Better Evidence, Better Policies for Achieving Health and Sanitation Access in Kenya

Conference Report

November 21, 2017
Radisson Blu Hotel
Upper Hill Area, Nairobi, Kenya

About the Health, Water and Sanitation Conference

On 21 November 2017, the Vision 2030 Delivery Secretariat and Innovations for Poverty Action (IPA) organized a one-day policy forum in Nairobi to disseminate evidence from research studies, relevant policy lessons and innovations in health, water and sanitation. The forum was organized within the policy framework of the National government through the Ministry of Health, Vision 2030 (Economic and Social pillars) and the health priorities of Kenya's county governments.

The event brought together local and global researchers, policymakers, donors, and implementing organizations in both the private and public sectors. During the forum, attendees discussed solutions that work in improving the Kenyan health and WASH sectors with Sustainable Development Goal 3 in mind ("to ensure healthy lives and promote well-being for all at all ages"). The conference provided the opportunity for key stakeholders to consider the relevance of research findings in designing future national and county health and WASH strategies.

This report summarizes the sessions held and research findings shared at the conference, and concludes with some policy recommendations and important considerations for the way forward.

Opening

Mr. Suleiman Asman, IPA Country Director, opening the event.

Mr. Suleiman Asman, IPA Kenya's Country Director, welcomed all participants to the conference and thanked them for taking the time to attend this important dissemination event. After introducing IPA's work as a global research organization operating in the global South, Mr. Asman explained that despite the many efforts to reduce poverty globally, we still have 1.2 million people living in poverty. In its collaboration with Vision 2030, IPA conducts research on what works and moves it to policymakers to make sure that new programmes are informed by research evidence.

Mr. Asman introduced the topic of the conference, explaining that the one-day event was dedicated to discussing how to strengthen the quality of research, sharing the latest research results in the health and sanitation domain, and discussing the way forward to further strengthen the body of evidence to inform Kenyan policymakers. The Director General of Vision 2030, **Dr. Julius Muia**, expressed Vision 2030's key interest in fostering research aimed at reducing poverty. Vision 2030 is a framework that guides Kenya's planning, budgeting, monitoring and evaluations and other frameworks. The overall goal is for Kenya to be a globally competitive, prosperous nation with a high quality of life by 2030. To do that, the country needs to maintain a sustained economic growth of 10% yearly at least, look at clean and secure environment, and in the political pillar determine that we must operate within a democratic system.

Dr. Muia further explained that health, water and sanitation are hosted in the Vision's social pillar and the sector goal is equitable, affordable, quality health care. The global competitiveness index shows that Kenya is doing well in terms of business impact of malaria but some lifestyle problems remain: HIV prevalence, business impact of HIV, number of tuberculosis cases. There has been commendable progress in the water and sanitation sector with increased access to safe water, even though the situation is still critical in Northern Province, the Lake Victoria Region and the Coast. Due to the poor performance in the health sector Kenya risks to not be a competitive country and fail its overall goal. Overall, Kenya ranked 117 out of 135 countries in the global competitiveness index, and is positioned in the fourth and last quartile.

For this reason, the Vision identified 12 flagship projects in the health sector and 8 in the environment, water and sanitation sector. One key project is mainstreaming research and development in health and the Conference speaks directly to this project. Dr. Muia underlined that poor health is a major contributor to poverty and researchers should work to understand how poor health is contributing to slow development. He commended IPA's timely work and expressed the wish that the evidence shared with the meeting will find its way in the planning for next year.

Dr. Kepha Ombacho represented the Cabinet Secretary for Health, Dr. Cleopa Mailu. Dr. Ombacho commended the initiative of IPA and Vision 2030 to bring human health topics high in the policy agenda and expressed the interest in the conference that provided a platform for dialogue between all parties involved in the heath sector. Dr. Ombacho reminded the forum that SDG3 ensures the promotion of the well-being for all, at all ages, including communicable and non-communicable diseases, access to affordable and safe medicines, maternal health. SDG3 also calls for more evidence-based policymaking in health and seeks to ensure availability and sustainable management of water for all.

The constitution of Kenya 2010 is the overarching framework that has developed delivery of health case largely to the county government. Kenya Vision 2030 also provides the broad policy framework in which health issues are tackled. The health bill 2017 seeks to establish a health framework in Kenya and is aligned to the health policy 2013-14.

Significant progress has been made with reducing issues related to maternal health. In addition, progress has been made in WASH, reducing malaria, TBC and the spread of HIV and AIDS: much more is needed to eradicate a number of diseases related to water, sanitation and hygiene. Health is one of the biggest determinants of society's economy and is connected to other key aspects of sustainable development.

Dr. Ombacho stated that it is the Ministry's commitment to increase the use of evidence into policies and make progress in the health sector in Kenya. He also ensured that the research findings presented at the Conference will be appraised, synthesised and applied to policymaking.

Dr. Julius Muia, Director General-Vision 2030 (left) sharing a handshake with Dr. Kepha Ombacho, Director of Public Health, Ministry of Health.

Keynote Presentation

WASH Benefits Study

Dr. Clair Null, Mathematica Policy Research

Dr. Null presented on the WASH Benefits Study. She noted that there is little evidence on whether existing water quality, sanitation and hygiene (WASH) interventions lead to lasting improvements in child health, growth and development and whether nutrition (N) programs, combined with WASH interventions or delivered alone, can reduce growth faltering or improve child growth and development.

Dr. Null noted that testing these issues was the key objective of the WASH Benefits study, though a cluster-randomized trial that was conducted between 2012 and 2016 in Bungoma, Kakamega and Vihiga counties. The study enrolled 8,246 pregnant women in clusters (villages). Clusters were randomised to active control (household visits to measure mid-upper arm circumference), passive control (data collection only), or compound-level interventions including household visits to promote target behaviours.

Outcome of the study:

- None of the intervention reduced the prevalence of diarrhoea, which was high among young age group at 27% similar to 2014 Demographic and Health Survey (DHS) of the comparable group.
- W, WSH, and WSHN interventions reduced Ascaris prevalence from 30% in control to 18%. This suggests that it might be contaminated water that makes children ingest eggs. No interventions reduced Trichuris, Hookworm, or Giardia infection prevalence, perhaps because the prevalence of Trichuris and Hookworm was quite low (less than 3%) and the prevalence of Giardia was high at 39%.
- The N and WSHN interventions led to major reductions in the prevalence of anemia, vitamin A, B12 and Folic Acid. This suggests that WSHN interventions had a larger impact than N alone.
- The H and WSHN interventions showed an improvement in child development after one year although no differences in motor skills after year two. Regrettably none of the other interventions had any effect on child growth. Almost a third of children in the control group were stunted and the WSHN intervention reduced this by only 5%. The study also suggested of a lower mortality rate in the WSHN intervention arm.

Dr. Clair Null sharing the WASH Benefits study results.

A similar study done using the same design in Bangladesh, although with more intense promotional interventions (weekly), showed higher adherence, and gave similar results in terms of parasite prevalence and impact on diarrhea (except from W). The study also showed strong effects on child development from all interventions and significant reduction in mortality in WSHN arm. The results of another study done in Zimbabwe with some contextual similarities (but with 50% open defecation) with the WASH Benefits study showed slightly higher adherence although same outcomes as in case for Kenya.

Dr. Null provided a summary of the suggestions that the evidence collected with the WASH Benefits study suggests:

It is possible to integrate WSH and WSHN without compromising adherence, but there is almost no evidence of added benefit from either combination.

These W, S, and H interventions did not reduce high levels of diarrhoea (but reduced parasite infections). This is inconsistent with previous literature.

- W, S, and H interventions did not improve growth suggesting that community-level interventions starting from lower coverage might be able to.
- Growth improvements from nutrition counselling plus supplementation were remarkably consistent but small.

Access to Health Services

Africa Health Markets for Equity

Rita Cuckovich, University of California, Berkeley and Avery Seefeld, University of California, San Francisco

Ms. Seefeld (left) and Ms. Cuckovich responding to participants' questions.

Ms. Cuckovich presented the quantitative aspects of the Africa Health Markets for Equity project and Avery Seefeld illustrated the qualitative aspects of the research. The purpose of the AHME study, they said, is to increase the use of quality essential health services by poor people in Kenya, Ghana, and Nigeria (exited March 2017) through a market-based approach. This is done through social franchising, linking franchised private providers with government health insurance schemes that target the poor, and supporting policies that promote functioning health markets to improve the range and quality of primary healthcare services provided by low-cost private health providers. Ms. Cuckovich highlighted some of the baseline quantitative results from household and clinic surveys which showed, amongst other indicators, that over 40% of households had at least one member having health insurance albeit with under 15% of clinics accepting such insurance.

The qualitative study, presented by Ms. Seefeld focused on trying to understand how AHME's changes to the supply and demand of quality care in Kenya and Ghana affect patients, providers, and policymakers. After three rounds of data collection in 2013, 2015 and 2017, AHME found that the greatest effect has been on mediating the relationship between providers and the national health insurance schemes (NHIs) but that there is still work to do on connecting NHI-enrolled low-income patients with NHI-accredited private providers especially considering that a majority of clients were already accredited before joining interventions.

Health Amongst the Elderly

Dr. Luca Saraceno, HelpAge International

Dr. Luca Saraceno of HelpAge International focused on the issue of health services for marginalized groups of the society such as the elderly. Dr. Luca highlighted the increasing number of older persons aged over 60 years in Kenya since 1989, which has been growing by over 3.5% per year above all other population segments subsequently leading to a rise in the parent support ratio from 2 in 1950 to 10 in 2009.

Dr. Luca also mentioned that the SDGs focused on access to health for older persons and touched on the "Leave No One Behind" agenda as a key aspect to engage on older people's rights to health. He also talked about the existing policy instruments, indicating the path towards inclusive health services at global and national levels and the future challenges ahead for older persons in Africa and Kenya but also some opportunities that can be harnessed in accessing their health services.

Dr. Luca Saraceno sharing a remark.

Medical Health Tourism

Dr. Amit Thakker, Kenya Healthcare Federation

Dr. Thakker discussed the need for more health for money rather than for more money for health, questioning the use of the Abuja declaration when funds are not used for the right purpose and citing that prevention is better and cheaper than cure. He also discussed the need to empower communities contending that most medical issues can be sorted at home, to reduce queues in health facilities and therefore ensuring faster medical access and care for patients who visit these facilities. He mentioned that while the health sector across the globe has seen impressive changes in the health indicators, there still lies a potential threat of a demographic crisis.

Dr. Thakker also urged organizations that offer support with subsidies to think about sustainability; in fact, most often when such subsidies are removed, households slide back into their previous state. The presenter singled out insurance, mentioning that it is unlikely to provide solutions for the poor and that coverage of universal healthcare provides no incentives to get solutions to healthcare problems. He also called out on counties to change healthcare management to increase trust in the public health facilities.

He then gave an opportunity to Dr. Mulwa the Health CEC in Makueni County to give a picture of some of the accomplishments of his county. Dr. Mulwa cited improvement in preventive, curative and promotive indicators in his county and the positive change achieved with the utilization of the sectoral inter-governmental forum countrywide. He also mentioned that since the devolution of health to the counties was implemented, Makueni had moved from primary healthcare to implement social welfare insurance schemes.

Dr. Amit Thakker giving his presentation.

Maternal Health

Session 1: Strengthening People-Centered Accessibility, Respect and Quality for Maternity, Family Planning and Abortion Services Project

Ms. Avery Seefeld, University of California, San Francisco

Ms. Seefeld's presentation illustrated the initial results of the SPARQ project that aims at improving the quality of person-centered care (PCC) for delivery and family planning (including post-partum) among poor women in Kenya and India. Previous work by SPARQ showed that facility deliveries are increasing globally. Delivering a facility, though, is not a stand-alone intervention to reducing poor outcomes. Discrimination, disrespectful care, abuse, and stigma are all barriers to accessing care. High quality PCC seeks to ameliorate these barriers through provision of care that is compassionate, respectful, and responsive to the individual patient's need.

The SPARQ project's formative research conducted systematic reviews to understand the various types of interventions that have been implemented to improve person-centred care. The researchers then used this data as a guide to identify PCC areas that are in need of improvement at the facilities.

The baseline data showed that there is little variation across mean overall PCC scores between intervention and control sites and the average overall score is 60 out of 100. In addition, close to 20% of women experienced verbal abuse at some point during their facility experience. Fortunately, physical abuse was reported less frequently.

The next steps of the research will entail creating quality teams in the intervention facilities to brainstorm and rapidly test solutions to PCC problems. Successes and failures will be shared regularly between facility quality teams. Every three months, the teams will shift to addressing a new aspect of PCC quality. The quality improvement success will be evaluated though rapid cycle evaluations.

Improving structural quality such as ensuring consistent electricity and water supply is critical to improving quality of care. However, this is simply not enough. Improving the processes of care is integral to ensuring improved outcomes. This encompasses both the clinical and interpersonal provision of care. As noted, identifying how to improve PCC has the potential to change how care is experienced by and provided to the patient, resulting in potentially improving clinical outcomes and reducing maternal morbidity and mortality.

Ms. Avery Seefeld delivering her talk.

Session 2: Impact of Pre-commitment to Delivery Facilities on the Quality of Maternal and Neonatal Care

Ms. Ginger Golub, Innovations for Poverty Action

Ms. Golub stated by informing that 1.2 million women and new-borns die yearly in delivery or shortly after that. Very few facilities in Kenya have experience in C sections, 49% have referral capacity and a high percentage of women report abuse during birth giving. Therefore, delivering at a health facility does not mean that there is high quality care and we are not guaranteed that mortality will be lower.

The research project tested two types of cash transfers in 24 clustered settlements in and around Nairobi, to encourage women to deliver in a facility of their choice. The "labelled transfer" of 1,000KSh is given during pregnancy and is unconditional, but provided with the message that cash intended to help woman deliver where she wants. The "pre-commitment transfer" consists in the "labelled transfer" plus a conditional transfer paid if delivery occurs in the facility to which she pre-commits during pregnancy. The randomized controlled trial that involved 553 women tested these interventions on women's choice of facility, on the quality of facility she uses and on her perceptions of care quality.

Only 32% of women in the control group delivered where they wanted to deliver; this increased by about 14% in the pre-commitment arm. Similarly, in the pre-commitment arm we observed a 17% increase of delivering where she was considering at midline and were she perceived to be the highest quality facility, compared to those in the control. When looking at the perceived technical quality of delivery facilities as well as obstetric care quality across arms, we do not observe any impact of the cash transfers. However, when the patient's perception of the non-technical quality shows an improvement with an additional 7% of women reporting never being disrespected/ in both cash transfer arms. The study also shows an improvement in routine care across both intervention arms (14.5 and 10% increase).

Women are more likely to deliver in facilities where they want to deliver when cash transfers have a pre-commitment feature. This is associated with improvement in the non-technical quality of care. Though results are mixed, Ms. Golub suggested that a larger study could look more into the conditional cash transfers and better understand how to nudge women to facilities that are higher in obstetric and new-born care.

Conclusions and Policy Recommendations

Delivered by: Dr. Sathy Rajasekharan, Jacaranda Health

The presentations delivered in the Maternal Health Session sparked a vivid debate that clearly highlighted a number of challenges to ensuring adequate maternal and child health. In fact, despite the overall advances made in the health sector, a considerable number of women in Kenya report a poor experience during childbirth. It was also noted that there is a very wide range in the quality of care offered to women across health facilities, with a large number of facilities scoring low in the level of care (outcome of one study). The discussion clearly highlighted that the structural quality of the care received cannot improve health outcomes alone, but it is necessary to fully research and understand the process quality if a sustainable improvement to maternal health care is to be reached.

The two studies also showed that it is possible, with some innovation in the process of care, to improve health outcomes for pregnant women and their babies. Person-centered care (PCC), in fact, is associated with better health outcomes for women. The study presented during the session also showed that there is a clear potential in adapting the study tools for use in public facilities, instead of private clinics only, thus reaching a greater number of women. Moreover, pre-commitment and cash grants can shift behavior and influence the choice of delivery that women make. It was noted, though, that not all answers are available and that the most pressing research agenda should study how to best nudge women to plan delivery and stir the choice towards facilities that provide high-quality obstetric and new-born care.

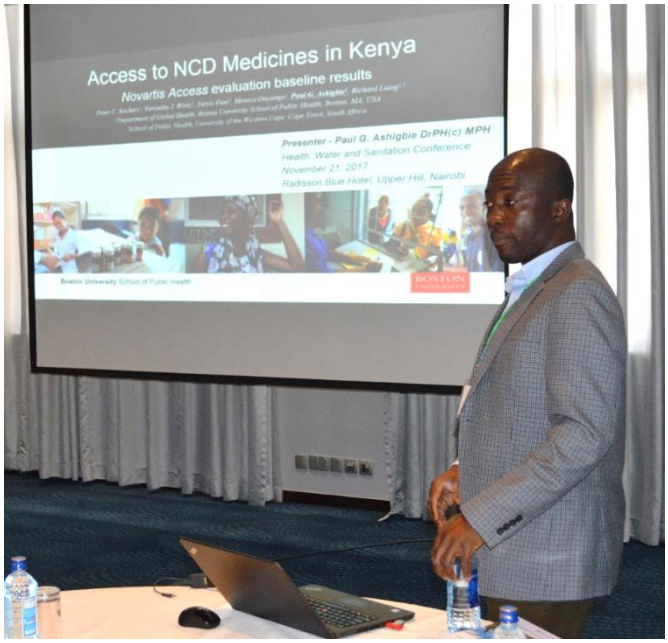
The participants to the working session agreed on four key policy recommendations that have been brought to the attention of policymakers and the Kenya Vision 2030:

- It is necessary to adopt tools to monitor patient experience.
- Patient satisfaction should be a focus of attention and it is necessary to analyze in detail the patient's experience to correct the approach adopted by health facilities.
- As in other sectors of the economy, financing is a barrier to accessing quality maternal care. It is thus recommended to devise a financing strategy to empower the client (e.g., insurance or credit facilities could be options to consider in policymaking).
- While more research is needed, policymakers are encouraged to start discussing the possibility of signaling the quality of the health facilities to mothers and prospective mothers.

Management of Non-Communicable Diseases (NCDs)

Session 1: NCDs and NCD Medicines in Kenya: Availability, Price, and Diagnosis

Dr. Paul Ashigbie, Boston University



Dr. Paul Ashigbie sharing the NAP results.

Dr. Ashigbie presented initial results of a study that aims at evaluating the impact of the low-cost medicine *Novartis Access Programme* on the availability and price of NCD medicines at health facilities and households in 8 counties in Kenya. The program targets 15 medicines for four common non-communicable diseases.

The survey revealed that the availability of NCD medicines is generally very low across health facilities. Dr. Ashigbie went further to state that availability of medicines increases as we move up the hospital levels while there is disparity in medicine availability between private and public health facilities. The survey also unveiled that public health facilities are more likely to have medicines for free and there are wide price variations across provider types (with prices generally lower in the public sector, followed by private-non-profit facilities).

In addition, diabetes medicines seem to be the most available with 83.8% of the households interviewed having at least one medicine for the disease treated, followed by hypertension (77.5%) and finally asthma (54.7%). Medicine prices place extra financial burden on households with diabetes leading to $9.8 more in household expenditures and hypertension increasing expenditures by $6.4. Some of the coping strategies households have developed include borrowing money from relatives and a credit system with the pharmacy employees.

Dr. Ashigbie concluded his presentation by noting the limited availability of NCD medicines especially in the public sector and underlining that despite coping mechanisms against the high cost of medicines, poor patients are still overwhelmed by the cost of managing NCDs. It also appears that wealth-related disparities exist in accessing NCD medicines, with the poor being required to pay more for the same medicines and often living far from health facilities.

Session 2: NCDs in the Post-2015 Development Agenda

Dr. Joseph Kibachio, Ministry of Health

Dr. Kibachio started by explaining the link between NCDs and Vision 2030, with emphasis on the NCDs' global burden causing 60% of deaths. He reiterated that moving forward there is need for a paradigm shift in handling the NCDs at the MOH in Kenya.

He reported that Cardiovascular diseases (CVD) accounts for 37%, Diabetes at 4%, other NCDs at 24%, respiratory diseases at 8%, while malignant neoplasms (cancers) 27%. He went further to explain the NCD burden on the poor households: the poorest groups not only bear higher risks for NCDs but, once they develop an NCD, they also face higher health and economic impacts. The poor have less access to medical care, allowing NCDs to progress to advanced states resulting in higher levels of mortality and disability. Given their complexity and chronic character, medical expenditures for treatment of NCDs are a major cause for tipping households into poverty.

He emphasized that the challenges facing the NCDs include lack of adequate budgetary allocation, lack of joint planning with the NCDs department, and lack of efficient diagnostic equipment and infrastructures for early diagnosis in public health facilities in Kenya. To address these challenges, he said that the MOH has made several policy recommendations as follows:

- Prioritize NCDs in the current healthcare budgets and targeted financing and strengthen and re-orientate the healthcare systems to address NCDs.
- Convene national policy discussion on NCDs
- Foster multi-sectoral/partnerships engagement to deal with NCDs and integrate NCD prevention and control in multi-sectoral platforms in Kenya.
- Develop a strategy to emphasize an integrated approach addressing NCDs and their risk factors.
- Foster prevention and control using existing primary healthcare platforms such as community health services, maternal and child health, school health, and disease surveillance as entry points.

Conclusions and Policy Recommendations

Delivered by: Dr. Charles Mwandawiro, Kenya Medical Research Institute

The group discussion that followed the two presentations highlighted two clear challenges related to the management of non-communicable diseases: the access to NCD-related services is lacking in various levels of the healthcare system and NCDs are not sufficiently prioritized in the national agenda. Hence sources of finance are lacking, leading to significant challenges in accessing quality healthcare for non-communicable diseases.

The key research questions to be further explored in the field of NCDs lead to the following high-priority research agenda:

- The study of the mechanisms underlying the improved access of households, particularly the poorest, to high-quality services related to the care for non-communicable diseases.
- The study of early (as well as prompt) and accurate diagnosis mechanisms for non-communicable diseases.

The key policy recommendations that emerged from this engaging session are:

- It is necessary to undertake effective, evidence-based, and cost-effective interventions to prevent and manage non-communicable diseases.
- There is an urgent need for multi-sectoral engagement and joint planning on NCDs.
- It is recommended to closely integrate NCDs with other healthcare services.

Water and Sanitation

Session 1: Povu Poa "Cool Foam": A New Water Efficient Handwashing Station with Low-Cost Foaming Soap

Dr. Clair Null, Mathematica Policy Research

The presentation illustrated results of a study conducted by IPA in Western Kenya between 2013-2016 with the objective to introduce the practice of regular handwashing with soap to households and institutions. From a related study, handwashing with soap appeared to be a key challenge in most of households and institutions. This led to the need to come up with new measures to address this issue.

To address user preference, in-depth and focus group discussions with respondents in the field helped identify that the design of the handwashing station would need to be easy to use across all ages, should conserve water to address the issue of scarcity, and should be secure (i.e., not prone to theft). Above all, the design had to be cheap and made from easily available materials for feasibility and affordability.

To achieve these objectives, the project tested several water delivery mechanisms, soap dispensing and structures of the handwashing stations among which two Povu Poa systems (one with bucket and the other one consisting of a portable pipe) to compare the results after use over time. Key results show that, out of the models tested, the Povu Poa systems used 30% to 77% less water compared with the conventional systems and they used 94% to 99% less soap than the other tested systems.

In a Randomized Controlled Trial in 30 primary schools, clinics and households, Povu Poa models were further tested to establish if Povu Poa influenced the student handwashing behaviour after toilet use. The pre-intervention and follow-up results show that handwashing with soap would increase from 0 to 32% and handwashing with water would increase from 13% to 45%. In addition, when tested at health at clinics, Povu Poa also posted an increase of 77% in handwashing with soap. Generally, Povu Poa models proved to be cheaper by far and more sustainable after testing in schools, clinics and institutions with large populations. A further willingness to pay study also suggested that there is a strong preference for the bucket model due to its bigger carrying capacity, better aesthetic, and steadiness.

The results of this study are encouraging and researchers are working on refining the design for mass production and on identifying effective manufacturing, sales and distribution strategies for East Africa with the objective to measure uptake and health impacts at scale.

Session 2: Sanitation and Hygiene for Improved Health

Mrs. Catherine Mwango, Kenya Water for Health Organization

Mrs. Mwango highlighted that the constitution of Kenya states that every Kenyan has a right to adequate housing and to reasonable standards of sanitation and clean and safe water in adequate quantities. Nonetheless, the situation analysis of sanitation in Kenya (2015) shows that

access to WASH services is lower in poorer communities and among vulnerable groups. 60% of the poorest communities practice open defecation as compared to 1% in the wealthiest neighbourhoods. National estimates for 2015 by the JMP indicate that 30% (31% of urban and 30% of rural) Kenyans had access to private improved sanitation, including sewerage. In urban areas, an additional 27% of the population used shared latrines. In rural areas, open defecation was estimated to be practiced by 15% of the population (JMP).

The presenter illustrated that improvement of shared latrines, the existence of sanitation facilities in institutions and public places, the low access to sanitation in private houses as well as cultural beliefs and practices are key challenges to the achievement of the sustainable development goal 6.2 on Sanitation and Hygiene. In addition, she noted that it is necessary to promote inclusive sanitation and hygiene with menstrual health management as an integral component in institutions and at the household level.

Community Led Total Sanitation (CLTS) was identified as one of the methods that ensures full social inclusion in the goal to eradicate open defecation. But Mrs. Mwango explained that social inclusion in sanitation and hygiene management is far from being achieved and it is necessary to further focus on applying social models in WASH programmes for school and communities, developing sanitation facilities that cater for the needs of different vulnerable groups, and create "special sanitation units" for the physically challenged.

Mrs. Mwango concluded by sharing some key policy recommendations in the sector:

- It is urgent to implement directives to include water and sanitation facilities in construction plans in newly urbanizing areas.
- Develop a clear sanitation value chain and invest in infrastructures for dry sanitation, which includes solid waste management.
- Mainstream menstrual health management in the sanitation space.
- Develop a more robust sanitation monitoring tool to track the progress towards Sustainable Development Goal 6.2.

Conclusions and Policy Recommendations

Delivered by: Mr. Tobias Omufwoko, Wash Alliance

An engaging and heated group discussion followed the session, with participants providing input and comments to distill the future research agenda to unveil unanswered questions in the water and sanitation sector and to highlight key policy lessons drawn from the studies presented over the course of the day.

The participants agreed that the key challenges in the sector are:

- The low budgetary allocation at central and country government level for water and sanitation;
- The diffused perception that sanitation is often disregarded and dealt with as a "poorer cousin of water";
- The lack of informed decision-making despite the large availability of data and tools, e.g., sanitation monitoring tool.

Together with these challenges, though, the participants noted a number of opportunities such as the clear possibilities for collaboration and sharing within the community of water and sanitation practitioners as well as the numerous interventions in the sector by various partners. In addition, the legal and policy frameworks for the water and sanitation sectors are well-established, serving as an excellent enabling environment. Finally, sanitation monitoring tools are widely available and used, and constitute a significant basis of data that can be promptly used for decision-making.

Based on the research findings presented as well as the engaging discussion and sharing of lessons learnt, the working group suggested five key policy recommendations:

- Policies should have a broader focus to include other innovative models in water use.
- Rural areas should be upgraded with adequate sanitation systems and clear directives should be implemented to include water and sanitation facilities in construction plans.
- Cities and towns should be "re-engineered" in the water and sanitation domain, and solid waste management, recycling, and dry sanitation should be key.
- While sanitation monitoring tools exist, it is recommended to develop a more robust sanitation monitoring tool taking into account the Sustainable Development Goals.
- Additional research opportunities exist, especially in the WASH and Nutrition sectors, and policymakers are required to work in closer partnership with researchers to ensure data-driven policymaking.

Closing Session

Way Forward

Mr. Suleiman Asman, Innovations for Poverty Action

Mr. Asman started by thanking all participants for attending the event. He mentioned his excitement at what had been learnt from the conference and on all the evidence that has been developed so far, and informed participants that several other studies are ongoing and results will be available soon. He highlighted that IPA's mission is to share learning and data, and the Conference was a first step towards it. Mr. Asman also said that what is most important is that the findings can be moved to implementation and practice. He emphasized the need to use data and evidence to inform policy, and that IPA is ready to collaborate with organizations to work on policy-relevant evaluations. Mr. Asman finally recalled that there is limited evidence on what programmes really work to reduce poverty and called for more rigorous, high-quality research to be undertaken to answer key policy questions.

Closing Remarks

Dr. Julius Muia, Vision 2030 Delivery Secretariat

Dr. Julius Muia gave the closing remarks of the conference and thanked the over 100 participants who attended. He also mentioned that Vision 2030 is working on finalizing the third medium term plan, and that it would be important to put together the discussions from the conference to inform policy and government action moving forward and that Vision 2030 would work with IPA on this. Dr. Muia also said that Vision 2030 was keen to pursue more of such partnerships and events because innovation is key and exciting for any society, especially in the WASH and Health sectors. He gave the promise that Vision 2030 would take this agenda very seriously. He closed the conference by thanking the Ministry of Health, county governments, departments and agencies that were represented for their participation, IPA for coordinating the conference in collaboration with Vision 2030, and the researchers and presenters for an excellent job.

Participants keenly following the discussion.

Dr. Muia and Mr. Asman sharing a moment after the conference.

Annex 1: Agenda

8:00 - 8:30 AM	**Arrival & Registration**
8:30 - 8:45 AM	**Welcome & Opening Remarks** *Mr. Suleiman Asman, Country Director, IPA-Kenya*
8:45 - 9:00 AM	**Health and WASH in the Vision 2030** *Dr. Julius M. Muia, PhD, EBS Director General, Vision 2030 Delivery Secretariat*
9:00 - 9:15 AM	**Keynote Speech** *Dr. Cleopa Mailu, EBS. Cabinet Secretary, Ministry of Health*
9:15 - 10:15 AM	**Water, Sanitation and Health (WASH-Benefits study)** *Dr. Clair Null, Mathematica Policy Research*
10:15 - 10:30 AM	**Tea Break**
10:30 AM -12:00 PM	**Access to Health Services (15 minutes per presentation)** 1. Africa Health Markets Equity project a. AHME impact evaluation: *Ms. Rita Cuckovich, University of California, Berkeley* b. AHME qualitative evaluation: *Ms. Avery Seefeld, University of California, San Francisco* 2. Health among the elderly: *Dr. Luca Saraceno, HelpAge International* 3. Medical health tourism: *Dr. Amit Thakker, Kenya Healthcare Federation* Session moderator: *Dr. Andrew Mulwa, Makueni County*
12:00 - 1:00 PM	**Q&A session/Plenary session (Panel of presenters)**
1:00 - 2:00 PM	**Lunch**
2:00 - 3:00 PM	**Breakout sessions** Two presentations in each session for 20 minutes & 10 minutes for Q&A **Session 1: Management of non-communicable diseases** 1. Novartis Access Project: *Mr. Paul Ashigbie, Boston University* 2. Department of Non-communicable Disease: *Dr. Kibachio Joseph Mwangi, Ministry of Health* Policy Moderator: *Dr. Charles Mwandawiro, Kenya Medical Research Institute* **Session 2: Sanitation and Hygiene** 1. Soapy Water Hand Washing Stations: *Dr. Clair Null, Mathematica Policy Research* 2. Kenya Water for Health Organization: *Ms. Catherine Mwango, Kenya Water for Health Organization* Policy Moderator: *Mr. Tobias Omufwoko, Wash Alliance* **Session 3: Maternal health** 1. Strengthening People-Centered Accessibility, Respect and Quality for Maternity, Family Planning, and Abortion Services Project: *Ms. Avery Seefeld, University of California, San Francisco* 2. Impact of Pre-commitment to Delivery Facilities on the Quality of Maternal and Neonatal Care: *Ms. Ginger Golub, IPA-Kenya* Policy Moderator: *Dr. Sathy Rajasekharan, Jacaranda Health*

Annex 2: List of Participants

Name	Institution
Dr. Kepha Ombacho	Ministry of Health
Mr. Benjamin Murkomen	Ministry of Health
Mr. Neville Okwaro	Ministry of Health
Dr. Kibachio Joseph Mwangi	Ministry of Health
Mr. Charles Kandie	Ministry of Health
Mr. Joseph Rotich	Moi Teaching and Referral Hospital
Mr. Japhet Keitany Cherutich	Moi Teaching and Referral Hospital
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Dr. Joan Osoro Mbui	Nairobi Hospital
Ms. Eunice Nyiya	Nairobi Hospital
Sn. Scholar Kisia	Nairobi Hospital
Senewa G. Mesopirr	National Environment Management Authority
Prof. Michael Kiptoo	South Eastern Kenya University
Mr. Martin Omondi	IPE GLOBAL (Africa Limited)
Ms. Sheila Atieno	IPE GLOBAL (Africa Limited)
Dr. Sathy Rajasekharan	Jacaranda Health
Ms. Rachel Jones	Jacaranda Health
Prof. P. Aloo-Obudho, PhD	Karatina University
Dr. Charles Mwandawiro	KEMRI
Mrs. Catherine Mwango	Kenya Water for Health Organization
Dr. Leunita A. Sumba	Kenya Water Institute
Dr. Andrew Mulwa	Makueni County Government (CEM-Health)
Dr. G. Gumba	Mathare Teaching and Referral Hospital
Ms. Rosline Kihumba	HelpAge
Dr. Luca Saraceno	HelpAge
Mr. Suleiman Asman	Innovations for Poverty Action
Mr. John Buleti	Innovations for Poverty Action
Dr. Claudia Casarotto	Innovations for Poverty Action
Mr. Atanus Mutisya	Innovations for Poverty Action
Mr. Frank Odhiambo	Innovations for Poverty Action
Mr. Geoffrey Onyambu	Innovations for Poverty Action
Mr. John Mboya	Innovations for Poverty Action
Mr. Kelvin Gichia	Innovations for Poverty Action
Ms. Ginger Golub	Innovations for Poverty Action
Ms. Janet Nakuti	Innovations for Poverty Action
Dr. George Otieno Rae	IPE GLOBAL (Africa Limited)
Mr. Patrick Jetmark Miruka	AfricaScan Inc
Mr. Zablon Anyenda	Agakhan University Hospital
Mr. Daniel Kurao	AMREF
Mr. Paul Ashigbie	Boston University
Mr. Francis Meyo	Busara Center for Behavioural Economics
Mr. Rashid Mohamed Diis	Northern Kenya Region
Ms. Doris Kimbui	Kenyatta National Hospital

Mr. Samuel Mungai	Mount Kenya University
Ms.Priscilla Kinyari	Water Sector Trust Fund
Mr. Thomas Owino	Siaya County Government
Mr. Martin Masinde	Bungoma County Government
Mr. Oyugi Kamdani	Nairobi County Government
Heouje Ikore	Kisumu County Government
Mr. Fred Aselua	Kilifi County Government
Ms. Leah Ochundo	Kenya Health Federation
Ms. Avery Seefeld	University of California, San Francisco
Ms. Rita Cuckovich	University of California, Berkeley
Ms. Nelly Nyadaua	Femmehub.com
Ms. Christine Oduor	PS. Kenya
Mr. Centrad Onyango	PMS Africa
Hamet Kimani	Sanergy
Mr. Alex Lirung	K24 TV
Beauregard Nyangi	Signs Media
Mr. John Kabuchi	KEMSA
Mr. Lilian Okuih	Medocal Medix
Mr. Mohammed Musa	Northern Water Services Board
A. N. Osman	
Dr. Toro AJ	Kiambu County Government
Mr. Lucy Njambi	Nairobi Water
Mr. Robert Kinyua	Makueni County Government
Ms. Wanjiku Njire	Vision 2030
Ms. Naomi Wafula	Vision 2030
Ms. Virginia Mwangi	Vision 2030
Ms. Ada Mwangola	Vision 2030
Ms. Veronica Muthoni Okoth	Vision 2030
Ms. Veronicah Muchiri	Vision 2030
Mr. Idi Masoud	Vision 2030
Dr. Julius M. Muia, PhD, EBS	Vision 2030
Mr. Tobias Omufwoko	WASH Alliance
Ms. Josephine Karimi	Water and Sanitation for the Urban Poor
Dr. Edwin Rugut	Water Resources Management Authority
Ismail Fahmy M. Shaiye	Water Services Trust Fund
Ms. Wanjiku Kuria	World Vision
Dr. Clair Null	Mathematica Policy Research
Mr. Elijah Kiema	Samaritan Purse
Ms. Miriam Nzomo	Samaritan Purse
Ms. Mitchell Oguna	Sanergy
Mr. Bob Mboya	Signs Media
Ms. Jackline Njue	Signs Media
Ms. Jackline Omega	Signs Media
Dr. Ali Adan Ali	Umma University
Ms. Ann Robins	UNICEF Kenya
Ms. Jane Bevan	UNICEF Kenya

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