

MALARIA IN PREGNANCY COUNTRY PROFILE

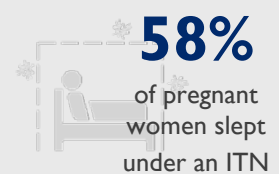
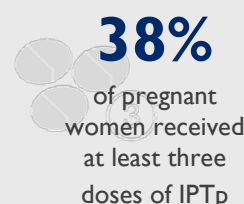
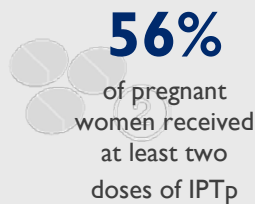
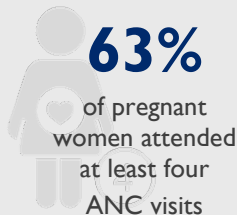
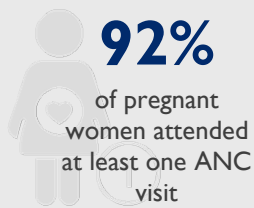
KENYA

July 2018

BACKGROUND

Kenya has adopted the World Health Organization's three-pronged strategy for combating malaria in pregnancy (MiP): (1) intermittent preventive treatment in pregnancy (IPTp)¹ via directly observed therapy (DOT), (2) distribution and use of insecticide-treated nets (ITNs), and (3) case management of MiP. The country adopted IPTp in 1998 with its first malaria strategy, but did not implement the national IPTp policy until 2001. In 2009, Kenya revisited its policy to target moderate to high transmission areas (i.e., the lake and coastal endemic regions) with IPTp.

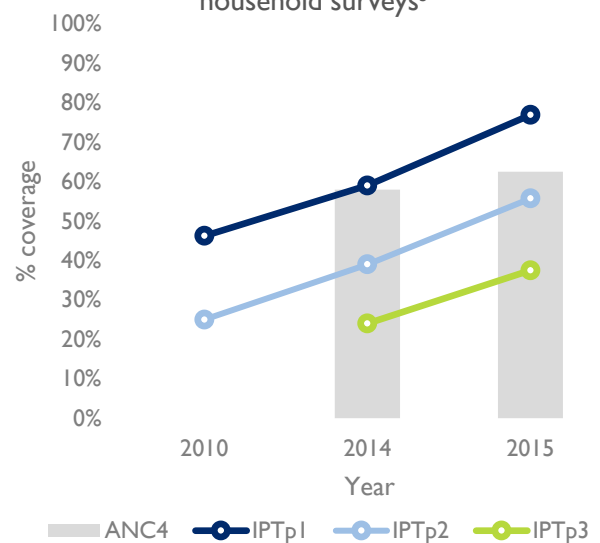
AT A GLANCE²



POLICY & IMPLEMENTATION

Kenya's IPTp policy, developed by the Ministry of Health's National Malaria Control Programme (NMCP) and Department of Reproductive Health, calls for pregnant women to receive sulfadoxine-pyrimethamine (SP) via DOT at every antenatal care (ANC) visit after quickening, with subsequent doses at intervals of at least 4 weeks. However, quickening can occur well after the recommended IPTp initiation time of 13 weeks' gestation. The policy recommends IPTp in the 14 malaria-endemic counties in western Kenya and on the coast. Kenya has an MiP Technical Working Group chaired by the Department of Reproductive Health, with the NMCP serving as the secretariat.

Figure A. IPTp and ANC coverage, from household surveys³



¹ IPTp1, IPTp2, and IPTp3 refer to at least one dose, at least two doses, and at least three doses, respectively, of IPTp with SP.

² Note these are subnational data representing IPTp-implementing areas only. NMCP, Kenya National Bureau of Statistics (KNBS), and ICF International. 2016. *Kenya Malaria Indicator Survey 2015*. Nairobi, Kenya, and Rockville, MD, USA: NMCP, KNBS, and ICF International.

³ The y-axis shows coverage for the most recent pregnancy resulting in a live birth—in the previous 5 years for ANC and in the previous 2 years for IPTp—among women ages 15–49 who were interviewed for the survey. Note these are subnational data representing IPTp-implementing areas only. (i) Division of Malaria Control (DOMC), KNBS, and ICF Macro. 2011. *2010 Kenya Malaria Indicator Survey*. Nairobi, Kenya: DOMC, KNBS and ICF Macro. (ii) KNBS, Ministry of Health, National AIDS Control Council (NACC), Kenya Medical Research Institute (KMRI), National Council for Population and Development (NCPD), and ICF International. 2015. *Kenya Demographic and Health Survey 2014*. Rockville, MD, USA: KNBS, Ministry of Health, NACC, KMRI, NCPD, and ICF International. (iii) *Kenya Malaria Indicator Survey 2015*.

SERVICE DELIVERY

Kenya has had great success in ensuring coverage of at least two ANC visits, resulting in more than 95% of women receiving ITNs at ANC.⁴ The Health Information Management System (HMIS) shows coverage of both IPTp1 and IPTp2 at over 70%, although there has been some fluctuation, likely due at least in part to stock-outs of SP. According to the HMIS, IPTp1 coverage was 85% in 2011. It dropped to 56% in 2015 when stock-outs peaked, but was 75% in 2016. Training on the updated IPTp policy is under way.

In a recent study funded by the Bill & Melinda Gates Foundation on group ANC in Kisumu, groups of up to 15 pregnant women with similar gestational ages attended ANC together at facilities. Preliminary data from the study indicate that group ANC had a positive effect on coverage of all four IPTp doses among women in the study. Final analysis is in process.

COMMUNITY ENGAGEMENT

Under the Maternal and Child Health Integrated Program and transitioning to the Maternal and Child Survival Program (MCSP) in 2014, community health volunteers (CHVs) in Bungoma County received training on the promotion of MiP. CHVs conducted monthly home visits to identify pregnant women, encourage them to attend ANC early in pregnancy, and educate them on the benefits of IPTp and the importance of starting it early in the second trimester. The CHVs reached 44,133 pregnant women, contributing to a 50% increase (from 24% to 36%) between October 2014 and March 2016 in the proportion of pregnant women initiating ANC by 20 weeks' gestation.⁶ Based on its successful pilot, the intervention was rolled out in all four malaria-endemic counties supported by the President's Malaria Initiative. The counties showed a marked increase in uptake of IPTp1 (from 51% to 79%) and IPTp2 (from 42% to 68%) between 2014 and 2017.⁷ These increases are in line with the overall increases in IPTp coverage after SP stock-outs ended, making it difficult to determine the precise impact of the community outreach. The intervention has been scaled up to 30 malaria-endemic sub-counties, which may have contributed to the positive trend in IPTp uptake.

Counties are responsible for providing the community data collection tools to the CHVs to capture indicators such as ITN use by pregnant women and ANC referrals, but due to inconsistent supply of data collection tools, data collection and reporting at the community level remain a challenge.

Figure B. IPTp coverage among ANC attendees, from routine reporting systems⁵

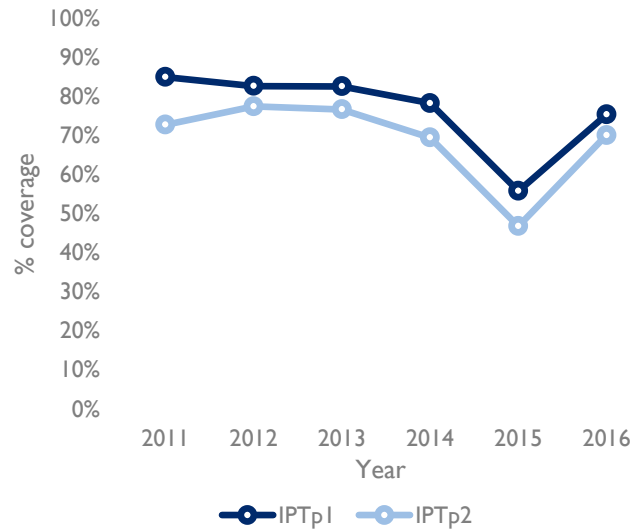
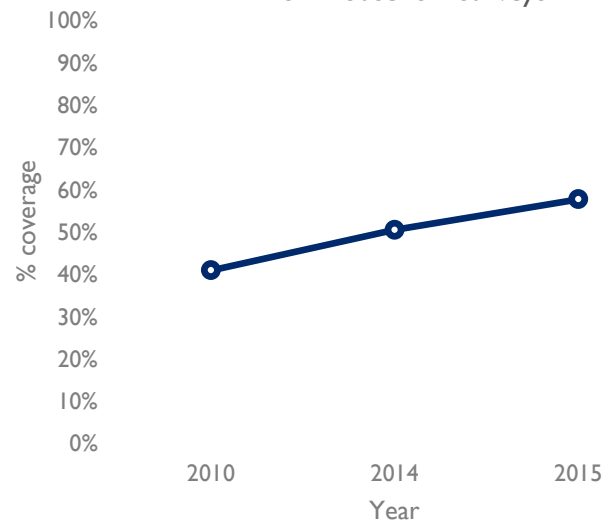


Figure C. ITN use among pregnant women, from household surveys⁸



⁴ Data drawn from HMIS 2016.

⁵ The y-axis shows coverage of women who attended ANC at facilities reporting to the HMIS. The data source for this figure is HMIS 2011–2016. Note these are subnational data representing IPTp-implementing areas only.

⁶ MCSP. 2017. *MCSP Annual Report October 1, 2015–September 30, 2016*. Accessed June 22, 2018 at: <https://www.mcsp-program.org/wp-content/uploads/2017/03/MCSP%20PY2%20Annual%20Report-%20Redacted.pdf>

⁷ Gains were concentrated around the endemic zones where MCSP was working. Work with CHVs focused on the counties of Bungoma, Homa Bay, Kisumu, and Migori. Data is from the District Health Information System 2014–2017.

⁸ The y-axis shows percentage of pregnant women who slept under an ITN on the previous night of the survey. Note these are subnational data representing IPTp-implementing areas only. MIS, 2010; DHS, 2014; MIS, 2015.

COMMODITIES

SP stock-outs were a major challenge between late 2014 and the first half of 2016 because of financial difficulties after decentralization of health services and reduced county budgets. A recent quality of care survey found that 75% of facilities had at least 7 days of SP stock-outs in the preceding 3 months.⁹ The President's Malaria Initiative is investing in strengthening supply chain management for malaria commodities at all levels in the country to avoid further challenges.¹⁰

MONITORING & EVALUATION

While policy indicates that IPTp should be administered through DOT, it is not tracked in the HMIS. Although ANC registers have been updated to capture three doses, summary data captures only one dose, and two or more doses of IPTp. The third dose of IPTp is not yet reflected in HMIS, which tracks only up to two doses. The HMIS currently tracks pregnant women with malaria but not the treatment they receive.

This profile is made possible by USAID and the Maternal and Child Survival Program and does not reflect the views of USAID or the United States Government.

⁹ Machini B, et al. 2017. *Monitoring outpatient malaria case management under the 2010 diagnostic and treatment policy in Kenya: Progress January 2010–September 2017*. Nairobi, Kenya: Malaria Control Program, Kenya Ministry of Health.

¹⁰ President's Malaria Initiative. 2017. *Kenya Malaria Operational Plan FY17*. Accessed June 22, 2018 at: <https://www.pmi.gov/docs/default-source/default-document-library/malaria-operational-plans/fy17/fy-2017-kenya-malaria-operational-plan.pdf?sfvrsn=6>