THE WORLD BANK GROUP ARCHIVES

PUBLIC DISCLOSURE AUTHORIZED

Folder Title:	Kenya - Health Rehabilitation Project - Implementation Completion Report / Performance Audit Report File
Folder ID:	1836317
Series:	Completion Reports and Audit Reports
Dates:	1/1/1998 - 12/31/1998
Fonds:	Records of the Office of Operations Evaluation
ISAD Reference Code:	WB IBRD/IDA OPE-06
Digitized:	11/22/2019

To cite materials from this archival folder, please follow the following format:
[Descriptive name of item], [Folder Title], Folder ID [Folder ID], ISAD(G) Reference Code [Reference Code], [Each Level Label as applicable], World Bank Group Archives, Washington, D.C., United States.

The records in this folder were created or received by The World Bank in the course of its business.

The records that were created by the staff of The World Bank are subject to the Bank's copyright.

Please refer to http://www.worldbank.org/terms-of-use-earchives for full copyright terms of use and disclaimers.

THE WORLD BANK
Washington, D.C.

© International Bank for Reconstruction and Development / International Development Association or
The World Bank
1818 H Street NW
Washington DC 20433
Telephone: 202-473-1000
Internet: www.worldbank.org

PUBLIC DISCLOSURE AUTHORIZED

KENYA: Health Rehabilitation Projec
(Cr. 2310-KE)
Implementation Completion Report

Archives
1836317
R2004-092 Other #: 9 Box # 207975B
Kenya - Health Rehabilitation Project - Implementation Completion Report
Performance Audit Report File

DECLASSIFIED
WITH RESTRICTIONS
WBG Archives

Document of
The World Bank

FOR OFFICIAL USE ONLY

DECLASSIFIED
OCT 03 2018
WBG ARCHIVES

Report No.: 18740

IMPLEMENTATION COMPLETION REPORT

KENYA

HEALTH REHABILITATION PROJECT
[Credit No. 2310-KE]

December 23, 1998

Africa Human Development Group 1
Eastern and Southern Africa
Africa Region

This document has a restricted distribution and may be used by recipients only in the performance of their official duties. Its contents may not otherwise be disclosed without World Bank authorization.

CURRENCY EQUIVALENTS

Currency Unit = Kenya Shilling
Appraisal: US$ 1 = KSH 23.0
Project Closing: US$ 1 = KSH 59.7

WEIGHTS AND MEASURES

Metric System

FISCAL YEAR OF BORROWER

July 1 - June 30

ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
CBS	Central Bureau of Statistics
DPD	Department of Policy Planning and Development
GOK	Government of Kenya
HIV	Human Immuno-deficiency Virus
HRSSD	Human Resources and Social Services Department
ICR	Implementation Completion Report
IDA	International Development Association
KNH	Kenyatta National Hospital
MOH	Ministry of Health
MOPW	Ministry of Public Works
MPND	Ministry of Planning and National Development
NAHS	Nairobi Area Health Services
NCC	Nairobi City Council
NHIF	National Health Insurance Fund
PMO	Provincial Medical Officer
SAR	Staff Appraisal Report
SDR	Special Drawing Rights
USAID	United States Agency for International Development
WMS	Welfare Monitoring System

Managers and Staff Responsible	
Vice-President:	Callisto Madavo (AFRVP)
Country Director:	Harold Wackman (AFCO5)
Sector Manager:	Ruth Kagia (AFTH1)
Task Team Leader:	Andrew Follmer (AFTH1)

FOR OFFICIAL USE ONLY

TABLE OF CONTENTS

DECLASSIFIED
OCT 03 2018
WBG ARCHIVES

PREFACE V

EVALUATION SUMMARY I

Introduction i
Project Objectives i
Implementation Experience and Results i
Future Operations and Key Lessons Learned ii

PART I: PROJECT IMPLEMENTATION ASSESSMENT 1

Introduction and Background 1
Project Objectives 1
Achievement of Project Objectives 2
Implementation Experience 3
Major Factors Affecting the Project 7
Project Sustainability 8
Borrower Performance 9
Bank Performance 9
Assessment of Outcome 10
Future Operations 11
Key Lessons Learned 12

PART II: STATISTICAL ANNEXES 14

Table 1a: Summary of Assessments: Health Rehabilitation Project
Table 1b: Summary of Assessments: Kenyatta National Hospital Component
Table 1c: Summary of Assessments: Nairobi Area Health Services Component
Table 1d: Summary of Assessments: Health Planning and Analysis Component
Table 1e: Summary of Assessments: Welfare Monitoring System Component
Table 2: Related Bank Credits
Table 3: Project Timetable
Table 4: Credit Disbursements, Estimated and Actual
Table 5: Key Indicators of Project Implementation
Table 6: Key Indicators for Project Operation
Table 7: Studies Conducted
Table 8: Project Costs - Staff Appraisal Report Estimates and Actual Expenditures
Table 9: Project Financing
Table 10: Status of Legal Covenants
Table 11: Compliance with Operational Manual Statements
Table 12: Bank Resources: Actual Staff Inputs
Table 13: Bank Resources: Missions
Table 14: Out-Patient Utilization of Nairobi Area Health Facilities
Table 15: Kenyatta National Hospital Performance Targets
Table 16a: Ministry of Health Budget: Total Public Health Expenditures
Table 16b: Ministry of Health Budget: Functional Composition of Recurrent Health Budget
Table 16c: Ministry of Health Budget: Economic Composition of Recurrent Health Budget

This document has a restricted distribution and may be used by recipients only in the performance of their official duties. Its contents may not otherwise be disclosed without World Bank authorization.

APPENDICES

Appendix A: Completion Mission's Aide Memoire
Appendix B: Civil Works Report
Appendix C: Borrower's Evaluation Report
Appendix D: Borrower's Comments on Draft ICR
Appendix E: Map of Kenya

This document has a restricted distribution and may be used by recipients only in the performance of their official duties. Its contents may not otherwise be disclosed without World Bank authorization.

IMPLEMENTATION COMPLETION REPORT
KENYA
HEALTH REHABILITATION PROJECT
(Cr. 2310-KE)

PREFACE

This is the Implementation Completion Report (ICR) for the Kenya Health Rehabilitation Project, for which Credit 2310-KE in the amount of SDR 21.6 million (US$31.0 million equivalent at the prevailing exchange rate) was approved on November 14, 1991, and made effective on July 7, 1992.

The credit closed on June 30, 1998, after a one-year extension of the original closing date. The last disbursement was made on December 8, 1998. An undisbursed balance of SDR 1.8 million (US$ 2.5 million at the prevailing exchange rate) will be canceled once refunds due from the Government are received and the accounts closed. A review of Statements of Expenditures indicated that US$175,373 is due to be refunded to IDA by the Government; in addition, US$385,037 was not recovered from the Special Accounts and is due to be refunded to IDA by the Government.

The ICR was prepared by Mr. Andrew Follmer, the Human Development Group I, Eastern and Southern Africa; and was reviewed by Mrs. Ruth Kagia, Sector Manager, AFTH1, and Mr. Harold Wackman, Country Director for Kenya. The borrower reviewed the draft report before it was finalized.

This report was prepared during an ICR mission in September, 1998, comprising Mr. Andrew Follmer (Team Leader), Mr. Dick Coppinger (Civil Engineer, Consultant), Ms. Wacuka Ikua (Operations Officer), Mr. Lucas Ojiambo (Economist), Mr. Dahir Warsame (Procurement Specialist), and Mr. John Ogallo (Financial Management Specialist). The ICR is based on information collected during that mission and on material from the project files.

The borrower contributed to preparation of the ICR by contributing views as reflected in the Completion Mission's Aide Mémoire (Appendix A), by preparing a separate Project Completion Report (Appendix C), and by providing detailed comments on the parts of the ICR as it evolved and formally responding to the draft ICR (Appendix D).

IMPLEMENTATION COMPLETION REPORT
KENYA
HEALTH REHABILITATION PROJECT
(Cr. 2310-KE)

EVALUATION SUMMARY

INTRODUCTION

1. The Government of Kenya (GoK) undertook the Health Rehabilitation Project to reduce public spending on urban hospitals and increase resources devoted to more cost-effective preventive and primary health programs. It sought to encourage continued sector reform and facilitate a reallocation of resources from the curative health care system to preventive and primary services. Further, the inadequate financing of health facilities made the introduction of cost-sharing an urgent need.

2. In addition, a component was added to the project to strengthen the Central Bureau of Statistics' capacity to produce survey results in a timely manner, as well as to strengthen the capacity in the Social Sector Department of the Ministry of Planning and National Development to perform meaningful analysis of the results of such surveys and provide advice, based on that analysis, to MPND and the social sector ministries for policy design.

PROJECT OBJECTIVES

3. The objectives of the Health Rehabilitation Project were: (i) to support the GoK's program of health sector reform by (a) rehabilitating Kenyatta National Hospital to reduce its burden on the overall budget and permit an increase in expenditure on preventive and primary health; (b) improving the delivery of health services in the Nairobi area; and (c) preparing for future policy, managerial, and investment reform in health; and (ii) to support the development of a National Household Welfare Monitoring and Evaluation System. The project objectives proved overly-ambitious, partially due to capacity constraints.

IMPLEMENTATION EXPERIENCE AND RESULTS

4. Overall, the project objectives were partially achieved and the outcome was marginally satisfactory. The project did successfully rehabilitate KNH and enable that institution to achieve its institutional development objectives, but the principal objective of reducing the hospital's burden on the MOH budget was not achieved, primarily because the NAHS component failed to achieve its objective of becoming the principal provider of primary and secondary care in the Nairobi area thus allowing the decongestion of KNH. The objectives of the Health Planning and Analysis component were fulfilled, with a successful user fee program being instituted, significant capacity being developed, and the MOH's Health Sector Reform program benefiting from significant contributions. On the other hand, the WMS component only partially achieved its objectives, with progress in the statistical sub-component being largely unsustainable and the objectives of the analytical sub-component being only partially fulfilled.

5. ***Implementation experience***. The credit was extended by one year as significant improvement in implementation was evident by the original closing date of June 30, 1997. Less than 40 percent of the funds had been disbursed by the original closing date, but the one year extension resulted in disbursement

of an additional 52 percent of credit proceeds. All the civil works under this project proved problematic, suffering from lengthy delays and increased costs. Re-introduction of the MOH's aborted user fees was a condition of effectiveness, and the system was soon cited and continues to be recognized as being among the best in Sub-Saharan Africa. The disbursement of credit proceeds was hampered by weak financial management and a shortage of counterpart funds. Audits were consistently late, and the final review of Statements of Expenditures has uncovered several cases in which expenditures were wrongly claimed from the credit. Subsequently, IDA requested in January, 1999, that US$175,373 be refunded by GOK.

6. ***Major Factors affecting the project***. Factors which were seen to negatively affect the project are: (i) an economic downturn since 1992/93 which led to high inflation and the depreciation of the Kenyan shilling, resulting in cost variations, as well as constraining counterpart funds; (ii) the poor supervision of civil works; (iii) the inordinately slow processing of payment applications; (iv) coordination of the four loosely-related components across multiple institutions proved unworkable, and the MOH lacked the authority to coordinate the various agencies involved in the project; (v) the lack of coordination and consensus under the NAHS component; (vi) the lack of capacity in the MPND to implement IDA projects; (vii) the delays in KNH civil works caused by the hospital being slow in turning over parts of the hospital to the contractor; and (viii) weak procurement capacity.

7. ***Borrower Performance*** was satisfactory during Identification and Preparation, but unsatisfactory at Appraisal, when the GOK's irresolution on the issue of re-instatement of user charges at health facilities indicated a lack of appreciation of and commitment to the recurrent cost implications of the proposed investment. The Government also seemed less willing to address critical issues of sustainability, financial feasibility, and problems with project design. Borrower performance during implementation was unsatisfactory overall. However, except for the problematic issues of late payments which caused significant delays in civil works across the project, supervision of the KNH component and the Health Planning and Analysis component were largely satisfactory. Implementation of the two components requiring inter-Ministry cooperation and supervision was unsatisfactory. This is largely due to the difficulties encountered in supervising and implementing the components across multiple Ministries, and the lack of capacity in the ministries that were paired with the Ministry of Health.

8. ***Bank Performance*** was satisfactory at Identification, when the focus was mainly on KNH. Preparation was satisfactory in the case of the KNH component, but unsatisfactory in the NAHS component, as much of "preparation" was left to take place during implementation. Preparation of the Health Planning and Analysis component was satisfactory, and no WMS component was planned until after Appraisal. At Appraisal, the Bank's performance was unsatisfactory overall, but satisfactory for the KNH and Health Planning and analysis components. During supervision, performance was deficient.

FUTURE OPERATIONS AND KEY LESSONS LEARNED

9. The GOK should complete the civil works at the NCC clinics promptly, and their completion should be a condition of appraisal of the next IDA credit to the health sector. Further, a satisfactory preventive maintenance plan should be developed and effected to ensure the sustainability of the Government and IDA's investment in these clinics. Finally, the Strategic Plan for health services in the Nairobi area should be fully implemented. An aggressive target for reducing KNH's reliance on the MOH budget should be a condition of appraisal for the next IDA credit to the health sector. In addition, the Government should commission a study of whether, and to what degree, the support provided to KNH is an appropriate model for other hospitals undergoing the transition to autonomous institutions. Regarding the WMS component, a Task Force has been established to prepare a Strategic Plan for statistics that will

address the need for strengthening and reform of CBS, with its report expected in April, 1999. This report will form the basis against which donors will be requested to pledge support.

10. A number of key lessons can be drawn from the experience of this project:

(i) *Implementation across Ministries*: Implementation of projects across ministries is difficult, especially when the lines of authority, support arrangements, and expectations of interaction between ministries are not clearly defined.

(ii) *Relevance of Components*: Components that are not consistent with the core purpose of a project should not be added for reasons of expediency rather than relevance, especially if additional ministries would become involved.

(iii) *Inter-dependence of Components*: When the ability of one component to achieve its objectives is dependent on the success of another component, the relationship between the components must be carefully considered at appraisal and throughout implementation, with particular attention to (i) timing of activities in one component relative to those in the other, (ii) relative degrees of preparation, (iii) relative levels of capacity, (iv) susceptibility of each component to risks relative to the other.

(iv) *Closing Dates*: Decisions with regard to whether to grant project extensions should be made sufficiently in advance to allow for continuity of activities and maximum utility of the extension. Activities likely to extend beyond the closing date should not be approved prior to the official extension of a project.

(v) *Procurement Capacity*: Procurement capacity should be thoroughly assessed at appraisal, and provisions made at that time to address any inadequacies in capacity. The use of an independent, external procurement agent can contribute to successful implementation through facilitating procurement and building capacity.

(vi) *Importance of Close Monitoring and Supervision*: The experience of this project clearly demonstrates the direct relationship between intensified implementation support and implementation effectiveness. The achievements of the final year of implementation and the improved relationship with the Borrower are largely due to intensified supervision by IDA.

(vii) *Counterpart Funds and Financial Management*: A further rationalization of the GoK's portfolio of projects, consistent with the Bank's CAS, is required, as evidenced by the implementation delays caused by the unavailability of the required GoK counterpart funding. In addition, strengthened financial management and the introduction of accountability measures are necessary to avoid repeated implementation delays.

IMPLEMENTATION COMPLETION REPORT
KENYA
HEALTH REHABILITATION PROJECT
(Cr. 2310-KE)

PART I: PROJECT IMPLEMENTATION ASSESSMENT

INTRODUCTION AND BACKGROUND

1. The Government of Kenya (GoK) undertook the Health Rehabilitation Project to reduce public spending on urban hospitals and increase resources devoted to more cost-effective preventive and primary health programs. By the start of the project, recurrent expenditures were increasingly constrained by an MOH budget which was consumed to a growing degree by capital expenditures (from 13.2 percent of MOH budget in 1985 to 27.6 percent in 1990).[1]

2. Kenyatta National Hospital (KNH), Kenya's largest hospital (1,500 beds) and the national teaching and referral hospital, transferred from MOH control to being incorporated as a parastatal in 1987. Demand for services exceeded the hospital's capacity by the late 1980s, with most services being for primary and secondary care, and only a limited percentage representing its principal tertiary function. Service volume increased rapidly as occupancy exceeded 100 percent and outpatient visits rose 34 percent between 1987 and 1989. Quality declined with shortages of drugs and supplies, long delays in diagnosis, and deteriorating physical conditions. These problems were compounded by over-congestion of KNH due to the under-utilization of other, less-costly Nairobi-area health facilities (Table 14). Lower-level health facilities operated inefficiently and failed to fulfill their necessary role in the health service delivery system as the main providers of primary and secondary care. Furthermore, the inadequate financing of health facilities made the introduction of cost-sharing an urgent need.

3. In addition, the Central Bureau of Statistics, while it had conducted household surveys at irregular intervals, lacked capacity to produce survey results in a timely manner. Furthermore, the Social Sector Department of the Ministry of Planning and National Development lacked the capacity to perform meaningful analysis of the results of such surveys and provide advice, based on that analysis, to MPND and the social sector ministries for policy design.

PROJECT OBJECTIVES

4. The objectives of the Health Rehabilitation Project were: (i) to support the GOK's program of health sector reform by (a) rehabilitating Kenyatta National Hospital to reduce its burden on the overall budget and permit an increase in expenditure on preventive and primary health; (b) improving the delivery of health services in the Nairobi area; and (c) preparing for future policy, managerial, and investment reform in health; and (ii) to support the development of a National Household Welfare Monitoring and Evaluation System.

---

[1] Staff Appraisal Report (SAR)

5. The project was designed to achieve these objectives through implementation of the following components:

a) ***Kenyatta National Hospital (US$19.6 million)***: The physical rehabilitation and institutional development of the hospital included (i) civil works to upgrade and rehabilitate existing buildings and facilities; (ii) financing medical and non-medical equipment, beds, and vehicles; (iii) financing HIV/AIDS-related supplies; (iv) training of managers and technicians; and (v) technical assistance and computers to strengthen the management of finance, personnel, procurement. It was hoped that this would equip the hospital to become autonomous and more financially self-sustaining.

b) ***Nairobi Area Health Services (US$4.2 million)***: This component was designed to overcome inadequacies at lower-level Nairobi facilities and the absence of a functioning referral system. Project elements included (i) technical assistance to develop a strategic plan for the Nairobi area, with modest funding for its initial implementation; and (ii) rehabilitation and construction, equipment, training, and technical assistance to meet priority needs at selected Nairobi City Council (NCC) and MOH facilities and achieve interim improvements in service delivery.

c) ***Strengthening Health Planning and Analysis and Preparing Sector Reform (US$ 3.0 million)***: Project elements included (i) technical assistance, staff training, computers and office equipment for the Division of Planning and Development; and (ii) analytical studies and technical assistance to prepare a reform program and a public investment program for the health sector.

d) ***Developing a National Household Welfare Monitoring and Evaluation System (US$2.0 million)***: This component was to be implemented by the Ministry of Planning and National Development (MPND) and included strengthening the district-level Central Bureau of Statistics (CBS) office network and the Social Sector Department through (i) technical assistance and training in data processing and analysis; and (ii) computers, vehicles and office equipment.

6. *Evaluation of Project Objectives*. The objectives of the project were appropriate and responsive to the country's needs in the health sector, though slightly vague and made somewhat disjointed by the addition of the Welfare Monitoring System component. The latter became more evident during implementation when this component proved difficult to coordinate and supervise through the Ministry of Health. Though consistent with the Bank's CAS and the Government of Kenya's objectives for the sector at the time, the project objectives proved overly-ambitious, partially due to capacity constraints which were not adequately identified as risks in the SAR.

ACHIEVEMENT OF PROJECT OBJECTIVES

7. The design of the project was overly-complex in its implementation arrangements, and resembled four loosely-related sub-projects with varying success in realizing their respective objectives. Since the Bank's practice at the time of preparation did not require the inclusion of monitorable indicators in the SAR, supervision missions' ability to gauge and guide the progress of the project was hampered; in contrast, the KNH component did include such indicators, and the quality of supervision was subsequently better.

8. *Kenyatta National Hospital*: Despite substantial delays, the hospital was successfully rehabilitated, with very positive impact in the form of improved quality of care and improved management (Table 15). While institutional development objectives were largely achieved, the failure of the NAHS component to achieve its objectives made the decongestion of KNH impossible; in fact, the improved

services at KNH attracted an increased number of patients (Table 14). Therefore, it was impossible for KNH to abandon primary and secondary care. Since cost-sharing fees--though higher at KNH than at other facilities--do not provide for full cost recovery, the hospital's burden on the MOH budget was not reduced. Nevertheless, the MOH did manage to significantly increase the share of funds spent on preventive and promotive health services from 15 percent of the MOH budget at effectiveness to 28 percent in 1997-98[2], with most of this increase being attributable to incremental increases in the MOH's total budget in recent years.

9. *Nairobi Area Health Services (NAHS)*: The NAHS component was not as extensively prepared as the KNH component. The lack of a strategy for achievement of objectives left much of "preparation" to take place during implementation. The result was that insufficient progress was made to enable the Nairobi area health facilities to become the principal providers of primary and secondary care and allow KNH to focus on its principal tertiary and teaching functions. There are tentative indications that the increased physical, human, and financial resources now available might enable the objectives of this component to be partially achieved in the future.

10. *Health Planning and Analysis*: This component fulfilled its objectives. The highly-successful user fee program is a model for other countries. The Department of Planning and Development (now renamed the Department of Policy, Planning and Development) was strengthened through the implementation of recommendations made by IDA supervision missions. Significant capacity was developed through the training component, and the studies financed by the project contributed to the preparation of the *Health Policy Framework Paper (1994)*, the basis for Government's program of health policy and health financing reforms. Though the implementation of this program has been slow, the project's objective of contributing to the preparation of the Health Sector Reform program can be viewed as almost fully achieved.

11. *Welfare Monitoring System*: This component also only partially achieved its objectives. The statistical sub-component provided the physical and capacity-building inputs necessary to strengthen CBS's capacity to generate useful data and improve the quality of the data delivered, despite implementation difficulties, weaknesses in the timeliness of delivery, and declining capacity. However, the objective of the analytical sub-component to strengthen the capacity of HRSSD to provide meaningful analysis of these statistical outputs was only partially fulfilled.

IMPLEMENTATION EXPERIENCE

12. The implementation progress of this project was largely unsatisfactory up to the Mid-Term Review, beginning with the Government's delay in fulfilling the condition of effectiveness requiring the reintroduction of user fees. More aggressive restructuring of the project seems to have been warranted at the mid-term review, particularly with regard to the KNH and NAHS components. Nonetheless, implementation did begin to improve about a year later in 1995.

13. **Disbursements and Financial Management**. Disbursements data show that, after an initial lag, most activities fell even further behind. Less than 40 percent of the funds had been disbursed by the original closing date. Due to the progress in procurement, MOH's efforts to address the payment backlog, and intensified supervision by IDA, the one year extension resulted in disbursement of an additional 52 percent of credit proceeds. Delays on the part of the Government in processing payment applications (PAs) were a significant factor in implementation delays. Though it remains a serious problem, the final few

[2] Ministry of Health, Republic of Kenya

months of implementation did benefit from some improvement in this regard: a PA Tracking System was introduced in late 1997, accompanied by an limited reduction in the number of steps in the PA process. Streamlined payment procedures and the introduction of accountability measures will be necessary for the successful implementation of any future IDA credit to the health sector.

14. In addition to the unnecessarily complicated payment process, financial management within the Project was weak. The Ministry relied on IDA to monitor expenditures and commitments *vis-a-vis* the category allocations and total credit amount. Basic accounts information for the project required an inordinate amount of time to produce, and the Ministry had difficulty processing payments under the credit within the four-month disbursements grace period after project closing because planned expenditures had not been sufficiently provided for in the budget and the necessary Authority to Incur Expenditures (AIEs) had not been obtained. Audit performance improved over the life of the project. Though the majority of the audits were unqualified, they were consistently late. Finally, a review of Statements of Expenditure has indicated several cases under both MOH and MPND in which expenditures totaling US$175,373 were wrongly claimed from the credit and are to be refunded to IDA.

15. **Government Contribution**. The SAR estimated GoK contribution to this project of 10.1 percent of total project costs; however, actual GoK contribution was only 7.4 percent (Table 8b). The required counterpart funds were frequently unavailable, and the Government's inability to finance the recurrent costs led to situations in which implementation was stymied by the implementing agencies' inability to finance basic operating expenditures such as photocopies and fuel. IDA amended the Development Credit Agreement in November, 1997, to allow for financing of incremental operational costs from the credit proceeds.

16. **Procurement**. There was limited procurement of goods under this credit during the original project life. The one major tender (KNH Medical Equipment) that had proceeded to evaluation was canceled. It was agreed during the February 1997 supervision mission that GTZ would be contracted as the procurement agent for all ongoing and future procurements. The impact of this decision was an easing of the procurement bottleneck, as a detailed procurement plan was developed and seven tenders were successfully floated, with contracts awarded totaling US$6.2 million. The medical and other equipment procured made it possible for the project to close with its development objectives fulfilled to a much greater degree.

17. **User Fees**. Throughout project preparation, a major focus of the Bank was on the re-introduction of user fees in Kenya's health sector. Introduced in 1987, they were rescinded by the Government two years later due to public opposition. The Bank worked with the GoK throughout preparation to ensure that these fees could be re-introduced without the disorganization and poor management that had plagued their 1987 introduction, and funds were re-allocated from the IDA-financed Third Population Project to finance a public awareness campaign. Re-introduction was a condition of effectiveness, and the system was soon cited as being among the best in Sub-Saharan Africa. It has generated significant funds which have been invaluable in enabling health facilities to withstand the current fiscal crisis and shrinking of the health sector budget. Collections have risen from less than KSH 100 million in the first year to an estimated KSH 400 million in 1997-98 (excluding KNH), and measures recently enacted to streamline and strengthen internal controls on the collection, accounting, and use of these revenues are expected to lead to further increased collections in the current year.

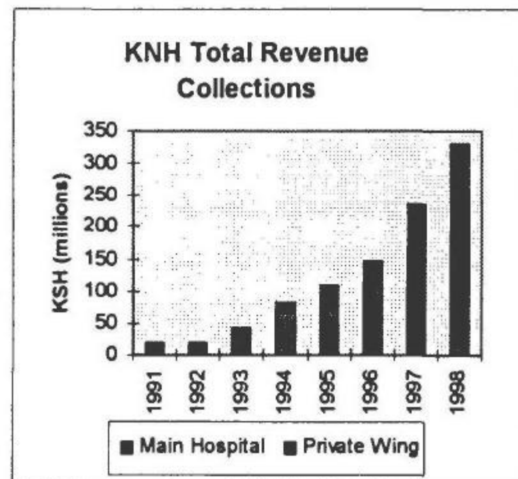
18. **Civil Works.** All the civil works under this project proved problematic. The performance of both MOPW in the implementation of civil works at KNH and of the NCC in implementation of their civil works were ineffective. MOPW project management structure and administrative processing procedures

were cumbersome, and personnel frequently changed. Communications between the implementing agency and the MOPW were virtually non-existent, and the resources of MOPW for supervision of works was limited. This resulted in the dilution of responsibilities which was manifested in poor results. During the extension of the project, the situation improved with increasing progress noted by supervision missions. This was apparently due to (i) intensified supervision and cooperation by the hospital; and (ii) intensified supervision by IDA supervision missions and field staff. The supervision by NCC of the civil works at their clinics was poor, and the contractors were largely unsupervised. In addition, civil works across the project were consistently plagued by late payments to contractors. This caused lengthy delays and increased costs. An accounting of the reasons for the inordinate delay in the completion of these works, and the subsequent 30 percent cost overrun at KNH, can be found in Appendix B.

19. **Extension of Closing Date**: By the original closing date of June 30, 1997, significant improvement was evident, though it was questionable at the time whether a one-year extension would result in significantly greater achievement of the project's development objectives. The results clearly demonstrate that granting the extension proved to be the right decision. A renewed commitment on the part of both implementing agencies and the Bank, aided in procurement matters by the impressive performance of the recently-hired procurement agent, are the major factors behind this dramatic improvement in the final year of implementation.

Kenyatta National Hospital:

20. The main areas in which major improvements are attributable to the project are: (i) improvement in clinical efficiency and capacity: the training program financed by this project significantly augmented clinical capacity, and KNH has been able to retain staff after they return from training; (ii) management: the training program also greatly enhanced managerial capacity within the institution; (iii) financial sustainability: while the hospital's share of health budget rose from 12.8 percent in 1992 to 16.9 percent in 1998, it has demonstrated a capacity to generate significant revenues and there is evidence that this level of MOH financing is not necessary. KNH's private wing succeeded in becoming self-sustaining, largely due to the project's investment, and it has generated a surplus since 1994. While this department consumes only 9 percent of the hospital's budget, it currently contributes 40 percent of hospital revenues -- a figure likely to increase given the recent expansion of the wing.



Source: Kenyatta National Hospital

21. KNH's reliance on the Ministry of Health budget was not reduced; in fact, KNH's allocation as a share of the MOH budget actually increased during the project. While the major cause for this was the failure to decongest KNH, part of the reason may be the manner in which the funds are allocated. The KNH share of the MOH budget decreased from 16.4 percent in 1995/96 to 15.1 percent in 1996/97. The budget for the last year of the project provided for a further decreased share to KNH. However, since the KNH budget is negotiated separately with Treasury without the involvement of MOH, it was not subject to the same decreases experienced by the MOH due to the Government's fiscal constraints. Subsequently the KNH grant comprised a larger share of the MOH budget than originally planned. This might be addressed by removing the KNH budget from its protected position by involving the MOH in the negotiation of the KNH budget and capping it as a percentage of the MOH budget.

22. In addition, the following factors are expected to further increase the hospital's capacity for revenue generation: (i) a pending fee increase, currently under review by the hospital board; (ii) the project-financed expansion of the private wing; and (iii) the leasing of recently-completed, project-financed private doctor's offices. The latter comprises a complex of 57 offices, a pharmacy, and a laboratory. While the current annual revenue approaches KSH 5 million, there is potential for significantly greater revenue generation, as the current rents charged appear to be significantly below market rates. This should be addressed during the annual review of these charges. Finally, while the financial objectives of the KNH component were not fully achieved, the experience of this component and the potential for realization of those objectives in the future indicate that the design was sound.

Nairobi Area Health Services

23. The NAHS component produced a satisfactory strategic plan for Nairobi Area at the outset, as scheduled. However, there were unrealistic expectations at the pace of change that could be expected at NCC clinics (and thus the pace of decongestion at KNH) after the formulation of this strategic plan. Due to insufficient cooperation between NCC and MOH, the commitment to implement the NAHS component developed only gradually. These delays were partially attributable to the fact that the Ministry of Local Government and relevant local authorities had not been involved during project preparation, though their support was necessary for successful implementation. Approximately a year before the original closing date, an implementation proposal was finally prepared and approved by the Bank. Despite clear guidelines in the plan, services throughout the area only marginally improved, and shortages of drugs, staff and supplies led to lack of service available at NCC clinics.

24. With an original closing date of June 30, 1997, contracts for the rehabilitation of 14 of the 46 NCC clinics under this component were awarded in November, 1996 -- with an estimated completion time of 6-7 months. Given that it was uncertain at that time whether the project would be extended, and given the problematic history of civil works in Kenya projects, the Bank should not have given "no objection" for the award of these contracts. Even with the one-year extension, works at many of the sites remained incomplete at project closing, with three clinics still closed and several more only partially operational (Appendix B). NCC has informed IDA that it is completing all the works using its own funds, and that all the clinics will be fully operational by January 1, 1999. Though work has continued since project closing and some progress is evident, the history of these works indicates that this is unlikely. Supervision of these works by NCC has been inadequate.

25. The PMO-Nairobi has responsibility for secondary/hospital-based services in the Nairobi area (except KNH), and it was envisioned that the project would finance the conversion of three facilities to serve as provincial and district hospitals for Nairobi. The mid-term review re-allocated US$4.5 million from KNH to the NAHS component to complete and upgrade three hospitals, though delays in preparing the proposals for these activities led to their cancellation at the time of the extension. However, despite the fact that it also received project support only in the form of equipment, one facility -- Mbagathi Hospital, formerly an infectious disease facility that was part of KNH -- was opened as a district hospital for the Nairobi area.

Health Planning and Policy

26. This project was intended to create an enabling environment for decentralization and health sector reform. Support was provided to develop plans for decentralization of fiscal responsibilities, which was then to be piloted under the Kenya STI Project (Cr. 2686). The project also facilitated the development of the "Health Policy Framework Paper (1994)" which has become the guiding document for the current

Health Sector Reform Program. Numerous other studies were prepared under the credit which further helped establish a strong foundation for the reform program, these are detailed in Table 7. In addition, numerous activities were financed during the last 18 months of the project to support the nascent Health Sector Reform program: (i) special studies and pilot tests on resource needs leading to the preparation of business plans for four district hospitals in preparation for the piloting of the Ministry's Hospital Autonomy Concept in district hospitals; (ii) support to the Health Sector Reform Secretariat in the form of vehicles, equipment, and operations and maintenance support.

27. The capacity of the Division of Planning and Development was strengthened through the (i) provision of technical assistance; (ii) local and international training for staff; and (iii) the procurement of computer hardware and software. To strengthen the planning function of the Ministry, supervision missions repeatedly urged that the Planning Unit of MOH be headed by a Chief Economist. This was adopted, and the position is currently held by a Deputy Chief Economist. However, the recommendation that the MOH hire its own economists who would identify with the Ministry, has not been implemented. Thus, all economists still belong to the Ministry of Planning and are subject to frequent turnover.

Welfare Monitoring System Component

28. Following effectiveness, the component experienced problems in accessing and utilizing project funds. This appears to be largely due to delays in decision-making and payment processing, but also due to the fact that neither the Human Resources and Social Services Department (HRSSD) nor CBS had any experience with IDA projects. Despite their lack of familiarity with IDA rules and procedures being cited repeatedly in the Aide Memoires of the WMS supervision missions, sufficient action was not taken by the GOK or the Bank. In addition, the rapid turnover of staff and loss of experienced staff within CBS resulted in declining capacity and created systemic problems. Despite these constraints, CBS conducted three welfare monitoring surveys. This component provided the household data for the Bank's 1995 Kenya Poverty Assessment, and the data was instrumental in the preparation of the Poverty Profile for Kenya. In addition, other reports based on this data have contributed to the national debate on poverty.

29. The analytical sub-component received substantial parallel financing from GTZ, with that agency financing a long-term social policy advisor, a budget to support some of the analytical activities detailed in the SAR, and substantial training. HRSSD successfully conducted a Participatory Poverty Assessment that has been a model for other such assessments in Africa. On the other hand, five studies were planned to be financed by the Bank, but satisfactory TORs had not been completed by the original project closing date, and these activities were canceled at that time.

MAJOR FACTORS AFFECTING THE PROJECT

Factors Beyond the Government's Control

30. Factors which lay outside the control of the Government of Kenya that were seen to have a significant, negative effect on project implementation were: (i) an economic downturn since 1992/93 which led to high inflation and the depreciation of the Kenyan shilling, resulting in cost variations, as well as constraining counterpart funds; (ii) the poor performance of the original civil works contractors at KNH, leading to the appointment of MOPW to supervise the works, and (iii) delays related to the Bank's internal re-organization in 1996 (see *Bank Performance*).

Factors Under the Government's Control

31. Implementation of this project was seriously hampered by numerous factors which were within the control of the Government. Perhaps the most significant of these was the inordinately slow processing of payment applications. Other factors include: (i) coordination of the four loosely-related components across multiple institutions proved unworkable, and the MOH lacked the authority to coordinate the various agencies involved; (ii) the poor performance of the MOPW in supervising the KNH civil works, once responsibility for this supervision was shifted to that Ministry; and (iii) the lack of coordination and consensus under the NAHS component.

Factors Under the Implementing Agency's Control

32. Finally, under the control of the implementing agency were other detrimental factors: (i) though the slow payments were partially attributable to the Ministry of Finance, the MOH's own processes and inefficiency contributed to the delays; (ii) the lack of capacity in the MPND to implement IDA projects was not adequately addressed by the Government (or IDA) despite being repeatedly mentioned in supervision missions' Aide Memoires; (iii) inadequate supervision by NCC of the civil works at NCC clinics; (iv) the delays in KNH civil works caused by the hospital being slow in turning over parts of the hospital to the contractor; (v) weak procurement capacity, with the Ministry showing a weak commitment to address this deficiency; and (vi) weak implementation capacity in MOH and NCC.

PROJECT SUSTAINABILITY

33. The outlook for project sustainability is uncertain. In the KNH component, it is likely that the ongoing strengthening of capacity and hospital systems will result in continued improvement in the hospital's performance indicators. The expected increases in revenue generation and the fair prospects for NCC facilities to take at least some of the primary care burden off KNH indicates that congestion should at least stop worsening, and may improve partially. The hospital has prepared a preventive maintenance program that is expected to be implemented by the end of the year which should contribute to the sustainability of the investment in physical rehabilitation. In addition, the project-financed experience of KNH is making the transition to an autonomous institution is serving as a model for the transition to autonomy at Coast General Hospital in Mombasa and the Eldoret National Referral and Teaching Hospital. Applying this experience more broadly to the transition of Provincial hospitals to autonomy might be addressed in the context of the Health Sector Reform Program.

34. The prospects for sustainability of investments under the NAHS component are less certain, as it is yet unclear when the remaining civil works will be complete and all the facilities fully operational. Proposed increases in user fees and recent changes mandating that 100 percent of user fees be maintained by the facilities increase the chances for proper maintenance of the investment. NCC has assured the Bank that a preventive maintenance plan will be developed and implemented by January 1, 1999, though work on this has yet to begin. It is feared that staffing problems may continue despite recent hiring of large numbers of doctors and nurses as there is little evidence that traditional problems of disorganized management and ineffective utilization of staff have been addressed. In addition, the lack of any formal procurement mechanism for drugs implies that adequate funding alone will be insufficient to ensure a steady and reliable supply of drugs to NCC facilities, without which decongestion of KNH is unlikely.

35. The outlook for sustainability of the Health Planning and Analysis component is largely reflected in the progress of the country's Health Sector Reform program. Though implementation of the program is

disappointingly slow, it is progressing and is expected to result in a new IDA Health Sector Development Credit once sufficient progress is made in the implementation of preparatory activities.

36. Finally, sustainability of the WMS component is unlikely. There is an urgent need to improve the CBS's data systems and to improve the quality and timeliness of sectoral statistical systems and statistical reporting. However, the statistical system as currently structured and resourced is incapable of meeting these demands. Donor support has been channeled to ad-hoc donor-driven activities, instead of focusing support on resolving underlying systemic and structural problems, which have worsened. Until these issues are addressed, further ad-hoc support is unlikely to yield any useful long-term benefits.

BORROWER PERFORMANCE

37. *Identification and Preparation* was satisfactory in the Borrower's cognizance of the critical issues to be addressed and an expressed political will to institute the necessary reforms; however preparation was hampered due to capacity constraints, a lack of internal consultation, and a lack of experience with Bank projects in the sector. At *Appraisal*, the Borrower's performance was not satisfactory. The Government's irresolution on the issue of re-instatement of user charges at health facilities indicated a lack of appreciation of and commitment to the recurrent cost implications of the proposed investment, and this endangered the progress of the project. Regarding the KNH component, the hospital overestimated the speed with which they would turn over sections of a hospital to the contractor for rehabilitation.

38. During *Implementation*, Borrower performance was mixed. Except for the issue of late payments which caused significant delays in civil works across the project, implementation of the KNH component and the Health Planning and Analysis component was largely satisfactory. Implementation of the two components requiring inter-Ministry cooperation was unsatisfactory. This is largely due to the difficulties encountered in implementing the components across multiple Ministries, and the lack of capacity in the ministries that were paired with the Ministry of Health. Performance across all components improved significantly in the final year of the project.

BANK PERFORMANCE

39. ***Identification and Preparation***. *Project Identification* focused mainly on KNH, and successfully identified the critical issues and areas in which IDA-financed intervention was necessary and appropriate. *Project Preparation* was satisfactory for the KNH component. The Bank preparation team prepared extensive analysis of the situation at KNH, complemented by additional work done by USAID, which evolved into a well-designed component. Preparation of the NAHS component was unsatisfactory, as much of "preparation" was left to take place during implementation. Preparation of the Health Planning and Analysis component was satisfactory, and no WMS component was planned at this stage.

40. ***Project Appraisal*** The Bank's performance at this stage was unsatisfactory overall, but merits examination by component:

a. *KNH Component*: Appraisal was marginally satisfactory in the case of this component, with most relevant risks being identified. One significant risk that was not addressed was the risk of having the success of the KNH component partially contingent on an NAHS component which was hampered by numerous risks. In addition, the performance targets proved unrealistic.

b. *NAHS Component*: In this case, appraisal was not satisfactory. The only risk identified was the weak political consensus among the relevant actors, and this was not given sufficient attention as evidenced by the fact that the Ministry for Local Government (since renamed Ministry of Local Authorities) was not involved. In addition, the SAR failed to identify as risks (i) the lack of capacity in NCC to implement the project and supervise the activities to be financed, and (ii) the unclear implementation arrangement across ministries which both suffered from weak capacity.

c. *Health Planning and Analysis Component*: Appraisal of the Health Planning and Analysis Component was satisfactory.

d. *WMS Component*: Appraisal of this component was not satisfactory. The appraisal mission took place after the project had been negotiated. Though there had been two previous missions by the Bank's Statistical unit, this project's managing unit was not involved, and it was treated from the beginning as a detached project. Neither the risks of this approach nor the risk posed by the unclear implementation arrangement across ministries that both suffered from weak capacity were addressed.

41. ***Supervision***. Bank performance at this stage was deficient. The project documentation indicates much less-intensive follow-up by the Bank and less in-depth scrutiny of critical issues and problems than during preparation. The quality of supervision was mixed. With regards to the KNH component, supervision was largely satisfactory. Supervision was also satisfactory for the Health Planning and Analysis component. However, for the NAHS component, supervision was unsatisfactory. Throughout supervision, the WMS component was treated as a separate project, with separate supervision missions -- only one paragraph in the Mid Term Review is dedicated to this component. This resulted in the component receiving insufficient support from the MOH, as the main implementing agency, and the World Bank's task team. Fragmented responsibility and accountability on the part of the Bank contributed to the implementing agencies' lack of familiarity with IDA procedures and an inability to operate in accordance with them.

42. Overall, the Bank was overly optimistic in assigning project ratings until the last two years of the project. The Borrower also indicated that the Africa Region's 1996 re-organization had a negative effect on the project, with the quality of supervision and responsiveness by IDA greatly decreased during the one-year following the re-organization. The Borrower was dissatisfied with the confusion and uncertainty over the project extension, with a decision not being made until two days before the scheduled closing date. Supervision of all components improved significantly after the naming of a new task team for the one-year extension period, as evidenced in increased Borrower satisfaction and dramatic improvements in implementation. Notably, intensified supervision was achieved without increased resources for supervision due to an increased reliance on field office and operations staff for non-technical aspects of supervision.

ASSESSMENT OF OUTCOME

43. Overall, the project's outcome was marginally satisfactory, with the improved performance of both the Borrower and the Bank in the final year ameliorating the unsatisfactory outcome that would have resulted had the project closed on the original closing date. While the *KNH component* failed to achieve its main objective of reducing KNH's burden on the MOH budget, the investment and implementation experience of this component has reversed the contentious nature of issues regarding hospital autonomy and the authority to generate and retain revenues from cost sharing. The GoK is now ready to repeat this experience by granting autonomy to additional hospitals. The existence of a national teaching hospital that

has become autonomous, generates a substantial percentage of its recurrent expenditures from cost sharing, and at the same time has managed to improve the quality of care, is unique in the region.

44. The outcome of the *NAHS component* was clearly unsatisfactory, with the development objectives not being achieved, uncertain prospects for sustainability, and the civil works comprising the main activity under this component being unfinished. The objectives of the *Health Planning and Analysis component* were largely achieved, and its outcome can be rated satisfactory. Finally, the *Welfare Monitoring System component*, despite the objectives of the statistical sub-component being substantially fulfilled, had an unsatisfactory outcome due to the poor prospects for sustainability and the partially unrealized objectives of the analytical sub-component. Given that most of the project activities and procurement were completed so near the project closing, these assessments are largely based on preliminary indications of impact. Therefore, it is strongly recommended that an impact evaluation study be conducted approximately 12 months following the publication of this report.

FUTURE OPERATIONS

45. First, the Government should complete the civil works at the NCC clinics, and their completion should be a condition of appraisal of the next IDA credit to the health sector. Second, a satisfactory preventive maintenance plan should be developed and effected, as has been done at KNH, to ensure sustainability of the Government and IDA's investment in these clinics. Finally, the Strategic Plan for health services in the Nairobi area should be implemented. The Health Sector Reform Program should include comprehensive provisions to address the deficiencies in the management and operation of these facilities. While the planned piloting of contracts with private firms to operate rehabilitated clinics presents a feasible option that might later be expanded, an interim solution should be enacted, such as transferring responsibility and resources for these facilities to the MOH, or at least increasing the MOH's authority over these facilities.

46. While it is important that KNH be assured of the resources necessary to sustain the project's investment and the resulting progress, its share of health budget resources is disproportionately large. Considering its demonstrated (and growing) ability to generate revenue, sharp reductions in the MOH grant to KNH are warranted. An aggressive target in this regard should be a condition of the proposed IDA Health Sector Development Credit. In addition, the Government should commission a study of whether, and to what degree, the support provided to KNH is an appropriate model for other hospitals undergoing the transition to autonomous institutions. Considering that it is already being used as a model for two such transitions, this study should be implemented promptly as a preparatory activity for the Health Sector Reform Program. With regard to the latter, the inputs financed under this project are becoming dated due to the slow pace of the reforms program, and the sustainability of this investment requires the MOH to intensify its commitment to advancing the implementation of that program.

47. A Task Force--comprising Ministry of Finance, Central Bank of Kenya and MPND--was established in April, 1998, to prepare a Strategic Plan for statistics to articulate goals for the statistical system for next decade, the outputs and services that it would be expected to deliver in order to achieve these goals, and the resources and means by which they would be delivered. This Task Force will address the need for strengthening and reform of CBS, with its report expected in April, 1999. This report will the basis against which donors will be requested to pledge support.

KEY LESSONS LEARNED

48. A number of key lessons can be drawn from the experience of this project:

(i) *Implementation across Ministries*: Implementation of projects across ministries is difficult, especially when the lines of authority, support arrangements, and expectations of interaction between ministries are not clearly defined.

(ii) *Relevance of Components*: Components that are not consistent with the core purpose of a project should not be added for reasons of expediency rather than relevance, especially if additional ministries would become involved.

(iii) *Inter-dependence of Components*: When the ability of one component to achieve its objectives is dependent on the success of another component, the relationship between the components must be considered at appraisal and throughout implementation, with particular attention to (i) timing of activities in one component relative to those in the other, (ii) relative degrees of preparation, (iii) relative levels of capacity, (iv) susceptibility of each component to risks relative to the other.

(iv) *Closing Dates*: Decisions to extend projects should be made sufficiently in advance to allow for continuity of activities and maximum utility of the extension. Activities likely to extend beyond the closing date should not be approved prior to the official extension of a project.

(v) *Stakeholder Consultation*: Key stakeholders, particularly those with an important role in implementation, should be involved from project identification, through preparation and appraisal, and throughout implementation.

(vi) *Monitorable Indicators*: Clear performance indicators should be agreed upon at appraisal to ensure effective and timely implementation, and to enable proper monitoring. Annual Workplans/ implementation plans also contribute to the depth and quality of supervision.

(vii) *Procurement Capacity*: Procurement capacity should be thoroughly assessed at appraisal, and provisions made at that time to address any inadequacies in capacity. The use of an independent, external procurement agent can contribute to successful implementation through facilitating procurement and building capacity.

(viii) *Importance of Close Monitoring and Supervision*: The experience of this project clearly illustrates the relationship between intensified supervision and implementation progress. The impressive achievements of the final year of implementation and the improved relationship with the Borrower are largely due to intensified supervision by IDA.

(ix) *Counterpart Funds and Financial Management*: A further rationalization of the GoK's portfolio of projects, consistent with the Bank's CAS, is required, as evidenced by the implementation delays caused by the unavailability of the required GoK counterpart funding. In addition, strengthened financial management and the introduction of accountability measures are necessary to avoid repeated implementation delays.

Box: 1: Health Rehabilitation Project Positively Impacts KNH's Ability to Handle Bomb Blast Crisis

On August 7, 1998, a terrorist bomb exploded in downtown Nairobi, killing 253 people and injuring more than 5,000 others. This placed an enormous strain on Nairobi-area health facilities as victims, with varying degree of injuries, arrived hundreds at a time requiring emergency medical treatment. As the largest of Kenya's hospitals, KNH treated the greatest number of victims. On the day of the bombing, 1,500 people arrived at KNH, with 341 ultimately being admitted and 1,159 being treated and released.

World Bank Health staff had the opportunity to witness how the hospital and its staff handled the crisis. Though the hospital was initially overwhelmed by the massive influx of injured, an impressive triage system was in place within the hour, and hospital staff were seen to be functioning in an efficient and organized manner. The capacity of the hospital and the staff to manage the crisis so effectively was partially credited to the impact of the physical rehabilitation and institutional development financed by the Health Rehabilitation Project. Ministry of Health and KNH officials cited the following areas as those in which the project-financed activities had the greatest impact on their ability to handle the crisis:

- *Casualty (Emergency) Ward*: The civil works under the project had replaced a small, poorly-equipped casualty ward with a larger, better-equipped and more efficiently-designed ward and outpatient clinics. As this was the point of entry for the injured, this improvement was viewed as pivotal in KNH's successful management of the crisis.

- *Training*: The Borrower's Evaluation Report cited the training of staff as one of the project activities having the most positive impact on the facility. The increased capacity resulting from the large volume of training (particularly in emergency and trauma medicine) financed under the project was credited with providing crucial staff with the technical and management skills necessary to handle the crisis.

- *Equipment*: Most of the equipment procured under the project had been delivered to the hospital during the weeks immediately prior to the bombing, and some of the equipment proved invaluable to staff provide better care to a greater number of patients.

PART II: STATISTICAL ANNEXES

Kenya
Health Rehabilitation Project
Table 1a: Summary of Assessments

	Substantial	Partial	Negligible	Not applicable
A. Achievement of objectives				
macro policies				X
sector policies	X			
financial objectives		X		
institutional development		X		
physical objectives		X		
poverty reduction				X
gender issues				X
other social objectives		X		
environmental objectives				X
public sector management		X		
private sector development				X
	Likely	**Unlikely**	**Uncertain**	
B. Project sustainability			X	
	Highly satisfactory	**Satisfactory**	**Deficient**	**Highly unsatisfactory**
C. Bank performance				
identification		X		
preparation assistance		X		
appraisal			X	
supervision			X	
D. Borrower performance				
preparation		X		
implementation			X	
covenant compliance		X		
operation		X		
E. Assessment of outcome		X		

Kenya
Health Rehabilitation Project
Table 1b: Summary of Assessments
Kenyatta National Hospital Component

	Substantial	Partial	Negligible	Not applicable
A. Achievement of objectives				
macro policies				X
sector policies	X			
financial objectives		X		
institutional development	X			
physical objectives	X			
poverty reduction				X
gender issues				X
other social objectives		X		
environmental objectives				X
public sector management	X			
private sector development				X
	Likely	**Unlikely**	**Uncertain**	
B. Project sustainability	X			
	Highly satisfactory	**Satisfactory**	**Unsatisfactory**	**Highly unsatisfactory**
C. Assessment of outcome		X		

Kenya
Health Rehabilitation Project
Table 1c: Summary of Assessments
Nairobi Area Health Services Component

	Substantial	Partial	Negligible	Not applicable
A. Achievement of objectives				
macro policies				X
sector policies			X	
financial objectives		X		
institutional development		X		
physical objectives		X		
poverty reduction				X
gender issues				X
other social objectives			X	
environmental objectives				X
public sector management			X	
private sector development				X
	Likely	**Unlikely**	**Uncertain**	
B. Project sustainability		X		
	Highly satisfactory	**Satisfactory**	**Unsatisfactory**	**Highly unsatisfactory**
C. Assessment of outcome			X	

Kenya
Health Rehabilitation Project
Table 1d: Summary of Assessments
Health Planning and Analysis Component

	Substantial	Partial	Negligible	Not applicable
A. Achievement of objectives				
macro policies				X
sector policies	X			
financial objectives	X			
institutional development	X			
physical objectives	X			
poverty reduction				X
gender issues				X
other social objectives				X
environmental objectives				X
public sector management		X		
private sector development				X
	Likely	**Unlikely**	**Uncertain**	
B. Project sustainability	X			
	Highly satisfactory	**Satisfactory**	**Unsatisfactory**	**Highly unsatisfactory**
C. Assessment of outcome		X		

Kenya
Health Rehabilitation Project
Table 1e: Summary of Assessments
Welfare Monitoring System Component

	Substantial	Partial	Negligible	Not applicable
A. Achievement of objectives				
macro policies				X
sector policies		X		
financial objectives				X
institutional development		X		
physical objectives		X		
poverty reduction	X			
gender issues			X	
other social objectives				X
environmental objectives				X
public sector management			X	
private sector development				X
	Likely	**Unlikely**	**Uncertain**	
B. Project sustainability		X		
	Highly satisfactory	**Satisfactory**	**Unsatisfactory**	**Highly unsatisfactory**
C. Assessment of outcome			X	

Kenya
Health Rehabilitation Project
Table 2: Related Bank Credits

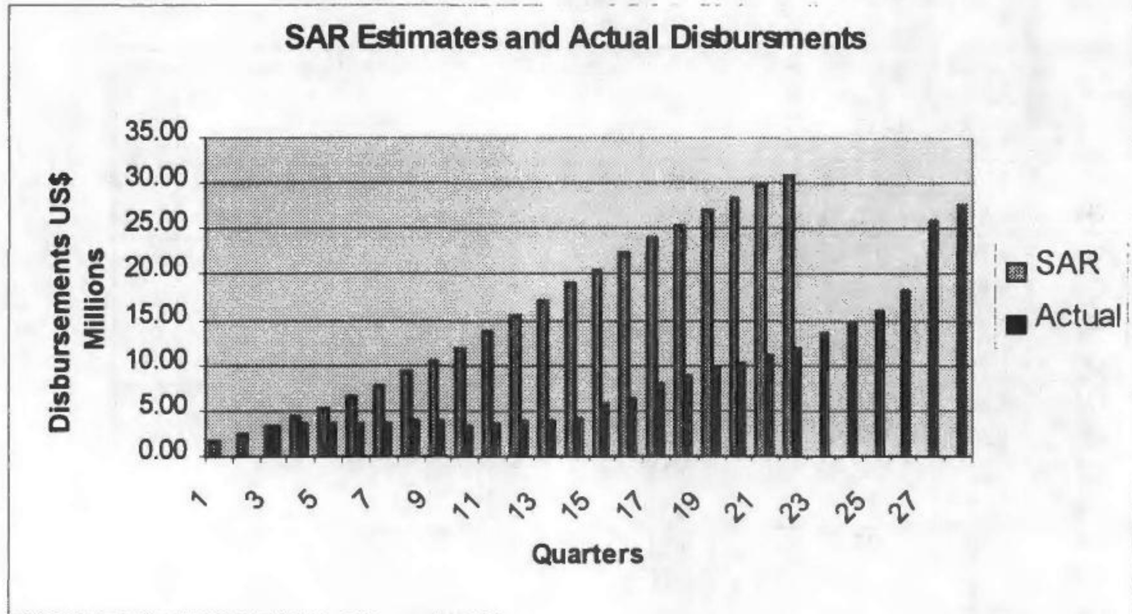
Credit	Purpose	Year of Approval	Status
Past Operations			
1. First Population Project (US$ 12 million)	The project objective was to significantly reduce the population growth rate.	1974	Closed
2. Second Population Project (US$ 23 million)	The project objectives were to (i) reduce fertility, and (ii) improve accessibility and quality of rural health services.	1983	Closed
Parallel Operations			
1. Third Population Project (US$ 12.9 million)	The project objectives were to: (i) strengthen capacity of the National Council for Population and Development; (ii) create demand for Family Planning services through IEC activities; and (iii) increase the availability, accessibility, and quality of Family Planning services.	1988	Closed June, 1996
2. Fourth Population Project (US$35 million)	The project objectives were to: (i) strengthen capacity of the National Council for Population and Development; (ii) create demand for Family Planning services through IEC activities; and (iii) increase the availability, accessibility, and quality of Family Planning services.	1990	Closed June, 1998
Following Operations			
1. Sexually Transmitted Infections Project (US$40 million)	The project objectives are to: (i) strengthen the institutional capacity at the national and district levels to design, implement, monitor and evaluate interventions; (ii) promote preventive measures to reduce the risks of STI transmission; and (iii) enhance both health sector and community provision of physical and psychological care and develop strategies to mitigate the socio-economic consequences of STI/HIV.	1995	On-Going Closing December, 2000
Planned Operations			
1. Health Sector Reform Project	An APL which will support the Government of Kenya in implementing its Health Sector Reform Program which focuses on (i) equitable allocation of government resources; (ii) increased cost effectiveness of resource allocation; (iv) continued management of population growth; (iv) enhanced regulatory role of he government; (v) increased private sector and community involvement in the health sector; and (vi) increased and diversified per capita flows to the health sector.	Planned, 2000	

Kenya
Health Rehabilitation Project
Table 3: Project Timetable

Steps in Project cycle	Date Planned	Date Actual
Identification	----	April-May, 1989
Preparation	August, 1989	August, 1989
Appraisal	May-June, 1990	October, 1990 March, 1991 (WMS)
Negotiations	February, 1991	February, 1991
Board Presentation	July, 1991	November, 1991
Signing	December 11, 1991	December 11, 1991
Effectiveness	March 12, 1992	July 7, 1992
Mid-Term Review	September 30, 1993	March 31, 1994
Project Completion	June 30, 1995	June 30, 1998
Loan Closing	June 30, 1997	June 30, 1998

Kenya
Health Rehabilitation Project
Table 4: Credit Disbursements, Estimated and Actual

Yr/Quarter		SAR Estimates Quarterly (US$ millions)	SAR Estimates Cumul. (US$ millions)	Actual Quarterly (US$ millions)	Actual Cumul. (US$ millions)	Actual Cumulative as % of Credit
FY1992	Q3	1.70	1.70	0.00	0.00	0
	Q4	0.80	2.50	0.00	0.00	0
FY1993	Q1	0.90	3.40	3.28	3.28	10.6
	Q2	0.95	4.35	0.19	3.47	11.2
	Q3	0.95	5.30	0.01	3.48	11.2
	Q4	1.20	6.50	0.00	3.48	11.2
FY1994	Q1	1.25	7.75	0.14	3.62	11.7
	Q2	1.55	9.30	0.18	3.80	12.3
	Q3	1.25	10.55	0.11	3.91	12.6
	Q4	1.25	11.80	-0.49	3.42	11.0
FY1995	Q1	1.85	13.65	0.22	3.64	11.7
	Q2	1.85	15.50	0.29	3.93	12.7
	Q3	1.55	17.05	0.00	3.93	12.7
	Q4	1.85	18.90	0.12	4.05	13.1
FY1996	Q1	1.55	20.45	1.86	5.91	19.1
	Q2	1.85	22.30	0.48	6.39	20.6
	Q3	1.60	23.90	1.57	7.96	25.7
	Q4	1.50	25.40	0.75	8.71	28.1
FY1997	Q1	1.60	27.00	0.88	9.59	30.9
	Q2	1.50	28.50	0.49	10.08	32.5
	Q3	1.30	29.80	0.94	11.02	35.5
	Q4	1.20	31.00	0.89	11.91	38.4
FY1998	Q1			1.60	13.51	43.6
	Q2			1.19	14.70	47.4
	Q3			1.21	15.91	51.3
	Q4			2.32	18.23	58.8
FY1999	Q1			7.66	25.89	83.5
	Q2			1.60	27.49	91.6



SAR Estimates and Actual Disbursments
Disbursements US$ Millions
35.00
30.00
25.00
20.00
15.00
10.00
5.00
0.00
1
3
5
7
9
11
13
15
17
19
21
23
25
27
Quarters
SAR
Actual

Kenya
Health Rehabilitation Project
Table 5: Key Indicators of Project Implementation

Item	Unit	Estimated	Actual	Comment
A. Rehabilitation of Kenyatta National Hospital				
1. Physical Rehabilitation of Hospital	%	100%	100%	
2. Equipment of Hospital	%	100%	63%	Some lots were not given "no objection" as the credit was, at the time of contract award, fully committed.
3. Hospital fulfillment of performance objectives (8): see Table 15	number	8	2	Despite impressive improvements in performance, original targets proved to be overly-ambitious. These should have been revised at mid-term review to be more realistic.
4. Training of staff	number	135	135	
5. Share of MOH Budget	%	11.9%	16.9%	11.9% is the target for 1995/96, the last year for which targets were defined by IDA. GOK target for 1997/98 was 13.0%
6. Decongestion of KNH	number of out-patients	<500,000	804,000	Unable to be fulfilled due to being contingent on success of Nairobi Area component, which was being implemented concurrently and suffered severe delays
B. Nairobi Area Health Services				
1. Rehabilitation of 14 NCC clinics	%	100%	85%	One zone was 100% complete; the other two zones were 80% complete.
2. Equipment of NCC clinics	%	100%	100%	All planned procurements completed.
3. Rehabilitation of Matharere and Mbagathi Hospitals and Pumwani	%	100%	0%	Canceled at time of extension.
4. Adoption of Strategic Health Plan for Nairobi Area		Adopted	Adopted	Plan was adopted, but implementation has been insufficient.
5. Increased utilization	number of out-patients	n/a	n/a	
6. Training of staff	% of Planned	Int'l: 100% Local: 100%	Int'l: 95% Local: 20%	Capacity was lacking in NCC to organize local training programs.

Note: No performance indicators were provided in the Staff Appraisal Report. These indicators have been developed from the staff appraisal report.

Item	Unit	Estimated	Actual	Comment
C. Health Planning and Analysis				
1. Completion of studies	number	6	6	See Table 7
2. Foster future Health Sector Reform	appraisal of new credit	1994	Planned FY2001	At time of project effectiveness, it was envisioned that a Health Sector Reform credit would be effective in 1994.
3. Share spent on preventive & promotive	% of budget	25%	28%	Assumes a targeted increase of 2 percentage points annually.
4. User Fees: Collections per year	KSH	400 million	400 million	
D. National Household Welfare Monitoring and Evaluation System				
1. Submission of satisfactory implementation program	Y/N	Yes	Yes	
2. statistical sub-component				
a. Strengthen district level CBS office network	Y/N	Yes	Yes	Reduced delays and improved quality of survey returns.
b. finalize new master sample frame	date complete	1994	1994	
c. develop improved designs for household surveys	date complete	1994	1994	
3. analytical sub-component (HRSSD)				
a. Improve quality of in-depth analysis	Y/N	Yes	No	
b. Increase utility of outputs to decision-makers	Y/N	Yes	No	

Kenya
Health Rehabilitation Project
Table 6: Key Indicators for Project Operation

Project Impact to be maintained	Follow-up actions being taken	Issues Outstanding	Planned Actions
Kenyatta National Hospital			
Physical Rehabilitation of Hospital	Institution of Preventive Maintenance and Safety Plans	Actual and budgeted O&M expenditures still below target of 6.0% of recurrent budget	Target will continue to be 6.0%. Implementation of new programs and completion of rehabilitation will raise actual.
Equipment of Hospital	Training on proper use of equipment being provided; service contracts for maintenance.		Savings generated by use of new equipment to be set aside for their replacement at end of useful life.
Improved Performance as measured by Performance Indicators	KNH continues to set annual performance targets and monitor its own performance.	With the closing of the credit, it is not clear that there is a body outside KNH to whom the institution is accountable for its performance by these measures.	Continuing health sector reform program and transition to autonomy of other hospitals will include intensified monitoring of how these institutions perform.
Increased Capacity	KNH continues to develop annual training plans and set aside substantial annual training budget.	KNH has proven able to retain staff upon their return from training, so this is not a problem.	Staff trained under the credit will continue to serve as trainers within the facility to pass on the skills/knowledge gained.
Increased Revenue Generation	Further increase in fees under consideration; in-demand private wing expanded with recently-increased fees; and private doctors' offices now complete.	Share of MOH budget to KNH has not decreased. Rent charged at private doctors' offices appears to be below market.	Annual review of fees charged.

Project Impact to be maintained	Follow-up actions being taken	Issues Outstanding	Planned Actions
Nairobi Area Health Services			
Physical Rehabilitation of 14 Clinics	(i) Facilities being completed with GOK funds. (ii) User fees now retained 100% at facility, so facility has funds available for its own maintenance. (iii) Cost-sharing fees under review.	(i) Unfinished works. (ii) Lack of preventive maintenance plan or other formal provision for sustainability of investment. (iii) Lack of some materials needed for proper maintenance. (iv) Prospects for "contracting out" rehabilitated clinics to private sector are uncertain, though there is much interest in NCC and MOH in proceeding.	(i) Tentative commitment to produce and implement a maintenance plan by Jan. 1, 1999. (ii) User fees to be increased. (iii) Additional cost sharing revenues from other activities dedicated to maintain facilities.
Equipment of Clinics	User fees now retained 100% at facility, so facility has funds available for upkeep, repair and replacement of equipment, and these fees are under review.	Lack of formal plan for maintenance and upkeep of equipment.	Tentative commitment to include equipment in promised maintenance plan.
Increased Capacity	(i) Short-term training to be financed by NCC to keep skills up-to-date. (ii) Preparation of annual training plans continue.		Budget for training to be implemented.
Health Planning and Analysis			
Promotion of Health Sector Reform	Continued preparation, and initial implementation, of Health Sector Reform program.	Slow progress of Health Sector Reform Program and development of new donor projects to support the program.	Various studies necessary for Health Sector Reform to continue (Mid-Term Expenditure Framework, National Health Accounts, Legal Review, and others) are underway or under preparation.

Project Impact to be maintained	Follow-up actions being taken	Issues Outstanding	Planned Actions
Health Planning and Analysis (continued)			
Increased Share of Budget spent on Preventive and Promotive Health Services	It is hoped that KNH reliance on MOH budget *will* be reduced, and those savings will enable further increases in preventive and promotive health care spending.	(i) Continued reductions in MOH budget raise concern that this category of spending will be constrained. (ii)Fear that, due to detached MOH and KNH budget negotiations, reduced reliance of KNH on Treasury may not translate into increased funds for MOH.	
Successful User Fee Program	User Fee System continues to be strengthened through streamlining and strengthening of procedures, and increased fees expected to boost revenue.	Not clear whether newly autonomous hospitals will also have KNH's right to set its own fees.	Fees continue to be reviewed, and raised periodically.
Welfare Monitoring System			
Strengthened district level CBS office network	Task Force preparing National Statistical Policy and Strategic Plan to address sustainability of CBS and future of Kenya's statistical program.	Inadequate provision for future funding of CBS, with little current prospect of additional donor support.	Task Force Report and recommendations due in April, 1999. Expected to form basis for Sessional Paper.
Increased capacity within CBS	Task Force preparing National Statistical Policy and Strategic Plan to address sustainability of CBS and future of Kenya's statistical program.	Capacity built is threatened by high staff turnover and inadequate provisions for bureau's sustainability.	Task Force Report and recommendations due in April, 1999.

Note: Indicators were not provided in the SAR or in the President's reports. The above indicators have been developed from the SAR.

Kenya
Health Rehabilitation Project
Table 7: Studies Conducted

Study/Purpose of Study	Consultants	Status	Impact of Study
1. *Nairobi Area Health Services Study*: A thorough situation analysis of the NAHS: assess utilization of existing health facilities and other resources; distribution and coverage and prepare a Strategic Health Plan for the Nairobi Area, the implementation of which would relieve congestion at KNH	Development Solutions for Africa, Ltd.	Completed and Accepted by Borrower	Strategic Plan adopted. Partially implemented due to inability of NCC to give assurance to IDA that it would fully utilize and maintain the facilities and equipment included in the Investment Plan (part of Strategic Plan)
2. *Pharmaceutical Procurement and Distribution Study*: An in-depth analysis of the pharmaceutical procurement and distribution system for the MOH and to make recommendations and prepare an Action Plan. It was also to focus on treatment protocols, prescriptions and cost-effective use of drugs.	Mr. John O'Quick	Completed and Accepted by Borrower	The study recommendations were piloted in a number of districts and have now been incorporated in the Ministry's rural health facilities.
3. *Health Manpower Study*: Analysis of stock of MOH manpower by staff category; assess distribution and utilization; focus on staffing norms and age structure and make appropriate recommendations on the future Health Manpower Development and prepare a long-term strategy for education and training of health personnel, given the MOH policy of shifting more resources toward preventive, promotive and PHC activities and programs.	Development Solutions for Africa, Ltd.	Completed.	The study recommendations have been partially implemented. Further work is being done to improve staff distribution between urban and rural areas in line with study recommendations.
4. *Curative Gap Study*: An assessment of the resource gap for the curative sector for the MOH. The first component, the Cost and Quality of Care analysis, was completed. The second component, the Family Rationalization Study, was not completed because the consultant hired to conduct the study failed to do so and the contract was terminated on instructions from the Attorney General.	Component 1: Mr. Stephen Mausau, Chartered Accountant. Component 2: Mr. Jorgen Jensen	Partially Completed	The Cost and Quality Study showed that the Ministry's curative sector is underfunded and cannot sustain the quality of care that private institutions are able to provide. This has provided strong rationale for back-shifting of curative care to the private/NGO sector as postulated in Kenya's Health Policy Framework (November, 1994).

Study/Purpose of Study	Consultants	Status	Impact of Study
5. *Study on Rehabilitation Needs of the MOH's Buildings and Major Equipment*: A survey of the MOH buildings and major equipment on sample basis; assess rehabilitation needs of these facilities and prepare estimated costs for each of the six geographic zones for purposes of inclusion in a long-term PIP for the Public Health Sector in the context of rehabilitation and consolidation of existing infrastructure and biomedical equipment.	Lead Consultants (by zone) (i) Mruttu Salman & Associates; (ii) Triad Architects; (iii) Conte Design Architects; (iv) Inbred Architects; (v) Wanjohi Consulting Engineers; (vi) Plano Consultant Architects.	Description of needs and cost estimates completed and submitted to MOH.	Study has given clear indication of physical status of MOH buildings and what is required to put them in a status where they can be put on a Preventive Maintenance Program.
6. *Study on Coordination of Intersectoral Activities in Health Sector*. To formulate recommendations for increasing coordination of said activities to improve efficiency and effectiveness.		Not Completed.	After initial delays in the implementation of this activity, it was canceled by the Borrower during the mid-term review as it did not address coordination in the context of a more decentralized MOH.

Kenya
Health Rehabilitation Project
Table 8. Project Costs - Staff Appraisal Report Estimates and Actual Expenditures
(US $ Millions)

	Appraisal Estimates			Actual		
Expenditure category	**GoK/KNH**	**IDA**	**Total**	**GoK/KNH**	**IDA**	**Total**
1. Civil Works	1.5	13.0	14.5	1.2	11.2	12.4
2. Equipment, Vehicles, Materials, and Supplies	-	8.3	8.3	-	8.1	8.1
3. Consultants' Services, Studies, and Training	-	8.5	8.5	-	7.8	7.8
4. HIV/AIDS-Related Supplies	-	1.2	1.2	-	0.1	0.1
5. Incremental Operational Costs*	2.0	-	2.0	1.0	0.4	1.4
Total project costs	**3.5**	**31.0**	**34.5**	**2.2**	**27.6**	**29.8**

Source: Government of Kenya/Ministry of Health
* The Development Credit Agreement was amended in November, 1997, to allow for the financing of Incremental Operational Costs which facilitate the implementation of the project.

Kenya
Health Rehabilitation Project
Table 9. Project Financing
(US $ Millions)

Source	Appraisal Estimates (US$ M)	Actual Expenditures (US$ M)
IDA	31.0	27.6
Govt./KNH	3.5	2.2
TOTAL	34.5	29.8

Source: SAR and Government of Kenya/Ministry of Health

Kenya
Health Rehabilitation Project
Table 10: Status of Legal Covenants

DCA Reference	Description of Covenant	Covenant type	Present status	Original date	Actual date	Comments
Article II Section 2.02 (b)	The Borrower shall open and maintain three special accounts (KNH, MOH, and MPND).	1	C	N/A	N/A	Initially, the accounts were all opened and functioning. KNH account was closed and consolidated with MOH account. As accounting capacity at KNH increased, it was agreed that a separate account for KNH would be re-opened in 1996; this was never done as MOH decided it was impractical given that payments would still have to follow MOH channels.
Article III Section 3.01 (e)	The Borrower shall make a grant from its own resources to KNH in a manner and at a level satisfactory to IDA.	4	C	N/A	N/A	The budgeted amounts were adequate. There was initially a problem of shortfalls in the actual transfers, but this was satisfactorily resolved after the mid-term review in 1994.
Article III Section 3.04	The Borrower shall, by September 30 annually, furnish to IDA evidence of an increase in spending on preventive health services as a share of both budgeted and actual recurrent spending by MOH from general revenues.	2	C	N/A	N/A	Complied.
Article III Section 3.05 (a)	The Borrower shall by March 31, 1992, implement the reorganization of DPD, in a manner satisfactory to IDA.	5	C	3/31/92	3/31/92	The division was re-organized, but the staffing was considered by IDA to be unsatisfactory due to transfers back to the Ministry of Planning. The department was subsequently strengthened with the secondment of a Deputy-Chief Economist and a Senior Economist.
Article III Section 3.05 (b)	The Borrower shall by March 31, 1992, establish and thereafter maintain the MOH Committee on Health Policy, Strategic Planning and Development.	5	C	3/31/92	3/31/92	The committee was formed and continues to function.
Article III Section 3.06 (a)	The Borrower shall, by March 31 1992, assume responsibility for KSH 45 million being KNH's accounts payable as of June 30, 1987.	2, 3, 11	C	3/31/92	3/31/92	The funds were transferred to KNH.
Article III Section 3.06 (b)	The Borrower shall, by June 30, 1993, assume responsibility for KNH's accounts payable, following confirmation thereof in KNH's audited accounts for 1987/88, 1988/89, and 1989/90.	2, 3, 11	NC	6/30/93		Kshs. 5.5 million were included in the FY96/97 revised estimates under Account DII-717-315-000-295 and were disbursed during that FY, and the balance was to be paid in FY97/98. Thus far, none of the balance for this FY has been paid, and it seems unlikely to be paid.
Article III Section 3.07 (a)	The Borrower shall, by September 30, 1993, carry out jointly with IDA and KNH, a mid-term review of the progress in carrying out the project.	9	CD	9/30/93	3/31/94	The mid-term review took place in March, 1994.
Article III Section 3.07 (b)	The Borrower shall implement the recommendations of the mid-term review.	9	CD	N/A	N/A	The recommendations were implemented.
Article IV Section 4.01 (a)	The Borrower shall maintain financial records and accounts in accordance with sound accounting practices in respect of Parts B, C, and D of the Project.	1	C	N/A	N/A	Records and accounts were maintained.

DCA Reference	Description of Covenant	Covenant type	Present status	Original date	Actual date	Comments
Article IV Section 4.01 (b)	The Borrower shall, no later than six months after the end of each financial year, submit for IDA's review audit reports of all project accounts, including those for the Special Accounts.	1	CD	N A	N A	These were frequently submitted after a delay.
Article IV Section 4.01 (c) (i)	For all expenditures with respect to which credit withdrawals for Parts B, C, and D of the Project were made on the basis of Statements of Expenditure (SOE), the Borrower shall maintain, in accordance with sound accounting practices, records and accounts reflecting such expenditures.	1	C	N A	N A	The records were maintained.
Article IV Section 4.01 (c) (ii)	For all expenditures with respect to which credit withdrawals for Parts B, C, and D of the Project were made on the basis of Statements of Expenditure (SOE), the Borrower shall retain all records as evidence of expenditures until at least one year after IDA has received the audit report for the fiscal year in which the last withdrawal from the Credit Account or payment out of the Special Account was made.	1	CD	N A	N A	The Borrower was in compliance, though with frequent delay.
Article IV Section 4.01 (c) (iii)	For all expenditures with respect to which credit withdrawals for Parts B, C, and D of the Project were made on the basis of Statements of Expenditure (SOE), the Borrower shall enable IDA's representatives to examine such records.	1	C	N A	N A	The Borrower has been in compliance.
Article IV Section 4.01 (c) (iv)	For all expenditures with respect to which credit withdrawals for Parts B, C, and D of the Project were made on the basis of Statements of Expenditure (SOE), the Borrower shall ensure that the audit reports include a separate opinion on the SOE as to whether the SOEs submitted during such fiscal year together with the procedures and internal controls, can be relied upon to support the related withdrawals.	1	CP	N A	N A	The Borrower has been in compliance until the final year, this is still considered outstanding
Article IV Section 4.02 (a)	The Borrower shall reintroduce outpatient consultation user charges at the December 1989 levels by July 1, 1992, at District and Sub-District Hospitals.	10, 2	C	1 1 93	1 1 93	The charges were introduced on time
Article IV Section 4.02 (b)	The Borrower shall reintroduce outpatient consultation user charges at the December 1989 levels by January 1, 1993, at Health Centers.	10, 2	CD	4 1 93	7 1 93	The charges were introduced after a delay.
Article IV Section 4.03	The Borrower shall, until completion of the Project, maintain a graduated structure of user fees for health services at levels satisfactory to IDA, differentiating between dispensaries, health centers, public hospitals, and KNH. Such structure shall include provisions, satisfactory to IDA, for exemptions based on need.	2, 10, 12	C	N A	N A	Graduated fees, including an appropriate exemption mechanism for the poor, are in place for KNH, provincial and district hospitals, and health centers. The fee levels were increased in October, 1994, for provincial and district hospitals and health centers. KNH has worked out a new fee structure which was effected in January, 1997. Fees are constantly under review, and a proposal to increase fees was under consideration at time of ICR mission.

DCA Reference	Description of Covenant	Covenant type	Present status	Original date	Actual date	Comments
Schedule 4 Para. 1	The Borrower shall maintain the Nairobi/PHMB chaired by the Director of Medical Services which shall oversee the development of the strategic plan. The strategic plan shall have the following elements:	5, 12	C	N/A	N/A	A Nairobi Health Services Development Plan 1994-2010 has been prepared by a standing committee which was given the responsibility by the Office of the President to prepare a strategic plan for health services in the Nairobi area.
Schedule 4 Para. 1 (a)	(a) Establishment of an organizational structure with authority, accountability and responsibility for health services.	5, 12	C	N/A	N/A	The organizational structure was presented to the Government. However, DPM and Cabinet approval has never been given.
Schedule 4 Para. 1 (b)	(b) Coordination of all health services in the area, including referral protocols and transport arrangements.	5, 12	CP	N/A	N/A	The priority areas are outlined in "Nairobi's Health Services, Proposals for Donor Assistance, June 1995" prepared by the Committee. Formal referral systems are in place for KNH; this process has been facilitated by the opening of the Mbagathi District Hospital but hindered by the lack of progress in the NAHS NCC component.
Schedule 4 Para. 1 (c)	(c) Deployment of medical faculty from the University of Nairobi to extend teaching and training downward from KNH to secondary and primary facilities.	5, 12	C	N/A	N/A	This was completed except for transport arrangements not being in place.
Schedule 4 Para 1 (d)	(d) Prepare a Public Investment Program for Nairobi which identifies health priorities and proposes to meet them through consolidation, rehabilitation and maintenance of existing facilities and future capital and human resources development activities.	5, 12	CP	N/A	N/A	Rehabilitation is still underway; consolidation is still incomplete; and future provisions are uncertain for capital and human resources.
Schedule 4 Paras. 2,3,4,5 & 6	DPD shall prepare and plan future health sector reform under the guidance of the Committee on Health Policy, Strategic Planning and Development. DPD shall carry out various studies and complete them by June 30, 1993.	12	C	6/30/93	6/30/93	The MOH prepared the Health Policy Framework Paper "Investing in Health". The paper was approved by the Cabinet and launched by the Minister of Health in December, 1994. The results of the studies have been incorporated in the Policy Framework Paper and are being used in the implementation of the health sector reform agenda.
Article IV Section 4.01 (a)	KNH shall maintain records and accounts in accordance with sound accounting practices.	1	C	N/A	N/A	Records and accounts were maintained.
Article IV Section 4.01 (b) (i)	KNH shall have its records, accounts and financial statements (balance sheets, statements of income and expenses, and related statements) for each fiscal year audited.	1	CD	N/A	N/A	These were completed with delay.
Article IV Section 4.01 (b) (ii)	KNH shall furnish to IDA six months after the end of each fiscal year: (a) certified copies of its financial statements for such year as so audited, and (b) the report of such audit.	1	CD	N/A	N/A	These were submitted after delays.
PA Schedule Para. 1	The Director of KNH shall be responsible for implementation of the Project. Day-to-day project management shall be coordinated by the head of the KNH Planning Unit.	5	C	N/A	N/A	Borrower was in compliance.

DCA Reference	Description of Covenant	Covenant type	Present status	Original date	Actual date	Comments
PA Schedule Para. 2	KNH shall furnish to IDA at least three months prior to the beginning of each fiscal year, a revised institutional development plan, a revised training plan and an overall hospital budget, including, *inter alia*, a fee schedule satisfactory to IDA.	2, 5, 9, 11	CD	NA	NA	Borrower was not in compliance prior to mid-term review. Afterward, the Borrower was in compliance, but with delays in some earlier years.
PA Schedule Para. 3	KNH shall furnish to IDA within one month of the end of each quarter, quarterly progress reports.	9	C	NA	NA	Borrower was in compliance.
PA Schedule Para 4	KNH will review and revise the performance targets annually in coordination with the preparation of its annual budget and submit such targets to IDA by March 31 of each year.	9	C	NA	NA	Borrower was in compliance.
PA Schedule Para. 5	KNH will revise its 5-Year Implementation Plan on a bi-annual basis to be submitted to IDA in May 1992, 1994 and 1996.	9, 10, 12	CD	NA	NA	The plans were submitted to IDA after delays.
PA Schedule Para. 6	KNH shall fill the positions of Hospital Director, Deputy Director (Clinical Services), Head of Planning, Deputy Director of Administrative Services, Head of Finance, Head of Personnel and Training, Chief Administrative Officer, and the Supplies and Procurement Manager by September 30, 1992.	5	CD	9 30 92	4 30 95	Complied with after delay
PA Schedule Para. 7	KNH shall, by June 30, 1992, review its relationship with the University of Nairobi to reach agreement on the reporting relationship and coordination of personnel between KNH and the University.	5	CD	6 30 92	9 14 94	Agreement reached.
PA Schedule Para. 8	KNH shall, by March 31, 1992, develop charges for services rendered to the Kenya Medical Training College and the Kenya Medical Research Institute.	2, 11	CD	3 31 92	12 31 96	KNH introduced meters for water and electricity in these institutions so that they pay directly to the supplying agencies, rather than reimbursing KNH. The use of students and lecturers across the institutions is not subject to any fees from either of the institutions
PA Schedule Para. 9	KNH shall appoint a Management Advisor under Terms of Reference acceptable to IDA.	5	C	NA	NA	This position was filled; subsequently, it was agreed during the Mid-Term Review that this position had become redundant because of the strong leadership that had developed at KNH.
PA Schedule Para. 10 (i)	KNH shall introduce computerization of accounts by December 31, 1994.	1, 5, 9	NC	12 31 94	NC	Management Accounting Unit is in place. Manual accounts were set up awaiting computerization, which did not take place under the project.
PA Schedule Para. 10 (ii)	KNH shall, from 1995 onwards, prepare quarterly financial reports to be used as a tool for improved financial forecasting and management information.	1, 5, 9	C	NA	NA	Quarterly reports were produced, as required. It is anticipated that the system will be refined with computerization.
PA Schedule Para. 10 (iii)	KNH shall implement a management accounting system by June 30, 1993.	1, 5, 9	CD	6 30 93	6 30 94	KNH introduced a management accounting system. Budgeting based on defined cost centers will be initiated as soon as the computerization is effected.

DCA Reference	Description of Covenant	Covenant type	Present status	Original date	Actual date	Comments
PA Schedule Para. 11	KNH shall, by June 30, 1993, introduce actual vs. planned budget analysis for all functional units and will provide to IDA a detailed account for all major deviations.	12	CD	6 30 93	6 30 97	The reports are available from June 30, 1997, onwards, though manually produced.
PA Schedule Para. 12	KNH shall cost major medical services and increase fees with the aim of full cost coverage for out-patients by 1995. KNH shall furnish to IDA for review by March 31 of each year its draft budget for the next year, including its proposed fee structure and depreciation schedule.	1, 2	CD	N A	N A	Major fee increase was last done in February, 1997. Minor fee increases are made continuously within KNH when determined to be necessary.
PA Schedule Para. 13 (i)	KNH shall, by September 30, 1993, complete the exercise of transferring staff who have opted to remain with MOH, from KNH to MOH and resolve any differences in the number of staff working vs. the number of staff paid.	5	C	9 30 93	3 31 93	Borrower is in compliance.
PA Schedule Para. 13 (ii)	KNH shall, commencing March, 1992, undertake quarterly reviews of authorized posts and abolish non-essential, unfilled posts.	5	C	N A	N A	The Hospital Board decided that the review should be completed on a yearly basis; the most recent review was completed by March 31, 1998.
PA Schedule Para. 13 (iii)	KNH shall, by June 30, 1992, adopt those recommendations of the Dept. of Personnel Management Report on the improvement of the Personnel and Training functions within the Hospital that would lead to an effective and efficient Personnel and Training Department.	5	C	6 30 92	6 30 92	Borrower in compliance
PA Schedule Para. 13 (iv)	KNH shall, by June 30, 1992, establish a Manpower Information System comprising of, *inter alia*, personnel records, personnel statistics and personnel registry.	5	C	6 30 92	6 30 92	This exercise was completed with the assistance of personnel/manpower consultants
PA Schedule Para. 13 (v)	KNH shall review its training projections in a systematic manner by March 31 of each year to ensure that the training programs remain consistent with the overall objectives of the hospital.	5	CD	N A	N A	The last review was completed by March 31, 1998
PA Schedule Para. 14 (i)	KNH shall, by December 31, 1992, undertake an inventory of existing stocks, write-off obsolete items, bring prices to current price levels, and bring records up to date.	5	C	12 31 92	12 31 9 2	Records are kept up to date. This exercise is completed annually.
PA Schedule Para. 14 (ii)	KNH shall, by December 31, 1992, introduce computerization of stock management.	5	NC	12/31/92	NC	This exercise was contingent on the KNH computerization, which was canceled due to the unlikelihood of it being completed prior to the project closing date. The computerization will take place, financed by other funds.
PA Schedule Para. 14 (iii)	KNH shall, by December 31, 1992, recruit an inventory materials management specialist under terms and conditions satisfactory to IDA.	5	C	12 31 92	12 31/9 2	Person was hired

DCA Reference	Description of Covenant	Covenant type	Present status	Original date	Actual date	Comments
PA Schedule Para. 15	The KNH Pharmaceutical Committee shall, by December 31, 1992, produce a list of main drugs and pharmaceuticals that are to be used in KNH. this list will be revised and updated annually.	10	C	12 31 92	12 31 9 2	The list is updated annually.
PA Schedule Para. 16	KNH shall, by December 31, 1992, establish a Supplies Committee to monitor consumption of supplies and to develop a standardized list of supplies to be used at KNH.	10, 12	CP	12 31 92	CP	Borrower was in compliance in the areas of drugs and general items.
PA Schedule Para. 17 (i)	KNH shall, by December 31, 1992, develop and implement a system for preventive and curative maintenance.	10, 12	CD	12 31 92	12 31 9 4	This was carried out. Measures to ensure adequate funds for maintenance were put in place, including establishment of a separate account.
PA Schedule Para. 17 (ii)	KNH shall, by December 31, 1992, develop and implement a safety plan.	10, 12	CD	12 31 92	3 31 98	This was implemented alongside the overall maintenance system. Compliance was partial until the completion of the civil works.
PA Schedule Para. 17 (iii)	KNH shall, by December 31, 1992, prepare proposals for correct housekeeping procedures.	10, 12	CD	9 14 94	12 31 9 6	(Deadline revised) This has been completed to the extent possible. It will be refined now that civil works are complete and bio medical equipment has been delivered.
PA Schedule Para. 17 (iv)	KNH shall, by December 31, 1992, prepare and implement guidelines for the inclusion of maintenance, safety, and housekeeping criteria in future acquisitions and purchasing.	10, 12	C	9 14 94	9 14 94	(Deadline revised) Copies of summary guidelines submitted to IDA.
PA Schedule Para. 18 (i)	KNH shall, by December 31, 1992, conduct an assessment of clinical quality and administrative efficiency in the following departments: Laboratory, Theatre, Pharmacy, CSSD TSSU, X-Ray, and Casualty.	9	C	9 14 94	6 30 94	(Deadline revised) All areas were assessed and reports prepared. Implementation was initiated and reviewed in June, 1994. The Quality Assurance Unit has trained various departments in quality assurance
PA Schedule Para. 18 (ii)	KNH shall, by June 30, 1995, perform assessments of efficiency and quality of services on all remaining departments.	9	C	6 30 95	6 30 95	Assessments were completed and continue to be conducted on a continuous basis
PA Schedule Para. 18 (iii)	KNH shall, by April 30, 1993, establish and implement a quality assurance plan that is acceptable to IDA.	9	C	4 30 93	4 30 93	Borrower was in compliance, and the plan has been implemented.
PA Schedule Para. 18 (iv)	KNH shall, by April 30, 1993, appoint a quality assurance manager at department head level and by May 31, 1993, establish a quality assurance department.	9	C	5 31 93	5 31 93	Borrower complied by naming manager and establishing department. A new manager was named in 1995
PA Schedule Para. 19	KNH shall, starting in 1993, define performance targets for each functional area and compare them with actual figures at the end of each year. In 1994, KNH shall define targets for the number of units to be produced in each functional area using the data of 1993.	5, 9	C	9 14 94	9 14 94	(revised deadline) Details provided in KNH Annual Workplans.
PA Schedule Para. 20	KNH shall, in 1993, calculate the direct costs of each functional area, using the installed cost accounting system.	2	CP	1993	1997	This has been done manually since 1997. Full compliance contingent on the canceled KNH computerization.
PA Schedule Para. 21	KNH shall operate its Private Wing according to its budget and without subsidy from the other operations of the hospital.	2, 10, 11	C	N A	N/A	The Private Wing has produced a surplus for the last three years.

DCA Reference	Description of Covenant	Covenant type	Present status	Original date	Actual date	Comments
PA Schedule Para. 22	KNH shall construct office space and rental to KNH consultants to see and treat private patients. KNH shall ensure that the operation of the said offices will not be subsidized by KNH's other operations.	10, 11	CP	9 14 94	3 31 98	Construction completed March 31, 1998. Current rent fees are insufficient to cover actual costs, though will be reviewed annually.

Covenant types:

1 = Accounts/audits
2 = Financial performance/revenue generation from beneficiaries
3 = Flow and utilization of project funds
4 = Counterpart funding
5 = Management aspects of the Project or executing agency
6 = Environmental covenants
7 = Involuntary resettlement
8 = Indigenous people
9 = Monitoring, review, and reporting
10 = Project Implementation not covered by categories 1-10
11= Sectoral or cross sectoral budgetary or other resource allocation
12 = Sectoral of cross-sectoral policy/ regulatory/institutional action
13 = Other

Present status:

C = covenant complied with
CD = complied with after delay
CP = complied with partially
NC = Not Complied

Kenya
Health Rehabilitation Project
Table 11: Compliance with Operational Manual Statements

Statement Number and Title	Comments
OD 10.60 Accounting, Financial Reporting, and Auditing **OD 13.10 Borrower Compliance with Audit Covenants**	**Paras. 26-27 of OD 10.60** state that, as a minimum, financial reports should normally comprise a statement of receipts and payments, as well as total project costs and sources of financing, and that the supporting schedules of statements should disclose annual and supplemental budget allotments, actual expenditures under each budget category for which Bank financing is furnished, and the actual expenditures and amounts of Bank disbursements claimed. In short, financial reporting should cover all accounts pertaining to project expenditures, irrespective of sources of financing. Audits were submitted for all years, though they were usually delayed (submitted after the due date). Separate audit reports were submitted for the three Special Accounts under the project, and for each Part of the project using SOEs (2).
OP 6.30 Local Cost Financing and Cost Sharing	The Bank usually expects the Borrower to demonstrate commitment to the project by making a 10% minimum contribution to project cost (net of taxes and duties). The Borrower's contribution totaled 7.4% percent of total project cost versus the estimated contribution of 11.3% projected at appraisal.
OD 13.30 Extension of closing dates	The Bank may approve for selected disbursements covering only part of a project to permit (a) implementation of some mutually agreed, high priority contracts; (b) the extension of the validity of letters of credit covered by a special commitment or (c) provision for retention payments, when the conditions for release (e.g. completion of performance tests or expiration of a warranty period) are met after the closing date. The Bank allowed 4 months after the project closing date for disbursements retention payments for a number of civil works contracts and procurement contracts.

Kenya
Health Rehabilitation Project
Table 12: Bank Resources: Actual Staff Inputs[1]

	Planned		Revised		Actual	
Stage of project cycle	Weeks	US$	Weeks	US$	Weeks	US$
Preparation to appraisal	N/P	N/P	N/P	N/P	162.1	300.3
Appraisal	N/P	N/P	N/P	N/P	41.8	70.6
Negotiations through Board Approval	N/P	N/P	N/P	N/P	33.1	80.7
Supervision[1]	208.4	394.8	248.7	422.3	273.6	450.6
Completion	16.5	13.7	21.9	20.9	13.3	13.8
TOTAL	N/P	N/P	N/P	N/P	523.8	918.0

Source: FACT Cost Report run on December 22, 1998
[1] Assumes FY1986-FY1995 actual expenditures were equal to planned (and revised planned). The World Bank Information System did not retain the "planned" figures for those years.

Kenya
Health Rehabilitation Project
Table 13: Bank Resources: Missions

Stage of project Cycle	Month/ year	Number of persons	Days in field	Specialized staff skills represented	Implement -ation status	Develop- ment Impact	Types of Problems
Identification	Apr./May 1989	8	21	Economist, Financial, Insurance, Public Health			Re-Introduction of User fees; need to monitor impact of user fees on welfare of poor; proposed changes to NHIF infeasible; KNH need for rehabilitation.
Preparation	Aug. 1989	6	17	Economist, Operations, Public Health, Hospital Management, Civil Works			Re-Introduction of User fees; KNH accounts payable.
Appraisal	Oct. 1990	7	19	Economist, Operations, Public Health, Hospital Management			Finalization of KNH audits, KNH accounts payable, need to increase KNH revenues, re-instatement of user fees.
Appraisal (WMS)	Mar. 1991	3	22	Economist, Statistician			Cost estimates incomplete. Need for revised medium-term work program for CBS. Component not included in GOK budget for coming year.
Post-Appraisal	Jan. 1991	3	7	Economist, Architect			Re-instatement of user fees; MOH planning function.
Supervision	Oct. 1992	5	11	Economist, Operations, Architect, Hospital Management			KNH targets not met; vacant posts in KNH; KNH financial management; KNH quality control; lack of progress in Nairobi Area component
	Mar. 1993	2	11	Statistician, Operations	2	1	Procurement and disbursement problems
	Aug. 1993	6	18	Public Health, Operations, Architect, Hospital Management, Statistician	2	2	KNH financial management; KNH not decongested; lack of progress on Nairobi Area component; delays in WMS data processing and outputs.
Mid-Term Review	Mar. 1994	6	18	Public Health Specialist, Operations, Statistician, Insurance Planner	2	2	Delays in civil works; failure of KNH to fulfill financial performance objectives; weak planning function of MOH; delays in WMS surveys
Supervision	Aug. 1994	5	9	Public Health, Operations, Architect, Hospital Management	S	U	Lack of progress on Nairobi Area component; KNH failure to fulfill agreed actions and meet performance targets; KNH consuming rising share of MOH budget; vacant important posts in MOH.
	Feb. 1995	3	12	Public Health, Operations	S	U	Lack of primary and secondary health care in Nairobi hampering means KNH still congested. Lack of planning capacity in MOH.
	Sep./Oct. 1995	7	12	Operations, Architect, Financial, Physician, Statistician	S	S	Separate special account should be re-opened for KNH; delays in payment process, particularly for civil works; KNH not meeting performance targets; lack of progress in Nairobi Area component; lack of understanding of implementation procedures in WMS component, slow implementation in this component.

Stage of project Cycle	Month/ year	Number of persons	Days in field	Specialized staff skills represented	Implement -ation status	Develop- ment Impact	Types of Problems
	Feb./Mar. 1996	6	12	Health Programming, Operations, Architect, Financial, Procurement	S	S	KNH not meeting performance targets; KNH civil works disbursement delays; shortfall in counterpart funds;
	Sep./Oct. 1996	8	17	Public Health, Statistician, Operations, Procurement, Financial, Architect	U	S	Delays in civil works; delays in procurement; loss of senior CBS staff affecting WMS component
	Feb. 1997	7	17	Public Health, Operations, Accountant, Physician, Economist, Civil Engineer	U	S	Delays in civil works; slow improvement in Nairobi area services; KNH not decongested; completion of activities and disbursement impossible for June 30, 1997 closing date; Mathare and Mbagathi hospital rehabilitations unlikely with 1 year extension.
	Sep. 1997	5	10	Public Health, Operations, Civil Engineer	U	S	Delays in civil works; financial management; procurement improved; Mbagathi hospital rehabilitation canceled as completion unlikely
	Feb. 1998	5	21	Public Health, Operations, Financial, Civil Engineer	U	S	Delays in KNH civil works; NCC civil works unlikely to be completed; procurement improved; financial management improved
Completion	Sep. 1998	6	11	Operations, Statistician, Civil Engineer, Financial, Procurement			

Kenya
Health Rehabilitation Project
Table 14: Out-Patient Utilization of Nairobi Area Health Facilities

Facility	1991	1992	1993	1994	1995	1996	1997	1998	% Change
1. Kenyatta National Hospital	N/A	N/A	594,982	558,300	396,425	387,659	427,087	946,559	+59%
2. Mbagathi District Hospital	N/A	N/A	N/A	N/A	N/A	56,098	37,618	33,768	-40%
3. NCC Clinics									
Division I									
Baba Dogo Dispensary	N/A	N/A	N/A	13,133	18,750	12,319	N/A	N/A	N/A
Bahati Health Center	N/A	N/A	N/A	10,830	14,713	17,539	N/A	8,870	-18%
Dandora One	N/A	N/A	N/A	17,061	25,042	29,917	N/A	29,042	+70%
Eastleigh Health Center	N/A	N/A	N/A	16,028	16,527	26,166	N/A	19,098	+19%
Embakasi Dispensary	N/A	N/A	N/A	9,864	12,760	12,388	N/A	N/A	N/A
Jericho Dispensary (24 hour)	N/A	N/A	N/A	47,369	51,218	76,291	N/A	59,534	+26%
Kaloleni Dispensary	N/A	N/A	N/A	8,967	13,549	15,066	N/A	N/A	N/A
Kasarani Dispensary	N/A	N/A	N/A	8,628	14,991	11,536	N/A	N/A	N/A
Kariobangi Health Center	N/A	N/A	N/A	18,567	24,439	29,692	N/A	N/A	N/A
Lunga Lunga Health Center	N/A	N/A	N/A	13,103	14,495	13,175	N/A	12,252	-6%
Makadara Disp./Maternity	N/A	N/A	N/A	8,642	25,424	10,551	N/A	N/A	N/A
Mathare North Health Center	N/A	N/A	N/A	13,419	22,350	26,600	N/A	28,898	+115%
Pumwani Dispensary	N/A	N/A	N/A	14,732	18,248	21,939	N/A	N/A	N/A
Ruai Dispensary	N/A	N/A	N/A	6,750	8,758	13,286	N/A	N/A	N/A
Umoja Dispensary	N/A	N/A	N/A	14,037	16,454	19,107	N/A	N/A	N/A
Division II	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Kahawa Health Center	N/A	N/A	N/A	N/A	26,417	32,441	32,711	20,466	-23%
Kangemi Health Center	N/A	N/A	N/A	N/A	36,697	43,026	N/A	N/A	N/A
Karen Health Center	N/A	N/A	N/A	N/A	27,715	33,567	26,088	16,491	-40%
Langata Health Center	N/A	N/A	N/A	N/A	27,205	31,978	31,628	44,264	+63%
Ngara Health Center	N/A	N/A	N/A	N/A	26,551	20,633	closed Nov. 1996 - present for rehabilitation		
Riruta Health Center	N/A	N/A	N/A	N/A	42,672	51,598	46,320	41,483	-2%

Source: KNH, PMO-Nairobi, NCC, years are fiscal years

Notes: 1. Complete data on all 46 NCC clinics was not available, and available data was incomplete for some years. 2. For those not in existence at start of project or for which data not available, % change is from their first year or first year for which data available. 3. 1994 figures for NCC clinics are approximations based on reporting for January-August, 1994. 4. 1998 figures for all facilities are approximations based on reporting for January-August, 1998.

Kenya
Health Rehabilitation Project
Table 15: Kenyatta National Hospital Performance Targets

	1989/90	1990/91	1991/92	1992/93	1993/94	1994/95	1995/96	1996/97	1997/98	1998/99
Productivity Targets										
Avg inpatient stay (days)										
Target:	8.6	8.5	8.3	8.0	7.7	7.4	7.1	8.4	8.2	8.0
Actual:		9.8	9.8	9.3	8.7	9.2	8.6	8.6	8.6	-
Staff/ 1000 patient days:										
Target:	5.4	5.4	5.3	5.0	4.8	4.6	4.4	7.0	7.0	7.0
Actual:		5.3	5.6	5.56	5.54	6.17	5.75	7.8	7.8	-
Financial Targets										
Oper. costs/inpatient day (constant 1990/91 Kshs)										
Target:	578	602	600	600	600	580	555	800	800	800
Actual:	513	394	457	352	523	614	946	783	757	-
Net income (current Kshs. million)										
Target:	(0.9)	0.0	0.0	0.0	0.0	0.0	4.0	0	0	0
Actual:	(37.6)	24.0	(75.9)	2.2	68.8	301.6	371.7	395.2	-	-
Fees/Rec. Expend. (%)*										
Target:	1.8	3.6	15.0	15.0	17.2	21.7	22.8	20	22.5	25
Actual:	7.7	7.9	4.3	8.5	13.2	14.7	16.4	17.5	16.8	-
KNH Grant/rec. exp. (%)										
Target:	94.9	82.5	82.3	76.0	72.7	72.0	71.4	80	77.5	75
Actual:	78.8	87.6	76.2	88.0	66.0	105	91.8	113	106	-
KNH Grant as % of MOH Budget										
Target:	13.7	12.5	13.2	12.9	12.6	12.2	11.9	15.0	13.0	12.0
Actual:	10.2	9.8	12.8	13.4	16.7	16.0	16.4	15.1	16.9	-
Facility Targets										
Maint. as % of Rec. exp.										
Target:	2.2	3.8	5.0	6.0	6.0	6.0	6.0	4.5	5.0	6.0
Actual:	2.4	1.6	1.9	1.5	2.2	3.8	3.9	4.0	4.0	4.36**

Notes: Operating Costs = Total recurrent expenditure less depreciation. Target for 1996/97 and after defined solely by KNH due to failure to agree with IDA on revised targets. Net income is inaccurately calculated as funds remaining in accounts at end of year, due to irregularity of payments from MOH, net income actually approximates zero.

*(Fees include user charges & NHIF reimbursement). **budgeted

Kenya
Health Rehabilitation Project
Table 16a: Ministry of Health Budget: Total Public Health Expenditure

	1990/91 Actual	1991/92 Actual	1992/93 Actual	1993/94 Actual	1994/95 Actual	1995/96 Actual	1996/97 Actual	1997/98 Budget*
Total Expenditure (KSH millions)								
Recurrent	2,576.1	2,956.7	3,410.5	4,465.0	5,724.3	7,222.3	7,727.1	9,648.4
Development	752.3	730.4	1,086.0	1,951.9	1,108.0	1,675.0	2,616.4	6,008.7
Total	3,328.4	3,687.0	4,496.5	6,416.9	6,832.3	8,897.2	10,343.5	15,657.1
Total Expenditure (1986 constant prices)								
Recurrent	1,580.5	1,516.2	1,375.2	1,230.0	1,223.1	1,523.7	1,494.6	1,678.0
Development	461.5	374.5	437.9	537.7	236.7	353.4	506.1	1,045.0
Total	2,042.0	1,890.8	1,813.1	1,767.7	1,459.9	1,877.1	2,000.7	2,723.0
Total Expenditure (percentages)								
Recurrent	77%	80%	76%	70%	84%	81%	75%	62%
Development	23%	20%	24%	30%	16%	19%	25%	38%
Total	100%	100%	100%	100%	100%	100%	100%	100%
Real Growth Rate								
Recurrent	n/a	-4%	-9%	-11%	-1%	25%	-2%	12%
Development	n/a	-19%	17%	23%	-56%	49%	43%	106%
Total	n/a	-7%	-4%	-3%	-17%	29%	7%	36%

*Provisional
Source: Government of Kenya

Kenya
Health Rehabilitation Project
Table 16b: Ministry of Health Budget: Functional Composition of Recurrent Health Budget
(percentages)

	1994/95 Actuals	1995/96 Actuals	1996/97 Actuals	1997/98 Budget*
National Level				
Central Administration & Planning (HQ)	4.6	3.6	4.4	3.2
Central Medical Store	0.6	0.5	0.5	0.6
Kenyatta National Hospital	17.0	17.3	15.6	14.6
Specialized Hospitals	2.2	1.9	1.9	2.3
National Health Insurance Fund	0.9	0.2	0.1	3.4
Health Training Colleges (KMTC) - Central**	1.3	1.3	1.3	1.2
Engineering & Production Units	0.3	0.3	0.3	0.1
Grants to NGOs	0.2	0.3	0.1	0.0
Sub-total	**27.1**	**25.3**	**24.1**	**25.5**
Provincial Level				
Provincial Administration & Planning	1.4	1.3	1.4	0.6
Provincial Hospitals	13.4	13.2	14.1	15.6
Health Training Colleges (KMTC) - Province**	1.4	1.3	1.4	1.3
Port Health Control	0.4	0.4	0.4	0.4
Sub-total	**16.6**	**16.2**	**17.3**	**18.0**
District Level				
District Hospitals	37.4	38.2	37.9	37.8
Rural Health Centres and Dispensaries	9.7	10.0	10.5	12.7
District In-Service Training Services	0.1	0.0	0.0	0.0
Rural Health Training and Demon. Centers	1.2	1.1	1.0	1.3
Health Training Colleges (KMTC) - District**	2.0	1.9	2.0	1.9
Sub-total	**50.3**	**51.1**	**51.4**	**53.8**
Vertical Programs				
National AIDS Control Program	0.1	0.2	0.1	0.1
Sexually Transmitted Infections Program	0	0	0	0.1
National Quality Laboratories	0.0	0.0	0.0	0.0
Environmental Health	3.6	3.8	3.7	0.1
Communicable and Vector Control Diseases	0.6	2.0	2.0	0.7
Nutrition	0.1	0.1	0.0	0.1
Family Planning & MCH	0.6	0.5	0.5	0.3
Health Education	0.1	0.1	0.1	0.1
National Public Health Laboratories Services	0.9	0.8	0.7	0.7
Government Chemists	0.0	0.0	0.0	0.4
Sub-total	**6.0**	**7.5**	**7.1**	**2.7**
TOTAL	**100**	**100**	**100**	**100**

Source: Government of Kenya
Notes: * Provisional
**The allocation of resources KMTC between Central, Provincial and District Levels for the years 1995/96, 1996/97, 1997/98 are based on the allocation reported in 1994/95.

Kenya
Health Rehabilitation Project
Table 16c: Ministry of Health Budget: Economic Composition of Recurrent Health Budget

	1994/95 Actuals	1995/96 Actuals	1996/97 Actuals
Personnel			
Salaries	42.6	36.5	35.5
Allowances (fixed)	15.4	19.1	18.8
Allowances (variable)	0.5	0.4	0.4
Gratuity and Pension Contribution	0.8	0.1	0.1
Technical Assistance	0.1	0.3	0.4
Sub-total	**59.4**	**56.4**	**55.2**
Drugs & Supplies			
Drugs	8.3	9.8	10.0
Medical Supplies	0.7	0.8	0.7
Miscellaneous Supplies	2.3	1.5	2.2
Food	4.5	3.3	3.5
Sub-total	**15.8**	**15.4**	**16.4**
Utilities	**3.0**	**2.9**	**3.8**
Transport			
Operating Expense	1.8	1.6	1.8
Travelling & Accomodation	0.9	0.5	0.7
Hire of Transport, Machinery, and Plant	0.0	0.0	0.0
Sub-total	**2.7**	**2.1**	**2.5**
Maintenance & Replacement			
Equipment	0.6	0.5	0.7
Vehicles	0.0	0.0	0.1
Buildings	0.2	0.2	0.2
Sub-total	**0.8**	**0.7**	**1.0**
Grant & Other Expenditure			
Grants	18.2	22.3	21.0
Other Expenditures	0.1	0.1	0.1
Sub-total	**18.3**	**22.4**	**21.1**
TOTAL	**100**	**100**	**100**

Source: Government of Kenya

Kenya
Health Rehabilitation Project
Appendix A: Completion Mission's Aide Memoire
September 23-30, 1998

1. A World Bank mission visited Kenya from September 23-30 for the purpose of preparing the Implementation Completion Report (ICR) for the Kenya Health Rehabilitation Project (Cr. 2310-KE), which closed on June 30, 1998, after a one-year extension. The mission comprised Andrew Follmer (mission leader, AFTH1), Wacuka Ikua (AFMKE), Lucas Ojiambo (AFMKE), John Ogallo (AFMKE), Dahir Warsame (AFMKE), and Dick Coppinger (Civil Works Consultant). The mission was postponed from its previously-scheduled dates in August to allow the Ministry of Health to focus on the addressing the needs arising from the August 7 bomb crisis in Nairobi.

2. The mission would like to express its appreciation to the representatives of the Ministry of Health, Kenyatta National Hospital, Nairobi City Council, Provincial Medical Officer-Nairobi, and Central Bureau of Statistics who worked with the Bank during the mission, and the months leading up to the mission, to review the implementation of the project. Most of the discussions during the mission are reflected in the Implementation Completion report.

Borrower Contribution

3. The degree of preparation for this mission by the Government of Kenya and Kenyatta National Hospital was impressive. A comprehensive draft Borrower Evaluation report had been prepared prior to the mission's arrival, and this report provided a solid basis for discussion. **The final Borrower Evaluation Report, of which a 10 page Executive Summary will be attached to the ICR, will be submitted to the Bank by October 9, 1998.** The Borrower will also submit to IDA formal comments on the draft ICR, which will be sent by IDA following the mission.

Procurement

4. A procurement review is being conducted of the project by IDA. **As of one month subsequent to the end of this mission, the Government of Kenya had not yet made available all the materials necessary to complete this review as requested by IDA. Given that the GoK's timely cooperation with such reviews is a legal requirement under the Development Credit Agreement, IDA expects that the requested documents will be made available by GOK immediately.** All goods and equipment procured under this project have been delivered, and distribution of these goods continues at an impressive rate. At the time of the mission, 4 to 5 trucks per day were departing Nairobi to deliver these items to health facilities throughout the country. These goods and equipment are expected to have a significant impact on the capacity of these facilities to provide quality health care.

Disbursements

5. **The project is currently under its disbursements grace period, which ends October 30, 1998.** Since project closing, the majority of the remaining balance of this credit has been disbursed. Currently, approximately 14% of the credit is undisbursed, though most of this is expected to be disbursed prior to the closing of the books. **The GOK had the goal of submitting all pending withdrawal requests to IDA by September 30, 1998; however, as of October 26, few had been received.** In addition, a thorough Statement of Expenditures (SOE) review is underway. **Unfortunately, this review has not been completed as of one month after the mission because the GOK has not made available all the documents necessary for the review as requested by IDA. Given that the GOK's timely cooperation**

with such reviews is legally required under the DCA, IDA expects that the requested documents will be made available by GOK immediately.

Outstanding Audits

6. The SOE audit for KNH is currently outstanding, and disbursements against SOEs for this category are consequently under suspension. The MOH has verbally informed IDA that all SOEs covered in the MOH Audit of SOEs are, in fact, KNH SOEs, as the MOH did not utilize SOEs under this credit. **IDA has requested a letter confirming this information, which was received. However, queries remain to be addressed before the suspension can be lifted. These were communicated to the Government in a letter from the Country Director.** Furthermore, it was agreed that the Ministry of Health shall seek to address all audit qualifications from the most recent audits by the close of disbursements on November 30, 1998.

Development Objectives

7. The mission notes that the one-year extension of the project granted by IDA resulted in significantly greater fulfillment of the development objectives than would have been the case had the project closed as originally planned on June 30, 1997. A thorough discussion of the Achievement of Objectives, and an Assessment of Outcome, is included in the draft ICR.

Unfinished Civil Works Under the Nairobi Area Health Services Component

8. **The mission is disappointed to note that the civil works at the 14 Nairobi City Council clinics, which were expected to be completed by June, 1997, at the time of contract award, were incomplete at the time of project closing and remain incomplete.** Work continues on these clinics, financed by GoK, and it is uncertain when they will be complete, though NCC estimates that all clinics will be completed and fully operational by January 1, 1999. Three of the clinics are closed, and several more are only partially operational. **IDA will only finance the percentage of the work deemed to have been completed prior to June 30, 1998.** Furthermore, the ICR will recommend that completion of these clinics to the satisfaction of IDA be a condition of appraisal for any future IDA credit to the health sector in Kenya. The mission also concluded that current provisions for the sustainability of IDA's investment in these clinics is unsatisfactory, and the MOH is encouraged to work with NCC to address this issue.

Welfare Monitoring System: Sustainability

9. The mission has expressed serious concern about the sustainability of IDA's investment in the Welfare Monitoring System component. There is a serious need to strengthen the institution and systems of the Central Bureau of Statistics which is threatening that institution's ability to provide the invaluable statistical outputs on which decision-makers throughout the Government depend. The level of current GoK funding is inadequate to address these needs, and additional donor support is not anticipated. A Task Force has been named to examine these issues and follow up on the recommendations of the February, 1998, IMF Mission; the report of this Task Force is expected to be completed by April, 1999.

Agreed Actions and Schedule for Completion of ICR

Agreed Action	Date Due
1. MOH to submit to IDA disbursement estimates/schedule by category	Immediately (fulfilled)
2. Borrower to submit final Borrower Evaluation Report (hardcopy and diskette)	October 9, 1998 (outstanding on October 26, 1998)
3. IDA to provide draft ICR to Borrower for comment (as of Oct. 26, unable to be fulfilled due to GOK's delay in providing documents requested for SOE and procurement reviews)	October 23, 1998
4. End of Disbursements Grace Period	October 31, 1998
5. Borrower to Address all Audit Qualifications	November 30, 1998
6. Borrower to provide IDA with comments on draft ICR	November 6, 1998
7. Dissemination of Final ICR	December 31, 1998

Kenya
Health Rehabilitation Project
Appendix B: Civil Works Report (September, 1998)

PART I: KENYATTA NATIONAL HOSPITAL
PART II: NAIROBI CITY COUNCIL CLINICS

PART I: KENYATTA NATIONAL HOSPITAL

Completion Status. The project is fully complete. Not only is the project fully complete but the final account, inclusive of all claims, is complete and has been agreed by the Contractor. In general the outcome of the project can be regarded as very successful although there was a considerable overrun in the contract period . The initial contract period was 75 weeks commencing in May 1995 and due for completion in October 1996. The project was finally completed in March 1998 and the actual contract period was 148 weeks, a time overrun of almost 100%.

Reasons for extended contract period.

i) *Hospital operations*. The effect of maintaining the hospital in a fully operational state during the implementation of the work was underestimated in the original contract programme. The result of the situation was that work on almost all sections of the hospital had to be done in stages. Time was lost by the client in vacating areas and making them available to the contractor and similarly time was lost in taking over and transporting operations to a completed area. The Client was therefore unable to hand over areas to the Contractor as planned and the time lag in transporting operations to a completed areas was also considerable.

ii) *Increased dilapidations*. The original surveys for the scope of the rehabilitation works were done in 1990 and the actual rehabilitation was done in some areas up to 6 or 7 years later. Over this time the condition of some of the facilities in the hospital, particularly with regard to mechanical and electrical services, had deteriorated rapidly. The implications of this situation were that complete dilapidation surveys had to be redone as soon as new areas were handed over to the contractor. These often resulted in an increase in the scope of work and causes for further delay (approval of extra costs, importation of specialised items etc).

iii) *Nature of the work.* Rehabilitation work by its very nature is more difficult to plan than new work and the Client was often faced with difficult decisions as to where to draw the line with the rehabilitation work. The complexity of hospital construction and the inter dependency of services and builders work was often the cause of delays. In any situation rehabilitation work involves the taking of detailed inventories by the Hospital, the PIT and the contractor before work can commence. This can be time consuming and cause delays.

iv) *Late instructions.* In the case of increased dilapidation's and an increase in the scope of work instructions to the contractor are inclined to be delayed. The extra work involves negotiation by the PIT, with both the Client and the Contractor, and agreement and approval of extra costs before instructions can be issued and work can commence.

v) *Project management services.* The project management structure was cumbersome and involved too many parties: KNH Management and Users, MOPW Project Managers, sub divisions of MOPW (structural, mechanical, electrical quantity surveying etc) and the sub consultants/structural, mechanical).

Design and quality of construction. The work in this project comprised the rehabilitation of the existing hospital and therefore the extent of the new design work was limited. The scope of the work undertaken was found to be appropriate as was the design of the new works (e.g. the new mortuary). The quality of workmanship was found to be acceptable to good. Some isolated areas of poor workmanship were observed mainly in the finishing of the toilets in the wards of the tower block. The general standard of workmanship can be regarded as good and the users declared their satisfaction with the end product.

Changes to the original scope of work. There have been considerable changes to the original scope of work and these have been detailed separately in an attached "Statement of Final Account". Most of these changes have been necessitated either by (i) increased dilapidations: these have been caused either by further deterioration between the time of the original survey and the time of executing the work or inadequate initial dilapidation surveys; or (ii) modified Users requirements: the personnel involved in the rehabilitation at the time of the projects inception and its actual execution changed and their requirements and policies were often different. In general terms the changes made to the original project scope of work are considered appropriate and justified. In financial terms the effect of the changes in the original scope of work have resulted in an increase in the value of work done from Kshs 401 M to Kshs 520 M. This represents an increase of 30%.

Financial aspects of the Project.

i) *Final account.* The final account for the project has been thoroughly scrutinised and found to be in order. The final account is summarised in the following table.

ITEM	ORIGINAL CONTRACT	FINAL A/C	% INCREASE	REMARKS
Prelims	19,275,000	19,275,000	-	
Builders Work	235,171,970	289,824,906	+23%	Increase of 23% due mainly to increased dilapidations and increase in scope of work requested by KNH.
Mechanical Installation	117,727,286	156,256,318	+33%	33% increase due to increased dilapidations, indadequate initial site surveys (steam system) and additional Client requirements regarding Circulating Water Steriliser and Oxygen back up system.
Electrical Installation	28,667,288	46,097,095	+60%	Increase of 60% due to increased dilapidations and additional scope of work requested by KNH.
Loss/ Expense Claim		61,901,335		15% of original contract.
Interest on Delayed Payments		4,192,369		1% of original contract
Totals	**400,841,545**	**586,547,024**	**+46%**	

ii) *Loss /Expense Claim.*
The contract period was extended by a period of 74 weeks. A detailed exercise was performed by the PIT to apportion the blame for the delay between the Employers and the Contractor. The details are contained

in the Progress Review Report as at 31st March 1998 attached to this report. The outcome of the report apportioned 63% of the blame on the Employer and 37% on the Contractor. This claim was settled as indicated in the following table.

ITEM	AMOUNT (Shs)	REMARKS
Loss on Prolongation period	35,912,000	25% Prelims, 52% Supervision, 23% Plants Equip.
Fluctuations on Material + Labour	18,396,000	Only paid for extended contract period.
Loss on Advance Payment Security	3,609,000	Delayed release by Employer
Additional Security	2,630,000	-
Overtime	1,352,000	-
Extended Prelims for sub contractor	648,000	-
Total	**61,901,000**	

iii) *Interest on delayed payments.* The project has suffered from a history of delayed payments. Apart from the cash flow problems and delays that the delayed payments have caused the contractor the direct cost to the project has been significant amounting to 4.2 M Shs. The delays in payments beyond the 56 days stipulated in the Contract are detailed below.

	Delay in Local Currency Payment		Delay in Foreign Currency Payment	
	World Bank	G.O.K	World Bank	G.O.K
Advance Payment	-	310 days	-	572 days
Certificate 1	60 days	217 "	61 days	481 "
Certificate 2	19 "	176 "	26 "	249 "
Certificate 3	140 "	135 "	29 "	208 "
Certificate 4	10 "	95 "	-	168 "
Certificate 5	70 "	91 "	63 "	164 "
Certificate 6	16 "	44 "	16 "	117 "
Certificate 7	56 "	193 "	33 "	251 "
Certificate 8	57 "	39 "	8 "	39 "
Certificate 9	40 "	16 "	42 "	147 "
Certificate 10	49 "	92 "	77 "	98 "
Certificate 11	24 "	67 "	37 "	100 "
Certificate 12	44 "	17 "	39 "	17 "
Certificate 13	84 "	73 "	73 "	72 "
Certificate 14	82 "	95 "	66 "	93 "
Certificate 15	87 "	114 "	100 "	106 "
Certificate 16	56 "	92 "	57 "	61 "
Certificate 17	93 "	115 "	93 "	84 "

Project and Construction Management. The Project Management structure has been extremely cumbersome and has been such that it has been difficult for the PIT (Project Implementation Team) to function efficiently. The original lead Consultants for the project were terminated due to non performance and the MOPWH (Ministry of Public Works and Housing) were appointed. This meant that there were far too many parties involved: KNH Management, MOPWH Project Manager (who was answerable to his

superiors) the sub divisions of the MOPWH (structural , mechanical, electrical, quantity surveying) and all the sub consultants for the various disciplines (structural mechanical etc).

The PIT was faced with several changes in key personnel over the duration of the Project and many changes in the Hospitals requirements. There were also increased dilapidations over the period. With so many personnel involved the decision making process was slow and a more autonomous arrangement for the Project Management would have been more effective.

Despite this arrangement it is a credit to the personnel involved particularly in the last 18 months of the project, that it was completed successfully.

Sustainability: With regard to sustainability in terms of maintenance of buildings and equipment it is considered that the in-house capacity of KNH is weak, both in terms of human and physical resources.

PART II: NAIROBI CITY COUNCIL REHABILITATION OF CLINICS.

Completion Status. The degree of completion on this project is very disappointing. The 14 clinics in the Nairobi City Council have been divided into 3 zones for the purposes of this project. The scope of work and completion status at 30/6/98 and 30/9/98 which are the dates at which the Credit closed and the date of the final inspection respectively are shown in detail on the attached chart. The status can be summarised as follows:

i) *Western Zone*. The work in this zone is substantially complete. There are however serious defects at 2 out of the 4 clinics. At 1 of the clinics the foul sewerage system is not operational and at the second there are serious roof leaks. These defects are seriously affecting the operation of the clinics and need to be attended to by Nairobi City Council as a matter of urgency.

ii) *Central Zone*. The work in this zone is only approximately 80% complete and due to non payment to the Contractors all work was basically at a standstill at the time of the field inspection. The consequences of this situation are that out of the 5 clinics in this zone affected by the rehabilitation project sections in 3 of the clinics are not yet in usable condition. The most critical items regarding completion are the sewerage systems at 1 of the clinics, installation of water tanks at 3 clinics and the completion of the flooring at 2 clinics.

iii) *Eastern Zone*. The work in this zone is also only approx 80% complete due to non payment to the Contractor. Of the 5 clinics involved 2 clinics are not in a usable condition due to the incomplete works. The most critical items of incomplete work are roof leaks in two of the clinics, incomplete flooring in 2 clinics, and installation of water tanks at 3 clinics.

Design work related to the rehabilitation. The bulk of the work in this project involves the rehabilitation of existing facilities and therefore the design was basically determined by the form of the existing facilities. The design of the existing clinics is generally considered to be appropriate for the areas and the populations they are serving.

Changes to the original scope of work. There have been several revisions to the original scope of work during the execution of the contracts for the following reasons:

i) inadequate original site investigations and surveys.
ii) Undermeasurement of critical items of work in the original Bill of Quantities.

iii) Overemphasis at planning stage on upgrading the external works which was unnecessary.
iv) Pressing need to prevent encroachment on, and possibly security to, the facilities particularly in areas of high population density.
v) Due to the poor performance of the NCC and the Contractors in the early stages of the contract and the expiry of the credit the NCC opted to reduce the scope of work in the eastern and central zones. The criteria was to endeavor to ensure that all critical items were completed prior to the termination of the project credit.

Quality of work. The quality of workmanship and materials on the project was not particularly good. The main reasons for this being the appointment of contractors of a lower grade and also poor supervision on the part of the NCC. The main areas of concern are the quality of timber and the effectiveness of treatment of the timber structure used in the new pitched roofs. The standard of masonry work is generally acceptable but the finish in some units is poor. Other example of poor workmanship and materials include internal finishing details such as ironmongery on doors and woodwork to cabinets and cupboards which was poor in some units. The concrete quality on a few of the water tower structures was poor and there was no evidence of quality control and testing being done by the NCC supervision.

Implementation and project management.

i) *Design stage*. Inadequate site investigations and surveys at design stage have resulted in many variations to the scope of work becoming necessary during the course of the work. The detailing and documentation provided for tendering was not of a high standard and there are many instances where the work items have been undermeasured in the contract Bills of Quantities.

ii) *Supervision*. The standard of supervision of the work has been poor . The lack of transport resources within NCC has meant that regular visits to site by NCC architects, inspector and quantity surveyors has been irregular and the work has been executed by the Contractors largely unsupervised.

iii) *Contract administration*. This has been poor. The initial contract formalities took an inordinate amount of time. The records of site measurements, site meetings and contract correspondence are not comprehensive.

iv) *Payment procedures*. There have been severe delays in payments to the contractors which have had a very negative effect on the project. The payment delays are detailed separately. They have resulted in severe cash flow problems with the contractors, forcing them to slow down the progress. It has also created an atmosphere of distrust amongst the contractors and with the slow down in progress enthusiasm from all parties involved in the project has waned. Procedures both within the NCC and MoH are very bureaucratic and initiatives introduced during previous supervision missions have failed to reduce the delays. Apart from the cost to the project in terms of completion delays the cost to NCC in terms of interest payable for late payments under the contracts is likely to be significant.
A separate chart has been attached to this report indicating the extent of the payment delays on the project.

Sustainability. With regard to sustainability the NCC claim that they are fully geared up as regards staff, furniture, medical equipment and consumables to run the clinics effectively. Of the clinics that are already operating there was evidence of shortage of medical supplies and furniture. The general lack of resources and efficiency within NCC does not auger very well for the smooth running and sustainability of the rehabilitated clinics. Factors that show these indications are the fact that of all the lab/ dental units already completed in the Western zone none are furnished and operational and the existing clinic at Kayole which was completed almost 10 years ago has not yet been opened.

Kenya Health Rehabilitation Project: Appendix B (continued)
Nairobi City Council - Rehabilitation of Health Facilities: Scope of Work and Progress

Zone 1 (Western) Fahari Building + Civil Engineering Contractor

Clinic	Original Value Kshs	Revised Value Kshs	Scope of work	Estimated Completion Status 30/6/98	Completion Status 1/9/98	Remarks
	18,554,275	19,991,000				
Kangemi Status: OPEN	4,871,111	5,176,000	New boundary wall New laboratory Re roofing Internal rehab. Boundary wall + Gate Resurface roads	100% 100% 100% 100% 100% Nil	100% 100% 100% 100% 100% Nil	New laboratory complete but not in use. Resurfacing of roads omitted from the work. Boundary wall added to scope of work. Building works undermeasured in original BoQ.
Riruta Status: OPEN	3,514,910	3,860,000	New Lab/ Dental unit Re roofing. Internal rehabilitation. Levelling of Car park.	100% 100% 100% 100%	100% 100% 100% 100%	New laboratory complete but not in use. Surfacing of car park omitted from the work. Building works undermeasured in original BoQ.
Karen Status: OPEN	3,650,885	4,545,000	New laboratory. New toilet block. New gate + fence. Internal rehabilitation. Re roofing of waiting area.	100% 100% 100% 100% 100%	100% 100% 100% 100% 100%	New laboratory complete but not in use. Surfacing of road works omitted. Foundation problems at laboratory and toilet blocks resulted in increased cost.
Lang'ata Status: OPEN	5,393,501	6,326,000	New Lab /dental unit. Re roofing. Internal rehabilitation. Resurfacing of road.	100% 100% 100% Nil	100% 100% 100% Nil	New laboratory complete but not in use. Resurfacing of road omitted from the work. Size of the laboratory increased. Foundation problem at new lab and dental unit resulted in increased cost.

Kenya Health Rehabilitation Project: Appendix B (continued)
Nairobi City Council - Rehabilitation of Health Facilities: Scope of Work and Progress

Zone 2 (Central) Reef Building Systems

Clinic	Original Value Kshs	Revised Value Kshs	Scope of work	Estimated Completion Status 30/6/98	Completion Status 1/9/98	Remarks
	18,429,081	**17,602,000**				
Ngara Status: CLOSED	7,253,955	8,062,000	New Lab/ Dental unit Re roofing. Internal Rehab. Water Tower + Tank. Resurface carpark/ Access. Boundary wall. Electrical.	0% 90% 60% 80% + 0% 0% 0% 90%	Omitted. 100% 80% 90% +0% Omitted. 5% 95%	Laboratory omitted from the work. Water Tower and Tank added. Resurfacing of car park omitted. Boundary wall added i.o fence. Roofing undermeasured in BoQ. Burglar proofing undermeasured in BoQ. Internal finishing undermeasured in BoQ. **NCC estimates fully operational: Oct. 31, 1998**
Eastleigh Centre Status: Partially OPEN	4,788,041	4,409,000	New lab and waiting area. Re roofing. Water tower + tank. Int. Rehab of maternity clinic. Resurfacing car park. Fence and gate. Drainage Rehab.	0% 90% 80 + 0% 65% 0% 0% 0%	Omitted. 100% 90 + 0% 75% Omitted 0% 0%	Laboratory omitted. Water Tower + Tank added. Resurfacing of car park omitted. Fence, gate and drainage omitted. Roofing and burglar proofing undermeasured in BoQ. **NCC estimates fully operational: Nov. 30, 1998**
Bahati Health Centre Status: Partially OPEN	4,026,345	4,093,000	New laboratory. Re roofing Water Tower + Tank. Internal rehab. Car park/ access road. Fencing. Rehab of sewer.	0% 90% 40 + 0% 60% 0% 0% 20%	Omitted. 100% 50 + 0% 80% Omitted. 0% 40%	New laboratory omitted. Water Tower and Tank added. Car park/ access road omitted. Roofing undermeasured in BoQ. Rehabilitation of sewerage added. **NCC estimates fully operational: Nov. 15, 1998**
Ngaira Status: OPEN	451,408	538,000	New dental unit. Reroofing of TB Clinic.	0% 0%	Omitted. 0%	New dental unit omitted. Reroofing of TB clinic added.
Jericho Status: OPEN	1,434,305	47,406	New dental unit + lab.	Omitted.	Omitted.	Laboratory abandoned at foundation stage.

Kenya Health Rehabilitation Project: Appendix B (continued)
Nairobi City Council - Rehabilitation of Health Facilities: Scope of Work and Progress

Zone 3 (Eastern) G.G. Gachara Construction

Clinic	Original Value Kshs	Revised Value Kshs	Scope of work	Estimated Completion Status 30/6/98	Completion Status 1/9/98	Remarks
	18,366,035	**15,663,000**				
Kayole Status: CLOSED	1,702,296	495,000	Laboratory. Car park paving + Drainage.	100% 0%	100% Omitted.	Room in existing clinic modified into a lab. **Clinic was completed 10 years ago under World Bank-financed Urban II Project, but was never opened. NCC estimates fully operational: Jan. 1, 1999**
Industrial Area. Status: Partially OPEN	3,222,671	2,337,000	New lab and dental unit. Internal Rehab. Boundary wall , Paving Drainage.	55% 15% 65%	65% 20% 75%	External works reduced. Burglar bars undermeasured in BoQ. **NCC estimates fully operational: Nov. 30, 1998**
Mathare North Status: Partially OPEN	5,259,926	3,341,000	New laboratory and dental unit. Roof repairs. Internal rehab. Water Tower + Tank. Car park and drainage. Boundary wall.	65% 60% 50% 60+0% 0% 0%	70% 80% 70% 80+0% Omitted. 10%	Water Tower + Tank added. Boundary wall added. Car park and drainage omitted. **NCC estimates fully operational: Nov. 30, 1998**
Dandora Status: Partially OPEN	3,985,117	3,058,000	Re roofing. Internal Rehab. Water Tower + Tank. Resurfacing and renewing paving.	90% 70% 80 + 0% 0%	100% 90% 100 + 0% Omitted.	Water Tower and Tank added. Resurfacing of car park + entrance omitted. Burglar bars undermeasured in BoQ. **NCC estimates fully operational: Oct. 31, 1998**
Kahawa Status: Partially OPEN	5,421,090	4,952,000	Re roofing. Internal rehabilitation. Water Tank + Tower. New fence and gate. Resurfacing.	90% 60% 60 + 0% 0% 0%	100% 70% 80 + 0% 10% Omitted.	Rehabilitation of sewer omitted from BoQ. Boundary wall added. Resurfacing of road omitted. Burglar bars omitted in original BoQ. **NCC estimates fully operational: Nov. 30, 1998**

Kenya
Health Rehabilitation Project
Appendix C: Executive Summary of Borrower's Evaluation Report

I. PROJECT OBJECTIVES

The Kenya Health Rehabilitation Project had the following objectives:

A. To support the Government's Programme of Health Sector Reform, which began with the Health Care Financing Programme (Cost- sharing/ Programme) by: -

1. Supporting the rehabilitation upgrading and institutional development ofKenyatta National Hospital (KNH) in order to reduce its burden on the overall Ministry of Health budget and permit an increase in expenditure on preventive, promotive and Primary Health Care;
2. Improving the delivery of Health Services in the Nairobi area outside KNH in order to decongest the latter; and
3. Preparation for future policy, managerial and investment reforms in health.

B. To support the development of a National Household welfare monitoring and Evaluation System that is being coordinated by the Ministry of Planning and National Development through the Central Bureau of Statistics (CBS).

II. COMPONENTS

A. KENYATTA NATIONAL HOSPITAL COMPONENT

Project Objectives.
Before the onset of the project, the service volume was increasing rapidly but quality was declining with shortages of drugs and supplies, long delays in diagnosis and deteriorating physical conditions. The project aimed at strengthening clinical services and establish revenue generating private services by reinforcing cost sharing thus supporting increased mobilization of resources for health from sources other than general revenues. It also aimed at securing financial sustainability and reducingKNH's burden on MoH recurrent budget from 14% downwards to allow for allocation ofMoH resources to preventive and primary services.

Achievement of Project Objectives
Despite significant improvements by KNH in many of the performance targets, it has not been able to meet the targets set by IDA. Two main reasons are attributed to this: (i) Thefulfilment of many of the targets was dependent on fulfilment of other wider conditions many of which were outside the preview of KNH. To date, they have not been fulfilled; and (ii) Many of the targets were also unrealistic given the difficulties KNH was experiencing at the time in respect to finances and management capacity. KNH has however made improvements in all the indicators, although at a rate lower than set targets.

1. Rehabilitation of Buildings and structures

The works are completed, with the following results: (i) Cleanliness and improved infection control systems; (ii) Working environment improved i.e. emergency services area (casualty), theatres, wards and clinics; (iii) Expansion of work space i.e. treatment rooms, casualty examination rooms and consulting/ doctors rooms; (iv) Cost of maintenance in clinical areas has been reduced greatly; (v) Creation of private practise within the hospital i.e. consultancy practice and a private wing; (vi) Increase revenue i.e. new mortuary; (vii) Prior to the project, people used to shun the hospital and for those who sought services in the hospital, they could not get adequate drugs. Prior to the project, the services were sluggish due to the

constraints occasioned by the existing layout. Due the face-lift, better services resulted to fewer complaints from the general public, the staff morale improved due to better working environment especially in the theatres, casualty and hospital waste disposal.

2. Training of Managers and Technicians.
The aim of this component was capacity building. To date, 135 people/hospital staff have been trained. The types of training undertaken has gone in: (i) Improving skills and professional/technical capacities of the hospital personnel; (ii) Increased clinical efficiency and effectiveness; (iii) Improved patient care as indicated by the fall in ALOS; (iv) Improved financial, personnel and procurement services.

3. Procurement of medical and non-medical Equipment
This was geared at supporting the ambulatory services, operations and patient care related services, and has had the following positive results: (i) Improvement in efficiency on patient care i.e. lowering the operations waiting lists, improved patient management in the wards and clinics resulting to quick recovery periods, thereby lowering the average length of stay (ALOS); (ii) Improvement of the working systems (patient management) hence short queues in clinics, and decline in ALOS; (iii) Performance of specialised operations/cases i.e. Kidney transplants, dialysis, and open-heart operations and trauma surgery; (iv) Reducing the cost of patient care due to improved patient management and thus reduced ALOS; (v) Reduced expenditure on biomedical equipment maintenance; (vi) Increased revenue through user fees: high patient turnover due to efficient booking system and short queues. In terms of equipment, more new and state of the art equipment in the medical field were acquired resulting in improved services and patient care. Fatalities to the hospital dropped. The offering of private practice in the hospital has increased the sense of ownership among workers. People work by choice and not by force. This has increased efficiency. In addition, the enlargement of the private wing and consultancy suits has ensured availability of doctors and expertise, whenever they are needed. There is more satisfaction resulting from effective services.

Outcomes
(i) Civil Works: Satisfactory:
(ii) Equipment: Satisfactory:
(iii) Training: Highly satisfactory.

Key factors affected achievements of the major objectives:

1. Major shortfalls in the funds which had been budgeted e.g. the funds were not enough to cover all areas especially buildings works which were in the original BQs. This has various related causes : The changes made from what was expected in BQs hence increase in dilapidation in buildings and cost overruns. The fluctuation of the currency in favour of the dollar meant that more shillings were spent per every dollar.
2. Dependency on the treasury grant has not fallen as expected, as other service providers have failed to give adequate services in the Nairobi area.
3. Due to external environment and despite the fact that service delivery at KNH has improved, congestion has continued to be a major problem, as intervention in those areas targeted to reverse the flow of patients have not been successful i.e. Nairobi City Council clinics.
4. There was lack of performance by consultants in the initial stages (thus termination of Edon Consultants) which delayed the implementation of the project. This had a multiplier effect causing delays especially in civil works, where there was poor measurement of works. This led to increase in extra works as the contractor entered the site, i.e. increase in dilapidation. It then implied that more time was needed to complete the project and the need for more financial resources.

5. There was a problem in accessing the co-financing from the GOK (10%) which delayed the processing of payments.
6. The processing of 90% through the Special Account proved to be cumbersome. It is so involving and long as it passes through MoH, Treasury and CBK/Bank before reaching to the payee. The time taken always exceeded the contractual time (56 days) agreed upon thus occasioning interest claims by the contractor.
7. There was need for more training as concerns the international competitive bidding procedures. There should be clear instructions on what the Bank expects on ICB, in their evaluation and awarding. As this initially lacked, it meant that the first ICB the hospital advertised was not successful due to lack of clarity on procedures. This then meant cancellation, waste of time to the bidders and the hospital together with loss of value in terms of the number and price of the equipment which eventually was ordered (price fluctuations).
8. The Bank has not been giving adequate technical advice especially on the area ofcomputerisation. This eventually meant that the computerisation envisaged could not take place.

B. NAIROBI AREA HEALTH SERVICES COMPONENT (US $ 3.5 MILLION BASE COST)

The objective of the Nairobi Area Health services Component was to improve the delivery of Health Services in Nairobi area outside KNH with a view to decongesting the latter so that it could serve as a true National Referral Teaching and Research Hospital. This objective was to be achieved by introducing interim improvements in service delivery developing a strategic health plan for Nairobi Area, and a modest funding for its initial implementation.

Achievement of Project Objectives
Using IDA funds under the Credit a strategic health plan for the Nairobi area was developed by a consultant working closely with the MOH, MOH_NCC and the Provincial Medical officer Nairobi. Although there were initial delays in the implementation of the strategic plan due to inability by NCC to demonstrate that it would be in a position to efficiently run and sustain the health facilities to be rehabilitated/improved, this condition was eventually met and work on rehabilitation of 14 clinics commenced and has largely been completed. Priorities for selection of facilities for rehabilitation were identified in the strategic plan. Development Credit funds have also been used to procure Medical Equipment, office equipment, vehicles and other fixed equipment required by the NCC Public Health Department to offer services to the Nairobi Population.

Capacity Building
Apart from rehabilitation of NCC facilities and purchase of equipment, Credit funds have been used to train a significant number of NCC health workers ranging from professional, Technical and Administrative personnel to facilitate better management of facilities rehabilitated and improved by the project.

NAIROBI CITY COUNCIL
The strategic plan for health services in Nairobi Area was completed in 1992. The studies from the strategic plan showed that Nairobi City Council with 46 clinics and one Maternity Hospital was capable of providing Primary Health Care services to about 70% of the urban residents who happen to fall into the low income group. Apart from Pumwani Maternity Hospital, Nairobi City Council has no facilities offering secondary care. But this would be taken care of by rehabilitating Provincial Medical Office facilities which included upgrading three facilities: (i) Mbagathi Hospital, (ii) Pumwani Hospital, and

(iii) Mathare Hospital. Later, the Mutitu Committee report of June, 1996 was to recommend the Management of all the Public facilities in Nairobi through the Nairobi Health Management Board.

The specific objectives of the NCC Component were:

1. Rehabilitation of selected Nairobi City Council clinics - Annex 1
2. Provision of improved and effective health care services with special focus on the low income groups within the catchment areas of the clinics on the main entry roads and densely populated estates (improved utilization).
3. Improvement of the referral system by making Nairobi City Council facilities operational and instituting a graduated cost-sharing program.
4. Public Education on preventive and promotive health care.
5. To improve human, financial and resource management of health services within Nairobi City Council and the Provincial Medical Office - Nairobi.

Implementation Experience

As at 30th June 1998, when the credit closed, the 13 clinics under rehabilitation were in various stages of completion. The contracts had been divided into three zones in the implementation of the civil works component of this project. (i) Western Zone, (ii) Central Zone, and (iii) Eastern Zone

Generally, the work in the Western Contract Zone had been completed by 30th June 1998, apart from a few decades which were identified. As for the Central and Eastern Zone, the work is about 90% complete on average. The two zones were particularly affected by delays in payment and performance of the contractors. The contractor for Western Zone was able to complete the work by practically financing the project from his own finances. It is expected that in another 4 weeks, all the outstanding works will have been completed.

On the training that was part of the objectives, there has been varying achievements. The training had been divided into two categories: (a) Overseas training, and (b) Local training. The overseas component is almost 100% completed and various cadres of key managerial and professional cadres have benefited. The local component, however, was hardly implemented. The reason was lack of capacity within Nairobi City Council to organize and the refusal of IDA to approve a consultant to undertake the training.

Major factors affecting the Nairobi City Council Component

The design of the project focused mainly on attaining the objectives of theKenyatta National Hospital component and did not take into account the requirement of Nairobi City Council which would lead to the attainment of the overally objective of this project. The fact that Nairobi City Council and/or Ministry of Local Authorities were not involved in the original design has therefore, had a negative impact on the project. The fact that Nairobi City Council was the implementing agency but the accounting officer belonged to another Ministry - Ministry of Health also had an effect in the overall execution of this project. The implementing officers at the lower levels of the Ministry could not acquire the ownership of the project, as it was seen as a 'foreign' Nairobi City Council project. This was to be reflected in the payment delays and other aspects.

The capacity of Nairobi City Council to manage and supervise the execution of this project is adequate. There have however, been logistical problems:

i) Lack of in-built motivation to the technical officers
ii) Inadequate transport

iii) Institutional constraints within Nairobi City Council that have resulted in poor planning and implementation.

Sustainability of Nairobi City Council Component

In July 1998, the Nairobi City Council adopted a recommendation to retain**all** the user fees generated at each facility and utilize it for the essential services. The Council had adopted in February, 1998 a recommendation to increase user fees and broaden the criteria for charge of user fees.

Within the last 18 months, the Council has employed the following cadres:

Doctors	-	32
Clinical Officer	-	23
Registered Nurses	-	30
Enrolled Community Nurses	-	100
Laboratory Technologists	-	5
Pharmaceutical Technologist	-	1

All these cadres, plus the procurement of equipment is expected to make a**major** impact of delivering the health services and lead to attainment of the overall objectives of the project.

Borrower's Performance

The performance of Nairobi City Council in the execution of this project may seem unsatisfactory. This is true as a number of factors has led to this. The fact that Nairobi City Council was omitted at the design stage, then the late implementation with only 18 months to go before the credit closure made matters worse. Nairobi City Council was not duly addressed at the appraisal. Then there have been issues of capacity and motivation which have negatively affected the project.

Bank's Performance

The Bank should have insisted on Nairobi City Council participation at the design stage, and later during the appraisal. The Bank's decision to allow Nairobi City Council use its procurement procedures in March, 1996 made a significant **positive** impact to the project. Another major positive decision by the Bank was to give the one year extension which has had a tremendous impact on the project objectives.

Assessment of Outcome

a) City Works: As of 30th September 1998, there is a very good coverage of all the planned works. The remaining portion should be completed within the next four weeks.

b) Training: The local component has not been successfully implemented. This leaves a gap which remains to be addressed in future. The overseas component has been successfully implemented. The beneficiaries, the health managers will make a significant impact on the delivery of services.

c) Procurement of Equipment: This has been accomplished through the procurement agent - GTZ.

NAIROBI PROVINCIAL MEDICAL OFFICER'S COMPONENT

The role of the PMO Nairobi is crucial to the de-congesting of KHN in that whereas the MOH-NCC is supposed to provide public health/Primary Health Care facilities and services, the PMO has an obligation to provide secondary/hospital based curative services outside Kenyatta National Hospital

During the time of appraisal the project sought to provide Technical Assistance to meet priority needs at selected Nairobi City Commission and Ministry of Health facilities under the jurisdiction of the PMO. In the strategic plan therefore and since Nairobi Province does not have a Provincial hospital, the PMO proposed: (i) completion of the 288 bed Pumwani Provincial General Hospital (Pumwani Nyayo wards that were initiated on Harambee basis.); (ii) Upgrading of Mbagathi Hospital into a full fledged District Hospital for Nairobi; and (iii) conversion of an existing old Ward atMathare Psychiatric Hospital into an Outpatient Department and Rehabilitation of the sewage system at an estimated cost of Ksh.20 Million and Acquisition of Medical and other equipment for the rehabilitated and completed facilities. However, except for the upgrading of Mbagathi Hospital, these activities were not undertaken under the credit due to delays in preparing proposals acceptable to IDA. The upgrading ofMbagathi received support from the credit in the form of medical equipment, and the planned physical rehabilitation was not undertaken for the same reason of delays. The PMO's office Nairobi also received support in the form of vehicles, equipment, and the training of staff.

The shortcomings that had hindered implementation were addressed by the new team that joined the Project just before the one year's extension. Redress of these shortcoming and the appointment of Ms. GTZ on November 1996 as a procurement Agent turned the project implementation around as will be illustrated under the part dealing with assessment of Outcome.

C. HEALTH PLANNING AND ANALYSIS COMPONENT (US $ 2.0 MILLION BASE COST)

The objective of this component was to strengthen capacity for Health Planning and Analysis and preparing for future policy, management and investment reform in health, in line with the letter on Health Policy.

The component included building of capacity of the Ministry's Division of Planning and Development (now division of policy, Planning and Development) carrying out a series of analytical studies on the health sector, and supporting the Ministry's Health Sector Reform initiatives, including support to the Health Care Financing Secretariat, establishing a public investment programme (PIP) for health; and developing a phased programme for reform.

Activities Carried Out by Project Component

Since the inception of the project, a number of important activities were financed from the proceeds of the Project under this component. These activities ranged from strengthening the capacity of the DPD through short- and long-term training both locally and overseas; support to the Health Care Financing Secretariat (HCFS); Support to the Ministry's Health Sector Reform secretariat; financing the Burden of Diseases workshops both locally and overseas; financing the World Development Report (Investing in Health Workshop in June 1993; financing a workshop of the review of the Draft KENYA HEALTH POLICY FRAMEWORK paper and supporting sponsorship of over 20 senior managers at the Ministry's Headquarters; Provincial and District Levels to attend strategic management and management of change in the U. K., USA and to undertake short technical courses. This activity was undertaken to support implementation of preparatory activities on the Health Sector Reform Project.

With the proceeds of the project, the following activities were undertaken:-

Strengthening the Division of Planning and Development

The capacity of the Division of Planning and Development was strengthened through Provision of Technical Assistance (Mr. Ian Sliney); staff training both locally and abroad and purchase of computers

and computer software for use by the Department and posting of more senior staff to the Division including a Chief Economist (Now Deputy Chief Economist) to Head the Division.

During the life of the project, a total of eleven (11) officers working in the Division of Planning and Development and the HCF Secretariat were sponsored for both short courses and long courses leading to the award of Masters' Degrees in Planning and Public Health.

Support to the Health Sector Reform Secretariat (HSRS)

During the last eighteen months of the project life, considerable support was extended by the project to support HSRS activities. The major activities in this area included: (i) Carrying out special studies and pilot tests on resource needs and preparation of 'Business plans' for four (4) District Hospitals (Kiambu, Thika, Machakos and Kajiado) in preparation for piloting of the Hospital Autonomy concept in District Hospitals; (ii) Support to operations and maintenance of the Health Sector Reform Secretariat by provision of O and M finds from the proceeds of the project; and (iii) Purchase of vehicles; office equipment (including computers and software and furniture for the use by the HSRS.

Analytical Studies on the Health Sector

During the life of the project the following major studies were undertaken and the results are being used in the formulation of the Ministry's long term PIP in the context of rehabilitation and consolidation of existing health infrastructure. These are: (i) Study that led to the preparation of a strategic Health plan for the Nairobi area to help relieve congestion at KNH; (ii) A health manpower study and a long term strategy for education and training of Health personnel in Kenya (By M/S Development Solutions for Africa); (iii) The pharmaceutical procurement distribution and use study (Mr. John O' Quick); (iv) The Curative Gap Study which was coordinated by the Division of Planning and Development and; (v) A study on the rehabilitation needs of the Ministry's buildings and major equipment.

Achievement of Project Objectives

In the context of the Project objectives, this component satisfactorily achieved the objectives contained in the Staff Appraisal Report of November 30, 1990. The findings and recommendations contained in the analytical studies are being utilized in formulating the sector's Medium Term Expenditure Framework (MTEF) and focusing attention on the core areas of the Ministry's Medium and Long Term Public investment Programme (PIP). The project's activities telescoped into the preparation of the Ministry's POLICY FRAMEWORK PAPER OF NOV. 1994 and will give important and relevant information for the preparation of the Health Sector Reform Project currently underway.

Impact of the Ministry's Cost Sharing Programme

Since the inception of the Cost Sharing Programme in 1989, revenue collection from both user charges and reimbursements from the NHIF have risen steadily from less thanKsh. 100 million to over Khs.391 Million in 1996/97. The estimate for 1997/98 was over Ksh.400,000. A total figure for the period will be given when the revenue account is finalised and audited. 75% of the revenues collected is used by the collecting institutions and 25% is used to finance Preventive and PHC activities in the districts in which the collecting facilities are located.

Revenue raised through cost sharing supplements funds provided to the Ministry through the Exchequer. It has greatly assisted the Ministry in sustaining operations and maintenance expenditures in the since the inception of the programme. Measures have been put in place to streamline and strengthen internal controls on the collection; accounting and use of Cost Sharing revenues. These measures are expected to lead to a realisation of higher collection levels from 1998/99 Financial Year onwards.

Assessment of Outcome: Given the component's objective, the overall outcome was satisfactory.

D. WELFARE MONITORING SYSTEM (MINISTRY OF PLANNING AND NATIONAL DEVELOPMENT)

Objectives

The overall objectives of the project were:-

(a) Strengthening of the district Central Bureau of Statistics Office network through the provision of technical support and training.

(b) Strengthening the social sector department of MPND in developing its capacity to carry out analytical work.

Specific objectives

(i) Establish an information system that will provide timely indicators on living standards for different population groups;

(ii) Monitor and inform policy-makers of changes in living standards, particularly for the vulnerable groups;

(iii) Develop the analytical capability to relate changes in the living standards to national policies and programmes.

Achievement of Project Objectives

Overall, the project has made positive progress in achieving its objectives, despite apparently low disbursement levels arising from failure to submit claimable expenditures and slow process of clearing the audits e.g. project, special account and the statement of expenditures (SOEs).

So far three volumes of reports have been prepared from survey data. These include:

(1) Welfare Monitoring Survey II Basic Report, 1996
(2) Incidence and Depth of Poverty in Kenya Vol. 1, 1997
(3) Poverty and Social Indicators Vol. II, 1998
(4) Social Atlas for Kenya, 1998
(5) Major highlights of Welfare Surveys have also been published in the annual Economic Surveys; 1990, 1997, 1998.

Round three of the welfare monitoring survey covering all non-arid districts was completed on schedule and data capture using optical scanners was completed in February, 1998. Data cleaning of both the core and consumption module including the agriculture module is in progress under the supervision of the lead consultants. Provisional results will be forwarded to the Task Team Leaders and the Bank on or before 10th June, 1998.

Implementation Record, Disbursements and Submission of Audits

Although all project expenditures were properly recorded, storage of records in easily retrievable format proved difficult in some districts including the headquarters either due to lack of adequate storage facilities or to institution of a poor monitoring system. The separation of authority of AIE holder from ownership of accounting documents affected contributed to substantial delays in submission of audited accounts and disbursements of funds to the project. Despite the slow process of disbursements, the project managed to improve its performance beginning 1995 and since then the allocated funds for field operations were fully utilized. This may however not reflect satisfactorily from creditor's viewpoint since the expenditures were GOK and reimbursements took time to effect.

Major Factors Affecting the Project

The delays experienced in implementing the planned activities as per approved annual work plans is attributed to a number of factors:

(1) Procurement procedures of services (e.g consultants) were found to be long and unclear.

(2) Due to misunderstanding between the implementers and the borrower planned activities were interrupted due to suspension of the credit particularly in 1994/95.

(3) Some of the equipment procured for data capture (i.e. scanners) had no spares parts available locally and the procedures for procurement of these such items within the credit agreement from overseas suppliers were unfamiliar. This contributed to serious delays in data processing and analysis.

(4) Staff training on use of scanners was inadequate and this remains a major bottleneck in the department. It has not been possible to bring the training consultant on board before termination of the project.

(5) The network system which was envisaged to take place during the extension period of the project could not take off because the World Bank Review Mission in August, 1997 felt that the probability of the department moving to the new Central Bank of Kenya building was high. Consequently, all activities related to installation, hiring of consultant, training on its management and administration have not taken place.

(6) Creditor's procedures and guidelines on the operations and management of the credit accounts appear to have been unfamiliar with both the accountants and administrators of the project for a considerable period. This therefore contributed to untimely submission of the audits and statements of account.

(7) Staff turnover due to lack of advancement also contributed to slowing down the delivery of services.

III. PROJECT SUSTAINABILITY

The experience gained in reforming KNH has already been applied to transform the status ofEldoret Referral and Teaching Hospital and the Kenya Medical Training College, into parastatal / semi-autonomous institutions through Legal Notices. Also with support from USAID and JICA, the Ministry is using the KNH Model to transform Coast General Hospital,Mombasa the largest provincial hospital into a parastatal similar to KNH. This goes to show the project was formulated and implemented to provide for the future sustainability of Kenya's Public health sector in the face of dwindling per capita financial resources from the Exchequer.

A. KNH: SUSTAINABILITY

Works and Equipment: There is a provision for the maintenance cost in the budget i.e. about 6% of the recurrent budget. On new machines and equipment's, maintenance contracts have been signed by major companies to maintain the equipment, and the suppliers have been required to train the users on equipment supplied. In addition, in-house training on new equipment has been conducted through this credit and JICA. Adequate maintenance procedures and safety plans have been put in place. The savings and revenue generated within the first five years after commissioning of the equipment will be set aside to enable the hospital to make replacements if and when the need arises.

Training: Enhancing in-house training, already a budget of about Kshs.20 million p.a. (0.5 million US DOLLARS) has been set aside for continuing training programmes. There is an on-going in-house training in the established Training Centres of KNH by those who benefited from the project training. These are basically the management and clinical courses. Medical students both from the University and

MTC are expected to benefit from the expertise currently in the hospital. Given that about 135 trainees have benefited from the project, their service to the hospital and their contribution towards training their colleagues is expected to continue. Thus the sustainability of training is ensured in terms of the beneficiaries and their expected input.

B. HEALTH PLANNING AND ANALYSIS COMPONENT SUSTAINABILITY

By focusing on efficiency and effectiveness of operations in the public health sector and supporting Health Care Financing initiatives in hospitals and Health Centers the activities of the component are highly sustainable.

C. WMS: SUSTAINABILITY

Because of the team spirit that has prevailed during the implementation phase of the project, it will be possible to continue relying on local expertise within the institutions to undertake data collection and analysis. However, due to limited resources available to the two sister departments, major activities such as the Welfare Monitoring programme which covers around 12,000 households from 62 districts will be difficult to implement without external support.

IV. BORROWER'S PERFORMANCE

Given the circumstances under which the borrower operated during the first four years of Project implementation (explained above), the Borrower's performance was satisfactory. There were constraints which were created within the system: e.g. the processing of the payments at times took too long time.

V. BANK'S PERFORMANCE

Initially, the performance of the Bank was below expectation particularly with regard to the utility of Supervision Missions. However, with the new Task Team that came in 18 -24 months before the Project closed on 30.6.1998 the performance rose way above average in terms of tackling and resolving implementation bottlenecks and providing an enabling environment for better performance. The improvement in Bank performance applied both to the Nairobi and Washington offices. The impact of their good performance is clearly reflected in the implementation progress and disbursements made during the last 18 months of the project's life.

Under the KNH component, in some instances the Bank did not perform as it was expected. There were no clear cut guidelines on the procedure for ICB. On the matter of the Computerisation programme, there was no adequate technical advice provided. The hospital is trying to see how it can work on this crucial programme. With regard to the civil works, the Bank was very understanding and agreed to accept the changes including the extra works and the need for extension of the project period. The Bank was also fast in processing the "no objections" to some of the requests the borrower was passing and also trying to harmonise the system especially in processing the payments in theMoH. Finally, in training, this is the component with lots of success.

VI. KEY LESSONS LEARNED

The key lessons learned during the implementation of the Kenya Health Rehabilitation include the following:

1. There is need to involve all key stakeholders at the time of project formulation; preparation, and appraisal, as well as at each stage of implementation through effective teamwork.
2. Clearly defined performance indicators /standards have to be agreed upon at the time of project appraisal to ensure effectively and timely implementation.
3. Adequate procurement capacity is a pre-requisite, for effective project implementation.
4. Preparation of realistic annual work plans; Procurement and Training plans forms an integral part of effective project implementation.
5. Where many implementing officers/agencies are involved in the implementation of various components of a project a mechanism for regular and independent monitoring of implementation of Project activities, and disbursements is indispensable.
6. On civil works, extra care need to be taken in the initial stages during the preparation of the project. These initial stages have negatively affected the implementation of the project. This involves the identification of areas to be rehabilitated and their structural implications.
7. The procedure of payment especially through special accounts should be looked at with the aim of shortening the process.
8. The Bank should be in a position to give alternative technical advise on what the borrower wants e.g. the issue of KNH computerisation where the hospital had given so many proposals to the Bank, but the Bank fails to give the best feasible alternative.
9. The issue of primary health care (especially environmental factors) is very crucial if the project on health sector can have successful outcomes. Future projects need not only to cover the buildings and equipment in clinical areas but move/expand to the peripheral environment. More emphasis is expected in primary health care so as to reduce preventable diseases.

THE COMPLETE BORROWER'S EVALUATION REPORT IS AVAILABLE FROM THE PROJECT FILES.

Kenya
Health Rehabilitation Project
Appendix D: Borrower's Comments on Draft Implementation Completion Report

As the Borrower had the opportunity to comment on an earlier draft of the ICR during the ICR mission, and these comments were reflected in the Aide-Memoire and revised draft ICR, the Borrower opted not to provide further comments on the final draft.

Kenya
Health Rehabilitation Project
Appendix E: Map of Kenya

IBRD 22751

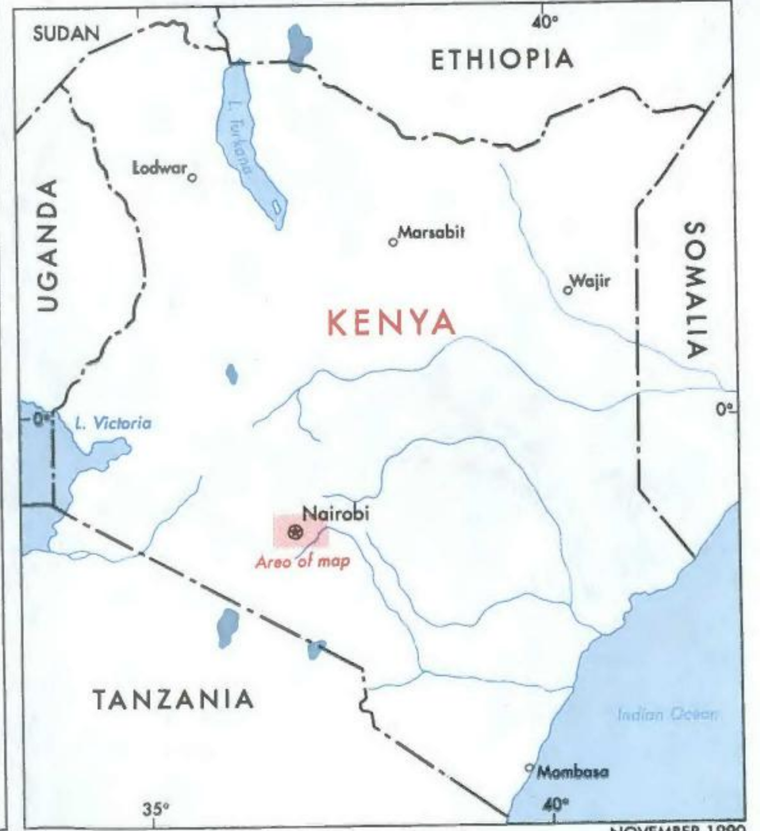
KENYA
NAIROBI AREA HEALTH FACILITIES

Health Centers and Hospitals:
- ■ Government
- □ City Commission
- ○ Private

- Main Roads
- Railroads
- Rivers
- Division Boundaries
- City Boundary
- International Boundaries

This map has been prepared by The World Bank's staff exclusively for the convenience of the readers and is exclusively for the internal use of The World Bank and the International Finance Corporation. The denominations used and the boundaries shown on this map do not imply, on the part of The World Bank and the International Finance Corporation, any judgment on the legal status of any territory or any endorsement or acceptance of such boundaries.

To Thika
Ruiruaka R.
Karural R.
To Kiambu
KASSARANI DIVISION
PUMWANI DIVISION
Lower Kabete Rd.
Thika Rd.
Juja Rd.
Waiyaki Way
Nairobi R.
Naivasha Rd.
St. Austins Rd.
Thogoto Rd.
DAGORETI DIVISION
Koma Rock Rd.
Outer Ring Rd.
MAKADARA DIVISION
Kenyatta Nat'l. Hospital
Ngong R.
Dagoreti Rd.
Karen Rd.
Wilson Airport
Langata Rd.
Mombasa Rd.
Jomo Kenyatta Int'l. Airport
KIBERA DIVISION
Nairobi National Park
Mbagathi R.
To Mombasa



NOVEMBER 1990

Record Removal Notice

File Title	Barcode No.
Kenya - Health Rehabilitation Project - Implementation Completion Report / Performance Audit Report File	1836317

Document Date	Document Type
December 29, 1998 - July 14, 1999	Correspondence

Correspondents / Participants

Subject / Title
General correspondence; Project Information Forms;

Exception(s)
Deliberative Information

Additional Comments

The item(s) identified above has/have been removed in accordance with The World Bank Policy on Access to Information or other disclosure policies of the World Bank Group.

Withdrawn by	Date
Shiri Alon	October 04, 2018

Archives 01 (March 2017)