



USAID
FROM THE AMERICAN PEOPLE

**HEALTH POLICY
INITIATIVE**

IMPROVING RESOURCE ALLOCATION IN KENYA'S PUBLIC HEALTH SECTOR

MARCH 2010

This publication was produced for review by the U.S. Agency for International Development (USAID). It was prepared by Brian Briscoe, Suneeta Sharma, and Margaret Saunders of the Health Policy Initiative, Task Order I.

Suggested citation: Briscoe, Brian, Suneeta Sharma, and Margaret Saunders. 2010. *Improving Resource Allocation in Kenya's Public Health Sector*. Washington, DC: Futures Group, Health Policy Initiative, Task Order I.

The USAID | Health Policy Initiative, Task Order I, is funded by the U.S. Agency for International Development under Contract No. GPO-I-01-05-00040-00, beginning September 30, 2005. Task Order I is implemented by Futures Group International, in collaboration with the Centre for Development and Population Activities (CEDPA), White Ribbon Alliance for Safe Motherhood (WRA), and Futures Institute.

IMPROVING RESOURCE ALLOCATION IN KENYA'S PUBLIC HEALTH SECTOR

MARCH 2010

The views expressed in this publication do not necessarily reflect the views of the U.S. Agency for International Development or the U.S. Government.

TABLE OF CONTENTS

Acknowledgments	iv
Executive Summary	v
Abbreviations	vii
I. Introduction	1
Purpose	1
Methodology	1
Rationale for Intervention: Distribution of Poverty in Kenya	2
II. Findings of the Literature Review on Health Resource Allocation	6
Overview on Resource Allocation.....	7
III. Findings on Resource Allocation in Kenya	9
Background	9
Resource Allocation among Government Ministries and Sectors.....	10
Kenya’s Public Health Budget in Perspective.....	12
FP/RH’s Share of the Public Health Budget	13
Resource Allocation within the Public Health Sector	15
Kenya’s Resource Allocation Criteria (RAC) Formula	15
District-level Budgeting	16
District-level Resource Allocation	17
Reconciling District-level Requests with Health Resource Allocations	19
IV. Findings on Women’s Participation in Resource Allocation.....	21
Obstacles to Women’s Participation in the Resource Allocation Process.....	21
Findings of the Legal Review.....	22
Findings on Kenyan Law in Relation to FP/RH.....	23
The Effects of Kenyan Laws on Women’s Participation in Resource Allocation for FP/MH.....	24
The Financial Management Act of 2004.....	24
Legal Notice 162 of the Public Health Act, 1992	25
V. Conclusions and Recommendations	26
Annex A: The Eight Provinces of Kenya (numbers) and Health Policy Initiative Study	
Districts (dots)	29
Annex B: Poverty Map of Kenyan Districts	30
Annex C. Findings of the Literature Review: Summary Table	31
Annex D. Findings of the Literature Review: Case Studies	36
References.....	43

ACKNOWLEDGMENTS

The authors thank the following experts for their ideas and insights, which are reflected in this report.

- Prof. Germano Mwabu, School of Economics, University of Nairobi
- Prof. Patricia Kameri-Mbote, Consultant on Kenyan Legal Affairs, Strathmore University
- Dr. Eric Othieno Nyanjom, Kenya Institute for Public Policy Research and Analysis
- Dr. Dayl Donaldson, Economist, Health Policy Initiative, Task Order 1, Futures Group
- Mr. Sam Munga, Head/Division of Health Care Financing, Ministry of Medical Services, Government of Kenya
- Dr. Josephine Kibaru, Head/Division of Family Health Services, Ministry of Public Health and Sanitation, Government of Kenya
- Dr. Janet Wasiche, Department of Reproductive Health Services, Ministry of Public Health and Sanitation, Government of Kenya
- Dr. Per Tidemand, Managing Director, Dege Consult
- Mahesh Karra, Economist, Health Policy Initiative, Task Order 1, Futures Group

EXECUTIVE SUMMARY

This report examines equitable financing and resource allocation at decentralized levels for family planning (FP) and reproductive health (RH) programs in Kenya. The USAID | Health Policy Initiative, Task Order 1 investigated the institutional, legal, and political environment affecting budgetary decisionmaking in the public health sector. The research team focused on how budgetary planning and resource allocation functions under decentralization and how decentralization affects equity in resource allocation for FP and RH.

The Health Policy Initiative analyzed the legal and political criteria used to allocate health resources among Kenyan provinces by conducting (1) a preliminary literature review on health resource allocation in developing countries; and (2) Kenya-specific research—including a literature review; a formal survey targeting health sector professionals, FP clients, and other stakeholders; research and focus group discussions on women’s participation in the health resource allocation process; and a review of Kenyan laws related to FP/RH services. The rationale for this research—in the context of rising poverty and unequal distribution of health resources across regions and programs—was that a multifaceted analysis of the government’s health resource allocation decisionmaking processes should reveal ways to improve equity in access to healthcare.

Study Findings

Decentralization has been a stated policy objective for Kenya since 1994; however, the allocation of health sector financial resources remains highly centralized and opaque, relying primarily on previous years’ budget allocations rather than on health needs indicators. Equitable or fair resource allocation can only be accomplished by considering variation in needs across geographic and economic groups. The Health Policy Initiative’s research revealed that the allocation of health sector funds in Kenya has not accounted for differences in health achievement, access, and provision costs across the regions, provinces, and districts.

As part of its analysis, the research team examined the extent of women’s participation in the health budget allocation processes. There is a logical correlation between women’s representation on budgetary committees and increased attention to programs that affect women’s health, such as FP/RH programs. Findings from surveys, focus groups, and interviews support this correlation between increased representation of women in health resource allocation decisionmaking and increased attention to FP resource allocation. Although obstacles exist to women’s participation, a 2004 legal decree mandates minimum female representation on select budget committees at all sub-regional levels.

Recommendations

Kenya could further improve equity in resource allocation across subnational governments and at the decentralized level. The government could also take steps to further promote women’s participation in decisionmaking, as a means of supporting women’s involvement in local planning and management of FP/RH programs. The following are recommendations to accomplish these goals.

To improve equity in resource allocation across subnational governments:

- Improve data collection at the subnational levels
- Develop provincial and district capacity to plan and manage resources
- Improve collaborative planning to align budget requests with allocations
- Broaden the implementation of needs-based resource allocation criteria

To ensure adequate allocation of resources to FP/RH programs at the decentralized level:

- Strengthen the legal and institutional frameworks for decentralized resource allocation by formalizing the budgetary process and resource allocation procedures
- Create citizen monitoring in communities for FP/RH services
- Address the under-funding of health and FP/RH programs at subnational levels by mobilizing new resources, leveraging resources through FP/HIV integration, and advocating for the inclusion of FP into social health insurance
- Increase the efficiency of allocation decisionmaking, which, in turn, increases equity and efficiency in service delivery

To promote women's participation in decisionmaking at the decentralized level:

- Educate political and community leaders about the benefits of women's involvement in planning and management of FP/RH programs
- Include men in the education process
- Target efforts to support and promote the mandate of female representation to areas with high levels of poverty to encourage compliance with legal mandates for representation
- Conduct further research on key factors that foster women's participation to develop advocacy and support measures to integrate women into decisionmaking processes.

ABBREVIATIONS

AIDS	acquired immune deficiency syndrome
AIE	Authority to Incur Expenditure
AOP	Annual Operational Plan
BOPA	Budget Outlook Paper
BSP	Budget Strategy Paper
DHMB	District Health Management Board
DHMT	District Health Management Team
DRH	Division of Reproductive Health
EG	equalization grants
FGD	focus group discussion
FHS	family health services
FP	family planning
FY	fiscal year
GOK	Government of Kenya
GOU	Government of Uganda
GOT	Government of Tanzania
HIV	human immunodeficiency virus
HMIS	health management information system
HSSP	Health Sector Strategic Plan
KES	Kenya shillings
LDG	Local Development Grant
LGAs	local government authority
LGDP	Local Government Development Program
LGRP	Local Government Reform Program
MCF	Municipal Common Fund (Chile)
MDG	Millennium Development Goal
MO	medical officer
MOH	Ministry of Health
MOPHS	Ministry of Public Health and Sanitation
MOMS	Ministry of Medical Services
MTEF	Medium-term Expenditure Framework
MWG	Macro-Working Group
NBS	National Bureau of Statistics
NGO	nongovernmental organization
NHA	National Health Account
NHSC	National Health Services Committee
PBB	Program-Based Budget
PHC	primary healthcare
PPHC	preventive and promotive healthcare
PRSP	Poverty Reduction Strategy Paper
RAC	resource allocation criteria
RH	reproductive health
RHS	reproductive health service
SWAp	Sector-wide Approach
SWG	Sector Working Group
Tsh	Tanzanian shillings
USAID	United States Agency for International Development
WHO	World Health Organization

I. INTRODUCTION

Purpose

This research report examines public sector health financing and resource allocation at decentralized levels in Kenya and other developing countries. The USAID | Health Policy Initiative, Task Order 1 conducted this study to help the Government of Kenya (GOK) realize its stated goal of decentralizing public health resource allocation in ways that most efficiently and effectively address existing inequities in access to health resources across regions and socioeconomic groups.

The Health Policy Initiative investigated the institutional, legal, and political environments affecting budgetary decisionmaking in the public health sector, with special attention to the ways that budgetary planning and resource allocation function under decentralization and how decentralization affects the allocation of resources to family planning/reproductive (FP/RH) programs. The research was designed to (1) improve equity in resource allocation among subnational governments, economic groupings, and health programs; (2) promote the participation of women in decisionmaking at the subnational level to promote equitable access to gender-related health services, such as FP/RH; and (3) promote other steps to ensure the adequate allocation of resources to FP/RH programs at the decentralized level.

Methodology

The Health Policy Initiative analyzed the legal and political criteria used to allocate public sector health resources across Kenya by conducting (1) a preliminary literature review on health resource allocation in developing countries; and (2) Kenya-based research—including a literature review; key informant interviews of public health sector professionals, FP clients, and other stakeholders on health resource allocation processes; focus group discussions on the participation of women in the health resource allocation process; and a review of Kenyan laws related to FP/RH services. The Health Policy Initiative debriefed policymakers at various levels of government on the research findings.

The preliminary literature review focused on identifying strategies that developing countries have developed to improve the allocation of health resources. The research team briefly examined strategic approaches; allocation methods; formula details, if applicable; implementation mechanisms for the allocation; data surveillance methods; and evidence of results or impact. Subsequently, the research team identified two countries of particular interest and relevance to Kenya—Tanzania and Uganda—and prepared more detailed case studies of their health resource allocations.

Because many of Kenya's subnational resource allocation processes are not documented in legal or academic literature, the Kenya-specific research included analyzing these processes and outcomes by conducting a literature review, followed by a survey of 27 District Health Management Team (DHMT) members in six Kenyan districts: Kisumu (12 respondents), Nyando (6), Koibatek (6), Kitui (2), and Nyambene (1). The research team also conducted six focus group discussions (FGDs) with FP clients and other stakeholders in the Kisumu, Nyando, and Koibatek districts; in each district, one male-only FGD and one female-only FGD was held for 8 participants each. In the Kitui and Nyambene districts, the team conducted joint female/male FGDs of 13 and 12 participants, respectively (see Table 1).

Table 1. Focus Group Participants in Five Districts

District	Participants			
	FGD for Males	FGD for Females	FGD for Males and Females	Total
Kisumu	8	8		16
Nyando	8	8		16
Koibatek	8	8		16
Kitui			13	13
Nyambene			12	12
				73

These surveys and FGDs provided background on how resources are allocated from the central to the regional and district levels and informed much of the district-level analysis of health resource allocation described in the following sections.

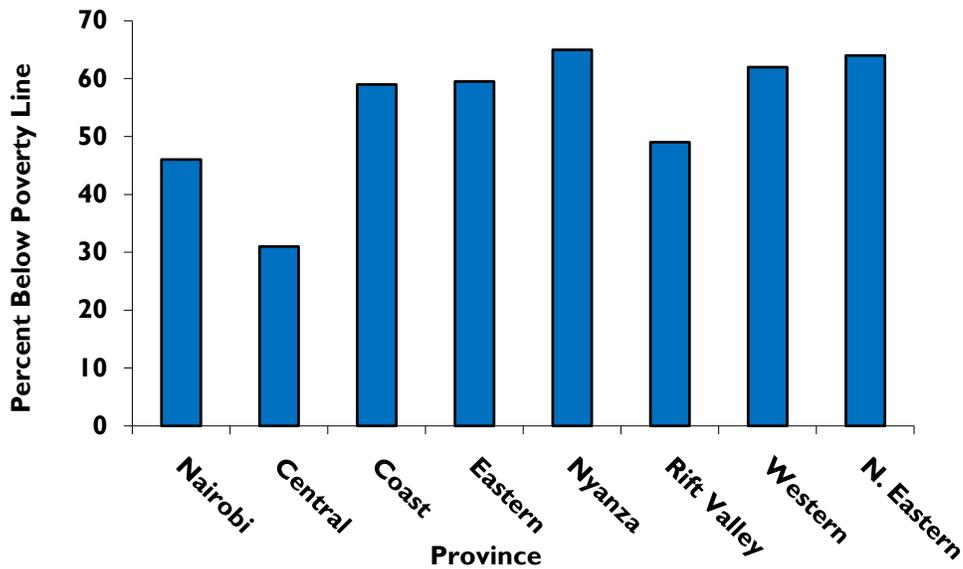
This report presents the findings of (1) the literature review on needs-based health resource allocation; (2) the study on the resource allocation process at the national and district levels in Kenya, including an overview of the national- and district-level health budgets; (3) the research related to women’s participation in the process, obstacles to their participation, and the legal, regulatory, and government policies that allow for women’s participation. The final section summarizes conclusions and recommendations based on the findings.

Rationale for Intervention: Distribution of Poverty in Kenya

Between the 1970s and 2000, the share of Kenya’s population classified as poor grew from 29 percent to about 57 percent (Library of Congress, 2007). Figure 1 shows the poverty incidence in Kenya as of 1997, graphing the percentage of residents living below the poverty line by geographic location.¹ Of Kenya’s eight provinces, the percentage of residents living below the poverty line in six provinces was above 50 percent; the remaining two provinces, Nairobi and Central Province, had slightly lower percentages. (See Annex A for a map of Kenya’s eight provinces. See Annex B for a map of Kenya’s poverty status that graphically illustrates how poverty is concentrated and distributed throughout the country.)

¹ The 1997 Welfare Monitoring Survey defined poverty as “...those who cannot afford basic food and non-food items” (Central Bureau of Statistics, 1997). Absolute poverty was defined as KES 1,239 per person per month in rural areas and KES 2,648 in urban areas.

Figure I. Poverty incidence: Percentage of residents living below the poverty line, 1997



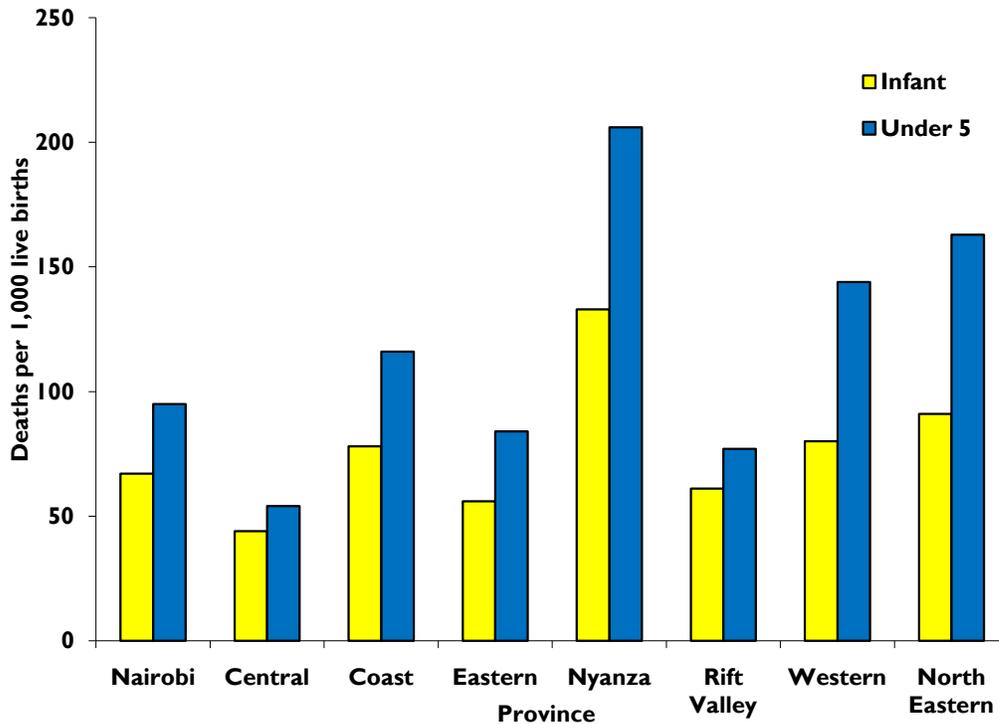
Sources: Central Bureau of Statistics, 1997; Kabubo-Mariara and Ndeng'e, 2004. See also Annex B, Poverty Map of Kenyan Districts.

Linkages between poverty and health conditions

Health conditions in the Kenyan provinces, such as infant mortality, child mortality, and fertility rates, demonstrate the correlation between high levels of poverty and poor health outcomes. Analysis of Demographic and Health Survey data indicates that poor health conditions are disproportionately concentrated among the least wealthy segments of society. Figure 1 shows the poverty incidence in Kenya, which is the percentage of residents living below the poverty line, by province. Figure 2 presents Kenyan infant and under-five mortality rates as of 2003, sub-divided by province.

Comparing Figures 1 and 2, one can observe that the poorest people living in the poorest provinces—such as the North Eastern, Nyanza, and Western provinces—experience much higher rates of infant and child mortality than do the wealthiest Kenyans residing in wealthier provinces, such as the Nairobi and Central provinces.

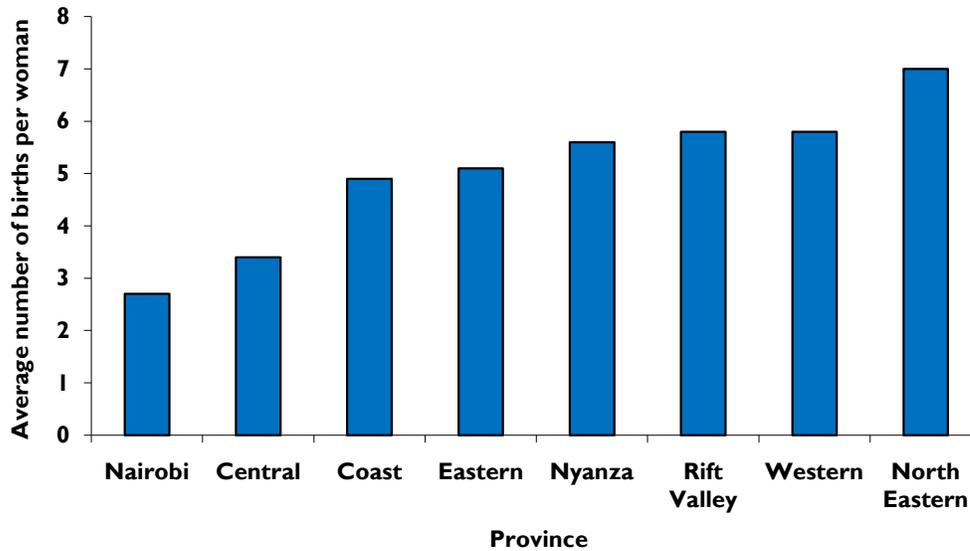
Figure 2. Mortality among infants and children under 5 in Kenya, 2003



Source: Central Bureau of Statistics, 2003.

Family size is another indicator related to maternal and child health that is correlated with poverty. Figure 3 presents the total fertility rate and number of children per woman by province. It shows that women residing in the Nyanza, Western, Rift Valley, and North Eastern provinces have, on average, about twice as many children as do women residing in the wealthier province of Nairobi. High fertility rates have several implications for health planning; for example, they (1) adversely affect maternal and child mortality; (2) raise the costs of providing healthcare to women and children; (3) reduce the funds that low-income families can devote to healthcare; and (4) translate into rapid population growth in areas already economically disadvantaged, which therefore require proportionally higher investments in healthcare.

Figure 3. Kenya: total fertility rates, by province, 2003



Source: 2003 Kenya Demographic and Health Survey.

In this context of rising poverty and unequal health outcomes, it is important to understand the government's resource allocation policies. Budgetary allocation protocols that ignore the disproportionate need for health resources can reinforce and even worsen the inequality of health conditions across provinces and income groups. The resource allocation process also is linked to the decentralization of health management in Kenya, which influences the decisionmaking process in determining how to spend resources. Decentralization and equitable resource allocation have been stated policy objectives in Kenya during the past decade;² yet, in practice, the allocation of health sector resources remains highly centralized.

In theory, the efficiencies gained from decentralizing health resource allocation decisions would help to address some inequality in health resources by empowering subnational leaders, who may be more familiar with the needs of their local populations. Such decentralization of decisionmaking, however, also brings new challenges to maintaining the political will for FP and other RH services, as subnational decisionmakers may prove less aware than their national-level counterparts of the importance of FP/RH. Furthermore, women may not be represented or may be under-represented at the local policymaking level, making it difficult for their perspectives and needs to be fully considered. Studies show that women's leadership of local governing bodies significantly influences the allocation of local government resources in developing countries (Chattopadhyay and Duflo, 2004).

² For example, these are mentioned in the Kenya Health Policy Framework (Government of Kenya, 1994).

II. FINDINGS OF THE LITERATURE REVIEW ON HEALTH RESOURCE ALLOCATION

To gain insight on the challenges Kenya faces, as well as possible solutions, the research team examined the experiences of nine countries—seven in sub-Saharan Africa and two in Latin America. Through reviewing available reports, the team studied the selected countries’ health resource allocation policies and formulas in the context of decentralization. This review focused on health sector resource allocation; it did not examine the full array of health reform interventions, such as broader approaches to political reforms or efforts to develop capacity-building mechanisms to bolster subnational governance.

Researchers have found that, in many countries, for administrative reasons, resource allocation often is based on existing ministry structures and bureaucratic demand rather than on need (Diderichsen, 2004). Yet, in the interests of both horizontal and vertical equity, it is necessary that resource allocation be based more on need. The preponderance of the “inverse care law”—in which the under-privileged with greater burdens of disease receive comparatively fewer resources across countries, regions, or socioeconomic groups—perpetuates and often deepens the inequality of health outcomes. Such inequalities cannot be reversed unless resource allocation frameworks include needs-based resource allocation criteria.

Developing countries are increasingly using needs-based formulas to guide their allocation of health resources. The indicators of need most frequently used are

- The size of the population in each area;
- The demographic composition of the population (given that young children, the elderly, and reproductive-age women tend to have a greater need for health services);
- Levels of ill-health; and
- Socioeconomic status (given the strong correlation between ill-health and low socioeconomic status and that the poor are most reliant on publicly funded services) (Semali and Minja, 2005).

Annex C summarizes the nine countries’ experiences with health resource allocation in the context of decentralization. The findings make it clear that policies designed to promote equitable allocation of health resources can take many forms. Each country’s experience illustrates a complicated patchwork of laws, allocation formulas, monitoring mechanisms, and results.³

- Each country used a strategy to improve equity that was linked with its general approach to decentralization. The type of methodology for moving resources (money) from the center to subnational governments greatly affects the country’s effort to improve equity in health service provision.
- The formulas for resource allocation vary by country. In the two examples from Latin America, Chile based its redistribution on a per capita formula, while Colombia developed a needs-based formula adjusted for various poverty-related factors, such as poverty levels, unmet basic needs, and quality-of-life indicators.
- In Chile and Colombia, there is evidence of a redistribution of resources, with increased investment in poorer districts. The government of Chile created the Municipal Common Fund to redistribute resources among municipalities. This was accomplished by collecting revenues based on estate taxes and vehicle license plates and other methods that place a disproportionate burden on the wealthiest. These revenues created a pool of funds that were distributed on a per-capita basis, ensuring that resources spread from wealthier to poorer municipalities. By contrast,

³ The scope of this paper cannot allow for a thorough examination of each case, but it highlights budgetary allocation methodologies designed to improve equity.

Colombia improved equity by raising investments in relatively needy municipalities and district facilities, while holding constant those resources that flowed to other municipalities, thus taking advantage of an expanding overall health resource envelope to promote equity.

- Several African countries have created resource allocation formulas to address equity concerns during the allocation process. Each country's formula addressed population factors and poverty variables, and weights were assigned to each factor in the formulas. Several countries, such as South Africa and Zambia, based their revised allocation formulas on a "material deprivation index," along with population factors. Many of these countries rely on a combination of National Health Accounts (NHAs) and district-wide reviews to monitor data and expenditures.

The research team prepared two case studies with more in-depth information on Tanzania and Uganda—countries with some similarities to Kenya (see Annex D). The case studies provide an overview of the decentralization process and explain how the resource allocation formulas were developed and introduced as part of that process. There is some evidence that resource allocation formulas have produced positive results; although, in Tanzania, the formula has been applied to only a portion of health system block grants. The implementation of a needs-based allocation formula has been a positive achievement, but obstacles remain to the further achievement of health equity. In Uganda, the case study overview focuses on the fiscal decentralization process in the health sector. Uganda has developed a district health system that allows for transparent and equitable resource allocation across health sub-districts. In both countries, resource allocation formulas and procedures have not yet been developed to address inequitable allocation of human resources, commodities, and supplies.

Overview on Resource Allocation

Incorporation of needs-based allocation criteria into allocation decisions

Resource allocation formulas can help countries to redress inequities in access to healthcare by systematically and objectively incorporating needs-based criteria into allocation decisions. However imperfect the underlying data or their weighting may be, such efforts can help nations make progress toward achieving equitable access to healthcare. Other African nations that face the same health challenges as Kenya have implemented effective approaches to ensure the equitable allocation of resources, including the introduction of needs-based criteria into their budgetary processes. Most of these nations face inequalities of access to healthcare, poor data collection and availability, and severe budgetary constraints similar to those of Kenya.

Challenges of employing resource allocation formulas

The challenges related to employing resource allocation formulas are important to understand if policymakers wish to avoid or minimize the possible negative repercussions. The most obvious shortcoming of relying on poverty indicators or other regional data is that updated, reliable, and valid data are often difficult to find across all regions and districts. However, data-based policy formulation can raise awareness of data gaps and motivate all involved to produce more accurate and timely data. This includes development partners, who may find that a donor recipient's augmented need for timely funding data creates new opportunities to more closely coordinate activity funding and information sharing—as exemplified by the Tanzania experience with sector-wide approach (SWAp) integration, discussed in Annex D (Mapunda, 2003).

Nations often face the challenge of creating new incentives to report poverty and poor health. The poorer the region, the more funding the region may receive as a result of the new process, so each region may be motivated to document and potentially exaggerate its negative indicators; this kind of impact already has been identified in Kenya. Kenyan Members of Parliament claimed that some reporting has been manipulated in this manner, according to several local press reports (East African Standard Newspaper,

2008). For these reasons, it is important to choose allocation components that are less susceptible to manipulation—such as geographic distance or mortality indicators. Insulating the data collection agencies from political pressure also can help to maintain the integrity of data collection and prevent the emergence of resource theft through data manipulation.

Another significant challenge of relying on poverty and health indicators to allocate resources emerges when a subnational entity achieves relative improvement. Perversely, such a region would receive less in subsequent rounds when allocations are based on need. Countries must consider whether it is acceptable to allow relative improvement in health or poverty indicators to lead to declines in successful regions' share of health resources.

A final notable weakness in many health resource allocation formulas is their failure to address equity in human resource and drug allocations. Often these two resources prove more difficult to quantify in monetary terms because their costs are difficult to calculate or estimate.

III. FINDINGS ON RESOURCE ALLOCATION IN KENYA

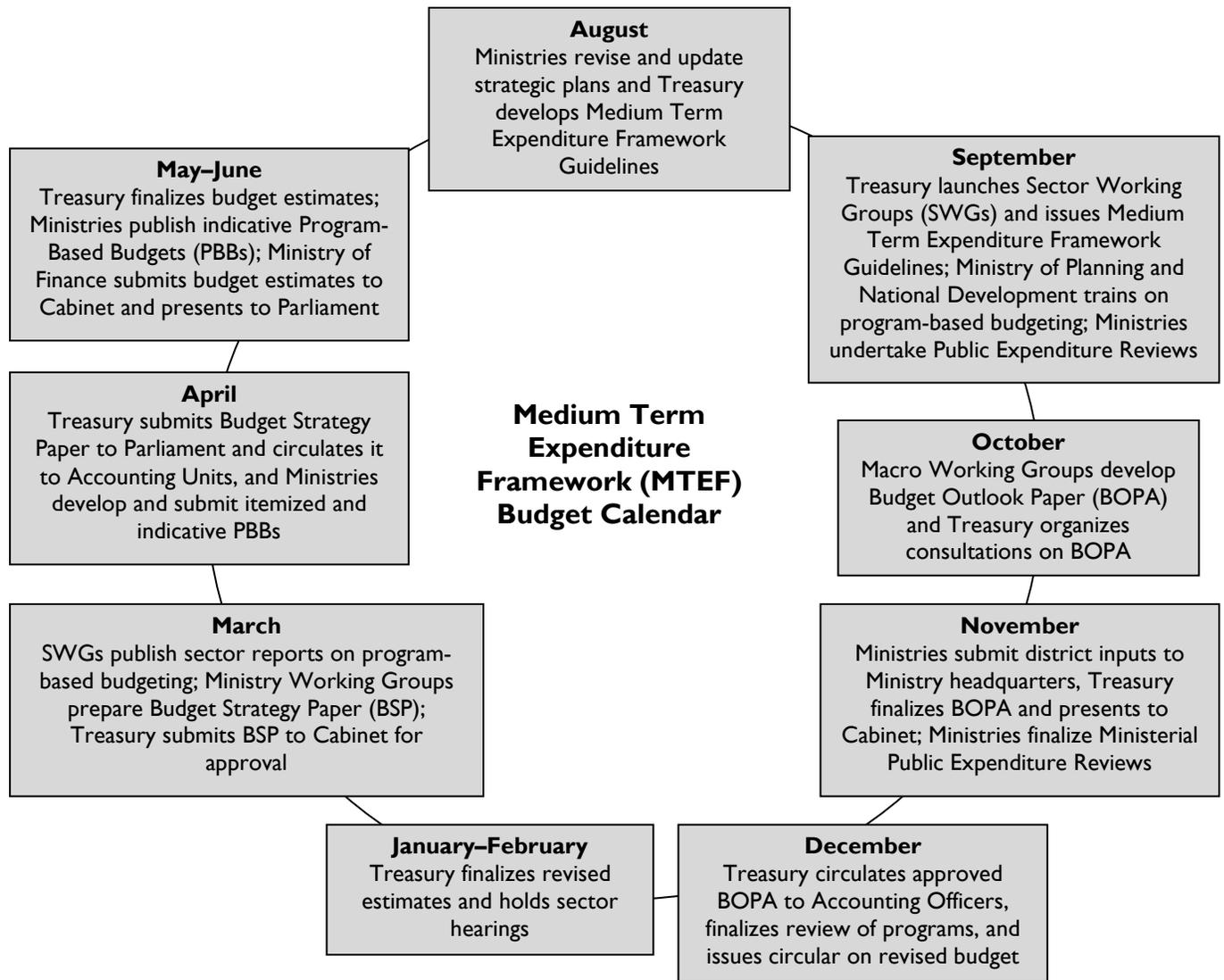
Background

In the initial decades of independence, national budget resource allocation in the public sector in Kenya was incremental, with government departments getting a fixed raise each year proportional to the Treasury's anticipated volume of resources (Peterson, 1994). Resource allocation decisions only diverged from this approach to the extent that local interests gained preferential treatment through political patronage (Widner, 1992). These approaches reinforced regional and sectoral disparities inherited at independence in 1963.

By the late 1980s, Kenyan officials began to rethink public sector resource allocation procedures and introduced a three-year rolling and forward budget framework, in which the budget fiscal year (FY) took into account the proposed activities of the two succeeding FYs. Despite this reform's emphasis on activity-based allocation, Kenyan budget processes remained largely devoid of needs-based criteria. At the end of the 1990s, Kenya espoused the medium-term expenditure framework (MTEF) approach to budgeting, along with poverty reduction strategic planning. As with the previous forward budgeting system, Kenya's MTEF approach involves three-year spending cycles in which the last two years include activities designed to support and bolster the activities of the first budget year (Oyugi, 2005). However, in a significant departure from previous budgeting approaches, Kenya linked resource allocation to proposed outputs.

In theory, the Treasury sets expenditure ceilings for sector working groups (SWGs) of stakeholders who must agree on budget allocations within the group, keeping in mind sector priorities from action plans and the national development plan. The presumption is that membership in these SWGs is broad enough to give voice to national and subnational priorities. In reality, however, information from the sub-sectors and the subnational level does not flow well to the SWGs, and the subnational agendas often are ignored. Consequently, sub-sectoral groups such as FP/RH providers—which do not have strong political lobbies—are unlikely to influence SWG allocation decisions. Figure 4 presents the MTEF Expenditure Framework Budget Calendar that outlines the budget allocation cycle and identifies how sectors are involved in the process.

Figure 4. Medium-term budget/expenditure framework



Source: Treasury Circular No. 11, Oct. 8, 2007.

Resource Allocation among Government Ministries and Sectors

Before the implementation of the three-year MTEF budget approach, annual budget calendars were rigid, and subnational entities such as ministries and their district sector heads were unable to exert much influence on budgeting officers at the Ministry of Finance. Consequently, ministries and their district heads invariably failed to obtain requested resources, which undermined implementation of their planned activities. The MTEF approach tries to solve this problem by allowing more time for ministries to receive input from stakeholders before allocating available resources.

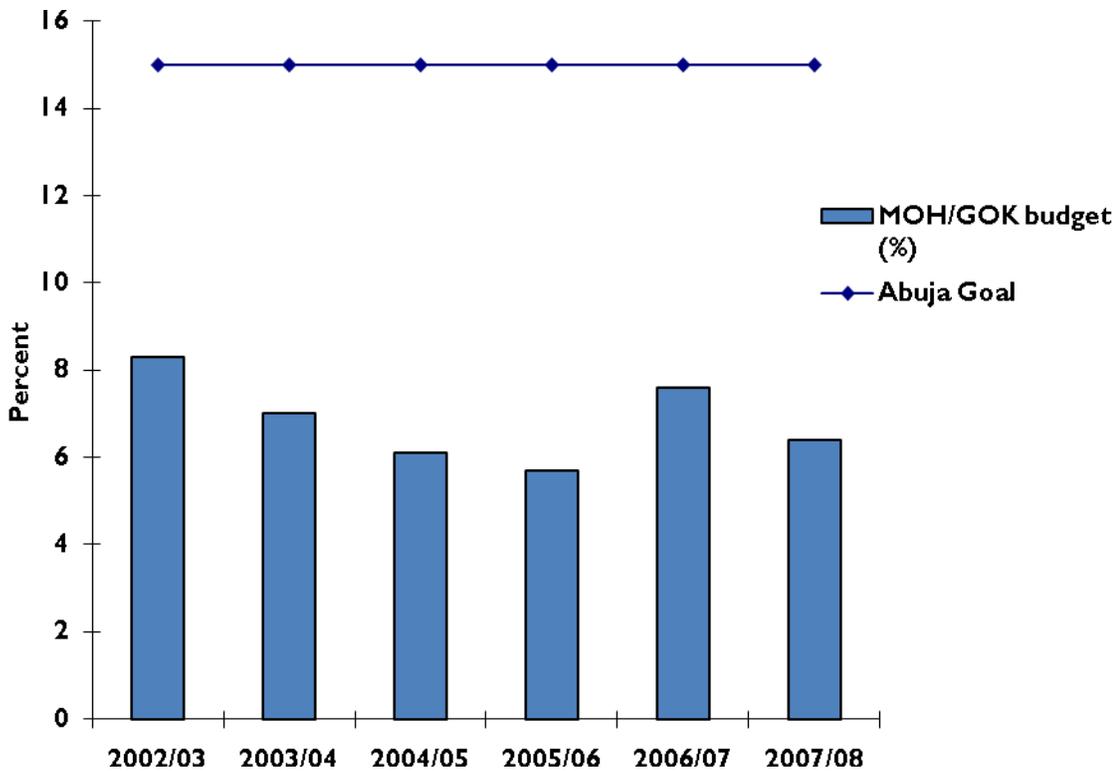
At the national level, MTEF has eight SWGs; the health sector shares a group with education and labor.⁴ The Treasury (part of the finance ministry) has a Macro-Working Group (MWG) that estimates a national

⁴ The numbers of SWGs have varied since the inception of MTEF in 1999, with health moving into and out of an exclusive group. The latest position can be seen at <http://www.treasury.go.ke>. The MTEF approach also has subnational structures but they have not been operationalized.

resource envelope based on anticipated national revenues plus potential resources from development partners. The MWG provides each SWG with a resource envelope reflecting a budget ceiling within which the latter is expected to operate. According to several members of the MWG in the finance ministry, it is theoretically possible to negotiate respective SWG ceilings, but in practice, there is often little scope for changing allocations among SWGs. This leads to a largely incrementalist approach to resource allocation among SWGs.

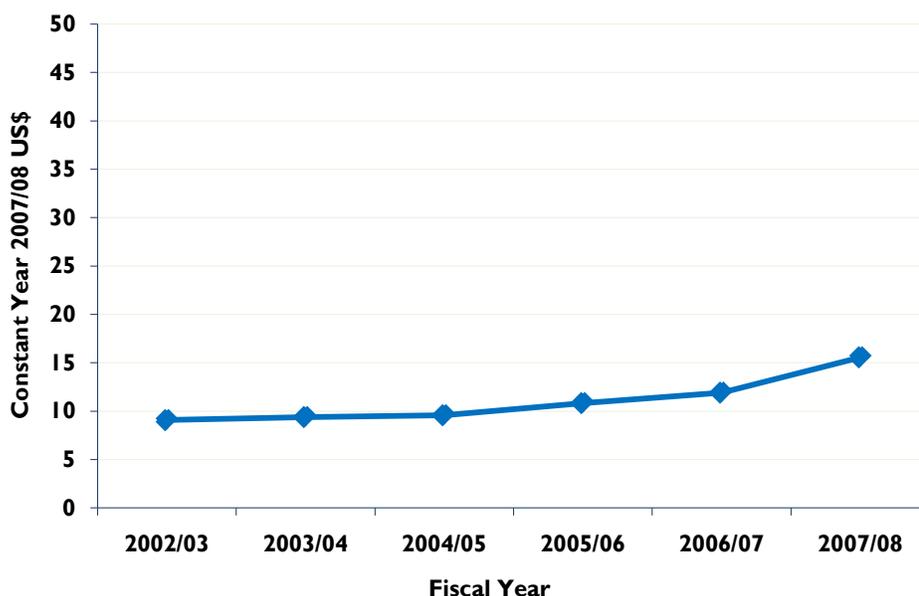
Kenya signed the 2000 Abuja Accord that encourages African heads of state and governments to allocate 15 percent of public spending to the health sector. To date, however, Kenya’s health sector budget has—by some measures—never risen above 10 percent of total public spending. This failure to meet the goals of the Abuja Accord underscores the political weakness of the health sector lobby in capturing public resources. Figure 5 shows that the Ministry of Health’s (MOH) share of the national budget decreased from the 2002/03 through the 2005/06 budgets. In 2006/07, the MOH share increased but declined again in 2007/08. In all these years, the MOH share of the national budget was well below the Abuja Accord goal for allocation of 15 percent of public spending to the health sector. Figure 6 shows that per capita health expenditures in Kenya have increased from less than US\$10 in 2002/03 to slightly more than US\$15 in 2007/08.

Figure 5: Ministry of Health’s share of national budget



Source: Ministry of Medical Services, 2008.

Figure 6: Kenyan per capita health expenditures, in constant year 2007/08 dollars



Sources: Health Policy Initiative analysis using health expenditure data from Ministry of Medical Services, 2008; Central Bank of Kenya exchange rates; and CIA World Factbook inflation rates for Kenya (CPI).

The SWG membership includes public and private sector stakeholders who rely on their bargaining skills and the goodwill of other stakeholders to acquire resources. The 2008 split of the health ministry into two separate ministries complicates this bargaining process by introducing another level of negotiations over health resources. However, splitting the health sector into one ministry focused on curative services and another focused on preventive and promotive healthcare (PPHC) is likely to provide a boost in resources for the PPHC sector—it allows the PPHC bureaucracy to advocate for preventive and promotive priorities as leaders of a ministry instead of junior partners within a single health ministry.

Kenya's Public Health Sector Budget in Perspective

Table 2 shows the allocations of the Ministerial Budgeting Committee for FY2002/03 to FY2007/08. The total gross health budget has increased during this period, but the MOH share of the GOK budget has fluctuated; since 2003/04, the MOH share has been less than half of the recommended Abuja Accord Goal of 15 percent. Similarly, the rate of per capita spending falls far below the World Health Organization's (WHO) recommended rate, which was US\$34 per person⁵ in 2007. Although Kenya's per capita spending rose from 2005/06 to 2007/08, it still was only 40 percent of the WHO recommended rate in 2007/08. Recurrent expenditures have captured the largest share of the health budget, although that share has decreased throughout the period under review, falling from a high of 94 percent of the budget in 2002/03 to a low of 70 percent in 2007/08.

⁵ http://www.who.int/tb/features_archive/commission_for_africa/en/index2.html, accessed on April 26, 2010.

Table 2. Overview of Kenya’s health budget, FY2002/03 to FY2007/08

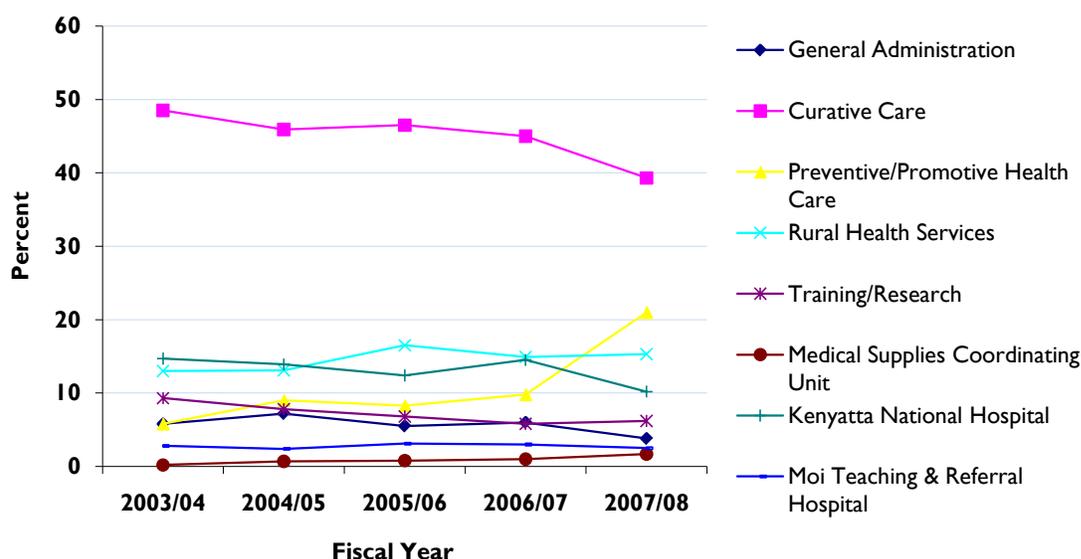
	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	Period average
Total Gross Health Budget (constant 2007/08 US\$ million)		317	332	385	437	543	403
MOH share of GOK budget (percent)	8.3	7	6.1	5.7	7.6	6.4	6.9
MOH health expenditure per capita (constant 2007/08 US\$)	9.1	9.4	9.6	10.8	11.9	15.6	11.1
Recurrent expenditures’ share of health budget (percent)	94.0	94.0	91.0	86.0	78.0	70.0	85.5

Source: Health Policy Initiative analysis of Ministry of Medical Services data, 2008.

FP/RH’s Share of the Public Sector Health Budget

Analysis of Kenya’s historical budget data reveals that curative care has typically received almost half the share of funding between 2002 and 2008, although the share decreased to 40 percent of health resources in 2007/08 (see Figure 7). When combining hospital allocations at the provincial, district, and sub-district levels with allocations to the national referral hospitals—Kenyatta and Moi—hospitals accounted for an average of 61 percent of all allocations during the review period. This level of curative spending crowds out funding for delivery outlets, such as the Rural Health Services, which are closest to the majority of Kenya’s poor rural residents. The pattern of spending that leaves modest resources for PPHC—providing basic services—also is likely to disadvantage FP/RH services to the poor. However, between 2006/07 and 2007/08, the percentage of resources received by PPHC doubled.

Figure 7: Percent shares of health resources, FY2003/04 to FY2007/08



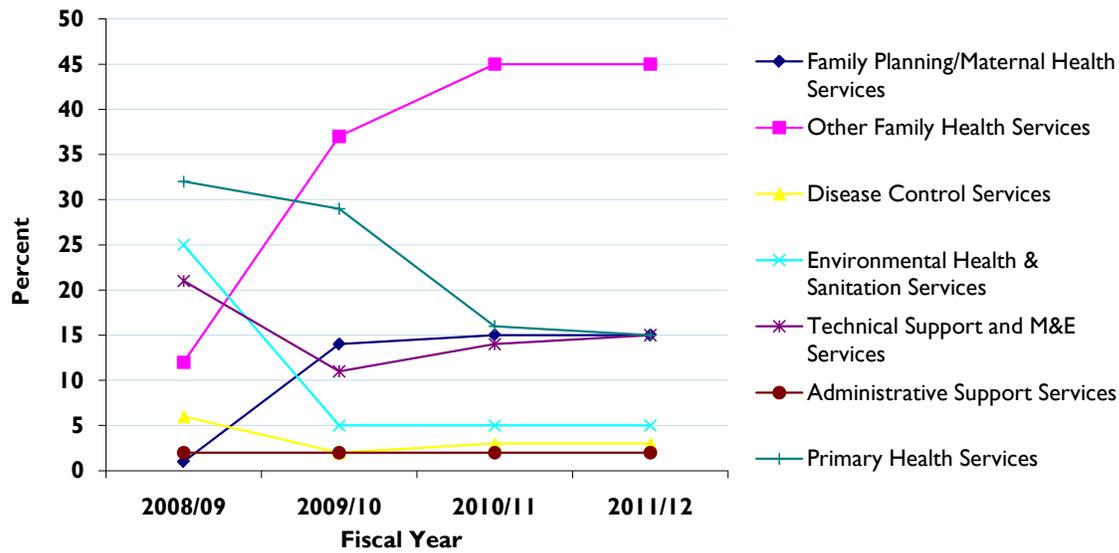
Source: Ministry of Medical Services, 2008.

The head of Family Health Services (FHS), whose purview includes the Division of Reproductive Health (DRH), pointed out that, since 2005, there had been a greater attempt to incorporate departmental interests into the MTEF process. The Ministry of Public Health and Sanitation (MOPHS) budget is developed with extensive participation from all five technical and six supportive departments. The divisions now have an opportunity to go to Treasury to defend their budgetary requests. The head of FHS has reported that other SWG members have become quite sympathetic to the need to increase MOPHS resources. However, DRH officials lamented the weak capacity in the ministry for planning, priority setting, and costing that undermined its ability to take advantage of available opportunities during the first to fourth annual operational plans (AOPs). The WHO is now training MOPHS provincial teams in these areas specifically to improve capacity to contribute to AOPs 5.

Kenyan officials traditionally have relied on development partners to fund the PPHC budget. According to the Health Policy Initiative's survey of the districts, their perception was that this relative neglect was due to the over-concentration of resources on curative rather than preventive care, the exclusion of communities from decisions on how to deploy healthcare resources, and communities' lack of understanding regarding the content and benefits of PPHC. The DHMT member survey indicates a general misunderstanding of different kinds of healthcare; 13 percent of the DHMT respondents could not distinguish between curative care, reproductive health services (RHS), and PPHC; another 41 percent displayed only partial awareness of the distinctions.

Figure 8 shows the budget share projections across all PPHC programs of MOPHS from FY2008/09 to FY2011/12. The "Other Family Health Services" category includes funding for HIV/AIDS programs; funding for these services has risen sharply, from about 12 percent in FY2008/09 to about 45 percent of the budget share for all PPHC programs in FY2010/11 and FY2011/12. Family Planning and Maternal Health Services increased sharply, from about 2 percent of the budget share of all PPHC programs in FY2008/09 to about 14 percent in FY2009/10 and 15 percent in FY2010/11 and FY2011/12. The projections also call for a decrease in budget share for Primary Health Services, Environmental Health and Sanitation Services, Technical Support and Monitoring and Evaluation Services, and Disease Control Services.

Figure 8: Budget share projections for all PPHC programs, FY2008/09 to FY2011/12



Source: Internal communications with staff of the Department of Family Health, Government of Kenya. Note: Data for FY2008/09 are estimates; numbers for all other years are projections.

Resource Allocation within the Public Health Sector

When the MOH acquires its share of resources from the SWG envelope, the health ministry⁶ distributes its resources among different health priorities. The Health Policy Initiative was unable to find any documentation on how this process works, but a knowledgeable official reported that it is done through a Ministerial Budgeting Committee attended by all department heads. Each head brings budgetary proposals to this committee and relies on persuasion, political influence, and the good will of other departments to allocate resources. Only a small portion of these resources are allocated on a more objective and measurable basis through a Resource Allocation Criteria formula, as detailed below.

Kenya's Resource Allocation Criteria Formula

Since 2000, the MOH has allocated 10 percent of its funds on the basis of a Resource Allocation Criteria (RAC) formula. As shown in Table 3, the RAC uses weighted variables to reflect the relative need of various Kenyan districts. The formula is only applied to the recurrent budget in allocating money to curative care (hospitals and sub-district hospitals) and Rural Health Facilities (health centers and dispensaries). The RAC was designed to bring an end to the long-standing incrementalist practice of resource allocation that fails to address variations in need in different regions of the country. Under the incrementalist approach, the ministry merely increased district allocations by a flat rate, without regard to factors such as poverty rates, local population characteristics, service use, and case loads or relative burden of disease. Implementing the RAC formula attempts to address the need for a transparent, objective, efficient, and equitable resource allocation process.

⁶ Because the health sector was led by one ministry before 2008 (most of the research period), this review often refers to both the Ministry of Medical Services and MOPHS as the "Ministry of Health," as this was the designation prior to the 2008 division into two separate ministries.

Table 3. Weighted variables in Kenya's RAC

Vote 317 – District Hospitals		Vote 335 – Rural Health Facilities	
Variable	Weight	Variable	Weight
Poverty rate	0.20	Infrastructure	0.15
Bed use	0.40	Under-5 population	0.20
Outpatient case load	0.20	Poverty rate	0.30
Accident area	0.05	AIDS cases	0.05
Fuel costs	0.15	Females of reproductive age (15 to 49)	0.20
		Area of district (sq. km.)	0.10
Total	1.00	Total	1.00

Source: Kenya MOH, 2009.

A major potential constraint to the equity impact of such formulas is the poor quality of data used in the formula. Workload and morbidity data captured by the ministry's Health Management Information System (HMIS) reflect wide variations in reporting rates across regions and over time. The ministry acknowledges the challenges involved in using the RAC formula; for one thing, ministry officials are inadequately trained in its use, sometimes resulting in misuse and miscalculations. Also, the aggregation levels within databases are too high, obfuscating potentially wide health or wealth discrepancies that might exist within regions. Fixing this problem would require more data collection at sub-district levels. Finally, the ministry acknowledges a weak framework for monitoring RAC implementation. For example, government officials report an ongoing need to track centrally purchased supplies and resources that go directly to the districts. These challenges are similar to those facing neighboring Tanzania and Uganda (as documented in Annex D), as they also attempt to implement resource allocation formulas.

District-level Budgeting

Under the National Health Sector Strategic Plan II, the health ministry requires districts to produce AOPs that are costed. These AOPs serve as district budget requests to the ministry. It is not clear how the top-down provisions of the RAC formula are reconciled with the bottom-up requests of the AOPs from the districts. Reconciling the two processes by standardizing their data sources and methodologies probably would make both processes more effective, as demonstrated in the following examples.

Health Policy Initiative researchers visited six Kenyan districts—Kajiado, Kisumu East, Kitui, Koibatek, Nyambene, and Nyando—to gain a better understanding of the interactions between subnational and national health resource stakeholders.⁷ This fieldwork elicited survey responses from two district medical officers (MOs) of health and 27 DHMT members. The district medical officers explained that in generating their budget requests, they initially undertake a monitoring and evaluation activity to determine the extent to which their current AOPs are being implemented. The MOs use indicators to measure performance and then set new targets within the anticipated financial resource envelope they have received from ministry headquarters.

The MOs get these health indicators from multiple sources, including their own databases, the health ministry's HMIS, and development partners. This is problematic because these databases use varied data collection and analytical methods that result in different estimates of financial resource needs. The MOs specified indicators for decisionmaking that include service delivery rates, efficiency levels through the proxy of case fatality, previous funding levels, and logistical support systems (through the proxy of

⁷ These districts had been part of a previous study (Oyaya and Rifkin, 1998).

stockouts). These indicators do not match those employed by the RAC formula. This is one of many reasons why the budgeting and resource allocation process may produce discrepancies between budget requests, allocated resources, and actual disbursements in the form of Authority to Incur Expenditure (AIE).⁸

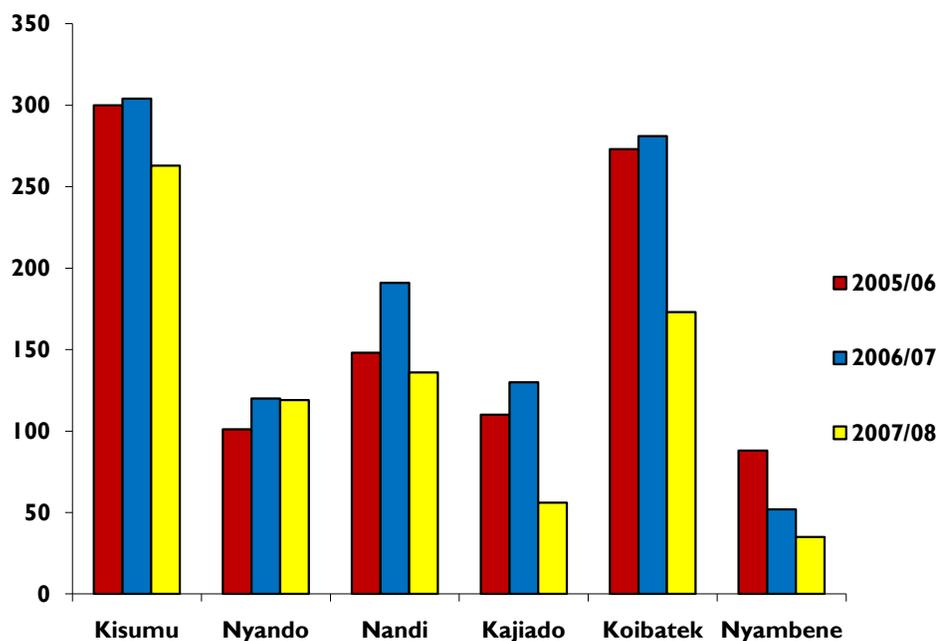
The MOs noted that they were well aware of the national MTEF and health ministry budget calendar. They were aware, for example, that the districts' budgetary requests must be submitted to the Provincial Director of Medical Services by March for inclusion in the ministry's budget. The MOs receive their resource allocation feedback either through the ministry's planning department or the Health Reform Secretariat.

District-level Resource Allocation

The Ministerial Budgeting Committee is responsible for allocating resources among services and across regions. The output of this activity is reflected in the district allocation budgets. Figure 9 presents the actual per-capita allocations to the MOH for the Health Policy Initiative study districts in the three most recent fiscal years. It is important to note that the allocation data are different from resources actually disbursed. As noted previously, HMIS data collection is incomplete and inconsistent. For example, the data sometimes omit health facility visitors when the facility submits late or incomplete returns. Consequently, the data are not reliable enough to allow for analysis of the relationships between changes in attendance or return visits and changes in demand for services. Any correlation could reflect either causation or varying reporting performance. The fieldwork did not capture outlays from development partners working in FP/RH; the data below present only the government's share of the total actual per-capita allocations.

⁸ Once the government budget is passed by Parliament, Treasury releases money to ministries in four tranches through the fiscal year, as this money largely comes from the tax revenues generated as a result of the provisions of the same budget. Consequently, field officers, such as MOs, may not spend until they receive an AIE from their ministry headquarters.

Figure 9: Actual per-capita allocations to MOH in study districts, FY2005/06 to FY2007/08 (Kenyan Shillings Per Capita)



Source: MOH, district allocation budgets, various FYs divided by each district's total population in 2008.

The 2008 split of the Ministry of Health into the Ministry of Medical Services (MOMS) and MOPHS complicates tracking the resources shown in Figure 9. At the district level, the curative/hospital budget is tracked exclusively by MOMS through the Hospital Superintendent, while the RHS budget is tracked by MOPHS through the MOH head of the public health department in the district. The bulk of district healthcare delivery takes place in hospitals; under the new structure, the district department head of the MOH has no budgetary control over the pre-eminent healthcare delivery facilities.

Figure 9 demonstrates that per capita spending varies dramatically among districts and that this finding consistently holds true between 2005 and 2008. It is not possible to provide further in-depth commentary on the trends in allocations to different districts in the above Figure 9. Efforts to access the Ministerial Budgeting Committee minutes were unsuccessful, and the study was not able to obtain any details about the process of allocating money to districts.⁹ Across the three FYs, for example, only one district's allocations—Nyando's—initially rose and then remained stable. In four districts—Kisumu, Nandi, Kajiado, and Koibatek—there was an increase in allocations in FY2006/07, followed by a decrease in allocations in FY2007/08; in the districts of Kajiado and Koibatek, the decrease from FY2006/07 to 2007/08 was substantial. Finally, in Nyambene District, there was a steady decrease in allocations each fiscal year.

District-level budgets show some of the same characteristics observed at the national level: recurrent spending is larger than development budgets and curative spending is much larger than the spending on

⁹ Anecdotal evidence from the district teams suggests that the process is largely in the hands of an individual rather than a committee.

preventive and public healthcare measures. Modest development budget resources indicate that the government relies on communities and nongovernment stakeholders to fund infrastructure development. Additional resources are available from the Constituency Development Fund and Local Authority Trust, but these groups rarely integrate their activities with those of related government departments such as the MOH. Consequently, facilities are constructed that cannot be equipped or staffed. The dominance of curative services also results in a focus on hospitals; such a focus tends not to benefit the rural poor who live farther away from hospitals.

Reconciling District-level Requests with Health Resource Allocations

It is useful to compare district-level budget requests and actual disbursements to ascertain whether the budget process is sensitive to subnational needs. However, the recent split of the health system between MOMS and MOPHS complicates analysis and budget tracking. In addition, there was a low district-level response rate to the Health Policy Initiative survey on budget data. Table 4 compares disbursements to district MOHs with district budget requests. The table indicates that there is a low rate of disbursements compared to budget requests. In Kisumu East and Koibatek, actual district-level disbursements fall far short of district-level MOH allocation requests. In Kisumu East, actual disbursements varied significantly among the various years—from a low of 7.4 percent of the budget request in FY2007/08 to a high of 22.4 percent of the budget request in FY2008/09. In Koibatek, allocations were only a fraction of district budget requests—2.3 percent in FY2007/08 and 1.2 percent in FY2008/09. Altering resource allocation procedures at the national level to improve health equity must be accompanied by improvements in aligning actual disbursements with requested allocations. During interviews, the staff of district MOHs explained that they respond to such budget gaps by scaling down activities and/or requesting supplementary resources from local nongovernment sources. For example, for FY2009/10, the DRH expects to actually receive about 50 percent of its resource demand; DRH must seek alternative sources of financing for the remaining 50 percent of the budget. The anticipated budget shortfall is expected to cause staff shortages and will undermine the delivery of planned activities.

Table 4. Comparison of disbursements to district MOHs with district budget requests¹⁰

		FY2005/06	FY2006/07	FY2007/08	FY2008/09
Kisumu East	AIE received	10,180,080	6,380,244	3,872,734	5,251,284
	Percent of request	**	18.6	7.4	22.4
	FP/RH allocations	**	**	150,000	**
Koibatek	AIE received	10,476,598	3,540,184	1,452,869	707,187
	Percent of request	**	**	2.3	1.2
	FP/RH allocations	**	460,000	165,000	**

Source: Responses from respective districts' MOH offices given during the Health Policy Initiative survey.

**Data are not complete because districts did not provide all the requested data.

According to the findings of the Health Policy Initiative survey, DHMT members demonstrated a low level of awareness when queried about their budgets. Two-thirds of the respondents did not know how the MOH allocates money at the sub-district level, and about one-third of DHMT members who were aware that their MOH allocates money at the sub-district level said they did not know the criteria employed to allocate resources to their districts. Only one respondent out of 30 knew the amount of his MOH budget.

¹⁰ These figures exclude AIEs released to the medical superintendents, so comparisons should not be made to the data from other tables.

Survey responses on FP and RH demonstrated that DHMT members were familiar with the importance of FP and RH for health. The majority of health workers (59 percent) were aware of the significance of FP/RH services. Respondents noted that these services had the capacity to improve the overall well-being of families. They understood that these services enable people to plan families, with a subsequent positive impact on maternal health and better chances of child survival. Finally, they expressed an awareness of the link between FP/RH services and achievement of the Millennium Development Goals (MDGs).

IV. FINDINGS ON WOMEN'S PARTICIPATION IN RESOURCE ALLOCATION

This study originally intended to analyze any correlation or causation between increased women's participation in budget allocation processes and increased funding for FP/RH services. The dearth of district-level data on FP funding, however, makes such data analysis impractical. Interviews with district officials did, however, reveal useful insights into the relationships between women's participation in the health resource allocation processes and allocation outcomes. The interviews provided a glimpse into the current state of women's representation in subnational decisionmaking bodies.

Across the six districts, 91 percent of respondents felt that FP/RH decisions are not being made by the right people. The medical officer in Kisumu East District reported that no women are involved in district-level FP/RH planning and budgeting activities. Officials in Koibatek District reported that female department staffers are heavily involved in identifying FP/RH needs and planning and budgeting for interventions.¹¹ Qualitative evidence reveals that these staffers took part in the promotion of FP/RH activities that resulted in the targeting of (scarce) resources toward improved FP/RH services.

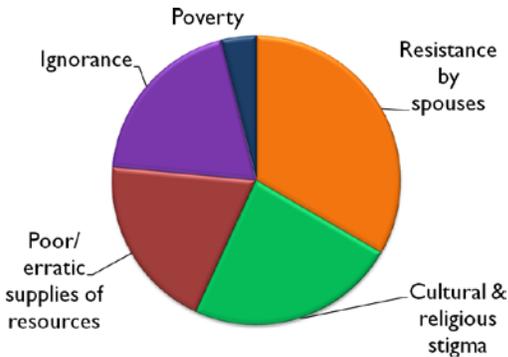
Obstacles to Women's Participation in the Resource Allocation Process

Figure 10 summarizes survey respondents' perceptions of the obstacles to greater participation of women in the resource allocation process, as well as the potential benefits from increasing their participation. Respondents were allowed to provide more than one suggestion. For women, resistance by spouses to FP/RH and cultural and religious stigma against FP/RH are the principle obstacles to participation. Men also cited male chauvinism and traditions as key obstacles to support for FP/RH. Most of the obstacles to women's participation require education and attitudinal changes, although poor/erratic supplies of resources remain an important obstacle for women, and constrained FP/RH choices was an obstacle cited by men. There was general agreement between women and men that the potential benefits of women's participation in FP/RH allocation processes include increased access to FP/RH services; women also cited factors such as improved health for women, children, and families. Box 1 notes some of the voices behind the statistics, with quotes from focus group discussions in different districts.

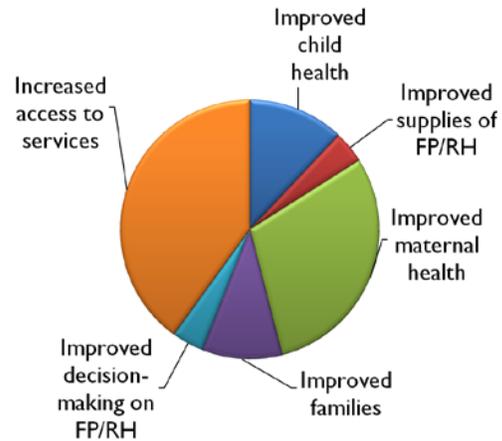
¹¹ The female staffers included district public health nurses, district health education officers, and district reproductive health coordinators. The males included district MOs, district public health officers, district health administrative officers, and district health officers.

Figure 10: Obstacles to women’s participation in FP/RH decisionmaking and potential benefits of gender representation in FP/RH management

Obstacles for Women’s Participation in FP/RH Management



Potential Benefits of Women’s Representation in FP/RH Management



Box I. Voices behind the Statistics:

Participants of Kisumu Men’s FGD argued that women are too busy or uneducated to participate in decisionmaking:

“When I consider how my wife is ever busy, most women cannot get time to participate in decisionmaking.”

“I don’t expect somebody who is not educated to make decision, she can make wrong decisions.”

Female participant in Nyando Women’s FGD argued that male chauvinism is ingrained in Kenyan society and traditions:

“Tradition is only good if it bears fruits, but me personally, I haven’t seen any fruit, it is dangerous to us women!”

Findings of the Legal Review

Kenya has a dual legal system; statutory law applies alongside customary law.¹² The gap between these two types of laws has important consequences for women, especially in cases where the Constitution allows for application of customary law in personal law matters. For example, the Kenyan Constitution broadly states that any type of discrimination is prohibited; however, most women's lives are governed by a separate set of local laws based on religion or custom, which the Constitution also allows. Table 5 summarizes the important implications of this dual legal system in terms of the statutory versus

¹² The Judicature Act explains the sources of law in Kenya as the Constitution, all written laws, common law, doctrines of equity, the statutes of general application in force in England on August 12, 1897 (the date Kenya became a British protectorate), and African customary law in civil cases in which one or more of the parties are subject to or affected by such law.

customary law approaches to issues of equality, harmful practices against women, child marriage, and polygamy.

Table 5. Achieving reproductive health goals in Kenya: Statutory versus customary law

Reproductive Health Intervention	Statutory Law Provisions	Customary Law Provisions
Equality	<ul style="list-style-type: none"> Section 82 of the Constitution, which provides protection from discrimination, includes the sex attribute as one of the descriptions covered by the term “discriminatory.” Section 82(4) of the Constitution specifically exempts personal, religious, and customary laws from challenge, even if they are discriminatory. 	<ul style="list-style-type: none"> Women regarded as minors under the care and control of a male. As a result <ul style="list-style-type: none"> women cannot own or inherit property women do not participate in public life women have limited decisionmaking powers
Elimination of Harmful Practices <i>Violence against Women</i> <i>Child Marriages</i> <i>Polygamy</i>	<ul style="list-style-type: none"> Domestic violence addressed under general criminal and civil offenses of assault and battery. No domestic violence courts exist. Rape is a criminal offense punishable by a maximum of life imprisonment and no minimum sentence. However, marital rape not recognized as an offense. Female circumcision is prohibited under the Children Act. Sexual Offences Act provides for various categories of sexual offenses against women and children. Early marriages of children prohibited under the Children Act. Minimum age of marriage under the Marriage Act is set at 16 years with consent. Various definitions of “child” under civil and criminal laws. Illegal and Penal Code provides for offense of bigamy. 	<ul style="list-style-type: none"> Wife beating accepted as a form of cultural “disciplining” of wife. Rape is an offense, not against the victim but against her family. The same is true for impregnating a single woman. Cultural attachment to female circumcision as a rite of passage among some ethnic groups. No minimum age; girls can be betrothed at birth. Polygamy is allowed. Wife inheritance practiced among some communities.

Source: Mbote et al. 2009.

Findings on Kenyan Law in Relation to FP/RH

Most of the Kenyan laws that regulate reproductive health issues have remained the same since the country attained independence in 1963, and some laws and regulations impede women’s access to FP/RH services. For example, the Penal Code criminalizes abortion, except in instances where a woman’s life is in danger. Because of these restrictions on abortion, many Kenyan women seek them clandestinely under medically unsafe and life-threatening conditions; in fact, unsafe abortions are one of the leading causes of maternal mortality in Kenya (Ziraba et al. 2009). Important legal developments have taken place following recommendations made in 1999 by the Task Force formed to review laws that conflict with the fundamental rights of women. The establishment of the National Commission on Gender and the work of

nongovernmental organizations (NGOs) such as the International Federation of Women Lawyers/Kenya have increased attention to reproductive health issues.

In 2004, a draft National Social Health Insurance Bill proposed the establishment of a fund to facilitate provision of accessible, affordable, and high-quality healthcare services to all, regardless of age, economic, health, and social status. The policy framework for the bill identified the constitutional guarantee of a right to health as one of the prerequisites for long-term effectiveness of the proposed national social health scheme. It also pointed out some of the challenges to providing improved healthcare in Kenya—a weak judicial system and a lack of effective enforcement of existing laws and ethical guidelines related to healthcare. The Sessional Paper for the bill underscored the need for defining exemption criteria for population categories that are unable to contribute to the Social Health Insurance Fund. This demonstrates that there was awareness of the need to empower some sections of the population to access healthcare. The paper also anticipated decentralization of management to the provincial and district levels. Neither the policy nor the bill was finalized.

The Draft Reproductive Health Rights Bill of 2007 provides for the recognition of the basic right of couples and individuals to decide freely and responsibly the number, spacing, and timing of their children and to have the information and means to do so. It also maintains the right to attain the highest standard of sexual and reproductive health. It declares the right to make decisions regarding reproduction free from discrimination, coercion, and violence. It requires the minister responsible for health to make regulations to improve access to high-quality FP information and services; prescribe guidelines to guarantee all persons access to contraceptives; and protect an individual's right to give full, informed consent before accepting a contraceptive method. Part V on safe motherhood and childbirth requires the minister to promote best practices on safe motherhood and childbirth, provide for the registration of facilities and service providers, and facilitate the provision of free maternal care in all public hospitals. It also provides for the integration of reproductive healthcare with HIV/AIDS services; the provision of reproductive healthcare to adolescents; the protection of adolescents from physical and sexual violence and discrimination, including cultural practices that violate their reproductive health rights; and proscription of female genital mutilation. The establishment of a tribunal to deal with breaches of the bill is a significant step toward the promotion of RH rights.

The Effects of Kenyan Laws on Women's Participation in Resource Allocation for FP/MH

The Financial Management Act of 2004

Kenyan laws such as the Government Financial Management Act of 2004 (hereafter referred to as 2004 Act) provide a modest boost to women's representation in budgetary decisionmaking. Previously, Legal Notice 162 of the Public Health Act of 1992 had established a basis for local participation in planning health programs through District Health Management Boards (DHMBs). The 2004 Act builds on this by requiring DHMB and DHMT boards—which convene to deliberate on resource envelope priorities, collaboration, and coordination efforts—to seat a minimum number of women. The 2004 Act therefore provides an entry point for scaling up resource allocations to FP/RH programs.

The 2004 Act also designates responsibility for the various aspects of government finance. It establishes a Health Sector Services Fund to provide resources and support capacity building in the management of health facilities. In addition, it supports and empowers rural communities to take charge of improving their own health and healthcare services. The officer responsible for administering the fund is charged with developing criteria for allocating funds to be approved by the National Health Services Committee (NHSC). This also provides an important entry point for bringing women into the resource allocation process.

Other potential entry points for improving the representation of women and the allocation of resources to FP/RH include the following:

- The NHSC and Health Facilities Management Committee at the provincial, district, sub-district, health center, and dispensary levels. The NHSC comprises ten members—at least two of whom must by law be women. The NHSC is responsible for approving the workplans of health facilities, ensuring equitable distribution of resources to the facilities, and reviewing and approving their annual expenditure statements.
- The provincial hospital management, district hospital management, and sub-district hospital management committees each have seven to nine members. One member must be nominated by women's groups in the area and one of the two persons nominated by community-based development organizations must be a woman. This ensures that there are at least two women members of the committee. The roles of the committees include supervising and controlling the administration of funds allocated to facilities, so membership on the committee may provide a strategic opportunity to advocate for increased FP/RH allocations.
- Seven to nine members sit on the health center management and dispensary management committees. Regulations require that membership include at least two women. As with the other management committees at the provincial and district levels, the roles of the committees include supervising and controlling the administration of funds allocated to facilities.

Legal Notice 162 of the Public Health Act, 1992

DHMBs were established through Legal Notice 162 of the Public Health Act in 1992. The purpose of DHMBs is to represent community interests in the health planning process and work with DHMTs, district hospital management teams, and health center teams to coordinate and monitor implementation of government and nongovernmental health programs. DHMBs oversee the provision of healthcare to ensure client representation and the prudent use of funds. They are responsible for planning, coordinating, monitoring, identifying implementation problems, recommending corrective actions, and recommending areas for levy of user charges. There is no specific provision for representation of women in DHMBs. Among the guiding principles of the user fee program are (1) local planning for use of revenue at facility and district levels and (2) protection of vulnerable groups through discretionary waivers for the poor and automatic exemptions for specific target services and age groups. These two principles provide an entry point for equity considerations, as well as increased allocations for FP/RH services.

DHMTs plan and coordinate health activities. The DHMB and the DHMT are required to convene regular district stakeholders forums to deliberate on resource envelope priorities and collaboration and coordination efforts. These institutions and forums also provide an entry point for scaling up resource allocations for FP/RH.

V. CONCLUSIONS AND RECOMMENDATIONS

Although decentralization has been a stated policy objective for Kenya since 1994, its implementation has been limited. In practice, the allocation of health sector financial resources remains highly centralized and opaque, relying primarily on previous years' budget allocations rather than health needs indicators. Equitable or fair resource allocation can be accomplished only by taking into consideration variation in need across geographic and economic regions. This research revealed that the process of allocating health sector funds to Kenyan regions has not taken into account differences in health achievement, health access, and provision costs across Kenyan regions and sub-regions.

Recommendations to improve equity in resource allocation across decentralized units are as follows:

Improve data collection at the subnational levels

The lack of disaggregated national and subnational data impedes effective implementation of resource allocation formulas. In addition, district and central government officials rely on different datasets to formulate budgets, and the differences in data make it difficult to align budget requests and budget allocations. At the subnational or district levels, there generally is weak capacity or incentive to collect data as a basis for requests for new resources or to plan and budget for future resource needs. There is also a weak capacity to store data in efficiently retrievable formats. Better data collection and usage at sub-district levels could contribute to improved information for more equitable resource allocation.

Develop subnational capacity to plan and manage resources

Decentralization implies an increase in subnational responsibilities for planning, implementing, and monitoring health services, yet subnational entities currently lack the capacity to shoulder these responsibilities. Subnational authorities also lack corresponding authority to secure resources and hold national-level policymakers accountable for promised funding and representation. The WHO has conducted some training on the preparation of budgets, but broader efforts are needed to build capacity to collect and use data, plan collaboratively, and manage resource allocation processes and formulas.

Improve collaborative planning to align budget requests with allocations

The research team observed a lack of synchronization between FP plans and resource allocations. There is a lack of collaborative planning between development partners, the central government, and the districts. Districts' lack of authority to shape spending plans and allocations also contributes to this problem. In the study areas, districts are simply informed of resource allocations that have been decided and rarely get the resources they request. Because their budgetary requests are almost never met, districts have no motivation to analyze their own funding needs, even when they have the capacity to do so. A more collaborative planning approach specifically aimed at bringing the districts into the process at earlier stages to formulate more realistic budget requests would improve the overall allocation process.

Strengthen the implementation of needs-based RAC

Kenya's needs-based RAC is a step in the right direction, but the scale of the program is too small to shift significant resources to more needy programs and districts. Current equity-based allocations apply to only 10 percent of the total government health budget, which itself accounts for roughly 30 percent of total health spending in Kenya. While it is understandable that the formula's initial application was modest to prevent abrupt and politically unsustainable changes to health resources allocation, a needs-based formula could have a greater impact on equity outcomes if it is applied to a larger share of the overall budget.

- Before expanding the application of needs-based resource allocation criteria, stakeholders will need to understand and forecast budgetary implications under various scenarios. Such exploration of scenarios will help allay fears that changing policies will harm particular regions or interest groups and could help to heighten awareness of the advantages and reasons for applying needs-

based formulas. Policy exploration may prove crucial to garnering adequate political support for the reform of health resource allocation procedures and criteria. Whatever design such initiatives take, it is vital that they are developed with a legal framework and guidelines to ensure sustainability and are aligned with the MOH, MOPND, and Vision-2030 Secretariat.

- Kenya could utilize different measurements of need to bolster the formula's sensitivity to actual variations in health needs and foil attempts at data manipulation. The country also could draw on Tanzanian and Ugandan experiences with resource allocation formulas. Indicators such as the population density—which tend to negatively correlate with transportation costs and therefore resource needs—may prove less susceptible to manipulation than some other indicators.

The research team also examined the extent of women's participation in the health budget allocation processes. There is a logical correlation between women's representation on budgetary committees and increased attention to health programs that affect women's health, such as FP/RH programs. Findings from surveys, focus groups, and interviews support this correlation between increased representation of women in health resource allocation decisionmaking and increased attention to FP resource allocation.

Recommendations to ensure adequate allocation of resources to FP/RH at the decentralized level are as follows:

Strengthen the legal and Institutional framework for decentralized resource allocation

In administrative terms, Kenya has a generally centralized governance system with some responsibilities and obligations delegated to subnational authorities. The extent to which authority and responsibilities are either decentralized or devolved appears to be somewhat arbitrary in the absence of specific legislated imperatives. Subnational levels of the MOH and activities such as FP/RH remain largely controlled at the national ministry level. The Health Policy Initiative found that there was often a discrepancy in study districts between stated resource allocation procedures and practices, in addition to discrepancies between resource allocation promises and disbursements at the district level. Currently, districts may be unable to reconcile district budget requests with disbursements because they are under-represented in allocation processes and because the processes themselves are undocumented and informal.

- Further steps are needed to formalize the budgetary process, along with other aspects of the government's resource allocation procedures. This would empower districts by allowing them to hold the national government accountable for its promises and procedures.
- Communities also could participate in supporting increased resource allocations to FP/RH through the creation of a community-level citizen monitoring process for FP/RH services.

Address the under-funding of health, FP/RH at subnational levels

The data showed that the health sector is severely under-resourced by global standards and the standards set by sub-Saharan Africa heads of state and government. Study results also revealed the inequitable allocation of resources among key service delivery levels. Although this study did not capture enough data to analyze the extent of the shortfall, it was sufficient to conclude that national-level shortfalls constrain allocations and activities at subnational levels. FP/RH activities have been shown to be particularly vulnerable to financial shortfalls.

- The changing political and funding environment has created various opportunities for FP resource mobilization. The following strategies can help to mobilize new resources for family planning: conduct evidence-based policy dialogue to include family planning in development programs, such as Vision 2030, MDGs, Poverty Reduction Strategy Paper (PRSP), and SWAp; create FP budget line items in district budgets; leverage resources through FP/HIV integration; and advocate for the inclusion of family planning in social health insurance.

- Target spending levels in tandem with increases in spending efficiency and rationalization of allocation decisionmaking to facilitate equity in service delivery. For example, the GOK could disproportionately increase PPHC spending, and the ministry could mandate FP/RH spending levels. Such policies would require a fundamental change in the ministry's and government's approaches toward PPHC and FP/RH so as to embrace these areas as primary responsibilities of the government rather than of development partners.

Recommendations to promote participation of women in decisionmaking at the decentralized level are as follows:

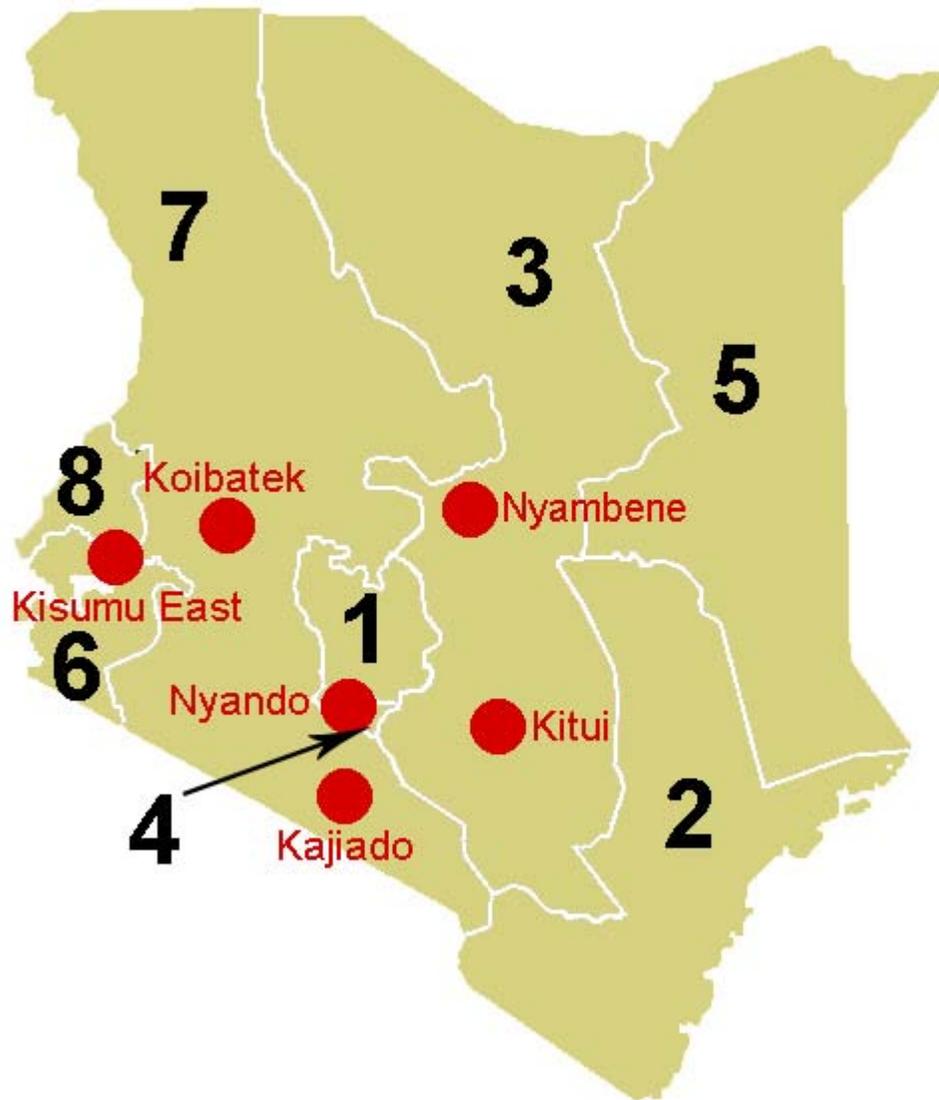
Increase women's participation in FP/RH planning and resource allocation

The study provided useful insights into the obstacles to women's participation in FP/RH planning and resource allocation in Kenya. In the district of Koibatek, women are participating in FP/RH planning and resource allocation but are not represented in other study districts. Further research on key factors that foster women's participation in Koibatek and similar districts could provide a basis for developing advocacy tools and support measures to help integrate women into the allocation processes. Qualitative research revealed that women and men are aware of obstacles to women's participation in FP/RH decisionmaking; efforts to promote women's participation should address these obstacles. Educating political and community leaders to acquire positive attitudes toward women in management would help reinforce such initiatives.

There is a basis in Kenyan law for support of women's participation in resource allocation for FP/RH. Passage of the Draft Reproductive Health Rights Bill of 2007 would ensure a comprehensive approach to FP/RH rights and services. Important legal measures to ensure that women do participate in defining, planning, and allocating resources for healthcare needs in Kenya include (1) support for women's representation on budgetary committees through the Government Financial Management Act of 2004 and (2) support for local participation in planning health programs through Legal Notice 162 of the Public Health Act of 1992.

- Steps to fully support and promote the recent mandate of female representation should target areas with high levels of poverty and draw on the knowledge of successful districts and champions of FP/RH to create an action plan to improve women's participation in all sub-regional levels.
- Advocacy with political, community, and health leaders to encourage compliance with the law should focus on the benefits of improving equity in health resource allocation and funding of FP/RH through enhanced participation of women.

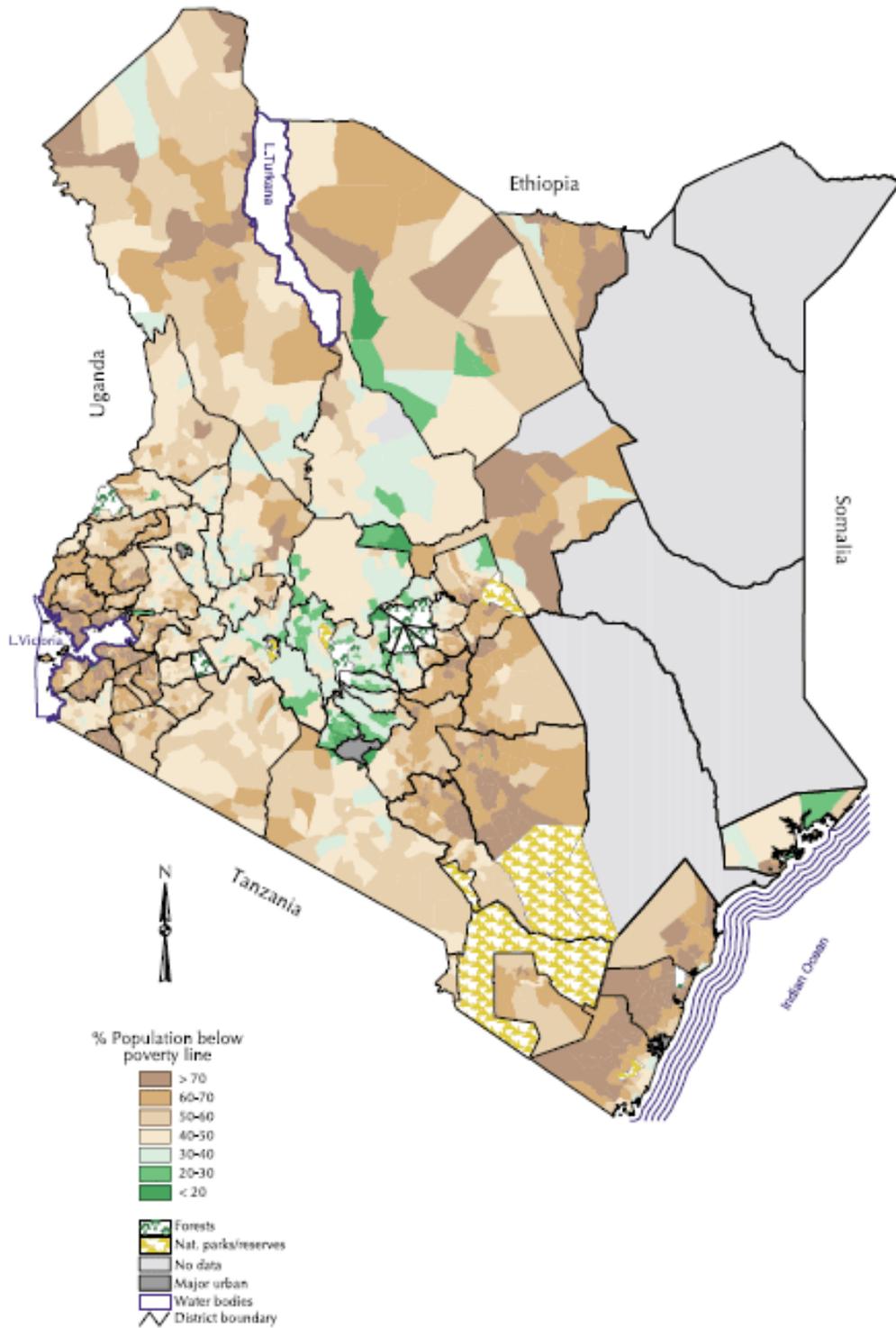
ANNEX A. THE EIGHT PROVINCES OF KENYA (NUMBERS) AND HEALTH POLICY INITIATIVE STUDY DISTRICTS (DOTS)¹³



1. Central
2. Coast
3. Eastern
4. Nairobi
5. North Eastern
6. Nyanza
7. Rift Valley
8. Western

¹³ Map of HPI study districts in Kenya created by the Health Policy Initiative, 2010.

ANNEX B. POVERTY MAP OF KENYAN DISTRICTS¹⁴



¹⁴ Source: The World Bank, <http://econ.worldbank.org/WBSITE/EXTERNAL/EXTDEC/EXTRESEARCH/EXTPROGRAMS/EXTPOVRES/0,,contentMDK:20306724~menuPK:791412~pagePK:64168182~piPK:64168060~theSitePK:477894,00.html>.

ANNEX C. FINDINGS OF THE LITERATURE REVIEW: SUMMARY TABLE

Table C1. Selected Countries' Strategies for Equitable Allocation of Health Resources in Decentralization

Country	Decentralization and Equity Strategies	Health Resource Allocation Method(s) (Vehicles for Moving Money from Center to Subnational Governments)	Formula Details (If Methods Include Formula)	PRSP or SWAp Mechanisms	Data Collection/ Surveillance Method(s)	Results/ Impact	Literature Source(s)
Chile	Decentralization Redistribution of wealth Devolution	Municipal Common Fund (MCF) (a horizontal equity fund to redistribute resources among the municipalities)	MCF receives revenue from local estate taxes, vehicle license plates (chief contribution from wealthiest municipalities), and commercial and industrial licenses; redistribution takes place based on per capita formula.			Equity was greatly improved by redistribution of resources from the wealthy to the poor through horizontal equity fund.	Bossert, 2000; Sanchez et al., 2006
Colombia	Decentralization (devolution) to municipal governments in 1993		Used population-based formula to allocate resources to municipal and district facilities; adjusted for poverty level, unmet basic needs, admin efficiency, quality of life indicators.	Financing Service Delivery Human Resources Targeting Governance		Equity was improved by increasing investment in the municipalities and district facilities rather than redistribution from the wealthier quintile.	Sanchez et al., 2006; Bossert, 2000, 2008

Country	Decentralization and Equity Strategies	Health Resource Allocation Method(s) (Vehicles for Moving Money from Center to Subnational Governments)	Formula Details (If Methods Include Formula)	PRSP or SWAp Mechanisms	Data Collection/ Surveillance Method(s)	Results/ Impact	Literature Source(s)
Ghana	Decentralization and delegation Deconcentration of budget flows but center retains control over staff pay, recruitment, allocations, and planning	SWAp funds go through Health Fund; others go through earmarked development partner funds		National Reproductive Health Policy and Standards (1996) and its attendant Service Policy Standards and protocols established SWAp		Progress made in deconcentrating health budgets; financial allocations now go directly to the districts from central government, improving disbursement times. District budget approvals, however, still controlled by center. Planning and budgeting improved through decentralization.	Mayhew, 2003; Bossert and Beauvais, 2002
Kenya	Decentralization Needs-Based Allocation Formulas	MTEF RAC	Since 2000, 10% of Government Health Budget allocated using RAC formula, which funds District Hospitals based on 5 weighted criteria and Rural Health Facilities based on 6 weighted criteria (see Section IV table).	SWAp implementation is weak.	Ministry's HMIS has uneven reporting rates; level of data aggregation is too high; weak monitoring of RAC implementation.		Kenyan Ministry of Health; Health Policy Initiative field research, 2009

Country	Decentralization and Equity Strategies	Health Resource Allocation Method(s) (Vehicles for Moving Money from Center to Subnational Governments)	Formula Details (If Methods Include Formula)	PRSP or SWAp Mechanisms	Data Collection/ Surveillance Method(s)	Results/ Impact	Literature Source(s)
Malawi		Funds include General Resource Fund, Education and Health Fund, and Capital Development Fund, all directly transferred to local authorities	In 2003–04, MOH allocated weighting— Population 50%; Poverty 15%; U5MR 20%; Remoteness 5%; Presence of CHAM facility 5%; Presence of Dist. Hosp. 5%; formula for the drug budget also being developed.		NHAs are used to track public and private expenditures.	Strength: Rural-urban variation has been accommodated in the formula. Formula is need based.	Chaulagai, 2005; Mujinja et al., 2006
South Africa	Seeks vertical equity and reduction of health inequalities using Deprivation Index with varying weights		Allocation formula: used the Deprivation Index with varying weights assigned. The variables include % of women, children, uneducated, unemployed, standard of living, etc.			Geographic reallocation and allocation across care levels.	Diderichsen, 2004

Country	Decentralization and Equity Strategies	Health Resource Allocation Method(s) (Vehicles for Moving Money from Center to Subnational Governments)	Formula Details (If Methods Include Formula)	PRSP or SWAp Mechanisms	Data Collection/ Surveillance Method(s)	Results/ Impact	Literature Source(s)
Tanzania	Political devolution, plus administrative and financial decentralization	Block grants	70% based on population; 10% regional poverty score; 10% vehicle route mileage; 10% under-5 infant and child mortality.	SWAp	National Bureau of Statistics (NBS) independently reviews data inputs for allocation formula every 3 years.	Allocation formula implementation limited in scope but working; fiscal and political decentralization face many obstacles.	Semali and Minja, 2005; Tidemand, 2005; Braathen et al., 2005; Mapunda, 2003
Uganda	Political, administrative, and financial decentralization; need-based for Equalization Grants, performance-based for local development grants (LDGs)	Conditional and Unconditional Block Grants and Equalization Grants MTEF	Equalization Grants 60% age stratified pop size; 20% inverse of Human Development Index; 20% inverse index of per capita donor and NGO spending in district. LDGs re-distribution to sub-district local governments use 85% population, 15% geographic size.	SWAp process began in 1998 with the development of Uganda's Health Sector Strategic Plan (HSSP) (2000/01–2004/05); has SWAp since 2000.	District-wide reviews and NHAs are used to monitor expenditures.	Some geographic re-allocation and vertical re-allocation; volume of resources under districts' control has significantly increased and helps equity; timeliness of transfers has improved dramatically.	Diderichsen, 2004; Ssewankambo et al., 2007; Kasumba and Land, 2003; Olico-Okui et al., 2005; Villadsen, 1996; Okuonzi and Lubanga, 1997

Country	Decentralization and Equity Strategies	Health Resource Allocation Method(s) (Vehicles for Moving Money from Center to Subnational Governments)	Formula Details (If Methods Include Formula)	PRSP or SWAp Mechanisms	Data Collection/ Surveillance Method(s)	Results/ Impact	Literature Source(s)
Zambia	<p>Health sector decentralization, delegation, and deconcentration</p> <p>District health boards created to oversee district health management teams charged with implementation of decentralized health service delivery</p> <p>Weighting population and rural-urban factors to attain equality in distribution</p>	District health basket is housed at autonomous Central Board of Health, stripping MOH of its service delivery role	2003—MOH revised formula; “Material Deprivation Index” was used as a population weight. Variables include Poverty Headcount Index; proportion of households with varying degrees of facilities and development; literacy rate; population; infectious diseases; eye infection incidence; health staff contact rate.	Sector Program Assistance involves disbursement of generalized resources following the implementation of policy or administrative reforms that are considered to be key constraints to sector progress.	Data chiefly obtained from Census and Living Conditions Monitoring Survey.		Frantz et al.; Phiri, 2003; Bossert and Chitah et al., 2001

ANNEX D. FINDINGS OF THE LITERATURE REVIEW: CASE STUDIES

Case Study: Health Resource Allocation in Tanzania

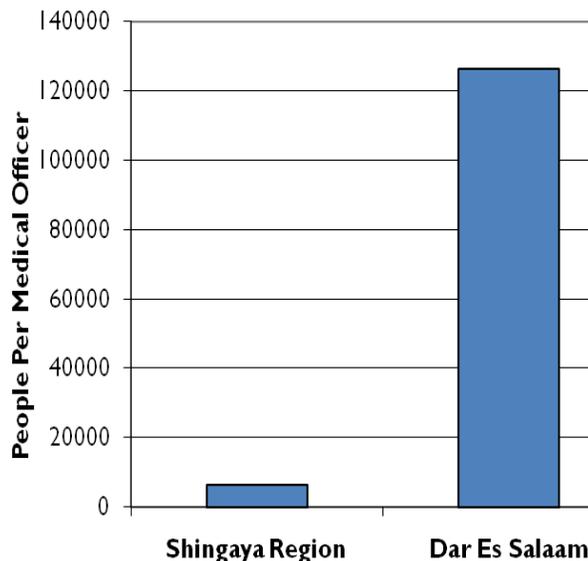
Background on Tanzania

Tanzania is one of the poorest countries in the world and has significant geographical variation in economic and health indicators. A 2000–2001 household survey on Tanzanian income poverty showed that 35 percent of Tanzanians live below the basic needs poverty line. Poverty is more severe in rural than urban areas. The poor in urban areas constitute only 13 percent of the country's poor people, while the rural poor account for 87 percent (Semali and Minja, 2005).

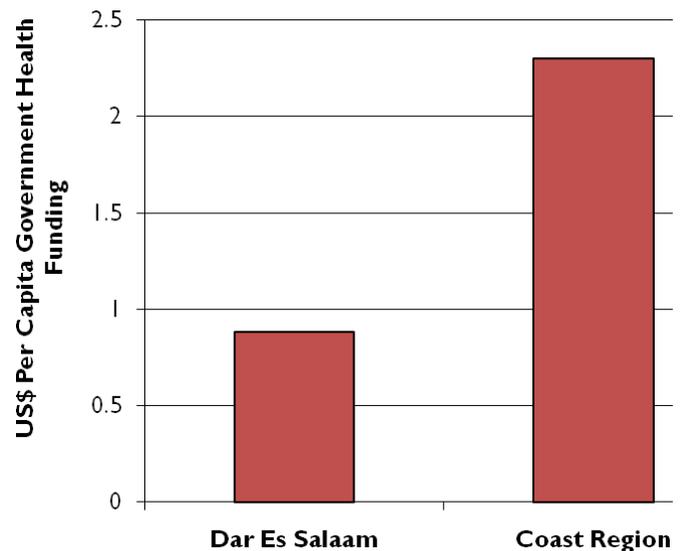
Tanzania's healthcare system is mainly funded by block grants, which are transfers from central to local governments. The allocation of block grants to regions and individual local governments largely determines how equitably healthcare resources are distributed among districts. Until recently, government funds to local governments were unevenly distributed, with some areas receiving more resources per capita than others. For instance, local government in the Coast Region consistently received more than other regions—an average of 11,234 Tanzanian shillings (Tsh) per person in 2002–2003, as compared to the Shinyanga Region's 5,260 Tanzanian shillings (Tsh) in receipts per person that same year. Figures 4 and 5 also show disparities in the allocation of grants to health districts. These disparities persisted because each year the districts received the previous year's allocation plus an increase to account for inflation (Semali and Minja, 2005).

Figures D1 and D2. Tanzanian health funding, regional discrepancies

People per Medical Officer, 1995



US\$ per Capita Government Health Funding, 2002



Source for both figures: Semali and Minja, 2005, quoting the Tanzanian MOH, 1995.

Addressing these inequities is particularly difficult, given the low level of overall funding available for health services (Semali and Minja, 2005).

Local government reform in Tanzania began in the mid-1990s, partly as a result of the dialogue between the Tanzanian government and the donor community. Since 1994, this process has occurred parallel to the transformation of Tanzania's economy from a socialist toward a market economy, the introduction of multiparty democracy, and enhanced donor support that has enabled a significant increase in public sector spending for social sector service delivery at local levels (Tidemand, 2005).

In 1997, Tanzania launched the Local Government Reform Program (LGRP), and the national government presented its Local Government Reform Agenda to a round table meeting of interested donors. The same year, the Regional Administration underwent substantial restructuring, whereby the regional level was abolished and most of the regional staff were transferred to the districts (Braathen et al., 2005).

In 1998, the government published the Policy Paper on Local Government Reform, further accelerating the reallocation process. One stated goal of this program was "to increase the resources available to local government authorities (LGAs) and improve the efficiency in their use." The essence of LGRP is to transfer duties and financial resources from the central to the local government levels (Braathen et al., 2005).

The executive summary of the policy on the Local Government Reform spells out how decentralization of government includes the following four policy areas:

1. Political devolution involves the devolution of powers and setting the rules for councils and committees, chairpersons, etc. Political decentralization implies the creation of real multi-functional governments at the local level within national legislation.
2. Financial decentralization is based on the definition of principles of financial discretionary powers of local councils (i.e., powers to levy taxes and the obligation of central government to supply local governments with adequate unconditional and other forms of grants).
3. Administrative decentralization involves the de-linking of local authority staff from their respective ministries, as well as procedures for establishment of a local payroll.
4. Changed central-local relations involves changing the role of central government vis-à-vis local councils into a system of inter-governmental relations, with central government having the overriding powers within the framework of the Constitution (Tidemand, 2005).

After setting these goals and making some initial progress with the amendment of the LG Act in 1999–2000, reform progress slowed until 2004. Delays can be explained by a combination of lack of proper technical guidance and political willingness (Tidemand, 2005).

Resource Allocation Formulas and Modalities

From 2004, Tanzania made significant progress on fiscal devolution as the Government of Tanzania (GOT) started to introduce a formula-based allocation of recurrent grants to LGAs to more equitably distribute resources and produce a higher degree of local budget autonomy (Tidemand, 2005). In 2003, the Tanzanian Ministry of Health developed Tanzania's first needs-based formula for the allocation of financial resources to LGAs based on the following four factors:

- Age- and sex-weighted population (weighted 50% in the allocation formula)

- Poverty levels, based on the Poverty Welfare Index of the geographical area under question (15% weighting)
- An index of mileage, to and within the LGA (15% weighting)
- Burden of disease, to incorporate under-five and adult mortality rates, plus any others available (20% weighting) (Mapunda, 2003)

At that time, work had also been commissioned through the LGRP to propose an objective, equitable, and transparent system of intergovernmental grants. Issues of data availability, reliability, and the relative incentive effects of different factors were considered when selecting the formula, as was the need to phase in formula implementation to prevent abrupt changes in LGA allocations. The draft report of the reform program proposed the following three options for both vertical and horizontal resource allocation for the health sector:

1. Population (100%), as with the current basket fund. This is both simple, objective, and transparent, and recognizes the size of the LGA's population as the primary determinant of demand for healthcare.
2. Population (80%), land area (15%), and poverty count (5%), recognizing the greater needs of rural and poor LGAs. Weights were determined based on implicit policy priorities.
3. Population (70%), regional poverty count (10%), vehicle route mileage (10%), and infant or under-five mortality (10%) (Semali and Minja, 2005).

The third formula most closely reflected the Ministry of Health's proposed formula, and in January 2004, the GOT adopted it. (The main difference between the two formulas is the heavier weighting for population in the selected formula—70% compared with 50%). This new formula recognized the individual as the main client-recipient of health services, so 70 percent of the health funds are distributed in proportion to the population of each district. In addition, councils receive additional resources for three "special needs categories": the special needs of the poor population (10% of health resources); the special needs of the rural population (10%); and the special needs of districts with a higher-than-average burden of disease (10%). It recognizes the higher operational cost of delivering health services in rural and scarcely populated areas, including the higher costs involved in drug distribution and supervision. The formula also aims to redirect resources to areas with a high burden of disease. The under-five mortality rate was considered an appropriate proxy for this purpose (Semali and Minja, 2005).

The Government of Tanzania tasked its NBS to independently review relevant data every three years. Basket funds—which are donor funds pooled under the SWAp initiative—had previously been allocated to local governments on an equal per capita basis, but the new formula recognizes a number of variables other than population size as important in determining the relative need for health services in each area. In addition to basket funds, the same allocation formula also is being applied to block grants allocated to each district. Close monitoring has been required to ensure that releases based on the formula actually reach the intended beneficiary sector and that funds are spent in accordance with national and local priorities (Tidemand, 2005).

Impact of the allocation formula in Tanzania

Since 2004, the allocation formula has been applied only to a portion of health system block grants, thereby limiting its effectiveness in reducing disparities in health resource allocations. Experts have recommended changing grant procedures to expand adherence to the formula-based recurrent grant system. Specifically, this would require a change in the processes and procedures with which local establishments are distributed and public servants are assigned across different LGAs (Boex and Tidemand, 2008).

Tanzania has made concrete improvements to the government's own recurrent transfer system since 2006. While there are still some issues to be resolved with respect to the application of the formulas, recurrent resources generally flow to the local government level in a predictable, transparent, complete, and timely manner. This stands in stark contrast to the less efficient inter-governmental transfer system of five years ago (Boex and Tidemand, 2008). A separate analysis of the GOT's allocation formula—performed by the Tanzanian MOH and Muhimbili University College of Health Sciences—is also encouraging. This statistical analysis concluded that the newly adopted formula was effective and appropriate in allocating resources and that the formula allocates resources between districts in almost precisely that the same ways of a more complicated and statistically derived deprivation index (Semali and Minja, 2005).

Despite the progress made during the past decade, Tanzania's implementation of fiscal and political decentralization faces many obstacles. A broader analysis of Tanzania's decentralization experience suggests that the implementation of needs-based allocation formulas is one positive achievement, but many challenges remain. Obstacles to achieving further health access equity include sections of the Constitution not conducive to decentralization; the absence of a clear legal framework for assignment of expenditures; disharmony among sectoral legislation, administrative, and political structures that do not ensure optimal administrative sizes for efficient service provision; too much interference from Members of Parliament in local matters; no clear fiscal decentralization strategy (although first steps have been taken regarding the systems of recurrent and development grants); and no local autonomy to hire and fire (Braathen et al., 2005).

Case Study: Health Resource Allocation in Uganda

Background on Uganda

Uganda chose to implement an ambitious program of decentralization beginning in the 1990s. The 1997 Local Government Act marked an important step in launching the process, operationalizing the provisions of the 1995 Constitution that had emphasized decentralization as the country's framework of governance (Kasumba and Land, 2003).

According to the Government of Uganda (GOU), the equitable distribution of public resources both between and within districts constituted one of the major goals of decentralization (Kasumba and Land, 2003). The GOU pledged to reduce the disparities in health outcomes between the lowest and highest income quintiles by at least 10 percent by 2010 (Ssewankambo et al., 2007). To this end, the health sector has formulated the National Health Policy and develops five-year HSSPs which, in 2000, shifted the health sector policy focus from project implementation to SWAp. In 2000, HSSP also focused more on primary healthcare (PHC) and re-allocated resources in favor of lower levels of care (Ssewankambo et al., 2007).

Resource Allocation among Sectors

The guiding principles for sector resource allocation, planning, and budgeting processes at all levels of service delivery are contained in the annual health sector Budget Framework Paper that is aligned to the GOU MTEF. The MTEF is the overall mechanism by which resources are allocated to and within sectors; resources are expected from government and include donor budget support. The MTEF sets sector and local government spending ceilings within a three-year rolling framework (Ssewankambo et al., 2007).

Allocation of resources within sectors is executed by SWGs that submit a schedule of the proposed allocations to the Ministry of Finance Planning and Economic Development (MOFPED) (Ssewankambo et al., 2007). At the district level, sector guidelines for allocation of funds between the different levels of care and inputs have been aligned with the Fiscal Decentralization Strategy. Under the strategy, beginning in FY2006/07, districts are allowed discretion to re-allocate up to 10 percent of their recurrent non-wage grants to unfunded or under-funded priorities within or across Poverty Action Fund sectors to address

local priorities. There is also room for the local governments to negotiate with the center on how resources should be allocated (Ssewankambo et al., 2007).

Resource Allocation among Subnational Governments

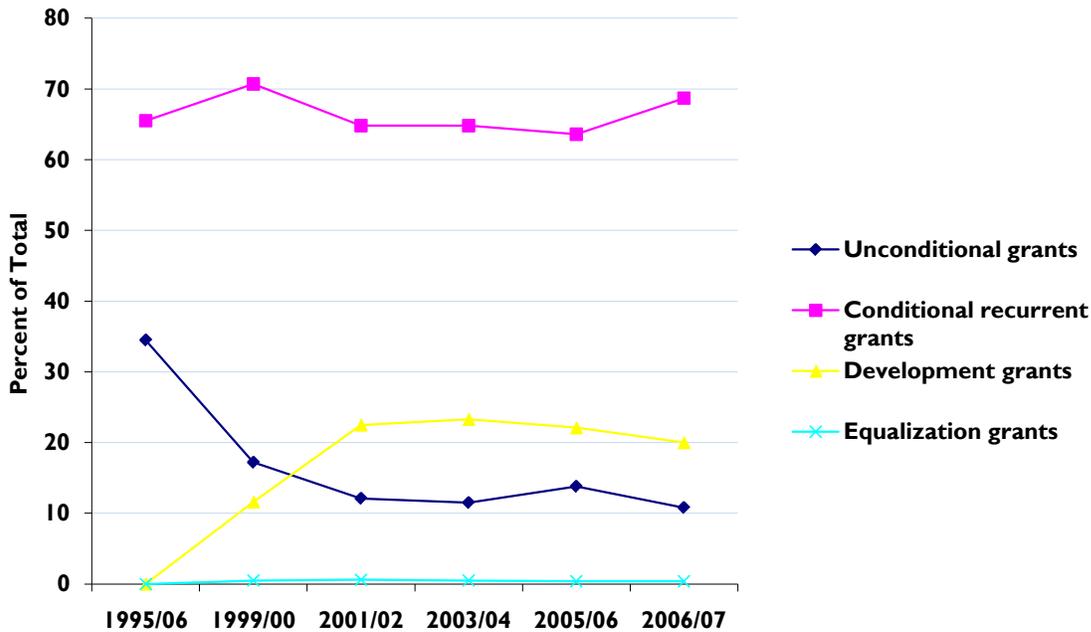
Political and administrative decentralization gained traction when the 1997 Local Government Act devolved substantial powers, functions, and responsibilities to local government. For instance, district, municipal, and town councils are expected to prepare their own development plans, based on locally determined priorities, for making, approving, and executing their own budgets and for making by-laws consistent with the Constitution and other existing laws. In addition, local authorities are mandated to hire, manage, and fire personnel. They manage their own payroll and separate personnel systems, and have their own independent District Tender Boards and independent District Service Commissions. Other than the 1997 Act, there has been no strategy document to provide overall guidance to the decentralization process (Kasumba and Land, 2003).

One of the most persistent challenges of decentralization has been working out an appropriate system of *fiscal* relations between the center and subnational governments. The small revenue-earning capacity of Ugandan local governments necessitates the transfer of financial resources to local councils through a system of conditional, unconditional, and equalization grants (Kasumba and Land, 2003). The formal objectives within the field of fiscal decentralization are embodied in the Fiscal Decentralization Strategy 2002, the results and work-plans derived from the Joint Annual Review of Decentralization, 2004, and, more recently, the Decentralization Policy Strategic Framework and the draft Local Government Sector Investment Plan of June 2006 (Boex and Tidemand, 2008). However, the Local Government Development Program (LGDP) has been the most important program to date supporting the decentralization process (Kasumba and Land, 2003).

Uganda's LGDP embodies the following three grant mechanisms, the last of which employs a formula to promote equity:

- The LGDP's local development grants allow local governments to fund their own development priorities.
- Its capacity-building grants allow local governments to build their capacity to utilize the development grants.
- Equalization grants (EGs) utilize formulas to promote the equitable distribution of resources across subnational governments (Kasumba and Land, 2003).

Figure D3. Composition of the LGDP Grants



Source: Ssewankambo et al., 2007, p. 40.

LDGs employ performance-based formulas. Local governments that demonstrate improvement in performance are eligible for a 20 percent increase in their LDG allocations the following year, while those that show poor performance take a 20 percent reduction in their allocations, thereby emphasizing the importance of continuous improvement (Kasumba and Land, 2003).¹⁵

The health sector resources allocated to districts (the PHC conditional grant to districts, lower levels, and NGOs) are horizontally allocated among districts, taking into consideration the size of the population, poverty levels, health status of the district, special health needs, and access to other funding sources. Therefore, needs-based criteria partially drive allocations of conditional grants (Ssewankambo et al., 2007).

EGs also employ a needs-based formula to distribute resources to subnational governments, but their importance should not be overstated, as they continue to represent less than one percent of total grants (Ssewankambo et al., 2007).

¹⁵ Once LDG money reaches a district, it is further sub-divided among local governments using the formula from the Local Governments Act of 1997. The district sends 65 percent of the total grant to the sub-county, calculated on the basis of population (85%) and geographic size (15%); the sub-counties, in turn, distribute 30 percent of their allocation to parishes and indicative planning figures. Local governments are required to spend 80 percent of the funds on priority sectors under the Poverty Eradication Action Plan to ensure the realization of government's broad national objectives. However, unlike the conditional grant system, local governments decide where and how to make the investment. Accessing the LDG requires 10 percent counterpart funding by the beneficiary local government to promote local ownership and stimulate local revenue generation efforts (Kasumba and Land, 2003).

District-wide reviews and NHAs are used to monitor expenditures.

Impact of the fiscal decentralization process in Uganda

Two studies that assessed the Ugandan health sector initiatives have highlighted some positive results. The first study concluded that fiscal decentralization has resulted in the transfer of substantial financial resources in absolute terms to district health programs (including RHS), although resources are still inadequate to reduce infant mortality rates and maternal mortality ratios. Districts have used some of the non-earmarked centrally transferred funds to construct infrastructure for several lower-level health centers, thus substantially expanding physical access to basic health services, including RHS (Olico-Okui et al., 2005). It is important to note, however, that although grants to districts rose in absolute terms, they fell as a percentage of total government spending and gross domestic product between 2002 and 2007 (Ssewankambo et al., 2007).

The second study noted that, after Uganda implemented various reforms to more clearly define responsibilities at each level of government, the percentage of PHC Central Government funds released on time to the health sector increased from 33 percent in 2000/01 to 97 percent in 2002/03, indicating an improvement in GOU commitment to the sector (Ssewankambo et al., 2007). The same study gave Uganda good marks for allocating more resources to the district health system between 2001 and 2006; the study concluded that the district health system allows for a transparent and equitable allocation of resources across health sub-districts and health units. These allocation formulas and procedures, however, have yet to address the inequitable allocation of human resources (Ssewankambo et al., 2007).

REFERENCES

- Boex, J., and P. Tidemand. 2008. "Intergovernmental Funding Flows and Local Budget Execution in Tanzania." Amsterdam: Royal Netherlands Embassy.
- Bossert, T. 2000. *Decentralization of Health Systems in Latin America: A Comparative Study of Chile, Colombia, and Bolivia*. Boston: Data for Decision Making Project, Harvard School of Public Health.
- Bossert, T. 2008. *Decentralization of Health Systems: Decision Space, Innovation and Performance*. Boston: Harvard School of Public Health.
- Bossert, T., and J. Beauvais. 2002. "Decentralization of Health Systems in Ghana, Zambia, Uganda and The Philippines: A Comparative Analysis of Decision Space." *Health Policy and Planning* 17(1): 14–31.
- Bossert, T., and Chitah. 2001. *Decentralization of Health Systems in Zambia: Resource Allocation and District Performance*. Boston: Harvard School of Public Health.
- Braathen, E., A. Chaligha, and O. Fjeldstad. 2005. *Local Governance, Finances and Service Delivery in Tanzania*. Oslo: The Norwegian Agency for Development Cooperation, Norwegian Institute for Urban and Regional Research.
- Central Bureau of Statistics, Kenya. 1997. Welfare Monitoring Survey 1997. Nairobi: Government of Kenya.
- Central Bureau of Statistics, Kenya. 2003. Kenya Demographic and Health Survey 2003. Accessed in November 2009 at www.measuredhs.com.
- Chattopadhyay, R., and E. Duflo. 2004. "Women as Policy Makers: Evidence from a Randomized Policy Experiment in India." *Econometrica* 72(5): 1409–1443.
- Chaulagai, Chet N., C. Moyo, J. Koot, H. Moyo, T. S mb kungsi, F. Khung , P. N ph i. 2005. *Design and Implementation of a Health Management Information System in Malawi: Issues, Innovations and Results*. Oxford: Oxford University Press.
- CIA World Factbook. Available at www.cia.gov. Accessed in December 2009.
- Diderichsen, F. 2004. "Resource Allocation for Health Equity: Issues and Methods." HNP Discussion Paper.
- East African Standard Newspaper. "Stand Behind Poverty Index or Quit." November 20, 2008. Retrieved from <http://www.eastandard.net/editorial/InsidePage.php?id=1143999678&cid=16&>.
- Government of Kenya. 1994. *Kenya Health Policy Framework*. Nairobi: Government of Kenya.
- Government of Kenya, Ministry of Finance. 2007. *Treasury Circular No. 11*, October 2007.
- Kabubo-Mariara, Jane, and Godfrey K. Ndeng'e. 2004. "Measuring and Monitoring Poverty: The Case of Kenya." PPT presentation accessed on January 19, 2010 at: www.worldbank.org/afr/padi/kenya_Poverty.ppt

Kasumba, G. and A. Land. 2003. "Sector-Wide Approaches and Decentralization Strategies Pulling in Opposite Directions? A Case Study from Uganda." Maastricht: European Centre for Development Policy Management Maastricht.

Library of Congress, Federal Research Division. 2007. "Country Profile-Kenya." Page 9.

Mapunda, M. 2003. "Experiences in Resource Allocation in Tanzania, Focusing on Sector Wide Approach (SWAp) and Health Basket Fund." *Bulletin of Medicus Mundi Switzerland* No. 91.

Mayhew, S.H. 2003. "The Impact of Decentralization on Sexual and Reproductive Health Services in Ghana." *Reproductive Health Matters* 11(21): 74–87.

Mbote, P., E. Nyanjom, G. Mwabu, and P. Owino. 2009. "Decentralization, Health Planning, Empowerment of Women and Reproductive Health Outcomes in Kenya." Draft Literature Review Consultant Report for the USAID | Health Policy Initiative. Nairobi.

Ministry of Medical Services. 2008. "Facts and Figures."

Mujinja, Phares, E. Kataika, D. Chimfwembe, J. Nabyonga, and E. Njau. 2006. *Resource Allocation in ECSA: Is Equity Being Fostered?* Arusha, Tanzania: East, Central and Southern African Health Community, Health Systems Development Program.

Okuonzi, S.A., and F.X. Lubanga. 1997. *Decentralization and Health Systems Change in Uganda*. Geneva: World Health Organization.

Olico-Okui, et al. 2005. *Understanding the Impact of Decentralization on Reproductive Health Services in Africa: Uganda Country Study Report*. Makerere University Institute of Public Health, Department of Health Policy, Planning and Management.

Oyaya, C., and S. Rifkin. 1998. Health Sector Reforms in Kenya: An Examination of District-level Planning. *Health Policy* 64(1): 113–127.

Oyugi, L.N. 2005. "The Budget Process and Economic Governance in Kenya." *NEPRU Working Paper* No. 98.

Peterson, S.B. 1994. "Budgeting in Kenya; Practice and Prescriptions." *Harvard Institute of International Development Discussion Paper* No. 481.

Sánchez, Anabella, Wendy Abramson, Nadia Olson, and Nora Quesada. 2006. *Decentralizing and Integrating Contraceptive Logistics Systems in Latin America and the Caribbean: Considerations for Informed Decision Making throughout the Health Reform Process*. Arlington, VA: USAID DELIVER, Project.

Semali, I.A., and G. Minja. 2005. "Deprivation and the Equitable Allocation of Health Care Resources to Decentralised Districts in Tanzania." Regional Network for Equity in Health in Southern Africa (EQUINET), *EQUINET Discussion Paper* No. 33.

Ssewankambo, E., P. Tidemand, and J. Steffensen. 2007. *Local Level Service Delivery, Decentralization, and Governance: A Comparative Study of Uganda, Kenya and Tanzania*. Education, Health and Agriculture Sectors for the Japan International Cooperation Agency, Uganda Case Report, Final Report.

- Tidemand, P. 2005. *Tanzania Country Case Study of Local Development*. Dege Consult Draft.
- Villadsen, S. 1996. Decentralization of Governance. In Villadsen S, Lubanga F (eds). *Democratic decentralisation in Uganda. A New Approach to Local Governance*. Kampala: Fountain Publishers.
- Widner, J. 1992. *The Rise of the Party State in Kenya: from 'Harambee' to 'Nyayo.'* Berkeley, CA: University of California Press.
- Ziraba, Abdhahah, N. Madise, S. Mills, C. Kyobutungi, and A. Ezeh. 2009. "Maternal Mortality in the Informal Settlements of Nairobi City: What Do We Know?" Retrieved from <http://www.reproductive-health-journal.com/content/6/1/6>.

Health Policy Initiative, Task Order I
Futures Group
One Thomas Circle, NW, Suite 200
Washington, DC 20005 USA
Tel: (202) 775-9680
Fax: (202) 775-9694
Email: policyinfo@futuresgroup.com
<http://ghiqc.usaid.gov>
<http://www.healthpolicyinitiative.com>