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PERFORMANCE AUDIT REPORT

KENYA

THIRD AND FOURTH POPULATION PROJECTS
(CREDITS 1904 & 2110-KE)

June 28, 2000

Sector and Thematic Evaluation 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

DfID	Department for International Development (UK)
GoK	Government of Kenya
ICR	Implementation Completion Report
IEC	Information, Education and Communication
NCPD	National Council for Population and Development
NORAD	Norwegian Development Agency
ODA/DfID	Overseas Development Administration/Department for International Development (UK)
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development

Fiscal Year

Government of Kenya: July 1 – June 30

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The World Bank
Washington, D.C. 20433
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Office of the Director-General
Operations Evaluation

June 28, 2000

MEMORANDUM TO THE EXECUTIVE DIRECTORS AND THE PRESIDENT

SUBJECT: Performance Audit Report on Kenya
Third and Fourth Population Projects (Credits 1904-KE and 2110-KE)

Attached is the Performance Audit Report prepared by the Operations Evaluation Department (OED) on the Third and Fourth Kenya Population Projects, which were supported by IDA Credits of US$12.9 million and US$35 million, respectively. Population III was approved on May 10, 1988, and closed on June 30, 1996. An undisbursed balance of US$194,000 was cancelled at closing, in addition to $112,000 that had been previously cancelled due to misprocurement. Population IV was approved on March 27, 1990, and closed on June 30, 1998, after a one-year extension, and an undisbursed balance of US$7.05 million was cancelled on March 11, 1999. For both projects, over half of all disbursements took place less than one year before project completion.

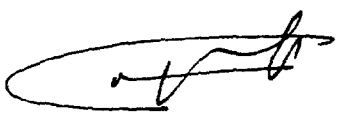
The Third and Fourth Population Projects were essentially the same project. They shared three primary objectives: (a) strengthen the capacity of the National Council for Population and Development (NCPD) to plan, program, finance, coordinate and monitor population program activities; (b) create acceptance of and demand for family planning services through the implementation of a strategically planned and coordinated IEC program; and (c) increase the availability, accessibility, and quality of family planning services provided by the government and NGOs. The major difference was that Population IV included significantly increased allocations for contraceptives and supplies,

Both projects failed to achieve their development objectives. Despite extensive investments in overseas training for NCPD, few staff were retained, and NCPD is arguably weaker than when the projects began. Although government and donors had expected Population IV to meet most of the county's contraceptive needs through the late-1990s, the projects failed to complete a major procurement until 1996. The subsequent decision to hire an independent procurement agent allowed rapid procurement and disbursement prior to the projects' close, but contributed little to resolving procurement bottlenecks in the government system. Civil works initiated under Population III—including voluntary surgical contraception units and NGO family planning clinics—were mostly still incomplete by the end of Population IV. The IEC programs were poorly designed and implemented, and the impact was not assessed.

Project implementation was severely undermined by systemic bottlenecks in Borrower payment and financial management systems, as well as financial crisis that constrained counterpart funds. Bank supervision focused almost exclusively on "policy dialogue," however, and until the change in task teams in 1996, did little to help resolve implementation problems. Furthermore, project design and supervision experience prior to 1996 suggests numerous breakdowns in the Bank's own control and accountability systems, including failures by the task manager and Bank management to enforce Bank operating procedures and minimal standards of accountability for project funds.

The overall project outcome for both projects is rated as unsatisfactory (the same as in the ICRs). Institutional development impact also was neglibible for both projects (the same as in the ICRs). Project sustainability is rated as unlikely (compared to *uncertain* for the Population III ICR, and unlikely for Population IV) . Bank and Borrower performance are rated as unsatisfactory (similar to the *deficient* rating in the ICRs). Although both supervision and implementation performance improved after 1996, the improvements were not sufficient to compensate for the serious shortcomings of previous project design and supervision.

The major lesson emerging from these projects is that accountability begins at home. While IDA's current emphasis on improving governance in Kenya is appropriate, its credibility requires maintaining similar, if not higher, standards for its own staff and operations. Several other lessons are salient. The projects illustrate that the Bank and the Borrower can significantly improve performance of problem projects through intensified Bank supervision—including devolving greater responsibility to staff in the Bank's resident mission—and setting clear performance standards for borrower implementation. Finally, in countries with acknowledged governance problems, it is important that the Bank clearly diagnose the source of weaknesses in capacity or governance, identify appropriate remedies, and seek to strengthen accountability systems at both national and sector levels.



Attachment

Contents

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

Principal Ratings

Population III	*ICR*	*Audit*
Outcome	Unsatisfactory	Unsatisfactory
Sustainability	Uncertain	Unlikely
Institutional Development	Negligible	Negligible
Borrower Performance	Deficient	Unsatisfactory
Bank Performance	Deficient	Unsatisfactory

Population IV	*ICR*	*Audit*
Outcome	Unsatisfactory	Unsatisfactory
Sustainability	Unlikely	Unlikely
Institutional Development	Negligible	Negligible
Borrower Performance	Deficient	Unsatisfactory
Bank Performance	Deficient	Unsatisfactory

KEY STAFF RESPONSIBLE

Population III	*Task Manager*	*Division Chief*	*Country Director*
Appraisal	Vulimiri Jagdish	Francis Lethem	Callisto Madavo
Midterm Review	Beatrice Hebling/ Vulimiri Jagdish*	Jacob V. Lutsenburg Maas	Francis Calaco
Completion	Kaori Miyamoto	Ruth Kagia	Harold Wackman

Population IV	*Task Manager*	*Division Chief*	*Country Director*
Appraisal	Vulimiri Jagdish	Dennis Mahar	Callisto Madavo
Midterm Review	Beatrice Hebling/ Vulimiri Jagdish*	Jacob V. Lutsenburg Maas	Francis Calaco
Completion	Andrew Follmer	Ruth Kagia	Harold Wackman

* Ms. Hebling was formally named task manager in 1992, but Dr. Jagadish remained on the project team, and retained responsibility for major project decisions until his retirement in 1995.

Preface

This is a Performance Audit Report (PAR) on the Third and Fourth Kenya Population Projects. The projects supported capacity building for the National Council for Population and Development (NCPD); programs to increase demand for family planning services; and direct provision of contraceptives and related supplies. Population III and IV were supported by IDA Credits Nos. 1904 and 2110-KE for US$12.9 million and US$35 million, respectively. Population III was approved on May 10, 1988, and closed on June 30, 1996. An undisbursed balance of US$194,000 was cancelled at closing, in addition to $112,000 that had been previously cancelled due to misprocurement. Population IV was approved on March 27, 1990, and closed June 30, 1998, after a one-year extension, and an undisbursed balance of US$ 7.05 million was cancelled on March 11, 1999.

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 Health Rehabilitation Project (the latter is discussed in a separate report). The mission included interviews with government officials, Bank and donor field staff, and nongovernmental organizations. Documentary sources include the projects' Implementation Completion Reports, the Staff Appraisal Reports (SAR), independent audit reports, and project files.

The author expresses' appreciation to all those who made time for interviews and provided documents and information, including officials at the Ministry of Health, the Nairobi City Council, the National Council for Population and Development (NCPD), and current and former World Bank staff.

Following customary procedures, copies of the draft audit report were sent to the relevant government officials and agencies for their review and comments. Comments received from NCPD have been incorporated into the PAR as Annex B.

1. Introduction

1.1 The Kenya Third and Fourth Population Projects represent a sobering example of what can go wrong when poor project design and supervision by the World Bank takes place in a context of weak borrower managerial and accountability systems. Yet they also provide a useful case study of a gradual effort by the Bank and borrower to address long-standing implementation problems through strengthened supervision and implementation, following a change in task managers. Finally, while the project experience suggests that the Bank's current emphasis on improving governance and transparency in Kenya is appropriate, it provides a reminder that the Bank's credibility depends on enforcing similar standards for its own staff and operations: in other words, accountability begins at home.

Background

1.2 Despite once having had the highest fertility rate in the world, Kenya has experienced impressive improvements in fertility-related indicators over the past two decades. The total fertility rate dropped from 6.7 in the late 1980s to 4.7 children per women in the late 1990s, and the contraceptive prevalence rate (CPR) among married women has increased from 7 to 39 percent.[1] Socioeconomic factors played a major role in this change—improvements in female education, urbanization, and significant increases in school fees all increased the demand for smaller families. Despite the initial resistance to family planning, the government—with significant support from international donors—established a national family planning program that sought to increase availability of family planning services in both urban and rural areas, and to increase demand for family planning through information, education, and communication (IEC) efforts. Knowledge of modern contraceptive methods has exceeded 95 percent for the past decade. Among women not using and not intending to use contraceptives, the major reasons are infertility (20 percent), wanting more children (15 percent), respondent or spouse opposed (16 percent), and fear of side effects (12 percent). Currently less than 1 percent of non-users give access or cost as reasons for non-use.

1.3 Currently 58 percent of contraceptive users obtain supplies through public sources, down from 71 percent in 1989.[2] These data suggest that the government-sponsored program has contributed to increased contraceptive prevalence, although the relative contribution of supply versus demand factors is difficult to ascertain. Yet the importance of private sector is growing relative to public provision. Among types of contraceptives, only 25 percent of condoms are provided through the public sector, compared to a 40 percent in 1993. The percentage of contraceptive pills provided by the public sector has declined from nearly 80 percent in 1993 to 65 percent in 1998.[3] The vast majority of private suppliers, however, receive their contraceptive supplies through public sector procurement and distribution channels. Half of pill users receive

1. National Council for Population and Development, Central Bureau of Statistics, and Macro International. 1998. Kenya Demographic and Health Survey.
2. National Council for Population and Development, Central Bureau of Statistics, and Macro International. 1998. Kenya Demographic and Health Survey.
3. Public sector includes government hospitals as well as Community Based Distributors. Private sector includes NGO and mission hospitals, private medical services, and shops and pharmacies.

them free of charge; of these over half said they would be willing to pay something for pills—yet 43 percent said they would not be willing to pay.[4] The market for contraceptives is therefore becoming increasingly differentiated, with greater scope for private involvement. Yet a significant proportion of poor women still depend on subsidized provision.

1.4 The population sector in Kenya has depended heavily on external donors support, including from the World Bank. Population I (Cr. 468-KE) began in 1974 and closed in 1979. It was one of the first International Development Association (IDA) credits in the population sector worldwide, and provided $12 million to help establish the organizational and infrastructure base for family planning services. Population II (Cr. 128-KE, 1983-1990), with a credit amount of $23 million, sought to increase demand for and access to family planning services in rural areas.

1.5 Demographic survey results in the mid-1980s, however, found that fertility indicators were changing more slowly than expected, and that demand for contraception remained relatively low. Population III (US$12.9 million) was designed to further increase demand for family planning, and to expand service provision through both governmental and nongovernmental organizations. The project was developed in collaboration with the United Kingdom's Overseas Development Administration (now DfID), the United Nations Population Fund (UNFPA), and the Norwegian Development Agency (NORAD), and approved by the Board in 1988.[5] In 1989, however, results from the Demographic and Health Survey (DHS) found that both demand for and use of modern contraceptives had increased significantly. Nearly all contraceptives had been supplied on a grant basic by bilateral donors, but these (including USAID and ODA/DfID) were planning to scale back their direct support for provision. This led to a request from government and other donors that IDA help finance the anticipated shortfall.

1.6 Rather than restructure Population III, the Bank rapidly designed and approved (in 1990) Population IV. With a credit of $35 million, Population IV had essentially the same objectives as Population III, but with significantly increased allocations for public sector contraceptive procurement. Other donors designed their assistance programs on the assumption that Population IV would finance much of the contraceptive needs of the public sector through the late-1990s.[6]

1.7 Several external factors have significantly influenced the population and health sectors in Kenya over the past decade. The first is the HIV/AIDS epidemic, which is contributing to a reversal in the health gains achieved during the 1980s, and creates the added challenge of integrating sexual and reproductive health into traditional family planning programs. Second, the onset of economic crisis in the early 1990s and subsequent economic stagnation have contributed to fiscal stringency and persistent shortfalls in agreed project counterpart obligations. Third, the growing crisis of governance nationwide has contributed to systemic shortcomings in government accountability and managerial systems in both central and sectoral ministries. In response to governance concerns, international donors have either reduced support, or increasingly bypassed government through parallel or external implementing arrangements. After two decades of emphasis on sustaining lending volumes, the World Bank's most recent Country Assistance Strategy for Kenya places governance at the center of its policy dialogue. Total Bank lending

4. "Willingness to pay" data can be difficult to interpret, because it does not distinguish between women who cannot afford to pay, versus those who might otherwise have paid but have become accustomed to not paying because of free government provision.
5. OED/DfID originally provided $8.4 million in parallel financing ($7.8 million actual). NORAD originally pledged $5 million in parallel financing, but soon withdrew from Kenya in response to governance concerns.
6. Project design for Population III and IV included components to strengthen direct provision of family planning services by NGOs, but not steps to expand other private supply channels—either through social marketing, or increased provision by the private commercial sector (private doctors, pharmacies, and shops).

volumes have been reduced dramatically, although the social sectors have been protected relative to others.

2. Project Objectives and Relevance

2.1 As acknowledged in the project Implementation Completion Reports (ICRs), the third and fourth Population Projects were essentially the same project. They shared three primary objectives: (a) strengthen the capacity of the National Council for Population and Development (NCPD) to plan, program, finance, coordinate and monitor population program activities; (b) create acceptance of and demand for family planning services through the implementation of a strategically planned and coordinated IEC program; and (c) increase the availability, accessibility, and quality of family planning services provided by the government and NGOs (see Box 2.1).

2.2 In addition to substantially increased provisions for contraceptive procurement, Population IV provided direct funding for a number of activities—including support for IEC and expanded service provision by NGOs—that were financed by ODA/DfID under Population III. In both projects, the NCPD played a key implementing role, including for policy development, IEC, and coordinating the NGO component.

2.3 The overall objectives of Population III were relevant to the needs of the sector at the time, and consistent with government policies. Project design and implementation did not address some of the key constraints that had plagued earlier projects, however, which significantly reduced the project's potential impact. Although Population IV represented a response to an anticipated shortfall in contraceptive availability, Population III should have been restructured rather than designing a new project. Population II was still disbursing, and Population III had barely begun disbursing, when Population IV became effective. As noted in the Population IV Implementation Completion Report, the combined projected disbursements for Population III and IV exceeded the implementation capacity of the ministry, and parallel administrative arrangements placed an undue burden on the implementing agencies. Furthermore, Population IV was presented to the World Bank Board even though required audits for Population II and 3 still were not completed—a violation of Bank regulations.

2.4 Project designs did not ensure that appropriate systems and capacity were in place for procurement, financial management and accounting, or design and supervision of civil works.[7] In addition, although the projects included provisions for "capacity building," they did not diagnose the underlying causes of weak performance, or analyze whether and how project-financed interventions would overcome previous constraints. Project designs gave inadequate attention to assessing the market for contraceptives—either on the supply or demand side. They did not sufficiently analyze consumer demand for voluntary surgical contraception in particular, or assess the commitment of government to the proposed voluntary surgical contraception units (VSCUs).[8] Project designs also gave limited attention to the growing role of the private sector contraceptive

7. Various donors had supplied most of Kenya's contraceptive needs through grant financing, using parallel procurement arrangements. As a result, the MOH had little experience with or capacity for procurement. Although inadequate assessment of procurement capacity has been a common problem in IDA health projects, it was a particular problem for these. The World Bank Africa Region now requires procurement and financial management assessments prior to project approval.

8. Currently, only 6 percent of female contraceptive users choose sterilization, and male sterilization is rare (1998 KDHS).

provision, and did not assess whether financing for public procurement of contraceptives might "crowd out" private provision.

Box 2.1: Projects Components:

To increase NCPD's capacity, population III included (i) construction and equipping of a national headquarters buildings for the NCPD and for the National Family Planning Association of Kenya; (ii) establishment and construction of an additional 14 district Population Offices; (iii) development of a manpower development plan for NCDP staff, and for coordination of training activities throughout the population program; and (iv) development of a national IEC strategy and implementation plan. Population IV sought to further improve NCPD's effectiveness by: (i) developing a national management information system for family planning databases; (ii) establishing district computer facilities; (iii) enhancing research, the evaluation, and staff training.

To *strengthen demand for family planning*, the projects planned to (i) expand IEC activities of four government ministries and six NGOs; and (ii) produce IEC materials for NCPD. Population IV also planned to sponsor income generation activities for women's and men's groups.

To *expand the supply of family planning services*, Population III activities included: (i) establishing 13 MOH facilities for voluntary surgical contraception units (VSCUs); (ii) expanding urban family planning programs through the upgrading of clinics; (iii) expanding service delivery points through the upgrading of 140 clinics and dispensaries; (iv) establishing community-based distribution program; (v) establishing training facilities; (vi) clinic construction and training support for four NGOs. Population IV planned to finance: (i) Provision of vaginal spermicides and injectable contraceptives to supplement contraceptives supplied by donors; (ii) Introduction of Norplant as a method of contraception; (iii) Strengthening of the existing MOH contraceptive logistics system; and (iv) Establishment of systems to monitor the side effects of clinical contraception.

2.5 The mid-term review for both projects took place in 1993, in a context of growing concern about the HIV/AIDS epidemic. The Bank and government agreed not to change the projects' objectives (which would have required Board approval), but instead substantially reallocated resources among activities, reducing infrastructure and increasing allocations for contraceptives, drugs, and supplies—including reallocating $5 million from Population III to help finance drugs for sexually transmitted infections (STIs). While the mid-term review highlighted various implementation problems—including with regard to procurement and financial management—it did not present a clear strategy to overcome them (see below). At the completion of Population III in 1996, several incomplete activities were rolled into Population IV, including completion of construction for the VSCUs, and a $5 million dollar research contract for AIDS care that had been initiated following the mid-term review (see below).

3. Achievement of Development Objectives

3.1 Both projects failed to achieve their development objectives. Although Kenya experienced a continued reduction in fertility rates and increased contraceptive prevalence between 1988 and 1998, these improvements cannot be attributed to the projects. The Bank's earlier population investments and policy dialogue may have contributed to that success, but as noted in the ICR for Population IV, the reduction trend was established by the early 1990s, and few activities had been completed prior to the 1998 Demographic and Health Survey. Many of IDA-financed activities that could have influenced the CPR were either not implemented or

implemented sufficiently poorly that impact was probably very limited. Project disbursements increased beginning in 1996, largely as a result of agreement between MOH and the Bank to hire an independent procurement agent. The departure in 1995 of the original task manager also helped improved relations between the Bank and borrower, which in turn contributed to progress in resolving long-standing implementation issues. The contraceptives and supplies procured during the one-year extension of Population IV will help cover projected government needs for two years. Most reportedly reached service delivery points, but the sheer volume of commodities arriving in a short span of time made it difficult to closely monitor distribution.

Strengthening the Capacity of NCPD

3.2 The projects sought to strengthen the capacity of the NCPD through construction of a new national headquarters and 14 district population offices; developing information management systems; and extensive staff training. The outcome was disappointing. With the exception of staff training, most of the components were not completed. Plans for construction of the national headquarters and district offices were canceled at the mid-term review. Despite spending more than $2 million on overseas training, few staff were retained at NCPD.

3.3 IDA helped establish NCPD in the early 1980s, and together with other donors subsequently financed a significant portion of program and administrative costs. NCPD played an important coordinating and advocacy role with respect to population activities in the 1980s, and attracted a number of skilled and motivated staff. By the early 1990s, however, NCPD had become increasingly involved in implementation, and was perceived by many partners as seeking to expand its own institutional presence rather than serve a coordinating role. In addition, NCPD's unclear relations with its parent ministry—Home Affairs and National Heritage—created a number of problems with regard to program management.[9] In the mid-1990s, it was transferred to the higher-profile Ministry of Planning and National Development, but continues to be plagued by perceptions of ineffectiveness.

3.4 The poor performance is in large part a result of the weak commitment by GoK to NCPD, serious problems and delays with central payment and audit systems, and managerial shortcomings at NCPD. During project implementation, NCPD directors changed regularly, and many senior staff positions were left unoccupied. Staff returning from training often found that their new skills were not being utilized, prompting them to seek employment elsewhere. NCPD management did not have control over some key obstacles to implementation, including long delays in the completion of audit reports by the Auditor General, and consistent delays in the release of funds by their parent ministry. Neither NCPD management nor GoK were proactive, however, in seeking resolution to these bottlenecks. Yet a number of critical project activities that were within NCPD control—such as the development of an IEC strategy—were only completed when UNFPA stepped in with extensive technical assistance.

3.5 Yet IDA shares responsibility for the poor results. IDA's initial largess in funding NCPD, and weak accountability for project funds—including for international training—distorted incentives for staff and the organization (see below). The projects gave NCPD responsibility for financing NGO sub-projects, despite its lack of experience in managing such activities. By initially agreeing to finance construction for a new headquarters and district offices, IDA implicitly endorsed NCPD's planned expansion. Although initial IDA assessments of NCPD management and implementation capacity were positive, IDA staff and management became

9. The Kenya Vice-President in the early 1980s had been a strong advocate for population, and was also Minister of Home Affairs. With his departure, NCPD was left without a high-level "champion," and without a clear rationale for its location within its parent ministry.

increasingly concerned with NCPD performance by the early 1990s. Staff made a number of recommendations to improve of the internal and external constraints to implementation.[10] IDA was not always consistent in its diagnosis of problems, however, or in following up recommendations.[11] While the decision to cancel construction at the mid-term review was justified in light of government budget constraints and the need to refocus NCPD's role, it came only a year after IDA had issued a "no objection" to proceed with construction. Neither IDA nor DfID are planning to channel future project funds through NCPD.

Increasing Availability and Quality of Family Planning Services

3.6 The projects sought to increase access to family planning services through construction of new facilities (including voluntary surgical conception units at district hospitals, and NGO clinics) and procurement sof contraceptives.

3.7 *Contraceptives and supplies:* The major success was the introduction Norplant, with cofinancing from FINIDA. Yet except for procurements (Norplant and vaginal foaming tables) done on an "emergency" basis, the projects did not successfully complete a procurement until 1996. Several bilateral donors were able to secure funds on a emergency basis to cover shortfalls, however. The ICR for Population IV notes that this calls into question whether extensive loan financing was in fact needed. IDA's failure to meet its original commitments, however, contributed to strained relations with donor partners. The tenders completed through the procurement agent during the year of Population IV should help maintain supplies for a number of vital contraceptives through the year 2000. A few items were procured in excessive quantities and may expire before being fully used.[12] The compressed time and large volume made it difficult to review in detail all the items to be procured, and distribution systems were put under pressure by the volume of commodities.[13]

3.8 *Clinic Construction:* The achievements with expanding infrastructure were disappointing. Fewer than half of the 13 voluntary surgical contraception units (nine of which were carried over from Population III) were completed as of 1999, and only four were operational. Because of flaws in design, siting, and construction—as well as low demand for surgical contraception—those that have been completed are underutilized. Of the 21 NGO clinics financed under Population IV, only five were completed at project closing. Chronic delays in processing payments for contractors financially destabilized some of the smaller NGOs. The extension period allowed completion of a number of civil works that would have remained

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10. These included recommendations for NCPD to reduce its role in program implementation, and refocus the role of the Council. IDA staff also sought to address some of the problems brought about by NCPD's location in the Ministry of Home Affairs, including establishing separate accounts for NCPD.

11. A number of supervision reports, and the ICRs for Population III and IV, highlighted the problem of NCPD's location in the Ministry of Home Affairs, but the Mid-term Review stated that "...the main issue is not one of location but of function. The mission recommends against any moves at this time." The ICRs for Population III and IV, however, suggest that the relocation will enhance performance. While concerns regarding NCPD's increased involvement in implementation were valid, IDA and other donors had contributed to giving NCPD increased implementation responsibilities. Furthermore, despite the lack of a manpower plan, IDA continued to finance overseas training until the component was suspended in 1997.

12. Contraceptives procured included vaginal foaming tablets, DepoProvera, injectable Norplant, and condoms. The procurements for condoms and DepoProver represented approximately a one-year supply. The procurements for VFT and Norplant were excessive, however. By the end of 2001, nearly half of the VFTs may expire, up to two-thirds of the Norplant.

13. IDA and the MOH had originally agreed to contract with a local private company for the distribution, rather than the USAID-sponsored Family Planning Logistics Management (FPLM) system. The local contractor was soon overwhelmed as the shipments arrived, and FPLM was asked to assist with distribution. In retrospect, planning and costing for logistics and distribution could have been better incorporated into the initial procurement plans.

unfinished otherwise, and the completed NGO clinics are contributing to improved service access.

Increasing Demand for Family Planning through IEC

3.9 The IEC component of the projects achieved little impact. This is particularly disappointing in light of the importance accorded to IEC in project designs. Under Population III, IEC activities sponsored by NGOs (with ODA financing) may have made a contribution, but the quality and effectiveness varied considerably. IDA-financed intersectoral activities under Population III, and NGO activities under Population IV, made little progress because of persistent problems in accessing project funds and processing payments. Population IV directly financed the development of materials by the IEC unit in NCPD. Some materials were produced, but were not adequately pre-tested or properly evaluated, and the messages often were too general for a country where awareness of contraceptive methods was already high. The Bank's 1993 mid-term review was highly critical in its assessment the NCDP's performance in IEC, and recommended that IEC material production should be tendered out. This was not acted upon by NCPD, however. Although development of an IEC strategy by NCPD was a condition for Population III, this was not completed until 1996 (only after UNFPA provided additional funding).

Developing National Population and Reproductive Health Policies

3.10 The ICR for Population III asserts that despite the "mixed" performance of individual project components, the project—and Bank presence in the population sector in general—contributed to the development of national population and reproductive health policies, and helped to keep population and reproductive health on the government's political agenda. The Bank clearly played a key role (through the First and Second Population Projects) in helping to establish the policy and institutional framework for population activities in Kenya. Interviews with officials from government, donors, and NGOs further suggest that the Bank has helped keep population and reproductive health issues on the agenda of sectoral ministries as well as the ministry of finance. Beginning in the early 1990s, the Bank was active in encouraging the MOH and government to give increased attention to the HIV/AIDS epidemic.[14]

3.11 The original task manager established personal access to the highest political levels in government, and played on these connections extensively during project design and supervision. This approach may have contributed to the political profile of population and reproductive health. But it also created resentment (and even fear) among implementing agencies, and contributed to tensions with donor partners.

3.12 Other donors provided most of the direct support for the development of policy documents.[15] The Population Policy was developed with substantial external technical assistance, particularly from UNFPA. While the resulting document reflected the prevailing international consensus, it did not reflect a consensus within the country. As noted in the Population IV ICR,

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14. The most tangible result of this activity was the approval by IDA of the Sexually Transmitted Infections Project, which provided $40 million for STI drugs and other supplies. Yet project design again did not address fundamental problems of procurement and distribution of commodities. It took over two years to complete the first procurement, and systems to project drug needs, track distribution, and measure impact were inadequate.

15. The government drafted a national population policy during Population III which outlined a multisectoral approach to population, clarified the roles of various organizations (including NCPD), and advocated the introduction of an integrated reproductive health approach to family planning, consistent with the international consensus that emerged following the 1994 conference in Cairo. The Division of Family Health in the Ministry of Health also developed a Reproductive Health Strategy (with financing from DfID).

the Population Policy failed to pass parliament, largely because of opposition by church organizations to reproductive health programs for adolescents. The Policy has since been substantially modified, and resubmitted to Parliament. Many members of the reproductive health community believe that NCPD and government have become sufficiently wary of controversy, however, that their ability to exercise leadership on reproductive health issues has diminished. These problems illustrate the key weakness to the policy approach taken by the Bank and some other donors—too much focus on developing documents, strengthening central policy agencies, or dialogue with senior officials, and not enough on helping to foster the coalitions necessary for implementing policy change.

4. Supervision and Implementation Experience

4.1 Project supervision and implementation through 1995 was deficient. As of the 1993 mid-term review, the projects were three years behind schedule, and had only disbursed $1.3 million. Despite restructuring following the mid-term review in 1993, progress was limited until departure in 1995 of the original task manager.[16] Project supervision improved subsequently, as IDA and the MOH improved relations and began to more proactively address problems. Regional Bank management also changed in 1996, and a new task team was brought in 1997, just before the approval of the Population IV extension. The decision to hire an independent procurement agent in 1996 led to rapid disbursement just before the close of each project. Population III disbursed $4.5 million in the last four months of the credit (for STI/HIV drugs and supplies) and Population IV disbursed $19.1 million in the final three quarters of the credit extension.

4.2 The initial poor performance partly reflected weaknesses in government commitment, capacity, and governance. Yet Bank supervision both neglected and exacerbated the problems. The style and performance of the original task manager had much to do with this. The original task manager focussed on using the political system to increase attention to population issues, while giving limited attention the details of project implementation, field supervision, or Bank rules and regulations. This approach was successful in terms of designing and approving projects—consistent with the Bank's own incentive system—but failed at the implementation stage. Because of the original task manager's high level political connections, even senior officials in the MOH were afraid to challenge his decisions or performance. Furthermore, this approach to supervision reinforced some of the major weaknesses of the Kenya system—including excessive concentration of decision-making at senior levels, poor communication among different government agencies, and a lack of accountability and transparency for expenditures. Despite growing disbursement lags and other implementation problems,[17] supervision reports continued to rate project progress as "satisfactory," and progress toward development objectives as "highly satisfactory," through 1994, because of progress in sector-wide indicators. Bank Management was also complicit in not exercising effective oversight, and in not taking stronger steps earlier when problems with the original task manager became evident.[18]

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16. The implementation specialist that formally took over as task manager in 1992 gave increased attention to implementation problems, but was constrained by the continued presence of the original task manager on the project team.

17. Internal correspondence suggest that by 1994, the task team and manager were under pressure from Bank regional management as a result of significant disbursement lags in both projects.

18. Donor partners expressed concern to Bank management regarding the "operating style" of the task manager as early as 1990. Formal responsibility for task management was transferred to a junior staff member in 1992, but the original task manager continued to retain significant control over major project decisions until his departure from the World

4.3 Following the original task manager's departure, subsequent task managers began to improve relations with the MOH and to make progress in addressing various problems that had plagued project implementation. Changes in leadership at the MOH also helped strengthen borrower resolve to address problems and improve accountability. Resident mission staff became more involved in project supervision following the mid-term review, and played an increasingly important role in addressing project implementation problems. Although initially reluctant to grant an extension to Population IV, the initiative shown by the MOH in the year prior to the extension were sufficient to convince Bank management to approve a one-year extension. The Borrower's ICR points with pride to the rapid progress in this short time, which exceeded disbursements for any previous project in Kenya.

4.4 The decision to extend Population IV was appropriate, and regional management and task team members did a commendable job of seeking to address long-standing implementation issues. Yet as information subsequently came to light regarding the Bank's shared responsibility for several of the major problems (including the overpayment of student stipends, and the approval of a single-source contract for AIDS research—see below), regional management indicated limited interest in further investigations or follow up. As such, the Bank's role in project shortcomings were not properly discussed with or acknowledged to the Borrower.

Audits

4.5 Audit reports for both projects were submitted on average two years late, and the majority were qualified, sometimes extensively. Poor audit performance was the result of extremely poor record keeping by MOH, limited accounting experience by NGOs, backlogs at the Auditor General's office, and general low priority accorded by MOH or GoK. Yet the Bank neither assessed financial management systems of MOH, NCPD, or NGOs, nor provided assistance in strengthening financial management, until the final years of the projects. During the early 1990s, IDA and ODA repeatedly threatened to suspend disbursements to provoke action. But IDA did not carry through, losing credibility and straining relations with ODA.[19] Furthermore, Bank management presented Population IV to the Board despite outstanding audits from Population II and III, in violation of Bank regulations. The became increasingly engaged in trying to address the systemic weaknesses in the GOK auditing system beginning in the mid-1990s, but progress has been slow.

Financial Management

4.6 Chronic delays in accessing project funds and processing payments to suppliers, contractors, and NGOs undermined nearly every aspect of project implementation. The government's payment system was highly centralized, and financial management in the MOH was extremely poor. Mulitiple stages for approvals contributed to delays and increased opportunities for rent-seeking. In addition, implementing agencies initially were expected to incur expenses and then claim reimbursement from the project. Yet fiscal crisis and rigid budget

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Bank in 1995. Despite evident problems in Population III and IV, the original task manager was given responsibility for designing several new projects, including STI projects in Kenya and Uganda. Regional management deserves credit for taking steps that led to the former task manager's retirement from the Bank in 1995, but the situation should have been addressed more forcefully earlier.

19. In 1992, IDA and ODA jointly agreed to suspend disbursements if audits were not forthcoming. ODA carried through, suspending Population III disbursements for nine months, but Bank management ignored the earlier commitment and continued disbursements—apparently because of pressures in the Bank's Africa Region to maintain disbursement levels. The ODA project completion report for Population III expressed strong concern about IDA's weak enforcement of audit compliance.

ceilings imposed by the Ministry of Finance in the early 1990s meant that funds were often not available. IDA initially did not assess the payment system during project design, or provide technical assistance to strengthening financial management. Although the Bank introduced a special account for the projects in 1991, the MOH made limited use of it initially due to a lack of experience. Although payment problems persist, increased attention to financial management by IDA and MOH leadership from the mid-1990s led to improved use of the special account and more rapid payment processing.

Civil Works

4.7 Civil works under the projects were plagued by inadequate design and siting; weak supervision by the Ministry of Public Works, MOH, and IDA; and chronic delays in payments to contractors, which led to many abandoning sites for extended periods. With the possible exception of some of the NGO clinics, the impact of civil works has been limited. OED concurs with the conclusion of the ICR for Population IV that IDA should limit future financing of civil works.

- *NCPD Headquarters and District Offices*: These constituted the largest planned civil works expenditure under the two projects, but were cancelled following the mid-term review. The planned construction was difficult to justify given the expense, bottlenecks at the programmatic level, and the government's poor record in implementation of civil works. Yet IDA gave a "no objections" to proceed with construction in 1992, then cancelled the civil works at the mid-term review in 1993. NCPD strongly opposed the cancellation, and remains bitter about the decision. This undermined dialogue on other components.

- *NGO Clinics:* Under Population IV, four NGOs[20] received IDA financing through NCPD for the completion of civil works, including 21 clinics. Late payments by GoK led to extensive delays and financial hardship and legal difficulties for NGOs, as they were either forced to find funds from other programs to proceed with construction, or were faced with litigation from contractors for non-payment. In addition, some communities had difficulty raising the required counterpart funds, delaying implementation. As noted earlier, five clinics were completed and operational at project closing, with the completion rates for others averaging about 85 percent. Those that are completed have helped increased access to services, but for the smaller NGOs in particular, the costs may have outweighed the benefits.

- *VSCUs:* Voluntary Surgical Contraceptives Units were to have been constructed at 14 district hospitals, which were carried over from Population II. Because of payment delays, low MOH ownership, and limited field supervision by IDA, civil works contracts had stopped for at least three years after the mid-term review. IDA was apparently unaware of the stoppage until the ICR mission for Population III, which found that only five had become operational. IDA and the MOH agreed that the remainder would be completed under Population IV, but only half were operational at the time of the ICR mission. Because of design flaws, inadequate siting, and limited demand for surgical contraception, even the completed facilities are under utilized.

20. The NGOs receiving IDA support for clinic construction were the Family Planning Association of Kenya (FPAK), Crescent Medical Aid Society of Kenya, Kenya Catholic Secretariat, and Seventh Day Adventist Church.

Procurement

4.8 The bulk of Population IV project funds were devoted to contraceptives, and following the mid-term review, IDA and the government agreed to reallocate $4.5 million from Population III for procurement of STI drugs and supplies. Yet except for procurements done on an "emergency" basis (Norplant and vaginal foaming tables), the projects did not successfully complete a procurement until after the hiring a procurement agent in 1996. The repeated delays or cancellation of IDA-financed procurements became a major source of tension with other donors, who had counted on IDA-financing in their own programs, and had repeatedly raised concerns about limited procurement capacity in the MOH and bottlenecks in the IDA procurement processes.[21]

4.9 The MOH had limited skills and experience with procurement, took a long time to prepare bidding documents, and did not consistently follow IDA guidelines in awarding contracts. An additional factor in the delays was that a local manufactures' agent used IDA grievance procedures to aggressively challenge unsuccessful bids, which resulted in cancellation by IDA and re-tendering of several major procurements.[22] A 1996 independent procurement audit report was highly critical of MOH financial management, contract administration, and procurement practices, as well as the limited interest shown by MOH management in strengthening performance in these areas. Yet the report was also critical of the Bank's role.[23] The review found that IDA population project design documents did not address procurement risks or implementing agency capacity, provided little guidance for planning procurement, and included no provisions for technical assistance. The review also found that until the departure of the original task manager in 1995, IDA supervision missions gave limited attention to procurement issues, and "no objections" were regularly issued on basis of inadequate evidence.[24] IDA subsequently took a number of steps to strengthen procurement oversight and project supervision in response to the report, some of which had been initiated prior to the review. Yet although the stated purpose of the report was to improve dialogue with borrower governments on procurement issues, it was not released, and the findings were not adequately discussed with MOH officials.[25]

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21. In 1995, USAID, UNFPA, and ODA took the unusual step of writing a joint letter to implore Bank management to end the impasse in Bank procurements, through hiring an external procurement agent. This was agreed to a year later, after the hiring of a procurement agent was made a condition of approval for the 1995 Sexually Transmitted Infections Project.

22. The MOH had extremely negative experiences with this particular agent, and actively sought to disqualify his bids, sometimes by inconsistent application of approval guidelines. A 1996 Bank-sponsored procurement review found that MOH had acted improperly in its efforts to exclude the agent (SGS Societe Generale de Surveilliance S.A., "World Bank Procurement Audit in Kenya: Main Report. 1996"). This situation might have been avoided, however, if MOH had sought advice, or IDA had provided guidance, as to how to properly factor in poor supplier performance in bid evaluations.

23. SGS Societe Generale de Surveilliance S.A., "World Bank Procurement Audit in Kenya: Main Report. 1996. The report was one of four country reports on procurement commissioned by World Bank senior management. The report found several problems, as well as numerous irregularities in the procurement and bidding process. Yet it was highly critical of IDA performance. "The Bank adjusted late and slowly to what was an obvious system failure in the procurement performance under all three health projects."

24. "The quality of Bank supervision of procurement issues appeared to have been very dependent on the inclination of the project's task manager. In the case of both Population projects, a change of task manager in 1995 led to a noticeable increase in the attention paid to procurement performance. Prior to the change, procurement-related issues hardly featured in supervision reports." The audit's executive summary also states: "With regard to the health projects there was pervading sense of unethical behavior. The audit came across a number of examples of Bank internal memos, Bank correspondence with implementing agencies, internal implementing agency memos and other supposedly confidential information being in the hands of third parties." SGS Societe Generale de Surveilliance S.A, 1996.

25. One of the Regional Managers responsible for the project at this time stated that the SGS report was not released because the findings went beyond the available evidence, and the auditors had not adequately interviewed relevant staff. Not all Bank staff familiar with the audit agreed with this assertion, however.

4.10 The hiring of an independent procurement agent significantly facilitated the procurement process. Yet the procurement agent was not a panacea. The $4.5 million in STI/HIV drugs and supplies purchased with the remainder of Population III funds in 1996 languished at the port in Mombassa for nearly a year because neither IDA or GoK had adequately allocated funds to pay suppliers or port fees. IDA and GoK subsequently agreed to use Letters of Credit for major IDA procurements to reduce such problems in the future. The tenders completed through the procurement agent during the 1-year project extension should help sustain supplies of critical contraceptives through the year 2000. As noted earlier, distribution problems were not sufficiently anticipated during these final procurements, and several items were procured in excessive quantities. The forthcoming District AIDS and Reproductive Health Project, however, includes increased provisions for logistics, including forecasting and distribution.

4.11 Although capacity building was part of the terms of reference for the procurement agent, there has been limited skills transfer to MOH or General Medical Stores staff. This was in part because MOH seconded junior staff to work with the agent, and in part because the emphasis was on disbursement, not capacity building. Past experience suggests that the MOH still is not well-equipped to handle large procurements. The government has recently established the Kenya General Medical Supplies as an agency under a independent board of directors, however. If strong management sustained and political interference limited, this agency could develop capacity for procurement and logistics.

Training

4.12 Population III and IV together invested over $2 million USD in training nearly 80 persons from MOH and NCPD. Most trainees were from NCPD's central office, and contrary to project design, about 80 percent attended 1-4 years overseas degree programs.[26] Non-transparent selection of trainees and poor utilization of trained staff resulted in only seven individuals trained were still employed by NCPD at the conclusion of Population IV. While the development of a national manpower development plan was supposed to help rationalize trainee expenditures within NCPD and the population sector overall, NCPD did not develop the plan. Yet the Bank regularly issued "no objections" for training based on limited justification.[27] Although supervision reports noted that many NCPD staff seemed focussed mostly on securing overseas training so that they could advance to positions outside the organization, the Bank's lax approach to financing training contributed to distorted staff incentives. NCPD staff state that the goal of the training program was to increase overall capacity in the sector, and that it was anticipated that many participants would return to other organizations. Most in fact have returned to Kenya, and many are working for other family planning or reproductive health organizations. Yet the cost clearly outweighs the apparent impact.

4.13 The training component was canceled in 1997 following the discovery that several overseas students had submitted falsified subsistence expense claims.[28] Following the cancellation, however, NCPD produced evidence (missing from IDA project files) that the

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26. ODA/DfID provided an additional $0.7 million for training and other capacity building activities under Population III.

27. Following the mid-term review, staff at the resident mission became more involved in reviewing requests for training, which helped strengthen oversight. Headquarters staff, however, continued to issue approvals for training with limited scrutiny until the mid-1990s. After 1995, training requests were more closely monitored.

28. This discovery led to audits by the Kenya Auditor General as well as an independent auditor. The audits took place at a time of heightened pressure on the government by the Bank to demonstrate resolve against corruption. NCPD staff report that the Auditor General and the IDA-sponsored independent auditor carried out their investigations with a presumption of guilt on the part of NCPD and the students, and without fully informing them of the charges against them. Despite evident problems in the training program, greater attention should have been to due process.

previous Bank task manager had authorized the subsistence allowances well in excess of IDA and GOK guidelines.[29] IDA did not reverse the cancellation (it was too late to do so), but also did not sufficiently acknowledge to NCPD that IDA staff were in part responsible for the situation.

Monitoring, Evaluation, and Research

4.14 The project design document for Population III contained various plans for monitoring and evaluation, including independent assessments of each projects sub-components in the second and fourth years of implementation. Except for a few ad hoc studies with apparently little follow-up, these plans were not implemented. Population IV allocated $1.5 million for various research activities, including research on reproductive health through the Institute of Primate Research. This component was weakly supervised by IDA and NCPD, and while some research was conducted, the operational and policy relevance is unclear.

4.15 One of the more disturbing aspect of the projects was the decision, following the mid-term review, to award a $5 million single-source joint contract to Moi University and Johns Hopkins University for research on AIDS care. The decision to fund the universities was apparently negotiated at a senior political level and signed by the Permanent Secretary; no other staff at MOH, NCPD, or the Bank's resident mission were consulted. Most strikingly, the component had already disbursed nearly US$1 million before it was submitted for approval through normal IDA procedures, and before staff at the World Bank Resident Mission were aware of it. This contract raised a number of concerns, and was the subject of two independent audits in 1996.[30] While no wrongdoing was determined on the part of the universities, the relevance of the research remained uncertain. The balance was initially rolled into Population IV, and then cancelled.

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29. In the early 1990s, the task manager sent an email to the project officer in the MOH insisting that the subsistence allowances for a particular graduate student were entirely inadequate, and should be increased to US$30,000 per annum. NCPD responded that they should not make an exception for a single student, and reached an agreement with the task manager that all graduate students trained through the projects would receive $30,000 annually, while undergraduates would receive $15,000. IDA guidelines require, however, that subsistence allowances are based on university guidelines, which were half or less of the approved amounts. When the subsequent task manager—who was unaware of the earlier "no objection"—queried the amount of claims, several students submitted falsified documents suggesting that University guidelines were the same as what they had been previously receiving. In the course of subsequent audits, NCPD produced a copy of the earlier "no objection" from the original task manager.

30. On September 20, 1994 the MOH sent a request to the IDA for $9.8 million to support a home care project for HIV/AIDS sufferers, jointly implemented by Moi University and Johns Hopkins University. Bank management agreed to allocate approximately $0.5 million for start-up costs. On September 26, 1994, the "former" task manager "accidentally" sent a draft fax issuing a "no objection" to allocate $5 million from the Population projects for this activity. Because it was a draft, no other parties were copied. The next day, the correct fax was issued, with copies provided to relevant officers, but MOH subsequently claimed not to have received the second fax. The original project proposal included limited detail on implementation arrangements, and although the project component was to have submitted financial statements to the MOH and the resident mission, no such statements had been prepared a year later. The SGS procurement audit included an extensive review of this contract, stating that: " It is not clear that expenditure items presently being funded under the Moi/Hopkins project legitimately fall under the project... Examples of questionable project-financed items include the medical expenses of relatives of staff... and salary support for the Dean of Moi University." Although a new project proposal was prepared following the audit, and supervision was subsequently tightened, the decision to cancel was clearly justified.

5. Ratings

Outcome

5.1 Coincidence between the project implementation period and improvements in sector indicators -- such as declining fertility during Population III and IV—does not justify a satisfactory rating. For both these projects, OED agrees with the ICR finding that outcomes for both projects were unsatisfactory overall. Project implementation for Population IV was highly unsatisfactory until 1995. While recognizing improvements in the last years, these were not sufficient to mitigate earlier lapses in performance. Both the Bank team and the borrower deserve credit for subsequently resolving bottlenecks that had constrained implementation. Yet disbursing nearly half the project's funds in the final year before closing does not represent an unambiguous success. The pressure to spend such large quantities of money in such a short time sends a mixed signal regarding efficiency and effectiveness in the use of scarce loan funds.

Institutional Development

5.2 Institutional development in both the NCPD and Ministry of Health were negligible. Despite massive investments in overseas training for NCPD staff from both Population III and IV, few of the staff were retained. Although trainees may have made some contribution to the sector overall, the impact does not justify the cost. The Bank paid little attention to institutional issues during project supervision, and despite regular complains regarding "lack of capacity" during supervision reports, did not develop a consistent strategy to address capacity constraints. Although subsequent decision to use an procurement agent was appropriate as a short-term measure, it has not contributed to strengthening borrower systems.

Sustainability

5.3 Sustainability for Population III and IV is considered unlikely because of the weak contribution to institutional capacity, continued financial constraints on the government, and continued dependence of the Kenya health sector on external donor support. Future sustainability will depend on increased attention to sector financing and reform, as well as overall economic performance. The increased reliance of the Bank and other donors on parallel implementation arrangements also concerns for long-term sustainability. Reduced reliance on such arrangements will require concerted efforts by GoK to strengthen accountability systems within the health sector and nationally.

Bank Performance

5.4 Bank performance was unsatisfactory overall, and highly unsatisfactory until the departure of the original task manager. OED is sufficiently concerned about Bank performance through 1995, that a highly unsatisfactory rating could be justified. But OED also wishes to clearly acknowledge the efforts by the subsequent teams—both in Washington and at the Resident Mission—to rectify problems that they inherited, improve relations with the borrower, and to try to achieve some development impact.

Borrower Performance

5.5 Borrower performance was unsatisfactory overall for both projects, but with notable improvements in the final year or two. This coincided with leadership changes in the MOH, and improved supervision by IDA. The current MOH leadership has signaled a stronger commitment to accountability and development effectiveness in the future. The challenge for the future will be to sustain high levels of efforts on both sides throughout the life of a project or program.

6. Issues and Lessons

6.1 From the late-1970s and early 1980s, the international population and development community has devoted substantial resources toward establishing and strengthening the Kenya population program. While the Bank played a key and influential role through the 1980s, it incurred substantial damage to its reputation—both within Kenya and in the population community internationally—as a result of poor supervision and lax accountability for these projects through 1995. The subsequent teams have made significant progress in repairing the Bank's reputation and relations with partners. While MOH officials are positive about current relations, overcoming donor skepticism regarding the Bank's seriousness with regard to development effectiveness and accountability has been more difficult.[31]

6.2 Many of the "lessons" cited in the ICRs for Population III and IV are really issues of accountability, not lesson learning. It should not require two projects with a total investment cost of $47 million—money that the borrower must repay—for the Bank to "learn" that a new project should not be designed without addressing fundamental deficiencies in the previous project; that borrower capacity, management, procurement, and accountability systems should be properly assessed; or that field visits are necessary for effective supervision. Yet to extent that MOH and IDA eventually began to make progress in resolving long-standing sectoral problems, the ICRs' contention that the projects represented a "learning process" is valid. The project experience also suggests the following lessons.

Accountability Begins at Home

6.3 The project experience prior to 1996 illustrates numerous breakdowns in the Bank's own control and accountability systems, including failures by the original task manager and Bank management to enforce Bank operating procedures and minimal standards of accountability for project funds. While IDA's current emphasis on improving governance in Kenya is appropriate, its credibility requires maintaining similar, if not higher, standards for its own staff and operations.

"Cleaning up" Problem Projects

6.4 Subsequent task teams and management deserve credit for taking steps to address long-standing implementation problems. Through more extensive use of staff at the Resident Mission, the Bank was able to strengthen supervision without increasing expenditures. Relations between the Bank and MOH improved significantly in the final years of the projects—a point that is

31. For example, during OED-sponsored workshop on the pharmaceutical procurement in Nairobi in June 1999, a number of donors expressed concern that the Bank continued to focus excessively on project approval and disbursements, and did not give sufficient attention to the efficient use of funds.

emphasized with appreciation by MOH officials. In addition, although serious systemic problems still persist within the MOH, MOH staff and management showed they were capable of responding to a combination of performance targets and more proactive Bank supervision. As such, while not sufficient to alter an unsatisfactory rating, the joint efforts created a basis for future cooperation. Yet the rush to spend over half of the Population IV credit in just one year sent a mixed signal regarding the use of scarce loan resources, and the priority of development impact versus disbursement—and should not be seen as a precedent for future projects.

Implementing Projects in a Weak Governance Context

6.5 Governance problems in Kenya are widely acknowledged, and government implementation of these projects suggests numerous and sometimes serious shortcomings with transparency and accountability. Yet governance problems are not unique to Kenya. The country has many trained and skilled professionals, and while terms of service in government are poor, OED was impressed by the dedication and competence of many of the staff interviewed. The MOH currently has a strong management team in place that wants improve the Ministry's reputation. When central government and implementing agencies show little commitment to addressing fundamental governance problems, sectoral programs will be affected, and IDA should consider not lending. Yet while many of the systemic governance problems will require high-level political commitment to address, there may be scope for improving managerial and accountability systems at the sectoral level, and to some extent centrally.

6.6 As IDA goes forward with the District AIDS and Reproductive Health Project, several lessons from Population III and IV may be applicable. First, the source of weaknesses in capacity or governance should be clearly diagnosed, and appropriate remedies negotiated. The decision to include financial management and procurement assessments as part of project appraisal, for example, is an important step. Second, IDA and the borrower should agree on clear performance targets, both in terms of the progress toward development objectives and accountability systems. Conditions should be minimal, but should be closely monitored and nforced. Third, supervision needs to be proactive, and involve both headquarters and resident mission staff. Where necessary, bottlenecks involving central processes need to be raised at a high level, with IDA potentially playing a facilitating role in programming solutions between central and sector ministries. Finally, IDA needs to balance the use of parallel or independent implementing agencies that facilitate project implementation with efforts to strengthen the borrower systems. The recent steps to make the Kenya General Medical Stores autonomous will be an important challenge in this regard.

Annex A

BASIC DATA SHEET

KENYA—THIRD POPULATION PROJECT (CREDIT 1904-KE)

Key Project Data

	Appraisal estimate	*Actual or current estimate*	*Actual as % of Appraisal estimate*
Total project costs (US$)	28.3	21.5	76
Credit amount (US$)		12.9	
Cancellation (US$)		26.0	
Date physical components completed: June 30, 1998			

Cumulative Estimated and Actual Disbursements *(US$ million)*

	FY89	*FY90*	*FY91*	*FY92*	*FY93*	*FY94*	*FY95*	*FY96*	*FY97*
Appraisal estimate	0.2	1.3	3.4	5.8	8.0	10.0	11.5	12.2	12.2
Actual	0	1.0	2.9	3.1	3.4	4.9	7.3	10.6	12.6
Actual as % of estimate	0	75	84	53	42	49	63	89	103
Date of final disbursement: December 2, 1996									

Project Dates

Steps in project cycle	*Original*	*Actual*
Identification/Preparation	September 23, 1985	September 23, 1985
Pre-appraisal	June 30, 1986	February 16, 1987
Appraisal	September 30, 1986	August 31, 1987
Negotiations	March 31, 1987	March 14, 1988
Board presentation	June 1, 1987	May 10, 1988
Signing	June 15, 1987	October 24, 1988
Effectiveness	July 1, 1987	January 31, 1989
Midterm Review	December 31, 1990	August 27, 1993
Project Completion	June 30, 1996	June 30, 1996
Credit closing	October 31, 1996	December 9, 1996

Staff Inputs (staff weeks)

Stage of project cycle	*Actual*	
	Weeks	US$
Preparation to Appraisal	44	66,006
Appraisal	69	114,323
Negotiations through Board Approval	92	176,879
Supervision	105	201,551
Completion	45	72,200
Total	355	650,959

Annex A

Other Project Data

Borrower/Executing Agency:

Related Bank Credits

Credit title	*Credit*	*Purpose*	*Year of approval*	*Status*
Preceding Operations				
First Population		Significantly reduce the population growth rate.	1974	Closed
Second Population		Reduce fertility and improve the accessibility and quality of rural health services.	1983	Closed
Following Operations				
Fourth Population		Increase the availability, accessibility, quality of family planning; strengthen the demand for family planning services through IEC activities; and strengthen the capacity of NCPD.	1990	On-Going
Health Rehabilitation		Support the government's reform of the health sector by: a. rehabilitating Kenyatta National Hospital to reduce its burden on the overall budget and permit an increase in expenditure on preventive and primary health; b. improving delivery of health services in the Nairobi area; c. preparing for future policy and managerial reform; and d. support the development of a National Household Welfare Monitoring and Evaluation System.	1991	On-Going
Sexually Transmitted Infections		a. strengthen the institutional capacity at the national and district levels to design, implement, monitor and evaluate interventions; b. promote preventive measures to reduce the risks of STI transmission; and c. enhance both health sector and community provision of physical and psychological care and develop strategies to mitigate the socioeconomic consequences of STI/HIV.	1995	On-Going

Annex A

KENYA—FOURTH POPULATION PROJECT (CREDIT 2110-KE)

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

	Appraisal Estimate	*Actual or current estimate*	*Actual as % of Appraisal estimate*
Total project costs	35.8	33.1	92.5
Credit amount	35.0	28.9	82.6
Cancellation (US$)		7.05	
Date physical components completed: June 30, 1996			

Estimated and Actual Disbursements

FISCAL YEAR	QUARTER	*SAR Estimates (US$M)*		*Actual (US$M)*		*Actual Cumulative as % of Credit*
		Quarterly	*Cumul.*	*Quarterly*	*Cumul.*	
1991	Q1	0.50	0.50	00.0	00.0	0.0
	Q2	0.50	1.00	00.0	00.0	0.0
	Q3	0.50	1.50	00.0	00.0	0.0
	Q4	0.50	2.00	00.0	00.0	0.0
1992	Q1	0.69	2.69	0.55	0.55	1.6
	Q2	0.69	3.38	2.50	3.05	8.7
	Q3	0.98	4.36	0.33	3.30	9.4
	Q4	0.98	5.34	0.67	4.05	11.6
1993	Q1	1.17	6.51	0.28	4.33	12.4
	Q2	1.17	7.68	0.43	4.76	13.6
	Q3	1.32	9.00	0.00	4.76	13.6
	Q4	1.32	10.32	0.24	5.00	14.3
1994	Q1	1.62	11.94	0.13	5.13	14.7
	Q2	1.62	13.56	0.04	5.17	14.8
	Q3	1.49	15.05	0.02	5.19	14.8
	Q4	1.49	16.54	0.00	5.19	14.8
1995	Q1	2.15	18.69	0.00	5.19	14.8
	Q2	2.15	20.84	0.53	5.72	16.3
	Q3	1.57	22.41	0.00	5.72	16.3
	Q4	1.57	23.98	0.00	5.72	16.3
1996	Q1	1.56	25.54	0.79	6.51	18.6
	Q2	1.56	27.10	1.10	7.61	21.7
	Q3	1.41	28.51	0.24	7.85	22.4
	Q4	1.41	29.92	0.45	8.30	23.7
1997	Q1	1.41	31.33	1.13	9.43	26.9
	Q2	1.41	32.74	0.25	9.68	27.7
	Q3	1.13	33.87	0.28	9.96	28.5
	Q4	1.13	35.00	0.66	10.62	30.3
1998	Q1			0.41	11.03	31.5
	Q2			0.09	11.12	31.8
	Q3			0.00	11.12	31.8
	Q4			5.48	16.60	47.4
1999	Q1			8.84	25.44	72.7
	Q2			4.80	28.88	82.5

Annex A

Project Dates

	Original	*Actual*
Identification	---	1988
Preparation	April 1989	April 1989
Appraisal	October 1989	October 1989
Negotiations	February 1990	February 1990
Board Presentation	May 1990	March 27, 1990
Signing	May 1990	May 21, 1990
Effectiveness	August 20, 1990	September 25, 1990
Mid-Term Review	December 1992	August 1993
Project Completion	December 31, 1996	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	26.6	53.6
Appraisal	N/P	N/P	N/P	N/P	16.9	35.0
Negotiations through Board Approval	N/P	N/P	N/P	N/P	8.4	19.2
Supervision[a]	134.1	273.8	176.9	313.8	187.0	309.6
Completion	17.0	20.0	18.7	21.5	15.9	18.7
Total	N/P	N/P	N/P	N/P	254.8	436.1

Source: FACT Cost Report run on February 10, 1999

a. Assumes FY1986–FY1995 actual expenditures were equal to planned (and revised planned). The World Bank Information System did not retain the "planned" figures for those years.

Annex A

Mission Data

Stage of project cycle	Date (mm/yr.)	No. of persons	Duration of mission (# of days)	Specialized staff skills represented[a]	Performance rating		Types of problems
					Implement. Status	Develop. Objectives	
Identification	1988			b/			
Preparation				b/			
Appraisal				b/			
Supervision	10/1990	3	12	PS, A, IECS	1	1	Insufficient budgetary allocation from GOK. Delay in meeting conditions of disbursement. Little preparation by NCPD and NGOs for project effectiveness.
	3/91	3	8	PHS, PS, A	1	1	Failure of borrower to comply with IDA procurement procedures.
	9/91	3	11	PHS, PS, A	2	1	Failure of borrower to comply with IDA procurement procedures. Slow operating procedures in NCPD. Late audits.
	1/92	2	11	PHS, PS	2	1	IEC workplan not prepared. Procurement delays. Delayed disbursements to NGOs.
	2/93	4	11	PS, O, A, PHS	2	1	Insufficient GOK budget allocation. Slow reporting by NCPD. Slow implementation. Inability of NGOs to access funds.
Mid-Term Review	8/1993	10	18	PHS, O, IECS, PS, A, DR	2	1	Unsatisfactory compliance with legal covenants. Delays in release of funds and payments. Procurement delays. Implementation delays.
Supervision	3/94	4	10	PHS, O, IECS, DR	2	1	Slow disbursements. Delays in NGO activities.
	9/94	4	11	PHS, FPS, PS	U	HS	Delays in finalizing IEC Strategy. Delays in release of commodities from Port of Entry. No progress on implementation of income generating activities. Procurement delays.
	2/95	3	19	PHS, O	U	HS	Disbursement delays. Civil Works delays. Delay in disbursements to NGOs.
	10/95	7	12	O, PHS, DR	U	S	Delay in selection of procurement agent. Failure to comply with IDA procurement guidelines. Overdue audits. Insufficient GOK budget allocation. Little progress on IEC, income generating activities, and procurement. Civil works delays due to slow payment by Treasury.
	9/96	6	18	O, A, FM, P	U	S	Overdue audits. Delayed civil works.
	2/97	7	17	O, A, A, HDE, HS, E	U	S	Funding gap unless project extended. Possible misuse of funds under Moi-Hopkins contract. Civil works delays.
	6/97	3	7	HDe, o	U	U	Extension issues.
	9/97	9	15	PHS, E, O, A	U	U	Civil works delays. Outstanding audit qualifications. Suspension of disbursements.
Completion	12/98	4	8	O, P, FM	U	U	Unfinished civil works. Poor financial management and slow payment process. Outstanding audit qualifications. Inability to process some final disbursements.

a. AC = Accountant; Ar = Architect; DR = Donor Representatives; FPS = Family Planning Specialist; FM = Financial Management; HDE = HD EconomistIECS = IEC Specialist; O = Operations; P = Procurement; PS = Population Specialist; PHS = Public Health Specialist.
b. Aide-Memoire missing from files/archives.

Annex A

Other Project Data

Borrower/Executing Agency: Government of Pakistan and Government of Punjab

Related Bank Credits

Credit title	*Purpose*	*Year of approval*	*Status*
Preceding operations			
First Population Project (US$12.0 million)	The project objective was to significantly reduce the population growth rate.	1974	Closed
Second Population Project (US$23.0 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 NCPD: (i) 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
Health Rehabilitation Project (US$31.0 million)	The project objectives were: (i) support the GOK's program of health sector reform by: (a) rehabilitating Kenyatta National Hospital; (b) improving health service delivery in the Nairobi area; and (c) preparing for future policy, managerial, and investment reform in health; and (ii) to support the development of a National Household Welfare Monitoring System.	1991	Closed June 1998
Following Operations			
Sexually Transmitted Infections Project (US$40.0 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 onsequences of STI/HIV.	1995	On-Going Closing Decemb er 2000
Planned Operations			
Health Sector Reform Project	An APL which will support the Government of Kenya in implementing its Health Sector Reform Program which focuses on (i) equitable allocation of government resources; (ii) increasedd cost effectiveness of resource allocation; (iii) continued management of population growth; (iv) enhanced regulatory role of the government; (v) increased private sector and community involvement in the health sector, and (vi) increased and diversified per capita flows to the health sector.	Planned 2000	

Annex B

Comments from the Borrower

MINISTRY OF FINANCE AND PLANNING
NATIONAL COUNCIL FOR POPULATION AND DEVELOPMENT

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Telephone: Nairobi 711600
Fax: 718308
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Ref. No. NCPD 18/3 VOL IX(19)

CHANCERY BUILDING
VALLEY ROAD
P.O. Box 48994
NAIROBI

.9th June, 2000.. 20.....

Mr. Ridley Nelson
Acting Manager
Sector and Thematic Evaluation Group
Operations Evaluation Department
The World Bank

Fax: (202) 522 3123

Dear Mr. Nelson

RE: KENYA THIRD AND FOURTH POPULATION PROJECTS (CREDIT 1904 AND 2110 – KE): DRAFT PERFOMANCE AUDIT REPORT

Your letter of 17th May 2000 on the above subject refers.

We have reviewed the draft report and wish to compliment the authors for their balance and objectivity. Obviously the document makes for very depressing reading but we feel it nevertheless reflects the realities of the events, actions and shortcomings on the ground.

Having acknowledged the general balance of the document, we wish to record our reservations on one or two observations/conclusions that may be somewhat incorrect.

Annex B

The correct position on paragraph 3.12 sentences 1 and 2 is that UNFPA provided substantial financial and not technical assistance in the development of the Population Policy document. Furthermore the allusion in sentence 6 that ..."NCPD and government have became sufficiently wary of controversy, that their ability to exercise leadership on reproductive health issues has diminished" is, in our opinion, rather misleading. It may be that what is being noted is the mirror image of the donor shift during this period from population/reproductive health issues to governance issues. Otherwise, other than the sensible need to move cautiously on some sexuality issues to avoid unnecessary cultural frictions (thus hurting the population programme), there has been no overt government decision to avoid controversy. Indeed the current membership of the NCPD Council, with Dr. Khama Rogo, former outspoken Chairman of the Kenya Medical Association as Chairman, is too representative of the broad spectrum of opinion in the population programme to be cowed or silenced easily. It is our submission therefore, that our efforts to build consensus at every step may have been misunderstood.

With regard to the IEC component, we concur that little was achieved since the conditionality for implementation of this component - the IEC Strategy - was accomplished late in the project cycle. However, the contention in paragraph 3.9 sentances 7 and 8 to the effect that NCPD did not act on the 1993 Mid-term review recommendation that IEC material production be tendered out is not totally correct. It is on record that at around this time NCPD commissioned African Centre for Communication and Development (ACCD) to develop Video programmes targeting adolescent reproductive health and other social issues affecting the youth. Many of these were subsequently aired by Stellavision T.V. Channel.

Annex B

Aside from these few observations, we think the report has attempted to bring out some of the omissions in the ICR. While the two reports point out donor reluctance to channel future funding through NCPD, we feel this merits further consideration given that the government has itself acknowledged its internal constraints and is presently in the process of major reforms.

Yours sincerely

K. Chepsiror

Ag. DIRECTOR/NCPD