Global Financing Facility for Women, Children and Adolescents

Progress made in the implementation of the RMNCAH+N investment framework through the GFF partnership, civil society and other stakeholders

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Acronyms and Abbreviations

CoG	Council of Governors
CRA	Commission on Revenue Allocation
CSO	Civil society organization
CSO GFF Hub	Civil Society GFF Resource and Engagement Hub
DANIDA	Danish International Development Agency
DFH	Division of Family Health
DHIS2	District Health Information Software Version 2
FCDO	Foreign, Commonwealth and Development Office
FIC	Fully immunized child
FP	Family planning
FY	Fiscal year
GFF	Global Financing Facility
HENNET	Health NGOs Network
IDA	International Development Association
IF	Investment framework
MCP	Multistakeholder country platform
MoH	Ministry of Health
PBF	Performance-based financing
PFM	Public financial management
PHC	Primary health care
PHRD	Japan Policy and Human Resources Development
RH TWG	Reproductive Health Technical Working Group
RMNCAH+N	Reproductive, maternal, newborn, child and adolescent health and nutrition
THS-UCP	Transforming Health Systems for Universal Care Project
TOR	Terms of reference
UHC	Universal health coverage

Executive Summary

In 2014, the Global Financing Facility for Women, Children and Adolescents (GFF) was announced, targeting countries with the highest burden of maternal and child mortality. The aim of the funding is to ensure targeted efforts toward interventions that will reduce preventable maternal, newborn, child and adolescent deaths and improve their overall health, leading to a better quality of life. Kenya is among the four initial front-runner countries. Kenya's reproductive, maternal, newborn, child and adolescent health and nutrition (RMNCAH+N) investment framework (IF) was completed in January 2016. The framework development process was consultative and inclusive, bringing together a diverse range of stakeholders, including civil society. Implementation of the framework started in fiscal year (FY) 2016/17.

This case study reviews and captures the progress made in ensuring domestic and external resources are mobilized for RMNCAH+N interventions; how the process has catalyzed prioritization of RMNCAH+N within decentralized systems; improvements in the health indicators; engagement and coordination of all the actors including civil society and other stakeholders; and enhancement of mutual accountability across all the actors.

CSO GFF Hub

This study was commissioned by PAI on behalf of the Civil Society GFF Resource and Engagement Hub (CSO GFF Hub). PAI recognizes that resilient health systems are crucial to a country's ability to meet a population's health needs. Core to this work is improving global- and national-level financing to sustain health systems and implement policies that ensure quality of care, health equity and access to essential health services. The GFF has the potential to catalyze improvements in health and quality of life for all individuals, especially women, children and adolescents. Since 2015, PAI has been engaging with the GFF at the global level, including health- and nutrition-focused civil society organizations (CSOs) in GFF countries and potential GFF countries. Our long history of promoting meaningful CSO and youth engagement, combined with our approach — driven by country partners — to the work provides us with unique access and potential for impact. As a result, we elevate effective country CSO voices to harness the GFF as a vehicle for transformational change.

Through the Bill and Melinda Gates Foundation's investment, PAI has hosted the CSO GFF Hub since 2018. This investment has enabled PAI, through the CSO GFF Hub, to scale up civil society engagement in the GFF and to realize effective and sustainable health financing for women, children and adolescents. The CSO GFF Hub's main functions include serving as a virtual forum for public information on the GFF; supporting the development of resources and tools; and, most importantly, providing capacity-building and capacity-strengthening engagement support grants and technical assistance. The CSO GFF Hub serves this role by supplementing the coordination role of the Civil Society Coordinating Group (CSCG) by providing CSOs and youth-led organizations engaging in the GFF with small grants and technical support, including coalition strengthening. The CSO GFF Hub hosts a website (www.csogffhub.org) with a repository of resources and tools for civil society on the GFF as well as country profiles and a knowledge exchange, all of which provide a country-level snapshot of GFF-related activity.

Methods

Data was gathered through key informant interviews, a desk review of the RMNCAH+N IF document, Ministry of Health (MoH) project status reports, World Bank project reports, family planning (FP) forecasting and quantification reports, MoH performance financing allocation data and other documents. A total of 36 documents and data sources were reviewed.

Progress made on health indicators

Significant progress has been achieved across all the four RMNCAH+N indicators that are used to track progress. Fully immunized child (FIC) and antenatal care indicators are on course despite the disruption of primary health care (PHC) services due to COVID-19. Status of select indicators that are being tracked are as follows:

- The national FIC coverage improved from 77% in quarter two (Q2) 2019 to 89% in Q2 2020 but slightly dropped to 85% in Q2 2021.
- The trend for antenatal care coverage remained at 52% in Q2 2019 and Q2 2020 and increased to 56% in Q2 2021.
- The births attended by skilled personnel indicator also improved — 65% in Q2 2019, 78% in Q2 2020 and 84% in Q2 2021.

While progress was achieved, there was a decline in coverage of modern FP methods from 47% to 45% in Q2 2019. This further declined to 20% in both Q2 2020 and Q2 2021. The decline is also linked to the disruption of PHC services due to the COVID-19 pandemic and a shortage of long-acting FP commodities.

Civil society and other stakeholders' engagement in the GFF partnership

Civil society was not well-informed of the GFF process. However, efforts were made by international nongovernmental organizations that were familiar with the financing approach to sensitize them. Civil society embraced its role and began engaging the MoH, World Bank and Council of Governors (CoG) — the political and governance structure within the decentralized system in Kenya — so as to ensure that they were included in the process.

Through the Health NGOs Network (HENNET), civil society organized itself into three task committees — advocacy, accountability and implementation — to support implementation of Kenya's RMNCAH+N IF. These task committees are comprised of members that were engaged in specific activities as defined by the task name. Civil society developed the GFF CSO scorecard to track the implementation of the RMNCAH+N IF and GFF partnership. CSOs were also instrumental in advocating for the formation of the multistakeholder country platform (MCP).

Formation of the MCP

The Guidance Note on Inclusive Multi-stakeholder Country Platforms in Support of Every Woman Every Child, hereafter referred to as "the Guidance Note," outlines the formation for using an existing platform as a country governance mechanism that is expected to enable and facilitate coordination, learning, course-correction and mutual accountability by continuous review and use of data among all stakeholders.[1] The country platform membership is drawn from a diverse range of stakeholders, including sectors such as the Ministry of Finance and technical agencies, that will enable effective implementation of the IF.

In January 2021, Kenya formed and launched its MCP. The MoH led the consultative meetings on the membership and the development of the terms of reference (TOR), clearly outlining the roles and responsibilities. During the launch, members developed an annual work plan to guide their activities.

Domestic and external financing and increasing expenditures for RMNCAH+N

The conditional and performance-based financing (PBF) approach used in the Transforming Health Systems for Universal Care Project (THS-UCP) increased allocation to the health sector at the county level. Domestic allocation to health increased from an overall average of the total county budget of 27% in FY 2017/18 to 33% in FY 2019/20. The GFF partnership also mitigated the gap in FP commodity financing allocating $20 million over a five-year period between FY 2016/17 and FY 2020/21. Continuous civil society engagement and advocacy among the decision-makers resulted in prioritization of FP commodities within the GFF partnership resources.

Enhancing accountability for results

Tracking progress and results using accountability tools such as scorecards has continued to increase accountability for resource utilization and results. Supported by UNICEF and the African Leaders Malaria Alliance, the MoH uses the RMNCAH+N scorecard, which serves as the main monitoring tool at the national and county levels. Through HENNET, in 2017 and 2018, civil society mobilized and developed the first two Kenya GFF CSO scorecards which assessed the foundations of the GFF partnership, in view of an effective rollout at the national and county levels. Both tools have been used to trigger action within MoH on various issues relating to access of services and incentivizing counties to work toward improving their health indicators and attract funding. GFF CSO scorecards enabled targeted advocacy toward funding disbursement challenges that were later addressed as well as the formation of the country platform.

Key takeaways

Through HENNET, civil society played a key role in highlighting some of the GFF partnership challenges and strengthening understanding of the partnership approach within the government and across stakeholders.

The conditional granting mechanism and PBF approach that is used in Kenya's GFF partnership has played a significant role in increasing county-level domestic and external resources for health as well as overall country financing for health.

The design of the PBF approach was reviewed at various stages to ensure it responds to the emerging issues and challenges at the county level. For instance, the resource flow challenges that were experienced were addressed using the new public financial management (PFM) criteria. Civil society's subnational-level work and engagement with county departments of health contributed to the identification of these PFM challenges.

Working with MoH leadership, the Kenyan government and World Bank, civil society — represented by HENNET — played a key role in ensuring the formation and launch of the RMNCAH+N MCP. Sustaining and ensuring the platform responds to its coordinating role and needs of the various actors will be critical in its success.

Utilization of the GFF partnership resources in mitigating the FP commodity gap enabled community access to FP services. However, the long-term sustainability of FP commodity security, as well as RMNCAH+N intervention efforts, will need to be addressed as the GFF partnership comes to an end.

Background

In 2014, the GFF was announced, targeting countries with the highest burden of maternal and child mortality. The aim of the funding is to ensure targeted efforts toward interventions that will reduce preventable maternal, newborn, child and adolescent deaths and improve their overall health, leading to a better quality of life. Formation of the GFF partnership was informed by the need to finance proposed sustainable development goals focusing on healthy lives, and ultimately plays a critical role in supporting Every Woman Every Child's renewed Global Strategy for Women's, Children's and Adolescents health 2016-2030.[2] The partnership aligns in-country partner efforts to provide smart, scaled and sustainable financing for RMNCAH+N.[3]

The GFF partnership is committed to ensuring that all women, children and adolescents survive and thrive. It is anchored in the five GFF principles that are reflected in the 2030 sustainable development goals, which also focus on strengthening health systems to save lives and support countries in achieving universal health coverage (UHC) by 2030. The five GFF principles are:

- Country leadership and ownership
- Equity and inclusion
- Efficiency in scale
- Results and impact
- Complement and catalyze

To date, the GFF has expanded ninefold from four high-burden countries in 2015 to 36 in 2021.

By June 2020, a total of $602 million had been invested in grants. This is linked to $4.7 billion country loan financing from the World Bank, International Development Association (IDA) and International Bank for Reconstruction and Development (IBRD). Additional funding is provided from external and domestic financing sources, supporting better alignment of financing for RMNCAH+N through a common country RMNCAH+N IF.

Significant improvements in accessing quality health services by women, children and adolescents are noted in the initial GFF countries. For instance, in Ethiopia, out-of-pocket expenditures reduced from 34% to 30% of the total government health expenditure, indicating reduced out of pocket due to the increased government resources using the IDA loan facility toward health. In other countries such as Kenya and Democratic Republic of Congo, domestic resources for health increased, enhancing service coverage and overall health outcomes.[4]

Despite progress made so far in improving RMNCAH+N indicators in the majority of GFF countries, the COVID-19 pandemic continues to threaten these gains, putting the high-burden countries at risk. As a result of governments' shifting priorities during COVID-19, essential health services experienced severe disruption. This was evidenced by lockdowns and the closure and transformation of some facilities into isolation centers. Patients also feared seeking services due to the risk of infection at health facilities, increasing their risk of dying or experiencing other health complications. Other vulnerabilities and risk factors include job losses, school closures and gender-based violence.[5]

This case study was commissioned by PAI as part of efforts under the CSO GFF Hub to document and share the GFF partnership experience, key successes achieved in Kenya and opportunities for improvements. The lessons are unique but have cross-cutting implications and insights that may resonate with other GFF countries.

The main purpose of Kenya's GFF partnership case study is to document and share lessons learned from the GFF partnership implementation, recognizing that the partnership is implemented through the Kenya RMNCAH+N IF and supported by stakeholders and the World Bank.[6] Key successes and lessons learned from the implementation include:

- Approach used in implementing the GFF partnership;
- Progress in Kenya's RMNCAH+N indicators since the start of the GFF partnership;
- Civil society and other stakeholders' engagement in the GFF partnership;
- Increased domestic and donor financing for RMNCAH+N including FP;
- Catalyzed county (subnational level) budget allocation for health in decentralized settings; and
- Enhanced accountability for results using scorecard management tools.

The case study responds to the following questions:

- To what extent has the GFF partnership improved RMNCAH+N indicators in Kenya?
- How has the GFF partnership improved stakeholder coordination and collaboration, including ensuring transparency in information sharing and accountability for results?
- To what extent has the GFF partnership increased domestic and external financing for RMNCAH+N and health in general?
- How has the partnership improved accountability for RMNCAH+N results?

While focusing on the GFF principles and approach, the case study outlines the GFF partnership approach in Kenya, stakeholder engagement through the country platform, improvement of the RMNCAH+N indicators, approach used in increasing domestic resources for health in general as well as accountability for RMNCAH+N results in decentralized contexts. Stemming from the findings of the case study, other GFF countries can identify key successes and lessons to foster learning and knowledge exchange.

Method

Data was gathered through a detailed desk review of GFF annual reports,[7] World Bank annual project reports, the RMNCAH+N IF, financial reports, scorecards, RMNCAH+N commodities forecasting and quantification reports, approved annual work plans, quarterly reports and performance financing allocation data, among other documents. A total of 36 documents and data sources were reviewed. The data that was included in the analyses covered the period between the 2014 launch of the GFF partnership and August 2021. It was supplemented through other publicly available documents from county government reports, financial allocations and donor or implementing partner reports, as well as research literature.

Additionally, qualitative evaluation through key informant interviews from civil society, World Bank and the MoH program management unit were conducted.

The study limitations include:

- Varied responses from stakeholders which may have been presented in the most favorable light;
- Lack of sufficient information to assess the modalities around the county-level allocation using the PBF approach; and
- Transition and/or high turnover of staff within the program unit at the national and county levels, resulting in information gaps.

The GFF Partnership in Kenya

The process of developing Kenya's RMNCAH+N IF was consultative and inclusive, bringing together a diverse range of stakeholders, including civil society. The RMNCAH+N IF was viewed as an opportunity to align investment with a common country goal. In May 2016, the World Bank approved the project appraisal document that outlined the implementation approach of THS-UCP, with financing from the World Bank IDA and co-financing from the GFF Trust Fund and the Japan Policy and Human Resources Development (PHRD) Fund. The project became effective in September 2016.[8] THS-UCP became the localized implementing project of the GFF partnership at the national and county levels in Kenya. The total allocation at the start of the project was $191.1 million over a five-year period, illustrated in Table 1.

TABLE 1: GFF PARTNERSHIP FUNDING STREAMS

World Bank IDA financing	$150 million
GFF Trust Fund	$40 million
PHRD Fund	$1.1 million

Other bilateral partners — the Foreign, Commonwealth and Development Office (FCDO, formerly the Department for International Development), Danish International Development Agency (DANIDA) and U.S. Agency for International Development — provided funding through the Multi-Donor Trust Fund.

This fund complements THS-UCP and the implementation of the RMNCAH+N IF by strengthening health systems through the provision of technical assistance and capacity building for better and sustainable results. These activities mainly focused on planning and budgeting, monitoring and evaluation and supply chain management. The additional funding from the Multi-Donor Trust Fund for technical assistance ranged from an estimated annual allocation of $7 million to about $13 million. Currently, active bilateral partners include DANIDA and FCDO.

The implementation of the RMNCAH+N IF aligns effectively with the GFF partnership principles. THS-UCP, which is financed by the World Bank and the GFF Trust Fund, promotes country leadership and ownership as it localizes and domesticates GFF partnership resources to counties.

At the start, the partnership targeted the following high-burden counties:

- Garissa
- Homabay
- Isiolo
- Kakamega
- Kisumu
- Lamu
- Mandera
- Marsabit
- Migori
- Nairobi
- Nakuru
- Siaya
- Taita-Taveta
- Turkana
- Wajir

Most of these counties continue to face high levels of poverty, insecurity, infrastructural challenges, inequity and marginalization, resulting in poor maternal and newborn health indicators. These counties contributed to 98.7% of all the maternal deaths in the country.[9]

However, consultations were held to enable the project to disburse funds to all 47 counties as beneficiaries, based on the parameters that address equity, such as the poverty index and total population. The arguments favored all the counties benefiting from this new funding stream to support RMNCAH+N interventions. Further data analysis of the data showed population pockets that indicated very poor health indicators across all counties. As the process moved into the implementation phase, embedding the PBF approach at the county level has increased focus on results among the health workers and managers. Complementary financing from the Multi-Donor Trust Fund provided through technical assistance has helped to coordinate and enhance effectiveness of the national and county governments in ensuring that results are achieved.

Health and nutrition improvements for women, children and adolescents

Implementation of the RMNCAH+N IF is anchored on evidence-based, high-impact "best buy" interventions. Government ownership and leadership are important in the process because they support the alignment of RMNCAH+N efforts across partners and donors through various funding streams.

RMNCAH+N investment across partners and stakeholders include, THS-UCP IDA financing, co-financing from the GFF Trust Fund and the PHRD Fund, DANIDA UHC conditional grant, FCDO and other donor funds that are disbursed through implementing partners such as Jhpiego, PATH, Population Services International and Amref Health Africa, among others.

THS-UCP is a major source of funding for national and county governments, and is comprised of three key components:

1. **Component 1**: improving PHC results — including service delivery, utilization and quality of PHC services at the county level with a focus on RMNCAH+N. Additionally, part of the funding is earmarked to procure RMNCAH+N strategic commodities, such as FP.
2. **Component 2**: strengthening institutional capacity to better deliver quality PHC services in relation to component 1.
3. **Component 3**: cross-country and intergovernmental collaboration and project management, facilitating project implementation.

The financing allocation of each component portfolio from the three funding streams is shown in Table 2.

TABLE 2: THS-UCP COMPONENT ALLOCATIONS

Source: THS-UCP, MoH and CoG

Project Components	Project Cost (in USD millions)	IDA Financing	GFF Trust Fund	PHRD Fund	Financing (%)
Component 1	150	115	35	–	100%
Component 2	15.1	9	5	1.1	100%
Component 3	26	26	–	–	100%
Total Cost	**191.1**	**150**	**40**	**1.1**	**100%**

These components' allocations were reviewed recently in consultation with the government of Kenya as follows:

- **Component 1**: improving PHC results ($141 million)
- **Component 2**: strengthening institutional capacity ($28.7 million)
- **Component 3**: cross-county and intergovernmental collaboration and project management ($11.4 million)
- **Component 4**: contingency emergency response ($10 million)

Major reviews of the project components were related to the UHC agenda, part of the country's Big Four Agenda — food security, affordable housing, manufacturing and affordable health care for all — that is outlined in the Third Medium Term (MTP3) of Vision 2030. This means $14 million from Component 3 had to be reallocated to Component 2 in order to finance the country's priorities in addressing the UHC agenda. With the emergence of the COVID-19 pandemic, the government of Kenya activated the Contingency Emergency Response Component in the amount of $10 million, allowing a revision of the project development objectives, reallocating the funds across components and disbursement categories as well as updating the results framework.[10]

Funding to counties reduced from $150 million to $141 million over the five-year project period. Table 3 shows the status of funds disbursement as of August 1, 2021.[11]

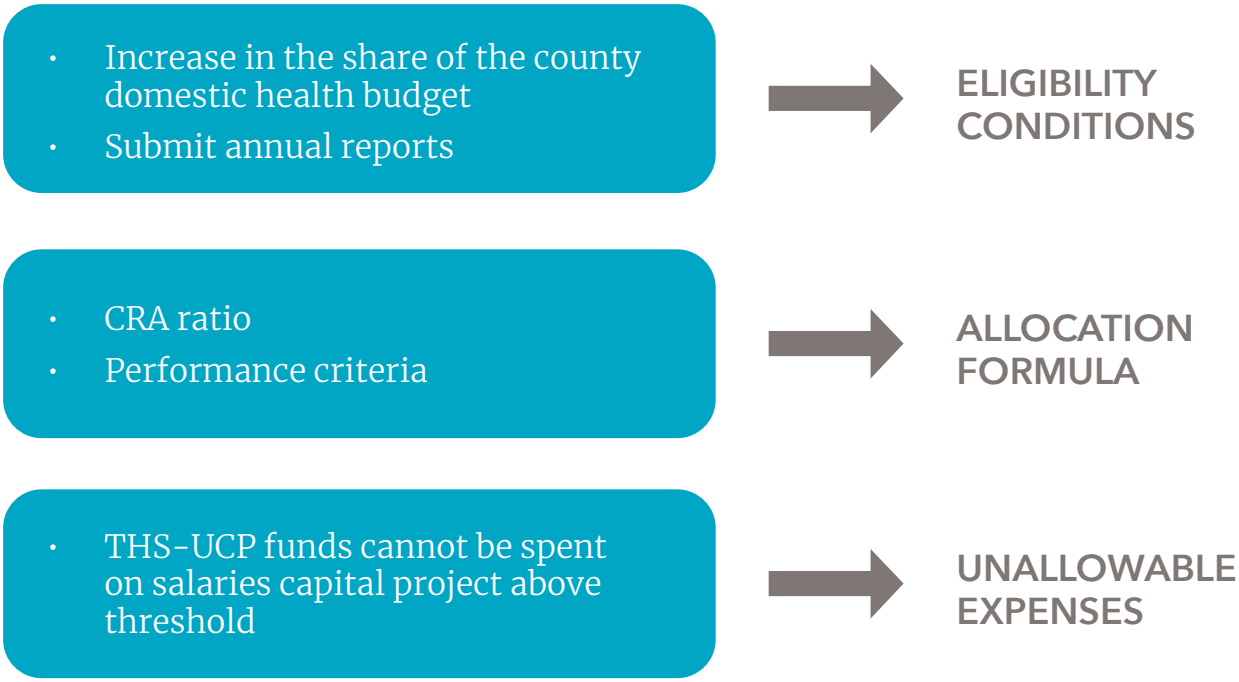
TABLE 3: DISBURSEMENT OF FUNDS STATUS

Source: World Bank Report 2021

Funding Stream	in USD millions	
	Total Initial Allocation	Disbursements as of August 1, 2021
IDA financing	150	132.2
GFF Trust Fund	40	29.3
PHRD Fund	1.1	0.7
Total Cost	**191.1**	**162.2**

Component 1 includes funds for Kenya's 47 counties. The resource allocation across all the counties is based on the Commission on Revenue Allocation (CRA) ratio and meeting certain conditions as shown in Figure 1. The CRA ratio considers population (45%), basic equal share (25%), poverty (20%), area (8%) and fiscal responsibility (2%). To be eligible, counties must increase their share of the county domestic budget for health from year to year and submit the subsequent annual reports.

FIGURE 1: MINIMUM CONDITIONS FOR COUNTY ALLOCATION



The allocation formula used to allocate the shareable government revenue is used to allocate THS-UCP funds, including the performance criteria based on health indicators outlined in Figure 2 and the PFM criteria on timely flow of funding disbursements which is defined by getting 100% of the funding in the next fiscal year. Eligibility is 100% if disbursed to the user county health departments within the first 15 days of the county receiving the funds; 75% if it is disbursed within 16-25 days; 50% if disbursed within 26-35 days; 25% if disbursed within 36-45 days; and after 46 days, the county receives 0% of the amount in the next fiscal year. Table 5 defines the criteria.

Counties are also expected to meet the conditions of unallowable expenses reviewed through the submitted financial reports.[12] Counties accessed the THS-UCP funding from FY 2017/18 as an initial seed grant based on these conditions. However, for the following years, a performance-based approach was used in addition to the minimum conditions.

Progress made on the RMNCAH+N indicators

FIGURE 2: RESULTS FRAMEWORK INDICATORS

- **Children immunized with the third dose of pentavalent (%)**
- **Pregnant women attending at least four antenatal care visits**
- **Births attended by skilled health personnel (%)**
- **Women between the ages of 15 and 49 currently using a modern FP method (%)**
- **Pregnant women attending antenatal care who received iron/folate supplements (%)**
- **Health facilities inspected and meeting safety standards**
- **Reports submitted to District Health Information Software Version 2 (DHIS2) in a timely manner (%)**

Since the start of the GFF partnership, significant progress has been made in improving the RMNCAH+N indicators nationally and at the county level. In addition to the effects COVID-19 has had on access to essential services such as immunization, FP and antenatal care, the pandemic has also slowed other indicators, including the timely submission of reports from the counties.

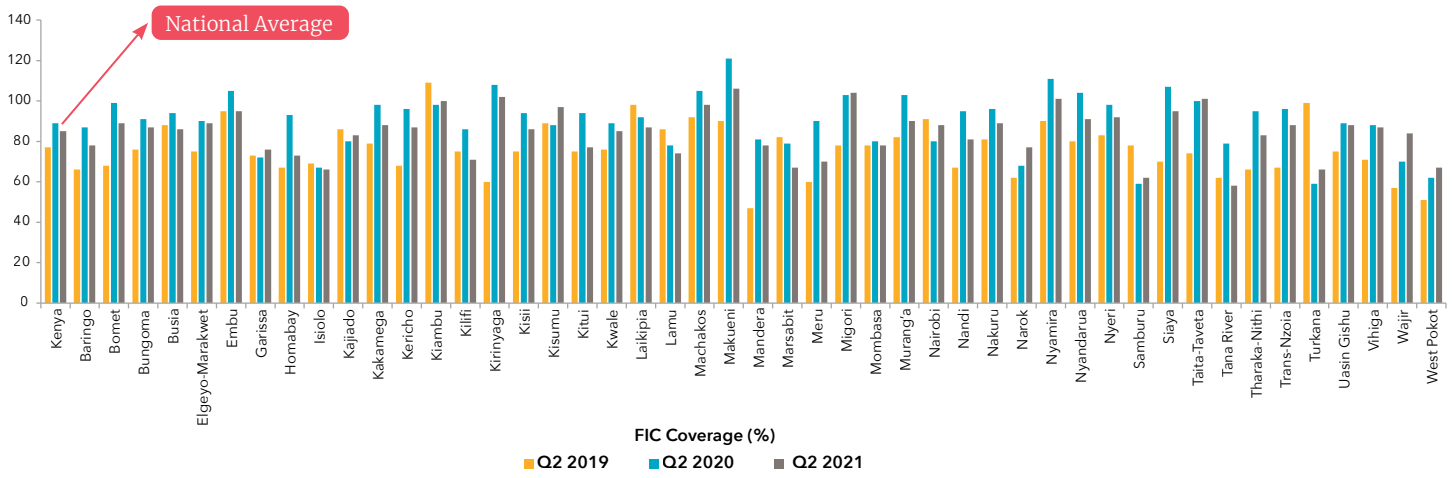
Still, PHC indicators showed improvement in 2020, then a decline in 2021. Figure 3 shows trends in coverage of some essential health service indicators relating to RMNCAH+N in Q2 of each year from 2019 to 2021. The health indicators analyzed include:

- FIC;
- Percentage of pregnant women attending fourth antenatal care visit;
- Modern FP method coverage; and
- Timely submission of DHIS2 reports.

The national FIC coverage improved from 77% in Q2 2019 to 89% in Q2 2020 and slightly dropped to 85% in Q2 2021. The FIC coverage indicator improved in some counties, such as Migori, Narok, Wajir and West Pokot. The trend for antenatal care coverage remained the same in Q2 2019 and Q2 2020 at 52% and increased to 56% in Q2 2021. However, modern FP method coverage declined from 47% to 45% in Q2 2019 and Q2 2020, respectively, and again to 20% in Q2 2021. Some of the counties with the highest burden showed decline in FIC coverage between 2019 and 2021. These include Isiolo, Laikipia, Lamu, Samburu and Turkana due to the disruption of PHC services because of the COVID-19 pandemic.

FIGURE 3: FIC COVERAGE 2019-2021

Source: MoH RMNCAH+N scorecards

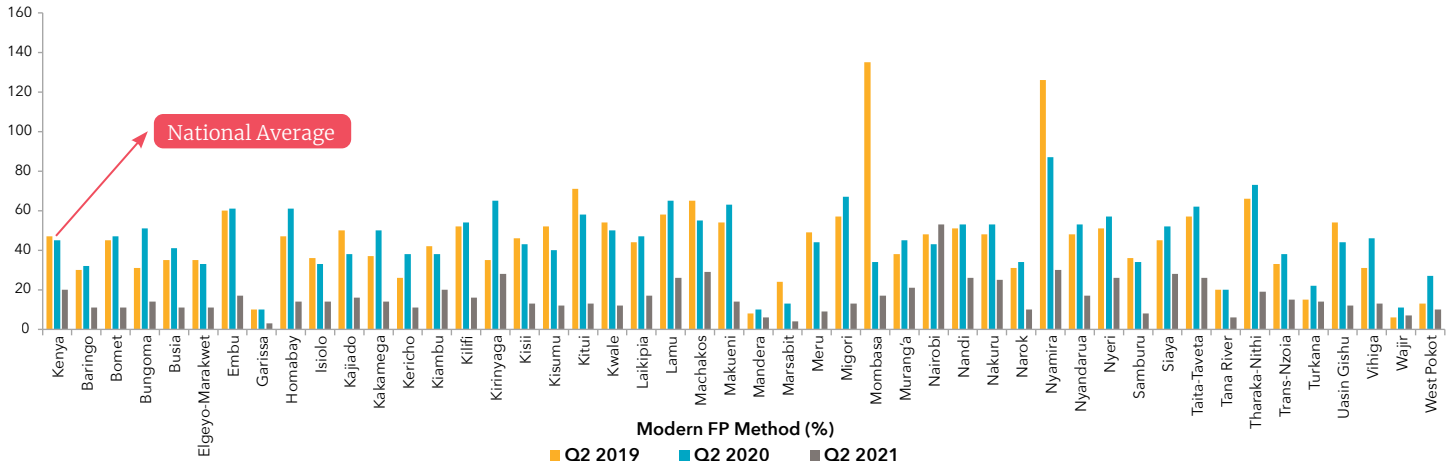


Modern FP method coverage declined and remained low in Q2 2021. Some counties with the highest coverage in Q2 2019, such as Kisumu, Kitui, Machakos, Mombasa and Nyamira, showed significant decline in coverage.

Overall, the national average showed a decline in FP coverage over the three years between Q2 2019 and Q2 2021 (Figure 4) due to shortage of long-acting commodities and disruption of PHC services due to COVID-19.

FIGURE 4: MODERN FP METHOD 2019-2021

Source: MoH RMNCAH+N scorecards

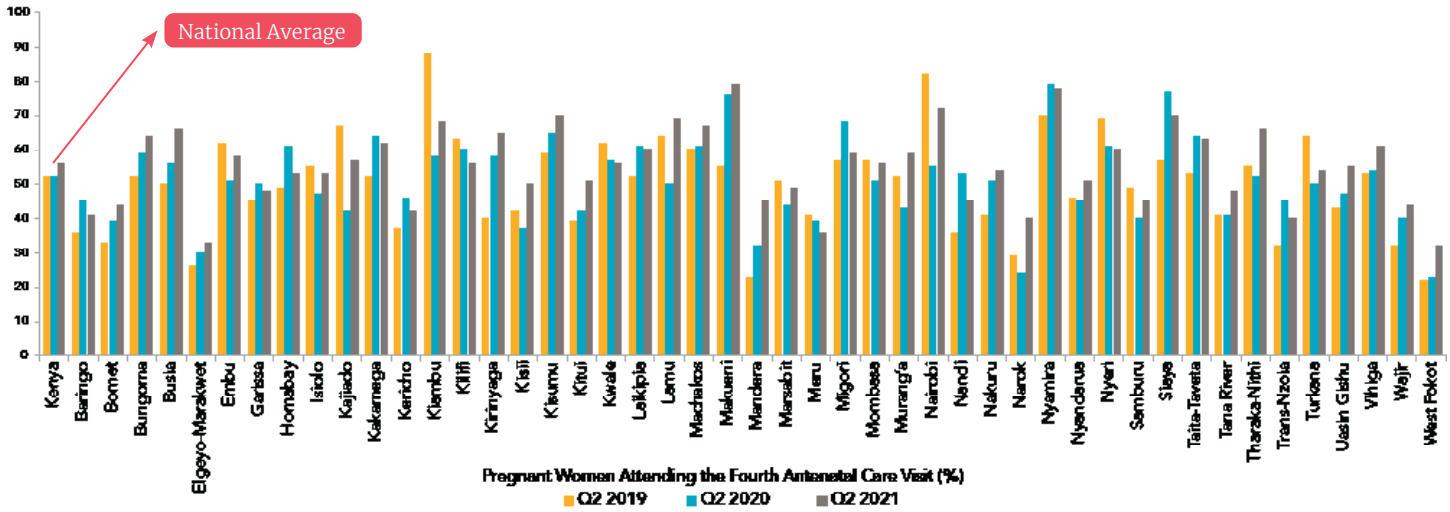


The proportion of pregnant women attending the fourth antenatal care visit remained constant in Q2 2019 and Q2 2020 but increased in Q2 2021 nationally. A few counties that had good coverage in 2019 declined significantly in Q2 2020 and Q2 2021, including Embu, Isiolo, Kajiado, Kiambu, Kilifi, Kwale, Lamu, Marsabit, Mombasa, Nairobi, Nyeri and Turkana.

These counties include a mix of high-burden and urban counties. The urban counties may have been affected by the increased number of COVID-19 cases as well as fewer women seeking services due to lockdowns and curfews (Figure 5).

FIGURE 5: PREGNANT WOMEN ATTENDING THE FOURTH ANTENATAL CARE VISIT 2019-2021

Source: MoH RMNCAH+N scorecards



One of the health systems indicators that is currently being tracked is the timeliness of county DHIS2 report submissions. This indicator was not affected and remained at a national average of 95%, 96% and 95% for the three years in Q2 2019, Q2 2020 and Q2 2021, respectively.

Civil society engagement in the GFF partnership

At the outset, civil society in Kenya's health sector, represented through HENNET, was not aware of the GFF partnership. Several consultative and sensitization events were conducted to enable them to understand its role and engage effectively in the entire GFF partnership process.

The engagement process entailed the development of the RMNCAH+N IF, designated country platform, donor alignment of investments towards a common RMNCAH+N policy framework as well as monitoring and tracking progress. Existing infrastructure to support civil society engagement was not developed at the time due to the devolution process that had just been enacted.

Additionally, it was not clear whether the country was going to target the investment in the 22 high-burden counties initially proposed or in all 47 counties (subnational governments). Each of the counties faced various challenges in relation to RMNCAH+N and this delayed the initiation of the GFF partnership process. In the long run, all counties were included and a formula for the allocation of funds was agreed upon, based on the county resource allocation ratio for the initial year FY 2016/17. This ratio is used to allocate the shareable revenue from the national to county levels. Another parameter based on need — defined as "skilled births not attended to" — is also applied.

In 2017, civil society — comprised of HENNET members, including Jhpiego, Kenya (through AFP), PATH, Evidence for Action (E4A), WACI Health, Amref Health Africa, Health Rights International and others — held workshops to sensitize its members on the GFF partnership and their roles. Civil society had to be proactive in engaging the MoH, World Bank and CoG to ensure its members were included in the process. After the workshops, civil society developed internal engagement structures to support implementation, accountability and advocacy efforts related to the implementation of the RMNCAH+N IF and the overall GFF partnership processes. HENNET organized itself into three task committees — advocacy, accountability and implementation. Further, through support from HENNET members, civil society was involved in RMNCAH+N activities, such as annual work planning that included RMNCAH+N advocacy and accountability activities that were developed to guide its engagement and add value.

Transparent and inclusive national- and county-level coordination through Kenya's MCP

The Guidance Note outlines the formation or use of an existing platform as a country governance mechanism.[13] This mechanism enables coordination, learning, course-correction and mutual accountability by continuous review and use of data. The country platform membership is drawn from a diverse range of stakeholders including other sectors, such as the Ministry of Finance and technical agencies, that will enable effective implementation of the IF. Country platforms can function effectively if they have annual work plans with clear meeting agendas, documentation of agreements and actions that will be taken, as well as the persons responsible for the actions. GFF countries can also form subnational platforms, particularly in countries where health services are decentralized to the county level, such as in Kenya and Nigeria.

Kenya's MCP was launched in January 2021. The challenges caused by the delayed development of the country's partnership and coordination framework 2018–2030 partly slowed the formation of the country platform. The Kenya Health Sector Partnership and Coordination Framework 2018–2030 process had to be finalized and completed concurrently with the formation of the MCP, requiring both processes to happen in parallel.[14] The framework provides guidance on how best to coordinate and align efforts toward improving health for all Kenyans and across all stakeholders (national and county governments, development partners, implementing partners and private health service providers). It also represents the aspirations and obligations that have been agreed upon by all the stakeholders.

The MCP was not included in discussions of the partnership and coordination framework structure. Despite the GFF developing and disseminating the GFF country implementation guidelines,[15] there had not been formal engagement and dissemination to ensure effective implementation of these guidelines at the country level. The GFF implementation guidelines outline the role of national governments and other stakeholders (e.g., civil society, women and youth, private sector, donors, professional associations) for engagement and participation for effective implementation of the in-country GFF processes, including coordination and alignment. Although a majority of GFF countries have country platforms or equivalent platforms, their functionality has been found to be suboptimal, drawing from assessments conducted by the CSO GFF Hub and the World Bank, emphasizing the need for the GFF to elaborate on the functionality of MCPs and to better align the implementation guidelines as well as the Guidance Note.[16,17]

The MCP formation process involved the engagement of the Division of Family Health (DFH). Stakeholders explored changing the Reproductive Health Technical Working Group (RH TWG) to be the MCP. However, it was found not fit for purpose. The process required that the TORs for the RH TWG be redefined. Additionally, senior leadership at the national level within the MoH was missing in the existing RH TWG structure, so it was not possible to address the role of the MCP within the working group. Furthermore, the RH TWG only focused on reproductive health issues. These issues further delayed formation of the MCP.

It took intense engagement from civil society, together with the DFH and other partners who provided technical assistance in drafting several versions of the TORs. Intensive advocacy was directed to the director general of health, the DFH team, the technical unit within the MoH and other senior Kenyan government officials, who eventually agreed and supported the process by instructing their technical officers within the DFH to finalize the MCP TORs. Regular updates were shared with the director general of health and chief administration secretary of health, who serves as the MoH GFF focal person. The CoG was also targeted in the advocacy, strengthening the intergovernmental coordination and alignment. Changes related to GFF focal point and in-country liaison fast-tracked the finalization of the TORs and formation of the MCP.

The membership of the country platform was outlined in the TORs. It included private-for-profit entities, civil society, the Ministry of Education, Ministry of Finance and gender sectors, among others, bringing together all matters pertaining to RMNCAH+N. Through HENNET, PATH provided technical assistance in this process, including convening the initial meeting that led to the launch of the platform in January 2021. A work plan was developed, though its implementation has been affected by COVID-19. A smaller secretariat committee was formed to lead implementation of the daily activities that require urgent action and decision-making.

Formation of the country platform require inclusion of the youth constituent. However, its role in the MCP at the national and county levels will need to be defined going forward to enable youth to engage effectively. There is need for advocacy to ensure that the MCP is institutionalized nationally and subnationally. At the county level, existing structures can incorporate the RMNCAH+N agenda in the regular county stakeholders' forum quarterly meetings. Moving forward, the MCP will need support from the country GFF focal points and liaison officer, in addition to champions and influencers who can support sustaining the MCP efforts and civil society in ensuring effective functionality.

The private sector consists of an array of stakeholders comprising of faith-based and private health facilities; the pharmaceutical industry including manufacturing, health insurance companies and pharmacies; and other delivery channels. The private sector entities are members of the MCP through the Kenya Health Federation. Over the years, the private sector has grown substantially, controlling over 50% of health facilities in Kenya, including not-for-profit facilities. Despite the perception that private for-profit health facilities exclusively serve wealthy individuals, there is also evidence that poorer groups visit private facilities just as much as wealthier groups.[18] The MoH acknowledges the increasing role of the private for-profit sector in delivering RMNCAH+N services. Concerns regarding quality of care, affordability and regulation of the private sector may undermine health outcomes and these may need to be addressed in future engagement. Clearly, the role of the private sector in service delivery is evident, however, the contribution of the private sector in the implementation of the RMNCAH+N IF and its engagement in the MCP will need to be clearly outlined to ensure its contribution is explicitly captured.

Domestic financing and increasing expenditures for women's, children's and adolescents' health

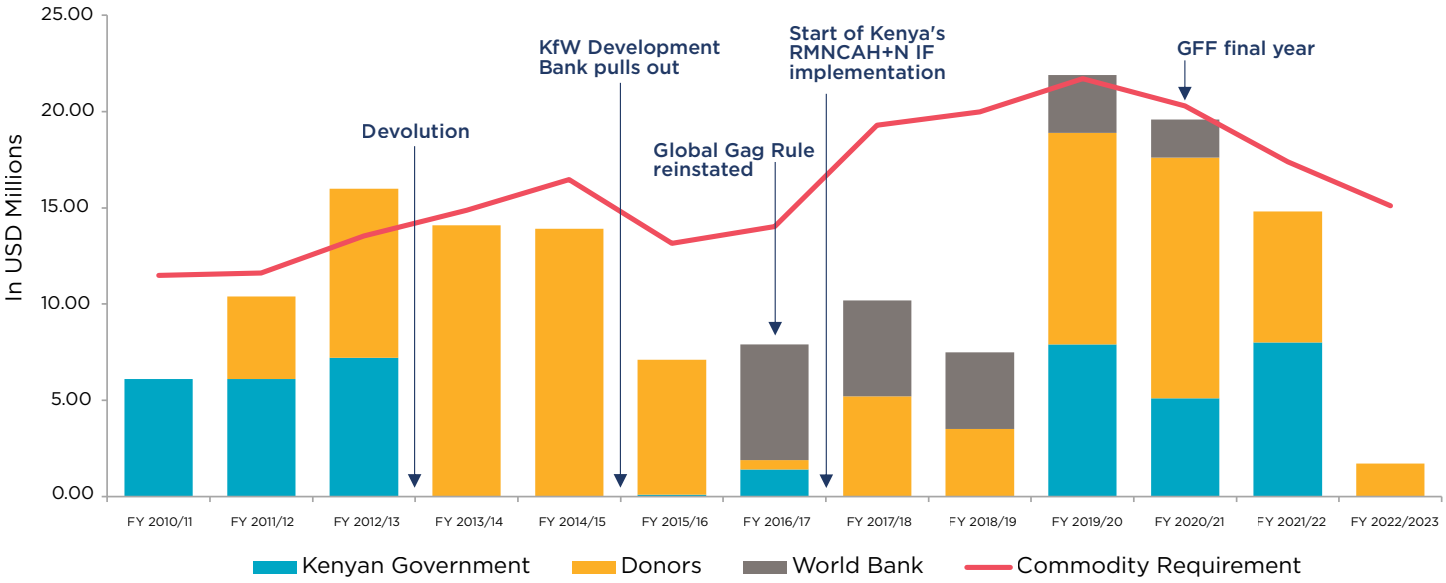
During the development process of the RMNCAH+N IF in Kenya, a series of consultations were held. FP advocates from civil society constituencies that were working with the Reproductive Health Supplies Coalition learned that the GFF was not going to include FP commodities. It is against this backdrop that the FP advocates began engaging to ensure that critical aspects of the RMNCAH+N continuum of care, such as FP, are included.

At the start of the IF development process, Kenya had just undergone the devolution process where health programming responsibilities were transferred to county governments. Disappointingly, domestic allocation to FP commodities reduced significantly due to the transfer of national funding to the county governments as part of the shareable resources to be used across various sectors. A closer examination of the devolution process shows that it presented both unique opportunities and challenges for the health sector. For instance, in FP programming, it reduced the gains made in increasing FP financing, especially procurement of FP commodities using domestic funding streams. It was not clear what modalities existed for procuring health sector strategic commodities, such as vaccines, antiretroviral drugs, HIV test kits and FP commodities. This became clearer later, following consultations with diverse groups, where consensus was reached on what constituted strategic commodities. The arguments at the time emphasized the importance of centralizing the procurement of strategic commodities to allow for quality assurance and regulation of pharmaceuticals and other critical commodities.

In FY 2004/05, Kenya had succeeded in securing a budget line earmarked for FP commodities at the national level. This success was critical to ensure government-led commodity security shifted away from donor reliance.[19] However, in 2013, the funds allocated to national procurement of FP commodities were included as part of the shareable resources to the counties during the devolution process. The changes affected FP commodity financing from government. An MoH FP forecasting and quantification analysis of the FP commodity financing trends is shown in Figure 6.[20,21]

FIGURE 6: FP COMMODITY FINANCING TRENDS FY 2010/11-FY 2022/23

Source: MoH and Clinton Health Access Initiative FP dashboard



Despite counties taking more responsibilities in delivering health services, county resources are largely spent on staff and salaries. Resources to staff salaries are considered "personnel emoluments" and ranged between 71.9% in FY 2017/18, 75.8% in FY 2018/19 and 76.8% in FY 2019/20. Human resources for health are a core component of health care delivery systems and receive the largest share in allocation of health resources. It is also considered a key determinant of quality of care. Although the human resources for health allocation was the largest, counties continue to face insufficient levels of staff and low remuneration, which affects the ability to deliver quality services and retention of health care workers. As counties grapple with these health systems issues, limited funds are left for program implementation, including FP.

> **"Family planning is to maternal health what immunization is to child health."**
>
> *– Dr. Khama Rogo, lead health sector specialist, World Bank*

FP advocates continued to engage the government of Kenya to ensure that the World Bank and other donors had included FP as part of Kenya's RMNCAH+N IF. Advocates reached out to the World Bank country office team, the DFH within the MoH and the National Council for Population and Development to ensure that there was buy-in to include FP in the GFF partnership, which was being initiated in the country by the government and the World Bank.

All stakeholders were brought on board and led in advocating for FP commodities financing. It was during this time that Dr. Khama Rogo shared, "Family planning is to maternal health what immunization is to child health." Finally, it was agreed that FP had to be included in the IF.

Civil society played a significant role in moving the agenda forward with the relevant government entities. These negotiations led to the inclusion of FP in the budget using the GFF grant. A total allocation of $20 million over a five-year period between FY 2016/17 to FY 2020/21 was agreed upon. The government and other donors had to meet the remaining funding gap.

After seeking an extension due to experienced delays in disbursements and the effects of COVID-19, the GFF grant now comes to an end in June 2022. Still, conversations to ensure FP commodity security have begun. Donors held discussions with the MoH to agree on a memorandum of understanding that anticipates FY 2023/24 as the year when government should be able to allocate its own domestic resources for FP commodities. However, the memorandum is yet to be signed. Advocates are pushing the government to meet its commitment by increasing domestic resources allocation for FP from $7.8 million to $15.2 million by 2025.

Catalyzing county-level budget allocation for health using RMNCAH+N indicators

THS-UCP, managed through the CoG health office, is part of the GFF partnership. Its main funding is from the GFF grant and IDA loan. The project has played a key role in supporting counties to scale-up evidence-based, cost-effective RMNCAH+N high-impact interventions that are identified at the county level. Counties are required to develop annual work plans that align to the RMNCAH+N IF. These work plans are expected to include interventions that focus on improving the functionality of existing health facilities to deliver PHC services, as well as improve demand for services at facility and community levels.

The project uses a performance-based approach that is based on minimum conditions being met, in addition to the resources being allocated to counties based on improved PHC results. The THS-UCP annual allocations are provided in Table 4.

TABLE 4: ANNUAL AND TOTAL THS-UCP ALLOCATIONS

Activity	in USD millions					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Performance based	12.5	27.5	30	30	30	**130**
RMNCAH+N strategic commodity	6	5	4	3	2	**20**

Allocation of Year 1 funding was based on need indicators measured by:

- Proportion of births not attended by skilled health professionals (Kenya Demographic Health Survey 2014);
- CRA ratio, based on the poverty index, land area, population, roads, health services index, agriculture service, urban services and other county services (Kenya CRA ratio 2020);
- Minimum conditions as per Year 1;
- Timely submission of financial and project reports;
- County overall budget allocated to health is at a minimum 20% of total county budget and higher than previous year in the subsequent years; and
- New, performance-based PFM criteria is applied.

THS-UCP implementation faced challenges, mainly delays in disbursement of funds due to issues with funding flows. A new PFM criterion was developed to address the delay in disbursement of funds to the County Department of Health from the County Revenue Fund Special Purpose Account. CSO advocates supported county health departments by voicing these concerns with relevant authorities, pushing to ensure that these funds were reserved for RMNCAH+N interventions. A performance approach that included service delivery indicators and minimum conditions, such as increasing budget allocation to health, was seen as a workable solution that could address the experienced delays. Therefore, an additional PFM criterion was included in the conditions to be met by counties (Table 5).

TABLE 5: NEW PFM ALLOCATION CRITERIA

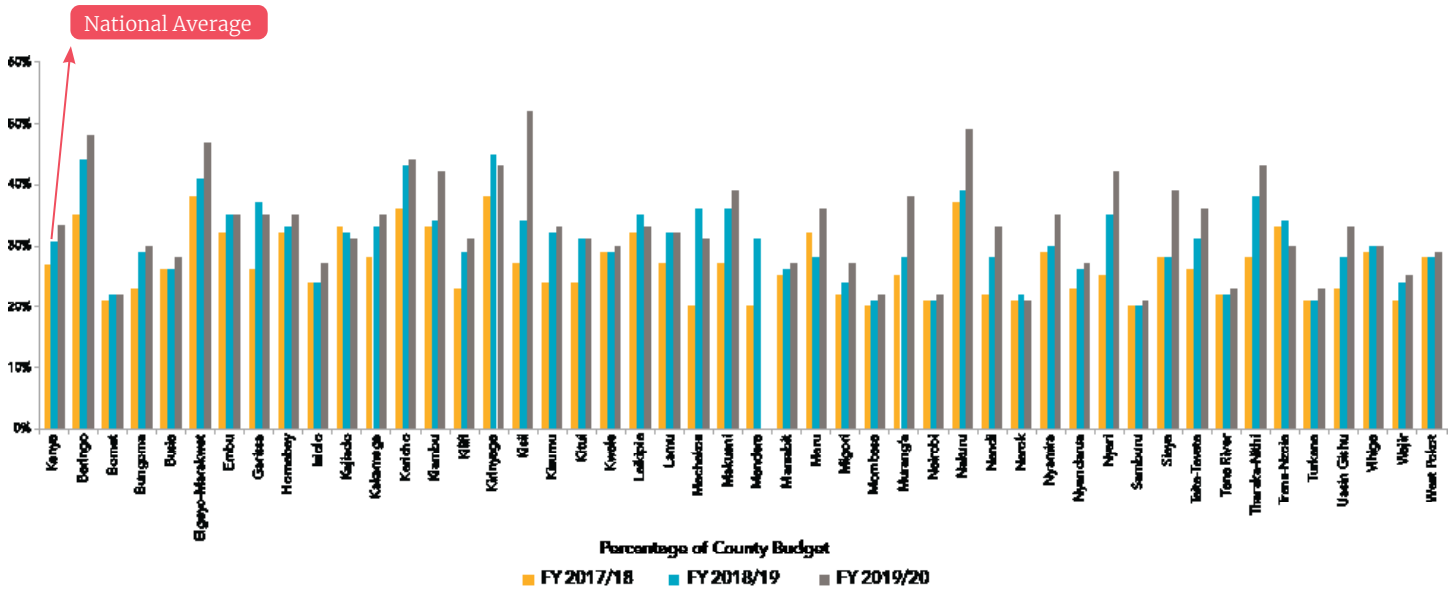
Moving FY 2017/18 funds from the County Revenue Fund to the Special Purpose Account	
Within	**Eligibility for FY 2018/19**
1-15 days	100%
16-25 days	75%
26-35 days	50%
36-45 days	25%
After 46 days	0%

In the first year of the GFF partnership, counties had to meet basic conditions, including a minimum allocation of 20% of the county budget to health. Participating counties had to sign intergovernmental participation agreements indicating such. They were also required to open a Special Purpose Account, with the mandatory signatories identified from the health department and to develop annual work plans, which were forwarded to the World Bank.

The PBF approach used in THS-UCP increased allocation to the health sector at the county level. Conversely, domestic funding for RMNCAH+N through the GFF partnership, illustrated in Figure 7, shows the average increase across the counties and the year-by-year increase of county allocations for FY 2017/18, FY 2018/19 and FY 2019/20.

FIGURE 7: DOMESTIC RESOURCE ALLOCATION FOR THE HEALTH SECTOR

Source: MoH, THS-UCP project management unit



In FY 2019/20, Baringo, Elgeyo-Marakwet, Kirinyaga, Kisii, Nakuru, Nyeri, Siaya, Tana River and Tharaka-Nithi counties significantly increased their domestic budget allocation to health. Overall, the average allocation for health in the counties increased from 27% in FY 2017/18 to 33% in 2019/20.

The PBF approach enabled the shift from inputs-based budgeting to a results-based model, increasing accountability for results at the county level. This PBF model applies four main service delivery indicators and an additional PFM indicator to reimburse county governments. Counties have embraced this approach and view it as an incentive opportunity for them to attract more resources to support RMNCAH+N programming within a resource constrained environment.

The final year of implementation for the RMNCAH+N IF was 2020. There are plans to conduct an evaluation of the framework to assess the extent to which the goals and targets outlined have been met. However, at the time of writing, the evaluation has not been completed.

Enhancing Accountability for Results Through Management and Accountability Tools

Tracking progress and results using accountability tools, such as scorecards, is a good practice that ensures there is transparency and accountability. The MoH uses the RMNCAH+N scorecard, which is supported by UNICEF and the African Leaders Malaria Alliance. The RMNCAH+N scorecard serves as the main monitoring tool at the national and county levels. Inputs into the scorecard are pulled from DHIS2. Through regular quarterly meetings at the county level, scorecard outcomes are reviewed and discussed with a wide range of RMNCAH+N stakeholders. These meetings are used as opportunities where stakeholders discuss progress, challenges and solutions, driving course-correction through an action tracker that is linked to the scorecard. Engagement of the CSOs in these review meetings is suboptimal and varies across counties.

RMNCAH+N scorecard

The RMNCAH+N scorecard tracks progress of the service delivery indicators which are used to trigger action among the health workers, county assembly members and implementing partners to influence resource allocation and improve services in specific RMNCAH+N focus areas. Additionally, data demand and use aspects are strengthened through the review process, which also informs evidence-based advocacy efforts. The process has improved prioritization, resources and programming across partners, and reduced duplication of efforts. The scorecard has also increased ownership and enhanced good management practices and performance in counties.

GFF CSO accountability scorecard versions 1 and 2

In 2017, civil society, through HENNET, mobilized and developed the first GFF CSO scorecard. The main purpose of the scorecard was to assess whether the foundation of the GFF partnership was in place for an effective rollout at the national and county levels. The scorecard sought to track implementation of the GFF processes alignment to key documents, GFF principles and goals, as well as monitor implementation of Kenya's RMNCAH+N IF and the health financing strategy that was under development at the time. The scorecard was to be used to hold all the stakeholders accountable for their commitments to RMNCAH+N. Stakeholders at the national and county levels were to use the scorecard findings in facilitating dialogue on the effectiveness of the GFF partnership process.

The GFF CSO accountability scorecard reviewed five key areas:

1. Status of the GFF partnership process: the stage at which a country is in the GFF partnership process, such as the development of the IF, existence of complementary financing, health financing strategy, project appraisal document approval, etc.
2. MCP: the formation of the country platform, whether MCP clearly outlines roles and responsibilities, etc.
3. Civil society engagement: presence of a civil society coalition, whether the coalition is represented in the MCP and development of its engagement strategy.
4. Design of key documents: IF developed, resources used to support priorities outlined, existence of IF and health financing strategies, costed implementation plans included, IF priorities are included in the IF strategy and project appraisal document is consistent with the IF priorities.
5. Status of implementation: the availability of annual progress reports, annual work plans at the national and county levels reflect priorities of the IF, increases in government investment in RMNCAH+N, engagement with private sector and whether GFF partnership funding is disbursed in a timely way.

FIGURE 8: GFF CSO ACCOUNTABILITY SCORECARD SCORING SYSTEM

MULTISTAKEHOLDER COUNTRY PLATFORM (MCP) STATUS ASSESSMENT SCORECARD SCORING METHODOLOGY			
GFF Process and Platform	**GREEN**	**YELLOW**	**RED**
Existence of MCP	*The MCP is in place, including technical working group, state-led mechanisms, SWAp, national country platform and GFF Taskforce*	*The MCP is in the process of formulation and MOUs and TORs are drafted*	*The MCP is NOT in place*
Composition and Representation	**GREEN**	**YELLOW**	**RED**
Representation of constituent members in the MCP	*List of constituent members is available AND includes at least six of the following constituents: CSOs, MoH, MoF/MoP, World Bank, private sector, multilateral and bilateral donors, youth and adolescents and subnational/ federal states*	*List of constituent members is available OR it includes three of the following constituents: CSOs, MoH, MoF/MoP, World Bank, private sector, multilateral and bilateral donors, youth and adolescents and subnational/ federal states*	*List of constituent members is NOT available and fewer than three members are included*
Transparency of the selection process of constituent members	*The election process is transparent AND CSOs decide who represents them*	*Process of elections is transparent OR CSOs decide who represents them*	*Process of election is NOT transparent AND CSOs do NOT decide who represents them*
Number of slots allocated to CSO constituency	*At least two slots are allocated for CSOs*	*One slot is allocated for CSOs*	*NO slots are allocated for CSOs*
CSO constituency elects its own representatives	*More than 60% of the respondents said "YES"*	*At least 50% of respondents said "YES"*	*More than 60% of the respondents said "NO"*
MCP Functionality	**GREEN**	**YELLOW**	**RED**
MOUs and TORs clearly outline MCP roles and responsibilities	*MOUs and TORs are available AND outline the roles and responsibilities of the MCP*	*MOUs, TORs OR outlined roles and responsibilities of the MCP are available*	*MOUs and TORs, as well as outlined roles and responsibilities of the MCP, are NOT available*
MOUs and TORs are publicly available	*MOUs and TORs are publicly available*	*MOUs and TORs are available, sometimes publicly online*	*MOUs and TORs are NOT publicly available*
Participation of MCP constituent members in contributing to the meeting agenda	*Constituent members contribute to the agenda in at least one annual meeting*	*Irregular constituent member contribution to the agenda of the meeting*	*Constituent members DO NOT contribute to the agenda of the annual meeting*
Regularity of MCP meetings	*Regular meetings are held at least biannually as per the MOUs and TORs*	*At least one irregular meeting AND ad hoc meetings are held*	*NO meetings are held*
CSOs have a consultative process on RMNCAH+N issues	*More than 60% of respondents said "YES"*	*At least 50% of respondents said "YES"*	*More than 60% of respondents said "NO"*
Regular updates on RMNCAH+N IC implementation and progress to constituent members	*More than 60% of respondents said "YES"*	*At least 50% of respondents said "YES"*	*More than 60% of respondents said "NO"*
Sharing of implementation reports	*Progress reports AND regular updates are shared with constituent members*	*Progress reports OR regular updates are shared with constituent members*	*Progress reports and regular updates are NOT shared with constituent members*
Technical and financial reports available online	*Technical reports AND financial reports are available online*	*Technical reports OR financial reports are available online*	*Technical reports and financial reports are NOT available online*

The findings of the scorecard were validated by all stakeholders in 2017 ahead of the Civil Society, Pre-Investor's Group Annual Meeting. MoH, CoG, World Bank, HENNET and its members, with support from PATH, supported the validation process. During the validation meeting, CSOs raised issues related to the delay in disbursement of funding by the MoH to counties, noting that funding had only been released to the national level. This led to the fast-tracking of the fund disbursement process. Following a series of meetings and engagements with the National Treasury, the funds had not been included in the County Allocation and Revenue Act, meaning review was required during the supplementary budget process. Other priorities that were identified include:

- Fast-tracking the establishment of the country platform;
- Finalizing and operationalizing the civil society engagement strategy; and
- Clearly defining the role of the private sector in the GFF partnership at the country level.

The GFF CSO accountability scorecard Version 2 (2018) applied the same methodology using the same indicators identified in Version 1 (2017), to determine whether progress or improvements had been made in the implementation of the GFF processes, the alignment of key documents and the implementation of the RMNCAH+N IF and health financing strategy. Minor adaptations were made as the new government shifted its focus to the Big Four Agenda. The focus shifted from developing a health financing strategy to developing sustainable financing that promotes movement toward achieving UHC.

Version 2 scorecard findings were used by civil society to facilitate dialogue and advocacy on the effectiveness of the GFF process, engagement, co-financing arrangement and governance structures. The findings were presented and validated by stakeholders. Some recommendations that emerged from the validation meetings include:

- Advocating for increased participation by CSOs at the country platform and effective feedback to the CSOs coordinating group;
- Engaging in planning, implementation and monitoring of the IF at the national and county levels to ensure prioritization of RMNCAH+N;
- Finalizing the CSO engagement strategy and memorandum of understanding; and
- Developing a 2019 CSO work plan of activities.

The above recommendations enabled CSOs to identify key priorities for their accountability and advocacy focus areas:

- Fast-tracking the formation and implementation of the country platform — or the RMNCAH+N Interagency Coordinating Committee. (At the time, the partnership framework was being drafted and an Interagency Coordinating Committee was discussed.)
- Participating in planning, implementing and monitoring of the IF, and aligning it with the UHC agenda at the national and county levels.
- Mobilizing and tracking private sector contributions in the implementation of the country's RMNCAH+N IF.

Lessons Learned from the Kenya GFF Partnership

Improving health allocation and spending for RMNCAH+N interventions: The conditions that were provided for counties to allocate a minimum of 20% of the total county health budget to health and gradually increase the allocation in subsequent years improved domestic resources for health. It will be important for national and county governments, in collaboration with the CoG, to ensure that resources raised domestically for health are used for the intended purpose and spent efficiently for greater impact. Conversely, the new PFM criteria applied as a condition to receive subsequent funding for THS-UCP under the GFF partnership has also improved domestic resource flows to departments of health at the county level, as well as spending on the approved planned interventions.

Improving services for adolescents and youth: Delivery of health services to adolescents and youth, a frequently marginalized community, is critical in improving some of the health indicators and issues, such as teenage pregnancies. The results or reports do not disaggregate data to show utilization of services by this group. At the service delivery level, adolescents and youth wish to be empowered and engaged, to voice their issues at the county level or through the health facility boards and committees. At the national level, further analysis of the routine DHIS2 data can help policy and decision-makers use specific adolescent and youth data to address some of the challenges faced when accessing services.

MCP: The formation and launch of the MCP is a great achievement for Kenya. The coordinating structures that existed were mainly technical working groups that focused on different technical areas along the RMNCAH+N continuum. The RMNCAH+N platform provides a space to bring all these related issues together and discuss progress and challenges aligned to achievement of the RMNCAH+N IF goals. Further strengthening of the accountability role of the country platform will be required. For decentralized health systems such as in Kenya, the engagement of the county governments through the coordination structures at that level will be important in cascading these efforts.

Private sector engagement in the GFF partnership: The private sector, through the Kenya Health Federation, has been engaging and participating in meetings of the country platform. As an important stakeholder in the health service delivery, its role needs to be enhanced to include their strategic contribution toward implementation of the RMNCAH+N IF.

RMNCAH+N focus within the broader PHC and UHC agenda: The government's Big Four Agenda highlights UHC as a key component. Progress toward achievement of UHC will require investments in strengthening PHC, one of the key pillars under UHC. RMNCAH+N interventions are critical areas that are included within the PHC framework, which is anchored on the health systems building blocks. Sustainable financing for RMNCAH+N beyond the GFF partnership will require a shift towards embedding RMNCAH+N within the country UHC agenda, specifically the PHC pillar, to ensure equity and inclusion in service delivery are addressed.

Nutrition component lagging: At the launch of the MCP, Kenya's MoH monitoring and evaluation unit presented the RMNCAH+N scorecard, which showed poor nutrition indicators. In most of the GFF partnership countries, nutrition has been left out, but now countries are beginning to mainstream nutrition more within the RMNCAH+N-related issues. In Kenya, the nutrition component was not explicitly included in the RMNCAH+N IF.

Building resilient health systems: The IF did not include critical health system building blocks that required strengthening, except for the reporting under the health information system. Given that the PBF approach requires utilization of DHIS2 to track performance at the county level, this indicator was included in the results-based financing mechanisms. Other components such as commodity supplies under the health products and technologies building block — critical in ensuring access — were also not addressed.

COVID-19 and post-pandemic recovery measures: There was less of a focus on essential services when the COVID-19 pandemic struck. It took concerted effort by civil society and other stakeholders to highlight and emphasize the disruption and continuation of essential services from the supply side. On the demand side, there was fear among communities accessing these services and this may have affected service utilization. Despite the initial challenges, technological innovations on tracking COVID-19 posit opportunities that could utilize existing COVID-19 infrastructure in addressing RMNCAH+N issues, such as referral system and tracking, which are very weak at the county and national levels.

Conclusion

This case study suggests that the GFF partnership in Kenya has played a significant role in increasing domestic resources for health at the county level and overall country financing for health, using the conditional granting mechanism and PBF approach. The design of this approach was reviewed at various stages to ensure it responds to the emerging issues at the county level. For instance, the resource flow challenges that were experienced were addressed using the new PFM criteria.

The Kenyan government through MoH leadership, working together with the World Bank and civil society represented by HENNET, played a key role in ensuring the formation and launch of the RMNCAH+N MCP. Sustaining and ensuring the platform responds to its coordinating role and needs of the various actors will be critical to its success. Civil society played a key role in highlighting some of the GFF partnership challenges and strengthening the understanding of the GFF partnership approach within the government and across stakeholders.

This led to some notable achievements, such as the formation of the country platform, improvement in funding flows and disbursements to counties, among others. Additionally, through the utilization of the GFF partnership resources, civil society helped to mitigate the FP commodity gap, enabling access to FP services for communities. However, long-term sustainability of FP commodity security as well as RMNCAH+N intervention efforts will need to be addressed as the GFF partnership came to an end in 2020.

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