CAPACITY KENYA

END OF PROJECT EVALUATION

FINAL REPORT

February 11, 2014

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CONTENTS

Acronyms and Abbreviations ii
Acknowledgements iv
Executive Summary 1
Key Evaluation Findings 2
Conclusions 3
Contextual Background 5
Kenya's Health Care system and Human Resources for Health 5
The Role of USG in Addressing HRH in Kenya 7
Evaluation Purpose and Scope 7
Evaluation Design and Methodology 8
Data Collection Approach 8
Data Analysis 11
Work Plan and Timeline 11
Key Evaluation Findings 12
Rationale and Relevance 12
Project Performance: Effectiveness and Efficiency 14
Discussion by Evaluation Questions 24
Challenges, Obstacles, and Lessons Learned 27
Sustainability 28
Recommendations for Follow-on Design 31
ANNEXES i
Annex A: End-of-Project SOW i
Annex B: List of Documents Reviewed vii
Annex C: List of Key Informant Interviews Conducted viii
Annex D: Survey Data xii
Annex E: Evaluation Time-Line And Schedule xvii
Annex F: Selected Data Collection and Respondent Interview Instruments xix

ACRONYMS AND ABBREVIATIONS

AHEC	Area Health Education Centres
AMREF	African Medical Research Foundation
APHIA	AIDS, Population and Health Integrated Assistance
ART	Anti-Retroviral Therapy
BSc	Bachelor of Science
CDC	Center for Disease Control
CH	Community Health
CHAI	Clinton Health Access Initiative
CHAK	Christian Health Association of Kenya
CHEW	Community Health Extension Worker
CHMTS	Community Health Management Teams
CHW	Community Health Worker
CKP	Capacity Kenya Project
CO	Clinical Officer
COC	Clinical Officers Council
COE	Center of Excellence
COP	Communities of Practice
CPD	Continuing Professional Development
CU	Community Unit
CUE	Commission for University Education
DASCO	District AIDS/STI Committee
DCHS	Division of Community Health Services
DFID	Department for International Development
DOMC	Division of Malaria Control
DPHK	Development Partners in Health operating in Kenya
DPM	Department of Personnel Management
DRH	Department of Reproductive Health
DSRS	Division of Standards and Regulatory Services
ECPD	Electronic Continuing Professional Development
FBO	Faith Based Organization
FP/RH	Family Planning/Reproductive Health
GAVI	Global Alliance for Vaccines and Immunization
GFATM	Global Fund for AIDS, TB and Malaria
GoK	Government of Kenya
GRC	Global Resource Centre
HCSM	Health Commodity and Service Management
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HPP	Health Policy Project
HQ	Headquarters
HR	Human Resource
HRD	Human Resource Department
HRH	Human Resource for Health
HRIO	Health Records Information Officer
HRIS	Human Resource Information System
HRM	Human Resource Management
HW	Health Workforce
ICC	Inter-Agency Coordinating Committee
ICT	Information and Communication Technology
IGA	Income Generating Activity
IHRIS	Integrated Human Resources Information Systems
IHRM	Integrated Human Resources Management
IR	Intermediate Results
JICA	Japan International Cooperation Agency
KCCB	Kenya Conference of Catholic Bishops
KEC	Kenya Episcopal Conference

KEMSA	Kenya Medical Supplies Authority
KIHSM	Kenya Institute of Health Systems Management
KMPDB	Kenya Medical Practitioners and Dentists Board
KMTC	Kenya Medical Training College
KNH	Kenyatta National Hospital
LMIS	Learning Management Information System
MSH (LMS)	Leadership Management and Sustainability
LMS	Learning Management System
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
MoH	Ministry of Health
MOMS	Ministry of Medical Services
MOPHS	Ministry of Public Health and Sanitation
MSH	Management Sciences for Health
NAL	Northern Arid Lands
NASCOP	Kenya National AIDS & STI Control Programme
NCK	Nursing Council of Kenya
NGO	Non-Governmental Organization
NHHRD	National Health Human Resources Development
NHIF	National Hospital Insurance Fund
NHRH	National Human Resources for Health
NHRHSP	National Human Resource for Health Strategic Plan
NHTRP	National Reproductive Health Training Plan
OSH	Occupational Safety and Health
PEPFAR	President's Emergency Plan for AIDS Relief
PLC	Peer Learning Cycles
PLHIV	People Living with HIV
PMP	Performance Monitoring Plan
PNA	Performance Needs Assessment
PSC	Public Service Commission
PSI	Population Services International
RH	Reproductive Health
RHP	Rapid Hire Plan
RRI	Rapid Results Initiative
SMS	Short Messaging Services
SOW	Scope of Work
TA	Technical Assistance
TB	Tuberculosis
TOT	Training of Trainers
TRG	Training Resource Group
TWG	Technical Working Group
USAID	United States Agency for International Development
USG	United States Government
VCT	Voluntary Counseling and Testing
WCI	Work Climate Improvement
WHO	World Health Organization
WISN	Workload Indicator for Staffing Need

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The Team appreciates the support received from all stakeholders who provided valuable time and sincere insights during interviews and focus group discussions during site visits.

The CKP End-of-Project Evaluation Team
February 2014

EXECUTIVE SUMMARY

USAID/Kenya's Office of Population and Health (OPH) contracted AMEX International to conduct an end-of-project evaluation of the Capacity Kenya Project (CKP). The purpose of the evaluation was to identify successes and lessons learned from the implementation of the CKP as well as to discern new approaches to enhance the effectiveness of human resources for health (HRH) follow-on program. (See Annex1: Scope of Work)

Specific evaluation questions that guided the evaluation include the following:

- What is the progress of the CKP towards achievement of the specific project objectives and OPH's objectives?
- Did the project employ new state-of-the-art methods for addressing the HRH issues in the country that are based on a clear assessment of knowledge and behavior?
- Did the CKP demonstrate technical knowledge; analytical depth; and a logical, results-based approach in order to meet the objectives of the project?
- Did the project employ feasible and realistic strategies for meeting each of the objectives in the areas of HIV/AIDS, RH, FP, MCH, and malaria?
- To what extent has the project built capacity of local organizations, government departments, and other private sector partners? To what extent have other sustainability efforts have been made?
- What were specific challenges, obstacles, and lessons learned in the implementation of the project?
- To what extent has the CKP engaged the different stakeholders, especially the GoK and other strategic donors?
- What are the current HRH gaps at national and county levels?
- What approaches should USAID adopt in designing the follow-on project?
- What opportunities and assumptions can be considered in supporting HRH management systems in the devolved systems?

End-of-project Evaluation Methods

The Team employed the following methodology for conducting the evaluation:

- *Review of over 25 documents and secondary data sources,* provided by USAID/Kenya, the CKP, and obtained based on KIIs
- *Almost 70 Key informant interviews (KIIs)* with CKP individual stakeholders and selected beneficiaries, at the Nairobi and regional levels
- *10 Focus Group Discussions (FGDs)* with various groups of stakeholders and individual program beneficiaries
- *Direct observation during 4 site visits* to assess management controls over the equipment, vehicles and property storage, and maintenance at the level of the CKP's sub-grantees
- *Online survey* distributed to a sample of 700 respondents to attain quantifiable findings about CKP implementation
- *10 Exit Interviews* with clients and patients receiving health services in CKP-supported sites

Copies of the data collection instruments used can be found in the Annex E.

The following data analysis methods were used: comparison matrix, content analysis, online survey using Survey Monkey, and key question scale. The Team triangulated quantitative and qualitative data to verify data quality, and legitimize findings by evaluating alternative explanations, disconfirming evidence, and

searching for negative cases. The Team has made every effort to ensure that all recommendations reached during the evaluation have been derived via the triangulation of evidence from diverse data sources.

The evaluation sites included Nairobi and Nairobi county, Rift Valley, Eastern, and Nyanza/Western regions. This evaluation was implemented between November 25, 2013 and January 2014: the final detailed timeline is presented in Annex D.

KEY EVALUATION FINDINGS

The evaluation found the CKP's project design and original work plans were ambitious, albeit in line with the priorities of the GoK and within the USG mandate and priorities. While not in a formal way, the CKP was the 2nd phase, an Associate Award, following onofthe Global Capacity Project implemented in 2004 – 2009 by the same consortium of partners lead by IntraHealth, so relevance of project design was likely. The CKP's all-inclusive approach to stakeholder engagement covered both ministries of health and the FBO sector with limited attention to the private sector at national and sub-national levels, and was reflected in an exhaustive list of significant, desired outcomes to address the projects intermediate results. Due to the wide scope of the project that called for expertise in various domains, the CKP was designed to be implemented by an IntraHealth lead consortium that included MSH, Deloitte, AMREF and TRG. As per the cooperative agreement between USAID/Kenya and IntraHealth, each partner was assigned a domain.

Capacity Kenya Project achievements

Under IR 1*:"Strengthened and institutionalized HRH strategies, plans, policies and practices at the national and provincial levels that will enable an increase in the number of health workers and promote the provision of quality HIV/AIDS, FP/RH, MCH, malaria and TB services at the community level,"* a number of successful activities and outcomes occurred, including: iHRIS development, RHP deployment and management, Community Health Workforce strategy development, and innovative projects to increase CHW retention and motivation. The project's successful and strategic engagement with the stakeholders in the HRH arena has been remarkable and effective in helping meet the project's objectives as well as those of USAID/Kenya.

Certainly, the most sustainable outcomes of the project, with high potential impact, were achieved Under IR2: *"Improved opportunities for addressing the knowledge and skills needed by workers at all levels, including the community, for the provision of quality services for HIV/AIDS, FP/RH, MCH, malaria, TB and primary health care in general.*" The majority of activities were implemented systematically using a result's based approach, including: conducting performance needs assessments (PNAs) which laid the CKP's "baseline"; TA conceptualizing and implementing the first national HRH conference; supporting Kitui FP Center of Excellence with equipment and training on E-technology and mLearning; faculty training in converting and uploading E-content on CPD; providing scholarships to underprivileged students from NAL; TA to KNDI, NCK, and COC, and successful provision of technical advisors to key organizations which has built their capacities. RHPs hiring for the facilities and areas was need-based.

Project's work to accomplish*IR3 "Workforce performance system in place to improve productivity and retention for the delivery of HIV/AIDs, FP/RH, MCH, malaria, and TB services"* was characterized by successful engagement with the GoK on testing out and implementing high impact and low-cost interventions, related to occupational safety and work environment, introduction of performance appraisals and coaching mechanisms, and was found effective in improving HW's productivity and retention. The CKP's contribution to developing and providing trainings on labor laws, E-technology, and supportive supervision was praised by HRH-ICC members.

Challenges and Lessons Learned

- IHRS has great potential, however, only a small proportion of which has been capitalized on with the following gaps: inclusion of data outside of data from the MoH payroll by linking with the bulk filling system, connection to other databases and inclusion of at least data on RHPs, and data use for decision-making.
- Despite strategic hiring, RHP subsequent absorption, often accompanied by transfers, was not thought through by the MoH, possibly due to limited use of the iHRIS for decision making. Reported instances included when RHP transfers were not always communicated to those in charge at the facilities, and that their outflow was not well monitored. Majority of RHPs do not have an exit strategy after their contracts with CKP if MoH does not absorb them; and if urgent measures are not taken the departure of RHPs would create a significant void in service provision.
- Dissemination of CKP's accomplishments related to CHW did not appear as vigorous and systematic, despite the great potential for scale-up and replication by other IPs.
- Noted challenges at demonstration sites included poor basic computer skills (also voiced as a problem with iHRIS roll-out to counties) and connectivity issues; ability to train adults with through on-the-job training,
- The scholarship model implementation raised concerns among students, including poor communication about its transfer to FUNZOKenya.
- CKP model of relying on other partners like APHIAPlus, to provide IGAs to their CUs need to be reconsidered for different type of arrangement and different partner type.
- The introduction of potentially promising AHECs did not move far mostly due to lack of assigned budget and buy-in.
- Without a significant buy-in from the MoH to continue with the CPD, the sustainability of training efforts is not as clear, especially in the move to devolved systems, at a county level.
- The project's limited engagement with the private sector appears to be a missed opportunity, especially given the membership of Deloitte: one of the world's top management consulting firms that is known to work well across sectors.

CONCLUSION

The Team found that the CKP has been successful in achieving the vast majority of specific project objectives set forth by OPH and most key performance indicators as outlined in the 2013 PMP. However, many of the indicators did not have targets. This was done in the face of fairly ambitious planned outcomes and moving priorities of the GoK. As the discussion below will illustrate, the degree of convergence between project work plans and project implementation was found to be relatively high. This is especially true in the second half of the project after significant changes occurred in CKP leadership.

Given the breadth and depth of the project outcomes, the successful achievement of planned activities are remarkable, while evaluation also found evidence that the consortium might have been spread too thin in an effort to implement project activities. Both internal and external partners noted "growing pains" of the project early stage, mostly addressed in the second half of the project. While mentioned in an exhaustive list of outcomes, strategic and effective engagement with the private sector was limited.

The evaluation findings indicate that the CKP team has demonstrated:

- *Technical knowledge*: especially in the second half of the project after there were significant staff changes brought about by the new leadership (knowledge of the MoH, staff familiarity with HRH issues, and technical expertise of TA and even RHPs)
- *Analytical depth* :illustrated in achieving selected outcomes (PNAs, baselines, evaluations of interventions, setting up demo and control sites, documents and plan development); however, some

outcomes may have suffered from the project's wide scope which did not allow for focused and in-depth analytical grounding (CPD, HRD, etc.)

- *Predominantly logical approach:* in project design and implementation but not necessarily results-based approach to implementation, due in part to project's wide and changing scope and also impacted by the changing political environment that CKP faced from the outset of implementation

The following ***key lessons learned*** should be considered in the future project design:

- The importance in formalizing agreements with the government and other relevant stakeholders;
- The importance of paying careful attention to basic issues such computer skills and connectivity with ICT-driven interventions;
- The need to consider simple and low-resource interventions that can yield high impact results;
- The critical role of an effective monitoring and evaluation framework which would be able to measure project outcomes and impacts. Additionally, focus on SMART indicators,[1] which would allow for monitoring of project achievement in a comprehensive way.

Several key recommendations relate to gaps in HRH programming, in light of existing projects like FUNZO and LMS:

- Focus on TA and ICT driven programming with a significant training component;
- Use multi-sectoral approach to address HRH and HRD issues, for example;
- Use good practices like RHP recruitment, occupational safety, and work environment interventions (should be picked up by the GoK and/or scaled-up);
- Develop increased knowledge management among development partners, with the provision of documentation detailing support provided by partners to facilitate gap analysis and data use for project design;
- Additional effort toward fostering positive coordination and collaboration between MoH HQ and health teams at the county levels (leadership, coaching, conflict resolution, team building, etc.)
- Strategically coordinate and help private, public and FBO sectors liaise, and exchange experiences. Engage private sector purposefully, based on evidence and their motives, i.e. for strategic advising, training, etc.

The table below provides recommendations specific to level of implementation in line with devolution:

County	National/HQ level
Need for county level HRH-ICCs: TA in establishing team and linking to national and with each other for knowledge exchange.	Change management needed at the MoH HQ level for smooth transition.
Significant capacity building around HRM and iHRIS, including basic computer skills and sense of ownership.	Continued work on iHRIS, digitizing records and safe transfer of HW data from national to county level.
Due to a particular challenging situation, the Northern Region assessment findings should be disseminated and TA should be planned for to implement them. Mechanisms should be in place for CKP scholarship recipients from NAL to be guaranteed employment for future development of that region.	Provide TA and continued support to KMTC in devolving medical education, and specifically Kitui COE in becoming a regional center and an exemplary hub.

[1] http://www.toolkitsportdevelopment.org/html/topic_03DF8A69-0DAC-47D5-8A14-1E1833901BFE_BBA5D8DC-5C40-4F9C-A6A4-0268098134D7_1.htm

TA around building Health Public Service Commission at the country level.	Need for increased engagement with private sector as its share in providing medical education and employment is increasing.
Use of iHRIS at county levels for decision making: RHPs or similar type of mechanism for streamlining HW hiring would need to be distributed to fill in gaps rather than focus on providing one type of support (i.e., at CCC).	Helping national level councils/regulatory bodies (NCK, KMPDB, KMTC) to embrace devolved system, and build their capacity to work with counties on developing and implementing regulations: either through offices or innovative mechanisms.
CKP-type support in hiring, either through RHPs or similar mechanism, is needed to continue offering services because counties currently do not have the capacity to hire. Discussions need to be had with APHIAPlus and other partners to identify where the most need is.	Increase engagement of the community health services unit (formerly, the division of community health, at MoH HQ) in future policy and planning, and provide TA to CHMTs on the ground in implementing the strategy.
Advocacy for implementation of CHW strategy; need to explore the role of Community Health workers (CHWs) and Community Health Committees (CHC). The CKP intervention models in CHW performance enhancement and NHIF interventions need to be scaled up.	KEMSA HQ needs to engage individual counties for future supplies needs support. TA will be needed to take the good work of KEMSA to the counties. The TA model success at KEMSA needs to be properly captured in a separate report and disseminated widely for possible replication by partners and MoH Support KEMSA in decentralizing their services to the counties.
Sensitization about and capacity building in implementing hiring mechanisms used for boarding RHPs could help address the fears of HRWs about the hiring processes at a country level in the devolution.	Need to harmonize incentive mechanisms for stakeholders to attend workshops and other events across development partners. Issues related to USAID regulation of not paying per diem/out of pocket allowances appeared to have affected performance/outputs.

CONTEXTUAL BACKGROUND

KENYA'S HEALTH CARE SYSTEM AND HUMAN RESOURCES FOR HEALTH

The World Health Organization (WHO) defines Human Resources for Health (HRH) as "all the people engaged in actions whose primary intent is to enhance health," thus the cornerstone of the health sector to produce, deliver, and manage services.[2] Issues such as inadequate staffing levels, lack of appropriate skills, poor staff attitude, low morale, and weak supervision among HRH would undermine the quality of public health services provided and have an effect on poor health outcomes among the population.[3]

As Kenya started receiving support for HIV/AIDS, TB, malaria, and immunization services under PEPFAR, GFATM, and GAVI in 2004 – 2005, the Government of Kenya (GoK) and development partners recognized that increased service provision was threatened by the lack of sufficient and qualified human resources in the health sector—in public, FBO, and private sectors.

Kenya's health care system faces critical HRH demands similar to the health systems in many African countries: severe shortages of essential cadres, persistent inability to attract and retain health workers, poor and uneven remuneration among cadres, poor working conditions, inadequate or lack of essential tools and medical and non-medical supplies, unequal distribution of staff, and diminishing productivity among the health workforce, etc. Characteristics of Kenya's HRH include an average of 1.3 health

[2]Everybody's business: strengthening health systems to improve health outcomes – WHO's framework for action. Geneva, World Health Organization, 2007 (http://www.who.int/healthsystems/strategy/everybodys_business.pdf, accessed 10 January 2009).

[3] MOPHS Strategic Plan 2008-2012.

workers per 1,000 people—one health worker (43%) below the World Health organization (WHO) benchmark of 2.3 health workers per 1,000 population. Kenya also has one doctor and 12 nurses and midwives per 10,000 people.[4] At the CKP's inception, the country was challenged by an inability to attract and retain health workers, especially in the public sector: there were a total of 1,850 attritions in 2008, as compared to 262 in 2012, a reduction of 31 percent. The majority of attritions in 2008 were due to illness (1,399) and from 2008 – 2012 they were mainly due to contract expirations (1,091). Unlike the period from 2008 – 2012, the analysis of staff leaving MoH service during the three-year period from 2005 – 2007 shows that retirement was the main reason for attrition: 2.6 per annum.[5]

Structural issues behind low retention included performance management issues, unequal distribution of staff, and low productivity among the health workforce. The regional disparities in HRH distribution have also been impeding coverage of donor-funded programs.[6] In 2010, the greater number of health workers employed by the government and FBOs/NGOs were concentrated in Rift Valley (12,879), Central (8,752), and Nairobi (8,752).[7]There is a scarcity of health workers in the Kenya countryside, especially in the North Arid Lands (NAL), where health workers are less likely to agree to work due to factors such as poor working conditions, harsh environmental conditions, and an unsafe working environment.[8]

Notably, in the last decade, Kenya has seen a significant rise in the number of institutions providing health-related training and research. The four medical training institutions for doctors in Kenya include Nairobi, Moi, Kenyatta, and Egerton Universities, with the University of Nairobi being the sole training institution for dentists. Government-sponsored Medical Training Colleges (MTCs) represent 71% (17) of clinical officer training institutions in the country. Limited data exit on the actual number of private institutions offering health-related training in the country; however, the annual output of the health workforce has risen steadily in recent years due to the increase in health training institutions. AMREF has been training in community health since the early 1990s, and has prioritized research, capacity building, and advocacy in HIV/AIDS, TB, Malaria, etc. While the output of health workers has steadily increased, the majority of HRH have just started to fill in the gaps created in previous decades.

Kenya has a wide range of health facilities operated by the Government, Faith-based Organizations (FBOs), Non-Governmental Organizations (NGOs), international organizations, and private sector bodies. The distribution of health facilities shows that the Ministry of Health accounts for 42.9% of the total health facilities in the country; the private sector accounts for 37.8% of facilities, FBOs for 11.4%, NGOs for 3.7%.[9] The MoH-run health facilities increased from 3,709 in 2011 to 3,951 in 2013.[10] The increase in the number of health facilities in the country has had implications for HRH, creating a demand not only for additional numbers, but also for improved quality of the health workforce. There are also other public institutions that offer medical services, including: the Kenya Medical Training College (KMTC), which offers mid-level medical training; the Kenya Medical Research Institute (KEMRI), which conducts medical research; and public universities (University of Nairobi - College of Health Sciences, Moi University, and Kenyatta University),which offer advanced medical training. The Kenya Medical Supplies Agency (KEMSA) procures and distributes drugs and other medical and non-medical supplies to all public health facilities nationally, while the National Hospital Insurance Fund (NHIF)

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[4]Kenya Institute for Public Policy Research and Analysis (KIPPRA), 2012. Kenya Economic Report 2012.
[5] Source: MoH, USAID and FUNZOKenya, September 24, 2013.[5]
[6]WHO (2006).Taking Stock: Task Shifting to Tackle Health Workers Shortage.
[7] Annual Operational Plan 7 2011/2012
[8] HRH Assessment Report for Northern Kenya: Overview of Health Workforce Distribution across 10 Counties. May 2013 (USAID/CKP)
[9]MoH HIS Annual Report 2012 (Draft).
[10] Kenya HIS

finances or subsidizes medical bills for HRH members and their dependents, primarily in the public sector.

In spite of, and in addition to, the above described challenges, a fundamental transformation is underway in Kenya with the advent of the new Constitution which is expected to significantly change the landscape of the health sector in Kenya, with major implications for HRH. As per the Constitution of Kenya 2010, the country has started transitioning from the eight administrative provinces to the 47 County Governments in the devolved system of government; thus creating two structures of government: the National Government and the 47 County Governments. Article 174 of the new constitution identifies one of the objectives of devolved governments as promotion of social and economic development and the provision of proximate, easily accessible services throughout Kenya; the facilitation of the decentralization of state organs, their functions and services from the capital of Kenya; and enhancement of checks and balances and the separation of powers.[11]The Constitution of Kenya 2010 provides an overarching, conducive legal framework for ensuring more comprehensive and people driven health service delivery, which is intended to enhance access to services for all Kenyans, especially those in rural and hard-to-reach areas.[12]

THE ROLE OF USG IN ADDRESSING HRH IN KENYA

For about three decades, the United States Agency for International Development (USAID)/Kenya has supported activities in the population, health, and nutrition sectors in Kenya under a series of bilateral agreements aligned with Government of Kenya (GoK) priorities. These programs have been implemented at both the national and regional (provincial) levels. Since the mid-2000, USAID/Kenya's health portfolio has been predominantly focused on HIV/AIDs prevention, care, and treatment, as Kenya has been a priority country for the President's Emergency Plan for AIDS Relief (PEPFAR II) and receives significant funding to address HIV/AIDS and related problems. Similarly, funding by the President's Malaria Initiative (PMI) has continued for malaria programs.

Under the 2006 – 2010 the AIDS, Population and Health Integrated Assistance (APHIA II) program, USAID/Kenya, and its implementing partners made significant gains in the area of HIV/AIDS (treatment, care, support, and prevention), TB, child survival, malaria, and increased use of FP services as well as integration of RH and HIV services. The 2009 Kenya APHIA II assessment findings highlighted several opportunities for future investment, including areas of leadership and management, policy, financing, human resources, the private sector, commodities and logistics, and monitoring and evaluation. While this is different from a strictly vertical disease approach, the purpose has been to support Kenya health system strengthening, where the health system would rely on public, private, and other sectors at national, sub-national, and community levels to meet the national health sector objectives.

EVALUATION PURPOSE AND SCOPE

The Capacity Kenya Project (CKP) is a systems strengthening project aimed at addressing the cross-cutting issues affecting the HRH in the country for effective integrated health services delivery. The CKP was developed to support the achievement of USAID/Kenya's Strategic Objective 3 (SO3): *Reduce fertility and the risk of HIV/AIDS transmission through sustainable, integrated FP, Malaria interventions, and health services* by: improving the enabling environment for the provision of health services; increasing the use of proven, effective interventions to decrease the risk of transmission and mitigate the impact of HIV/AIDS; and increasing customer use of FP, RH, and Malaria interventions as well as Child Survival services. The bulk of funding for the CKP has been allocated from the PEPFAR budget and comprises several program areas under PEPFAR, with the remaining funds coming from the malaria, child survival and health (CSH) earmarks, and a smaller proportion from RH and FP initiatives.

[11]Government of Kenya (2010). The Constitution of Kenya 2010. Kenya Law Reports: Nairobi.
[12] MOMS & MOPHS, Kenya Health Policy 2013-2017.

The purpose of the Capacity Kenya Associate Award (AID-623-LA-09-00001) is to strengthen Human Resources for Health (HRH) systems of the public, faith-based, and private health sectors to ensure enhanced delivery of primary health care to improve health outcomes for the people of Kenya. IntraHealth has been leading the consortium of four key partner organizations: the African Medical Research Foundation (AMREF), Deloitte Consulting Ltd, Management Sciences for Health (MSH), and the Training Resources Group (TRG).The CKP was designed to improve health outcomes through addressing HRH issues related to forecasting, recruitment, performance improvement, and retention, especially to low-level facilities and rural, hard-to-reach areas. The CKP design sought to address these issues by implementing activities under the following three intermediate results:

IR1: Strengthened and institutionalized HRH strategies, plans, policies and practices at national and provincial/regional levels that will enable an increase in number of health workers and promote the provision of quality services.

IR2: Improvedopportunitiesforaddressingtheknowledgeandskillsneededbyworkersatalllevels, including community, for provision of quality services.

IR3: Workforceperformancesysteminplacetoimproveproductivityandretention for the delivery of HIV/AIDs, FP/RH, MCH, malaria, and TB services.

The purpose of the CKP end-of-project evaluation was to identify successes and lessons learned from the project's implementation as well as to discern new approaches that would enhance the effectiveness of an HRH follow-on program. The evaluation methodology developed will help USAID/Kenya's Office of Population and Health to:

- Generate the highest quality evidence to establish the extent to which the implementation of the CKP was responsive and effective in accomplishing set objectives in line with USAID/Kenya's health implementation framework; and
- Provide insight into the design of a follow-on project that is responsive to HRH needs in a devolved system of governance.

The CKP evaluation team consisted of one international consultant, who served as a Team Leader and two Team Members, national technical evaluators with experience in monitoring and evaluation of public health programs, specifically HIV/AIDS, as well as qualitative and quantitative data collection and analysis.

This evaluation methodology and work plan, developed by the evaluation team, included the key evaluations questions based on the SOW, and identified by USAID/Kenya (see Annex A).

This evaluation report is presented in five chapters. After this introductory chapter, the next chapter describes evaluation design and methodology used, including descriptions of data collection and analysis, and instruments. Chapters four and five present evaluation findings and discussion of specific evaluation questions, CKP intermediate results and selected outcomes, program impacts to date, challenges and lessons learned, and issues of sustainability of CKP's achievements. The final chapter presents recommendations for the follow-on project.

EVALUATION DESIGN AND METHODOLOGY

DATA COLLECTION APPROACH

The evaluation team (hereafter called "the Team") evaluated the project by focusing on key evaluation questions. The evaluation design, methodology, and work plan were originally proposed in the evaluation proposal and finalized in collaboration with USAID/Kenya at the start of the evaluation. The Team employed the data collection methods described below, and the specific evaluation questions that guided the evaluation can be found in Annex E.

1. Documents and secondary data sources: The Team reviewed relevant literature provided by USAID/Kenya and the CKP, and obtained via KIIs. (Final list is available in Annex B).

2. Key informant interviews (KIIs): In-depth and semi-structured interviews were conducted with CKP individual stakeholders and selected beneficiaries. The Key informants were purposefully selected with the help of the CKP team in consultations with the USAID/Kenya team, and the list was amended throughout the data collection process based on actual KIIs. While the direct beneficiaries were captured primarily at the regional level in the health facilities, the majority of KIs were based in Nairobi and in the three selected regions. The utilized KII guides included questions directly linked to key evaluation questions, and the responses provide information about program implementation, as well as highlighting influential issues, concerns, and directions for the future programming by key decision-makers at the Nairobi and regional levels. Table 1 below provides a snapshot of KIIs by broad categories. The full list is provided in Annex C.

Table 1. List of Key Informant Interviews (KIIs) conducted, by sample size

Agency/Designation:	Sample
MoH – Nairobi and other GoK	16
Regulatory bodies	6
KMTC (HQ and Kitui CEO)	7
FBOs	4
Other Institutions (KEMSA, NASCOP, Futures Group/HPP)	3
USAID/PEPFAR	6
Development Partners (Global Fund, CHAI, UNICEF)	3
CKP Consortium Partners	11
Sub-national (HR officers, CH Focal persons, Health Executives, principals)	18
Total	74

3. Focus Group Discussions (FGDs): The Team conducted10 FGDs with various groups of stakeholders and individual program beneficiaries, as shown in Table 2 below. The FGDs were conducted using an abridged list of questions from the KII questionnaire guide, depending on the target group.

Table 2. Focus Group Discussions conducted, by location, size and date

	FGD Target Group	Number of participants	By sex		Location	Date, 12/ 2013
			F	M		
1	Capacity Hires/RHPs at Mbagathi District Hospital, CCC	10	5	5	Nairobi County	Dec 4
2	Capacity Hires/RHPs at Migosi Health Center	9	4	5	Kisumu City/Nyanza	Dec 9
3	Community Health Workers from Upper Kanyakwar CU	8	4	4	Kisumu/Nyanza	Dec 10
4	iHRIS team at the MoH	5	1	4	Nairobi	Dec. 6
5	Scholarship recipients at KMTC/Kitui COE	8	3	5	Kitui, Eastern	Dec 10
6	Students-users of Resource Center and E/M-Learning at KMTC/Kitui COE	20	14	6	Kitui, Eastern	Dec 10
7	Faculty of KMTC/Kitui COE	5	4	1	Kitui, Eastern	Dec 10

8	APHIAPlus Directors	6	4	2	Nairobi, IntraHealth Office	Dec 9
9	HRH-ICC members: DFID, Futures Group/HPP, MoH	5	3	1	Nairobi, IntraHealth Office	Dec 16
10	Technical Advisors to NASCOP and KEMSA	6	2	4	Nairobi, IntraHealth Office	Dec 16
	Total:	**82**				

4. Observation site visits: To ensure uniformity of coverage across sites, the Team used a structured observation checklist during site visits. Observation checklists helped assess management controls over the equipment, vehicles, and property storage, and maintenance at the level of the CKP's sub-grantees.

5. Online survey: Online surveys were conducted among CKP stakeholders within the domains of the KIIs and FGDs and provide quantifiable findings about CKP implementation. The purpose of the online survey was to obtain evaluation coverage of six regions targeted by the CKP and involved other relevant stakeholders who would not otherwise have an opportunity to share their opinions and experiences on the CKP. The sampling list of 700 included: CKP trainees, participants of various working groups organized and coordinated with the CKP, TAs, the HRH Task Force, the HRM directorate, the Clinical Officers Council, the Nursing Council of Kenya, the Kenya Nutrition and Dieticians Institute, pharmaceutical and medical laboratory councils, and CKP staff, etc. Response rate was 31%: 53% were women and as many 90% of the respondents indicated that they were from regional and county levels, which is significant and met the survey purpose. Survey findings were triangulated with qualitative data and document review. It should be noted that since a quarter of respondents came from CKP project staff, caution was made in incorporating findings. Data for selected questions can be found in Annex D. The majority of questions were multiple choice. Unless specified otherwise, responses are out of total number of responses

Table 3. Online Survey Responses, by type of stakeholder

Stakeholder group	Response Percent	N
MoH/Government of Kenya (Nairobi)	1.8%	4
Government of Kenya (County level)	5.0%	11
Capacity Hire/RHP	69.8%	155
Capacity Kenya Consortium Partner (MSH, Deloitte, AMREF, TRG)	1.8%	4
Member of the Community of Practice (Peer Learning Cycle, CHAK & KCCB; HRM, NH HRD WG and WCI)	0.5%	1
FBO (CHAK, KEC, SUPKEM, etc.)	0.9%	2
Private Sector	0.5%	1
CK/IntraHealth staff	23.0%	51
Answered Question	100%	222
Skipped Question		**15**

6. Exit Interviews: Several exit interviews with clients and patients receiving health services in CKP-supported sites were conducted to ascertain clients' perceptions of changes in service delivery in the CKP-supported sites.

Data collection instruments can be found in the Annex F.

DATA ANALYSIS

The main thematic areas were identified by each evaluation question, namely rationale and relevance, project performance, lessons learned and sustainability, and recommendations for follow-on design. The following data analysis methods were used:

- Comparison matrix: the Team examined program effectiveness by comparing the CKP's actual achievements with its respective work plan and results framework, targets, and accomplishments. The Team screened reports and PMP data for trends and comparison progression template was developed and used to monitor the progress of achievement by each Intermediate Result (IR) area.
- Content analysis method was used to review project-related documents, GoK technical guidelines and strategies, USAID/Kenya and PEPFAR/Kenya reports, etc., in order to identify themes and patterns, and proxy evidence that the results are attributable to the project actions.
- Online survey using Survey Monkey was administered to CKP stakeholders to attempt to gather quantifiable data on their experience of and opinions on the CKP.
- Key question scale was used to define each evaluation question and set a scale of achievements for each evaluation area so that all Team members used the same criteria to evaluate the CKP.

The Team triangulated quantitative and qualitative data to verify data quality and legitimize findings by evaluating alternative explanations, disconfirming evidence, and searching for negative cases. The Team made every effort to ensure that all recommendations reached during the evaluation have been derived via the triangulation of evidence from diverse data sources.

The evaluation approach had several limitations:

- This is not an impact evaluation; therefore, direct attribution of the impact of Capacity Kenya cannot be established. Information on perceived impact of the project would be derived from triangulation of collected data, without reference to a baseline.
- Purposeful sampling was utilized for the regions that could be captured. However, all six CKP regions could not be fully covered by the evaluation.
- The evaluation was implemented in an extremely tight timeline, due to the 50-year Jubilee celebration and upcoming Christmas and New Year holidays.
- As expected and documented in the Methodology/Work Plan, exit interviews had small sample sizes and the online survey received a low response rate due to the evaluation timing and cultural preferences for in-person interaction. The available results were used to complement the wealth and depth of the qualitative data, rather than make any conclusions based on quantifiable evidence.

WORK PLAN AND TIMELINE

The evaluation methodology and work plan were developed remotely and the actual data collection started on December 3. It completed on December 18, and was followed by data analysis and report writing. A detailed timeline with the day-by-day agenda is presented in Annex E.

The evaluation sites were selected with the help of the CKP team in consultation with USAID/Kenya. Evaluation field work was conducted in Nairobi, Rift Valley, Eastern, and Nyanza/Western region.

Throughout the evaluation, the Team maintained close contact with USAID/Kenya and provided regular updates by mail and in-person. The CKP, AOR, and relevant USAID/Kenya team members were copied on all relevant email communications with the CKP and other stakeholders.

The Team presented preliminary findings to USAID/Kenya and feedback was incorporated into the final evaluation report.

KEY EVALUATION FINDINGS

The findings are presented in four key areas. The first section presents evidence relating to the original and evolving rationale and design of the CKP. The second section examines project implementation effectiveness and efficiency. The third and fourth sections focus on lessons learned and sustainability aspects respectively.

RATIONALE AND RELEVANCE

The Capacity Kenya Project Associate Award led by IntraHealth International, continued work done by IntraHealth and partners between 2004 – 2009 under the Global Capacity Project, whose goal was to increase the ability of the public health sector to rapidly mobilize additional qualified health workers and also to strengthen long-term human resources for health planning and management.[13]Through a range of targeted activities, the Capacity Kenya Project aimed to help Kenya's Ministry of Health (MoH) expand access to HIV/AIDS services in order to deliver quality health programs across the country. In line with GoK and USG priorities, the CKP took a broader approach beyond HIV/AIDS to include other health priorities such as malaria, MCH, TB, etc. The combination of familiar consortium partners, with significant expertise in relevant fields (training for AMREF, leadership and management for MSH, private sector methodology for Deloitte, while the role of TRG was not clear), was supposed to facilitate project accomplishments. Additionally, collaboration in achieving project objectives through adopting an all-inclusive approach to stakeholder engagement was intended to cover both ministries of health, the FBO sector, and other stakeholders at national and sub-national levels.

The Team found a high degree of convergence between GoK, USAID, and CK project objectives, both at the outset of the CKP and thereafter. The Team found unanimous agreement regarding the importance, relevance, and timeliness of the CKP and the way its objectives addressed priorities of the GoK, the USG, as well as other development partners.

The Team observed mixed feelings about how well lessons learned from the predecessor project and relevant assumptions were incorporated into the project design. Some noted how successful and logical it was while other opinions are summarized by the following statement "the design had its flaws. If one was to go back today knowing what we know now, one would take a totally different approach", (CKP staff). The evaluators agreed that project scope could have been narrower, and more focused.

On the positive side, the CKP recognized the changing HRH landscape in Kenya caused by the 2010 Constitution. Despite having background knowledge from the previous project, the CKP undertook stakeholder consultations to ensure that project objectives are met within the environment of the ongoing reforms that will ensue, and that implementation is aligned to the new policy, systems, and structures under development. Review of key documents produced by the GoK, USG, and KIIs with various stakeholders found that the CKP's focus on one of the pillars of the HSS,[14] with a broad objective of strengthening HRH systems of the public, faith-based, and private health sectors to improve health service delivery, and filled the existing gap. Additionally, the original project design which focused on working at a national level—with the Ministry of Health and other GoK HR management departments such as the National AIDS Control Program (NASCOP), Division of Reproductive Health (DRH), National AIDS Control Council (NACC), and institutions such as the Kenya Medical Supplies Agency (KEMSA)—was a perfect fit for the situation at that time.

The importance and relevance of the CKP was noted both externally and internally to the CKP*:*

[13]http://www.capacityproject.org/index.php?option=com_content&task=view&id=50&Itemid=90

[14] "WHO's framework for action for strengthening health systems" http://www.who.int/healthsystems/strategy/en/

> "Original intentions were good. HRH was not a topic before. The MoH HR has always been fundamentally poor and only paid salary, and HRM and HRD involvement came in the right time." (KII at the MoH)
>
> "From a project standpoint, project has been catalectic with MoH" and "the project has really done a lot in breaking unbroken grounds." (CKP staff)

By design and in its implementation approaches, the project has been heavily aligned with the priorities of the GoK and has been operating within GoK guidelines and policies on HRH.

- *National HRH strategic plan 2009 – 2011* upon which most of the project interventions are anchored: supporting the NHRHSP's goal of reducing health inequities and reversing decline in key health indicators by providing a framework to guide and direct interventions, investments, and decision making in the planning, management, and development of human resources.
- *The second National Health Sector Strategic Plan of Kenya (NHSSP II) 2005 – 2010,* which intended "to improve the use and performance of the already available personnel, as it increased the numbers, quality, and mix of the workforce in order to address shortages." Additionally, NHSSP called for sound management principles at the central level, building additional human capacity in line with the health needs of the population, and shifting to demand-driven health workforce development.
- *The Kenya Vision 2030,* [15]which recognizes that the country's main potential lies in its people, and identifies Human Resource Development as a key Foundation for National Socio-economic Transformation: special responsibility was placed on the HR Development Sector for the provision and coordination of services relating to education, labor, medical services, public health, and sanitation in order to create a globally competitive and adaptive human resources.

As mentioned in the introduction, the 2010 constitution which called for implementation of devolved structures of government was also reflected in CKP implementation, in that extra focus was paid to working with countries, building their capacities (retention and ICT demo-sites), and addressing their foreseen needs (iHRIS).

Furthermore, document review and multiple KIIs with members of the USG team (OPH, PEPFAR) showed that the project has been operating within the USG mandate and priorities:

- Though awarded in 2009 before launch of *USAID/Kenya's Implementation Framework* in January 2010, CKP design and implementation operated within that framework as well as within the USAID conceptual project architecture emphasizing a more deliberate and stronger national focus whilst retaining the regional service delivery program (APHIA*Plus*).However, the scope has been expanded not only to encourage the delivery of quality health services, but also to strengthen leadership, in-country capacity building, and systems development so as to ensure long-term sustainable services.
- The *Kenya Partnership Framework of 2009*[16]was organized around the four core pillars of the KNASP III, selected pillars being Health Sector HIV Service Delivery, Community/Area-based HIV Programs, and governance. It is predicated upon a series of high-level goals and objectives, including reduced HIV incidence through increased capacity of Kenyan facilities and providers to deliver more effective and better integrated prevention programs.
- The PEPFAR HRH strategy[17] targeted training and retention of new health workers, support for HR mapping and planning, education of health care professionals, and innovative retention strategies.

[15]http://www.vision2030.go.ke/
[16]http://www.pepfar.gov/countries/frameworks/kenyapf/137931.htmAccessed November 25, 2013
[17]http://www.pepfar.gov/about/strategy/ghi/134855.htm Accessed December 28, 2013

PROJECT PERFORMANCE: EFFECTIVENESS AND EFFICIENCY

In addressing the HRH issues in Kenya, the project adopted a comprehensive and logical approach which involved engaging with various stakeholders in the health arena. Due to the wide scope of the project, which called for expertise in various domains, the CKP was designed to be implemented by an IntraHealth-led consortium that included MSH, Deloitte, AMREF, and TRG. As per the cooperative agreement between USAID/Kenya and IntraHealth, each partner was assigned a domain.

The Team found that the CKP has been successful in achieving the vast majority of specific project objectives set forth by OPH as well as most key performance indicators as outlined in the 2013 PMP. For selected activities, for example, health workers' training, HRM, leadership and governance, CKP was able to plan for and incorporate measures for accomplishing other outcomes, such as transition to FUNZOKenya. This was achieved in the face of fairly ambitious planned outcomes as well as the moving priorities of the GoK in light of devolution. As the discussion below illustrates, the degree of convergence between project work plans and project implementation was found to be relatively high, especially in the second half of the project, after significant changes in CKP leadership.

> "For someone involved with the GoK, and such a huge task, so many things would come up with HRH-ICC, always wondered how they kept focused, looked sporadic. A lot of respect for [CKP] leadership." (Private sector representative)
>
> "Designed to find solutions to many things, fairly ambitious." (CKP staff)
>
> "Project objectives were achieved, especially outcome areas…focused on a sector wide approach to human resource for health issues." (CKP staff)

Given the breadth and depth of the project outcomes, the successful achievement of planned activities is remarkable. The evaluation also found evidence that the project might have spread itself too thin in an effort to implement project activities. The following sections address both the positive and challenging sides of the Capacity Kenya Project and how those manifested themselves.

IR1: strengthened and institutionalized HRH strategies, plans, policies and practices at the national and provincial levels that will enable an increase in the number of health workers and promote the provision of quality HIV/AIDS, FP/RH, MCH, malaria, and TB services at the community level.

After the initial challenges in navigating the MoH environment and resulting delays, voiced by MoH staff, stakeholders, and even the CKP team,a unit was established within the GoK with the mandate and capacity for HRH planning, budgeting, budget advocacy, and policy development and coordination—which partially became the mandate of the HRH-ICC, under the MoH leadership, with CKP support.

The next desired outcome focused on supporting HRH planning and policy related analytical work and implementing demonstration projects by education institutions and providing advisory services in the GoK. The HRH-ICC, one of the project's main accomplishments, brought together various stakeholders involved in the HRH issues, both government and development partners, indicating a country-led process. Since then, the CKP has been facilitating a secretariat that was set up with a technical assistance (TA) coordinator paid by CKP but seated at the MoH HQ, who, with a clear mandate and scope of work, was intended to streamline operations. The operations are supported by the Technical Working Group (TWG). With significant support from the CKP, the national level HRH-ICC has become the key stakeholder leadership group guiding the development of HRH in Kenya: a fully functional body actively involved in monitoring the implementation of the recommendations of the first HRH conference;[18] developing the first and second HRH National strategic plans; and generally shaping critical initiatives

[18] http://www.capacitykenya.org/hrhconference/

such as health workforce mapping and the development of such key HRH guiding documents as a plan to support devolution of health services, community health worker strategy, etc.

For the development of the second national HRH strategy—almost completed at the time of this evaluation—the CKP was instrumental in ensuring that the HRH gains made through the first NHRH Strategic Plan would be mainstreamed to inform HRH policy and interventions after the project period.

The Team found a significant amount of evidence that the CKP was responding to the ongoing devolution, and that the project has been instrumental in supporting the roll-out of HRH-ICCs at the county level. Capacity Kenya has initiated this activity with Nairobi County and, as a result, now has a model for supporting county-level HRH-ICCs that can be replicated in the other 46 counties.

One of the planned activities under *Outcome 1.2* was to develop and institutionalize the HRH leadership and management development program that started later in 2010. This was achieved through conducting a rapid assessment that identified gaps such as the need for balancing HR personnel and the lack of concrete evidence for implementing occupational health and safety by the MoH. The latter gave rise to the development of occupational and safety training (OSH) at the regional level, highly praised by MoH.

The strengthening of HR directorates to facilitate policy development, planning, and coordination at both national and regional levels was starting to take shape with the leadership and guidance of HRH-ICC. In order to manage the process, the CK project separated HRM from the leadership focus under the MSH-supported LMS project, which was synergized and aligned with the CKP. The LMS advisors were located at APHIA offices, or regional ministries similar to MEASURE Evaluation advisors, and worked at the pre-service level through changing curricula and making leadership and management stronger for various cadres. Likely due to the fact that CKP stakeholders were not fully aware of the strategic separation between CKP and LMS, several KIIs noted that the CKP did not address governance and leadership at the MoH nor that HRM was addressed properly: "If the understanding of HRM was well captured, project would have worked better." (FBO representative) Better communication to stakeholders may have prevented confusion about respective roles of CKP, LMS, and FUNZOKenya too.

The evaluation team agrees with the perception of the key informants and the CKP team that the time and effort required to implement many tasks had been underestimated, including the amount of lobbying necessary to increase profile of HRH, and engaging private sector featured in project's objectives and work plans. CKP's prominent role in the first HRH conference and in the effective functioning of the HRH-ICC under MoH leadership are notable. However, despite their membership in the HRH-ICC, the private sector did not appear to be fully aware of the important developments—e.g., the iHRIS or the second HRH strategic plan.

Significant achievements under *Outcome 1.3* included development of a human resource information system (HRIS), the data from which is used for HRH planning and policy as well as the installment of a bulk filing system that contributed to increased amounts of HRH data and laid the foundation for improved HR data use at both national and county levels.

The purpose of developing an HRIS that can provide adequate data on the HRH situation, as well as allow for streamlining of HRH data use ,is to increase effective HRH planning and policy formulation, which require easy access to sound empirical evidence on the situation in the sector. Such empirical evidence includes: types of HW cadre available, their distribution and transitions, reasons why and at what rate health workers leave the health sector, etc. One of the main accomplishments of the CKP was the establishment of the iHRIS at the MoH which further increased the amount and accessibility of HRH data through the expansion of the iHRIS network from national to county levels.

The Team found abundant evidence of an ambitious vision for and streamlined implementation of iHRIS, especially in the last two years of the project. iHRIS at MoH/Afya House captures basic data of all MoH

staff on government payroll and is intended to streamline HRH data use, including monitoring for ghosts workers. At the time of this evaluation, 47 county health managers have been instructed on iHRIS. The system has been rolled out to 26 counties, and it was reported that users at both national and county levels have been instructed on how to enter, retrieve, and use data for decision making purposes. Furthermore, successful installment and use of iHRIS in CHAK-affiliated FBOs has been noted.

High level of satisfaction by MoH staff was expressed over the "huge step" in installing the bulk filing system at Afya House: as evidenced by the Team, the database has streamlined access to records and is being well maintained by MoH staff.

Despite its great inherent potential and an already significant expansion to the county levels, the Team has made several observations about the iHRIS database that are of concern:

- It is unclear whether HRIS development was a "felt" need; the system does not appear to have a sense of MoH ownership, in that it's not being used for decision-making and the missing strategic awareness and development linking it to the bulk system.
- Currently, the dataset in the iHRIS is almost a replica of the GoK IPPD, despite technical capacities to contain significantly more and broader data. The system is not yet linked to bulk filing; such information is still in hard copy—i.e., files such as academic papers and letters of appointment have not been scanned and attached to iHRIS. (The CKP did not have a mandate to link the two systems, even though it would make great programming sense to do this.)
- Although intended, at the time of evaluation, the iHRIS at the MoH HQ does not capture HRH data of the private and FBO sectors, despite the fact that both have been involved in CKP oversight committees and the HRH-ICC. As FBO and private sector representatives indicated, there was no incentive for them to contribute. There are also issues of confidentiality, unless there is a mandate that the MoH has to request. Furthermore, contract workers, including RHPs, are not captured.
- The HRIS has a performance management module; however, the MoH instead uses a paper-based performance management module.
- With some exceptions, the majority of MoH managers have not been using the system for decision making, partially due to its incompleteness and perceived lack of ownership by MoH.
- For now, administrative rights to the iHRIS have remained at Afya House, which is likely to cause issues with devolvement of HR functions starting in 2014.
- The use of interoperability functions and communication between the iHRIS and similar databases, such as PEPFAR/CDC- supported NCK database, has not been thought through when iHRIS was set up, nor appeared to be under discussion at the time of evaluation.

Overall, findings spoke to the great potential of the iHRIS; several KIIs at both national and county levels envisioned that it would be better accommodated and used for decision making at the county level, especially in light of devolvement of HR hiring and management of the health workers.

The CKP has made significant strides in establishing HRH planning and management expertise in key GoK regional centers and in key private (for-profit and not-for-profit) institutions (*Outcomes 1.6 and 1.7*). The noteworthy project achievements include support of the MoH in developing schemes of service and review of job descriptions, preparation of transitional work plans for resource mobilization and prioritization in the devolved system, support to the MoH to consolidate staffing plans for the counties, and providing advocacy around HRH financing mechanisms by working with the MoH to estimate budget requirements for newly allocated health workers. MoH HR acknowledged the positive contribution of the CKP in sensitizing and mainstreaming their national and sub-national teams on Occupational Safety and Health (OSH) and new labor laws.

One of the main accomplishments under *Outcome 1.7* was a significant contribution by the CKP towards increased and improved HRH supply at the community level**.** The CKP has worked with the GoK and others to develop mechanisms for determining needs, developing deployment programs, facilitating staff performance evaluations, identifying priority positions/gaps, advertising for positions in hard-to-reach locations, preparing shortlists, actual hiring of staff, as well as other HR functions. Document review and KIIs found abundant evidence of achievement of the desired outcomes. This includes the successful contribution that CKP made to the GoK's adopting more transparent hiring and deployment practices, including a merit-based hiring system with interview guides and score sheets, as well as developing a database to track the applicants.

The RHP component, one of the cornerstones of the CKP, was primarily implemented as planned. Working jointly with provincial medical offices, with APHIA-plus partners providing core HR roles, the CKP has been effective in managing hiring and payroll while the MoH has been overseeing the centrally managed HRM functions in each locality. The Team confirmed the findings of the mid-term review, including: a robust consultative process identifying needs with partners at the local level; proper and transparent advertisement of positions; as well as joint shortlisting and interviewing processes and appointment by the MoH—used both at national and sub-national levels. Both RHPs and GoK staff described the processes as transparent. In light of the constitutional mandate for HW hiring to be done at a county level, the CKP has started working at the county levels and mainstreaming this best practice into the national and county HR hiring system, although implementation of this process is in the early stages. It should be noted that lack of transparency and hiring expertise were voiced as main fears by the Kenya HW as they were participating in the strike at the time of this evaluation. Most RHPs in FGDs and KIIs noted that the process was not only fair but also comparatively short; also stating that the actual work of RHPs was effective and their presence brought positive development at the facilities where they were serving.

The high quality of the work performed by RHPs, as well as their work ethic, was praised by MoH staff on the ground and at the HQ level. Some specified, "the induction of capacity RHPs is very good, It makes performance good from the beginning", (KII with MoH staff). Overwhelmingly, there was a strong sense that "Capacity hires are too few against a huge demand for their services" due to success of the RHP program in improving health indicators. (MoH staff at Kisumu)

While the Team found evidence of RHP hiring being need-based for the facilities and areas, their subsequent absorption, often accompanied by transfers, was not thought through by the MoH, possibly due to limited use of the iHRIS for decision making. Moreover, some CKP stakeholders noted that the RHP transfers were not always communicated to those in charge at the facilities, and that their outflow was not well monitored.

Even though the RHP component was one of most successful components of the CKP, several challenges and issues for consideration have evolved. The evaluation found that RHPs' perception of the quality of supervision varied by site, from good technical level expertise by APHIAPlus, lack of supervision either by the MoH or APHIAPlus or the CKP, and refusal by the MoH to acknowledge RHPs as their supervisees. A significant number of RHPs reported challenges in managing the time sheet process that lead to delays in hires receiving their salaries and gratuity. One staff explained:

> "There were delays in salary being processed and no communication from those in charge, leaving us in limbo and this demoralized people. There was also poor management of the timesheets leading to salary delays because they [CKP] would claim they had not received it [timesheet], forcing you to prepare a new one. Leave forms were also poorly processed and would get lost. There were also delays in gratuity for those leaving, some getting their gratuity as much as eight months after." (FGD with RHPs at Mbagathi District Hospital)

> "They [MoH staff] treat us well. We feel like we are one with APHIAPlus. Initially, they used to involve us in their activities, but these days they don't. They come to our rescue when we are short of medical supplies. They used to support us in 'supportive supervision' but stopped." (RHP in Kisumu)

Whereas the CKP institutionalized the help desk (bulk SMS platform) for sharing concerns, some RHPs did not see evidence of issues being resolved or did not receive any feedback. A significant number of issues with RHPs were raised during the MTE early in 2012: health insurance plans which are different from those of MoH staff, inability of RHPs to get bank loans to repay with the check-off system, lack of flexibility in working shifts, and training opportunities are among the issues mentioned. RHPs did not consider training adequate, especially compared to that for MoH colleagues; which was more evident in sites where the RHP is the only staff in the health facility.

The main issue repeatedly voiced throughout the evaluation concerned the future of RHPs past the project's end in April 2014. Whereas a significant amount of work has been done to ensure that RHPs join the MoH system (in 2009-2010 about 850 RHPs and in 2013 alone 129 RHPs were absorbed by government), only 50% of all RHPs ever hired by the CKP had been absorbed and the absorption of the remaining 850 RHPs does not appear as likely within the remaining time-frame. At the time of this evaluation, the CKP and the MoH admitted to ongoing communication about absorption of RHPs, however, the evaluation team found that GoK did not demonstrate confidence in being able to address this issue by the end of CKP. Moreover, GoK's commitment did not come out as strongly as their perceived need of HRH, especially in rural and hard-to- reach places, and in light of significant outflow of HRW in fear of upcoming devolution of HW hiring to county levels. Unanimously, RHPs and their MoH colleagues fear gaps in coverage that the end of contract in April 2014 would create.

> "The entire concept needs review. Where they are managing a CCC, and it's only them and then they close down will that cause a crisis? There will be a crisis this is why I have always said capacity or whoever who cares to listen must make noise and as fellows who are also down here must also make noise at somebody who cares to listen so as this deal is done the way we used to do it." (MoH staff, Kisumu)

The issue of cadres of RHPs, also recognized as such by both the MoH and the CKP, has also impeded their absorption, and probably should have been considered at the project onset. For example, VCT counselors and data clerks are not the MoH cadre, hence they cannot be really absorbed as such, without the required diplomas. Additionally, training of nurses to fulfill, for example, VCT functions, could be a more efficient way rather than absorbing only those trained in provision of VCT.

Under *Outcome 1.8,* the CKP was to support development of innovative approaches for PLHAs, Youth, Women, and Health Corps focusing on HIV prevention, care, and treatment, namely the development of evidence-based practices that creatively contribute to increasing CHWs through small grants schemes in the selected pilot sites. The CKP was also tasked with developing an HRH model for the community health workforce (Community Health Extension Workers (CHEWs), Community Health Committee members, and Community Health Workers) with the Division of Community Health Services. The Team found evidence of successful implementation of the model with nine key elements, including TA to the Division of Community Health Services in developing an CHW HR strategy to improve training, recruitment, deployment, motivation, re-training, retention and management of health workers at community level), aimed at reducing dropout rates, technical and financial support to develop the Master Community Health Units Listing, and project's contribution to Kenya's concept note towards the 1 million campaign for CHW's.[19]The CKP did not, however, do very well in reporting/disseminating

[19]http://1millionhealthworkers.org/partners/

information on these interventions: selected relevant documents had never been released to the MoH and other stakeholders, thereby denying the project the opportunity to advertise their achievements.

IR2: improved opportunities for addressing the knowledge and skills needed by workers at all levels, including the community, for the provision of quality services for HIV/AIDS, FP/RH, MCH, malaria, TB, and primary health care in general.

The achievements under this intermediate result (IR) included conducting needs assessments, pre- and in-service trainings of HRH, as well as supporting continued professional development (CPD).

Regional performance needs assessments (PNA), completed under *Outcome 2.1* at the onset of the project and disseminated to key stakeholders, for *Outcome 2.1* helped identify major gaps at pre-service, in-service, and CPD as well as made recommendations for improvements. PNA "laid the foundation" (Former MoH HR staff),served as a "basis for the future" (AMREF), and helped link regulations, training institution with service delivery, priorities for CKP activities The TWG then prepared priority action points for implementation, with a focus on engaging with stakeholders in implementing PNA recommendations. The Nursing Council of Kenya (NCK) acknowledged the great role of the national PNA, noting that its results were unbundled at the Nursing Conference held in December 2012.[20]

The CKP desired *Outcome 2.2* targeted establishing and clearly delineating national and sub-national mandates, structures, and systems for managing, coordinating, implementing, and monitoring implementation of pre-service and in-service training and CPD, with a focus on the Kenya Medical Training College (KMTC), where a mapping and skills audit was conducted in all 31 campuses. Following an evaluation for their staff, a five-year HR Strategic Plan was developed. Another noteworthy line of support by the CKP was the establishment of a Family Planning Center of Excellence at their mid-level training institution (KMTC Kitui), defining and implementing parameters of COE in a training institution, and establishing committee & management systems to drive COE at Kitui:

> "Kitui COE is rated the best in the whole country and is better equipped than all the other KMTCs; people have come from as far as Lesotho to learn from this model." (Principal, KMTC Kitui COE)

The CKP's TA included update of the pre-service nursing curriculum in collaboration with the UNC,[21] scaling up the RH module and converting 12 RH units to E-content; developing of a learning tool (checklist) to monitor students' progress during their practicums and its strengthening through the M-learning platform; training of20 faculty members on E-learning and E-conversion of content, which brought about a marked difference in terms of students' exposure to learning materials and skills, for graduating students, especially in comparison to previous years and with other KMTCs which do not have the same facilities.

> "Capacity Kenya made us have a very effective method of teaching which is not in many other institutions." (Principal, KMTC Kitui COE)

Additionally, the project uploaded the FP module for E-CPD at KMTC Kitui, which was then replicated in four ICT demo sites; trained the faculty and ICT staff on navigating the LMS with FP content, how to design and upload assessments and grade students using the LMS including other additional necessary operational features.[22]The College is now paying for COE's internet connection, repairs, maintenance and procured additional computers and insurance of equipment which were provided by the project.

[20]http://www.mchip.net/node/1439
[21]http://nursing.unc.edu/2012/06/
[22]CKP Annual Progress Report FY 2013, final version Dec 2013

Notwithstanding these accomplishments, several matters came up during the evaluation:

- Failure to develop the planned Gender Policy due to staffing oversight: CKP TA hired to develop the Gender Policy left after only one consultative meeting with KMTC, and new person was not hired;
- Delays in HR mapping caused a delay in KMTC meeting their targets for that quarter and resulting in a poor performance rating, Although there was an agreement between CKP and KMTC on planned activities and funding available, it appeared that funding disbursement technique used was not positively accepted by KMTC, although it was in line with USAID rules;
- Perception from KMTC was that the CKP was not prioritizing multiple competing activities well;
- Issues with the procurement process of equipment for the skills lab including mannequins and simulators, which resulted in misunderstanding between the needs of the college and purchases made. KMTC leadership at HQ and Kitui CEO felt that the process was not as participatory and some of the equipment purchased and brought to the center did not fit in with their required specifications (BP machines as one example). Additionally, there was an expressed feeling that high costs and length of procurement could have been avoided by purchasing locally instead of shipping from the USA.
- Retention, motivation, and quality of teaching staff especially in the skills lab are an issue; furthermore, there was an observed need to balance attention paid to students with attention paid to faculty, through CPD or other ways to address faculty competency gaps.
- Limited storage for simulators, mannequins, and skills for computer maintenance, and need for additional equipment, as the 15 computers/3 laptops/30 mobile handsets were not optimal for student use; however, the college was now in the process of acquiring additional equipment.
- Poor quality of, and access to, Wi-Fi internet connection; this is significant especially since the computer lab working hours are already limited due to shortage of staff and thus lack of time that is available to students. Attempts to address this issue were noted at the time of the evaluation.
- Unmet need to monitor performance in the key result areas (outcomes) and milestones in the CKP and COE interaction. Moreover, although CKP project reports mentioned tool for monitoring use of Learning Management Systems (LMS) and skills lab utilization in the resource center and skills, its evidence was not found by the evaluation team.

Overall, the evaluation team found sense of appreciation of the work of CKP for KMTC, and likely continue of collaboration due to remaining needs. For example, KMTC had requested support from Capacity to review selected HR policy documents (two-thirds gender rule, 5% requirement for work for persons with disabilities; affirmative action, etc) in tune with the new constitution and devolution. KMTC has had discussions with CKP started negotiating for a continuance, but further discussions and work have been on hold, pending the project end. KMTC has also started exploring other avenues and partners to collaborate with.

The implementation of planned activities in the *Outcome areas 2.4* and *2.5* focused on the Continuing Professional development (CPD) was notable and included development and dissemination of core curricula guidelines for Clinical Officers Council (COC) and Nursing Council of Kenya (NCK) to standardize pre-service training (PST)and in-service training (IST), TA to the CPD unit of the MoH in support of the National Reproductive Health Training Plan (NRHTP) and developing national CPD accreditation guidelines in PST and IST. The CKP successfully provided TA to KNDI in the design and development of the Core Curriculum for Certificates, Diplomas, and Bachelor of Science Degrees in Nutrition and Dietetics.

The CKP provided significant amount of TA which resulted in strengthening CPD accreditation systems in NCK, COC, KMDPB boards and councils. In fact, NCK noted that the CPD framework that they had developed was so successful that the GoK was considering replicating it.

This set of activities was not fully completed as it was transitioned to the FUNZOKenya Project, linking with the National Cross Cadre CPD Technical Working Group aimed at providing a wider access to modules to the health workers and accreditation of these modules by the Institute of Human Resources Management (IHRM) to provide CPD to HR practitioners.

The CKP was not as effective in implementing such strategies as the Area Health Education Centres (AHECs) championed by the Project in collaboration with the University of North Carolina (UNC). Conceptualized in the US[23] as a model concept to increase interest in health sciences among youth and especially from NAL, the plan was to combine an E-learning hub where HWs could update skills and youth could access information easily and conveniently. While the CKP managed to establish coordination with UNC and several Kenyan twinning institutions such as University of Nairobi, the agreed-to plan of action by key stakeholders did not work out partially due to lack of an actual budget line and seemingly ad-hoc addition of this activity and the newness of the concept. Additionally, high levels of insecurity in the NAL served to further undermine establishment of AHECs.

In line with Vision 2030 of digital Kenya, under desired *Outcome 2.6,* the CKP put a significant amount of effort into establishing and assessing the success of project demonstration on use of Information Communications Technology (ICT) in training. The CKP and KMTC supported scale up of eLearning opportunities in RH and FP in selected demo sites (Garissa, Mombasa, Murang'a, Kisumu and Kitui), based on the gains made from the eLearning activities in Kitui COE. However, as is evident from the 2013 PMP, certain gaps impeded the full success of this center and replicating these efforts;

- Malfunctioning software due to connectivity issues, thus limited use of *Blackboard Collaborate* software installed in the five demo sites to enhance teaching options through technology use.
- Insufficient timeframe for comprehensive training by AMREF, which resulted in AMREF having to do conversion of E-content themselves, making it necessary for KMTC to collaborate with other partners for ongoing training of faculty on basic IT skills.

In addition to collaboration and coordination in the HRH sector, the CKP has been actively involved in, and commended for developing Community of Practice (COP) and coordination mechanism as well as conducting meetings addressing HRH issues (*Outcome 2.7),* namely the first National HRH Conference, held in Nairobi from the 7th to the 9th of December 2011.[24] Multiple stakeholders, including members of the HRH-ICC, acknowledged the effective work done by the CKP in preparing resource mobilization for the inaugural conference, illustrating the effective coordination of the CKP mechanisms. The HRH Conference "propelled HRH issues high" (FGD with HRH-ICC) and "its action plans were strong" (Dr. Francis Kimani, Director of Medical Services (DMS), MoH, Nairobi) so that they were picked up by the key stakeholders for implementation. The HRH-ICC, under the MoH leadership, has also been involved in actual monitoring of how milestones were being implemented. Plans for the subsequent conference were not in place by the time of this evaluation despite the recommendation for it to happen every two years, with one taking place before the close of the CK project. The Team was informed that one of the reasons was the HRH-ICC's decision to instead host the Kenya Leadership Management Governance (LMG) conference[25] in 2013, in collaboration with one of the CKP implementing partners (MSH) under a different agreement with USAID/Kenya.

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[23] http://www.med.unc.edu/ahec/

[24] At the time of evaluation KMTC HQ in Nairobi was following up with Safaricom for broadband expansion;

[24] http://www.capacitykenya.org/wp-content/uploads/2012/09/FINAL-CONFERENCE-REPORT-9-28-12.pdf

[25] http://www.hsm-kenya.org/index.php/lmg-conference

One of the resolutions coming out of the HRH conference was the establishment of a Community of Practice (COP), pursued by the HRH-ICC. Capacity Kenya Project's assistance in launching and running the COP and related Peer-Learning Cycles represents another dimension of the CKP's effort to collaborate and coordinate in the HRH arena. Through the four COPs and peer learning cycles, Capacity Kenya has been able to facilitate peer-to-peer knowledge and information exchange among main actors directly involved in the HR development and management, but without involvement of outside experts and consultants, a sustainability measure in itself. The benefits of reduced overall costs and increased ownership and likelihood of participants continuing to learn from each other through the relationships and networks they develop together were positive effects. For instance, the CHAK team noted the value of such networking and the linkages between KCCB and CHAK. Thirty peer facilities, developed through the COP, have broadened the avenue for inter-denominational sharing of HR best practices. However, at the time of this evaluation, it was not clear how the accomplishments can be scaled up and maintained because the COP administrator sits in the CKP office. At the time of the evaluation, CHAK was considering using the Short Messaging System (SMS) platform/ technology for their COP and Capacity Kenya was working with the MoH (HRH Directorate) to identify an administrator to coordinate the COPs, including the virtual communication through *Zoho* platform.

The evaluation found solid evidence and a high level of satisfaction with the overall impact of the CKP's support for the long-term advanced degree training with a focus on public health administration, health management, organizational development, and other relevant courses, including provision of pre-service scholarship schemes to Northern Kenya and other Arid Lands. Under this O*utcome 2.8*, the project has awarded 193 scholarships: for pre-service (159) and in-service (34). The CKP-supported program has specifically targeted a wide range of disciplines, including Nursing, Laboratory Technology, Nutrition, Health Records Management and Information Technology, Pharmaceutical Technology, Radiography at for pre-service and in-service training.

Whereas the overall scholarship scheme had a significantly positive impact as voiced by students and KMTC scholarship program Focal Person, certain issues also caused disappointment, "When we started with Capacity Kenya, they were paying our school fees, but when we started going for field experience to Kitui (District Hospital), we were not given money, like transport to cater for ourselves"(student, Kitui Campus).Although in July 2013, the payment mode was changed, with the school fees being paid directly to the college while the students received a yearly accommodation, food and upkeep allowance to cater for these expenses, the glitches in communication related to transfer of scholarships from the CKP to FUNZOKenya left students worried: at the time of evaluation, the scholarship scheme has 99 continuing students, who are being transitioned to the FUNZOKenya scholarship scheme for continuity[26]

Although timely and strategic activity transfer signaled good planning, the following challenges hindered its smooth implementation: delays in fund disbursements to the colleges for payment of students' fees and website problems that locked out potential scholarship applicants for FY2012 – 2013. Furthermore, at the time of evaluation, neither students nor college administration were clear on the mechanism of scholarship transition from CKP to FUNZOKenya: "we're also not aware; we've not been communicated to" (KMTC management), as well as general implications of the transition.

> "For example, during the interview, we were told we'll work in our [home] areas for three years; we heard that information during [the] interview. Up to now, we don't know if it's true or wrong… we don't know if we work for three years in our areas. Are they going to pay us for

[26]Annual Progress Report: FY 2013 Progress Report: The FUNZOKenya Project (launched in 2012 to build on the successes of Capacity Kenya in strengthening pre-service education of health workers) has taken over some of the CKP activities, including implementation of the scholarship scheme under the administration of the Higher Education Loans Board (HELB); scholarships for the remaining recipients were transitioned in March 2013.

the job we do there, or we'll pay back the scholarship by working free? We don't know, and there's no communication." (Scholarship recipients, Kitui COE)

In addition to the significant work with providing in-scholarship program, the CKP was supposed to support provision of fellowships in emerging areas, as per *Outcome 2.9*. Planned activities included establishing the National Fellowship Program for support in emerging areas, such as public-private partnerships (PPPs), ICT in training, and a fellowship program to support PEPFAR funded programs. The Evaluation findings indicate that this outcome area went through a slow take-off, mostly due to shortage of appropriate skills inherited from Global Capacity project from the onset, confusion over the fellowship versus scholarships and mechanisms for implementation, and change of focus in support of more in-service trainings. Since the mid-term review, when this area was flagged for significant underachievement, Pfizer[27]supported-fellow joined the project for three months and provided TA in iHRIS implementation in the FBO sector in two hospitals. Subsequently the most recent fellow (six months) from Pfizer supported the CKPM&E Team in documentation of project achievements and was instrumental in preparing technical briefs and monitoring the IRs for project lessons learned for improvement during this last year of implementation as well as for communications team support. However, the fellow was recalled to the US due to security concerns following the Westgate Mall Terrorists attack but continued to support the project for another month until the end of her fellowship in October 2013.

Under the last *Outcome 2.10*for this IR the project was supposed to focus on providing TA to the Global Fund for Tuberculosis, AIDS and Malaria (GFATM) Grants Management process, at NOC level & for the Malaria program, strengthening PR to enhance coordination and support in planning, M&E, based on the identified needs. Evaluators found information on limited engagement of the CKP with the GFATM at the early stage. Subsequent discussions between the USAID and UNAIDS resulted in decision for the CKP to minimize its work on GFTAM because of significant engagement by others projects; CKP work under this outcome area shifted to PMI support to DOMC. Successfully implemented activities were CKP technical support with restructuring poorly performing KCM Grants through two training workshops (retreats) organized by the CKP, assessing the capacity of KEMSA's Human Resource and organization of the training workshops for the members, as part of the restructuring process. Specific HR-related support by the CKP included helping them understand how they rated, to work on the necessary reforms and communicate to GFTAM on their rating in the programs between their partners. In slight contrast to the reports, interviews with the DOMC confirmed limited but effective engagement between the CKP and the DOMC, namely around developing country malaria profiles.

IR3: Workforce performance systems in place to improve productivity and retention for the delivery of HIV/AIDS, FP/RH, MCH, malaria, and TB services, particularly at the community level.

The first two outcomes under this IR focused on improving health workers' productivity and retention by scaling up high impact and cost effective interventions in 17 demonstration sites and 17 control sites. Working with the GoK, the CKP used innovative approaches to strengthen leadership and management, established structures, policies and systems to improve occupational safety and health among the health workforce and systems for performance management across the health system.

KIIs, including at the Kimalel demonstration site, found the approach to be very effective, and PMP illustrated achievement of the related Key Performance Indicators and confirmation by CKP's evaluation of three demonstration sites. Main noted achievements included: provision of computers and UPS for the E-CPD staff program, comfortable desks and chairs for the staff, filing cabinets, gloves, masks,

[27]http://www.pfizer.com/

gumboots, aprons for the casuals, appropriate facility signage, and segregation of female and male changing and wash rooms; training on basic working environment safety and enforcement of procedures for disposal of waste and hazardous materials, resulting in conducive and positive work climate environment:

> "Staff is now happier since they have a better, conducive working environment; they have a sense of self-worth and who one is…nobody feels superior or inferior to anybody else; they're happy to tell you who they are: 'I am a sweeper' or 'I am a nurse'… we have come a long way!" (Staff, Kimalel HC)

HRM training on workers' rights in regard to labor law requirements and sensitization on human relations and staff welfare, reward and recognition system for staff, have brought positive changes in attitudes among staff, especially in their approach to patients as well as among themselves.

The significant successes did not go without challenges such as staff shortages to support the demonstration site-facilities and difficulties associated with on-the-job trainings. The E-learning program hasn't commenced since staff lack the basic computer skills needed to use it; at the time of evaluation three staff members were enrolled into computer classes. Furthermore, retention of trained staff has been an issue; finding a solution has been challenging since recruitment, deployment and transfer of staff is a prerogative of the ministry. Use of lessons learned from demo-site evaluations and potential scale-up is pending as the newly elected county officials are still in the process of planning their annual budgets and work plans.

Under *Outcome 3.5,* CKP supported the MoH to simplify performance contracting systems as well as to design and validate a cascading mechanism and approach for performance contracts. The CKP worked with the demo-sites and other facilities with RHPs to strengthen performance management at facility level, using identified FBO and MoH coaches, which was commendable: "Coaching was helpful, to bring collaboration between FBOs and MoH" (KII with CHAK). Furthermore, several KIIs noted the increased motivation among staff to use local resources, including setting targets and continuous performance monitoring, which later helped facilitate performance appraisals.

The TA provided by the CKP in developing and implementing short-term management and supervisory skills trainings (*Outcome 3.6*) using the E-technology on performance management, performance appraisal, supportive supervisions, work climate retention, discipline, grievance, and termination policies, was effective (468 trained against PMP target of 350) and praised by members of MoH HQ HRH-ICC and in the regions. Evaluation team confirmed that selected modules[28] had been uploaded through the global human resource for health (GRC) website, the mention of their use during the county induction week after dissemination to the 47 county coordinators came up in KIIs as well.[29]

DISCUSSION BY EVALUATION QUESTIONS

The evaluation findings about specific project achievements against CK project objectives, even in light of identified challenges and shortcomings, point out that the CKP team has demonstrated:

- *Technical knowledge*, especially in the second half of the project after significant staff changes brought about by the new leadership (knowledge of the MoH, staff familiarity with HRH issues, and technical expertise of TA and even RHPs:

  > "I can tell you, you cannot conclude the history of KEMSA without a paragraph and big paragraph on the role they (CKP TAs) played." (KEMSA CEO)

[28] Capacity Kenya Project APR FY2013

[29] http://www.hrhresourcecenter.org/elearning/course/view.php?id=16

- *Analytical depth* ,illustrated in achieving selected outcomes (PNAs, baselines, evaluations of interventions, documents and plan development), while some outcomes may have suffered from the project's wide scope which did not allow for focused and in-depth analytical grounding (CPD, HRD, etc.):

  > "Capacity put us on our toes. We must understand our human resource patterns…a very interesting scenario is when they showed us that in Kisumu… In our county we have about 121 health staff between the ages of 55 to 60 alright…exiting the system in the next five years!...but if you look at the people entering or who have entered in the past, there are 18 and most between 24 and 39years." (MoH staff at Kisumu)

- Predominantly *logical and results-based approach* in project design and implementation: the CKP's efforts in building and using evidence, taking step-by-step approach, and project M&E (TA with instituting performance contract, and focusing on health work safety as one of the indicators in the performance contract, procurements for demo-sites based on gaps identified during baseline, etc.).

  > "Capacity did a baseline three years ago on the working environment, infection prevention, staff performance, staff productivity. They later brought the report, and a template for working on the issues…The role of coaches was to support the facility staff with technical issues that they were having challenges with." (Busia demo-site)

  > "Capacity came several times to check on progress and to see what the issues were—there was constant communication and they'd send feedback so we felt supported/motivated despite the challenges."(KII at Kimalel HC)

Also expressed aptly by the Chair, Kenya Nutritionists and Dieticians Institute;

> "Even as we worked on what was originally planned and that eventually succeeded very well, Capacity Kenya did not stop there; they were the first to suggest a follow up to help us see the weaknesses of what had been achieved; our accomplishments...they were keen to see the process to completion, but obviously within a timeframe that they were themselves adjusting to...all along, they were cautioning us about the timelines, in relation to what we needed to accomplish."

Several stakeholders also reported continuous follow up and support to facilities. This has cemented relationships that have enabled identification of bottlenecks and prompt resolution as well as sustained the implementation momentum in an environment of competing priorities

The Team found some evidence of CK project's attempt to employ new state-of-the-art methods for addressing the HRH issues in Kenya that are based on clear assessments of knowledge and behavior, such as using PNAs, audits and assessments to develop work plans, strategic plans, as well as bulk SMS messaging, ICT, E-learning and M-platforms.

- HRH assessment for Northern Kenya which was carried out in 2010 resulted in the design of a scholarship model for ensuring retention and sustainability of HRH for the hard-to-reach areas;
- Use of "virtual manager" developed by Deloitte to manage RHPs which involved three components: the help desk, bulk SMS and time sheets;
- "They [the CKP] were ready and willing to support the ministry so that they can achieve something. They asked if we had a body, guidelines or something. And we told them we had nothing not even a committee." (KIII with OSH)

However, it appears that not enough attention was given to the basics, such as E-literacy levels and internet accessibility, when iHRIS and E-CPD were rolled out.

The Team found knowledge and selection of appropriate interventions depending on the needs and the best way to meet the project objectives:

- "CKP…also gave CHWs lunch and transport. They also increased NHIF coverage by paying for CHWs NHIF for 6 months, and the CHWs pay the remaining payments." (FGD in Western region)
- "They assisted in conducting a risk assessment survey and many other things." (KII with OSH, Nairobi)
- "Capacity has helped us by procuring the bulk filling system, scanners, computers, printers, and hired casual staff for us. They have been very effective." (KII at the MoH, Nairobi)
- CKP has built capacity of the organizations to the large degree, although with slight variations by sector. The most capacity was built in FBO sector, i.e. in CHAK, where it is also sustainable due to the fact that the key person was absorbed. Significant capacity was being built by TAs in NASCOP, KEMSA, and DRH, etc. Provided support was related to HR (setting up and streamlining procedures such as staff and management meetings, etc.) and technical aspects (technical guidelines development). Within MoH, the evaluation found that the capacity of departments was built, especially given the size of dedicated investments. The CKP approach on placing individuals, and keeping their managerial oversight at the CKP, has allowed TAs to focus on technical work, without being affected by internal politics and management issues, and helped to increase capacity to discourage dependency on other implementing partners. While beneficial for CKP, the noted challenge was that unlike DFID-funded TA, CKP TAs did not bring actual money, only skills and expertise, which was a harder sell from the beginning "Capacity has helped MoH leadership in managing HR complexities." (KII at the MoH HQ)

The degree of the CKP's contribution to improved HRH capacity and performance in Kenya was high: the majority of RHPs and their colleagues expressed a clear sense of their contribution to the workplace. Notably, the fact that many of them have already been absorbed by the government indicates their important role in health care delivery and recognized value that they bring to the workplaces, either in the MoH or the FBO sector such as CHAK.

The evaluation design did not allow for a survey of beneficiaries, but the exit interviews and selected KIIs and FGDs helped understand the degree of the CKP's contribution to improved health outcomes of beneficiaries. The patients have benefited from the service quality. Interviews held with patients at the Kimalel Health Centre demonstration site and Mbagathi District Hospital revealed that quality of health care provision has improved greatly in the last one year and five years respectively. Additionally, an inventory of equipment and tools provided by Capacity at the beginning of the project showed them to be very well maintained and in good working condition:

- "We were sampled as one of the facilities among those facilities that were giving a 100+ deliveries per quarter…we have come from an average of 15 to an average of 125." (Busia demo-site)
- "The project has been good to the community. If capacity ends today, the community will suffer. The project has really benefitted the community of Migosi." (RHP)
- "The target setting by capacity has helped to improve health indicators in the community." (FGD at the CU)

As evidenced by evaluation findings, the CKP routinely and mostly positively engaged with the stakeholders. Practically all Capacity Kenya Project's stakeholders reported high level of engagement and the approach found largely collaborative with ministries of public service, education, State for the Development of Arid and Semi-arid lands, as well as USAID implementing partners at both regional (APHIA Plus) and national levels:

- *Other USAID-funded projects:* Remarkably, while the common understanding is that the CKP was designed to assist APHIA2 with hiring health workforce, perceptions of how well their interests were incorporated into CKP design were mixed and APHIAPlus did not appear fully aware of significant CKP achievements beyond RHPs. The evaluation team found mention of "supportive supervision" performed by APHIAPlus, but limited mention of other work. Overall, team found appreciation of CKP work with APHIAPlus "Capacity hires have been of great help to APHIAPlus in achieving targets. They have been especially outstanding in achieving HIV/AIDS targets". (FGD with APHIA plus directors).

On another note, several respondents noted that USAID-supported LMS project had been synergized and aligned together with staff being allocated at APHIA offices, or regional ministries like MEASURE Evaluation.

- *GoK:* the CKP and USAID/Kenya were praised by the MoH for streamlining salaries, while other development partners operated outside of the MoH salary structure. Capacity Kenya developed the scholarship program in collaboration with the MoH, the then Ministry of Development for Northern Kenya and other Arid Lands (MODNKAL), the Kenya Conference of Catholic Bishops (KCCB), the Christian Health Association of Kenya (CHAK) and the Kenya Medical Training College (KMTC). More than one representative of the MoH mentioned that "CKP has been keeping them on their toes," and the relationship was characterized as "cordial. The MoH has come to appreciate the value of the project despite early challenges." (IntraHealth staff)
- *Other development partners:* While the CKP generated strong links with other development partners through the HRH-ICC, the CKP mid-term review found information on the project's engagement with such stakeholders as the UN, other donors and even the DPHK through conferences. End-of-project evaluation found almost no evidence of such engagement outside of the HRH-ICC.

CHALLENGES, OBSTACLES, AND LESSONS LEARNED

The Team found evidence that certain overarching challenges impeded successful implementation of the project objectives:

- The two ministries of health at the project inception and their merger afterwards: the existence of two ministries of health posed challenges for the project before 2013, and the new structure at the MoH resulted in increased transfers and significant leadership turnover in key level positions at the MoH and other key GoK agencies.
- Lack of GoK resources and input from development partners to conduct a national health workforce mapping exercise.
- The increase of salaries by the MoH for their staff forced CPK to equally increase salaries for RHPs, which negatively affected other program areas of the project as resources had to be shifted.
- The devolution of MoH staff at the national level posed challenges for the CKP.
- Issues related to USAID regulation of not paying per diem/out of pocket allowances decreased stakeholders' motivation to attend training workshops; thus affecting performance/outputs.
- A 2013 circular from the MoH instructing the national level office not to undertake county-level capacity and skills building activities until further notice delayed implementation of malaria related activities.
- Sustainability of KMTC Kitui COE activities.
- Discussions pertaining to sustainability of Capacity Kenya interventions at KMTC took longer than expected due to bureaucracies in the system. Delay in formation of a steering committee to formulate an exit strategy has brought a lot of challenges.

- APHIAplus Nairobi Coast is in closeout mode, which poses a challenge for the project's transition plans for activities that were started to support APHIAplus in streamlining their service delivery to community health services.

The following *lessons learned* during the CKP implementation should be considered when designing future programs:

- Critical role of needs assessments to identify what development partners need for support so they don't spread themselves too thin.
- There should be a clear MOU and a negotiated timeline between the MoH/government and a similar project on transitioning of RHPs.
- Flexibility of funding while maintaining its needs base, but priorities should be reevaluated when duplication of effort between the development partners is discovered.
- The big role of M&E in monitoring the success of activities.
- Patience is needed for adaptation to project implementation and the likely resultant changes to ensure buy-in and positive impact.
- To ensure buy-in and to increase likelihood of project's positive impact, timelines should be considered in order to cater for resultant changes that are likely to occur, e.g., changing staff attitudes. Project design should allow for adequate time to create and measure impact.
- Special caution should be made in designing the project due to government bureaucracy, e.g., taking budget making processes into consideration.
- All stakeholders appreciated and emphasized that the evidence based consolidation process to inform the development of the second HRH Strategy is a critical step in development of HRH policies and plans.
- Limited internet connectivity when ICT related interventions are designed. Ensure there's robust internet connectivity.
- Formalization of all types of engagements to ensure accountability of partners around key commitments.
- Consideration of simple and non-resource interventions at the demonstration sites—for example, training on personnel relationships, communication at the workplace, and courtesy by health workers which can lead to enhanced client and health worker satisfaction.

SUSTAINABILITY

Sustainability is an overarching theme of the CKP design. IRs targeted *strengthening* and *institutionalizing* HRH strategies, plans and practices, improved opportunities to *addressing knowledge and skills*, and introducing workplace performance systems for improved productivity and *retention*. In their own words, "since 2009, Capacity Kenya has been implemented with a focus on the longer-term sustainability of key project activities and initiatives to support HRH in Kenya."[30] Selected outcomes focused specifically on attaining results that would contribute to the increased likelihood of sustaining project accomplishments and the overall impact of the HRH situation in Kenya: long-term technical assistance and capacity building at key health institutions, pre-service scholarships, ICT demo-sites and sites with schemes to improve productivity and retention with possibilities of scale-up, development of CHW strategy and its pilot, iHRIS development, etc. Notably, several practices in implementing the CKP are likely to help sustain project efforts and outcomes:

[30] CKP APR FY2013

- The majority of CKP interventions have targeted GoK institutions and stakeholders, as well as regulatory bodies, as well as FBO sector.
- The GoK was directly involved in recruiting and inducting the RHPs and scholarship recipients, and the CKP facilitated induction of the MoH leadership cadre.
- The CKP has contributed to increased capacity of various GoK staff and institutions through mentorship provided by seconded TAs (KEMSA, NASCOP, MoH, DRH).
- Outside of the GoK, the CKP has also trained the CEOs of FBOs as TOTs in HRM practices so they would be able to transfer their knowledge as part of OJTs for fellow staff.
- At the time of the evaluation, selected guidelines/strategic plans, developed with TA from the CKP have already been used as road maps for institutional development, including specifically in the HR, advocacy, and financial planning (CHW strategy, KNDI, NCK, KMTC Code of Conduct, etc.) and it is the intent that others would follow suit (KEMSA).
- Foundation laid by TA in developing guidelines and plans, some of which are likely to be implemented by the GoK due to their high level of participation in the development.

Evaluation findings indicate that the following accomplishments of the CKP are likely to sustain after the end of the project:

- Increased profile, visibility of and understanding of HRH issues nationwide, after the first national HRH conference of 2010, and the HRH strategic plan development and implementation.
- Improved capacity of service delivery through the provision and absorption of RHPs.
- Increased access to high quality education through scholarships and improved resources, CPD providers, and regulatory bodies.
- iHRIS database, with its potential to be used for management and decision making around budgeting and resource allocation, and links to bulk filing system.
- Improved working conditions for health workers due to the low cost and high return.
- Increased health workers' access to information through bulk SMS and in-service training through e/m learning.
- Streamlined HR management practices, including basic HR plans and tools, job descriptions to guide service delivery.
- At a national level, a key next step to support long-term sustainability of the HRH-ICC is to secure permanent funding from the MoH for the secretariat function.

Below please find outcome-specific accomplishments that are worth mentioning in this context.

CKP-supported setting up of the HRH-ICC, chaired by the GoK, has been and is likely to sustain as a key forum of key HRH stakeholders. This will not only keep HRH high on the agenda, but also will facilitate advocacy, knowledge sharing and shaping critical initiatives such as health workforce mapping, health worker forecasting, development of a plan to support devolution of health services, development of the community health workers strategy, review of the first NHRH strategic plan, and the preparation of Kenya's HRH Commitment for 2013 – 2017. Development of the second national HRH strategy, under the coordination of the HRH–ICC Secretariat, ensures that the HRH gains made through the first NHRH strategic plan are mainstreamed to inform HRH policy and interventions after the project period. At a national level, a way to further long-term sustainability of the HRH-ICC could be to secure permanent funding from the MoH for the secretariat function or to obtain a commitment for rotating membership between stakeholders involved. However, the strategy to scale up the approach which was based on setting up HRH-ICC at the level of Nairobi County, and which is relatively unique, can hardly

be replicated in the other 46 counties. Necessary strategic adjustments would have to be made to roll out successfully and obtain a buy-in in terms resources.

Significant capacity building around iHRIS and its roll-out to almost all the counties has increased the utilization of iHRIS data toward long-term sustainability of an HRIS for health workers nationwide. While the bulk filing system installed in the MoH is in use and is being maintained by MoH staff, its future and relationship to iHRIS is uncertain, thus undermining the sustainable use of iHRIS for its full potential.

Towards sustainability of the COE, KMTC increased the number of computers in the resource center and added eLearning programs on the LMS, as well as trained teaching staff. The skills lab had a more structured schedule to increase its access and efficiency and the college is now paying for COE's internet connection, repairs, maintenance and insurance of equipment provided by the project. According to a staff member at the Coordinating Unit, KMTC HQ, it would be useful to convert the whole curriculum to facilitate distance learning programs. Referred to as "blended learning," it would be very useful as it includes a few face-to-face sessions as well as practicals meant to build on what the students have learned previously.

While not sustainable per se due to the fact that it's a USAID-funded project, collaboration with FUNZOKenya and linkage with the National Cross Cadre CPD Technical Working Group aims to provide wider access to the modules to the health workers. Accreditation of these modules by the Institute of Human Resources Management (IHRM) to provide CPD to HR practitioners in the health sector will also go a long way to sustain the uptake of the E-Modules.

Pilot testing the performance appraisal for CHWs, which has been adopted, is part of the sustainability plan, and is built into the functionality of the assessment tool for CUs. The NHIF initiative has also been adopted by the MoH as one of the strategies towards motivating the CHW volunteers in the *1 million CHWs campaign initiative for Africa* that was approved by the Cabinet Secretary.

Selected RHP interventions like recruitment, staff retention and bulk SMS are already being used by the MoH as well, without CKP support.

A scale up of the demonstration sites with improved work climate, through retention and productivity interventions, such as introduction of performance appraisals and coaching mechanisms, was found effective in improving HW's productivity and retention, and has showed an avenue for low cost replication and ongoing implementation that will sustain the initiative.

Despite the likely sustainability of the CKP's accomplishments, the future is relatively uncertain for some:

- Governance of HRH in Kenya and peer-level HRH stakeholder leadership groups.
- The level of orientation for 47 county health managers on their new roles and responsibilities;
- Sustainability of gains made at demonstration sites: retaining trained staff due to the fact that recruitment, deployment and transfer of staff is a prerogative of the MoH; the Team hopes their skills would be effectively used elsewhere, ideally at a county level.
- Limited strategic engagement with the private sector.
- Questionable sustainability of gains made at the Kitui COE, if support from other development partners is not identified: high turnover and inconsistent quality of faculty and low motivation.
- Unclear future of the COPs: at the time of evaluation, the CKP indicated that the project was working with the MoH (HRH Directorate) to identify a focal person to become the administrator coordinating the COPs, including the virtual communication through *Zoho* platform.

Additionally, the Team found it challenging to obtain KII's opinions on the sustainability of selected interventions, due to the transfer of a significant number of CKP activities to the FUNZOKenya Project.

When asked about the future of the CKP's achievements and interventions, the majority of KIIs mentioned that FUNZOKenya would take charge. The same response was produced when asked about some activities that fell under LMS project. Neither should count towards sustainability measures per se, as they transitioned to another USAID-funded project.

RECOMMENDATIONS FOR FOLLOW-ON DESIGN

The USAID approach in designing the follow-on project should consider lessons learned and challenges encountered by the CKP and mentioned throughout the report and in sections A – D. The ongoing process of devolution opens up significant opportunities for investment and capacity building by creating a tangible impact closer to the service delivery and population. However, certain assumptions should be considered in supporting HRH management systems in the new devolved system of government in Kenya.

- Unlike health system, HR under education did not devolve, due to significant lobbying by teachers. Teacher service commission works, and should be used by the health sector as an example. Additionally, a forum for exchange of experiences should be developed between teachers and health workers at a county level especially.
- Before significant investment are made by development partners, the county-level MoHs need to demonstrate that their motivation for devolution is improved service delivery at a community level rather than a new level of bureaucracy and centralized services at a county level
- HRH interventions should be multi-sectoral in nature. For example, where training and capacity building are involved, the significant role of educational sector should be considered.
- While a new project needs to respond to the needs of counties, the regulatory role of the HQ level in developing national guidelines has to be maintained and supported.
- For the time being, the RHP model needs to be redesigned to fit into the county government system. While the Team found evidence of RHP hiring being need-based for the facilities and areas, their subsequent absorption, often accompanied by transfers, was not thought through by the MoH, possibly due to limited use of the iHRIS for decision making. Better communication channels between those in charge at the facilities and RHP managers need to be established.
- For improved outcomes and better impact, discussion of harmonization of per-diem policies between development partners and communication to the GoK needs to be taken to a higher level and resolved.
- The devolved system highlights the need for capacity building at the county level even more so because it brings HRH and service delivery even closer to each other and to communities: the same capacity building that has happened at the HQ level needs to trickle down to the county level.

- Develop sustainable strategies to support COPs and peer learning cycles, peer-to-peer knowledge and information, including e-platforms.
- Introduce effective communication as an important cross-cutting component, internally within the project and externally to stakeholders. Extra effort needs to be made to disseminate project accomplishments to USAID IPs and other development partners, to a avoid duplication, share lessons learned, and improve outcomes.
- Target low and control projects scope to ensure focus and in-depth analytical grounding for targeted interventions and activities.
- Strategically engage with private sector.

The new project should take into consideration the specific objectives of the *second HRH strategic plan*, namely:

- Align the development of HRH Strategic plan to the Kenya Health Sector Strategic and Investment Plan 2013 – 2017, Public Service Commission Act 2012 and other evidence-based HRH proposals, reports and assessments;
- Articulate future HRH investment areas in consultation with the GoK, HRH coordination mechanism in the National HRH Strategic plan;
- In liaison with the TWG on development of the HRH strategic plan ,engage stakeholders at all levels to seek their inputs in areas to be articulated in the next NHRHSP;
- Collate inputs and draft the NHRHSP including, but not limited to, implementation framework for identified HRH priorities, budgetary estimates, resource mobilization plan, monitoring and evaluation plan and tools, and the implementation structures to support implementation of the identified priorities.

The evaluation identified a significant number of current HRH gaps at national and county levels, most of which had at least been approached by the CKP during the project implementation:

- Standalone system HMIS and HRIS, which do not communicate. Pension departments based on PSC and MOF, need to work with them on digitizing in isolation;
- Lack of institutional frameworks for managing health workers;
- The level of quality of services offered and work ethic offered by RHPs is concentrated in the Comprehensive Care Centre (CCCs);
- Achievements made at staff retention demo-sites in NAL can be easily scaled up to support the counties. Recruitment needs to be need and facility based, i.e., hire for specific facilities; and
- Many of those with HR responsibilities in the health sector still lack the necessary management and leadership skills, and these should be developed in a comprehensive project package, as originally intended by the CKP design.

Several recommendations can be made, most of which would apply to the MoH HQ and national level but with foreseen implications for the country as whole:

- The next project or project phase should be more TA and ICT driven;
- Good practices like how recruitment of RHPs was done openly need to be adopted by the GoK at national and county levels;
- Increased knowledge management among development partners, provision of documentation detailing support provided by partners to facilitate gap and data analysis for project design;
- There is a need for extra effort in fostering positive coordination and collaboration between the HQ and county levels: leadership, coaching, conflict resolution, team building, etc.;
- The changing environment calls for an increased inquiry into the needs of the MoH at HQ and county levels to ensure they have representation during devolution planning meetings and to get a better understanding of the requirements of devolved health services;
- Work with FBO sector to identify strategies to smooth their transition to the devolved system. FBOs may have to be repositioned. For example, discussion about free maternity in public facilities, whereas FBOs cannot provide as they're for-profit entities.

The table below provides recommendations specific to level of implementation in line with devolution:

Table 4. CKP Follow-On Design Recommendations

County	National/HQ level

Need for county level HRH-ICCs: TA in establishing team and linking to national and with each other for knowledge exchange.	Change management needed at the MoH HQ level for smooth transition.
Significant capacity building around HRM and iHRIS, including basic computer skills and sense of ownership.	Continued work on iHRIS, digitizing records and safe transfer of HW data from national to county level.
Due to a particular challenging situation, the Northern Region assessment findings should be disseminated and TA should be planned for to implement them. Mechanisms should be in place for CKP scholarship recipients from NAL to be guaranteed employment for future development of that region.	Provide TA and continued support to KMTC in devolving medical education, and specifically Kitui COE in becoming a regional center and an exemplary hub.
TA around building Health Public Service Commission at the country level.	Need for increased engagement with private sector as its share in providing medical education and employment is increasing.
Use of iHRIS at county levels for decision making: RHPs or similar type of mechanism for streamlining HW hiring would need to be distributed to fill in gaps rather than focus on providing one type of support (i.e., at CCC).	Helping national level councils/regulatory bodies (NCK, KMPDB, KMTC) to embrace devolved system, and build their capacity to work with counties on developing and implementing regulations: either through offices or innovative mechanisms.
CKP-type support in hiring, either through RHPs or a similar mechanism, is needed to continue offering services because counties currently do not have the capacity to hire. Discussions need to be had with APHIAPlus and other partners to identify where the most need is.	Increase engagement of the community health services unit (formerly, the division of community health, at MoH HQ) in future policy and planning, and provide TA to CHMTs on the ground in implementing the strategy.
Advocacy for implementation of CHW strategy; need to explore the role of Community Health workers (CHWs) and Community Health Committees (CHC). The CKP intervention models in CHW performance enhancement and NHIF interventions need to be scaled up.	KEMSA HQ needs to engage individual counties for future supplies needs support. TA will be needed to take the good work of KEMSA to the counties. The TA model success at KEMSA needs to be properly captured in a separate report and disseminated widely for possible replication by partners and MoH Support KEMSA in decentralizing their services to the counties.
Sensitization about and capacity building in implementing hiring mechanisms used for boarding RHPs could help address the fears of HRWs about the hiring processes at a country level in the devolution.	Need to harmonize incentive mechanisms for stakeholders to attend workshops and other events across development partners. Issues related to USAID regulation of not paying per diem/out of pocket allowances appeared to have affected performance/outputs.

HRH development should continue to be a high priority for the GoK and development partners as it provides the necessary skills and competencies to serve as resource for the development process of Kenya, and has a long term impact on the population of Kenya. Capacity Kenya Project has made a significant contribution to this end, but a lot of work remains, especially in the new system of devolved government.

ANNEXES

ANNEX A: END-OF-PROJECT SOW

A.1 Introduction

The objective of this task order is to provide a project evaluation of the Capacity Kenya Project. The task order will support USAID/Kenya's Office of Population and Health (OPH) to:

I. Establish the extent to which the Capacity Kenya project implementation was effective and efficient in accomplishing set objectives in a responsive way and in line with USAID's health implementation framework and the country needs

II. Provide insights in to the design of a follow-on project that is responsive to the human resources for health (HRH) needs in a devolved system of governance

USAID/Kenya

USAID/Kenya's OPH focuses on programming development activities across four teams – Family Health, Malaria, HIV/AIDS and Health Systems – utilizing resources from initiatives and direct Congressional appropriations. The OPH strategy, which is elaborated through a five-year Health Implementation Framework for the health sector, provides a rationale and structure for programming resources for the period 2010-2015.

The Implementation Framework is based on the Government of Kenya's (GoK) recent health policy and strategy frameworks, and builds on the successes of and lessons learned from OPH's prior assistance. The Implementation Framework clearly builds on the successes of the AIDS, Population and Health Integrated Assistance (APHIA) programs by maintaining a focus on integrated services and assuring increased coverage of the key interventions in order to reach service targets and objectives. However, the scope has been expanded to not only encourage the delivery of quality health services but also to strengthen leadership, in-country capacity building, and systems development to ensure long-term sustainable services.

OPH's current assistance centers on supporting local institutions, at both the national and sub-national levels and in both the public and private sectors, to improve health outcomes and impact through sustainable country-led programs and partnerships. The program specifically seeks to achieve four major results:

1) Strengthened leadership, management and governance for sustained health programs;
2) Strengthened health systems for the sustainable delivery of quality services;
3) Increased use of quality health services and information; and
4) Enhanced social determinants of health (SDH) to improve wellbeing of targeted communities and populations.

OPH applies five cross-cutting elements in its approach to achieving the Strategic Objectives and Results, namely involvement with the whole market, innovation, youth-focus and gender-focus, and equity.

For the foreseeable future, OPH's health portfolio will be predominantly focused on HIV/AIDS prevention, care and treatment as Kenya is a priority country for The President's Emergency Plan for AIDS Relief (PEPFAR) and receives significant funding to address HIV/AIDS and related problems. Similarly, resources available from the President's Malaria Initiative (PMI) assure continued funding for malaria programs. However, because of declines or plateaus of health indicators among key target groups, OPH

will seek additional funding to balance the current program to increase coverage for family planning, maternal, neonatal, and child health, nutrition/food security, and safe water and hygiene.

OPH also operationalizes strong linkages to other sectors in order to address contextual factors that impact on health but have conventionally been perceived as outside of the control of the health sector. Referred to as the "social determinants of health" these include such factors as educational level, literacy, environment, and social-cultural norms and structures which generally impact negatively on the poor, marginalized and underserved populations.

Incorporating tenets of United States Government (USG) strategies and international mandates together with needs and priorities in Kenya, OPH developed the following guiding principles that serve as the reference point for program planning and implementation:

- Assure country-led and country-owned programs
- Align to Kenyan, USG and development partner strategies
- Invest in leadership, capacity building and systems development for long-term
- Sustainability
- Maximize a client-centered approach through integration of services and systems
- Increase involvement of the private sector in health care delivery
- Ensure strategic collaboration and coordination
- Manage for results with mutual accountability

While the goal is to focus on the establishment of a sustainable national health system for all Kenyans, the program places priority on the poor, marginalized, underserved, and high risk populations. The implementers of this Five Year Implementation Framework continue to use the proven approaches, but are mandated to seek maximum innovation and creativity. Further, the Implementation Framework urges data use, analysis and evidence-based decision making to test approaches and interventions that might achieve greater public health impact.

Kenya is in the beginning stages of rolling out a new devolved system of government with 47 new counties in accordance with the new constitution. Concurrently, the USAID/Kenya Mission is in the process of developing its new five-year Country Development Cooperation Strategy (CDCS). The Mission is thinking outside of the box to align with Kenya's political transition and process of decentralization to the 47 new devolved governments Development Objective statements are still in the final stages of formation and it is likely that the Mission will move away from traditional, office-led objectives and more towards transformative and integrated objectives that reflect Kenya's Vision 2030 goals. Moving forward, it is expected that all technical offices, including OPH, will design new projects that will directly contribute to the new Mission Development Objectives. As Kenya moves to implement its new devolved government structure, OPH will re-configure activity management processes and GoK and partner communications to focus more intensively at the county level.

A.2 Background

The Capacity Kenya Project (CKP) was awarded to support the achievement of USAID/Kenya's Strategic Objective 3 (SO3): Reduce fertility and the risk of HIV/AIDS transmission through sustainable, integrated FP, Malaria interventions and health services. SO3 focuses on improving the enabling environment for the provision of health services; increasing the use of proven, effective interventions to decrease the risk of transmission and mitigate the impact of HIV/AIDS; and increasing customer use of FP, RH, Malaria interventions and CS services.

The bulk of funding for the Capacity Kenya Project is allocated from the PEPFAR budget and comprises several program areas under PEPFAR, with the remaining funds coming from the malaria and child survival and health (CSH) earmarks and a smaller proportion from reproductive health (RH) and family planning (FP) initiatives. As this is a systems strengthening project, it addresses the cross cutting issues affecting the human resources for health (HRH) in the country for effective integrated health services delivery.

Capacity Kenya Project broad objective is strengthening human resources for health systems of the public, faith-based, and private health sectors to improve the delivery of primary health care at community level. This is a national level project anchored and working closely with the GoK human resources management department and departments such as NASCOP, DRH, NAAC and institutions such as KEMSA. The Capacity Kenya Project has worked collaboratively with Ministry of public service, Ministry of education, Ministry of state for the development of Arid and semi-arid lands. The project also works closely with USAID implementing partners at both regional (APHIA *plus*) and national level partners. The project also has strong links with other development partners through the Human Resources for Health-Interagency Coordination Committee (HRH ICC) were all stake holders with an interest in HRH converge coordinate and harmonize their interventions.

The Capacity Kenya Project was designed to improve health outcomes through addressing HRH issues related to forecasting, recruitment, performance improvement and retention especially to the low level facilities and rural and hard to reach areas. The national direction on HRH is to have adequate, equitably distributed, motivated and highly skilled HRH. The project seeks to address these issues based on three objectives:

1. Strengthened and institutionalized HRH strategies, plans policies and practices at national and provincial/regional levels that will enable an increase in number of health workers and promote the provision of quality services
2. Improved opportunities for addressing the knowledge and skills needed by workers at all levels, including community for provision of quality services
3. Workforce performance system in place to improve productivity and retention for the delivery of HIV/AIDs, FP/RH, MCH, malaria and TB services

The project operates within the USG regulations and GoK guidelines and policies on HRH. There is a National Human Resources for Health strategic plan 2009-2012 upon which most of the project interventions are anchored, however the second National HRH strategic plan 2013- 2018 is in the formative stages.

The country is in transition process of implementing devolved governance structures, health services including health workforce will be managed by the 47 county governments. This is a shift from the previous practice in which the HRH function was managed centrally. This requires a paradigm shift and the approach of supporting HRH management systems. The counties require support to develop the relevant capacity for HRH management to ensure services are not interrupted and there are adequate equitably distributed health workers. There is need for USAID support to HRH management in future to factor in these changes.

A.3 OBJECTIVES

Key Objectives

The contractor shall conduct an independent evaluation (referenced as “the evaluation” hereafter), and provide a report of the findings of the evaluation of IntraHealth’s performance in the implementation of the Capacity Kenya program, throughout the period April 2009 to August 2013. The primary audience of the evaluation report will be USAID and other U.S. Government officials. A public version of the report shall also be provided.

The evaluation shall focus on evaluating the effectiveness of the Capacity Kenya Project and on evaluating both technical and administrative aspects of this activity. The evaluation shall assess program effectiveness and outcomes, its fit to USAID/Kenya's new health implementation framework, as well as sustainability. The evaluation approach shall include both evaluation design as well as development of an evaluation model, which assesses implementation and evaluation processes, outputs and outcomes. The evaluation process shall elicit information that will inform the follow-on project design in line with the current devolved HRH management functions.

A.4 SCOPE OF WORK

Overall scope for the evaluation must include:

i) A determination of whether the USAID/Kenya funded Capacity Kenya Project has contributed towards meeting mandated targets and to the extent that the intended results have been achieved;
ii) An assessment of the project's impact;
iii) An assessment of how well the project has operated under USAID's health implementation framework including any challenges that this approach may be causing.
iv) Identification of unique strategies and approaches employed by USAID/K funded Capacity Kenya Project that have been instrumental in achieving outcomes
v) Identification of the HRH challenges and gaps in the devolved systems of government
vi) Appropriate approaches that would effectively address HRH gaps at the county level in a devolved system of government
vii) Good practices and lessons from the current capacity Kenya project that will inform the design of the follow on project
viii) Recommendations for addressing issues as have been identified in the course of the evaluation; and
ix) Recommendations for strengthening the HRH management systems in devolved county structures and better aligning it to USAID's health implementation strategy.

At minimum, the evaluation must address:

Overall project performance:

- Progress of the Capacity Kenya Project towards achievement of the specific project objectives and OPH's objectives.
- Did the project employ new state-of-the art methods for addressing the HRH issues in the country that are based on a clear assessments of knowledge and behavior?
- Did Capacity Kenya Project demonstrate technical knowledge, analytical depth, and a logical, results-based approach in order to meet the objectives of the project?
- Did the project employ feasible and realistic strategies for meeting each of the objectives in areas of HIV/AIDS, reproductive health and family planning and maternal and child health, and malaria?

Capacity Building:

- The extent the program has built capacity of local organization, government departments and other private sector partners and other sustainability efforts have been made.

Technical Assistance:

- Specific challenges, obstacles, lessons learned in the implementation of the project.
- The extent Capacity Kenya Project has engaged the different stakeholders especially the GoK, other strategic donors and other stakeholders.

Follow-on design:

- What are the current HRH gaps at national and county levels?
- Approaches USAID should adopt in designing the follow-on project.

- Opportunities and assumptions that can be considered in supporting HRH management systems in the devolved systems.

The evaluation shall provide empirical evidence to answer these questions. Conclusions shall be based on findings as recommendations for future mission action will be based on an assessment of the results of the evaluation exercise.

Contractor Specific Tasks:

The Contractor shall:

A. Meet with USAID to review the Scope of Work and the proposed work plan.
B. Review documents provided by USAID and the Implementing partner

   Document Review: OPH will provide the assessment team with a package of electronic briefing materials related to the USAID/Kenya programs prior to the start of in-country work for their review. Copies of materials not available electronically, will be available at the Mission once the teams arrive. This documentation will include but not be limited to:

   1) USAID/Kenya Five Year Implementation Framework for the Health Sector (2010-2015).
   2) The APHIAplus Service Delivery RFA.
   3) PEPFAR Country Operational Plan (COP) and Strategy Statement.
   4) GoK health strategies, policies, guidelines, protocols e.g. Kenya National AIDS Strategic Plan (KNASP), National Health Sector Strategic Plan (NHSSP), HRH strategy and policy papers.
   5) KDHS 2008 report.
   6) Capacity Kenya's project monitoring data.

C. Conduct key interview with staff from the following offices:-
   1. USAID/Kenya's Program Development and Analysis Offices
   2. USAID/Kenya's Office of Population and Health Office
   3. USAID/Kenya's Controller's Office and
   4. USAID Kenya's Regional Contract's Office
   5. PEPFAR Coordinating Office in Kenya
D. Interview the Implementing Partner for the Capacity Kenya Project
E. Interview key Government of Kenya officials including;
   1. Director (s) in the ministry of health
   2. Heads of department i.e. HRH management and HRH development
   3. County government representatives (selected)
   4. Former provincial heads (selected)
F. Interview/meet with supported NGOs and sub-grantees being supported under this activity and conduct field visits as will be agreed upon with the OPH director or his/her designate.
G. In order to assess several DQA issues, conduct a survey of beneficiaries, identify a representative sample using factors such as:
   - Type of assistance
   - Women and Men
   - A mix of older and younger beneficiaries
   - Rural Vs Urban etc.

Specifically this will include health workers under Capacity Kenya project payroll, heads of selected Facilities where the health workers are based, Technical Assistants TAs and Heads of departments where the TAs are based i.e. KEMSA, NASCOP, Reproductive health departments.

The survey will collect qualitative and quantitative data to be used in answering a variety of questions in the SOW. A variety of methods might be used, including:

- Structured questionnaire with open ended and close ended questions
- Individual interviews

Data sources and collection methodologies must also be noted in the final evaluation report. The evaluation team is encouraged to submit qualitative data on program achievements and results.
Proposed work plan and methodology must be approved in advance by USAID.

Additional Evaluation Constraints and Requirements:

I. Evaluation of the Program Management of Capacity Kenya Project.

To answer evaluation objectives, the evaluation team must gain an understanding of Capacity Kenya Project activities as well as the key indicators used to measure the contribution of those activities toward meeting mandated targets. This information must then be reviewed against the results and associated targets reported to USAID/Kenya over the Life of the Project (LOP).

Capacity Kenya Project Monitoring and Evaluation staff must be interviewed to determine how Capacity Kenya Project results were obtained from sub-partners. As part of this process, an understanding of the Capacity Kenya Project systems and sampled partner systems and registers used to record PEPFAR data including the use of monthly forms used to summarize data for reporting to USAID/Kenya must be developed. Additional procedures to test the data's validity and reliability may need to be considered. Implementing sub-partner officials in sampled provinces where Capacity Kenya Project is working in must be interviewed to gain an understanding of sub-grantee activities that are supported by Capacity Kenya Project and methods of data collection. Results must be traced as noted on selected monthly reports to the underlying source documentation.

The evaluation must assess management controls over the equipment, vehicles and property procurement storage and maintenance at the level of the Implementing Partner- Capacity Kenya Project and sub-grantees under this activity.

II. Evaluation of the program's technical approach in the development of HRH interventions in the health sector

To determine to what extent sound technical approaches were being employed by the Capacity Kenya Project in working with GoK and other Stakeholders and strengthening their capacity to deliver HRH interventions, the evaluation team must interview Capacity Kenya Project program staff, sub-partners, including GoK.

The evaluation must document to what extent Capacity Kenya Project's strengthening approaches and activities and key program components have influenced GoK and grantee systems, processes and procedures along the continuum of the HRH interventions.

III. Evaluation of the Program's effectiveness

Evaluation of the program's impact must be based in part on interviews with the USAID Mission, PEPFAR Office, implementing partner staff, sub-grantees, relevant stakeholders and Kenyan government officials.

The contractor must review documents as part of the evaluation procedures. These included excerpts from the Capacity Kenya Project Cooperative agreement with USAID/Kenya, agreements with sub-partners, and their respective scopes of work.

ANNEX B: LIST OF DOCUMENTS REVIEWED

1. Capacity Kenya Project Cooperative Agreement
2. Capacity Project Kenya Mid-term Review
3. Kenya DHS2008report
4. Kenya HIV/MCH SPA, 2010 - Final Report (English) http://measuredhs.com/publications/publication-SPA17-SPA-Final-Reports.cfm

USG and GoK Strategy Documents:

5. National Human Resources for Health Strategic Plan 2009-2012
6. USAID/KENYA 5 year implementation framework for the Health Sector (2010 – 2015)
7. Reversing the trends; The second National Health Sector Strategic plan of Kenya. NHSSP 11 – 2005 – 2010.
8. Kenya National AIDS Strategic Plan (KNASP) 2009/10-2012/13 http://www.nacc.or.ke/nacc%20downloads/knasp_iii_supporting_docs.pdf
9. PEPFAR/Kenya Country Operational Plans 2009-2012
10. HIV/AIDS Partnership Framework with the Government of the Republic of Kenya (December 2009)
    http://www.pepfar.gov/countries/frameworks/kenyapf/137931.htm
    http://www.pepfar.gov/reports/guidance/framework/120741.htm
11. HUMAN RESOURCES FOR HEALTH (HRH) ASSESMENT REPORT FOR NORTHERN KENYA: Overview of Health Workforce Distribution across 10 Counties. May 2013.
12. END TERM EVALUATION REPORT. SECOND NATIONAL HUMAN RESOURCES FOR HEALTH STRATEGIC PLAN (NHRHSP, 2009-2012) "Reversing the Trends" "Serving the Health Workforce in Kenya". SHORTER-POPULAR VERSION
13. LESSONS LEARNED. A Reflection on Resource Mobilization Initiatives in Western, Nyanza, Coast and Central Provinces in Kenya. 2013
14. Provincial HRM Assessment Report and Action Plan for Eastern Province. October 2009.
15. Provincial HRM Assessment Report and Action Plan for Western Province. November 2009.
16. Provincial HRM Assessment Report and Action Plan for Nyanza Province. October 2009.
17. Provincial HRM Assessment Report and Action Plan for Nairobi Province. October 2009.
18. HRM Assessment Report and Action Plan for FBO Demonstration Sites. October 2009.
19. Evaluation of the Implementation of Human Resources Management Action Plans by Tier 3 Facilities in Central, Coast, Eastern and Western Regions in Kenya. July 2013.
20. Kenya Medical Supplies Authority. COPORATE WIDE HUMAN RESOURCES REVIEW. Organization Review and Workload Analysis. 2013

Capacity Kenya's project monitoring data:

21. USAID Kenya - Capacity Kenya Project, Annual Progress Report (FY 2013 Progress Report)
22. Capacity Kenya Performance Monitoring Plan Results Table, Updated: 30th September 2013 (APR 2013)
23. Capacity Kenya Annual Work Plan. October 1 2009 – September 30, 2010. Revised Draft.
24. Capacity Kenya Annual Work Plan. October 2010 – September, 2011.
25. Capacity Kenya Work Plan FY2013/2014. October 1, 2013 – April 15, 2014.
26. Performance monitoring plan results table. Update Oct., 2010 – March 2011
27. Performance monitoring plan results table. Update Oct., 2011 – March 2012
28. Performance monitoring Report –April –Sept.30,2010 & Oct.1, 2009 –Sept 30, 2010
29. Performance monitoring Report – Oct.1 2010 – March 31,2011
30. Semi – Annual performance monitoring Report – Oct 1, 2011 – March 31, 2012
31. Work plan. April to Sept., 2009; FY2011 -2012

ANNEX C: LIST OF KEY INFORMANT INTERVIEWS CONDUCTED

Contact Person	Institution	Designation	Location
MoH HQ - Nairobi			
Dr. Kimani Mwihaki	MoH	Director General	Nairobi
Dr. Shariff S K	MoH	Director, Public Health and Sanitation	Nairobi
Hannah Kimemia	MoH	Director - HRM	Nairobi
John Waiganjo	MoH	HR Officer	Nairobi
Lucy Ogoye	MoH	Sr. Health Admin Officer	Nairobi
Andrew Nyanchoga	formerly MoH now MOE	former MoH HRM Director HRM	Nairobi
Dr. Mwitari	MoH	former Head of DCHS	Nairobi
Dr. Soti	MoH	former Head of DOMC	Nairobi
Patrick Musichi	MoH	HR Officer - focal person for iHRIS & Bulk sms	Nairobi
Josiah Maina Mwai	MoH	iHRIS	Nairobi
John Kioko	MoH	iHRIS	Nairobi
Francis Gwama	MoH	iHRIS	Nairobi
Jane Ouma	MoH	Bulk Filing /registry officer	Nairobi
Dr. Manasseh	MoH OSH	Technical staff	Nairobi
Dr. Florence Bett	MoD&P	Human Capital/MONDKAL that was absorbed	Nairobi
Rebecca Kiptui	DOMC	Technical staff	Nairobi
Regulatory bodies			
Elizabeth Oyier	NCK	Registrar	Nairobi
Maurice Osano		HR officer - focal person for project on ICB	Nairobi
Prof Julia Ojiambo	KNDI	Chairperson	Nairobi
Joyce Atinda		Acting CEO	Nairobi
Mr. Kisoo	COC	Registrar	Nairobi
Mr. Daniel Yumbya	KMPDB	CEO	Nairobi
KMTC			
Charles Onudi	KMTC	Director	Nairobi
Mary Kanyottu			Nairobi

Contact Person	Institution	Designation	Location
Lucy Kuria		Project focal person - Scholarships	Nairobi
FBOs			
Samuel Mwenda	CHAK	Director General	Nairobi
Patrick Kyallo	CHAK	HR Advisor	Nairobi
Latiff Shabban	SUPKEM		Nairobi
Jacinta Mutegi	KEC	National Executive Secretary	Nairobi
Other Institutions			
Dr. John Munyu	KEMSA	CEO	Nairobi
Stephen Muchiri	Futures Group/HPP	Program Director, Health Policy Project	Nairobi
Dr. Gathari Ndirangu	former Advisor seconded to DRH (now at JPHIEGO's MCHIP)	RH Advisor	Nairobi
USAID/PEPFAR			
Kathy Raleigh	USAID/OPH	Health Officer	
Hanna Dagnachew	Department of State/PEPFAR	Deputy Coordinator	Nairobi
Maxwell Marx	Department of State/PEPFAR	Senior Advisor, Policy & External Relations	Nairobi
Dr. Sheila N. Macharia	USAID/OPH	Senior Health Manager	Nairobi
Daniel Wachira	USAID/OPH	Program Specialist (Malaria)	Nairobi
Camile Garcia	USAID/Kenya	Contracting and Agreement Officer	Nairobi
Development Partners			
Gerald Macharia	Clinton Health Access Initiative	Country Director	Nairobi
Loise Nteere	Global Fund	Secretariat	Nairobi
Arletty Pinel	UNICEF	Consultant	Nairobi
Capacity Kenya Project: Consortium Partners			
Karen Caldwell	MSH	Project Director - LMS	Nairobi
Omar Ahmed Omar	MSH	Deputy Project Director	Nairobi

Contact Person	Institution	Designation	Location
Josephine Mbiyu-Kinyua	MSH	Senior Technical Advisor	Nairobi
Kimani Njoroge	Deloitte	Partner - Human Capital Department	Nairobi
James Nyamosi		Manager, seconded to IntraHealth	Nairobi
Peter Ngatia	AMREF	Director - Capacity Building	Nairobi
Meshack Ndolo	Capacity Kenya/IntraHealth	Project Director	Nairobi
Janet Muriuki		Deputy Director	Nairobi
Linet Oyucho		Technical staff	Nairobi
Mathew Thuku		Technical staff	Nairobi
Michael Ochieng		M&E Director	Nairobi
Sub-national			
Nairobi County			
Dr. Suleh	Mbagathi DH	Medical Superintendent	Nairobi
Gregory Mwinamo	Mbagathi DH	Administrator, CCC	Nairobi
Esther Mbithi	Mbagathi DH	Senior CO/Head of HIV/AIDS Department	Nairobi
Sam Ochola	Nairobi County	County Health Coordinator	Nairobi
Kisumu			
Ms. Benter Oyuko	MoH	HR Officer - Kisumu County	Kisumu
Ann Malubi	MoH	HR Officer - Kakamega County	To be interviewed in Kisumu
Rose Betty	MoH	CH Focal person - Kisumu County	Kisumu
Dr. Lusi Ojwang	MoH	County Health Coordinator	Kisumu
Dr. Misore	APHIAplus: Western	COP	Kisumu
Nakuru			
Dr. Benedict Osore	MoH	Health Director	Nakuru
Dr. Samuel Mwaura	MoH	Permanent Secretary/Chief Officer, Health Services	Nakuru
Jescica Musisi	MoH	HR Officer - Nakuru County	Nakuru

Contact Person	Institution	Designation	Location
Anderson Chelugo	Kimalel HC	CO/in-charge Kimalel HC	Nakuru
Joyce Kemuge	Kimalel HC	KECHN	Nakuru
Mr. Sam Gitau	MoH	Health Executive/Minister	Nakuru
Kitui/Eastern			
Justus Kioko	KMTC Kitui	Principal	Kitui
Bernard Nderitu	KMTC Kitui	Coordinator- Kitui CoE	Kitui CoE
Jemimah Kyalo	KMTC Kitui	Coordinator- Skills lab	Kitui CoE
Lenah Gatuiri	Kyaango Dispensary	RHP- Capacity Hire,	Mutomo District
Eric Mutuiri	Yongela HC	RHP- Capacity Hire,	Mutomo District
Agnes Mualuko	KMTC	Project focal person - KMTC Kitui	Kitui
Mary Awino Anyango	Bumala B demo site	Nursing officer in-charge	

ANNEX D: SURVEY DATA

Table D1: Respondent Perception Regarding the Basis of Capacity Kenya Project's Approach

Answer Options	Response Percent	Response Count
Knowledge	44.0%	91
Behavior	12.1%	25
Policy	75.4%	156
Other (please specify)		9
Answered Question		**207**
Skipped Question		**30**

Table D2: Respondent Perception of CKP Implementation Methods Used to Meet Objectives for HIV/AIDS, RH and FP, MCH, and Malaria; by Percentage of Respondents (Number of Respondents = 237)

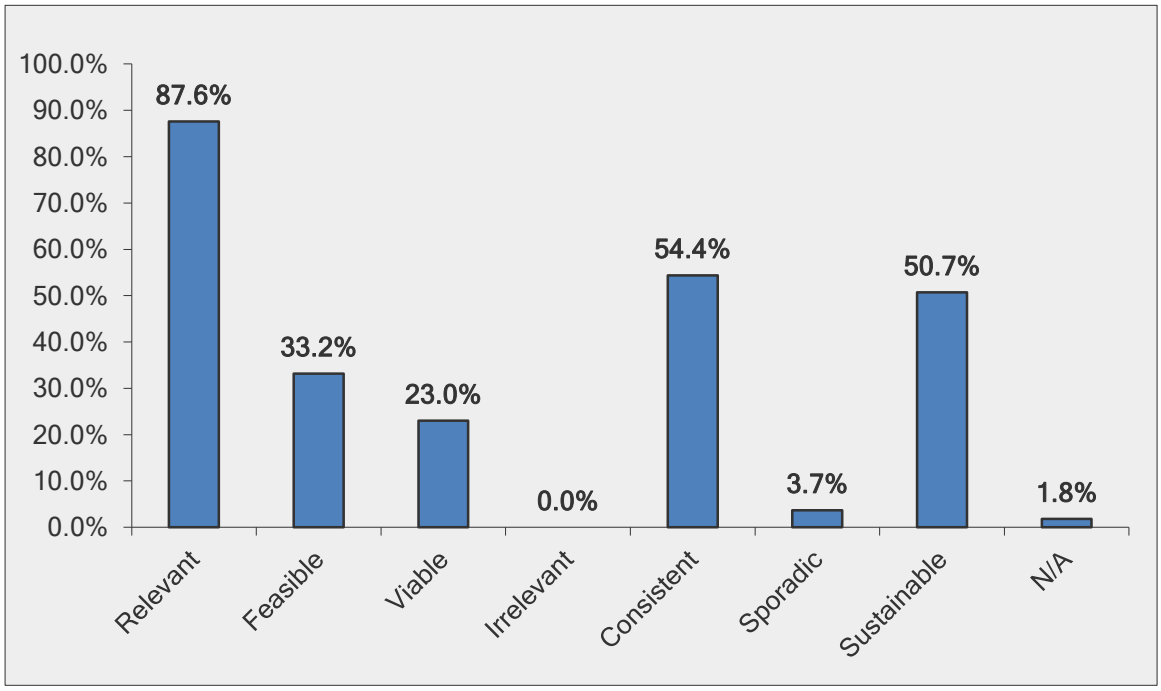


Table D3: Ranking of CKP Effectiveness, by Type of Intervention (Number of Respondents = 237)

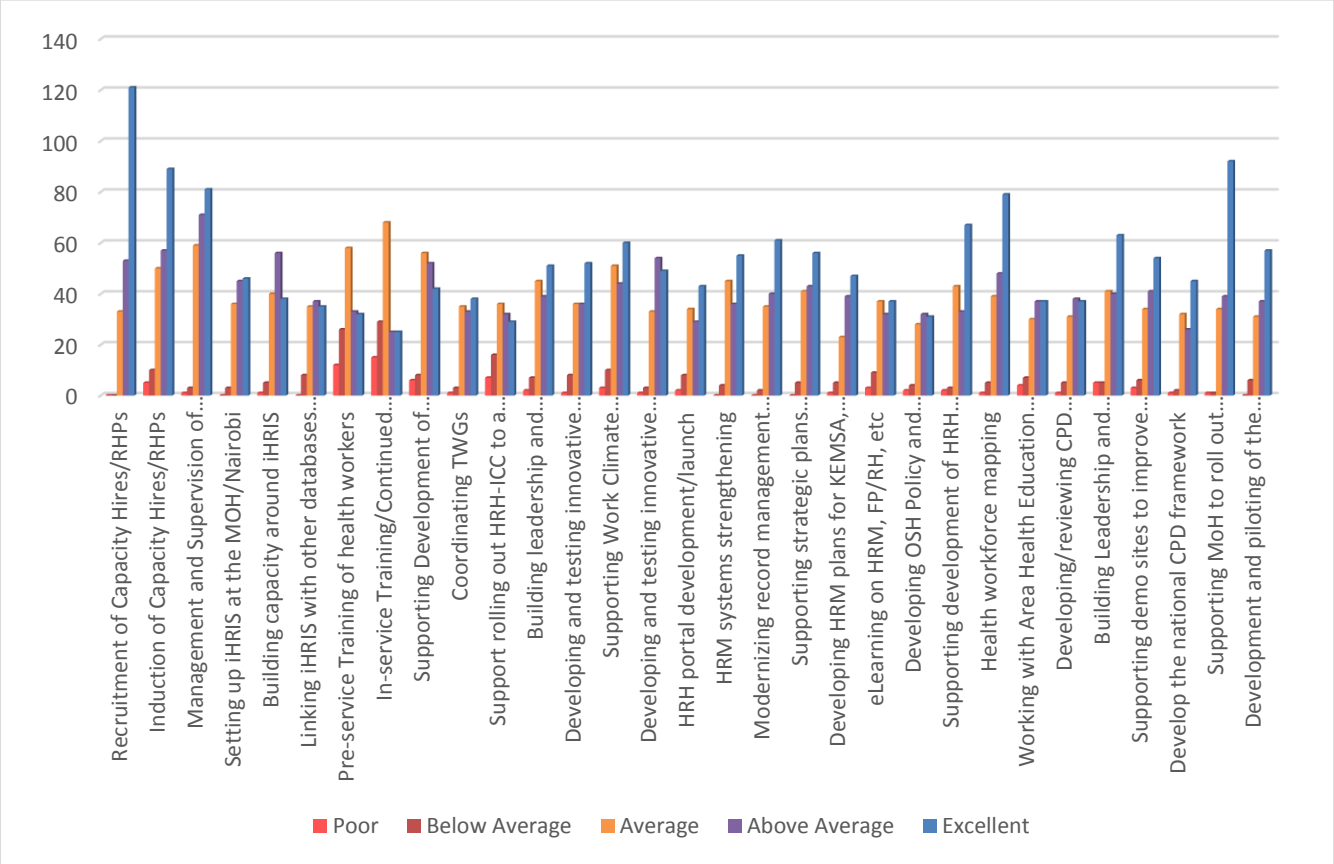


Table D4: Respondent Perception of the Likelihood of Sustainability of CKP Accomplishments (Number of Respondents = 237)

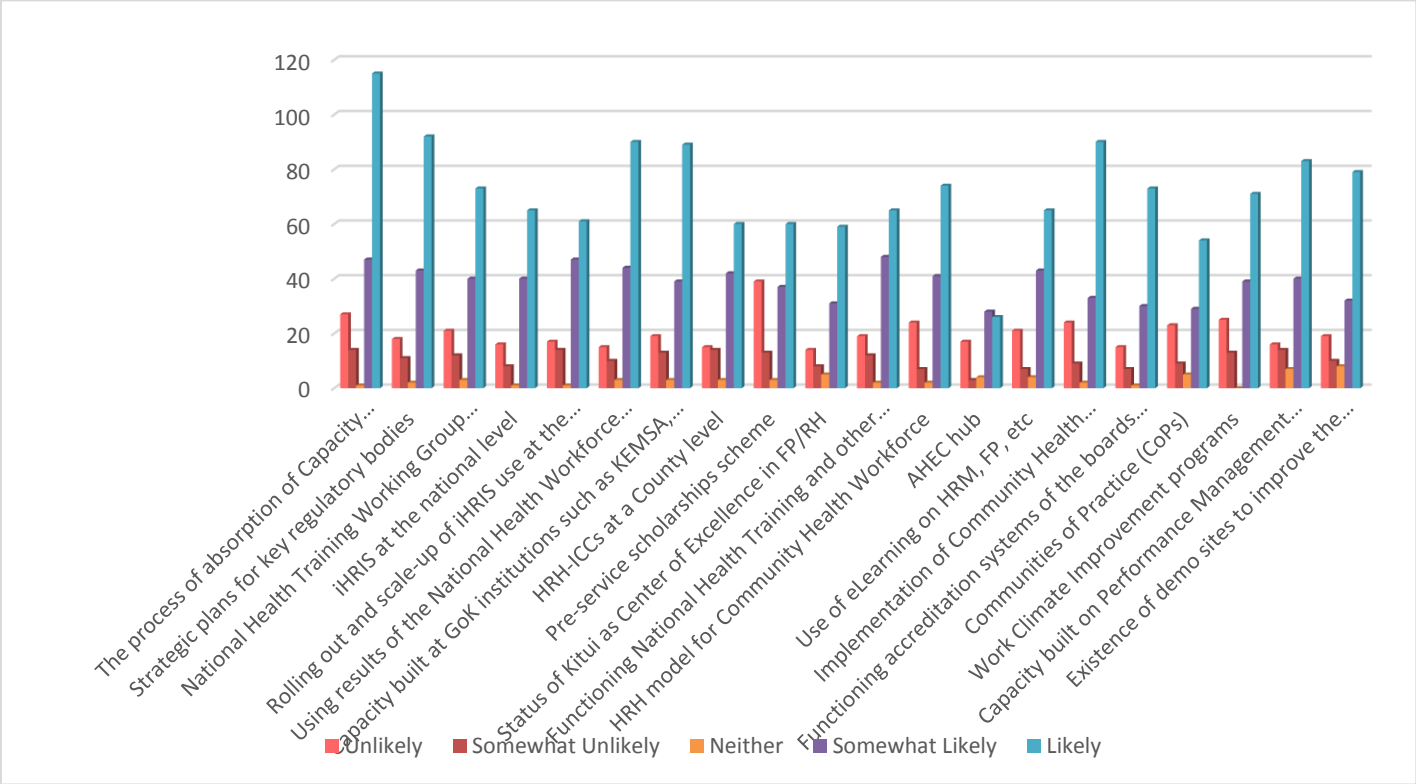


Table D5: Respondent Awareness of Specific CKP Efforts Undertaken to Address Sustainability, by Proportion of Respondents (Number of Respondents = 237)

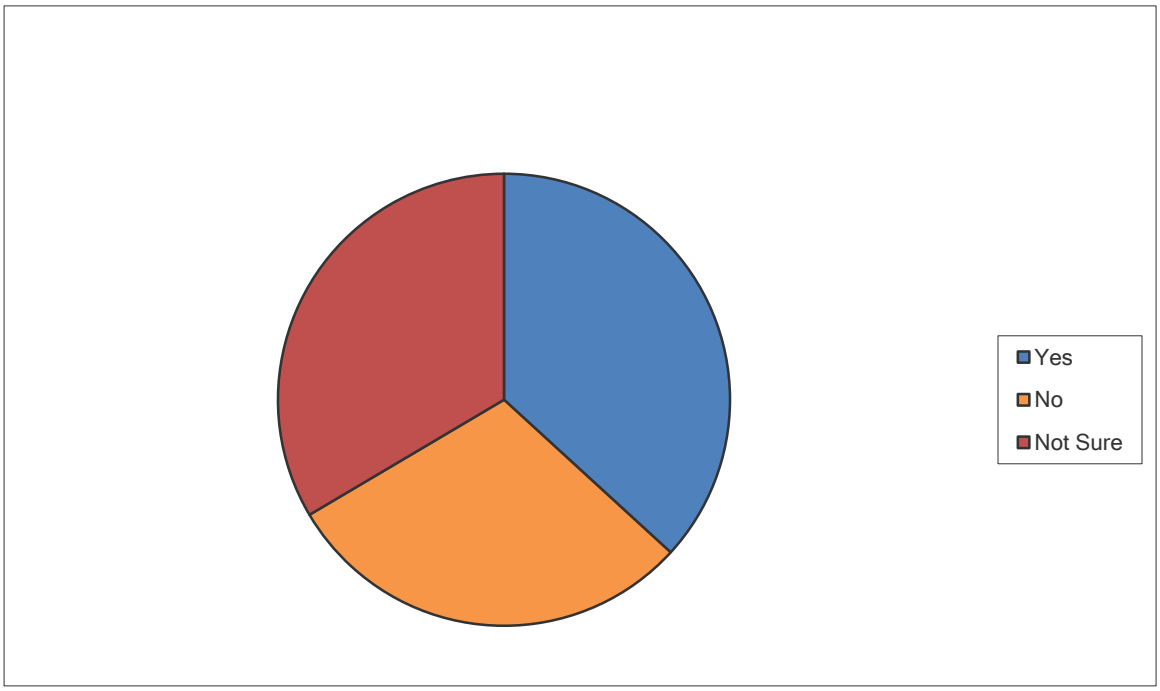
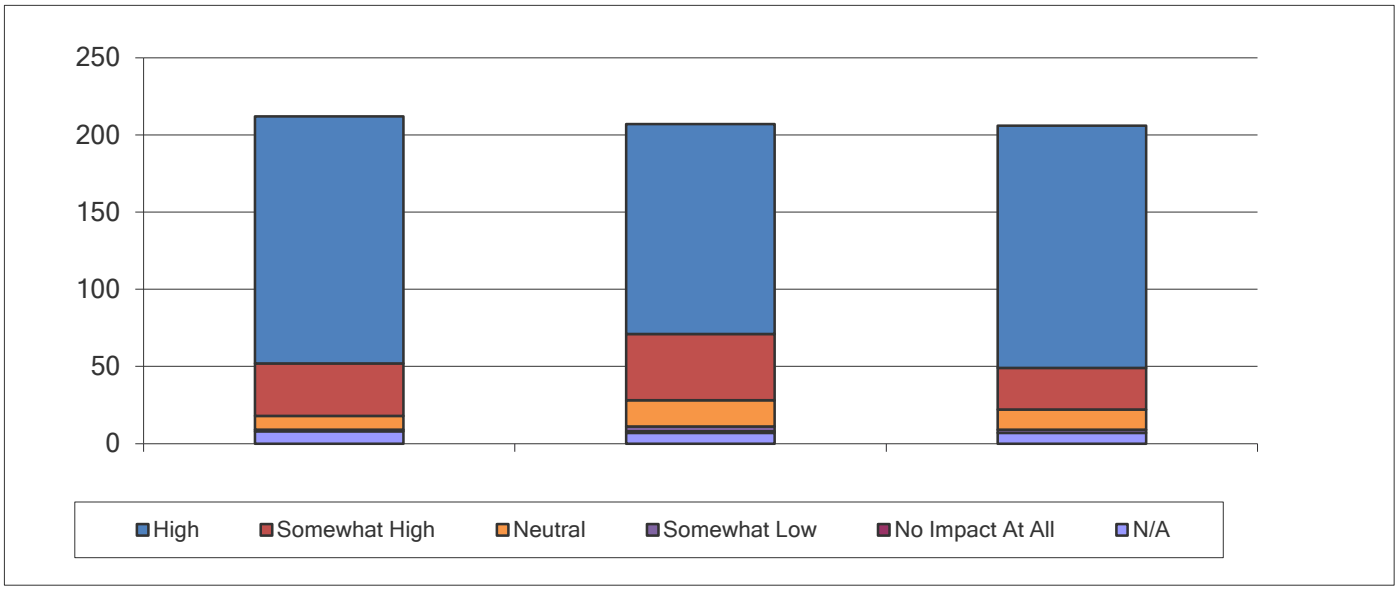


Table D6: Respondent Perception of Overall Impact of CKP, by Respondent Distribution (Number of Respondents = 237)



ANNEX E: EVALUATION TIME-LINE AND SCHEDULE

Timeline:			AGENDA	
November 2013		**Item Group 1**	**Item Group 2**	**Item Group 3**
Washington DC, USA /Nairobi, Kenya: 25-29	Preparation/travel	Document review,	Evaluation/Methodology plan submission to USAID/Kenya	Team Leader's trip from Washington DC to Nairobi
Nairobi: Sat, 30 November		**11am-5p**m Evaluation Team Meeting	**5- 6pm** Debrief with Peter Waithaka, USAID/Kenya at Crowne Plaza hotel	Revision of on Eval Methodology/Plan
December 2013				
Sunday, 1 Dec		Revision of Methodology/Eval Plan	Contacting Key Informants as per contact list provided by Peter Waithaka	Finalization of Data Collection Instruments
Monday, 2 Dec		**10am-12.30**: Meeting with USAID/Kenya and USG team	**3-6pm:** Meeting with Capacity Kenya project team	Update schedule and contact list; review documents
Tuesday, 3 Dec	Data collection	**9.30am** Andrew Nyachoga (formerly MoH, now MOE)	**2pm** Patrick Kyallo (CHAK) Tentatively Sam Ochola (County Health) **3pm** LatiffShabban (SEMPA)	Finalize Evaluation and Methodology Plan
Wednesday, 4 Dec		7.30am Dr. Sharif MoH, USAID/Kenya to accompany 8am Dr. Suleh (Medical Superintendent, Mbagathi)	Mbagathi District Hospital: KIIS: Dr. Suleh (Medical Superintendent) and Gregory; Focus Group Discussion with Capacity Hires at Mbagathi District Hospital	2pm- Kimani Njoroge & James Nyamosi (Deloitte) 3.30pm-Karen Calwell (MSH)
Thursday, 5 Dec		**8am** Sam Ochola (County Health) **10am – 4.15pm** Capacity Kenya staff (Intra Health)	AM: Team departs for Rift Valley Province, Nakuru: Kimalel demo-site visit at Baringo County (FGD with RHP or TAs)	Tentatively Dr. Maurice Siminyu (Bungoma County)
Friday, 6 Dec		**8am** Dr. Soti (MoH) **9.30am** Meshak Ndolo (Capacity Kenya IntraHealth)	**8am-2pm** Hannah Kimemia & team (HRM); FGD with HRIS team **4pm** Gerald Macharia (CHAI)	Noted development, Data coding
Sat-Sun, 7-8 December		Team's return from Rift Valley Region	Data coding, data analysis	Sun: Joseph M. to depart for Nyanza/Western
Mon, 9 Dec	Data collectio	**7.30-9.30am** Interviews at USAID/Kenya with USG team, including PEPFAR team	**2pm** Dr. Mwitari (MoH) **2.30** Elizabeth Oyier& Maurice Osano(NCK)	Fieldwork in Kisumu: At least 5 KIIs;

		8am Louise Nteere (Global Fund) **11.30-12.30:** FDG at APHIA Directors' Meeting	**4pm** Capacity Kenya/MSH team	1 team member to depart to the Kitui
Tue, 10 Dec		**7.30-9am** USAID/Kenya: OPH team; **9am:** Team Leader to depart to Kitui for 1 day	Kitui: KIIs faculty, CEC, KMTC principal; FGDs with students and scholarship beneficiaries	Fieldwork in Busia: KII with Dr. Siminyu with demo site in-charge; FGD with staff.
Wed, 11 Dec		**10am:** Joseph M returns to Nairobi **10.15am** Dr. Munyu (KEMSA) **12-** Meshack Ndolo (Capacity/IntraHealth)	**2pm** Dr. Mwendwaof **(**CHAK) **4.00pm:** Rebecca Kiptui (DOMC) **4-5pm**Lucy Ogoye (MoH)	Mutomo: FGD with CK hires from 3 facilities (CK to confirm), Exit interviews and KIIs; Data coding, data analysis
Thu- Fri, 12-13 Dec		**Thu, Dec 12**- 11am AMREF at Crowne Plaza	Public Holiday; Data coding, data analysis	**Fri, Dec 13 AM:** Team meeting, Preliminary findings development
Sat-Sun, 14-15 December	Data collection, data analysis, work on preliminary report	Team meeting, Data coding, data analysis	Presentation development for debrief with USAID/Kenya	
Mon, 16 Dec		**8am:** Charles Onudi **8am** Lucy Kuria& Agnes Mualuko(KMTC) **9.30-11am:** NASCOP & KEMSA Technical advisors **11am-12.30:** HRH ICC (WHO, DANIDA, DFID, HPP and JICA);	**2pm** PHONE interview with Dr. Anisa Omar **2-3pm** Joyce Atinda and Prof Ojiambo (KNDI) **3.30**Dr. Florence Bett **(**Capital/MONDKAL) Tentative Mr. Kisoo (COC)	Tentative PHONE interview with RHP in Kitui **(NJERI to follow-up**) Data analysis and triangulation; Presentation development for debrief with USAID/Kenya.
Tue, 17 Dec		Data analysis and triangulation;	**1-3pm:**Feedback meeting/outbriefing to USAID/Kenya; KIIs in Nairobi (TBD);	Team meeting **10pm:** Team Leader departs for Washington DC
18-31 Dec		Remaining data collection in Nairobi	Final report development: Nairobi & Washington DC	
January 2013				
Washington DC, USA /Nairobi, Kenya		Draft submission to USAID/Kenya	Incorporate feedback from USAID/Kenya; Final Evaluation Report Submission	End of project debrief: remotely with potential participation of Kenya-based consultants

ANNEX F: SELECTED DATA COLLECTION AND RESPONDENT INTERVIEW INSTRUMENTS

F1: KII QUESTIONNAIRE GUIDE

STATEMENT OF VERBAL CONSENT

Dear Participant,

Hello, I'm _____. Thank you for volunteering to take part in this study to evaluate the Capacity Kenya project, aimed at finding out how well the program has been meeting the needs of outside partners/personnel like you. In order to record your participation in the CKP's final evaluation, we must have your permission.

This interview should not take more than 45 minutes to complete. We can discuss any concerns you may have during your interview.

KII is a personal discussion and other than the interviewer and a note taker, no-one else but the interviewer will be present unless you would like someone else there. The recordings of your verbal responses will be used for analysis only, and will not be distributed beyond the evaluation team. We will not identify your name and link to any quotes in any public reports summarizing the findings of these interviews, unless you request this. A list of all interviewees will be included as an annex except for anyone who does *not* wish to disclose his or her status but prefers to remain anonymous.

The report will be completed in January 2013, and will be circulated to the Capacity Kenya Project team, USAID/Kenya and PEPFAR team/Kenya, and other stakeholders shortly after that. If requested, it will also be shared with all those who are interviewed.

Participation in this survey is voluntary and you can choose not to answer any individual question or all of the questions. However, we hope that you will participate in this interview since you have valuable insight into the program. We may want to contact you again in the next several days to confirm information.

I have had the study explained to me. I have understood all that has been read/explained and had my questions answered satisfactorily. I understand that I can change my mind at any stage and it will not affect me in any way.

I AGREE FOR THE INTERVIEW TO BE RECORDED
_____YES / NO

Would you like to participate in this interview? If face-to-face: Have them sign and leave a copy of this form with THEM).

RESPONDENT _____AGREES TO BE INTERVIEWED YES / NO

DATE _____DEC, 2013

(name printed)

I have followed the evaluation SOP to obtain consent from the participant. S/he apparently understood the nature and the purpose of the study and consents to the participation in the study. S/he has been given opportunity to ask questions which have been answered satisfactorily.

Designee/evaluator's signature: _____

DATE _____DEC, 2013

NAME 1 Male 2 Female
DESIGNATION
PERSONAL EXPERIENCE

I would like you to talk a little about your own involvement with Capacity Kenya Project during the life of the program. Please tell me what **you do** for CKP (e.g. activities) and what are the activities have you been involved in?

1. PROJECT PERFORMANCE: EFFECTIVENESS AND EFFICIENCY

1.1 Are you familiar with CKP goals and objectives? IF YES, to what degree has CK project been effective in achieving them?

1.2 Did the CKP use results-based approach in order to meet the objectives? Was *knowledge/behavior/policy* the basis of this approach?

1.3 Was the CKP design and implementation approach based on common sense and clear logic? Any challenges that the implementation approach may be causing? *Examples of negative consequences?*

1.4 Where implementation methods feasible in meeting the objectives *in areas of HIV/AIDS, RH and FP and maternal and child health, and malaria?* Any concrete examples?

1.3 What challenges has the CK project faced in implementing its activities? Could they have been avoided?

1.4 Do you believe the capacity of CKP staff was adequate for implementing CKP activities (technical knowledge; analytical depth)? IF NO, please explain.

1.5 Have they been effective in THEIR RESPONSE TO Q1.1?

ADD DEPENDING ON KEY INFORMANT'S DESIGNATION:

- *Engaging with (INFORMANT'S ORGANIZATION)?*
- *Engaging the different stakeholders, especially the GoK and other strategic donors?*
- *Training health workers, including nurses, to fulfill their responsibilities?*
- *Building capacity of local organizations, government departments, and other private sector partners?*
- *Coordinating National Health Training Working Groups*
- *Developing and testing innovative financing strategies in HRH*
- *Developing and testing innovative RHP recruitment model to mobilize health workers for USG partners and GoK*
- *Supporting DOMC to align to the devolved system of government?*
- *HRH portal development/launch*
- *Modernizing record management system (in line with MSPS guidelines) and communication strategies*
- *Hosting and developing action plans after HRH conference*
- *Developing HRM plans for KMESA, NASCOPP, NCK and COC*
- *Developing OSH Policy and implementation plan for MOMs/MOPHS*

- *Health workforce mapping*
- *Working with Area Health Education Centers (AHECs)*
- *Developing/reviewing CPD accreditation standards/guidelines for the NCK*
  - *Rolling out HRIS across the country*
  - *Designing the governance structure for the AHEC hub*
  - *Undertake a study to document the experiences and lessons learned in working with PLWHAs (Nyanza?)*
  - *Identify modalities of transitioning to APHIAPlus, the innovative approaches in working with community support groups.*
  - *Implementing the student tracking tool and document lessons learned to expand the scholarship program*
  - *Supporting MoH to roll out Ministerial Performance Contracts to the lowest level*
- *Establishing a functional coordination mechanism for the National Health Workforce Awards Scheme.*
- *Developing a package of interventions to implement a simple rewards and sanctions scheme at the sub-national level*
- *Complete the development and piloting of the HRM Professional Development Module for health managers*
- *Developing and implementing the student tracking tool*

1.6 To the best of your knowledge, what groups of people have benefited the most from CKP, think both of direct and indirect benefit (skills, resources, etc.)? WHY?

LISTEN FOR RESPONSES AND PROBE IF NECESSARY.

- *Health service providers (RHPs, VCTs, etc.) (BY CADRE for online survey, from page 12)*
- *CHWs*
- *Pre-service trainees*
- *PHTM*
- *PLWHAs*
- *FP clients*
- *Pregnant women and children under 5*
- *ANC clients*
- *Communities (list to be filled during evaluation launch)*
- *Other:*

1.7 Do you think CKP treated/ served equally?

• *Male and Female staff*	*Yes*	*No*
• *Male and Female beneficiaries*	*Yes*	*No*
• *Different ethnic groups*	*Yes*	*No*
• *Different age groups (Youth, elderly, etc.)*	*Yes*	*No*

IF the respondent says NO to any of the four categories above, ask them to explain why they said No, and write their answer below. Any other equity issues?

1.8 How has the relationship between CKP and GoK worked during the life of the project? Any concrete examples of engagement?

1.9 How has the relationship between CKP and FBOs and private sector Health providers worked during the life of the project? Any concrete examples of engagement *(positive and negative)*?

What about other donors and stakeholders?

- DFID
- Clinton Health Initiative
- World Health Organization
- DANIDA
- APHIAplus
- Others

2. RELEVANCE

2.1Do you think the CKP addressed the needs of targeted beneficiaries (CONFIRM THAT, during the life of the CKP was developed and in the way services were delivered? IF NO, ask Why do you think so?

2.2 Which do you think were the most useful and beneficial components of CKP? Were there any that were not as useful?

PROBE IF NECESSARY

- *Innovative approaches supported for PLHAs, Youth, Women and Health Corps focusing on HIV prevention, care & treatment*
- *Capacity building in HRH planning and management (GoK, for-profit and not-for-profit) institutions*
- *TA with developing HRH policies, guidelines, budgets developed and monitored and advocacy conducted*
- *HRIS*
- *TA establishing a unit within GoK for HRH planning, budgeting, policy development and coordination*
- *TA at 4 key agencies Kenya Medical Supplies Agency (KEMSA); DRH, NASCOP – Antiretroviral Treatment and NASCOP – Nutrition*
- *Costing of the National Health Training Policy (NHTP);*
- *Development of core curriculum guidelines for pre-service and in-service training in close consultation with COC and KNDI*
- *Finalization of the procurement and delivery of Kitui KMTC skills lab equipment and material*
- *Refining the Curriculum for a Generic HRM Course for Supervisors at various levels of the health system.*
- *OTHER: TBD*

2.3 Did the project employ current and relevant methods for addressing the HRH issues in Kenya?

2.4 Was project relevant within the current HRH policy landscape in Kenya? How does the CKP project's approach align with the priorities of the GoK, and how far/well has the program helped to achieve those priorities? Examples?

2.5 (USG team) What about the priorities of the USG/Kenya teams?

- USAID new health implementation framework?
- PEPFAR Partnership Framework and HRH technical consideration?

(FOR CKP staff and USG) Any challenges faced while aligning to the current landscape both for donor (USAID) and government?

2.6 Have the CK project activities complement with the priorities of other international and bilateral donors? Were they well integrated were program activities with those implemented by others?

- DANIDA
- Clinton Health Initiative
- WHO
- GTZ
- United Nations
- Other?

2.7 If a similar project was developed, what should be the focus interventions? Why?

2.8 At which level should activities be implemented (county or national)? Please propose specific activities that such a project could implement at the county/national level.

3. SUSTAINABILITY

3.1 What do you think would happen to CKP accomplishments? Do you believe they would stay after CKP is over? Please comment on which results are most likely to sustain after the program (likely, not likely and why?).

- *Hosting alongside the MoH the first annual HRH Conference in Kenya;*
- *Development of strategic plans for key regulatory bodies;*
- *Supporting National Health Training Working Group (NHTWG).*
- *National Health Workforce Mapping exercise*
- *Modernizing MoH records and support for the MoH's registry through implementation of a Bulk Filing System*
- *Capacity built at GoK institutions such as KEMSA, NASCOP and DRH.*
- *Providing pre-service scholarships scheme*
- *National Health Training and other Technical Working Groups*
- *AHEC hub*
- *Skills obtained in Information Communications Technology (ICT) trainings*
- *Use of checklist and evaluation tool for assessing training institutions compliance to the guidelines.*
- *Functioning accreditation systems of the boards and councils (NCK, CoC, KMDPB), National Nurses Association of Kenya (NNAK)*
- *Communities of Practice (CoPs)*
- *Pre-Service and in-service scholarships: During the period under review, fees payment for the sixty students/entrants to the scheme was completed.*
- *Fellowships in emerging areas such as public-private partnerships and ICT*
- *Worker productivity and retention in project-supported regions*
- *Design a skill-building program on Performance Management for Health Leaders.*
- *Implementing the student tracking tool and document LLs to expand the scholarship program as part of sustainability measures*

3.2 Were there specific efforts has CKP undertaken to address the issue of sustainability in project activities? Do you believe there are mechanisms in place to ensure smooth transition and continuously addressing human capacity development issues—in HIV /AIDS, TB, Malaria, RH/FP management?

- Local institutional capacities/ systems (e.g., supportive leadership)
- *Stakeholders readiness to continue supporting or carrying out specific programme/project activities/ replicate the activities in other regions or sectors of the country; adapt programme/project results in other contexts*

3.3 Is there a place/role for [ORGANIZATION] in implementing activities after CKP ends? IF SO, what is it?

4. LESSONS LEARNED FOR FOLLOW-ON DESIGN

4.1 (FOR CKP staff and USG only) What mechanisms were put in place for tracking and documenting any lessons that were learned in the life of the project?

4.2 What unexpected events/circumstances, positively or negatively affected the success of CKP activities?

4.3 What unintended effects of the CKP have you noticed? We are thinking of surprising effects – things that were not initially planned or expected to be results of CKP? What would you consider to be viable solutions to challenges faced by the project?

4.4 To finalize, what do you think was the overall impact of CKP on:

- (Strengthening and institutionalizing) HRH strategies, plans policies and practices at national and provincial/regional levels to enable an increase in number of health workers and promote the provision of quality services;
- Improved opportunities for addressing the knowledge and skills needed by workers at all levels, including community for provision of quality services;
- Introducing work force performance system to improve productivity and retention for the delivery of HIV/AIDs, FP/RH, MCH, malaria and TB services.

4.4 What lessons were learned that should be considered by donors in designing future strategies and programs?

F2: FOCUS GROUP DISCUSSION GUIDE FOR CAPACITY HIRES

District ……...…Office/Facility/Site……..

Date (day/month/year):____/____/____ Time focus-group discussion began: _:____

Name of facilitator: _____Time focus-group discussion ended: ___:____

Name of recorder: _____:_____

Gender of group: male: _5____ female: __5____

A. PROJECT PERFORMANCE: EFFECTIVENESS AND EFFICIENCY

1. How did you become a Capacity Hire? Why?
2. What was your experience being hired: successes/challenges? Was the CKP approach to hiring process based on logic, and knowledge of the situation on the ground? Any discrimination issues: gender, ethnicity, religion?
3. Do you believe the capacity of CKP staff was adequate and efficient? (PROBE IF NECESSARY)
   - *handling your recruitment*
   - *induction process once you were hired*
   - *providing training opportunities to fulfill your responsibilities*
   - *responding to your concerns, advocating on your behalf (loans, absorption by GoK, counties, health insurance)*
   - *ensuring conducive working environment as per OSH (Occupational Safety and Health) policy*
   - *providing updates/ongoing communication (by SMS)*
   - *handling your file*
   - *Etc.*
4. What has been your experience with the use of time-sheets: positive and challenges? And overall remuneration structure/salary?
5. Have you gone through performance appraisal and what was your experience?
6. Do you receive supportive supervision? Who handles it and how? What has been your experience?
7. What has your relationship been with GoK staff in the hospital in similar position? What about administrative, financial staff and management?

B. MOTIVATION AND RETENTION

8. What have been the incentives to stay in your position? What is your exit strategy at the end of your contract when Capacity finishes?
9. Do you feel motivated? What are ways would help improve your motivation as you play your roles in the project as a capacity hire.

F3: KEY EVALUATION QUESTION SCALE

Evaluation focus and domain	Evaluation Questions	Examples of Ratings System	Scale Notes
1. Project Performance (Effectiveness and efficiency)	What is the progress of the CKP towards achievement of the specific project objectives and OPH's objectives?	3 = Estimated at more than 70% allocation. Progression occurs directly and systematically from problem analysis> 2 = Allocation estimated at50-70%. Reasonable progress and indicative trend 1 = Estimated at less than50%allocation. Progression circumstantial and inconsistent.	*"to what degree"* requires a scale of efficacy.
	Did the CKP demonstrate technical knowledge; analytical depth; and a logical, results-based approach in order to meet the objectives of the project?	3 = All program activities have a logical and deliberate designation and almost all staff have the required knowledge 2 = More than half the program's actions have a logical and deliberate designation and some staff have the required knowledge 1 = Less than half the program's actions have a logical and deliberate designation and limited staff (less than½staff) have the necessary skills.	
2. Relevance	Did the project employ new state-of-the art methods for addressing the HRH issues in the country that are based on a clear assessments of knowledge and behavior?	3 = Almost universally CKP relied on assessments of knowledge and behavior to employ state-of-the art methods for addressing the HRH issues 2 = Evidence of reliance on assessments of knowledge and behavior to employ state-of-the art methods for addressing the HRH issues in half of the instances 1 = Limited evidence of using assessments of knowledge and behavior to employ methods for addressing the HRH issues	*"relevance"* needs context to identify and prioritize salient issues for GoK and USG.
	Did the project employ feasible and realistic strategies for meeting each of the objectives in the areas of HIV/AIDS; RH, FP, and MCH; and malaria?		
3. Capacity Building and Technical Assistance; Sustainability	To what extent has the program built capacity of local organizations, government departments, and other private sector partners?	3 = Almost universally the capacity has been built 2 = CKP has contributed to selected capacity building 1 = Limited examples and instances of capacity building	"*sustainability"* requires a timeline to account for effects outside the control of program, beneficiaries, donors. (Sustainable Development):
	To what extent have other sustainability efforts have been made?	3 = Most of the activities that are developed for continuity can be absorbed and continued at minimal cost or	

		investment in training , upgrading equipment , change in existing conditions. 2 = Some of the activities developed for continuity can be absorbed by another entity, but would require a moderate cost or the investment in training , upgrading equipment, change in existing conditions. 1 = Few activities developed for continuity (e.g. , non-food aid) can be absorbed by another entity without significant cost or investment in training, upgrading equipment , change	The activities may continue beyond the life of the project without total dependence on external input and a level of quality, which does not compromise the well-being of man, the environment or institutional performance.
4. Lessons Learned and Follow-on design	What were specific challenges, obstacles, and lessons learned in the implementation of the project?	3 = CKP has engaged systematically and is almost fully aligned with the scale and scope both with the priorities of the GoK, USG, etc. 2 = Semi-consistent and productive engagement with stakeholders and alignment of CKP design and activities with their priorities 1 = Limited engagement and CKP design and implementation less than half aligned.	*"lessons learned"* should be articulated in relation to the other categories.
	To what extent has the CKP engaged the different stakeholders, especially the GoK and other strategic donors?		
	What are the current HRH gaps at national and county levels?	3 = Changed the level of performance by more than half of the results (positive or negative). 2 = Changed the level of performance of about half of the results (positive or negative). 1= Do not change the level of achievement over a quarter of the results (positive or negative).	
	What approaches should USAID adopt in designing the follow-on project?		
	What opportunities and assumptions can be considered in supporting HRH management systems in the devolved systems?	3 = Significant amount of consequences side and in all aspects (positive or negative). 2 = Only some consequences/secondary result and not in every aspect (positive or negative). 1= No consequence/result secondary areas (positive or negative).	

F4: EXIT INTERVIEW QUESTIONNAIRE

CLIENT CONSENT

Hello, my name is _____. Thank you for agreeing to participate in this study and to answer a few questions aimed at finding out about the services that you've been receiving here at _____ (*facility name*), and how well the program has been meeting the needs of clients like you.

This interview should take about 10-15 minutes to complete and your participation is voluntary. You can choose not to answer any individual question or all of the questions; you can change your mind at any time and withdraw. This will not affect your ability to receive health services at this facility. However, we hope that you will agree to participate in the interview since your views will be of benefit to the USAID and GoK I will not record your name, or quote you in any public reports…..
We can discuss any concerns you may have during your interview.
Do you agree to participate? Yes agree _____ No, don't agree _____

Date of interview: __Dec___2013_____
Facility: _____
Interviewer _____
Region: _____

Background information:

How old are you? _____ *(record age in years)*
Gender *male* _____ *female*_____

1) What was the **main** service that you came for today?
   - FP
   - ANC
   - MNCH
   - Curative
   - HIV/AIDS related services (VCT, CCC etc.)
   - Other: _____
2) Did you receive the service(s) that you were seeking today? Yes____ No ___
   Was referred _____
   (If NO, reason (s) why not)
3) Do you think the time you waited in the queue before first seeing a provider was acceptable, or it was too long? *(Circle response)*
   Acceptable Too long
4) In general, how would you rate the services that you receive at this facility? Would you say they are (*Circle response*):
   i. Very good ii. Not satisfactory
   iii. Good iv. Poor
   v. Satisfactory vi. Very poor

   (Ask about rating for the possible different services client has received over this period of time)
   Why do you say so?

5) How long have you been seeking health services in this facility? _____ *(months/years)*
   Do you remember the first time? _____ *(months/years)*

6) If you think back to the first time you visited this facility seeking health services , how would you describe/rate the quality of services that you have received (progressively) over the last _____ *(number of years stated)*? Why do you say that?

_____
_____

OR

Briefly, how would you describe the quality of services that you have received in this facility/in the community over the last _____ *(number of years stated)*?

Probe for:

i. Participant's views on the different types of services (if s/he has received more than one type of service over the time they've been coming to the facility for health services)

ii. Which services/what aspect of service provision has changed over the years? (attitude of staff, waiting time, availability of (better) facilities, commodities etc.)

iii. If there has been additional types of health services offered to clients/community members over this time [outreach services in the community e.g. FP, immunizations/child welfare] etc.

_____
_____

Thank you very much for your time. The information you have given is very useful for us.

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