Health Systems Strengthening Evaluation Collaborative

HSS Evaluations in Kenya

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Working Group 2: Priority 1

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Contents

Acronyms

CSO	Civil Society Organizations
DANIDA	Danish International Development Agency
DPHK	Development Partners for Health in Kenya
HSS	Health systems strengthening
HENNET	Health NGO Network
HPT	Health Products and Technology
HWA	Health Workforce Accounts
ICC	Interagency Coordinating Committee
IGF	Intergovernmental Forum
IPC	Infection, prevention and control
KDHS	Kenya demographic and health survey
KEMRI	Kenya Medical Research Institution
KEPSIE	Kenya Patient Safety Impact Evaluation
KHHEUS	Kenya Household Health Expenditure and Utilization Survey
HHFA	Harmonized Health Facility Assessment
KHSSP	Kenya Health Sector Strategic Plan
JICA	Japan International Cooperation Agency
MDA	Ministries, Departments and Agencies
M&E	Monitoring and Evaluation
MED	Monitoring and Evaluation Directorate
MoH	Ministry of Health
MTR	Mid-Term Review
NCD	Non-Communicable Diseases
NGO	Non-Governmental Organization
NHA	National Health Accounts
NHIF	National Hospital Insurance Fund
NHWA	National Health Workforce Accounts

PETS	Public Expenditure Tracking Survey
RMNCAH	Reproductive Maternal Neonatal Child and Adolescent Health
SAGA	Semi-Autonomous Government Agencies
SWG	Sector Working Group
UHC	Universal Health Coverage
UNICEF	United Nations International Children's Emergency Fund
USAID	United States Agency for International Development
WHO	World Health Organization

Executive Summary

Introduction

The goal of health systems strengthening (HSS) evaluation is to better understand and improve HSS funding and programming. Experience suggests that evaluating the contribution and impact of HSS investments is highly complex, with measurement and evaluation efforts that can be difficult to design, implement and interpret. In addition, the objectives of HSS evaluations can vary depending on the stakeholders, which include countries, technical and academic partners, and donors.

Objectives and methodology

The overarching objective was to examine stakeholders' interests and needs regarding HSS evaluations and to examine the institutional structures and processes that support HSS evaluation in Kenya. This was done using a case-study approach, with qualitative methods deployed to understand the HSS evaluation ecosystem in Kenya through a document review of key policies, guidelines relating to HSS evaluations and reports of the various health system (HS) evaluations. The views of 17 key stakeholders from government stakeholders, academic and research institutions, private sector organizations and multilateral and bilateral agencies implementing HSS programs were sought.

Findings

HSS policy in Kenya: There is no policy or guiding document currently in existence to guide HSS evaluations in Kenya, and neither is there a coordinating body that oversees all HSS evaluations commissioned by the various actors.

Actors involved in HSS evaluations in Kenya: There are several actors involved in HSS evaluations in Kenya, they include state and non-state actors who are involved in varied capacities, such as financial assistance, technical assistance and infrastructure. The state actors are the Ministry of Health (MoH) and respective semi-autonomous government agencies (SAGAs), the Kenya National Bureau of Statistics (KNBS) and the regulatory bodies. The non-state actors involved are the bilateral and multilateral organizations, such as the World Bank, World Health Organization (WHO), USAID, UNICEF, the Global Fund, JICA and DANIDA , whose involvement is largely financial support and the provision of technical assistance. Other actors are the civil society organizations (CSOs), acting through the Health NGO Network (HENNET).

Commissioning of HSS evaluations: Most HSS assessments and evaluations are commissioned by the MoH, however, other actors do commission HSS evaluations. There is a structured way of involving all actors during the planning and execution of HSS evaluations through appointment to steering committees and technical working groups.

Linkages in the HSS evaluation ecosystem: Linkage among actors in health in Kenya is very strong, however, there is a need for better coordination to allow for a structured way of identifying the HSS evaluations needed to inform policy, while optimizing available resources and avoiding duplications of efforts.

Routine and ongoing efforts to measure HS performance in Kenya: The HSS evaluations are performed either before the implementation of an intervention; midway through the implementation of an intervention, such as a strategic plan; or at the end-term of an intervention. Most of the HSS evaluations conducted are comprehensive; however, they are not conducted in a systematic manner. The funding of HSS evaluations is largely supported by donors and partners, who take up close to 98% of the funding, thus making the HSS evaluations likely to be *ad hoc,* depending on the availability of funds from the donors.

Dissemination and use of evidence in decision making: Findings from evaluations have been shared in various forums, such as the following: the Development Partners for Health in Kenya (DPHK), intergovernmental fora (IGF), interagency coordinating committees (ICCs) and through publication on the MoH's website. Feedback is also provided to stakeholders through virtual and physical dissemination meetings, policy briefs, cabinet papers and publications. Findings from these assessments have been used to conduct further in-depth evaluations, and have also been used in planning, budgeting and policy document development by both the government and partners. Several evaluations have been used to inform policy over the past five years, and for the scale up of pilot projects. Poor investment in the dissemination of findings has contributed to poor uptake of HSS evaluation findings.

Conclusions

Even though the country has no policy or guidelines on the conduct of HSS evaluations, and no coordinating body to oversee all evaluations commissioned by different actors, HSS evaluations are still being conducted and results are being used to inform decision making. The actors involved in HSS evaluations are well known and coordinate well through existing health sector coordinating structures, though further efforts to improve the coordination should be encouraged to avoid duplication of efforts. The government should also invest in evaluations to reduce the donor reliance that could potentially lead to inconsistency and to a lack of comprehensiveness in the evaluations. The outputs of these HSS evaluations should be shared widely, at both a national and county level for informed decision making.

Recommendations

- The MoH should adapt the Kenya evaluation policy, monitoring and evaluation (M&E) norms and standards, and the evaluability assessment checklist to enhance the HSS evaluation process.
- As a way of mobilizing government resources for HSS evaluations, reorganize and reposition the M&E division of the MoH, to be placed at the office of the Principal Secretary/Cabinet Secretary, for enhanced accountability and transparency.
- Strengthen the coordination of HSS evaluations by having a body that is mandated to coordinate HSS evaluations.
- Develop and implement a clear dissemination strategy for all HSS evaluations, to ensure that the evaluation findings are presented in a systematic manner.
- Deliberately engage academic institutions to conduct the evaluations, which would build practical skills and provide an affordable and relevant workforce, making evaluations more affordable.

Introduction

Health systems strengthening (HSS) is widely understood to be key to achieving universal health coverage and to ensuring robust responses to health emergencies. In recent decades, global health investors have put more attention and investment towards HSS, leading to accelerated efforts to evaluate HSS policies and programs initiated by those investments. Yet, a common definition and framework for how to evaluate HSS interventions remains elusive, hampering efforts to strengthen, coordinate and amplify HSS programs.

The Health Systems Strengthening Evaluation Collaborative (HSSEC) brings together key global and national stakeholders to suggest ways to strengthen the quality of evaluations of health systems strengthening (HSS) investments in LMICs and to improve coordination across stakeholders in this space. The Collaborative believes that to move HSS evaluation beyond its current fragmented form, leadership and commitment for advancing and changing ways of working must come at least partially from the joint action of three key groups of stakeholders: (i) country-level stakeholders, including governments, practitioners, and communities, (ii) donors that fund HSS and HSS evaluation, and (iii) evaluators and academics who are involved in HSS evaluation.

As part of the HSSEC, a working group was convened to look at HSS evaluations from a national perspective, and to identify lessons learned and opportunities for further strengthening HSS evaluations. The first priority of this group was to build a better understanding of the institutional structures and processes that support HSS evaluations, and opportunities to strengthen processes to enhance national HS evaluation capacity and to better respond to institutional needs. Three countries– Ghana, Rwanda and Kenya– were identified for these in-depth case studies. This report presents findings from the Kenya case study.

Objectives and Key Questions

The overarching objective was to examine stakeholders' interests and the needs of HSS evaluations, and to examine the institutional structures and processes that support HSS evaluations in Kenya.

The specific objectives were to:

- Examine the institutional structures and processes that support HSS evaluations in Kenya
- Determine the interests and needs of HSS evaluations among various stakeholders in Kenya
- Understand how HSS evaluations by external donors are designed, commissioned and experienced by stakeholders in Kenya
- Identify opportunities for strengthening HSS evaluations in order to support Kenya's policy development and implementation

Methodology

A case-study approach utilizing qualitative methods was deployed to understand the HSS evaluation ecosystem in Kenya. Data collection methods included document reviews of key policies, guidelines relating to evaluations and reports of the various health system evaluations. It also included seventeen key stakeholder interviews, from the government, academics and research institutions, private sector organizations implementing HSS programs, and multilateral and bilateral agencies. A thematic analysis was conducted on the interview transcripts, while a content analysis was undertaken for data from the documents reviewed.

Key Findings

HSS evaluation policy in Kenya

The Monitoring and Evaluation Directorate (MED) at the State Department of Planning has developed M&E norms and standards (Government of Kenya, 2020), and the Kenya evaluation guidelines (Government of Kenya, 2020) that provide guidance to all the public sector institutions on how to prepare for and conduct evaluations. These guidelines clearly outline the programs and projects to be evaluated, the purpose of the evaluation, the type of evaluation, the timelines, the partners to be involved and responsibilities. These guidelines are to be customized by the respective ministries, departments and agencies (MDA).

Regarding the existence of customized policies and guidelines that govern the conduct of health system evaluations, the MoH, whose key mandate is to develop policies and guidelines and to provide technical assistance to the counties is yet to customize the existing M&E policies and guidelines from the MED to an HSS evaluation approach. Most HSS evaluations are outlined in the M&E frameworks of the various strategies, such as the health sector strategic plan, which has an accompanying M&E framework that outlines how and when key HSS evaluations should be conducted. Other HSS evaluations are guided by legislation, for instance, the program performance review that was commissioned by the sector working groups, is a comprehensive HSS evaluation that was conducted prior to the budgeting process to inform resource allocation to key priority areas, and the performance review of the annual work plans, both of which are guided by the Public Financial Management Act of 2012.

Actors involved in HSS evaluations in Kenya

The state Department for Planning, through the MED, is functionally responsible for the coordination of the M&E of all government policies, programs and projects. This mandate was derived from the Presidential Executive Order No. 1 of 2020 (Government of Kenya, 2020) on the M&E of economic trends in the country.

The MED is charged with 'promoting the M&E culture and practice in the public sector, strengthening capacities for M&E at all levels (national and county governments) to track implementation of Kenya Vision 2030, tracking the implementation of the medium-term plans (MTPs) and Kenya Vision 2030, providing the national government with policy implementation feedback for efficient resource reallocation over time.'[1]

Every year, the Directorate develops a research and evaluation agenda, which includes the policy, project, program or topic to be evaluated; the type of evaluation to be undertaken; the methodology and tools to be used; the stakeholders and their roles and responsibilities; and the resources required. The agenda is drafted by a multi-stakeholder team comprised of state and non-state actors and led by the MED office. There is poor coordination between the MoH's M&E division and the MED, and a lack of dissemination of the guidelines and tools to be used to conduct these evaluations. The emphasis of a coordinated way of developing an evaluation agenda has not been established.

The MoH has an M&E division, while the programs, the SAGAs and the regulatory bodies have their own programmatic M&E information sections. These sections are tasked with conducting and commissioning various HSS evaluations.

Other actors involved in HSS evaluations are the bilateral and multilateral organizations, such as the World Bank, the WHO, USAID, UNICEF, the Global Fund, JICA and DANIDA, whose involvement is largely financial support and the provision of technical assistance. Other agencies, such as the KNBS, the CSOs, acting through the HENNET, the Kenya Medical Research Institution (KEMRI) and

[1] https://monitoring.planning.go.ke/mandate-functions/

the Kenya Medical Practitioners and Dentists Council (KMPDC). Their involvement is largely through the provision of technical assistance to design the HSS evaluations, conduct analytics and advanced analytics, dissemination and feedback.

Commissioning of HSS evaluations

Several health system assessments and evaluations have been conducted in Kenya, Annex 1. These assessments and evaluations are largely commissioned by the MoH through their respective departments, programs, regulatory bodies and the SAGAs in health; they involve several stakeholders, from donors and implementing partners, academia and research institutions and the civil society. Before any MoH-commissioned HSS evaluation is conducted, governance and coordination structures are defined through the appointment of members to the HSS evaluation steering committees; in these committees there is representation from the leadership of key HSS actors and from a technical working group, comprised of the technical teams from the various actors. A secretariat is also identified from the MoH.

The division of M&E commissions the comprehensive health system evaluations, for example the mid-term review (MTR) of the Kenya Health Sector Strategic Plan (KHSSP), while other programs (i.e. disease specific) commission their respective HSS evaluations, such as the following:

- The Central Planning and Monitoring Unit, who commission evaluations relating to planning, finance and budgeting, such as the sector working group assessments – national health accounts (NHA), Kenya Household Health Expenditure and Utilization Survey (KHHEUS), and PETS (Public Expenditure Tracking Survey);
- The malaria program commission and the malaria indicator assessments; MTR of the malaria strategy;
- The HIV program – the Kenya AIDS indicator survey and the MTR of their strategy;
- The TB program and the TB prevalence survey;
- The pharmacy and poisons board, who commission evaluations relating to drug safety;
- The KMPDC, who have commissioned assessments around COVID-19 readiness and universal health coverage (UHC) scale-up readiness.

Research and academic institutions have also commissioned some HSS assessments. There is, however, no single organization that coordinates the different evaluations that are conducted by these programs and departments.

Other actors, such as the private sector and partners (development and implementing), through partnerships with academic and research institutions, have commissioned evaluations that are either program-specific, disease-area-specific, or specific to a certain area of interest, such as quality of care. Evaluations commissioned by external actors do not always involve the MoH, thus the utility of such findings in informing policy is a challenge. Some partners jointly commission evaluations with some SAGAs, such as the National Hospital Insurance Fund (NHIF) and KEMRI. This allows for better acceptance of the findings by policymakers as these institutions are part of the MoH.

In terms of the scope of execution, the comprehensive and thematic (based on the HS building blocks and the disease program) HS evaluations that are commissioned by the MoH have national and subnational representation, which provides an overall picture of the health sector's performance. HSS evaluations commissioned by other actors are only conducted in a few counties, this is either due to budget constraints or to being limited to a region of interest, thus they miss out on the heterogenicity across the subnational regions.

Linkages in the HSS evaluation ecosystem

Linkage among actors in health in Kenya is very strong. However, there is a need for better coordination to allow for a structured way of identifying the HSS evaluations needed to inform policy, while optimizing the available resources and avoiding the duplication of efforts. The development partners have an active forum, the DPHK, who meet regularly and discuss various topical areas in health. The MoH has periodic meetings with the DPHK to discuss health priority areas and to mobilize resources. The MoH has also launched a partnership framework that has ICCs based on the health system building blocks that discuss the priorities per building block that could inform the HSS evaluation priorities. The ICCs have representation from both state and non-state actors. The policymakers would, therefore, need evidence from evaluations based on identified priorities that would meet national and international health goals and obligations.

Routine and ongoing efforts to measure HS performance in Kenya

The capacity to conduct HSS evaluations in Kenya has grown in a progressive manner and is mainly government led. However, special capacities, for example, samplers, statisticians and analysts, are usually co-opted from academia and research institutions to further boost and strengthen the MoH's capacity for sustainability.

The formative HSS evaluations are either *ex ante* and performed before the implementation of an intervention, such as the Kenya Patient Safety Impact Evaluation (KEPSIE), which guided the rollout of joint health inspections; or MTRs, undertaken midway through the implementation of an intervention, such as a strategic plan, to address any potential problems in design and implementation; and finally, process evaluations that examine the process of implementing a project or program to determine whether the project or program is operating as planned. The summative evaluations include the end-term evaluations of interventions, such as the end of pilot UHC evaluation; and end-term reviews of strategies, which are conducted to inform the priorities in the next strategy. *Ex post* evaluations have also been conducted, for example, the evaluation of the free maternity program that was conducted to assess the impact of the program.

Most of the HSS evaluations that are conducted are comprehensive; however, they are not conducted in a systematic manner and they lack clarity on the necessity of a follow up evaluation and on when this follow up should be conducted. Some of the reasons why the evaluations are not conducted in a systematic manner include the prioritization of monitoring over evaluations; inadequate human resource capacity to conduct evaluations, in terms of skills, numbers and distribution; and inadequate domestic funding for evaluations, thus there is a heavy reliance on donors to conduct HSS evaluations.

> *'I've not seen us as a country defining our evaluation agenda as a sector that is so specific, drilling down beyond what is done routinely, or what is required, to asking ourselves what we need.'*
>
> Another respondent said: *'most government investments have been put in strengthening routine health information for monitoring, with minimal to low government investment in evaluations, and donors being the main financiers for evaluations.'*

In terms of the periodicity of the HSS evaluations, some are done annually, such as the annual performance reviews and the program performance reviews; while others are done every five years, such as the MTR of the various strategies, including the KHSSP, demographic health surveys, health facility assessments and service provision assessments. Furthermore, some HSS assessments are conducted as a one-off or without clear documentation on when the next one should be conducted, while some of the assessments done may have differing indicators, resulting in poor comparison over time. The funding of HSS evaluations is largely supported by donors and partners,

who use nearly 98% of the funding, thus making the HSS evaluations likely to be *ad hoc*, depending on the availability of funds from the donors.

The prioritization of HSS evaluations is based on:

- Prevailing overall government priorities, such as UHC and non-communicable diseases (NCDs), including mental health.
- International priorities and reporting obligations, such as the tracking of SDGs, COVID-19 evaluations to measure the impact of the pandemic and investments on the health systems, and civil registration assessments.
- The evaluations as outlined in ministerial documents and guided by law, such as the annual performance reviews and the program performance reviews, and the MTRs of the strategies.
- The existing capacities to undertake the HSS evaluations, for example the service delivery indicator assessment, health facility assessment, vis a vie newer assessments whose methodology may not be well known.
- The availability of funding and interest of the funder, given that these evaluations are largely donor driven.

Dissemination and use of evidence in decision making

The findings from evaluations have been shared in various forums, for example: the DPHK, IGF, ICC and through publication on the MoH's website. Feedback is also provided to the stakeholders through virtual and physical dissemination meetings. It was noted that: *'we are still kind of building a culture of use of evidence and it's not been fully institutionalized, to allow people to look forward to the findings to inform policies.'* Other forms of dissemination have been through policy briefs, cabinet papers and publications. One of the respondents noted that: *'a lot of investments are done in the conduct of health systems evaluations with minimal investments in dissemination.'*

The respondents felt that the use of the evidence generated for decision making was at an acceptable level. Proper dissemination enhances the use of the findings, with one respondent noting that: *'we optimally use the results of the evaluations, referring to them here and there. Since the team that was fully involved in the evaluation really understand what was collected, they keep going back to the report as reference.'* Reports from these assessments have been used to conduct further in-depth evaluations, and have been used in planning, budgeting and policy document development. This information has also been used as a source of information when writing proposals to obtain funding. Products from such assessments include policy briefs and cabinet papers for advocacy and visualizations in platforms such as the Kenya Health Observatory. These evaluations have also been used to inform future strategies and priorities.

Several evaluations have been used to inform policy over the past five years, for example:

the KEPSIE led to the rollout and institutionalization of the Joint Health Inspections Checklist, as a way of ensuring quality and patient safety; the KHHEUS and the NHA have been used to provide evidence on the high out-of-pocket spending of households on health, hence the implementation of social health insurance for the indigents; the MTR findings highlighted issues relating to mental health and NCDs, hence the prioritization of these interventions; the Harmonized Health facility Assessment (HHFA) also provided baseline information in terms of the availability and readiness of health facilities to deliver UHC; sector working group program performance reviews inform the budgetary allocations to the health sector; information from the Kenya Demographic Health Survey (KDHS), which highlighted the burden of maternal mortality, led to the prioritization and funding of reproductive, maternal, neonatal, child and adolescent health (RMNCAH), through the Global Financing Facility and the World Bank, among others. The health system assessment of 2019

highlighted the gaps in health products and technology (HPT), prompting the country to develop an HPT strategy to ensure sustainable and consistent HPT.

There is a challenge when it comes to disseminating and using this data at a subnational level. One partner noted that: *'as we do the assessments, we need to see how much we can go deeper at the county level…that helps the counties and ourselves and the government to know which areas of the system are weakest…'.*

Barriers to the uptake and use of HSS evaluations include a lack of involvement in the evaluation process by key stakeholders and the MoH, and poor investment in the dissemination of findings. As noted by one partner: *'we need to do a better job in terms of dissemination, making sure that we have a dissemination brief, a link to online platforms, but also doing a wider dissemination within the country with the different counties…I know there have been several dissemination meetings, but in my opinion, they are not sufficient.' Another partner noted that: 'when we are doing the assessments, we mainly focus on the data collection, analysis and the reporting, while having less emphasis on utilization…'.*

Conclusions

Even though the country has no policy or guidelines on the conduct of HSS evaluations, and no coordinating body to oversee all the evaluations commissioned by different actors, HSS evaluations are still being conducted and results are being used to inform decision making. The actors involved in HSS evaluations are well known and coordinate well through the existing health sector coordinating structures, though further efforts to improve the coordination should be encouraged to avoid the duplication of efforts. The government should also invest in evaluations to reduce the donor reliance that could potentially lead to inconsistency and a lack of comprehensiveness of the evaluations. The outputs of these HSS evaluations should be shared widely, at both a national and county level for informed decision making.

Recommendations

1. The MoH should adapt the Kenya evaluation policy, the M&E norms and standards and the evaluability assessment checklist to enhance the HSS evaluation process.
2. As a way of mobilizing government resources for HSS evaluations, reorganize and reposition the M&E division of the MoH, to be placed at the office of the Principal Secretary/ Cabinet Secretary for enhanced accountability and transparency.
3. Strengthen the coordination of HSS evaluations by having a body that is mandated with the coordination of HSS evaluations.
4. Develop and implement a clear dissemination strategy for all HSS evaluations to ensure that the evaluation findings are presented in a systematic manner.
5. Deliberately engage academic institutions to conduct the evaluations, which would build practical skills and provide an affordable and relevant workforce, making evaluations more affordable.

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Annex 1: Evaluations conducted in the past five years

Evaluation	Year conducted	Objectives	Methods employed	Who commissioned	Major findings
Health sector working groups reviews	2017-2021	Assess the performance of the entire health sector in a program-based approach, including the budget reviews	Desk review of program performance	Central Planning and Program Monitoring Unit and Finance Unit	Non-communicable conditions including mental health are still a major challenge. Human resource, health products and technology are still major challenges hindering service delivery Financing for health is still inadequate, at approximately 6–8%, far from the Abuja declaration
Annual performance reviews	Annual	To take stock of the extent to which implementation has led to improvements in outputs, outcomes and eventually impacts; achievements and existing gaps, as well as identifying areas of prioritization for the next planning period.	Desk review of program performance	MED	
MTR of the Health Sector Strategic Plan	2020/21	To assess the overall progress made in the implementation of the objectives in the KHSSP.	Qualitative and quantitative approaches through desk review of program	Monitoring and Evaluation Division	URTIs, diarrhea, skin diseases, malaria and other diseases of the respiratory system are the leading causes of morbidity. Outputs (access, quality and demand of services) score-92% Service delivery and quality systems score: 78%. Health workforce performance indicators: 67% Health care financing performance score: 67%

Evaluation	Year conducted	Objectives	Methods employed	Who commissioned	Major findings
			performance, key informant interviews (KIIs) and focus group discussions (FGDs)		Health infrastructure performance score: 78% Health product and technology score: 56% Health information performance score: 78% Leadership and governance performance score: 67% Overall progress in achievement of all strategic objectives ranged between 73%–100%.
HHFA	2018	To assess the availability and readiness of health facilities, to offer quality health services.	Quantitative and qualitative approaches using four modules: availability, management, readiness, quality and safety, and community.	MED	**Availability:** The service availability index for infrastructure, workforce and service utilization was at 100%, 40.4% and 31.2% respectively. **Health infrastructure:** health facility density was at 2.2 against WHO standards of 2 per 10,000 population; inpatient bed density was at 13.3 against WHO standards of 25 per 10,000 population; bed occupation rates were at 46% against the KHSSP set standard of 80%. **Health workforce**: national core health workforce density is at 15.6per 10,000, against the WHO set standard of 23. **Service utilization:** average number of outpatient visits per person per year was 1.2 against the KHSSP target of 5. **General service readiness** Facilities had an average readiness of 60%, based on the five areas below. **Basic amenities** (sanitation facilities, consultation rooms, water source, power, emergency transport, computer with internet access): health facilities have 55% of basic amenities at any point in time, with only 6% having all the basic amenities at any point in time. **Basic equipment** : health facilities have 77% of all basic equipment at any point in time, while only 24% of facilities had all basic equipment items. **Standard precautions for infection prevention** (disposable syringes, disinfectant, safe disposal of sharps, latex gloves, storage of sharps waste and infectious waste, soap/water/alcohol scrub): health facilities have 65% of infection prevention items at any point in time. Only 12% of facilities have all items for infection prevention. **Diagnostic capacity** (HIV, Malaria, Syphilis, pregnancy, blood glucose, urinalysis and hemoglobin tests): health facilities have 56% of expected

Evaluation	Year conducted	Objectives	Methods employed	Who commissioned	Major findings
					diagnostic equipment, while only 17% of health facilities have all the basic equipment. **Essential medicines:** facilities had 44% of all essential medicines at any given time, with none of the health facilities having all essential medicines. **Service specific availability and readiness.** Availability and readiness was assessed for these service areas: Reproductive, maternal, neonatal and child health services Communicable diseases Non-communicable conditions Blood transfusion emergency care Medicines Advanced diagnostic services Quality and safety **Management and finance** Two thirds of facilities reported having a core management team responsible for oversight. About half of facilities had systems for determining client opinions. Majority of facilities (94%) received external supervision from sub county and county, or national. Pharmaceutical reporting system was present in 73% of facilities. IPC (Infection prevention and control) monitoring system: approximately a third of facilities had IPC guidelines. A fifth of the facilities reported that over 75% of their inpatient clients had health insurance, and less than 25% of the outpatients had a form of insurance. **Quality and safety** Inadequate quality of health services across the country with wide variance across managing authorities, levels of care and urban/rural. **Community**

Evaluation	Year conducted	Objectives	Methods employed	Who commissioned	Major findings
					The services expected to be delivered through the community health services are available through suboptimal. Barriers to access of health services in community include costs associated with travel to the health facilities and negative attitudes of some health workers at the facility level.
National Health Accounts	2021	To estimate the total expenditures related to health	Qualitative and desk review of program reports	Central Planning and Program Monitoring Unit	The total health expenditure (THE) in Kenya was KSh 497.7 billion (USD 4,920 million) in 2018/19, from KSh 442 billion (USD 4,315 million) in 2016/17, representing an increase of 13% . THE in 2018/19 accounted for 5.6% of GDP, a slight increase from 5.5% in 2016/17. The government expenditure on health as a percent of total government expenditure increased from 10.8 % in 2016/17, to 11.7 % in 2018/19. The per capita spending on health increased by 9 %, from USD$97.4 in 2016/17 to USD$105.8 in 2018/19.
KHHEUS	2018	To estimate the household expenditure on health		Central Planning and Program Monitoring Unit	Insurance coverage in Kenya Out-of-pocket expenditures on health
National Health Workforce Account	2021	To progressively improve the availability, quality and use of data on health workforce through monitoring of a set of indicators	Qualitative and desk review of program reports	Kenya Health Human Resources Advisory Council	Data for some indicators submitted to the WHO and NHWA(National Health Workforce Accounts) data portal
Kenya Health System Assessment	2019	To provide a snapshot of the current state of Kenya's health systems in terms of the six WHO building blocks.	Desk review qualitative assessments through KIIs.	USAID	**Governance:** A range of political, administrative and financial functions have been delegated to 47 counties. The Health Act No. 21 of 2017 brought the pieces of health legislation together under one unified framework. Lack of clear, uniform management structures at county level and limited capacity to develop appropriate health laws.

Evaluation	Year conducted	Objectives	Methods employed	Who commissioned	Major findings
					Weak enforcement of health laws and norms, especially in the private sector. **Health Financing:** Autonomy in the counties on how they finance healthcare. Commitment by government to achieve UHC through financial protection. Funds for health at the county level flow through the county revenue fund. External funding is declining. Allocations to health varies across the counties and is at the discretion of the counties. **Service delivery:** Health service delivery is fully developed, except for the tertiary hospitals (level 6). There exists a Kenya Essential Package for Health that ensures that all who need to access services do so without financial hardship. Functioning of regulatory bodies is poorly coordinated. Poor quality of services at primary level make people seek basic services at higher level facilities. **Human Resources for Health (HRH):** Scarcity of health specialists and poorly distributed available specialists. HRH forms the largest expenditure item at county level. Inadequate data on HRH from the private sector and poor utilization of data from the integrated human resources information system (iHRIS). **Health Management Information Systems:** Numerous programs with specific monitoring and evaluation systems, that mainly satisfy the reporting needs of the funders. Many components of the Health Management Information Systems are not interoperable. Weak culture of utilizing data. There exists a unified reporting system, for reporting aggregated data-DHIS2. Private health facilities reporting is weak.

Evaluation	Year conducted	Objectives	Methods employed	Who commissioned	Major findings
					Medical products, vaccines and technologies: The pharmaceutical services unit at the MoH is responsible for sector-wide pharmaceutical policy development, but this overall oversight has been weak. The Kenya Medical Supplies Authority (KEMSA) is responsible for procurement and distribution of the bulk of pharmaceutical products for the public sector health facilities. Mission for Essential Drugs and Supplies (MEDS), supplies private sector. Counties are still struggling to finance HPT. Many unregistered pharmacies exist in Kenya, with counterfeit medicines being an important public health and safety issue.
Context and status of evidence use in policy formulation in the health sector in Kenya, report of a baseline policy analysis study	2016	To assess the extent and context of research evidence's use in formulation of policies at the MoH	Qualitative research methodology-KIIs and literature reviews	African Institute for Development Policy (AFIDEP)	MoH to consider use of evidence in policy formulation, since it is critical to the success of its policies and programs. Shortage in capacity both in numbers and levels of expertise at MoH regarding policy formulation. No budget line for the policy formulation processes, making the MoH turn to partners for support, a process that could lead to overt influence in the policy direction. Sources of evidence to inform policy, like the DHIS2 and HMIS are either missing or incomplete. Absence of a central portal where all policy-related government data could be archived and accessed. Lack of a mechanism by which the MoH can regularly access evidence from other institutions that conduct health policy-relevant research in the country.

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