# Kericho County Health Sector Evaluation

**Jointly by the Monitoring & Evaluation Directorate in the National Treasury and Planning and the Evaluation Society of Kenya with support from the World Bank**

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## Acknowledgements

This report is the result of a collaboration between the Government of Kenya through the Monitoring and Evaluation Directorate (MED) National Treasury and Planning, the Council of Governors (COG), the County Government of Kericho, the Evaluation Society of Kenya (ESK), and supported by the World Bank Group's Kenya Accountable Devolution Team with funding from DANIDA, DFID, the EU, Finland, Sweden, and USAID.

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## Abbreviations

| | |
|---|---|
| ADP | Annual Development Plan |
| AIC | African Inland Church |
| AIDS | Acquired Immune Deficiency Virus |
| ANC | Ante Natal Clinic |
| CADP | County Accountability Development Priorities |
| CDF | County Development Fund |
| CHMT | County Health Management Team |
| CHV | Community Health Volunteer |
| CHW | Community Health Worker |
| CIDP | County Integrated Development Plan |
| CIMES | County Integrated Monitoring and Evaluation System |
| CoG | Council of Governors |
| CT | Computed Tomography |
| CTC | Circulating Tumour Cells |
| DANIDA | Danish International Development Agency |
| DFID | Department for International Development |
| DHMB | District Health Management Board |
| DHMT | District Health Management Team |
| ENT | Ear Nose and Throat |
| ESK | Evaluation Society of Kenya |
| EU | European Union |
| FGD | Focus Group Discussion |
| GoK | Government of Kenya |
| H/C | Health Center |
| HANDS | Health and Development Service |
| HDU | High Dependency Unit |
| HIV | Human immune-deficiency Virus |
| HMIS | Health Management Information System |
| HMT | Hospital Management Team |
| ICT | Information Communication Technology |
| ICU | Intensive Care Unit |
| ISO | International Organization for Standardization |
| JICA | Japan International Cooperation Agency |
| KADP | Kenya Accountable Devolution Program |
| KDHS | Kenya Demographic and Health Survey |
| KDSP | Kenya Devolution Support Program |
| KDSPA | Kenya Devolution Support Program Accountability |
| KEMSA | Kenya Medical Supplies Authority |
| KHSSP | Kenya Health Sector Strategic and Investment Plan |
| KNBS | Kenya National Bureau of Statistics |
| M&E | Monitoring and Evaluation |
| MCA | Member of County Assembly |
| MDG | Millennium Development Goal |
| MED | Monitoring and Evaluation Department |
| NBU | New-born Unit |
| NCD | Non-Communicable Disease |
| NEMA | National Environment Management Authority |

| | |
|---|---|
| NHIF | National Health Insurance Fund |
| NIMES | National Integrated Monitoring and Evaluation System |
| OECD | Organization for Economic Development |
| OPD | Outpatient Department |
| PHO | Public Health Officer |
| PWD | Person with Disability |
| RE | Rapid Evaluation |
| SCHMT | Sub-County Health Management Team |
| SDG | Sustainable Development Goals |
| SNV | StichtingNederlandseVrijwilligers (Netherlands Development Organization) |
| TB | Tuberculosis |
| TBA | Traditional Birth Attendance |
| ToR | Terms of Reference |
| VCT | Voluntary Counseling Treatment |
| WASH | Water Sanitation and Hygiene |
| WHO | World Health Organization |

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## Executive Summary

### Background

The purpose of the rapid evaluation was to assess health service delivery in Kericho compared to before Devolution. The review covered the years 2013-2017. The rapid evaluation was a joint initiative by the Monitoring & Evaluation Directorate (MED) in the National Treasury and Planning and the Evaluation Society of Kenya (ESK). The rapid evaluations were supported by the World Bank's Kenya Accountable Devolution Program with funding from the Danida, DFID, Finland, EU, SIDA, and USAID. The initiative reinforces the multi-stakeholder efforts of promoting the evaluation function as part of the Sustainable Development Goals (SDGs) in alignment to the Government of Kenya Vision 2030 and the EvalSDGs Vision. The pilot employed a mixed approach characterized by team effort and stakeholder participation with a special focus on community voice during data collection.

### Context

The health sector in Kericho County provides primary health care and services. The County had 14 hospitals (includes 1 referral, 6 sub-county, 2 faith based and 5 private hospitals), 22 health centres and 178 dispensaries in 2017. These comprised of 151 (70.5%) public, 38 (17.8%) private, 19 (8.9%) faith based organisations and 6 (2.8%) non-governmental health facilities.

For the period under review, the county health care system is responding to a number of challenging diseases, including HIV and AIDS at a prevalence rate of 5.6% in 2012 and 3.4% in 2017. Malaria incidence was at 49.4 percent and flu at 19.45 percent. Other infectious diseases included stomach-ache at 3.6 percent, diarrhoea 2.95 percent and respiratory tract diseases at 1.6 percent. Tuberculosis and non-communicable diseases (NCDs), such as diabetes and hypertension, were on the increase. Malnutrition is a public health problem and there was a rise in diet-related non-communicable diseases.

To address the above issues, in 2013 the County Government of Kericho initiated health projects in six sub-counties as part of the County Integrated Development Programme (CIDP). Commendably, the CIDP (2013-2017) focused on improving maternal and child health and upgrading health centres and facilities. The primary focus of the CIDP was on curative rather than promotive and preventive services. There was limited focus on preventive health strategies in the field interactions beyond efforts supported by partner such as the national government, World Bank, UNICEF, UNFPA, USAID, Global Fund, DFID, Danida, JICA, PEPFAR, SNV, HANDS, Brighter Communities Worldwide, Walter Reed, Health and Development Service (HANDS), Brighter Communities World Wide, PSK, Christian Health Education (CHAK), SUPKEM and the private sector.

### Key Findings

Findings produced mixed results with regards to efficiency, effectiveness, relevance, impact and sustainability of the health projects as outlined below.

### Key Achievements

1. **Alignment of Kericho County's CIDP and Health Sector Policy to global, regional and country priorities namely**: SDGs (Goals 2/3/6 and the then MDGs 4/5/6), African Union's Abuja Declaration/

(target of allocating at least 15 percent of their annual budget to improve the health sector). Kenya Constitution 2010 and Vision 2030's social pillar on *'Investing on the People of Kenya'*, under the health sector.

2. **Some Needs Assessments Conducted**. According to the 13 FDGs for various committees (one (1) CHMT and five (5) SCHMTs and (7) HMTs), Needs Assessments involving their participation by some departments to determine health care technical priorities such as theatres, based on evidence were conducted.
3. **General health outcomes for the citizenry improved compared to the period before Devolution.** Table 1 shows improvements in some indicators in the assessment period. The maternal mortality, under-five moratlity and infant mortality rates reduced in the plan period from 488/100,000, 74/1,000 and 52/1,000 to 360/100,000, 39/1,000 and 22/1,000 respectively. The percentage of pregnant women accessing preventable ARVs rose from 60 percent in 2012 to 98 percent in 2017 and those attending four Ante- Natal Clinic (ANC) visits rose from 33.6 percent to 38 percent within the same period. In 2017, 62 percent of children < 1 year were provided with ILITNs for malaria control, compared to 42.8 percent in 2012.

**Table 1: Health service delivery outcomes 2012 Versus 2017**

| Indicator | 2012 | 2017 | Comments |
|---|---|---|---|
| **Improved Outcomes** | | | |
| *Maternal Mortality rate (MMR) | 488/100,000 | 360/100,000 | Due to improved skilled deliveries |
| *Under-five Mortality Rate (U5MR) | 74/1,000 | 39/1,000 | Due to strengthened capacity building on IMCI, availability of rotavirus & other commodities like copper & zinc |
| *Infant Mortality Rate (IMR) | 52/1,000 | 22/1,000 | |
| *HIV prevalence % | 5.6 | 3.4 | Implementation of the global HIV 90 90 90 Strategy |
| **% HIV pregnant women receiving preventable ARVs | 60 | 98 | Availability of consistent supplies |
| **Number of eligible clients on ARVs | 60 | 96 | |
| **% targeted children < 1 year provided with ILITNs | 42.8 | 62 | Improved supply & distribution by GOK/partners |
| **% targeted pregnant women provided with ILITNs | 50 | 60 | |
| **% ANC clients attending ≥ 4 ANC visits | 33.6 | 38 | Improved after awareness creation in first visit |
| Poorly-Performed Outcomes | | | |
| **% Children <5years fully immunized | 69 | 67 | Due to fewer outreaches |
| **% population with hypertension | 3.1 | 18.8 | Low nutrition & preventive services |
| **% population with diabetes | 0.6 | 1.2 | Low nutrition & preventive services |
| **% Pregnant Women attending 1st ANC | 84 | 73 | Low promotion & outreaches |
| **% WRA receiving family planning coverage | 51.2 | 37 | Potentially due to low outreach and/or low supplies |
| **% Low birth weight infants <2500 gram | 6.2 | 38 | Low nutrition awareness and poverty |

Source:
*MoH Health Sector Performance Review Report 2013-2017 & Priorities for Implementation of health services 2018/2019 for Kericho County
**MoH (2017) Kericho County Health at a Glance

4. **Installation of critical health infrastructure had far-reaching effects in improved service delivery and quality of life for citizens.** These include high resolution 64 slices CT Scan at the county referral hospital, a 32 slices CT Scan machine at Kapkatet hospital, renal dialysis unit, and a state-of-the-art Intensive Care Unit (ICU). A standard new-born unit and state-of-the-art ISO standard level laboratory at the county referral hospital are all now critical installations offering transformative services. With these infrastructures, hospitals can now offer more major life-saving surgeries.
5. **Increased staffing.** Over 500 new medical staff were recruited by the county government which contributed to improving health service delivery. Nonetheless, more staffing is needed still as the evaluation found that some health centres did not have even a single clinical officer or were run by two or three nurses. Several dispensaries had only one nurse who handled all the cases at the facilities.
6. **Kericho county has 70 health facilities**. This translates to a health facility/population density of 2.2/10,000. This is commendable as it is above the WHO recommendation of 2.0/10,000 population density. Nonetheless, there is a need to rationalize the existing facilities without further expansions. Some of the level two facilities that have structures of level three could be upgraded with appropriate staffing.
7. **Customer Satisfaction**. Through established feedback mechanism of user satisfaction surveys, **community** stakeholders, to a large extent, expressed satisfaction that many services had improved.
8. **Collaborations with Kenya National Bureau of Statistics.** Commendably, the Department of Finance and Planning collaborates with the Kenya National Bureau of (KNBS) at the county level in terms of statistics and data collection which promotes a health strategy and projects that are evidence-driven.
9. **Health Information Management System (HIMS).** This provides monitoring data for the health strategy. Nevertheless, the System is not used to provide indicator data for tracking of CIDP health projects.
10. **Draft M&E Policy Exists. Some Needs Assessments Conducted.** According to the discussion in the 13 focus groups (one (1) CHMT and five (5) SCHMTs and (7) HMTs some communities 'needs assessments by some departments were conducted to determine needs, based on evidence, while others did not.
11. **Kericho county experienced the least level of industrial unrest amidst a surge of widespread strikes in the country**. The relative calm and contentment may be attributed to deliberate efforts on promotions, training opportunities, and other incentives essential in sustaining a motivated human resource base.
12. **Commendably, the election of health committees in dispensaries and health centres was representative and democratic.** Gender equity and inclusivity of both the youth and vulnerable populations were observed. However, involvement of the committees in design, planning and implementation of CIDP projects was reported to be minimal.

### Challenges

1. **More focus on curative than promotive and preventive services**. Attention to curative care without deliberate investment in preventive health is less effective in holistic health management and especially towards improved health indices in a community. For instance, there was limited mention of preventive health strategies in the field interactions. The percentage of children under five years fully immunized reduced to 67% in 2017 from 69% in 2012. In addition, women in reproductive age receiving family planning coverage reduced to 37% in 2017 from 51.2% in 2012. There was an increase in NCD cases such as hypertension from 3.1% in 2012 to 18.8% in 2017. Diabetic cases rose from 0.6% in 2012 to 1.2% in 2017. These were attributed to low nutrition and preventive services. Moreover, most of the preventive and promotive care services were attributed to the partners outlined above and not the government.

   **Irregular medical supplies and decreased outreach services.** Compared to the period before devolution, facilities reported more dry spells of supplies, of an average two to six months.

Outreach services essential for more health access to the community were reported to have been reduced in the period under review except in one sub-county.

2. **The existence of a health service bill that is yet to be endorsed by the county assembly.** While other departments, development partners, and national government are working in health sector-related activities, these are not coordinated and harmonized.
3. **Lack of health financing legislation.** Occasioning untimely and irregular release of funds, delays in project implementation, including inadequate supply of commodities at the health centres and dispensaries, in both curative and preventive health services.
4. **Some projects' prioritization and identification** were reported to have limited public participation and not informed by evidence-based needs on the ground.
5. **Low public participation**. The evaluation found that the constitutional dictates, notwithstanding, the Finance and Economic Planning have "Project Implementing Committees" filled with technical staffs' only. There is no community participation in these. In their response technical team, noted that oftentimes, calls for their participation are met with low responsiveness. Potentially it was pointed out, owing to limited capacities.
6. **Limited deployment of technology.** The health management information system is installed. However, it is only being used for outpatient. At the time of evaluation, it was not operational due to a lack of computers.
7. **Gap in M & E, including baselines such as the status of equipment before devolution.** The projects planned for the health sector were in the form of activities and not "projects." An M&E plan was neither included in the activities or projects implemented, nor were there any specific monitoring reports or health services evaluation conducted. As such the generation of these "*projects*" was not results-based, including budgetary allocations.
8. **The sustainability of some installations was a challenge**. Some maternity wings/ staff houses/theatres in several facilities were constructed but were yet to be used several years later. That owing to inadequate personnel to offer services or lack of equipment to make them operational. Other structures were not in use as the health staff stated they were not comfortable using them due to poor workmanship.

### Main Recommendations

1. **Strengthen preventive and promotive health care services to** address non-communicable diseases and other public health problems through increased government and diversified funding from partners as well as community outreaches for enhanced access to services such as immunizations and nutritional care education.
2. **Streamline and facilitate timely funds disbursement by Treasury and county government towards regular acquisition and management of commodities** in health centres/dispensaries and staff capacity strengthening, with augmentation of this by solicitating more partners' support.
3. **Hasten endorsement of the health services management bill by county assembly** towards the entrenchment of a legal framework on financing and staffing. Empowered by that establish a central multi-disciplinary coordinating unit for oversight with a special focus on results and quality service.
4. **Enhance policymakers (including MCAs) level of engagement and capacities** through awareness-creation and trainings on the Public Finance Management Act and budgeting to improve resource use in the county and development outcomes. Priority projects are discussed with relevant stakeholder, including the department of health to explore spearheading this at this right from budget planning to execution stages.
5. **Ensure inclusive deliberate, structured political, technical, and community participation** in project identification, design, implementation, reporting, monitoring & evaluation. This by building their capacities. Operationalization of the CIMES' Guidelines *Public Participation Fora*, provides a platform for this.

6. **Facilitate support supervision**, especially in health centres and dispensaries, for improved service delivery by tapping into more stakeholder support in the provision of utility vehicles, equipment and other requirements.
7. **Strengthen capacities for health committees and staff** through awareness-creation and trainings on project management supported by government and partners. Training Courses in project M&E, including virtually by use of recordings with a set periodicity as as quarterly delivery.
8. **Deploy comprehensive technology health care management**, including purchase of more computers and installation of an integrated computerized system – similar to the current HIV/COVID management between the national and county levels, with requisite trainings and other relevant equipment through national budget and partners' support. On this, there is need to discuss and prioritize the level of health facilities to be targeted as at level 5 and which diseases could be priority in terms of prevalence rates and other county/local contexts.
9. **Strengthen existing collaborations with KNBS** to harness its rich data resources in tracking of monitoring indicators and feeding into evaluations. For example, through its monthly, quarterly and/or annual surveys/census programs and administrative data, some of which is derived from Geo-space analysis at the click of a button for an evidence-driven health strategy and projects.
10. **Operationalize robust gender and social-equity-responsive sector-wide M&E Systems in every department.** And with clear linkages e.g, to the HIMS that in turn feeds into a centralized System coordinated by the Economic Planning. Significantly**,** with adequate budgetary allocations, technical support and public participation to track progress and provide feedback on CIDP indicators and other aspects of project implementation. For instance, of great potential value-addition could be some earmarked budget to add to the HIMS' UNICEF-supported SDGs indicators but whose information on those related to CIDP projects are absent. Sensitization of the need for this is one of the first steps and consensus of other related aspects like reporting periodicity.
11. **To increase sustainability, operate within the WHO norms of permitting budgets and capacities.** Significantly, have maintenance budgets based on commensurate personnel, physical facilities and equipment. Also include maintenance costs in the planning and budgeting stages. Ensure good quality workmanship that gives value for money.
12. **Finalization of Draft M&E Policy by County Assembly,** enactment and enforcement of relevant legal framework to operationalize it.
13. **Conduct mid and end-term reviews of the current and future CIDPs** with the aim of making projects results focused.
14. **As part of the implementation of recommendations, support counties to develop a County Evaluation Plan (CEP) that includes rapid evaluations for key sectors.** The evaluation findings could then be featured in County Annual Progress Reports (CAPRs) on the implementation of CIDPs. Also, findings could help answer important knowledge gaps for the Medium-Term Plan (MTP) III implementation period.
15. **Strengthen SDGs implementation through an evaluation mechanism** that tracks progress at higher outcome/impact results levels of related health indicators and for other sectors as outlined above which is prioritized on the HIMS based on county context, in terms of disease prevalence. That in turn could potentially facilitate these levels of results' systematic capture in the GOK/UN Voluntary National Review Report (VNR) for Kenya i.e., on the implementation status of the SDGs.

## Kericho County, COG and 2021 National M&E Week Response

- Kericho county agreed with the evaluation's findings that were reinforced at the annual M&E week and by the COG. For example, it was pointed out that they are not only an eye-opener but factual and cut-across other departments.
- The county looks forward to technical support on the implementation of recommendations for improved and evidence-based policy decision-making, investment choices and planning as well as the nurturing of a robust M&E System. Moreover, it was observed that sharing of the findings report with other counties will add value, towards peer-to-peer learning, experience sharing and consideration for potential replication.

## 1. Background

### i. Geography and Demography


Kericho County is an agricultural county located in the Rift Valley region between longitude 35º 02' and 35º 40' East and between the equator and latitude 0 23' South. The county is well drained with several rivers with outlets either in the Mara or the Lake Victoria. The county receives relief rainfall. The highest is in the central highlands being about 2125 mm while the lower parts receive the least amount of 1400 mm. This map shows the location of Kericho county shaded in red. According to the Kenya census of 2019, Kericho has a total population of 901,1777. Males are 450,741, females 451,008 and intersex 28. In age groups, 0-14 years comprise 354,800; 15-64 years 513,854 and 65+ years 33,084. The county has six sub-counties namely: Kericho East, Kericho west, Sigowet/Soin, Bureti and Kipkeleion west and Kipkeleion East. This Map of Kenya depicting Kericho county[1].

### ii. Leadership and Governance

The devolved health sector has adopted an operating system borrowed from the District Health Management Team which operated before devolution. These teams were modelled on the defunct District Health Management Teams (DHMTs) and the District Health Management Board (DHMB). This has given birth to a County Health Management Team (CHMT) and Sub-County Health Management Teams (SCHMTs); Hospital Management Team (HMTs) at the hospitals and health committees at the H/Cs and dispensaries.

While at the hospital level membership is drawn from heads of departments and the facility in charge, at the H/Cs and dispensaries, membership is drawn from the community members. The adopted leadership and governance structure is not adequately anchored in the legal framework at the county. Members of

[1] This map was sourced from Kenya National Bureau of Statistics (KNBS) site

the HMTs; CHMT and SCHMTs acknowledged that these structures were handicapped in legal mandate. The health services management bill is yet to be passed by the County Assembly to accommodate this.

### iii. Regional/ National/County Health Sector Contexts

The health sector global commitments are outlined in the 2015 Sustainable Development Goals (SDGs - Goals 2/3/6 and the then MDGs 4/5/6). Earlier in, April 2001, heads of state of African Union countries met and pledged to set a target of allocating at least 15 percent of their annual budget to improve the health sector through the signing of "The Abuja Declaration: Ten Years On." Premised on these regional and other international commitments, the government of Kenya undertook many measures to improve its health services. These include stipulating the right to health in the 2010 Kenyan Constitution, emphasizing the interdependent relationship between the right to health and economic development in The Kenya Vision 2030, and outlining procedures to provide health services nationwide in The Kenya National Health Policy (2014-2030).

According to the Annual Health Sector Performance Report 2015-2016 and Priorities Implementation Framework of Health Service 2017/2018 for Kericho County, the health sector planning process is guided by the: Kenya Constitution (2010), Kenya Vision 2030, Kenya Health Sector Policy (2014/2018), Kenya Health Sector Strategic Plan (2014-2018) and Investments Plan, CSSHP and Annual work plans and Health Sector M & E Framework at National and Counties.

Kericho county's population faces many issues, among them, on average, the distance to the nearest health facility being 15 kilometres. Kericho health sector is understaffed; for example, for every 23,000 patients, there is only one doctor available to provide medical services, while at the national level, every 4,831 patients have one doctor to provide services to them. Additionally, every 2,000 patients have only one nurse to provide services to them, while at the national level, every 628 patients have one nurse to provide services to them.

In 2013, the county suffered from many prevalent diseases. HIV and AIDS pandemic remained a key challenge in the County at the rate of 5.6% in 2012 and 3.4% in 2017 while 49.4 percent of the population was infected with malaria, 19.45 percent flu, 3.6 percent stomach-ache, 2.95 percent with diarrhoea and 1.6 percent with respiratory tract diseases. Tuberculosis and non-communicable diseases (NCDs) such as diabetes, hypertension were on the increase. Malnutrition was a public health problem and there was a rise in diet-related non-communicable diseases.

Against this backdrop, the mandate of the health sector in Kericho County is to ensure access to basic health care and services. In 2013, guided by the above frameworks, it launched the CIDP, 2013-2017. In it, it reiterated and emphasized the right to health as one of the fundamental rights critical in achieving economic development. To this end, the county implemented several procedures to ensure equitable access to healthcare services, such as introducing cost-sharing, waiving fees, and providing cost exemption. Further, it focused on improving maternal and child health and upgrading of health centres and facilities.

Between 2013 and 2017, the county implemented a total of 215 CIDP health projects namely: Upgrade Kericho District hospital to level 5 (five); Employ more medical staff;Construct staff houses especially in all health facilities; Connect all health facilities with electricity, generators, or renewable energy; Purchase more ambulances; Expand coverage of health benefits; Promote preventive care; and Support people living with HIV/AIDs.

Within the same period, the County had 14 hospitals (includes 1 referral, 6 sub-county, 2 faith based and 5 private hospitals), 22 health centres and 178 dispensaries in 2017. These comprised of 151 (70.5%) public, 38 (17.8%) private, 19 (8.9%) faith based organisations and 6 (2.8%) non-governmental health facilities.

### iv. National/County M&E Contexts

The MED co-ordinates the operationalization of the National Integrated Monitoring and Evaluation System (NIMES) and the County Integrated Monitoring and Evaluation System (CIMES) through a multi-stakeholder approach. The Systems track the implementation of the Vision 2030 policies, programmes and projects. CIMES document provides guidance for county governments on how to establish and maintain effective monitoring and evaluation systems., in alignment to the NIMES and related regional and global M&E agendas.

However, the recent Annual Capacity and Performance Assessment undertaken as part of the Kenya Devolution Support Program (KDSP) found that monitoring and evaluation is nascent in most counties. Evidence-driven capacities, demand, and utilization are weak. MED's mandate includes supporting the counties to address capacity challenges and help define standards and systems for effective monitoring and evaluation of the CIDPs. In line with this, MED, in collaboration with ESK under the EvalSDGs Global EvalVision for promoting the evaluation of the SDGs, conceived this pilot study (with potential for replication) to assess the first CIDP projects in the health sector in Kericho for 2013-2017.

## 2. Purpose of the Rapid Evaluation

The government's basic reasons to engage in M&E is the need to enhance the public sector's performance, improve evidence-based decision-making processes, and increase political accountability and transparency (Mackay, 2007). The Constitution of Kenya (2010) requires adherence to principles of good governance.

Against this, the purpose of the Rapid Evaluation (RE) was to assess health service delivery in Kericho compared to before Devolution. The review was from 2013-2017. Rapid evaluations are meant to be conducted within a short time, systematically taking into account context, against limited resources and by use of mixed methods highlighting action-oriented recommendations for project improvement through lessons learned. This particular study is aimed at giving affirmative action to the evaluation function which has been left behind by monitoring in the country. Findings are also earmarked to inform potential replication of the project to the other Counties, towards its increased demand and utilization by government.

## 3. Objectives of the Evaluation

The results of the projects' objectives in the CIDP were assessed by comparing what was prevailing before Devolution and after, for the period in review. In the assessment, integration of the cross-cutting issues of gender and social-equity were taken into account. Accordngly the assessment applied the OECD criteria as outlined.

- Relevance of the selected CIDP health projects in terms of their alignment with the beneficiaries/ county's needs and priorities as outlined in the Vision 2030, AU's Abuja Declaration and the SDGs.

- Effectiveness of CIDP health projects implemented by Kericho between 2013 and 2017 in transforming the communities lives for the better.
- Efficiency of the CIDP health projects in relation to set timelines, resource allocations and coordination.
- Within permitting realities, determined some of the impact of the CIDP health projects by focusing on the projects' identifiable intended and unintended (positive and negative) results, taking into account primary and secondary long-term effects that could evidently be attributable to the evaluated projects.
- Measures, if at all, taken by the county to ensure the sustainability of the results of the implemented projects.
- Drawing of lessons learned, good practices, and recommendations for policymakers in the county and wider national and global potential learning.

## 4. Methodology

### I. Sampling Procedure

The sample in this rapid evaluation was drawn from the health projects implemented in the six sub-counties. A sampling frame stratified the projects into four strata in line with the CIDP health projects. The sampled facilities were: seven (7) Levels 5 and 4 hospitals (District and Sub-district), Ten (10) Level 3 (Health Centres), and thirteen (13) Level 2 (dispensaries).

### II. Data Collection

A mixed approach comprising desk review of key documents, advocacy and training workshops, key informant interviews, focus group discussions, community meetings, observations and preliminary-findings validation workshops were employed to collect data as outlined below.

#### i. Secondary Data Desk Review

The team reviewed the documents related to the CIDP and its implementation and achievement between 2013 and 2017. Integral to this was quantitative data derived from the County health management information system.

#### ii. Primary Data

- Towards increased demand and utilization of evaluation, advocacy workshops targeting high political leadership (Governors/MPs/Senator/MCAs, County Executive Committees (CECs) and trainings on rapid evaluation methodology for technical staff at all levesl and sectors were conducted.
- Research Assistants Team. Composed of nine undergraduate students these were selected from the sub-counties as part of capacity building and employment affirmative action to the local youth. The team received training and pre-tested the tools prior to data collection. Each consultant worked with two research assistants during data collection and transcription. Adequate supervision was provided accordingly, to ensure data quality.
- The team carried out field data collection in all the six sub-counties from 8th to 23rd August 2019, that comprised: 21 Interviews with key informants; 18 FGDs with the County and sub-County health management teams, hospital management teams, health committees in the health centres and dispensaries, Health Committee of the National Assembly, and Youth Bunge; 14 Community meetings - 10 within the dispensaries (Level 2) and 4 within the health centres (Level

3) facilities. Observations were made of the projects visited in the health facilities and the one public toilet.

- Pre-liminary findings validation workshop was conducted targeting the relevant stakeholders.

### III. Data Analysis

Data were analyzed using themes to identify connections between the sub-themes in relation to planning and implementation of projects in the health sector during the 2013 -2017 CIDP in Kericho County. These themes and sub-themes included: situation before and after devolution, alignment to national/regional and global commitments' priorities, citizen participation and engagement, commodities and supplies, equipment, infrastructure, leadership and governance (human resource, health service provision and logistics and support supervision), health financing and sustainability.

### IV. Data Management and Quality Control

The team integrated the World Bank data quality standards, in the entire process of data collection and analysis to better achieve the objectives of this rapid evaluation and to understand the extent to which the information could be trusted and used to influence management decisions as outlined below.

**World Bank Quality Control**

- **Validity:** the team collected qualitative and quantitative primary and secondary data that has a direct relationship with the CIDP (2013-2017), assigned highly qualified personnel to collect data, and reported data quality problems and proposed solution to address them.
- **Integrity:** the team clearly defined the process of data flow and the team roles and responsibility, and shared documents, to monitor and track changes to minimize the risk of transcription error or data manipulation. The research assistants and the consultants recorded the interview and meetings. They transcribed the data and translated it into English. Typed transcripts were coded to capture emerging themes. The team analyzed the data using those themes.
- **Precision:** the team designed the data collection tools in a way that helped them to collect sufficient level of qualitative and quantitative detail to conduct proper analysis and facilitate management decision-making.
- **Reliability:** the team established procedures for data collection, maintenance, and documentation.
- **Timeliness:** the team developed a regularized schedule of data collection and analysis and established data storage mechanisms that allowed them to access data and meet management needs.

### V. Dissemination of Findings

Pre-dissemination findings validation and events were held at the county levels, as well as presentations of the findings to COG technical team and during the National M&E Week. All these events provided rich data that strengthened the findings. Further dissemination is planned through wider stakeholder workshops and embeddment of the reports/policy briefs in the MED/COG/Counties/ESK websites.

### VI. Quality assurance and coordination

- Reference Team composed of seven members: two MED officers, two World Bank officers, one ESK coordinator, and two consultants. The team oversaw the quality of the evaluation process according to the terms of reference.

- The focal team at the County-level that coordinated the project at that level composed of three members: the Chief Economist, M&E Officer Economic Planning, and M&E officer from the Department of Health Services.

## 5. Limitations

The limitations experienced in the course of this rapid evaluation were:

- Limited baseline data and other information related to regular monitoring. There was minimal baseline data available for the first CIDP. Most baseline information was therefore collected in retrospect during the primary data collection with targeted questions to the key informants and community meetings as well as FGDs with health committees on what the situation was like before Devolution.
- Difficult access to a few projects sites. The roads leading to some of the project sites were rugged and almost impassable due to heavy rains. However, the team succeeded in conducting all the planned meetings and engaging all the targeted stakeholders.This was possible because the consultants operated with the research assistants in two teams which were able to visit the different sites simultaneously with effective coordination from the department of Health. The teams were tenacious and stretched the working hours beyond the conventional 8.00 AM to 5.00 PM.
- Language Barriers. The data collection tools were developed in English language. However, the majority of the targeted community members were comfortable providing answers in their local language. The consultants and the research assistants had to translate the tools into and from the local dialect (Kipsigis). The team tested the tools before using them widely.
- Time-consuming quality assurance and control processes for the field data collection.The data collected by the research assistants was in the local language, translated and recorded in English, and then transcribed. However, since the data was not tape recorded, the team had to recheck the data through reviewing the hard copies of the tools which was time-consuming. We propose to include the costs of data recording and transcription in the budget of future evaluations.
- COVID-19 context delayed the planned timely completion of evaluation including holding of the findings' stakeholder dissemination workshops. This also led to higher budget implications compared to the initial allocation.

## 6. Findings

Results were mixed on the achievement of the set Kericho CIDP health sector objectives' priorities. This section presents the main findings of the rapid evaluation. They are are structured across the five evaluation OECD evaluation criteria as follows.

### Relevance

### Key Achievements

**I. Alignment to National/Regional and Global development priorities as follows.**

- **The 2010 Kenyan Constitution** stipulates the right to the highest attainable standards to health care services, emphasizing the inter-dependent relationship between this and that of economic development. Accordingly, the Kenya National Health Policy (2014-2030) exists whose implementation is under the Health Bill, 2015 that among others focuses *to '……establish a*

*national health system which encompasses public and private institutions and providers of health services at the national and county levels and facilitate in a progressive and equitable manner, the highest attainable standard of health services……'.*

- **Kericho health policy goal** is, "attaining the highest possible standards of health in a manner responsive to the needs of the population'. Accordingly, it aligns to the above national health policy and constitutional aspirations.
- **A draft Health Bill** to operationalize the policy exists, and is awaiting ratification by the County Assembly.
- **Kericho Health Sector Strategic Plan 2013/14 – 2017/18 was developed aligned to all the above**. The CIDP's objectives are to: reduce child mortality; improve maternal health; combat HIV/AIDs, malaria and other diseases. It was not officially launched but used to inform health service delivery.
- **Alignment to related national, regional and global development priorities.** All these are premised on the global, regional and country policies namely; SDGs (Goals 2/3/6 and the then MDGs 4/5/6), African Union **'s** Abuja Declaration/ (target of allocating at least 15 percent of their annual budget to improve the health sector) and Vision 2030's social pillar on investing on the people of Kenya, under the health sector.

II. **Multi-stakeholder funding and technical support**. Some impressive outcomes and impacts as outlined below were evident. Some of the partners that contributed to these included; national government, World Bank, UNICEF, UNFPA, USAID, Global Fund, DFID, Danida, PEPFAR, Health and Development Service (HANDS), Brighter Communities World Wide, PSK, Christian Health Education (CHAK),SUPKEM and the private sector

III. **Some Needs Assessments were Conducted**. According to the 13 FDGs for various committees (one (1) CHMT and five (5) SCHMTs and (7) HMTs), Needs Assessments involving the participation by some departments to determine health care technical priorities such as theatres, based on evidence were conducted, while others did not. Table 2 summarizes this finding.

**Table 2: Identification of health needs according to the FGDs with CHMTs, CHMTs and HMTs in Kericho County**

| Needs Assessment | N =13 |
|---|---|
| Departments initiate the process of needs assessment | 9 |
| SCHMTs are not aware of the projects & not involved in needs assessment, supervision and implementation of projects (especially infrastructure) | 2 |
| SCHMTs & HMTs are aware of the projects & are involved in needs assessment but are minimally involved in the supervision and implementation of projects (especially infrastructure) | 7 |
| Project priorities are done by CHMTs and the MCAs | 5 |

IV. **Some Identified Evidence-based Needs Met**. According to these discussions, the needs identified during the first CIDP focused on maternal/child health care access to health services. These findings indicate that the CIDP health strategies and their implementation were relevant and appropriate to the needs of the targeted beneficiaries in the county as per global and country priorities. The following, including on (table 3) were some of the specific achievements:

- **Maternal and child health initiatives included**, new-born units (NBUs), maternity wings and services boosted, among others, as noted in one FGD. "*Mothers received maternal services such as family planning and children received immunization which reduced costs and travelling to other places for these services" (*15/08/2019, Kanene dispensary, FGD, dispensary committee).
- **Vulnerable population initiatives (persons with HIV and AIDs)** included reduction of referral cases through provision of improved equipment such a CT Scan and ambulances to hasten referrals. CT Scan is available now in level four public hospitals therefore reducing the referral cases.
- **Emergency services initiatives.** To address trauma and emergency cases, a causulty unity was constructed in Kaptegat Hospital. It was complete at the time of the evaluation but yet to be opened. An ambulance was planned and purchased for each sub-county during the review period to enhance emergency access to health services.

**Table 3: Main health needs addressed during the CIDP 2013-2017 according to the FGDs with CHMTs, SCHMTs and HMTs**

| Needs CIDP Projects Addressed | N= 13 |
|---|---|
| Availability of water to address water shortages | 2 |
| Reduce distance travelled by community to access health services (construction of dispensaries) | 3 |
| Reduce referral cases (Theatres and equipment) | 4 |
| Maternal and child services (maternity Wards, New-born units (NBU), equipment) | 6 |
| Fasten referrals (Ambulances) | 5 |
| Mortuary | 2 |
| Staffing | 2 |

## Challenges

The following main challenges were highlighted before and during CIDP implementation:

I. **Minimal Community participation** in identifying and prioritizing projects in the hospitals. Reportedly, the hospital management identified the projects largely with minimal community involvement. However, for the projects within the health centres and dispensaries, there was some involvement of the community through their elected health committees.

II. **Decreased awareness raising/outreach about primary healthcare**. Health education and primary health care is undertaken in liaison with the community units in four of the six sub-counties. The WASH services that include latrines and springs protection and community sensitization and IEC materials and health promotion are funded by donors such as TI, SNV. Preventive services focus majorly on mother and child health through immunizations, family planning, child welfare clinic,maternity service and ante natal clinic (ANC) and postnatal care. The county needs to intensify its awareness raising activities about primary healthcare.

III. **Low focus on promotive and preventive care.** Partners, such as Health and Development Services (HANDS), implement program about nutrition in schools. However, there is a need to scale up such programs due to the increasing number of cases infected with non-communicable diseases which are linked to nutrition, such as diabetes, hypertension, and cancer.

## Effectivess

### Key Achievements and Challenges

This rapid evaluation assessed the status of health effectiveness in Kericho County by comparing the situation before and after devolution, in line with what was planned against the actual, in the CIDP.

#### I. Situation before Devolution

- Malaria at 49.4 percent, flu 19.45 percent stomach-ache 3.6 percent, diarrhoea 2.95 percent and respiratory tract diseases 1.6 percent at the start of 2013 (CIDP, 2013-2017).
- Tuberculosis and non-communicable diseases (NCDs) such as diabetes, hypertension were on the increase.
- According to the Kenya Demographic Health Survey (KDHS), 2014, children aged 12-23 months fully vaccinated coverage was at 71.8 percent, antennal clinics attendance was reported at 97.1 percent and 62.2 percent reported as delivering in the health facilities and 64.4 percent had been delivered by a skilled health provider.
- The use of contraceptives for family planning was reported at 62.9 percent which was slightly lower compared to the national figure of 65.4 percent (KDHS, 2014).
- Malnutrition was a public health problem and there was a rise in diet-related non-communicable diseases. Under nutrition of children aged below five years of stunting and wasting stood at 28.7 percent and 12.4 percent respectively all above the national prevalence of 26 percent and 11percent respectively while obesity of the same age group is on the rise at 4 percent (KDHS, 2014).
- Among women of reproductive age (15-49 years) those undernourished with body mass index (BMI) <18.5kg/$m^2$ were 6.4 percent and those overweight/obese >25.0kg/$m^2$ were 32.8 percent.

#### II. CIDP objectives after Devolution

The health sector objectives were to eliminate communicable diseases and halt Aand revere non-communicable diseases (Kericho County Strategic Plan 2014-2017). The CIDP planned to reduce infant and maternal mortality; address health and sanitation; reduce HIV and AIDs prevalence from 5.1 percent to 3 percent in 2017; reduce non-communicable conditions that were on the rise; and focus on support system and access to health care through national hospital insurance fund (NHIF). There were no specific targets for many of these initiatives at the sub-county or facilities level.

#### III. Mixed Results of CIDP

- Commendable achievements were reported for the period under review (table 4). For instance, the maternal mortality, under-five moratlity and infant mortality rates reduced in the plan period from 488/100,000, 74/1,000 and 52/1,000 to 360/100,000, 39/1,000 and 22/1,000 respectively. The percentage of pregnant women accessing preventable ARVs rose from 60 percent in 2012 to 98 percent in 2017 and those attending four Ante- Natal Clinic (ANC) visits rose from 33.6 percent to 38 percent within the same period. In 2017, 62 percent of children < 1 year were provided with ILITNs for malaria control, compared to 42.8 percent in 2012.

- Nonetheless, findings of this rapid evaluation reveal that the bulk of the health services available at the county were curative.
- Minimal health promotion initiatives and/or preventive health care. Immunization and family planning coverage decreased and there was a significant rise in NCDs such as hypertension and diabetes. Immunization could have been affected by lack of outreaches during the implementation period while increase in NCDs may be attributed to minimal focus on preventive services such as nutrition and lifestyle factors in addressing modifiable factors that lead to these conditions. Table 4 shows the outcome health indicators that improved and those that declined in the assessment period.
- The limited engagement in health promotion and preventive health was viewed as a real challenge. Addressing health promotion and preventive health services is considered a major way of reducing the disease burden.

**Table 4: Improved and Poor Performing Health Outcome Indicators 2012 versus 2017**

| Indicator | 2012 | 2017 | Comments |
|---|---|---|---|
| **Improved Outcomes** | | | |
| *Maternal Mortality rate (MMR) | 488/100,000 | 360/100,000 | Due to improved skilled deliveries |
| *Under-five Mortality Rate (U5MR) | 74/1,000 | 39/1,000 | Due to strengthened capacity building on IMCI, availability of rotavirus & other commodities like copper & zinc |
| *Infant Mortality Rate (IMR) | 52/1,000 | 22/1,000 | |
| *HIV prevalence % | 5.6 | 3.4 | Implementation of the global HIV 90 90 90 Strategy |
| **% HIV pregnant women receiving preventable ARVs | 60 | 98 | Availability of consistent supplies |
| **Number of eligible clients on ARVs | 60 | 96 | |
| **% targeted children < 1 year provided with ILITNs | 42.8 | 62 | Improved supply & distribution by GOK/partners |
| **% targeted pregnant women provided with ILITNs | 50 | 60 | |
| **% ANC clients attending ≥ 4 ANC visits | 33.6 | 38 | Improved after awareness creation in first visit |
| **Poorly-Performed Outcomes** | | | |
| **% Children <5years fully immunized | 69 | 67 | Due to fewer outreaches |
| **% population with hypertension | 3.1 | 18.8 | Low nutrition & preventive services |
| **% population with diabetes | 0.6 | 1.2 | Low nutrition & preventive services |
| **% Pregnant Women attending 1st ANC | 84 | 73 | Low promotion & outreaches |
| **% WRA receiving family planning coverage | 51.2 | 37 | Potentially due to low outreach and/or low supplies |
| **% Low birth weight infants <2500 gram | 6.2 | 38 | Low nutrition awareness and poverty |

Source:
*MoH Health Sector Performance Review Report 2013-2017 & Priorities for Implementation of health services 2018/2019 for Kericho County
**MoH (2017) Kericho County Health at a Glance

## IV. Contributory factors to improved and/or declining outcomes.

Baseline status of equipment before devolution was largely not available, except a few notable ones in hospitals, health centers and dispensaries. To bridge the gap, the consultants gathered the data in retrospect by integrating related questions as to how the situation was before Devolution in the key informant, FGDs and community meeting interviews. The improved health outcomes can be attributed to increased investment in service delivery with purchase of equipment and building infrastructure initiatives having received most of the projects' funds. For example the FGD of the HMT in Sion/Sigowet affirmed this. The county aimed to recruit workers in the CDF funded health facilities and build capacity by training traditional birth attendants (TBAs) and supervising public health officers (PHOs).

In future planning, equipment could be more specific and maintenance costs for the same be included at the design stage. Below the factors that may be attributed to the improved and/or declining outcomes.

### i. Health Infrastructure

- Increase in primary care facilities from 139 in 2013 to 156 in 2017 was achieved. Some of the projects were new with a number carried forward from the constituency development fund (CDF) initiatives as well as some supported by partners.
- The main projects were construction of maternity wards, orthopaedic workshops and theatres; renovation of existing facilities and increasing the medical training colleges. There is one referral hospital, Kericho and six public hospitals in the sub-counties with the exemption of Belgut sub-county that has no hospital. The county established the country's third largest ultra-modern ICU/HDU at a cost of KES 85M at the Kericho County Referral Hospital; an ultra-modern 5-bed Renal Unit, 3 imaging blocks, 3 Operating Theatres, one modern Mortuary and modern Accident and Emergency unit in various health facilities.
- The county also established a Regional Blood Bank at the Kericho County Referral Hospital.; Other key achievements were the refurbishment of 103 Level 2 and 3 health facilities and construction of 19 new dispensaries (Kericho County April 2016//2017). Eleven (11) dispensaries were partially completed while several others stalled. Some infrastructure projects stalled or were not completed due to inadequate funds and for some reasons were not known. Tabel 5 further below, illustrates the diverse infrastructural development projects earmarked across the entire county health facilities.
- Installations such as maternity wings and staff houses, theatres in several facilities were constructed but were yet to be used several years after completion. Most of the failure to put such facilities to use was attributed to lack of the requisite staffing and in some cases poor workmanship of the same. Sentiments like this quote from a FGD give a view of the observed status.

Table 5: Main CIDP 2013-2017 Targets and outputs

| **Project** | **CIDP Target** | **Outside CIDP** | **Outputs** | |
|---|---|---|---|---|
| | | | **Complete** | **Partially Complete** |
| New facilities | 44 | 2 | 3 | 7 |
| Maternity wards | 96 | 0 | 14 | 37 |
| Inpatient Wards | 9 | 6 | 1 | 0 |
| Outpatient wards | 32 | 0 | 19 | 8 |

| | | | | |
|---|---|---|---|---|
| Staff houses | 63 | 0 | 11 | 20 |
| Purchase of land | 52 | 0 | 9 | 0 |
| Laboratories | 50 | 0 | 4 | 8 |
| Drug store | 1 | 0 | 1 | 0 |
| HDU/ICU | 2 | 0 | 1 | 0 |
| Total | 349 | 8 | 63 | 80 |

Source: Draft Health Sector Performance Review Report 2013/2014 – 2016/17

### ii. Equipment

- At the Hospitals Level: Installation of Closed Circuit Television at the Kericho County Referral Hospital and Kapkatet, Londiani and Sigowet Sub-county hospitals; use of Compact Disks in the Imaging Unit (instead of the old films), thereby saving costs and increasing efficiency and the installation of a 64-slice CT Scan at the Kericho County Referral Hospital. Theatre and X-ray equipment were also acquired for the level four hospitals (Annex 3).
- At the Health Centres and Dispensary levels: Equipment acquired were for laboratories, new-born units, and maternity wards. Some facilities were supplied with equipment which remained idle in the stores due to lack of human resources to operate them. These were primarily laboratory and maternity equipment as noted in the FGD.
- Hospital beds and infant cots were purchased in many dispensaries and health centres although some were lying idle during this evaluation.

### iii. Hiring of staff

- Human resource is essential for quality service delivery.
- Based on the health report, over 500 new medical staffs were recruited to improve service delivery (Kericho County April 2016/2017). Health staff were employed at the county and sub-county levels while in the H/Cs and dispensaries, there were fewer staff than before devolution, with majority of them being on contract terms. An issue that was stated to be demotivating.
- Moreover, it was noted that in all the facilities a certain level of staffing deficit was experienced.
- Some health centres did not have even a single clinical officer and were run by two or three nurses while several dispensaries had only one nurse who handled all the cases at the facility.
- Referral was reported as an uphill task since the facilities at these levels operated with neither ambulances nor utility vehicles. The situation was not any better in the sub county hospital. It was noted that in the last five years most staff were on contract unlike before when most staff were on permanent and pensionable terms. The contract terms were said to be a source of de-motivation and apathy among the staff.

"*… there are large disparities in the remuneration of contract staff and those on permanent basis even with the same qualifications and work engagement"*. There is apparent minimal staffing to address preventive and promotive services such as nutritionists and for public health that are essential to address the increasing non-communicable conditions. On health workforce, staffing on specialization does not include nutritionists (Kericho County April 2016/2017).

### iv. Health Service Provision

- The health sector objectives were to eliminate communicable diseases and halt and revere non-communicable diseases (Kericho County Strategic Plan 2014-2017). The CIDP planned to reduce infant and maternal mortality; address health and sanitation; reduce HIV and AIDs prevalence from 5.1percent to 3percent in 2017; reduce non-communicable conditions that were on the rise; and focus on support system and access to health care through national hospital insurance fund (NHIF). There were no specific targets for many of these initiatives at the sub-county or facilities level.
- Voluntary Counselling and Testing (VCT) across the county was considered as one of the highlights in terms of high-quality services which have continued to be very good, before and within the current dispensation. The evaluation findings were indicative that the support system was good, and services were of acceptable standards. It was also noted that both the designated personnel and the supplies necessary for the VCT services were regular and in place most of the times. These services were to a large extent supported by the national government and other development partners such as PEPFAR and hence had designated staff and supplies. They were not solely dependent on the county health systems.
- Improvements in water service provision for the hospitals, H/Cs and dispensaries through boreholes that are fully functional and water tanks in several facilities contributed to better health access and delivery. The focus of building the capacity of health human resources was at the county level not at dispensaries and H/Cs.
- Outreach services that are essential for health access to the community minimal. There was an some increase of outreach services in Kipkelion East sub-county from from 24 to 84 while in other five sub-counties there was a decline.
- The county scraped emergency ambulance service fees and the NHIF provided for free maternity services for women through the "*Linda Mamaservices"* for maternity cases in health centres and hospital as a means to improve health services access. Acquisition of ambulances of enhanced the referral systems.

### v. Logistics and Support Supervisions

- The county planned to reduce the distance to the nearest health facility from 5 to 15 km to an average of 1 km. Access to health services was enhanced and shortened through construction/rehabilitation of Health Centres (H/Cs) and dispensaries.
- Improved road network further, contributed to enhanced peoples' access to health services in the county.
- These in turn occasioned the hiring of additional contract staff.
- Every health facility planned to have an ambulance to facilitate referrals and improve health services access by the community members. The county acquired ten fully equipped ambulances to enhance the referral system.
- Increased number of ambulances improved quick referral services. However, lack of utility vehicles made supervision of health services and outreaches suffer contributing to weakened services.
- Medical Officers of Health at the Sub-County levels observed that facilities there have minimal resources. For instance, members of the HMTs; CHMTs SCHMTs acknowledged that these structures were neither funded nor provided with the requisite logistics such as utility vehicles for supervision, meal allowances and other logistics for supervision.

### vi. Community Participation

- People's participation in development and services that concerns them is enshrined in the Kenya Constitution 2010. Community participation, including their responsiveness and/or lack therefore, has a bearing one way or another in health outcomes/impacts. In this case, albeit in limited ways, as reported elsewhere their particpation, in the CIDP implementation contributed one way or another in the achievement of results.
- Communication is done in each Ward and Sub-county who informs people to turn up for public participation. The Citizen's Delivery Unit in the Office of the Governor communicates to citizens. The citizens are also communicated through the County Newsletter, Civic Education Unit and through the Department of Youth Affairs, Sports and ICT.
- Community units exist in four of the six sub-counties. These units engage the community in activities related to health as the community health workers (CHWs) act as link between the community and the health facilities. Their focus is on health service delivery and provision but not on development projects.

> "*the community units are in only four sub-counties and the involvement of these units in the development efforts in the sector was minimal during the first CIDP"* (KII on 13/08/2019). Public participation takes place before production of a document to get views of the public. During these meetings, they are informed on what has been done and what is in the forthcoming ADPs. "*For any projects, the county comes to the dispensary committee at the end of the year. They do not call forums to get contribution from the committees and community before they suggest a project"*

- The Finance and Economic Planning department have "Project Implementing Committees" which are technical staff but reportedly, there is no community participation in them.
- CHMTs, SCHMTs and HMTs perceptions of community involvement in health projects during the FGDs (table 5) indicate that gender, youth and persons with disabilities are considered during the election of committees in the health centers and dispensaries and given a chance to contribute during the committee meetings on health projects.

**Table 6: Perception of community involvement in the health projects according to the FGDs with CHMTs, SCHMTs and HMTs**

| Perception of involvement | N=14 |
|---|---|
| Less community involvement in the hospitals as there are no boards | 4 |
| Community involved indirectly through MCAs | |
| SCHMTs especially PHOs seek ideas from the community through community meetings | 6 |
| Community involved through public participation annually and during community dialogue meetings in identification of projects | 6 |
| Through chief *barazas* | 3 |
| Community is not involved in prioritization, design, implementation and monitoring | 5 |
| Gender, youth and persons with disabilities are considered during the election of committee in the health center and dispensaries and given a chance to contribute during the committee meetings | 8 |

## Challenges

- Infrequent availability of drugs and limited laboratory facilities in some health centres and dispensaries. There was enhanced access to health services to all, but this gain is diminished by

the frequent delays /lack of medicines/drugs in some facilities. Renovations and maintenance of most H/Cs and dispensaries were not budgeted for; hence the facilities were run down.

- Renovations and maintenance of most H/Cs and dispensaries were not budgeted for; hence the facilities were run down.
- Delays /lack of medicines/drugs in some facilities. Renovations and maintenance of most H/Cs and dispensaries were not budgeted for; hence the facilities were run down.
- Based on the findings, the community's engagement in the development efforts in the health sector was done mainly through health facility committees during the first CIDP. The direct community engagement was done through barazas community meetings and society meetings.
- The election of committees was representative and democratic. Gender equity and inclusivity of both the youth and vulnerable populations were observed. The local chiefs were members of such committees and were present in most of the interviews during this rapid evaluation exercise.
- However, in half of the community meetings (7) conducted for this evaluation, the participants felt they were not involved or engaged in deciding on projects.
- For instance, based on the fourteen community meetings (table 5), 50 percent of the community meetings felt that the community was not engaged in the identification of health projects in the dispensaries and health centres. However, 64 percent of these meetings felt committees selected are engaged in decision making on behalf of the community in terms of identification of projects sites and making decisions on behalf of the community. Community involvements are in terms of manual work and raising funds and provision of project sites.
- Minimal Engagement of the Sub-county Health Management Team (SCHMT). The involvement of the sub-county health management teams was low in project identification, design, planning, maintenance and supervision. Freedom of speech is evidenced by more dialogue now than before devolution.
- No Community and Health Staff Engagement in the County's Development Efforts. That there was no involvement of health staff and the community in infrastructure and other development efforts in the county was evident. As noted by staff by statements such as "*involvement and communication in the county as concerns development projects is a challenge"* (FDG with SCHMT).
- Minimal Community Engagement at Hospitals Level. There was minimal community engagement in the design and implementation of health projects in hospitals. Such projects were designed and implemented by the technical health staff.
- Minimal Community Engagement at Health Centres and Dispensaries Level. Health committees in health centres and dispensaries contributed in identifying projects' sites and providing suggestions on the projects. The committees also represented the dispensaries and health centres in public participation activities organized by the County. Construction of H/Cs and dispensaries was completed with minimal engagement of the community and health facility staff.

## Efficiency

## Key Achievements

### I. Health Financing

Health care financing is not only expensive but complex and difficult to sustain. The complexity of health financing is exacerbated by the unpredictability of some of the needs, limited insurance cover among most of the service seekers and thus making it a net exchequer supported service.

The County Budget review and Outlook Paper shows performance of previous budget in terms of figures and actual performance while the County Feascal Strategy Paper provide detailed report on performance and how current budgets is performing and plan to improve during the upcoming budget. These are disseminated to the County Assembly. An analysis of budget allocations revealed that**:**

- The Ministry of Health with the support of multi-stakeholders e.g, through KEMSA- and the County government provide for development and salary for employed staff.
- At the county level only hospital and health centres offering services covered by the National Hospital Insurance Fund (NHIF) direct monies from the fund. Dispensaries and health centres without any direct funds from NHIF must depend on the county revenue. Such units experience long dry spells and service delivery is grossly affected. Overall revenue flow does not cover expenditure in the sector.
- The NHIF for inpatient and outpatient care and *Linda Mama* provide for free maternity services.
- Financing at the health centres and dispensaries, is by DANIDA. This provides for costs of catering, domestic travels, committee allowances, sanitary supplies and payment of casual workers. The Ministry of Health and the County government provides for development and salary for employed staff. The NHIF for inpatient and outpatient care and *Linda Mama* provide for free maternity services.
- All other collections accruing from health services are banked in the collection county revenue account.

### II. Commodities: Pharmaceuticals and Non-pharmaceuticals

- The CIDP focused on building one central store at the county, established four improved pharmacies and builds drug stores annually.
- According to the Department of Health Report, during the plan period the construction of a County Central drug store ensured buffer stocks of drugs and improved the drug supply chain in the county.
- In the sub-county hospitals and H/Cs and dispensaries, stores were established by partitioning some rooms in the existing facilities.

### III. Improved Bureaucracy

- There are two channels of commodities at county and national level. At the hospital level the devolved system has reduced bureaucracy and the red tape associated with procurement of commodities.
- Facilities can order both directly and through the county bulk procurement system. The flexibility at this level allows the facilities to prioritize and access their essentials.
- However, the health centres and dispensaries reported more frustration in terms of erratic supply in both pharmaceuticals and non-pharmaceuticals. This level reported long spells of out of stock and thus prescriptions without dispensing.

## Challenges

### I. Lack of Legislation to Allow Health Facilities Retain Funds for Operations

- The gap leaves most of facilities dry of resources in both curative and preventive health services.

### II. Delayed Project Implementation

- In terms of timing, projects did not start as planned due to delays in release of funds.
- Compounding this are the limted systems and practices in place to enhance efficiency in the project implementation processes.

### III. Inadequate and Inconsistent Supply of Drugs at Health Centres/Dispensary Levels

- Supply of commodities such as drugs, vaccines and other consumables swung between extremely irregular to a smooth regular flow. Some facilities reported spells of no supplies lasting two to six months on average.
- The supplies procured through the county systems was said to be most irregular while supplies such as tuberculosis (TB) drugs, HIV/AIDS support systems, and vaccines supplied through the national government systems were regular (monthly) and predictable.

> "*…there are no drugs unlike before devolution. The availability of drugs in the facility is poor at times though not that bad but the supply delays…Sometimes there is a shortage of drugs because the facility is serving many people because of its location (Patients buy drugs sometime in the Chemist… In the last quarter they received very minimal supplies…. Sometimes patients purchase from the chemists when there is an acute shortage of drugs that even painkillers were not available…it was raised that the nurse in charge does not take full responsibility …. it was noted that someone undisclosed staff takes drugs from the facility…there is low supply of commodities from the sub-county. It does not meet the increased patient population using the facility."*

- Other gaps noticed were in the area of reproductive health, several facilities were without essentials in contraceptives for several months.
- At the H/Cs and dispensary levels, storage facilities and drug supplies are inadequate and supplies inconsistent. The dispensaries and H/Cs reflected a general persuasion that access to

both pharmaceuticals and non-pharmaceuticals was poorer than before devolution, but non-pharmaceuticals are less of a challenge. The different group's perceptions on the status of drugs in the facilities are shown in figure 2.

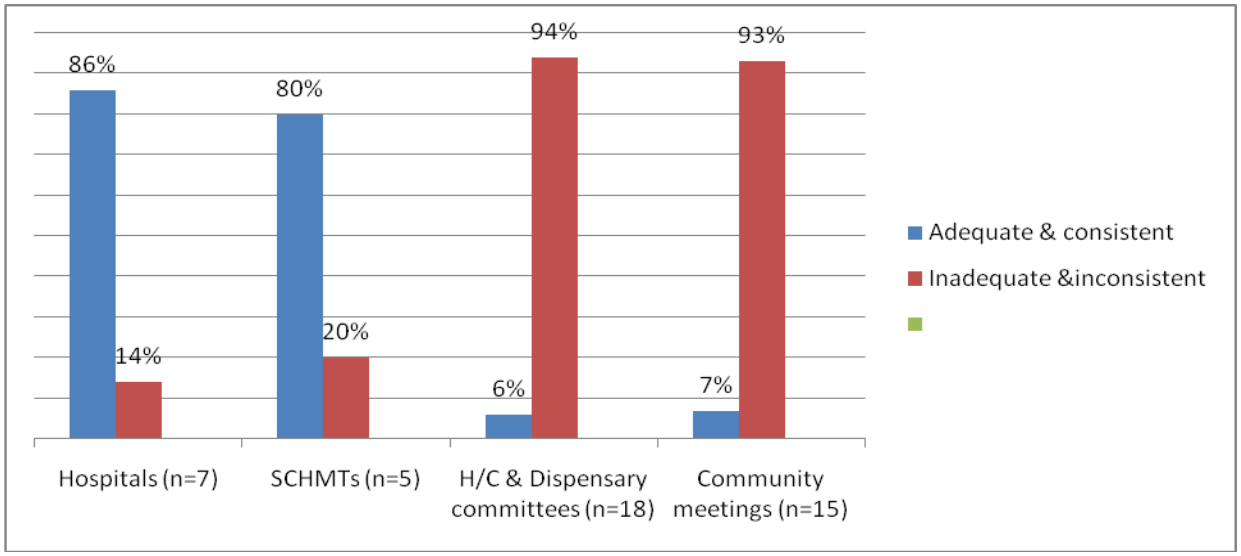


**Figure 1: Perception of drugs supply in the health facilities according to different respondents**

### IV. Low Staff Capacity

- The situation in the H/Cs and dispensaries is worsened by the limited supervision, low staff and capacity to handle pharmaceuticals and non-pharmaceuticals.
- Support supervision could be enhanced through the provision of utility vehicles at the sub-county level.
- Staff at the dispensaries and health centres need a capacity building program in terms of managing pharmaceutical and non-pharmaceutical commodities.
- Engagement of technologists at the sub-county level to cater for several facilities may contribute to better management of commodities at the health centres and dispensaries.

### V. Weak Coordination, supervision, maintenance and monitoring

- There were several cases of projects implemented with minimal local committee's involvement. The level of inclusivity and consultation with the beneficiaries was equally minimal.
- In some cases it was reported that projects have stalled for several years.
- Some structures were not in use and the health staff stated they were not comfortable to use them due to poor workmanship while others were not in use due to lack of personnel.
- It was further noted that there were some infrastructural projects in the CIDP, that the local facility leaders had no idea on such projects.

## VI. Leadership and Governance

- Focus is on the health management processes and the effectiveness of the management arrangements instituted at the different levels of engagement in health delivery systems. These comprise the decision-making processes, level of inclusivity and engagement of the various stakeholders and the general operations framework of health services.
- The devolved health sector has adopted an operating system borrowed from the District Health Management Team which operated before devolution. These teams were modelled on the defunct District Health Management Teams (DHMTs) and the District Health Management Board (DHMB). This has given birth to a County Health Management Team (CHMT) and Sub-County Health Management Teams (SCHMTs); Hospital Management Team (HMTs) at the hospitals and health committees at the H/Cs and dispensaries.
- At the hospital level membership is drawn from heads of departments and the facility in charge, at the H/Cs and dispensaries, membership is drawn from the community members. The CHMT; SCHMTs and HMTs and H/C and dispensary committees are functional.
- Nevertheless, while other departments, development partners, and national government are working in health sector-related activities, these are not coordinated and harmonized and therefore affected the efficiency and effective mnagement of servce delivery.
- Moreover, the adopted leadership and governance structure is not adequately anchored in the legal framework at the county.
- Members of the HMTs; CHMT and SCHMTs acknowledged that these structures were handicapped in legal mandate. The health services management bill is yet to be passed by the County Assembly to accommodate this.
- The need to have these structures embedded in a county legal framework could not be overemphasized. Absence of such entrenchment might have been responsible for apparent disengagement from some of the members of HMTs who felt both excluded and lacking in mandate to function.

> "*…all major decisions are run by the medical superintendent... the hospital management boards are no longer functional… the health management team chaired by the medical superintendent do quarterly meetings and minutes copied to chief officers...all heads of departments at the county and or the hospital are members of the HMT, courtesy of their office…".*

> "*…the HMT inherited the policies from the ministry of health; roles and policies…are neither in place nor…documented legally. The only documentation is the appointment of membership. The memo is circulated by the administrator on matters to be deliberated on in the meeting. There is less involvement of the sub-county team by the county leadership on projects. Area Member of County Assembly just decides on where to do the constructions in the facility and what to be done hence the technical persons' ideas and contributions are not taken into consideration during the implementation of the project…".*

- The HMTs comprised all the heads of health departments at the sub county. Nevertheless, it was noted that at this level the structure was less streamlined compared to the CHMT. The SCHMT membership ranged from 10 to 15 or even more, with three core members of the

team comprising the Medical Officer, Public Health Nurse, and the Public Health Officer. It was the core three who would be facilitated to conduct supervisory visits. It was noted that the other members of the SCHMT felt excluded and played a peripheral role in the health management in the sub county.

- The health management teams coordinated services across the sub-county; acted as a link between the health department and the community; ensured that the approved services were offered as expected; provided a supervisory role; conducted quarterly data quality audits across the departments; did batch to batch validation of laboratory reagents by sampling segments; analysed emerging trends on facility basis and the results compared with the expected standards; conducted supervision and mentorship based on or informed by identified data issuesIt was noted that the public participation in the sub county level on matters health was largely through the public health officers who operated mostly at the community level. Both at the health facility level and in the FGDs, it was reported that:
- All the dispensaries and health centres had functional health committees elected by the local communities to manage the local running of projects and services in the facility. "*Election was done based on gender, vulnerability, age, and religion* (FGD, Momoniat H/C).
- These committees were not directly involved in the regular oversight in the CIDP project implementation, a function played by either the sub county health teams and or the county health leadership. The lack of local supervision role tended to compromise the quality of outputs. These committees were responsible for suggesting most of the projects at the facility levels. However, involvement of the committees in design and implementation of CIDP projects was minimal.
- The projects at the dispensary and health centre levels were implemented through an oversight from the county level. The local committees neither had the specifications of the scope of the projects nor the budgets. In most of the dispensaries and health centres, both the local committees and the community members felt that the county and sub county health leadership did not engage with them adequately and thus tended to operate in isolation. This mood is well captured in statements like the textbox above.
- Legalization of the leadership and governance structures will enhance resources allocation to have these structures function for improved health services delivery.

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## Impact

### Key Achievements and Challenges

The RE within permitting capacities and timelines established the extent to which the interventions may have contributed in the realization of higher-level development objectives in health at the county level; and the lasting effect of the intervention in proportion to the overall situation of the target group or those affected. The intended and unintended outcomes/impacts of the interventions were assessed. The aspects of strategic positioning of the projects in guaranteeing continued access to the positive effects of the interventions were assessed**.** The permanence of the utility value of the interventions was sought. The following trends emerged from the data collected:

- The community stakeholders were satisfied that some services had greatly improved since the devolution systems were implemented. The strategic display of service charters in most of the health facilities was backed by practice in the referral county hospital. In the FGDs it emerged that

customer satisfaction was experienced by many. The hospitals had a feedback mechanism and there was frequent feedback from clients through the user satisfaction surveys.

- The health services in the CIDP (2013-2017) ventured into critical health infrastructure in the hospitals. These services had far reaching effects in improved quality of life for the citizenry. These services include high resolution 64 slices CT Scan at the county referral hospital, a 32 slices CT Scan machine at Kapkatet hospital; renal dialysis unit; and a state-of-the-art Intensive Care Unit (ICU), a standard new-born unit, state of the art ISO standard level laboratory at the county referral hospital are all critical installations offering transformative services.
- The impact of these services both in the short term and the long term are potentially sustainable through a good management of the cost sharing element. It was clear in both the community meetings and the FGDs that the patients served through these units are not only getting the physiological healing but get financial relief. The services are closer and cheaper than the equivalent in facilities in Nairobi and Kisumu which were the destinations of choice before such services were available in the county.
- Specifically, the now well resourced hospitals have great operating theatre services where major surgical services are offered, and lives are saved. Some of these services were once only available through referral outside the county are now accessible at their doorstep.
- The number of mothers delivering at home was on the decline as health worker assisted deliveries were on the increase. The increase in use of health facilities was as a result of the increase in health facilities, short distances covered to health facilities and low costs incurred.
- The devolution of the health sector had some lasting effects on health delivery in the county. Although the function was devolved, there was no due legislation to domicile the functions and operations of its structures at the county level. Structures such as the HMTs and SCHMTs were neither embedded in the national or county level legal framework to provide an operational mandate. This made budget allocation to support services like field supervision, composition of such teams and reporting lines difficult to implement.
- Other unintended issues revolve around the pharmaceutical and non-pharmaceutical supply system established through KEMSA that was to a large extent disrupted without necessarily a commensurate alternative. This led to the observed supplies challenges such as too little too late. Facilities seemed to run without supplies for several months. All these are likely to compromise the health status of the citizens.
- Devolution and the shifting of the health sector from the national government to the county disrupted the support to the health care system without bridging the transitional gap. For example, it was reported that before devolution, most of the rural health facilities used to conduct outreach services to the communities in hard to reach areas. Such outreach services were reportedly missing due to lack of funding and the essential logistics. Such lapses are likely to lead to low immunization coverage and thus poor health status.
- An evaluation system to track SDGs implementation at the higher outcome/impact results levels is lacking.

### Sustainability

- The impact and sustainability of routine services that improved due to the projects implemented during the 2013 – 2017 CIDP is dependent upon the county health department's commitment to a lasting support system, including allocation of maintenance budgets and their execution.

- Some of the gains that may be unsustainable without such entrenchment include the provision of ambulance services which is still limited to a few hospitals and one health center (Sosiot), theatre services in the main hospitals, renal dialysis at the county referral hospital, CT scan services at the county referral hospital and Kapkatet hospital, complex laboratory services and ICU services at the county referral hospital.
- The said un-sustainability of these functions outside of the government systems was captured in sentiments in the statement by community members.

## 7. Monitoring and Evaluation

### Key Achievements

- Kericho M & E function is coordinated under Economic Planning department under the oversight of the director with an M & E Officer. Each department including Health has a M & E coordinator.
- The M&E coordinators from health and other sectors have been trained on CIMES use and other forms of trainngs by MED, among others, but they require continuous training on the same especially as pertains to CIDP projects.
- Existence of the Health Information Management System (HIMS) enables the Health Sector provide rich monitoring data for its strategy that is aligned to the Vision 2030 and the SDGs. Nonetheless, the System does not provide indicator data for tracking of CIDP health projects.
- Some Needs Assessments are aonducted in the health sector. According to the discussion in the 13 focus groups (one (1) CHMT and five (5) SCHMTs and (7) HMTs some communities 'needs assessments by some departments were conducted to determine needs, based on evidence, while others did not.
- Draft M&E Policy exists awaiting approval by the County Assembly.
- The county has a draft indicator handbook with baselines and has adopted the CIMES guidelines prepared by MED and CoG. Nonetheless, base line data for most projects was hard to come by, hence the filling of the gap in retrospect during this evaluation process.
- The Department of Finance and Planning collaborates with the Kenya National Bureau of Statistics (KNBS) at the county level in terms of statistics compilation and data collection. There is need for this to be strengthened.
- Data to monitor sector development plans is obtained through desk reports, field reports and secondary data. There is no standardized tool/instrument for collecting data on development projects.
- The County Delivery Unit in the Governor's office monitors the flagship projects and high impact projects
- The JICA supported project on Capacity Development Project for the Devolved Management of Devolved Health Systems (OCCADEP) in Kericho focuses on supporting planning and budgeting and linking the two. This needs to be cascaded down to the health centres and dispensaries for effectiveness in planning, implementation and budgetary controls of services. But this may be hampered by structures and equipment such as lack of computers in most H/Cs and dispensaries.

### Challenges

- The recent Annual Capacity and Performance Assessment undertaken as part of the Kenya Devolution Support Program (KDSP) found that monitoring and evaluation is nascent and largely weak, in most counties, including Kericho. Evaluation function has been left behind in terms of capacity, demand and utilization in Kenya, including Kericho.
- The 2013-2017 CIDP, the projects planned for Kericho health sector were in the form of activities and not projects. As such the generation of these "projects" was not results based. There is need to strengthen project preparation, design, implementation and monitoring and evaluation using the project cycle approach that is results based for health projects.
- There is no approved budget for M & E in the departments. However 2 percent of the sector budget is proposed in the draft policy. Approval of the M & E policy will provide legal backup of the M & E functions and budgetary allocation for the same and in so doing, boost the demand and utilization of the evaluation function
- Well-designed and used M&E systems are essential for effective implementation of CIDP projects. The rapid evaluation therefore also examined the M&E arrangements in place in the section. Unfortunately, the evaluation found that there is no systematic monitoring and evaluation of the CIDP health projects in Kericho.

## 8. Lessons learnt based on this rapid evaluation

There were neither project specific evaluation reports available in the county nor generic health services evaluation conducted in the period covered by the CIDP 2013 -2017. Exploration into the existing frameworks and practices revealed the following practices:

- There may be better processes of evaluation including monitoring of the quality of projects and the results if there is a more enabling environment for the various teams operating in health services in the county, in a coordinated and harmonized manner, including tapping more into other existing data systems such as the KNBS towards robust evaluations.
- Preparation for monitoring and evaluation is a stage set at the project design level and thus not a component which can either be grafted or even embedded later in the implementation point and expected to grow roots. As such an M&E plan was not included in the activities or projects implemented in the life of the 2013 -2017 CIDP. Similarly, the practice both at the county and the sub county level did not seem to have much room for an elaborate M&E process.
- The projects were largely stand-alone activities implemented by different sections of the department of health and the county government and relevant departments. In some instances, the projects seemed to have been implemented in an uncoordinated manner between the facility, Sub County and even the county level. Often, none of the levels seemed to engage in a coordinated manner to set priorities and agree on both the design and implementation of certain projects, leave alone the M&E components.
- Based on the foregoing, review of the current CIDP to address the shortcomings as a result of leaving out key aspects during the planning stage such an M&E and to strengthen the results focus in county projects will add value to the achievement of expected outcomes.
- Ownership of evaluation findings by all relevant stakeholders from the national to county levelsd was greatly enhanced by the advocacy workshops undertaken for this evaluation that included top

political and executive leadership. This is a potential best practice that may add great value as the project is replicated.

## 9. Recommendations

This rapid evaluation suggests a number of recommendations categorized under the following two categories.

### I. Policy Recommendations

Based on this rapid evaluation, these recommendations are made for policy in Kericho:

- Facilitate the processes of evidence-based decision-making through approval of the Health Service Management bill, draft a monitoring and evaluation policy and indicator handbook to strengthen resource allocation and establish a data management system.
- Establish a multi-disciplinary coordination mechanism by legal means to oversee development projects with a focus on results and quality service provision.
- Review the current Fiscal Strategy Paper with the aim of making projects results focused.
- Include maintenance costs in the budgeting for infrastructures and equipment projects.
- Implement strategies to ensure families use National Hospital Insurance Fund.
- Train policy makers and Members of the County Assembly on Public Finance Management Act and budgeting to enhance resource use in the county to achieve intended outcomes.
- Conduct mid and end-term reviews of the current and future CIDPs with the aim of making projects results focused.
- As part of the implementation of recommendations, support counties to develop a County Evaluation Plan (CEP) that includes rapid evaluations for key sectors. The evaluation findings could then be featured in County Annual Progress Reports (CAPRs) on the implementation of CIDPs. Also, findings could help answer important knowledge gaps for the Medium-Term Plan (MTP) III implementation period.
- Strengthen SDGs implementation through an evaluation mechanism that tracks progress at outcome/impact levels of related health indicators and for other sectors as outlined above which is prioritized on the HIMS based on county context, in terms of disease prevalence. That in turn could potentially facilitate these levels of results' systematic capture in the GOK/UN Voluntary National Review Report (VNR) for Kenya i.e., on the implementation status of the SDGs.Undertake rapid evaluations of development projects or sectors to provide lessons learnt for improved decision making and service delivery for the citizens in the county.
- We propose to include the costs of data recording and transcription in the budget of future evaluations.
- Develop a deliberate and structured community participation and engagement process in project identification, design and implementation process, that could include the operationalization of Public Participatory Fora of the CIMES Guidelines.

### II. Practice Recommendations for the Health Sector

The following recommendations are made for the health sector in Kericho county based on this RE:

- Strengthen preventive and promotive health care services to address the increasing non-communicable diseases and public health concerns and increase outreaches to enable access to services such as immunizations.
- Conduct needs assessments for all projects towards more improved evidence-based investment choices.
- Train health committees and staffs on roles and functions and results-based management to improve and strengthen health care services delivery.
- Entrench the Hospital Management Teams, County Health Management Team, Sub-County Health Management Teams and health committees in a legal/official framework.
- Strengthen existing collaborations with KNBS to harness its rich data resources in tracking of monitoring indicators and feeding into evaluations. For example, through its monthly, quarterly and/or annual surveys/census programs and administrative data, some of which is derived from Geo-space analysis at the click of a button for an evidence-driven health strategy and projects.
- Develop tools for monitoring projects for the Health Management Information System.
- Rationalise physical facilities in terms of numbers to operate within the World Health Organization (WHO) norms while equipment and facilities that are not in use need to be put into good use.
- Streamline and facilitate the acquisition of commodities in the health centres and dispensaries and build staff capacity in terms of commodity management.
- Build the building of human resources at the health centres and dispensaries to contribute to improved service delivery.

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