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Strengthening the Sustainability of Kenya's Tuberculosis Response:

An Assessment of County-Level Engagement in Planning and Budgeting Processes

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USAID
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NATIONAL TUBERCULOSIS, LEPROSY AND LUNG DISEASE PROGRAM

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ABOUT HS4TB

The USAID Health Systems for Tuberculosis (HS4TB) project seeks to transform the way country leaders and health system managers understand and work toward TB control and elimination. HS4TB is a five-year USAID contract focusing on health systems priorities that most directly support achievement of TB outcomes, with a focus on health financing and governance in the USAID TB priority countries. The project helps countries increase domestic financing, use key TB resources more efficiently, build in-country technical and managerial competence and leadership, and support policy formation and dissemination. HS4TB is led by Management Sciences for Health (MSH) in partnership with Nathan Associates and Open Development.

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ACRONYMS AND ABBREVIATIONS

AWP	annual work plan
BROP	Budget Review and Outlook Paper
CBROP	County Budget Review and Outlook Paper
CDOH	County Department of Health
CFSP	County Fiscal Strategy Paper
CHMT	County Health Management Team
CIDP	County Integrated Development Plan
CRF	County Revenue Fund
CSOs	civil society organization
FY	fiscal year
HBP	health benefits package
HS4TB	Health Systems for Tuberculosis
KES	Kenyan shilling
KII	key informant interview
M&E	monitoring and evaluation
MOH	Ministry of Health
MOU	memorandum of understanding
MTEF	Medium-Term Expenditure Framework
NHIF	National Hospital Insurance Fund
NSP	National Strategic Plan
NTLD-P	National Tuberculosis, Leprosy and Lung Disease Program
PBB	program-based budget
PSRA	priority-setting, planning, and resource allocation
OCOB	Office of the Controller of Budget
NSP	National Strategic Plan
TB	tuberculosis
TWG	technical working group
UHC	universal health coverage
USAID	United States Agency for International Development

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EXECUTIVE SUMMARY

Introduction. While Kenya has recently reached some important milestones in TB epidemic control, the country faces a massive TB funding gap. The National Tuberculosis, Leprosy and Lung Disease Program (NTLD-P) TB National Strategic Plan (NSP) 2019–2023 identified county government budgets as an important potential source for increased financial resources for TB, given the considerable increase in public revenues at this level following devolution. To mobilize funds from county governments for TB, the NTLD-P seeks to improve TB planning and budgeting at the county level. However, these topics have not yet been systematically explored for the TB context.

Objectives. This assessment explores the prescribed county government planning and budgeting processes that are relevant to the county TB sub-program following devolution; assesses the nature and level of participation by county TB coordinators in these processes; identifies the challenges in county planning and budgeting processes affecting the financial viability and autonomy of county TB sub-programs; and describes cross-cutting governance issues affecting effective budgeting and planning for TB at the county level.

Methods. Counties were selected for this qualitative assessment using objective selection criteria—preference was given to counties with a higher county government budget per capita, lower general county budget absorption rates, lower percentage of county budget allocated to health, lower health services budget absorption rate, and higher TB case notification rate per 100,000. Data was collected through both desk review and key informant interviews with TB coordinators, County Department of Health (CDOH) staff, County Treasury officials, and other key stakeholders.

Findings. Through desk review and key informant interviews, the assessment generated the following main results:

- ***County-Level TB Planning***. During implementation, TB activities in county health sector annual work plans (AWPs) tend to be ignored in favor of development partner work plans. County integrated development plans (CIDPs), which stipulate the five-year development priorities of each county, do not prioritize TB as the sub-program is viewed as donor- rather than government-funded. County-specific TB NSP "implementation frameworks" would be suitable alternatives to TB strategic plans.
- ***County-Level Budgeting for TB***. TB coordinators' role in budget preparation is weak. While their involvement is stronger in budget approval steps, their role is quite passive—they tend to only participate in budget approval decisions if summoned by the County Assembly. TB activities in county health AWPs are heavily underfunded due to decision makers' perception of TB as a donor-funded program, weak advocacy expertise among TB coordinators, lack of alignment between development partner work plans and AWPs, and fiscal space constraints as a result of drought and hunger. Another reason TB activities in health AWPs are underfunded is the low absorptive capacity of the TB sub-programs, which also threatens longer term viability of TB funding. This low absorptive capacity stems from delays in intragovernmental transfers to county revenue funds and consequent rationing behaviors from county treasuries.

- ***Cross-Cutting Governance Issues***. Most of the TB coordinators interviewed have clearly defined planning and budgeting roles in their CDOHs' organograms. None of the TB coordinators interviewed received training on any of the budget and planning process capacities presented. Collaboration between TB coordinators and NTLD-P is generally sufficient, while room for improvement exists in CDOH-TB coordinator collaboration. Most of the counties have TB stakeholder forums, but associated costs are covered by donors.

Recommendations. To address the challenges identified in the assessment, the following steps are recommended:

- Alignment should be fostered between donors' work plans and TB activities in county health sector AWPs (including alignment regarding what parts of the TB response will remain donor-supported and what will be county-supported).
- Medium-term advocacy plans should be formulated at the county level with a view to shifting county decision makers' perception of TB as a donor-funded program.
- Understanding of the budget process should be increased among TB coordinators.
- TB coordinators' capacity with respect to financial analysis, costing, priority setting, and evidence-based budget advocacy should be built.
- TB coordinators should be trained to develop county-level TB NSP implementation frameworks.
- Funding of TB stakeholder forums should be transitioned from donors to domestic sources.

INTRODUCTION

Although Kenya has seen a decline in incidence rates over the last few years, TB remains one of the leading causes of death from infectious disease in the country.

In 2021, the World Health Organization estimated an incidence rate of 261 per 100,000 population, a decline from its 283 per 100,000 population estimate in 2020. In the same period, the National Tuberculosis, Leprosy and Lung Disease Program (NTLD-P) reported a case notification rate of 164 per 100,000 population, indicating a case detection gap of 48%. The facts that 67% of people with TB do not seek treatment and that 27% of TB-affected households face catastrophic costs—which, for multidrug resistant patients, increases to 83% of households—constitute key challenges in the national TB response. In addition, 20% of people diagnosed with TB are not notified through the nationwide electronic TB case reporting system (NTLD-P 2023, NTLD-P 2019, Ministry of Health (MOH) 2018).

Financial resources required to address these challenges and build upon recent achievements in epidemic control are increasing at a time when the country's TB program is under-funded and relies heavily on external resources. The NSP 2019–2023 has an estimated total financing gap of KES 15.21 billion (approximately KES 138 million, or USD 27.65 million, per year), which represents approximately 50% of its needs. The main funding sources are the government, the US Agency for International Development (USAID), the Global Fund, and out of pocket expenditure by households, with a high proportion of TB-affected households experiencing catastrophic costs. Over the years, for every dollar spent by the Government of Kenya (GOK) on TB, donors spent USD 2.8. In fiscal year (FY) 2022/23, donor contributions represented almost 80% of the total direct TB budget: 21% came from USAID, 58% came from the Global Fund, and 21% came from the national government. Now that Kenya has attained middle-income status, Global Fund and other partner support is slated to decline, which means the government urgently needs to mobilize domestic resources for TB (McDade et al. 2021, Global Fund 2020, National Treasury 2020, NTLD-P 2019).

To close the funding gap, the NSP calls for:

- Enhanced advocacy to national- and county-level authorities to increase allocations to TB interventions
- Integration of TB, leprosy, and lung diseases into the harmonized health benefits package (HBP) as well as the National Hospital Insurance Fund's (NHIF's) benefits package
- Establishing TB and leprosy disease status for inclusion in the National Social Protection Policy
- Direct community-based health insurance scheme investments towards TB interventions
- Innovative financing for TB
- Building the capacity of NTLD-P staff in grant writing and management to mobilize additional funds to the program

Key documents summarized in Box 1 provide some information on the health financing context and main policy levers for health and TB financing in Kenya. The documents share a commitment to increased domestic resource mobilization for health, with the *Kenya Health Sector Transition Roadmap* highlighting the need to use county health budgets for TB to meet increased domestic financing needs for TB during the upcoming donor funding transition (NTLD-P 2019).

A number of the documents in Box 1 note some lack of clarity about which parts of health (e.g., commodities, salaries, program activities, clinical services, etc.) will be supported primarily by which funding channels (national, county, NHIF, etc.) in the future and about the exact timetable for any shifts in the priority or purpose of those various funding channels. Such changes will affect the county-level TB funding conversation, and TB funding strategies (including strategies for county-level TB funding) will need to align with that evolving framework.

As mentioned in the NSP, county government budgets constitute an important potential source for increased financial resources to TB. In 2010, Kenya promulgated a new constitution to establish two levels of government—one central government and 47 semi-autonomous county governments. Devolution provided county governments with significant public resources to allocate across government sectors at their discretion. Public revenues managed by counties include central block grants (called "equitable share"), central conditional or unconditional grants,[1] own-source revenues, and cash balances carried over from the previous year (called "reconciled cash balance"). According to the Office of the Controller of Budget (OCOB), which reports the annual government-managed revenue available to counties, resources for FY 2021/22 from own-source revenue, equitable share, conditional grants, and reconciled cash balance accounted for 8% (KES 36 billion), 78% (KES 340 billion), 3% (KES 12 billion), and 11% (KES 48 billion), respectively, of the county government-managed resources tracked by the OCOB. Notably, the OCOB did not track unconditional grants, and conditional grants came exclusively from external sources (OCOB 2022).

Since devolution, county governments have been increasing their health allocations, where total county government health allocations as a share of total county government budgets were 13% immediately following devolution and 25% in FY 2016/17. Budget allocations to health by national and county governments grew nearly three times, from KES 78 billion to KES 217 billion, between FY 2013/14 and FY 2019/20, which reflected counties increasing their health allocations from KES 42 billion to KES 124 billion and the MOH increasing its health allocations from KES 36 billion to KES 93 billion. The rise in county health budgets is more apparent when comparing county health budgets to the MOH budget, which in FY 2020/21 were KES 133 billion and KES 114 billion, respectively. These correspond to 54% and 46% of total government health budgets; as mentioned in the previous paragraph, conditional grants come from external sources and are not included in the total from the previous sentence (ROK & MOH 2022, HP+ 2021a, Dutta et al. 2018).

To ensure that county government allocations, disbursements, and expenditures to TB increase alongside the expanding budgetary space for health at the county level, improvements in TB planning and budgeting processes at this level will be required. To make these improvements, the NTLD-P aims to develop a phased capacity-building plan to enable TB county coordinators to effectively cost proposed interventions, set priorities, conduct program-based budgeting, justify budgets, and advocate for proposed allocations to TB. As these topics have not yet been systematically explored, an assessment of the key strengths and deficiencies in TB planning and budgeting processes is required.

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[1] Unconditional grants are those that are not contingent on any specific behavior or purpose. Resources from "equitable share" are also unconditional but are distributed across counties based on a formula by the Commission on Revenue Allocation. Therefore, in the Kenyan context, "unconditional grants" are understood to be unconditional transfers separate from monies already calculated in a given county's equitable share.

Box 1. Foundational Documents on the Financing Landscape for TB and Health in Kenya

2022 Budget Review and Outlook Paper. Each Budget Review and Outlook Paper (BROP) reports the Government of Kenya's fiscal standing from the previous year, provides macroeconomic projections, and establishes budget ceilings for each government sector over the remaining years in the current Medium-Term Expenditure Framework (MTEF). The BROP 2022 set respective health sector budget ceilings for FY 2023/24, FY 2024/25, and FY 2025/26 of KES 148 trillion, KES 158 trillion, and KES 167 trillion, which correspond to 6.6%, 6.4%, and 6.3% of projected total ministerial expenditure over these coming years (National Treasury 2022).

Kenya Health Sector Transition Roadmap. The Roadmap outlines strategies to transition predominately donor-funded health services—such as TB, HIV, and malaria—to domestic sources, as external funding for these services is slated to decline. The document refers to county health budgets as a source of "immediate transitional financing" for TB, for which domestic financing requirements are expected to nearly double from KES 0.9 billion to KES 1.7 billion over 2023–2029 (MOH 2022).

Kenya Universal Health Coverage Policy 2020–2030. The Universal Health Coverage Policy seeks to "ensure that all Kenyans have access to essential quality health services without suffering financial hardship" by increasing access to health services; ensuring that health services are efficient, safe, timely, acceptable, and effective; improving financial risk protection; and making the health system more responsive to emerging threats. Multiple policy strategies in the document underscore the need to increase county government investments in key system inputs, such as human resources for health and health products and technologies (MOH 2020).

Kenya Health Financing Strategy 2020–2030. Kenya's Health Financing Strategy charts a 10-year vision to enhance domestic resource mobilization to the health sector, advance risk pooling through the establishment of the Social Health Insurance Fund and voluntary health insurance mechanisms, and align health purchasing mechanisms to equity and efficiency. Notably, the Strategy seeks to establish county-level health funds that ring-fence 100% of government health allocations at this level by 2030 (MOH n.d.).

National Strategic Plan for Tuberculosis, Leprosy and Lung Health, 2019–2023. The NSP 2019–2023 prioritizes enhancing quality of care; improving TB screening and treatment; and integrating services for the three diseases into the UHC Essential Benefits Package and National Health Insurance Fund. To close its annual funding gap, the NSP recommends increasing domestic resource mobilization, integrating services into financial risk protection schemes, and mobilizing additional donor funds (NTLD-P 2019).

Kenya Health Financing System Assessment, 2018. This assessment examines how health financing trends are predicted to be affected by devolution; the National Hospital Insurance Fund as a means to advancing the country towards universal health coverage; private sector engagement in the health sector; and prospects for increasing resource mobilization to health from public sources. National and county government budgets are noted as primary sources of funds for declining donor-financed vertical programs (Dutta et al., 2018).

Is Kenya Allocating Enough Funds for Healthcare? Findings and Recommendations from National and County Budget Analyses. The policy brief presents the results from a national- and county-level health budget analysis. One of the recommendations from the brief is to build county health officials' capacity in planning and budgeting as a means to improving resource allocation (HP+ 2021a).

Strengthening Stewardship and Implementation of Kenya's Health Policy and Financing Agenda. The brief provides a synopsis of Kenya's free maternal health care initiative, Linda Mama; county governments' shift from line-item to program-based budgeting; and reinstatement of the national budget line item for HIV commodities. To accelerate the transition from line-item to program-based budgeting in the health sector, the Kenya School of Government, Health Policy Project, and Health Policy Plus Project developed a program-based budget curriculum and trained government staff in 26 counties on the curriculum. More detail on this capacity-building process is covered in *Building the Capacity of 12 Counties in Program-based Budgeting* (HP+ 2021b, HP+ 2016).

The Journey to Universal Health Coverage: How Kenya Managed the Inclusion of Disease Programmes in its Health Benefits Package. The case study assesses the process the country followed to develop and prioritize entitlements within its harmonized health benefits package, analyzes enabling factors during this process, and summarizes potential challenges the country may face in future efforts to refine the package. Some respondents interviewed for the case study revealed that, because the transition from donor to domestic funds for vertical programs (such as TB) will not happen in the near term, including these services in the HBP is not an immediate priority (Chi & Regan 2021).

OBJECTIVES

To address the key information gaps discussed in the previous section, the general objective of this assessment was to examine the planning and budgeting processes for TB in Kenya at the county level via the following specific objectives:

- Understand the prescribed county government planning and budgeting processes that are relevant to county TB sub-programs following devolution.
- Assess the nature and level of participation of county TB coordinators in these processes.
- Identify the challenges in county planning and budgeting processes affecting the financial viability and autonomy of county TB sub-programs.
- Describe cross-cutting governance issues affecting effective budgeting and planning for TB at the county level.

METHODS

The findings for this assessment were generated through qualitative research. Following a desk review, the assessment team performed key stakeholder informant interviews in five counties—Busia, Mombasa, Nairobi, Tana River, and Turkana—that were selected following the process discussed in the next section.

COUNTY SELECTION

The NTLD-P, USAID Kenya Mission, and HS4TB participated in the process for selecting five counties for the assessment. Nairobi was chosen due to its strategic and political significance. To select the remaining four, counties were assigned a preference score based on five criteria: general county government budget per capita; county health budget as a share of the general county budget; general county budget absorption rate (expenditure as a share of budget); county health budget absorption rate; and TB case notification per 100,000 people.

The scoring and thresholds were developed with the following rationale: preference (lower scores) was given to counties with a relatively high county government budget per capita, low general county budget absorption rates, low percentage of county budget allocated to health, low health services budget absorption rate, and high TB case notification rates per 100,000. Counties with a high county budget per capita and low general county budget absorption rate were preferred (and received the lowest scores) because they have greater unused budgets that can be allocated to TB. Similarly, counties with the lowest health budget absorption rates were preferred as they still have room to optimize spending their health services budget and may be open to increasing TB's share of the health budget. Also, counties with a lower percentage of the county budget allocated to health are preferred as budget increases for vertical health programs tend to be more difficult to secure when budgetary decision makers perceive that the health budget is already high. Lastly, counties with high TB case notification rates were preferred as they are most likely to benefit from increased funding in the budget for TB. Counties with a preference score lower than 60% were eligible for selection. The four remaining counties were selected from the list of eligible counties based on political significance and geographic dispersion.

DATA COLLECTION

A desk review of CIDPs, CDOH AWPs, county budgeting guidelines, county program-based budgets (PBBs), and other key documents was conducted (see the desk review findings below for details about these documents and how they relate to each other). HS4TB, in collaboration with NTLD-P, developed two separate standardized key informant interview (KII) questionnaires for county TB coordinators (annex A) and other key informants (annex B). Next, 27 KIIs were conducted jointly by NTLD-P and HS4TB with county TB coordinators, county directors of health, county health planners, heads of budget and planning at county treasuries, members of county TB technical working groups (TWGs), and MOH & NTLD-P officials.

DATA ANALYSIS

The assessment team analyzed the KII responses using thematic coding, whereby similar responses were assigned common themes and aggregated. Themes were then shortlisted for inclusion in this report based on their frequency and pertinence to the assessment objectives as well as the findings from the desk review.

FINDINGS

DESK REVIEW FINDINGS

Devolution is established in the 2010 Constitution of Kenya by the creation of a new governance structure that includes 47 semi-autonomous subnational governments known as counties (GOK, 2010). Devolution introduced new sets of actors, including the county assembly, which is responsible primarily for approving county development planning and budgets, and the county executive committee, which is responsible for supervising the administration and delivery of services in the county and all decentralized units and agencies within the county.

With the establishment of county governments in 2012, CDOHs became responsible for leading priority-setting, planning, and resource allocation (PSRA) for health, in line with the functions prescribed under the Fourth Schedule of the Kenyan Constitution (GOK, 2012a). Anchored in the Public Finance Management Act of 2012, the PSRA processes prescribe a continuum of critical activities and requirements to facilitate priority-setting, resource allocation, budget alignment with existing resource envelopes, legislation, and budget execution (GOK, 2012b).

The national government is responsible for coordinating and engaging with counties to ensure that national health priorities (including those for TB) are adequately reflected in county-level planning documents such as those discussed in further detail in table 1. The national government also supports counties by issuing guidance, formulating policy, supporting capacity building initiatives as needed, enforcing quality and standards control, conducting performance reviews, and other functions.

Table 1 distills the key steps of the detailed county-level planning and budgeting process for a TB audience. While not part of this annual planning and budgeting process, each county's five-year CIDP serves as an important reference document to inform the prioritization of activities and budget advocacy

in all steps. Prepared every five years, the CIDP establishes the medium-term development priorities for the county and is sector-wide (i.e., not specific to health). The CIDP sets priorities down to the sub-program level, which is where TB sits. CIDP development follows four major steps: (1) technical and public consultations and identification of priorities, (2) costing of medium-term priorities and submission of resource requirements, (3) consolidation of draft plans by sector, and (4) validation and finalization of the draft plans. Step 2 generates 5-year budget projections for each sector. CIDP sectoral budget projections often differ from those in the MTEF, *County Budget Review Outlook Paper* (CBROP), and *County Fiscal Strategy Paper* (CFSP), as the CIDP projections reflect proposed resource requirements by sector while those in the latter three documents are calculated by the National Treasury as a function of expected medium-term revenues (see table 1 for descriptions of the MTEF, CBROP, and CFSP). CIDP budget projections are not provided below the sector level (i.e., for TB).

Table 1. Key Steps in the Annual County-Level TB Planning and Budgeting Process

Step 1: County Treasury Releases Budget Circular	
Date	August 30 prior to the relevant fiscal year
Description	The budget circular sets priorities for the coming fiscal year. Priorities can be set at the sub-program (i.e., TB) level. The budget circular does not include any budgetary information, including budget ceilings.
Advocacy Audience	County Treasury
TB Advocacy Objective	Convince the Treasury to include specific TB interventions in the budget circular so that circular can serve as an advocacy resource later in the process.
Advocacy Priority Level[2]	Lower
Step 2: County Treasury Submits the CBROP to the County Executive Committee for Approval	
Date	September 30 prior to the relevant fiscal year
Description	The CBROP includes provisional budget ceilings for each sector. Budget ceilings are not set below the sector level, although they are disaggregated by recurrent vs. development expenditure. In addition to the provisional budget ceilings set for the upcoming fiscal year, the CBROP includes sectoral expenditure projections for the subsequent two fiscal years. Together, the provisional budget ceilings for the following year and expenditure projections over the subsequent two years constitute the MTEF. Each year, in advance of the September 30 deadline, the County Treasury can revise the next-year ceilings or subsequent annual expenditure values relative to the amounts from the previous year's CBROP. In developing these amounts each year, the County Treasury considers the health sector working group report. The health sector working group comprises sectoral department heads (including the County Director of Health), development partners, local actors such as civil society organizations (CSOs) and academic institutions, and private sector actors. In its report, the working group estimates programmatic resource gaps based on the

[2] In analysis, the assessment team assigned advocacy priority levels to each TB planning and budgeting process step based on the degree to which explicit funding decisions are typically made at the sub-program (i.e., TB) level vs. at higher (program or sector) levels within that step. Of course, the degree to which TB advocates should prioritize different process steps will vary as a function of each county's political economy. This table does not seek to capture these county-specific considerations and is instead supposed to provide a generic overview of where TB advocates should focus their advocacy efforts based on the assessment results.

	provisional health sector ceiling and may advocate for an increase to the ceiling.
Advocacy Audience	County Treasury
TB Advocacy Objective	Convince the County Treasury to increase the health sector budget ceiling for the following year, relative to the previous year's CBROP projection for the following year, at a level commensurate with the planned increase to the TB budget.
Advocacy Priority Level	Lower
Step 3: County Treasury Submits the CFSP to the County Assembly	
Date	February 28 prior to the relevant fiscal year
Description	The CFSP includes revised sector-level ceilings. The revised sector-level ceilings are developed based on feedback from the sector heads (including County Director of Health) and on a public hearing.
Advocacy Audience	County Treasury
TB Advocacy Objective	Convince the County Treasury to increase the health sector budget ceiling for the following year, relative to the previous year's CBROP projection for the following year or relative to the CBROP's health sector ceiling, at a level commensurate with the planned increase to the TB budget.
Advocacy Priority Level	Lower
Step 4: CDOH Drafts the AWP and PBB	
Date	March–April prior to the relevant fiscal year
Description	The AWP consists of four components: an overview of the county's health sector situation, a summary of the county's key health challenges alongside interventions intended to address the challenges, a quarterly program-based implementation plan, and the PBB. The AWP includes both county government-funded and donor-funded activities. The PBB lists proposed allocations by sub-program, including TB, which can be in the Special program or Preventive & Promotive Care program, depending on the county. There are four programs in the PBB. Several other sub-programs in addition to TB are included in its program. A selected drafting team is responsible for reviewing and validating the draft AWP while the County Director of Health provides final approval.
Advocacy Audience	Selected drafting team, County Director of Health
TB Advocacy Objective	Convince the drafting team and County Director of Health to include the increased TB budget in the AWP's PBB.
Advocacy Priority Level	Higher
Step 5: County Health Management Team (CHMT) Submits the AWP and its PBB to the County Treasury	
Date	April prior to the relevant fiscal year
Description	The CHMT is an oversight body sitting at the top of the CDOH and is composed of the County Director of Health, County Executive Committee Member, and County Chief Officer of Health. The TB Coordinator typically has regular access to the County Director of Health via weekly meetings between the Director and the sub-program heads. The team can revise the PBB at the sub-program level and therefore can reduce the proposed budget for TB.
Advocacy Audience	CHMT

TB Advocacy Objective	Defend the proposed TB budget or advocate to increase the TB budget originally proposed to the CHMT.
Advocacy Priority Level	Higher
Step 6: County Treasury Submits Budget Estimates to County Assembly	
Date	April 30 prior to the relevant fiscal year
Description	The Treasury uses the sectoral AWPs and PBBs to develop budget estimates, disaggregated at the program level; therefore, at this stage, the TB budget estimates are consolidated with the other sub-programs in the program to which TB belongs. In a separate section of the document, the budget estimates list target outputs at the sub-program level, such as percentage of TB patients tested for HIV, percentage of TB patients who completed treatment, and number of newly diagnosed TB cases.
Advocacy Audience	County Treasury
TB Advocacy Objective	Convince the Treasury to submit the program budget to the County Assembly at the value presented in the health AWP.
Advocacy Priority Level	Moderate
Step 7: County Assembly Approves Budget	
Date	June 30 prior to the relevant fiscal year
Description	The County Assembly considers the budget estimates document and may revise amounts at the program level, at their discretion, before providing final approval via the passage of the County Appropriation Bill.
Advocacy Audience	County Assembly, especially Health and Budget Committees
TB Advocacy Objective	Convince the County Assembly to approve the program budget, in which the TB sub-program sits at the value previously proposed in the health sector AWP.
Advocacy Priority Level	Moderate
Step 8: Preparation of Supplementary Budget Estimates for Submission to Treasury	
Date	July–August of the relevant fiscal year
Description	The County Treasury accepts submissions of supplementary budget estimates during the first two months of the fiscal year. Budget estimates are listed at the program level. The CDOH Budget Team is responsible for relaying supplementary budget estimates from programs to the CHMT for approval.
Advocacy Audience	CHMT
TB Advocacy Objective	In cases where the approved program budget in which TB sits is lower than that in the AWP, convince the CHMT to submit a request for supplemental budget.
Advocacy Priority Level	Moderate
Step 9: Preparation of Budget Requisitions from the CDOH to the County Treasury	
Date	July 1–June 30 of the relevant fiscal year
Description	To initiate the process of mobilizing funds for TB during budget implementation, the TB Coordinator first submits a request for funds, per the disbursement calendar in the health sector AWP, to the CDOH Chief Officer of Health. Upon reviewing the request, the Chief Officer submits a budget requisition for the TB activity/activities to the County Treasury.
Advocacy Audience	Chief Officer

TB Advocacy Objective	Convince the Chief Officer to submit TB budget requisitions per the AWP disbursement calendar and at the listed funding amount
Advocacy Priority Level	Higher
Step 10: Release of Funds from County Treasury	
Date	July 1–June 30 of the relevant fiscal year
Description	The Director of Budget at the County Treasury reviews and verifies CDOH budget requisitions. If the budget requisition documentation is in order and there are sufficient revenues within the County Revenue Fund (CRF) (each county's account into which own-source revenues and fiscal transfers from the central level are consolidated), then the Treasury releases funds at the requested amount from the CRF to the CDOH's Operational Account for expenditure on the corresponding TB activity/activities. While TB coordinators can track county government spending via the Integrated Financial Management System, the system only tracks expenditures down to the program level. As a result, TB coordinators must manually track executed budget requisitions for TB to compare spent against approved budgets.
Advocacy Audience	Director of Budget, County Treasury
TB Advocacy Objective	Convince the Director of Budget at the Treasury to release funds to the CDOH for the corresponding TB activity/activities per the AWP disbursement calendar and at the listed funding amount.
Advocacy Priority Level	Higher

Sources: HP+ 2017, conversations with two anonymous County Treasurers

KEY INFORMANT INTERVIEW FINDINGS

County-level TB Planning

TB activities in county health AWPs tend to be ignored in favor of development partner work plans. Development partners account for the majority of TB funding at the county level. However, according to key informants, there is little alignment between partner TB work plans and TB activities in county health AWPs. For instance, stakeholders feel that TB activities and budgets are sometimes "forcibly linked" to those of HIV activities and budgets as a result of donors. TB coordinators are therefore left to deprioritize and often ignore many of the activities in their county health AWPs while putting development partners' priority interventions first.

As county-level decision makers view TB as a donor-funded program, TB interventions do not receive sufficient attention in CIDPs. CIDPs do not adequately reflect the short-term and long-term priorities of the TB sub-program, according to key informants. In one county, late submission of inputs from the TB coordinator caused the sub-program to be deprioritized in the CIDP. All of the TB coordinators interviewed have been involved in the first two stages of CIDP development (technical and public consultations and identification of priorities; costing of medium-term priorities and submission of resource requirements), while only some have been involved in the final two stages (consolidation of draft plans; validation and finalization of draft plans).

County-specific TB NSP "implementation frameworks" would be suitable alternatives to TB strategic plans. Key informants were asked about their awareness of TB strategic plans at the county level. Only one TB coordinator indicated that such a strategic plan existed in their county, but it is possible the coordinator was referring to the NSP as the County Director of Health in that county was not aware of a county TB strategic plan having been developed. NTLD-P has not explicitly asked TB coordinators to develop TB strategic plans, instead preferring county-tailored "implementation frameworks" of the NSP. County Directors of Health would likely prefer NSP implementation frameworks to strategic plans as well, as they had concerns about the proliferation of strategic plans specific to each sub-program and the implications it would have on administrative workload during annual county planning processes. One CDOH officer felt that the CIDP was the appropriate planning document in which TB activities could be included. Respondents felt that insufficient guidance is available on how to develop these types of implementation frameworks and that counties lack the financial resources to source technical assistance in this area.

County-Level Budgeting for TB

The role of TB coordinators in budget preparation is weak; while involvement is stronger in the budget approval stage, their role here is quite passive. The majority of TB coordinators interviewed have not been involved in generating annual CDOH budget estimates (step 4 in table 1). Most of the TB coordinators stated that they coordinate with program officers to conduct resource mobilization efforts, but whether such efforts were targeting county government vs. donor funds was unclear. Some TB coordinators claimed that they are not involved in the legislative approval stage of the process (step 7 in table 1) unless the County Assembly calls upon them to clarify questions about the proposed budget, while one TB coordinator has actively pursued meetings with members of the County Assembly to defend the budget for TB. A member of the NTLD-P noted that "the success of TB budget allocation at the county level highly depends on the ability of CDOH to canvas at the county meeting [with people] like the Chief Executive Minister of the County and County Assembly [members]," suggesting that enhanced coordination of advocacy efforts with the County Director of Health may be a successful tactic for defending TB budget increases during the legislative approval phase. TB coordinators' advocacy efforts to County Treasuries during the budget preparation and approval stages (steps 1–7) are non-existent, according to respondents. TB coordinators also require familiarity with steps that occur after the budget has been approved. The TB coordinators who responded to the question indicated that they have minimal to no knowledge of the overall county budget implementation process (steps 8–10). However, most of the TB coordinators stated that they are familiar with the process of requisitioning TB allocations during budget implementation.

The TB coordinators interviewed agreed that county TB sub-programs are heavily underfunded. While respondents felt that all TB expenditure categories are underfunded, the most severely underfunded categories were shown to be commodities, preventive activities, and contact tracing. There were mixed responses from respondents regarding whether county government budgets currently constitute a significant share of TB financing, while the majority of respondents felt that off-budget donor contributions to TB constitute a significant share. Table 2 displays the funding sources across TB expenditure categories, according to respondents. Respondents did not have clear perspectives on which funding source is most appropriate for each expenditure category, whether currently or in the future as donor support declines. Respondents felt that health insurance does not

constitute a significant share of TB financing. Key informant interviews revealed the following reasons for the underfunding of county TB sub-programs:

- ***Decision Makers' Perceptions***. As mentioned above, decision makers view TB as a donor-funded sub-program and therefore have little incentive to increase county government funding to the sub-program.
- ***Low Absorptive Capacity***. This is discussed in the paragraph below.
- ***Weak Advocacy Expertise***. TB coordinators' advocacy efforts, if they exist, tend to be more passive than proactive, as indicated previously in this report.
- ***Misalignment of Donor Funds***. Despite the range of donors financing TB programming at the county level, little donor funding supports TB activities in county health AWPs. While a few financial partners based at the county level are involved in AWP development and the Kenyan fiscal year often does not align with financial partner program years, respondents stressed the need for involving more partners in the AWP development process.
- ***Fiscal Space Constraints***. The national government has declared droughts and hunger as national emergencies in certain counties, which has resulted in significant reductions in, or, in the worst case, total dissolution of, TB budgets. One County Health Planner noted that "the issues to address are so many [and] the funding remains scarce. We also have insecurity, we also have severe drought and malnutrition, and even MOH had to contribute some funds to food insecurity. Hence, it is difficult now to justify why we need more money for TB."

Table 2. Funding Sources by TB Cost Category

Category	Sources
Purchase of anti-TB medicines	MOH, donors
Purchase of TB diagnostic commodities	County governments, MOH, donors
Salaries of TB clinical staff	County governments, donors
Salaries of TB public health staff	County governments
Payment of stipends for community health volunteers	County governments
Supportive supervision, monitoring and evaluation (M&E), review meetings (including data quality audits)	County governments, MOH, donors
Trainings and mentorship	County governments, MOH, donors
Activity budgets for TB public health activities, such as active case finding, private provider engagement, or contact investigation	County governments, MOH, donors

Low absorptive capacity of county government funds budgeted for TB also explains the severe underfunding of county TB sub-programs and more broadly threatens the longer-term financial viability of TB sub-programs. County Treasuries indicated that they anchor TB budget allocations based on previous allocations and expenditures. Because Treasuries do not award new funding to programs or sub-programs demonstrating an inability to spend down approved funds from previous years, county TB sub-programs' low absorptive capacity has impeded the expansion of county government TB budgets. The main reasons respondents cited for low absorptive capacity are:

- ***Misalignment between Allocated and Disbursed County Health Funds***. Similarly, during budget implementation, county health sector funds are often reprioritized to other purposes within the CRF.
- ***Delays in Intragovernmental Transfers to CRFs***. These delays result in lower disbursements from CRFs to county health sectors and, as a result, the county TB sub-program. County Treasuries accordingly engage in rationing behaviors when receiving budget requisitions from different sub-programs and have a tendency to favor other sub-programs over the TB program. One County Health Planner indicated that donors have stepped in to cover sub-program expenses, which are seldom fully funded by CRF disbursements: "Our annual budget is KES 180 million but we only get like KES 2 million; hence, we rely too much on donors. So, we do AWPs with stakeholders, and partners usually… fund the deficits because GOK rarely funds the total amount, so lots of activities are not done due to shortages of funds." Transfer delays as described by this respondent are common in other counties, as all county governments receive each equitable share disbursement at the same time. However, a significant portion of committed equitable share funds are transferred on time throughout the year and constitute a potential source of potential increases to county-level TB funding. The graph in figure 1 illustrates this trend, where the majority of committed equitable share funds were available to CRFs in any given quarter throughout FY 2021/22.

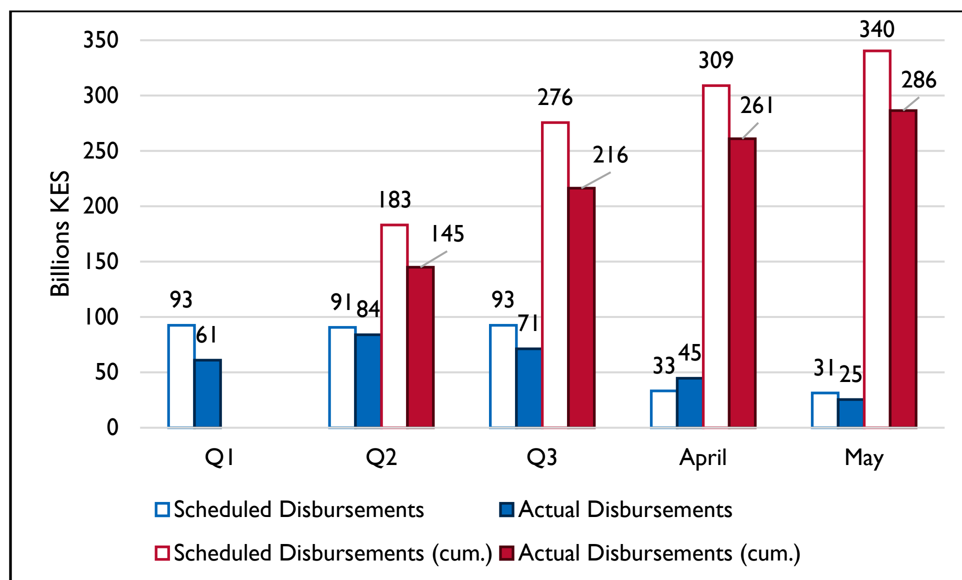

Figure 1. Scheduled and Actual Transfers of Equitable Share Revenue from National Treasury to CRFs, FY 2021/22

Source: Parliament of Kenya 2022

Respondents proposed a diverse range of approaches for reducing the resource gap faced by county TB sub-programs. These included enhancing TB coordinators' understanding of the county budget process, including budget advocacy activities in county health AWPs, realizing cost efficiencies through integrating TB with other vertical programs, exploring public-private partnerships,

strengthening TB stakeholder engagement mechanisms, digitizing revenue and expenditure tracking systems, and integrating screening and treatment services into the NHIF benefits package.

Cross-cutting Governance Issues

Most of the interviewed TB coordinators' planning and budgeting roles are clearly defined in the CDOH organogram. In one of the other counties, the CDOH organogram is still awaiting legislative approval. Having clearly articulated roles in planning and budgeting is important for TB coordinators to justify time and attention spent on these efforts. However, the TB coordinators interviewed all felt that their broad programmatic roles are well-supported within the organogram. In addition, most of the TB coordinators have a clear job description or terms of reference.

None of the TB coordinators interviewed received training on any of the budget and planning process capacities presented. These capacities are knowledge of the county budget and planning process, evidence-based planning and advocacy, resource mobilization, and resource tracking. Moreover, among the TB coordinators, County Health Planners, and County Directors of Health interviewed, only one respondent—a County Health Planner— acknowledging having received any training in evidence-based planning and advocacy and resource tracking. This suggests that capacity-building activities focused on TB planning and budgeting could be included as part of a broader training package targeting a range of officials in CDOHs.

Collaboration between TB coordinators and NTLD-P is generally sufficient, but room for improvement exists with respect to collaboration between County Directors of Health and TB coordinators. County health and TB officials generally feel that their level of collaboration with the NTLD-P on planning and implementation of priority TB interventions is adequate. Many respondents felt that they are given sufficient space to share county-level TB issues with the NTLD-P and that they receive solid training, mentorship, and guidance from the NTLD-P on new interventions. At the county level, collaboration between the County Directors of Health and TB coordinators (who sit in the CDOH) is weaker, where the County Directors interviewed feel that they do not have sufficient engagement with TB coordinators and lack information on which TB activities should be prioritized and on funding bottlenecks in the TB sub-program. However, TB coordinators have regular access to County Directors through weekly CDOH staff meetings.

Most of the counties have TB stakeholder forums, but associated costs are covered by donors. In most of the counties with such forums (also referred to as TWGs), sub-county and private sector representatives are members. County Health Management Teams, CSOs, GeneXpert Task Force members, laboratory and/or pharmacy representatives, associations, and nurses-in-charge are members in two counties. Development partner representatives are members in each county. Stakeholder forums typically meet quarterly, and more frequent stakeholder forums are organized at the sub-county level. Respondents feel that TB stakeholder forums are instrumental in planning, priority-setting within AWPs and CIDPs, and conducting TB programmatic reviews. Most forums discuss strategies to increase TB financing and lead TB budget advocacy efforts; forum members support the MTEF development process in two of the counties with such forums. Development partners fund forums on a rotational basis. Recent experience from the one county without such a forum underscores the need for domestic financing of these forums: "We have not been meeting, did not have funding, [and

there is] no allocation for [the] TWG. As [a] TWG, we plan to meet early next month and we plan to be meeting twice every quarter."

RECOMMENDATIONS

Based on the findings from this assessment, the following recommendations should be considered by county TB coordinators, NTLD-P, and their development partners:

1. **Foster alignment between donors' work plans and TB activities in county health AWPs**. As donors will likely continue to be the dominant funding source for TB interventions at the county level in Kenya until county TB budgets increase (and remain an important payer thereafter), it is critical that their activities are in alignment with TB activities in county health AWPs, especially activities funded off-budget. Otherwise, county TB sub-programs will continue to prioritize supporting donor-led activities over those in county health AWPs. As part of this alignment, there should be greater clarity regarding which aspects of the TB response will shift from being financed externally to domestically and when that will occur. TB coordinators can pursue the following options to promote greater cohesion between work plans:

    - ***Elevate county AWP-donor work plan alignment within TB stakeholder forum/TWG meeting discussions***. As partners already tend to be members of these forums, meetings serve as a natural environment to build momentum around work plan alignment. Forum members can go a step further to make work plan alignment a standing agenda item for meetings or even create a subcommittee focused on the issue.
    - ***Convene donors in co-creation workshops***. TB coordinators can invite donors to in-person or virtual meetings in which development partners' work plans are co-created via live discussion with TB coordinators.
    - ***Include TB coordinators in donor grant proposal development***. If implementing partners consult TB coordinators to ensure that the programmatic priorities they are proposing are in alignment with existing or planned TB priorities in county health AWPs, then consequent development partner work plans are more likely to be aligned with these AWPs.
    - ***Encourage or require TB donors to sign Memoranda of Understanding (MOUs)***. In some counties, partners have signed MOUs requiring partners to prioritize TB activities in their work plans, which supports TB priorities in county health AWPs and envisaged for future AWPs. To scale this approach, NTLD-P should secure buy-in from donors at the central level and then roll out the approach in individual counties in partnership with financial partners.

2. **Formulate medium-term advocacy plans at the county level with a view to shifting county decision makers' perception of TB as a donor-funded program.** The assessment revealed that a main source of a number of the challenges faced in TB planning and financing is that TB is viewed as a donor-funded rather than a government-funded sub-program. This perception impedes advocacy efforts to increase county TB budgets and orients county health officials towards activities in development partner work plans at the expense of those in county health AWPs. Once County Directors of Health, key County Assembly members, and County Treasuries understand the value of investing county government funds in TB—at a time when donor funds are slated to decline—and are convinced of how scaling up TB interventions advances their particular health care, political, and socioeconomic development agendas, annual budget advocacy efforts targeting these

audiences will be more successful. The consequent gradual rise in county TB budgets as a share of total TB financing at the county level would then serve as important leverage in efforts to secure a more prominent position for county TB activities in CIDPs and result in increased prioritization of TB activities in county health AWPs relative to development partner work plans.

3. **Promote increased understanding of the budget process among TB coordinators**. While the previous recommendation will foster a more conducive environment for county government investments in TB to increase, TB coordinators will still need to assume a more active role in advocating at different stages within the budget process to ensure that TB allocations and disbursements increase. To perform these annual planning, budgeting, and advocacy activities, TB coordinators must understand not only the formal county budget process but also the key advocacy windows during which they should intervene (and with what evidence). The aim of table 1 is to address some of these key knowledge gaps. As TB coordinators have limited time to conduct advocacy and resource mobilization activities in addition to their existing scope of work, they will need to prioritize the steps at which they choose to intervene to defend their budget or advocate for an increase. The priority steps will vary as a function of unique political economy considerations within each process (i.e., at which step the TB budget is regularly being cut). However, the desk review findings suggest that advocacy efforts targeting steps 4–5 and 9–10 should be prioritized in most settings as these are the points at which budget allocations specific to TB are most explicitly being made (as opposed to decisions at higher levels, i.e., program or sector level).

4. **Build TB coordinators' capacity in financial analysis, costing, priority setting, and evidence-based budget advocacy**. TB coordinators indicated that they have received no training in these areas even though they will need the skills to adequately lead the activities covered in the first two recommendations in this section. Training modules should be developed for each of these areas and added to the Digital Academy platform. Subsequently, in-person training events should be held with TB coordinators in each county using these modules. As some of the TB coordinators interviewed stated that their roles in planning and budgeting are not clearly defined within the CDOH organogram, it is important for these roles to be explicit—whether in the organogram or in their job description/terms of reference—so TB coordinators feel empowered to take a leadership role in financial management and planning.

5. **Train TB coordinators on developing county-level TB NSP implementation frameworks**. TB coordinators claimed that they do not have the expertise required to develop and cost TB NSP implementation frameworks, which are essential for establishing the medium-term programmatic vision for TB interventions in a given county and are useful for priority-setting for, and costing TB activities in, health sector AWPs. Further, having a TB NSP implementation framework could elevate the status of the TB sub-program within the CIDP and justify enhanced engagement from TB coordinators during the final two stages of CIDP development (consolidation of draft plans; validation and finalization of draft plans), where TB coordinators tend to be less involved and TB sub-programs are at risk of further deprioritization.

6. **Transition funding of TB stakeholder forums from donors to domestic sources.** Findings from the key informant interviews showed that TB stakeholder forums are instrumental in planning, priority-setting within AWPs and CIDPs, and conducting TB programmatic reviews and also have

the potential to positively influence TB financing at the county level. However, as the interviews revealed, these forums go in and out of existence with the ebb and flow of financial support from donors. County governments seem like a logical funding source for TB stakeholder forums as they already constitute a common source for other meeting costs.

REFERENCES

1. Chi, Y-Ling & Regan, L. 2021. *The Journey to Universal Health Coverage: How Kenya Managed the Inclusion of Disease Programmes in its Health Benefits Package*. Center for Global Development. Available: https://www.cgdev.org/sites/default/files/Journey-to-uhc-Kenya.pdf
2. Dutta, Arin et al. 2018. *Kenya Health Financing System Assessment, 2018: Time to Pick the Best Path.* Washington, DC: Palladium, Health Policy Plus. Available: http://www.healthpolicyplus.com/pubs.cfm?get=11323
3. Global Fund. 2020. *Funding Request TB/HIV - 2020*. Geneva: Global Fund.
4. Government of Kenya (GOK). 2012a. *County Governments Act No. 17 of 2012*. Nairobi: National Council for Law Reporting. Available: http://www.parliament.go.ke/sites/default/files/2017-05/CountyGovernmentsAct_No17of2012_1.pdf
5. Government of Kenya (GOK). 2012b. *Public Financial Management Act No. 18 of 2012*. Nairobi: National Council for Law Reporting. Available: http://www.parliament.go.ke/sites/default/files/2017-05/Gazette_Notice_Vol._No._CXVII___No._26.pdf
6. Government of Kenya (GOK). 2010. *The Constitution of Kenya*. 2010. Nairobi: National Council for Law Reporting. Available: http://www.parliament.go.ke/sites/default/files/2017-05/The_Constitution_of_Kenya_2010.pdf
7. Health Policy Plus (HP+). 2021a. *Is Kenya Allocating Enough Funds for Healthcare? Findings and Recommendations from National and County Budget Analyses.* Washington, DC: Palladium, Health Policy Plus. Available: http://www.healthpolicyplus.com/ns/pubs/18441-18879_KenyaNCBABrief.pdf
8. Health Policy Plus (HP+). 2021b. *Strengthening Stewardship and Implementation of Kenya's Health Policy and Financing Agenda*. Washington, DC: Palladium, Health Policy Plus. Available: http://www.healthpolicyplus.com/ns/pubs/18558-18984_LegacyImpactBriefKenya.pdf
9. Health Policy Plus (HP+). 2017. *How County Health Leadership Can Influence County Budgets*. Washington, DC: Palladium, Health Policy Plus. Available: http://www.healthpolicyplus.com/ns/pubs/7152-7272_KenyaCountyPoster.pdf
10. Health Policy Plus (HP+). 2016. *Building the Capacity of 12 Counties in Program-based Budgeting*. Washington, DC: Palladium, Health Policy Plus. Available: http://www.healthpolicyplus.com/ns/pubs/2039-2064_PBBKenyaCountries.pdf
11. McDade, Kaci et al. 2021. *Reducing Kenya's Health System Dependence on Donors*. Brookings. Available: https://www.brookings.edu/blog/future-development/2021/03/02/reducing-kenyas-health-system-dependence-on-donors/
12. Ministry of Health (MOH). 2022. *Kenya Health Sector Transition Roadmap*. Nairobi.

13. Ministry of Health (MOH). 2020. *Kenya Universal Health Coverage Policy 2020–2030*. Nairobi. Available: http://guidelines.health.go.ke:8000/media/Kenya_Universal_Health_Coverage_Policy_2020__2030.pdf
14. Ministry of Health (MOH). 2018. *The First Kenya Tuberculosis Patient Cost Survey 2017*. Nairobi. Available: https://www.chskenya.org/wp-content/uploads/2018/07/TB-Patient-Cost-Survey-2018.pdf
15. Ministry of Health (MOH). N.d. *Kenya Health Financing Strategy 2020–2030*. Nairobi.
16. National Treasury. 2020. *Commitment Letter for Counterpart Financing under Global Fund Grants for the Next Grant Implementation Period (July 1, 2021; June 30, 2024)*. Nairobi, Kenya.
17. National Treasury. 2022. *2022 Budget Review & Outlook Paper*. Nairobi. Available: https://www.treasury.go.ke/wp-content/uploads/2022/12/2022-Budget-Review-and-Outlook-Paper.pdf
18. National Tuberculosis, Leprosy, and Lung Disease Program (NTLD-P). 2023. Estimates shared by NTLD-P.
19. National Tuberculosis, Leprosy, and Lung Disease Program (NTLD-P). 2019. *National Strategic Plan for Tuberculosis, Leprosy, and Lung Health, 2019–2023*. Nairobi. Available: https://nltp.co.ke/national-strategic-plan-2019-2023-3/
20. Office of the Controller of Budget (OCOB). 2022. *County Governments Annual Budget Implementation Review Report for the FY 2021/22*. Nairobi. Available: https://cob.go.ke/reports/consolidated-county-budget-implementation-review-reports/#
21. Parliament of Kenya. 2022. Report of the Standing Committee on Finance and Budget on the County Governments (Equitable Share) Cash Disbursement Schedule for Financial Year 2022/23. Nairobi. Available: http://www.parliament.go.ke/sites/default/files/2022-08/Report-%20county%20government%20%28equitable%20share%29%20cash%20disbursement%20schedule%202022-2023.pdf
22. Republic of Kenya (ROK) & Ministry of Health (MOH). 2022. National and County Budget Analysis FY 2020/21. Nairobi. Available: http://guidelines.health.go.ke:8000/media/National_and_County_Budget_Analysis_FY_2020-21_April_2022.pdf

ANNEX A. TB COORDINATOR KEY INFORMANT INTERVIEW GUIDE

Strengthening the Sustainability of Kenya's TB Response:

An Assessment of County-Level Engagement in the Planning and Budgeting Processes

Interview Guide for TB Program Coordinators at the County Level

Introduction

Tuberculosis is one of the health programs (alongside Malaria and HIV), that have traditionally relied on donor funding for both program implementation and purchase of commodities. However, with Kenya attaining a lower middle-income status, it has become imperative to put more emphasis on domestic sources for funding TB and progressively transitioning from donor dependence. The National Tuberculosis, Leprosy and Lung Disease Program (NTLD-P), with technical assistance from the USAID Health Systems for Tuberculosis (HS4TB) project, is using this assessment tool to collect qualitative data on the state of county health financing and Public Financial Management (PFM) issues that may impact on services delivery and financing of TB interventions in the target counties (Mombasa, Turkana, Busia, Nairobi, Tana River). Findings of this assessment will be used to jointly develop a capacity building plan which leverages on opportunities within the 2012 PFM Act to enhance county financing for TB and health. Responses will be confidential and submitted anonymously.

Respondent Details:

Name:

Designation:

- TB Coordinator
- County Director of Health
- Chief Officer for Health
- County Health Planning coordinator

How long have you been in this position?

County/Institution

- Busia
- Mombasa
- Nairobi
- Tana River
- Turkana

Date of Interview:

Start Time:

End Time:

Now we request to get your views regarding TB programming at the county on three areas: Planning process, Budgeting process, and Governance framework.

Planning Process

1. At your level of the planning and budgeting process (e.g., county level), do you undertake TB planning and budgeting for (a) government funding; and/or (b) donor funding? Please answer the following, first for government TB planning and budgeting, and then for donor TB planning and budgeting:
    - What are the major budget categories that you use?
    - Which are the most and least significant budget categories in terms of total budget amount?
    - Are any of those budget categories chronically underfunded? Which ones?
2. Counties are required to undertake long and medium-term planning through preparation of 10 year sectoral plans and the 5-year County Integrated Development Plans (CIDP). What specific role(s) do you play in each of the steps below?
    - Stage 1: Technical/Public consultations and identification of priorities
    - Stage 2: Costing of medium-term priorities and submission of resource requirements
    - Stage 3: Consolidation of draft plans
    - Stage 4: Validation and finalization of the draft plans
    - any other
3.
    a) Did the previous CIDP (2018-2022) adequately reflect both short term and long-term priorities for the TB Program at the county level?
        - Yes
        - No

    b) If no identify some of the challenges experienced in the CIDP development process that may cause TB priorities to be overlooked.

    c) What are some of the best practices for including TB priorities in the CIDP?
4. Does the county have a TB-specific strategic plan?
    - Yes

- o No

5. **If no w**hat are some of the main challenges in the development of a TB-specific strategic plan for the county?
6. What are some of the best practices in the development of a TB-specific strategic plan for the county?
7. If there is a county TB strategic plan, to what extent does the county health Annual Work Plan(AWP) draw from the county TB strategic plan and CIDP?
8. Apart from TB-Specific plan and CIPD is there any other factors that inform TB program activities in the AWP?
9. Are there any challenges that arise in coordinating or aligning planning and budgeting across multiple sources of funding for TB? E.g., do the budget categories, timelines and processes differ for county, central MoH and donor funding? In what way?

10. In what areas do you collaborate with the NTLD-P on planning and implementation of priority interventions for TB? In your opinion, is this collaboration adequate? If not, what areas should be strengthened?

Budgeting process

Medium Term Expenditure Framework and Budget Process

1. The county budget preparation process is organized into four important stages. Could you describe how familiar you are with each of the four stages? What has been your role in each stage?
   - ☐ Priority setting and resource mobilization
   - ☐ Preparation of budget estimates
   - ☐ Legislative approval
   - ☐ Budget Execution
2. What approaches have been effective in your county in maintaining or increasing the county government budget allocation to the TB programmes?
3. What are some of the challenges in the county process for budget allocation to the TB programme, and with the use of those funds? Are there any issues with:
   - ☐ Availability of timely funding information (resource mapping from donors and government) to inform the planning and budgeting process?
   - ☐ Timely disbursement of county TB funding and thus fund availability for timely TB program implementation?
   - ☐ Coordination of funding flows from different sources (central government, donors, and county governments)?
   - ☐ Utilization of disbursed funds at county level? If there is weak absorptive capacity, please describe the major causes of such low abortive capacity, and any issues with timely reporting of budget utilization.
4. Has there been any experience of allocating non-salary budgets from county government coffers for TB (e.g., for activities)? Are there any other programs and areas at the county level that

received such earmarked non-salary allocation? If yes, which programs receive significant activity budgets and what are the drivers and justifications of such allocations?

5. The county budget process offers multiple opportunities for programme managers and departmental heads to advocate for increased budget allocation to their programmes. What has been your experience in advocating for increased TB funding?
   b) In your opinion, how could your role or engagement in the annual planning and budgeting process be strengthened to ensure increased resource allocation for TB activities within the County?
6. In your opinion, on a scale of 1 to 3 (where 1= Effective, 2= somewhat effective and 3=not effective), how effective would the following interventions be to increasing the county government budget allocation to the TB program?

   - ☐ Including more TB interventions in the AWP
   - ☐ TB resource mobilization and advocacy planning
   - ☐ Improving transparency in the health sector budgeting process
   - ☐ Establishing TB specific sub-programme in the county health department programme based budget (PBB)
   - ☐ Strengthening TB stakeholder engagement mechanisms
   - ☐ Advocating for greater budget allocation with county treasury
   - ☐ Advocating for greater budget allocation with county executive
   - ☐ Advocating for greater budget allocation with county assembly

   Please explain the reasons for these choices.

7. Is TB a stand-alone sub-program in the AWP and PBB in your county?
   - o Yes
   - o No
8. If no, how do you think the TB interventions might better stand out within county planning and budgeting formats?
9. Approximately what proportion of costed TB activities in the AWP were fully funded by the county in the last financial year? *(Select one)*
   - o 100%
   - o 75%-100%
   - o 50%-75%
   - o 25%-50%
   - o Less than 25%
10. How does the county cater for the TB funding shortfall in the AWP? *(Select all that apply)*
    - ☐ Mobilize off budget funding from implementing partners.
    - ☐ Make use of budgets from integrated programming (e.g., that includes related programmes such as HIV & Malaria)
    - ☐ Any other ____
11. What would you say are the key challenges in allocating public resources to TB activities in the county?
12. In your role, what actions do you take during the planning and budgeting process to address these challenges?

How are budgets for different programmes and specifically for TB activities determined within the department of health?

<u>Funding Sources for County TB Programme</u>

1. How significant are the following sources for funding the TB Program in the county currently?

Funding Source	**Significant (comprises >30% of total TB budget)**	**Somewhat significant (comprises >10 to <30% of TB budget**	**Not significant (comprises <10% of total TB Budget**	**Not sure**
County government				
National government (NTLD-P)				
Donors (on-budget)				
Donors/Implementing partners (off budget)				
Others (specify)				

2. What three strategies does the CDOH use to mobilize additional funding for TB to meet budgetary shortfalls?

3. Is there an active TB stakeholders' forum in the county? If yes, who are the key members? *(Select all that apply)*
   - ☐ CSOs
   - ☐ Implementing partners
   - ☐ Private sector
   - ☐ Donors
   - ☐ Other county departments
   - ☐ Others____
4. How effective is the stakeholders' forum in mobilizing funding for TB? *(1= Effective, 2= somewhat effective and 3=not effective)*
5. What strategies would you recommend improving effectiveness of the stakeholder engagement forums?
6. What strategies does the county use to ensure off-budget resource commitments by other donors are realized and included in the AWP?

Funding Source	**Purchase of Anti-TB medicines**	**Purchase of TB diagnostic commodities**	**Salaries of TB clinical staff**	**Salaries of TB public**	**Payment of stipends for CHVs**	**Supportive supervision, M&E, review meetings including**	**Trainings & Mentorship**	**Activity budgets for TB public health activities, such as active case finding, private**	**Others (Specify)**

				health staff		**data quality audits**		**provider engagement, or contact investigation**	
County government									
National government (NTLD-P) domestic funds									
Donors (on budget)									
Donors/Implementing partners (off budget)									
Others (specify)									

7. For each funding source, do they cover all, a majority, a minority, or none of the budget for the following categories:

8. How should the above allocations change in the future: which funding entities (central government vs donor vs county government) should take on more or less responsibility for funding these different TB budget categories? Why?
9. In the medium to long term, and considering any health financing trends or reforms, which opportunities and threats exist for ensuring sustainable TB financing and service delivery
10. What would be the best approaches to enhance advocacy efforts for increased TB funding for the counties?

Budget Implementation

1. Are you familiar with the budget implementation process? If yes, please describe it.
2. In your estimation, what proportion of funded TB interventions in the previous AWP were implemented?
    - 100%
    - 75%-100%
    - 50%-75%
    - 25%-50%
    - Less than 25%
3. Are you familiar with the process of budget requisition for TB allocations? If yes, please describe it.

4. What are the three key challenges affecting utilization/absorption of funds in the CDOH?
5. What are the three key challenges that affect absorption of TB budget?
6. Have you been trained in the following budgeting process capacities? if no why?
    - ☐ Knowledge of the entire county planning and budget process
    - ☐ Evidence based planning and advocacy.

- ☐ Resource mobilization
- ☐ Resource tracking

<u>Governance Frameworks</u>

1. Does the CDOH have a functional organogram/organizational structure? (*Select one and explain)*
   - o Yes
   - o No
2. As the county TB coordinator, are your TB roles in general well supported within the organogram? (*Select one and explain)*
   - o Yes
   - o No
3. As the county TB coordinator, are your roles specifically in TB planning and budgeting well supported within the organogram? (Select one and explain)
   - o Yes
   - o No
4. Do you have a clear job description or terms of reference? (*Select one and explain)*
   - o Yes
   - o No

5. How much autonomy do you have in utilizing the TB allocation in the approved PBB? (*Select one and explain)*
   - o Complete autonomy
   - o Semi-autonomy
   - o No autonomy

Kindly provide a copy of the following documents if available:

- ***County TB Strategic Plan***
- ***County Integrated Development Plan***
- ***County Department of Health Annual Work Plan for the past three years (FY 2020/21, FY 2021/22 and FY 2022/23)***
- ***County Budgeting Guidelines for the past three years (FY 2020/21, FY 2021/22 and FY 2022/23)***
- ***County Programme Based Budget for the past three years (FY 2020/21, FY 2021/22 and FY 2022/23)***
- ***County TB resource mobilization plan***
- ***TB TWG/coordination/stakeholders forum TORs***

ANNEX B. INTERVIEW GUIDE FOR OTHER KEY INFORMANTS

Strengthening the Sustainability of Kenya's TB Response:

An Assessment of County-Level Engagement in the Planning and Budgeting Processes

Key Informant Interview Guide for County Treasury, CDOH Leadership and National Ministry of Health

Introduction

Tuberculosis is one of the health programs (alongside Malaria and HIV) that have traditionally relied on donor funding for both program implementation and purchase of commodities. However, with Kenya attaining a lower middle-income status, it has become imperative to put more emphasis on domestic sources for funding TB and progressively transition from donor dependence. The National Tuberculosis, Leprosy and Lung Disease Program (NTLD-P), with technical assistance from the USAID Health Systems for Tuberculosis (HS4TB) project, is using this assessment tool to collect qualitative data on the state of the county health financing and Public Financial Management (PFM) issues that may impact services delivery and financing of TB interventions in the target counties (Nairobi, Mombasa, Tana River, Busia, and Turkana). Findings of this assessment will be used to jointly develop a capacity building plan which will leverage opportunities within the 2012 PFM Act to enhance county financing for TB and health. Responses will be confidential and submitted anonymously.

Interviewer Details

Name:

Respondent Details:

Name:

Designation:

- MOH NTLP official
- County Treasury (planning officer/economist)
- Member of county TB TWG
- Other (specify): ____

How long have you been in this position?

County/Institution

- Busia
- Mombasa
- Nairobi
- Tana River
- Turkana
- MOH – NTLD-P

Date of Interview:

Start Time:

End Time:

KII Questions

I. County Treasury

1. Does the county hold sector hearings where departmental priorities and resource allocations are discussed? (*Select only one answer)*
    - Yes
    - No
2. *Regardless of answer to #1:* How does the county treasury determine budget allocation ceilings to the different departments?
3. What are the major funds flow challenges that the county experiences from the County Revenue Fund (CRF) account to the different departments in the county?
4. What typically happens to departments like the County Departments of Health when the county experiences funds flow obstacles from the County Revenue Fund?
5. Given that donor funding has been on decrease, what strategies for domestic resource mobilization would you recommend to the national and county governments to ensure increased county funding for such programmes like TB?

II. MOH NTLD-P

1. In what areas do you collaborate with the counties on implementation of priority interventions for TB?

2. To what extent do you agree with the following statement "***National TB strategic priorities are adequately reflected in the following county planning documents***"

	Strongly agree	**Agree**	**Disagree**	**Don't Know**	**Explain**
AWP					
County TB strategic plan					
County CIDP					
Approved County PBB Budget					

3. How does the NTLD-P support counties (not just the target counties) to mobilize resources for implementation of the national strategic priorities of the TB program? *Please explain*

4. What types of co-financing or similar mechanisms are the national government using to leverage or Influence County funding decisions for TB?

5. What are three (or more) key challenges that arise in coordinating or aligning planning and budgeting across multiple sources of funding for TB? *E.g., do the budget categories, timelines and processes differ for county, central MoH and donor funding?*

6. What are the NTLD-P priorities for any type of TB program costs that should be covered by counties vs. which should be covered by national or donor funds?

7. What are the primary sources of funding for the broad categories of TB budgets outlined below:
   - ☐ TB drug commodities
   - ☐ TB diagnostic commodities
   - ☐ Salaries of TB clinical staff
   - ☐ Salaries of TB public health staff
   - ☐ Supportive supervision and M&E activities
   - ☐ TB trainings
   - ☐ Activity budgets for TB public health activities such as active case finding, private provider engagement, or contact investigation.

8. In your opinion, do you think responsibilities for the above budget categories should change in the future? If so, how?
   Prompt: Which funding entities in Q7 (central government vs donor vs county government) should take on more or less responsibility for funding these different TB budget categories? Why?

9. In the next five years, and considering any health financing trends or reforms, what kinds of opportunities and threats do you anticipate to sustainable TB financing and service delivery? Why?
   - Opportunities:
   - Threats:

III. County TB TWG/coordination/stakeholders forum Member

1. What is the composition of your County TB TWG/ coordination/stakeholders forum?

2. How often do the county TB TWG/coordination/stakeholders forums and/or meetings take place?

3. How does the TB TWG/coordination/stakeholders forum finance its operations?

   Prompt: Such as:

   ☐ *Contributions from TWG member organizations*
   ☐ *County funds*
   ☐ *Other________________________*

4. What roles do member organizations play in the TB TWG/coordination/stakeholders forum?
   Prompt: Such as:

   ☐ *Support TWG operations*
   ☐ *Chair TWG meetings and follow up actions for implementation.*
   ☐ *Resource mobilization for TB*
   ☐ *Evidence generation for advocacy*
   ☐ *Other _______________________________________*

5. To what extent do the TB TWG/coordination/stakeholders forum resolutions inform the county TB planning?

6. How does the TB TWG/coordination/stakeholders forum participate in the county-level health sector working group meetings and MTEF budget preparation process?

7. How does the TB TWG/coordination/stakeholders forum advocate for increased county TB financing?
   Prompt: Such as:

   - ☐ *Hold advocacy meetings with county assembly*
   - ☐ *Hold advocacy meetings with county treasury (outside MTEF timelines)*
   - ☐ *Generate and share evidence-based advocacy information (charts, banners, etc.)*
   - ☐ *Mobilize CSOs to promote TB financing agenda*
   - ☐ *Any other* ______________________________________

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