PROJECT INFORMATION DOCUMENT (PID)
APPRAISAL STAGE

Report No.: PIDA61910

Project Name	Transforming Health Systems for Universal Care (P152394)
Region	AFRICA
Country	Kenya
Sector(s)	Health (100%)
Theme(s)	Child health (30%), Health system performance (30%), Population and reproductive health (30%), Nutrition and food security (10%)
Lending Instrument	Investment Project Financing
Project ID	P152394
Borrower(s)	National Treasury
Implementing Agency	Ministry of Health
Environmental Category	B-Partial Assessment
Date PID Prepared/Updated	01-Apr-2016
Date PID Approved/Disclosed	07-Apr-2016
Estimated Date of Appraisal Completion	15-Apr-2016
Estimated Date of Board Approval	15-Jun-2016
Appraisal Review Decision (from Decision Note)	The chair authorized the team to appraise and negotiate the project. The appraisal will be completed pending disclosure of the safeguards instrument.

I. Project Context

Country Context

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 5th 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 six 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 seven percent in the next two years.

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, while more recent projections suggest a slightly lower poverty headcount in the range of 34 and 42 percent in 2011. 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 notably, but the country's Gini index of 48.5 in 2005 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).

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 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 healthcare. The building blocks for devolution are still evolving, including county governmental structures, mechanisms for intergovernmental cooperation and coordination and mechanisms to transfer resources to deliver on policy priorities.

The Government of Kenya (GOK)'s Second Medium Term Plan (MTP 2013-2017) 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 services, access to clean water, and education are priority areas for the government. The MTP also emphasizes full implementation of the devolution as required in the Constitution, and prioritizes developing the capacity of county governments and improving coordination between the two levels of government.

Sectoral and institutional Context

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 insecticide treated nets. However, neonatal mortality had a much slower rate of decline in the last decade, with more than 42 percent of deaths under five years of age occurring in the first month of life. Despite improvements in the nutrition status since 2003, more than one in four children under five are still stunted. The total fertility rate (TFR) reduced to 3.9 births per woman after a decade of stagnation, but the maternal mortality ratio remains unacceptably high at 362 per 100,000 live births in 2014. Many women still do not have access to quality essential services. Also, teenage pregnancy remains high with 18 percent of girls between 15 and 19 years old having begun childbearing. 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 and TFR ranges from 6.4 among women in the lowest wealth quintile to 2.8 among those in the highest wealth quintile.

Utilization of essential health services has improved on average, but wide disparities persist. Utilization of outpatient services has 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. However, nearly 40 percent of births are not attended by skilled health workers. Utilization of essential services among socio-economic groups and geographic areas still varies considerably and significant inequity remains. For example, skilled birth attendance is 22 percent in Wajir County compared to 93 percent in Kiambu County;

and 31 percent in the poorest wealth quintile compared to 93 percent in the richest wealth quintile.

Demand- and supply-side barriers have hampered utilization and coverage of essential services. On the demand side, sociocultural 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 counties and poor health provider attitudes impede the demand for essential services including RMNCAH services. For example, total demand for family planning is only 33 percent in North Eastern region, compared to 83 percent in Eastern region. This difference illustrates the need to address issues that impede demand in North Eastern region before intensifying supply-side interventions. On the supply side, key health system barriers include: (i) weak stewardship and evolving governance structures; (ii) inadequate health information and civil registration and vital statics systems; (iii) inadequate management of human resources for health; (iv) insufficient essential medicines and medical supplies; (v) inadequate and inequitable health care financing; and (iv) poor quality of care.

The share of health expenditure out of total government expenditure has remained low (6.1 percent) and about a third of health expenditure comes from out-of-pocket payment. Although per capita health expenditure has 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 eight to six percent during the same period. While government expenditure, as a share of total health expenditure, 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 because of a significant decrease in contributions by development partners (DPs), from 32 percent to 26 percent. A significant part of external financing still remains off-budget, uncoordinated, and unpredictable, and primarily targets a few diseases such as HIV/AIDS, tuberculosis, and malaria. Several health financing initiatives have been introduced but 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 arrangements.

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 enjoy 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.

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 is still wide variation among counties and more than half of the county health budget was allocated to personnel emoluments.

Roles and responsibilities need to be further clarified and capacity needs to be strengthened to implement the new mandates. Roles and responsibilities for national and county levels are outlined in the Constitution, and subsequently in the Health Policy 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 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, devices and plant, human resources for health management and development, monitoring and evaluation (M&E), and so on) leaving room for interpretation. 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 institutional and implementation arrangements including intergovernmental structures are still evolving. For instance, the Constitution envisaged conditional grants to counties from the national level to support priority national initiatives. However, an appropriate framework to transfer funds to the counties that are acceptable to both levels of government has not been established and the lack of an agreed framework has affected the flow of additional funds to counties for improving delivery of devolved services. Currently, the National Treasury is developing a framework for conditional grants to transfer funds to county governments in devolved sectors.

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 reproductive, maternal, newborn, child and adolescent health (RMNCAH) services, especially in underserved areas. 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 the partnership coordination of the health sector among all stakeholders.

II. Proposed Development Objectives

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.

III. Project Description

Component Name

Improving PHC Results

Comments (optional)

Component 1 aims to improve the delivery, utilization and quality of PHC services at the county level with a focus on RMNCAH. This component will focus on: (i) making existing facilities functional to deliver quality essential PHC services; and (ii) increasing demand for services at the community and facility levels.

Component Name

Strengthening Institutional Capacity

Comments (optional)

Component 2 aims to strengthen institutional capacity to better deliver quality PHC services under Component 1. This component will focus on four key areas:
2.1. Improving Quality of Care
2.2. Strengthening Monitoring and Evaluation (M&E) and Civil Registration and Vital Statistics
2.3. Building Capacity to Deliver Quality RMNCAH Services
2.4. Supporting Health Financing Reforms towards UHC

Component Name

Project Management

Comments (optional)

Component 3 aims to facilitate and coordinate project implementation and enhance cross-county and intergovernmental collaboration. This will include two areas:
3.1. Project Management (including M&E and fiduciary activities)
3.2. Cross-county and Inter-governmental Collaboration

IV. Financing *(in USD Million)*

Total Project Cost:	191.10	Total Bank Financing:	150.00
Financing Gap:	0.00		

For Loans/Credits/Others	**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

V. Implementation

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, Kenya Medical Training College and Civil Registration Department will be jointly responsible for the implementation of national and county level activities under Component 2 (for example, technical assistance). County governments will be responsible for implementation of activities in their counties under Component 1. Project implementation plans will be integrated into the AWP of all implementing entities.

Project management will the responsibility of the Project Management Team (PMT) for the ongoing health project. The PMT will be responsible for overseeing the timely and effective implementation of the Project. They will receive and compile financial and technical reports from each of the 47 counties and all national implementing entities and forward them to the Project sub-technical working group at the Intergovernmental Health Forum for review and then onward submission to the Bank. Currently, the PMT lacks adequate capacity to coordinate both the ongoing and the new Projects. Thus, the government will be required to: (i) assign and/or recruit additional staff with the appropriate skills set (for example, financial management, procurement, project management, M&E, and so on) to oversee the successful implementation of the Project; (ii) build staff capacity; and (iii) make resources available to carry out their day-to-day functions.

VI. Safeguard Policies (including public consultation)

Safeguard Policies Triggered by the Project	Yes	No
Environmental Assessment OP/BP 4.01	×	
Natural Habitats OP/BP 4.04		×
Forests OP/BP 4.36		×
Pest Management OP 4.09		×
Physical Cultural Resources OP/BP 4.11		×
Indigenous Peoples OP/BP 4.10	×	
Involuntary Resettlement OP/BP 4.12		×
Safety of Dams OP/BP 4.37		×
Projects on International Waterways OP/BP 7.50		×
Projects in Disputed Areas OP/BP 7.60		×

Comments (optional)

VII. Contact point

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