# Final Report of a Learning Assessment of the Health Governance Programme

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## List of Acronyms

| | |
|---|---|
| ANC | Antenatal Care |
| CA | Christian Aid |
| CAB | Christian Aid Bangladesh |
| CAK | Christian Aid Kenya |
| CDF | Community Development Foundation |
| CHF | Community Health Framework |
| CHV | Community Health Volunteer |
| CHW | Community Health Worker |
| DFID | UK Department for International Development |
| EQs | Evaluation Questions |
| F2F | Father to Father |
| FGD | Focus Group Discussion |
| FGM | Female Genital Mutilation |
| GoK | Government of Kenya |
| HG | Health Governance |
| HERAF | Health Rights Advocacy Forum |
| HSD | Health Service Delivery |
| HSS | Health Systems Strengthening |
| IGA | Income Generating Activity |
| IRCK | Inter-religious Council of Kenya |
| KENERELA | Kenya Network of Religious Leaders Living with or Personally Affected by Aids |
| KII | Key Informant Interviews |
| M2M | Mother to Mother |
| MCA | Member of County Assembly |
| MCH | Maternal and Child Health |
| MDG | Millennium Development Goal |
| MoH | Ministry of Health |
| NCCK | National Council of Churches of Kenya |
| NEPHAK | The National Empowerment Network of People living with HIV/AIDS in Kenya |
| NIDP | Narok Integrated Development Programme |
| PPA | Programme Partnership Arrangement |
| PLWD | People Living with Disabilities |
| PLWHA | People Living With HIV/AIDS |
| PNC | Postnatal Care |
| SBOF | Social Budget Observatory Frameworks |
| SIR | Social Intelligence Reporting |
| SRH | Sexual and Reproductive Health |
| TBA | Traditional Birth Attendant |
| TOC | Theory of Change |
| TOR | Terms of Reference |
| TRDP | Transmara Rural Development Programme |

# Executive Summary

## 1. Overview / Context

While Kenya has the potential to be one of Africa's great success stories, it has challenges with poverty, inequality and governance. Only a few of the Millennium Development Goals have been met and progress on improving maternal Health (MDG 5) has been very slow. A major positive change has been the new constitution, which provides for a right to health and considerably strengthens rights for women. At the same time, Kenya is in the midst of implementing the highly ambitious devolution process, which is proving very challenging.
Within this context, over the last few years, Christian Aid Kenya (CAK) has changed the focus of its health programme from health service delivery towards health governance (HG). This change has been driven by recognition that continuing to plug holes in public health service delivery is not sustainable, and unlikely to improve overall health outcomes for poor and vulnerable groups without also building communities' capacity both to participate in and influence the health decisions that affect them, and to hold government accountable for delivering on its obligations.

CAK's health programme is delivered through ten partner organisations, six of which operate as implementing organisations at local / county level, and the other four as advocacy specialists principally at national level. Programme content includes general community health; maternal and child health; HIV, malaria and TB; and sexual and reproductive health, as well as multi-level advocacy and rights / gender awareness training.

## 2. Purpose of the evaluation

Kenya is one of five country studies being carried out as part of an organisational assessment of Christian Aid's (CA's) work on accountable governance. The purpose of the evaluation of Kenya's health governance programme is to identify specific 'governance' approaches; generate evidence of programme impact; and assess the challenges, dynamics, and strategies for success in transitioning from a programme focused mainly on community health service delivery to a programme focused on health governance.

The study is framed around the following **evaluation questions**:

1. How does work on social norms, equitable institutions and health service delivery/systems strengthening interact to bring about improved health outcomes for the poor? What is the balance between these different aspects?
2. What is the role of women, what can we learn about women's participation, what can we learn about working politically – and how this looks different for men and women, (and other grouping - e.g. PLWHA, women in SRH and MCH projects?
3. How has the local programme implementation linked up with national advocacy processes?
4. How have power relations between community, partners and government institutions shifted through our work, what can we say about the quality of engagement with government institutions, or other relevant bodies?
5. What has changed in how partners understand their role and approach in governance work, what 'added value' do they identify through the approach and our engagement/support?
6. Document how PPA strategic funding has impacted on the evolution of the Kenya program from a community health focused project to broader health governance programming.

## 3. Methodology

In conducting the five country studies, Christian Aid were keen to pilot innovative evaluation methodologies with potential to be used in future evaluations of its programmes. In order to "capture the nuance and complexity of the programme, alongside identification of key areas of success and change", Christian Aid proposed a theory-based evaluation methodology for the study. In response, INTRAC developed a theory-based evaluation methodology, incorporating contribution analysis. A separate methodological guidance document has been produced, which outlines the methodology in more detail (Annex C).

CAK purposely selected two field sites for the evaluation in Kaimbu and Narok Counties, where focus group discussions were held with community members. These were complemented by partner workshops and individual interviews as well as document review. One INTRAC consultant worked alongside a regional CA staff member seconded as a peer reviewer, with the aim of strengthening evaluation capacity within CA as well as analysis and sense-making capacities within the assessment team.

The following **limitations** apply to the study:

- Overall, CAK's Health Governance programme is quite complex and varied and the evaluation was only able to investigate some of it in any detail (e.g., there was little focus on programme elements supporting People Living with HIV / AIDS).
- As the evaluation methodology used in this study relies on a testable Theory of Change (ToC), and existing ToCs that had been developed over the years lacked sufficient specificity, a more robust ToC had to be developed and validated through an iterative process throughout the study visit to Kenya. This reduced time available for field work and analysis.
- The evaluators were not able to meet with any county/national health officials, or other NGOs delivering health programmes in nearby areas.

## 4. Overall findings

*Transitioning from health service delivery to health governance*

A number of key issues have acted as both carrots and sticks to stimulate the shift in CAK's health programme from traditional health service delivery to one that combines health system strengthening, health governance and work on social norms. Principal among these drivers was: recognition by CAK that continued funding of health service delivery was unsustainable; weaknesses in Kenya's health policy implementation and service delivery; and changes in CAK's programme funding streams that stimulated new thinking.

The transition has progressed well, with all three components (health systems, health governance and social norms) included across the programme, although these manifest differently across projects, depending on how long they have been in existence and what is appropriate to particular community contexts. That said, the transition is still on-going; health service delivery / system strengthening are still the strongest elements, while the emphasis on governance aspects of the programme is patchier and implementation is not yet delivering planned health and equity gains.

There is evidence that some health outcomes are improving (for example, for mother and child health in Narok) but CAK's cessation of funding for straight health service delivery has also created some voids in partner programmes and short term dissatisfaction among communities.

*Governance Approaches*

While CAK's health programme has shifted to be more focused on health governance, it has continued to concentrate on the community level as its main entry point. Here, the focus is on stimulating demand for health rights and accountable service provision through a number of participatory mechanisms. However, with the exception of one or two specific national policy advocacy campaigns, there is little or no focus on strengthening the supply side directly (only by using demand strengthening as a driver).

Apart from some national partners sometimes using local partners to mobilise communities, few specific collaborative advocacy activities involving both CAK's local and national partners seem to be happening yet. The roles of local partners have changed more than at the national level, and local partners capacity and confidence to engage in advocacy seems to have been much enhanced (principally through training from national partners and one or two local advocacy successes). However, the in-flux nature of devolution implementation is having a significant impact on all the health governance work, with all partners generally still quite unclear about how, through who, and where to best affect change.

*Power shifts*

There is evidence of positive power shifts at household level, between genders, and from government to community. CAK has done some very useful power and gender analysis work but this doesn't always seem to be included or acted on sufficiently well to achieve desired governance and health outcomes. While CAK partners are genuinely trying to empower communities, there is evidence that some partners are continuing to 'represent' communities instead of putting more emphasis on empowering them and strengthening their voice to represent themselves - though this issue is recognised. Equally importantly, county-level interaction with government is progressing but engagement is perhaps not initiated by partners / communities early enough in project cycles.

*Gender*

The role of women in Kenya is quite varied across urban and rural areas, and different ethnic and age groups. In general programme interventions are being targeted separately for women and men, especially where social norms are likely to strongly influence outcomes. However, gender targeting is mostly focused on health service delivery / HSS and social norms, with relatively less on other governance aspects of projects (i.e. rights training and empowerment activities are quite limited in scope). Additionally, it seemed that other vulnerable groups (for example, those with disabilities) and /or different age groups (especially younger people) are not currently being consciously targeted.

*Added Value of CAK and PPA Funding*

Overall, CAK, partners and evaluators agree that the transition to a HG-focused programme has been a 'game changer!'. CAK's focus on HG and its support are clearly appreciated by partners. Although advocacy actions have yet to reach full potential, the programme has enhanced partner capacity and confidence to engage in advocacy issues. More generally, it has attracted further resources and build new partnerships; and has the potential to be replicated.

Much of this is due to the influence of PPA funding with its emphasis on sustainability, which has also enabled new national partners to be brought on board and the piloting of interventions that were subsequently funded by others.

## 5. Impact of CA's HG Programme on Health Outcomes (So Far)

To assess the impact of CAK's HG Programme on planned health outcomes, the evaluators used a retrospectively reconstructed ToC to explore: what changes CAK's intervention intended to contribute to; to what extent implementation happened as intended; and what evidence there is that short- and medium-term changes materialised in the way predicted. Using contribution analysis, the evaluators identified, examined and eliminated alternative explanations for causes of change, to build a credible narrative of what CA's contribution has been to changes. (A fuller explanation is contained in the accompanying methodological guide - see Annex C.)

The analysis of the ToC found that links between the planned programme inputs and outputs to the expected immediate / intermediate outcomes (the results chain) have relatively strong logic, with one result clearly linked to the next. However, a number of assumptions were originally not clearly articulated, or have not held, or have held only partially. These principally relate to expectations of government not being fulfilled.

Interventions were generally implemented as planned, but with some inconsistency and patchiness.

The evidence of short and medium term changes materialising was mixed (not unexpectedly, generally strongest at lower parts of the results chain (immediate outcomes) and weakening at higher levels (intermediate outcomes). – see table below.

| | | |
|---|---|---|
| **Intermediate Outcome** | Health policies, plans and budgets are responsive to the needs and priorities of communities | Some evidence of only a few positive results (e.g. staff being allocated). |
| **Intermediate Outcome** | - Communities meaningfully engage in advocacy | Patchy evidence of mixed results. |
| | - Increased demand for health services | Good evidence available for most services, though more mixed results for some e.g. family planning. |
| **Immediate Outcome** | - Strong community governance structures and active groups in place | Reasonably robust evidence of groups being in place but they are not always strong and with varying levels of activity. |
| | - Communities empowered to claim rights and demand accountable health governance | Reasonably robust evidence that information dissemination and training are being delivered to good effect. |
| | - Communities able to interpret local health status information, define their health priorities, and monitor services being delivered | Reasonably robust evidence that information dissemination and training are being delivered but communities 'technical' capacity appears limited to only relatively few people. Less technical approaches to defining priorities and monitoring services are probably more prevalent. |

The evaluators also assessed the influence of external factors on the results chain. This was done using a scoring mechanism, details of which can be found in the main body of the report. Some of the influences found to be quite significant were: (+ve) the provision from June 2013 of free maternity services and primary care services offered at community-level clinics and dispensaries, which had mixed effects; (-ve) traditional knowledge and beliefs that generally undermined programme approaches.

In conclusion, the contribution analysis suggests that CAK can make the strongest claim to putting 'Strong community governance structures and active groups in place', while 'Health policies, plans and budgets are responsive to the needs and priorities of communities' is the weakest. The other outcomes[1] demonstrated some but not extensive claims for contribution to observed changes.

## 6. Key Challenges and Issues for attention going forward

*Devolution of Health Services*

As mentioned above, some assumptions and contextual factors have proved challenging and influenced the achievement of results. Specifically, the implementation of devolution and the expectation by CAK that a devolved health system will be effectively managed, responsive, transparent and accountable. The latter will no doubt improve but it is currently struggling, and CAK needs to put much more emphasis on supply side interventions, strengthening the capacity and equity of especially county government institutions (e.g. through proactive briefings), and bringing government along with CAK / partners at early stages in project cycles.

*Governance Approaches*

There also needs to be greater clarity and agreement about how/who/where to best affect change in this in-flux environment. While awareness-raising and training on rights and governance issues is being delivered, a more consistent and systematic programme is needed to take advantage of all the opportunities available to improve governance (for example, expanding social budgeting to cover resourcing and implementation phases more). Some good work is being done but CAK needs to facilitate a broadening and deepening of partners' approaches so that existing effective materials and practices are delivered more proactively, uniformly and in an appropriate order across the programme. This includes advocacy work, where little collaborative action between partners, and with other civil society advocacy platforms, seems to be happening.

*Representation*

Acting on all of the above would go some way to helping facilitate more community-driven engagement in the governance arena. CAK encouraging partners to work beyond 'representing' communities more towards strengthening their voices, and interventions being less partner-driven, would improve programme efficacy and sustainability. Ensuring outputs (such as those of SIR teams) are shared more within and across communities would also help general empowerment. There is also a need to develop some approaches to deal with the demotivating aspects of communities actually advocating and trying to access health services, and conducting social audits and social budgeting activities (albeit in a fairly limited manner), for government then not to act or respond. Achieving all this will not be easy, and needs significant commitment to a more community-led approach and fostering opportunities to support communities to take forward their demands themselves.

*Social Norms*

Although already one of the programme strands, interventions designed to address some unsupportive social norms are not being implemented sufficiently strongly to deal with the

[1] 'Communities meaningfully engage in advocacy', 'Increased demand for health services', 'Communities empowered to claim rights and demand accountable health governance', and 'Communities able to interpret local health status information, define their health priorities, and monitor services delivery' showed

constraining factors (mostly relating to gender and age roles, but also to contentious issues such as family planning). For example, gender targeting is mostly focused on health service delivery / HSS and social norms (F2F support groups and gender-focused training of mixed groups of CHWs), with much less on governance aspects of projects (rights training and empowerment activities). Specific and appropriate targeting of younger age groups, and broadening the scope of rights and awareness raising, will challenge existing power relations within communities but should facilitate greater and more sustainable gains and should be a key element of social norms and empowerment work in the future.

*Programme 'Models'*

CAK has seen the successes of its work in Kiababu (Kiambu), and to a slightly lesser extent in Sitoka (Narok / Transmara), as models. However, many of the conditions have changed so much that these 'models' are not really replicable. Although much of CAK's health programme has also moved on, and there has definitely been some learning around the importance of collaborative and multi-stakeholder development (e.g. of the clinic at Kiababu's), CAK and its partners may want to review their vision and targeting of community health facilities as platforms for improved health governance opportunities in the future.

*Staff Expertise*

Through lack of funding and/or local specialist expertise, work on tax and fair revenue financing appears to have dropped from CAK's programme. This should be a key element in any health governance programme, especially since health financing is an area of particular importance and challenge in the Kenyan context. More efforts in this direction would fill what is a significant gap in programme approach and help to complete the circle of governance.

## 7. Recommendations and areas of further investigation

**CAK and its partners need to strengthen governance aspects of their HG programme**, especially:

- Taking a more systematic approach to the application of different governance mechanisms and interventions, including helping partners agree what approaches and materials are most appropriate and effective to be delivered in what order and in what combinations.

- Putting more emphasis on county government capacity building and bringing government along at early stages in project cycles, including through proactive relationship development and briefing key MCAs and officials (e.g. MCAs on the health management committee, clerks to the latter, and female MCAs).

- Developing better 'intelligence' and packaging evidence of community level learning for collaborative advocacy at county and national levels (e.g. by methodically collecting, analysing and documenting community level data in a user-friendly manner and using it to act with others).

- Focus more on empowering and supporting communities to represent themselves (and to stay motivated in the face of minimal government response).

Additionally, **CAK and partners should**:

- Emphasise more systematic follow-up, feedback and mechanisms for broader sharing of information with, within and across communities for group sustainability, community empowerment and advocacy.

- Target awareness-raising activities and training at, and in support of, young people (male and female, separately and together).

- Go beyond gender and PLWHA to other vulnerable groups such as those with disabilities.

- Recognise and plan for the importance of timing - e.g. for proactively planning budget cycle influencing and monitoring, and for other advocacy work; plus accommodating the slowness of cultural change and government change management.

- Through an updated power analysis, review their understanding of the role of key individuals (e.g. First Ladies, MPs, MCAs, church leaders), all of whom can strongly influence context and the programme both positively and negatively.

- Use their ToCs as a project management and monitoring tool to inform programming, activity designs and project implementation.

- Consider how CAK staff expertise in tax and revenue (and advocacy?) can be brought back into the programme.

## 8. Conclusions and potential lessons

There is good evidence that CAK's health programme has transitioned from a health delivery programme to one much more focused on health governance. Overall, CAK's HG team understands what it is trying to do – the HG ToC is plausible – and it is achieving some positive results with immediate and mid-term outcomes being partially delivered. Even so, evidence suggests that, overall, programme delivery is quite variable and that health service delivery / systems strengthening remains strongest, with governance aspects less so.

**Key Lessons from CAK's Experience**

- It takes time to transition a programme and it can only happen with a strong vision of how key components can and should link together e.g. in a Theory of Change (ToC).

- The ToC needs to include full identification and consideration of underpinning assumptions, and an assessment of external factors that may/will influence planned outcomes.

- An appropriate combination of partners with complementary skills and experience needs to be facilitated and supported to work together effectively.

- Partners having to radically change their roles and responsibilities as part of any transition may require additional support, especially to manage the expectations of those they serve.

- Regular and effective monitoring needs to be in place for the programme to adjust to changes in both internal and external environments.

- With devolution of power and public services, some doors for influencing close, but new opportunities (such as new elected members, committees, etc.) are there and waiting to be identified and utilised.

- There is no short cut or alternative to empowering communities so that they are able to drive change for themselves (i.e. NGO-driven change will never be sustainable).

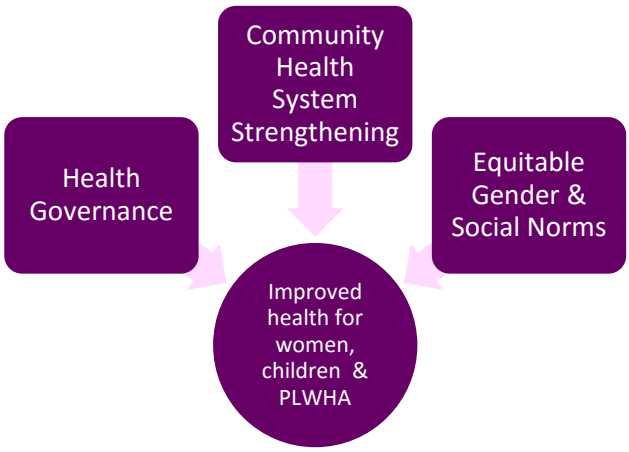
- Culture change is slow and non-linear.

# 1. Overview of Christian Aid Kenya's Health Governance Programme

Christian Aid (CA) was first registered in Kenya in 1997. From an early focus on rural development it has shifted its emphasis to sustainable livelihoods, accountable governance and community health.

Of most relevance to this study, Christian Aid Kenya (CAK) has, over the last few years, changed the focus of its health programme from health service delivery more towards health governance (HG). This change has been driven by recognition that continuing to plug holes in public health service delivery is not sustainable, and unlikely to improve overall health outcomes for poor and vulnerable groups without also building communities' capacity both to participate in and influence the health decisions that affect them, and to hold government accountable for delivering on its obligations.

This shift has been supported by UK Department for International Development's (DfID) Programme Partnership Arrangement (PPA) funding that has enabled CAK's health programme to transition to an approach based on three strands: health governance (HG); community health systems' strengthening (HSS); and equitable gender and social norms.




This work is delivered through ten partner organisations, six of which operate as implementing organisations at local / county level, and the other four as advocacy specialists principally at national level.

Geographically the programme is broad, covering communities in Nairobi and the Counties of nearby Kiambu, Machakos in the east, Isiolo in the north, Narok in the southern Rift Valley, and Homa Bay and Kisumu around Lake Victoria in the west – see map below.

Programme content is similarly broad and includes general community health; maternal and child health (MCH); HIV, malaria and TB; and sexual and reproductive health, as well as multi-level advocacy and rights / gender awareness training. Different programme elements variously focus on women, women and children, and whole communities, as appropriate.

CAK's health programme is aligned with CA's global strategy 'Partnership for Change' (including the strategic objectives on Power to Change Institutions; Right to Essential Services, and Equality for All), and its December 2013 Community Health Framework.

## 2. Context

'Kenya has the potential to be one of Africa's great success stories from its growing and youthful population, a dynamic private sector, a new constitution, and its pivotal role in East Africa'. However, addressing the challenges of poverty, inequality [and] governance 'will be a major goal for the country'.[2]

Sadly, Kenya has met only a few of the Millennium Development Goals (reduced child mortality, near universal primary school enrolment and narrower gender gaps in education). Despite also making significant progress towards combating HIV/AIDS, Malaria and other Diseases (MDG 6), progress towards the eradication of extreme poverty and hunger (MDG1), achieving environmental sustainability (MDG 7) and improving maternal Health (MDG 5) has been very slow. To enhance efforts, the Kenyan Government developed an MDG Acceleration Framework, a main focus of which has been on strengthening the health system for raising the demand for maternal and new born health services from women, families and communities.

Although Kenya has suffered from various periods of political unrest and a system of ethnically-based patronage (both often related to land), a major change in the Kenyan context has been the enactment in 2010 of the new Constitution, which crucially gives Kenyans a range of rights, such as health, and considerably strengthened rights for women – including a requirement that not more than two-thirds of the members of elective public bodies shall be of the same gender. However, political life and the overall culture, traditional beliefs and practices in Kenya remain predominantly male-oriented, with rights and gender awareness still very low. Constitutional gains for women and other vulnerable groups, in many cases, have yet to be realised.

As a result of the new Constitution and the general election of 2013, Kenya is in the midst of implementing a highly ambitious devolution process, which involves the transfer of key functions and financing from central government to an entirely new level of sub-national (county)

[2] http://www.worldbank.org/en/country/kenya/overview October 2015

government. This is proving very challenging, and at times chaotic, with many politicians and officials jostling for control within the new structures, with administrative systems far from sufficiently developed.

Kenya's devolution, adopted following the March 2013 general elections, is expansive in scope and implementation timelines. A significant portion of public finances and responsibility for service delivery in health, agriculture, urban service and local infrastructure was rapidly devolved to 47 new county governments in less than a year, instead of the planned three-year transition period. This ambitious devolution shifts some key decision-making from central to county governments, creating a window of opportunity for more 'bottom-up' engagement, backed by a Constitution and legal framework that include provisions for government to share information, consult the public and regularly gather citizen feedback. "*Kenya has a powerful legislative landscape, providing an array of clear, pragmatic provisions and principles*," said Mwanamaka Mabruki, Principal Secretary, Ministry of Devolution and Planning. "*The challenge now is on implementation, providing an enabling environment for service delivery with the necessary capacities, systems, and regulations at county level*." (World Bank, April 2015)

## 3. Purpose and scope of the evaluation

This study is part of CA's periodic organisational assessments, this time on CA's work on accountable governance, which aims to generate evidence of impact, explain complexity, and generate learning across CA. Kenya is one of five country studies in the impact assessment, each using different evaluative designs and approaches to understand and document a range of different governance programmes that CA has implemented.

In common with the other country studies, the purpose of the evaluation in Kenya is:

- To generate evidence of the impact CA's work has / is having, and
- To generate learning across CA – on discrete areas of work, but also on how connections are made across the organisation on different pieces of work.

The Kenya country study's focus is on health governance, and particularly on:

a) Assessment of the challenges, dynamics, strategies for success etc. in transitioning from a programme focused mainly on community health service delivery, to a programme focused on health governance: why did this happen, how did this happen, what has been the impact and what can we learn?
b) Identification of specific 'governance' approaches within the programme – with an emphasis on the work on health financing and resourcing, budget advocacy, social budgetary observatory frameworks, other social accountability mechanisms such as community monitoring and participation mechanisms - how have these been developed, what has been their role and impact, what learning there is in relation to our broader questions on governance? Of particular interest are local to national linkages; questions of how 'working politically' and engaging with issues of power and powerlessness at local level interact with advocacy; and the use of advocacy tools nationally.

Outputs of this study include this report on CAK's experience of transitioning to health governance and a guide to the evaluation methodology (see Annex C). The former will be shared with health and/or governance programme audiences, while the latter is meant to contribute to internal CA capacity building and is intended mostly for use by other CA country offices.

The scope of this research has considered activities and outcomes mostly within the period 2010 - 15, roughly when DfID PPA funding has been in place (though a few entries on the 'timeline' go back as far as 2005).

The Terms of Reference (ToR) for this study states that evidence gathering should be focused on projects that have been / are being delivered in Kiababu, Kiambu County and in Narok County (specifically, Sitoka) by teams from the National Council of Churches of Kenya (NCCK) and the Transmara Rural Development Programme (TRDP) respectively, plus some of the work of Nairobi-based partners involved in national policy advocacy. Although not all CAK partners are active in those areas, all ten have been consulted at an initial workshop, and/or during field visits or individual meetings in Nairobi.

The ToR also stipulates that the scope of this study should include engagement with the programme's Theory of Change (ToC) for Health, and exploring its assumptions, strategies and translation into practice.

# 4. Methodology

CA indicated in the organisational governance assessment tender documents that it wanted to test a range of innovative evaluation designs[3]. So, to "capture the nuance and complexity of the programme, alongside identification of key areas of success and change", the methodology that was chosen combined a theory-based evaluation approach with contribution analysis. The evaluation addressed six key evaluation questions (EQs) set out below, with contribution analysis used to give an indication of the contribution to impact that the health governance strand of the health programme is able to claim.

**Key steps in Contribution Analysis[4]**

Step 1: Set out the attribution problem to be addressed

Step 2: Develop a theory of change and risks to it

Step 3: Gather the existing evidence on the theory of change

Step 4: Assemble and assess the contribution story, and challenges to it

Step 5: Seek out additional evidence

Step 6: Revise and strengthen the contribution story

## 4.1 Key questions

1. How does work on social norms, equitable institutions and health service delivery/systems strengthening interact to bring about improved health outcomes for the poor? What is the balance between these different aspects?

[3] Note that good evaluation practice is to select the evaluation methodology based on 'best fit' to the purpose, key questions, context, time and resources available etc.

[4] John Mayne (2008) Contribution Analysis: An approach to exploring cause and effect

2. What is the role of women, what can we learn about women's participation, what can we learn about working politically – and how this looks different for men and women, (and other grouping - e.g. PLWHA, women in SRH and MCH projects?
3. How has the local programme implementation linked up with national advocacy processes?
4. How have power relations between community, partners and government institutions shifted through our work, what can we say about the quality of engagement with government institutions, or other relevant bodies?
5. What has changed in how partners understand their role and approach in governance work, what 'added value' do they identify through the approach and our engagement/support?
6. Document how PPA strategic funding has impacted on the evolution of the Kenya program from a community health focused project to broader health governance programming.

Wherever possible, data was triangulated by using multiple data sources and different ways of collecting data to explore the same question; for example, individual key informant interviews, and workshops and follow-up interviews with CA and partner field / management staff (in separate groups to ensure all voices were heard), complementing community focus group discussions.[5] In total, evidence was gathered from document review; 7 workshops / group discussion meetings with CAK and partner staff; 6 focus group discussions with female and male community members in Kiambu and Narok / Transmara; and 8 key informant interviews with national and local leaders and officials, and national partner staff – making approximately 120 respondents. Notes of all of these discussions are available on request.

Contribution analysis has principally been used to elaborate on questions of impact, with explicit reference to the programme's ToC together with an assessment to discount alternative explanations for the changes that have occurred. The steps involved are detailed in the accompanying methodological guide (see Annex C) but, briefly, the analysis required an explicit articulation of whether and how change has happened and what changes CA's intervention has contributed to, in what ways. By establishing to what extent implementation happened as intended, and what evidence there is that short- and medium-term changes have materialised in the way predicted, the methodology builds a credible narrative around what CA's contribution has been to changes. Crucially, the analysis also involves identifying, examining and eliminating alternative explanations for causes of any observed change.

## 4.2 Sampling of field sites and community groups

Sampling of communities to visit followed feasibility criteria and practical considerations and pre-dated the development of a testable ToC. Kiambu and Narok / Transmara were chosen as field visit sites because impact case studies had already been developed by CAK as a component of its annual PPA reporting, and to avoid overexposure of any one group to too many visitors. (Interesting programme work is being delivered in other areas but many of them had recently had a lot of CA visitors.). The projects and community groups visited were chosen as a purposive sample reflecting different points in programme transition from health service delivery towards a more HG approach, and involving differing emphases on the three health programme strands.

The assessment team was one INTRAC consultant working alongside a CA staff member seconded from its Ghana country office as a Peer Reviewer, as part of a capacity-building

[5] See Annex B for visit schedule / interview list, and the Bibliography.

element to the evaluation, at the request of CA. In addition, CAK and partner staff played liaison, technical advisory, translation and observer roles throughout the in-country visits. The majority of discussion and interviews were conducted in English, with some translation into Swahili, Maasai and Kikuyu.

## 4.2 Limitations

On investigation, it transpired that CAK had a number of project and programme ToCs that had been developed over the last few years. However, none of these were 'testable' for this evaluation's purpose (i.e. they had not been developed for project management, monitoring or impact assessment, and/or they were too broad or too specific). Therefore, another appropriately bounded and evaluation-specific ToC had to be developed[6] and validated through an iterative process throughout the study visit to Kenya. This consequently reduced the time available in-country for field work, data analysis and contribution analysis. This was compounded by the fact that trying to work through the latter often took a back seat to gathering evidence for other key evaluation questions.

Overall, the Kenya Health Governance programme is quite complex and varied and the evaluators were only able to investigate some of it in any detail. For example, both ToR specifications for geographical foci and time constraints meant that projects focused on People Living with HIV / AIDs (PLWHA) were not covered in any depth. Partner organisations involved in projects supporting PLWHA participated in the initial partner workshop in Nairobi, where a range of programme-related changes were identified. However, many of the latter were quite general and often reflected the successful delivery of project activities rather than higher level impacts.

Time constraints also meant that evaluators were not able to meet with any county / national health officials, but this was at least partially to do with their lack of availability in meeting with us. Time constraints also precluded meeting with other NGOs delivering health programmes in similar areas. However, attempts were made to learn about other potential counterfactuals (for example, another health facility in Kiambu that hadn't been officially registered yet, and therefore weren't entitled to official staff or basic medication). These are discussed as part of the contribution analysis in section 6 below.

Finally, the evaluation methodology was not easy for CAK / partner staff to understand, especially why the ToC was a key part of the evaluation and the iterative nature of it. This added to the time required to do it and did not always generate the participation and evidence required (i.e. partners identifying key changes that were actually only the successful delivery of outputs, as mentioned above). While this is understandable when introducing a new methodology, more time would have been needed to ensure real capacity building of staff.[7]

[6] This was based on the PPA ToC which had better causal linkages in comparison to the others and more clearly represented the team's execution strategy based on what they had earlier envisioned.

[7] While it is difficult to state definitively how much more time would be needed, it is fair to say that a 'standard' evaluation timeframe does not allow time for capacity building during the process; in this case, perhaps an additional week would have been necessary to fully include and enable staff participation throughout the process.

# 5. Findings

## 5.1 Transitioning from Health Service Delivery to Health Governance

The timeline pictured below was created by CAK staff at a facilitated workshop in Nairobi. They were asked to identify key 'events'/ changes that had occurred and been instrumental in driving the refocusing of their heath programme - above the line related to programme events and changes, and below it related to external factors. A typed version of the timeline can be found at Annex D.

A similar exercise was conducted with partner staff, and data was then compared and analysed as part of the reconstruction of a programme ToC and consideration of relevant external factors.

The key internal issues revealed were:

- recognition of the unsustainability of continued funding of health service delivery that appeared to be driven by CA's 2013 Community Health Framework; and the Global Health, PPA and Health Governance workshops in 2013/14
- the importance of funding streams coming to an end and stimulating '*what next?*' discussions
- PPAs key role in enabling the shift in focus to HG
- increased belief in an advocacy approach
- changes of CAK staff driven by loss of core funding and start of PPA funding
- new partners being brought on board by PPA programme

Important external factors were deemed to be:

- the HIV Prevention & Control Act (2006) that criminalised transmission of HIV / AIDS
- the period of confusion caused by the split in the Ministry of Health into medical and public health (2009-12)

- Kenyan civil society moving into more public policy, governance & rights focus (after a period of considerable political unrest)
- the new Constitution (2010)
- Devolution & new government (2013 onwards)
- Free maternity services policy (2013)

Some of the agreement among current CAK and partner staff as to what had been key for the transition to happen seemed to be driven by which of them were, and were not, around at any particular time, and where they had shared experience. Also, memories were obviously clearer for more recent events and less so for the earlier ones. Having said that, the CAK staff team includes a number of individuals who have worked together for many years, and there was a lot of agreement in this timeline exercise that everyone seemed to find refreshing and motivating (having seen how much they had come through!).

There is no doubt that a combination of factors - both within and beyond CAK control - operating as both carrots and sticks - have come together to encourage and accelerate the health programme transition over the last three or four years.

## 5.2 Development of specific 'governance' approaches[8]

The CAK HG programme has continued to focus on community level as its main entry point, and it has concentrated on stimulating demand for health rights and accountable service provision through a number of mechanisms, including:

- Creating new governance structures such as Mother to Mother (M2M) and Father to Father (F2F) Support Groups (that operate alongside formal structures) – It is not clear how these discussion groups have been developed or chosen, but they appear to be relatively important for engaging and sharing information with a wide range of people in different villages on matters related to health (e.g. prevention measures, availability of services, the benefits of take-up of services, the right to health, etc). In the two field sites visited, Community Health Workers (CHWs) had been created in Kiambu and M2M / F2F support groups in Narok - but not vice versa yet as they have been chosen to address different project priorities.

- Income Generating Activity (IGA) / Savings Groups - Additionally, some of CAK's local partners (e.g. Transmara Rural Development Programme - TRDP) have created these types of groups as a way of mobilising and sustaining community activity for health governance approaches to be effective. Development of these types of groups has been required as a compensatory mechanism for not paying any stipend or expenses for active community group members, which other NGOs are providing. The groups get together for example for their monthly savings meetings, and health governance issues are then included on the agenda as well.

- Community capacity building delivered by partners (singly and jointly) with CAK support - for example, for health facility management, rights / civic education, and social accountability. Where capacity building has been delivered it has proven quite empowering and effective (e.g. with CHWs) but training is frequently just 'awareness-raising (i.e. not very in-depth); or applied to only a small numbers of people (e.g. social audit training). Feedback loops and wider sharing within communities, and between communities and partners / government, can be quite weak. Additionally, there does not seem to be a common suite of capacity building activities or an order in which activities are delivered for particular communities - but this obviously relates to context (see EQ1 below).

- Partners utilising with communities approaches developed or sanctioned by government - such as Service Charters, volunteer Community Health Workers, and Social Budget Observatory Frameworks (SBOF) / Social Intelligence Reporting (SIR) - for credibility and potential acceptance. These governance structures and social accountability tools help to ensure

[8] For impact – see section on Contribution Analysis

quality services are being delivered to citizens, though most were developed ten or more years ago. Although officially recognised, government entities have not been using SBOF / SIR (lack of funding and/or interest?). Some NGOs (specifically, the Inter-Religious Council of Kenya, a CAK PPA partner) have been using them because of a belief that outputs from community-led SIR activities are more likely (than random community demands) to be accepted by government and acted upon. Also, with new Constitutional requirements for community participation in public forums and budgeting processes, SIR has become more relevant, especially as government seems not to have stipulated or adopted any other formal mechanism to address that need. In Kiambu, another CAK PPA partner, the National Council of Churches of Kenya, has created and trained SIR teams (12 people in total) that have conducted a social audit of government infrastructure projects in their area, and used that knowledge and credibility to actively contribute to (open to all) county public budget discussions as a result.

- Facilitating community Action Days, Dialogue Days & *barazas* (village meetings) - led by various different local champions (and local chiefs). These are activities aimed at broad, often multi-purpose, community engagement to mobilise and create awareness and buy-in, and validation of community priorities, not necessarily specifically governance focused but perhaps with an element of that, depending on the point in a project cycle.

Additionally, CAK's HG programme is using a range of approaches that span governance levels and entry points. For example:

- Brokering partnerships between communities, partner NGOs, and government (e.g. County-level Public Health Officers and national parliament Constituency Development Fund managers). The Kiababu Case Study below provides a good example of this key aspect of CAK's governance approach, which promotes and takes best advantage of available synergies. This approach also includes partner to partner linkages and capacity building, especially for advocacy related interventions at community, county and national levels.[9]

- Support for national advocacy campaigns – for example, HIV financing[10].

- Social budgeting – for CAK and partners, this approach to governance is additional to SBOF mentioned above and includes a mix of:
  - facilitating community voicing of priorities at big open public forums for county budget planning / validation / approval;
  - partners providing information specific to particular communities about what money is in government county budgets related to their areas (for health, roads, etc);
  - partners having proactive discussions with county / national officials to input ideas prior to budget drafting (for example, for 'Mothers' Companions[11]); and
  - active lobbying at national level to persuade government to allocate and maximise sufficient resources for key health challenges (e.g. equitable HIV financing).

The biggest issue related to all of this is knowledge of appropriate timing and opportunities being sought at the right point in policy/budget-making cycles, within the currently very fluid context of devolution.

To sum up, with the exception of focused national policy advocacy campaigns, almost all of CAK and its partners' health governance interventions focus on strengthening demand. Evidence from this evaluation suggests that there is little currently aimed at strengthening the supply side (except aspects of health service delivery such as through co-funding of community-level health facilities).

[9] See EQ4 below for further discussion
[10] See 6
[11] See EQ2 below

For example, in terms of governance, there are currently only a few attempts at building accountability or capacity of Members of County Assemblies (MCAs) or health officials, both of which have new responsibilities across areas of policy and resourcing that they are generally not familiar with - and this is not being done across all projects. Although CAK works through local level partners, more focus on helping the county-level government to improve its policy making and efficient service delivery could also be included, as CAK also works with national partners well-able to join forces with local partners to build the capacity of county officials.

## 5.3 EQ1 Interaction of social norms, equitable institutions and health service delivery / systems strengthening for improved health outcomes

This is a key part of the health programme's transition and relates directly to ideas contained in CA's Community Health Framework and developed at the various international health governance workshops mentioned in the timeline above. The general thesis is that to improve health outcomes, all three strands have to be considered, and interventions designed, to address barriers to achieving positive and equitable health outcomes.

In CAK's case, the need for the shift away from straightforward health service delivery has also been driven by its own recognition of supply-side weaknesses in government policy implementation and service delivery capacity; by earlier work on stigma and exclusion of HIV communities; and the prevalence of traditional beliefs and practices among, for example, the Maasai, that are deemed to prevent equitable participation in (health) decision-making and access to (health) services.

An example of how projects are being planned and developed is the establishment of the Sitoka community health facility, alongside inputs to increase women's uptake of professional birth delivery. These involved: power shifts away from traditional birth attendants (TBAs); awareness-raising among fathers of the benefits of ante-natal and clinician-supervised births; and empowerment of the community to self-manage the facility and demand increased and more accountable service provision from the county government. All of the above has meant that young women have much more say over their and their baby's health, and that there are now many more supervised births, 24 hour service provision at the health facility, and a model for new TBA roles that is about to be replicated across Narok County.[12]

TBAs & support groups at Sitoka health facility

[12] See EQ2 below and Narok case study at Annex E for more detail

In terms of balance between the three components, all three have been, and are, included across the programme, and relative emphasis on each of them is generally appropriate to particular community contexts. For example, consideration of social norms is less in the Kiambu project, which is focusing on health service delivery and government responsiveness on a much broader level than in Narok, where the project is focusing on MCH which requires addressing inherent social norms.

However, across the programme, health service delivery is still the strongest element and, while governance work is happening to varying degrees across the project portfolio, the emphasis on the governance aspects of the programme is patchier and implementation not sufficiently progressed to deliver planned health and equity gains. For example, gender / rights awareness training and more specialist social audit capacity building haven't been covered in any depth in Sitoka (yet), and efforts to engage county health officials has been slow and often too late in the project cycle to gain their buy-in and support. Addressing unsupportive social norms, and the need for capable and equitable institutions, is crucially important for institutionalising approaches and strengthening outcomes to be more sustainable - but the latter isn't yet happening sufficiently across CAK's HG programme.

## 5.4 EQ 2 Role of women and their participation

The role of women in Kenya is quite varied across urban and rural areas, and different ethnic and age groups. In relation to health governance, some women (and men) are ill-informed, powerless and suffer from unnecessary health-related problems, while others are well educated, and have sufficient capacities to participate fully and implement their own and others' health decisions.

For example, the nurses and clinical officer in the Kiababu and Sitoka health facilities are both female, as are many politicians, especially since the new Constitution requires that at least a third of official representation must be women. The latter includes women who are now members of the Maasai Council of Elders, which CAK partner Narok Integrated Development Programme (NIDP) are providing with capacity building support to ensure they are able to use this new space and have their voices heard effectively

In Kiambu, both women and men are being trained as health facility management committee members, CHWs and social auditors so that together they can prioritise community health needs and articulate them at official levels. A female member of the social audit team is even planning to run for office at the next country government elections. Even more significantly, as mentioned above, although the TBAs themselves aren't working more politically, NIDP / TRDP's model of 'Mothers Companions' highlights the changing role of women and the importance of dealing with different age groups as well as genders.

**'Mother Companions'**

Traditional Birth Attendants (TBAs) had previously been perceived by the Ministry of Health as their 'enemies' because of their harmful practices. But NIDP / TRDP has remodelled the TBAs' roles into 'Mother Companions' that are incentivised to accompany women in labour to the clinic or nearest hospital for the birth of their babies. This has enabled major changes in household, community and political power. The TBAs, who were older women (sometimes the pregnant women's mothers-in-law), traditionally advised men about their pregnant wives and were the greatest determinant of whether births were in hospitals or performed by them at the family home. In exchange, the TBAs were given token payments and held a lot of power in the community. NIDP / TRDP worked with the TBAs to change their roles, which they say they are happy with as they no longer have such a burden of responsibility. They now agree that mothers and children are better served in the clinic / hospital. Project funding was used to provide reimbursement of travel expenses to the clinic/hospital and for 'mothers' packs' (soap, a baby towel and a wash basin), which fathers may not ordinarily be prepared to pay for. This change of roles, and the concomitant shift in power away from TBAs and men towards younger women, has enabled NIDP / TRDP to successfully advocate for county government to adopt this model, including a separate budget line to provide mothers' packs.

In general, programme interventions are being targeted separately for women and men, especially where social norms are likely to strongly influence outcomes. For example, at the Sitoka project, culture has been positively influenced through F2F forums, which are influencing power, gender and resources at the community level so that, for example, family planning uptake and skilled birth deliveries are improving.

Also, men and women are engaged differently before they are brought together (for example, over issues such as Female Genital Mutilation (FGM) that are discussed with boys as well as girls). Previously health was not a key issue for communities to attend meetings but, through specifically engaging men, things have improved, in that some of them now turn up, and some men have been surprised at new information that has been provided by the project (on family planning and child birth, for example). Men also now see engagement in management of the health facility as being worthy of their attention – "*now that there's a health centre, it's necessary to know about health issues*", especially as many of them still believe that "*men are head of everything*" (quotes from focus group discussions in Sitoka, Narok).

However, gender targeting is mostly focused on health service delivery / HSS and social norms (for example, F2F support groups and gender-focused training of mixed groups of CHWs), with much less on governance aspects of projects (rights training and empowerment activities). Although we were only able to look at projects in two counties (unfortunately not those focused on supporting PLWHA), it seemed that other vulnerable groups, such as for those with disabilities, and /or different age groups, particularly younger people, are not currently being consciously targeted. Many partners rely on the communities themselves for identifying and supporting normally excluded individuals and groups.

For example, in Narok / Transmara, younger people are seen by the older generation as being much better informed than themselves (before or currently) but, paradoxically, the elders do not believe that younger people have sufficient status to influence change in the community. This kind of differentiation is not particularly being addressed in project design.

## 5.5 EQ 3 Links between local programme and national advocacy processes

CAK's partner mix is good, with expertise in policy advocacy and understanding of key governance issues at national level complementing experience and knowledge of on-the-ground community / county level challenges and solutions. Additionally, CAK has facilitated an extensive programme of advocacy and governance capacity building for local partners, delivered by national partners, for example on the public budget cycle. This has served to inform both groups of opportunities for further collaborative gains.

There is evidence of effective interventions at both county and national levels. These include, for example: at the county level, communities gaining increased health service provisions such as another nurse, longer opening hours and/or more appropriate drugs, plus the mother companions model mentioned above; and at national level, HIV financing.

There is some evidence of linkages between the two. For example, NEPHAK, one of CAK's national partners, is working in four counties with local HIV support groups so that (usually female) representatives are nominated for a place at, and enabled to play active roles in, the county governments' public forums using NEPHAK's briefings on national policies. Evidence from local level is then fed back to the national partner for use in further higher-level advocacy.

Apart from some national partners on occasion using local partners to mobilise communities, few specific collaborative advocacy activities involving both CAK's local and national partners seem to be happening yet, despite the need for this approach in the current context where it is now difficult to do

advocacy work on health from a national level and its devolution now requires a much more bottom up approach. Nevertheless, partners feel that the approaches they are using are suitable, and that there is a lot happening at the community/county levels. However, it was suggested that there is a need to draw together local advocacy evidence for national advocacy interventions, and to facilitate more collaborative national interventions that would strengthen the links both between county and national level partners and across national partners (such as KENWA, KENERELA and IRCK). This would help collective gains to be made from coming together in common cause.

It appears that confidence being built from individual advocacy successes (for example, NIDP / TRDP getting 'mothers' packs' adopted into country budget lines) has acted as a strong driver for programme transition, but the in-flux state of devolution implementation is having a huge influence on all the health governance work, with partners generally still quite unclear about how / who / where to address to best affect change.

Opportunities to influence are being identified (such as targeting MCAs on county assembly health committees, and using relationships with national officials to access information at county level). Coupled with that, partners recognise that local partners have the advantage of being known, with first-hand knowledge of key personalities, at county level, and that this can be used alongside the advocacy skills and approaches shared by the national partners (who bring credibility from their relationships at national level). However, this mutual support and collaboration still appears to be quite random and not fully considered or utilised in a systematic way.

Similarly, although CAK recognises the positive changes in Kenya with CSOs reclaiming space in the past few years, CAK (and its partners?) don't seem to be actively or committedly involved in larger CSO collaborations such as thematic networks focused on the health sector as a whole, or social budgeting collaborations aimed at influencing overall national budget drafting phases. This seems to be a missed opportunity. However, CAK does believe it is the only NGO in Kenya taking an HG approach to its health programmes, which, if true, means it has the potential to play a leading role.

The loss of CAK's core funding, specialist staff members, and its capacity to lead and promote advocacy on tax and revenue issues is regrettable, especially in the current politico-economic environment in Kenya where significant gains could be made around the devolution process (influencing country level revenue and expenditure).

## 5.6 EQ 4 Shifting power relations

There is evidence of positive power shifts at household level, between genders, and between community & government (sometimes facilitated by partners).

| **Examples of shifts in power** | |
|---|---|
| **What** | **Sitoka community now successfully calling for MCAs to come to them. "Before the community used to be called, now we're calling them - when are you guys coming [*to hear what we've got to say / sort out our problems*]?" → Now there is a road to the community.** |
| How it happened | The community had been requesting a road for 20 years but with no success. They recently wrote a proposal to the county government and the road has now been built. |
| Critical factors | Various explanations were provided …<br>- TRDP's project has empowered men and women through civic education and health facility management training. "Information provided was key for communities to demand their rights. They did not know about the devolution process".<br>- Devolution, and the fact that the community feel that government services are |

| | |
|---|---|
| | now nearer and “we can go direct”, and “they are from within and understand”<br>- The existence of the new health centre persuaded the county to build the road. |
| Changed policies / practice | Sitoka is now on the map in a variety of ways!<br>Larger numbers of women, children and men are attending the health centre.<br>TRDP’s mobile clinic has expanded its geographical coverage and moved to a daily schedule.<br>There are increased referrals and transportation to the nearest hospital for the more difficult births.<br>Drugs and equipment are more easily and regularly supplied. However, “the MCA has listened to our request for more machines for the health clinic but nothing has happened yet.” |
| **What** | **Kiababu community’s demands for more health services has been met, including the establishment and expansion of a health facility; 24 hour service provision at the health facility and an increase in nurses from 3 to 9.** |
| How it happened | See case study at Annex G for full details. Briefly,<br>- community had been asking for the existing shell of a health centre building to be developed for many years<br>- NCCK became engaged with a very supportive local MP who helped NCCK / the community to access infrastructure funding<br>- CAK provided funding for equipping the health facility and community training[13]<br>- the county responded positively to NCCK / community demands for staff and medicines for the new health facility |
| Critical factors | Briefly, key factors are:<br>- Civic education and training for community members (CHVs, social auditors and health facility management) by NCCK<br>- NCCK approach to local MP, who voluntarily ceded power to community structures and demands<br>- CAK / NCCK brokering and facilitating a partnership with Constituency Development Fund (CDF) managers and CDF Committee members, MoH, and community<br>- There was sufficient land around the health facility for a maternity unit to be added. |
| Changed policies / practice | MP was supportive of Kaibabu’s ‘model’ and had intended to ‘roll it out’ across the constituency but those now responsible (county health officials) are less persuaded / currently lack sufficient power and control to take it forward. |
| **What** | **Kiababu / Kiambu communities are having their demands and voices heard in public beyond their immediate community.**<br>**CHVs feel that power relations between duty-bearers and community members have improved in favour of citizen engagement in comparison to years before the project / devolution -“we stand on a more advantaged position than we were some time back”.**<br>**CHVs and other community representatives have also been selected to sit on e.g. the county bursary committee.** |
| How it happened | Community members were mobilised and trained, and their participation in county budget discussions / public forums has been facilitated by NCCK and CAK. |
| Critical factors | NCCK creation, training and facilitation of a team of social auditors from 12 different Kiambu congregations, as well as a group of 50 CHVs.<br>Public participation is a requirement for devolved country health / budget processes. |
| Changed policies / practice | Not much yet as there are “challenges with citizen participation - civic education is very important but the system is not keen on it” (quote by supportive local MP).<br>Although public county budget discussions have only been announced at very short notice and done quite superficially, community representatives felt that it was a step in the right direction at least. |

[13] The local MP’s Constituency Development Fund provided a roof, windows and doors for the building. CAK funded training delivered by partner NCCK (for e.g. CHWs and community members of the health facility management committee) and equipment (e.g. beds, chairs, notice boards, scales, stethoscopes, etc). Government provided staff and basic medicines.

| What | Power shifts away from TBAs and men towards young women encouraging the take-up of MCH services in Sitoka. |
|---|---|
| How it happened | See EQ2 above and Narok case study at Annex F for more detail.<br>NIDP / TRDP reconceived the role of TBAs, and lobbied on how they could be used more, including paying them transport money for bringing mothers to Health Centres. |
| Critical factors | - Model acknowledged the power TBAs have at home and the need for that to be accommodated.<br>- The name change of TBAs to 'mother companions' allowing MoH buy-in. |
| Changed policies / practice | Many more pregnant women, young mothers, and children now attending health facilities but women say that although they are already 'empowered', and speak during community meetings, they don't have the power to implement decisions. |

These examples of power shifts suggest that contexts are often much more complex than project designs acknowledge and/or seek to address. CAK has done some very useful power and gender analysis work but this doesn't always seem to be included or acted on sufficiently well to achieve desired governance and health outcomes.

That said, (like many peoples of the world) the Maasai have a long-established and well-integrated culture that is often not very welcoming of new ideas. Indeed, even among the women, there is clear evidence of resistance to (especially certain types of) family planning, so power issues also relate to the importation and rationalisation of alien theories and practices that may or may not have been packaged appropriately for the context. In other words, there are many interactive links between, and a need to balance, governance approaches with social norms, ideally through sensitive and well thought through project planning monitoring and adaptation as and when required. TRDP staff acknowledged that "*sometimes social norms slow the process for increased knowledge*" (i.e. increased knowledge doesn't automatically lead to planned change).

Furthermore, while CAK partners are genuinely trying to empower communities, for example by informing them and facilitating their inputs to public forums, there is also evidence of limited shifts in power from some NGO partners to communities, for example by continuing to 'represent' communities instead of putting more emphasis on empowering them and strengthening their voice to represent themselves. Reassuringly, one partner voluntarily said that "*moving forward, we will use citizen-led approaches such as identifying key individuals to be empowered to raise key advocacy issues*", so the issue is recognised.

As mentioned in EQ3 above, power relationships have changed substantially through the devolution process, and there may also be some undercurrents of power tensions between the evolving roles and remits of local and national partners. Relationships between national partners and government seem quite strong, though it isn't clear whether these are shifting much or not. Equally important, county level interaction with government is progressing but engagement is perhaps not initiated early enough in project cycles (i.e. too late to encourage their support?). In the little evidence that was found, both sides appear to have an element of responsibility for this.

## 5.7 EQ 5 Role of partners and CA's 'added value'

National partners are having to refocus on devolved processes - but they are not having to change their main mode of operation i.e. it is still mostly advocacy and governance work. However, the capacity / level of understanding of some of the new county representatives may be much less than partners are used to dealing with.

For local partners that are principally community development / social welfare NGOs, there have been big changes. They have had to focus more on governance (moving from service delivery to advocacy and facilitation); learn new skills & approaches (much more community mobilisation and awareness-raising / training); and deal with the frustrations of communities and local government officials at the reduction in health service delivery (i.e. that Christian Aid are no longer funding).

Due to the on-going implementation of constitutional change, the past two years have generally been a challenge for citizen participation and accessing avenues to redress issues, and it's still not clear for partners sometimes as to what avenues to use. Some partners are relying on 'holding the hand' of communities (sometimes too much or too tightly) and taking them to the right people, while other partners appear to have developed more nuanced and insightful understanding of approaches to improve governance at different levels: for example, recognising the need for different approaches in working with men on gender issues; recognising how project successes attract and engage politicians (i.e. they want to be associated with successes and can be led to support replication and/or scaling up); and recognising the need for "*more evidence to back up our noise*" (i.e. for advocacy interventions).

**Added Value from CAK's HG Approach, Engagement and Support**

During partner staff workshops in Nairobi and in the field, various responses have been given to this question, including:

- It's been a game changer!
- They've awakened sleeping policies, communities, strategies and SBOF
- Attracted more resources and built new partnerships
- Increased partner confidence to engage
- Enhanced partner capacity to the level of setting advocacy issues
- Cross-partner learning and also beneficiary communities cross-learning
- Supported the piloting and testing of potential models for replication elsewhere
- Supported IRCK to participate in a technical review workshop organised by government that should have positive knock-on effects in the future.

CAK's focus on HG and its support are clearly appreciated. Indeed, requests were also made for additional support to harmonise the work of partners, especially to develop a more systematic approach to generic training (for example in rights, gender and advocacy), and facilitation to improve collaboration and reduce competition – "*so that we're all bought in to the idea that we're all working towards the same overall project / programme goals*".

## 5.8 EQ 6 Impact of PPA funding

Initially, PPA funded a health governance workshop with CA programme staff in March 2014, which led to the development of CA's Community Health Framework and also a global health briefing paper on institutions and social norms innovations. Both were facilitated by John Kitui, originally as CA's Global Community Health Adviser and now CAK's Country Manager.

The emphasis on sustainability in the PPA programme design has been very influential in changing the service delivery focus to a more advocacy-focused model.

PPA funding has also significantly strengthened the health programme by bringing on board new national partners skilled in governance issues and advocacy approaches to compliment the local community / rural development partners.

PPA has enabled piloting of interventions now developed and funded by others – for example, some of the social norms work is now being scaled up as part of the EU-funded Maternal and Child Health project in Narok and the Comic Relief-funded Sexual and Reproductive Health project, also in Narok. Both projects continue the local-national partner collaborations created in the PPA extension phase.

All partners recognise the instrumentality of PPA funding and the change of emphasis – one said that it had made them think more about where they fit between communities and government, and (as mentioned above) another called it a *'game changer!'*.

## 6. Contribution of CA's HG Programme to Health Outcomes (So Far)

**Partner workshop identifying and agreeing HG programme impacts**

This analysis process involved critically reviewing CAK's existing health-related ToCs and creating a more refined version. This was mostly based on CAK's PPA Health programme ToC because it was the earliest and provided a good starting point to assess the effect of transitioning to a more governance-focused programme, as well as assessing the contribution of CA's HG programme to improved health outcomes.

The retrospectively reconstructed ToC overleaf was refined, and validated as a true depiction of how CAK and partners expect(ed) their interventions to work, through an iterative process of review and consultation with stakeholders to assess the logic of the causal links, test the plausibility of the assumptions, clarify any significant gaps, and determine how much (if at all) the ToC was contested.

The key question for the contribution analysis was how has the HG programme impacted on health outcomes – i.e. what has its contribution been? In answering this question, issues such as which interventions or strategy have contributed what, or most, to programme outcomes, and what aspects of the HG intervention or the context led to a contribution being made, have also been considered.

As part of the evaluation, this ToC was tested against relevant existing evidence (such as prior research, programme reports on activities implemented and observed results, and broader contextual information), and new evidence from stakeholders through workshops, FGDs, KIIs, and impact-grid exercises, to examine its claims of causation. In particular, the case studies of Kiababu and Narok have been used as evidence of the extent to which the ToC has been realized in practice and to identify key factors (including external ones) that may form the basis of other alternative ToCs.

However, the process of iteratively testing and gathering more data to strengthen the evaluation was truncated by insufficient time for fully conclusive findings. The following can therefore be taken as broad indications, but further more in-depth investigation should be done for more robust conclusions, once CAK is confident that there have been further HG changes and results and impact can be further demonstrated and used to test the ToC and assumptions.

## 6.1 Findings

As with the whole report, this assessment is based on data gathered from a range of sources, using different methods, including secondary data review, FGDs and interviews with CAK and partner staff and communities in order to triangulate data as much as possible within time/ resource constraints.

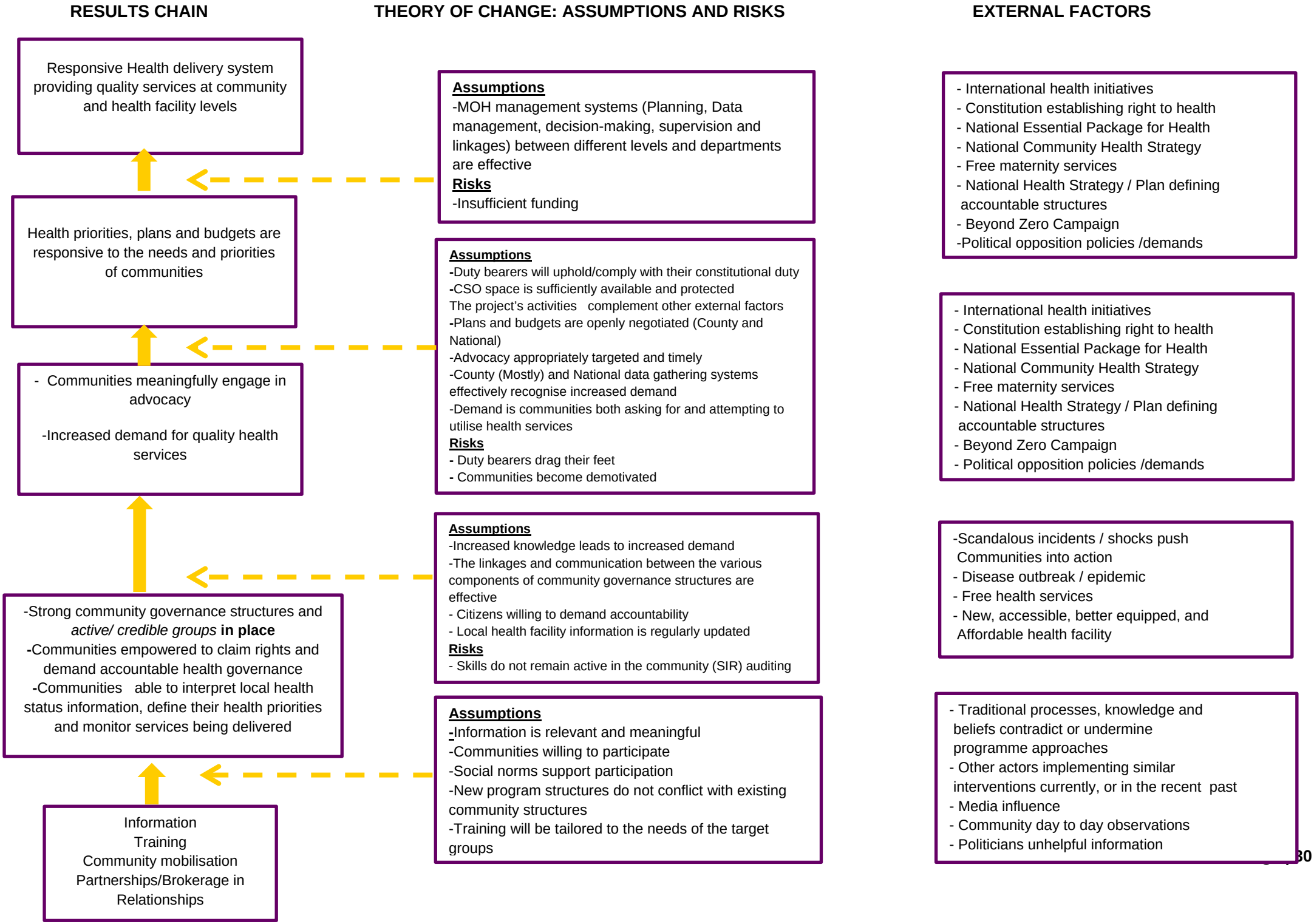
**Has the retrospectively constructed ToC been implemented as planned?**
Yes, generally as planned, but training delivery and content appears to have lacked consistency, and any approaches to improving local government capacity have been patchy.

**What evidence is there that short- and medium-term changes have materialised in the way predicted?**
As would be expected, there is mixed evidence of changes that have occurred, which are generally stronger at lower parts of the results chain and relatively weaker at higher levels – see table 1 below. The quality of existing evidence is weakened by the general lack of quantification, clear identification of who participants are, gender breakdowns, etc., and the extent of change being difficult to isolate and understand. This points to the need for improvements in partners' monitoring and evaluation.

Table 1: Evidence of achievement of outcomes at different levels

| | | |
|---|---|---|
| **Intermediate Outcome** | Health policies, plans and budgets are responsive to the needs and priorities of communities | Some evidence of only a few positive results (e.g. staff being allocated). |
| **Intermediate Outcome** | - Communities meaningfully engage in advocacy | Patchy evidence of mixed results. |
| | - Increased demand for health services | Good evidence available for most services, though more mixed results for the likes of family planning. |
| **Immediate Outcome** | - Strong community governance structures and active groups in place | Reasonably robust evidence of groups being in place but they're not always strong and with varying levels of activity. |
| | - Communities empowered to claim rights and demand accountable health governance | Reasonably robust evidence that information dissemination and training are being delivered to good effect. |
| | - Communities able to interpret local health status information, define their health priorities, and | Reasonably robust evidence that information dissemination and training are being delivered but communities 'technical' |

| | | |
|---|---|---|
| | monitor services being delivered | capacity appears limited to relatively few people. Less technical approaches to defining priorities and monitoring services are probably more prevalent. |


RESULTS CHAIN
THEORY OF CHANGE: ASSUMPTIONS AND RISKS
EXTERNAL FACTORS
Responsive Health delivery system providing quality services at community and health facility levels
Health priorities, plans and budgets are responsive to the needs and priorities of communities
- Communities meaningfully engage in advocacy
-Increased demand for quality health services
-Strong community governance structures and active/ credible groups in place
-Communities empowered to claim rights and demand accountable health governance
-Communities able to interpret local health status information, define their health priorities and monitor services being delivered
Information
Training
Community mobilisation
Partnerships/Brokerage in Relationships
Assumptions
-MOH management systems (Planning, Data management, decision-making, supervision and linkages) between different levels and departments are effective
Risks
-Insufficient funding
Assumptions
-Duty bearers will uphold/comply with their constitutional duty
-CSO space is sufficiently available and protected
The project's activities complement other external factors
-Plans and budgets are openly negotiated (County and National)
-Advocacy appropriately targeted and timely
-County (Mostly) and National data gathering systems effectively recognise increased demand
-Demand is communities both asking for and attempting to utilise health services
Risks
- Duty bearers drag their feet
- Communities become demotivated
Assumptions
-Increased knowledge leads to increased demand
-The linkages and communication between the various components of community governance structures are effective
- Citizens willing to demand accountability
- Local health facility information is regularly updated
Risks
- Skills do not remain active in the community (SIR) auditing
Assumptions
-Information is relevant and meaningful
-Communities willing to participate
-Social norms support participation
-New program structures do not conflict with existing community structures
-Training will be tailored to the needs of the target groups
- International health initiatives
- Constitution establishing right to health
- National Essential Package for Health
- National Community Health Strategy
- Free maternity services
- National Health Strategy / Plan defining accountable structures
- Beyond Zero Campaign
-Political opposition policies /demands
- International health initiatives
- Constitution establishing right to health
- National Essential Package for Health
- National Community Health Strategy
- Free maternity services
- National Health Strategy / Plan defining accountable structures
- Beyond Zero Campaign
- Political opposition policies /demands
-Scandalous incidents / shocks push Communities into action
- Disease outbreak / epidemic
- Free health services
- New, accessible, better equipped, and Affordable health facility
- Traditional processes, knowledge and beliefs contradict or undermine programme approaches
- Other actors implementing similar interventions currently, or in the recent past
- Media influence
- Community day to day observations
- Politicians unhelpful information

**Which links in the ToC are strong and which are weak?**

Linkages up the results chain have relatively strong logic that has been agreed with CAK's HG team and senior staff, and management and field staff representatives of partner organisations. However, not many assumptions were articulated in original project logframes / ToCs. Although more have been included in this reconstructed ToC, a number of assumptions have either not held, or have held only partially – see table 2 below. A traffic light system has been used: green = assumptions/ risks held; orange = partially held; red = not held

Table 2: Analysis of ToC assumptions and risks

| **Which Assumptions Have Held?** | |
|---|---|
| MoH management systems (e.g. planning, data management, decision-making, supervision), and linkages between different levels and departments, are effective | No |
| Duty bearers will uphold/ comply with their constitutional duty | Not always, though some try |
| CSO space is sufficiently available and protected | Generally, yes but some participatory platforms have only limited availability |
| The project's activities complement other external factors | See discussion below. |
| Plans and budgets are openly negotiated (County and National) | No |
| Advocacy appropriately targeted and timely | Partially - generally appropriately targeted but perhaps not specifically enough. Timing difficult due to govt's short & changing timescales. |
| County and National data gathering systems effectively recognise increased demand | Not known |
| Demand is communities both asking for and attempting to utilise health services | Yes |
| Increased knowledge leads to increased demand | Generally yes for governance factors, but for uptake of health services some social factors have proven restrictive. |
| Linkages and communication between the various components of community governance structures are effective | In theory yes, but in practice only partially. Not enough feedback and broader sharing. |
| Citizens willing to demand accountability | Yes. |
| Information is relevant and meaningful | Generally, yes. |
| Communities willing to participate | Mostly yes, but not always extensive. |
| Social norms support participation | Mixed - re-examine ToC & implementation |
| New program structures do not conflict with existing community structures | Yes |
| Training will be tailored to the needs of the target groups | Not always (e.g. for gender, youth). |
| Risks:<br>Insufficient funding | Mixed - often just mismanaged. |
| Duty bearers drag their feet | Yes |
| Communities become demotivated | Mixed - dependent on perceived gains, positive feedback, commitment required |
| Skills do not remain active in the community (SIR) | Not known |

The above analysis suggests that communities are certainly being empowered and are trying to influence, but their demands aren't being fully acted on.

Unfortunately, input from county and national Ministry of Health officials, and the views of MCAs, proved difficult to obtain (which should be rectified before any remedial action is taken). However, evidence provided by CAK partner NEPHAK indicates that a large part of this inaction relates to severe problems in devolved health spending - apparently county health budgets are, on average, 25-40% underspent. According to county governments this is because funds arrive late and with strings attached, but national government says it will not provide subsequent funds until previous tranches are properly accounted for. All of this leads the Ministry of Finance to say that it cannot justify increasing health spending against such huge underspends.

In conclusion, the failure of the assumptions around health service systems (being transparent, open to participation and well-managed) to hold true brings the credibility of the ToC into question and explains why the links to the mid-upper levels of the results chain, and programme results, are weak.

**Have any External Factors Significantly Influenced Observed Results?**

As part of this study, the external factors identified as potentially influencing links in the results chain were scored by CAK's HG team according to the extent of influence they perceived each one had actually had on programme results - see table 3 below.

Table 3: Analysis of influence of external factors

| **Results Chain** | **External Factors**<br>*To what extent have these had an influence on programme results?* | **Score**<br>1=weak<br>5=high |
|---|---|---|
| **Final Outcome**<br>Responsive health delivery system providing quality services at community & health facility level | | |
| ↑ | + Free maternity services<br>+ National Essential Package for Health/ Community Health Strategy<br>+ Beyond Zero Campaign<br>± Media influence<br>± International health initiatives<br>+ Constitution establishing right to health<br>+ National Health Strategic & Investment Plan defining accountable structures<br>± Political opposition policies / demands | 3<br>3<br>3<br>3<br>2<br>2<br>1<br>1 |
| **Intermediate Outcome**<br>Health policies, plans and budgets are responsive to the needs and priorities of communities | | |
| ↑ | + Free maternity services<br>+ National Essential Package for Health / Community Health Strategy<br>+ Beyond Zero Campaign<br>± Media influence<br>± International health initiatives<br>+ Constitution establishing right to health<br>+ National Health Strategic & Investment Plan defining accountable structures<br>± Political opposition policies / demands | 3<br>3<br>3<br>3<br>2<br>2<br>1<br>1 |
| **Intermediate Outcome**<br>- Communities meaningfully engage in advocacy | | |

| | | |
|---|---|---|
| - Increased demand for health services | | |
| | + Free health services<br>± Scandalous incidents / shocks (e.g. death of a child) push communities into action<br>± Disease outbreak / epidemic<br>± New, accessible, better equipped, and affordable health facility | 4<br>2<br><br><br>1<br>1 |
| **Immediate Outcome**<br>- Strong community governance structures and active groups in place<br>- Communities empowered to claim rights and demand accountable health governance<br>- Communities able to interpret local health status information, define their health priorities, and monitor services being delivered | | |
| | - Traditional knowledge and beliefs contradict or undermine programme approaches<br>+ Politicians helpful information<br>± Media influence<br>± Community day to day observations<br>- Politicians unhelpful information<br>± Other actors implementing similar interventions currently, or in the recent past | 3<br><br>3<br>2<br>1<br>1<br>1 |
| **Outputs**<br>- Information<br>- Community mobilisation<br>- Partnerships / brokered relationships | | |

From these ratings, and from other evidence collected as part of this study, it can be concluded that the following external factors that scored '3s' and '4s' have influenced HG programme outcomes.

- The provision from June 2013 of **free maternity services, and primary care services** offered at Level 1 (i.e. community) clinics and dispensaries, has had a significant effect on raising numbers of people accessing (especially maternity) services at these health facilities, including at Kiababu and Sitoka.

- **The National Essential Package for Health / Community Health Strategy**, which was initiated in 2006 as part of the 2nd National Health Sector Strategic Plan of Kenya, and has been built on by the National Health Strategic & Investment Plan 2013-2017 (which, even though it defined accountable structures, itself scored only a '1'). These strategic policies have provided a framework for how community health care services have be planned, financed, managed and delivered. Because CAK's HG programme has chosen to utilise a range of government approaches and to try to build partnerships with government, the Community Health Strategy especially has shaped HG programme interventions – but in a positive and complimentary manner.

- **Media influence** – while the media can and does influence both public opinion and political decision-making, there doesn't seem to have been any particular positive or negative stories or coverage over the last few years that has specifically affected observed changes or programme results. It is likely that this is an on-going background influence, rather than one that has played a pivotal role.

- **Politicians' helpful information** - interestingly, CAK staff added this as a counter to another external factor that had been defined as 'politicians' unhelpful information' and may reflect a recognition of interjections such as the First Lady's 'Beyond Zero Campaign' (an initiative aimed at reducing maternal and child mortality in Kenya) that they also allocated a '3'. However, the latter was only mentioned once in any written or verbal evidence for this study and, even then, not very positively.

- **Traditional knowledge and beliefs** contradict or undermine programme approaches - even though this has been a specific strand of work in the transition to a HG programme, because this study has focused on the governance aspects of the health programme, it was agreed to treat social norms as an external factor for this ToC reconstructed for the evaluation. As such, there is ample evidence that cultural and social beliefs and practices have had a significant influence on programme interventions, especially in relation to gender issues. However, it is also true that programme interventions have aimed to accommodate and/or challenge these influences to deliver planned results, but to what degree has this been achieved? To obtain a clear answer to this would require another more in-depth study of more than just two field sites but some initial findings from Sitoka (mostly) and Kiambu are:

  - › Men are now taking an interest in health issues and the management of the health facility
  - › Women are having skilled births, and attending ante- and post-natal clinics
  - › Children are being vaccinated much more than before the project
  - › TBAs have been successfully changed into 'mothers companions'
  - › Take-up of family planning is still very mixed (even among women many types are rejected)
  - › Age-hierarchy isn't being challenged and younger people aren't being specifically targeted
  - › Women have been empowered, but increased participation doesn't always lead to decision-making power.

  Unfortunately, HIV wasn't a focus issue in either of these project sites, nor was the study able to look into the recently started Sexual and Reproductive Health project, but both presumably would have brought out other social and cultural issues that may or may not be being sufficiently addressed by project interventions. Apart from gender and PLWHA, no other socially differentiated and vulnerable groups have been targeted (as in those with disabilities and/or mental health issues).

Finally, although CAK staff perceptions are very important, both to this study and because of their own influence on programme management, one other external factor seems to have had more influence on results than staff have indicated - the constitutional right to health. As this forms the fundamental basis for almost all the governance work, it seems underscored as a '2'. (All the other external factors identified in the ToC / table above are agreed as lacking consequence and/or are being successfully managed by programme interventions so as not to be a significant (negative) external influence.)

**Evidence on Validity of ToC from Kiababu and Sitoka Case Studies**

While it was not possible to investigate the effects of all of the external factors above in any

depth, the two case studies of Kiababu and Sitoka offer a good opportunity for 'reality checking' the ToC. The key points from that analysis are:

- Within the limits of these cases, the ToC generally holds true, though assumptions on county plans and budgets; advocacy appropriately targeted and timely; and supportive social norms hold more true in Kiababu than for other programme interventions areas;
- Communities were already demanding services and facilities before information and training were provided by the projects, but partner support and relationship brokerage has helped to make them more successful;
- Both cases already had available land with shells of buildings that were renovated by CDF money before that national funding stream began to be influenced more by devolved government;
- Kiababu benefitted from the local MP voluntarily relinquishing power over 'his' CDF money and allowing a local committee (including community representatives) to make decisions over that funding[14];
- Both health facilities have successfully been officially registered[15]
- Both project interventions have created staffed and operating health facilities through partnerships between NGOs, community and government;
- Both have experienced increased demand for, and take-up, of health services;
- Each has used different governance interventions - CHWs and SIR / M2M and F2F - with positive (but under-fulfilled) results;
- Interventions at Sitoka have focused on addressing social norms with increased health service up-take and some improvements in women's participation in health-related decisions.

What isn't clear from these two cases is the question of whether there was already high demand for health care as a key driver for establishing a health facility in the community in the first place, or has demand for health services increased because there is now a health facility (chicken and egg?), or is it equally due to the provision of free health care?

Also, although CAK refers to Kiababu as a model (i.e.'the Kiababu model') that undoubtedly has many positive features that others can learn from, there are too many idiosyncrasies and specific aspects of its history for it to be generally replicable elsewhere.

**So, how much contribution to observed results can CA claim?**

Given all of the above, it seems that CAK's HG programme has generally been implemented as planned, but with a number of assumptions not fully holding true. It has delivered some positive but under-fulfilled results, with the help of free maternity / health care and the hindrance of some social norms that project interventions haven't yet adequately addressed. This is summed up below.

[14] In the past, and elsewhere in Kenya, members of the national parliament have often used Constituency Development Fund money for their own means (e.g. to thank people for their votes).

[15] Since devolution, this has become particularly difficult (impossible?) as county governments are not taking on any new responsibilities for staffing or providing medicines, even where this is not fulfilled for existing registered facilities. These facilities were registered and therefore officially recognised before powers were devolved from national to county level. Currently, county governments can withhold registration as a way of not expanding their resource commitments – if a health facility isn't registered, it isn't entitled to any official provision of staff or medicines (i.e. communities have to fund everything themselves).

**Conclusion of Contribution Analysis**

Note that scoring in columns 1 and 2 is based on analysis in Tables 1-3 above, with 1= low, 2= medium, 3= high; the scoring was done by the lead evaluator.

| Column | 1 | 2 | | |
|---|---|---|---|---|
| Outcomes | Degree to which outcome realised (Table 1) | Level of contribution of CAK programme relative to other external factors (Table 3) | Contribution 'score' (col. 1 x col. 2) maximum score = 9 minimum score = 1 | Strength of evidence (high, medium, low) |
| O1 - Health policies, plans and budgets are responsive to the needs and priorities of communities | 1 | 1.5 | 1.5 | medium |
| O2 - Communities meaningfully engage in advocacy | 1.5 | 2 | 3 | medium |
| O3 - Increased demand for health services | 2.5 | 1 | 2.5 | Low-medium |
| O4 - Strong community governance structures and active groups in place | 2 | 2.5 | 5 | medium |
| O5 - Communities empowered to claim rights and demand accountable health governance | 1.5 | 2 | 3 | medium |
| O6 - Communities able to interpret local health status information, define their health priorities, and monitor services delivery | 1.5 | 2 | 3 | Low-medium |

Clearly, this analysis is illustrative rather than definitive; most organisations working in governance/ advocacy-related areas would struggle to achieve a maximum contribution score, particularly at the highest levels of the results chain, as by definition this type of work is heavily influenced both by factors (such as policy change, devolution, provision of free health services) and actors (government and other stakeholders) outside the control of the programme/ organisation. In addition, the results of such work can take a long time to realise, and change cannot always be observed within short term programme timeframes.

However, it is possible to say that:

- The degree to which outcomes have been realised shows achievement of O1 is weakest and achievement of O3 is strongest
- However, the level of CAK's contribution is relatively low for O3 - as mentioned above, this is due to external factors including the provision of free health services
- CAK's contribution to achieving the outcomes is generally moderate to strong – and strongest for O4 'Strong community governance structures and active groups in place i.e. this may not have happened without CAK's contribution.
- However, CAK's added value in achieving O1 and O3 is unclear.

Based on the analysis, it may be useful for CAK to revisit the Theory of Change and use this as a starting point for strengthening the analysis of change pathways and assumptions, as well as identifying whether and how best to improve monitoring data to enable the ToC to be tested and validated in future. This would strengthen CAK's ability to articulate and evidence its contribution and impact in future. Some broad immediate recommendations are suggested below.

| **Outcome** | **Recommendations** |
|---|---|
| O1 - Health policies, plans and budgets are responsive to the needs and priorities of communities | Revisit pathway and assumptions related to this outcome; more evidence needed viz CA added value and contribution to achieving this |
| O2 - Communities meaningfully engage in advocacy | Revisit pathway and assumptions related to this outcome |
| O3 - Increased demand for health services | More evidence needed viz CA contribution to achieving this outcome |
| O4 - Strong community governance structures and active groups in place | This is working well, keep doing it |
| O5 - Communities empowered to claim rights and demand accountable health governance | Revisit pathway and assumptions related to this outcome |
| O6 - Communities able to interpret local health status information, define their health priorities, and monitor services delivery | Revist pathway and assumptions related to this outcome |

NIDP / TRDP staff considering the validity of the reconstructed ToC

# Conclusions

A brief version of evaluation findings and conclusions was shared with, and validated by, CAK at a feedback workshop prior to the evaluation team leaving Kenya.

There is good evidence that CAK's health programme has transitioned from a health delivery programme to one much more focused on health governance, although of course there is further work to be done to strengthen this, as discussed throughout this report and below.

## Approach

While some of the approaches used may be common to almost all governance work (e.g. brokering partnerships, community mobilisation and capacity building), some are obviously more thematically and contextually specific. For example, gender-differentiated M2M and F2F support groups have been created as indirect and potentially less contentious approaches to awareness-raising about the new constitution's rights to health and participation.

Also, CAK's entry point for its governance interventions is specifically through community health, and the notion of 'health' provides a fairly wide arena for engaging communities and all levels of government on women's empowerment, as well as issues being tackled in relation to PLWHA; the latter also providing opportunities to impact on a range of generic governance challenges such as exclusion, equity and legal entitlements, personal privacy, etc.

Though most of CAK and its partners' health governance interventions focus on strengthening demand, they also use a number of relatively standard approaches and entry points to influence and strengthen public policy, financial management and accountability such as national advocacy campaigns and social budgeting. They have also deliberately chosen to utilise a number of GoK approaches (such as Service Charters, volunteer Community Health Workers, and Social Intelligence Reporting) to increase the credibility and acceptability of their outputs.

Nevertheless, the emphasis on strengthening the supply side i.e. helping county government to improve its policy making and efficient service delivery, is much less.

## Results

Overall, CAK's HG team understands what it is trying to do – I.e. the HG ToC is plausible – and it is achieving some positive results with immediate and intermediate outcomes being at least partially delivered. For example, there is evidence of:

- Communities now prioritising health needs
- Communities able to advocate for the allocation of devolved funds (even if not actually delivered)
- Increased engagements between communities and duty bearers e.g. MP, MCAs, County officials
- Increased demand for, access to, and uptake of health services
- Some social norms beginning to change
- Community involvement in health decision making at facility, sub-county & county level (though with less impact at the latter two).

Shifts in power have also been realised. For example, communities in Sitoka and Kiababu successfully made their voices heard, and established and helped to manage their community health facilities. Additionally, TBAs were successfully remodelled away from harmful practices

into being ‘mothers’ companions’, with concomitant reductions in their own and men’s domestic power, while CAK partners successfully persuaded county government to adopt this model.

Even so, evidence suggests that, overall, programme delivery is quite variable and that health service delivery / systems strengthening is still strongest, with governance aspects less so.

## The role of CAK and Partners

Nonetheless, findings show that, mostly facilitated through PPA funding, CAK has:

- Built new partnerships
- Increased partner confidence to engage
- Enhanced partner capacity in terms of thinking beyond service delivery to the higher level changes they are aiming for, and the advocacy issues and approaches that could be used to influence and achieve these
- Supported the piloting and testing of models for replication elsewhere
- Attracted more resources

PPA funding provided the catalyst for CAK to identify and engage new partners that have been able to provide more specialist governance skills and experience for older (local) partners, and also allowed CAK to provide training and support to partners that has broadened their focus from health services delivery to health governance.

Although the cessation of health service delivery was initially quite problematic for local level partners, both they and the national level partners have clearly adopted the new HG approach, and combined and developed their respective skill sets and roles to enable and support the communities they serve. There is still a tendency for partners to ‘represent’ communities rather than taking the time and effort to empower communities fully to represent themselves – although this appears to at least be recognised by partners as a priority requirement.

## Contribution of CAK’s HG Programme to Observed Results

CAK’s HG programme has generally been implemented as planned, though with a number of assumptions not fully holding true. It has delivered some positive results, although these have not been fulfilled fully yet. Some of the higher level changes observed have been influenced by positive external factors, such as e.g. the provision of free maternity / health care. While progress has been hindered by other negative external factors, such as some social norms, that project interventions have not yet been able to adequately address.

While more time and investigation needs to be put into strengthening the evidence base, preliminary findings on the contribution of CAK’s HG work to outcomes detailed in the ToC developed through this evaluation for the health governance work show that the ‘overall contribution score’ is highest for the lower level outcome ‘Strong community governance structures and active groups in place’, and weakest for the highest level outcome ‘Health policies, plans and budgets are responsive to the needs and priorities of communities’. However, the analysis is illustrative and to develop a better understanding of what is a complicated picture, it may be useful for CAK (and Christian Aid more broadly) to revisit the ToC. Some recommendations have been suggested above related to revisiting some of the change pathways and assumptions, and putting in place monitoring processes to allow CAK to better test, revise and adapt its ToC in future. This would help CAK to better understand and articulate its impact and value added in relation to the higher level changes it aspires to achieving.

## Key challenges / areas of attention going forward

- *Devolution of Health Services*

  As mentioned above, some assumptions and contextual factors have proved challenging and influenced the achievement of results. Specifically, the implementation of devolution and the assumption by CAK that a devolved health system will be effectively managed, responsive, transparent and accountable (which has not held true). While this situation may improve, CAK meanwhile needs to put much more emphasis on 'supply side' interventions. These could include strengthening the capacity and equity of especially county government institutions (e.g. through proactive briefings), and bringing government along with CAK / partners at early stages in project cycles.

- *Governance Approaches*

  There also needs to be greater clarity and agreement about how/who/where to best affect change in this in-flux environment. While awareness-raising and training on rights and governance issues is being delivered, CAK and partners have not yet developed a consistent and systematic programme that takes advantage of all the opportunities available to improve governance (for example, expanding social budgeting to cover resourcing and implementation phases more). Some good work is being done but CAK needs to facilitate a broadening and deepening of partners' approaches so that existing and effective materials and practices are delivered more proactively, uniformly and in an appropriate order across the programme. This includes advocacy work, where little collaborative action between partners, and with other civil society advocacy platforms, seems to be happening.

- *Representation*

  Acting on all of the above would go some way to helping facilitate more community-driven engagement in the governance arena. CAK encouraging partners to work beyond 'representing' communities, and interventions being less partner-driven, would improve programme efficacy and sustainability. Ensuring that outputs (such as those of SIR teams) are shared more within and across communities should also help general empowerment. There is also a need to develop some approaches to deal with the demotivating aspects of communities actually advocating and trying to access health services, and conducting social audits and social budgeting activities (albeit in a fairly limited manner), for government then not to act or respond. Achieving all this will not be easy, but significant commitment to a more community-led approach and developing opportunities to support communities to take forward their demands themselves, needs to be fostered more.

- *Social Norms*

  Although already one of the programme strands, interventions designed to address some unsupportive social norms are not being implemented sufficiently strongly to deal with the constraining factors (mostly relating to gender and age roles, but also to contentious issues such as family planning). For example, gender targeting is mostly focused on health service delivery / HSS and social norms (F2F support groups and gender-focused training of mixed groups of CHWs), with much less on governance aspects of projects (rights training and empowerment activities). Specific and appropriate targeting of younger age groups, and broadening the scope of rights and awareness raising, will challenge existing power relations within communities but should facilitate greater and more sustainable gains and should be a key element of social norms and empowerment work in the future.

- *Programme 'Models'*

  CAK has seen the successes of its work in Kiababu (Kiambu), and to a slightly lesser extent in Sitoka (Narok / Transmara), as 'models' of good practice. However, many of the conditions have changed such that these 'models' are not really replicable. For example, it is unlikely that infrastructure funding from the national Member of Parliament's Constituency Development Fund will be spent on health facilities now that county government is responsible for that. Also, it may be a very long time before country governments begin to register new community health facilities, thus increasing their obligation to provide staff and basic medicines. Although much of the programme has also moved on, and there has definitely been some learning around the importance of collaborative and multi-stakeholder development (e.g. of the clinic at Kiababu's), CAK and its partners may want to review their vision and targeting of community health facilities as platforms for improved health governance opportunities in the future.[16]

- *Staff Expertise*

  Through lack of funding / local specialist expertise, work on tax and fair revenue financing appears to have dropped from CAK's programme. This should be a key element in any health governance programme, especially since health financing is an area of particular importance and challenge in the Kenyan context. More efforts in this direction would fill what is a significant gap in programme approach and help to complete the circle of governance.

## 7. Recommendations and areas of further investigation

Overall, there is potential to harness opportunities more and to increase impact. In order to do this, **CAK and its partners could strengthen governance aspects of their HG programme**, especially:

- Taking a more systematic approach to the application of different governance mechanisms and interventions, including helping partners agree what approaches and materials are most appropriate and effective to be delivered in what order and in what combinations
- Putting more emphasis on county government capacity building, and bringing government along at early stages in project cycles, including through proactive relationship development and briefing key MCAs and officials (e.g. MCAs on the health management committee, clerks to the latter, and female MCAs)
- Developing better 'intelligence' and packaging evidence of community level learning for collaborative advocacy at county and national levels (e.g. by methodically collecting, analysing and documenting community level data in a user-friendly manner, and using it to act with others).
- Focus more on empowering and supporting communities to represent themselves (and to stay motivated in the face of minimal government response).

Additionally, **CAK and partners should**:

- Emphasise more systematic follow-up, feedback, and mechanisms for broader sharing of information with, within, and across communities for group sustainability, community empowerment and advocacy.

[16] As an aside, the role of CHWs is apparently being reviewed by the GoK, and this may create questions around the sustainability of CAK use of these structures and interventions.

- Target awareness-raising activities and training at, and in support of, young people (male and female, separately and together).
- Go beyond gender and PLWHA to other categories of vulnerable groups such as those with disabilities.
- Recognise and plan for the importance of timing - (e.g. for proactively planning budget cycle influencing and monitoring, and for other advocacy work; plus accommodating the slowness of cultural change and government change management)
- Through an updated power analysis, review their understanding of the role of key individuals (e.g. First Ladies, MPs, MCAs, church leaders), all of whom can strongly influence context and the programme both positively and negatively
- Use their ToCs as a project management and monitoring tool to inform programming, activity designs and project implementation.
- Consider how CAK staff expertise in tax and revenue (and advocacy?) can be brought back into the programme.

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**Conclusions**

There is good evidence that CAK's health programme has transitioned from a health delivery programme to one much more focused on health governance. Overall, CAK's HG team understands what it is trying to do – the HG ToC is plausible – and it is achieving some positive results with immediate and mid-term outcomes being partially delivered. Even so, evidence suggests that, overall, programme delivery is quite variable and that health service delivery / systems strengthening remains strongest, with governance aspects less so.

**Potential Learning from CAK's Experience**

- It takes time to transition a programme and it can only happen with a strong vision of how key components can and should link together.
- The latter needs to include full identification and consideration of underpinning assumptions, and a comprehensive assessment of external factors, that may / will influence planned outcomes.
- An appropriate combination of partners with complimentary skills and experience needs to be facilitated and supported to work together effectively.
- Partners having to radically change their roles and responsibilities as part of any transition may require additional support, especially to manage the expectations of those they serve.
- Regular and effective monitoring needs to be in place for the programme to adjust to changes in both internal and external environments.
- With devolution of power and public services, some doors for influencing close, but new opportunities (such as new elected members, committees, etc.) are there and waiting to be identified and utilised.
- There is no short cut or alternative to empowering communities so that they are able to drive change for themselves (i.e. NGO-driven change will never be sustainable).
- Culture change is slow and non-linear.

Finally, Christian Aid has asked INTRAC to provide some direction in terms of wider learning that can be drawn from the two country studies that INTRAC was involved in (Bangladesh and Kenya) and that could be packaged and shared across CA's global governance programmes. An attempt has been made to do this below, based on the (limited) evidence that emerged across the two studies. This would have been easier to do through a process where ToRs and key questions were shared across the four country studies and cross-cutting questions prioritised for each study/ across the four studies in advance of the field work.

Therefore, the suggestions below should be further discussed and validated by CA's governance team/ leads, including against the other two country studies, not conducted by INTRAC.

**Some initial lessons and recommendations emerging from the Bangladesh and Kenya country studies to potentially inform CA's governance work globally**

- More systematic approaches to and guidance on governance programming (what it means, what changes it is aspiring to, what the key elements are, how it manifests at different levels) in-country, along with materials and resources and focussed training and capacity building for CA's partners is both appreciated and crucial for partners to be able to strengthen governance work.

- Developing and using Theories of Change more dynamically and systematically in the design, monitoring and evaluation of governance programmes could help CA to better articulate the changes it is aspiring to and to more clearly assess (and articulate) its added value, impact and contribution to achieving its governance and advocacy aims in future.

- Theories of Change should include an explicit analysis of how change happens in governance programmes (change pathways), an analysis and articulation of assumptions at different levels, and a process for testing, validating and reviewing these on a regular basis. Alongside this is needed adequate M&E capacity to evidence and report on change at outcomes and impact level.

- A crucial aspect of CA's added value in governance work in any context is in its role in sharing information and facilitating collaboration between governance actors, including between different NGOs (CA's partners and others) and relationship building with local and national government structures.

- CA's partners' governance work appears to be rooted in community-level work, particularly group formation and mobilisation, that identifies and facilitates practical entry points for communities and vulnerable groups and individuals to begin to engage more with duty-bearers, and articulate and demand more accountability and changes in power relations. However, there needs to be more focus on understanding (and then articulating and planning) how to move from this level to higher level outcomes such as communities being able to hold duty-bearers to account and influence the supply side of good governance.

- In order to achieve higher level governance and advocacy objectives, CA and partners need to develop better planned, more systematic approaches to address 'supply side' constraints and barriers i.e. how to (support communities to) influence duty-bearers to respond to demands, how to build an evidence base and constituency of support for national level advocacy work. Starting points for this could include better use of power analysis to identify advocacy 'targets' and potential 'allies' and collaborators at different levels, as well as developing advocacy strategies within governance programmes. Technology use could be important here, as it has been in enhancing the demand side of governance.

- Within governance work at community level, analysis is needed on intra-group and intra-household power relations in order to avoid reinforcing existing or creating new power imbalances (e.g. between illiterate and literate women, between mobile phone owners and non-owners etc).

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# Annex A: Evaluation Terms of Reference

**Scoping of the Accountable Governance assessment of impact and learning in Kenya**

This short note suggests the scope and focus for the Kenya country study which is being commissioned as part of our wider organisational assessment of our work on accountable governance. The aim of the wider assessment is to:

- To generate evidence of the impact our work has had/is having
- To generate learning across Christian Aid – on discrete areas of work, but also on how connections are made across the organisation on different pieces of work.

This assessment process will include four country studies, using different evaluative approaches to understand and document a range of different governance **programmes** we have implemented. These country studies are serving multiple audiences. Firstly we intend that they will deepen our understanding of programme practice and be useful for sharing across our country programmes, beyond this we aim to:

- generate a series of materials which can be shared with our external stakeholders, including supporters, churches and funders that are illustrative of our programming approaches in governance, and share both impact and the complexity of process (i.e. change in governance is often non-linear, and involves a range of complicated power dynamics)
- Identify ways in which our public policy and advocacy work regionally, globally and in the UK can better build on and respond to programme experience and learning; equally important will be to find areas of our programme work which would benefit from deeper integration with our policy insight and analysis.

The Kenyan country study will focus on our work in the area of health governance. We are particularly interested in how integrating a governance approach has enhanced the impact of our health work in Kenya, and to learn lessons from the evolution of this programme.

**Describing the Kenyan Health Programme**

Christian Aid began working on HIV in Kenya in 2006 but about four years ago the programme shifted to taking a broader community health approach – including maternal and child health, Malaria, TB, and primary health care. This approach has continued evolving and the programme has now been structured, focusing on three thematic areas: health governance, community health systems strengthening and gender equity and social norms. This reflects Christian Aid's Community health framework which links three factors in 'making the right to health services a reality' (health services development, equitable social norms and equitable institutions).

In Kenya the Right to Health was enshrined in the constitution in 2010. The Kenya programme has a range of different funders of their health work (PPA funding, Comic Relief, EC, Bread for the World, UK Aid Match and Virgin Unite) and therefore extensive work across different parts of Kenya – often with a focus on HIV, maternal and child health , primary health care, Sexual Reproductive Health and Gender .The PPA has been instrumental in supporting the evolution of the health programme, and encouraging a focus on preventative services in community health, community participation and advocacy, holistic approaches to HIV – including a focus on social

norms, and advocacy for policy change linking local work to national policy and advocacy on HIV, health financing and MCH policy.

The PPA programme (which will be evaluated later this year) had identified 10 advocacy issues as part of the broader programme, and central to this has been a focus on building partners capacity to 'do advocacy' through training and accompaniment. Through this approach there is evidence of PLWHA successfully advocating on health related issues.

In other work, for example through the Virgin Unite funded programme, where a key element of the approach was to provide motorbikes to community health workers to enable them to reach many isolated households, there has been a recent focus on transitioning the model to the Ministry of Health, and working with the government to take over the project. Interventions on health governance are implemented at community, county and national levels and targeting changes in policy, increase in resource allocation and improvement in health service delivery. This work is embedded in a citizen driven health governance approach which is key to communities enjoying their right to health services. Outcomes are related to improved resource allocation to health services, transparency, accountability, and community voice and participation in the prioritization, management and governance of health resources.

While the majority of this work is currently happening under the PPA project, the other projects i.e. SRH, MCH and RTN have integrated health governance to ensure equitable access to health services, with specific indicators developed. Linkages between projects and synergies between partners have been created to support the integration of health governance processes and enhance leverage. A key area of the work has been building the capacity of local level health partners in advocacy and governance by partners with expertise in national and community level health advocacy, these partners include; Inter-Religious Council of Kenya (IRCK), Centre for Rights Education and Awareness (CREAW), National Empowerment Network of People Living with HIV (NEPHAK), Health Rights Advocacy Forum (HERAF).

The partners have been providing training and accompaniment to other partners on health budget advocacy, community participation in budget monitoring and involvement in social accountability mechanisms for health service delivery, access and rights and to enable them to engage in the various budget making platform set ups, for example 'Social budgeting and observatory forums' with a view to empowering communities to engage with social budgeting processes, and monitor and influence county level resource allocation and expenditure.

Budget analysis at this level indicates that the majority of the budget is spent on recurrent costs, with little available for capital investment or improvement of health facilities. To date most of the work on budget analysis has focused on expenditure, however, there has also been some analysis on tax and revenue raising – for example, in Narok where there is high revenue from tourism, and an interest in advocating for higher allocations to health. Our budget analysis work is an entry point to engage with Tax Justice Advocacy. This work is not yet well developed, however we have an interest across Christian Aid in better integrating our work on Tax and Rights to Essential Services so it would be important to understand this further.

**Assessment of Impact and Learning: questions and methodology**

This part of the assessment will focus at to levels:

1. Assessment of the challenges, dynamics, strategies for success etc. in transitioning from a programme focused mainly on community health service delivery to a programme focused on

health governance – why did this happen, how did this happen, what has been the impact and what can we learn?

2. Identification of specific 'governance' approaches within the programme – with an emphasis on the work on health financing and resourcing, budget advocacy, social budgetary observatory frameworks, other social accountability mechanisms such as community monitoring and participation mechanisms – how have these been developed, what has been their role and impact, what learning is there in relation to our broader questions on governance in the overall ToR. Of particular interest will be the local to national linkages – questions of how 'working politically' and engaging with issues of power and powerlessness at local level interact with advocacy and use of advocacy tools nationally.

***Key questions:***

1. How does work on social norms, equitable institutions and health service delivery/systems strengthening interact to bring about a health governance programme? What is the balance between these different aspects?
2. What is the role of women, what can we learn about women's participation, what can we learn about working politically – and how this looks different for men and women, (and other grouping - e.g. PLWHA, women in SRH and MCH projects?
3. How has the local programme implementation linked up with national advocacy processes?
4. How have power relations between community, partners and government institutions shifted through our work, what can we say about the quality of engagement with government institutions, or other relevant bodies?
5. What has changed in how partners understand their role and approach in governance work, what 'added value' do they identify through the approach and our engagement/support?
6. Document how PPA strategic funding has impacted on the evolution of the Kenya program from a community health focused project to broader health governance programming

***Methodology:***

The assessment will focus on two geographic zones funded by PPA. These include Kiambu and Narok. Additionally partners involved in national level policy advocacy (based in Nairobi) will also be targeted.

The programme is currently guided by a Theory of Change for Health, which has been developed in Kenya drawing from Christian Aid's Global Community Health Framework. Therefore it will be important for the evaluation to engage with this theory of change, and explore its assumptions, strategies and translation into practice.

The programme has a long history, and the transition to a rights based programme is relatively recent, it is likely that there will be areas of strong governance work, some areas which are more easily described as a located in a service delivery/systems strengthening approach – with some elements of connection and potentially some areas of disconnect. It will therefore be important to use an approach which can capture the nuance and complexity of the programme, alongside identification of key areas of success and change.

*Potential approaches include Realist Evaluation, Critical Story of Change or Process Tracing.*

Within the broad methodological approach there are a series of standard methods that we would expect to form the basis of the assessment:

- Literature review
- FGDs, KIIs (including with MP, reps of county government), HH interviews
- Secondary data: health facilities, county budgets
- Value for money assessment?

The approach should be both empowering and useful for the Kenyan programme/participants involved in the assessment, and generate a useful product for use internally across Christian Aid and with our external stakeholders.

**Timing and process**

The Kenyan Country Programme will host a 10-14 day visit sometime between July-September, it is suggested that we recruit an external consultant with experience in qualitative research and evaluation.

- June: recruit consultant, further define ToR, questions, background materials etc. develop communication plan
- July or Aug: country visit
- Sept: draft report(s) – Kenya comments, IA SG and governance staff comments
- End Sept: workshop with others involved in the review
- Oct: final report – to board

**Outputs**

A written evaluation report (focused on a health programming audience or governance audience):

- Understanding of processes and approach in the Kenyan Programme
- Examples of impact/stories of change among the partners, participants and CA itself
- Key challenges/areas of attention going forward
- Learning/Recommendations for CA more broadly

Extended case studies/stories of change and impact which can be used externally to illustrate the work.

Participation in the workshop in September to identify broad themes that feed into deepening our understanding of particular issues of governance (for example, working politically, quality engagement, interaction between governance and gender/social norms – incl. PLWHA, and the role of financial literacy, advocacy etc.)

## Annex B: Visit Plan

| Date | Event | Place |
|---|---|---|
| Tuesday 22 September | Workshop with CAK staff (expectations of study, timeline exercise and discussion of ToC) | Nairobi |
| Wednesday 23 September | Workshop with partner staff (Timeline and Impact Grid exercises and discussion of ToC) | Nairobi |
| Thursday 24 September | FGDs with CHWs, 'Leaders', and NCCK staff | Kiambu |
| Friday 25 September | KIIs with:<br>-CDF Chairman, Githunguri Sub-County, Kiambu<br>- SIR / social audit team member<br>- NCCK Youth Religious Leader<br>- Local MP<br>- Chairman of Kathangari health facility & CHW Chairperson<br>- two NCCK staff | Kiambu |
| Saturday & Sunday | Construction of revised ToC | Nairobi |
| Monday 28 September | FGD with NIDP, TRDP and CHP partner staff<br>(ToC validation and impacts discussion) | Narok and Kilgoris, Transmara |
| Tuesday 29 September | Meeting with TRDP partner staff<br>KII with Sitoka nurse<br>FGDs with health facility management committee, TBAs, M2M and F2F groups | Kilgoris and<br>Sitoka, Transmara |
| Wednesday 30 September | Travel back to Nairobi<br>KIIs with NEPHAK Executive Director, and CREAW senior staff member | Kilgoris and Nairobi |
| Thursday 1 October | Analysis of findings | Nairobi |

| | | |
|---|---|---|
| Friday 2 October | Analysis of findings, preparation of presentation, and feedback workshop with CAK staff. | Niarobi |

## Annex C: Methodology Guide

To follow.

## Annex D: Timeline

| | 2005 | 2006 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 |
|---|---|---|---|---|---|---|---|---|---|---|
| Strategy | | Start of CA Kenya Program | | End of CA 'East Africa' and move into thematic structure | Start of Comm. Dev. Approach into HIV programme | Violence Against Women and Health linkage recognised with partner COVAW | 'Partnership for Change' corporate strategy roll out and CAK realignment | Advocacy success in HIV financing & SAVE model adoption creates increased belief in advocacy approach | CAK Health Strategy review | |
| | | | | | | | CA Global Community Health Framework | CAK Country Strategy reviewed | | |
| Projects / Funding | | CBCO (HIV Orphans USAID funded project - 2011) | Rural Transport Network for Health launched | 'Filling the Gap' HIV project - Comic Relief funded | 'Vital Voices' EU-funded project (incl. Comm. Dev. Fund utilisation and decision-making) - 2012 | Start of PPA (partners expanded from 7 to 12) | End of Comic Relief funding | MCH - EU project | PPA extension | MCH (Isiolo) - UK Aid Match |
| | | | | | | | | | Sexual & Reproductive Health project - Comic Relief | Action 2020 - DfID |
| | | | | | Global Transparency Fund - 2013 | Reduction in CAK core funding (2011/12) | | Kiaibabu 'model' began | MCH (Isiolo) - Bread for Work funded project | |
| Studies / workshop | | | | | | PPA Baseline (with focus on advocacy) | CAK analysis of MoH contribution to overall HIV funding | SROI study (as part of Filling the Gap project) - early 2013 | Advocacy Capacity Assessment | |
| | | | | | | Advocacy training (for PPA partners?) - NEPHAK) | Social accountability workshop | Global Health Workshop | Health Governance workshop, Abuja | |
| | | | | | | | | PPA (London) workshop integrating health & livelihoods & governance | | |

<table>
<tr><td rowspan="3">Other</td><td></td><td></td><td></td><td></td><td></td><td></td><td colspan="2">Loss of CA HIV staff</td><td>HERAF = new partner</td><td></td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td colspan="2">ex-Country Manager input / support on tax issues for health governance program</td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td colspan="3">CA Gov. Officer input / support on governance for health governance program</td><td></td></tr>
<tr><td rowspan="6">External Factors</td><td rowspan="5">HIV Prevention & Control Act criminalising people who infect others</td><td rowspan="6">Community Development Fund started</td><td rowspan="5">Post-election violence - recognition of links between women, violence & health</td><td colspan="3">MoH split (into medical & public health) = period of confusion</td><td colspan="2">Devolution & new government</td><td rowspan="6"></td><td rowspan="6"></td></tr>
<tr><td rowspan="4"></td><td colspan="3">Kenyan civil society moves into more public policy, governance & rights focus</td></tr>
<tr><td>Constitution established Right to Health</td><td rowspan="3">National ‘Essential Package for Health’</td><td>PEFAR (HIV fund) ends / shift in USAID funding</td><td>Free maternity services policy</td></tr>
<tr><td rowspan="2">Presidential sign-off on HIV Financing Act = confidence booster (advocacy works!)</td><td>National Health Strategy policy / plan? - defined accountable devolved structures</td></tr>
<tr><td>Public Benefit Organisations Act</td></tr>
<tr><td>2nd National Health Plan (2005 - 2010)</td><td colspan="3">National Community Health Strategy developed (from Public Health Strategy)</td><td></td><td>Health workers strike</td></tr>
<tr><td colspan="4"></td><td></td><td></td><td></td><td>Beyond Zero (MCH / HIV etc) campaign sponsored by 1st Lady</td></tr>
<tr><td colspan="4"></td><td></td><td></td><td></td><td>New County 1st Ladies - some become ‘champions’ on health-related issues</td></tr>
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## Annex E: Narok Case Study

### Social Norms Certainly Matter in Development Programming!

Sithoka is a community in the Transmara County of Kenya. It lies ……

Florence …..is a Registered Community Health Nurse, employed by the county government who was posted to Sitoka eight months ago when the community requested a nurse to run the facility that had been provided by Christian Aid. She is the only nurse in the community and takes care of all in-patient and out-patient needs including referrals, assessments and examinations.

“When I reported to this community, there was a nurse who had been employed by the community but she had not conducted any deliveries. The Community Health Workers were trained to mobilise the community on the importance of ANC/PNC, skilled deliveries etc. and now some of the women report to the facility for deliveries”.

Florence says there are still women who deliver at home because they think she is too young and rather prefer being attended to by Traditional Birth Attendants who are usually elderly. She added that there is also a long standing practice of home deliveries in Sithoka and surrounding communities. In addition to these, transportation is usually a problem for the hilly mountainside of Sithoka residents, some of whom have to travel several kilometres to access the health facility and would rather prefer delivering at home. There is also a perception that episiotomy and caesarean sections are bad for women, and Florence says that the women sometimes even prefer “a tear”, when they deliver at home, to delivering in the hospital to avoid such procedures.

According to Florence, among the community perceptions is the issue of women who practice Family Planning being branded as “harlots”. Due to this, most of the women in the community practice Family Planning secretly and prefer not to take their hospital cards home to avoid detection by their partners and others. This has led to injectable and implants being the most preferred methods for women in this community, because they can’t be detected easily. Condoms and pills are the least preferred Family Planning methods because of their visibility.

In a focus group discussion with 17 women from the community, they admitted that the project had been helpful especially for the women in the community because of the savings scheme the Mother-to-Mother support groups undertake. They also felt it had been useful for the men due to the Father to Father groups, but power relations change slower than expected. They explained how men still meet alone to discuss certain issues, without the involvement of women, and cited the example of how discussions on the road, which has recently been constructed in the community, did not involve the women. When asked why that happened, a number of the young respondents said in unison **“gender inequalities!”** The women were generally of the view that more education was still needed for the men in the community on gender and family planning.

Asked if the intervention could still achieve the desired objectives without interacting with social norms, the young women again replied in the affirmative but explained that it would take a longer period to achieve the objectives in that scenario. In their own words, “that would be vision 2050, without tackling social norms”.

The need to properly consider social norms cannot be overemphasised in development programming.

# Annex F: Kiababu Case Study

## The Story of Kaibabu- from the community's perspective!

**How it all started**

NCCK piloted a social audit health project in Kurama, Kiambu, funded by the EU before the commencement of the PPA. Outcomes of the initial social audit project included a by-election which saw a woman elected for the first time. All these events led to surrounding communities requesting for an extension of the project to their areas which led NCCK to request Christian Aid for assistance.

NCCK convened an internal regional meeting at which the religious leaders chose representatives to learn from Kurama's health project, which had been promoted as a success, to be replicated in other communities. Christian Aid responded to the NCCK request with PPA funding. Another contributing factor was the fact that CA partner IRCK had also implemented the SBOF and shared learning with other CA partners. Christian Aid directed that SBOF be used for the NCCK's project in Kiambu.

The SBOF is a government policy which seeks to match social needs with government budgets. The framework is currently being operationalised by a few NGOs in the country. Implementing the SBOF according to the framework meant that NCCK had to reconstitute the CDF committee and constitute community health volunteers as well as SIR teams.

**Interventions**

With PPA funding, NCCK assisted the MoH to reconstitute the CDF according to government Act and MOH led their training for 10 days. NCCK held consultations at the community and various levels and CHVs were selected from different villages and trained on HIV/TB, Maternal Health issues, etc, to do health education and household visits and refer cases to the hospital. The CHVs were trained to conduct outreaches to improve service delivery. They are supervised by the Public Health Officer who consolidates their reports and submits to the various levels

SBOF/SIR teams were identified by communities, recruited and trained according to MoH procedures. The teams collect data for Health Committee of County Assembly. NCCK brokers and empowers by developing understanding of government structures and making communities aware. SIR teams have been trained to incorporate social needs of the community in the county budget. NCCK assists the SIR teams to analyse the findings and facilitates a memo to the health committee with the needs of the community incorporated. Monthly reports to MoH are copied to NCCK.

The CDF was also trained by NCCK on the SIR/SBOF and they disburse funds based on priorities.

The Kiababu Health Centre story started in 2012. The structure was initiated years earlier by the defunct council and was in a deplorable state (not even a roof). The nearest functional health centre was about 5km. Through the SIR team, the community asked the CDF to renovate the building which was granted and CA provided equipment through PPA funds.

The community is now empowered through the use of the SBOF and presents priorities to county authorities which are considered in county budgets and allocations. Some requests which had been made by SIR teams on behalf of the community include requests for fencing for the hospital, a stand-by generator and a water tank.

The health centre could not handle the caseloads when it commenced operations and the community had to lobby the CDF and the MoH for more staff. As a result, 6 new staff have been posted to the facility. The community also engaged the CDF to repair a bad road through by submitting a proposal.

NCCK leads the process of engagement with duty bearers when the SIR teams collect information?

**Outcomes for Community**

The Kiababu community certainly attributes the outcomes to NCCK and Christian Aid. "We could not have achieved the outcomes without NCCK / Christian Aid - they trained us to identify sicknesses during outreaches; we got mobile phones to communicate with expectant mothers; communities have been empowered to demand for services; nutrition training helped expectant mothers to be healthier; they taught us simple hand-washing technique to teach the communities; we treat jigger infestations with disinfectants; and we also conduct deworming / water treatments. We used to walk as far as 5km to access health services, now we walk from our houses to the facility. Since the establishment of the facility, 13 new-borns have been delivered by skilled attendants".

In spite of these gains, CHVs say there is still a lot more to be done in engaging with government officials "The public health department is sometimes not happy with CHVs activities – for example, reported cholera cases were dismissed by the public health department as rumours.

Overall, most community members were of the view that power shift from duty-bearers to community members has improved in favour of citizen engagement in comparison to years before the project / devolution. As one CHV put it -"we stand on a more advantaged position than we were some time back but community empowerment needs to be done continuously- more capacity building needed".

"Being a village at the interior, we could not have gotten the prominence the Kiababu case has gotten without empowerment". Evidence – through the indulgence of NCCK, we had voice and empowerment; we never knew that the county government had money we could claim. We realised our rights – there is a fund set up by county governments for PLWD and knowing that helped us to advocate for our rights.

**Recommendations for NCCK/CA**

- CHVs requested financial empowerment through income generating activities or stipends; cameras, stationery etc. to record stories encountered during outreach; first aid kit; ID cards; and smartphones for registration on Kujuwa platform

<u>Sustainability</u>

- CHVs positive they can continue their activities after project's end date**.** "We have recognition in the community and are selected to serve on committees such as the county bursary. Our passion for the work will ensure we continue because the community now holds us accountable"