Joint Assessment of Kenya's Health Sector Strategic Plan (KHSSP)

November 2012

Abbreviations

CG	County Government
DP	Development Partner
FBO	Faith Based Organization
GOK	Government of Kenya
HENNET	Health NGO's Network
JANS	Joint Assessment of National Strategies.
KHP	Kenya Health Policy 2012-2030 / Kenya Health Care Federation
KHSSP	Kenya Health Sector Strategic & Investment Plan, July 2012 - June 2017
KEPSA	Kenyan Private Sector Alliance
IHP+	International Health Partnership
ICC	Inter Agency Coordinating Committees
MOMS	Ministry of Medical Services
MOPHS	Ministry of Public Health and Sanitation
NG	National Government
NGO	Non Government Organization
NHSSP II	National Health Sector Strategic Plan II
WB	World Bank
WG	Working Group

Table of Contents

Acknowledgements 3
Introduction 4
Background and Objectives 4
Methodology 5
JANS Team 5
1. Main Observations 6
1.1. Overall observations and recommendations 6
1.2. Situation analysis and programming 7
1.3 Process 8
1.4 Cost and budgetary framework 9
1.5 Implementation and Management 10
1.6 Monitoring, Evaluation and Review. 11
2. Assessment of the KHSSP (July 2012-June 2017) 13
2.1 Situation Analysis and Programming 13
2.2 Process 18
2.3 Cost and Budgetary Framework 20
2.4 Implementation and Management 24
2.5 Monitoring, Evaluation and Review 28
3 Annexes 30
3.1 TOR for conducting a Joint Assessment of the draft Kenya Health Sector Strategic Plan, KHSSP .. 30
3.2 List of Persons Met 34
3.3. Work Program JANS Kenya 35

Acknowledgements

The JANS team would like to thank the various organisations that made our assignment possible by providing their comments and ideas on the content and process of developing this draft version of the NHSSP. We would like to mention in particular:

- The Planning departments of the MOMS and the MOPHS
- The Chief Economists of both Ministries
- The Ministry of Planning (MOP)
- Members of the various technical working groups (TWG)
- Members of KEPSA / KHF and HENNET
- The Development Partners in Health of Kenya (DPHK)
- The heads of programs, being NASCOP, Child Health, Reproductive Health and TB.
- The National Health Insurance Fund (NHIF)
- The WHO and the DPHK secretariat for their valuable administrative support.

Team members of the Kenyan JANS are:

- Dr Jarl Chabot / Public Health - Service Delivery and Team Leader
- Ato Abebe Alebachew / Economist
- Dr Prosper Tumusiime / Public - Systems
- Mr Samwel Ongayo / HENNET
- Dr Mercy Bannerman / HIV-AIDS specialist
- Ato Netsanet Workie / Economist

All team members participated in their personal capacity

Nairobi, 07 November 2012.

Introduction

Background and Objectives

The new Constitution of Kenya[1], formally adopted in August 2010, proved a landmark for the new development direction of the country. Not only all sectors of Government of Kenya (GOK), but also civil society and the private sector became engaged in a new and uncertain process of reform and change to prepare for the implementation of the major and sweeping changes the new Constitution demanded. In essence, the Constitution introduced a 'rights-based approach' for all Kenyans and a 'devolution of power' to two levels of government: National Government (NG) and County Government (CG)
Before the adoption of the Constitution, the country had already developed in October 2007 its "Vision 2030[2]", being a long-term vision, spelling out its intention to transform Kenya into a rapidly industrialized middle-income nation by the year 2030.

The Constitution and the Vision 2030 provided all sectors of government the necessary broad direction to prepare for the new situation. Together, the two Ministries of Health, Ministry of Medical Services (MOMS) and the Ministry of Public Health and Sanitation (MOPHS), constituted various working groups (WGs) with participants, coming from all stakeholders and provided the necessary guidelines and Terms of References. As a result, the two Ministries published a "Position Paper[3]" in 2011, a Health Bill[4] in 2012 and the Kenya Health Policy[5] (KHP 2012-2030), while at the same time drafting and revising various versions of the Kenya Health Sector Strategic & Investment Plan (KHSSP July 2012 - June 2017).

As a final stage before formalization of the plan, the Government proposed to the International Health Partnership (IHP+) secretariat to have an independent joint assessment of the content and process of the KHSSP, the JANS. The Terms of Reference[6] (TOR in Annex) guiding this joint assessment process highlights the following aim and objectives for this assignment:
The overall aim of the independent assessment is to review the content and development process for the KHSSP to ensure they have met expectations of different actors in health.
Specifically, the assessment will:

- Assess the comprehensiveness of the content of the KHSSP in terms of its implementation of the Kenya Health Policy imperatives
- Document the process of elaboration of the KHSSP, and make recommendations on any additional process issues the sector needs to address prior to formal launch of the plan
- Develop a shared understanding of the KHSSP amongst all sector actors, including its strengths and weakness
- Provide guidance to health sector actors on how to support and fund the strategy
- Assess adequacy of the KHSSP to provide guidance to program-based investments.

An essential contextualissue, specific for Kenya at the moment and being an all pervading element of this JANS, is the fact that the KHSSP has to address the major issues of the Constitution, in particular the

1Government of Kenya, 2010. The Constitution of Kenya
2Government of Kenya, 2007. Vision 2030: a globally competitive and prosperous Kenya
3MOMS and MOPHS, 2011. Position Paper: implications of the implementation of the Constitution for the Health Sector.
4 Government of Kenya, June 2012. The Health Bill
5MOMS and MOPHS, 2012. Kenya Health Policy 2012-2030
[6]MOMS and MPHS, 2012.Terms of Reference for conduction a Joint Assessment of the draft KHSSP.

devolution to 47 counties and the 'right to health' approach, without clear insights how on these changes will play out after the elections (envisaged for March 2013*).*

This situation has blurred what the overall strategic objectives of the KHSSP should be and made it also difficult for JANS team to form an informed value judgment about the strength and weaknesses of the strategic plan. Furthermore, while fiduciary issues are very high in Kenya, the latest JANS tool lowered down its importance, as JANS does not substitute for a fiduciary assessment by the development partners when they are going to provide funding. The Kenyan JANS team did not have a financial management and procurement specialist within the team and their findings are therefore only limited to the documents review that it undertook.

Methodology

Between 21st till 31st October 2012 a mixed international and national team reviewed the KHSSP, using the combined Joint Assessment Tool and Guidelines[7] (version 2, September 2011), as developed by the IHP+ Secretariat. The team initiated its work, meeting the technical core team, constituted of senior staff of the planning departments of both ministries in charge of coordinating the assignment. A work program was developed, allowing the team to meet all the main departments within the two ministries (including the main programs), major stakeholders in the sector, such as the Development Partners (DPs), HENNET (the umbrella organisation of NGOs and Faith Based Organisations in the sector) and the Kenya Health Care Federation (KHF) , the health sector board of the Kenyan Private Sector Alliance (KEPSA). (See list of persons met in Annex).

Based on a recent multi-stakeholders consultation in Hammamet[8], the Kenyan JANS team met with another IHP+ consultant to discuss how to improve harmonisation and alignment of development partners' procedures for assessing national strategies in order to enhance confidence of financiers in the independently assessed strategies. Similarly and at the request of the IHP+ secretariat in Geneva, the team gave special attention to the issue of synergy between the KHSSP and the strategies and plans being used by the various (major) programs in the country, funded through GFATM and GAVI. Three 3 sets of issues were looked at:

A. Technical issues around sub-sector / program strategies
B. Issues related to balance, coherence and synergy between program strategies and overall sector strategy
C. Aspects of joint assessment that should be done on a sector not a program specific basis

JANS Team

Members of the JANS team in Kenya were:

NAME	PROFESSION	ATTRIBUTE FOCUS
Ato Abebe Alebachew	Economist	5 - 9 and 13
Dr Prosper Tumusiimme	Public Health / Systems	10 - 12 and 15 - 16
Dr Jarl Chabot	Public Health / Services	1 - 4 and 14
Mr Samwel Ongayo	Public Health / Private not-for-profit	HENNET (5)
Dr Mercy Bannerman	HIV/AIDS / NASCOP	HIV - AIDS (10)
Ato Netsanet Workie	Economist	8 - 9 and 13

[7]IHP+, September 2011. Combined Joint Assessment Tool and Guidelines (draft, Version 2)
[8]IHP+, February 2012. Consultation on Lessons Learned and future directions.

1. Main Observations

1.1. Overall observations and recommendations

KHSSP is aligned to vision 2030 and Kenya health policy. It also tries to bring in some of the implications of the new constitution, specifically the bill of rights and devolution.
Although there are some minor editions required, overall, the structure of the report is well thought out and internally coherent and consistent. The strategic plan took a 'systems approach' and all the health sector outcomes and investment areas are considered. While participation by non-state actors is not as much as it hoped for, there is reasonable engagement and participation by program managers within the two ministries.

KHSSP is being developed in an uncertain environment and dynamic legal and institutional change.
There are a lot of unknowns that will affect the design and implementation of the KHSSP in the next few years. These include: (a) the unbundling functions between the National and 47 County levels are yet to be worked out with the Transitional Authority and the mechanics of transition (one time or phased approach) is yet to be decided; (b) the institutional arrangement both at the national level (two ministries coming into one) and at County level is yet to be decided; (c) although the vertical and horizontal allocation of resources between the national government and country governments and among country governments are worked out, it is not clear how this will play out when it comes to the resource allocation to health sector at two levels of government; (d) the implication of the veterinary services into the health sector and how it will influence strategies and institutional arraignments is not yet clear; (e) while the government is working on medium term plans in line with vision 2030, the outcome of the March election may bring some changes in the priorities and flagship programs, depending on the agenda of the winning political party.

The KHSSP based its service delivery targets and interventions around a 'comprehensive' KEPH, which seems to have shifted the focus to tertiary and secondary / curative care. This makes prioritization and ranking flagship programs difficult. The health systems outcomes (six objectives) seem overlapping. The alignment of sub sector programs with the main strategy is not clear, as most managers of programs interviewed by JANS seemed to have little knowledge of KHSSP targets and strategies. Leadership and inspiration are needed from both Ministries to bring all programs on board and develop a shared vision and target for the coming five years. Outside the public sector, there is a need to establish a national consensus and ownership by the private for profit (KEPSA), by NGO / CSO and other stakeholders, implementing programs within the health sector. KHSSP will also benefit if its draft is shared and inputs from the upcoming? county structures are included.

The overall recommendation therefore is the following:

1. Higher MOHs officials need to drive the revision and finalization of KHSSP politically, with the participation of a broad forum of stakeholders. This will enhance ownership by government and buy-in by other stakeholders and create a national consensus around the systems investment priorities and the strategic directions of the sector for the next five years. The private sector umbrella organizations (KEPSA and HENNET) need to be supported to bring their members on board and reach a common understanding and positions around the strategic plan. Contracting partners need to have an input in setting priorities in the health sector.
2. Ensure that the situation analysis is more comprehensive and justify the selection of the main priorities (flagships) of the KHSSP, the 6 policy objectives and the 7 investment areas.

3. Develop a costed devolution roadmap with the transitional authority and include a chapter on the roadmap in the KHSSP to guide its implementation.
4. Revisit the prioritization of the plan and explore whether there is overlap among the six strategic objectives. As part of this, consider reviewing the relevance and effectiveness of KEPH and revise the 'revised KEPH' as per the findings of this review. Once this is agreed upon, review the norms and standards to go with the 'revised" KEPH as part of the implementation of KHSSP.
5. Ensure that the various Strategic plans of the national programs (RH, HIV/AIDS, TB, Malaria, NCD etc.) and their targets are fully aligned with the KHSSP
6. Clearly elaborate what KHSSP will do differently which will help to achieve the intended targets. Also, elaborate in more detail the following areas:
    a. Community Health;
    b. Voice and a Rights-based Approach;
    c. Public Private Partnership (PPP) and MOH relation to the NGO/CSO sector through HENNET,
    d. Health financing,
    e. Strengthening sector coordination and promoting aid effectiveness agenda (ownership, alignment, harmonization, mutual accountability and results) in the sector
7. Continue the work on the costing and financing estimates and address the various weaknesses with a broad and active participation of all stakeholders.
8. Consider reducing the number of indicators in the KHSSP and ensure that targets are more realistic. It is advisable to select a smaller set of core indicators for overall sector performance, based on KHSSP priorities, that could eventually be turned into County Score Cards.

The JANS team recommends that revision and finalization of the NHSSP will take the following processes into consideration: First, there should be national consensus on the strategic plan with meaningful participation of all -both internal and external - stakeholders. Second, the core team, possibly with some expansion, should revise the plan by incorporating comments from the external stakeholders meetings, the JANS and the views to be generated during the national consensus meetings to be held soon. Third, missing sections like devolution road map needs to be included KHSSP. Fourth, revisit all strategic directions in each of the investment areas to beef up the 'how questions' more than the what related questions. Fifth, once the counties are established, consult with them and revise the plan based on the input generated if necessary. And finally, finalize the document with the launch of the strategic plan with full endorsement of the relevant authorities.

1.2. Situation analysis and programming

Several detailed and exhaustive studies and reviews of NHSSP II were carried out with broad inputs from various stakeholders in the last two years to inform the development of KHP and KHSSP, including those related to health financing in the sector (equity, efficiency, use). There is coherence between KHP and KHSSP in terms of priorities and objectives (6 health outcomes and 7 investment priorities) that guide both documents to contribute to the realization of vision 2030. The six policy objectives address the overall disease burden (morbidity and mortality) in the country. Furthermore, KEPH was revised and now includes NCDs in its package. Service delivery levels have been regrouped from 6 to 4 levels and proposals for unbundling of functions between national and county levels have been described to respond to the devolution agenda. However, this should be more articulated in the form of a roadmap in the next few months. KHSSP has a clear, coherent and well-developed conceptual framework, (from inputs to impacts), showing priority areas of investment and measures of success. Most of the proposed

interventions are effective and relevant. Most of the targets have been annualized to guide implementation.

Although the model used stipulates that bottleneck analysis will inform the planning, costing and budgeting process, KHSSP situational analysis has not captured well the bottlenecks that the sector is trying to address and it does not fully justify the policy objectives and the priorities adopted in the KHSSP.

The best practices and lessons learnt from NHSSP II implementation were not well captured. As a result, the revised KEPH does not allow for proper priority setting. Updated norms and standards have not yet been defined, making costing problematic (e.g. NCD, tertiary care). Proper and systematic review on KEPH implementation does not seem to have informed its revision. The future looking sections of NHSSP did not systematically capture either the implications of the emerging issues (e.g. devolution) nor the 'strategic shifts' that KHSSP will do 'differently' to improve performance. While the strategy is very articulate on 'what' needs to be achieved in the coming five years, it is inadequate in elaborating 'how' strategic directions, imperatives and targets will be achieved. Several overarching policy priorities, such as UHC, Rights-based approach, community health, people-centered systems, and health financing are not well captured. Strategic collaboration between state and non-state actors (PPP and HENNET) is only marginally addressed. Several essential services do not get the attention expected, based on their contribution to the Disease Burden (Maternal health, Nutrition, HIV/AIDS treatment).On the other hand, violence / injuries does not seem to merit a different strategic objective, as it could better fitunder curative care (NCD). Strategies and interventions to work with other ministries have not been spelled out. Similarly, interventions to achieve equity and efficiency have not been described in some detail. Moreover, many of the targets in KHSSP seem too ambitious.

The situation analysis should be sharpened to explicitly show why the new health priorities of the KHSSP are selected. It should also provide an explanation about what worked and what didn't during NHSSP II to guide better focus and programming. The sector should work towards having only one sector medium term plan with defined high priority areas of KHSSP becoming the 'flagship programs' in the next five years. It is advisable to revisit the strategic objectives with the view to eliminate overlaps among them and making them sharper (e.g. NCD, violence and injuries etc.). The number of indicators and their ambitious targets should be reduced and made more realistic. The reduced number of national indicators should be selected with the view to introduce county scorecards and county league tablesfor enhancing performance.

1.3 Process

The KHSSP development process was led and steered by the core group and seven working groups composed of staff mainly from the two MOH ministries and the DPs. The Inter Agency Coordinating Committees (ICCs) were not used to drive the process, which ideally should have been their roles. These groups developed the draft KHSSP and presented it to the internal and external stakeholders' consultation. There was also active participation from some of the program managers (e.g. HIV/AIDS, TB, HR) during the development of this strategic plan.

Although the Core Team tried to reach out to the private sector, both for profit and not-for-profit, their efforts were not successful to bring these stakeholders on board, due to (i) inability of the coordinating agencies (KEPSA and HENNET) to bring their members on board and (ii) several communication and planning problems. Furthermore, it is reported that effectiveness of the TWGs was low and varied among them. The most significant challenge though was the inadequate political steering given by the

two Ministries. This has resulted in low ownership of KHSSP by the programs within the two Ministries and inadequate buy-in by the private and NGO sector.

Although KHSSP included some of the constitutional dispensation, there are many **'Known-unknowns'** that affected the content, quality and process of KHSSP. These include: (a) the form and extent of devolution in the health sector and its road map for implementation; (b) to what extent the KHSSP and Medium Term Plan (MTP) align and assist the sector in the coming five years; (c) what is the implication of the devolution to the regulation of the sector; (d) the political commitment to produce health for Kenyans has so far not been followed by increased government resource allocation (remained at less that 7% of GOK spending); it is not clear how this will play out after the counties come into being; and e) the implications of the veterinary sector in the future MOH structure and on the KHSSP.Although some programs are active and participated in the development of KHSSP, most of them are still using and following their own respective sub-sector strategies. There are only limited indications that programs are developing their sub-sector strategies that will be aligned to this KHSSP.

It is therefore recommended to:

- *Expand the space for meaningful policy dialogue and create national consensus on sector strategic priorities by enabling HENNET and KEPSA to play an active role;*
- *Create full ownership within public institutions (e.g. programs, NHIF), bringing counties on board before the finalization and endorsement of the strategic plan.*
- *Finalize the costed Devolution Road Map and include it as a chapter/section within the strategic and investment plan.*
- *The Stakeholders to consider ensuring that the strategic plan meets all MTP requirements (e.g., flagship programs at national and county levels, projects to be funded through PPP, risk and its mitigation measures) and become the only medium sector strategy for sector.*
- *The two MOHs to guide and steer all programs to develop their sub-sector strategies aligned to KHSSP in terms of time frame, strategic interventions and priorities, indicators and targets and to the best possible, resource requirements.*

1.4 Cost and budgetary framework

The costing methodology used is the recently developed 'One Health tool', which is reported to link planning with budgeting. KHSSP is costed and its costing structure is broadly aligned to the 6 strategic objectives (health outcomes) and 7 investment priority areas, as outlined in both the KHP and KHSSP. Furthermore, it was also possible to cost KHSSP by major program areas at the 4 different levels (tiers) of the health system. Some of the programs provided the information required about their interventions to implement the strategy with baselines, targets and unit costs that are the necessary inputs for costing. On the financing side, resource projections have been made for the GOK and development partners on their expected spending in the coming five years, allowing the presentation of the projected 'resource gaps' for implementing KHSSP.

While the JANS team was provided with some cost sheets with interventions, it was not able to access the tool and its logic of costing. The methodology and the assumptions used for costing were not clear. There are some known gaps in the costing and financing section. First, because of overlaps, inadequate information on cost effective intervention and baselines, it is uncertain how accurate are the estimates for NCDs, violence/injuries and health related strategic objectives. Secondly, KEPH –being inclusive of all services - lacks prioritization. The absence of (new) norms and standards to go with it makes cost estimates of the package uncertain. Thirdly, there is lack of scenarios in cost and budget estimates to show different levels of ambitions and fiscal space possibilities. While the model can estimate the returns on investment in terms of morbidity and mortality reductions, this is yet to be carried out. Cost and budget estimates are yet to be disaggregated into (i) development and recurrent and (ii) national and county levels. Financial projections are yet to reflect the known sources of funding in the health sector: cost sharing, NHIF, and private sector contributions. Even the GOK projection is inconsistent and inflated compared to Budget Review and Outlook Paper (BROP) projections. Both the costing and financial projections estimates are yet to be validated in a meeting with program and investment area managers through a review and agreement on targets, interventions and assumptions used. With the devolution, there is a need to clarify the channels of funding for nationally mobilized external resources (GF, GAVI, bilateral agencies) in the KHSSP to guide implementation. The absence of a funding gap for program areas (e.g. HIV/AIDS, child health, etc.) could affect future funding proposals in these areas.

Having realistic costing and financing estimates aligned with government planning and budgeting process is critical not only for future fund mobilization but also for implementing the KHSSP. It is therefore necessary to address the above weaknesses before the finalization of KHSSP. KHSSP should also enhance its section on health financing and articulate strategic actions that are required to develop and implement the health-financing strategy in the next five years

1.5 Implementation and Management

The organization of services through a four-tier system of health services delivery, the functions at each level and the relevant governance and the sector leadership framework have been well described and areas of priority investment have been identified. The strategy takes equity into consideration and provides for KEPH in special settings, including congregated settings, at risk populations and hard-to-reach areas. However, the strategy does not provide a plan for improving the referral system and little mention is made on logistics management system and maintenance of infrastructure and equipment.

Fiduciary (financial management and procurement) gains achieved in HSSP II are recognized and the strategy provides clear direction to build on these gains (e.g. national roll out of IFMIS and KEMSA pull system, strengthen the community involvement in the facility committees). On the other hand, despite the draft Bill approved by Cabinet, it was not clear how KEMSA would operate as first point of call for procurement of medicines and other health commodities for counties in the face of devolution.

The current strategy inherits a robust operational planning system from HSSP II. It describes roles and responsibilities for national and county levels and provides annual planning and monitoring timelines, however it does not provide a clear mechanism to ensure linkage of county operational plans to the national strategy and is not explicit on how support for planning and budgeting will be provided in the devolved context and neither does it mention any technical assistance plans.

The HR gap is identified and various mechanisms to address technical and managerial support to lower levels are proposed but the plan's requirement of five to six times the current number of HR in the 5 year period raises feasibility issues, in view of lack of mention of the capacity for HR production, absorption, distribution and retention

Targets for leadership and governance to foster ownership, alignment, and harmonization as well as setting and enforcing standards have not been provided and given awaited elections in March 2013, the vertical and horizontal coordination mechanisms between National and County Health structures remains to be decided. At the implementation (county) level, the relation between County Health Services and the various programs (SRH, HIV) still needs to be clarified.

Although the structures for SWAp and Aid Effectiveness exist, they are not fully functional. The MOH is encouraged to strengthen its AID Effectiveness agenda in the next version of the KHSSP and with new devolved structures, there is an opportunity to make the national structures lighter and more functional and to improve on the voice and accountability of the population which has not been well defined or operationalised.

The development of the devolution road map with the Transitional Authority together with the county capacity development plan with its costing will require to be developed and included as a chapter in the KHSSP. The plan should define the planning, budgeting, monitoring and review mechanisms that provide detailed guidelines on the proposed work and consultation between the MOH, Counties, programs and other stakeholders (KEPSA and HENNET). It also needs to articulate mechanisms to strengthen the SWAp / AID Effectiveness agenda and the coordination mechanisms between the DPs, the private sector, HENNET and cater for the devolved levels as well.

1.6 Monitoring, Evaluation and Review.

The plan introduces innovative dissemination of reports and policy dialogue through the Annual State of Health in Kenya and its popular version, the district/constituency stakeholders' forum and different communication channels, and promotes joint review at all levels. Another good practice embodied in the plan is that actionable recommendations are targeted from assessment and review of performance with implementation tracking plans. Although the strategy mentions a bottom-up approach for JRM , it is not clear how this will be achieved both in information generation and dissemination.

The M&E plan provides for impact, outcome, output and input/process indicators with their baselines and targets, data sources, mostly routine/country based sources. However, the indicators are too many and some without annualized targets, while the definition and interpretation of the 'composite index'

has not been clarified. On the contrary, there are very few indicators related to hospital management and performance.

The roles and responsibilities in M&E, other than M&E units, including for private sector are not defined, especially for data collection, analysis and use, the approach to address data gaps is not clear as well as how the capacity of the M&E units at county levels will be built or strengthened.

Efforts should be made to come up with a smaller set of core indicators for overall sector performance, based on the KHSSP priorities and the plan should consider developing County Score Cards for comparing performance among them. At the same time, a deliberate plan should be put in place to build capacities of the counties, especially in planning, budgeting and reporting. The plan should include mechanisms for quarterly feedback which should be as simple as possible for all to understand. It should allow both the counties and the MOH to review their performance, highlight bottlenecks and take appropriate actions.

2. Assessment of the KHSSP (July 2012-June 2017)

2.1 Situation Analysis and Programming

Situation Analysis & Programming Clarity and relevance of priorities and strategies selected, based on sound situation analysis
STRENGTHS
Attribute 1: The KHSSP is based on a sound situational analysis Δ The two Ministries undertook several detailed and exhaustive studies, such as (i) in 2010 the "Health situation trends and distribution 1994-2010 and projections for 2011 - 2030"; (ii) the 2009 Kenya Demographic and Health Survey (KDHS); (iii) the 2009 client satisfaction survey and two policy related reviews, being the March 2012 Draft End Term Review of the NHSSP II (2005-2010), in particular its systems and governance over that time period. All these studies have been undertaken with substantial inputs from relevant stakeholders and have informed the development of the KHP (2012-2030) and later the KHSSP 2012-2017; these studies o Reviewed not only demographic and burden of disease issues (using disaggregated data), but also coverage and trends of the major disease programs, health systems and financing over a 10-15 year period. o Assessed various risks and made practical recommendations to the GOK as part of its Vision to become a middle-income country in 2030. This led into the inclusion of a specific objective on the Non-Communicable Diseases (NCD)as new feature in the KHSSP. o Reviewed the current status and challenges of various health systems building blocks (health service delivery, human resources, infrastructure, health products and technology, HMIS and leadership and governance). Δ The challenges of health financing in the sector (resource adequacy, equity and efficiency n resource use,) are well described in KHSSP (section 5.6). The situation analysis is also available in other documents: situation analysis done 2010 for Kenya health policy, the technical working group reports and other government reports. The sector has also detailed analysis of sector financing trends and challenges in the MTEF framework 2012/13-2014/15[9]and the government's projections for financing in the Budget Review and Outlook paper[10]. Furthermore, health-financing issues were also analyzed in the draft health financing policy and strategy papers.[11]. The analysis clearly identified the major issues around the health financing. *Attribute 2: Clear goals, policies, objectives, interventions and expected results are defined* Δ Vision, Goals and Mission of the KHSSP has been well defined and are derived from the Vision 2030 and the Kenyan Health Policy 2012-2030.There is very high coherence between the KHP and the KHSSP in terms of priorities and objectives (six health outcomes and seven investment priorities). Δ KHSSP has a well structured and internally consistent definition of impact, outcome, output and investment (input) targets-described in different chapters of the document. The planning

[9] Health sector working group, October 2012,

[10]Ministry of Finance, September 2012, Budget Review and Outlook Paper

[11]

framework used has enabled such coherence to come out strongly.

- Δ With an exception of the few numbers, most of the impact, outcome, output and input targets are time bound with clear definition of their baselines, targets annually at mid-term and end of program period. Each of the six health outcomes and seven investment areas has own targets and priority interventions. In service delivery there are services that the KHSSP targets to eliminate, contain conditions and expand access. There are target for underserved groups like congregated areas, at risk population, including people with disabilities and hard to reach areas.
- Δ The Kenya essential package of health (KEPH) was revised to become more comprehensive and its service delivery mechanism regrouped from six to four tiers of health system. It now includes non-communicable diseases within the package.
- Δ The KHSSP has a well thought out conceptual framework with a goal of universal coverage and clear targets, objectives, functions, institutional mechanisms and sources of funding. It has also shown priority areas of investment and measures of success for the plan period. It outlined strategy to scale up output based financing mechanism to promote efficiency of resource use.

Attribute 3: Interventions are feasible, appropriate, equitable and based on evidence

- Δ The six policy objectives address the overall disease burden (morbidity and mortality) in the country.
- Δ Experiences with implementation of the KEPH during NHSSP II have been analyzed and updated against the background of the devolution and the new KHP
- Δ KEPH interventions have been brought under each of the 6 policy objectives by level of care and by cohort (p. 19ff), thus facilitating its implementation at the county level.
- Δ Annual KEPH targets for each of the 6 policy objectives have been stated (p. 20/21)
- Δ Proposed interventions have been tested, are effective and relevant to respond to the country health needs.
- Δ The devolution will allow even more flexibility in their implementation, based on the specific county context.
- Δ The details of KEPH implementation by level and by cohort for each of the 6 policy objectives provides useful details of the intended interventions that will be undertaken
- Δ KHSSP addresses systems that will impact on equity and efficiency, mainly through the upcoming devolution to 47 Counties, bringing services closer to the clients.
- Δ Annual output targets specific for access and quality of care (p. 36/37) as part of the KEPH have been defined.

Attribute 4:Assessment of risk and mitigation strategies are included

WEAKNESSES

Attribute 1: Strategy based on sound situational analysis

- ∇ KHSSP itself does not include an overview of the main findings from this situational analysis.
- ∇ KHSSP only summarizes (p7-12) the challenges during NHSSP II implementation
- ∇ It does not draw out the "Lessons Learned" and the implications for the next plan.
- ∇ This omission leaves a gap as there is no clear justification for the choice of the six policy objectives and their interventions
- ∇ KHSSP builds the justification of its objectives not on the situational analysis but on (i) the Constitution; (ii) Vision 2030; (iii) the Kenyan Health Policy and (iv) the end term review of the NHSSP II.
- ∇ There is a 'disconnect' between the situational analysis, the policy objectives and the priorities of

the KHSSP.

- ∇ The strategic direction of the KHSSP is to a large extent the same as the NHSSP II. However, there are a few modifications in the KEPH and in the WHO building blocks (the 7 investment areas);
- ∇ There is nowhere a paragraph that explains what the KHSSP will do different / better than NHSSP II, trying to convince the reader that this KHSSP is likely to achieve its objectives.
- ∇ Several overarching policy priorities are not addressed in KHSSP, such UHC, people-centered systems and community health

Attribute 2: Clear goals, policies, objectives, interventions and expected results are defined

- ∇ Strategic and Investment targets are not annualized.
- ∇ Given the trend of the last five years, many of the stated targets do seem ambitious and KHSSP does not explicitly spell out strategies (except devolution) that all stakeholders will do 'differently' to enhance performance. The target for reducing off budget support from 60 to 5% is not only high but strategies to achieve it have not been set out. The existence of significant resource gaps in the plan also cast doubt on feasibility of targets.
- ∇ Service delivery has many targets but the strategic interventions are not specified like other investment areas
- ∇ There are some targets and strategies whose targets are yet to be specified.
- ∇ There strategy seems too generic and lack guidance on what the major strategic directions will be to mobilize additional resources both from government, specifically with the coming of devolution and two tiers of resource allocation, and from DPs. It is also not clear what strategies are to be used to move towards universal coverage. It is also very thin in the area of public private partnership.
- ∇ The need of county's capacity building to enable them negotiate with county government on resource allocation may be considered for inclusion;
- ∇ The need to formulate a top-down-bottom up planning, budgeting systems and building capacity may be considered as one of the priority in the coming few years.

Attribute 3: Interventions are feasible, appropriate, equitable and based on evidence

- ∇ The revised KEPH is so comprehensive which makes prioritization within KHSSP (vague and sometimes appear unrealistic.
- ∇ Because the norms and standards for the revised KEPH is to be developed, the feasibility of the interventions remains uncertain as the inclusion of non communicable diseases imply among others improved investment on tertiary care and for which no clear strategic direction is spelt out. The KHSSP includes the community level (L1) without making it operational. Community health has been given a very low priority.
- ∇ Dispensaries and health centers (HC) provide different services and should not be merged together under Level 2.
- ∇ The linkage between the KEPH essential health services (section 3.4) and the interventions by the various programs has not been analyzed and addressed.
- ∇ A few important services have not been included in the proposed essential services or in the prevention of health risks (Nutrition)
- ∇ By separating essential interventions (3.4) from health promotion (3.5), service provision will increasingly become more curative oriented and thus less effective in the longer run.
- ∇ The section on multi-sectoral interventions (3.6) does ably list the other ministries that have impact on health but does not spell out the strategies and interventions that will be

implemented as part of KHSSP to enhance multi-sector interventions.

- ∇ While there are general statements on enhancing equity and efficiency in KHSSP, the interventions to achieve these aims are not spelt out clearly. Implicitly, the KHSSP assumes that the devolution to the counties will address concerns such as geographical and economic barriers to access and use of services
- ∇ There are no contingency plans for health emergencies included in the KHSSP

Attribute 4: Risk assessment and proposed mitigation strategies

- ∇ There is not risk assessment of possible obstacles to implementation and the inclusion of mitigation measures included in the KHSSP

IMPLICATIONS FOR SUCCESSFUL IMPLEMENTATION

Attribute 1: Strategy based on sound situational analysis

- The poorly defined relation between the available, relevant situational analysis and the absence of a selection of clear priority areas (and flagships) has left the KHSSP without a solid basis for the choice of its most important interventions and targets.

Attribute 2: Clear goals, policies, objectives, interventions and expected results are defined

- There is no clear relation between Vision and goals with the policy objectives of the KHSSP.
- The target values of most indicators have been set (unrealistically) high.

Attribute 3: Interventions are feasible, appropriate, equitable and based on evidence

The overall priority of the KHSSP is service oriented and not community oriented. The proposed expansion of infrastructure and staff will likely increase costs without necessarily improving health. Much will depend on how the County health teams define their priorities and direct their resources

Attribute 4: Assessment of risk and mitigation strategies are included

From this version of the KHSSP it is not possible to make an assessment of the likelihood of a successful implementation of the KHSSP.

SUGGESTED ACTIONS

Attribute 1: Strategy based on sound situational analysis

- ⇒ The section on situation analysis could be strengthened much more than it is now. It should justify explicitly the new health priorities of the KHSSP with the consequences for the program interventions and allocation of resources. It should also provide an explanation about what worked and what did not in NHSSP II to guide better focus and programming.

- ⇒ Define the very high priorities of KHSSP that could be a flagship programs in the next five years.

- ⇒ Define specific measurable objectives for some of the six policy objectives (specifically those linked to non-communicable diseases.
- ⇒ Review the targets of to make them more realistic.
- ⇒ Expand the section on community health within the KEPH, providing guidance to the counties how they should implement their community health related activities
- ⇒ Make a distinction in the text and the tables between dispensaries (L-2A) and Health Centre (L-2B)

⇒ Address explicitly in section 3.4 the operations to be undertaken as part of the KEPH and those implemented by the programs (Sexual and Reproductive Health, HIV/AIDS, TB, Malaria).

Prepare a risk assessment on the possibility of an effective implementation of the KHSSP, including the mitigation measures for each risk identified: suggested topics could be:

- Effective devolution in place mid 2013.
- Financial resources available in time
- Good collaboration between National and county health authorities
- Planning, budgeting and reporting harmonized
- Development Partners actively engaged

2.2 Process

Process Soundness and inclusiveness of development and endorsement of HSSP III
STRENGTHS
Attribute 5: Multi-stakeholder involvement in the development and endorsement of KNHSSP and its annual work plans Δ Seven working groups were established (from various programs from the two ministries and DPs) that have worked on the various chapters of the strategy Δ A core team from the two ministries consolidated the Strategy and the investment plan and presented it to the internal stakeholders where participants reviewed the plan. The strategy was revised to reflect comments received from the internal review. Δ The revised draft was presented to the external review (in which 34 government 25 DPs and 5 IPs were represented). The Ministry of Planning also felt involved. The comments of the external review will be incorporated together with JANS comments once this process is concluded. *Attribute 6: High level Political Commitment* Δ KHSSP is aligned with the Kenya Health policy, which in turn is aligned to Kenya's vision 2030. The strategic plan targets were developed with a vision to help Kenya achieve the health status of middle-income countries. Both the policy and the strategy are focusing on the six service delivery outcomes and the seven investment areas. *Attribute 7: Coherence with higher and lower level strategies and plans* *The KHSSP has been informed by several policy level documents such as vision 2030, KHP.*
WEAKNESSES
Attribute 5: Multi-stakeholder involvement in the development and endorsement of KNHSSP and its annual work plans ∇ Overall there is weak participation from lower levels and non-state actors. Although some provinces reported to have been engaged, there is weak involvement of lower levels at the moment and is planned to happen after the election and establishment of counties. Although the steering group reached out for participation to private sector coordinating institutions (HENNET and KEPSA), there is very limited involvement of members of these stakeholders. This is mainly due to inefficiency in communication as well as the weaknesses of the umbrella organization to bring their members on board. As result, the buy in by the non-state actors and lower levels to the KHSSP's overall directions and targets is uncertain. The effectiveness of the working groups varies a lot but was in general been weak as an instrument to bring programs and other stakeholders on board. The strategic plan is not clear about the public private partnership directions to be taken in the next five years. *Attribute 6: High level Political Commitment* **'Known-unknowns'** affected the content, quality and process of the strategic plan: ∇ Implication of the veterinary sector in the future MOH structure and on the strategy itself ∇ Because of a lot of unknowns in the implementation of the devolutions, the strategic plan is too generic in its strategies for strengthening the country health systems and coordination with the national level. Clear strategic interventions to take the sector forward are yet to be

spelt out

- ∇ A parallel process is currently is on going to develop medium term health plan as per the requirements of the Ministry of planning. The sector needs to come out with clear flagship program from KHSSP and also include some of the major omissions (targets for reducing inequality by genders and by location; mainstreaming climate change and gender) in to the KHSSP. It may benefit from having one strategic plan with a chapter devoted on the flagship programs. The strategy is hoped to guide the alignment to County Strategic Plans when they become to being- but it is not time to assess this.
- ∇ While there are areas of activities directed at strengthening regulations (establishing FDA), strategic action for taking the regulation of premises, professions, products and practice not clearly spelt out. This is clearly important now with the devolution as development of standards and enforcement by all counties will be an important area of challenge.
- ∇ The national commitment on the share of the health sector from overall government spending is stagnating at about 7 % at best and according to the BROP it will increase only up to 8.1% by 2015. While the KHSSP is fully in line with these projections, it increased this share to 12% in two years after 2015.
- ∇ KHSSP in its current form does not explicitly include efforts that the two Ministries are working to get cabinet approval. These include efforts on establishing Kenya Health Service Authority, Council of professionals, National ambulance service, transforming NHIF into National Health Insurance Fund.
- ∇ The new constitutions clearly brought veterinary Services as part of the health sector. The implication of this inclusion to the structure of the MOH and the strategic plan is unclear.
- ∇

Attribute 7: Coherence with higher and lower level strategies and plans

- ∇ The various sub sector strategies have their own strategic plan with different time frame, vertically organised and with different costing and financing estimates. It is therefore essential that the leadership of the two ministries issue a circular to guide all programs to develop aligned subsector strategies within a specific period of time.

IMPLICATIONS FOR SUCCESSFUL IMPLEMENTATION

Lack of political leadership will result is poor ownership and leadership by government. Weak participation will negatively affect buy-in by all actors to the new shifts and strategies envisaged. These will affect implementation of the plan. Alignment with higher government wide objectives and frameworks and subs sector strategies on the other hand will facilitate the implementation of the plan. Challenges related to commitment, ownership, buy-in and alignment to national and sub sector strategies have to be addressed if KHSSP is to generate the needed health impact.

SUGGESTED ACTIONS

1. Expand the space for meaningful policy dialogue and create national consensus on sector strategic priorities: this can be achieved through:
   - ⇒ Reinforcing the core team and the technical working groups**.**
   - ⇒ Enabling HENNET and the KEPSA (assisting them in covering the cost) to call a meeting of their members to have a common position on strategic directions. These should help strengthen some strategic interventions that will foster public private partnership in the

coming five years, including setting out clear responsibilities and deliverables on both sides.

⇒ Engaging the top management of the two Ministries to show the necessary leadership and help build ownership on the plan by all the programs and SAGAs.

⇒ Working with some implementing partners with specific experience and expertise on some investment areas (HR and health care financing for instance) to help incorporate some of the "how' issues that are currently missing in the plan.

2. Finalize a devolution road map with its cost implication in collaboration with the transitional Authority and include it as a section in the strategic and investment plans. This may include some of the systems strengthening and capacities that need to be built in the coming five years, including planning and budgeting process, coordination and sector stewardship and joint decision-making.
3. Include in the strategic plan all the MTP requirements (e.g., flagship programs at national and county levels, projects to be funded through PPP, risk and its mitigation measures) and ensure the sector has one medium term plan for the coming five years.
4. While the draft final strategic plan may be developed, ensure that there is consultation and buy-in from the Counties before finalizing the plan. Provide a window of opportunity for revising the strategic plan to incorporate some of the valuable feedbacks to be generated from the counties.

2.3 Cost and Budgetary Framework

Costs and Budgetary Framework Soundness and feasibility
STRENGTHS
Attribute 8: Expenditure Framework including comprehensive budget/costing Δ Overall, the costing framework does match the planning framework. The costing is in line with the strategic objectives and seven investment areas, although one of the investment areas (governance and leadership) is yet to be costed. It also costed the various programs-(HIV, AIDS, Child health, etc.,)-which could help understand how much it will cost to achieve some of the priority services and programs. Δ The costing depended heavily on the different interventions outlined in the revised KEPH to generate the resource requirements for each of the services. This implies that it takes into account the departures of the KHSSP from NHSSP. Δ Different programs were involved in providing the necessary information (interventions, baselines and targets as well as documents for unit costs) to help the costing team generate the estimates. Attribute 9: Realistic budgetary framework and funding projections Δ The projections include GOK and DP Contributions. Requests for contribution of DPs were sent out. 8 out 20 DPs provided their projections while twelve DPs are yet to provide their financial projection. This effort needs to be enhanced. Shadow budget has served to project the resources from the development partners.
WEAKNESSES

Attribute 8: Expenditure Framework including comprehensive budget/costing[12]

- ∇ Although the costing tool uses bottleneck analysis in its framework, there is no trace in KHSSP that bottleneck analysis is done and guided the planning and costing processes.
- ∇ Uncertain cost estimated: Of all the service delivery areas, the costing of the non-communicable diseases, violence, injuries and risk factors and health related sectors were challenging due to two reasons; (i) the evidence on the cost effective intervention is very limited; and (ii) even for those interventions included in the costing exercise, there was lack of information on baselines and unit costs. This makes the cost estimates of these strategic interventions uncertain. The comprehensiveness of KEPH (i.e., lack of prioritization) as well as the lack of revision of the norms and standards associated with the revised KEPH, posed a challenge for the costing o the strategic plan. Given that the unit costs are based on what is currently collected from the programs, this is likely to understate the cost of KHSSP.
- ∇ No validation meeting was carried out between the costing team and program to validate the targets, assumptions and unit costs. It is therefore likely that there is inconsistence between the targets used in the KHSSP and what is costed and also in the unit costs used. The JANS team was able to notice some inconsistencies between the targets used in costing what is in KHSSP as a target. It is therefore necessary for the costing team to work with the various TWGs, in addition to programs; to ensure that what is costed is KHSSP and not the various subsector programs like child, maternal health or HIV/AIDS.
- ∇ Gaps in costing alignment to budgeting process: Government budgets are allocated as recurrent or development budget and the costing estimates should be aligned to this basic requirement. Therefore the cost estimate need to show development and recurrent resource requirements to help not sector to budgeting in the next few years but also to monitor adherence to the requirement that 30% of government budget be spent on development budget. It is also helpful if costing also reflects the requirements at the national and devolved structure, once agreement is reached on functional unbundling. Tiers of costing (levels of care) are different in their definition and costing chapter.
- ∇ The cost estimates do seem only to capture public sector costs and the strategic plan is sector strategic plan. The major assumptions used in the costing model are not explicitly presented in the document. Furthermore, cost estimates are not projected based on different levels of ambitions (low, medium and high) –scenarios- to allow programming during the implementation process.
- ∇ The six strategic objectives do not seem to be mutually exclusive. There is no clarity on the dividing line between communicable, non-communicable diseases and basic services on one hand and non-communicable, injuries, and etc., on the other hand. It is therefore uncertain how the overlaps between these disease areas are costed and how the health systems commonalities taken into account are controlled.

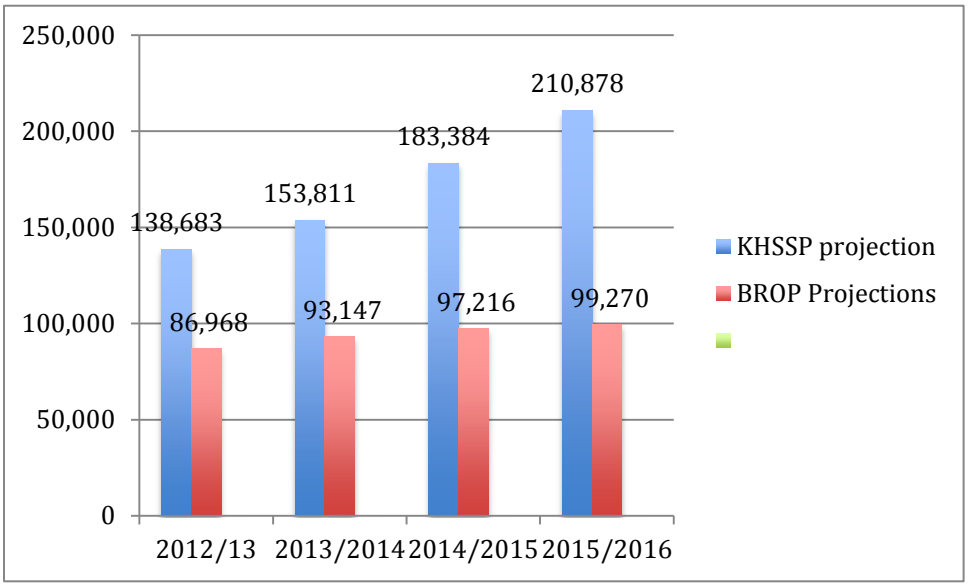
Attribute 9: Realistic budgetary framework and funding projections

- ∇ The resource projections shown in the KHSSP is limited to GOK and DP contributions. Cost sharing and NHIF, which accounted for about 13 billion birr in 2011, was not included as sources financing for the sector. The contribution of the NHIF is expected to grow to more than 22 billion per year in 2015.

[12] The JANS team was provided with some of the costing outputs (unit costs by intervention) generated from the tool. However it was unable to access methodology, the assumptions and to verify the targets used in costing against the targets set in the document.

- ∇ KHSSP by and large includes service delivery activities of private sector contributions. However, in terms of financing, the contribution of private sector (CSO and private sector) in isn't included. This understates the health investments of the sector.
- ∇ While there is a BROP that projects the contribution of the GOK to the health sector to 2015, the costing sections state that it is based on the projection of the last two years achievements. The divergence between the KHSSP and BROP projections range from 59% in 2012/13 to 112% in 2014/15 as shown in the figure below.

KHSSP and BROP projections on GOK contribution



Source: BROP September 2012 and KHSSP.

- ∇ Health financing strategy that aims at increasing availability of funding through various innovative mechanisms have not been dealt in the detail that it deserves (universal coverage strategies, performance based financing; public private partnership, etc.). The resources projections by the NHIF for financing are not included. How to address equity was not clear except general statements
- ∇ Resources projections in a devolved environment would add value if done by the two levels of government: national and county.
- ∇ The resource projections need to provide scenarios (base case, medium and high scenarios.
- ∇ Work out the financing areas by broad program areas to see the inequalities among the different program areas.

IMPLICATIONS FOR SUCCESSFUL IMPLEMENTATION

The uncertainty about feasibility cost estimates cast doubt on the feasibility of achieving the plan. Proper financial projection about future availability of funding will create confidence for both the leaders and partners to exert the necessary effort.

SUGGESTED ACTIONS

- ⇒ Ensure key strategic actions are included to develop and implement health Financing strategy in the next five years. Some of the recommendations from the NHIF include: enhancing universal coverage with a target of having at least 68% coverage by 2017 which may be achieved through: Public Education, Awareness and Advocacy on importance of Health Insurance (to commence ASAP); finalizing the Healthcare Financing Strategy by June

2013; Establishment of the Health Benefits Regulatory Authority by August 2013; Establishment of an Access and Equity Fund for financing indigents and difficult diseases by Sept 2013; Enhance Efficiency of NHIF (by implementing recommendations of the IFC Strategic Review); Legislate for mandatory Insurance (Every Kenyan to belong to a health plan) by March 2014; (2)There is also need to have the role of demand-side financing clearly highlighted to ensure that the financing gap for health services that is already existing and that may arise as a result of devolution is addressed. The role of Prepaid health insurance should be considered in line with more operational autonomy for public sector healthcare providers; (3) Encouraging more investment in the sector by creating incentives could also have a positive bearing for the health sector during the plan period. These should be discussed with Treasury for buy-in; and (4) adequate financial resources should also be directed to lower level facilities to strengthen the Referral System.

- ⇒ The service delivery TWG may consider prioritizing KEPH and/or explore whether there is an overlap among the six strategic objectives to help the costing TWG to base its estimation on solid ground.
- ⇒ Address the weaknesses of costing and financing estimates through a broad and active participation of all stakeholders.
- ⇒ Better articulate and strengthen the fiscal space analysis by including cost sharing, NHIF resources into the projection.
- ⇒ Advisable to have different scenarios of costing (different levels of ambition-low, medium and high) and costing (different assumptions of growth of government and donor resources). This will help the strategy to relate the ambition in targets to what is available during operational planning.
- ⇒ Advisable to have financing gap analysis by program objectives and investment areas to guide future resource allocation.

2.4 Implementation and Management

Implementation and Management Soundness of arrangements and systems for implementing and managing the programs contained in the national strategy
STRENGTHS
Attribute 10: Operational plans detail how the strategy will be achieved Δ Mechanism to develop and support operational plans has been in place prior to the development of the plan Δ Roles and responsibilities, in the context of devolution, are well described both for the national and county levels Δ Annual planning and monitoring timelines are provided for both national and county levels *Attribute 11: Describes how resources will be deployed to achieve outcomes and improve equity* Δ CRA has developed resource allocation criteria (Population 45%; basic equal share 25%; poverty index 20%; land area 8% and fiscal responsibility 2%)[13] and submitted to cabinet for approval. This will transfer about 33% of the resources to county governments. Further more, the PFM states that overall government wide 30% of resources should be invested on development programs Δ An overview of organization of health service delivery is provided with the four-tier system: National referral services; Country Health Services; Primary Care Services; and Community Health Services Δ Functions for each level are well described and the targets for priority investment areas are provided Δ The strategy provide annual investment targets for the five year period and the principles of equity and efficiency are mentioned to underpin the health investments Δ The strategy caters for provision of the KEPH to special settings (congregated settings, et risk populations and hard-to-reach areas, thus addressing equity concerns *Attribute 12: Adequacy of institutional capacity* Δ The strategy provides a synthesis of issues regarding current status of HR in terms of distribution, attraction and retention, institutional performance and training capacity building Δ The HR in place and the required HR for the new plan are provided, hence giving an insight of the gap to be filled Δ The strategy addresses support of lower levels with tools and guidelines, orientation of health staff and operations and logistical support, including supportive supervision *Attribute 13: Financial management and procurement* *Based on document review* *Attribute 14: Governance, accountability, management and coordination mechanisms* Δ Sector leadership framework is well described and definitions of partnership, stewardship and governance, the responsibilities of the MOH, the County Health Departments (CHMT and CHSF), the County Health Facility management Teams (Level 2), the Semi Autonomous Government

[13]CRA, August 2012, Recommendations on Sharing of Revenue Raised Nationally Between the National and County Governments for the Fiscal Year2012/2013.

Agencies (SAGA), the legal / regulatory bodies (based on the KHP) and other ministries and institutions involved in the sector spelt out.

- Δ Over the last years, the two Ministries (MOMS and MOPHS) have done a commendable job in providing regular annual operational plans (AOP) and annual reports, providing updates on new developments, oversight over the performance of the lower levels and reporting on relevant indicators (against targets)
- Δ After the elections, the two Ministries (MOMS and MOPHS) will be merged into one MOH.Fortunately, they have been able together to enforce important government policies and keep one information management and one AID effectiveness agenda.
- Δ KHSSP is giving priority to the private for profit sector, more than to NGO/CSOs/FBOs
- Δ The various functions and responsibilities of most of the future institutions of GOK have been well described, both at the level of MOH (p. 101-103) and at the County level (p. 104-105)
- Δ The planning and budgeting process has been well aligned with the national budget timeline of GOK, the MOH and the County time frames.

WEAKNESSES

Attribute 10: Operational plans detail how the strategy will be achieved

- ∇ Not clear what mechanism will be put in place to ensure linkage of the county operational plans to the national strategy

Attribute 11: Describes how resources will be deployed to achieve outcomes and improve equity

- ∇ The horizontal allocation will create cash rich[14] and cash poor Counties, and this will have impact on health sector allocation at the county levels. This is generally not well reflected in the plan.
- ∇ How program resources are going to be allocated, given the PFM proclamation and the nature by which some of the resources are going to be mobilized, is not yet clear and as a result KHSSP doesn't say much about it.
- ∇ Referral is mentioned with its four elements for operationalization but there is no defined plan to improve the referral system
- ∇ It is not clear on what basis the resources to be invested are arrived at and whether they are linked to the priority investments
- ∇ No clear allocation criteria of resources across levels and between different actors
- ∇ Although non-state actors are said to play a significant role, it is not clear how they will be appropriately resourced.
- ∇ Very little is mentioned about the status of the logistics management system and how to improve it
- ∇ There is no quantified assessment of medicines, materials and equipment to allow identification of specific gaps
- ∇ Despite the mention of maintenance of infrastructure and equipment, it is not clear what approaches will be adopted to bring this about.

Attribute 12: Adequacy of institutional capacity

- ∇ The basis for computing the required HR for the new plan is not clear
- ∇ The plan requires five to six times the current number of HR in the 5 year period, raising

14

feasibility issues (Are these numbers available, can they be absorbed?)

- ∇ Strategy does not mention of the mechanisms to adopt for improving HR production
- ∇ Strategy does not describe how support for planning and budgeting will be provided given the devolved context
- ∇ The strategy has not analysed the technical assistance needs and neither has it come up with a technical assistance plan

Attribute 13: Financial management and procurement

Component of PFM[15]	Main gaps identified
Funds flow	The slow flow of project funds through GOK systems has been the single biggest obstacle to project implementation in Kenya, leading to a number of DPs bypassing the GOK systems. As a result, the on-going major reforms in this area, including the operation of CBK-based Treasury Single Account, the requirement for new projects to have their accounts at CBK and the move to eliminate redundant bureaucratic funds flow procedures, are expected to significantly improve overall project turn-around
Internal control	Despite having the necessary legislation and policy in place, Kenya has not scored very well in the fight against fraud and corruption involving public funds. Repeated cases of open breaches of established regulations and controls, records falsification and manipulation, as well as limited Government action on reported fraud/corruption cases have all diminished DP confidence in the use of Government oversight, governance and control arrangements for their projects.
Financial reporting	Financial reporting in Kenya is presently fragmented and with a fair amount of duplication. As in budgeting and accounting, the full implementation of IFMIS is expected to be a key milestone in securing an acceptable single integrated financial reporting framework for both GOK and DP operations. IFMIS is also expected to facilitate GOK's progressive compliance with IPSAS and enhance the acceptability of DP projects' end-year financial statements being prepared as part of the line ministry's comprehensive financial statements
External audit	Government external audit arrangements have undergone significant improvements in the recent past. However, there still exists ample room for more improvement in the effectiveness of the annual audit through deliberate reduction of duplication of the audit effort and sustained capacity strengthening of the SAI (OAG

[15] MOF and Development Partners, 2012, KENYA: Report on the Review of the Use of Country Financial Management Systems by donor Financed projects- FY 2011/12

Attribute 14: Governance, accountability, management and coordination mechanisms

- ∇ While the coordination and partnership frameworks and role and responsibilities are defined, the strategies to strengthen them and make them work better are not described in KHSSP.
- ∇ There are no targets set for the leadership and governance section to achieve in terms of fostering ownership, alignment, and harmonization as well as for the regulatory institutions to set and enforce standards.
- ∇ With the elections still some 6 months ahead, the vertical and horizontal coordination between National and County Health structures remains to be put into reality.
- ∇ At the implementation (county) level, the relation between County Health Services and programs still need to be clarified.
- ∇ The coordination mechanisms between MOH and DPs (p. 107) have been rather dormant for some time. With the new devolved structures, there is an opportunity to make the national structures lighter and more functional.
- ∇ The structures for SWAp and Aid Effectiveness exist, but their performance leaves to be desired. Only 2 DPs are actively engaged in this agenda. The MOH is encouraged to strengthen its AID Effectiveness agenda in the next version of the KHSSP.
- ∇ Voice and accountability of the population (p. 98) has not been well defined or operationalized.

IMPLICATIONS FOR SUCCESSFUL IMPLEMENTATION

- ∇ The successful implementation of KHSSP III will very much depend on how well the county governments are engaged and supported in planning and operationalization of the strategic plan in a devolved context
- ∇ Realization that the success of this plan will rely on harnessing the contributions of all stakeholders (state, non-state, private sector, etc.), and on clear understanding of their roles and functions and the requisite resources
- ∇ Non-objective basis for the required health investments will jeopardize the achievement of the objectives of the plan
- ∇ Capacity at county level will initially be limited and will take time to be built and this will have a bearing on the performance of the counties in implementing the plan

SUGGESTED ACTIONS

- ∇ Rapid engagement with the Transition Authority on agreeing on a roadmap for devolution of health functions to the county government, clearly defining the interim roles each level will play.
- ∇ Roles of all stakeholders, including private sector, CSOs, other government sectors should be clarified and their engagement, including resourcing made more explicit
- ∇ Greater efforts should be made to base estimation of health system investments on the actual gap required to achieve the set targets, make realistic investment targets and ensure coherence across the health investments.
- ∇ Capacities of counties should be assessed, gaps identified and relevant technical assistance procured or provided, until capacity is fully built.

2.5 Monitoring, Evaluation and Review

Monitoring, Evaluation and Review Soundness of review and evaluation mechanisms and how their results are used
STRENGTHS
Attribute 15: The plan for M&E is sound, reflects the strategy and includes core indicators, sources of information, methods and responsibilities for data collection, management, analysis and quality assurance Δ The M&E plan describes the indicators with their baselines and targets for impact, outcome, output and input/process Δ The data sources are mentioned for each indicator and most sources are routine/country based sources Δ The M&E plan introduces the idea of using a composite index which could provide for easy comparisons Δ The plan is innovative with the Annual State of Health in Kenya and its popular version, in addition to the annual health sector performance report, quarterly performance review reports and AWP report and dissemination through different communication channels. *Attribute 16: There is a plan for joint periodic performance reviews and processes to feed back the findings into decision making and action* Δ The plan intends to undertake joint performance reviews at all levels (community, sub-national and national) Δ The plan takes on the recommendation from the MTR of KHSSP II to strengthen policy dialogue at sub-national level to engage civil society and partners in the planning and sector review processes Δ A district/constituency stakeholders' forum is suggested to receive reports from primary care facilities and DHMT. Δ Actionable recommendations are targeted from assessment and review of performance with recommendation implementation tracking plans
WEAKNESSES
Attribute 15: The plan for M&E is sound, reflects the strategy and includes core indicators, sources of information, methods and responsibilities for data collection, management, analysis and quality assurance ∇ The indicators are many (close to 100) ∇ The indicators within a policy objective, though said to remain fixed in number, are indicated to change (use different indicator) during implementation ∇ No annualized targets for the indicators ∇ The composite index is yet to be defined and its interpretation is yet to be understood ∇ The M&E plan in the strategy does not describe how and when the data for the indicators would be collected (However, it is said to be well described in a separate M&E framework document) ∇ Data gaps and how they will be addressed are not well brought out. ∇ Not clear how data from the private sector will be captured/integrated into the national HIS. ∇ The roles and responsibilities in M&E, other than M&E units are not defined, especially for data collection, analysis and use

- ∇ It is not clear how the capacity of the M&E units at county levels will be built or strengthened.

Attribute 16: There is a plan for joint periodic performance reviews and processes to feed back the findings into decision making and action

- ∇ Although the plan cites the recommendation of the MTR of KHSSP II to reform the JRM to become bottom up both in information generation and dissemination, it does not describe how it will be achieved in KHSSP III.

IMPLICATIONS FOR SUCCESSFUL IMPLEMENTATION

- Too many indicators could be difficult to follow if the capacity for data collection, analysis and reporting is limited, especially with new county structures, yet to be put in place.
- A composite index , if not clearly interpretable by all stakeholders at all levels, could be a deterrent, especially when used to rank performance
- The ability of the counties to collect and handle data will be crucial for the success of the performance monitoring and review
- Feedback to lower levels regarding performance based on information they generate would help these levels to improve their performance

SUGGESTED ACTIONS

- Efforts should be made to come up with a smaller set of core indicators for overall sector performance
- A deliberate plan should be put in place to build capacities of the counties, especially in planning and management
- Given the need to work with counties to develop a sector annual working plan, the timeline as well as the process of annual planning and budgeting process may need to be revisited.
- Mechanisms for regular feedback should be included in the plan and the feedback should be as simple as possible for all to understand.

3 Annexes

3.1 TOR for conducting a Joint Assessment of the draft Kenya Health Sector Strategic Plan, KHSSP

Background

The Health Sector has been interpreting the 2010 constitution since August 2012. A Health Sector position paper was initially developed that articulated the proposed sector direction to address the emergent constitutional imperatives. Since then, with guidance from the health sector position paper, the Country has enacted a number of enabling laws to facilitate translation of the constitution. In addition, the Health Sector has defined a new Policy Direction in the Kenya Health Policy, 2012 – 2030 that outlines the Country's long-term imperatives in attaining the overall Health goals for Kenyans.

Since January 2012, the Health Sector has been undergoing a process to define its Medium Term objectives and priorities. This process has culminated in a draft Kenya Health Sector Strategic Plan, for the period July 2012 to June 2017. This plan highlights the sector medium term Health Service Objectives, plus the investment priorities the sector needs to prioritize in order to attain these health objectives. It is designed as a plan around which all health sector support – public, donor, and private – are intended to rally around during the coming 5 years. It marks the first time that the Government is providing all Health Sector actors with a single plan to facilitate alignment of all sector efforts, in line with the principles of the 2005 Paris Declaration on Aid Effectiveness.

As a final stage before formalization of the plan, the Government is proposing to have an independent assessment of the content and process of the KHSSP. This should review the level of inclusiveness in its development, and its comprehensiveness in covering the important elements needed to appropriately implement the Kenya Health Policy. The recommendations from this process will be incorporated into the strategic plan finalization process. It is anticipated that this shall build the confidence of all health sector actors to actively Align behind the strategic plan during its implementation. These Terms of Reference are designed to guide this independent assessment process.

Objectives

The overall aim of the independent assessment is to review the content, and development process for the KHSSP to ensure they have met expectations of different actors in health. Specifically, the assessment will:

- Assess the comprehensiveness of the content of the KHSSP in terms of its implementation of the Kenya Health Policy imperatives
- Document the process of elaboration of the KHSSP, and make recommendations on any additional process issues the sector needs to address prior to formal launch of the plan
- Develop a shared understanding of the KHSSP amongst all sector actors, including its strengths and weakness
- Provide guidance to health sector actors on how to support and fund the strategy
- Assess adequacy of the KHSSP to provide guidance to program-based investments

It is expected the assessment will provide independent evidence, and where needed guidance, of the soundness of the KHSSP content and development process. It shall enhance the quality and relevance of the KHSSP as a strategy development tool to help build confidence in the process and content of the strategy. It is also expected that the assessment shall contribute to funding decisions and ensuring that funding is closely aligned to the national strategy to help potential funders decide how much confidence they have in the strategy and thus how to support it. It is finally anticipated that by conducting the assessment, the Government shall reduce transaction costs associated with different independent

assessments of its strategic approach requested by different sector actors by having one process to review the plan.

Methodology

This independent assessment shall be based on the methodology of the Joint Assessment of National Strategies (JANS). The JANS is a tool and process to assess the quality of a strategic plan prior to, during or at completion of development of the plan. Its benefits are shown in the table below.

Benefits of a JANS assessment

Benefits for Government	Benefits for partners
Enhanced quality of strategy	Greater confidence in strategy and systems for implementation, so fewer agency–specific processes, lower transaction costs
Facilitates more partners to go 'on plan'	Opportunity for consultation
More streamlined processes for getting funding approved	Joint agreement on approaches to address weaknesses, leading to a more effective, coordinated response
More use of shared reporting processes	
Leads to lower transaction costs; longer term, more predictable funding, better implementation	

The JANS will be carried out by a mix of sector actors. It is expected that each of the recognized sector constituents shall contribute to the JANS assessment – Government, non state actors, and external actors, each of whom would assess the content of the plan relative to their constituents, and assess adequacy of the process as seen by a different constituency. To ensure independence of the JANS team, it shall be led by at least two external persons to guide and coordinate the process.

Members of the JANS team

Constituent	Source	Requirements	Role
Independent assessors (3)	External to Kenya	Have positive experience in JANS assessments process and methodology Have some knowledge of the Kenya Health System	Provide overall leadership to process Guide other assessors on conducting, and interpreting the methodology
Government representatives (2)	Selected by Government	Understand expected role of Government actors in development of KHSSP Have knowledge / experience of the Kenya Health System	Assess the content of the KHSSP relating to Government expectations Assess external / implementing partners involvement in the KHSSP development
External Partner representatives (2)	Selected by DPHK	Understand expected role of external partners in development of KHSSP Have knowledge / experience of the Kenya Health System	Assess the content of the KHSSP relating to Government expectations Assess Government / implementing partner involvement in the KHSSP development
Implementing partner representatives (2)	Selected by HENNET and KEPSA	Understand expected role of implementing partners in development of KHSSP Have knowledge / experience of the Kenya Health System	Assess the content of the KHSSP relating to Government expectations Assess Government / external partner involvement in the KHSSP development

The assessment team shall

1) Review all the policy documents of the sector – the Kenya Health Policy, KHSSP, and planned Annual Work Plan framework. This is because different attributes and processes are captured in different documents
2) Hold interviews with key informants representing the different sector stakeholders, to understand contextual issues, and understand their perceptions on quality of the KHSSP
3) Hold, where needed, meetings / workshops with stakeholders to collect joint feedback and recommendations groups of stakeholders may have on how to strengthen the KHSSP prior to its launch in November

The assessment will be done based on **5 groups of generic attributes** considered the foundation of a sound national strategy, each with clear attributes (see Annex 1). These five generic attributes are:

- **SITUATION ANALYSIS AND PROGRAMMING** Clarity and relevance of priorities and strategies selected, based on a sound situation analysis
- **PROCESS** Soundness and inclusiveness of development and endorsement processes for the national strategy
- **COSTS AND BUDGETARY FRAMEWORK FOR THE STRATEGY** Soundness and feasibility
- **IMPLEMENTATION AND MANAGEMENT** Soundness of arrangements and systems for implementing and managing the programs contained in the national strategy
- **MONITORING, EVALUATION AND REVIEW** Soundness of review and evaluation mechanisms and how their results are used

For each of these, four areas will be reported on, relating to each of these attributes:

(1) Identified Strengths in the KHSSP;
(2) Identified Weaknesses in the KHSSP;
(3) Implications for Successful Implementation of the plan; and
(4) Suggested Actions the sector should consider, prior to launch of the KHSSP in November

Milestones and reporting

The assessment shall be conducted over 2 weeks, starting 22 October 2012. The milestones in the process are shown in the table below

KHSSP Assessment milestones

	Sept	**Oct**				**Nov**			
	24 – 30	*01 – 07*	*08 – 14*	*15 – 21*	*22 – 28*	*29 – 04*	*05 – 11*	*12 – 18*	*19 – 25*
KHSSP Stakeholders workshop	27								
Identification of assessment team	29								
Briefing and sharing of documents with assessment team		09							
Sharing inception report by team leader			15						
Formal assessment team briefing				21					
Assessment exercise					22	02			
Sharing of assessment report						01			
Briefing of HSCC, and agreement on completion process for KHSSP						02			
Submission of final assessment report							06		

	Sept	Oct				Nov			
	24 – 30	*01 – 07*	*08 – 14*	*15 – 21*	*22 – 28*	*29 – 04*	*05 – 11*	*12 – 18*	*19 – 25*
KHSSP core team addressing emerging issues								12-16	
Submission of final draft of KHSSP								16	
HSCC endorsement of final KHSSP draft									21

3.2 List of Persons Met

Name	0rganization	Position
Dr Custodia Mandlhate	World Health Organization	WR
Dr Humphrey Karamagi	World Health organization	Health system specialist
Gandham Ramanna	World Bank	
Katie Bignmoe	World Bank	
Joyce Bett	World Bank	
Dr Kiambati	MOMS	TPMD
Dr Maina	MOMS	Planning
Mrs Kimema	MOPS	Head, Human Resources section
Dr David Kima	MOMS	Director mental health
Dr Agutu	MOPS	Deputy Director child health
Rafael Awako	MOPS	Officer
Dr Adelo	MOPS	Program officer
Dr Grace Ikahu	MOPS	SWAP Secretariat
Dr Ruth Kitetu	MOPS	SADMS
Dr Samuel Were	MOPS	TPMD
Dhimn Mungti	MOPS	Officer
John Owar	Ministry of Planning	
Sandra Erikson	DPHK Secretariat	Coordinator
Stephan Wanyee	UNFPA	
Ketema Bizuneh	UNICEF	
Gurumurthy Rangaiaya	UNAIDS	
Rodha Njiguna	DANIDA	
Louis Robinson	DFID	
Maria Francisco	USAID	
Alice Micheni	USAID	
Joyce Kyalo	USAID	
Marwa Fadhili Chaha	NHIF	
Dr Amit	Private sector association	Director
Dr Paul	Private sector	Vice-chair
Thomas Maina	Futures Group	HPP
Robinson Kahuthu	Futures Group	HPP, senior policy advisor
Omar Ahmad	MSH/LMS	
Edwin Mbugua	MSK	
Nober Rakiro	Fun 30 Kenya	
Meshack Ndolo	Capacity Kenya	
Evalene Kebachi	KANCO	
David Karanja	KEC	Catholic health communication
George Okello	CHAK	
Ruth Wanja	HENNET	
Zoddack Okeno	HENNET	
Lucy Ngaya	AKHS-CHD	
Adelaide Khamasi	CPOA	
Lilina Otisa	LVCT	
Anita Msabeni	LICASU Kenya	
Angela Tatoa	FHOK	
Kennedy Mwamzia	FHOK	

3.3. Work Program JANS Kenya

DATE	MORNING	AFTERNOON
Sunday 20.10		?? Arrival Prosper Tumusiime (PT) 12.45 Arrival JC and AA (ET 801)
Monday 21.10	10.00 Meeting Core Team & Briefing (MOH)	
Tuesday		14.30 Meet Costing Team (HSRS) 19.00 Meeting Sam Ongayo (support to Hennet)
Wednesday	09.00 Devolution and HC Meeting (Hilton)	09.00 Devolution and HC Meeting (Hilton)
Thursday	10.00 DP of Health in Kenya (DPHK/Palacina)	12.30 KEPSA 15.00 HENNET
Friday	09.00 Human Resources & M&E 11.00 Medical Products . Infrastructure (PT) 11.00 Service Delivery (AA + JC)	
Saturday	08.00 Departure Prosper Tumusiime	Start first draft
Sunday	Start first draft	Arrival Netsanet (WB) Arrival Mercy Bannerman (UNAIDS)
Monday 29.10	10.00 NASCOP (failed) 11.00 Child Health (all)	14.00 Health Policy Project (USAID) 14.30 Reproductive Health (Mercy)
Tuesday	11.30 UNAIDS (DP)	14.30 NHIF (AA + Netsanet) 14.30 NASCOP (JC + Mercy)
Wednesday	07.00 AID Effectiveness Team (WB &DANIDA) 08.00 MOP	14.00 Costing Team (AA + Netsanet Workie) 16.00 Team to review presentations (ppt)
Thursday 01.11	08.30 Treasury 10.00 Team to review the zero presentation 11.30 Debriefing to Core Team (PanAfrique)	14.00 MTP meeting (PanAfrique)
Friday 02.11	07.00 Debriefing to the sector (PanAfrique)	All stakeholders represented
Monday 05.11	Prepare / discuss First Draft (internally)	
Wednesday 07.11	Submit First draft to Core Team	
Monday 12.11	Receive comments from Core Team	
Thursday 15.11	Finalize and submit the JANS report (second Draft)	