I. Program Overview

A. The Millennium Challenge Account Threshold Program for Kenya (MCA TP) addressed public procurement reform, with a particular emphasis on the healthcare sector.

With MCA TP support:

- More than 2,000 Government of Kenya (GOK) procurement professionals received training on how to conduct proper procurement
- Procurement reviews, generally highly critical, of the highest spending government entities are now posted on a public website, a key achievement in increasing transparency
- Approximately 400 potential private sector suppliers have participated in sessions designed to heighten their awareness of proper procurement practice and thus become demanders for non-corrupt practices
- Systems, equipment and training were implemented to support introduction of a demand-driven "pull system" for distribution of healthcare commodities
- Support for the development of an Enterprise Resource Planning system for healthcare supply chain management was instrumental in the launch of that GOK-funded effort, which is critical to the GOK in achieving its goals in reducing waste and fraud
- Transparency International-Kenya trained "Public Watchers" who will monitor the advertisement of tenders in their areas, observe tender processes and the execution of projects

In summary, and as further discussed in Sections II and III below, the MCA TP for Kenya can be described as a mixed success. Certainly capacity was built at the Public Procurement Oversight Authority (PPOA) which, at the onset of the MCA TP, existed more on paper rather than as an actual operating entity. As a result of the MCA TP, PPOA was left with many of the basic tools to fulfill its mandate. However, even as PPOA's capacity as a regulatory authority was increased, the lack of capacity at the procuring entity level remains profound. Further, the PPOA continues to be plagued by internal management weaknesses that hamper its effectiveness. Implementation of e-procurement, perhaps the "signature" activity envisioned under the MCA TP, was never implemented despite multiple extensions of the Program for that purpose.

Under Component 2, substantive institutional changes necessary to achieve deeper results were impeded during the life of the Program by only recently resolved uncertainties in the governance of the Kenya Medical Supplies Agency (KEMSA) and its relationship to its parent ministry. With that said, the renewed interest by other development partners (including PEPFAR) to support KEMSA with technical assistance and to use KEMSA as a procuring entity can be attributed to the improvements in supply chain management achieved by KEMSA due to the MCA TP. While some results were eventually achieved under Component 3, implementation was well below expectations largely due to

inadequacies of the original implementing partner and a late start by the subsequent partner.

In terms of the MCA eligibility indicator that the Threshold Program was intended to address, the sole "target" of the Program was the Control of Corruption indicator. However, it was always understood – by USAID/Kenya, the GOK and MCA TP staff – that success in reducing corruption in the public procurement system would only address one discrete source of corruption in Kenya (albeit an important one), and could not *in and of itself* "move" the eligibility indicator. And in fact, the Control of Corruption indicator was not noticeably affected by the MCA-TP.

B. The MCA TP for Kenya was signed on March 23, 2007. The agreement, which had an original end date of September 30, 2009, was subsequently extended (in part) to December 31, 2010. The Program consisted of three components:

- Component 1: Reforming the Public Procurement System
- Component 2: Improving Healthcare Procurement and Delivery
- Component 3: Civil Society Monitoring of Procurement Reform and Healthcare Procurement and Delivery

The original and revised level of funding for each Component was as follows; the reason for revision of funding levels is discussed under Program Implementation (Section II; Narrative Discussion of Component 2).

	Original Funding Level	**Revised Funding Level**
Component 1	$ 5,618,964	$ 6,028,995
Component 2	$ 6,316,036	$ 5,856,005
Component 3	$ 788,000	$ 838,000
TOTAL	$12,723,000	$12,723,000

The implementing partners for the MCA-TP were as follows:

	Implementing Partner	**Type of Agreement**	**Agreement Number**	**Award Date**
Component 1				
	Tetratech ARD, Inc.	Contract	DFD-I-00-05-00218-00	09/27/2007
	PPOA	Implementation Letter (IL) [1]	#6	09/23/2008

[1] An Implementation Letter (IL) is an agreement between USAID and a host country government entity. In the particular case of the Kenya MCA TP, ILs provided that the host country entity act as an implementing

	Implementing Partner	Type of Agreement	Agreement Number	Award Date
	PPOA	IL	#7	08/28/2009
	e-Sokoni	Purchase Order	615-0-00-07-00185-2	10/10/2007
	PricewaterhouseCoopers	Purchase Order	615-C-00-08-00020	01/11/2008
	SRA International	Contract (Buy-in to USAID/W instrument)	IRM-E-24-06-00012	09/30/2009
	Utali Hotel	Purchase Order	615-O-00-09-0004	11/25/2008
	UNON Printing	Purchase Order	615-O-00-10-00070-01	07/07/2010
Component 2				
	Management Sciences for Health/Strengthening Pharmaceutical Systems (MSH/SPS)	Cooperative Grant Agreement	GHN-A-00-07-00002-00	09/17/2007
	Mantrac (1)	Purchase Order	623-C-00-09-00015-00	01/07/2009
	Mantrac (2)	Purchase Order	615-O-00-09-00097	08/31/2009
	Blackwood Hodge	Purchase Order	623-C-00-09-00016-00	02/01/2009
	Geff Refrigeration	Purchase Order	623-C-00-09-00017-00	12/23/2008
	Precise	Purchase Order	623-C-00-09-00018-00	12/22/2008
	Nation/Standard Newspapers	Purchase Order	615-O-00-08-00061 & 62	06/24/2008
Component 3				
	KIPPRA	IL	#4	02/14/2008
	PACT Kenya	Cooperative Agreement Grant	623-A-00-06-00056-00	02/16/2010

partner for an activity through a host country contracting arrangement. Procedures for implementation of host country contracting are governed by ADS 305. Payment to the host country entity can vary with the IL; in the case of the MCA TP, payment to KIPPRA was on a cost-reimbursement basis, whereas vendors contracted by PPOA were paid directly by USAID with no funds directly paid to PPOA.

C. The principal Government of Kenya (GOK) partners were:

- Component 1: Public Procurement Oversight Authority (PPOA)
- Component 2: Ministry of Medical Services (MOMS) and Kenya Medical Supplies Agency (KEMSA)
- Component 3: Kenya Institute for Public Policy Research and Analysis (KIPPRA)

Under Component 1, key activities included training GOK procurement officials as well as PPOA staff and Public Procurement Advisory Board members, an awareness campaign to raise knowledge of the PPOA and the 2005 Public Procurement Act amongst the general public, supporting PPOA to conduct comprehensive reviews of the procurement and recordkeeping practices of the highest-spending procuring entities, and developing and disseminating standard procedure manuals to support good procurement practice among procuring entities. Component 3 complemented these activities by seeking to build the capacity of civil society organizations to act as effective, credible procurement "watchdogs."

Under Component 2, the MCA TP focused on strengthening transparency and accountability in the health sector to reduce opportunities for corruption by strengthening KEMSA's procurement capacity and accountability, improving supply chain management of public health resources, establishing capacity within the (former) Ministry of Health to monitor KEMSA's procurement function and assess its compliance, and strengthening the supervision of medical supplies delivered to rural health facilities.

D. Amongst the original motivations for the MCA TP was a 2005 "Independent Procurement Review" conducted jointly by the Government of Kenya and the European Union. This review identified several critical problems with the then current procurement system such as weak oversight institutions, a lack of transparency, poor linkages between procurements and expenditures, delays and inefficiencies and poor records management. The MCA TP (particularly Components 1 and 3) was designed to address these weaknesses. In the development of Component 2, the Government of Kenya identified the former Ministry of Health (now two separate ministries: Ministry of Medical Services and Ministry of Public Health and Sanitation) and its medical supplies procurement and delivery body (KEMSA) as being particularly susceptible to waste, fraud and abuse throughout the procurement and delivery process. This, combined with USAID's own investment in the Kenya health sector ($391 million for FY 2010), meant that a spotlight on healthcare procurement and supply chain management was a natural choice for Component 2.

The MCA TP was an integral pillar of the GOK's broad Public Finance Management Reform Strategy, supported by all major development partners in Kenya.[2] In addition, the MCA TP followed on preliminary work supported by USAID/Kenya in 2006 that assisted the GOK in the drafting of the implementing regulations for the Public Procurement and Disposal Act which was the basis upon which PPOA was founded.

[2] Because of weaknesses in the management of the Public Finance Management Reform Program, PPOA has received little monetary support from the Program, although the potential to benefit from the Program remains.

II. Program Implementation

A. Narrative Discussion of Component 1

As noted earlier, Component 1 was motivated by the GOK's desire to address a key component of corruption, government procurement. According to the Millennium Challenge Corporation's February 2009 Indicator Analysis (citing a report from the Kenya Anti-Corruption Commission), 80% of corruption in Kenya is linked to procurement. As well, the GOK hoped that efficiencies in procurement would lead to substantial cost savings. MCA TP support under Component 1 was largely focused on building the capacity of the PPOA to fulfill its mandate as a procurement regulatory authority, and secondly to build capacity at the procuring entity level to implement Kenya's new procurement law. A key part of this was intended to be the implementation of e-procurement (electronic procurement).

When the MCA TP was signed in 2007, the GOK had only twelve weeks prior promulgated the regulations that formally established the PPOA. At that time, the PPOA had an Acting Director General on secondment from the World Bank, no permanent offices, little equipment and minimal professional staff, both seconded from the Ministry of Finance.[3]

Tetratech ARD (Tt ARD), the contractor jointly chosen by USAID and PPOA to provide technical assistance to PPOA, began activities on the ground in October 2007.[4] Under their original Statement of Work (derived entirely from the MCA TP proposal), Tt ARD was mandated to:

- Strengthen the capacity of the PPOA
- Design and implement a PPOA internal website
- Roll out new procurement regulations and guidelines
- Institute proper records management protocols for public procuring entities

Additional activities were added with the 2008 revision of the MCA TP Component budget, consistent with the above themes. While the project team was based in Nairobi, activities were carried out in an additional six Kenyan cities/towns.

Activities under Component 1 in building the capacity of PPOA were numerous and will not all be elaborated in this section. Key amongst these were the creation of a system for conducting and then publicly disseminating the results of reviews of major, high-spending public procuring entities (PEs), a comprehensive program of training PEs on the then largely unknown Procurement Act and Regulations, and development of a suite of easy-to-use manuals for PEs as well as for potential bidders. Records management by PEs, a key concern of the aforementioned 2005 Independent Procurement Review, was addressed under the MCA TP although the profound weaknesses in most PE's records system resisted all but notional improvements during the life of the Program.

[3] PPOA received assistance from the African Development Bank in 2008 to establish its own offices with equipment.
[4] Implementation of e-procurement was not part of the Tetratech ARD contract.

However, a discussion of Component 1 is naturally dominated by e-procurement and the failure to implement this key activity during the Program. To review, e-procurement (in the context in which it was used in the MCA TP) refers to a system in which the tender process is automated and online: bidding opportunities are posted online with bidding documents available for download, bids are submitted electronically through a secure e-tender box and the results of tenders are posted.[5] (Because of the delay in implementing e-procurement, the PPOA used and continues to use non-USG resources to publicly post some tender opportunities and results on a website that they developed for that specific purpose.)

Implementation of e-procurement required several preliminary steps even before a vendor selection could be made. As a first step, the PPOA and USAID/Kenya jointly selected (through an international competitive process) a consultant firm to assess the needs and capabilities of GOK PEs to implement e-procurement and develop a roadmap for the strategic and phased implementation of such a system, including developing the highly technical specifications for procurement of the system. As well, under the MCA TP, support was given to review the prevailing legal environment for e-procurement and whether or not 2008 legislation for e-transactions provided a sufficient legal basis for e-procurement.

Shortly after the signing of the MCA TP, it was jointly agreed by USAID/Kenya and PPOA that implementation of e-procurement could best be handled through a Host Country Contract mechanism whereby PPOA would be the contracting agent, engaging the vendor themselves (with active participation by USAID/Kenya as dictated by ADS 305). While recognizing that this was perhaps an unconventional choice, the decision was based on sound technical and management considerations: (1) MCA TP support was only sufficient to implement Phase I of an intended three-phase program. If the vendor contract was between USAID/Kenya and the vendor, at its expiration PPOA would be left to negotiate a non-competitive contract for follow-on work which they considered to be an unattractive option; (2) The high profile of e-procurement within the GOK, as well as its highly technical nature, meant that PPOA was reluctant to cede direct control over the vendor to USAID/Kenya.

The vendor selection process, while lengthy and certainly complex, was not unusually fraught with difficulty. PPOA, which had undertaken a multi-GOK agency approach starting with the development of the e-procurement strategy, consulting extensively with numerous GOK stakeholders, continued in this spirit in vendor selection by including other GOK agencies as part of the Technical Evaluation Committee. The World Bank came on as a partner to e-procurement, agreeing to finance the purchase of necessary hardware which had been budgeted under the MCA TP. However, inconsistent messaging from the Ministry of Finance - MOF (PPOA's parent ministry and the signatory to the MCA TP) as to how e-procurement should be implemented caused delay

[5] A more fulsome definition of e-procurement would include other tasks; these were the main features to be supported under MCA TP.

(in part prompting an extension of the Program to December 31, 2010) and as we will see, ultimately killed the project as part of MCA TP.

In April 2010, a vendor for implementation of e-procurement was finally selected after an exhaustive international competitive process. Unfortunately, celebrations proved to be premature as the selection was immediately challenged by an unsuccessful bidder, a common (and in this case ironic) occurrence in Kenya. While the Public Procurement Administrative Review Board immediately found the challenge to be entirely without merit and instructed PPOA to continue the procurement, the unsuccessful bidder lodged an appeal at the Kenya High Court in July 2010. The matter currently remains in the court.[6]

As alluded to above, the Ministry of Finance sent conflicting messages throughout 2009 and 2010 as to whether or not PPOA should implement e-procurement as a stand-alone system or as part of the GOK's overall IFMIS (Integrated Financial Management Information System). IFMIS, which the GOK has struggled to implement for seven or more years, was explicitly considered as an implementation option in 2008 as part of the development of the e-procurement strategy and rejected as a sub-optimal technical choice.[7] And even though the MOF was part of the e-procurement task force convened by PPOA in early 2008 and were party to the decisions made therein, they continued to raise the issue causing PPOA to delay the selection process repeatedly in 2009. Finally in November 2010 as the court process wore on, the MOF definitively informed USAID/Kenya and PPOA that in their estimation, e-procurement should be implemented as a module of the IFMIS (which they are currently revamping) and that PPOA should not under any circumstance procure a stand-alone e-procurement system. Thus, the GOK did not request a further extension of the MCA TP and e-procurement, as part of the MCA TP, was officially dead.

At its inception, PPOA had the advantage of a charismatic, respected Acting Director General (DG). Unfortunately, this individual departed in August 2008 for personal reasons. The replacement DG (who was only formally confirmed in December 2010), while generally understood to be honest in the performance of his duties, was also generally acknowledged as a less effectual leader, causing not only a loss of momentum and staff morale but in terms of the MCA TP, diminished PPOA's effectiveness and credibility among more powerful GOK entities. While a lack of timely decision-making by the DG certainly negatively impacted some Program activities, the effect of the lack of a strong leader was more profound – engagement with other potentially powerful GOK entities who could have advanced the cause of procurement reform (such as Parliament or the Kenya Anti-Corruption Commission - KACC) was all but non-existent, media relations were entirely absent and the resources of other development partners (always on

[6] As the proposed procurement was between PPOA and the intended vendor, USAID/Kenya is not a party to the suit.
[7] Nevertheless, IFMIS solution providers were free to bid on the e-procurement system as part of the competitive process.

offer) were not effectively engaged. Certainly PPOA staff speculated that e-procurement might have met a different end under a more forceful leader.

Other internal management weaknesses at PPOA impeded Program results. Without a substantive DG, staff remained employed on a secondment basis which was not resolved until December 2010. This not only diminished morale, it meant that critically needed additional professional staff could not be added until existing staff was "regularized." (It is only now in early 2011 that new PPOA staff is coming on board.) As a result, PPOA simply lacked the capacity to fully exploit initiatives started by the MCA TP contractor. To quote from the Tt ARD September 2009 final report, "PPOA [has had to rely] heavily on the engagement of consultants to carry out activities; consequently, sustainability is a matter of concern, particularly when resources are insufficient for engagement on consultants…"

Discussion of RRT Indicators

- Indicator #2: Comprehensive procurement reviews of high value PEs completed and published on PPOA website

  Baseline: 0
  Target: 6
  End of Program Actual: 10

  This was perhaps the singular achievement under the Component 1, a milestone for transparency for Kenya; they have attracted the interest of the new director of the KACC. Procurement reviews were generally critical and certainly created unease amongst the PEs. However, it must be stated that we were disappointed that the reviews have not garnered the public attention that we had envisioned, which can be attributed in large part to the PPOA's unwillingness to engage with the media and/or civil society organizations.

- Indicator #3: Key PEs implement proper procurement recordkeeping procedures

  Baseline: 0
  Target: 6 PEs with a passing score
  End of Program Actual: 0

  The requirements of the Procurement Act on PEs *viz* recordkeeping are understandably demanding because of the potential for poor recordkeeping to disguise corruption. Under the MCA TP, PEs were generally receptive to the training and one-on-one mentoring, but their ability to implement proper practices was limited by lack of staff and in some cases proper storage facilities. (All 6 indicator sample PEs did achieve improvements, but still fell well short of what we could consider a passing grade.) Certainly awareness of the importance of recordkeeping was raised by the MCA TP and in follow-on activities under

USAID/Kenya's core Governance program, we have finally begun to see more notable improvements in recordkeeping.

- Indicator #4: Use of framework contracts by GOK

  Baseline: 0
  Target: Achievement of 3 milestones
  End of Program Actual: 1

  Guidelines for the use of framework contracting were developed in early 2009 but were not broadly promulgated until June 2010, after the expiration of this aspect of the MCA TP. While the PPOA did engage several PEs in a pilot effort to use this contracting methodology, simple inaction by PPOA (compounded by varying interpretations of the law concerning multi-user versus single-user contracts) meant that framework contracting was not widely implemented. However, this does remain a priority of the PPOA.

- Indicator #5: Number of PEs reporting (quarterly) large procurements to PPOA

  Baseline: 16
  Target: 48
  End of Program Actual: 128

  PEs are mandated by law to report procurements over a certain monetary value to PPOA. While we are generally pleased with the progress made under the MCA TP in this regard, we have continued to work with PPOA to refine this procedure under our follow-on program to broaden the type of information that PPOA collects as well as to increase the ease of reporting by PEs.

Narrative Discussion of Component 2

The intent of Component 2 as stated in the MCA TP proposal was "to strengthen transparency and accountability in the health sector thereby reducing opportunities for rent-seeking which should in turn improve access to affordable health care." Component 2 was in part supported by the work under Component 1; in implementing Component 1, support for the health sector procuring entities and staff (training, manuals, public awareness) was prioritized. All Component 2 activities concluded on schedule, September 30, 2009.

To deliver technical assistance under Component 2, USAID entered into a Cooperative Agreement Grant with Management Sciences for Health/Strengthening Pharmaceutical Systems (MSH/SPS). The choice of MSH/SPS was based on extensive consultation with our GOK partners over several months. MSH/SPS mobilized in September 2007. USAID/Kenya also undertook several direct procurements of materials handling equipment (reach trucks, fork lifts, pallets, cold chain boxes) for KEMSA warehouses.

In mid-2008 the GOK strongly signaled its commitment to the success of the MCA TP by allocating its own resources to procure certain equipment for KEMSA (related to a computerized enterprise resource planning ─ ERP ─ system and a cold chain management system) that had been part of the original MCA TP budget. As a result, we were able to re-program approximately $0.5 million of MCA TP funds from Component 2 to Component 1. While the procurement of most ERP commodities was supported with GOK own funds, substantial support was provided by the MCA TP to KEMSA to integrate the ERP into KEMSA business practices, such as development of KEMSA ICT governance structures, development of an ERP Testing Master Plan and creation of the overall "roadmap" for ERP implementation. (KEMSA went on to win the "PlusOne" award at the 2010 East Africa CIO 100 Symposium for its implementation of the ERP.)

With the formation of a new coalition Kenyan government in February 2008, the Ministry of Health was split into two entities: the Ministry of Medical Services (MOMS) and the Ministry of Public Health and Sanitation (MOPH). This proved to have serious detrimental effects on MCA TP implementation as dissension arose concerning the assignment of responsibilities between the two ministries. For example, MOPH has responsibility for lower-level health facilities such as dispensaries, whereas responsibility for other facilities (such as district, provincial and referral hospitals) is with MOMS. In the reorganization, KEMSA fell under MOMS. As a result, MOPH did not trust KEMSA to serve its facilities and delayed the transfer of procurement duties to KEMSA for non-pharmaceutical supplies. Animosity between these two entities, as well as the lack of clarity of the relationship between KEMSA and both Ministries concerning the flow of government funds, was one of the specific causes for the deterioration of the RRT Indicator #7, as described below.

In July 2008, KEMSA was rocked by the dissolution of its Board of Directors over alleged mismanagement; KEMSA's Chief Executive Officer was placed on compulsory leave.[8] The GOK formed a task force to carry out an independent assessment of KEMSA; USAID found the task force members to be of renowned integrity. The task force issued its recommendations in October 2008 and Kenyan President Kibaki signed an official gazette notice assenting to the proposed changes in the KEMSA Board, per the report, in May 2009. In the interim, however, many Component 2 activities were delayed awaiting the finalization of the task force recommendations to ensure that the activities would be consistent with whatever strategic direction emerged from the task force process. Particularly, activities to support better corporate governance ground to a halt.

The task force recommendations (116 in total) were in part developed with MCA TP support, drawing on analyses conducted under MCA TP on pricing, leakage and wastage in the health sector supply chain. The recommendations focused on issues of supply chain management as well as overall KEMSA governance. Many of the task force

[8] The former CEO was arraigned in 2010 on charges related to an improper tender that took place during his tenure however our understanding is that these charges will likely be dropped as there appears to have been no impropriety on his part. His dismissal from KEMSA was solely related to poor management. He is no longer with the GOK.

operational level recommendations have been implemented with plans in place to implement more resource intensive and/or long term recommendations (such as upgrading the KEMSA warehouses to international standards). However the key recommendation to "ring fence" the KEMSA budget whereby it would appear as a specific line item in the Kenya national budget (under MOMS) remains outstanding.

While the reorganization of KEMSA was ultimately successful ─ a new committed, professional Board and CEO was finally sworn in mid-2010 ─ the interim period was marred by bureaucratic inertia that specifically impacted MCA TP performance. With no Board to take decisions, relatively routine matters were referred to the MOMS Permanent Secretary for approval. One specific example that illustrates the effect of this situation concerns a proposed GOK circular that would empower rural health facilities to manage commodities in support of a demand-driven "pull" distribution system. Without a Board to drive the process, the circular was never released leaving rural health facilities behind in the implementation of this distribution system (an objective of MCA TP). Lacking a Board, human resource decisions and policy were left in abeyance leaving KEMSA inadequately (and improperly) staffed, and the KEMSA-MOMS relationship remained murky.[9]

A 2009 audit by the MOMS Supply Chain Oversight Committee (established with MCA TP support) of KEMSA's procurement, warehouse and distribution system was completed and presented to senior GOK officials. While commending the ongoing implementation of a demand-driven "pull" distribution system, the audit found continued non-compliance with some procurement regulations, and significant and persistent weaknesses in warehousing and distribution practices. A key finding was that the absence of an audit committee compromised the effectiveness of the internal audit function.

With all that said, the MCA TP did create a platform that gave other development partners more confidence in KEMSA. After the conclusion of the Program, the World Bank (who had already communicated its intention to withdraw $100 million in support to KEMSA), instead worked with USAID and other development partners to design a new program of support. Under PEPFAR, the USG has embedded technical advisors at KEMSA to consolidate the gains achieved under the MCA TP. KFW (of Germany) is now using KEMSA for procurement of family health commodities. DANIDA remains KEMSA's key development partner for the further roll-out of the pull distribution system. Perhaps most impressively, because of the changes that took place under the MCA TP, KEMSA has been recommended by the GOK to manage procurement for the Global Fund to Fight AIDS, Tuberculosis and Malaria. The Global Fund assessed KEMSA and found them to be capable to manage the procurement of HIV/AIDS commodities; approval for malaria and tuberculosis is expected to follow.

[9] For example, the "old" KEMSA had a staff contingent of 90 persons; the "new" KEMSA staffing pattern includes 330 positions.

Discussion of RRT Indicators

- Indicator #6: Average percentage of stock records that correspond with physical counts for a set of indicator drugs in the central KEMSA warehouse

  Baseline: 0%
  Target: 100%
  End of Program Actual: 90%

  Following training of warehouse staff, the stock management system was overhauled to ensure the timely update of records. As well, internal tracking procedures were improved.

- Indicator #7: Average percentage of time out of stock for a set of indicator drugs in the central KEMSA warehouse

  Baseline: 22%
  Target: 0%
  End of Program Actual: 31%

  As discussed above, achievement of this indicator was negatively influenced by the re-organization of the former Ministry of Health. KEMSA cannot procure stocks until funds are released to it by MOPH and MOMS. While funds were released from the GOK Treasury in a relatively timely way, delays ensued in the release of funds from MOMS and especially MOPH to KEMSA. While it was anticipated that KEMSA would publish its delivery schedules online, this was never achieved because KEMSA could not guarantee delivery in the absence of timely disbursement of funds.

- Indicator #8: Percentage by value of KEMSA medicines purchased through competitive tender

  Baseline: 100%
  Target: 100%
  End of Program Actual: 93%

  For the last annual tender reported, KEMSA undertook several non-competitive procurements when the competitive process failed to yield a responsive bid.

- Indicator #9: Percentage of average international price paid for last regular procurement of a set of indicator drugs

  Baseline: 60%
  Target: <100%
  End of Program Actual: 43%

The successful achievement of this indicator can be attributed to the more stringent application of the then-new procurement laws and regulations. As well, with MCA TP support an internet site was created, for the first time publicly posting the prices paid by KEMSA.

- Indicator #10: Turn-around time for hospital orders

Baseline:	24 days
Target:	7 days
End of Program Actual:	20 days

The principal cause for the deterioration of this indicator was disorganization at the KEMSA warehouse that delayed the inventory exercise and thus the fulfillment of new orders. In part, this was due to the decision by KEMSA in late 2008 to withdraw its request under the MCA TP for a warehouse racking system in favor of other additional materials handling equipment. (At that time, it was KEMSA's expectation that another development partner would support the racking system; it is now being procured with PEPFAR funds.)

Narrative Discussion of Component 3

The intended purpose of Component 3 was to create "demand" amongst civil society and the greater public for procurement reform by equipping a set of civil society organizations (CSOs) with the expertise and tools to engage meaningfully as champions of proper procurement practice. In large part, this objective was not achieved.

The original implementing partner for Component 3 was the Kenya Institute for Public Policy Research and Analysis (KIPPRA), a respected GOK parastatal "think tank" with whom USAID/Kenya had worked in the past. The choice of KIPPRA as an implementing partner arose in 2006 during the MCA TP negotiations and was largely the choice of the GOK. While KIPPRA proved to be proficient in executing activities that were close to its core research mandate, the organization struggled in its role as a coordinator for small CSOs interested in procurement reform. The program manager assigned by KIPPRA had numerous and presumably more pressing other activities and departed mid-way through the MCA TP. The subsequent program manager – again a dedicated and competent researcher – also proved to have a multiplicity of responsibilities such that insufficient attention was devoted to MCA TP implementation. As a result, a second Component 3 implementing partner (PACT Kenya) was added late in the MCA TP.

One of KIPPRA's main intended activities was to design and implement a comprehensive, statistically significant survey of the public procurement process in Kenya, encompassing procurement officials, bidders and in the case of the healthcare

supply chain, end users of GOK health services.[10] KIPPRA did in fact achieve this, although delays in implementation meant that they were only able to implement one follow-up survey to the original baseline survey. In implementing the surveys, KIPPRA worked closely with Africa Youth Trust (AYT), a CSO that was chosen by KIPPRA through a competitive process to work alongside KIPPRA. The intent in doing so was to build AYT's technical competency in government procurement issues enabling them to be a more effective advocate for reform. While AYT was indeed an active and enthusiastic participant, it is unknown if they have subsequently used this knowledge to continue activities in this area. As well, the intent was for KIPPRA to engage with more than one CSO in the implementation of the survey, which did not occur. KIPPRA presented the follow-up survey in a public forum, however they did not engage in any activities to support its wide dissemination.

PACT Kenya was added as an implementing partner in early 2010; Component 3 was extended to June 30, 2010 to allow for additional time to implement activities. PACT was chosen because USAID/Kenya had an existing program with PACT (Kenya Civil Society Strengthening Program) to which MCA TP activities could be added. Under PACT Kenya, sub-grants were made to four Kenyan organizations: Transparency International-Kenya, the Center for Governance and Development, the Kenya Alliance of Residents Associations and Mars Group Kenya. While all four CSOs implemented activities (described in Section B below), their effectiveness was limited partly due to their late start. In cannot be said that their activities noticeably raised the profile of public procurement reform in Kenya.

The role of PPOA must be acknowledged as well. While PPOA was supportive of the role of KIPPRA during the negotiation of the MCA TP, they gradually lost interest in Component 3 activities. Of course it was not (and could not be) the role of PPOA to implement Component 3 activities, however it was anticipated that there would be constructive dialogue between PPOA and CSO actors; this did not occur. KIPPRA seemingly never apprised PPOA of its activities (unless prodded by USAID to do so); PPOA did not appear at events sponsored by PACT sub-grantees when invited.

There are no RRT indicators associated with Component 3.

[10] Key findings of the survey were that the promulgation of the Procurement Act in 2007 led to an increase in positive perceptions of public procurement, however perceptions of graft in the system remains high. The survey was shared with MCC in 2010 and is included herein as an Appendix.

B. The tables below summarize the key outputs and outcomes of the Program. [11]

Component 1 Key Outputs
More than 2,000 GOK procurement professionals received training on how to conduct proper procurement
Easy-to-use general and sector-specific procurement manuals developed and distributed to PEs
Procurement reviews, generally highly critical, of the highest spending government entities are now posted on a public website, a key achievement in increasing transparency
Guidelines for Potential Bidders developed and disseminated at trainings for more than 400 private sector companies
Comprehensive strategy for the implementation of e-procurement developed
Guidelines for framework contracting developed
Updated standard tender documents developed to reflect the new law
Guidelines for procurement under public-private partnerships developed
Radio and television advertisements created to raise the profile of PPOA
Component 1 Key Outcomes
Public awareness of the procurement law and the PPOA raised
A sustained program of procurement reviews of PEs is in place, in part using non-USG resources
Knowledge of procurement law and procedures among PEs who participated in training events increased from "average" to "good"[12]
Reporting of procurement activities by PEs in accordance with the law has improved
Tender opportunities and results are more publicly available online and in the media

[11] The Millennium Challenge Corporation (MCC) defines outputs as "the immediate and direct results of an activity." ("Number of persons trained" is explicitly considered in the guidance provided by MCC to be an output.) MCC defines outcomes as "changes in knowledge, attitudes, beliefs or behaviors directly resulting from Threshold Program activities."

[12] Based on a January 2011 assessment conducted by Pan-African Research Services

Component 2 Key Outputs
744 district and facility health system staff trained in commodity management in support of a demand-driven "pull" system of healthcare commodity distribution, including training of trainers
25 national and provincial health staff trained on quantification of health commodities
829 provincial and district health staff trained on how to supervise rural health facilities, including training of trainers
137 KEMSA staff trained on warehouse operations and inventory tracking
82 provincial level health staff trained on supply chain audit procedures
National Quality Control Laboratory (NQCL) and Pharmacy and Poisons Board (PPB) staff trained on quality assurance systems
Procurement of laboratory reference substances for NQCL for quality assurance testing
National surveys on leakage and wastage in the public health supply chain completed
National survey on prices paid for health commodities completed
Prices paid by KEMSA posted on a public website, increasing transparency
Warehouse materials handling equipment (fork lifts, reach trucks, pallets, cold chain boxes) procured for KEMSA warehouses
Standard Operating Procedures for procurement, warehousing and distribution developed
Supply Chain Oversight Unit established and operational at MOMS
ICT equipment provided to the MOMS Supply Chain Oversight Unit, and selected provincial and district GOK hospital pharmacists
Limited automation (basic ICT equipment and internet connectivity) completed at four KEMSA depots outside of Nairobi
Component 2 Key Outcomes
Prices paid for drugs procured by KEMSA declined

Inventory stock records in KEMSA warehouses accurately reflect the actual stocks on hand
The GOK finalized the transfer of procurement of medical supplies to KEMSA because of its increased confidence in KEMSA's ability to procure competitively
MOMS has the ability to collect and analyze procurement process data and monitor KEMSA delivery schedules, in fulfillment of its oversight mandate
A demand-driven "pull" system of commodity distribution is in place in four provinces, allowing for more efficient and effective distribution based on local disease patterns and stock levels
NQCL has increased the range of tests that they are able to carry out with increased confidence in test authenticity. NQCL was qualified in 2009 by the World Health Organization (WHO); NQCL quality assurance testing results are now WHO-recognized

Component 3 Key Outputs
Two independent surveys of actors (procuring entities, bidders, end users) in procurement and the healthcare supply chain completed and publicly disseminated
Grassroots CSOs and Constituency Development Fund committees trained by larger CSOs on key aspects of the Procurement Act
Procurement "Public Watchers" trained in four cities
Web portal created dedicated to the activities of PPOA, procurement appeals, procurement reviews and tender opportunities
Component 3 Key Outcomes
Participation by one civil society organization (Africa Youth Trust) in the design and implementation of the surveys increased their capacity to engage as a procurement "watchdog"

C. Discussion of Sustainability of MCA TP Achievements

Component 1: Certainly there are constituents for public procurement reform in Kenya, both in the GOK and amongst the development partner community. The MOF has certainly shown no indication of emasculating the work of PPOA; the PPOA enjoys a separate line item in the national budget that was modestly increased in the last 2010/2011 budget cycle and is considered by PPOA to be sufficient (just) to implement its mandate. During the implementation of MCA TP, PPOA staff incorporated Program activities into their own work objectives signaling their acceptance of the MCA TP as a core part of their work. However, at the end of the day, procurement does not happen (usually) at PPOA; it is the work of the PEs. Whether or not procurement practices are deeply reformed in Kenya will depend not only on the enforcement powers of the PPOA but as well on a shift in culture at the level of the PEs. During the MCA TP (and since) we have seen some inkling of that amongst lower level procurement officials, but little evidence at the senior management level. Media interest remains intermittent and public discussion of procurement at the highest levels of the GOK remains unhelpfully fixated on imaginary weaknesses in the law.[13]

Other development partners are keenly interested in procurement reform, either because of their participation in the Public Finance Management Reform Program, the OECD Use of Country Systems initiative, or to ensure the effectiveness of their own programs that are implemented directly through the GOK. At this writing, GIZ (formerly GTZ) has begun a second phase of multi-year support to PPOA, including embedding a technical advisor. Other major development partners remain engaged through the broader Public Finance Reform Program, however an upcoming re-positioning of that strategy in mid-2011 to focus on implementation of the constitution and devolvement of public finance duties may mean that procurement reform is left out in the cold if the PPOA is not proactive in stating the case for continued support for procurement work with the newly created sub-national entities. It should be noted that the Procurement Act does give PPOA the ability to raise funds for its operations through a small levy on government contracts. However, the PPOA has never sought to use this mechanism believing (rightly so) that they are not yet at a stage whereby they would be viewed as having credibly "earned" this income.

Component 2: KEMSA as a public entity will not go away in the foreseeable future; this option was explicitly considered and discarded by the GOK task force in 2008. And as described earlier, the work accomplished under MCA TP attracted the attention and support of other development partners to KEMSA. The needs of KEMSA remain deep and development partner resources remain necessary for its transformation. Within the GOK, we are encouraged by the composition of the new KEMSA Board of Directors and its CEO who seem firmly committed to the success of KEMSA. However, the key issue of the flow of funds through the national budget to KEMSA is yet to be resolved with the

[13] This is not to say that the Procurement Act is perfect; some changes are necessary and have been proposed.

Ministry of Medical Services and until this is resolved, KEMSA will likely always be hamstrung in its operations.[14]

Component 3: Support for CSO engagement in procurement activities will by its nature always require development partner support. Several development partners (the World Bank in particular) have expressed a desire to continue the work in this area that was initiated under the MCA TP, although no definite programs have yet emerged. However, it must be noted that with the passage of a new constitution in August 2010 much of the focus of Kenyan CSOs (and its development partners including USAID) has naturally shifted to implementation of the constitution.

D. Other Events or Factors

Shortly after the launch of activities on the ground, Kenya experienced serious political violence in late 2007/early 2008 in the wake of the disputed presidential election. While program activities naturally slowed down or ceased for some weeks, the effect was largely transitory except as it led to the split in the Ministry of Health (as part of the new coalition government). The effect of the unanticipated GOK task force on KEMSA has been discussed previously.

[14] A committee of Chief Financial Officers from KEMSA, MOF, the two Ministries of Health and a development partner representative was recently formed to address this issue.

E. Flow of Funds Table (Quarter ending December 31, 2010)

Bilateral Instrument	Start and End Dates	Bilateral Obligation		Disbursement to Date	Accrued Expenditures as of 12/31/2010
DAGA	3/23/2007 – 12/31/2010	$12,723,000	—	$9,695,942.34	$9,719,518.34
Sub-obligations					
Implementing Partner	**TCP Component Number**	**Total Estimated Cost (TEC)**	**Amount Sub-Obligated to Date**	**Disbursements to Date**	**Accrued Expenditures as of 12/31/2010**
ARD	1	$3,982,819	$3,982,819	$3,947,164.71	$3,947,164.71
e-Sokoni	1	$56,810	$56,810	$56,810	$56,810
Pricewaterhouse Coopers (PWC)	1	$173,000	$172,170	$159,012.36	$159,012.36
PPOA: e-Procurement (Implementation Letter)	1	$2,380,000	$2,380,000	$2,721.85	$2,721.85
PPOA: Printing of Procurement Manual (Implementation Letter)	1	$25,000	$25,000	$22,568.86	$22,568.86
Venue for e-procurement workshop	1	$1,300	$1,300	$1,081.24	$1,081.24
SRA International	1	$20,395	$20,395	$0 [1]	$20,395
UNON Printing	1	$33,741	$33,741	$22,094	$25,275
MSH/SPS	2	$4,275,000	$4,275,000	$4,275,000	$4,275,000
USAID Direct Procurement of Medical Warehouse Equipment	2	$749,720	$749,720	$722,597.99	$722,597.99
Newspaper advertisements for procurement of equipment above	2	$2,280	$2,280	$2,014.28	$2,014.28
KIPPRA	3	$336,000	$336,000	$285,266.05	$285,266.05
PACT-Kenya	3	$332,000	$332,000	$199,611 [2]	$199,611
TOTALS		$12,368,065	$12,367,235	$9,695,942.34	$9,719,518.34
Projected Approximate De-Obligation					**$3,003,481.66**

[1] $19,134.19 was disbursed post 12/31/2010.
[2] According to the 12/31/2010 Phoenix report, the amount disbursed is $336,000. This was an error that was subsequently corrected in January 2011 and will be reflected on the March 31, 2011 quarterly report; the amount shown on the chart above is current and correct.

III. Lessons Learned

USAID/Kenya has demonstrated its acceptance of the value of the work started under the MCA TP. With the conclusion of Component 1 activities implemented by Tt ARD on September 30, 2009, USAID/Kenya immediately began a $3 million follow-on program of support that will conclude March 31, 2011. Under our new Office of Population and Health Implementation Plan, $25 million has been allocated to health system strengthening that includes KEMSA.

With the benefit of hindsight, at least two things are clear concerning Program design and implementation. One, it is insufficient to support procurement reform only at the level of the regulator. The focus on the PPOA was necessary and appropriate for Kenya at the time, and yet more resources should have been allocated in the original plan for the "hands-on" work necessary at the PE level. Two, the engagement of KIPPRA as the primary implementing partner for Component 3 was inappropriate and unworkable almost from the start, and their mandate should have been cut and resources redeployed far earlier than was the case. That this was not done in a more timely fashion was seemingly based on the perception that as the GOK had brought KIPPRA to the table as part of the original negotiation, it was incumbent upon USAID/Kenya to keep them there. As it turned out, KIPPRA almost welcomed the eventual curtailment of their duties.

The MCA TP originally had a 30-month time horizon from the agreement signing in March 2007 to the original closing date of September 30, 2009 (subsequently extended in part to December 31, 2010). Even including e-procurement, there was nothing inherent in the design of the MCA TP that made completion of the intended *activities* unachievable within its original time horizon; in fact, the two largest implementing partners (MSH/SPS and Tt ARD) exhausted their funds as of the original end date. However, the larger question is whether the goals of the program – profound changes in the entrenched procurement practices of hundreds of government procuring entities and revamping of a deeply troubled healthcare supply chain – was achievable in 30 months. Clearly not. For this reason, USAID/Kenya has continued its work with PPOA and KEMSA with its own resources.

The GOK has always maintained and continues to maintain its desire for a Compact Agreement, a desire that was only heightened by the signing of a Compact with neighboring Tanzania. Certainly the interest expressed by the MOF's Governance Unit in MCA TP implementation throughout the life of the Program reflected the desire to perform admirably under the MCA TP and hopefully increase the likelihood for a Compact. (It was the MOF Governance Unit that decided to expend additional GOK

resources under Component 2, for example.) However, as Compact eligibility is driven by performance on the eligibility indicators, it was evident that a Compact would not be forthcoming regardless of GOK performance under the MCA TP. *For Kenya, the MCA TP was not a credible incentive for a Compact because it was only tangentially related to the relevant eligibility indicator.*

While donor coordination was always an explicit goal of the MCA TP, the high level of success in catalyzing other donor interest (not always during the MCA TP implementation period) was unexpected. MCA TP support lent credibility to the KEMSA task force process and encouraged other development partners to either stay or "get into the game." The World Bank, through its ICT support project, was an unexpected partner in e-procurement.

IV. Appendixes

1. Tt ARD Final Report (Component 1)
2. Tt ARD Midterm PMP Report (Component 1)
3. MSH/SPS Final Report (Component 2)
4. KIPPRA Terminal Survey (Component 3)
5. Independent Procurement Review (IPR) – May 2005
6. Kenya Indicator Analysis – February 2009
7. Contact information for USAID Staff
8. Draft IG Performance Audit (2009) with ODP Comments – Not Final