REPUBLIC OF KENYA

NATIONAL AND COUNTY HEALTH BUDGET ANALYSIS

FY 2020/21

MINISTRY OF HEALTH

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FOREWORD

Annual national and county budgets reflect the policy and resource allocation decisions that determine the activities, programmes, and services that will be delivered within a financial year. Tracking these allocations reveals national and county governments' resource allocation patterns and measures the alignment of these allocations with regard to governmental health policy priorities.

This report, a follow-on to the *National and County Health Budget Analysis 2019/20,* examines how public health sector financial resources were allocated for the 2020/21 fiscal year in comparison to the allocation patterns of the preceding two years. This analysis will continue to be produced annually to inform the budgeting process in the health sector.

The findings provide evidence for national and county policymakers and decisionmakers to inform public health budget allocation planning by functional area. Thus, it can serve as an advocacy tool to source additional funding and improve allocative efficiency. Policymakers can also use the findings to examine whether allocations to health were directed towards the most cost-effective programmes and activities, as well as assess compliance with programme-based budgeting as stipulated in the Public Finance Management Act of 2012.

The information provided in this analysis enables comparison of Kenya's health budget against international health financing benchmarks, such as the Abuja Declaration targets. The analysis also provides a cross-comparison to challenge counties to increase their respective health spending. This analysis contributes towards improved health financing with the aim of achieving better health outcomes.

ACKNOWLEDGEMENTS

The Ministry of Health (MOH) is grateful to the institutions that provided access to the data used in this study. The ministry acknowledges the financial and technical support provided by the U.S. Agency for International Development (USAID) and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) through the Health Policy Plus (HP+) project.

The study used data from several sources, including two previous budget analysis reports, the Office of the Controller of Budget, the National Treasury, the MOH, and county government offices, to compile the final report. The ministry is grateful to those institutions and the officers who facilitated the acquisition of data, especially the county departments and health staff who provided the raw data without which this analysis would not have been possible.

A team from the MOH conducted the analysis, guided by Stephen Macharia, director of planning, and assisted by Terry Watiri, economist. HP+ senior policy advisor Robinson Kahuthu provided technical assistance, supported by Caroline Njoroge and Cheruiyot Kiprotich of HP+. Stephen Macharia and Dr. David Khaoya, a programme director for HP+, conducted final technical reviews. The ministry is grateful to all of those who worked in the background to ensure successful completion of this analysis. Finally, the ministry welcomes continued support for future national and county health budget analyses, as well as recommendations to improve the contents and use of the findings.

ABBREVIATIONS

AIDS	acquired immune deficiency syndrome
FY	fiscal year
GDP	gross domestic product
HIV	human immunodeficiency virus
Ksh	Kenyan shilling
MOH	Ministry of Health
PBB	programme-based budgeting
TB	tuberculosis

EXECUTIVE SUMMARY

Government budgets act as indicators of policy, priorities, programmes, and planned activity implementation over a specific fiscal period. In Kenya, the budget process is defined by the country's constitution and elaborated in the Public Finance Management Act of 2012.

The Kenya Constitution of 2010 introduced devolution, in which health functions are shared between the national and 47 county governments. Pre-devolution, resources flowed directly from the National Treasury to the Ministry of Health (MOH) to finance health activities in the country. After promulgation of the new constitution that introduced devolution, the transfer of functions and funding to the counties began in fiscal year (FY) 2013/14. The National Treasury provides direct funding to counties, which then individually and independently determine how much to allocate for health services according to their mandates and priorities.

The ministries, departments, and agencies of national and county governments develop budgets following set guidelines, which then are approved by their respective legislative bodies. Since FY 2015/16, both levels of government have been required to adopt a programme-based budgeting approach. This report examines the trend in fiscal allocations by health sector priority areas from FY 2018/19 to FY 2020/21. Unless otherwise noted, all Kenyan shilling (Ksh) values reported are in nominal terms—that is, not adjusted for inflation. The findings presented in this report provide evidence that can help national and county policymakers understand allocation patterns by different economic and functional areas.

Total Government Budget Allocation to Health

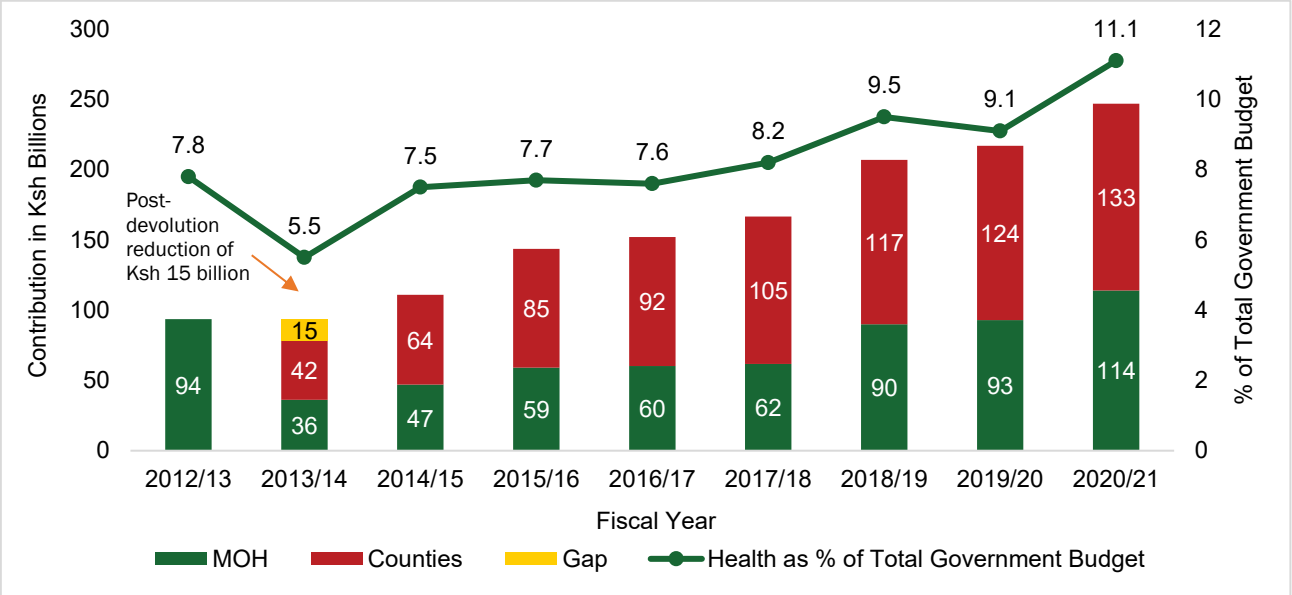
The public sector health budget expanded from Ksh 94 billion in FY 2012/13 (pre-devolution) to Ksh 247 billion in FY 2020/21—a more than two-fold expansion. In real terms, overall allocation to health has had limited growth—by 109 percent between FY 2013/14 and FY 2020/21. Real allocation to health over the past three fiscal years has increased by 7.5 percentage points,[1] whereas per capita real allocation to health has increased by 2.5 percent over the same period.[2] As illustrated in Figure ES.1, health as a proportion of total government budget has increased steadily since FY 2013/14, reaching 11.1 percent in FY 2020/21. The proportion remains below the Abuja Declaration recommendation of 15 percent.[3] In the last three fiscal years alone, Kenya's public health budget increased by Ksh 40 billion, with counties assuming more responsibility for the increase in health budget allocation.

[1] Real allocation is calculated using the consumer price index reported by the World Bank Open Data, based on 2013 prices.

[2] Population data used in this calculation are as reported by the Kenya National Bureau of Statistics' *Economic Survey 2021*.

[3] The Abuja Declaration is a pledge made in 2001 by members of the African Union during a conference in Abuja, Nigeria, in which the member nations pledged to increase their health budgets to at least 15 percent of their annual budgets and requested Western donor countries to increase their support.

Figure ES.1: Pre- and post-devolution budget allocations to health



Sources: Republic of Kenya, 2012/13–2020/21; Republic of Kenya, 2013/14–2020/21

National Budget Allocation to the Ministry of Health

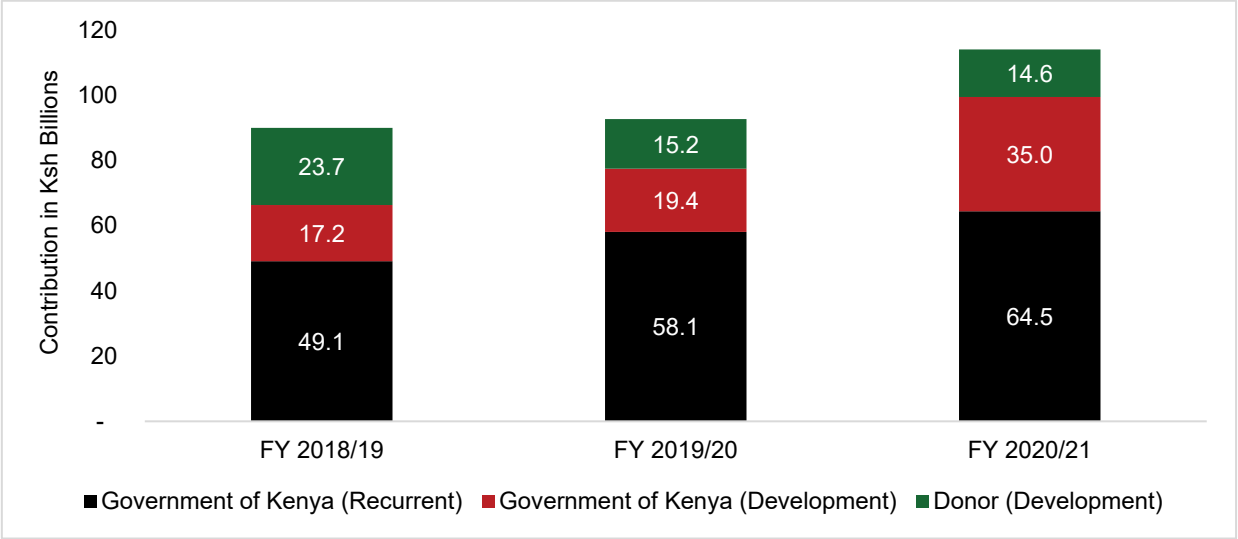
In FY 2020/21, the MOH was allocated Ksh 114 billion—an increase from the Ksh 90 billion and Ksh 93 billion allocated in FY 2018/19 and FY 2019/20, respectively. This sum constituted 6.5 percent of the national government budget—a significant increase from the 5.1 percent allocated in FY 2018/19 and 4.8 percent allocated in FY 2019/20. In absolute terms, the MOH budget increased by 27 percent over the three-year period.

Ministry of Health Budget Allocation

Figure ES.2 shows the MOH budget allocation from FY 2018/19 to FY 2020/21. The share of recurrent allocation increased (in absolute terms) from Ksh 49.1 billion in 2018/19 to Ksh 58.1 billion in 2019/20 and Ksh 64.5 billion in FY 2020/21. Most of this amount was allocated to grant transfers to the eight semi-autonomous government agencies (SAGAs) under the ministry, which consumed 61.9 percent of the recurrent budget (or Ksh 39.9 billion).[4] These SAGAs were expected to raise 39 percent of the Ksh 39.9 billion from internal revenue (i.e., user fees and sale of medical supplies). Transfers to universal health coverage programmes, including free primary care services, and transfers to level 5 hospitals constituted 5.9 percent and 6.7 percent of the recurrent budget, respectively. Allocations to personnel emoluments decreased from 15.5 percent in FY 2018/19 to 14.8 percent in FY 2019/20 before increasing to 17.6 percent in FY 2020/21. The balance of 7.8 percent was allocated to operations and maintenance.

[4] The semi-autonomous government agencies under the MOH are the Moi Teaching and Referral Hospital, Kenya Medical Supplies Authority, Kenya Medical Research Institute, Kenya AIDS Control Council, Kenya Medical Training College, Kenyatta University Teaching, Referral, and Research Hospital, and Mwai Kibaki Referral Hospital Othaya.

Figure ES.2: MOH budget allocation in Ksh billions, FY 2018/19–2020/21



Source: Republic of Kenya, 2018/19–2020/21a

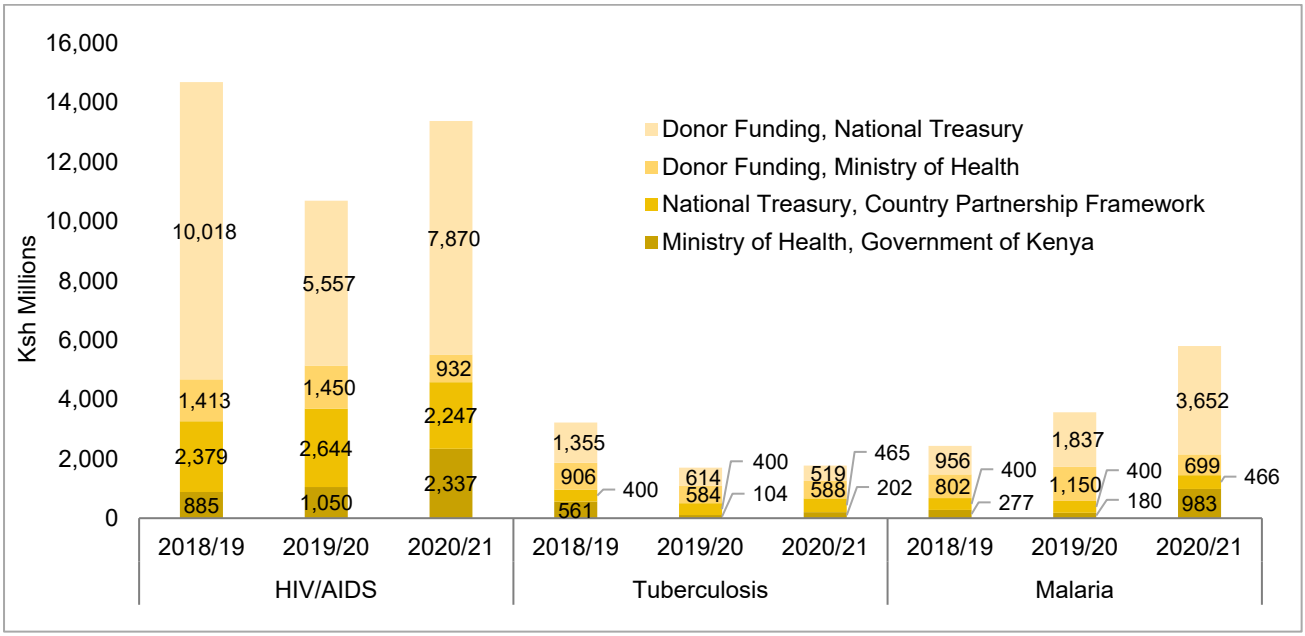
Donors contributed 29 percent (or Ksh 14.6 billion) of the MOH development (capital) budget of Ksh 49.6 billion in FY 2020/21, down from 44 percent (Ksh 15.2 billion) in FY 2019/20. The overall decline in donor funding over FY 2018/19–2020/21 can be mainly attributed to a one-off loan to purchase medical equipment (computerized tomography [CT] scanners) in FY 2018/19 and the government's full takeover of funding the health systems management component of the national immunisation programme in FY 2020/21. Much of the donor funding was allocated to HIV, tuberculosis (TB), and malaria at 15 percent; COVID-19 emergency response at 18 percent; and universal health coverage-related programme support at 43 percent. The remaining 24 percent was allocated to other smaller programmes. In contrast, the government contributed 71 percent (or Ksh 35 billion) of the MOH development budget in FY 2020/21, up from 56 percent (Ksh 19.4 billion) in FY 2019/20 and 42 percent (Ksh 17.2 billion) in FY 2018/19. In FY 2020/21, most of this funding was allocated to universal health coverage (36 percent), programmes related to medical equipment (18 percent), and the Free Maternity Care Programme (12 percent). Regarding allocation to universal health coverage, the MOH is prioritizing financing through the development budget as opposed to the recurrent budget, which declined over the same period. The other 34 percent was allocated to categories such as MOH headquarter projects, capital grants to SAGAs, and government of Kenya counterpart funding.

The proportion of the FY 2020/21 total (recurrent and development) MOH budget allocated to the national referral and specialized services programme remained the highest, at 37 percent, after expanding by 6 percent between FY 2018/19 and FY 2020/21. The proportional allocation for preventive, promotive, reproductive, maternal, neonatal, child, and adolescent health services increased slightly, from 11 percent in FY 2018/19 to 12 percent by FY 2020/21.

Funding for Ministry of Health Strategic Services (Government and Donors)

Overall, the government continues to increase its funding of strategic health services, which have been heavily donor dependent. However, the increases are not sufficient to offset declining donor support, as illustrated in Figure ES.3.

Figure ES.3: Funding for MOH strategic services, FY 2018/19–FY 2020/21



Source: Republic of Kenya, 2018/19–2020/21a

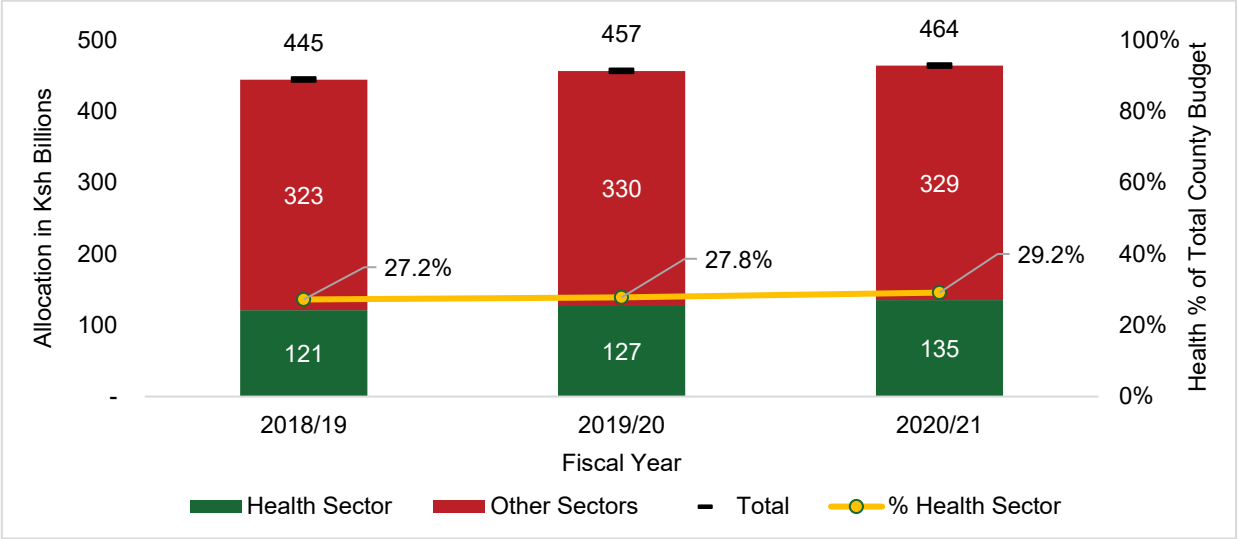
Note: Allocation data only include budget provisions that are directly identifiable as targeted funding for the specific facilities providing the services. The figures also exclude allocations to other ministries that undertake in-kind interventions related to the three programmes and exclude items funded indirectly, including personnel and other shared overhead.

Donors provide on-budget support to key strategic services using two government budget streams: the MOH and the National Treasury for key commodities. In the last three fiscal years, donor contributions to HIV/AIDS, TB, and malaria through the MOH budget have each dropped by almost 35 percent, for a total decline in funding of Ksh 902 million. Donor contributions to key strategic services through the National Treasury have dropped for HIV/AIDS (21 percent) and TB (62 percent) but increased significantly for malaria (282 percent). Funding allocation to HIV and malaria by the government of Kenya have increased to respond to the declining donor contributions. In the last three fiscal years, government funding for HIV increased by 164 percent (Ksh 1,452 million) and malaria by 254 percent (Ksh 706 million). TB, on the other hand, has experienced declining funding from both donors and the government; government funding declined by 64 percent (Ksh 359 million) since FY 2018/19.

County Government Allocations to Health

In FY 2020/21, county governments increased their allocations to health as a percentage of total county budgets to 29.2 percent (Ksh 135 billion), up from 27.8 percent (Ksh 127 billion) in the previous year. Figure ES.4 on county government allocations indicates an increased commitment to health by these governments. However, the allocation is still below the pre-devolution levels of 35 percent that the national government had allocated to counties for health services. The five counties that allocated the highest proportion of funding to health were Murang'a, Nyeri, Embu, Baringo, and Machakos. The lowest five were Nairobi, Wajir, Mandera, Turkana, and Tana River. However, 29 counties increased the proportion of their budgets allocated to health between FY 2019/20 and FY 2020/21.

Figure ES.4: County governments' allocations to health and all other sectors, FY 2018/19–FY 2020/21



Source: Republic of Kenya, 2018/19–2020/21b

Note: For FY 2020/21, the Ksh 135 billion for county health budgets differs from the Ksh 133 billion presented in Figure ES.2 because it includes additional transfers received from the MOH that counties have discretion to allocate.

The average share of county health budgets allocated for recurrent expenditures increased from 78.7 percent in FY 2018/19 to 82.3 percent in FY 2019/20 and then slightly decreased to 81.5 percent in FY 2020/21, compared to the recommended 70 percent. Personnel expenses continue to increase and constituted the lion's share of the recurrent budget. The share of the recurrent budget allocated to personnel expenses increased from 75.8 percent in FY 2018/19 to 76.8 percent in FY 2019/20 and 77.2 percent in FY 2020/21. In FY 2020/21, 43 counties were noncompliant regarding the recommended percentage.

The aggregate proportion allocated to the development budget remains well below the 30 percent recommended by the Public Finance Management Act of 2012. The development budget constituted 18.5 percent of the total health budget in FY 2020/21, a decline from 21.3 percent in FY 2018/19.

Overall, counties increased their average per capita allocations to health from Ksh 2,671 in FY 2019/20 to Ksh 2,785 in FY 2020/21. In FY 2020/21, the five counties with the highest per capita allocations were Lamu, Marsabit, Taita-Taveta, Isiolo, and Tana River; the lowest five were Bomet, Homa Bay, Bungoma, Migori, and Nairobi. Overall, 27 out of 47 counties increased their per capita health budget allocations.

Recommendations

This study explores Kenya's FY 2018/19–FY 2020/21 budget allocations to the MOH to determine whether the allocations were appropriate for achieving the intended health priorities and to inform future health sector resource allocations. The study findings have led to the following recommendations:

- To align resource allocations to achieve health sector policy priorities and the Abuja Declaration recommendation of 15 percent of government resources going to health, the Kenyan health sector needs additional domestic financing, both at the national and county levels. The MOH and the National Treasury need to work together to enhance and explore additional resources of domestic funding, including allocating an increased share of

government tax revenue to the health sector and scaling up National Health Insurance Fund coverage to mobilize funds adequately from both mandatory and voluntary contributor segments. More immediately, maximizing efficient targeting and spending, prioritizing coordination across government and development partners, and fully executing health resources could yield considerable gains and value for money, and reduce resource wastage.

- Increased resource allocation should be prioritized efficiently, targeting donor-dependent health initiatives, such as HIV, TB, and malaria. The ministry also should prioritize areas that have received inadequate budget allocations, such as preventive, promotive, and reproductive, maternal, neonatal, child, and adolescent health. Policies that help mobilize private investment in healthcare services can serve to drive economic growth in addition to helping supplant reduced donor funding. The MOH can encourage growth in resources directed to the health sector through the pursuit of policies that help to catalyze private investment by reducing regulations, expanding the contracting capabilities of private health providers, and actively encouraging local private institutions to invest in the health sector.
- Because SAGAs account for a significant portion of its budget, the MOH should explore innovative resource mobilization concepts such as increasing SAGAs' budgets from user fees and expanding the adoption and uptake of insurance coverage to partially shift the cost of healthcare coverage. Expanding greater adoption of health insurance schemes will require strong political will from local governments and the MOH.
- Although advocating for additional resources for health at the county level is warranted, counties need to ensure resources are allocated more efficiently to health priority areas that increase value for money, including directing more resources to cost-effective preventive and promotive health services. Additionally, counties should enhance advocacy efforts to ensure they are prioritizing key disease programmes such as HIV, malaria, and TB during planning and budgeting processes. To prioritize these programmes, counties need to capitalize on the evidence from county-specific budget and expenditure analyses.
- Counties need to reduce their overreliance on the national government's shareable revenue by enhancing collection of revenue from local taxes. They also need to increase and streamline revenue collection by expanding the population covered by insurance and focusing on promoting primary care as a more cost-effective means of delivering care.
- Counties must prioritize rationalizing their staffing plans and exploring strategies to ensure budget allocations to personnel are needs-based and informed by evidence and to ensure that resource allocations for other key health inputs are adequate. Effectively using data and greater in-depth analysis is needed to understand the underlying drivers in personnel budgets and determine how best to allocate resources to meet Kenya's increasing need for skilled health personnel.
- Counties should invest in technical capacity strengthening in planning and budgeting to effectively adopt the programme-based budgeting approach in their planning and budgeting processes. This budget approach has been proven to increase efficiency in resource allocations and link inputs with programme outcomes.

INTRODUCTION

The constitution of Kenya recognizes health as a fundamental right and an important driver of economic growth. It is chief among the country's foundational health documents along with other major policy documents such as Kenya Vision 2030, the Kenya Health Policy (2014–2030), county integrated development plans, and county health strategic plans (Republic of Kenya, 2008; Republic of Kenya, 2014). They often highlight the government's obligation and commitment to ensure Kenya attains the highest standard of living for its population by providing high-quality and equitable health services with respect to geography, gender, and economic conditions. Thus, national and county governments are required to create an enabling environment for public and private sector investment in health service delivery.

Financial resources are essential for implementing national and county policies and strategies. National and county governments are expected to structure their respective budgets towards achieving the policy commitments outlined in their respective guiding documents. At the national level, the 2020 Budget Policy Statement, the Kenya Health Sector Strategic Plan 2018–2023, and the Medium-Term Expenditure Framework highlight infrastructure, education, health, and social safety nets as the priority focus areas of the government for fiscal year (FY) 2020/21. The Health Sector Strategic Plan specifically articulates the government's commitment to continue increasing health sector funding to achieve the Abuja Declaration target of allocating at least 15 percent of the annual budget to health (Republic of Kenya, 2018; WHO, 2011). Counties usually align their respective medium-term planning and budgeting frameworks to national strategies while also considering localised priorities.

This analysis of national and county health budgets compares the respective budgets against national and county governments' priorities, and compares trends over the last three years (i.e., FY 2018/19 through FY 2020/21). It also examines how the national and county governments allocate their health budgets. The Kenyan national government has identified four priorities for the 2017–2022 development cycle: (1) manufacturing, (2) food security and nutrition, (3) universal health coverage (through the National Health Insurance Fund), and (4) affordable housing. Collectively, these areas are called the "Big Four" agenda (Kenyatta, 2017). This analysis also assesses how the country has attempted to implement universal health coverage as part of the Kenyan government's Big Four national medium-term development agenda and respond to dwindling donor funds. It explores the government's progress towards assuming budgetary responsibility for donor-funded health programmes.

The analysis briefly reviews the health policy priorities that the various governments intend to address, as well as the macroeconomic settings in which these governments operate. It reviews data on Ministry of Health (MOH) and county health allocations from FY 2018/19 to FY 2020/21 to assess how financing aligns with health priorities. The study also includes a trend analysis to show investments in the public health sector and progress towards increasing domestic resources for health. In addition, it analyses MOH and county health budgets using recurrent and development categories; economic categories; the five programmes identified by the MOH under the programme-based budgeting (PBB) approach; and by MOH strategic programmes that include HIV, malaria, and tuberculosis (TB). The analysis concludes with a set of recommendations to guide policy- and decision-makers in ensuring that budgets are better aligned to sector priorities. The findings equip health sector actors with evidence to advocate for adequate resources for the sector.

Macroeconomic Context

Kenya's economic growth varied over the three years encompassing 2017–2019: 4.8 percent in 2017, 6.3 percent in 2018, and 5.4 percent in 2019 (Republic of Kenya, National Bureau of Statistics, 2020). Most sectors posted slowed growth in 2019 compared to their 2018 performance. Growth in 2019 can be attributed to service activities, such as wholesale and retail, transport and storage, finance and insurance, public administration, defense, and real estate.

The National Bureau of Statistics economic survey further reports that the 2020 economic outlook is projected to be slow due to global economic interruptions and restrictions on the tourism/ hospitality, education, agriculture, construction, and manufacturing sectors as a result of the COVID-19 pandemic. This slowdown is likely to lead to diminishing disposable incomes for the population. The National Bureau of Statistics has observed that, due to increased investment in the health sector by national and county governments in 2019, the performance of this sector is expected to improve despite diminishing disposable incomes. The bureau also noted a 10.6 percent increase in population coverage under the National Health Insurance Fund over the 2019/20 period (Republic of Kenya, National Bureau of Statistics, 2020).

Table 1 shows Kenya's economic outlook, including projections for FY 2021/22. According to the 2020 Budget Review and Outlook Paper, the economy has taken a hit, especially following expenditure pressures due to the COVID-19 pandemic, but is expected to recover soon, thus maintaining the health sector's growth (Republic of Kenya, National Treasury and Planning, 2020).

Table 1: Kenya's economic outlook FY 2019/20–FY 2021/22

Indicator	2019/20	2020/21	2021/22	Change
Gross domestic product (GDP) growth	2.6	5.3	5.9	▲
Fiscal deficit as a % of GDP	7.8	8.9	7.1	▼
Real GDP	4	4	5.2	▲
Total revenue as % GDP	17	16.5	16.2	▼
% of nominal debt to GDP	60.7	63.8	64.6	▲
Health sector growth, in Ksh millions	93	114.04	117.85	▲

Performance of Selected Health Priority Areas

The health sector is a key component of the longer-term development agenda called the Kenya Vision 2030. Its social pillar envisions a healthy and productive population able to fully participate in and contribute to other sectors of the economy. The District Health Information Survey and the 2014 Demographic and Health Survey document improved performance in key health indicators. For instance, the Demographic and Health Survey notes remarkable declines in under-five mortality (from 112 to 52) between 1998 and 2014 and infant mortality rates (74 to 39 per 1,000 live births) (Republic of Kenya, National Bureau of Statistics and ICF, 2015). DHIS2 data show that the proportion of fully immunised children increased from 72.8 percent in 2016 to 82.7 percent in 2021. These gains are attributed to improved health service delivery, intensified immunisation campaigns, and widespread distribution of insecticide-treated bed nets.

Important advances also have been made in managing and controlling HIV. Data from UNICEF's 2020 World AIDS Day Report indicate that HIV prevalence among adults 15–49 years in Kenya has declined to 4.5 percent in 2019 from 6 percent in 2013. New HIV infections among all ages has

declined from 95,000 in 2007 to 33,000 in 2020. Kenya has also had relative success in scaling up access to antiretroviral treatment, rising to 78 percent with 1.1 million Kenyans in 2019 from 13 percent with 184,000 Kenyans a decade ago (Republic of Kenya, NASCOP, 2020). If these gains can be sustained through increased programme-targeted health spending, Kenya is on track to achieving its related national health goals.

Reproductive and maternal health indicators are less positive. Although contraceptive prevalence increased from 39 percent in 2003 to 61 percent in 2017, it is still far below the Family Planning 2020 target of 70 percent. Use of antenatal care services remained steady at 92.8 percent in 2020, and use of skilled birth attendants was at 70.2 percent in 2016, below the target of 90 percent (UNICEF, 2020b).

Budgeting Process

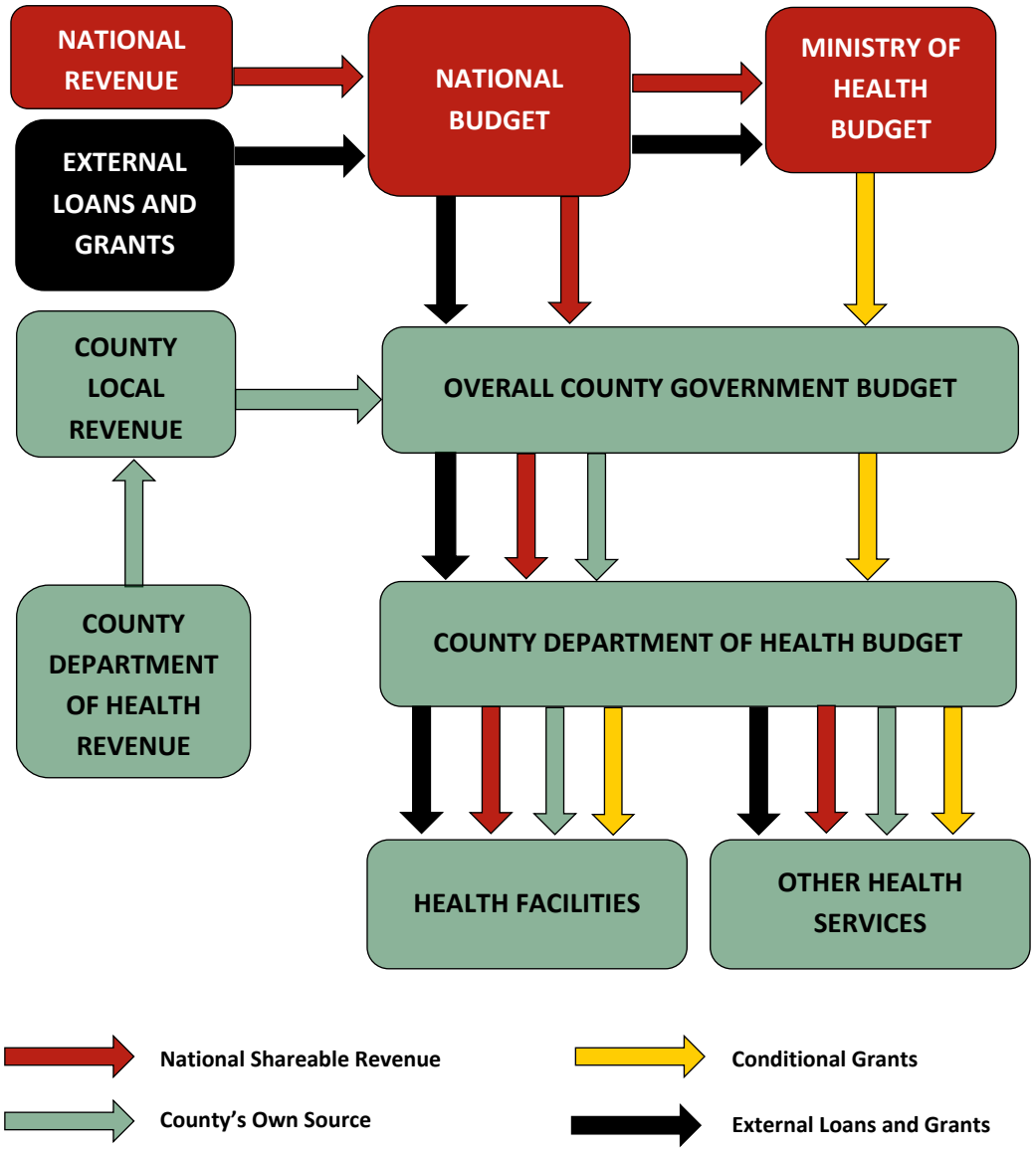
According to the Public Finance Management Act of 2012, the National Treasury issues aggregate budget ceilings for national spending. These ceilings are based on the economic outlook, projected tax revenue, donor commitments, and other government income such as user fees. After setting aside payments for consolidated fund services (i.e., pensions, national debt, and related expenses), the Intergovernmental Budget and Economic Council develops budget allocation proposals for the national and county governments and other independent constitutional bodies. The budget proposals are adopted after approval by Parliament. National and county governments are provided with notional budget targets to allocate among sectors and institutions under their authority, including health. Inter-county allocations are determined by a formula proposed by the Commission on Revenue Allocation and approved by Parliament every five years. In this process, as outlined in Figure 1, the National Treasury allocates a lump sum amount to counties, which individually and independently determine budget allocations for health services according to their priorities and mandates.

There are significant competing needs for resources at both the national and county levels. Allocations to health indicate the priority the various governments place on health issues compared to other sectors. If the national budget ceiling is reduced, these budget allocations are also reduced.

The process of allocating budget resources to the respective sectors is the same at the national and county levels. The county and national treasuries communicate the budget ceilings to the various sectors through the Budget Review and Outlook Paper or the County Budget Review and Outlook Paper, which are normally released in September and must be approved by the cabinet and legislative assembly at each level of government. Although the Budget Review and Outlook Paper provides the initial indication of the amount the health sector might receive, interventions and advocacy for more health funding should be done before its release.

Sector working groups guide their respective ministries or departments in preparing three-year rolling budget plans for programmes and activities. At both the national and county levels, these groups prepare reports that inform the cabinet and county executive committees so they can refine their sector ceilings. Strong justifications for additional funding may lead to an adjustment of the annual ceilings, which are published in the Budget Policy Statement (national) and County Fiscal Strategy Paper (county). These publications are released in February of each year and determine the final ceilings approved by Parliament at the national level and by the county assemblies at the county level.

Figure 1: Kenya's financial resources-sharing arrangement



National ministries and county departments can influence the amounts allocated to them through effective advocacy during the development of sector working group reports. Although ministries and departments originate, justify, and advocate for their budget allocation proposals, it is their respective treasuries and legislative assemblies that make the final decision on how much is allocated to health and other sectors. In addition, ministries and departments are not allowed by law to transfer funds between the approved development and recurrent allocations. They are also required to budget for all existing personnel. However, they have significant flexibility in shaping the allocations by prioritizing the most cost-effective and efficient programmes.

The National Assembly approves final budgets for the national government and county assemblies do so for the county governments. The assemblies may amend the budget at this stage, though positive and continuous engagement between the executive and the legislative assemblies during the budgeting process usually results in few or no amendments.

Programme-Based Budgeting

The Public Finance Management Act of 2012 required the national government and counties to adopt PBB starting in FY 2014/15. The national government has fully adopted the approach. However, disaggregation of personnel expenses by programme and sub-programme remains a challenge at the county level. Programme-based budgeting, according to the Public Finance Management Act of 2012, has two goals:

1. To improve the prioritization of expenditures in the budget to help allocate limited county government resources to those programmes of greatest benefit to the community
2. To encourage county government departments to improve the efficiency and effectiveness of service delivery by changing the focus of public spending from inputs to outputs and outcomes

Programme-based budgeting requires that budgets link all financial resources and activities to outcomes and outputs generated by the budgeting entity. This approach ensures a greater focus on targeted results compared to the traditional approach of increasing budget line items by a set incremental amount.

Study Objectives

The main objective of this analysis is to characterize national and county government budget allocations to the health sector and provide the necessary evidence that can effectively inform health planning and budgeting at national and county levels.

Specifically, the study examines four allocations:

1. Total government budget allocation to health
2. National and county budget allocations to health
3. Comparisons/trends of county budget allocations to health
4. National and county budget allocations to health by key economic inputs

The proportion and level of government funds allocated to health indicate the level of commitment towards achieving national health goals. When allocated and used efficiently, increases in public spending on health can lead to improved access to care, especially for indigent and vulnerable groups. Increased spending on health also has the potential to increase the efficiency of healthcare delivery systems if a greater proportion of the new funding is directed towards more efficient public health programmes.

In Kenya, a gradual and sustainable expansion of the health budget is desirable for four reasons:

1. It will enable the health sector to absorb the impact of the expanded administrative costs of devolution while still providing the level of service that existed before devolution.
2. It will allow Kenya to move more quickly towards the national goal of universal health coverage.
3. It will promote progress towards achieving the Abuja Declaration commitment of allocating 15 percent of the public budget to health.

4. It will provide a measure of sustainability in delivery of health services, especially if expansion comes from domestic sources.

This analysis is intended to inform planning and budgeting processes at national and county levels.

METHODS

This study analysed initial MOH and county budget allocations to the health sector for FY 2018/19, FY 2019/20, and FY 2020/21 in nominal terms. MOH data were obtained from the budget estimates issued by the National Treasury for every fiscal year. County budget data were obtained from various sources: the Commission for Revenue Allocation, the Office of the Controller of Budget, and, in some instances, county treasuries.

The analysis examines the gross health budget by recurrent and development economic categories and by specific inputs. The gross budget comprises revenue from local taxes; monies collected and directly spent at the point of collection, where services are provided; and foreign funding provided through the budget (Appropriations in Aid). This analysis does not examine off-budget resources provided by donors. Thus, the analysis does not necessarily present all resources available to the health sector.

Limitations

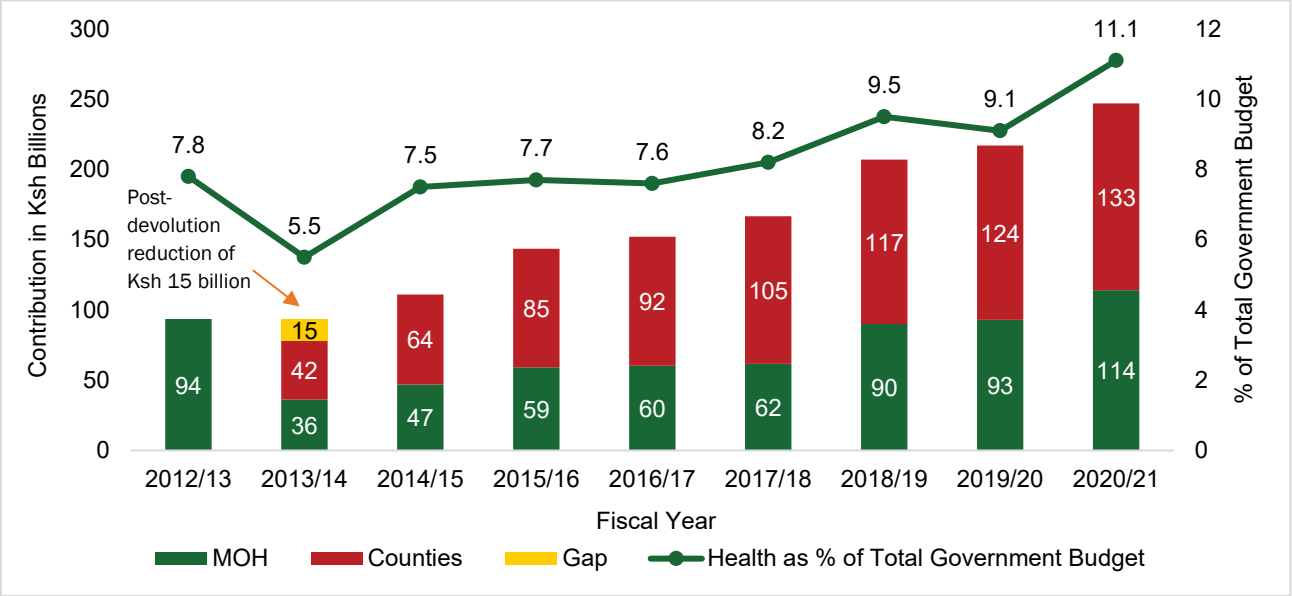
Data from the Commission for Revenue Allocation and the Office of the Controller of Budget have not been audited by the Office of the Auditor-General as of the time of writing the report, thus allowing some inconsistencies with final county budgets. The authors of this study note that, in some instances, the budget format was inconsistent and sometimes difficult to use when trying to access information. The counties presented budgets in different formats and did not strictly adhere to the standard Charter of Government Accounts' format for budget presentation. Some counties have not adopted PBB and, in some cases, the budget data were in line-item budgeting format, limiting the disaggregation of data in this analysis. Additionally, weaknesses were noted in counties' misclassification of expenditure items between recurrent and development categories. This analysis attempted to correct such identified mistakes by reclassifying them correctly to the extent possible.

KEY FINDINGS

Government Budget Allocations to Health Pre- and Post-Devolution

The Kenya Constitution of 2010 introduced devolution, defined as the sharing of health functions and resources between the national and 47 county governments. Devolution was implemented after the general elections in March 2013, and the transfer of functions and funding to the counties began in the budget for FY 2013/14. Figure 2 shows the proportion of the government budget allocated to health by the national and county governments for the period of FY 2012/13 through FY 2020/21.

Figure 2: Pre- and post-devolution budget allocations to health



Sources: Republic of Kenya, 2012/13–2020/21; Republic of Kenya, 2013/14–2020/21

Since devolution, national and county governments have continued to increase their allocations to health, both in absolute terms and as a proportion of the total government budget (see Figure 2). In absolute terms, the combined budget allocations to health continued to expand gradually, from Ksh 78 billion in FY 2013/14 to Ksh 247 billion in FY 2020/21 (a 216 percent increase). In nominal terms, the MOH increased its contribution from Ksh 36 billion to Ksh 114 billion and county contributions increased from Ksh 42 billion to Ksh 133 billion. In real terms, however, overall allocations to health have seen very limited growth—by 109 percent between FY 2013/14 and FY 2020/21.[5] Real allocations to health over the past three fiscal years have increased by 7.5 percentage points, whereas per capita real allocations to health have increased by 2.5 percent over the same period.[6]

The combined proportion of the total government budget allocated to health by national and county governments also has increased but has not yet reached the government's 15 percent target. Combined

[5] Real allocation is calculated using the consumer price index reported by the World Bank Open Data, based on 2013 prices.

[6] Population data used in this calculation are reported by the Kenya National Bureau of Statistics' *Economic Survey 2021*.

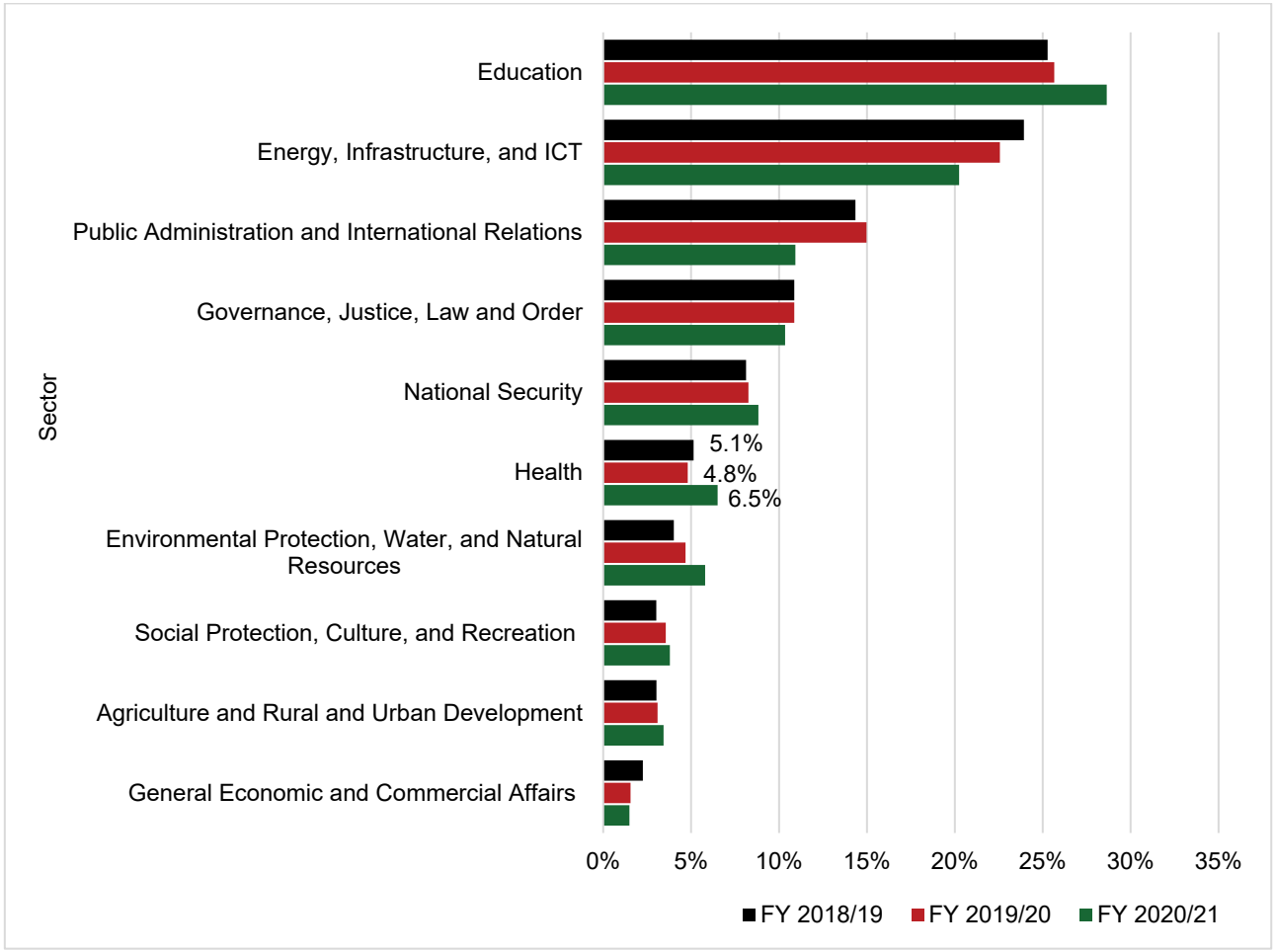
budget allocations to health by national and county governments as a proportion of the total government budget increased from 5.5 percent in FY 2013/14 to 11.1 percent in FY 2020/21.

Disaggregating the proportional increases at the national (MOH) and county level reveals the priority given to health at each level of government. The national health budget allocation as a proportion of the total government budget has increased only marginally, from 5.1 and 6.5 percent in the past three fiscal years. The health sector ranks sixth in budget allocations, as discussed next.

National Government Budget Allocation by Sector

The national budget is allocated among 10 sectors, as defined in their respective National Treasury circulars (Republic of Kenya, 2018/19–2020/21c). In the clustering of sectors, most clusters subsume more than one ministry or state department however the ministries of health and education are the only ministries in their respective sectors. Figure 3 shows the proportion allocated to the 10 sectors at the national level for FY 2018/19 through FY 2020/21. The top three sectors in budget allocation are (1) education; (2) energy, infrastructure, and information and communications technology (ICT); and (3) public administration and international relations. These three sectors received more than half of the total national government budget allocation. The health sector was allocated 5.1 percent of the national budget in FY 2018/19, 4.8 percent in FY 2019/20, and 6.5 percent in FY 2020/21. Despite a 1.7 percent increase in its government budget allocation, the health sector (MOH) ranking did not change for three consecutive years.

Figure 3: Proportion of national government budget allocation by sector



Source: Republic of Kenya, 2018/19–2020/21a

Ministry of Health Allocations to Recurrent and Development Budgets

MOH allocations to the recurrent budget increased from Ksh 49.1 billion in FY 2018/19 to Ksh 58.1 billion in FY 2019/20, and further expanded to Ksh 64.5 billion in FY 2020/21 (see Table 2). The proportion of the MOH budget allocated to recurrent expenditures increased from 55 percent in FY 2018/19 to 63 percent in FY 2019/20 before decreasing to 57 percent in FY 2020/21. The government—through the recurrent budget—is the main contributor to increases in the health budget, which expanded by 10.9 percent from FY 2019/20 to FY 2020/21. Allocation to the development budget decreased from Ksh 40.9 billion in FY 2018/19 to Ksh 34.6 billion in FY 2019/20, before expanding to Ksh 49.6 billion in FY 2020/21. The proportional allocations to development over the three years were 45, 37, and 43 percent, respectively. The development budget, which includes donor on-budget resources, increased significantly, by 43.3 percent between FY 2019/20 and FY 2020/21.

Table 2: MOH allocations to recurrent and development budgets (Ksh and percentage of MOH budget), FY 2018/19–FY 2020/21

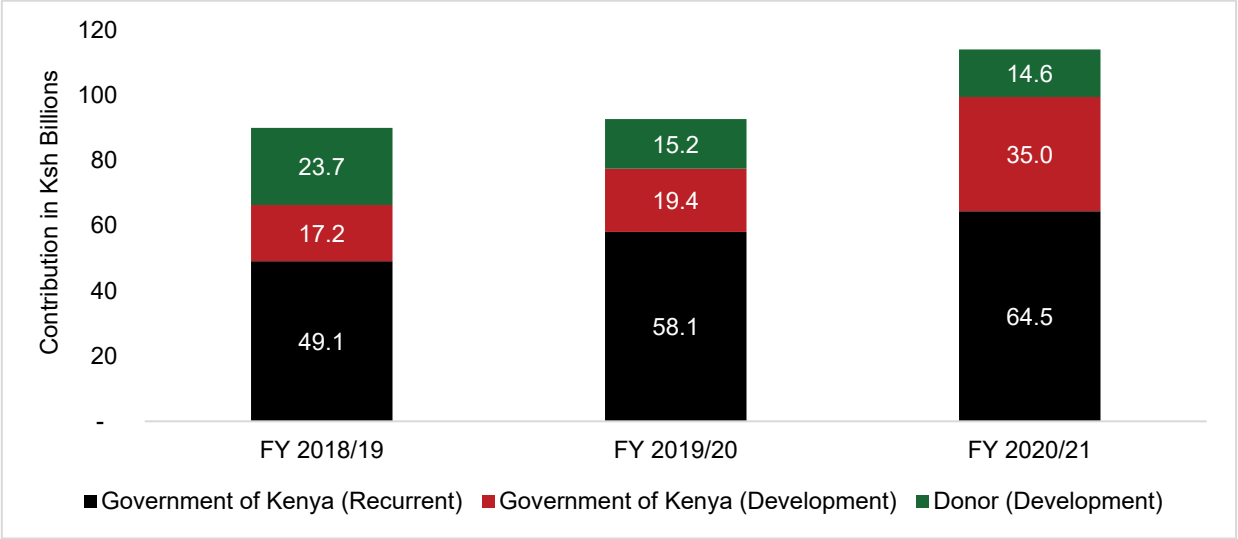
Budget	2018/19	2019/20	2020/21	Percentage change, 2019/20–2020/21
Recurrent	Ksh 49.1 billion (55%)	Ksh 58.1 billion (63%)	Ksh 64.5 billion (57%)	+10.9%
Development	Ksh 40.9 billion (45%)	Ksh 34.6 billion (37%)	Ksh 49.6 billion (43%)	+43.3%

Source: Republic of Kenya, 2018/19–2020/21a

Contribution to the Ministry of Health Budget by Source

The MOH budget comprises both allocations from the government and grants and loans from donors. Figure 4 presents the trend in MOH recurrent and development financing as well as donor contributions (loans and grants) allocated to the development budget, under which funding for national strategic programmes for HIV, TB, malaria, medical commodities/drugs, and vaccines is provided. The donor component of the budget declined from Ksh 23.7 billion in FY 2018/19 to Ksh 14.6 billion in FY 2020/21. The overall decline in donor funding over FY 2018/19–FY 2020/21 can be mainly attributed to a one-off loan to purchase medical equipment (computerized tomography [CT] scanners) in FY 2018/19 and the government's full takeover of funding the health systems management component of the national immunisation programme in FY 2020/21. In this fiscal year, the government of Kenya increased its allocation to the MOH's development budget by Ksh 15.6 billion—sufficient to offset the declining donor support in the last three years. However, the government's increased contribution to the development budget is not strategically targeted to make up for the declining donor support that funds the MOH's key strategic programmes. As discussed later in this report, the largest share of this increase is allocated to universal health coverage and government counterpart funding, leaving strategic programmes, such as HIV, still dependent on donor support.

Figure 4: MOH budget allocation in Ksh billions, FY 2018/19–2020/21



Source: Republic of Kenya, 2018/19–2020/21a

Ministry of Health Recurrent Budget by Spending Classification

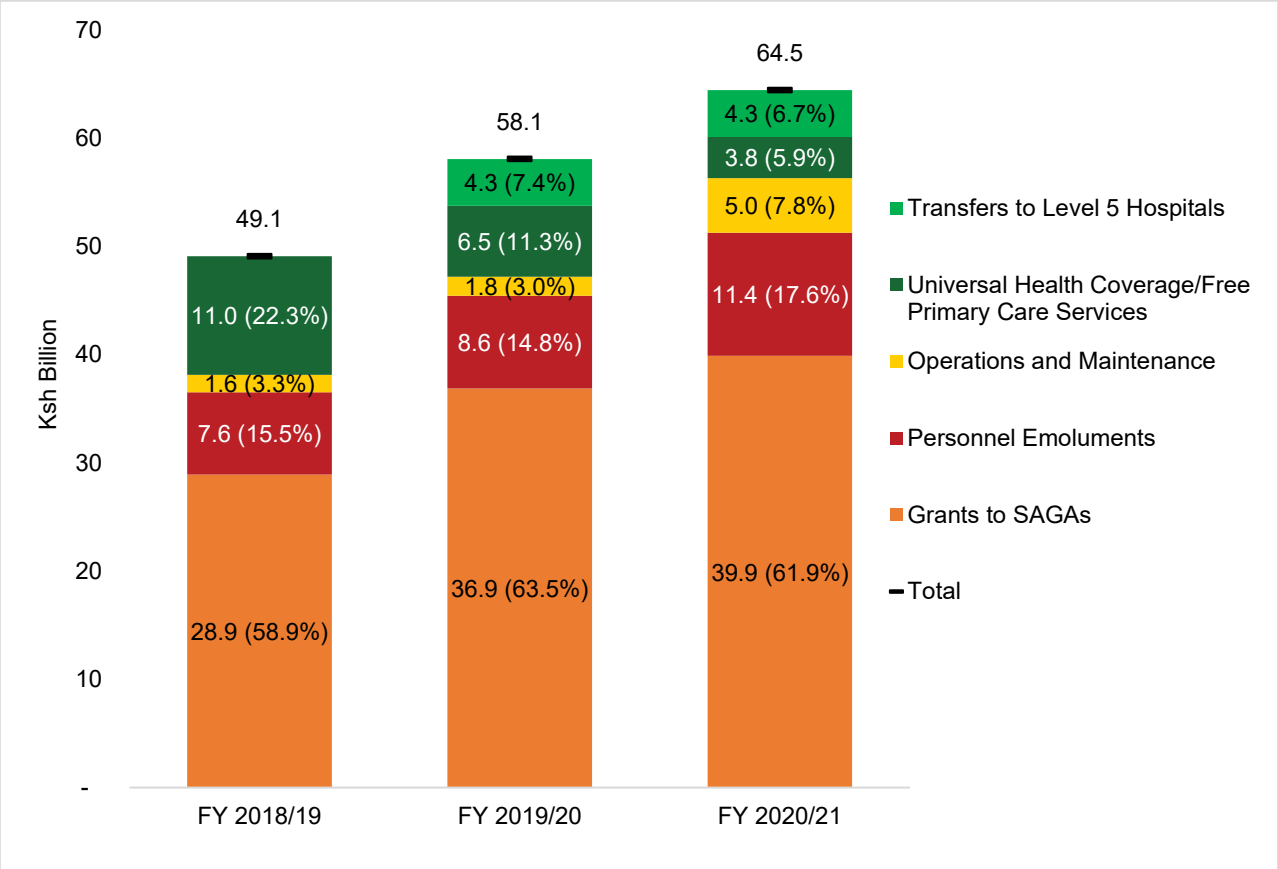
Figure 5 presents a breakdown of the recurrent budget across the key spending categories under the MOH from FY 2018/19 to FY 2020/21. They are (1) grants to the eight semi-autonomous government agencies (SAGAs);[7] (2) personnel emoluments; (3) reimbursements for removal of user fees at facilities, which have been combined with universal health coverage grants; (4) transfers to level 5 hospitals; and (5) operations and maintenance.

Referring to Figure 5, the rapid expansion of the MOH recurrent budget has been driven by increases in budget allocations to SAGAs, which increased from Ksh 28.9 billion in FY 2018/19 to Ksh 39.9 billion in FY 2020/21. The grants amounted to 61.9 percent of the MOH recurrent budget in FY 2020/21, having decreased marginally from 63.5 percent in the previous year. Allocations for personnel emoluments also increased significantly during this time, from Ksh 7.6 billion in FY 2018/19 to Ksh 11.4 billion in FY 2020/21. During FY 2020/21, the MOH allocated Ksh 4.3 billion, or 6.7 percent of its budget, to transfers to level 5 hospitals, a category not included in the MOH budget in FY 2018/19. Operations and maintenance remained fairly constant, at around 3 percent, between FY 2018/19 and FY 2019/20 but increased significantly to 7.8 percent in FY 2020/21. This change is partly attributable to the purchase of personal protective equipment to ensure safe access to treatment and care.

Figure 5 also shows that during FY 2020/21, the MOH allocated Ksh 3.8 billion, or 5.9 percent of the MOH recurrent budget allocation, earmarked for universal health coverage, comprising Ksh 2.9 billion to grants for scale-up of universal health coverage and a further Ksh 900 million to the free primary healthcare programme. This amount was a decrease from the previous years' allocation for universal health coverage of Ksh 11.0 billion in FY 2018/19 and Ksh 6.5 billion in FY 2019/20, however, commensurate increases were observed under the development budget, indicating the MOH's preference for financing universal health coverage through the development budget.

[7] SAGAs are publicly funded institutions with the autonomy to manage and account for their budget and operations independent of the mother ministry; they usually are governed by distinct legislation, but their funding is channelled through the mother ministry. The MOH has eight such institutions.

Figure 5: MOH recurrent budget allocations by major classification, FY 2018/19–FY 2020/21



Source: Republic of Kenya, 2018/19–2020/21a

Proportion of Ministry of Health Recurrent Budget Allocations to Semi-Autonomous Government Agencies

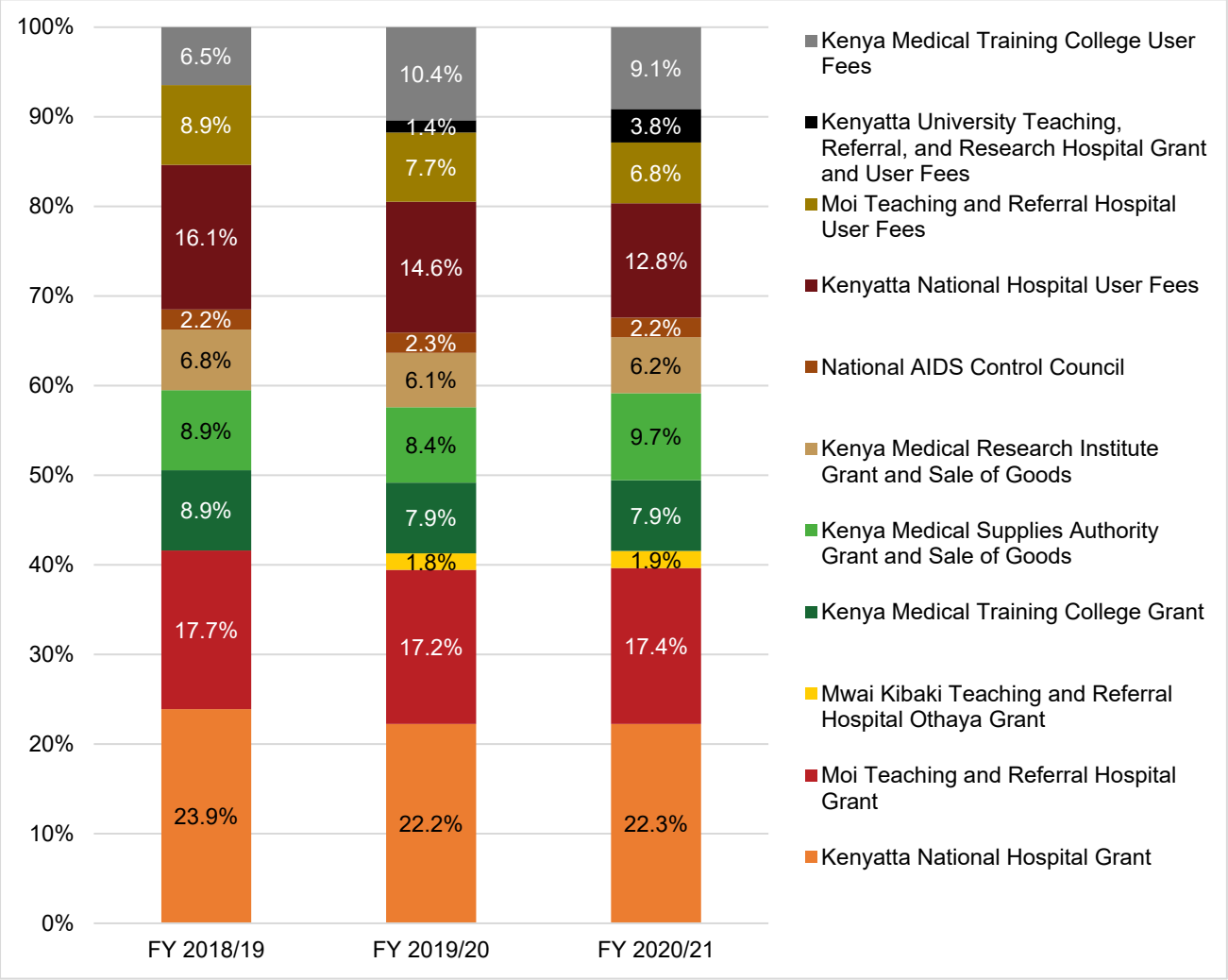
As of FY 2020/21, eight SAGAs were under MOH administration and funded through ministry grants as well as their own revenue generated through user fees and sale of goods and services. Figure 6 shows the breakdown of MOH recurrent budget allocations to the eight SAGAs in FY 2018/19–FY 2020/21. Of the Ksh 39.9 billion that the MOH allocated to SAGAs in FY 2020/21, 61.3 percent was in the form of government grants, whereas 38.7 percent was from revenue generated internally by the institutions through user fees and the sale of goods and services. Allocation to SAGAs increased in FY 2020/21, up from Ksh 28.9 billion in FY 2018/19 and Ksh 36.9 billion in FY 2019/20. The budget expansion in FY 2020/21 was driven by increases in grant allocations to most of the agencies.

As shown in Figure 6, four hospitals—(1) Kenyatta National Hospital, (2) Moi Teaching and Referral Hospital, (3) Kenyatta University Teaching, Referral, and Research Hospital, and (4) Mwai Kibaki Teaching and Referral Hospital Othaya—accounted for about 65 percent of MOH recurrent budget allocations to SAGAs in both FY 2019/20 and FY 2020/21. In FY 2018/19, the allocations to Kenyatta National Hospital and Moi Teaching and Referral Hospital comprised 67 percent of the MOH recurrent budget (Kenyatta University Teaching, Referral, and Research Hospital and Mwai Kibaki Teaching and Referral Hospital Othaya had not been established in that financial year).

In both FYs 2019/20 and 2020/21, Kenyatta National Hospital received the largest grant allocation, at 22 percent, a decline from 24 percent in FY 2018/19; followed by Moi Teaching and Referral Hospital, at 17 percent in FY 2020/21 and FY 2019/20, down from almost 18 percent in FY 2018/19.

Kenyatta University Teaching, Referral, and Research Hospital and Mwai Kibaki Teaching and Referral Hospital Othaya received a combined 6 percent of the MOH recurrent budget grant allocations to SAGAs in FY 2020/21, an increase from 3 percent in FY 2019/20. The Kenya Medical Training College was allocated 8 percent in grants in both FYs 2019/20 and 2020/21, a decline from 9 percent in FY 2018/19. The Kenya Medical Supplies Authority was allocated about 10 percent in FY 2020/21, an increase from 8 percent in FY 2019/20.

Figure 6: MOH recurrent budget allocations to SAGAs, FY 2018/19–FY 2020/21



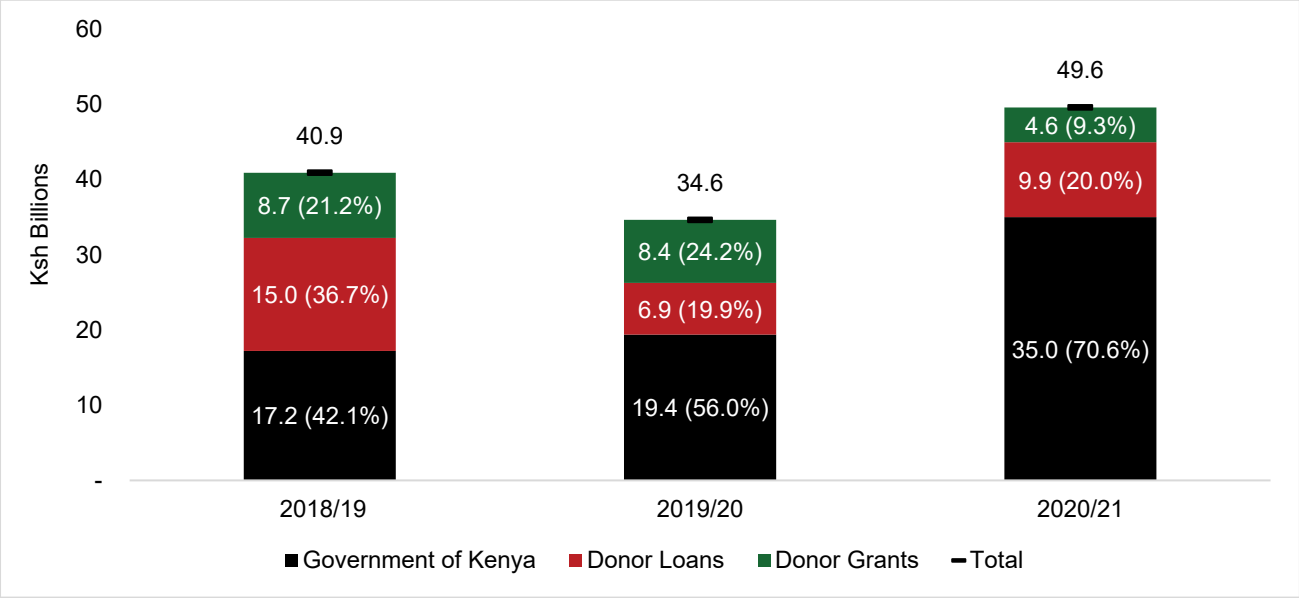
Source: Republic of Kenya, 2020/21a

Ministry of Health Development Budget

The MOH's development budget includes funds provided by the national government and from donors through loans and grants. The amounts and share contributed from each of the sources for FY 2018/19 through FY 2020/21 are presented in Figure 7. The MOH development budget increased to an all-time high of Ksh 49.6 billion for FY 2020/21. This increase was significantly different from the two previous fiscal years, especially FY 2019/20, which experienced a drop compared to FY 2018/19. The most significant increase in contributions in FY 2020/21 came from the government of Kenya. The government's relative contribution has continued to climb, from a low of 42.1 percent (Ksh 17.2 billion) in FY 2018/19 to 56.0 percent (Ksh 19.4 billion) in FY 2019/20, and reaching an all-time high of 70.6 percent (Ksh 35.0 billion) in FY 2020/21. Although donor loans have remained constant as a

proportion of the total development budget in the last two fiscal years, an increase of Ksh 3 billion was observed between FY 2019/20 and FY 2020/21. On the other hand, donor grant contributions decreased significantly, from Ksh 8.7 billion in FY 2018/19 to Ksh 4.6 billion by FY 2020/21. This pattern shows that the government is gradually transitioning from a donor-dependent development budget to domestic public financing, offsetting its reliance on declining donor funds, especially donor grants. If this trend is maintained, the government is on track to improve development budget predictability and expand investment in the health sector to advance universal health coverage.

Figure 7: Composition of MOH development budget, FY 2018/19–FY 2020/21



Source: Republic of Kenya, 2018/19—2020/21a

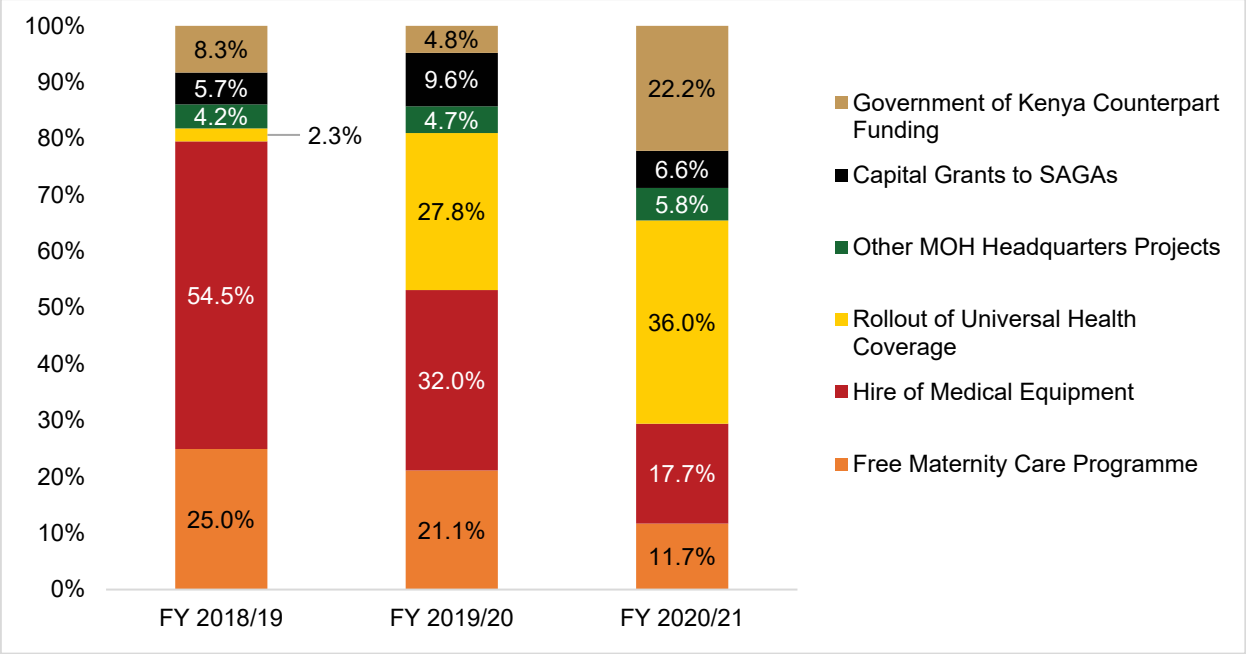
Ministry of Health Development Budget by Spending Classification

Figure 8 shows the distribution of the MOH development budget provided by the national government for FY 2018/19–FY 2020/21 by key programme area. As illustrated, MOH development budget allocations to the key programme areas have shifted over the past three fiscal years. Some areas have had significant increases, whereas others have decreased. In particular, allocation to the rollout of universal health coverage has seen a significant increase, from 2.3 percent (Ksh 0.4 billion) in FY 2018/19 to 36.0 percent (Ksh 12.6 billion) in FY 2020/21, comprising the highest proportion of the development budget. This trend is a clear indication that the MOH is prioritizing financing universal health coverage through the development budget as opposed to the recurrent budget, for which universal health coverage declined over the same period (as shown previously in Figure 5).

Similarly, government counterpart funding, which is the government's contribution to donor-funded programmes that include HIV, TB, malaria, clinical waste management, the Kenya Health Sector Support Project, nutrition, and vaccines and immunisation, increased from 8.3 percent (Ksh 1.4 billion) in FY 2018/19 to 22.2 percent (Ksh 7.8 billion) in FY 2020/21. Consequently, financing of the Free Maternity Care Programme and hire of medical equipment have dropped from 25.0 percent (Ksh 4.3 billion) and 54.5 percent (Ksh 9.4 billion) in FY 2018/19 to 11.7 percent (Ksh 4.1 billion) and 17.7 percent (Ksh 6.2 billion) in FY 2020/21, respectively. Allocations to capital grants to SAGAs and other MOH headquarters projects have largely remained constant over the past three fiscal years.

These trends illustrate the MOH's shifting development budget priorities. Universal health coverage, inclusive of the Free Maternity Care Programme, is clearly a priority at the national level; the MOH allocated nearly half of the development budget to these initiatives. Funding for the Free Maternity Care Programme is earmarked to cover reimbursement to facilities providing free maternity care through the National Health Insurance Fund. Additionally, the government's increase in counterpart funding demonstrates its increasing commitment to key disease programmes.

Figure 8: Allocation of government of Kenya development budget to key programme areas, FY 2018/19–FY 2020/21



Source: Republic of Kenya, 2020/21a

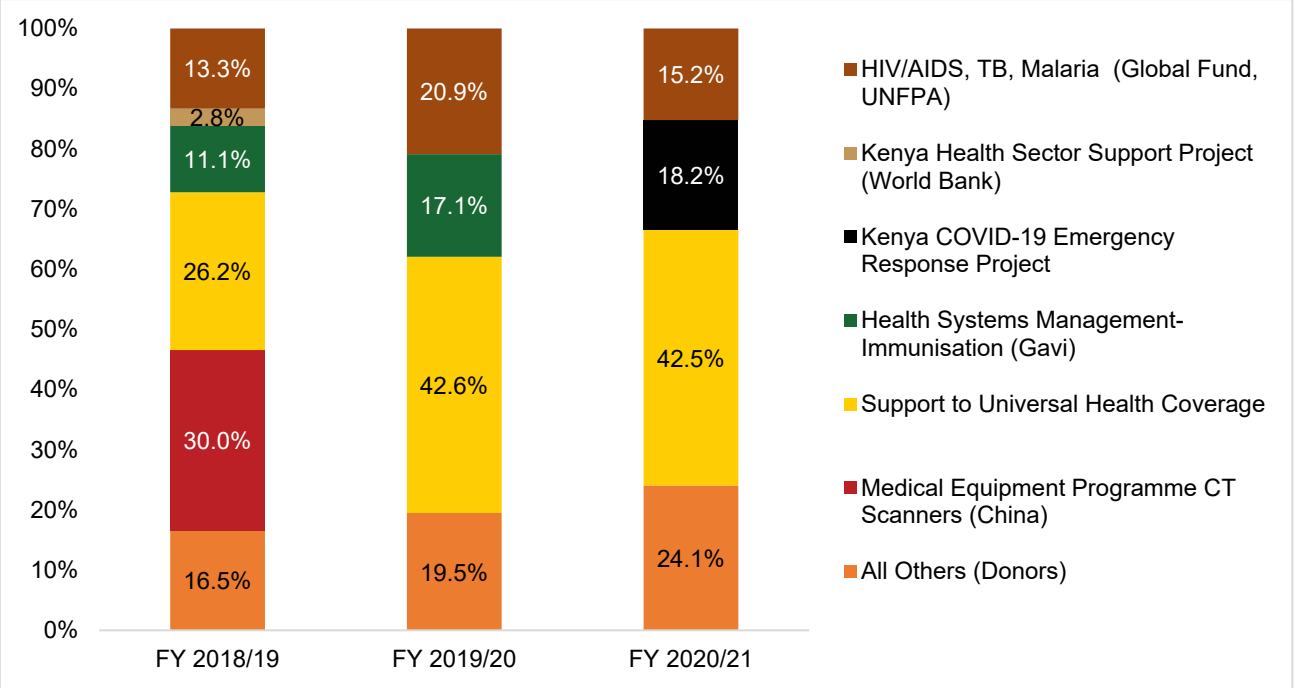
Ministry of Health Development Budget from Donor Sources by Spending Classification

Through their loan and grant contributions, donors support several key health programmes in Kenya, with financing channelled through the MOH development budget. Figure 9 presents a summary of these contributions by spending classifications in FY 2018/19, FY 2019/20, and FY 2020/21. As shown, universal health coverage has received the bulk of donor contributions, aligning with the MOH's prioritization of the programme. In FY 2020/21, the proportion of donor resources allocated to the rollout of universal health coverage was 42.5 percent (World Bank—36.3 percent; Denmark's development cooperation Danida—6.2 percent), a significant increase from 26 percent in FY 2018/19 (World Bank—21.9 percent; Danida—4.3 percent).

In FY 2020/21, donor contributions through the MOH's development budget to strategic services (i.e., disease programmes), including the HIV, TB, and malaria programmes, constituted just 15.2 percent of donor funding, which was provided by the Global Fund and the United Nations Population Fund (UNFPA). Contributions slightly decreased from Ksh 3.1 billion in FY 2018/19 to Ksh 2.2 billion in FY 2020/21. However, in proportional allocation, this funding represents an increase from 13.3 percent in FY 2018/19 to 15.2 percent in FY 2020/21. These disease programmes receive additional technical and financial support from donors—most notably the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). However, this support is expended directly through USAID implementing partners.

Immunisation and related health systems support was allocated Ksh 2.6 billion annually in both FY 2018/19 and FY 2019/20 (11.1 percent and 17.1 percent, respectively) from Gavi, the Vaccine Alliance, with no allocation in FY 2020/21. In FY 2020/21, the MOH expended 18.2 percent (Ksh 2.66 billion) of donor resources on the COVID-19 emergency response. The remaining 24.1 percent was allocated to other programmes with allocations below Ksh 0.2 billion, including nutrition, the East Africa Laboratory Network, and the Environmental Health programme.

Figure 9: Proportion of the MOH development budget from donor sources by programme, FY 2018/19–FY 2020/21



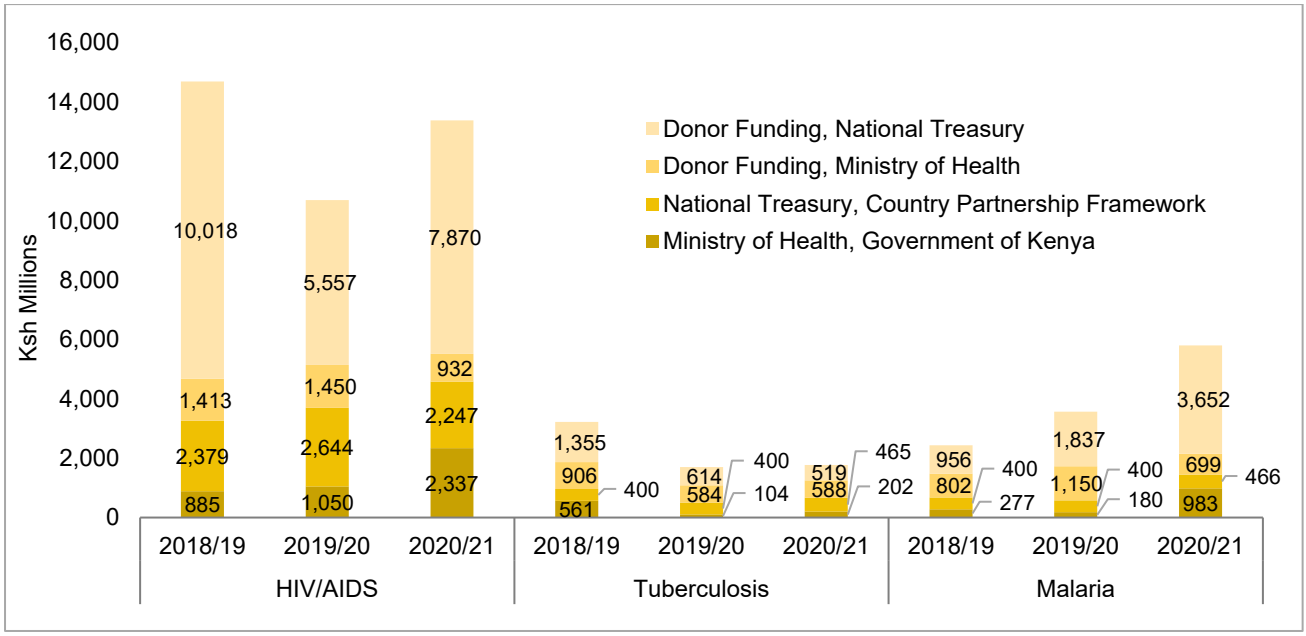
Source: Republic of Kenya, 2018/19–2020/21a

Funding for Ministry of Health Strategic Services (Government and Donors)

Figure 10 illustrates a more detailed assessment of both government and donor contributions to MOH strategic services. The assessment shows trends in allocations to each of these strategic services and highlights how resource allocation has shifted between the government of Kenya and donors over the past three fiscal years. Donors provide on-budget support to key strategic services using two government budget streams: the MOH and the National Treasury for key commodities. In the last three fiscal years, donor contributions to HIV/AIDS, TB, and malaria through the MOH budget have each dropped by almost 35 percent, for a total decline in funding of Ksh 902 million. Similar declining donor funding is observed through the National Treasury budget for HIV/AIDS (21 percent) and TB (62 percent), except for malaria where donor support increased significantly to 282 percent. Funding allocations to HIV and malaria by the government of Kenya have increased to respond to declining donor contributions. In the last three fiscal years, government funding for HIV increased by 164 percent (Ksh 1,452 million) and for malaria by 254 percent (Ksh 706 million). TB, on the other hand, has experienced declining funding from both donors and the government; government funding declined by 64 percent (Ksh 359 million) since FY 2018/19. It should be noted, however, that due to a multilateral funding agreement with the Global Fund through the Country Partnership Framework,

additional allocations were made available and spent directly under the National Treasury budget; these amounts are presented in Figure 10.

Figure 10: Funding for MOH strategic services, FY 2018/19–FY 2020/21



Source: Republic of Kenya, 2018/19–2020/21a

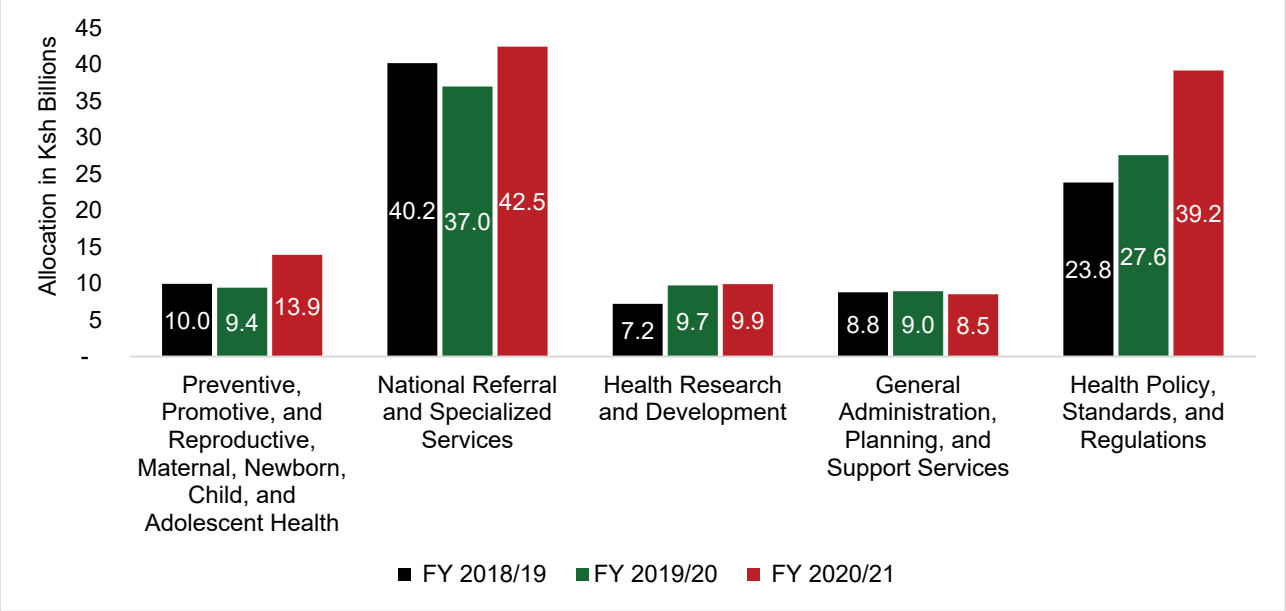
Note: Allocation data only include budget provisions that are directly identifiable as targeted funding for the specific facilities providing the services. The figures also exclude allocations to other ministries that undertake in-kind interventions related to the three programmes and exclude items funded indirectly, including personnel and other shared overhead.

Analysis of Ministry of Health Allocations to PBB Programmes

Findings presented thus far in this report have analysed health budget allocations at the microlevel by assessing trends in MOH and donor allocations to strategic services, national programmes, and other budget classifications. Figure 11 illustrates health budget allocations (both recurrent and development) from the perspective of the MOH's five designated programmes through which all health services and the health mandate is delivered. In Kenya, these are programme-based budgeting (PBB) programmes; this section of the report analyses how health resources are distributed across these programmes.

Although increases can be observed across most of these programmes, the MOH has largely prioritized national referral and specialized services and health policy, standards, and regulations, which comprises universal health coverage-related activities, including subsidies. These two programmes received 71 percent (Ksh 81 billion) of the MOH's entire budget for FY 2020/21. Health policy, standards, and regulations has received the highest increase in allocation, from Ksh 23.8 billion in FY 2018/19 to Ksh 39.2 billion in FY 2020/21. The reproductive, maternal, newborn, child, and adolescent health services programme saw a marginal increase in FY 2020/21 but received only 12 percent (Ksh 13.9 billion) of the MOH budget.

Figure 11: MOH budget allocations to PBB programmes, FY 2018/19–FY 2020/21

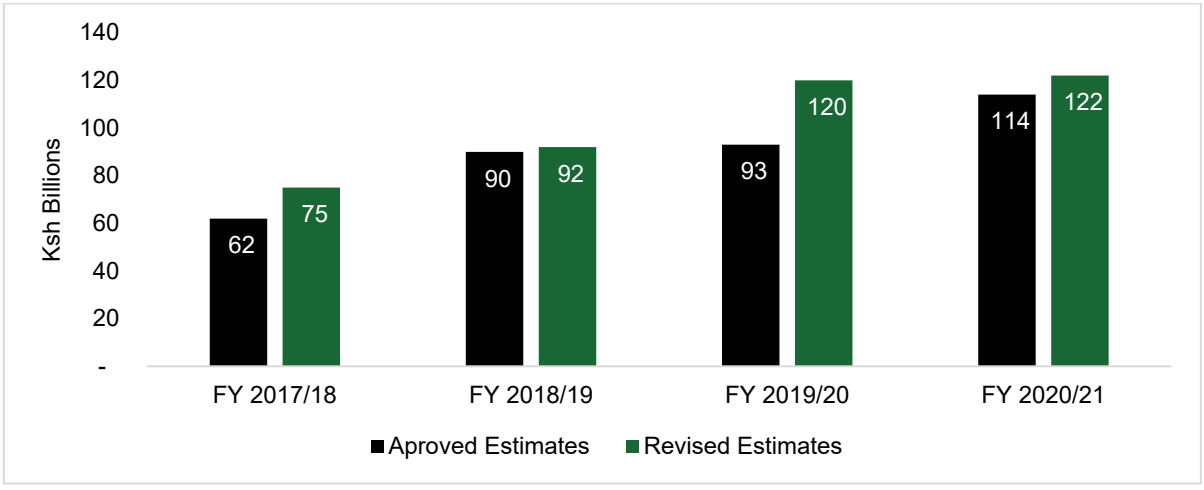


Source: Republic of Kenya, 2018/19–2020/21a

Comparative Analysis of Approved and Revised Estimates[8]

The MOH conducts a mid-year budget review to consider new funding or allocation changes; this review results in a revised budget by the end of the financial year. This situation arises when a ministry successfully requests additional funding from the National Treasury or when the National Treasury on its own adjusts a ministry's allocation ceiling. Figure 12 shows a comparison between the approved and revised estimates for the national health budget over FY 2017/18–FY 2020/21. As Figure 12 shows, mid-year budget reviews have resulted in increased budget allocations for the MOH. FY 2019/20 saw a considerable increase, which resulted from channelling additional resources to respond to the COVID-19 pandemic.

Figure 12: Comparison between MOH approved and revised estimates, FY 2017/18–FY 2020/21



Source: Republic of Kenya, 2012/13–2020/21

[8] The revised estimates for FY 2020/21 are based on half-year Controller of Budget data.

County Allocations to Health

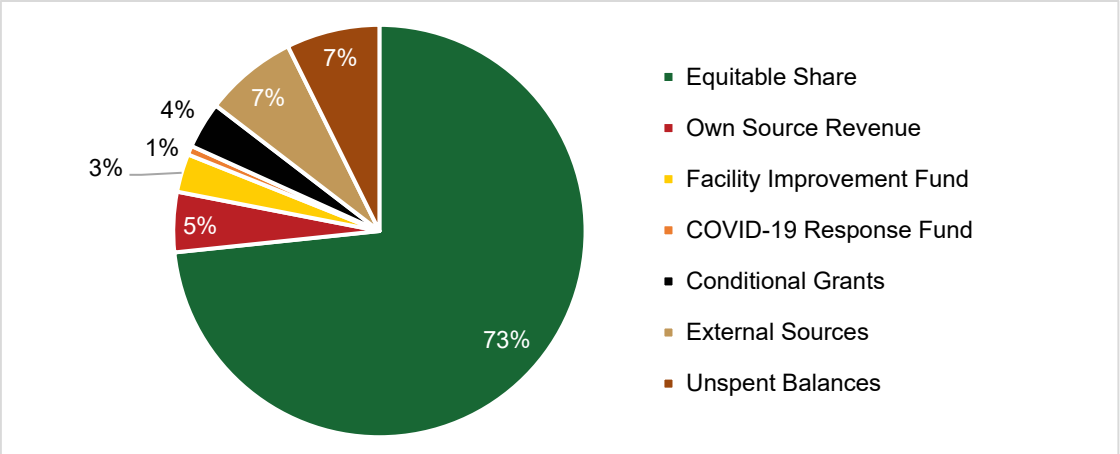
Since the onset of devolution in FY 2013/14, counties in Kenya have continued to provide a range of health services based primarily on the functions assigned by the constitution. To deliver these services, county governments allocate resources to health departments through annual budgets to finance their operations and investments. This section analyses the pattern of county financing for public health services.

Sources Contributing to County Health Budgets

County health budgets aggregate their funding from various sources, comprising funds from an equitable share of revenue disbursed by the national government; conditional grants given for specific purposes, mostly from the MOH; user fee revenue; other county revenue from sources outside of the health sector; COVID-19 grants (specific for FY 2020/21); donor provisions when provided on-budget; and a budget provision to carry over unspent balances from the previous year. Of all 47 county budgets analysed in this study, only three (Kericho, Meru, and West Pokot) reported the funding sources for their FY 2020/21 health budgets.

The proportion of contributions to the health budgets of the three counties is shown in Figure 13. Data from the three counties for FY 2020/21 indicate that counties rely heavily on equitable share to fund healthcare services (73 percent),[9] whereas county sources contributed 15 percent (own source revenue—5 percent, user fee revenue—3 percent, and unspent balances—7 percent). The remainder was financed by external sources at 7 percent and only 1 percent from the COVID-19 response fund.

Figure 13: Sources of health funds for Kericho, Meru, and West Pokot counties, FY 2020/21



Source: Republic of Kenya, 2020/21a

Overall Allocations to Health by County Governments

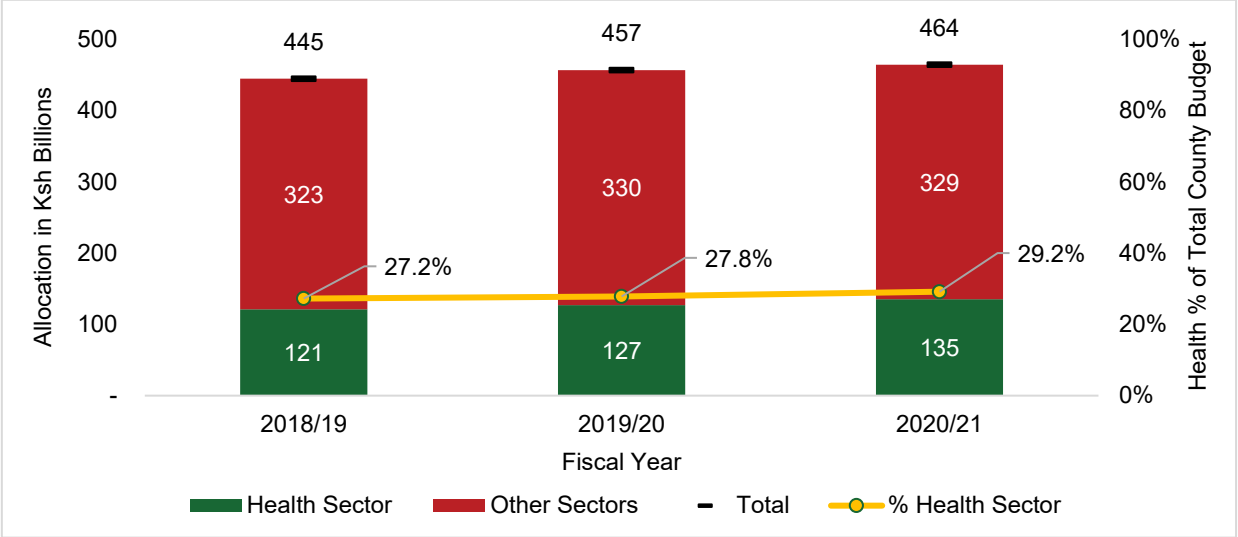
The proportion of counties' health budgets in relation to their total county government budgets indicates the priority level that county governments place on the health sector. Figure 14 shows counties' budget allocations to health during FY 2018/19–FY 2020/21. Counties' budgets expanded from Ksh 445 billion in FY 2018/19 to Ksh 457 billion in FY 2019/20 and Ksh 464 billion in FY

[9] "Equitable share" is defined as the monies county government receive from the National Treasury that have been raised from ordinary tax revenue. The national ordinary revenue is first shared between the national and county governments; subsequently, the lump sum is allocated and shared equitably among the 47 counties.

2020/21, representing an increase of 4 percent over the three-year period (and a slight increase of 2 percent between FY 2019/20 and FY 2020/21). Proportional allocations to health increased slightly more than overall growth in county government budgets, representing 12 percent growth from FY 2018/19 through FY 2020/21.

Figure 14 also shows that county government allocations to the health sector as a percentage of total county government budgets increased over the period, from 27.2 percent in FY 2018/19 to 29.2 percent in FY 2020/21. This finding is an indication that health remains a priority sector for county governments.

Figure 14: County governments' allocations to health and all other sectors, FY 2018/19–FY 2020/21



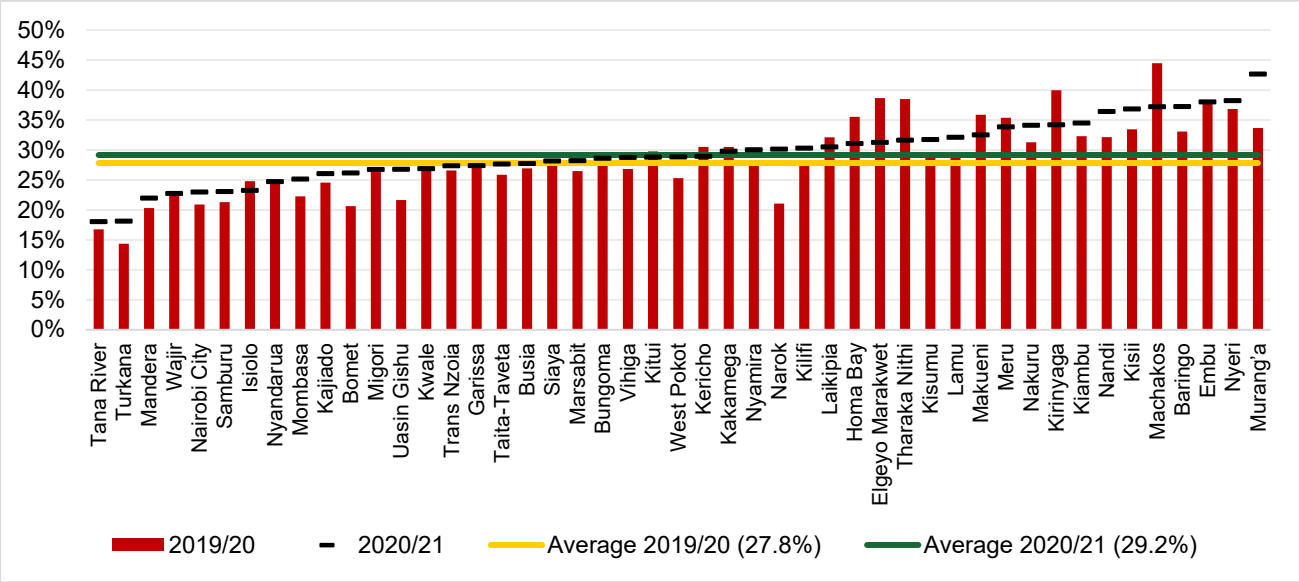
Source: Republic of Kenya, 2018/19–2020/21b

Note: For FY 2020/21, the Ksh 135 billion for county health budgets differs from the Ksh 133 billion presented in Figure 2 because it includes additional transfers received from the MOH that counties have discretion to allocate.

Allocations to Health by County

As Figure 15 shows, counties on average increased the proportion of their budgets allocated to health during FY 2019/20–FY 2020/21. However, increases in allocation to health were not uniform across all counties. The aggregate proportion of county budgets dedicated to health increased from 27.8 percent in FY 2019/20 to 29.2 percent in FY 2020/21, with most counties (29 of 47) increasing the proportion of their budgets to health over the two fiscal years. Health budget allocations decreased in 15 counties, whereas three counties maintained their allocations. Seven counties achieved or surpassed the estimated pre-devolution allocation of 35 percent in FY 2020/21, compared to nine in the previous year. The data in Figure 15 do not suggest any apparent uniqueness between counties allocating a higher proportion to health and those allocating a lower proportion; low-performing counties have the potential to increase their proportional allocations to health.

Figure 15: Allocations to health as a percentage of total county budget, FY 2019/20 and FY 2020/21

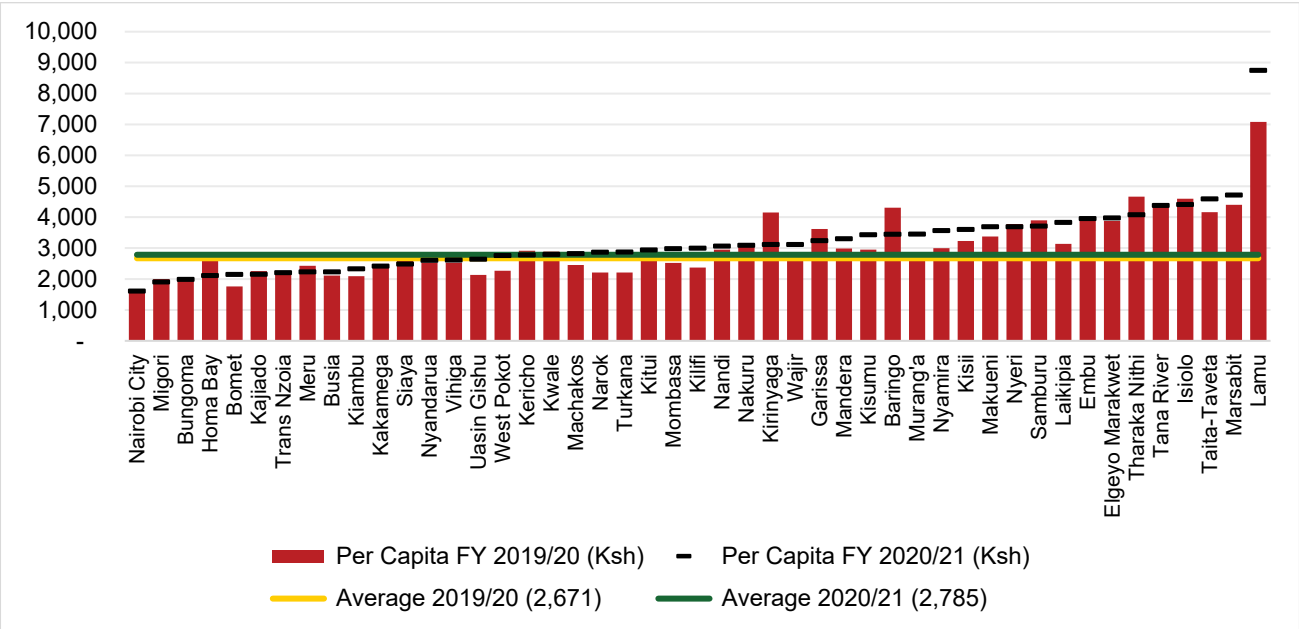


Source: Republic of Kenya, 2019/20–2020/21

Per Capita Allocations to Health by County

Per capita allocations provide a valuable measure of a county's commitment to the health sector. Figure 16 provides per capita health budget allocations by county for FY 2019/20 and FY 2020/21. Counties collectively increased their per capita budget allocations to health by 4.3 percent between FY 2019/20 to FY 2020/21, from Ksh 2,671 to Ksh 2,785, in nominal terms and adjusted for population. Per capita allocations varied across counties in FY 2020/21, ranging from Ksh 1,606 in Nairobi County to Ksh 8,746 in Lamu County. More than half of the counties (27 out of 47) increased their health budget per capita allocations. However, 20 counties decreased their per capita allocations in FY 2020/21.

Figure 16: County per capita health budget allocations, FY 2019/20 and FY 2020/21



Source: Republic of Kenya, 2019/20–2020/21

County Health Budget Allocations to Recurrent and Development Activities

County governments determine the proportion of funds to be allocated to their recurrent and development activities. The Public Finance Management Act of 2012 recommends that over the medium term, counties allocate at least 30 percent of their budgets to development activities and 70 percent or less to recurrent activities. The intent is to consistently invest in expansion and yet maintain provision of services. This section analyses how counties allocated funding for recurrent and development activities during FY 2018/19–FY 2020/21.

Overall Health County Recurrent and Development Expenditure Allocations

Table 3 shows that counties' health sector budgets continued to be dominated by recurrent activities, making up 78.7 percent in FY 2018/19, 82.3 percent in FY 2019/20, and 81.5 percent in FY 2020/21. This trend represents an overall increase in the proportion of these budgets allocated for recurrent expenditures, and thus an overall decrease in development expenditure allocations. Absolute allocations for recurrent expenditures increased from Ksh 95.3 billion in FY 2018/19 to Ksh 104.5 billion in FY 2019/20 and Ksh 110.3 billion in FY 2020/21. Allocations to development expenditures decreased from Ksh 25.8 billion in FY 2018/19 to Ksh 22.5 billion in FY 2019/20 before increasing to Ksh 25.1 billion in FY 2020/21. The increasing budget allocations for health are disproportionately channelled towards recurrent expenditures, even as the aggregate proportion allocated to development remains well below the 30 percent recommended by the Public Finance Management Act of 2012.

Table 3: Recurrent and development health sector allocations, FY 2018/19–FY 2020/21, Ksh billions

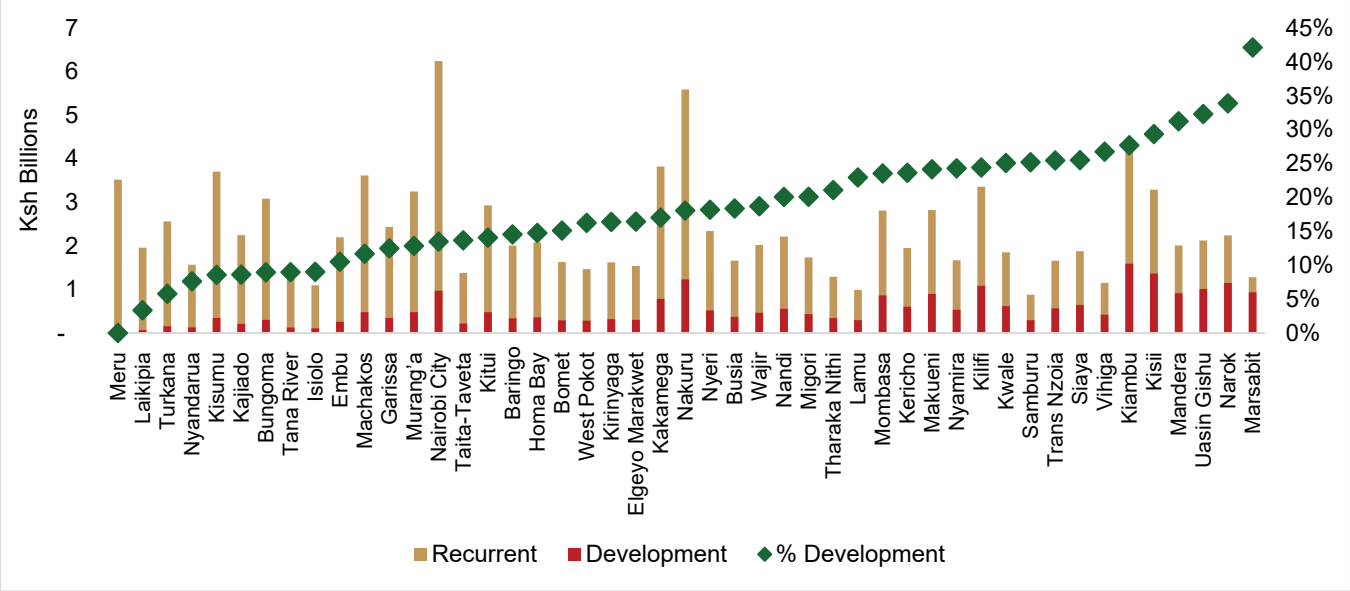
VOTE	FY 2018/19	FY 2019/20	FY 2020/21
Recurrent	95.3 (78.7%)	104.5 (82.3%)	110.3 (81.5%)
Development	25.8 (21.3%)	22.5 (17.7%)	25.1 (18.5%)
TOTAL	121.1 (100%)	127.0 (100%)	135.4 (100%)

Source: Republic of Kenya, 2018/19–2020/21b

Proportion of Budget Allocations to Recurrent and Development Budgets by County

The level of funding for development and its proportion of the total health department's budget indicates the level of capital investment in the health sector and the overall expansion of longer-term infrastructure. There are significant variations among counties in the proportion of their development budget allocations, regardless of the absolute amounts allocated to health. Figure 17 presents recurrent and development allocations by county for FY 2020/21, ranked by percentage of budget allocated to development. The proportion allocated for development ranged from less than 1.0 percent in Meru to 42.1 percent in Marsabit (see Annex 1, Table A.1 for individual county health budget allocation).

Figure 17: Allocations to recurrent and development activities by county, FY 2020/21



Source: Republic of Kenya, 2020/21b

Table 4 lists 43 counties that allocated less than 30 percent of their health budgets to development expenditures (i.e., more than 70 percent to recurrent), which is below the recommended threshold; four counties met that threshold. These four counties show no common characteristic, indicating that other counties have the potential to allocate a higher proportion of funds to their development budgets.

Table 4: Proportion of counties' health allocations dedicated to recurrent activities, FY 2020/21

61–70%	71–80%	80–90%	Over 90%
Marsabit: 57.9% Narok: 66.1% Uasin Gishu: 67.7% Mandera: 68.8%	Kisii: 70.6% Kiambu: 72.3% Vihiga: 73.2% Siaya: 74.5% Trans Nzoia: 74.5% Samburu: 74.8% Kwale: 74.9% Kilifi: 75.6% Nyamira: 75.7% Makueni: 75.8% Kericho: 76.4% Mombasa: 76.5% Lamu: 77.0% Tharaka Nithi: 78.9% Migori: 79.9% Nandi: 79.9%	Wajir: 81.3% Busia: 81.6% Nyeri: 81.8% Nakuru: 81.9% Kakamega: 83.0% Elgeyo Marakwet: 83.6% Kirinyaga: 83.6% West Pokot: 83.8% Bomet: 84.9% Homa Bay: 85.2% Baringo: 85.5% Kitui: 85.9% Taita-Taveta: 86.3% Nairobi City: 86.5% Murang'a: 87.2% Garissa: 87.5% Machakos: 88.3% Embu: 89.5%	Isiolo: 91.0% Tana River: 91.0% Bungoma: 91.0% Kajiado: 91.4% Kisumu: 91.4% Nyandarua: 92.4% Turkana: 94.2% Laikipia: 96.6% Meru: 100%

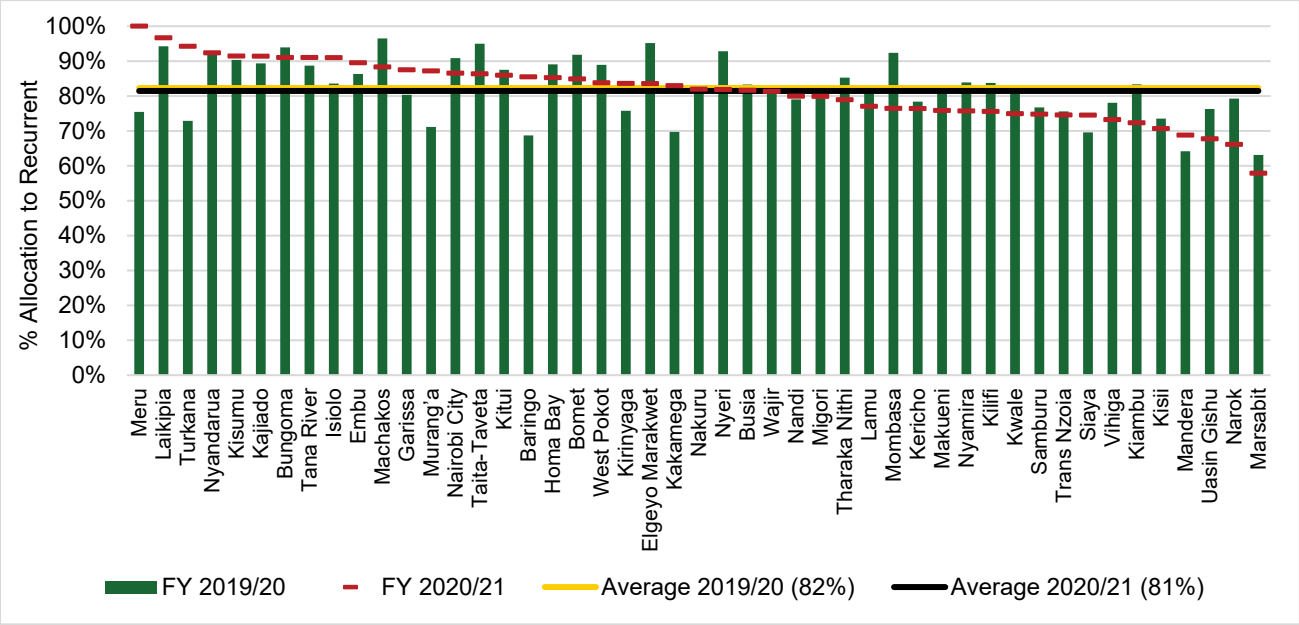
Source: Republic of Kenya, 2020/21b

Trends in Recurrent versus Development Allocations by County

Figure 18 presents recurrent health budget allocations as a percentage of total health allocations during FY 2019/20 and FY 2020/21 by county. On average, the proportion of county health budgets

allocated to recurrent decreased slightly from 82.3 percent in FY 2019/20 to 81.5 percent in FY 2020/21. The proportion of the total health budget dedicated to recurrent activities increased in 17 counties (Meru, Turkana, Baringo, Murang'a, Kakamega, Kirinyaga, Isiolo, Garissa, Siaya, Mandera, Embu, Laikipia, Tana River, Kajiado, Kisumu, Nandi, and Nakuru). Substantial decreases in recurrent allocations were observed between FY 2019/20 and 2020/21 in 20 counties (Mombasa, Narok, Elgeyo Marakwet, Kiambu, Nyeri, Taita-Taveta, Uasin Gishu, Machakos, Kilifi, Nyamira, Bomet, Tharaka Nithi, Makueni, Kwale, Marsabit, West Pokot, Vihiga, Lamu, Nairobi City, and Homa Bay). Overall, this trend suggests that counties are not limiting recurrent allocations in their budgets.

Figure 18: Recurrent allocations as a percentage of health allocations by county, FY 2019/20 and FY 2020/21



Source: Republic of Kenya, 2020/21b

County Health Budget Allocations by Economic Category

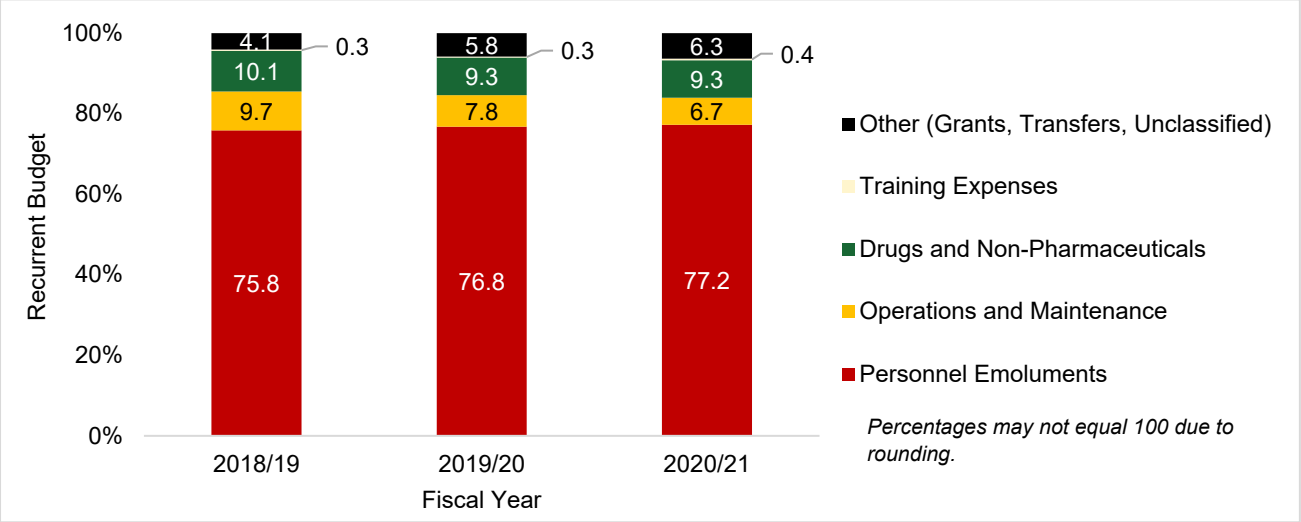
As counties move towards implementing PBB, it is prudent to analyse budget allocations by key health inputs. Programme-based budgeting classifies allocations according to specific programmes, disaggregated into sub-programme and economic categories. Programme-based budgeting guidelines propose disaggregation of the recurrent budget into four economic categories: personnel emoluments; operations and maintenance; drugs and non-pharmaceuticals; and training and other, including grants and transfers. However, health sector budgets are more informative if critical service delivery inputs are identified and separated from the operations and maintenance categories. This separation enables counties to demonstrate allocations to priority key inputs. The development budget is disaggregated into three economic categories: transfers, grants, and other development expenditures; equipment and furniture; and buildings. The following two sub-sections examine how counties allocated their recurrent and development budgets by economic categories.

Health Recurrent Budget Allocations by Economic Category

Figure 19 presents the trend in counties' health recurrent budget allocations by health sector economic category. Allocations for personnel emoluments comprised the largest share of the recurrent budget, increasing from 75.8 percent in FY 2018/19 to 77.2 percent in FY 2020/21. The growing increase of the proportion of the health budgets allocated to personnel emoluments is gradually crowding out much-needed resources for other key recurrent inputs. Budget allocations to operations and

maintenance and drugs and non-pharmaceuticals have decreased during the last three fiscal years. If left unchecked, counties will face a shortage of resources to deliver key health services to those in need.

Figure 19: County health recurrent budget allocations by economic category, FY 2018/19–FY 2020/21

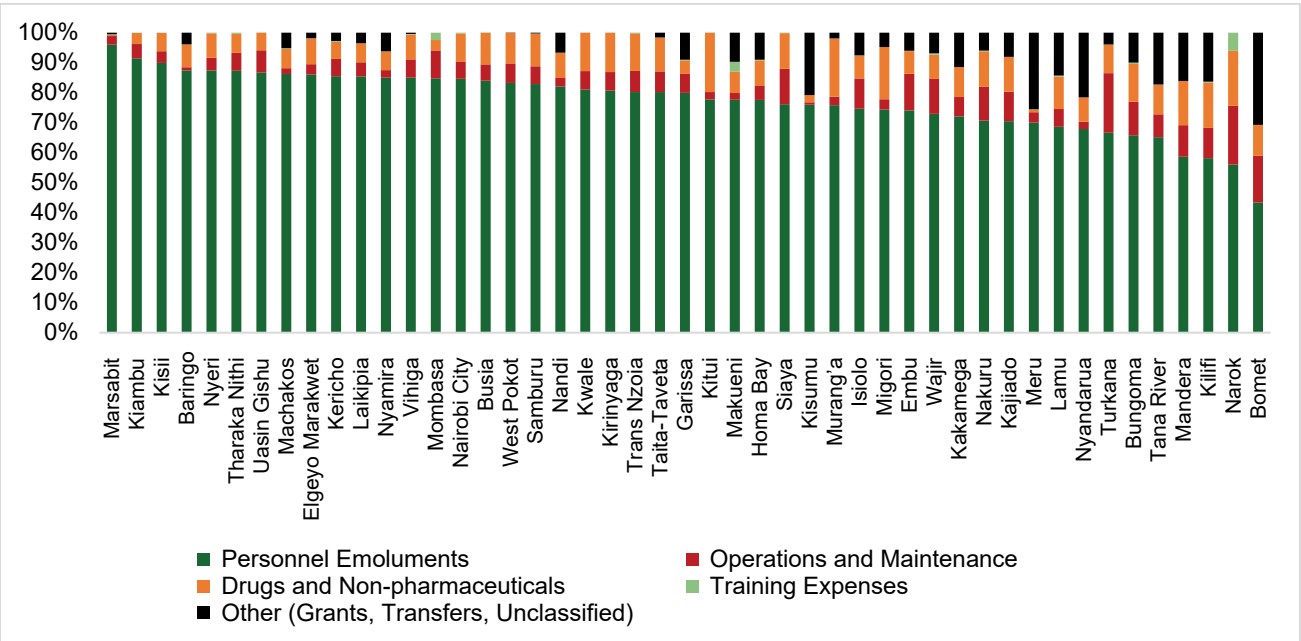


Source: Republic of Kenya, 2018/19–2020/21b

Health Recurrent Budget Allocations by Economic Category by County

FY 2020/21 recurrent budget allocations varied across counties. Figure 20 shows individual counties' allocations to personnel emoluments; drugs and non-pharmaceuticals; training; operations and maintenance; and other, including grants, transfers, and unclassified expenditures.

Figure 20: Health recurrent budget allocations by economic category by county, FY 2020/21



Source: Republic of Kenya, 2020/21b

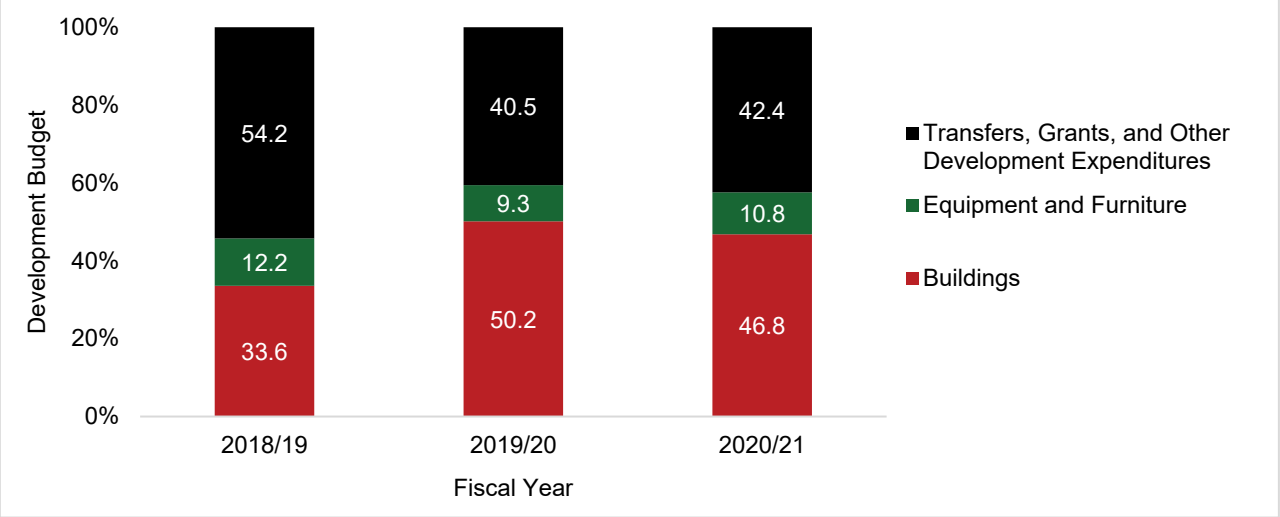
As shown in Figure 20, during FY 2020/21, Bomet, Narok, Kilifi, and Mandera counties allocated less than 60 percent of their recurrent budgets to personnel emoluments, freeing up fiscal space for other

critical health inputs. At the other extreme, Marsabit and Kiambu counties allocated more than 90 percent of their recurrent budgets to personnel emoluments, leaving less than 10 percent for other critical inputs. Allocations to personnel emoluments exceeded the average (77.2 percent) for 27 out of the 47 counties.

Health Development Budget Allocations by Economic Category

As noted previously in Table 3, there was an overall decrease in counties' allocation to development budgets, both as an absolute amount and as a proportion of their health budgets. Figure 21 shows the trend in development budget allocations by economic category over the three-year period. The proportion of expenditures allocated to investment in construction projects (buildings) increased from 33.6 percent in FY 2018/19 to 50.2 percent in FY 2019/20 before declining to 46.8 percent in FY 2020/21. Construction plus equipment and furniture totalled 45.8 percent in FY 2018/19, 59.5 percent in FY 2019/20, and 57.6 percent in FY 2020/21. The proportion of funds allocated to transfers, grants, and other development decreased from 54.2 percent in FY 2018/19 to 40.5 percent in FY 2019/20 before increasing slightly to 42.4 percent in FY 2020/21.[10]

Figure 21: County health development budget allocations by economic category, FY 2018/19–FY 2020/21



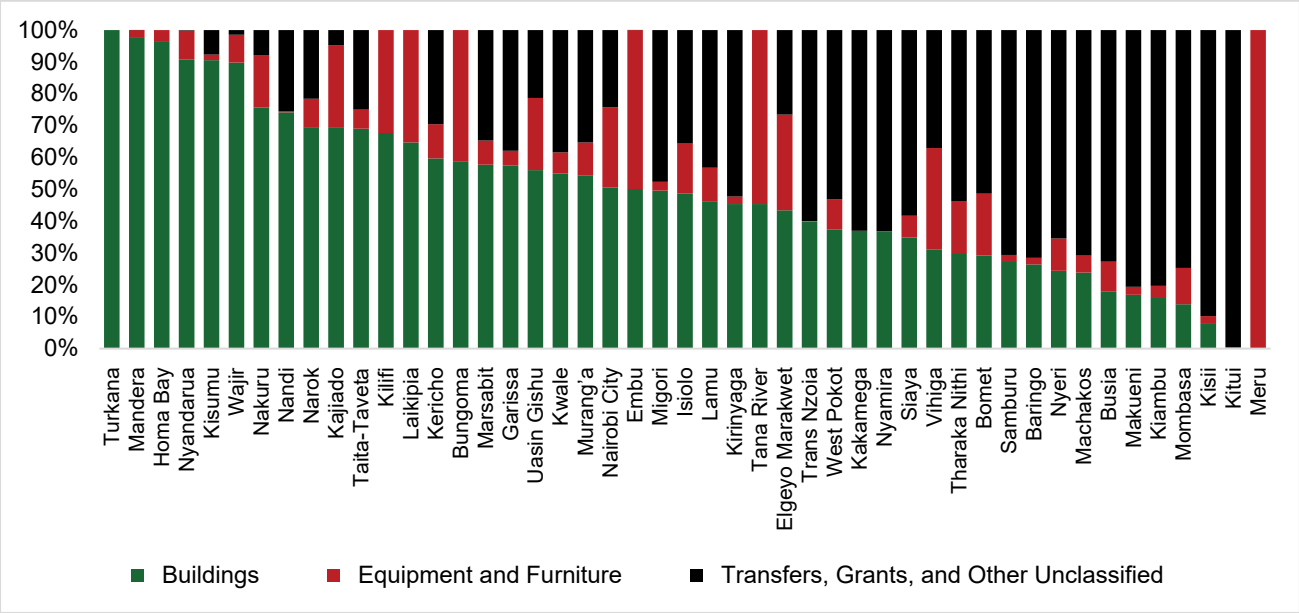
Source: Republic of Kenya, 2018/19–2020/21b

Health Development Budget Allocation by Economic Category by County

Similar to recurrent budget allocations, FY 2020/21 development budget allocations also varied across counties. Figure 22 shows individual counties' allocations for FY 2020/21 to buildings; equipment and furniture; and grants, transfers, and other development expenditures not classified among these categories. Almost half of the counties have expanded their physical infrastructure by allocating more than 50 percent of their development budgets to buildings. However, counties that seem to allocate little or no funds to buildings reported the highest allocation of the development budget under the category of transfers, grants, and unclassified, which may incorporate elements of buildings and equipment. If that is the case, it suggests counties are preferring to implement infrastructure expansion through grants and transfers.

[10] Counties apportion part of their development budget as bulk grants and transfers to institutions they own and to semi-autonomous facilities; these entities budget independently and expend the grants or transfers provided.

Figure 22: County health development budget allocations by economic category, FY 2020/21



Source: Republic of Kenya, 2020/21b

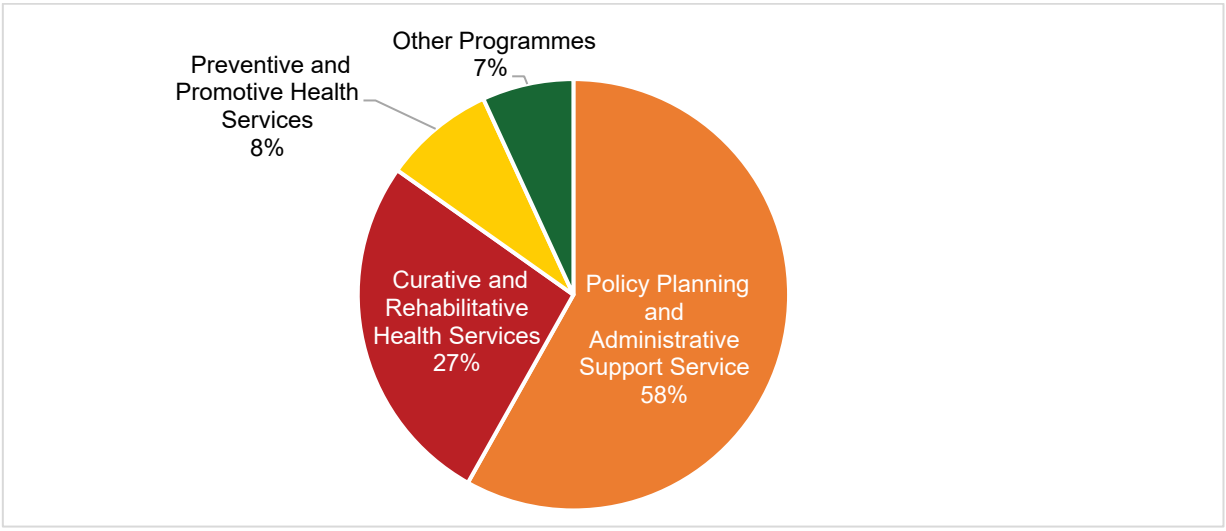
County Health Allocations to Programmes

For the first time, the national and county budget analysis collected and analysed county budget allocations by key programme through which counties deliver their health mandates, which align with Public Finance Management Act requirements. Counties allocate health resources to these programmes to (1) finance infrastructural developments and personnel emoluments in the Department of Health (policy planning and administrative support service programme); (2) provide quality treatment and care in health facilities (curative and rehabilitative health services programme); and (3) reduce the incidence of preventable illnesses and mortality through services for communicable and non-communicable diseases, family planning, and maternal and child health, among others (preventive and promotive health services programme). Figure 23 shows the overall county budget allocations to these programmes for FY 2020/21.

Institution of these programmes is not consistent across all counties. Some counties have not yet instituted all of these programmes as part of their planning and budgeting. Among all of the counties, 32 instituted all three programmes while the rest of the counties either did not institute any or instituted only one or two of the three programmes. "Other" programmes refer to those that were not categorized under the three major programmes. Programme data were not available for nine counties and thus were not included in the analysis.

Based on the available data, inefficiencies in county resource allocations are clear, with more funding going towards curative care as opposed to preventive and promotive care, increasing the demand for curative care as a result. Furthermore, inefficient allocations are seen in the large amount going to policy planning and administrative support, which funds personnel emoluments in counties.

Figure 23: County budget allocations to programmes, FY 2020/21



Source: Republic of Kenya, 2020/21b

County Allocations for COVID-19 Emergency Response

In response to the COVID-19 pandemic, counties received additional resources from the MOH and Danida. In addition, some counties repurposed existing resources. Resources for COVID-19 were disbursed to counties in the last quarter of FY 2019/20 and allocated in FY 2020/21. As a result, data for COVID-19 allocations were sourced from revised estimates from the Office of the Controller of Budget that included balances brought forward from the prior fiscal year. For FY 2020/21, counties included COVID-19 disbursements in their first supplementary budgets due to late disbursements of FY 2019/20 COVID funds. FY 2020/21 budgets were required to be submitted for approval at county assemblies at the end of April of 2020. Some counties, such as Bungoma, Kitui, and Vihiga, did not budget for COVID-19.

According to the FY 2019/20 County Budget and Implementation Review Report (Republic of Kenya, Office of the Controller of Budget, 2020a), the national government disbursed Ksh 5 billion for COVID-19 responses to the various counties through the MOH as conditional grants for COVID-19 interventions. A further Ksh 2.36 billion was disbursed to cover allowances for frontline healthcare workers dealing with the COVID-19 pandemic. Additionally, counties received Ksh 350 million from Danida. County governments cumulatively allocated a total of Ksh 5.39 billion to mitigate the effects of the pandemic from their internal revenue sources.

In FY 2020/21 (Republic of Kenya, Office of the Controller of Budget, 2020b), counties cumulatively received an allocation of Ksh 10.83 billion for COVID-19 interventions, comprising Ksh 5.04 billion allocated in the FY 2020/21 budgets and Ksh 5.78 billion as cash balances from FY 2019/20. The timing of the fund releases was very close to the end of FY 2019/20; thus, several county governments did not prepare budgets for utilizing the COVID-19 grants in that year, so they brought forward the balance in FY 2020/21.

CONCLUSIONS AND RECOMMENDATIONS

This study sought to explore Kenya's budget allocations to the MOH. The main question addressed is whether these resources were allocated appropriately during FY 2018/19–FY 2020/21 to achieve the country's intended health priorities, with a view to informing resource allocation policies in the health sector. The study findings lead to the following conclusions and related recommendations.

Conclusions	Recommendations
• Kenya continues to increase its allocated budget share to health, reaching a high of 11.1 percent of the total government budget in FY 2020/21. Between FY 2013/14 and FY 2020/21, the health budget has expanded by 216 percent, from Ksh 78 billion to Ksh 247 billion. Despite the significant increase, the overall budget allocation to the health sector falls short of the 15 percent of government resources to health recommended by the Abuja Declaration and the government's own commitment. The expansion of the health budget in real terms is much more limited, growing by 109 percent between FY 2013/14 and FY 2020/21, and by 7.5 percentage points over the past three fiscal years. The per capita distribution of the health budget is more revealing; over the past three fiscal years, Kenya's population has increased by 5 percent, whereas the per capita real allocation has increased by only 2.5 percent. • A closer analysis of the MOH budget reveals that the health sector continues to fall behind other sectors, ranking sixth in government allocation priorities. Over the last three fiscal years, proportional budget allocations to the MOH at the national level have increased marginally, from 5.1 percent in FY 2018/19 to 6.5 percent in FY 2020/21.	• To align resource allocations to achieve health sector policy priorities and achieve the 15 percent of government resources to health recommended by the Abuja Declaration, the Kenyan health sector requires additional domestic financing, both at the national and county levels. The MOH and the Ministry of Finance need to work together to enhance and explore additional resources of domestic funding, including allocating an increased share of government tax revenue to the health sector and scaling up National Health Insurance Fund coverage, thus adequately mobilizing funds from both mandatory and voluntary contributor segments. More immediately, maximizing efficient targeting and spending, prioritizing coordination across government and development partners, and fully executing health resources could yield considerable gains and value for money, and reduce resource wastage.

Conclusions	Recommendations
• Donor on-budget funding continues its declining trajectory, from Ksh 23.7 billion in FY 2018/19 to Ksh 14.6 billion in FY 2020/21. Budget allocation data for FY 2020/21 show that the government has significantly increased funding for donor-supported strategic services to offset the decline in donor funding, especially for HIV/AIDS and malaria. However, government expenditures have traditionally fallen short of initial allocations, leaving uncertainty as to the resources that will be strategically targeted and expended in full. Despite the decline, core disease programmes, such as HIV/AIDS, TB, and malaria, remain dependent on donor funding. • Looking at the MOH's budget allocations through the five PBB programmes, national referral and specialized services and health policy, standards, and regulations have dominated the MOH's overall budget in the last three fiscal years, leaving limited resources for preventive, promotive, and reproductive, maternal, neonatal, child, and adolescent health.	• Increased resource allocations should be prioritized efficiently to target donor-dependent health initiatives, including HIV, TB, and malaria. Secondarily, the ministry should prioritize areas that have received inadequate budget allocations, like preventive, promotive, and reproductive, maternal, neonatal, child, and adolescent health. • Policies that help mobilize private investment in healthcare services can serve to drive economic growth in addition to helping supplant reduced donor funding. The MOH can encourage growth in resources directed to the health sector by pursuing policies to catalyse private investment, such as reducing regulations, expanding the contracting capabilities of private health providers, and actively encouraging local private institutions to invest in the health sector.
• Grants to SAGAs have dominated the MOH's recurrent budget, averaging 60 percent for the past three fiscal years, with user fees from these agencies contributing an insignificant portion towards total allocation. Such inefficiencies significantly limit the fiscal space for the MOH to sufficiently allocate to other priority programmes.	• Because SAGAs account for a significant portion of its budget, the MOH should explore innovative resource mobilization concepts like increasing SAGAs' budgets from user fees and expanding the adoption and uptake of insurance coverage to partially shift the cost of healthcare coverage. Expanding greater adoption of health insurance schemes will require strong political will from local governments and the MOH.

Conclusions	Recommendations
• The combined proportional allocation to health continue to increase at the county level, albeit with noticeable inter-county variations. On average, counties allocated 29.2 percent of their budgets to health in FY 2020/21, an increase from 27.8 percent in FY 2019/20. However, this level of resource allocation still falls below the estimated 35 percent the national government was spending in counties before devolution. • Most counties (29 of 47) increased their proportionate health budgets over the two fiscal years, whereas 15 counties experienced decreases, and three maintained their allocations. Seven counties achieved or surpassed the estimated pre-devolution allocation of 35 percent in FY 2020/21, compared to nine in the previous year.	• Although advocating for additional resources for health at the county level is warranted, counties need to ensure resources are allocated more efficiently to health priority areas that increase value for money, including directing more resources to cost-effective preventive and promotive health services. Additionally, counties should enhance advocacy efforts to ensure key disease programmes like HIV, malaria, and TB are prioritized during the planning and budgeting processes. To accomplish such advocacy, counties need to capitalize on the evidence from county-specific budget and expenditure analyses. • Counties need to reduce their overreliance on the national government's shareable revenue by enhancing collection of revenue from local taxes. They also need to increase and streamline revenue collection by expanding the population covered by insurance and focusing on promoting primary care as a more cost-effective means of delivering care.

Conclusions	Recommendations
• County health sector budgets continue to be dominated by recurrent expenses, most of which are allocated to personnel emoluments. In FY 2020/21, average recurrent budget constituted 81.5 percent of county overall budgets, an increase from 78.7 percent in FY 2018/19. Although inter-county variations do exist, 43 out of 47 counties allocated more than 70 percent of their budgets to recurrent activities, crowding out resources for key development investments. As a result, allocations to county development budgets have been in decline, reaching a low of 18.5 percent in FY 2020/21. The Public Finance Management Act of 2012 recommends a threshold of 30 percent for development budgets, which is not being met by most counties. • The rising allocation to personnel emoluments across counties is a concerning trend. Counties allocated 77.2 percent of their resources to personnel emoluments in FY 2020/21, an increase from 75.8 percent in FY 2018/19. Although this assessment did not conduct an in-depth analysis of personnel budgets and resource needs, the increasing allocations might be a response to accommodating the acute need for health personnel in Kenya. According to a study published by IntraHealth International, Kenya employs 17 health workers per 10,000 population, falling short of the World Health Organization recommended minimum of 23 per 10,000 population (Milo et al., 2021). Nonetheless, the MOH and counties need to ensure sufficient resources are available for critical health inputs, such as drugs, non-pharmaceuticals, and operations. At the same time, the ministry must rationalize health personnel budgets that efficiently and effectively respond to counties' personnel needs.	• Counties must prioritize rationalizing staffing plans and exploring strategies to ensure budget allocations to personnel are needs-based and informed by evidence and to ensure that resource allocations are adequate for other key health inputs. Effectively using data and greater in-depth analysis is needed to understand the underlying drivers in personnel budgets and determine how best to allocate resources to meet Kenya's increasing need for skilled health personnel.

Conclusions	Recommendations
• Findings show that adherence and capacity to adopt the PBB approach to planning and budgeting remain low and vary among counties. The three most common programmes instituted in 32 counties were preventive and promotive health, curative health, and policy, planning, and administrative support services. Preliminary findings show inefficiencies in county resource allocations, with more funding going towards curative care (27 percent) as opposed to preventive care (8 percent). The main cost driver, accounting for 58 percent, is policy planning and administrative support budgets, which include personnel emoluments in counties.	• Counties should invest in technical capacity strengthening in planning and budgeting to learn to effectively adopt the PBB approach in their planning and budgeting process. The PBB approach has proven to increase efficiency in resource allocations and link inputs with programme outcomes.

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ANNEX 1: COUNTY HEALTH BUDGET ALLOCATION, FY 2020/21

Table A.1: Total budget and health allocation

County	Total Budget (Ksh)	Health Allocation (Ksh)		
		Total	Recurrent	Development
Baringo	6,306,909,057	2,347,744,197	2,006,400,472	341,343,725
Bomet	7,347,905,276	1,920,602,393	1,630,123,723	290,478,670
Bungoma	11,835,998,884	3,386,592,560	3,083,064,163	303,528,397
Busia	7,348,593,856	2,036,984,720	1,662,772,085	374,212,635
Elgeyo Marakwet	5,905,553,797	1,844,978,770	1,541,750,714	303,228,056
Embu	6,464,660,318	2,457,028,490	2,199,033,247	257,995,243
Garissa	10,176,759,490	2,785,870,687	2,437,538,896	348,331,791
Homa Bay	7,862,589,002	2,441,186,967	2,080,866,777	360,320,190
Isiolo	5,195,908,193	1,206,712,444	1,097,932,444	108,780,000
Kajiado	9,442,814,081	2,458,757,502	2,246,597,502	212,160,000
Kakamega	15,482,761,690	4,608,483,582	3,823,587,031	784,896,551
Kericho	8,851,766,093	2,559,006,697	1,954,261,106	604,745,591
Kiambu	16,684,832,796	5,752,309,470	4,158,310,374	1,593,999,096
Kilifi	14,677,777,384	4,445,653,963	3,359,931,207	1,085,722,756
Kirinyaga	5,679,035,514	1,941,638,757	1,623,320,187	318,318,570
Kisii	12,656,214,782	4,659,120,274	3,291,065,681	1,368,054,593
Kisumu	12,780,355,751	4,053,011,276	3,705,771,143	347,240,133
Kitui	11,839,810,619	3,409,479,937	2,929,873,414	479,606,523
Kwale	9,206,476,136	2,472,808,067	1,852,656,226	620,151,841
Laikipia	6,649,197,849	2,028,059,474	1,959,986,252	68,073,222
Lamu	4,007,076,735	1,286,395,509	990,952,933	295,442,576
Machakos	11,016,948,638	4,097,613,214	3,618,455,962	479,157,252
Makueni	11,446,609,853	3,721,268,046	2,821,876,359	899,391,686
Mandera	13,319,725,092	2,923,464,913	2,010,118,853	913,346,060
Marsabit	7,857,000,131	2,215,731,869	1,282,137,000	933,594,869
Meru	10,400,422,802	3,519,807,245	3,519,432,395	374,850
Migori	8,124,371,198	2,171,752,930	1,735,079,411	436,673,519
Mombasa	14,634,579,687	3,677,301,511	2,811,450,725	865,850,786
Murang'a	8,744,396,936	3,728,331,714	3,249,327,874	479,003,840
Nairobi City	31,433,645,196	7,216,479,092	6,244,081,892	972,397,200
Nakuru	20,004,481,264	6,822,878,220	5,589,840,057	1,233,038,163
Nandi	7,611,517,868	2,770,628,538	2,214,241,904	556,386,634
Narok	11,256,020,000	3,391,721,802	2,242,109,047	1,149,612,755

County	Total Budget (Ksh)	Health Allocation (Ksh)		
		Total	Recurrent	Development
Nyamira	7,341,614,743	2,204,475,888	1,668,666,128	535,809,760
Nyandarua	6,866,689,050	1,695,242,894	1,565,842,814	129,400,081
Nyeri	7,489,754,244	2,861,711,841	2,341,526,436	520,185,405
Samburu	5,108,601,391	1,177,067,956	880,440,312	296,627,644
Siaya	8,951,560,005	2,520,490,313	1,877,455,907	643,034,406
Taita-Taveta	5,780,669,523	1,597,013,028	1,378,693,841	218,319,187
Tana River	7,839,945,374	1,413,976,255	1,287,226,255	126,750,000
Tharaka Nithi	5,179,465,196	1,637,926,763	1,292,626,316	345,300,447
Trans Nzoia	8,145,509,973	2,227,368,187	1,660,366,745	567,001,442
Turkana	15,032,757,284	2,720,395,853	2,563,080,886	157,314,967
Uasin Gishu	11,727,087,098	3,137,065,536	2,123,791,386	1,013,274,150
Vihiga	5,479,887,578	1,574,945,829	1,153,352,593	421,593,236
Wajir	10,944,104,687	2,486,267,178	2,020,953,300	465,313,879
West Pokot	6,075,359,951	1,750,132,900	1,465,932,122	284,200,778
Total	464,215,722,064	135,363,485,253	110,253,902,098	25,109,583,155

Table A.2: Recurrent and development budget analysis

County	Recurrent breakdown					Development breakdown		
	Personnel emoluments	Operation & maintenance	Drugs & medical supplies	Training expenses	All other recurrent	Buildings	Equipment & furniture	Grants, transfers, & other unclassified
Baringo	1,753,756,118	21,098,800	153,045,554	0	78,500,000	90,227,978	7,000,000	244,115,747
Bomet	707,300,000	254,039,177	166,691,478	828,590	501,264,478	85,000,000	56,364,500	149,114,170
Bungoma	2,028,608,265	344,777,224	388,886,446	12,520,644	308,271,584	178,034,987	125,493,410	0
Busia	1,396,329,590	91,071,641	174,942,013	428,841	0	67,300,000	34,799,610	272,113,025
Elgeyo Marakwet	1,326,895,610	53,096,694	132,072,500	600,000	29,085,910	131,676,231	91,166,551	80,385,274
Embu	1,629,099,428	268,366,059	166,546,483	3,000,000	132,021,277	129,317,038	128,628,205	50,000
Garissa	1,948,907,287	156,684,089	106,500,000	6,268,000	219,179,520	200,000,000	16,310,514	132,021,277
Homa Bay	1,614,123,285	97,107,885	178,000,000	4,500,000	187,135,607	347,000,000	13,320,190	0
Isiolo	819,944,167	110,493,779	83,276,350	892,000	83,326,148	53,000,000	17,000,000	38,780,000
Kajiado	1,584,215,654	220,574,603	259,391,644	1,050,000	181,365,601	147,000,000	55,160,000	10,000,000
Kakamega	2,757,574,340	246,331,702	380,541,357	0	439,139,632	290,214,024	0	494,682,527
Kericho	1,670,144,625	113,179,055	110,892,001	5,347,364	54,698,061	361,000,000	65,000,000	178,745,591
Kiambu	3,802,667,201	199,046,027	151,097,146	5,500,000	0	258,000,000	56,000,000	1,279,999,096
Kilifi	1,953,991,348	338,653,393	509,500,000	8,900,000	548,886,466	735,077,435	350,645,321	0
Kirinyaga	1,309,392,757	101,210,000	212,717,430	0	0	144,500,000	7,400,000	166,418,570
Kisii	2,958,601,561	128,764,120	200,000,000	3,700,000	0	106,258,880	33,350,000	1,228,445,713
Kisumu	2,815,206,895	29,994,000	90,000,000	0	770,570,248	314,500,000	6,000,000	26,740,133
Kitui	2,276,411,563	72,936,054	579,755,772	770,025	0	0	1,847,166	477,759,357
Kwale	1,502,077,613	113,557,337	237,021,276	0	0	340,633,961	41,420,000	238,097,880
Laikipia	1,674,597,093	91,676,204	124,912,955	0	68,800,000	44,068,787	24,004,435	0
Lamu	680,000,000	58,860,265	107,000,000	3,500,000	141,592,668	136160576	31,600,000	127,682,000
Machakos	3,119,638,342	69,904,594	234,347,681	6,775,000	187,790,345	114,393,046	25,501,345	339,262,861
Makueni	2,191,446,320	63,298,273	200,500,000	93,050,001	273,581,765	151,907,312	22,721,804	724,762,570
Mandera	1,178,980,809	210,842,759	296,862,330	0	323,432,955	891,079,970	22,202,000	64,090

County	Recurrent breakdown					Development breakdown		
	Personnel emoluments	Operation & maintenance	Drugs & medical supplies	Training expenses	All other recurrent	Buildings	Equipment & furniture	Grants, transfers, & other unclassified
Marsabit	1,230,693,286	37,300,000	4,500,000	3,000,000	6,643,714	539,142,277	70,820,000	323,632,592
Meru	2,463,875,490	121,585,472	30,895,056	4,192,500	898,883,877	0	374,850	0
Migori	1,290,507,081	59,035,856	302,620,591	0	82,915,884	216,579,371	12,028,322	208,065,826
Mombasa	2,383,380,833	261,681,595	96,770,495	69,617,802	0	120,734,981	98,651,092	646,464,713
Murang'a	2,464,296,176	91,419,248	630,000,000	2,000,000	61,612,450	260,000,000	50,000,000	169,003,840
Nairobi City	5,286,177,001	347,073,691	594,017,700	16,813,500	0	492,100,000	244,658,500	235,638,700
Nakuru	3,953,457,446	627,264,862	663,540,297	11,004,875	334,572,577	933,498,092	202,715,133	96,824,938
Nandi	1,817,356,093	62,300,000	185,000,000	2,500,000	147,085,811	412,769,207	2,185,792	141,431,635
Narok	1,256,387,599	438,956,575	411,205,431	135,559,442	0	796,888,319	104,958,288	247,766,148
Nyamira	1,418,567,690	41,406,217	102,630,000	2,207,000	103,855,221	196,260,000	1,000,000	338,549,760
Nyandarua	1,063,302,359	38,165,214	126,975,852	167,617	337,231,772	117,394,756	11,794,751	210,574
Nyeri	2,046,645,164	98,839,213	190,593,459	5,448,600	0	127,029,026	52,825,000	340,331,379
Samburu	729,605,506	52,165,358	95,000,000	1,090,000	2,579,448	80,710,000	6,500,000	209,417,644
Siaya	1,430,125,092	220,710,815	224,000,000	2,620,000	0	224,228,832	43,932,622	374,872,952
Taita-Taveta	1,105,469,097	94,990,287	156,238,152	0	21,996,305	150,750,000	13,000,000	54,569,187
Tana River	838,543,415	98,649,240	126,800,000	500,000	222,733,600	57,500,000	69,250,000	0
Tharaka Nithi	1,128,652,591	76,893,725	82,460,000	4,620,000	0	103,623,621	56,387,500	185,289,326
Trans Nzoia	1,332,100,000	116,466,745	208,300,000	3,500,000	0	226,126,165	900,000	339,975,277
Turkana	1,708,930,916	508,025,029	243,000,000	2,520,000	100,604,941	157,314,967	0	0
Uasin Gishu	1,843,323,817	155,314,393	124,653,176	500,000	0	567,844,479	229,452,262	215,977,409
Vihiga	980,274,356	70,278,237	96,000,000	1,800,000	5,000,000	131,000,000	134,411,277	156,181,959
Wajir	1,474,049,635	235,121,768	163,792,206	9,057,425	138,932,265	417,773,720	40,747,090	6,793,069
West Pokot	1,220,709,246	95,031,800	148,500,287	0	1,690,790	106,400,000	26,700,000	151,100,778
Total	85,166,339,760	7,404,239,074	10,251,993,118	436,349,226	6,994,980,920	11,752,018,038	2,706,227,530	10,651,337,587