KENYA COORDINATION MECHANISM

Nyeri, Isiolo, Meru Counties Oversight Report

18th To 23rd May 2014

The oversight mission was conducted to obtain feedback on the implementation of Global Funds activities across the three disease components under the new devolved system of Government in Kenya. The exercise is also in line with Standard Operating Procedure (2010), within the KCM Oversight Plan (2010) which provides guidance on how to conduct an oversight visit.

The Oversight aims at ensuring transparency and accountability in the implementation of Global Fund grants by assessing whether the grants are used appropriately, timely and effectively, and that work plans are implemented in timely and effective manner in order to achieve the intended intermediate and long term results.

Oversight Team Members

The team consisted of the following:

National Oversight Committee NOC

1. **Dr Sobbie Mulindi**-Team Leader: National AIDS Control Council (NACC): Representative
2. **Jonathan Mwaniki**-NOC Member: KECOFATUMA: CSO Representative
3. **Loise Nteere**- KCM Secretariat

Supported by:

ICC's and Programs

4. **Dr. Micah Anyona-**Team Secretary: HIV & AIDS Interagency Coordinating Committee (ICC) – Ministry of Health
5. **Andrew Wamari**: Malaria ICC (Malaria Control Unit)
6. **Aiban Rono**: TB ICC (TB, Lung and Leprosy Control Unit)

Principal Recipients:

7. **Catherine Maingi**: Principal Recipient-Agent – (KEMSA) – HIV & AIDS, TB and Malaria Grants
8. **Donald Otieno:** PR (Kenya Red Cross Society) Non State Implementers – HIV and AIDS grant
9. **Gerald Bombe:** PR (Kenya Red Cross Society) Non State Implementers – HIV and AIDS grant
10. **Duke Mobegi:** PR (AMREF Health Africa) – Non State implementers – TB and Malaria grants
11. **Samson Musau:** PR-AMREF Health Africa) – Non State implementers – TB and Malaria grants
12. **Isaac Maina:** PR (Care International in Kenya) – Non State implementers – HIV and AIDS grant
13. **Nathan Kivuva:** PR (Kenya Red Cross Society) Non State Implementers – HIV and AIDS grant

Table of Contents

1. Introduction

The Kenya Coordinating Mechanism (KCM) is mandated to conduct Grant oversight as one of its core governance functions in the implementation of Global Fund grants. The exercise is undertaken at least twice in every six months to obtain feedback from implementers, identify and resolve any bottlenecks and also document best practices for sharing. The oversight plan is meant to enable KCM carry out its oversight function in an organized, transparent and documented manner to facilitate successful grant performance that involves stakeholders within and without the KCM membership.

2. Background

In line with the KCM Oversight Plan (2010), grant oversight is a high profile function focusing on the "big picture" of grant implementation. It is a scan across grants to identify cross-cutting issues and focuses on the broad objectives and service delivery approaches to identify and resolve issues that might hinder successful implementation of the grant. Oversight aims at ensuring transparency and accountability in the implementation of Global Fund grants by assessing whether the grants are used appropriately, timely and effectively, and that work plans are implemented in timely and effective manner in order to achieve the intended intermediate and long term results. It also helps in accessing whether bottlenecks are identified and action taken promptly.

The KCM oversight procedures and processes are intended to enable the KCM to:

- Orient members on their oversight roles and responsibilities
- Identify bottlenecks in grant implementation and offer solutions
- Be informed of grant implementation for purposes of transparency, accountability, and the preparation of new grant proposals
- Promote stronger relationship between the PR and the KCM
- Provide a process for participation of non-KCM members in overseeing Global Fund grants

Oversight typically focuses on several questions that are at the core of effective grant implementation:

- Where is the money?
- Where are the drugs, medical supplies and equipment?
- Are Sub Recipients receiving required resources?
- Are Sub Recipients receiving technical assistance?
- Are the grants being implemented as planned?
- What are the bottlenecks to grant implementation and how can they be resolved?
- Is a reprogramming of activities necessary to meet evolving country needs?
- Are the results meeting the performance targets?
- How is the linkage between National and County Governments?
- What measures are in place to cub duplication of resources?

Since 2011, KCM has conducted various oversight visits at the Coast Nyanza Western, Some parts of the Rift Valley and Upper Eastern Regions of the country. In line with KCM efforts to cover most of the counties in the country, it was decided that in the current 2014 visit, a further six counties namely Nyeri, Isiolo, Meru, Bungoma, Kakamega and Nakuru were to be visited by separate teams.

3. Scope and Methodology of the oversight

The KCM Oversight Plan (2010) outlines the role of KCM while the Standard Operating Procedures (2010) provide guidance on how to conduct oversight visits.

The Kenya Coordination Mechanism (KCM) secretariat took charge of the logistics with the Interagency Coordinating Committees (ICCs)/Principal Recipients(PRs) taking lead in the identification of areas and sites under their jurisdiction.. The following mix of methods were used during the oversight

i) **Focus Group Discussions:** The team members held discussions with the County Executive Committee, County and Sub-county health management teams, health facility teams and other stakeholders e.g. support teams to determine the progress of health programs

ii) **Observation:** The team members made observations and captured data in their note books and also took photographs prior to obtaining consent especially at facility, individual and community level.

iii) Site verification: the oversight team verified the information obtained during the focus group discussions and key informant interviews at the service delivery points.

iv) **Key informant interviews:** Meetings were held with key decision makers and opinion leaders in the counties that were visited. This was to get general ideas and findings on how Global Fund and health programs were progressing in the counties

Summary of the methods used

Method	Tally
Observation	All
Focus Group Discussions	7
Site verifications	4
Key informant interviews	3

Number of Health Management Teams and Principal Recipients sites visited:-

S/No.	CHMTs/Principal Recipients	No. of Sites
1	County Health Management Teams (each of the counties)	3
2	The National Treasury	2
3	Care International	4
4	AMREF Health Africa	3
5	Kenya Red Cross Society	2
	Total Sites visited	14

NB:
During visits to any of the public institutions collaborating with non state actors implementers, observations were made on the linkages (public/private partnerships). It was observed that activities were adequately harmonized and gaps identified were due to lack of enough resources.

4. Health System Observation and Finding

4.1.Health Service Delivery

- TB/HIV Integration has been attempted in most facilities though there are some challenges. Only one out of the five facilities visited had attempted to integrate. Co-location of these services was not available increasing the chances of defaulters or in some cases duplicated efforts in tracing. There is need to integrate all TB/HIV services to be offered under one roof.
- There is little support from the county in terms of capacity building for the health care workers. Most of the health care workers met had not participated in any training in the past one year. The county teams need to undertake a capacity needs assessment, develop a capacity-building plan and advocate for resources to carry out targeted capacity building for the health care workers in the three disease programs with support from the national level..
- There was concern about an imminent stock out of TB commodities that could affect service delivery. Some facilities received less commodities than the ones requested for. Paediatric TB drugs were not available is some facilities. The national program needs to initiate dialogue with the county TB and leprosy coordinators and county executive committee members on how to quantify TB commodities based on the available data to inform funds allocation for TB control at the county level.
- Counties are not fully aware of the available Global Fund support from the national level. Nutrition support for HIV is available in some facilities but nutrition support for the TB program is not available. There is need for sensitization of the health care workers and the counties on how they can access this support. The distribution lists need to be shared out by NASCOP with partners to help in patient referral.
- There is stock out of test kits reagents due to lack of clarity on the roll out of the new HTC algorithm. This is because the country is going through a transition to a new testing algorithm on which the distribution of new commodities is affected.
- Service delivery in HIV clinics had been affected by lack of functional CD4 machines in the Isiolo county referral hospital even after borrowing one from Meru level 5 which had also broken down. In Meru there was stock out of CD4 testing reagents. The two referral hospitals had received gene Xpert machines from the TB program aimed at improving service delivery.

4.2.Medical Products Vaccines and Technology

- There is continuous availability of commodities at facility level with minimal reported cases of stock-outs for medicines and test kits. First-line TB medicine is in short supply and in some areas there is a stock-out.
- Some counties have institutionalized re-distribution of medicines both within the counties and in the case of anti-malaria medicines between counties.
- Facilities are using commodity management best practices such as first expiry first out to minimize expiries for medicines and non-pharmaceutical items.

- There is need to enhance accountability in commodities management by adopting a single receipt point and linkages with various storage and dispensing points in larger facilities (county referral hospitals).
- All facilities and county teams need orientation on the new ordering mechanisms from KEMSA requiring that all standard order forms (SOF) for medicines and other commodities sent to KEMSA be accompanied with a local purchase order (LPO).
- There is need for the national level to build capacity of counties on forecasting and quantification skills to ensure that medicines, non-pharmaceuticals and equipment needs are accurately determined and shared with relevant stakeholders.
- A stock out of first line TB medicine, occasioned by the disbursement of national Government medicine budget allocations to counties without requisite information, is being experienced and needs to be addressed urgently.
- All counties recommended and endorsed that procurement of vaccines, TB, HIV, malaria medicines and related test kits needs to be done nationally to ensure quality, standardization and economies of scale are achieved.

4.3.Health Workforce

- It was noted that counties have made efforts in deploying human resources at both county coordination level and service delivery areas.
- At the coordination level a few gaps were noted where some counties had not appointed key officers or those in office were in acting capacity.
- There were major concerns at service delivery points where the few staff existing complains of heavy work load and risk burn out.
- The expertise and numbers to manage the three diseases are not adequate. There is need to identify staff and train them to be able to offer quality service at service delivery points.
- The fact that there is still shortage of staff calls for greater budget allocation to health in order to meet the health needs.

4.4.Health Financing

- Each of the counties had allocated funding to health while some counties had allocated funds to support the three diseases as well.
- In order to ensure smooth flow and access to funds, some counties had special bank accounts for health projects like the health services support funds and for donor projects like DANIDA supporting dispensaries and health centers.
- The main source of funding for health financing was through national allocation (Development partner and national Government resources), local revenue and local partners.
- Some counties had challenges in mapping of stakeholders at the county level. It was reported that though some partners were on the ground, they were not active.
- The counties are proposing that they are involved during resource mobilization at the national level especially during proposal development and also when discussing the funding allocation. This will enable them address their unique challenges. A case in point is Isiolo County whose vast

geographical, cultural and mobile lifestyles challenges cannot be compared to most of the other counties.

- A great proportion of health budget is allocated to servicing a huge wage bills with little funds left for infrastructure development and maintenance and other recurrent expenditure. For example in Isiolo 80% of the health budget is taken up by salaries and other emoluments. At the same time, HR is inadequate.

4.5.Governance and Leadership

- In each county, there exists county a health management team led by the county executive in the political arm, chief officer of health and county director of health in charge of technical issues.
- Other technical personnel are county chief nurse, county nutritionist, county HIV/AIDS coordinator, County TB coordinator, county malaria coordinator, county public health officer, county records officer and county health administrator.
- Each of these officers has clearly defined roles in the management of health at their respective counties.
- It was also demonstrated that there is political commitment at the county level to address the challenges posed by the three diseases. These structures have enabled the counties to coordinate the delivery of services and also engagement of all the key stakeholders in health at the county.
- It was however noted that there is still weak linkage between implementers at the county and the health system.
- In some counties, technical alignment to the county structures is still a challenge while the political alignment has settled down to business.

4.6.Health information

- Reporting on standard/routine facility based information through the HIS and other reporting mechanisms are quite well done with good reporting rates and adherence to scheduled timing.
- Implementing electronic medical records (EMR) systems to manage patient information is available at select institutions with others planning for the same.
- Sharing of programmatic achievements and financial reports by non-state actors with county health management teams needs to be institutionalized.
- Dissemination of information through health bulletins would assist in addressing information gaps at sub-county and community levels
- Harmonization of TB and HIV efforts in defaulter and contact tracing is needed to avoid duplication of efforts and resources.
- Regular orientation and capacity-building for new staff, those whose roles have changed and non-state actors is required to ensure continuity and better quality of reports.
- Relevant reports on community based activities needs to be aligned with the routine HIS systems where applicable.
- There is need to enhance data for decision making especially at county level to inform planning, performance monitoring and budget allocation.

- There is need for proper work plans and close collaboration between KEMSA and counties to effectively roll out of ZIDI, a tool which will consolidate all commodity management information system and create inter phase with the HIS platform.

4.7.Community System Strengthening

- There was a functional community structure which has driven demand for service uptake at all facility levels across the three programs. However these structures are not sufficiently funded and the stakeholders need more capacity to undertake their roles. This includes areas such as patient support services in form of transport for needy patients and community health volunteers as well communication for defaulter/contact tracing and volunteers.
- There is need for the review of community strategy policy regarding stipends for community health workers to be harmonized with current cost of living. Counties need to work with the Central government to standardize remuneration across different development partners and allocate resources to strengthen community strategy for support supervision and data reviews.
- There is a total disconnect in terms of data sharing between partners support for community initiatives and county health teams. This is as a result of underutilization of the HIS in terms of tracking community data.
    - There is need for utilization of existing data reporting systems at county and facility levels in terms of entry and analysis for decision making.
- There is good linkage between community structures and other GOK structures such youth, agriculture, education which needs to be strengthened and rolled out to other counties.
- CHWs have received different trainings under different partners which has enabled them carry out community activities successfully. Though there is need for refresher trainings and more support from the county.
- Most of the community health workers as well as programme beneficiaries such as People living with HIV and Youth groups have started various IGAs that have enabled them to continue carrying out their activities. However there is need for support in form of training in entrepreneur skills and funds to scale up interventions.

5. GFATM Specific Finding

In additional to the above general observations, the mission made the following observation in respect to the GFATM programs.

Description	HIV	TB	Malaria
Where is the money?	National Treasury, Kenya Red Cross and the HIV Round 10 SRs under both G.o.K and KRCS. Cares grant has ended.	National Treasury and AMREF Health Africa/CHAK/KANCO/CHAT	National Treasury , AMREF Health Africa
Where are the drugs, medical supplies and equipment?	**Successes** • There was no reported cases of stock outs for ARVs **Challenges** • Poor transition resulting in a few sites within the counties visited with reported HIV test kits stock-outs • Some counties had non-functional CD4 machines (Isiolo)	**Successes** • Gene Xpert in place and in use • Nutrition anthropometric equipment available • **Challenges** • There were stock outs in 1st line TB drugs due to devolution	**Successes** • County teams are actively redistributing malaria medicines and test kits as necessary • Commodity (drugs and test kits) reporting is now using the DHIS platform **Challenges** • Adherence to test, treat and track policy to ensure rational use of medicine is sub-optimal
Are Sub Recipients receiving required resources?	• There is adequate funding except for facilitating community health workers with umbrellas, raincoats and gumboots	• There are adequate resources except for disbursement delay challenges	• There are adequate resources
Are Sub Recipients receiving technical assistance?	• There is a close working relationship for the implementing SRs but there is a weak county level technical assistance	• There is a close working relationship for the implementing SRs but there is a weak county level technical assistance	• There is a close working relationship for the implementing SRs but there is a weak county level technical assistance
Are the grants being implemented as planned?	• Delays for some activities due to the devolution transition, re-programming of activities	• There are no specific challenges apart from delays in receiving 1st line drugs.	• There are challenges in funds flow from non state PR (AMREF Health Africa)

What are the bottlenecks to grant implementation and how can they be resolved?	• Late disbursements from GF, there is need to fast track disbursement lead-times from Global Fund to the PRs this will ensure the country has adequate time to absorb the funds in line with each programmatic objective. • There is need to initiate GF country negotiations earlier to ensure seamless transitions across phases for each disease component. • in the funds flow (what do we say here) to the counties and there is need to have county-specific agreements on the financing mechanism		
Is a re-programming of activities necessary to meet evolving county needs?	There is need to review the stipends for CHWs and harmonized with current cost of living	There is need to revise targets for defaulter tracing	There is need to re-program due to more accurate reporting for routine datasets and consumption data. Funds for key activities such as Stakeholder engagement will need to be reviewed upward due to a shift from few provincial administrative units to 26 county administrative units.
Are the results meeting the performance targets?	The performance largely meets targets except for TB program	The performance largely meets targets except for TB program	The performance largely meets targets.

6. Annex

6.1. County GF Support

This is a summary table of GFATM support in the County of Nyeri County

Disease	PR	Quantified Value of support
Malaria	The National Treasury (R4 & 10)	
	AMREF Health Africa (R10)	N/A
HIV/AIDS	National Treasury (R7 and 10)	
	Kenya Red Cross-KRCS(R10)	
TB	The National Treasury (SSF)	
	AMREF Health Africa (SSF)	

This is a summary table of GFATM support in the County of Isiolo County

Disease	PR	Quantified Value of support
Malaria	The National Treasury (R4 & 10)	
	AMREF Health Africa (R10)	N/A
HIV/AIDS	The National Treasury (R10)	
	Kenya Red Cross-KRCS(R10)	
TB	National Treasury (SSF)	
	AMREF Health Africa (SSF)	

This is a summary table of GFATM support in the County of Meru County

Disease	PR	Quantified Value of support
Malaria	National Treasury (R4 & 10)	
	AMREF Health Africa (R10)	N/A
HIV/AIDS	The National Treasury (R10)	
	Kenya Red Cross-KRCS(R10)	
TB	National Treasury (SSF)	
	AMREF Health Africa (SSF)	

6.2. Summary of sites visited by the oversight mission

Day	Site	People met
Day 1-19th May 2014	Nyeri County Health Office	County health team & Chief Officer
	Naromoru Catholic Dispensary-	Tour of the hospital
	Naromoru Sub-County Hospital/Kenya Red Cross/NCCK	Community Health Workers (CHWs) and Beneficiaries
	Aguthi Patient Support Group/ Care Kenya/KENWA	PLWHA, CHWs,
Day 2-20th May 2014	Isiolo County Health Office	Isiolo County Health Team
	Isiolo TB Manyatta	County/Sub-County Health Members, CHAT officials
	Isiolo Stadium/Care Kenya/Food for the Hungry	Youth Group members
Day 3-21st May 2014	Meru County Office	Meru County Executive Committee Member for Health, County Chief Health Officer, County and Sub-County Health Management teams
	Meru Level V Hospital	Hospital Management Team and sections heads
	Githongo/ Care Kenya/Food for the Hungry	Youth Group members
Day 4-22nd May 2014	Nyambene Sub-county Hospital/Kenya Red Cross/	Hospital Management Team , PLWHA, CHWs, Beneficiaries
	Maua Mission Hospital/TB Clinic	Facility in Charge, TB Clinician
	Kianjaga/ Care Kenya/Food for the Hungry	Youth Group Members
Day 5-23rd May 2014	Meru Town	Report writing

7. Guidelines for KCM Oversight Site Visits

Site visits can be to a PR's office, an SR's office, or a project implementation sites. The size of the team visiting a field site should be 4-8 people's maximum, including KCM members, technical experts, PR representatives, and observers.

There are three types of site visits: to provide general orientation, to increase awareness of grant implementation and maintain relationships, and to address a specific issue raised during a CCM or Oversight Committee meeting.

The recommended guidelines for carrying out site visits are summarized in the table below. See the Standard Operating Procedures section on Oversight for further details.

The principles of transparency, cooperation, and support underlie every site visit: there are no surprise visits by KCM members. In addition, the purpose of site visits is neither to address day-to-day management issues (a PR role) nor to "audit" regular reports (an LFA role).

Careful planning is recommended to ensure effective, helpful oversight visits. The KCM team should have clear information on program deliverables prior to a visit. The PR should assist in providing this information and in advising on issues that the KCM team should be aware of before proceeding to the site. Thus, allowing time for preparation means that the KCM team will not waste time asking questions for which answers have already been provided in written reports or for which clarifications can be easily given by the PR without a visit.

In addition, careful planning means that PR staff will be available and prepared to respond to KCM questions. Planners need to set time limits for the visit to avoid making excessive demands on the PR and SRs; and visitors need to stick to those time limits. The limits on time require careful planning to ensure key issues are addressed.

KCM Role	**PR Role**
• Plan visits with PR: no surprise visits. • Understand program deliverables. • Be familiar with PU/DR or dashboard reports. • Have clear objectives for visit. • Abide by policy for conflict of interest • Maintain confidentiality. • Set and stick to realistic time limits. • Address highest-priority issues first. • Draft report to Technical Committees • Send feedback to the host site, SR, and PR.	• Work with KCM to choose appropriate sites. • Assist KCM to understand program, including implementation issues. • Facilitate a positive environment for visit. • Assure staffs are available to answer KCM's questions. • Assure information requested by KCM is available.