

**KENYA ROLL BACK MALARIA CONSULTATIVE MISSION:
ESSENTIAL ACTIONS TO SUPPORT THE ATTAINMENT OF THE
ABUJA TARGETS**

23 October – 01 November 2003

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1. EXECUTIVE SUMMARY

The Roll Back Malaria Board, representing the global RBM partners, requested the RBM Partnership Secretariat to conduct a series of country consultative missions to determine what additional inputs Category 1 countries would require to support the attainment of the Abuja Targets. The purpose of the country consultative missions is to re-invigorate co-operation between the RBM partnership and countries to support progress towards achieving the Abuja Targets.

This report contains findings of the REAPING mission to Kenya, which was undertaken between 23rd October and 1st November 2003. The mission undertook the following key activities in order to help arrive at the essential actions needed in order to fill implementation gaps in the Kenya national malaria control programme and RBM partnership efforts towards achieving the Abuja targets. The mission team (i) reviewed available documents on RBM, (ii) conducted a workshop with the RBM partnership in Kenya to critically review existing documents and plans, (iii) interviewed a number of country-level RBM partners in Kenya, and finally (iv) held a consensus meeting to agree on the way forward.

ITNs are currently being distributed through both public and private sector channels, with efforts primarily focused in 15 districts where malaria transmission is endemic and stable. Household coverage is estimated at 20%.

Twenty-one districts of Kenya are identified as epidemic prone. epidemic forecasting, prevention and control activities are restricted to 15 highland districts, and comprise monitoring and Irs, although IRS coverage is vary variable (20% to 70%).

IMCI has been adopted as the mechanism for ensuring prompt and effective malaria case management and 15 districts have begun implementation.

The strategy adopted for malaria in pregnancy is the provision of IPT to pregnant women after the 1st trimester. By the end of 2003 it is expected that MIP will have reached 60% of health facilities in at least 40 districts and 100% of health facilities will have trained health workers and focussed ANC kits. 11% of pregnant women are able to access ITNs and the number of pregnant women receiving 2 doses of IPT has increased to 30%

The key outcomes from this REAPING mission to Kenya were as follows:

The baseline, against which progress in relation to the Abuja targets must be measured, largely comprises scattered information from different localised research projects. As a result, baseline for measuring progress on Abuja targets and milestones may prove unreliable.

Kenya has received healthy financial backing for its planned programmes with pledged funding from DFID, plus a successful global fund application. Strategic plans have been drawn up, revised and are now incorporated into district business plans, ready for implementation. However, the component relating to clinical case management of malaria using the IMCI strategy still remains to be funded. There were differences in approaching this critical issue between the various stakeholders; and it is this that actually delayed the commitment of funds to this crucial malaria control component. The consensus meeting held confirmed and approved of the essential actions presented in this report.

The essential action and financial gap identified in Kenya is:

IMCI Training to Health Workers

Essential Need:	There are 40 malaria prone Districts without supplementary resources for IMCI
The Target by 2005	To have At least 60% of Private/public HF practitioners trained & practising IMCI
Proposed action	Mobilise human resources for capacity building (TOT training) and material resources (Training materials, Drugs, weighing Scales, etc) and then ensure rolling out at district level
Essential Gap	Estimated at USD 1,800,000

It should be emphasised that the gaps, resource requirements and essential actions identified are additional and complementary to those currently planned and budgeted for within existing resources in the country, including Global Fund monies.

Other essential actions (funded) include

1. Mobilise additional resources and ensure rolling out
 - Ensure Implementation of GFATM proposal
 - Mobilise resources for capacity building and resources & ensure rolling out at district level
2. Drug policy reviewed and consensus on change to CT reached
 - Mobilise resources to ensure regular sampling and analysis of antimalarials on the market
 - Collect data on CT options
3. Develop mechanisms to allow all pregnant women access to free IPT in mission health facilities; Roll out IPT services in 23 districts; Introduce and roll out IPT services in 47 districts
4. Review and clarify policy guidelines on ITNs to pregnant women; Improve targeting of ITNs to pregnant women through the voucher system; Mobilise resources to procure 1.5 million ITNs
5. Facilitate the availability of 1.7 million ITNs and 5.1million re-treatment kits over 2 years. One time distribution to children under 5 years old
6. Mobilise resources to procure additional buffer stocks (pumps, chemicals, drugs, protective gear, etc)
7. Develop capacity for epidemic forecasting in collaborating institutions.
8. Mobilise resources and sub contract media experts to implement the communication strategy;
 - Develop capacity at the DHE on malaria issues; Include malaria in school health programmes
9. Conduct special surveys to generate up to date evidence for Abuja summit; Strengthen operational research and linkages among DOMC, Partners and research communities. Conduct baseline research on key strategies, (current status, methodologies, impact, etc)

The REAPING mission team also helped the Kenya RBM partnership re-examine Abuja targets and desired milestones. The Country Support Package detailing the desired targets set, essential actions, and the level of investments required to carry out those actions is presented in sections eight and nine of this report.

Acknowledgements

The Malaria Consortium would like to acknowledge the support and collaboration received in undertaking this mission from all that took part in the process. In particular the Malaria Consortium would like to acknowledge the following stakeholders for their input into the Kenya REAPING mission process: The Ministry of Health and Directorate of Malaria Control (Kenya), the RBM global secretariat (Geneva), DFID (Kenya), UNICEF (ESARO), UNICEF (Kenya Country Office), World Bank (Washington and Kenya Country Office), the WR and WHO (Kenya Country Office), Netmark, AMREF (Kenya).

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3. ABBREVIATIONS

ACT	Artemisinin-based Combination Therapy
AFRO	African Regional Office of the WHO
AMREF	African Medical and Research Fund
ANC	Ante-Natal Care
BIs	Bamako Initiative health posts
CBO	Community Based Organization
CDC	Centers for Disease Control and Prevention
CHW	Community Health Worker
CORPs	Community Resource Persons
CQ	Chloroquine
CT	Combination Therapy
DANIDA	Danish International Development Agency
DCH	Division of Child Health
DDC	District Development Committee
DEH	Division of Environmental Health
DFID	Department for International Development
DHE	Division of Health Education
DHMT	District Health Management Team
DMS	Director of Medical Services
DOMC	Division of Malaria Control
DVBD	Division of Vector Borne Diseases
EARN	Eastern Africa RBM Network
FANC	Focussed Ante-Natal care
GFATM	The Global Fund to fight AIDS, Tuberculosis and Malaria
GoK	Government of Kenya
HF	Health Facility
HMIS	Health Management Information Systems
IEC	Information, Education and Communication
IDSR	Integrated Disease Surveillance and Response
IGA	Income Generating Activity
IMCI	Integrated Management of Childhood Illnesses
IPT	Intermittent Preventive Treatment
IRS	Indoor Residual house-Spraying
ITN	Insecticide Treated Net
KeNAAM	Kenyan NGO Alliance Against Malaria
KCO	Kenya Country Office (UNICEF)
MC	Malaria Consortium
MIP	Malaria in Pregnancy
MoF&P	Ministry of Finance and Planning
MoH	Ministry of Health
NGO	Non-Governmental Organization
NHSSP	National Health Sector Strategic Plan
NMS	National Malaria Strategy
PHC	Primary Health Care
PHMT	Provincial Health Management Team
PSI	Population Services International
REAPING	Roll Back Malaria Essential Actions, Progress, Investment, Gaps
SIDA	Swedish International Development Agency
SMITN	Social Marketing of ITNs
SP	Sulphadoxine-Pyrimethamine
TA	Technical Assistance
TOT	Training of Trainers
UK	United Kingdom
UNICEF	United Nations Children's Fund
UNICEF / ESARO	UNICEF Eastern and Southern Africa Regional Office
RBM	Roll Back Malaria
RBM/SEC/WHO	RBM Secretariat (WHO)

VAT

Value Added Tax

WB

The World Bank

WHO/KCO

World Health Organization / Kenya Country Office

4. INTRODUCTION

The Roll Back Malaria Board representing the global RBM partners requested the RBM Partnership Secretariat to conduct a series of country consultative missions to determine what additional inputs Category ONE countries¹ would require to support the attainment of the Abuja Targets. The RBM Partnership Secretariat requested the Eastern Africa RBM Network (EARN) – which represents partners in the sub-region – to participate in these country consultative missions.

The purpose of the country consultative mission is to:

- Re-invigorate co-operation between the RBM partnership and countries to support progress towards achieving the Abuja Targets.

The expected outcomes of the missions are:

- Status of RBM implementation in relation to the Abuja plan and targets and the milestones set for the remaining two years of the Abuja plan period
- Identification of the essential actions (beyond those already planned) that need to be implemented during 2004 and 2005 to maximise country action to achieve the Abuja Targets
- A Country Support Package that details the additional investments required to carry out these essential actions

The REAPING mission team to Kenya comprised: Dr S. A. Ochola (Head, DOMC), Dr W. Akhwale (Deputy Head, DOMC), Dr James J. Banda (RBM Partnership Secretariat/ WHO), Dr Mores Loolpapit (AMREF – Kenya), Dr John M. Chimumbwa (NetMark), Dr Suprotik Basu (World Bank), Dr Thabale Ngulube (Consultant – Malaria Consortium) and Dr Melanie Renshaw (UNICEF – ESARO).

5. METHODOLOGY

The methodology employed included gaining consensus on the Kenya REAPING Desk review summary document, undertaking work group sessions along the lines of the Kenya RBM Strategy interspaced with plenary sessions (see Annex 2 and Annex 4), as well as conducting interviews with Ministry of Health personnel and partners (WHO, DFID, WB and UNICEF – Kenya Country Offices; see Annex 1). During the plenary sessions, a series of tools were developed to help overcome problems encountered by strategy working group members. Finally, a final tool was developed with which all work groups were able to zero in on the gaps and thereafter come up with some essential actions to be undertaken to reach the Abuja targets.

The above activities culminated in a consensus meeting (see Annex 2) chaired by the Director of Medical Services and attended by senior officials from the Ministry of Health and members of the Kenya RBM partnership. At this meeting, the Head of DOMC presented a summary of the issues deliberated on and some of the desired essential actions to reach the Abuja targets. Following comments and issues raised in the presentation, a consensus building discussion took place following which the proposed draft of Essential Actions and the Country Support

¹ The RBM Partnership Secretariat categorised African countries into 3 groups. Category One countries are those considered most ready to rapidly scale up the coverage of interventions and Kenya is classed as a Category One country.

Package were revised accordingly and next steps agreed on with the Head and Deputy Head of the Division of Malaria Control (DOMC) of the Ministry of Health.

6. SUMMARY SITUATION ANALYSIS

Malaria control and prevention activities in Kenya fall under the control of the Division of Malaria Control (DOMC). The current implementation strategies recognize that the malaria burden is not uniformly distributed in Kenya. Based on this, different approaches are undertaken for different districts depending on the level of malaria prevalence. In addition to this factor, malaria control in Kenya is complicated by the increasing levels of resistance to its current first line drug – sulphadoxine-pyrimethamine (Fansidar™). Resistance levels of up to 40% have been reported. The country is thus actively considering another drug policy change, this time from SP to an Artemisinin-Based Combination Therapy (ACT) as first line drug. Other problems faced in the control and prevention of malaria concern the availability of drugs for disease control. Shortages of drugs are still being experienced, particularly in relation to implementation of the intermittent Preventive Treatment (IPT) strategy. The DOMC recognises a shortage of specific skills among health workers in order to effectively implement all the necessary strategies that constitute an effective malaria control programme. In this regard, the DOMC has embraced the IMCI strategy (using a modified community IMCI framework) as a way to improve health worker skills as well as the skills of community based health volunteers.

In terms of vector control strategies, the promotion of insecticide treated nets (ITNs) and indoor residual spraying (IRS) are the two major approaches. The IRS approach is mostly used in the control of highland, epidemic malaria; while the ITN strategy is used as a major vector control strategy for malaria control in districts subject to more stable malaria transmission. The DOMC has enlisted the support of other partners from the private sector and civil society to implement these components. Of particular note is the collaboration between PSI and the Kenyan business sector in the social marketing of ITNs. Members of parliament (MPs) in the Kenyan National Assembly have been involved in efforts to try to boost ITN coverage through the public sector. These two approaches have helped increase coverage as well as improve targeting with these interventions. The DOMC is also considering the use of a voucher scheme as a way to target and increase ITN coverage among pregnant women and children under 5 years of age, using antenatal care clinics in the public sector as a point of distribution.

Most of the current malaria control and prevention activities have been focussed in 40 of the 72 districts of Kenya. Even in these districts, coverage has not been district wide. Thus a key concern for the DOMC is to ensure that the above interventions are scaled to district wide coverage as well as to scale the interventions to all the remaining districts in Kenya. In this way, the targets met will more correctly reflect the spirit and content of the Abuja declaration. The specific issues and desired activities are outlined in the sections that follow below.

6.1. Malaria transmission and burden

Malaria is considered to be a major health problem in 40 of the 72 districts in Kenya. The malaria situation in the 40 districts comprises 25 malaria endemic districts and 15 epidemic prone districts in the highland areas of Kenya. Hence the Kenya RBM programme is concentrating more in these 40 districts where malaria is a major problem. Though malaria is not considered to be a major health problem in the remaining 32 districts, the Kenya RBM

programme also proposes to spread some of the activities to these districts. Such activities include reaching the areas with malaria communication messages and materials.

6.2. Policy and strategy environment and partnerships

Health Sector Reforms are part of the wider economic reforms being implemented by the Kenya Government (GoK) in all sectors to stimulate economic growth and reduce poverty and unemployment. The reform agenda aims to promote and provide quality curative, preventive, promotive and rehabilitative health care to all Kenyans, with key strategies including development of alternative financing options, human resource development, strengthening drug and medical supplies and equipment procurement and logistics systems, as well as health support systems, governance and service delivery at all levels. The Government is fully committed to decentralising the authority for decision-making, resource allocation and management of health services to district and facility levels, thereby allowing for greater participation of communities in providing health services and implementing essential clinical and public health packages. The role of co-operation with the private sector, Non-Governmental Organisations (NGOs), donors, other Government ministries, research and training institutions, and religious organisations in health services provision is acknowledged.

6.3. ITNs and other vector control measures

With respect to vector control, two approaches will be used. In areas where malaria is endemic, ITNs will be the principal method for controlling malaria; while in epidemic prone districts an early warning detection system, combined with indoor residual spraying activities and effective clinical care services will be the major approach for controlling malaria. The key aspects to these two approaches are as follows:

6.3.1. ITN Strategy

The policy framework underlying this strategy proposes that the GoK will increase access to insecticide treated net services amongst people at risk of malaria in Kenya, especially young children and pregnant women.

The GoK will promote alternative approaches to vector control in accordance with special ecological risks. The targets set for 2006 are that 60% of the population at risk will sleep under nets and that at least 50% of these nets will be regularly treated with insecticides. The strategies put forward for achieving these set goals include creating an enabling environment; demand creation; taxation reduction / removal; protecting economically vulnerable groups; provision of subsidised, donor-assisted ITN services to special groups; and formation of an ITN Working Group to support regulation and registration as well as promoting donor consistency.

6.3.2. ITN Policy

An ITN policy is currently in place and policy guidelines are available, with adoption of market segmentation across the public sector and the commercial sector. In the public sector distribution of ITNs the policy stipulates free net distribution to pregnant women through ANC. For the rest of the population, the policy for the public sector encourages distribution through

NGOs/CBOs incorporating various cost sharing and income generating activity (IGA) approaches. In the private/commercial sector, the ITN policy in Kenya uses social marketing approaches to communicate health information for demand creation. These initiatives are being undertaken by PSI (Kenya) and demand creation for ITNs is on-going in 15 malaria endemic districts.

All ITNs are subsidised to some extent as a result of the government's removal of VAT on ready-made nets. The price of ITNs is still considered to be high, especially when obtained through the commercial sector. Efforts to seek further concessions and clarification on the removal of other taxes and tariffs on ITNs and related malaria control and prevention products are on-going.

In readiness for scaling up activities under this strategy, demand creation through social marketing is on-going and the DOMC has established an ITN technical working group to review and widely disseminate the revised guidelines on the ITN policy. Social marketing approaches in the 15 districts are being supplemented with the formation of local ITN advocacy groups.

A number of other approaches are being piloted to increase the distribution and targeting of ITNs for maximum impact on the poor and vulnerable groups. In addition, pilot studies are underway on mass net re-treatment approaches in a few districts; as well as on the distribution of nets through political systems at constituency level with the participation of parliamentarians. This approach also demonstrates the political will that supports the ITN strategy and net distribution in Kenya.

GFATM funds have been disbursed and received in Kenya and the DOMC has plans to pilot the voucher scheme as a tool for targeting the distribution of ITNs to the poor and vulnerable groups. The ITN component under the GFATM proposal envisages the acquisition of 800,000 ITNs over 2 years (400,000 per year) targeting pregnant women (200,000) and children under 5 years (200,000) each year.

The summary situation regarding ITN coverage in Kenya is that there is free net distribution to pregnant women through the antenatal clinics (ANC) at public health facilities. The social marketing of ITNs (SMITNs) is on-going in the country with emphasis in malaria endemic regions; and the distribution of ITNs through donors, NGO/CBOs (through some form of income generating activities and various cost sharing approaches) is taking place in a few districts. Current ITN distribution is estimated at 1.68 million nets (1.1 m through PSI; 200,000 (UNICEF); 50,000 (WHO); 50,000 (CDC) and 280,000 (Commercial sector). For an estimated 5 million households this gives a maximum coverage of 34% at one net per household. However, studies show that 20% of the households have at least one net and that 1% of these nets are retreated regularly. Despite the challenges and strengths listed above, the DOMC is hopeful of meeting the Abuja target of at least 60% of the households with nets by 2006, and to have 50% of these nets regularly re-treated. The DOMC is working to overcome the following challenges:

1. Insufficient insecticide stocks to mount large-scale mass net re-treatment.
2. Lack of sufficient nets to support vulnerable groups.
3. High costs of ITNs due to custom duty levied on ready-made nets
4. Poorly developed private sector (nets/insecticide producers and distributors)
5. Need to develop mechanisms to reach vulnerable groups (poor member of society)

The DOMC identifies the following as being the essential actions required in order to meet the Abuja targets: (i) Improve mass net re-treatment activities; (ii) Extend distribution of nets to all vulnerable groups; (iii) Procurement of nets and insecticide to cover districts not covered by GFTAM; (advocate for a further adjustment of taxes and tariffs on ITN products; (iv) Expand private sector involvement to go beyond SMITNs; and (v) to develop effective modalities to reach the socio-economically vulnerable groups.

6.4. Epidemic Preparedness and Response and Other Vector Control Activities²

Introduction - The current approach to epidemic control of malaria is based on a policy of geographical segmentation. The programme identifies 15 malaria epidemic prone districts in Kenya. Malaria epidemic preparedness, control and prevention activities are currently concentrated in these 15 districts of Kenya. Much of this work has been carried out under the highland malaria (HIMAL) project. Currently the HIMAL project is developing epidemic forecasting techniques for early detection of malaria epidemics in 2 districts. The establishment of a Regional Forecasting Centre in Eldoret has been proposed, to facilitate identification and mapping of high risk areas in the 15 epidemic-prone districts. However, the DOMC also recognises 6 districts in the lowland areas of Kenya as malaria epidemic prone, but no epidemic preparedness activities are currently implemented in these areas.

Current Situation – At current policy developments, 15 of 21 epidemic prone districts collect data, but data are inadequate, not collected in a timely fashion, and not effectively used. These 15 districts also carry out IRS activities, but with coverage of between 20 and 70 % of the target high risk areas detected. The arid and semi-arid areas are currently not covered and some 6 districts in these areas of Kenya need further work programmes on malaria epidemics.

Desired Targets and the Way Forward - The GoK will encourage districts defined as prone to epidemics to establish an effective early warning and detection system, as part of the Health Management Information Systems (HMIS) and Integrated Disease Surveillance and Response (IDSR), which support the DOMC's capacity to mount effective responses.

Districts prone to epidemics will be encouraged to provide indoor-residual house-spraying and novel drug management schemes to prevent and contain epidemics detected through surveillance systems. The targets set for 2006 are that (a) 80% of epidemic prone districts will have an early warning and detection system for local malaria epidemics; (b) 60% of districts will respond to reliable warning signals through their DOMT and POMT; and that (c) 60% of confirmed epidemics will be effectively contained through selective interventions, including community mobilisation, effective case management, ITNs and/or IRS.

Desired Essential Actions - The key activities to be undertaken with this strategy are (i) develop a capacity for forecasting epidemics, (b) develop early warning and early detection systems, (iii) undertake targeted interventions (such as community and service provider mobilisation; secure emergency drug supplies; and conduct indoor residual house-spraying (IRS). The expected outcomes from these actions would be (a) Improved capacity on epidemic

² This area of the RBM strategy in Kenya appears to attract HIGH attention for the GoK. In commenting on the consensus meeting presentation and to underscore concerns government concerns, the DMS said that he "was pleased to note that the presentation by the Head of the DOMC mentioned epidemic preparedness activities because the Minister of Health had recently asked him whether we would not be getting an epidemic outbreak of malaria this year".

detection and monitoring; (b) Effective mass drug administration in epidemics using anti-gametocidal drugs; (c) Increased capacity for coverage with IRS for prevention and control of epidemics in the 15 epidemic prone districts; and (d) Regular updating of buffer stocks of drugs, insecticides and equipment and health staff alerted to impending epidemics.

Other Vector Control Measures - The vector control strategy in Kenya proposes to use other control methods to **supplement** the above measures where such methods are considered appropriate. The other vector control activities considered include (a) Source reduction through larval control [use of larvivorous fish, larviciding with chemicals, filling in or draining breeding sites], (b) Promoting personal protection [such as using mosquito coils, repellent creams, household screens or the tethering of cattle to act as zooprophylaxis], (c) Aerial space spraying [“fogging” for adult vectors in selected urban areas, hotels and housing], and (d) Environmental management [implementation of broad approaches to ensure minimal vector breeding in agricultural schemes such as irrigation or dams].

Funding - Funding for activities under this area of the RBM strategy in Kenya has been pledged from DFID and WHO

6.5. Access to Clinical Case Management: providing effective, prompt treatment

Introduction - The policy framework for this area of the strategy proposes that the GoK will ensure all people at risk of malaria and those managing the disease have access to IEC to improve fever recognition and treatment and management of severe/complicated malaria. The Kenyan government has since 1997 adopted the IMCI Strategy as an approach to effective treatment of malaria and other illnesses in children. IMCI is included in the National Health Sector Strategic Plan (NHSSP) of 1999 to 2004. In the search for effective treatment of malaria, the government effected a change of drug policy from chloroquine to SP 1999. The Malaria business plans so far developed for scaling up RBM have also adopted IMCI strategy for case management

Current Situation – The situation regarding effective case management and prompt treatment is reflected through the implementation of the following plans and activities.

1. Capacity to implement IMCI has been built in 15 Districts.
2. 30% of OPD attendance accessing effective treatment with SP through health facilities
3. The IMCI approach has been included in the NHSSP 1999 to 2004.
4. Adaptation of training materials and surveys on local terms (3 districts) and foods and fluids was done between 1998 and the year 2000.
5. Development of the National IMCI implementation plan has been completed
6. Malaria business plan adopted IMCI strategy for case management
7. A Harmonised IMCI and DOMC Case management training document has been produced and is in use (2003).
8. Capacity building in implementation of IMCI at provincial, district and community levels is ongoing
9. Development of the IMCI District implementation plan for use in all the Districts
10. The desired contents for the IMCI supplementary drug kits have been developed
11. The supply of essential equipment (e.g. laboratory) for service delivery is ongoing
12. Biennial review of the implementation process has started with the early implementation phase review having taken place in 2002
13. A National IMCI implementation plan has been developed

14. IMCI case management training modules adapted for Kenya situation have been developed and some modules have been printed through funding from the World Bank (for National level) and DANIDA (for the Coast province).
15. Guidelines for District IMCI implementation have been developed.

The Way Forward – The plan is to scale up the implementation of IMCI to all the 70 districts in Kenya. Of these, 15 districts have a capacity but need rolling out for 100% coverage in their districts. Some 40 districts are scheduled to start implementing district IMCI and scale up activities throughout their areas by 2005. The GFATM funding includes resources to support IMCI implementation in 15 districts. In addition, there are plans to develop/adapt a community IMCI (c-IMCI) implementation framework in order to scale up work activities on the ground, especially so in BI-districts (through community-oriented and communication strategies). There are also plans to adapt and/or develop and produce community IMCI materials; with the aim to produce adequate IMCI guidelines and training materials suitable for all levels of service delivery.

Desired targets - In this regard, the targets set for 2006 were that (i) 80% of households at risk of malaria to receive targeted IEC, (ii) 80% of GoK health facilities to have continuous and adequate supplies of drugs essential for the management of malaria, (iii) 80% of all anti-malarials provided through formal and informal sectors to be of internationally acceptable pharmacological standards, (iv) 60% of fever cases which are treated at home by family members or caretakers will be managed appropriately, (v) 80% of all cases of fever treated by CHWs or out-patient facilities will be managed according to national recommendations, and that (vi) 80% of first-line therapeutic failures and severe, complicated malaria cases correctly will be managed by health personnel in appropriate health facilities.

Districts require support in the form of funds, guidelines and training materials, IMCI kits, and equipment, in order to ensure (i) the training of up to 60% of health workers in IMCI; ii) scaling up implementation of c-IMCI (through integrated training of CORPs by the key divisions in the Ministry of Health); iii) Equipping health facilities with adequate supply of IMCI drugs; and iv) Equipping the Bamako Initiative health posts (BIs) with adequate BI essential kits.

Scaling up Activities - The above targets will be achieved through improved awareness among client communities, improved case-management by service providers, ensuring adequate drug supply, appropriate drug registration, legislation and quality control, ensuring drug donations conform to national policy, monitoring drug efficacy, greater co-ordination with the informal sector, increasing awareness of appropriate action among the community as a whole, developing and applying strategies for improving dispensing practices by shop-keepers and other important health providers in the community, such as the traditional healers; ensuring adequate drug legislation to allow for easy access to effective anti-malaria drugs and maintaining effective regulatory control of drug products in the community

Other activities for scaling up IMCI include the development of a Community IMCI strategy and the incorporation of the IMCI drugs into the essential drugs kit.

Funding – It was hoped that funding for activities under this category would come from the WHO, DFID, and WB. No funds were committed at the time of this REAPING mission.

6.6. Malaria in Pregnancy (MIP)

Introduction - Malaria is recognised as a special area for attention in the Kenya RBM strategy. In this regard, the strategy adopted in Kenya for malaria in pregnancy is provision of intermittent presumptive treatment (IPT) to pregnant women after the 1st trimester. By the end of this year, the RBM programme in Kenya will have (a) tested MIP indicators, (b) harmonised guidelines for focussed antenatal care (FANC) services, (c) reached 60% of HF in at least 40 districts providing IPT to pregnant women, (d) attained the goal to have 100% of health facilities with trained health workers will have FANC kits and that the programme will have identified lead (drug) candidates to replace SP with combination therapy (CT).

Current Situation - A number of achievements have been recorded in this area of the RBM strategy. By 2001, training in FANC and MIP was given to health workers in 23 districts, and a baseline survey conducted in 2 districts (Busia, Kilifi) then additional 5 (Bondo, Migori, Homabay, Kwale & Taita Taveta). The work activities were piloted in the 2 baseline districts for a period of 6 months. By the year 2002 the RBM partnership had developed training materials and undertook advocacy campaigns in 15 districts (involving all health workers and all DHMTs), as well as involving 7 PHMT members. In the year 2003 advocacy work continued in 4 additional districts to DHMT members and all health workers. So far, the RBM partnership has successfully undertaken supportive supervision to 17 districts in 2003. The current standing in terms of relevant MIP indicators is given as follows:

1. Proportion receiving Ferrous/Folic supplementation is not known (supplements are given but are not recorded)
2. Situation of anaemia in pregnancy unknown as no records were reviewed.
3. Knowledge about danger signs in pregnancy by ANC clients was 25%
4. Knowledge about danger signs in service providers was 15%
5. No pre-service training on FANC or MIP
6. The provision of SP at ANC has increased at health facilities surveyed / supervised
7. Number of pregnant women using ITNs has increased 15%; with 11% of pregnant women able to access ITNs
8. Number of pregnant women receiving 2 doses of IPT has increased to 30%

The essential actions needed in order to accelerate progress towards achieving the Abuja targets were identified as follows:

1. Increased advocacy and adequate supply with IEC materials
2. Scaling up in additional 49 districts (up from the current 23)
3. Expanded Training of community CORPS
4. Increasing the availability of ITNs to pregnant women
5. Increasing laboratory services to easily and quickly detect anaemia in pregnancy
6. Improved record keeping
7. Take steps to overcome the current severe shortage of staff to implement FANC/MIP programmes by employing more technical staff to implement FANC/MIP.
8. Establish Youth Friendly Centres, and
9. Enhance communication at all levels among stakeholders.

Funding - A number of donors have pledged financial support to help with the implementation of programmes in the FANC/MIP strategy. These include the GoK, WHO, DFID, UNICEF, Global Fund (GFATM), and USAID.

Key innovations planned - Among the key activities to be undertaken in this regard will include developing FANC Kits that will include SP and Haematinics as well as undertaking a consultative drug policy review meeting in support of the IPT policy.

6.7. Malaria Drug Policy

The republic of Kenya implemented a drug policy change in 1998, moving from CQ to SP for 1st line drug, and adopting amodiaquine as the 2nd line drug, with quinine reserved for severe and complicated cases of malaria. Due to increasing resistance to SP, there are efforts to review the current Anti Malaria Drug Policy with suggestions to move away from SP to an artemisinin-based combination therapy (ACT) as 1st line. A working group on malaria treatment is now in place to review progress and advise on drug policy change by the end of 2004. In the interim, there is need to carry out tests on the efficacy of possible drug combinations to be considered for use in combination therapy (CT) as first line antimalarial drug.

Implementation: So far and in line with the current drug policy, training on the current drug policy guidelines have been given to health workers, CORPs and shopkeepers and the drug policy guidelines have been widely disseminated. As such guidelines on the use of SP are now available at all health facilities, retail outlets and in the communities. Measures are in place to implement and sustain the quality control of antimalaria drugs on the retail markets in Kenya. There are also moves to harmonise SP guidelines developed

Current coverage statistics on the new drug policy show that 67% of patients in OPD receive SP but there is a treatment failure of 45%; some 68% of patients with a negative blood smear receive anti-malarial drugs, and that 23% of SP prescriptions reviewed showed that the drugs were given at doses below those recommended. In addition, studies have shown that there were wide variations in pharmacological standards of SP available on the commercial market in Kenya. With respect to second line and third line antimalarial drugs, studies showed that there was insufficient supply of Amodiaquine and Quinine at public health facilities in Kenya.

The challenges: The spectre of increasing resistance to SP has triggered concerns and calls for a review of the current antimalarial drug policy, with a view to change it once more. The key issue is that it will be unacceptable to continue with a 45% SP resistance level. The DOMC hopes that by the end of the year 2005, at least 40% of health facilities in Kenya will be using a more efficacious antimalarial drug. Due to the expected long process required before implementation of an appropriate combination therapy in Kenya and the need to set up a functional pharmacovigilance system before introducing CT in Kenya, the DOMC hopes that Amodiaquine can serve as first line drug in the interim.

Process to change the 1st line drug: The desired actions to take on the change of drug policy are expected to start off with a national debate to develop consensus and focus on the need to change. Following national consensus on drug policy change, it is possible that there will be need for an emergency procurement of a substitute interim first line antimalarial drug (possibly to amodiaquine). In the mean time preparations will have taken place to set up a planned structure for procurement and implementation of CT drugs. The DOMC is mindful that it will take some time to change over to CT from the time the decision to change is made. It is expected that a functional pharmacovigilance system will be in place by the year 2005 to monitor any drug reactions to the CT drugs.

6.8. Supportive strategies

The Kenya RBM strategy proposes to undertake a number of activities that are cross-cutting in terms of their impact. Key among these areas of strategy is the monitoring and evaluation component as well as adopting an integrated communication strategy.

6.8.1. *Monitoring, Evaluation and Research*

The policy statement in this area of the strategy proposes that the GoK will ensure adequate monitoring and evaluation of the strategic approaches to malaria prevention and control as outlined in the national malaria strategy (NMS). The GoK will promote targeted, operational research that supports the implementation of the NMS and will provide effective channels of communication between control and research communities.

The strategy proposes to undertake periodic impact assessments at the health facility and community levels. The strategy further proposes to establish working collaborative links with the research community in Kenya (whether public or private institutions) for sharing of knowledge and information on malaria. Other desired research activities supported in the NMS include:

- (a) Monitoring success of the NMS towards its stated targets for 2006,
- (b) Tailoring RBM core and supplementary indicators to suit the NMS,
- (c) Liaising to ensure the incorporation of appropriate malaria components in the HMIS and IDS,
- (d) Conducting national surveys every three years,
- (e) Re-defining 2010 targets in light of data collected
- (f) Providing secretariat support to a national Working Group on Monitoring and Evaluation,
- (g) Liaising with other health sub-sectors, the Central Bureau of Statistics and the National Council for Population and Development,
- (h) Supporting Provinces and Districts in developing local monitoring and evaluation of malaria control, and
- (i) Providing secretariat support to a Malaria Research Working Group.

6.8.2. *Communication and IEC*

The GoK will implement a multi-pronged integrated media campaign strategy to ensure that all Kenyans have access to appropriate; accurate and culturally relevant information about malaria control and management, so effective behavioural change is achieved.

Current Situation - The national communication strategy has been developed and spells out the IEC policy. In the meantime, work has already begun to select from the existing materials the appropriate ones for use. It was expected that the national strategy for scaling up the use of the national communication strategy would be in place by December 31st, 2003.

Coverage of IEC based on existing materials is at 50% of districts. At community level, the percentage of households that had received any printed any IEC material relating to malaria control and prevention in the 12 months preceding the last evaluation was 2%. The challenge here is to cover the next 50% of the districts as well as raising the coverage with IEC materials at community/ household level. The RBM programme in Kenya hopes to increase coverage

with IEC materials such that at least 40% of households would receive some printed IEC materials related to malaria control and prevention within the next 1 to 2 years. This target figure is based on the following assumptions:

- That the strategy document will be officially adopted by close of 2003.
- That the funds for IEC will still be available both from DFID and the Global Fund; and that these funds will be adequate for national scaling up the IEC strategy.
- The existence of KeNAAM will complement efforts by the IEC strategy
- That CORPs who would form the backbone of the IEC drive will be trained in malaria control and prevention messages/ activities.
- Working in collaboration with KeNAAM, 70% of CORPs would have been engaged in the distribution of IEC.

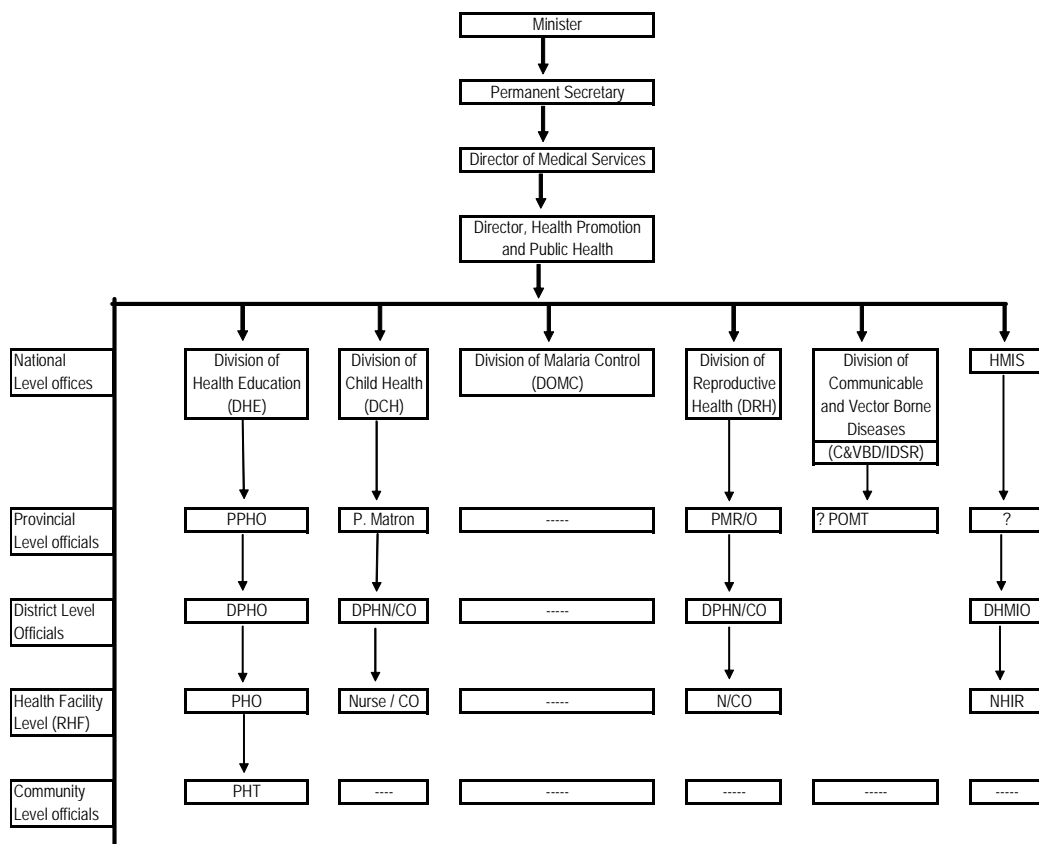
The way Forward - The target set in this strategy to be achieved by 2006 is that 80% of households nation-wide should have received targeted IEC on all key messages from at least one source every 6 months to support the previously defined strategies. In order to achieve this target the programme proposes setting up an IEC Working Group (to ensure co-ordinated and complimentary approaches; that messages are in concert with national policy recommendations; that resource needs are defined; monitoring strategic direction; and liaising with other technical Working Groups to set priorities and ensure unmet needs are remedied. Other desired approaches include ensuring the existence of (a) Partnerships at district and community levels for education and skills building, (b) Partnerships with Non-Government, not-for-profit health care providers, (c) Partnerships with Private Sector manufacturers and distributors of malaria products, (d) Partnerships with other Private Sector Organisations, and (e) Partnerships for sponsorships. The activities to be undertaken in support of these approaches will include the holding of workshops, contacts with the mass media, media relations, publishing and distributing print materials, involvement in school health programmes and malaria day activities, developing epidemic community awareness schemes as well as Resource centre and a web-site

6.9. Malaria Control and the Health System

6.9.1. Organisation of malaria control in Kenya

The Government of Kenya, through the Ministry of Health, is the principal institution in charge of malaria control and prevention activities in Kenya. Malaria control is organised into a separate division (DOMC), placed in the directorate of health promotion and public health. Recently, the DOMC has received some funding from DFID (Kenya) to build offices and provide some work place infrastructure, such as furniture (tables, chairs, conference room, etc) and equipment (computers, photocopiers, vehicles, etc). The staffing situation at the DOMC was said to be much improved with 20 employees, 4 of whom are qualified to PhD level.

Figure 1: Organizational Structure for Malaria Control in Kenya



Of the several disease control divisions at the ministry, the DOMC is the most recent, having been carved out of the division of communicable and vector borne diseases. As such, the DOMC establishment does not go beyond the central level structure (see figure 1). This lack of lower level structures was said to hinder effective supervision in the provinces and districts. Thus the DOMC tended to rely on the goodwill of other divisions and their provincial as well as district level health managers in effectively implementing its work programmes to reach some of the Abuja targets³. To this end, the RBM partnership in Kenya has served a positive role by extending the DOMC work activities for the control and prevention of malaria in the country. One of the expressed and desired essential actions for strengthening the supervisory activities of the DOMC was to seek direct staff establishment for representation at the provincial level.

6.9.2. Health systems development

The average annual growth of the Government's contribution to the health sector is a reflection of its commitment towards supporting health services in the country. MOH's recurrent budget during the financial year 2001/2002 accounted for about 7% of the Government's total expenditure. Out of the recurrent budget 70% covers curative services and 21% supports PHC

³ For examples, the Division of Reproductive Health may take on the responsibility for co-ordinating the development of training materials, pre- and in-service training, IEC and distribution of supplies, while the DOMC to provide technical support where needed and the PHMTs and DHMTs have the responsibility for implementing malaria control and prevention programmes.

activities. Out of this 70%, two-thirds is directed towards supporting personnel emoluments, while approximately 21% are used for the purchase of drugs and supplies, leaving 9 % available for operations and maintenance. While donor funding represents only 3% of the overall expenditure on health by the various contributors, it accounts for over 90% of the development budget i.e. the budget for capital expenditure, grants and any credits to the government.

6.9.3. Human resources

Human resources capacity within the Ministry of Health is reported to be largely adequate in terms of staffing levels, although a need for further training has been expressed. Training needs have been expressed on clinical care through the IMCI approach as well as for the implementation of the Malaria in Pregnancy (MIP) component through the IPT approach. Training needs were based on the specific needs for each of the RBM strategy areas. It is not known if a Human Resources strategy exists for the health sector in Kenya.

6.9.4. Logistics

Planning and budgeting for malaria control in Kenya starts from the grass roots structures. The health centres, dispensary and community based health structures prepare their plans and budgets for consolidation into the district budget by the District Health Management Teams (DHMTs). The DHMTs collect these budgets and plans from the public sector and add onto them plans and budgets from NGOs and the mission health structures along with plans and budgets from the private sector. The DHMT consolidates all these plans and budgets for consideration and prioritisation by the District Health Stakeholders' Forum into a sub-sector 5-year District Development Plan. The unified sub-sector plans and budgets are then submitted to the District Development Committee, which prioritizes the sub-sector projects within the district. In undertaking these roles, the DDC works closely with the provincial level and the Ministry of Health (MoH) officials to ensure that guidelines for project prioritization and district expenditure ceilings are adhered to. The provincial level prioritized DDC plans and budgets based on known district requirements, liaising closely with the Ministry of Health in the process.

The MoH liaises closely with the Ministry of Finance and Planning (MoF&P) to negotiate a budget ceiling to be used in coming up with a health budget as well as to take the MoH budget proposals to the MoF&P for inclusion into the national budget.

6.9.5. Financial resources

The public service in Kenya has established channels for disbursing funds to health institutions and projects country-wide. These disbursement guidelines are followed and adhered to by financial controlling officers at all levels. The table below gives an example of funds disbursed in the 2001/2002 financial year under the ministry of health budget.

The GoK funds are channelled through district treasuries and are supplemented by funds from the Facility Improvement Fund (generated through cost sharing). Funds from the cooperating partners, such as the World Bank, DFID, SIDA and DANIDA are channelled directly to the districts. The total earmarked expenditure for malaria (public, private and donors) is estimated at US\$ 23,115,000 for 2002/2003.

To implement the National Malaria Control Strategy, MoH, together with partners and with support from RBM/HQ and AFRO, has developed 13 district-integrated plans of action and six divisional plans. These business plans have been consolidated into a single National Business Plan, in which the JICC has identified priority activities that require support from the GFATM. The Business Plan identifies malaria activity coordinating mechanisms and will bring on board implementing partners including JHPIEGO, PSI and AMREF to participate, particularly in areas of their expertise.

Table 1: Health spending 2001/2002

	Total national health spending 2001/2002 (USD)	Spending per capita (USD)
Public	149,000,000	4.94
Private	(estimate) 131,000,000	(estimate) 4.34
Total	280,000,000	9.27
External donor contribution	(9%) 25,200,000	0.83

7. ABUJA TARGETS – WILL THEY BE MET?

The key Kenya RBM National Strategy and Abuja 2005 targets are:

- 60% of under-fives and pregnant women sleeping under ITNs by 2005.
- 60% of pregnant women receiving IPT1 and IPT2 by 2005.
- 60% of under-fives with fever receiving effective treatment within 24 hours by 2005.

The existence of the malaria strategy business plans, coupled with the guidelines contained in the national malaria strategy document as well as the strong financial commitment from the local RBM cooperating partners; and supplemented with knowledge gained from the recent REAPING mission to Kenya give hope that sufficient planning and commitment exists to reach the desired Abuja targets. On the one hand, the REAPING mission to Kenya succeeded in helping the DOMC and partners to identify the essential actions that were needed to try meeting the desired Abuja targets for the year 2005. Though financial commitment had already been made to some of the planned activities, the efforts of the REAPING mission assisted the DOMC in formulating a clearer understanding on what it would mean, in terms of critical actions to implement, to reach the 2005 Abuja targets (see Tables 2 and 3).

The REAPING mission to Kenya also succeeded in bringing together partners for an open discussion of issues and essential actions for achievement of the Abuja 2005 targets. A case was made for support for IMCI implementation in Kenya. The country co-operating partners were interested but reluctant to fund the IMCI activities due to the high cost involved (estimated at US\$1,000 per person trained). Consensus was reached that costs could come down if the IMCI training could be streamlined to meet the malaria case management interests of Kenya, rather than covering the full course. Another suggestion was that the cost of the IMCI training could come down if priority training was to focus on the 40 malaria endemic districts on the priority list of the DOMC, with training “piggy-backing” on other RBM activities. Other suggestions made were that the organisers of IMCI training could actually help cut costs further by undertaking their training workshops in more modest hotel settings as opposed to using more expensive hotels. IMCI training was identified as the essential gap in

funding of RBM activities in Kenya (Table 3), with no co-operating partners committing funds to it.

Discussions with some of the local donor partners brought out some apprehensions on logistical issues around monitoring and evaluation, as well as on financial flows to districts. Suggestions were made that there was need to have a more senior ministry of health official to be regularly briefed on progress of RBM implementation using a user friendly presentation format of data. This approach would help to keep the focus of senior ministry officials on what was taking place on the ground in terms of RBM implementation; rather than a situation where they waited for periodic briefings from the DOMC. In addition, it was expected that the DOMC would soon be overstretched with supervisory activities as nationwide scaling of RBM implementation progressed. It was also observed that existing guidelines on financial flows did not take into account the scale of funds that financial officers at district level could reasonably handle. This situation has at times meant that extra signatures were required in order to move such monies to districts; thereby introducing more red tape and leading to delays in the release of funds. In some cases it was noted that financial officers were not familiar with procedures regarding handling of “non-GoK” money, leading to a situation of blocked funds. These concerns echoed by co-operating partners were also frequently echoed in the group work presentations made by those that worked on the various theme areas of the Kenyan RBM strategy.

The lack of empirical data and models that would allow us to make firm estimates means that the estimates on attaining the Abuja targets for 2005 (Table 2 and 3 below) should be interpreted as broad indications. Moreover, the estimates given shared a number of assumptions, which included:

- That the release of funds will be **timely** both for implementation and supervision⁴
- That the national strategy document will be officially adopted by close of 2003.
- That the money pledged to the various areas of the strategy by partners will be available and be adequate for national scaling up of the various malaria control programmes.
- KeNAAM and other RBM partnerships for intensified community based malaria control and prevention activities in Kenya will continue to exist
- Number of pregnant women using ITNs will increase by 15%
- Number of pregnant receiving IPT will increase to 30%
- Laboratory staff will be trained in microscopy and rapid diagnostic tests (RDTs)
- That quality controlled products will be available to support effective outcomes from the use of these products.
- Effective first-line drugs (expected to be combination therapy) will be approved
- A Conducive working environment will exist
- That there will be availability of trainers and trainees to expand and improve the skills base of health workers⁵

⁴ This logistical aspect was expressed by many stakeholders during the work groups’ sessions and in discussions with other country RBM partners. The issues in contention were that there were lengthy procedures in accessing donor funds. Even when such funds arrived, procedural delays and the bureaucracy in the financial control systems made access to these funds difficult. As a result, some DHMTs or other recipients experienced delays in program implementation and supervision, while in some cases, it was reported that recipients gave up trying to access the donor funds all together.

⁵ The issues giving rise to the assumptions in these last two bullets centred on differences in the perceptions and costing of desired interventions. The cost of undertaking IMCI exemplified the impact of such differences on programme implementation. The cost of IMCI was described as prohibitive (at USD 1,000 per trainee) and pledged donor funds could not be released as a result. Though willing to fund the programme, the alternative view

- That the pledged investment by Government and Partners will be forthcoming

Due to the paucity of data giving periodic and more representative measures of outcomes, it was not possible to prepare graphs of progress made to date and thereby gauge the potential to attain the Abuja targets. Much of the available data on outcomes in Kenya had been obtained from selected discrete studies. This is reflected in the information provided below.

The following stand out as the current performance on selected RBM targets, from the different studies so far undertaken by various groups and individuals on malaria in Kenya.

7.1. ITN coverage among under-fives

It is estimated that by the end of 2005, 60% of under-fives will be sleeping under an insecticide-treated mosquito net if the following occurs:

Table 2: ITNs

Year	Assumptions and actions
2002	Coverage was estimated based on available data from 1999-200 RBM Baseline survey (Snow, 2003) <ul style="list-style-type: none"> • Coverage is 4.0%.
2005	<ul style="list-style-type: none"> • The continued existence of the KENAAM (NGOs and CBOs) for the RBM partnerships in Kenya • There will be enough insecticide to mount large-scale mass net re-treatment. • Taxes and tariffs on ITNs will be waived or reduced further on ready nets. • Mechanisms to reach vulnerable groups and the poor members of society will be developed and applied. • Creating an enabling environment • There will be adequate demand created on ITNs • There will be the provision of subsidised, donor-assisted ITN services to special groups • Donor consistency (on funding commitments) • Coverage increases to 60%.

NB. An important assumption for this target is that funds will be available to purchase ITNs for a one-time distribution to all children under 5 years and that the availability of IEC materials/messages along with the work of the KeNAAM RBM partnerships will impact positively in this regard.

7.2. IPT coverage among pregnant women

It is estimated that by the end of 2005, 60% of pregnant women will be receiving 2 doses of IPT (IPT1 and IPT2) if the following occurs:

Table 3: IPT

Year	Assumptions and actions
2002	Coverage was estimated based on available data from 1999-2002 RBM baseline survey (Snow, 2003) <ul style="list-style-type: none"> • Coverage is 4.6% (both doses).
2005	<ul style="list-style-type: none"> • Provision of IPT will be free of charge through ANC services • The Division of Reproductive Health to take responsibility for co-ordinated development of training materials, pre- and in-service training, IEC and distribution of supplies

was that IMCI training could be adapted and made more cost-effective. The other point of contention mentioned being that while the DOMC was anxious to support quick funding to the 40 malaria prone districts of Kenya, the IMCI secretariat was focusing on securing funds to for training in all 72 districts as part of RBM.

<ul style="list-style-type: none"> • The DOMC will provide technical support and monitoring of drug sensitivity and efficacy • The PHMTs and DHMTs responsible for implementing • Coverage increases to 60%.

NB. An important assumption for this target is that Number of pregnant women receiving IPT has increased to 30% from current levels as of October 2003.

7.3. Access to effective treatment for under-fives

It is estimated that by the end of 2005, 60% of under-fives with fever will be receiving effective treatment within 24 hours if the following occurs:

Table 4: Treatment

Year	Assumptions and actions
2002	Coverage was estimated based on available data from 1999-2002 RBM baseline survey (Snow, 2003) <ul style="list-style-type: none"> • Coverage is 4.4% fevers in previous 14 d in children <5 that were treated with SP within 48 hours
2005	<ul style="list-style-type: none"> • That greater awareness among client communities will be created • That efforts will be made at ensuring adequate drug supply • There will be appropriate drug registration, legislation and quality control measures • There will be appropriate measures to ensure that drug donations conform to national policy • There will be rigorous monitoring of drug efficacy • That the following will apply to the informal sector <ul style="list-style-type: none"> - Increasing awareness of appropriate action among the community as a whole - Developing and applying strategies for improving dispensing practices by shop-keepers and other important health providers in the community, e.g. traditional healers - Ensuring adequate drug legislation to allow for easy access to effective anti-malaria drugs - Maintaining effective regulatory control of drug products in the community • Coverage increases to 60% of under-fives with fever will be receiving effective treatment within 24 hours

NB. An important assumption for this target is that a decision for an effective anti-malaria drug will be reached soon, in view of increasing resistance level to SP.

8. THE ESSENTIAL ACTIONS

The RBM movement in Kenya has been put in place and the DOMC has been given an essential capacity to manage the programme. Links between the DOMC and the districts on malaria control and prevention have been established, as can be ascertained from the malaria business plans developed for 13 districts. Funds for malaria control activities have been pledged by the RBM partnerships at both the country level and the global level (GFATM). The pledged GFATM funds have since arrived in Kenya and are accessible to the DOMC. The DOMC were of the view that districts were geared to and ready to scale up malaria control and prevention activities if the pledged additional funds from the partnerships could be made available timely.

This REAPING mission to Kenya has enabled the DOMC and the RBM partnership in Kenya to refocus its approach as well as to identify essential gaps in the planned programme implementation and enabled the programme management to identify desired essential actions

to help attain the Abuja targets by the year 2005. Gaps were identified in terms of additional skills needed, desired scales of interventions to be undertaken, as well as problems with the financial accounting system and financial flows to support scaling up of programme implementation. The REAPING mission helped to harmonise some misconceptions and misunderstandings between stakeholders in the RBM partnerships and consensus was reached on some issues. A case in point concerned the harmonised perception on the cost of implementing IMCI in Kenya.

Useful suggestions and ideas were brought out regarding how best the scaling up of RBM in Kenya could be undertaken with greater efficiency. A proposal was made to try developing a tool for tracking progress on RBM by higher management level in the ministry. Such a tool would need to be simple and very user friendly, yet provide sufficient information to inform higher management of progress made on the ground towards fulfilling set goals and targets. Other useful suggestions concerned the need to examine different systems of financial flows of different governments with a view to harmonising their performance and capacity to administer the additional funds pledged by the partnerships and required for scaling up RBM implementation at country levels.

The essential actions given below are those that are currently unfunded, but are deemed necessary by the DOMC and the Kenya RBM Country partnership, in order to accelerate implementation and reach the Abuja 2005 targets given earlier in this report.

As earlier stated, funding to IMCI activities was unavailable due to a number of reasons. This area is thus an essential gap that needs funding in order to help achieve some of the set Abuja targets.

8.1. Case Management

8.1.1. IMCI Training to Health Workers

Essential Need:	There are 40 malaria prone Districts without supplementary resources for IMCI
The Target by 2005	To have At least 60% of Private/public HF practitioners trained & practising IMCI
Proposed action	Mobilise human resources for capacity building (TOT training) and material resources (Training materials, Drugs, weighing Scales, etc) and then ensure rolling out at district level
Essential Gap	Estimated at USD 1,800,000

Will the desired essential actions be sufficient to address the identified gaps in order to meet the Abuja targets? The DOMC felt comfortable that with the current level of funding and the plans so far developed with districts, the set Abuja targets can be reached. The major worry they had concerned whether the existing regulations would enable the DOMC and partners to access these funds in a timely manner to help with progress in implementation. The DOMC has received some substantial funding from the DFID, while their global fund application was also approved and the global funds were coming at the time of concluding this consultative mission to Kenya.

9. PROPOSED COUNTRY SUPPORT PACKAGE: ESSENTIAL ACTIONS & INVESTMENTS – KENYA

Strategic approaches	Strategies	Practice / Issues	Targets for 2005	Essential actions	
Case management	IMCI	Capacity to implement in 15 districts	At least 60% of Private/ public HF practitioners trained & practising IMCI	Mobilise additional resources and ensure rolling out	
		GFATM to support 15 Districts	At least 60% of Private/public HF practitioners trained & practising IMCI	Ensure Implementation of GFATM proposal	
		40 Districts without supplementary resources for IMCI	At least 60% of Private/public HF practitioners trained & practising IMCI	Mobilise resources for capacity building and resources & ensure rolling out at district level	
	Diagnostic	Proficiency done in all districts	At least 60% of Private/ public HF Lab personnel trained	1 Mobilise resources & ensure capacity building 2 Mobilise resources & ensure rolling out at district level	
	Drug policy	Policy review is needed			
		1 st line SP, 2nd line AMQN, Severe malaria QUININE		At least 60% of malaria cases treated with effective drug	Drug policy reviewed and consensus on change to CT reached
		The efficacy monitoring in 4 sentinel sites		At least 80% of antimalarial drugs conform to international pharmaceutical standards	Mobilise resources to ensure regular sampling and analysis of antimalarials on the market
	Increasing resistance to SP above		Adopt CT for treatment of malaria	Collect data on CT options	
MIP	IPT	23 districts already implementing IPT	To cover 60% of pregnant women in 70 districts with IPT	Develop mechanisms to allow all pregnant women access Free IPT in mission health facilities; Roll out IPT services in 23 districts; Introduce and roll out IPT services in 47 districts	
	ITN	Distribution of free / subsidized ITNs to Pregnant women has begun in 40 districts.	Cover at least 60% of pregnant women in at least 40 districts; Target and cover at least 60% of pregnant women with ITNs in the remaining 30 districts	Review and clarify policy guidelines on ITNs to pregnant women; Improve targeting of ITNs to pregnant women through the voucher system; Mobilise resources to procure 1.5 million ITNs	
Vector control	ITN	Approx. 1.7 million ITNs (covering an average of 30% households) have been procured through a mix of approaches: Social marketing is active in 27 districts, direct distribution in 40 districts, and the commercial sector. Pregnant women and children and children under five years have been targeted for free ITNs distribution	At least 60% of Households will have ONE bed net; That at least 50% of these nets will be regularly retreated	Facilitate the availability of 1.7 million ITNs and 5.1million retreatment kits over 2 years. One time distribution to children under 5 years old	
Epidemics	IRHS with EFFECTIVE CASE	Community spray teams have been established in 15 highland epidemic prone districts. An average of 30% of dwellings in targeted areas has been sprayed. No	All districts in highland epidemic prone areas to achieve 80% of targeted dwellings; Establish a collaborating centre for malaria	Mobilise resources to procure additional buffer stocks (pumps, chemicals, drugs, protective gear, etc); Develop capacity for	

	MANAGEMENT	system to forecast epidemics exist. (epidemics are currently managed through malaria case management)	epidemic forecasting	epidemic forecasting in collaborating institutions.
Supporting Structure				
IEC		National communication strategy in development; Fragmented dissemination of IEC; 50% of districts covered with IEC materials; So far 2% of households have received IECs	Develop / or roll out a large mixed-media national communication campaign; Reach at least 80% of households with at least one malaria message. 100% of districts covered with IEC messages	Mobilise resources and sub contract media experts to implement the communication strategy; Develop capacity at the DHE on malaria issues; Include malaria in school health programmes
M&E		RBM baseline data collected; nationally RBM core indicators data collection ongoing in six sentinel sites; Drug sensitivity sentinel sites have been established; Large amount of malaria research available and ongoing	To have up to date evidence of the outcome and impact of malaria control interventions	Conduct special surveys to generate up to date evidence for Abuja summit; Strengthen operational research and linkages among DOMC, partners and research communities. Conduct baseline research on/in key strategies, (current status, methodologies, impact, etc)
Programme support		Has Good staffing; Has new building and infrastructure; Poor integration with other divisions; Business plans have been developed with 25 districts	Maintain and sustain staffing; Better integration with other divisions	Establish malaria contact/ focal persons at sub-national level; Expand business planning to cover the remaining 45 districts

Table 5: The Essential Actions and Essential Budget to Reach Abuja Targets

Targets for 2005	Essential actions	Investment Gaps			YEARLY COST (US\$)		Meeting the Gap
		Human Resource	Commodities	Equipment	2004	2005	
At least 60% of Private/public HF practitioners trained & practising IMCI	Mobilise additional resources and ensure rolling out	None	Training materials, drugs	Scales	100,000	100,000	DFID, UNICEF
At least 60% of Private/ Public HF Practitioners trained & practising IMCI	Ensure Implementation of GFATM proposal	None	Training materials, drugs	Scales			GFATM?
At least 60% of Private/ Public HF practitioners trained & practising IMCI	Mobilise resources for capacity building and resources & ensure rolling out at district level	TOTs	Training materials, drugs	Scales	1,800,000	1,800,000	
At least 60% of Private/public HF Lab personnel trained	1) Mobilise resources & ensure capacity building; 2) Mobilise resources & ensure rolling out at district level	TOTs	Training manuals, reagents	Microscopes, Hb metres	50,000	50,000	GFATM, WHO
At least 60% of malaria cases treated with effective drug	Drug policy reviewed and consensus on change to CT reached	Technical assistance			200,000		WHO, EANMAT
At least 80% of antimalarial drugs conform to international pharmaceutical standards	Mobilise resources to ensure regular sampling and analysis of antimalarials on the market		Drugs, reagents		250,000		DFID, WHO
Adopt CT for treatment of malaria	Collect data on CT options	Technical assistance			20,000,000		MTEF, WHO, UNICEF, DFID
To cover 60% of pregnant women in 70 districts with IPT	Develop mechanisms to allow all pregnant women access Free IPT in mission health facilities; Roll out IPT services in 23 districts; Introduce and roll out IPT services in 47 districts	TOTs		Delivery kits	100,000	100,000	DFID, WHO, UNICEF, JHPIEGO
Cover at least 60% of pregnant women in at least 40 districts; Target and cover at least 60% of pregnant women with ITNs in the remaining 30 districts	Review and clarify policy guidelines on ITNs to pregnant women; Improve targeting of ITNs to pregnant women through the voucher system; Mobilise resources to procure 1.5 million ITNs		700,000 ITNs	Vehicles	2,600,000	2,600,000	UNICEF, WHO
At least 60% of Households will have ONE bed net; That at least 50% of these nets will be regularly retreated	Facilitate the availability of 1.7 million ITNs and 5.1million retreatment kits over 2 years. One time distribution to children under 5 years old	TA	1.7million ITNs	Vehicles	2,000,000	2,000,000	UNICEF, WHO, PSI

All districts in highland epidemic prone areas to achieve 80% of targeted dwellings Establish a collaborating centre for malaria epidemic forecasting	Mobilise resources to procure additional buffer stocks (pumps, chemicals, drugs, protective gear, etc) Develop capacity for epidemic forecasting in collaborating institutions.	TA FOR CENTRE	1 metric ton of insecticide, coartem	1000 pumps	1,000,000	1,000,000	UNICEF, WHO
Develop / or roll out a large mixed-media national communication campaign; Reach at least 80% of households with at least one malaria message. 100% of districts covered with IEC messages	Mobilise resources and sub-contract media experts to implement the communication strategy; Develop capacity at the DHE on malaria issues; Include malaria in school health programmes	TA on communication strategy	Materials	Audio visual	500,000	500,000	UNICEF, WHO, DFID
To have up-to-date evidence of the outcome and impact of malaria control interventions	Conduct special surveys to generate up to date evidence for Abuja summit; Strengthen operational research and linkages among DOMC, Partners and research communities. Conduct baseline research on/in key strategies, (current status, methodologies, impact, etc)	TA		Computers	500,000	500,000	WHO, UNICEF, KEMRI/WELL COME TRUST
		TOTs		Computers	200,000	200,000	WHO, UNICEF
Annual Totals expected in order to reach Abuja targets (US \$)					29,300,000	8,850,000	
Essential gap needed to get the Abuja targets (US\$)					1,800,000	1,800,000	

10. ANNEX 1: LIST OF PERSONS AND ORGANISATIONS CONSULTED

WHO (Kenya) Country Office
 DFID Kenya
 UNICEF Kenya Country Office
 World Bank Country Office - Kenya

10.1. Participants at Consensus Meeting, 30th October 2003 at DOMC

RBM REAPING MEETING HELD IN THE DOMC CONFERENCE ROOM 30 th OCTOBER 2003					
ATTENDANCE LIST					
No.	NAME	ORGANIZATION	No.	NAME	ORGANIZATION
1	Dr R. S. Muga	DMS (MoH)	16	N. B. Mageto	DOMC
2	Marilyn McDonagh	DFID	17	Kwabena Larbi	DFID/ DOMC
3	Annah WAMAL	DCH	18	Dr Suprotik BASU	RBM / World Bank
4	Blanche K. M. TUMBO	DEH	19	Eric WERE	DOMC
5	Charity W. Kirundu	DOMC	20	Charity Ndwiga	DOMC
6	Jacqueline A. Nyanga	DOMC	21	Dr David SANG	DVBD
7	Ruth Kihava	DOMC	22	Dr S. Ochola	DOMC
8	James Sekento	DOMC / MoH	23	Dr Melanie Renshaw	UNICEF / ESARO
9	Dr T. J. Ngulube	Malaria Consortium	24	Abimbola Williams	UNICEF / ESARO
10	Dr Mores Loolpapit	AMREF	25	Timothy Musombi	DOMC
11	Dr Willis Akhwale	DOMC	26	Joseph Mwongela	DHE
12	Dr John Chimumbwa	Net Mark	27	Dr James J. Banda	RBM/SEC/WHO
13	Dr Grace Miheso	UNICEF KCO	28	C. M. Wang'ang'a	DCH
14	Dr Beth Rapunda	DOMC	29	Dr A. M. NGINDU	WHO/KCO
15	Dr Kiambo Njagi	DOMC			

11. ANNEX 2: AGENDA OF CONSENSUS MEETING (30 OCTOBER 2003)

Item Serial Number	Activity	Responsibility
1	Introductory remarks and self introduction of participants	Dr S. Ochola
2	The Background and Purpose of the REAPING Mission to Kenya	Dr James J. Banda
3	Presentation by the Head, DOMC, MoH (Kenya)	Dr S. Ochola
4	Comments and Reaction by the Guest of Honour	The Director of Medical Services, MoH, Kenya (Chair)
5	Discussions, Consensus on the Essential Gaps and issues raised	Plenary Open Discussion

12. ANNEX 3: DOCUMENTS REVIEWED DURING COUNTRY CONSULTATIVE MISSION

- 1) Kenya REAPING Desk Review - The Malaria Consortium
- 2) Monitoring progress and evaluating the outcomes and impact of the Kenyan National Malaria Strategy: A review of baseline status and a framework for future monitoring. Report prepared for the Division of Malaria Control, Ministry of Health and the Government of Kenya (GoK) with support from the Department for International Development (UK) – Kenya January 2003; by R. W. Snow, Professor of Tropical Public Health, University of Oxford, & Head of the malaria public health group, Kenya Medical Research Institute – Wellcome Trust Collaborative Program, Kenya

13. ANNEX 4: PROGRAMME OF ACTIVITIES TO IDENTIFY GAPS AND ESSENTIAL ACTIONS

Re-Structured Programme of Activities for the REAPING Mission to KENYA – October 2003

Day and Date	Morning	Afternoon
Wednesday 22 nd October 2003	Departed Lusaka for Kampala via Nairobi	Arrived Kampala Midnight
Thursday 23 rd October 2003	Briefing and Review of Procedures and documents for the mission (Dr Graham Root)	Briefing and Review of Procedures and documents for the mission (Dr Graham Root and Ms Allister Bell). Departed for Nairobi at 19.50 hrs
Friday 24 th October 2003	Meeting with Dr Mores Loolpapit of AMREF. Driven to the DOMC to brief the Deputy Head (Dr Willis Akhwale) about the mission. The DOMC Head, Dr Sam Ochola, had left for a scheduled fieldwork activity and had delegated the REAPING Mission assignment to the Deputy Head.	Briefing Dr Akhwale on the mission and making up a time table of work activities for the DOMC and the REAPING Mission. An MICC meeting was planned for Thursday 30 th October in the afternoon. Because many of the staff responsible for specific areas of the RBM strategy were out on fieldwork, the DOMC deputy head suggested he would use the weekend to prepare work briefing, in readiness for work input on Monday 27 th October.
Saturday 25 th and Sunday 26 th	DOMC Preparations	DOMC Preparations
Monday 27 th October 2003	Meeting with and Briefing to ALL DOMC Staff and RBM Strategy work Groups. Discussions undertaken and key issues about the mission clarified. Mode of work agreed upon. A request was made to bring on board staff from other MoH divisions and other RBM partnership members. Group work commenced as DOMC staff.	Group Work Session 1 Group work with plenary by end of the day. The work groups decided that they needed more information concerning the operations of the voucher scheme as a tool to help target the delivery of ITNs to defined groups, such as pregnant women.
Tuesday 28 th October 2003	The session started with a review of progress made the previous day followed by a short presentation on the operations and performance of the ITN voucher scheme as piloted in Zambia (Dr John Chimumbwa, Netmark). Following discussions and clarifications on the voucher scheme, Group work Session 2 started and continued in the afternoon.	Group work session 2 continued with plenary by end of day. A review of progress made so far was done by the REAPING Mission team with a view to refocus the group work inputs to specifics. Group work approaches and work tools were designed for use. The work would be completed in 3 more focused group work sessions.

Wednesday 29 th October 2003	Group Work Session 3 <ul style="list-style-type: none"> Review past to present situation in your area 	Group Work Session 4 <ul style="list-style-type: none"> Compare present situation with ABUJA targets Determine what can be realistically achieved by end 2005 Determine what EXTRA efforts needs to be put in to achieve set targets by 2005
Thursday 30 th October 2003	Meeting with the WR (WHO Offices) Group Work Session 5 ⁶ <ul style="list-style-type: none"> Costing (using broad estimates) of the area Group Work Session 2 	MICC Partnership Meeting <ul style="list-style-type: none"> Convene the MICC to share costed additional Essential Actions to reach the Abuja targets. Meeting with DFID (DFID Office)
Friday 31 st October 2003	Facilitation with Essential Actions; Meeting with UNICEF	MEETING with World Bank Officials (Kenya Country Office); Consensus on the NEXT steps

Guideline Issues to Focus on During Group Work Sessions 3 - 5.

- Capture the **Developments that have taken place** in your particular area of Malaria Strategy over the last 3 years or so by focusing on:
 - Policy** Developments - [How far have we gone to developing policies to enable scaling up interventions?]
 - Strategy** Developments - [Do we have guidelines in place to implement strategies? Have these guidelines been shared with Districts?]
 - What are the **key OUTCOMES** from current level of performance of the programme (baseline situation) for the strategy being discussed?
- How does the existing baseline situation in your area of strategy compare with the **ABUJA targets**?
- What would be the more **realistic targets** to set and/or achieve by end of 2005?
- What actions will it take **to reach the set targets** by the end of 2005 [What are the ADDITIONAL Essential actions needed to meet set targets]?⁷
- What are the **assumptions made** for things to happen so as to enable reach set targets (annually?)
How are you aiming/ strategizing to achieve set targets
What role is there for the DOMC on Decentralization (and vice-versa)? What kind of metamorphosis is required of the DOMC towards providing supportive supervision?

⁶ Group work session 5 could not be done because group work session 4 took longer to accomplish. The REAPING mission team sat to review progress and discuss all group work sessions done with each of the groups separately in order to sharpen focus on essential actions as well as to collectively gauge realism to reach Abuja targets. A core group was formed to coordinate and take this step forward and present completed work at the forthcoming regional malaria meeting in JINJA - Uganda (November 2003).

⁷ Ask yourselves – What can realistically be achieved over the next 2-3 years to 2005? With what kind of actions [policies, strategies, guidelines, etc] can these be achieved?