Report Number: ICRR0024156

## 1. Project Data

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|---|---|
| **Project ID**<br>P152394 | **Project Name**<br>Transforming Health Systems |
| **Country**<br>Kenya | **Practice Area(Lead)**<br>Health, Nutrition & Population |

| L/C/TF Number(s) | Closing Date (Original) | Total Project Cost (USD) |
|---|---|---|
| IDA-58360,TF-A2561,TF-A2792 | 30-Sep-2021 | 170,739,534.44 |
| **Bank Approval Date** | **Closing Date (Actual)** | |
| 15-Jun-2016 | 30-Sep-2023 | |

| | IBRD/IDA (USD) | Grants (USD) |
|---|---|---|
| Original Commitment | 191,100,000.00 | 41,100,000.00 |
| Revised Commitment | 190,949,060.33 | 40,949,060.33 |
| Actual | 171,043,352.73 | 40,140,789.78 |

| Prepared by | Reviewed by | ICR Review Coordinator | Group |
|---|---|---|---|
| Livia Maria Angelica Benavides Matarazzo | Judyth L. Twigg | Susan Ann Caceres | IEGHC (Unit 2) |

## 2. Project Objectives and Components

### a. Objectives

The project development objective (PDO) as stated in the Financing Agreement was “to improve utilization and quality of primary health care services with a focus on reproductive, maternal, newborn, child and adolescent health.” The PDO in both the Project Appraisal Document and the Global Financing Facility (GFF) Grant Agreement was the same.

The PDO was modified in October 2020, to state: “to improve utilization and quality of primary health care services with a focus on reproductive, maternal, newborn, child, and adolescent health services and to

provide immediate and effective response to an eligible crisis or emergency." This new definition of the PDO allowed for the inclusion of an emergency component to support the response to the COVID-19 pandemic.

This ICRR concurs with the assessment in the ICR (p. 16) that there were three objectives under the revised PDO: (a) to improve utilization of primary health care services with a focus on reproductive, maternal, newborn, child, and adolescent health services, (b) to improve quality of primary health care services with a focus on reproductive, maternal, newborn, child, and adolescent health services, and (c) to provide immediate and effective response to an eligible crisis or emergency.

During the project implementation period, the PDO-level indicators were modified as follows: (a) the target was increased for three indicators, (b) the indicator on child immunizations was replaced with another that specified the type of vaccine, and the corresponding target was increased, (c) one indicator was revised and had a minor reduction in its target, (d) one intermediate indicator was upgraded to a PDO-level indicator, and the target was increased, (e) the core sector indicator on health, nutrition, and population was revised according to corporate guidelines, and (f) a PDO-level indicator was included to monitor achievement of the new objective on the emergency response. Even though most of these changes clarified indicators and/or increased the scope of the project, a split evaluation is carried out as a new objective was added to this project.

### b. Were the project objectives/key associated outcome targets revised during implementation?

Yes

### Did the Board approve the revised objectives/key associated outcome targets?

Yes

### Date of Board Approval

20-Oct-2020

### c. Will a split evaluation be undertaken?

Yes

### d. Components

**Component 1: Improving Primary Health Care Results** (appraisal: USD 150.0 million, of which USD 115.0 million International Development Association [IDA], USD 35.0 million GFF; restructuring: USD 141 million, of which USD 106.0 million IDA, USD 35.0 million GFF; actual: USD 131.2 million total, of which USD 98.7 million IDA, USD 32.5 million GFF). This component aimed to improve the delivery, utilization, and quality of Primary Health Care (PHC) services at the county level with a focus on reproductive, maternal, newborn, child, and adolescent health (RMNCAH). The component would support improving the functionality of existing facilities to deliver PHC services and increasing the demand for services at the community and facility levels. The component used a performance-based approach to support both supply- and demand-side activities at the county level, nationwide. The performance-based approach had two parts. Initially, seed funding was to be provided to counties contingent on their compliance with basic conditions, including the submission of a supplementary budget for approval by the County Assembly, opening a county special purpose account, and designation of a project accountant and an internal auditor. For each subsequent year, counties would have to meet a set of minimum conditions, namely, that the overall share of the county budget allocation (for Year 2) and expenditures (for Years 3-5) were higher than the previous

year (with the purpose of showing an increase in overall health budget allocation), and that the annual project financial and technical report for the previous financial year was submitted on time. Allocations to each county were based on agreed performance indicators related to the RMNCAH PHC services.

**Component 2: Strengthening Institutional Capacity** (USD 15.1 million, of which USD 9 million IDA, USD 5 million GFF, and USD 1.1 million Policy and Human Resources Development Fund [PHRD]; restructuring: USD 28.7 million, of which USD 22.6 million IDA, USD 5 million GFF, and USD 1.1 million PHRD; actual USD 28.4 million, of which USD 21.6 million IDA, USD 6.8 million GFF). The project would support institutional strengthening to better deliver PHC services as described in Component 1. This component would address three specific areas for institutional strengthening:

**Subcomponent 2.1. Improving Quality of Care.** This subcomponent would support the Department of Health Standards, Quality Assurance and Regulations and the Health Regulatory Boards to strengthen routine inspections of health facilities and institutionalize quality assurance towards their certification. The subcomponent would also support the Division of Family Health (DFH) to develop and disseminate RMNCAH strategies and guidelines and conduct operations research. Finally, the subcomponent would support the strengthening of midwife training through the Kenya Medical Training College.

**Subcomponent 2.2. Strengthening M&E and Civil Registration and Vital Statistics (CRVS).** The project would support the Divisions of Monitoring and Evaluation (M&E), Health Research Development, and Health Informatics to operationalize the sector M&E framework, strengthen the Health Information System (HIS), and pilot innovative approaches to improve coverage of vital events registration within the health sector.

**Subcomponent 2.3**. **Supporting Health Financing Reforms towards Universal Health Care (UHC).** This subcomponent would support the Division of Health Care Financing (DHCF) to disseminate the Health Financing Strategy (HFS) to get buy-in from stakeholders, conduct analytical work to inform the implementation of HFS and health financing reforms towards UHC, and build capacity for UHC leadership at the national and country levels.

**Component 3: Cross-county and Intergovernmental Collaboration, and Project Management** (USD 26 million IDA; restructuring USD 11.4 million IDA; actual USD 8.8 million IDA). This component aimed to enhance cross-county and inter-governmental collaboration, including addressing demand- and supply-side barriers. The component also was to fund project management at the national and county levels, and included project M&E, fiduciary activities, safeguards, and technical assistance (TA) in support of project implementation.

**Component 4: Contingency Emergency Response Component (CERC)** (appraisal: USD 0 million; restructuring: USD 10 million IDA; actual: USD 6.9 million IDA). The CERC Component was created as part of the World Bank's support to the government to strengthen health security and pandemic preparedness in the January 2020 restructuring. The CERC was activated in March 2020 to respond to the emergency from the COVID-19 pandemic. Funds were reallocated during the restructuring of October 2020. This component intended to support the purchasing of medical supplies and equipment, capacity building and training, quarantine isolation and treatment centers, and risk communication. In addition, the CERC was to support case finding and contact tracing, and the quarantine of exposed health workers, as well as the purchase of tents to manage surge capacity for isolation.

### e. Comments on Project Cost, Financing, Borrower Contribution, and Dates

The total project cost at appraisal was USD 191.1 million, of which USD 150 million was financed through an IDA credit, USD 40 million from GFF, and USD 1.1 million through the Japan PHRD. Actual project disbursements were USD 171.0 million, of which USD 130.8 million was from the IDA credit (87 percent), USD 39.2 million from the GFF grant (98 percent), and USD 0.9 million from the PHRD grant (86 percent). Approximately USD 15.76 million of the IDA credit was cancelled.

The IDA credit was approved on June 15, 2016, the GFF grant was approved on April 27, 2016, and the PHRD grant was approved on June 7, 2016. The project became effective on September 29, 2016. The midterm review was carried out on March 25, 2019. The original closing date was September 30, 2021.

The project had six Level 2 restructurings, as follows:

1. On June 24, 2019, a restructuring was carried out to address challenges identified during the midterm review and accommodate the government's UHC initiative, as follows: (a) modification of components' scope and costs to include the UHC initiative, namely changes in counties' eligibility criteria, and reallocation of funds to purchase medicines, supplies, and other inputs for level 4 and 5 hospitals to deliver quality services including, but not limited to, RMNCAH services, (b) reallocation of project financing between disbursement categories to reflect the changes in the scope of components, (c) amendment to the project's results framework to reflect more exact baseline data (obtained after project launching), revise targets in light of implementation progress during the initial phase, and specify the description of selected indicators, (d) adjustment of the institutional and implementation arrangements by creating a Steering Committee to provide overall oversight for the project, and (e) modification of risk ratings, where the rating for "sector strategies and policies" was revised from Modest to Substantial, given the complexity in the implementation of an ambitious UHC initiative. The risk rating for social safeguards was also revised from Modest to Substantial because there were delays in rolling out safeguard instruments to the county level.
2. On January 31, 2020, a restructuring was carried out to include a CERC, considering that Kenya was highly vulnerable to epidemics and natural disasters. This component would allow the government to have rapid access to funds for emergency response. One million dollars were allocated to this component from components 2 and 3.
3. On October 20, 2020, a restructuring responded to the government's activation of the CERC to respond to the COVID-19 pandemic. The PDO was modified with the addition of "and to provide immediate and effective response to an eligible crisis or emergency," and USD 9 million were reallocated from Component 1 to Component 4. In addition, the results framework was revised to add one PDO-level indicator and two intermediate indicators.
4. On March 26, 2021, a restructuring extended the IDA credit by 24 months, from September 30, 2021, to September 30, 2023.
5. On September 15, 2021, the closing date of the GFF was extended by 21 months, from September 30, 2021, to June 30, 2023, and the PHRD by 8 months from September 30, 2021, to May 31, 2022. This restructuring also reallocated funds between disbursement categories.
6. On May 26, 2023, a final restructuring was processed to reallocate funds between disbursement categories.

## 3. Relevance of Objectives

### Rationale

At the time of appraisal, Kenya had been experiencing strong economic growth of around 5.6 percent per year, but this growth had not been inclusive. There were disparities between rural and urban areas and among counties. As part of its development strategy, the Second Medium Term Plan (MTP 2013-2017), Kenya embarked on an ambitious devolution process, where services, including health care, were devolved to the newly created 47 counties.

During the decade prior to appraisal of this project, the population's health status had improved, but there were some key indicators that had seen little improvement. Moreover, there was considerable variation in health conditions by geographic area and socioeconomic status. Both supply- and demand-side barriers were thought to be causing this slow improvement. On the supply side, there were problems with governance in the health system, human resource shortages (especially in remote areas), insufficient essential medicines and medical supplies, inadequate and inequitable health care financing, and poor quality of care. On the demand side, the barriers included socio-cultural beliefs and practices, low status of women, poverty, high cost of services (including transportation), long distance to health facilities in some areas, and poor health provider attitudes.

The project aimed to improve the utilization and quality of primary health care services with a focus on RMNCAH. The design was aligned with the Kenya Health Sector Strategic and Investment Plan 2014-2018 and the Kenya Health Policy 2014-2030. At closing, the project was aligned with the Kenya Health Sector Strategic and Investment Plan 2018-2023, the Kenya Vision 2030, and the Kenya Kwanza Manifesto 2022, all of which prioritized primary health care towards achieving UHC.

The objectives were relevant at appraisal with respect to the Country Partnership Strategy for Kenya (CPS, FY 2014-FY 2018) and at closing in the Country Partnership Framework (CPF, FY 2023-2028). The CPS included, under its second domain "Protection and Potential- Delivering Shared Prosperity," the outcome "Improved Social Service Delivery for Vulnerable Groups, Particularly Women," which addressed health, nutrition, and reproductive health services. Under the third domain, "Consistency and Equity – Delivering a Devolution Dividend," the outcome "Better Provision of Health and Sanitation Services by Counties" addressed the provision of health services at the county level. The CPF, at closing, included the objective "Shrink Disparities in Learning and Health Outcomes." This objective recognized the need to support the UHC initiative in Kenya.

The project design built on prior experience in-country, particularly on the Kenya Health Sector Support Project (P074091). This project piloted a results-oriented approach focusing disbursements against performance-linked indicators on PHC results. The pilot faced several challenges which led to several lessons that were adopted by this project, namely the need of an adequate regulatory framework, ensuring clear funds flow arrangements in the context of the devolution framework, and capacity building at the health facility level to perform the necessary fiduciary roles. Technical assistance and capacity building were also identified as key components to ensure that the various stakeholders be able to perform the required tasks, especially in the context of a devolution process. Finally, in the context of the COVID-19 pandemic, the CERC was activated to support the emerging health crisis caused by this disease.

**Rating**
High

## 4. Achievement of Objectives (Efficacy)

### OBJECTIVE 1

#### Objective
Improve utilization of primary health care services with a focus on reproductive, maternal, newborn, child, and adolescent health services

#### Rationale
The theory of change for this objective stated that utilization of PHC services would improve by increasing supply of these services and fostering demand at the community and health facility levels. This would be achieved by: (a) ensuring that all 47 counties would be funded through performance-based allocations to scale up evidence-based key priority interventions in their PHC Annual Work Plans (AWP), (b) training staff in all 47 counties on evidence-based AWP formulation and development of the AWP appraisal system, as well as on planning and budgeting, (c) developing, costing, and disseminating a benefit package for RMNCAH, (d) equipping and training staff from community health units (CHUs) in order to increase the number of functional CHUs, as well as strengthening of the Kenya Medical Training College (KMTC); and (e) engaging communities in order to increase the coverage of vulnerable marginalized groups.

**Outputs**

Annual work plans were improved through the standardization and harmonization of guidelines, tools, and templates; implementation of a quality assurance system; training; and continuous support.

The number of functional community units increased from a baseline of 302 units to 9,400 units, significantly exceeding the original target of 2,400 units and the revised target of 5,331 units. Functionality included the implementation of five skill labs in the KMTC, renovation of maternity wings, equipping of regional blood transfusion centers, and implementation of waste treatment facilities.

Demand for health services was fostered through capacity building and procurement of equipment for the CHUs, as well as through dialogue with the community to enhance understanding of PHC.

784 community health nurses at the KMTC were trained, all of which passed the nursing council exams. Training was targeted to vulnerable and marginalized groups (VMG), especially in the arid and semi-arid land counties. A survey carried out of the nurse graduates showed that, out of the 399 nurses surveyed, 138 were fully employed in the health sector. VMG communities reported that having a nurse who understood their language and culture encouraged community members to attend health services.

52 VMG plans were implemented, including key priority interventions at improving utilization of health services for VMGs.

Contraceptives equivalent to more than 6.2 million couple-years of protection were distributed to health facilities across all 47 counties.

The benefit package was developed, costed, and disseminated.

The number of people who received essential health, nutrition, and population (HNP) services was 15.39 million people, exceeding the target of 10.06 million (this target was not revised). Of these, the number of children immunized was 7.64 million children, exceeding the target of 5.40 million children, and the number of deliveries attended by skilled health personnel was 7.76 million, also exceeding the target of 4.66 million deliveries.

The lessons learned from the UHC Phase 1 were documented and disseminated.

**Outcomes**

The percentage of children immunized with the third dose of Pentavalent vaccine increased from a baseline of 79.5 percent to 85.4 percent, exceeding the original target of 76 percent and the revised target of 84 percent.

The percentage of pregnant women who attended at least four antenatal care (ANC) visits increased from a baseline of 39.7 percent to 53.8 percent, exceeding the original target of 46 percent and the revised target of 52 percent.

The percentage of women between the ages of 15-49 years currently using a modern family planning (FP) method was 37.7 percent at closing, below the baseline of 47.8 percent, the original target of 45 percent, and the revised target of 52 percent. As explained in the ICR (p. 17), there were problems with the measurement methodology for this indicator. It was designed to use, as a proxy, the frequency of visits to health facilities for consultation on modern contraceptives, as recorded in the Kenya Health Information System (KHIS). However, during the same period, there was a shift towards long-acting FP methods that did not require frequent visits to health facilities. The ICR presented an assessment of this indicator using data from the Kenya Demographic and Health Survey (KDHS), which showed that the percentage of women between the ages of 15-49 years currently using a modern FP method increased from 53 percent in 2014 to 57 percent in 2022, in the case of married women. The result for all women in the 15-49 age range was 39.1 percent in 2014 and 42 percent in 2022. These numbers were consistent with the results obtained through the Performance Monitoring for Action (PMA) survey, where the results for this indicator were 53 percent for married women in 2014 and 61 percent for married women in 2022, and 42 percent for all women in 2014 and 46 percent for all women in 2022. The percentage increase seen under the KDHS and the PMA, 3 and 4 percentage points, respectively, is slightly below the targeted change as per project design of 4.2 percent.

### Rating
Substantial

## OBJECTIVE 2
### Objective

Improve quality of primary health care services with a focus on reproductive, maternal, newborn, child, and adolescent health services

### Rationale

Improvement in the quality of services would be achieved through: (a) the improvement of health facility infrastructure and availability of essential equipment, (b) increasing the provision of FP commodities, (c) increasing the number of health human resources through both training of midwives and contracting of new health workers, (d) increasing the number of health facilities that were inspected and met safety standards, (e) increasing the number of health facilities with capacity and tools to conduct quality of care assessments and maternal and perinatal death surveyance and response, and (f) improved monitoring and data quality through capacity building at the district level, improvement in the reporting of vital events, and improved evidence-based decision making.

**Outputs**

Three bills in support of the health financing reform towards UHC were developed with project support: the Facility Improvement Fund Act, the Primary Health Care Act, and the Social Health Insurance Bill. All three assured financing for PHC.

A Quality-of-Care Certification and Accreditation Framework for the Health Sector was developed.

The number of facilities inspected for safety standards was 6932 facilities, exceeding the original target of 70 and the revised target of 1,635 facilities. Inspection of health facilities was achieved through the development of an electronic joint health inspection checklist (e-JHIC) together with procurement of inspection tablets, training of inspectors, and carrying out of biannual review meetings at the county level.

Two operations research activities were completed to inform policy/strategy on RMNCAH, meeting the target. These were: (a) the Kangaroo Mother Care Report, which assessed different capacities for this type of care across facilities, and (b) Uptake of Iron and Folic Acid Supplements (IFAS) among women of reproductive age.

The percentage of reports submitted to District Health Information Systems (DHIS) in a timely manner increased from a baseline of 88.8 percent to 98.4 percent, exceeding the original target of 85 percent and slightly exceeding the revised target of 98.0 percent.

The percentage of births registered within six months of occurrence increased from a baseline of 65.9 percent to 80.6 percent, slightly exceeding the target of 80.0 percent (this target was not revised). This was achieved through the strengthening of the Civil Registration System, which included capacity building at the local level of 570 chiefs and assistant chiefs as well as 450 health personnel, sensitization of county health management, and a mobile registration pilot in two counties.

The health information systems were strengthened through both capacity building and the development of the health sector M&E Investment Case, which addressed the gaps identified in the assessment.

100 percent of grievances registered in relation to delivery of project benefits were addressed, exceeding the end target of 80 percent (this target was not revised).

100 percent of implementing entities submitted the annual financial management and technical report on time, exceeding the original target of 80 percent and the revised target of 95 percent.

**Outcomes**

Births attended by skilled health personnel increased from a baseline of 57 percent to 75.5 percent, exceeding the original target of 64 percent and the revised target of 67 percent.

The percentage of facilities that were inspected and met safety standards increased from a baseline of 0 percent to 37 percent, below the target of 50 percent (this target was not revised). As indicated in the ICR (p. 19), while the number of inspected facilities exceeded the target, the percentage of those that met the standards was below the target. Further to this, the implementation of the inspection process faced challenges that hindered the re-inspection of health facilities, including delays in the scale-up of inspections, challenges faced in the transition from a manual data collection system to an electronic one, low uptake of inspections at the county level, and logistical challenges for inspectors to visit the facilities.

The percentage of women attending ANC, supplemented with iron and folic acid, increased from a baseline of 31 percent to 74 percent, exceeding the original target of 40 percent and the revised target of 73 percent.

Achievement of this objective is rated Substantial due to results on attendance at ANC and skilled birth attendance, but barely so, given the challenges with facilities meeting targeted safety standards.

### Rating
Substantial

## OBJECTIVE 3
### Objective
The project initially did not contain a third objective.

### Rationale
The project initially did not contain a third objective.

### Rating
Not Rated/Not Applicable

## OBJECTIVE 3 REVISION 1
### Revised Objective
Provide immediate and effective response to an eligible crisis or emergency

### Revised Rationale
This objective aimed to respond to a potential eligible crisis or emergency, should it occur. The response would be tailored to the context of the emergency. During the life of the project, the COVID-19 pandemic

struck, impacting Kenya. Containing contagion was a priority during the early stages of the pandemic. The focus of this objective was on reporting and investigation of suspected cases of COVID-19. To achieve this, the designated laboratories needed appropriate diagnostic equipment, and vulnerable and marginalized communities had to be reached in their indigenous languages to disseminate health promotion messages and risks faced with respect to this disease.

**Outputs**

The number of designated laboratories with COVID-19 diagnostic equipment increased from a baseline of 2 to 41 laboratories. The target of 8 was significantly exceeded, as during the implementation period, the government expanded the number of designated laboratories in the context of a very rapid expansion of the disease.

100 percent of vulnerable and marginalized communities were reached in their indigenous languages, above the target of 80 percent.

**Outcomes**

100 percent of the reported suspected cases of COVID-19 were investigated based on national guidelines, above the 80 percent target.

### Revised Rating
High

## OVERALL EFFICACY
### Rationale
The first and second objectives (to improve utilization of primary health care services with a focus on reproductive, maternal, newborn, child, and adolescent health services, and to improve quality of primary health care services with a focus on reproductive, maternal, newborn, child, and adolescent health services) were partially achieved. Efficacy under the original objectives is rated Substantial.

### Overall Efficacy Rating

Substantial

## OVERALL EFFICACY REVISION 1
### Overall Efficacy Revision 1 Rationale

The added third objective (to provide immediate and effective response to an eligible crisis or emergency) was fully achieved and rated High. The aggregation of achievement of all three objectives is indicative of a Substantial rating for efficacy under the revised objectives.

### Overall Efficacy Revision 1 Rating

Substantial

## 5. Efficiency

The cost benefit analysis (CBA) carried out at the time of appraisal adopted the approach of economic evaluation of complex interventions. This approach was used because it was not possible to determine the exact combination of interventions that would be carried out during the life of the project. Benefits included lives saved (for both mothers and children) and increased productivity, valued at USD 954.2 million. The total cost was estimated as USD 174.9 million, resulting in a total benefit of USD 779.2 million, that is, a benefit-to-cost ratio of about 5.5:1. The sensitivity analysis showed that, even if only half of the estimated benefits were achieved, the project would continue to be economically viable. The CBA did not estimate an internal rate of return.

The ICR did not carry out a CBA, but it argued that the evidence indicated that the type of interventions carried out as part of the project had significant economic impact. For example, as per UNICEF data, childhood vaccination would provide a return of USD 20 per USD invested in low- and middle-income countries. Also, research carried out in Kenya showed that protective equipment for healthcare workers during the COVID-19 pandemic led to an 11-fold return on investment. The project team later delivered a rigorous CBA, based on the same key assumptions as the analysis at appraisal, using data from the project implementation period. This analysis found, at a three percent discount rate, a net present value of benefits and costs of USD 9 billion and USD 166.5 million, respectively, producing a benefit-to-cost ratio of 54:1. The cost per disability-adjusted life year averted was USD 39, lower than cost-effectiveness thresholds found through several peer-reviewed studies on health interventions in Kenya.

However, despite the highly positive results of the economic analysis – which are expected for human development interventions -- the project faced a number of challenges resulting in inadequate implementation efficiency. The project started with significant delay due to the lapse of another loan in the Kenya portfolio. This resulted in the freeze of all World Bank disbursements in the country. The COVID-19 pandemic significantly impacted activities that required group engagement and travel, such as joint health inspections, and limited the availability to the project of County Departments of Health, which were focused on minimizing the spread of COVID-19. Perhaps most significantly, project design included a decentralized implementation model that, in practice, meant that there were 48 subprojects, that is, 47 counties and the Ministry of Health. The project team stressed that the Bank recognized the extent to which implementation through evolving decentralized government mechanisms could lead to delays and made concerted efforts to offset those challenges, including through incentivizing timely transfer and availability of project funds to an account jointly administered by county treasury and health departments, embedding part of the project management team in the Council of Governors offices, taking several steps to strengthen intergovernmental collaboration, strengthening processes for county annual work planning, budgeting, and performance review, and regular engagement with the National Treasury on timely transfer of project funds to the counties, among others. Despite these efforts, however, there were recurrent delays in the transfers of funds to counties, approximately six months into each fiscal year. Thus,

counties only had half a year, each year, to implement project activities. Expenditure reporting at the county level faced significant delays. There was frequent staff turnover, particularly at the county level. For example, nearly half of the counties had at least three changes in county procurement officers. This high turnover rate required permanent support in training new staff on World Bank fiduciary and safeguard policies. Inspection of health facilities, which was an important contribution to improving quality of primary health care services, faced challenges with respect to delays, low uptake of inspections at the county level, low numbers of re-inspections, and overall logistical challenges. The project had to be extended by 24 months, at which point 91 percent of the total project commitments and 87 percent of the IDA commitment were disbursed.

### Efficiency Rating

Modest

a. If available, enter the Economic Rate of Return (ERR) and/or Financial Rate of Return (FRR) at appraisal and the re-estimated value at evaluation:

| | Rate Available? | Point value (%) | *Coverage/Scope (%) |
|---|---|---|---|
| Appraisal | | 0 | 0<br>☐ Not Applicable |
| ICR Estimate | | 0 | 0<br>☐ Not Applicable |

* Refers to percent of total project cost for which ERR/FRR was calculated.

## 6. Outcome

Relevance of objectives is rated High, as objectives were fully consistent with the context of the health sector in Kenya, and were framed within government's strategy, as well as with the World Bank CPF. Efficacy is rated Substantial under both the original and revised objectives, as the original objectives (Objectives 1 and 2) were rated Substantial, and the new objective (Objective 3) was rated High. Efficiency is rated Modest due to significant implementation inefficiencies. These ratings are consistent with an overall outcome rating under both the original and revised objectives of Moderately Satisfactory, indicating that there were moderate shortcomings in the project's preparation, implementation, and results.

### a. Outcome Rating

Moderately Satisfactory

## 7. Risk to Development Outcome

The project was designed to be implemented using country systems, both at the central and county government levels. This contributed to building institutional capacity at the budget and planning level, as well

as in the provision of health services. In addition, the project's focus on data development and utilization helped in building technical capacity for development outcomes.

The ICR (p. 32) identified two key areas of risks to development outcomes. The first is linked to budget availability, once the project closed. The risks are related to ensuring availability of medical supplies, particularly for family planning. In addition, counties could change their budgetary allocation priorities to other sectors beyond the health sector. A second risk is that the project financed the training of 784 community health nurses, but only one-third were fully absorbed into the health sector. A further risk is that the transition to digitalization was still ongoing at project closure, with consequent problems with the flow of information. These risks could be mitigated through continued dialogue under the recently approved (February 2024) Building Resilient and Responsive Health Systems project (P179698), which continues to focus on improving the utilization of quality primary health services.

## 8. Assessment of Bank Performance

### a. Quality-at-Entry

Project design aimed to support RMNCAH services both on the demand and supply sides. As such, the project used a results-based financing model to fund local governments responsible for the provision of health services. The results framework was adequate to measure achievement of the project objectives, except for the indicator on FP.

While the Bank had advocated focusing the project on those counties that were poorer and where indicator performance was worse, there was a push from the government to cover all 47 counties, as part of the devolution process. To compensate, the project included a greater financial allocation to those poorer-performing counties to ensure that they were prioritized. The project design was informed by global evidence on maternal and child health and by lessons learned from the earlier health project (Kenya Health Sector Support Project, P074091).

Project design was complex, as it included several interventions linked to maternal and child health in 47 counties that had very different health profiles. The use of a results-based financing model provided a good framework that incentivized local governments to spend adequately the funds that were transferred to them. The project supported the purchase of medical inputs. However, since all these purchases were carried out at the county level, procurement was highly fragmented, which typically results in less efficient processes.

#### Quality-at-Entry Rating

Satisfactory

### b. Quality of supervision

The World Bank team carried out regular implementation support missions twice a year, as well as monthly meetings with counterparts. Missions and meetings were carried out in person, since much of the task

team was based in the country. Missions and meetings migrated to virtual mode during the COVID-19 lockdown. Missions included both technical and fiduciary support. There was continuity in Bank staff during the preparation and supervision of the project.

The Bank reacted proactively to the need to make changes in project and results framework design. There were six restructuring processes carried out during the life of the project, in which specific indicators were modified to ensure adequate monitoring of project progress. A CERC objective and component were included allowing for the Bank to support response efforts during the COVID-19 pandemic, and to adapt to the new UHC policy issued by the government. The restructurings also extended the project by 24 months to compensate for project launching delays and changes in government policies.

The project supervision team faced a daunting task of supervising implementation at the central government level as well as in 47 counties. As indicated in the ICR (p. 31), resources were insufficient to carry out in-depth supervision and support to counterparts in each county, especially on safeguards, procurement, and financial management. Even under challenging conditions that were beyond the project's control, the team managed to work with clients to achieve the project's objectives.

### Quality of Supervision Rating
Satisfactory

### Overall Bank Performance Rating
Satisfactory

## 9. M&E Design, Implementation, & Utilization

### a. M&E Design
The project was designed to use country systems for monitoring and evaluation, relying mainly on the KHIS. A second source of data was the Kenya Demographic and Health Survey. Therefore, M&E arrangements were well-embedded institutionally.

Objectives were clearly stated, and each had corresponding indicators. During implementation, several indicators had to be modified, in some cases to improve the indicator, in others because the data was not available for the original indicator or the quality of the data was inadequate. This was the case for the PDO-level indicators on immunization and on facility inspections.

As part of the preparation process, a number of limitations were identified in the KHIS. As a result, project design included support to improve M&E capacity as well as registration of vital events. A USD 1.1 million PHRD grant aimed to support the reactivation and capacity building at the central and county levels. The GFF grant supported the strengthening of the vital statistics registry at the local level. A multi-donor trust fund was also secured to provide technical assistance to improve the KHIS, support for conducting data quality audits, and scaling up digitalization.

### b. M&E Implementation

Since the project M&E relied on country systems, mainly the KHIS, data were available to carry out regular monitoring for the project. During the implementation period, indicators were revised to improve their quality, reflect revised baseline values, replace those where quality data was not available, and revise targets based on progress.

The project also provided support, as designed, to improve M&E systems. A capacity assessment at the county level was carried out to determine gaps and address them. There were joint annual M&E review meetings, and the project supported transition to the new International Classification of Diseases (ICD-11) and improvement in the registration of vital statistics.

### c. M&E Utilization

Monitoring data were widely used to monitor progress towards the achievement of the PDO and make changes as needed. RMNCAH scorecards were developed using data from KHIS to monitor progress. The county annual work plans were also informed by the RMNCAH data.

### M&E Quality Rating

Substantial

## 10. Other Issues

### a. Safeguards

The project was rated as Environmental Assessment Category B, partial assessment, at the time of appraisal. The main factor triggering Environmental Assessment OP/BP 4.01 was the potential adverse environmental impacts associated with medical wastes, generated by the provision of PHC services. The Ministry of Health updated its Health Care Waste Management Plan and made it public prior to project approval. No major civil works were planned, other than maintenance and minor renovation, so an Environmental and Social Management Plan was prepared. Throughout project implementation, environmental safeguards were rated Moderately Satisfactory because some gaps were observed at the county level. Supervision was under the responsibility of the Project Management Team (PMT) with the support of County Public Health Officers (CPHOs). Monitoring activities were carried out, but with some challenges because of the high turnover of CPHOs. At appraisal, the risk rating was deemed low; however, the rating was raised to moderate during the mid-term review, continuing all the way to project closing.

The project also triggered the Operational Policy on Indigenous Peoples (OP/BP 4.10), as vulnerable and marginalized groups would be present in the project area. The government prepared a vulnerable and marginalized groups' framework (VMGF) in consultation with these groups. The framework included a plan for social assessment, a framework for consultation with affected communities, and participatory monitoring and reporting, among other items. Social safeguards were rated Moderately Satisfactory up until project closing, when the rating was downgraded to Moderately Unsatisfactory due to incomplete implementation of three activities in the VMGF. Still, according to the ICR (p. 28), most of the activities were completed with

considerable impact on the uptake of health services by vulnerable and marginalized communities, complying with the relevant OP at project closing.

The grievance redress mechanism (GRM) gave particular emphasis to the areas where vulnerable and marginalized groups were located. County focal points were trained. In some cases, toll-free lines were established to encourage feedback. The GRM was embedded in existing health facility suggestion boxes, and complaints were channeled directly to the Ministry of Health. All complaints were addressed.

### b. Fiduciary Compliance

Procurement risk was rated High at the time of appraisal through to November 2019, when it was modified to Substantial. Performance ratings were consistently Moderately Satisfactory throughout project implementation. Overall, procurement policies were complied with, except for some specific cases. The procurement post review (PPR) and a 2022 internal audit found cases of non-compliance with respect to missing records, inadequate capacities, and inadequate contract review and award processes. These issues resulted in delays in implementation. The PPR and internal audit made recommendations for improvements in procurement processes. As reported by the task team, subsequently procurement processes improved.

Financial management risk was rated Substantial at the time of appraisal and continued with this rating throughout the life of the project. Performance ratings were Moderately Satisfactory during the same period. Even though the Bank carried out regular trainings, financial management at the county level was weak. The issues identified included unsupported payments, commingling of project funds, cashbook alterations, delays and weak maintenance of the imprest register, and delays of funds flows. At the central level, the PMT financial management was adequate, and fiduciary oversight of the project was deemed sufficient. Financial audits were generally clean, and issues that were flagged were adequately addressed.

### c. Unintended impacts (Positive or Negative)

None

### d. Other

N/A

## 11. Ratings

| Ratings | ICR | IEG | Reason for Disagreements/Comment |
|---|---|---|---|
| Outcome | Satisfactory | Moderately Satisfactory | Significant implementation inefficiencies, including recurrent |

| | | | |
|---|---|---|---|
| | | | delays in the transfer of funds to counties and high turnover among county officials. |
| Bank Performance | Satisfactory | Satisfactory | |
| Quality of M&E | Substantial | Substantial | |
| Quality of ICR | --- | Substantial | |

## 12. Lessons

The ICR (P. 32) provided lessons that are summarized below:

**Data availability is critical to ensure adequate monitoring of project implementation.** The project faced challenges in measuring indicators, particularly those related to reproductive health. This was due to the design of the indicator, which relied on measuring frequency of visits to health facilities to obtain family planning care. This indicator was designed assuming demand would be mainly for short-term family planning methods. In reality, preferences transitioned to longer-term methods that did not require frequent visits to facilities. In addition, local health facilities still used paper-based systems that did not facilitate the reporting process.

**Implementation of projects in a devolved context raises the level of complexity for project implementation.** The results-based mechanism facilitated project implementation, as it adjusted to the various priorities at the local level. However, challenges remained due to delays in the transfer of funds to counties, as well as weak institutional capacity at the local level to carry out procurement and financial management and to comply with safeguard responsibilities. Staffing in the PMT was not sufficient to support and supervise 47 counties, which had frequent staff turnover.

## 13. Assessment Recommended?

No

## 14. Comments on Quality of ICR

The ICR was results-oriented and well written, providing a clear analysis of the project's achievements and challenges. The theory of change was based on the results framework in the PAD, but it was not consistent with the three objectives under the revised PDO. The theory of change could have included the critical assumptions underlying the results chain. The quality of evidence was largely adequate, with some limitations. The ICR was consistent with the guidelines and internally consistent, with occasional lapses. The ICR did not include an ex-post cost benefit analysis.

### a. Quality of ICR Rating

Substantial