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PROJECT INFORMATION DOCUMENT (PID)
CONCEPT STAGE

Report No.: PIDC23870

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	10-May-2015
Date PID Approved/ Disclosed	13-May-2015
Estimated Date of Appraisal Completion	21-Dec-2015
Estimated Date of Board Approval	18-Feb-2016
Concept Review Decision	Track II - The review did authorize the preparation to continue

I. Introduction and Context

Country Context

Kenya's economy remains robust with continued strong economic performance in 2013, but is vulnerable to emerging challenges. The gross domestic product (GDP) growth rate remained around 4.7 percent driven by strong consumption, public investment in infrastructure and higher industrial and services output. Growth was underpinned by macroeconomic stability, including single-digit inflation that supported demand for goods and services and a stable exchange rate. The inflation averaged 5.7 percent in 2013, and is estimated to be 6.1 percent in November 2014. However, Kenya's growth is exposed to internal and external shocks such as frequent drought, deteriorating security situation, expansionary fiscal policy, and tightening of global monetary conditions. The regional peers are catching up with Kenya's growth, possibly indicating that Kenya is not able to achieve its full potential.

The poverty level is high and varies considerably by location. The latest reliable data show that the

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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. Some social indicators have improved notably, yet inequality is still high (Gini of 47.4): there are significant differences in opportunities and outcomes by gender and location. For example, poverty levels vary widely between rural (50 percent) and urban (34 percent) areas as well as between counties: around 12 percent in Kajiado to more than 90 percent in Turkana. Kenya's Human Development Index value has also improved from 0.455 in 2000 to 0.535 in 2013, but Kenya still remains in the low human development category (147th out of 187 countries).

Kenyan people's desire for change manifests in the Constitution of Kenya (2010), that resulted in a highly ambitious and fast track 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 delivery of health services. The building blocks for devolution, including the county governmental structures, intergovernmental relationship mechanisms for intergovernmental cooperation and coordination, and mechanisms to transfer resources to deliver policy priorities are still evolving.

Sectoral and Institutional Context

Kenya has started to make some progress towards achieving the health Millennium Development Goals (MDGs) since 2000, but is unlikely to achieve its MDG targets. Kenya successfully reduced the prevalence of HIV and AIDS among adult population from 7.2 percent in 2003 to 5.6 percent in 2012. The under- five mortality rate (U5MR) that fell from 115 in 2003 to 52 in 2014 is driven mainly by declines in post-neonatal mortality and child mortality. However, there was limited progress in reducing neo-natal mortality (NNMR), which is critical for achieving MDG 4 and closely linked to maternal health. The maternal mortality ratio (MMR) of over 400 per 100,000 live births remained stagnant over the past decade and achievement of MDG 5 remains out of reach. Total fertility rate (TFR) is reduced to 3.9 in Kenya, after a decade of stagnation, but the adolescent birth rate is high with 18 percent of girls aged between 15 and 19 years giving birth due to early marriage and high unmet need for family planning (23%). Also, more than one in four children under five are stunted even though the nutrition status has improved since 2003. Inequity in health status by socioeconomic and geographic factors is considerable in Kenya but improving in some indicators. For example, MMR in Mandera, Wajir, Turkana, and Marsabit counties is estimated to be higher than 1,000 per 100,000 live births. But the gap in urban-rural differentials in infant mortality has narrowed over time.

Access to and use of essential health services is mixed. The use of health services has increased from 1.7 annual visits per capita in 2003 to 3.1 visits in 2013. Vertical disease control programs have made marked achievements, contributing to improved health status. For example, ownership and utilization of insecticide treated nets (ITNs) have increased substantially and immunization coverage improved notably between 2003 and 2009, even though coverage has stagnated since 2009 for both immunization and use of ITNs. Delivery of key reproductive and maternal health services such as antenatal care (ANC) four times or more, skilled delivery, postnatal care (PNC) in less than two days, contraceptive prevalence rate (CPR), and met need for family planning have also improved during the last decade. However, wide disparities in access to and utilization of essential services by socio-economic and geographic status remain. For example, the proportion of delivery by skilled health workers was 31 percent in the poorest quintile and 93 percent in the richest quintile; 22 percent in Wajir and 93 percent in Kiambu. The recent household survey suggests that the public sector is the main source of health care services for about 60 percent of the population.

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Primary health care services are pro-poor, but the richest 20 percent of population benefit more from hospital services for both outpatient and inpatient care.

Improving coverage of key essential services has been hampered by both supply side and demand side issues. Recent studies show that the health workers are unevenly distributed with serious shortages among the counties that need them most and about a quarter of staff were absent from duty on an announced visit (as high as 42% in rural public health centers). Challenges in relations to the skills of the health workers in managing common conditions are also noted: for example, while nearly two thirds (62%) of skilled health workers in Kenya accurately diagnosed post-partum hemorrhage and neonatal asphyxia, only one in five (19%) were able to adhere to at least half of clinical guidelines to manage each of the two conditions. In addition, over three quarters of the facilities had minimum functioning equipment (77%), but only over a half of the facilities (57%) had basic infrastructure such as water, electricity, and sanitation and the availability of essential drugs for maternal care was low at 59%. Devolution is beginning to address some of these supply side challenges by enhancing the local accountability and oversight. Several factors such as poverty, sub-optimal women's empowerment, harmful cultural beliefs and practices, long distance to health facility especially in arid and semi-arid land (ASAL), and provider attitude are reported to impede the demand and use of essential services, especially maternal and child care services.

Health expenditure continues to rely heavily on out-of-pocket payments and external resources. Per capita health expenditure doubled from US$20 in 2003 to US$45 in 2012, but the government health expenditures as a percentage of total government expenditures declined from 8 percent to 6 percent during the same period. According to National Health Accounts, public health expenditure as a share of total health expenditure (THE) increased from 29 percent in FY2009/10 to 36 percent in FY2012/13. However, out-of-pocket payments also increased from 30 percent to 32 percent of THE as contribution by donors decreased significantly from 35 percent to 20 percent of THE during the same period. A significant part of external financing still remains off-budget targeting few diseases such as HIV/AIDS, tuberculosis and malaria.

The government has taken several initiatives to improve the delivery of primary healthcare services. In 2010, the government, with support from the World Bank Group (WBG) and Danish International Development Agency (DANIDA), introduced the Health Sector Services Fund (HSSF) that provides funds directly to primary health care facilities and encourages the community to actively participate in the management of primary health care services. Shift to a pull system of supply chain management coupled with capitalization of the Kenya Medical Supplies Authority (KEMSA) slightly improved the availability of tracer drugs. Political commitment to improve maternal and child health outcomes has also increased at national and county level.

To reduce financial barriers to accessing essential health services, the government has also introduced several health financing initiatives such as abolishment of user fees at primary health care facilities and free maternal care at public health facilities. With support from the WBG, Kenya is in the initial stages of implementing a health insurance subsidy for the poor (HISP) pilot program, which aims to provide comprehensive outpatient and inpatient care for the poor in both public and private facilities starting with 500 households in each county. A results based financing (RBF) program is being scaled up in 20 ASAL counties, focusing on core primary health care services that are known to improve health outcomes for women and children effectively and efficiently. These initiatives are, however, not well coordinated, resulting in a fragmented health financing system, which does not provide effective and efficient services of adequate quality due to high

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administration costs arising from different implementation arrangements and time requirements for staff. Thus, 80 percent of Kenyans, most of them working in the informal sector, still do not have effective coverage for healthcare and end up making large out of pocket payments. A recent study estimated that nearly 2.6 million Kenyans fall in to poverty or remain poor due to ill health each year.

Two key institutions leading health financing initiatives, the Ministry of Health (MoH) and the National Hospital Insurance Fund (NHIF), have been undergoing reforms, but important weaknesses persist. The MoH has developed a draft Universal Health Coverage (UHC) Roadmap, which is currently being reviewed internally. Once the Roadmap is approved, the Government of Kenya (GoK) will develop the health financing strategy, which will identify the core technical elements and the practical solutions to address health financing related challenges. The NHIF is the main health insurer in Kenya covering about 7.8 million Kenyans (approximately 20 percent of the population). Based on the strategic review undertaken by International Finance Corporation (IFC) that identified key areas of weaknesses such as sub-optimal governance and low efficiency, the NHIF has adopted some reforms such as publishing accounts in the local newspapers and on their website, implementing a quality improvement program, and decreasing high administrative cost. The NHIF management, with support from the GoK, is keen to fast track other reforms to improve its efficiency and accountability and prepare for UHC.

Devolution presents opportunities to address challenges in the Kenya health system, but also poses new challenges for the country especially with the rapid transition. Devolution can improve equity by taking resources closer to the pe ople and promoting accountability. However, the early evidence shows that devolution might erode the recent achievements unless u rgent attention is given to manage the transition. As one of the most devolved sectors, nearly two thirds of the total public health allocations have been devolved to counties in FY 2013-14, accounting for 30 percent of the county sharable revenue. However, a rapid assessment estimated that only 13 percent of county revenue was allocated on health, thus possibly constraining the health service delivery. Health expenditures at county level need to be studied more thoroughly.

While the institutional and implementation arrangements are being developed, delivery of essential services may be further constrained. With devolution, 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 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 (e.g., resource mobilization, maintenance of health infrastructure including medical equipment, devices and plant, human resources for health management and development, monitoring and evaluation, etc), but disagree on the division of labor between them, due partly to limited capacity to adapt to their newly mandated roles and responsibilities. While the 2010 Constitution envisaged conditional grants to counties from the national level to support priority national initiatives, an appropriate framework to provide conditional grants to the sites where services are delivered was not established before devolution, affecting the flow of available funds for service delivery to counties. Currently the National Treasury is working on developing a framework for Performance Grants to County Governments.

Relationship to CAS

The proposed operation is fully aligned with the Country Partnership Strategy (CPS) for Kenya

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(FY14-FY18) that supports the Vision 2030, the blueprint for making Kenya ‘a middle income country providing a high quality of life to all its citizens by 2030’, and human development remains central to this goal. In order to help Kenya achieve this objective, 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.' Under this domain, health is identified as a pressing priority and the CPS aims to scale-up the combined resources of International Development Association (IDA) and IFC, alongside other partners. 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 will inform a series of IDA operations including the proposed health operation to help counties and national agencies to make devolution work. The proposed operation thus will support both domains by improving delivery of and utilization of quality maternal, newborn, and child health care services in underserved areas and strengthening equitable service delivery in a devolved setting. The CPS’s strong focus on results and accountability is also well rooted in the proposed operation.

II. Proposed Development Objective(s)

Proposed Development Objective(s) (From PCN)

The project development objective (PDO) is to improve the delivery and use of quality essential health care services in the targeted counties with a focus on reproductive, maternal, newborn, child and adolescent health (RMNCAH) services.

Key Results (From PCN)

The key result (outcome) indicators will include:

- Pregnant women attended four or more ANC services (percentage/number)
- Deliveries conducted by skilled attendant (percentage/number)
- Children 12-23 months fully immunized (percentage/number)
- Contraceptive prevalence rate (percentage/number)
- The targeted poor insured and visited outpatient services at least three times per year (percentage/number)

The key results including intermediate outcome indicators will be refined during the preparation.

III. Preliminary Description

Concept Description

The proposed Project would comprise two components that focus on key areas under the Kenya Health Policy 2014-2030, and Kenya Health Sector Strategic and Investment Plan (KHSSP) 2014-2018: (i) to improve maternal and child health outcomes given that neonatal and maternal mortality as well as undernutrition among children under five years old have been stagnant since 1993; and (ii) to build appropriate institutional capacity in order to make progress towards UHC in the recently devolved Kenyan health system. The latter includes strengthening institutional capacity at the national level to foster development of equitable, efficient, and sustainable national health financing strategies (e.g., reduce out-of-pocket payments, especially by the underserved populations) to achieve the national health goals, and increasing capacity at the county level to plan, budget, implement, and monitor the effective delivery of essential package of health services. The Project will primarily target chronically underserved areas/counties for RMNCAH service delivery

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and the poorest for health insurance, taking other partners' presence and implementability of the proposed operation into account.

Component 1: Improving access to and utilization of quality RMNCAH services among the underserved populations (initial estimation: US$ 100 million)

The GoK is in the process of developing an integrated multi-year RMNCAH Investment Framework to address persistently high maternal, neonatal and child morbidity and mortality. A National Steering Committee chaired by the Director of Medical Services and supported by an integrated Technical Working Group has been appointed to lead the development of the national RMNCAH Investment Framework. The RMNCAH Investment Framework specially aims to: (i) increase demand for and utilization of RMNCAH services by improving knowledge, attitudes, and behaviors of communities towards the continuum of essential care services such as family planning, ANC, skilled delivery, PNC, and adolescent reproductive health services; (ii) increase access to RMNCAH services by strengthening county's capacity (e.g., financing, workforce, products, information and governance) to deliver effective and efficient integrated interventions at the communities and facilities; and (iii) improving quality of RMNCAH services by ensuring constant availability of essential inputs (e.g., human resources, equipment, commodities, water, etc.) and enforcing quality of care standards for improved client experience, patient safety and effectiveness of care.

Component 1 will support the roll out of an integrated RMNCAH Implementation Plan in a few targeted counties with high burden of maternal and neonatal mortality. Inequity in terms of access, utilization, and health outcomes is considerable by location with the top ten counties accounting for 55 percent of maternal deaths. In consultation with the MoH, counties and development partners (DPs) supporting the roll out, the targeted counties under this operation will be selected. Each selected county will develop an evidence-based Implementation Plan under the National Health Policy, RMNCAH Investment Framework, and County Integrated Development Plan to address county specific supply and demand barriers to achieve the results agreed. The MoH along with implementing partners at the county level will provide technical support. Given the crucial roles the private sector (for profit, not for profit and faith based) plays in delivering health services in Kenya, the proposed operation will support the targeted counties to leverage the private sector more effectively. Also special attention will be paid to the financial accessibility among the poor in the selected counties by providing free/subsidized health insurance.

Component 2: Strengthening institutional capacity to make progress towards UHC (initial estimation: US$ 50 million)

The Government and stakeholders in Kenya are committed to providing UHC, and have a shared view that every Kenyan should have access to a comprehensive health cover. It is therefore important to develop and test UHC models that can work in the Kenyan context. The NHIF has been identified as the preferred institution for delivering UHC in Kenya. While the NHIF is by far the largest health insurance provider in Kenya, it is fraught with several governance and efficiency challenges. It has recently been implementing reforms to improve its efficiency and accountability and in so doing gain the trust of Kenyans. Although some progress has been made especially in reducing the administrative costs during the last few years, a recent institutional assessment shows that NHIF has potential for further improving efficiency to enable more Kenyans especially those working in the informal sector access a comprehensive health cover.

Component 2 will thus support the development/implementation of: (i) MoH's health financing strategy; (ii) NHIF's strategic plan promoting the reform agenda; and (iii) counties' capacity development plan to enable them to improve the delivery of essential health services especially for the targeted counties. The emphasis will be on strengthening capacity of the MoH to effectively guide the development and implementation of the National Health Financing Strategy, and that of NHIF to be a more efficient and transparent institution to fulfil its mandate. The proposed operation will also support improvements in coverage and quality of essential services in targeted counties by supporting counties identified through a transparent selection process to develop, implement, and monitor service improvement plans for UHC with focus on RMNCAH results. Special attention will be given to targeting the underserved populations, building on lessons learned from the ongoing RBF and HISP.

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IV. Safeguard Policies that might apply

Safeguard Policies Triggered by the Project	Yes	No	TBD
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	

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V. Financing (in USD Million)

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

Financing Source	Amount
BORROWER/RECIPIENT	0.00
International Development Association (IDA)	150.00
Total	150.00

VI. Contact point

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