REPORT OF THE MINISTRY OF HEALTH (MoH) REPRODUCTIVE MATERNAL HEALTH SERVICES UNIT (RMHSU) &/MeTA KENYA LEARNING AND SHARING FORUM

6TH SEPTEMBER 2018, 67 AIRPORT HOTEL-MACHAKOS COUNTY

RMHSU-MeTA Forum
Inter-County and National RH Consultative & Dissemination Forum
6 September, 2018
67 AIRPORT HOTEL
MACHAKOS COUNTY

LEARNING & SHARING AGENDA

Objectives

a) Strengthen coordination of national and county level interventions
b) Convene a county and national learning and sharing dialogue on RH outcomes and interventions across the different counties while identifying areas of need for partner interventions.
c) Dissemination and distribution of RMNCAH IEC materials and policy documents.
d) Sharing of best practices for policy implementation at county and national level.

	AGENDA ITEM	TIMING
1.	Registration (**Florence Ireri/ Zainab**) Introductions and setting the agenda (**Mary Magubo-RMHSU**)	09.00am-09.15am
2.	Opening and welcome remarks **(Dr. Gondi- RMHSU Head)**	09.15am – 09.30am
2.	*Moderator: Grace Wasike* Panel Presentations - Advocacy for UHC and the RH Commodities in the benefits package **(JohnpaulOmollo-PATH** - Current status of SRH Commodities in select counties: **Dr. J. Maina (RMHSU-MoH)** - Dissemination of RH communication strategy**(Mary and Grace-RMHSU- MoH)** - HAI: MeTA concept**(D.Kibira-HAI**) - MeTA Kenya: Health Systems Strengthening for SRHC (**Dorothy Okemo- HAI/MeTA Kenya**) DISCUSSIONS	09.30am-10.30am
	TEA BREAK	10.30am-11.00am
3.	*Moderator: Angela Nguku* County Presentations 1 and Discussions: *Access to SRH Commodities and ACSM : The challenges and gaps that counties face* - Kitui - Makueni	11.00am – 12.00am

	- Machakos - Meru - Embu - TharakaNithi	
4.	Partners presentations and perspectives of work at national and county level: - White Ribbon Alliance: - HENNET: *Supporting health CSOs in Kenya* - *Evidence for Action* - Amref Health Africa: *A case for County CHS bills: as a factor to achieving UHC* - Carolina for Kibera- *Youth friendly services: sharing of best practices*	12.00pm -12.30pm
5.	Presentation and dissemination of the current RH IEC Materials and policy documents	12.30pm-13.00pm
7.	Vote of thanks and closing Remarks: County Director of Health	13.00pm-13.15pm
8.	Logistics, Lunch and Departure	13.15pm- 14.30

The Forum, the first of its kind titled "learning and sharing agenda" was held on the 6th of September, 2018 at 67 Airport Hotel in Machakos County 20 Kilometers from Nairobi. The forum started with a round of introductions and expectations from the participants. There were 41 participants drawn from the national Ministry of Health officials from the RMHSU, representatives from 7 counties \i.e. the County Directors of Health, County Pharmacists, County Health Promotion Officer and the Reproductive Health Coordinators from. Machakos, Kitui, Makueni, Meru, Embu, Tharaka Nithi and Nairobi, CSO representatives and members of the mainstream media. Some of the participant expectations included:

Ministry of Health (MoH)- Reproductive Maternal Health Services Unit (RMHSU)

- To learn what the counties are doing as far as SRH is concerned
- To disseminate some key policy documents
- Identify gaps and recommendations for follow up post the forum

The Counties

- To hear other county experiences and share experiences
- To learn more updated best practices around SRH and the information gap
- Expectation of a way forward on challenges around access to SRHC
- Find a way to coordinate national and county engagement on RH and MH
- Get ideas on how to reduce teenage pregnancies
- Strategies to achieve more with limited resources
- Tips on how to empower communities on their SRH needs
- Effective linkage between referral and networking on SRH
- How to improve uptake of RH commodities

CSOs

-networking

- learn more from others

- learn about the interventions at county level on SRHC

Media

- Learn
- Get stories from the forum for the health segments

OBJECTIVES OF LEARNING AND SHARING FORUM

1. Strengthen coordination of County and National level interventions.
2. Convene a county and national learning and sharing dialogue in RH outcomes and interventions across the different counties while identifying areas of need for partner interventions.
3. Dissemination and distribution of RMNCAH IEC materials and policy documents.
4. Sharing of best practices for policy implementation at county and national level.

PRESENTATION 1: Advocacy for UHC and HR commodities in the UHC Essential Benefits Package – by Johnpaul Omollo- MeTA Kenya Council member

As a member of the Essential Benefits Package committee constituted by the cabinet secretary for Health, MeTA Kenya council member, Johnpaul Omollo started off by demystifying UHC by defining what it was and what it wasn't. This was a good starting point as there remains a lot of misinformation on what UHC is and how it correlates with NHIF. UHC in Kenya is anchored in among other commitments and obligations in SDG3 and specifically target 3.8 and is a goal in itself that is looking at universal coverage of people irrespective of their status, provision of all quality health services and issues around financing and lowering out of pocket expenditure for health.

He pointed out that the four UHC pilot counties were Machakos, Isiolo, Kisumu and Nyeri and the roll out of the pilot is expected to commence on 1st November 2018 for the entire population of the pilot counties. He further distinguished between Universal Health Coverage and Universal Health care" Universal Health Coverage is about promotive, preventive, palliative care with community health being at the core of it all. It does not mean free coverage for all possible health interventions regardless of cost, it is not just about health financing rather focuses on health systems and not just about medical services rather about equity, social inclusion, financial protection and development interventions. The process was progressive, while universal health care is focused on the diseases and care given to citizens that were already sick and required medical attention.

For UHC to work there is need for supply side to match with demand side as it addresses issues of access, coverage, quality and safety to deliver value and not volume. In conclusion he reiterated that UHC cannot be achieved without getting back to the basics of Primary Health Care that include intergrating cost effective interventions addressing common needs and illnesses, health education, maternal and child health and essential medicines.

Research is also an important component in achieving UHC as it informs policy and regulations, ignites partnerships and is a potential source of domestic resource for health

J.P Omollo- MeTA Kenya council member making his presentation on UHC

PRESENTATION 2: DISSEMINATION OF THE RH COMMUNICATION STRATEGY- GRACE WASIKE- ACSM COORDINATOR- MOH-RMHSU

Some of the core areas of priority and advocacy include

- Inadequate research and M/E RMNCAH for advocacy SNCC programs
- Low resource allocation RMNCAH at county and national level to support ATW
- Unavailable advocacy strategy for RMNCAH
- Current RMNCAH advocacy interventions include : media involvement and strengthen social accountability and citizen led advocacy

Recommendations

- Development of advocacy strategy for RMNCAH
- Mapping of advocacy and communication champion
- Establishment of RH social media platforms

Opportunities to accelerate response to RMHSU include

- Healthcare financing through the linda mama initiatives
- Stakeholder involvement both at county and national level

PRESENTATION 3: HAI/META CONCEPT- D. KIBIRA- HAI/HEPS UGANDA

Denis made a presentation that gave an overview of MeTA, the work of Health Action International and the Health Systems Advocacy Partnership (HSAP). HSAP started in 2016 and geared towards building strong health systems to deliver equitable, accessible and high quality Sexual Reproductive Health Rights, services and commodities as well as creating strong civil society to engage effectively with governments, the private sector and other stakeholders for health systems. This partnership is being implemented at global, regional and county level in Kenya, Uganda, Tanzania, Zambia and Malawi by four partners i.e. Health Action International, Amref Health Africa, ACHEST, Wemos Foundation and the Dutch Ministry of Foreign Trade and Development.

The Medicines Transparency Alliance (MeTA) began in 2009 as a strategic initiative in response to MDG8 and was supported by DFID, World Bank and WHO and piloted in 7 countries including Ghana, Uganda, Zambia, Jordan, Philippines, Peru and Kryrgyzstan. This initiative was aimed at improving access to medicines through multi-stakeholder participation and was stewarded by the Ministry of Health. Kenya, Tanzania, Uganda and Zambia are the countries that are part phase 3 of MeTA.

MeTA principles are about availability and access to medicines and information, cost to consumers, quality of medicines and rational use of these medicines.

MeTA structure includes a Council which is a governing body of core institutions in the medicines sector including government, private sector and CSOs, a secretariat and a national stakeholder forum that meets annually to exchange information.

Denis also shared select SRH indicators for HSA countries as shown below:

MeTA in phase 3 is focusing on commodities because, access to medicines is a crucial element in the fulfillment of the right to health, medicine account for 20-60% of health spending in developing countries, upto 90% of populations in developing countries buy medicines out of pocket yet affordability is one of the top reasons why medical care is not sought. He summarized by sharing the MeTA strategy which is evidence, capacity and intervention through providing tools and training for measurement of commodities, building capacity in data collection and policy analysis, SRH commodities policy training and facilitating multi-stakeholder platforms

PRESENTATION 4: META KENYA: HEALTH SYSTEMS STRENGTHENING FOR ACCESS TO SRHC

The MeTA Kenya Coordinator made a presentation of the work of MeTA in Kenya and close partnership with the MoH through the RMHSU as well as some interaction at county level. She highlighted the following as some of the achievements of MeTA over the last two years:

- Facilitation of found table discussions between multi-stakeholders to generate innovate solutions around supply of SRH commodities through the MeTA Council to which both the MoH and the counties are represented through CoG secretariat..
- Convening national and county level forums to support learning and sharing for greater coordination and nteraction at the different levels of governances and policy e.g. this MeTA Forum.
- Supporting and strengthening collaboration mechanisms at RMHSU including supporting the ACSM TWG, supporting dissemination of key IEC material, supporting and inputting into various processes e.g. the RMNCAH ICC ToRs and composition.
- Stepping up rights based advocacy efforts to increase awareness of reproductive health rights and commodities supply based on demand and need by providing evidence through our availability affordability studies undertaken in select counties in the public, private, mission sector facilities. As well as providing evidence based, valid and actionable data to counties and facilities with findings and recommendations on improving access to SRHC.
- Increasing the capacity of local CSOs to effectively advocate and capacitate the communities they work with to increase demand for SRH commodities- a fact that was continually raised by the counties present as a gap that needed greater intervention.
- Partnering with project partners i.e. Amref to convene media houses and launch the lower Eastern African Media Network on Health Lower Eastern Chapter to not only cover general health stories but be accessible to counties to highlight key stories and share information without having to pay for it- as was also raised by the participants.
- Identifying and working with champions on emerging issues around SRHC e.g. in discussions with Kakamega, Narok and Makueni first ladies, Narok on issues around advocacy to reduce teenage pregnancies.
- Engaging one on one with county officials to support and engage in advocacy efforts to improve access to RH commodities- support county level MeTA councils.

The MeTA Kenya Coordinator making her presentation on the achievements in Kenya

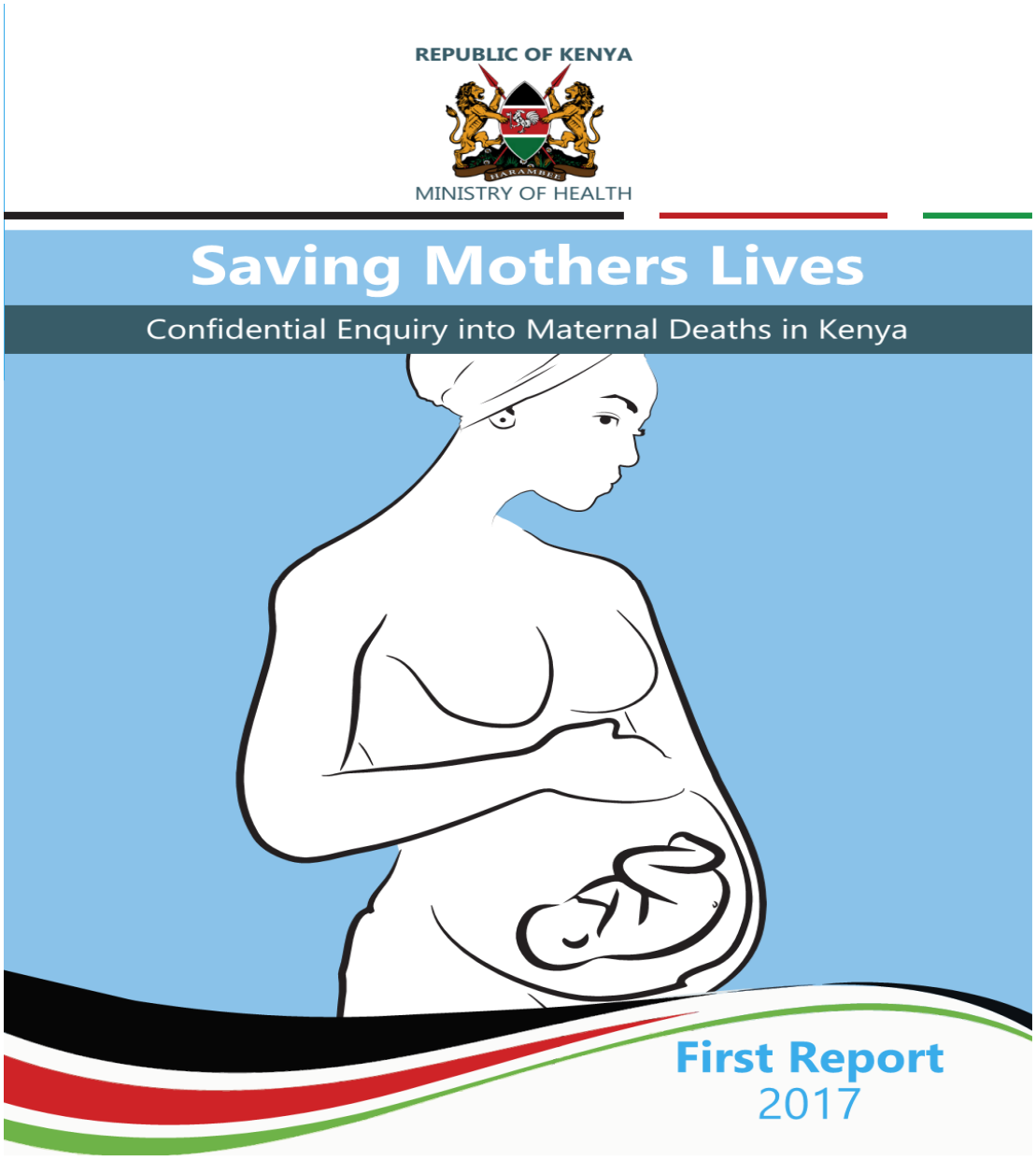
Advocacy efforts focus on rights based approach by increasing awareness of reproductive health rights and commodities supply based on demand. This is achieved through stakeholder forums, undertaking research on availability and affordability of SRH commodities in counties in public, private and mission hospital both in urban and rural settings. In 2017 the counties surveyed were Nairobi, Mombasa, Nakuru, Meru, Kisumu, Kakamega and Vihiga. This year 2018 the same above counties were surveyed with an addition of Isiolo, Narok, Makueni and some part of Kitui.

PRESENTATION 5: DISSEMINATION OF THE CONFIDENTIAL ENQUIRY INTO MATERNAL DEATHS IN KENYA 2017 REPORT- MARY MAGUBO MOH-RMHSU

While taking the participations through the presentation of the findings of the first every Confidential Enquiry into Maternal Deaths study commissioned by the Ministry of Health. Mary commenced her by stating that the purpose of the study was:

- To take actions to eliminate preventable maternal deaths
- Approx. 6000 women die due to pregnancy related complications in Kenya every year
- Implementing the Global Strategy for Women's and Children's Health

- MPDSR is a strategy to document the burden of maternal and perinatal deaths, causes and avoidable factors, with a clear response plan to avoid future deaths
- Contributes to the achievement of Sustainable Development Goals (SDGs)



Objectives of the study

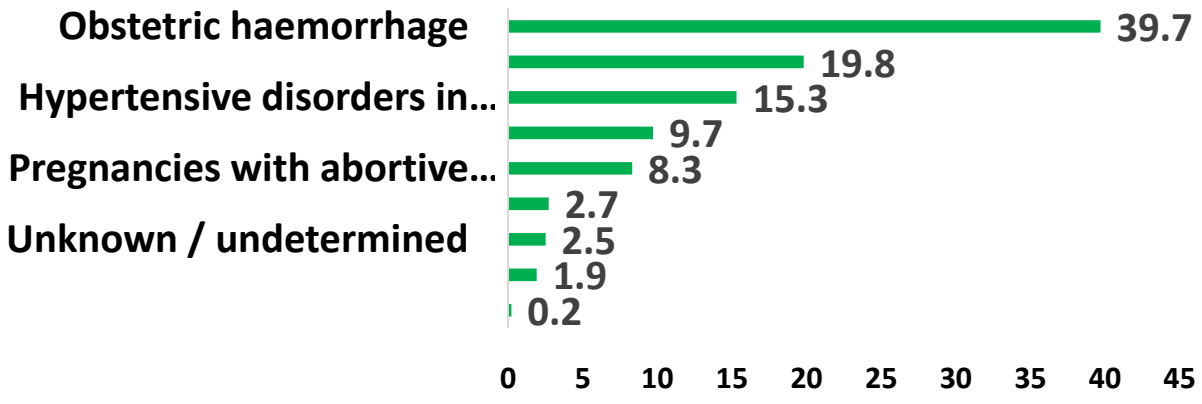
- To document the burden of maternal and perinatal deaths.
- To gain understanding of the health system failures that lead to maternal and perinatal deaths
- Raise awareness among health professionals, administrators, programme managers, policy makers and community members avoidable factors in the facilities and the communities
- Stimulate action to address avoidable factors thereby prevent future maternal and perinatal deaths

The Key principles of the study were

- No blame policy
- Death reviews focus on health systems not individuals
- A zero-reporting principle is adopted, meaning that reports are submitted regularly even if no death has occurred.
- Documentation of patient case notes is the main source of information for facility based death reviews
- Relatives are the main source of information for verbal autopsy.
- Death audit data are anonymised and CANNOT be used for disciplinary or litigation purposes.
- The death reviews are incomplete without response to prevent avoidable factors in the future.

Some of the findings are illustrated below:

Underlying causes of Maternal Death



Maternal Death among Adolescent Mothers n=43

- 43 (8.9%) were young mothers aged below 20 years
- 27 (62.8%) were having their first pregnancy
- 9(20.9%) their second pregnancy
- One adolescent mother was having their 4th pregnancy
- Leading cause of death:
    - Obstetric haemorrhage -12 (27.9%)
    - Pregnancy related infection -10 (23.3%)
    - Pregnancy with abortive outcomes – 6 (14.0%)

Associated factors

- Associated factors categorized into:
    - Health care worker (75.4%)
    - Administrative (34.9%)
    - Patient /family factors (41.9%)
    - Community factors (6.0%)
- 89.3% of the maternal death had one or more associated factors
- Health care worker factors:
    - Delay in starting treatment (32.9%)
    - Inadequate clinical skills (28.1%)
    - Inadequate monitoring (26.9%)

Frequently identified gaps in care

- Incorrect management with correct diagnosis
- Infrequent monitoring
- Prolonged abnormal observation without action

- Incorrect diagnosis

Delay in referral (especially level 3)

RECOMMENDATIONS

COUNTY PRESENTATIONS

The counties had been asked to prepare a presentation on access to SRH commodities and ACSM: The challenges and gaps that counties face.

Each county shared how they are actually improving access to sexual reproductive health, what are the challenges they face in doing the same, what mitigation measures are they taking basing on the challenges. As the counties shared their presentations there were questions and inputs from the rest of the participants.

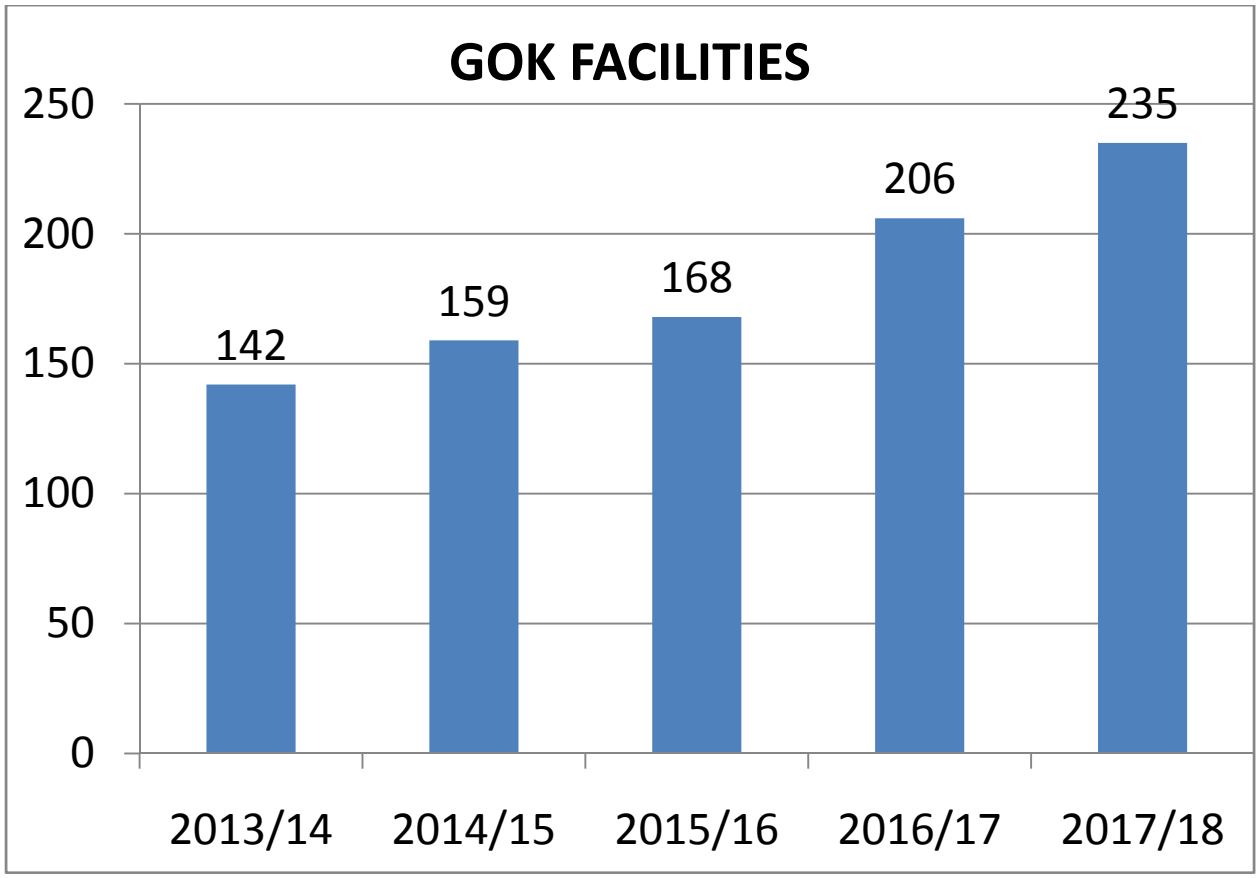
MAKUENI COUNTY PRESENTATION

COUNTY HEALTH PROFILE

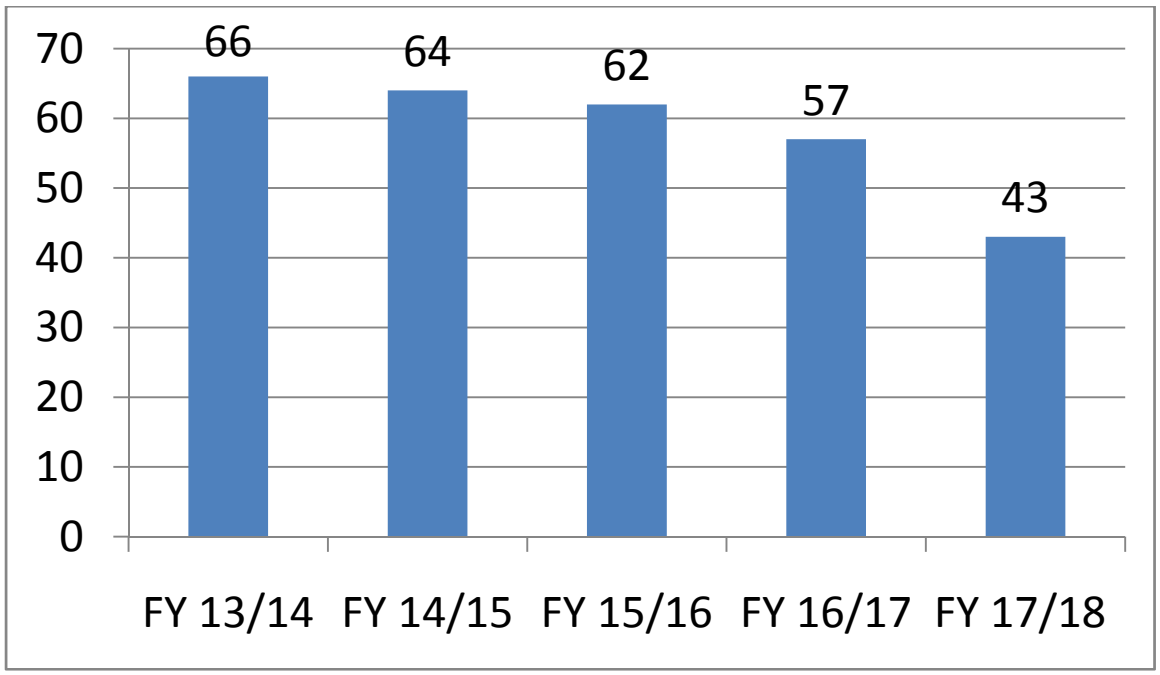
- As at January 2018, the county had an estimated population of 978,932.
- The average size per household is currently at 5 persons per household.
- The county is currently divided into 6 sub-counties; Makueni, Kaiti, Kibwezi east Kibwezi west, Mbooni**,** Kilome. There are 30 wards in the County

Health Workforce

	2013/14	2017/18	Change	Change (%)
Specialists doctors	**7**	**12**	**5**	**71**
Medical officers	**26**	**61**	**35**	**135**
Pharmacists	**8**	**12**	**4**	**50**
Dentists	**4**	**9**	**5**	**125**
Nurses	**438**	**701**	**263**	**60**
Clinical officers	**63**	**97**	**34**	**54**
PHOs	**92**	**95**	**3**	**3**
HTC counsellors	**0**	**58**	**58**	**NA**
HRIOs	**17**	**21**	**4**	**25**
Other cadres	**386**	**468**	**82**	**21**
Total	**1052**	**1536**	**484**	**46**



WRA RECEIVING FP COMMODITIES (%)



A) Health Promotion

- This is done mainly through political forums e.g. the governors peer conference and county first ladies forums
- During sports events, through learning institutions, at religious forums, at market places, show grounds, Mombasa highway, SGR terminals and at health facilities
- At global health day celebrations
- Through local media

a) The gaps in Health information

- Few health promotion officers
- Inadequate information education communication materials
- Limited health promotion equipment
- Lack of communication strategies, policies and guidelines in health promotion
- Negative cultural practices, beliefs, myths and misconceptions
- Herbal drug marketers
- Inadequate transportation
- Low health literacy levels
- Religious sects, language barrier, political influence
- Lack of health promotion standard toll for M&E, regulatory body council and reporting tools

b) Way forward in improving the gaps

- Training of more health promotion officers, enriching of curriculum and employment of more HPOs
- Capturing of promotion data in KDHIS
- Launch of health promotion and communication strategy in counties
- Increase budget allocation for preventive, promotive health services
- Establish health knowledge resource center
- Avail tools required for production and dissemination of quality health information, including research
- Conduct health promotion trainings to CHVs, health workers and key opinion leaders
- Establishing strong health promotion units at county level and strengthen political goodwill.
- Intergrating media houses in health promotion
- Conduct health promotion trainings on CHVs, health workers and key opinion leaders.

Makueni county official making their presentation

B. Makueni: Access to SRH Commodities

a) The situation and achievements

- Places quarterly orders for essential medicines and medical supplies from KEMSA, FP commodities are quantified and requested for resupply
- Quantification of items is supported by data on consumption reported in DHIS on a monthly basis
- The county has embraced concept of FP method mix
- County has constructed a county store at the referral hospital to act as a buffer store for health commodities
- The county has in place monthly FP reporting tools
- All facilities commodity managers have been trained on proper quantification and forecasting of FP commodities which have seen an improvement in quality of commodity reports.
- Most health care workers (especially maternity and MCH) have been trained on proper use of CHX GEL for code care
- The RH/FP unit allocated a utility vehicle to aid in supervision and redistribution of commodities.

- The county has allocated funds to support the RH unit, this will be used to improve update of RH services through outreaches, maternity open days, capacity building of HCW on best practices, RH support supervision etc
- Whatsup forums in place for all sub county pharmacists and sub county RH Coordinators to share updates, challenges, concerns pertaining to commodity management

b) The challenges

- Storage- most sub-county hospitals do not have adequate storage capacity, this limits the quantities the county can hold as buffer stock to avoid stockouts.
- Transport- the county has inadequate utility vehicles that can be utilized to redistribute commodities with the county.
- LMIS/ KEMSA challenges in ordering RH commodities so far FP commodities are not intergrated in the EMMS standard order form
- Lack of implanon NXT in most facilities
- Need for continous capacity building of staff on quantification and reporting especially to newly employed staff.

MACHAKOS COUNTY PRESENTATION

A. Gaps in access to SRH Commodities

- inconsistent supply of SRH commodities
- stock outs of long term methods
- distribution challenges to the rural facilities
- limited outreaches
- knowledge gaps of the stakeholders
- Inadequate IEC materials
- Limited messages through local stations and media
- Unavailability of funds for advocacy and communication for SRH

B. Challenges and gaps in RMNCAH

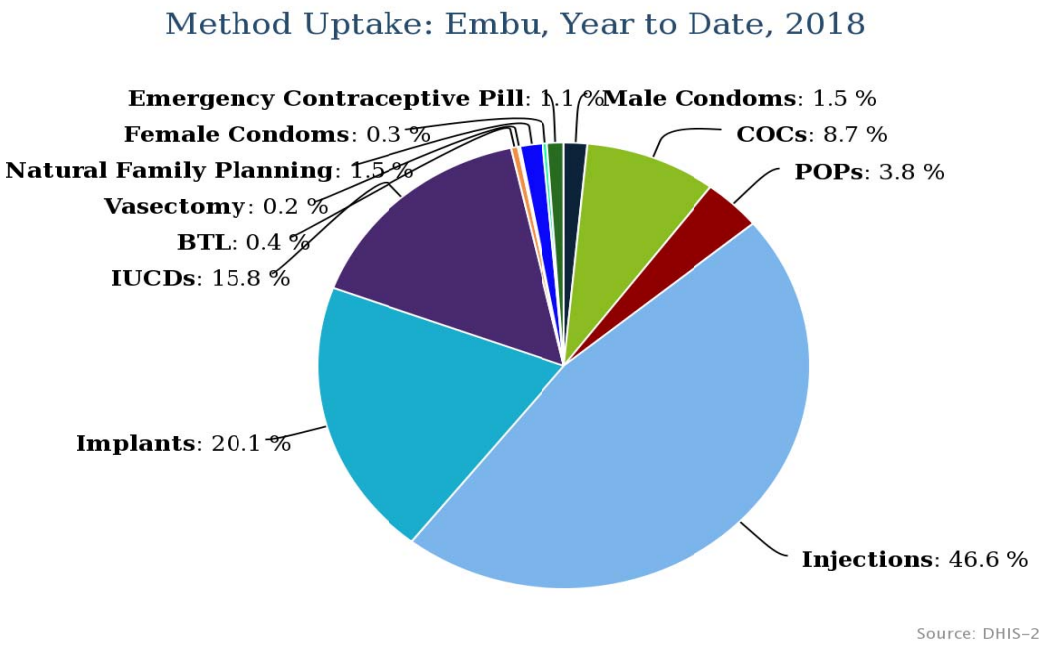
- Inadequate public awareness and sensitization in the community, learning institutions and churches.
- Lack of education and communication on RMNCAH in the community.
- Lack of proper linkage, referral and networking for continuum of care.
- Weak community strategy leading to few or non functional community units.
- Knowledge gap among stakeholders – few community and health care workers trained.
- Limited follow-up care through home visits and defaulter tracing system
- Gender issues leading to low male involvement.
- Cultural and religious barriers.
- Few mentors and role models.

- Lack of comprehensive wellness centres for the youth
- Few community forums e.g. Chiefs barazas and dialogue days for dissemination of RMNCAH information.
- Limited facilitation by stakeholders
- Few partnerships in RMNCAH advocacy.

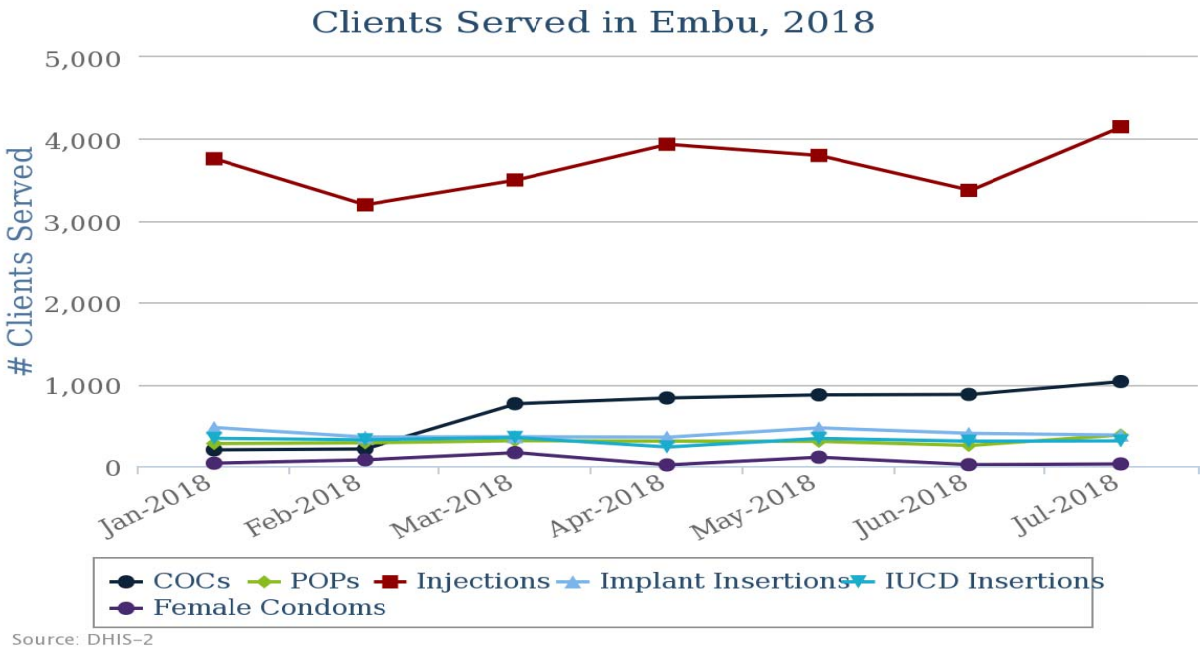
C. Recommendations

- Enhanced investment in advocacy and sensitization /communication.
- Embracing universal health coverage.
- Promotion of a County led and owned systems approach in RMNCAH.
- Partnerships and collaboration with all stakeholders.
- Strengthening community health systems to deliver responsive RMNCAH.
- Enhanced community engagements and participation.
- Strengthening HCBC and support systems.
- Strengthening effective linkages referral and networking.
- Gender mainstreaming
- Integration (one stop shop) of RMNCAH services.
- Increase outreach activities to the community

EMBU COUNTY PRESENTATION



CLIENT SERVICE STATISTICS 2018



Embu County - Facility Contraceptives Consumption Report and Request Form - Apr to Jun 2018

Name	Actual Reports	Expected Reports	Percent	Reports On Time	Percent On Time
Mbeere South Sub County	96	96	100	96	100
Manyatta Sub County	149	150	99.3	149	99.3
Mbeere North Sub County	58	60	96.7	58	96.7
Runyenjes Sub County	88	96	91.7	87	90.6
Embu County	391	402	97.3	390	97

Embu County - MOH 711 Integrated Summary Report: Reproductive & Child Health, Medical & Rehabilitation Services - Jan to Jun 2018

Name	Actual Reports	Expected Reports	Percent	Reports On Time	Percent On Time
Runyenjes Sub County	180	180	100	159	88.3
Mbeere North Sub County	120	120	100	110	91.7
Mbeere South Sub County	201	204	98.5	194	95.1
Manyatta Sub County	323	336	96.1	312	92.9
Embu County	824	840	98.1	775	92.3

B. COMMODITIES CHALLENGES EMBU COUNTY

- There exists a programmatic disconnect between commodity reporting (on DHIS2) and requesting (LMIS2), since they both use different platforms.
- Erratic supply of RH commodities from KEMSA because, as it stands, their delivery is still predicated on purchases of Essential Medicines and Medical Supplies from the same Authority.
- National level supply chain interruptions have led to a state where at no time is the entire catalog of RH commodities available at KEMSA leaving limiting the element of choice to providers and clients.
- Health financing in the county has faced serious challenges, not least, revenue allocation irregularity, leading to logistical disruption of many activities that had been planned surrounding support supervision, advocacy, social mobilization, hampering of referral systems.
- The County Health Department has drafted and is tabling a Health bill in the county Assembly that once enacted, will be a great leap forward in the stemming of the existing systematic gaps in the reproductive health sector.

THARAKA NITHI COUNTY PRESENTATION

Tharaka-Nithi County borders the Counties of Embu to the South and South West, Meru to the North and North East, Kitui to the East and South East. The county lies between latitude 00^0 07' and 00^0 26' South and between longitudes 37^0 19' and 37^0 46' East. The total area of the County is 2,662.1 Km^2; including the shared Mt Kenya forest estimated to have 360Km^2 in Tharaka Nithi County. Tharaka Nithi has 3 constituencies- Chuka Igambang'ombe Maara and 6 sub counties: Chuka, Igambang'ombe, Mwimbi, Muthambi, Tharaka North, Tharaka South.

Leadership and Governance Advocacy

- CIP on FP in place
- RH/FP , ACSM TWG in place
- CHS Forum in place
- CHMT/SCHMT/HMT in place and meets regularly
- Conducted 2 surveys- KAP on female cancers & SMART Survey on Nutrition that included immunization (2016)

Health Facilities Distribution

SUBCOUNTY	TOTAL Health facilities					
	Hospitals	Health centers	Dispensaries/Med. clinics	Total	Private	FBOs
Chuka	3	4	34	41	16	6
Igambang`ombe	0	1	15	16	1	1

Mwimbi	2	4	26	32	8	2
Muthambi	0	2	15	17	2	3
Tharaka North	0	2	12	14	3	2
Tharaka South	3	4	20	27	2	4
Total	8	17	121	148	32	18

MATERNITY DELIVERIES

Period / **Sub County**	**Jul 2014 to Jun 2015**	**Jul 2015 to Jun 2016**	**Jul 2017 to Jun 2018**
Chuka	**2,779**	**2,889**	**2,130**
Igambang'ombe	**155**	**166**	**127**
Muthambi	**211**	**156**	**72**
Mwimbi	**1,498**	**1,341**	**1,467**
Tharaka North	**167**	**211**	**327**
Tharaka South	**1,529**	**1,988**	**1,938**

Total	**6,339**	**6,751**	**6,061**

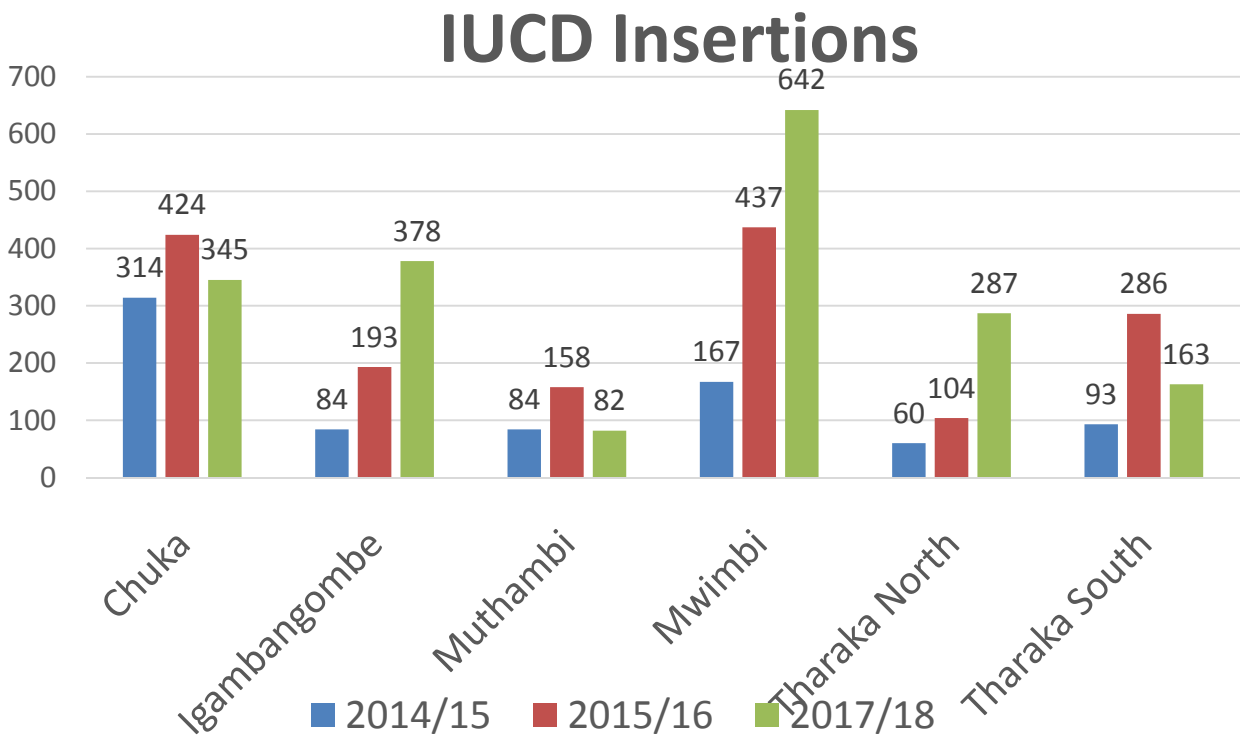
SHORT TERM FAMILY PLANNING METHODS

Period	Jul 2014 to Jun 2015				Jul 2015 to Jun 2016				Jul 2017 to Jun 2018			
Sub County	Pills Combined oral contraceptive	Pills progestin only	FP Injections	Total	Pills Combined oral contraceptive	Pills progestin only	FP Injections	Total	Pills Combined oral contraceptive	Pills progestin only	FP Injections	Total
Chuka	1,884	789	10,515	13,188	2,016	701	9,458	12,175	170	554	6,032	6,756
Igambang'ombe	760	152	4,684	5,596	608	204	4,615	5,427	32	119	1,997	2,148
Muthambi	1,386	154	5,383	6,923	1,193	228	4,632	6,053	25	229	2,987	3,241
Mwimbi	2,206	220	11,034	13,460	1,994	366	9,589	11,949	994	387	4,941	6,322
Tharaka North	1,164	161	6,027	7,352	266	61	5,319	5,646	113	15	4,852	4,980
Tharaka South	789	358	10,782	11,929	849	265	9,995	11,109	264	311	3,439	4,014
Total	8,189	1,834	48,425	58,448	6,926	1,825	43,608	52,359	1,598	1,615	24,248	27,461

LONG TERM FAMILY PLANNING

Period	Jul 2014 to Jun 2015		Total	Jul 2015 to Jun 2016		Total	Jul 2017 to Jun 2018		Total
Sub County	IUCD insertion	Implants insertion		IUCD insertion	Implants insertion		IUCD insertion	Implants insertion	
Chuka	314	720	1,034	424	737	1,161	345	848	1,193
Igambang'ombe	84	516	600	193	740	933	378	231	609
Muthambi	84	434	518	158	295	453	82	460	542
Mwimbi	167	504	671	437	606	1,043	642	331	973
Tharaka North	60	519	579	104	601	705	283	356	639
Tharaka South	93	568	661	286	926	1,212	163	776	939
Total	802	3,261	4,063	1,602	3,905	5,507	1,893	3,002	4,895

LONG TERM FP UPTAKE



OPPORTUNITIES THARAKA NITHI

- Goodwill from the TNCG
- Trained HR
- THS- UCP
- Receptive communities

CHALLENGES THARAKA NITHI

- FP commodity stock outs
- Only 4 CEmONC & 20 BEmONC sites
- Limited referral-few ambulances
- Currently no partner supporting RMNCAH comprehensively
- County has only one HPO
- No communication Equipment

- Limited transport

RECOMMENDATIONS THARAKA NITHI

- Review our CIP & start planning 2019/2013 CIP
- Commodity security
- Strengthen Health promotion
- Strengthen referral system
- Dissemination of the KQMH Assessment report and implement the recommendations

CONCLUSION AND VOTE OF THANKS

The learning and sharing agenda was a success because all the above objectives were met. The coordination between the national and county interventions has been improved and there was demand for forums to be held in other regions to bring together counties. RMHSU disseminated a number of key IEC materials including the RH Communication strategy, the CEMD report,…., sharing of best practice was done through group presentations and discussions of counties. The other milestone achieved was media involvement in the forum. The media presence plays a vital role of passing information to the general public, most counties voiced their concern of how expensive the media was and were happy to hear about the AMNH and the fact that the lower Eastern chapter had just been launched and would be available to work with counties to report health stories.

In his vote of thanks, the County Director for Health for Meru County thanked all the participants who took time from their busy schedules to participate in the forum. Indeed the forum lived upto the expectation to exchange idea, learn from each other, share lessons learnt and best practices. He expressed his appreciation of partners that supported work in county but noted that from the discussions more was required to create demand for SRH services, community education needed to be upscaled. In conclusion he recommended the need to provision of a standardized template for presentations to ensure that all presenters followed a specific format to make the forum more focused and to bring out the salient issues being presented.

Embu County Director of Health making closing remarks

WAY FORWARD AND CROSS CUTTING ISSUES

1. The learning and sharing agenda was such an insightful forum that should be extended to all the regions to cover all the 47 counties of Kenya in order to improve the service delivery to the mwananchi.
2. There was more work needed around demand creation. Citizen engagement, public awareness and community sensitization were identified as critical elements that needed more focus. There is need to match supply with demand and for communities to be aware of SRH rights and services available to them.
3. The issue of KEMSA procurement and reporting system needed further intervention.
    - There exists a programmatic disconnect between commodity reporting (on DHIS2) and requesting (LMIS2), since they both use different platforms.
    - Erratic supply of RH commodities from KEMSA because their delivery is predicated on purchases of essential medicines and medical supplies and ordering of RH commodities is not intergrated in the EMMS standard order form hence the challenge. Erratic supply of RH commodities from KEMSA because, as it stands, their delivery is still predicated on purchases of Essential Medicines and Medical Supplies from the same Authority.
    - National level supply chain interruptions have led to a state where at no time is the entire catalog of RH commodities available at KEMSA leaving limiting the element of choice to providers and clients.

4. Identification of and use of champions to mentor and act as role models especially to the youth as one of ways of curbing teenage pregnancies was one of the interventions shared widely.
5. The issue of limited resources allocated to ACSM, IEC material and promotive work was an key issue; packaging of information and identifying members of the county assembly to support budgetary allocations was one of the strategies that was discussed while making the most of the available limited resources.
6. Media was seen as a key player in health reporting and providing information to communities. One of the key take aways was the lower eastern African media network on Health that was launched by MeTA Kenya and Amref and that has a pool of health journalists that would be available to work with the county to support the communication of key messages to the masses.

Media interview (KTN) on SRHC on the sidelines of the MeTA Forum

AMNH Lower Eastern chapter elected officials

The AMNH Lower Eastern team after the inaugural meeting held on 5th September in partnership with Amref Health Africa