

# **UNDERSTANDING THE GLOBAL FINANCING FACILITY: The Case Study of Kenya**

**Commissioned by WACI Health, KANCO and HENNET**

**February 2017**

## **1.0 INTRODUCTION:**

The objective of this report is to support the Kenyan CSOs towards an in-depth understanding of the Global Financing Facility (GFF) and develop clear roles and responsibilities within the GFF framework for effective accountability.

**The analysis involved an in-depth review of the Kenya Investment Framework and Program Appraisal Document (PAD) to respond to the following;**

- i. Comparison of the key priorities as detailed in the Kenya investment Framework and those that are included in the Program Appraisal Document (PAD), to enable key RMNCAH stakeholders understand what is funded by GFF in Kenya.
- ii. Identify gaps in the Program Appraisal Document (PAD)
- iii. Are there high impact interventions that are included in the Investment Case but are not funded in the PAD? Of the areas that are funded in the PAD, which level of government is taking lead (national or counties)? Is it established which counties will receive GFF, and are there identified specific needs per each of the counties?
- iv. Has the funding prioritized specific needs of the funded counties?
- v. The extent to which the Investment Framework and PAD make reference and prioritize nutrition

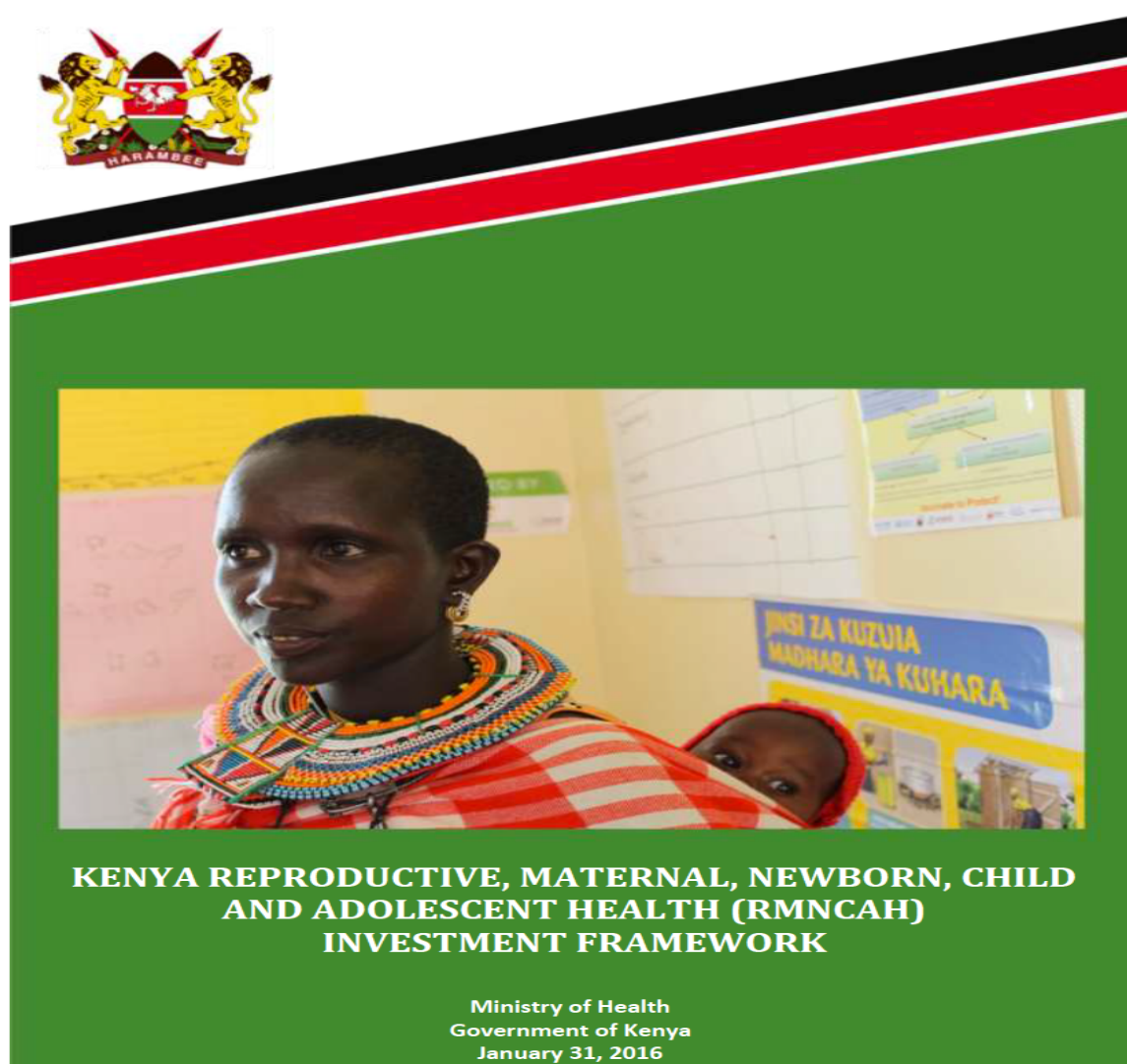
This reported is authored by Prof Peter Gichangi, BSc, MBCHB, MMED(O/G), Ph.D. Associate Professor, University of Nairobi, with financial support from RESULTS Educational Fund.

## 2.0 A CASE STUDY OF KENYA

Global financing facility (GFF) with other global intervention are aimed at addressing key elements of sexual and reproductive health, more specifically reproductive, maternal, newborn, nutrition, child, and adolescent health (RMNCAH). By availing resources for RMNCAH, GFF is likely to change key health indicators and address some elements of Sustainable Development Goal (SDGs) in Kenya. Key in the pathway to achieve the intended objectives is to have all the players contribute their bit. In implementation of health programs in Kenya and elsewhere, civil society organizations (CSOs) play a significant role in different elements of the implementation. In particular, CSOs have been shown to be efficient in demand creation, advocacy, mobilization of active citizen participation and monitoring. To better understand what CSOs in Kenya can do to contribute to achievement of GFF investments in Kenya, Kenya Reproductive, Maternal, Newborn, Child, and Adolescent health (RMNCAH) and Project Appraisal Document (PAD) were analysed.

### 2.1 FINDINGS FROM RMNCAH AND PAD ANALYSIS

#### 2.1.1 RMNCAH INVESTMENT FRAMEWORK



## **VISION**

A Kenya where there are no preventable deaths of women, new-born or children and; no preventable still-births, where every pregnancy is wanted, every birth celebrated and accounted for; and where women, babies, children and adolescents are free of HIV/AIDS, survive, thrive and reach their full social and economic potential.

## **Guiding principles**

1. Respect human and reproductive health rights and promote gender equality as envisioned in article 43 of Kenya Constitution;
2. Promote shared prosperity by making strategic investments in the health sector which will contribute to equitable growth and development;
3. Enhance efficiency, productivity, quality of services, and accountability through scale-up of evidence-based high impact interventions, performance measurement, incentives and integration;
4. Nurture a health system that is resilient, responsive and accountable to client needs and also capable of leveraging private, FBOs, civil society and community health delivery mechanisms and structures;
5. Ensure country and county leadership and ownership that will provide appropriate stewardship based on the national health sector strategies and county RMNCAH implementation plans integrated with the planning and budgeting processes and cycles;
6. Promote continuous learning by doing, course corrections and innovation

## **What are the proposed areas of investment?**

As a result, three main strategies are at the core of the RMNCAH investment framework:

1. Address disparities and increase equitable coverage through prioritized investments in underserved counties, and accelerate action for underserved and marginalized populations.
2. Address prioritized demand side barriers to increase utilization, coverage and affordability of RMNCAH services.
3. Address prioritized supply side bottlenecks in the health system to improve access to high impact interventions delivered efficiently and effectively while ensuring financial protection for the poor.

The RMNCAH framework proposed activities to enhance transparency, citizens' participation and social accountability. Enhanced transparency is essential to the integrity of the health sector. Transparency can be achieved via citizens' participation in relevant decision-making bodies and social accountability which can be led CSOs, like those working under the Health NGO Network (HENNET).

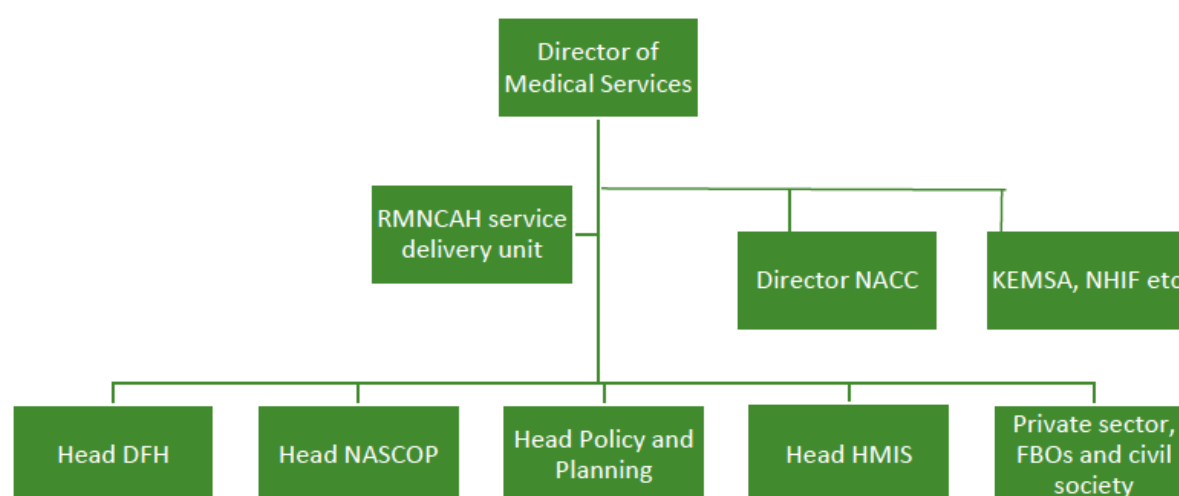
Key actions to enhance transparency, accountability and citizen participation:

1. Ensure that all health facilities disclose key information (e.g. names of key technical staff posted to the facility, budgets and availability of tracer commodities) to the community.
2. Ensure that all health facilities have elected facility management committees in place as per the norms established.
3. Establish a national complaints registry for the health sector through the MOH and monitor the responsiveness.

4. Reactivate the social accountability technical working group and client feedback mechanisms such as citizen's report cards, community score cards or client satisfaction surveys.
5. Institutionalize the use of social accountability for RMNCAH achievement using tools such as score cards.

Under governance and stewardship, a service delivery unit was proposed, see figure 19 abstracted from RMNCAH. Civil society are recognized as one of the implementers of the proposed activities in the investment framework.

**Figure 19: Organogram of MOH Oversight Committee for RMNCAH**



Source: RMNCAH 2016:53

For measurement and accountability, the following activities were proposed:

1. Investments to be made to strengthen the District Health Information System (DHIS) and Civil registration and vital statics (CRVS).
2. To improve population level data collection to inform planning, help to assess achievement of population level changes, improve governance and accountability, and ensure the rights of Kenya's citizens.
3. To enhance Citizens' engagement. The social accountability technical working group to be reactivated and innovative approaches to be rolled out to receive citizens' feedback.
4. To establish an independent review group/body to assess RMNCAH achievements on an annual basis by triangulating service statistics and survey data.

## 2.1.2 PROJECT APPRAISAL DOCUMENT

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Report No: PAD1694

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT APPRAISAL DOCUMENT

ON A

PROPOSED CREDIT  
IN THE AMOUNT OF SDR 105.9 MILLION  
(US\$150 MILLION EQUIVALENT)

AND A

PROPOSED GRANT  
IN THE AMOUNT OF US\$40 MILLION  
FROM THE GLOBAL FINANCING FACILITY

AND A

PROPOSED GRANT  
IN THE AMOUNT OF US\$1.1 MILLION  
FROM THE JAPAN POLICY AND HUMAN RESOURCES DEVELOPMENT FUND

TO THE

REPUBLIC OF KENYA

FOR A

TRANSFORMING HEALTH SYSTEMS FOR UNIVERSAL CARE PROJECT

May 24, 2016

Health, Nutrition and Population Global Practice  
Africa Region

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The Project reflects priority strategies identified in the RMNCAH investment framework to address:

1. disparities and inequitable coverage through investments to underserved populations and areas;
2. prioritized bottlenecks that prevent the delivery and scale up of proven, high-impact, evidence-based interventions to women, children and adolescents;
3. vital gaps in the health system to support an efficient and effective delivery of high-impact RMNCAH interventions optimizing existing, and mobilizing new public and private sector investments in the health sector; and
4. community engagement to generate demand, promote behavior change, and enhance social accountability (SAc).

The RMNCAH investment framework builds on the existing Civil registration and vital statistics (CRVS) strategy. The Government has been in the process of developing a Health Financing Strategy (HFS). The evidence-based, high-impact interventions identified in the RMNCAH investment framework will inform the development of county annual work plans (AWPs) to address their specific prioritized bottlenecks or areas where they are lagging behind. International Development Association (IDA) and GFF funding will leverage other DP financing including increased financing from domestic sources and the private sector. To harmonize programs, DPs agreed to support and coordinate their financing in support of the RMNCAH investment framework. Though the Project will also benefit from other ongoing World Bank projects (PAD 2016:11). None of the existing WB projects address CSOs.

### Where is the funding going?

Component 1: Improving PHC Results (US\$150 million consisting of US\$115 million equivalent credit from IDA and US\$35 million grant from the GFF TF). Component 1 aims to improve the delivery, utilization, and quality of PHC services at the county level with a focus on RMNCAH. This component will use a performance-based approach by employing minimum conditions and allocating resources to the counties based on their improved PHC results.

This component will also earmark funding for RMNCAH strategic commodities. From the PAD, RMNCAH strategic commodities are those captured in the MoH. 2016 Family Planning Commodity Quantification and Supply Planning Review for FY2015/16 to 2016/17 Technical Report. Nairobi.

**Table 3. Annual and Total Allocation (US\$, Millions)**

|                              | Year 1 | Year 2 | Year 3                                     | Year 4                                            | Year 5                                        | Total |
|------------------------------|--------|--------|--------------------------------------------|---------------------------------------------------|-----------------------------------------------|-------|
| Performance-based allocation | 12.5*  | 27.5   | 30<br>(+ any undisbursed amount in Year 2) | 30<br>(+ any undisbursed amount in Years 2 and 3) | 30<br>(+ any undisbursed amount in Years 2-4) | 130   |
| RMNCAH strategic commodity   | 6      | 5      | 4                                          | 3                                                 | 2                                             | 20    |

Note: \*Allocation in Year 1 is smaller due to a shorter implementation period (that is, six months) and sensitization as well as capacity building required.

Source: PAD 2016:14

Counties will then use the performance-based allocation to support priorities identified in their Annual Work Plans (AWPs) to further improve utilization and quality of key Primary Health Care (PHC) services.

Component 2: Strengthening Institutional Capacity (US\$15.1 million consisting of US\$9million equivalent credit from IDA, US\$5 million grant from the GFF Trust Fund (TF), and US\$1.1 million grant from the Policy and Human Resources Development Fund (PHRD) TF). Component 2 aims to strengthen institutional capacity<sup>35</sup> to better deliver quality PHC services under Component 1. This component will focus on three key areas:

Subcomponent 2.1. Improving Quality of Care (US\$8.3 million). The Project will support:

(i) The Department of Health Standards, Quality Assurance and Regulations as well as the Health Regulatory Boards to:

- strengthen routine inspections of public and private health facilities; and
- institutionalize quality assurance towards certification

(ii) The Division of Family Health (DFH) to: develop and/or disseminate RMNCAH-related strategies and guidelines, including improving adolescent sexual and reproductive health (ASRH), newborn health and nutrition to address high teenage pregnancy, neonatal morbidities and stunting; and conduct operations research; and

(iii) The Kenya Medical Training College (KMTC) to strengthen midwifery training.

Subcomponent 2.2. Strengthening M&E and CRVS (US\$5.0 million). The Project will support the Division of M&E, Health Research Development and Health Informatics to:

(i) operationalize the sector M&E framework;

(ii) strengthen the HIS; and

(iii) pilot innovative approaches to improving coverage of vital events registration within the health sector (for example, incentivizing registration, piloting a mobile CRVS office, and linking birth registration with MCH services) in close collaboration with the CRS.

Subcomponent 2.3. Supporting Health Financing Reforms towards UHC (US\$1.8 million). The Project will support the Division of Health Care Financing (DHCF) to:

(i) disseminate the HFS to get buy-in from various stakeholders drawing from the recently completed stakeholder analysis;

(ii) conduct analytical work to inform the implementation of HFS and health-financing reforms towards UHC; and

(iii) Build capacity for UHC leadership at the national and county levels.

Component 3: Cross-county and Intergovernmental Collaboration, and Project Management (US\$26 million equivalent credit from IDA). Component 3 aims to enhance cross-county and intergovernmental collaboration as well as facilitate and coordinate project implementation. This will include two areas:

Subcomponent 3.1. Cross-county and Intergovernmental Collaboration (US\$16 million).

The Project will finance activities that promote cross-county initiatives and intergovernmental collaboration to address common demand- and supply-side barriers. Examples include cross-county study tours to share knowledge and capacity building activities in areas that affect several counties, such as drafting county health bills and improving SCM of strategic commodities.

A call-for-proposal approach will be used. Every year, the project management team (PMT) will issue a call for proposals in collaboration with the national and county governments and facilitate TA for proposal reviews.

The Project sub-TWG with support from TA will approve the final selection of proposals, which will be concurred by the Bank. The winner(s) will be required to implement the proposals and report the outcomes and lessons learned through the Intergovernmental Forum for Health to facilitate cross-county learning.

Subcomponent 3.2. Project Management (including M&E and fiduciary activities) (US\$10 million). The Project will finance project management staff at national and county levels of government, office equipment, operating costs, and logistical services for day-to-day project management. The following will be supported:

- (i) M&E activities such as annual cross-county verification through peer reviews, periodic surveys, and process evaluation to monitor implementation progress and address any implementation challenges;
- (ii) fiduciary activities such as hiring an independent integrated fiduciary review agent (Independent Integrated Fiduciary Review Agent (IIFRA));
- (iii) safeguards activities such as conducting social assessment and preparation or revision of safeguards-related plans; and
- (iv) TA and capacity building activities to support the Project sub-TWG under the Intergovernmental Forum for Health in carrying out their responsibilities, among others, reviewing the quality of AWP, verifying county performance, and selecting proposals to promote cross-county and intergovernmental collaboration.

## Project cost and financing

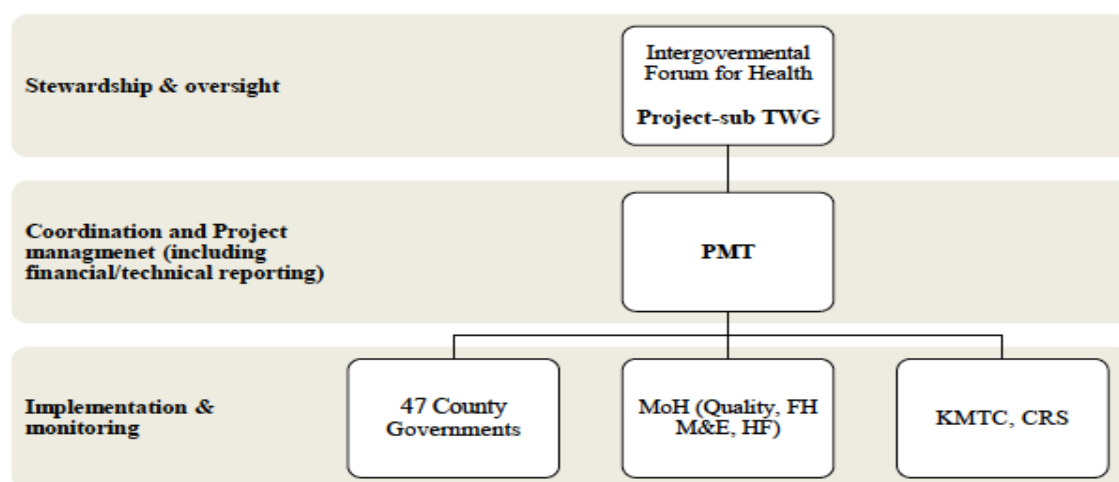
Table 5. Project Cost by Component and Financing (US\$, Millions)

| Project Components                                                          | Project Cost | IDA | GFF TF | PHRD TF | % Financing |
|-----------------------------------------------------------------------------|--------------|-----|--------|---------|-------------|
| 1. Improving PHC Results                                                    | 150.0        | 115 | 35     | -       | 100         |
| 2. Strengthening Institutional Capacity                                     | 15.1         | 9   | 5      | 1.1     | 100         |
| 3. Cross-county and Intergovernmental Collaboration, and Project Management | 26.0         | 26  | -      | -       | 100         |
| Total cost                                                                  |              |     |        |         |             |
| Total Project Costs                                                         | 191.1        | 150 | 40     | 1.1     | -           |
| Total Financing Required                                                    | 191.1        | 150 | 40     | 1.1     | -           |

Source: PAD 2016:18

The Project will be implemented by multiple entities in line with the Constitution. Existing institutional structures at the national and county levels will be used to implement the Project as summarized in figure 3.1 in the PAD. The MoH, Kenya Medical Training College (KMTc), and CRS will be jointly responsible for the implementation of national and county-level activities under Component 2 (for example, TA). County governments will be responsible for implementation of activities in their counties under Component 1 with support from Kenya Medical Supplies Authority (KEMSA) for procurement. Project implementation plans will be integrated into the AWP of all implementing entities.

**Figure 3.1. Institutional and Implementation Arrangements**



Source: PAD 2016:51

### **Social safeguards**

The Project triggers Operational Policy (OP) 4.10: Vulnerable and Marginalized Groups (VMGs) and the applicable laws and regulations of the GoK. The VMGs and other stakeholders (for example, CSOs) will be actively involved in monitoring project implementation at various levels through participation in health management structures. The VMGF for the Project was disclosed on April 13, 2016 on the MoH website ([www.health.go.ke](http://www.health.go.ke)) and the Bank's InfoShop (PAD 2016:30).

### **Citizen engagement (CE)**

1. CE is the two-way interaction between citizens and governments or the private sector that gives citizens a stake in decision-making with the objective of improving the intermediate and final development outcomes of the intervention.
2. The implicit theory of change in promoting CE in health care service is that communities with a participatory stake in the functioning of health facilities are more likely to use and support them and take greater care of their own health needs. CE can also help hold service providers accountable for results.
3. For this reason, CE mechanisms are designed to make communities more aware of the services provided, more involved in the management of the facilities, better able to communicate with service providers and, in turn, feel more responsible for the successful functioning of the facilities.

4. Between 2011 and 2013, the MoH, with support from the Bank, tested integration of SAc approaches,<sup>56</sup> which is part of CE, in selected health facilities across the country.
5. The pilot demonstrated that SAc holds considerable promise for achieving better local governance and health service delivery. Following the pilot, the MoH developed a manual to assist service providers and communities in adopting and implementing SAc practices in service delivery.
6. This underscored the fact that until recently service provision has largely been supply driven with little or no input from the citizens.
7. This Project will leverage on these guidelines to integrate CE in service delivery as a means of ensuring that citizens have a greater voice; that the health system is accountable to its citizens in improving utilization and quality of PHC services; and that it responds to their needs in its quest to improve access to and demand for quality PHC services.
8. As a means of strengthening the health system's institutional capacity, a critical component to improved CE will be to strengthen the Government's Community Health Strategy (CHS) by reviewing and reinforcing the community unit AWP template and planning processes.

CE will contribute to achievement of the Project Development Objectives (PDO) through:

1. improved demand for health services as a result of enhanced community participation in decision-making and management processes;
2. improved governance as a result of strengthened health facility governance structures;
3. empowered communities as a result of functional community units and increased community participation in health service delivery; and
4. improved quality of health services as a result of feedback systems and GRM.

The proposed CE activities are expected to be undertaken by two key actors:

1. CHMTs should ideally appoint a focal person for CE within the team to guide the process; and
2. health facilities at all levels of care are expected to designate their CHEWs as the CE focal persons at the facility level and existing community fora.

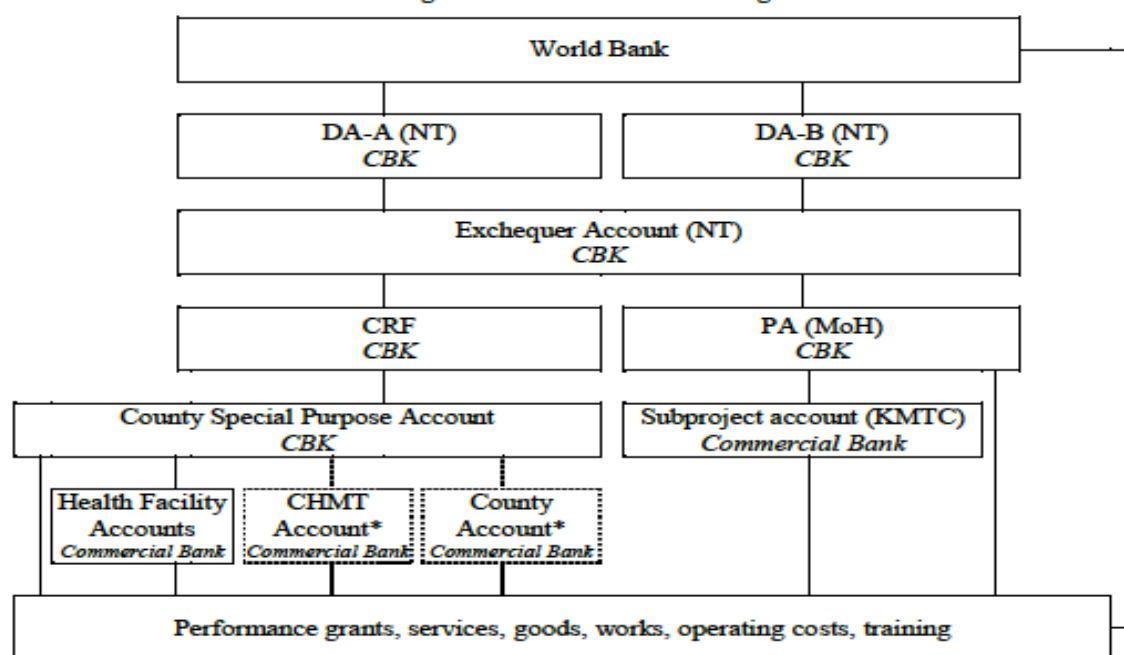
### **Useful to know**

Social accountability (Sac) mechanisms will be implemented such as display of project information and disbursements on sign boards erected in public places and local government offices. In addition, the Bank and GoK will ensure public disclosure of all project annual audit reports in line with the Access to Information Policy of July 2010. The Bank will also conduct regular in-year FM reviews of Project activities to enhance internal controls.

Figure 3.3 from the PAD illustrates funds flow arrangements. From the illustration, it is not clear how CSOs would receive money from GFF program. There is no direct contracting by the Bank to CSOs as demonstrated by this quote "Direct contracting may be an appropriate method when it can be justified that competitive bidding is not advantageous and it meets the requirements of paragraph 3.7 of the Procurement Guidelines after consultation with the Bank". It is however possible that implementing entities may directly subcontract CSOs if they determine there is need to do so. This

is not suggested or proposed in the PAD. Hopefully, this will be included in the operations manual.

**Figure 3.3. Funds Flow Arrangements**



Source: PAD 2016:55

The PAD provides formula for distribution of available resources. The amount of seed funding per county for the first year will be determined as follows (PAD 2016:41).

$$\text{County allocation}_n = \text{Total annual allocation} * \frac{\text{CRA}_n * (100 - \%SBA)_n}{\sum_1^N (\text{CRA}_n * (100 - \%SBA)_n)}$$

where

- CRA = CRA according to County Allocation of Revenue Act
- SBA = Skilled birth attendance
- N = Total number of eligible counties
- n = County

Source: PAD 2016:41

### 3.0 Discussion

Civil society organization (CSOs) are important players in matters of health care delivery in Kenya. CSOs are an important partner in health care development, performing roles ranging from direct service delivery to advocacy for access to health for all (Ekirapa et al 2012; Juma et al 2015). From this recognition, CSOs were involved in several consultations with the team developing the RMNCAH investment framework and the PAD. In the RMNCAH document, clear role of CSOs was identified. These included but not limited to: enhancing transparency, citizen participation, social accountability and oversight of program implementation under monitoring and accountability. It was anticipated that these roles and associated funding would be elaborated in the Project appraisal document (PAD) for Kenya.

CSOs participated in several consultations leading to the development of the PAD. In the PAD, CSO role of monitoring and accountability is recognized. CSOs are expected to play a role in cross-county verification as members of the team including Health Management Team (CHMT) member, a clinical staff selected from the best performing health facility, and an implementing partner (PAD 2016:13) or as stakeholders (PAD 2016:30). In the pathway to Improve the Utilization and Quality of PHC Services, there is reference to contracting of CSOs among others under Human resources to address component 1 (PAD 2016:11).

From the RMNCAH and the PAD, civil society organization may have a role at the community level in generating/creating demand for services under component 1. There is no specific language in the PAD on how CSOs will be involved. Only in one instance is there reference to contracting CSOs among other human resource requirements to address component 1. From the PAD, it is not clear whether there are resources earmarked for demand creation activities. Again, the details might be included in project operation manual which may detail the process of contracting and resource allocation for the contracted services.

The CSO role of demand creation seem to be lost in the PAD with reference of community health workers as the drivers of demand creation (PAD 2016:13). It is envisioned that under component 1, strengthening of community units to (i) deliver preventive and promotive health care including access to safe water and sanitation, improved hygiene practices and nutrition, and (ii) engage the community to improve accountability of PHC services through citizen engagement (CE) mechanisms (for example, community dialogue days) will be done.

Though, CHW, by nature of their placement in the community positions them to create demand, they are usually overburdened by other priorities such as HIV/AIDS, TB, community management of childhood infection etc. for them to pay required attention to demand creation for services. Second, not all communities have functional community units or they do not exist in some setting. Where there are no community units, who will be responsible for demand creation? From the foregoing, alternative strategies to address demand creation for services will be needed. As noted in the RMNCAH and also in the PAD, this role could easily be fulfilled by CSOs.

In conclusion, the RMNCAH and PAD, proposed GFF investments in Kenya could greatly benefit from CSO contribution. Some of the CSOs may have limitations to allow them to effectively deliver what is expected of them, especially small indigenous CSOs. Large local CSOs and international CSOs have over time developed systems which are robust enough to allow delivery of expected services. For small local CSOs to realize the desired goal to improve the well-being of low-income populations, programs to build their management capacity will be essential. They can be mentored by the large local or international CSOs.

## 4.0 References

Ekirapa A, Mgomella GS, Kyobutungi C. Civil society organizations: capacity to address the needs of the urban poor in Nairobi. J Public Health Policy. 2012 Nov;33(4):404-22. doi: 10.1057/jphp.2012.33.

Juma C, Sundsmo A, Maket B, Powell R, Aluoch G. Using information communication technologies to increase the institutional capacity of local health organisations in Africa: a case study of the Kenya Civil Society Portal for Health. *Pan Afr Med J*. 2015 May 8;21:23. doi: 10.11604/pamj.2015.21.23.5130.

Ministry of Health, 2016. *Kenya Reproductive Maternal Neonatal Child and Adolescent Health* (RMNCAH) Investment Framework [http://www.globalfinancingfacility.org/sites/gff\\_new/files/documents/Kenya%20RMNCAH%20Investment%20Framework\\_March%202016.pdf](http://www.globalfinancingfacility.org/sites/gff_new/files/documents/Kenya%20RMNCAH%20Investment%20Framework_March%202016.pdf)

World Bank 2016. Project Appraisal Document for the TRANSFORMING HEALTH SYSTEMS FOR UNIVERSAL CARE PROJECT. Report No: PAD1694 <http://documents.worldbank.org/curated/en/215261467995371106/pdf/PAD1694-PAD-P152394-IDA-R2016-0122-1-Box396259B-OUO-9.pdf>

## PART II



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### 1.0 THE GLOBAL FINANCING FACILITY AND NUTRITION IN KENYA

Nutrition is considered an essential building block for healthy development and the well-being of women and children. Nutrition is therefore a priority area for Global financing facility (GFF) investments. Worldwide, 156 million children under 5 are stunted. Undernutrition is an underlying cause of about 45% of all child deaths while anemia is the cause of about 20% of maternal deaths. Poor maternal nutrition during pregnancy increases children's risk of dying or being stunted. The first 1,000 days from conception to 24 months are critical for ensuring adequate nutrition due to the rapid pace of brain development during this period. Sustainable Development Goal 2 (target 2.2) calls for ending all forms of malnutrition by 2030, which includes achieving, by 2025, internationally agreed upon targets on stunting and wasting in children under 5 years of age, and addressing the nutritional needs of adolescent girls, pregnant and lactating women. Well-nourished women, children and adolescents live healthier lives, with greater resilience to life-threatening disease. However, nutrition programs are underfunded or not advocated for as other health issues. To better understand what civil society groups in Kenya can do to support advocacy for nutrition, Kenya Reproductive, Maternal, Newborn, Child, and Adolescent health (RMNCAH) and Project Appraisal Document (PAD) were analyzed.

## 2.0 NUTRITION AND THE GFF'S INVESTMENT CASES

All of the GFF country Investment Cases call for increased funding for nutrition with aims to:

1. End malnutrition as a cause of maternal and child morbidity and mortality and improve maternal, newborn, infant and young child nutritional status
2. Scale up the coverage, quality and utilization of cost effective nutrition services, focusing on pregnant women, lactating women and children under 5 (especially those aged 0 through 24 months)
3. Increase equitable access to nutrition services
4. Strengthen the delivery of nutrition services through performance-based financing (PBF) and other tools.

### GFF INVESTMENTS IN NUTRITION

The GFF supports a variety of nutrition interventions:

1. Integrating nutrition into the full continuum of maternal and child health services, by focusing on actions such as increasing breastfeeding rates, improving counseling on infant feeding and early stimulation and the prevention and treatment of maternal anemia
2. Building capacity at the community and health-facility levels, by supporting counseling on infant and young child feeding; better management of moderate acute malnutrition and severe acute malnutrition; and the scale up of Kangaroo Mother Care to assist low birth weight babies
3. Providing commodities, such as micronutrient supplements and fortificants, ready-to-use therapeutic foods, and deworming medications
4. Increasing the community-based delivery of nutrition services, through the use of community health workers and early childhood development workers
5. Reaching underserved areas, by setting up mobile clinics and using a rapid in-and-out approach in security challenged settings to deliver services
6. Supporting the Baby-Friendly Hospital Initiative, which encourages breastfeeding and other best practices for infant survival.

### WHY INVEST IN NUTRITION

It is estimated that investing an additional US \$2.2 billion per year in nutrition over the next 10 years from 2015 will help to save 2.2 million lives and result in 50 million fewer stunted children by 2025 (Investing in Nutrition: The Foundation for Development, 2016). The GFF will contribute to filling this gap using its financing approach, which includes: supporting domestic resource mobilization to ensure nutrition is prioritized in the national budget;

Ensuring the efficiency of complementary financing by working with countries to provide a clear set of priorities in Investment Cases, including specific nutrition services that financiers (both public and private) can align behind; and, linking

catalytic grant financing with International Development Assistance (IDA) or International Bank for Reconstruction and Development (IBRD) resources to increase the available envelope for health financing, including for nutrition.

## 3.0 FINDINGS FROM RMNCAH AND PAD ANALYSIS

### 3.1 RMNCAH investment framework

Kenya has made some progress on nutrition indicators. Nutritional status of children under-five has improved with a decline in stunting from 35% in 2008/9 to 26% in 2014. However, one out of every four children still remain shorter for their age, a factor that adversely affects their future health, well-being and economic productivity. Persistent malnutrition and micronutrient deficiencies prevent Kenya from making rapid progress in reducing neonatal, infant, and child mortality.

Nutrition was proposed in the investment case as a high impact intervention for children. Specifically, this was to consider: oral rehydration salts and zinc for diarrhoea treatment; breastfeeding counseling and support, complementary feeding counseling and support, management of severe malnutrition in children, and Vitamin A supplementation in infants and children.

### 3.2 Improvement of Nutrition, particularly for Early Childhood Development

Growing evidence highlights the urgent need to build on child survival gains by focusing new efforts not only on saving children's lives but also on supporting the healthy development of their brains during the first few years of life. Interventions at this time are especially important for those children growing up in the most disadvantaged and vulnerable communities, who already face multiple adversities and whose societies also suffer the consequences of those deprivations. Early child development (ECD) programs were proposed as good entry points which must not only start early during brain development but must also be inter-sectoral, going beyond education to encompass health, nutrition and protection.

### 3.3 Proposed key immediate actions:

1. Scale-up sustained behavior change communication for promotion of breastfeeding and
2. appropriate and timely complementary feeding.
3. Promote integrated delivery of essential nutrition services with essential health services at facility and community level reducing missed opportunities to deliver micro-nutrients (iron and folic acid, vitamin A, multiple micronutrients and zinc) to pregnant/lactating women and children.
4. Involve Community health workers (CHWs) and early child development (ECD) teachers in the promotion of hand washing, delivery of micronutrients and supplementary nutrition programs.
5. Continue school deworming program for children (2-5 years) with 2 doses each year.

6. Pilot cross-sector community driven approaches to improve household food security and dietary diversity.

Under the 9-proposed package of services for children in the RMNCAH investment framework, below, 5- are nutrition related.

1. **Oral rehydration therapy**
2. Zinc for diarrhea treatment
3. Antibiotics for treatment of dysentery
4. Pneumonia treatment in children 0-4 years
5. Vitamin A for measles treatment in children 0-4 years
6. **Breast feeding counselling and support**
7. **Complementary feeding counselling and support**
8. **Management of severe malnutrition in children 0-4 years**
9. **Vitamin A supplementation in infants and children 6-59 months**

Under immediate actions to address nutrition, the following activities were proposed:

1. Develop sustained behavior change communication for breast feeding promotion followed by appropriate and timely complementary feeding
2. Reduce missed opportunities to deliver micronutrients (iron and folic acid, vitamin A, multiple micronutrients and Zinc) for pregnant women and children by promoting integrated delivery at facility and community levels.
3. Involve community health workers and ECD teachers in the promotion of hand washing, delivery of micronutrients and supplementary nutrition programs.
4. Continue school deworming program for children (2-5 years) with 2 doses each year.
5. Pilot cross-sector community driven approaches to improve household food security and dietary diversity

Of the proposed investment portfolio under RMNCAH investment framework, it was proposed to avail total of 15% (Kshs 41,041, 000,000) of the budget for nutrition (RMNCAH 2016:61, table 4).

### 3.4 Project appraisal document (PAD)

The impact of undernutrition is expounded in the project appraisal document. Kenya project is proposed to be accomplished via three components. Through these components, it is anticipated that implementing a set of evidence-based interventions that are high-impact and cost-effective is expected to improve equity and efficiency and contribute to Universal Health Coverage (UHC). One of the pathways to improve utilization and quality of Primary Health care (PHC) services is demand creation. Under component 1, advocacy, communication and social mobilization (ACSM) will be done for preventive and promotive health care including safe water, sanitation, hygiene and nutrition through functional community units (PAD 2016:12).

### 3.5 Brief summary of different components of the PAD in Kenya.

Component 1 which aims to improve the delivery, utilization, and quality of PHC services at the county level with a focus on RMNCAH will increase demand for services at the community and facility levels. This activity includes strengthening of

community units for delivery of preventive and promotive health care including access to safe water and sanitation among others. Counties will be supported to scale up evidence based, county appropriate supply- and demand-side key priority interventions along the continuum of care as described in the RMNCAH investment framework. Community units will be strengthened to deliver preventive and promotive health care including access to safe water and sanitation, improved hygiene practices and nutrition, and engage the community to improve accountability of PHC services through citizen engagement (CE) mechanisms (for example, community dialogue days). The high impact intervention along the continuum of care at community level specifically mention nutrition supplementation for women during antenatal care and promotion of optimal care for children (PAD 2016:39).

Component 2 aims to strengthen institutional capacity to better deliver quality PHC services under Component 1. This component has three subcomponents: Subcomponent 2.1 - Improving Quality of Care; Subcomponent 2.2 - Strengthening monitoring and evaluation (M&E) and civil registration and vital statistics (CRVS); and Subcomponent 2.3 - Supporting Health Financing Reforms towards UHC.

Under Subcomponent 2.1, the Project will Support the Division of Family Health (DFH) to develop and/or disseminate RMNCAH- related strategies and guidelines, including improving adolescent sexual and reproductive health (ASRH), newborn health and nutrition to address high teenage pregnancy, neonatal morbidities and stunting. By addressing high impact evidence based nutrition specific intervention, it is anticipated that 4,200,000 people would have received essential health, nutrition and population services by the 5<sup>th</sup> year of program implementation from a baseline of 3,704,547 (PAD 2016:34).

In addition, the Project will support operations research on acceptability of micronutrient supplementation of women of reproductive age (WRA). which is a high impact and cost-effective intervention for reducing infant and maternal morbidity and mortality in developing countries. The Nutrition Unit will determine factors that will promote coverage, uptake, and use of micronutrient supplementation as one of the selected high-impact interventions and inform the design of national guidelines for micronutrient supplementation in WRA.

Component 3 aims to enhance cross-county and intergovernmental collaboration as well as facilitate and coordinate project implementation. This component has two subcomponents: Subcomponent 3.1 - Cross-county and Intergovernmental Collaboration and Subcomponent 3.2 - Project Management (including M&E and fiduciary activities). This component does not mention nutrition specifically though activities under this component will influence nutrition programming.

### **3.6 Resources for nutrition program in the context of other priorities**

Yearly estimates were made by dividing the indicated budget with the numbers of years the funding was to last. The figures obtained are rough guides as opposed to the actual amounts spent since the program periods may have changed such as budget variation or duration changes. This data should be interpreted with that caution. Of the donor supported activities, about USD 267,495,257 is spent yearly of which USD 55,104,276 (20.6%) is spent on programs which mention nutrition. Only 2.6%

(6,898,744.45) of annual program support is specifically spent on programs dedicated to nutrition annually. Nutrition specific donor supported programs include: nutrition and health program plus by USAID for period 2015-19 with a total budget of USD 3,455,036; Nutrition program by EU with a budget of USD 20,516,142 for period 2014-2018 and Transform nutrition program by DFID with a budget of USD 8,629,614 for the period 2010-17 (PAD 2016:72-73).

## 4.0 Discussion

Throughout the two documents, RMNCAH and PAD, there is clear reference to nutrition and importance in investing in nutrition programs. What is lacking being details of the specific nutrition interventions. Understandably, the RMNCAH and PAD being high level documents, they would be lacking in specifics. These are supposed to be elaborated in the project operation manual. This manual is still under development by Ministry of Health and will be publicly released once it is ready.

The PAD does not specifically address nutrition commodities. Though there are several nutrition intervention programs in Kenya such as Scaling up Nutrition (SUN), micronutrient initiative (MI), and general government iron and folate (IFA) program for pregnant mothers, without a clear nutrition procurement plan, then, the envisioned demand creation for nutrition services may not achieve the desired objectives and results. Civil society voice in advocating for procurement of nutrition related supplies will be critical in raising the profile of nutrition interventions.

From the RMNCAH and the PAD, civil society organization may have a role at the community level in generating/creating demand for nutrition services. There is no specific language in the PAD on how civil society organization will be involved. From the PAD, it is not clear whether there are resources earmarked for demand creation activities. There is language weaving nutrition demand creation into the work of community health workers. Though, CHW, by nature of their placement in the community positions them to create demand, they are usually overburdened by other priorities such as HIV/AIDS, TB, community management of childhood infection etc. for them to pay required attention to demand creation for nutrition services. Second, not all communities have functional community units or they do not exist at in some setting. Where there are no community units, who will be responsible for demand creation? From the foregoing, alternative strategies to address demand creation for nutrition services will be needed. Could the civil society be the missing link?

With the changing economic status of Kenya to middle-income countries with associated reduction in donor funding, the future of nutrition programming cannot be guaranteed. Environmental factors such as recurrent severe drought affecting mass population do not make the situation of nutrition programs better. There is concern that every so often, there is a generation of Kenyans exposed to severe undernutrition which will compromise their future health and life. Unfortunately, some of the effects of undernutrition such as diminished brain development is not reversible.

According to the Lancet nutrition report (Black et al., 2013), undernutrition (e.g. fetal growth restriction, stunting, wasting) and deficiencies of vitamin A and zinc along with suboptimum breastfeeding accounted for 45% of all child deaths in 2011. Key obstacles to improving high levels of undernutrition among children include suboptimal nutrition for pregnant/lactating women, poor early childhood feeding and caring practices, low coverage for micronutrients and knowledge gaps among CHWs and health workers.

Early childhood is the time when brain development lays the foundation of a child's physical and mental health that will affect everything from longevity to the lifelong capacity to learn, ability to adapt to change and the capacity for resilience. Interventions at this time are especially important for those children growing up in the most disadvantaged and vulnerable communities, who already face multiple adversities and whose societies also suffer the consequences of those deprivations. Nutrition program addressing early childhood needs must not only start early during brain development but must also be inter-sectoral, going beyond education to encompass health, nutrition and protection (Bhutta et al 2013, UNICEF State of the World's Children, 2001).

From the RMNCAH and PAD, proposed GFF investments in Kenya are in line with global GFF planned investments as regards to nutrition. Implementation of proposed intervention are likely to have significant impact on nutrition indicators in Kenya. Sustaining the funding levels will remain a challenge. Advocacy for sustained funding will be critical.

## 5.0 References

Bhutta ZA, Das JK, Rizvi A, Gaffey MF, Walker N, Horton S, Webb P, Lartey A, Black RE; Lancet Nutrition Interventions Review Group.; Maternal and Child Nutrition Study Group. Evidence-based interventions for improvement of maternal and child nutrition: what can be done and at what cost? *Lancet*. 2013 Aug 3;382(9890):452-77. doi: 10.1016/S0140-6736(13)60996-4. Epub 2013 Jun 6. Review. Erratum in: *Lancet*. 2013 Aug 3;382(9890):396.

Black RE, Victora CG, Walker SP, Bhutta ZA, Christian P, de Onis M, Ezzati M, Grantham-McGregor S, Katz J, Martorell R, Uauy R; Maternal and Child Nutrition Study Group. Maternal and child undernutrition and overweight in low-income and middle-income countries. *Lancet*. 2013 Aug 3;382(9890):427-51. doi: 10.1016/S0140-6736(13)60937-X. Epub 2013 Jun 6. Review. Erratum in: *Lancet*. 2013. 2013 Aug 3;382(9890):396.

Ministry of Health, 2016. *Kenya Reproductive Maternal Neonatal Child and Adolescent Health* (RMNCAH) Investment Framework [http://www.globalfinancingfacility.org/sites/gff\\_new/files/documents/Kenya%20RMNCAH%20Investment%20Framework\\_March%202016.pdf](http://www.globalfinancingfacility.org/sites/gff_new/files/documents/Kenya%20RMNCAH%20Investment%20Framework_March%202016.pdf)

UNICEF 2001. The State of the World's Children, 2001. <https://www.unicef.org/sowc/archive/ENGLISH/The%20State%20of%20the%20World's%20Children%202001.pdf>

World Bank 2016. Project Appraisal Document for the TRANSFORMING HEALTH SYSTEMS FOR UNIVERSAL CARE PROJECT. Report No: PAD1694  
<http://documents.worldbank.org/curated/en/215261467995371106/pdf/PAD1694-PAD-P152394-IDA-R2016-0122-1-Box396259B-OUO-9.pdf>