European Union

STUDY REPORT

ASSESSMENT ON THE HEALTH SYSTEMS GAPS FOR MCH & SRH IN THE ARID & SEMI-ARID AREAS TO INFORM PROGRAM AND POLICY LEVEL ENGAGEMENT OF CSOs

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STUDY UNDERTAKEN BY PARTICIPATORY DE VELOPMENT CONSULTANCY (PDC)
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LIST OF ACRONYMS

ASAL	- Arid and Semi-Arid Areas
AWP	- County Annual Wok Plan
CBHMIS	- Community Based Health Management Information System
CHS	- Community Health Strategy
CHEW	- Community Health Extension Worker
CHW	- Community Health Worker
CSO	- Civil Society Organizations
SCHIS	- Sub County Health information System
EU	- European Commission
FBO	- Faith-Based Organization
HENNET	- Health NGOs Network
HMIS	- Health Management Information System
ICC	- Inter-agency Coordinating Committee
JPWF	- Joint Program of Work and Finance
MCH	- Maternal and Child Health
MDG	- Millennium Development Goal
MFL	- Master Facility Listing
MOH	- Ministry of Health
NGO	- Non-Governmental
NHA	- National Health Accounts
PDC	- Participatory Development Consultancy
PHO	- Public Health Officer
PHT	- Public Health Technician
PPPH	- Public Private Partnership for Health
SRH	- Sexual and Reproductive Health
TOR	- Terms of Reference

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TABLE OF CONTENTS

EXECUTIVE SUMMARY

Background

The Tana North Integrated MCH project is a 3 years project covering 2013- 2016 and funded by the EU and the Ministry for Foreign Affairs of Finland, and implemented in a consortium of HENNET, Finnish Red Cross and Kenya Red Cross in Tana North Sub County. This study sought to conduct an assessment on the health systems gaps for maternal and child health (MCH), sexual and reproductive health (SRH) and nutrition in the arid and semi-arid areas (ASAL) to inform program and policy level engagement of civil society organizations.

Methodology

This study was an exploratory non experimental study seeking to determine the enhancers and barriers to health care access and utilization in ASAL. Data collection targeted both secondary and primary sources. Secondary sources included existing literature in the respective sub sectors while the primary data were gathered through qualitative approaches.

Findings

Healthcare access barriers included both demand side barriers and supply side barriers. The supply side barriers included inadequate human resource capacity in terms of numbers, skill levels and mix. Some services could not be provided at the facility because the service providers at the facility did not have the necessary skills. In some cases, non SRH services were prioritized and SRH cases would be attended only is there were no service seekers for the other health services. In Tana River, it was noted that the scarcity of healthcare workforce had led to engagement of CHWs to man some health facilities in spite of the inadequacies associated with this work force and the policy provisions in regard to their roles. Human Resources for Health (HRH) changes were attributed to low number of local workforce since the admission into the training institutions was centralized, with a quota system of recruitment hence only few locals secured chances. Healthcare access was further compounded by the sparse distribution of health facilities and the geographical terrain making expensive and time consuming to navigate to the health facilities.

Nutritional component of MNCH was noted to be scarce in all the three counties. Breast feeding practices were noted to be low since the mothers had energy consuming errands that required long distance travels, leading to early weaning of children. Nutritional commodities were not available and when they were availed through partners, transportation to the health facilities remained a challenge due to none budgetary allocation for distribution in spite of the sparse distribution of health facilities. Tana River was particularly had hit with malnutrition due to low agricultural productivity. SRH was therefore not prioritized as a major issue and this was evident in the low number of SRH implementing CSOs. Free MNCH had affected quality of services since demand exceeded supply. This led to communities avoiding public facilities and shifting focus to traditional methods or the private facilities for service provision. Youth friendly services were not given a priority in the counties. This was a setback especially in Kitui County where teenage pregnancies had risen as a result of inadequate health education, gender based violence including rape and defilement. The youth were stigmatized and hence did not present their young ones for services at the health facilities.

Poverty levels, Negative attitude of male partners towards health seeking and community resistance to FP especially in Kajiado, were also noted as some of the population barriers to healthcare utilization for

MNCH/ SRH. FP was considered a lesser priority by the communities (just as it was considered in the same light by the service providers), there was male dominance on asset ownership and economic income that further compromised decision making powere on healthcare utilization with a biased in favour of men. Cultural issues, myths and misconceptions attributed to knowledge gaps and inadequate access to health education, were also noted as key barriers.

Commodity security was a cross cutting challenge in all the three counties and was a reason that was often provided by the locals for not seeking health services in the local public health facilities. Cold chin facilities were noted to be a major issue and this derailed the efforts to expand access to immunization services. Nutritional commodities were never prioritized in the county and national health sector budgets and there was overreliance on partners for support.

There were no resource allocations in planning the outreach programs by the county and national government and outreaches were mainly supported by partners. Implementation of the community strategy was also supported by partners and phased sustainability challenges when the partner support ceased. None of the counties had achieved 50% the number of community units required in the county. The few established units faced challenges of CHW incentivization costs, when the partners withdrew support. The CUs were however noted to have expanded access and utilization of health services, where they existed.

The main sources of resources were from the development and implementing partners, national and county governments. Most of the SRH resources provided by partners were erratic and based on availability of funds. The activities implemented by CSOs were informed by evident need as recognized by the government partners. CSOs integrated their work within MOH structures through joint strategic planning, participating in steering group and technical working groups meetings. The CSO priority setting was however noted to be donor driven in some cases and that at times, the priorities were not in line with county priorities. CSOs were however reported to come up with fixed work plans and imposed them on the target communities and the partners. The CSOs implementing RH activities were noted to be low in number and there was call for scale up in CSO activity in the RH program in the ASAL. Because of their resource provisions in the sector, the CSOs were also noted to at times dominate decision making processes. In Tana River, insecurity was noted to have greatly hindered access and utilization as health ceased to be a priority. Flooding and food insecurity were also noted as other highly prioritized challenges that required response and that made health a lesser priority.

Communities and service providers did not embrace health from a human rights perspective and the right holders were not empowered to hold the duty bearer accountable. Although devolution is envisioned to provide greater opportunity for interaction between the citizens and the government, this had not taken effect since sensitization and relevant platforms for engagement gad not been established.

The institutional framework and administrative structures under the devolved government had not taken effect and there were gaps in discharge of duties. A number of CSOs, on the other hand had not internalized the Kenya health policy framework 2012-2030 as well as the health sector strategic plan. There was inadequate understanding on devolution (legal policy frame works; devolution of functions) among the CSOs and the health care workers.

The decentralization of funds to the county level does not include a policy on the proportion of the funds allocated to the health sector. It is possible that the county governments may not prioritize resource allocation for the health sector. Majority of the ASAL population rely on dispensaries and health centers for service access. These facilities have always received low financial resource allocation with a greater chunk of the government resource allocation (70 %+) going to the secondary and tertiary facilities. The national government still has control on significant health sector budget.

Recommendations

There will be need for the CSOs to work with the government to outline HRH strategies for health worker training, retention and incentivization, specifically aimed at strengthening HR capacity for ASAL counties. Capacity building for local population will need to be prioritized. Empowerment of CHWs and local volunteers will need to be considered as part of the strategy, to enable the undertake some of the responsibilities left as reserve for the higher levels of healthcare providers.

Male involvement, community health talks, Continuous health worker; Integration of community strategy into the health care worker training curriculum; Sustainable CHW incentivization are some of the areas that needed program focus.Joint planning and performance management for health services in the ASAL counties should include development of interventions targeted at sparsely distributed populations and pastoralist communities with health education and service provision activities targeted at expansion of MNCH access.

Strengthening resource planning and coordination between the county government and the partners should be of priority to enhance synergy in partner efforts, priority setting and continued performance monitoring in the sector. Joint planning should be moved a notch higher to include joint proposal writing for donor/ DP support. Integration can be improved by having a coordination body/office for government and CSO and timely communication to enable joint planning. Priority setting can be improved by improving the scope of projects already identified and diversifying issues. The CSOs in the relevant sectors with experience in strengthening devolved governments to identify revenue sources and to raise revenue should support the ASAL counties to be able to generate resources from diverse sources, plan, budget and oversee spending efficiently

Food security and sustainable livelihoods should be included as a long term solution to the extreme food needs in Tana River County. This will help curb the recurrent food shortage that greatly compromises the county performance on nutrition. Health implementing CSOs should engage with other stakeholders in the County to explore innovative approaches to food production.

Participation of CSOs in policy and strategic planning platforms at the county and national levels will enable them represent the citizens in ensuring that the state is accountable in allocating and managing public resources and that the policies, plans and achievements in implementation are a reflection of their expectations.

There was evident need to the need for capacity building through training on Legal framework that guide devolution including County health strategic investment plans, the County Government Act, the Health policy, the Intergovernmental relations act, and the public finance management act etc.

Awareness creation and sensitization of citizens about the services available in health facilities and how to demand for missing services and medical supplies is a key mandate of the CSOs and local leaders.
The CSOs working at the county level should establish mechanisms of engagement with the county government to advocate for adequate allocation of resources to the health sector at this level. Healthcare access/ equity in ASAL should be a policy issue of which the national government should be targeted with advocacy to address. There should be linkages between the ASAL CSOs and their counterparts at the national level and with the local actors in order to strengthen a continuum of forums for articulation of community interests and establishment of platforms & actions for engagement. Peer networks will ensure local actors and platforms link to national non-state-actor platforms.

1.0 INTRODUCTION

1.1 Background

The Tana North Integrated MCH project is funded by the EU and the Ministry for Foreign Affairs of Finland, and implemented in a consortium of three: HENNET, Finnish Red Cross and Kenya Red Cross. The project implementation is planned to cover 3 years spanning 2013 to 2016 in Tana North Sub County and addresses the MCH needs and policy targets by contributing to the expansion of Community Health Strategy (CHS) in the hard to reach and marginalized populations living within Tana North Sub County. It aims to achieve this through empowerment of communities to use and demand for MCH and SRH related services and simultaneously enhance the capacity of Ministry of Health (MOH) to attend to the needs of the communities. This calls for adequate understanding of program and policy factors behind the demand component and the supply side of healthcare. This study sought to conduct an assessment on the health systems gaps for maternal and child health (MCH), sexual and reproductive health (SRH) and nutrition in the arid and semi-arid areas (ASAL) to inform program and policy level engagement of civil society organizations (CSO) in devolved system of governance.

1.3.1 Specific Objectives of the project

1) Increased access to and demand for MCH services in the target communities targeting 14’450 U5 children and 22’579 women
2) Improved nutritional practices of pregnant and lactating women and children less than 5 years of age targeting 14’450 children and 1’581 women
3) Increased access to and use of SRH services targeting 22’579 women and 22’579 men
4) Enhanced capacities of the healthcare delivery system to provide MCH, SRH and nutrition related services guided by the MOH CHS

2.0 STUDY CONTEXT

The project implementation coincides with the transition period when Kenya is struggling to align its structures and systems to the devolved government in line with the constitution as passed in 2010. It is appreciated that there is a lot of disparity across regions and that certain regions, especially the ASAL are likely to lag behind, considering comparative advantage observed in the more developed counties. It calls for a combined effort of all stakeholders including the CSO sector, development partners, the government and the communities to play significant roles in ensuring that the counties keep pace with development and that there is no disparity in healthcare access for the disadvantaged ASAL population. One of the key areas that were noted to be likely to be affected was the health sector, with a potential of inadequate systems to support health programs and services towards the attainment of the health Millennium Development Goals (MDG). MCH, SRH and nutrition have been recognized as some of the core sub themes of health that require a lot of support. Against this background, HENNET seeks to determine the current status including barriers and enhancers to service access and utilization, both at the program level and at policy level. It is envisioned that this study will help assess the current strengths and weaknesses within the health systems and to outline the priority interventions that can be supported/ undertaken by CSOs to improve health outcomes across the core areas of MCH, SRH and nutrition. The specific objectives will therefore be as outlined below.

The Kenya health policy framework is aligned to Kenya's Vision 2030 (Kenya's national development agenda), the Constitution of Kenya and global health commitments. It uses a three-pronged framework (comprehensive, balanced and coherent) to define policy direction. The policy proposes the formation of county health departments with the role of creating and providing an enabling institutional and management structure responsible for "coordinating and managing the delivery of healthcare at the county level. The county health management teams bear responsibility for provision of "professional and technical management structures" and for coordination of the delivery of health services through health facilities in the county.

2.1 Devolution of healthcare in Kenya (Responsibilities of the National & of the County governments)

National Government

- Health policy
- Financing
- National referral hospitals
- Quality assurance and standards
- Health information, communication and technology
- National public health laboratories
- Public-private partnerships
- Monitoring and evaluation
- Planning and budgeting for national health services
- Services provided by Kenya Medical Supplies Agency
- (KEMSA), National Hospital Insurance Fund (NHIF), Kenya

County Government

- County health facilities and pharmacies
- Ambulance services
- Promotion of primary health care
- Licensing and control of agencies that sell food to the public
- Disease surveillance and response
- Veterinary services (excluding regulation of veterinary professionals)
- Cemeteries, funeral homes, crematoria, refuse dumps, solid waste disposal
- Control of drugs of abuse and pornography
- Disaster management
- Public health and sanitation

- Medical Training College (KMTC) and Kenya Medical
- Research Institute (KEMRI)
- Ports, borders and trans-boundary areas
- Major disease control (malaria, TB, leprosy

2.2 Organization of healthcare in the devolved System

Health care is in a four tired system in the devolved structure[1]. The counties are responsible for three levels of care: community health services, primary care services and county referral services. The national government has responsibility for national referral services.

Community health services*:* This level is comprised of all community-based demand creation activities, that is, the identification of cases that need to be managed at higher levels of care, as defined by the health sector.

Primary care services: This level is comprised of all dispensaries, health centres and maternity homes for both public and private providers.

County referral services: These are hospitals operating in, and managed by a given county and are comprised of the former level four and district hospitals in the county and include public and private facilities.

National referral services: This level is comprised of facilities that provide highly specialized services and includes all tertiary referral facilities.

Barriers to healthcare access and to realization of desired health outcomes in Kenya include geographical and wealth inequalities founded on uneven patterns of development and marginalization. The ASAL regions form part of the marginalized regions that have manifested underperformance on the key health MDGs including manifestation of high child and maternal mortality rates. The health seeking behavior and health service utilization decision making power has been reported to be major barriers to service utilization even in instances where there is adequate service availability and accessible service outlets. Health education, particularly in the public sector, in rural areas, and in more remote parts of the country has been noted as a challenge both in previous studies and in this study.

[1] Kenya Health Policy, 2012 -2030. Ministry of Medical Services and Ministry of Public Health and Sanitation

3.0 METHODOLOGY

3.1 Study Design

This study was an exploratory non experimental study seeking to determine the enhancers and barriers to health care access and utilization in ASAL. These factors were explored at the decentralized levels, starting at the sub county level and traversing the health systems hierarchy through the county units to the national level. Data collection targeted both secondary and primary sources. Secondary sources included existing literature in the respective sub sectors while the primary data were gathered through qualitative approaches. The study employed method mix in generating required information and information from diverse sources were triangulated to generate valid deductions. Key informant interviews, group interviews and review of existing literature were used to generate information for the study.

3.2 Description of Study Region and Study Population

The study targeted ASAL areas. The project implementation county (Tana River) was the primary target county of study. Additionally, two counties of Kajiado and Kitui were randomly selected for comparative analysis and for validation of findings that may be generalized across the ASAL counties. Kajiado County has a total of 294 health facilities and 267 community units. In 2013, the county recorded 4+ ANC visits of 11,658. The number of facility deliveries was recorded at 10,803 and the number of women receiving at least 2 doses of intermittent treatment of malaria in pregnancy at 998. Kitui County on the other hand recorded 12, 393 4+ANC visits, with a total of 365 health facilities and 2,212 community units. The number of health facility deliveries for Kitui was 15, 799 and the number of women receiving at least 2 doses of intermittent treatment of malaria in pregnancy was 437 for the year 2013. Of the 12 counties prioritized under ASAL in the Global Alliance for Vaccines and Immunization (GAVI), Tana River had the second lowest score on 4+ANC visits coming only after Mandera. It was also second in rank of poor performing counties on the number of facility deliveries, recording 2,386 and trailing closely behind Samburu (2,254). According to the Master Facility Listing (MFL), Tana River County has a total of 65 health facilities while the Sub County Health information System (DHIS) does not report the figures on number of community units for this county. The doctor to population ratio for the county is estimated at 1: 41,000, infant mortality at 14/1,000 and under 5 mortality rate at 93/1000. The health spending in Taita Taveta is estimated at KSh. 48 per person.

The selection of Tana River County, apart from being the target implementation County for the project, has been considered to purposefully represent the poor performing counties of ASAL. Kajiado and Kitui on the other have been considered well performing countiesin ASAL, going by their performances on the MCH indicators as described in this section. It is however imperative to note that the two counties of Kajiado and Kitui are only considered well performing relative to their peers in the ASAL but still, as typical of the rest of the ASAL counties, lag behind in MCH indicators, when considered on a national scale. [2]75.0% of HIV positive pregnant women in Kajiado, for example, do not deliver in a health facility comparing closely to 77.0% of pregnant women in Kitui County, who do not deliver in the facility. 44.0% of the pregnant women attend the recommended 4+ANC visits in Kajiado, compared to 35% in Kitui. While 34.0% of Kajiado residents had their sexual intercourse before the age of 15, 39% of those in Kitui encountered their first sexual intercourse before the age of 15. Comparing the two counties with Tana River county, the later scored 47% for the proportion of the population encountering sexual intercourse before the age of 15; 74% of HIV positive pregnant women not delivering at a health facility and 37% of expectant mothers attending 4+ ANC visits. The full

[2] HIV & AIDS Profile Kajiado County

immunization coverage for Tana River County is estimated at 66.7% against the national grid of 83.0%[3]. Nutrition indicator performance in the county is reported at 27.5% against a national score of 15% (underweight) and 29.0% against a national score of 30.0% (stunted)[4]. In the 2012 comparison, the CPR for Tana River County was recorded at 19.8% against a national record of 45% prevalence[5]. The births delivered at a health facility however scored a high of 44.0% compared to a national score of 22.3%[6].

Kajiado County is located in the Rift Valley and is divided into 3 Sub Counties including Kajiado Central, Kajiado North and Loitoktok. Four Sub counties including Kitui, Nyuso , Mutumo and Mwingi were mapped into Kitui county. Tana River County is located in the Coast region of Kenya and borders Garissa to the North, Isiolo to the Northwest, Lamu to the Northeast, Kilifi to the Southeast, Taita Taveta to the South, and Kitui to the West.

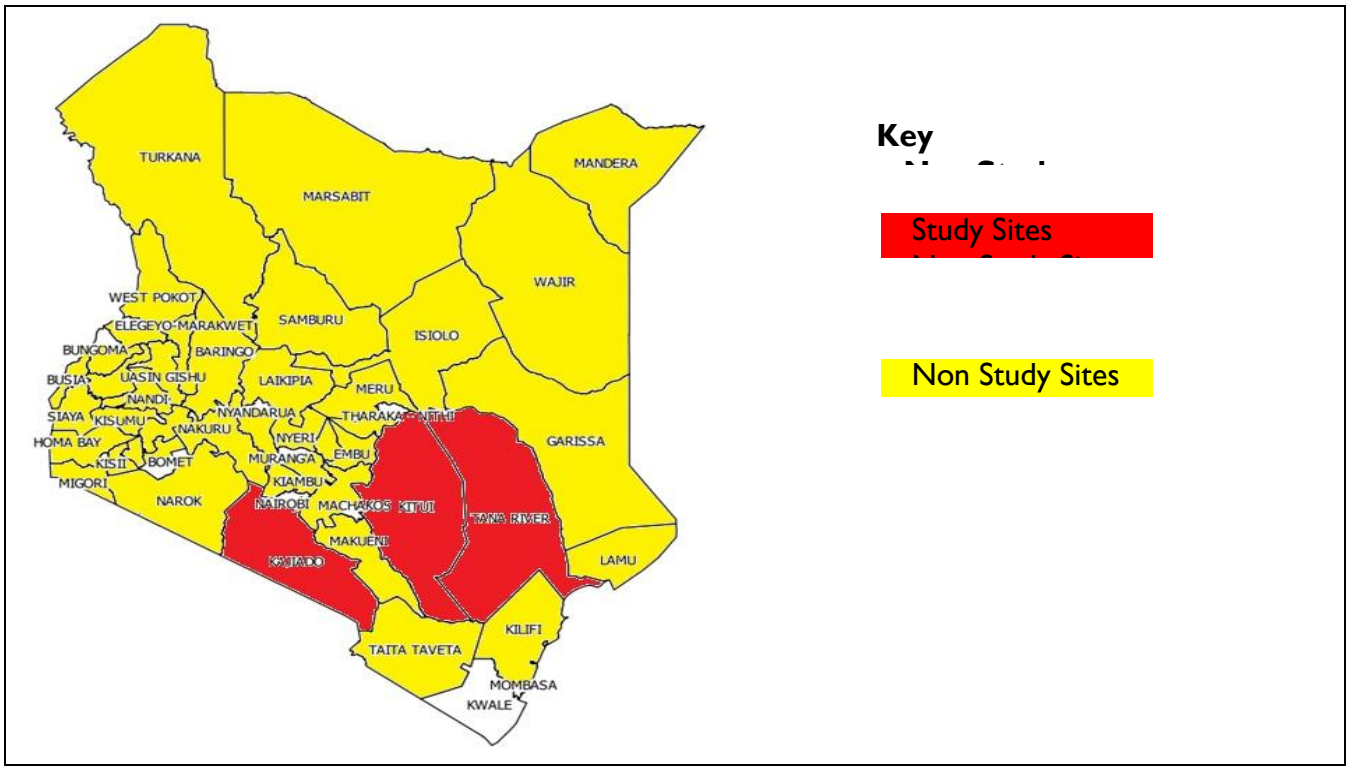

Figure 1: Map of Kenya showingthe study counties

Sample and Sample Selection

The primary data collection was through qualitative approaches, mainly Key Informant Interviews (KIIs). The sample selection was purposive and targeted health planners and policy makers as well as implementers in the Civil Society sector and in the government (MOH and Transition Authority). HENNET, through its network, introduced the study to the counties and sought availability of the

[3] Kenya Health Information System, Division of Vaccines and Immunization
[4] Kenya Demographic and Health Survey, 2008/2009; counties where the small survey had not been undertaken assumed provincial averages. Calculations and standard multipliers were applied by the Division of Nutrition
[5] Kenya Health Information System, Division of Reproductive Health
[6] Kenya Health Information System, Division of Child Health; facility delivery data were provided by the Division of Child Health; total number of deliveries was estimated from 2009 census data

respondents under the respective categories. The interviews with implementers under the civil society sector included key implementation staff in SRH and MCH. The sample for the government officers will be derived from the key technical directors/ officers in SRH and in MCH. Interviews with the ICC members targeted representation of the CSO ICC membership (I KII) and representation of the government/ MOH (1KII).

Data Analysis

Data analysis was based on the emergence of themes across the sub populations included in the study. The themes were compared across the counties. Further validation was performed through comparative analysis, looking at the data from secondary sources and data from the interviews.

Study Limitations

This study was conducted to provide general information that would guide program planning and implementation across the ASAL counties. It is possible that the study may apply to majority of ASAL counties but may not apply to all.

3.2 Key Research Questions and Variables of Study

The study sought to answer 2 key research questions. The research questions revolved around MCH & SRH programs and policy factors, specifically in regard to ASAL counties. The actual and expected roles of CSOs were assessed in the realms of the policy issues and the program perspective, in regard to expansion of MCH & SRH service access and utilization. Factors on access and utilization were again broadened to access, supply and demand perspectives.

Key Research Questions

I. What are the gaps in the actual and expected CSO roles in advocating and strengthening MCH and SRH programs and policies at the county government?

II. What are program and policy factors that retard or accelerate MCH and SRH service utilization in ASAL regions?

4.0 FINDINGS DISCUSSIONS & RECOMMENDATIONS

4.1 Research Question I: What are program and policy factors that retard or accelerate MCH and SRH service utilization in ASAL regions?

4.1.1 General Overview

In Tana River County, although healthcare supply was reported to be low, it was noted that the demand was also minimal. Erratic commodity supply for FP methods such as insertions was also noted as major challenge in FP service provision. Inadequate provider skills in provision of methods such as insertions and low staff levels further compounded RH service access. Reporting skills were low and reporting was not considered a priority by many service providers who considered service provision the core business in their routine work. The county government was however reported to have undertaken some initiatives and employed 160 health workers. Partners worked together with the county government to train health workers in provision of integrated services. MNCH HRH capacity gaps were observed especially in nutrition and skilled delivery. Food insecurity was a major problem and malnutrition was common among children Coordination and logistics remained a challenge as the health facilities were widely distributed. There was overreliance on partners to support transport of commodities and supplies. Tana River had limited number of CSOs focusing of reproductive health. As a result, the RH agenda did not receive the necessary attention and most issues were addressed/ responded to without proper coordination.

"Most parents feed children on camel milk and ugali (maize meal), and are ignorant of other nutrients they can get from other foods that are locally available" (IMC).

In Kitui, free services were reported to have resulted in poor quality as demand exceeded supply. This led to communities avoiding public facilities and shifting focus to traditional methods or the private facilities for service provision. FP service utilization and health facility delivery in Kitui were both noted to be low with an approximate health facility delivery at 45% and modern contraceptive use at 45%. Healthcare service demand was noted to exceed supply, especially for services sought by the youth. The youth population was reported to form the highest population segment in the county. Teenage pregnancies were high, an observation that was partly associated with rape and defilement of minors. High teenage pregnancies were particularly highly prevalent in Mwingi and Migwani. In spite of this evident need for youth services, there were no adequate youth friendly services in place.

"There's only one youth friendly clinic that served 367 clients in the previous one year" (County Nurse")

There were low performances in MNCH indicators in Kitui County especially in Nutrition. Challenges in nutrition are acute and chronic malnutrition is experienced during drought seasons. As of August 2014, 9400 children under 5 were malnourished, accounting for the highest in the country at 40%. Exclusive breast feeding for infant and young children was at 45%, while micronutrient deficiency of Vitamin A was 65% and immunization was at 73% which is below national

"Poor or lack of transport and communication infrastructure is a major problem as most remote routes are served by one vehicle" (CHMT)

target (HMIS). Initiation of breastfeeding was low and at the same time children were weaned early. Reasons provided for early weaning included lack of milk, overarching workload and commitment of mothers in household responsibilities such as fetching water for domestic use that involved walking long distances. Other issues in the county are stunted growth, underweight and sporadic diseases such as measles and diarrhea. All facilities in the county had the potential to provide MCH services but not all facilities were able to provide immunization services due to lack of cold chain facilities. There were high neo-natal deaths as skilled deliveries at at 26%. Only one center in the county was well equipped to handle neo-natal care. The common scenario was a staffing of only one clinical officer and 2 nurses, at the Sub County hospitals. This compromised quality of care at these facilities, considering that this level of hospital is expected to have at least one qualified medical doctor. Overall, there were inadequate reporting mechanisms with weak data capture systems including limited capacity of health workers in reporting and unavailability of reporting tools. This came out in all the three counties.

The recommendations provided to scale up MNCH and SRH services targeted at the youth included working with youth groups and out-of-school groups to implement health education activities. Engagement with informal workplace groups to spread health promotion messages and advocacy for change in knowledge, attitude and practice through radio programs. On the supply side, establishment of youth friendly services was acknowledged as the main approach to expand access for the youth.

4.1.2 Supply Side Barriers to SRH/ MNCH Service Utilization

4.1.2.1 Inadequate health facilities

The health facilities in the counties were sparsely distributed and physical access was not achievable for majority of the population. Physical access was further jeopardized by inadequate transport & communication network. The population spent several hours travelling to access services. It therefore took a lot of effort for the citizens to make decisions on whether to seek healthcare services from the 'difficult to access' health facilities or to opt for 'alternative medicine'- traditional and herbal medicines. This was further confounded by the geographical terrain (Kajiado) that did not allow for ease in mobility to the locations of the service outlets.

"There are no operational health facilities for distances as far as 50 kilometers and the roads are depilated so that the most common means of transport is on foot. "Between Chardende and Bura is 80km and there is no health facility and between Bangale and Bura is 100km and no facility (SCHMT-Tana North County)

4.1.2.2 Inadequate Staff Levels

Availability of RH services was reported to be inadequate in many health facilities. There was uneven distribution of healthcare workforce which was skewed in favor of health facilities in urban settings. Low staff levels were associated with low staff retention (high turnover). Some health facilities were reported to be managed by community health workers while others were run by one nurse who had to multi task in all service areas and related administrative duties. The providers were also noted to have limited skills and narrow scope in service provision hence could only provide limited number of services specifically in regard to FP service provision. There were no opportunities for training, whether as part time continuing education or in service trainings. Mentorship opportunities were unavailable since the facilities did not retain highly skilled providers who would mentor the upcoming providers.

Health facilities are normally not operational on a consistent basis due to lack of health personnel and in some cases, facilities closed due to lack of personnel" (CHMT-Kajiado).

The CHWs did not have adequate skills to offer basic services apart from basic first aid and condom distribution, yet the expectations were beyond what they can offer. RH was not considered apriority at the service outlets and in case other conditions/ service requests were presented, the RH service provision would be shelved as the available provider attends to 'more deserving' cases. In certain cases, the health facilities had to be closed when the only staff in the dispensary had to attend to issues/ commitments outside the station such as meetings, leave or even personal issues. Staff attitude was also reported to be poor resulting in suspicion between the health care provider and the community. Staff attitude could be a function of the hardship environment, overwhelming workload and inadequate equipment for service provision which ultimately led to burn out and demotivation among the service providers.

Human resource challenges was a cross cutting issue for the 3 counties and was manifested in the case of MNCH and SRH. The ASAL counties are generally challenged by the shortage of local trained health care workers, a challenge that is attributed to limited number of locals access admissions into the training institutions due to the centralized admission system. Health worker retention (for none locals posted to the counties) is low since the posted staff stay for short durations before moving out to the other regions.

4.1.2.3 Commodity and Service availability

The ultimate result of inadequate staff levels and unreliable commodity security was unavailability of consistent and reliable FP methods and MNCH services. In most cases during the facility visit, a client would miss a preferred service either because the method is not available (absence of FP commodity) or because the service provider available at the facility did not have the requisite skills required for administration of the method. Poor commodity supply was a common reason given by the local communities for not accessing and utilizing services during health promotion activities. This resulted in preference for alternative medicine and use of traditional birth attendants. Availability of nutritional commodities and supplies were usually a challenge as distribution to the far flung health facilities was difficult. Services were not adequately available as cited in the case of nutrition services for children under 5, in which only height and weight are looked into as indicators of nutritional status". Cold chain facilities were reportedly the main challenge in the management of immunization commodities.

> *"Why go to the health facility you will not even find the nurse and if you find her there will be no medicine"(CHMT- Tana River), in regard to community excuses for not going to the health facilities for services.*

Recommendations

Equipment provision and HRH strengthening was identified as a cross cutting priority for all counties and applicable for both SRH and MNCH. HRH capacity strengthening will need to take into consideration the numbers and cadre of staff, including their distribution across each county. Skill mix will need to address the capacity of available staff to provide a range of services (multiplicity of skills and task shifting).

Art. 235 of the Constitution, empowers the counties to establish offices and employ individuals performing functions allocated to them in Fourth Schedule. The article therefore provides the counties with the benefit of employing qualified healthcare providers. It was foreseen in the analysis of the

challenges posed in the transition period as devolution took effect, that marginalization may be further aggravated by this provision, when some counties are endowed with resources to employ and retain healthcare workers while others do not.

In line with the provision of the constitution, there is an opportunity for the county governments to explore for potential public private partnership arrangement that will see the county government strengthened in commodity security while the private companies secure market for their supplies. Strategic partnerships with medical supply agencies to capacity build the county governments on commodity security and to ensure undisrupted supply of essential consumables and supply to the ASAL regions.

Strong partnerships should be fostered between the county government and the implementing partners in order to achieve the desired technical and financial input. M&E mechanisms should be established and strengthened to allow for performance progress monitoring and evaluation.

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4.1.3 Population barriers to RH Service Utilization

In all the three Counties, economic challenges and high poverty levels were cited as key barriers to healthcare access. The main challenge was in commuting/ travel costs associated with long distances covered to the health facilities and the high service costs charged at the outlet facilities. Negative attitude of male partners towards FP was a major population barrier to FP access, alongside other socio cultural factors. The belief that women should give birth to many children was deeply rooted in the culture of the communities. Violence against women was highly manifested and women did not seek medical attention even after they were subjected to gender violence by their spouses. There was general resistance to FP in the community. This was strongly manifested in Kajiado County while in Tana River, it came out that in the same manner the service providers did not prioritize RH/FP clients, the community also considered FP a lesser priority in the ranking of health care needs. At the household levels, the ownership of long term assets was noted to be under the male spouses who doubled as the household heads and as the decision makers for healthcare seeking in the households. Again, it was the male population who had strong negative attitude towards FP and therefore the less likelihood that household resources would be availed for FP health service utilization. Other barriers included cultural issues, myths and misconceptions surrounding modern contraception and child birth. Women opted for FP services that could not be noticed by their husbands and that they did not have to frequent the health facility to receive.

"Few women visit hospital after violence, or even for a checkup, because of the patriarchal social structure. There are a number of socio cultural beliefs that prevent WRA from accessing FP services. The local community for example believe that one should have as many children as possible as you don't know how many will survive" or "It is the will of God to have as many children as you can get" (CHMT-HOLA).

"It is also difficult to implement RH services as you get into conflict with culture and religion. Some only come to hospital when it is too late and they have no alternative and it has become a matter of life or death" (UML)

"The preferred FP method here is Depot medroxy progesterone acetate. It is not visible and can be used by women without the knowledge of men. Again, Depot medroxy progesterone acetate does not require frequent

Stigmatization of those receiving nutritional support, was noted as one of the barriers to healthcare access/ utilization. Stigma was especially manifested on the community members/ families that received nutritional support. In the communities of Tana River County, there are cultural elements that favor child delivery by traditional birth attendants since it is widespread belief that, "men should not see the nakedness of a woman who is not his wife, even if it is a health professional". There was also little understanding about the need for rest and additional nutritious food during pregnancy. Men did not appreciate that women needed to rest during the period they were pregnant. Decision making in health service seeking was done by men. In the absence of the husband, the mother in law would keep watch on the pregnant woman and insist that only the husband would consent to health facility service

for the wife. The myths and misconceptions were attributed to knowledge gaps and inadequate access to health education. In spite of the efforts by the CSO partners to expand information access, sparse population and unfavorable geographical terrains in the ASAL regions made in difficult to expand population reach.

In Kitui County, cultural issues surrounding delivery in health facilities such as the belief that the disposal of the placenta should be done at homestead, were noted to retard health facility service uptake. Indigenous religions that prohibited the use of modern medicine were also identified as a key barrier in the region. Members of the 'Kabonokia sect" for example, would not visit any health facility for any reason. In the County, the youth did not present their children for ante-natal care and immunization coverage for their young ones was low due to stigma. High poverty levels and low literacy were reported as barriers in all the three counties. Mechanisms to be explored to expand access and utilization of MNCH/ SRH services included male involvement and community health talks. Continuous health worker trainings on current and emerging health issues should also be included in the support package. This will enable the health workers to target the local population with context relevant health issues.

4.1.3.1 Outreach Programs

There were no resource allocations in planning the outreach programs by the county government. In Tana River, RH outreach activities were mainly supported by partners including KRC, AHPIA, Diocese of Garissa, among others in Tana River County where the outreach activities mainly targeted the hard to reach areas such as Walsorea, Subukia, Titila, Boka and Sala. For a few select health facilities, the outreach activities were conducted once a week, but in general, once a month for the other facilities. Outreaches supported by partners benefitted from logistics support provided by partners while the facilities planned and implemented the outreaches. Specifically KRC and IMC partnered with the county health team in 14 sites for outreach programs specifically for MNCH every two weeks. A community-based component was initiated, which is 'mother-to-mother' support groups where trained community health workers visited households to provide ante-natal counseling and conduct post-natal care visits within 48 hours after birth to ensure essential neo-natal care.

"For most of the residents, the only health care they have ever known is the outreach programs" CHMT-Tana River

In Kajiado, the outreach activities were organized at facility level and supported by partners. They were noted to be entirely dependent on erratic partner funding in spite of being the most effective way of reaching the most undeserved members of the county. In Kitui, no outreaches had been conducted in 2014 due to reduced funding, while the last ones were held in 2013 and were supported by partners specifically, World Vision. Outreach activities were conducted monthly in 10 stations considered remote and were supported by CSO partners such as APHIA and Marie Stopes.

4.1.3.2 Community Strategy

Community strategy is the mechanism through which households and communities take an active role in health and health related issues and its objectives are: community empowerment, to bring healthcare closer to the people, the establishment of community health units and the enhancement of community-health facility linkages. Community health services level is one of the four tiered levels and was established with a sole purpose of promoting community participation.

In Tana River County the community health strategy model was recognized to have worked well and a number of community units were established. The functionality of the units had not however achieved the desired threshold, with only 11 out of 50 units that were functional. The CHWs in the 11 unit had been trained and were capable of reporting. The CS was observed to be effective in enhancing access and utilization. There was an observed disparity in referrals from CS sites when compared with none CS sites.

In Kitui County, 79 out of 223 units (33%) had been formed but were not fully functional at the time of the study. Establishment of all the 79 CUs was supported by APHIA.

In Kajiado County, establishment of community units was started in 2010 and at the time of the study, 69 units had been established. Out of the expected 163 CUs, this translated to 45%. A major setback was noted to be in the inadequacy of resources. APHIA plus project of USAD had initially supported the CUs but stopped paying for CHW stipends. This led to demotivation of the CHWs since there were no other incentivisation mechanisms in place. A number of CSOs had supported the establishment of CUs and provision of incentives to CHWs but sustainability issues were not factored in. Community strategy was instrumental in facilitating access and utilization of health services, for example in Mashuru, a remote and marginalized region had recorded an increase of skilled delivery from 3 -13 in one year (2013) and Meto from 0 to 3. Records indicated referrals from the trained community health workers. One of the reasons for embracing skilled delivery despite being attended to by male nurses is fast recovery after child birth. The communities prioritized hospital delivery because of these benefits of quick recovery. The community strategy had however contributed to improved immunization and is an effective mechanism for defaulter tracing. The trained CHWs were reported to be instrumental in enhancing preventive health, referrals and defaulter tracing. Community strategy provided an opportunity to strengthen community partnerships through participatory joint planning, implementation and monitoring of community activities. This fostered ownership, a key element in sustainability of community projects. Appreciation and engagement with communities were noted to have been effective in areas where the health care workers appreciated the communities but ineffective where the health workers had a negative attitude towards the communities.

> *"Community heath strategy has reduced distances to health facilities as they offer basic first aid. Some CUs have evolved to community based organizations to provide services that compliment health systems''. CSO IP*

> *"The community strategy has helped identify needs in the county such as disability which is now prioritized as a need in the county. This year, 22 disabled under age of fifteen years were referred by CHWs to the county hospital. CHMT- Kajiado*

> *Mindset of health care workers "feel community is primitive and they have nothing to offer them" (DORCAS AID).*

Apart from the financial resource challenges, other challenges with the community strategy included inadequate M&E systems, with no baselines against which to assess performance progress. There were also policy bottlenecks since there was no community health services policy to guide its implementation. An opportunity exists in the current development of community health services policy and in the review of the strategy for alignment to the new policy.

> *"Ideally they should be informed by data but these areas are the ones that do not have personnel to generate data" (County Community strategy head- Kajiado)*

The data capture mechanisms at the health facilities was also identified as a gap, noting that the service providers did not prioritize data capture and reporting.

Recommendations

Administrative units provide potential mechanisms through which health issues could be articulated. The units were respected in the community and ownership of health issues by the local leaders, especially those issues that were heavily impacted by the socio-cultural context, could achieve great milestones when approached this way. If/ when the nymba kumi initiatives are implemented, they would form alternative approaches for community health strengthening.

Stakeholders recommended integration of community strategy into the health care worker training curriculum so that it is well understood by the health work force at all levels. This will ensure that as the HCWs exit the training institutions, they have adequate background and knowledge on the community strategy and that no additional resources will be required to provide them with this training.

CHW incentivization mechanisms (policy issue) will need to be put in place. The incentivization mechanisms will need to be sustainable without over dependence on the implementing partner support, as was the case at the time of this study.

While strengthening the strategy as is currently, it will be important to prioritize distribution of reporting tools on time to make reporting functional.

Other Strategies that can be explored to expand access and utilization of services may include introduction and strengthening of nomadic clinics to incorporate the nomadic lifestyle and provide healthcare at point of need. In health education, women groups may be targeted as a health education forum and women group leaders trained to pass information. Short term strategies will include expansion of ambulance services to cover remote areas. This will ensure that the populations in remote locations are served. Outreach activities will need to be expanded and budgetary allocations should not be left in the hands of the partners but rather, should be factored in by the government as well.

Components of SRH that would require great support from the CSO partners included: specialized services such as vasectomy, BTL and the outreach programs. CSOs will also need to expand health education activities aimed at strengthening advocacy for access and utilization of skilled delivery and attendance of antenatal clinics. Nutritional support for pregnant mothers and children under five will also be an overriding priority in future programs.

Engagement with the County government in planning and performance management for health services in the ASAL counties should include development of interventions targeted at sparsely distributed populations and pastoralist communities with health education and service provision activities targeted at expansion of MNCH access.

Health promotion activities should be emphasized at the community level and at the lower health facility levels. CSOs should also focus on School health programs, specifically targeting immunization, Vitamin A and deworming programs.

Maternal health particularly facility/skilled delivery, focused ante-natal clinics and EMTCT. Child health should focus on infant and young child nutrition. Neonatal care should include expansion in equipment such as incubators, baby warmers, establishment of new born baby units etc.

Another recommendation that was specific to Kitui County was on expansion of CSO support for GBV survivors. This recommendation was in the light of the high prevalence of GBV in Kitui County.

4.1.4 Resource Flow for SRH and MNCH Programs in the ASAL Counties

The main source of financial resources for health include budgetary allocation to both levels of government; Equalisations fund to be managed by national government or by counties as conditional grant for health; Through grants or donation from a development partners/ charitable entities to both levels of government; Through money raised by counties through taxes and licenses an through Loans. Under the Constitution and the PFM Law, each sector has the power to approach donors for funding In addition, the constitution guarantees the powers of the county government to enter into public private partnership (PPP) arrangements.

The main sources of resources were from the development and implementing partners, national and county governments. The main contributions of the county government in resourcing of the health sector were mentioned to include staff employment and construction of structures. Most of the SRH resources provided by partners were erratic and based on availability of funds. There were no guaranteed continuity in CSO support to the sector and at times, the support could be stopped abruptly and without notice. Activities supported by CSOs where funds allow include capacity building and provision of equipment/ medicines for use. CSOs were involved in decision making though the stakeholder forums where the county government discussed joint strategic planning with them. It was also an opportunity for CSOs to position themselves/activities in the county. The activities implemented by CSOs were informed by evident need as recognized by the government partners. The CSOs implementing RH activities were however noted to be low in number and there was call for scale up in CSO activity in the RH program in the ASAL.

"The CSOs interventions are in line with the county needs as they come here for baseline surveys. They are even more aligned than the national government plans to our needs," (CHMT).

Some CSOs were however reported to come up with fixed work plans and imposed them on the target communities and the partners.

In Kajiado County, the main sources of resources for MNCH were county government, partners such as UNICEF, Feed the Children and ADEO. Support is through the provision of equipment and funds to implement activities. County government resource allocation was far from adequate in terms of human resources and supplies. CSOs participated in strategy planning for the county and CSO support was integrated into government county framework in the planning sessions. The CSOs were noted to engage consultatively with the relevant government department on the identified needs. CSOs integrated their work within MOH structures in the following ways: strategic planning, participating in steering group and technical working groups meetings. CSOs also attended quarterly health facility in-charge meetings and worked with county health management teams in order to prioritize the

"…… However many times, the CSO partners have their priorities and try to impose these on the county because they have access to donor funds and push for their implementation agenda." CHMT- Tana River

needs of the county. The CSO priority setting was however noted to be donor driven in some cases and that at times, the priorities were not in line with county priorities. Because of their resource provisions in the sector, the CSOs were also noted to at times dominate decision making processes. The same case applied in Kajiado County in which the CSOs played a significant role in resource allocation for MNCH and are also involved in county planning, drafting of action plans such as the nutrition action plan, support outreaches, structural construction, providing hospital equipment and personnel. Resources were minimal and could not facilitate supportive supervision to strengthen some of the already identified gaps.

Recommendations

Many stakeholders including both healthcare workers and CSOs did not understand resource allocation in the health sector and resource flow from the two levels of government. For better harmonization of resource flow, there was evident need to strengthen resource planning and coordination mechanisms with joint planning between the county government and the partners. Continued participation in the relevant forums would enhance synergy in partner efforts, priority setting and continued performance monitoring in the sector.

Joint planning should be moved a notch higher to include joint proposal writing for donor/ DP support. In this arrangement, the implementing partners will write a proposal jointly with the government, capitalizing on their diverse strengths and potential areas of synergy. Currently the Health Sector-Wide Approach "Health-SWAP" brings together government, donors, NGOs, the private sector and civil society. With devolution the definition of government refers to 48 entities. The SWAP approach will need to be decentralized so that there is adequate coordination of stakeholders and resources within the counties

Food security and sustainable livelihoods should be included as a long term solution to the extreme food needs in Tana region. This will help curb the recurrent food shortage that greatly compromises the county performance on nutrition. Health implementing CSOs should engage with other stakeholders in the County to explore innovative approaches to food production.

The areas of MCH which were identified to require more resource support included Behavior change and advocacy activities on family planning and uptake of safe deliveries through skilled personnel. Expansion of community health strategy will help achieve key objectives of MNCH. Antenatal care services could be scaled up through the outreach activities, while provision of youth friendly services was emphasized as a key recommendation to expand service utilization by the youthful population segments.

Integration of stakeholder activities can be improved by having a coordination body/office for government and CSO and timely communication to enable joint planning. Priority setting can be improved by improving the scope of projects already identified and diversifying issues.

The CSOs in the relevant sectors with experience in strengthening devolved governments to identify revenue sources and to raise revenue should support the ASAL counties to be able to generate resources from diverse sources, plan, budget and oversee spending efficiently

4.1.5 Stakeholder Engagement

There were no specific stakeholders' forums for SRH where SRH issues were discussed by implementing partners, in Tana River. The RH issues were however discussed in the general health stakeholder forums that were held once every quarter. The stakeholder forums were usually supported by partners and organized by the county health department. The stakeholder forums were not consistent at the time of the study, an observation that was attributed to reducing partner funds.

In Kajiado County, there were nutrition coordination meetings in which nutrition issues were discussed. The forums were coordinated by the county health teams and funded by partners. It was however noted that the meetings had not been held in the previous one year, as at the time of the study. In Tana River County, there were quarterly technical forums for nutrition and SRH. Nutritional stakeholders' forum was held monthly and was acknowledged to have greatly contributed to improving nutritional interventions in the county. In all counties, the stakeholders' forums were mainly funded by CSO partners who were usually the main participants together with relevant Government departments. The forums, managed by county health officials and supported by partners, did not however take place when the partners did not provide financial support. Alternative forums that were established by CSOs in advancing MCH and MCH access and utilization in community level forums such as dialogue days, leaders meetings and health talks at facility level.

In Kitui, the main stakeholders' forum that existed in the county was a general forum for all health partners held once per quarter. It was acknowledged by the stakeholders that this may not be a very useful forum as specific issues were not discussed but general health issues with each given inadequate time.

Quarterly stakeholder forums depend on availability of resources "only one has been held this year" (CHMT Kitui). CSO participation can be increased through joint planning to avoid duplication and even distribution of partners in the county "some areas tend to attract CSOs than others" (CHMT)

CSO attendance and participation is very high (without their attendance and support there would be no forums"(County health director- Kitui).

Recommendations

There were evident needs for county health management teams to meet more regularly to analyze gaps and seal them appropriately. Technical working groups should be established for each of the sub themes in each health program area to allow for routine monitoring of the context and implementation of adoptive/ responsive mechanisms

SRH should have its special forums to discuss its issues as opposed to joint forums for the entire sector which did not allow adequate time to exhaustively discuss RH issues. CSO coordination will need to be strengthened. The IPs implementing RH for example will need to be better coordinated so that activities are harmonized and resources prioritized to achieve the desired results. The coordinated network of the IPs at the county level will also provide a forum for united voice and communication with the

government. Rather than having a generalized health forum, specific sub sector forums will enable more meaningful and effective coordination.

4.2 Research Question II: What are the gaps in the actual and expected CSO roles in advocating and strengthening MCH and SRH programs and policies at the county government?

4.2.1 General Overview

Section 43 (1) of the Constitution states that: 'every person has the right to the highest attainable standard of health including reproductive health care'. In addition to this, specific RH policies exist and include the National Reproductive Health Policy (NRHP, 2007); the National Reproductive Health Strategy (NRHS, 1997-2010); the National Roadmap for Accelerating the attainment of MDGs related to Maternal and Newborn Health in Kenya; and the Adolescent.

Devolution, as per the provisions of the constitution, recognizes the right of communities to manage their own affairs and to further their development; recognizes protection and promotion the interests and rights of minorities and marginalized communities as a priority; envisions social and economic development and the provision of proximate, easily accessible services throughout Kenya. The Kenya constitution 2010 guarantees health for all. The following articles touch directly on health as a right:

- Art. 26;Every person has the right to life
- Art.42; Every person has the right to a clean and healthy environment
- Art. 43. (1) Every person has the right— (a) to the highest attainable standard of health, which includes the right to health care services, including reproductive health care
- Art. 53. (1) Every child has the right—(c) to basic nutrition, shelter and health care
- Art. 56. The State shall put in place affirmative action programmes designed to ensure that minorities and marginalised groups—(e) have reasonable access to water, health services and infrastructure.

Devolution of the health systems was aimed at promoting access to health services throughout Kenya; addressing discrimination of the low potential/ marginalized areas.; addressing problems of bureaucracy in matters of health service provision especially procurement related problems; promoting efficiency in the delivery of health services; addressing problems of low quality of health services

Participation of citizens in making and implementing public policy decisions is a core national value and principle of governance as provided by the constitution. Historically, the civil society sector has always played key role in promoting and claiming the rights of different social groups. CSO should create space for their engagement through identification and strengthening of the relevant platform and audience in advocating such rights. The CSOs have long history not only in supporting health sector but as well other sectors within the marginalized areas. The experience and wealth of knowledge accumulated over time would be a great asset that would guide planning and implementation of strategies within the health sector. Non-state actors including CSOs were not however adequately consulted and involved as independent partners in the health sector planning at the devolved levels. This was as a result of ineffective coordination mechanisms.

4.2.2 Constitutional Provisions and Devolution

The Kenya health policy framework (KHPF) and the National health sector strategic plan (NHSSP) were considered key strategic documents in the sector and that would guide program implementation if well-tailored to the ASAL context. There were however fears that it might take time to interpret the strategies and policies to serve ASAL areas, noting that ASAL are unique settings and that the strategies were broad and generic to covers the entire nation, without putting into context the regional diversities. The stakeholders noted that there was limited support from the national government and that the funds allocated to the county governments in the ASAL were inadequate to meet the needs, including execution of functions that had been transferred from the national to the county government. Devolution had enhanced supply of the commodities in the ASAL counties since they decision making on the procurement of such commodities had been decentralized. The procurement was context specific and hence only the required commodities were procured. Referral systems were noted to be adequately in place. Although human resource strengthening was still a challenge, allocation of resources and recruitment of staff was noted to have received some attention from the county governments and that it was among the priorities of the these decentralized governance structures.

"There are no identified threats posed by devolution, instead there are more advantages as the services have been moved closer to the communities". "It is easier to lobby for funding for local issues as they are understood by the local counties and it comes faster if not immediately". Devolution has enabled more staff to be employed and retained. "Look at those houses they have no reason to leave the county as they are accommodated". "KHPF 11 and NHSP looks at issues at the national level/general level. "The real unique needs of the ASAL areas are not factored in. There is need for specific health plan for the ASAL areas as opposed to the big plan for everybody". CHMT- Tana River

Political choices interference was indicated as one of the prime challenges to adequate implementation of MNCH/ SRH programs and that decisions were made based on how popular they were with the population.

"When fully implemented, it would be an answer to the local health needs since there is already a change with the limited implementation that is being conducted. "I needed an anesthetic machine for the operating room it has already been ordered what the national government has never done in years"(SCHMT Hola).

"Poor understanding of health issues by policy makers in the county and decisions made are based on political mileage as opposed to health needs. One of the prioritized health needs is building of mortuaries to preserve cadavers." (CHMT- Kitui)

There was a perception that nutrition was not a priority in the national government and that the same trend had been passed on to the county government. There were therefore proposals that the ASAL county governments should develop context specific policies and strategies to improve nutritional services.

In Tana River, insecurity was noted to have greatly hindered access and utilization as health ceased to be a priority. Flooding and food insecurity were also noted as other highly prioritized challenges that required response and that made health a lesser priority.

MNCH and SRH needs of ASAL counties are unique. The uniqueness needs to be factored in planning and the provisions of the constitutions and the health sector

"The unique maternal neo-natal health issues in the ASAL regions have been given little attention in policy and strategy documents of the Health sector" (CHMT).

strategies need to be incorporated in the county plans and strategies. CSOs can position themselves to better support SRH by joint planning with county government and opening offices in the county as opposed to working from offices in Nairobi. It was noted that some CSOs developed their programs at the national level and pushed their programs to the county level. Working with the CHMTs, the stakeholders noted would allow the CSOs to integrate well and advocate for pro-ASAL area agenda. Benefits of Devolution were seen in better resource management, better service delivery, faster decision making and expansion of health services.

Recommendations

Devolution has been implemented across all sectors and this provides an opportunity for learning on what has worked in the transfer of functions. It will be of interest for the health CSOs to engage with other actors in the other sectors and share experiences on the devolution, including how the CSOs have aligned their support to the devolved systems in the other sectors. This will enhance synergy and learning to foster adoptive change in line with devolution across the sectors. Information sharing between the government and CSOs should be strengthened. Operationalized plans that are informed by devolution objectives, targets and timelines should be shared with stakeholders for ownership and support. This will cultivate proactive engagement among stakeholders that jointly share a vision and are well guided on sector expectations including the expected results of devolution. Again, this will provided the CSOs with an opportunity to assess the plans and objectives against their strategies and identify key areas of linkage that the CSOs may provide technical or financial support.

Efforts should be put in place to increase fiscal transparency and accountability from the CGs to citizens as a means to fight corruption. CSO role is seen in empowering communities to expand citizen participation in CG planning, procurement, social auditing. Capacity building should also target CGs to ensure that they have institutionalized policy to ensure citizen engagement. County information centers should publicize and sensitize the communities on the county policies, plans, revenues, budgets and activities, research, names and contacts, complaints and participatory mechanisms. CSOs should support the county governments to establish information access and utilization forums that would enable interaction of citizens with their devolve governance structure, including their involvement in planning and decision making. The CSOs would be instrumental in strengthening citizen engagement in planning, budget and oversight process. HENNET should strengthen its presence in the sub counties and should have focal persons/ organizations to spearhead such an agenda.

The county governments should develop and adopt responsive mechanisms aimed at addressing the needs at the lower levels of service provision and that operate under the devolved government. CSOs should identify systemic gaps in responsiveness of the county government to such needs and devise strategies for empowerment through capacity building or advocacy activities. Operations research should be conducted periodically on key aspects of health systems strengthening and healthcare provision. This will help generate context specific evidence for action by the county government in a timely manner.

Opportunity exists in the devolution to empower the county governments and health management teams for good governance. Good governance and accountability are known to have a greater impact on performance and outcomes than funding does. The implementation of devolution however requires time and results may not be expected overnight. It therefore calls for patience among stakeholders, while working collaboratively to overcome the obstacles through commitment, learning and corrective

actions based on the implementation experiences. There is need for flexibility since some of the provisions of the legal and policy frameworks on which devolution is pegged had not been implemented in the current context and hence the need to appreciate adoptive changes as appropriate. There will be need to explore and adopt international best practices in devolution as documented based on country experiences where devolution has been effectively implemented to improve healthcare access in similar settings.

4.2.3 Advocacy for cascading international and national commitments to the County level

In Kenya, primary funding for healthcare comes from three sources: public, private and donors. Private providers are attracted by economic factors including the ability to pay. This implies that the private providers are less likely to establish healthcare services in ASAL regions that experience high poverty levels. Kenya is one of the signatories to the 2001 Abuja Declaration, with a commitment of allocating at least 15 percent of its national budget to health. This has not been achieved in the past. In the past, resources have been used to meet curative health care provided in higher level health facilities which are largely inaccessible to poor women and little resource allocation for healthcare services. The decentralization of funds to the county level does not include a policy on the proportion of the funds allocated to the health sector. It is possible that the county governments may not prioritize resource allocation for the health sector. Majority of the ASAL population rely on dispensaries and health centers for service access. These facilities have always received low financial resource allocation with a greater chunk of the government resource allocation (70 %+) going to the secondary and tertiary facilities. The national government still has control on significant health sector budget.

Recommendations

CSOs will need Advocacy for expanded resource allocation for Primary healthcare. HENNET should coordinate its member CSOs working at the county level should establish mechanisms of engagement with the county government to advocate for adequate allocation of resources to the health sector at this level. Healthcare access/ equity in ASAL should be a policy issue of which the national government should be targeted with advocacy to address.

There should be linkages between the ASAL CSOs and their counterparts at the national level and with the local actors in order to strengthen a continuum of forums for articulation of community interests and establishment of platforms & actions for engagement. Peer networks will ensure local actors and platforms link to national non-state-actor platforms.

The advocacy agenda of CSOs should be evidence based rather than a blanket advocacy for increased resource allocation for ASAL, there should be more focused, need based resource consideration. A central focus for example would be the need for healthcare equity through increased financial and physical access to healthcare services. There is a consensus on equalization fund for the disadvantaged counties. There ought to be a mechanism that specifically addresses the healthcare disparities in regard to equity, an issue that CSOs should emphasize in their advocacy agenda.

4.2.4 Sensitization of Citizens for awareness creation on social accountability

In community participation CSOs have remained the main financing mechanism for outreach activities. The outreach activities play pivotal role in linking health facilities and communities. Chapter eleven of the constitution of Kenya (2010) on devolution stipulates the requirement for the transfer and distribution of some state functions to smaller, semi-autonomous units of government. Health is among

the social services that the county governments have been mandated to oversee. Devolution provides an opportunity for the county governments, working with the local stakeholders, to devise context relevant innovations and to prioritize health issues. The proximity of County governments to their communities makes it possible to win community confidence and trust through inclusion in development issues using participatory approaches. One of the aims of devolution is to create more intense community involvement in order to adjust service delivery approaches to communities' specific needs. The county governments are responsible for provision of primary healthcare, an important component for provision of basic MNCH services and that is responsive to the health MDGs.

Recommendation
Awareness creation and sensitization of citizens about the services available in health facilities and how to demand for missing services and medical supplies is a key mandate of the CSOs and local leaders. Through a strengthened community engagement platform, the citizens are able to ensure that health is prioritized in projects funded using the devolved funds. Civil society oversight of procurement, community planning forums, CA public hearings, performance management plan targets/ progress and citizen advisory boards are priority areas of CSO work that will need to be emphasized in the advocacy agenda.

4.2.5 Capacity building of relevant institutions on Devolution and Relevant Legal Frameworks

The main challenges of the transition that had been preempted prior to the implementation of the 2010 constitution of Kenya included: Institutional competence and capacity gaps; inadequate knowledge and understanding on the Constitution and devolution; resource constraints. There was inadequate understanding on devolution (legal policy frame works; devolution of functions) among the CSOs and the health care worker. A number of CSOs have not internalized the Kenya health policy framework 2012-2030 as well and the health sector strategic plan. These two documents came as a result of the revision of the previous versions of the policy and strategy documents and were aimed at aligning the health sector short term and long term plans to the current constitution.

Recommendation
There was evident need to the need for capacity building through training on Legal framework that guide devolution including County health strategic investment plans, the County Government Act, the Health policy, the Intergovernmental relations act, and the public finance management act etc. Understanding of these policies and strategies will enable the County stakeholders including the CSOs to understand how the health sector strategies and operations fit within the devolved system of governance. Empowerment initiatives may be implemented through trainings and joint planning activities with the CHMTs and Sub County HMTs where such policies and strategic documents guide program planning.

4.2.6 Empowerment of health service providers and Citizens on Human rights based approaches

Corruption has been highlighted in a lot of literature as one of the underlying factors that have prevented realization of full potential and returns from healthcare investment. Sensitization of the communities on their rights to healthcare and on social accountability will enable the citizens to be proactive in participating in healthcare planning including decision making for resource allocation. They will also act as watchdogs and whistle blowers for their own resources to ensure that the healthcare investment achieves the expected returns. The human rights- based approach to health

services provision, stipulates that services providers and services users have rights and responsibilities that complement each other. One of the biggest challenges experienced in developing countries lies not in the ability to develop sound policies and strategies but the ability or commitment to implement established policies and strategies. CSOs act as watchdogs and advocates for MNCH and RH policies and commitments especially in regard to the rights of the marginalized populations

Recommendation

Awareness creation among the health care workers on the right to health, in line with the Constitution will be an important strategy that will empower the two levels to engage with CHMTs in pursuing quality health for the local population. . Participation of CSOs in policy and strategic planning platforms at the county and national levels will enable them represent the citizens in ensuring that the state is accountable in allocating and managing public resources and that the policies, plans and achievements in implementation are a reflection of their expectations.