Annual Review – post April 2018

Title: Reducing Maternal and Neonatal Deaths in Kenya		
Programme Value £ (full life): £64.6m		**Review Date: September-October 2018**
Programme Code: 202549	**Start Date:** 14/11/2013	**End Date:** 31/3/2023

Summary of Programme Performance

Year	2013/2014	2014/2015	2015/2016	2016/2017	2017/2018			
Programme Score	**B**	**A**	**B**	**B**	**A**			
Risk Rating	**Medium**	**Medium**	**Moderate**	**Moderate**	**Moderate**			

DevTracker Link to Business Case:	https://devtracker.dfid.gov.uk/projects/GB-1-202549/documents **https://ec.vault.dfid.gov.uk/otcs/cs.exe?func=ll&objId=35878062&objAction=viewheader**
Vault Link to Log frame:	**Vault Ref: 41465583** **Vault Link: https://ec.vault.dfid.gov.uk/otcs/cs.exe?func=ll&objId=41465583&objAction=viewheader**

Acronyms

ANC	Antenatal Care
BEmONC	Basic Emergency Obstetric and Neonatal Care
CEmONC	Comprehensive Emergency Obstetric and Neonatal Care
CHEW	Community Health Extension Worker
CHV	Community Health Volunteer
CICF	County Challenge Innovation Fund
DHIS	District Health Information System
DSF	Demand-Side Financing
GoK	Government of Kenya
HMB	Human Milk Bank
HSS	Health Systems Strengthening
ICF	International Climate Fund
KDHS	Kenya Demographic and Health Survey
KMC	Kangaroo Mother Care
KMTC	Kenya Medical Training College
MDTF	Multi-Donor Trust Fund
MNH	Maternal and Newborn Health
MoH	Ministry of Health
MPDSR	Maternal and Perinatal Death Surveillance and Response
NHIF	National Hospital Insurance Fund
PBF	Performance-Based Financing
TBA	Traditional Birth Attendant
THS-UC	Transforming Health Services for Universal Care
UBT	Uterine Balloon Tamponade
UHC	Universal Health Coverage

A. Summary and Overview

Description of programme Kenya has some of the highest rates of maternal and neonatal mortality in the world at 360/100,000 and 22/1,000 live births respectively (Kenya Demographic and Health Survey, KDHS, 2014). Translated into numbers - this equates to about 7000 maternal deaths and 29,000 neonatal deaths per year in Kenya[1]. The DFID-funded Reducing Maternal and Neonatal Death in Kenya programme aims to reduce mortality through increased access to and utilisation of quality maternal and newborn health (MNH) services. The original programme design focused on improving the knowledge and skills of health workers to provide emergency obstetric and neonatal care (EmONC), strengthening health systems and interventions to increase demand for MNH services in six of Kenya's 47 counties (Homa Bay, Turkana, Garissa, Kakamega, Nairobi and Bungoma[2]).

Training for health workers has been implemented by the Liverpool School of Tropical Medicine (LSTM); health systems strengthening and demand-side interventions in Bungoma has been implemented by Marie Stopes International/Options Consultancy Services (Options) under the 'MANI programme'; and health systems strengthening and demand-side interventions is implemented in the other five counties by UNICEF (ended at the end of 2017). LSTM have provided support to train health workers to be better skilled and better able to provide quality of care during birth, including both in-service (on the job) and pre-service (whilst still in training colleges) trainings for health workers. LSTM have also developed robust evidence on the scale of maternal deaths, conducting the first ever national study into the scale and cause of maternal deaths in Kenya - the confidential enquiry into maternal deaths (CEMD) with support from this programme.

Options and UNICEF have implemented green energy upgrading of health facilities in their respective counties using renewable technology installation. This has improved electricity supply and cost-effectiveness since power is generated from solar energy and is easy to maintain. Furthermore, Options, together with KPMG, has managed a County Innovation Challenge Fund (CICF) to test and scale up innovative approaches in the six programme counties. Options has also engaged a media partner, Internews, to improve media reporting of health issues and build the capacity of government health officials and journalists. UNICEF was also responsible for health system strengthening (HSS) support to the national Ministry of Health (MoH) and overall programme coordination.

The programme faced several challenges including doctors/nursing strikes in the counties following grievances about salaries, working conditions and promotions. The strikes affected delivery of essential services such as antenatal clinics, skilled delivery and immunisation services. Other challenges faced are low supplies in the blood bank which is a common problem in the counties. Although the Kenya National Blood Transfusion Service has been tasked with distributing blood across Kenya, many health facilities are faced with shortages.

The programme started in November 2013 and was due to end in 2019. Through an addendum to the Business Case it has now been extended to March 2023 with a total programme budget of £64.6m[3].

The programme overall has significantly changed since its inception. The timeframe for the remaining components and summary of changes are listed here:

- The UNICEF component of the programme was closed at the end of 2017 following a DFID Portfolio Quality Review where the decision was taken to focus on the stronger performing elements of the programme
- Options' activities in Bungoma and Internews activities will be completed at the end of 2018.
- CICF activities will be completed in June 2019.
- LSTM activities are expected to be extended until March 2023,
- New health system strengthening (HSS) technical assistance for MNH to the MoH and 20 priority counties, will be funded together with the US and Denmark, through a World Bank Multi-Donor Trust Fund (MDTF) from September 2018 to September 2022.

[1] The first ever national confidential enquiry into maternal deaths in Kenya -which this programme supported -put the number of maternal deaths at 6-8000/year. The neonatal deaths figure comes from DHIS2 -the national health information system and is widely understood to be an underestimate.

[2] These six counties were chosen when the programme started based on having some of the worst MNH indicators in the country.

[3] The extension from 2019 to 2023 was worth £4m to enable DFID to join the WB-administered multi-donor trust fund (MDTF).

- An independent evaluation component, implemented by Health Research for Action Ltd (HERA), will continue until January 2020[4].

Summary supporting narrative for the overall score in this review

The programme has made good progress since the 2017 DFID Annual Review and has scored an overall 'A' (outputs exceeded expectations). At the current rate of progress, it is on track to meet its original outcome and output targets for 2019 (see Sections B and C).

Options has demonstrated strong management and technical capacity and has achieved or exceeded outcome and output milestones, with significant improvements seen in Bungoma in skilled delivery and antenatal care (ANC) attendance and a substantial reduction in stillbirths. In addition, because of Options actions to strengthen Maternal and Perinatal Death Surveillance and Response (MPDSR), the 6 sub-counties in Bungoma receiving programme support are now reporting 100% of maternal deaths and 75% of perinatal deaths. Overall, maternal deaths are easier for health workers to review since they are fewer compared to perinatal deaths. Health workers often cite high workload as an impediment to reviewing perinatal deaths.

Bungoma is the leading county in the country for perinatal death reporting, an area where most other counties are struggling. The MANI project team thinks that these have been achieved thanks to the combination of supply and demand-side interventions linked to a focus on health system strengthening at county, sub-county, facility and community levels. The reporting levels in Bungoma are currently far higher than other counties[5].

The CICF is well managed by Options and KPMG and has met its targets; many of the innovations tested are being taken up by counties or other partners and the CICF has ensured that evidence and lessons learned are widely shared. Support for a media partner, Internews, through Options has added considerable value, through increasing the visibility of MNH issues in print and broadcast media and building the media relations and communications capacity of the MoH, county health teams, programme implementing partners and CICF grantees. The work of Internews has also helped to increase the openness and accountability of national and county MoH officials; as the country Reproductive Health coordinator in Bungoma commented, she no longer runs away and hides when the media calls.

LSTM has exceeded milestones for health worker in-service training, has strengthened county capacity to conduct EmONC training, mentorship/supportive supervision, and played a significant role in providing technical assistance and support to the national MOH to produce the first national Confidential Enquiry into Maternal Deaths, which has increased the profile of MNH. The report has also stimulated the national review of MNH quality of care standards. LSTM has supported the development of structures to support the implementation of the national MPDSR guidelines at national level. Feedback during field visits, from county health teams and health workers, highlighted the value that is placed on the EmONC training, the recognition of its quality, and the appreciation of its impact on knowledge and skills. Progress with other LSTM planned activities, including development of a national mentoring package, strengthening perinatal death reporting and integration of EmONC into pre-service training has been constrained by lack of MoH funding. There has been a delay in reviewing and approving the syllabus which is required to update pre-service training curriculum materials with EmONC and MPDSR, due to lack of funding.

Recommendations for the year ahead

<u>Sharing learning from the programme</u>

- Detailed lessons learned from this review will be used to inform the future design (next phase) of the programme – which predominantly focuses on support to LSTM and the WB MDTF[6]. (Action point for health advisers in the DFID Kenya Basic Services Team.)
- Options and DFID should hold a structured debriefing of the Bungoma programme to review achievements, challenges and lessons learned to inform the next phase of the MNH programme

[4] This contract will have to be extended now to reflect the overall programme extension and allow a full evaluation of our support through the MDTF as well.

[5] As seen in DHIS2 (District Health Information Software version 2).

[6] These are annexed for ease of reference.

as well as wider programming for MNH within the universal health coverage (UHC) agenda. Lessons learned from Option's experience of operationalising Linda Mama[7] would be particularly useful for the latter. Lessons learned can also inform future work with the MDTF. (Action point for the programme SRO to take forward with MANI).

- Options' approach to transition planning has been exemplary and it would be useful to document this so that other programmes can learn from the experience. (Action point for the DFID Kenya Basic Services Team).
- Options and KPMG to consolidate and share with DFID learning from the CICF regarding the design and management of innovation challenge funds. 9Action point for the programme SRO to take forward with Options and KPMG).

For the future phase (next five years) of the programme

- DFID to explore options for continued funding for one of the CICF-supported innovations which stands out as warranting ongoing support – the human milk bank (HMB) CICF project (either from DFID or other partners) which PATH is implementing, to allow the project to complete set-up, evaluate implementation and impact[8]. This HMB will be the second largest in Africa and the first in the East and Central African region. This HMB is expected to make a significant impact in improving survival rates for pre-term babies and is an important 'proof of concept' (precedent) for East Africa. (Action point for the DFID Kenya Basic Services Team Leader).
- DFID to ensure that the logframe (and possibly the theory of change) is revised to reflect changes to the programme. The logframe for the next five years of the programme will be significantly different to the logframe for the past five years of the programme. (Action point for the SRO of the programme.)
- DFID to consider how the impact and sustainability of interventions in the six counties can be tracked after the end of programme activities, including through subsequent annual reviews and the independent evaluation; this could provide useful learning about the sustained impact of different approaches taken by Options and UNICEF. (Action point for the SRO of the programme).
- DFID to consider whether a PCR for 'part one' of the MNH programme (covering what has been achieved at outcome level in the first five years) is a sensible approach given the next five years of the programme ('part two') will involve different components and partners. (Action point for the SRO of the programme).
- DFID to extend the contract with HERA to reflect the programme extension (to 2023[9]). (Action point for the SRO of the programme).

NB – improving health often involves working on both the 'supply' and 'demand' side. Supply side interventions involve improving the supply of health care services and demand means improving the demand for health care services. This programme was designed to work on both. Both outputs one and two concern supply side interventions –better trained staff and better functioning health systems respectively. Output three is about increasing demand for maternal health services.

B: DETAILED OUTPUT SCORING

Output Title	*Health workers have the knowledge and skills to provide quality care and EmONC*		
Output number per LF	1	**Output Score**	**A+**
Impact weighting (%):	30%	Impact weighting % revised since last AR?	N

[7] The Linda Mama programme is the Government of Kenya's ambition to remove fees from maternity care/make giving birth free in Kenya.

[8] This stands out as one important innovation which the CICF has supported which needs ongoing support.

[9] HERA contract currently ends in 2020 which will now not enable comprehensive evaluation of the whole (extended) programme.

Indicator(s)	Milestone(s) for this review	Progress
1.1 Number of additional health workers trained in EmONC (disaggregated by sex)	9,550: 7,150 direct; 2,400 indirect	9,957: 6,804 direct; 3,153 indirect (as of end June 2018) (Direct disaggregated by gender since Q1 2015: female 69%; male 31%) **Score: A+**
1.2 Proportion of health facilities followed up quarterly	90%	100% (34 facilities of 34 eligible for follow up in this period) (as of end of July 2018) **Score: A+**
1.3 Percentage of (i) maternal deaths (facility level) and (ii) perinatal deaths (facility level) for which death review forms are submitted to the DHIS and of (iii) health facilities that have made the required adjustment to service provision and/or management practices based on MPDSR	Bungoma (6 sub-counties) (i) 100% (ii) 65% (iii) 65%	Bungoma (6 sub-counties) (i) 100% (ii) 75% (iii) 83% **Score: A+**
1.4 Percentage of pre-service students demonstrating an improvement in knowledge and skills at completion of EmONC training	90%	95% of pre-service students have demonstrated an improvement in knowledge and skills, specifically: • 99% of pre-service students trained at Egerton University (November 2017) • 94% of pre-service students trained at Nairobi KMTC (June 2018) **Score: A+**
1.5 Number of EmONC skills sessions conducted in skills labs for each pre-service institution	1 per institution (4 institutions supported)	4 institutions were supported in 2018 **Score: A**
1.6 Number of tutors able to deliver EmONC competency based pre-service training	32 (from 4 additional KMTCs supported)	26 midwifery tutors from 4 additional KMTCs trained in 2018 **Score: B**

Key points

This output concerns training health workers to be better able to safely deliver babies, contributing to reducing the high maternal and newborn death rates in Kenya. It involves pre-service training (when health workers are still in training colleges) and in-service training (when health workers have qualified and are working in health facilities). Indicators 1.1, 1.4 and 1.5 concern training and indicator 1.6 involve training the tutors. It also concerns the health workers then correctly reporting deaths in national health information systems and following up on the cause of death – known as maternal and perinatal death surveillance and response (indicator 1.3). This output also looks at how health workers are followed-up after trainings – which is known as supportive supervision (indicator 1.2).

- **Pre-service training (Indicators 1.4 and 1.5)**
    - There has been some progress with integration of EmONC in pre-service training for nurses this year but less than anticipated. While the Nursing Council[10] has approved the curriculum and the KMTCs are willing to include this in their programme, the Nursing Council still needs to finalise the official syllabus and supporting tools. LSTM has trained over 150 KMTC and university tutors as EmONC trainers and some KMTCs have started to deliver pre-service

[10] The Nursing Council is the professional body for nurses in Kenya.

EmONC training to nursing students. Health workers highlighted the need for EmONC pre-service training for clinical officers and obstetricians also.

- With future DFID support, LSTM plans to scale up pre-service training to an additional six KMTCs in the next phase of the programme, to achieve cumulative coverage of 20 of the 56 KMTCs in Kenya[11].

- **In-service training (Indicator 1.1)**
  - LSTM has exceeded its 2018 milestone for in-service training; fewer health workers have been trained directly but more have been trained indirectly. This is a positive trend, which indicates that counties and/or other partners are taking greater responsibility for delivering EmONC training to newly recruited health workers, using master trainers trained by and equipment provided by LSTM. In some cases, counties have requested LSTM to provide quality assurance; in others, counties have used quality assurance staff trained by LSTM.
- **Supportive supervision (Indicator 1.2)**
  - There has been slow progress with development of a national mentorship package. The MoH has requested technical support from LSTM and LSTM has agreed to provide this but the MoH needs to identify funding for related activities. LSTM aims to support the development of a package that draws on the best aspects of different mentoring approaches and that can be implemented by counties using existing staff and within available budgets[12].
- **Maternal and perinatal death surveillance and response (Indicator 1.3)**
  - LSTM through its support for the national MPDSR Secretariat has completed data collection and analysis for the second confidential enquiry report covering 2015 and 2016, as well as developing guidelines, tools and a training package. However, the action plan arising from the first confidential enquiry report, published in February 2018, has not yet been presented to partners at the MPDSR committee; this is expected to happen at the next meeting in November 2018.
  - Rates of perinatal death review and reporting remain very low in most counties. Options support for MPDSR has resulted in Bungoma being one of the few counties that reviews and uploads 100% of maternal deaths and the leading county in the country for reviewing and uploading perinatal deaths (59% overall and 75% in the 6 Options-supported sub-counties)[13]. Options has also demonstrated that effective mentorship can improve the confidence and skills of health workers in lower level facilities. Both MPDSR and mentorship are included in the county's 2018-19 work plan and budget for the World Bank's flagship health programme Transforming Health Systems for Universal Care THS-UC.

Lessons identified this year, and recommendations for the year ahead linked to this output

- High staff turnover in health facilities is still a challenge and this has implications for the sustainability of programme interventions as trained staff are not retained. In some facilities where LSTM had completed in-service EmONC training, many of those trained have left and until pre-service training is fully institutionalised, ongoing in-service training for some newly recruited staff will be required.
- Capacity to manage and fund in-service EmONC trainings at county level is generally weak, although some counties have included this in their annual budget and have started to conduct training. Because of LSTM support, counties have master trainers and equipment; the main gap is funding for the costs of venues, accommodation and travel, as well as for consumables and replacement equipment. LSTM support to develop a sustainable model of county managed training, needs to include exploring how these costs can be contained. This will need to be

[11] Covering all 56 KMTCs would require additional funding to train an additional 150 tutors and procure equipment which is something LSTM can pursue with other donors. In the meantime, the idea is for the DFID-supported counties to model what 'good can look like'.

[12] The indicator does not measure this, so the score is not affected, but something for DFID and LSTM to focus on in the next phase of support.

[13] These figures are taken from DHIS2 where the very low levels of reporting of perinatal deaths can be seen.

complemented by national and county action to address inadequate allocation of resources for health.

Recommendations:

- LSTM should strengthen the link between mentoring and EmONC training, including systematically collecting information from mentors about areas of weakness, so that these can be given more attention during training. Neonatal resuscitation and management of the sick newborn appear to be areas where health workers at lower level facilities lack confidence.
- LSTM should work with the MoH to identify funding for the development of a national mentorship package and with counties to support implementation of the package.
- LSTM should continue to advocate with the MoH to take forward the action plan based on the recommendations of the confidential enquiry report and proactively track and report on progress. Specifically, DFID, LSTM and other partners should advocate for the MoH to implement its commitment to second staff to the MPDSR Secretariat to strengthen work on perinatal death review and reporting.
- LSTM should take forward its plans to develop a sustainable model for county implementation of EmONC in-service training and identify where support may be required to refresh master trainers; clear criteria should be developed, in addition to willingness to cost share and avoiding duplication with other partners, to identify target counties to receive support, giving priority to the 20 priority counties.
- LSTM should develop an ambitious plan for the next phase of the programme that ensures all KMTCs have trained tutors and can deliver pre-service EmONC training; the MoH is supportive of this. In addition, LSTM should work with the MoH, KMTCs, DFID and other partners to identify opportunities to secure funding for EmONC training equipment for KMTCs. Coordination will be needed with UNFPA plans to support a stand-alone pre-service midwifery curriculum.
- DFID to encourage World Bank MDTF support to national MoH and counties to include strengthening health financing and human resources for health, as well as planning and budgeting, to maximise the future sustainability of MNH programme interventions to date.

Output Title	*Health systems strengthened to manage and deliver MNH services in Homa Bay, Turkana, Kakamega, Garissa, Nairobi and Bungoma counties*		
Output number per LF	2	**Output Score**	**A**
Impact weighting (%):	50%	Impact weighting % revised since last AR?	N

Indicator(s)	Milestone(s) for this review	Progress
2.1 Innovation Fund projects demonstrate successful new approaches to improving delivery for quality MNH services	8 innovative projects completed, findings disseminated; 3 approaches applied more widely[14]	As of end of Q2 2018, 5 innovation and 3 scale up projects completed and findings disseminated through meetings, events and documentation; specific counties have adopted a number of innovations such as the Uterine Balloon Tamponade (UBT) project are informing national scale up **Score: A**
2.2 Bungoma county has a consolidated annual work plan and budget that includes maternal and new-born health services	Bungoma county annual work plan (AWP) improved based on lessons learned and includes financial contributions from partners	Bungoma 2018/19 AWP was improved. The number of partners whose financial contributions were included increased from four in the previous year to six; additional stakeholders including health facility in-charges and community health workers (CHWs)were involved in AWP development **Score: A**
2.3 Number of management systems supported and strengthened to objective standards and implemented at county level	n/a	Bungoma targets for the Organisational Capacity Assessment achieved in 2017; ongoing capacity development and assessment has been transitioned to the county
2.4 Level of installed capacity of clean energy as a result of ICF support	n/a	Bungoma targets for clean energy achieved in 2017; system maintenance has been transferred to the county
2.5 Number of health facilities installed with rainwater harvesting systems	n/a	Bungoma targets for rainwater harvesting achieved in 2017; system maintenance has been transferred to the county
2.6 Percentage of 37 performance-based financing (PBF) facilities receiving quality bonus	Bungoma 90%	97% of the 37 participating facilities **Score: A+**

Note that reporting on this output is only for Options work in Bungoma plus the CICF-supported innovations which operated in six counties in 2018[15].

Key points

- **Indicator 2.1 -**The CICF has disbursed 85% of its total grant value and is on track to achieve 100% by the end of its implementation timeframe; 19 projects have been funded over three rounds and nine of these have ended or are close to completion[16]. Projects have addressed physical access to services, financial access to services, quality of care, commodities and technologies, health information systems and culturally appropriate services. Most will be sustained by the relevant county or support from other partners. The CICF has been effectively managed, the partnership between Options and KPMG has worked well, and grantees are positive about the support they have received. The one area of concern is that there was no plan for how important innovations could continue to receive support once the programme ended and the Human Milk Bank (HMB)

[14] This means scaled up/replicated by others

[15] These are the six counties the MNH programme initially worked in (Homa Bay, Turkana, Kakamega, Garissa, Nairobi and Bungoma).

[16] See CICF website for more details on the projects supported: https://mnhcicf.org/

project is one such innovation that warrants ongoing support and has not yet found any future funding to see the project through its initial set up and evaluation.

- **Green energy -** Feedback during Annual Review field visits, and Options' reports, suggest that green energy interventions, in particular the installation of solar systems, have enabled facilities to provide services when there are power outages – this is especially critical for deliveries, many of which take place at night – and to provide mothers with hot water for washing, as well as reducing electricity bills.
- **Indicators 2.3-2.5 –** did not have milestones for 2018 (targets for these were met in 2017 and not revised as the programme extension was for close out and transition and so not all activities continued in 2018, plus the county had already taken over the maintenance of these systems.)
- **Transition planning /exit strategy –** Options have successfully implemented a well-planned exit strategy in Bungoma. Most programme activities and interventions will be transitioned to the county government or partners and county and sub-county health teams are confident that the progress achieved in Bungoma can be sustained without Options' support. This has been achieved despite the changes in county health management team leadership following elections in late 2017.

Lessons identified this year, and recommendations for the year ahead linked to this output

- Partnership with county and sub-county health officials and facilities, clear communication with Options' implementing partners, a systematic approach and timely planning ahead have been critical factors in successful transition planning in Bungoma. DFID agreement to Options' request to a contract extension to allow enough time to plan and implement an exit strategy, including transitioning to new funding opportunities, has increased the likelihood that activities and impact will be sustained.
- Internews' experience suggests that it takes time to establish trust with MoH but once this happens there is a willingness to engage with the media in a positive way. The national MoH and county health teams now initiate contact with the media if they have information that they wish to communicate with the public.

Recommendations:

- Options and DFID to hold a structured debriefing of the Bungoma programme to review achievements, challenges and lessons learned to inform the next phase of the MNH programme as well as wider programming for MNH within the UHC agenda. Lessons learned from Option's experience of operationalising Linda Mama would be particularly useful for the latter.
- Options to present lessons learned from HSS in Bungoma to the World Bank MDTF advisory group, to inform support to counties through the MDTF.
- Options' approach to transition planning has been exemplary and it would be useful to document this so that other programmes can learn from the experience.
- Options and KPMG to consolidate and share with DFID learning from the CICF to inform any future challenge fund design.
- DFID to explore options for continued funding for the human milk bank (HMB) CICF project (either from DFID or other partners) which PATH is implementing, to allow the project to evaluate implementation and impact[17]. This human milk bank is the second largest in Africa and will be the first in the East and Central African region. This HMB is expected to have significant effects in improving survival rates for pre-term babies and is an important 'proof of concept' (precedent) for East Africa.
- DFID to consider options for engaging Internews in improving public dialogue, media engagement and GOK communication on FP programming and UHC as well as MNH issues.

[17] This stands out as one important innovation which the CICF has supported which needs ongoing support.

Output Title	*Increased demand for and uptake of maternal and new-born health services in Bungoma county*		
Output number per LF	3	**Output Score**	**A**
Impact weighting (%):	20%	Impact weighting % revised since last AR?	N

Indicator(s)	**Milestone(s) for this review**	**Progress**
3.1 Number of poor women covered by Demand-Side Financing (DSF) schemes	Bungoma 35,000 (cumulative)	42,361 transport vouchers have been distributed (vs. 23,363 as of end of 2017); voucher distribution has ended to allow vouchers distributed to be redeemed before the programme ends **Score: A** (as only 59% of these had been used, see below).
3.2 Percentage of supported Community Units (CUs) that are fully functional as per national guidelines	100% of 73 supported CUs	In Bungoma, as of end 2017, 100% of 73 CUs supported were fully functional as per national guidelines **Score: A**
3.3 Percentage of women receiving at least 4 ante-natal care (ANC) contacts during pregnancy	Bungoma 49%	As of end of Q2 2018 59% of pregnant women in Bungoma received at least 4 ANC contacts (increase from baseline in 2014 of 41%) **Score: A+**

Key points

- **Indicator 3.1 -** The transport voucher[18] has enabled more poor women to access skilled delivery. The utilisation rate of the voucher stands at 59% with a cumulative total of 25,166 vouchers used as of end of June 2018. Provision of transport vouchers is one of the few programme interventions that will not transition to the county or partners; there is a risk that without this intervention the improvement in the numbers of women giving birth in a facility and in the presence of a skilled birth attendant (SBA) could be reversed. However, individual health facilities have expressed interest / intention to engage transporters locally through use of the Linda Mama revenue.
- **Indicator 3.3 -** Many counties are finding it difficult to achieve four ANC contacts during pregnancy; the updated guidance from WHO recommending eight contacts will be a challenge to achieve. Anecdotal feedback suggests that barriers to achieving four ANC contacts include: many women come late on in pregnancy for their first ANC visit and, despite free maternity care, some facilities expect women to pay for laboratory tests, which some may not be able to afford.

Lessons identified this year, and recommendations for the year ahead linked to this output

- The increase in ANC uptake reflects extensive community and facility efforts to promote use of ANC services, improve quality of care, and the impact of the GoK's Linda Mama initiative and of Options' use of defaulter tracing. Community Health Volunteers have played a vital role in encouraging uptake of care and use of defaulter tracing has also been helpful, as targeted reminders to mothers via mobile phone, increases their sense of being valued and of receiving a personalised service.

[18] Vouchers are commonly used in health programmes to address financial demand side barriers such as the cost of the traveling to a health facility. These transport vouchers enabled pregnant women to travel freely to deliver on a motorbike and the motorbike drivers were then reimbursed by the programme for the number of vouchers they had collected.

- The use of traditional birth attendants (TBAs) as Birth Companions has contributed to increased uptake of both ANC and skilled delivery. Options has achieved this without providing financial incentives to TBAs to change their role. TBAs have been given training and access to savings and loans schemes, which have enabled them to establish businesses to replace lost income[19]. One former TBA met during the review noted that she had established a business selling children's clothes and could combine this with her home visits to women to encourage them to use MNH services. In addition, an Options qualitative study found that factors that motivated TBAs to be Birth Companions included recognition of their role in service delivery and better knowledge of the risks of home delivery.

Recommendation:

- Options to document and share lessons on community and demand-side interventions that have contributed to increased uptake of MNH care services. As far as possible, the next annual review and/or the MNH evaluation which HERA is undertaking should continue to track these interventions, to assess their longer-term sustainability and impact without Options' support.

C: THEORY OF CHANGE AND PROGRESS TOWARDS OUTCOMES

Summarise the programme's theory of change and any major changes in the past year

The programme's original theory of change, which balances supply- and demand-side interventions, remains relevant in the Kenya context. However, the next phase of the programme will largely focus on TA to strengthen health systems; other than training-related activities, there will be less emphasis on direct support for service delivery, e.g. provision of supplies, infrastructure upgrading; and there will be no direct support for demand-side interventions, e.g. DSF, community health services. The theory of change will need to be revised to reflect this.

Describe where the programme is on track to contribute to the expected outcomes and impact, and where it is off track and so what action is planned as a result in the year ahead

Progress towards outcome indicators is summarised in the table below and indicates that the programme is on track to contribute to expected outcomes in Bungoma, and that there has also been progress towards some expected outcomes in some of the five UNICEF-supported counties (even though the UNICEF component of the programme has not been operational since the end of 2017).

Figures for Bungoma are for the six (of 10) sub-counties where Options has provided support. Figures for the five UNICEF counties are included to show trends over time. For the UNICEF counties, DHIS data for 2014 and January-June 2018 and the original logframe milestones for 2018 are included for indicators 1, 4, 5 and 6; no up-to-date data is available for UNICEF counties for indicator 3. Data for Embakasi, one of the UNICEF-supported Nairobi sub-counties is not included as there is no overall figure in the DHIS. UNICEF data for 2017 is included for indicator 2 to provide a total cumulative figure for additional births delivered by a skilled birth attendant that will be attributable to the programme as of the end of 2018.

Overall, available data suggests that Bungoma has performed more strongly against key indicators than the other programme counties. All counties show an improvement in the SBA rate since 2014, with Bungoma achieving the most significant increase. Progress with improving caesarean section, obstetric case fatality and stillbirth rates is mixed although, again, Bungoma has performed well overall.

Indicator	Baseline 2014	Milestone 2018	Achieved 2018	Comments

[19] Global efforts to see more women delivering in the presence of the skilled birth attendant (SBA i.e. someone properly trained to deal with birth such as a midwife, nurse or doctor) have been threatening for traditional birth attendants – typically women in the village who are trusted and have 'helped' many women deliver but with no formal training. This is because the global drive to increase SBA rates has been to encourage women to stop using TBAs who therefore lost out on their 'trade'/form of income. Therefore, some interventions being sensitive to this have tried to give TBAs a role either in onward referring of women to SBAs and/or alternative income generation efforts.

1. Skilled birth attendance rate	Bungoma: 41% Kakamega: 57% Homa Bay: 51% Garissa: 38% Turkana: 38% Kamukunji sub-county (Nairobi): 131%	Bungoma: 60% Kakamega: 66% Homa Bay: 70% Garissa: 52% Turkana: 48% Kamukunji sub-county (Nairobi): 219%	Bungoma: 80% Kakamega: 63% Homa Bay: 55% Garissa: 56% Turkana: 57% Kamukunji sub-county (Nairobi): 228%	Milestone significantly surpassed in Bungoma SBA rate increased (less significantly) in all other 5 counties too; 2 of the 5 UNICEF counties and Kamukunji sub-county in Nairobi have achieved the 2018 milestones Note that milestones and data reported for Nairobi sub-counties reflect weaknesses in population data, particularly denominators, and wide catchment areas
2. Number of additional births delivered by a skilled birth attendant	Bungoma: n/a UNICEF: n/a	Bungoma: 11,959 UNICEF: 55,968 (2017)	Bungoma: 12971 UNICEF: 49,734 (2017)	As of end Q2 2018; on track to achieve milestone by end Q3 UNICEF did not achieve the 2017 milestone Programme cumulative total will be 61,693 (vs. original target for 2018 before the UNICEF component closure of 78,656; UNICEF 68,968 and Bungoma 9,688)
3. Health facilities able to provide BEmONC and CEmONC	Bungoma: BEmONC 0; CEmONC 1	Bungoma: BEmONC 16; CEmONC 4	Bungoma: BEmONC 27; CEmONC 3	Bungoma BEmONC milestone significantly surpassed; only 3 facilities achieved CEmONC in Q2 of 2018 (as opposed to 5 in Q1) due to a lack of commodities.
4. Caesarean section rate (% live births delivered by CS)	Bungoma: 6.9% Kakamega: 5% Homa Bay: 4% Garissa: 11% Turkana: 7% Kamukunji: 23%	Bungoma: 10% Kakamega: 8% Homa Bay: 7% Garissa: 10% Turkana: 8% Kamukunji: 22%	Bungoma: 8% Kakamega: 7% Homa Bay: 5% Garissa: 9% Turkana: 6% Kamukunji: 20%	10% has been achieved in Bungoma in previous years; 8% is the figure for Q2 of 2018 (WHO recommends a rate of 5-15%); access to CS has improved as a result of the increase in CEmONC facilities. Mixed progress in UNICEF counties, with some improving and some worsening.
5. Obstetric case fatality rate (% of women with obstetric complications admitted to a facility who die)	Bungoma: 2.5% Kakamega: 2.1% Homa Bay: 4.2% Garissa: 4% Turkana: 4% Kamukunji: 0.9%	Bungoma: 1.7% Kakamega:<2% Homa Bay: 1.5% Garissa: <2% Turkana: 1.5% (Milestone for Nairobi not specific sub-counties)	Bungoma: 1.7% Kakamega: 6.9% Homa Bay: 2.3% Garissa: 2.7% Turkana: 4.6% Kamujkunji: 0.4%	Target achieved in Bungoma due to improved identification and management of mothers with maternal complications and increased availability of EmONC services Mixed progress in UNICEF counties.

6. Stillbirth rate (number of stillbirths/1,000 total births)	Bungoma: 28 Kakamega: 23 Homa Bay: 27 Garissa: 26 Turkana: 21 Kamukunji: 3	Bungoma: 17 Kakamega: 10 Homa Bay: 20 Garissa: 20 Turkana: 22 Kamukunji: 11	Bungoma: 15 Kakamega: 21 Homa Bay: 20 Garissa: 22 Turkana: 21 Kamukunji: 22	Target in Bungoma achieved due to improved quality of care, increased availability of EmONC services, improved referral system and mentorship for health workers from lower level facilities to improve skills in managing maternal complications and referral decision making. Mixed progress in UNICEF counties.

Key points

- The progress against outcomes above is not entirely comparing like with like with the five UNICEF supported counties (until Dec 2017) and the one MANI-supported programme since the counties UNICEF were working with have not had support from this programme for a year whilst the support in Bungoma is still current. The Evaluation component of this programme can look at the sustained impact of our support in all six counties over time (post-support in both cases).
- However, the results achieved in Bungoma county are impressive, particularly the significant increase in the SBA rate and a significant decrease in the stillbirth rate over time. MANI programme thinks this is due to the support for community activities to increase demand, including transport vouchers, and efforts to improve service delivery, including increasing the availability of EmONC and enhancing the quality of care.
- Increased BEmONC availability, together with mentoring for health workers in lower level facilities conducted by Options and LSTM, is reported to have played a key role in decongesting CEmONC facilities, by improving health workers' ability to manage complications and reducing unnecessary maternal referrals; this was confirmed during meetings with county health teams and health facility staff in Bungoma, Homa Bay and Kilifi.
- Readiness to provide BEmONC and CEmONC requires regular and rigorous monitoring rather than one off measurement; as Bungoma data shows, the EmONC status of facilities can change quickly as a result of the availability or not of drugs and supplies as well as skills.
- The introduction of the GoK's free maternity care policy in 2013, now called the Linda Mama programme, increased uptake of services including skilled delivery. During field visits, data shared by some facilities showed that the dramatic increase in deliveries also contributed to a short-term increase in maternal death; facility staff attributed this to the lack of a commensurate increase in staff to meet increased demand, which compromised quality of care.

Explain major changes to the logframe in the past year

For LSTM, the 2018 output milestones were revised where targets had been exceeded in 2017.

For Options, at outcome level, the SBA target was increased by 4% and the stillbirth target was renegotiated with DFID to ensure that it was realistic and achievable. A new output indicator (2.7 Percentage of PBF facilities (37 facilities) receiving quality bonus) was added to reflect PBF activities in Bungoma; output milestones were agreed for 2018 to reflect the extension of the contract to the end of December 2018 and the target for the percentage of women receiving at least 4 ANC contacts was increased to 49%, a 5% increase from 2017 performance of 44%.

Describe any planned changes to the logframe as a result of this review

The logframe will be substantially revised within the next quarter following this review to reflect: the closure of the UNICEF component; the upcoming close out of Options activities in Bungoma and the CICF; the extension of the accountable grant with LSTM; and the addition of DFID support for technical assistance (TA) for HSS via the World Bank MDTF.

The revised logframe will cover the period October 2018 to March 2023 and will reflect the shift in emphasis of the programme set out in the Business Case addendum and the MDTF Results Framework. The overarching objective of the next phase of the programme is to support the GoK to achieve the targets in its Reproductive Maternal, Newborn Child and Adolescent Health (RMNCAH) Investment Framework and to accelerate progress towards UHC.

The revised logframe will reflect the following specific programme objectives:

- Strengthen national-level health systems through the MDTF: To support GOK, and the MoH, in particular, to achieve sustainable health sector financing, including through increased allocation of domestic resources, and plans for UHC, and to strengthen other health systems building blocks including human resources for health and supply chain management which are essential parts of a functioning health system needed to be able to deliver MNH services.
- Build county capacity through the MDTF: To build capacity to plan, budget for and manage financing and delivery of health services. In line with the RMNCAH Investment Framework, priority will be given to the 20 counties with the worst MNH health indicators, the lowest coverage and utilisation of MNH services, and the weakest capacity. These priority counties include the current six programme counties. The programme will build on the approach to HSS taken by Options in Bungoma, including support for wider use of the Organisational Capacity Assessment tool to identify priority needs and monitor improvements in capacity.
- Institutionalise skills and systems for quality care through LSTM: To complete in-service EmONC training of health workers providing MNH care and support, counties to manage and deliver repeat trainings, institutionalise EmONC within pre-service training, institutionalise follow up and mentoring within the national supervision system and institutionalise MPDSR at national, county and health facility levels.

Underpinning these objectives is a greater emphasis on building sustainable capacity, institutionalising systems and reducing dependence on external support. While the expected impact and outcome of the programme will remain unchanged, the indicators used to monitor the outcome, and the outputs and indicators used to monitor them, will need to be revised to reflect the revised scope of the programme, including a less intensive approach to county support, and what it can deliver.

The outputs will be amended to focus on: sustainable health sector financing and strengthened systems at national level; increased county capacity to plan, budget for and manage MNH services; and institutionalised training, mentoring and monitoring of quality of MNH care.

D: VALUE FOR MONEY

Assess VfM compared to the proposition in the Business Case, based on the past year

LSTM: For the year under review, EmONC direct training costs (47%) and staff and office costs (32%) remained the largest cost categories for this component of the programme. Costs were driven largely by the number of people trained and the ancillary costs of training that include accommodation, transport and allowances. The main cost components have not varied significantly from the previous year, when direct training costs and staff costs constituted 50% and 27% of the budget, respectively.

Options: Grants for CICF projects (39%), fees for staff and consultants (36%), and voucher funds and programme activities (17%) were the main cost components. The total budget allocated to Community Health Volunteers (CHVs) and TBAs was relatively small, just under £120,000 for the year under review, but this component was one of the strong contributing factors to the success of the programme in Bungoma. Key cost drivers included the number of CICF projects and programme activities requiring consultants such as training. Vouchers for transport constituted less than 3% of the overall Bungoma budget.

Partners have continued to monitor value for money in line with the agreed framework from 2015, specifically on economy and efficiency. Data on effectiveness is being monitored and supplied to HERA, which is expected to conduct a cost-effectiveness analysis in 2019.

Economy: Overall, the partners track economy and there are several processes and activities in place to ensure good economy. LSTM continues to monitor the cost per participant in training, and costs per participant decreased by 8% in nominal terms between 2014 and 2018 to £318 per participant. Options' costs per trainer trained are lower (£53), reflecting the different scope of training across the two partners' activities. In Bungoma, average quarterly reimbursements to CHVs increased from approximately £10 per volunteer to £12.01 in 2018, owing to an increase in the reimbursement paid per volunteer from KES200 to KES500 during the year, in a bid to increase voucher distribution and utilisation. The average daily fee rates for consultants vary, with Bungoma at £354.79 per day and the CICF at £128.07. Options realised cost savings from collaboration with other partners of up to £11,600 during the year, where MannionDaniels and CICF only paid for the proportion of costs for various activities, with other NGOs or counties contributing the rest.

Efficiency & Effectiveness: The most recent cost-effectiveness analysis conducted in 2017 indicated that the programme was highly cost effective, with a cost per DALY averted of £737, set against a benchmark of the GDP per capita of Kenya, which is currently approximately £1,100. HERA plan to repeat this cost-effectiveness analysis in 2019. Performance at outcome level has been very strong, with most outcome level indicators met or surpassed in Bungoma, under the Options component. For example, the SBA rate has surpassed the target of 60% and is currently at 80%; cumulatively more than 12,000 additional births have been delivered by a skilled birth attendant and more facilities (27) are providing BEmONC services than projected (16). The obstetric case fatality rate has decreased, to 1.7%, meeting the target of 1.7% while the stillbirth rate of 15 per 1,000 almost reached the target of 17 and overall has decreased from 28 per 1,000 since 2014. Without Options' support, it is unlikely that this magnitude of health systems strengthening and improvement in health outcomes in Bungoma would have been achieved during the programme period. All support to Bungoma county health management team, sub-county teams and health-facilities has gradually been handed over to the county authorities over the last year (transition period).

Equity: The programme is equitable, as it targets disadvantaged communities and regions with poor health outcomes e.g. Bungoma. The programme's focus on MNH prioritises women and young children who, in most settings, have worse health outcomes than the rest of the population. Specifically, Bungoma is one of the counties which, in 2014, when the programme started had some of the worst MNH indicators in Kenya, with most basic MNH coverage statistics below the national average.

As noted in the 2017 annual review, the Business Case does not set targets to be achieved for economy and efficiency, but proposes benchmarking costs to similar and related programmes in Kenya. None of the partners is actively benchmarking performance with other programmes. This is due to a combination of factors, some of which are beyond their control, e.g. obtaining reliable cost data from other programmes/competitors is not straightforward, the uniqueness of some of the programme elements, e.g. the CICF, make benchmarking difficult. Partners have requested additional support from DFID on monitoring and measuring VfM which would enhance their capacity to report on the necessary indicators.

As also noted in the 2017 annual review, the VfM framework the implementing partners are using contains some weak indicators which may not be able to illustrate how well VFM is being achieved by the programme. The framework in place can be improved, and some suggestions include the following:

- Disaggregating key unit costs by specific activity, e.g. cost per training reported by specific training conducted, not aggregated across all training activities in the programme.
- Benchmarking key costs against comparable DFID programmes in Kenya and the region.
- Reporting on key programme metrics such as proportion of programme overhead costs in relation to total budget.

Nevertheless, most indicators reported by the partners in the year under review show economy and efficiency performance comparable to the previous year. There are no trigger points identified in the Business Case. The Business Case target for cost effectiveness performance of £100 per DALY averted is unlikely to be met. There have been substantial revisions to the scope of the programme since the

project commenced. The closure of the UNICEF component, and many of the assumptions that informed the Business Case targets for cost effectiveness no longer hold.

Explain whether and why the programme should continue from a VfM perspective, based on its own merits and in the context of the wider portfolio

The MNH programme represents good VfM, and should continue. The ongoing programme activities should continue to deliver good results and the focus on sustainability will enable the supported counties, particularly Bungoma, to leverage the support from the programme and continue improving health outcomes among the target population beyond DFID's support. It can be anticipated that the follow-up cost-effectiveness study due to be conducted next year will show that the programme continues to be highly cost effective.

E: RISK

Overall risk rating: Moderate. The overall risk rating is unchanged.

Both LSTM and Options (and Options' partners) have risk matrices and systems for monitoring risk, which are updated quarterly. The risks identified in the Business Case remain. However, the risk matrix will need to be updated to reflect the changes in the context and the programme and a separate risk matrix developed for the MDTF.

Changes in the risk context:

- Some risks have increased or emerged since the risk registers were developed, including those associated with security, staff transfers and turnover in county governance and health management structures, reduced central funding for counties and problems with funds flow to counties and facilities, £:KES exchange rate fluctuations due to the weaker £, and heavy rains. LSTM reports that, due to increased security risks in counties bordering Somalia, activities have been relocated or undertaken by county reproductive health coordinators. Heavy rain and flooding increased the operational costs of some activities as alternative travel arrangements were required. The late 2018 increase in taxation on fuel introduced by the Government of Kenya is likely to increase other costs.
- Other risks, such as political uncertainty and health worker strikes have decreased since the 2017 annual review, although future industrial action by health workers cannot be ruled out and strikes by university lecturers have affected LSTM activities in 2018. To mitigate against this risk DFID will be much quicker to engage diplomatic efforts to help avert a future strike given the detrimental health impact of the last strikes.
- Increased focus on UHC as a political and national priority presents an opportunity to increase coverage of and access to health services, although achieving the country's UHC agenda will require a significant increase in domestic investment in health. It will also be critical to ensure that the UHC package includes comprehensive MNH care, including the cost of laboratory tests, which are reported to be a deterrent for some poorer women, and that the push to achieve increased coverage does not undermine the quality of care.

Key risks affecting successful delivery of results:

- Lack of ownership, commitment and action by national MoH could undermine progress with planned LSTM activities, in particular, the development of a national mentorship package and strengthening MPDSR, including taking forward the recommendations arising from the confidential enquiry into maternal death. The MoH has limited capacity and much of its attention has been focused on the UHC agenda and other more immediate priorities. DFID will continue to engage with senior leadership in the MoH to encourage greater leadership and responsiveness on this matter.

- Management and leadership capacity is variable and remains weak in some counties; efforts to strengthen county capacity to plan and budget for and manage health services are also undermined by frequent changes in county governance and health management personnel. A Key lesson can be learnt here from the Bungoma county work where a county plan was put in place to reduce staff turnover.
- Options has implemented a transition strategy in Bungoma and most programme activities will be sustained after the Options component ends in December 2018, either by the county or by partners. One key risk for sustainability is that the county plans to support many of the activities using World Bank THS-UC funding; longer-term sustainability will depend on county financing after this programme ends.
- Many counties have increased their health budgets but a significant proportion of these are accounted for by improvements in infrastructure and the costs of staff salaries, particularly in counties that are recruiting staff to address HRH gaps. This leaves limited funding for specific activities such as repeat EmONC in-service training or post-training mentoring. One mitigating action for is that LSTM is seeking a cost-sharing agreement with counties for future health worker training work.
- The shift in the next phase of the programme to a different, and less intensive, model of technical support for HSS across a larger number of counties could undermine achievement of the programme impact and outcome, and it will be critical for DFID to monitor the relevance, quality and effectiveness of TA inputs.

Update on partnership principles

The partnership principles for Kenya were last updated in April 2017 and will be updated again later in 2018. The last update concluded that, while the GOK has a strong commitment to poverty reduction, UK aid will not be channelled directly through GOK financial systems until there is evidence of substantial improvements in the integrity of financial management systems. Both Options and LSTM have worked with national and county governments to deliver shared objectives but have not channelled funds through GOK systems.

F: DELIVERY, COMMERCIAL & FINANCIAL PERFORMANCE

Performance of partners and DFID, notably on commercial, and financial issues

Narrative and financial reporting: Both LSTM and Options have met DFID quarterly narrative and financial reporting requirements.

The following table shows funds disbursed to date for the current programme partners.

Partner	Total budget (£)	Disbursed by DFID to Q2 2018 £	Balance
Options (Bungoma including CICF and ICF)	22,909,537.00	21,329,087.65	1,580,449.35
LSTM	10,317,232	9,146,544.67	1,170,687.33
HERA	300,000	-	300,000
World Bank	4,000,000	500,000	3,500,000

Overall the quality of financial management of both implementing partners has been satisfactory. LSTM has made efforts to reduce the variance between quarterly forecast expenditure and actual expenditure following feedback from DFID in early 2018, and monthly forecast updates have been reinstated.

Partner and DFID performance: Options has performed strongly, delivering against targets and payment milestones, which have been approved by DFID. Achievement of the payment milestone related to increased caesarean section rate, due in Q4 2017, was delayed because of health worker strikes, but submitted and approved in Q2 2018. Performance of Options' partners at national and county levels and partnership management has also been effective; the Bungoma consortium has taken a one project

approach rather than working separately. LSTM performance has also been good, although progress in some areas has been constrained by factors related to the MoH.

Coordination and communication between Options and LSTM, and by both partners with DFID, has been positive and productive. Since the UNICEF component closed, DFID has coordinated the programme and Options and LSTM have separate meetings with DFID to update on progress. The decision to close the UNICEF component was communicated officially to counties not long before the component ended and this allowed little time for UNICEF to plan for transition. There was no meeting with remaining programme partners to discuss the implications of the close of the UNICEF component for programme coordination and it would have been helpful if DFID had organised this. Internews has worked well with CICF partners and has also provided useful support to LSTM on media engagement. Both LSTM and Options have a good working relationship with the national MoH and with county health teams in the counties where they operate.

LSTM and Options have engaged in national coordination and technical committees e.g. the National Pre-Service Training Task Force, National MPDSR Committee and the MNH Technical Working Group, although the latter has met infrequently. There is no mechanism for national coordination of government and heath donors and technical agencies, although various structures have been established focusing on UHC.

Recommendation:

- DFID to ensure that changes to programmes and the implications of changes are communicated clearly and as early as possible to relevant stakeholders.

Asset monitoring: Both LSTM and Options have systems in place to record and monitor assets procured with DFID funds; both partners have submitted updated asset registers as required and Options submitted a final asset register for the Bungoma component in September 2018. Options has also developed asset registers for CICF partners and submitted asset disposition plans for grantees that have closed out or are shortly to close out. During field visits for this review, all equipment and other assets procured with DFID funds that were observed had a visible UKaid logo.

Date of last narrative financial report(s)	LSTM Sept 2018; Options Sept 2018
Date of last audited annual statement (s)	LSTM March 2018 for FY ending 31 July 2017; Options for FY ending December 2017

Summary information from recent audits was as follows:
MSI (Options) – The audited financial statement covers the period Jan-Dec 2017. The auditor's opinion was that MSI's group financial statement and company financial statements give a true and fair view of the state of the group's and of the company's affairs as at 31 Dec 2017.

LSTM - The audited financial statements cover the period for the year ended 31 July 2017. The auditor's opinion is that proper books of account have been kept and the accompanying financial statements which are in agreement give a true and fair view of the financial position of LSTM as at 31 July 2017.

G: MONITORING, EVIDENCE & LEARNING

Monitoring

Options has an effective monitoring framework and the team in Bungoma meets regularly with the county and six sub-county health management teams as well as conducting regular visits to supported health facilities. Learning from activities in Bungoma and the CICF has been used to inform programming. LSTM

also conducts regular visits to counties to conduct follow-up visits to facilities and monitor programme activities. Both partners provide quarterly progress reports to DFID and capture beneficiary feedback and human-interest stories.

The annual review was conducted by external health and VfM consultants with inputs from DFID Kenya. Meetings were held in Nairobi with DFID, Options and KPMG (CICF), PATH (CICF grantee), Internews, LSTM, MoH and the World Bank. Field visits to Bungoma, Kilifi and Homa Bay counties included meetings with county and sub-county health management teams, health personnel at county and sub-county hospitals and health centres, KMET, Mount Kenya University, RCTP-FACES, Afya Africa Research, SCI (CICF grantees), and community members (including community health workers and MNH service beneficiaries).

Evidence

Evidence has been used to improve policy and programming in several ways. MPDSR data is being used to improve facility management of deliveries as well as to advocate for action to address the main causes of maternal death. MPDSR data shows that haemorrhage is one of the main causes and, as a result, several counties have established or are planning to establish blood banks or blood bank satellites to improve the availability of safe blood. For example, Kakamega has established a blood bank, Kilifi is in the process of doing so, and Options has supported Bungoma to establish a blood bank satellite and blood donation strategy. Options has also documented lessons concerning availability of safe blood in a briefing sheet that has been shared at national and county levels. CICF projects are also generating evidence that is influencing policy and practice, for example, on KMC, UBT and potentially telemedicine and electronic medical record systems. Internews adapted its strategy in the second year of implementation to target heads of department in the MoH and broadcast and print media editors, to strengthen support for the work of government officials and journalists trained earlier.

Based on evidence of effectiveness in changing health worker attitudes, which in turn increased uptake of services, LSTM has integrated Respectful Maternity Care into EmONC training[20]. Training has also been revised to reflect changes in WHO guidelines on newborn resuscitation as well as issues such as fistula and female genital mutilation (FGM). LSTM has completed several operational research studies. Articles have been published or will be published e.g. on the knowledge and skills of health workers before and after EmONC training in sub-Saharan Africa countries including Kenya; lessons from implementing MPDSR in 10 countries and specifically from implementing MPDSR in Kenya; health systems governance for CEmONC facilities, and implementing the free maternity services policy in Kenya. Other published articles are on important topics, e.g. systematic reviews of definitions of community health workers and of social return on investment methodology, stillbirth classification, but are perhaps less directly relevant to the MNH programme in Kenya. Further publications are due in the next 12 months.

HERA has just completed an evaluation inception report and plans to visit Kenya in Q4 of 2018 to conduct interviews, facility assessments and focus group discussions in Bungoma as well as to collect data relating to the CICF and LSTM's work. In 2019, HERA will conduct a household survey in Bungoma, to collect data for comparison with Options' baseline data. The evaluation will compare sub-counties supported by Options and sub-counties not receiving Options support (although in some cases, other partners are providing support for MNH) and HERA will submit a final evaluation report in Q3 of 2019. Comparison with UNICEF counties is not included in the evaluation Terms of Reference[21].

Learning

As part of Options' exit from Bungoma, there has been a major focus on capturing and disseminating learning and evidence. Options has developed a learning agenda and has produced a series of policy and technical briefs and case studies, on a range of topics. These include on MPDSR and perinatal death review and reporting, lessons learned from annual planning and budgeting and the impact of devolution, the method and outcomes of the Organisational Capacity Assessment and Options' approach to HSS,

[20] A common reason women have not wanted to give birth in institutions in Kenya is the poor 'customer care' they received from staff. Many women have been treated badly by staff. Respectful maternity care is about treating mothers who are giving birth with respect.

[21] This may need to be revised as it is unclear why these counties/activities were not included. The overall contract with HERA now needs to be extended to reflect the programme extension.

operationalisation of Linda Mama, re-orienting TBAs as Birth Companions, and the impact of DSF and PBF on uptake and quality of MNH care.

Options has also presented findings at a range of conferences and meetings, including the Africa Forum on Quality and Safety in Healthcare in February 2018, International Africa Society for Blood Transfusion Congress in June 2018, 13th Scientific Conference of the East, Central and Southern African College of Nursing in September 2018, and the 5th Global Symposium on Health Systems Research in Liverpool in October 2018. Additional learning products will be produced between now and the end of 2018.

The CICF also has a communications and learning strategy. The CICF team is organising an innovation track at the 2nd ever African Union's (AU) Maternal Health Conference in Nairobi in October 2018 to showcase and share learning from CICF projects as well as specific forums to share learning on telemedicine and interoperability of electronic health (e-health) approaches. The CICF website has been improved and CICF and its partners have also made good use of social media to share project activities and findings. Each CICF project will result in a learning brief or peer reviewed paper. To date, the CICF and its partners have produced policy briefs, guidelines on HMB, quality obstetrics and perinatal care, and e-health, training manuals on KMC and UBT, and journal articles. Internews has helped to publicise CICF projects through media articles and videos.

Internews has made a significant contribution to raising the visibility of MNH issues, strengthening relationships between government health officials and the media and improving the quality of media coverage of MNH, through training national and county MoH, journalists and editors and supporting joint meetings. Media interest has been particularly high with respect to CICF projects including human milk banking, KMC and telemedicine. Internews support was also instrumental in supporting the MoH to make public the findings of the confidential enquiry into maternal deaths.

LSTM has also disseminating learning through conferences and meetings including the Kenya Obstetrical and Gynaecological Society Conference in February 2018 and the Kenya Health Forum in March 2018.

Progress on recommendations from previous reviews

1. DFID to review the programme target for additional births attended by a skilled birth attendant in view of the early closure of the UNICEF component. *Not revised but will be changed following this annual review as follows: original cumulative programme target for 2018 was 78,656 (UNICEF 68,968; Options 9,688); revised target 61,693 (UNICEF 49,734 achieved by end of 2017; Options 11,959 revised up from 9,688 due to contract extension and agreed with DFID)*.
2. DFID to communicate the decision to close the UNICEF component to the counties and plan join follow-up visits with UNICEF. *Decision was communicated, including through DFID meetings with counties; no follow up or transition planning undertaken by UNICEF*.
3. UNICEF to develop a one pager for each county that summarises investment, activities and improvements, assesses the implications of closure, and develops an exit strategy and plan for more detailed discussion with counties. *This was not taken forward by UNICEF as they are still engaging with these counties to a limited degree*.
4. DFID to explore options for scaling up/extending programme activities post contract end. *DFID extended the contract with Options to December 2018 to allow for transition planning and exit; LSTM activities will be extended for a further 4 years from April 2019 to March 2023 through a Business Case addendum to the programme*.
5. LSTM to support the MoH and counties to develop and deliver a national mentorship package. *Limited progress. LSTM received a formal request for support to develop a national mentorship package from the MoH in August 2018; progress is contingent on identifying funding –so the extension to LSTM's work under this programme needs to consider this*.
6. Consider replacing Output indicator 2.2 as all counties now have annual work plans and budgets. *Will be replaced when the logframe is revised to reflect DFID support for HSS for MNH through the World Bank MDTF*.

7. DFID to finalise with the World Bank the development of a MDTF to support HSS. *DFID has agreed to provide £2m to the MDTF in total to end February 2020 through an Administrative Arrangement signed in September 2018*[22].
8. DFID to ensure that partners receive additional support on VfM to strengthen the current VfM framework, develop capacity to measure the VfM impact of their activities and conduct an end-line cost-effectiveness study. *No progress since 2017; this recommendation needs to be taken forward during the next phase of the programme*.
9. LSTM to support the MoH and counties to develop a strategy to identify and train newly recruited health workers and conduct repeat EmONC training in facilities with high staff turnover. *No strategy yet developed; LSTM proposes to take this forward under the next phase of the programme through developing and testing a model for supporting counties to independently manage repeat trainings and monitor the impact of training*.
10. LSTM to support the MoH in the planned health facility assessment of impact and sustainability of EmONC training. *No progress. LSTM has offered to provide technical support if the MoH is able to secure additional funding for this activity*.
11. Options and LSTM to follow-up with the national MoH to ensure mandatory reporting of perinatal deaths. *This was discussed at the MPDSR committee meeting in July 2018 and MoH has confirmed that the next confidential enquiry report will include a review of perinatal deaths; subsequent progress has been limited awaiting MoH commitment to provide staff to work with LSTM on perinatal death issues in the National MPDSR Secretariat. Progress at county level will require printing and provision of the required tools and forms and minor revisions to the DHIS; the main hold up appears to be funding to cover the costs of printing*. *Options support has assisted Bungoma to become the top performing county on reporting of perinatal death*.
12. Options to ensure that CICF project findings are shared with wider stakeholders, especially national and county governments. *Options recruited a communications consultant to strengthen documentation and sharing of learning and evidence, improve the website and use of social media platforms; strengthened engagement with county health teams; produced a series of policy and technical briefs and manuscripts for publication; presented at conferences and meetings and is organising an innovation track as part of the upcoming AU MNCH conference in Nairobi*.
13. Options and HERA to undertake further analysis of ANC utilisation to generate more evidence on the reasons why women are not adhering to the recommended four visits during pregnancy. *HERA has been contracted by DFID and will consider this and other issues as part of the programme evaluation. Options has improved ANC performance in Bungoma through a combination of interventions* (see Output 3).

[22] The business case addendum which was approved was for an additional £4m for the MDTF element of the programme which runs until 2022. However, money spent beyond 2020 (the current spending review period) needs approval from Treasury/now Management Accounts Group. This takes time and so DFID Kenya has signed an AA with the WB for the first two years and will then sign another AA for the second two years once the approval for outer year spend comes through and subject to the performance of the MDTF in the first two years.

Annex

More detailed recommendations relevant to the next phase of the programme:

- LSTM should work with the MoH to identify funding for the development of a national mentorship package and with counties to support implementation of the package.
- LSTM should continue to advocate with the MoH to take forward the action plan based on the recommendations of the confidential enquiry report and proactively track and report on progress. Specifically, DFID, LSTM and other partners should advocate for the MoH to implement its commitment to second staff to the Maternal and Perinatal Death Surveillance and Response (MPDSR) Secretariat to strengthen work on perinatal death review and reporting.
- LSTM should take forward its plans to develop a sustainable model for county implementation of EmONC in-service training and identify where support may be required to refresh master trainers; clear criteria should be developed, in addition to willingness to cost share and avoiding duplication with other partners, to identify target counties to receive support, giving priority to the 20 priority counties.
- LSTM should develop an ambitious plan for the next phase of the programme that ensures all Kenya Medical Training Colleges (KMTCs) have trained tutors and can deliver pre-service EmONC training; the MoH is supportive of this. In addition, LSTM should work with the MoH, KMTCs, DFID and other partners to identify opportunities to secure funding for EmONC training equipment for KMTCs. Coordination will be needed with UNFPA plans to support a stand-alone pre-service midwifery curriculum.
- DFID to encourage MDTF support to national MoH and counties to include strengthening health financing and human resources for health, as well as planning and budgeting, to maximise the future sustainability of MNH programme interventions to date.
- DFID to consider options for engaging Internews in improving public dialogue, media engagement and GOK communication on FP programming and UHC as well as MNH issues.

Summary of key recommendations for next year

Action	Timeline	Responsible
1. Review Output Indicator 3.1 to measure 'Number of poor women covered by Demand-Side Financing schemes' based on use of vouchers rather than distribution only for future programmes	By December 2018	DFID
2. Document new changes in the logframe	By December 2018	DFID
3. Develop a new logframe to include all the new components of the MNH programme	By February 2019	DFID
4. Commission a review of the MNH programme that documents changes that have taken place since the UNICEF component closed	By January 2019	DFID

Has the logframe been updated since the last review? Yes, DFID agreed on the following amendments to the logframe:

- Output indicators related to UNICEF were deleted since the UNICEF component of the programme was closed in November 2017.
- New output indicators for MANI were integrated and old ones deleted based on the reviewed logframe approved by DFID on March 2018.