GAVI Health System Strengthening Support Evaluation

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Kenya Desk Study

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Abbreviations and Acronyms

AOP	Annual Operational Plan
GAVI	Global Alliance for vaccine and immunization
HSCC	Health Sector Coordinating Committee
ICC	Interagency Coordinating Committee
JPWF	Joint Program of Work and Funding
KEPH	Kenya Essential package for health
KHSWAp	Kenya Health Sector Wide Approach
Ksh	Kenyan Shilling
MOH	Ministry of Health
NHSSP II	National Health Strategic Plan II

Summary of key findings and recommendations

The GAVI HSS window was opened at a very opportune time for Kenya. In 2006 a number of key strategic health sector documents had just been developed and agreed amongst health sector stakeholders, and the Ministry of Health was searching for funding to help implement these strategies.

Kenya decided to submit a proposal for the GAVI HSS window for US$ 9 million to cover a period of three years (2007 – 2010). The design of the proposal was initially led by the Child Health Interagency Coordinating Committee, though the Health Sector Coordinating Committee provided inputs later in the proposal development process. Kenya focused the objectives of HSS on removing health systems bottlenecks for increased immunization coverage including: a) low community demand for immunization; b) lack of human resources for outreach work and cold chain maintenance and c) poor monitoring and weak community mobilization by governance structures.

The strengths of the proposal lay in its selection of districts using 'total gain' criteria, which relate to increasing opportunities for improving immunization coverage; picking the community level intervention as a priority action for HSS and the existence of systems strengthening plans. In selecting districts the existence of other development partners that could potentially finance community strategy implementation were also considered. This was expected to improve the synergy between GAVI HSS and other financiers on one hand and have a country wide effect on the other. In terms of human resources deployment, only health facilities without staff were selected.

The weaknesses identified included the narrow definition of health systems strengthening and weak participation of NGOs and other development partners (besides WHO and UNICEF) during proposal development. The HSS proposal was developed to tackle only those measures that would increase immunization coverage and did not address more upstream health system issues that could have had a larger impact. Also, the funding provided by GAVI HSS, relative to other funding sources for the health sector, is very limited, thus reducing the catalytic effect GAVI HSS might have. That being said, the MOH has focused GAVI HSS resources on kick-starting their 'level one' (community health) programme in the hope that once the program is operational it will catalyse increased funding from other donors.

The Kenya GAVI HSS proposal suffered a number of delays after the initial submission. The IRC gave conditional approval to the proposal, and the Ministry of Health took some time in responding to these. Once the proposal was approved there was a further nine month delay in sending funding to Kenya. This delay appears to have been for two main reasons. The first was that the Ministry of Health was not able to provide banking arrangements that satisfied GAVI Secretariat requirements, while the second related to the general political crisis in the country after the December 2007 elections. There does not appear to have been any extra support offered to Kenya to put in place the necessary conditions for releasing HSS funds. The program was finally initiated in July 2008.

The HSS proposal was entirely country driven as its priorities were taken from the menu of health system strengthening plans. The planning and programming of the fund is aligned to the annual operational plans at all levels of the systems. However, GAVI reporting requirements are poorly aligned with Kenya systems, as the APR cycle is entirely different from the GoK reporting cycle. Predictability of funding and the implementation of HSS was affected by political factors related to election problems and the split of the former Ministry of Health in to two separate ministries and the time taken to demarcate their responsibilities. CSOs are involved in the implementation process through their coordinating umbrella organizations. The sustainability of newly recruited staff through GAVI funding remains uncertain in view of the fact that the government was unable to meet some of the requirements of the proposal.

Despite the challenges the country faced with GAVI HSS start-up, the progress the MOH has made in implementing the HSS proposal is satisfactory as 90 % of the community units were already in place by the end of 2008 and all human resources have been employed. However, it is not clear from the APR whether the newly established community units were funded by GAVI HSS alone, and if not, what proportion of the overall funding is provided by GAVI HSS. The APR indicates that other areas of progress, e.g. testing of district tools, were funded from elsewhere due to delays in GAVI HSS funding. These issues highlight the significant challenges of understanding how GAVI HSS funding fits in with the overall funding architecture in the health sector in countries like Kenya, which have already invested in developing system wide approaches. The APR does not appear to be a useful tool for doing this, and could in fact be misleading. Greater consideration needs to be given to using existing health sector reporting mechanisms, which do monitor, and differentiate between, different sources of funding.

1 Scope, Approach and Methodology

1.1 Background

This report contains the findings of the case study conducted in Kenya in May 2009 as part of the GAVI HSS Evaluation Study. The evaluation conducted in the following countries, all of them recipients of GAVI HSS grants: Burundi, Cambodia, Democratic Republic of Congo (DRC), Ethiopia, Kyrgyzstan, Liberia, Nepal, Pakistan, Rwanda, Vietnam and Zambia. This current study is one of an additional 10 countries which were also studied that did not involve country visits but just review of available documentation combined with email/phone interviews by the study team. These countries were Bhutan, Honduras, Georgia, Ghana, Nicaragua, Nigeria, Sierra Leone, Sri Lanka, Yemen and Kenya.

Other issues relating to the overall study methodology (evaluation framework, key questions, study components, guidelines for data collection, sampling method, and etcetera) are publicly available documents that can be requested for HLSP. To keep this report short these broader methodological issues will not be discussed here. A summarised description of the study approach can be found in Annex 3.

GAVI Alliance (GAVI) health systems strengthening (HSS) provides support to strengthen the Kenyan Health systems with a budget worth of $ 9.9 million over four years period. This preliminary finding is entirely based on few days of literature review. The team did not have first hand information at county level. The conclusions and recommendations therefore may not be as precise and complete as we would wish them to be.

The consolidation of the literature review, however, as far as information allows, follows closely the global methodology developed for this evaluation and tries to answer the critical evaluation questions:

- What has been the experience at country level with GAVI HSS in terms of *each* of the following aspects: design, implementation, monitoring, integration (harmonization and alignment), management, and; outputs/outcomes?
- What have been the main strengths of GAVI HSS at the country level, and what are the specific areas that require further improvement?
- How has GAVI HSS been supported at regional and global levels—what are the strengths of these processes and which areas require further improvement?

- What has been the value-added of funding HSS through GAVI as compared to other ways of funding HSS? And
- What needs to be done, and by when, at country, regional, and global levels to prepare for a more in depth evaluation of impact of GAVI HSS in 2012?

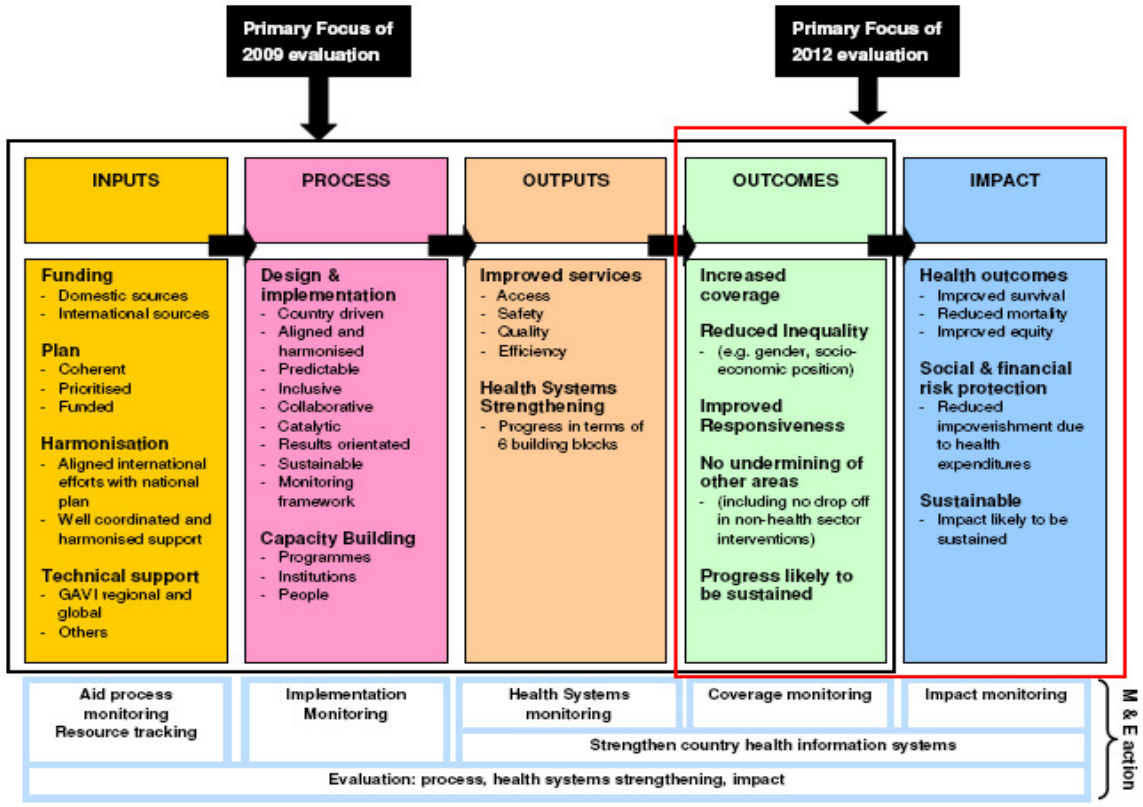
1.2 Brief conceptual framework of the Evaluation

This evaluation is being conducted to inform three areas of decision making:

1. The Board decision in 2010 about whether or not to increase the funding available to the GAVI HSS window.
2. How to improve current and future implementation. (This is valid even if the window is not expanded, because there are considerable sums of money which have been awarded but not yet disbursed).
3. To enhance the quality of the 2012 evaluation.

It is important to note given the little time elapsed since the first HSS applications were approved in 2006 that this evaluation - the first one ever conducted on the GAVI HSS component - focuses primarily on issues linked to: proposal design; approval and review processes; early start up measures; nature of inputs, processes and outputs involved in grant implementation and annual performance review; and assessment of activity and outputs achieved to date. The study also reflects on the nature and quality of global, regional and national technical support systems delivered by a range of stakeholders in support of HSS grants. The conceptual framework for this evaluation is shown in Figure 1.

Figure 1: The conceptual framework - logical progression from inputs to impact



The information for this desk review was obtained through review of all relevant policy, programmatic and evaluation reports carried out in the sector for the last four years, review of GAVI HSS proposal, APR report (2008) and other GAVI related guidelines and assessment reports carried out at the global level.

Our priority questions have been summarised in Box 1 below.

Box 1: Examples of Questions for the HSS Evaluation Study

- Is GAVI HSS on track to achieve what it set out to (in general and in individual countries)? If not, why not? How might GAVI HSS be improved?
- What would have happened if GAVI HSS had not been created? Is it additional money and does it add value to existing ways of doing business?
- Are the "right" bottlenecks being identified – i.e. are they priorities and relevant to the desired outcomes?
- Are design and implementation processes consistent with GAVI principles?
- What factors can be linked to countries being on- or off-track?
- Are HSS-related monitoring frameworks well designed? Do they measure the right things? Are they being appropriately implemented? Do they take into account country capacity to deliver?
- Are they consistent with existing country monitoring frameworks? Where they differ, what value is added and at what expense in terms of extra transactions costs?
- What do we know about outputs and outcomes? How realistic is it to try and attribute improved outputs and outcomes to GAVI support? What are some of the key contextual factors which influence results?
- How sustainable are the results likely to be?
- What have regional and global support mechanisms delivered?
- What effect have they had – how could they have been improved?
- What should the 2012 evaluation cover and what need to be done now to support it?

2 Snapshot of the Kenyan health system

2.2 Health Indicators and progress towards MDGs

Kenya issued its long term health strategy paper in 1994, the Kenya Health Policy Framework Paper. The Framework Paper outlined the long term health reform agendas that the government wanted to pursue to improve the efficiency and effectiveness of the health sector. Following that, two medium term National Health Sector Strategic Plans, (NHSSP) have been developed. NHSSP II 2005=2010), the strategy that is guiding the health sector at present, aims at reversing the declining health trends through:

- Increasing equitable access
- Improving quality and responsiveness to client needs
- Improving efficiency and effectiveness
- Fostering partnership, and
- Increasing financing to the sector.

One of the distinguishing features of the Kenyan health strategic plan II has been its move away from disease based to cohort based[1] policies including the life style promoting essential package for health - the "Kenya Essential Package for Health (KEPH)" - to ensure that MDG targets can be met. It gives priority to strengthening of district health systems with the introduction of community level services as part of the formal health system[2]. It also acknowledges that the public sector alone will not reverse the declining trend in health outcomes and aims at fostering partnership with all actors. It also acknowledged the commitments made in the Paris Declaration on alignment and harmonization and included it as measure of progress in partnership.

The "Health Sector Wide Approach" (HSWAp) in Kenya is a recent phenomenon. Stakeholders in 2005 defined the objective of Kenyan health SWAp as 'to improve the health status of the Kenyan people through working together with all stakeholders as partners in the health sector with: one sector strategy (NHSSP II) under leadership of MOH; one expenditure framework, common monitoring and evaluation framework, common management arrangements (CMA), and ensuring all-inclusive coordination and achievement of clearly defined milestones.

[1] Six cohorts define the essential health packages: pregnancy and new borne, early child hood, children under five, late child hood, adolescence, adults and elderly. The service required to each cohort and the indicators of performance have been defined. Some of cohort services like the elderly are still in infancy stage.

[2] Level one services, the community strategy implementation has been defined as part of the formal system with defined catchment population and defined number of community level health cadres.

During a workshop, stakeholders also agreed that the major principles underlying partnership in Kenya will be mutual respect and trust, transparency, accountability, openness and readiness for genuine dialogue[3].

One of the major agreements reached during the design phase of Kenya HSWAp was to review the strengths and weaknesses of the various systems (this included service delivery, human resources, infrastructure, procurement, public financial management, performance monitoring) and develop improvement plans[4]. During the design phase, all various improvement plans were developed with the involvement of independent national and international consultants. The consultants were led by rapid "Results Initiatives Teams" established to fast track this process. A Joint Program of Work and Funding (JPWF) - bringing all the elements together - was drafted, appraised and endorsed by all stakeholders in June 2006. The "Joint Program of Work and Funding" has been serving as a programme document that forms the basis for funding the health sector for 2006-2010. Though initially there was lack of full consensus on the comprehensiveness of the JPWF, Kenyan health systems and its strategic and programmatic plan were fully assessed and reassessed/analyzed, but very little has been done to fund these plans and seek concrete improvements.

In 2006 when GAVI HSS was initiated, Kenya developed the main elements for good partnership and implementation of the Paris Declaration in order to meet MDG goals for health, particularly:

- One strategy-NHSSP II
- One program document with country defined priorities- JPWF
- Partnership framework- Code of Conduct[5]
- An institutionalized systems of joint planning, appraisal and monitoring of health plans and performance[6]
- The introduction of the result based management in the public sector to deliver results for Kenyans as a measure for Ministry's performance appraisal by the government

Furthermore, implementation plans were drawn up for strengthening "level one" health services (community health) together with plans for development of health system elements

[3] MOH, KHSWAp, Concept Paper, 2005.
[4] Ibid.
[5] Development partners, NGOs, MOH and Treasury signed this document as an instrument of alignment and harmonization.
[6] Since 2007 Kenya has institutionalized bottom up and resource constrained planning process in the sector and in spite of the reorganization of the sector into to Ministries after the election, the planning process is still bringing these two ministry plans in one operational plan.

(planning, human resources, procurement, financial management, monitoring and evaluation, to some degree governance and coordination). All of these plans were looking for funding for implementation. At this very moment the call for GAVI HSS proposal was made.

3 The GAVI HSS proposal – inputs, outputs and progress to date

3.1 HSS proposal design

As described in section two above, the JPWF forms the main guide for programmatic intervention in Kenya. Its priorities are to:

i. address equity by expanding access to basic services with special focus on the community level;

ii. enhance health gains by strengthening and scaling up the delivery of cost-effective interventions (especially at system levels 2–4), including strengthened human resources for health (HRH) and other systems related inputs;

iii. enhance efficiency and budget effectiveness in particular by:

- improving availability of commodities and funds at facility level through an effective supply chain
- public financial management (PFM) system, linked with an
- operational performance-based monitoring and evaluation system (PME) and
- results-based management (RBM) procedures and

iv. strengthen sector stewardship and partnerships with all stakeholders by ensuring clarity of roles and responsibilities in a rationalized organizational setting and institution of joint planning, funding and monitoring arrangements[7].

The call for a GAVI HSS proposal came when the country was looking for funding to implement this programme. When the invitation for the proposal reached Kenya on 28th June 2006, the ministry initially gave coordination of the proposal development process to Kenyan Expanded Immunization Programme (KEPI) assisted by Child Health ICC.

The concept of health systems strengthening was initially not clear for the design team and there was a tendency to develop a proposal for strengthening the EPI programme. After some time, the Health Sector Reform Secretariat, that coordinated the health sector strategic plans and systems strengthening, was involved in the development of the proposal and technical assistance from donors was brought in (DFID financed Essential Health services /EHS/, Sida financed Rural Integrated Health Services /RIHS/ and WHO) to support writing of the proposal.

[7] MOH, Joint program of Work and Funding, June 2006

Selection of the intervention areas: The main criteria used to select the three main intervention areas:

i. level one (community) services;
ii. human resources and;
iii. strengthening monitoring and governance structures at district levels and below.

The ICC at that point understood that HSS should by and large focus on removing health systems bottlenecks for increasing immunization coverage: Low community demand for immunization; lack human resources for outreach work; and cold chain maintenance and poor monitoring and weak community mobilization by governance structures.

The child health Interagency Coordinating Committee (ICC) was chaired by the head of health promotion and prevention department and its members were from MOH, UNICEF, WHO, and a DANIDA financed project called Health Sector Program Support (HSPS).

The ICC met a number of times to decide on a number of issues:

- To decide on the main type of intervention to be financed by HSS funding;
- to decide the criteria for district selection for HSS funding;
- to review and provide comments on the draft report and;
- to approve the proposal for submission.

At that time the health sector coordination committee (HSCC) was under formation. The decision to apply was made by the ICC. When group was formed, the Health Sector reform Secretariat was presenting GAVI issues in the HSCC.

3.2 HSS application and approval processes

Kenya's Health Systems Strengthening Proposal was reviewed by the Independent Review Committee (IRC) in November 2006. GAVI Secretariat communicated its review through a letter of November 24 2006. The committee assessed the proposal as sound and conditionally approved it subject to the few concerns raised by the IRC being addressed. The concerns were the following: HSS money was supposed to cover costs of health professionals (90 Enrolled Community Nurses (ECN) and 170 Public Health Technicians (PHT). It was not clear how they would be financed after HSS support ends. This was a particular concern because of the large financial gap for human resources shown in the proposal. IRC recommended that the country address the issue of *sustainability*. The IRC also stated that the proposal was overly focused on methodology (how and why interventions were selected to be carried out), while insufficiently demonstrating an *implementation plan* of tasks and timelines. It was also necessary to better understand how *external inputs through the SWAp process*

were related to the HSS. It was not clear if geographical areas covered by the GAVI HSS would be targeted by other partners as well. It recommended that:

a) strategies addressing the sustainability of components #1 and #2 be clearly articulated;
b) an HSS Implementation plan (covering all three components) be provided (including timelines);
c) indicators be revised and expanded;
d) interaction/relationship with funding from other sources be better described;
e) types and lengths of training to be described in the context of other similar capacity building efforts;
f) the financial projections to be made in US$.[8]

IRC recommended that the health sector coordinating committee should participate in and support the implementation of the revised proposal.

After receiving the IRC comments, the Health Sector Reform Secretariat revised the proposal and resubmitted for approval to the Health Sector Coordinating committee. The HSCC discussed and approved the resubmission of the proposal on 3rd April 2007. The proposal was submitted on 20th April 2007 noting the following revisions:

- Government and development partners were to invest additional resources in the components #1 and #2 of the program. For the first time, level one (community services) had been included in the functional budget structure. The government started, in its 2007/08 budget, to absorb staff recruited through support from the development partners.
- All the outputs of HSS were given specific timelines in an implementation plan (a new section was included). In addition there is a schedule of activities in each of the intervention areas. The activities are framed in such a way that they can easily be 'monitorable'.
- A specific section was included to show how progress will be measured on a quarterly and annual basis.
- Three annual HSS impact and 18 quarterly progress indicators were identified and included.
- The total resource requirement for the interventions, the funding from Government of Kenya (GOK) and other development partners as well as the gap were demonstrated for two interventions (community interventions and Human resources (see table 2.2 and 2.5)). The resources requirement suggested in the proposal are sector wide while the available resources figures are limited to public service due to limitation of information.

[8] GAVI Alliance Secretariat, 2007, letter to MOH, dated November 24th.

- Training was to be provided after the development of a training manual to be used nationally.
- A manual for strengthening governance structures and the monitoring process would be prepared.

HSCC endorsed the proposal for submission.

Though the proposal was initially submitted simultaneously with countries in the first round, Kenya's HSS proposal was approved on July 26th 2007 in the third round.

3.3 HSS Start Up Measures

The GAVI Alliance approved a total of $9.9 million for HSS support. The annual breakdown of the approved support is presented on table 1.

Table 1 Approved HSS support

2007/8	2008/09	2009/10	Total
$3,741,500	$2,964,000	$3,197,500	$9,903,000

The approval letter requested that Kenya complete and submit by the HSS section of the Annual Progress Reports for 2006 by 15th September 2007 - though it had not yet started – to be endorsed by the ICC and the Health Sector Coordinating Committee to enable GAVI to release the funds for 2008.

Once the approval was received, the opening of a bank account was required, demanding approval from the Ministry of Finance. This approval was delayed for some time. As a result, the first disbursement reached the country no sooner than middle of 2008 further delaying implementation of HSS activities.

3.4 HSS Progress to date

As described above pre-GAVI HSS there was a menu of health systems strengthening plans looking for financing for implementation. These plans had clear objectives and activities with defined cost estimates. The GAVI HSS drafting team could choose among their unfunded priorities and fit them to the resource limits given to the Kenya for HSS support. This helped the drafting process considerably.

The proposal was also facilitated in its selection of intervention districts by pre-existing analysis of systemic bottlenecks for immunization. Districts were selected based on the 'total gain' (efficiency gain from reducing dropout rate and access gain from reaching the unreached

child). Districts were ranked according to their potential total gain; 22 districts with the highest potential total gain were selected for GAVI HSS support. These 22 districts account for 66% of children that have not accessed immunization and 49% of those who have not completed their immunizations, or 59% of potential total increase.

In selected districts, the existence of other development partners that could potentially finance community strategy implementation was also considered. This was expected to improve the synergy between GAVI HSS and other financiers on one hand and have a country wide effect on the other. In terms of human resources deployment, only health facilities without staff were selected[9].

3.5 Weaknesses in HSS Proposal

There were weaknesses in the proposal development process. A first relates to a narrow understanding of health systems strengthening. Only removing the immunization constraints was considered. Upstream health systems issues were not considered during the proposal formulation phase.

Participation of other actors, with the exception of UNICEF, WHO and MOH and some technical assistance, was very limited. NGOs and the private sector were not involved in the development and review of the proposal directly. However, they were part of the stakeholders that initially developed the strengthening plans picked up for HSS financing.

Finally, the funding given to Kenya was not sufficient for any broad systemic change. With the exception of community level services, which the HSS proposal help initiated, its catalytic effect has been limited.

[9] GAVI Alliance Secretariat, 2008, Good Examples from Country Proposals, P 18.

4 Alignment of HSS with GAVI principles and values

4.1 Country Driven

As was described above, the country proposal was inspired by the various strengthening plans that were developed as part of JPWF. The priorities were selected by the drafting team in consultation with Child Health ICC. Thus, the proposal is clearly country owned. On the other hand, all stakeholders did not have the same understanding and commitment in the implementation of the Level One services, the main activity funded by HSS funding. The ownership of the community strategy was not fully enshrined in the management of the MOH and at district and provincial level. This is evident from the various revisions to the strategy that have since taken place.

4.2 Is GAVI HSS support aligned?

4.2.1 Alignment with National Plans and Systems and Harmonization

The GAVI HSS support is fully integrated into the annual AOP process. All the district health plans, the provincial consolidation and the national consolidated plan, reflect the support of the GAVI HSS. Resource envelopes from the MOH are given to the districts as a start up of the planning process to ensure inclusion in the comprehensive district health plan of 2008/09. For example, in the AOP 4, the following is reflected in the national plan.

Table 2 Total known resources for AOP 4 implementation

Agency	Indicated resources available for 2008-09 (Kshs)	% contribution
ADB	0	0.0%
Clinton Foundation	1,334,945,010	1.5%
DANIDA	1,024,669,878	1.2%
DFID	3,442,419,760	3.9%
EU	362,622,781	0.4%
French Embassy	0	0.0%
Gates Foundation	0	0.0%
GAVI	2,615,000,000[10]	2.9%
GDC	1,227,393,318	1.4%
GFATM	3,872,000,000	4.3%

[10] This GAVI contribution includes both HSS and ISS funding

Agency	Indicated resources available for 2008-09 (Kshs)	% contribution
GOK	33,002,133,610	37.1%
FIF resources	1,986,848,811	2.2%
Irish Aid	0	0.0%
Italian Cooperation	593,616,780	0.7%
JICA	1,092,580,200	1.2%
Netherlands	0	0.0%
SIDA	0	0.0%
UNAIDS	0	0.0%
UNFPA	195,760,150	0.2%
UNICEF	254,275,240	0.3%
USG	36,424,928,130	40.9%
WFP	201,492,150	0.2%
WHO	448,859,367	0.5%
World Bank	953,532,150	1.1%
TOTAL INPUTS	89,033,077,336	100.0%

Source: AOP 4.

While the contribution is reflected in the fiscal plan using the Kenyan fiscal year, its reporting requirement does not fit into the Kenyan fiscal year as GAVI requests APRs in the first four months of the beginning of a calendar year. The Kenyan Fiscal year starts in July and ends in June while the GAVI fiscal year runs from January to December.

4.3 Is GAVI HSS funding predictable?

4.3.1 Predictability and flexibility of funding

Funds were not transferred to Kenya for 2007 implementation. Implementation was re-scheduled to start as of June 2008, during AOP 4, rather than AOP3. This was mainly because of the non-availability of a bank account (which was required to meet GAVI requirements) and the election crisis in Kenya, which resulted in the split of the Ministry of Health into two after the formation of the new coalition government. Though the country requested the approved amount for 2007/08, GAVI secretariat disbursed about 56% of both the request and the approved amount. In addition to the contextual factors indicated above, the disbursement might have been reduced by the GAVI secretariat due to the fact that only

two months of implementation remained in 2007/08. The first disbursement took place on 30th April 2008, nine months after the HSS approval and just two months before the end of the financial year. This seems to be the only disbursement made so far. The effort to make funding more predictable was overtaken by dramatic political events in Kenya.

Table 3 Approved HSS support and its disbursement

Year	2007/8	2008/09	2009/10	Total
Planned	$3,741,500	$2,964,000	$3,197,500	$9,903,000
Disbursed	$3,741,500	$2,089,500		

4.4 Is GAVI HSS accountable, inclusive and collaborative?

4.4.1 Inclusiveness

The role of the civil society in the implementation of the main component of the HSS support, *the community strategy* is clearly recognized since community health services have been predominantly carried out by the civil society groups. They were involved in the development of a community strategy in which African Medical Research Foundation (AMREF), representing NGOs, was a main actor. In the GAVI HSS implementation process, civil society organisations are members of the Health Sector Coordinating Committee (HSCC), the secretariat (through HENNET-Health NGOs/CBOs Network) of the Community Strategy Technical Working Group and also are members of the District Health Stakeholders' forum, where the annual planning process is discussed and agreed up on. Thus it is fair to describe the CSO's to be included in the GAVI HSS processes.

4.5 Does GAVI HSS have a catalytic effect?

4.5.1 Additionality and Catalytic Effect

Though HSS has three main intervention areas, a significant part of this support is planned for strengthening *level one* services (implementation of community strategy). This service was mainly funded by NGOs and not GoK resources. In 2008/09 GoK allocated to level one services about 89 million Ksh. This is expected to be the beginning of government's commitment towards increasing financing this level of service. GAVI HSS thus seems to have had a catalytic effect.

Some development partners contribute directly to districts/facilities or through NGOs. This complicates the analysis of additionality. But there is no evidence to show that GAVI HSS funding caused a withdrawal of resources from the sector either by development partners or by government. In fact, as was shown in the APR 2008, some of the activities originally planned to be implemented through GAVI HSS were in fact later financed through other sources of funding. As far as can be understood with limited access to details, additionality seems to be the case.

4.6 GAVI HSS sustainability issues

4.6.1 Sustainability

Kenya's public health technicians, enrolled nurses, are the cadre of professionals that are working as health extension workers. They have been employees on the government payroll for a long time. The community strategy redefined their roles to be an active player in the provision of level one services. They will be supported by CORPs, now re-baptized as community health workers, who will work on voluntary basis, with minor motivational compensation. The GAVI HSS does involve recruiting additional CHEWs, which will add burden on the fiscal space of the government by increasing human resource costs. GoK was not able to meet the cost of advertisement to employ these staff, as had been set out in the HSS proposal. If this is taken as a measure of the ability of the government to take up the wage cost after the completion of the HSS funding, sustainability is questionable.

5 Is HSS on track to achieve its objectives?

5.1 Objectives of the HSS in Kenya

The health systems strengthening proposal identified three areas of sector priorities that will contribute towards the realization of sector objectives for support from HSS. The main areas of intervention identified were[11]:

- Support to implementation of *Level one services* in underserved areas: scaling up of level one services which entails, the skill improvement of Community Owned Resource Persons (CORPs). They were very recently in 2009, renamed as community health workers(CHWs) and re-equipment of CHEWs (community health extension workers) in the intervention districts, (provision of appropriate transport means for outreaches to the community level in the intervention areas and support for the operation of level one services as outlined in the community strategy);

- Support to recruitment of staff[12] in underserved and hard to reach areas - particularly officers that have direct impact on increased immunization coverage (Nurses, public health technicians and medical engineers); and

- Support to strengthen governance and performance monitoring systems at lower levels.

Though the proposal was approved by the board for implementation in July 2007, the implementation of activities were not started until July 2008 because of delays in opening a GAVI HSS bank account thereby delaying the disbursement of funds.

[11] MOH, proposal for health systems support 2006.
[12] While infrastructure is also a noted weakness, interventions regarding its strengthening shall be sought through other sources. This is because immunization-related infrastructure weaknesses fall out of the scope of the HSS, while costs of the system-related infrastructure weaknesses are too high in relation to the amount of resources available through HSS.

Table 4 Status of some of the major results of HSS in 2008

Strategy	Objective	Indicator	Baseline Value	Target	Status as of 2008	Reasons for non achievement of targets
Improving access to and utilization of health services	Taking health services to the community level	Percentage of community health units operationalized	115	400 new Communit y units	363 new Community units formed	85% of the funds were received from GAVI.
Improving Human resource for Health	Opening more service delivery points and improving health service access	percentage of health workers recruited	0	260	260 health workers recruited and working	
Improving utilization of immunization services	Reduce drop-out in immunization coverage	Percentage coverage of measles vaccine	80%	85%	70%	The post-election violence disrupted immunization services and reduced reporting.
Improving access to immunization services	Ensure all children below the age of one year are fully immunized	Percentage coverage for fully immunized children	76%	85%	66%	The targets were not achieved because Kenya experienced post-election violence in 2008. This disrupted immunization services and also reduced reporting.
Improving child survival in target districts	Reduce under five mortality rate through improved immunization coverage	Under five mortality rate	115	Reduction in under five mortality rate	92	

Source APR 2008, page 53.

As can be seen from table 4, Kenya was able to establish 363 of the 400 community units within one year of implementation. All staff that were planned to be recruited through HSS support have been employed and deployed. Some activities in all the three components were also carried out through other sources of financing and the HSS funding was reprogrammed (see annex 1_ detailed activity implementation report of APR 2008).

Some activities that were planned to strengthen health systems, particularly community health services, performance monitoring, evaluation and governance are not yet carried out as planned in the HSS proposal.

The total spending reported in the APR 2008 was **$4,072,000**. The HSS support for 2008 was audited by the Controller and Auditor General in spite of the fact that funding was delayed. According to the audit report, the financial statements have been prepared in accordance with the international standards, and fairly present the receipts and payments. The report though noted that the financial statements do not include information on the project as well as a note or a statement of non-current assets as per the Treasury guidelines.[13]

[13] Kenya National Audit, Report of The Controller and Auditor General on Financial Statement of GAVI HSS Support

6 Major Challenges

There are many factors that have contributed to lower than expected/planned achievements. These can be categorized under three main elements:-

i. **Slow start up**: Because of slow progress in meeting the disbursement requirements, Kenya only managed to get the first tranche of disbursement in the first half of 2008. Though preparatory works took place, this affected the pace of implementation. In spite of the proposal having been approved two years ago, Kenya has so far not implemented one full year of the GAVI HSS proposal.

ii. **Election crisis:** The 2008 post-election situation in Kenya stopped most activity implementation during and after the election. A huge displacement of people took place then and a major effort had to be made that changed the focus of the Ministry to this emergency at the expense of regular activities, including GAVI HSS implementation.

iii. **Split of the Ministry of health into two Ministries:** The split of the Ministry of Health into two ministries, following the post election events, had implications for stewardship of the health sector by the two new ministries. The definition of boundaries and allocating roles and responsibilities between the two ministries took time. This was made worse by a major change in the composition of senior management of the two ministries resulting from transfers and retirement of officers who were championing the SWAp process, including the implementation of GAVI HSS[14].

Our recommendations to improve the alignment of the GAVI HSS in Kenya, based on this document review, are the following:

- APRs are following the January to December while the Kenyan Fiscal year and results reporting follow July-June calendar. This mismatch did create difficulties for Kenya to report achievements. It is therefore recommended that GAVI HSS align to Kenya's fiscal year and sector wide reporting framework.

[14] MOH, AOP3 performance report, draft, Feb 2009, p11.

Annex 1 Summary of HSS activities implemented by intervention area

Annex 1.1 Level one service

Major Activities	Planned Activity	Level of Achievement in %
Objective 1:	**Building the capacity of the community health extension workers (CHEWs) and community-based resource persons to provide services at level 1.**	
Activity 1.1	Identify and train 4 TOTs per targeted district	100%
Activity 1.2:	Training to re-tool community health extension workers.	80%
Activity 1.3	Identify and train CORPs	80%
Objective 2:	**Providing implementation and follow up support for level 1 services for the targeted districts**	
Activity 2.1:	Establish Community Based Information Systems with chalkboards, messages and registers at strategic sites for each selected community unit.	80%
Activity 2.2:	CHEWs Monitor activities of CORPs	80%
Activity 2.3	Support to selected districts in assessing, and rewarding performance of community units	80%
Activity 2.4	Preparing of tender documents to purchase of motor cycles for Community Health Extension Workers and bicycles for Community Health workers per community in selected districts	100%
Activity 2.5	Purchase and supply of 1 motorcycle and 10 bicycles for Community Health Extension Workers and Community Health workers respectively per community unit in selected districts	80%
Activity 2.6	Support the development and implementation of local level Communication mechanisms	80%
Activity 2.7	Support HFs to undertake Integrated Outreaches each 15 days, with allowances for health facility staff	80%
Objective 3:	**Strengthening health facility–community linkages through effective decentralization and partnership for the implementation of LEVEL ONE SERVICES**	
Activity 3.1	Hold district LEVEL ONE SERVICE orientation workshops, for District Health Stakeholders Forum, and other opinion leaders.	100%
Activity 3.2:	Hold LEVEL 1 services orientation workshops, for Division Health Stakeholders Forum and other opinion leaders	100%
Objective 4	**Strengthening the community to progressively realize their rights for accessible and quality care and to seek accountability from facility-based health services.**	
Activity 4.1	Support CUs to hold monthly local health days (1/month)	80%
Activity 4.2	Support holding of quarterly divisional health days	80%
Activity 4.3	Support annual meetings on evidence-based planning, implementation, monitoring, evaluation and feedback at committee levels	80%

Annex 1.2. Human resources

Major Activities	Planned Activity for reporting year	Report on progress[15] (% achievement)
Activity 1.1	Seeking of approval for recruitment of identified Health Workers	100%
Activity 1.2	Seeking authority to recruit identified Health Workers from Directorate of Personnel Management, Ministry of Finance and PSC	100%
Activity 1.3	Advertisement for identified health workers.	100%
Activity 1.4	Interviews for selected candidates	100%
Activity 1.5	Recruitment, and support to selected candidates	100%

[15] For example, number of Village Health Workers trained, numbers of buildings constructed or vehicles distributed

Annex 1.3 Performance monitoring and governance

Major Activities	Planned Activity for reporting year	Progress	Any explanation
Objective 1			
Activity 1.1	Consultant to develop working draft for training manuals based on agreed framework and annual review	100%	100%
Activity 1.2	Hold a 4 day working retreat with stakeholders to complete/reviewing training tools annually	100%	100%
Activity 1.3	Testing of tools in the district	100%	This activity was completed through funds from other sources. The money for this activity was re-allocated to other activities in this report.
Activity 1.4	Induction of Provincial, and district managers on PME	100%	The number of Districts increased from 20 to 53. The original 20 districts in the proposal were split to create 53 districts. We inducted 177 mangers instead of the planned 78. This increased the cost significantly.
Activity 1.5	Training in the identified districts using the training manuals developed	100%	
Objective 2			
Activity 2.1	Supportive supervision to follow-up of capacity building in the districts with poor timelines and completeness of data		
Activity 2.2	Development of quarterly summary of performance of district (data compilation and analysis)		
Activity 2.3	Support to quarterly performance review meetings during AOP3,AOP4, and AOP5		
Objective 3			

Activity 3.1	Development of guidelines, and training manuals for Governance strengthening, particularly at implementation level	The Guidelines have not been prepared. We are currently piloting another guideline developed through UNICEF's support. This activity will be undertaken in the next financial year.
Activity 3.2	Training village, facility, and divisional Health Stakeholders Committee's on roles and functions in Governance in health	
Activity 3.3	Provide operational support to annual district health summit	
Activity 3.4:	Printing of governance and monitoring tools to be used in underserved areas	Printing will be done when guidelines have been completed.
Activity 3.5:	Development of guidelines, and training manuals for district health management team on leadership and management, as well as performance monitoring	The Management Sciences for Health's Leadership Development Program (LDP) guidelines has been adopted for training pending finalization of Ministry guideline.
Activity 3.6	Printing of leadership and management guidelines and training manuals	The MSH guidelines are already printed through USAID support
Activity 3.7	Training the district health Management team on leadership and management as well as performance monitoring	
Activity 3.8	Training the facility staff on leadership and management as well as performance monitoring	

Annex 2 List of Documents Reviewed

GAVI Alliance Secretariat, 2007, letter to MOH, dated November 24th.

GAVI Alliance Secretariat, 2008, Good Examples from Country Proposals.

Jarl Chabot, 2007. Joint Support Program for the Kenyan health sector.

Kenya national Audit office, 2008. Report of the controller and Auditor General on Financial statement of GAVI HSS support.

MOH 1994. Kenya Health Policy Framework

MOH 2006c. Health Systems strengthening proposal

MOH 2009. Annual Performance Report

MOH, 2005a. National Health Strategic Plan II.

MOH, 2005b. KHSWAp 2005, Concept Paper.

MOH, 2006a, Taking Level One Services to the Community.

MOH, 2006b Joint program of Work and Funding, June 2006.

MOH, 2007, Midterm Review Report.

MOH, proposal for health systems support 2006.

MOH, various Issues, Annual Performance Reports for AOP1, AOP2, AOP3.

MOH, various Issues. Annual operational Plans, AOP1, AOP2, AOP3, AOP4, Draft AOP5.

Annex 3 Summary GAVI HSS Evaluation Approach

The GAVI Alliance HSS Evaluation Study Approach

On February 2009 HLSP Ltd won the contract for the 2009 GAVI Health Systems Strengthening (HSS) support Evaluation. The expectation for this evaluation is to determine to what extent operations at country level and support from global and regional levels, as well as trends in health systems and immunization are heading in the right (positive) direction. Qualitative and quantitative information will be collected and analyzed both retrospectively as well as prospectively beginning from the time that the application process commenced in country throughout implementation and monitoring and evaluation of the project to date.

There are five main objectives and areas of evaluation:

1. What has been the experience at country level with GAVI HSS in terms of *each* of the following: design, implementation, monitoring, integration (harmonization and alignment), management, and outputs/outcomes?
2. What have been the main strengths of GAVI HSS at the country level, and what are specific areas that require further improvement?
3. How has GAVI HSS been supported at regional and global levels—what are the strengths of these processes and which areas require further improvement?
4. What has been the value-added of funding HSS through GAVI as compared to other ways of funding HSS?
5. What needs to be done, and by when, at country, regional, and global levels to prepare for a more in-depth evaluation of impact of GAVI HSS in 2012?

The GAVI HSS evaluation will develop five In-depth country case studies. These are structured in such as way that independent consultants teamed with local consultants spend time in countries documenting country experiences. We anticipate up to two visits to each in-depth country between the period of May and June 2009. The first visit will focus largely on interviewing key country stakeholders to map key areas of interest, information and gather initial data. This visit may also include engaging / commissioning a local research institution to conduct further research into particular districts/ activities. During the second visit we anticipate any outstanding stakeholder interviews being conducted, all data collated and subsequently presented to all key stakeholders. We will explore with national stakeholders the opportunity and convenience of conducting an end-of-mission 'validation workshop' in order to provide countries with feedback on the in-depth case studies, and seek validation of these.

In addition, the results from the in-depth case studies will be complemented by the results of 6 on-going GAVI HSS Tracking Studies being conducted by the JSI-In Develop-IPM research group that will become fully fledged GAVI HSS Evaluation studies. Finally, the HSS Evaluation team will desk review all HSS application forms, HSS proposals and HSS Annual Progress Reports produced to date in order to develop a database of HSS countries. All these sources of information put together will aim to answer the five study questions mentioned above.