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**PERFORMANCE AUDIT REPORT**

**KENYA**

# HEALTH REHABILITATION PROJECT
# (CREDIT 2310-KE)

May 26, 2000

*Sector and Thematic Evaluations Group*
*Operations Evaluation Department*

## Currency Equivalents (annual averages)

Currency Unit = Kenya Shilling
Appraisal: US$1 = KSH23.0
Project Closing: US$1 = KSH 59.7

## Abbreviations and Acronyms

| | |
|---|---|
| GOK | Government of Kenya |
| ICR | Implementation Completion Report |
| KNH | Kenyatta National Hospital |
| MOH | Ministry of Health |
| NCC | Nairobi City Council |
| OED | Operations Evaluation Department |

**Fiscal Year**

Government of Kenya: July 1 – June 30

| | | |
|---|---|---|
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The World Bank
Washington, D.C. 20433
U.S.A.

Office of the Director-General
Operations Evaluation

May 26, 2000

## MEMORANDUM TO THE EXECUTIVE DIRECTORS AND THE PRESIDENT

**SUBJECT: Performance Audit Report on Kenya**
**Kenya Health Rehabilitation Project (Credit 2310-KE)**

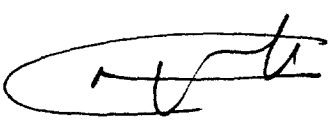
Attached is the Performance Audit Report prepared by the Operations Evaluation Department (OED) on the above project, which was approved in November 1991, for US$31 million. The project closed in June 1998 after a 1-year extension, and an undisbursed balance of US$2.5 has been canceled.

The objectives of the Health Rehabilitation Project were to rehabilitate Kenyatta National Hospital (KNH) to reduce its burden on the overall health budget—thus freeing resource for preventive and primary care—and to improve the delivery of primary health services in the Nairobi area. The project also included subcomponents for health sector policy development, and the establishment of a National Household Welfare Monitoring and Evaluation System. The reintroduction of cost recovery for health services was a condition of effectiveness for the project. The project supported the government's efforts to make Kenyatta Hospital autonomous from the Ministry of Health, and benefited from parallel USAID technical assistance.

The project made substantial progress improving the quality and efficiency of KNH, and cost recovery was reintroduced at all levels of the health system. Yet the government's health budget allocated to KNH increased rather than decreased over the life of the project, and little progress was made in improving the availability or quality of primary health services in Nairobi. Design of the Nairobi health services component was left for future implementation, and key issues regarding the roles of the Ministry of Health and the Nairobi City Council were never resolved. The health sector policy development component produced several studies, but limited progress was made toward health sector reforms. The welfare monitoring component contributed to two poverty surveys, but was not well coordinated with the other components.

The overall project outcome is rated as marginally unsatisfactory (compared to marginally satisfactory in the ICR), because the major stated objectives of the project were not achieved, despite significant improvements at KNH. Institutional development impact was modest overall, with substantial progress at KNH balance by negligible improvements in Nairobi health services. Project sustainability is rated as uncertain (as in the ICR). Both Bank and Borrower performance are rated as unsatisfactory (instead of satisfactory in the ICR). KNH performance was satisfactory throughout, and both MOH and Bank supervision performance improved substantially in the final two years of the project. But these improvements were not sufficient to compensate for the serious neglect of the primary health care component for most of the project's life.

The main lessons learned from this project are: (a) while increased hospital autonomy is a necessary but not sufficient condition for improved hospital performance, the Kenyatta Hospital experience demonstrates that good public sector performance is possible in Kenya despite continued problems with governance; (b) autonomous hospitals are likely to attract more resources rather than less, suggesting that future efforts to increase autonomy must directly address cost-containment issues; (c) investment projects, even with conditions attached, may not be effective instruments for addressing "allocative" problems; and (d) strengthening urban referral systems often requires action and improved coordination among a number of different levels of government, which in turn requires extensive consultation during design and implementation.



Attachment

# Contents



This report was prepared by Timothy Johnston (Task Manager) and April Harding, who audited the project in June 1999. William Hurlbut edited the report, and Pilar Barquero provided administrative support.

## Principal Ratings

| | *ICR* | *Audit* |
|---|---|---|
| Outcome | Marginally Satisfactory | Marginally Unsatisfactory |
| Sustainability | Uncertain | Uncertain |
| Institutional Development | Partial | Modest |
| Borrower Performance | Satisfactory | Unsatisfactory |
| Bank Performance | Satisfactory | Unsatisfactory |

## Key Staff Responsible

| | *Task Manager* | *Division Chief* | *Country Director* |
|---|---|---|---|
| Appraisal | Nicholas Burnett | Dennis Mahar | Callisto Madavo |
| Midterm | Beatrice Hebling/ Vulimiri Jagdish | Jacob van Lutsenburg Maas | Francis Calaco |
| Completion | Andrew Follmer | Ruth Kagia | Harold Wackman |

# Preface

This is a Performance Audit Report (PAR) on the Kenya Health Rehabilitation Project. The project supported refurbishment and institutional development at Kenya's major referral hospital, upgrading of the primary clinics in Nairobi, and other sector and financing reforms. It was supported by IDA Credit No. 2310-KE for US$31 million, and was approved on November 14, 1991. The credit was closed on June 30, 1998, after a one-year extension, and an undisbursed balance of US$2.5 has been canceled.

This audit report derives from an Operations Evaluation Department mission to Kenya in June 1999, which reviewed the performance of this project as well as the Third and Fourth Population Projects (the latter are discussed in a separate report). The mission included interviews with government officials, Bank and donor field staff, and with staff and management at Kenyatta National Hospital. Documentary sources include the project's Implementation Completion Report, the Staff Appraisal Report (SAR), and project files.

The authors express appreciation to all those who made time for interviews and provided documents and information, including officials at the Ministry of Health and the staff and management of Kenyatta National Hospital.

Following customary procedures, copies of the draft audit report were sent to the relevant government officials and agencies for their review and comments. Comments were taken into account in the text, and have been included in the PAR as Annex B.

# 1. Introduction

**Background**

1.1 During the 1970s and 1980s, Kenya made substantial gains in the health status of its population. By the late 1980s, health indicators were better than those of most other countries at similar levels of development. This was largely due to the rapid expansion of government-financed programs during this period. The overall improvement in health status indicators concealed a wide variation among districts, however, and between rural and urban areas. Mortality and morbidity rates showed a prevalence of preventable diseases that could have been averted by a combination of effective primary health care service and basic public health programs. In the late 1980s, HIV/AIDS emerged as a major threat; currently, an estimated 14 percent of adult Kenyans are infected. AIDS is reducing many of the health gains of the 1980s and placing a growing burden on the health system.

1.2 Despite earlier successes, by the late 1980s, the Kenyan health system faced a number of serious challenges:

- *Declining resources for health:* Ministry of Health (MOH) expenditure averaged about 6 percent of total public expenditure throughout the 1980s, but a steady increase in capital expenditures (28 percent of the MOH budget in 1990) increasingly squeezed recurrent expenditures. This decline fell most heavily on non-wage expenditure—which reduced the efficiency, quality, and coverage of public health care. Although services were provided for free, drugs were often in short supply, and patients often had to buy their own drugs.

- *Inefficient allocation of health expenditures:* Government health expenditures were biased toward urban and curative services, which focused subsidies on the non-poor. Preventative and promotive services received only 15 percent of the MOH spending in the late 1980s, while curative received 66 percent. Kenyatta National Hospital, the national referral hospital, received a disproportionate percentage of public resources, while rural services were under-financed.

- *Breakdown in the referral system:* Kenyatta National Hospital (KNH) was supposed to be at the apex of the national referral system, followed by the provincial hospitals, district hospitals, and finally the primary level of care. Yet the poor state of the lower-level facilities, combined with no check on self-referral, led to increased service demand on the hospitals and to severe congestion problems at KNH.

- *Inefficient KNH management:* KNH was plagued by overcrowding; was short of appropriate inputs, including consumables, functioning equipment, and pharmaceuticals; and had staff that were inadequately trained and motivated.[1] The hospital had little discretion over essential management functions such as staff hiring and wage levels, fees and revenue, equipment procurement, or construction and maintenance. Revenues from cost recovery were returned to the central treasury, providing no incentive for improved financial performance.

1. See Collins, David, Grace Njeru and Julius Meme, "Hospital Autonomy: The Experience of Kenyatta National Hospital," Management Sciences for Health, 1996.

**Initial Reform Efforts**

1.3 Public dissatisfaction with declining service quality lead to growing government recognition of the need for reforms. In 1987, the World Bank sponsored a study to review health sector financing, in preparation for a health sector reform project. The report recommended improved revenue generation, cost containment, and efficiency of service delivery through the establishment of user fees for government health services, and shifting government financing toward basic health services. The report suggested that KNH was the best place to start a move toward increased managerial autonomy, especially in planning, budgeting, and fee collection.[2] Other donors, including the U.S. Agency for International Development (USAID), were also actively involved in policy studies and dialogue regarding reform options.

1.4 Partly as a result of this and other studies, the Government of Kenya (GOK) initiated two major policy changes in the late 1980s. First, in 1987, the government converted KNH into a parastatal corporation, which was intended to transfer much day-to-day decision-making control to the hospital and oversight responsibility to a newly created Board of Directors. The hospital could retain revenues from user fees, manage its own procurement, and had greater latitude over hiring, firing, and promotions. Second, in December 1989, the government introduced graduated user fees for all public health facilities—a departure from its initial policy of free government services.

1.5 These changes did not have the intended results, however. Despite increased autonomy, the MOH staff were loath to let go of the centerpiece of the public system, and the hospital board was not prepared to take control. The hospital was unable to fill key positions—especially in financial management. Because the reforms did not address problems in basic health services in Nairobi, hospital congestion increased. In addition, the user fee policy was not well designed or implemented, generating strong public backlash. The public was poorly informed of the need and rationale for the change, and, because fees were not retained at facilities, quality did not improve. Exemptions for the poor were ineffective, and service fell by nearly 50 percent in some districts. In response, the government largely suspended user fees in 1990.

# 2. Project Design and Objectives

2.1 Following this disappointing experience, the World Bank and USAID decided to proceed in parallel to develop with the government more comprehensive and sustainable sector reforms. The overall goal was to reintroduce cost recovery and shift resources toward primary care by improving management, efficiency, and cost recovery at KNH, thus "freeing-up" resources for lower-level services. Originally, the Bank considered financing an adjustment operation, but on further discussion, it was agreed that USAID would fund an adjustment project—with a large technical assistance component—while the Bank would focus on supporting investments.

2.2 The Health Rehabilitation Project became, in a sense, an investment project with much wider sector reform ambitions. To reduce the financial burden of KNH, the project sought to increase revenue generation and improve efficiency of the hospital. The project financed extensive rehabilitation and some institutional development, and it was complemented by

2. World Bank, Kenya: Review of Expenditure Issues and Options in Health Financing, September 30, 1987, Washington, D.C., 1987.

extensive USAID-funded technical assistance. As a *quid pro quo* for these investments, the Bank and USAID projects both included conditions that the government was to steadily reduce KNH funding in favor of primary care and rural services. To relieve congestion at KNH, the project's second component sought to improve the quality and availability of primary and secondary care in Nairobi. As a condition for this component, the government was to develop and implement a strategic plan for Nairobi health services, including a strategy for resolving the governance and coordination problems plaguing these services. Third, the project included a health policy component, including consultant studies and training, to lay the groundwork for further system-wide reforms.

2.3 The phased reintroduction of cost recovery, starting at hospitals but eventually including the primary level, was made a condition of project effectiveness.[3] To address concerns regarding the impact of cost recovery on the poor, a fourth welfare-monitoring component was added late in the design process. The Central Bureau of Statistics in the Ministry of Planning and National Development would be assisted with implementation of a national poverty monitoring system. The project is summarized in Table 1.

**Table 1: At-a-Glance — Health Rehabilitation Project**

| | |
|---|---|
| **Credit No.:** 2310 | **Approved:** November 14, 1991 |
| **Total cost:** US$34.5 million | **Effective:** July 7, 1992 |
| **World Bank credit:** US$31 million | **Closed:** June 30, 1998. |
| | **Disbursement record:** US$2.5 million canceled at close |

**Objectives:**

- To support the GOKs program of health sector reform by:
  - Rehabilitating Kenyatta National Hospital (KNH) to reduce its burden on the overall health budget and permit and increase in expenditure on preventative and primary health
  - Improving the delivery of services in the Nairobi area
  - Preparing for future policy, managerial, and investment reform in health
- To support the development of a National Household Welfare Monitoring and evaluation system

**Components:**

- Physical rehabilitation and institutional development of KNH
- Development of Nairobi-area health services
- Support for health sector planning and preparing sector reform
- Developing a national household welfare monitoring and evaluation system.

2.4 Perhaps symptomatic of its sector reform ambitions, the project included more than 60 other conditions or "covenants." As noted above, foremost were the reintroduction of cost recovery, shifts in government funding away from KNH, and development of a strategic plan for Nairobi health services. A further 29 of the conditions specified various management or regulatory changes for KNH.[4] As discussed later, borrower commitment to fulfilling the covenants varied, Bank enforcement was uneven, and the large number contributed to a lack of prioritization.

3. After extensive negotiations with the government, the Bank agreed that introduction at tertiary levels would be sufficient for the project to proceed, with the stipulation that user fees would be subsequently introduced at district and clinic levels following a public information campaign.

4. The Bank was not alone in encouraging these changes. USAID was heavily involved in the health sector and health policy issues at the time of project preparation, and included similar conditions in their projects.

2.5 The project was approved by the World Bank's Executive Board in 1991, but only after debate. Executive Directors questioned the complexity of project design and whether the project went against Bank policy to focus on primary care. In addition, several Directors expressed concern regarding the deteriorating governance situation in Kenya, and wondered whether approving the project might send the wrong signal to the government.

2.6 Despite the stated emphasis on primary care in the design documents, most of the project investments went to upgrading facilities at KNH, and the hospital was given priority by both Bank staff and government during project design and implementation. The KNH component benefited from prior sector studies by Bank staff and consultants, and from extensive analytic work conducted under the USAID-sponsored REACH project. This preparatory work also engaged hospital managers and senior staff in discussions regarding hospital reform priorities, such that KNH was well-prepared to begin implementation once the project became effective.

2.7 In contrast, the Nairobi City Services component was prepared hastily. Project preparation centered on senior staff in the MOH, KNH, and the project unit. Key stakeholders, including the Nairobi City Council (NCC) and the Provincial Medical Office for Nairobi, had little or no involvement during preparation. Design for both the KNH and social welfare monitoring components was mostly left for the implementation phase, and no clear arrangements were established for coordinating project implementation.

2.8 Although the various project components were linked conceptually, they involved different implementing agencies, leading the Implementation Completion Report (ICR) to conclude that the project was really four loosely linked sub-projects. In particular, the social welfare monitoring component probably should have developed as part of a separate project—indeed, supervision for this component eventually was split off from the other three. Yet the weaknesses associated with multiple implementing entities might have been mitigated if project design had been more participatory and thorough and initial supervision had been more effective.

# 3. Project Implementation Experience

3.1 As described in the ICR, project implementation was repeatedly delayed. By the original closing date in June 1997, less than 40 percent of the project funds had been disbursed. The reasons were several. First, government was late in meeting some conditions of project effectiveness—including the reintroduction of user fees. Second, supervision of construction was weak, and several contractors performed poorly and had to be replaced. Third, procurement of equipment and supplies was consistently problematic, with several major bids being canceled. Fourth, weak financial management by the GOK led to delays in payments to contractors and suppliers and to consistently late submission of project audits—many of which were qualified. Fifth, increased fiscal constraints, together with uneven government commitment resulted in government providing only 7 percent of its expected 10 percent contribution to project costs.

3.2 Staff continuity was a problem both for the borrower and the Bank. The Permanent Secretary for the MOH changed several times during project implementation, as did task management for the Bank. The non-KNH components were given less attention during supervision through 1995, although political gridlock within the city of Nairobi contributed to a lack of progress with the Nairobi health services component, and the Ministry of Planning (responsible for the Social Welfare Monitoring component) had little experience with project

implementation. Project supervision and implementation subsequently improved and were further strengthened by giving increased project responsibility to the local sector specialist in the Bank's country office, as well as by increased commitment by senior MOH officials to address project bottlenecks.

3.3 Because of implementation delays, the project eventually received a "problem" classification in the Bank's portfolio monitoring system. Rather than cancel the remaining balance, the Bank and government agreed to extend the project by one year. In the year prior to the extension, the Bank and government also agreed to several other changes in project management, including the hiring of an independent agent to facilitate procurements. Improved procurement, the MOH efforts to address the payment backlog, and intensified IDA supervision resulted in the disbursement of an additional 52 percent of the credit during the extension. Because of delays in the submission of audit reports by the government, however, the extension was not formally approved until just a few days before the original closing date. This made planning for the extension difficult for both the Bank and the MOH staff, and resulted in the cancellation of several key project activities, including physical upgrading of secondary referral facilities in Nairobi and computerization of Kenyatta National Hospital.

3.4 OED concurs with the ICR's judgment that extending the project was appropriate and probably will result in greater development impact than would have been achieved otherwise. Despite the compressed time period, the independent procurement agent performed well; procurement and distribution of goods went relatively well despite the compressed schedule and previous difficulties. Although many of the items purchased were included in earlier procurement plans, some MOH and KNH officials reported that the tight time schedule resulted in the procurement of some items that were more expensive, less appropriate, or had higher recurrent costs implications than might have been procured with more careful planning. The Bank had provided little up-front training in procurement planning, but KNH already had established an internal procurement committee for its own purchase. In contrast, the Provincial Medical Office in Nairobi had little experience in dealing with Bank procurements, and experienced a number of problems. The agent was supposed to have trained MOH officials, but the MOH did not provide qualified counterparts. Thus, while bypassing the MOH's own procurement systems substantially increased disbursement, the project did not address the systemic problems that had plagued earlier procurement.

**User Charges**

3.5 In response to project covenants, the government reintroduced user charges at KNH and provincial hospitals in 1991, and districts and subdistricts in 1992, and clinics in 1993 (after the originally-agreed date). The Bank and USAID worked with the government to improve the design and implementation of cost recovery, and the Bank reallocated funds from an ongoing population project to finance a public information campaign. KNH and MOH facilities were permitted to retain the proceeds from user charges, which were to go to non-wage recurrent costs. Districts retained 25 percent of all funds in a pool for preventive activities. The public largely accepted the new charges, and utilization declined only modestly. Collections have risen from less than KSH 100 million in the first year to an estimated KSH 400 million in 1997/98 (excluding KNH), and are expected to rise further through improvements in collections, accounting, and a planned fee increase.

3.6 The cost recovery system has provided an important additional source of revenue for the government health system, and the design and implementation represent a significant improvement on the initial effort. District officials report that cost recovery revenue has become

an important source of funding for recurrent costs, including drugs and supplies. Several problems remain, however. Foremost, while the poor are partially protected by exemptions for essential preventive services (such as vaccination), the fee waver system for the poor is ineffective. One survey found that nearly three-quarters of the poor paid for their care, and that 60 percent of those seeking an alternative to a government facility did so due to cost or dissatisfaction with service, or both.[5] Improvements in service quality at district level have been undermined because increased revenue from fees have been offset by declines in central government transfers. In recent years, districts have received nearly no supplemental funding from government for non-wage recurrent expenses. Thus, although problems with exemption systems are common throughout the region,[6] the assertion in the ICR and project supervision reports that the system is considered among the best in sub-Saharan Africa overstates the cost recovery program's success.

3.7 Despite the project's supposed focus on improving the quality of primary and secondary health services in Nairobi, the Bank did not monitor cost recovery experience in the capital. Although Nairobi City clinics established user charges for consultations and drugs, all proceeds continued to be returned to the City Council, and were used to subsidize non-health activities. This contributed to declining clinic quality, placing further pressure on KNH. Fee retention was finally approved in November 1998, following the project's close.[7]

**Kenyatta National Hospital Component**

3.8 The KNH component of the project had two parts: physical rehabilitation and equipment; and institutional development. The latter sought to build on and consolidate the formal changes in governance made when the hospital was converted to a parastatal in 1987. The KNH component took the lion's share of project resources (US$19 million of US$31 million) and attention in preparation and supervision.

3.9 The quality and efficiency of hospital clinical services and management processes clearly improved over the project period, and the project contributed to that improvement, both through its investments and institutional development components. Yet the project's stated objective—to reduce the financial burden of KNH on the health system—was not achieved. Instead of declining, budgetary allocations to KNH increased from 12.8 percent of the MOH budget in 1992 to 16.9 percent in 1998, and remains above 15 percent. This section, therefore, seeks to answer two related questions: what contributed to quality and efficiency improvements, and why did the percentage of budget allocation increase rather than fall?

***Improving Hospital Performance***

3.10 The support to KNH under the project was complemented by a range of other interventions. The combined impact of the following contributed to improved performance during the project implementation period:

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5. Newbrander, William, David Collins, and Lucy Gilson, "Equity in the Provision of Health Care: Ensuring Access of the Poor to Services Under User Fee Systems," paper presented to REDSO Conference, Harare, May 1997.

6. Gilson, Lucy, "The Lessons of User Fee Experience in Africa," Health Policy and Planning, Vol. 12, No. 4, 1997.

7. Remarkably, this issue apparently was not raised by the Bank during project supervision. Following the official close of the project, however, local Bank staff and the NCC health officials initiated discussions with the NCC, which finally approved fee retention in November 1998. This has reportedly contributed somewhat to improved drug availability and increased service utilization.

- *Strengthened Leadership:* Prior to project effectiveness, a number of steps were taken at the senior political level in Kenya to strengthen hospital leadership.[8] In 1992, President Moi appointed a respected Kenyan businessman to serve as the new chairman of the hospital board, and gave him broad discretion and authority to improve hospital management and performance. The president then appointed an experienced Kenyan physician with strong management skills to serve as hospital director. The new leadership succeeded in attracting experienced civil servants to fill management positions in KNH. These leadership changes coincided with the beginning of the Bank project and proved crucial to the success of the KNH component and the overall hospital reforms.

- *Increased managerial flexibility:* During project design and implementation, the government initiated several changes to the rules and regulations governing the hospital, and in its relation to the Ministry of Health. First, in 1990 KNH staff were transferred from the MOH to KNH, with employees given a choice during a 2–3 year transition period to decide whether to stay at KNH or work at an MOH facility. The KNH board was then given discretion for hiring and firing. Second, with regard to revenue, the government gave the KNH board increased discretion to set the level of user fees (although the MOH retained approval rights), and allowed the hospital to retain fees without reducing budget transfers. Third, in 1994, partly in response to recommendations from the World Bank and USAID, KNH funding was converted from a line item in the MOH budget to a block grant. This removed MOH restrictions and dramatically improving the predictability of its funding flows. Since then, *all funds* allocated in the budget to KNH have been transferred directly to the hospital.

- *Increased revenue generation:* The strategy to strengthen the financial position of the hospital had several dimensions: First, KNH enhanced revenue through increased user charges, fee retention, and strengthened billing of insurance. Revenue from cost recovery increased from 4 percent of recurrent expenditure in 1991 to 17 percent in 1998/99. A planned increase in fee levels may further increase revenues in the near future. Second, the project financed construction and rehabilitation to create higher-amenity wards (a private wing) and private office space for doctors. The goal was to generate additional revenue for the hospital and to encourage doctors to remain on hospital grounds when they saw private patients. The private ward is now self-financing, and currently contributes 40 percent of hospital revenues (the office space for physicians is still subsidized).

- *Improved terms of service for staff:* In 1992, wages and benefits of KNH staff were upgraded from civil service levels to those for parastatals. This translated into nearly a 50 percent wage increase for many cadres, which allowed the hospital to attract doctors from the university medical school and made nurse wages competitive with the private sector (although hiring skilled managers and computer specialists remain difficult). These changes improved the retention and motivation of staff, but also had a significant budgetary impact.

- *Improved infrastructure and equipment:* Most of the planned physical rehabilitation was completed by the project's close, although with delays. Some of the delays were a consequence of the difficulties inherent in rehabilitating a working hospital, but the initial civil works contractors also performed very poorly. Responsibility was then transferred to the Ministry of Public Works, but their performance was also disappointing. Most of the

8. In 1991, the government appointed an external firm from the United Kingdom to take over management of the hospital. This was done without consulting the hospital board or senior management, however. The arrangement encountered stiff resistance, and the contract was rescinded after less than a year.

rehabilitation finally was completed, however, and contributed to process quality by improving the physical conditions within which services are delivered, improving staff morale and enhancing patient perceptions of hospital quality.

3.11 Most of the planned equipment was also eventually procured, but with substantial delays. A $3 million tender medical equipment initiated in 1994 eventually failed following a protracted evaluation process, and had to be re-bid in 1996.[9] Even though KNH established its own equipment procurement committee, procurement remained problematic until the Bank and the MOH agreed to hire an independent procurement agent during the one-year extension of the project. The equipment has contributed to improved clinical quality, although some of the equipment purchased was more sophisticated equipment than necessary, resulting in higher operations and maintenance costs to the hospital.[10] The major disappointment expressed by KNH management was that computer equipment needed to establish a management information system was never procured. As a result, even though establishment of effective management information systems was a major goal of this component, most record-keeping at the hospital is still done manually.

3.12 *Institution Building:* The institutional development sub-component had several components, and benefited greatly from a thorough assessment of KNH organizational, managerial, and clinical problems conducted in 1989 by John Snow, Inc. under the USAID-funded REACH project:[11]

- *Strengthened management and administration:* The KNH board and management sought to fill newly created positions with qualified managers, mostly drawn from other government departments. The project sponsored training and technical assistance to strengthen management systems. Specific changes included establishing an accrual accounting system and personnel management system, and strengthening key departments, including accounting, planning, and personnel. Because of staff turnover and lack of progress in computerization, however, some goals were not achieved (such as establishing full costing for services).

- *Increased efficiency and cost control:* The reforms sought to improve efficiency through more efficient use and mix of personnel, reduced average length of stay, better maintenance, and better monitoring of use of consumables and drugs. The institutional development plan included a work plan for conducting efficiency reviews in each major department. Among

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9. This tender experience was extensively reviewed in an independent procurement audit report commissioned by the World Bank in 1996. The report's summary states that "Poor advice from the Bank contributed to at least one major problem item procurement. This was the case with the KNH medical equipment tender." The audit found that KNH had undertaken "immense effort" with regard to this bid, although KNH could have been more proactive in seeking Bank guidance at key stages – particularly during the (nine month) bid evaluation process. Although Bank staff were responsive once problems emerged, initial advice from the Bank was in large part responsible for collapse of the original tender (suggesting bidding in lots/groups rather than for individual items). While sympathetic to KNH efforts, the report was highly critical of MOH procurement performance. (SGS Societe Generale de Surveilliance S.A., "World Bank Procurement Audit in Kenya: Audit Report." Geneva, Switzerland, 1996). The KNH tender was subsequently successfully re-bid through the independent procurement agent.

10. In the Borrower comments on the draft PAR, the current Director of KNH noted that although the new equipment had contributed to increased maintenance costs, the primary cause of increased electricity costs was a rise in tariffs by the state supplier of electricity. In addition, the Borrower notes that "... all equipment purchased, although [more] 'sophisticated than necessary' are being fully utilized and have assisted in the improvement of patient care."

11. REACH, "Kenyatta National Hospital -Master Plan," REACH Project, John Snow, Inc. Arlington, VA USA, July 1989. In describing the relative roles of USAID and the World Bank in the reform process, one KNH manager remarked: "USAID largely defined the rules, and the Bank helped finance their implementation."

other actions, hospital management reduced the number of lower-level unskilled staff, established an essential drugs list, and stopped providing free electricity and water to University facilities (one of the project conditions that the Bank insisted on enforcing). The average length of stay has only declined to only slightly, however, and the staff/patient ratio and operating costs per inpatient day both increased by about 50 percent, rather than declining as anticipated during project design.[12]

- *Enhanced clinical effectiveness and quality:* Improvements in the terms of service and strengthened links to the university medical school increased the availability of experienced physicians at the hospital. KNH management strengthened the role and responsibility of department heads, which improved accountability for clinical quality. The project sponsored extensive training for clinical staff, most of whom returned to their posts afterwards (in part because of improvements in terms of service). KNH staff report that training significantly improved clinical quality and was one of the most valuable contributions of the project. The project also helped establish a Quality Assurance Committee and quality assurance plan, supplemented by 36 months of technical assistance. The reforms have not resolved critical problems related to physician attendance and accountability, however, and recommendations by the Quality Assurance Committee do not appear to be regularly followed up by management.

- *Improved maintenance:* Insufficient maintenance had led to broken equipment and deteriorating physical facilities. The project included explicit targets to increase the proportion of hospital expenditure devoted to maintenance, which equaled only 1.6 percent in 1991. Funding for maintenance reached 4 percent in 1998, short of the target but a significant improvement. The hospital established its own maintenance crew and trained them in hospital equipment and facilities maintenance. Supervisors stayed the premises at all times, with the discretion and responsibility to make necessary repairs. In meetings with the maintenance departments, the OED team was impressed by the initiative shown to address maintenance concerns and improve efficiency of resource use.

3.13 Based on the mission's assessment, much of the progress at KNH appears to have been the result of strong analytical work in the early years of reform (mostly financed by USAID), and of strong leadership from the KNH board and management after 1991. The Bank contributions were important, but without these other factors, it is not clear that the same results would have been achieved.

### *Why Did the Budgetary Burden of KNH Rise?*

3.14 Several factors explain why the project's major objective—to reduce the percentage budget allocation to KNH—was not achieved. Officials in Kenya and the ICR point first and foremost to the lack of progress in improving primary services in Nairobi (see below). Improved quality at the hospital, together with declining quality of city clinics, has led to even higher congestion at the hospital. Although autonomous, the hospital is politically unable to fully enforce its referral role and turn away primary care patients. The AIDS epidemic also has led to an increased number of severely ill patients, who are difficult to treat and often unable to pay.

12. The average length of stay declined from 9.8 days in 1991 to 8.6 in 1998, but the staff per 1000 patient days increased from 5.3 to 7.8 during the same period, and operating costs per inpatient day increased from Kshs394 to Kshs 757 (in 1990/91 Kshs). The original targets were all substantially revised upward in 1996, but still have not been met except for operating costs per patient day.

3.15 Yet the discussion above suggest that other factors are also responsible. Despite the project's stated objective to reduce the hospital's budgetary burden, a number of the reforms actually increased the volume and stability of flows to the hospital. First, the 50 percent wage increases for hospital staff also represented a significant increase in transfers, which are often implicitly guaranteed by Treasury. Second, prior to the conversion of the KNH budget to a block, the MOH would often use the non-wage portion for other priorities. The block transfer from Treasury has thus helped secure resource flows to the hospital, yet the Ministry of Finance apparently was not committed to the target of reducing the percentage of budget allocations to the hospital. Autonomization and establishing an influential hospital board further strengthened KNH's bargaining position and political profile. As a result, KNH transfers have been protected even as the relative transfers to the MOH have declined. Third, as an investment operation, the project was in a weak position to enforce this covenant, and possibly because of disbursement pressures, the USAID also did not enforce their parallel covenant. Finally, the project invested heavily in improved infrastructure and equipment, which has contributed to additional recurrent costs.

**Lessons Learned from the KNH Reform**

*Autonomization and access:* Projects that support autonomization or corporatization of hospitals, especially when paired with increased user fees, must include tools to address impact on access for poor and monitor their functioning. Facility data can provide information on who is coming, but not on who is not coming (and why).

*Implementing autonomization:* Developing an appropriate legal and institutional framework for an autonomized hospital is clearly important, but it will take time, negotiation, and political support to translate autonomy on paper to autonomy in practice.

*Autonomy to do what?* Autonomization gives greater discretion to management, but it does not ensure that increased discretion translates into improved performance, quality, or efficiency. The governance of the institution—including the selection process and criteria for hospital board members—and the quality of leadership and management are critical.

*Measurement and performance:* Measurement of the right set of indicators can be a significant source of positive change. The KNH component indicators primarily focused on cost recovery and hospital efficiency (such as average length of stay). The other performance indicators were too general to provide much insight into hospital performance, particularly service quality. KNH has developed a number of indicators, particularly to monitor departmental performance, that have contributed to quality and efficiency improvements, but internal support has been weak, and the information collected is not always consistently collected and analyzed to track trends and identify areas for further improvement. KNH management felt that greater accountability in this area under the project would have been a major impetus for improvements in service quality and patient satisfaction.

*Sustainability of improvements:* Sustainability requires not just the right people but also the right structures for accountability. The existing funding and governance structure provides weak accountability mechanisms. The current system of historically based block grants relate funding levels neither to volume of services, nor quality, nor (targeted) patients served. Therefore the government is forced to rely on an implicit "social contract" regarding the role and responsibilities of KNH and the effective functioning of the board.

## Nairobi Area Health Services

3.16 Although improving the quality and availability of primary health services in the Nairobi area was critical to achieving project objectives, neither the government nor the Bank gave adequate attention to this component during both project design and supervision. Within a year of the original project closing date, key agreed reforms still had not been implemented, and planned civil works still had not begun. While the project design document identified the poor

coordination of health services in Nairobi as a major constraint,[13] little progress has been made in establishing a more coherent governance structure. As a result, despite some progress during the project extension, the quality and utilization of primary services have not substantially improved, and congestion at KNH has increased as a result of the relative quality improvements at the hospital.

3.17 The project design tried to take a multi-pronged approach: (i) requiring the establishment of a strategic plan to strengthen the coordination and governance of health services in Nairobi (possibly through the establishment of a board that would oversee all health services for the city); (ii) financing physical rehabilitation, equipment, and training for primary health services; (iii) financing the rehabilitation and establishment of secondary referral facilities. Although the project design document identified many of the challenges facing Nairobi area health services, the design of this component was left for implementation. The NCC and the Provincial Medical Office were only marginally involved in project design.

3.18 Both detailed planning for the use of funds and the development of a strategic plan for Nairobi health services were left for implementation. Soon after project approval, city council health staff and Nairobi Provincial Medical Office staff engaged in an intensive planning exercise to develop project priorities, and submitted them to the MOH and Bank for approval in late 1992. A Bank supervision mission praised the quality of the plan, but insisted that the disbursement condition would not be fulfilled until IDA received a more detailed proposal for use of project funds. Progress on this component then stalled, apparently due to bureaucratic disagreements between the MOH and the NCC, political conflicts with city government, and limited supervision by the Bank.[14]

3.19 In the Aide Memoire for the 1994 midterm review, the Bank blamed the MOH and city council for the lack of progress.[15] Although the original strategic plan had called for upgrading a general and maternity hospital to serve as secondary facilities, little progress had been achieved. The Bank, MOH, and KNH management therefore agreed to reallocate $4.5 million from the KNH component to split the Infectious Disease Hospital away from KNH and convert it to a district hospital for Nairobi. In 1995, the Permanent Secretary for Health established a team to develop an implementation plan for this component. In addition, the government established a senior-level commission (the Mutitu Commission) to explore options for strengthened coordination and governance of basic services in Nairobi.

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13. The NCC was responsible for primary health care, and ran a network of clinics throughout the city. These were generally of poor quality and underutilized, and most operated only from 8 a.m. to 5 p.m. Responsibility for secondary care rested with the Provincial Medical Office for Nairobi, but there were no real secondary facilities as such. KNH was formally limited to tertiary care (although in the past it ran several small satellite clinics for vaccination). As a result, there was very little coordination among the stages of the referral chain, and patients typically chose to bypass lower levels to attend KNH. Despite an oversupply of medical staff in Nairobi, the city council clinics were frequently understaffed because of lower wage rates than MOH and frequent late or non-payment of salaries by the city council.

14. Supervision reports through 1995 scold the MOH for a lack of progress, but indicate limited efforts by the Bank to resolve problems or facilitate consensus among stakeholders. MOH and City Council health staff report that they received little or no communications from the Bank or MOH from 1992-95, and often were not informed of Bank supervision visits. Former Bank task team members, in contrast, suggest that the Bank did try to facilitate progress, but that the volatility of the city's political leadership – including conflicts between the mayor and city council – made it very difficult to achieve consensus or follow through on agreed actions.

15. The Aide Memoire further asserted that the NCC was incapable of managing health services, and insisted that the government submit a plan for contracting out of the NCC services. This requirement did not appear to be well thought through by the Bank, and apparently was not followed up by either the Bank or borrower.

3.20 In March 1996, the Bank lifted the hold on disbursement for the component, with the understanding that all disbursements would have to be completed by the original closing date of June 1998.[16] The MOH submitted an 18-month plan for upgrading the Infectious Disease Hospital into a district hospital (it did not have an outpatient ward, maternity ward, or casualty department), but the Bank rejected the request due to lack of time. Funds original earmarked for the district hospitals were reallocated to equipment for the hospital and other project components. In contrast, the Bank gave the city council a "no objection" to rehabilitation of a number of clinics, even though there was not enough time to complete the work. Work on the clinics had barely commenced when the one-year project extension was approved.

3.21 Intensified supervision efforts by a new Bank supervision team and the borrower, facilitated by the procurement agent, resulted in substantial progress. Yet clinic construction experienced delays, and most still were not complete by the revised closing date. The NCC has committed to completing the clinics with its own funds, but several of the clinics are reportedly still not finished, and a few remain closed. The Infectious Disease Hospital has been formally opened as a district hospital, but has only a makeshift outpatient and maternity ward and is unable to divert substantial patients from KNH. The Provincial Medical Office received several vehicles and various equipment for district facilities, which was appreciated, although staff expressed concern regarding the quality of some of the items procured.[17]

3.22 The MOH and the Bank team deserve credit for the progress in the period prior to and following the extension, but the poor performance in the previous period limited the potential impact. Although city council health officials were pleased that the Bank approved clinic construction despite the lack of time, the ICR appropriately criticizes the decision to proceed with construction that could not be completed within the agreed time-frame. Staff of the Provincial Medical Office were disappointed that they had little to show after six years, and suggest the Bank should have been more flexible with the extension. Yet the poor performance of the MOH with regard to financial management, and tightened standards for granting of extensions within the Bank's Africa Region, resulted in a situation where Bank management would not have approved an extension of more than one year.

**Health Planning and Policy**

3.23 As noted in the ICR, this component was to be the foundation for decentralization and health sector reform. The project financed a number of policy studies and facilitated the development of the 1994 "Health Policy Framework Paper." Although a good description of the goals and vision for health sector reform, the paper provides less detail on how the goals will be achieved. Still, MOH staff assert that the paper remains a guiding document for a number of ongoing and planned reforms, including decentralization, cost recovery, reforms to the General Medical Stores, and hospital autonomy. The component also financed training, technical assistance, and equipment for the Division of Planning and Development, which appears to have strengthened its capacity. The ICR expresses disappointment, however, that the MOH never hired its own economist to lead the department.

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16. Because of outstanding audit reports, Bank management was not willing or able to consider an extension at this time.

17. Specifically, provincial staff were unhappy with the quality of some of the vehicles procured, and several of the refrigerators for storing vaccines and other medication were already broken. Provincial Medical Office officials appeared to have been given inadequate training and support in the procurement process, which may explain their higher level of dissatisfaction with procurement results than expressed by KNH management.

3.24 Although initial supervision reports suggest that a separate health reform project would be launched just two years after effectiveness of this project, major health reforms have remained in the planning stage. Several donors expressed concern that the Bank often appeared overly eager to finance a sector reform program, even in the absence of a clear strategy and commitment from the MOH and senior government officials. In the past year or two, the Bank appears to have adopted a more cautious approach toward comprehensive sector reforms. Recent changes in MOH leadership appear to have strengthened momentum on some key reform efforts, however.

**Social Welfare Monitoring**

3.25 As discussed in the ICR, this component experienced delays and problems in utilizing project funds. Neither the Human Resources and Social Services Department or the Central Bureau of Statistics (CBS) had previous experience with IDA projects. Financial management was particularly cumbersome; payment claims from CBS had to be processed through its parent planning ministry, which was often unable to provide initial funds to cover incurred expenditures. The ICR notes that neither the Bank nor the government took sufficient steps to address these problems. As noted above, this component was supervised separately from the rest of the project.

3.26 Despite these problems, CBS conducted three welfare monitoring surveys. The first was completed shortly after project effectiveness, but CBS staff report that it was done almost entirely by expatriate consultants, with little analytical involvement by local staff. The ICR reports that CBS capacity was undermined by turnover and loss of experienced staff. In contrast, CBS staff suggest that initially the expatriate consultants and the Bank placed low priority on building capacity in the unit. They report that they had to insist that they be sent for training to allow them to undertake analysis in subsequent surveys. The initial survey provided household data for the Bank's 1995 Poverty Assessment, and subsequent surveys provided the basis for the Poverty Profile for Kenya. Although release of this report was delayed until 1998, CBS staff suggest that it was instrumental in putting poverty on the political agenda in Kenya, and they note that the surveys and analysis were done entirely by local staff. In sum, it appears that despite various problems, the project made a contribution to strengthening survey and analytic capacity, although less than it might have.

# 4. Outcome and Ratings

4.1 While the Bank was only one of several players in the KNH reforms, the reforms and Bank support clearly contributed to improved quality at Kenyatta National Hospital. Yet the stated objective in the Health Rehabilitation Project was to increase resources available for primary care. Although available budget trend data are difficult to interpret, this does not appear to have happened. Furthermore, because of lack of progress in strengthening primary and secondary care in Nairobi, the objective of decongesting the hospital was not achieved. The latter two components appear to have achieved mixed success. Thus, while the KNH reforms themselves would merit a satisfactory rating, OED rates the project *marginally unsatisfactory* overall.

4.2 Institutional development was *modest* (similar to the *partial* rating in the ICR). Substantial progress at KNH was balanced by relatively little progress with Nairobi health services. Sustainability is *uncertain* (the same as the ICR), primarily because of the difficult fiscal

situation. Increased cost recovery has undoubtedly contributed to sustainability, but it is not yet fully covering recurrent expenditures at KNH and is unlikely to adequately finance district services without additional governmental support.

4.3 Although the Bank gave significant attention to the KNH component during project design and supervision, the Nairobi area health services component was not well designed or supervised. Supervision performance was weak for several years after project preparation. Bank performance subsequently improved, both at the country office and by headquarters staff, particularly during the year of project extension. Yet these improvements do not make up for earlier shortcomings, and a more flexible approach to the extension might have led to greater attainment of development objectives. Bank performance is therefore rated *unsatisfactory* (compared with satisfactory in the *unsatisfactory* ICR).

4.4 Borrower performance was deficient in a number of respects. Overall performance improved during the project extension, and performance by KNH management was satisfactory throughout. The Nairobi health services component experienced myriad problems, and senior government officials and the NCC have not demonstrated adequate commitment to resolving fundamental problems in primary- and secondary-level services. Chronic problems with financial management and audits hindered project implementation and the ability to plan for the extension. OED therefore rates borrower performance *unsatisfactory* (compared with *satisfactory* in the ICR) overall, but acknowledges good performance by KNH and general improvements during the extension.

# 5. Conclusions and Lessons

5.1 The Health Rehabilitation Project experience and the KNH reforms offer a number of valuable lessons with regard to hospital and health system reform efforts.

5.2 ***While increased hospital autonomy is a necessary but not sufficient condition for improved hospital performance, the Kenyatta Hospital experience demonstrates that good public sector performance is possible in Kenya despite continued problems with governance.*** Kenyatta was made autonomous in 1987, but it was not until 1991 that a new board and hospital management began exercising autonomy and the MOH began to relinquish control. Even then, various restrictions on revenue collection and staffing still had to be removed, and technical assistance and training was critical in helping the hospital realize gains from autonomy. Other key factors in the hospital's success—in addition to autonomy—include the appointment of a strong, independent hospital board (with a mix of public and private sector representatives); establishment of a strong senior management team; and the willingness by political leaders to respect the hospital's independence.

5.3 ***Autonomous hospitals are likely to attract more resources rather than less.*** Therefore, increased autonomy alone is unlikely to release resources for primary and preventative care, or to support the shifting of service delivery to more cost-effective settings.[18] This suggests that future

18. This observation is confirmed in similar reforms in other countries, both developing and developed, in "Innovations in Health Delivery: Reforms within the Public Sector," April Harding and Alex Preker (eds.), forthcoming, Oxford University Press, 2000.

efforts to increase autonomy must directly address cost-containment issues—including the plans underway in Kenya to extend autonomy to a number of provincial hospitals.

5.4 ***Investment projects, even with conditions attached, may not be effective instruments for addressing "allocative" problems.*** Projects that seek to improve allocation of public expenditures on health should look less at facilities and more at the revenue allocation process, and deal with the key actors in the budget process (e.g., Treasury and MOH). Yet weak ability to monitor and low leverage seem to be inherent to an investment project with policy conditionality. Disbursements cannot realistically be tied to government actions on the loan conditions—since those conditions are so indirectly related to the investment expenditures. Regardless of the instrument, conditions should be relatively few in number, and negotiated with relevant stakeholders. Consequences for non-compliance should be made explicit, and enforced consistently.

5.5 ***Strengthening urban referral systems often requires action and improved coordination among a number of different levels of government, which in turn requires extensive consultation during design and implementation.*** Involving two levels of government in the implementation of a project substantially increases the level of complexity. This increased complexity taxes both Bank and client capacity. Task teams must make provisions for dealing with incentive and capacity issues at each level if projects are to be successful. Supervision arrangements also must take into account the challenge of dealing effectively with multiple implementing and stakeholder bodies. The core objectives of this project could not be achieved without the active cooperation among the MOH, and the Ministry of Local Governments and the NCC. Despite the motivation and interest of the MOH, the local government bodies were not effectively brought into the project's design or supervision—and this contributed substantially to the unsatisfactory results of the project.

# Basic Data Sheet

## HEALTH REHABILIATION PROJECT (CREDIT 2310-KE)

## Key Project Data *(amounts in US$ million)*

| | *Appraisal Estimate* | *Actual or current estimate* | *Actual as % of appraisal estimate* |
|---|---|---|---|
| Total project costs | 34.5 | 29.8 | 86.4 |
| Credit amount | 31.0 | | |
| Cancellation (US$) | | 2.9 | |
| Date physical components completed: June 30, 1996 | | | |

## Cumulative Estimated and Actual Disbursements

| *Fiscal Year* | *QUARTER* | *SAR Estimates (US$M)* | | *Actual (US$M)* | | *Actual Cumulative as % of Credit* |
|---|---|---|---|---|---|---|
| | | *Quarterly* | *Cumul.* | *Quarterly* | *Cumul.* | |
| 1992 | Q3 | 1.70 | 1.70 | 0.00 | 0.00 | 0 |
| | Q4 | 0.80 | 2.50 | 0.00 | 0.00 | 0 |
| 1993 | Q1 | 0.90 | 3.40 | 3.28 | 3.28 | 10.6 |
| | Q2 | 0.95 | 4.35 | 0.19 | 3.47 | 11.2 |
| | Q3 | 0.95 | 5.30 | 0.01 | 3.48 | 11.2 |
| | Q4 | 1.20 | 6.50 | 0.00 | 3.48 | 11.2 |
| 1994 | Q1 | 1.25 | 7.75 | 0.14 | 3.62 | 11.7 |
| | Q2 | 1.55 | 9.30 | 0.18 | 3.80 | 12.3 |
| | Q3 | 1.25 | 10.55 | 0.11 | 3.91 | 12.26 |
| | Q4 | 1.25 | 11.80 | -0.49 | 3.42 | 11.0 |
| 1995 | Q1 | 1.85 | 13.65 | 0.22 | 3.64 | 11.7 |
| | Q2 | 1.85 | 15.50 | 0.29 | 3.93 | 12.7 |
| | Q3 | 1.55 | 17.05 | 0.00 | 3.93 | 12.7 |
| | Q4 | 1.85 | 18.90 | 0.12 | 4.05 | 13.1 |
| 1996 | Q1 | 1.55 | 20.45 | 1.86 | 5.91 | 19.1 |
| | Q2 | 1.85 | 22.30 | 0.48 | 6.39 | 20.6 |
| | Q3 | 1.60 | 23.90 | 1.57 | 7.96 | 25.7 |
| | Q4 | 1.50 | 25.40 | 0.75 | 8.71 | 28.1 |
| 1997 | Q1 | 1.60 | 27.00 | 0.88 | 9.59 | 30.9 |
| | Q2 | 1.50 | 28.50 | 0.49 | 10.08 | 32.5 |
| | Q3 | 1.30 | 29.80 | 0.94 | 11.02 | 35.5 |
| | Q4 | 1.20 | 31.00 | 0.89 | 11.91 | 38.4 |
| 1998 | Q1 | | | 1.60 | 13.51 | 43.6 |
| | Q2 | | | 1.19 | 14.70 | 47.4 |
| | Q3 | | | 1.21 | 15.91 | 51.3 |
| | Q4 | | | 2.32 | 18.23 | 58.8 |
| 1999 | Q1 | | | 7.66 | 25.89 | 83.5 |
| | Q2 | | | 1.60 | 27.49 | 91.6 |

## Project Dates

| | *Original* | *Actual* |
|---|---|---|
| Identification | -- | April-May 1989 |
| Preparation | August 1989 | August 1989 |
| Appraisal | May-June 1990 | October 1990<br>March 1991 (WMS) |
| Negotiations | February 1991 | February 1991 |
| Board Presentation | July 1991 | November 1991 |
| Signing | December 11, 1991 | December 11, 1991 |
| Effectiveness | March 12, 1992 | July 7, 1992 |
| Mid-Term Review | September 30, 1993 | March 31, 1994 |
| Project Completion | June 30, 1995 | June 30, 1998 |
| Loan Closing | June 30, 1997 | June 30, 1998 |

## Staff Inputs (staff weeks)

| Stage of Project Cycle | *Planned* | | *Revised* | | *Actual* | |
|---|---|---|---|---|---|---|
| | *Weeks* | *US$* | *Weeks* | *US$* | *Weeks* | *US$* |
| Preparation to Appraisal | N/P | N/P | N/P | N/P | 162.1 | 300.3 |
| Appraisal | N/P | N/P | N/P | N/P | 41.8 | 70.6 |
| Negotiations through Board Approval | N/P | N/P | N/P | N/P | 33.1 | 80.7 |
| Supervision[a] | 208.4 | 394.8 | 248.7 | 422.3 | 273.6 | 450.6 |
| Completion | 16.5 | 13.7 | 21.9 | 20.9 | 13.3 | 13.8 |
| **Total** | N/P | N/P | N/P | N/P | 523.8 | 918.0 |

*Source:* FACT Cost Report run on December 22, 1998.

a. Assumes FY1986–95 actual expenditures were equal to planned (and revised planned). The World Bank Information System did not retain the "planned" figures for those years.

# Mission Data

| *Stage of project cycle* | *Date (mm/yr.)* | *No. of persons* | *Duration of mission (# of days)* | *Specialized staff skills represented** | *Performance rating* | | *Types of problems* |
|---|---|---|---|---|---|---|---|
| | | | | | *Implement. Status* | *Develop. objectives* | |
| Identification | April/May 1989 | 8 | 21 | E,F,I,PH | | | Re-introduction of User fees; need to monitor impact of user fees on welfare of poor, proposed changes to NHIF infeasible; KNH need for rehabilitation. |
| Preparation | August 1989 | 6 | 17 | E,O,PH,HM, CW | | | Re-Introduction of User fees; KNH accounts payable. |
| Appraisal | October 1990 | 7 | 19 | E,O,PH,HM | | | Finalization of KNH audits, KNH accounts payable, need to increase KNH revenues, re-instatement of user fees. |
| Appraisal (WMS) | March 1991 | 3 | 22 | E,S | | | Cost estimates incomplete. Need for revised medium-term work program for CBS. Component not included in GOK budget for coming year. |
| Post-appraisal | January 1991 | 3 | 7 | E,A | | | Re-instatement of user fees; MOH planning function. |
| Supervision | October 1992 | 5 | 11 | E,O,A,HM | | | KNH targets not met, vacant posts in KNH; KNH financial management; KNH quality control; lack of progress in Nairobi Area component. |
| | March 1993 | 2 | 11 | S,O | 2 | 1 | Procurement and disbursement problems. |
| | August 1993 | 6 | 18 | PH,O,A,HM,S | 2 | 2 | KNH financial management; KNH not decongested; lack of progress on Nairobi Area component; delays in WMS data processing and outputs. |
| Mid-Term Review | March 1994 | 6 | 18 | PHS,O,S,IP | 2 | 2 | Delays in civil works; failure of KNH to fulfill financial performance objectives; weak planning function of MOH; delays in WMS surveys. |
| Supervision | August 1994 | 5 | 9 | PH,O,A,HM | S | U | Lack of progress on Nairobi Area component; KNH failure to fulfill agreed actions and meet performance targets; KNH consuming rising share of MOH. budget; vacant important posts in MOH. |
| | February 1995 | 3 | 12 | PH,O | S | U | Lack of primary and secondary health care in Nairobi hampering means KNH still congested. Lack of planning capacity in MOH. |

| Stage of project cycle | Date (mm/yr.) | No. of persons | Duration of mission (# of days) | Specialized staff skills represented* | Performance rating | | Types of problems |
|---|---|---|---|---|---|---|---|
| | | | | | Implement. Status | Develop. objectives | |
| | Sep./Oct. 1995 | 7 | 12 | O,A,F,Ph,S | S | S | Separate special account should be re-opened for KNH; delays in payment process, particularly for civil works; KNH not meeting performance targets; lack of progress in Nairobi Area component; lack of understanding of implementation procedures in WMS component, slow implementation in this component. |
| | Feb/Mar. 1996 | 6 | 12 | HP,O,A,F,Pr. | S | S | KNH not meeting performance targets; KNH civil works disbursement delays; shorfall in counterpart funds. |
| | Sep./Oct. 1996 | 8 | 17 | PH,S,O,Pr,F, A | U | S | Delays in civil works; delays in procurement; loss of senior CBS staff affecting WMS component. |
| Supervision | February 1997 | 7 | 17 | PH,O,Ac,Ph, E,CE | U | S | Delays in civil works, slow improvement in Nairobi area services; KNH not decongested; completion of activities and disbursement impossible for June 30, 1997 closing date, Mathare and Mbagathi hospital rehabilitations unlikely with 1 year extension. |
| | Sept. 1997 | 5 | 10 | PH,O,CE | U | S | Delays in civil works; financial management; procurement improved; Mbagathi hospital rehabilitation canceled as completion unlikely. |
| | February 1998 | 5 | 21 | PH,O,F,CE | U | S | Delays in KNH civil works; NCC civil works unlikely to be completed; procurement improved, financial management improved. |
| Completion | Sept. 1998 | 6 | 11 | O,S,CE,F,Pr | | | |

Ac = Accountant; A = Architect; CE = Civil Engineer; CW = Civil Works; E = Economist; F = Financial; HP = Health Programming; Ph = Physician; Pr – Procurement; PHS = Public Health Specialist; HM = Hospital Management; IP = Insurance Planner; O = Operations; S = Statistician.

# Other Project Data

Borrower/Executing Agency:

## Related Bank Credits

| *Credit* | *Purpose* | *Year of approval* | *Status* |
|---|---|---|---|
| **Past Operations** | | | |
| First Population Project (US$12 million) | The project objective was to significantly reduce the population growth rate. | 1974 | Closed |
| Second Population Project (US$23 million) | The project objectives were to (i) reduce fertility, and (ii) improve accessibility and quality of rural health services. | 1983 | Closed |
| **Parallel Operations** | | | |
| Third Population Project (US$12.9 million) | The project objectives were to: (i) strengthen capacity of the National Council for Population and Development; (ii) create demand for Family Planning services through IEC activities; and (iii) increase the availability, accessibility, and quality of Family Planning services. | 1988 | Closed June, 1996 |
| Fourth Population Project (US$35 million) | The project objectives were to: (i) strengthen capacity of the National Council for Population and Development; (ii) create demand for Family Planning services through IEC activities; and (iii) increase the availability, accessibility, and quality of Family Planning services. | 1990 | Closed June 1998 |
| **Following Operations** | | | |
| Sexually Transmitted Infections Project (US$40 million) | The project objectives are to: (i) strengthen the institutional capacity at the national and district levels to design, implement, monitor and evaluate interventions; (ii) promote preventive measures to reduce the risks of STI transmission; and (iii) enhance both health sector and community provision of physical and psychological care and develop strategies to mitigate the socio-economic consequences of STI/HIV. | 1995 | On-Going Closing December 2000 |
| **Planned Operations** | | | |
| Health Sector Reform Project | An APL which will support the GOK in implementing its Health Sector Reform Program which focuses on (i) equitable allocation of government resoruces; (ii) increased cost effectiveness of resource allocation; (iv) continued management of population growth; (v) enhanced regulatory role of the government; (vi) increased private sector and community involvement in the health sector; and (vii) increased and diversified per capita flows to the health sector. | Planned, 2000 | |

## Borrower's Comments

**KENYATTA NATIONAL HOSPITAL**
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**Ref: KNH/DEV/2/A/VOL. V/048** **Date: 10TH May, 2000**

Gregory K. Ingram, Manager,
Sector and Thematic Evaluations Group,
Operations Evaluation Department,
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UNITED STATES OF AMERICA.

Fax: (202) 522-3123

Dear Gregory,

**Re: Health Rehabilitation Project ( Credit 2310- KE)**
**Draft Performance Audit Report**

Kenyatta National Hospital is totally in agreement with the draft Performance Audit Report (PAR), as compiled by the Operations Evaluation Department of the World Bank, regarding the Health Rehabilitation Project for the Ministry of Health generally and in particular, the issues pertaining to KNH.

However, there are a few areas that needs clarification and or rewording to reflect the situation on the ground. These areas include:

1. Pg. 13, Paragraph 3.11 regarding the costs of operations and maintenance to the hospital.
   Although the increase in the number of equipment purchased contributed to a rise in the electricity costs (since they must consume power when in operation), this does not constitute the doubling of electricity consumption as the report indicates.
   After the project completion, the supplier of electricity ( KPLC), increased the tariffs which led to a significant rise in electricity costs (for all consumers). The hospital considers this rise in tariffs to be a major contributor to the increasing electricity costs.

2. In addition all equipment purchased, although 'sophisticated than necessary' are being fully utilised and have assisted in the improvement of patient care (pg.13).

3. Pg. 17 under 'Lessons Learned from the KNH Reform', KNH while giving due cognisance to the fact that the Chairman and the Director "team"was instrumental in the improvements during the Reform, it does not agree with the assertion that 'managerial effectiveness and performance are deteriorating' after the turnover.

It is noteworthy that almost all the managers in place now were *there during the* **Reform and they were very instrumental** to the success of the team. These same managers continue to perform their duties with the same vigour as before.
It is debatable whether, as an institution improves its performance from the worst possible scenario towards better services, a point is reached whereby the rate of change (i.e. improvement) is less than apparent because it is adding onto a better situation as opposed to changing from a worse position to a more desirable position. This does not mean that the hospital has reached its optimal point beyond which it can not improve its performance.

All in all, KNH is in agreement with the Report. These few highlighted areas would come out in the final report better if revised along the suggested lines.

Thank you.

Sincerely,

**H. W. WAWERU FAAD,**
**DIRECTOR.**