - South collaboration in the fields of family planning and reproductive health. Institutionalizing ICPD within the COMESA region is a mission that Kenya, Uganda and Sudan need to take seriously. We should, for example, collaborate in establishing

one condom factory serving the COMESA market and reduce the price we pay for imported condoms from the OECD countries.

There is need to include people from the indigenous private sector in our forums, and ensure that we have not dared to indoctrinate our governments against allowing the market to interfere with the health of our people. The next ICPD+20 or some interim encounter in between should pay attention to this urgent matter.

Our partnership should not simply be one between government and NGOs, where NGOs often assume they carry the responsibility of the civil society, or that they are civil society in its entirety. The partnership must be one of government, NGOs, the private sector, professionals, popular movements and interest groups. The partnership is deliberately expanded so that it captures this elusive animal called civil society.

“Those Who Have Ears Let Them hear; Those Who Have Eyes Let Them See”

At future encounters within our dynamic partnership, these other partners will be brought on board as we discuss the relevant development initiatives that will improve our population and reproductive health initiatives.

Excerpts from a speech by Prof Anyang' Nyong'o at a conference for South – South Partners in Wuhan China

Community Intervention Key to Improved Service Delivery

By Wilson N. Liambila



Photo: Kenya Community Development Foundation

Involving women in community health activities significantly helps improve maternal health services in the rural areas

A recent study, conducted jointly by the Population Council, Nairobi University, and the Ministry of Health in Western Kenya, indicated that community preparedness is a vital factor in strengthening service delivery interventions.

Increasing the proportion of babies delivered under the supervision of health professionals significantly reduces maternal and infant health risks during delivery. The Kenya Demographic and Health Survey (KDHS) 2003 revealed that skilled health workers attend to only 29% of the births in Western province, and, in the five years preceding the survey, 70% of women delivered at home. The KDHS also noted that mothers who attended antenatal clinics (ANC) during pregnancy were less likely to deliver at home.

Many obstacles prevent women from delivering in health facilities. These include inadequate finances, equipment and supplies; low public confidence in health facilities; and proximity to health facilities.

The study piloted a number of projects in Kakamega, Vihiga, Bungoma and

Lugari districts through women groups and other government department such as social services, provincial administration and civil registration. There were several community level interventions that aimed at increasing the utilisation of maternal services by reducing the first and second delays: reducing the time in deciding to seek appropriate care and reducing the time in reaching appropriate health facilities. The community level interventions were introduced as part of the broader Safe Motherhood demonstration project activities.

Examples of interventions addressed were birth preparedness schemes; prepayment schemes for emergency referrals; domiciliary care; community based information, education and communication activities; and working with a number of rural health facility development committees to strengthen referral practices.

The outcome indicators included;

- ◆ Increase in the number of new cases of ANC (first visit) receiving various services;
- ◆ Increase in the proportion of women delivered by skilled health staff;

- ◆ Increase in the proportion of women attending postpartum care;
- ◆ Proportion of facilities with access to functioning telephone for emergencies;
- ◆ Proportion of health facilities with access to an ambulance for emergency referral;
- ◆ Increase in number of dispensaries conducting deliveries; and
- ◆ Proportion of women at household level able to recognize or mention danger signs in pregnancy.

Utilization data for maternal services showed a steady increase in the proportion of women who attended ANC, delivery, and postpartum care services between the baseline (year 2000) and endline period (2003). For example, the proportion of ANC attendees receiving presumptive treatment for malaria rose from 36% to 84%. The proportion of ANC clients attending ANC at least four times, as recommended by the WHO, increased from 55% to 58%. The number of women attending post-natal check-ups increased from 7% at baseline to 29% at endline. In addition, the proportion of dispensaries conducting deliveries increased from 14% to 45%, and the proportion of women at the household level who were able to recognise or mention danger signs in pregnancy, e.g., hypertension, fits, headache, and swelling, increased from 31% at baseline to 47% at the endline.

These trends confirm that community preparedness must run simultaneously with institutional preparedness so that the two levels can complement each other in strengthening service delivery interventions.

Findings from the Safe Motherhood Project in Western Kenya

Mr. Wilson N. Liambila is a Programme Officer with Population Council, wliambila@pcnairobi.org

News

New UNFPA

By David Kinyua

On July 12 2004, the new UNFPA country representative, Dr. Kemal Mustafa accompanied Dr. Richard Muga, the Director NCPD and a number of officers from the two organisations on a tour of population and reproductive health programmes in Western Kenya. The previous day, the team had attended the 2004 World Population Day celebrations at the Bukhungu Stadium in Kakamega district.

The tour provided an early opportunity for them to interact with programme managers and beneficiaries at the community level. The team paid courtesy calls to the Provincial Commissioner, Western Province, and to the District Commissioners Kakamega, Vihiga, Butere and Mumias districts, which provided a forum to review some of the pressing welfare needs in the province.

In his remarks, Dr. Mustafa stressed the need for integrated programming and incorporation of the private sector to support population and reproductive health projects. This approach can ensure sustainability of the programme in areas such as



Dr. Kemal Mustafa,
new UNFPA Country
Representative

Amukowa with community support. The team was impressed by the CBO's activities, which include a school for orphans, tailoring, and carpentry schools for the youth and provision of medical support and home based care for people living with HIV/AIDS.

So far, RUSH has reached 674 adults and 140 orphans. The CBO works with 50 widows in a basket weaving and knitting project and advocates for a return to school policy and provides social support to girls after pregnancy. Dr. Mustafa said that the CBO's efforts should serve as an example for self-help development. Dr. Njau of the UNFPA also praised the CBO's women empowerment programmes. She urged couples to visit VCT centres before marriage and to attend health centres during pregnancy.

Country Rep Tours

contraceptive availability.

The team visited the Reaching the Unreached through Self-Help (RUSH), a community based organisation (CBO) in Kakamega that was started by a local couple, Mr. and Mrs.

The team toured projects in Vihiga, Butere/Mumias districts. In Mumias, Dr. Mustafa viewed the Mumias Muslim Community Project (MUMCOP), which has benefited substantially from UNFPA funding. MUMCOP runs a centre that provides medical services and promotes girl child education through a girls' secondary school established in 2001. The CBO has also initiated income generation activities for the community. Dr. Mahmoud, who runs the centre, explained that the centre refers patients with serious complications to the Mumias District Hospital and St. Mary's Hospital. Other notable places toured include the Butere/Mumias District Hospital and Ensare Health Centre in Vihiga district.

Dr. Muga appreciated the problems highlighted by the Ensare community members but challenged them to work towards owning the project in order to ensure its sustainability. Dr. Mustafa praised the community's interest in the project and for being candid with their problems. However, he also challenged them to ensure its sustainability in view of reduced funding from the government and development partners.

Mr. David Kinyua is a Documentation Officer at NCPD

KSPA 2004 Kicks Off

By Dr. Paul Kizito

In an effort to ensure provision of high quality services to clients seeking reproductive health care, the Ministry of Planning and National Development (National Council for Population and Development) in collaboration with the Ministry of Health (Division of Reproductive Health) and Central Bureau of Statistics, is conducting the '2004 Kenya Service Provision Assessment Survey (KSPA). This is the second survey to be undertaken in Kenya, the first having been done in 1999.

The survey, whose main objective is collection of quality data on the functioning of health services related to maternal health, child health, family planning, STI's and

continued on page 23



Prof. Anyang' Nyong'o, Minister for Planning receives keys from USAID Deputy Director for KSPA fieldwork

Africa Re-affirms commitment to implementing the MDGs and ICPD POA

By Karugu Ngatia

On June 7-11 2004, representatives from 52 African Countries assembled in Dakar –Senegal to review the progress made ten years after adopting the International Conference on Population and Development (ICPD) Programme of Action.

Nations re-affirmed strong commitment to ensure full implementation of the ICPD Programme of Action and the Millennium Development Goals and adopted a Declaration as Africa's blueprint for further implementation in the next ten years. One of the key issues addressed in the declaration is maternal and infant mortality and morbidity.

Africa records the highest number of deaths due to pregnancy related complications worldwide (1000 deaths per 100,000 live births every year). Most of these deaths are preventable, which underscores the critical need to take strategic actions to save women's lives.

To address this issue, African nations declared that they would redouble their efforts to reduce maternal and infant mortality and morbidity through provision of basic and



ECA Ministerial Conference on ICPD at 10 held in Dakar Senegal 5-12 June 2004. Kenya was elected Vice President of the follow up committee on ICPD POA implementation

comprehensive reproductive health care services. This is in light of the many factors that contribute to the deaths such as unsafe abortions, lack of access to quality family planning services, essential obstetric care, and ending obstetric fistula. The impact of unsafe abortions and complications that arise was also targeted as a major issue of concern.

The way forward for Kenya is through the provision of comprehensive maternal health care services and ensuring that skilled personnel with the necessary drugs, equipment, supplies, and referral services attend to all births. The strategy should increase public demand for

services through education, stronger partnership with NGOs, the private sector, and development partners.

"As part of this process, the NCPD will continue to focus on issues of gender equity, reproductive health rights, and programme management as well as advocacy," says Dr. Richard Muga, the director of the NCPD. Information and reproductive health services should include adolescents and young women, who face high rates of maternal deaths and have the least access to quality services," Dr. Muga adds.

At the close of the conference, the African Ministers holding the portfolio of population and development welcomed with satisfaction the ten-year review of the ICPD Programme of Action. The review was contained in the report "ICPD- 10th Anniversary- Africa Region Review Report" and its findings on the progress made, the constraints encountered, and the way forward."

They reaffirmed the strong commitment of the African countries to the principle objectives and actions contained in the ICPD Programme of Action and recognized that the millennium development goals (MDGs) can not be achieved unless further action is taken to assure full implementation of the Programme of Action.

Key areas for further actions include: integration of population into development, poverty eradication, reproductive health and reproductive rights, HIV/AIDS, maternal and infant mortality and morbidity, gender equality, equity and empowerment of women, violence against women, adolescents and youth families, migration, refugees and displaced persons, and data for development planning.

They called on all countries to support mechanisms to build and sustain partnerships with NGOs since they play an important complementary role. Further, they urged all governments and other actors, including bilateral and multilateral donors, United Nations organisations, and international financial institutions to pursue efforts at all levels to intensify implementation of the Dakar-Ngor Declaration and the ICPD Programme of Action.

To ensure follow up of activities, a committee comprising representatives of five countries was set up with Senegal as Chair and Kenya as the Vice-Chair.

Mr. Karugu Ngatia is a Senior Assistant Director of Population, and Head of Programmes Division- NCPD

State of the World Population Report 2004

By David Kinyua

Countries are making good progress in carrying out a bold, global action plan that links poverty alleviation to women's rights and universal access to reproductive health. Governments have embraced the International Conference on Population and Development (ICPD) Programme of Action as an essential blueprint for realizing development goals. Ten years into the new era opened by the ICPD, the quality and reach of family planning programmes have improved safe motherhood and HIV prevention efforts are being scaled up. According to The State of World Population 2004 report from the United Nations Population Fund (UNFPA), inadequate resources, gender bias and gaps in serving the poor and adolescents are undermining further progress as challenges mount.

To promote safe motherhood and to stem the spread of HIV/AIDS, much more must be done towards ensuring reproductive health and rights, including those of the world's 1.3 billion adolescents.

Ten years after Cairo:

- More than 350 million couples still lack access to a full range of family planning services.
- Complications of pregnancy and childbirth remain a leading cause

of death and illness among women: 529,000 die each year, mostly from preventable causes.

- Five million new HIV infections occurred during 2003; women are nearly half of all infected adults, and nearly three fifths of those in sub-Saharan Africa.
- While fertility is falling in many regions, world population will increase from 6.4 billion today to 8.9 billion by 2050; the 50 poorest countries will triple in size, to 1.7 billion people.



The tenth anniversary of the ICPD is an opportunity for governments and the international community to renew their commitments and identify ways to overcome the remaining challenges.

These were the key highlights of the State of the World Population report launched in September 2004 in

Nairobi by the Minister for Planning and National Development, Hon. Prof. Anyang' Nyong'o'. The UNFPA Kenya Country Representative, Dr. Kemal Mustafa, delivered a message from the UNFPA executive director, Dr. Thoraya Ahmed Obaid, that underscored the key remaining obstacles to implementing the ICPD Programme of Action — inadequate resources and gaps in services to the poor and marginalized groups. Dr. Obaid said that half a million mothers still die during childbirth every year and there is a need for greater commitment to overcome these problems and realize the promise of Cairo.

"The state of the world population 2004 report from the UNFPA, the United Nations Population Fund, assesses progress and ongoing constraints in carrying out the Cairo plan. It examines the key issues the plan covers: population and poverty, people and the environment, migration and urbanization, gender equality, reproductive health and family planning, safe motherhood, HIV/AIDS prevention, adolescents' needs, and reproductive health in emergency situations."

The UNFPA hopes that it will serve as a valuable source of information on these issues.

Mr. David Kinyua is a Documentation Officer at NCPD



Kenpop Launched

Minister for Planning and National Development, Hon. Peter Anyang' Nyong'o launched the NCPD newsletter, Kenpop News, during the World Population Day 2004 held in Kakamega in July. The newsletter has been well received by partners working in the population and reproductive health field.

KDHS (2003) Fact Sheet on Maternal Health

Antenatal care	% of women who received antenatal care from a health professional (for the last live birth in the 5 years preceding the survey)	88
Tetanus toxoid	% of women who received at least 2 tetanus toxoid vaccinations during pregnancy (for the last live birth in the 5 years preceding the survey)	52
Anti malarial care	% of pregnant women who slept under an insecticide-treated mosquito net (the night before the survey)	4
	% of women who received intermittent preventive treatment with antimalarial medication (during antenatal care visits)	4
Delivery care	% of births in the 5 years preceding the survey attended by a health professional (for the last live birth in the 5 years preceding the survey)	42
Postnatal care	% of women who went for postnatal care within 2 days of delivery	10
Maternal mortality	Maternal Mortality ratio (per 100,000 live births)	414
Care seeking knowledge by mothers	% of mothers with a child aged 0 to 59 months who know a specific sign of illness that would indicate that the child should be taken to a health provider	99
Fertility	Total Fertility Rate (Number of children per woman)	4.9
	% of women age 15-19 who are now pregnant	23
	Median age at first intercourse for women age 20-49 (years)	17.8
	Median age at first marriage for women age 25-49 (years)	19.7
	% of Married women (age 15-49) wanting no more children	49
	Mean ideal number of children per woman	3.9
Family Planning	% of married women using any method	39
	% of women (married and not married) using any method	28
	% of married women using any modern method	32
	% using the contraceptive pill	8
	% using the IUD	2
	% using implants	2
	% using female sterilisation	4
	% using the male condom	1
Unmet Need for Family Planning	% Total	25
	% For spacing	14
	% For limiting	10
Female Genital Cutting	% Prevalence among women age 15-49	32
HIV/AIDS	% HIV prevalence among women	9
	% of women who used condom at first sex	12
	% of women age 15-49 who have been tested for the AIDS virus	13
	% of women age 15-49 who know a place to test for the AIDS virus	63
	% of women age 15-49 who correctly stated 2 ways of avoiding HIV infection (having sex with only one partner who has no other partners and using a condom everytime they have sex)	58
	% of women age 15-49 who correctly identified 2 misconceptions about HIV/AIDS (they say that AIDS can't be transmitted through mosquito bites and that a healthy looking person can have the AIDS virus)	56
	Negative attitudes towards those living with HIV (e.g. teacher should stop teaching)	39
PMTCT	% of women age 15-49 who believe that AIDS can be transmitted from mother to child during pregnancy, delivery and breastfeeding	48
	% of women who know AIDS can be transmitted through breastfeeding	72

Saving Women's Lives

Addressing the Issues

By Dr. Richard Muga

There are about 529,000 maternal deaths in the world every year. Forty five percent of these occur in sub-Saharan Africa. This translates into one death every minute. For each mother who dies, more than 20 others develop maternal related disabilities. As we view the magnitude of these statistics, it is time we found a way to address the problem as a matter of social responsibility.

Use of Antenatal Care services in Kenya

The uptake of ANC services is low. Although about nine in every 10 women attend an ANC clinic at least once during pregnancy, only 14% visit in the first trimester as recommended by the World Health Organisation (WHO). Moreover, only about six out of 10 women attend ANC services four or more times as also recommended by the WHO. This could be a major contributing factor to the high rate of maternal mortality.

Place of Women in the MDGs

Women are faced with many burdens including biological burdens related to long working hours, trekking long distances, as well as physical and psychological burdens brought about by balancing domestic chores with other maternal responsibilities. Achievement of the Millennium Development Goals (MDGs) therefore, is impossible without giving the woman a central role.

Strategies to Reduce Maternal Mortality

Mothers should have access to emergency obstetric care (EmOC) and a functioning referral system. This is based on evidence that the combination of quality EmOC services with referral support is the most effective way to reduce maternal deaths and disabilities.

Reducing several delays that increase the risk of maternal mortality is critical. Reducing the time in deciding to seek appropriate care, in reaching appropriate health facilities, and receiving appropriate care at the facility are three critical factors. There is need to better understand the cause of delays and explore possible strategies to address the problems. For example, can a nurse on call at a health facility pay for a taxi or some form of transport in case of an emergency and get compensation later?

We also must support women's and couples' expressed desires to avoid unwanted or unplanned pregnancies. How can we ensure that all women have access to contraceptive options? Have we explored all possible options? Statistics tell us that we still need to do more.



The Director of Medical Services, Dr. James Nyikal (left) and the Minister for Planning Hon. Anyang' Nyong'o. The Ministry of Health and the Ministry of Planning are working together to ensure women's health receive higher government priority

Abortions and Family Planning

Over 5 million abortions occur in Africa every year — 34,000 of which result in death. Effective family planning and post-abortion care can help lower maternal mortality by 25%. It is important to note that abortion is not a means of family planning. Family planning reduces fertility, hence diminishes the lifetime risk of maternal deaths. Equally important is the fact that it liberates and empowers women and reduces the demand for illegal abortions. The focus should be directed towards access to accurate information and services in sexual reproductive health with a comprehensive contraceptive method mix.

Maternal Health: Facilitating and Confounding Factors

Several factors place mothers at risk. The subordinate status of women in society, discriminatory traditional practices, poor environmental conditions including lack of clean water, poor nutritional status, and early marriage are some of the factors. A continuous cycle of pregnancy and excessive workloads also undermine women's health. The situation is made worse by lack of information, limited control of resources at home, harmful cultural practices and traditions, domineering male attitudes, insecurity, and inadequate health care.

Cost of Inaction

If the world does not address reproductive health issues, the MDG of reducing maternal mortality by half will not be achieved. On the contrary, projections show that there will be 2.5 million maternal deaths, 7.5

continued on page 16

Maternal health in Kenya

By George Kichamu

Kenya has a population of 32.8 million people (2004) with women of child bearing age (15-49) numbering slightly over 8 million. Like most countries in sub-Saharan Africa, Kenya's maternal mortality rate is high. According to the Kenya Demographic and Health Survey (KDHS) 2003, Kenya has a maternal mortality ratio of 414 deaths per 100,000 live births.

There are regional variations with some provinces such as North Eastern registering higher maternal mortality ratio than the national average. There is however an indication of decline in maternal deaths from 590 per 100 000 live births in 1998 to the current 414 per 100 000.

Antenatal care

Every year 1.5 million women get pregnant in Kenya, with 3000 to 6000 dying from pregnancy related conditions (one in every 20 women). The KDHS 2003 indicates that 88 per cent of these women attend antenatal care clinics at least once during pregnancy, but only 52 per cent make more than 4 visits, far below the recommended number of 12. This is a decline from 1998 when 60 per cent of women had 4 or more visits. In addition, only 11 per cent of women obtain antenatal care in the first trimester of pregnancy and less than half have received care before the sixth month of pregnancy.

Women's Education and ANC

Women's education is associated with antenatal care coverage. Women with higher education are more likely to have received care from a medical doctor than those with no education (24 per cent versus 15 per cent). The proportion of women who receive no antenatal care declines steadily as the education level increases.

Delivery Care

The KDHS showed that 59 per cent of Kenyan women deliver at home, with only 11 per cent of these cases being assisted by a trained traditional birth attendant (TBA's). Thus a majority of the women are at risk of delivery complications and this

leads to high maternal deaths. In addition only 10 per cent of women who deliver at home attend post natal care in the first two days after delivery.

Use of mosquito nets

With regard to anti-malarial indicators, KDHS data shows that only 4 per cent of pregnant women slept under an insecticide treated mosquito net the night before the survey and a similar percentage received intermittent preventive treatment with anti malarial medication during antenatal care visits.

HIV/AIDS

HIV/AIDS prevalence among women aged 15-49 is estimated at 8.7 per cent of those tested. But only 13 per cent of those interviewed had ever been tested according to KDHS 2003. In addition despite the high levels of knowledge of HIV/AIDS, only 12 per cent of women have used a condom at first sex.

Causes of Maternal Deaths

Most causes of maternal deaths are preventable and manageable if detected early. In most of these cases the main cause of death are haemorrhage, sepsis, hypertensive diseases in pregnancy, ruptured uteruses, unsafe abortions and obstructed labour. Other indirect causes include malaria, anaemia, tuberculosis and HIV/AIDS.

Why the poor maternal healthcare system in Kenya?

The KDHS revealed that 42% of women were attended by a health professional at their last live birth in the five years preceding the survey. Weak linkages that exist between communities and health facilities hamper health-seeking behaviour. Another major factor is the inadequate provision of the absolute minimum obstetric care.

According to the Kenya Service Provision Assessment Survey (KSPA) of 1999, the majority of Kenyan health facilities are not equipped for managing obstetric complications. Major problems exist in the availability of medicines, supplies, and equipment that compromise the ability to deliver adequate care. The KSPA noted that of the facilities surveyed, only two fifths of hospitals and less than one third of maternity's had all the



elements necessary to perform all the functions of the basic essential obstetric care (BEOC). It further noted that only about a quarter of hospitals surveyed and 15% of maternities were assessed as ready to provide comprehensive essential obstetric care (CEOC), low levels of provider competence and skills and the lack of supportive supervision are other inhibiting factors.

Poor Infrastructure

At the lower level of the health system, facilities that do not have the capacity to treat certain obstetric complications must be able to provide basic first aid and then transfer the women quickly to higher levels of care for definitive treatment. The KSPA noted that most Kenyan health facilities do not have the capacity to transfer women rapidly in the event of an obstetric emergency. Less than half of facilities surveyed, mainly in the private sector, had a vehicle and a driver available in case of an emergency. Nearly three quarters of surveyed facilities had access to a telephone or short wave radio at the facility while another quarter had access on an emergency basis.

The KSPA revealed that only 3 out of 5 health centres have electricity, one fifth of the health centres surveyed obtain their water from a source outside the health centre and about the same proportion do not have a year round source of water.

Low public health confidence in public health facilities and physical barriers such as long distances covered to reach the nearest health facility are other major contributing factors.

Reducing Maternal Mortality in Rural Areas

In Kenya and in most developing countries, the majority of the population live in rural areas. Health centres and dispensaries are the nearest and most frequently used sources of health care but access remains poor.

In urban areas, the average distance to a health facility is 4 km compared to 5 to 8 km in densely populated rural settings and 20 to 25 km in the semi arid areas. Due to this, unqualified health practitioners and TBAs play a significant role in healthcare delivery. The healthcare system is generally limited and medical institutions are mostly understaffed and inadequately equipped as illustrated below.

Urban vs. Rural Distribution of Health Personnel

Category	Urban %	Rural %
Key health personnel	54	46
Clinical Support Staff	68	32
Public promotive health	27	13
Administration and maintenance staff	61	44
Total	56	44

Source: Central Bureau of Statistics, 1995

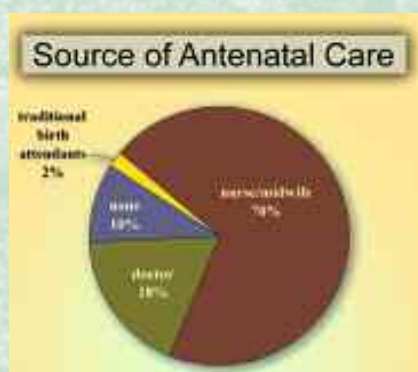


Source: KDHS 2003

enrolled community nurses and one clinical officer respectively. The health centres are equipped and staffed to manage cases not normally managed at primary level.

Major constraints

An acute staff shortage brought about by a freeze in employment and frequent transfers are some major factors that inhibit delivery of maternal health services. There are also few female midwives in some areas. Poor facility infrastructure, inadequate equipment and supplies and lack of ambulances and communication equipment undermine the provision of basic essential care and also inhibit the referral capacity of rural health centres.



Source: KDHS 2003

At the community level, reproductive health services are provided by community health workers, community based distributors and traditional birth attendants. At the rural dispensaries and health centres, which provide primary level reproductive health care, there are at least two

Training of the required number of midwives on BCOC is expensive hence the number of professional midwives is marginal. Huge investments in time and money are also required to ensure that all health centres have the required referral facilities in place.

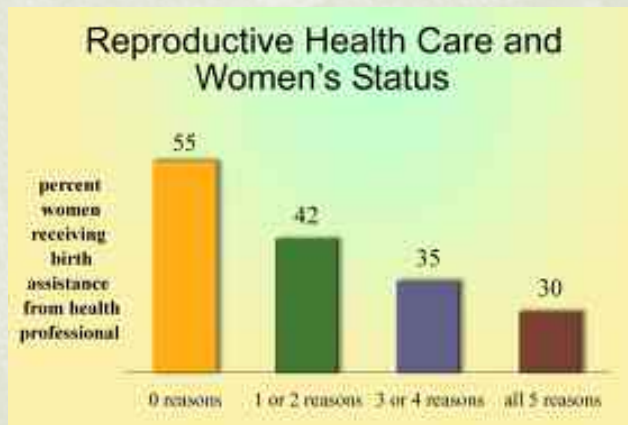
Crosscutting issues

Several issues come up as the cross cutting issues to the access of maternal health services.

- ♦ A poor referral system
- ♦ Inadequate equipment and supplies
- ♦ Low competency skills by service providers
- ♦ Inadequate community mobilization activities and approaches
- ♦ A weak health information system.

Strategies used to address maternal health

The Department of Reproductive Health (DRH) has used several methods to address maternal health issues. Advocating for safe motherhood, capacity building of health staff (on life saving skills post abortion care and focused ante natal care), improved



Source: KDHS 2003

service delivery (the government is trying to improve provision of supplies and equipment with support from various development partners) strengthening infrastructure such as power and water supply, monitoring and supervision by District Health Management Teams and community participation.

The safe motherhood model

The safe motherhood model has the following components:

- ◆ Pre Pregnancy services: Many women get pregnant when suffering from malaria, anaemia etc. all of which need to be addressed.
- ◆ Focused antenatal services
- ◆ Clean and safe delivery
- ◆ Targeted post-partum care
- ◆ Neonatal care
- ◆ Family planning
- ◆ Post abortion care: abortion accounts for one-third of all maternal deaths
- ◆ Prevention of mother to child transmission of HIV/AIDS

Safe motherhood has benefited from a sound family planning, the safe motherhood initiative, prevention of mother to child transmission guidelines, and management of malaria during pregnancy. In addition, there has been transfer of post-abortion care and Norplant delivery skills to nurses at health facilities. These activities have led to increased family planning utilisation and antenatal attendance.

Emphasis now is on enabling peripheral facilities such as dispensaries to offer maternity services, as well as on community participation to enhance maternity care.

For example, through facilitation of transportation of pregnant women through setting up of community financing schemes and rehabilitating old vehicles to act as ambulances for referral patients. Other strategies include the use of CORPS to conduct community sensitization, and health centre development through purchase of communication equipment to speed up the referral process.

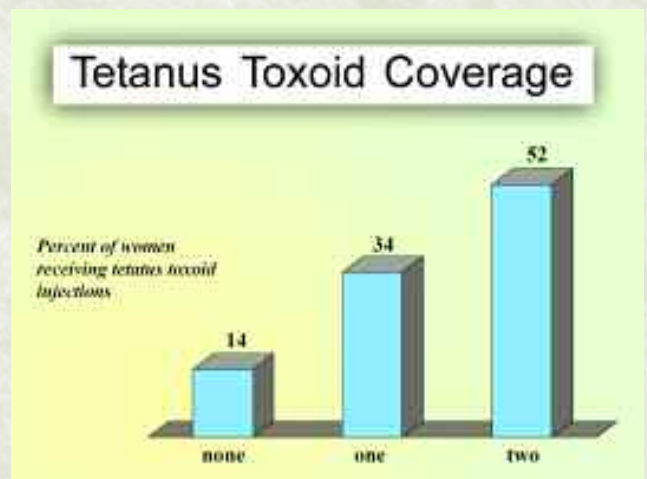
Policy and Programmatic implications

In the National Health Sector Strategic Plan (NHSSP), reproductive health has been identified as one of the priority packages the Ministry of Health will address. The KDHS and KSPA surveys are therefore important tools in the effort to address reproductive health gaps.

The KDHS has consistently recorded a fact that has been for many years; as a mother's educational level rises, so does the likelihood that she will seek professional healthcare during pregnancy and after childbirth. The government is striving to ensure all girls attain basic primary school education with the introduction of the free primary school education in 2002.



Source: KDHS 2003



Source: KDHS 2003

There is a need for secondary healthcare facilities to keep in contact and offer closer supervision to primary healthcare facilities. This can be achieved by offering regular maternal outreach services so that they can bolster the skills of the primary healthcare staff.



Source: KDHS 2003

Mr. George Kichamu is a Senior Assistant Director at the NCPD and Head of the IEC and Advocacy Division

Case study

Maternal Death: What went wrong?

By Dr. Pamela Godia

An assessment of the quality of hospital records in a district hospital in Kenya by a team from the Department of Reproductive Health revealed that a 16 year old girl died while receiving medical care at the hospital. At time of admission, the girl worked as a house-help and had gone to visit her mother at their rural home when she went into labour. The girl, Anna (not her real name), attended antenatal clinics but had not travelled with the card. Given her young age, and this being her first pregnancy the team were curious to know what happened at home and at the facilities she visited before she died.

Anna's mother told them that on Saturday morning at around 8.00am, her daughter started having lower abdominal pains. Her mother took her to a nearby (almost a kilometre away) private nursing home right away. At the nursing home, they found that the midwife in charge was not in but the nurse aid who attended to them told them not to worry because Anna "would deliver very soon." However, the labour did not progress very well from that point on. At around midnight on the same day, the labour pains stopped and Anna did not have any other complaints, so they went home to sleep.

The next day, Sunday, at 10.00am, Anna's mother decided to take her daughter to a close by private hospital. They hired a vehicle to take them there at Ksh.500. The nursing home was an hours drive away. The doctor was called from his quarter and he examined the girl. He told them that the baby was big and so he would have to perform a caesarean section.

Before a caesarean section is done, the private hospital requires one to pay a deposit of Ksh.20,000, which Anna's mother did not have. She pleaded with the doctor to perform the operation but he told her "You do not look like people who have a farm or a cow to sell so as to raise Ksh.20,000," and hence refused to perform the operation.

They hung around the mission hospital for about an hour pondering their next move and decided to go to the district hospital. They travelled in the same vehicle and gave the owner another Ksh.500. on the way there,

- they met the midwife from the nursing home they had gone to on Saturday. She urged them to go with her to the nursing home to see whether she could deliver the girl.
- On examining Anna, the midwife told them that the baby was "stuck and she referred them to the district hospital.
- They arrived there at 2.30pm.

- They were directed to the maternity ward and Anna sat on the hospital benches while her mother and a friend processed her admission. A nurse at the ward told them that so that Anna could be admitted, they had to buy Jik (a disinfectant bleach) at Ksh.80, two to three pairs of gloves, cotton wool for around Ksh.70, sutures and needles. The nurse on duty told them that without those supplies "they could not touch the patient." After an hour, Anna's mother got the supplies and the girl was admitted into the labour ward. Anna's mother and her friend waited for another hour before her daughter was examined.

- On examination, a nurse told them that Anna would have to be operated on. Her mother was asked to wait outside, but she remembers that by 8.00pm, her daughter had not yet gone to the theatre. The next morning, on Monday, Anna's mother went to see her daughter at the hospital. She did not find her on her bed so she asked the patients on the adjacent beds who informed her that "patients who had gone to theatre the previous night had not yet come back." She saw a nurse who came and told her that her daughter was operated on, delivered a baby boy, but they both later on passed away.

Dr. Pamela Godia is a Programme Manager at the Division of Reproductive Health, Ministry of Health



The cost of a Comprehensive Safe Motherhood Programme

By Colette Obunga



The maternal user fee costing study shows that the government needs four times its current spending to meet current maternal health needs

The Kenyan government needs four times the normal budgetary allocation to ensure the achievement of the goals and objectives of the Kenya Safe Motherhood Programme (KSMP). These were the findings of a Safe Motherhood Unit Costing study undertaken recently by the Department of Reproductive Health (DRH) at the Ministry of Health (MOH) with technical assistance from the POLICY Project. The study is the first of its kind on the cost of safer motherhood services in Kenya and was conducted in six study districts: Embu, Kajiado, Kakamega, Machakos, Nakuru and Thika. All public hospitals, health centres and dispensaries were sampled.

The World Health Organisation (WHO) Mother Baby Package outlines an essential cluster of maternal and newborn health interventions. The goal of the Kenya Safe Motherhood Programme (KSMP) is to apply these to reduce maternal and neonatal morbidity and mortality. Estimates from the cost study show that the Government is currently spending Ksh. 42 million (US\$ 560,000) annually per district to provide new born and maternal care. This is equivalent to Ksh. 54.00 (approximately US\$ 0.71) per person. The per capita (per person) spending ranges from a low of Ksh. 43 in Thika district to a high of Ksh. 68.00 in Nakuru district.

However, the study found that to provide comprehensive maternal and neonatal care according to the KSMP standards, the government requires Ksh. 202 million (US\$ 2.7 million) per district annually or around Ksh. 227.00 (US\$ 3.00) per capita. This represents an increase in treatment cost of approximately Ksh. 160 million per district per annum. When multiplied by all the 72 districts in Kenya, the end sum is Ksh. 11.5 billion a year.

The study also established that the largest expenditure is on wages and salaries. It revealed that clinical staff time is the single largest input cost item and that average treatment costs rise as one moves up the health care system. Other cost factors considered in the study and analysis were: blood and blood products; consumable supplies (e.g. gloves, syringes and needles, disposable IV sets, etc); drugs; emergency transport (fuel cost); hospital bed and food; laboratory supplies; and personnel costs.

Further analysis of the findings reveals that for a comprehensive KSMP to be achieved, the highest average unit treatment costs by intervention at the dispensary level will be those relating to family planning, followed by treatment of syphilis, treatment of other STDs, and antenatal care, in that order.

- The rise in treatment costs per case for these interventions will be due to increases in the number of contacts per client/episode, which will in turn call for more staff time, drugs and/or supplies.
- For syphilis and other STI treatment, the infected women's partners will also be treated. Antenatal care, family planning and post-partum care will constitute the major total treatment cost components, owing to the large number of clients who require these interventions.

- At the health centre level, the most expensive interventions are presently for the treatment of haemorrhage followed by normal delivery care, antenatal care and severe anaemia, in that order.
- Under the KSMP, the treatment costs by intervention will be highest for the treatment of haemorrhage, sepsis, abortion complications and normal delivery, in that order.

- In the hospitals, the most costly intervention on a per capita basis is eclampsia a serious condition which occurs during pregnancy and is marked by high blood pressure, weight gain, protein in the urine and possibly seizures. The condition is costly due to the high demands it makes on staff time – a woman with eclampsia requires almost constant supervision by skilled personnel for the first two or three days. The next most expensive interventions at this level are Caesarian-section and hemorrhage, in that order.

- All in all, the study findings can be used by MOH policy makers, planners, and programme managers to utilize the Ministry's limited resources more efficiently by level of facility. The findings can also be used to plan and programme packages in Safe Motherhood and as a quick reference on the cost of safe motherhood services.

Findings from a cost study by DRH/MOH Kenya

Colette Obunga, is a Programme officer with POLICY Project.

More information on the study can be obtained from the POLICY Project Email: policy@policy.or.ke

Cervical Cancer Screening Methods

By *Dr. Josephine Kibaru*

According to WHO only 5% of women in developing countries have been screened for cervical cancer, compared to more than 40% in developed countries. As a result, the majority of women in Africa present the invasive disease at an advanced stage when treatment is more expensive and seldom effective. Although statistics are limited in Kenya, it has been reported that there are 10 to 15 new cases of cervical cancer in Nairobi each week. Data from hospital-based registries in Kenya indicate that cancer of the cervix accounted for 70-80% of all cancers of the genital tract and 8-20% of all cancer cases for the 10-year period 1981-1990.

Unlike other cancers, cervical cancer can be successfully prevented by the timely identification and treatment of women who have pre-cancerous cervical lesions. It is a slowly progressing condition that develops over 10-15 years, providing ample opportunity to offer effective treatment before invasive cancer takes hold. Screening women for cervical pre-cancer provides an opportunity to reduce the morbidity and mortality and is quite feasible due to the fact that the cervix is a surface organ, which is easily accessible for inspection.

The Ministry of Health, through the Division of Reproductive Health (DRH) is in the process of initiating a national Cervical Cancer Prevention Program. The DRH will be responsible for its implementation. This program will ultimately save the government money, as the number of women with cancer needing care in gynaecology wards and clinics reduces.

Prevention through screening

Based on the natural history of cervical cancer and its epidemiology, women aged 30 to 49 years should be screened for the disease. The service model to be used in Kenya is a screen-triage-and-treat approach for pre-cancerous lesions (sometimes referred to as "see, see, and treat"). This involves screening routinely at

the primary level health facilities and opportunistically at higher-level health facilities. A good screening test is one that is acceptable to women and providers, accurate, reproducible, safe, practical, affordable and available. To screen effectively in the Kenyan rural setting, an approach that will meet the stated characteristics is needed.

Visual inspection with acetic acid (VIA)

This is the procedure that was initially used in a pilot screening project in Western Kenya with support from PATH. VIA involves looking at the cervix with a good light after swabbing it with 3-5% acetic acid (table vinegar). VIA is a non-invasive procedure that can be performed by any health provider who has received adequate training. Results are available immediately, and all system elements necessary for the VIA procedure are readily available locally. A recent study of 55,000 women in Africa and India demonstrated sensitivity for VIA of 77% and a specificity of 85% for high-grade pre-cancerous lesions. Experience in Western Kenya has shown that VIA is a safe, affordable, accessible and clinically acceptable means of providing primary cervical cancer screening with the potential for immediate referral. Nurses and clinical officers are capable of making a screening assessment using acetic acid after adequate training. VIA can also be used as a preliminary step to help providers identify key cervical landmarks before using a test such as VILI to decide the screening result.

Visual Inspection with Lugol's Iodine (VILI)

VILI involves looking at the cervix with a bright light (torch or

lamp) after swabbing it with Lugol's Iodine solution. Abnormal areas (pre-cancerous lesions) do not contain glycogen stores and do not stain dark brown. These abnormal areas become obvious to the naked eye because they show up as bright yellow areas. During its use in Western Kenya, providers have found it easier to learn than VIA. According to the study in India and Africa the sensitivity of VILI (92%) is higher than that of VIA and specificity at 85% is similar; it is also more reproducible than VIA.

Cervical cytology (Pap smear)

The Pap smear has been used for many years and has become the standard test for cervical cancer screening. However, it requires highly trained staff, reagents, transportation and good patient follow up. In Kenya it is difficult for rural health facilities to collect Pap smear specimens, send them to laboratories for processing and return the results to the women in a reasonable time. In most cases, women do not come back to the health facility to collect the results. Private physicians and clinics may continue to offer this screening method, and referral hospitals may use it to aid diagnosis but it will not be part of the primary screening approach of the national cervical cancer prevention program.

Dr. Josephine Kibaru is head of the Division of Reproductive Health



A woman is screened at a hospital: Unlike other cancers, screening for cervical cancer aids timely prevention of the disease

Fistula: The World Works towards Ending a Devastating Maternal Disorder

By Dr. Precy Cabrera



Mrs. Agnes Pareiyio who runs a girl rescue NGO in Narok, demonstrates to rural Maasai women the dangers of female genital cutting. Female genital cutting is one of the leading causes of fistula

Obstetric fistula, a devastating maternal condition, is one of the most neglected issues in international reproductive health. A fistula is a hole that forms between a woman's bladder or rectum, leaving her constantly leaking urine or faeces. Most women with fistula conditions end up isolating themselves out of embarrassment or being ostracised by society.

Obstetric fistulae are usually the result of prolonged, obstructed labour. "Nearly all

women with obstetric fistulae are below 20 years of age," says Dr. Precy Cabrera, a programme officer at UNFPA Kenya, "some patients are as young as 13 years old." Young girls are more vulnerable to obstetric fistulae because of their physical immaturity with a less developed pelvis.

The Department of Reproductive Health (DRH) at the Ministry of Health has launched a campaign in April 2003 to end the fistula in Kenya. The DRH is implementing the project with technical assistance from the UNFPA, which launched a global campaign to end fistula in 2003.

A task force made up of the MOH, UNFPA Kenya, NGOs and fistula experts was formed to chart the way forward. The task force observed that

data on obstetric fistula are scanty and commissioned an assessment in four districts where the condition is suspected to be most prevalent: Mwingi District in Eastern Province, Kwale in Coast Province, Homa Bay in Nyanza Province, and West Pokot District in Rift Valley Province.

The needs assessment survey set out to establish the magnitude and the contextual factors related to obstructed fistula. It is estimated that around 3,000 cases of fistula occur in Kenya annually but less than 10% are treated each year," Dr. Cabrera adds.

The study, soon to be released, shows that harmful cultural practices, poverty and the rugged physical expansive terrain all play a large part in the high incidence of fistula in the districts. Early marriage and early sexual debut place girls at a high risk since they conceive when their bodies are not yet ready for the demands of pregnancy and childbearing. Preference for untrained traditional birth attendants to assist at birth is a recipe for prolonged labour, a major cause of obstetric fistula.

Dr. Precy Cabrera is a Programme Officer at the UNFPA

continued from page 9

Addressing the Issues

million child deaths, and 49 million maternal disabilities in Africa. On the other hand, the cost of Safe Motherhood Components in low income countries is only 90 dollars for prenatal and safe delivery care, 12 dollars for family planning, 11 dollars for sexually transmitted infections, 5 dollars for post abortion care, and one dollar for preventing postpartum haemorrhage. Our partners need to help us with availing these services.

To achieve our maternal health goals, we must focus our attention on the following issues: good leadership (not necessarily political, but rather from any organisation which can ensure our men change their attitudes towards women), ensuring the girl child goes to school, and having responsive

health care systems targeting women, children and youth. We need to enhance public- private partnerships because we must all admit that as much as the government strives to offer health care services to all, we need support from the private sector to reach our goals.

And as for partnerships, it is all-visible. Without longstanding international partnerships, Kenya's healthcare would be far behind, but we need to get the best out of our partners by highlighting the needs our mothers still have and by mobilizing the commitment and resources to ensure our mothers stay healthy)

Dr. Richard Muga is the Director, NCPD

News from Partners

The Net Culture in Kenya

By Bernard Muthaka

An intensive five-year effort by Population Service International (PSI) to create a mosquito net culture in Kenya is on track to put 40% of pregnant women and rural children under five and 60% of urban children under five — the groups most vulnerable to malaria — under insecticide-treated nets (ITN) by 2006. The 25% mark for women and rural children was passed in 2003.

Applying the Strategy in Kenya

By building on an existing social marketing platform in Kenya that has strong relationships with government, the commercial trade, local NGOs and marketing agencies, PSI was able to scale up its program and the commercial ITN trade rapidly through the introduction of a heavily-promoted social marketing brand into a fragmented, under-developed market.

Malaria Campaign Educates, Changes Behavior

PSI/Kenya implements innovative and entertaining communications



PSI branded kiosks are located throughout malaria endemic areas in Kenya



Women line up to receive insecticide treated nets that are distributed through Maternal Child Health clinic.

programs to educate people about malaria transmission and prevention. The KAP study showed significant increases during the PSI intervention period in the percentage of adults who have correct knowledge of malaria transmission and the effectiveness of ITNs. Awareness of ITNs as an effective malaria prevention strategy increased from 3% in 2001 to 44% in 2003.

Informational programs are held in antenatal clinics, community women's group meetings and marketplaces to reach rural women. PSI trains and employs nurses, health educators and direct marketing groups. In rural communities, PSI holds events such as the Supanet Festival, where people have a day-long opportunity to learn about malaria and the need for ITNs through a combination of drama, discussion and games.

Scaling up Rural Net Ownership

During the second half of the project (2004-2007), PSI is increasing its focus on the rural population. To that end, PSI/Kenya, continuing to

support the Ministry of Health, is targeting pregnant women and children under five with a highly-subsidized ITN (consumer price USD \$0.60) through public and private health facilities in malaria endemic areas and a slightly less subsidized net (USD \$1.25) through rural retail outlets. This initiative is rapidly expanding ownership and use of ITNs by vulnerable groups in rural areas.

In addition, PSI is introducing the long-lasting ITNs recently approved by the World Health Organization and targeting them to rural pregnant women and children under five. This ensures that all nets targeted at the most vulnerable are effectively treated for their lifespan.

PSI's Vision for Fighting Malaria

In the 26 African countries most affected by malaria, 350 million people live at high risk of malaria. PSI's vision is to market ITNs and PPT to maximize access to effective prevention and treatment, consistent with the RBM targets. PSI works with governments, the private sector and other NGOs to achieve the RBM goal of halving the burden of malaria by 2010.

Mr. Bernard Muthaka is a media liaison officer at PSI-Kenya, muthaka@psikenya.org

Expanding Community Contraceptive Choice



Mr. David Nalo, Permanent Secretary Ministry of Planning is welcomed by Dr. Richard Muga, Director NCPD to open the ICPD + 10 NGO Chapter review Meeting

Community based distribution of contraceptives has proved to be an important concept initiated by the Maendeleo ya Wanawake Organisation (MYWO) in sustaining maternal and child health and family planning.

The Maternal and Child Health Family Planning (MCH/FP) Programme uses community based distributors (CBDs) selected by community members to enhance reproductive health services through contraceptive provision, IEC activities, and to provide home based care for people living with HIV/AIDS. The CBDs must be respected individuals in their community, knowledgeable, and interested in community development. They must also be literate in the local vernacular, and completed primary school education. A two-week training programme on family planning and HIV/AIDS/STI's prepares them for their work as CBDs.

The CBDs activities include clinic talks, barazas, and home visits. Clients may receive services at their homes or visit the CBDs at appointed service centres. The CBD services are well accepted in the community because of their accessibility, availability, affordability, confidentiality, and quality. They provide clients with information on family planning, contraceptive methods advice on best possible alternatives, distribute oral

contraceptives, condoms, and foaming tablets, and refer the clients to the nearest health centre for medical examinations. They are trained to insert Intra uterine Contraceptive Devices (IUCD), and intradermal implants such as Norplant, and also administer injectables.

Currently, the programme operates in 10 districts (Muranga, Kakamega, Bungoma, Nandi, Siaya, S. Nyanza, Machakos, Kirinyaga, Embu and Kitui) and has recruited 1,238 CBDs, who are in turn supervised by 57 CBD supervisors. This is by far the largest CBD programme in Kenya in terms of national coverage and the number of CBD agents in the field.

To meet the challenge of reduced donor funding while making the services more accessible, MYWO introduced new initiatives, which included the

distribution of contraceptives through depot holders. The depot holders are sites where clients access services without having to see a community-based worker. They registered relatively high Contraceptive Prevalence Rates (CPR) in some of the districts meaning that most of the people were well informed on the available contraceptive options.

Today, the programme managers collaborate with private clinics to offer FP services and supply the clinics with contraceptives that are then distributed to clients at a small fee. At the end of every month, the programme co-ordinators collect records on the number of people served and pay a small percentage to the clinic. The programme also has sites in the community that distribute pills and condoms. The contraceptives are found at particular shops and market places where the CBDs have businesses that double as depots.

These sites are strategically placed and clients have access to services round the clock. In addition, the districts identified kiosks and bars where they place condoms and pay supervisory visits to monitor records. The depot holders are trained by CBDs on distribution and record keeping. The programme intends to phase out some CBDs in the future when the depot holders are well established.



Source: Maendeleo ya Wanawake

Pioneering "Child to Child" initiative



By **Debbie Gachuhi**

At the 14th International AIDS Conference in Barcelona, July 2002, the Kenya Girl Guides Association (KGGA) Peer Education Life Skills Programme on HIV and AIDS Prevention was honoured for 'its pioneering work with young people' by the FHI Institute for HIV and AIDS. The Association was praised especially 'for mobilizing community leaders to support HIV and AIDS programmes for young girls who are not yet sexually active.' The programme was cited as a global best practice.

The KGGA is an organisation that aptly tapped into its resources to deal with the HIV/AIDS pandemic. Having been active in Kenya for over 80 years, KGGA is one of the oldest youth associations in the country with a national membership of over 130,000 girls and young women, representing every race, ethnicity, culture, class, and religion in Kenya. Its Programme "provides opportunities for girls and young women to develop to their fullest potential as responsible citizens." Their continued success is due to the members' strong belief in the Association's mission and goal, as well as the members' commitment to improving the lives of Kenyans. The Girl Guides consist of a range of Brownies, Guides, Rangers, and Ranger Cadets, all between the ages of 6 and 25 years. Adult Guides in the KGGA serve as leaders and role models for their members.

Building upon existing capacity and prior experience of the

KGGA, in 1999, with support from the Family Health International (FHI) IMPACT Project, the KGGA implemented a Peer Education Life Skills Programme on HIV and AIDS Prevention. The programme aims to equip young girls and women with information and skills for developing positive and sustainable reproductive health behaviours in order to remain HIV and AIDS free.

The KGGA organised seminars countrywide where a training manual that was pre-tested in three provinces was developed. The seminars aimed to empower young girls to become aware of their sexual reproductive health rights, to prevent exploitation and high-risk behaviour by adopting a "child to child" approach, and to use guides to reach peers with information on sexual reproductive health education. Other materials developed through the same process include a handbook, talking points, and a badge system.

To date, a core group of more than 900 Girl Guide Leaders have been trained, and approximately 50,000 Girl Guides in over 900 schools have been trained in Life Skills for HIV and

AIDS prevention. In addition, close to 5000 Girl Guides have earned at least one HIV and AIDS badge. The programme is monitored and evaluated through regular visits to the schools and through quarterly reports from Guide Leaders and Girl Guides.

There is anecdotal evidence from the project to show that girls who have completed this process feel more confident in delaying their sexual debut. The project has also helped show that implementing a structured program at a stage when young people are forming their attitudes on sexuality provides a window of opportunity to positively influence their behaviour well into adulthood.

The project approach has been replicated in 28 sub-Saharan African Countries and the KGGA has also been approached by several organisations including the Kenyan Union of Teachers to assist them in developing a national HIV/AIDS curriculum. The KGGA is also seeking ways to involve boys through the scout movement.

Debbie Gachuhi is a consultant on Population and Health issues



The girl guides share reproductive health messages during key functions

District Briefs

Youth Sexual Reproductive Health in Western Province

By *Peter Nyakwara*

Several organizations are currently undertaking Youth Sexual Reproductive Health and Development activities in Western Province. Notable among them include Uzima Foundation, Family Planning Association of Kenya (FPAK), and REACHING THE UNREACHED through SELF-HELP (RUSH), among others.

With the formulation and adoption of the Adolescent Reproductive Health and Development Policy (ARH&D), more organizations are likely to initiate programmes targeting the young in line with the policy and emerging issues.

Unavailability of youth friendly VCT services, fear of knowledge of HIV status, and insistence on parental consent by counselors for those below 18 years of age are some of the factors that contribute to young people not accessing VCT services. The FPAK responded to this need and initiated the Community REACH project in 2003. The project conducts viewer listenership sessions once every month so as to offer the youth a podium to share and discuss sexual reproductive health issues. The sessions are very popular with the youth.

Uzima Foundation is a charitable trust that runs youth groups in five districts of Western Province: Busia, Vihiga, Butere-Mumias, and Bungoma. The organisation aims to empower young people and collaborates with various groups conducting reproductive health activities to achieve its goal. It currently works with 60 youth groups throughout the province. The trust also runs 20 youth groups in Nairobi and 40 in Nyanza province.

RUSH is a CBO that was initiated by a couple in Kakamega. The CBO runs a school for orphans, a tailoring school and a carpentry school for the female and male youth. RUSH runs a programme that encourages girls who have dropped out of school due to pregnancy to resume with their studies after delivery. The CBO also supports income generation activities, conducts home based care for PLWHA, and collaborates with the St. John Ambulance and the National Organisation of Peer Educators (NOPE) to run a Youth Parent Programme.



Mr. Peter Nyakwara is the District Population Officer Kakamega

Culturally Sensitive IEC Activities

By *Emmanuel Adienge*

A community-based programme in Migori district – the Rural Based AIDS Prevention Programme (RAPP) – is using unique IEC activities to communicate behaviour change messages.

RAPP conducts HIV/AIDS awareness and advocacy activities in schools, churches, and public meetings, and raises awareness through video shows. The films are on Luo traditions and HIV/AIDS and cover many health concerns. The CBO has a resource centre that offers IEC services and Video Cassettes. The Programme activities

are concentrated within four divisions of Migori District: Suba West, Suba East, Uriri and Nyatike. Requests for video shows are received from as far as Suba district and Kuria Districts.

RAPP came together with other CBOs to form the first Voluntary Counseling and Testing Centre in Migori district in November 2003. The CBOs contributed funds to renovate an old council building to host the services.

Mr. Emmanuel Adienge is the District Population Officer Migori

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The Head of IEC Division,
National Council for Population and Development,
P.O. Box 48994, Nairobi, Kenya

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HIV/AIDS, will also shed light on the declining health and demographic indicators as reported in the 2003 Kenya Demographic and Health Survey. In addition, the survey findings will evaluate the progress made towards achievement of the Millennium Development Goals, the Economic Recovery Strategy and the United Nations Development Assistance Framework (UNDAF). The information will be used to assess progress made with regard to policies set in the National Health Sector Strategic Plan (1995-2004) as well as to provide inputs for the proposed Sector Wide Health Strategic Plan (2005-2010).

KSPA is a national survey covering all the provinces in Kenya and for the very first time North Eastern Province will be covered. There are 18 teams collecting the data with each team comprising three nurses, one social scientist and a field coordinator. The 2004 KSPA is being funded by the government of Kenya, with support from USAID, DFID, UNICEF and ORC Macro International.

Dr. Paul Kizito is a Deputy Director at the NCPD and the head of Policy Division



Prof. Anyang' Nyong'o, Minister for Planning being briefed on data entry process for KSPA at NCPD

Poem By S.P. Seki

Of Scourge and Garrulous Chameleons

*The scourge snaking
and chameleons spewing
Snipers snap. while scorpion-tails
Reign: Like splashing spittle
Hollow pot-bellies munching and crashing.*

*The untiring mourners:
Myriad eyes. the moan of the wounded
Naked. stifled staunchly.
In every nook and cranny orating nonchalance
Corpses creeping for crisps.*

*The scourge and flashy clothes
Withering thighs frizzling
Armed scorpions frisking
Whilst the gentry gingerly
Pass on to oblivion
Clinging to their loot
Loosening hard buttocks to their graves
O cursed drunken debaucheries!*

Mr. S.P. Seki is a senior education officer at the Ministry of Education. The poem is drawn from an unpublished manuscript

CAFS Courses Strengthened KENWA

By Florence Kimata

"As an HIV positive woman leading a woman oriented support group for people living with HIV/AIDS (PLWHA), I have learnt and gained a lot from the Centre for African Family Studies (CAFS) courses. When the CAFS/ Glaxo Smithkline (GSK) initiative began, I was invited to participate in the first course on Advocacy and Fundraising for PLWHA groups. I attended several sessions but did not complete the entire course, due to other office commitments. At the time, KENWA was still in its infancy with a membership of 1500 women drawn mainly from Mathare and Korogocho slums in Nairobi. However, we also had members in rural Kiambu, Muranga, and Nakuru districts."

The advocacy course put in perspective the difference between advocacy and policy

change from the popular definition of lobbying. Advocacy is real only when aimed at changing policy and creating an enabling environment at national, regional and international levels. Currently, I am an international advocate for the Global Network for People living with HIV/AIDS (GNP+) representing Africa. I have visited the Japanese parliament, the US senate, and the UK parliament to advocate for an increase in their contribution to the Global fund for Malaria, TB and HIV/AIDS. My presentations were well received at these forums and I am glad to have attended the CAFS courses that strengthened my advocacy skills. I also attended a course on communication and public speaking training at CAFS, which has also played a major role in improving my public speaking skills.

In 2001, KENWA's representatives attended a proposal writing course at CAFS. Upon return to the office, my colleagues put these skills to full use and embarked on a proposal that was submitted to and funded by the Global Fund. This proposal was a single entry and not part of the Country Coordinating Team proposal. In 2002, only two proposals from Kenya were funded and ours was among them. We are grateful to have gained the skills to write such winning proposals and now the skills are being harnessed as my colleagues work in teams to develop more proposals and help others learn from our experience! "

Asunta Wagura is the Executive Director of Kenya Network of Women with AIDS (KENWA) is one of the CAFS most outstanding Alumna.

Florence Kimata works with CAFS

Beyond the Numbers: WHO Guide for Safe Delivery

In developing countries, one woman in 16 dies of pregnancy-related complications compared to one in 2800 in developed countries. Most of these deaths can be averted even where resources are limited, but in order to do so, program managers require the right kind of information upon which to base actions. Knowing the statistics on levels of maternal mortality is not enough—we need information that helps us identify what can be done to prevent such unnecessary deaths.

Beyond the numbers is a publication developed by the World Health Organisation (WHO) that presents ways of generating more useful information. The approaches described go beyond just counting deaths to developing an understanding of why they happened and how they can be averted. For example, are women dying because:

- ♦ they are unaware of the need for care, or unaware of the warning signs of problems in pregnancy?

or

- ♦ the services do not exist, or are inaccessible for other reasons,

such as distance, cost or sociocultural barriers?

or

- ♦ the care they receive is inadequate or actually harmful?

Experience in the use of these approaches from around the world has shown that successful implementation can take place at all levels—from an individual health care facility up to the national level. A fundamental principle of these approaches is the importance of a confidential, usually anonymous and non-threatening environment in which to solicit information about factors leading to adverse maternal outcomes. Ensuring confidentiality ensures openness in reporting which provides a more complete picture of the precise sequence of events. Participants, including health providers, community workers, and family members should be assured that the sole purpose is to learn from past tragedies and save lives in the future—not to apportion blame. These reviews seek only to identify failures in the health care system. They must never be used to provide the basis for litigation, management sanctions, or blame.

These approaches can also be used to review a range of health care aspects,

including structures, outcomes, or processes. In *Beyond the numbers*, WHO describes reviews of two specific health outcomes—maternal deaths and life-threatening complications or near misses—and one kind of process intervention (clinical care). Reviews can be conducted at the community, health care facility, district, or national level.

Who is this guide for?

Beyond the numbers is directed at health professionals, health care planners and managers working in the area of maternal and newborn health who are striving to improve the quality of care. Those who could most benefit should be in a relevant position and be willing to take remedial action based on the findings. The approach can be applied through empowering health professionals to critically evaluate current practices and to change them, if necessary. Because action is the ultimate goal of these reviews, it is important that those with the ability to implement the recommended changes actively participate in the process.

The guide can be downloaded from the WHO website, www.who.int, and can also be got from the WHO Kenya country office

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