A Further Analysis

of the Kenya Service Provision Assessment

2004

Summaries of Selected **NCAPD Working Papers 2008**

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THE *KENYA WORKING PAPERS* SERIES is an unreviewed, unedited prepublication series of papers reporting on studies in progress. The papers summarized here are based on further analysis of data collected in the 2004 Kenya HIV/AIDS and Maternal and Child Health Service Provision Assessment (KSPA).

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The views expressed herein are those of the authors and do not necessarily represent the views of the Government of Kenya, NCAPD, USAID, UNICEF, DFID or the organizations with which the authors are affiliated.

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Abbreviations

AIDS	Acquired immune deficiency syndrome
ANC	Antenatal care
ART	Anti-retroviral therapy
ARV	Anti-retroviral drugs
DHMB	District Health Management Board
DHMT	District Health Management Team
DHS	Demographic and Health Survey
DMOH	District medical officer of health
DPHN	District public health nurse
EmOC	Emergency obstetric care
FBO	Faith-based organization
HIV	Human immuno-deficiency virus
HRD&M	Human resource development and management
IEC	Information, education and communication
IMCI	Integrated management of childhood illnesses
KDHS	Kenya Demographic and Health Survey
KSPA	Kenya Service Provision Assessment
MCH	Maternal and child health
NCAPD	National Coordinating Agency for Population and Development
NGO	Non-government organization
NHSSP	National Health Sector Strategic Plan
PMTCT	Prevention of mother-to-child-transmission (of HIV)
STI	Sexually transmitted infection
VCT	Voluntary counselling and testing
WHO	World Health Organization

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Background to the 2004 Kenya Service Provision Assessment (KSPA): Further Analysis

By Paul Kizito, Laurie Liskin, Vane Lumumba, Kiersten Johnson, Samuel Ogola and Ani Hyslop

INTRODUCTION

The 2004 Kenya Service Provision Assessment (KSPA) collected information on the preparedness and capacity of the formal health sector to provide basic and advanced level services for child health, maternal health and family planning, as well as HIV/AIDS and other communicable diseases. Information collected was similar to that from the 1999 KSPA, and supplementary to household information on demand for services from the 2003 Kenya Demographic and Health Survey (KDHS). Additional information on supervision was also collected from District Health Management Teams (DHMTs).

Results from the assessment were disseminated to key stakeholders at both national and regional levels. The information was shared with over 500 participants drawn from government departments, non-government organizations (NGOs), private health institutions, the private sector and development partners. The objectives of the dissemination seminars were to:

- Share the key findings related to the services assessed with data providers and data users.
- Promote and increase the use of the 2004 KSPA data for programme planning and evaluation.
- Familiarize participants with the SPA methodology and format of the report for use in decision making.
- Identify the priority areas needing further investigation.

JUSTIFICATION FOR THE FURTHER ANALYSIS

Dissemination workshops for the KSPA revealed gaps in knowledge around key elements of health service provision that could not be addressed without further analysis of the data beyond what had already been completed for the final report. Some of the issues for further analysis were raised by participants in regional and national dissemination seminars and during data users' workshops. It was thus deemed important that further analysis be undertaken in an effort to fill the gaps.

The objectives for the further analysis were to:

- Build capacity of Kenyan researchers to analyse and use KSPA data sets (including linking KSPA, KDHS data and other related surveys.
- Conduct programme-oriented analysis to inform policy, programmes, and decision making.

- Provide information on reproductive health services that help to inform the observed trends in Kenya's contraceptive use prevalence and fertility rate.
- Build on lessons learnt in the design of future KSPA surveys.

TOPICS FOR FURTHER ANALYSIS

After the regional and national seminars, a meeting of over 30 experts was organized by the National Coordinating Agency for Population and Development (NCAPD) to brainstorm on gaps and issues that need to be further analysed. Participants were first given an overview of the 2004 KSPA, after which the key gaps identified from the disseminations were shared. They were then divided into different groups depending on their expertise. Key areas for discussion were identified as: maternal health, child health, family planning, HIV/AIDS, and district-level analysis of the national health system. Each group had a policy person and a technical person in the specific areas. These areas were later synthesized and specific study topics were generated as follows:

a.) ***Maternal health: Influence of provider training on quality of emergency obstetric care in Kenya:*** Studies show that quality emergency obstetric care (EmOC) services need to be available to every pregnant woman over and above health worker responsiveness to life threatening complications. In this analysis we test the hypothesis that there is a positive relationship between service provider training and provision of quality EmOC services.

b.) ***Child health: Child health services in Kenya:*** Holistic approaches to improving child survival, such as the Integrated Management of Childhood Illnesses (IMCI) strategy, are practices that have been shown to improve health outcomes for children. This analysis examined the current practices in the management of childhood illnesses and identified opportunities for intervention.

c.) ***HIV and AIDS: Meeting the HIV-related health care needs of Kenyan youth:*** The purpose of this analysis was to describe the types and locations of facilities that are most in need of improving service provision to youth; where youth were most likely to go to get services related to sexually transmitted infections (STIs) and HIV, and which facilities were most likely to fail in the provision of selected elements of service provision.

d.) ***Family planning: Evidence from Kenya's 2004 Service Provision Assessment on family planning services in Kenya:*** The specific task of the research was to identify the factors associated with readiness of Kenyan health facilities to provide quality, appropriate care to those seeking contraceptive services; to assess the degree to which health care providers foster informed selection of an appropriate contraceptive method; and to assess the extent to which clients perceive services to be of high quality.

e.) ***Integration of HIV-related and family planning services:*** As Kenya experiments with a strategy that seeks to implement the integration of family planning and prevention of mother-to-child-transmission (PMTCT) services, this paper analyses the extent to which family planning services have been and can be integrated into PMTCT services within health facilities and programmes in Kenya. Specifically, the analysis sought to determine the proportion of family planning sites that also provide PMTCT services on-site or

within the same facility, and the proportion of PMTCT sites that provide family planning counselling or other family planning services on-site or within the same facility.

f.) ***District level analysis of the national health system:*** Effectiveness of health service provision, especially within a decentralized health framework depends on the strength of the district level institutions. To assess the current effectiveness of the DHMTs in meeting their responsibilities, data from the 2004 KSPA were analysed to determine the degree to which DHMTs meet the norms and standards on governance, management and human resource development as stipulated in the establishment. This phase of the analysis also sought to determine the degree to which procurement plans and the mechanisms of management of stores exist in the districts and are followed; to describe the state of infrastructure, equipment and communication in the districts; and to describe the source of funding for medicines, equipment and building maintenance in the districts.

TEAM SELECTION PROCESS AND TRAINING

Following review and approval of the research topics by Macro International and NACPD, a call for proposals was issued requesting experts to form teams that included a health specialist, a demographer, and a graduate student or new professional, all with expertise in the relevant area. The proposals were vetted by a committee including the participation of Macro International and NACPD and the best bidder was selected. There was a detailed training of the selected teams by a facilitator from Macro International for a duration of one week in June 2007. This was largely participatory, involving the refinement of the research questions and the data to be used from KSPA 2004. Group work and plenary presentations created an opportunity for review and further refinement. The facilitator also took the teams through the process of writing journal abstracts and papers.

The teams embarked on the literature review, analysis and writing of the manuscripts. There was extensive communication between the writers and the reviewing committee members and the facilitator from Macro International. This interaction was particularly fruitful especially with the provision of current literature from Macro International on the relevant topics. On three occasions, the teams met to give presentations on their work, share their difficulties and successes during the course of their research, and receive constructive critique from other research team members.

Each of the study teams worked on its papers using analysis plans that members had developed themselves. The results of the analyses have been compiled by the teams into working papers that were presented at a stakeholder workshop held on 4 June 2008 in Nairobi. The feed back from this forum has been incorporated into the final working papers. The summaries presented in this publication were prepared by the authors to provide a snapshot of the research. The reports containing summaries of the main papers are on the Macro International and NCAPD websites.

CHALLENGES

A workshop to kick off the further analysis process is an excellent idea and was fully appreciated by the researchers. Time remained a key limitation, however, as one week is not adequate to achieve teambuilding and cover the preparatory ground for data analysis. In

future, more time should be dedicated to allow the researchers to focus exclusively on these complex and time-consuming analyses. Generally there was limitation on some of the questions for which data were not available. These limitations are outlined in each of the summaries as appropriate.

SUMMARY ONE

Influence of Provider Training on Quality of Emergency Obstetric Care in Kenya

By Joyce Olenja, Josephine Kibaru, Thaddaeus Egondi and Pamela Godia

INTRODUCTION

Along with infectious diseases, maternal and neonatal conditions account for a substantial part of the health gap between rich and poor countries; for example, more than 99% of maternal deaths occur in the developing world. The majority of the deaths are due to direct obstetric complications including haemorrhage, sepsis, eclampsia, obstructed labour and unsafe abortion practices. Studies show that most women who develop complications do not have any known risk factors and there is no way of knowing whether they will develop any of them. Therefore, quality emergency obstetric care (EmOC) services need to be available to every pregnant woman over and above health worker responsiveness to life threatening complications. In Kenya, the ratio of basic and comprehensive EmOC services to 500,000 people is 2.7 and 1.7 facilities, respectively (KSPA, 2004).

In addition to demonstrating that many facilities offering obstetric services lack the equipment and basic supplies necessary to support the provision of quality antenatal care (ANC), delivery and postnatal care (PNC) services, the 2004 KSPA further showed that health providers' levels of knowledge, competency and skills are not up to date with the recommended practices. While training of service providers is an important element in the provision of quality maternity care, less than 20% of health workers interviewed had received training in focused ANC or PNC in the last three years. Among caregivers providing delivery services, only 18% had received training in life-saving skills, while 37% had received training in prevention of mother-to-child transmission of HIV (PMTCT) during the last three years.

Conceptually, it is envisaged that specific key inputs are essential and that these interact synergetically to produce improved quality of care, which engenders high client satisfaction and hence greater demand for and utilization of the services. These key inputs include availability of EmOC services per 500,000 population, emergency transport, availability of essential supplies and equipment, 24 hour availability of health personnel, use of partograph, and well-trained health workers. In this paper we focus on the element of training. We test the hypothesis that there is a positive relationship between service provider training and provision of quality EmOC services.

DATA AND METHODOLOGY

Subsequent to the 2003 KDHS, Kenya implemented a nationally representative survey of health care facilities, the 2004 KSPA. This survey focused on basic-level health services, particularly those important for women and children. For this analysis, we focus on the maternal health component, which assessed counselling and screening during ANC visits, the environment available during labour and delivery, and postnatal care. To identify predictors of quality provision of EmOC, we selected for analysis the subset of 185 of the health care providers to whom both the health worker interview questionnaire and maternal health provider knowledge questionnaire were administered.

Dependent Variable

Our definition of quality care was based on the recommended actions that must be taken in case of particular obstetric complications. Each correct action was given a value of one point. Providers who mentioned four or fewer actions were classified in the poor quality category, while those who mentioned five or more were classified in the good quality category. Level of care quality was therefore classified as either poor or good. This binary classification was adopted for the multivariate analysis.

Statistical Analysis

The unit of analysis for this study was the health care providers to whom both the health worker interview and maternal health provider knowledge questionnaires were administered. Since a sample of available providers was selected for interview, the provider's weight was used in this analysis. Bivariate analyses were conducted using chi-square tests of independence. Logistic regression was used to assess the association between in-service training and the provision of quality care, adjusting for the described independent variables.

RESULTS

Univariate Results

All health workers interviewed indicated that they provide delivery services and most provided ANC/postpartum care (99%). The majority of providers interviewed were male (87%). Overall, comprehensive knowledge of actions to take in the event of a retained placenta is low among relevant service providers: fewer than one-quarter of obstetric caregivers have the knowledge-based ability to provide good quality care under these circumstances. Service providers trained in life saving skills in the past one or two years were more likely to have the knowledge required to provide good quality care in the event of a retained placenta and in the event of postpartum haemorrhage, compared with those who had not received recent training (p-value 0.029 and 0.001).

The association between training in post-abortion care and knowledge to provide good quality care was statistically significant only in the event of unsafe abortion (p-value 0.025). Health providers from either government or non-government managed facilities were not different in their knowledge of how to provide good quality services for complications resulting from any of the complications. Health provider category was significantly associated with quality care provision in case of retained placenta and postpartum haemorrhage (p-values 0.008 and 0.003, respectively). Registered nurses/midwives were

more likely to have the knowledge to provide good quality care for women with retained placenta and postpartum haemorrhage.

With regard to facility type, ability to provide good quality service was below 50% for all categories, with hospital-based providers faring the best in any of the three complications and clinic/dispensary-based providers faring the worst. Years of experience was found to be associated with quality care provision for both retained placenta and postpartum haemorrhage complications (p-values <0.001 and 0.006, respectively).

Multivariate Results

Retained Placenta. In the bivariate analysis, a provider's ability to name actions for management of retained placenta was significantly associated with training in life-saving skills. After adjusting for facility type, the years of providing delivery services and operating authority, the health providers who received in-service training in life saving skills were 2.5 times more likely to demonstrate ability to provide quality service based on actions named for clients with retained placenta complications (p=0.084). The provider's ability to name the appropriate actions for clients with complications of retained placenta was also found to be associated with the facility type and the number of years the provider had been providing delivery or ANC services. Compared with clinic/dispensary, providers from hospital were 4.2 times more likely to name appropriate actions (p=0.064). The more years of experience health care providers had with delivery services, the more likely they were to be able to name appropriate actions for handling clients with complications of retained placenta. This relationship attained significance only for those who had been in practice for ten or more years, although the evidence for this association is not very strong.

Unsafe Abortion. Considering appropriate actions for clients with complications from unsafe abortion, training in post-abortion care was found to be significantly associated (p=0.046) with the naming of appropriate actions in handling women presenting with such complications. After adjusting for other characteristics, providers who trained in post abortion care were 3.8 times more likely to name the appropriate actions, compared with those who did not receive the training. Training is the only variable in the model that is significantly ($p<0.05$) associated with appropriate knowledge of post-abortion care.

Postpartum Haemorrhage. After adjusting for facility type, managing authority and the cadre of the provider, providers who had in-service training in life saving skills were more than three times more likely than those who did not have recent training to name several actions for managing clients with postpartum haemorrhage complications. Additionally, health care providers from the hospitals were three times more likely to provide good care for women with postpartum haemorrhage complications than providers from clinic/dispensary facilities, and those in practice for the greatest number of years were over six times more likely than those in practice for the fewest number of years to cite appropriate interventions.

CONCLUSIONS AND RECOMMENDATIONS

Evidence from a variety of studies isolates training as one of the key elements necessary for the provision of quality care. Appropriately trained personnel and provision of necessary supplies and equipment and supplies and equipment are critical to the development and implementation of EmOC services. Our analysis has demonstrated that training is a critical element in the detection and management of complications. Recent training in relevant

subject matter was found to be significantly ($p<0.05$) and positively associated with the ability to provide quality care in the event of unsafe abortion and postpartum haemorrhage; training was also positively associated with the ability to provide appropriate care in the event of a retained placenta ($p< 0.10$).

The obvious recommendation is to ensure that up-to-date, quality training is provided to a broad base of health workers at all types of facilities, particularly at local facilities that are the first point of contact for women experiencing an obstetric emergency. A discussion of details on how to implement training programmes more broadly, especially in the face of staff shortages, is beyond the scope of this paper. It is recognized, however, that there are logistical obstacles to increasing the number of health workers who receive training. Further, although we isolated the element of training for this analysis, it is clear from these findings that for optimal service outcome, quality of care training has to be undertaken within the context of improved infrastructure as a support to service delivery.

SUMMARY TWO

Child Health Services in Kenya

By Annah Wamae, George Kichamu, Irene Muhunzu and Francis Kundu

INTRODUCTION

The Kenyan government is committed to the achievement of the primary target of Millennium Development Goal number 4: reducing the infant mortality rate by 21% and the under-five mortality rate by 32% by the year 2015. In order to reduce mortality among children under five, the Government of Kenya through the Ministry of Health has developed and implemented new approaches to child survival efforts. One key child survival strategy, Integrated Management of Childhood Illnesses (IMCI), promotes the use of every opportunity by the provider to assess a child's current status and take preventive measures, and has been recommended as a cost-effective intervention. In the 2004 KSPA survey, child health service provision was compared with standard guidelines for IMCI. The survey shows that four out of five facilities offer all three basic child health services (curative care, immunization and growth monitoring). In all three, however, there are gaps in providing these important basic and preventive care services.

Prevention

Opportunities to promote preventive health interventions each time a child is brought to a facility for consultation are being missed. Among these are assessments of immunization, weight and feeding practices for children under 24 months. This also contributes to an explanation of the decrease in overall immunization coverage and existing levels of chronic malnutrition documented in the 2003 KDHS. Assessment for general danger signs (cough or difficult breathing, diarrhoea, and fever) in sick children is also poor.

Treatment and Counselling

Treatment guidelines offer service providers updated and approved recommendations for medication and infection control. Guidelines of any kind, including the new WHO-prescribed IMCI guidelines, were available in less than a quarter of facilities offering sick child services, while treatment protocols were found in only one in five facilities. Although many child illnesses can easily and safely be treated at home as long as caregivers know what to do and what danger signals to watch for, the 2004 KSPA results indicate that most health care providers fail to help caregivers protect children's health. Few counselling materials and visual aids are available and where they exist, they are rarely used.

Quality of Care

IMCI strategy aims at ensuring good quality of health services by improving health workers' skills in case management of childhood illnesses. KSPA results show that a very low proportion of child health providers had received in-service training related to IMCI during the 12 months prior to the survey.

Conceptually, holistic approaches encompass components from the health facility such as availability of drugs and supplies, from the health system such as skills training, and from

the family and community component of care-seeking practices. Using this conceptual framework, the study analyses client observation, exit interview and facility inventory data from the 2004 KSPA to describe the degree to which Kenyan health care providers take a whole-child approach to health care, as well to discern the factors associated with the practice of a holistic approach to child health care.

DATA AND METHODOLOGY

To address the research question, data from the 2004 KSPA, which covered a total of 440 health facilities in Kenya, were analysed. The survey included all levels of facilities (i.e., dispensaries, clinics, health centres, hospitals, maternities and nursing homes) operated under a variety of authorities including government, private, non-government and faith based. The sample was drawn from about 3,500 health facilities, which were stratified by province and by district before selection.

The data for our analysis of child health service provision were collected using the following instruments: facility inventory questionnaire, health worker interviews, observation of sick-child consultations, and an exit interview of the caregiver of a sick child. *SPSS 13.0* software was used to run frequencies on the variables of interest to this analysis. Bivariate analyses and chi-square tests were also carried out to establish the relationships among the variables and their deviation from normal distributions respectively.

Dependent Variables

The dependent variables were derived from three different KSPA data sets: the facility inventory, health worker interviews, and the observation of sick-child consultations and exit interviews of the caregiver. Three composite dependent variables representing the holistic approach to child health care were created to measure the following: full assessment of sick child, proper counselling of the child's caregiver and facility support services for holistic care of sick children.

Full assessment of the child was based on: whether the provider checked for four major symptoms, checked for three danger signs, asked the caregiver about the child's feeding, checked for immunization and vitamin A status, and conducted proper growth monitoring. Proper caregiver counselling was indicated by the following three variables: counselling on drugs, counselling on child's illness and counselling on feeding. Availability of facility support services was derived from the facility inventory specifically: equipment availability and job aids availability.

Independent Variables

The independent variables used in the analysis include facility type, facility managing authority, region, qualifications of the provider and sex of the provider.

RESULTS

The findings indicate that almost all health providers missed critical opportunities to conduct a full assessment of a sick child. Enrolled nurses compared with registered nurses exceeded the average performance in terms of conducting a full assessment of a sick child, but only 3% of enrolled nurses conducted such an assessment. Providers in Western

Province were most likely to perform a comprehensive assessment of the sick child, and yet only 10% of them did so.

Major Signs and General Danger Signs

The analysis shows that health care providers failed to ask for the major symptoms and danger signs in sick children. Assessment of all four major symptoms and all three danger signs in health facilities is quite low, at 3.2% and 5.9%, respectively. Health care providers at national hospitals are most likely to assess all four major symptoms (7.8%), followed closely by those at clinics (7.1%), while dispensary-based providers are the least likely to evaluate children for all major symptoms (1.4%). The proportion of doctors and enrolled nurses assessing sick children for all major signs and danger signs (16% and 20%, 4.5% and 8.5%, respectively) is slightly higher compared with registered nurses (3.8% and 4.3%) and clinical officers (2.8% and 3.7%).

Complete Physical Examination

Only 4.7% of health care providers conducted a full physical examination of the sick child presented to them. There are marked differentials in the performance of a complete physical examination according to type of health facility, with maternities registering a fairly high proportion of complete exams (14.8%), while health centres registered the lowest at only 3.7%. A comparably large although relatively low proportion of enrolled nurses (12.1%) and doctors (10%) were able to conduct a complete physical examination.

Caregiver Asked about Feeding Practices

Caregivers were rarely asked about feeding practices of sick child during consultations: only 2.5% of providers did so. Although still quite low, the national referral hospital had the highest percentage of caregivers who were asked about feeding, at 6.9%, followed by health centres (2.9%) and dispensaries (1.6%).

Immunization and Vitamin A Status

Only a small proportion of health care providers check for immunization and vitamin A status (4.8%). Providers at health centres performed best at 7.2% in child immunization and vitamin A status, compared with the national referral hospitals and dispensaries (4.0% and 3.2%). There was considerable variation by type of provider, with doctors, enrolled nurses and enrolled midwives most likely to check for both immunization and vitamin A status of the child compared with registered nurses and registered midwives. The child's immunization and vitamin A status were three times more likely to be checked at a government/public facility (6%) than at a non-government facility (1.8%), while female providers were more than twice as likely to check for both vitamin A and immunization status than males (6.9% compared with 2.6%).

Growth Monitoring Properly Done

Overall, 17.3% of the facilities conducted growth monitoring properly. Non-government facilities (19.8%) performed better than government/public facilities (16.4%). Enrolled midwives and doctors were most likely to conduct growth monitoring properly, at 23.8% and 23.3%, respectively, while 18.3% of enrolled nurses, 15% of clinical officers and 14.6% of registered midwives conducted growth monitoring properly.

Counselling of Caregiver

Ten per cent of all health care providers counselled caregivers on oral drugs during the sick child consultations. Male providers were more likely to counsel caregivers than their female counterparts (11.7 and 8.8%). Caregivers in Eastern and Nairobi were least likely to be

counselled on oral drugs (about 2% each). Those in Central (46%), followed by North Eastern (20%), were most likely to be counselled on oral drugs.

The counselling of caregivers on the children's illness was generally poor. Providers in clinics and maternities were the most likely to counsel caregivers, with about one in every five being counselled. Health centres were least likely to counsel caregivers: only one in every ten caregivers was counselled. Doctors (23%) and enrolled nurses (17%) were more likely to counsel caregivers than registered nurses (3.8%) and registered midwives (1%). Female health workers were 1.5 times more likely to advise the caregivers on the illness of the children than male health workers. Findings indicate that caregivers were rarely counselled on feeding – only 6% of providers did so. Counselling on feeding was more likely to be done at maternities (14.8%) and hospitals (12.7%) than elsewhere, with caregivers least likely to be counselled on feeding at health centres (4.8%).

Facility Support

Only 14.4% of child health care providers had IMCI training in the past one year. Referral hospitals and clinics registered high proportion of health providers receiving IMCI training in the past one year at 19.5 and 25%, respectively. Doctors and enrolled midwives were most likely to have received recent training (23% each), while registered nurses were least likely (14.8%). Dispensaries had the lowest percentage of trained health workers at 45%, while clinics and maternities had 48.6% and 48.9%, respectively. There was a notable lack of essential equipment with only 12.5% of facilities having all essential equipment. As expected, hospitals were more likely to be stocked with essential equipment at 21.4%. About 10% of health centres and 14% of dispensaries and maternities were stocked with essential equipment; clinics recorded none.

DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

The results demonstrate that health providers are not following the IMCI guidelines recommended for assessing all signs and symptoms and conducting a complete physical examination in sick child consultations, and thus are missing out on critical opportunities to holistically promote child health.

Generally, doctors, followed by enrolled nurses, are slightly more alert in their assessment and examinations than registered nurses and clinical officers. Female health providers are more likely to assess for all signs and symptoms than their male counterparts. Strategies should be devised to promote the level of commitment of health care providers who are not performing.

Poor assessment and examination of sick children is evident in both government and non-government health facilities. Emphasis of the IMCI protocol and guidelines should therefore be stressed not only at all levels of public health delivery systems but also in private facilities. The low percentage of children whose immunization and vitamin A status was checked may be attributed to the fact that vitamin A supplementation was a new policy, and more government facilities compared with non government were sensitized on vitamin A.

IMCI skills training should therefore be intensified to improve health workers' case management in promotion of child health care in a holistic approach. To ensure that skilled attendance is provided at all levels of health care delivery system, regular supportive supervision needs to be enhanced, especially in dispensaries and health centres.

SUMMARY THREE

Assessment of Family Planning Services in Kenya: Evidence from the 2004 Kenya Service Provision Assessment Survey

By Alfred Agwanda, Anne Khasakhala and Maureen Kimani

INTRODUCTION

Improving quality of care is seen as a necessary goal for family planning programmes worldwide. The is emphasis has been reinforced by efforts to monitor the quality of care at every level of service delivery. Many studies take the perspective that comprehensive and quality family planning services provision must include an assessment of the needs of clients. The programme must offer a variety of methods, and provide complete and accurate information about all methods offered to ensure informed choice. On the other hand, providers should have the necessary technical skills to offer the methods safely, be trained in technically accurate and culturally appropriate counselling techniques, and be able to use this knowledge effectively. Services should be convenient, accessible and acceptable to clients. In addition, follow-up care to ensure continuity of services and an adequate logistics system to ensure a continuity of supplies are essential.

This study focused on two areas related to these core elements: facility readiness to provide quality services and health care provider facilitation of informed method choice. Specifically, the study aimed to identify the factors associated with the readiness of Kenyan health facilities to provide quality, appropriate care to those seeking contraceptive services; the degree to which health care providers foster informed selection of an appropriate contraceptive method; and the extent to which clients perceive services to be of high quality.

Facility Readiness to Provide Quality Services

Facility readiness is defined as a measure of factors that promote delivery of good quality services, such as the availability of infrastructure equipment, supplies and trained staff. Factors influencing facility readiness may range from system-wide targeted interventions such as public and private investments in family planning service delivery, to the management and training of the required personnel, health system laws, and regulations including standards and guidelines.

Provider Ability to Foster Informed Contraceptive Choice

Providers of reproductive health information and services are critical conduits through which clients obtain family planning information and counselling, upon which basis they may make an informed decision about contraceptive use. Service providers are a key component in determining the quality of family planning services, but several barriers may constrain their ability or willingness to provide quality care. These barriers range from local community customs, myths and insufficient knowledge and the limited skills of providers,

to medical barriers and practices based on rationales that limit clients' access to contraception.

Client Satisfaction

The quality of care, whether measured according to objective standards or from the perspectives of clients or providers, is believed to influence reproductive health outcomes through improved client satisfaction and contraceptive use behaviour. Client opinion, especially regarding satisfaction with services, is a subjective way of measuring quality of family planning services. Satisfied clients are more likely to revisit the services, pass on positive messages by word of mouth to others and continue use of a particular family planning method. On the other hand, dissatisfied clients are more likely to narrate their negative experiences to their contacts.

Cultural values, perceptions of the role of the health system and interactions with providers shape client perceptions. These perceptions in turn affect how clients view the risks and benefits of care, which may vary according to the social environment. Nevertheless, some studies have indicated that there are some commonalities in what clients consider as important aspects of quality of care in family planning services. One such factor is the waiting time to receive services, while another is the cost of accessing the services – although clients may also be willing to pay higher costs if they believe that services are of high quality.

DATA AND METHODOLOGY

This analysis uses data from the 2004 Kenya Service Provision Assessment (KSPA), which obtained information from a sample of 440 facilities out a total facility population of 4,742. These facilities included hospitals, health centres, dispensaries, maternity homes and clinics. They were randomly sampled except for the two referral and eight provincial hospitals in the country. The facilities selected provide national and provincial level information on child health, maternal health, family planning and infectious disease through the use of a variety of data collection methods. The data used in this study come from facility inventories, the family planning observation protocol and family planning client exit interviews.

Methods

The study utilized facility readiness, provider service provision and client satisfaction as the dependent variables. Each dependent variable was derived as composite score and further classified into three categories: low, medium and high. The independent variables included in the facility readiness score were the region in which the facility was located, the facility type and managing for facility readiness. Provider service provision included all the variables utilized in the facility readiness and characteristics of the provider (sex) and client (age, education). The client satisfaction model included all the variables utilized for provider provision in addition to waiting time to receive services and whether the provider talked about other methods as a proxy for informed choice.

Analytical Methods

Both bivariate and multivariate regression methods were applied. The main analytical tool utilized in the study was the ordinal regression method since the dependent variables were ranked categories. The model uses the cumulative response probabilities $Yij = Pr(Y< j)$ rather than category probabilities for simplicity and in its general form can be written as:

$$Link\ Y_{ij} = \{?j - [ß_1X_{i1} + \ldots + ß_pX_{ip}]\} / exp[t_1Z_1 + \ldots + t_mZ_m]$$

where:

Yij is the cumulative probability of the j^{th} category for the i^{th} case.

$?_j$ is the threshold parameter some times referred to as the cut off parameter for the j^{th} category.

$X_{i1} \ldots X_{ip}$ are predictor variables that influence the response variable.

$ß_1 \ldots\ ß_p$ are the regression coefficients that account for the linear differences in the response variable (location components).

$Z_1 \ldots Z_m$ are predictor variables that influence the dispersion of the response variable (scale component).

$t_1 \ldots t_m$ are scale coefficients that account for the differences in variability.

The estimates for both location and scale parameters can be presented as cumulative odds ratios. The location ratios greater than one represent the relative likelihood of being placed on higher rank score compared with the reference category. The scale parameter estimates represent the extent to which the dispersion depends on the factor included in the part of the model. Values greater than one represent the extent to which the category tends to disperse compared with the reference category.

RESULTS, DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

The results are based on the cumulative odds ratios for each independent variable (namely, facility readiness, provider performance and client satisfaction). For facility readiness, there are marked differences by location, facility type and managing authority. In particular, government facilities are close to five times being more likely to be ready compared with the non-government facilities. Facilities in North Eastern and to some extent Eastern provinces are less likely to be ready to provide family planning services. Health centres and dispensaries were more likely to have lower scores, but more importantly was the fact that facility type influenced the dispersion of the readiness score.

Provider service provision scores were generally high, with the only important differences in performance scores being the effect of region. In general, the performance was similar whether in government or non-government owned facility, or whether in hospital or lower level facilities. Although concerns have been raised about the way providers interact with younger clients, leading to the clamour for youth-friendly services, provider performance did not differ by age of client or level of education.

Client satisfaction seems to be highly dependent on the facility type, managing authority, sex of the provider and the waiting time. Clients visiting clinics, health centres and hospitals were less likely to be satisfied with services compared with those that had visited maternities. Chances of satisfaction in government supported facilities were far reduced, even though such facilities were more ready to provide quality family planning services. Similarly, clients in Nyanza were less likely to be satisfied although the facilities were much more ready with high performing providers. Clients appeared to be more satisfied with female providers, despite both males and females having similar levels of performance. Waiting time to receive services – as expected – continues to be the greatest source of dissatisfaction.

The composite indicator scores for facility readiness were generally low and the items lacking in the facilities were simple: visual aids, guidelines, towels and speculum. Staff supervision, training and record keeping were key management items that appeared low in many facilities, the most affected being facilities in North Eastern and Nairobi provinces. Provider service provision and client satisfaction scores were generally high. The most noticeable weakness in provider service provision was the use of visual aids during consultation. While visual aids (including manuals, posters, flipcharts and flowcharts) can be valuable and inexpensive tools, their use during consultation may be controversial. Some providers feel that using visual aids decreases their credibility with clients, while others may be inadequately trained and supervised on their use. Nevertheless, studies have indicated that visual aids help clients choose the method that matches their reproductive goals and also enhances quality of care expectations.

When we compare all the models, we find that clients were less satisfied in Nyanza even though Nyanza had facilities that were more ready, along with high performing providers. In contrast, North Eastern Province, with less ready facilities, registered high client satisfaction and high provider performance. Similarly, despite government facilities being more ready, clients were still more likely to be less satisfied with their services.

Other than waiting time to receive services, client perception may also be influenced by provider behaviour. What is intriguing was the fact that clients were more likely to be satisfied with female rather than male providers. This corroborates an earlier study by UNFPA on eight developing countries, which concluded that clients were more satisfied when they were examined by female rather than male providers.

Given these results, it is therefore imperative that programme planners and implementers revamp health centre, clinics and dispensaries to appropriate standards so as to include all basic elements of family planning service provision. In addition, North Eastern Province facilities deserve proper attention since they do have motivated workers and clients who are satisfied but do not have proper infrastructure to provide quality services. Facilities in Nairobi need improvements in supervision and staff retraining as the results do indicate that training has only focused in other regions. There is need to educate the clientele on the availability of appropriate services within government facilities, in addition to improving those factors that lead to client dissatisfaction.

SUMMARY FOUR

Meeting the HIV-Related Health Care Needs of Kenyan Youth: Evidence from Kenya's 2004 Service Provision Assessment

By Robert C.B. Buluma, Robert K. Ayisi and Solomon C.J. Mumah

INTRODUCTION

In Kenya, more than half of all new HIV infections occur among young persons aged 15–24. Early prevention efforts are critical in order to both avoid HIV infection during youth as well as to set good, life-long health habits. One way to ameliorate the HIV-related risks facing the youth is to ensure that young people have access to health services that meet their specific needs. Using data from the 2004 Kenya Service Provision Assessment (KPSA), we assess the strengths and weaknesses of Kenyan health facilities in providing youth-friendly HIV services by identifying the current prevalence of youth-friendly services, establishing differential treatment of youth clientele, and discerning where the need for additional services is greatest.

There is therefore a clear need for youth-friendly HIV services in Kenya, given the high prevalence of HIV in the country and the high levels of risky sexual activity occurring among youth. To increase access to counselling about safer sexual behaviour, to counselling and testing for HIV itself, and to psychosocial and medical support for those who do test positive for HIV, it is important that young people, especially those who are sexually active, have access to youth-friendly HIV services. Grounded in this perspective, we analyse data from the 2004 KSPA in order to assess the strengths and weaknesses of Kenyan health facilities (and the systems supporting them) in providing youth-friendly HIV services in two programme areas – STIs and HIV/AIDS cases. The results obtained are expected to be used for policy formulation, monitoring, evaluation and programming by both the Government and other stakeholders involved in provision of HIV/AIDS health related services.

DATA AND METHODOLOGY

We based our analysis on the 2004 KSPA, which was designed in part to collect baseline information on the capacity of the formal health sector in Kenya to provide both basic and advanced level HIV/AIDS and other health information necessary to monitor trends in facility performance.

Data

The sample used for KSPA 2004 was obtained from a list of 4,742 health facilities in Kenya. These included hospitals, health centres, maternity hospitals, dispensaries, clinics and stand-alone voluntary counselling and testing (VCT) facilities throughout Kenya, managed by various stakeholders including the government, NGOs, private-for-profit and faith-based organizations (FBOs). The study focused on 453 health facilities selected at random from a frame of all the facilities developed for the purpose of conducting the 2004 KSPA, out of which 440 were covered to provide both national and provincial level estimates. Data were weighted during analysis to account for the differentials caused by over sampling errors and to represent the actual distribution of facilities in the country.

Methods

To establish the availability of youth-friendly HIV services and materials in Kenyan facilities, descriptive statistical methods were used to analyse the facility inventory data according to health facility background characteristics such as region, urban/rural, managing authority and facility type. The health facility (n=440) and the STI/VCT units (n=xx) were the units of analysis for this element of our inquiry.

The next step in the analysis was to establish unequal treatment of youth in receipt of HIV-related services. We therefore used STI client-provider interaction observation data and exit interview data. We divided clients being seen at an STI consultation into a youth group (under 21 years of age) and an adult group (21 years of age and older), and looked for differences in key elements of service provision in a bivariate analysis using chi-square tests of independence to establish significant differences ($p<0.05$) between services received by youth clients and those received by adults. Although our research interest was in youth-friendly HIV-related services, we used STI consultation observation data instead of VCT data to establish differential treatment, because such data were not collected for VCT consultations. It was assumed that STI service provision provides a reasonable proxy for HIV-related service provision because HIV-related services (such as offering VCT or counselling on HIV-related risks of unprotected sex) should be key elements of an STI consultation. The unit of analysis here is the health care provider/client dyad (n=xx)

To determine where needs for youth-friendly HIV services are greatest, we first discern whether there are types of facilities that youth are more likely to attend than adults, again using bivariate analysis and chi-square tests to establish significant differences. Then, based on our findings from the analysis of differential treatment of youth, we identify which types of providers and facilities are most likely to provide substandard care for the elements where youths receive biased care. It is expected that this information will allow a targeted approach to the upgrading of youth-friendly HIV services in Kenya. The unit of analysis here is the health facility.

RESULTS

The results indicate that youth in Kenya have limited access to youth-friendly services as only 6.1% of facilities provided any youth-friendly services. Even fewer provided youth-friendly HIV-related services and there is lack of relevant HIV-related educational materials targeting the youth. This evidence underscores the need for immediate finalization of the guidelines and policies geared towards implementation of youth-friendly services.

The data show that most facilities offering STI (88.9%) and VCT (84.2%) services had trained youth-friendly services staff present on the day of the survey, but that guidelines on youth-friendly services were available in only 19% of facilities offering STI services. The data

show further that over two-thirds of the VCTs had youth-friendly services components in separate rooms, which the Government should take advantage of as youth are particularly insistent upon privacy during their visits to health facilities.

The analysis indicates that the majority of persons who attended STI clinics were adults, 83.4% compared with only 16.6% youth. More youth attended STI services in Coast health facilities (33.3%), Nairobi (32.1%) and Western (31.3%). The youth are more likely to visit dispensaries (20.9%) and health centres (13.3%) than other health facilities. A major information, education and communication (IEC) campaign should be put in place to encourage the youth to visit STI clinics so that they can be attended to whenever they have STI problems. This could also offer an opportunity to health providers to discuss with the youth issues related to their sexuality and HIV/AIDS.

Problems experienced by clients are a major hindrance to visiting health facilities, especially the youth. Data on problems experienced by clients were obtained from both observations and exit interviews. The results indicate that clients experienced problems because of waiting times and the unavailability of medicines in the STI clinics, as these two variables are highly significant at 95% confidence levels. More than half of adults reported having problems with waiting time, compared with only 15.8% of the youth. Similarly, a third of adults indicated that obtaining medicines from the STI facilities was a problem, compared with only 5.3% of the youth. Indeed, 75% of adults and 86.7% of youth indicate that they received medication. The health facilities need to put in place policies that encourage reduction of waiting time for clients who attend STI clinics and also develop policies that would enhance the availability of medicines in health facilities to deter clients from resorting to self-medication when drugs are lacking in health facilities.

Using the facility inventory data, we demonstrate that only 6% of health facilities offered any type of youth-friendly services; where informational materials for youth were available, only 2% were on the topic of HIV. Using data from observations of client-provider interactions as well as exit interviews we show that youth are not provided with the same standard of treatment as adult clients: they are less likely to be offered an HIV test (27.3% of adults compared with 5.3% of youth) or to be warned of the risks of HIV and other STIs; less likely to be engaged in any kind of condom-related discussion; and less likely to receive a genital examination (34.1% of adults compared with 10.5% of youth). Female clients are worse off, as only 22.4% of them had genital examination done, as opposed to 48.4% of the males, and less likely to receive a diagnosis from the provider. Similarly, adults are more likely than youth to be given a diagnosis of the medical problem they are suffering from. The results further show that youth are less likely than adults to be asked about recent sexual relationship status (monogamous or multiple partners). This bias against youth in service provision is more troubling since youth were significantly more likely than adults to report that they don't know ways to protect themselves from STIs and HIV/AIDS (42.1% of youth compared with 7.9% of adults).

To determine the types and locations of facilities that are most in need of improving the provision of services to the youth, we looked at where youth were most likely to go to get STI and HIV-related health services, and we examined which facilities were most likely to fail in the provision of selected elements of caregiving. Our findings indicate that only 19% of the health facilities had guidelines on youth-friendly service and the majority of persons who attended STI clinics were adults (83.4%) compared with only 16.6% of youth – who are most likely to be females as male youth did not visit any STI clinics. And for female clientele who visited STI clinics, youth accounted for only 24.7% compared with 75.3% adult females. The analysis further shows that most registered nurses (92.9%) followed by enrolled nurses (87.5%) do not perform genital examinations when attending to STI clients.

Regionally, Rift Valley seems to have more problems, as over 68.2% of health workers did not ask about recent sexual history, 81% did not perform genital examinations and 61.9%

did not mention risk of HIV to clients. Most health workers, irrespective of the facility they are working in, did not perform genital examination.

Observation data of providers during their course of duty were collected to measure examination standards for STI service provision. Adult clients were more likely to be asked about history of recent sexual contacts (81.8%) than were the youth (57.9%). Similarly, adults were more likely to be asked about current sexual relationship status, role of condoms in preventing STIs and HIV/AIDS, the risk of HIV/AIDS, protection from STIs and HIV/AIDS, ways clients know to protect themselves from STIs and HIV/AIDS. This implies that although there are more staff specifically trained to handle youth-friendly services, it appears there is a barrier when serving the youth. Programmes need to be put in place to encourage health providers to talk to the youth freely. Rift Valley Province, specifically, should be targeted as it experiences more problems in terms of serving the youth who visit STI clinics. It is of paramount importance to determine the reasons behind this scenario; we suspect it could be associated with cultural beliefs proscribing adults from discussing sexually-related issues with the youth. This would perhaps call for different approaches to solve the problem.

In conclusion, establishing safer sexual behaviour from puberty becomes arguably the most important and potentially most effective long-term weapon against the continued spread of HIV among the youth in Kenya. This can only be done if the Government puts in place facilities that offer youth-friendly services – policies or guidelines specifically developed to address services offered to the youth in various health facilities. These policies or guidelines must emphasize the use of specially trained staff, availability of separate rooms or locations in the facility, discounted or free services, and educational materials targeting the youth, among other attributes.

SUMMARY FIVE

Decentralizing Kenya's Health Management System: An Evaluation

By Patrick M. Ndavi, Samuel Ogola, Paul Kizito and Kiersten Johnson

INTRODUCTION

Kenya's centralized approach to health care systems decision making has been blamed for, among others, regional/provincial disparities in the distribution of health services, inequities in resource allocations, and unequal access to quality health services, with resultant provincial/regional differentials in the indicators of health. The Kenya Ministry of Health's commitment to address the inherent constraints in the health sector have included deliberate decentralization efforts aimed at strengthening the effective implementation of activities at the district level, while fostering closer coordination and collaboration amongst the line ministries, donors, organizations and other stakeholders.

Specifically, in these efforts local District Health Management Boards (DHMBs) and District Health Management Teams (DHMTs) have gradually assumed responsibilities for running the facilities under their jurisdiction through a single line grant, annual work plans and procurement plans. Thus, the aim for the DHMT component of the 2004 Kenya Service Provision Assessment in 2004 (KSPA 2004) was to provide information for functioning of both DHMTs and DHMBs in the country

The objective was to assess the current effectiveness of the district health management systems in meeting their responsibilities, through the analysis of data from the DHMT survey that was a component of the KSPA 2004. Conducted towards the end of the First National Health Sector Strategic Plan (NHSSP I, 1999–2004), the DHMT survey evaluated the achievements of the plan at the district level.

The survey was conducted by the National Coordinating Agency for Population and Development (NCAPD) with technical assistance through the MEASURE Demographic and Health Survey (DHS) project. The key question addressed in this survey was: To what level do DHMTs and DHMBs meet the norms and standards on governance and management, human resource development and management, commodity management, infrastructure development, health care financing, budgeting and management, and performance monitoring as stipulated in their establishment?

METHODOLOGY

The DHMT survey collected data from 57 (83%) of the 69 DHMTs in the country. All the DHMTs were covered in Nairobi, Central, Coast and Western provinces, but not all of those in Rift Valley, Eastern and Nyanza provinces. The district population officers administered the questionnaires to the district public health nurse (DPHN) and the district medical officer of health (DMOH). None of the members of the DHMBs were included as respondents. In

general, the coverage of the DHMTs in the country (except for Nyanza Province) was representative and the responses would reflect the true picture of DHMTs in the country. The guidelines for functioning of the DHMBs were available and used in the analysis to provide the norms and standards for their functions; on the other hand, the relevant guidelines for DHMTs were not available and current and past district medical officers of health provided information on the functioning of these structures.

RESULTS

The failure to undertake the DHMT survey in close to 20% of the DHMTs has implications for the external validity of the findings. At the same time, if these DHMTs were not reached because of the difficult terrain or insecurity, then the achievement of (particularly) women's sexual and reproductive rights in these areas remains a challenge.

Governance and Management

As key components of governance and management, most (90%) of DHMTs hold meetings at least quarterly (every three months) and maintain records of the meetings, but implementation of any decisions from such meetings was not assessed. Crucial to governance are meetings between DHMTs and other stakeholders on reproductive health and safe motherhood programme activities, but these occurred infrequently. It was not possible to determine if these met the required standards, however, as these were not available. On their part, 75% of the DHMBs hold meetings every three months, or more often, but this did not distinguish whether these were full board meetings (required to meet quarterly) or meetings of the three standing committees (these should hold six meetings in a year). Close to 83% of these management structures maintained records for such meetings. An organizational chart showing the relationships among different sections and departments and their responsibilities for overall health care services management and delivery in the district was available in less than 50% of the districts. Although most of the DHMTs had plans for improving reproductive health and safe motherhood services, less than a quarter implemented them on schedule. Exclusion of the health facility management teams, important components of district health systems, was a weakness in the assessment of the impact of decentralization.

Human Resource Development and Management (HRD&M)

The elements assessed for HRD&M included promotion, appraisal, motivation, supervision, adherence to code of conduct and continuing medical education activities. While promotion criteria based on performance and additional training were used by about one-third of the DHMTs, mechanisms for staff appraisal were more objective than criteria for staff promotion in that work plans and job description were utilized by about one-half and three out of five of the DHMTs, respectively. Mechanisms for staff motivation cited by the districts were tea for staff (about 81%), access to services like phones (42%), and awards and letters of appreciation (35%), pointing to expressed positive attitude by DHMTs towards rewarding and motivating staff in the districts.

Leave and duty rosters, frequent supervisory visits, and staff meetings assured adherence to code of conduct in most DHMTs. While two-thirds of districts had guidelines or policies for supervision of reproductive health and safe motherhood activities, targets for implementing and executing supervision plans were met by less than 20% of the DHMTs, mostly because of the unavailability of funds and transport. Continuing medical education activities were reported by about half of the DHMTs; the most frequently attended courses

in the previous 12 months were on PMTCT (90%), malaria (77%) and family planning (68%). Other CME was for IMCI (54%), as well as infection prevention, essential obstetric care and management skills courses, each reported by 51% of DHMTs.

Not assessed through this survey was the existence of norms and standards that would be used to determine the optimum number of staff required, their skills, and the mix of competencies for both technical and support staff.

Commodity Management

The issues explored in the DHMT survey on commodity management included procurement and store management. All districts should have procurement plans, yet only two-thirds had procurement plans for drugs and supplies, and about 58% had quarterly to annual procurement plans; 21% had weekly to monthly plans. Because a mixture of "push" system for outpatient drug kits and "pull" system for inpatient drugs and supplies existed, it was not possible to determine whether commodity management met any laid down norms and standards, if these existed at all. On management of stores, about nine out ten DHMTs had ledgers for monitoring stores and requisition forms as well as a system for distribution of excess supplies.

Infrastructure, Transport and Equipment

The DHMT questionnaire sought information on repair and maintenance of equipment, and availability of communication and transport for emergencies. Most (98%) districts contracted with the provincial workshop for repair and maintenance work, with some of the work being done locally or by private enterprises. Most of the government district hospitals (93%) and close to three-quarters (74%) of the health centres used telephone or two-way radio to communicate with a referral facility to arrange transport during emergencies, while about one-half of districts (54%) reported that government dispensaries had such amenities at their disposal. On-site transport available for emergencies was reported available by 90% of district hospitals and six out of ten health centres, but very few dispensaries under government management. Close to 86% of the districts reported that NGO/mission/private health facilities had on-site transport available for emergencies.

Healthcare Financing, Budgeting and Management

The DHMT data revealed that nearly 90% of districts had both recurrent and development funds that fiscal year (2004/05) with less than 10% of these districts reporting adequate funding for medicines, equipment and building maintenance. Central government funding for health care services in the districts was supplemented by prepayment schemes, local government, revolving funds (Bamako type); these funding sources contributed 56%, 25%, 19% and 37%, respectively. Private insurance and donors seemed not to be major sources of funding for health services.

Performance Monitoring

In the DHMT survey, assessment of the performance of districts in reproductive health (RH) and safe motherhood (SM) revealed that 90% and over of the districts had an official designated to monitor the performance of health facilities in provision of antenatal care, childbirth services, PMTCT services and services for mothers with complications. At the same time, 70% of districts had an official who monitored performance of facilities in the provision of postpartum care. At least eight out of ten districts designated officials for monitoring the implementation of district health plans, the financial performance of the government facilities, and the inventories of equipment and supplies in the district.

CONCLUSIONS AND RECOMMENDATIONS

Exclusion of 20% of the DHMTs from this survey jeopardizes the validity of the findings, while at the same time underscoring the fact that difficult terrain and insecurity constrain the attainment of women's sexual and reproductive rights. District health management systems include more than DHMTs and DHMBs and these need to be assessed in future with the appropriate respondents chosen, and not DPHNs and DMOHs only. There is urgent need to disseminate developed guidelines for effective functioning of DHMTs. In future, assessment of DHMBs should include the three standing committees to exhaustively determine the functioning of this structure – which did not happen in the current survey.

Monitoring of implementation of actions from meetings of DHMTs and DHMBs is also required. Combining several programmes for supervision will mobilize enough resources to facilitate meeting of supervision targets, since supervision plans, guidelines and policies exist. Mechanisms should be strengthened to facilitate commodity security in Kenya. Perhaps increasing annual budgetary allocations to the agreed 15% to ministries of health, in tune with the Abuja Accord, may provide the financial resources required for medicines, equipment and maintenance of buildings.

A Further Analysis
of the Kenya Service Provision Assessment
2004

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