Republic of Kenya
Ministry of Health

Organizational Capacity Development Project for the Management of Devolved Health Systems in Kenya (OCCADEP)

Completion Report

November 2019

Japan International Cooperation Agency

IC Net Limited
Koei Research & Consulting Inc.

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Project Activities Photos

1st Project Steering Committee in Nairobi on 9th Feb 2015

Performance Review Report Internal Review Meeting in Kericho on 5th Nov 2015

Situation and problem analysis workshop on MTEF cycle management in Kirinyaga on 11th Nov 2015

Training on priority target setting for AWP in Kericho on 18th Jun 2016

HSIGCF on 2nd Mar 2016

Workshop to review MTEF and AWP planning process in Kericho on 11th May 2016

Stakeholders' Forum for the inputs on the draft County Health M&E Plan on 1st Sep 2016

Review meeting to fix a framework of the Program Based Budgeting in Kericho on 17th Feb 2017

AWP planning and finalization of the priority setting in Kericho on 1st Mar 2017

Kericho AWP stakeholder meeting with sub-counties on 12th Feb 2018

HSIGCF stakeholders meeting on 15th Feb 2018

AWP meeting at Kipkelion West, Kericho on 20th Feb 2018

AWP Meeting at Kutus, Kirinyaga on 2nd Mar 2018

HSIGCF in Naivasha on 9th May 2018

Kirinyaga Stakeholders Meeting on 6th Jun 2018

Project Steering Committee on 13th Jun 2018

Study Visit to Kisumu on 18th Jun 2018

Study Visit to Kisumu on 18th Jun 2018

9th Project Steering Committee on 9th July 2019

Kericho Strategic Plan Workshop
from 9th to 12th July 2018

TOT training of MTEF tool in Kericho
from 1st to 2nd Sep 2018

Monitoring in Kirinyaga East Subcounty in Dec 2018

AWP sensitization workshop for HFs
from 12th to 15th Feb 2019

AWP Process Review with AWP Handbook validation and
APR preparation workshop in Kirinyaga on 18th Jun 2019

Mutual Learning Forum in Kirinyaga on 3rd Jul 2019

SCHMTs looking at MTEF process guide

MTEF management tool demonstration at Ministry of Health

9th Project Steering Committee at Ministry of Health on 9th July 2019

APR sensitization and allocation with CHMT/SCHMT in Kericho on 16th July 2019

Health Forum from 14th and 15th August 2019

Stakeholders Meeting in Kirinyaga on 17th Sep 2019

10th Project Steering Committee on 20th Sep 2019

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Abbreviations

APR	Annual Performance Review
AWP	Annual Work Plan
CBROP	County Budget Review and Outlook Paper
CDOH	County Department of Health
CEC	County Executive Committee
CHEW	Community Health Extension Worker
CHMT	County Health Management Team
CHRIO	County Health Records and Information Officer
CHSP	County Health Strategic Plan
CHV	Community Health Volunteer
COH	County Chief Officer for Health
COG	Council of Governors
C/P	Counterpart
CS	Cabinet Secretary
CU	Community Unit
DANIDA	Danish International Development Agency
DMS	Director of Medical Services
DP	Development Partner
FY	Financial Year
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit (German Federal Agency for International Cooperation)
HF	Health Facility
HR	Human Resource
HSC/IGA	Department of Health Sector Coordination and Intergovernmental Affairs
HSIGCF	Health Sector Inter-Governmental Consultative Forum
HSM	Health System Management
JICA	Japan International Cooperation Agency
KHSSP	Kenya Health Sector Strategic and Investment Plan
MCA	Members of County Assembly
M&E	Monitoring and Evaluation
MOH	Ministry of Health (of Kenya)
MTEF	Medium Term Expenditure Framework
MTR	Mid-term Review
OCCADEP	Organizational County Capacity Development Project (Abbreviated common name of the Project)
PBB	Program Based Budgeting
PDM	Project Design Matrix
PFM	Public Finance Management
PSC	Project Steering Committee
PTM	Project Technical Meeting
R/D	Record of Discussions

SCHMT	Sub-County Health Management Team
UHC	Universal Health Coverage
USAID	United States Agency for International Development
WB-THS	World Bank Transforming Health Systems Project

1 Outline of the Project

1.1 Background

The Constitution of Kenya 2010 introduced devolution in governance, through which the eight administrative regions (formerly the 8 provinces) were restructured into 47 counties and the responsibility of health service delivery was devolved to the counties while the national government retained the functions of leadership in policy development, management of national referral facilities and capacity development. The goal of devolution in health is to enhance equity in resource allocation thereby improving service delivery for all Kenyans, especially those residing in rural areas.

The Government of Kenya requested JICA for a technical cooperation project to strengthen management capacity for devolved health systems based on the achievements of the "Project on Strengthening Management for Health in Nyanza Province (JICA SEMAH Project)". JICA SEMAH Project was implemented from 2009-2013 to strengthen capacities of health management teams in the former Nyanza Province.

1.2 Framework of the Project

The project design of "Organizational Capacity Development Project for the Management of Devolved Health Systems in Kenya: OCCADEP" (hereinafter "the Project") was agreed upon through Record of Discussions (R/D) signed on 8th July 2014 and its implementation started from 19th November 2014 as a five- year project. In May 2015, both Japanese and Kenyan sides modified the Project design and its activities based on the results from situation analysis and other assessments and later selected 2 partner counties in July 2015 for implementation. Furthermore, in November 2016, both sides revised the indicators for the Project purpose and Output 2 in the Project Design Matrix (PDM2).

In March 2017, Mid-term Review (MTR) was conducted in order to assess the progress and achievement of the first half of the Project. The MTR concluded that the initial Project Purpose was too ambitious and that the Project had not progressed as planned. It was concluded that the activities targeting the MOH were completed and that the focus should be shifted to provide intensive support to the two partner counties in order to strengthen their management capacities with emphasis on AWP/MTEF cycle management.

During the third term, PDM was revised through consultation with HSC/IGA, County Directors and CHMT members of Health of Kericho and Kirinyaga, JICA Kenya Office and JICA Headquarters.

In the fourth term, the Project held its 7th Project Steering Committee (PSC) on the 13th of June 2018 and the PDM version 3 was approved.

1) Overall Goal:

Devolved Health Systems are strengthened to ensure equitable and quality services in

achieving Universal Health Coverage in Kenya.

<Indicators>

1. The budget allocation of non-salary within the recurrent budget in the Partner Counties are at least 25% and 30% for Kirinyaga and Kericho respectively[1]
2. At least 6 counties including the Partner Counties are utilizing the MTEF tools developed by the Project.

2) Project Purpose

Managerial functions of County Department of Health (CDOH)[2] are strengthened.

<Indicators>

1. CHMTs, SCHMTs have monitored and evaluated at least 50% of Health Facilities using at least one of the MTEF tools developed by the Project.
2. Annual Work Plan (AWP) and Annual Performance Review (APR) of health sector are submitted by April and November respectively every fiscal year.
3. At least 50% of county specific action points signed in the way forward/resolution at the Health Sector Intergovernmental Consultation Forum (HSICCF) are implemented in the Partner Counties.

3) Outputs

Output 1

Mutual support and learnings among MOH and CDOHs are strengthened through HSIGCF and other mechanisms

<Indicators>

1-1 Way forward/ resolution and action points are confirmed at every HSIGCF.

1-2 Events to share the lessons learned from the Counties are held more than twice by the end of the Project.

1-3 Best Practices and lessons learned from the Partner Counties are documented and disseminated through the MOH website and/or in other forms

Output 2

MTEF cycle management (Planning, budgeting, implementation and monitoring) is strengthened in CDOHs of Partner Counties.

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[1] This indicator was added in May 25, 2018 after the meeting with the HSC/IGA.

[2] CDOH here means the CDOH in the partner counties.

<Indicators>

2-1 At least 4 MTEF tools (i.e. User-friendly AWP/MTEF Annual Cycle work flow-chart, AWP Practical Guideline, MTEF management tool, etc.) are developed and disseminated in Partner Counties by the Project.

2-2 At least 70% of CHMT and Health Facilities in each Partner County utilize more than one of the MTEF tools developed by the Project.

4) Activities

1-1 [Ministry of Health (MOH)] Identify and strengthen county coordination and support mechanism in MOH.

1-2 [Human Resource Development (HRD)] Identify capacity gaps and available training programs in county health systems management (HSM).

1-3 [HRD] To develop HSM county training strategy

1-4 [Health Sector Coordination and Intergovernmental Affairs (HSC/IGA)] Provide technical support to HSIGCF between two levels of government to discuss issues of common interest.

1-5 Share the lessons learned of the Project through existing fora and other occasions among counties.

2-1 [HSC/IGA, HRD] To conduct situation analysis to identify county's managerial challenges and CDOH core functions.

2-2 [Project Steering Committee (PSC)] To identify Partner Counties of the Project.

2-3 Provide technical assistance for the health sector Medium Term Expenditure Framework (MTEF] cycle (or planning, budgeting and review cycle) to the partner counties.

2-4 [Partner Counties] Document experience and lessons learned from implementation of MTEF/AWP cycle in the Partner Counties.

2-5 [Partner Counties] Provide feedbacks to intergovernmental frameworks on lessons learned

5) Important Assumptions

- HSIGCF is held regularly after FY2018/19.
- Fund for convening HSIGCF is secured by Kenyan side.
- Turn-over of CDOH staff trained on the health management by the Project does not adversely affect Project activities.

6) Direct Project Target Groups:

Ministry of Health (MOH) personnel involved in managerial capacity development of counties, and members of County Department of Health (CDOH) of Kericho and Kirinyaga

7) Members of PSC

MOH

- Director of Medical Services, MOH (As Chair / Project Director)
- Head, Department of Health Sector Coordination and Inter-Governmental Affairs (As Project Manager)
- Head, Department of Policy Planning and Health Care Financing
- Head, Department of Health Standards, Quality Assurance and Regulation
- Head, Department of UHC coordination

County

- Kericho County Executive Committee Member for Health
- Kirinyaga County Executive Committee Member for Health

JICA

- Chief Representative, JICA Kenya Office
- JICA Experts

Any other members accepted by the Chair

8) Input from Japanese side

Input from Project Start to September 2019 is shown below.

(1) Experts

Input of the Project experts is shown below. For more information, see Annex3.

- First term：November 2014 – May 2015
  - Mr. Tsuyoshi Ito (Chief Advisor)
  - Mr. Naoki Take (Deputy Chief Advisor/Health Systems Management)
  - Ms. Kaori Saito (Community Health Planning)
  - Ms. Chiaki Kido (Health Monitoring and Evaluation)
  - Ms. Kunika Wakamatsu (Training Planning)
  - Ms. Akiko Tsuru (Communication and Advocacy)
  - Ms. Kayoko Takaki (Project Coordinator/Training Coordination)
- Second term：August 2015 – June 2017
  - Mr. Tsuyoshi Ito (Chief Advisor)
  - Ms. Kaori Saito (Health System Management/County Health Planning)

- Ms. Chiaki Kido (Health Monitoring and Evaluation)
- Ms. Kunika Wakamatsu (County Training Planning)
- Ms. Yumiko Inoue (County Training Planning)
- Ms. Hazel Miseda Mumbo (County Health Human Resource Development)
- Ms. Kayoko Takaki (Project Coordinator/Horizontal Learning)
- Ms. Hiromi Kono (Project Coordinator/Horizontal Learning)
- Ms. Tomoko Shibuya (Project Coordinator/Horizontal Learning)

➢ Third term：January 2018 – April 2018
- Ms. Shioko Momose (Chief Advisor/Health System Management1)
- Dr. Yasushi Sawazaki (Assistant Chief/County Health Planning)
- Mr. Nobuyuki Hashimoto (Public Finance and Administrative Operation Advisor (CDOH))
- Ms. Tomoko Shibuya (Project Coordinator/Health System Management 2)
- Mr. Shinichi Kimura (Project Coordinator/Training Program)

➢ Fourth term：May 2018 – September 2019
- Ms. Shioko Momose (Chief Advisor/Health System Management 1)
- Dr. Yasushi Sawazaki (County Health Planning)
- Mr. Nobuyuki Hashimoto (County Health Management Advisor, Public Finance and Administration Operation 1)
- Ms. Yuki Kobayashi Sangala (MTEF Cycle Operation Advisor, Public Finance and Administration Operation 2)
- Ms. Rena Mizuno (IT Tool Development Expert, Public Finance and Administration Operation 3)
- Ms. Tomoko Shibuya (Project Coordinator/Health System Management 2)
- Mr. Shinichi Kimura (Project Coordinator/Training Program)

(2) Budget related output

Comparison of planned and actual output of the budget during project implementation is shown below.

Table 1: Comparison of planned and actual output of the budget

	Item	Planned	Actual
November 2014 – May 2015	Equipment	1,556,000	647,000
	Project Direct Cost	18,999,000	15,645,000
August 2015 – June 2017	Equipment	524,000	495,000
	Project Direct Cost	77,205,000	42,895,000
January 2018 – April 2018	Equipment	38,000	245,000
	Project Direct Cost	9,718,000	24,282,000
May 2018 – September 2019	Equipment	257,000	(Provisional) 252,000

	Project Direct Cost	24,709,000	(Provisional) 23,981,000

(3) Workshops and Trainings
The workshops and trainings conducted during the project period is shown in the annex 4.

(4) Provision of facilities and equipment from Japanese side
The facilities and equipment provided by the Japanese side during the project period is shown in the table 2.

Table 2: Output of facilities and equipment from Japanese side

Name of facility and equipment provided	Quantity	Amount (JPY)
Vehicle	2	9,756,000
Laptop computer	10	1,258,000
Photocopy machine	1	495,000
Projector	2	195,000
Desktop computer	3	179,000

9) Input from Kenyan side

(1) Counterpart
Kenyan counterpart of the project is shown in the table 3.

Table 3: List of counterparts

Title	Name	Period
Project Director	Dr. Nicholas Muraguri Director of Medical Services	August 2015 – December 2017
	Dr. Jackson Kioko Director of Medical Services	January 2018 - February 2019
	Dr. Wekesa Masasabi AG. Director General for Health	March 2019 – September 2019
Project Manager	Dr. David Kiima Head, Department of Health Sector Coordination and Intergovernmental Affairs at MoH	August 2015 - June 2016
	Dr. Patrick Amoth Head, Department of Health Sector Coordination and Intergovernmental Affairs at MOH	January 2018 - February 2019
	Dr. Osman Warfa Director of Health Sector Coordination & Intergovernmental Relations	February 2019 - September 2019
Focal point	Dr. John Kihama Head of Intergovernmental Affairs Division at MOH	August 2015 – February 2019
	Dr. Jackson Omondi Division of Partnership Coordination at MoH	March 2019 – September 2019

County Director of Health, Kericho	Dr. Betty Lang'at	August 2015 - September 2019
County Director of Health, Kirinyaga	Dr. Esbon Gakuo	August 2015 - December 2017
	Mr. George Karoki	January 2018 - September 2019

(2) Provision of facilities and equipment from Kenyan side

Office space, fuel and light expense and telephone charge were provided throughout the project period.

2 Progress of the Project

2.1. Summary of First Term to Fourth Term

As explained in the Background, this project was designed in the midst of the devolution process. Under the devolution process, CDOH had to take over some roles that were formerly implemented by MOH such as payment of emoluments for the employees and management of health service delivery within the respective counties.

Therefore, the Government of Kenya and the Government of Japan agreed on a technical cooperation Project to strengthen the managerial functions of CDOH for the duration of 5 years.

The Project was implemented over a period of four terms that had distinct aims. The following summarizes what has been conducted in each term.

2.1.1 First Term (November 2014 – May 2015)

The managerial functions of CDOH was targeted to be strengthened through **(a) strengthening managerial support functions and coordination mechanisms in the National level**, **(b) strengthening leadership and managerial capacities of CHMTs**[3], and **(c)strengthening horizontal learning mechanism among and within CHMTs**[4].

Right after devolution, Department of Health Sector Coordination/Inter-Governmental Affairs (HSC/IGA) was established at MOH. In order to achieve (a), HSC/IGA was selected as the counterpart (C/P) of the Project because it had the mandate to coordinate intergovernmental-affairs and harmonize the national and counties' health priorities. The main roles and responsibilities of HSC/IGA were to manage health sector inter-governmental affairs, coordinate HSIGCFs and its technical committee meetings, coordination of technical assistance to the

[3] This was changed to CDOH in July 2015.

[4] This was changed to CDOH in July 2015.

counties, coordination of harmonization of county health priorities with the national health priorities, etc.
In the first term, the Project held two workshops in order to build capacity of HSC/IGA.

Together with HSC/IGA and the DPs, the Project conducted an assessment on the organizational structure of the 47 counties. Based on the result of the assessment, the Project assisted Human Resource Department in identifying the training needs of the CDOH and to support the M&E Unit in developing the health indicator manual. In addition, Kericho and Kirinyaga were selected as partner counties to implement concrete activities in order to achieve (b) and (c).

2.1.2 Second Term (August 2015 – June 2017)

(a) Strengthening managerial support functions and coordination mechanisms in the National level

The Project continued to support Human Resource Department in analysing existing training curriculums and jointly developed training strategy. It also supported the M&E Unit to finalize the Indicator Manual.
Regarding activities in supporting HSC/IGA, the Project supported both financially and technically in holding 6 HSIGFs. The Project also supported in formation and holding of Technical Committee meetings. In addition to this, the Project worked together with HSC/IGA in developing Core Function Working Paper which aimed to define the exclusive and concurrent functions that MOH and CDOH have to perform.

(b) Strengthening leadership and managerial capacities of CDOH

The Project also started activities in the two partner counties in the field of APR, AWP and M&E.

(c) Strengthening horizontal learning mechanism among and within CDOH

In regards to the promotion of horizontal learning mechanism among and within CHMTs, the Project established the Best Practice Committee. The Committee defined the criteria of best practice and collected information from 47 counties and selected cases that fulfilled the criteria and awarded them.

(d) Results of Mid-term Evaluation

Based on the activities conducted in term 1 and 2, Mid-term evaluation was conducted in March 2017 and concluded as follows.

- On-going devolution resulted in many emerging and changing needs, to which the Project had difficulty in addressing during its implementation.

- The Project had completed the tasks targeting the MOH as was originally planned.
- It was unlikely that the Project purpose would be achieved by 2019 with the current Project design and implementation structure.
- There were weak linkages between each output and the Project Purpose in terms of design and implementation.
- The Project's focus should be shifted to provide needs-based support to the two county governments in practicing their core functions with emphasis on AWP/MTEF cycle management.
- Full-fledged activities in the two partner counties should start with identifying which capacities of whom at each stage of AWP/MTEF cycle need to be strengthened, and then conducting a gap assessment (baseline), followed by determining of the target level and a road map to reach the target.

2.1.3 Third Term (January – April 2018)

Based on the result of the Mid-term Evaluation, the Japanese Experts team was re-organized in order to provide targeted support shifting the focus of the project from MOH to CDOH of the partner counties.

Discussions were held with HSC/IGA on how to manage the HSIGCF in light of recommendations from the mid-term review. The reason why the mid-term review team suggested to stop the support to HSIGCF was because it was not held regularly and even when it was held, it was judged as less effective and not efficient. These issues were also identified when JICA Kenya Office and MOH conducted a review of performance of the HSIGCF. It was concluded among HSC/IGA, JICA and the Project team that the Project would only provide technical support for the latter part of the implementation.

Regarding support to the two partner counties, 2-3 Japanese experts were always stationed in Kericho and Kirinyaga and held several participatory workshops in order to identify the county needs towards building capacity in managerial functions. Although many of CHMT members believed that following the MTEF Cycle was important for the management, almost all of them lacked the knowledge on what MTEF Cycle was. Therefore, the Project developed a tool called "MTEF Cycle Calendar" which is a poster where all levels of CDOH could identify what they should do in order to work within the MTEF cycle. In addition, the Project started to develop an organizational chart that tried to grasp the hierarchy on how the planning and budgeting were

done; how to monitor the implementation and performance; how the budget execution is done and how it is tracked; and how the performance review is done for the next planning phase. During this period, the Project developed an organizational chart; assisted in the development of AWP; identified challenges in financial tracking; and gaps in knowledge on PBB and MTEF cycle.

Based on the activities conducted in the first two months of the third term, the Project developed the third version of PDM together with HSC/IGA and the two partner counties. The Project outputs were redefined as **(a) Managerial support functions and coordination mechanisms at national level are strengthened**, and **(b) Leadership and managerial capacities of CDOH are strengthened**. However, the focus of the Project placed more emphasis on (b) and minimal on (a) as was recommended by the Mid-term evaluation.

2.1.4 Fourth Term (May 2018 – September 2019)

(a) Managerial support functions and coordination mechanisms at national level are strengthened

Regarding HSIGCF, the Project sought to provide technical support the HSIGCFs if it would be held regularly. During the period of fourth term, HSIGCF was not held regularly. The Project supported the HSC/IGA in finalizing the HSIGCF Operation Manual and assisted preparation of reports for the two HSIGCF that were held in May 2018 and February 2019 respectively.

As strengthening coordination at national level through HSIGCF was identified as difficult in the third term, the Project invited MOH in various activities such as Study Visit to Kisumu County, Kericho County Health Forum, and APR/AWP stakeholders meeting.
In addition, the Project held workshops and meetings such as Project Technical Meetings, AWP Handbook Validation workshop, Strategic Plan & UHC Roadmap Workshops so that it could serve as a platform for MOH to provide guidance to CDOHs and the CDOHs to share with MOH the challenges of the CDOHs regarding MTEF Cycle management and how MOH could improve in regards to coordination and harmonization.

Documentation of Good Practices in the partner counties and materials and tools developed by the Project are all posted on the MOH website in WORD format so that MOH can always make revisions as necessary.

(b) Leadership and managerial capacities of CDOH are strengthened

In the fourth term, the Project developed various tools so that the partner CDOHs were able to follow the MTEF Cycle and held many workshops in order to improve the quality of planning and performance reviews.

In Kenya's health sector, the planning for the financial year starts from reviewing the previous year's performance. APR's main purpose is to review the previous year's performance based on AWP, identify the challenges, and set priorities for the next financial year.

In principle, the APR has to review the performance on what was planned in AWP. However, the Project team observed that the APR does not necessarily match with the AWP and that many indicators in the APR were not understood by CHMTs. In addition, the APR report for which the template is prepared by MOH is so extensive that CHMTs use all the energy in filling the required information and do not have enough time to analyse and identify priorities to incorporate for the next AWP.

AWP should be finalized before April 30th so that it can be submitted to the County Treasury in time for the County Budget Estimates. However, since not many CHMT members knew about this, the AWP was not finalized in time. In addition, AWP is supposed to be a management tool to monitor progress of implementation including financial transaction. However, AWP was not utilized as such and existence of AWP was often forgotten after its finalization.

One of the main initiatives that were taken in the partner CDOHs were involvement of health facilities in planning and performance review process. Before the Project, both counties were developing their APRs and AWPs among CHMT members. However, with the Project, SCHMT and level 2-3 facilities were also involved. The inclusion of SCHMTs and level 2-3 facilities was somewhat epoch-making because it made it possible to rework on the fundamentals. For example, the CHMT used to request the level 2-3 facilities to develop their AWPs but they were never consolidated or checked by SCHMT nor CHMT and therefore, these AWPs were just made because they were told to do so and it was merely a wish-list with no substance. However, in the course of the implementation of the Project, CHMT started to customize the templates of both APR and AWP for each level of facilities, provided information on budget ceilings and guidance to priority setting. In Kericho County, the Project supported in conducting data review meetings for all Sub-Counties so that they could analyze the quality of data they input in their data system. This again was very important

since this exercise made SCHMTs and CHMT realize the extent of officers not understanding how to complete or validate the data they were required to submit.

The Project together with the two partner counties agreed that the linkage between plan and budget was weak. The Project supported the two partner CDOHs in how they can monitor financial transaction in both PBB and line item based. It also developed a tool that can monitor the financial transaction that can tell when the money was spent for what activities from which source and what was the absorption rate compared to the plan. These information can be seen in a dashboard where the managers can realize in a glance on what is happening to their resources and make appropriate decisions.

In order to enhance leadership, the Project initiated mutual learnings among CDOHs of various counties. The Study Visit to Kisumu was conducted to learn about community health strategy; various stakeholders meetings and County Health Forum were supported to advocate the MCAs to increase health budget; MTEF tool trainers/facilitators were nurtured and they have trained four counties on MTEF cycle management and how to utilize MTEF Tools.

12 MTEF Tools were developed in the course of the third and fourth term (see attachment 7 for details).

2.2. Activities implemented in First and Second Term

As the scope and activities within PDM have changed after the Mid-term Evaluation, table 4 describes the activities completed in the First and Second Term in accordance with the activities that were defined in the PDM.

Table 4: Activities implemented based on PDM Version 1 and 2

Activities	Activities Implemented
1-1 To identify and Strengthen county coordination and support mechanism in MoH	HSC/IGA prepared institutional capacity development plan with the Project team in March 2015. Two priority functions were identified: (1) Serving as the Health Sector IGF secretariat and (2) Coordination of schedules for Intergovernmental events. On (1) above, the Project supported HSC/IGA to organize HSIGCF Meetings since 2015, through participation in preparation committee meetings.

	On (2) above, the inter-agency schedule coordination group was set up comprising focal persons from MOH, Council of Governors (COG), National AIDS Control Council (NACC), National Hospital Insurance Fund (NHIF), Kenya Medical Supplies Authority (KEMSA), Kenya Medical Training College (KMTC) and Development Partners for Health in Kenya (DPHK), with the group TOR and SOP as well as the info collection template.
1-2 To identify capacity gaps and available training programs in county health systems management.	The Project participated in the exercise of Training Needs Assessment (TNA) led by HRD Unit/MOH in March 2015, and assisted inclusion of additional questionnaires to Counties on LMG training needs. County responses to TNA highlighted the confusion in the counties (CDOH) on their roles and responsibilities under on-going devolution. The Project supported MOH/HRD to conduct Skills Gap Assessment (SGA) in April-May 2016.
1-3 To develop HSM county training strategy	"Common Strategy for Human Resource Capacity Building" was developed in Nov. 2016, and finalized in March 2017. Common strategy aims to standardize the curriculum of the training on Health System Management. The Project supported HRD to: a) develop a facilitator guide and a manual for the participants to enable the training institutes to develop training curriculum in line with the Strategy, and (b) coordinate with key stakeholders to activate the training database called "iHRIS-Traing" which had been developed by Intrahealth, but not been used by CDOHs.
1-4 To convene HSIGCF between two levels of government to discuss issues of common interest	The Project supported 6 HSIGCFs during the First and Second Term. HSC/IGA and CEC Health Forum negotiated to (a) share the meeting cost between MOH, Partners and Counties, and (b) set up 5 Thematic Technical Committees (TTC) (Healthcare Finance, Human Resource for Health, Health Products and Technologies, Service Deliver and PPP, and Joint Evaluation and Quality Management) under HSIGCF, so that TTCs can discuss

	substantial technical issues one day ahead of every HSIGCF.
1-5 To clarify the definition of functional CHMTs and its measurement methods.	"Functional CHMTs", one of the indicators in KHSSP M&E framework (2014-2018) has been identified as a good indicator that would be able to measure the strengthened managerial capacity of the County health team. The Project worked with the M&E Unit to assist their work to revise the Indicator Manual that would provide definitions to all the M&E indicators in health sector in Kenya. Out of 5 Technical Working Groups formulated for this purpose, the Project team was a member of the Health Investment TWG to define health system management indicators. The first draft of the revised Indicator Manual was developed in June 2016 and further revised in June 2017.
2-1 To conduct situation analysis to identify county's managerial challenges and CDOH core functions.	The situation analysis on the county health system in the 47 counties was conducted in Jan.-May 2015 through literature reviews, questionnaire survey and sample site visit to Mombasa, Migori, Narok, Makueni and Meru. The final report was completed in February 2017. Intergovernmental working group called "CDOH Core Function Working Group" was set up in Jan. 2016. The zero-draft of the core functions was developed which include the Exclusive Function" and the "Concurrent Function" of the 8 health investment areas defined in the KHSSP. The final draft was developed and shared with all CECs in Sept. 2016.
2-2 To identify partner counties of the Project	Kericho and Kirinyaga were selected as partner counties based on the criteria set at the Project PSC in May 2015: (a) Counties with middle range key service delivery performance indicators, (b) proportion (%) of health sector budget in the County, (c) limited development partner support in the area of HSS.
2-3 Assistance for MTEF cycle (Planning, budgeting and Reviewing) to the partner counties	Activities with the partner counties started in Nov. 2015 with a workshop on situation analysis on the MTEF management. Following are main areas of support by the Project to the two partner counties.

	【Kericho】 - Reviewed the existing materials for priority and target settings and supported TOTs on priority and target settings at county and sub-county level - Held the AWP planning orientation where the Project introduced consolidation tools developed by SEMAH Project to be used for aggregating the numerical data at sub-county and county levels. - Supported a consultative meeting to reactivate the County Health M&E TWG, which resulted in establishment of 2 sub-committees (for priority setting and drafting the M&E framework), and supported a series of sub-committee meetings. Through these processes, M&E Plan (originally called M&E Framework) was finalized and launched in March 2017 with the presence of Kericho County Governor. - Supported 2 workshops to prepare for APR and Mid-Term Review of County Health Strategic Plan in October 2016 and January 2017 and provided technical inputs in the process of finalizing a report and customized the MTR template. - Supported CDOH to revise the AWP templates and MTEF template for PBB, and customized the tools for AWP/MTEF Planning (Templates and tools are available for all levels: county, sub-counties, facilities). - Supported a 2-day AWP orientation with HFs and CUs at 6 sub- - counties in March 2017 to initiate the planning process for 2017/2018 AWP. - Provided CDOH and SCHMT with one-day training on basic management, including the topics of overview of "management objectives, HR management and team management, communication management, and financial management in June 2016.

	【Kirinyaga】 - Supported the training on MTEF cycle management based on the existing PBB materials and induction on AWP planning with facilitation by Division of Health Policy and Planning (December 2015-January 2016). - Customized the planning tools based on the existing AWP template and oriented CHRIO and SCHRIOs on how to use the tools. - Supported an orientation for CHMT members on AWP planning. The team member made a presentation at the orientation. - Supported MTEF Departmental working group to prepare for a budget proposal in Sept.-Oct. 2016.
2-4 To exact lessons learnt from the partner counties' experiences.	Planned for the Third Term
2-5 To provide feedbacks to inter-governmental frameworks and the county training strategies	Planned for the Third Term
3-1 To reinforce recognition mechanism and dissemination fora for good practice.	The National Annual Performance Report (2013-14) contained a section of Best Practices in service delivery, but there was neither systematic selection nor sharing of the best practice. The Project supported M&E Unit/MOH to (a) establish the Best Practice Committee, (b) Best Practice Guideline, including modifying the Best Practice Reporting Format, (c) select the Best Practices for 2014/2015.
3-2 To document experience and lessons learnt from implementation of MTEF and AWP cycle in the partner counties	Planned for the Third Term

3-3 To share the lessons learnt of the Project through existing fora.	Planned for the Third Term

2.3. Activities implemented in Third and Fourth Term

After the Mid-term Evaluation conducted in March 2017, some of the activities of PDM have changed. Table 5 describes the activities completed in the First and Second Term in accordance with the activities that were defined in the PDM version 3.

Table 5: Activities implemented based on PDM Version 3

Planned Activities	Actual Performance as of September 2019
1-1 To identify and Strengthen county coordination and support mechanism in MOH	The activity was completed in the first half of the Project.
1-2 To identify capacity gaps and available training programs in county health systems management.	The activity was completed in the first half of the Project.
1-3 To develop HSM county training strategy	The activity was completed in the first half of the Project.
1-4 To provide technical support to HSIGCFs between two levels of government to discuss issues of common interest.	- The 11th meeting's minutes and reports were finalized in February 2018. The 12th meeting was held in February 2019. The Project supported the HSC/IGA to prepare the minutes of the meeting and finalization of the report. - The Project technically supported in drafting and finalizing an HSIGCF operation manual through HSIGCF Review Stakeholder Meeting and the 11th HSIGCF.
1-5 To share the lessons learned of the Project through existing fora and other occasions among counties.	- Lessons' learnt have been compiled. The experiences of the partner counties were shared at the PTMs held in April and Nov 2018, Kericho's Study Visit to Kisumu, Kericho County Health Summit and HP+'s PBB workshop. - The MTEF tools were presented at the Kericho County Health Summit held in January 2019.

	- MTEF Management Tool was introduced and hands on training was provided to Nyeri CDOH (27-29 May), Kisumu CDOH (10 June) Migori (11th&23rd of September) and Machakos (5th and 13th of September) of the year 2019. - AWP Handbook for level 2-3 Health Facilities was validated by CDOHs from Nyeri, Kericho, Kirinyaga, Kisumu and MOH. - Mutual Learning Forum was held in Kirinyaga and Kericho and Nyeri participated.
2-1 To conduct situation analysis to identify county's managerial challenges and CDOH core functions.	The activity was completed in the first half of the Project
2-2 To identify partner counties of the Project.	The activity was completed in the first half of the Project
2-3 To provide technical assistance for the health sector Medium Term Expenditure Framework (MTEF) cycle (or planning, budgeting and review cycle) to the partner counties.	- The Project has been supporting health management teams of the partner counties to review FY2017/18 AWP (Kirinyaga, in February 2018), to develop FY2018/19 AWP (February-March 2018) and Strategic Plan (July-August 2018), to develop FY 2017/18 APR (July - September 2018) and to develop FY 2019/20 AWP (February - April 2019) and FY 2018/2019 APR (July – September 2019). - The Project also provided several training opportunities to the partners such as Data Review Meeting (Kericho) and TOTs for MTEF tools, i.e. Organizational Structure, MTEF Calendar, MTEF Process Guide, MTEF Management Tool and AWP Handbook for Level 2-3 Facilities.
2-4 To document experience and lessons learned from implementation of MTEF cycle in the partner counties.	- Experiences of the two partner counties were documented and are uploaded in the MOH Website. - Kisumu Study Visit Report was documented

	together with Kericho CDOH and was shared at PTM and with GIZ. Contents discussed in PTMs were also documented. - Experiences of two partner counties were further discussed and documented during the AWP Handbook validation and AWP/APR process review workshop held in June 2019.
2-5 To provide feedbacks to intergovernmental frameworks on lessons learned	- Copies of the MTEF Process Guide were distributed at the12th HSIGCF. - MTEF calendar was presented and disseminated to all 47 counties at WB-THS's AWP meeting in May 2018 - The MTEF tools were presented at WB-THS and DANIDA joint monitoring meeting in Nov. 2018. - The MTEF tools were presented at the 6th Annual Devolution Conference held in Kirinyaga in March 2019 - The tools were also presented and provided hands-on training to Finance as well as UHC Departments of MOH in December 2018 and again to Finance Department and Partners in February 2019. - The dashboard generated by MTEF Management Tool on Kericho's WB-THS Project was presented at a meeting of WB-THS Project in July 2019. - MTEF Tools were presented and distributed at the Health Forum 2019.

3 Results of the Terminal Evaluation

The three tables in this section presents the assessment and the progress that was determined in the Terminal Evaluation. Further progress made after the Terminal Evaluation is indicated in italics

3.1. Status of Indicators towards the Project Purpose

Project Purpose which was "Managerial functions of County Department of Health (CDOH)[5] are strengthened" had three indicators. All indicators except the one related to HSIGCF was assessed as "unmeasurable" since it did not fulfil the assumptions stated in the PDM.

Table 6: Status of Indicators towards the Project Purpose

Objectively Verifiable Indicators	Progress as of April 2019
1. CHMTs, SCHMTs have monitored and evaluated at least 50% of Health Facilities using at least one of the MTEF tools developed by the Project.	**Achieved** Financial Transaction Record & Information Sheet recently has been used by CHMTs and SCHMTs for monitoring and evaluation at health facilities in both partner counties. Both counties have attained the target value. At the time of Terminal Evaluation: Kirinyaga 82% Kericho 56.5%
2. Annual Work Plan (AWP) and Annual Performance Review (APR) of health sector are submitted by April and November respectively every fiscal year	**Achieved** The APR and the AWP has been submitted in a timely manner since FY2017-18.
3. At least 50% of county specific action points agreed in the way forward/resolutions at Health Sector Intergovernmental Consultative Forum (HSIGCF) are implemented in the partner counties.	**Unmeasurable** The assumption in PDM was that this indicator can only be measured when the HSIGCFs were held regularly but the HSIGCFs were not held regularly. Even when it was held, the way forward/resolutions and county specific action points were not discussed in the HSIGCF and therefore, no county specific action point were identified.

3.2. Status of Indicators towards the Outputs

There were two outputs to be achieved within the Project period which were:

Output 1

Mutual support and learnings among MOH and CDOHs are strengthened through HSIGCF and other mechanisms

Output 2

MTEF cycle management (Planning, budgeting, implementation and monitoring) is

[5] CDOH here means the CDOH in the partner counties.

strengthened in CDOHs of Partner Counties.

Output 1 had three indicators and Output 2 had two indicators. The Progress stated in the table is what was written in the Terminal Evaluation Report. Activities conducted after the terminal evaluation are written in Italics.

Table 7: Status of Indicators towards the Outputs

Objectively Verifiable Indicators	Progress
1-1. Way forward/resolutions and county specific action points are confirmed in every HSIGCF.	**Unmeasurable** The assumption in PDM was that this indicator can only be measured when the HSIGCFs were held regularly and the HSIGCFs were not held regularly. Even when it was held, the way forward/resolutions and county specific action points were not discussed in the HSIGCF.
1-2. Events to share the lessons learned from the Counties are held more than twice by the end of the Project.	**Achieved** Four events were held for mutual learning: 2 PTMs, Kisumu Study Visit, Kericho County Health Forum *Three more series of activities were held from May to September 2019.* *Joint Learning Forum, Joint AWP Handbook Validation Workshop. MTEF Management Tool Training for 4 non-partner counties.*
1-3. Best Practices and lessons learned from the partner counties are documented and disseminated through the MOH website and/or in other forms	**Achieved** Two tools developed by the Project (MTEF Process Guide and MTEF Management Tool) have been available in the MOH website together with the lessons learnt from "APR development" and "data management" from the partner counties. *10 other MTEF Tools and 1 best practice leaflet were uploaded on the MOH Website and distributed in occasions such as Health Forum and Joint County Activities by September 2019.*
2-1 At least 4 MTEF tools (i.e. User-friendly MTEF Annual Cycle work flow-chart, AWP Practical Guideline, MTEF management tool, etc.) are developed and disseminated in partner counties[6] by the Project	**Achieved** Seven tools have been developed and disseminated: 1) MTEF Cycle Calendar (1st and 2nd version) 2) MTEF Management Organization Structure (1st and 2nd version) 3) MTEF Process Guide 4) MTEF Management Tool (1st and 2.5 version)

[6] CHMT, SCHMT and Health Facilities.

	5) Financial Transaction Record and Information Sheet for HF (a manual report format of Management Tool Ver.1) 6) MTEF Management Data Aggregation Tool (1st and 2.5 version) 7) Level 2-3 Health Facility AWP Development Handbook (Draft) *Level 2-3 Health Facility AWP Development Handbook was validated and finalized. Third version of MTEF Management Tool and its Aggregation tool was completed. Other MTEF Tools such as Instruction Booklet for MTEF Management Tool, Technical Instruction Booklet for MTEF Management Tool and MTEF Management Tool Maintenance Manual were also finalized.*
2-2. At least 70% of CHMT and Health Facilities in each partner county utilize more than one of the MTEF tools developed by the Project.	**Achieved** More than one MTEF tools have been used by all health county teams and by the persons in charge at all health facilities, including hospitals in the two partner counties. (See attachment 6).

3.3. Results of Terminal Evaluation based on DAC Evaluation Criteria

(Excerpts from the Terminal Evaluation Report)

3.3.1. Relevance

Relevance is rated as high. The Project Purpose and Overall Goal are relevant in terms of the needs of the health sector in Kenya, the national development policy and Japanese Official Development Assistance policy to Kenya.

1) Relevance to Kenya's Health Policy/Strategies

Aiming at creating a globally competitive and prosperous country with a high quality of life by 2030, the Kenya Vision 2030 set the goal of the Health Sector to provide equitable, affordable and quality healthcare to all citizens. The third Mid-Term Plan (2018-2022) for Vision 2030 outlines the implementation of National Capacity Building Framework to entrench devolution in order to safeguard the delivery of quality services to citizens to achieve Universal Health Coverage. Strengthening of health system (Overall Goal) is priority in the Kenya Health Sector Strategic and Investment Plan (2014–2018) (KHSSP III) that serves to advise county and national governments on operational priorities in health and guide the allocation of resources under the medium-term expenditure framework (MTEF) process. These policy directions are matched to the objectives of the Project.

2) Relevance to Needs of the Target Group

The Project intervention covers needs of stakeholders at the central and county governments.

In the current intervention scenario, the needs of the target groups, i.e. MOH/HSC/IGA and 2 partner counties (Kirinyaga and Kericho) are captured less comprehensively than in the previous one.

In the first half, the Project focused on supporting MOH/HSC/IGA technically and financially to strengthen the coordination mechanism of IGF covering all the stage in planning, implementation and reporting for the IGF. The current engagement of the Project with MOH/HSC/IGA is limited to technical support while its focus moved to the two partner counties to strengthen capacity of health management teams in management of MTEF cycle, which fully responded to needs of the target groups at county, sub-county and facility levels.

3) Relevance to Japan's Development Assistance Policy

The objectives of the Project are aligned to Japanese ODA policy in health sector so called "Basic Design for Peace and Health" (2015) which addresses strengthening health systems toward achieving UHC as a specific measure under one of the pillars, "Promotion of UHC throughout the human lifecycle." Improvement of access to health care services by people living in remote areas and in poor families through strengthening of the health system is the priority in Japan's Aid Policy to Kenya (2012)

Health systems strengthening (Overall Goal) is the priority areas of TICAD VI (2016). According to declaration, strengthened health systems is the foundation for achieving universal health coverage (UHC) which will contribute to strengthening preparedness for public health emergencies, as well as to improving the quality of life. It was further declared that there should be particular emphasis on country and community-led resilient, inclusive, and sustainable health systems supported by effective policymakers and managers to ensure country ownership and by coordinated international assistance, including efforts to increase global funding for health system strengthening to ensure health services to all individuals throughout their lives.

3.3.2. Effectiveness

Effectiveness is satisfactory. In light of the indicators set in the PDM3, the Project Purpose has not been fully achieved at the time of the Terminal Evaluation.

Two (quantitative) indicators related to capacity development of the partner counties (Indicator 1 and 2) have been already achieved. Referred to "3-4 Achievement of Project Purpose", it is fair

to conclude that the Project has significantly been contributing to establish a solid foundation of management.

Of the three indicators, there has been no progress in the indicator referring implementation of county specific action points agreed at HSIGCF (Indicator 3). It is not the issue whether or not the action points are agreed in HSIGCF, rather it is more an essential issue that has yet to be agreed to develop action points. The fact that HSC/IGA has faced difficulties to hold HSIGCF regularly means that there is little prospect of an agreement by the end of the Project. The bottlenecks for holding HSIGCF are funding constrains, divergent interests between MOH and counties and pre – election engagements and transition in county leadership after the general elections of 2017.

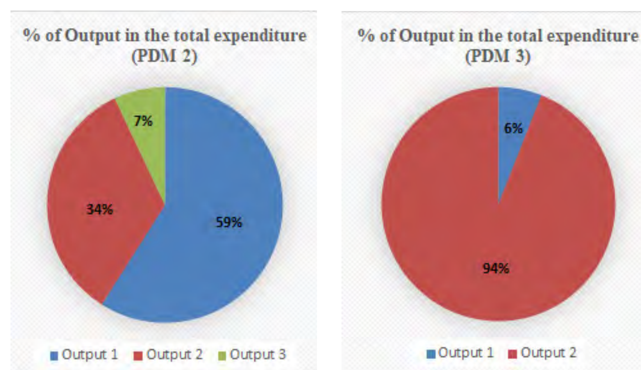
3.3.3. Efficiency

Project's efficiency in the second half is rated as fair.

The second half of the Project started with the focused project framework in accordance with the recommendations drawn by the MTR conducted in March 2017（See 4-1 (1) and 4-2 (1). The new strategic direction was put into the practice.

1) Relations between Inputs and Activities/ Outputs

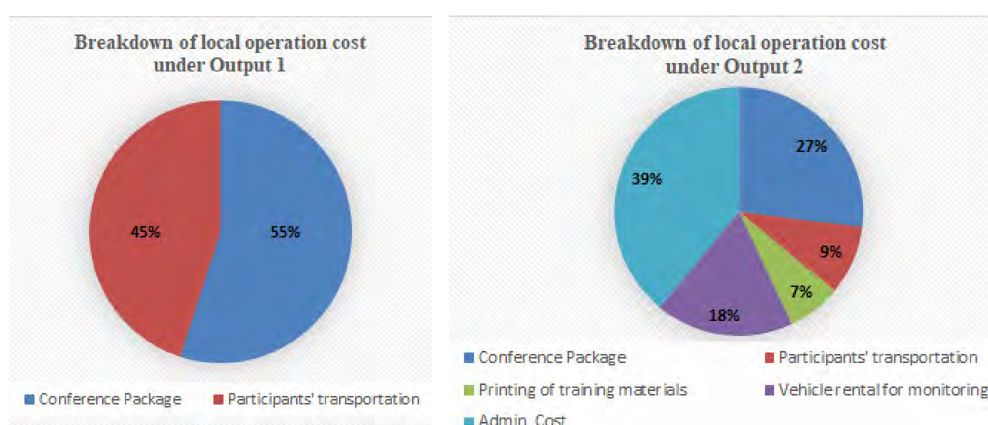
As shown in the pie chart, the majority of the project fund was expended for county activities under Output 2 of PDM3. Considering the relationship between the achievement of each Output and the expenditure, it is fair to conclude that the efficiency of the project in the second half is higher than that in the previous period.



The expenditure to support MOH/HSC/IGA has been minimal for the second half. While MOH/HSC/IGA was facing challenges with holding regular IGF, the noted contribution of the Project/JICA was the technical and financial support to develop an IGF Operation Manual upon the request by MOH. The manual contains recommendations on strengthening functions and operations of IGF that are worth considering, and it is expected that the MOH/HSC/IGA takes a lead for putting the conceptual idea into the practice based on the consensus among key

stakeholders.

The following charts show the breakdown of local operation cost under each Output. All the funds allocated for activities at the central level were used for IGF meetings, while nearly 40% of the fund allocated for county activities were used for the training (Conference Package and transportation for the participants). No project fund was used for non-project activities.



2) Contributing and Constraining Factors

Appropriateness of Inputs Contributing factors to increase efficiency is, in addition to the focused project design, long-term deployment of Japanese team members with expertise matching to the needs in the Partner Counties, with combination of the placement of 2 local assistants in the partner counties respectively to not only monitor and follow-up activities in the sub-counties and the health facilities, but also promote communication between Japanese members and Kenyan stakeholders. In addition, the Japanese team members appreciated the proper assignment of a focal point of the Project for activities under Output 1 and the continuous engagement in the project activities. Counterparts in the partner counties are also continuously involved in the project activities. In Kirinyaga, a focal person to the Project was assigned and has been contributing to implement the activities. Another contributing factor was reported as the termination of the employment of local consultants leading to decrease the expenditure, without adversely affecting the progress toward the achievement of the Output.

3) Changes of Important Assumption

Another constraining factor is seen in the important assumption: Fund for convening HSIGCF was not secured by Kenyan side (Important Assumption to achieve Output) that became a bottleneck to regular holding of HSIGCF after FY2018/19 (Important Assumption to reach the project purpose).

3.3.3. Impact

１）Potential in Achieving Overall Goal

According to the intervention scenario outlined in the PDM3, it is expected that the devolved health system in Kenya is strengthened by 2024 or earlier (Overall Goal). One indicator of Overall Goal that refers to an increase in budget allocation of non-salary part within the recurrent budget in the two partner counties has been progressing satisfactorily at the time of the Terminal Evaluation.

On the other hand, while it has not been confirmed whether non-partner counties use the MTEF/AWP tools developed by the Project, the Project is currently disseminating the MTEF/AWP tools in the 4 UHC pilot countries identified by the Ministry of Health. The future possibility of roll-out of MTEF/AWP management is expected. On the one hand, considering the fact that it will take 1.5 years from now for the partner counties to complete the entire MTEF/AWP cycle management by using the MTEF Management Tool version 2.5, it may still be too early to prospect the future outlook.

The Project has been making continuous effort toward its end in September 2019. The recent effort by the Project toward the achievement of the indicator is to create demand from non-partner counties to adopt and use the tools not only by sharing experiences of the partner counties through MoH Website, but also by making presentations on the use of the tools at various opportunities where key stakeholders participate. To reach the target after the end of the Project, such conditions need to be fulfilled with initiatives of the Kenyan stakeholders as (1) availability of certified trainers for the MTEF/AWP cycle management; (2) commitment of the County Assembly and Executive in securing budget for activities necessary to manage the cycle in a participatory manner; and (3) engagement of the national government to create opportunities or to identify the on-going process where the tools would be used or examined, e.g. application in the 4 pilot counties (Isiolo, Kisumu, Nyeri and Machakos) for the UHC Programme. The actions to fulfill these conditions are expected to contribute to strengthening devolved health systems, which will ultimately lead to achievement of the Overall Goal.

2) Unintended Effect

There has not been significant positive unintended effect at the time of the Terminal Evaluation, but it should be noted that some of the trained counterparts in the partner counties have been facilitating the training in their own counties.

No negative effect was either reported or observed at the time of the Terminal Evaluation.

3.3.4. Sustainability

The overall sustainability of the project effects after completion is assessed as satisfactory. While the policy environment will most likely remain favorable over time, there are some concerns with financial aspects. The level of technical sustainability is judged as fair.

1) Policy Sustainability

The policy environment required to sustain the effects of the project after completion is deemed as favorable. National level policies and strategies prioritize capacity development for management of devolved health systems. On the other hand, partner county medium term plans, strategic and annual work plans although being updated at the time of the Terminal Evaluation, have also captured as priorities of the development of management and technical skills and competencies for improved service delivery

Considering the assignment of roles and functions in the devolved health system as described in the Constitution of Kenya, 2010, the Ministry of Health of the National Government is mandated for among others, policy development, strategic leadership and stewardship, capacity development and training for counties and these functions are also captured in the Kenya Health Policy, 2014 – 2030. The health policy also takes into account the objectives of devolution, which include among others enhancing capacities of the two levels of governments to effectively deliver health services in accordance with their respective mandates.

2) Financial Sustainability

The prospect for financial sustainability for the Project at the time of the Terminal Evaluation seems weak although the evaluation team took note of planned measures aimed at mobilizing and allocating budget necessary to sustain the effects of the Project. While there are structures set up at the national level to support inter-governmental consultation and cooperation, sufficient budget allocation has not been secured to make the structures fully operational and the counties were reported to be ill – prepared to meet obligations required of them for cost sharing towards inter-governmental activities. On the other hand, CDOH of the partner counties still suffer from limited budget allocation and delayed disbursements to health facilities for their operations.

The HSIGCF has not been held regularly as planned as budget constraints have recently hampered its operations particularly following the suspension of funding to MOH by key Partner s. While MOH will continue to seek budget allocation from the exchequer to HSC / IGA (the focal point for the HSIGCF), support for HSIGCF in the interim period is still dependent on contributions by potential partner s and cost sharing with the Counties. Ultimately it is expected that measures will

be put in place to ensure that the HSIGCF is fully funded from Government sources.

As regards budget to health in the partner counties, efforts are being made by CDOHs to lobby their County Assemblies to increase allocations to the health sector. For instance, in the wake of the Study Visit by Kericho CDOH to Kisumu County, Members of the County Assembly (MCAs) on the tour recognized funding for community health services as a high priority based on lessons from Kisumu County. In addition, the health summit held in Kericho (Jan 2019) also introduced the MCAs and other county executives to the APR, County Health Strategic Plan, AWP and UHC Roadmap from which they appreciated performance and health sector needs that require increased funding. The Members of the health committee of the County Assembly have since pledged to table proposals for a bill to be passed in the Assembly to allow increased funding for the health sector. As at the time of the Terminal Evaluation, the bill was underway in the County Assembly to allow Authority to Incur Expenditures (AIEs) to be issued to lower level health facilities in the county.

However, interviews conducted with SCHMTs revealed concerns about financial sustainability after the end of the Project. For example, SCHMTs in Kericho indicated that they would face challenges in raising funds to conduct monthly activities such as data reviews, review of financial expenditure reports, quarterly performance reviews at the county level and the annual activities involving development of AWPs, conducting APRs and stakeholder forums.

In order to address the challenges around sustainable financing, the CDOHs indicated that they aim to budget for MTEF cycle management activities as part of their routine operations7. They also plan to use the available MTEF tools to generate evidence for advocacy for support from the political leaders to increase resource allocation to the health sector. Currently, the limited budget allocation and delays in disbursement from the County Revenue Fund (CRF) still hamper the efficiency of AWP implementation across the health facilities. It is expected that the CDOH continues to engage the County leadership to ensure that timely disbursements are made from CRF to health facilities to improve efficiency in operations and quality of services.

3) Technical Sustainability

The technical sustainability although fair is not concrete enough at the time of the Terminal Evaluation. On the one hand, the CHMT and SCHMTs in the partner counties have gained knowledge and skills in evidence-based planning commodity management, financial management,

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[7] The estimated cost (conference package and participants' transportation) for AWP and APR is 800,000-900,000 each. (Sources: Project Team).

data management and mentorship skills among others in the MTEF/AWP operation. However, challenges remain in the health facilities.

The evaluation members observed in the two partner counties that SCHMTs and health facility managers are actively involved in the AWP and budget making process. The evaluation team also looked at draft AWPs for 2019/20 for selected health facilities in Kirinyaga and noted that activities for capacity development through training, mentorship, continuing medical education (CME) and OJT were well captured and budgeted for.

The results of the interview to CHMTs and SCHMTs indicates that the interviewed managers feel that their capacity of AWP planning has been improving due to the introduction of the effective tools and the training. The self-assessment is consistent with assessment by the Japanese team members. According to their observation, in Kericho all five CHMT members and 3-5 members in 6 SCHMTs are capable of consolidating AWP by using the MTEF Management Tool, and 4 CHMT members are able to facilitate the training on multiple tools. At least 2 members in six SCHMT and 6 managers at the hospital in total each can use multiple tools independently. In Kirinyaga, 4 CHMT members is capable of facilitating the training on multiple tools and nearly 20 managers at each level recently have been using multiple tools independently.

At the same time, however, the evaluation team observed some weaknesses in the health facility AWPs developed by Kirinyaga County in the areas of priority and target setting, selection of interventions to address root causes of the challenges identified and linking activities to appropriate budget line items. These are areas that will require further skills development through mentorship by SCHMTs.

4) Institutional Sustainability

Institutional sustainability is fairly sufficient particularly in the partner counties to allow continuation of the Project effects. The national and county governments established the HSIGCF which has had mixed results in discussing and resolving the cross-cutting issues between the two tiers of government. The MOH department responsible for HSIGCF faces difficulties in budget allocation for its operations. There is also a challenging issue in timely communication between MOH and the Council of Governors (COG) on matters HSIGCF.

It was noted by the Terminal Evaluation team that although a performance review of the HSIGCF was conducted in 2017 and an operational manual developed and approved by the HSIGCF co-chairs, the forum has not been regularly convened. The structures (secretariat and thematic technical committees) necessary to support planning, synthesis of health issues, documentation, communication, implementation and follow up on the resolutions from HSIGCF have not been

fully functional. The Terminal Evaluation team is of the opinion that going forward, both levels of government should re-visit the HSIGCF operational manual to gain consensus and implement its provisions and proposals for an effective HSIGCF.
From the Terminal Evaluation, it was also evident that the HSC/IGA has gaps in staffing in numbers. There has been high attrition among senior staff who remained at MOH after devolution and hence the need to consider measures to fill in the gaps. On the other hand, in the partner counties particularly in Kirinyaga, the CHMT has utilized the organization chart that was developed with support from the Project and identified gaps in staffing and taken appropriate measures to address the gaps. Overall, the partner counties have retained all the counterparts that were trained through the Project and this remains an asset for institutional memory.

3.5. Conclusion

The project was formulated soon after the introduction of the county system in 2014 and its implementation in the first half was greatly challenged in the face of the ambitious intervention scenario and many new and changing needs in the devolution process. Despite the changing situation and needs under the devolution, the Evaluation Team concludes that the overall performance of the Project is satisfactory, as of the terminal evaluation juncture, six months before completion of the Project.

4 Actions taken towards the Recommendations from the Terminal Evaluation Report (TER)

The Terminal Evaluation Team made recommendations to MOH and the Project on what should be done by end of the Project. Table 8 states what measures have MOH and the Project taken by September 2019.

Table 8: Actions taken towards the Recommendations from the Terminal Evaluation

Recommendation Until the end of the Project (Sep 2019) **Output1**	
(1) The Project and the MOH complete activity 1-5 “Share the lessons learned from the Project through existing fora and other occasions among counties” to scale up the implementation of activities nationally.	Shared “MTEF Cycle Calendar”, “MTEF Process Guide”, the “MTEF Management Tool” and “AWP Handbook for level 2-3 Health Facilities” to Nyeri and Kisumu CDOHs. Held Mutual Learning Forum in Kirinyaga inviting Kericho and Nyeri (2nd July).

(2) In doing (1), the MOH presents the MTEF/AWP tools to other counties through the several existing channels for demand creation (i.e. Introduction of tools on the website of MOH and at existing meeting occasions such as Kenya Health Forum) and also demonstrates the use of MTEF tools at the existing conference and workshop occasions.	"MTEF Management Tool", "MTEF Management Data Aggregation Tool Ver. 3.0" and "AWP Handbook for level 2-3 Health Facilities" have been disseminated. "AWP Handbook for level 2-3 Health Facilities" and its sensitization tool in Power Point are posted on MOH website to enable all the counties to access. MTEF Tools were presented and distributed in Kenya Health Forum 2019.
(3) In parallel with (2), the Project confers certificates to the trainers (TOTs) on MTEF/AWP cycle to facilitate training in their counties and non-partner counties when requested, by providing the certificate and the awarding them the title "Peer Facilitator for MTEF Cycle Management".	Have conducted an assessment exercise and certified each trainer based on their knowledge and abilities. Refer to (5) below.
Until the end of the Project (Sep 2019) **Output2**	
(1) The Project shares the actual cost for the necessary routine activities for MTEF/AWP cycle, such as workshop for consolidation of AWP and data review meeting to help CHMT use the cost for lobbying at the assembly to increase the allocation to health.	Done during the FY2019/20 AWP formulation and is incorporated in the FY2019/20 AWP.
(2) The Project and CHMT complete activity 2-4 "Document experience and lessons learned from implementation of MTEF cycle in the Partner Counties" and 2-5 "Provide feedbacks to intergovernmental frameworks on lessons learned". In relation to 2-4 and 2-5, CHMTs summarizes good practices and benefits from using MTEF tools.	Activity 2-4 was conducted during the "AWP Handbook validation and AWP/APR process review workshop" held in partner counties in June 2019 in both Kericho (25th) and Kirinyaga (18th), and Mutual Learning Forum held on 2nd July 2019 where Kericho, Kirinyaga, and Nyeri attended. Experiences and lessons learnt are all documented and selected lessons learnt are uploaded in the MOH website.
(3) The MOH designates the department(s) responsible for updating and revising the manuals, guidelines and tools developed by the Project.	We have learned that while the Chief Representative of JICA Kenya Office visited the PS in June 2019, the PS designated HSC/IGA to continue as the C/P of the Project.
(4) The MOH and partner counties explore the existing meeting and workshop	Since there is not much occasion to present experiences on how to implement activities in

occasions provided by other development partners, such as workshops on THS-UCP by the World Bank, to present experiences on how to implement activities in harmonization with MTEF cycle. In addition, the MOH and partner counties implement the MTEF/AWP cycle management activities in alignment with other programs implemented by development partners.	harmonization with MTEF cycle, the Project has invited neighboring counties of the Partner Counties to OCCADEP's activities and held one extra PSC on 9th of July to present the experiences to the new heads of Department of MOH. Kericho presented their absorption rate of THS-UC FY2018/2019 using the dashboard generated by MTEF Management Tool at WB-THS meeting on 10th of July.
(5) As described in the part of Conclusion, the Project ends before the completion of the current MTEF/AWP cycle. The Project, the MOH and partner counties therefore establish the necessary mechanism to implement the MTEF/AWP cycle by the initiatives of MOH and partner counties, after the end of the Project. For instance, the Project and partner counties foster Peer Facilitators to lead the necessary trainings.	Together with JICA Kenya, it has been in discussion with MOH. The Partner counties have signed a Joint Communiqué on way forward (see Attachment 9). Have certified the MTEF Management Tool peer facilitators in September 2019. 4 categories of Peer Facilitators are: Master Trainer, Lead Trainer, Senior Facilitator, Facilitator a) Master Trainer (Kirinyaga 3, Kericho 3) b) Lead Trainer (Kirinyaga 3, Kericho 4) c) Senior Facilitator (Kirinyaga 1, Kericho 3) d) Facilitator (Kirinyaga 3, Kericho 7)

5 Lessons Learned in Accordance to the Project Implementation

5.1 Working with HSC/IGA as C/P

The Project started in the midst of the devolution process and HSC/IGA was chosen to be the C/P. HSC/IGA had just been established in the course of devolution with the mandate to coordinate intergovernmental-affairs and harmonize the national and counties' health priorities. In the first half of the Project period, the Project held activities in order to build capacity of HSC/IGA and supported holding HSIGCF which was the main work for HSC/IGA. In the course of supporting HSC/IGA, the Project faced challenges such as lack of personnel and resources within the HSC/IGA. Based on these challenges, the Mid-term Evaluation team concluded that the Project had to focus its activities to CDOHs in the partner counties in order to achieve the Project purpose. The activities to be implemented in the partner counties were to enhance managerial skills through managing the MTEF Cycle. In reality, it was not the HSC/IGA who had the expertise in MTEF Cycle management but HSC/IGA continued to be the C/P by connecting the Project to Department of Policy Planning. In addition, the Project together with HSC/IGA have held various meetings with the Department of Policy and partner CDOHs in order to share the lessons learned from their

respective counties.

The lessons learned from this experience is that even when the direction or scope of the Project changes in the middle of the Project period, if both the Project and C/P are flexible, there is no need to change the C/P. The Project managed to cooperate and collaborate with the existing C/P and sought together the most efficient way. This was possible because at the end of the day, all health departments work for the attainment of better health service delivery.

5.2 Japanese Experts stationed in the Partner CDOH

It was identified in the Mid-term Evaluation that the activities implemented in the partner counties did not necessarily meet the needs of the CDOHs. This can be explained that before the Third Term, the focus of the Project was more in MOH and therefore, the Project could not assess the needs of the CDOHs accurately.

In the Third Term, the Japanese Experts were stationed in the counties and started assessing the situation through participatory approach and also by visiting and communicating with the CHMT members in their offices. By doing these kinds of ground work, the Japanese Experts were able to see the daily routine work of CHMT members and started making organizational chart and also often visited the Health Facilities to assess their needs on managing the MTEF Cycle. In terms of MTEF Cycle Management, the Japanese Experts checked what the milestones were within the Cycle. The first thing that the Japanese Experts identified as an obstacle for management was the lack of linkage between the plan and the budget. This issue was shared with the CHMT and they also admitted that it had always been their concern as well. In addition, although CHMT members understood that they had to follow the MTEF Cycle, they did not actually know what MTEF was. The Project made MTEF Calendar and MTEF Process Guide so that CHMT, SCHMTs, and managers of Health Facilities understand what they have to do for what purposes, throughout the year. The Japanese Experts also held meetings with the County Treasury to clarify how the budget issue is communicated with CDOH. These thorough and detailed work accompanied by good communication with the CDOH officers resulted in the development of various MTEF Tools and materials that are utilized by the CDOH.

The lessons learned here is that it is very important that the Japanese Experts themselves are embedded in the counties if the work is to be conducted in the counties. Again, correct assessment to identify the real needs can only be possible when one has the right approach and right communication method. Though it seems very basic, it is important to build trust first in

order to be able to identify the real needs that would lead to the development of appropriate tools to be utilized.

5.3 Incorporation of MTEF cycle management as CDOH's routine work

There is always a risk of resistance when the Project introduces new methods for improving health system management. The resistance derives when it requires extra work and when the organizations have their own ways that have already been internalized. Therefore, the Project developed tools that were designed to facilitate their already existing working-method and introduced them by demonstrating how the tools can easily be adapted to their routine work.

The Project not only conducted workshops but held hands-on trainings in each working site of individual CDOH officers and made sure it would not bring cumbersome extra work. For instance, Health Facilities submit health service data to SCHMT every month. The Project required to submit the financial transaction report within this monthly routine. It was additional work compared with the past, but it was received positively since the financial transaction report submission was to be done via existing routine of SCHMT. Similarly, the Project introduced an Excel Program File using the same format as their AWP template which made their routine work more effective and saved long consolidating hours. CDOH recognized the usefulness of the newly introduced tools because it did not require additional burden that could be considered as extra job. The Excel Program File, the MTEF Management Tool and the Data Aggregation Tool for MTEF Management, not only made the consolidation work easy in planning process, but also facilitated the implementation monitoring and regular financial reporting. Various tools were developed through the Fourth Term in this manner which the tools became indispensable for their health system management.

The following are the points that are important so that the officers can incorporate new tools for their routine work.

- The tools must match with the actual needs of CDOH's perspective and must be easy-to-use that can make the work faster and efficient.
- The tools, especially the MTEF Management Tool and its Aggregation Tool, were designed to play three roles; (a) diagnosis, (b) management, and (c) heuristic. The more users utilize the tool, the more management issues become clearer. Issues such as lack of linkage between plan and budget or lack of linkage between expenditure and performance, can be solved if the tool is constantly used. The tools were designed for the users to be able to

learn and acquire management skills simultaneously.

- Many practical sessions were held using the tools with actual information conducting hands-on trainings. This made it easy for the officers to internalize as their routine work. For better understanding and learning, the advanced officers in using the tools were requested to teach others during the session, and a number of certified members were fostered whom became trainers/facilitators and started training other CDOHs.

5.4 Framework of PSC

In the first half of the Project, the target area of the Project was all 47 counties and it was agreed by the PSC members to hold the PSC meeting quarterly. In addition, since the project focus was not clear, all the heads of Department of MOH were PSC members. In the course of the Project, members started not participating or sent representatives that kept on changing and the meeting lost substance. In the latter part of the Project period, it was agreed to change the membership to those who were closely related to the Project and decided to hold the PSC annually and when needed. What the Project found out in the latter part of the Project period was that more technical meetings between MOH and the partner CDOHs were needed and therefore made another structure that hosted the Project Technical Meeting.

The lessons learned is that when a Project starts, people can be excited and may have ambitious plans. Generally, PSC meetings involve many high-ranking officers who are very busy. Even though the PSC members have the enthusiasm in the beginning of the Project, it is unrealistic that all Heads of Department can gather every quarter for the Project that they barely work with. This kind of arrangement makes the PSC lose substance and therefore no ownership is nurtured by MOH.

5.5 Effectiveness of Expertise in Public Administration Management in Health System Management

The Project conducted a needs assessment in the Third Term and it was identified that the challenges in order to improve 'Health System management' was not the lack of health knowledge of CDOH, nor leadership quality alone, nor governance issues but lack of basic public administrative operation issues such as how to plan, budget, monitor implementation and financial status, review and plan again based on the review.

The Project therefore introduced new tools that were designed to adapt and assist actual operation

on the ground. MTEF Tools were designed to have three aspects; (a) diagnosis, (b) management, and (c) heuristic.

For example, the biggest challenge that was identified by the partner CDOHs and the Project in terms of management was the lack of linkage between the plan and the budget. Every year, the CDOH made their budget in PBB in their AWPs. However, the CDOH managed the budget in line-items. Therefore, the CDOH was only able to know how much budget was spent for each line items but was not able to know how much was spent for each program and activity. This made it impossible to monitor the implementation status of the program or activities. In order to analyse their performance, it was important to know how much input each program and activity had been invested and see if it correlates with the movement of the health indicators. However, as mentioned above, since the CDOH managed the budget only in line items, analysis of input and output was impossible. The MTEF Management Tool that was developed by the Public Administration Management Expert (who joined from the 3rd term) was able to tackle this issue.

The below are the main features of the MTEF Management Tool:

1) The Project modified the AWP's section 3.2 (PBB part) to an Excel Format using its Macro function which enabled to show the budget and expenditure in both PBB and Line-Item based in one click.
2) By inserting expenditures regularly into the tool, implementation status and the absorption rate of the budget can be monitored.
3) By monitoring the implementation status and the absorption rate of each program and activity, the managers can make the right decisions according to their priorities.

The expertise in Public Administration Management made it possible to respond quickly in materializing effective methods. It is observed that there are similar public administration management issues in various development projects in other sectors or organizations. Therefore, the "OCCADEP model" could be one of the project models which can be expanded to tackle similar issues in other sectors.

6 For the Achievement of the Overall Goal after Project Completion

6.1 Measures taken for the Recommendations from the Terminal Evaluation after the Completion of the Project

The Terminal Evaluation conducted in March 2019 made recommendation towards MOH and

partner CDOHs on what activities to undertake in order to sustain the achievements made by the Project. Although these recommendations are measures to be taken after the Project completion, the Project had done some ground work together with MOH and CDOHs.

Table 9: Recommendation from the Terminal Evaluation after the Completion of the Project and Actions Taken

Recommendation from the Terminal Evaluation and measures taken by the Project
For Output 1: (1) MOH and partner counties share the lessons learnt and good practices with other counties by capitalizing on existing workshops and conference occasions. (2) MOH follows up on activities and conduct monitoring in partner counties and the MOH will roll out the MTEF tools in the UHC pilot counties. Measures taken for: (1) The Project uploaded all the lessons learnt, all materials and MTEF Tools developed by the Project on the MOH Website http://www.health.go.ke/health-best-practice/. MOH can always access them in the Website and in case they need to be updated, the Project has made the WORD version available on the same Website. (2) The Project has already linked Kericho CDOH to Kisumu and Migori CDOHs; and Kirinyaga CDOH to Nyeri and Machakos CDOHs. These links were made through Study Visit, County Health Forum, AWP Handbook Validation Workshop and Training of MTEF Management Tool. The Project expects that this relation will continue after the Project and further expand to other counties.
For Output 2: (1) The MOH and partner counties maintain the current series of activities for MTEF/AWP cycle management for 2019/2020, and revise MTEF tools accordingly (2) The MOH follows up on partner counties and conduct monitoring of MTEF/AWP cycle activities that will contribute to other counties. (3) The MOH and partner counties implement the necessary activities identified from the implementation of the Project for further strengthening of capacity building. Measures taken for: (1) In order to sustain the achievements through the Partner CDOHs, Kericho and Kirinyaga

CDOHs developed a Joint Communiqué which states what they will do after the completion of the Project. (see attachment 8). The Joint Communiqué was signed by the County Director of Health of Kericho and Kirinyaga.

MOH and the partner CDOHs recognize the importance of the implementation of (2) and (3). However, in reality it is not an easy task considering the existing resources. Therefore the Project together with HSC/IGA took actions to link them to WB-THS with the support of JICA Kenya Office and the JICA UHC Advisor to MOH.

6.2 Prospects in Achieving the Overall Goal

Overall Goal is set to be achieved after 3-5 years after the completion of the Project. The Overall Goal is "Devolved Health Systems are strengthened to ensure equitable and quality services in achieving Universal Health Coverage in Kenya".

It was agreed in the 7th PSC held in June 2018 that the indicators to be measured to assess whether the Overall Goal was achieved were:

1. The budget allocation of non-salary within the recurrent budget in the Partner Counties are at least 25% and 30% for Kirinyaga and Kericho respectively[8]
2. At least 6 counties including the Partner Counties are utilizing the MTEF tools developed by the Project.

Table 10: budget allocation of non-salary within the recurrent budget in the Partner Counties

	Base Line (2014/2015)	(2015/2016)	(2016/ 2017)	(2017/ 2018)	(2018/ 2019)	target (2021/22)
Kericho	29%	30%	29%	17.1%	23.3%	30%
Kirinyaga	21.7%	20.6%	23.4%	27.1%	22.4&	25%

Table 11: Number of Counties utilizing MTEF Tools

Baseline (2016/2017)	(2017/2018)	(2018/19)	Target (2021/22)
0	2 (Partner Counties)	2 (Partner Counties)	6

In order to achieve Indicator 1, the Project had been in discussion with the partner CDOHs for the last few years. Most of the budget of CDOH is spent on salaries of staff members and those who work for CDOH. The partner CDOH and the Project recognized that in order to achieve UHC,

8 This indicator was added in May 25, 2018 after the meeting with the HSC/IGA.

the importance should not only be focused on human resource but also on the quality of health service delivery. However, the partner CDOHs have told the Project that increasing the percentage of non-salary within the recurrent budget is not an easy task because it is difficult to convince the Members of County Assembly (MCAs) regarding the needs of investing money into activities related to health delivery. Both partner CDOHs explained that it was easy to convince the need of infrastructure because it is visible but investing in activities or trainings were difficult. Therefore, the Project created opportunities so that the CDOH officers can discuss with the MCAs on this regard. The Project invited the MCAs in the events held in the respective counties such as AWP and APR stakeholders meetings, Study Visits and County level Health Forums. These opportunities motivated the CHMT and SCHMT members to brush up their advocacy skills and strategize what would be the best way to convince the MCAs. Through inviting the MCAs to these events, the CDOH officers and MCAs strengthened their partnership and with improved advocacy skills of CDOH officers, the MCA Health Committee's understanding on health issues in the county has increased and were taken more serious. This can be proved by the participation of the MCAs in the events the Project had invited. The first time that the Project invited the MCAs in Kericho in 2018, no one joined. However, after one year, 10 MCAs have joined the meeting held by Kericho CDOH. It is expected that in the course of 3-5 years after the completion of the Project, the relationship between MCAs and CDOHs would become stronger and is expected that the non-salary portion will increase.

In order to achieve Indicator 2, the Project developed 12 MTEF Tools together with the partner CDOHs. The Project also conducted various workshops on how to utilize these MTEF Tools. In addition, the Project nurtured trainers/facilitators[9] that can teach other officers on how to use them.

The followings are some examples.

- ✓ MTEF Cycle Calendar and MTEF Process Guide were distributed in Health Forums and HSIGCFs.
- ✓ AWP Handbook for level 2-3 was validated together with the partner CDOH and CDOHs from Nyeri and Kisumu.
- ✓ MTEF Management Tool training was conducted by Kericho Trainers/Facilitators to Kisumu

[9] See attachment 9 for list of trainers/facilitators.

and Migori CDOH, and Kirinyaga Trainers/Facilitators to Nyeri and Machakos CDOHs. These trainings were implemented together with the JICA UHC Advisor and JICA Kenya Office.

- ✓ Several MTEF Tools were presented and distributed in Devolution Conference and meetings held by WB-THS.

It is expected that by the course of the years, the relationship with CDOH and MCAs would be stronger by continued advocacy from the CDOH which would lead to the increase of budget allocation of non-salary within the recurrent budget. Together with the increase in budget, it is expected that the partner CDOH would be promoting the utilization of the MTEF Tools not only in their respective counties but also in other counties. Through these activities, it is expected that the overall goal would be achieved.

6.3 Concerns in Achieving the Overall Goal

The MTEF Tools were developed based on the Public Finance Management Act 2012. The Project supported the partner CDOHs so that they can submit the AWPs and APRs in a timely manner following the MTEF cycle. By improving the reviewing process looking both the health indicators and financial transaction, the Project made the management level possible to take correct intervention plans based on the analysis, challenges and priority setting. Through this reviewing and planning exercise, the Project had made it clear on how to link the plan and review; how to link the plan to the budget; how to monitor expenditures; how to link the project based budget with line items. However, since these tools were developed in the latter part of the Project, most of the tools were mainly used in FY 2018/19 and three months of FY 2019/20. In this regard, it is important that MOH monitors the progress of the utilization of MTEF Tools in the partner CDOHs and other counties that have been introduced to MTEF Tools.

The following are some concerns identified that may impede the achievement of the overall goal.

(1) Delays on sending the templates of AWP and APR to CDOHs from MOH

One of the challenges that was seen during the Project period was that the MOH had not sent the AWP and APR templates in time following the MTEF Cycle. CDOH has to submit the AWP by April so that the County Treasury can take it up to the County Assembly in time. However, the AWP template for FY2018/19 was sent to the counties in end March. This

brought frustration to CDOH officers because AWP is supposed to consolidate information from bottom-up. If the CDOH follows the MTEF Cycle, the information of all health facilities has to be consolidated by the CHMTs by middle to end March. The new FY2018/19 AWP template was sent from MOH when both partner CDOH had finished consolidating all the information from Health Facilities to SCHMTs and then to CHMT. Because of this delay of sending the template by MOH, the CHMT and SCHMT had to call again all the Health Facilities to gather new information and redo some sections that had been changed from the previous template. The same thing happened with FY 2018/19 APR template. The new FY 2018/19 was sent when the partner CDOHs were about to finish its consolidation of data. If this situation continues, it would impede the motivation of CDOHs to develop a meaningful AWPs and APRs which should result in better health service delivery.

(2) Frequent changes of the templates of AWP and APR

As mentioned in (1) above, the templates were not only sent in time but also the contents of the templates have been changing without discussion with the CDOHs. The FY 2018/19 APR template had created more confusion because the new template was asking for information that was not in the FY 2018/19 AWP. The APR is a review of the AWP and therefore the information required must be linked with the AWP.

In addition, if there is a big change in the budget part of the AWP in the near future, it will also affect the utilization of MTEF Management Tool because the MTEF Management Tool is based on the budget part of the FY 2018/19 AWP template (section 3.2). The AWP Handbook for Level 2-3 Health Facilities that has been developed was also based on the same AWP template. The Project is concerned that if the templates keep on changing and if the MTEF Tools are not updated accordingly, the CDOHs may be less likely to use the MTEF Tools that were developed by the Project.

(3) Changes in condition of the DPs

The Project thinks that one of the main reasons that the CDOHs are developing their AWPs in time is because the submission of AWP is a condition to receive funds from WB-THS. However, as the WB-THS will end in 2021, it is important that the MOH makes sure to monitor the timeliness and the quality of the AWPs from CDOHs. Without such proper monitoring of AWP process, there is a risk that MTEF Tools such as MTEF Calendar, MTEF Process Guide, MTEF Management Tool and AWP Handbook for Level2-3 Health Facilities may not be utilized.

6.4 Recommendation in Achieving the Overall Goal

As mentioned in 6.1, it is expected that CDOH continues to advocate to the MCAs about important issues in order to improve the health service delivery in the respective counties and to promote the utilization of MTEF Tools for better management following the MTEF Cycle.

The followings are the recommendation in order to achieve the overall goal which also takes into account the concerns mentioned in 6.3.

(1) Recommendation to achieve Indicator 2

- ✓ Partner CDOHs to advocate to the MCAs utilizing information derived from MTEF Management Tools such as the link between financial investment and the health indicators based on programs. By promoting these kinds of quality evidence-based analysis, it is expected that the MCAs would be convinced to increase the non-salary portion in the recurrent budget.
- ✓ In order to sustain the relationship with the MCAs, it is important to continue inviting them to important events such as AWP and APR Stakeholders meetings. In order to enable to hold the events, strategical involvement of DPs are crucial.

(2) Recommendation to achieve Indicator 2

- ✓ Partner CDOHs to implement the Joint Communiqué that was developed and signed in July 2019 (see Attachment 9).
- ✓ MTEF Tool trainers/facilitators to promote the utilization not only in their respective counties but in other counties when they are requested.
- ✓ MOH should inform the CDOHs well in time in case the templates are due to change. The reason for change should be explained and consultation between CDOHs should be conducted. In case the FY 2020/21 AWP template is to be changed, it should be communicated to the CDOHs not later than January 2020. Regardless, the APR should also be changed as the two templates should be linked.
- ✓ MOH is expected to present the MTEF Tools in inter-governmental events such as Health Forums, in coordination with the partner CDOHs in order to promote the utilization of MTEF Tools in other counties.

Project Design Matrix (PDM): Version 0 (February 2014)

Title: Organizational Capacity Development Project for the Management of Devolved Health Systems in Kenya

Period: 5 years (2014-2019)

Direct Target Group: Personnel involved in managerial capacity development of counties within Ministry of Health, and members of County Health Management Teams (CHMTs), Sub-County Health Management Teams (SCHMTs) and Health Facility Management Teams (HFMTs) of 47 counties

Narrative Summary		Objectively Verifiable Indicators	Means of Verification	Important Assumptions
Overall Goal				
Devolved Health Systems are strengthened to ensure equitable and quality services in achieving Universal Health Coverage in entire Kenya.	1	Core Health indicators (e.g. MMR, U5MR, IMR & Immunization rate) are improved	DHIS, KDHS	
	2	Service utilization[1] of the poorest 40% at health facilities is increased.	KDHS	
	3	Incidence of catastrophic expenditure is decreased.	Population-based survey documents	
Project Purpose				
Managerial functions[2] of County Health Management Teams (CHMTs) are strengthened.	1	Scores of functional assessment of CHMTs are increased	Functional assessment	Changes of the national policy and strategies in health sector do not affect implementation of the project activities.
	2	Performance assessment score of health facilities is improved.	Performance assessment	
Outputs				
1 **Managerial support functions and coordination mechanisms in the National level are strengthened.**	1	Score of functional assessment of county support function (e.g. mentoring, displaying results)	Records of intergovernmental forums, number of mentoring	
2 **Leadership and managerial capacities of CHMTs are strengthened.**	1	Timely submission of joint annual work plan	Planning documents	
	2	Training impact assessment	Training reports	

[1] Service utilization indicators are number of antenatal care, skilled birth attendance, and other indicators from “Improve quality of and access to essential person-centred health service” in Kenya Health Sector Strategic and Investment Plan (KHSSPI 2013-2017).

[2] Managerial functions are defined as functions necessary to ensure achievement of nationally and locally set goals while responding to the needs, demands and expectations of the people they serve. Such dimensions as leadership, human resource management, financial management, work place management, team building, facilitation, coordination, information sharing and communication etc. can be included.

No.	Narrative Summary / Activities			
3	**Horizontal learning mechanism among and within CHMTs is strengthened.**	1 Number of publications, access of website/social media, and events to share good practices and lessons learnt.	Project records	
Activities		**Inputs**		1. Personnel deployment and transfers are stable during the project period. 2. Co-financing of project activities by GOK and partners are smoothly implemented.
1	**Managerial support functions and coordination mechanisms in the National level are strengthened.**	**Japan**	**GOK**	
1-1	To identify and strengthen county coordination and support mechanism in MOH.	**Dispatch of Experts** 1. Chief Advisor 2. Health Systems Management 3. Training Coordination 4. Communication and Advocacy 5. Project Coordinator **Equipment and Material** 1. Necessary equipment and materials for the project activities 2. Other equipment and materials mutually agreed upon as necessary **Local Costs** 1. Training and forums (cost sharing with MOH, County and Partners) 2. Research and publications 3. Other activity costs	**Counterparts** 1. Project Director 2. Project Manager 3. Technical Staff 4. Training institutions 5. Other personnel mutually agreed upon as needed. **Facilities, equipment and materials** 1. Office space for the Project 2. Necessary equipment and materials for the project activities **Local Costs** Operational costs for implementing activities	
1-2	To strengthen coordination mechanism of national expertise to deliver harmonized training and mentoring for CHMTs.			
1-3	To strengthen the coordination mechanism of Inter-governmental Health Committee and coordination of the development partners' support.			
1-4	To strengthen national monitoring mechanism to assess the progress of managerial capacity development and the performance of CHMTs.			
2	**Leadership and managerial capacities of CHMTs are strengthened.**			
2-1	To conduct assessment on skills gaps and challenges facing the devolved health systems.			
2-2	To conduct trainings (TOT) and mentoring support to CHMTs by national expertise.			
2-3	To support implementation of good managerial practices at stakeholder forums, TWGs etc..			
2-4	To support CHMTs to conduct managerial trainings and supportive supervision to sub-county, health facilities and community health systems.			

2-5	To demonstrate and verify good managerial practices at model CHMTs.			
3	**Horizontal learning mechanism among and within CHMTs is strengthened.**			**Pre-conditions** 1. Clear MOH structure and job descriptions. 2. Clear CHMT structure and job descriptions 3. SWAp mechanism is maintained.
3-1	To support establishment of horizontal learning mechanism for devolved health systems.			
3-2	To support documentation and publication of lessons-learnt, good practices and research results.			
3-3	To reinforce recognition mechanisms and dissemination fora for good practices.			

Project Design Matrix (PDM): Version 1 (July 2015)

Title: Organizational Capacity Development Project for the Management of Devolved Health Systems in Kenya

Period: November 2014 - September 2019 (5 years)

Direct Target Group: Ministry of Health (MOH) personnel involved in managerial capacity development of counties, and members of County Department of Health (CDOH) of all 47 counties of Kenya

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Important Assumptions
Overall Goal			
Devolved Health Systems are strengthened to ensure equitable and quality services in achieving Universal Health Coverage in entire Kenya.	1 Core Health Indicators at national level (Maternal Mortality Ratio [MMR], Under Five Mortality Rate [U5MR], and Infant Mortality Rate [IMR]) are improved.	- Kenya Demographic Health Survey (KDHS)	
	2 Service utilization of antenatal care, delivery conducted by skilled attendants, and child immunization of the poorest 40% is increased.	- KDHS	
Project Purpose			
Managerial functions[1] of County Department of Health (CDOH) are strengthened.	1-1 County Health Management Teams (CHMTs) of partner counties become functional.[2] [baseline (2013): 0 CHMT out of 2 partner CHMTs was functional] 1-2 Percent (%) of counties with functional CHMTs is increased. [baseline (2013): 0% = 0 CHMT out of 47 CHMTs was functional]	- Kenya Health Sector Strategic and Investment Plan (KHSSP) 2014-2018 / Health Information System (HIS)	Health financing reform to improve access to health services is maintained.
Outputs			
1 Managerial support functions and coordination mechanisms at national level are strengthened.	1-1 Functions of Health Sector Coordination and Intergovernmental Affairs (HSC/IGA) are set up. 1-2 County health systems management training strategy is developed based on needs of the counties, and revised based on feedback from experiences in the partner counties 1-3 Number of Inter-governmental Health Forum (IGF) convened.	- List of the functions of HSC/IGA - County health training strategy - Minutes of the IGF	Data for the CHMT functionality are timely available for all the 47 counties.

[1] Managerial functions are defined as functions necessary to ensure achievement of nationally and locally set goals while responding to the needs, demands and expectations of the people they serve.

[2] "Functional County Health Management Teams (CHMTs)" will be defined in the Evaluation Guideline which is planned to be prepared by Monitoring and Evaluation Unit of MOH.

2	Leadership and managerial capacities of CDOH are strengthened.	2-1 2-2	Partner counties develop and implement County Health Sector Annual Work Plan (AWP) through: a) situation analysis / review of achievements in previous year, b) priority setting, c) consideration on equity, d) advocacy to county assembly, e) progress monitoring of activities and output/outcomes, f) review and evaluation of the Plan. Implementation rate of planned activities.	- County Health Sector AWP - Mentoring Report - County health annual and quarterly performance report - County Health Sector AWP - Mentoring Report	
3	Horizontal learning among CDOH is strengthened.	3-1	Number of documents and events to share lessons learnt and good practices.	- Documents on the lessons learnt and good practices - Records of the events	
Activities		**Inputs**			
1	**Managerial support functions and coordination mechanisms at national level are strengthened.**	**[Japan]** **Dispatch of Experts** 1. Chief Advisor 2. Health Systems Management 3. Training Coordination 4. Communication and Advocacy 5. Project Coordinator **Equipment and Material** 1. Necessary equipment and materials for the project activities 2. Other equipment and materials mutually agreed upon as necessary **Local Costs** 1. Training and forums (cost sharing with MOH, County and Partners) 2. Research and publications 3. Other activity costs		**[Kenya]** **Counterparts** 1. Project Director 2. Project Manager 3. Technical Staff 4. Training institutions 5. Other personnel mutually agreed upon as needed. **Facilities, equipment and materials** 1. Office space for the Project 2. Necessary equipment and materials for the project activities **Local Costs** 1. Operational costs for implementing activities	Fund for convening Intergovernmental Health Forum is secured by Kenyan side. Turn-over of CDOH staff trained on the health management by the Project is low.
1-1	[Ministry of Health (MOH)] To identify and strengthen county coordination and support mechanism in MOH.				
1-2	[Human Resource Development (HRD)] To identify capacity gaps and available training programs in county health systems management (HSM).				
1-3	[HRD] To develop HSM county training strategy.				
1-4	[Health Sector Coordination and Inter Governmental Affairs (HSC/IGA)] To convene Inter-governmental Health Forum (IGF) between two levels of government to discuss issues of common interest.				
1-5	[Policy, Planning and Health Care Financing] To clarify the definition of functional CHMTs and its measurement methods.				

2	**Leadership and managerial capacities of CDOH are strengthened.**			
2-1	[HSC/IGA, Human Resource Development (HRD)] To conduct situation analysis to identify county's managerial challenges and CDOH core functions.			
2-2	[Project Steering Committee (PSC)] To identify partner counties of the Project.			
2-3	[Health Policy & Planning, HRD, Quality and Standard; Training Institutions] To provide technical assistance for the health sector Medium Term Expenditure Framework [MTEF] cycle (or planning, budgeting and review cycle) to the partner counties.			
2-4	[Partner Counties] To extract lessons learnt from the partner counties' experiences.			
2-5	[HRD, Quality and Standard; Training Institutions] To provide feedbacks to inter-governmental frameworks and the county training strategies.			
3	**Horizontal learning among CDOH is strengthened.**			**Pre-conditions**
3-1	[MOH, Counties] To reinforce recognition mechanism and dissemination fora for good practice			Medium Term Expenditure Framework (MTEF) is maintained. Devolution of health service delivery is maintained as County's responsibility.
3-2	[Partner Counties] To document experience and lessons-learnt from implementation of AWP cycle in the partner counties.			
3-3	[Partner Counties] To share the lessons learnt of the Project through existing fora.			

Project Design Matrix (PDM): Version 2 (revised on 22 November 2016 at the 6th Project Steering Committee meeting)
Title: Organizational Capacity Development Project for the Management of Devolved Health Systems in Kenya
Period: November 2014 - September 2019 (5 years)
Direct Target Group: Ministry of Health (MOH) personnel involved in managerial capacity development of counties, and members of County Department of Health (CDOH) of all 47 counties of Kenya

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Important Assumptions
Overall Goal			
Devolved Health Systems are strengthened to ensure equitable and quality services in achieving Universal Health Coverage in entire Kenya.	1 Core Health Indicators at national level (Maternal Mortality Ratio [MMR], Under Five Mortality Rate [U5MR], and Infant Mortality Rate [IMR]) are improved.	- Kenya Demographic Health Survey (KDHS)	
	2 Service utilization of antenatal care, delivery conducted by skilled attendants, and child immunization of the poorest 40% is increased.	- KDHS	
Project Purpose			
Managerial functions[1] of County Department of Health (CDOH) are strengthened.	1 Medium-Term Expenditure Framework (MTEF) and Annual Work Plan (AWP) of health sector are approved by County Executive Committee (CEC) member for health by the end of November and March of each fiscal year, respectively. (blank) / Baseline (plan of 2015/16) / Target (plan of 2018/19) **MTEF** Kericho County / [Yes/No] / Yes Kirinyaga County / [Yes/No] / Yes Other 45 counties / x % - Yes / y % - Yes **Annual Work Plan** Kericho / [Yes/No] / Yes	- Annual monitoring by the Project	- Health financing reform to improve access to health services is maintained

[1] Managerial functions are defined as functions necessary to ensure achievement of nationally and locally set goals while responding to the needs, demands and expectations of the people they serve.

county		
Kirinyaga county	[Yes/No]	Yes
other 45 counties	x % - Yes	y % - Yes

2 % of health facilities supervised by CDOH/sub-county at least four times per year

	Baseline (in 2013/14)	Target (in 2017/18)
Kericho County	x1 %	y1 %
Kirinyaga County	x2 %	y2 %
Other 45 counties	x3 % (median)	y3 % (median)

- Annual performance review reports of the 47 counties

3 Performance monitoring meeting[2] conducted at least once a year

	Baseline (in 2015/16)	Target (in 2017/18)
Kericho County	[Yes/No] (number of meetings / year)	Yes (number of meetings / year)
Kirinyaga County	[Yes/No] (number of meetings / year)	Yes (number of meetings / year)
Other 45 counties	x % - Yes	y % - Yes

- Annual monitoring by the Project

[2] Performance monitoring meeting is defined as a meeting which monitors progress of implementation of activities in the annual work plan (AWP) and health service indicators during a year at county level.

No.	Narrative Summary	No.	Objectively Verifiable Indicators	Means of Verification	Important Assumptions
		4	Counties submitting annual performance review (APR) report to CEC by November of each year (columns: county / Baseline (report of 2015/16) / Target (report of 2017/18)) Kericho County / [Yes/No] / Yes Kirinyaga County / [Yes/No] / Yes Other 45 counties / x % - Yes / y % - Yes	- Annual performance review reports of the 47 counties - [Indicators 1-4 are suggested to be included in and monitored under "Kenya Health Sector Strategic and Investment Plan (KHSSP) 2019-2023"]	
Outputs					
1	Managerial support functions and coordination mechanisms at national level are strengthened.	1-1	Functions of Health Sector Coordination and Intergovernmental Affairs (HSC/IGA) are set up. [baseline (2013): not set up]	- List of the functions of HSC/IGA	- Data for the CHMT functionality are timely available for all the 47 counties.
		1-2	County health systems management training strategy, as a component of an integrated county training strategy for health, is developed based on needs of the counties, and revised based on feedback from experiences in the partner counties. [baseline (2013): not developed]	- County health training strategy	
		1-3	Number of Inter-governmental Health Forum (IGF) convened. [baseline (2013): 0]	- Minutes of the IGF	
2	Leadership and managerial capacities of CDOH are strengthened.	2-1	Partner counties develop MTEF and AWP of health sector with: a) situation analysis / review of achievements in previous year (columns: Baseline (plan of 2015/16) / Target (plan of 2018/19))	- County Health Sector AWP - Mentoring Reports by JICA expert team	

MTEF		
Kericho county	[Yes/No]	Yes
Kirinyaga county	[Yes/No]	Yes
Annual Work Plan		
Kericho county	[Yes/No]	Yes
Kirinyaga county	[Yes/No]	Yes

b) priority setting

	Baseline (plan of 2015/16)	Target (plan of 2018/19)
MTEF		
Kericho county	[Yes/No]	Yes
Kirinyaga county	[Yes/No]	Yes
Annual Work Plan		
Kericho county	[Yes/No]	Yes
Kirinyaga county	[Yes/No]	Yes

c) consideration on equity towards Universal Health Coverage (UHC)[3]

	Baseline (plan of 2015/16)	Target (plan of 2018/19)
MTEF		
Kericho county	[Yes/No]	Yes
Kirinyaga county	[Yes/No]	Yes

[3] Universal Health Coverage is defined as a status that all people have access to needed health services of sufficient quality and that the use of these services does not expose the user to financial hardship. Inequity in the health service utilization and the financial risk protection due to area of residence (urban/rural), household income, gender, education levels, age (children and the aged), ethnicity (minorities), and others needs to be reduced to promote equity towards UHC.

Annual Work Plan		
Kericho county	[Yes/No]	Yes
Kirinyaga county	[Yes/No]	Yes

d) coordination with relevant stakeholders including development partners (DPs) / implementation partners (IPs)

	Baseline (plan of 2015/16)	Target (plan of 2018/19)
MTEF		
Kericho county	[Yes/No]	Yes
Kirinyaga county	[Yes/No]	Yes
Annual Work Plan		
Kericho county	[Yes/No]	Yes
Kirinyaga county	[Yes/No]	Yes

e) public participation

	Baseline (plan of 2015/16)	Target (plan of 2018/19)
MTEF		
Kericho county	[Yes/No]	Yes
Kirinyaga county	[Yes/No]	Yes
Annual Work Plan		
Kericho county	[Yes/No]	Yes
Kirinyaga county	[Yes/No]	Yes

<table>
<tr>
<td></td>
<td>
2-2 Budget allocation to the health sector is no less than 30% in the partner counties (excluding external funding).
<table>
<tr><th></th><th>Baseline (2015/16)</th><th>Target (2018/19)</th></tr>
<tr><td>Kericho county</td><td>[Yes/No] (x%)</td><td>Yes (x2%)</td></tr>
<tr><td>Kirinyaga county</td><td>[Yes/No] (y%)</td><td>Yes (y2%)</td></tr>
</table>
2-3 % of actual health budget compared to required health budget based on the AWP is increased.
<table>
<tr><th></th><th>Baseline (2015/16)</th><th>Target (2018/19)</th></tr>
<tr><td>Kericho county</td><td>x1 %</td><td>x2% (increased)</td></tr>
<tr><td>Kirinyaga county</td><td>y1 %</td><td>y2% (increased)</td></tr>
</table>
2-4 Budget execution rate is increased.
<table>
<tr><th></th><th>Baseline (2015/16)</th><th>Target (2018/19)</th></tr>
<tr><td>Kericho county</td><td>x1 %</td><td>x2% (increased)</td></tr>
<tr><td>Kirinyaga county</td><td>y1 %</td><td>y2% (increased)</td></tr>
</table>
</td>
<td>
- County budget
- County Health Sector AWP
- County budget
- County reports
</td>
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<tr>
<td>3 Mutual learning among CDOH is strengthened.</td>
<td>Number of documents and events to share lessons learnt and good practices. [baseline</td>
<td>- Documents on the lessons learnt and good practices</td>
</tr>
</table>

<table>
<tr><td colspan="2"></td><td>(2013): 0]</td><td>- Records of the events</td><td></td></tr>
<tr><th colspan="2">Activities</th><th colspan="3">Inputs</th></tr>
<tr><td>1</td><td>Managerial support functions and coordination mechanisms at national level are strengthened.</td><td rowspan="10">[Japan]

Dispatch of Experts
1. Chief Advisor
2. Health Systems Management
3. Training Coordination
4. Communication and Advocacy
5. Project Coordinator

Equipment and Material
1. Necessary equipment and materials for the project activities
2. Other equipment and materials mutually agreed upon as necessary

Local Costs
1. Training and forums (cost sharing with MOH, County and Partners)
2. Research and publications
3. Other activity costs</td><td rowspan="10">[Kenya]

Counterparts
1. Project Director
2. Project Manager
3. Technical Staff
4. Training institutions
5. Other personnel mutually agreed upon as needed.

Facilities, equipment and materials
1. Office space for the Project
2. Necessary equipment and materials for the project activities

Local Costs
Operational costs for implementing activities</td><td rowspan="10"></td></tr>
<tr><td>1-1</td><td>[Ministry of Health (MOH)] To identify and strengthen county coordination and support mechanism in MOH.</td></tr>
<tr><td>1-2</td><td>[Human Resource Development (HRD)] To identify capacity gaps and available training programs in county health systems management (HSM).</td></tr>
<tr><td>1-3</td><td>[HRD] To develop HSM county training strategy.</td></tr>
<tr><td>1-4</td><td>[Health Sector Coordination and Inter Governmental Affairs (HSC/IGA)] To convene Inter-governmental Health Forum (IGF) between two levels of government to discuss issues of common interest.</td></tr>
<tr><td>2</td><td>Leadership and managerial capacities of CDOH are strengthened.</td></tr>
<tr><td>2-1</td><td>[HSC/IGA, Human Resource Development (HRD)] To conduct situation analysis to identify county’s managerial challenges and CDOH core functions.</td></tr>
<tr><td>2-2</td><td>[Project Steering Committee (PSC)] To identify partner counties of the Project.</td></tr>
<tr><td>2-3</td><td>[Health Policy & Planning, HRD, Quality and Standard; Training Institutions] To provide technical assistance for the health sector Medium Term Expenditure Framework [MTEF] cycle (or planning, budgeting and review cycle) to the partner counties.</td></tr>
<tr><td>2-4</td><td>[Partner Counties] To extract lessons learnt from the partner counties’ experiences.</td></tr>
</table>

No.	Activities			
2-5	[HRD, Quality and Standard; Training Institutions] To provide feedbacks to inter-governmental frameworks and the county training strategies.			
3	**Horizontal learning among CDOH is strengthened.**			**Pre-conditions**
3-1	[MOH, Counties] To reinforce recognition mechanism and dissemination fora for good practice			- Medium Term Expenditure Framework (MTEF) is maintained. - Devolution of health service delivery is maintained as County's responsibility.
3-2	[Partner Counties] To document experience and lessons-learnt from implementation of MTEF and AWP cycle in the partner counties.			
3-3	[Partner Counties] To share the lessons learnt of the Project through existing fora.			

Project Design Matrix (PDM): Version 3 (revised on 13 June 2018 at the 7th Project Steering Committee meeting)
Title: Organizational Capacity Development Project for the Management of Devolved Health Systems in Kenya
Period: November 2014 - September 2019 (5 years)
Direct Target Group: Ministry of Health (MOH) personnel involved in managerial capacity development of counties, and members of County Department of Health (CDOH) of all 47 counties of Kenya

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Important Assumptions
Overall Goal			
Devolved Health Systems are strengthened to ensure equitable and quality services in achieving Universal Health Coverage in Kenya.	1 The budget allocation of non-salary items within the recurrent budget in the Partner Counties are at least 25% and 30% for Kirinyaga and Kericho respectively.	Budget composition from CDOH. The data can also be found in APR	
	2 At least 6 counties including the Partner Counties are utilizing the MTEF tools developed by the Project.	On site visit and interview.	
Project Purpose			
Managerial functions of County Department of Health (CDOH) [1]are strengthened.	1 CHMTs, SCHMTs have monitored and evaluated at least 50% of Health Facilities using at least one of the MTEF tools developed by the Project. 2 Annual Work Plan (AWP) and Annual Performance Review (APR) of health sector are submitted by April and November respectively every fiscal year. 3 At least 50% of county specific action points agreed in the way forward/resolutions at Health Sector Intergovernmental Consultative Forum (HSIGCF) are implemented in the Partner Counties.	- Monitoring by the Project (monthly report) - Monitoring by the Project (monthly report) - Monitoring by the Project (monthly report)	-
Outputs			
1 Mutual support and learnings among MOH and CDOHs are strengthened through HSIGCF and other mechanisms.	1-1 Way forward/resolutions and county specific action points are confirmed in every HSIGCF. 1-2 Events to share the lessons learned from the Counties are held more than twice by the end of the Project. 1-3 Best Practices and lessons learned from the	- Minutes and the report of the HSIGCF - Reports from the Project (monthly report) - Website of MOH, Project	- HSIGCF is held regularly after FY2018/19

[1] CDOH here means the CDOH in the partner counties.

			Partner Counties are documented and disseminated through the MOH website and/or in other forms.	materials, etc.	
2	MTEF cycle management (planning, budgeting, implementation and monitoring) is strengthened in CDOHs of Partner Counties.	2-1	At least 4 MTEF tools (i.e. User-friendly MTEF Annual Cycle work flow-chart, AWP Practical Guideline, MTEF management tool, etc.) are developed and disseminated in Partner Counties[2] by the Project	- Materials developed by CHMT and OCCADEP	
		2-2	At least 70% of CHMT and Health Facilities in each Partner County utilize more than one of the MTEF tools developed by the Project.	- Monitoring by the Project (monthly report)	
Activities		**Inputs**			
1	**Mutual support and learnings among MOH and CDOHs are strengthened through HSIGCF and other mechanisms**	**[Japan]** **Dispatch of Experts** 1. Chief Advisor 2. Health Systems Management 3. Training Coordination 4. Health Planning 5. Project Coordinator		**[Kenya]** **Counterparts** 1. Project Director 2. Project Manager 3. Technical Staff 4. Training institutions 5. Other personnel mutually agreed upon as needed.	Fund for convening HSIGCF is secured by Kenyan side.
1-1	[Ministry of Health (MOH)] Identify and strengthen county coordination and support mechanism in MOH.	**Equipment and Material** 1. Necessary equipment and materials for the project activities 2. Other equipment and materials mutually agreed upon as necessary **Local Costs** 1. Training and forums (cost sharing with MOH, Counties and Partners)		**Facilities, equipment and materials** 1. Office space for the Project 2. Necessary equipment and materials for the project activities **Local Costs** 1. Operational costs for implementing activities	Turn-over of CDOH staff trained on the health management by the Project does not adversely affect Project activities.
1-2	[Human Resource Development (HRD)] Identify capacity gaps and available training programs in county health systems management (HSM).				
1-3	[HRD] To develop HSM county training strategy.				
1-4	[*Health Sector Coordination and Intergovernmental Affairs (HSC/IGA)*] Provide technical support to HSIGCFs between two levels of government to				

[2] CHMT, SCHMT and Health Facilities.

	discuss issues of common interest.			
1-5	Share the lessons learned of the Project through existing fora and other occasions among counties.			
2	**MTEF cycle management (Planning, budgeting, implementation and monitoring) is strengthened in CDOHs of Partner Counties.**			
2-1	[*HSC/IGA, HRD*] To conduct situation analysis to identify county's managerial challenges and CDOH core functions.			
2-2	[*Project Steering Committee (PSC)*] To identify partner counties of the Project.			
2-3	Provide technical assistance for the health sector Medium Term Expenditure Framework (MTEF) cycle (or planning, budgeting and review cycle) to the Partner Counties.			
2-4	[*Partner Counties*] Document experience and lessons learned from implementation of MTEF cycle in the Partner Counties.			
2-5	[*Partner Counties*] Provide feedbacks to intergovernmental frameworks on lessons learned.			

Work Activity Chart Term 1

No.	Activities	2014			2015					
		10	11	12	1	2	3	4	5	6
1	Organizing the Project Steering Committee									
2	Prepare work plan for the first stage									
3	Confirming the responsible departments/office for the county Health Management in MOH and its scope of work									
4	Clarifying a TOR of the Inter Governmental Forum for Health and Supporting preparations of holding a meeting									
5	Setting up the core functions of CHMTs and establishing self-capacity evaluation of the CHMT									
6	Analyzing activities conducted by MOH and other Stakeholders for strengthening health Management capacity of CHMT									
7	Situation analysis of Health Systems in Counties									
8	Setting up Indicators of evidence-based assessment of the project outcomes									
9	Situation analysis and standardization of the existing training courses of the health management of CHMT									
10	Establishing the human resource database for health systems management training and mentoring to CHMT									
11	Identifying the Monitoring tools of CHMT core function and/or capacity by MOH									
12	Selecting the partner counties									
13	Developing the Mutual Learning Mechanism									
14	Support to organize the 2nd National Conference on Leadership, Management and Governance									
15	Reviewing the PDM and the project activities									
16	Compiling the project progress report									
17	Public Relations									

Work Activity Chart Term 2

Output	Activity Group (Responding to the indicators of the Outputs)	Activities	2016					2017					
			8	9	10	11	12	1	2	3	4	5	6
1. Managerial support functions and coordination mechanisms at national level are strengthened.	Strengthening of coordination functions of the HSC&IGA.	Setting up of the Intergovernmental Event Calendar	■										
		Support for collection and update of event schedule by HSC/IGA		■	■	■		■	■	■	■	■	
		Support for revision of work procedure of the HSC/IGA								■			
	Development of the county health systems management training strategy.	Formulation of the Common Strategy	■	■	■	■	■	■					
		Development of facilitators and participants manuals				■	■						
		Conducto of training of trainers					■						
		Establishement of a training database				■	■	■	■				
	Development of the CDOH Core Function.	Hold the stakeholders' forum for inputs towards the CDOH Core Function			■								
		Finalization of the CDOH Core Function			■								
		Endorsement of the CDOH Core Function					■		■				
	Improvement in the M&E framework of the county health systems management capacity building	Support to revision of Indicator Manual			■	■							
		Support of assessment of functionality of CDOH						■	■				
	Regularization of the Intergovernmental Health Sector Consultative Forum.	Internalization of the SOP of the IGF/TTC		■		■							
		Review of the SOP			■	■	■						
		Support for establishment of a sustainable operation framework of the TTCs		■	■								
		Support for conduct of IGF/TTC		■	■	■		■	■		■	■	
2. Leadership and managerial capacities of CDOH are strengthened.	Support of the Partner Counties for development of the AWP and the MTEF plan.	Development of the MTEF department budget proposal		■	■								
		Development of the AWP					■						
		Organization of the review workshop and making action plans									■		
	Support of the Partner Counties for advocacy of the AWP and the MTEF plan for their budget negotiation.	Support for advocacy to Health Committee of County Assembly for the budget negotiation			■	■		■	■				
		Organization of the review workshop and making action plans									■		
	Support of the Partner Counties for implementation and monitoring of the AWP and the MTEF plan.	Development of the County Health M&E Plan	■	■									
		Implementation of quarterly monitoring			■			■			■		
		Implementation of the priority activity plans to strengthen the continuous monitoring											
		Organization of the review workshop and making action plans									■		
	Support of the Partner Counties for evaluation of the implementation of the AWP and the MTEF plan.	Development of the County Health M&E Plan	■	■									
		Implementation of the midterm review of the County Health Strategic Plan and annual performance review of the previous year		■	■								
		Organization of the review workshop and making action plans									■		
	Extract lessons and good practice form the activities in the Partner Counties.	Extract lessons and good practice form the activities in the Partner Counties.			■			■			■		
	Provide feedback to the national policies, strategies, guidelines and so on.	Documentation of the lessons learnt and good practices from the partner county support experiences					■	■	■	■	■	■	■
		Share the the lessons learnt and good practices as feedback in the relevant forums					■	■	■	■	■	■	■
3. Mutual learning among CDOH is strengthened.	Support of MOH and the Partner Counties for sharing of lessons learnt and good practices regarding health system management.	Conduct of the Best Practice Selection of the year 2015/16	■	■	■	■	■						
		Improvement of sharing and replication promotion functions of the Best Practice		■	■	■	■	■	■				
		Considring casual infromation sharing platform								■	■	■	■
Other Important Activities	IGF			◆		◆			◆			◆	
	Health Sector Congress					◆							
	PSC					◆		◆		◆		◆	
	Progress Report		◆						◆				
	Project Report												◆
	Project Mid-term Evaluation									■			

Work Activity Chart Term 3

	Activity	Plan/Actual	2018 January	2018 February	2018 March	2018 April
【1】	**Cross-cutting activities**					
(1)	Work Plan（3rd Term）	Plan				
		Actual				
(2)	Meeting with JICA Kenya Office and C/Ps	Plan				
		Actual				
(3)	Project Progress Report	Plan				
		Actual				
【2】	**Capacity Building of Parner Counties**					
(1)	Recruitment of Local Assistants for activities in the partner counties.	Plan				
	Rcruitment was conducted twice	Actual				
(2)	Analysis of current situation and process of AWP/MTEF cycle (Update the existing documents and information)	Plan				
	Analysis of current situation and process of AWP/MTEF cycle (Update the existing documents and information) and Developemnt of MTEF tool	Actual				
(3)	Supporting workshop in parner counties	Plan				
	Supporting AWP developemnt workshop	Actual				
【3】	**Strenthening the coordination with the MOH**					
(1)	Meeting with JICA Kenya office and C/P of the MOH	Plan				
		Actual				
(2)	Analysis of IGF review report	Plan				
	IGF review stakeholder meeting, Revision of IGF Manual	Actual				

No.	Activity	
(3)	Meeting with HSC/IGA	Plan
		Actual
(4)	Development of activity plan of term 4 with JICA Kenya office, C/P of the MOH and the other stakeholders	Plan
		Actual
【4】	**Developemnt of Activity Plan**	
(1)	Start-up meeting with JICA Kenya office and C/P of the MOH	Plan
		Actual
(2)	Start-up meeting with CHMT, SCHMT and other stakeholders and data collection	Plan
		Actual
(3)	Submission of the draft of activity plan to JICA Kenya office and MOH	Plan
		Actual
(4)	Holding conference to discuss activity plans and PDM revision	Plan
		Actual
【5】	**Development of PDM**	
(1)	Submission of the first draft of PDM developed based on the activity 【1】【2】【3】	Plan
		Actual
(2)	Discussion of first draft of PDM with JICA Kenya Officer	Plan
		Actual
(3)	PDM developemnt workwhop with partner counties (about current output 2)	Plan
		Actual
(4)	Discussion of PDF final draft with JICA Kenya office and C/P of MOH	Plan
		Actual

Work Activity Chart Term 4

Activity	Plan/Actual	2018								2019								
		May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Output 1: Mutual support and learnings among MOH and CDOHs are strengthened through IGF and other mechanisms.																		
Activity 1-4 : [Health Sector Coordination and Inter Governmental Affairs(HSC/IGA)] Convene Inter-governmental Health Forum (IGF)between two levels of government to discuss issues of commoninterest.																		
1-4.1 Finalize Operation Guideline	Plan																	
	Actual																	
1-4.2 Techical Assistance to IGF when held	Plan	The IGF were not held regularly and the plan kept on being postponed.																
	Actual																	
Activity 1-5 : Share the lessons learnt of the Project through existing fora and other occasions between counties.																		
1-5.1 Share the lessons learnt of the Project through study tours and other occasions	Plan																	
	Actual																	
1-5.2 Share the lessons learnt of the Project through IGF and MOH homepage.	Plan																	
	Actual																	
Output 2: MTEF cycle management (Planning, budgeting, implementation and monitoring) is strengthened in CDOHs of Partner Counties.																		
Activity 2-3 : Provide technical assistance for the health sector MediumTerm Expenditure Framework [MTEF] cycle (or planning,budgeting and review cycle) to the partner counties.																		
2-3.1 Provide technical assistance to APR and AWP	Plan																	
	Actual																	
2-3.2 Conduct monitoring, supportive supervison on activites, expenditures and review of prioritized health indicators of the county.	Plan																	
	Actual																	
2-3.3 Develop MTEF tools and train the targeted group on how to use plan	Plan																	
	Actual																	
Activity 2-4 : [Partner Counties] Document experience and lessons-learnt from implementation of MTEF and AWP cycle in the partnercounties.																		

2-4.1 Document utilization of the MTEF tools and extract lessons learned.	Plan																	
	Actual																	
2-4.2 Document the whole MTEF cycle experience and extract lessons learned	Plan																	
	Actual																	
2-4.3 Document the lessons learned from other Project supported activities from study tours, Strategic Plan development and Sensitization event for assembly members.	Plan																	
	Actual																	
Activity 2-5 : [Partner Counties] Provide feedbacks to inter-governmental frameworks on lessons learnt.	Plan																	
	Actual																	

Input of the Project Experts

The details of the project experts dispatched during project period from June 2014 to September 2019 is shown below.

The detail od the Project Experts

Position	Name	Assignment Period	M/M
1st Term : November 2014 – May 2015			
Chief Advisor	Mr. Tsuyoshi Ito	① Nov – Dec 2014 (22 days) ② Jan 2015 (22 days) ③ Mar – Apr 2015 (34 days) ④ May 2015 (23 days)	3.37 MM
Deputy Chief Advisor/Health System Management	Mr. Naoki Take	① Nov – Dec 2014 (37 days) ② Jan – Mar 2015 (71 days) ③ May 2015 (23 days)	4.60 MM
Community Health Planning	Ms. Kaori Saito	① No – Dec 2014 (19 days) ② Jan – Apr 2015 (88 days) ③ Apr – May 2015 (38 days)	4.60 MM
Health Monitoring and Evaluation	Ms. Chiaki Kido	① Feb – Mar 2015 (23 days) ② Apr – May 2015 (33 days)	1.87 MM
Training Planning	Ms. Kunika Wakamatsu	① Jan – Feb 2015 (23 days) ② Apr – May 2015 (33 days)	1.87 MM
Communication and Advocacy	Ms. Akiko Tsuru	① Jan – Mar 2015 (56 days)	1.87 MM
Project Coordinator/Training Coordination	Ms. Kayoko Takaki	① Nov – Dec 2014 (36 days) ② Apr 2015 (17 days)	1.77 MM
2nd Term : August 2015 – June 2017			
Chief Advisor	Mr. Tsuyoshi Ito	① Aug – Dec 2015 (114 days) ② Jan – Mar 2016 (70 days) ③ May – Jul 2016 (78 days) ④ Aug – Nov 2016 (107 days) ⑤ Jan – Apr 2017 (76 days) ⑥ May – Jun 2017 (33 days)	15.93 MM
Health System Management/County	Ms. Kaori Saito	① Aug – Dec 2015 (122 days) ② Jan – May 2016 (135 days)	16.13 MM

Health Planning		③ Jun – Sep 2016 (77 days) ④ Oct – Dec 2016 (56 days) ⑤ Mar – Jun 2017 (94 days)	
Health Monitoring and Evaluation	Ms. Chiaki Kido	① Sep – Oct 2015 (21 days) ② Nov – Dec 2015 (40 days) ③ Feb – Apr 2016 (50 days) ④ Oct – Nov 2016 (30 days) ⑤ Jan – Feb 2017 (35 days)	5.87 MM
County Training Planning	Ms. Kunika Wakamatsu	① Jan – Feb 2016 (29 days)	0.97 MM
County Training Planning	Ms. Yumiko Inoue	① May – Jun 2016 (50 days) ② Nov – Dec 2016 (40 days) ③ Jan 2017 (7 days) ④ Jan – Mar 2017 (44 days)	4.70 MM
County Health Human Resource Development	Ms. Hazel Miseda Mumbo	① Sep – Nov 2015 (91 days) ② Mar – Apr 2016 (61 days) ③ Sep – Nov 2016 (91 days) ④ Mar – Jun 2017 (102 days)	11.50 MM
Project Coordinator/Horizontal Learning	Ms. Kayoko Takaki	① Aug – Oct 2015 (60 days) ② Jan – Feb 2016 (30 days) ③ Apr – May 2016 (51 days) ④ Jul – Sep 2016 (35 days)	5.87 MM
Project Coordinator/Horizontal Learning	Ms. Hiromi Kono	① Nov – Dec 2016 (37 days)	1.23 MM
Project Coordinator/Horizontal Learning	Ms. Tomoko Shibuya	① May – Jun 2017 (44 days)	1.47 MM
3rd Term : January 2018 – April 2018			
Chief Advisor／Health System Management1	Ms. Shioko Momose	① Jan – Feb 2018 (51 days) ② Mar – Apr 2018 (23 days)	2.47 MM
Assistant Chief／County Health Planning)	Dr. Yasushi Sawazaki	① Jan 2018 (26 days) ② Mar – Apr 2018 (35 days)	2.03 MM
Public Finance and	Mr. Nobuyuki	① Jan – Apr 2018 (80 days)	2.67 MM

Administrative Operation Advisor (CDOH)	Hashimoto		
Health System Management 2	Ms. Tomoko Shibuya	① Jan 2018 (15 days) ② Mar – Apr 2018 (9 days)	0.80 MM
Project Coordinator／Training Programme	Mr. Shinichi Kimura	① Jan – Apr 2018 (93 days)	3.10 MM
4th Term : May 2018 – September 2019			
Chief Advisor／Health System Management1	Ms. Shioko Momose	① May – Jun 2018 (48 days) ② Jul – Sep 2018 (50 days) ③ Oct – Dec 2018 (64 days) ④ Jan – Apr 2019 (89 days) ⑤ May – Jul 2019 (70 days) ⑥ Aug – Sep 2019 (44 days)	12.17 MM
County Health Planning	Dr. Yasushi Sawazaki	① Sep – Oct 2018 (52 days) ② Feb – Mar 2019 (52 days)	3.47 MM
County Health Management Advisor (Public Finance and Administration Operation (1))	Mr. Nobuyuki Hashimoto	① May – Jul 2018 (50 days) ② Aug – Oct 2018 (61 days) ③ Nov – Dec 2018 (28 days) ④ Jan – Mar 2019 (74 days) ⑤ May – Jul 2019 (55 days) ⑥ Aug – Sep 2019 (41 days)	10.30 MM
MTEF Cycle Operation Advisor (Public Finance and Administration Operation (2))	Ms. Yuki Kobayashi	① May – Jul 2018 (57 days) ② Jul – Oct 2018 (69 days) ③ Nov 2018 (14 days) ④ Dec 2018 (8 days) ⑤ Feb – Apr 2019 (51 days) ⑥ Jun – Jul 2019 (39 days) ⑦ Aug – Sep 2019 (42 days)	9.33 MM
IT Tool Development Expert (Public Finance and Administration Operation (3))	Ms. Rena Mizuno	① Aug – Sep 2018 (32 days) ② Jan – Mar 2019 (49 days) ③ May – Jun 2019 (26 days)	3.57 MM
Health System Management 2	Ms. Tomoko Shibuya	① Jul – Oct 2018 (82 days) ② Jan – Mar 2019 (68 days)	6.83 MM

		③ May – Jul 2019 (55 days)	
Project Coordinator／Training Program	Mr. Shinichi Kimura	① May – Jul 2018 (69 days) ② Oct – Dec 2018 (64 days) ③ Mar – Apr 2019 (35 days) ④ Jul 2019 (25 days) ⑤ Aug – Sep 2019 (44 days)	7.90 MM

Workshops and Trainings

The detail of Workshops and Trainings conducted from November 2014 to September 2019 is shown below.

The detail of workshops and trainings

Training	Period	Participants	Place
Situation and Problem Analysis Workshop on MTEF Cycle Management	4 to 6 Nov 2015	30 ×3 days（CHMTs, SCHMTs）	Kericho
Detailed Action Planning Workshop	30 Nov 2015	30（CHMTs, SCHMTs）	Kericho
Situation and Problem Analysis Workshop on MTEF Cycle Management	11 to 13 Nov 2015	25 ×3 days（CHMTs, SCHMTs）	Kirinyaga
HSC/IGA Department Workshop on Scheduling	15 Dec 2015	10	Nairobi
Sensitization Meeting for CHMT on AWP Planning	8 Mar 2016	30（CHMTs, SCHMTs）	Kirinyaga
Workshop Training on MTEF	21 to 22 Apr 2016	30 ×2 days（CHMTs, SCHMTs）	Kirinyaga
MTEF and AWP Planning Process	11 May 2016	30（CHMTs, SCHMTs）	Kericho
Training on Basic Management Skills	30 Jun 2016	25	Kericho
Preparation of the Draft Kericho County M&E Framework	26 to 27 Jul 2016	15 ×2 days（CHMTs, SCHMTs）	Kericho
M&E Planning Meeting	7 Sep 2016	20（CHMTs, SCHMTs）	Kirinyaga
Finalization of the Priority Setting of Kericho CDOH	1 to 2 Mar 2017	30 ×2 days（CHMTs, SCHMTs）	Kericho
MTEF/AWP Planning Process Review Workshop	20 Apr 2017	30（CHMTs, SCHMTs）	Kericho
Quarterly Data Monitoring Meeting	21 Apr 2017	15（CHMTs, SCHMTs）	Kericho
AWP Orientation Meeting for Community Units and Primary Health Care Facilities	16 May 2017	15（CHMTs, SCHMTs）	Kirinyaga
AWP Stakeholders Meeting	9 Feb 2018	38（CHMT、SCHMT、Stakeholders）	Kericho
AWP Sensitization Training to SCHMT Members	12 Feb 2018	47 人（CHMT、SCHMT）	Kericho
AWP Sensitization Training to Health Facilities	20 to 22 Feb 2018	30×6 subcounty×4 days（CHMT、SCHMT）	Kericho
AWP Sensitization Workshop for Sub Counties and Health Facilities	2 Mar 2018	87（CHMT, SCHMT, Hospital/HCs）	Kirinyaga
Annual Workplan /Budget Review by Health Managers	5 to 6 Mar 2018	32×2 days（CHMTs, SCHMTs）	Kirinyaga

AWP Sensitization for Community Unit Reps and CHEWs	8 Mar 2018	116（CHMT, Sub County HF staffs, CHEW and CHV）	Kirinyaga
CDOH AWP 2018/19 Consolidation Workshop	20 to 22 Mar 2018	9×3 days（CHMT, SCHMT）	Kirinyaga
AWP Consolidation Workshop	19 to 21 Mar 2018	9×3 days（CHMT, SCHMT）	Kericho
AWP Stakeholder Meeting	28 Mar 2018	26（CHMT, SCHMT, HMT, Education Dept., Partners）	Kericho
Stakeholder's Meeting for AWP	6 June 2018	36（CHMT, SCHMT, HMT, Partners）	Kirinyaga
MTEF Tool Training for Kirinyaga's Sub-County CHRIOs	11 Jun 2018	13（SCHMT）	Kirinyaga
Kisumu Study Tour on Community Health Strategy	19 Jun 2018	41（CHMT）	Kisumu
Kisumu Study Tour, Airport Health Center, Kongony & Airport CU visit	20 Jun 2018	37（CHMT）	Kisumu
Strategic Plan Development Workshop	3 to 6 Jul 2018	35×4 days（CHMT, SCHMT）	Kirinyaga
Data Review Training and MTEF tools	5 to 6 Jul 2018	20×2 days（CHMT, SCHMT）	Kericho
Strategic Plan Development Workshop	9 to 12 Jul 2018	23×4 days（CHMT, SCHMT）	Kericho
APR Kick-off Workshop	1 Aug 2018	36（CHMT, SCHMT）	Kericho
Strategic Plan Finalization Workshop	8 to 10 Aug 2018	22×3 days（CHMT, SCHMT）	Kirinyaga
Consolidation of APR by SCHMT	23, 24, 27, 28 Aug 2018	30×4 days（SCHMT）	Kericho
Workshop for Introduction of APR Template to CHMT and SCHMT	31 Aug 2018	43（CHMT, SCHMT）	Kirinyaga
TOT for MTEF Tools	3 to 4 Sep 2018	22×2 days（CHMT, SCHMT）	Kericho
Consolidation of the Sub County APR Workshop	6 to 7 Sep 2018	28×2 days（SCHMT）	Kirinyaga
Data Review and MTEF Tools Dissemination	6 to 7 Sep 2018	28×2 days（CHMT, SCHMT）	Kericho
APR Consolidation	10 to 14 Sep 2018	19×5 days（CHMT, SCHMT）	Kericho
TOT for MTEF Tool	13 to 14 Sep 2018	25×2 days（CHMT, SCHMT）	Kirinyaga
APR County Consolidation Workshop	17 to 19 Sep 2018	22×3 days（CHMT, SCHMT）	Kirinyaga
TOT2 for MTEF Management Tool	24 to 25 Sep 2018	18×2 days（CHMT, SCHMT）	Kericho
TOT Training for MTEF Tools	3 to 4 Oct 2018	24×2 days（CHMT, SCHMT）	Kericho
Data Review and & MTEF Data Entry Meeting	8 to 9 Oct 2018	37×2 days（CHMT, SCHMT）	Kericho

Facility in Charge Meeting	16 Oct 2018	68（CHMT, SCHMT）	Kirinyaga
Annual Performance Report Validation/County Annual Performance Template Consolidation	18 to 19 Oct 2018	27×2 days（CHMT, SCHMT）	Kirinyaga
APR, UHN and Strategic Plan Workshop	22 to 26 Oct 2018	15×5 days（CHMT, SCHMT）	Nakuru
APR Stakeholders Meeting	13 Nov 2018	41（CHMT, SCHMT）	Kirinyaga
Data Review Meeting	6 to 7 Dec 2018	32×2 days（CHMT, SCHMT）	Kericho
Kericho Health Summit Meeting	18 Jan 2019	70（CHMT, SCHMT and others）	Kericho
Mid-Term Review of Kirinyaga Annual Workplan 2018/2019	24 Jan 2019	77（CHMT, SCHMT）	Kericho
TOT Meeting for MTEF Management Tool	25 Jan 2019	36（CHMT, SCHMT）	Kericho
TOT for MTEF Management Tool	30 Jan 2019	53（CHMT, SCHMT）	Kirinyaga
CHMT-SCHMT Sensitization Workshop for AWP	7 Feb 2019	48（CHMT, SCHMT）	Kericho
Health Facilities Sensitization and Training	12 to 15 Feb 2019	100×4 days（CHMT, SCHMT and others）	Kericho
Introduction to MTEF Management tool ver 2.5	18 Feb 2019	18（CHMT, SCHMT）	Kirinyaga
AWP Sensitization Meeting for CHEWS, Sub-county and HF	28 Feb to 1 Mar 2019	85×2 days（SCHMT）	Kirinyaga
SCHMT Consolidation	12 to 15 Mar 2019	48×4 days（SCHMT）	Kericho
SCHMT AWP Consolidation	19 to 21 Mar 2019	29×3 days（SCHMT）	Kirinyaga
CHMT AWP Consolidation	19 to 21 Mar 2019	30（CHMT, SCHMT）	Kericho
CHMT AWP Consolidation	26 to 28 Mar 2019	21×3 days（CHMT, SCHMT）	Kirinyaga
AWP Stakeholders Meeting	5 Apr 2019	36（CHMT, SCHMT and others）	Kirinyaga
TOT4 for 2018/2019 Data Compilation and Facilitator Training Meeting	28 to 29 May 2019	24×2 days（CHMT, SCHMT）	Kirinyaga
TOT4 for FY 2018/2019 Data Compilation and Facilitator Training	3 to 4 Jun 2019	22×2 days（CHMT, SCHMT）	Kericho
AWP Process Review with AWP Handbook Validation and APR Preparation Workshop	18 Jun 2019	35（CHMT, SCHMT）	Kirinyaga
AWP Process Review with AWP Handbook Validation and APR Preparation Workshop	25 Jun 2019	32（CHMT, SCHMT）	Kericho
Mutual Learning Forum (Kericho + Kirinyaga + Nyeri)	2 Jul 2019	47（CHMT, SCHMT）	Kirinyaga
APR Sensitization and	16 Jul 2019	41（CHMT,	Kericho

Allocation with CHMT/SCHMT		SCHMT）	
APR Sensitization and Allocation with Hospital	17 Jul 2019	42（CHMT, SCHMT）	Kericho
APR Sensitization and Allocation of CHMT/SCHMT and Hospital	19 Jul 2019	57（CHMT, SCHMT）	Kirinyaga
APR CHMT Consolidation	20 to 23 Aug 2019	43×4 days（CHMT, SCHMT）	Kericho
APR SCHMT Consolidation	21 to 23 Aug 2019	27×3 days（CHMT）	Kirinyaga
APR CHMT Consolidation	27 to 29 Aug 2019	30×3 days（CHMT, SCHMT）	Kirinyaga
APR County Consolidation	27 to 30 Aug 2019	15×4 days（CHMT、SCHMT）	Kericho
TOT5 final (Keying in Approved Budget; Facilitator certification)	3 to 4 Sep 2019	25×2 days（CHMT、SCHMT）	Kirinyaga
APR Validation Workshop	6 Sep 2019	40×1 days（CHMT, SCHMT）	Kericho
APR Validation Workshop	9 Sep 2019	28（CHMT, SCHMT）	Kirinyaga
TOT5 final (Keying in Approved Budget; Facilitator certification)	9 to 10 Sep 2019	25×2 dyas（CHMT、SCHMT）	Kericho
APR Stakeholder Meeting	12 Sep 2019	45（CHMT, SCHMT, Stakeholders）	Kericho
APR Stakeholder Meeting	18 Sep 2019	45（CHMT, SCHMT, Stakeholders）	Kirinyaga

Minutes of Project Steering Committee Meeting
For Organization Capacity Development Project for the Management of Devolved Health Systems in Kenya
Tuesday, 9th Dec 2014
9:30am – 12:15pm
The Heron Portico Hotel, Milimani, Nairobi

ATTENDANCE

No.	Name	Title	Organization/Department	Comment
1	Dr David Kiima	SDDMS	Head, Department of HSC & IGA , MOH	Chair
2	Dr John Kihama	DDMS	Department of HSC & IGA, MOH	
3	Dr Nancy M. Njeru	ACP	Department of HSC & IGA, MOH	Taking Minutes
4	Mr. Tsuyoshi Ito	Chief Advisor	MoH/JICA Project	
5	Mr. Naoki Take	Deputy Chief Advisor	MoH/JICA Project	
6	Ms. Kayoko Takaki	Project Coordinator	MoH/JICA Project	
7	Prof. Satoru Watanabe	JICA Advisor at MoH	MoH/JICA Project	
8	Ms. Kumiko Yoshida	Project Formulation Advisor	JICA Kenya	
9	Mr. Elijah Kinyangi	National Programme Officer	JICA Kenya	
10	Dr Jackson Kioko	SDDMS	Head, Department of PPS	
11	Dr. Rael Mutai	SADMS	Division of Health Care Financing, MOH	
12	Dr. P. Santau Migiro	DDMS	Department of Curative and Rehabilitation Health Services, MOH	
13	Ms. Jenovefa Njoroge	Ass. Director	Division of MOH, MOH	
14	Ms. Catherine Mahihu	Admin. Officer	MoH/JICA Project	Taking Minutes
15	Ms. Kaori Saito	County Health Planning Specialist	MoH/JICA Project	

AGENDA

1. Opening Remarks
2. Self-Introductions
3. Confirmation of Agenda
4. Frame work and strategy for the project (JICA)
5. Establishment of Intergovernmental Affairs Secretariat
6. Members of Kenyan Counterpart
7. Members of Project Steering Committee (PSC)

8. Planned activities for the project (JICA)
9. AOB
10. Remarks (JICA)
11. Closing Remarks (MOH)

BRIEF DESCRIPTION

Min 1: Opening Remarks (MOH)

The Chair, Dr. David Kiima, gave the welcoming remarks. The Director of Medical Services, Dr. Nicholas Muraguri, sent his apologies for his absence. Dr. Kiima chaired the meeting on his behalf.

Min 2: Self-Introduction

The Chair asked members to make introductions.

Min 3: Confirmation of Agenda

The agenda was adapted as stated.

Min 4: Framework and Strategy for the Project (JICA)

The presentation by Mr. Ito introduced the background to the 5 year project whose overall goal is that devolved health systems are strengthened to ensure equitable and quality services in achieving universal health coverage in entire Kenya. The presentation (done in phases) gave details of the project purpose, immediate outcomes, discussed the strategies of the project, the proposed activities, the various stages of the project and proposed processes of strengthening coordination and clarification of roles and responsibilities. Discussions were made at length especially in line with the timelines presented; coverage of the 47 counties; the need to shorten the pilot phase and carry out the actual implementation of the project; and the actual technical capacity of JICA team to implement the project.

DISCUSSIONS OF FRAMEWORK AND STRATEGY OF THE PROJECT

a) Standardization of training

- The project proposed extracting important elements from the existing training curriculum to make sure they are useful and responds to the demands of the counties. However, this will be done through a consensus effort with other stakeholders.
- This process of the project will have a focus in managerial aspects at county level.

- Discussions and consensus formulation with stakeholders will be important to harmonize existing training with demands of the counties.

b) Situation analysis scope

- The situation analysis will assist the project to understand the existing structure of CHMTs, service provision, health performance and other conditions of the counties. A standard structure of CHMT is available but the analysis will investigate what is actually being implemented.
- Dr. Jackson Kioko spear-headed the structuring process of CHMTs across the country although some counties have changed the structure. This could be used as a starting point.
- Situation analysis will involve three main activities – 1) literature review, 2) questionnaire survey, and 3) visit of 5 counties in urban, rural and arid and semi-arid areas.
- Situation analysis will consider the results from the 2nd National Leadership Management and Governance Assessment being currently undertaken.

c) Training in the 2nd and 3rd Stage

- The 2nd stage activities of undertaking “trials” of the training and the horizontal learning mechanism at the partner counties can be changed to state “piloting” instead to prevent making it sound like an experiment.
- The Project proposed that the 2nd stage can be flexible and activities in the 3rd stage can be moved forward to the 2nd stage. Plans for further activities can be concluded later.
- Clustering of counties in terms of regions (former provinces) will be considered during training. Trainings can be organized for a group of 5 counties, then 10 counties but these activities will be revised based on discussions with the MOH counterparts.

d) Scope of the project

- Concerns were raised regarding the capacity and efficiency to reach all 47 counties including the National Government, and capacity build all counties and achieve overall goal of the project - the ability of the project to carry out capacity building in the last two years of the project was raised. JICA has sufficient capacity to implement the project nationwide as it is focusing on the managerial and not the technical capacities
- Counties involved in other initiatives organized by DPs may have different understanding of the roles of CHMTs.
- Need linkage with other capacity development initiatives, best practises from other JICA projects and engagement with political leaders for accessing resources.

e) Financial input

- The project budget covers coordination activities, outreach and training programs.

f) Other discussions

- The role of partner counties is to work together to standardize the training before going to the rest of the counties.

- A selection criterion for the counties (in first stage) will be done in consultation with the Ministry
- The Chair requested the project to provide further clarification of "trial and piloting" of the training and the horizontal learning mechanism at the partner counties.
- The Chair also requested the project to clarify whether the project will go to levels below CHMTs. The project replied it focuses on County Health Management Teams (CHMT) and not the facility management teams.
- A situation analysis for the current structures and operations of CHMTs at the counties will be done and presented to the National Health and Leadership Congress. However, the Kenya Health Policy and the National Health Sector Strategic Plan and the Ministerial Sector Strategic plans as well as the integrated County plans will be considered to inform the CHMT structures.
- From the onset, Constitution of Kenya, the Devolved Acts of County Governments, the Inter-governmental Acts, the Inter-governmental Forum, and Council of Governors need to be considered in implementing the project. This will be coupled with overall alignment to avoid duplication in Capacity building activities where engagement of other development partners will be done at a different platform to enhance alignment of capacity building activities.
- After the situation analysis informs the planning, we will know which counties are doing poorly and which are willing to participate. No bias should be directed towards some counties.
- Other elements need to be included such as the Kenyan Health Policy, National Health Sector Strategic Plan, Ministry's Health Strategic Plan, and Integrated County Strategic Plan.
- Need to work with heads of departments and ensure the CS and PS are in the know and informed what will be impacted. Also, the need to follow due process to incorporate county representation early enough in the project initiation stage was emphasized.
- Need to take stock of how many trainings are going on parallel to each other.
- Inter-governmental issues are the main objectives of the project. The project has two different platforms: to strengthen the inter-governmental arm and also provide capacity development.

Min 5: Establishment of Inter-governmental Affairs Secretariat

- Dr. David Kiima is the Head, Department of Health Sector Coordination and Inter-governmental Affairs
- Dr. Kihama was proposed as the contact person for Health Sector coordination & Intergovernmental Affairs (HSC & IGA)
- The council of governors needs a secretariat as well for ease of communication

- The last meeting identified these thematic issues to be reported to the Inter-governmental Forum:
  - HR for Health
  - Healthcare Financing
  - Medical Equipment
  - Health Products & Technology
- The project will incorporate the useful comments and questions discussed in the meeting regarding the WP. The PS will approve or appoint someone to approve the WP and share with the DMS and CS.
- The project needs to be presented to the Sector forum set for 15th March 2015 for buy in and consultation and followed thereafter with the official launch of the project

Motion was moved by the Chair to approve what the project presented in draft form of the WP and the project will incorporate the comments based on the meeting discussions and the MOH will review and incorporate any missing information and present to DMS, PS and CS for approval. Motion carried.

Min 6: Members of Kenyan Counterparts

- The Chair pointed out that there is need to look at the Ministerial Strategic Plan and see where this WP fits and those individuals involved in those areas will be the project's counterparts.
- The coordination mechanism falls under DMS, and the docket of Policy, Planning and Health Financing. Someone will be identified from this department.
- The Human Resource Development (HRD) department will be highly involved in the project.
- PS had identified HRD as the main department for the project. However, there is still confusion regarding the appropriate lead department for the project.
- HRD does training and coordination but the technical part is not HR's alone. The Health Policy and Planning department falls under the coordination docket according to the constitution.
- Other counterparts can be picked from other directorates under the umbrella of HRD.
- HRD can lead the process. The head of HRD can be the main contact person or delegate the main contact person.
- The Chair can do a write up to the heads of departments to appoint someone to be the counterpart and these names forwarded to HRD. Mr. ITO will provide the areas of need for counterparts

Min 7: Members of the Project Steering Committee (PSC)

- Dr. Kiima, Head HSC & IGA was proposed as the projector manager. Other heads of departments form the Project Steering Committee.
- Council of Governors can nominate one person to join the Committee (Director of County Health or CHC for Health) including County Secretariat under the Health Sector.
- Ensure invitation is done officially to the Chair or Vice Chair requesting this type of representation in our committee.
- PS/Chair can write to the CEC for health requesting representation in the project.
- The letter to CEC should be sent before the next PSC meeting requested to be held in January to finalize committee membership.
- DPs can be engaged in other forums.

Min 8: Planned Activities for the project (JICA)

Discussion of project activities

- Official launch of the project: Needs to be launched to inform stakeholders. Announcement of the project can be done at the next congress then launched separately if possible by the CS.
- Another forum other than the National Health and Leadership Congress should be selected to introduce the concepts modified in Activity 2 with County Executives for Health Form.

Min 9: Closing Remarks from JICA and MOH

- Both the JICA Kenya representative and Chair thanked everyone for coming and sharing their input and giving good responses and feedback.
- Support from this project will assist universal coverage to be realized. Need for devolution support.
- Both JICA team and MOH will ensure that the project succeeds and is an example in the health sector.

POST MEETING ACTIONS

No.	Action	Assigned To	Timeline
1.	Project be presented in the Sector Forum on 15th March 2015	Project and MOH	
2.	Revise work plan to address comments given	Mr Ito	Jan 2015
3.	Share the discussion progress with the DMS, CS & the PS	Dr Kioko/Dr Kiima	11th Dec 2014

4.	Follow up for county representation (Write letter)	Dr Kihama	11th Dec 2014
5.	Identification of officers by each Directorate(Write letter)	Dr Kihama	
6	Project to provide further clarification on "trial/ piloting" of the training and the horizontal learning mechanism at the partner counties.	Project	
7	The project to provide clarification on whether it intends to go to levels below CHMTs.	Project	
8	Elements to be included in the situation analysis: The Constitution, the Devolved Acts of County Governments, the Inter-governmental Acts, Kenyan Health Policy, **National Health Sector Strategic Plan**, Ministry's Health Strategic Plan, and Integrated County Strategic Plan.	Project and MOH	
9	Involvement of the Inter-governmental Forum, Council of Governors, CS, PS and Heads of Departments	Project and MOH	
10	Share areas of need for counterparts	Mr. ITO	
11	Liaise with those coordinating the congress to see if the project announcement can be included.	Project and MOH	

MEETING END TIME: **12.15pm**

DATE OF NEXT MEETING: **January 2015. Final date to be announced.**

Minutes of Project Steering Committee Meeting on

Organization Capacity Development Project for the Management of Devolved Health Systems in Kenya

Monday, 9th February 2014

9:00am – 1:00pm

The Sarova Panafric Hotel, Nairobi

Attendance

No.	Name	Title	Organization/Department
1	Dr. Nicholas Muraguri (Chair of the meeting)	Director of Medical Services	MOH
2	Dr David Kiima	Head	Department of HSC & IGA MOH
3	Dr. Maurice P. Siminyu	Chair of CEC Council	CEC Health, , Busia County
4	Dr. Izaq Odongo	Head	Department of Curative and Rehabilitation Health Services, MOH
5	Dr. Jackson Kioko,	Head	Department of Preventive and Promotive Health, MOH
6	Mr. Fred E'O'G Mwango		Department of Administration, MOH
7	Mr. David Njoroge	Head	Human Resource Development Division, Department of Administration, MOH
8	Mr. M.S. Gitaru	Head	Human Resource Management Division, Department of Administration, MOH
9	Dr. Charles Kandie	Head	Quality Assurance Division, Department of Standard, MOH
10	Dr John Kihama	Head of division	Inergovrenmental Affairs Division, Department of HSC & IGA, MOH
11.	Dr. Jackson Omondi	Head of Division	Health Sector Coordination
11	Ms. Maki Ozawa	Deputy Director	JICA Human Development Department, JICA
12	Mr. Elijah Kinyangi	National Programme Officer	JICA Kenya
13	Prof. Satoru Watanabe	JICA Advisor at MoH	MoH/JICA
14	Mr. Tsuyoshi Ito	Chief Advisor	MoH/JICA Project
15	Mr. Naoki Take	Deputy Chief Advisor	MoH/JICA Project
16	Ms.Kaori Saito	County Health Planning	MoH/JICA Project
17	Ms. Kunika Wakamatsu	Training Planning	MoH/JICA Project
18	Ms. Akiko Tsuru	Communication and Advocacy	MOH/JICA Project
19	Ms. Kayoko Takaki	Project Coordinator	MoH/JICA Project
20	Ms. Catherine Mahihu	Admin. Officer	MoH/JICA Project

Agenda

1. Opening Session Speeches
    a. Head/HSC&IGA – Dr. David Kiima
    b. JICA Kenya – Mr. Elijah Kinyangi
    c. Chairperson Health CEC – Dr. Maurice P. Siminyu
    d. Opening Remarks and launching of the PSC - Director of Medical Services – Dr. Nicholas Muraguri
2. Project briefing (Framework, strategy, management structure and latest situation of the progress) and Briefing on Project Work Plan – Project Team
3. Plenary Discussions
4. Way forward

The meeting was called to order at 9 am by the moderator, Head/Health Sector Coordination & Inter Governmental Affairs, Dr. David Kiima. The meeting started with a word of prayer by Ms. Eunice Ambani followed by self-introductions, after which Dr. Kiima gave the welcoming remarks and an overview of the objective of the meeting.

Min.1/02/09: Opening Session – Moderator: Dr. David Kiima (Head/HSC&IGA)

Elijah Kinyangi; JICA Team Rep: - Mr. Kinyangi appreciated all the members for taking the time to attend the 1st PSC meeting. He noted JICA was excited to launch the project as a follow-up of the work done by the SEMAH Project in Nyanza, providing a platform to roll-out to all the other 47 counties. He also pointed out that JICA was pleased that the Chairperson of Health CEC, Dr. Siminyu was in the meeting to share perspectives from the counties. He finally noted that the meeting was an opportunity to share information related to the project have a common understanding on the strategies for the project and he looked forward to its successes.

Opening Remarks and Launching of the PSC Dr. Muraguri: Director of Medical Services: - In his remarks, Dr. Muraguri was grateful and pleased to be part of the meeting. He announced that he had visited 42 counties in past six months, and during his visit he witnessed the willingness and passion for devolution in the counties. After the reorganization of services, changes at managerial levels and the political aspect, what he expected to find was competent people in the right positions, but he found a mixed grill with people in important positions that did not match their skill sets. He recognized that the project was very much aligned with the plans of MOH. He recognized that the current situation affected certain services such as procuring drugs, service delivery, resource allocation and human resource management. The Director reiterated that support was needed at county level to deliver on their mandate and there were functions at county level that cut across all

the directorates and decisions being made at county level affected the national level. He also added that lower levels at counties needed to know how to organize themselves. Certain challenges that the Director noted including: allocation of budget, quantification of commodities, and management of important contracts. He concluded by noting that the JICA support was welcomed. There was a lot of information from the SEMAH project in Nyanza where Dr. Kioko, Head/PPH, was a part of, and there was need to build on the good work done by the last project. He emphasized that he was personally available to chair the quarterly PSC meetings, and for day-to-day affairs, Dr. Kiima would be available. He reaffirm that the leadership (both the PS and CS) of MOH was very supportive and available for consultation. He stated that he looked forward to a fruitful output and counties were ready to be engaged and both arms of government were in support of each other. Finally the Director appreciated and commended Dr. Siminyu's support and work in mobilizing the counties.

Rep of Secretary Administration – MOH, Mr. Fred Mwango: Mr. Mwango, appreciated being part of the meeting and the project because there was a lot of discrepancies and disharmony regarding what pertains and operates at the county and what operates and pertains at the national level, and since the national level is supposed to administer the policies in the health sector, he noted he was glad that the national level was beginning the process through concurrence, cooperation and consensus.

Head/Preventive and Promotive Health – Dr. Jackson Kioko: Dr. Kioko reiterated that the lessons learnt through the SEMAH project would be applied in the project and his full support for the process was guaranteed.

Chairperson Health CECs Forum – Dr. Maurice P. Siminyu: In his remarks, Dr. Siminyu conceded that rapid devolution of the health sector brought a lot of problems, but those on the ground welcomed the change. He also pointed out that the counties tried to be independent since the constitution regards them as distinct governments. However, counties were inter-dependent and operate by cooperation and consultation and therefore there must be a cooperation mechanism that allows counties and the national level for mutual communication. He noted that counties were guided by the policies made at national level. Those policies are customized to county relevance, discussed at cabinet level, then passed at the county assembly, then approved by the Governor. At the county level, he noted that apart from the county cabinet, counties were guided by council of governors which have the summit, where communication with the national government was done and chaired by the President. He conceded that the channels of communication between the counties and the national level were a challenge, but now there would be a secretariat for the council of

county executives based in Delta house, Westlands, and in the future there would be a single secretariat both for the council of governors and the council of county executives. Dr. Siminyu pointed out county executives would want to make sure the health sector performed well, since health was viewed as a barometer of success of the devolution. He thanked the national government for Management Equipment Services (MES) project to the county governments for buying medical equipment for diagnostic, surgical and anesthetic use. He also pointed out that now county governors have increased the percentage of revenue given to the health sector (average 20-30%), which are going into development projects, ICUs, emergency units, sub-county hospitals, and new ambulances have increased significantly due to improved referral systems.

Min. 2/02/09: Project briefing (Framework, strategy, management structure and latest situation of the progress and Briefing on Project Work Plan – Chief Advisor, Mr. Tsuyoshi Ito, Deputy Chief Advisor, Mr. Naoki Take, County Health Planning, Ms. Kaori Saito and Communication and Advocacy, Ms. Akiko Tsuru)

Moderator: Project Manager, Dr. David Kiima

The Chief Advisor was grateful to all for coming to inaugurate the project. In his presentation, he noted there is need to develop a shorter name for the project which would be discussed in the near future. In the presentation, he described the project purpose and noted that the project may need to target a little wider than just CHMTs to cover other members of the county departments of health. In describing the three outcomes of the project purpose, he pointed out that the purpose of the coordination mechanisms development is to strengthen the department of HSE&IGA and through the department, support better coordination on the county side. The Chief Advisor also indicated the project does not intend to develop a new training program, but review existing training program and then re-organize and harmonize them to make them appropriately target development of necessary competencies of the counties. He stated that the project had been coordinating and closely working with HRD unit of MOH for devolvement of a common strategy regarding county training. As an practical approach for harmonization of training programs, the Chief advisor indicated that the project did not have intention to introduce a stand-alone training program, but with coordination with other partners, the project proposed to introduce categorization of training subjects in to basic, practical and advanced, which would be more suitable to the situation that a single standardized package of training may not be applicable for all counties due to differences in capacity of staff in the counties. He also emphasized the importance of a linkage between managerial planning and financial management, harmonization of county planning and sub-county or facility level planning. He also noted that horizontal learning would utilize the exiting experiences of counties, therefore the

goals would be to enhance the horizontal learning among counties and self-learning within the counties to allow them to be more self-reliant. He also indicated that for the impact assessment, the project would come up with indicators together with the HSC&IGA department.

The project team members also presented on areas they would be working as follows; harmonization of training programs through review of existing curriculum and supporting a training needs (TNA) assessment being conducted by Ministry of Health; Situation analysis in the 47 counties to grasp an overall picture of the current situations regarding county health systems; horizontal learning system and Mentoring and Evaluation.

Min. 3/02/09: Plenary Discussion

General areas of concern deliberated upon in the forum were as follows:

- Counterparts: Dr. Kiima announced that the names of the counterparts would be received soon. He also pointed out that HRM was inadvertently left out of PSC and should be included. Dr. Kiima was in consultation with department heads, some have not given the names of the people to be nominated. He anticipated submitting the names of the counterparts soon after DMS's approval.
- Allocations of funds for health sector in counties: The priorities for fund allocation are set by Governors' preference in counties and therefore, the amount and proportion of fund allocation for health in counties are varied. Dr. Siminyu shared an idea of regulating the fund allocation for health sector by National/County law (e.g. certain percentage of total budget should be allocated for health as of mandatory) to secure certain amount of budget for health related use, as Commission on Revenue Allocation (CRA) only allocates the budget, not involved in actual usage of the budget.
- Annual Work Plans (AWP) of counties: Dr. Siminyu mentioned some counties have developed or currently developing strategic plans, and the consultants were drawn from the national level and were aware of the national strategic plan. Mr. Njoroge pointed out that to maintain proper linkages between the counties and the national level, county strategic plans should be shared so they are in alignment with the national strategic plans and there is a planned TNA where both counties and the national government can share their AWPs.
- Structure of county department of health and CHMT: Dr. Siminyu noted that currently CHMTs are being reconstituted, through reshuffling, election or replacement of incompetent CHMT members, but competent CHMT members would retain their positions. In general, many of CHMT members are also heads of departments at county level and they are responsible for improving actual health service performance at sub-county and facility levels as well. Mr. Njoroge added that subjecting those who joining and existing CHMTs to the some parts of county training program would assist in mitigating changes and

maintaining sustainability of skills and competencies at county level. Mr. Ito clarified that the project would like to develop a common strategy with MOH and the project would support identifying areas of training and target people to be trained, but the main focus of the project would be on capacity building of CHMTs and county department of health for their health system management.

- Impact Assessment. The project intended to assess not only CHMTs but also the department as a whole, or assessment of the county health department could be added as one of the indicators.
- Training: Dr. Kioko suggested making customer management a compulsory training subject to reduce service quality gaps (Referring to the project briefing PPT).

Min 4/02/09:Way forward-Moderator: Dr. Kiima

- Need to separate inputs that would have an impact and those that would not fit to the project.
- Names of Kenyan project counterparts will be provided as soon as possible.
- PSC meeting will be held quarterly.
- PSC members to send comments on the Work Plan of the project by the end of the week (13th February) to Dr. Kihama and Mr. Ito. The Project team shall prepare a revised plan and share it with the PSC members through email by the end of the following week and thereafter, the work plan will be finalized.
- Dr. Siminyu would assist the selection of counties for situation analysis.
- PSC members need to link to prepare for the next PSC taking into consideration the county TNA, Kenya Health and Leadership Congress, HRH Conference and Inter-governmental Forum.

Min 5/02/09: Closing remarks

- Ms. Ozawa, expressed JICA's appreciation to the member of the PSC for their attendance to this 1st PSC meeting. She also explained that support for UHC and for management strengthening under the devolution were the priority issues for JICA, and eventually, the project was expected to contribute to health service provision in this country.
- Dr. Siminyu expressed his gratitude to JICA and PSC members for the commitment to the project.
- Dr. Kiima closed of the meeting.

END

Minutes of the Second Project Steering Committee Meeting for MOH / JICA Organization Capacity Development Project for the Management of Devolved Health Systems in Kenya

Date: Wednesday, 27th May 2015
Venue: The Silver Springs Hotel
Time: 9.00am to 1.30pm
Circulate to: All members of the project steering committee

PSC Members Present:

No	Name	Organization	Position
1.	Dr. David Kiima	MOH	Head, Dept. Health Sector Coordination & Inter-governmental Affairs
2.	Dr. Mohammed Kombo	Lamu County	CEC Health Services / Vice Chair, Council of County Health Executives
3.	Ms. Cirindi Murianki	MOH	Head, Human Resource Development Unit
4.	Dr. Jackson Omondi	MOH	Head, Division of Health Sector Coordination, Dept. Health Sector Coordination & Inter-governmental Affairs
5.	Mr. Julius Mutiso Mulonzi	MOH	Deputy Chief Health Records and Information officer, Dept. Health Sector Coordination & Inter-governmental Affairs
6.	Ms. Lydia Kamau	MOH	Quality Assurance Officer
7.	Ms. Kumiko Yoshida	JICA Kenya	Project Formulation Advisor
8.	Mr. Elijah Kinyangi	JICA Kenya	Program Officer
9.	Prof. Satoru Watanabe	JICA/MOH	JICA UHC / Health Financing Advisor
10.	Mr. Tsuyoshi Ito	JICA project	Chief Advisor
11.	Mr. Naoki Take	JICA project	Deputy Chief Advisor / Health Systems Management
12.	Ms. Kaori Saito	JICA project	County Health Planning Specialist
13.	Ms. Kayoko Takaki	JICA project	Project Coordinator / Training Coordinator
14.	Dr. Hazel Mumbo	JICA project	Training Coordination Specialist

In Attendance:

No	Name	Organization	Position
15.	Mr. Kenichi Ito	JICA HQ	Mission Leader, JICA Consultative Mission Team / Director, JICA Human Development Department
16.	Dr. Makoto Tobe	JICA HQ	Member, JICA Consultative Mission Team / Senior Advisor, JICA Human Development Department
17.	Ms. Maki Ozawa	JICA HQ	Member, JICA Consultative Mission Team / Deputy Director, JICA Human Development Department
18.	Ms. Catherine Mahihu	JICA project	Administration Officer
19.	Ms. Emi Onosaka	JICA project	Intern

Apologies:

No	Name	Organization	Position
20.	Dr. Nicholas Muraguri	MOH	Director of Medical Services
21.	Dr. Jackson Kioko	MOH	Head, Dept. of Preventive and Promotive Heath
22.	Dr. John Kihama	MOH	Head, Division of Inter-governmental Coordination, Dept. Health Sector Coordination & Inter-governmental Affairs
23.	Dr. Andrew Mulwa	Makueni County	CEC Health Services / Chair, Council of County Health Executives
24.	Dr. Elizabeth Ogaja	Kisumu County	CEC Health Services and Promotion of Health Investments / Secretary, Council of County Health Executives
25.	Mr. David Njoroge	MOH	Director, Huma Resource Management & Development

Agenda:

1. Welcome and Introduction - Dr. D. M. Kiima
2. Opening Remarks
   a. Head, Dept. HSC/IGA – Dr. D. M. Kiima
   b. Vice Chair, Council of County Health Executives – Dr. Kombo MB
   c. Mission Leader, JICA Consultative Mission Team – Mr. Kenichi Ito
   d. Head, Dept. HSC/IGA – Dr. D. M. Kiima, Rep for Director of Medical Services – Dr. N. Muraguri
3. Confirmation of the Minutes of 1st PSC Meeting
4. Progress of the Project - Project Team
5. Future Direction of the Project - JICA Mission Team
6. Plenary Discussions
7. Way forward
8. Closing Remarks
   a. Representative, JICA Kenya Office – Ms. Kumiko Yoshida
   b. Vice Chair, Council of County Health Executives – Dr. Kombo Mohamed
   c. Head, Dept. HSC/IGA – Dr. D.M. Kiima

Min.1/27/05/15 - Welcome Remarks and Introduction

The meeting was called to order at 9:05am by the chair, Dr. Kiima, Head of Department of Health Sector Coordination & Inter-governmental Affairs (HSC/IGA). The chair welcomed MOH colleagues, JICA consultative mission and project teams to the second PSC meeting.

Min.2/27/05/15 - Opening Remarks

Dr. D.M. Kiima - Head, Dept. HSC/IGA

In his speech, Dr. Kiima welcomed and thanked JICA for the support in implementing this project in particular and for the technical and financial assistance in Kenya. He noted that Kenya was implementing the new constitution albeit with successes and challenges. He reiterated that the two levels of government are distinct and interdependent and carry out their functions through consultation and collaboration, building consensus through communication, coordination and commitment to achieve

the ultimate goal of higher standards of health care provision. He further outlined the functions of the two levels of government as stipulated in the fourth schedule of the constitution which include the national government's role to provide capacity building assistance at county and national level.

Dr. Kombo MB, Vice Chair, Council of County Health Executives

In his remarks, Dr. Kombo conveyed his gratitude to JICA and MOH for inviting him to the meeting. He shared some of his experiences with devolution. He noted that since devolution, Lamu County had employed a total of 60 new staff members, while Mandera County had employed 200 new nurses. The County Government in Lamu had bought a wide range of new laboratory equipment to enhance service delivery developed health infrastructure and the purchased new ambulances. In his conclusion, he encouraged and supported the project's direction in ensuring that all regions and counties are covered to help address the health inequality across the country.

Mr. Kenichi Ito, Mission Leader, JICA Consultative Mission Team

Mr. Ito thanked MOH stakeholders, the Vice Chair of Council of County Health Executives and JICA Project team members for attending the meeting. He reiterated that the overall background of the project was in line with the goal of the Ministry of Health, to strengthen managerial functions of the county health teams. He observed that the first phase of the project's preparatory activities and a series of assessments of the current situation in Kenya had been achieved. He expected fruitful discussions and consensus building on the overall direction of the project.

Director of Medical Services (DMS)

On behalf of the DMS, Dr. Kiima assured the participants of the MOH is commitment to the Project. He noted that the situation analysis and the M&E workshop conducted in the first phase of the project provided information useful for the future direction of the project.

Min. 3/27/05/15 - Confirmation of the Minutes of 1st PSC Meeting

The minutes of the 1st PSC meeting held on 9th February 2015 were confirmed with corrections as a true record of the meeting's proceedings. The confirmation was proposed by Mr. Elijah Kinyangi and seconded by Ms. Maki Ozawa.

The corrected version of the minutes of meeting will be printed, signed and filed for

record purposes.

Min. 4/27/05/15 - Progress of the Project – Project Team

The Project team made a comprehensive presentation on the progress of the project activities. The topics covered by the presentations were as follows;-

- Overview of the Project
- Stages of the Project
- Progress of the 1st stage as of May 2015
  - Overall progress
  - Strengthening of coordination mechanism
  - Situation analysis
  - Core functions of CDOH
  - Harmonization of health systems management training
  - Monitoring and evaluation of management capacity of counties
  - Development of horizontal learning mechanism

As for details of the presentation, refer to the Appendix.

Min. 5/27/05/15 - Future Direction of the Project - JICA Mission Team

Mr. Kenichi Ito, Ms. Maki Ozawa and Dr. Makoto Tobe the visiting mission members of the JICA consultative Mission for the Project presented the proposals for revision of the Project Design Matrix (PDM, Version 1). The proposals were based on the discussions between MOH and JICA during the consultative mission and had the following highlights:

Item	Version 0 (25th February 2014)	Version 1 (27th May 2015)	Comments/Changes
Direct Target Group	Personnel involved in managerial capacity development of counties within ministry of health, and members of county Health Management	Ministry of Health (MoH) personnel involved in managerial capacity development of counties, and members of County Department	Changed. Members of Sub County Health Management Teams and Facility

	Teams (CHMTs), Sub county Health Management Teams (SCHMTs) and Health Facility Management Teams (HFMTs) of 47 counties	of Health (CDoH) of all 47 counties	Management Teams were excluded from the direct target group
Overall Goal	Devolved health Systems are strengthened to ensure equitable and quality services in achieving Universal Health Coverage in entire Kenya	Devolved health Systems are strengthened to ensure equitable and quality services in achieving Universal Health Coverage in entire Kenya	No change. The overall goal was judged to be relevant to the current situation
Project Purpose	Managerial functions of County Health Management Teams (CHMTs) are strengthened	Managerial Functions of County Department of Health (CDoH) are strengthened	Changed from CHMT to CDOH. The 2 dimensions addressing achievements in partner counties through project intervention and achievement at national level respectively were maintained
Output 1	Managerial support functions and coordination mechanisms in the National level are strengthened	Managerial support functions and coordination mechanisms at National level are strengthened	Changed from CHMT to CDOH. The outputs as originally set are still effective as a means of achieving the project purpose
Output 2	Leadership and managerial capacities of CHMTs are strengthened	Leadership and managerial capacities of CDOH are strengthened	

Output 3	Horizotnal learning mechanism among and within CHMTs is strengthened	Horizontal learning among and CDOH is strengthened	

Min. 6/27/05/15 - Plenary Discussions

<u>Scope of Department of the HSC/IGA</u>

Mr. Kinyangi asked a clarification about the scope of the Health Sector Coordination Division under the HSC/IGA. Dr. Kiima responded that its scope was still not clear while the scope of the Intergovernmental Affairs Division is to maintain the communication channel between the national and county governments. This was partly because the Health Sector Coordination Framework was still under consideration and there are other players involved in coordination including the Health Sector Steering Committee, the Public Private Partnership Unit, and so on.

<u>CHMT and CDOH</u>

There was an opinion that it would be difficult to define the function of a CHMT and develop indicators if the structures of CHMTs are different according to counties as seen in the situation analysis report. Also, CHMT is a part of CDOH and management function of CDOH is not limited to the CHMT. Due to this consideration, the JICA Consultative Mission Team proposed to change the direct target group of the Project from CHMT to CDOH.

There was a question about the definition of the "managerial function" in the project purpose. The JICA Consultative Mission Team responded that the project purpose in the PDM should be very specific which shall be defined during the mid-term review after the CDOH core functions were clarified with the support of the Project.

Dr. Kombo pointed out that the core functions of the CDOH should be considered the different jurisdictions of CDOH in different counties. He observed that some CDOHs were assigned their responsibilities by their respective county governments for health and sanitation, while others were for health and environment. Therefore, the scope of works of CDOHs are different according to the portfolio they were assigned, making it difficult to consider the CDOHs as homogeneous units.

Project Design Matrix

There were comments that the objectively verifiable indicator 1-1 and 1-2 under the output 1 of the PDM should be stated with clearer expressions. The JICA Consultative Mission Team responded that the indicators were to be improved when the Version 1 of the PDM was finalized.

Selection of Partner Counties

Dr. Kiima stressed the importance of having criteria for selecting two partner counties. The process should include consultation with other stakeholders, looking at the county health profiles and other elements such as availability of financial resources for county health service delivery.

There was another proposal that the selection of partner counties should also consider county health performance as captured in the annual performance report of MOH. In this regard, counties ranked in the middle-range in terms of the health performance would be potential candidates for partner counties since the possibility of success of technical transfer and that of obtaining useful lessons for other counties would be higher.

Ms. Ozawa expressed her opinion that it would be desirable to have candidates of the partner counties by August 2015 to meet the original implementation plan of the Project

Min. 7/27/05/15 - Way Forward

PSC Membership

Based on the minutes of the 1st meeting of the PSC, Ms. Ozawa requested the chair for correction of the list of names of PSC members. Dr. Kiima noted that in the first PSC meeting, it was agreed that the PSC membership from MOH consisted of the DMS as the chair and all existing department heads. The Dept. HSC/IGA of MOH was designated as the secretariat. Other members of the PSC included chair of the Council of County Health Executives, JICA Representative(s), JICA UHC Advisor and members of the project team. Prof. Watanabe noted that it was agreed that the representative of development partners be removed from the PSC membership. Dr. Kombo requested that the chair of the HR Committee and secretary of the Council of County Health Executives be added to the PSC membership to bolster county representation. Dr. Kiima noted that the DMS needs to be consulted before changing the membership because that

the PSC as constituted was inaugurated by the DMS at the first PSC meeting.

Selection of Partner Counties

Based on available results from studies conducted so far (Situation Analysis and TNA) and mapping by Development Partners, the project will provide information to the Chair and Vice Chair of the Council of County Health Executives to facilitate consultation with other CEC members and propose names of two counties for further consultation with the DMS. The information shared by the Project should include suggestions from the technical team based on review of county performance against selected health indicators and other relevant considerations.

Revision of PDM

The JICA mission was to revise and finalize the PDM and then share the revised draft Minutes of Discussion (M/D) and PDM with the members of the PSC through the JICA Kenya office. The JICA mission would then receive feedback on the final drafts and then send the agreed M/D for signature by the DMS.

Record of 1st PSC Meeting

The Minutes of the 1st PSC meeting would be revised by the project team based on the discussion at the 2nd PSC meeting and would be shared with the PSC members for feedback.

Action Points

Action	Responsible	By When
Selection of two partner counties	-Council of County Health Executives -Project Chief Advisor -DMS	Next PSC meeting in August
Revision of Minutes of the 1st PSC meeting	Project team	By 13th June 2015
Finalization of Version 1 of the PDM	JICA Consultative mission team	Next PSC meeting in August

Min 8/27/05/15 - Closing Remarks

Ms Yoshida, JICA Kenya Office, thanked Ministry of Health for organizing the PSC

meeting. She also thanked the JICA HQ mission team for their hard work to come up with the refined project concept and PDM as discussed during the meeting. She noted that devolution is everybody's business in Kenya including the developing partners. It is JICA's commitment to work with GoK to improve people's access to quality health care and to achieve Universal Health Coverage by 2030, while coordinating with other DPs for better harmonization of technical assistance tools and approaches.

Dr. Kombo on behalf of the Council of County Health Executives expressed his gratitude to JICA and PSC members for the commitment to the project. He noted that UHC is a national goal and that he was honored to be part of the project. He was thankful to the national government and JICA for providing an opportunity to change the face of health care in the country.

On behalf of the DMS, Dr. Kiima thanked the JICA Mission team, the Project team and colleagues in MOH for the partnership between JICA and the government of Japan not only in health but in other sectors as well. He noted that MOH is committed to seeing the success of this project and outcomes that positively impact the Kenya Vision 2030 and progress towards achieving Kenya's development goals.

The meeting was adjourned at 1:30 pm.

Minutes of the Third Project Steering Committee Meeting for MOH / JICA Organization Capacity Development Project for the Management of Devolved Health Systems in Kenya

Date: Monday, 28th September 2015
Venue: The Silver Springs Hotel
Time: 2:00 pm – 4:00 pm
Circulate to: All members of the project steering committee

PSC Members Present

No	Name	Organization	Position
1.	Dr. David Kiima	MOH	Head, Dept. Health Sector Coordination & Inter-governmental Affairs
2.	Dr. Andrew Mulwa	Makueni County	CEC Health Services / Chair, Council of County Health Executives
3.	Mrs. Hellen Chepkirui Rono Ng'eno	Kericho County	CEC Health Services
4.	Mrs. Joyce Muriithi	Kirinyaga County	CEC Health Services
5.	Dr. Jackson Omondi	MOH	Head, Division of Health Sector Coordination, Dept. Health Sector Coordination & Inter-governmental Affairs
6.	Dr. John Kihama	MOH	Head, Division of Inter-governmental Coordination, Dept. Health Sector Coordination & Inter-governmental Affairs
7.	Ms. Rachel Kamau	MOH	Head, Patient and Health Care Workers Safety Unit, Dept. Health Standards, Quality Assurance and Regulations
8.	Ms. Wilder Muturi	MOH	Principal HRD Officer
9.	Mr. John Wanyungu	MOH	M&E Officer, Dept. Health Sector Coordination & Inter-governmental Affairs
10.	Ms. Eunice Ambani	MOH	Technical Officer, Dept. Health Sector Coordination & Inter-governmental Affairs
11.	Mr. Kazuhiro Tambara	JICA Kenya	Senior Representative
12.	Ms. Kumiko Yoshida	JICA Kenya	Project Formulation Advisor

No	Name	Organization	Position
13.	Mr. Elijah Kinyangi	JICA Kenya	Program Officer
14.	Prof. Satoru Watanabe	JICA/MOH	JICA UHC / Health Financing Advisor
15.	Mr. Tsuyoshi Ito	JICA project	Chief Advisor
16.	Ms. Kaori Saito	JICA project	Health Systems Management / County Health Planning Specialist
17.	Dr. Hazel Mumbo	JICA project	County Human Resources for Health Development Specialist
18.	Ms. Kayoko Takaki	JICA project	Project Coordinator / Mutual Learning Specialist

In Attendance

No	Name	Organization	Position
1.	Ms. Catherine Mahihu	JICA project	Administrative Officer

Agenda

1. Welcome by Head, Dept. HSC/IGA - Dr. David Kiima
2. Self-introduction
3. Opening remarks
    a. Director of Medical Services – Dr. Nicholas Muraguri
    b. Chair, Council of County Health Executives – Dr. Andrew Mulwa
4. Confirmation of the Minutes of 2nd PSC Meeting
5. Introduction of the Partner Counties
6. Work Plan of the 2nd Stage of the Project – Project Team
7. Plenary discussions
8. Way forward
9. Closing remarks
    a. Senior Representative, JICA Kenya Office – Mr. Kazuhiro Tambara
    b. Chair, Council of County Health Executives – Dr. Andrew Mulwa
    c. Head, Dept. HSC/IGA - Dr. David Kiima

Min.1/28/09/15 - Welcome Remarks and Introductions

The meeting was called to order at 14:15 by the chair, Dr. Kiima, Head of Department of Health Sector Coordination & Inter Governmental Affairs. The chair welcomed MOH colleagues, the Chair of Council of County Health Executives, Representatives from the two partner counties, JICA Kenya Office and the Project team members to the third PSC meeting. He conveyed apologies from the Director of Medical Services who was unavailable due to other official engagement.

Min.2/28/09/15 - Opening Remarks

Dr. D.M. Kiima - Head, Dept. HSC/IGA
In the absence of the Director of Medical Services, Dr. Kiima requested for opening remarks by Dr. Andrew Mulwa.

Dr. A. Mulwa, Chair, Council of County Health Executives
Dr. Mulwa conveyed his appreciation to all the members gathered for the 3rd PSC meeting, although this was the first occasion for him to attend PSC meeting. He encouraged the members to actively participate in the meeting for fruitful discussions.

There was one concern was raised by Dr. Mulwa concerning the membership of PSC. Due to what he considered as an imbalance in representation between the national government and the county governments, he requested the PSC to consider increasing number of representatives from the counties. He suggested inclusion of the Vice Chair and the Secretary of the Council of County Health Executives as members of PSC.

Dr. Kiima understood the concern raised by Dr. Mulwa, and the PSC members agreed to include the Vice Chair and the Secretary of the Council of County Health Executives in the PSC.

Min.3/28/09/15 - Confirmation of the Minutes of 2nd PSC Meeting

The agenda on confirmation of the minutes of the 2nd PSC meeting held in May 2015 was deferred to the next PSC meeting. Summary of the minutes shall be prepared beforehand of next PSC meeting and the confirmation shall be made based on the summary to be tabled at the next meeting.

Min.4/28/09/15 - Introduction of the Partner Counties

Kericho and Kirinyaga counties were selected and expressed their willingness to collaborate with the Project as partner counties to improve managerial capacities of CDOH members. Both counties were officially recognised at the PSC meeting as partners of the Project. The CEC member for Health from each county introduced themselves and the accompanying county health directors.

Min.5/28/09/15 - Work Plan of the 2nd Stage of the Project - Project Team

<u>Presentation on the Project framework by Mr. Ito, Chief Adviser</u>

The Project team made a comprehensive presentation on the Project framework and work plan for the 2nd stage. The topics covered by the presentations were as follows;-

- Objectives of the Project
- Four components of the Project and its approach
- Three stages of the Project and activities implemented in the 1st Stage
- Activity plan of the 2nd stage
    - Coordination mechanism
    - Clarification of core functions of CDOH
    - Harmonization of county training programme
    - County support for MTEF cycle management
    - Development of horizontal learning
- Composition of the Project Team

As for details of the presentation, refer to the Appendix.

Min.6/28/09/15 - Plenary Discussions

<u>Questions on technical aspects of health service delivery in the counties</u>

Ms. Kamau, Head of the Patient and Health Care Workers Safety Unit of the Department of Health Standard and Quality Assurance and Regulations, raised a question on how the Project could contribute to reinforcing technical capacity with regard to the patient and healthcare workers' safety, in addition to the managerial capacities of counties. According the Ms. Kamau, there were needs in capacity development in the area patient and healthcare workers' safety and that counties require further improvement of related techniques.

Dr. Mulwa responded to her questions by stating that MOH had a responsibility for human resource development in health sector, and counties were in need of technical support from MOH. He added that necessary regulations and guidelines developed by the ministry regarding capacity development including patient and health workers' safety need to be disseminated to support counties. In addition, he expressed his expectation that the Project targeted strengthening managerial capacities that could contribute in every aspect of service delivery and improvement of health performance.

In his rejoinder, Mr. Ito pointed out that priority issues for managerial capacity development should be raised from the counties but not by the Project. The Project was in a position to support the counties, but the decision makers regarding the type of support required were the CDOH. In other words, if capacity development for patient and healthcare workers' safety was a priority for a county, the project may address the issue through strengthening of management capacities that would contribute in improving occupational health and safety issues.

Ms Yoshida, Project Formulation Advisor of JICA Kenya Office, suggested that if there were any documents regarding patient and health workers' safety produced by the national government, then dissemination of those documents could as well be supported by other development partners.

Expected deliverables of the 2nd Stage

Mr. Kinyangi, Programme Officer of JICA Kenya Office, inquired from the Project team what specific deliverables the Project expected to produce in the second stage.

In his response, Mr. Ito listed up the expected outcomes as follows: identification and substantiation of effective communication channels between the two levels of government; training harmonisation through developing the common strategy; identification of measurable indicators in regard to monitoring and evaluation of health systems management; and systematised process of selecting best practice and enhancement of a mutual-learning system.

Indicators for Functional CHMT

Ms. Yoshida raised several concerns and suggestions: that the definition of the "Functional CHMT" and elaboration of the Core Function of CDOH need clear

methodologies; the term of “self-evaluation” should probably be changed to “self-assessment”; MTEF Cycle support should include budgeting and resource mobilization; relationship between different levels of the mutual-learning system (national, county, sub-county and facility) should be clarified; and the mutual-learning may need to consider possibility of a web-based learning platform.

Responding to the points raised, Ms. Saito, Health Systems Management/County Health Planning Specialist, informed the Core Function Working Group has started discussion on break down of the Core functions in into “What” and “How”, where “What” describes detail actions necessary and “How” shows the means to apply them to the health service provision.

Dr. Kiima asked whether the term of “functional” meant those ideal for CHMTs of the two partner counties, or those that would be a common understanding and all counties would refer to.

Mr. Ito pointed out that the Core Functions would not be an obligatory standard. More important point is to make avail a model set of functions which would support CDOHs to identify their own functions and use it for establishment of effective organization structures.

Horizontal Learning

Dr. Kiima proposed that the term of the “horizontal” be changed in order to avoid misunderstanding by stakeholders. He suggested the use of “benchmarking” as an alternative that may assist in making the intention of the horizontal learning clearer. Another proposal from him was to set up clusters of counties that could learn from each other should be done carefully not to duplicate with the existing arrangement.

Min.7/28/09/15 - Way Forward

Action Points

Action	Responsible	By When
Preparation of the minutes of both the Partner County Introductory Meeting and the 3rd PSC Meeting, and a summary of the 2nd PSC Meeting	-Project team -Dept. HSC/IGA	Next PSC meeting

Prepare a program of work for the support to the Partner Counties.	Project team	Before the first meetings in the Partner Counties in October
Project to initiate meetings with the two partner counties.	Project team	In October
Revise the draft Work Plan and obtain the approval from PSC	Project	

Min.8/28/09/15 - Closing Remarks

Mr. Tambara, Senior Representative, JICA Kenya

Mr. Tambara thanked Ministry of Health and the project team for organizing the PSC meeting. He noted that the project being at the beginning of the second stage, would better move forward rather than spend time to develop drafts and have more discussions with stakeholders. A trial and error approach would be more effective as it takes time to build consensus across a wide range of stakeholders. He also pointed out that everyone had their own definition of core functions, but he noted that the functions should be derived from outcomes. Measuring outcomes defines its functionality. Identify the key factors to produce such outcomes and those outcomes might be part of functionality. He concluded his remarks by thanking the project team, county and MOH representatives for their commitment in ensuring the success of the Project.

Dr. A. Mulwa, Chair, Council of County Health Executives

Dr. Mulwa expressed his gratitude to JICA and PSC members for the meeting. He noted that the discussion focused on how best the partnership could deliver health services to everyone in the Counties. Going forward, he pointed out that proper structure of the Inter-Governmental Forums (IGF), Technical Working Group for COG, COG and other platforms is urgently needed. This would be discussed by the health committee of COG to define the way forward.

Dr. D.M. Kiima, Head, Dept. HSC/IGA

Dr. Kiima, MOH, thanked the JICA, the project team and colleagues of MOH, on behalf of the DMS, for their support and the partnership. He agreed with Dr. Mulwa that restructuring of IGF meetings is necessary but noted that there is need for a road map to mobilize resources (finances, time and human resources), work with the Council of Governors and its committees and ensure those two bodies meet regularly and to synchronize their activities. He concluded that MOH would be committed to see the success of this project, outcomes that impact Kenya Vision 2030, and achieving the

country's health development goals.

The meeting was adjourned at 16:25 pm.

Minutes of the Fourth Project Steering Committee Meeting for MOH / JICA Organization Capacity Development Project for the Management of Devolved Health Systems in Kenya

Date: Wednesday, 3rd March 2016
Venue: The Silver Springs Hotel, Nairobi
Time: 9:00am to 2:00pm
Circulate to: All members of the Project Steering Committee

PSC Members Present

No.	Name	Organization	Position
1.	Dr. David Kiima	MOH	Head, Dept. Health Sector Coordination & Inter-governmental Affairs
2.	Dr. Mohammed Kombo	Lamu County	CEC Health Services / Vice-chair, Council of County Health Executives
3.	Dr. Elizabeth Ogaja	Kisumu County	CEC Health Services and Promotion of Health Investments / Secretary, Council of County Health Executives
4.	Mrs. Hellen Chepkirui Rono Ng'eno	Kericho County	CEC Health Services
5.	Mr. Wambu Miano	Kirinyaga County	CEC Health Services
6.	Dr. John Kihama	MOH	Head, Division of Inter-governmental Coordination, Dept. Health Sector Coordination & Inter-governmental Affairs
7.	Mr. John Wanyungu	MOH	M&E Officer, Dept. Health Sector Coordination & Inter-governmental Affairs
8.	Dr. Pauline Duya (for Dr. Onyancha)	MOH	Dept. Health Standard, Quality Assurance and Regulations
9.	Dr. Anne Wamae (for Dr. Odongo)	MOH	Head, Clinical Practice Division, Dept. Curative Service
10.	Ms. Kumiko Yoshida	JICA Kenya	Project Formulation Advisor
11.	Mr. Elijah Kinyangi	JICA Kenya	Program Officer
12.	Prof. Satoru Watanabe	JICA/MOH	JICA UHC / Health Financing Advisor
13.	Mr. Tsuyoshi Ito	JICA project	Chief Advisor
14.	Ms. Kaori Saito	JICA project	Health Systems Management / County Health Planning Specialist
15.	Ms. Chiaki Kido	JICA project	Health Monitoring and Evaluation Specialist
16.	Dr. Hazel Mumbo	JICA project	County Human Resources for Health Development Specialist
17.	Ms. Kayoko Takaki	JICA project	Project Coordinator / Mutual Learning Specialist

In Attendance

No.	Name	Organization	Position
1.	Mr. Simion Ndemo	JICA project	County Support Assistant
2.	Ms. Catherine Mahihu	JICA project	Administrative Officer

Apologies

No.	Name	Organization	Position
1.	Dr. Jackson Kioko	MOH	Ag. DMS and Head, Dept. of Preventive and Promotive Heath
2.	Dr. Andrew Mulwa	Makueni County	CEC Health Services / Chair, Council of County Health Executives
3.	Mr. Kazuhiro Tambara	JICA Kenya	Senior Representative
4.	Dr. Jackson Omondi	MOH	Head, Division of Health Sector Coordination, Dept. Health Sector Coordination & Inter-governmental Affairs

Agenda:

1. Welcome and introduction – Dr. Kiima
2. Opening remarks
    a. Director of Medical Services (Acting), Chair of the Meeting – Dr. Kioko
    b. Chair, Council of County Health Executives – Dr. Mulwa
3. Confirmation of the Minutes of the 2nd and 3rd PSC meetings
4. Appointment of the Project Director
5. Progress and achievement of the Project – Project Team
6. Plenary discussions
7. Short project title
8. Any Other Business
9. Way forward
10. Closing remarks
    a. Representative, JICA Kenya Office
    b. Chair, Council of County Health Executives – Dr. Mulwa
    c. Director of Medical Services (Acting) – Dr. Kioko

Min.1/03/03/2016 - Welcome and Introduction

The meeting was called to order at 10:15 am after a long wait to form a quorum. The CECs for Kisumu, Kericho and Lamu joined after the meeting had started. Apologies were given for above mentioned persons.

Min.2/03/03/2016 - Opening Remarks

By the time the meeting started, Dr. Kioko who indicated through an apology of being late had not arrived in the meeting, Neither Dr. Kombo who was to give opening remarks on behalf of the Council of County Health Executives. The session was skipped for a moment.

Min.3/03/03/16 - Confirmation of the Minutes of the 2nd and 3rd PSC Meetings

Minutes of the past two PSC meetings (the 2nd PSC meeting which happened on 27th May, 2015 and the 3rd PSC meeting of 28th September, 2015) were examined. Notable areas to be amended included that:

1. The format of writing the minutes should be the same to avoid confusion;
2. Action points to be captured to elicit response and knowledge of way-forward.

Examples of the second point above are:

1) Min.5/27/05/15 of the second PSC meeting - Future direction of the Project

   There is need to have descriptions for the output 2 and 3.

2) Min.6/27/05/15of the second PSC meeting - Plenary Discussion

   Some items should be deleted like sentence 1 in the table and clarification for the sentences 2 and 3 from top of the table. The items should be numbered for ease of reference.

3) Heading of the minutes of the 3rd PSC meeting:

   The title of the project should be captured well and indicate that the minutes were for the 3rd PSC meeting.

4) Attendance list of the 3rd PSC meeting:

In capturing the positions of attendants, they should be captured in full, e.g., County Executive Committee Member for Health but not as in the case of number 9 and 10 in the minutes of 28th September.

5) Min.3/28/09/15 of the 3rd PSC meeting - Opening Remarks:

Name of Dr. Muraguri should be replaced by that of Dr. Kiima since Dr. Muraguri was represented by him. Also the name of Dr. Mulwa should be replaced with the one of Dr. Kombo.

6) Min.2/28/09/15 of the 3rd PSC meeting - Confirmation of the Minutes of 2nd PSC Meeting:

It should be interchanged with Min.3/28/9/15 of the Opening Remarks to capture the spirit of flow of agenda.

7) Min.6/28/09/15 of the 3rd PSC meeting Plenary Discussions

The minute statement is hanging since it does not capture what was agreed.

It was resolved that the appointed rapporteurs (Secretariat) to revert to the long version of the plenary discussions of the 2nd and 3rd PSC meeting minutes and capture the action points properly, acquire approval via email and signatures before they are brought to the next PSC meeting for confirmation.

The decision by the chair for this amendment was proposed by Mr. Elijah Kinyangi of JICA and was seconded by Dr. Hazel of the project.

Min.4/03/03/2016 - Appointment of the Project Director

It was agreed that by design of project architecture, the DMS office is vested with the position of the Project Director regardless of the person who is occupying the office of DMS.

Min. 5/03/03/2016 - Project Progress and Achievements – Project Team

The Project team made a comprehensive presentation on the progress of the project activities. The topics covered by the presentations were as follows;-

- Overview of the Project (Four components of the Project and its approach)
- Stages of the Project

- Progress of the 2nd stage as of February 2016
  - Basic strategy
  - Strengthening of coordination mechanism
  - Clarification of core functions of CDOH
  - Monitoring and evaluation of management capacity of counties
  - Harmonization of county training program
  - County support for MTEF cycle management at Kericho, Kirinyaga
  - Development of horizontal learning mechanism

As for details of the presentation, refer to the Appendix.

Min.6/03/03/2016 - Plenary Discussions

Intergovernmental Event Schedule Coordination

There was a comment that the MOH should try to involve the counties to schedule coordination by the HSC/IGA. Mr. Ito responded that focal persons for the scheduling will include a representative from Council of Governors (COG).

County Training on Health Systems Management

Dr. Ogaja commented that the counties do not have clear method to determine how many number of health workers are necessary to deliver proper health services, and hence, county health managers need to attend a training on the WHO's method of human resource assessment. Dr. Hazel responded that each county would need to prepare its HRD policy and training plan once the Common Strategy is in place in order to fill the gaps in Human Resources for Health, therefore, the WHO's method would be examined to see if it can be used in the context of Kenya.

There was also a concern on how the training curriculum on management is linked to the carrier development and promotion of trained staff. Dr. Hazel responded that the accredited institutions would offer the training courses, which will be in accordance with the standard curricula of the Common Strategy, and the certificate issued will be recognized through the CPD mechanism.

Organizational Structure of CDOH

Mr. Miano raised that the Core Functions will help in harmonizing the functions of the CDOH in all the counties. In order to secure the buy-in from the COG, the Core Function is necessary to be compliant with relevant laws and regulations. Ms. Saito responded that the COG would be fully involved in the process of Core Function formulation.

There was a suggestion that the County Government Act 2012 was worth referring for the Core Function formulation since CEC supervises all the functions of county operations within their docket.

There was anotther comment raised that the Core Function would only serve as a prototype of how CDOHs seem to function.

Mrs. Ng'eno commented that the communication between the Project and counties needs to involve CEC, because CEC was the one who is answerable in most occasions.

MTEF Cycle Management

Mrs. Ng'eno raised the issue that, in most counties, there were notable capacity gaps mainly in M&E, health economics, and MTEF management. Also, the Chief Officers for Health need to be sensitized on MTEF planning cycle.

Ms. Saito shared information on future action of MOH that MOH was now on track in preparing a AWP guideline which will incorporate the Program Based Budgeting, and that the Project would follow up this move by the MOH.

Min.7/03/03/2016 - Short Project Name

Among the eight suggested acronyms, "OCADEP" scored 4, receiving the highest votes. However, because the acronym did not include a term of "County," there was a unanimous vote to add another "C" for county to make it "OCCADEP", and approved by the PSC members.

The name should always read as follows: "MOH/JICA-OCCADEP" This name from now henceforth shall be officially recognized and used unless otherwise stated.

Min.8/03/03/2016-Any Other Business

No AOB was raised.

Min.9/03/03/2016-Way Forward

Action	Responsible	By When
Revisit WHO's assessment method of work force training needs.	The project team	No timeline
Consider the promotion requirement and CPD aspects in the revision of the management training curriculum.	The project team, MOH	According to the Common Strategy Steering Committee
Look at issues of challenges faced by counties: "sensitization of health economist on health services in the public sector," "week management structure," "capacity development of CO who may come from other field than the health" and "effective communication among CDOH staff."	The project team	In the course of the support to the Partner Counties
Secure involvement of county representative for the strengthening of the "scheduling" function of HSC/IGA.	The project team, MOH	By kick off of stakeholders meeting on the scheduling
Follow up the latest activity by MOH on AWP Planning Guideline.	The project team	Immediately
Drafts of the minutes of the 2nd and 3rd PSC meetings should be revised and shared among the PSC members.	The project team, JICA Kenya	By end of March

Min.10/03/03/2016-Closing Remarks

JICA Kenya was happy on the collaboration and gains already shown and asked for same commitments in future.

Dr. Kombo, on behalf of Council of County Health Executives, mentioned that he was excited that the MOH and the counties are working in harmony and hoped the same spirit would continue.

Dr. Kiima closed the meeting, on behalf of Dr. Kioko, by thanking all who participated

The meeting ended at 2.00pm and date of next meeting will be communicated.

Minutes of the Fifth Project Steering Committee Meeting for MOH / JICA Organization Capacity Development Project for the Management of Devolved Health Systems in Kenya

Date: Wednesday, 13[the] July 2016
Venue: Sarova Panafric Hotel, Nairobi
Time: 9:00am to 12:00pm
Circulate to: All members of the Project Steering Committee

PSC Members Present

No.	Name	Organization	Position
1	Dr. Jackson Kioko	MOH	Ag. Director of Medical Services
2	Dr. Mohammed Kombo	Lamu	CEC Health Services / Vice-chair, Council of County Health Executives
3	Dr. Elizabeth Ogaja	Kisumu	CEC Health Services and Promotion of Health Investments / Secretary, Council of County Health Executives
4	Mrs. Hellen Chepkurui Rono Ng'eno	Kericho	CEC Health Services
5	Mr. Wambu Miano	Kirinyaga	CEC Health Services
6	Dr. John Kihama	MOH	Ag. Head, Dept. Health Sector Coordination & Inter-governmental Affairs
7	Dr. Pauline Duya (rep. Dr. Pacifica Onyancha)	MOH	Dept. Health Standard, Quality Assurance and Regulations
8	L.M Thiga (rep. Dr. Izaq Odongo)	MOH	Head, Dept. of Curative and Rehabilitation Services
9	Aloice Sudhe (rep. Ms Cirindi Murianki)	MOH	Head, Division of Human Resource Development, Department of Human Resource Management and Development
10	Dr. Jackson Omondi	MOH	Head, Division of Health Sector Coordination Dept. Health Sector Coordination & Inter-governmental Affairs
11	Mr. Kazuhiro Tambara	JICA Kenya	Senior Representative
12	Ms. Kumiko Yoshida	JICA Kenya	Project Formulation Advisor
13	Mr. Elijah Kinyangi	JICA Kenya	Program Officer
14	Prof. Satoru Watanabe	JICA Kenya	JICA UHC / Health Financing Advisor
15	Mr. Tsuyoshi Ito	MOH/JICA OCCADEP	Chief Advisor
16	Ms. Kaori Saito	MOH/JICA OCCADEP	Health Systems Management / County Health Planning Specialist
17	Dr. Hazel Mumbo	MOH/JICA OCCADEP	County Human Resources for Health Development Specialist

In Attendance

No.	Name	Organization	Position
1	Ms. Maiko Fujima	MOH/JICA OCCADEP	Accounting Supervisor
2	Mr. Simion Ndemo	MOH/JICA OCCADEP	County Support Assistant
3	Catherine Mahihu	MOH/JICA OCCADEP	Administrative Officer
4	Lornah Mutegi	MOH/JICA OCCADEP	Assistant Administrator
5	Mr. Fredrick Mutugi	MOH	Intern

Apologies

No.	Name	Organization	Position
1	Dr Andrew Mulwa	Makueni	CEC for Health Services / Chair, CEC Council of County Health Executives

Agenda:

1. Welcome – Ag. Head, HSC&IGA, Dr. John Kihama
2. Self-introduction
3. Opening remarks
   (a) Director of Medical Services (Acting), Dr. Jackson Kioko
   (b) Chairperson, CEC Health Forum, Dr. Andrew Mulwa
4. Confirmation of the minutes of the 2nd, 3rd and 4th PSC Meetings
5. Overall Progress and achievements of the projects – Project Team
6. Progress (Achievements and challenges) of the partner county support – Partner Counties
7. Proposal on the PDM indicators
8. Plenary discussions
9. AOB
10. Way forward
11. Closing remarks
   (a) Senior representatives, JICA Kenya Office, Mr. Kazuhiro Tambara
   (b) Dr. Andrew Mulwa
   (c) Dr. Jackson Kioko

Min 1/13/07/2016 – Welcome

The meeting was called to order at 9:45 am by the Ag. Head of the Department of Health Sector Coordination and Intergovernmental Affairs, Dr. John Kihama. It was officially opened by a call to prayer. This was offered by Dr. Hazel Mumbo.

Min 2/13/07/2016 – Introductions

These were made by way of self-introduction.

Min 3/13/07/2016 – Opening remarks

(a) Chair of the PSC, Ag. Director of Medical Services, Dr. Jackson Kioko

Dr. Kioko started off by offering an apology for being late and made the following remarks:

(1) He appreciated the progress made by the Project and underscored the importance of dedicating more time and effort towards the realization of the Project goals and objectives.
(2) He said the Project is geared towards addressing the challenges of management capacity development and service delivery improvement at the counties. As such, he suggested that the counties should establish structures that are responsive to the health needs of the people and should become the epicenters for learning of quality service delivery improvement.
(3) He mentioned that the counties should strive to demonstrate six main characteristics. These are:
    - Transformative and value based leadership: The counties should be transformative and exhibit value based leadership in the devolved health systems. They should thus adopt a holistic approach to achieve health strategic objectives and other international obligations.
    - Service delivery effectiveness: Such effectiveness should be improved in terms of waiting time at hospitals (turn-around time), type of personnel, their cultures, competencies and processes. In addition, he called for a re-engineering in systems and mechanisms that are better able to interrogate the quality of service delivery.
    - Responsive to the health needs of the people: The counties should be able to come up with institutions that are responsive to the health needs of the people.
    - Human capacity management: The counties should identify needs for human resource management and imparting of necessary skills to the health workers of the counties.
    - Competitive institutions: The county departments need to be competitive institutions, which would serve to boost productivity, competitiveness and service delivery. Such institutions would therefore be able to compete for resources.
    - Inclusive approach: The counties should consider a health system which also embraces outside the box of the county department to find the best use of scarce resources.

(b) Vice Chair, CEC Council of County Health Executives, Dr. Mohammed Kombo (on behalf of Chair, Council of County Health Executives, Dr. Mulwa)

(1) Dr. Kombo began by registering apologies from Dr. Mulwa, the Chair of CEC Council of Health Executives, who was late due to traffic. He then proceeded to commend the Ag Director of Medical services, Dr. Kioko for commenting on key issues that are fundamental to the growth and development of the devolved health system.
(2) He reiterated Dr. Mulwa's comments on the need for a holistic approach towards health service delivery. This, he said, should be done from a three dimensional perspective, that is, 1) personnel and capacity or skills; 2) financing and accountability; and 3) public participation in the access and demand for services. Public participation is an indicator of how beneficial the Project is to the people. It would thus lead to ownership of the Project. However, he pointed out that there are still many challenges in the counties such as lack of staff and financing, which led to underserving the people and inaccessible health care facilities. Some of the population still lives beyond 5 km of such amenities.
(3) In closing, he thanked the national government for its guidance and collaboration with the counties in perpetuating growth. He also thanked the MOH/JICA-OCCADEP for supporting the two counties, Kericho and Kirinyaga, which other counties can borrow their experience from and replicate in their own.

Min 4/13/07/2016 – Confirmation of previous PSC Minutes

There was consensus that the minutes of the second and third PSC meeting would be confirmed retrospectively by having the participants in these meetings propose and second the minutes. The comments that had been raised before were reflected in these minutes. In the absence of the persons that attended these two meetings, then the minutes would remain unconfirmed but subsequent ones will be confirmed at every subsequent meeting.

<u>Concern</u>

It was found that the minutes of the third PSC meeting were in a different format compared to other meeting minutes, though content did not change. Mr. Ito was tasked to amend the format and re-share the minutes.

<u>Matters arising from the fourth PSC meeting minutes</u>

(1) On page 2, the Attendance List. It was pointed out that the reference for CEC for Health in the counties should not be the same. For Kericho, Lamu and Kirinyaga, the title should read, "CEC for Health Services" and that for Kisumu should read "CEC Health and promotion of Health Investments"
(2) Spelling error. Makuneni should read Makueni

(3) On the same page, the reference. CEC Health Forum for the counties should appropriately read as “CEC County Health Executives”.
(4) Min 3/10/2016. There is an assumption that the action points that were captured were reflected in the review. The standard of making reference to the minutes should be adhered to.
(5) Min 4/10/2016 on Appointment of the Project Director. There was a concern that the county representatives are also referred to as the Project Directors, but it was clarified that the project concept and the signed Record of Discussion between the two governments (Japan and Kenya) has this position of the Project Director vested within the office of the DMS at the national level.
(6) There was a concern that the proposed Health Bill requires that the County Directors of Health be under the national government rather than the county government, a matter which the counties are vehemently against.
(7) Min 5/10/2016 on Project Progress and Achievements. It was suggested that the achievements and key issues be highlighted to avoid disconnect. This portion of the minutes should thus be expanded to pick on some of the achievements or they be highlighted in the annex.
(8) Min 6/10/2016. There was concern whether there is a national HRD policy which counties can use as a template for their own customization. The response was “Yes”. , There are drafts of the Training Policy and the Training Guideline. However, still there was an issue that training needs assessment should be done in a standardized way but most of the counties were not aware of any methodology. Since only a few of the health mangers were trained on the WISN methodology, which is a training needs assessment method recommended by WHO, there was a call for proper training on methodology so as to boost capacity building in this regard.
(9) Min 8/10/2016, AOB. This minute item seemed misplaced, since it appears as the last item in the meeting agenda.
(10) Min/9/10/2016, The Way Forward. These minutes shall be responded to in current PSC meeting and presentations. There was concern that real timelines need to be assigned for the stated action points. 31st July was proposed as the deadline for these action points.
(11) Action Pont 2. It was also proposed that specific individuals from the Project team who are responsible for certain indicated actions be pinpointed so as to improve effectiveness of minutes reporting. As well, a report should be given on the progress and challenges for ideal solutions

<u>Confirmation of the fourth PSC meeting minutes</u>

The minutes were proposed for confirmation by the CEC for Health Services, Kirinyaga –Mr. Wambu Miano and seconded by CEC for Health Services, Kericho –Mrs. Hellen Ngeno

Going forward, it was suggested that a more appropriate approach be adopted towards handling of minutes as well as provision of a folder for the chairman which contains all confirmed and

signed minutes. A concern was further raised that the counties should not be the only ones confirming the minutes, rather, all attendees should at least participate in this exercise.

Min 5/13/07/2016 – Overall Progress and Achievements of the Project - (See annex 1)

(1) Mr. Tsuyoshi Ito gave an overview of the project, and then briefed on the progress and the way forward of the strengthening of the coordination mechanism of the HSC/IGA.
 1) Progress
 (a) IGF
  - 5 Thematic Committee has been set up, draft SOP for TTC/IGA preparation has been developed.
 (b) Schedule coordination
  - Focal person groups (MOH departments, COG, NACC, NHIF, KEMSA, KMTC, DPHK) has been set up with a TOR and a coordination guideline. Schedule coordination for the 1st quarter has been conducted as a traial.
 2) Way Forward
 (a) IGF
  - Activation of the TTCs
 (b) Schedule coordination
  - Better coordination with the COG for the schedule coordination

(2) Dr. Jackson Omondi briefed on the progress and the way forward of the Core Functions
 1) Progress
  - Draft of the Core Functions has been shared through Dr. Kombo to the counties.
  - The senior managers of the ministry will be briefed on it before a stakeholders' meeting.
 2) Way Forward
  - Hold an expanded stakeholders forum for health sector validation and then send it to COG.

(3) Ms. Kaori Saito spoke on the progress and the way forward of the M&E support
 1) Progress
 (a) Indicator Manual
  - Participated to the retreat of all TWGs and the zero draft of the third version of the Indicator Manual was produced.
 (b) Functional CDOH assessment
  - Draft of the Functional CDOH Assessment Framework was prepared (See annex 2)
 2) Way Forward
 (a) Indicator Manual
  - The Mid-term Review of the KHSSP will be the main activity of the M&E Unit of the MOH and finalization of the Indicator Manual will use lessons and findings from the Mid-term Review exercise.
 (b) Functional CDOH assessment

- Start using this for the Partner County support

(4) Dr. Hazel Mumbo explained the progress and the way forward of the Common Strategy

1) Progress

The Common Strategy Steering Committee has four Sub-committees: Management; Technical; Coordination; and M&E. The Project supported three Sub-committees except the Technical Sub-committee.

(a) Management Sub - Committee.
- TNA report was finalized.
- Assessment of gaps in existing curriculum was completed and major gaps were identified as M&E, HSS- Research, PBB, and Financial Management
- Standard curricula for management area including "general" and "technical" were drafted.

(b) Coordination subcommittee
- A SOP and flow charts for training implementation and coordination have been prepared.
- The SOP and the flow charts have been incorporated into the MOH Training Guideline.

(c) M&E subcommittee
- Frameworks of the training implementation monitoring and the evaluation have been prepared.

2) Way Forward
- Cross cadre CPDs will be arranged for the management curricula.
- Stakeholder sensitization on the Common Strategy will be conducted.
- Content and manuals for the management curricula will be develop by November 2016.

(5) Mr. Ito presented on the Mutual Learning

1) Progress
- Selection framework was established.
- 1st selection according to the prepared guideline was completed.
- The 1st selection process was reviewed.
- Draft report is underway

2) Way forward
- The award winners selected to be awarded during the midterm review meeting.
- Strengthening of sharing and promotion of the the Best Practice

Min 6/13/07/2016 – Progress (achievements and challenges) of the Partner County Support

The Progresses of the Partner County Support were presented by the CECs of the two Partner Counties.

(1) Kirinyaga County (See annex 3)
  (a) Benefits provided
  - Health managers have a better understanding on MTEF
  - Draft AWP plan for 2016/2017 is ready
  (b) Challenges
  - Competing tasks
  - Inadequate support for AWP preparation in terms of finances
  - Non health members at the county assembly needs to be sensitized
  - Materials for county sensitization does not include budget plans
  - Different financial calendars of different partners
  (c) Way forward
  - Review timelines of identified action points
  - Capacity build health managers and health care providers on MTEF
  - Develop an M&E framework
  - Disseminate the 2016/2017 AWP to the sub-counties and the health facilities

(2) Kericho County (See annex 4)
  (a) Achievements
  - Ability to prepare an AWP according to the MTEF cycle
  - Improved knowledge on AWP planning
  - M&E TWG has been established with a clear TOR
  (b) Challenges
  - Underutilization of AWP at the facility level
  - Inadequate understanding on monitoring indicators
  - No M&E framework at the county
  (c) Way forward
  - Develop an M&E framework with priority indicators
  - Sensitization on priority indicators to the sub-counties and the facilities
  - Train staff on AWP implementation
  - Strengthen the Supportive Supervision
  - Train staff on the Scorecard and link it with the AWP

Min 7/5/2016 – Proposal on the PDM indicators - (See annex 5 and 6)

The Project presented 12 indicators as a proposal on the Objectively Verifiable Indicators of the Project Purpose of the PDM.

  (a) Way forward
  - Collect comments from the PSC members on the most appropriate indicators
  - Prepare draft proposal for sharing
  - Final confirmation of the indicators in the next PSC**.**

Min 8/13/07/2016 – Plenary discussions

(1) How quality of services can be demonstrated given that the indicators measuring this are challenging.

Response

Due to the fact that carrying out a client satisfaction survey is cumbersome, in that there are many and diverse opinions to be scrutinized, it was suggested that universal indicators should be availed and measured across all counties.

Project purpose: Limited to the scope and yet there are many interventions by the partners in the counties.

Quality of care: The Ministry to pick a set of indicators to be used by counties to measure this.

Self-assessment: Which other parameters can be used to show that progress is being made in giving quality care.

It was decided that quality be defined comprehensively because its meaning is very subjective.

Core function finalization: Will shape up various areas within the counties and help to reduce discriminate delivery of services. Once the document is ready it will be used to capacity build and strengthen organization arrangement**.**

(2) When will the other counties benefit from the leadership management capacity strengthening support? This is because the experiences shared by the two counties being supported was exciting – Dr. Ogaja from Kisumu.

Response

What the team from the two counties presented drew in some best practices that may be shared or replicated in the other counties. There may be no direct support as such but in some instances some neighboring counties may benefit by being invited to partake in the trainings offered.

CDOH core function*:* The time line has been lost and there is need for the WGs to meet and catch up. This document should be shared through the county representatives.

Health Bill: How it may affect the way we operate in future should be put into perspective

Appreciation about best practices*:* Although not many potential clients submitted, we need to circulate the best practice guidelines to the counties for emphasis.

Min 9/13/07/2016 – Way Forward

1. Amend and send final draft of the 4th PSC minutes
2. Apply the standard method of drafting minutes to all PSC meetings

3. Signing of the minutes of the previous PSC meetings (at the beginning of the next PSC meeting)
4. Arrange for quarterly in-house meeting for DMS briefing before actual PSC.
5. Finalize all sets of documents so that they can be launched at the same time
6. Send the PDM indicator document to select the indicators and give feedback on identified deadline.
7. Recirculate the RD and project brief document to the Council of County Health Executives so that they can share with their Governors.
8. Prepare a filing system of the project documents- especially for PSC.
9. All other way-forwards mentioned in the presentation should be adhered to.

Min 10/13/07/2016 - AOB

Mr. Elijah Kinyangi, from JICA Kenya Office, said that progress of the Project reveals that the bilateral relationship is strong and thanked Dr. Kihama in his new capacity as head of HSC/IGA. He mentioned TICAD 6 Conference for resilient HS for UHC.

Dr. Ogaja commented on the issue of managing health projects and whether infrastructure projects are value adding. She suggested the need for assistance in handling this issue, since some of those contracted to do the work end up being very ineffective.

Min 11/13/07/2016 - Closing Remarks

(a) Senior Representative, JICA Kenya Office, Mr. Tambara

He observed that devolution is still in process and that demarcation of responsibilities is a challenge. He however noted that the Project is making progress, based on the presentations made and that he remained confident that the activities designed for the counties will progress well till the end.

(b) Vice Chair, CEC Council of County Health Executives, Dr. Mohammed Kombo

This was done on behalf of Dr. Mulwa by Dr. Kombo. He thanked everyone present and said that day's discussions had been fruitful.

(c) Acting Director of Medical Services, Dr. Jackson Kioko

Dr. Kioko appreciated the progress made thus far, particularly in the two counties and said that since we are in transition from the MDGs to SDGs, we need to learn from projects that have been concluded like the SEMAH project.
He said the DMS office will be committed to support this project until the end for success.

He said investing in health is equivalent to investing in development and therefore NT needs to realize why they need to put more money in health. He delivered an example where, when accidents occur, they end up in the health sector.

He was glad that the idea of MTEF is being embraced in the counties and asked counties represented to set up systems to support this cause in a participatory manner.

Political messages for the politicians is that they need to invest in the people whom they always depend on.

On social protection for health, he called for the use of existing opportunities like CHWs to register every household for UHC coverage.

He made the following suggestions:

1. All documents that are lined up for launching should be ready and launched in a single event.
2. Project team to have in house meeting quarterly prior to the PSC meeting.
3. IHRIS concept is the best thing that has happened, and it will help target the right people.
4. AWP planning involvement of the county assembly to mobilize resources if good so that the right decisions are made.
5. Counties to strive in the attainment of 40% of the total budget allocation. In making AWPs, counties should target this percentage.
6. Since the quality of care is measured by presence of commodities, the allocation to commodities should be greater.
7. That county profile information on allocation of resources to health will be publicized to help in social accountability and said that the score card will even be owned by the politicians.

Min 12/13/07/2016 - Adjournment

The meeting ended with a word of prayer at 14:30 hours and next meeting is purposed to happen in early November 2016. The exact date shall be confirmed to the members before then.

Minutes of the Sixth Project Steering Committee Meeting for MOH / JICA Organization Capacity Development Project for the Management of Devolved Health Systems in Kenya held on 22nd November 2016 at Silver Springs Hotel, Nairobi

In attendance

(a) PSC Members Present

No.	Name	Organization	Position
1	Dr. Jackson Kioko	MOH	Ag. Director of Medical Services
2	Mrs. Hellen Chepkurui Rono Ng'eno	Kericho	CEC Health Services
3	Mr. Joseph Ngochi (rep Mr. Wambu Miano)	MOH	County Clinical Officer OCCADEP- Focal person
4	Dr. Pacifica Onyancha)	MOH	Dept. Health Standard, Quality Assurance and Regulations
5	Ms Maki Ozawa	JICA HQ	Deputy Director, JICA Human Development Department
6	Dr. Makoto Tobe	JICA HQ	Senior Advisor on Health
7	Ms. Kumiko Yoshida	JICA Kenya	Project Formulation Advisor
8	Mr. Tsuyoshi Ito	MOH/JICA OCCADEP	Chief Advisor
9	Ms. Kaori Saito	MOH/JICA OCCADEP	Health Systems Management / County Health Planning Specialist
10	Dr. Hazel Mumbo	MOH/JICA OCCADEP	County Human Resources for Health Development Specialist
11	Ms. Hiromi Kawano	MOH/JICA OCCADEP	Project Coordinator/ Mutual Learning Specialist
12	Ms. Yumiko Inoue	MOH/JICA OCCADEP	Training Planning Specialist

(b) Secretariat

1.	Dr. John Kihama	MOH	Ag. Head, Dept. Health Sector Coordination & Inter-governmental Affairs
2.	Dr. Jackson Omondi	MOH	Head, Division of Health Sector Coordination Dept. Health Sector Coordination & Inter-governmental Affairs

(c) Co – Opted Members

No.	Name	Organization	Position
1	Mr. Simion Ndemo	MOH/JICA OCCADEP	County Support Assistant
2	Catherine Mahihu	MOH/JICA OCCADEP	Administrative Officer
3	Lornah Mutegi	MOH/JICA OCCADEP	Assistant Administrator

(d) Apologies

No.	Name	Organization	Position
1	Dr Andrew Mulwa	Makueni	Chair, CEC Council of County Health Executives; CEC for Health Makueni
2	Dr. Mohammed Kombo	Lamu	CEC Health Services / Vice-chair, Council of County Health Executives
3	Dr. Elizabeth Ogaja	Kisumu	CEC Health Services and Promotion of Health Investments / Secretary, Council of County Health Executives
4	Dr. Peter Kimuu	MOH	Head, Dept. Standards, QA and Regulation
5	Dr. Izaq Odongo	MOH	Head, Dept. of Curative and Rehabilitation Services
6	Mr. David Njoroge	MOH	Director, HRM-HRD
7	Dr. Ruth Kitetu	MOH	Head, Health Sector Policy & Strategic Planning Unit
8	Ms Cirindi Murianki	MOH	Head, Human Resource Development Unit
9	Mr. Musyimi F.K.	MOH	Head, Secretary Administration
10	Mr. Elijah Kinyangi	JICA Kenya	Programme Officer

Agenda

1. Welcome – Head, HSC&IGA, MOH
2. Self- Introductions
3. Opening remarks
    a. Director of Medical Services – Dr. Jackson Kioko
    b. Chairperson, Council of County Health Executives – Dr. Andrew Mulwa
4. Revision of the Project Design Matrix (PDM)
5. Confirmation of the minutes of the 5th PSC Meeting
6. Annual Plan of the Project – Chief Advisor of the Project
7. Overall Progress and achievements of the Project – Project team
8. Progress of the Partner County Support
    a. Council of County Health Executives, Kericho, Mrs. Hellen Chepkurui Rono Ng'eno
    b. Council of County Health Executives, Kirinyaga, Mr. Wambu Miano
9. Plenary discussions
10. A.O.B
11. Way forward
12. Closing remarks
    a. Senior Advisor of Health, JICA – Dr. Makoto Tobe
    b. Chairperson, Council of County Health Executives – Dr. Andrew Mulwa
    c. Director of Medical Services – Dr. Jackson Kioko

Minute 1/22/11/2016: Welcome Remarks and self-introduction

The meeting was called to order at 10.57 a.m. by the chair, Dr. John Kihama, who requested a volunteer to pray and afterwards, asked the members present to introduce themselves. He welcomed the members to the 6th PSC meeting of the MOH/JICA-OCCADEP and wished them a productive discourse.

Minute 2/ 22/ 11/2016: Opening remarks

Dr. Jackson Kioko - Project Director, Director of Medical Services.

1) The Chairperson of the PSC, the Director of Medical Services, was called upon to give his remarks. He began by appreciating the organizers of the project meeting for their consistency and commented on the importance of having time-bound programs in future so as to enable members to organize themselves well around allocated time.
2) He remarked upon the timeliness of the project with the devolution of health sector to the counties.
3) He said that the ministry remains committed to the management and functioning of county health systems and added that the ministry will continue to uphold the delivery of its promises through functional health systems in the country. There is thus need to strengthen the leadership and management structures in Kenya's health system so as to ensure the above promises are met and services are provided.
4) He said some of the challenges the counties are facing stem from CHMTS not empowering the teams below them in supportive supervision, which would enable them to effectively interrogate what's happening below them.
5) He emphasized on the role of the project in post 2015 health targets and Kenya's vision 2030. In the same breath, he urged that there is need for counties to own the Project and drive the process.
6) He eventually appreciated the members present and expressed his interest in visiting one of the partner counties in order to gain greater insight about their perception of the project

Min 3/22/11/2016: Revision of Project design matrix (PDM)

1) Dr. Tobe from JICA- Tokyo Office took the members through version 1 of 2015 background information about the project design matrix and the three output areas.
2) He said that the primary responsibility of delivering quality health services now lies squarely on the devolved counties, hence the need for JICA to strengthen managerial capabilities in all counties. He indicated that the functionality of CHMT and its managerial functions have to be measured so as to use them as project purpose indicator.
3) Under output 2 of strengthening leadership and managerial capacities of CDOH, he emphasized that people need to be empowered to conduct advocacy, monitor how plans are implemented and review achievements. From his presentation, it was clear that planning, prioritization and equity are important components to consider before the implementation phase.
4) The objective of his presentation was to build consensus around the indicators to be used in measuring the impact of the project through midterm evaluation.
5) On strengthening the managerial functions of CDOH in all 47 counties, the project purpose indicators were proposed as follows;
    a. MTEF / AWP of counties are approved by County Executive Committee member of health by end of November and March respectively each year.

b. Percentage of health facilities supervised by CHMT/ SCHMT at least on a quarterly basis each year.
c. Performance monitoring meeting at least once each fiscal year
d. APR reports submitted by counties to CEC by November each year.

6) On Strengthening the leadership and managerial capacities of CDOH within the 2 partner counties, the output 2 indicators proposed were:
   a. Partner counties develop MTEF / AWP plans with;
      - Situation analysis
      - Priority setting
      - Equity towards UHC
      - Coordination
      - Public participation

The above indicator should be accompanied by descriptive analysis.

b. Budget allocation to the CDOH
   - The domestic resource to the department was reconsidered from 30% to 40%
c. Percentage of actual health budget compared to the required budget on AWP is increased.
d. Budget execution rate is increased.

There was concern raised on execution rate in that many factors influence this indicator but it was clarified that measuring the indicator will come along with its share of bottle necks. Dr. Kioko commended the use of this indicator, saying that it will address inefficiencies on the side of financial management and proper utilization of allocated resources.

Concerns and comments

1) There was concern regarding what exactly is measured in supportive supervision and whether there was any reference to a standardized supervisory tool.
2) In regards to supervision, two important points were raised. First, there is need for strengthening SCHMTs which will be able to assist the CHMTs in supervision within the sub counties. Secondly, self- evaluation is key, where the health facilities supervise themselves and the CHMTs and SCHMTs come in to verify that comments deserve their assigned weights using the standard tool.
3) In regards to the 30% allocation to the health department, it was argued that most of it goes to salaries and thus there is need for continuous advocacy for more allocation. During such advocacy, personal emoluments need to be removed so as to better determine the actual proportion that will be used to operationalize the health function.
4) The DMS pointed out that the issues around allocation arose from the fact that no costing was done prior to devolving health. He suggested the need to enclose the 40% within the national budget from the on-set.
5) It was generally agreed that the indicator of 30% be revised to read 40%.
6) On support supervision, it was mentioned that it is difficult to collect all support supervision reports from all 47 counties, but instead collect APR reports from all the

counties which have support supervision component and thereafter a sample study may be done.

7) It was confirmed that there is a standard support supervision tool but indicators are revised now and then. The national team needs to prioritize county visits and institute continuous quality improvement; further, it needs to allocate finances to conduct supportive supervision at least once a year.
8) On output 2, there is need for standardization of AWP budget allocations and also to identify a denominator for budget allocation.
9) Dr. Kihama asked members present to propose and second the amendments that were made on the PDM. Dr. Oyancha proposed and was seconded by Mr. Ngochi of Kirinyaga County.
10) There was a general agreement that baseline data be collected by end of February 2017 so as to be incorporated in the Project mid-term review in March 2017.

Min 4/22/11/2016: Confirmation of previous minutes and action points from the 5th PSC.

1) Though page 7 of the 5th PSC minutes talked about various annexes, these were not included in the minutes. It was agreed that this will be added in the final version of the minutes. In terms of action points, they should be able to show the persons responsible and timelines.
2) On page 12 action point 1, there was a concern whether the ISO has provided any standard means of numbering. It was agreed that the numbering applied in the 6th minutes should be adopted going forward. It was further pointed out that the 1st, 2nd, 3rd and 4th minutes still remain drafts as they had no official signatures. It was decided that these minutes should be duly signed and that both names of the proposer and seconder be included in the minutes so as to authenticate the documents.
3) In addition, going forward, previous minutes should be confirmed before matters arising are discussed.

The following action points from the 5th PSC were not realized:

Number of action point as in the table.	Action point	Status of Action point or what is being done
3.	Provision of folder with all confirmed and signed minutes	Follow up on the signing of previous minutes
8.	More involvement of COG in schedule coordination	A CoG representative appointed but has not yet attended a meeting. A proposal to visit to the COG to enable them understand how scheduling work will be done and why their participation is necessary
9.	Hold expanded stakeholders forum on	Not yet done

	CDOH Core Functions	
10.	Start using functional CDOH assessment for partner support	Not yet done but Kericho has got the M&E plan which they may start using. Kirinyaga do not have any M&E Plan.
12	Stakeholder sensitization on common strategy to be conducted.	Ongoing
13.	Content and manuals for management curricula to be developed by November, 2016.	Will be achieved by end of November.

4) It was proposed that action points related to the partner counties would be addressed during their presentations.

On endorsement of the minutes as true record of the proceedings of the 5th PSC, Dr. Omondi proposed and was seconded by Ms. Yoshida from JICA – Kenya office.

Concerns

1) The list of persons in attendance should be separated so that it is easier to distinguish the members of the PSC committee, the secretariat, and the coopted members in attendance.
2) As well, it was noted that any amendments in previous minutes should be included under matters arising and not under confirmation of minutes.

Min 5/22/11/2016: Annual plan of the Project

The Chief Advisor of the project proposed that the members go through the report and raise their concerns or inputs, if any.

Reference was made to page 15 on the Gantt chart which should be reviewed every month and then shared with the PSC members so that they can understand project progress. It was further proposed that monthly meetings between HSC/IGA and the project be reactivated in order to enhance this process.

Min 6/22/11/2016: Overall progress and achievements of the project

The achievements are a reflection of the period July 2016 to October 2016. The important pillar in the first, second and third stages is mutual learning to be used in both levels of government. **(See Annex 1)**

A. He briefed on the achievements and the way forward of the strengthening of the coordination mechanism of the department of HSC/IGA.

Achievements and Outputs

- Strengthening of coordination mechanisms i.e. activation of TTCs, and Intergovernmental event scheduling with HSC/IGA
- Supported IGF for 2nd quarter of the year and coordinated with DPHK on involvement of DPs in the TTCs
- Set up online shared calendar that captures all intergovernmental events; however not much information has been uploaded to this calendar.
- The Schedule Coordination Focal Person Group had difficulties in collecting event schedule information in a timely manner.

Way forward:

- Support finalizing the participation of DPs to TTCs by the next TTC/IGF meeting (by the end of March 2017).
- Support HSC/IGA to establish linkages with other major health conferences by the end of May 2017.
- Reconsideration of schedule coordination with a more realistic and efficient method by end of Quandary 2017.

B. Ms. Saito briefed on the clarification of core function of CDOH

Achievements and Outputs

- Basic consensus was formed among the two governments.

Way forward:

- Briefing to the PS and the CS by the end of 2016.
- Hold a stakeholders' forum in January 2017.
- Reflect the inputs/comments given at the stakeholders' forum in February 2017.
- Forward the revised CDOH Core Function to COG.
- Wait for the Health and Biotechnology Committee for their review.
- Endorse the CDOH Core Function at an IGF meeting by the end of the third quarter of the 2016/17 financial year.

C. Ms. Saito spoke on the progress and the way forward of the M&E support

Achievements and Outputs

- Found that the functionality of CHMT was difficult to be represented universally by one or two indicators.
- The project supported defining and addition of wider range of indicators, which are regarded as important to see the managerial function of CDOH.

- The zero-draft of the 3rd version of the Indicator Manual was compiled in July 2016, and waiting for feedback from the MTR results.
- Based on the analysis of DHIS data, it was found out that availability of data in the health leadership and management area was very low

Way forward:

- Focus is now clarification of indicators for management areas.
- Stakeholder's meeting to share feedback from the Mid-Term Review of KHSSP in January 2017.
- Hold an Investment TWG to clean-up indicators of the management area in February 2017.
- Sharing final draft and collection of comments during February to March 2017.
- Finalization of the 3rd Indicator Manual by the end of March 2017.
- Data collection through county APR reports to complement DHIS data until February 2017.
- Analysis of available data on the baselines of the indicators in January 2017.
- Collect current data to see the progress during January to February 2017 for the Mid-term review of the project in May 2017.
- Candidate indicators for the CDOH Core Functions were selected from the indicator manual currently being revised
- Assessment by using the candidate indicators would be conducted in the partner counties to monitor the functionality of the CDOH of the partner counties as well as CDOH management capacity.

D. Dr. Hazel Mumbo explained the achievements and the way forward of the Standardization of county training for management area (Common Strategy)

Achievements and Outputs

- The draft of the Common Strategy Report.
- Final drafts of the Technical and General Health Systems Management Curricula.
- Agreement on iHRIS-Train reactivation among the key stakeholders.

Way forward:

- Common Strategy Report Launching in January 2017.
- Finalize the Participants' and Facilitators' manuals by the Common Strategy launching.
- Planning of the TOT for the management training curricula in January, 2017.
- Sensitization of stakeholders on the Common Strategy by the 3rd quarter of the year 2016/17 through national and cluster HRH-ICCs.
- Sensitization and advocating stakeholders on use of iHRIS-Train data base.
- Support HRD for implementation of the Common Strategy from January 2017

E. Ms. Kawano presented the achievements and way forward of the Mutual Learning

Achievements and Outputs

- The "Guideline on the Best Practice Selection" was finalized. It includes concept brief, selection criteria, award categories, best practice reporting format, and scoring sheet.
- Best Practice selection timeline for 2015/16 was prepared, however, the activities have not been implemented.
- The award ceremony for the 2014/15 took place at IGF Meeting.

Way forward:

- Support the 2015/16 selection of the Best Practice.
- Strengthening of sharing and promoting function of the Best Practice.
- Introducing mutual learning concept to the Partner Counties

Concern.

1) DPHK interests are captured in every thematic area and it should thus be able to choose a representative for each thematic areas. However, due to conflicting interests among DP members, who represent their own organizations rather than DPHK, it may be difficult for them to create synergy in representing in the TTCs. Caution therefore should be taken not to create parallel structures of representation. The issue to be discussed at the next TTCs forum and also with the DPHK (Dr. Onyancha).
2) On Miss Kaori's presentation, the indicator manual does not have the same indicators like the project PDM. Therefore the project implementation and progress monitoring will be separate. There was a proposal from the members that the indicators be included in the manual.
3) There was a clarification however that the indicators for AWP are included in the manual but those of the MTEF have not been included yet.

Min 7/22/11/2016: Progress from partner counties as presented by CECs.

Kericho:

The progress in Kericho County was presented by its CEC, Mrs. Hellen Ngeno, who also used the opportunity to share Kericho's M&E plan with some of the members present.

The achievements and aligned activities are as in **Annex 2.**

Kirinyaga

The presentation for Kirinyaga was done by Mr. Joseph Ngochi, who represented the CEC Mr. Wambu Miano. **(See Annex 3)**

Mr. Ngochi cited the following challenge:

1. Most members of Kirinyaga CHMT possess inadequate skills in programme based budgeting. There is thus urgent need for training around this.

Funding for all activities to take off as planned.

Min 8/22/11/ 2016: Plenary discussion

Due to time constraints – the committee did not go to plenary since most of the issues had been discussed at different stages of presentation.

Min 9/22/11/2016: Way forward

The Way forward was agreed upon as shown in the table below. There was a concern that in the subsequent PSC meetings – the way forward to be arranged as per the various output areas.

Action	Timeline	Responsibility
PSC		
Collect signatures for the previous minutes.	December 2016	PSC Secretariat
Prepare a filing system for the project documents.	Immediately after the minutes signing	PSC Secretariat
Mid-term review		
Collect baseline and the latest data for all PDM indicators and conduct self-evaluation.	End of February 2017	JICA expt. team
Conduct a Mid-term review of the project.	March 2017	JICA
Schedule coordination		
Visit to COG secretariat for event schedule coordination.	December 2016	HSC&IGA
Reconsider schedule coordination for more realistic and efficient methods.	End of January 2017	HSC&IGA
IGF		
Finalize the DP participation to the	End of March 2017	HSC&IGA

TTCs.		
Establish linkages between IGF and other major health conferences.	End of May 2017	HSC&IGA
CDOH Core Function		
Brief the CDOH Core Function to the PS and the CS.	End of December 2016	HSC&IGA
Hold a stakeholders' forum for the CDOH Core Function.	January 2017	CDOH TWG
Reflect the inputs/comments given at the stakeholders' forum to the CDOH Core Function.	February 2017	CDOH TWG
Forward the revised CDOH Core Function to the COG Health and Biotechnology Committee for approval.	April 2017	CDOH TWG
Present the CDOH Core Function for endorsement at an IGF meeting.	March 2017	CDOH TWG
Indicator Manual		
Conduct capacity assessment using the candidate indicators for the CDOHs of the Partner Counties to monitor the functionality of the CDOH.	January 2017	Partner Counties
Hold a stakeholder's meeting to share feedback from the Mid-Term Review of KHSSP to the Indicator Manual.	January 2017	M&E Unit
Hold an Investment TWG to clean-up indicators of the management area.	February 2017	Investment TWG
Share the final draft of the Indicator Manual and collect comments.	February to March 2017	M&E Unit
Finalize the 3rd Indicator Manual.	End of March 2017	M&E Unit
Common Strategy		
Disseminate the final draft of the Common Strategy.	January 2017	HRD Unit

Finalize the Participants' and Facilitators' manuals.	January 2017	HRD Unit
Plan TOTs for the management training curricula.	January, 2017	HRD Unit
Sensitize stakeholders on the Common Strategy through national and cluster HRH-ICCs.	March 2017	HRD Unit
Sensitize and advocate stakeholders on use of the iHRIS-Train.	March 2017	HRD Unit
Implement the Common Strategy.	From January 2017	HRD Unit
Best Practice		
Conduct the selection of the 2015/16 Best Practice.	From December 2016 till March 2017	M&E Unit
Strengthen the sharing and the replication promotion functions of the Best Practice.	From January 2017	M&E Unit
Introduce a mutual learning mechanism to the Partner Counties.	From January 2017	M&E Unit
Overall direction of the project		
Direct the project activities to be converged on the focus area of the strengthening of the MTEF/AWP cycle management capacity in the 4th and 5th year of the project.	Whole remaining period of the project	Project manager, Chief advisor

Min 10/22/11/2016: AOB

There was no AOB.

Min 11/22/11/2016: Closing remarks

(a) Dr. Makoto Tobe, Senior Advisor Health from Japan.

He said that since the partner counties were now aware of the indicators to be tracked, they could leverage on the indicators to advocate for more technical and financial support to improve planning. He also expressed his surprise that the project was the one still making presentations on annual work plans and overall progress, despite having been

operational in the country for the last 2 years. He emphasized that this is a Kenya project and therefore ownership should be exhibited.

(b) Mrs. Hellen Ng'eno, CEC Kericho.
She expressed her gratitude to the project and MOH team for enabling the county to surpass others in embracing effective planning. She said the lessons learnt will be shared with other counties. She was grateful that an agreement was reached to adjust the indicator for measuring the health department allocation to 40% and asked the National Government to assist in making counties understand that the only devolved function is health and thus it needs a lot of support financially. She thanked the JICA – OCCADEP team, the JICA-Tokyo team and Ministry Officials for making vital contributions to strengthen county understanding and improve leadership and finally expressed her hope to see 100% supportive supervision.

(c) Mr. Ngochi, representative from Kirinyaga
He appreciated the project and indicated that the county was very much willing to fast track activities with project and MOH so as to be at par with Kericho County. He said that if the 40% target is realized, then the county will accomplish many activities effectively. He promised to brief the CEC about the progress encountered at the meeting.

(d) Dr. Kihama, Chair of the meeting.
On his part, he said that devolution came with its challenges but that the project would be instrumental in addressing some of these challenges

Min12/22/11/2016: Adjournment

The meeting ended at 14:56 pm

MINUTES OF THE SEVENTH PROJECT STEERING COMMITTEE MEETING

FOR

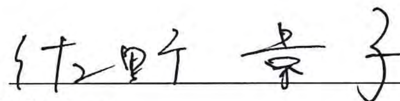
Organization Capacity Development Project for the Management of Devolved Health Systems in Kenya (OCCADEP)

The 7th Meeting of the Project Steering Committee (hereinafter referred to as "the PSC") of Organization Capacity Development Project for the Management of Devolved Health Systems in Kenya ((hereinafter referred to as "OCCADEP") was held on 13th June 2018. OCCADEP is jointly implemented by the Ministry of Health (MOH), Kericho and Kirinyaga Counties (hereinafter referred to as "the Partner Counties") and Japan International Cooperation Agency (JICA) as a five-year project that commenced in November 2014. The 7th PSC meeting aimed to (1) review the progress, (2) revise the composition and the frequency of PSC, (3) revise the Project Design Matrix (PDM), and (4) discuss and approve the work plan for the period ending September 2019.

The PSC members and participants exchanged their views and ideas for the way forward. Through this meeting, the PSC composition and frequency were revised and the 3rd version of PDM and the work plan were approved.

The detailed contents and discussion are attached hereto.
Nairobi, Kenya
13th June, 2018

Dr. Jackson Kioko
Director of Medical Services
Ministry of Health, The Republic of Kenya



Keiko Sano
Chief Representative
JICA Kenya Office

Dr. Patrick Amoth
Head, Department of Health Sector Coordination and Intergovernmental Affairs
Ministry of Health, The Republic of Kenya

Shioko Momose
Chief Advisor,
Organization Capacity Development Project for the Management of Devolve d Health Systems in Kenya

The 7th Project Steering Committee (PSC) meeting of the Organization Capacity Development Project for the Management of Devolved Health Systems in Kenya (OCCADEP) was held on 13th of June 2018 at Pan Afric Hotel in Nairobi.

1. Opening Session

The meeting was called to order at 9.30 a.m. by Dr. John Kihama, Head of Intergovernmental Affairs Division at MOH. He welcomed the participants to the meeting and invited a prayer that was led by Mr. George Karoki, County Director of Health, Kirinyaga County. The participants made self-introductions.

2. Welcome Remarks

2.1 Dr. Patrick Amoth, Project Manager, Head of Department of Health Sector Coordination and Intergovernmental Affairs thanked and all the participants for sparing time to attend the PSC meeting. He noted that although the project had achieved notable success, PSC members should keep in mind that the remaining project implementation period was short and a lot has to be accomplished before the end in September 2019.

2.2 He requested the leadership and guidance of Dr. Kioko, the Project Director, Director of Medical Services, on the revision of the PSC composition and its frequency, and Project Design Matrix (PDM) to make OCCADEP more effective and efficient to achieve its goal and purpose.

2.3 He further noted that OCCADEP was important with significant lessons to be learned and aims to eventually be scaled up to all the other counties in the country.

3. Opening Remarks

Dr. Jackson Kioko - Project Director, Director of Medical Services

3.1 Dr. Kioko began his remarks by appreciating the attendance of the participants at the meeting. He was concerned at the fact that the PSC had not been meeting regularly as required and advised members to adhere to the schedule that was initially agreed at the signing of the Record of Discussions (R/D). He however, acknowledged the numerous challenges faced within the ministry in terms of providing leadership that prevented the PSC from being held.

3.2 He reminded members that OCCADEP was developed to enhance the capacity of the county governments to be able to respond to the numerous health needs of the population immediately after devolution. He noted that OCCADEP was designed based on the experiences and outcomes from the SEMAH project implemented in the former Nyanza Province that delivered successful results.

3.3 Given the remaining short project implementation period, he urged members to realign their thinking towards making contributions to the nation's overall goal of achieving Universal Health Coverage (UHC).

3.4 He emphasized that revision of the PSC composition should be guided by certain principles of representation and availability of members that would add value to the Project.

3.5 He acknowledged the structural and operational challenges faced in the counties and the need to adopt and disseminate the standardized organizational structure in the county health

departments, and the need to have visionary leaders and managers that understand what needs to be done within the county, sub-counties, facilities and community units in order to achieve UHC.

3.6 He appreciated what the project has been able to accomplish and was looking forward to learning the progress made by OCCADEP and the activities planned for the remaining project period.

4. Overall Progress and Achievements of OCCADEP

Dr. Patrick Amoth – Project Manager, Head of Department of Health Sector Coordination and Intergovernmental Affairs

Dr. Amoth briefed members on the overall progress and achievements of the Project as summarized in the following section.

4.1 The designing of the Project started when the government of Kenya requested JICA for technical assistance to strengthen the organizational capacity under the devolved health system.

4.2 The overall goal of the project is that devolved health systems are strengthened to ensure equitable and quality services in achieving UHC in Kenya. The project purpose is to ensure that managerial functions of the partner county departments of health (CDOH) are strengthened.

4.3 The management structure of the project is comprised of the Project Director, Project Manager, counterparts at national and county levels and the PSC.

4.4 Proposal to change the frequency of the PSC meetings from quarterly to twice a year and to conduct Project Technical Meetings (PTM) to complement the PSC.

- October or November 2018: PTM to discuss the progress of the first quarter of the fourth term of OCCADEP and share learnings and way forward.
- March 2019: PTM to discuss on progress of the second quarter of the fourth term of OCCADEP and assess achievement based on the indicators set in the PDDM.
- April or May 2019: PSC to discuss on the results of the Terminal Evaluation.
- September 2019: Final PSC for evaluating the Project's achievement and closure of OCCADEP.

The PTM would review progress and exchange lessons learned and the minutes of meeting would be shared with the PSC members for information. He also proposed that instead of the PSC reporting to the Health Sector Coordination Committee (HSCC) as indicated in the R/D, the committee should report annually to the UHC Steering Committee.

4.5 He further proposed revision of the PSC membership as follows:

(MOH)

- Director of Medical Services, MOH (As Chair / Project Director)
- Head, Department of Health Sector Coordination and Inter-Governmental Affairs (As Project Manager)
- Head, Department of Policy Planning
- Head, Department of Health Standards, Quality Assurance and Regulation
- Head, Department of UHC coordination

(Counties)
- County Executive Committee (CEC) members of health from Kirinyaga
- County Executive Committee (CEC) members of health from Kericho

(JICA)
- Chief Representative, JICA Kenya Office
- JICA Experts

Any other members accepted by the Chair

4.6 He highlighted the achievements made by the project during the course of its first-half period and shared the summary of recommendations of the Mid-term Review (MTR) conducted in March 2017. Activities implemented in the third term and the plans for the fourth term of the project were also explained. He noted that based on the results of the MTR, the Project Design Framework had to be revised to focus more on the two partner counties with emphasis on building capacity for the Medium Term Expenditure Framework (MTEF) cycle management.

4.7 He concluded that the project was contributing to the efforts for achievement of UHC through: strengthening consultation and cooperation between national and county governments for accelerated actions around UHC; building county capacities in order to deliver quality health services; and identifying and scaling up of best practices.

5. Progress of Reforms on the Health Sector Intergovernmental Consultative Forum (HSIGCF)

Dr. John Kihama, Head of Intergovernmental Affairs Division at MOH.

5.1 Dr. Kihama took members through the progress on the HSIGCF reforms. He noted that the HSIGCF during its 9th session held on 15th February 2017 had discussions on its operations and governance structures and need to strengthen its operations. Following the discussions, MOH in consultation with the Council of Governors (COG) and with support from JICA Kenya Office, commissioned a study by a local consultant to review the performance of the HSIGCF during the term between 2013 and 2017. The purpose of the review was to identify opportunities to improve and re-align the HSIGCF so that it can perform its role more efficiently and effectively.

5.2 He explained the findings of the review highlighting the following key issues:

- The two legislations (The Intergovernmental Relations Act Section 13 (2) and the Health Act 2017) are not conflicting but rather complementing each other in terms of giving a new direction on how IGF should operate.
- The forum was launched without a clear definition of roles and responsibilities for actors.
- The need to put in place mechanisms and systems to track implementation of resolutions and recommendations from the HSIGCF.
- Challenges exist in the leadership and composition of Thematic Technical Committees (TTCs).
- Weakness in documentation of outputs from committees and HSIGCF meetings.
- Lack of a proper budget plan and funding for HSIGCF and TTC meetings

5.3 He noted that based on the review, a draft operational manual was developed and discussed at the HSIGCF Reforms Stakeholders Meeting held on 15th and 16th February 2018 and subsequently at the 11th IGF held on 9th and 10th May 2018. The following are the recommendations generated from the two meetings:

- Composition of TTCs
  - i. Each TTC should have a maximum 15 members
  - ii. Members of each TTC will comprise of:
    - MoH: Heads of Departments, Heads of relevant divisions and units (maximum 3 people)
    - County Directors of Health (CDH) : maximum 8 people
    - SAGAs: 1 person
    - DPs: maximum 3 people
- HSIGCF Secretariat
  - i. MOH and COG to nominate the staff, 2 nominees from MOH and 2 nominees from COG.
  - ii. There should be an office for the secretariat preferably at National Hospital Insurance Fund (NHIF). However, options of locating the secretariat at MOH or COG can also be considered.
  - iii. Meanwhile, the current arrangement of the secretariat function can be maintained at MOH with active links with COG.
- Recommendation on Budget and Financing for Operations of the HSIGCF
  - i. The MOH/National Government should bear the responsibility of funding the HSIGCF under the UHC agenda.
  - ii. Funding for the HSIGCF to be shared by both levels of governments effective from FY 2019/2020 onwards. In the meantime, the MOH/National Government to mobilize resources for FY 2018/2019.
  - iii. For efficiency gains, the HSIGCF should leverage on sector meeting and events that bring together the national and county governments.
  - iv. Whenever there are emerging issues that require consultations through HSIGCF both levels of governments will co-finance the meetings.

5.4 In his conclusion, he noted that the way forward was to finalize the operational manual in consultation with Council of County Executive Committee Members for Health and COG Secretariat, and submit the operational manual to the co-chairs of the HSIGCF for final approval.

6. Progress of the Kericho County Support

Dr. Betty Langat, County Director of Health, County Department of Health (CDOH), Kericho County

6.1 Dr. Langat gave a brief description of Kericho County's demographics, the distribution of health facilities, and background information on OCCADEP's support in the county.

6.2 She also introduced the activities achieved through OCCADEP's support highlighting the development of the M&E plan, Annual Working Plan (AWP), tools to manage MTEF cycle and organogram and work flowchart to facilitate the MTEF cycle.

6.3 She pointed out that the County still faced challenges in planning at the community level. Other challenges included: a) AWP templates being sent late from MOH; b) consolidation and utilization of AWP at the sub-county level was still weak; c) lack of a clear link between AWP activity budget and actual expenditure; and d) members of County Assembly Health Committees not actively involved in the development of AWPs and lobbying for funding to the sector.

6.4 Dr. Langat presented the following next steps and recommendations for the county:

a. Linking AWP activity budget to actual expenditure
b. Strengthening capacity of County leadership, such as assembly members on health activities.
c. Support for health sector Annual Performance Review (APR)
d. Support for monthly and quarterly data review meetings
e. Strengthening Community health units
f. End term review of County Health Sector Strategic and Investment Plan (CHSSIP)1
g. Development of the 2018/2022 CHSSIP 2
h. Conducting stakeholders meetings for planning and review of sector activities

7. Progress of the Kirinyaga County Support

Mr. George Karoki, County Director of Health, CDOH, Kirinyaga County

7.1 Mr. Karoki gave a brief overview of the activities conducted through support of OCCADEP in the county since the beginning of the year. He noted that the CDOH held a series of meetings in the beginning of 2018 to update Dr. Agnes Gachoki, new CEC for Health in the county on the previous activities carried out by the Project prior to her appointment.

7.2 The value added support by OCCADEP included: a) a mid-term review of the 2017/2018 CDOH annual work plan; b) revision of the AWP to realign to the revised county budget; c) preparation of the 2018/2019 AWP as an advocacy and negotiation tool for the 2018/2019 budget; d) increased participation by lower level health facilities in the planning process; and e) boost of confidence for CHMT members in the health planning process.

7.3 The planned activities in the county with the support from OCCADEP were explained as follows:

a. Development of the CHSSIP 2018-2022- May-November 2018
b. Review of the 2017/18 AWP performance - August 2018
c. Development of the 2019/2020 MTEF Budget – August 2018-April 2019
d. Monitoring and Evaluation Framework and plan Development - May-October 2018
e. M&E implementation is the key.
f. Development of Kirinyaga County Health Department AWP 2019/2020 January 2019-April 2019 and implementation of the electronic MTEF management tool
g. Study visits, sharing lessons learned among other CDOHs

7.4 Dr. Gachoki added that the 2018/19 AWP is aligned to the county's 5-year County Integrated Development Plan (CIDP) and the CDOH is revising the CHSSIP with OCCADEP's support to realign it to the CIDP.

8. Demonstration of the MTEF Management Tool

Mr. Isaac Langat, County Health Administrative Officer, Kericho County

8.1 Mr. Langat demonstrated the skills acquired from technical transfer by the Project on how to enter AWP data into the excel MTEF Management tool developed by the project.
8.2 Dr. Langat, Director CDOH Kericho, noted that the source document for data that feeds into the MTEF management tool was the county's approved budget, and the tool will be used by county accountants for tracking expenditure linked to activities in the AWP.
8.3 Mr. Langat noted that the tool will enhance efficiency and productivity of the county health department in managing, planning, budgeting and monitoring. He recommended that some adjustments be made to make the tool more user-friendly.

9. Comments from the PSC Members and Participants

9.1 Dr. Kioko pointed that there is need for a paradigm shift in financing for the health sector from a system that rewards poor performance exhibited by high morbidity and mortality rates. He underlined the need of mindset change to focus more on preventive and promotive and not a system that focuses on facility – oriented curative services for a sick population.
9.2 Dr. Kioko made reference to the proposed revision of the frequency of PSC meetings noting that given the sense of urgency in the remaining project period, meeting twice a year would hinder monitoring activities to make a meaningful impact to this project. He also suggested realigning the PSC meetings to the UHC's meeting cycle so that there would be proper flow of information.
9.3 Ms. Momose, Chief Advisor to OCCADEP explained that PTMs were planned to be held to provide a technical layer that would analyze the issues to be addressed by the PSC. She also added that most of the participants at the PTM were also members of the PSC.
9.4 As regards the way forward for the HSIGCF reforms, Dr. Kioko advised that clear timelines be set to guide the necessary actions. He emphasized that timelines for implementation of the HSIGCF recommendations were necessary to enable reporting on the actions to be carried out.
9.5 Dr. Gachoki agreed with Dr. Kioko that there was need to focus more on preventive and promotive health measures. She said that the community health approach is important for achieving UHC and shared that in strengthening community health, Kirinyaga County had purchased android phones for the Community Health Extension Workers (CHEWs) to collect data from households. She also expressed her appreciation to the project for assistance in development of a brochure for the health facilities in-charges to chart their activities on a monthly basis, which will go a long way in helping them achieve the county's deliverables.
9.6 A question was raised regarding the rationale behind choosing Kisumu and Kakamega counties for the study tour with Members of County Assembly (MCA) planned for the following week. Dr. Kioko pointed out that Siaya County could have been considered for learning on Community Health Strategy given that the County is paying Community Health Volunteers

(CHVs) based on performance, which has improved the health indicators and coverage of preventive health services over time. As for the timing, Dr. Langat pointed out that although the study tour would not respond to advocacy for lobbying for funding for the financial year 2018/19, MCAs attending the study tour will have information to support CDOH in securing funding during the supplementary budget process in January 2019.

9.7 Several suggestions were raised regarding the MTEF management tool such as:

a. MTEF management tool to be utilized at sub-county level in order to consolidate information from facilities and community units.
b. CECs and CDOH should have a more summarized chart or dashboard in order to monitor data swiftly.

9.8 It was noted that harmonizing the structure at the county level to generate confidence by involving all concerned was key. This involved linking the work specified for each actor with the available resources in order to relate actual expenditure with items are already been planned.

9.9 By virtue of OCCADEP's partnership with Kericho and Kirinyaga counties, Mr. Kinyangi noted that JICA Kenya Office has targeted some of the available training programs in Japan and other countries to benefit the two partner counties. He encouraged the CHMTs to harness the knowledge and skills of the ex-participants of training programs and cascade the same to other levels in the overall context of improving the quality of services in the counties.

10. Revision of the Project Design Matrix (PDM) and Work Plan for the 4th Term

Ms. Shioko Momose – Chief Advisor, JICA-OCCADEP

10.1 Ms. Momose explained the proposed revisions to the PDM as contained in version 3 to the PSC for consideration and approval. She explained the reasons for the revisions citing the recommendations agreed in the MTR conducted in March 2017. The main reasons were that the initial PDM was deemed to be too ambitious, and therefore had to be revised in the scope of the remaining period focusing the activities on the two partner counties. A detailed comparison table of PDM version 2 and version 3 was provided (Annex 5).

10.2 Ms. Momose explained the logical framework of PDM and how the indicators were selected based on the activities and expected outputs. She also gave a detailed explanation of the evaluation process at each stage of the project and how it will be assessed.

10.3 She also added that during the third term, intensive discussions were held with HSC/IGA, CDHs and CHMT members of the partner counties, JICA Kenya Office and JICA Headquarters on the proposed revisions. The proposed revisions to the PDM were also discussed and agreed in principle at the PTM held on 3rd April 2018.

10.4 Following the detailed presentation on the PDM, Ms. Momose explained the work plan for the fourth term in which the activities and sub-activities were based on the revised PDM. She highlighted the schedule and clarified the contents of activities linking to the expected outputs.

11. Approval of Composition & Frequency of PSC, Revised PDM Ver.3 and Work Plan

11.1 Comments and observations were invited from the PSC on the revised PDM and work plan for the fourth term. The PSC unanimously adopted and approved the revised PDM version 3 (Annex 4) and work plan for the fourth term (Annex 6) with the following recommendations:

a. The title of the PDM be changed to 'PDM Version 3 Approved on 13th June at the 7th PSC Meeting
b. Under the overall goal, indicator 2, the six counties will be identified through study tours and partner counties' presentations at the HSIGCF to promote the tools developed by OCCADEP to other counties.

11.2 Based on the guidance given by Dr. Kioko on the composition and frequency of the PSC and comments given by Ms. Momose, the PSC concluded the meeting twice a year was sufficient. It was agreed that the PTM would complement the PSC to provide a technical layer to OCCADEP that would enable to analyze the issues to be addressed by the PSC. Therefore, the PSC adopted and approved the proposed revisions to the composition and frequency of the PSC (Annex 3).

12. A.O.B

12.1 Ms. Yuki Kobayashi, MTEF Cycle Operation Advisor, reiterated the concerns of Dr. Langat regarding the importance of logically inter-linking the CHSSIP, CIDP, and AWP in the correct order. She appealed to the ministry and development partners supporting the formulation of CHSSIP and AWP templates that the templates be availed at the appropriate timing so that CDOH team can work according to the MTEF Cycle Calendar, and they do not have to rework on the template when availed late.

13. Closing Remarks

Mr. Shinjiro Amameishi, Senior Representative, JICA Kenya Office

13.1 Mr. Amameishi expressed his appreciation for the active participation of the members. He acknowledged the challenges faced by the counties in implementing the MTEF life cycle and linking CHSSIP to the CIDP and AWP. He also noted the challenges faced by the national government in activating the HSIGCF to enable effective communication, consultation and dissemination of good practices. He stressed the importance of HSIGCF taking appropriate actions in implementing its resolutions and recommendations.

13.2 Dr. Amoth assured JICA of the ministry's full commitment to HGICF. He stated that the 12th HSIGCF would be held in November 2018 when the department will have funds in supplementary budget and was confident that the next HSIGCF will be fully supported by the national government.

Dr. Agnes Gachoki, CEC Kirinyaga

13.3 Dr. Gachoki commended participants on the interactive discussions on very pertinent issues affecting the routine delivery of health services in the counties. She thanked the OCCADEP team for making vital contributions to strengthen the county's understanding on the importance of health planning and budgeting. She remarked that being hands-on with the project, she is able to brief the County governor for Kirinyaga and discuss with members of

the county assembly to advocate for more financial support to the health budget. She also expressed hope that in the future the county will be able to allocate more funds for planning and set up an M&E unit for sustainability after the project closes.

Annex1: Program of PSC
Annex2: List of Participants
Annex3: New Composition of PSC members and its frequency
Annex4: PDM Ver3
Annex5: Comparison sheet of PDM Ver2 and Ver 3
Annex6: Work Plan

TIME	Agenda Item	PRESENTER
08:00 - 08:30	Registration	Kate, Judy
08:30 - 09:00	Welcome /Prayers /Introductions	Dr. John Kihama, Head of IGA Div.
09:00 - 09:20	Opening remarks	Dr. Jackson Kioko, DMS, Project Director
09:20 – 09:40	Overall progress and achievements of the project	Dr. Patrick Amoth, Head of Dept. HSC/IGA, Project Manager
09:40 – 09:55	Progress of the HSC/IGA on IGF Reforms	Dr. John Kihama, Head of IGA Div.
09:55 – 10:25	Progress of the Partner County Support o CEC or Director of Health, Kericho County o CEC or Director of Health, Kirinyaga County	Dr. Shadrack Mutai, CEC /Dr. Betty Langat, CDH/ Dr. Agnes Gachoki, CEC / Mr. George Karoki, CDH
10:25-10:40	Demonstration of the MTEF Management Tool	CHMT member from Kericho
10:40 – 11:00	**HEALTH BREAK**	
11:00 – 11:20	Revision of the Project Design Matrix (PDM) and Work Plan for the 4th term	Momose Shioko, Chief Advisor, JICA-OCCADEP
11:20 – 11:40	Comments from the floor	Dr. John Kihama, Head of IGA Div.
11:40 – 11:50	Approval of Composition & Frequency of PSC, PDM and Work Plan	Dr. Jackson Kioko, DMS, Project Director
11:50 – 12:00	A.O.B	Dr. John Kihama, Head of IGA Div.
12:00 – 12:40	Closing remarks o CEC for Health, Kericho and Kirinyaga County o Senior Representative, JICA Kenya Office o Director of Medical Services,	Dr. Shadrack Mutai, CEC Kericho & Dr. Agnes Gachoki, CEC Kirinyaga Mr. Shinjiro Amameishi, Senior Representative, JICA Kenya Office Dr. Jackson Kioko, DMS, Project Director
12:40 – 14:00	**HEALTH BREAK**	

List of Participants

(a) PSC Members Present

No.	Name	Organization	Position
1.	Dr. Jackson Kioko	MOH	Director of Medical Services
2.	Dr. Agnes Gachoki	Kirinyaga	County Executive Committee, Health
3.	Dr. Patrick Amoth	MOH	Head, Dept. of Health Sector Coordination and Inter-governmental Affairs (HSC&IGA)
4.	Shinjiro Amameishi	JICA Kenya	Deputy Representative
5.	Kumiko Yoshida	MOH JICA	JICA Expert/ UHC Advisor
6.	Shioko Momose	JICA OCCADEP	Chief Advisor/ Health System Management
7.	Nobuyuki Hashimoto	JICA OCCADEP	County Health Management Advisor
8.	Yuki Kobayashi	JICA OCCADEP	MTEF Cycle Operation Advisor
9.	Shinichi Kimura	JICA OCCADEP	Project Coordinator /Training Programme

(b) Secretariat

No.	Name	Organization	Position
1.	Dr. John Kihama	MOH	Head, Div. IGA, Dept. HSC&IGA
2.	Dr. G.K Toromo	MOH	Dept. HSC&IGA
3.	Stephen Cheruiyot	MOH	Economist, Dept. HSC&IGA

(c) Co – Opted Members

No.	Name	Organization	Position
1.	George Karoki	Kirinyaga	County Director of Health
2.	Dr. Betty Langat	Kericho	County Director of Health
3.	Itsuko Shirotani	JICA Kenya	Project Formulation Advisor
4.	Elijah Kinyangi	JICA Kenya	Senior Program Officer, JICA Kenya Office
5.	Isaak Langat	Kericho	Sub-County Assistant Chief Health Administrative Officer
6.	Dr. Collins Biwott	Kericho	Sub County Department of Health, Kipkelion East

7.	Wilfred M. Mutemi	Kirinyaga	County Public Health Officer
8.	Henry Onyiego	MOH	Dept. Policy Planning
9.	Catherine Mahihu	OCCADEP	Administrative Officer
10.	Njeru Judy C. Muthoni	OCCADEP	Project Assistant. Kirinyaga County

Annex 3

Agreed Revision on PSC structures at 7th PSC on 13 June 2018

- PSC conducted twice a year.
- Report annually to UHC Steering Committee
- Members

(MOH)

- Director of Medical Services, MOH (As Chair / Project Director)
- Head, Department of Health Sector Coordination and Inter-Governmental Affairs (As Project Manager)
- Head, Department of Policy Planning
- Head, Department of Health Standards, Quality Assurance and Regulation
- Head, Department of UHC coordination

(Counties)

- CECs for Health from Kericho and Kirinyaga

(JICA)

- Chief Representative, JICA Kenya Office
- JICA Experts

Any other members accepted by the Chair

Annex 4

Project Design Matrix (PDM): Version 3 (revised on 13 June 2018 at the 7th Project Steering Committee meeting)

Title: Organizational Capacity Development Project for the Management of Devolved Health Systems in Kenya (OCCADEP)

Period: November 2014 - September 2019 (5 years)

Direct Target Groups: Ministry of Health (MOH) personnel involved in managerial capacity development of counties, and members of County Department of Health (CDOH) of Kericho and Kirinyaga.

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Important Assumptions
Overall Goal			
Devolved Health Systems are strengthened to ensure equitable and quality services in achieving Universal Health Coverage in Kenya.	1 The budget allocation of non-salary items within the recurrent budget in the Partner Counties are at least 25% and 30% for Kirinyaga and Kericho respectively. 2 At least 6 counties including the Partner Counties are utilizing the MTEF tools developed by the Project.	Budget composition from CDOH. The data can also be found in APR - On site visit and interview.	
Project Purpose			
Managerial functions of County Department of Health (CDOH) are strengthened.	1. CHMTs, SCHMTs have monitored and evaluated at least 50% of Health Facilities using at least one of the MTEF tools developed by the Project.	- Monitoring by the Project (monthly report)	

CDOH here means the CDOH in the partner counties.

	2. Annual Work Plan (AWP) and Annual Performance Review (APR) of health sector are submitted by April and November respectively every fiscal year. 3. At least 50% of county specific action points agreed in the way forward/resolutions at Health Sector Intergovernmental Consultative Forum (HSIGCF) are implemented in the Partner Counties.	- Monitoring by the Project (monthly report) - Monitoring by the Project (monthly report)	
Outputs			
1 Mutual support and learnings among MOH and CDOHs are strengthened through HSIGCF and other mechanisms.	1-1 Way forward/resolutions and county specific action points are confirmed in every HSIGCF. 1-2 Events to share the lessons learned from the Counties are held more than twice by the end of the Project. 1-3 Best Practices and lessons learned from the Partner Counties are documented and disseminated through the MOH website and/or in other forms.	- Minutes and the report of the HSIGCF - Reports from the Project (monthly report) - Website of MOH, Project materials, etc.	HSIGCF is held regularly after FY2018/19
2 MTEF cycle management (planning, budgeting, implementation and monitoring) is strengthened in CDOHs of Partner Counties.	2-1 At least 4 MTEF tools (i.e. User-friendly MTEF Annual Cycle work flow-chart, AWP Practical Guideline, MTEF management tool, etc.) are developed and disseminated in Partner Counties by the Project 2-2 At least 70% of CHMT and Health Facilities in each Partner County utilize more than one of the MTEF tools developed by the Project.	- Materials developed by CHMT and OCCADEP - Monitoring by the Project (monthly report)	

CHMT, SCHMT and Health Facilities.

Annex 4

Activities	Inputs		
1. Mutual support and learnings among MOH and CDOHs are strengthened through HSIGCF and other mechanisms.	**Japan**	**Kenya**	
1-1 [*Ministry of Health (MOH)*] Identify and strengthen county coordination and support mechanism in MOH.	**Dispatch of Experts**	**Counterparts**	Fund for convening HSIGCF is secured by Kenyan side.
1-2 [*Human Resource Development (HRD)*] Identify capacity gaps and available training programs in county health systems management (HSM).	1. Chief Advisor 2. Health Systems Management 3. Training Coordination 4. Health Planning 5. Project Coordinator	1. Project Director 2. Project Manager 3. Technical Staff 4. Training institutions 5. Other personnel mutually agreed upon as needed	
1-3 [HRD] To develop HSM county training strategy.			
1-4 [*Health Sector Coordination and Intergovernmental Affairs (HSC/IGA)*] Provide technical support to HSIGCFs between two levels of government to discuss issues of common interest.			
1-5 Share the lessons learned of the Project through existing fora and other occasions among counties.	**Equipment and Material** 1. Necessary equipment and materials for the project activities 2. Other equipment and materials mutually agreed upon as necessary	**Facilities, equipment and materials** 1.Office space for the Project 2.Necessary equipment and materials for the Project activities	Turn-over of CDOH staff trained on the health management by the Project does not adversely affect Project activities.
2. MTEF cycle management (Planning, budgeting, implementation and monitoring) is strengthened in CDOHs of Partner Counties.			
2-1 [*HSC/IGA, HRD*] To conduct situation analysis to identify county's managerial challenges and CDOH core functions.			
2-2 [*Project Steering Committee (PSC)*] To identify partner counties of the Project.			
2-3 Provide technical assistance for the health sector Medium Term Expenditure Framework (MTEF) cycle (or planning, budgeting and review cycle) to the Partner Counties.	**Local Costs** Training and forums (cost sharing with MOH, Counties and Partners)	**Local Costs** Operational costs for implementing activities	
2-4 [*Partner Counties*] Document experience and lessons learned from implementation of MTEF cycle in the Partner Counties.			
2-5 [*Partner Counties*] Provide feedbacks to intergovernmental frameworks on lessons learned.			

Annex 5

Comparison Table PDM ver 2 and ver 3

PDM ver2 (approved in Nov 2016 at the 6th PSC)	Revised PDM (ver3)
Overall Goal Devolved health systems are strengthened to ensure equitable and quality services in achieving UHC in entire Kenya.	Devolved health systems are strengthened to ensure equitable and quality services in achieving UHC in Kenya.
Project Purpose Managerial functions of CDOH are strengthened.	same
Output1 Managerial support functions and coordination mechanisms at national level are strengthened.	Mutual support and learnings among MOH and CDOHs are strengthened through HSIGCF and other mechanisms.
Output2 Leadership and managerial capacities of CDOH are strengthened.	MTEF cycle management (planning, budgeting, implementation and monitoring) is strengthened in CDOHs of Partner Counties.
Output3 Mutual learning among CDOH is strengthened.	
Indicator for Overall Goal 1. Core Health Indicators at national level (Maternal Mortality Ratio [MMR], Under Five Mortality Rate [U5MR], and Infant Mortality Rate [IMR]) are improved. 2. Service utilization of antenatal care, delivery conducted by skilled attendants, and child immunization of the poorest 40% is increased.	1. The budget allocation of non-salary within the recurrent budget in the Partner Counties are at least 25% and 30% for Kirinyaga and Kericho respectively. 2. At least 6 counties including the Partner Counties are utilizing the MTEF tools developed by the Project.
Indicators for Project Purpose 1. Medium-Term Expenditure Framework (MTEF) and Annual Work Plan (AWP) of health sector are approved by County Executive Committee (CEC) member for health by the end of November and March of each fiscal year, respectively. 2. % of health facilities supervised by CDOH/sub-county at least four times per year	1. CHMTs, SCHMTs have monitored and evaluated at least 50% of Health Facilities using at least one of the MTEF tools developed by the Project. 2. Annual Work Plan (AWP) and Annual Performance Review (APR) of health sector are submitted by April and November respectively every fiscal year. 3. At least 50% of county specific action

3. Performance monitoring meeting[3] conducted at least once a year 4. Counties submitting annual performance review (APR) report to CEC by November of each year	points agreed in the way forward/resolutions at Health Sector Intergovernmental Consultative Forum (HSIGCF) are implemented in the Partner Counties.
Indicator for Output 1 1. Functions of Health Sector Coordination and Intergovernmental Affairs (HSC/IGA) are set up. 2. County health systems management training strategy, as a component of an integrated county training strategy for health, is developed based on needs of the counties, and revised based on feedback from experiences in the partner counties. 3. Number of Inter-governmental Health Forum (IGF) convened.	1. Way forward/resolutions and county specific action points are confirmed in every HSIGCF. 2. Events to share the lessons learned from the Counties are held more than twice by the end of the Project. 3. Best Practices and lessons learned from the Partner Counties are documented and disseminated through the MOH website and/or in other forms.
Indicators for Output2 1. Partner counties develop MTEF and AWP of health sector with: a) situation analysis / review of achievements in previous year b) priority setting c) consideration on equity towards Universal Health Coverage (UHC)4 d) coordination with relevant stakeholders including development partners (DPs) / implementation partners (IPs) e) public participation 2. Budget allocation to the health sector is no less than 30% in the partner counties (excluding external funding). 3. % of actual health budget compared to required health budget based on the AWP is increased. 4. Budget execution rate is increased.	1. At least 4 MTEF tools (i.e. User-friendly MTEF Annual Cycle work flow-chart, AWP Practical Guideline, MTEF management tool, etc.) are developed and disseminated in Partner Counties5 by the Project 2. At least 70% of CHMT and Health Facilities in each Partner County utilize more than one of the MTEF tools developed by the Project.
Indicators for Output 3 1. Number of documents and events to share lessons learnt and good practices.	
1.1 [Ministry of Health (MOH)] To identify and strengthen county coordination and support mechanism in MOH.	same

Performance monitoring meeting is defined as a meeting which monitors progress of implementation of activities in the annual work plan (AWP) and health service indicators during a year at county level.

Universal Health Coverage is defined as a status that all people have access to needed health services of sufficient quality and that the use of these services does not expose the user to financial hardship. Inequity in the health service utilization and the financial risk protection due to area of residence (urban/rural), household income, gender, education levels, age (children and the aged), ethnicity (minorities), and others needs to be reduced to promote equity towards UHC.

CHMT, SCHMT and Health Facilities.

1.2 [Human Resource Development (HRD)] To identify capacity gaps and available training programs in county health systems management (HSM).	same
1.3 [HRD] To develop HSM county training strategy.	same
1.4 [Health Sector Coordination and Inter Governmental Affairs (HSC/IGA)] convene Inter-Governmental Health Forum (IGF) between two levels of government to discuss issues of common interest	1-4 [Health Sector Coordination and Inter Governmental Affairs (HSC/IGA)] Provide technical support to HSIGCF between two levels of government to discuss issues of common interest.
	1-5 Share the lessons learned of the Project through existing fora and other occasions among counties.
2.1 [HSC/IGA, HRD] To conduct situation analysis to identify county's managerial challenges and CDOH core functions.	same
2.2 [*Project Steering Committee (PSC)*] To identify partner counties of the Project.	same
2.3 [Health Policy & Planning, HRD, Quality and Standard; Training Institutions] To provide technical assistance for the health sector Medium Term Expenditure Framework [MTEF] cycle (or planning, budgeting and review cycle) to the partner counties.	2.3 To provide technical assistance for the health sector Medium Term Expenditure Framework (MTEF) cycle (or planning, budgeting and review cycle) to the Partner Counties.
2.4 [Partner Counties] To extract lessons learnt from the partner counties' experiences.	same
2.5 [HRD, Quality and Standard; Training Institutions] To provide feedbacks to inter-governmental frameworks and the county training strategies.	2.5 To provide feedbacks to intergovernmental frameworks on lessons learned.
3.1 [MOH, Counties]To reinforce recognition mechanism and dissemination fora for good practice	
3.2 [Partner Counties] To document experience and lessons-learnt from implementation of MTEF and AWP cycle in the partner counties.	
3.3 [Partner Counties] To share the lessons learnt of the Project through existing fora.	
Target Group MOH personnel involved in managerial capacity development of counties, and members of County Department of Health (CDOH) of all 47 counties of Kenya.	**Target Group** Ministry of Health (MOH) personnel involved in managerial capacity development of counties, and members of County Department of Health (CDOH) of Kericho and Kirinyaga.

Annex 6

Work Plan

Overall Goal : Devolved Health Systems are strengthened to ensure equitable and quality services in achieving Universal Health Coverage in Kenya.

Project Objective : Managerial functions of County Department of Health (CDOH) are strengthened.

Activities	Term 4																
	2018								2019								
	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Output 1: Mutual support and learnings among MOH and CDOHs are strengthened through IGF and other mechanisms.																	
Activity 1-4 : [Health Sector Coordination and Inter Governmental Affairs(HSC/IGA)] Convene Inter-governmental Health Forum (IGF)between two levels of government to discuss issues of commoninterest.																	
1-4.1 Materialize Operation Guideline																	
1-4.2 Techical Assistance to IGF when held																	
Activity 1-5 : Share the lessons learnt of the Project through existing fora and other occasions between counties.																	
1-5.1 Share the lessons learned of the Project through study tours or other meetings																	
1-5.2 Share the lessons learnt of the Project through IGF and MOH homepage.																	
Output 2: MTEF cycle management (Planning, budgeting, implementation and monitoring) is strengthened in CDOHs of Partner Counties.																	
Activity 2-3 : Provide technical assistance for the health sector MediumTerm Expenditure Framework [MTEF] cycle (or planning,budgeting and review cycle) to the partner counties.																	
2-3.1 Provide technical assistance to APR and AWP																	
2-3.2 Conduct monitoring, supportive supervison on activites, expenditures and review of prioritized health indicators of the county.																	
2-3.3 Develop MTEF tools and train the targeted group on how to use																	
Activity 2-4 : [Partner Counties] Document experience and lessons-learnt from implementation of MTEF and AWP cycle in the partnercounties.																	
2-4.1 Document utilization of the MTEF tools and extract lessons learned.																	
2-4.2 Document the whole MTEF cycle experience and extract lessons learned																	
2-4.3 Document the lessons learned from other Project supported activities from study tours, Strategic Plan development and Sensitization event for assembly members.																	
Activity 2-5 : [Partner Counties] Provide feedbacks to inter-governmental frameworks on lessons learned.																	

Annex 6

MANAGEMENT	OUTPUT 1	OUTPUT2	MONTH/ YEAR	MTEF Tools				
	Mutual support and learnings among MOH and CDOHs are strengthened through IGF and other mechanisms.	MTEF cycle management (Planning, budgeting, implementation and monitoring) is strengthened in CDOHs of Partner Counties.		**MTEF Chart**	**Governance Structure**	**MTEF Brochure**	**MTEF Management Tool**	**AWP Practictical Guideline**
	(i) Technical support for IGF when held <till the end of the Project> **(ii) Revise IGF Operation Manual**	(a) AWP Stakeholders meeting (KI) (b) County Health Investments and Strategic Plan formulation (KE&KI) (c) Sensitization of Assembly members regarding Health Sector Budget (KE) **(d) M&E activities in the MTEF Cycle <Continue up to the end of Project>**	**May-2018**	Ver.1 dissemination and obtaining feedback	Ver.1 dissemination and obtaining feedback	Development of Draft Ver.1	Development of Prototype	
PSC	(iii) Study Visit & MCA Advocacy for Kericho (Kisumu & Kakamega)		**Jun-2018**				Testing Prototype, training, obtaining feedback, and development of Ver.1	
			Jul-2018	Revising Ver.1 and development of Ver.2	Revising Ver.1 and development of Ver.2			
		(e) APR development process (KE&KI) (f) County Health Summit (KE)	**Aug-2018**					Development of Ver.1
			Sep-2018	Training and dissemination of Ver.2, obtaining feedback, and development of Ver.3 (final version)	Training and dissemination of Ver.2, obtaining feedback, and development of Ver.3 (final version)	Finalising Ver.1, training and dissemination	Finalisation of Ver.1, training and dissemination.	
	(iv) Study Tour for Kirinyaga		**Oct-2018**					
	(v) Technical Meeting (MOH&Partner CDOHs)		**Nov-2018**					
	(vi) Document best practices from Output 2 (Partner Counties)		**Dec-2018**					
	(vii) Provide feedback to IGF from Output 2 activities	(g) AWP process including Stakeholders' Meeting (KE&KI)	**Jan-2019**			Training and dissemination of Ver.1, obtaining feedback, development of Ver.2	Obtaining feedback on Ver.1 and development of Ver.2	
			Feb-2019					Dissemination of Ver.1 obtaining feedback, and development of Ver.2
Endline Survey	(viii) Technical Meeting (MOH&Partner CDOHs)		**Mar-2019**					
Terminal Evaluation & PSC			**Apr-2019**					
		(h) AWP process including sensitisation to MCAs (KE&KI)	**May-2019**					
			Jun-2019					
			Jul-2019	Dissemination of Ver.3 (final version)	Dissemination of Ver.3 (final version)	Dissemination of Ver.2 (final version)	Dissemination of Ver.2 (final version)	
			Aug-2019					
PSC			**Sep-2019**					

MINUTES OF THE 8TH MEETING OF THE PROJECT STEERING COMMITTEE

FOR

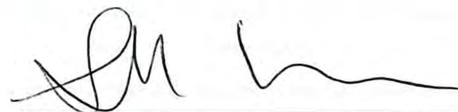
Organization Capacity Development Project for the Management of Devolved Health Systems in Kenya (OCCADEP)

The 8th Meeting of the Project Steering Committee (hereinafter referred to as "the PSC") of Organization Capacity Development Project for the Management of Devolved Health Systems in Kenya ((hereinafter referred to as "OCCADEP") was held on 22nd March, 2019. OCCADEP is jointly implemented by the Ministry of Health (MOH), Kericho and Kirinyaga Counties (hereinafter referred to as "the Partner Counties") and Japan International Cooperation Agency (JICA) as a five-year technical cooperation project that commenced in November 2014 scheduled to end in September 2019.

The 8th PSC meeting aimed to (1) Review the progress of project, (2) Hear the results of the terminal evaluation assessed by the Terminal Evaluation team.

Through this meeting, the evaluation team presented the recommendations towards end of the project and after the project. However, the report was not approved at the meeting since it was not verified in advance. The summary of proceedings and the main points discussed is contained in the document attached hereto.

Dr. Patrick Amoth
Head
Department of Health Sector Coordination and Intergovernmental Affairs
Ministry of Health, The Republic of Kenya



Shioko Momose
Chief Advisor
Organizational Capacity Development Project for the Management of Devolved Health Systems in Kenya

ATTACHED DOCUMENT

1. Welcome /Prayers/ Introductions

The meeting was called to order at 9.30 a.m. by the session chair, Dr. John Kihama. Following brief prayers, the participants introduced themselves. He welcomed the participants to the PSC meeting of OCCADEP and wished for a productive session. The agenda of the meeting is contained in Annex 1 while the list of participants is included as Annex 2.

2. Opening Remarks

Dr. Patrick Amoth, Head, Department of Health Sector Coordination and Intergovernmental Affairs (HSC/IGA), Ministry of Health

3.1 On behalf of the Project Director, Dr. Patrick Amoth (Project Manager) welcomed the participants to the meeting. He thanked JICA-OCCADEP project for their work in Kericho and Kirinyaga. He also appreciated the support of OCCADEP toward the Health Sector Inter-Governmental Consultative Forums (HSIGCFs).

3.2 He reminded participants that the core of the meeting was to hear the results of terminal evaluation as the project was coming to an end in September 2019. He stated that the Project has achieved great milestones including development of the MTEF tool as a key innovation during the implementation period. It is imperative that the MTEF tool and other key lessons learnt be scaled up to other counties for UHC.

3.3 He stated that KES 30 million will be disbursed to counties as conditional grants in support of the UHC and that planning, budgeting and expenditure reporting will be pegged on Counties' utilization of the MTEF Management tool in order to follow-up the grants. He reported that this proposal was shared with the Director of Medical Services (DMS) who was equally supportive of the idea. Taking note that the MOH has low budget absorption rates (34%), Dr. Amoth observed that application of the MTEF Management Tool would also be useful for MOH management to streamline planning, budgeting and expenditure tracking. He noted the available opportunity to introduce the tool to the County Directors of Health at the forum to be chaired by the DMS as provided for in the Health Act, 2017.

3. Report on Overall Progress of the Project

Ms. Shioko Momose, Chief Advisor, OCCADEP; Dr. John Kihama, HSC/IGA, Dr. Betty Lang'at, Director, Kericho County Department of Health; Dr. Esbon Gakuo, Programs Coordinator, Kirinyaga County Department of Health

Ms. Shioko Momose explained the background and the framework of the Project and outlined the activities implemented for the first half of the Project. Dr. John Kihama explained about the activities implemented for Output 1, while Dr. Betty Lang'at and Dr. Esbon Gakuo from

Kericho and Kirinyaga respectively explained about the activities implemented for Output 2 in the partner counties.

The PowerPoint presentation that was used to explain the overall progress of the Project is contained in Annex 3.

4. Summary Result of Terminal Evaluation

Ms. Keiko Kita, External Evaluator; Ms. Yumiko Yoshii, JICA Headquarters; Dr. Mutile Wanyee, MOH

The terminal evaluation was carried out jointly by the Japanese and Kenyan evaluation team. The evaluation team members presented the summary results from the evaluation. Relevance of the Project was evaluated as "high", effectiveness as "satisfactory", efficiency as "fair", impact as "relatively low" and sustainability as "satisfactory". The team also presented several recommendations towards the end and after the end of the Project as well as lessons learnt. The PowerPoint presentation that was used to explain the summary results from the terminal evaluation is attached in Annex 4.

5. Plenary Discussion

5.1. Ms. Momose (Chief Advisor to OCCADEP) stated that in assessment of the Achievement of the Overall Goal, description of Indicator number 2 was not correct and thus it cannot be judged that there is "no progress". She underlined the fact that the Project has already made efforts utilizing the MTEF tools in the 2 partner counties and have been presenting the MTEF tools to other counties and therefore there was no justification to assess the impact as "relatively low".

5.2. Dr. Amoth said that there was significant progress towards project goals and purpose and there was need to anchor MTEF tools to conditional grants. Dr. Amoth mentioned that this tool has the potential to be used in the four UHC pilot counties.

5.3. Mr. Kinyangi (JICA) inquired whether MOH had any concrete ideas on how to anchor utilization of the MTEF tool to the conditional grants to the Counties. Dr. Amoth responded that this requires discussion and consensus building among the stakeholders and therefore is work in progress

5.4. Ms. Yoshida (UHC Advisor to MOH) said that she was happy to learn that the Project has progressed a lot since 2017. She suggested that the link to the website where the MTEF tools are posted should be shared widely so that people can easily access the webpage.

5.5. Dr. Wanyee (co – evaluator) stated that the monitoring and evaluation unit was in charge of collecting and sharing the good practices. She said that there was a need for making the lessons learnt of the partner counties available to all in the Ministry of Health. She suggested that the MTEF tools developed in the Project should be presented at the Kenya Health Forum, 2019.

5.6. Mr. Cheruiyot (HSC / IGA) mentioned that the Project has made wonderful achievements and that lessons learnt can be used for other counties. He said that both MTEF

Management tool and the MTEF Process Guide should be utilized so that the officers follow the MTEF cycle.

5.7.Dr. Wanyee underscored that she had noticed a significant change in the planning and budgeting process during the terminal evaluation visit to Kirinyaga where she witnessed the Sub County Annual Work Plan consolidation.

5.8.Dr. Wanyee also commented that there was a need to increase consultations through HSIGCF.

5.9.Dr. John Kihama, stated that the frequency of the meetings as well as the funding for HSIGCF were issues beyond the control of HSC/IGA as these are handled at the top leadership of MOH and Council of County Executives for Health.

6. Demonstration of the MTEF Management Tool.

Dr. Esbon Gakuo, Programs Coordinator, Kirinyaga County Department of Health

6.1.Dr. Esbon Gakuo said that the MTEF Management tool acts as a management implementation tool for conducting activities in AWP. The tool has the ability to auto-generate reports for decision making. The tool links planned health activities and health expenditure with key health indicators which can also be tailored to cater for any stand-alone health project with an implementation plan and a budget line.

6.2.Then, Dr. Gakuo demonstrated how to use the MTEF Management tool.

7. Plenary Discussions.

7.1. Mr. Cheruiyot praised the MTEF Management Tool as it can now minimize data errors. It can track service delivery activities and is able to showcase what activities can improve the quality of health services. This will help improve service delivery indicators. The continued use of the tool both for planning and monitoring was emphasized.

7.2. Mr. Cheruiyot stated that the National Government was responsible for capacity building, setting standards and development of tools and guidelines. There are many health systems such as IFMIS that need to be integrated together and that it's being looked into by the Ministry of Health.

7.3. On the perceived linkage to Integrated Financial Management Information System (IFMIS), Dr. Gakuo clarified that IFMIS is a payment tool and cannot handle planning and budgeting. Therefore, the MTEF Management Tool is complementary to IFMIS.

8. Closing Remarks

Ms. Shioko Momose, Chief Advisor, OCCADEP; Mr. Tsunenori Aoki, Director of Health Team 1, Health Group 1, Human Development Department, JICA

8.1.Ms. Momose thanked the joint evaluation team for their work. She emphasized that the Project will continue until September 2019 and requested the Kenyan evaluation team members to become supporters of the Project. She asked the Kenyan counterparts to study well the recommendations from the evaluation report and think together how to respond to them.

8.2.Mr. Aoki stated that he has learned that the Project added value and made an impact in the area of management. He said that he had heard voices in the county that the capacities of the health officers have been strengthened through utilizing the MTEF tools. He said that the tools should be repeatedly used while going through the MTEF cycle to further strengthen managerial capacities. He underlined that the project is in line to achieve the Universal Health Coverage target in the counties, and urged Kericho and Kirinyaga to share their experiences with other counties as a way to scale up the utilization of MTEF tools. He stated that the project's work was progressive and the National Government should have a way to support and monitor the progress of the activities utilizing the tools as well as updating the tools.

8.3.Finally, he thanked the participants for their inputs and the co-evaluators for participating in the process of terminal evaluation. He then mentioned that JICA was exploring more opportunities either internal or external, to offer support especially to the Ministry of Health.

ANNEX

1. Program
2. List of participants
3. Progress Report
4. Summary of Result of Terminal Evaluation

Annex 1

MOH/JICA - OCCADEP

ORGANIZATIONAL CAPACITY DEVELOPMENT PROJECT

FOR THE MANAGEMENT OF DEVOLVED HEALTH SYSTEMS IN KENYA

PROJECT STEERING COMMITTEE MEETING

VENUE: **Panafric Hotel, Nairobi** DATE: **22nd March 2019**

PROGRAM

TIME	Agenda Item	PRESENTER	Session Chair
08:30 - 09:00	Registration	Ms. Mercy Ronoh	Mr. John Kihama
09:00 - 09:15	Welcome /Prayers /Introductions	Dr. John Kihama	
	Remarks	CEC for Health, Kericho and Kirinyaga County	
09:15 - 09:30	Opening remarks	Dr. Patrick Amoth, Head DHSC/IGA, Project Manager	
09:30 – 10:00	Progress of the Project - Overall Framework of the Project - Activities for Output 1 - Activities for Output 2	 Ms. Shioko Momose Dr. John Kihama Dr. Betty Lang'at Dr. Esbon Gakuo	
10:00 – 11:40	Report of Terminal Evaluation	Evaluation Team	
11:40 – 12:00	**HEALTH BREAK**		
12:00 – 12:45	Demonstration of the MTEF Management Tool	Dr. Esbon Gakuo	Mr. Stephen Cheruiyot
12:45 – 13:30	Plenary Discussions		
13:30 – 13:45	Closing remarks o Representative, JICA o Project Manager	 Mr. Tsunenori Aoki (Director, HRD, JICA) Dr. Patrick Amoth	
13:45 – 14:30	**HEALTH BREAK**		

List of Participants (Annex 2)

(a) Evaluation Team

No.	Name	Organization	Position
1.	Tsunenori Aoki	JICA	Director, Human Development Department (HDD)
2.	Yumiko Yoshii	JICA	Deputy Director, HDD
3.	Keiko Kita	JICA	External Evaluator
4.	Dr. Mutile Wanyee	MOH	Senior Deputy Director of Medical Services (SDMMS)
5.	Dr. Joseph Gichimu	MOH	Economist

(b) PSC Members

No.	Name	Organization	Position
1.	Dr. Patrick Amoth	MOH	Head, Dept. of Health Sector Coordination and Inter-governmental Affairs (HSC & IGA)
2.	Dr. John Kihama	MOH	HSC & IGA
3.	Stephan Cheruiyot	MOH	Economist, Dept. HSC & IGA
4.	Shioko Momose	JICA OCCADEP	Chief Advisor/ Health System Management
5.	Nobuyuki Hashimoto	JICA OCCADEP	County Health Management Advisor
6.	Dr. Yasushi Sawazaki	JICA OCCADEP	County Health Planning

(c) Co – Opted Members

No.	Name	Organization	Position
1.	Dr. Esbon Gakuo	Kirinyaga CDOH	Programme Coordinator
2.	Dr. Betty Langat	Kericho CDOH	County Director of Health
3.	Shoko Isokawa	JICA Kenya	JICA Representative
4.	Elijah Kinyangi	JICA Kenya	Senior Program Officer, JICA Kenya Office
5.	Kumiko Yoshinda	MOH/JICA	JICA Expert / UHC Advisor
6.	Kipkurui Japheth	MOH	Intern
7.	Mercy Ronoh	JICA OCCADEP	Assistant Administrative Officer
8.	Eric Mureiithi	JICA OCCADEP	Project Assistant. Kirinyaga County
9.	Njeru Judy C. Muthoni	JICA OCCADEP	Project Assistant. Kirinyaga County

MINUTES OF THE 9TH PROJECT STEERING COMMITTEE MEETING FOR Organization Capacity Development Project for the Management of Devolved Health Systems in Kenya (OCCADEP)

The 9th Meeting of the Project Steering Committee (hereinafter referred to as "the PSC") of Organizational Capacity Development Project for the Management of Devolved Health Systems in Kenya ((hereinafter referred to as "OCCADEP") was held on 9th July 2019 at Afya House, Nairobi. OCCADEP is jointly implemented by the Ministry of Health (MOH), Kericho and Kirinyaga Counties (hereinafter referred to as "the Partner Counties") and Japan International Cooperation Agency (JICA) as a five-year technical cooperation project that commenced in November 2014 and ends in September 2019. The 9th PSC meeting aimed at (1) sharing the the overall progress of the project to the new PSC members, (2) sharing the lessons learnt from the activities implemented in FY2018/19 by Partner Counties and their way forward, and (3) confirming the work plan for the remaining period towards September 2019.

The PSC members and participants exchanged their views and ideas on the way forward.

The detailed contents and discussion points are attached hereto.

Nairobi, Kenya

9th July 2019

Dr. J. Wekesa Masasabi
Director General
Ministry of Health, The Republic of Kenya

Katsutoshi Komori
Chief Representative
JICA Kenya Office

Dr. Osman Warfa
Head
Department of Health Sector Coordination and Intergovernmental Relations
Ministry of Health, The Republic of Kenya

Shioko Momose
Chief Advisor
Organizational Capacity Development Project for the Management of Devolved Health Systems in Kenya

Attachment

1. Welcome / Prayers/ Introductions

The meeting was called to order at 9.00 a.m. by the session chair, Dr. Jackson Omondi (see Annex 1 and 2 for the program and list of participants). He then invited Dr. Abel Nyakiongora, Head, Department of Health Sector Coordination and Inter-governmental Relations to welcome the Members to the 9th PSC meeting on behalf of Dr. Osman Warfa, the Project Manager. He conveyed Dr. Warfa's apologies for not making it for the meeting due to other competing engagements. He then asked the participants to introduce themselves and thanked them for their attendance. He finally welcomed Dr. Joel Gondi to give the Director General's opening remarks.

2. Opening Remarks

Dr. Joel Gondi, Senior Deputy Director of Medical Services, Ministry of Health

Dr. Joel Gondi conveyed the apology from the Project Director, Dr. John Wekesa Masasabi who could not join the meeting. He read the opening remarks from the Project Director (see Annex 3).

The Project Director in his remarks first thanked JICA for continued support in health sector both at national and county level. He stated that as health sector, they had the great responsibility of providing quality health to all Kenyans, as reflected in Kenyan national policy documents and SDGs. He mentioned as a country, Kenya made significant progress specifically for maternal, newborn, child, adolescent and nutrition health, through concerted efforts with partners including JICA.

He said that when the health sector was devolved, there were challenges in leadership, budgeting, monitoring and evaluation, but learnt from the good lessons and achievements from the previous JICA project for Strengthening of Health System Management in Nyanza Province implemented from 2009 to 2013. OCCADEP Project commenced at opportune time to strengthen the health systems in Kericho and Kirinyaga Counties though initially meant for 47 counties. He said that he is aware that Kisumu and Nyeri counties have benefitted from OCCADEP, especially in how to manage the MTEF Cycle.

He promised that MOH will continue to engage JICA in all of their programs for the success of UHC, and that the success and lessons learnt from the two counties using the MTEF tools can be replicated in other counties.

Finally, he appealed to the participants that as the project ends in September this year, there is need to look at sustainability component in their deliberations, so that the gains made in the four counties are not reversed but supported.

3. Overall Progress of the Project

- **Dr. Jackson Omondi, Head Division of Partnership Coordination**
- **Ms. Shioko Momose, Chief Advisor, OCCADEP**

Dr. Jackson Omondi on behalf of the Project Manager took the participants through the background of the project and what was achieved in the first half of the Project period (two and half years) of the whole project period of November 2014 to September 2019. He explained the project framework, structure and the functions and composition of the PSC.. Then, he presented the major achievements and explained that the Mid-Term Review conducted in March 2017 recommended the change of focus of the project to 2 areas: (i) enhancing mutual learning between MOH and Counties, and (ii) strengthening MTEF cycle management in the two partner counties.

Ms. Shioko Momose then explained the progress in the second half of the Project period, after the Mid-Term Review, from January 2018 to July 2019. She explained that for mutual learning, OCCADEP developed HSIGCF Operational Manual, provided technical assistance to 11th and 12th HISGCF, held

two Project Technical Meetings, introduced MTEF tools to MOH departments, and facilitated various learning forums such as Kisumu Study visit for Kericho CDOH; validation of AWP Handbook, involving Nyeri and Kisumu counties; Mutual Learning Forum among Kericho, Kirinyaga and Nyeri counties. For strengthening MTEF cycle management, she explained OCCADEP mainly supported AWP and APR processes, and presented the tools developed by the project, i.e. MTEF Process Guide, MTEF Cycle Calendar, Organizational Chart, AWP Handbook for level 2-3 facilities, and MTEF Management Tool and Consolidation Tool for financial tracking.

She emphasized that for the post project sustainability, OCCADEP nurtured trainers in Kericho and Kirinyaga who can train other counties for MTEF management cycle and MTEF Management Tool. She also indicated that Kirinyaga and Kericho signed a joint communique witnessed by Nyeri and JICA Kenya Office (see Annex 4), which outlines the plan of how they are going to promote sustainability after the project ends. She also projected the Ministry website where all the tools and best practices identified by the Project are uploaded for easy access. Finally she presented the results of the Terminal Evaluation held in March 2019 according to the five criteria. She then touched upon the recommendations from the terminal evaluation and the activities to be conducted before the end of the project in September 2019. She appealed to the participants in the meeting that the main activities to be conducted were to advocate the lessons leant and to promote the MTEF/AWP Tools to other counties through existing fora, which the Ministry is urged to actively facilitate and coordinate. The presentation is attached as Annex 5

4. Demonstration of the MTEF Management Tool

Dr. Esbon Gakuo, Programs Coordinator, Kirinyaga County Department of Health

Dr. Esbon Gakuo underlined that the MTEF management tool strengthened the managerial functions at the County Department of Health (CDOH), especially for the financial management part. By showing MTEF Cycle Management Calendar, he explained that it helped CDOH to plan and budget within the timeframe as the calendar was designed to follow the cycle. He explained that the Tool brought the planning and budgeting processes together and made it realistic linking the plan and the financial transaction. He stated that the two counties started using the Tool from 2018 to review and monitor the plan, and were able to mentor health facilities using the Tool.

He emphasized that the Tool can be used for any health project as long as they have a plan and a budget. He suggested MOH to officially recommend the counties to adopt the tool for AWP, which will enable CDOHs to populate the financial tracking information not only by facilities but by all levels. He told the members that the tool was developed by JICA OCCADEP in collaboration with Kirinyaga and Kericho CDOHs. He then demonstrated the functions of the MTEF management tool.

Dr. Betty Langat, County Director of Kericho CDOH presented an example of application of the MTEF Management Tool in tracking the funds from the World Bank THS-UC project against the budget approved by the World Bank, which is reflected in County Allocation of Revenue Act (CARA). She showed the Dashboard generated by the MTEF Management Tool that showed how much has been absorbed and the level of implementation for each activities that was planned for THS-UC Project. She emphasized that it is quite important especially for managers to first tease out what could be the problem of funding and implementation from the Dashboard. Then to move to other sheets to check (i) when money was paid and spent; (ii) how much they have spent or not spent for specific programs, activities, and line items; (iii) which individuals were paid; (iv) if the activities were done, were there any impacts to the health indicators. She stated that the reasons Kericho used the MTEF Management Tool for THS-UC were because the fund was ring-fenced, budget was clear, and activities were approved. She concluded by saying that the tool makes the use of funds very transparent, and because it is an electronic

file, it enables one to showcase what is funded and what is not funded in a timely manner and therefore can be used for an advocacy tool such as requesting MCAs for specific budgets.

5. Achievements of FY2018/19 of Kericho CDOH and Kirinyaga CDOH and the way forward

The session was facilitated by Mr. Elijah Kinyangi, Chief Program Officer, JICA Kenya Office. In the session, Dr. Betty Langat and Dr Esbon Gakuo presented the activities carried out and their achievements made with the support of JICA OCCADEP.

5.1. Kericho County

Dr. Langat reported that Kericho CDOH managed to combine sub-county monthly meetings with data review meetings supported by OCCADEP. She said that by combining these two, the SCHRIOs could give feedback to facilities which not only improved the data quality but also the health performance indicators. Regarding APR, with OCCADEP support, the county was able to develop the APR from the facility level to the county level. She testified that they could identify which facilities were facing challenges and they managed to compare and analyze why a certain sub-county was not performing well in indicators. Regarding Kericho county health summit, she expressed that it was a great opportunity to share the achievements and plans with the stakeholders and would like to continue holding the event. She said that through the summit, the CDOH managed to obtain lots of support and could influence MCAs to change their inclination from building new facilities to strengthening health systems. Dr. Langat emphasized that they would use the AWP handbook and MTEF tools for mentorship to staff at health facilities, because they saw the improvement in AWPs when OCCADEP provided trainings and would encourage facilities, including hospital management teams to utilize their own AWPs in order to improve service delivery.

5.2. Kirinyaga County

Dr. Gakuo made the presentation on behalf of the County Director, Mr. George Karoki who sent an apology. He outlined the progress made since the previous PSC meeting held in March 2019. He explained that the AWP was developed using MTEF Management Tool with experts' mentorship to health facilities. He explained that CHMT monitored the submission of monthly financial expenditure reports by the health facilities. He elaborated how refresher training of trainers for the Tool was conducted and mentioned that they had done a participatory assessment in order to examine the level of understanding of the participants who had undergone trainings on how to utilize the tools. Some of the trained health staff have already served as trainers and extended training to the Nyeri CDOH team on how they can utilize the tool for pilot UHC fund.

In June 2019, Kirinyaga CDOH validated the AWP Handbook and reviewed their activities along the MTEF Cycle. In July, the lessons learnt were shared with Kericho and Nyeri counties through the mutual learning event held in Kirinyaga county. In the same event, Kirinyaga CDOH and Kericho CDOH developed a joint communique that outlines the plan that the two counties will implement from October 2019 in order to sustain the achievements of the project. For the next APR process, he stated that Kirinyaga would also involve the health facilities for the first time. He concluded by saying that the biggest achievements from OCCADEP was that health managers of all levels became very familiar with the MTEF cycle, and that the quality of planning has improved. In addition, he stated that MTEF Management Tool helped to link the annual work plan with budget, and it enabled them to track financial information. He expressed the willingness to share all these lessons learnt, best practices and the MTEF Tools with other counties.

6. Plenary Discussion

6.1. Source of data and ability to use the data

Q. Dr. Lily Nyaga asked a question on the validity of the health information data and the ability to confirm that the data entered reflected what had been achieved from the funds invested.

A. Dr Gakuo responded that health service data are readily available from DHIS, nevertheless, he explained that the MTEF Management Tool allowed users to think of what activities, inputs, and programs have to be carried out to improve the health indicators. He noted that the Tool brought the financial information that was previously lacking, and enabled them to link it to the indicators.

A. Dr. Langat added that the data from DHIS was of poor quality and that was why Kericho CDOH conducted data review workshops to clean the data. She hoped that in the next APR, officers would be able to analyze if there are any indicators for which the targets set were not achieved. It should be further analyzed to check if the issue was properly addressed through the planned activities, or if the issue was about the quality of data.

6.2. Sustainability of OCCADEP

Q. Mr. Karani commended the Project and sought to know what mechanism had been put in place to sustain the achievements after the end of the project.

A. Dr. Gakuo responded that for the time being, activities supported by OCCADEP were included under THS-UC budget up to FY2020/21. Dr. Langat said that Kericho CDOH have budgeted the data review, data cleaning and other activities in the county budget even though initially there was no budget for planning. She mentioned that by 2021, the county would be able to take up the budget and institutionalize the planning process.

6.3. MTEF Management Tool

6.3.1. Dr. Nyakiongora thanked the presenters for the good presentations and commented that there was a weak linkage between the allocated budget and the planned activities in the past but it was important to be able to break each activities into line item budgets.

He then asked two questions: (1) to what extent do the finance officers who do the budgeting are involved in AWP process, and (2) if the program based budgeting have program managers who receive the budget and are accountable for the results that come from the investments made.

Response to (Q1)

Dr. Gakuo said that the success of the tool depends on the access to the information on financial transactions. The access to the financial information depends on the commitment of top leadership. He stated that Kirinyaga CDOH did not have much access to County Government Budget information, which is due to confidentiality and issues around transparency. He said this would be one of the major challenges for scaling up the MTEF management tool. He further explained that it was not easy to have access to the financial information if the top management is not willing to release financial information. He explained that in many counties, most of financial information is still held at county level, and is not devolved to the lower spending units. The financial information is not devolved from the county department to sub-counties and facilities, except for cases such as DANIDA program that involves direct disbursements from national government to facilities through the CRA and Special Purpose Accounts (SPA).

On the part of Kericho County, Dr. Langat responded that the scenario is slightly different from Kirinyaga. Kericho County Government has decentralized the budgeting to the department and they have given a ceiling to do the budgeting, and expenditure was recorded in the department. She explained that accountants have been employed at the County Department of Health (CDOH) and have access to the financial information through them. Therefore, especially for projects, CDOH can obtain financial information without going through the County Finance Department. However, some expenditures are still not documented and some of the issues are still not clear. She emphasized that Chief Officers and CEC are trying to decentralize to the accountants so that they can use the Tool. Based on the THS-UC report, she feels that there is a need for political will for promoting transparency and accountability through the use of the Tool.

Response to (Q2)

Dr. Gakuo said that with regard to Program Managers, there are several management positions already conceptualized based on the organizational chart for management prepared by OCCADEP but they are not yet effected in Kirinyaga.

As for Kericho County, Dr. Langat said they have two Chief Officers. One is, Chief Officer Medical services who is in charge of curative services and the other for Preventive and Promotive in charge of primary health care services. Only one Chief Officer is the accounting officer. The department of health services had proposed 3 directors but the approved Organogram has only one director of health service. She mentioned that this would depend on the organization of individual counties.

6.3.2. Dr. Muleshe asked if the tool can give an early warning and if the tool is able to compare multi-year trends in performance.

Dr. Gakuo responded that the tool can be used anytime to capture the expenditure on the dashboard, so it can be checked at any time, weekly or monthly basis. In addition, he emphasized that the tool can be consolidated to see sub-county and countywide performance.

He further explained that if there was a need to compare the budget year to year, it will require dashboards for the respective years, as much as the Tool covers for MTEF 3 years.

6.3.3. Mr. Karani asked at what stage is expenditure captured.

In response, Dr. Langat referred to the THS-UC FY2018/19 summary report generated from MTEF Management Tool in which the expenditure was entered right after each payment was done. The summary report indicated that the activities planned for the first and second quarter were not done, although the funding was received.

Q. At this point, Mr. Kinyangi sought to know why there was no expenditure from July to March and why activities planned for immunization were not carried out.

A. Dr. Langat explained that the County had a new Chief Officer for Finance who was required to co-sign with Chief Officer for Health. The Chief Officer Finance did not have the token to enable access to IFMIS for the first and second quarter; hence Kericho CDOH did not have access to the THS fund during that period. For why the immunization activity was not implemented, Dr. Langat explained that the planned activity was the procurement of gas and cylinders for fridges at health facilities for vaccine storage. This was planned to be done by the Procurement Office of the County who failed to float bids.

6.3.4. Dr. Muleshe asked about the challenges faced in using the MTEF management tool.

Dr. Gakuo said that the big challenge was resistance to information disclosure and transparency while the other challenge was lack of IT knowledge and skills by the users such as nurses who required constant mentorship. Dr. Langat added that the utilization of the tool requires a lot of commitment at initial stages, because staff had to key-in the details of the AWP into the Tool from hard copy that needed a lot of commitment and acceptance. She also shared that facilities fear the financial transparency imposed by the tool and wonder if the Tool would be used as evidence for disciplinary action if funds were misappropriated.

6.3.5. Dr. Kariuki first congratulated the two counties and asked how much time it takes to enter the information and how the tool can accommodate additional information required based on county executive orders and development partners' work plans that come in the middle of the fiscal year. On a different note, he commented that UHC should be implemented within the existing three programs and not to be a separate program as was shown in the Tool presented.

Dr. Gakuo responded that the whole process of entering data does not take much time since the standard activities are all entered from the drop-down list of the MTEF Management Tool. He emphasized that the whole county should use one uniform tool. He also explained that the tool can accommodate additional information and / or revisions arising from mid-stream executive orders and he demonstrated the column to be filled-in in the tool for revised budget or any new / additional funds. Dr. Langat said that it takes just one day to enter the data in the tool. It takes a lot of time to develop AWP in the beginning, but for monitoring and implementation phases, it takes just half a day.

6.3.6. Dr. Karimi asked if additional staff should be hired for using the tool and if they could use this tool for county budget other than THS-UC fund.

Dr. Langat said that Kericho county plans to do this for THS-UC and other DP funded Project as a pilot. After obtaining political goodwill and acceptance based on the pilot results, they would use the Tool for county budget tracking and presentation.

6.3.7. Ms. Moleen Cheptoo asked if there is any plan to share the knowledge, skills and the tool to other counties.

Dr. Langat mentioned that Kericho and Kirinyaga counties have already shared with Kisumu and Nyeri counties, and hoped to sensitize them again. If there is a buy-in from the Ministry, she felt that the Kericho trainers can go to train other counties.

Ms. Momose commented by saying that OCCADEP will end in September 2019. So far, Kericho and Kirinyaga Counties have worked very hard and they have confirmed that utilization of the MTEF Management Tool is not difficult. Ms. Momose said that the whole process together with Kericho and Kirinyaga was like trial and error and needs follow-up at least quarterly so that the two counties can perfectly utilize the tool. She mentioned that Kisumu and Nyeri have been sensitized and capacitated, but funds are needed for follow-up. She said it would be a good start using the Tool for THS-UC budget, since THS-UC is straight forward and there would not be any transparency issues. She advocated for a buy-in from THS-UC which can help the scale-up of the tools.

6.3.8. Dr. Lily Nyaga asked about the ownership and the training capacity of two partner counties in terms of MTEF Management Tool. She also asked how the tool can be accessed and shared.

Dr. Gakuo said that there was an assessment of competence in using and teaching MTEF Management Tool, and that now there are 25 to 30 members who have competence at CHMT, SCHMT and hospital level. He also responded by saying that the tool is in excel worksheet and stand alone, not web-based, which can be shared with individuals easily. The only limitation is posed on the number of people who can edit the tool.

7. Closing Remarks

Mr. Shinjiro Amameishi, Senior Representative, JICA

Mr. Shinjiro Amameishi started by appreciating the attendance at the meeting by the new members of PSC and in taking great interest regarding Project activities. He mentioned that he was impressed with the presentations made by Kirinyaga and Kericho, and appealed to the Ministry that this model needs to be up scaled as it was also recommended by the Terminal Evaluation team. He finally mentioned that although this project will end, JICA may consider further support to relevant activities.

Dr. Abel Nyakiongora, Head Department of Health Sector Coordination and International Health Relations, Ministry of Health

In his closing remarks, Dr. Nyakiongora stated that the meeting had been focused and exciting. He attended the meeting where Ms. Momose had briefed the Director General who is the Project Director of the project. He said that MOH will follow up with JICA with regards to the support after the project ends in September. Finally, he thanked the members for their participation and he declared the meeting closed at 12.48 pm.

ANNEX

1. Meeting Program
2. List of participants
3. Opening Remarks by Director General (Project Director)
4. Joint Communique by Partner Counties
5. Presentation on Overall Progress

MINUTES OF THE 10TH PROJECT STEERING COMMITTEE MEETING FOR

Organization Capacity Development Project for the Management of Devolved Health Systems in Kenya (OCCADEP)

The 10th Meeting of the Project Steering Committee (hereinafter referred to as "the PSC") of Organizational Capacity Development Project for the Management of Devolved Health Systems in Kenya ((hereinafter referred to as "OCCADEP") was held on 20th September 2019 at Panafric Hotel, Nairobi. OCCADEP is jointly implemented by the Ministry of Health (MOH), Kericho and Kirinyaga Counties (hereinafter referred to as "the Partner Counties") and Japan International Cooperation Agency (JICA) as a five-year technical cooperation project that commenced in November 2014 and ends in September 2019. The 10th PSC meeting aimed at (1) sharing the overall framework and achievement of the project, (2) reviewing status of the Health Sector Inter-Governmental Consultative Forum (HSIGCF) and its Operational Manual, (3) sharing the activities in managing the MTEF Cycle in the Partner Counties and its achievements, and (4) discussing challenges identified and the way forward on improving managerial function of County Department of Health.

The PSC members and participants exchanged their views and discussed the way forward on how to sustain and further expand the achievements of OCCADEP after its completion.

The detailed contents and discussion points are attached hereto.

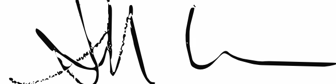
Nairobi, Kenya

20th September 2019

Dr. J. Wekesa Masasabi
Director General
Ministry of Health, The Republic of Kenya

Katsutoshi Komori
Chief Representative
JICA Kenya Office

Dr. Osman Warfa
Head
Directorate of Health Sector Coordination and Intergovernmental Relations
Ministry of Health, The Republic of Kenya



Shioko Momose
Chief Advisor
Organizational Capacity Development Project for the Management of Devolved Health Systems in Kenya

Attachment

Welcome / Prayers/ Introductions

The meeting was called to order at 8.40 a.m. by the session chair, Dr. Jackson Omondi (see Annex 1 and 2 for the program and list of participants). He then invited Dr. Osman Warfa, Acting Director for Health Sector Coordination and Inter-governmental Relations to welcome the Members to the 10th PSC meeting on behalf of Dr. John Wakesa Masasabi, Acting Director General (DG) for Health and the Project Director. He then asked the participants to introduce themselves and thanked them for their attendance.

1. Opening Remarks

Dr. Warfa conveyed the apology from the Project Director, Dr. John Wekesa Masasabi, DG who could not join the meeting and Dr. Amoth who was to stand in for Dr. Masasabi. He read the opening remarks from the Project Director.

The Project Director in his remarks first thanked JICA for continued support in health sector both at national and county level. He stated that as health sector, they had the great responsibility of providing quality health to all Kenyans, as reflected in the Constitution of Kenya, 2010, Kenya Health Policy (2014-2030), Kenya Vision 2030) and SDGs. He mentioned that as a country, Kenya has made significant progress specifically for maternal, newborn, child, adolescent and nutrition health, through concerted efforts between the two levels of governments and with support from development partners including JICA.

He said that when the health sector was devolved, there were challenges in leadership, planning, budgeting, monitoring and evaluation, but learnt from the good lessons and achievements from the previous JICA project for Strengthening of Health System Management in Nyanza Province implemented from 2009 to 2013, OCCADEP Project commenced at an opportune time to strengthen the health systems in Kericho and Kirinyaga Counties though initially meant to reach all the 47 counties.

He said that he was aware that four other counties were trained by OCCADEP partner counties, especially in how to manage the MTEF Cycle.

He promised that MOH will continue to engage JICA in all of their programs for the success of long term vision and aspirations of UHC, and that the success and lessons learnt from the two counties using the MTEF tools should be spread to all other counties. He also added that MOH through National Treasury had already submitted the request for another project to JICA to build on the gains by OCCADEP towards sustaining the MTEF cycle management.

2. Progress of the Project

(ア) Overall Framework of the Project and its Achievements

○ Ms. Shioko Momose, Chief Advisor, OCCADEP

Ms. Shioko Momose took the participants through the background of the project, the project framework, structure and the functions and composition of the PSC. She then explained what was achieved during the whole project period of November 2014 to September 2019, alongside the 2 areas of focus: (i) enhancing mutual learning between MOH and Counties, and (ii) strengthening MTEF cycle management in the two partner counties.

For mutual learning, OCCADEP implemented followings:

- Supported 7 HSIGCFs

Attachment

- Developed HSIGCF Operational Manual
- Provided technical assistance to 11th and 12th HSIGCF
- Supported HRD on several materials including Common Strategy for Human Development and Capacity Building
- Supported the then HSC/IGA on drafting the Core Function Working Paper which defines the roles and responsibility between MOH and CDOH
- Conducted Kisumu Study visit for Kericho CDOH Team (June 2018)
- Supported Kericho County Health Forum and invited Kisumu and Kirinyaga (Jan 2019)
- Sharing of learnings from managing AWP in financial terms (May and June 2019, to Kisumu by Kericho, Nyeri by Kirinyaga)
- Conducted Joint validation for AWP Handbook for level 2&3 (June 2019 in Kirinyaga with MOH and Nyeri, in Kericho with Kisumu)
- Conducted Mutual Learning Forum (July 2019 in Kirinyaga, with Kericho and Nyeri)

For strengthening MTEF cycle management, OCCADEP implemented following:

- Supported AWP and APR processes which merged top-down and bottom-up flows
- Supported the data review for sub counties
- Supported the development of County Health Sector Strategic Plan and UHC Roadmap
- Development of Tools to assist the MTEF Cycle Management (MTEF Tools) such as (i) Planning, Budgeting and Performance Review Process Guide for Health Sector, (ii) MTEF Calendar, (iii) Organizational Chart, (iv) AWP Handbook for Level 2&3 Health Facilities, and (v) MTEF Management tool and consolidation tool.
- With the partner counties, concluded with Joint Communique for activities to be conducted after the end of the Project
- Trained 60 officers of Kericho and Kirinyaga CDOH for MTEF Tools, who were assessed and categorized into 5 levels of (i) Chief Master Trainer, (ii) Master Trainer, (iii) Lead Trainer, (iv) Senior Facilitator, and (v) Facilitator.
- Chief Master Trainers, Master Trainers and Lead Trainers have been teaching staff in other counties. Kirinyaga trained Nyeri and Machakos CDOHs on how to track financial flows on CDOH utilizing MTEF Management Tool. Kericho trained Kisumu and Migori on how to track financial flows on CDOH utilizing MTEF Management Tool.
- The trainers can be deployed anywhere to teach Program-based Budgeting (PBB) and how to track financial flows based on AWP or funded projects such as the World Bank's THS-UC.
- For Machakos and Migori, the THS-UC Project was used to demonstrate how MTEF Management Tool could help the management in decision-making.

As for challenges faced during the support, she stated that the way AWP/APR templates were continuously revised and released later than the timing set in the county MTEF Cycle disrupted the counties in developing

timely AWP/APR through top down and bottom up approaches. She made a plea to MOH that this is a serious issue and needs to be taken up in the future.

She indicated that all the MTEF Tools and products of OCCADEP are uploaded on MOH Best Practice link on the Website and the revision of Tools and updating of the Website are responsibilities of HSC/IGR.

She then ended by reminding the participants on the recommendations made by the Joint Terminal Evaluation Team towards the sustainability after OCCADEP ends as follows:

Output 1

- The MoH and partner counties share the lessons learnt and good practices with other counties by capitalizing on existing workshops and conference occasions.
- The MoH follows up on activities and conduct monitoring in partner counties and the MoH will roll out the MTEF tools in the UHC pilot counties.

Output 2

- The MoH and partner counties maintain the current series of activities for MTEF/AWP cycle management for 2019/2020, and revise MTEF tools accordingly
- The MoH follows up on partner counties and conduct monitoring of MTEF/AWP cycle activities that will contribute to other counties.
- The MoH and partner counties implement the necessary activities identified from the implementation of the Project for further strengthening of capacity building.

(イ) IGF and IGF Operational Manual

- **Dr. Osman Warfa, Acting Director for Health Sector Coordination and Inter-governmental Relations**

Dr. Warfa started by acknowledging that the project has left all the expertise and requirements for the Kenyan side to sustain the good achievements by OCCADEP, and appealed to the certified trainers from the two partner counties to train other counties on the same.

He then presented OCCADEP activities on HSIGCF and HSIGCF Operational Manual as follows:

- Legal framework of HSIGCF anchored in the Intergovernmental Relations Act 2012 and the Health Act 2017 (Part IV)
- Review of 2013-17 HSIGCFs were conducted to analyze the structure of HSIGCF and challenges regarding participation and resources
- HSIGCF Operational Manual was developed based on the review results and finalized in July 2018.
- The Operational Manual covers: (i) mandate and TOR, (ii) structure, (iii) composition, (iv) outline and roles of secretariat, (v) TOR of thematic technical committee, (vi) scheduling and convening, (vii) agenda setting and venue selection, (viii) communication and reporting, and (ix) financial arrangements of HSIGCF

Attachment

He also updated the meeting with the two recent developments. Firstly, the summit would be held any time, which was being discussed at the level of County governors and the President. Secondly, the Ministry of Devolution and ASALS (MODA) is finalizing the development of intergovernmental framework.

The main objective of the Framework is to establish an intergovernmental mechanism that promotes consultation and cooperation between the National and County Governments with a view to facilitate seamless implementation of the Government policies and programmes and MOH is involved in this process.

He stated that the structure has been revised so that the Ministry of Devolution & ASALS would be taking sectoral issues to the summit of two levels of government, only when they cannot be sorted at the level of the sector and with even with Ministry of Devolution. What is foreseen is that in the next summit, probably 1 or 2 issues would be tabled and resolved within the shortest time possible. This is the direction to be aimed at.

He also shared that Ministry of Health and CoG are discussing how to implement Kenya Health Forum Action Plans in terms of who is to do what and when, and these would be discussed in the next consultative forum, which is being planned now.

He explained that there is discrepancy on the membership of intergovernmental forum set in the Health Act 2017 and the Intergovernmental Relations Act 2012 but relevant parties are working on it to reaching a consensus.

Regarding the funding of HSIGCF, he stated that MOH has no budget and the upcoming meeting would be supported by the World Bank THS project. He also appealed to other development partners (DPs) to provide their support in the future meetings and requested counties to capture the participation cost in their budget. He continued to say that there would be a calendar in the future so that MOH could request DPs for support in good time.

While explaining on the Operational Manual, he shared the lesson learnt from the recent Kenya Health Forum, jointly organized by the MOH, the Senate, National Assembly and CoG. He stated that CoG and other parties would prefer to be notified in good time and in consultation beforehand for the next Health Forum.

As for the structure of HSIGCF, he shared that they would merge the six Thematic Technical Committees (TTCs) into four under the Partnership Framework. He also shared that it is discussed that a part of HSIGCF be cascaded to the Health Summit.

Regarding the Secretariat, he touched upon the initiative to bring other sectors such as energy, water, ICT and sanitation, in order to realize UHC.

In terms of scheduling, he expressed that MOH would hold the HSIGCF twice a year, saying it was already held in February 2019 and another HSIGCF is planned in October for which the agenda is being drafted. He also explained that the communication and invitations should be sent out to COG at least 21 days prior to the event.

At the end he explained the way forward as follows:

- Proposed dates for the next HSIGCF planned in mid-October were communicated to COG and CECs with the request of agenda identification.
- Institutions were asked to nominate the members to the planning committee, which would be in charge of communication, identifying an appropriate venue, and who should be the participants. We

are aware that the committee would take the roles of the Secretariat as a result of lessons leant from the recent Health Forum.

- Resource mobilization from DPs would start soon.
- The two major agenda are to discuss how to implement the Health Forum Action Plans and to discuss Partnership Framework. Governors could also attend because there are some action points that came out from the Health Forum Action Plans need to be discussed by Governors and CS. The two issues had already been agreed.

(ウ) Comments, Questions and Answers

(1) Sandra, DPHK Secretariat's comments and a question

- She firstly commented about MTEF/AWP alignment, saying that there are also other DPs who are supporting county planning and budgeting, so leadership of MOH is needed in collecting best practices of MTEF/AWP from OCCADEP as well as other agencies. She proposed Dr. Warfa to lead the process with planning unit and M&E Unit, saying that that is the only way to keep OCCADEP's achievement alive.
- Regarding budgeting for IGF processes, she commented that donor funding has been reducing in the past few months and would continue to shrink. She appealed for sustainable financing from within the government – both counties and MOH, and less reliance on the partners.
- Lastly, she posed a question on how the HSIGCF is linked to the partnership structures that are coming on board soon, and how TTCs from county level is linked with the proposed ICC thematic working groups that would be sector-wide.

(2) Dr. Wangia, Project Manager of WB-THS's comment and a question

- She asked that as most of the mandate of providing technical assistance lies in the national government, if OCCADEP trained MOH on the MTEF tools. She said that it would be easier to expand use of the tools to all the counties from MOH compared to from county to county approach.

(3) Dr. Agata's comment

- He stated that although at onset OCCADEP was designed to cover entire country but after consultation with MOH at the Midterm Evaluation exercise, it was decided to concentrate on the two partner counties to come up with products that are sharable to other counties. OCCADEP was able to demonstrate how these MTEF tools can be shared, and thanks to Kirinyaga and Kericho, four other counties were trained. The issue now is for MOH to take advantage to share and expand of what was already been achieved. The question is also directed to World Bank's THS that one of the components of THS is to support county to county collaboration. How are you going to support expansion of this program through that county to county collaboration?

(4) Ms. Momose's response

- Regarding compilation of the best practices, she mentioned that all the best practices of OCCADEP are uploaded on the MOH website, nevertheless, she appealed to M&E Unit of MOH to request counties to fill best practices in their APRs on how MTEF Tools were utilized and its contribution to their management in the counties. She also requested M&E Unit to guide counties on how to identify and document best practices.

Attachment

- As for MOH Trainers of MTEF Tools, she shared that OCCADEP made presentations to UHC department and Finance Department. She explained that OCCADEP attempted to train MOH officers but due to unavailability created by competing tasks and frequent transfers to other departments this did not go far. But she reiterated that OCCADEP managed to train county officers who can train other counties.

- She explained that it turned out to be difficult to capture all the money flow using MTEF Management Tool under the current county set-up, and that is why it was proposed to use the Tool to capture and analyze THS funding, such as disbursement and absorption.

- She explained that OCCADEP discussed with many DPs on MTEF Cycle Management and PBB support. She expressed hope that THS-UCP could take up the MTEF Tools for dissemination, saying that Kirinyaga, Kericho, Machakos, Migori, and Nyeri would be able to train other counties. She also appealed to JICA Kenya Office to support until they can take off.

(5) Dr. Warfa's response

- Regarding the link of HSIGCF and DPs, he responded that the involvement of DPs is covered under Partnership Structure, but it is also possible to locate DPs in the structure of HSIGCF. (Mr. Elijah Kinyangi of JICA Kenya Office explained that since the forum was of intergovernmental nature, DPs were defined and involved as observers) Dr. Warfa expressed his view that DPHK could be linked in the structure in a dotted line to create a clearer picture of the DP engagement.

- Regarding how MOH could take up good practices from OCADEP and disseminate to other counties, he stated that forums with CECs, Chief Officers and CHMT Forum could be used for that. He went on and asked Dr. Wangia if THS-UCP could support one of these forums so that these best practices could be shared.

(6) Dr. Wangia's response

- She shared an idea that the THS-UC project accountants' training to be held in October 2019 would be an appropriate forum to share the MTEF Tools, explaining that the tool can firstly be introduced for tracking THS-UCP funding but eventually can be used for the entire funding available for AWP implementation.

- She added that other forums like AWP planning forums, which are held three times a year inviting County Director of Health, THS-UCP Focal Person and CHRIO, could also be utilized by MOH to slot some time for sharing these good practices. In addition, accountants can also be invited for refresher trainings.

(7) Dr. Warfa's response

- He proposed that not only MTEF Tools but also how to develop a high quality AWP was supported by OCCADEP and that could be shared at such forums. He noted that the Tools could also be shared by CEC Kericho, Kirinyaga and Machakos, adding that findings from OCCADEP Project should be discussed at such forums, not to forget UHC presentation forums where Dr. Betty Langat, Kericho County Department of Health could be invited. In conclusion, he emphasized that further dissemination of the products from the two OCCADEP partner counties is possible.

(8) Dr. Warfa's question

- He then asked a question to the two partner counties if they observed any changes in the challenges for the THS-UCP fund absorption by using MTEF Management Tool.

(9) Dr. Langat's response

- She stated that absorption of funds improved in the THS-UCP in Kericho from 30% to 58% and that Kericho managed to use the Tool to analyze which activities were not implemented. She elaborated by saying that the county discovered bottlenecks in delays in the procurement processes and that discussed the issue with County Treasury, who agreed to develop a tool to monitor procurement processes.

(10) Mr. Karoki's response

- He explained that all the money to the county budget is deposited in one County Revenue Fund (CRF), which makes it difficult for the health sector to access their fund.
- He also stated that an issue of procurement is even making the situation more difficult to realize the absorption within a given time.
- He stated that the Tool made CDOH from lower levels of the facilities to management level to understand what the problems are, and that they were able to think about how to achieve the targets.
- He shared that THS-UCP funding absorption rate in Kirinyaga is 60%.

(11) Dr. Omondi and Dr. Langat

- They suggested that Regional Economic Bloc forums could be another forum for sharing good practices.

3. Activities in Managing the MTEF Cycle and its Achievement

○ **Mr. George Karoki, Kirinyaga County Director of Health**

He opened his presentation by saying that the lessons from OCCADEP are well grounded in the CDOH, and that they would roll them out to other counties.

He then talked about how AWP and APR processes have evolved comparing before and after the support of OCCADEP. He summarized that both partner counties were conducting those activities before OCCADEP but with the support of OCCADEP, they were done in a more organized and systematic manner focusing on quality. He noted that:

- APR process became a result of both top-down and bottom up processes, especially in Kericho where they started the process from level 2-3 facilities.
- Data ownership was strengthened in Kericho through data review meeting, and in Kirinyaga, through APR validation, the data was owned by CDOH before presenting it to stakeholders.
- During the period of the OCCADEP, APR was presented to stakeholders which had never happened before.

Attachment

- During the period of the OCCADEP, in Kirinyaga, AWP process began from Community Units, and in Kericho from level 2-3 facilities.
- By using MTEF Management Tool for AWP, CDOH can obtain accurate budget information such as allocated budget and its balances and a dashboard can be produced automatically.
- With the budget ceilings given to level 2-3 facilities in Kirinyaga, the AWP became more realistic and was not wish lists like before. Budget guideline was given on how to use DANIDA funding and not to exhaust the fund to pay only for casual workers.
- Standardized health activity list was developed for all level of CDOH in Kirinyaga. Later, Kericho thought the idea useful and developed their standardized activity list

He then pointed out challenges faced by the two counties: (i) delays in sharing the templates by MOH often being sent out too late, and (ii) the latest APR template does not correspond with that of AWP.

He ended by sharing that Kericho and Kirinyaga signed the communique in order to sustain and expand the good achievements of OCCADEP. He also stated that they have already trained on MTEF Tools in four counties and declared that through the suggested forums, they would roll them out to other counties.

4. Challenges Identified and Way Forward on Improving Managerial Function of CDOH

o **Dr. Betty Langat, Kericho County Director of Health**

Before the presentation by Dr. Langat, Mr. Kinyangi shared his experience from the Kericho APR Stakeholders Meeting held in the previous week, saying that Kericho managed to mobilize diverse stakeholders ranging from Deputy County Commissioner to MCAs who were keen about county health performance, County Health Bill, and DPs and private hospitals who shared their areas of support and interest.

Dr. Langat explained the major challenges faced by the partner counties for the consecutive two years during the time of OCCADEP support. She elaborated the issue of lack of linkage between the AWP and APR templates, stating that the APR template received recently for FY2018/19 required extra information, for which they had never set the baseline and targets because they were not in AWP template. She appealed to MOH that they need to work on these two templates so that they are linked.

She also explained that following MTEF cycle, AWP is supposed to feed the County Budget needed by April but the new template for FY2018/19 AWP was sent by MOH in end of March 2018 when the County had completed all the AWP process. In terms of APR, she explained that the report is supposed to inform County Budget Review and Outlook Paper (CBROP) in the county that is needed by end September. However, the recent letter from CoG stated that APR process should start in October. She appealed that MOH and CDOH should all operate within the timelines defined along the MTEF Cycle.

She went on to explain what OCCADEP developed together with partner counties: MTEF Cycle Calendar, Organizational Structure, Planning, Budgeting and Performance Review Guide for the Health Sector (MTEF Process Guide), AWP Handbook for Level 2 & 3 health facilities, MTEF Management Tool/MTEF Management Data Aggregation Tool. She recommended MOH to utilize MTEF Cycle Calendar as well.

She then presented the four functions of MTEF Management Tool with examples:

- Links AWP and Program Based Budget (PBB)
- Links Activity and Line-Items

- Auto-generates various reports
- Enables to monitor PBB based AWP implementation status that enable decision making (dashboard)

She stated that one thing they have not actually worked on critically was the link between the activity expenditure and the outcome in terms of the indicators. She then gave the example of immunization activity that stalled after they analyzed performance using the tool they identified that the bottleneck was county procurement system, and CDOH is now working with the County Treasury for improvement. She said they would intensify utilizing the tool for this purpose from now on.

She explained the achievements of the Tool, including the submission of Financial Transaction Sheet by level 2-3 facilities to track DANIDA fund, which was entered by SCHRIO into the Tool.

Then she showed the dashboard of the Tool filled with THS funding information, demonstrating how it is easy to monitor utilization of fund against budgeted and approved budget, by program and sub-program.

Finally, she explained the challenges of using the Tool at county level, saying that it is easy to use for World Bank-THS and DANIDA projects but there has been complications in using it for County Budget, which she elaborated as follows:

- In Kericho, facilities and SCHMT had been budgeting for what they would not spend. For example, Level 2-3 facilities had been asked to budget in their AWP for drugs and non-pharmaceuticals, which they do not get funding nor procure by themselves. They could not monitor what is not in their AWP when they themselves do not receive funds as spending units. Similarly, level 4 facilities had also been asked to budget for 100 % of drugs and non-pharmaceuticals and lab reagents in their AWP, when they themselves would only handle 20% of those. Furthermore, SCHMT had been planning their activities in their SCHMT AWP, but currently they are not allowed to handle any funding at their level, until the Health Bill is approved by MCAs.
- After developing AWP using MTEF Management Tool, which also tracks the funding and expenditure, they came to conclusion that it would be simpler for each level to budget for what they receive and spend. That means, level 2-3 facilities budget for service delivery activities and items which can be spent from DANIDA fund, Linda Mama, and Foregone Fee. For level 4 facilities, they should budget for what can be spent from FIF, Linda Mama, and NHIF, all the rest should be budgeted by CHMT, including drugs, non-pharmaceuticals and lab reagents for level 2-4 for which CHMT is in charge for procurement and distribution, together with CHMT and SCHMT activities. In this way each level will be able to track what they budgeted for in the AWP. This is based on the principle that AWP is a planning tool, at the same time, AWP is also supposed to be a management tool to monitor implementation progress (including tracking financial progress).
- The needs for certain activities or items which are not directly handled by level 2-4 facilities but by CHMT, such as development projects, personnel emoluments, and drugs, can be notified by level 2-4 facilities to CHMT so that CHMT can budget for them under their AWP. In this sense, CHMT is expected to be more active in managing their AWP.
- She explained that in Kericho, although the location of development project is decided by MCAs, facilities can express their priorities.

Attachment

5. Plenary Session.

(1) Mr.Pepela's comments

- He stated that since devolution, MOH had had lots of hurdles in terms of issuing AWP/APR templates in good time. There were a number of partners introducing different tools and guidelines in addition to those of National Treasury.
- He also said that the national level also follows MTEF cycle but still have challenges, for example, for FY2019/20, the national level is still consolidating the AWP.
- He expressed the need for MOH to move in time and communicate centrally from the Planning Office to CoG and not from any other channels.

(2) Dr. Nyakiongora's comments and a question

- He appreciated the presentation and valued the MTEF Tools saying that when he was a district medical officer there was no such guidelines. He also promised to post MTEF Cycle Calendar in his office and to bring it to his county.
- He stated that planning has big challenges in terms of linking line item based budget and activities. He went on and asked how far the standardized activity list is able to capture activities which are dynamic and may change from year to year, and that if it is able to capture primary health activities of level 1 in level 2-3 facility work plan.

(3) He expressed that the tools are also needed in MOH and Ministry of Finance, who provide overall guidance to the MTEF process. He commented on the importance of engaging the National Treasury since MOH is not really in control of MTEF Cycle.

(4) Mr. Karani's questions

- He asked if Kericho has any tool that helps in monitoring their activities, such that they do not wait for the end of the year to realize they did not do certain activities.
- He also posed a question if Kericho has County Department of Public Works which could help Level 2-3 facilities to plan for construction in terms of costing.
- Lastly, he asked which indicators changed after OCCADEP's intervention.

(5) Mr. Pepela's comments

- He commented that the recommendation of moving health products budgeting from facilities to CHMT is a good idea because County Pharmacist is indeed doing it.
- He would like to urge national level directorates to use MTEF Management Tool by filling in standardized activities.

(6) Dr. Agata's comments

- He stated that when it comes to transforming health systems, OCCADEP is actually deeply embedded in the direction of UHC, more specifically through utilizing MTEF tools. He urged that initiatives of OCCADEP should have already been owned by MOH through the major projects that are now being implemented.

- He recognized that OCCADEP was able to strengthen CHMT, HMT, and SCHMT as critical entities in this transformation. He urged MOH to ensure that partners who are providing support for UHC to take account of these three entities.

(7) **Mr. Mbui's response**

- He pointed out that the tool is dynamic because the information set in the Tool can be modified by the Administrator (with access control), who is able to add and / or remove certain information such as programs and sub-programs in the master file. He introduced an example of adding UHC as the 4th program in the Tool when they taught the application of the tool to a UHC pilot county. He cautioned, however, that the change of activity list can only be done before it is given to the facilities because the data filled-in the tools would eventually be aggregated for the whole county. He also explained that 45 health indicators are linked to the activity.

(8) **Dr. Langat's response**

- She explained that the Tool had gone through a series of developments and upgrading over a year and thus the entry of THS-UCP was done in the 4th Quarter, although the Tool itself can monitor from the 1st to 4th Quarter. She indicated that for FY 2019/20, Kericho had managed to enter THS-UCP plans so that it can be monitored monthly and quarterly.

- Regarding working with the Department of Public Works, she explained that they are able to get Bill of Quantities (BQs) and construction costs and give them to the facilities. However, what she wanted to emphasize was that it is the CHMT who expends the construction budget and not the level 2-3 facilities.

- For changes in terms of indicators, she said that the Tool was able to help following up resources and improvement in terms of indicators.

(9) **Dr. Wangia's question**

- She asked if the Tool would show the savings per activity, such as a case where the planned activity was carried out 100% but the planned budget for the activity was spent only 90%.

(10) **Dr. Muleshe's question**

- He stated that county politics are very dynamic and that there is a high turn over of officers in the County Department of Health, who were made champions and consultants of the Tools. He asked if the counties have put in place measures for sustainability.

(11) **Dr. Langat's response**

- She stated that the Tool is able to capture the amount spent and balances, just like a vote book shows line item and its balance. She added that the Tool can generate reports on line-budget expenditure as well. She elaborated that the Tool can indicate delays in implementation, which can attract the user to find the root causes for delays.

(12) **Mr. Karoki's response**

- He noted that even in cases where some officers left CDOH, capacity development can continue, because they had managed to achieve this far as a team, and the key officers, who are HRIOs, had always been involved. He also observed that some facility in charges were also trained through OCCADEP.

- He indicated that other sector county departments could also use this tool, not only Health Department.

(13) Ms. Kobayashi's comment

- She reminded the meeting that AWP Handbook has a section at the end that proposes how AWP template should be improved.

(14) Mr. Wanjala's questions

- He asked how this tool was used for resource mobilization and actualizing AWP so that it would not remain as a wish list, and how each partner's commitment was reflected in AWP.

(15) Dr. Langat's response

- As for resource mobilization, she explained that it was done through APR. She elaborated by saying that they reviewed FY(X-1) activities and came up with challenges and priorities which they shared with stakeholders, who are expected to select what priorities they could support. She went on and said that they would be able to use this tool for advocating to the MCAs so that they could allocate more budget to health.

(16) Mr. Karoki's response

- He explained that the Tool builds and promotes transparency and they showed it to the partners.
- His intention is to bring County Department of Finance on board with utilization of this tool so that the County Government is aware CDOH has a tool to monitor the approved budget for health activities. He mentioned that so many activities were not able to take off because of the political interests.

6. Closing Remark

- **Mr. Shinjiro Amameishi, Senior Representative, JICA Kenya Office**

He firstly expressed on behalf of JICA, sincere appreciation for the efforts made by MOH and OCCADEP JICA Expert Team and the CHMTs from Kericho and Kirinyaga. He said he was very much impressed with the big achievements. He recognized that the latter half of this project after the mid-term review held in March 2017, has made a tremendous progress.

He stated that one of the biggest achievements were that the two counties utilized the MTEF Management Tool and it is functioning. In addition, their knowledge experience had already been shared with other 4 counties.

He stated that two issues should be taken up. One is the sustainability issue by the two counties to disseminate the tool to other counties. He said that in order to realize sustainability of the achievements derived from the Project, the two counties are expected to maintain and further strengthen themselves to become model counties. He mentioned that the other issue was to roll out the MTEF Tools. He appealed to MOH that although there were some challenges in HSIGCF, he expected the forum to further function in this regard. If the two counties became model counties and MOH's efforts were combined, he believed that they can roll out the system.

He concluded that OCCADEP would come to an end in a week's time but JICA has an intention to formulate another project to support further the expansion of MTEF Management Tool, for which they would send a detailed planning survey mission. He thanked once again the MOH, OCCADEP team, and the two counties.

Dr. Omondi thanked the members for their participation and the meeting was closed with a word of prayer at 12.48 pm.

ANNEX

1. Meeting Program
2. List of participants

Annex 1: Program

MOH/JICA - OCCADEP
ORGANIZATIONAL CAPACITY DEVELOPMENT PROJECT
FOR THE MANAGEMENT OF DEVOLVED HEALTH SYSTEMS IN KENYA
PROJECT STEERING COMMITTEE MEETING

VENUE: Pan Afric Hotel DATE: 20th September 2019

PROGRAM

TIME	Agenda Item	PRESENTER	Session Chair
08:30 - 09:00	Registration	Ms. Mercy Ronoh	
09:00 - 09:15	Welcome /Prayers /Introductions	Dr. Osman Warfa Head DHSC/IGA, Project Manager	
09:15 - 09:30	Opening remarks	Dr. John Wekesa Masasabi Director General Project Director	
09:30 – 09:50	Progress of the Project - Overall Framework of the Project and its Achievements	Ms. Shioko Momose Chief Advisor, JICA-OCCADEP	Dr. Jackson Omondi
09:50 – 10:10 **10:10 – 10:30**	- IGF and IGF Operational Manual - Q&A	Dr. Osman Warfa	
10:30 – 10:50	**HEALTH BREAK**		
10:50 – 11:20	Activities in Managing the MTEF Cycle and its Achievement	Mr. George Karoki County Director Kirinyaga CDOH	
11:20 – 11:50	Challenges Identified and Way Forward on Improving Managerial Function of CDOH	Dr. Betty Langat County Director Kericho CDOH	Mr. Elijah Kinyangi
11:50 – 12:20	Plenary Discussions		
12:20 – 12:50	Closing remarks o Senior Representative, JICA Mr. Shinjiro Amameishi		Dr. Jackson Omondi
	HEALTH BREAK		

Annex 2:

List of Participants

(a) Ministry of Health

No.	Name	Position
1.	Dr. Osman Warfa	Director of Health Sector Coordination & Intergovernmental Relations
2.	Dr. Abel Nyakiongora	Head, Department of Health Sector Coordination and International Health Relations (HSCIHR)
3.	Dr. Stephen Muleshe	Head, Department of Intergovernmental Relations
4.	Dr. David Kariuki	Head, Department of Health Policy, Research and Development
5.	Dr. Jackson Omondi	Head, Division of Partnership Coordination, Department HSCIHR
6.	Dr.Elizabeth Wangia	Project Manager-THS
7.	Dr. Rebecca Kiptui	Head UHC Secretariat
8.	Mr. Erastus Karani	Regional B Coordinator, Department of Intergovernmental Relations
9.	Mr. Phirez Ongeri	Regional C Coordinator, Department of Intergovernmental Relations
10.	Mr. Samson Mosiere	Regional D Coordinator, Department of Intergovernmental Relations
11.	Mr. Johnny Musyoka	Regional E Coordinator, Department of Intergovernmental Relations
12.	Ms. Pepela Wanjala	Deputy Director Health Records Information Management, Department of Health Informatics and Monitoring and Evaluation
13.	Ms. Kumiko Yoshida	UHC Advisor (JICA Expert)
14.	Anthony Komen	Statistician, Department of Health Informatics and Monitoring and Evaluation

(b) Counties

No.	Name	Position
1.	Dr. Betty Langat	Kericho County Director of Health
2.	Ms. Emily Cheres	County Reproductive Health Coordinator, Kericho County
3.	Isaac Langat	Health Administrative Officer, Kericho County
4.	Moses Ngetich	County Clinical Officer, Kericho County

5.	Shadrack Korir	Bureti Sub County Health Record & Information Officer, Kericho County
6.	Dr. George Karoki	Kirinyaga County Director Of Health
7.	Jane W. Kabungo	County Nutrition Coordinator, Kirinyaga County
8.	Elizabeth Chomba	County Monitoring and Evaluation, Kirinyaga County
9.	Julius Mbui	Kirinyaga South Sub County Health Record & Information Officer, Kirinyaga County

(c) Development Partners

No.	Name	Position
1.	Sandra Erickson	DPHK Secretariat
2.	Per Clausen	DANIDA Adviser

(d) JICA Kenya Office

No.	Name	Position
1.	Mr. Shinjiro Amameishi	Senior Representative
2.	Ms. Shoko Isokawa	Representative
3.	Dr. Naphtali Agata	Health Sector Consultant
4.	Mr. Elijah Kinyangi	Senior Program Officer

(e) JICA OCCADEP

No.	Name	Position
1.	Ms. Shioko Momose	Chief Advisor/ Health System Management
2.	Mr. Nobuyuki Hashimoto	County Health Management Advisor
3.	Ms. Yuki Kobayashi	MTEF Cycle Operation Advisor
5.	Mr. Kimura Shinichi	Project Coordinator
6.	Ms. Mercy Ronoh	Administrative Assistant

MTEF Tools distributed and sensitized/trained in the partner counties

Tools	Status of Utilization					
	Kericho			Kirinyaga		
	CHMT	SCHMT (6 SCHMTs)	HF (161 HFs including hospitals)	CHMT	SCHMT (5 SCHMTs)	HF (62 HFs including hospitals)
Cycle Calendar	100%	100%	100%	100%	100%	100%
Process Guide	100%	100%	100%	100%	100%	100%
Management Tool Ver. 1 for FY2018/19	100%	100%	N/A (Financial Transaction Record and Information Sheet was prepared)	100%	100%	N/A (The Financial Transaction Record and Information Sheet was prepared)
Financial Transaction Record and Information Sheet for HF (both the original & the revised version)	N/A	N/A	100%	N/A	N/A	100%
Data Aggregation Tool Ver.1 for FY2018/19	100%	100%	N/A (The Tool is not meant for HFs)	100%	100%	N/A (This Tool is not meant for HFs)
Management Tool Ver. 2.5 for FY2019/20	100%	100%	N/A (The AWP Program Based Service Delivery Plan FY2019/20 was prepared)	100%	100%	N/A (The AWP Program Based Service Delivery Plan FY2019/20 was prepared)
AWP Program Based Service Delivery Plan FY2019/20	N/A	N/A	100%	N/A	N/A	100%
Data Aggregation Tool Ver.2.5 for FY2019/20	100%	100%	N/A (The Tool is not meant for HFs)	100%	100%	N/A (This Tool is not meant for HFs)
AWP Handbook for Level 2&3 Health Facilities	100%	100%	100%	100%	100%	100%

AWP Handbook - For Level 2&3 Health Facilities <sensitization tool>	100%	100%	100%	100%	100%	100%
Management Tool Ver. 3.02 for FY2020/21 onward	100%	100%	N/A (Financial Transaction Record and Information Sheet was prepared)	100%	100%	N/A (The Financial Transaction Record and Information Sheet was prepared)
Data Aggregation Tool Ver.3.02 for FY2020/21 onward	100%	100%	N/A (The Tool is not meant for HFs)	100%	100%	N/A (This Tool is not meant for HFs)
Instruction Booklet of ' MTEF Management Tool'	100%	100%	N/A	100%	100%	N/A
Technical Instruction Booklet of ' MTEF Management Tool' for the Tool Administrators	Partly (The Tool Administrator only)	Partly (The Tool Administrator only)	N/A	Partly (The Tool Administrator only)	Partly (The Tool Administrator only)	N/A
MTEF Management Tool Ver.3.0 MAINTENANCE MANUAL (*1)	N/A (Announced and posted on MOH website only)	N/A (Announced and posted on MOH website only)	N/A (Announced and posted on MOH website only)	N/A (Announced and posted on MOH website only)	N/A (Announced and posted on MOH website only)	N/A (Announced and posted on MOH website only)
MTEF Management Data Aggregation Tool Ver.3.0 MAINTENANCE MANUAL (*2)	N/A (Announced and posted on MOH website only)	N/A (Announced and posted on MOH website only)	N/A (Announced and posted on MOH website only)	N/A (Announced and posted on MOH website only)	N/A (Announced and posted on MOH website only)	N/A (Announced and posted on MOH website only)

Note:

1) The underlined part are the MTEF Tools that was completed after the Terminal Evaluation.

2) 1 & 2: Both MAINTENANCE MANUALs are not the subject for distribution but for being used by venders that would be outsourced.

List of MTEF Tools

MTEF Tool No. 01a	Kericho CDOH MTEF Management Organization Structure
File name in the MOH website	MTEF Tool_01a_Kericho CDOH Organization_20190828_fin
Style & Format	Poster, PDF (*Word version was provided to Kericho CDOH for possible revision)
Objective	Making public CDOH structure in Kericho to all health personnel
How to use	Paste on the office wall to expose to all health personnel to understand the structure of CDOH's public health units and facilities as well as responsible personnel in each health subject.
Expected Users	All health personnel in Kericho CDOH including Community Unit

MTEF Tool No. 01b	Kirinyaga CDOH MTEF Management Organization Structure
File name in the MOH website	MTEF Tool_01a_Kirinyaga CDOH Organization_20190828_fin
Style & Format	Poster, PDF (*Word version was provided to Kirinyaga CDOH for possible revision)
Objective	Making public CDOH structure in Kirinyaga to all health personnel
How to use	Paste on the office wall to expose to all health personnel to understand the structure of CDOH's public health units and facilities as well as responsible personnel in each health subject.
Expected Users	All health personnel in Kirinyaga CDOH including Community Unit

MTEF Tool No. 02	MTEF Cycle Calendar
File name in the MOH website	MTEF Tool_02_MTEF Cycle Calendar_V3.2
Style & Format	Poster, PDF (*Word & Excel versions are also posted on MOH website)
Objective	Making public MTEF cycle of County Health Department to all health personnel
How to use	Paste on the office wall to expose to all health personnel to understand the work process of Health management under MTEF cycle.
Expected Users	All health personnel in CDOHs in whole Kenya counties

MTEF Tool No. 03a	MTEF Management Tool Ver.3.02
File name in the MOH website	MTEF Tool_03a_MTEFmgtTOOL_allcounties_V3.02_20190912
Style & Format	Electric tool, Excel (Macro program) file
Objective	Smoothing management in planning, budgeting, financial monitoring and reporting
How to use	Using the instruction guide, operate the file for AWP preparation, expenditure

	monitoring, which produces various analytical and report forms.
Expected Users	All health managers at various levels who are responsible for planning, costing, budgeting and/or expenditure monitoring

MTEF Tool No. 03b	**Data Aggregation Tool for MTEF Management Ver 3.00**
File name in the MOH website	MTEF Tool_03b_DataAggTool_V3.00_20190823
Style & Format	Electric tool, Excel (Macro program) file
Objective	Consolidation of AWPs and financial transactions of concerned health units under CDOH
How to use	To consolidate various MTEF Management Tools, this tool is used. All data of AWP costing and expenditure of Sub-county level and County level.
Expected Users	CHMT and SCHMT responsible person for consolidation

MTEF Tool No. 03c	**Instruction Booklet of ' MTEF Management Tool' for the Health Officers under CDOH**
File name in the MOH website	MTEF Tool_03c_UsersBooklet_MTEFmgtTool_201908
Style & Format	Guidebook, PDF (*Word version was posted on MOH website)
Objective	Guiding MTEF Management Tool Users on how to operate it
How to use	MTEF Management Tool users can refer it step by step.
Expected Users	All health managers at various levels who are responsible for planning, costing, budgeting and/or expenditure monitoring

MTEF Tool No. 03d	**Technical Instruction Booklet of ' MTEF Management Tool' for the Tool Administrators**
File name in the MOH website	MTEF Tool_03d_AdminBooklet_ MTEFmgtTool_201908
Style & Format	Guidebook, PDF (*Word version was posted on MOH website)
Objective	Guiding MTEF Management Tool Administrator on how to set the master tool before distribution
How to use	MTEF Management Tool Administrators can refer it to set up the tool.
Expected Users	Appointed administrators under each CHMT (3-5 people)

MTEF Tool No. 03e	**MTEF Management Tool MAINTENANCE MANUAL**
File name in the MOH website	MTEF Tool_03e_MTEFMgtTool_MaintenanceManual_201908

Style & Format	Technical Manual, PDF (*Word version was posted on MOH website)
Objective	Provision of the tool program design layout for IT vendors to maintain and revise MTEF Management Tool
How to use	For general maintenance and possible revision of MTEF Management Tool, the outsourced vendors can refer it when contracted.
Expected Users	IT vendors who have enough knowledge on Microsoft- Excel VBA

MTEF Tool No. 03f	**MTEF Management Data Aggregation Tool Ver.3.0 MAINTENANCE MANUAL**
File name in the MOH website	MTEF Tool_03f_DataAggTool_MaintenanceManual_201908
Style & Format	Technical Manual, PDF (*Word version was posted on MOH website)
Objective	Provision of the tool program design layout for IT vendors to maintain and revise Data Aggregation Tool for MTEF Management
How to use	For general maintenance and possible revision of Data Aggregation Tool for MTEF Management, the outsourced vendors can refer it when contracted.
Expected Users	IT vendors who have enough knowledge on Microsoft- Excel VBA

MTEF Tool No. 04	**Planning, Budgeting and Performance Review Process Guide for Health Sector -Simple Guide to MTEF for Health Sector**
File name in the MOH website	MTEF Tool_04_Process-Guide-for-Health-Sector
Style & Format	Guidebook, PDF (*Word version was posted on MOH website)
Objective	Guiding health personnel as a reference of annual work process by month under MTEF cycle
How to use	Using the guide in this book, all health personnel can understand when and what to do by who in health management in MTEF cycle.
Expected Users	All health personnel in CDOHs in whole Kenya counties

MTEF Tool No. 05a	**AWP Handbook for Level 2&3 Health Facilities - A guide on developing AWP**
File name in the MOH website	MTEF Tool_05a_AWP-Handbook-20190710-min
Style & Format	Guidebook, PDF (*Word version was posted on MOH website)
Objective	Guiding health personnel to prepare each section of AWP for level 2 & 3
How to use	Using the guide in this book, health personnel at facility level 2 & 3 can understand how to prepare AWP.
Expected Users	All health personnel in Level 2 & 3 facilities in whole Kenya counties

MTEF Tool No. 05b	**AWP Handbook - For Level 2&3 Health Facilities <sensitization tool>**
File name in the MOH website	MTEF Tool_05b_AWP Handbook-PPT
Style & Format	Sensitization manual, PPT
Objective	Presentation manual for CDOH presenter to guide health personnel to prepare each section of AWP for level 2 & 3
How to use	Using this presentation slides, health personnel at facility level 2 & 3 are sensitized on how to prepare AWP.
Expected Users	CHMT or SCHMT representative who can deliver a presentation to all health personnel in Level 2 & 3 facilities

List of Materials Developed for Human Resource Development, HSICF, etc

Human Resource Related	**Training Curriculum for Health System Management**
Objective	The document analyses the existing curriculum for management of health systems and assesses the current needs of the County Departments of Health (CDOH) in the wake of devolution.

Human Resource Related	**Training Needs Assessment of Kenya's Health Work force**
Objective	This report identifies skills gap in Health Specialist, Clinical and Management staff at post-graduate and post-basic levels needed for effective service delivery at all levels of the health system; in-service training needs and the number of healthcare workers that require training at the County level to effectively deliver KEPH; and assesses capacities of CDH, CHMT and SCHMT in leadership and management for service delivery.

Human Resource Related	**Existing Health Systems Management Curriculum Analysis**
Objective	Making public MTEF cycle of County Health Department to all health personnel
How to use	Paste on the office wall to expose to all health personnel to understand the work process of Health management under MTEF cycle.
Expected Users	All health personnel in CDOHs in whole Kenya counties

Human Resource Related	**Leadership in Health Systems Management: Common Strategy**
File name	MTEF Tool_03a_MTEFmgtTOOL_allcounties_V3.02_20190912 (on MOH website)
Style & Format	Electric tool, Excel (Macro program) file
Objective	This document is developed to address the discrepancies encountered in the implementation of the training function of the Human Resources for health in the sector at the National and County levels. It gives step by step procedures for conducting training that should be followed by all stakeholders involved in training health workers.
Expected Users	All health managers and DPs who are planning to conduct trainings in the Health Sector.

Devolution Related	**Core Function Working Paper**
Objective	The document was developed in the midst of devolution when the roles and responsibilities were not clear between MOH and CDOHs.

Inter-Governmental related	**HSIGCF Operation Manual**
Objective	An Operational Manual that has been developed in order to hold an effective and efficient HSIGCF. The manual was signed by the CS and Chair of Health CECs Forum
How to use	To be used in planning, implementation and follow-up processes.
Expected Users	To be used mainly by the Secretariat of HSIGCF The Operation Manual is posted on the website http://www.health.go.ke/wp-content/uploads/2019/07/IGF-Operations-Manual_signed.pdf

Joint Communiqué

Issued at

Mutual Learning Forum

Between

Kirinyaga CDOH & Kericho CDOH

In attendance

Nyeri CDOH

Supported by JICA-OCCADEP

2nd July 2019

Joint Communiqué

Kericho and Kirinyaga County Departments of Health (hereinafter referred to as The CDOH) hereby commit themselves to the following agenda:

Regarding Dialogue Days:

1. The CDOH will support Level 1 interventions by developing a community health services bill (Kericho) and lobbying for the adoption of the Community Health services bill by the respective County Assemblies as the cornerstone for achieving UHC (both Kirinyaga and Kericho).
2. The CDOH will foster mutual learning and exchange visits among Community Units within the county and also outside the county to learn best practices from well performing Community units.

Regarding Monthly Reporting & Data Review:

1. All health units including community units and health facilities will be encouraged to utilize data for monitoring and decision making.
2. The CDOH will strive to conduct monthly data reviews to improve data quality and service uptake
3. The CDOH will encourage all Health facilities and Sub-counties to utilize the MTEF Management Tool to track implementation of their AWPs.

On Quarterly Performance Reporting and stakeholder engagement:

1. The CDOH, jointly with its partners and stakeholders, will conduct quarterly performance reviews to appraise implementation progress and share best practices.
2. The CDOH shall hold at least 2 stakeholder fora annually which will provide a framework for information sharing among stakeholders, comparing achievements against targets and sharing best practices.

On Annual Work Plan (AWP) & Annual Performance Review (APR) processes:

1. That the CDOH will formally adopt the draft "AWP Handbook for Level 2&3 Health Facilities" and disseminate to all planning units within the department.
2. During budgeting process, the CDOH will prioritize AWP and APR development activities as

a means of entrenching sustainability and utilization of internal funding.

3. The department will adopt a participatory bottoms-up approach to annual review of the Annual Work Plan
4. Where possible, the CDOH shall utilize the MTEF Management Tool especially the summary reports and dashboard to monitor and evaluate the annual plans at ALL levels
5. The CDOH shall endeavor to participate in the National Health Summit and showcase best practices.

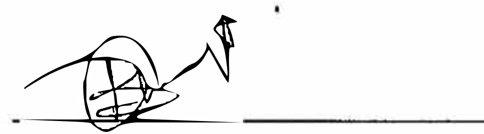
Regarding utilization of the MTEF Management Tool:

1. The CDOH will endeavor to monitor and mentor the utilization of the MTEF Management Tool at ALL public health facilities especially for tracking financial information.
2. Where financial information is not available at the health facility/service delivery level, the CDOH shall designate responsible officers to provide and populate the data into the MTEF Management Tool.
3. The CDOH will utilize the MTEF Management Tool to monitor THS UC funds in the FY 2019/2020.

Kirinyaga County

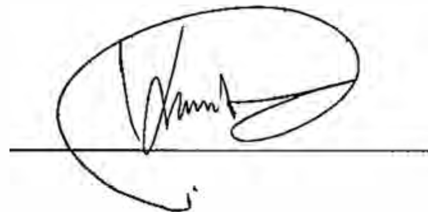
Mr. George N. Karoki, County Director of Health

Kericho County

Dr. Betty Langa't, County Director of Health 

Witnessed by

Dr. Nelson Muriu, County Director of Health, Nyeri

Mr. Elijah Kinyangi, JICA-Kenya 

Ms. Shioko Momose, JICA-OCCADEP

2019.7.2

List of MTEF Management Trainers (Kirinyaga CDOH)

No.	Status of Certificate	Name	Position
1	Master Trainer	Esbon Gakuo	Pharmacist
2	Master Trainer	Julius Mbui	SCHRO, Kirinyaga South
3	Master Trainer	Jackline Munene	Manager, Kimbimbi Hospital
4	Lead Trainer	Ruth Wambui	CHRIO
5	Lead Trainer	Elizabeth Chomba	County M&E Officer
6	Lead Trainer	Eric Muriithi	OCCADEP Project Staff
7	Senior Facilitator	Judy Claire Muthoni Njeru	OCCADEP Project Staff
8	Facilitator	Wilfred M. Mutemi	County Health Promotion Officer
9	Facilitator	Benson Mwangi	SCHRIO, Kirinyaga West
10	Facilitator	Eric Mutugi	SCHRIO, Kirinyaga Central
11	Facilitator	Ruth Mwai	Deputy County Nursing Officer
12	Facilitator	Faith Ngatia	SCHRIO, Kirinyaga East
13	Passing Grade	David Maina Njoroge	SCHRIO, Kirinyaga North
14	Passing Grade	Ephantus Mugo	Sub-County Nursing Officer
15	Passing Grade	Jackson Njagi	Hospital HRIO
16	Passing Grade	Pauline Kiai	Hospital HRIO
17	Passing Grade	Esther Njuguna	Hosiptal HRIO, Sagana
18	Passing Grade	Dennis Maina	Sub-County Nursing Officer
19	Passing Grade	Mary Nguri	Hospital HRIO

List of MTEF Management Trainers (Kericho)

No.	Status of Certificate	Name	Position
1	Master Trainer	Isaac Langat	Assistant Chief Health Administrative Officer
2	Master Trainer	Charles Terer	Sub County AIDS and STI Coordinator
3	Master Trainer	Shadrack Korir	SCHRIO
4	Lead Trainer	Limo David	SCHRIO
5	Lead Trainer	Beatrice Chelangat	SCHRIO
6	Lead Trainer	Edmond Koech	OCCADEP Project Staff
7	Lead Trainer	Willy Kipyegon	OCCADEP Project Staff
8	Senior Facilitator	Valerie Langat	Sub County AIDS and STI Coordinator
9	Senior Facilitator	John Kikwai	SCHRIO
10	Senior Facilitator	Kirui Collins	Medical Superintendent (SCHMT Bureti)
11	Facilitator	Gilbert Kipngetich	Sub County AIDS Coordinator
12	Facilitator	Eric Yegon	ICT Officer for County Government
13	Facilitator	Lilian Maritim	SCPHN
14	Facilitator	Daisy C. Kilel	Hospital Accountant
15	Facilitator	Davies Sang	Hospital Accountant
16	Facilitator	Anne Koske	Health Administrative Officer
17	Facilitator	Vincent Tanui	SCHRIO
18	Passing Grade	Mesheak Rotich	HRIO
19	Passing Grade	Stanley Tonui	Sub County Reproductive Health Coordinator
20	Passing Grade	Paul Cheruiyot	SCHRIO