AID EVALUATION AND IMPACT ANALYSIS OF SIDA’S SUPPORT TO THE KENYAN HEALTH SECTOR

By

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A Thesis Submitted to the School of Humanities and Social Sciences in Partial Fulfillment of the Requirement for the Degree of Masters in International Relations

UNITED STATES INTERNATIONAL UNIVERSITY
DECLARATION

I hereby declare that this Thesis is my original work. It has not been published or presented in any other institution. All materials obtained herein from other sources are duly acknowledged.

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DEDICATION

This thesis is dedicated to my father who is proud of me, who is keen on what I study and what I learn. His passion for development has trickled down to me. I also dedicate this thesis to my mother who has always believed in me and has given me technical support.
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I give special thanks to my parents who supported me technically and financially throughout my studies.
ABBREVIATIONS AND ACRONYMS

AIA Appropriation in Aid
AU Africa Union
DAC Development Assistance Committee
DCG Donor Coordination Group
DFRD District Focus for Rural Development
DHMTs District Health Management Teams
DPF Development Partnership Forum
ECHo European Commission Humanitarian Organisation
EU European Union
FMS Financial Management Systems
GNI Gross National Income
GNP Gross National Income
GoK Government of Kenya
GoS Government of Sweden
HSRS Health Sector Reform Secretariat
JPWF  Joint Programme of Work and Funding
KDHS  Kenya Demographic Health Survey
KHPF  Kenya Health Policy Framework
KJAS  Kenya Joint Assistance Strategy
LFA   Logical Framework Analysis
MDGs  Millennium Development Goals
MFA   Ministry of Foreign Affairs
MIDC  Ministry of International Development Cooperation
MoF   Ministry of Finance
MoH   Ministry of Health
MSek  Million Sweden Kronor
NGOs  Non-Governmental Organisations
NHA   National Health Accounts
NHSSP-I National Health Sector Strategic Plan- Phase I
NHSSP-I National Health Sector Strategic Plan- Phase II
NRC   Norwegian Refugee Council
<table>
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<tr>
<th>Acronym</th>
<th>Description</th>
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<tr>
<td>OECD</td>
<td>Organisation for Economic Cooperation and Development</td>
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<td>ODA</td>
<td>Official Development Assistance</td>
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<td>PBAs</td>
<td>Programme Based Approaches</td>
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<td>PRS</td>
<td>Poverty Reduction Strategies</td>
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<td>PS</td>
<td>Permanent Secretary</td>
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<td>RHP(s)</td>
<td>Rural Health Programme(s)</td>
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<td>RIHS</td>
<td>Rural Integrated Health Services</td>
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<td>SADEV</td>
<td>Swedish Agency for Development Evaluation</td>
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<td>SAPs</td>
<td>Structural Adjustments Programmes</td>
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<td>SIDA</td>
<td>Swedish International Development Agency</td>
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<td>SPS</td>
<td>Sector Programme Support</td>
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<td>SRHR</td>
<td>Sexual and Reproductive Health Rights</td>
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<td>SWAps</td>
<td>Sector-Wide Approaches</td>
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<tr>
<td>TA</td>
<td>Technical Advisor</td>
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<tr>
<td>ToR</td>
<td>Terms of Reference</td>
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<td>TSec</td>
<td>Thousand Sweden Kronor</td>
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<td>Acronym</td>
<td>Full Form</td>
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<tr>
<td>UN</td>
<td>United Nations</td>
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<td>USD</td>
<td>United States Dollar</td>
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<tr>
<td>UTV</td>
<td>SIDA’s Evaluation Department</td>
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<td>WHA</td>
<td>World Health Assembly</td>
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ABSTRACT

Sweden, through its aid for international development has supported African countries such as Kenya, Ethiopia and Zambia. On Sweden’s development cooperation with Kenya, the thesis analyses SIDA’s funding policy in theory and practice. An analysis of SIDA’s support to the Kenya health sector is carried to give guidance on how funding policies and previous health policies have influenced the outcome(s) of the intervention. In practice, the study shows how policies have been applied in programme implementation. SIDA’s evaluation process is also analysed to conclude if evaluation was accurate in judging outcome of the programme.

The research entails qualitative data from primary sources; such as correspondences with SIDA-Kenya personnel, study of conference papers, working papers, health sector programme documents, as well as report findings. The research also entails data collected from secondary sources such as library materials; books, journals, articles and publications.
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CHAPTER ONE

1.0 Introduction

In 1960, leading donor governments worldwide formed the Development Assistance Committee (DAC) with the aim of promoting aid. This aid was named the Official Development Assistance (ODA). Countries giving this ODA were to give it from 0.7 percent of their Gross National Income (GNI) (Martinusen, 1999). The United Nations (UN) Charter was formed in 1945 by countries giving ODA. Poverty being the central focus, the ODA charter was aimed at promoting socio-economic development as well as improving the living standards of the poor. Many developed countries and almost all countries in Europe adhere to the ODA requirements.

Narrowing down to Kenya, development cooperation with Sweden aims at improving the living conditions of Kenyans who live in absolute poverty (King, 2004:144). Sweden aims to do these by focusing its efforts towards economic and development cooperation between development agencies, Kenyan leaders and the civil society. In 2007, donor agencies established a donor-recipient development cooperation known as the Kenya Joint Assistance Strategy (KJAS) 2008 – 2012 which was adopted in September. KJAS was drawn up jointly by most of the major bilateral, multilateral donors concerned with the Kenyan Government (Ministry of Foreign Affairs, 2009:12). To date, 17 donors have signed it.
1.1 Background of Study

Sweden has had funding relations with Kenya for about 50 years, ever since 1963 (SIDA, 2010:1). These have been years of improved reforms on Swedish Aid, as well as increment of Swedish fund to Kenya. On improved reforms, donors have been altering their methods of administering aid by placing policy decisions on the Embassies through the Ministry of Foreign Affairs. This was done so that the donor agency itself can focus on the technicalities and implementation of the aid as well as conducting evaluation processes and impact analysis.

Some of the Kenyan social sector programmes and projects funded by SIDA (bilaterally) are as follows (Weeks, 2002)\(^1\);


- Health Sector Programme\(^2\).

- National Agriculture and Livestock Extension Programme.

According to Weeks (2002:29-37), SIDA’s involvement with Kenya’s health sector dates back to 1969. SIDA recently supported the Rural Health Programmes (RHPs) which was later named the Rural Integrated Health Services (RIHS) support programme.

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\(^1\) Publications on these SIDA funded projects can be obtained from SIDA’s case study Kenya (2010:16) as well as the article “Supporting ownership: Swedish development cooperation with Kenya, Tanzania, and Uganda” (Weeks et al 2002: 22). More on social sector programmes (particularly on health sector) is detailed further in chapter II.

\(^2\) See Kenya’s Health Sector Framework (1994).
1.2 Statement of Research Problem and Questions

1.2.1 Problem Statement

According to Riddel, (2007) it has been difficult to assess the impact of aid because most donors link their successes to the utilization of all funds. SIDA is satisfied when its funded project meets its output targets, those measured by physical actions undertaken and utilization of funds (Riddel, 2007:167).

The gap identified in this research is that SIDA’s impact analysis does not measure its contribution at the national intervention. This gap is as a result of various shortfalls on areas of evaluation and impact assessment; shortfalls resulting from policy issues as well as participatory concerns on inclusiveness during evaluation and impact analysis.

SIDA does not apply participatory evaluation processes with agencies, government etc. who are carrying out the same intervention. For instance, according to SIDA’s evaluation policy, SADFW (which is a SIDA’s Technical Assistance unit) does not carry out joint evaluations with partner countries (OECD 2010:114). This makes it difficult for SIDA to identify its share of impact towards national development. "We cannot talk of results, if we cannot refer to overall or national contribution towards changes; both economic and political changes in a country" (Jerve et al., 2008: 33). There is speculated reluctance by project evaluators to analyse national impact of their interventions, even when the information can be obtained. On the SIDA supported RHIS programme which shares the same goal as Kenya’s goal (on decentralisation of health services), SIDA fails to measure its contribution to that of the national intervention’s towards decentralisation.
More on this has been described in the literature review and analysed in the other chapters of the thesis.

1.2.2 Research Questions

In addressing this problem, the research attempts to answer the following significant questions;

1.3.2.1 How does the Swedish donor agency measure impact of their aid?

1.3.2.2 Do policies with the donor or recipient countries affect implementation of programmes as well as assessing impact?

1.3.2.3 Is the Swedish aid effectiveness in Kenya measured efficiently?

1.3 Objectives of Study

1.4.1 To explore health policies in Kenya.

1.4.2 To explore how SIDA policies and processes influence impact of sector programmes in Kenya.

1.4.3 To analyse SIDA’s evaluation process and impact assessment.

1.4 Significance of Study

According to the SIDA evaluation manual, second revised edition, impact is defined as “the totality of the effects brought about by an intervention” (Molund, 2004:12). Impact also refers to effects in the long term or effects at the scale of societies, communities, or systems (Molund,
Impact of aid is measured on the well-being of the recipients or on economic improvements in the recipient country.

One of the challenges with aid evaluation is that implementers tend to look at impact by making assumptions about impact rather than empirically verify impact (Jerve et al., 2008).” With this hitch in evaluation, the big question that will be tackled in the thesis is on whether SIDA funding policies and implementation of its programmes in Kenya’s health sector have been efficient and effective. Donor data suggests that between ten and twenty-five percent of projects have failed to meet their immediate objective, or have had extremely limited success, or else the data on the projects have been so poor that it has not been possible to form a judgment on project performance (Riddel, 2007:167).

The study aims at evaluating aid and impact assessment through causal effect (linking causes to effects) in the following areas

- Analyse health policies as well as SIDA funding and how they lead to outcomes and impact of a programme.

- Analyse SIDA’s participatory and inclusiveness in implementation as well as evaluation of programme and the impact it has in the programme and the health sector.

- Analyse SIDA’s evaluation process that leads to the findings on impact of the programme - This will assess if the process is all inclusive and if it is efficient in measuring SIDA’s contribution to the national intervention.
1.5 Literature Review

1.5.1 Preamble

Literature review of this thesis entails data sourced from primary sources such as study of situational and previous years’ reports, journals (online and printed), conference and working papers, published report findings from SIDA database and target strategy papers.

Secondary sources of data will include reviewing of published books, newspaper articles as well as relevant internet sources.

1.5.2 Gap in Literature Review

The overall assessment of outcome as well as impact of programmes by SIDA’s support to Kenya’s health sector has only looked into its own contribution. SIDA’s evaluation assessment of programme outcomes, particularly on health sector, does not factor in contributions by other agencies and local government’s initiatives towards the same intervention. As a result, SIDA is unable to measure its own share of contribution, towards that of the national intervention.

Previous studies with Gibson (2005) have found little consonance between aid levels and desirable changes in macro-level indicators. Tracing the overall relationship between aid and its impact at the national and international level requires accurate, reliable and consistent data over time (Riddel 2007:166). The gap in assessing the overall impact of aid is as a result of challenges in gathering data. Another factor is that most aid evaluations tend to deal with aid connections under the rubric of ‘relevance’ only, i.e. to make assumptions about impact rather than empirically verify impact (Jerve et al., 2008). This situation could also be as a result of seeking for verification of impact where it is hard to identify. It is difficult to measure impact from
assumptions where facts have not been verified. Some critics state that assessment of SIDA’s programme level performance is normally hampered by poor data, making it extremely difficult to assess donor contribution to wider development progress. To this day, individual bilateral donors are still not able to produce clear evidence to document the wider contribution that the aid is making to aggregate growth and poverty reduction (Klein, 2005).

As a result of these, SIDA may not be in a position to measure its national contribution towards development and economic growth. Bilateral donor evaluation should focus more directly on the findings of the most comprehensive and rigorous attempt to access the overall impact of country programmes (Kifle, 1997).

1.5.3 Review of Literature

_A Historical Trajectory_

Policy makers, scholars as well as aid practitioners have through time, written articles which aim at questioning the effectiveness of aid in reducing poverty and accelerate growth of the economy (Dollar, 2000a; Martens et al., 2002). The Paris Declaration which focused on improving aid effectiveness was signed by about 50 countries, (Lundstrom, 2006:1; OECD, 2008). Sweden is one of the countries that agreed to adhere to the Paris principle.

In 1965 the Sweden’s development cooperation established SIDA to be a representative of the government of Sweden through which the government allocates 1% of its GNP towards ODA (Gibson 2005:133). SIDA’s involvement with Kenya’s started as early as 1970s (Ekroth, 2000; Weeks, 2002).
Health Reforms in Kenya

According to Muga (2004) document, "Health Systems in Kenya", health sector in Kenya has gone through many reforms, with the aim of making the health policy to be more friendly to the beneficiaries as well as improving the health status through restructuring of the health sector. The 1994 Health policy framework was designed with the aim of stopping, then reversing the deteriorating health care situation. Kenya’s recent policy aimed to ensure that health services trickles down to the rural areas, through decentralisation and transferring responsibility to the districts (Oyaya, 2003).

In 1999, SIDA supported the vision of Kenya’s 1994 Health policy framework (decentralisation of health services), by starting the Rural Health Integrated Services (RHIS) programme (Weeks 2002:31; Crouch, 2005).

Aid Efficiency and Effectiveness

The thesis analyses how SIDA’s funding policy has influenced the outcome(s) of the RHIS intervention. Previously, there have been various criticisms by scholars and policy makers concerning SIDA’s funding policies. In early 90s, Swedish Ministry of Foreign Affairs funded a series of in-depth studies that looked at the impact of Swedish aid in multiple countries but Swedish Ministry included a substantial analysis of the wider effect of all aid in these multiple countries. A number of single country impact reports have been produced though most of these were not done in-depth or rigorously” (Molund, 2004). Other scholars state that there has been a main focus with development agencies, on better systems for managing inter-agency information, but this policy is different from the SIDA’s discourse on knowledge. The report,
“Does SIDA learn” by Riksrevisionsverket, emphasises issues of policy, consistency, leadership and personnel policies as hindrances to SIDA’s effectiveness as a long term Organisation (Riksrevisionsverket, 1988).

The thesis also analyses the levels and extent at which SIDA engages with external development communities. Historically, here have been various criticisms by scholars and policy makers on SIDA’s inclusiveness in its interventions on a particular sector. Criticisms focused on how SIDA practices its knowledge of partnership. Carlsson in his 2000 paper, concludes that SIDA has had more aspirational than actual attention to partnership in evaluation (Forss, 2008). King (2004) in his book states that SIDA evaluation departments are challenged by the new knowledge and learning which puts emphasis on considerations on how partners and their knowledge are to be included and how to share findings. It also highlights that there isn’t enough participation by other partners in SIDA’s evaluations, hence limiting SIDA’s opportunities to learn. He further highlights SIDA’s unwillingness to fund the Global Development Network and the development getaway. He attributed this as SIDA’s unwillingness in promoting partnership (King, 2004).

The 2009 SIDA’s Kenya strategy report states that its evaluation process goals rely on data from other development partners that has not been collected (Embassy of Sweden, 2010). This is a challenge from the recipient country’s inability to improve data collection and inability to be consistent in collecting data over time. Most governments of poor countries have no data on the numbers of people living in poverty over time. The SIDA’s Kenya strategy 2009 report also states that most donor agencies do not have sufficient data on poverty levels and poverty trend of a country. In the case of bilateral relations between Sweden and Kenya, it is the role of the recipient country (in this case Kenya), to ensure that it has reliable data accumulating from the
previous interventions. Donors do not regard information storing (on recipient countries) as their role. Information on performance and progress of a particular intervention, must be based on accurate baseline data (gathered at the start of the project) however, bureaucracy from recipients lead to difficulty in the ability to disseminate data. Baseline survey that is usually conducted by the aid recipient country is considered national information; to mean that the information obtained is from previous interventions by the government and various stakeholders over time.

This thesis analyses data on new aid paradigm’s impact upon learning within SIDA as well as review whether SIDA policies in performing evaluation has been efficient in assessing impact. SIDA’s evaluation process during the implementation of Kenya health programmes is analysed to verify if evaluation has been accurate in judging outcome of the programme. There have been various criticisms by scholars and policy makers on efficiency in evaluation. African commentators in Abidjan have stated various challenges towards Sweden’s development cooperation’s vision and also questioned its records (Kifle et al., 1997). This Abidjan review states that there is limited evidence of effective evaluation from SIDA programmes. Some policy makers have stated that knowledge management doesn’t seem to be a core concern of SIDA at the operational level. According to Kenneth King, SIDA for more than a decade, have highlighted the importance of knowledge, yet SIDA has not followed the knowledge management trends of other agencies (King, 2004). “SIDA points to its willingness, but lacks to apply or to practice. SIDA is actively involved in evaluation, only that the quality and effectiveness of this learning is deemed inadequate” (King, 2004:152). Other writers have stated presentation and visibility of SIDA’s action plans are too modest. A working paper, “Are evaluations Useful” written by Carlsson et al. (1999) and co-authored by Anne-Marie Fallenius is open about the weaknesses of SIDA’s evaluation in terms of learning and knowledge; arguing
that evaluation is weak in generating new knowledge and it is inadequate in knowledge sharing (Carlsson, 2000; King, 2004). Others state that the evaluations cover only the tangible, readily available and measurable information from a project, rather than trying to get at deeper reasons for successes and failures (Gibson, 2005: 3151). When donors conduct evaluation assessment, focus is more on findings and conclusions instead of focusing on understanding if the findings are as per expected in the initial objectives of an intervention. Most organisations normally use evaluations as procedural administrative directives, instead of embracing it as opportunities to spread and adopt learning in the practice of development.

There are other factors to do with SIDA’s evaluation processes that result to its limitation in impact analysis. Assessments and reviews of the wider impact of a project have successfully used criteria to judge impact which is not centrally, and often not even peripherally, important to the purpose of aid when first given (Riddel, 2007:191). This is a situation whereby impact assessment is conducted for a purpose which is different or deviating from the initial purpose of the intervention. There is a lack of connection between impact of the aid and the development intervention; difficulty linking cause and effect. “Aid yields results, but we know too little about how it works and the magnitude of the impacts” (Jerve & Villanger, 2008). The difficulty in identifying impact could be as a result of not taking into account the unexpected factors that through time, could alter the impact of the project.

**Best Practices**

SWAps and PBAs have become very popular with donors. Sector-Wide Approach (SWAps) entails a group of donors supporting a particular sector such as health, with the aim of helping it achieve the goals and objectives of a government expenditure programme they contribute
SWAPs is intended to make aid delivery more effective by fostering greater recipient responsibility. It can only be utilised where ownership is deemed to be strong and where financial systems and management structures can sustain accountability and transparency (Weeks, 2002:59, 60). The second is the Programme Based Approaches (PBAs) which entails cooperation between donors and the government to align priorities aimed at improving impact assessment of programmes. World Bank even in its implementation of a parallel RHIS programme in its 8 pilot districts, has been key in practicing PBAs. To date, World Bank still remains the only agency which provides explicit ratings for its funded programmes (World Bank, 1999).

1.6 Theoretical Framework

Aid donors have a responsibility of making sure that the funds provided towards development are well utilized and accounted for. To ensure that the funds are used efficiently and effectively, policies and conditions are usually developed and signed as treaties by the two parties; the donor and the recipient. Development depends on the capacity of a country to steer its own development in the desired direction, including the capacity to participate in international cooperation on equal terms. (SIDA, 2000a:9; OECD, 2001).

Development theory describes the most efficient and best methods for achieving the desired change. This theory is relevant to this thesis as the thesis entails negotiations that lead two states settling into agreements. Developing countries (Kenya as recipients), have comparative advantage while settling for negotiations with developed countries. In the case of Kenya, there was expansion of the rural health facilities soon after Kenya’s independence where the local government took over the health sector. In the 70s, SIDA assisted Kenya with this global
strategy for health through construction of rural health facilities, supply of drugs as well as strengthening planning and management of the Rural Health Programme (RHP)

Development theory is also applicable in this thesis because recipient government (in this case; Kenya) retains strong institutions but only requires help to rebuild its physical infrastructure (Gibson, 2005: 65). Kenya as the recipient government is aware of its needs and is willing to accept the condition of a negotiating framework for development cooperation. Kenya also has the negotiating strength to choose among donors, yet still has the strength to approach other donors, based on its needs. Such negotiating power reduces the effect of power asymmetries. Development theory addresses fundamental issues of agreements between Sweden and Kenya, whereby negotiating strategies lead to development cooperation between the two states. This has promoted the Kenya’s national strategy as well as retaining the donor (and recipient’s) interests. Some of the treaties and agreements signed are such as the Kenya Joint Assistance Strategy (KJAS), established in 2007 which led to the Sweden and the Kenya government coming up with a cooperation; a development strategy for the period 2009-2013 (Ministry of Foreign Affairs, 2009:2). SIDA’s cooperation with Kenya aims at improving the livelihoods of Kenyans who live in absolute poverty. Sweden is also committed to strengthening the Government of Kenya’s leadership as well as strengthening development partners to adhere to Paris principle³ (SIDA, 2010). Some of the agreements between Sweden and Kenya on the health reforms are such as the National Health Sector Strategic plan 1994-2004 and the Rural Health Programme.

³ This is the Paris treaty or agreement whereby Sweden co-chairs the Development Partnership Forum (DPF) which focuses on aid effectiveness in developing countries.
The thesis applies the development theory instead of the bilateral theory because bilateral theory by its nature, has more of its focus on trade. It is more relevant for two developed countries thus not so relevant between developed and developing states. The case of the latter scenario (bilateral theory with developed and developing states) would result to a weak recipient whereby the recipient (developing country)’s interests would materialize much later in time and in the process, results to the recipient, having to initiate further negotiations so that their interests can be attained sooner, rather than later. Bilateral theory creates symbiotic relations (co-existence and co-dependence) between the two states. Such a symbiotic economic relationship can help the developed nations to access market from developing countries, while developing countries gain through employment. This (Bilateral) theory would not apply to the thesis. After all, the negative impacts this theory would have to the recipient country, led the DAC to adopt guidelines for untying foreign aid so as to reduce these negative effects (Degnbol, 1999:14). This led to the development theory. For instance, on SIDA’s support to the Kenya’s health sector, aid was untied making public tenders to be open to the recipient country and not to the donor country (Edward, 2008).

1.7 Hypotheses

1.7.1 Donor and recipient countries provide policy guidelines on how a programme is implemented.

1.7.2 Funding policies and processes have a direct link to the performance of a programme.
1.7.3 The quality of information collected during evaluation determines impact of intervention.

1.8 Methodology

The research entails gathering data from the primary or/and secondary data. Primary sources of data collection entails correspondences with some SIDA personnel and personnel from Kenya’s health sector, study of findings from situational reports, conference papers, working papers, target strategy papers, programme documents as well as strategic plans for the relevant health programme, There is an analysis of health policy documents and other official texts from SIDA and the local government’s monitoring and evaluation directorate.

Secondary sources of data include, but are not limited to reviewing of published books, research, journals (online and printed), reports from SIDA database, newspaper articles as well as relevant internet sources.

There is use of quantitative and qualitative data analysis. For quantitative data analysis, the thesis has obtained tabulated or figurative data from SIDA and World Bank reports and database as well as published report findings from the Government of Kenya as well as the SIDA. Statistical information is interpreted so as to give meaning. The data obtained will then be analysed to give conclusion of SIDA’s support to Kenya’s health sector.

Methods of qualitative data analysis that have been used in this study entail discourses that look into changes in funding policies and health policies over time. These are regarded as periodic changes such as with the Sweden’s support to Kenya’s health sector; the changes in policies and approaches, as well as changes with Kenya’s health sector policy over time. The evaluation
process will be clearly illustrated from the data. The thesis applies a triangulation interdependent relationship between the donor agency, recipient (government) and the civilians.

The discourse adopts phenomenological narratives whereby from the data analysis, the thesis gives its individual views from its findings as well as from testing the views of writers and scholar’s on SIDA’s funding and evaluation processes. The thesis also has a causal-effect approach whereby causes are linked to specific effects or outcomes (dependent variables).

The time frame for the observation from which the thesis can obtain information on the case study of the RHIS programme and on Kenya’s health sector reforms is slightly over three years and over three decades respectively.

1.9 Structure of the Study

Chapter One: Introduction

This chapter provides a background and introduces the objectives of the thesis. It looks into the hypothesis and the problem presented in this chapter. Literature review comes later to give brief information on the areas to be studied. The various methodologies for data collection are also listed.

Chapter Two: Processes and Approaches of SIDA funding

This chapter entails a comprehensive literature review on the historical processes of Swedish bilateral cooperation with Kenya and also the Kenya health sector reforms. This explores the Development Theory which is the main theory used in the study. The
chapter then narrows down to SIDA funding policies and processes, exploring how they have been practical in SIDA’s support to Kenya’s health sector.

Chapter Three: Evaluation of SIDA’s Intervention to Kenya

After looking at the policies and processes of SIDA funding to Kenya’s Rural Health Integrated Services Sector in the previous chapter, chapter three looks at the evaluation policies and processes of SIDA’s intervention in Kenya’s Rural Health Integrated Services. It also looks at the opportunities and challenges encountered during the evaluation processes and impact assessment of the RHIS programme.

Chapter Four: Data Analysis

Chapter four focuses on the following;

- Analysis and illustrations of causal effect in the following three areas;
  
  - On how SIDA policies and programme implementation influences or affects the outcome and impact of the programme.
  
  - SIDA’s inclusiveness in the evaluation process and the impact it has on impact assessment.
  
  - Whether there were challenges in aggregation and the reasons to that.

- Testing writers and scholar’s views on SIDA’s funding policy, evaluation and impact assessment.
Chapter Five: Conclusion

In this final chapter, the thesis gives the findings on efficiency of SIDA policies and effectiveness in implementation of its supported programme. It also gives its findings on the efficiency of its evaluation process.

The thesis also highlights some policy recommendations such as on effective application of the Sector Wide Approaches (SWAps) and Programme Based Approach (PBA) in a development programme.
CHAPTER TWO

DEVELOPMENT COOPERATION WITH SWEDEN AND KENYA

2.0 Swedish Development Cooperation

In 2012, Sweden was the 5th largest government donor. It spent US$5.2 billion (SEK 35.5 billion) on net Official Development Assistance (ODA). Since 1975, the UN target has been that developed countries should give 0.7% of their Gross National Income-for ODA (SEEK Development, 2013). The ODA development theory emerged after World War II. Its aim was to re-build Europe after World War II. Development was to be initiated whereby capital countries were to provide to the poorer areas of the world. During post-World War II, many economic and social aspects had deteriorated. There were oil shocks, debt crises, financial and trade imbalances and increasing inequalities during the 1980s (OECD, 2008b). During the mid-1980s, ODA was introduced as the development thinking and practice (Sagasti, 2005). ODA was also known as the Washington Consensus which led to the beginning of new approaches to development thinking and practice (Claude, 2000; Sagasti, 2005). Official development assistance can also be seen as development activities of the colonial powers towards their former colonies.

Sweden has recently been exceeding the amount expected of the ODA. The 2013 budget allocated US$5.8 billion (SEK 38.2 billion) for development cooperation (which would equal 1% of GNI) (SEEK Development, 2013).

Swedish development cooperation emphasis is on poverty reduction. Its goal is to create conditions that will enable the people living in poverty to improve their quality of life and their standards of living. Its priorities are democracy and human rights, gender equality and the role of
women, including maternal and child health, climate and environment, agricultural development and food security (Martinussen, 1999). The Swedish Development Cooperation aims at achieving the Millennium Development Goals (MDGs).

Sweden’s 2013 policy statement focus on aid effectiveness, innovation and results-based financing for development (SEEK Development, 2013)

Sweden recently supports 33 countries. Most of these countries are in Africa. It reduced the number from 67 to 33 so as to focus on effectiveness of aid in fewer countries (DAC Peer Review, 2009).

2.1 Sweden Development Cooperation Funding Policies

In Sweden, Parliament makes laws on how its ODA is to be allocated while the government of Sweden implements the decisions made by parliament. Law making is left to the parliament and law enforcement is left to the government of Sweden through its ministries. The government ministries are limited to policy formulation.

Sweden’s Policy for Global Development

It established by the Swedish government ministries, Ministry of Foreign Affairs (MFA) is responsible for policies of development cooperation agencies such as its involvement in policy reforms for SIDA, while SIDA is to provide technical assistance in implementation of projects and programmes (MFA, 2009). Guidelines for SIDA’s operations are thus set by the government of Sweden through the MFA.
The Sweden’s Policy for Global Development covers a range of sectors such as humanitarian assistance, policy coherence among others (Lundstrom, 2006:141; DAC Peer Review, 2009). The Policy for Global Development emphasises that Swedish development assistance should be based on lives, experiences, capacities and priorities of poor people (SIDA, 2005c).

**Paris Declaration on Aid Effectiveness**

Sweden has strong support from its government as well as parliament in its commitment to the aid effectiveness agenda, to work in line with the 2005 *Paris Declaration* and the 2008 *Accra Agenda for Action*. The Paris principle entailed a meeting held in Paris, in 2005 with stakeholders from both the developed and developing countries to improve ways in which aid is delivered and managed. This is with the purpose to achieve the Millennium Development Goals (MDGs). It was felt that with the increase in volumes of aid, there also need to be increase in aid effectiveness in reducing poverty. The Paris declaration entailed commitment on the following (OECD, 2008)

- **Ownership**- in partnership, partner countries are to take lead over their development policies, and strategies.

- **Alignment**- Donors to give their support through national development strategies and procedures of the partner/recipient countries’

- **Harmonisation**- Donors’ actions to be harmonized with the procedures of the recipient country.

- **Managing resources as well as results.**
Donors and recipient countries to have mutual accountability for development.

The Accra agenda was a follow up meeting to put emphasis to countries to be keen in implementing the Paris principle. The Minister for International Development Co-operation states: "The Accra Agenda is the step forward" (MFA, 2008f).

The application of aid effectiveness has been applicable in Sweden's budget for development cooperation, ever since 2006 (Acedevo et al., 2004). 2006 and 2009 budget papers applied the goals and indicators of the Paris Declaration and its 2008 and 2009 monitoring surveys included the ownership aspect of aid effectiveness (DAC Peer Review, 2009).

Policy coherence for development

The DAC's Synthesis Report on Policy Coherence for Development identifies political commitment, improved co-ordination, monitoring, analysis and reporting systems as the basis of the policy (OECD, 2008c). The policy provides guidance to the development co-operation system. It positioned policy coherence at the heart of Sweden's approach to development, and put Sweden at the forefront among donors who are committed to the coherence policy.

OECD reports state that Africa received the largest amount of ODA from Sweden, through Sweden's "Strategy for Africa" (OECD, 2010; DAC Peer Review, 2009) and Kenya happens to be in the list of Africa's top ten recipients of Sweden's ODA in 2007.

Figure 1: Sweden's government institutions involved in policy making (OECD, 2010)

4 The Strategy for Africa has an overall goal to improve living standards of those living in absolute poverty.
2.1.1 Sweden Funding Policies in the Health Sector

Sweden health policy document was developed by the health division within the department for democracy and social development in collaboration with the department of research cooperation, division of humanitarian assistance and representatives from SIDA departments. SIDA’s support to the health sector is guided in strategies in reducing poverty, human rights, gender equality as well as creating a sustainable environment (SIDA, 2000a).

In 2011, Sweden allocated USD million 329.25 to the social sector (which entails education, health and population. 2013 policy for Sweden’s MFA increased support towards maternal health, curbing infant and child mortality and promote Sexual and Reproductive Health Rights (SRHR) (SEEK Development, 2013). The Swedish government’s focus for the period 2011—2015 entail efficiency of health systems, prevention and control of non-communicable diseases, promotion of health, SRHR and curbing health threats that result from antibiotic resistance (SEEK Development, 2013).
SIDA’s cooperation in the health sector aims to achieve the following objectives (SIDA, 2000a):

- Sustainable and effective health systems
- Coverage of quality health service nationwide
- Strengthen the role of health sectors in influencing health policies.

2.2 SIDA

SIDA was established in 1965 through Sweden’s development cooperation, basically to manage Sweden’s bilateral cooperation with aid-recipient countries. It is an agent for the government of Sweden through which the government allocates 1% of its GNP towards ODA (Gibson, 2005:133). Specifically, SIDA implements 72% of Sweden’s ODA, while Sweden’s Development Cooperation directly implements 28% of its ODA (OECD, 2010). SIDA agency thus forms a critical institution towards development assistance.

SIDA participates in international development cooperation by promoting development in partner countries. Development cooperation is a means to strengthen society by combating poverty and encouraging economic, social and democratic reforms as well as protecting the environment (SIDA, 2005a). SIDA provides technical assistance, spreads information about assistance as well as providing funding. Spending for bilateral cooperation is primarily managed by SIDA. SIDA has various forms of support: project support (directly to projects), sectoral support or commodity support (assistant to purchase a certain item) (Gibson, 2005; Acedevo et al., 2004). According to OECD, DAC Peer Review 2009, SIDA channels its resources through
the recipient governments, multilateral co-operations, EU and NGOs and has its geographic focus is on countries in Africa, Asia, Latin America, and Central and Eastern Europe.

Based on the Swedish global development policy, SIDA identifies knowledge, health and social development aspect as one of its five focus areas for its bilateral development cooperation. Decisions on SIDA funding policies and budget allocations and are made in Sweden parliamentary budget process.

**Development Theory**

The approach to SIDA’s funding depends on the recipient country. SIDA’s support depends with the efforts and developmental needs of the recipient country (SIDA, 2005a). SIDA’s proposes strategies for the recipient country for the recipient’s government to approve. Development cooperation is encouraged as follows (SIDA, 2005a);

- Through policy dialogues with the partner country,
- Putting aid supported programmes in the national context
- Donor coordination whereby the recipient country carry out leadership.
- Mobilisation of local resources.
- The donor (SIDA) and the partner (recipient country) both contribute financially.
Programming

Guidelines for SIDA’s operations are set by the Swedish government. However, SIDA reports progress of its activities to the Minister for International Development Cooperation (SEEK Development, 2013).

Figure 2: Programming of SIDA’s bilateral cooperation

2.3 Policies and Approaches in Kenya’s Health Sector

2.3.1 History and Emergence of the Kenya’s Health Sector Reforms

Health sector reforms in Kenya came from a history of stagnating socio-economic and political factors that affected health services. Kenya is faced with a challenge of declining economy whereby population growth is faster than the growth in per capita income (Oyaya, 2003). According to SIDA’s Health Division Document (Ekroth, 2000:25), the Kenyan population has increased from 25.3 million to 32.3 million between 1980 – 2000; hence the population density increasing per square kilometer. Poverty has increased and more than half of Kenyans live in absolute poverty. The number of the poor increased by four times (Oyaya, 2003:114) from 1972 to year 2000. The poor in remote, arid and semiarid areas account of the biggest population of 80 percent living in rural areas.
The deteriorating economy and increased poverty has negative effects in the health sector. According to the Kenya Demographic Health Survey (KDHS), infant mortality rates and under-five mortality rate have increased as well as malnutrition, Malaria, HIV/AIDS and other diseases (Ministry of Planning and National Development, 2003). Although more than half of Kenya’s population lives in poverty, the National Health Accounts stated that 51 percent households contributed to total expenditures on health in 2002 (Kenya NHA 2001/2002) yet at the same time, the population living in poverty do not have the funds to seek medical attention (SIDA, 2005). The Ministry of Health faces a crisis whereby available resources and facilities cannot cater for the demand as a result of a bigger population seeking medical service.

2.3.2 Evolution of Health Services Policy in Kenya

The Health Sector reforms of Kenya have a reviewed history and development of reforms in the health sector from independence to 1995. During the 19th century- modern health services and Kenya health policies started during the missionaries’ era and the colonial times before independence. In 1963 after Kenya’s independence, the local government took over the health sector and expanded rural health facilities with the aim of meeting the needs of the rural population. In the 1970, the Ministry of Health took over smaller health centers and dispensaries run and due to the inability to maintain these newly taken up facilities, MoH introduced cost sharing policy in whereby people had to pay for consultation fees so as to receive health care (Muga, 2004).
National Health Accounts

National Health Accounts (NHA) was designed to help policy makers and health sector managers to improve performance of health systems and to make policies from information on financial resources. In 1998, the first NHA was produced by the MoH using data from 1994. This data was sourced from the 1994 Welfare Monitoring Survey of household expenditures and the MoH budget Analysis. NHA are used by donors and development agencies to guide them in policy dialogue with the government of the recipient country.

The Ministry of Health uses this data for policy purposes and to formulate strategy papers. The 2002 NHA results were used in the formulation of Kenya Health Policy Framework of 1994 and the National Health Sector Strategic Plan (NHSSP) 1999–2004 whereby efforts changed from preventive towards curative, preventive and promotive health care services. NHA was also used in the formulation of the NHSSP 2005–2010.

The 1994 Health Policy Framework

The Kenya’s Health Policy Framework (KHPF)’s goal is “To promote and improve the health status of all Kenyans through the deliberate restructuring of the health sector to make all health services more effective, accessible and affordable,’ which entails halting and reversing the deteriorating health care situation (Ekroth, 2000:33). The goal’s theme, “decentralisation of power and authority to the district level” (Oyaya, 2003). The document analyses factors affecting Kenya’s health sector and highlights of the reform agenda for implementation of health policies, which is to sustain the institutional functions and the overall performance of the health sector.
The Government of Kenya aims to ensure that health services trickles down the marginalized regions and the most vulnerable groups, thus puts its focus on decentralisation and allocating responsibility to the districts (Oyaya, 2003). The government devolves its support to the districts by strengthening them to deliver proper health care. The government also involves the community in provision of health services which are to be managed by the district health management teams. The reforms also entailed cost sharing (by the local government and the recipients of health services) so as to transfer funds from Ministry of Health (MOH) to the Districts through their district bank accounts.

NHSSP-I and II

The National Health Sector Strategic Plan phase I was written and launched in July 1999 to translate 1994 KHPF objectives into implementation. The Health Sector Reform Secretariat (HSRS) was established under the MoH to develop and implement the NHSSP whilst SIDA supported the programme financially.

The strategic plan focused on the following;

- Decentralisation

- Health services such as on reproductive health, immunization programmes, integrated childhood illnesses, malaria, environmental health and HIV/AIDS.

- Revised budget system whereby the districts shall be requesting for funding based on the District Health Plans. Districts send budget request the MoH. MoH discusses these budgets with the MoF, for allocation of resources thus the District Health Plans serve as linkages
between the districts needs and the financial allocations (SIDA, 2000; Ministry of Health, 1999).

The National Health Sector Strategic Plan 2005 – 2010 (NHSSP II) was approved and adopted in 2005. The plan proposed a SWAp implementation process. In October 2005, the NHSSP-II had joint consultative process on the Kenyan Health SWAp (KHSWAp) where there were discussions on areas for follow up around key intervention areas on governance, budgeting and financial management, procurement, monitoring, staffing and capacity building (Embassy of Sweden, 2006).

2.2.3 SIDA’s Involvement in Kenya’s Health Sector

Budget Allocation

Table 1: Exchange rate Swedish Kronor (SEK) per United States dollars (USD)

<table>
<thead>
<tr>
<th>YEAR</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>8.0781</td>
<td>7.3460</td>
<td>7.4724</td>
<td>7.3733</td>
<td>6.7575</td>
<td>6.6797</td>
<td>8.2950</td>
</tr>
</tbody>
</table>

Table 2: Allocations for Kenya’s Health Sector (Embassy of Sweden: SIDA- Kenya 2005 – 2010 reports)

<table>
<thead>
<tr>
<th>YEAR</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amount in Thousand Sek (TSeK)</td>
<td>48329</td>
<td>42447</td>
<td>29262</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amount in Million Sek (MSeK)</td>
<td>279</td>
<td>330</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

According to Weeks (2002), SIDA’s involvement with Kenya’s started around the same time in the 1970s. SIDA’s approach is that of development cooperation and not development assistance. SIDA centered on supporting Kenya in improving access to the curative and prevention health services. This is the long-term focus of Swedish health sector assistance, ‘to support the recipient

5 TSeK - Thousand Swedish Kronor
6 MSeK - Million Swedish Kronor
countries in their efforts to build up and develop well structured, nation-wide health systems (Weeks, 2002). In 1977, Kenya adopted the World Health Assembly (WHA) “Global Strategy for Health for All by the year 2000,” which aimed at ensuring that all Kenyans have accessibility to health facilities by the year 2000 (Oyaya, 2003:115) whist through 1969 to 1986, SIDA concentrated in community based health care, construction of rural health facilities, continuing education, supply of essential drugs, family planning activities and strengthening of planning and management as part of their contribution in assisting Kenya with the global strategy for health (SIDA, 1986; Wamai, 2004). SIDA’s first health sector assistance policy in 1982 focused on preventive rather than curative care to villages, recognition of local traditional skills and focused on development of human resources rather than investment in infrastructure (SIDA, 1986). In 1983, Kenya came up with a document known as “District Focus for Rural Development” (DFRD) which observed that districts are the most effective and strategic unit for planning and delivering health services in Kenya (Moi, 1986).

In 1986, the Kenya government published the ‘National Guidelines for the Implementation of Primary Health Care in Kenya policy which focused on decentralisation, community participation, and collaboration of other sectors (Oyaya, 2003:117; Mwabu, 1998:27). In 1989, the policy shifted from government wholly providing the services to a system where the beneficiaries and recipients of these services have to incur costs so as to obtain the services. A cost-sharing policy in the health sector was introduced which aimed at giving support to primary health care, improve services and strengthen district facilities.

Between the mid-1980s to 1990s was a major shift from health sector support to project-centered assistance to sector-wide assistance. This was a change from the previous constructions
of health centres and training institutions in the 1970s. There was an increment in assistance to the Kenya national guideline for promotion of primary health care sector (Muga, 2004). In 1992, District Health Management Boards were created. Kenya also introduced treatment fee which resulted to resources increasing at local level, leading to improvements in the health systems. However, poverty level in the country resulted to the majority, being unable to access health facilities. In 1992,

World reports produced by the Kenya health care sector, as follows:

- Investing in Health document in 1993
- 1994 Kenya Health Policy Framework

The health situation analysis component in the National Health Accounts was financed by SIDA and EU in collaboration with AMREF (Hjortsburg, 2001; SIDA, 2000). After the first NHA, the policy makers concluded that the government was the major financer for health care but the second NHA revealed that households accounted for more than 53 percent of health care expenditure whereas the government financed less than 20 percent (Glennegard et al., 2007).

The 2002 NHA was initiated by the MoH and USAID and financed by SIDA. The MoH took lead in conducting the second round of NHA and invited more partners to collaborate. The 2002 Kenya NHA depended on both primary and secondary data from Households’ health Expenditure, Utilization Survey and from MoH and other government publications (such as the Kenya Demographic and Health Survey 2003) respectively. From the household surveys, NHA
was able to capture private expenditures on health as well as people’s access to medical services from the utilization survey. These were both carried out in 2003 and the results were used to formulate policies and strategies. The accounts were to determine the distribution and allocation of resources to the health sector and SIDA uses this expenditure data to allocate resources to the health sector as well as to carry out policy dialogues with the partnering government.

SIDA was also involved in the formulation of the NHSSP-I document and in the setup of the Health Sector Reform Secretariat (HSRS) which is to spearhead the reform process (Oyaya, 2003, Crouch, 2005). The local government facilitated decentralization by increasing authority for making decisions, allocating resources and passing management of health care to the DHMTs.

**RHIS**

The RHIS first took shape in 1995 and replaced SIDA health sector support on curative and preventive health services. According to Tamm (2002), RHIS was formed by SIDA to focus on decentralization of health systems. This would promote access to health services in the rural areas. From the 1994 NHSSP to the RHIS programme, SIDA agreed to support the health sector through implementation of the 2000-2003 RHIS programme. “Decentralisation of health services” is the main objective of the NHSSP 1994-2004 strategy (Ministry of Health, 1999; Embassy of Sweden, 2006).

**National Health Sector Strategic Plan II**

SIDA and DFID supported the NHSSP II 2005-2010 strategy with the aim of reversing the low/poor health indicators, to curb high morbidity and mortality rates so as to achieve the MDGs
(Embassy of Sweden, 2007; Lehmann et al., 2011:15). Reproductive Health is one key health component aspect factored in the NHSSP II. It aimed at reducing child and infant mortality as well as to promote maternal health.

KJAS

The Kenya Joint Assistance Strategy (KJAS) was SIDA’s proposal for a new cooperation strategy with Kenya. SIDA submitted the proposal to the Swedish Government and it was approved since its main focus was on poverty reduction. KJAS aims to enable the poor to improve their living standard and to realize their human rights (Embassy of Sweden, 2008).
CHAPTER THREE

EVALUATION BY SWEDISH DEVELOPMENT COOPERATION

3.0 Swedish Development Cooperation Evaluation Policies

Molund (2004) and Forss (2008) define evaluation as a careful and systematic retrospective assessment of the design, implementation, and results of development activities. SIDA (2005b) describes evaluation as part of a project cycle.

The Development Assistance Committee Network on Development Evaluation has a forum which has representatives of the evaluation departments of both bilateral and multilateral development organisations. The representatives work on improving the evaluation practice and strengthen its use as an instrument for development co-operation policy (OECD, 2010). There are three levels of independence in Swedish system for evaluating development co-operation (Molund, 2004):

- Swedish Agency for Development Evaluation (SADEV)7 - It was established in 2006 as an independent agency working with the evaluation departments of SIDA, other DAC members and reporting directly to Sweden parliament (DAC Peer Review, 2009). This agency is separate from the government and all organisations responsible for the implementation of Swedish development assistance. It has its own board and budget and its task is to produce evaluations of Swedish development co-operation. SADEV’s evaluation topics should be relevant for government decisions on development co-operation (DAC Peer Review, 2009).

7 SADEV was established in 2006. This is much later after the establishment of the 1995 SIDA’s evaluation policy.
UTV - UTV is SIDA's own evaluation department which stands for Department of Evaluation and Internal Audit. It evaluates performance of programme implementation and evaluates performance of interventions. UTV advises regional and sector departments on evaluation process.

- External Evaluators- SIDA's line departments hire external evaluators to evaluate projects and programmes.

In summary, SADEV undertakes evaluation of the Swedish development co-operation while UTV evaluates SIDA’s financed programmes and projects. While SADEV evaluates SIDA’s performance in the health sector, UTV evaluates SIDA’s activities (SIDA, 2005b; Bandstein, 2008). Each of the above department as well as the embassy conducts evaluations within its own area of responsibility.

3.1 Swedish Development Cooperation Evaluation Processes

Brun (2008) and Forss (2008) highlight the evaluation processes as follows;

SADEV carries out its evaluation as follows (Brun, 2008);

- An evaluation handbook based on Development Assistance Committee (DAC) quality standards for development evaluation. The handbook has a checklist that will ensure quality of work.

- Annual Reports - Management follow-ups and responses are included in the SADEV's annual report.

- Distribution of evaluation findings (in form of reports) to Parliament.
- Dissemination of information in Sweden through the press and media.

UTV carries out its evaluation as follows (Forss, 2008);

- A Strategic Management Group comprising of directors who ensure quality standards are kept during evaluation (by using a DAC’s tracking grid during evaluation).

- Once evaluations have been completed and compiled, they are posted on SIDA’s website and distributed to the Swedish media.

- Smaller departments within SIDA evaluate their own projects and programmes whereas UTV advises these smaller departments.

In general, SADEV and UTV have to work with partnering/recipient countries so as to carry out evaluations.

**Reporting**

According to Molund (2004), UTV reports to the Director-General of SIDA (the board), who reports to the Minister for International Development Cooperation based at the Ministry of Foreign Affairs (MFA) in the Swedish Government while the SADEV Director of Evaluation reports to the Director-General who reports to the Swedish Government.
3.2 SIDA’s Evaluation Policy


SIDA has adopted the evaluation policy standard criteria below (which is a recommendation by the OECD/DAC) for evaluation of development interventions (Chianca, 2008; OECD, 2010b; Molund, 2004):

- Efficiency - how results justify costs for an intervention.

  - Effectiveness - the level whereby a development intervention achieves its objectives.

  Effectiveness looks at the other criterias such as impact, relevance and sustainability
Additional criteria (sub-criteria) can still be used, such as performance standards which looks at appropriateness (how inputs and activities are tailored to local needs, and the requirements of ownership, accountability, and cost-effectiveness), coverage of an intervention, quality of evaluation, participation, multi-dimensional approach through coherence as well as connectedness of humanitarian problems (Molund, 2004).

**Figure 4: Model of a systematic approach to evaluation quality (Forss, 2008:12).**

According to Forss (2008), quality questions asked during evaluation are as follows:

- Do SIDA evaluations adequately address the evaluation questions formulated by SIDA in the TOR?

- Do SIDA evaluations provide valid and reliable information on efficiency, effectiveness, impact, relevance and sustainability?

- Do SIDA evaluations contain a clear and consistent analysis of attribution and explain how and why the interventions contributed to results?

- Do SIDA evaluations have an appropriate design for impact evaluation?
• Is the evaluation process in SIDA evaluations well documented and transparent, so that readers can make an independent assessment of validity and reliability?

• Do SIDA evaluations include a valid and reliable analysis of the management of interventions?

• Do SIDA evaluations provide clear and focused recommendations for specified target groups?

• Do SIDA evaluations document interesting and useful lessons learned from the interventions that were evaluated?

An evaluation Terms of Reference (ToR) is core in the monitoring and evaluation phase of implementing and assessing impact of a programme. The ToR is the main instrument on how the assignment should be carried. It documents the main points of agreement between SIDA and its partners (Moland, 2004:76). The format for ToR for SIDA financed evaluations entails the following components (Moland, 2004):

- Purpose of evaluation

- Background of intervention

- Participation by stakeholders – participation in research, reporting and disseminating information from the evaluation.

- Evaluation questions - questions relevant to evaluation criteria, policy issues and performance standards.
- Lessons learnt and recommendations

- Methodology - method to be used to collect and analyse data.

- Work plan and schedule

- Reporting

- Evaluation team - qualifications of evaluators.

3.2.1 Amendments on SIDA Evaluation Policies

In 2005 came major improvements to the previous document. Swedish policy for development co-operation formed point of references (evaluation manual also being a point of reference) for the formulation of questions for evaluation purposes/ processes (Molund, 2004:71). The improvements entailed designing a SIDA evaluation manual incorporating ideas from manuals from NGOS and other development agencies. Such were evaluation guidelines from DANIDA, EU, Finland, Inter-American Development Bank, the US’ Centre for Development, Information and Evaluation (CDIP), UNDP Norway among others.

Improvements were made as follows (SIDA, 2005b:25- 43);

➢ Addition of the following criteria (SIDA, 2005b; Molund, 2004);

- Relevance- appropriateness of a development strategy or a programme/project, in relation to the partner country and the needs of its people.

- Effectiveness and cost efficiency
- Feasibility - assesses if there are right conditions for successful implementation of the programme/project. It also assesses if the implementing parties have the capacity, resources and will for successful implementation.

- Sustainability

- Coordination and consultations - this assesses interactions between donors such as SIDA, the recipient country and other development partners, including SIDA. Coordination ensures that it does not hamper with partner's internal management structures.

- Risks and risk management

Changes from evaluation of project/programme approach to sector wide approach - When there is change from a project approach to a SWAp, the balance between the internal and external factors change (SIDA, 2005b). The issues that arise in all SWAPs are as follows:

- The political dimension - Sector Programmes are dependent on political support and sensitive to political changes. Success of SWAPs depends on political goodwill.

- The financial management system - Proper accountability is needed especially in procurement matters.

- Strategy for implementation - clarity and capacity to implement a programme and the main actors or implementers.
- Lessons learned from previous cooperation in the sector- These lessons provide baseline information for the decision that led to a SWAp.

- Political and financial linkages to national strategies for poverty reduction.

- Changes to joint evaluation-: UTV commissions external consultants to conduct its evaluations jointly with other donors. This entailed co-ordination and sharing evaluation plans (Brun, 2008).

- Brun (2008) highlights the inclusion of SADEV and Sweden National Audit- the two units were established to further scrutinise SIDA’s performance as well as to evaluate the development cooperation. Sweden’s National Audit Office also conducts audits on the Swedish development co-operation’s performance.

- SIDA on evaluation management- SIDA is presented a new internal Evaluation Secretariat (audit office) which conducts joint evaluations with other donors or partners. Activities include (SADEV, 2008; Dahlgren, 2007);

  - Working with those on specific sectors and those in the field, to conduct evaluations on topics identified by the teams.

- Give advises to internally-conducted project and programme evaluations.

- Capacity development in partner countries on evaluation.
CHAPTER FOUR

DATA ANALYSIS AND FINDINGS

4.0 Preamble

The Chapter carries out an empirical analysis of the pattern and nature of SIDA funding and evaluation policies in regards to SIDA’s health sector supported programme. Interpretation of these policies is critical in the causal-effect analysis of this thesis.

Data analysis and illustration on causal effect are based on the following three areas;

a) An account for how Kenya’s health reforms and policies have influenced policies and implementation of the SIDA supported programmes.

b) Influence or effects of SIDA policies and programme implementation on the outcome and impact of the programme. The chapter also aims at applying SIDA’s funding and evaluation policies in the RHIS intervention. This will analyse efficiency and effectiveness of SIDA supported programmes.

c) SIDA’s participatory and inclusiveness in the evaluation process and the impact it has on impact assessment- The chapter will analyse the levels and extent at which SIDA engages with external development communities. This will analyse the outcomes, hence effectiveness of the programme.

d) Analysing SIDA’s evaluation process that lead to the findings on impact of the programme- This thesis will analyse impact upon learning within SIDA as well as review
whether SIDA policies in performing evaluation are efficient in assessing impact. This will assess if the process is all inclusive and if it is efficient in measuring SIDA’s contribution to the national intervention.

e) Analysis of how challenges and opportunities have influenced the outcome of the intervention.

4.1 Sweden Development Cooperation

Figure 3: Programming for Bilateral Cooperation
Above is the structure in which Sweden allocates its ODA for development cooperation. While parliament makes laws on allocation of funds, the government of Sweden comes up with policies to guide the use of funds. The government forms ministries which come up with these policies. SIDA is established to give technical support; basically, to implement the development cooperation activities (Sorbom, 2006). This simple diagram demonstrates these.

### 4.2 Kenya’s Health Policies

According to Hjortsberg (2001) National Health Accounts are used to describe all expenditure flows by the government, NGOs as well as household expenditure. They describe sources of funds as well as allocation for funds. The purposes of coming up with the NHAs is to attain information on the resources available in the country. Kenya government accounted for less than half of the health care resources in Kenya, while NGOs and private health providers holds more than half of these resources. NGOs account for more than half of the hospitals, health centers and outpatient facilities (Oyaya, 2003). Private providers of health care continue to grow gradually yet still, NGOs do not account to the government. This has made it difficult to implement SWApS and PBAs effectively, since it is impossible to measure impact with institutions the government doesn’t partner with. This undermined the potential impact of the programme.

#### 4.2.1 Kenya’s Health Policies on SIDA Supported Programmes

As reviewed earlier in chapter II, the Kenya NHA was designed for policy makers of the health sector in the recipient country as well as for donors, in their efforts to make evidence-based policies. These policies led Kenya in coming up with health policies such as the 1994 Kenya Health Policy Framework, the NHSSP-I among others. NHA also assist SIDA in allocating its
funds to some programmes in the health sector such as the NHSSP-I and II, Rural Health Integrated Services among other programme in Kenya.

The Kenya’s Health Policy Framework (KHPF) as well as the NHSSP-I carried the theme, “decentralisation of power and authority to the district level” (Ekroth, 2000:33). Kenya was moving towards provision of health facilities to the grassroots, hence a devolved support to the districts health sector assistance. In 2000, SIDA supported Kenya’s initiatives on decentralisation. In the mid-1980s, Kenya adopted health sector support also shifted from project-centered assistance to sector-wide assistance (Weeks, 2002). Later, SIDA was keen to adopt the Sector Wide approaches in Kenya’s NHSSP-I

Causal-Effect Influences on SIDA-Funded Programmes

- Lack of sufficient data on baseline information on health status in Kenya, from which discussions (that lead to policy formulation) are held between donor and recipient country. For instance, the first NHA in 1998 stated that the local government is the major contributor and financer of health care in Kenya but the NHA 2002 revealed that households accounted for more than half of health care, NGOs financed a significant amount while the government financed the least (Ministry of Health, 2004a). This led to donors coming up with policies that had little impact to the recipient country. For instance, Kenya signed the Abuja Declaration in 2001. This declaration was from the Africa Union (AU) and it entailed that members states of the AU should commit 15 percent of their total government spending on health (Muga, 2004:11). The Abuja declaration came as a result of the health needs in African countries. There was need to promote health care services and to invest on preventive and curative facilities in African countries, which have high mortality rates as a
result of prevalence of diseases such as Malaria, HIV/AIDS among others. This felt needs resulted to the Abuja declaration policy. However, Kenya has been unable to reach this goal. In 2002 (after signing the Abuja declaration), Kenya realized they are unable to attain the 15% allocation due to the fact that they did not have the capacity to provide it. The 1998 NHA had provided insufficient information that the government of Kenya is the major health financer in Kenya, yet according to the NHA 2002, the government was the least financer. This example demonstrates that lack of sufficient data can result to poor formulation of policies which may not yield to maximum impact of a programme or intervention.

- Implementation of SWAps needed a political approach. However unstable political conditions in Kenya, as well as lack of political commitment can result to unsuccessful implementation of the SWAps and sector- programmes.

4.2.2 Swedish Development Cooperation Funding Policies

Before the revision of SIDA’s funding policy in year 2000, there had been no consideration for aid effectiveness practices between donor and recipient countries. Elements such as capacity Development of programme implementers in partner country, SWAps and PBAs among others, had not been applicable. The approach was mainly bilateral (involving only two countries; the donor and the recipient), thus there were no partnerships with other agencies or organisations.

Causal-Effect Influences on Impact

- Programmes are generally successful when partner countries are involved from the beginning. This will create ownership of the programmes by the partner country. SIDA’s previous policies and approach does not contribute towards capacity development of partners from the recipient country (SIDA, 2000). Lack of capacity development to the partner
country decreases chances of the project or programme from being owned by the recipient country. Lack of capacity development deprives the recipient country with knowledge on how to sustain and manage the programme.

- SIDA funding policy does not reflect shared views and priorities by the partner country therefore the interventions can lack commitment, ownership and coordination from stakeholders, both in implementing as well as sustaining the intervention.

- The policy did not include strategies of governance such as financial management reform by recipient countries. The practice of ownership and sustainability by the recipient country would thus be difficult as the programme would be perceived as donor imposed.

4.2.3 Swedish Development Cooperation Evaluation Policies

The Sweden's evaluation policy below was approved in 1995 and was applicable in the initial funded SIDA projects. As per chapter III on the subject on SIDA’s evaluation policy, some of the key features in evaluation focused on bilateral cooperation between the donor (SIDA) and the recipient. Other than the criterias used for evaluation, there was a standardized ToR for evaluation purpose (Persson, 1998). This initial evaluation policy was applicable in the NHSSP-I SIDA support to the Kenya’s health programme.
Causal-Effect Influences on Findings

- There was delay in improving the evaluation tool even when SIDA funding policies had been upgraded to fund sectors. SIDA evaluation policy was improved in 2005 (Molund, 2004:22) which was 5 years after SIDA started funding sectors through SWAps, hence during that period (2000 – 2005), SIDA was using an outdated tool to monitor sector programmes. This definitely affects the quality of evaluation (when using an outdated tool to monitor a
programme). The 1995 policy for evaluations was only applicable to SIDA projects, but was not efficient in evaluating programmes and sectors.

- UTV does not carry out joint evaluations with partner countries (Oyaya, 2003:17). This affects the potential for ownership of the programme by the partner/recipient country.

- There were contradictions on partnership in the 1995 evaluation policy. On one hand, SIDA has a right to exercise control. On the other hand, development cooperation should be in the spirit of partnership (Charlsson, 2000:18; SIDA, 2005b:20; Molund, 2004). Evaluations initiated by SIDA are usually expert evaluations. “SIDA in consultation with partner organisations formulate the questions and externally recruited expert evaluators provide the answers” (Molund, 2004:21). These expert evaluators conduct the evaluation activity. SIDA doesn’t apply participatory evaluation (which according to the SIDA manual is viewed as the alternative to expert evaluation). Yet still, SIDA’s policy states that evaluations should be carried out in a spirit of partnership. SIDA policy also encourages joint evaluations and a practice which is to be adopted by the OECD/DAC country members yet evaluation is left to the external evaluators. According to Molund (2004) further contradictions are evident whereby SIDA states that its policy supports popular participation in evaluation.

- Lack of absorption of the national monitoring framework in SIDA’s interventions. This can result to a weak monitoring performance in the programmes. Initially, SIDA did not absorb the recipient country’s evaluation systems, human resource management, financial management, drugs and medical systems. Kenya’s monitoring framework is not absorbed in SIDA funded programmes. This is as a result of not having a partnership policy on evaluation. There was lack of involvement by partner countries in evaluation, yet at the same time, SIDA didn’t invest in capacity development of partner country on SIDA’s evaluation
mechanisms. As a result, ownership is cut from both angles of programme intervention. The challenges render evaluation under-represented. The evaluation may lack the quality aspect due to inability to capacity develop partners involved in implementation.

4.3 Reforms with SIDA Policies

In year 2000(s), there was a major shift and improvements in applying further principles for Effective Aid in application of Paris declaration. The improvements were applicable to SIDA-Kenya Health sector programmes since they were applied to SIDA’s policies and programmes, for its implementation in recipient countries. Such special features are as follows (SIDA, 2005b);

Sector Programme Support and Sector-Wide Approach

Sector Programme Support is (SPS) the term used by SIDA to support Sector Wide Approach process. It entails long-term support to development at the sector level, embracing a sector policy and a sector expenditure programme (SIDA, 2005b). The term “Sector-Wide Approaches” was later adopted to replace SIDA’s policy of Sector Programme Support (Grafiska, 2000). The SWAp policy reflected the need for the development cooperation to shift from project support to programme support. This shift from project approach to a SWAp changes the balance between the internal and external factors. The changes incorporated are such as dialogues, agreements to goals and policies of intervention and joint efforts in evaluation. SIDA’s policy for sector programme support adheres to and embraces the SWAp principles described as follows (Grafiska, 2000).
- Principle of strong national ownership and political commitment- a code of conduct is established between the recipient country (partners) and external partners. The code of conduct applies the new modalities of interaction and cooperation.

- Establishment of common goals and a common policy framework- there are policy dialogues and adjustments of SIDA’s initial framework and adopting the partner’s implementation procedures, establish joint monitoring of resources.

**SIDA Policy for Capacity Development**

Capacity Development policy is SIDA’s approach and initiative to strengthen the capacity of cooperating partners so as to have a clear picture of the roles played by each partner. Sweden development cooperation policy document on Africa states that Sweden shall participate in building capacity in Africa through providing more support for basic education with a focus on the training of government employees; developing the capacity to perform evaluations and analyses; and a policy for development cooperation (Gustafsson, 2001). SIDA increases capacity development for partners by increasing support for national systems of education, training, and research. Capacity development is incorporated as an objective in SIDA funded programmes.

**Policy on Ownership**

Decentralisation to district levels of administration enhances ownership whereby decisions can be made at district level (Edgren, 2003:14). The aim of this is to encourage aid partnership and to discourage dependency on aid. Decentralisation encourages participation by civil societies and it also encourages integration of area development projects (SIDA, 2005a).
Knowledge for development

SIDA takes part in various research works for knowledge development. For instance, the Linkoping university of Sweden as well as Moi University in Kenya carries out research for knowledge development. Research is conducted on ill health, environment degradation, infectious diseases and food shortages (SIDA, 2005b).

Delegated Cooperation and Programme Based Approach

Through delegated cooperation, programme-based approaches comes as a result of donors coming together to jointly support a national and/or sector programme for poverty reduction (Oden et al., 2009).

The aid effectiveness agenda comes in when Sweden rationalizes on the countries it will work with as well as the number of sectors to be supported in each country hence concentrating its efforts in those sectors. Sweden’s new Guidance on PBAs states that all SIDA development co-operation should be programmatic. It also states that, “In all of its work, SIDA should ensure that the principles of the Paris Declaration are operational, in order to effectively achieve development results for people living in poverty” (SIDA, 2008).

Budget Support for Poverty Reduction

The budget is aimed to support implementation of the country's Poverty Reduction Strategy (PRS). Resources are channeled directly through the partner country's own financial management system (DAC Peer Review, 2009).
4.3.1 Application of New Reforms to Kenya’s Health Sector

Rural Health Integrated Services

The Rural Integrated Health Services (RIHS) programme is an example of a programme implemented after the 2000 improved funding policy was approved. The programme was however caught in between the transition from the 1995 evaluation policy to the 2005 newly adopted evaluation policy. The programme was to be implemented between 2000 – 2003. However, due to delays in implementation, it extended to 2005. Come December 2005, the programme was granted a six-month extension until June 2006 so as to support the ongoing Health Sector Wide Approach process that was aimed at addressing the policy constraints. (Embassy of Sweden, 2006). The RHIS programme focused on capacity building and was also aimed at promoting service delivery through decentralisation, in 6 districts. The programme adopted Kenya’s financial and procurement procedures. Funds for the programme were channeled to the Ministry of Finance (MoF) and through requests from the MoH, funds were allocates to the district through the district Authority to Incur Expenses (AIE). On evaluation, there was a mid-term review which implemented the initial evaluation template and evaluation ToR that were described in chapter three.

NHSSP-I and NHSSP II

These strategies were implemented between 1999 – 2004 and 2005 - 2010 respectively. From year 2000s, SIDA adopted the sector wide approaches whereby Sweden worked with partners to support a sector (in this case, the health sector). The NHSSP-I strategy implementation was a Sector Wide Approach for the health sector. The health sector entailed a joint consultative
process. There was capacity development for the staff involved in implementation of the sector (Embassy of Sweden, 2006).

On budgetary allocation to partner country financial management systems, the NHSSP-I strategy enabled districts to send budgetary requests to the MoH through the provinces. MoH uses this budget requests as basis of discussions with the MoF on allocation of resources (SIDA, 2000). This is an indicator that the purpose of the new changes in SIDA’s funding policy is to support the implementation of the country's strategy whereby budget support is channeled directly through the partner country's own financial management system. The funds from the donor are to be channeled through the recipient country’s MoF.

Programme Based approaches is evident in the National Health Sector Strategic Plan- II programme. Bilateral donors such as DANIDA, DFID, SIDA and USAID were involved in supporting this sector so as to reverse the low health indicators (high mortality and morbidity rates) so as to achieve the MDGs. According to the Embassy of Sweden (2006) report, a SWAp Bridging Agreement covering January to September 2007 had been signed in 2006. It aimed to support capacity development as well as implementation of SWAp’s as per the NHSSP II’s Annual Operation Plan (AOP). Donor funds were sent in July 2007 to support the AOP. A 2006–2010 Joint Programme of Work and Funding (JPWF), procurement plan, performance monitoring framework, health norms and standards had been established.

Other SIDA Health Programmes in Kenya

By 2007, Improvements in SIDA programmes were evident and were highlighted in the 2008 Survey on Monitoring the Paris Declaration as follows (OECD DAC, 2010);
- Swedish aid is untied- there is room for dialogue between donors, partners on the priority area as per the recipient country’s health policies.

- A lot of use of the procurement and the financial management systems- Sweden were able to incorporate their financial resources through recipient countries’ (including Kenya) financial management and procurement systems.

- Increment of proportion of aid in alignment to partner country systems- the increment was to facilitate the introduction of sector programmes approaches (from the initial projects approach).

In 2007, SIDA came up with the Kenya Joint Assistance Strategy proposal. KJAS cooperation with Kenya was adopted in September 2007. It was signed by 17 donors and was drawn up by bilateral and multilateral donors (Ministry of Foreign Affairs, 2009:12).

The Swedish 2008 – 2012 KJAS strategy applies the Paris principles as follows (Ministry of Foreign Affairs, 2009: 12):

- Transition to SPS.

- Increase in the proportion of government-to-government support provided through PBAs.

- Channeling all donors’ development resources through the Kenyan government systems.

- Coordinating of its activities with those of other donors.

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4.4 Reforms with Swedish Development Cooperation Evaluation Policies

Chapter III highlights the major changes that were implemented in the previous evaluation policy. These changes were implemented in 2005 and were a modification of the existing 1995 evaluation policy. The development cooperation policy emphasises the importance of an independent structure to evaluate international development co-operation. The policy led to the establishment of the Swedish Agency for Development Evaluation (SADEV) in 2006 which has a mandate to produce evaluations on any aspect of Swedish development co-operation, whether bilateral or multilateral (DAC Peer Review, 2009). SADEV contributes to regular reporting to parliament on progress against all policy coherence objectives, and evaluate progress against one of the global challenges in detail every year to complement the government’s overall report (OECD, 2010).

Much as SIDA evaluation function has changed, SIDA still safeguards its existing strengths and capacities, hence the evaluation function is more of modifications to the existing evaluation policy/function. Under SIDA’s previous evaluation policy, UTV reported directly to the SIDA Board. The new policy provides an opportunity UTV to conduct joint evaluations with other donors and partners. The joint evaluation will then report directly to the Director General. The Director General’s role is to will approve the team’s evaluation plan and budget as well as to receive evaluation reports.

The improvements (from the initial evaluation policy) are summarized in the chart below;
Figure 5: 2005: Evaluation policy - Procedures for Technical Assistance and Reporting

**SWEDEN Parliament**

**DAC**

**SADEV Director of evaluation**

**SWEDEN Government Ministry of Foreign Affairs**

**Minister for International Development Cooperation**

**Director general - SIDA**

**REPORTING**

**SECTOR EVALUATION**

**SADEV**
- Evaluates Swedish Development Cooperation
- Evaluates and scrutinizes SIDA’s performance

**Sweden National Audit Office**
- Audits the Swedish Development Cooperation
- Scrutinizes SIDA’s performance

**UTV (Department for Evaluation of SIDA)**
- Evaluates projects and programmes
- Evaluates activities

**Embassy of Sweden**

**External consultants**
Evaluates programmes, aid policies and aid modalities

**Other Donors or Partners**
- Evaluate SIDA’s programmes

Advisory roles
CHAPTER FIVE

5.0 Conclusion

Sweden has had strong support from its government as well as parliament. Ever since 2009, SIDA has been committed to giving 1% of its GNI the ODA (DAC Peer Review, 2009). Sweden thus exceeds the expected 0.7%. Poverty reduction has been on the overall goal for Sweden’s approach in development cooperation. For instance, the KJAS focused on enabling the poor to improve their living standard and to realize their human rights. Sweden has also been committed to the aid effectiveness agenda which are based on the principles of ownership, alignment, harmonization, results and mutual accountability for development (OECD, 2008). As a result of many developed and developing countries acknowledging the Paris declaration as measure for aid effectiveness, the conclusion to the Thesis has to be in line with the Paris declaration, as most countries and states use the Paris principles to measure effectiveness.

The thesis’ chapter two has detailed a comprehensive literature review on the historical processes of Swedish bilateral cooperation with Kenya and also the Kenya health sector reforms that explored the Development Theory. SIDA funding policies and processes have been explored and applied to Kenya’s health sector. Chapter three had a comprehensive study of the evaluation policies and processes of SIDA’s interventions in Kenya’s health sector. It also looked at the opportunities and challenges encountered during the evaluation processes and impact assessment of the programmes.

Data analysis and findings in chapter four focused entailed data analysis and findings on various angles on SIDA’s support to Kenya’s health sector. These would lead to a solid conclusion to the
thesis. The analysis explored how Kenya’s health reforms and policies have influenced policies and implementation of SIDA supported programmes in the country. It also provided findings on the influences and effects of SIDA policies on the outcomes and impact of SIDA funded programmes. This was with the aim of testing the efficiency and effectiveness of SIDA supported programmes. SIDA’s evaluation policies and processes were analysed so as to assess its efficiency in accessing impact. With the study, the conclusion is that SIDA came up with various reforms and policies which turned out to be effective implementation of the Paris declaration on aid effectiveness principles.

Impact and effectiveness of SIDA’s programmes in Kenya’s health sector cannot be looked at in isolation because SIDA has been partnering with its recipient country (in this case, Kenya). However, SIDA’s efforts, policies and procedures can be looked at in isolation. SIDA funding policies and programmes have been effective in implementation on the outcome and impact of the programme. On ownership principle for effectiveness, Sweden has applied the goals and indicators of the Paris Declaration in its development cooperation budget. Budget Support for Poverty Reduction is effective through channeling all donors’ development resources through the Kenyan government systems. Resources are channeled directly through the partner country’s own financial management system (DAC Peer Review, 2009) and there is a lot of use of the procurement and the financial management systems. SIDA has put its aid supported programmes in the national context and have enabled the recipient country to carry out leadership. Through adoption of Kenya’s implementation procedures, Sweden through SIDA has made effective policy reforms on the ownership aspect of aid effectiveness. Other improvements such as capacity development policy established are a positive move towards ownership and sustainability of SIDA programmes by the partner country.
On the alignment principle of aid effectiveness, reforms towards working with partner countries have been effective. For instance, according to the SIDA looks forward manual, SIDA has been involved in policy dialogues on developmental needs of the partnering country and in the formulation of strategic plans and policies in the Kenyan health sector. SIDA was involved in the setup of the Health Sector Reform Secretariat (HSRS) which is to spearhead the reform process of the NHSSP-I (Oyaya, 2003) and has also been involved in the budget supports implementation of the Kenya’s Poverty Reduction Strategy (PRS).

SIDA has coordinated its activities with those of other donors through policy dialogues and adjustments of SIDA’s initial framework hence applying the harmonization principle of aid effectiveness. This joint partnerships and harmonization are such as with the USAID in supporting Kenya’s 2002 National Health Accounts and partnership with World Bank in supporting the RHIS programme. Programme Based approaches has also encouraged partnerships and harmonization, as such as in the collaboration between DANIDA, DFID, SIDA and USAID in supporting the recent NHSSP-II programme. Establishing SWAPs in RHIS, NHSSP-I and II programmes has been an effective principle in aid effectiveness through Increment of aid to facilitate SWAPs. In 2006, A SWAP bridging agreement had been signed which continually supports capacity development and in implementation of SWAPs in the NHSSP II programme.

There have been various critics of SIDA’s evaluation policies and processes. In 2000, Carlsson in his book “Are Evaluations Useful,” had concluded that SIDA has had more aspirational than actual attention to partnership in evaluation. King (2004) stated that there isn’t enough participation by other partners in SIDA’s evaluations, hence limiting SIDA’s opportunities to
learn. He further stated that SIDA involved in evaluation is active, only that the quality and effectiveness of this learning is deemed inadequate (King, 2004: 152). However, once SIDA reformed and updated its evaluation policy in year 2005, SIDA’s evaluation policies became efficient in obtaining findings on intervention, as well as assessing impact of SIDA programmes. On the **results** principle for aid effectiveness, SIDA’s Sweden joined the DAC Network on Development Evaluation with the aim of improving evaluation practice and making it relevant for development cooperation, (OECD, 2010). Such improvements as factoring in appropriateness, coverage of an intervention, quality of evaluation and participation (Molund, 2004) rendered SIDA’s evaluation policy as focused, hence effective. Efficiency of SIDA’s evaluation policy is evident through its relevance. SIDA uses its evaluation manual as a point of reference on the formulated questions for evaluation purposes/ processes (Molund, 2004:71). Changes from evaluation of project/ programme approach to sector wide approach enabled SIDA to create an evaluation strategy that factor internal and external influences (SIDA, 2005b), hence increasing efficiency in obtaining results.

SIDA through its evaluation process has been participatory and inclusive and this has rendered its evaluation to be effective. SIDA’s recent and improved evaluation manual incorporates ideas from manuals from DANIDA, EU, Finland, Inter-American Development Bank, the US’ Centre for Development, Information and Evaluation (CDIP), UNDP Norway among others (these being some of the main donor agencies worldwide). **Mutual accountability** principle of effective aid is evident through the practice of joint monitoring of resources as well as joint monitoring of SIDA funded programmes. For instance, SIDA manages joint evaluation by establishing UTV evaluation secretariat to conduct joint evaluations with other donors and its country partner through co-ordination and sharing evaluation plans (Brun, 2008). Such joint evaluations of the
performance of the sector were carried out such as on indicators on child immunization, deliveries by skilled persons, treatment on Childhood Illness and distribution of bed-nets for pregnant women and children (Embassy of Sweden, 2007). Through interviews with SIDA personnel, it is evident that SIDA also partners with the Ministry of Planning, Monitoring and Evaluation directorate in conduction evaluation of SIDA health programmes. SIDA also capacity develops partner countries on evaluation.

Challenges and opportunities have also influenced the outcome of SIDA’s intervention. As stated earlier, SIDA does not work in isolation and much as SIDA’s efforts, policies and processes are effective towards positive impact of its programmes, SIDA has faced challenges with implementation as a result of factors to do with external influences by the partnering country. Such factors are such as political instability, weak policies and few incidences of inaccuracy in data collection by the partner country (Kenya). The following are the recommendations on development cooperation between SIDA and Kenya, as pertains the health sector.

5.2 Recommendations

Through Sweden’s recent policies and focus that led to an increased support towards health (SEEK Development, 2013), SIDA should strengthen the role of Kenya’s health sector in influencing health policies. NGOs finance a significant amount while the government financed the least (MoH, 2004a). Private providers of health care continue to grow gradually yet still, NGOs do not account to the government. As a result of inability of Kenya’s government to control or monitor NGOs, there have been three main shortfalls. One is that donors such as SIDA have been unable to quantify their measure of contribution in the country’s health sector. This was the main gap that was identified in the thesis. The second shortfall of Kenya’s weak health
policies led to donors coming up with policies that had little impact to the recipient country. For instance, Kenya signed the Abuja Declaration in 2001 which entailed that members states of the AU should commit 15 percent of their total government spending on health (Muga, 2004:11). This was not possible for Kenya because its government contributes the least in the country’s health sector. The third shortfall is that it has been difficult to implement SWApS and PBAs effectively, since it is impossible to measure impact with institutions the government doesn’t partner with.

Sweden through SIDA can support Kenya in developing better policies. One way to do this is through capacity building of people in Kenya’s top management positions in the health sector. Once Kenya has been supported on better health policies, Kenya will be able to give accounts of NGOs involved in the health sector thus is will be possible to measure impact of health interventions by NGOs, agencies and other partners in Kenya’s health sector. In collaboration with Sweden embassy (regarded as an international community in Kenya’s aspect), SIDA can meet with Kenya’s cabinet secretaries and principles secretaries in the health sector as well as the planning, devolution and finance ministries so as to share ideas that will improve health policies in Kenya.

SIDA can also recommend health policies to some Kenya members of parliament. These policies if deemed friendly to Kenyan citizens can be discussed in parliaments as bills on health and once they are passed, they will be factored in as health acts.

SIDA can support the partner country (Kenya) to improve their research and data collection methods (to avoid inaccurate data such as that of the 1998 NHA collected from 1994 Kenya’s data bank). The first NHA in 1998 stated that the local government is the major contributor and
financer of health care in Kenya but the NHA 2002 revealed that households accounted for more than half of health care. Accurate data leads to formulation of efficient policies thus capacity building on research methods as well as utilizing partner country’s experts to carry out these researches will be efficient in obtaining accurate data. Linkoping University of Sweden works with Moi University of Kenya in carrying out such researches. However, this should be expanded, so that a wider group of experts as well as research and health experts in management country positions can participate in research work.

There are other external factors that may be beyond SIDA’s control. For instance, SIDA may not be able to influence political stability and good will yet political stability is important in the implementation of SWAps and PBAs. SIDA may not be able to control or contain the political climate however, SIDA can support the county governments and work with the National government but at district levels in retaining effective programmes such as decentralization of health services.
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