BORESHA

THE GSK AND SAVE THE CHILDREN MATERNAL AND NEWBORN HEALTH SIGNATURE PROGRAMME IN KENYA

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HELPING TO SAVE ONE MILLION CHILDREN'S LIVES

ACKNOWLEDGEMENTS

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For more information on the GSK and Save the Children Signature Programme in Kenya, including Phase 1 Final Report and Phase 2 Endline Survey Report, please contact:

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Save the Children exists to help every child reach their full potential. In the UK and around the world, we make sure children stay safe, healthy and keep learning, so they can become who they want to be.

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EXECUTIVE SUMMARY

Every year, 64,500 children in Kenya die before reaching the age of five, mostly of preventable causes,[0] and almost half of these deaths occur in the newborn period (the first 28 days of life). In Phase 1 (2014-2017), the GSK and Save the Children Partnership Programme in Kenya tested high impact and innovative public health interventions at the community level to increase demand for maternal and neonatal health (MNH) services, and at the health facility level to improve service availability and quality of care. Through sustained engagement with key decision makers, Save the Children built the case for responsible, increased public spending on health.

The second phase of the programme (2018-2021) sought to embed the sustainability of key interventions tested in Phase 1 in Bungoma and Busia counties, take these activities to scale across Kenya and strengthen the focus on identifying key innovations to help prevent maternal and newborn mortality.

Working on the basis of the Government of Kenya's (GoK) Community Health Strategy, the project successfully maintained and embedded the functionalities of community health units (CHUs). Community health volunteer (CHVs) motivation and retention was fostered, not least through the community health unit savings and loans associations (CHUSLA) initiative, which proved hugely effective in addressing the lack of government investment in community health systems.

Strengthened community referrals mechanisms saw a marked increase in the uptake of antenatal care (ANC) visits and facility-based deliveries. Health facilities and health care workers were supported through a number of measures including supportive supervision and maternal and perinatal death surveillance and response (MPDSR). The programme successfully introduced 7.1% Chlorhexidine digluconate (CHX) for cord care. The product is now included in the Kenya Essential Medicines List and counties catalogue, and all of Kenya's 47 counties are reporting on the CHX indicators in the Kenya Health Information System (KHIS). Similarly, the kangaroo mother care (KMC) method was successfully established in 18 scale-up counties (including Bungoma and Busia) where 85 health facilities are now providing KMC services to preterm and low birthweight babies and their mothers.

To support the sustainability and embedding of initiatives, the programme saw engagement at all government levels, and significant financial and technical support in the areas of budgetary allocations, policy reforms and systems strengthening. As a result of increased focus on community data, there has been a notable improvement in reporting, management of data and increased service utilisation, as well as a marked improvement in the use of data for decision making by health managers in the two programme counties. Engagement of civil society actors and consistent advocacy efforts contributed to an increase in budget allocation and health care spending during the project's lifespan, as well as a significant increase in allocation of health care workers at primary health facilities.

[0] https://www.unicef.org/kenya/health

Geofrey Tanui, the programme's coordinator for community health service delivery, with Bumula sub-county administrators

INTRODUCTION

Maternal and newborn health in Kenya

Under-five mortality in Kenya has fallen from 102 deaths per 1,000 live births in 1990, to 43 deaths per 1,000 live births in 2019. However, every year, 64,500 children still die before reaching the age of five, mostly of preventable causes[1], and almost half of these deaths occur in the newborn period (the first 28 days of life). The neonatal mortality rate in Kenya is 22/1,000 live births, with leading causes including asphyxia, complications of prematurity and sepsis[2]. The maternal mortality rate is 362/100,000 live births,[3] with leading causes being postpartum haemorrhage, hypertensive disorders and sepsis.[4]

Kenya's density of skilled health care workers (doctors, nurses, midwives) is 13.2/1,000 population, which is far below WHO's minimum recommendation of 23/1,000. This shortage is even worse in rural and marginalised areas due to the poor distribution of health workers. Most health workers are concentrated in urban areas, even though nearly 75 per cent of the Kenyan population live in rural areas.

Progress towards reducing maternal and newborn mortalities has been slow, mainly due to: limited availability of skilled health care workers and skilled attendants during pregnancy and delivery; poor geographical and financial accessibility; and low uptake of health care services before, during and after delivery – all leading to a high rate of home deliveries. The lack of reliable access to emergency obstetric and newborn care furthermore contributes to the mortality rate.

Boresha, The GSK and Save The Children Maternal and Newborn Health Signature Programme in Kenya

The first phase (2014-2017) of the GSK and Save the Children partnership aimed to contribute to an accelerated reduction in maternal and newborn mortality in Bungoma County[5] in western Kenya, to be achieved through three main outcomes:

- Increase access to and use of quality integrated maternal and newborn health (MNH) services at community level.
- Increase human, institutional and facility capacity to provide quality MNH services at facility and community levels.
- Advocate for an increase in human and financial resources for health, including efficient management of allocated budget for MNH services.

The project tested high impact and innovative public health interventions at the community level to increase demand for MNH services and at the health facility level to improve service availability and quality of care. The demand creation strategy included women's groups, men's *barazas* (meetings), reorientation of traditional birth attendants (TBAs) to professional birth companions, increased awareness of the National Health Insurance Fund, and implementation of village savings and loans associations (VSLAs) to address community health volunteers (CHVs) motivation and attrition rates.

To increase human and institutional capacity and improve service delivery, health care workers were supported through training, clinical mentorship and supportive supervision, and the project introduced chlorhexidine gel (CHX) for the prevention of newborn umbilical cord infection and kangaroo mother care (KMC) – a life saving intervention for preterm and low birthweight babies. Institutional capacity was strengthened through infrastructural improvements in maternity units including renovations, solar installations, and procurement of medical equipment for management of labour and associated maternal and newborn complications.

[1] https://www.unicef.org/kenya/health
[2] KDHS 2014
[3] Trends in maternal mortality 2000 to 2017: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. Geneva: World Health Organization; 2019
[4] KDHS 2014
[5] And in Busia County through DFID funding

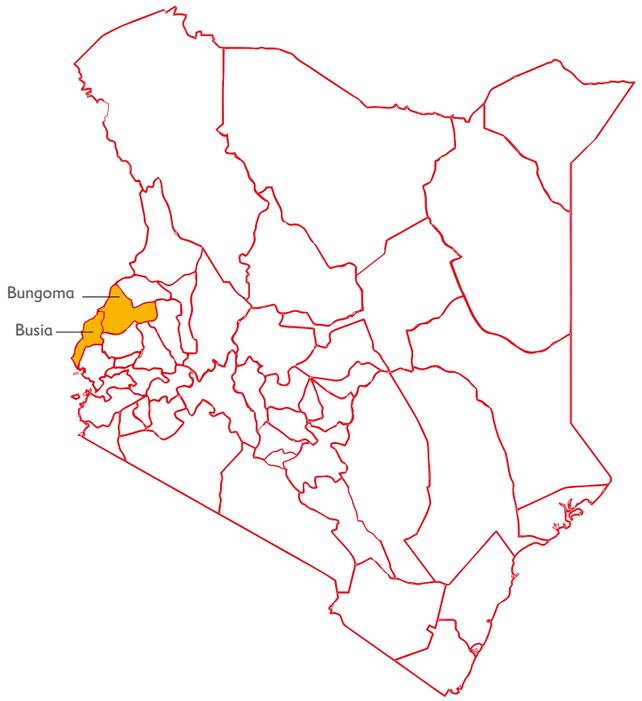
The project sustained engagement with key decision makers, building the case for responsible, increased public spending on health, not least by supporting the preparation of the 2018-2022 County Integrated Development Plan. Save the Children lobbied for the five-year plan to prioritise recruitment of health care workers, completion and equipping of primary health facilities, adequate budget allocation toward essential commodities and access to health services through the provision of medical insurance for all households in need.

Phase 1 of this programme saw some impressive results,[6] including increased number of deliveries assisted by a skilled birth attendant, successful KMC and CHX pilots leading to scale-up across other counties and increased investment in health from the county budget. This laid the foundations for Save the Children to meaningfully participate in law and policy reform engagements at both the national and county levels to ensure that the government embrace programme interventions, thus embedding them in the health system across Kenya and reinforcing sustainability.

The second phase of the programme (2018-2021) sought to embed the sustainability of key interventions tested in Phase 1 in Bungoma and Busia counties, take these activities to scale across Kenya and strengthen the focus on identifying key innovations to help prevent maternal and newborn mortality. This meant a shift away from direct implementation towards the provision of technical assistance to the Ministry of Health (MoH) and partners, and advocacy for the national adoption of ready-to-scale initiatives.

The COVID-19 pandemic affected implementation for almost half of phase 2. Lockdowns and restrictions meant adapting programming and activities, and significant resources were allocated to the COVID-19 response, including training of health care workers and dissemination of preventative behaviour messaging.

This report outlines a number of successes and lessons from phase 2 of The GSK and Save The Children Maternal and Newborn Health Signature Programme in Kenya. [7]



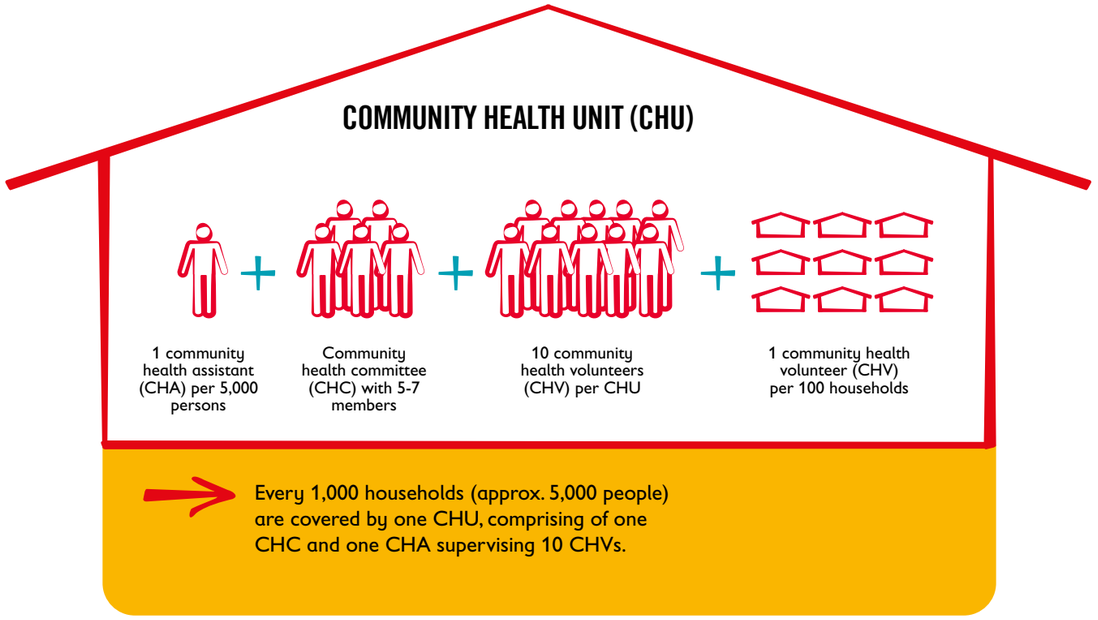
[6] See The GSK and Save The Children Maternal and Newborn Health Signature Programme in Kenya
[7] The full endline evaluation report is available upon request

COMMUNITY INTERVENTIONS

Strengthening community health systems is a vital element in bringing critical health care services to mothers and newborns, in particular in hard-to-reach areas. The community health system model implemented by the programme in Phase 1 saw great achievements in increasing the demand for and access to MNH services. Building on these achievements and working on the basis of the Government of Kenya's (GoK) Community Health Strategy, Phase 2 of the project established and/or conducted basic community health training of:

- 184 community health units (CHUs)
- 145 community health assistants (CHAs)
- 1,289 community health committee (CHC) members
- 1,875 community health volunteers (CHVs)

Community health units



The CHCs play an important governance and leadership role in advocating for resources for the improved health of their communities, whereas CHVs educate on antenatal care (ANC), skilled birth attendance, exclusive breastfeeding, male involvement and other key MNH indicators. The CHAs are employed by the sub-county government, and are tasked with supporting and supervising CHCs and CHVs.

Phase 2 of the project aimed to maintain and embed the functionalities of CHUs through the following key activities:

- Advocacy for community health legislation at the county to ring fence funds for community health services.
- Advocating for the County Department of Health to budget for monthly stipends for CHVs.
- Supporting the MoH in developing standard operating procedures and conducting quarterly dialogue days with CHUs to build the capacity of community members to prioritise their health issues. From these key issues, CHVs and community members developed action plans to strengthen access to health facility services.
- Providing technical support to the sub-county community strategy focal persons to conduct targeted small group conversations, and CHU-conducted community meetings to discuss sustainability of community health services.
- Supporting the MoH to improve the quality of CHV work through supportive supervision and data quality assurance to improve the mapping of pregnant women and increase defaulter tracing and referral, thus increasing utilisation of ANC and skilled birth attendance.
- Conducting CHU functionality assessments and spot checks of CHCs aimed at strengthening community linkages, CHV performance and CHU sustainability.

Headline results

By end of project:

- Qualitative discussions with CHU members revealed that the training received had equipped the CHVs and CHCs with the knowledge and confidence to train their communities on health issues, advise pregnant mothers to attend ANC clinics, help mothers to prepare birthing plans, promote and encourage mothers to deliver in hospitals, and address other health related issues such as water and sanitation.
- Ninety-three per cent of the 185 CHUs are fully functioning (up from 63 per cent at end of Phase 1), and seven per cent are partly functioning.
- Of the 1,875 CHVs, 78 per cent have been retained, and all of the remaining 22 per cent, who have left since programme start, have been replaced by the counties.


IT TAKES A VILLAGE… Malinda village is a model for strong community health systems and referral mechanisms. L-R: Proud CHU Chairman Protus Wasike with CHV Fatuma Saidi, new mother Maureen Sifina, who used a *boda boda* (motorbike) ambulance to go to hospital for delivery, and professional birth companion Agnes Khaemba holding Maureen's three-week-old baby.

Tine Frank/Save the Children

CASE STUDY

"We're not going to backtrack…"

When you bring in the right knowledge to the right people in the right way, the potential to save the lives of mothers and their newborns is huge. In few places is this more evident than in Malinda village, Bumula sub-county. As Chairman of the Kabula B CHC, Protus Wasike, puts it: "This training Save the Children gave, at the end of the day, they're saving our community."

Protus has been one of the driving forces in his community since the programme started and has witnessed a lot of changes over the years. "All these skills that have been put into us, we're implementing them on the ground. Like professional birth companions and referrals for ANC and safe deliveries, because of that we are seeing a lower death rate for mothers and children and a better relationship between the communities and the health facilities." Speaking of activities that took place in Phase 1 of the programme, such as the men's *barazas,* Protus says the new behaviours are still there. "Before, a man from this community would never accompany his wife for delivery, but that has completely changed after the *barazas*. Even if the *barazas* no longer take place, the change in behaviour is still there."

Fatuma Saidi, one of the many women CHVs trained under the programme relishes the opportunity to help her fellow women. "Once we have shared our knowledge with the mothers, they pass it on to other community members, they're able to take care of each other. Sometimes, I realise that the women have already started their ANC visits before I even speak to them, just because of advice from their friends and neighbours. I like seeing that. Since we started this project, none of our mothers give birth at home anymore. The deaths we used to see before in young children, they are no longer there. I feel so thankful when I see these healthy children, growing well."

These stories are not just found in Malinda village. In Mount Elgon sub-county, at the other end of Bungoma county, Jackeline Masibai echoes the changes witnessed by Protus and Fatuma. As the sub-county reproductive health co-ordinator, Jackeline knows very well the impact the CHVs are having. "We are one of the sub-counties doing really well on our child health indicators," Jackeline explains. "For example, our child immunisation rate is around 90 per cent, and that is because of the knowledge the communities are getting through our CHVs. Save the Children helped us reach


CHV Fatuma Saida with her daughter

Tine Frank/Save the Children

Professional birth companion, Agnes Khaemba, with one of her clients, Milicent Wesonga and three-month-old Tiana. Tiana is Milicent's third child, and this was the first time she delivered in a hospital. "If I have more children, I will have them at the hospital. It's much better."

Tine Frank/Save the Children


Protus Wasike, Chairman of the Kabula B CHU

Tine Frank/Save the Children

communities and people in remote areas, they trained the CHVs on how to pass on this information. Before, people might have had the knowledge, but they were not able to pass on the information. Now they know what they're supposed to do."

Back in Malinda village, Protus is demonstrating what else an empowered CHU can achieve. "We never knew how to write proposals until Save the Children brought us these skills. Now we have bought land, built a small clinic, employed a nurse and constructed a water tank. All that we have achieved as a CHU, our members are even joining leadership boards in schools and health facilities because of this exposure." With the programme now coming to an end, how does Protus see the years ahead? "I am happy because of the life changes. I have a healthy family and the community keeps changing. I think we're able to sustain these changes because the skills and the technical knowledge is here."

Fatuma couldn't agree more. "The way I see it, since where we are now is so promising for everyone, we will not backtrack. We will keep advancing."

Community health unit savings and loans associations

During Phase 1, all 184 CHUs in Bungoma County received seed funding of 100,000 KES (US$875) (DFID-funded Busia County CHUs received 50,000 KES (US $438) to set up simple savings and loans facilities, known as community health unit savings and loans associations (CHUSLA), referred to as VSLAs in Phase 1 of the programme. Created with the aim of enabling CHUs to start income generating activities to sustain their members, the intervention served as a key incentive to keep CHVs motivated and engaged.

PREPARATORY PHASE
2 MONTHS

- Entry meetings with county health management team
- Community entry meetings
- Training of CHUSLA facilatators/mentors

INTENSIVE PHASE
2 MONTHS

- Training of community health units (CHU)
- Registration of CHUSLA/opening of bank account
- Provision of records and savings equipments
- Provision of seed fund
- Weekly mentorship visits by facilitator/mentor

DEVELOPMENT PHASE
6 MONTHS

- Monthly mentorship visits
- Additional training on personal financial management, income generating activities
- Refresher training on basic CHUSLA concepts
- Additional training on advocacy and partnership building

MATURITY PHASE
4 MONTHS

- Monthly mentorship visits
- End of cycle and share-out
- Reflection on progress and ammendments of by-laws
- Planning for new cycle

As a high impact Phase 1 intervention, a number of activities took place in Phase 2 to sustain the CHUSLAs beyond programme end:

- Working with the MoH to develop research questions and objectives for CHUSLA operation research, completion of the research, and provision of continued technical support for the implementation of CHUSLAs.
- Providing technical support using findings from the operation research to initiate the process of developing a CHUSLA toolkit as an innovative approach to community health sustainability.
- Lobbying for CHUSLAs to be included in the Community Health Department Unit annual work plans.
- Continuous strengthening of national MoH Division of Community Health Services engagement on plans to scale up the CHUSLA intervention, including field visits, sharing of best practices and research findings, and the development and dissemination of the CHUSLA toolkit.
- Training of master trainers to build CHUSLA capacity in their respective counties for scale up of the intervention.
- Policy brief with the national Division of Community Health Services to inform CHUSLA policy and direction for counties to roll out the CHUSLA intervention as a best practice for community health.

The CHUSLA sustainability mechanism introduced by the programme has proven hugely successful in addressing the lack of government investment in community health systems, demonstrating that the health system is capable of taking on the CHUSLAs as their implementation requires minimal resources and are relatively easy to sustain by the communities themselves. A study completed in Year 3 suggested that CHUSLA is a cost-effective approach to incentivising CHVs and has a positive impact on the sustainability of CHUs as well as CHV retention.

Funding community referrals systems beyond the project

In addition to positively impacting the CHV retention rate, the CHUSLA intervention also proved key in sustaining two community referral mechanism interventions from Phase 1 in a number of CHUs and health facilities: professional birth companions and *boda boda* (motorbike) ambulances. The project had successfully re-orientated 419 women from traditional birth attendants (commonly used for home deliveries) to professional birth companions for deliveries at health facilities and supported them with a financial incentive of 100 KES (US $0.88) per skilled birth attendance referral. Similarly, 42 CHUs identified local *boda boda* drivers as ambulances transporting women in labour to nearby health facilities. Despite intensive lobbying of the MoH to take over the financial incentives, and the recognition of these as a valuable part of the community referral system, not all health facilities have been able to put this into practice. Many CHUs, however, through their income from CHUSLA activities, were able to continue the funding of these mechanisms, thus ensuring a continued high uptake of facility-based ANC attendance and deliveries. A project survey conducted in early 2021 found that:

Thirty-four per cent of health facilities supported by the programme were reimbursing transport for professional birth companions using Linda Mama funding, and 14 per cent were still reimbursing CHVs.

Half of the identified 42 CHUs were sustaining the *boda boda* ambulance intervention either through CHUSLAs or their linked health facilities.

CHUSLA costs vs. CHV stipends Bungoma County

Paying all 3,200 CHVs in Bungoma County a monthly stipend of KES 2,000
= 76.8m KES/year (US$ 672,692)

One-off seed funds of 100,000 for all 320 CHUs in Bungoma County
= 32m KES (US$ 280,288)

Headline results

- At national level, the Division of Community Health Services included CHUSLA operation research activities in their annual work plans, participated in CHUSLA field visits, and supported development of a process monitoring tool that will be part of the tools for scale up of the intervention.
- By providing them with a steady income, CHUSLAs have proven to add confidence and dignity and promote the creation of social support among CHVs, which affects the quality of their work and results. This has been key in improving CHV motivation and retention rate.
- The project saw an increase in the number of health facilities and CHUs budgeting for reimbursements of professional birth companions and *boda boda* drivers.
- By project end, four new counties had shown interest in adopting the CHUSLA intervention and were at various stages of sourcing funding and allocating resources.
- Busia County included the CHUSLA intervention in their community health legislation to sustain community health platforms. This was a direct result of the project demonstrating and advocating for the initiative

CASE STUDY

Saving for a better life

One of the main barriers to the long-term sustainability of community health systems is the lack of funding. Often, donor funded projects result in a revitalising of CHUs, but resource restrained counties can struggle to take on the costs after project end. This, in turn, often leads to CHUs gradually dissolving and CHVs ceasing their vital activities in the communities.

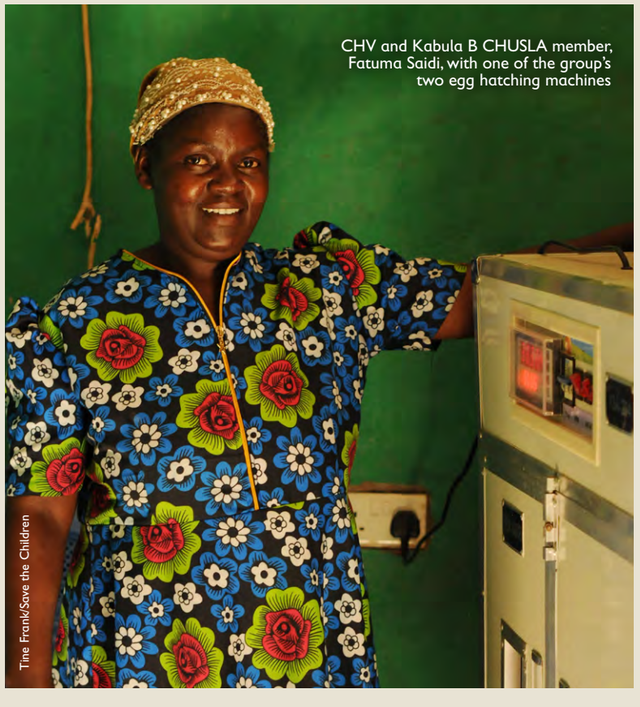
Save the Children's CHUSLA intervention aimed to address this barrier by setting up the CHUs to become financially self-sufficient and, at the same time, improve motivation and retention rates among CHU members and CHVs.

"Before Save the Children introduced the CHUSLA model to us, we didn't know about this type of savings and loans." The members of the Kaptama CHV CHUSLA group in Mount Elgon sub-county say they were sceptical at first, wondering what the catch was. "Already after the first cycle we saw how we could share the money among ourselves and earn interest on our savings. That made us very happy, and we committed to continue with the CHUSLA." That was five years ago and, today, despite Save the Children no longer supporting the group directly, the stories and examples of change shared by the members come in thick and fast. Most of the CHVs have bought cows and many have started businesses with small loans from the CHUSLA: one has a small shop, another does poultry farming, and one sells ballast from the local quarry.

In Bumula sub-county, Protus Wasike, the chairman of the Kabula B CHU, explains why he thinks the CHUSLA initiative has been so successful in his group. "When you engage yourself in something that you know is getting you an income, that way everyone is working towards that target, and everyone gets something in return." In addition to the individual CHVs setting up their own small projects, such as poultry rearing, the CHU has set up a number of income generating activities from group contributions and proposal for funding. They have invested in a tent and chairs, that they rent out for functions, and two egg hatching machines that provide the CHU with a steady income stream. "It all goes back to the training by Save the Children," Protus says. "Before, we never knew about these sort of activities. Now people are seeing how important the CHUSLA is, and how it helps them pay for their school fees."

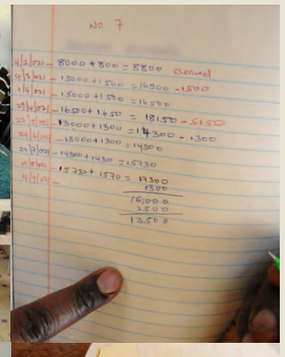
It is not just the group members who have realised the benefits of saving, according to Fatuma Saidi, a CHV and CHUSLA member. "Teaching about savings and how to invest is now part of the health education I do as a CHV. For example, if a mother is expecting, we teach them how to be better prepared by saving some money. That way, she can buy clothes for the baby and make sure she can reach the hospital to deliver there, and even have some money left for when the baby is born."

Though these may all sound like fairly small initiatives, they have proven to have a huge impact on the members' quality of life. The Kaptama CHV CHUSLA group members all agree that they are now able to provide their children with better food and education. "Not only are we better CHVs because of the training Save the Children gave us, but we are also able to improve our own children's lives."



CHV and Kabula B CHUSLA member, Fatuma Saidi, with one of the group's two egg hatching machines

Tine Frank/Save the Children



Kaptama CHV CHUSLA members at their weekly meeting

Kaptama CHV CHUSLA member in front of the shop she started with a loan from the group.

Tine Frank/Save the Children

Community-level lessons and recommendations

- Support and training of CHUs and individual members has had a direct and marked positive influence on motivation and retention rates of CHVs, and has led to strengthening of the community referral system.
- Leadership is key for successful implementation and sustaining of the CHUSLA intervention. CHUSLAs succeeded or failed depending on the strength of the CHU leadership (CHA, chairperson, record keeper and box holder). To improve chances of fully embedding and sustaining CHUSLAs, there is need to strengthen governance mechanisms and build CHUSLA leaders' capacity to adopt good governance and leadership roles. This includes capacity to establish and support conflict resolution committees, implement and enforce the CHUSLA constitution and methodology, such as introduction of loan guarantors, ensuring quality documentation, and lead reviews for constitution and annual elections.
- Inadequate finances coupled with short repayment terms negatively affected members' borrowing ability. The CHUSLA infrastructure should be used to secure funding from other sources, such as Youth Funds and Women Fund, and lobby for county budget allocation to increase fund base.
- Some CHUSLAs had wider effect into the community, building social safety nets and strengthening advocacy efforts to increase investment in health. Some CHUs used CHUSLAs to sustain women's groups, men's *barazas* and to promote birth planning as well as encouraging a saving culture in the community. Some CHUSLAs supported resource mobilisation to establish new health facilities, community water projects and expanding income generating activities into businesses.
- When there was inadequate support and influence from the CHAs to the CHUSLAs, it could lead to negative results or failure to operate in some CHUs. There is need to integrate community health supervision to include CHUSLA by the sub-county health management teams.
- Improved motivation, wellbeing, and feeling of dignity and economic empowerment has been recorded in successful CHUs and individual CHVs, leading to households taking control of their own health matters to a greater extent. Changes from traditional gender norms have been recorded, such as female CHVs making financial decisions and managing household finances, a role typically reserved for men.

"Since Save the Children started this programme, we have seen a change in attitude to premature babies, the communities now accept that they can grow up like other children. We have seen male involvement that was not there before, they support the mothers and bring family members for health care services. There has been a similar change in mothers-in-law, who tend to be quite conservative and have great influence on households' health seeking behaviours. Now, many of them are leaving behind old traditions and become birth companions to their daughters-in-law, ensuring that they deliver with the help of skilled birth attendants.

"The dialogue days that Save the Children introduced in Phase 1 have continued and are now part of routine service delivery funded by the sub-county. Many CHUs have set up CHUSLAs that will help the continued work of CHVs, so they can keep strengthening the response at community level. Even in the areas where the programme was not able to reach, we now have this CHUSLA framework and are tasking the county to allocate appropriate resources to keep the CHVs working. Because of the training the CHVs have received they are able to keep community groups active, even without much support."

Emmanuel Luvai,
Community Health Services Coordinator, Busia sub-county

FACILITY INTERVENTIONS

While the health facility needs revealed in the programme baseline survey were enormous, targeted and needs-based support to health facilities and systems, directly linked to facility functionality, has enabled the programme to positively impact the availability and provision of quality MNH services. Phase 2 activities focused on strengthening and embedding Phase 1 interventions, including training and continuous support of health care workers, provision of standard guidelines and job aids, improving supply chain management, strengthening health facility management committees, supporting maternal and perinatal death surveillance and responses (MPDSR), kangaroo mother care (KMC) for premature and low birthweight babies, and chlorhexidine (CHX) for umbilical cord care.

Antenatal care and skilled birth attendance

Antenatal care (ANC) is vital not only in managing pre-natal conditions, but it is also proven to increase the likelihood of facility-based deliveries resulting in improved health outcomes for mother and newborn as well as a higher uptake of immunisation services.

With the high number of CHVs still active beyond the direct support received in Phase 1, ongoing health education in the communities continues to support increased uptake of four ANC visits. The steady increase during the life of the programme is also reflected in the level of skilled birth attendance and the number of mothers receiving postpartum care within 48 hours.

Child immunisation and ANC day at Malaba Dispensary in Busia sub-county

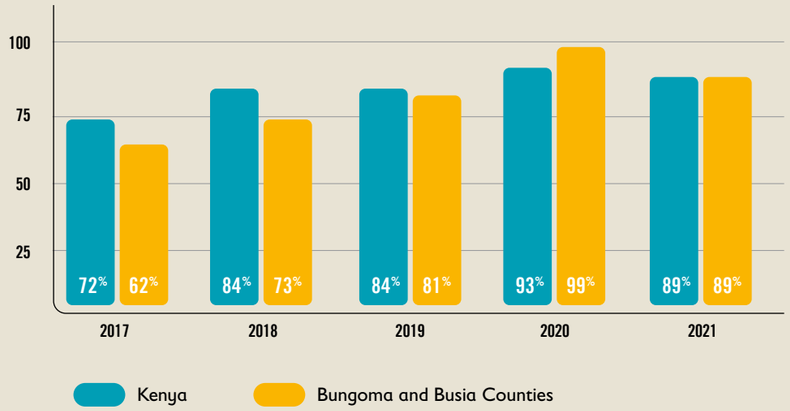
Tine Frank/Save the Children

Headline results

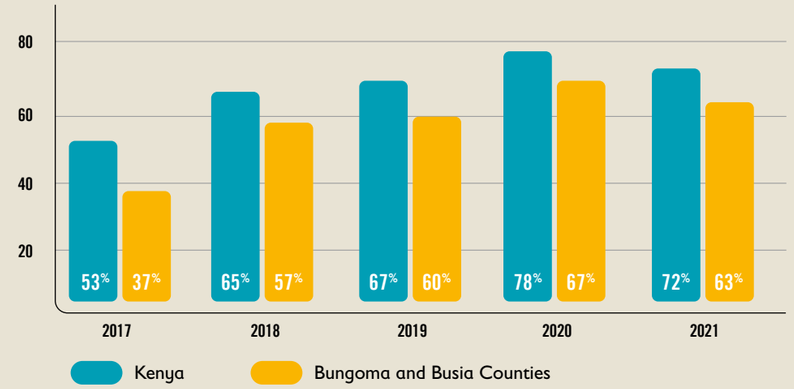
Through a combination of improved community referral mechanisms and support at facility level, a steady increase was recorded throughout Phase 2 of the programme:

- The share of pregnant women attending both their first, and their first and fourth ANC visits increased significantly by 27 and 17 percentage points respectively. It should be noted that, despite this achievement, nearly half (47%) of pregnant women still do not attend four ANCs, and further progress is needed.
- Similarly, the number of women delivering with the help of a skilled birth attendant increased by 26 percentage points, and women receiving postpartum care within 48 hours increased by 16 percentage points.
- This increase in facility level attendance before and during delivery also has a positive impact on other child health indicators, such as immunisation rates.

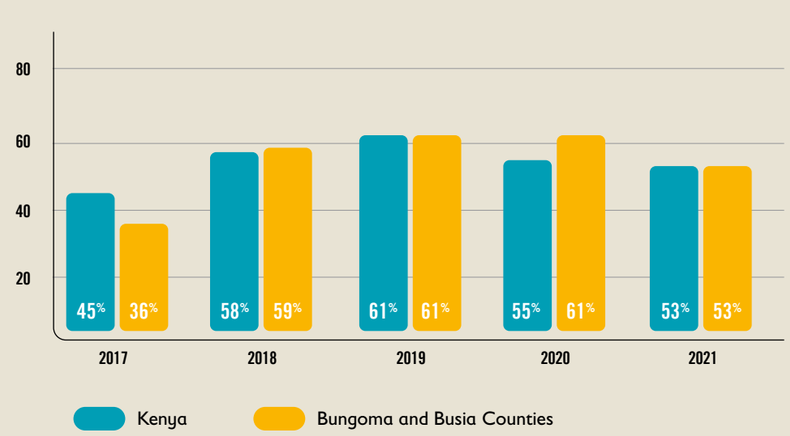
PERCENTAGE OF PREGNANT WOMEN ATTENDING 1ST ANC VISIT



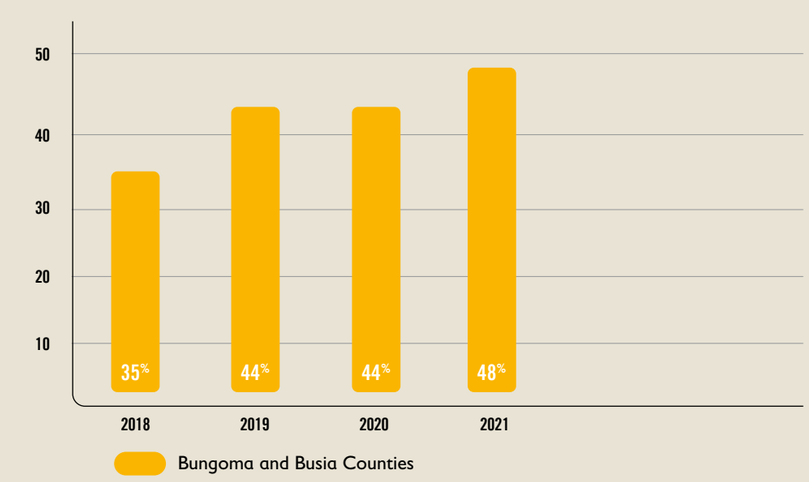
PERCENTAGE OF WOMEN DELIVERING WITH A SKILLED BIRTH ATTENDANT



PERCENTAGE OF PREGNANT WOMEN COMPLETING 4 ANC VISITS



PERCENTAGE OF MOTHERS RECEIVING POSTPARTUM CARE WITHIN 48 HOURS



The data for 2021 does not include the month of December. It should be noted that any data on health care seeking behaviour and provision of services in 2020 and 2021 would be affected by the health workers' strike and COVID-19 restrictions (Bungoma and Busia were classified as red zones for several months, which severely restricted movement).

CASE STUDY

Community linkage for improved service provision

One of the main contributing factors to Kenya's maternal and newborn mortality rates is the high number of women delivering at home, especially in rural and hard-to-reach areas. Behaviour change initiatives and strengthening referral mechanisms at community level have proven hugely successful in persuading mothers to deliver their babies at health facilities rather than at home. As such, this was a key part of the health education training provided by Save the Children to CHVs and communities as a whole.

Facility-based deliveries not only improve the health outcomes for mother and child, they also contribute to strengthening resource restrained clinics and hospitals. Through Linda Mama – a free health insurance targeted at Kenyan women, particularly in rural areas, that covers the pregnancy and first three months of the baby's life – the health facility receives 2,500 KES (US$22) per successful delivery. Says Clara Bundotich, Public Health Nurse for Bumula sub-county. "With increased deliveries, we get more money from the government. Here at Bumula Sub-County Hospital we have been able to add three casual nurses to handle deliveries, on top of the five permanent ones." Clara explains that the professional birth companions established under the Save the Children programme are a very important feature of this 'business model'. "Even after the direct support from Save the Children ended, we have continued to support the professional birth companions with 100 KES (US$ 0.88) for every woman they bring to the hospital for delivery."

Reflecting on the time before the programme, Clara says: "Before Save the Children supported us, most mothers would deliver at home and the deliveries we had at facilities were quite low. We also had neonatal deaths because some mothers may be delivering pre-terms, or the mothers would end up having complications and die at home. That was a bad picture that we had back then. Here, at the sub-county hospital, the deliveries were like 15-20 in a month. After several interventions with support from Save the Children, we're now having an average of 115 deliveries. And it's not just here. In Kabula for example, in their last report they had almost 80 deliveries and they had zero stillbirths or perinatal deaths. When we see those kinds of numbers, we know that we're managing that first stage very well."

Agnes Khaemba is a professional birth companion from Kabula who used to work as a traditional birth attendant, assisting mothers in home deliveries. "We had big problems before," Agnes explains. "It used to happen that mother or baby could die at home. So many times that happened, more than I can remember. Now, after the training and taking the mothers to hospital, I have not experienced a single death. I'm now enjoying this work because I see the success at the hospital, I'm not sitting in the house with all these complications." In Phase 1 of the programme, Agnes and her colleagues were supported with 200 KES (US$ 1.75) per delivery, but since 2018, she has continued her work for free, accompanying 4-5 mothers every month. "I just continued to assist my community; I can't just leave the mother, so I keep volunteering."

"Now that the programme is coming to an end, I feel we have made great strides in terms of performance in the health facilities."

According to Dr Mathias Lukorito from the Bungoma Office of the County Director of Health, these changes are happening throughout the county. "At the end of the day, we look at the impact of the support Save the Children and other partners have given us. The indicators have improved in terms of health seeking behaviour, especially at community level where we see that mothers are going to the facility for ANC. The ANC attendance has increased and that also impacts on skilled deliveries, because we encourage the ones who attend ANC to deliver at a facility, so that has increased as well." This is echoed by Emmanuel Luvai, Community Health Services Coordinator in Busia sub-county. "Before, our facility-based deliveries were as low as 23 per cent, and now it's up to almost 70 per cent. That is just a tremendous improvement."
When a programme ends, the concern is always whether the achievements and impact will remain. Jackeline Masibai, Reproductive Health Coordinator in Mount Elgon sub-county is confident that the changes she has been seeing will be long-lasting. "In 2017, when Save the Children stopped paying the professional birth attendants, we were worried they would stop referring the mothers. But they are still working and referring – not all of them, but at least half are still active. Because they have the knowledge. You know, when you don't have the knowledge, you just do what you can do, but now the knowledge is here."where we are now is so promising for everyone, we will not backtrack. We will keep advancing."

Monika Makokha started to assist mothers in home deliveries in 1989. After Save the Children trained her, she is now a professional birth companion providing encouragement and emotional support to women delivering at health facilities.

Jackeline Masibai at Mount Elgon Sub-County Hospital. "Our deliveries have doubled during the programme, and the complications have reduced. The last time we had a maternal death at this hospital was in 2017."

Kangaroo mother care

Kangaroo mother care (KMC) –early, prolonged and continuous skin-to-skin contact and exclusive breastfeeding– is a high impact/low cost intervention specifically targeted at improving the survival rate of pre-term and low birthweight babies.

In Phase 1, Save the Children coordinated with MoH in Tanzania and Malawi to organise KMC exposure visits and training on KMC for county officers and health workers to witness and strengthen implementation and impact. Bungoma county was supported in establishing five centres of excellence and set up KMC units in 30 health facilities, and the uptake of KMC monitoring tools was advocated for through continued engagement at the national MoH level. Phase 2 focused on the scale up of this intervention through:

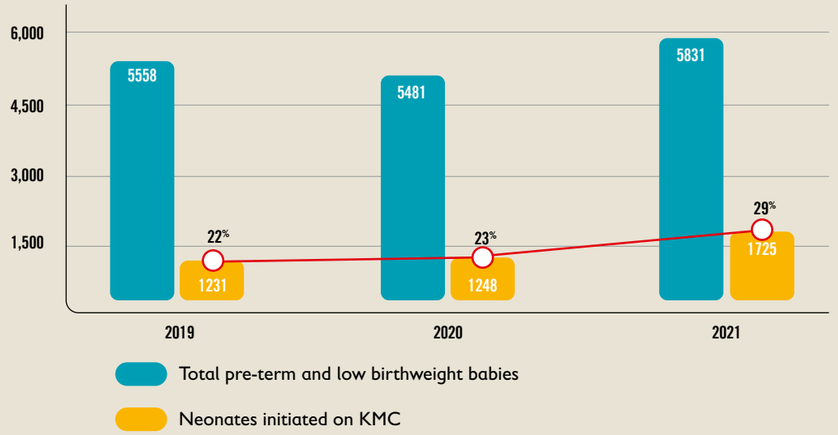
- Inclusion of KMC in quarterly supportive supervision visits, and technical assistance to sub-county health management teams to further support existing and new KMC sites.
- Supporting KMC sites through mentoring on relevant technical skills and basic information on the current guidelines.
- Provision of airtime to KMC staff to improve follow-up of discharged mothers and babies, and support to initiate KMC mother-to-mother support groups.
- Collaborating with the Division of Neonatal and Child Health and newborn technical working groups to identify counties for KMC scale up, and supporting exchange learning visits, advocacy and sensitisation for initiation of KMC services.
- Launching a KMC Champions Network group via online platform (WhatsApp) to encourage engagement and mentoring between health care workers across KMC sites.
- Advocating with MoH for development of monitoring tools, which enabled inclusion of newborn indicators (KMC and CHX) into the Kenya Health Information System (KHIS), and working with MoH for inclusion of KMC indicators in the KHIS.

Headline results

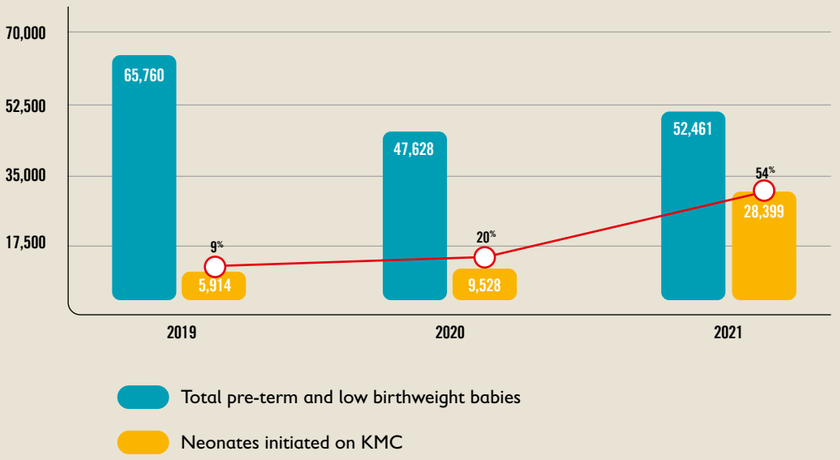
The programme has seen some truly impressive results in scaling up and embedding the KMC intervention.

- By project end, 40 counties (18 directly supported through the project, 22 by other partners) are reporting on KMC indicators newly embedded in the KHIS.
- A total of 85 health facilities in 18 scale-up counties (including Bungoma and Busia) are providing KMC services to low birthweight babies and their mothers.
- More than 45,000 neonates were initiated on KMC in the programme and scale-up counties.

NEONATES INITIATED ON KANGAROO MOTHER CARE - BUNGOMA AND BUSIA COUNTIES



NEONATES INITIATED ON KANGAROO MOTHER CARE IN THE 18 SCALE UP COUNTIES



CASE STUDY

Giving low birthweight babies a fighting chance

Any health care worker you meet in Kenya will have that one story that stands out, that case that they will never forget. For Nurse Everline Wakhome at Malaba Dispensary in Busia county, that story is Stella. Some years back, Stella gave birth to a pre-term baby at her home. Distressed, and knowing the baby was going to die, Stella simply put him in a corner and waited for him to stop breathing. After two days, the baby was still fighting for his life, and Stella took him to Sister Everline.

"I weighed him," Sister Everline says, holding out one hand to demonstrate how tiny he was. "He only weighed 1.2kg." Then her face lights up, "but you should see him today! He is now two years old, and so healthy and so smart. You wouldn't believe it!" How does a 1.2kg baby survive, without an incubator, without access to oxygen supplement and special feeding? "Ah, but you see, I believe that nature's incubator is magic," Everline says, pointing to her chest. "The warmth is constant, and I think the baby feels protected."

This "nature's incubator" is what is at the very core of the kangaroo mother care (KMC) method. Prolonged skin-to-skin contact and exclusive, on-demand breastfeeding dramatically improves the chance of survival for low birthweight infants – even when they are as tiny as Stella's boy was. Sister Everline had learned about the method through Save the Children at her previous clinic in Kocholia. "When I saw this tiny 1.2kg baby, I knew I couldn't just leave him to die, I had to try." Not only was this boy the start of KMC at Malaba Dispensary, but Stella is now a mentor to other KMC mothers at the clinic. "Every time I have a new kangaroo mother who is doubting, I call on Stella to come and share her experience," says Sister Everline. "I tell her, 'Come and give them your story, come with the baby so they can learn from you'."

One such mother was 26-year-old Evelyn Abwalat Omayot who gave birth to twins weighing 1.7kg and 2.2kg. When Sister Everline introduced KMC to her, she struggled to see how she could manage with two babies. "Then the husband asked if he could also do it," Sister Everline says, her face beaming. "So, he took one baby and mama took the other, and every time they came to the clinic, they carried one each on their chest. It was very beautiful." Today, the twins are healthy and active 1-year-olds. When Evelyn thinks back to those days, she is very appreciative of her husband. "Our family and neighbours were all very surprised," she says. "Nobody had ever seen a man carry around his baby like that." Sister Everline agrees, "Most African men, especially here in our community, see twins as something bad. They think the twins are not theirs and many of them leave their wives. But this one, he was there with his baby, supporting his wife."


Evelyn Abwalat Omayot with her healthy "kangaroo babies" Mumbi and Juliana.

Tine Frank/Save the Children


Sister Everline Wakhoma with what she fondly calls "my mamas at Malaba Dispensary, Busia County.

Tine Frank/Save the Children


Ruth Cherop with her baby boy, Leon, born the previous night. This is Ruth's second child enrolled in KMC at Mount Elgon Sub-County Hospital. "As soon as I saw him, I knew I would come to KMC. I like the feeling of skin to skin because it helps my child grow."

Tine Frank/Save the Children


Nurses at Bungoma Referral Hospital demonstrating KMC to a new mother.

Tine Frank/Save the Children

Today, Save the Children has set up KMC services in 85 health facilities across 18 counties, and another 22 counties have KMC facilities set up by other partners. "The level KMC has reached, it's sustainable," says Dr Allan Govoga, Programme Manager at the national MoH Division of neonatal and Child Health. "We own it now, it's one of the key interventions in premature care and it's no longer partner driven. Save the Children supported setting it up and, today, the work is still going on." Apart from a few counties remaining, KMC services are now nationwide. In Kirinyaga county, for example, they managed to secure funding from their county government after training by Save the Children and a learning exchange visit in Bungoma. "We started services in 2018 and it is still running," says Irene Muthee, Reproductive Health Coordinator for Kirinyaga county. "It really has been a success story. We realised we could manage babies as little as 1.5kg, even with just one paediatrician and a few nurses. Before, we would lose a lot of our premature babies, but after we started with KMC we have only lost a few. We appreciate this work so much."

Speaking to various health care providers from around the country, the sense is very much that KMC is here to stay. "When I leave this clinic, we have other people I have mentored on KMC," says Sister Everline. "They will continue the work."

Chlorhexidine

Infections and sepsis are a major cause of newborn mortality in Kenya, largely due to traditional and unhygienic umbilical cord care practices. The use of 7.1% Chlorhexidine digluconate gel (CHX) for cord care was successfully piloted in Phase 1, clearly demonstrating the acceptability and willingness to use CHX. Phase 2 focused on capitalising on these gains for a national scale up of access to CHX through:

- Incorporating CHX into supportive supervision visits by county and sub-county health management teams.
- Mapping of new counties for CHX introduction and scale up and collaborating with the Division of Neonatal and Child Health to produce a scale up plan informing the roll out.
- Technical support to partners in the development and dissemination of IEC materials for CHX.
- Supporting cascade training of key decision makers including county pharmacists, reproductive health coordinators and health care workers to encourage procurement and uptake of CHX.
- Working with national MoH for inclusion of CHX into the KHIS, develop and disseminate revised MoH tools with CHX reporting, and costing and finalisation of the national CHX scale-up plan.
- Alignment of CHX scale-up plan to the Division of Neonatal and Child Health 2020-2024 strategic plans, including technical working group meetings and finalisation and launch of CHX IEC materials, followed by regional meeting to review the implementation progress of KMC and CHX.

Headline results

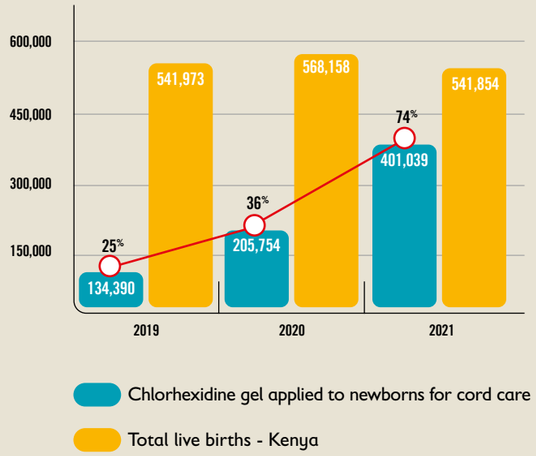
- 7.1% Chlorhexidine digluconate gel is now included in the Kenya Essential Medicines List and counties catalogue.
- All MNH training materials and paediatric protocols have included CHX as part of essential newborn care services.
- In Phase 2, more than 700,000 newborns received CHX for cord care. By project end, all of Kenya's 47 counties are reporting on the CHX indicators in the KHIS.

Enabling access to CHX gel in Kenya

Responding to a global call, the GSK and Save the Children Partnership worked together to reformulate chlorhexidine (CHX) – an antiseptic used in a GSK mouthwash – for the prevention of umbilical cord infections that too often lead to neonatal sepsis and, in worst cases, death.

Combining GSK's science, regulatory and manufacturing expertise with Save the Children's insight and expertise in reaching marginalised families, the 7.1% Chlorhexidine digluconate gel has been specifically designed for remote communities. It is heat-stable, and can endure long, hot journeys without the need for refrigeration, and can be easily administered by health workers as well as mothers in the communities where they most need it.

CHLORHEXIDINE GEL APPLIED TO NEWBORNS FOR CORD CARE



"Back in 2014, nobody really knew about CHX. Save the Children supported us in developing a sensitisation package for introducing this new product, and helped with supportive supervision and how to scale it up. Now, all counties use CHX, it's included in the basic commodities list for children under five, and health facilities know how to cost it and ensure it's in stock. Cord infection used to be one of the leading causes of admission for newborns, but now we don't see that many cases."

Dr Allan Govoga,
Programme Manager, Division of Neonatal and Child Health

"It's a good drug, we're using it for all the babies. It reduces sepsis and helps the mother to not use those traditional herbs and materials. With CHX, the cord heals very fast and we're not getting a lot of sepsis, which is good because it can be difficult for a newborn to survive that."

Everline Wakhome,
Maternity Nursing Officer, Malaba Dispensary

"In the beginning, we got the CHX from Save the Children, but that stopped during Phase 1 of the programme. They, and other partners, lobbied with the county government to include the drug on the essentials list, and now CHX is budgeted for from the county".

Jackeline Masibai,
Reproductive Health Coordinator, Mount Elgon sub-county


Tine Frank/Save the Children


Tine Frank/Save the Children

"I gave birth to my first three children at home. That is before Christine and the other CHVs were trained by Save the Children and counselled us in mothers' groups. After that, I delivered Deborah at the hospital, where they put CHX on her cord after she was born. With my other children I used lizard dung, and they would get infections and swelling, and have pain in their stomach which stopped them from feeding properly. With Deborah I see a big difference, she is a healthy child and was always feeding well. Now, I share this knowledge from Christine in church meetings and women's groups – I tell all my friends and family about the things I have learnt."

Emily Chebet,
Makunga village, Mount Elgon

Supportive supervision

Investment in supportive supervision and mentorship ensures continuous medical education, updated health policies put in practice, improved motivation among health care workers and, as such, improved quality of MNH care and services. It also has the potential to greatly improve the quality of data essential for efficient budgeting and procurement.

Phase 2 sought to embed the regular supportive supervision visits facilitated by the programme in Phase 1 through:

- Support to county and sub-county health management teams to conduct data quality review meetings, quarterly MNH supportive supervision visits to health facilities and mentorship/targeted on-the-job training
- Working with MoH technical leaders to revise the supportive supervision reporting template and develop a comprehensive, consolidated tool incorporating CHX, KMC, nutrition and community health strategy indicators, covering all service points for reproductive, maternal, neonatal, child and adolescent health (RMNCAH).
- Supporting integrated quarterly RMNCAH data review meetings to compare community and facility data as well as ensuring facilities reported accurate KMC and CHX data.


Rounds in the Bungoma Referral Hospital maternity ward

Tine Frank/Save the Children

Headline results

- The revised supportive supervision tool helped improve the development of action plans and quality of reports submitted by supervision teams.
- As a result of increased focus on community data, there has been a notable improvement in reporting, management of data and increased service utilisation.
- A marked improvement in the use of data for decision making by health managers across the two counties.

Why supportive supervision matters

At Wasio Dispensary, a supportive supervision action point led to re-organising of staff to ensure 24-hour services. This change led to an increase in skilled deliveries from 0 to 7 in just one reporting period.

"Supportive supervision is important because, at times, you get updates from the MoH and you want the health facility to get the information at the same time. The supervision visit is an opportunity to communicate to administrators and health care workers, at the health facility where they work. For example, an important update on guidelines of how to resuscitate a baby, you are able to show them from where they work. It also makes it easier to look at MNH indicators, maybe there is increase in deliveries at home and you're able to make decisions and act on this information straight away. When we're doing data quality reviews, we're able to verify them there and then to avoid discrepancies in the HMIS, you can follow up and fix it right away instead of waiting till end of month."

Clara Bundotich, Public Health Nurse, Bumula sub-county

Maternal and perinatal death surveillance and response

Maternal and perinatal death surveillance and response (MPDSR) is the practice of formally reviewing maternal and newborn deaths and stillbirths in order to identify lessons and actions that could prevent future deaths and stillbirths. As such, MPDSR is a key tool in improving MNH care, and is vital for enhancing evidence-based policy, planning and service delivery by addressing the underlying causes of maternal and neonatal deaths.

Phase 2 sought to embed the regular MPDSR review meetings facilitated by the programme in Phase 1 through:

- Support to county and sub-county health management teams to conduct data quality review meetings, quarterly MNH supportive supervision visits to health facilities and mentorship/targeted on-the-job training
- Training of health facilities in MPDSR and support to establish committees, and ongoing support to conduct quarterly MPDSR review meetings and development of action plans.
- Sensitisation of sub-county reproductive health officials in MPDSR summary tool developed by the MoH and the Transforming Health Services grant through the World Bank.
- Supporting sensitisation of community-level verbal autopsy committees.

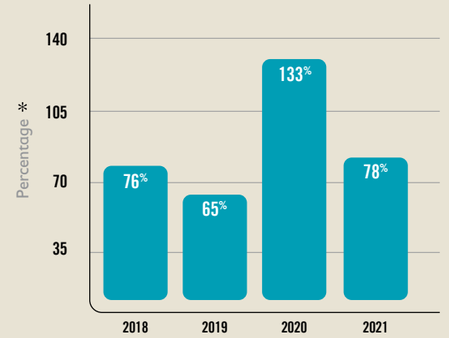
Headline results

- The end-line evaluation revealed that 100% of the 41 health facilities surveyed were conducting regular MPDSR review meetings.
- During the last year of the project, the MoH developed an MPDSR summary tool which captures maternal and perinatal deaths and audits, maternal complications, health facilities with MPDSR committees and track the implementation of the response. Data is shared with the national MPDSR committee on a bi-annual basis.
- To improve reporting the project supported eight sub-counties to sensitise 134 health workers on the new MPDSR reporting tools.

Facility level lessons and recommendations

- The reorientation of traditional birth attendants into professional birth companions to champion the MNH agenda at community level ensured that more pregnant women started visiting the health facilities for ANC, delivery and postnatal services.
- Addressing traditions and cultural beliefs through behaviour change and information materials, mentorship and mother-to-mother support groups played a major role in the successful rollout of KMC.
- The provision of KMC scale up is feasible within the existing health care system
- The use of health care workers and 'Champion Mothers' helped spearhead the KMC agenda.
- Establishing or strengthening the referral system for premature newborns ensured linkages from community to facility that positively impacted the referral of newborns for KMC initiation.
- Supportive supervision and mentorship have been instrumental in ensuring quality of service to MNH interventions, including care to low birthweight babies under the KMC intervention.
- Ensuring that review of previous supportive supervision visit action points take place helped track the implementation of action points ahead of developing new ones.

PERCENTAGE OF REPORTED PERINATAL DEATHS AUDITED - BUNGOMA AND BUSIA COUNTIES



Percentages were calculated based on actual audited perinatal deaths against the forecasted (as opposed to actual) number of deaths, resulting in a figure above 100%

- Ensuring that health workers possess adequate skills to manage reporting tools, and the availability of tools, was paramount to achieve accurate and timely data collection and submission in the KHIS.
- Putting mechanisms in place to institutionalise perinatal death reviews in all health facilities improves quality of care, audits and reporting.
- Increased demand for MNH services can put pressure on human resource at health care facilities. Optimal service delivery, especially where there is high demand, requires adequate numbers of qualified staff.
- Capacity building is required for health facilities, sub-county and county MPDSR committees to develop actions to respond to issues identified in MPDSR audits.

ADVOCACY & SUSTAINABILITY

Health information, policies & financing

Advocacy and institutional support and capacity building were key aspects of taking forward evidence from Phase 1, and scaling up and embedding interventions in the health systems at sub-county, county and national levels. To achieve this, Phase 2 saw engagement at all levels, and significant financial and technical support in the areas of budgetary allocations, policy reforms and systems strengthening, through:

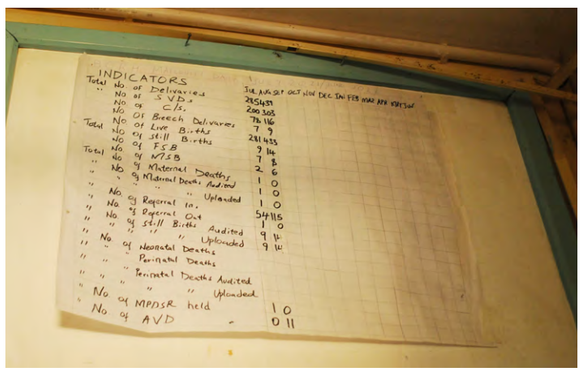
Institutional support & policies

- Revisions, development and launch of key RMNCH guidelines, including on CHX, KMC and MPDSR, with relevant protocols and job aids produced and distributed to health facilities as reference materials during mentoring and provision of services.
- Providing financial and technical support to the Division of Newborn Child Health (DNCH) to develop annual work plans to ensure scale up of CHX, KMC and CHUSLA interventions.
- Supporting county MoH managers to attend one-month training courses in leadership and governance at the Kenya School of Governance, building their skills in planning, programme-based budgeting, advocacy and negotiation. Follow-up included workshops for knowledge sharing on leadership and governance.
- Supporting the drafting, pre-testing, validation, finalisation and distribution of a new neonatal inpatient register for integration in the MoH summary tool and nationwide roll out, for introduction of CHX and KMC indicators into the National Health Management integrated system (HMIS).
- Support to the development of the DNCH strategy 2020-2024 that will provide the direction for the implementation of the national policy, outlining priority programming themes and providing an M&E framework to guide monitoring and evaluation of the policy and strategy.
- Support to the DNCH newborn technical working group to finalise comprehensive newborn protocols that included care of sick and small newborn babies.
- Technical support towards revision of the Community Health Strategy (CHS) policy 2020-2025 and development of National Community Health Digitization Strategy for 2020-2025

> "I been nurse for 17 years. When I look at the change, when I see the interventions where we had support, I normally say that Save the Children is actually like our angels in Bumula sub-county. Because some of these interventions we wouldn't have been able to do on our own. When I see this happening now, and I compare to the time when I started as a nurse… we used to have a lot of maternal and newborn deaths. Now, with the Save the Children interventions, I really feel overjoyed, I really can't express how grateful I am. If not for them, I think I would be telling a different kind of story today."
>
> **Clara Bundotich,**
> Public Health Nurse, Bumula sub-county

Health information

- Supporting regular data quality audits to establish gaps and discrepancies in data entry and summaries for community and health facility data collection, and data review meetings for sub-county and county management teams.
- Support to sub-county and county health records and information officers to conduct data quality assessment and data review meetings, and sensitisation on revised MNH registers to clarify indicator definitions and address inconsistent data entry at source, as well as data collection, documentation and reporting to strengthen CHX and KMC data collection.
- Technical support to the Department of Family Health (DFH) to establish knowledge management platform.



> "One achievement we can be proud of is improvement in data collection. For some time, we had a problem with data, and Save the Children developed an in-patient newborn register. The project has been key in supporting the ministry and ensuring this data is included in the HMIS. We no longer need to ask the facilities for numbers, we just access and have the key indicators right away, like how many facilities are doing KMC or CHX, it's just there in the database. This is a great achievement in newborn care and Save the Children ensured this."
>
> **Dr Allan Govoga,** Programme Manager, Division of Neonatal and Child Health

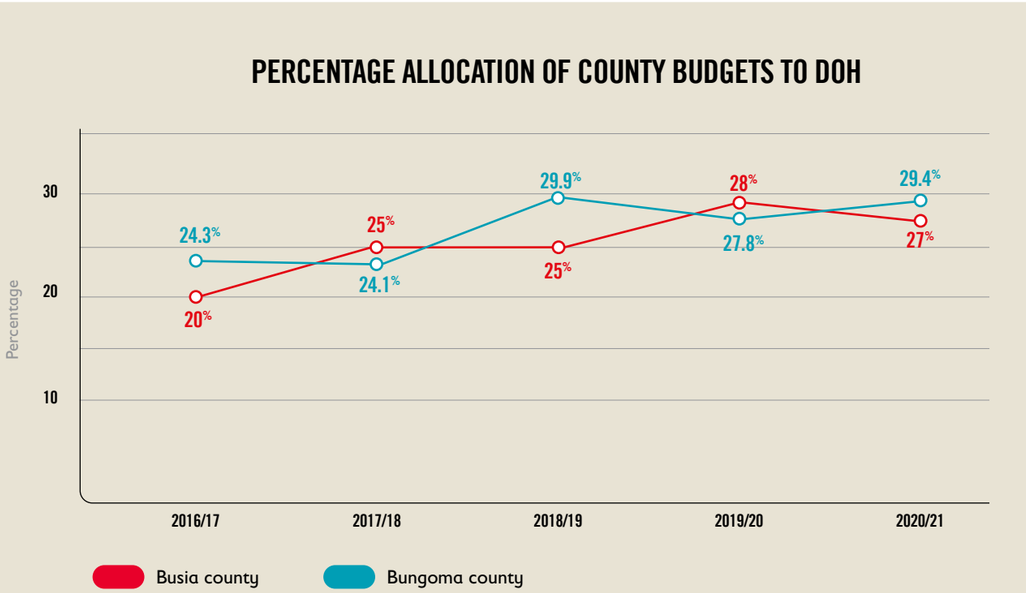
Health financing

- Supporting budget analysis process to analyse trends in public investment in MNH at county-level.
- Conducting public expenditure reviews to inform the development of the Health Care Financing Bill.
- Supporting quarterly meetings with department of health officials, county assembly members and budget committee officials to advocate for increased budget allocations for MNH and human resources for health and enhance sustainability of programme interventions.
- With other development partners, supporting the National Hospital Insurance Fund to review the County Integrated Development Plan for 2018-2022.
- Technical support to CHDU to draft a community health advocacy tool kit to guide MoH and development partners in advocating for community health financing at different levels.

> "At the county level, in terms of coordination, Save the Children and other partners have done a lot of advocacy to members of the county assembly. This has really helped to strengthen the leadership's understanding of their responsibility to apportion resources. During my time working in Busia, I have seen many projects, and not all of them succeed. But this Save the Children partnership has been a very successful project, and I am sure that many years from now, people who come after us will pick out this intervention, it will benefit many generations. The staff and attitude are still there, even when staff are transferred within the county, they carry with them the knowledge and carry on in other places beyond the project area. That's what we need basically, an innovation that can live beyond the project area. It's a blessing for all of us."
>
> **Emmanuel Luvai,** Community Health Services Coordinator, Busia sub-county

Headline results

- Consistent increase in budget allocation and health care spending during the project's lifespan.
- Significant increase in allocation of health care workers at primary health facilities, in line with the recommendations made for the 2018-2022 County Integrated Development Plan.
- County health management teams demonstrated improved capacity to lead on annual work plan processes, developing roadmaps and providing leadership with minimal support from partners.
- A recorded improvement in MoH staff's skills in programme-based budgeting and supportive supervision at health facility and sub-county level.
- Budget allocations were secured for key programme interventions such as reporting tools, mentoring, KMC equipment and procurement of CHX.
- Inclusion of KMC and CHX key performance indicators in the national MoH annual targets.
- As a result of data quality audits, supportive supervision and data review meetings, an improvement in consistency, timeliness and completeness of reporting was noted.
- In 2020, as a result of continued engagement and advocacy by the programme, Bungoma county drafted CHVs regulations 2020, health services regulations 2020 and policy guide on facilities establishment, which provided guidance and a framework on the operationalisation of the 2019 County Health Services Act.



It is important to note that even when there have not been annual increases in budget allocations (as in 2019/2020), project advocacy efforts were vital in minimising the reduction in health spending through consistent lobbying at sub-county and county levels.

Civil society and advocacy

Civil society actors will play a hugely important role in sustaining the programme's advocacy and sustainability efforts in the future. The programme has continued to collaborate and build capacities of civil society organisations (CSOs) and health development partners to monitor health indicators and how government resources are allocated and utilised.

In Phase 2, support saw the formation of a county budget lobby group under the umbrella of Health NGOs Network (HENNET), with ongoing support of quarterly meetings to review county health indicators and progress on the implementation of the 2019 County Health Services Act. HENNET, the Bungoma Chapter Child Rights Network (BCCRN), Busia Health Development Forum and Civil Society Organizations Forum, with the ongoing support of the project, have continuously engaged decision makers in the health department and county assembly to advocate for budget allocation, expenditure and accountability. This engagement contributed to an increase in budget allocation to health and the recruitment of health care workers, and furthermore helped secure the Bungoma county government's commitment to allocate more resources to health in the 2018-2022 County Integrated Development Plan.

"Save the Children have supported us by facilitating the convening of various meetings around budget advocacy and development, supporting network meetings and budget analysis, and training CSOs on social accountability. Through civil society, Save the Children have also helped build the social accountability capacity of county government staff in the county treasury. Now they have invested in CSOs through training of trainers and I believe that, with the training and skills received, and because the training is targeted at various organisations under the CSO network, they will be able to continue the good work. The long term impact is seeing meaningful participation of citizens to realise improved service delivery. We have benefited a lot."

Ezekiel Odeoh,
Rural Empowerment Develop
Organisation Kenya, member of HENNET

Advocacy and sustainability lessons and recommendations

- The involvement of county government staff increased ownership of the programme interventions which was instrumental for the success of the advocacy efforts to improve the budgetary allocation for health.
- National coordination structures, such as the three thematic working groups supported by the programme, were important to review and adapt emerging global evidence, operationalise national policies and guidelines, analyse bottlenecks and provide opportunities for learning during implementation of KMC and CHX.
- The engagement of local civil society networks increased community participation in advocating for government commitment and ownership of the programme interventions. This also increased the sustainability opportunities for advocacy efforts as the local CSOs continued to increase their capacity to engage policy makers and county leaders.
- The synergy created through multiple projects that consolidated the efforts of CSOs to engage policy makers on issues affecting children, including child friendly county revenue generation and taxation, made it possible to influence increased allocation to health.

"I want to appreciate our key partners at Save the Children. We have worked together very well, from the beginning to now. For interventions to succeed you need the support of the national government, and we were always aware of what was happening in Busia and Bungoma, even at scale up to national level we were fully involved. It has been a successful project, even now that it is coming to an end you don't feel they're leaving a big gap because they ensured we reached a level of sustainability."

Dr Allan Govoga,
Programme Manager, Division of Neonatal and Child Health

Tine Frank/Save the Children

CONCLUSION

Boresha, the GSK and Save The Children Maternal and Newborn Health Signature Programme in Kenya set the ambitious objective of changing attitudes, behaviours and policies. That requires time. This programme managed to achieve its results thanks to an 8-year long period of investment and commitment that was necessary to test, refine and embed changes in the Kenya health system. While in Phase I, the programme directly tested high impact and innovative public health interventions at community and facility levels, in Phase II, Save the Children took a back-seat approach. This approach led to external stakeholders taking ownership of most of the programme activities years before the programme's end.

Joint planning with the MoH at the county and national levels from the onset of the programme ensured that MoH started taking ownership of interventions early on, thus also promoting the sustainability of the interventions. For continuity of the interventions beyond the programme period it is critical to co-create with the county and national MoH to foster ownership and ensure interventions are included in the health system, in policies and guidelines, and with sufficient funds allocated.

Over the past eight years, the programme has seen a number of significant changes as a result of a unique mix of initiatives at community-level, facility-level, and county and national MoH levels: The CHUs remain functioning with skilled and motivated CHVs working to progress the overall health of their communities, many of them financially self-sufficient thanks to the CHUSLA groups; women attend ANC visits at a much higher level; the number of home deliveries has drastically decreased, with a corresponding increase in facility-based deliveries; kangaroo mother care and CHX for cord care has been scaled up through most of Kenya and fully integrated into the national health information system; and the programme leaves behind CSOs and county health departments better equipped to advocate for health financing. All these factors combined have resulted in an overall improvement in MNH indicators, not least a reduction in maternal and newborn mortality.

Tine Frank/Save the Children

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