Internal Ex-Post Evaluation for Technical Cooperation Project

conducted by Kenya Office: September 2018

Country Name	Project for Strengthening Community Health Strategy
Republic of Kenya	

I. Project Outline

Background	The Government of Kenya developed the Community Health Strategy (CHS) in 2006 to establish an effective community health service system, develop capacity of community health personnel, promote people's behavior change on utilization of health services including immunization, safe delivery and nutrition, and strengthen linkages between communities and health facilities. On the other hand, the Community Health Units (CHUs) were not established as planned and some of the existing CHUs were not fully functioning. Under such circumstances, the Ministry of Public Health and Sanitation (Restructured to the Ministry of Health (MOH) in 2013) needed to develop necessary guidelines, framework of CHS monitoring and evaluation (M&E), and community-based health information system, and so on, in order to accelerate implementation of CHS in the country.		
Objectives of the Project	Through 1) networking of CHS-related stakeholders, 2) development of guidelines and tools for CHS implementation and M&E, and 3) verification of these guidelines and tools through operational researches, the project aimed at strengthening an evidence-based policy cycle for implementation of CHS, thereby contributing to acceleration of roll-out of effective CHS implementation. Note: CHS was developed in 2006 and revised in 2014 to support implementation of the national health strategy for strengthening the health system at the community level. Its major components include: i) establishment of CHUs, ii) Training of the oversight committee (Community Health Committee (CHC)), health personnel (Community Health Volunteers (CHVs) and Community Health Extension Workers (CHEWs), and iii) Networking of community and dispensaries/health centres as link facilities for the CHUs.		
	Overall Goal: Roll-out of effective CHS implementation is accelerated. Project Purpose: Evidence-based policy cycle for implementation of CHS is strengthened through national capacity development.		
Activities of the project	1. Project site: Nairobi, Kiambu, Embu and Isiolo Counties[1]. 2. Main activities: Development of guidelines and tools for CHS implementation and communication strategy, development of CHS M&E plan, conducting of operational researches, etc. 3. Inputs (to carry out above activities) Japanese Side 1) Experts from Japan: 9 persons 2) Training in Japan: 7 persons 3) The third country training (Ghana): 6 persons 4) Equipment: vehicles, equipment for data management, etc. 5) Operation cost for workshops, materials/equipment, hiring local consultants, etc. Kenyan Side 1) Counterpart Staff allocated: 6 persons 2) Land and facilities: Office space for JICA experts and Kenyan staff, etc. 3) Operation cost for electricity and water services, fuels, etc.		
Project Period	October 2011 to September 2014	Project Cost	(ex-ante) 360 million yen, (actual) 421 million yen
Implementing Agency	Ministry of Public Health and Sanitation		
Cooperation Agency in Japan	Global Link Management, Inc.		

II. Result of the Evaluation

[Special perspectives considered at the ex-post evaluation]
- For verification of continuity of the project effects, continuity of Indicator 2 for the Project Purpose (approval of CHS policy related documents and products) was not confirmed but interpreted by verifying the utilization status of the policy related documents (Indicator 1).
- Indicator 3 of the Project Purpose (number of innovative approaches adopted for CHS based on findings from CHS implementation) did not have a target figure. For verification of its achievement and continuation at the ex-post evaluation, if there was any adopted approach (more than one) at the project completion, it was judged that it was achieved. If any adopted approach has been sustained, it was judged that it has continued.

1 Relevance

<Consistency with the Development Policy of Kenya at the time of ex-ante evaluation and project completion>

The project was relevant with the development policy of Kenya, prioritizing prevention and health promotion and capacity building at the community level for decentralization of health service provision set forth in the "Vision 2030", the "National Health Sector Strategic Plan II" (2005-2012) and the "2nd Medium Term Plan (MTP II)" (2012 - 2017), at the time of the ex-ante evaluation and project completion.

<Consistency with the Development Needs of Kenya at the time of ex-ante evaluation and project completion >

CHU coverage was at 32.4% (2009) and there were needs to develop guidelines and tools for roll out of CHS countrywide. After devolution of health services in 2013, there were needs to strengthen MOH's capacity to perform leading, supporting and checking functions for implementation of CHS. The project was consistent with development needs of Kenya at the time of both the ex-ante evaluation and project completion.

[1] Following the devolution in 2013, former eight provinces were restructured into 47 counties. Counties are divided into sub-counties.

<Consistency with Japan's ODA Policy at the time of ex-ante evaluation>

The "Country Assistance Program for the Republic of Kenya" (2000) identified the health sector as one of the prioritized areas for support Thus, the project was relevant with Japan's ODA policy at the time of the ex-ante evaluation.

<Evaluation Result>

In light of the above, the relevance of the project is high.

2 Effectiveness/Impact

<Status of Achievement for the Project Purpose at the time of Project Completion>

The Project Purpose was achieved. By the project completion, more CHS policy-related documents were developed than planned, and two documents were revised (Indicator 1). Most of these documents were approved or officially accepted by MOH (Indicator 2). Furthermore, eight innovative approaches for CHS implementation were adopted (Indicator 3).

<Continuation Status of Project Effects at the time of Ex-post Evaluation>

It can be judged that the project effects have continued. First, most of the documents and products developed by the project and surveyed at the ex-post evaluation have been fully utilized (Indicator 1). The number of CHUs has increased countrywide, and the training packages for CHVs[2] and CHCs are utilized when new CHUs are established or when CHU functionality is strengthened. Some development partners including Amref Health Africa digitized CHV training materials so that CHVs could learn using their mobile phones. Community Health Assistant (CHA) training curriculum was piloted at Kenya Medical Training College (KMTC) in 2017, and it is planned to be introduced as part of in-service training for CHAs. On the other hand, according to community health-related workers in the visited counties for the ex-post evaluation, the CHS Communication Strategy has been partially implemented. MOH uploaded various materials including the CHS Communication Strategy on the website but has not actively disseminated it to the counties due to budget constraints. The "CHS Brief," a brochure published during the project to show CHS-related progresses and issues has not been newly published and distributed due to the financial constraints. Second, most of the innovative approaches applied by the project have been utilized (Indicator 3). One of the good examples is "participation of CHS field-level implementers in community health conferences and related meetings." In Embu county, CHVs and CHC members participated in seminars on health rights and advocacy and water sanitation and hygiene, and in Garissa county, field-level workers are invited to quarterly dialogues with UNFPA to learn and share experiences. The "role of the Goodwill Ambassador for CHS in advocacy activities" is not specifically targeted, but her roles have been taken over by the officers at the national, county and sub-county levels. There is a plan to identify CHS Champions at the county level who perform the Ambassador's role. On the other hand, "support for journalists for CHS dissemination" has not been conducted due to financial constraints.

<Status of Achievement for Overall Goal at the time of Ex-post Evaluation>

It is judged that the Overall Goal has been achieved from the following reasons. All the available health indicators were improved compared to the period before the project (Indicator 1)[3]. According to the Community Health Development Unit (CHDU) of MOH, this improvement has been attributed to CHUs' functionality and high performance. For example, CHVs play an important role in identifying pregnant women at household levels and referring them to health facilities. In addition, CHVs and CHC members actively conduct awareness campaigns on immunization and defaulter tracing. According to MOH data on status of CHUs and the interviewed head of CHDU, as a result of continuing CHS-related policies and approaches, the total number of CHUs has increased and the national coverage reached 55% in 2018. The country-wide percentage of the fully functional CHUs did not reach the target (Indicator 2), but the percentage increased over time in the surveyed counties.

<Other Impacts at the time of Ex-post Evaluation>

Involvement of CHVs has brought several impacts. As positive impacts, first, by recruiting young CHVs, their busy CHS activities have reduced potential for social crimes committed by the idle youth within communities (Nairobi County). Under the national government initiative for community-based security management, CHVs are able to identify and report crimes and other security risks to relevant authorities. Second, in Nairobi and Embu Counties, some former CHVs and CHC members gained popularity through CHS activities and got elected as members of the County Assemblies. This is an advantageous situation for CHS Focal Persons (coordinator for CHS at the county level to advocate for funds for CHS implementation through the County Assemblies. Third, CHVs are selected from both genders, which has enabled them to work in a harmony and complementary manner in order to handle different health issues at the community level. As negative impacts, some CHVs are relied upon by members of poor households and have to incur personal expenses for provision of food items or transportation to health facilities. Also, there were reports of conflicts of responsibilities between some public health officers at the community level and CHVs, but it is expected that this friction will be resolved by clear job descriptions at County Departments of Health.

<Evaluation Result>

Therefore, the effectiveness/impact of the project is high.

Achievement of the Project Purpose and Overall Goal

Aim	Indicators	Results
(Project Purpose) Evidence-based policy cycle for implementation of CHS is strengthened through national capacity development.	Indicators: 1. At least 9 CHS Policy related document/products are developed and 4 document/products are revised based on findings from CHS implementation by the end of the Project. (Baseline: 0)	Status of achievement: Achieved (Continued). (Project Completion) - 24 documents (guidelines and tools) were newly developed, among which 15 were technically and financially supported by the project. Two documents (CHV basic training facilitator's guide and four CHIS tool) were revised. Note: CHIS: Community Health Information System. (Ex-post Evaluation) - Among 11 documents and products surveyed , seven have been fully utilized (CHV

[2] CHVs are selected among community residents and support CHAs' (ex-CHEW) work for provision of health services. CHAs are employed by the County Government.

[3] With regard to the indicator of fully immunized children, it decreased from 2013/14 to 2016/17, though it was still larger than 2008/09. One of the reasons was temporary service disruption due to the nationwide strikes by nurses in the period after devolution of services in 2013.

<table>
<tr><td></td><td></td><td>Training Package, CHEW (CHA) Training Package, CHC Training Package, CHV Technical Modules, CHIS Tools, CHS Research Agenda and M&E Plan), and three have been partially utilized (CHS Communication Strategy, Communication Health Service Standards and MCUL documents). One has not been maintained (CHS Brief).
Abbr: MCUL: Master Community Unit List (Database for functional CHUs).</td></tr>
<tr><td></td><td>2. At least 50% of CHS policy related documents and products, which are developed and/or revised, are approved by CHS Inter-agency Coordinating Committee and presented to Health Sector Coordination Committee by the end of the Project (Baseline:0)</td><td>Status of achievement: <u>Achieved.</u>
(Project Completion)
- Among the 24 developed documents and two revised documents, 21 (80%) were approved by the Interagency Coordinating Committee, presented by MOH or officially signed by the Minister of Health.</td></tr>
<tr><td></td><td>3. No. of innovative approaches adopted for CHS based on findings from CHS implementation.</td><td>Status of achievement: <u>Achieved (Continued).</u>
(Project Completion)
- Eight innovative approaches were adopted.
a) Operational researches in three different environments.
b) Identification of important CHS-related survey items and national research agendas for prioritization.
c) Participation of CHS field-level-implementers in community health conferences and opportunities for information sharing.
d) Utilization of CHS website as information sharing platform.
e) Utilization of CHIS indicators and reference sheets.
f) Involvement of the CHS Ambassador in advocacy activities.
g) Financial support for journalists for CHS diffusion.
h) Capacity development, review and assessment of the health personnel.
(Ex-post Evaluation)
- Among the eight innovative approaches, four have been fully sustained (a, b, c, e), and two have been partially sustained (d, h). One has been substituted by an alternative (f). One has not been sustained (g).</td></tr>
<tr><td>(Overall goal)
Roll-out of effective CHS implementation is accelerated.</td><td>1. Key indicators (e.g. immunization, exclusive breastfeeding, ANC+4, skilled delivery, utilization of FP, ITN, latrine coverage, water treatment) are improved (Baseline: CHS Evaluation Report, 2010)</td><td>Status of achievement: <u>Achieved.</u>
(Ex-post Evaluation)
- There is an increasing trend in all of the available indicators.
<table>
<tr><td></td><td>2008/09</td><td>2013/14</td><td>2016/17</td></tr>
<tr><td>Delivery in health facilities</td><td>43%</td><td>61%</td><td>72%</td></tr>
<tr><td>Pregnant women attending ANC (4+ visits)</td><td>42%</td><td>49%</td><td>49%</td></tr>
<tr><td>Fully immunized children</td><td>77%</td><td>84%</td><td>79%</td></tr>
<tr><td>Infants (0-5 months) on exclusive breastfeeding</td><td>13%</td><td>32%</td><td>61%</td></tr>
<tr><td>Targeted pregnant women provided with LLITNs</td><td>49%</td><td>80%</td><td>88%</td></tr>
<tr><td>Households with improved sanitation</td><td>n.a.</td><td>48%</td><td>59%</td></tr>
</table>
Note: Data of “Kenya Demographic and Health Survey 2008/09” was used as the baseline since that of 2010 was not available.</td></tr>
<tr><td></td><td>2. Proportion of fully functional Community Units in Kenya is increased from 28% in 2012 to 100% in 2017</td><td>Status of achievement: <u>Partially achieved.</u>
(Ex-post Evaluation)
- The proportion of fully functional CHUs in the country increased from 28% in 2012 to 75% in 2018. The data for 2017 was not available.
- In the three counties visited (Nairobi, Embu and Isiolo), the proportion of fully functional CHUs increased/decreased from 2012 to 2017 (28% to 99%, n.a. to 100% and a reduction from 55% to 47%, respectively).</td></tr>
</table>

Source: Project Completion Report, CHU data provided by CHDU and CHS Focal Persons of Nairobi, Embu and Isiolo Counties.

3 Efficiency

Outputs were produced as planned. Although the project period was as planned (ratio against the plan: 100%), the project cost exceeded the plan (ratio against the plan: 117%). Therefore, the project efficiency is fair.

4 Sustainability

<Policy Aspect>

Community health promotion is prioritized in the national development plan, “Kenya Health Policy” (2012-2030), “Kenya Health Sector Strategic Plan,” and the “MTP III of Vision 2030” (being drafted as of April 2018).

<Institutional Aspect>

Following the devolution of health services in 2013, institutional structure for CHS implementation has changed, but functions have remained same and shared between the national and county governments. CHDU at MOH is responsible for formulation of policies and strategies, guidelines and capacity building of counties. At the county level, the County Health Management Team (CHMT) and the Sub-county Health Management Team (SCHMT) develop annual work plan and budget, coordinate resource mobilization from development partners, support CHU establishment, functionality and review their work. The number of the personnel at CHMT varies from 10-18, and it is sufficient to perform their duties, according to the interviewed CHMTs. At the community level, CHVs conduct CHS activities such as health talks and assessment at households, message delivery to households, and referral, and so on. CHCs provide oversight while CHVs’ work is supervised by CHAs. Ten CHVs are assigned for each CHU as per the guidelines, but the number is not sufficient to meet all health needs of community residents. There are issues of demotivation or dropout of CHVs. The number of CHAs

varies among CHUs, but the total number in the country (4,000) is much less than the target (45,000).

<Technical Aspect>

CHMT personnel including the CHS Focal Persons have sufficient knowledge and skills for supervising CHS implementation, as training on supervision is part of the regular capacity building activities targeting CHMTs. CHMT personnel receive sensitization sessions while the CHS Focal Persons attend training on CHS supported by development partners. Training packages for CHAs, CHVs and CHCs developed by the project have been utilized, as explained earlier. Besides training opportunities given by MOH, some counties have a plan to incorporate training on CHS within their own planning and budgeting.

<Financial Aspect>

Both MOH and the County Departments of Health (CDOHs) pay only staff salaries and costs for utilities and services such as communication and electricity and allocate funds from development partners for project activity implementation. At MOH, there is no specific budget for community health, but funds are budgeted and disbursed under programs for family health or those that target issues such as malaria, nutrition and reproductive health. In the counties surveyed (Nairobi, Embu and Isiolo), current budgets are not sufficient to cover all the community health activities, although the overall budget allocation for the health sector has been increasing. Efforts have been made such as legislative frameworks for creation of financial incentives for CHVs, and budget proposals have been made for increased funding for CHS implementation in Nairobi, Kiambu, Embu and Isiolo Counties: 100 million Kenya Shillings (KES) for the next five years, 5 million KES for one year and 50 million KES for one year, respectively.

<Evaluation Result>

Therefore, the sustainability of the effectiveness through the project is fair.

5 Summary of the Evaluation

Through the project activities, the Project Purpose was achieved. In other words, the evidence-based policy cycle for CHS implementation was developed with outputs such as CHS-related policy documents and approaches. This achievement has mostly continued for roll-out of CHS implementation nationwide. As a result, the number and percentage of the fully functional CHUs have increased, which leads to improvement in key health indicators. Regarding the sustainability, issues of shortage in the number of CHVs and CHAs were identified, and more funds were needed to expand CHS implementation at the community level, but CHS-related personnel have sustained sufficient skills. As for the efficiency, the project cost exceeded the plan.

Considering all of the above points, this project is evaluated to be satisfactory.

III. Recommendations & Lessons Learned

Recommendations for Implementing agency:

- For further expansion of CHS implementation at the community level, it is recommended to MOH to: 1) create a budget line for CHDU and allocate resources for CHS policy, strategy and technical support to counties in the annual MOH budget; 2) conduct advocacy activities for the County Governments by utilizing CHS advocacy kit; and 3) mobilize resources within KMTC for training of CHAs.
- It is recommended to CDOHs to: 1) expand community health activities in the annual work plan; 2) increase budgets for training and recruitment of more CHAs and; 3) provide financial and material compensation for CHVs. CDOHs should also initiate dialogue with members of the health committee at County Assemblies to rally their support for increasing funding to CHS. It would be effective to pass an act at County Assemblies for CHS promotion in order to provide the legal framework to secure certain budgets for community health activities.
- It is recommended to MOH and CHDU to inform CHMTs and SCHMTs on the available CHS-related materials on the website and promote their use as long as they have access to the internet.
- There is a plan to identify CHS Champions at the county level who perform the advocacy role. It is recommended to CDOH to specify their responsibilities for CHS advocacy and assign necessary budgets, in collaboration with the County Governments.

Lessons learned for JICA:

- After the general election in 2013, devolved governance was introduced and 47 counties were established. In line with the devolved health system, while MOH retains responsibilities for development of health policies and standards and capacity development of counties, functions of service provision were delegated to County Governments. The project was not negatively affected by this devolution, as it aimed at capacity development of MOH for the evidence-based policy cycle for CHS implementation and developed policy documents including training packages for community-level health workers. Thus, it successfully resulted in expansion of CHUs and good performance of CHCs. These successes were underpinned by careful selection of multiple partners ranging from the national level (MOH) to the community level (CHCs), which could retain principal responsibilities for CHS roll-out including capacity building of the county- and community level health personnel. In order to avoid negative influences of devolution or other political and administrative changes, at the project formulation stage, political situations and prospects should be carefully examined and the implementing agency needs to be carefully selected from those that would not be adversely affected by political changes and governance systems.

CHVs Action Plan at Tupendane CHU, Isiolo County


Handwashing Facility at Community