CHILD SURVIVAL AND DEVELOPMENT

SITUATION

Kenya’s health indicators have continued to decline over the last fifteen years though recent data may show that things are beginning to look up. The 2003 Kenya Demographic and Health Survey (KDHS) reported infant and child mortality at 77 and 115 deaths per 1,000 live births respectively while more recent data from the 2005/2006 Kenya Integrated Budget Household Survey (KIHBS) report an improvement of infant and child mortality at 60 and 92 per 1000 live births. Geographic disparities prevail with around 54 under-five deaths per 1,000 live births in Central province compared to 250 in Nyanza province. Yet Kenya also has one of the highest numbers of newborn deaths in the African region with a neonatal mortality rate of 33 per 1,000 live births and approximately 43,600 deaths occurring every year. Despite renewed focus on child survival, achieving the Millennium Development Goal targets in under-five mortality (33/1000) and infant mortality (26/1000) by 2015 presents serious challenges. It is similarly unlikely that the government will achieve maternal mortality targets (147/100,000) by 2015. The current MMR of 414/100,000 translates to an average of 4,500 women dying every year due to pregnancy related complications, most of which are preventable.

The factors contributing to the poor child health status are: malnutrition, a high incidence of diseases, inadequate health care and hygienic practices at household level, poor environmental and living conditions, and the HIV/AIDS pandemic. Poor access to health services, long distances to cover in getting to a health facility, inadequacies in the health care system, for example, a lack of drugs, supplies, personnel, and compounding poverty, are all contributory factors.

UNICEF CHILD SURVIVAL AND DEVELOPMENT PROGRAMME

The UNICEF Child Survival and Development Programme will contribute to: Increased equitable access and use of quality essential social and protection services with a focus on vulnerable groups; Reduction in humanitarian impact and risk of natural and human made disasters; Evidence–informed and harmonized national HIV Response to deliver sustained reduction in new infections, scaled up treatment, care, support and effective impact mitigation.
The Programme will specifically aim to contribute to a reduction in infant, child and maternal mortality through support to interventions of proven effectiveness in water, sanitation, hygiene, health and nutrition and by supporting and accelerating result-based interventions and promote accelerated investment on health from the GOK, private investment and donor funding.

The Child Survival and Development Programme has three components, as follows:

**HEALTH**

The health component of CSD will support the Government of Kenya to scale up high impact interventions through implementation and monitoring of evidence based integrated interventions. Support will focus upstream to enable effective policy development and leveraging of resources for child health. Strengthening of the lower levels of the health system that focus on the community, dispensaries and health centres will also be emphasised.

The key outputs of the health component include;

1. **Women and Child friendly policies for survival and development implemented effectively**
   - This will include support towards reviewing and or finalizing the following documents; i) child health policy, ii) nationals vaccine policy, iii) the child survival and development strategy, iv) the national malaria strategy and the v) diarrhoea control strategy.
   - The Marginal budgeting for bottlenecks (MBB) exercise focusing on CSD will be under taken by the end of 2009 to support the health sector MTEF planning and budgeting process with the aim of influencing policy and increasing the resource base and investments for child survival.
   - Support the institutionalization of maternal and peri-natal deaths records nationally
   - Participate in health sector coordination activities to promote accelerated child survival and development activities.
   - Support evidence based planning, monitoring, evaluation and research to strengthen CSD activities including support to the Kenya Service Provision Assessment, a national immunization coverage study and conducting a national child survival and development disparity study

2. **80% of women aged 15-49 years and 80% U5 years old children use quality evidence-based essential integrated (health, nutrition, and HIV/AIDS) services by 2013 including in emergency situations**
   - Support Malezi Bora (Good Nurturing) and the Child Alive campaigns which are strategies for stimulating increased participation, demand and use by the public in maternal and child health and nutrition programs.
   - Support to scaling up both facility and community IMCI, ORT/Zinc, paediatric ART and comprehensive treatment services for HIV, strengthen routine immunization services.
   - Scale up maternal and Neonatal health using demand side funding/voucher scheme to increase institutional deliveries and appropriate care of the newborn.
   - Support the scale up of facility-based emergency obstetric care, the Integrated Management of Childhood Illness (IMCI) including the community component, PMTCT-plus and care, treatment
and support of children infected and affected by HIV with priority to poor and hard to reach districts.

- Support the achievement of universal coverage of interventions like immunization, insecticide-treated nets, deworming and intermittent presumptive therapy for pregnant women, with a particular focus on reaching poor, hard-to-reach and marginalized communities and families. New vaccines, such as, Rota virus and pneumococcal, will be introduced and cold chain capacity strengthened.

3. 50% of households practicing improved care practice
- UNICEF will support the scale up of community level CSD interventions through the special emphasis on empowering people who are poor and reducing disparities by building the capacities of women, families and communities to support and complement the continuum of care from home to health facilities.
- These strategies include improving home care practices and care seeking behaviors for key maternal, newborn, child survival and development including PMTCT and the delivery of cotrimoxazole to HIV infected children.
- Support the scale up of the community strategy including training of community health workers, community health extension workers and establishing the community health information system.

NUTRITION
Malnutrition continues to threaten significant proportion of Kenyan children and women. The most recent countrywide study done in 2005/06 (Kenya Integrated Household Budget Survey 2007) shows persistently poor nutrition outcomes with marginal increases in stunting (33%), wasting (6.1%) and underweight (20.2%) compared to 2003 data. Prevalence of wasting is highest in the North Eastern Province (25.8 percent) which is a marginal decline from 27.8 percent in 2003. During periods of food insecurity in Arid and Semi Arid (ASAL) districts in the, levels of acute malnutrition have reached 37% (<-2 Z scores and oedema) in some divisions. It is noted that Eastern, Nyanza and Coast provinces registered an increase in wasting levels while Nairobi, Central, Rift Valley, Western and North Eastern provinces registered a decline in wasting between 2003 and 2006.

UNICEF KENYA NUTRITION COMPONENT
Nutrition component will enhance capacities for sustainable improvement of nutrition (i) at national level, (ii) within systems and structures for delivery of services and (iii) in households, and the enormous constraint on human capital caused by malnutrition will be used as a focus for advocacy.

Key priority areas of focus are: Infant and young child nutrition; micronutrients and management of acute malnutrition, incorporating issues related to HIV; as well as emergency preparedness and response. At the national level, UNICEF will support increased advocacy to ensure coordination, implementation and monitoring of the Food and Nutrition Policy and Strategy. UNICEF will strengthen national, district and community systems and structures through which nutrition related services are delivered with focus on human resource capacity, development of job-aids and ongoing
provision of essential nutrition supplies and equipment. Support will be given to the development and maintenance of an efficient nutrition information system. Acknowledging the critical role of behaviour and household practices in nutrition, UNICEF will support communications and community systems that support behaviour change related to infant and young child feeding, diet (including consumption of fortified foods) and uptake of essential actions particularly vitamin A supplementation. In keeping with the spirit of ECHUI, the partnership with WFP and others will be strengthened. UNICEF will continue to monitor micronutrients deficiencies and work with partners including private sector for fortification.

OPPORTUNITIES

Policies and guidelines are already in place on all major technical areas of intervention including:

- Nutrition and Mortality Assessment
- Management of Malnutrition
- Infant and Young Child Feeding
- Micronutrients
- Nutrition and HIV

There is also growing commitment in the private sector to ensure that basic food commodities are fortified eg. Salt with iodine, flour with iron, oil and sugar with vitamin A.

Commitment from both Ministries of Health to include nutrition commodities in the essential drug list and on the health budgets (initial start in 2007 with progressive inclusion in 2008 and 2009).

In 2008, the nutrition information system was established with new databases, website, quarterly bulletin and other valuable information resources.

The Nutrition Technical Forum was established in late 2007 and represents a valuable forum for coordination of nutrition interventions within the health sector. All key NGOs and both Ministries are involved.

CHALLENGES

Over the past few years, the nutrition sector in Kenya has invested heavily on ensuring that policies, guidelines and standards in key technical areas were developed, agreed and published. The process has been slow and cumbersome in many cases but these critical processes have now been completed and the level of readiness for implementation is high. Unfortunately, allocation of resources has fallen short of requirements although 2008 has seen progress in a willingness to have essential nutrition commodities listed in the budget preparation process.

Coordination of nutrition actions in the health sector has been strengthened significantly through the establishment of the Nutrition Technical Forum and the Nutrition Information System is in place to monitor interventions.
Two of the remaining gaps are the required level of political commitment and passion at national level. This can be seen in the lack of an inter-sectoral coordination and mechanism for the proposed Food and Nutrition Policy and the related low level of resource allocation. The level of technical and operational readiness for implementation of high-impact interventions is therefore high. Adequate and sustained financing of nutrition interventions over a five to ten year period will have a substantial impact.

WATER AND SANITATION

SITUATION

Access to improved water supply stands at 48 percent in the rural areas while the national average is 53 percent. The sanitation situation is worse with more than 50% of urban poor and more than 70% of rural poor without access to sanitation. Regional/geographical disparities prevail in all cases posing serious challenges. 75% of primary care givers and 71% of secondary caregivers do not wash hands with soap at critical times. About 70% of all schools do not have adequate toilet facilities and safe water supply. The recent disputed presidential elections have reversed some of the previous gains.

In order to address the above gaps, the Government put in place a Water Sector Reform guided by the Water Act 2002. The reforms provide for decentralization of service delivery to 7 Regional Water Services Boards who have mandate for asset development and management. The Parent ministry returns Policy regulation functions. In spite of the reforms, however capacity challenges exist at many levels. First, the Boards themselves have not been fully capitalized hence face serious human resource capacity gaps. Many donors have still remain sceptical of the reforms and have opted to take a wait and see attitude, with many preferring to finance only Urban based water supply which are likely to return a profit. The rural water segment therefore remains largely unfunded. Community level structures for management of water facilities remain weak making more than 30 per cent of community managed water facilities fail.

Diarrhoea still remains a challenge in Kenya. Poor hygiene practices and consumption of unsafe water remain the biggest underlying factors. A National Sanitation and Hygiene Policy has been enacted in 2007 and is expected to guide future action.

The Hygiene and sanitation policy document is guided by the Kenya Health Sector Strategic Plan and outlines demand creation for sanitation and Hygiene Improvement. It has the following vision to create and enhanced and enabling environment in which all Kenyans will be motivated to improve their hygiene behaviour and environmental sanitation, and which gives people access to the necessary support to achieve this.
**UNICEF WATER AND SANITATION COMPONENT (WASH)**

The WASH programme is aligned with the Kenya Vision 2030 and the Education and Health SWAPs within the Kenya Joint Assistance Strategy (KJAS). It focuses on the most disadvantaged, vulnerable, internally displaced, and informal settlements. At the national level, the programme is focusing on policies, legislation and reforms.

The programme supports capacity building for partners including government NGOs, CBOs and children and communities. It supports logistical and skills development to enhance effective and participatory approaches for broader participation of the primary stakeholders. Other areas include advocacy support, through information, communication and social mobilization. The programme will converge interventions in health, nutrition, HIV/AIDS and water and sanitation through the integration of services and empowering community caring practices in support of Child Survival and Development.

The WASH component aims to achieve the following results:
Improved care practices of 50 per cent of households for nutrition, WES and health nationwide by 2013, Increased utilization of water and sanitation services for households, schools, health facilities, particularly for vulnerable populations by 2013 and development and effective implementation of women and child friendly policies.

Specific results will include at least 1.3 million new users of safe and sustainable sources of drinking water and other 1.9 million NEW practitioners adopting appropriate hygiene practices especially hand washing with soap or ashes and 1.65 million people delivering new sanitation facilities.