Achieving progress for mothers, babies, and children in Kenya

In a detailed analysis using multiple data sources in this issue of *The Lancet Global Health*, Emily Keats and colleagues[1] show that Kenya made some progress in reducing maternal and newborn mortality between 2003 and 2015, and made greater progress in reducing child mortality between 1998 and 2015, after earlier increases in mortality. Their analysis is useful because it also shows variations by region and by wealth quintile of key intervention coverage along the continuum of care for mothers, babies, and children. These innovative equity analyses will enable the Kenyan Government to improve their geographical and socioeconomic targeting of these vital interventions. Work on the political and logistical feasibility of such targeting is now urgently needed to make pro-poor policies and their effective implementation a reality, and to make progress towards achieving maternal, neonatal, and child mortality targets within the Sustainable Development Goals (SDGs) in Kenya.

As other human development indicators also improve—notably, female literacy and the associated later first birth, greater birth intervals, and higher socioeconomic status, all of which are associated with lower mortality—further gains can be expected. Results from the multivariable analyses by Keats and colleagues highlight the roles of such distal determinants,[1] but what are immediately policy-relevant to the acceleration of mortality reduction (especially maternal deaths, stillbirths, and neonatal deaths, which lag behind child mortality) are the proximal determinants of quality of care during labour and delivery. Although the Lives Saved Tool analyses also highlight the role of skilled birth attendance,[1] Keats and colleagues are unable to explore quality of care in detail because the required information about the content, timing, and manner of patient–provider contacts is unavailable. Efforts to routinely measure quality of care are being developed[2,3] and need to be integrated into national systems, along with institutionalisation of quality improvement methods in pre-service training, routine practice, and supportive supervision. There also needs to be increased funding for and use of implementation science and systems research, to ensure that intervention coverage is translated into quality care.[4]

Notably, skilled birth attendance was also found by Keats and colleagues to be one of the most inequitable coverage indicators, remaining so in 2014.[1] In Kenya, out-of-pocket expenditure as a proportion of total health expenditure has decreased from approximately 42–50% during 1996–2010 to approximately 26% during 2012–14.[5] In view of the remaining inequity in skilled birth attendance and other coverage indicators, and out-of-pocket expenditure being a barrier to accessing available care,[1] further improvements towards equitable financing are needed, along with efforts to improve quality.

Community interventions[6] also need to be scaled up to ensure timely access to both community-based and facility-based care, and community health workers need to be formally integrated into and paid by the government health system in Kenya. The current crisis of low morale and widespread strikes by nurses and doctors in Kenya[7] highlights that the Government needs to urgently reconsider its approach to the public sector health workforce in the country if both quality and equity are to be achieved and further progress made.

The Kenya Countdown to 2015 country case study, one of ten, will enable the Government to take stock and plan for the future, to address identified gaps in health systems and policies, financing, and equitable coverage of key interventions. The Countdown to 2015 initiative has done a good job of tracking the progress on maternal, newborn, and child health indicators towards meeting the Millennium Development Goals, and now Countdown to 2030 is continuing this vital work, with an expanded focus, towards achieving the SDGs.[8] The SDG period presents many opportunities for improved and coordinated measurement and tracking in Kenya—such as the Health Data Collaborative[9]—and greater financing and concerted action, towards achieving SDG targets.[2]

The multivariable analyses by Keats and colleagues identified factors associated with higher coverage of key interventions in Kenya.[1] Current and prospective efforts tracking key indicators and their determinants over time could enable time-series regression and more sophisticated causal inference analyses in future. Such analyses should provide further enlightenment about what interventions work and how, where, and when they work, to enable the demand, provision, and receipt of timely and good quality care for all who need it.

There needs to be a focus on improvement of mechanisms to translate evidence into policy and practice in Kenya,[10] so that the analysis of Keats and colleagues, and those that follow, speak to those in charge of formulating and delivering the necessary policies. It is important to recognise that country-based researchers, who often have the attention of such policymakers and managers,[10] need to lead and disseminate such analytical efforts.

The results of the Kenya Countdown to 2015 country case study[1] show that concerted and coordinated action by a responsive government and partner organisations can lead to results. With increased efforts in quality of care, equitable financing, community interventions, and improved monitoring, targeting, and implementation, accelerated gains can be made.

Tim Colbourn
University College London (UCL) Institute for Global Health, UCL, London, WC1N 1EH, UK
t.colbourn@ucl.ac.uk

1   Keats EC, Ngugi A, Macharia W, et al. Progress and priorities for reproductive, maternal, newborn, and child health in Kenya: a Countdown to 2015 country case study. *Lancet Glob Health* 2017; **5:** e782–95.
2   Kruk ME, Kelley E, Syed SB, Tarp F, Addison T, Akachi Y. Measuring quality of health-care services: what is known and where are the gaps? *Bull World Health Organ* 2017; **95:** 389.
3   Kruk ME, Pate M, Mullan Z. Introducing *The Lancet Global Health* Commission on High-Quality Health Systems in the SDG Era. *Lancet Glob Health* 2017; **5:** e480–81.
4   Nambiar B, Hargreaves DS, Morroni C, et al. Improving health-care quality in resource-poor settings. *Bull World Health Organ* 2017; **95:** 76–78.
5   World Bank. Out-of-pocket health expenditure (% of total expenditure on health). World Development Indicators. http://data.worldbank.org/indicator/SH.XPD.OOPC.TO.ZS?locations=KE (accessed June 30, 2017).
6   Lassi ZS, Bhutta ZA. Community-based intervention packages for reducing maternal and neonatal morbidity and mortality and improving neonatal outcomes. *Cochrane Database Syst Rev* 2015; **3:** CD007754.
7   The Lancet. Kenya's nurses strike takes its toll on health-care system. *Lancet* 2017; **389:** 2350.
8   Victora C, Requejo J, Boerma T, et al. Countdown to 2030 for reproductive, maternal, newborn, child, and adolescent health and nutrition. *Lancet Glob Health* 2016; **4:** e775–76.
9   Health Data Collaborative. Kenya. https:// www.healthdatacollaborative.org/where-we-work/kenya/ (accessed June 20, 2017).
10   Ponge A. Evidence for policy influence and legislation in Kenya: what lessons for researchers, policy-makers and legislators in the East African community partner states? *Afr J Soc Sci* 2013; **3:** 61–73.