Republic of Kenya

FY2023 Ex-Post Evaluation Report of
Japanese ODA Loan Project
"Health Sector Policy Loan for Attainment of the Universal Health Coverage
(Phase 1) (Phase 2)"

External Evaluator: Shima Hayase, IC Net Limited

0. Summary

The projects were Development Policy Loan (DPL[1]) programs to support the achievement of Universal Health Coverage (UHC[2]) in Kenya. Phase 1 aimed to rectify economic and physical disparities in access to health services by supporting the formulation of direction for promoting UHC, the formation of a central and county foundation, and the expansion of three major UHC-related programs[3], thereby contributing to the achievement of UHC and the promotion of social development.

Phase 2 aimed to achieve UHC, economic stability, and social development by supporting the implementation of high-priority policies for achieving UHC through policy dialogue and financial support and strengthening health financing and health service delivery capacity.

The projects were fully aligned with Kenya's development policies, health sector guidelines, and development needs from the time of appraisal to ex-post evaluation. In the Phase 1 plan, logical issues were identified in the structure of the policy matrix and its indicators. Drawing from lessons learned in the previous phase, in Phase 2 planning, a mechanism was established to allocate funds for intended activities while adhering to the constraints of the DPL. However, challenges in checking and monitoring the outcomes of Phase 1 implementation persisted, even at the time of the ex-post evaluation.

The projects were consistent with Japan's development cooperation policy at the time of appraisal. As for internal consistency, the collaboration envisaged at the time of appraisal was implemented, and effects were realized. Still, external consistency could not be confirmed as it was limited to coordination with other donor projects. For these reasons, relevance and consistency are moderately low.

Regarding effectiveness, the policy actions in both phases were achieved. The operational and effect indicators in Phase 1 were achieved, but this did not lead to an improvement in the key

[1] It supports improving economic development plans and policies in developing regions. It differs from project-based loans, in which loans are provided for specific projects in that they provide funds based on the progress of policy actions agreed upon by the borrower country and JICA. In recent years, confirming that the borrower government has implemented reform items in line with the direction has become common. Then, it concluded a loan agreement and provided funds upon achievement of the reforms, which are incorporated into the recipient country's budget. (Efforts to Increase Development Effectiveness of Projects | Our Work | JICA)

[2] UHC (Universal Health Coverage) refers to the principle that all individuals can access appropriate health promotion, prevention, treatment, and rehabilitation services at an affordable cost. The goal is for everyone to be able to enjoy healthcare services without experiencing financial hardship. (Overview | What We Do - JICA)

[3] A. Free Maternity Service (FMS), B. Health Insurance Subsidy Program (HISP), C. Health Sector Service Fund (HSSF)

health indicator of maternal mortality rate. The continuation of financial actions was limited in Phase 2, which strengthened health financing and the capacity to provide health care services. Regarding impact, the target for the ratio of government health expenditure to general government expenditure was achieved ahead of schedule. Still, the target for the proportion of the population covered by insurance was not achieved. For these reasons, the effectiveness and impact are moderately low.

Regarding the sustainability of the projects, only items that can be analyzed are included. Still, since the UHC fund management agency is in a transitional period, attention needs to be paid to the system, organization/structure, finances, and risk response.

1. Project Description

Project Location

Photo 1: A community health promoter demonstrating how to make a home visit (Photo by the external evaluator)

1.1 Background

In Kenya, public health insurance was managed by the National Health Insurance Fund (NHIF). NHIF, established in 1964, provided public health insurance primarily for civil servants and formal sector workers. However, due to limitations such as benefits being restricted to inpatient care only, the number of subscribers remained stagnant. Even when private insurance members and those covered by community-based health insurance were included, Kenya's overall health insurance coverage was limited to about 20% of the total population.

Kenya's long-term national development plan, *Vision 2030* (2008–2030), aimed to "provide quality healthcare services to the entire population at affordable prices." However, achieving UHC for all was challenging due to issues such as insufficient national spending on the health sector, the fragility of the public health insurance system and healthcare service delivery, disparities in healthcare access between regions and social classes, and governance issues resulting from decentralization.

Against this background, Phase 1 of the project was requested to support formulating strategies to promote UHC, establishing national and local infrastructure, and expanding the three major UHC-related programs.

The Kenyan government sought to strengthen healthcare coverage through the three major UHC programs: 1) the Free Maternity Service (FMS) program[4], 2) the Health Insurance Subsidy Program[5] (HISP) to subsidize insurance premiums for people with low incomes, and 3) the Health Sector Service Fund[6] (HSSF) to improve the operation of service delivery facilities. Despite these efforts, the number of people enrolled in national health insurance remained stagnant[7].

It was necessary to increase government health spending to expand healthcare coverage through public insurance. However, the share of government health expenditure in total government spending was significantly below the policy target of 12% (set for 2022), standing at just 7% in 2018[8]. Moreover, improving access to healthcare services, enhancing the physical infrastructure of health facilities, and raising the quality of healthcare services were urgent priorities.

In response to these challenges, the Kenyan government requested Phase 2 of the project to support strengthening health financing necessary to achieve UHC, ensure the quality of medical services, and enhance the monitoring and evaluation infrastructure for UHC-related indicators.

1.2 Project Outline

(Phase1) To reduce economic and physical disparities in access to healthcare services by facilitating the following priority initiatives of the Kenyan government with regard to the attainment of UHC: (i) preparation of various UHC-related policy documents, (ii) creation of UHC-related program manuals and allocation of a government budget, and (iii) enhancement of health systems led by county governments. Thereby contributing to the achievement of UHC and the promotion of social development in Kenya.

(Phase2) To accelerate the achievement of UHC's priority policies through strengthening health financing and service delivery through policy dialogue and on-budget support, thereby promoting Kenya's economic stability and development efforts.

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[4] The programme, which started in June 2013, aims to eliminate the cost of childbirth in accredited healthcare facilities and the costs for maternity services, prenatal and postnatal checkups, and newborn care. This initiative is commonly known as the Linda Mama Program.

[5] This program promotes enrollment in NHIF by subsidizing the insurance premiums for the poor, with the government covering the costs.

[6] Established in 2010 as direct operational grants for primary healthcare facilities facing financial constraints due to the 2004 implementation of free healthcare services. The funds were allocated explicitly for operational expenses such as salaries for support staff (e.g., cleaning staff and security personnel), fuel costs, facility renovation, utility bills, and outreach activities.

[7] 19.9% of the total population, Source: Kenya Household Health Expenditure and Utilization Survey 2018

[8] The Medium-Term Plan: MTP III 2018-2023

Loan Approved Amount / Disbursed Amount	(Phase 1) 4,000 million yen / 3,996 million yen (Phase 2) 8,000 million yen / 7,992 million yen	
Exchange of Notes Date / Loan Agreement Signing Date	(Phase 1) August 2015 / August 2015 (Phase 2) August 2020 / August 2020	
Terms and Conditions	Interest Rate	(Phase 1) 0.25% (Phase 2) 0.95%
	Repayment Period (Grace Period)	(Phase 1) 40 years (10 years) (Phase 2) 30 years (10 years)
	Conditions for Procurement	General United
Borrower / Executing Agency	The Government of the Republic of Kenya	
Project Completion[9]	(Phase 1) March 2017 (Phase 2) March 2022	
Target Area	All over the Republic of Kenya	
Main Contractor(s) (Over 1 billion yen)	-	
Main Consultant(s) (Over 100 million yen)	-	
Related Studies (Feasibility Studies, etc.)	-	
Related Projects	<Technical Cooperation> Project for Strengthening Community Health Strategy (2011-2014), Project for Organizational Capacity Development for Devolved County Health Systems in Kenya (2014-2019), Project for Strengthening the Accountability in the Management of County Health Services (ongoing), Partnership for Health Systems Strengthening in Africa (Phase 2) (2016-2021) <Other Agencies> World Bank: Health Sector Support Project (2010-2015), Social Protection Network (2011-Multi-Donor)	

[9] The definition of the completion of this project is the completion of the loan disbursement.

2. Outline of the Evaluation Study

2.1 External Evaluator

Shima Hayase, IC Net Limited

2.2 Duration of Evaluation Study

This ex-post evaluation study was conducted with the following schedule.

Duration of the Study: December 2023 - February 2025

Duration of the Field Study: May 12 - June 9 and September 29 - October 12, 2024

2.3 Constraints During the Evaluation Study

These projects are program-based policy loans that include numerous policy actions, making it difficult to compare inputs and outputs. Therefore, the analysis focused on "Relevance," "Coherence," "Effectiveness," and "Impacts." "Sustainability" was only addressed where applicable, and no sub-rating was provided. Since no sub-ratings were assigned to all six evaluation criteria, no overall rating was given.

In addition, in the case of DPL, the ODA Loan funds are provided based on confirmation that policy actions have been achieved. The ODA loan funds are incorporated into Kenya's national budget. Thus, there was no mechanism for tracking the use of the ODA loan. Since there was no information on when and how much was allocated to health expenditures and intended programs, it was not possible to quantitatively analyze the contribution and degree of the program's intended impacts.

Phase 2 of the project was completed in March 2022. Since the target for the effectiveness indicators was set to be evaluated two years after the completion of the project, a comparison of actual results in 2024 with the target values was planned to assess the project's impact. However, at the time of this evaluation, the 2024 health indicators and UHC-related data had not yet been released, so the most recent available data was used for the analysis.

Additionally, since Kenya's policies and organizational reforms concerning UHC were in a transitional phase at the time of ex-post evaluation, the updated information reflects data collected until the end of October 2024.

3. Results of the Evaluation

3.1 Relevance/Coherence (Rating:②[10])

3.1.1. Relevance (Rating:②)

3.1.1.1 Consistency with the Development Plan of Kenya

Kenya's long-term national development plan, *Vision 2030* (2008–2030), as well as the *Medium*

[10] ④: Very High, ③: High, ②: Moderately Low, ①: Low

Term Plans (MTPs) for the second to fourth periods from the time of the appraisal to the ex-post evaluation[11], and the long-term health sector plan, the *Kenya Health Policy 2014-2030*[12], all aimed to "provide quality healthcare services to the entire population at affordable prices" by 2030.

In the five-year health sector plan, the *Kenya Health Sector Strategic & Investment Plan (KHSSP) 2014–2018*, providing essential healthcare services through public health insurance was identified as a key goal. Furthermore, the *Kenya Universal Health Coverage Policy 2020–2030*[13] was formulated as a policy to promote UHC to ensure that all Kenyans have access to essential, quality medical services without suffering economic hardship.

Therefore, from the time of the appraisal to the ex-post evaluation, the achievement of UHC has consistently been a priority for both the national government and the health sector, aligning well with the objectives of these projects.

3.1.1.2 Consistency with the Development Needs of Kenya

(1) Development Needs

The trends in Kenya's key health indicators are shown in Table 1 below. The under-five and infant mortality rates have been declining, and by the completion of Phase 2 of the project (2022), the target values outlined in the *Third Medium-Term Plan (MTP 2018-2023)* were achieved. However, the maternal mortality rate in Kenya has been on the rise. For these indicators, it appears unlikely that the targets set for 2030 under the *Sustainable Development Goals (SDGs)* will be met.

Table 1: Kenya's Key Health Indicators

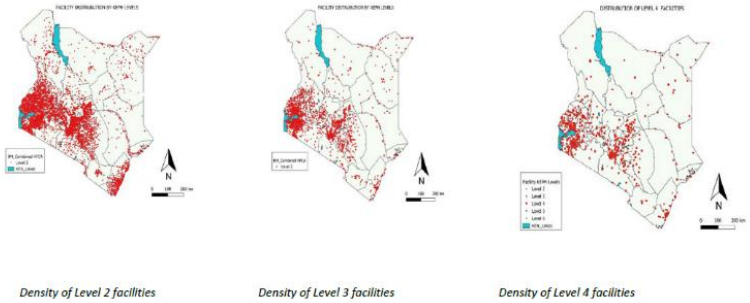
Indicator / Year	Phase 1					Phase 2			SDGs	MTP III
	2015	2016	2017	2018	2019	2020	2021	2022	2030	2022
Under-5 Mortality Rate (per 1,000 live births)	47.5	46.3	45.4	44.3	43.4	43	41.9	41.1	25	45
Infant Mortality Rate (per 1,000 live births)	22	21.9	21.7	21.5	21.3	21	20.7	20.4	12	30
WHO: Maternal Mortality Rate (per 100,000 live births)	483	505	490	512	503	530	N/A	N/A	70	300

(Source: WHO Mortality database[14])

At the time of appraisal, the following issues were identified in addition to the health indicators, as shown in Table 2. None of these had been resolved at the time of ex-post evaluation.

[11] Phase 2 (2013-2017), Phase 3 (2018-2022), Phase 4 (2023-2027).
[12] Comprehensive National Health Policy Framework (universalhealth2030.org)
[13] UHC POLICY 2020-2030 B5 (kippra.or.ke)
[14] WHO Mortality Database - WHO (Accessed August 10, 2024)

Table 2: Development Needs and the Situation at the Time of Ex-post Evaluation

Development Needs	The Situation at the Time of Ex-post Evaluation
Some health-related indicators in Kenya face challenges.	The maternal mortality rate has been higher than at the time of appraisal. While access to services is improving, there are issues with the quality of healthcare services, equipment and technology, and disruptions due to healthcare worker strikes, resulting in delays and inadequate service delivery.
Addressing regional and economic disparities has been an urgent issue.	Regional and economic inequality with the three northern counties has not improved. The factors include a low number of insurance subscribers, high out-of-pocket costs at healthcare facilities that prevent access, and inadequate road infrastructure, which makes it difficult to reach healthcare service providers.
There are challenges in ensuring free healthcare services and maintaining their quality.	There are issues with providing free healthcare services and ensuring their quality. Free medical services have been introduced at health centers and clinics. Under the system, facilities submit medical claims to the county and NHIF for reimbursement. However, delays in payments from NHIF and the lack of self-funding at these facilities have led to difficulties in sustaining services and maintaining their quality.
Services available to public health insurance subscribers are limited, and the proportion of the population enrolled has not increased.	The proportion of the population enrolled in public health insurance has not increased. Although the government subsidizes insurance premiums for low-income households, this has not increased enrollment. The retention rate, ideally 100%, is below 50%. Inhibiting factors include poor fund management, fraudulent payments, and other operational issues hindering membership growth.[15]
There are disparities in healthcare facilities covered by insurance / a shortage of healthcare professionals, and significant gaps between healthcare facilities and regions.	The concentration in urban areas remains unchanged. Primary Health Care (PHC) facilities are concentrated in major cities such as Nairobi, the western region, and Mombasa.  figure 1: Distribution of PHC facilities and sub-county hospitals in Kenya[16] (Note) from the left, the distribution of clinics, health centers, and sub-county hospitals is shown in red.
Challenges in Achieving UHC	There are governance issues. When presidential elections occur every five years, changes in administration lead to staff turnover. Additionally, at the county level, there is a tendency for new hires to be made when a governor changes, which creates challenges in maintaining continuity.

(Source: The information at the time of appraisal is based on materials provided by JICA. The situation at the time of the ex-post evaluation is derived from responses to questionnaires from the Ministry of Health and interviews.)

[15] NHIF Audit Report 2023 (parliament.go.ke/sites/default/files/2024-06/Report of the Departmental Committee on Health on its Consideration the inquiry into alleged Fraudulent Payments of Medical Claims and Capitation to Health Facilities by the National Health Insurance Fund.pdf (Accessed August 10, 2024)

[16] Ministry of Health: Kenya Health Facility Census Report September 2023

(2) Financial Needs

At the time of the appraisal for Phase 1, a forecast of the financial resources required for the health sector, along with the available resources and the gap, was presented (Table 3). It was explained that substantial funding would be needed to expand the UHC program and improve its quality and that relying solely on the Kenyan government's budget and insurance premium revenues would make it difficult to secure the necessary budget. According to the data at the time of appraisal of Phase 2 (Table 4) and the ex-post evaluation (Table 5), this gap appeared to have further widened.

Table 3: Financial Gap in the Health Sector at the time of Phase 1 Appraisal

(unit: million KES[17])

Fiscal Year[18]	2012/13	2013/14	2014/15	2015/16	2016/17
Available Resource	223,524	236,036	248,624	264,596	282,209
Financial Resources Required	244,550	286,044	291,855	305,612	334,489
Financial Gap	-21,026	-50,008	-43,231	-41,016	-52,280

(Source: Material provided by JICA)

Table 4: Financial Gap in the Health Sector at the time of Phase 2 Appraisal

(unit: million KES)

Fiscal Year	2018/19	2019/20	2020/21	2021/22	2022/23
Available Resource	440,976	389,668	393,257	379,954	384,119
Financial Resources Required	446,277	495,000	522,490	579,483	622,118
Financial Gap	−5,301	−105,332	−129,223	−194,529	−237,999

(Source: *WHO Kenya Health Sector Strategic Plan*[19])

Table 5: Financial Gap in the Health Sector at the time of Ex-post Evaluation (unit: million KES)

Fiscal Year	2024/25	2025/26	2026/27
Available Resource	147,599	156,408	160,928
Financial Resources Required	371,851	411,377	456,781
Financial Gap	−224,252	−254,969	−295,853

(Source: *MTEF HS WG Report*[20])

[17] Kenyan Shilling 1KES= 1.09896 Yen (as of October 1, 2024 Currency Converter | Foreign Exchange Rates | OANDA)

[18] Kenya's budget year: from July 1st to June 30th of the following year.

[19] WHO Kenya Health Sector Strategic Plan fa.indd (Accessed November 7, 2024)

[20] Ministry of Health Sector Working Group Report Medium Term Expenditure Framework (MTEF) for the Period 2023/24-2025/26 (Health-Sector-Report.pdf)

These projects are DPL aimed at achieving the UHC programs and have contributed to resolving these issues. However, even at the time of ex-post evaluation, many development needs and funding shortages remain. Therefore, it can be said that the projects are highly relevant to development needs.

3.1.1.3 Appropriateness of the Project Plan and Approach

(1) Project Plan and Approach

The Phase 1 project plan had the following issues:

1) Logical Structure of the Policy Matrix

In Phase 1, the plan aimed to address economic and physical disparities in access to healthcare services by expanding the three major UHC programs: (a) FMS, (b) HISP, and (c) HSSF. While the policy action for (a) was limited to securing the necessary budget, both (b) and (c) were only focused on creating manuals without specific actions to allocate the funding. Furthermore, the expected qualitative outcome of (c) was the "improvement in the quality of healthcare services in HSSF-targeted facilities." However, as HSSF was a program designed to cover running costs such as staff salaries and operational expenses, improving service quality required several additional logical steps.

2) Gap between Outcome Indicators and Effectiveness Analysis

The outcome indicators set for the project were: (a) "the delivery rate at healthcare facilities," (b) "the number of households benefiting from HISP," and (c) "the number of facilities targeted by HSSF." Since these indicators were related to only some categories in the policy matrix, quantitative indicators should have been set at a level that confirms results for each of the categories (eight categories).

3) Lack of Mechanisms to Monitor the Effectiveness of the ODA-Loan

The project aimed to support the implementation of the three major UHC programs, thereby contributing to the achievement of UHC. Therefore, in addition to checking the implementation status of these programs, it was necessary to follow up on the Ministry of Health's supervision of the fund to ensure that the programs' fund management organization functioned appropriately and indirect support was provided through the dispatch of individual experts, etc. The National Assembly Departmental Committee on Health conducted an audit[21] to ensure the soundness of NHIF, and problems have been identified regarding fraudulent claims such as overcharging for medical fees through fictitious patients and falsification of medical treatment details, multiple claims for medical expenses, and sloppy fund

[21] Report of the Auditor General on National Health Insurance Fund for the Year ended 30 JUNE, 2023 (dated on May 8, 2024) Report of the Departmental Committee on Health on its Consideration the inquiry into alleged Fraudulent Payments of Medical Claims and Capitation to Health Facilities by the National Health Insurance Fund.pdf (parliament.go.ke)

management in the operation of NHIF. The government itself recognizes that improvements in its operations are necessary. Furthermore, the report indicated that NHIF had a low member retention rate and was not generating a stable flow of contributions.

4) Response to Instability in Systems and Funding Sources

With the completion of the World Bank's program in 2020, subsidies for HSSF, one of the three major UHC programs, were discontinued. Furthermore, due to an initiative by the newly elected President Ruto in 2022, the Social Health Authority (SHA) was established to take over the management of UHC funds, replacing NHIF. However, the transition process to SHA and the future direction of the UHC programs were not communicated to healthcare service providers, and in July 2024, the closure of the 1) FMS and 2) HISP programs was announced. According to the JICA Kenya Office, such changes were unforeseen.

In Kenya, many programs are developed based on donor contributions, meaning the sustainability of such programs heavily depends on donors' decisions. Sudden policy changes or institutional shifts are common, especially following national or local elections. Considering the potential risks of program termination or changes by the donors, it would have been prudent to anticipate such risks and consider scenario planning as part of the project strategy.

Considering the lessons learned in Phase 1, the following approaches were adopted in Phase 2.[22]

1) Efforts to Allocate Budget to the Health Sector and Program Activities

Considering the DPL's characteristics, Phase 2 moved toward a results-based approach (Pay for Success: PFS). This approach ensured that funds from general fiscal support were directed toward the Ministry of Health, and a policy matrix was established to ensure that the Ministry's budget aligned with the activities intended in accordance with the agreements of both countries. For example, policy actions, such as policy formulation and consultations that did not require significant budgets, were designed to include activities like capacity-building training or equipment procurement. The budget was then allocated to support the realization of these actions. The disbursement of funds for the next tranche was linked to the achievement of these policy actions.

2) Establishment of a Steering Committee Involving the Ministry of Finance

In the case of the DPL, the loan funds are not tied to specific uses or sectors; instead, they are integrated into the general budget of the partner country. A strong commitment from the Ministry of Finance is required to ensure that the loan funds are used for the intended purposes. Therefore, a steering committee comprising the Ministry of Finance and the Ministry of Health was established as the lead body for project implementation. To achieve the objectives

[22] Interview with a JICA senior advisor (April 10, 2024)

of the DPL, it was necessary to monitor the progress of actions and indicators regularly, and if progress was unsatisfactory, discuss corrective measures. UHC Experts and the JICA office were also involved in the steering committee. While the activities and outcomes of the steering committee were not included in the policy matrix, it served as a platform for policy dialogue aimed at the program's objectives, providing Japan, as the donor, with opportunities to engage in discussions on progress and contributions.

(2) Application of Evaluation Results and Lessons from Past Similar Projects to This:

At the time of appraisal of Phase 1, lessons learned from other donor projects in Kenya indicated the need to strengthen measures to reduce governance and corruption risks. In response, a private third-party organization was planned to monitor the project, but no private organization was hired to monitor it during implementation.

In Phase 2, lessons learned from past loan projects indicated that combining the project with other assistance projects, such as the dispatch of policy advisor and technical cooperation projects, was essential to implement general budget assistance smoothly. As will be described later in the section on internal consistency, the implementation of this project was coordinated with the dispatch of individual experts and technical cooperation projects as planned at the time of appraisal, and it can be said that the lessons learned were utilized.

In the plan for Phase 1 of this project, logical issues were found in the policy matrix's structure and indicators. In Phase 2, based on the lessons learned from the previous phase, a mechanism was created to ensure that funds were directed at the intended activities within the constraints of the DPL. However, issues related to checking and monitoring the effects of Phase 1 implementation remained at the time of ex-post evaluation.

3.1.2 Coherence (Rating:③)

3.1.2.1 Consistency with Japan’s ODA Policy

The Japanese government's *Global Health Diplomacy Strategy* (formulated in May 2013), the *Fifth Tokyo International Conference on African Development* (TICAD V) (held in June 2013), and *the Seventh Tokyo International Conference on African Development* (TICAD 7) (held in August 2019) all stated its cooperation in promoting UHC.

JICA Country Analysis Paper for the Republic of Kenya" (April 2011) (March 2018) at the time of appraisal also stated the need to create and strengthen systems that eliminate income and regional disparities and ensure equal access to health services for all and the policy of cooperation.

For these reasons, it can be said that these projects, implemented to strengthen health policies and service delivery capacity toward achieving UHC, are highly consistent with Japan's aid policy.

3.1.2.2 Internal Coherence

At the time of appraisal, the following three collaborations were envisaged.

1) The UHC policy Advisor was dispatched to the Kenyan Ministry of Health. The advisor supported the formulation and implementation of UHC-related policies, including the policy actions of this project, and provided daily technical inputs to the UHC-related departments of the Kenyan Ministry of Health and the UHC Steering Committee for various policy documents, including roadmaps.
2) In the technical cooperation projects "Project for Strengthening Community Health Strategy" (2011-2014) and "Project for Organizational Capacity Development for Devolved County Health Systems in Kenya," support was provided for strengthening the budget management capacity of counties.
3) In 2016, the "County Health Office Core Function Working Group" was established by representatives of the county health offices, the Ministry of Health, and related donors. It was tasked with clarifying the role of the county (primary provider of PHC services) and the role of the central government (establishment of national policies and standard guidelines) in documents.

As the collaboration was implemented as envisaged and contributed to promoting the implementation of this project, it can be said that the internal consistency is high.

3.1.2.3 External Coherence

During Phase 1, the WB implemented the Health Sector Support Project to assist the Kenyan government in achieving UHC. JICA planned to participate in monitoring UHC-related programs by the Ministry of Health and the WB. In addition, the WB was formulating new UHC-related program loans. JICA also considered co-financing in subsequent phases. However, there was no specific collaboration, and Phase 2 was a policy loan provided solely by JICA.

For Phase 2, the Development Partners for Health in Kenya (DPHK) meetings[23], held regularly by major donors in the health sector, were used to share information and coordination regarding the project. Several donors carried out UHC-related activities but did not specifically collaborate with this project.

These projects were consistent with Kenya's development policies and needs from the time of appraisal to the time of ex-post evaluation. There were some problems with the project plan, such as a discrepancy between the logical structure of the policy matrix in Phase 1 and the outcome indicators in the indicator setting and the effect analysis. Learning from the challenges of Phase

[23] The health sector partners (Development Partners for Health in Kenya: DPHK) include the central government (Ministry of Health, National Assembly Health Committee), counties (county health offices, county health committees), donors, as well as health care service providers and facilities (religious organizations, NGOs, private institutions). They hold regular meetings to exchange information and coordinate on UHC.

1, many innovative approaches were taken in Phase 2. However, issues related to checking and monitoring the effects of Phase 1 implementation remained at the time of ex-post evaluation.

Regarding coherence, these projects were consistent with Japan's development cooperation policy at the time of appraisal. There was internal coherence as collaboration and effects with other JICA projects in Kenya were confirmed. Still, in terms of external coherence, although there was coordination with health sector partner meetings and other aid agencies, no collaboration was observed.

Therefore, its relevance and coherence are moderately low.

3.2 Effectiveness and Impacts[24] (Rating:②)

3.2.1 Effectiveness

The evaluation is based on the status of policy actions at each phase's program completion (completion of loan disbursement), the achievement of operation and effect indicators, and the achievement of qualitative effects. The policy matrix, which includes the programs' outcomes and status after project completion, is provided in Appendices 1 and 2.

3.2.1.1 Achievement of Policy Actions

The status of achievement of the policy actions set at the time of appraisal and the continuation and effect of those actions at the time of ex-post evaluation are shown below.

(1) Phase 1

Achievement of Policy Actions: Achieved as planned.

13 policy actions set to achieve UHC were completed by February 2015 for the first tranche (prior actions). All policy actions for the second tranche (trigger actions) were completed by December 2015.

At the time of project completion, the policy action "(10) The Health Care Financing Strategy was drafted, and the outlined of essential health package is shared with the UHC Steering Committee" was only at the draft stage, and the draft had not yet been formally approved. Upon reviewing the situation during the ex-post evaluation, it was found that the health financing strategy *UHC 2018-22 Roadmap* had been formally approved. However, the exact date of approval could not be confirmed.

Continuation and Effectiveness at the Time of Ex-post Evaluation: At the time of ex-post evaluation, the effects are expected to be primarily maintained.

The effects of policy actions related to Policy Areas I and III continued at the time of the ex-post evaluation. There is a possibility that the reform of the UHC program in Kenya will have some impacts, but as of the time of the ex-post evaluation, the program's effects are expected to be primarily maintained.

[24] When providing the sub-rating, Effectiveness and Impacts are to be considered together.

Of the three major UHC programs in policy area II, it has been decided that HISP and FMS will be transferred to the new fund. The transition from NHIF to SHA, which took place in October 2024, is expected to result in changes to the format. Still, there is confusion at the field level as the specific transition process and content changes have not been communicated to counties and health facilities. As stated in "3.3.1 Policy and System, (1) Sustainability in Policy Aspect" in the Sustainability section, the Kenyan government intends to maintain the basic policy. At present, the effects are expected to be largely retained. However, it is necessary to take immediate action to prevent the impact of the confusion from spreading. In addition, in July 2024, the suspension of benefits from NHIF was announced. The Health Sector Services Fund (HSSF) / Results-Based Financing (RBF) was discontinued before the ex-post evaluation.

Policy Area	Continuation of Policies and Effects at the Time of Ex-post Evaluation
I. Preparation of various UHC-related policy documents.	◎ National Health Policy has been updated. ◎ The five-year Health Sector Strategic and Investment Plan has been updated. ○ Although the roadmap has not been updated, the health financing strategy reflects the roadmap's contents, ensuring a degree of continuity.
II. Developing manuals for UHC-related programs and securing the Kenyan government budget.	△ HISP and FMS will be transferred to a newly established fund. The programs' content, budget, and transfer process are unclear. △ Although the number of FMS beneficiaries has increased, issues with service quality and improvements to access are still in progress. ✕ The HSSF/RBF is no longer in operation. The grant ended in 2018, and some funding was transferred to other donor programs.
III. Strengthening health systems led by county governments.	○ The Ministry of Health has been restructured, but the Health Sector Intergovernmental Coordination Bureau continues to function. It also continues to coordinate with counties. ◎ Awareness activities for counties are continuing.

(Note) The status of achievement of policy actions is explained with the following symbols: ◎ Continuing and effects are being observed, ○ Continuing, △ Continuing, although not fully implemented, × Not continuing.

(2) Phase 2

Achievement of Policy Actions: Achieved as planned.

Of the 20 policy actions set at the time of appraisal, the first tranche (prior actions) was achieved by April 2019. The second tranche (trigger actions) was aimed to be achieved by December 2019 but was achieved in December 2020. The third tranche (trigger actions) was aimed to be achieved in December 2020 but was achieved 15 months later, in February 2022.

Continuation and Effect Generation at the Time of Ex-post Evaluation: Health financing-related actions continue to a limited extent.

In the policy area "1. Strengthen Health Financing," the Ministry of Finance and the Ministry of Health returned to their normal budget preparation relationship after the project was completed. Hence, the Ministry of Finance is not as actively involved as it was during the implementation of this project.

There are problems with the flow of funds to health facilities, especially at the county and facility levels that provide medical services. The introduction of the Medium Term Expenditure Framework (MTEF) and Health Technology Assessment (HTA) was limited.

In policy area "2. Improve Service Delivery and Quality," training on disseminating a standard model for health care service provision quality was conducted for all counties, and clinical guidelines were also established. Still, there are issues with operation and quality.

In the policy area "3. Strengthen Monitoring and Evaluation Capacity to monitor impacts regarding UHC related programs and activities," efforts were made to digitize the system, and a monitoring and evaluation system was also established. Still, there are issues with continuous operation and implementation in the counties.

Policy Area/ Policy Action	Continuation of Policies and Effects at the Time of Ex-post Evaluation
1. Strengthen Health Financing	
1-1 Budget Projection Related to the Health Sector	△ A subsequent document on the analysis of health financing sources has been prepared, but the Ministry of Finance did not develop it as part of a joint team. △ At the time of ex-post evaluation, the Ministry of Finance had not assigned any personnel specifically dedicated to discussions on UHC with the Ministry of Health.
1-2 Efficient Fund Flow for Health Facilities	△ The Ministry of Health recognizes that the funding flow is functioning, but there are issues with the funding flow at the county and facility levels, where health services are provided.
1-3 Budget Management along with Medium Term Expenditure Framework (MTEF)	× It has not progressed to implementation in all counties.
1-4 Introduction of Health Technology Assessment (HTA)	× It has not been institutionalized.
2. Assurance of Health Services Quality	
2-1 Dissemination of the Kenya Quality Model for Health (KQMH)	△ All counties have undergone training, and evaluations by KQMH have also been conducted, but sustainability challenges exist.
2-2 Formulation of Clinical Protocols	◎ A review of the related list was conducted, and protocols were formulated. △ There are challenges regarding implementation and quality.
3. Strengthen Monitoring and Evaluation Capacity	
3-1 Digitalization for Health Information System	◎Policies have been outlined, and progress is being made at the national, county, and PNC service facility levels.
3-2 Formulating the Monitoring and Evaluation System	△ Although the basic system has been put in place, there are challenges to be overcome in terms of continuous operation and implementation at the county level.

(Note) The status of achievement of policy actions is explained with the following symbols: ◎ Continuing and effects are being observed, ○ Continuing, △ Continuing, although not fully implemented, × Not continuing.

3.2.1.2 Quantitative Effects (Operation and Effect Indicators)

(1) Phase 1: Indicators (a) and (b) were achieved, but (c) was excluded from the judgment

because it was discontinued.

The project objective was to "To reduce economic and physical disparities in access to healthcare services." The operation and effect indicators were set as "(a) Percent of Deliveries Conducted at Health Facilities," "(b) Number of Poor Households Covered by HISP," and "(c) Number of Facilities Implementing HSSF-RBF."

As shown in Table 6, (a) facility delivery rate and (b) Number of HISP beneficiary households exceeded the target in fiscal 2019/20, two years after the project was completed. (c) The number of HSSF-RBF facilities exceeded the target in 2016 but was terminated before the target year. In addition, because it was a program to subsidize facility operations, it is difficult to analyze the causal relationship with the project objective of improving access to health services.

Table 6: Operation and Effect Indicators of Phase 1

Indicator/ Fiscal Year (unit)	Baseline	Target	Actual					
	2012/13	2 years after Project Completion 2018	2015	2016	Target Year[25] 2019/20	2020/21	2021/22	2022/23
(a) % of Deliveries Conducted at Health Facilities (%)	44	65	61	57	67	*73*	*79*	**89**
(b) Number of Poor Households Covered by HISP (household)	0	42,300	17,491	181,968	*253,400*	*253,400*	*253,400*	N/A
(c) Number of facilities implementing HSSF-RBF (facility)	8	1,331	155	1,903	Ended 2018, No Continuation			

(Source: Baseline and target values from materials provided by JICA, actual values from the Project Completion Report, *MTEF HS WG Report*, **Kenya Health and Demographic Survey 2022**)

(2) Phase 2: All except indicator (c) were achieved.

The project objective was "strengthening health financing and health service delivery," the following operation and effect indicators, (a) to (f), were set. 2024 is the target year[26], but as no data is available, a judgment will be made based on the most recent data.

As shown in Table 7, all operation and effect indicators were achieved except for "(c) Number of Health Technologies Assessed by Health Benefit Advisory Panel (HBAP)." The reason for not achieving the targets is that while the broad framework of HTA has been considered, it has not yet been institutionalized, and medical technology assessments cannot be carried out.

[25] Project completion is defined as "completion of disbursement" and was scheduled for January 2016. The actual loan close is March 2017, with the target year being March 2019, two years after project completion.

[26] The project completion is defined as "completion of disbursement" and was planned to be completed in February 2021. According to material provided by JICA, it was set to March 2022, so the target year will be March 2024, two years after the project is completed.

Table 7: Operation and Effect Indicators of Phase 2

Indicator/Year	Baseline	Target	Actual					Achieve-ment
	2018	2023	2018/19	2019/20	2020/21	2021/22	2022/23	
(a) PFM Act and/or Relevant Regulations Revised	—	Achieved	—	—	Achieved	Achieved	Achieved	◎
(b) Number of Counties trained on MTEF process guide	2	6	4	6	6	6	N/A	◎
(c) Number of Health Technologies Assessed by Health Benefit Advisory Panel (HBAP)	0	2	0	0	0	0	0	×
(d) Number of counties coached and mentored on KQMH Implementation	0	23	4	9	12	47	N/A	◎
(e) Number of clinical guidelines and treatment protocols developed.	0	3	0	0	0	3	N/A	◎
(f) Formulary for the UHC-Essential Benefit Package developed	—	Achieved	—	—	Achieved	Achieved	Achieved	◎

Source: Baseline and target values are from materials provided by JICA. Actual values are from the provisional version of the Phase 2 Project Completion Report)
(Note) Achievement status is indicated by ◎ = achieved, × = not achieved.

3.2.1.3 Qualitative Effects (Other Effects)

The qualitative effects of Phase 1 anticipated at the time of appraisal were: (a) Strengthening the Health Administrative Capacity of County Governments, (b) Improving the Quality of Free Maternal Services, and (c) Improving the Service Quality of HSSF-RBF Target Facilities. The anticipated qualitative effects of Phase 2 were (d) Expansion of Targets and Coverage of HISP and (e) Promoting Economic Stabilization and Social Development in Kenya. As a result of analyzing the pathways through which project effects emerge, (e) corresponds to an impact, which will be dealt with in the impact section below.

The status of achievement of each qualitative effect is shown in Table 8 below.

Table 8: Achievement of Qualitative Effects

Qualitative Effects	Achievement
(a) Strengthening the Health	◎Coordination between the Ministry of Health and the Counties Continues. ・ Regarding Health Sector Inter-Governmental Affairs (HSC/IGA),

Administrative Capacity of County Governments	which consists of the Cabinet Secretary, the governors of each county, and the county health sector representatives, a health forum is held every quarter to coordinate between the central and county levels (however, due to budgetary constraints, it is challenging to have quarterly meetings). ◎ Community health delivery organizations have been strengthened. ・ To strengthen the county's administrative role in expanding UHC, new Community Health Units (CHUs) have been established, linked to primary healthcare facilities (Level 1 facilities). A CHU comprises one Community Health Assistant and ten Community Health Promoters (CHP) deployed to villages. These CHPs were previously known as Community Health Volunteers (CHVs). ・ The field survey confirmed that the outreach activities of the CHP play a key role in registering and disseminating healthcare-related information and raising awareness within local communities. It was reported that the CHPs contributed to reducing waterborne infections by educating residents about proper toilet management and safe drinking water practices. (Source: Interviews with CHPs in Machakos County) ・ The Ministry of Health has continuously provided Training of Trainers (TOT), awareness sessions, and technical support to the CHMT.
(b) Improving the Quality of Free Maternal Services	△ The FMS has been Implemented, and the Number of Users has Increased; However, There are Issues with the Quality of the Services. ・ In 2016, the program transitioned to the NHIF and was made free of charge. As a result, the number of users has surged; however, this has not reduced maternal mortality rates. ・ There are economic disparities in the quality of maternal services. Certain medical services such as ultrasound examinations, and certain medical complications that arise during pregnancy, such as hypertension and malaria, are not covered under the FMS program, leading to out-of-pocket costs for patients. ・ Although medical facilities are supposed to receive reimbursement from the NHIF, payment delays have harmed the health facilities, preventing them from earning adequate revenue and resulting in unpaid bills. This has also hurt service delivery, with some private health facilities having to stop providing free obstetric services under the FMS programme due to a lack of funds.[27] ・ Facility deliveries increased from 70% in 2017 to 78% in 2020, with 1,163,712 pregnant women registered and 784,220 births recorded as outcomes of the NHIF programme.[28] △Access to Quality FMS Services has not yet been Sufficiently Improved. ・ Many pregnant women live far from health facilities, cannot afford maternal services, and face other barriers to receiving quality care.[29] △The Transition to the New Fund is Unclear. ・ The program was announced to end in July 2024 and transition to the Social Health Insurance Fund (SHIF). However, at the time of ex-post evaluation, no clear guidance or specific details on how the transition would occur were provided.
(c) Improving the	As shown in the section on relevance, there is a gap in the logical structure

[27] Performance Audit Report on Linda Mama Programme by the National Health Insurance Fund (IMPLEMENTATION-OF-THE-LINDA-MAMA-PROGRAMME-BY-NHIF.pdf)
[28] Vision 2030 Flagship Programme/Projects Progress Report (FY 2020/2021)(VISION-2030-FLAGSHIP-PROGRAMMES-AND-PROJECTS-PROGRESS-REPORT-FOR-THE-FY-2020_2021-Final.pdf)
[29] International Commission of Justice Kenya Section Report (dated on April 26, 2024)

Service Quality of HSSF-RBF Target Facilities	between the program covering running costs and the improvement of the quality of health services, so the current situation at the time of the ex-post evaluation is described. ・ HSSF-RBF was Terminated. The WB's Kenya Health Sector Support Project (KHSSP) was officially terminated on June 30, 2018, and the county accounts reserved for this fund were closed. The decision to continue Performance-based financing (PBF) after KHSSP was left to the counties and many counties incorporated RBF activities into the WB's follow-on project, the THS-UC (Transforming Health Systems for Universal Care) program. Still, the counties were unable to sustain payments to facilities and staff compensation.
(d) Expansion of Targets and Coverage of HISP	◎The Program has been Expanded. ・ In January 2022, the NHIF Act was amended to expand the scope of the HISP under it from orphans and vulnerable children to include elderly and severely disabled households. It was renamed the Health Insurance Subsidy (HISP-OVC) Programme. The number of eligible households exceeded the target, and as of June 30, 2022, 254,368 OVC households were eligible, and 368,775,878 Kenyan shillings had been paid out as benefits.[30] △The Transition to the New Fund is Unclear ・ It has been announced that the NHIF will end in July 2024 and be replaced by the Social Health Insurance Fund (SHIF). Still, no specific process was communicated at the time of the ex-post evaluation as to how the transition would take place.

(Note) The status of the achievement of qualitative effects is marked as follows: ◎Continued/Effects Observed, ○ Continued, △ Insufficient but Continued, × Not Continued.

Policy actions were achieved in both phases. Through these policy actions, such as conducting health financing analyses, exploring legal frameworks for building financial flows to healthcare facilities, and engaging with the Ministry of Health and the Ministry of Finance, the projects strengthened health financing and the capacity to provide healthcare services.

Regarding operational effectiveness indicators, the objective of reducing disparities in access to health services, targeted in Phase 1, was met. The number of households covered by the Health Insurance Subsidy Program (HISP) increased, the number of FMS users rose, and the facility-based delivery rate improved. However, challenges remained, such as issues with the quality of services provided at facilities, access barriers due to distance and economic disparities, and these did not lead to improvements in maternal mortality rates. Although irregular, coordination between the Ministry of Health and the counties has been maintained through forum meetings regarding strengthening county governments' health administrative capabilities. The Community Health Management Teams established at the county level have contributed to improving and expanding access to healthcare services through home visits.

For Phase 2, the policy actions to strengthen health financing and healthcare service provision capacity have seen continued action on UHC-related documentation. Still, actions concerning

[30] Ministry of Health Sector Working Group Report Medium Term Expenditure Framework (MTEF) for the Period 2023/24-2025/26 (Health-Sector-Report.pdf)

financial aspects have had limited continuation.

In summary, implementing the program has resulted in limited achievement of the expected outcomes.

Photo 2: Nairobi County Health Center

Photo 3: The Delivery Room at a Local County Health Center (Photo by the external evaluator)

3.2.2 Impacts

3.2.2.1 Intended Impacts

The impacts for both phases were "Contribution to the Achievement of UHC" and "Contribution to Social Development." In Addition, the impact set for Phase 2, "Contribution to Kenya's Economic Stability," will also be included in the analysis.

(1) Contribution to the Achievement of UHC

The analysis will be based on "(a) Percentage of Government Health Expenditure over General Government Expenditure" and "(b) Percentage of Population Covered by any Health Insurance" up to the time of the ex-post evaluation.

Table 9: Contribution to the Promotion of UHC

Indicator/ Fiscal Year	Baseline	Target	Actual				
	Appraisal	Project Completion 2023	2018/19	2019/20	2020/21	2021/22	2022/23
(a) Percentage of Government Health Expenditure over General Government Expenditure	6.7% 2015	9%	7.2%	8.2%	8.9%	9.3%	N/A
(b) Percentage of Population Covered by any Health Insurance	19.9%	60%	N/A	89%	46%	55%	N/A

(Source: Baseline and target values are from materials provided by JICA, and actual values are from the *Ministry of Health Sector Working Group Report Medium Term Expenditure Framework (MTEF) for the Period 2023/24-2025/26*

(a) Percentage of Government Health Expenditure over General Government Expenditure: The target was achieved.

Government expenditure has gradually increased over the years, reaching 9.3% in fiscal 2021/22, ahead of the target of 9% (Table 9). However, according to the Ministry of Health, this cannot be considered a direct increase in contribution to UHC, as there has been increased expenditure on the health sector due to the spread of COVID-19.

(b) Percentage of Population Covered by any Health Insurance: As of the first half of 2022, this has not been achieved and is unlikely to be achieved by the target year.

The figure increased to 46% in fiscal 2020/2021 and 55% in fiscal 2021/2022 (Table 9), but according to interviews with the Ministry of Health, it will be difficult to achieve the target figures by the end of the target year. This is because the spread of COVID-19 has created a vicious cycle in which people suffer from economic downturns, job losses, and reduced incomes, making it difficult to pay insurance premiums, resulting in a decrease in the number of people enrolled in public health insurance.

(2) Contribution to Social Development

1) The Number of NHIF Members

The number of NHIF members has been increasing yearly, with a notable rise in the proportion of members from the informal sector benefiting from government subsidies (Table 10). According to a special audit report on NHIF, an analysis of the financial statements for the past three years revealed that while the insurance premium collections have tripled, the benefit payouts have increased fivefold during the same period, resulting in benefit payments exceeding the contributions made to NHIF. Furthermore, the retention rate of members remains at 44%, indicating that the system is facing challenges in achieving stable operations.[31]

Table 10: Transition of the Number of Public Insurance (NHIF) Members

(Unit: individuals)

	2020/21	Proportion	2021/22	Proportion
Formal Sector (Salary Earners)	4,645,981	33%	4,821,632	31%
Informal Sector (Low-income Household)	9,295,817	67%	10,637,602	69%
Total	13,941,798	100%	15,459,234	100%

(Source: Ministry of Health Sector Working Group Report Medium Term Expenditure Framework (MTEF) for the Period 2023/24-2025/26)

2) Key Health Indicators

The key health indicators, such as under-five and infant mortality rates, have improved. However, the maternal mortality rate has worsened. While the number of users has increased, there are concerns about the quality of services, as pointed out by the Ministry of Health's UHC division.

[31] Report of the Departmental Committee on Health on its Consideration the inquiry into alleged Fraudulent Payments of Medical Claims and Capitation to Health Facilities by the National Health Insurance Fund.pdf (parliament.go.ke)(Accessed August 10, 2024)

Table 11: Transition of the Key Health Indicators

Indicator/ Year		Phase 1					Phase 2		
	2014	2015	2016	2017	2018	2019	2020	2021	2022
Under-5 Mortality Rate (per 1,000 live births)	48.9	47.5	46.3	45.4	44.3	43.4	43	41.9	41.1
Infant Mortality Rate (per 1,000 live births)	22.1	22	21.9	21.7	21.5	21.3	21	20.7	20.4
WHO: Maternal Mortality Rate (per 100,000 live births)	507	483	505	490	512	503	530	N/A	N/A

(Source: WHO Mortality database[32])

(3) Contribution to Kenya's Economic Stability

Although it was not possible to analyze the financial flow of the projects, according to the Ministry of Health, the projects contributed to reducing the government's burden by supporting capacity building and promoting the digitization of information systems that could not be addressed through the government budget due to the fiscal deficit.

Table 12 shows the proportion and amount of health expenditure in the government's total expenditure and the share of health expenditure in Gross Domestic Product (GDP). While the proportion of health expenditure in total government expenditure and the amount of government health spending has been increasing, the share of government health expenditure in GDP has not grown, and it does not meet the 5% target recommended by the WHO.

Table 12: The Proportion and Amount of Health Expenditure in Government Expenditure and the Share of Health Expenditure in GDP

Items / Year		Phase 1					Phase 2	
	2014	2015	2016	2017	2018	2019	2020	2021
Proportion of Health Expenditure in Government Expenditure	7.8%	8.1%	8.0%	6.8%	7.2%	8.2%	8.9%	9.3%
Amount of Government Health Expenditure (100 million KES)	929	1,095	1,267	1,423	1,600	1,993	2,301	2,608
Percentage of Health Expenditure in GDP	4.9%	4.8%	4.8%	4.0%	4.1%	4.4%	4.5%	4.5%

(Source: Global Health Observatory Data Repository, WHO)

3.2.2.2 Other Positive and Negative Impacts

(1) Impacts on the Environment, Resettlement and Land Acquisition

Regarding the environmental impacts of both phases, they were classified as Category C according to the *International Organizations Guidelines for Environmental and Social Considerations* (issued in April 2010) because undesirable environmental effects were deemed minimal. No resettlement or land acquisition was anticipated. No negative impacts have been reported for either phase.

[32] WHO Mortality Database - WHO (Accessed August 10, 2024)

(2) Gender Equality

In Phase 1, the impact of the FMS program was expected. Phase 2 was a project to support the improvement of maternal and child health indicators through the provision of essential health and medical services, including maternal and child health, and was classified as a "Gender Informed (Significant) GI(S)[33]" project according to JICA's gender classification. The number of service users increased as obstetric health services were made free of charge under the FMS program. However, due to issues with the quality of services and access, the expected impact, such as an improvement in maternal mortality rates, has not been realized.

(3) Marginalized People

Promoting HISP and other programs in Kenya was expected to improve low-income people's access to medical facilities and reduce poverty. The Kenyan government revised HISP in January 2022, expanding the target population from orphans and vulnerable children to older people and severely disabled households. Since HISP was intended to be promoted in Phase 1, it is assumed that it has made a broader contribution.

(4) Social Systems and Norms, People's Well-being and Human Rights, Unintended Positive / Negative Impacts

No assumptions were made at the time of appraisal for either phase, and no unexpected impacts were identified during implementation or at the time of ex-post evaluation.

Concerning contributions to the promotion of UHC, government health expenditures have risen over the years. The ratio of government health expenditures to the government's fiscal general expenses reached the target ahead of schedule. Still, on the other hand, the ratio of the population covered by the social health security scheme did not reach the target.

The number of people enrolled in public insurance from the informal sector that receive government subsidies has increased. The expansion of benefits to people experiencing poverty has promoted the achievement of UHC. Still, it has also led to an outflow of formal sector enrollees who pay insurance premiums, and the low enrollment rate is also an issue. In addition, many problems were discovered in the public insurance fund management organization. A new organization was established, and it is now managing the fund. As it is still in the transitional stage at the time of the ex-post evaluation, the effects are expected to be largely retained. However, it is necessary to take immediate action to prevent the impact of the confusion from spreading. As for other impacts, there will be almost no negative impacts.

As of above, the programs have achieved their objectives only to a certain extent. Therefore, effectiveness and impact of the projects are moderately low.

[33] Projects that do not directly set goals for promoting gender equality or women's empowerment in their project purpose or overall goal but explicitly incorporate specific initiatives that contribute to gender equality and women's empowerment.

3.3 Sustainability (Rating: Not Assigned)

In this evaluation, only the assessable aspects of "Policy and System," "Institutional/Organizational," "Financial," and "Preventative Measures to Risks" are analyzed, and no sub-rating to sustainability is given.

3.3.1 Policy and System

(1) Sustainability in Policy Aspect

The national development policies at the time of the ex-post evaluation are *Vision 2030 (2008-2030)* and the *Medium-Term Plan IV (2023-2027)*, and the medium-term policy for the health sector is *Kenya Health Sector Report 2024/25-2026/27 Medium-Term Expenditure Framework*. Both prioritize ensuring UHC and indicate related programs such as securing health sector human resources and improving access to medical service facilities.

The new administration of President Ruto, launched in September 2022, also indicates the achievement of UHC as a priority issue (*BIG 4 Agenda*). In October 2023, at the initiative of the President, the President signed the following four bills to improve health policies and the financing environment toward achieving UHC. From the above, it can be said that the sustainability of the policy is guaranteed.

The Primary Health Care Act, 2023: Establish a framework for primary health care delivery, access, and management to ensure equitable distribution of health services.
The Social Health Insurance Act, 2023: The scope of coverage for the National Health Insurance was expanded to all Kenyans, removing employment requirements. In addition, the National Health Insurance Fund (NHIF) was abolished, and three new funds were created: the PHC Fund, the Chronic, Emergency and Critical Illness Fund, and the Social Health Insurance Fund (SHIF). The Social Health Insurance Authority (SHA) was established to manage them.
The Facility Improvement Financing (FIF) Act, 2023: The act is the legal basis to provide health facilities with financial autonomy to manage the revenues they collect from user fees, insurance contributions, and other sources. It aims to eliminate delays in payment and diversion of revenues to non-health expenditures at the county level, which previously occurred due to revenues from PHC facilities being consolidated into county revenue funds.
The Digital Health Act, 2023: The aim is to establish an integrated digital health information system, strengthen data governance, and protect personal health information.

(2) Sustainability of System Aspect

Based on the *Social Health Insurance Act* signed by the President in October 2023, NHIF, established in 1965, was to be abolished, and a new organization, SHA, was established to manage financing contributing to UHC.

The decision to transition was made due to issues such as fraudulent receipt of medical fees and unaccounted funds within the NHIF organization and the problem of a lack of insurance subscribers and insurance premium revenue. In addition, There was a challenge in that it was difficult to motivate self-employed workers to join the system because the premium was collected by deducting it from the salary. The new organization will set the premium amount according to income, so the scope of the application will be expanded[34].

The transition process will involve consultations between the Transition Committee, established in February 2024, NHIF, SHAs, and the Ministry of Health. It will complete the transition to the new fund within 12 months, as stipulated by law. The Transition Committee is expected to develop legal and institutional frameworks, guidelines, and operational mechanisms for assets and liabilities, human resources and pensions, other employee benefits, and a clear roadmap for dissolving NHIF[35]. The transition process faced criticism due to its rapid implementation and perceived lack of preparation. Following the rollout, many health facilities experienced operational challenges due to the abrupt shift to the new system. Public communication was insufficient, leading to widespread uncertainty among health facilities, particularly regarding the FMS program, which had served many mothers across the country.

SHA officially began operations on October 1, 2024. Still, there was confusion, such as members being unable to receive treatment covered by insurance because their registration data had not been transferred from the previous organization and more than half of the medical facilities not being registered with SHA due to a lack of awareness[36]. One of the reasons medical facilities were hesitant to register was that NHIF had owed hospitals KHS 30 billion (approximately JPY 35 billion) in unpaid medical fees, and the matter had been left unresolved. In mid-October 2024, it was announced that the Kenyan government would shoulder the owed amount. However, the government's payments to medical institutions and the registration of medical institutions are still in progress[37]. As such, the system is in a transitional period, and it is unclear whether it will be able to resolve the problems of the previous fund and maintain its sustainability.

3.3.2 Institutional/Organizational Aspect

(1) Executing Agency

In Phase 1, the Policy, Planning, and Health Financing Department was responsible for supervising the project within the Ministry of Health. In Phase 2, the UHC Coordination Department established within the Ministry of Health was responsible. The Resource Mobilization Department was involved in project supervision and monitoring at the Ministry of

[34] Interview with the Advisor for the Ministry of Health
[35] Social Health Authority (SHA) kicks off registration – USAID HERO (ku.ac.ke)
[36] SHIF mess: How transition to new healthcare system was bungled | Nation、More than half of private hospitals yet to register on SHA portal | Nation
[37] State to pay hospitals Sh30bn owed by NHIF | Nation

Finance.

At the time of the ex-post evaluation, the organization and personnel of the Ministry of Health had been significantly changed. In August 2024, the Ministry of Health was reorganized, and the entire organization was divided into the Department of Medical Services and the Department for Public Health and Professional Standards. The Health Sector Coordination & Research Directorate of the Public Health and Professional Standards Department is responsible for UHC-related tasks, and the Health Sector Coordination & Intergovernmental Relation Division and the International Health Relations Division were established under it. The former is responsible for coordination with government agencies and counties, including UHC, and the latter for coordination with donors.

The Ministry of Finance was no longer the implementing body for considering financial resources for UHC, and the allocation of budgets from the general account to the health sector had reverted to the regular system in which applications from each ministry were submitted and reviewed by the relevant department each fiscal year.

(2) Organization and Personnel at the County Level

According to the Ministry of Health, frequent gubernatorial elections, changes in county leaders, and personnel changes at the county level make it difficult to plan and strengthen the capacity of personnel and maintain continuity because trained personnel do not stay in the organization.

(3) Fund Management Organization

As shown in the previous section on the system aspect, the fund management organization was transferred from NHIF to SHA. However, it is still in the transition period, and many unclear points about the system and organizational structure exist.

As such, at both the central and local levels, organizational restructuring and personnel changes frequently occur due to the influence of the political situation, so it is expected to be challenging to ensure the organization's and structure's sustainability. SHA has only just been established and is still in the transition period from NHIF, so it is impossible to judge the organization's sustainability.

3.3.3 Financial Aspect

(1) National Government, Ministry of Health

Table 13 shows the trends in national revenue and expenditure. Expenditures have exceeded revenue in every fiscal year. In May 2020, the International Monetary Fund (IMF) changed Kenya's debt distress risk assessment from "medium" to "high". US rating agency Moody's Investors Service also downgraded the country from "B2 stable" to "B2 negative". Kenya's public debt was expected to reach 8.4 trillion Kenyan shillings, with a GDP ratio of 76%[38].

[38] JETRO Report (Japanese only) Economic recovery expected, but huge debt and security challenges remain

Table 13: Trends in Kenya's Revenues and Expenditures (unit: 1 billion KES)

	(I)					(II)			
Fiscal Year	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Revenue	1,250	1,424	1,515	1,675	1,753	1,775	2,231	2,384	2,725
VAT	1,112	1,253	1,312	1,440	1,428	1,485	1,837	1,960	2,160
Others	110	144	176	204	306	254	363	400	542
Grants	28	27	28	30	20	37	31	23	22
Expenditure	1,777	2,164	2,111	2,390	2,565	2,706	3,023	3,218	3,605
Wages & Salaries	1,029	1,219	1,320	1,500	1,645	1,767	2,135	2,309	2,678
County Transfer	264	285	306	360	325	391	352	416	380
Development	484	660	486	529	595	549	536	494	546
Revenue - Expenditure	-527	-740	-597	-715	-812	-931	-792	-835	-881

(Source: Central Bank of Kenya Government Finance Statistics[39])

The trends in the Ministry of Health's budget are shown in the section on relevance, "3.1.1.2 Consistency with the Development Needs of Kenya," and the required financial resources have exceeded the amount of available financial resources over the years.

(2) Management Organization of Public Healthcare Financing

A new system ensuring UHC was rolled out by SHA on 1st October 2024, replacing the former NHIF's role. Judging SHA's performance was impossible because there was not enough information at the time of the ex-post evaluation. Still, the reason for the transfer was that there were significant problems with the management of NHIF.

3.3.4 Preventative Measures to Risks

The risk raised at the time of appraisal was Kenya's political and economic situation. At the time of the ex-post evaluation, there were frequent demonstrations among the public expressing dissatisfaction with the domestic political and economic situation. If the situation worsens, it cannot be denied that the central and local governments will be affected.

When the Kenyan government announced a proposal to increase taxes on daily necessities to reduce the fiscal deficit, protests escalated, mainly among young people. On June 25, 2024, violent demonstrators stormed into the National Assembly, and security forces opened fire, killing dozens of people[40]. In response to the anti-government criticism, the president reshuffled his cabinet, but 10 were simply reappointed and replaced in their posts, which did not go well with the public. The assets of cabinet members have been published in newspapers and elsewhere, but public discontent with the candidates with significant assets shows no signs of subsiding[41]. If this

(Kenya) | Points of interest for African business in 2021 - Special feature - Regional and analytical reports - Overseas business information - JETRO (jetro.go.jp) (accessed August 15, 2024)

[39] Government Finance Statistics | CBK (centralbank.go.ke) (accessed October 30, 2024)

[40] Tokyo Shimbun News (Japanese OnlyKenyan President begins cabinet reshuffle as anti-government protests show no signs of calming down: Tokyo Shimbun TOKYO Web (tokyo-np.co.jp) (accessed July 30, 2024)

[41] JETRO Business News dated on August 13, 2024 (https://www.jetro.go.jp/biznews/2024/08/87d6f6c17f90ccdd.html)

leads to organizational restructuring or personnel transfers, or if it leads to decisions to reduce health expenditures, it could pose a risk to the effectiveness of this project.

Based on the above, policy sustainability has been ensured through the mid-to-long-term policies of the nation's health sector and the presidential initiative. Regarding the system, SHA was established after numerous problems were discovered with NHIF, which had been responsible for managing the National Health Insurance Fund. At the time of the ex-post evaluation, information on SHA was still limited, and it was unclear whether the system, structure, and financial sustainability required to resolve the problems of the previous fund could be guaranteed. The Ministry of Health and the County Health Offices frequently undergo organizational restructuring and personnel transfers, making it difficult to guarantee organizational, structural, and financial sustainability. In addition, frequent demonstrations against the political and economic situation have occurred throughout the country, raising concerns about the risk of sustainability.

4. Conclusion, Lessons Learned and Recommendations

4.1 Conclusion

The projects were DPL programs to support the achievement of UHC in Kenya. Phase 1 aimed to rectify economic and physical disparities in access to health services by supporting the formulation of a direction for promoting UHC, the formation of a central and county foundation, and the expansion of three major UHC-related programs, thereby contributing to the achievement of UHC and the promotion of social development.

Phase 2 aimed to achieve UHC, economic stability, and social development by supporting the implementation of high-priority policies for achieving UHC through policy dialogue and financial support and strengthening health financing and health service delivery capacity.

The projects were fully aligned with Kenya's development policies, health sector guidelines, and development needs from the time of appraisal to ex-post evaluation. In the Phase 1 plan, logical issues were identified in the structure of the policy matrix and its indicators. Drawing from lessons learned in the previous phase, in Phase 2 planning, a mechanism was established to allocate funds for intended activities while adhering to the constraints of the DPL. However, challenges in checking and monitoring the outcomes of Phase 1 implementation persisted, even at the time of the ex-post evaluation. The projects were consistent with Japan's development cooperation policy at the time of appraisal. As for internal consistency, the collaboration envisaged at the time of appraisal was implemented, and effects were realized. Still, external consistency could not be confirmed as it was limited to coordination with other donor projects. For these reasons, relevance and consistency are moderately low.

Regarding effectiveness, the policy actions in both phases were achieved. The operational and effect indicators in Phase 1 were achieved, but this did not lead to an improvement in the key health indicator of maternal mortality rate. The continuation of financial actions was limited in Phase 2, which strengthened health financing and the capacity to provide health care services. Regarding impact, the target for the ratio of government health expenditure to general government expenditure was achieved ahead of schedule. Still, the target for the proportion of the population covered by insurance was not achieved. For these reasons, the effectiveness and impact are moderately low.

Regarding the sustainability of the projects, only items that can be analyzed are included. Still, since the UHC fund management agency is in a transitional period, attention needs to be paid to the system, organization/structure, finances, and risk response.

4.2 Recommendations

4.2.1 Recommendations to the Executing Agency

None

4.2.2 Recommendations to JICA

None

4.3 Lessons Learned

The necessity of monitoring relevant programs and the organization managing them.

Phase 1 of this project aimed to promote the implementation of the three major UHC programs to contribute to the achievement of UHC. Therefore, it would have been necessary to check the target programs' progress of policy actions and monitor the Ministry of Health's oversight of the fund operating organization to ensure the program's fund management was functioning correctly. When the fund-operating organization implements the programs targeted by the policy actions, it is advisable to monitor the supervision of the fund-operating organization by the Executing Agency.

Considering measures to deal with project risks in unstable political and economic countries.

In countries where there is a high possibility that they will be in an economically difficult situation from the time of appraisal to the time of ex-post evaluation, where elections will bring about frequent announcements of personnel and system changes, and where they will be affected by the suspension of program funding from other donors, it is advisable to identify possible risks at the time of appraisal and consider countermeasures to those risks.

5. Non-Score Criteria

5.1 Additionality

None

(End)

Appendix 1_Policy Matrix (Phase 1)

◎Continued/Effects Observed, ○ Continued, △ Insufficient but Continued, × Not Continued.

	Category	Policy Action for the 1st Tranche (action to be taken by Feb 2015)	Policy Action for the 2nd Tranche (action to be taken by Dec 2015)	Responsible Section	Donors (at the time of appraisal)	Coordination with JICA and othe donors' projects/programs	Means of varification	Continuation and Development
I. Policy documents								**Continuation of Policies and Effects at the Time of Ex-post Evaluation**
1	Health Policy	(1) National Health Policy that incorporates management of health sector in the developed system as stipulated in the Constitution of Kenya, 2010, is approved by CS, MoH		Policy, Planning and Healthcare Financing Department MoH, and Intergovernmental Relations MoH	JICA	**JICA Expert (Yen Loan / Health Finance)** ・provided support in developing UNC roadmap ・provided technical supports to UHC Steering Committee in developing policy papers.	development of National Health Policy	◎**Health Policies Updated** National Health Policy 2014-2030(July 2014) Kenya Health Financing Strategy 2020-2030
2	Kenya Health Sector Strategic and Investment Plan 2014-2018	(2) The consultation with countries and other stakeholders on the draft Kenya Health Sector Strategic and Investment Plan 2014-2018 is held	(9) Kenya Health Sector Strategic and Investment Plan 2014-2018 is approved by the PS, MOH	Policy, Planning and Healthcare Financing Department MoH	WB , German DevelopmentCooperation (GDC), USAID		development and approvval of 5-year Kenya Health Sector Strategic and Investment Plan	◎**The five-year Health Sector Strategic and Investment Plan has been updated** Kenya Health Sector Strategic Plan 2018-2023 HEALTH SECTOR REPORT MEDIUM TERM EXPENDITURE FRAMEWORK (MTEF) FOR THE PERIOD 2024/25-2026/27 (December 2023)
3	UHC Roadmap	(3) A ministerial draft of the UHC Roadmap based on the approved Concept Note is prepared and shared with Development Partners	(10) The Health Care Financing Strategy is drafted and the outlined of essential health package is shared with the UHC Steering Committee	Policy, Planning and Healthcare Financing Department MoH	Social Health ProtectionNetwork(P4H), WB, USAID,JICA, German DevelopmentCooperation (GDC),WHO		development and sharing of UHC Roadmap, and outline of essential health package is shared with steeling committee	○**Although the roadmap has not been updated since its creation, the contents of the roadmap are reflected in the health financing strategy, maintaining a certain degree of continuity.** UHC 2018-22 Roadmap developed and approved The roadmap for achieving UHC has not been updated, but is integrated into the sector-wide health financing strategy.
II. Health Financing Program for UHC								**Continuation of Policies and Effects at the Time of Ex-post Evaluation**
4	HISP	(4) HISP implementation manual is finalized					development of HISP Mannual	△ **It is unclear what the content, budget, and transition process of the program will be, as it will be transitioned to a new fund system.** It has been declared that the program will end in July 2024 and transition to the Social Health Insurance Fund (SHIF), but no specific policy has been indicated as to how the transition will take place at the time of the ex-post evaluation. ◎ **The program has been expanded.** In January 2022, the NHIF Act was revised, and the HISP under it was expanded in scope from households with orphans and vulnerable children to households with elderly people and severe disabilities. The name has changed to the Health Insurance Subsidy (HISP-OVC) Programme. As of June 30, 2022, 254,368 OVC households are eligible, and a total of 368,775,878 Kenyan shillings have been paid as benefits. (Source: MTEF HS WG report)
5	FMS (Free Maternal Service)	(5) FMS concept note is prepared and GOK budget on FMS for FY2014/2015 is approved	(11) FMS Operation Manual that incorporates the results of the situation analysis is prepared and GOK budget on FMS for FY 2015/16 is approved.	Policy, Planning and Healthcare Financing Department MoH, and National Health Insurance Fund(NHIF)	WB	**WB Health Sector Support Project** ・financial supports and technical cooperation to UHC related program	Development of FMS Opeation Manual Securing and allocating budget for FMS	△ **The free obstetric care (Linda Mama) program was implemented and the budget was secured, but there are problems with the funding system.** ・ In 2016, the program was transferred to NHIF and made free. This led to a dramatic increase in the number of users, but it has not reduced maternal mortality. A policy was announced to end the program in July 2024 and transfer it to the Social Health Insurance Fund (SHIF), but at the time of the ex-post evaluation, there was no concrete progress. ・In 2022/2023, more than 1.2 million pregnant women were registered with the Linda Mama program, with 927,102 births, of which 84% were attended by skilled medical personnel. This is a significant jump from 65% in 2021/22. 65% of program recipients attended at least four ANC visits. (Source: MTEF Health Sector Report) ・However, there are still financial hurdles when seeking skilled obstetric care services. Ultrasound scans and some medical complications that occur during pregnancy, such as high blood pressure and malaria, are not covered by the program and are, therefore, at the individual's own expense. - Under the program, NHIF reimburses health facilities. Still, reimbursement delays have negatively impacted health facilities, preventing them from making adequate revenue and resulting in non-payment of fees. This has also harmed service delivery, with some private health facilities being forced to stop providing free obstetric services under the program due to a lack of funds. (Source: 2022 Performance Audit Report on the Implementation of the Linda Mama Program) △ **It is unclear what will happen to the free obstetric services program as it will be transferred to a new system** - With the transition to the Social Health Insurance Fund (SHIF), obstetric service providers have not been given any specific information about how the free obstetric services program will continue, causing confusion (Source: Interviews at Machakos County Health Facilities) △ **Access to services has not yet improved sufficiently.** ・"Comprehensive Evaluation Report: Implementation of the Free Maternity Services (FMS) Program in Kenya's Decentralized Health System: Ministry of Health" points out that "Many women still live far from health facilities, cannot afford to pay for obstetric services, and face other barriers to receiving quality care." (Source: International Commission of Justice Kenya Section Report* dated April 26, 2024)
6	HSSF/RBF (Health Sector Service Fund - Results Based Funding)	(6) HSSF-RBF implementation manual for ASAL that includes verification methodology for health facility is prepared and shared with 20 ASAL counties.		Policy, Planning and Healthcare Financing Department MoH	WB		Preparation of HSSF-RBF manual Sharing the manual with 20 ASAL counties	× **Not continuing. Subsidies ended, and some activities were transferred to other programs.** ・Supported by WB, but subsidies ended in 2020. (Source: Questionnaire responses to the Ministry of Health) ・As the WB Kenya Health Sector Support Program (KHSSP) officially ended on June 30, 2018, the county accounts set aside for this fund were closed. The decision to continue PBF (Performance-based financing) after KHSSP was left to the county and many counties incorporated RBF activities into the WB's follow-up program, the THS-UC program (Transforming Health Systems for Universal Care**). Payments to facilities and staff compensation could not be maintained, but monitoring of service delivery indicators continues. Kenya Medical Training College: THS-UC took over the training of nurses at KMTC. (Source: PCR(I))
III. Health System Strengthening								**Continuation of Policies and Effects at the Time of Ex-post Evaluation**
7	Coordination of Developed Health System	(7) Terms of Reference of Department of Health Sector Coordination and Intergovenmental Affairr in MOH is clearly defined.	(12) Training needs assessment of health systems management at the county level is conducted.	(7) Policy, Planning and Healthcare Financing Department MoH, and Intergovernmental Relations MoH (12) Human Resource Development Unit, Administration, Directore of Health Standards and Quality Assurance, and Policy, Planning and Healthcare Financing Department MoH	(7) JICA, WB (tentative) (12) WHO, WB, UNICEF, USAID,JICA, GIZ	JICA Technical Cooperation **"Project for Organizational Capacity Development for Devolved County Health Systems in Kenya"** has been supporting the activities.	define TOR in coordination of UHC, define the training needs of health system management at the county level	○ **The Ministry of Health has been restructured, but the Health Sector Inter-Governmental Affairs Department continues to function. It also continues to coordinate with counties.** ・By government notification in 2023, the Ministry of Health has been reorganized into the Department of Medical Services and the Department for Public Health and Professional Standards. The Health Sector Inter-Governmental Affairs Department has been combined with the Research Department and placed under the Health Sector Coordination & Research Directore, becoming the Health Sector Coordination & Intergovernmental Relations Division. The International Health Relations Division has taken over donor coordination. ・The Health Sector Inter-Governmental Affairs (HSC/IGA) comprises the Cabinet Secretary, the governors of each county, and the county health sector representatives. The Ministry of Health is responsible for the Health Sector Coordination & Intergovernmental Relations Division, and quarterly health forums are used to coordinate (however, quarterly meetings are difficult due to budgetary constraints). ◎ **At the district level, a unit specializing in PHC and home visit staff has been established to expand UHC. This is to meet their training needs.** ・In order to strengthen the administrative role of districts to expand UHC provision, new community health units linked to primary health care facilities (level 1 facilities) have been established. The goal is to establish one unit per 5,000 people, and as of June 2023, 8,778 units have been formed, exceeding the target of 8,663 units nationwide. (Source: MTEF Health Sector Report) ・Community health units are required to have one Community Health Assistant and 10 Community Health Promoters (CHPs, formerly known as volunteer CHVs) to be dispatched to villages. A total of 30,000 people were recruited across the 47 districts nationwide. In response to this training need, the Division of Community Health of the Ministry of Health provided support for training CHVs in 2019/2020. (Source: Responses to the questionnaire to the Ministry of Health)
8	Community Health	(8) Standards for Community Health Service is approved by PS, MOH	(13) Standards for Community Health Service is disseminated within MOH and among County Governments.			JICA Technical Cooperation **"Project for Strengthening Community Health Strategy" (2011 to 2014)** assisted in developing draft of Standards for Community Health Service.	development of Standards for Community Health Service number of county government desemminated how the standards were dessemnated within MoH and County Governments	◎ **Information-raising activities in districts are continuing.** - Information-raising activities are being carried out through health forums by the Ministry of Health and district representatives, the MoH website, and through activities in districts by development donors. (Source: Responses to a questionnaire sent to the Ministry of Health)

Appendix 2 Policy Matrix (Phase 2)

Category	Background	Policy Action for 1st Tranche (by the end of March 2019)	means of verification	Policy Action for 2nd Tranche (by the end of December 2019)	means of verification	Policy Action for 3rd Tranche (by the end of December 2020)	means of verification	◎Continued/Effects Observed, ○ Continued, △ Insufficient but Continued, × Not Continued. Continuation and Development
1. Strengthen Health Financing （8 actions）								**Continuation of Policies and Effects at the Time of Ex-post Evaluation**
1-1 Budget Projection	Financial sustainability of UHC beyond 2022 will be assured through midterm budget projection	(1) Projection of government reveune, budget allocation to health compared with budget necessary for allaining UHC is drafted. (Budget Department, the National Treasury and Planning (TNT) and UHC Coordination Department, MoH in charge)	Report on projection	(7) Budget Projection on UHC prepared by TNT is published on the website of TNT. (Budget Department, TNT and UHC Coordination Department, MOH in charge)	Budget Outlook Paper and Health Sector Technical Working Group Report			**△ Subsequent documents have been prepared, but the Ministry of Finance did not prepare them as a joint team.** In December 2023, the Health Sector Working Group Report and the Health Sector Report were prepared in response to the Medium Term Expenditure Framework (MTEF) for the 2024/25-2026/27 period. The Ministry of Finance is at the top of the list of stakeholders but was not involved in their preparation. **△ At the time of the ex-post evaluation, the Ministry of Finance did not have a department dedicated to UHC.** The UHC joint team established in the Ministry of Finance at the time of project implementation was abolished, and at the time of the ex-post evaluation, the process of requesting and reviewing the budget for the health sector was the usual one. The Ministry of Finance's donor liaison officers are determined by region, and the person in charge of Asia (Korea and others) is the liaison officer for JICA.
1-2 Efficient Fund Flow for Health Facilities	Public Financing Management (PFM) Act restricts developed health facilities to retain user fees and purposed conditional grants for health do not reach facilities as intended.	(2) MoH proposed the revision of PFM Act to establish efficient fund flow to health facilities. (Quality Assurances, Standards and Regulations Department, MoH in charge)	letter of MoH which describes the work progess to JICA	(8) Revised PFM Act and/or relevant regulations are drafted and submitted to the relevant authorities in order to establish efficient fund flow to the health facilities. (Quality Assurance, Standards and Regulation Department, MoH in charge)	Revised PFM Act and /or relevant regulations drafted by MoH			**△ The Ministry of Health believes that the fund flow is functioning as expected, but there are problems at the county and medical institution levels.** - The PFM ACT stipulates that all funds, including FIF (Facility Improvement Fund), should not be diverted to other county budgets, and that the County Revenue Fund (CRF) should be used for level 4-6 medical facilities. FIFACT 2023 indicates a policy to strengthen the supervision capacity of medical facilities so that the income at medical facilities can be retained and used for expenditure. (Source: Questionnaire response to the Ministry of Health) - According to interviews with health facilities in the county, the fund flow is inefficient. After providing services to patients, the facility bills the NHIF, but the reimbursement process takes too long, which puts pressure on the facility's management. (Source: Interview with Machakos County Hospital) - NHIF is to be abolished, and a new Social Health Insurance Fund (SHIF) is to be established, but the transition period is prolonged because the Supreme Court ruled it unconstitutional. No specific operation method has been given to counties and service providers.
1-3 Medium Term Expenditure Framework （MTEF）	JICA's technical cooperation project developed MTEF process guide and MTEF management took Kirinyaga and Kericho are using MTEF management tool to link the Annual Work Plan and MTEF and financial expenditures.	(3) MTEF process guide is developed and uploaded on the website of MoH to share with counties (Policy, Planning and Healthcare Financing Department, MoH in charge)	Printed copy of website of the MTEF process guide	(9) 4 additional counties are trained on MTEF management tool. (Machakos, Nyeri, Migori, and Kisumu counties) (Quality Assurance, Standards and Regulation Department, MoH in charge)	Training Report			**× It has not been implemented in all counties**. The "Project for Strengthening Accountability in County Health Service Management" supported and implemented the implementation in Kirinyaga and Kericho counties only. Other counties showed interest, but there was insufficient awareness-raising for dissemination and they were not accepted. There were frequent changes in governors and county leaders and the resulting personnel changes, so training did not take root. Kirinyaga and Kericho counties also had long-term administrations, so personnel were stable. (Source: Responses to questionnaire to the Ministry of Health)
1-4 Health Technology Assessment（HTA）	Health Benefit Advisory Panel (HBAP) designed essential health benefit package for UHC. Introduction of HTA is necessary to make the benefit package for UHC more cost effective. MoU on Technical assistance for UHC including HTA was signed between Kenya and Thailand in January 2019.			(10) The conceptual framework for institutionalization of HTA in Kenya is proposed. (UHC Coordination Department, MoH in charge)	Conceptual framework for Institutionalization of HTA in Kenya	(15) Policy, strategic and legislative framework for institutionalization of HTA in Kenya is presented to the Cabinet Secretary (CS), MoH. (UHC Coordination Department, MoH in charge)	Presentation material for CS	**× Not yet institutionalized** ・Incorporating HTA into the Kenya UHC package is expected to improve cost efficiency, but due to a lack of financial support, it has not yet been institutionalized. (Source: Responses to a questionnaire sent to the Ministry of Health)
2. Improve Service Delivery and Quality (6 actions)								**Continuation of Policies and Effects at the Time of Ex-post Evaluation**
2-1 Kenya Quality Model for Health（KQMH）	KQMH was finalized and Training of Trainiers for KQMH was conducted to 47 counties. Mentorship and coaching on Quality Improvement (QI) at County Health Management Team (CHMT) and selected facilities is necessary for implementation of KQMH at county and facility levels.	(4) Mentorshp and coaching on QI at CHMT and selected facilities is implemented which the UHC Phase 1 counties. (Quality Assurance, Standards and Regulation Department, MoH in charge)	Mentorship and coaching report	(11) Membership and coaching on QI is escalated to other 4 counties outside the pilot counties (Quality Assurance, Standards and Regulation Department, MoH in charge)	Mentorship and coaching report	(16) Mentorship and coaching on QI expanded to additional 15 counties (Quality Assurance, Standards and Regulation Department, MoH in charge)	Mentorship and coaching report	**△ All districts have undergone training and evaluations by KQMH have been conducted, but sustainability is an issue.** ・ Trainers in all districts have undergone training for trainers, and refresher courses are also provided annually. Each district has a KQMH officer. ・ The spread of the standard model contributes to improving the quality of health services, but sustainability is an issue due to high staff turnover and lack of sustainability of financial support. (Source: Questionnaire response to the Ministry of Health) ・In fiscal year 2022/23, a total of 109 health facilities were evaluated using the KQMH criteria, while 50 health facilities were evaluated in the previous fiscal year (2021/22). (Source: Health Sector Report 2023-2027) ・With each election, significant changes occur in county government agencies, including health departments. There are issues with the sustainability of implementation policies and the retention of trained personnel, making it difficult to maintain continuity.
2-2 Clinical Protocols	Drug prescribed at public facilities and clinical protocols are not standalized and updated. Country-specific clinical pathways do not exist for the diseases that are not donor funded. Professional associations such as Kenya Medical Practitioners and Dentists Booard are willing to participate in development of the clinical protocols. The latest essential medecines list was developed in 2016.			(12) Formulation for the UHC-Essential Benefit Package is drafted. (Curative and Rehabiliable Department, MoH in charge)	Drafted formulary for the UHC-Essential Benefit Package	(17) Formuary for the UHC-Essential Benefit Package is developed. (Curative and Rehabilitative Department, MoH in charge)	Formulary for the UHC-Essential Benefit Package	**◎ The relevant lists were reviewed and the following were established:** Kenya Essential Medicines List (KEML) 2023 (October 13, 2023), Kenya National Medicines Formulary (KNMF) 2023 (October 13, 2023), Specification for Kenya Essential Diagnostics List (KEDL) KEML is being promoted on the Ministry of Health website, and in addition, the Kenya Medical Supply Authority (KEMSA) and the Directorate of Health Products and Technology (DHPT) are conducting awareness-raising activities for counties. (Source: Questionnaire response to the Ministry of Health) **△ There are issues with operation and quality.** KEMSA is responsible for the supply of medicines to counties, but the supply does not match the demand of each facility (Source: Interview with counties during the first field survey) The establishment of a Quality-of-Care Authority is being considered to oversee the certification of medical service providers by KEMSA and NHIF (Source: Questionnaire response to the Ministry of Health)
						(18) Clinical guidelines and treatment protocols for three priority areas are developed. (Curative and Rehabilitative Department, MoH in charge)	Clinical guidelines and treatment protocol	**◎ Related lists have been reviewed and guidelines (KEML, KNMF, KEDL) have been established.** **△ There are issues with operation and quality.**
3. Strengthen Monitoring and Evaluation Capacity to monitor impacts regarding UHC related programs and activities (6 actions)								**Continuation of Policies and Effects at the Time of Ex-post Evaluation**
3-1 Digitalization for M&E of UHC related indicators	Data collection for District Health Information System (DHIS) 2 is not fully digitalized. The means of data collection of DHIS 2 should be changed from manual paper to digital device especially for facility level 1, 2 and 3.	(5) Number of necessary equipment for digitalization of DHIS2 is identified. (Research and Monitoring and Evaluation Department, MoH in charge	Needs assessment results on the equipment for digitalization of DHIS2	(13) Standalized framework for assessing existing health information systems, and budget estimate for digitalization are developed. (Research and Monitoring and Evaluation Department, MoH in charge)	Framework document and budget estimate	(19)The procurement of necessary equipment for digitalization of DHIS 2 is started by MoH. (Research and Monitoring and Evaluation Department, MoH in charge)	Correspondences to counties on the procurement for digital device	**◎The policy has been set, and progress is being made at the national, provincial, district and community health delivery levels.** ・A server was installed in 2020. ・At the national level, the Ministry of ICT is working to standardize electronic health records. The Ministry of Health plans to standardize the Health Platform and integrate individual systems (COVID, HIV, tuberculosis, malaria). Counties will use the Electronic Medical Records System (EMRS). The Ministry of Health will provide training and set guidelines for its implementation. (Source: Questionnaire responses to the Ministry of Health) ・In FY2021/22, the electronic community health information system (eCHIS) was piloted in two districts (Kakamega and Kisumu). In FY2022/23, it will be introduced in seven districts. It will be used by community health promoters to provide services to households (Source: MTEF HS Report p.32) ・Although eCHIS terminals have been allocated (contribution by GIZ), there are issues regarding sustainability, such as the lack of allocation of communication fees to CHVs. (Source: Interviews in Machakos County)
3-2 Capacity Strengthening form UHC M&E	UHC M&E Framework is under preparation by UHC Coordination Department, MoH. UHC Dashboard is under preparation. Kenya Health Observatory is a web-based information platform to make data more available. It will be established by arougd August 2019 supported by WHO and Japan Policy and Human Recource Development Fund (PHRD) through WB.	(6) UHC M&E Framework (including indicators, M&E methods) is shared in the related departments of MoH. (UHC Coordination Department, MoH in charge)	UHC M&E Framework shared in MoH	(14) County Health M&H Unit is set up in 6 counties (Policy, Planning and Healthcare Financing Department, MoH in charge)	MoH records on County Health M&E Unit	(20) Data from DHIS2 is linked with Kenya Health Observatory. (Research Development and Monitoring and Evaluation Department, MoH in charge)	Printed copy of the website of Kenya Health Observatory	**△ Although the basic system has been established, there are issues with continuous operation and implementation in the districts.** ・M&E institutionalization guidelines have been formulated. ・UHC M&E data has been adopted as data to be managed by KHIS. A server dedicated to M&E data has been established, and an environment has been created in which data can be accumulated. ・The cause is unknown, but the UHC dashboard is not functioning and remains as it is. ・As some donors have withdrawn, data from years other than 2018 may not be the latest. ・The UHC M&E system is functioning in 15 districts. As the management system changes every time there is a change of government in a district, there are issues with sustainability and continuity. (Source: Responses to questionnaire to the Ministry of Health)

Africa Department / Human Development Department / Kenya Office
Japan International Cooperation Agency

Opinion of the JICA Implementing Departments on the Ex-Post evaluation of "Health Sector Policy Loans for Achieving Universal Health Coverage (Phase 1) and (Phase 2)"

1. Overall opinion

The ex-post evaluation report pointed out that, within the "Appropriateness of the Project Plan and Approach" in Phase 1 of the project, there were issues concerning the "checking and monitoring the outcomes". Specifically, the report refers to the "Logical Structure of the Policy Matrix," the "Gap between Outcome Indicators and Effectiveness Analysis," and the "Response to Instability in Systems and Funding Sources" on pages 9–10. We, as the JICA implementing departments, consider that, as described in section 2 below, the project was appropriately planned and implemented in terms of "checking and monitoring the outcomes." Furthermore, with regard to the lesson learned titled "The necessity of monitoring relevant programs and the organization managing them," the departments provide additional explanations in section 3, as this aspect was also implemented under the project.

2. Opinion on "checking and monitoring the outcomes"

I. Logical structure of the policy matrix

[Description in the Report]

In Phase 1, the plan aimed to address economic and physical disparities in access to healthcare services by expanding the three major Universal Health Coverage (UHC) programs: (a) the Free Maternity Service (FMS) program, (b) the Health Insurance Subsidy Program (HISP), and (c) the Health Sector Service Fund (HSSF). While the policy action for (a) was limited to securing the necessary budget, both (b) and (c) were only focused on creating manuals without specific actions to allocate the funding. Furthermore, the expected qualitative outcome of (c) was the "improvement in the quality of healthcare services in HSSF targeted facilities." However, as HSSF was a program designed to cover running costs such as staff salaries and operational expenses, improving service quality required several additional logical steps.

[Opinion of the JICA implementing departments]

Regarding the first underlined section, in a Development Policy Loan (DPL) program, key initiatives that promote the implementation of policies are positioned as policy actions whose achievements are conditions for disbursement, with the aim of substantively advancing the relevant policy area, including the actual allocation of human and financial resources. In the

cases of (b) HISP and (c) HSSF-RBF (Health Sector Services Fund – Results-Based Financing), there was a foreseeable prospect that the necessary budget would be secured, so it was not necessary to set budget allocation as a policy action. With regard to (b) HISP, 253,000 beneficiary households were recorded in 2022, far exceeding the target of 42,800 households, which was set as an operational and outcome indicator. With respect to (c) HSSF-RBF, the target number of facilities, which was also defined as an operational and outcome indicator, was achieved in 2016, prior to the target year of 2018. In other words, this shows that even without setting the budget allocation to these programs as a policy action, namely (b) and (c), sufficient budget was secured and results exceeding expectations were achieved.

Regarding the second underlined section, while the evaluator perceives that the supplementation of running costs does not directly lead to an improvement in the quality of health services, we consider that “improvement in the quality of health services” includes improvements in facility operations, such as the cleanliness of health facilities, and therefore, (c) HSSF-RBF is directly linked to this objective. This program consists of two layers, namely basic grants and additional grants, as described below, and each not only provides financial support for improvement of operations at primary health care facilities but also functions to elicit commitment from these facilities toward improving the quality of health services, thereby serving as a direct mechanism to enhance the quality of services at health facilities.

- Basic Grants: These are operational funds, such as those for salaries of support staff including cleaners and security guards, fuel costs, facility renovation costs, utility expenses, and outreach activities, that are disbursed directly to primary health care facilities without going through county governments. Primary health care facilities tend to suffer from chronic budget shortages, and following decentralization, county governments were granted authority over the operational budgets of public health facilities, which led to further reductions in funding in cases where local governments placed a low priority on health; thus, supplementation of running costs through basic grants was essential for primary health care facilities to continuously provide health services of adequate quality.
- Additional Grants: In addition to basic grants, these results-based grants are provided based on the quality of health services, and up to 60% of this grant could be used for personnel expenses of facility staff, meaning that the more a primary health facility improves the quality of its health services, the higher the staff salaries become, thus also functioning as an incentive to improve service quality.

II. Gaps between outcome indicators and analysis of effectiveness

[Description in the Report]

The outcome indicators set for the project were: (a) "the delivery rate at healthcare facilities,"

(b) "the number of households benefiting from HISP," and (c) "the number of facilities targeted by HSSF." Since these indicators were related to only some categories in the policy matrix, quantitative indicators should have been set at a level that confirms results for each of the categories (eight categories).

[Opinion of the JICA implementing departments]
The quantitative outcome indicators set for Phase 1 of this project are all directly related to the three priority UHC programs addressed in Policy Area II (formulation of manuals for UHC-related programs and securing of the Kenyan government budget: Sub-Policy Areas 4 to 6), but they are not limited to these alone; in promoting this policy area, they are also related to the contents of Policy Area I (formulation of various UHC-related policy documents: Sub-Policy Areas 1 to 3) and Policy Area III (strengthening of the health system led by county governments: Sub-Policy Areas 7 to 8). In other words, Policy Area I defines the positioning of each UHC program in UHC policy documents and functions as a prerequisite for Policy Area II, while Policy Area III aims to strengthen the health system through initiatives such as enhancing the functions of health administration, thereby contributing to the amplification of effects during the implementation phase of the UHC programs in Policy Area II. From this perspective, the three indicators, namely “(a) "the delivery rate at healthcare facilities,” “(b) "the number of households benefiting from HISP,” and “(c) "the number of facilities targeted by HSSF.” were set as outcome indicators that encompass the content of all policy areas and can thus be considered appropriate as quantitative indicators of the overall program's effects.

III. Response to Instability in Systems and Funding Sources
[Description in the Report]
With the completion of the World Bank's program in 2020, subsidies for HSSF, one of the three major UHC programs, were discontinued. Furthermore, due to an initiative by the newly elected President Ruto in 2022, the Social Health Authority (SHA) was established to take over the management of UHC funds, replacing NHIF. However, the transition process to SHA and the future direction of the UHC programs were not communicated to healthcare service providers, and in July 2024, the closure of the 1) FMS and 2) HISP programs was announced. According to the JICA Kenya Office, such changes were unforeseen.
In Kenya, many programs are developed based on donor contributions, meaning the sustainability of such programs heavily depends on donors' decisions. Sudden policy changes or institutional shifts are common, especially following national or local elections. Considering the potential risks of program termination or changes by the donors, it would have been prudent to anticipate such risks and consider scenario planning as part of the project strategy.

[Opinion of the JICA implementing departments]
When changes occur in a program due to external conditions or other factors, it is essential to adjust the policy actions through consultations among the relevant stakeholders, and in this project as well, such a possibility of change was anticipated from the planning stage of Phase 1, and although changes occurred after the project completion, they remained within the anticipated scope. Furthermore, even at the time of the ex-post evaluation, although there was confusion caused by the establishment of SHA, it was confirmed that the contents of each of the three programs, namely (a) FMS, (b) HISP, and (c) HSSF, were maintained, and it is therefore considered that the project plan appropriately reflected the direction of the Kenyan government's policy to promote UHC. The following responses have been taken for each program:

- FMS: As of July 2024, the tariffs to the benefit package under the Primary Health Care Fund and the Social Health Insurance Fund, both operated under the SHA framework, was announced, and it was confirmed that the costs for antenatal and postnatal checkups and deliveries previously covered by FMS would continue to be covered under the SHA framework.
- HISP: The Social Health Insurance Act stipulates that the government will subsidize insurance premiums for the indigents, and it was confirmed that, after the end of the evaluator's data collection period in late October 2024, the Ministry of Health officially announced that the government would bear the insurance premiums for the indigents through collaboration with the Inua Jamii program, a government social protection program, thereby ensuring the continuation of support consistent with that provided previously.
- HSSF: Although the program was ended, under the Facility Improvement Financing Act enacted in 2023, it was stipulated that the disbursement of funds directly to health facilities will continue within the SHA framework through the Primary Health Care Fund.

3. Lessons learned
[Description in the Report]
4.3 Lessons Learned
The necessity of monitoring relevant programs and the organization managing them.
Phase 1 of this project aimed to promote the implementation of the three major UHC programs to contribute to the achievement of UHC. Therefore, it would have been necessary to check the target programs' progress of policy actions and monitor the Ministry of Health's oversight of the fund operating organization to ensure the program's fund management was functioning correctly. When the fund-operating organization implements the programs targeted by the policy actions, it is advisable to monitor the supervision of the fund-operating

organization by the Executing Agency.

[Opinion of the JICA implementing departments]
Regarding monitoring, it has been conducted as described below, and the following is provided as supplementary information.
In order to effectively promote UHC policy in Kenya, JICA has not only provided financial cooperation through this project but has also dispatched experts to the Ministry of Health since 2017 to provide technical assistance for the promotion of UHC policy. As part of the activities of these experts, support has been provided for monitoring and promoting the implementation status of UHC policy in collaboration with the Ministry of Health, various committees, the NHIF, county governments, and healthcare facilities. In relation to the NHIF, JICA experts provided the Ministry of Health with recommendations during the revision of NHIF-related legislation and technical advice on the review of systems under the jurisdiction of the NHIF and also participated in monitoring consultations between the Ministry of Health and the NHIF.

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