REPORT NO.: RES32133

RESTRUCTURING PAPER

ON A

PROPOSED PROJECT RESTRUCTURING

OF

TRANSFORMING HEALTH SYSTEMS FOR UNIVERSAL CARE

APPROVED ON JUNE 15, 2016

TO THE

REPUBLIC OF KENYA

HEALTH, NUTRITION, AND POPULATION GLOBAL PRACTICE

AFRICA REGION

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ABBREVIATIONS AND ACRONYMS

ANC	Antenatal Care
BCR	Benefit-to-cost Ratio
BEmONC	Basic Emergency Obstetric and Neonatal Care
CBA	Cost-benefit Analysis
CS	Consulting Service
DHIS	District Health Information System
FM	Financial Management
GFF TF	Global Financing Facility Trust Fund
GoK	Government of Kenya
MoH	Ministry of Health
MTR	Midterm Review
PAD	Project Appraisal Document
PDO	Project Development Objective
PFM	Public Financial Management
PHC	Primary Health Care
PHRD TF	Policy and Human Resources Development Trust Fund
PMT	Project Management Team
RMNCAH	Reproductive, Maternal, Newborn, Child, and Adolescent Health
TWG	Technical Working Group
UHC	Universal Health Coverage

BASIC DATA

Product Information

Project ID	Financing Instrument
P152394	Investment Project Financing
Original EA Category	**Current EA Category**
Partial Assessment (B)	Partial Assessment (B)
Approval Date	**Current Closing Date**
15-Jun-2016	30-Sep-2021

Organizations

Borrower	Responsible Agency
Kenya National Treasury	Ministry of Health

Project Development Objective (PDO)

Original PDO

The project development objective is to improve utilization and quality of primary health care services with a focus on reproductive, maternal, newborn, child, and adolescent health services.

Current PDO

The project development objective is to improve utilization and quality of primary health care services with a focus on reproductive, maternal, newborn, child, and adolescent health services.

Summary Status of Financing

Ln/Cr/Tf	Approval	Signing	Effectiveness	Closing	Net Commitment	Disbursed	Undisbursed
IDA-58360	15-Jun-2016	04-Jul-2016	29-Sep-2016	30-Sep-2021	150.00	39.16	106.90
TF-A2561	15-Jun-2016	04-Jul-2016	29-Sep-2016	30-Sep-2021	40.00	17.83	22.17
TF-A2792	15-Jun-2016	04-Jul-2016	04-Jul-2016	30-Jun-2020	1.10	.44	.66

Policy Waiver(s)

Does this restructuring trigger the need for any policy waiver(s)?

No

I. PROJECT STATUS AND RATIONALE FOR RESTRUCTURING

A. PROJECT STATUS

1. **The project, which aims to 'improve utilization and quality of primary health care services with a focus on reproductive, maternal, newborn, child, and adolescent health services', was approved on June 15, 2016, and became effective on September 29, 2016.** The project seeks to achieve this project development objective (PDO) by (a) improving access to and demand for quality primary health care (PHC) services at the county level with a focus on reproductive, maternal, newborn, child, and adolescent health (RMNCAH) services (Component 1); (b) strengthening institutional capacity in selected key areas to improve utilization and quality of PHC services (Component 2); and (c) supporting cross-county and intergovernmental collaboration in the recently devolved Kenyan health system (Component 3). The project is placing a strong focus on results by allocating resources to each county based on their improved coverage of essential PHC services that are directly linked to the PDO and other factors, including equity.

2. **There were delays of over a year in initiating implementation because of a series of issues mostly not under the direct control of the implementing entities.** These issues included (a) lapsed loans in Kenya's portfolio that prevented any advances to new projects until early February 2017; (b) difficulty in amending the County Allocation of Revenue Act, hindering disbursement of conditional grants to counties in FY2016/17; (c) 11 months of health workers' strike that ended in October 2017; (d) multiple elections and transitions between August 2017 and December 2017 with the change of the majority of the county government leadership (for example, Governors and County Executive Committee for health and finance); and (e) suboptimal functionality of and limited human resources for the management of the integrated financial management information system.

3. **Project implementation is slowly getting back on track**. Currently, progress toward achievement of the PDO and the overall implementation progress are both rated Moderately Satisfactory. The PDO indicators that worsened during the protracted health workers' strike in 2017 have improved and three out of four PDO-level indicators and six out of eight intermediate results indicators were either achieved or surpassed the Year 2 targets and are on track to achieve the end-of-project targets (among those due for measurement in Year 2). All 47 counties continue to prepare integrated annual work plans that incorporate the county budget as well as the conditional grants (from both the national government and development partners, including the funds from the project) and are at various stages of implementing the activities that each county has proposed to address key bottlenecks in providing PHC services. The national entities have also been implementing various activities, including community nurse and midwifery training for 800 students. However, the disbursement rates are below Year 2 targets. The low disbursements are associated with delays in documenting expenditures at the county level, which affects the disbursement rate, as the project uses the statement of expenditure method; delays in internal approvals within the Ministry of Health (MoH); and limited fiduciary capacity to manage the workload. As of June 14, 2019, the project disbursed US$57.4 million, 31 percent of the total financing: US$39.2 million out of US$150.0 million from the IDA credit and US$17.8 million out of US$41.1 million from the Global Financing Facility Trust Fund (GFF TF) and US$0.4 million out of US$1.1 million from the Japan Policy and Human Resources Development Fund (PHRD TF).

B. RATIONALE FOR RESTRUCTURING

4. The rationale for the restructuring is twofold: (a) various implementation challenges requiring a restructuring were identified during the recently concluded mid-term review (MTR, April 2019) and (b) the Government of Kenya (GoK) universal health coverage (UHC) agenda. Each of these is described in more detail below.

5. **The MTR review conducted in April 2019 identified various challenges affecting implementation and potential solutions to address them.** Key issues identified include the following:

(a) **Results Framework.** Progress toward achieving the PDO is Moderately Satisfactory. The Results Framework will be revised to (i) ensure that it adequately reflects the PDO; (ii) reflect updated baseline values that were revised after project preparation; (iii) replace indicators with suboptimal data quality with more reliable indicators; and (iv) review targets based on the achievement analysis, revised baseline values, and revised indicators.

(b) **County eligibility criteria and resource allocation formula.** The project requires that, from Year 2, counties meet a minimum set of conditions to be eligible for funding. These include the share of the county budget allocation (for Year 2) and expenditure (for Years 3–5) for health (excluding conditional grants for health) needing to be higher than the previous year, but not less than 20 percent. However, several counties are already allocating over 30 percent of their overall budget to health, which in some cases, reflects large development expenditure that cannot be sustained over time. Furthermore, there are limitations in the timeliness and availability of expenditure data across the 47 counties. Recognizing this, a revision of the eligibility criteria is required. In the absence of a public financial management (PFM) condition, timely and complete transfer of health funds from the County Revenue Fund to the Special Purpose Account, which is a ring-fenced account for donor conditional grants, is at risk. Therefore, there is need to formalize a PFM condition which ensures that the Project county allocations are transferred on time and that the full amount of the allocation is transferred.

(c) **Institutional and implementation arrangements.** The functionality of the existing institutional and implementational arrangements is suboptimal. The project sub-Technical Working Group (TWG), which is responsible for facilitating key decisions affecting project implementation at both levels of the Government and coordination among various implementing entities, has only met twice since project effectiveness and has not performed their functions as envisaged in the Project Appraisal Document (PAD). To strengthen the governance requirements, a Steering Committee is proposed.

6. **The GoK is committed to achieving UHC by 2022.**

(a) In his inaugural speech, the President of the Republic of Kenya announced UHC as a key pillar that the Government will deliver during his second term. The current high-level political commitment presents an opportunity for Kenya to fast-track progress toward UHC.

(b) To achieve the UHC goal, the GoK requested the World Bank to support UHC implementation in four counties as a first phase of implementing the UHC vision. In a letter dated June 8,

2018, the GoK requested the World Bank to restructure the project to respond to the changing government priorities and co-finance the implementation of the UHC initiative. In a letter dated November 23, 2018, the government requested the Bank to support the UHC Phase I, which involves provision of free health services through removal of user fees in level 4 and 5 hospitals in four counties and strengthening service delivery in all levels of care (see 6.d).

(c) In Phase I of UHC, level 4 and 5 hospitals in participating counties are compensated for revenue lost due to user fees removal and additional resources provided to cater for expected increased utilization of health services. The removal of user fees is expected to increase utilization of health services and reduce the financial hardship among the underserved, thereby complementing the project activities (especially those under Component 1 – Improving Primary Health Care Results) and accelerating achievement of the PDO.

(d) A total of KSh 3.9 billion will be allocated to the four counties to support the UHC agenda based on a criterion[1] and is allocated as follows:[2]

(i) 80.91 percent as compensation for basic and specialized services provided, of which 70 percent are drawing rights from the Kenya Medical Supplies Agency (KEMSA), the central drug and equipment procurement agency.

(ii) 16.95 percent as health system strengthening investments to be channeled through the counties to support additional staff, training, and investments in the health management information system.

(iii) 2.07 percent as additional financing to community health workers program.

(iv) 0.08 percent as core public health investments in disease surveillance.

(e) Phase I of UHC is being implemented in four counties purposively selected by the GoK to represent varying disease burden and demographic characteristics as follows: (a) Kisumu, a densely populated, high HIV burden county; (b) Nyeri, a county with high levels of noncommunicable diseases; (c) Machakos, a moderate burden of disease county, with high rates of traffic accidents; and (d) Isiolo, a sparsely populated, arid county with a nomadic population. The main characteristics of the four counties are presented in table 1.

[1] The amount allocated to each county was based on criteria that take into consideration the equitable share ratio, population size, poverty levels, outpatient and inpatient utilization rates, health facility density, health workforce density, disease burden, and crude mortality rate.
[2] The percentage allocation for each category is based on recommendations of the Health Benefits Package Advisory Panel.

Table 1. Characteristics of Phase I UHC Counties

Indicator	Kisumu	Nyeri	Machakos	Isiolo	National
Population (2017)	1,158,402	814,394	1,203,041	157,000	47,626,685
Poverty head count (2015/16) (%)	33.9	19.3	23.3	51.9	36.7
HIV prevalence (%)	19.9	3.4	4.5	3.8	5.9
% of county budget allocated to health (FY2017/18)	27.1	35.3	35.3	23.7	27.0
% of households incurring catastrophic health expenditure (2013)	4.2	7.1	7.2	8.7	6.2
Number of level 2 and 3 facilities	191	300	293	47	831
Number of hospitals	23	10	11	3	509

(f) The Government is cognizant of the need for a phased implementation of UHC coupled with robust monitoring and evaluation (M&E) that can provide timely information to optimize scale-up plans. Phase I of UHC will be for 12 months, based on which the GoK plans to roll out UHC nationwide. The phased implementation of UHC will enable the GoK to rapidly test and draw lessons to inform the full scale-up by 2022. Specifically, Phase I will provide lessons on:

(i) The ability of the health system in the four counties to respond and adapt to increased demand of health services and the adequacy of the financing model (supply-side factors);

(ii) The extent to which providing free health care services enables improved utilization of health care services and financial risk protection (by reducing levels of out-of-pocket payments) (demand-side factors); and

(iii) The institutional and implementation capacity and factors that hinder successful rollout of the UHC program. Particular attention will be given to the role of PFM in service delivery and its implications for efficiency and effectiveness of public health systems.

(g) The M&E for Phase I of UHC will focus on its operationalization/implementation. While a rigorous impact evaluation of UHC Phase I will not be feasible given the nature of the implementation arrangements, continuous process evaluation focusing on demand- and supply-side factors, and institutional capacity to implement UHC initiative will be an integral part of the M&E. The planned evaluation will take two forms:

(i) A household survey to investigate changes in health service utilization and expenditures. The recently completed 2018 household health expenditure and utilization survey (KHHEUS 2018), a nationally and county representative survey, will provide baseline data on utilization and expenditure patterns in the four counties. To track changes in health expenditure and utilization over Phase I, a household survey will be implemented jointly with the Kenya National Bureau of Statistics.

(ii) Process evaluation will be undertaken to document the implementation experience. Two rounds of process evaluations will be conducted to: review the functionality (what is working, what is not working, how and why) of the governance, implementation

arrangements and processes - including fund flow and service delivery arrangements - and how these influence the outcome of the Phase I of UHC; document the experiences and opinions of different stakeholders in the implementation, with a focus on service delivery, financial management, provision of supplies among others; identify solutions to address implementation bottlenecks and document the enablers which can be leveraged for successful scale up.

(iii) Facility exit interviews will be conducted to document service users' firsthand experiences interacting with the health system under UHC.

(iv) Routine analysis and reporting on service utilization data and health commodities and medical supplies. Kenya uses the District Health Information System 2 (DHIS2) to collect routine service utilization data. Additionally, the KEMSA operates a logistics information system of the supplies delivered to health facilities. These data will be analyzed to identify trends in utilization levels, supplies distribution patterns, revenue and expenditure.

II. DESCRIPTION OF PROPOSED CHANGES

7. **The Level 2 restructuring proposes the following changes to the project:** (a) modification of the components' scope and cost to accommodate the GoK's UHC initiative, (b) reallocation of the project financing between disbursement categories, (c) amendment to the project's Results Framework, (d) adjustment of the institutional and implementation arrangements, and (e) modification of risk ratings.

8. **Modification of counties' eligibility criteria.** To strengthen the funding flow arrangements to the counties and address concerns raised regarding sustainability of annual budgetary increases to the health sector and timely availability of expenditure data, the following changes are required: (a) formalize the PFM condition where a county's annual allocation will be adjusted based on timely and full disbursement of funds from the County Revenue Fund to the Special Purpose Account, (b) for Years 3–5, eligibility of the county allocation will be based on budget data rather than expenditure data, and (c) counties that are already allocating equal to or more than 30 percent of total county budget to health will not be required to increase allocation in subsequent years. To effect these changes, the MoH will revise the intergovernmental participatory agreement, which guides the collaboration between the counties and the MoH on project implementation.

9. **Modification of the components' scope and cost to accommodate UHC Phase I.** Component 2 (Strengthening Institutional Capacity) aims to strengthen institutional capacity to better deliver quality PHC services at the county level. In particular, Subcomponent 2.3 'Supporting Health Financing Reforms towards UHC' plans to strengthen the MoH's capacity to lead health financing reforms toward UHC by (a) disseminating the health financing policy/strategy, (b) conducting analytical work to inform the implementation of health financing reforms, and (c) building capacity of the UHC leadership at the national and county levels. The original project design included scope for GoK to design and pilot different health financing mechanisms (of which removal of use fees is one), assess their feasibility in the Kenyan context and in so doing identify the most appropriate design mechanism for UHC scale-up. Operational research to evaluate the impact of health financing pilots was an integral part of Component 2.3. However, while the potential areas for pilot and operational research identified during project

preparation to inform the scale-up of health financing reforms for UHC are well aligned with the current UHC agenda, the project planned to finance small operational research only. Therefore, resources allocated to this subcomponent are not adequate to meet the Government's request to support Phase I of UHC. Out of the estimated total cost of up to US$39 million, the GoK will finance US$25 million from domestic resources and the World Bank will co-finance US$14 million. The World Bank resources will go toward procuring medicines, diagnostics, medical supplies and other commodities required to provide services. Procurement will be conducted by the KEMSA[3] on behalf of the MoH for onward distribution to the four counties. KEMSA is already procuring family planning commodities under the Project. The MoH will prepare a work plan on how these funds will be spent and will share it with the World Bank for approval. In a discussion with the GoK, it was agreed to reallocate US$14 million from Subcomponent 3.1 'Cross-county and Intergovernmental Collaboration' to Subcomponent 2.3 to support the UHC agenda. Subcomponent 3.1 aims to promote cross-county initiatives and intergovernmental collaboration to address common demand- and supply-side barriers to improve delivery and use of quality PHC. The remaining US$2 million for Subcomponent 3.1 will continue financing the proposals from counties and national entities to improve the delivery and use of quality PHC, but with a limited scope for one round.

Table 2. Project Cost by Component (US$, millions)

Project Components	Current				Proposed					
	Project Cost	IDA	GFF TF	PHRD TF	Project Cost	GoK	IDA	GFF TF	PHRD TF	Total cost
1. Improving Primary Health Care Results	150.0	115.0	35.0	—	150.0	-	115.0	35.0	—	150.0
2. Strengthening Institutional Capacity	15.1	9.0	5.0	1.1	**29.1**	**25.0**	**23.0**	5.0	1.1	54.1
3. Cross-county/Intergovernmental Collaboration and Project Management	26.0	26.0	—	—	**12.0**	—	**12.0**	—	—	12.0
Total project costs	191.1	150.0	40.0	1.1	191.1	**25.0**	150.0	40.0	1.1	216.1

10. **Reallocation of the project financing between disbursement categories.** The change in cost of the project components would also result in the reallocation of the project financing[4] between disbursement categories, as shown in table 3.

Table 3. Project Financing by Disbursement Category (US$, millions)

Disbursement Category	Current				Proposed			
	Financing	IDA	GFF TF	PHRD TF	Financing	IDA	GFF TF	PHRD TF
1A. Performance Grants under Part A1 of the Project.	130.0	105.0	25.0	—	130.0	105.0	25.0	—

[3] KEMSA is a government parastatal under the MoH and the procuring agency for essential medicines and medical supplies for the public sector

[4] Other than government financing

Disbursement Category	Current				Proposed			
	Financing	IDA	GFF TF	PHRD TF	Financing	IDA	GFF TF	PHRD TF
1B. Performance Grants under Part B2 of the Project	1.2	1.2	—	—	1.2	1.2	—	—
2A. Goods, consulting services , non-consulting services, training, operating costs under Parts A2; B1 other than (b)(i) and of the Project	32.8	17.8	15.0	—	32.8	17.8	15.0	—
2B. Goods, consulting services, non-consulting services, training, and operating costs under B1(b)(i) of the Project	1.1	—	—	1.1	1.1	—	—	1.1
2C. Goods under Part B1(c) (iv) of the Project					**14.0**	**14.0**		
3. Goods, works, consulting services, non-consulting services, training, and operating costs under Part C of the Project	26.0	26.0	—	—	**12.0**	**12.0**	—	—
Total financing	191.1	150.0	40.0	1.1	191.1	150.0	40.0	1.1

11. **Amendment of the project's Results Framework**. The changes to the Results Framework are discussed in detail in table 4. Indicators shown in italics are those affected by the revisions (changes in the indicator, its definition, categorization, baseline or target values, or dropped).

Table 4. Changes to Results Framework

PDO Indicators at Project Appraisal (PAD)	Indicator Post MTR/Indicator Definition Post MTR	Rationale
PDO-level indicators (utilization)		
Children younger than 1 year who were fully immunized (Percentage)	New indicator. Children immunized with the third dose of pentavalent (Percentage)	This is an internationally recognized proxy for completion of the vaccination series and the ability of the health system to reach children multiple times with an essential service and it is less prone to measurement issues.
Pregnant women attending at least four ANC visits (Percentage)		Targets were revised (increased) based on project achievement by December 2018. Note: There are concerns about double counting women because of the inability of the DHIS to track women over time.
Births attended by skilled health personnel (Percentage)		Revised targets (increased) based on Project achievement by the MTR.

PDO Indicators at Project Appraisal (PAD)	Indicator Post MTR/Indicator Definition Post MTR	Rationale
Women between the age of 15–49 years currently using a modern FP method (Percentage)		Baseline value and targets were revised based on update data and Project achievement by MTR. To note: the methodology to calculate this indicator is being revised due to challenges with double counting women. The values for this indicator may change in the next 6–12 months.
PDO-level indicators (quality)		
Inspected facilities meeting safety standards (Percentage)	Definition: Public health facilities (L2–L4) inspected which achieve at least 60 or more percent using the JHIC.	Revised indicator definition to specify that public health facilities and correct the score to be 60 percent or more (instead of 61). New data source: DHIS2.
Pregnant women attending ANC supplemented with IFA (Percentage)		This indicator was upgraded from an intermediate result indicator to PDO-level indicator for quality of care as it reflects the completeness/quality of ANC visits (clinical quality), and/or the availability of iron folic acid at facilities (structural quality). The targets from year 3 to end target were revised based on Project achievement by the MTR.
Intermediate indicators		
Component 1: Improved primary health care results.		
Health facilities offering Basic Emergency Obstetric and Neonatal Care (BEmONC) Services (Percentage)	Dropped	Indicator is dropped due to data quality issues including self-reported data without verification if the BEmONC functions being actually present, denominator (# facilities) not regularly updated, and unclear definition of facilities supposed to offer BEmONC services.
People who have received essential health, nutrition, and population services (Number) [Corporate Indicator]	Definition. Number of children receiving any vaccine between age 0 and 59 months and number of deliveries attended by skilled personnel (Cumulative number)	The indicator and its description were revised according to the new guidelines for the corporate indicators. This change had already been made through an interim ISR (ISR 06). Moreover, we added intermediate targets.
Component 2: Strengthened institutional capacity.		

PDO Indicators at Project Appraisal (PAD)	Indicator Post MTR/Indicator Definition Post MTR	Rationale
Facilities inspected for safety standards	Definition. Public health facilities (L2–L4) inspected for safety standards (Number).	The definition was revised to specify that the project will track inspections in public health facilities. The indicator was maintained but targets were revised from percentage to number to address data quality issues related to the list of facilities not being routinely updated.
Facilities submitting complete DHIS data in a timely manner (Percentage)	New indicator. Reports submitted to the DHIS in a timely manner (Number) Definition. Average percentage of forms 710 and 711 submitted to the DHIS by the 15th of the following month.	'Health facilities' was removed because level 2 and 3 facilities do not submit reports. Form 713 was removed because the data from form 713 were moved to the reporting tool M0H 711. The baseline value and targets were revised according to the new definition and based on Project achievement by MTR.
Registration of births (Percentage)	New indicator. Births registered within 6 months of occurrence (Percentage) Definition. Births registered at registration office within 6 months of occurrence.	Based on the Children's Code, article 157, in Kenya declarations of birth must be done within 6 months to the civil registrar of the place of birth and 8 months for births occurring outside the municipality perimeter or in a foreign country. Therefore, this indicator reflects both the number and timeliness of registration. Timeliness was specified in the Results Framework.
RMNCAH-related operations research completed to inform policy/strategy (Cumulative Number)	New indicator. RMNCAH- and UHC-related research completed to inform policy/strategy.	The indicator now includes UHC-related research. The end target for this indicator is reduced from 3 to 2 because initially identified research questions have already been investigated by partners. Furthermore, it was specified that the target is cumulative.
A benefits package developed, costed, and disseminated (Number)		No change.
Lessons learned from UHC Phase I documented and disseminated	New	Results from the process evaluation of UHC phase I should be documented and disseminated to inform the scale up.
Component 3: Cross-county/intergovernmental collaboration and project management.		
Functional community health units (Number)		The indicator was defined to measure the number of functional community units using three criteria according to the national

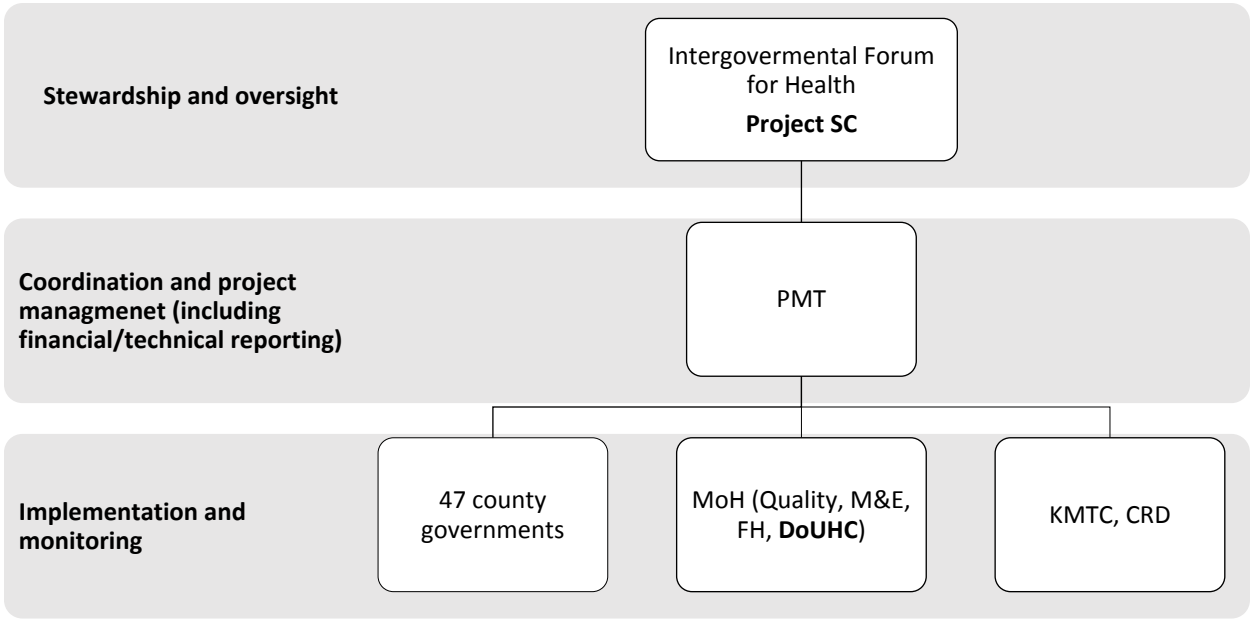
PDO Indicators at Project Appraisal (PAD)	Indicator Post MTR/Indicator Definition Post MTR	Rationale
	Definition. Average number of community units that report through the DHIS.	guidelines (see PAD). However, there are no data to measure all three criteria. To address this flaw, the functionality of the community unit is measured using the number of reports submitted using data from the DHIS (new data source). Baseline and target values were revised accordingly.
Grievances registered related to the delivery of project benefits that are addressed (Percentage)		No changes.
Implementing entities submitting the annual Financial Management (FM) and technical report on time (Percentage)	Definition. Implementing entities submitting the annual FM and technical report no later than 45 days after the end of each calendar quarter.	The description of this indicator was revised to define 'on time' according to the Financial Agreement. Also, the targets were revised to maintain achieved results by MTR.

Note: DHIS = District Health Information System; ANC = Antenatal Care; FP = Family Planning.

12. **Adjustment of the institutional and implementation arrangements**. To strengthen the institutional and implementation arrangements, the project sub-TWG will be replaced by a project Steering Committee. The Steering Committee will provide overall oversight for the project and will be co-chaired by the Principal Secretary, MoH and the Chief Executive Officer, Council of Governors. They will meet quarterly to review implementation progress, facilitate key decisions that affect project implementation at both levels of governments, and provide guidance on management of implementation bottlenecks. The technical functions[5] which were the responsibility of the sub-TWG will be taken up by the Project Management Team (PMT), supported by subject matter experts from the MoH. Technical assistance will be provided to the PMT as needed. To facilitate the implementation of UHC Phase I, institutional and implementation arrangements will be adjusted to include the entities responsible for implementation, management, and oversight of UHC Phase I within the existing government structure. Figure 1 shows the revised institutional and implementation arrangements.

[5] The sub-TWG was responsible for (a) validating the technical soundness of annual work plans and/or monitoring their implementation status, (b) verifying the county's performance; (c) making a final selection of the proposals to support cross-county and intergovernmental collaboration and monitor implementation; and (d) reviewing states' quarterly progress reports.

Figure 1. Revised Institutional and Implementation Arrangements [a]



Note: SC = Steering Committee; PMT = Project Management Team; M&E = Monitoring and Evaluation; FH = Family Health; DoUHC = Department of UHC; KMTC = Kenya Medical Training College; CRD = Civil Registration Department.
a. Any changes to the existing institutional and implementation arrangements are noted in **bold**.

13. **Modification of risk ratings**. While the 'overall' risk of the project continues to be rated Substantial, 'sector strategies and policies' is now rated 'Substantial' instead of 'Moderate' due to an intrinsic risk of implementing an ambitious initiative (UHC). The project will mitigate these risks by building the capacity of the national and county governments to lead the reform process and identify the best UHC model for Kenya. The rating for social safeguards has changed from 'moderate' to 'substantial' largely due to delays in rolling out safeguard instruments to the county level and limited sensitization of vulnerable and marginalized groups on the project services. However, this change reflects the status of the overall project implementation and is not specific to this restructuring.

III. APPRAISAL SUMMARY

A. TECHNICAL ANALYSIS

14. **Universal health coverage,** defined as ensuring all people receive quality health services when needed (promotive, preventive, curative, and rehabilitative) without being exposed to financial hardship, is a target for Sustainable Development Goal 3. UHC also potentially contributes toward the achievement of other key Sustainable Development Goals, including poverty reduction, reduced gender inequality, inclusive economic growth, and reduced inequalities.

15. **The benefits of UHC are clear.** High out-of-pocket payments are estimated to push about 1 million Kenyans into poverty each year, while close to 15 percent do not seek needed services because of affordability barriers. User charges are associated with reduced adherence to treatment, particularly for chronic conditions, resulting in advancement of disease, hospitalization, and more expensive treatments. In addition, many other indirect costs are incurred because of illness, which affect households' economic

development. Evidence from countries that have made progress toward UHC shows that removing financial barriers, accompanied by improvements in quality of care through strengthening infrastructure and human resources, as well as ensuring availability of medicines and diagnostic equipment, have resulted in significant improvements in utilization of services and decline in levels of out-of-pocket payments among the poor. Moreover, removal of user fees is associated with improved health outcomes, particularly among lower-income groups and children living in lower-and-middle-income-countries. By removing user fees in public health facilities in the four counties, UHC Phase I could improve access and reduce disparities in access to health care services between the rich and the poor. However, removal of user fees alone will not necessarily translate into UHC, unless Kenya puts in place adequate measures to address increased demand for services, including, but not limited to, additional human resources requirements, commodities and other inputs, and financial resources to compensate facilities for revenue gaps. Also important is the need to strengthen political commitment for reform and continuous engagement of all stakeholders on policy change.

B. ECONOMIC and FINANCIAL ANALYSIS

16. **UHC brings significant health and economic benefits.** UHC means that all people receive quality health services without suffering financial hardship. Under UHC people have access to a full range of preventive, curative, rehabilitative, and palliative health services that improve health outcomes and reduce mortality, especially for the poorer. Lower mortality rates and longer life expectancy translate into a larger and more productive workforce, thus contributing to the country's economic development. UHC also ensures that people who receive health services do not suffer from financial hardships, that is, they do not fall into or remain trapped in poverty due to high out-of-pocket expenditures. Lower incidence of impoverishing health spending means that households have more resources to make investments from which the country may benefit.

17. **The revised cost-benefit analysis (CBA) shows that the project remains an economically sound investment and supporting UHC Phase I further increases its return on investment.** The present value of the project's benefit increases from US$954.2 million to US$1,112.5 million, while the net present benefit rises from US$779.2 million to US$937.6 million and the benefit-to-cost ratio (BCR) also increases from 5.46:1 to 6.36:1, meaning a return of US$6.36 for US$1 invested. The sensitivity analysis shows that the project would remain an economically viable investment even assuming a discount rate of 6 percent (BCR 3.72:1) or assuming that UHC will reduce adult mortality only by half (BCR 5.89:1). If the social value of a life saved is taken into account, as in the CBA conducted at project appraisal (in the amount of 50 percent of annual GDP per capita), the BCR increases to 6.83:1.

18. **The results presented show that the project, with the proposed restructuring, is a sound economic investment.** The key assumptions used at project appraisal were maintained when updating the CBA (see table 5.1 in the PAD) and the following new assumptions were used to incorporate the impact of financing UHC Phase I in the four counties (table 6). Given the uncertainties around UHC Phase I, the CBA focuses on 12 months of health coverage. For this reason, it is assumed that adults benefit from UHC Phase I only in year 3, and for this year benefits to mothers are included in this group (hence removed from the category "Maternal health benefits" to avoid double counting). The revised CBA results are shown in table 7.

Table 6. Selected New (Health and Economic) Assumptions for Revised CBA

Assumptions	
Average reduction in adult mortality (per 1,000) per 10% increase in public health spending	1.45
Average adult mortality (per 1,000)	152
Households covered through UHC Phase I (%)	80
Budget execution rate (%)	75
Benefits associated with World Bank investment (%)	36

Table 7. Revised CBA

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Child health benefits						
Number of under-five deaths averted	920	945	976	1,003	1,036	4,881
Number of productive life years saved	32,209	33,089	34,171	35,104	36,252	170,824
Present value of productive years gained (US$, millions)	175.5	180.3	186.2	191.3	197.6	930.9
Maternal health benefits						
Number of maternal deaths averted	58	60		63	65	246
Number of productive life years saved	2,031	2,084		2,219	2,277	8,611
Present value of productive years gained (US$, millions)	4.4	4.5		4.8	4.9	18.6
Adult health benefits from UHC						
Number of adult deaths averted			2,483			
Number of productive life years saved			86,891			
Present value of productive years gained (US$, millions)			163.0			
Total health benefits (US$, millions)	**179.9**	**184.8**	**349.2**	**196.1**	**202.5**	**1,112.5**

19. **This CBA only focuses on the economic costs of saving lives and assumes that resources redirected from Component 3 will not affect the expected benefits for children and mothers in other project years.** In addition to reducing mortality, UHC is also expected to reduce morbidity and, thus, further increase the country's economic growth. Moreover, removing user fees in public hospitals and strengthening primary-level facilities will significantly increase equity, which is a key objective of UHC, but whose benefits are hard to monetize.

20. **The rationale for using public funds to support UHC Phase I is justified; however, questions arise about the long-term financial sustainability**. Evidence shows that (a) countries that have made significant progress toward UHC spend a significant share of public resources on health and (b) removing user fees does not translate to UHC, unless significant resources are provided to fill the revenue gap and meet the excess demand. Although the total project envelope remains unchanged because resources for Phase I are being reprogramed from Component 3, questions arise about the long-term financial sustainability of providing free health services in the public sector. The GoK has committed to increase public spending on health to facilitate progress to UHC by allocating US$25 million for UHC Phase I; however, at this point, the level of increase after Phase I is unclear.

21. **The total envelope for UHC Phase I of US$39 million would reflect a small increase of 0.3 percentage points in annual national government spending on health as a percentage of total national government spending; from 2.8 percent to 3.1 percent based on data from FY2016/17**. However, this amount would be significantly higher if the user fees removal approach was scaled up to the entire country. If the four counties were to meet the costs associated with user fees removal beyond Phase I, it

would reflect an increase in their recurrent expenditure of 39 percent to 75 percent, depending on each county's recurrent budget, and thus may not be financially sustainable, unless the national government allocates more resources to health, through conditional grants to counties.

22. **The financial sustainability of the UHC initiative will be further studied and discussed with the GoK along with the findings from the UHC operational research and potentially additional analytic work, as relevant.** The GoK will monitor direct and indirect (e.g. due to increased demand for health services) expenses related to UHC Phase I and consider various options to fund the initiative long-term.

I. SUMMARY OF CHANGES

	Changed	Not Changed
Results Framework	✓	
Components and Cost	✓	
Reallocation between Disbursement Categories	✓	
Overall Risk Rating	✓	
Institutional Arrangements	✓	
Economic and Financial Analysis	✓	
Technical Analysis	✓	
Implementing Agency		✓
DDO Status		✓
Project's Development Objectives		✓
Loan Closing Date(s)		✓
Cancellations Proposed		✓
Disbursements Arrangements		✓
Disbursement Estimates		✓
Safeguard Policies Triggered		✓
EA category		✓
Legal Covenants		✓
Financial Management		✓
Procurement		✓
Implementation Schedule		✓
Other Change(s)		✓
Social Analysis		✓
Environmental Analysis		✓

IV. DETAILED CHANGE(S)

COMPONENTS

Current Component Name	Current Cost (US$M)	Action	Proposed Component Name	Proposed Cost (US$M)
Improving Primary Health Care Results	150.00		Improving Primary Health Care Results	150.00
Strengthening Institutional Capacity	15.10	Revised	Strengthening Institutional Capacity	29.10
Cross-county and Intergovernmental Collaboration, and Project Management	26.00	Revised	Cross-county and Intergovernmental Collaboration, and Project Management	12.00
TOTAL	**191.10**			**191.10**

REALLOCATION BETWEEN DISBURSEMENT CATEGORIES

Current Allocation	Actuals + Committed	Proposed Allocation	Financing % (Type Total)	
			Current	Proposed
IDA-58360-001 | Currency: XDR				
iLap Category Sequence No: 1A	Current Expenditure Category: Performance Grants, part A1			
74,130,000.00	7,102,471.16	74,130,000.00	81.00	81.00
iLap Category Sequence No: 1B	Current Expenditure Category: Performance Grants, part B2			
850,000.00	0.00	850,000.00	100.00	100.00
iLap Category Sequence No: 2A	Current Expenditure Category: GDS,NCS,CS,TRG,OC,A2,B1 excpt B1bi			
12,570,000.00	6,260,183.06	12,570,000.00	54.00	54.00
iLap Category Sequence No: 2B	Current Expenditure Category: GDS,NCS,CS,TRG,OC,B1bi			
0.00	0.00	0.00	0.10	0
iLap Category Sequence No: 3	Current Expenditure Category: GDS,WKS,NCS,CS,TRG,OC part C			

	18,350,000.00	932,455.55	8,470,000.00	100.00	100.00
iLap Category Sequence No: 2C		Current Expenditure Category: Goods under Part B1(c) (iv) of the Project			
	0.00	0.00	9,880,000.00		100
Total	**105,900,000.00**	**14,295,109.77**	**105,900,000.00**		

TF-A2561-001 | Currency: USD

iLap Category Sequence No: 1A		Current Expenditure Category: Performance Grants, part A1			
	25,000,000.00	2,483,256.50	25,000,000.00	19.00	19.00
iLap Category Sequence No: 1B		Current Expenditure Category: Performance Grants, part B2			
	0.00	0.00	0.00	19.00	0
iLap Category Sequence No: 2A		Current Expenditure Category: GDS,NCS,CS,TRG,OC,A2,B1 excpt B1bi			
	15,000,000.00	7,730,905.37	15,000,000.00	46.00	46.00
iLap Category Sequence No: 2B		Current Expenditure Category: GDS,NCS,CS,TRG,OC,B1bi			
	0.00	0.00	0.00	46.00	0
iLap Category Sequence No: 3		Current Expenditure Category: GDS,WKS,NCS,CS,TRG,OC part C			
	0.00	0.00	0.00	0.10	0
Total	**40,000,000.00**	**10,214,161.87**	**40,000,000.00**		

TF-A2792-001 | Currency: USD

iLap Category Sequence No: 2B		Current Expenditure Category: Gds,NonCS,CS,Trg,OC PtsB1(b)i			
	1,100,000.00	239,061.71	1,100,000.00	100.00	100.00

Total	**1,100,000.00**	**239,061.71**	**1,100,000.00**

SYSTEMATIC OPERATIONS RISK-RATING TOOL (SORT)

Risk Category	Rating at Approval	Current Rating
Political and Governance	High	High
Macroeconomic	Moderate	Moderate
Sector Strategies and Policies	Moderate	Substantial
Technical Design of Project or Program	Substantial	Substantial
Institutional Capacity for Implementation and Sustainability	High	High
Fiduciary	Substantial	Substantial
Environment and Social	Low	Moderate
Stakeholders	Substantial	High
Other		
Overall	Substantial	Substantial

Results framework

COUNTRY: Kenya
Transforming Health Systems for Universal Care

Project Development Objectives(s)

The project development objective is to improve utilization and quality of primary health care services with a focus on reproductive, maternal, newborn, child, and adolescent health services.

Project Development Objective Indicators by Objectives/ Outcomes

Indicator Name	DLI	Baseline	Intermediate Targets				End Target
			1	2	3	4	
Improved utilization and quality of primary health care services *(Action: This Objective has been Revised)*							
Children immunized with the third dose of Pentavalent (Percentage)		79.50	80.00	81.00	82.00	83.00	84.00
Action: This indicator has been Revised	***Rationale:*** ***This is an internationally recognized proxy for completion of the vaccination series and the ability of the health system to reach children multiple times with an essential service and it is less prone to measurement issues.***						
Pregnant women attending at least four ANC visits (Percentage)		39.70	41.00	42.00	50.00	51.00	52.00
Action: This indicator has been Revised	***Rationale:*** ***Revised baseline value to add decimal number and revised targets(increased) based on Project achievement by the time of the MTR.***						
Births attended by skilled health personnel (Percentage)		57.00	57.00	59.00	66.00	67.00	67.00

Indicator Name	DLI	Baseline	Intermediate Targets				End Target
			1	2	3	4	
Action: This indicator has been Revised	***Rationale:*** ***Revised targets (increased) based on Project achievement by the MTR.***						
Women between the ages of 15-49 years currently using a modern FP method (Percentage)		47.80	48.00	49.00	50.00	51.00	52.00
Action: This indicator has been Revised	***Rationale:*** ***The baseline value and targets were revised based on updated data.***						
Inspected facilities meeting safety standards (Percentage)		0.00	0.00	0.00	25.00	40.00	50.00
Action: This indicator has been Revised	***Rationale:*** • ***Definition of the indicator specifies public health facilities and correct the score to be 60 percent or more (instead of 61)*** • ***Data source was updated (now DHIS2)***						
Pregnant women attending ANC supplemented with IFA (Percentage)		31.00	31.00	34.00	69.00	71.00	73.00
Action: This indicator is New	***Rationale:*** ***This indicator was upgraded from intermediate result indicator to PDO-level indicator (measuring quality of care) as it reflects the completeness/quality of ANC visits (clinical quality) and/or the availability of iron-folic acid at facilities (structural quality).*** ***The targets for year 3 to end target were revised based on the progress achieved by the MTR (66% by December 2018).***						

Intermediate Results Indicators by Components

Indicator Name	DLI	Baseline	Intermediate Targets				End Target
			1	2	3	4	
Component 1: Improved primary health care results							
Health facilities providing BEmOC (Percentage)		39.00	40.00	45.00	50.00	55.00	60.00
Action: This indicator has been Marked for Deletion	***Rationale:*** ***Indicator was dropped due to data quality issues including: self-reported data without verification if the BEmONC functions are actually present, denominator (# facilities) not regularly updated, unclear definition of facilities supposed to offer BEmONC services.***						
Pregnant women attending ANC supplemented with IFA (Percentage)		31.00	32.00	34.00	36.00	38.00	40.00
Action: This indicator has been Marked for Deletion	***Rationale:*** ***This indicator was upgraded from intermediate indicator to PDO-level indicator as it reflects the completeness/quality of ANC visits (clinical quality) and/or the availability of iron-folic acid at facilities (structural quality).***						
People who have received essential health, nutrition, and population (HNP) services (CRI, Number)		0.00	1,860,000.00	3,800,000.00	5,800,000.00	7,900,000.00	10,060,000.00
Action: This indicator has been Revised	***Rationale:*** ***Added intermediate targets***						
Number of children immunized (CRI, Number)		0.00					5,400,000.00

Indicator Name	DLI	Baseline	Intermediate Targets				End Target
			1	2	3	4	
Action: This indicator has been Revised							
Number of deliveries attended by skilled health personnel (CRI, Number)		0.00					4,660,000.00
Component 2: Strengthened institutional capacity							
Facilities inspected for safety standards (Number)		0.00	0.00	0.00	800.00	1,400.00	1,635.00
Action: This indicator has been Revised	***Rationale:*** ***The definition was revised to specify that the Project will track inspections in public health facilities.*** ***The indicator was maintained but targets revised from percentage to number to address data quality issues related to the list of facilities not being routinely updated.***						
Reports submitted to DHIS in a timely manner. (Percentage)		88.80	88.80	90.00	94.00	98.00	98.00
Action: This indicator has been Revised	***Rationale:*** • ***"Health facilities" was removed because level II and III facilities do not submit reports themselves.*** • ***Form 713 was removed because the data from form 713 were moved to the reporting tool MOH 711.*** • ***The baseline value and targets were revised according to the new definition and the Project achievements at the time of the MTR (December 2018)***						
Births registered within 6 months of occurrence (Percentage)		65.90	65.00	70.00	74.00	78.00	80.00
Action: This indicator has been Revised	***Rationale:***						

Indicator Name	DLI	Baseline	Intermediate Targets				End Target
			1	2	3	4	
	• ***Based on the Children's Code, article 157, in Kenya declarations of birth must be done within 6 months to the civil registrar of the place of birth and 8 months for births occurring outside the municipality perimeter or in a foreign country. Therefore, this indicator reflects both the number and timeliness of registration. Timeliness was specified in the RF.*** • ***The baseline value was revised based on updated data.***						
RMNCAH related operations research completed to inform policy/strategy (Number)		0.00	0.00	0.00	1.00	2.00	2.00
Action: This indicator has been Revised	***Rationale:*** ***The end target for this indicator is reduced from 3 to 2 because initially identified research question have already been investigated by partners.*** ***It was further specified that the indicator is expressed in cumulative number.***						
A benefit package developed, costed, and disseminated (Number)		0.00	0.00	0.00	1.00	1.00	1.00
Lessons learned from UHC Phase I documented and disseminated (Yes/No)		No					Yes
Action: This indicator is New	***Rationale:*** ***Results from the process evaluation of UHC phase I should be documented and disseminated to inform the scale up.***						
Component 3: Cross-county/intergovernmental collaboration and project management							
Functional community units (Number)		302.00	1,500.00	3,000.00	4,531.00	4,931.00	5,331.00
Action: This indicator has been Revised	***Rationale:***						

Indicator Name	DLI	Baseline	Intermediate Targets				End Target
			1	2	3	4	
	The indicator was defined to measure the number of functional CU using three criteria as per national guidelines (see PAD). However, there is no data to measure all three criteria. To address this flaw, the functionality of CU is measured using the number of reports submitted using data from DHIS. Baseline and targets values were revised accordingly.						
Grievances registered related to delivery of project benefits that are addressed (Percentage)		0.00	15.00	30.00	45.00	60.00	80.00
Implementing entities submitting the annual FM and technical report on time (Percentage)		0.00	15.00	30.00	95.00	95.00	95.00
Action: This indicator has been Revised	***Rationale:*** • ***The description of this indicator was revised to define "on time" as per financial agreement.*** • ***Also, the targets were revised to maintain achieved results.***						