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Report No: PAD1694

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT APPRAISAL DOCUMENT

ON A

PROPOSED CREDIT
IN THE AMOUNT OF SDR 105.9 MILLION
(US$150 MILLION EQUIVALENT)

AND A

PROPOSED GRANT
IN THE AMOUNT OF US$40 MILLION
FROM THE GLOBAL FINANCING FACILITY

AND A

PROPOSED GRANT
IN THE AMOUNT OF US$1.1 MILLION
FROM THE JAPAN POLICY AND HUMAN RESOURCES DEVELOPMENT FUND

TO THE

REPUBLIC OF KENYA

FOR A

TRANSFORMING HEALTH SYSTEMS FOR UNIVERSAL CARE PROJECT

May 24, 2016

Health, Nutrition and Population Global Practice
Africa Region

CURRENCY EQUIVALENTS
(Exchange Rate Effective April 30, 2016)

Currency Unit	=	Kenya Shilling (KES)
KES 99.4	=	US$1
US$1.42	=	SDR 1

FISCAL YEAR
July 1 – June 30

ABBREVIATIONS AND ACRONYMS

ACSM	Advocacy, Communication, and Social Mobilization
ANC	Antenatal Care
ASAL	Arid and Semi-arid Land
ASRH	Adolescent Sexual and Reproductive Health
AWP	Annual Work Plan
BEmONC	Basic Emergency Obstetric and Neonatal Care
BROP	Budget Review and Outlook Paper
CBA	Cost Benefit Analysis
CBK	Central Bank of Kenya
CBM	Community-based Monitoring
CDoH	County Department of Health
CE	Citizen Engagement
CEmONC	Comprehensive Emergency Obstetric and Neonatal Care
CFSP	County Fiscal Strategy Paper
CHC	Community Health Committee
CHEW	Community Health Extension Worker
CHMT	County Health Management Team
CHS	Community Health Strategy
CHW	Community Health Worker
CoG	Council of Governors
CPS	Country Partnership Strategy
CQI	Continuous Quality Improvement
CRA	County Revenue Allocation
CRF	County Revenue Fund
CRS	Civil Registration Services
CRVS	Civil Registration and Vital Statistics
CSO	Civil Society Organization
DA	Designated Account
DANIDA	Danish International Development Agency
DFH	Division of Family Health

DFID	U.K. Department for International Development
DHCF	Division of Health Care Financing
DHIS	District Health Information Software
DP	Development Partner
DQA	Data Quality Audit
EMMS	Essential Medicines and Medical Supplies
FM	Financial Management
FP	Family Planning
GDP	Gross Domestic Product
GFF	Global Financing Facility in Support of Every Woman Every Child
GiZ	*Deutsche Gesellschaft für Internationale Zusammenarbeit* (German Corporation for International Cooperation)
GoK	Government of Kenya
GRM	Grievance Redress Mechanism
GRS	Grievance Redress Service
HCWMP	Health Care Waste Management Plan
HFMC	Health Facility Management Committee
HFS	Health Financing Strategy
HiA	Health in Africa
HIS	Health Information Systems
HRH	Human Resources for Health
HSS	Health Systems Strengthening
IBRD	International Bank for Reconstruction and Development
ICB	International Competitive Bidding
ICD	International Classification of Diseases
ICT	Information and Communication Technology
IDA	International Development Association
IFA	Iron and Folic Acid
IFC	International Finance Corporation
IFMIS	Integrated Financial Management Information System
IFR	Integrated Financial Report
IIFRA	Independent Integrated Fiduciary Review Agent
JHIC	Joint Health Inspections Checklist
KDHS	Kenya Demographic and Health Survey
KEMSA	Kenya Medical Supplies Authority
KfW	*Kreditanstalt für Wiederaufbau* (German Development Bank)
KHHEUS	Kenya Household Health Expenditure and Utilization Survey
KHP	Kenya Health Policy
KHSSIP	Kenya Health Sector Strategic and Investment Plan
KHSSP	Kenya Health Sector Support Project

KMTC	Kenya Medical Training College
KNBS	Kenya National Bureau of Statistics
KQMH	Kenya Quality Model for Health
KSG	Kenya School of Government
LSTM	Liverpool School of Tropical Medicine
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDTF	Multi-Donor Trust Fund
MFL	Master Facility List
MoH	Ministry of Health
MPDSR	Maternal and Perinatal Death Surveillance and Response
MTP	Medium Term Plan
NCB	National Competitive Bidding
NGO	Nongovernmental Organization
NHIF	National Hospital Insurance Fund
NT	National Treasury
OAG	Office of the Auditor General
OP/BP	Operational Policy/Bank Procedures
PA	Project Account
PDO	Project Development Objective
PFM	Public Financial Management
PHC	Primary Health Care
PHRD	Policy and Human Resources Development Fund
PMT	Project Management Team
PNC	Postnatal Care
POM	Project Operations Manual
PPADA	Public Procurement and Asset Disposal Act
QIT	Quality Improvement Team
RBF	Results-based Financing
RMNCAH	Reproductive, Maternal, Newborn, Child, and Adolescent Health
RMNCH	Reproductive, Maternal, Newborn, and Child Health
SAc	Social Accountability
SAI	Supreme Audit Institution
SBD	Standard Bidding Document
SCM	Supply Chain Management
SoE	Statements of Expenditure
TA	Technical Assistance
TCIP	Transparency and Communications Infrastructure Project
TF	Trust Fund
TFR	Total Fertility Rate

THE	Total Health Expenditure
ToR	Terms of Reference
TWG	Technical Working Group
UHC	Universal Health Coverage
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VMG	Vulnerable and Marginalized Group
VMGF	Vulnerable and Marginalized Groups' Framework
VMGP	Vulnerable and Marginalized Groups' Plan
WA	Withdrawal Application
WHO	World Health Organization
WRA	Women of Reproductive Age

Regional Vice President:	Makhtar Diop
Country Director:	Diariétou Gaye
Senior Global Practice Director:	Timothy Grant Evans
Practice Manager:	Magnus Lindelow
Task Team Leader:	Yi-Kyoung Lee

REPUBLIC OF KENYA
Transforming Health Systems for Universal Care Project

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PAD DATA SHEET

Kenya

Transforming Health Systems for Universal Care Project (P152394)

PROJECT APPRAISAL DOCUMENT

AFRICA

Health, Nutrition, and Population Global Practice

Report No.: PAD1694

Basic Information			
Project ID P152394	EA Category B - Partial Assessment		Team Leader(s) Yi-Kyoung Lee
Lending Instrument Investment Project Financing	Fragile and/or Capacity Constraints [ ] Financial Intermediaries [ ] Series of Projects [ ]		
Project Implementation Start Date 15-June-2016	Project Implementation End Date 30-Jun-2021		
Expected Effectiveness Date 15-Sep-2016	Expected Closing Date 30-Sep-2021		
Joint IFC No			
Practice Manager Magnus Lindelow	Senior Global Practice Director Timothy Grant Evans	Country Director Diarietou Gaye	Regional Vice President Makhtar Diop
Borrower: National Treasury			
Responsible Agency: Ministry of Health			
Contact: Dr. Nicholas Muraguri		Title: Principal Secretary	
Telephone No.: 254-202717077		Email: pshealthke@gmail.com	

Project Financing Data(in US$, Millions)					
[ ] Loan	[ ] IDA Grant	[ ] Guarantee			
[X] Credit	[X] Grant	[ ] Other			
Total Project Cost:	191.10		Total Bank Financing:	150.00	
Financing Gap:	0.00				

Financing Source	Amount
BORROWER/RECIPIENT	0.00
International Development Association (IDA)	150.00
Global Financing Facility	40.00
Japan Policy and Human Resources Development Fund	1.10
Total	191.10

Expected Disbursements (in US$, Millions)

Fiscal Year	2017	2018	2019	2020	2021	2022	
Annual	10.00	35.00	40.00	40.00	40.00	26.10	
Cumulative	10.00	45.00	85.00	125.00	165.00	191.10	

Institutional Data

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

Cross Cutting Topics

[ ] Climate Change
[ ] Fragile, Conflict & Violence
[ ] Gender
[ ] Jobs
[ ] Public Private Partnership

Sectors / Climate Change

Sector (Maximum 5 and total % must equal 100)

Major Sector	Sector	%	Adaptation Co-benefits %	Mitigation Co-benefits %
Health and other social services	Health	100		
Total		100		

☑ I certify that there is no Adaptation and Mitigation Climate Change Co-benefits information applicable to this project.

Themes

Theme (Maximum 5 and total % must equal 100)

Major theme	Theme	%
Human development	Child health	30
Human development	Health system performance	30

Human development	Population and reproductive health	30
Human development	Nutrition and food security	10
Total		100

Proposed Development Objective(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.

Components

Component Name	**Cost (US$, Millions)**
Improving Primary Health Care Results	150.00
Strengthening Institutional Capacity	15.10
Cross-county and Intergovernmental Collaboration, and Project Management	26.00

Systematic Operations Risk-Rating Tool (SORT)

Risk Category	**Rating**
1. Political and Governance	High
2. Macroeconomic	Moderate
3. Sector Strategies and Policies	Moderate
4. Technical Design of Project or Program	Substantial
5. Institutional Capacity for Implementation and Sustainability	High
6. Fiduciary	Substantial
7. Environment and Social	Low
8. Stakeholders	Substantial
9. Other	–
OVERALL	Substantial

Compliance

Policy

Does the project depart from the CAS in content or in other significant respects?	Yes [ ]	No [X]
Does the project require any waivers of Bank policies?	Yes [ ]	No [X]
Have these been approved by Bank management?	Yes [ ]	No [ ]
Is approval for any policy waiver sought from the Board?	Yes [ ]	No [X]
Does the project meet the Regional criteria for readiness for implementation?	Yes [X]	No [ ]

Safeguard Policies Triggered by the Project	**Yes**	**No**
Environmental Assessment OP/BP 4.01	**X**	

Natural Habitats OP/BP 4.04		**X**
Forests OP/BP 4.36		**X**
Pest Management OP 4.09		**X**
Physical Cultural Resources OP/BP 4.11		**X**
Indigenous Peoples OP/BP 4.10	**X**	
Involuntary Resettlement OP/BP 4.12		**X**
Safety of Dams OP/BP 4.37		**X**
Projects on International Waterways OP/BP 7.50		**X**
Projects in Disputed Areas OP/BP 7.60		**X**

Legal Covenants

Name	**Recurrent**	**Due Date**	**Frequency**
Schedule 2. Section I. A.1. Project sub-technical working group (TWG)		30-Sep-2016	

Description of Covenant

The recipient shall establish, by no later than September 30, 2016, a project Sub-TWG, under Intergovernmental Health Forum, to be co-chaired by the MOH and a County representative.

Name	**Recurrent**	**Due Date**	**Frequency**
Schedule 2. Section I. D.1. Annual work plans	**X**		Yearly

Description of Covenant

The recipient shall prepare and furnish annual work plans appraised by the Project sub-Technical Working Group to the Association for its review and approval.

Name	**Recurrent**	**Due Date**	**Frequency**
Schedule 2. Section II. A.1. Project reports	**X**		Quarterly

Description of Covenant

The recipient shall monitor and evaluate the progress of the project and prepare project reports on the basis of indicators acceptable to the Association. Each project report shall cover the period of one calendar quarter, and shall be furnished to the Association not later than 45 days after the end of the period covered by such report.

Name	**Recurrent**	**Due Date**	**Frequency**
Schedule 2. Section II. A.2. Midterm review		31-Mar-2019	

Description of Covenant

The recipient shall, not later than thirty (30) months after the Effective Date, undertake, in conjunction with all agencies involved in the project, a comprehensive midterm review of the project.

Conditions

Source Of Fund	**Name**	**Type**
IDA	Article IV. 4.01.(a). Project management team	Effectiveness

Description of Condition		
The recipient has established a project management team under the terms of reference and experience acceptable to the Association.		
Source Of Fund	**Name**	**Type**
IDA	Article IV. 4.01.(b). Co-financing Agreements	Effectiveness

Description of Condition		
The Co-financing Agreements have been executed and delivered and all conditions precedent to their effectiveness or to the right of the recipient to make withdrawals under those agreements have been fulfilled.		
Source Of Fund	**Name**	**Type**
GFF	Article IV. 4.01-4.03. Legal opinion	Effectiveness

Description of Condition		
There shall be furnished to the World Bank a satisfactory legal opinion confirming that the execution and delivery of the Agreement on behalf of the recipient has been duly authorized or ratified by all necessary government action.		
Source Of Fund	**Name**	**Type**
IDA	Schedule 2.Section IV.B.1.(b). Project operations manual	Disbursement

Description of Condition
No withdrawal shall be made for payments made under Category (1)(a), unless the recipient has adopted the project operations manual, in form and substance satisfactory to the Association.

Team Composition

Bank Staff

Name	Role	Title	Specialization	Unit
Yi-Kyoung Lee	Team Leader (ADM Responsible)	Senior Health Specialist	Task Team Leader	GHN01
Joel Buku Munyori	Procurement Specialist (ADM Responsible)	Senior Procurement Specialist	Procurement	GGO01
Henry Amena Amuguni	Financial Management Specialist	Sr Financial Management Specialist	Financial Management	GGO31
Benjamin Kithome Kilaka	Safeguards Specialist	Consultant	Social Safeguards	GSURR
Christiaan Johannes Nieuwoudt	Team Member	Finance Officer	Disbursement	WFALA
Edward Felix Dwumfour	Safeguards Specialist	Senior Environmental Specialist	Environmental Safeguards	GEN01
Edwin Wafula Barasa	Team Member	Consultant	Health Financing	GHNDR

Elizabeth Laura Lule	Team Member	Consultant	RMNCAH	GHN01
Eva K. Ngegba	Team Member	Program Assistant	Administration	GHN01
Evelyn Anna Kennedy	Team Member	Senior Operations Officer	Quality Assurance	GHN01
Gandham N.V. Ramana	Team Member	Program Leader	Overall Guidance	AFCE2
Gibwa A. Kajubi	Safeguards Specialist	Senior Social Development Specialist	Social Safeguards	GSU07
Jane Chuma	Team Member	Sr Economist (Health)	Health Financing	GHN01
Joyce Cheruto Bett	Team Member	Program Assistant	Administration	AFCE2
Kishor Uprety	Counsel	Senior Counsel	County Lawyer	LEGAM
Maina Ephantus Githinji	Safeguards Specialist	Consultant	Environmental Safeguards	GENDR
Monica Gathoni Okwirry	Team Member	Program Assistant	Procurement	AFCE2
Racheal Njeri Mwaura	Team Member	Health Specialist	Public Health	GHNDR
Samuel Lantei Mills	Team Member	Senior Health Specialist	M&E; CRVS	GHN03
Son Nam Nguyen	Team Member	Lead Health Specialist	Health Systems	GHN01
Sophie Nelly Rabuku	Team Member	Program Assistant	Administration	AFCE2
Stephen Diero Amayo	Team Member	Consultant	Financial Management	GGODR
Susanne Ndunge Ndivo	Safeguards Specialist	Consultant	Social Safeguards	GSURR
Toni Lee Kuguru	Team Member	Consultant	Results Based Financing	GHN01
Yvonne Wangui Machira	Team Member	Consultant	Citizen Engagement	GHN01

Locations

Country	First Administrative Division	Location	Planned	Actual	Comments
Kenya	All 47 counties				

I. STRATEGIC CONTEXT

A. Country Context

1. **Kenya's economy remains robust.** Kenya has experienced strong economic growth of around 5.6 percent on average in the last five years making it the fifth largest economy in Sub-Saharan Africa. In 2014, the rebasing of Kenya's national accounts resulted in an upward revision of the gross domestic product (GDP) per capita and reclassification of Kenya as a lower-middle-income country. In 2015, the GDP growth rate was 6 percent mainly driven by public investment in infrastructure, lower oil prices, improved tourism performance and higher private-sector investments. Projections suggest that the economy will continue to grow by 7 percent in the next two years.[1]

2. **Kenya's economic growth has not been inclusive, thus high levels of poverty and regional and economic disparities exist.** The latest reliable data show that the poverty headcount in Kenya was 47 percent in 2005.[2] More recent projections from 2011 suggest a slightly lower poverty headcount in the range of 34 and 42 percent. Poverty levels vary widely between rural (50 percent) and urban (34 percent) areas, as well as among counties (for example, ranging from around 12 percent in Kajiado to more than 90 percent in Turkana). Some social indicators have improved significantly, but the country's Gini index of 48.5 in 2005[3] compares less favorably with other countries in the region. Kenya's Human Development Index has also improved from 0.455 in 2000 to 0.548 in 2014, but the country still remains in the low human development category (145 out of 188 countries).[4]

3. **Kenya has embarked on a very ambitious and rapid devolution process.** The 2010 Constitution of Kenya reflected the Kenyan people's desire for equity, transparency, and accountability, including access to basic services and resulted in the fast tracked devolution of responsibilities to 47 newly created counties. With a guaranteed unconditional transfer of national revenue, the county governments are expected to address local needs for devolved services, including health care. The building blocks for devolution are still evolving, including intergovernmental structures and mechanisms for intergovernmental cooperation and transfer of resources to deliver on policy priorities.

4. **The Second Medium Term Plan (MTP 2013–2017) of the Government of Kenya (GoK) has a strong focus on inclusive economic growth and the Sustainable Development Goals.** Aligned to Vision 2030, the MTP identifies key policy actions, reforms, and programs that will enable Kenya to achieve accelerated and inclusive economic growth. Primary health care (PHC), maternal and child health (MCH) services, access to clean water and sanitation, and education are priority areas for the Government. The MTP also emphasizes full implementation of

[1] http://data.worldbank.org/indicator/NY.GDP.MKTP.KD.ZG/countries/KE?display=graph.
[2] National poverty line of KES 1,562 per month in rural areas and KES 2913 per month in urban areas.
[3] World Bank. World Development Indicators. http://data.worldbank.org/data-catalog/world-development-indicators. Accessed on March 24, 2016.
[4] United Nations Development Programme. 2015. *Human Development Report 2015: Work for Human Development*. New York.

the devolution process, as required in the Constitution, and prioritizes developing the capacity of county governments and improving coordination between the two levels of government.

B. Sectoral and Institutional Context

5. **The health status of Kenya's population has improved over the last decade, but challenges, including considerable inequity, remain**. Under-five mortality and infant mortality rates were halved between 2003 and 2014 due to the increased use of essential health services such as immunization, vitamin A supplementation, and use of insecticide treated nets. However, neonatal mortality experienced a much slower rate of decline in the last decade, with more than 42 percent of deaths under 5 years of age occurring in the first month of life (table 1). Despite improvements in the nutrition status since 2003, more than one in four children under five were still stunted. The total fertility rate (TFR) reduced to 3.9 births per woman after a decade of stagnation, but the maternal mortality ratio remained unacceptably high at 362 per 100,000 live births in 2014. Also, teenage pregnancy remains high with 18 percent of girls between the ages of 15 and 19 having begun childbearing.[5] Moreover, a considerable variation in health status by geographic and socioeconomic factors remains. For example, the under-five mortality rate in 2014 ranged from 42 deaths per 1,000 live births in Central region, to 82 deaths per 1,000 live births in Nyanza region. TFR ranged from 6.4 among women in the lowest wealth quintile to 2.8 among those in the highest wealth quintile.

Table 1. Trends in Key Health Indicators

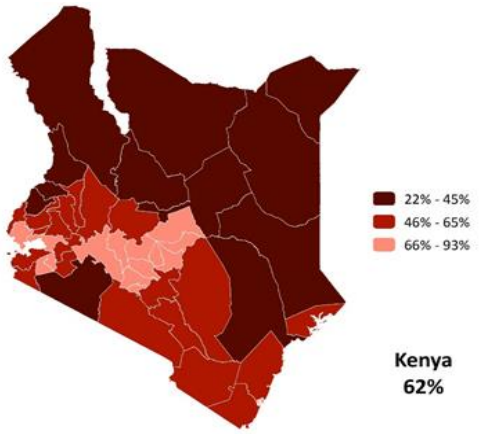
Indicators	2003	2008/09	2014
Health Status			
Neonatal mortality rate (per 1,000 live births)	33.0	31.0	22.0
Infant mortality rate (per 1,000 live births)	77.0	52.0	39.0
Under-five mortality rate (per 1,000 live births)	115.0	74.0	52.0
Stunting (% of children under 5 years of age)	35.8	35.2	26.0
Maternal mortality ratio (per 100,000 live births)	414.0	488.0	362.0
TFR (births per woman)	5.0	4.7	3.9
HIV prevalence (% of population of ages 15–49 years)	7.2	5.6	6.0
Utilization of Essential Services			
Antenatal care (ANC) visits four times or more (%)	52.3	47.1	57.6
Iron and folic acid (IFA) supplementation (% of pregnant women receiving 90+ IFA)	2.5	2.5	7.5
Skilled birth attendance (%)	41.6	43.8	61.8
Postnatal care (PNC) in 2 days (%)	48.7	47.1	52.9
Modern contraceptive prevalence rate (% of currently married women ages 15–49 using any modern method)	31.5	39.4	53.4
Full immunization (% of children ages 12–23 months)[a]	56.8	77.4	79.4
Vitamin A supplementation (% of children ages 6–59 months)	33.0	30.3	71.7
Use of insecticide treated nets (% of children under 5 years of age)	4.6	46.7	54.1

Sources: Kenya Demographic and Health Survey (KDHS) 2003, KDHS 2008/9, KDHS 2014, World Development Indicators, and Kenya AIDS Indicator Survey 2013; Ministry of Health (MoH) 2014.
Note: [a]Full immunization refers to BCG, measles, and three doses each of DPT-HepB-Hib and polio vaccine (excluding polio vaccine given at birth).

[5] KNBS (Kenya National Bureau of Statistics). 2015. *KDHS 2014*.

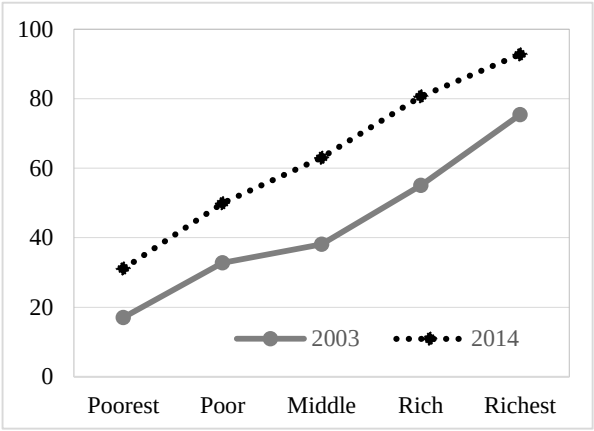
6. **Utilization of essential health services has improved on average, but wide disparities persist.** Utilization of outpatient services increased from 1.9 annual visits per capita in 2003, to 3.1 visits in 2013. Inpatient service utilization also increased from 15 admissions per 1,000 population to 38 admissions per 1,000 population during the same period.[6] However, many women still do not have access to essential PHC services, utilization among socio-economic groups and geographic areas still varies considerably, and significant inequity remains. For example, nearly 40 percent of births were not attended by skilled health workers in 2014 (table 1). Also, skilled birth attendance was 22 percent in Wajir county compared to 93 percent in Kiambu county (figure 1); and 31 percent in the poorest wealth quintile compared to 93 percent in the richest wealth quintile (figure 2).[7]

Figure 1. Skilled Birth Attendance by County



Source: KDHS 2014.

Figure 2. Skilled Birth Attendance by Wealth Quintile



Sources: KDHS 2003; KDHS 2014.

7. **Demand- and supply-side barriers have hampered utilization and coverage of essential services.** *On the demand side,* socio-cultural beliefs and practices, low status of women, poverty, high cost of services (including transportation), long distance to health facilities especially in arid and semi-arid land (ASAL) counties, and poor health provider attitudes impede the demand for essential services including reproductive, maternal, newborn, child, and adolescent health (RMNCAH) services.[8,9] For example, total demand for family planning (FP) was only 33 percent in North Eastern region, compared to 83 percent in Eastern region in 2014.[10] This difference illustrates the need to address factors that impede demand in North Eastern region before intensifying supply-side interventions. Key strategies to address demand barriers include: (a) strategic behavior change communication with key stakeholders to increase knowledge and improve health seeking behaviors of individuals, families, and communities; (b) use of demand-

[6] MoH. 2014. *2013 Kenya Household Health Expenditure and Utilization Survey (KHHEUS)*. Nairobi: GoK
[7] KNBS. 2015. *KDHS 2014.*
[8] Abuya T et. al. 2015. Exploring the Prevalence of Disrespect and Abuse during Childbirth in Kenya. PLoS One 10(4): e0123606
[9] MoH. 2015. *Kenya RMNCAH Investment Framework*; Health Policy Initiative Task Order 1. 2010. *EQUITY. Understand Barriers to Access Among the Poor.* Futures Group. Washington DC.
[10] KNBS. 2015. The total demand for FP is defined as the sum of unmet need plus total contraceptive use.

side financing; and (c) implementation of the Community Health Strategy (CHS) to build capacity of households to demand quality services.

8. **On the supply side, key health system barriers include**:

(a) **Weak stewardship and evolving governance structures.** Strong governance and stewardship for health is essential for effective management of the health systems and efficient delivery of PHC services especially at the county level. Key challenges in delivering effective and efficient health services include: limited use of evidence for decision-making, sub-optimal support and supervision, and inadequate management capacity. With the rapid devolution, governance structures are still evolving, resulting in (i) disjointed investment efforts; (ii) unsystematic engagement of stakeholders, including private sector and communities, during the planning and budgeting processes; and (iii) poor coordination that limits synergies among different actors in the health sector.

(b) **Inadequate health information and civil registration and vital statistics (CRVS) systems.** Despite some improvement in recent years, data, from the routine health information systems (HIS) such as the District Health Information Software 2 (DHIS2), are of low quality, often late, and incomplete. Moreover, data from various HIS are not linked and platforms to inform evidence-based decision making are still limited. The CRVS system that can provide necessary and up-to-date data for planning is in place, but incomplete registration of births (60 percent) and deaths (48 percent) persist.[11] The low registration of vital statistics is attributed to irregular supportive supervision and limited access to civil registration offices.

(c) **Weak management of human resources for health (HRH).** Although the overall number of trained health professionals has increased, absorption into the public sector and retention of health workers in hard-to-reach, rural areas remains a challenge. The result is HRH shortages, especially in midwifery, and uneven distribution of health professionals. The situation is exacerbated by high absenteeism, insufficient competency, and low productivity. For example, the absence rate of health workers during unannounced visits to health facilities was high at 27 percent.[12] The absence rates were higher in public facilities and most of the absences were sanctioned, pointing to weak management of HRH.

(d) **Insufficient essential medicines and medical supplies (EMMS).** Funding gaps for essential commodities, weak capacity to accurately quantify EMMS, and sub-optimal supply chain management (SCM) among other factors often result in stock-outs. Also, a lack of clarity regarding roles and responsibilities for procuring strategic health commodities has increased the challenges of EMMS management. In FY2015/16, counties agreed to shift responsibility for the procurement of vaccines to the national government to ensure sustained immunization coverage. However, there is still lack of clarity between the national and county levels in regard to the location of budget

[11] Civil Registration Services (CRS).
[12] Martin G. and O. Pimhidzai. 2013. *Service Delivery Indicators: Kenya*. World Bank.

and procurement responsibility of other strategic public health commodities, including those for FP.

(e) **Inadequate and inequitable health care financing.** The share of health expenditure, out of total government expenditure, has remained low (6.1 percent) and about one-third of health expenditure comes from out-of-pocket payments. Although per capita health expenditure increased in the last decade from US$45 in FY2001/02 to US$67 in FY2012/13, the share of health in total government expenditures declined from 8 to 6 percent during the same period.[13] While government expenditure, as a share of total health expenditure (THE), increased from 27 percent in FY2009/10 to 31 percent in FY2012/13, out-of-pocket expenditure also increased from 30 percent to 32 percent during the same period. The increase is attributed to a significant decline in contributions by development partners (DPs), from 32 percent to 26 percent (table 2). A significant part of external financing still remains off-budget, fragmented, uncoordinated, and unpredictable, and primarily targets a few diseases such as HIV/AIDS, tuberculosis, and malaria. In addition, there is a wide variation in the share of the county budget allocated to health, ranging from less than 5 percent up to 41 percent.[14] Planning and budgeting capacity is generally weak and varies across counties and different tiers of the health system.

Table 2. Trends in Key Health Financing Indicators

Indicators	2001/02	2005/06	2009/10	2012/13
THE per capita (US$)	44.6	51.8	55.8	66.6
THE (% of nominal GDP)	5.1	4.7	5.4	6.8
Public health expenditure (% of government expenditure)	8.0	5.2	4.6	6.1
Financing source as a % of THE				
Government (% of THE)			27.1	31.2
Corporations (% of THE)			11.4	10.1
Households (% of THE)			29.6	32.0
External donors (% of THE)			31.9	25.5

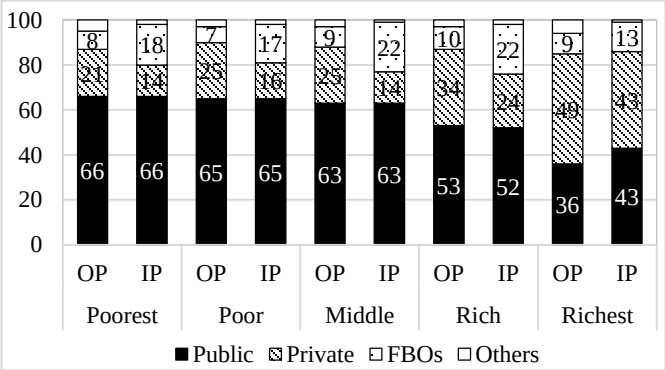
Source: Kenya National Health Account 2012/13.

(f) **Poor quality of care.** Health system weaknesses described above have resulted in poor quality of care. According to the baseline results from a safety pilot using the Joint Health Inspections Checklist (JHIC), over 95 percent of public and private health facilities inspected were "minimally or partially compliant" to the safety standards. The categories of laboratory services, general management, and recording of information scored worst at 28 percent of the maximum score.[15] Another facility survey showed that only 57 percent of facilities have basic infrastructure such as water, electricity, and sanitation.[16]

[13] MoH. 2014. *Kenya National Health Accounts 2012/13. Nairobi*.
[14] MoH. 2015. *2014/2015 National and County Health Budget Analysis Report*.
[15] Kenya Patient Safety Impact Evaluation: Presentation on Preliminary results from 3 counties by Guadalupe Bedoya (Nov 6 2015).
[16] Martin G. and O. Pimhidzai. 2013. *Service Delivery Indicators: Kenya*. World Bank.

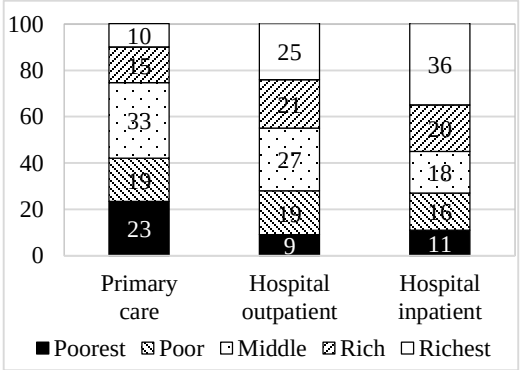
9. **The public sector is the main provider of health care services, especially for the poor**. Although the private sector (including faith-based organizations) owns about half of all health facilities in Kenya, the public sector accounts for more than two-thirds of all service utilization. The recent household survey[17] suggests that two-thirds of the poor utilize the public sector for their health care needs compared to only about one-third of the richest (figure 3). While PHC services are pro-poor, hospital services are not, with the richest 20 percent of the population benefitting more from hospital services for both outpatient and inpatient care (figure 4).

Figure 3. Utilization of Inpatient and Outpatient Health Services by Type of Providers



Source: KHHEUS 2013.

Figure 4. Utilization of Public Health Services by Wealth Quintile



Source: KHHEUS 2013.

10. **Several health financing initiatives have been introduced to better reach the poor but they are not well coordinated**. The abolishment of user fees in all PHC facilities (Levels 2-3) and free maternal care in public health facilities demonstrates the Government's commitment to universal health coverage (UHC), especially for women and children. With support from the World Bank Group, Kenya is piloting a health insurance subsidy program for the poor, which aims to provide comprehensive outpatient and inpatient care for the poor in both public and private facilities starting with about 500 households in each county. A reproductive health output-based aid voucher program, supported by the German Development Bank (*Kreditanstalt für Wiederaufbau*, KfW), has been ongoing in selected counties since 2005 to address demand-side barriers and improve women's access to health care. A results-based financing (RBF) program for a package of core PHC services is being scaled up in 21 ASAL counties. The Government is also providing health insurance for the elderly and the severely disabled. However, such initiatives are not well coordinated. This results in fragmentation of health financing, inefficient service delivery, duplication, and high operational costs due to different implementation and reporting arrangements.

11. **The leading institution implementing insurance schemes, the National Hospital Insurance Fund (NHIF), has been undergoing reforms, but important institutional weaknesses persist.** The NHIF is the main health insurer in Kenya covering about 7.8 million Kenyans (approximately 15 percent of the population). Strategic reviews of the NHIF, supported by the International Finance Corporation (IFC), identified key areas of weaknesses such as sub-

[17] MoH. 2014. *KHHEUS 2013*. Nairobi: GoK.

optimal governance and low efficiency.[18] Despite some recent improvements, the NHIF continues to have challenges in governance and operations (for example, high administrative cost).

12. **The Government is in the process of finalizing a Health Financing Strategy (HFS), which identifies a prioritized set of policies to address existing health financing challenges.** The HFS provides a framework that will enable Kenyans to benefit from their constitutional right to health and move towards UHC. It emphasizes the need to create fiscal space for health by increasing domestic resources through innovative financing mechanisms and efficiency gains. Making health insurance mandatory for all Kenyans and harmonizing donor support to ensure continued and aligned investment in the short-term will also increase resources for health. Separating service provision from purchasing is also critical for improved performance, cost-containment, and efficiency. The draft HFS is currently under internal review and stakeholder consultations to build consensus are also ongoing. Once the HFS is finalized and approved, the GoK will embark on dissemination and implementation.

13. **Devolution presents opportunities to improve Kenya's health service, but also poses new challenges with the rapid transition**. Devolution can improve equity by moving resources closer to the people and promoting accountability by making counties accountable for results. However, early evidence shows that devolution might also erode recent achievements unless urgent attention is given to the management of the transition and the functionality of the devolved systems and structures. In FY2013/14, nearly two-thirds of the total government budget for health had been devolved to counties, accounting for 30 percent of the equitable share given to counties. However, a rapid assessment estimated that only 13 percent of county revenue was allocated to health in FY2013/14, thus possibly constraining the delivery of health service. Although counties' health sector budgets increased to 22 percent in FY2014/15, there was still wide variation among counties and more than half of the county health budget was allocated to personnel emoluments.[19]

14. **Roles and responsibilities of both levels of government need to be further clarified and capacity needs to be strengthened to implement their new mandates.** Roles and responsibilities for national and county governments are outlined in the Constitution, and subsequently in the Kenya Health Policy (KHP) and the County Government Act. The national government is responsible for policy, regulation, norms and standards, national referral hospitals, selected national institutions, as well as capacity building and technical assistance (TA) to the counties. The counties own the health facilities in their territory and have the mandate to run the curative, preventive, and promotive, as well as environmental health services. There are a number of tasks that the two levels of government share (for example, resource mobilization, maintenance of health infrastructure including medical equipment and devices, HRH management, and monitoring and evaluation (M&E)) leaving room for differing interpretation of roles and responsibilities. The division of labor between the two levels of government remains a work in progress and there is urgent need to strengthen capacity to help each level fulfill their mandates. The Health Bill 2015,[20] if enacted, will further clarify these roles and responsibilities.

[18] Deloitte. 2011. *Strategic Review of the National Hospital Insurance Fund – Kenya.*
[19] MoH. 2015. *2014/2015 National and County Health Budget Analysis Report*.
[20] Kenya Health Bill 2015 is an act of parliament to establish a unified health system: (a) to coordinate the inter-relationship between the national government and county government health systems: and (b) to provide for regulation of health care service, health care service providers, and health products and technologies.

15. **The institutional and implementation arrangements including intergovernmental structures are still evolving.** For instance, the Constitution envisaged conditional grants from the national level to the county level to support national priority initiatives. However, an appropriate framework to transfer funds to the counties that is acceptable to both levels of government has not yet been established. This delay has affected the flow of additional funds to counties for improving delivery of devolved services. Currently, the National Treasury (NT) is developing a framework for conditional grants to transfer funds to county governments in devolved sectors.

16. **Improved DP coordination is critical to ensuring the efficient delivery of PHC services, especially during this transition period.** A large number of DPs, each using different tools, guidelines, and structures, are supporting the delivery of quality PHC with a focus on RMNCAH services, especially in underserved areas (see annex 3 for more details). The MoH is finalizing the Kenya Health Sector Partnership Coordination Framework to strengthen harmonization of planning, budgeting, and monitoring of results. This framework will guide partnership coordination of the health sector among all stakeholders.

C. Higher Level Objectives to which the Project Contributes

17. **The Project is fully aligned with the Country Partnership Strategy (CPS) for Kenya (FY2014–FY2018), the Vision 2030**, **the KHP 2014–2030, the Kenya Health Sector Strategic and Investment Plan (KHSSIP) 2014–2018 and the Kenya RMNCAH investment framework**. The CPS aims to support "inclusive growth to enable prosperity that can be shared by all." The second domain of CPS engagement aims to "protect the vulnerable and help them develop their potential in order to promote shared prosperity." With health as a pressing priority under this domain, the CPS aims to scale-up the combined resources of International Development Association (IDA) and IFC, alongside other DPs. The third domain of CPS focuses on building consistency and equity that has devolution at its core. The World Bank's large-scale capacity-building program and analytical and advisory activities inform a series of IDA operations including the Project to help counties and national agencies make devolution work. The Project supports both domains by improving delivery, utilization, and quality of PHC services in underserved areas while strengthening equitable service delivery in a devolved setting. The CPS's strong focus on results and accountability is also well rooted in the Project.

18. **The Global Financing Facility (GFF) in support of the Every Woman Every Child movement is a country driven partnership that aims to accelerate efforts to end preventable maternal, newborn, child, and adolescent deaths.** It is estimated that improved health outcomes and quality of life will prevent up to 3.8 million maternal deaths, 101 million child deaths, and 21 million stillbirths in high burden countries by 2030. The GFF seeks to support countries with an integrated health system approach that utilizes evidence-based solutions to improve RMNCAH outcomes. The GFF acts as a pathfinder in a new era of development financing by pioneering a model that shifts away from focusing solely on official development assistance. This approach combines external support, domestic financing and innovative sources for resource mobilization and delivery (including the private sector) in a synergistic way. The GFF aims to reduce inefficiency in health spending through smarter financing, resulting in a reduction in the resource needs for RMNCAH by 2030. The GFF also aims to mobilize additional funding through the combination of grants from a dedicated multi-donor trust fund (MDTF) for the GFF (GFF TF),

financing from IDA and International Bank for Reconstruction and Development (IBRD), and the crowding-in of additional domestic and external resources.

19. **Kenya is a front-runner country for the GFF with a grant of US$40 million from the GFF TF**. An RMNCAH investment framework, identifying prioritized bottlenecks and a set of smart evidence-based interventions for scale-up during the next five years, has been prepared and costed through an extensive, eight-month multi-stakeholder consultative process. Several consultations were held with county governments, the MoH, the Ministry of Interior and Coordination of National Government, the NT, various government entities at the national level, civil society organizations (CSOs), faith-based organizations, private sector, professional associations, and DPs. The Project reflects priority strategies identified in the RMNCAH investment framework to address: (a) disparities and inequitable coverage through investments to underserved populations and areas; (b) prioritized bottlenecks that prevent the delivery and scale-up of proven, high-impact, evidence-based interventions to women, children and adolescents; (c) vital gaps in the health system to support an efficient and effective delivery of high-impact RMNCAH interventions optimizing existing, and mobilizing new public and private sector investments in the health sector; and (d) community engagement to generate demand, promote behavior change, and enhance social accountability (SAc). The RMNCAH investment framework builds on the existing CRVS strategy and the Government is currently developing a HFS. Furthermore, evidence-based and high-impact interventions identified in the RMNCAH investment framework will inform the development of county annual work plans (AWPs) to address their specific prioritized bottlenecks or areas where they are lagging behind. IDA and GFF funding leverages other DP financing (see annex 3 for details) including increased financing from domestic sources and the private sector. Several DPs have agreed to support and coordinate their financing in support of the RMNCAH investment framework. Most of the DP support is currently focused on the underserved counties, identified also as priority counties in the RMNCAH investment framework (annex 3). The Project will also benefit from other ongoing World Bank projects (figure 5).

20. **The 'Performance and Results with Improved Monitoring and Evaluation' window of the Policy and Human Resources Development Fund (PHRD) aims to enhance the use of country system and promote evidence-based decision making by strengthening the M&E systems of the country.** Many low- and middle-income countries do not have robust M&E systems to adequately track the progress of national health programs and provide the requisite data for evidence-based decision-making at the national and sub-national levels. Investments in M&E systems are often fragmented and inefficient. In addition, these countries are further challenged by diverse and multiple reporting requirements. In order to respond to these challenges, the PHRD aims to provide tailored support to priority countries to improve the M&E systems and build capacity for ensuring the availability of timely, reliable, and quality data to (a) inform policy actions and evidence-based decision making at the national and sub-national levels and (b) monitor the progress of health programs and projects. Kenya has developed an M&E Framework and Guidelines that provide direction in setting up and operationalizing M&E systems in the health sector. However, the M&E Framework and Guidelines have not been fully implemented. The Project, with support from the PHRD, aims to address the key M&E system challenges at both levels of government by operationalizing the framework/guidelines so that limited resources will be used in the most effective and efficient manner.

II. PROJECT DEVELOPMENT OBJECTIVES

A. PDO

21. **The project development objective (PDO) is "to improve utilization and quality of primary health care services with a focus on reproductive, maternal, newborn, child, and adolescent health services."** The Project will achieve this objective by: (a) improving access to and demand for quality PHC services; (b) strengthening institutional capacity in selected key areas to improve utilization and quality of PHC services; and (c) supporting cross-county and intergovernmental collaboration in the recently devolved Kenyan health system. The Project is placing a strong focus on results by allocating resources to each county based on their improved coverage and quality of essential PHC services that are directly linked to the PDO and other factors including equity. The Project's support to strengthen the M&E system, including the routine HIS, will improve the quality of data for monitoring progress toward the achievement of PDO.

B. Project Beneficiaries

22. While the Project is expected to benefit the whole population, the **key beneficiaries are women of reproductive age (WRA) including adolescents and children under five who utilize PHC services most**. As DPs are already providing various supports, especially to the underserved counties[21] (see annex 3 for details), the Project will provide support to all 47 counties to address critical gaps not funded by domestic or external funding and to build institutional capacity. The Project will also use various mechanisms to identify and address inequity, such as underserved populations or areas, in each county. Bridging these gaps will help to improve utilization and quality of PHC services.

C. PDO Level Results Indicators

23. The key result (outcome) indicators are:

(a) Children younger than 1 year who were fully immunized (percentage)

(b) Pregnant women attending at least four ANC visits (percentage)

(c) Births attended by skilled health personnel (percentage)

(d) Women between the ages of 15–49 years currently using a modern FP method (percentage)

(e) Inspected facilities meeting safety standards[22] (percentage)

[21] A mapping of DP supported programs shows that the underserved counties noted as the priority counties in RMNCAH investment framework are currently supported by four or more DPs to improve RMNCAH services, except for Nakuru, Narok, and Trans-Nzoia which have two to three DPs supporting RMNCAH service delivery. See details in annex 3.

[22] At least 61 percent or above.

III. PROJECT DESCRIPTION

A. Project Components

24. The pathway to improve utilization and quality of PHC services is summarized in figure 5. Expected outcomes, which will be measured by the indicators listed above, include improved access to and quality of PHC services among the underserved and improved health seeking behaviors, eventually leading to improved utilization of quality PHC services. Implementing a set of evidence-based interventions that are high-impact and cost-effective is expected to improve equity and efficiency and contribute to UHC. The outcomes will be achieved through the three components depicted below.

Figure 5. Pathway to Improve the Utilization and Quality of PHC Services

Areas	Key issues	Key activities to address issues under			Outcome
		Component 1/3	Component 2	Other WB project/program*	
Stewardship /governance	▪ Weak PFM especially evidence-based decision-making ▪ Poor coordination and supportive supervision	▪ Training for evidence-based AWP formulation focusing on efficiency/ equity ▪ Supportive supervision ▪ Performance-based allocation ▪ Cross-county/ intergovernmental coordination	▪ AWP guidelines and appraisal system ▪ Annual performance review ▪ Capacity building	▪ Overall and health related PFM training (Devolution; KHSSP)	▪ Improved access to PHC services (especially among the under-served) ▪ Strengthened institutional capacity to improve utilization and quality of PHC services
HIS and CRVS	▪ Low data quality and incomplete reporting ▪ Unlinked and complex data platforms for decision-making ▪ Incomplete birth and death registration	▪ Incentive for timely and complete reporting through HIS ▪ Capacity building	▪ Updated HIS ▪ DQA ▪ Facility scorecard ▪ Integration of birth registration and MCH services (for example, immunization)	▪ Digitalization of birth/death registration and mobile registration pilot (TCIP)	
EMMS	▪ Insufficient budget allocation ▪ Weak SCM	▪ Procurement of EMMS including RMNCAH strategic commodities ▪ Advocacy for higher allocation especially for strategic EMMS and timely payment (also Component 2)	▪ RMNCAH guidelines	▪ KEMSA capitalization ▪ KEMSA SCM training (KHSSP)	
Infrastructure/equipment	▪ Non-functional facilities to provide essential services (for example, BEmONC, CEmONC)	▪ Rehabilitation of existing facilities ▪ Procurement and maintenance of essential equipment		▪ Procurement of essential equipment in ASAL counties (KHSSP)	
Human resources	▪ Shortage of skilled health workers	▪ Contracting (of health workers, NGOs/ CSOs)	▪ In-service training (for example,	▪ HRH management	

	especially in underserved areas ▪ Low competency and productivity	▪ Performance-based incentives ▪ Supportive supervision/ mentoring	RMNCAH guidelines) ▪ Midwifery training/ bonding	training (Devolution) ▪ RBF (KHSSP)	
Health financing	▪ Low budget allocation ▪ Fragmented health financing initiatives ▪ High OOP	▪ Advocacy for increased county budget on health ▪ Financial protection for the vulnerable	▪ HFS dissemination ▪ UHC capacity building ▪ Development of strategy and capacity building for financial protection of vulnerable groups	▪ TA to NHIF (KHSSP; IFC HiA)	
Quality of care	▪ Unsystematic inspection of facilities and providers ▪ Incomplete KQMH	▪ CQI (for example, patient safety, infection control, and certification)	▪ Inspection of private/public facilities using the JHIC	▪ Revision of KQMH framework[23] (IFC HiA)	▪ Improved quality of PHC services
Demand	▪ Lack of knowledge and information Sociocultural beliefs and practices ▪ Long distance to health facilities and high transport costs ▪ Limited funding for CHS implementation	▪ ACSM for preventive and promotive health care including safe water, sanitation, hygiene, and nutrition through functional comm. units ▪ Outreach services ▪ CE throughout PFM cycle ▪ Transport vouchers	▪ Operations research to reach underserved populations and areas including adolescents	▪ SAc training as part of PFM (KHSSP)	▪ Improved health seeking behaviors and demand for PHC services

Note: PFM = Public Financial Management; DQA = Data Quality Audit; BEmONC = Basic Emergency Obstetric and Neonatal Care; CEmONC = Comprehensive Emergency Obstetric and Neonatal Care; KEMSA = Kenya Medical Supplies Authority; ACSM = Advocacy, Communication, and Social Mobilization; KQMH = Kenya Quality Model for Health; CQI = Continuous Quality Improvement; NGO = Nongovernmental Organization; CE = Citizen Engagement; *Devolution = Devolution Support Program; KHSSP = Kenya Health Sector Support Project; TCIP = Transparency and Communications Infrastructure Project; HiA = Health in Africa. Please see DP support in annex 3.

Component 1: Improving PHC Results (US$150 million consisting of US$115 million equivalent credit from IDA and US$35 million grant from the GFF TF)

25. **Component 1 aims to improve the delivery, utilization, and quality of PHC services at the county level with a focus on RMNCAH**. It will support counties to scale up evidence-based, county appropriate supply- and demand-side key priority interventions along the continuum of care as described in the RMNCAH investment framework. This component will focus on: (a) improving functionality of existing facilities to deliver quality essential PHC services; and (b) increasing demand for services at the community and facility levels. The former includes expanding the availability of quality BEmONC and CEmONC, improving the referral system, and

[23] KQMH framework that aims to create a national quality assurance, improvement and accreditation framework to be referred to as Kenya Health Standards is under review by MoH and stakeholders.

ensuring RMNCAH commodity security. The latter includes strengthening community units[24] to (i) deliver preventive and promotive health care including access to safe water and sanitation, improved hygiene practices and nutrition, and (ii) engage the community to improve accountability of PHC services through citizen engagement (CE) mechanisms (for example, community dialogue days).

26. **This component will use a performance-based approach by employing minimum conditions and allocating resources to the counties based on their improved PHC results**. For the first year, after fulfilling basic conditions,[25] all counties will be eligible to receive seed funding based on the needs measured by a function of (a) proportion of births "not" attended by a skilled health professional in KDHS 2014 and (b) GoK's county revenue allocation (CRA) ratio, which takes the population and poverty level into account.[26] This initial allocation is intended to jumpstart implementation. For each subsequent year, in order to be eligible to participate, the counties will be required to meet a set of minimum conditions as follows: (a) the share of the county budget allocation (for Year 2) and expenditure (for Years 3–5) for health (excluding conditional grants for health) is higher than the previous year, but no less than 20 percent;[27] and (b) the annual Project financial and technical report for the previous financial year is submitted on time.[28] These conditions are to ensure that counties gradually increase domestic resources for the health sector to carry out health mandates and improve fiscal responsibility. Annual performance-based allocation for counties (table 3) will then be shared among all eligible counties as a function of (a) verified county performance; and (b) CRA ratio. County performance will be measured by the 'average change'[29] in a set of service delivery and health systems strengthening (HSS) indicators (table 4), reported through routine HIS such as DHIS2. Verification of reported performance will be conducted by annual peer review among the counties.[30] This method will also facilitate peer

[24] A community unit represents the lowest administrative level of the health system. Each community unit comprises about 5,000 people and is supposed to be served by a network of community health workers (CHWs) under the supervision of community health extension workers (CHEWs) who are trained public health officers/technicians, linked to the peripheral health facility, and a community health committee (CHC). CHWs deliver primary care services to households focusing on preventive and promotive health (for example, addressing environmental or socioeconomic risk factors) and refer clients to the peripheral health facility for advanced care. Each community unit should ideally have 2 CHEWs, each CHEW coordinating 25 CHWs. CHWs are recruited and managed by the 9 to 13-member CHC.

[25] For Year 1, each county must: (a) submit a supplementary budget for approval by the County Assembly; (b) open a county special purpose account at the Central Bank of Kenya (CBK); and (c) designate a project accountant and an internal auditor.

[26] Under the current CRA formula, county revenue is shared among the counties as follows: population (45 percent), poverty (20 percent), land area (8 percent), basic equal share (25 percent) and fiscal responsibility (2 percent).

[27] As one of the most devolved sectors, nearly two-thirds of government health care allocations have been devolved to counties in FY2013/14, accounting for about 30 percent of the county sharable revenue. The counties' average health sector budget as a percentage of the total county budget in FY2013/14 was only 13 percent. In FY2014/15 the allocation increased to 22 percent.

[28] PwC. 2015. *Provision of Technical Assistance in the Preparation of Individual and Consolidated Financial Statements for the County Government Entities for FY2014/15 – First Progress Report.* In FY2014/15, 41 counties submitted financial statements for audit by September 30 deadline as per Section 183 of the PFM Act.

[29] The formula will be subject to review in the subsequent years as needed. Details will be in the project operations manual (POM).

[30] Peer review is a cross-county verification and the cross-county verification team will be comprised of a County Health Management Team (CHMT) member, a clinical staff selected from the best performing health facility, an implementing partner and a representative from a CSO.

learning and knowledge sharing. In order to enhance transparency and quality of verification, external verifiers will also be invited to participate in peer review visits.

27. **This component will also earmark funding for RMNCAH strategic commodities.** A recent gap analysis[31] suggests that the GoK has a critical shortage of funding for RMNCAH strategic commodities especially FP commodities. The component will thus finance procurement of these commodities through KEMSA.[32] To promote sustainable financing for RMNCAH strategic commodities, while filling the immediate gap, the annual allocation will be made on a sliding scale over the life of the Project with the commitment of the GoK to gradually increase domestic financing (table 3).

Table 3. Annual and Total Allocation (US$, Millions)

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Performance-based allocation	12.5*	27.5	30 (+ any undisbursed amount in Year 2)	30 (+ any undisbursed amount in Years 2 and 3)	30 (+ any undisbursed amount in Years 2–4)	130
RMNCAH strategic commodity	6	5	4	3	2	20

Note: *Allocation in Year 1 is smaller due to a shorter implementation period (that is, six months) and sensitization as well as capacity building required.

Table 4. County Performance Indicators

1. Children younger than 1 year who were fully immunized (percentage)
2. Pregnant women attending at least four ANC visits (percentage)
3. Births attended by skilled health personnel (percentage)
4. Women between the ages of 15–49 years currently using a modern FP method (percentage)
5. Inspected facilities meeting safety standards (percentage)*
6. Facilities submitting complete DHIS data in a timely manner (percentage)

Note: *MoH and the counties will disseminate the safety standards and train inspectors in Years 1 and 2. Thus performance of indicator 5 will be used from Year 3.

28. **Counties will then use the performance-based allocation to support priorities identified in their AWPs to further improve utilization and quality of key PHC services.** Under the existing annual planning and budgeting process of the GoK**,** each county will prioritize investments in its AWP to address the county-specific bottlenecks for better PHC services with a focus on improved RMNCAH results. During the AWP development process, the MoH and DPs will provide TA (box 1 and annex 6) in the use of evidence as a decision-making tool, which will help counties prioritize investments that address the county specific issues. While each county has the flexibility to choose their own strategies to address their specific bottlenecks, only those

[31] MoH. 2016. *Family Planning Commodity Quantification and Supply Planning Review for FY2015/16 to 2016/17 Technical Report.* Nairobi.

[32] Payment will be made directly by the World Bank to the suppliers selected by KEMSA upon request from the GoK through direct payment. The MoH will cover the KEMSA fee upon delivery of RMNCAH strategic commodities to the counties.

interventions[33] proven to be effective and efficient in addressing key health sector challenges, including those described in the RMNCAH investment framework, will be supported by the Project. An AWP quality assurance system will ensure that the Project resources are used effectively, efficiently, and equitably. The Project sub-technical working group (TWG) under the Intergovernmental Forum for Health (as described in Component 3 below) will technically appraise AWPs before disbursement is made.[34] In order to harmonize the implementation of this component with the GoK annual budget cycle, counties will need to follow an annual timeline of key milestones, including reporting of county performance and peer review (see annex 6 for the milestones).

Box 1. Health Sector Planning Framework

Kenya has been implementing a health sector planning framework to align policies, plans and budgets. In the past six years this health sector planning and monitoring process has integrated the development and implementation of AWPs at all levels of the health structure including the communities. With devolution, counties are mandated to develop county specific County Integrated Development Plans and multi-year health sector strategic and investment plans linked to the KHP and KHSSIP, and to develop AWPs that reflect county health priorities, budget and expenditure frameworks (see details in annex 6).

Currently, the quality of county AWPs varies, as tools and technical support for the process of developing AWPs are uncoordinated. A review of several AWPs reveals some challenges: (a) unstandardized planning guidelines and training materials; (b) weak capacity to assess and prioritize bottlenecks and incorporate equity, effectiveness, and efficiency aspects; and (c) lack of a quality assurance/appraisal system.

Several measures will be established to improve the quality of AWPs. To address these challenges, the MoH, in close collaboration with the county governments and the DPs including the World Bank Group, is planning to: (a) standardize and harmonize planning guidelines and tools including templates for the counties; (b) develop a quality assurance/appraisal system of AWPs; (c) build evidence-based planning and budgeting capacity for counties with support from the Kenya School of Government (KSG) and DPs; and (d) coordinate DPs providing technical support in planning and budgeting to avoid duplication of support and ensure that all counties are covered.

Component 2: Strengthening Institutional Capacity (US$15.1 million consisting of US$9 million equivalent credit from IDA, US$5 million grant from the GFF TF, and US$1.1 million grant from the PHRD TF)

29. **Component 2 aims to strengthen institutional capacity[35] to better deliver quality PHC services under Component 1.** This component will focus on three key areas:

[33] Selected expenditure categories (that is, salary of civil servants excluding incentives, construction of a new building) will be ineligible. Renovation and rehabilitation are eligible up to a maximum of US$200,000.

[34] The Project sub-TWG will assess the technical soundness of the AWP. For example, the sub-TWG will check if (a) AWP is well aligned with the county budget estimates approved by the County Assembly, (b) the interventions proposed are technically and economically sound; and (c) interventions supported by the Project are well aligned with the national priorities, and so on. Once an AWP quality assurance/appraisal system is developed by the GoK, the Project will follow the GoK system.

[35] As per the 2010 Constitution, the national government will focus on formulation of policy, strategy, and guidelines as well as provision of TA to the county level only under Component 2 (for example, updating the DHIS2 manual and training of trainers at the national and county level) and the counties will be responsible for the activities within the counties (for example, training health workers and compiling data according to the new guidelines) under Component 1.

(a) *Subcomponent 2.1. Improving Quality of Care (US$8.3 million).* The Project will support:

(i) the Department of Health Standards, Quality Assurance and Regulations as well as the Health Regulatory Boards to:

- strengthen routine inspections of public and private health facilities; and
- institutionalize quality assurance towards certification;[36,37]

(ii) the Division of Family Health (DFH) to:

- develop and/or disseminate RMNCAH-related strategies and guidelines, including improving adolescent sexual and reproductive health (ASRH), newborn health and nutrition to address high teenage pregnancy, neonatal morbidities and stunting; and
- conduct operations research; and

(iii) the Kenya Medical Training College (KMTC) to strengthen midwifery training.

(b) *Subcomponent 2.2. Strengthening M&E and CRVS (US$5.0 million).* The Project will support the Division of M&E, Health Research Development and Health Informatics to: (i) operationalize the sector M&E framework; (ii) strengthen the HIS; and (iii) pilot innovative approaches to improving coverage of vital events registration within the health sector (for example, incentivizing registration, piloting a mobile CRVS office, and linking birth registration with MCH services) in close collaboration with the CRS.

(c) *Subcomponent 2.3. Supporting Health Financing Reforms towards UHC (US$1.8 million).* The Project will support the Division of Health Care Financing (DHCF) to: (i) disseminate the HFS to get buy-in from various stakeholders drawing from the recently completed stakeholder analysis; (ii) conduct analytical work[38] to inform the implementation of HFS and health-financing reforms towards UHC; and (iii) build capacity for UHC leadership at the national and county levels.

Component 3: Cross-county and Intergovernmental Collaboration, and Project Management (US$26 million equivalent credit from IDA)

30. **Component 3 aims to enhance cross-county and intergovernmental collaboration as well as facilitate and coordinate project implementation.** This will include two areas:

[36] MoH. 2015. *Kenya Health Quality Improvement Policy 2015 – 2030.* Nairobi: MoH

[37] Ministry of Medical Services & Ministry of Public Health and Sanitation. 2011. *Implementation Guidelines for the Kenya Quality Model for Health.*

[38] Potential areas of analytical work include: developing appropriate provider payment mechanisms and client-oriented primary care networks; designing and costing the essential package for health and developing a framework for updating it periodically; jointly with social protection secretariat, developing a framework for identifying the poor for the purposes of health insurance subsidies and piloting it in selected counties; and developing appropriate structures for pooling and purchasing arrangements.

(a) *Subcomponent 3.1. Cross-county and Intergovernmental Collaboration (US$16 million).* The Project will finance activities that promote cross-county initiatives and intergovernmental collaboration to address common demand- and supply-side barriers. Examples include cross-county study tours to share knowledge and capacity building activities in areas that affect several counties, such as drafting county health bills and improving SCM of strategic commodities. A call-for-proposal approach will be used. Every year, the project management team (PMT) will issue a call for proposals in collaboration with the national and county governments and facilitate TA for proposal reviews. The Project sub-TWG with support from TA will approve the final selection of proposals, which will be concurred by the Bank. The winner(s) will be required to implement the proposals and report the outcomes and lessons learned through the Intergovernmental Forum for Health to facilitate cross-county learning.

(b) *Subcomponent 3.2. Project Management (including M&E and fiduciary activities) (US$10 million).* The Project will finance project management staff at national and county levels of government, office equipment, operating costs, and logistical services for day-to-day project management. This also includes: (i) M&E activities such as annual cross-county verification through peer reviews, periodic surveys, and process evaluation to monitor implementation progress and address any implementation challenges; (ii) fiduciary activities such as hiring an independent integrated fiduciary review agent (IIFRA); (iii) safeguards activities such as conducting social assessment and preparation or revision of safeguards-related plans; and (iv) TA and capacity-building activities to support the Project sub-TWG under the Intergovernmental Forum for Health in carrying out their responsibilities, among others, reviewing the quality of AWPs, verifying county performance, and selecting proposals to promote cross-county and intergovernmental collaboration.

B. Project Financing

Financing Instrument

31. **The Project uses the Investment Project Financing instrument** and provides performance grants that are in line with the GoK's conditional grants.[39] The instrument would allow: (a) the Project to specify upfront non-tangible inputs (for example, capacity development, TA) essential to strengthen the institutional capacity to achieve the desired results; and (b) the Bank task team to work closely with the implementing entities at each and every step of implementation, including fiduciary management. The use of performance grants for Component 1 would hold county governments accountable for results while giving them the flexibility to appropriately tailor interventions to address county-specific demand- and supply-side bottlenecks in their AWPs.

[39] A transfer/grant from the national government to the county governments to support national priorities.

Project Cost and Financing

32. **The total cost of the Project is US$191.1 million equivalent**, of which US$150 million equivalent will be financed by an IDA credit, US$40 million will be financed by a grant from the GFF TF, and US$1.1 million will be financed by a grant from the PHRD TF.

Table 5. Project Cost by Component and Financing (US$, Millions)

Project Components	Project Cost	IDA	GFF TF	PHRD TF	% Financing
1. Improving PHC Results	150.0	115	35	-	100
2. Strengthening Institutional Capacity	15.1	9	5	1.1	100
3. Cross-county and Intergovernmental Collaboration, and Project Management	26.0	26	-	-	100
Total cost					
Total Project Costs	191.1	150	40	1.1	-
Total Financing Required	191.1	150	40	1.1	-

C. Lessons Learned and Reflected in the Project Design

33. **The Project design incorporated lessons learned from previous Bank engagements and will support the GoK** in the following ways:

(a) **A focus on results.** Global experiences show encouraging contributions from results-based approaches. The pilot in Kenya, though at the facility level, clearly demonstrated the operational feasibility of RBF in difficult operational conditions. The Project builds on this experience and will further strengthen the result-oriented approach in planning, budgeting, and implementation at the county level. Given the wide variations among the counties with regard to disease burden, priorities, and service delivery gaps, the Project will focus on performance and link disbursements to improving PHC results.

(b) **The role of TA and capacity building in HSS.** Strengthening health systems to provide quality health services requires capacity building in various stewardship and implementation functions. For this reason, the Project will finance TA in key areas, especially quality of care, health information, health financing, and strategic planning at both national and county levels. The TA and capacity-building efforts will focus on efficiency gains while considering competing demands and limited fiscal space.

(c) **Empowering county governments for results.** Since devolution, county governments have more autonomy over planning, budgeting, implementing, and monitoring PHC service delivery. As such, any new support should be coordinated with county governments and intergovernmental coordinating mechanisms to achieve their strategic priorities. A clear framework for conditional grants, agreed to by both levels of government, is a prerequisite. Also, creating the right governance structures, including effective results monitoring is critical in making devolution and service delivery successful. Ongoing IDA-financed projects (namely, KHSSP and East Africa Public Health Laboratory Networking Project) have successfully used peer reviews in their implementation.

(d) **A solid RMNCAH investment framework as the common platform for DP support.** As a front-runner country for the GFF, Kenya has developed an RMNCAH investment framework to scale up a set of effective, efficient, and equitable interventions through extensive consultations. The advantages of this approach include increased country ownership, more effective partnerships, better coordination and lower transactional costs, which in turn can result in higher likelihood of success. In this context, Kenya's RMNCAH investment framework forms the basis for the Bank, the GFF partners, as well as other stakeholders to support improved RMNCAH results.

(e) **Regulatory reform for improved standards in quality of care.** Sub-optimal regulatory enforcement due to lack of a harmonized, coordinated, and objective inspection system is a key barrier to measurable improvement in quality of care. The GoK in collaboration with private sector, Health Regulatory Boards and Councils, and the IFC HiA has developed and gazetted the JHIC to make inspections more efficient and effective with harmonized standards applied across public and private health facilities.

(f) **Context specific CE.** A CE pilot under the KHSSP that tested information sharing, community participation, and grievance redress mechanisms (GRMs) has demonstrated the value of constructive engagement between the public sector and citizens in which both sides benefit from genuine dialogue and shared ownership of the health facilities.[40] For example, the pilot contributed to improved uptake of health services, a reduction in community scepticism regarding facility-spending patterns when information on income and expenditure was made public, and a more positive attitude in both communities and health facility staff. The results also suggested that CE is location specific, emphasising the importance of understanding the local environment and avoiding pre-determined solutions. The Project will support these mechanisms to implement the CHS in addition to CE being incorporated in the AWP guidelines.

IV. IMPLEMENTATION

A. Institutional and Implementation Arrangements

34. **The Project will be implemented by multiple entities in line with the Constitution.** Existing institutional structures at the national and county levels will be used to implement the Project. The MoH, KMTC, and CRS will be jointly responsible for the implementation of national and county-level activities under Component 2 (for example, TA). County governments will be responsible for implementation of activities in their counties under Component 1 with support from KEMSA for procurement. Project implementation plans will be integrated into the AWP of all implementing entities**.**

[40] Machira Y and R Nizam. 2015. *Integrating Social Accountability in Healthcare Delivery: Lessons Drawn from Kenya*. Kenya Devolution; no. 4. Washington, D.C.: World Bank Group.

35. **Project management will be the responsibility of the PMT.** The PMT for the ongoing KHSSP will require additional capacity to coordinate both the KHSSP and the new Project. The MoH will thus be required to: (a) set up a dedicated PMT located in the Department of Health Sector Coordination and Intergovernmental Affairs; (b) designate staff with appropriate skills and/or recruit on exceptional basis to fill skills gaps; (c) build staff capacity; and (d) make resources available to the PMT for their day-to-day functions. Staff for cross-cutting functions (for example, procurement officer, project accountant, safeguards compliance officer) may be shared between the KHSSP and the new Project. The PMT will be responsible for overseeing the timely and effective implementation of the Project. The PMT's dedicated project manager will be responsible for the effective functioning of the Project. Designated coordinators for each component and an M&E officer will report to the project manager. As a member of the PMT, the Component 1 coordinator and assistant coordinators will initially be based at the Council of Governors (CoG). The PMT composition and location of the Component 1 coordinator and assistant coordinators will be reviewed within a year of implementation. The PMT will receive and compile quarterly and annual financial and technical reports from each of the 47 counties and all national implementing entities (that is, the MoH, KMTC, and CRS) and forward them to the Project sub-TWG at the Intergovernmental Health Forum, the NT, and the Bank (see figure 3.2 in annex 3 for details). The PMT will also prepare annual consolidated Project financial statements, have these statements audited, and submit the audit report to the Bank within the stipulated timelines.

36. **The Intergovernmental Forum for Health, which brings together senior health managers from national and county governments and key stakeholders, will provide stewardship and oversight of the Project.** Co-chaired by the Cabinet Secretary, MoH, and the Chair of the County Executive Committee for Health, the Intergovernmental Forum will provide the overall strategic direction and oversight for project implementation. A Project sub-TWG will be set up under the Intergovernmental Forum to facilitate key decisions that affect project implementation at both levels of government and coordination among various implementing entities.

B. Results Monitoring and Evaluation

37. **The Project's M&E will be an integral part of the country's regular M&E for the health sector**. The majority of the Project indicators are a subset of the sector's performance indicators which are also included in the RMNCAH investment framework (see annex 1 for the results framework) and will be monitored regularly (for example, quarterly) mostly through the existing routine HIS such as DHIS2. Data from household and facility surveys (for example, KDHS 2014 and the next KDHS expected in 2019) will also be used to validate selected DHIS2 indicators in the monitoring of progress towards the PDO.

38. **The Project will facilitate evidence-based decision-making through various measures.** These include: (a) streamlining various databases such as DHIS2, CRVS, and master facility list (MFL); (b) strengthening database interfaces (for example, deliveries reported through DHIS2 and births registered in CRVS); (c) improving mechanisms to generate summary statistics for decision making such as the dashboard features of DHIS2 (for example, automatic generation of scorecards from DHIS2 data); and (d) using selected indicators in DHIS2 including timely and complete reporting of HIS to allocate resources among counties upon verification. Any data collected (for

example, facility inspection data which are kept by various Health Professional Boards separately) will be linked to a HIS database to the extent possible for transparency.

39. **The Project will also support the GoK's efforts to improve data quality.** The MoH has recently developed a protocol for the DQA to ensure that collected information is accurate and reliable.[41] This protocol will be used for cross-county verification to encourage counties to improve quality of data. In addition, the Project will support other activities that can address factors[42] affecting quality of data such as revision of the indicator manual, training on DHIS2 and the M&E framework, and regular supportive supervision.

C. Sustainability

40. **The GoK's political commitment to improving delivery of PHC services and health outcomes has increased at both national and county levels.** The GoK has abolished user fees at all PHC facilities and initiated free maternal care at public health facilities. Also, with the strong political commitment to improve RMNCAH outcomes, Kenya became a front-runner country to benefit from the GFF and is currently developing a HFS. These and other initiatives to improve health outcomes have been strengthening Kenya's progress towards achieving UHC and the Sustainable Development Goals.

41. **The Project supports a subset of high-impact, cost-effective investments in the Government strategic plans.** In line with the aspirations of the 2010 Constitution, which guarantees the highest attainable standard of health as a right, KHP, the KHSSIP and the RMNCAH investment framework and other strategies provide the health sector's medium-term priority health investments. To ensure sustainability, the Project supports cost-effective investments identified in these GoK strategic plans, focusing on improving access to, demand for, and quality of services.

42. **The Bank financing will focus on increasing domestic financing for health and is not expected to create fiscal dependency.** Counties, on average, have increased the share of county budget on health from 13 percent in FY2013/14 to 22 percent in FY2014/15, suggesting that county governments have prioritized health despite many competing needs.[43] The Project will build on this momentum to increase domestic financing for health. For example, in order to receive any funding from the Project, counties are required to allocate at least 20 percent of the county budget on health and increase budgetary allocation and expenditure on health each subsequent year. Also, Project funding is less than 4 percent of the total health budget per year and thus the country can progressively absorb the Project costs with a marginal annual increase in total budget and/or allocation for health.

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[41] GoK. 2014. *Kenya Health Sector Data Quality Assurance Protocol.* Nairobi, Kenya: MoH, AfyaInfo Project.
[42] GoK. 2014. *Data Quality Audit Report.* Nairobi, Kenya: Division of Health Informatics Monitoring and Evaluation, MoH, AfyaInfo Project.
[43] MoH. 2015. *2014/2015 National and County Health Budget Analysis Report.* The county health budget was split between recurrent (75 percent) and development (25 percent) budget. However, 69 percent of the recurrent health budget was allocated to personnel emoluments, and 51 percent of the development health budget was allocated to construction of facilities, leaving little room for increasing operating cost.

43. **The Project strengthens devolution**. The GoK devolved governance of key sectors including health to ensure improved service delivery, greater accountability, and equity in human development, including health outcomes. However, the country has been experiencing transitional challenges due partly to incomplete devolution building blocks. By using the devolved government structures for the Project implementation and management as well as reinforcing intergovernmental coordination and collaboration, the Project will help advance the process of devolution. For example, since November 2015, in conjunction with Project preparation, both levels of government have participated in consultations to ensure that the Project reflects their respective needs to improve health outcomes. These consultations provided opportunities for both levels of government to frankly discuss and internalize their roles and responsibilities as per the 2010 Constitution. Implementation of the Project activities is expected to further clarify the roles and responsibilities and thus strengthen intergovernmental coordination and collaboration.

V. KEY RISKS

A. Overall Risk Rating and Explanation of Key Risks

44. **The overall risk of the Project is rated *substantial* due mainly to high 'political and governance' and 'institutional capacity' risks** (table 6). While the country is committed to improve health outcomes by focusing on results and improving accountability, it is going through a highly ambitious and fast tracked devolution. The country still needs to create proper governance and accountability structures, clarify the roles and responsibilities of national and county governments, and establish appropriate working relationships between the two levels. As the structures, functions, and coordination mechanisms between the two levels of government are still evolving, it is possible that other issues may arise in the execution of functions during Project implementation. The political commitment to PHC, especially to improve lagging maternal and newborn health outcomes, in the recently devolved Kenyan health system is strong. However, capacity to plan, budget, implement, and monitor delivery of equitable, efficient, high-quality PHC services varies among counties.

Table 6. Risk Ratings

Risk Category	Rating
1. Political and Governance	High
2. Macroeconomic	Moderate
3. Sector Strategies and Policies	Moderate
4. Technical Design of Project	Substantial
5. Institutional Capacity for Implementation and Sustainability	High
6. Fiduciary	Substantial
7. Environment and Social	Low
8. Stakeholders	Substantial
9. Other	
OVERALL	Substantial

45. **Other risk categories that can also substantially affect the achievement of the objective are 'technical design of project', 'fiduciary', and 'stakeholders'.** As noted above, the relationship between the national and county governments is complex and is still evolving. Thus the Project is designed to focus on results, while giving the implementing entities flexibility to

address the varying and changing needs. There is an increased intrinsic risk that the resources provided by the Project will not always be used most effectively and efficiently to achieve the best health outcomes, especially when adequate TA is not provided. The county fiduciary systems are not sufficiently robust even though the ongoing KHSSP is building the capacity of the county governments. Fiduciary capacity in planning and budgeting, treasury management, funds flows, accounting and financial reporting, audit and oversight, human resources management, and procurement is still evolving. Also, the PFM structure is being developed and thus, in-country disbursements of funds are likely to be delayed at both the national and county levels. Accountability concerns raised by the auditor general in the audit of counties could point to governance and corruption risks.

46. **The Project will mitigate the key risks** by supporting both levels of government to strengthen their capacity to execute their roles and responsibilities; and by leaving room in the Project design for flexibility and innovation to cope with unintended results (positive or negative) arising from the country situation. Capacity building activities are being implemented for county fiduciary and technical staff at the KSG under the ongoing health project. The Project, in close collaboration with DPs, will support counties to prepare, implement, and monitor evidence-based AWPs, which focus on high-impact, cost-effective interventions and the improvement of health system functionality. In addition to TA that will be provided under the recently approved Kenya Devolution Support Program and by other DPs in the health sector, the Bank task team is also in discussion with DPs to set up a TA facility where implementing entities can access quality and timely TA to mitigate the technical risks. The proposed TA facility will be supported by key DPs, initially the United States Agency for International Development (USAID) and the U.K. Department for International Development (DFID).

VI. APPRAISAL SUMMARY

A. Economic and Financial Analysis

Project Development Impact

47. **Strong and resilient health systems are at the center of development.** Resilient health systems respond to the needs of citizens, transform and adopt skills and techniques to provide best quality services, and are resilient to internal and external shocks. In 2013, Kenya embraced devolution and health service provision was devolved to the 47 county governments. The systems and institutions tasked with providing high quality health services under the devolved structure are weak but evolving. The Project will help lay the foundation for a stronger health system to improve utilization and quality of PHC service in Kenya by strengthening institutional capacity. In particular, the Project's support to build MoH and county capacity for implementing UHC reforms in Kenya will pave the way to improved access to health care services for the poor and enable Kenyans to realize their rights to quality health care as enshrined in the 2010 Constitution.

48. **The health benefits of investing in PHC and strengthening health systems are well documented globally**. Strong health systems and institutions, which deliver quality PHC services, coupled with increased uptake of high-impact interventions through community-based approaches

have been shown to be more cost-effective and better able to reach the poorest communities.[44] The medium- to long-term results include a reduction in maternal deaths, improvement of child survival rates, a reduction of chronic morbidity especially for mothers and children, and lowered incidence of non-communicable diseases later in life.

49. **The Project will contribute to the country's long-term economic growth** in the form of higher GDP arising from savings on health costs, increased labor force participation, and higher productivity. The only available evidence shows that one maternal death would reduce annual GDP per capita by US$0.42 (in 2015 prices)[45] in Sub-Saharan Africa. The cost of maternal deaths to the Kenyan economy can be substantial as close to 5,500 women die in Kenya each year.[46] High fertility rates also negatively impact a country's development due to increased investment in education, health, and other related areas in the long term; and delayed impact of 'demographic dividend'. Kenya could cumulatively save US$114.7 million per year if the unmet need for FP was addressed.[47] The potential pathways of the Project's development impact are described in more detail in annex 5.

50. **The Project will also contribute towards reducing indirect costs associated with seeking RMNCAH services.** In addition to contributing to economic development, the benefits of investing in RMNCAH services have important social value, which cannot be estimated quantitatively. The most recent data showed that the indirect costs of maternal deaths in Africa amounted to US$4.5 billion in 2010.[48] Other benefits of reduced morbidity and mortality for mothers and children include higher quality of life, higher nutrition status, better cognitive development, and improved performance at school.[49,50]

51. **In addition, the Project will promote equity and shared prosperity.** By increasing resources available for PHC services and community-based interventions, the Project has high potential to: (a) reach the poorest and most needy population, who hardly use hospital level services due to affordability and other access barriers; and (b) contribute to improved technical and allocative efficiency. Also, the Project will provide more funding for the underserved counties especially in Year 1 using the CRA formula, adjusted by county needs.

52. **A cost-benefit analysis (CBA) shows that the Project is a sound economic investment**. The present value of the Project's benefit is US$954.2 million and the cost is US$174.9 million. The net present benefit is US$779.2 million with a benefit-to-cost ratio of 5.46:1, meaning a return of US$5.46 for every dollar invested. Sensitivity analysis suggests that the Project would still be

[44] Adam T et al. 2005. Achieving the millennium development goals for health: Cost effective analysis of strategies for maternal and neonatal health in developing countries. *British Medical Journal.* 331: 1107–10.
[45] Kirigia J et al. 2006. Effects of maternal mortality on gross domestic product in WHO African region. *African Journal of Health Services.* 13: 86–95.
[46] MoH calculation based on KDHS 2014.
[47] Moreland S and S Talbird. 2006. *Achieving the Millennium Development Goals. The Contribution of Fulfilling the Unmet Need for Family Planning.* Futures Group/POLICY Project.
[48] Kirigia J et al. 2014. Indirect costs of maternal deaths in the WHO African Region in 2010. *BMC Pregnancy and Childbirth.* 14(299).
[49] Shonkoff J et al. 2012. An integrated scientific framework for child survival and early childhood development. *Pediatrics*. 129(2).
[50] Victoria, C et al., 2008. Maternal and child undernutrition: consequences for adult health and human capital. *The Lancet.* 371: 340–357.

economically viable even if it only achieved half of the benefits estimated. If the social value of a life saved (that is, 50 percent of annual GDP per capita) is taken into account, the benefit-to-cost ratio increases to 8.18:1.

53. **Rationale for public sector financing**: The use of public resources in this Project is justified for the following reasons:

(a) The 2010 Constitution gives all Kenyans the right to the highest attainable standards of health, including reproductive health and emergency treatment.

(b) Although Kenya has a vibrant private sector, which owns close to half of health facilities in the country, the public sector is the main source of health care services for the majority of the population, accounting for more than two-thirds of all service utilization, and remains the main source of care for the poor.[51]

(c) Interventions proposed under this Project such as immunization and other public health initiatives contribute to the public good and have positive externalities. Providing these services through the free market may lead to under-supply, undermine herd immunity, and pose public health risks. Investing public resources in these areas and providing subsidies to the private sector can reduce health care costs, contribute to healthy societies, and promote economic growth.

(d) There are wide inequities in access to RMNCAH and other services in Kenya,[52] which are best addressed using public sector resources due to market failures arising from limited competition, information asymmetry and externalities. Health workers generally know more than patients and this can foster supplier-induced demand, particularly in the private sector. Investing public resources is ethically justified to address existing inequities in access to RMNCAH services.

Financial Analysis

54. **The Project is financially sustainable because the investment accounts for less than 4 percent of the total health budget per year.** However, the share of Project funds as a percentage of non-salary recurrent expenditure for county-level activities is relatively high at almost 20 percent, assuming no changes in national and county budget allocation. This estimate is expected to decrease as budget allocation continues to increase over the 5-year period, as demonstrated by the increased allocation between FY2013/14 and FY2014/15. The health sector is still dependent on donor funding, which poses sustainability risks. The health sector may suffer residual impacts as donors exit leaving behind contingent liability from projects that were not aligned to government priorities.

B. Technical

55. **The Project finances a prioritized portion of the HSSIP 2014–2018 and other sector strategies focusing on PHC especially RMNCAH.** This includes: (a) AWPs at the county level,

[51] MoH. 2014. *KHHEUS 2013.* Nairobi: GoK.
[52] KNBS 2015. *KDHS 2014.*

and (b) a set of priority areas at the national level. These strategies aim to remove the most critical bottlenecks in service delivery areas such as HRH, SCM, HIS, quality of care/patient safety, and multi-sectoral collaboration to improve PHC outcomes.

56. **The KHSSIP and other sub-sector strategies including the RMNCAH investment framework are comprehensive and technically sound.** The development of these strategies was informed by a systematic bottleneck analysis. For example, the RMNCAH investment framework, developed in a consultative manner with all the key stakeholders over a period of eight months, encompasses: (a) a range of prioritized, evidence-based and high-impact RMNCAH interventions by levels of service delivery to provide a continuum of services, and (b) various HSS activities critical to the achievement of RMNCAH results. It aims to scale up evidence-based, high-impact interventions responding to county specific priorities.

57. **There are various accountability mechanisms embedded in the Project to hold actors at all levels accountable for results.** These include:

(a) At the front line, facilities will be held accountable for their performance through a facility performance scorecard.

(b) At the county level, county governments will be held accountable for their performance through the performance grants (for example, performance-based allocation per select PHC results improved).

(c) At the national level, selected implementers will be held accountable for their performance through the performance grants (for example, performance-based allocation paid to CRS per registration rate increased).

C. Financial Management

58. **While the financial management (FM) capacity of the MoH and counties is relatively strong, there are some weaknesses, which can be addressed during implementation.** A FM assessment of the MoH and 18 out of the 47 counties was conducted by the Bank FM team. The FM assessment, conducted in accordance with the FM practices manual issued by the Bank's Financial Management Sector Board on November 3, 2005, covered the six key FM elements of budgeting, accounting, internal control (including internal auditing), funds flow, financial reporting, and external auditing arrangements. There is adequate accounting capacity through national and county-level project accountants hired under the KHSSP. An IIFRA, also hired under the KHSSP, indicated that the FM arrangements at the CHMT and health facility levels are relatively strong. The Health Sector Services Fund Program, co-financed by the KHSSP, has detailed FM guidelines. However, some FM weaknesses persist and include slow disbursement of funds to health centers and dispensaries, poor records management, inadequate accounting of funds, and noncompliance with FM procedures. The MoH is in the process of addressing these weaknesses. This effort has been complemented by the Bank's own annual FM supervision reviews. The annual audit by the Supreme Audit Institution (SAI), Office of the Auditor General (OAG) was qualified on the basis of limitation of scope, because the auditor general was unable to verify funds sent to the county and health facilities due to 'lack of resources'. The matter is being handled by the GoK and the Bank as a portfolio-level issue, and it is expected that future

audits will be financed through IDA project funds. Other portfolio-level weaknesses include: (a) weak PFM processes especially the challenges in use of Integrated Financial Management Information System (IFMIS) by counties, and material audit qualifications of the FY2014 audit reports for all 47 counties; (b) inadequate accounting, internal control and auditing systems and capacity at county treasuries; and (c) weak internal audit function at county level and delays in setting up of oversight audit committees in line with the PFM law. The ongoing KHSSP is supporting PFM capacity building for CHMT. The Project will also develop the capacity of project staff, where necessary, to improve government systems and minimize these weaknesses.

59. **The Project will adopt the statements of expenditure (SoE) method of disbursement**. Two designated accounts (DAs) in US dollars will be opened by the NT at the Central Bank of Kenya (CBK): one for county performance grants (DA-A) and the other for all other activities (DA-B) at the national and county levels. For county level activities, funds will be disbursed, upon request by the MoH, from the DAs to a segregated county special purpose account[53] at the CBK through the exchequer account and county revenue fund (CRF). From the county special purpose account, the funds will be disbursed to existing accounts for health facilities. The counties will have the options of opening accounts for expenditures at the county level or incur expenditures directly from the special purpose account. For national level activities, funds will be disbursed from the DA-B to a project account (PA) in Kenya shillings which will be opened by the MoH at the CBK from which payment will be made. For CRS activities, the MoH will make payments and incur expenditures. The MoH will also transfer funds from the PA to a sub-account that will be opened by the KMTC at a commercial bank acceptable to IDA. The DAs will be replenished on the basis of a withdrawal application (WA) submitted to the Bank by the MoH through the NT.

60. **At the county level, Project implementation will be carried out by the County Department of Health (CDoH) under the guidance of the County Executive Committee for Health**. The funds will be budgeted under respective counties as grants revenue from the national government. The county governments are legal entities/accounting units and will be accountable for the funds and compliance as outlined by the eligibility criteria. The county treasury will be responsible for the FM arrangements at the county level, including disbursement of funds to health facilities and CHMTs, monitoring use of funds, and providing accountability for disbursed funds.

61. **A number of mitigating measures have been proposed to address the weaknesses noted at the county level and to further strengthen the MoH capacity**. These include the following:

(a) Designate a project finance officer, an assistant finance officer, and an internal auditor at the PMT. In addition, designate a project accountant and an internal auditor[54] for each of the participating counties. The candidates will be required to meet the criteria

[53] Each county will have one county special purpose account. If a county has already opened a county special purpose account for the KHSSP, then that county will not be required to open a second county special purpose account. The Chief Officer Health and Chief Officer Finance will be co-signatories for the account. The county special purpose account will avoid commingling of Project funds in the county operating accounts and minimize risk of Project funds being used on non-Project activities at the county level.

[54] The internal auditor at the county level will support the project on a part time basis and will be drawn upon as the need arises.

of terms of reference (ToR) cleared by the Bank and the short-listed candidates will be vetted and cleared by the Bank before being assigned;

(b) Prepare a detailed FM procedures manual for the Project;

(c) Hire an IIFRA that meets the criteria of a Bank-approved ToR. The IIFRA will send copies of the draft and final reports simultaneously and directly to the Bank;

(d) Set up corruption prevention and reporting, and SAc mechanisms including public reporting, complaints handling and disclosure of fiduciary information at the health facility level; and

(e) Enhance the capacity of the SAI OAG in the audit of the Project by funding OAG staff and/or outsourcing to private auditors when necessary.

62. **The conclusion of the assessment is that the FM arrangements have an overall residual risk rating of *substantial***, which satisfies the Bank's minimum requirements under OP/BP10.00, and therefore is adequate to provide, with reasonable assurance, accurate and timely information on the status of the Project as required by IDA. There are no outstanding FM issues in ongoing IDA financed projects implemented by the MoH (namely, KHSSP and the East Africa Public Health Laboratory Networking Project). The Ministry is in compliance with the financial covenants, with the quarterly integrated financial reports (IFRs) and annual audited financial statements being submitted to the Bank within the stipulated timelines. The form and content is also acceptable to the Bank.

D. Procurement

63. **Procurement activities will be carried out by the MoH, county governments, and KEMSA.** The MoH, through the PMT, will carry out procurement on behalf of the KMTC and CRS and assume overall responsibility for project coordination and management. County governments will be responsible for procurement activities below the World Bank shopping threshold. KEMSA will undertake procurement of: (a) all EMMS (including strategic commodities) and medical equipment under the Project; and (b) goods and non-consulting services above the World Bank shopping threshold. This arrangement will be reviewed during implementation. A centralized pool of key consultants may be available through the PMT to build the requisite implementation capacity and to provide TA as needed by the county governments.

64. **Procurement capacity of the implementing entities needs to be strengthened.** The Bank procurement team conducted an assessment to determine the capacity of the MoH and the county governments to implement procurement actions for the Project. The assessment reviewed the organizational structure for implementing the Project and the interaction between the Project's staff that are responsible for procurement duties and management of their respective agencies. The MoH has been implementing Bank-financed projects and their capacity to conduct procurement activities is considered satisfactory. However, there is less than sufficient capacity for an optimum operating procurement function at the county level, indicating the need for strengthening and capacity building.

65. **The Bank capacity assessment in the counties identified multiple procurement challenges.** The key procurement issues and risks that require mitigation measures include systemic weaknesses in the areas of: (a) office infrastructure; (b) capacity of procurement staff in the implementation of Bank-financed operations; (c) procurement planning; (d) procurement process administration, including award of contracts; (e) contract management; (f) records keeping; (g) constrained working environment and records storage facilities; and (h) procurement oversight.

66. **The conclusion of the assessment is that the procurement arrangements have an overall residual risk rating of *substantial***. A number of mitigating measures have been proposed to address the weaknesses noted at the county level and to further strengthen the MoH capacity. These include the following:

(a) Designate a procurement officer at the PMT with qualifications and experience acceptable to the Bank;

(b) Equip all entities with sufficient basic office infrastructure to facilitate project operations;

(c) Prepare a POM providing comprehensive and detailed, but simplified, procurement procedures and processes;

(d) Establish separate effective tracking systems for (i) procurement plan implementation and (ii) payment processing to suppliers and service providers; and

(e) KEMSA to procure all goods and commodities above the Bank's shopping threshold and all EMMS for county governments.

E. Social Safeguards

67. **The Project triggers Operational Policy (OP) 4.10: Vulnerable and Marginalized Groups (VMGs) and the applicable laws and regulations of the GoK**. OP 4.10 is triggered because it is likely that groups, which meet the criteria of OP 4.10, "are present in, or have collective attachment to, the Project area." The Bank has supported a number of projects in the health sector that have addressed the concern of the VMGs. As a result, the MoH has a good understanding of social safeguards. On the other hand, many CDoHs currently have limited capacity in the management of social safeguards issues. The MoH will need to work with counties to designate focal persons and strengthen their capacity to manage the safeguards. The MoH has prepared the vulnerable and marginalized groups' plans (VMGPs) under the ongoing health project, even though implementation has been slow mainly due to devolution. In addition, the MoH recently conducted a study that mapped out the VMGs in the country and provided additional qualitative information on the VMGs to enrich their plans.

68. **A vulnerable and marginalized groups' framework (VMGF) was prepared by the GoK, in consultation with the VMGs to provide a mechanism for the inclusion and informed**

participation of VMGs[55] in the Project, in a culturally appropriate manner. A public consultation attended by VMGs and other stakeholders was held on March 21, 2016. Prior VMGF consultations were held with sampled VMGs in Kiambu, Samburu, Baringo, and Kwale counties during data collection in February 2016. The VMGF spells out activities likely to be proposed for financing under the Project, identifies potential positive and adverse effects of such activities on the groups that meet the criteria of OP 4.10 and other VMGs. The VMGF also provides: (a) a plan for social assessment; (b) a framework/process for ensuring free, prior, and informed consultation with the affected communities at each stage of project preparation and implementation; (c) institutional arrangements including capacity building for screening project-supported activities, evaluating project effects on VMGs, preparing VMGPs, and addressing any grievances; and (d) participative monitoring and reporting arrangements, including mechanisms and benchmarks appropriate to the Project. The VMGs and other stakeholders (for example, CSOs) will be actively involved in monitoring project implementation at various levels through participation in health management structures. The VMGF for the Project was disclosed on April 13, 2016 on the MoH website (www.health.go.ke) and the Bank's InfoShop.

F. Environmental Safeguards

69. **The Project also triggers OP 4.01: Environmental Assessment and is assigned environmental category B based on the screening during project preparation**. There are no significant and/or irreversible adverse environmental and social issues anticipated from the investments to be financed under the Project. The Project will not support civil works other than maintenance and minor renovation of existing health facilities. The main environmental safeguard policy relates to health care waste management. Providing PHC services under the Project is likely to generate health care wastes, which present potential adverse impacts to the environment. The health care waste may be solid or liquid, including but not limited to infectious waste and other medical supplies that may have been in contact with blood and body fluids, highly infectious wastes (especially from the laboratories), and non-infectious waste from normal operations.

70. **The MoH has updated the Health Care Waste Management Plan (HCWMP) and disclosed it publicly**. The Bank has supported a number of projects in the health sector and thus the MoH has a good understanding of environmental risks related to health care waste. The MoH has built capacity within the national government to prepare a Health Care Waste Management Strategic Plan (2015–2020), which focuses on strategic and professional management of health care waste generated from the health care industry in Kenya. The MoH has also updated the HCWMP, which focuses on: (a) waste generation, segregation, storage, collection, transport, and final disposal practices; (b) technologies for waste disposal; (c) public awareness programs; and (d) relevant national legislation. As many CDoHs currently have limited capacity in the management of environmental safeguards issues, the MoH will need to strengthen counties'

[55] World Bank OP 4.10 Indigenous Peoples, July 2005. The OP 4.10 contemplates that different terminologies may be applied in different countries without affecting the application or substance of the policy. It states: "Indigenous Peoples may be referred to in different countries by such terms such as indigenous ethnic minorities; aboriginals, hill tribes, minority nationalities, scheduled tribes, or tribal groups." Given particularities with respect to the term Indigenous Peoples in Kenya, the 2010 Constitution of Kenya uses the term "vulnerable groups" and "marginalized communities". The use of such terminologies is in no way diluting the requirements for application of the policy.

capacity to manage the health care waste. The HCWMP was publicly disclosed on April 13, 2016 on the MoH website (www.health.go.ke) and the Bank's InfoShop.

71. **The Project has been screened to identify and address any potential climate and disaster risks and is rated *moderate* to the overall PDO risk** with possibly 'slightly reduced impact' due mainly to the possibility of extreme temperature, extreme precipitation/flooding, and drought. As a mitigation measure, the Project will: (a) support implementation of the HCWMP; (b) support rehabilitation of facilities (for example, improvement of water availability); (c) improve service delivery at the health facilities and during outreach services; and (d) strengthen activities that make the community units functional which can be used to re-educate communities about evacuation procedures.

G. Citizen Engagement

72. **CE is the two-way interaction between citizens and governments or the private sector that gives citizens a stake in decision-making with the objective of improving the intermediate and final development outcomes of the intervention.** The implicit theory of change in promoting CE in health care service is that communities with a participatory stake in the functioning of health facilities are more likely to use and support them and take greater care of their own health needs. CE can also help hold service providers accountable for results. For this reason, CE mechanisms are designed to make communities more aware of the services provided, more involved in the management of the facilities, better able to communicate with service providers and, in turn, feel more responsible for the successful functioning of the facilities.

73. **Between 2011 and 2013, the MoH, with support from the Bank, tested integration of SAc approaches,[56] which is part of CE, in selected health facilities across the country.** The pilot demonstrated that SAc holds considerable promise for achieving better local governance and health service delivery. Following the pilot, the MoH developed a manual to assist service providers and communities in adopting and implementing SAc practices in service delivery. This underscored the fact that until recently service provision has largely been supply driven with little or no input from the citizens.

74. **This Project will leverage on these guidelines to integrate CE in service delivery as a means of ensuring that citizens have a greater voice**; that the health system is accountable to its citizens in improving utilization and quality of PHC services; and that it responds to their needs in its quest to improve access to and demand for quality PHC services. As a means of strengthening the health system's institutional capacity, a critical component to improved CE will be to strengthen the Government's CHS by reviewing and reinforcing the community unit AWP template and planning processes. Indicators that support and enhance CE should be included.

75. **CE will contribute to achievement of the PDO** through: (a) improved demand for health services as a result of enhanced community participation in decision-making and management processes; (b) improved governance as a result of strengthened health facility governance structures; (c) empowered communities as a result of functional community units and increased

[56] Transparency and information sharing through various media, community participation through dialogue forums and community scorecards, and complaint handling mechanisms through various channels.

community participation in health service delivery; and (d) improved quality of health services as a result of feedback systems and GRM.

76. **Activities will be centered on the three components of CE** (see annex 7 for details).

(a) **Information sharing.** The extent to which health and operational information is made publicly and interactively available.

(b) **Community participation.** The improved functionality of community units as well as establishing community-based monitoring (CBM) mechanisms while also strengthening existing mechanisms such as inclusion of community representatives on the boards and management committees of health facilities.

(c) **GRM.** The extent to which feedback and GRM are available at the community level and whether/how the feedback loop is closed.

77. **The proposed CE activities are expected to be undertaken by two key actors**: (a) CHMTs should ideally appoint a focal person for CE within the team to guide the process; and (b) health facilities at all levels of care are expected to designate their CHEWs as the CE focal persons at the facility level and existing community fora.

H. World Bank Grievance Redress

78. Communities and individuals who believe that they are adversely affected by a World Bank supported project may submit complaints to existing project-level GRMs or the World Bank's Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed in order to address project-related concerns. Project-affected communities and individuals may submit their complaint to the World Bank's independent Inspection Panel, which determines whether harm occurred, or could occur, as a result of World Bank non-compliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the World Bank's attention, and Bank Management has been given an opportunity to respond. For information on how to submit complaints to the World Bank's corporate GRS, please visit http://www.worldbank.org/GRS. For information on how to submit complaints to the World Bank Inspection Panel, please visit www.inspectionpanel.org.

Annex 1: Results Framework and Monitoring

Country: Kenya

Project Name: Transforming Health Systems for Universal Care (P152394)

Results Framework

Project Development Objectives							
PDO Statement 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.							
These results are at	Project Level						
Project Development Objective Indicators							
		Cumulative Target Values					
Indicator Name	**Baseline**	**YR1**	**YR2**	**YR3**	**YR4**	**End Target**	
Children younger than 1 year who were fully immunized (Percentage)	73	73	74	75	75	76	
Pregnant women attending at least four ANC visits (Percentage)	40	41	42	43	44	46	
Births attended by skilled health personnel (Percentage)	57	57	59	61	63	64	
Women between the ages of 15–49 years currently using a modern FP method (Percentage)	41	41	42	43	44	45	
Inspected facilities meeting safety standards (Percentage)	0	0	0	25	35	50	

Intermediate Results Indicators						
		Cumulative Target Values				
Indicator Name	**Baseline**	**YR1**	**YR2**	**YR3**	**YR4**	**End Target**
Functional community units (Number)	1,549	1,700	1,900	2,100	2,300	2,400
Grievances registered related to delivery of project benefits that are addressed (Percentage)	0	15	30	45	60	80
Pregnant women attending ANC supplemented with IFA (Percentage)	31	32	34	36	38	40
Health facilities providing BEmOC (Percentage)	39	40	45	50	55	60
Facilities inspected for safety standards (Percentage)	0	0	0	25	50	70
Facilities submitting complete DHIS data in a timely manner (Percentage)	76	78	79	81	83	85
Registration of births (Percentage)	60	65	70	74	78	80
RMNCAH related operations research completed to inform policy/strategy (Number)	0	0	0	1	2	3
A benefit package developed, costed, and disseminated (Number)	0	0	0	1	1	1
Implementing entities submitting the annual FM and technical report on time (Percentage)	0	15	30	45	60	80
People who have received essential health, nutrition, and population services (Number)	3,704,547	3,800,000	3,900,000	4,000,000	4,100,000	4,200,000

Indicator Description				
Project Development Objective Indicators				
Indicator Name	**Description (indicator definition and so on)**	**Frequency**	**Data Source / Methodology**	**Responsibility for Data Collection**
Children younger than 1 year who were fully immunized	Children under 1 year who received three doses of OPV, three doses DPT (or pentavalent vaccine, that is, DPT plus HepB and Hib) and one dose each of BCG and measles vaccine before age of 12 months	Annual	DHIS2	CDoH
Pregnant women attending at least four ANC visits	Women between the ages of 15–49 years who had at least four ANC visits attended by trained health personnel	Annual	DHIS2	CDoH
Births attended by skilled health personnel	Births attended by skilled health personnel	Annual	DHIS2	CDoH
Women between the ages of 15–49 years currently using a modern FP method	Women between the ages of 15–49 years who are currently using a modern FP method	Annual	DHIS2	CDoH
Inspected facilities meeting safety standards	Public facilities (L2–L4) inspected which achieve at least 61 or more percent using the JHIC	Annual (from Year 3)	Administrative data	MoH Quality Standard
Intermediate Results Indicators				
Indicator Name	**Description (indicator definition and so on)**	**Frequency**	**Data Source / Methodology**	**Responsibility for Data Collection**
Functional community units	Community units that: (a) hold consecutive meeting/dialogue days[57]; (b) conduct action days; and (c) use four nationally approved community-HIS tools	Annual	Master Community Listing Tool linked to the MFL	CDoH
Grievances registered related to delivery of project benefits that are addressed	Grievances related to delivery of project benefits registered and addressed at the national and county levels	Annual	Grievance Registers	Focal persons at the national and county levels

[57] Community dialogue day is a meeting with the community (baraza) to discuss health indicators/problems identified from the community health information and CHWs, CHEWs, CHCs, community members and village elders take part in the meeting to plan specific actions to address the problems. Community action day is a monthly, one-day activity planned during the community dialogue day to address specific health issues (for example, clean up campaign, immunization outreach, latrine construction).

Pregnant women attending ANC supplemented with IFA	Pregnant women who received IFA supplements during ANC visits	Annual	DHIS2	CDoH
Health facilities providing BEmOC	Health facilities (L2–L4) providing BEmOC (administration of parenteral antibiotics, oxytocin, anticonvulsants; manual removal of placenta; removal of retained products; assisted vaginal delivery) at least once in the past three months	Annual	MFL	CDoH
Facilities inspected for safety standards	Facilities (L2–L4) inspected using JHIC	Annual (from Year 3)	Administrative data	MoH Quality Standard
Facilities submitting complete DHIS data in a timely manner	Health facilities submitting complete DHIS data (MoH forms 710, 711, and 713) in a timely manner (by the 15th of the following month)	Annual	DHIS2	MoH M&E
Registration of births	Births registered at civil registration office	Annual	CRS annual report	CRS
RMNCAH related operations research completed to inform policy/strategy	RMNCAH related operations research completed to inform policy/strategy	Annual	Project status report	MoH DFH
A benefit package developed, costed, and disseminated	A benefit package is developed, costed, and disseminated	Annual	Project status report	MoH DHCF
Implementing entities submitting the annual FM and technical report on time	Implementing entities submitting the annual FM and technical report on time	Annual	Project status report	PMT
People who have received essential health, nutrition, and population services	Use of essential health, nutrition, and population services is the sum of the number of children immunized (BCG); number of women and children who have received basic nutrition services (new visits for nutrition services); and number of deliveries attended by skilled health personnel.	Annual	DHIS2	MoH M&E

Annex 2: Detailed Project Description

Kenya: Transforming Health Systems for Universal Care Project (P152394)

1. The pathway to improve utilization and quality of PHC services is summarized in figure 2.1. Expected outcomes, which will be measured by the indicators in annex 1, include improved access to and quality of PHC services among the underserved and improved health seeking behaviors, eventually leading to improved utilization of quality PHC services. Special attention will be paid to inequity within each county (for example, the underserved populations and areas in each county through various mechanisms supported by the Project). Implementing a set of evidence-based interventions that are high-impact and cost-effective is expected to improve equity and efficiency and contribute to UHC.

Figure 2.1. Pathway to Improve the Utilization and Quality of PHC Services

Areas	Key issues	Key activities to address issues under			Outcome
		Component 1/3	Component 2	Other WB project/program*	
Stewardship /governance	▪ Weak PFM especially evidence-based decision-making ▪ Poor coordination and supportive supervision	▪ Training for evidence-based AWP formulation focusing on efficiency/ equity ▪ Supportive supervision ▪ Performance-based allocation ▪ Cross-county/ intergovernmental coordination	▪ AWP guidelines and appraisal system ▪ Annual performance review ▪ Capacity building	▪ Overall and health related PFM training (Devolution; KHSSP)	▪ Improved access to PHC services (especially among the under-served) ▪ Strengthened institutional capacity to improve utilization and quality of PHC services
HIS and CRVS	▪ Low data quality and incomplete reporting ▪ Unlinked and complex data platforms for decision-making ▪ Incomplete birth and death registration	▪ Incentive for timely and complete reporting through HIS ▪ Capacity building	▪ Updated HIS ▪ DQA ▪ Facility scorecard ▪ Integration of birth registration and MCH services (for example, immunization)	▪ Digitalization of birth/death registration and mobile registration pilot (TCIP)	
EMMS	▪ Insufficient budget allocation ▪ Weak SCM	▪ Procurement of EMMS including RMNCAH strategic commodities ▪ Advocacy for higher allocation especially for strategic EMMS and timely payment (also Component 2)	▪ RMNCAH guidelines	▪ KEMSA capitalization ▪ KEMSA SCM training (KHSSP)	
Infrastructure/equipment	▪ Non-functional facilities to provide essential services (for example. BEmONC, CEmONC)	▪ Rehabilitation of existing facilities ▪ Procurement and maintenance of essential equipment		▪ Procurement of essential equipment in ASAL counties (KHSSP)	
Human resources	▪ Shortage of skilled health workers	▪ Contracting (of health workers, NGOs/ CSOs)	▪ In-service training (for example,	▪ HRH management	

	especially in underserved areas ▪ Low competency and productivity	▪ Performance-based incentives ▪ Supportive supervision/ mentoring	RMNCAH guidelines) ▪ Midwifery training/ bonding	training (Devolution) ▪ RBF (KHSSP)	
Health financing	▪ Low budget allocation ▪ Fragmented health financing initiatives ▪ High OOP	▪ Advocacy for increased county budget on health ▪ Financial protection for the vulnerable	▪ HFS dissemination ▪ UHC capacity building ▪ Development of strategy and capacity building for financial protection of vulnerable groups	▪ TA to NHIF (KHSSP; IFC HiA)	
Quality of care	▪ Unsystematic inspection of facilities and providers ▪ Incomplete KQMH	▪ CQI (for example, patient safety, infection control, and certification)	▪ Inspection of private/public facilities using the JHIC	▪ Revision of KQMH framework[58] (IFC HiA)	▪ Improved quality of PHC services
Demand	▪ Lack of knowledge and information Sociocultural beliefs and practices ▪ Long distance to health facilities and high transport costs ▪ Limited funding for CHS implementation	▪ ACSM for preventive and promotive health care including safe water, sanitation, hygiene, and nutrition through functional comm. units ▪ Outreach services ▪ CE throughout PFM cycle ▪ Transport vouchers	▪ Operations research to reach underserved populations and areas including adolescents	▪ SAc training as part of PFM (KHSSP)	▪ Improved health seeking behaviors and demand for PHC services

Note: Please see DP support in annex 3.

2. The Project is comprised of three components. Components 1 and 2 will support selected key areas under the KHP 2014–2030, the KHSSIP 2014–2018 and other national strategies including the recently developed RMNCAH investment framework. Given the complexity of the newly devolved system of government, Component 3 will support cross-county and intergovernmental collaboration as well as project implementation and management at the national and county levels.

Component 1: Improving PHC Results (US$150 million of which US$115 million equivalent credit from IDA and US$35 million grant from the GFF TF)

3. **Component 1 aims to improve the delivery, utilization, and quality of PHC services at the county level with a focus on RMNCAH**. It will support counties to: (a) scale up evidence-based, county appropriate supply- and demand- side interventions; and (b) strengthen health systems by addressing the key bottlenecks in service delivery.

[58] KQMH framework that aims to create a national quality assurance, improvement and accreditation framework to be referred to as Kenya Health Standards is under review by MoH and stakeholders.

4. **Scaling up a set of high-impact, cost-effective interventions along the continuum of care is a priority**. It will support counties to scale up evidence-based, county appropriate supply- and demand-side key priority interventions along the continuum of care. This component will focus on: (a) improving functionality of existing facilities to deliver quality essential PHC services; and (b) increasing demand for services at the community and facility levels. The former includes expanding the availability of quality BEmONC and CEmONC, improving a referral system, and ensuring RMNCAH strategic commodity security. The latter includes strengthening community units[59] to: (a) deliver preventive and promotive health care including access to safe water and sanitation, improved hygiene practices and nutrition, and other public health measures; and (b) engage the community through CE to improve accountability of PHC services (for example, community dialogue days). The technical interventions for the continuum of care are summarized in figure 2.2.

Figure 2.2. High Impact Interventions along the Continuum of Care

	Adolescents and women	Antenatal care	Labor and birth	Postnantal care	Child
Referral and tertiary level facility	Reproductive health including FP; emergency care/post-abortion care; hospital care for injuries and illness of adolescents	Comprehensive care for prevention and management of prenancy complications	Skilled care at birth; comprehensive care for mothers and newborns with complications	Essential newborn care; care for small/ sick newborns; care of mothers with complication	Hospital care of childhood illness
First and secondary level facility	Reproductive health including FP; promotion of adolescent development; prevention of risk behavior, illness, and injuries; periodic check-ups; responding to health problems	Pregnancy care to prevent and manage complication of pregnancy; management of miscariage and incomplete abortion	Skilled care at birth; basic care for mothers and newborns with complications	Essential newborn care; care for small and sick newborns; PCN for mothers	Prevention and integrated management of childhood illness (inseticide treated nets vaccinations); nutrition (vit A and zinc)
Community	Community-based FP and sexuality education; preconception care, nutrition (IFA), and vaccines; prevention of harmful traditional practices; protection of adolescents through policies	Counseling and birth preparedness; health and nutritional education; nutrition supplements; education on birth spacing; FP	Promotion of facility delivery; clean delivery and simple early care; referral support including communication and transport	Essential newborn care at home; early detection and referral of complication; immediate newborn essential care; post-partum FP and counseling	Promotion of optimal care practices for the child at home including nutrition and hygiene; recognition of danger signs.

Source: Modified from draft Global Strategy for Women's, Children's, and Adolescent's Health (2015).

[59] Community unit represents the lowest administrative level of the health system. Each community unit comprises about 5,000 people and is supposed to be served by a network of CHWs under the supervision of CHEWs linked to the peripheral health facility. CHWs deliver primary care services to households focusing on preventive and promotive health (for example, addressing environmental or socioeconomic risk factors) and refer clients to the peripheral health facility for advanced care.

5. **Attention will also be paid to strengthening health systems to remove the key bottlenecks in PHC service delivery.** Key priorities in HSS that the component will support include:

(a) **Stewardship (including planning and budgeting) for health.** Technical and operational capacity building to enhance the competencies of county leaders and managers in planning, budgeting, managing, and coordinating the county health system.

(b) **Health information and CRVS.** Activities to improve availability, quality, and completeness of routine health information to ensure the use of data for decision-making at the county level (see the national level M&E activities in Component 2)**.** These include: (i) implementation of the M&E guidelines within each county; and (ii) building capacity in data collection and utilization per the national guidelines.

(c) **HRH.** Implementation of various strategies at the county level (for example, performance-linked incentives to motivate health workers, in-service training and other innovative approaches to attract HRH to work in remote areas or amongst underserved populations, contracting private sector, and so on).

(d) **EMMS and equipment.** Procurement and distribution of essential PHC EMMS and basic medical equipment including RMNCAH strategic commodities and capacity building in quantification, forecasting and SCM to minimize stock outs, overstock or expiry of commodities, including those related to FP.

(e) **Quality of care.** Supportive supervision according to the Joint Health Inspection Standards and implementation of low cost mitigation measures to improve safety in each facility (for example, cleanliness, protocols/standards operating procedures, low-cost supplies – gloves, color coded bins, record management, and so on).

6. **This component will use a performance-based approach by employing minimum conditions and allocating resources to the counties based on their improved PHC results**. For the first year, after fulfilling basic conditions,[60] all counties will be eligible to receive seed funding based on the needs measured by a function of (a) proportion of births "not" attended by skilled health professional in KDHS 2014 and (b) GoK's CRA ratio,[61] which takes the population and poverty level into account. This initial allocation is intended to jumpstart implementation.

7. For each subsequent year, the counties will be required to meet a set of minimum conditions as follows: (a) the share of the county budget allocation (for Year 2) and expenditure (for Years 3-5) for health (excluding conditional grants for health) is higher than the previous year, but no less

[60] For Year 1, each county must: (a) submit a supplementary budget for approval by the County Assembly; (b) open a county special purpose account at the CBK; and (c) designate a project accountant and an internal auditor.
[61] County revenue is shared among the counties as follows: population (45 percent), poverty (20 percent), land area (8 percent), basic equal share (25 percent) and fiscal responsibility (2 percent).

than 20 percent;[62] and (b) the annual Project financial and technical report for the previous financial year is submitted on time.[63] These conditions are to ensure that counties gradually increase domestic resources for the health sector to carry out health mandates and improve fiscal responsibility. Annual performance-based allocation for counties (table 2.1) will then be shared by all eligible counties as a function of (a) verified county performance; and (b) CRA ratio. County performance will be measured by the 'average change'[64] of a set of service delivery and HSS indicators (table 2.2), reported through routine HIS such as DHIS2.

8. **The total allocation of US$150 million for this component will be distributed over the life of the Project as follows:**

Table 2.1. Annual and Total Allocation (US$, Millions)

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Performance-based allocation	12.5*	27.5	30 (+ any undisbursed amount in Year 2)	30 (+ any undisbursed amount in Years 2 and 3)	30 (+ any undisbursed amount in Years 2–4)	130
RMNCAH strategic commodity	6	5	4	3	2	20

Note: *Allocation in Year 1 is smaller due to a shorter implementation period (that is, six months) and sensitization as well as capacity building required.

Table 2.2. County Performance Indicators

1. Children younger than 1 year who were fully immunized (percentage)
2. Pregnant women attending at least four ANC visits (percentage)
3. Births attended by skilled health personnel (percentage)
4. Women between the age of 15–49 years currently using a modern FP method (percentage)
5. Inspected facilities meeting safety standards (percentage)*
6. Facilities submitting complete DHIS data in a timely manner (percentage)

Note: *MoH and the counties will disseminate the safety standards and train inspectors in Years 1 and 2. Thus, performance of indicator 5 will be used from Year 3.

9. **The amount of seed funding per county for the first year will be determined as follows**:

$$County\ allocation_n = Total\ annual\ allocation * \frac{CRA_n * (100 - \%SBA)_n}{\sum_1^N (CRA_n * (100 - \%SBA)_n)}$$

where

CRA = CRA according to County Allocation of Revenue Act
SBA = Skilled birth attendance
N = Total number of eligible counties
n = County

[62] As one of the most devolved sectors, nearly two-thirds of government health care allocations have been devolved to counties in FY2013/14, accounting for about 30 percent of the county sharable revenue. The counties' average health sector budget as a percentage of the total county budget in FY2013/14 was only 13 percent. In FY2014/15 the allocation increased to 22 percent.

[63] PwC. 2015. *Provision of Technical Assistance in the Preparation of Individual and Consolidated Financial Statements for the County Government Entities for FY2014/15 – First Progress Report.* In FY2014/15, 41 counties submitted financial statements for audit by September 30 deadline as per Section 183 of the PFM Act.

[64] The formula will be subject to review in the subsequent years as needed. Details will be in the POM.

10. **The amount of performance-based allocation per county in Years 2–5 aims to address inequity in health outcomes and health systems and will be determined as follows**:

$$County\ allocation_n = Total\ annual\ allocation * \frac{CRA_n * RI_n}{\sum_1^N (CRA_n * RI_n)}$$

where

CRA = CRA according to County Allocation of Revenue Act
RI = Average change of indicators from the previous year
N = Total number of eligible counties
n = County

11. **The maximum allocation per county is set at 25 percent of the previous year's county health expenditure for operations[65] or US$3 million (whichever is lower) if only a few counties meet the eligibility conditions and/or improve results**. Any undisbursed amount will be carried over to the following year.

12. **Verification of county performance is a critical aspect of the component.** Verification ensures that disbursements are linked to improved results and the accuracy of reporting through DHIS2. While external verification conducted entirely by an independent agency may be more reliable and transparent, the Project decided to use annual peer review (cross-county verification) among counties to help them learn from each other and reduce the verification costs. This will also facilitate peer learning and knowledge sharing. As allocation to each county depends on the performance of all other eligible counties, cross-county verification is likely to work as external verification. In order to ensure transparency and quality of data, especially in the first couple of years of implementation, an external team will be recruited to manage the cross-county verification process. With support from the M&E Unit, the PMT (Component 1 coordinator and M&E officer) will be responsible for the coordination of peer verification[66] among counties, data compilation, and final verified results reporting to the Project sub-TWG at the Intergovernmental Forum for Health. Based on the verified results, the Project sub-TWG will determine 'per county allocation', which will be published in the Kenya Gazette to enhance transparency and accountability of the utilization of funds.

13. **Counties will then use the performance-based allocation to support priorities identified in their AWPs to further improve utilization and quality of key PHC services.** Under the existing annual planning and budgeting process of the GoK**,** each county will prioritize investments in its AWP to address county specific bottlenecks and improve RMNCAH results. During the AWP development process, the MoH and DPs will provide TA (box 2.1 and annex 6) in the use of evidence as a decision-making tool, which will help counties prioritize investments that address the county specific issues. While each county has the flexibility to choose their own strategies to address their specific bottlenecks, only those activities[67] proven to be effective and

[65] Expenditure for operations includes drugs, X-ray/lab supplies, and training expenses under the recurrent budget and vehicles, ambulances, equipment under the development budget.
[66] A team will be comprised of a CHMT member, a clinical staff selected from the best performing health facility, an implementing partner and a representative from a CSO.
[67] Selected expenditure categories (that is, salary of civil servants excluding incentives, construction of a new building) will be ineligible. Renovation and rehabilitation are eligible up to a maximum of US$200,000.

efficient in addressing key health sector challenges, including those described in the RMNCAH investment framework, will be supported by the Project. An AWP quality assurance system will ensure that the Project resources are used effectively, efficiently, and equitably. The Project sub-TWG under the Intergovernmental Forum for Health with support from TA (as described in Component 3 below) will technically appraise AWPs before disbursement is made.[68] In order to harmonize the implementation of this component with the GoK annual budget cycle, counties will need to follow a timeline for key milestones, including reporting of county performance and peer review (see annex 6 for the milestones).

Box 2.1. Health Sector Planning Framework

Kenya has been implementing a health sector planning framework to align policies, plans and budgets. In the past six years this health sector planning and monitoring process has integrated the development and implementation of AWPs at all levels of the health structure including the communities. With devolution, counties are mandated to develop county specific County Integrated Development Plans and multi-year health sector strategic and investment plans linked to the KHP and KHSSIP, and to develop AWPs that reflect county health priorities, budget and expenditure frameworks (see details in annex 6).

Currently, the quality of county AWPs varies, as tools and technical support for the process of developing AWPs are uncoordinated. A review of several AWPs reveals some challenges: (a) unstandardized planning guidelines and training materials; (b) weak capacity to assess and prioritize bottlenecks and incorporate equity, effectiveness, and efficiency aspects; and (c) lack of a quality assurance/appraisal system.

Several measures will be established to improve the quality of AWPs. To address these challenges, the MoH, in close collaboration with the county governments and the DPs including the World Bank Group, is planning to: (a) standardize and harmonize planning guidelines and tools including templates for the counties; (b) develop a quality assurance/appraisal system of AWPs; (c) build evidence-based planning and budgeting capacity for counties with support from the KSG and DPs; and (d) coordinate DPs providing technical support in planning and budgeting to avoid duplication of support and ensure that all counties are covered.

Component 2: Strengthening Institutional Capacity (US$15.1 million, of which US$9 million equivalent credit from IDA, US$5 million grant from the GFF TF, and US$1.1 million grant from the PHRD TF)

14. **Component 2 aims to strengthen institutional capacity at the national and county levels[69] to better deliver quality PHC services under Component 1.** This component will focus on three key areas: (a) improving quality of care; (b) strengthening M&E and CRVS; and (c) supporting health financing reforms towards UHC.

[68] The Project sub-TWG will assess the technical soundness of the AWP. For example, the sub-TWG will check if (a) AWP is well aligned with the county budget estimates approved by the County Assembly, (b) the interventions proposed are technically and economically sound; and (c) interventions supported by the Project are well aligned with the national priorities, and so on. Once an AWP quality assurance/appraisal system is developed by the GoK, the Project will follow the GoK system.

[69] As per the 2010 Constitution, the national government will focus on formulation of policy, strategy, and guidelines as well as provision of TA to the county level only under Component 2 (for example, updating the DHIS2 manual and training of trainers at the national and county level) and the counties will be responsible for the activities within the counties (for example, training health workers and compiling data according to the new guidelines) under Component 1.

15. *Subcomponent 2.1. Improving Quality of Care (US$8.3 million).* While Kenya has improved accessibility of PHC, the quality of care is still sub-optimal affecting utilization of services and health outcomes. The Project will support: (a) the Department of Health Standards, Quality Assurance and Regulations as well as the Health Regulatory Boards to (i) strengthen routine inspections of private and public health facilities, and (ii) institutionalize quality assurance towards certification;[70,71] (b) the DFH to (i) develop and disseminate RMNCAH related strategies, guidelines, and implementation frameworks including ASRH, newborn health and nutrition in order to address high teenage pregnancy, neonatal morbidities and stunting, and (ii) conduct operations research; and (c) the KMTC to strengthen midwifery training.

(a) **The Department of Health Standards, Quality Assurance, and Regulations as well as the Health Regulatory Boards will focus on:**

(i) **Strengthening routine inspections for enforcing minimum quality of care and safety standards**. In Kenya, health facilities must be inspected prior to licensing (private facility) or gazettement[72] (public facility) in order to operate. A minimum standard must be met for renewal of licenses or retention of gazettement. However, not all gazetted and licensed facilities are inspected.[73] Since 2009, the Government, with support from IFC, has introduced reforms to the inspection process and gazetted the JHIC in 2016 (Public Health Act Cap 242) to integrate the multiple processes of inspection into one comprehensive step[74] with more transparency to ensure minimum quality and safety standards. The Project will build upon lessons learned from the baseline survey of the Kenya Patient Safety Impact Evaluation[75] supported by IFC. The Project will support training inspectors to undertake county-wide inspection of all health care providers using the JHIC; and training county quality improvement teams (QITs) on the JHIC who can support PHC facilities in each county to achieve higher levels of quality and be 'inspection ready'. The inspectors will conduct inspections at public and private PHC facilities in Year 3 and onward. This should provide adequate time for the QIT to be trained and provide support to PHC facilities, and for the inspectors to be fully trained.

(ii) **Institutionalizing quality assurance towards certification**. With support from the German Corporation for International Cooperation (*Deutsche Gesellschaft für Internationale Zusammenarbeit,* GiZ), World Health Organization (WHO), Japan International Cooperation Agency (JICA), USAID, and IFC, the Department of Health Standards, Quality Assurance and Regulations has recently updated the KQMH for quality management in health facilities, and the CQI and

[70] MoH. 2015. *Kenya Health Quality Improvement Policy 2015 – 2030.* Nairobi: MoH
[71] GoK. 2011. *Implementation Guidelines for the Kenya Quality Model for Health.*
[72] Gazettement is a government process that publishes a notice declaring that the named health facility can provide health services at a stated level.
[73] GoK. 2011. *Implementation Guidelines for the Kenya Quality Model for Health*.
[74] GoK. 2015. *Implementation Guidelines for the Joint Health Inspections Checklist*.
[75] The impact evaluation aims to generate evidence regarding the impact of inspections on improving patient safety in Kakamega, Kilifi, and Meru counties and the type of action taken if a health facility is non-compliant with the minimum standards based on the JHIC.

provider certification guidelines at each level of care. The Project will support developing and disseminating the stepwise CQI framework and implementation guidelines (including accreditation framework for conforming assessment bodies to certify health care providers using the KQMH certification scheme); and rolling out the CQI system to counties and selected facilities using the established QIT. This involves sensitization and capacity building of CHMTs and QITs in CQI M&E tools and facilitating sharing of best practices.

(b) **The DFH will focus on:**

(i) **Developing/disseminating RMNCAH-related strategies/guidelines.** The Project will support the DFH to develop and disseminate RMNCAH related strategies and guidelines including maternal and child nutrition guidelines to address undernutrition; and the ASRH strategy and implementation plan, based on the ASRH policy launched in 2015. The Project and other partners will provide counties with support to develop and implement innovative ASRH interventions. The RMNCAH-related strategies/guidelines will be developed through a consultative process involving relevant stakeholders in nutrition and ASRH TWGs, including county governments, DPs, and the private sector. The developed strategies and guidelines will be systematically disseminated to the sub-county level.

(ii) **Conducting operations research to monitor implementation of recently launched guidelines and to inform new guidelines.** The Project will support operations research in the following areas:

- **Implementation gaps of the revised maternal and perinatal death surveillance and response (MPDSR) guidelines**. The MPDSR builds upon the Country Accountability Framework for Women's and Children's Health,[76] which defines priority areas including registration of vital events, maternal death surveillance and results.[77,78] The MPDSR guidelines were revised in 2015 in consultation with DPs[79] and launched in 2016. The DFH will evaluate the gaps in implementation of the revised MPDSR guidelines in Kenya.

- **Pilot to roll out the use of chlorhexidine for umbilical cord care.** Umbilical cord cleansing with 4 percent chlorhexidine is a cost-effective

[76] As part of the Every Woman Every Child movement, a global Commission on Information and Accountability for Women's and Children's Health was established in 2011 to ensure global reporting, oversight, and accountability for monitoring progress in women's and children's health. Countries developed Country Accountability Frameworks to monitor, evaluate, and review national health strategies that placed accountability at the country level.
[77] WHO. 2014. *A Review of Progress in Implementation of the Commission on Information and Accountability for Women's and Children's Health*.
[78] WHO. 2014. *Accountability for Women's and Children's Health 2014 Progress Report*.
[79] DFID, Liverpool School of Tropical Medicine (LSTM), United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), and WHO.

invention and reduces the risk of neonatal mortality and sepsis in low-income countries.[80] While the use of chlorhexidine has recently been approved in Kenya for umbilical cord care, it has not been widely implemented. The DFH will pilot the effective use of chlorhexidine in selected counties.

- **Acceptability of micronutrient supplementation of WRA.** Global evidence suggests that micronutrient supplementation in WRA is a high-impact and cost-effective intervention for reducing infant and maternal morbidity and mortality in developing countries.[81,82] However, in Kenya micronutrient deficiencies persist (for example, nearly half of WRA are anemic) due to poor dietary diversification, infections, and food insecurity.[83] Also, less than 10 percent received adequate quantity (90+) of IFA supplementation during pregnancy and about half of the women received postpartum vitamin A supplementation. The Nutrition Unit will determine factors that will promote coverage, uptake, and use of micronutrient supplementation as one of the selected high-impact interventions and inform the design of national guidelines for micronutrient supplementation in WRA.

(c) **The KMTC will focus on:**

(i) **Strengthening midwifery practice.** The recent training needs assessment[84] showed that there are midwifery skills gaps in health workers employed relative to the HRH norms and standards across most cadres but most critically in nurses trained in midwifery to manage CEmONC and complicated pregnancies. The Project will support the KMTC to train 800 nurse/midwives mostly from the underserved counties building on lessons learned from the ongoing KHSSP, which is supporting training of 400 community health nurses and midwifery skills laboratories located in eight ASAL counties.[85]

16. *Subcomponent 2.2. Strengthening M&E and CRVS (US$5.0 million).* Facilitation of evidence-based decision-making including prioritization of high-impact interventions during the planning and budgeting process requires accurate and reliable data collected and verified through routine information systems such as the DHIS2 and CRVS. The Project will support the Division of M&E, Health Research Development, and Health Informatics working closely with CRS[86] to:

[80] Karumbi J et al. 2013. Topical umbilical cord care for prevention of infection and neonatal mortality. *Pediatric Infection Disease Journal*. 32(1):78–83.
[81] Bhutta Z et al. 2008. What works? Interventions for maternal and child undernutrition and survival. *The Lancet*. 371(9610):217–440.
[82] Haider B and Z Bhutta. 2015. Multiple-micronutrient supplementation for women during pregnancy. *Cochrane Database of Systematic Reviews*. 11.
[83] Ministry of Public Health and Sanitation. *National Nutrition Action Plan 2012 – 2017*.
[84] MoH. 2015. *A Report on the Training Needs Assessment for the Ministry of Health*.
[85] Baringo, Bomet, Kajaido, Kilifi, Kitui, Kwale, Turkana and West Pokot counties.
[86] The CRS operates under the Ministry of Interior and Coordination of National Government. The CRS is mandated to collect, register, and compile information on all births, deaths, and the circumstances related to vital events.

(a) operationalize the M&E framework; (b) strengthen the HIS; and (c) pilot innovative approaches to improve coverage of vital events registration within the health sector.

(a) **Operationalizing the M&E framework.** The Project, with support from the PHRD Performance and Results with Improved Monitoring and Evaluation window, funded by the Government of Japan, will support the operationalization of the M&E framework to provide an enabling environment for a well-coordinated and functional M&E system at all levels of the health system. This will entail: (i) reactivating the non-functional M&E TWG by re-constituting TWG membership including the MoH, CDoHs, and partners, and developing a clear ToR; (ii) developing an M&E investment case, which will be used to mobilize resources domestically and from DPs; (iii) supporting the annual joint M&E review meetings, which will provide a platform for the performance review at both national and county levels; and (iv) finalizing the M&E institutionalization guidelines and systematically disseminating it down to the sub-county level.

(b) **Strengthening HIS**. The Project will strengthen a harmonized and sustainable HIS to monitor progress effectively and efficiently. This will involve the following activities:

(i) **Supporting the hosting of DHIS2, MFL, and data service servers** in the cloud infrastructure. The MoH is currently transitioning hosting responsibility from USAID's AfyaInfo and will benefit from Project support during the four-year transition period.

(ii) **Reviewing the indicators** of various units in the MoH and updating the HIS indicator manual and the DHIS tools. The current HIS indicator manual (2nd edition), developed in 2012, is currently being reviewed in a consultative manner and will include a number of indicators in five investment areas.[87] The HIS indicator manual (3rd edition) is expected to be launched in 2016. The Project will support a review and update of the HIS indicator manual in 2019 and the printing of M&E tools;

(iii) **Building capacity at the national and county levels in DHIS2 of both users and administrators and the DQA**. Once the HIS indicator manual (3rd edition) is launched and the new tools are developed, the Division of M&E, Health Research Development, and Health Informatics will conduct training on the new tools; and

(iv) **Rolling out the integrated facility performance scorecard,** which is being piloted in six counties[88] with support from the WHO. The scorecard is a standardized framework for performance monitoring at facilities and will provide health facility managers a snapshot of data on key performance indicators through a dashboard.

[87] The five investment areas are: (a) health input and process investment; (b) curative and rehabilitative services; (c) preventative and promotive health; (d) HIV/AIDS, tuberculosis, and malaria control; and (e) cross cutting issues.
[88] Baringo, Bungoma, Kilifi, Nakuru, Turkana, and Uasin Gishu.

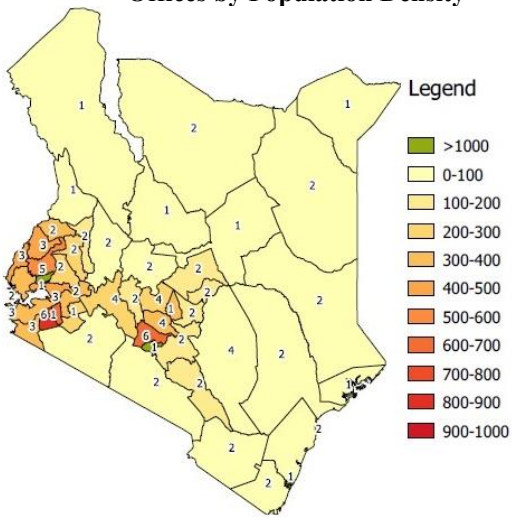
(c) **Improving CRVS.** Improving registration of vital events is critical to evidence-based decision-making. Efforts will focus on improving completeness and coverage of CRVS systems in collaboration with the CRS of the Ministry of Interior and Coordination of National Government, which is responsible for recording and issuing certificates for births and deaths. The Project will support:

(i) **Accelerating the registration of all births in Kenya through the MCH strategy.** According to KDHS 2014, 96 percent of children between 12 and 23 months received the BCG vaccine (typically given at birth), which contrasts sharply to the proportion of births registered (60 percent). Accordingly, an MCH strategy was developed to link birth registrations with MCH services (including immunization). The Project will support this effort to improve birth registration of children in Kenya through the sensitization of CHMTs and the orientation and training of RMNCAH staff on the MCH strategy during supportive supervision visits.

(ii) **Building capacity in the International Classification of Diseases (ICD) 10.** The Project will support the adoption and use of the International Form of Medical Certificate of Cause of Death and Community Death Notification. The Project will also support capacity building of coders in the use of ICD10 coding and certifiers according to ICD coding, rules, and practices. This effort will be conducted in collaboration with the CRS.

(iii) **Piloting a mobile registration office.** The Project will support a feasibility test using mobile units to register vital events in hard to reach areas with low coverage rates. In Kenya, there are only 107 local civil registration offices covering 289 sub-counties. Therefore, one local office may cover more than one sub-county. Long distance is a barrier to seeking registration services and is notably a challenge in the ASAL counties where population density is also low (figure 2.3). The Project will support a mobile registration office pilot in one county selected by the CRS and evaluate implementation challenges and bottlenecks that need to be addressed before scaling to other counties.

Figure 2.3. Distribution of Civil Registration Offices by Population Density



Source: CRS Annual Vital Statistics Report 2014.

(iv) **Strengthening capacity of registration agents through quarterly supportive supervision visits.** In health facilities, health workers act as registration agents recording vital events, while in the communities, assistant chiefs act as

registration agents. Every quarter, a team representing the local civil registration office and the local county government will conduct monitoring and supportive supervision visits to improve data quality and build capacity in CRS initiatives such as the MCH strategy and the use of the International Form of Medical Certificate of Cause of Death and Community Death Notification. The Project will provide performance grants to the CRS to increase birth registration rates from the current level (60 percent).[89]

17. *Subcomponent 2.3. Supporting Health Financing Reforms towards UHC (US$1.8 million).* The Government is in the process of finalizing the HFS. The strategy has an ambitious plan aiming to extend health insurance coverage to the entire population and achieve UHC by 2030. Substantial preparatory work is needed to inform the design, implementation, M&E of proposed reforms. The DHCF is responsible for spearheading the implementation of the HFS, but it has limited capacity to effectively conduct this mandate. The Project will support the DHCF to: (a) disseminate the policy/strategy to get buy-in from various stakeholders, drawing from the recently completed stakeholder analysis; (b) conduct analytical work to inform the implementation of HFS; and (c) build capacity for UHC leadership at the national and county levels.

(a) **Disseminating policy/strategy.** The Project will support the implementation of the HFS communication plan, which includes community sensitization, public awareness, and advocacy among key stakeholders (for example, trade-unions, private sector, members of parliament, county governments). The plan will be implemented through media campaigns (radio, television, and print), dissemination meetings, and workshops targeting different audiences.

(b) **Conducting analytical work to inform the implementation of HFS.** The Project will strengthen the MoH's capacity to lead health financing reforms towards UHC. Specifically, the Project will provide TA to the DHCF to conduct analytical work and operations research to inform the implementation of the HFS. Potential areas of analytical work will include: (i) developing appropriate provider payment mechanisms, focusing on diagnostic related groups and global budgets for hospital level, and capitation for PHC facilities; and assessing their feasibility in the Kenyan context; (ii) developing guidelines to inform the design of client-oriented primary care networks using two counties as case studies; (iii) developing an appropriate methodology to guide the design of an essential package for health (benefit package), the costed benefit package, and a framework for updating the package periodically to reflect the county's need and affordability; (iv) developing a framework to identify the poor for the purposes of health insurance subsidies, jointly with the social protection secretariat and pilot this endeavor in two counties; and (iv) developing the structures needed for pooling and purchasing arrangements, including appropriate revenue collection and pooling mechanisms, and purchasing through third party agents. Given the limited in-house capacity, TA will be contracted out initially, while in-house capacity is being built through short-courses, on-the-job training, and

[89] The CRS will receive an allocation of US$100,000 to scale up supportive supervision. Thereafter, at the end of each year, the CRS will receive an allocation of US$50,000 per each percentage point increase in birth registration from the baseline up to the project target of 80 percent. The CRS will receive an additional US$100,000 when the CRS reaches the birth registration rate of 85 percent.

mentorship from the contracted organization(s) and local academic institutions. This support will be coordinated closely with other DPs to leverage their support and provide a cohesive approach for the full implementation of the HFS.

(c) **Building capacity for UHC leadership**. The Project will build capacity for UHC leadership within the MoH and county governments through in-house courses on health systems and financing, conducted jointly with the World Bank Group Open Learning Campus. To build capacity of in-country institutions, the courses will be organized jointly with a local academic institution.

Component 3: Cross-county and Intergovernmental collaboration, and Project Management (US$26 million equivalent credit from IDA)

18. **Component 3 aims to enhance cross-county and intergovernmental collaboration as well as facilitate and coordinate project implementation.** Component 3 will support two areas:

19. *Subcomponent 3.1. Cross-county and Intergovernmental Collaboration (US$16 million).* The Project will finance activities that will promote cross-county initiatives and intergovernmental collaboration to address common demand- and supply-side barriers to improve delivery and use of quality PHC with a focus on agreed results. Examples include cross-county study tours to share knowledge and capacity building in areas that affect several counties such as drafting county health bills and improving SCM of strategic commodities. A call-for-proposal approach will be used. Every year, the PMT will issue a call for proposals in collaboration with the national and county governments and will facilitate TA for proposal reviews. The Project sub-TWG will approve the final selection of proposals, which will be concurred by the Bank. The winner(s) will be required to implement the proposals and report the findings and lessons learned through the Intergovernmental Forum for Health. The POM will detail the procedures and processes.

20. *Subcomponent 3.2. Project Management (including M&E and fiduciary activities) (US$10 million).* The Project will finance project management staff at national and county levels of government, office equipment and operating costs for day-to-day project management. This component also includes: (a) M&E activities such as annual peer reviews (cross-county verification), periodic surveys and process evaluation to monitor implementation progress and address any implementation challenges; (b) fiduciary activities such as hiring an IIFRA; (c) safeguards activities such as social assessment and preparation or revision of safeguards related plans; and (d) TA and capacity-building activities to support the Project sub-TWG under the Intergovernmental Forum for Health in carrying out their responsibilities, among others, reviewing the quality of AWPs, verifying county performance, and selecting proposals to promote cross-county and intergovernmental collaboration.

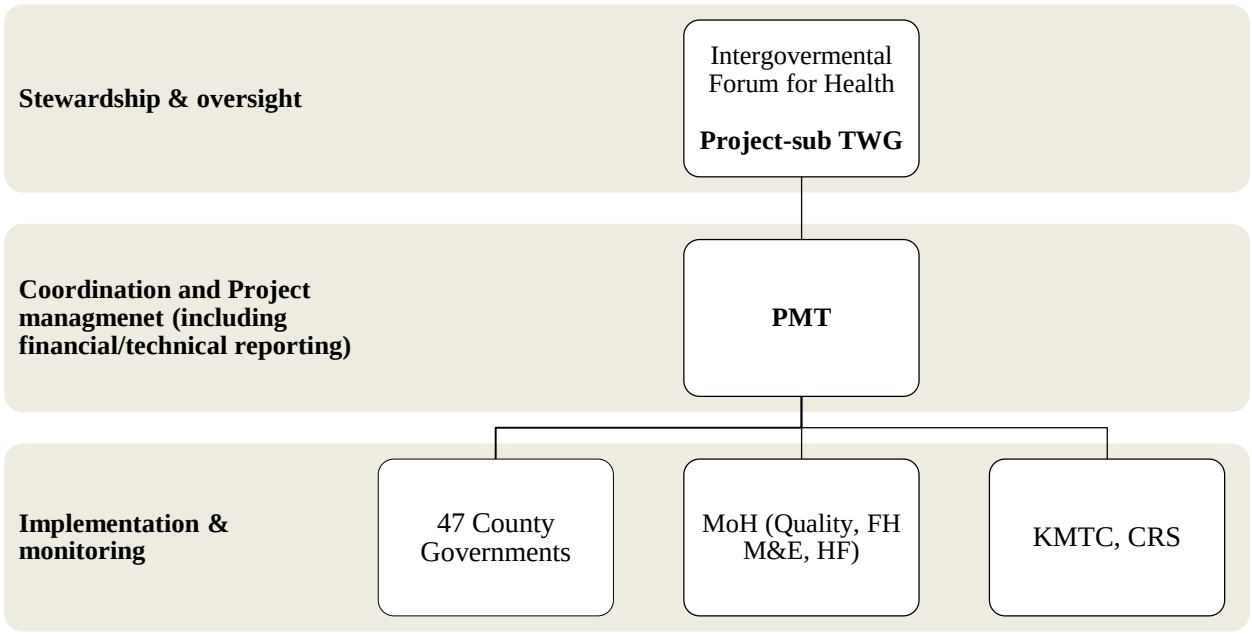
Annex 3: Implementation Arrangements

Kenya: Transforming Health Systems for Universal Care Project (P152394)

Project Institutional and Implementation Arrangements

1. **The Project will be implemented by multiple implementing entities in line with the Constitution.** At the county level, project activities under Component 1 will be implemented through existing county governance structures, which include the CDoHs, CHMTs, Hospital Boards for Level 4 and 5 facilities, and Health Facility Management Committees (HFMCs) for Level 2 and 3 facilities. Each county will be responsible for the activities proposed through the AWP, including safeguards activities. Activities under Component 2 will be implemented by the MoH jointly with the KMTC and CRS. The four departments/divisions in the MoH (that is, Quality Assurance and Regulations, Family Health, M&E, and Health Care Financing) will lead and/or participate in the implementation of activities to strengthen institutional capacity at the national and county levels. The KMTC will be responsible for implementing the midwifery training in close collaboration with the DFH, while the CRS will implement the CRVS related activities, jointly with the Division of M&E, Health Research Development and Health Informatics. Project implementation will be mainstreamed into the AWP of all implementing entities.

Figure 3.1. Institutional and Implementation Arrangements



Project Administration Mechanisms

2. **Project management will be the responsibility of the PMT**. The PMT of the ongoing KHSSP will require additional capacity to coordinate both the ongoing and the new Project. Thus, the MoH will be required to: (a) set up a dedicated PMT, located in the Department of Health Sector Coordination and Intergovernmental Affairs (or successor); (b) designate staff with appropriate skill sets and recruit on exceptional basis to fill skills gaps; (c) build staff capacity;

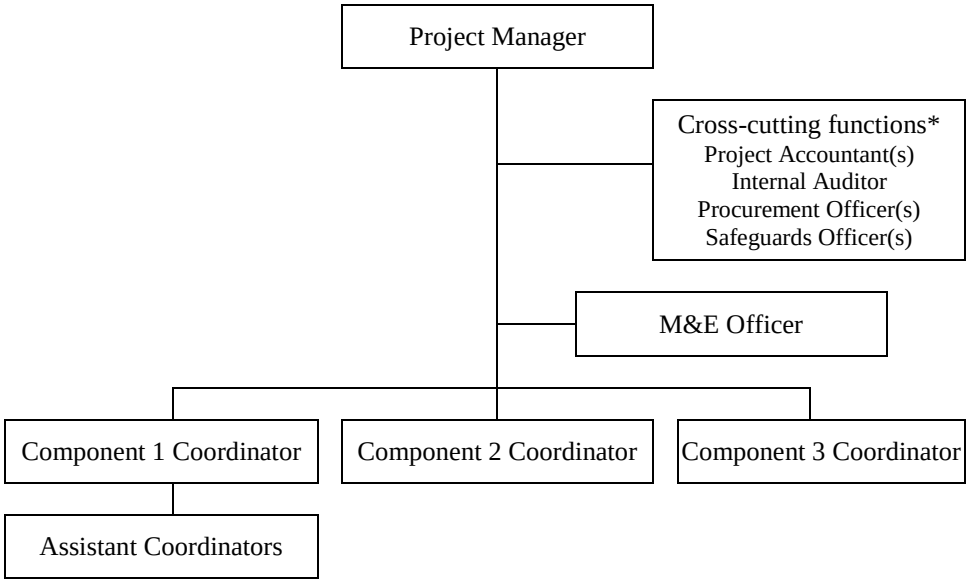
and (d) make resources available to conduct day-to-day functions. Staff for cross-cutting functions (for example, procurement officers, project accountants, safeguards officers) may be shared between the ongoing and new projects with additional staff with the appropriate skills set. The MoH and county governments will release those staff assigned to the PMT of any other duties and responsibilities so that they can fully dedicate themselves to project management. The PMT will be responsible for coordinating and managing the timely and effective implementation of the Project at the county and national levels. The PMT will have a dedicated project manager with overall responsibility for the effective functioning of the Project. Reporting to the project manager will be designated coordinators for each component and an M&E officer. The GoK will designate a coordinator for Component 1 as a member of the PMT. Component 1 coordinator will initially be based at the CoG and will be responsible, with support from assistant coordinators, for coordinating activities in all counties and ensuring that counties submit quality and timely financial and technical reports. Each implementing entity for Component 2 activities will assign a dedicated person to lead the Project activities in the division/department. The PMT will receive and compile quarterly and annual financial and technical reports from each of the 47 counties and all national implementing entities (MoH, KMTC, and CRS) and forward them to the Project sub-TWG at the Intergovernmental Health Forum, the NT, and the Bank for review. The PMT will also prepare annual consolidated Project financial statements, have these statements audited, and submit the audit report to the Bank within the stipulated timelines. The Project policies and procedures will be incorporated in the POM.

3. **The Intergovernmental Forum for Health will provide stewardship and oversight of the Project.** With devolution, the Intergovernmental Forum for Health was set up to bring health sector senior managers from national and county government levels and key stakeholders together to: (a) share experiences in managing devolved health services; (b) deliberate over issues affecting health service delivery under devolution; and (c) forge relationships between the two levels of government. Co-chaired by the Cabinet Secretary, MoH and the Chair of the County Executive Forum for Health, the Intergovernmental Health Forum will be tasked to provide the overall strategic direction and oversight for project implementation. A Project sub-TWG will be set up under the Intergovernmental Forum to facilitate key decisions that affect project implementation at both levels of government and coordination among various implementing entities. The Project sub-TWG will meet quarterly to: (a) validate the technical soundness of AWPs and/or monitor their implementation status; (b) verify county performance; (c) make final selection of the proposal(s) to support cross-county and intergovernmental collaboration and monitor implementation; and (d) review quarterly project status report (figure 3.1). TA will be provided to the sub-TWG as needed.

4. **Other stakeholder engagement will also be streamlined.** The DPs for Health Kenya (DPHK) provides a forum for consultation and coordination of DPs. The Project will ensure effective linkages between programs and/or projects supported by other DPs in support of the RMNCAH investment framework through the DPHK to maximize the likelihood of achieving the PDO and reduce duplication. CE activities will be undertaken at both county and health facility levels based on the MoH's *Implementers' Manual for Social Accountability in the Health Sector: for County Health Managers and Other Health Stakeholders* and the CHS (see annex 7 for details). The CHMT will provide overall leadership and direction for the CE in the counties. They will appoint a CE focal person for the county, who will work closely with the team and health facilities

to implement CE activities. At the facility level, CE will be led by HFMCs, working closely with CHEWs in settings where they exist.

Figure 3.2. Project Management Team



Note: * The cross-cutting functions will be handled by the ongoing KHSSP PMT, possibly with additional staff. After the KHSSP closes, they will be integrated into this Project PMT.

Financial Management, Disbursements, and Procurement

Financial Management and Disbursements

5. **The FM team conducted FM assessment of the MoH and 18 out of the 47 counties**. The objective of the assessment was to determine whether the two entities maintain effective FM arrangements to ensure that:

(a) funds channeled into the Project will be used for the purposes intended in an efficient and economical manner;

(b) the Project's financial reports will be prepared in an accurate, reliable, and timely manner; and

(c) the Project's assets will be safeguarded from loss, abuse, or malicious damage.

6. **The FM assessment covered the six key FM elements** of budgeting; accounting; internal control, including internal auditing; funds flow; financial reporting; and external auditing arrangements. The assessment was conducted in accordance with the FM practices manual issued by the Bank's Financial Management Sector Board on November 3, 2005.

7. **With the new Constitution, the health sector has been largely devolved to the 47 county governments.** The funds for county level activities from the Project are, therefore, treated as conditional grants from the national to the county governments. At the national level, the funds will be budgeted under the MoH as transfers to counties. At the county level, the funds will be budgeted under respective counties as grants revenue from the national government. The county governments are legal entities/accounting units and will be responsible for accountability of the funds and compliance as outlined by the eligibility criteria. Project implementation will be carried out by the CDoH under the guidance of the County Executive Committee Member for Health. The county treasury will be responsible for the FM arrangements at the county level, including disbursement of funds to health facilities and CHMTs, monitoring use of funds, and providing accountability for disbursed funds. For the national level activities, the MoH will be responsible for the preparation of its own AWP and sub-budgets.

8. **While the FM capacity of the MoH and counties is relatively strong, there are some weaknesses, which can be addressed during implementation.** There is adequate accounting capacity through national and county level project accountants hired under the KHSSP. The reports of the IIFRA also hired under the KHSSP indicate that generally the FM arrangements at the CHMT and the health facility levels are relatively strong. The Health Sector Services Fund Program co-financed by the KHSSP has detailed guidelines. However, some weaknesses have been noted which include slow disbursement of funds to health centers and dispensaries, poor records management, funds not properly accounted for, and noncompliance with FM procedures. The MoH is in the process of addressing these weaknesses. This effort has been complemented by the Bank's own annual FM supervision reviews. The annual audit by the SAI OAG was qualified on the basis of limitation of scope because the auditor general was unable to verify funds sent to the county and health facilities due to 'lack of resources'. The matter is being handled by the Bank and the GoK as a portfolio-level issue, and it is expected that future audits will be financed through IDA project funds. Other portfolio-level weaknesses include: (a) weak PFM processes especially the challenges in use of the IFMIS by counties, and material audit qualifications of the FY2014 audit reports for all 47 counties; (b) inadequate accounting, internal control and auditing systems and capacity at county treasuries; and (c) weak internal audit function at county level and delays in setting up of oversight audit committees in line with the PFM law. The ongoing KHSSP is supporting PFM capacity building for CHMT. The Project will also develop the capacity of project staff, where necessary, to improve government systems and minimize these weaknesses.

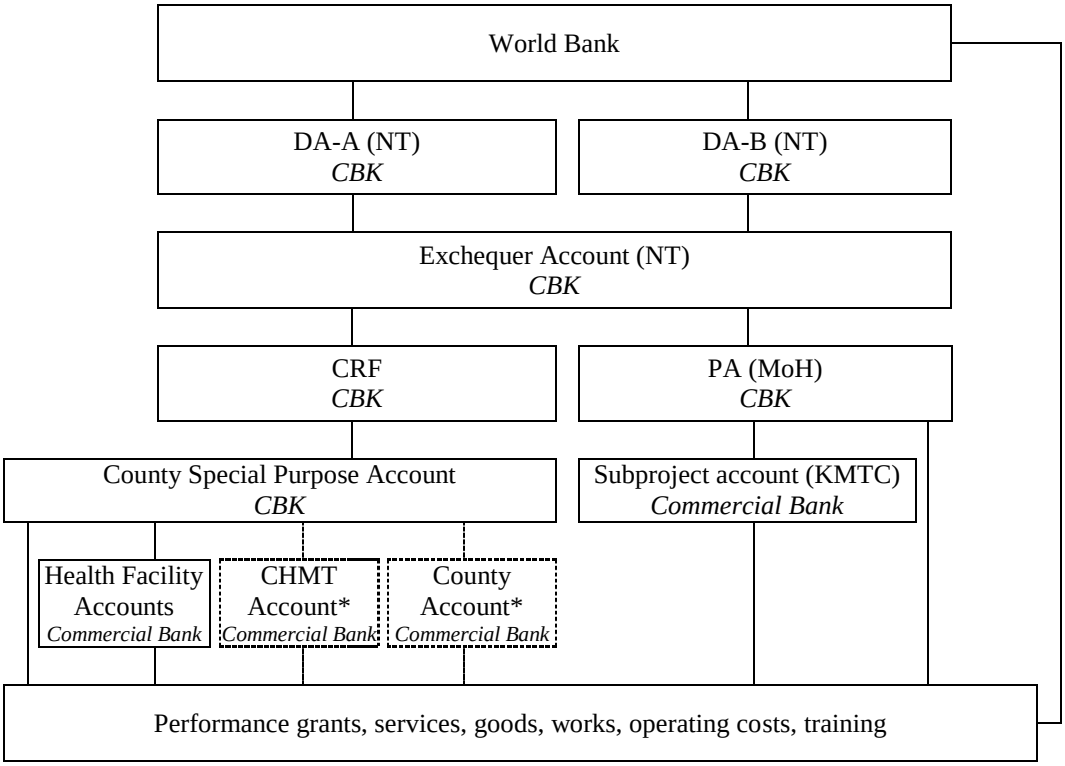
9. **The Project will adopt the SoE method of disbursement**. Two DAs in US dollars will be opened by the NT at the CBK: one for county performance grants (DA-A) and the other for all other activities (DA-B) at the national and county levels. For county level activities, funds will be disbursed, upon request by the MoH, from the DAs to a segregated county special purpose account[90] at the CBK through the exchequer account and CRF. From the county special purpose account, the funds will be disbursed to existing accounts for health facilities. The counties will have the options of opening accounts for expenditures at the county level or incur expenditures directly from the special purpose account. For national level activities, funds will be disbursed

[90] Each county will have one county special purpose account. If a county has already opened a county special purpose account for the KHSSP, then that county will not be required to open a second county special purpose account. The Chief Officer Health and Chief Officer Finance will be co-signatories for the account. The county special purpose account will avoid commingling of Project funds in the county operating accounts and minimize risk of Project funds being used on non-Project activities at the county level.

from the DA-B to a PA in Kenya shillings which will be opened by the MoH at the CBK from which payment will be made. For CRS activities, the MoH will make payments and incur expenditures. The MoH will also transfer funds from the PA to a sub-account that will be opened by the KMTC at a commercial bank acceptable to IDA. The DAs will be replenished on the basis of a WA submitted to the Bank by the MoH through the NT.

10. **The Project will also adopt the direct payment method for payments in respect of RMNCAH strategic commodities procured through KEMSA and delivered to the counties**. In this regard, KEMSA will contract eligible suppliers for the strategic commodities and ensure procurement and delivery of the supplies to the individual counties. Upon submission of a WA accompanied by relevant supporting documents, the World Bank will make direct payment to the supplier.

Figure 3.3. Funds Flow Arrangements



Note: *Optional

11. **A number of mitigating measures have been proposed to address the weaknesses** noted at counties and to further strengthen the MoH capacity. These include the following:

(a) Designate a project finance officer, an assistant finance officer, and an internal auditor at the PMT. In addition, designate a project accountant and an internal auditor[91] for each of the participating counties. The candidates will be required to meet the criteria

[91] The internal auditor at the county level will support the project on a part time basis and will be drawn upon as the need arises.

of ToR cleared by the Bank and the short-listed candidates will be vetted and cleared by the Bank before being issued contracts.

(b) Prepare detailed FM procedures manual for the Project.

(c) Hire an IIFRA on a ToR cleared by the Bank. The IIFRA will send copies of the draft and final reports simultaneously and directly to the Bank.

(d) Set up corruption prevention and reporting and SAc mechanisms including public reporting, complaints handling and disclosure of fiduciary information at health facilities level.

(e) Enhance the capacity of the SAI OAG in the audit of the Project by funding OAG staff and/or outsourcing to private auditors when necessary.

12. **The conclusion of the assessment is that the FM arrangements have an overall residual risk rating of *substantial***, in view of the outstanding implementation and FM arrangements for Component 1, which is the largest component. This satisfies the Bank's minimum requirements under OP/BP 10.00 and therefore is adequate to provide, with reasonable assurance, accurate and timely information on the status of the Project as required by IDA.

Summary of the FM Assessment

A. Country Issues

13. **Kenya has been progressively addressing weaknesses identified by Public Expenditure and Financial Accountability assessments**. The country has established the Public Sector Accounting Standards Board, strengthened the SAI OAG and aligned the ongoing PFM reforms with the 2010 Constitution. The country has also enacted the PFM law (PFM Act 2012) and formulated PFM regulations, which is a significant step in the PFM reform process in the country. The office of Controller of Budget, established under the new constitution, has also been effective in providing the necessary budget execution oversight. In addition, past weaknesses in the judiciary are progressively being addressed through a series of reforms including the appointment of a new chief justice and creation of the Supreme Court of Kenya. The Government has also re-launched the implementation of the IFMIS and deployed the system for use in the counties. This is aimed at addressing past concerns/weaknesses in PFM. Further, the Ethics and Anti-Corruption Commission has also been entrenched in the new constitution and it is expected to be more robust in the fight against corruption. The mandate of SAI OAG has also been expanded to include audit of all public funds at the national and county levels including those held by private entities. This is aimed at strengthening accountability over the use of public resources.

B. Project Specific Fiduciary Arrangements

Budgeting

14. **For Component 1, the conditional grants will be budgeted in the MoH as transfers to the counties**. With regard to Component 2, the MoH will be responsible for the preparation of its own AWP and sub-budgets, which will be harmonized and submitted for inclusion into the annual

budget for the ministry. This will include the budget for conditional grants (transfers) to participating counties. The Project budget will be prepared on the basis of the GoK standard chart of accounts, which also forms the basis for expenditure. Budget execution will be monitored through the IFMIS-based government vote book system as well as the quarterly IFRs submitted to the Bank.

15. **In a similar way, counties will budget for the Project funds as conditional grants revenue** from the national government. The Project budgets will be included as part of the county budget by the respective county treasuries and approved by the respective county assembly. Each county will be responsible for the preparation of its own AWP.

Accounting System and Capacity

16. **The MoH maintains adequate accounting capacity** headed by a qualified and experienced head of accounting unit (HAU) and chief finance officer (CFO) for budget purposes. The HAU and CFO both report to the principal secretary, MoH. The ministry maintains manual cashbooks, which run parallel to the IFMIS records. The Project will maintain segregated manual cashbooks complemented by customized Microsoft Excel spreadsheets for recording expenditure incurred at the national level through MoH. Similarly, the Project will maintain separate cashbooks in each of the counties and health facilities for recording expenditure incurred at the county level. Records at the health facilities will be maintained by the officers in charge of the facilities. The MoH will designate a finance officer, an assistant finance officer and an internal auditor to support project FM functions at the national level. The participating counties will also designate a project accountant and internal auditor to support project FM functions at the county level. The Project staff will be designated on the basis of a ToR prepared by the PMT and cleared by the Bank. The designated staff will also be vetted by the Bank before they are issued contracts. A comprehensive FM procedures manual will be developed for the Project. The manual will be used to provide guidance in payment processing and financial reporting under the Project.

Internal Controls and Internal Audit

17. **The MoH maintains elaborate internal control arrangements in line with government financial regulations and procedures.** The implementing entity maintains adequate procedures for approval and authorization of payments, proper segregation of functions, and internal check mechanisms. The payment processing system for the Project at the national level will be mainstreamed within MoH's accounting system, which has adequate controls.

18. **At the county level, the county designated project accountant will initiate payments, which will be processed through the respective county treasuries**. The Project FM procedures manual will set out the detailed internal control procedures for the Project at national and county levels.

19. **At the national level, the ministry internal audit function will ensure effective internal audit oversight of Project activities**. The ministry internal audit unit was noted to have adequate capacity with regard to both staff numbers and requisite qualifications and experience. Under the Project, a dedicated internal auditor will be designated. The MoH will hire an IIFRA on the basis of a ToR cleared by the Bank to conduct FM, procurement, and performance reviews on the

Project. The IIFRA will have forensic audit capacity. The IIFRA will submit draft and final copies of their reports directly and simultaneously to the Bank.

20. **SAc mechanisms will be implemented** such as display of project information and disbursements on sign boards erected in public places and local government offices. In addition, the Bank and GoK will ensure public disclosure of all project annual audit reports in line with the Access to Information Policy of July 2010. The Bank will also conduct regular in-year FM reviews of Project activities to enhance internal controls.

Funds Flow and Disbursement Arrangements

21. **One major FM risk affecting the entire Kenya portfolio is in-country funds flow delays from the DA to the PAs resulting in delayed project implementation**. The Bank team has been working closely with the Government to address this problem. As a way forward, the accountant general has established External Resources Sections in each ministry as a means of fast tracking the funds flow process. The other risk is delayed or partial release of funds from the ministry development account into the PA. To mitigate the risk of funds flow delays and piecemeal release of project funds by a line ministry, funds for the Project will not be disbursed through the ministry development account or county operating accounts.

Financial Reporting

22. **The MoH will be responsible for the preparation of quarterly IFRs,** which will be submitted to the Bank within 45 days after the end of the quarter. For county-level activities, each county will submit IFRs to the NT and MoH within 30 days after the end of the quarter to enable consolidation and submission to the Bank within 45 days after the end of the quarter. In the IFRs, each entity will indicate the respective amounts received against their respective expenditures under the Project. The IFRs will be used primarily for monitoring and financial reporting but not as a means of initiating disbursements from IDA because the Project will operate on the SoE method of disbursement.

23. **The MoH will ensure preparation of annual financial statements,** which will be submitted for external auditing within three months after the end of the fiscal year. The annual Project financial statements will be prepared in line with the standard format for donor-financed operations issued by the NT. Project financial statements from the individual counties will be consolidated by the MoH before submission for external audit. The annual financial statements will be prepared on the basis of the International Public Sector Accounting Standards cash basis of accounting issued by the Public Sector Accounting Standards Board for donor projects.

External Audit Arrangements

24. **The OAG, which is the SAI in Kenya and is responsible for the audit of all Bank funded operations in Kenya, will be responsible for the audit of the Project.** The OAG audited the MoH financial statements for the year ended June 30, 2014 and expressed an adverse opinion because of a number of weaknesses. These included: (a) a transfer not supported by adequate documentary evidence; (b) expenditure in excess of the approved budget; and (c) unauthorized misallocation of expenditure. In addition, the entity had omitted a large expenditure from the

financial statements and failed to provide some imprests. The OAG expressed an adverse opinion regarding the financial statements for the Ministry of Medical Services for FY2013 on the grounds of unsupported expenditure and weaknesses in maintaining accounting records.

25. **The OAG audit of various counties for the year ended June 30, 2014 revealed major fiduciary weaknesses in most counties** and the audit opinion issued by the auditor general consisted mainly of adverse and disclaimer opinions. The identified areas of weakness include: (a) inaccurate/unreliable financial statements; (b) poor assets controls including lack of assets registers even in some places for the current (new) assets; (c) lack of supporting documentation for expenditures and revenues; (d) un-accounted expenditures; (e) poor controls over staff allowances, advances, and imprest; (f) lack of supporting documents for training; (g) issues related with payment to county assembly members; (h) poor records management including anomalies in the general ledgers; (i) lack of updated cashbooks; (j) bank reconciliations not completed or not reconciling; (k) material procurement irregularities; (l) poor payroll controls and discrepancies in staff payments; and (m) challenges with revenue management including risk of misappropriation.

26. **The identified audit weaknesses at both the MoH and counties will be addressed during implementation.** In addition, the Project funds will be ring-fenced from ministry-wide fiduciary risks at the national level by ensuring segregated project accounts, cashbooks, and financial statements, operated, maintained, and prepared by the designated project accountants and bank account signatories. Similarly, project funds will not be co-mingled with other regular county operating funds at the CRF. The county-level project accountants will ensure proper records are kept for project financial activities. At the national level, the designated project accountant will ensure adequate accountability, including submission of all relevant information and explanations to the OAG as part of the audit process. The audit report and management letter will be submitted to the Bank within six months after the end of the fiscal year.

Risk Assessment and Mitigation Measures

27. The analysis of the assessment is presented in table 3.1.

Table 3.1 Risk Assessment and Mitigation Measures

Type of Risk	Initial Risk Rating	Brief Explanation	Risk Mitigation Measures Incorporated in Project Design	FM Condition	Residual Risk Rating
INHERENT RISK					
Country Level	S	This is based on the Country PFM environment and considers overall history of the country governance environment and corruption concerns.	▪ A more robust PFM Act 2012 is now in place, with on-going PFM reforms including the roll-out of IFMIS to the 47 counties, introduction of electronic fund transfer payments via G-Pay ▪ SAI OAG has been strengthened while the Office of Controller of Budget has been established to oversee budget execution. ▪ The Ethics and Anti-Corruption Commission has also been entrenched in the constitution to spearhead the fight against corruption.	No	S

Type of Risk	Initial Risk Rating	Brief Explanation	Risk Mitigation Measures Incorporated in Project Design	FM Condition	Residual Risk Rating
Entity Level	S	Political economy issues between the CoG and the national government affecting Project design. Revised conditional grants framework yet to be issued by the NT.	▪ On-going discussions between the CoG and NT	No	S
Project Level	S	Project design and implementation arrangements not yet finalized.	▪ On-going discussions between the CoG and NT	No	S
Overall Inherent Risk			**S**		
CONTROL RISK					
Budgeting	S	Budgeting arrangements for project not yet finalized.	▪ On-going discussions between the CoG and NT	No	S
Accounting	S	Weak accounting capacity at the county level.	▪ Designation of project accountants and internal auditors at the county level ▪ Regular FM trainings to be conducted for project staff	No (eligibility criteria)	M
Internal controls, oversight and risk management	H	Serious weaknesses noted for MoH, CoG and counties such as unsupported expenditure and imprests not surrendered.	▪ Hire of IIFRA ▪ Project funds ring-fenced from entity-wide risks ▪ Project FM and procurement manual to detail the internal control arrangements ▪ Regular internal audit oversight, Bank FM supervision, and OAG audit to strengthen controls	Yes; FM manual (disbursement)	S
Funds flow	S	Significant delays in funds flow from DA to PA could delay project implementation.	▪ Project funds for the national level activities will flow from DA to PA both at the CBK to reduce time taken. Funds will not pass through ministry development account or county operating account to minimize delays	No	S
Financial reporting	S	Risk of late submission of IFRs and annual audit reports from counties.	▪ Regular staff training	No	M
Auditing	H	FY2014 and FY2013 audit reports for the MoH and counties received adverse audit opinion.	▪ Project funds will be ring-fenced from other regular GoK funds. ▪ Regular monitoring including in-year fiduciary reviews by the Bank and entity Internal Audit Departments to enhance accountability	No	S
Overall Control Risk			**S**		
Overall Project FM Risk			**S**		

Note: H = High; S = Substantial; M = Moderate; L = Low.

C. FM Conditions

Action	Responsibility	Remarks
1. Develop FM procedures manual (as part of POM)	MoH	Before disbursing any funds for Component 1 performance grants
2. Designate project fiduciary staff at MoH and counties	MoH/counties	Before disbursing any funds for Component 2 and Subcomponent 3.1

D. Implementation Support Plan

28. Based on the outcome of the FM risk assessment, the following implementation support plan is proposed:

FM activity	Frequency	FM output
Desk reviews		
IFRs review	Quarterly	IFR review report
Audit report review of the Project	Annually	Audit review report
Review of other relevant information such as internal control systems reports	Continuous as they become available	FM review report
Onsite visits		
Review of overall operation of the FM system including internal controls	At least once every 12 months	FM review report
Monitoring of actions taken on issues highlighted in audit reports, auditors' management letters, internal audit and other reports	As needed	FM review report
In-depth FM reviews (if needed)	Annually or as needed	FM review report
Capacity building support		
FM training sessions	By effectiveness and thereafter as needed	Training sessions held

E. Conclusion of the Assessment

29. **The FM arrangements have an overall residual risk rating of *substantial***, which satisfies the Bank's minimum requirements under OP/BP 10.00 and therefore is adequate to provide, with reasonable assurance, accurate and timely information on the status of the Project as required by IDA.

Procurement

30. **Procurement for the Project will be carried out in accordance with the Bank's 'Guidelines:** Procurement of Goods, Works, and Non-Consulting Services Under IBRD Loans and IDA Credits and Grants by World Bank Borrowers' dated January 2011, revised July 2014; and 'Guidelines: Selection and Employment of Consultants Under IBRD Loans and IDA Credits and Grants by World Bank Borrowers' dated January 2011, revised July 2014, and the provisions stipulated in the legal agreement. The various items under different expenditure categories are described below. For each contract to be financed by the credit and grants, the different procurement methods or consultant selection methods, the need for prequalification, estimated costs, prior review requirements, and time frame are agreed between the borrower and the Bank in the procurement plan. The procurement plan, dated May 3, 2016, will be updated at least annually or as required to reflect the actual project implementation needs and improvements in institutional

capacity. The Project will carry out implementation in accordance with the 'Guidelines on Preventing and Combating Fraud and Corruption in Projects Financed by IBRD Loans and IDA Credits and Grants' dated October 15, 2006 (the Anticorruption Guidelines) and revised in January 2011 and the provisions stipulated in the Financing Agreement.

31. **Procurement implementation arrangements.** The Project comprises three components to be implemented by the MoH, county governments, KMTC, and CRS of the Ministry of Interior and Coordination of National Government. Due to varying capacity at the county government level, all procurement activities for general and health sector related commodities with contracts estimated to cost above the World Bank shopping threshold as defined in the procurement plan will be procured through KEMSA. This arrangement will be reviewed at the midterm review. KEMSA will follow all the procurement methods outlined in the financing agreement, and as further elaborated in the procurement plan approved by the Bank, including the use of the Bank's standard bidding documents (SBDs), review procedures, and documentation. The overall coordination of the Project will be carried out by PMT. The Intergovernmental Forum for Health, comprised of senior managers from the national and county governments and key stakeholder representatives, will provide overall stewardship and oversight of the Project.

32. **The PMT will be responsible for coordinating and managing the timely and effective implementation of the Project at the county and national levels**. However, there is need to strengthen the capacity of the PMT through: (a) designating full-time personnel and/or technical support competitively selected using procedures acceptable to the Bank with appropriate skill sets for the positions of FM, procurement, project management, and M&E; (b) training and building the team's capacity; and (c) making resources available to carry out their day-to-day functions. The PMT will be responsible for (a) overall project management and reporting; (b) providing the necessary TA and capacity building to the county governments and beneficiary institutions in the procurement and implementation phases for shopping and consultant services contracts under the Project; and (c) procurement activities under Components 2 and 3.

(a) Component 1 will support the improvement of delivery, utilization, and quality of PHC services at the county level with a focus on RMNCAH services and will be implemented by the respective county governments. The procurement activities envisaged under this component include, but are not limited to, the procurement of EMMS including strategic commodities, medical equipment, non-medical equipment/supplies (for example, printing of M&E tools, and so on), minor works as well as consultancy services and TA. EMMS and medical equipment as well as all contracts for goods above the World Bank shopping threshold will be procured by KEMSA. To effectively undertake and manage procurement activities under the Project, the county governments will be required to designate and maintain adequate procurement staff with qualifications and experience acceptable to the Bank. The PMT will provide TA to build the capacity of the county procurement staff.

(b) Component 2 will support strengthening of institutional capacity to better deliver quality PHC services under Component 1 focusing on (i) improving quality of care; (ii) strengthening M&E and CRVS; (iii) supporting health financing reforms towards UHC. The procurement activities envisaged under this component include, but are not limited to, the procurement of equipment, motor vehicles, information and

communication technology (ICT) and office equipment, TA and training. This component will be implemented by the MoH. In addition, MoH will also carry out procurement activities on behalf of KMTC and CRS. The MoH is currently implementing the KHSSP and the East Africa Public Health Laboratory Networking Project, in addition to past Bank-financed projects, and therefore has the requisite institutional framework, knowledge, and experience necessary for implementing Bank-financed operations.

(c) Component 3 will support activities that enhance cross-county and intergovernmental collaboration and that facilitate and coordinate project implementation. The procurement activities envisaged under this component include, but are not limited to the procurement of ICT and office equipment, consultant services for M&E, integrated fiduciary agent, surveys, performance verification, TA and training. This component will be implemented by the MoH jointly with the county governments. County governments' procurement requirements that exceed the World Bank shopping threshold will be procured through KEMSA.

33. **Use of national procurement procedures.** All contracts other than those to be procured on the basis of International Competitive Bidding (ICB) and consulting services shall follow the procedures set out in the Public Procurement and Asset Disposal Act (PPADA) of 2015. The PPADA 2015, enacted under an act of parliament in accordance with Article 227 of the Constitution, provides procedures for efficient public procurement of works, goods, and services using public resources and assets disposal by central government entities, county governments, state corporations, education institutions, and other government institutions. The PPADA sets out the following structure for the regulation of public procurement and asset disposal: (a) the NT responsible for public procurement and asset disposal policy formulation; (b) the Public Procurement Regulatory Authority responsible for procurement system monitoring and performance audit; and (c) the Public Procurement Administrative Review Board responsible for reviewing, hearing, and determining procurement and asset disposal related disputes. The PPADA sets out the rules and procedures of public procurement and provides a mechanism for enforcement of the law. Some provisions of PPADA are not fully consistent with the Bank Procurement and Consultants Guidelines and therefore these may not be applied for the implementation of this Project without modification. These provisions and their respective modifications are the following:

(a) PPADA Section 97: Instead, the tender submission deadline shall be set so as to allow a period of at least 30 days from the later of (i) the date of advertisement, and (ii) the date of availability of the tender documents.

(b) PPADA Section 4(2)(c): Instead, the Recipient's Government-owned enterprises shall be allowed to participate in the tendering only if they can establish that they are legally and financially autonomous, operate under commercial law, and are an independent agency of the Recipient's Government.

(c) The Recipient shall use, or cause to be used, bidding documents and tender documents (containing, among others, draft contracts and conditions of contracts, including

provisions on fraud and corruption, audit, and publication of award) in form and substance satisfactory to the Bank.

(d) PPDA Section 80(3)(b): Instead, evaluation of tender shall be based on quantifiable criteria expressed in monetary terms as defined in the tender documents. It shall not be based on merit points system.

(e) PPADA Section 155: Instead, no domestic preference shall be used in the evaluation of tenders. Therefore, as a result of the non-application of PPADA Sections 80 and 86(2) and Section 155, contracts shall be awarded to qualified tenderers having submitted the lowest-evaluated substantially responsive tender.

(f) PPADA Section 87: Instead, notification of contract award shall constitute formation of the contract. No negotiations shall be carried out prior to contract award.

34. **Procurement of goods.** Goods to be procured under this Project will include, but not be limited to: ICT equipment (hardware and associated software); medical, laboratory and office equipment; EMMS; and motor vehicles. The procurement will be carried out using the Bank's SBDs for all ICB and NCB contracts.

35. **Procurement of works.** Works to be procured under the Project are relatively small and include minor modifications and rehabilitation to existing facilities and services below the World Bank shopping threshold defined in the procurement plan. Contracts estimated to cost above the World Bank shopping threshold will be reviewed on a case-by-case basis and appropriate implementation arrangements and risk mitigation action plans will be agreed upon before the approval of the updated procurement plan.

36. **Procurement of non-consulting services.** Non-consulting services envisaged under the Project include printing of training materials, renting/leasing of ICT services, and leasing of office premises. The procurement will be carried out using the Bank's SBDs for all ICB and NCB contracts. The type and budget for such services will be defined and agreed upon between the borrower and IDA before their inclusion in the updated procurement plans.

37. **Direct contracting.** Direct contracting may be an appropriate method when it can be justified that competitive bidding is not advantageous and it meets the requirements of paragraph 3.7 of the Procurement Guidelines after consultation with the Bank. In particular, direct contracting may be used under the following circumstances: (a) where an existing contract for goods, awarded in accordance with procedures acceptable to the Bank, may be extended for additional goods of similar nature and character; (b) where the need for standardization of equipment or spare parts to be compatible with existing equipment may justify additional purchases from the original supplier; (c) where the required equipment is proprietary and obtainable only from one source; (d) where a contractor responsible for a process design requires the purchase of critical items from a particular supplier as a condition of a performance guarantee; and (e) in exceptional cases such as in response to a natural disaster.

38. **Use of framework agreements.** Framework contracting is permitted as an alternative to the shopping and NCB methods and may be used to implement procurements such as: (a) goods that can be procured off-the-shelf or are of common use with standard specifications; (b) non-

consulting services that are of a simple and non-complex nature and those that may be required from time to time by the same agency or agencies of the borrower; or (c) small value contracts for works under emergency operations. Such arrangements should not restrict foreign competition and should be restricted to a maximum duration of 3 years. The nature and budget for such goods including the circumstances and justification for its use, the particular approach and model to be adopted, the procedures for selection and award, and the terms and conditions of contracts will be defined and agreed upon between the GoK and the World Bank before their inclusion in the updated procurement plan.

39. **Procurement of EMMS.** The Project will finance the procurement of EMMS by the GoK. In this regard and due to the need for efficiency, quality control, competitive pricing, and elimination of duplication in the procurement process and associated costs, procurement of EMMS including strategic commodities by the GoK will be carried out by KEMSA.[92] In addition, KEMSA will also be responsible for the procurement of all other types of goods to be procured by county governments under the Project above the World Bank shopping threshold. This arrangement will be reviewed during the midterm review.

40. **Selection of consultants.** Consulting services to be procured under the Project include selection of firms and individuals for the provision of training services, information management services, policy reviews and development, program evaluation, external financial audit, and TA services. All consulting services will be procured using the Bank's Consultant Guidelines.

41. **Capacity building, training programs, and workshops.** Training and capacity-building activities, including the development of capacity in the procurement units and user departments of the implementing entities, will take place for the staff who are directly involved in project procurement activities to enhance their capability to manage the procurement process in compliance with both the Bank's and GoK's procurement guidelines. Training and capacity-building activities will include workshops, seminars, conferences, short-term courses, and on-the-job training. All training will be carried out on the basis of approved annual training plans as part of the AWPs that will identify the general framework of training activities for the year, including: (a) the type of training or workshop; (b) the personnel to be trained; (c) the selection methods for the institutions or individuals conducting such training; (d) the institutions which will conduct the training; (e) justification for the training, that is, how it would lead to effective performance and implementation of the Project and/or sector; (f) the duration of the proposed training; and (g) the estimated cost of the proposed training. Reporting will be required by trainees upon completion of training.

42. **Operating costs.** Operating costs for the Project are incremental expenses arising under the Project and based on AWPs and the budget approved by the Bank. Operating costs comprise the reasonable incremental expenses incurred by the implementing entities and approved by the Bank that are attributable to project implementation, management, and monitoring, consisting of the following costs: office supplies and consumables; communication; operation and maintenance of office vehicles; utilities, accommodation, per diem and travel costs paid to carry out project

[92] KEMSA was established as a state corporation with the mandate of procuring, warehousing, and distributing medical commodities to all public health facilities in the country and meets the eligibility requirements for award of contract under Bank-financed operations in accordance with the provisions of paragraph 1.10(b) of the Procurement Guidelines.

activities; reasonable bank charges; and allowances and salaries of contracted staff (excluding salaries of the recipient's civil servants). These items will be procured using the implementing entities' administrative procedures, which are reviewed and found acceptable to the Bank.

43. **POM.** The procurement procedures and SBDs to be used for each procurement method, as well as model contracts for works and goods procured, are presented in the POM.

Assessment of the Agencies' Capacity to Implement Procurement

44. **Procurement activities under the Project will be carried out by: (a) the MoH; (b) the county governments; and (c) KEMSA.** The MoH, through the PMT, will carry out procurement on behalf of the KMTC and CRS and also have the overall responsibility of project coordination and management. County governments will be responsible for procurement activities below the World Bank shopping threshold. KEMSA will undertake (a) procurement of all EMMS and medical equipment under the Project, and (b) procurement of goods and non-consulting services above the World Bank shopping threshold.

45. **Procurement capacity of the implementing entities needs to be strengthened.** An assessment of the capacity of the MoH and the county governments to implement procurement actions for the Project was carried out by the Bank procurement team. The assessment reviewed the organizational structure for implementing the Project and the interaction between the Project's staff who are responsible for procurement duties and management of their respective agencies. The MoH has been implementing Bank-financed projects and their capacity to carry out procurement activities is considered satisfactory. However, there is less than sufficient capacity for an optimum operating procurement function and therefore the need for strengthening and capacity building. Procurement in the counties is, however, faced with multiple challenges identified during the Bank's capacity assessment and appropriate mitigation measures to address these weaknesses will be proposed in the POM.

46. **The key issues and risks concerning procurement which require mitigation measures include systemic weaknesses in the areas** of: (a) office infrastructure; (b) capacity of procurement staff in the implementation of Bank-financed operations; (c) procurement planning; (d) procurement process administration, including award of contracts; (e) contract management; (f) records keeping; (g) constrained working environment and records storage facilities; and (h) procurement oversight. The agreed upon corrective and/or mitigation measures are the following:

(a) By effectiveness, second and/or recruit full-time procurement staff at the PMT with qualifications and experience acceptable to the Bank.

(b) After effectiveness, equip all entities with sufficient basic office infrastructure such as computers, printers/photocopiers, and reliable internet connectivity to facilitate project operations.

(c) Before disbursing any funds for Component 1, prepare a POM providing comprehensive and detailed, but simplified, procurement procedures and processes. The POM will, among other things,: (i) define the roles and responsibilities of all officers who will be working in any aspect of the Project procurement implementation; (ii) outline the sequence and timeframe for the completion of

procurement decisions for all procurement staff as well as the coordination of inputs from key players in procurement implementation; (iii) establish service standards for payment processing to suppliers and service providers; and (iv) define assessment criteria for staff who have received the relevant procurement skills and the appropriate indicators for assessing skills transfer.

(d) Establish separate, effective tracking systems for (i) procurement plan implementation and (ii) payment processing to suppliers and service providers.

(e) KEMSA will procure all goods and commodities above the Bank's shopping threshold and all EMMS for county governments.

47. **The overall project risk for procurement is assessed as *substantial*** based on the findings of the procurement capacity assessment and taking cognizance of the limited experience, existing capacity, and insufficient office infrastructure of the agencies carrying out procurement under the Project.

Procurement Plan

48. **The MoH has prepared a procurement plan for project implementation for Components 2 and 3, which provides the basis for the procurement methods**. The plan was discussed and agreed between the MoH and the Bank task team on May 3, 2016 and thereafter posted on the Bank's external website.

(a) Before disbursement, county governments will prepare individual procurement plans for project implementation to be reviewed and agreed with the Bank task team and thereafter consolidated by the PMT together with that of the national government and posted on the Bank's external website.

(b) The procurement plans will be updated in agreement with the Bank task team annually or as required to reflect the actual project implementation needs and improvements in institutional capacity. The Banks's review of procurement decisions will be provided in the procurement plan.

Frequency of Procurement Supervision

49. In addition to the prior review to be carried out from Bank offices, annual implementation support missions will be conducted to: (a) monitor implementation progress and identify any emerging risks; (b) help the GoK mitigate risks; and (c) carry out post review of procurement actions undertaken.

Environmental and Social Safeguards

50. Safeguards policies triggered by the Project are summarized in table 3.2.

Table 3.2. Safeguard Policies Triggered by the Project

Safeguard Policies Triggered	YES	NO
Environmental Assessment (OP/BP 4.01)	X	
Natural Habitats (OP/BP 4.36)		X
Forests (OP OP/BP 4.09)		X
Pest Management (OP/BP 4.09)		X
Physical Cultural Resources (OP/BP 4.11)		X
Indigenous Peoples (OP/BP 4.10)	X	
Involuntary Resettlement (OP/BP 4.12)		X
Safety of Dams (OP/BP 4.37)		X
Projects on International Waterways (OP/BP 7.50)		X
Projects in Disputed Areas (OP/BP 7.60)		X

Environmental Safeguards

51. **The Project triggers OP 4.01: Environmental Assessment and is assigned environmental category B** based on the assumption that health care related waste will be generated from the Project activities. There are no significant and/or irreversible adverse environmental and social issues anticipated from the investments to be financed under the Project. The Project will not support civil works other than maintenance and minor renovation of existing health facilities.

52. **The main environmental safeguard policy relates to health care waste management, in view of the risks associated with the Project.** Providing PHC services under the Project such as FP, ANC, skilled delivery, and PNC; and enforcing quality of care standards for improved client experience, patient safety and effectiveness of care are likely to generate health care wastes, which present potential adverse impacts to the environment. The envisaged environmental risks at project implementation include health care waste which may be solid or liquid, including but not limited to infectious waste and other medical supplies that may have been in contact with blood and body fluids, highly infectious wastes (especially from the laboratories), and non-infectious waste from normal operations.

53. **The GoK has updated the HCWMP and disclosed it publicly**. The MoH has prepared a Health Care Waste Management Strategic Plan (2015–2020), which focuses on strategic and professional management of health care waste generated from the health care industry in Kenya. The GoK has also updated the HCWMP, which focuses on waste generation, segregation, storage, collection, transport, and final disposal practices; technologies for waste disposal; public awareness programs; and relevant national legislation. The HCWMP was publicly disclosed on April 13, 2016 on the MoH website (www.health.go.ke) and the Bank's InfoShop.

54. **The Project has been screened to identify and address any potential climate and disaster risks and is rated *moderate* to the overall PDO risk** with possibly 'slightly reduced impact' due mainly to the possibility of extreme temperature, extreme precipitation/flooding, and drought. As a mitigation measure, the Project will: (a) support implementation of the HCWMP; (b) support rehabilitation of facilities (for example, improvement of water availability); (c) improve service delivery at the health facilities and during outreach services; and (d) strengthen

activities that make the community units functional, which can be used to reeducate communities about evacuation procedures.

Social Safeguards

55. **The Project also triggers OP 4.10: Vulnerable and Marginalized Groups and the applicable laws and regulations of the GoK**. OP 4.10 is triggered because it is likely that groups, which meet the criteria of OP 4.10 "are present in, or have collective attachment to, the Project area." The Government has developed a VMGF. This framework will provide a mechanism for the inclusion and informed participation of VMGs[93] in the Project, in a culturally appropriate manner.

56. **A VMGF was prepared in consultation with VMGs and a national public consultation, attended by VMGs and other stakeholders, was held on March 21, 2016**. The comments from the national public consultation forum were incorporated into the VMGF. Prior to the national forum, VMGF consultations were held with sampled VMGs in Kiambu, Samburu, Baringo and Kwale counties. The VMGF outlines the processes and principles of: (a) screening to determine if the Project activities will be undertaken in the vicinity of vulnerable and marginalized communities; and (b) preparing a VMGP, including the social assessment process, consultation and stakeholder engagement, disclosure procedures, and communication. The VMGF also spells out: (a) an appropriate gender and intergenerationally inclusive framework; and (b) appropriate grievance handling procedures at the community, county and national levels. The VMGs and other stakeholders (for example, CSOs, local leaders) will be actively engaged in (a) free and prior informed consultation of VMGs; and (b) monitoring project implementation at the various levels through, participation in health management structures. The VMGF for the Project was disclosed on April 13, 2016 on the MoH website (www.health.go.ke) and the Bank's InfoShop.

57. **It is generally envisaged that the VMGs[94] have limited access to health care services compared to other dominant groups and communities in Kenya**. Some of the contributing factors highlighted during field consultations included: (a) geographical isolation of VMGs in remote villages that are not easily accessible; (b) inadequate capacity to meaningfully participate in health governance structures; and (c) socio-cultural issues in some VMG communities that hinder health service uptake such as failure to breastfeed neonates until naming is done, which

[93] See footnote in the main text.

[94] The CoK, 2010, Article 260 'marginalised community' means: (a) a community that, because of its relatively small population or for any other reason, has been unable to fully participate in the integrated social and economic life of Kenya as a whole; (b) a traditional community that, out of need or desire to preserve its unique culture and identity from assimilation, has remained outside the integrated social and economic life of Kenya as a whole; (c) an indigenous community that has retained and maintained a traditional lifestyle and livelihood based on a hunter or gatherer economy; or (d) pastoral persons and communities, whether they are (i) nomadic or (ii) a settled community that, because of its relative geographic isolation, has experienced only marginal participation in the integrated social and economic life of Kenya as a whole; 'marginal group' means a group of people who, because of laws or practices before, on, or after the effective date, were or are disadvantaged by discrimination on one or more of the grounds in Article 27 (4). The State shall not discriminate directly or indirectly against any person on any ground, including race, sex, pregnancy, marital status, health status, ethnic or social origin, color, age, disability, religion, conscience, belief, culture, dress, language or birth.

could take a week, and preference for women to deliver at home where local health facilities are run by male midwifery.

58. **A key focus of the VMGF will be to propose proactive steps for VMGs to participate and benefit from the Project** as most of the impacts anticipated will be positive for all communities including for VMGs and minimal, if any, negative social impacts are anticipated from the Project. Positive impacts anticipated include: (a) increased demand for and utilization of PHC services by improving knowledge, attitudes, and behaviors of communities towards the continuum of essential care services such as FP, ANC, skilled delivery, PNC, and adolescent reproductive health services; (b) improved access to PHC services by strengthening the county's capacity (for example, financing, workforce, products, information and governance) to deliver effective and efficient integrated interventions at the communities and facilities; and (c) improved quality of PHC services by ensuring constant availability of essential inputs (for example, human resources, equipment, commodities, water, and so on) and enforcing quality of care standards for improved client experience, patient safety, and effectiveness of care.

59. **The main social risks are that of exclusion of the VMGs.** Social risks envisioned in the implementation process include: (a) possibility of elite capture at the community and county levels thus excluding target groups; (b) political capture as the Project is being launched in the lead up to the national elections in 2017; and (c) leakages of inputs and resources in remote facilities with limited supervision. These risks will be mitigated through the following: (a) capacity development of key project implementers; and (b) awareness creation and building capacity of VMG's community health structures (for example, CHWs) on PHC at the community level, advocacy skills to understand and influence the PHC services, use of appropriate participatory approaches for improving health services uptake, and application of SAc tools at community and county health services levels for enhanced accountability and transparency.

60. **Implementation of environmental and social safeguards will be mainstreamed in existing structures** to ensure that all safeguards issues are addressed in their routine services. The Bank has supported a number of projects in the health sector and these projects have addressed the concern of health care wastes and the VMGs. There is therefore a good understanding among the MoH counterpart on environmental and social risks related to health care wastes. The PMT at the MoH will: (a) work with counties to update existing social assessment; (b) develop/update the existing VMGPs and guide implementation of VMGPs, when required; (c) build capacity of national and county staff; (d) help them monitor implementation of VMGPs and HCWMP; and (e) report any safeguards-related risks and mitigation measures undertaken as part of the quarterly progress report to the Bank.

61. **Most of CDoHs are understaffed and have limited capacity in the management of environment and social issues** since the health sector was recently devolved**.** Many counties have less than 10 staff working in the relevant departments and most of them lack technical skills to manage the department functions adequately. A focal person will be designated to lead, under the guidance of the County Director of Health, on ensuring that: (a) the HCWMP is implemented and monitored; and (b) VMGs have access to needed services and they are engaged in decision-making/accountability structures including HFMCs. Local NGOs will be engaged when need arises to monitor the implementation of VMGP and where there are any gaps, the PMT will prepare a corrective action plan or update the approved VMGP.

62. **In order to mitigate risks, the Project will (a) provide training for relevant staff and (b) disclose the Project information including** detailed activities planned in a culturally appropriate and accessible manner. Training of the MoH staff will focus on building their capacity to interpret, apply, implement, and monitor the safeguards instruments. The county focal person and other stakeholders, including VMGs, will also be trained on the required polices and use of the social and environmental screening tools, checklists, and GRMs. Also, a participatory targeting approach to identify and support the underserved, including VMGs, will be adopted to minimize the possibility of certain groups being excluded from the activities supported under the Project,

Monitoring and Evaluation

63. **The Project's M&E will be an integral part of the country's regular M&E for the health sector**. The majority of the Project indicators are a subset of the sector's performance indicators (see annex 1 for the Results Framework) and they are monitored regularly through the existing routine HIS such as DHIS2 by the CDoH in each county and by the MoH M&E Unit at the national level. The GoK also carries out household and facility surveys regularly, including the KDHS. KDHS 2014 and the next KDHS expected in 2019 will be used to validate selected DHIS2 indicators.

64. **The Project will also support the GoK's efforts to improve data quality by implementing cross-county verification.** The MoH has recently developed a protocol for DQAs to ensure that collected information is accurate and reliable.[95] This protocol will be used to improve the quality of data and to verify accuracy of reported data through DHIS2. At the end of each calendar year, the PMT will organize a cross-county verification exercise with support from the MoH M&E Unit to ensure that disbursements are linked to verified results. A verification team[96] from each county will: (a) first be trained on a DQA by the MoH M&E Unit; (b) carry out a DQA of another county focusing on the agreed indicators based on the MoH DQA protocol; and (c) report the validated results to the PMT. An external team may be recruited to manage cross-county verification process and quality of verified data. With support from the M&E Unit, the PMT will compile and report the final verified results to the Project sub-TWG for decision-making on resource allocation. Detailed procedures will be included in the POM.

65. **Implementation of the Project will entail prospective process evaluation and explicit learning strategy.** The POM will elaborate on a prospective implementation evaluation plan to document and share lessons learned during project implementation.

Role of Partners

66. **In line with the Paris Declaration, the DPHK have been facilitating the agenda of country ownership, alignment, harmonization, and mutual accountability** in the health sector in a more coordinated manner with enhanced focus on results. The existing institutional mechanisms for such coordinated support and the existing Code of Conduct need to be revisited in the light of key changes that have taken place in the Kenyan health system.

[95] GoK. 2014. *Kenya Health Sector Data Quality Assurance Protocol.* Nairobi, Kenya: MoH, AfyaInfo Project.
[96] A team will be comprised of a CHMT member, a clinical staff selected from the best performing health facility, an implementing partner and a representative from a CSO.

67. **A large number of DPs are supporting the delivery of quality PHC with focus on RMNCAH services.** The World Bank Group is supporting (a) the MoH to implement RBF in 21 ASAL counties with focus on improving the use of quality RMNCAH services in primary care facilities and (b) the NHIF to pilot a health insurance subsidy program for the poor which aims to provide comprehensive outpatient and inpatient care for the poor. The World Bank Group has been working closely with other H4+ partners[97] to improve the delivery of essential services. Supported by the Reproductive, Maternal, Newborn, and Child Health (RMNCH) Trust, the H4+ led by the UNFPA are supporting six high burden counties[98] to improve MCH outcomes. The H4+ are currently developing a joint program that targets 15 high burden counties to increase utilization of quality RMNCAH and HIV services. DFID support for RMNCAH interventions in six high burden counties[99] is implemented through the UNICEF. This is complemented by a national initiative to build midwifery skills implemented through the LSTM. The United States Government continues to be the largest financier in the sector with focus on HIV and strengthening of health systems through strong TA. In addition, partners are supporting GoK to strengthen health systems to move towards UHC. For example, the Japanese Government is providing approximately US$40 million for the implementation of key government priorities and first phase implementation of the UHC road map. The KfW and GiZ are supporting institutional reforms of the NHIF and are keen to support initiatives that help to create a more efficient health insurance market in Kenya. The current donor mapping with focus on UHC/RMNCAH is shown in table 3.3.

Table 3.3. DP Support

Partner	Project	Project Period	Amount (US$)	Objective
UNFPA	Country Program	2014–18	34,900,000	Strengthen capacity to deliver comprehensive integrated MNH/HIV prevention services; generate demand and provide FP services; coordinate and implement compliance on GBV, RH rights and harmful cultural practices
H4+ (RMNCH Trust)	RMNCH Program	2015–16	13,000,000	Improve access to BEmONC/CEmONC services; generate community demand for life saving RH services and advocacy against harmful practices; strengthen county health systems
H4+ (DANIDA)	Reducing Preventable Maternal, Newborn and Child Deaths	2017–20	5,791,570	Increase utilization of integrated quality RMNCAH and HIV services to contribute to the reduction of maternal and newborn mortality
UNICEF	HSS	2014–16	2,750,000	HSS
	Community Health Program	2014–16	2,900,000	Strengthen community health services and demand generation
	Nutrition Program	2014–16	28,600,000	Scale up nutrition services and commodities
UNICEF (DFID)	MNH Program	2013–18	115,000,000	Increase access to and utilization of quality MNH services
JICA	Health Sector Support	2015–17	30,000,000	Budget support to achieve UHC

[97] WHO, UNAIDS, UNFPA, UNICEF, UN Women and the World Bank work together as the H4+ in a joint effort to improve the health of women and children and accelerate progress towards achieving MDGs 4 (reducing child mortality) and 5 (improving maternal health).
[98] Isiolo, Lamu, Mandera, Marsabit, Migori, Wajir.
[99] Homa Bay, Turkana, Bungoma, Kakamega, Garissa and urban slums of Nairobi.

	Capacity Building Project	2014–19	5,357,979	Strengthen managerial support functions and coordination mechanisms at national level and management capacity of CHMTs
DANIDA	Country Program - HSS	2016–20	5,067,623	Strengthen health system at national and county levels by providing and improving equitable access to quality health services
KfW	MNH Programme	2012–16	27,000,000	Increase access to MH, FP, GBV services
GiZ	HSS	2014–16	7,342,619	HSS
USAID/PEPFAR	USAID KEMSA Medical Commodities Program	2015–20	650,000,000	Establish and maintain efficient: (a) forecasting, acquisition, warehousing, distribution for US Government supported commodities; (b) quality assurance for HIV commodities;
USAID	Maternal and Child Survival Program	2014–19	6,371, 972	Reduce maternal and child mortality w/focus on HIV, PMTCT services and malaria in pregnancy
	Health Commodities and Service Management	2011–16	24,995,901	Strengthen pharmaceutical systems
	AMPATH	2012–17	74,900,000	Support integrated HIV care and treatment services including TB
	APHIAPlus Western	2011–16	143,360,990	Support integrated FP, MCH, malaria, nutrition, TB, HIV prevention care and HSS
	APHIAPlus National	2012–17	50,000,000	Support to integrated FP, MCH, malaria, nutrition, TB, HIV prevention care and HSS
	Nutrition and Health Program Plus	2015–19	3,455,036	Increase access to nutrition services linking to MNCH and HIV treatment
DFID	MNH Programme	2015–18	7,134,500	Build capacity for service delivery and demand creation
	HIV Programme	2013–16	5,707,600	Build capacity for MCH, PMTCT, HIV service delivery
	STEP UP	2011–16	8,561,400	Provide quality FP
	Transform Nutrition Programme	2010–17	8,629,614	Improve nutritional status of the poor
	WASH	2014–18	10,844,440	Improve access to sanitation and hygiene
EU	Nutrition Programme	2014–18	20,516,142	Strengthen delivery of nutrition services for women and children

Note: DANIDA = Danish International Development Agency; MNH = Maternal and Newborn Health; MNCH = Maternal, Newborn, and Child Health; GBV = Gender-based Violence; RH = Reproductive Health; PEPFAR = (The United States) President's Emergency Plan for AIDS Relief; PMTCT = Prevention of Mother to Child Transmission; WASH = Water, Sanitation, and Hygiene.

68. **A mapping of DPs[100] shows variation in the number of programs supporting PHC with focus on RMNCAH services** (ranging from one to nine programs per county). Eighteen out of 47 counties have five or more programs supporting PHC with focus on RMNCAH services. Three-fourths of the counties prioritized for investment in the RMNCAH investment framework are supported by five or more programs.[101] Thus, there is significant RMNCAH program presence in high burden counties. The Project will leverage existing support in those high burden counties.

[100] The mapping is limited to the presence of key donors (DFID, USAID/PEPFAR, KfW/GIZ, H4+, DANIDA, EU, JICA) in each county and does not reflect the magnitude of donor support on-budget or off-budget.

[101] The RMNCAH investment framework prioritized 20 counties based on MCH outcomes and equity. The counties with five or more DP programs include: Bungoma, Garissa, Homa Bay, Isiolo, Kakamega, Kilifi, Kitui, Mandera, Marsabit, Migori, Nairobi, Samburu, Tana River, Turkana, Wajir.

Annex 4: Implementation Support Plan

Kenya: Transforming Health Systems for Universal Care Project (P152394)

Strategy and Approach for Implementation Support

1. **The Implementation Support Plan for the Project is based on the following considerations:** (a) the annual planning, budgeting, implementation, and monitoring of Component 1 follows the county PFM process; (b) all activities under Component 2 are implemented by the MoH, CRS, and KMTC as part of their work program; and (c) the PMT coordinates the county and national level activities.

2. **As the building blocks for devolution are still evolving, the relationship between the two levels of government and among counties is complex.** It is expected that the situation will continue to change during the project implementation period. Thus, strong technical and hands-on operational support will be needed to maximize the impact of resources provided by the Project (and other DPs). Implementation support will focus on the following areas.

Implementation Support Plan

3. **TA for evidence-based decision-making and implementation.** As the situation among counties varies widely and the counties are asked to prioritize high-impact interventions to address their circumstances to improve health outcomes, a one size fits all type of TA is unlikely to work. The Bank task team, in collaboration with DPs, will provide a series of 'just-in-time' TA to both levels of government. A TA facility may be set up if the proposed MDTF (financed by USAID and DFID) materializes. The TA facility will support the implementing entities using a 'learn-as-you-go' strategic management approach as devolution itself is a learning process and requires risk taking and innovation adapted to the local situation.

4. **Hands on operational support.** Because some members of the PMT and the county governments have not implemented a Bank-financed project directly, the Bank team will need to provide extensive hands on operational support, in addition to those provided during the bi-annual missions, especially in the first two years of implementation. While all implementing entities will benefit from the initial training (for example, operations clinic) and hands-on support, the task team will use a 'risk-based approach' to operational support given the large number of implementing entities. Also, cross-county and intergovernmental knowledge sharing and learning will be encouraged throughout all stages of implementation.

5. **Bi-annual review and midterm review.** While task team members based in the country office will provide day-to-day implementation support for all operational aspects, bi-annual missions will be organized to review the progress and mitigate any risks in advance. Bi-annual missions will be completed by TA missions as needed. A formal midterm review will be organized about 30 months into implementation to assess Project implementation progress and make any changes necessary to accelerate implementation.

6. **Fiduciary and safeguards.** Fiduciary and safeguards training will be provided as part of the operations clinic during the Project launch. Fiduciary and safeguards staff are all based in the

country office and thus will allow timely support to the PMT as well as the implementing entities. During the bi-annual implementation support mission, the fiduciary and safeguards team will join the field trip and provide hands-on support to the county counterparts.

7. **M&E.** As Component 1 uses county performance indicators to share allocation among counties, the PMT and the Project sub-TWG will require intensive support to manage M&E of the Project including cross-county verification of results reported through DHIS2. The task team will work closely with the PMT to plan and implement the required Project M&E.

8. The main inputs and focus with regard to support to implementation are summarized in table 4.1 and table 4.2.

Table 4.1. Implementation Support Plan

Time	Focus	Skills Needed	Resource Estimate	Partner Role
First 24 months	- HSS - Quality of care - PFM - Project management (including fiduciary and safeguards)	- Health Specialist specialized in HSS (in devolved settings) - Health Specialists with background and experience in quality of care, M&E (including CRVS), and PHC/RMNCAH - Health Economist (financing) - PFM Specialist - FM Specialist - Procurement Specialist - Social Safeguards Specialists - Environmental Safeguards Specialist - Operations Officer	320,000 (Bank budget: 150,000; TF: 170,000) per year	- USAID/DFID may contribute to the MDTF to set up a TA facility/ secretariat
24–60 months	- HSS - Quality of care - PFM Project management (including fiduciary and safeguards)	- Health Specialist specialized in HSS (in devolved settings) - Health Specialists with background and experience in quality of care, M&E (including CRVS), and PHC/RMNCAH - Health Economist (financing) - PFM Specialist - FM Specialist - Procurement Specialist - Social Safeguards Specialists - Environmental Safeguards Specialist - Operations Officer	270K (Bank budget: 150,000; TF: 120,000) per year	USAID/DFID may contribute to the MDTF to set up a TA facility/ secretariat

Table 4.2. Skills Mix Required

Skills Needed	Number of Staff Weeks*	Number of Trips	Location
Task team leader	20	6	Washington DC
Health Economist (co-task team leader)	25	8	Nairobi
Health Specialist (HSS)	15	4	Washington DC
Health Specialist (PHC including quality)	25	8	Nairobi
Operations Officer (Project management)	25	8	Nairobi
M&E Specialist (HIS, surveys, CRVS)	25	8	Nairobi
PFM Specialist	10	3	Nairobi
FM Specialist	15	4	Nairobi
Procurement Specialist	15	4	Nairobi
Social Safeguards Specialist	10	3	Nairobi
Environmental Safeguards Specialist	10	3	Nairobi

Note: * Number of staff weeks required per year in the first two years of implementation.

Annex 5: Detailed Economic and Financial Analysis

Kenya: Transforming Health Systems for Universal Care Project (P152394)

1. **Pregnancy-related morbidity and mortality are significant global health concerns.** The WHO estimates that 42 percent of women who give birth experience at least mild complications during pregnancy, and 15 million women annually develop long-term disabilities attributable to pregnancy-related complications. About 50 to 80 percent of pregnant women in developing countries develop acute health problems, and between 8 and 29 percent develop chronic health problems because of pregnancy.

2. **The maternal mortality ratio remains high at 362 per 100,000 live births.**[102] Neonatal mortality accounts for 40 percent of mortality in children aged less than 5 years of age. The contrast between and within regions is stark. Effective interventions to reduce maternal and neonatal deaths exist, but they are not always available to those who need them most (that is, the poor and vulnerable population).[103]

Project Development Impact

3. **Strong and resilient health systems are at the center of development**. Resilient health systems respond to the needs of citizens, transform and adopt skills and techniques to provide best quality services, and are resilient to internal and external shocks. Kenya embraced devolution in 2013, and service provision was largely devolved to 47 county governments. Systems and institutions to provide high quality health services under the devolved structure are weak but evolving. By supporting the institutional strengthening at the county and national level, the Project lays a foundation for improving utilization of health care services in Kenya, which is critical for development. In particular, the Project's support of the MoH to build capacity for implementing UHC reforms in Kenya will pave the way to improved access to health care services for the poor and enable Kenyans to realize their rights to health as enshrined in the 2010 Constitution. Moreover, the GoK has identified UHC as one of the pillars that will enable Kenyans to benefit from being a middle-income country and the realization of Vision 2030.

4. **The economic benefits of investing in PHC and strengthening health systems are well documented globally.** The Project will potentially contribute to Kenya's economic development by reducing maternal deaths, improving child survival, reducing chronic morbidity especially for mothers and children, lowering the incidence of non-communicable- diseases later in life, saved health care costs, and strengthening institutions to deliver quality health care services under devolution. The potential pathways of the Project's development impact are described in more detail below.

5. **The Project will contribute to reducing maternal mortality and morbidity** by increasing the number of women attending the recommended ANC visits, promoting the delivery of a child under the care of a skilled birth attendant, and increasing uptake of FP among others. Reduced maternal mortality and morbidity (for example, obstetric fistula) not only enhance the

[102] KNBS. 2015. *KDHS 2014.*

[103] Kes A et al. 2015. The economic burden of maternal mortality on households: evidence from three sub-counties in rural western Kenya. *Reproductive Health.* 12(Suppl 1): S3.

current and future productivity, but also improve the quality of life for women and their family (see below). A community-based approach to improve uptake of these high-impact interventions will be adopted in the majority of the counties, as these have been shown to be more cost-effective and to reach the poorest communities more.[104]

6. **The Project will contribute to improved child survival and development by supporting a range of cost-effective, high-impact interventions to address the major causes of childhood mortality and morbidity in Kenya**. These include increasing vaccination coverage, health education, access to safe drinking water and improved sanitation. Also, investing in improving maternal, neonatal and child health together can have great returns as mothers are intricately involved in the lives of their children through adolescence to adulthood.[105,106] For example, a recent study showed a high link between maternal deaths and neonatal mortality in Kenya.[107] Of the 59 maternal deaths reported in a longitudinal study conducted between 2011 and 2013, only 15 babies survived the first 60 days of life: 25 percent of the babies born to a mother who died of maternal causes did not survive the first seven days of life compared to only 1 percent of babies whose mothers were still living. Poor health due to undernutrition of children whose mothers are dead or suffer from chronic morbidity contributes to stunting, poor cognitive development, and poor performance at school and for women, lower birth weight for their children.[108,109]

7. **The Project will contribute to saving health care costs related to maternal and child morbidity**. Many RMNCAH conditions cause not only death but disability too. For every death, there are a number of women and children with the same condition who survived, many with long-term disability requiring constant medical care. Maternal mortality costs Kenyan households about a third of their annual consumption expenditures, in addition to other costs related to lost income and withdrawing children from school.[110] The average total cost of seeking care for households that reported a maternal death amounted to KES 15,449 annually.

8. **The Project will contribute towards long-term economic benefit in the form of high GDP arising from increased labor force participation and productivity**. Healthier communities give rise to increasing investment in human and physical capital, generating higher rates of economic growth. Potential pathways through which the Project will contribute towards Kenya's economic development include:

[104] Adam T et al. 2005. Achieving the millennium development goals for health: Cost effective analysis of strategies for maternal and neonatal health in developing countries. *British Medical Journal.* 331: 1107–10.
[105] Moucheraud C et al. 2015. Consequences of maternal mortality on infant and child survival: a 25 year longitudinal analysis in Butajia Ethiopia (1987–2011). *Reproductive Health*. 12 (Supp 1): S1.
[106] Family Care International Kenya et al. 2014. *A Price too High to Bear. The Costs of Maternal Mortality to Families and Communities: Summary of Research Findings.* Nairobi: FCI Kenya.
[107] Ibid.
[108] Shonkoff, J et al. 2012. An integrated scientific framework for child survival and early childhood development. *Pediatrics.* 29(2).
[109] Victoria C et al. 2008. Maternal and child undernutrition: consequences for adult health and human capital. *The Lancet.* 371: 340–357.
[110] Ibid.

(a) By reducing the number of maternal deaths and maternal-health-related morbidities, women will continue to participate in the labor force, support their children through the critical development stages and contribute to other non-income generating activities that contribute to economic growth. It is estimated that one maternal death would reduce GDP by US$0.42 per capita per year (in 2015 prices)[111] in the African region and that indirect costs of maternal deaths in Sub-Saharan Africa amounted to US$4.5 billion in 2010.[112] The cost of maternal deaths to the Kenyan economy can be substantial as close to 5,500 women die each year.

(b) By addressing the causes of childhood mortality, more children will survive into adulthood, will be healthier, have higher cognitive development, complete education and actively participate in the labor force.

(c) By addressing the unmet needs for FP, Kenya can lower TFR, leading to lower health care and education costs, resulting in accelerated economic growth. It is estimated that Kenya could cumulatively save US$114.7 million per year if the unmet need for FP were addressed.[113]

9. **The Project will promote equity and shared prosperity by allocating resources based on an equitable formula**, which gives more weight to counties with the highest need and with better results. By increasing resources available for community based interventions and PHC services, the Project has high potential to reach the poorest and most needy population, who hardly use hospital level services due to affordability and other access barriers. By focusing on PHC and community-based interventions, the Project will also contribute to improvement in allocative efficiency.

CBA of a Combination of Interventions

10. **The CBA is a technique that relates the costs of a program to its key outcomes or benefits.** It compares the costs with the dollar value of all (or most) of a program's benefits. A major limitation with the CBA analytical approach is that it is difficult to value all benefits in monetary terms. Indirect benefits arise from mothers' contribution towards their families through social relations, nurturing infants and other children, up-bringing and socialization of children, education and health and contribution to wider communities. In Kenya, families that experienced a maternal death reported that the women who died had contributed an average of 61 hours of household work each week, including childcare, cooking, laundry, and fetching water and firewood.[114] Such benefits play a critical role in economic development, but they are difficult to measure quantitatively.

[111] Kirigia J et al. 2006. Effects of maternal mortality on gross domestic product in WHO African region. *African Journal of Health Services.* 13: 86–95.
[112] Kirigia J et al. 2014. Indirect costs of maternal deaths in the WHO African Region in 2010. *BMC Pregnancy and Childbirth.* 14(299).
[113] Moreland S and S Talbird. 2006. *Achieving the Millennium Development Goals. The Contribution of Fulfilling the Unmet Need for Family Planning.* Futures Group/POLICY Project.
[114] Ogwang et al. 2015. The economic burden of maternal mortality on households: evidence from three sub-counties in rural western Kenya. Reproductive Health; 12(Supp 1): S3.

11. **The CBA of the Project was based on a combination of interventions.** Due to its complex design, and lack of clarity on what combination of interventions will be implemented at the county level, it was not possible to conduct a CBA of specific interventions. Rather, the CBA presented here adopts the approach of economic evaluation of complex interventions. Together the combined set of interventions will contribute towards the reduction in morbidity and mortality in the population group of interest. Moreover, it has been shown that packages of RMNCAH interventions are more cost-effective than individual interventions, largely due to synergies on costs.

12. **The assumptions informing the analysis are summarized in table 5.1**. Given the complex nature of the Project, the CBA focuses only on interventions to address maternal and child mortality and uses a five-year time frame, consistent with the Project implementation period.

Table 5.1. Assumptions Guiding the CBA

Median age of children cohort saved	3
Median age of mothers saved	22
Age of onset of productivity	25
Number of productive years	35
Annual per capita productivity (GDP per capita in US$)	1,358
Annual rate of increase in productivity	5%
Discount rate (costs and benefits)	3%
Sensitivity analysis (discount rate)	5%

13. **The results presented in table 5.2 show that the Project is a sound economic investment**. The present value of the Project's benefits is US$954.2 million, while present value of the cost invested is US$174.9 million, assuming a 100 percent disbursement rate. This investment gives rise to a net present benefit (that is, benefits-costs) of US$779.2 million and a benefit-cost ratio of 5.46 (that is, 954.2/174.9). This means that for every dollar invested through this Project, a return of US$5.46 will be achieved. Sensitivity analysis suggests that the Project would be economically viable even if it only achieved half of the benefits estimated.

Table 5.2. 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 years saved	32,209	33,089	34,171	35,104	36,252	170,824
Present value of productive years gained (US$, Millions)	175.5	180.3	186.2	191.3	197.6	930.9
Maternal health benefits						
Maternal deaths averted	58	60	62	63	65	308
Number of productive life years saved	2,031	2,084	2,155	2,219	2,277	10,766
Present value of productive years gained (US$, Millions)	4.38	4.49	4.65	4.79	4.91	23.22
Total health benefits (US$, Millions)	179.9	184.8	190.9	196.1	202.5	954.2

14. **This analysis only focused on economic benefits related to saving lives**. There are many other benefits arising from saved lives and reduced morbidity. For example, if we introduced a social value of a life saved equal to 50 percent of annual GDP per capita the benefit-cost ratio of the Project's investment would be 8.18. As decisions on the allocation of resources are not based solely on considerations of CBA, it should be considered alongside other health system goals and feasibility of implementing these interventions.

Rationale for Public Sector Financing

15. **The use of public resources to address the objectives outlined in this Project is justified for the following reasons:**

(a) The Kenyan Constitution (2010) gives all Kenyans the right to the highest attainable standards of health, including reproductive health and emergency treatment. The GoK is committed to enabling Kenyans to realize this right to health, as demonstrated by its policies to remove user fees in all public PHC services and the provision of free maternity services in the public sector. Investing in RMNCAH is not only of sound economic value (as demonstrated by the CBA) but also a moral issue that cannot be left to the private sector.

(b) Although the private sector owns about half of all health facilities in Kenya, recent data suggest that the public sector remains the main health care provider, accounting for more than two-thirds of all service utilization.[115]

(c) Interventions proposed under this Project such as immunization and prevention of communicable diseases have positive externalities. In addition, there are wide inequities in access to RMNCAH and other services in Kenya, which are best addressed using public sector resources. Also, the Project has a heavy community based focus, which is known to be more cost-effective and to reach the poorest and needy population.

Financial Analysis

16. **Despite increase in government expenditure, Kenya has very limited fiscal space.** Kenya spent about 6.8 percent of its GDP on health in FY2012/13, equivalent to US$66.6 per capita. The proportion of total government allocation to health increased from 4.6 percent in FY2009/10 to 6.1 percent in FY2012/13. The government funding as a share of THE has increased from 27.1 percent in FY2009/10 to 31.2 percent in FY2012/13. The share of THE funded by households through out-of-pocket payment, however, increased from 29.6 percent in 2009/10 to 32.0 percent in FY2012/13 as donor funding is on the decline. Donor funding still remains high at 25.5 percent of THE. Recent studies suggest that Kenya has very limited fiscal space;

[115] MoH. 2014. *KHHEUS 2013.* Nairobi:GoK.

administration costs and salaries account for over 50 percent of total county budgets, leaving very little resources for development.[116, 117]

17. **The total government budget for health has increased in the last two years**. In FY2013/14, both county and national governments allocated US$910.6 million on health. This amount increased by 40.8 percent in FY2014/15 to US$1,281.3 million. There was no significant difference in allocation between the recurrent and development budgets in both years for national and county governments. For county governments, recurrent expenditure accounted for 75 percent of total county budgets in both financial years: personnel emoluments accounted for 69 percent of the recurrent budget, while medicines and other supplies accounted for about ten percent. At the national level, recurrent expenditure accounted for 56 percent of budget allocation in FY2013/14 and 55 percent in FY2014/15 (table 5.3).

Table 5.3. National and County Level Budget Allocation to the Health Sector (US$, Millions)

	FY2013/14			FY2014/15		
	Recurrent	Development	Total	Recurrent	Development	Total
National level	236.3	184.8	421.2	303.1	248.1	551.2
County level	367.5	121.9	489.4	547.6	182.5	730.1

18. **The Project is financially sustainable because the investment accounts for less than 4 percent of the total health budget per year**. However, the share of project funds as a percentage of non-staff recurrent budget at the county level is relatively high at almost 20 percent, assuming no changes in national and county budget allocation. This estimate is expected to become smaller as budget allocations continue to increase over the five-year period, as demonstrated by the increased allocation between FY2013/14 to FY2014/15.

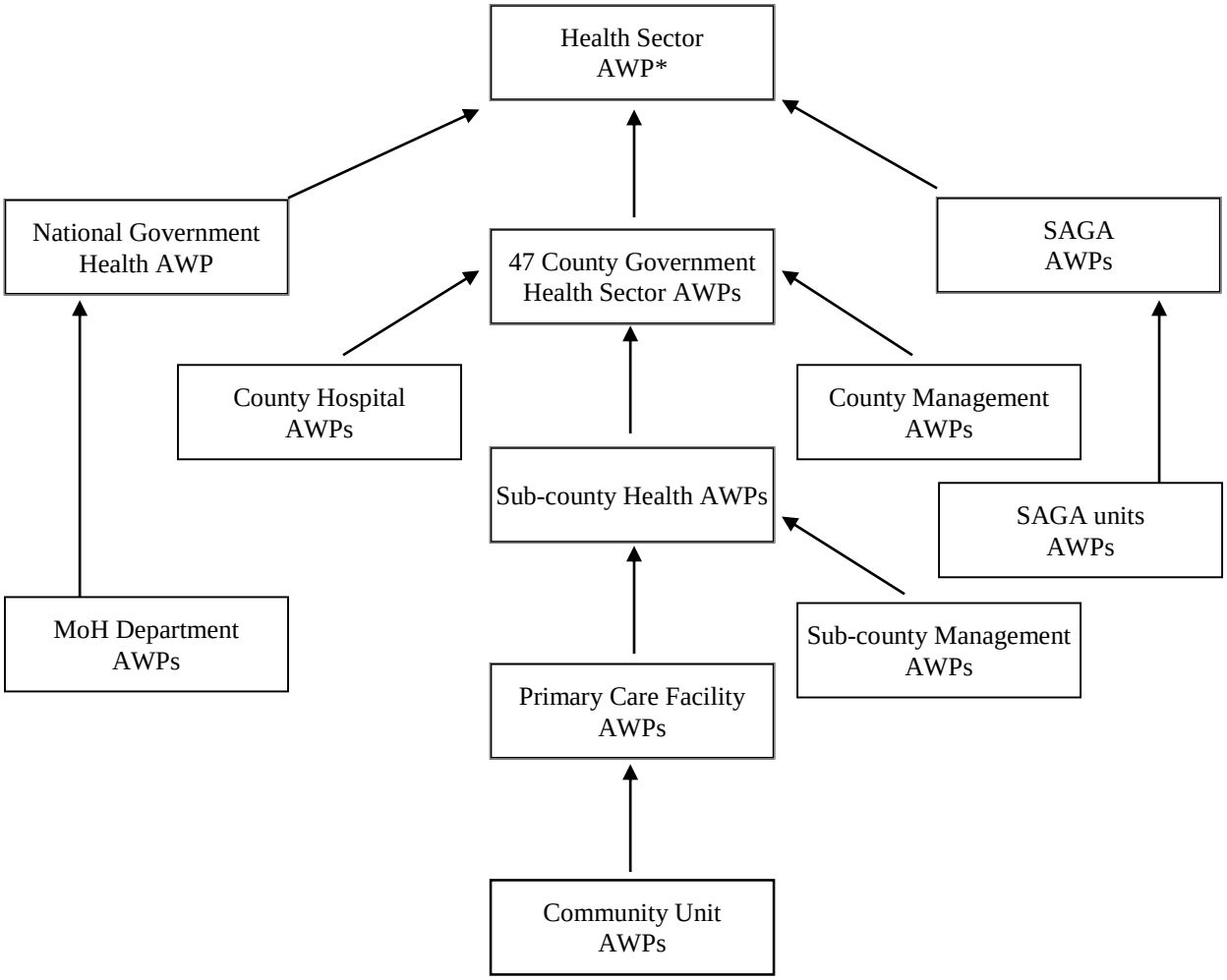
[116] Wanjala B. 2013. *Analysis of Fiscal Space and Policy Options for Targeted Intergovernmental Transfers, with Specific Focus on the Health Sector.* Washington, DC: World Bank Group.
[117] World Bank. 2014. *Decision Time: Spend More or Spend Smart. Public Expenditure Review*. Washington, DC: World Bank Group.

Annex 6: Annual Work Plan Development Process

Kenya: Transforming Health Systems for Universal Care Project (P152394)

1. **Kenya has been implementing a health sector planning framework to align policies, operational plans, and budgets**. In the past six years this health sector planning and monitoring process has integrated the development and implementation of AWP at all levels of the health structure. This process has been evolving to align with the KHP 2014–2030 and the KHSSIP 2014–2018, changes from restructurings of MoH and more recently the process of devolution. With devolution, counties are mandated to develop county specific County Integrated Development Plans and multi-year health sector strategic and investment plans linked to the KHP and KHSSIP and to develop AWPs that reflect county health priorities, budget and expenditure frameworks.

Figure 6.1. AWP Planning Linkages across Health Sector Tiers and Planning Units



Source: MoH. 2015. Draft AWP Guidelines.
Note: * Currently there is no collated health sector AWP; SAGA= Semi-Autonomous Government Agencies.

2. **The process of developing the AWP incorporates both a top down and bottom up approach to reflect (a) national priorities and (b) county priorities and needs including community inputs and ownership.** The MoH is responsible for setting national service delivery targets informed by the medium-term sector service achievement targets and the overall national health budget envelope including medium-term expenditure framework guidelines developed by the NT. Counties are responsible for prioritizing investments to address their specific health priorities and targets. County contributions to achieving national delivery targets and performance indicators are negotiated with counties based on their priorities and available county budget resources including off-budget resources and are informed by their demographic/epidemiological profiles and service delivery gaps.

3. **The MoH has developed planning templates for each tier of the health sector** (figure 6.1). The current county AWP template has two sections: (a) the annual performance section includes (i) a description of population and disease burden, (ii) prior year performance, trends and achievements, (iii) key milestones and challenges, (iv) health expenditure review, and (v) best practices; and (b) the annual plan section includes (i) key priorities (including baselines and targets) and interventions for the coming year, (ii) an annual budget, and (iii) a description of the process of developing the plan including CE. The plans are collated and consolidated at primary care facility, sub-county, county and national levels. Target setting and prioritization is both a top down and bottom up approach. Currently, there is no collated overall health sector AWP.

4. **The quality of county AWPs varies, as tools and technical support in the process of developing AWPs are uncoordinated.** Counties receive technical support from MoH and some counties have received additional technical support from United Nations partners, other DPs, and technical agencies. For example, USAID is supporting program based budgeting training in collaboration with the KSG, JICA is supporting strategy development, and UNICEF is supporting bottleneck analysis and introducing the use of Equitable Impact Sensitive Tool (EQUIST). UNFPA and GiZ are also providing technical support to their focal counties during the AWP process. As a result, the level of analysis and quality of the AWPs differ greatly between counties with many incomplete sections. Also, currently there is no system in place for appraisal and quality assurance. Reviews of several health sector AWPs reveal the following challenges:

(a) Technical capacity gaps in bottleneck analysis, planning, and budgeting have affected the prioritization process.

(b) Equity aspects are not adequately incorporated: interventions selected do not ensure equitable access and utilization of essential health services by underserved population groups and areas.

(c) Cost effectiveness and cost efficiency are not comprehensively utilized in determining priority interventions.

(d) Limited availability of information and data on resources especially off-budget resources makes it difficult to link the macro/micro-economic framework with county priorities and evidence-based planning within the epidemiological county specific profile.

(e) Planning guidelines, tools, and training materials have not been standardized. For example, a program-based budgeting approach is not yet reflected in the guidelines for AWPs.

(f) There is no quality assurance system to appraise the AWPs.

(g) Political interests may influence and skew priorities and resource allocations in the AWPs.

5. **To address the challenges above, the MoH will**:

(a) prepare and disseminate revised planning guidelines and templates for the counties;

(b) standardize and harmonize planning tools, curricula, and training materials;

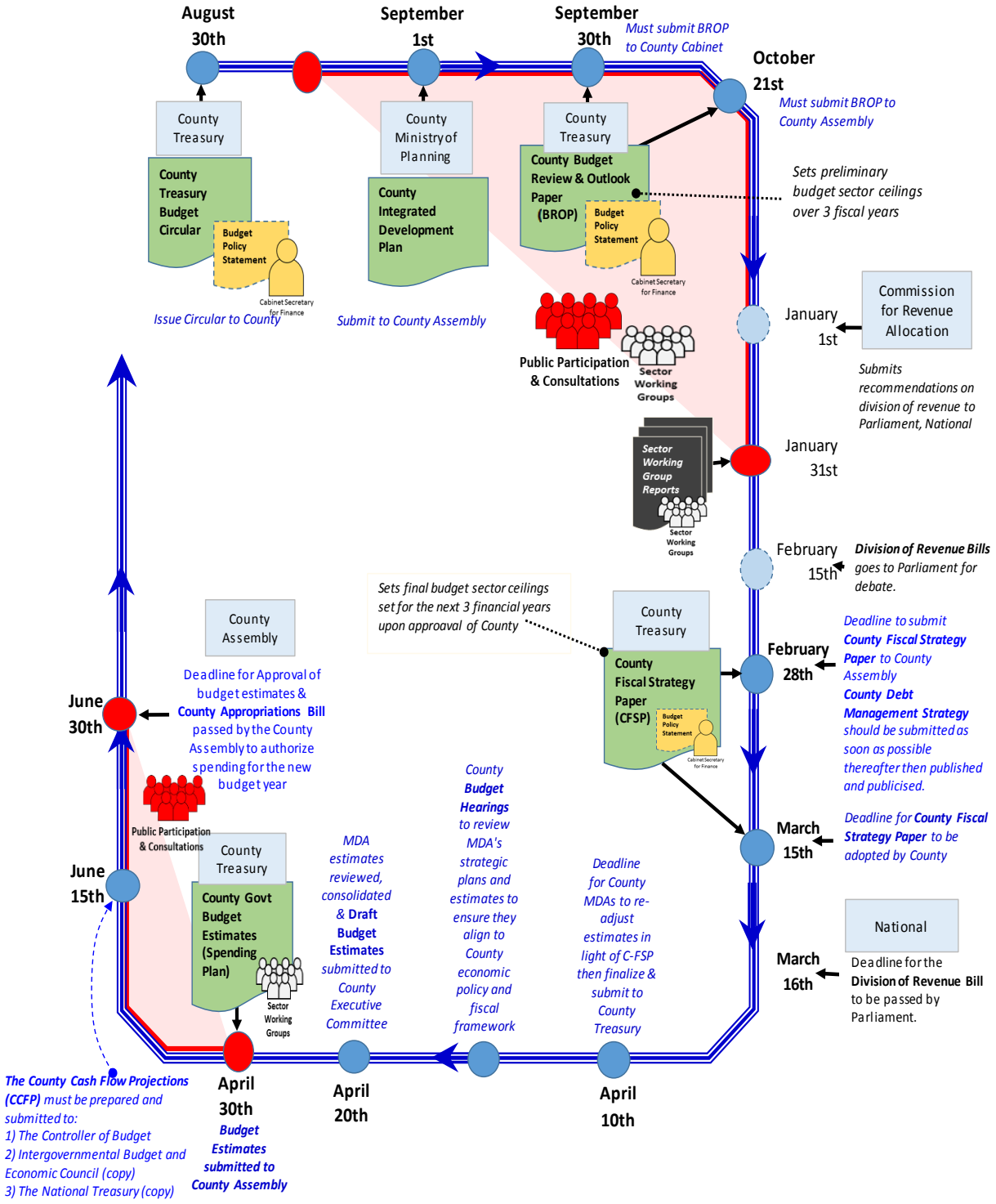
(c) develop a quality assurance/appraisal system of AWPs;

(d) build capacity in planning and budgeting for the counties with support from the KSG and other DPs; and

(e) coordinate DPs providing technical support in planning and budgeting to avoid duplication of support and ensure that all counties are covered.

6. The Project will support capacity building of counties in planning and budgeting to develop evidence-based AWPs in close coordination with the MoH as well as DPs (figure 6.2).

Figure 6.2. County Budget Process



Source: KSG. 2015. *Program Based Budgeting Manual for Health Sector.*

Annex 7: Integration of Citizen Engagement

Kenya: Transforming Health Systems for Universal Care Project (P152394)

1. **This annex highlights the proposed strategies to help develop a comprehensive CE strategy for the Project.** The Bank Group defines CE as the two-way interaction between citizens and governments or the private sector within the scope of the Bank Group interventions—policy dialogue, programs, projects, and advisory services and analytics—that gives citizens a stake in decision-making with the objective of improving the intermediate and final development outcomes of the intervention. The implicit theory of change in promoting CE in the health system service is that communities with a stake in the functioning of health facilities are more likely to use them and support them and take greater care of their own health needs. CE mechanisms are designed to make communities more aware of the services provided, more involved in the management of the facilities, better able to communicate with service providers and, in turn, feel more responsible for the successful functioning of the facilities.[118]

The Local Context for CE

2. **CE underlines both the right and the corresponding responsibility of citizens to expect and ensure that the Government acts in the best interests of the people**. Article 43 of the Kenya Constitution stipulates that every person has the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care. Integrating CE in health service delivery is an attempt to establish systems to ensure that citizens have greater voice; that the health system is downwardly accountable to them; and that it responds to their needs.

3. From a county perspective, the **County Governments Act, 2012 stipulates that governments should facilitate the establishment of structures for citizen participation (engagement)** in the conduct of the activities of the county assembly as required under Article 196 of the Constitution.[119] This includes promoting and facilitating citizen participation in the development of policies and plans, and delivery of services in the county through strategies such as the evaluation of the performance of the county government and public sharing of performance progress reports. In this regard, CE fits perfectly within the mandate of the Act; mainstreaming CE in the delivery of health care services will contribute to a county's goal to enhance citizen participation.

4. **Currently, health care providers are contending with increasingly enlightened populations demanding answers on the quality of and access to health care services they are entitled to receive.** The traditional approach to service delivery has been supply-side driven with little or no input from the demand-side. Moreover, there has been minimal collaboration with stakeholders to engage citizens in addressing the challenges that the health sector faces.

[118] Garg S and A Laskar. 2010. Community-Based Monitoring: Key to Success of National Health Programs. *Indian Journal of Community Medicine.* 35(2):214–216.
[119] Republic of Kenya. 2012. *The County Governments Act, 2012*. Edited by the Republic of Kenya. Nairobi: National Council for Law Reporting.

How CE will Contribute to the PDO

5. **CE will contribute to achievement of the PDO through**: (a) improved demand for health services as a result of enhanced community participation in decision-making and management processes; (b) improved governance as a result of strengthened health facility governance structures; (c) empowered communities as a result of functional community units and increased community participation in health service delivery; and (d) improved quality of health services as a result of feedback systems and GRM.

6. **It is proposed that practical CE activities are undertaken at both county and health facility levels** based on the MoH's *Implementers' Manual for Social Accountability in the Health Sector: for County Health Managers and Other Health Stakeholders*, published in 2014. This coupled with the CHS are, ideally, the blueprint for CE activities in the health sector. For the county level, the county governments and CHMTs are critical in leading the process.

Proposed CE Activities

7. **Activities will be centered on the three components of CE**.

(a) **Information sharing.** The extent to which health and operational information is made publicly and interactively available. Through CHS structure, the Project will seek to enhance information sharing for transparency on health care delivery and management.

(b) **Community participation.** The establishment of new community units and improved functionality of existing ones as well as establishing CBM mechanisms while also strengthening existing mechanisms such as inclusion of community representatives on the boards and management committees of health facilities.

(c) **GRM.** The extent to which feedback and GRM are available at the community level and whether/how the feedback loop is closed. The health system does not have an established and systematized GRM. The Project will seek to establish a mechanism where health service users can submit feedback and grievances on health services including malpractice and corruption issues building on existing CHS structures such as CHWs.

8. **The proposed CE activities are expected to be undertaken by two key actors**: (a) CHMTs who should ideally appoint a focal person for CE from within the team to guide the process; and (b) health facilities at all levels of care – who are expected to have their CHEWs as the CE focal persons at facility level. The proposed activities are listed in table 7.1.

Table 7.1. Proposed CE Activities at CHMT and Facility Levels

Responsibility	Activities
CHMT	*Management* ▪ Conduct training of trainers for all county-level CE focal persons and stakeholders. The overall goal of the training will be to enhance the capacity of CHMTs and stakeholders on integration of CE approaches. ▪ Appoint CE focal persons within the CHMT who will provide leadership in the integration of CE in service delivery ▪ Build capacity of health care providers through forums such as Continuous Medical Education and sensitize communities on CE through forums such as dialogue days ▪ Include the CE agenda in all forums where stakeholders are being engaged particularly during program formulation ▪ Ensure exit interviews are conducted in all health facilities annually with the involvement of community representatives such as CHC members and/or CHWs ▪ Carry out supervision of the integration of CE at all levels of health care provision in the county and ensure the integration is reflected in the performance contracting and appraisal for health workers; both incentives and sanctions should be established to support the process *Information Sharing* ▪ Publicize through media (television, radio, newspapers): (a) funds disbursements per facility in the county, including performance-based funding, partner funding, and user fees subsidies; (b) at least two major successful community activities such as dialogue or action days where community members have participated and benefited in one way or another, (c) patients' rights and responsibilities in health services;[120] and (d) health-related community events *Community Participation* ▪ Support the establishment of functional community units ▪ Pilot CBM primarily using community scorecards as a tool of monitoring health facility performance. CBM involves drawing in, activating, motivating, capacity building and allowing the community and its representatives, for example, community representatives such as Board/HFMC members, CHC members and CHWs or community based organizations (CBOs), to directly give feedback about the functioning of public health services. The community monitoring process involves a partnership between health care providers and managers (health system); the community and CBOs/NGOs. The emphasis of CBM should be laid on the developmental spirit of 'fact-finding' and 'learning lessons for improvement' rather than 'fault finding'. *GRM* ▪ Set up a phone number through which citizens can call or send short messages to highlight their complaints ▪ Support the establishment of effective GRMs in all levels of health care delivery wherein the following measures are put in place, (a) multiple complaint uptake locations channels, (b) fixed procedures for complaint resolution are documented illustrating prompt and clear processing guidelines (including reviewing procedures and monitoring systems), and (c) an effective and timely complaint response system to inform complainants of the action taken

[120] MoH. 2013. *The Kenya National Patients' Rights Charter, 2013*. Nairobi: MoH.

Responsibility	Activities
Health Facilities (Led by the In-Charge)	*Information Sharing* ▪ Prominently and publicly display the Service Charter in Kiswahili and/or relevant vernacular language; the Charter should include all user fee charges ▪ Display information, quarterly, on funds received and expenditure on the facility's board ▪ Display information on working hours, services provided, and outreach activities on the facility's board ▪ Display names and phone contact information of Board/HFMC members ▪ Display information on last date supplies received from drugs supply agencies such as KEMSA. *Community Participation* ▪ Through the facility's HEW, support the management of community units such that they are functional ▪ Regularly conduct dialogue and action days to share information with the community ▪ Include in the facility AWP priorities identified, during these dialogue and action days and/or any other forums ▪ Plan outreach activities based on community feedback regarding preferred locations and services provided ▪ Ensure the Board/HFMC meets at least quarterly ▪ Submit minutes of Board/HFMC meetings to the sub-CHMT *GRM* ▪ Make a complaint box available. The box should be placed strategically, locked, and include pen and paper ▪ Display the phone number for channeling complaints in the service charter and sensitize community members on its existence ▪ Identify trusted community members, outside of Board/HFMC members, and assign them to receive grievances that community members are not comfortable writing or calling about; post their names and contacts on the board ▪ Log all complaints and corresponding action taken in a complaint register

9. **The proposed CE activities will be monitored by two indicators**: (a) number of functional community units; and (b) percentage of grievances registered related to delivery of project benefits that are addressed (annex 1).

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