PROJECT INFORMATION DOCUMENT (PID)
CONCEPT STAGE

Report No.: 53444

Project Name	Kenya: Health Sector Support Project
Region	AFRICA
Sector	Health (85%), Sub-national government administration (10%); Central government administration (5%)
Project ID	P074091
Borrower(s)	REPUBLIC OF KENYA
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Environment Category	[ ] A [X] B [ ] C [ ] FI [ ] TBD (to be determined)
Date PID Prepared	February 15, 2010
Estimated Date of Appraisal Authorization	June 15, 2010
Estimated Date of Board Approval	September 15, 2010

Key Development Issues and Rationale for Bank Involvement

A. Country Background

Economic Development and Poverty

1. **After five years of economic revival up to 2007, Kenya is now experiencing a slow recovery from the four shocks of post-election violence, the oil and food price increases, the global financial crisis and the 2009 drought.** After the Kibaki Government took office in January 2003, Kenya experienced a period of strong economic growth which peaked at 6.9 percent in 2007. This positive trend ended in 2008, when growth contracted to 1.7 percent. The economic downturn is due to a combination of events. Post election violence in early 2008 caused widespread population displacement, loss of output and lower earnings from tourism. The international financial crisis also contributed with a fall in remittances and thus a decline in purchasing power. Drought has reduced farm production, the economic effects of which were exacerbated by high international food and fuel prices. Kenya's projected growth of 2.5 percent in 2009 is not even matching its population growth. At the same time, Kenya's present recovery, albeit slow, demonstrates the resilience of its economy.

2. **The poor have benefited from Kenya's growth, but poverty and inequality remain important challenges.** Despite Kenya's economic growth, little inroads have been made in

reducing poverty. It is estimated that 47 percent of Kenyans are poor today, compared with the officially estimated poverty rate of 48 percent in 1981. Earnings inequality is high, with a gini index of 0.693; and regional disparities are substantial, with the vast majority of the poor living in rural areas. Gender inequalities are persistent. Female-headed households tend to be significantly larger in size; and, compared to male headed households, their poverty incidence is higher. Women account for only 30 percent of total wage employment and 24 percent of civil service employment in Kenya, mostly in lower cadres. Although the economic growth of 2003-2007 brought benefits in terms of poverty reduction, the welfare gains over the period 1997-2005/6 mostly benefited the wealthiest quintiles and urban residents[1].

3. **Kenya is on track to achieve some Millennium Development Goals (MDGs), but not all.** It is not likely to eradicate extreme poverty and hunger (MDG 1), as per capita GDP growth rates have been too low and erratic to reduce sharply the proportion of people living in poverty. Free primary education, introduced in 2003, improved access (92.5 percent net enrollment in 2008) and completion rates (79.5 percent), so Kenya may reach MDG 2, but there are still about one million primary school age children out of school and many school leavers still have very low levels of learning achievements. With improved gender parity in education, Kenya may also achieve one target of MDG 3. Although preliminary results from the 2008-09 Demographic and Health Survey indicate that the child mortality rate fell from 115 in 2003 to 74 in 2007, and the infant mortality rate from 77 to 52, Kenya is still unlikely to achieve MDG 4. The prevalence of underweight, stunting and wasting has not changed much during the last 15 years, and malnutrition remains a key contributor to half of child and infant deaths in Kenya. Maternal mortality did not improve significantly in the 2000s, and so MDG 5 remains out of reach. By contrast, Kenya is likely to achieve MDG 6, as it has been able to sharply reduce its adult HIV prevalence rate, due in part to successful awareness-raising efforts that have led to less risky behavior. A large development agenda therefore remains.

Governance

4. **Kenya's politics are complex.** Political tension has often disturbed elections, and the December 2007 elections triggered widespread violence resulting in about 1,500 deaths. In response, international mediators helped to establish a coalition government, which now involves more than 40 ministries and 80 Cabinet members, including many veto holders who control large ethnic blocks of voters.

5. **Kenya has a mixed record on governance.** In comparison to its lower-income peers, Kenya scores well in areas such as voice and accountability, regulatory quality, revenue mobilization, public administration, macroeconomic management, and budgetary management, but poorly in areas such as rule of law and control of corruption.[2] Over the last couple of years, public financial management (PFM) has improved by linking the macroeconomic framework with fiscal planning, introducing an integrated payroll and

[1] The Kenya Poverty and Inequality Assessment (July 2008)
[2] See Kenya's Actionable Governance Indicators (AGIs), which draw on the Bank's CPIA ratings, the Worldwide Governance Indicators, Doing Business, PEFA indicators and other sources.

personnel database, and strengthening the capacity of internal and external audit and the Kenya Revenue Authority. There has also been progress in public sector reform through the introduction of results-based management (RBM) into the public service which has contributed to significantly more openness and transparency. Public systems have been strengthened to detect irregularities and the Government has shown initiative to act on corruption information and allegations. Recently, when fraud was discovered in the education sector, it was the Internal Audit Department of the Government that discovered the misappropriations of funds and the Ministry of Education (MOE) took immediate action to suspend the staff allegedly involved in fraud.

6. **Despite positive developments, governance and corruption remain a risk for any investment in Kenya.** There is an unfinished anticorruption agenda which includes investigating and prosecuting high-raking corrupt officials; resolving major scandals; and recovering stolen assets. The Government also needs to continue improving the governance systems; the Integrated Financial Management Information System (IFMIS) is still not functioning well; and more needs to be done to improve cash management, achieve program-based budgeting, and consolidate procurement reforms.

The Health Sector

Health Status and Trends

7. **After a period of stagnant and even deteriorating health indicators, Kenya has recently made some significant progress.** Between 1993 and 2003, infant and under-five mortality rates increased[3] and life expectancy dropped by about five years. However, the period 2003 to 2007 saw a turn in these negative trends. According to the 2008 Kenya Demographic and Health Survey (KDHS 2008), there were remarkable declines in under-five and infant mortality rates (from 115 to 74 and from 77 to 52 per 1000 live births, respectively). Some of the gains were probably due to the economic growth in that period, but they were also due to increases in immunization rates[4] and the increased use of mosquito nets[5]. The annual utilization rate of health services also increased during the period and stood at 2.6 visits per person in 2007, an increase from 1.9 visits in 2003. Overall, most health outcomes in Kenya now compare quite favorably with its East African neighbors.

8. **Nevertheless, there are serious health status challenges remaining**. These challenges include the following:

- **Health and service inequity.** These inequities are both geographical and socio-economic. Almost 90 percent of women in Nairobi deliver their babies in health facilities, a sharp contrast to the 17 percent in North Eastern Province. Differentials in immunization coverage

[3] from 60 to 78, and from 100 to 114, per 1,000 live births respectively

[4] The proportion of children under one year of age fully immunized rose from 58 percent in 2004/05 to 80 percent in 2006/07.

[5] Over the past five years, 13.5 million bed nets have been distributed, with the percentage of children sleeping under them rising rapidly to 52 percent in 2006, from 5 percent in 2003.

show that the proportions of children fully vaccinated in North Eastern and Nyanza Provinces are low compared to other provinces, with only 47 and 55 percent of children fully immunised, respectively. Coverage levels are close to 82 percent for children in Central Province. Coverage is also higher among children whose mothers have been to secondary school. It is also striking that young women aged 15-24 years are four times more likely to be HIV-infected (5.6%) than young men of the same age group (1.4%).

- **Health and poverty**. Poor people hardly use referral hospitals, with half of the consultations at referral hospitals being from the richest quintiles. The use of other hospitals is more widespread, but even here, the better-off use the facilities far more than the poor. Poor people rely on primary care, and indeed get a proportionate share of spending on primary facilities. Overall the poorest 20 percent of Kenyans lay claim to just 14 percent of the government health budget. By using publicly subsidized facilities, the richest quintile received an in-kind transfer representing 27 percent of the government health budget. The bottom forty percent of the population gain far less (and the top 20 percent far more) of the health budget.

- **Sustainability of improvements in health indicators**. It is doubtful that the improvements in under-five and infant mortality have been sustained in the period since 2007, due to the post-election violence, the institutional problems in the health sector and the disruption of services. Recent data from projects in the Nyanza province seem to confirm this fear.

- **Slow progress in reproductive, maternal and neonatal health indicators.** Maternal mortality remains high in Kenya with the maternal mortality ratio (MMR) officially estimated to be around 414 per 100,000 live births (though unofficial estimates put it around 1,000). According to the KDHS 2008, the total fertility rate is 4.6 births per woman. This is a slight decrease from the rate of 4.9 ten years ago. However, while the contraceptive prevalence rate increased from 39 percent in 2003 to 46 percent in 2007, it is still far below the MDG target of 70 percent. The proportion of women who deliver with skilled attendance is only 44 percent and has remained largely unchanged since 1993. Neonatal mortality is a particular concern and little progress has been made in recent years: 6 out of 10 infant deaths, and 4 out of 10 under-five deaths, occur during the first 28 days of life**.**

- **Nutrition is a continued challenge and varies greatly between regions** According to the KDHS 2008 findings, 35 percent of Kenyan children are stunted, while 14 percent are severely stunted. Stunting levels are slightly higher for boys than girls, and for rural children than for urban children. The prevalence of stunting varies by province from 29 percent in Nairobi to 42 percent in Eastern Province.

Health Services

9. **The health services in Kenya are provided by a wide range of players.** Health care providers include the Government, the Faith-Based Organizations (FBOs), other not-for-profit organizations, for-profit service providers and traditional healers. About 40% of the services are provided by the private sector[6]. The private for-profit sector is strong in urban

[6] An assessment of the private health sector has recently been undertaken by the IFC and USAID.

areas, whereas the public and the not-for-profit sectors provide the bulk of the rural services.

10. **The public services are generally inefficient and of low quality, and the lower levels of the public system, which mainly cater for the poor, are particularly weak.** The health system and services are divided into six levels: communities, dispensaries, health centers, district hospitals, provincial hospitals and national referral hospitals. The health services at the first three levels – where the poor and in particular poor women mainly seek their care[7] - are particularly weak:

- The financial management system fails to disburse funds to health facilities in a timely manner, which leads to inadequate operation and maintenance activities.

- There is a shortage of health staff in rural areas, due to a lack of incentives for staff to work there, and inefficient deployment and management of staff.

- There is considerable leakage and wastage of drugs and medical supplies. A lack of drugs in many lower level facilities forces patients who can afford to do so, to go and buy them elsewhere. Those who cannot afford to do so, often remain without treatment.

- Planning and management capacities are weak, although considerable capacity building has been taking place in the context of the SWAp.

11. **Improving health services at lower levels and strengthening systems will be critical for further improvements in health status.** While it is clear that some key health outcomes of Kenyans did improve in the period 2003-2007, it is likely that they were partly due to factors outside of the health sector, such as economic growth and education. Within the health sector, they were significantly due to specific program interventions, particularly for child health. However, the health indicators that depend on functional health systems and the provision of routine services (such as skilled attendance at birth, contraceptive coverage and routine immunizations) are now lagging behind. Kenya therefore has to increase investments for broader health systems strengthening and for lower level services, and also improve regional equity and targeting of the poor, while sustaining those targeted interventions that have demonstrated positive impact.

Health Financing

12. **Funding for the health sector has increased, but falls short of the required amount and is still inappropriately allocated.** Although Government health investments have increased in nominal terms, public expenditure on health is only 5-7 percent of total Government Expenditure[8]. This is considerably lower than the Government's own MTEF projections of 12 percent. Total health expenditure per capita is about US$27, which is higher than in most neighboring countries but still leaves a significant gap, as the annual

[7] Kenya Benefit Incidence Social Spending June 2008
[8] PER Health and GOK budget paper, variance partly due to some figures being actual expenditures and other estimates

cost to deliver the National Health Sector Strategic Plan II (NHSSPII) is estimated at US$35 per capita. There are also problems of inappropriate resource allocation, with relatively too much spent at the central and referral hospital levels and large informal out-of-pocket payments which affect access to services of the poor.

13. **There have been important signs of commitment to reform by the Government in addressing the health financing challenges.** The Government, in consultation with a wide range of stakeholders, has developed a broad strategy for the reform of health financing. The objectives are to: (i) achieve universal coverage and social health protection; (ii) improve public-private partnerships; and (iii) improve health regulations and standards; and (iv) improve capacity and quality in the public health system. In addition, there have been some important pilots undertaken to move forward with reforms, and more are planned. These include: (i) output-based approaches for maternal health services in Nyanza and Nairobi, and also for infant and child health services in the North-East Province; and (ii) the introduction of eligibility of outpatient services for reimbursement from the NHIF. Finally, there have been some welcome developments in the 2009/2010 budget: (i) the total government budget for health was increased by 21 percent; (ii) the share of resources for primary care rose relatively more than other subsectors; (iii) there was also a shift of resources towards public health activities; and (iv) there was an increased focus on the development budget.

14. **There are many development partners (DPs) in the Kenyan health sector providing considerable external support, but it is unbalanced and most of it is off budget. S**ignificant support is provided by various United States (US) organizations and by DFID, DANIDA, JICA, German Development Cooperation, African Development Bank, European Commission and UN organizations as well as by global health initiatives such as the Global Fund, GAVI and the IHP. Donor inputs have risen sharply from 16 percent of total spending in 2001/02 to 31 percent in 2005/06, but the new funds are mainly off budget and target disease-specific interventions that only partially benefit the health system at large. Additional contributions by and through implementing partners, particularly Non-Government Organizations (NGOs) and Faith-Based Organizations (FBOs), are substantial, but they are not well quantified. Most of the external support to the sector is currently delivered through projects and earmarked funding in the public sector, and largely concentrated on specific interventions for HIV/AIDS, TB, malaria, and immunization.

Health Sector SWAP

15. **The Kenyan health sector operates within a Sector-Wide Approach (SWAp).** The foundations for the SWAp are laid down in the National Health Sector Strategic Plan (NHSSP II) 2005-2012. Its goals are to reduce health inequalities and to reverse the downward trend in the health of the Kenyan people. The NHSSP II policy objectives are to: (i) increase equitable access to health services; (ii) improve service quality and responsiveness; (iii) improve the efficiency and effectiveness of service delivery; (iv) enhance the regulatory capacity of the MOH; (v) foster partnerships in improving health and delivering services; and (vi) improve the financing of the health sector. While the NHSSP II is ambitious in scope and its targets, and requires prioritization and clarity on

some important sub-sector policies, it is rooted in the Medium Term Expenditure Framework (MTEF) and does provide a viable overall planning framework (with specific policies and strategies to be developed and adopted as part of the Annual Operational Plans). The NHSSP II has outlined the Kenya Essential Package of Health (KEPH) for all levels. It is divided into interventions by age groups with the aim of establishing what key intervention and services that are needed, both for prevention and care, at each stage in life. The KEPH forms the basis of the costing of the NHSSP II.

16. **The NHSSP II is complemented by other key planning documents and processes.** These include the following:

- *Vision 2030* is the overall Government document setting out the long-term vision to guide Kenya's development up to the year 2030 in all sectors. This vision specifies so called "Flagship projects" for each sector to implement during the coming years. The Health Sector Services Fund (HSSF), KEMSA reform, increased human resources and health financing reforms are examples of such projects in the health sector.

- *Ministerial strategic plans 2008-2012* which have been developed by the MOMS (for medical services in district and referral hospitals) and by the MOPHS (for the lower levels of the system, including community, dispensaries and health centers, and also public health programs, within the broad parameters of the NHSSP II. These have translated the priorities in the NHSSP II and the Vision 2030 (which was developed after the NHSSPII) in to prioritized implementation strategies for the period 2008 – 2012.

- *Code of Conduct (CoC),* which has been agreed and signed by all principal stakeholders in the health sector. This is a living document signed by Development Partners, Faith-Based Organizations, Civil Society and representatives of the private for-profit sector. It spells out the principles of the SWAp, stipulates that everyone who signs undertakes to only support the jointly agreed priorities in the NHSSPII and other agreed sector strategies and designs the sector coordination framework. The CoC also serves as the IHP+ Compact for Kenya.

- *Joint Financing Agreement*, which sets out the funding arrangements for the sector linked to the Code of Conduct. There is no sector budget support mechanism to support all the priorities in the NHSSP II. Instead, the Government of Kenya and the Development Partners that are signatories to the Code of Conduct have agreed to pool funds for prioritized areas in the sector in line with the NHSSP II and the Vision 2030 flagship projects. Baskets are therefore being established to pool funds for the Health Sector Services Fund (HSSF), for essential commodities, for human resource and for technical support.

17. **The NHSSP II has been costed and gaps identified for further investments.** The Joint Programme of Work and Funding and the Joint Support Programme were developed in 2006-7 in order to prioritize and cost interventions in the NHSSP II for funding by Government and DPs, envisioning a more sector budget support-like arrangement. However, while the JPOWF was never utilized as a sector investment plan, it has served as a prioritization tool for DP and government investments. The priorities have fed into the Ministerial Strategic Plans, as well as into the Annual Operational Plans, which are now

utilized as implementation documents for the NHSSP II. Annual Operational Plans (AOPs), which have used annually since 2006 for translating priorities into annual action plans.

18. **The partners in the health sector have agreed to move towards a more harmonized and aligned sector program, in a phased manner, even though it is felt that the system is not yet solid enough for sector budget support.** The partners and Government agreed to start pooling funds for the key priority areas in the NHSSP II through a Joint Financing Agreement. These initial five pools will be for the Health Sector Services Fund (HSSF), Hospital Management Services Fund, Human Resources, Commodities and Capacity Development/TA. These are priority areas that need additional funding in order to address the key challenges and bottlenecks in the sector.

Sector Stewardship and Governance

19. **In common with other sectors, the health sector faces serious problems of governance, as clearly revealed by the experience of the IDA-financed DARE Project.** In July 2004, the Bank suspended the US$18 million district grants component of the DARE Project, as: (i) it was concluded that the component objective would not be reached; and (ii) there were serious accounting and reporting deficiencies. In the following year, a Forensic Audit was carried out, followed by a Detailed Implementation Review (DIR) in the first half of 2006 by the Bank's INT Department. The DIR concluded that there was credible information and evidence of widespread corruption within the Ministry of Health. Several important actions were taken in response: (i) the DARE Project accounts were recreated; (ii) an audit was carried out by a private firm; (iii) qualified accountants were attached to support the District Medical Officers of Health on all district health accounting issues; (iv) additional training in financial management was given to key staff; and (v) steps were taken to prevent the release of funds if there were accounting arrears.

20. **Major efforts have also been made to address other governance issues in the sector.** An action plan for governance strengthening and anti-corruption in the health sector has been developed, and this includes key actions such as: (i) the implementation of a new policy on procurement responsibilities at headquarters and decentralized levels, and also vis-à-vis KEMSA; (ii) the introduction of the HSSF and community participation and information dissemination; (iii) more effective functioning of the Audit, Finance and Facilities Management Committees; (iv) improved functioning of Internal Audit; and (v) public dissemination and monitoring of performance contracts. The Ministry of Medical Services (MOMS) and the Ministry of Public Health and Sanitation (MOPHS) have made significant progress in implementing these measures, by introducing the HSSF, by enhancing community participation through the Community Strategy and by making KEMSA the sector procurement agency (with the MOMS no longer involved in carrying out procurement activities).

21. **The Government has also strengthened sector coordination and governance mechanisms and revitalized the SWAp.** As part of the political settlement of March 2008, the MOH was split into the MOMS and the MOPHS. While initially this led to

problems of competition and inefficiency, the senior officials in the two ministries are now putting in place new coordination arrangements. There has also been an institutional review carried out to assess the collaboration arrangements, and steps are now being taken to strengthen core systems and structures, such as: (i) performance management, financial management, and human resource management; (ii) organizational structures and integrating mechanisms; and (iii) donor coordination. In particular, a Health Sector Coordinating Committee (HSCC) has been established at the highest level, and it is being supported by a Steering Committee comprised of staff of the two ministries (plus other key stakeholders).

22. **Notwithstanding these improvements, there are still governance and stewardship risks in the health sector**. The then Ministry of Health was still rated 9th out of 26 ministries in the aggregate annex of the Transparency International bribery index for Kenyan 2008. The Public Expenditure Tracking Surveys have shown that there are governance risks at all levels, and that the mismanagement particularly affects the poor as funds intended for lower levels often fail to reach there and people are being asked to pay for what should be (virtually) free services. The establishment of the HSSF is trying to address some of these concerns as it will directly release funds to health facilities at lower levels and as it contains an important element of public accountability in its governance set-up. It will, however, be crucial to continue the monitoring of governance indicators at all levels of the system. There are also governance concerns relating to the capacity in the two ministries to manage the sector and handle internal and sector-wide coordination and collaboration. While improvements have been made, there are still capacity concerns at both central and peripheral levels.

Health Sector Reforms

23. **Important progress has been on some key reforms recently.** The Government has recently made some substantial progress on key reforms identified in the NHSSP II to improve access and quality of particular health services[9]. For example,

- A new Health Financing Policy and Strategy has been developed. While the allocation of resources in the health sector in Kenya has been criticized in recent years, the budget 2009/10 also shows a substantial resource shift from curative to preventive services, in line with the resource prioritization in the NHSSP II. The Public Health Ministry has had its budget increased to Sh19.4 billion, up from Sh6.7 billion in Fy09.
- In a bid to boost healthcare at the local level, K.Sh20 million has been allocated as part of the economic stimulus package for the construction of a new health centre in each of the country's 210 constituencies.
- Another key reform in the sector is the establishment of the HSSF. The HSSF has been developed based on the successful model in the education sector of funds going directly to the schools. The concept has been thoroughly tested in the health sector in the Coast Province prior to roll-out. A Community Strategy has also been developed and launched.

[9] In recognition of the improved performance in the health sector, the rating in the Bank's Country Portfolio and Institutional Assessment has been raised from 3.0 to 3.5, subject to final confirmation.

- Important reform work is ongoing on hospital autonomy and improvement of the referral system aimed at increasing efficiency and quality of the services. A new Hospital Management Services Fund has been gazette, and is now being established.
- Another major reform achievement is in the area of sector procurement. The Kenya Medical Supplies Agency (KEMSA) has been the public procurement agency in the sector but has only recently been given the full mandate to act in this capacity with the central ministries moving out of procurement. This has paved the way for implementing the procurement reform agenda in the sector.
- The operations of KEMSA itself has been reviewed in detail, but by several DPs[10] and also through a high-level Task Force. As a result of the latter, a new Board has been appointed for KEMSA and a new business plan has been developed.
- The Government has developed a human resources for health (HRH) strategy to address bottlenecks and encourage more trained staff to work in remote areas. The Government has provided funding for the sector to hire 4,200 additional nurses during FY10.
- Encouragingly, in the 2007 Client Satisfaction Survey, about 90 percent of respondents reported that they had seen an improvement in services provided.
- All senior managers in the health sector now have individual performance contracts, and results-based financing is starting to be introduced in facilities and programs around the country.

B. Rationale for Bank Involvement

24. **The proposed Project is fully consistent with WB's Country Assistance Strategy (CAS) for Kenya 2004-2008, which particularly emphasized investing in people and governance, and the new Country Partnership Strategy (CPS).** In March 2007 a CAS Progress Report was prepared. The Project is consistent with three of the main pillars of this strategy: (i) strengthening public sector management and accountability; (ii) reducing vulnerability and strengthening communities; and (iii) investing in people. The CAS Progress Report emphasizes the need to pay greater attention to equity and investing in people, and proposed initiatives that more directly target the poorest (with continuing attention to the drivers of overall growth). This focus is proposed to remain in the upcoming CPS, which is currently under review). This proposed new CPS aims to support Government efforts to achieve Vision 2030, by bringing knowledge and best practices to help find solutions to Kenyan problems, working with local partners. It will also seek to ensure that all Bank activities help to improve governance by building responsive, capable and accountable state agencies. Bank interventions in Kenya will seek principally to unleash Kenya's growth potential. However, given Kenya's history of unequally shared development, the Bank will also seek to ensure that growth helps to reduce inequality and social exclusion, including by increasing the access of the poor to basic health services.

[10] Various assessments have been done by DANIDA, the African Development Bank, the USAID, the European Union and the Millennium Challenge Corporation. In particular, there has recently been an assessment of its procurement and financial management arrangements.

25. T**he proposed Project is also well aligned with the Bank's Health, Nutrition and Population (HNP) Strategy for Africa and the Bank's 2007 Health, Nutrition and Population Global Strategy, which aims to help client countries to achieve sustainable improvement in their health outcomes, especially for the poor.** The five key directions in this strategy are the following: (i) renewed focus on results; (ii) increased emphasis on health system strengthening; (iii) ensuring synergy between health system and priority-disease interventions; (iv) strengthening the inter-sectoral approach for health results; and (v) developing and supporting selectively global partnerships, building on comparative advantages at the country level. All of these principles underpin the Bank's proposed support for the health sector in Kenya.

26. **In addition, the proposed Project would build upon the Bank's past involvement in the health sector in Kenya[11].** Past support included: (i) the Sexually Transmitted Infections (STI) Project (Credit 2686, US$50 million, closed in December 2001); (ii) the DARE (Credit 3440, US$54 million, closed in September 2007); and (iii) KHADREP (Credit 3415, US$50 million, closed in December 2005). Current support includes the Total War Against HIV/AIDS (TOWA) Project (Credit, US$80, approved in June 2007). In addition to financial support, the World Bank has contributed to health sector development in Kenya through: (i) policy dialogue; (ii) donor coordination; (iii) technical assistance in health strategic planning, budgeting and financing, fiduciary and M&E issues, sector governance and SWAp architecture; and (iv) economic and analytical work, e.g. public expenditure reviews and country economic reports. In addition, through the existing Institutional Reform and Capacity Building Project, it is providing assistance for the rollout of the IFMIS in the health sector. The experiences in other social sectors, such as in the Education Sector and in the work with Orphans and Vulnerable Children and the wider social protection agenda, will also benefit the new health Project.

27. **The proposed Project would focus on areas where the Bank has a comparative advantage for supporting the sector.** The Bank is strategically placed to support the HSSF and the commodities pools. The Health Development Partners in Kenya (DPHK) have decided on a system where the partner with a comparative advantage takes the lead in one or several areas in the sector. The Bank is the lead in Procurement and Supply Chain Management and is a key partner for the HSSF and in health systems (together with DANIDA). The Bank has a solid reputation in the areas of health systems strengthening and procurement. Furthermore, it has a strong technical presence in Kenya in these fields and plays an important role and recognised role among the development partners. There is full support from the other development partners as well as from the Ministries of Health for the Bank to focus on the HSSF and the commodities in accordance with the suggested project.

[11] It should be noted that a new health project to support the SWAp was designed in 2007. A full package of documentation was prepared for a Decision Meeting. However, primarily due to concerns about governance in the country, the outbreak of post-election violence, the split of the Ministry of Health as part of the political agreement relating to the establishment of the Coalition Government, and the subsequent institutional problems facing the MOMS and MOPHS, it was decided by World Bank management that the project processing should be suspended throughout 2008.

28. **The Bank is uniquely positioned to help the sector for several other reasons.** The Bank is now the Chair of the DPHK, and the development partners want the Bank to lead the coordination of the sector and especially the external support to the pools through the Joint Financing Agreement. The Bank is playing a major role in the new the IHP+, and Kenya is one of the first wave countries. There is also new scope for collaborating closely with the IFC, which has developed the "Health in Africa Initiative" to step up its engagement and support of Africa's private health sector.

Proposed Project Development Objective(s)

29. The project development objectives are to: (i) improve access to quality essential health services for Kenyans, especially the poor; and (ii) improve governance, accountability and performance of health institutions, particularly at the district level and below.

30. The key project indicators are proposed to be:

(i) people using the essential package of health, nutrition and population services at facilities supported by the HSSF[12];

(ii) the number of beneficiaries (direct and/or indirect)[13];

(iii) health facilities (level 2-4) without tracer drugs for more than 2 weeks[14];

(iv) eligible children aged 12-23 months fully immunized in Northeast Province[15];

(v) facilities meeting financial management requirements[16].

31. The choice of indicators has been guided by the criteria that they are clear, relevant, adequate, economic and monitorable. As far as possible, the indicators have been selected

[12] There are two options proposed for the first indicator. Option 1 is the number of provinces successfully meeting criteria for improved access to essential package of health, nutrition and population services at facilities supported by the HSSF. The criteria are (a) % deliveries conducted by skilled attendant in health facilities: >50% (Baseline: 2 out of 8 provinces- Nairobi, Central); (b) % children fully immunized: >70% (Baseline: 3 out of 8 provinces- Central, Eastern, Rift valley); and (c) TB Cure Rates: >75% (Baseline to be obtained from HMIS). Option 2. The indictor remains the same. But it would have 3 sub-indicators to define essential health package. POI#1 a: % deliveries conducted by skilled attendant in health facilities : 42.6% (DHS 2008) target >60%; POI#1 b: % Children Fully Immunized: 68.3% (DHS 2008) target >80%; PoI# 1c: TB Cure Rates: 67% (NHSSPII baseline) target 75%.

[13] It is proposed to use new outpatient visits as this indicator is among the KEPH indicators and gender dis-aggregated data will be available from the facility records. New outpatient visits (Total) 22,516,265 (HMIS 2007-08) target >25,000,000. New outpatient visits (Female)??

14 The Health MIS already has a list of essential drugs. The proposed drugs for tracking could include: ACT, ORS, cotrimoxazole, amoxicillin, paracetamol susp (child) and quinine tablets for severe cases of malaria.

15 Eligible children aged 12-23 months fully immunized in Northeast Province (baseline: 47.4% (KDHS 2008) and 2013 target : 55%)

[16] Facilities meeting financial management requirements (baseline: 0, 2013 target : 80%). The target will be kept high, as this will be an important fiduciary requirement.

from indicators that are already collected within the country's health sector or government-wide - for some of the governance and accountability indicators.

32. The achievement of the development objective will be assessed through the following key indicators:

- Increase in people using basic package of health, nutrition or population services delivered by the Health Sector Services Fund (HSSF).
- Decrease in facilities reporting stock-out of tracer drugs (percent).
- Increase in people citing cost as reason for not accessing health care (percent) through innovative health financing.
- Timely completion of KEMSA anti-corruption action plan.
- Increase in health Facilities with unqualified audits.
- Increase in HSSF facilities having 24/7 access to referral services for care of sick children and comprehensive emergency obstetric care.

33. **The proposed Project would directly contribute to health-related MDGs by supporting the strengthening of Kenya's health system for better health outcomes.** These goals include: Goal 4 (reduce child mortality), Goal 5 (improve maternal health) and Goal 6 (combating HIV/AIDS, malaria and other communicable diseases). Given the clear linkage between health, poverty and economic development, the Project would ultimately contribute toward achieving Kenya's poverty alleviation and economic growth objectives. Improving services at lower levels and strengthening health systems will be critical if Kenya is to reach the MDGs related to health and reduce health inequities. The health indicators that depend on functional health systems and the provision of routine services are lagging behind in Kenya. It is recognized that the sector has to increase investments for health systems strengthening and for lower level services - together with efforts to improve regional equity - if the health MDGs and the NHSSP II targets are to be achieved. Key levels to strengthen are levels 1-3 of the health system, which is the aim of the HSSF. However, only strengthening the system at these levels will not be sufficient without parallel investments in essential commodities to ensure that the quality of services is improved.

34. **Additional resources are needed if service delivery is to be improved and if systems are to be strengthened.** Although Government health investments have increased in nominal terms, public and donor expenditure still fall short of the required amount to implement the NHSSP II. Therefore the Government and DPs have decided to prioritize investments in lower level services, particularly for the poor, through pooled funding mechanisms for key areas such as the HSSF, commodities, human resources and capacity development. It is foreseen that additional and targeted funds to these priority areas will improve sector performance and enhance equity of access to quality services in Kenya. The proposed Project would also support institutional arrangements and capacity building in the MOMS and MOPHS, as well as health policy development, to improve planning and decision making. Finally, the proposed Project would facilitate the implementation of the Bank-supported OVC Project, through strengthening the links with health facilities and helping to ensure that health-related conditionalities are met by beneficiaries.

Preliminary Project Description

The project would include the following components.

35. The proposed support will target primarily two of the key health systems and service delivery challenges in Kenya, namely the limited availability of quality of services at lower levels especially for the poor, through a two-component project: (i) Component I: Effective and transparent implementation of the Kenya Essential Package, and (ii) Component II: Availability of essential health commodities and supply chain management. Both components will have integrated support to improved governance, accountability and performance as cross-cutting measures.

Component I: Effective and transparent implementation of the Kenya Essential Package for Health (KEPH) through HSSF grants and performance strengthening (US$50 million).

36. **Health Sector Services Fund (US$ 40 million):** The GOK has established the HSSF as part of its efforts to delegate power and responsibility of health service provision to the community, as envisaged by the NHSSP II. The project would support the effective implementation of the KEPH through financing the HSSF targeted at health service delivery levels 1, 2 and 3. The HSSF is an important initiative to empower communities to take charge of improving their health by providing direct cash transfers to Health Facility Management Committees (HFMCs) in order to ensure delivery of health services and to improve quality through performance-based incentives. The HSSF aims to improve the delivery of quality essential services, especially at the sub-district and community levels, in an equitable and efficient manner. It will do this by providing financial resources for: (i) medical supplies, the employment of casual workers (clerks, guards, etc.), operational costs, and the maintenance and improvement (e.g. small repairs) of facilities; (ii) outreach work and enabling local communities to take charge of improving their own health; (iii) capacity building, especially in the management of health services; and (iv) strengthening FBO services and coordination.

37. **The HSSF roll-out is based on pilot-tested mechanisms for improved service delivery at lower levels.** The HSSF is not a new initiative, but rather a national roll-out of an already piloted model in the Coast and North-Eastern Provinces, supported by DANIDA. The lessons from the pilot have been built in to the national expansion that is now being undertaken by the Government. Some of the lessons learned from the evaluation conducted include the following: (i) the procedures were generally well-established, with HFMCs active in planning for and using the funds provided; (ii) accounting procedures were generally followed well; (iii) however, there was need for more HFMC training and additional documentation at facility level; (iv) the program was perceived to have had a highly positive impact, with increased utilization of health facilities, especially through the expanded outreach programs, thus improving access to health services; (v) although the pilot program resulted in a heavy workload for staff, the increased workload was offset by the improved working environment through availability of supplies and improved

infrastructure, and by the ability to hire more support staff; and (vi) health worker motivation was also improved through provision of allowances and performance incentives.

38. **The HSSF national structures have been established and the Government is starting to fund the HSSF.** The Government has published the regulations for the HSSF and institutional structures for implementation have been established at the national level[17]. The roles and responsibilities of HFMCs are clearly defined, and detailed operational guidelines for implementation have recently been finalized and are ready for field testing. Each HFMC will have 7-9 members (with at least 4 members selected from the community and 4 women), and will have the full responsibility for preparing and implementing the annual operational plans including accountability to manage and report the use of resources received and generated by the facility. The MOPHS is now building capacity for rolling out the HSSF at all the facility level ,well as at the District and Provisional health management teams, with support from a US$ 1 million project preparation facility (PPF) from the Bank (and also parallel support from DANIDA). The approved scope for HSSF also includes funding for facilities being operated by Faith Based Organizations (FBOs), but the implementation details still need to be agreed.

39. **The creation of HSSF provides a unique opportunity but it also poses some implementation challenges.** The most important of such challenges include ensuring adequate fiduciary safeguards, targeting services for underserved and poor populations, effectively engaging FBOs and other health providers through appropriate contracting mechanisms, and establishing reliable systems for monitoring the performance to introduce the principles of results based financing (RBF) in HSSF. Resource allocation criteria are being developed which will aim at improving regional disparities in service delivery. In parallel, the health financing policy and strategy will be implemented hand in hand with the HSSF in order to provide social health protection for the poor and poverty identification methods are being developed in conjunction with the Ministry of Gender, Children and Social Development. Work is also ongoing to determine the performance criteria and establishing a system for results based financing.

40. **Innovative projects to improve public private partnerships (PPP) will be piloted within the HSSF framework.** Several health facilities were established during the past five years under the Constituency Development Fund (CDF) Act which aims to address imbalances in regional development by supporting development projects at constituency level. While these facilities are being gradually taken over by the MOPHS, the potential for making them operational through private partnerships is being explored. Pilot testing of the private sector taking over the management of some CDF facilities has been proposed, and there is interest from all concerned partners with regard to how such a PPP could be used to strengthen community management. This PPP is being developed with support from the IFC in collaboration with the private sector representatives, MOPHS and other DPs.

[17] Gazette Notice Supplement No. 25 of June 5, 2009

41. **The Bank's support for HSSF can add value by bringing international knowledge and best practices to find locally relevant solutions for important challenges.** The proposed support for HSSF will be within the overarching framework of the ongoing SWAp and a separate financing basket has been created to allow participation of development partners willing to support the HSSF. Initially, GoK, DANIDA and the Bank will be joining the pool and other partners are expected to join soon. The HSSF support from IDA will finance facility grants, inputs required for reporting and fiduciary oversight at facility and district levels, pilots for results based financing, and technical assistance. The technical assistance will be focusing in the areas of establishment of resource allocation criteria to ensure effective targeting of underserved population groups and areas, contracting out services and contracting-in providers, and strengthening systems for assessing HSSF performance and impact.

42. **HSSF and Health Sector Governance and Stewardship (US$10 million):** While the project focuses primarily on service delivery, it is also recognized that the two health ministries need to be strengthened selectively in some of their main stewardship functions, especially at the district level. The governance strengthening would be done through:

- Strengthening voice and accountability, linked especially to the HSSF. This would include activities, such citizen report cards, community score cards, health ombudsman and citizens platforms, as well as independent external monitoring and auditing of performance and results.
- Supporting the phased implementation of the agreed national road map for health financing reforms through pilots and capacity building, and with coordinated support from the IFC. The support would be for selected pilots, capacity building and evaluations. These including activities relating to: the impact of removing user fees from primary facilities; the payment of public health facilities through output-based approaches (for hospitals) and capitation approaches (dispensaries and health centres); the extension of informal sector membership in the NHIF; studies on revenue collection and pooling; and enhancing district hospital management and efficiency to support the basic services through improved hospital management and referral support.

Component II: Availability of essential health commodities and supply chain management reform (US$50 million).

43. **Commodities (US$40 million):** A key challenge for access to quality care is the lack of drugs at lower levels of the public health system[18]. This component would be implemented in parallel with the HSSF, to ensure an improved availability of commodities in local level health facilities. According to the currently known financing gaps, support for commodities will focus on essential commodities for delivering the essential services especially at levels 1-3, and could (if funding has not been secured by other donors) include commodities for key health interventions such as child health, TB, malaria, immunization and family

[18] As part of the background analytical work carried out for the project, a PHRD grant was used to finance a comprehensive pharmaceutical study. The resulting 5-volume assessment included reports on (i) drug policy, (ii) access and institutional capacity, (iii) quality assurance, (iv) rational use of pharmaceuticals and procurement, and (v) a summary report.

planning. The project will support the provision of a rational list of EMMS and medical goods based on priorities given by MOMS/MOPHS for rural health facilities (RHF) from level 1 to 4, and will assist the MOMS/MOPHS to develop an essential list for levels 2 – 4.

44. **The Medium Term Procurement Plan (MTPP) for health commodities was introduced by MOH in 2005, and is used to improve the approach to mobilize and allocate funds for health commodities.** The revised version, drafted on 2009, covers the period of 2009/2010 to 2011/2012. The MTPP for 2009/10-2011/12 has been elaborated to help the MOMS/MOPHS to achieve efficiencies in forecasting and procurement planning to ensure drugs for patients. It is also a key instrument in the carrying out the Medium Term Expenditure Framework (MTEF). This is a multi-year procurement plan to ensure that the planning and budgeting for health commodities are embedded on the MTEF, which comprises a prioritized and costed list of drugs and medical supplies. The sources of funding are diverse and comprise GOK, development partners and users fees.

45. **Based on current analysis of the funding gaps, a total $50 million is estimated to be required to meet 100 percent of the needs at levels 2 and 3 for the next five years**[19]. It is planned for some of the external funding to be provided through the JFA. DANIDA, KfW, USAID, DFID and UNFPA are considered to be possible partners in the financing pool. Procurement of the commodities would be done by KEMSA, using World Bank procurement guidelines and primarily international competitive bidding for the financing made available for health commodities.

46. **KEMSA will be enabled to build a safety stock and absorb the shocks of unpredictable financing that is currently hampering its operations.** The project would therefore support procurements for 18 months' worth of supplies by making $20 million available in the first year, as well as helping the KEMSA to pilot a program for providing "supplementary" essential medicines for hospitals, funding by their revenues from cost-sharing. The remaining funds will be released in the special project fund to enable KEMSA to initiate the round two procurements. The release of funds is dependent on KEMSA being able to procure the commodities in a timely manner, and on the establishment of clear stocking policies.

47. **Close attention are being given to the financial flows.** Facilities will order their needs from KEMSA and payments will be made within 30 days of receipt of invoice by MOMS/MOPHS using the allocated budgets given to each facility virtually, known as drawing rights. The implementation of the drawing rights needs to be monitored to ensure it does not become the bottleneck in paying KEMSA on time. Timely and full payment of the invoices which will include the cost of commodities and distribution will enable KEMSA to build capital for the procurement of next fiscal year and hence the funds capital corresponding to US$ 40 million will be maintained. However KEMSA's day to day operations and investments are to be covered by GOK budget. If the system works, the availability of healthcare commodities will improve especially at levels 2 and 3, enabling

[19] This includes three months inventory, and assumes that DANIDA will continue their support after FY2012 and that the MOMS and MOPHS will increase their annual contribution from K.Sh. 4.7billion to 6.6 billion. The figure will be revised after assessment of the MTPP.

KEMSA to build trust and confidence with its clients by leveraging the fill rate on time. KEMSA will also build confidence with suppliers by paying their bills on time.

48. **Strengthening governance and institutional reforms to enhance the efficiency and transparency of KEMSA (US$10 million).** The KEMSA has been reviewed and assessed rather frequently in recent years, but the most comprehensive assessment of the organization was carried out by a Task Force in 2008. The main conclusions of the Task Force were that: (i) the legal framework needed to be updated; (ii) pooled funding should be introduced; (iii) procurement and distribution activities needed to be integrated; and (iv) capacity building is required in the Directorates of Finance, ICT, Procurement and Commercial Services. Since then, there have been some encouraging improvements in KEMSA's performance, for example in the fill-rate of orders at the local level. However, the management of procurement and the supply chain has continued to be a major constraint in the effort to deliver equitable, quality and efficient health care services. Since drugs and other medical supplies are paramount in the delivery of quality health care, there is need to strengthen KEMSA further to be a strategic procurement and distribution agency, operating at an international standard. In conjunction with other development partners (such as particularly USAID, DANIDA and the German Development Cooperation), it is planned for the project to support the following institutional strengthening strategies**:**

- Enhancement of procurement systems and support for the development and implementation of quality assurance.

- Installation of modern and efficient procurement records storage and retrieval system to improve document access, transparency and facilitate audits.

- Provision of support for governance strengthening and accountability with the specific focus on establishing a strategic supply chain unit, responsible for the Enterprise Resource Planning (ERP) system to mine and monitor data and provide critical key performance indicators (KPIs) for management decision-making and integrating supply chain functions. The project will support the development and implementation of a Quality Assurance (QA) process to ensure transparency and accountability.

- Refurbishment and strengthening of KEMSA central warehouse in Nairobi, and possibly three regional depots. This would include repairs and renovations of the building, purchase of materials handling equipment and installation of racking systems. Financing could also be used to support the implementation of Warehouse Management System (WMS) and technical assistance to establish inventory policies.

- Capacity building in contract management, and specifically to address the management of the outsourced transport. The support could include technical assistance in transport route optimization and in building capacity in performance-based contracts, especially the inclusion of vendor value-added service such as collecting stock status data from clinics.

- Capacity strengthening of staff of levels 2 – 4 to forecast, order, manage stocks and improve rational use of the drugs. The project will support a range of learning methodologies,

including, trainings, strengthening district supervision and establishment of systems and processes with the aim of improving efficiency in the use of the EMMS.

Safeguard policies that might apply

The safeguard policies that may apply to the Project are as follows:

49. **Environment. The main environmental safeguard policy relates to health care waste management, in view of the risks associated with the handling and disposal of medical waste.** The Project triggered OP.4.01, and the Project is classified as a Category B environmental safeguard project. The Government has already prepared a Health Care Waste Management Plan, and this has been reviewed and accepted recently in the pre-appraisal of the regional TB project. The plan has been publicly disclosed by the MOPHS and MOMS in the country. The Regional TB project will fund some of the laboratory activities relating to the plan, and some additional funding will be also availed from the health project for some other activities.

50. **Indigenous Peoples Policies (IPP).** The Project has also triggered OP4.10. An IPP framework had been developed by the MOPHS for the Regional TB Project, and that IPP has been updated to include the new health project. The documents have been reviewed by IDA and found to be acceptable. The MOMS and MOPHS have disclosed the documents in the country, and Bank has disclosed them in the InfoShop.

Tentative financing

Source:		**($m.)**
BORROWER/RECIPIENT		
INTERNATIONAL DEVELOPMENT ASSOCIATION		100
	Total	100

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