Project Evaluation: Summary Report

Kenya: Support to the Health Sector (HSP)

Project number	2013.2147.0
CRS purpose code:	12110 Health policy and administrative management
Project objective:	State and non-state actors of the Kenyan health system on national and county level implement relevant strategies to improve the coverage of basic health care services of high quality especially for the poor and informally employed people
Project term:	01/2014 until 12/2016
Project volume:	7,074,000 EUR
Commissioning party:	Federal Ministry of Economic Cooperation and Development
Lead executing agency:	Ministry of Health and Family Welfare (MoHFW)
Implementing organisations (in the partner country):	MoHFW, National Health Insurance Fund (NHIF), Kenya Accreditation Service (KENAS), County Health Management Teams (CHMTs) of supported counties (Kisumu, Vihiga, Kwale)
Other participating development organisations:	Other participants include the non-state partners. These are civil society organizations such as the umbrella organization for NGOs in the health sector (HENNET), professional associations of healthcare professionals, mergers of non-state (faith-based and private) service providers in the health sector, employer associations and cooperatives as potential customers of health insurance.
Target groups:	The poor and those employed in the informal sector, since these are the ones who are mostly excluded from access to appropriate healthcare services.

giz Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH

Project Description

Initial situation and framework conditions

During the last decade, the health situation in Kenya was characterised by strong fluctuations and has not been subject to a clear trend. According to the Kenyan Demographic and Health Survey (KDHS), child mortality under 5 years declined from 90 per 1,000 live births to 52 and infant mortality from 61 to 39 per 1,000 live births between 2003 and 2014 – both however, without reaching the targets for MDG 4 (under 5 mortality: 32, infant mortality: 22 per 1,000 live births). In 2014, 16% of children were underweight against an MDG target of 11%. Maternal mortality rate was at 362/100.000 live births, an improvement compared to the last decade (2003: 506. 2008: 488) but still far from the target for MDG 5 (147/100.000).

From 2012 onwards, the process of devolution (i.e. decentralisation) has implied new challenges. The responsibility for the management of health care has been transferred from the central government to the 47 counties. State and non-state actors are not yet sufficiently implementing strategies for a better coverage with appropriate quality basic health services, especially for poor and informally employed people (core problem). Current sector policies and strategies are committed to improve the (universal) access to health care and to improve the quality of health services. Improved access to healthcare services is addressed through reforms of the National Health Insurance Fund (NHIF). With regard to the quality of health services, an independent accreditation of health facilities has become a political priority. However, non-implementation of relevant strategies has negative effects at different levels. So far, financing mechanisms are not yet based on the needs of the new situation in the health sector. Hence, poor quality and financial access barriers still exist. On the supply side, the quality of health services is largely insufficient and negatively affected by a shortage of human and financial resources.

Strategic Approach

The objective of the TC measure "Support to the Health Sector in Kenya" (also referred to as Health Sector Programme, HSP) is: "State and non-state actors of the Kenyan health system on national and county level implement relevant strategies to improve the coverage of basic healthcare services of high quality especially for the poor and informally employed".

In Focal Area 1a (health financing) the HSP supports the Ministry of Health (MoH) to develop and implement policies to increase access to health care for the poor and informal sector employees. The main interventions are the development and adoption of a roadmap towards Universal Health Coverage (UHC) and the formulation of a Health Financing Strategy (HFS). Thematically, the optimizing of accountable and transparent utilisation of funds at County Level (particularly, the strengthening of the financial management at county and facility level in Kisumu, Kwale, Vihiga and Nairobi) also falls under this focal area.

In Focal Area 1b (NHIF support), NHIF processes are strengthened through personnel and organisational development. HSP supports the use of data for transparent communication through health informatics support. The project advises NHIF on the further development of existing programmes which include patients from poorer sections of society. HSP supports enrolment processes of the Health Insurance Subsidy Programme (HISP) in 14 counties in order to increase the number of people actually accessing health insurance. HSP further contributed to the formulation of the NHIF strategy for the informal sector. Support for costing of health services is provided through applications of the Dynamic Costing Model (DCM).

In Focal Area 2a (Quality Management/QM) an institutional framework for the accreditation and regulation of public and non-public health institutions in Kenya is developed. The national Kenya Accreditation Service (KENAS) is strengthened and the formulation of national quality standards (the Kenya Quality Model for Health, KQMH) is facilitated. Quality improvement processes are implemented in selected facilities through coaching and mentoring activities.

In Focal Area 2b (County Support/Sector Governance) the programme advises the County Health Management Teams (CHMTs) in Kisumu, Vihiga and Kwale on the strengthening of health management requirements which stem from the devolution. Core processes comprise (a) leadership, management and governance, (b) monitoring and evaluation, (c) planning and budgeting, (d) cooperation with non-state-actors.

Overall, the HSP aims at improving the implementation of strategies that increase the coverage of basic health care services of high quality, especially for the poor and informally employed. Thus, it contributes to the overall GDC programme objective, i.e. the equitable access to affordable and quality health services for the poor and informally employed.

Assessment of the programme design and the goal system

The methodological approach of the programme is coherent, i.e. the interventions within each focal area are consistently related to the module objective and strongly interlinked. The hypotheses underlying the results model are plausible. However, the structure of the results matrix differs to some degree from the operational structure (divided by health financing, quality management and county support/sector governance). This has been addressed through functional distribution of responsibilities, defining for each indicator lead and cooperation between the programme components.

At the operational level, the scope of the interventions and the cooperation system are well defined. At the results level, however, the actual reach of the HSP is not sharply discernible. Key results, such as the Health Financing strategy or the implementation of a sustainable and replicable pre-payment scheme for the poor and informally employed, are results of multiple contributions of different DPs and, therefore, not only attainable by the HSP support. Nevertheless, the results level of module objective indicators is adequate.

Basis for assessing the OECD-DAC criteria

The effectiveness of the programme is assessed according to the indicators for the module objective. In order to comply with the SMART-criteria, three out of five indicators have been partly adjusted regarding formal aspects: (a) Indicator 1 regarding the design of a social health protection mechanism was specified according to the actual intervention of HSP, i.e. referring to the targets of the HISP pilot support; (b) Indicator 2 regarding the improvement of county health planning comprised a reference to „nationally recognised QM-measures" which was potentially misleading and therefore eliminated; (c) Indicator 5 regarding the proportion of women with access to basic health services of good quality actually comprises several sub-indicators which were only named in general terms, but now made explicit in the modified indicator.

Whereas the module objective focuses on the implementation of strategies by health sector stakeholders, the results of strategy implementation would be the reference point for the impact assessment. Relevant variables refer to the number of people covered by social health insurance schemes and to the health situation of target populations. Furthermore, impact is to be assessed by the degree to which results of the HSP are replicated and shape the development of the health sector beyond the direct scope of the HSP („broad impact").

Basis for assessment according to the OECD-DAC criteria:	Individual and overall rating of the OECD-DAC criteria:
To determine the TC measure's overall rating, calculate the average of the individual ratings of the five OECD-DAC criteria. 14 – 16 Points: very successful 12 – 13 Points: successful 10 – 11 Points: rather successful 8 – 9 Points: rather unsatisfactory 6 – 7 Points: unsatisfactory 4 – 5 Points: very unsatisfactory	Relevance: 16 Points – very successful Effectiveness: 13 Points – successful Impact: 12 Points – successful Efficiency: 13 Points – successful Sustainability: 12 Points – successful Overall, the TC measure is rated 'successful' with a total of 13.2 out of 16 points.

Relevance (Are we doing the right thing?)

The HSP focuses particularly on two dimensions of health care access which represent core problems that directly affect the target groups (a) the financial barrier for health service access and (b) the quality of health services. Low insurance coverage correlates with unmet needs for health care whereas pre-payment mechanisms, as promoted by the HSP, could effectively detach healthcare access from the wealth status. Quality of care – also a focal area of the HSP – is also unevenly distributed and suffers from a lack of enforceable standards. The HSP multi-level approach towards QM (considering a national QM and Accreditation system, support capacities at county level and quality improvement at facility level) may have a significant effect on the quality of care, at least in the mid- and long-term (*Connection with a core problem of the target group: 4 out of 4 points*).

The HSP reflects the priorities set by national policies and strategies (e.g. Vision 2030, Kenyan Constitution of 2010, Kenyan Health Policy 2014-2030) and furthermore has made significant contributions to policy and strategy formulation, both at national level (e.g. Health Financing Strategy, Health Quality Improvement Policy 2015-2030) and county level (e.g. county health policy in Kisumu). It complies with the BMZ Health Sector Strategy (e.g. regarding the promotion of health as human right, social health protection, use of multilevel approaches) and is in line with international standards, particularly regarding its orientation towards UHC as pursued by SDG 3.8. It also directly contributes to further health-related SDG such as SDG 3.1 and 3.2 (reduction of maternal, neonatal and under-5-mortality) and SDG 3.7 (access to sexual and reproductive health-care services) (*Accordance with relevant strategies: 4 out of 4 points*).

The project is rated 'very successful' in terms of relevance with 16 points.

Effectiveness (Will we achieve the project's objective?)

Objectives indicator	Target value according to the offer	Current situation according to the project evaluation

(1) NHIF and/or other organisations have successfully piloted (i.e. met the pilot phase targets of) at least one replicable social health protection mechanism (e.g. solidarity principle) in areas attended by the HSP. (Baseline 01/2014: 0)	100% compliance with pilot targets, i.e. 500 enrolments in each of 14 counties attended by GIZ-HSP (until 12/2016)	Through enrolment support in 14 supported counties, approx. 6,000 households have been reached until 03/2016 with close to 90% of the targeted households being registered for the HISP. This means that approximately 80% of the target value of 500 households per county (i.e. 7,000 households in 14 counties) has been met by the time of the PEV. Nationwide, HISP is covering approx. 21,500 households in 47 counties. Thus, **the indicator is on track and can be achieved until the end of 2016**. With regard to informally employed populations, HSP gave technical inputs to the NHIF for the formulation of a strategy for the informal sector that aims at expanding the depth of coverage from in-patient services to a comprehensive package of benefits and extending the coverage to uncovered population segments.
(2) At least 2 of the 3 supported counties have begun to implement a comprehensive county health planning and budget (including state and non-state actor contributions to health care service), that prioritises the universal access to basic health services and provides measures of quality management for primary health care and health care providers. (Baseline 01/2014: 0)	2 counties (until 12/2016)	In all pilot counties, CHMTs have formulated budgeted annual work plans for the health sector. Further achievements in Kisumu have been the formulation of a county health policy, conducting a PET Survey and enhanced procedures of performance contracting. In other counties, the development of planning and budgeting capacities is still more incipient. All pilot counties have defined responsibilities for QM within the CHMTs, though respective work plans are not yet budgeted as required. The **indicator will be mostly achieved**.
(3) The number of tier 2 and 3 health centres and sub-county hospitals in the supported counties that receive payments for basic health services provided, has risen to at least 15. (Baseline 01/2014: 0)	15 health centres/hospitals (until 12/2016)	At facility level, 22 facilities are receiving advice in order to strengthen their financial management and comply with the requirements for the devolution of funds (Kisumu: 8, Vihiga: 6, Kwale: 5, Nairobi: 3). Since the support has been just initiated outcomes cannot yet be assessed, however, most of the targeted facilities can be expected to meet the requirements of the indicator until 12/2016. Thus, **the indicator is on track**. Additionally, the counties of Kisumu and Vihiga are tackling administrative barriers, e.g. Vihiga is promoting a law initiative that would allow the health facilities to retain their income.
(4) The number of tier 2 and 3 health centres and sub-county hospitals in the supported counties that is transparent about the use of their revenue for the effect-oriented improvement of its services to customers and users, has risen to at least 12. (Baseline 01/2014: 0)	12 health centres/hospitals (until 12/2016)	Indicator 4 develops from the same intervention package as Indicator 3 which is not yet in a stage to be assessed in terms of its outcome. An initial needs assessment has been concluded (December 2015), and a curriculum for a mentorship approach developed (February 2016). A first quarterly financial report will be published by the health facilities for the first quarter of 2016 (until May 2016). In conclusion, the **interventions aiming towards indicator 4 are on track**.
(5) In at least 2 of the supported counties, the proportion of women in their reproductive age who have access to basic health services of good quality has increased, measured in terms of (a) the proportion of deliveries that take place in health facilities (b) woman of reproductive age accessing Family Planning (FP)	Improved access in 2 counties (until 12/2016)	23 Facilities in Kisumu, Vihiga, Kwale and Nairobi have been sensitised on quality gaps, established QM teams and set up quality improvement processes. Repeated assessments provide evidence on positive changes, particularly regarding the areas of safety, clinical care and the interface of in-/out-patients. Achievement levels, however, differ significantly among the facilities. At the outcome level, positive trends are observed. The

commodities, (c) proportion of deliveries with skilled birth attendance. (Baseline 01/2014: individual for each proxy-indicator)		proportion of deliveries that take place in health facilities has gradually increased in all pilot counties, on average higher than nationally (significant progress in Kwale from 48% in 2013 to 71% in 2015) except one county which was at par with the national trend. The proportion of deliveries with skilled birth attendance in the pilot counties increased similarly to the national trend (except for a much higher increase in Kwale from 43% to 73%). Regarding access to FP commodities, upward trends have been observed in all HSP counties (+4%, 11% and 14% in Vihiga, Kisumu and Kwale) against a national downward trend (-3%). Overall, **a medium goal-attainment is anticipated for indicator 5**.

The evaluation team comes to the conclusion that until the end of the programme term (12/2016) the degree of goal-attainment for the module objective indicators is as follows: Indicator 1 will be achieved *entirely*, Indicator 2-4 *partly or entirely*, and Indicator 5 *partly* (*Goal Attainment: 3 out of 4 points*). No unintended negative results were observed (*4 out of 4 points*).

The project is rated 'successful' in terms of effectiveness with 13 points.

Overarching development results (impact) (Are we contributing to the achievement of overarching development results?)

Regarding the path towards UHC, programme support to consensus-building processes of sector stakeholders – particularly for the formulation of the Health Financing Strategy – has contributed to a better environment for sector reforms. The uptake of health insurance for the informal sector and the continuation of the HISP beyond the externally financed pilot term, however, depend on uncertain external variables (e.g. availability of resources; capacities, image and role of the NHIF). A contribution to the health situation of the Kenyan population is also made by contributing to better quality of health services. Regarding the effects of quality improvement at provider level, monitoring of facility-based maternal and neonatal health does not yet show conclusive results due to external confounding variables. More reliable data and longer timelines will be required to draw reliable conclusions (*Contribution to overarching development results: 3 out of 4 points*).

Regarding the potential for "broad impact", replicability and up-scaling potentials of the applied concepts have been very much in the focus of the HSP, e.g. regarding the pilot level enrolment support to the HISP, mentoring approaches in the contexts of QM and financial management, among others. However, the operationalisation of scaling-up processes and the identification of required resources is predominantly a remaining task (*Contribution to achieving broad impact: 3 out of 4 points*).

The project is rated 'successful' in terms of impact with 12 points.

Efficiency (Are objectives being attained cost-effectively?)

The evaluation concludes that the mix of tools applied by the GDC has been appropriate. The focal areas and interventions have been consistently linked and added value to each other. The multi-level approach has enabled the programme to facilitate synergies between the different intervention levels. Most programme interventions leveraged significant input of the counterparts. In the light of the medium-sized budget, the programme has managed to attend a wide scope of interventions that mostly generated outputs according to the expectations (*Appropriate use of project resources: 3 out of 4 points*).

Alignment with contributions of other DPs has been systematically pursued. In the area of health financing, synergies were achieved between the financing contributions (e.g. World Bank, IFC, KfW) for insurance schemes and technical assistance (e.g. operational research, enrolment support). Close coordination took place with many DPs for the formulation of the HFS. In the focal area QM, cooperation took place, among others, with IFC and WHO regarding the establishment of an accreditation/ certification system and with IFC, JICA and USAID regarding the review of quality standards. At county level, HSP worked with a wide range of DPs on specific topics. Cooperation with other German TC measures concentrates on the GIZ Good Governance Programme. Both programmes are currently collaborating to enhance accountability and good governance in in Kisumu County (*Coordination/cooperation with other GDC measures and international DPs: 4 out of 4 points*).

The project is rated 'successful' in terms of efficiency with 13 points.

Sustainability (Are the positive results durable?)

The HSP has been well oriented towards lasting changes. It has acted process-oriented, with a view on both immediate outputs and the establishment of institutional capacities. This includes the systematic incorporation of "sustainability mechanisms" into the programme strategy (entrenching functions in the partner system which initially are performed by external assistance). Nevertheless, there are challenges to sustainability related to the availability of funds for future health insurance implementation, to staff capacities and fluctuation and to governance issues (e.g. corruption risks, transitional problems arising from the devolution process, unpredictable pace of sectoral reform) (*Degree to which the achieved results will be durable: 3 out of 4 points*). Where possible, the HSP has considered interventions in order to reduce risks though the influence of the HSP on structural macro level constraints is of course limited. More attention should be directed towards the risk of underfunding of future insurance schemes, be it due to unsustainable financing of subsidies (HISP) or insufficient risk estimations regarding the implications of new target groups on the NHIF budget (*Consideration of risk factors: 3 out of 4 points*)

The project is rated 'successful' in terms of sustainability with 12 points.

Impressum

Deutsche Gesellschaft für
Internationale Zusammenarbeit (GIZ) GmbH

Sitz der Gesellschaft
Bonn und Eschborn

Friedrich-Ebert-Allee 40
53113 Bonn
T +49 228 44 60-0
F +49 228 44 60-1766

Dag-Hammarskjöld-Weg 1-5
65760 Eschborn/Deutschland
T +49 61 96 79-0
F +49 61 96 79-11 15

E info@giz.de
I www.giz.de