REPUBLIC OF KENYA

NATIONAL AND COUNTY HEALTH BUDGET ANALYSIS

FY 2019/20

MINISTRY OF HEALTH

August 2020

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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 fiscal 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 2018/19,* examines how public health sector financial resources were allocated over the 2019/20 fiscal year in comparison to the allocation patterns of the preceding two years. This is an annual product that helps inform the budgeting process in the health sector.

The findings provide information for national and county policymakers and decision makers to establish the level of resources allocated for public health spending. Additionally, they can serve as tools for sourcing additional funding and improving efficiencies in resource allocations. Policymakers can also use these findings to examine whether allocations to health were directed toward the most efficient programmes and activities and were compliant with programme-based budgeting as stipulated in the Public Financial Management Act of 2012.

These findings also include information that can provide benchmarks to compare the national budget to other countries as well as county-level budgets to other counties within Kenya.

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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, which made this analysis possible.

The study used data from several sources, including two previous budget analysis reports, the Office of the Controller of Budget, the National Treasury, the Ministry of Health, 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 of health staff who provided raw data to enable this analysis to be successful.

The analysis was conducted by a team from the MOH led by economist Terry Watiri. Technical assistance was provided by HP+ senior policy advisor Robinson Kahuthu. Technical review was provided by HP+ project director Stephen Muchiri, and data collection and analysis by HP+ program officer Caroline Njoroge.

ABBREVIATIONS

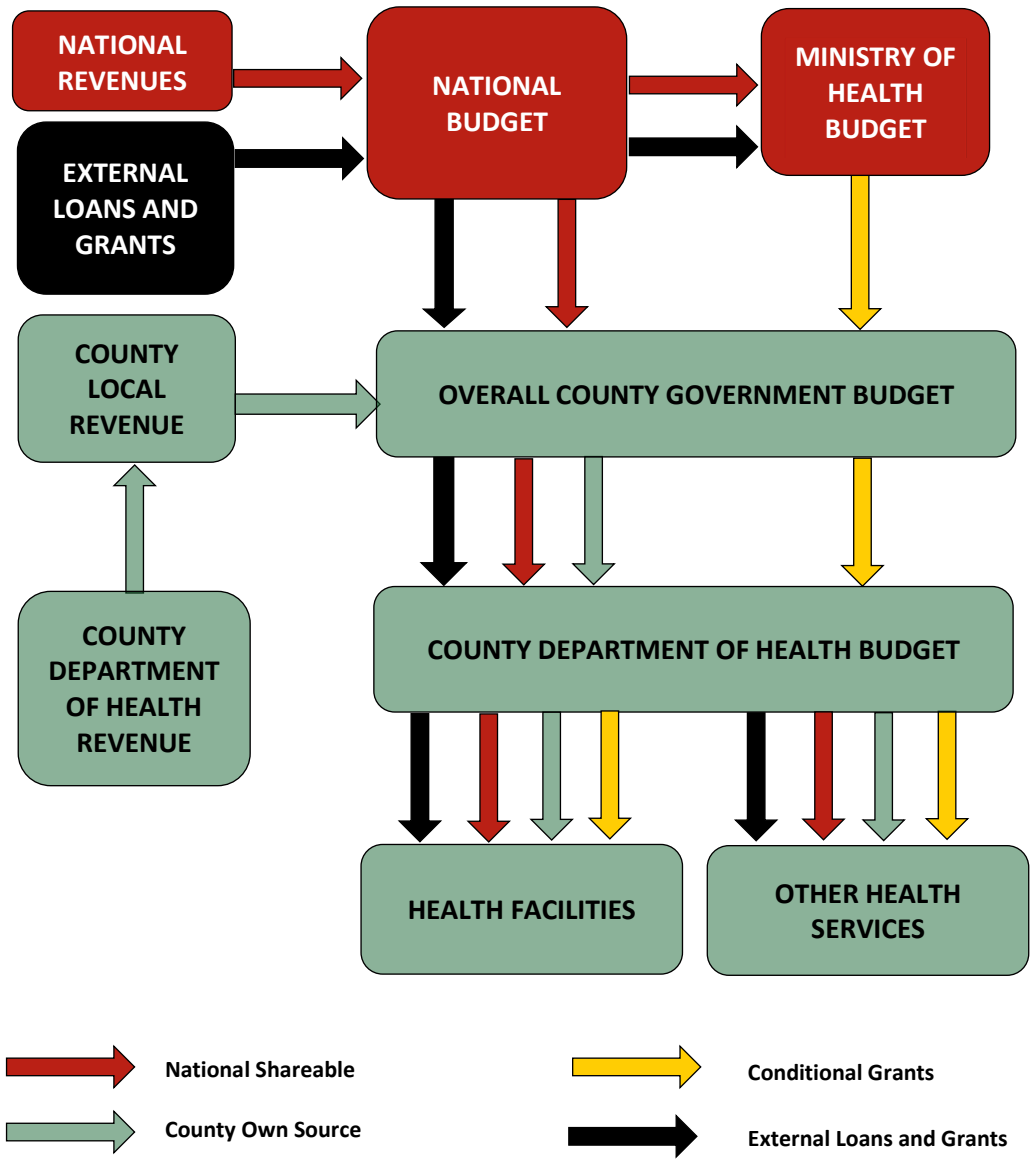
FY	fiscal year
HIV	human immunodeficiency virus
KDHS	Kenya Demographic and Health Survey
KEMRI	Kenya Medical Research Institute
KEMSA	Kenya Medical Supplies Authority
KHSSP	Kenya Health Sector Strategic Plan
KMTC	Kenya Medical Training College
KNH	Kenyatta National Hospital
KUTRRH	Kenyatta University Teaching Referral & Research Hospital
Ksh	Kenya shilling
MOH	Ministry of Health
MTRH	Moi Teaching and Referral Hospital
PFMA	Public Finance Management Act of 2012
RMNCAH	Preventive, Promotive, Reproductive, Maternal, Newborn, Child, and Adolescent Health Services

EXECUTIVE SUMMARY

Budgets are definitive instruments that detail planned government spending. They can act as an indicator of policy, priority, programmes, and activity implementation over a specific fiscal period. In Kenya, the existence of government budgets is a legal requirement. The budget process is defined by the country's constitution and elaborated in the Public Finance Management Act of 2012 (PFMA).

The Kenya Constitution of 2010 introduced devolution, sharing health functions 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 implementation of devolution, the transfer of functions and funding to the counties began in fiscal year (FY) 2013/14. In this process outlined in the diagram below, the National Treasury allocates lump sum amount to counties, who individually and independently determine how much to allocate for health services according to their mandates.

Kenya's financial resources sharing arrangement

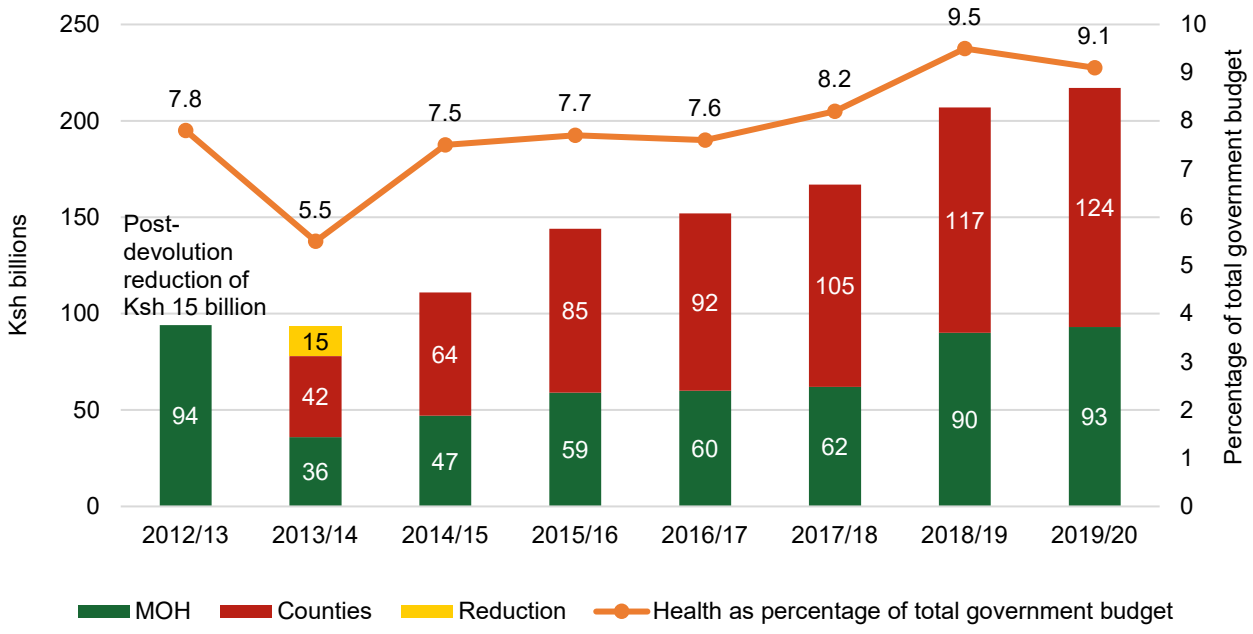


The ministries, departments, and agencies of national and county governments develop budgets following set guidelines, which then are approved by the respective legislative bodies. Beginning in FY 2015/16, both levels of government are required to adopt a programme-based budgeting approach. This report examines the trend in fiscal allocations by health sector priority areas from FY 2017/18 to FY 2019/20. All Kenya shilling (Ksh) values reported are in nominal terms, unless otherwise stated. Findings 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 217 billion in FY 2019/20—more than a two-fold expansion in nominal terms. Over the same period, the proportion of the public budget allocated to health registered a sharp drop from 7.8 percent in FY 2012/13 to 5.5 percent in the devolution transition year of FY 2013/14. As described in the bar chart below, it increased steadily to peak at 9.5 percent in FY 2018/19 before decreasing to 9.1 percent in FY 2019/20. The proportion remains lower than the 15 percent recommended in the Abuja Declaration.[1]

Pre- and post-devolution budget allocations to health



In the last three fiscal years alone, Kenya's public health budget increased by Ksh 50 billion with the MOH receiving 62 percent and counties receiving the remaining 38 percent of this expansion.

National Budget Allocation to the Ministry of Health

In FY 2019/20, the MOH was allocated Ksh 93 billion—an increase from the Ksh 62 billion and Ksh 90 billion allocated in FY 2017/18 and FY 2018/19, respectively. This sum constituted 4.8 percent of the national government budget—a marginal decrease from the 5.1 percent allocated during FY

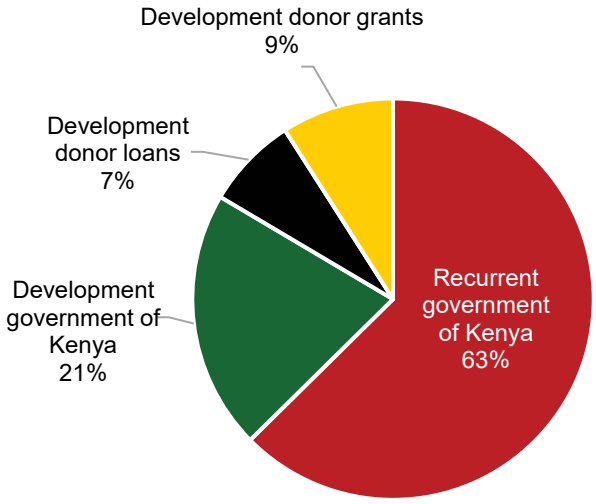
[1] The Abuja Declaration is a pledge made in 2001 by members of the African Union during a conference in Abuja, Nigeria. In it, the member nations pledged to increase their health budget to at least 15 percent of the state's annual budget and requested Western donor countries to increase their support.

2017/18 and a significant increase from the 3.7 percent allocated in FY 2016/17. The absolute budget for the MOH increased by 52 percent over the three-year period.

Ministry of Health Budget Allocation

The MOH increased the share of recurrent expenditures from 49 percent in FY 2017/18 to 55 percent in 2018/19 and then to 63 percent in 2019/20, as described in the pie chart below. In absolute terms, the MOH allocated Ksh 58.1 billion to the recurrent budget in FY 2019/20, with most of this amount allocated to grant transfers to the eight semi-autonomous government agencies under the ministry, which consumed 63.5 percent of the recurrent budget (or Ksh 36.9 billion).[2] Semi-autonomous government agencies were expected to raise 40 percent of their budgets from internal revenues. Transfers to universal health coverage programmes, including free primary care services, and transfers to level 5 hospitals constituted 11 percent and 7.4 percent of the recurrent budget respectively. Allocations to personnel emoluments decreased from 19.9 percent of the recurrent budget in FY 2017/18 to 15.5 percent in FY 2018/19 and 14.8 percent in FY 2019/20.

MOH budget financing, FY 2019/20



Donors contributed 44 percent (or Ksh 15.3 billion) of the MOH development (capital) budget of Ksh 34.6 billion in FY 2019/20, down from 58 percent (Ksh 23.7 billion) in FY 2018/19, a decline in donor funding to the MOH development budget. Much of the donor funding was allocated to HIV, tuberculosis and malaria at 21 percent, immunisation at 17 percent, and universal healthcare-related programme support at 43 percent, while the remaining 19 percent was allocated to other smaller programmes at values below Ksh 200 million. In contrast, the government's contribution to the development budget amounted to 56 percent of the MOH's development budget allocation (or Ksh 19.4 billion) in FY 2019/20, up from Ksh 17.2 billion in FY 2018/19 and Ksh 11.5 billion in FY 2017/18. In FY 2019/20, most of this money was allocated to programmes related to medical equipment (32 percent), universal health coverage (28 percent) and the Free Maternity Care Programme (21 percent).

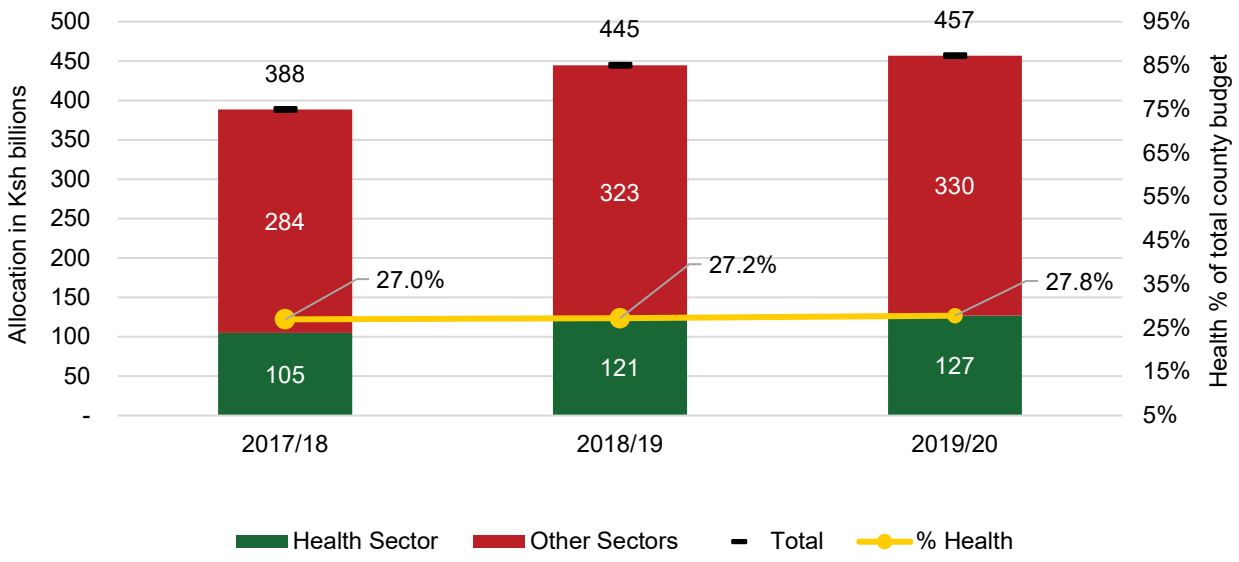
[2] Semi-autonomous government agencies under the MOH are Kenyatta Teaching and Referral Hospital, Moi Teaching and Referral Hospital, Kenya Medical Supplies Authority, Kenya Medical Research Institute, Kenya AIDS Control Council, Kenya Medical Training College, Kenyatta University Teaching and Referral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

The proportion of the FY 2019/20 total MOH budget allocated to the National Referral and Specialized Services programme remained the highest, at 40 percent, after expanding by 41 percent between FY 2017/18 and FY 2019/20. The proportional allocation for Preventive, Promotive, Reproductive, Maternal, Newborn, Child, and Adolescent Health Services declined from 14 percent in FY 2017/18 to 10 percent by FY 2019/20.

County Government Allocations to Health

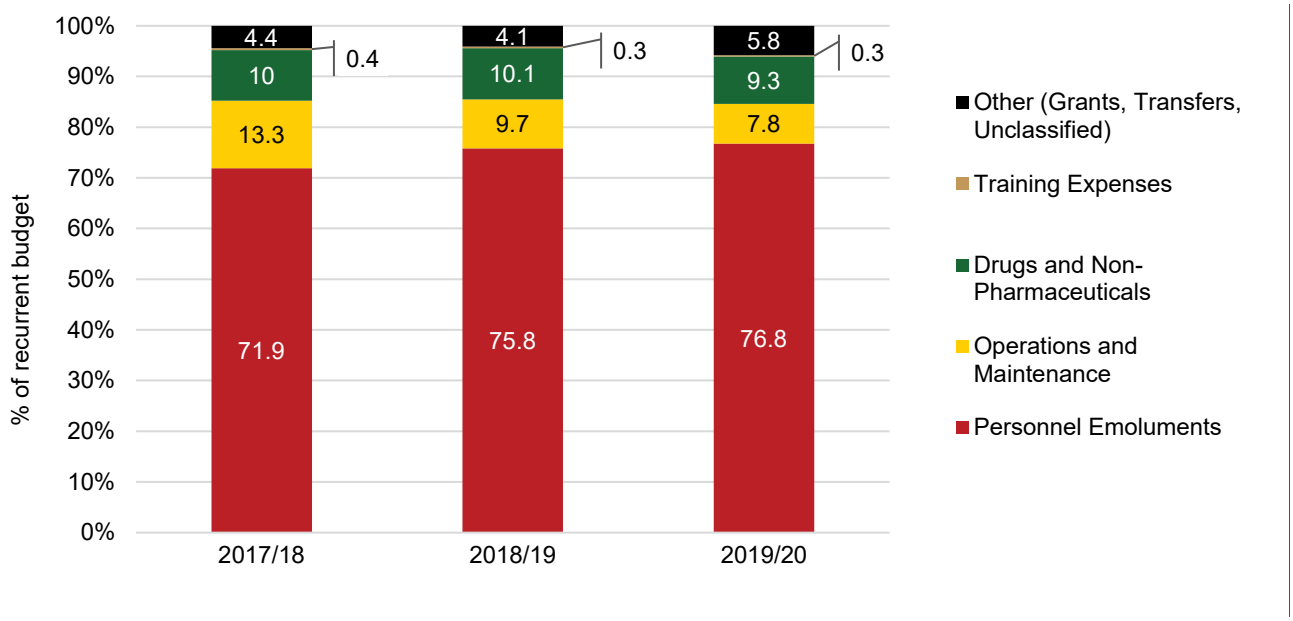
In FY 2018/19, county governments increased their allocations to health as a percentage of total county budgets to 27.8 percent (Ksh 127 billion), up from 27.2 percent (Ksh 121 billion) in the previous year. The bar chart on county government allocations indicates an increased commitment to health by county governments, the allocation is still below estimated pre-devolution levels of 35 percent and thus inadequate to deliver the services under counties' constitutional mandate. The top five counties that allocated the highest proportion to health were Machakos, Kirinyaga, Elgeyo Marakwet, Tharaka Nithi, and Embu. The lowest five were Nairobi, Bomet, Mandera, Tana River and Turkana. However, 28 counties increased the proportion of their budgets allocated to health between FY 2018/19 and FY 2019/20. The average share of the county's health budget allocated for recurrent expenditures decreased from 82 percent in FY 2017/18 to 79 percent in FY 2018/19 and then increased back to 82 percent in FY 2019/20, compared to the recommended 70 percent. In FY 2019/20, 42 counties were noncompliant regarding the recommended percentage.

County governments' allocation to health and all other sectors, FY 2017/18–FY 2019/20



A further breakdown of the data shows an increase in the proportion of the recurrent budget allocated to personnel expenses, from 71.9 percent in FY 2017/18 to 75.8 percent in FY 2018/19 and 76.8 percent in FY 2019/20, as indicated in the bar chart on county government recurrent budget allocations. Under the development budget, allocation to grants and transfers expanded from 15.8 percent in FY 2017/18 to 44.1 percent in FY 2018/19 before declining slightly to 38.9 percent in FY 2019/20. Allocation for the construction and rehabilitation of buildings increased from 48.1 percent in FY 2017/18 to 50.1 by FY 2019/20.

County health recurrent budget allocations (%) by economic category, FY 2017/18–FY 2019/20



Overall, counties increased their average per capita allocation to health from Ksh 2,531 in FY 2018/19 to Ksh 2,671 in FY 2019/20. In FY 2019/20, the five counties with the highest per capita allocation were Lamu, Tharaka Nithi, Isiolo, Marsabit, and Tana River; the bottom five were Kiambu, Migori, Bungoma, Bomet, and Nairobi. Overall, 32 out of 47 counties increased their per capita health budget allocations.

Conclusions and Recommendations

The findings indicate that, overall, national and county governments are allocating more funds in and increasing the public budgetary resources available to the health sector. The findings also draw other conclusions, including the following:

- Donor funding to the MOH is declining, and the national government's reliance on this source of funding is not sustainable.
- County health budgets are still low. They fall below the estimated proportion of 35 percent in the pre-devolution period and continue to be dominated by recurrent expenditures, most of which goes to personnel emoluments, raising concerns about resource allocation for effective and quality service delivery.
- The trend of increasing country funds to health demonstrates that some counties are potentially capable to increase the proportion of their budgets allocated to health, as evidenced by the 28 counties that increased such allocation between FY 2018/19 and FY 2019/20 that are not socioeconomically different from those that did not.

In the light of these findings and conclusions, the key recommendations of this study are as follows:

- The overall health budget needs to be expanded for two reasons:
    - To reduce over-reliance on donor resources for key programmes, including those related to HIV, tuberculosis, and malaria, and enhance domestic resource mobilisation for key programmes

    - To extend coverage and access to county-specific health priorities

- The MOH needs to align resource allocation to policy priorities, especially funding for Preventive, Promotive, Reproductive, Maternal, Newborn, Child, and Adolescent Health Services, including key strategic programmes, whose proportion of allocation has remained comparatively low over the three years.
- The MOH should also immediately implement mechanisms stipulated in the recently enacted Kenya Health Law 2017 to ensure that resources disbursed for free care at primary care facilities are used at the facilities to increase access and quality of service.
- Counties are constitutionally obliged to deliver most healthcare services and thus should allocate more resources to health—current resources are still inadequate. The focus for increases in health resource allocation should be those counties below the overall county average. Planning, budgeting, and advocacy capacities for those counties should be enhanced.
- As budgets expand, counties should strive to achieve technical efficiency by optimising allocations to critical health inputs.
- The MOH and partners should provide more technical support to counties because health budget allocations remain below the proportion allocated for services before devolution, even five years after.

INTRODUCTION

The constitution of Kenya recognizes health as a fundamental right and an important driver in spurring the country's economic growth. Chief among the country's foundational health documents are the constitution and other major policy documents—including *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 (Ministry of Health), 2014). They often highlight the government's obligation and commitment to ensure that Kenya attains the highest standard of living for its population by providing equitable health services. Such an achievement requires the provision of equitable health services with respect to geographic, 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.

Budgets are essential for implementation of national and county policies and strategies. National and county governments thus are expected to structure their respective budgets toward achievement of the policy commitments outlined in their respective guiding documents. At the national level, the 2019 Budget Policy Statement, the current Kenya Health Sector Strategic Plan III (KHSSP III), 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) 2019/20. The KHSSP III specifically articulates the government's commitment to continue to increase health sector funding to achieve the Abuja Declaration target of allocating at least 15 percent of the annual budget to health (WHO, 2011). Counties usually align their respective medium-term planning and budgeting frameworks to national strategies while considering localised priorities. This analysis of national and county health budgets therefore compares respective budgets against national and county governments' priorities and compares trends over the last three years.

This budget analysis covers FY 2019/20 and compares it with the previous two fiscal years. It also examines how the national and county governments allocate their health budgets. The Kenyan national government has stated its intent to pursue four areas during the 2017-2022 development cycle: manufacturing, food security and nutrition, universal health coverage (through the National Hospital Insurance Fund), and affordable housing, referred to collectively as the "Big Four" agenda (Kenyatta, 2017). The analysis also assesses how the country has attempted to implement universal health coverage in the Kenyan government's Big Four national medium-term development agenda and to respond to dwindling donor funds. It explores whether the government has tried to accommodate in the budget its expected takeover of funding donor-funded programmes.

The analysis briefly reviews the health policy priorities that the various governments intend to address, as well as the macroeconomic settings in which the governments operate. It reviews data on Ministry of Health (MOH) and county health allocations from FY 2017/18 to FY 2019/20 to assess how the funds align to health priorities. The study also includes a trend analysis to show investments in the public health sector and the progress toward increasing domestic resources for health. It also analyses MOH and county health budgets by recurrent and development categories, economic categories, and by the five programmes identified by the MOH under the programme-based budgeting approach.[3]

[3] MOH programmes under the programme-based budgeting approach are 1) Preventive, Promotive, Reproductive, Maternal, Newborn, Child, and Adolescent Health Services, 2) National Referral and Specialized Services, 3) Health Research and Development, 4) Health Policy, Standards and Regulations, and 5) General Administration, Planning, and Support Services.

Macroeconomic Context

The budget allocations to the health sector are analysed within Kenya's macroeconomic context, as the country's growth rate (among other factors such as political will and donor funds such as co-financing requirements) is thought to influence the allocations to different sectors of the economy, according to the *Economic Survey 2019* (Republic of Kenya (National Bureau of Statistics), 2019). The survey also reports that Kenya's economy remained robust over the last three years and notes that the country has enjoyed significant economic expansion, i.e., a growth rate of 6.3 percent in 2018, up from 4.9 percent in 2017. The survey reports that growth was attributable to increased agricultural production, accelerated manufacturing activities, sustained growth in transportation, and vibrant service sector activities. In the medium term, the survey reports, the economy is projected to expand at the same rate in 2019, and then is expected to stagnate due to the negative effects of delayed rainfall on agriculture, electricity, and water supply. However, the survey predicts that tourism, infrastructure development, and private sector confidence will help sustain the projected growth.

The economic growth is expected to translate into increased government revenues. In an ideal scenario, this economic growth would affect resource allocations to the country's priority sectors, including health.

Performance of Selected Health Priority Areas

The health sector is a key component of the longer-term development agenda referred to as 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 *Kenya AIDS Indicator Survey* (Republic of Kenya (NACC), 2012) and the *Kenya Demographic and Health Survey (KDHS) 2014* (Republic of Kenya and ICF, 2015) document improved performance in key health indicators. For instance, the *KDHS* also notes remarkable declines in under-five and infant mortality rates between 1998 and 2014, from 112 to 52 and from 74 to 39 per 1,000 live births, respectively. The proportion of children fully immunised increased from 65 percent in 1998 to 75 percent in 2014. These gains are attributed to improved health service delivery, intensified immunisation campaigns, and widespread distribution of insecticide-treated bed nets.

Gains have also been realized in the management and control of HIV. Data from the *KDHS 2014* indicate that HIV prevalence among adults 15–49 years has declined to 6 percent, from 7.4 percent in 2007 and 6.8 percent in 2003. Kenya has also had relative success in scaling up access to antiretroviral treatment, with 1,121,938 Kenyans on antiretrovirals in 2017, up from 500,000 reported in 2012 (Republic of Kenya (NASCOP), 2018). If these gains can be sustained through increased health spending targeting the specific programs, Kenya would be on track to realizing some of its national health goals.

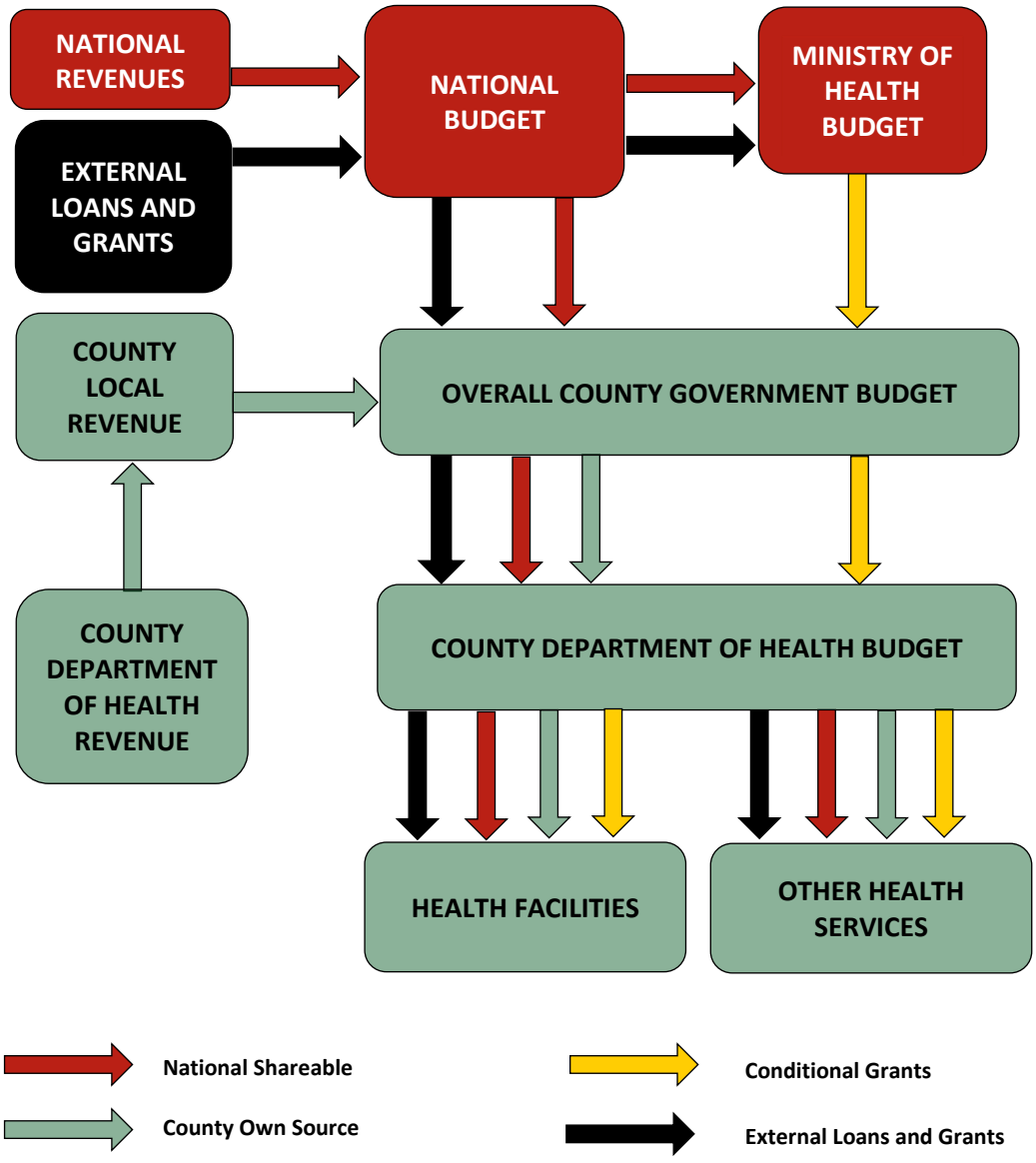
Reproductive and maternal health indicators are less positive. While contraceptive prevalence increased from 39 percent in 2003 to 61 percent in 2014, it is still far below the FP2020 target of 70 percent. Use of antenatal care services remains steady at 91.5 percent and use of skilled birth attendants is at 61 percent, below the target of 90 percent (Republic of Kenya and ICF, 2015).

Budgeting Process

According to the Public Finance Management Act (PFMA) of 2012, the National Treasury issues aggregate budget ceilings for national spending based on the economic outlook and expected

taxation revenues, donor commitments, and other funds anticipated to be realized as appropriations in aid, such as those realized by hospitals charging fees for services and used at the point of care. Proposals for sharing this aggregate budget, after setting aside payments for consolidated fund services (County Pension Fund—pensions, national debts, and related expenses), are developed by the Intergovernmental Budget and Economic Council, shared among the national and county governments and other independent constitutional bodies, and thereafter approved by Parliament. National and county governments are given indications of the amounts they can allocate for their sectors and institutions, 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, who individually and independently determine how much to allocate for health services according to their mandates.

Figure 1: Kenya's financial resources sharing arrangement



There are significant competing needs for resources at both the national and county level. Allocations to health indicate the priority the governments place on health issues compared to other sectors. If the national budget to be shared is low, the sharable pool will be low, and many sectors (including health) may then receive a smaller allocation.

The process of budget allocation to 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 released in September and which must be approved by the Cabinet and legislative assembly at each level of government. The *Budget Review and Outlook Paper* provides the first indication of how much the health sector might receive; interventions to advocate 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 allocations to proposed programmes and activities. At both the national and county level, these groups produce reports that inform the Cabinet and County Executive Committee in refining the 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; they are approved by Parliament at the national level and by the county assemblies at the county level.

National ministries and county departments can influence the amounts allocated to them through effective advocacy during the development of the 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 approved development and recurrent allocations. They are also required to budget for all existing personnel. At the same time, they have significant flexibility in shaping the allocations by prioritising the most cost-effective and efficient programmes.

Final budgets are approved by the National Assembly for the national government and by county assemblies 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 results in few or no amendments.

Programme-Based Budgeting

The PFMA of 2012 requires the national government and counties to adopt programme-based budgeting by the beginning of FY 2014/15. The national government has fully adopted the approach, but counties are struggling to fully do so, particularly in disaggregating personnel expenses by programme and sub-programme. Programme-based budgeting, according to PFMA 2012, has two goals:

- To improve the prioritisation of expenditures in the budget to help allocate limited county government resources to those programmes of greatest benefit to the community
- 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 outcomes 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 characterise national and county governments' budget allocations to the health sector from FY 2017/18 through FY 2019/20. It is anticipated that the results from this assessment will be used to inform planning and budgeting processes at national and county levels.

Specifically, the study examines four allocations:

1. Total government budget allocations to health
2. National and county budgets' allocations to health
3. County comparisons and trends for budget allocations to health
4. National and county budget allocations to key economic inputs that are used to produce healthcare

The proportion and level of government funds allocated to health indicate the level of commitment toward 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. They also have the potential to increase the efficiency of healthcare delivery systems if a greater proportion of the expanded funding is directed toward 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 promote progress toward achieving the Abuja commitment of allocating 15 percent of the public budget to health.
3. It will allow Kenya to move more quickly toward the national goal of universal health coverage.
4. It will provide a measure of sustainability in delivery of health services, especially if expansion comes from domestic sources.

Methods

This study analysed the MOH and county budget allocations to the health sector for FY 2017/18, FY 2018/19, and FY 2019/20 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. However, data from the Commission for Revenue Allocation and the Office of the Controller of Budget have not been validated by the counties as of the time of writing the report, allowing inconsistencies with final county budgets. The authors of this study note that, in some instances, gaining access to information in a consistent form was

challenging. 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 programme-based budgeting and in some cases, the budget data were in formats not suitable for this analysis.

The analysis examines the budget by recurrent (for expenditures on personnel and operations, and operations and maintenance) and development (for capital investment) categories. Weaknesses have been noted in counties' misclassification of expenditure items between recurrent and development. This analysis has attempted to correct this mistake by reclassifying correctly to the extent possible. For each of these budgets, there is a gross budget, which includes appropriation in aid (funds collected and used at the source or provided in kind), revenues from local taxes, and foreign assistance. This analysis does not examine the off-budget resources provided by donors that do not pass through the country's budget system and thus are not captured in the county estimates. Thus, the analysis does not present all resources allocated in the health sector.

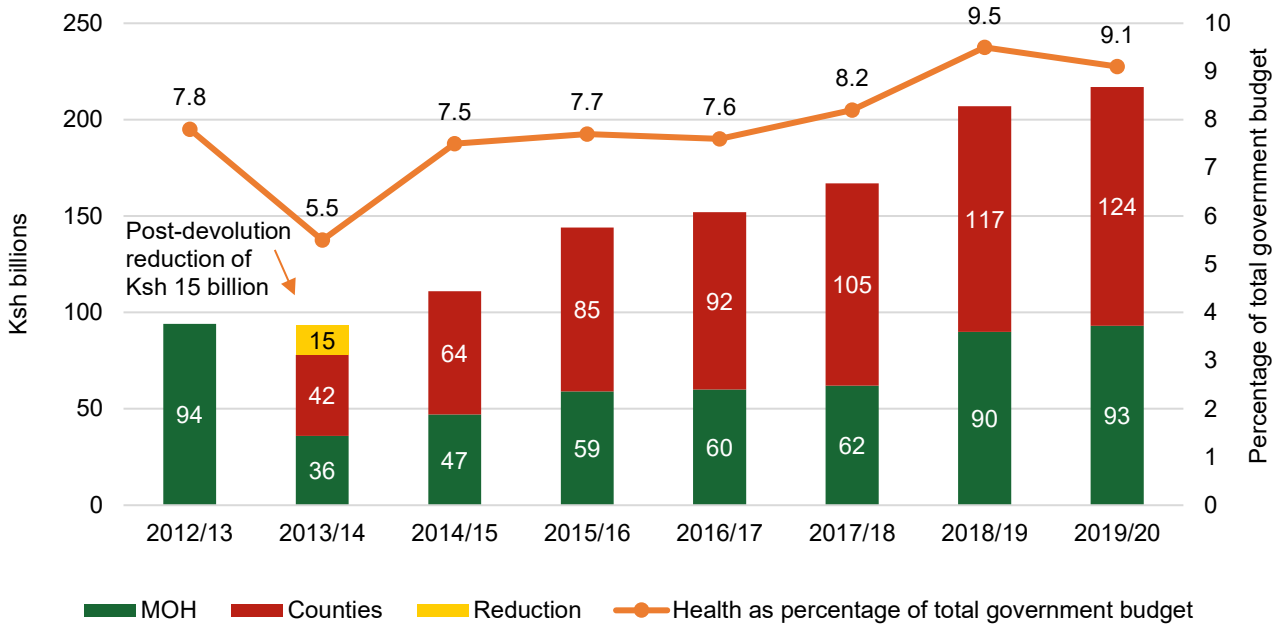
This report establishes the context of the analysis, covers its objectives and methodological approach, then presents detailed findings and recommendations for strengthening the public financial management system to respond to health system needs.

KEY FINDINGS

Government Budget Allocations to Health Pre- and Post-devolution

The Kenya Constitution of 2010 introduced devolution, sharing health functions 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 FY 2012/13 through 2019/20.

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



Sources: Republic of Kenya, 2012/13–2019/20, Republic of Kenya, 2013/14–2019/20

Figure 2 shows that the MOH budget of FY 2012/13 (pre-devolution) was Ksh 93.6 billion (7.8 percent of the total government budget), which included the funding for health functions devolved to the counties after the March 2013 elections. The allocation to the MOH dropped to Ksh 36.2 billion in the first year of devolution (FY 2013/14), as the newly formed counties made their own budgets and took up functions formerly funded through the MOH. In the same year, counties collectively allocated Ksh 42.1 billion, for a total of Ksh 78.3 billion allocated to health by both levels of governments—equivalent to 5.5 percent of the total government budget. The budget allocated to health thus decreased by Ksh 15.3 billion (from Ksh 93.6 billion to 78.3 billion) and 2.3 percentage points (from 7.8 to 5.5 percent) of the total government budget following devolution.

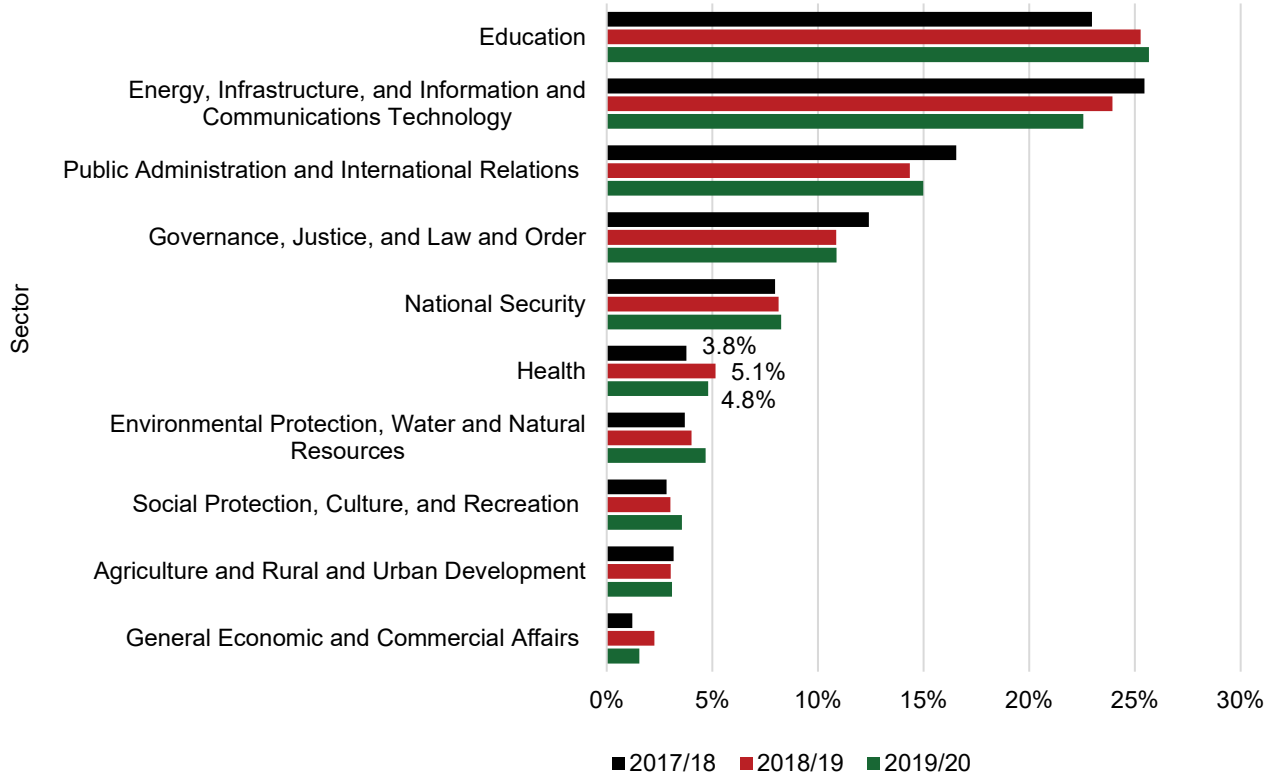
In absolute terms, the combined budget allocations to health continued to expand gradually, from the Ksh 78 billion in FY 2013/14 to Ksh 217 billion in FY 2019/20 (a 178 percent expansion). This increase was attributable mostly to county health budgets expanding over the same period—from Ksh 42 billion to Ksh 124 billion, a 195 percent expansion—faster than the MOH budget. The MOH budget increased from Ksh 36 billion in FY 2013/14 to Ksh 93 billion in FY 2019/20, a 158 percent expansion in nominal terms.

The proportion of the total government budget allocation to health by national and county governments combined has improved overall since devolution, increasing from 5.5 percent in FY 2013/14 to 9.1 percent by FY 2019/20. However, there has been a plateau in which the proportion of the total government budget allocated to health increased rapidly from 7.6 percent in FY 2016/17 to 9.5 percent in FY 2018/19 before decreasing to 9.1 percent in FY 2019/20 (Figure 2).

National Government Budget Allocation by Sector, FY 2017/18–FY 2019/20

The national government distributes funds in line with a circular issued by the National Treasury referred as the *Classification of the Functions of Government*, in which 10 sectors are identified for sharing of the national budget. Figure 3 shows the proportion allocated to the 10 sectors for FY 2017/18 through FY 2019/20.

Figure 3: Proportion of national government budget allocation by sector



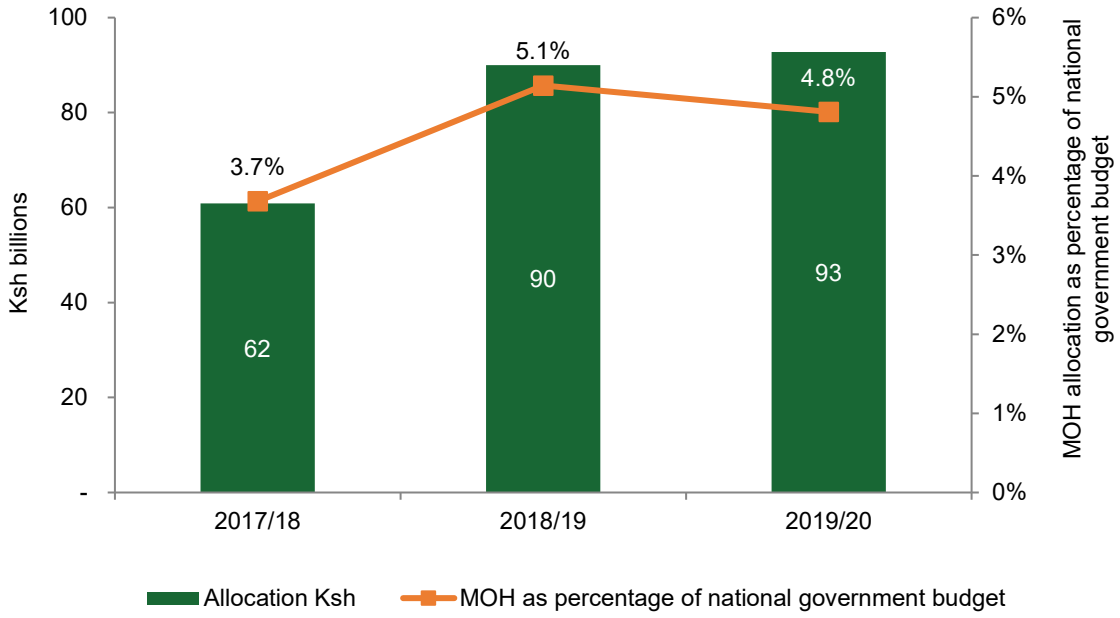
Source: Republic of Kenya, 2017/18–2019/20a

Figure 3 indicates that the top three sectors in terms of budgetary allocation are education, which continues to receive the highest allocation; followed by energy, infrastructure and information and communications technology; and public administration and international relations. The three sectors received almost half of total national government budget allocation. Health ranked sixth of the 10 sectors and was allocated 3.8 percent of the national budget in FY 2017/18, 5.1 percent in FY 2018/19, and 4.8 percent in FY 2019/20. In the clustering of sectors, most sectors contain more than one ministry or state departments; the MOH is the only ministry in the health sector.

National Government Budget Allocation to the Ministry of Health for FY 2017/18–FY 2019/20

The national government budget allocation to the MOH and its proportion of the total national government budget from FY 2017/18 through FY 2019/20 are shown in Figure 4.

Figure 4: National government budget allocation to the Ministry of Health, FY 2017/18–FY 2019/20



Source: Republic of Kenya, 2017/18–2019/20a

Figure 4 shows that national government increased allocations to health from Ksh 62 billion during FY 2017/18 to Ksh 90 billion in FY 2018/19 and to Ksh 93 billion in FY 2019/20 in nominal terms. The proportion of the budget allocated to health over the same period increased from 3.7 percent in FY 2017/18 to 5.1 percent in FY 2018/19 and decreased to 4.8 percent in FY 2019/20 due to faster growth in absolute total government budget relative to the health budget. The national government increased the MOH budget by 52 percent between FY 2017/18 and FY 2019/20, indicating the government's increased commitment to enhancing funding for health.

Ministry of Health Allocations to Recurrent and Development Budgets for FY 2017/18–FY 2019/20

The MOH allocation to the recurrent budget increased from Ksh 29.6 billion in FY 2017/18 to Ksh 49.1 billion in FY 2018/19 and further expanded to Ksh 58.1 billion in FY 2019/20 (Table 1). The allocation to the development budget expanded from Ksh 31.3 billion in FY 2017/18 to Ksh 40.9 billion in FY 2018/19 and decreased to Ksh 34.6 billion in FY 2019/20. The proportional allocation to development over the three years was 51, 45 and 37 percent, respectively.

Table 1: Ministry of Health allocation to recurrent and development budgets, FY 2017/18–FY 2019/20

Budget	2017/18	2018/19	2019/20	Percentage change, 2018/19–2019/20
Recurrent (all government of Kenya) (Ksh billions)	29.6	49.1	58.1	18.3%
Recurrent as percentage of MOH budget	*49%*	*55%*	*63%*	
Development (government of Kenya plus donor) (Ksh billions)	31.3	40.9	34.6	-15.4%
Development as percentage of MOH budget	*51%*	*45%*	*37%*	

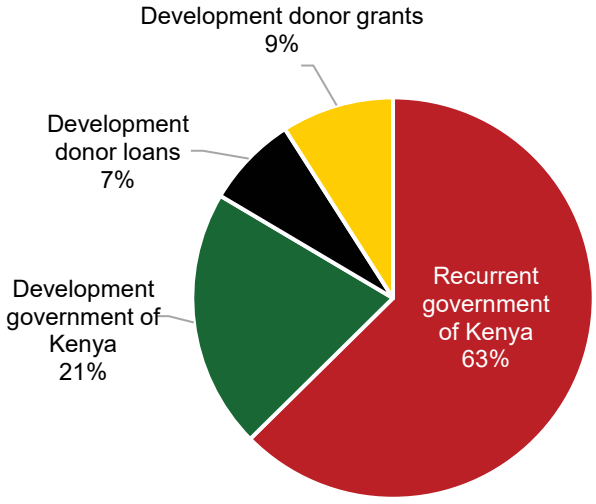
Source: Republic of Kenya, 2017/18–2019/20a

Referring to Table 1, the government—through the recurrent budget—is the main contributor to the increase in the health budget, which expanded by 18.3 percent from FY 2018/19 to FY 2019/20. The proportion of the MOH budget allocated to the recurrent expenditures increased from 49 percent in FY 2017/18 to 63 percent in FY 2019/20. The development budget, which includes donor on-budget resources, decreased by 15.4 percent between FY 2018/19 and 2019/20.

Ministry of Health Recurrent Budget by Spending Classification

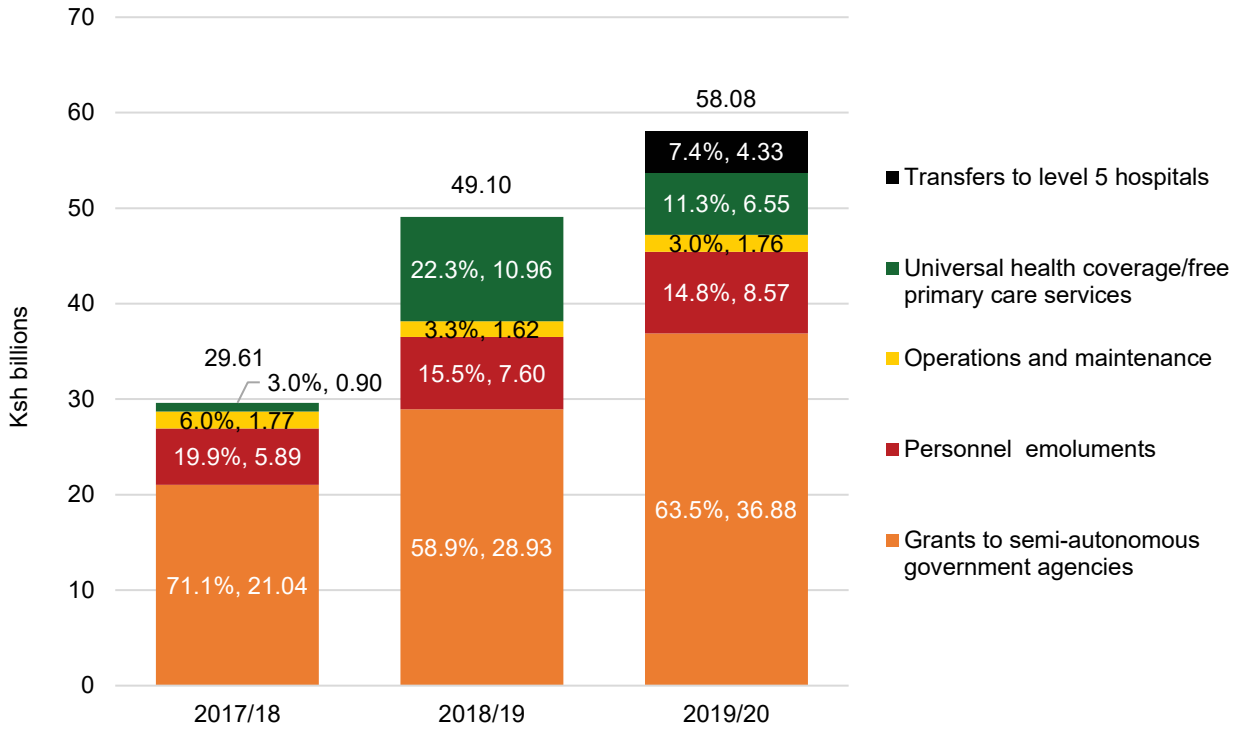
Figure 5 describes the division between development and recurring financing, while Figure 6 presents the breakdown of the recurrent budget across the key spending categories under the MOH for FY 2017/18 through FY 2019/20. They are grants to the six semi-autonomous government agencies; personnel emoluments; reimbursements for removal of user fees at facilities, which have been combined with universal health coverage grants; transfers to level 5 hospitals; and operations and maintenance.[4]

Figure 5: MOH budget financing, FY 2019/20



[4] Semi-autonomous government agencies are public-funded institutions with autonomy to manage and account for their budget and operations independent of the mother ministry and usually governed by a distinct legislation, but whose funding is channeled through the mother ministry. MOH has eight such institutions.

Figure 6: Ministry of Health recurrent budget allocation by major classification, FY 2017/18–FY 2019/20



Source: Republic of Kenya, 2017/18–2019/20a

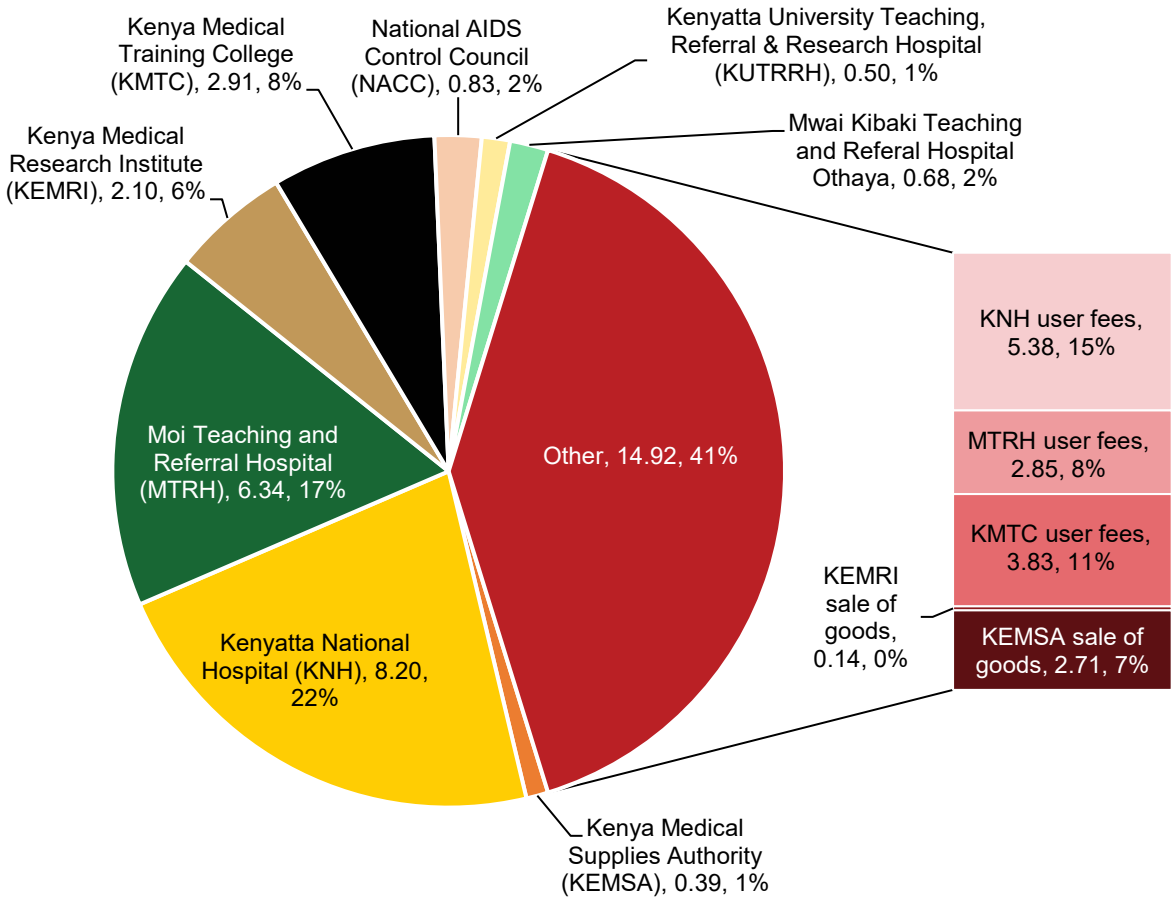
Referring to Figure 6, the rapid expansion of the MOH recurrent budget is driven by increases in ministry budget allocations to semi-autonomous government agencies, which increased from Ksh 21 billion in FY 2017/18 to Ksh 29 billion in FY 2018/19 and to Ksh 37 billion in FY 2019/20. The grants amounted to 63.5 percent of the MOH budget in FY 2019/20, having increased from 58.9 percent in the previous year. During FY 2019/20, the MOH allocated approximately Ksh 4 billion, or 7.4 percent of its budget, to transfers to level 5 hospitals, a category which had not been included in the MOH budget in the two previous fiscal years. Allocations for personnel emoluments increased significantly during this time, from Ksh 5.9 billion in FY 2017/18 to Ksh 8.6 billion in FY 2019/20. Operations and maintenance remained fairly constant between FY 2018/19 and FY 2019/20 but declined each year after FY 2016/17 as a proportion of the ministry budget.

Figure 6 also shows that during FY 2019/20, the MOH allocated Ksh 5.6 billion as grants for scale-up of universal health coverage and redirected Ksh 900 million previously used for the free primary healthcare programme, totalling Ksh 6.6 billion or 11.3 percent of the MOH recurrent budget allocation earmarked for universal health coverage. This sum is a decrease from the previous year's allocation for universal health coverage of Ksh 11.0 billion

Ministry of Health Recurrent Budget Allocations to Semi-Autonomous Government Agencies in FY 2019/20

As of FY 2019/20, eight semi-autonomous government agencies were administratively under the MOH and mainly funded through ministry grants. Figure 7 shows the breakdown of the recurrent budget allocation to the eight semi-autonomous government agencies in FY 2019/20.

Figure 7: Ministry of Health recurrent budget allocation to semi-autonomous government agencies, FY 2019/20 (Ksh billions)



Source: Republic of Kenya, 2019/20a

Referring to Figure 7, of the Ksh 36.9 billion allocated to semi-autonomous government agencies by the MOH in FY 2019/20, 59.6 percent was in the form of government grants, with 40.4 percent from revenues generated internally by the institutions through user fees and the sale of goods and services. These allocations represent significant increases from the previous fiscal year, which had a total allocation to semi-autonomous government agencies of Ksh 28.9 billion, with government grants constituting 61 percent and generated revenues 39 percent (Republic of Kenya (Ministry of Health), 2018). The budget expansion in FY 2019/20 was driven by agency revenue increases, an increase in the Kenyatta National Hospital grant allocation, and the addition of Kenyatta University and Mwai Kibaki hospitals as MOH semi-autonomous government agencies.

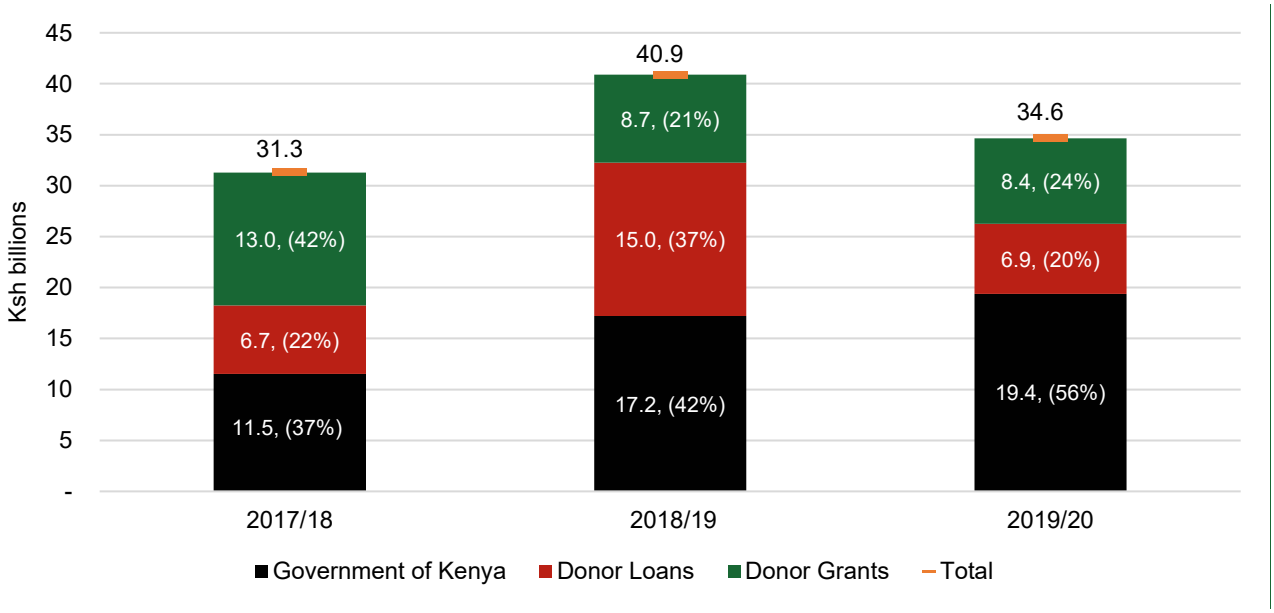
Figure 7 also shows that, four hospitals—Kenyatta National Hospital (KNH), Moi Teaching and Referral Hospital (MTRH), Kenyatta University Teaching, Referral & Research Hospital (KUTRRH) and Mwai Kibaki Teaching and Referral Hospital Othaya—accounted for about 65 percent of the MOH recurrent budget allocations to semi-autonomous government agencies. KNH received the largest allocation at 37 percent (22 percent grants and 15 percent user fees), followed by MTRH at 25 percent (17 percent grants and 8 percent user fees). KUTRRH and Mwai Kibaki Teaching and Referral Hospital Othaya received a combined 3 percent of the MOH recurrent budget allocations to semi-autonomous government agencies. The Kenya Medical Training College (KMTC) was allocated 8 percent and a further 11 percent in appropriations in aid, for a combined 19 percent. The Kenya

Medical Supplies Authority was allocated 1 percent but was expected to raise a further 7 percent from sales of goods, totalling 8 percent of the recurrent allocation to semi-autonomous government agencies.

Ministry of Health Development Budget for FY 2017/18–FY 2019/20

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 between FY 2017/18 to FY 2019/20 are presented in Figure 8.

Figure 8: Composition of development budget, FY 2017/18–FY 2019/20[5]



Source: Republic of Kenya, 2017/18–2019/20a

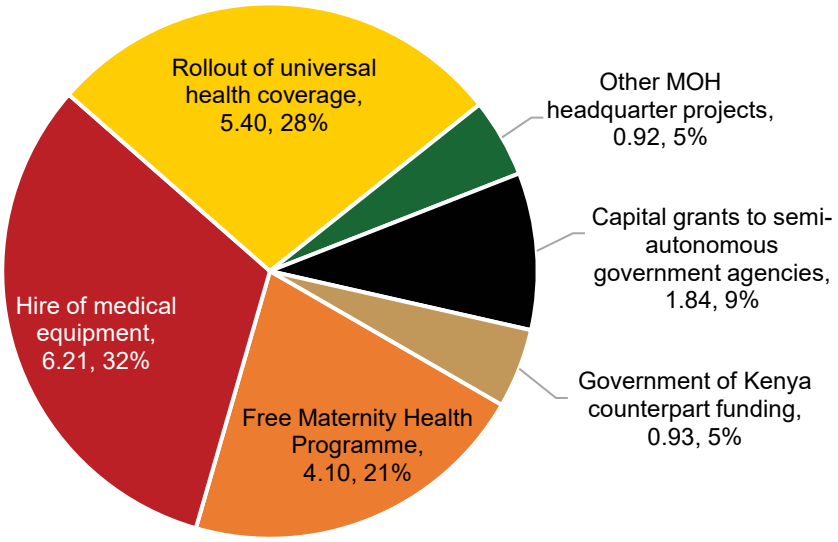
As illustrated in Figure 8, the MOH development budget increased from Ksh 31.3 billion in FY 2017/18 and Ksh 40.9 billion in FY 2018/19 before decreasing to Ksh 34.6 billion in FY 2019/20. The government of Kenya relative contribution has continued to climb from 37 percent (Ksh 11.5 billion) in FY 2017/18 to 42 percent (Ksh 17.2 billion) in FY 2018/19, reaching 56 percent (Ksh 19.4 billion) in FY 2019/20. The proportion represented by donor loans increased from 22 percent (Ksh 6.7 billion) in FY 2017/18 to 37 percent (Ksh 15 billion) in FY 2018/19 and then decreased to 20 percent (Ksh 7 billion) in FY 2019/20. Donor grant contributions decreased over the period, from Ksh 13 billion to Ksh 8.4 billion by FY 2019/20. Donors are therefore reducing their contributions to the MOH budget or possibly channelling support through off-budget support mechanisms. The trend also indicates that the MOH is substituting government of Kenya resources—which are more predictable as sources of financing—for donor grants and loans while gradually expanding its development budget.

[5] Percentages may not add up to 100 percent due to rounding.

Ministry of Health Development Budget by Spending Classification

Figure 9 shows the distribution of the MOH development resources provided by the national government for FY 2019/20 by key areas, amounts, and percentages.

Figure 9: Allocation of government of Kenya development budget to key areas, FY 2019/20 (Ksh billions)



Source: Republic of Kenya, 2019/20

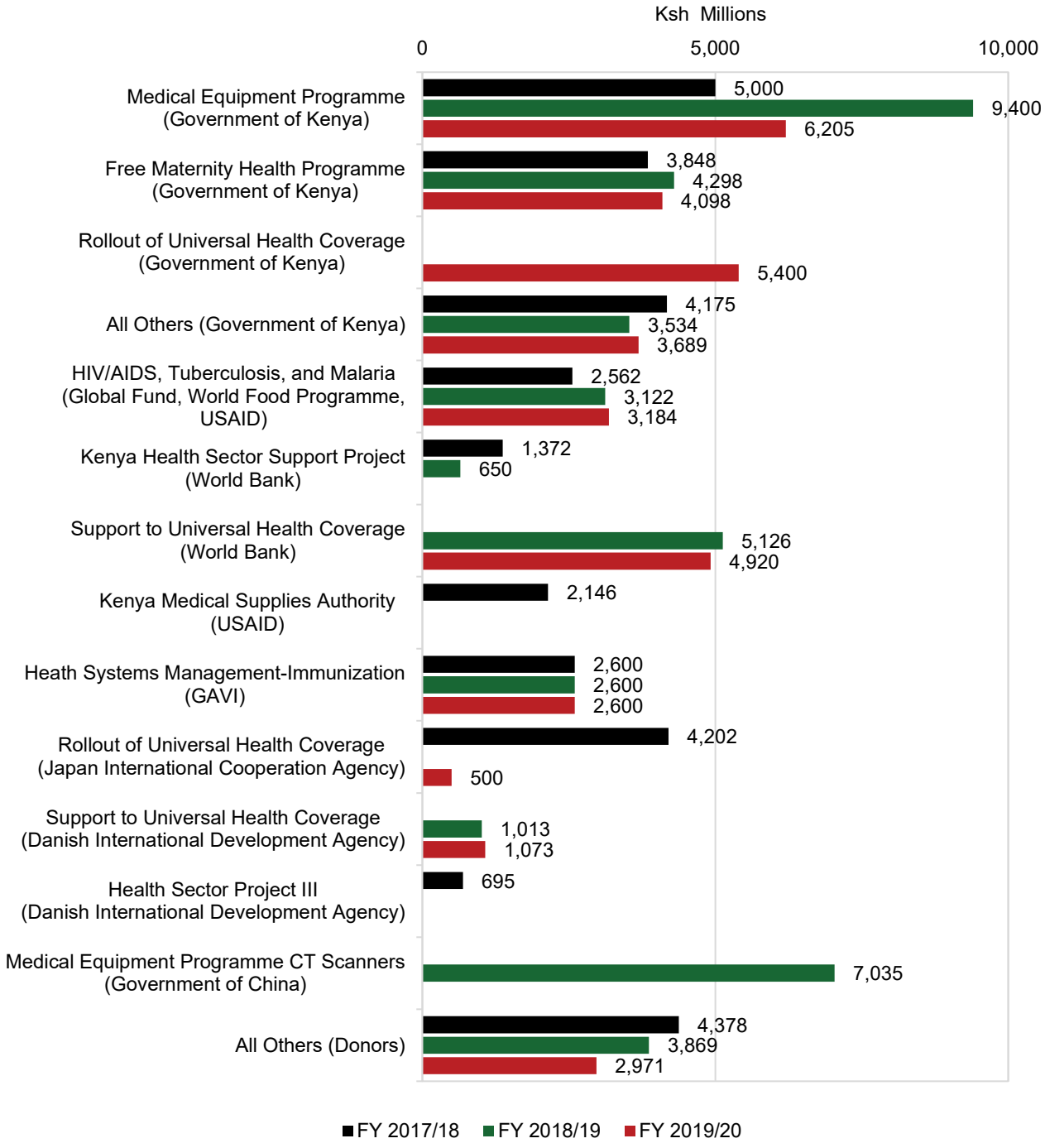
Within its development budget, the Ministry of Health earmarked highest proportion (32 percent) to the hire of medical equipment, followed by the rollout of the universal health coverage programme at 28 percent, and the free maternity programme at 21 percent. Considering that free maternity programme is essentially a universal health coverage initiative, the MOH essentially allocated almost half of government of Kenya development funds for activities directly related to universal health coverage and thus shows commitment to a universal health coverage agenda. Funding for the free maternity programme is earmarked to cover reimbursement to facilities providing free maternity care in FY 2019/20 through the National Hospital Insurance Fund.

The rest of the development budget was earmarked for government of Kenya capital grants to semi-autonomous government agencies (9 percent), the government's contribution to donor-funded programmes (counterpart funding of 5 percent), and other capital development projects under the national government (5 percent).

Programmes Under Development in FY 2017/18–FY 2019/20

Figure 10 presents a summary of allocations to various programmes of the total development budget of the MOH (national government and donor sources) in FY 2017/18, FY 2018/19, and FY 2019/20, by programme and source.

Figure 10: Ministry of Health development budget allocation to programmes, FY 2017/18–FY 2019/20



Source: Republic of Kenya, 2017/18–2019/20a
Note: Government of Kenya's National Treasury categorizes all U.S. Government support as USAID. USAID in this graph represents U.S. Government support from different agencies.

Figure 10 shows that the FY 2019/20 allocation for the rollout of universal health coverage was Ksh 5.4 billion from the government of Kenya and Ksh 6.0 billion from donor resources (World Bank Ksh 4.9 billion and DANIDA Ksh 1.1 billion) for a total of Ksh 11.4 billion, making this category the highest programme priority. If the Free Maternity Health Programme is considered a universal health coverage initiative, the total allocation for universal health coverage is Ksh 15.5 billion, or 44 percent of the entire MOH development budget.

Although there is a decline in the allocation, the medical equipment programme continues to be a priority to the MOH. The programme was allocated Ksh 5 billion in FY 2017/18, which was significantly increased to Ksh 9.4 billion in FY 2018/19 before reduced to Ksh 6.2 billion in FY 2019/20. This allocation represents 18 percent of the MOH development budget in FY 2019/20.

The allocation for the Free Maternity Health Programme increased from Ksh 3.9 billion in FY 2017/18 to Ksh 4.3 billion in FY 2018/19 and then decreased to Ksh 4.1 billion in FY 2019/20. However, more funding for other maternal and reproductive health-related activities is provided under the all others (government of Kenya) and all others (donor) categories in amounts smaller than can be presented in the figure. The Kenya Health Law 2017 has provisions which allow national and county governments, in consultation with the National Treasury, to earmark allocations for reproductive and maternity-related services.

The largest donor contribution to the HIV, tuberculosis, and malaria programme in FY 2019/20 came from the Global Fund to Fight AIDS, Tuberculosis and Malaria, which provided 46 percent of the funding, followed by the World Food Programme with 36 percent, and USAID providing 18 percent. There was a slight increase in the combined resources allocated to HIV by donors, from Ksh 2.6 billion in FY 2017/18 to Ksh 3.2 billion in FY 2019/20.

Immunisation and related health systems support was allocated Ksh 2.6 billion from Gavi, the Vaccine Alliance, annually for FY 2017/18, FY 2018/19 and FY 2019/20. The government of Kenya allocated Ksh 748 million to the programme in FY 2019/20, an increase from the Ksh 703 million allocated in the preceding two fiscal years.

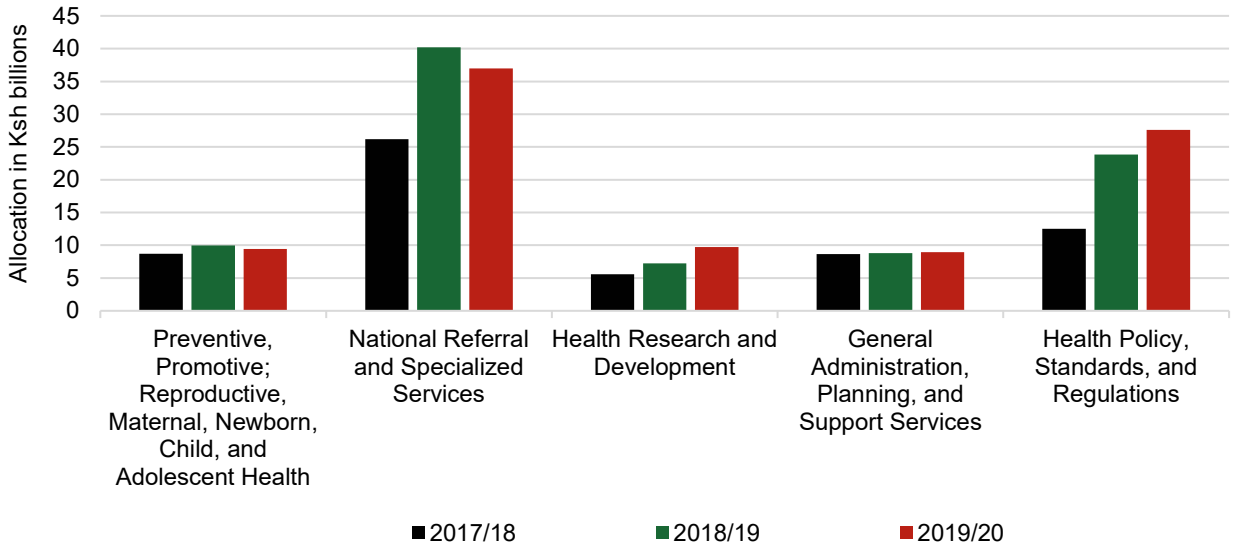
Figure 10 also indicates that the World Bank and Danish International Development Agency appear to have discontinued their funding of Health Sector Support programmes over the review period, and most probably may be directing those resources to the counties.

Analysis of Ministry of Health Allocations to Programmes

The MOH designates five programmes for delivering its mandate. Figure 11 shows the MOH budget allocation to programmes for FY 2017/18 through FY 2019/20, which includes the recurrent and development budgets. Figure 11 also shows growth over the period and the proportion of the programme allocation to the MOH budget.

Figure 11 shows increasing allocations to all programmes except Preventive, Promotive, Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCAH) and the National Referral and Specialized Services programmes, both of which declined during FY 2018/19–FY 2019/20. Significant increases are shown for Health Policy Standards and Regulations and the Health Research and Development programmes respectively. Some universal health coverage-related activities, including subsidies, are budgeted under Health Policy, Standards, and Regulations, and contribute to the growth observed under the two programmes

Figure 11: Ministry of Health budget allocations to programmes, FY 2017/18–FY 2019/20



Source: Republic of Kenya, 2017/18–2019/20a

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 primarily determined from functions assigned by the Constitution. To deliver these services, health departments are allocated resources by the county governments through annual budgets to finance their operations and investments. This section analyses the pattern of county financing for public health services.

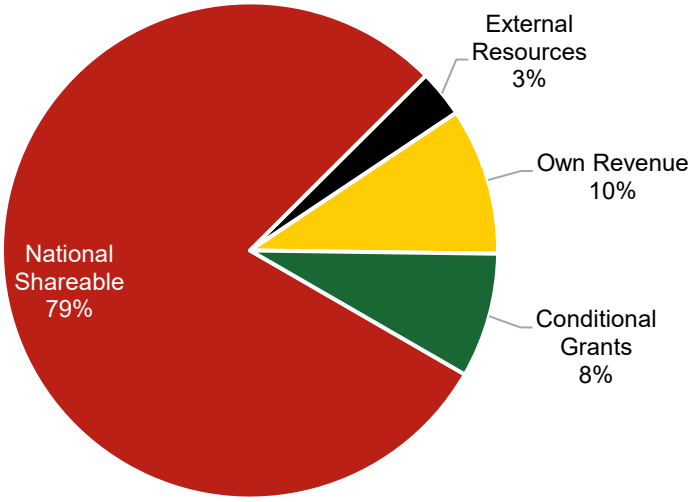
Sources of County Health Budgets

Health departments receive funds from (i) county government allocations, derived from national equitable shareable revenue, i.e., revenue raised nationally and shared equitably among the national and county governments, (ii) revenue generated from user fees charged for services,[6] (iii) conditional grants from the national government,[7] and (iv) external resources from donors. Contributions to the health departments' budgets are shown in Figure 12.

Figure 12 shows FY 2019/20 data on the source of funding for seven selected counties.[8] The largest share of county public health budgets is realized from allocations from national shareable revenue at 79 percent. Own revenues, when returned to the county health budget, contribute 10 percent, while conditional grants and external sources contribute 10 percent and 3 percent, respectively. Both forms of these financial sources are often unpredictable and not completely sustainable forms of resources for health, especially from external resources.

[6] Counties independently determine services for which they will charge user fees and how much to charge. Counties also decide whether these funds will be retained by the facility, transferred to the county health department, or transferred in periodic tranches to higher authorities for pooled uses along with revenues generated by other sectors.
[7] Conditional grants are meant to promote national government agenda at county level.
[8] Kilifi, Kisumu, Kitui, Migori, Mombasa, Nakuru, and Turkana counties.

Figure 12. Source of county health budget, FY 2019/20

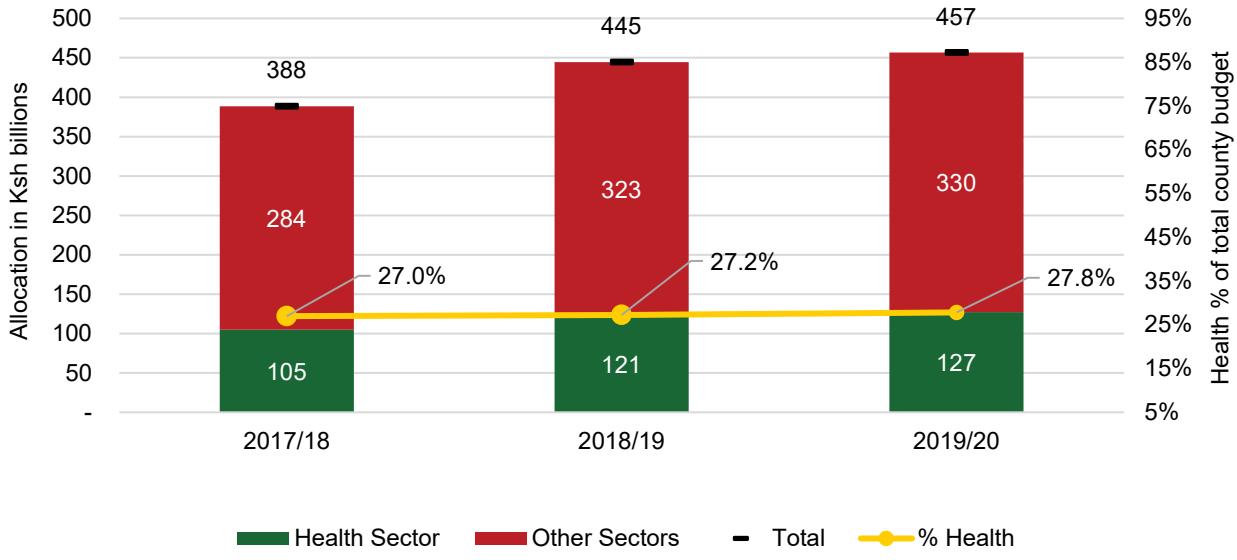


Source: Republic of Kenya, 2017/18–2019/20b

Overall Allocations to Health by County Governments

The proportion of the county health budget in relation to the total county government budget indicates the level of priority that county governments place on the health sector. Figure 13 shows counties' budget allocation to health during FY 2017/18–FY 2019/20.

Figure 13: County governments' allocation to health and all other sectors, FY 2017/18–FY 2019/20[9]



Source: Republic of Kenya, 2017/18–2019/20b

[9] For FY 2019/20, the Ksh 127 billion of county health budgets in Figure 13 differs from the Ksh 121 billion reported in the combined analysis section (Government Budget Allocations to Health Pre- and Post-Devolution). Ksh 127 billion includes the transfers received from the MOH budget since the counties have discretion to allocate the funds once transferred.

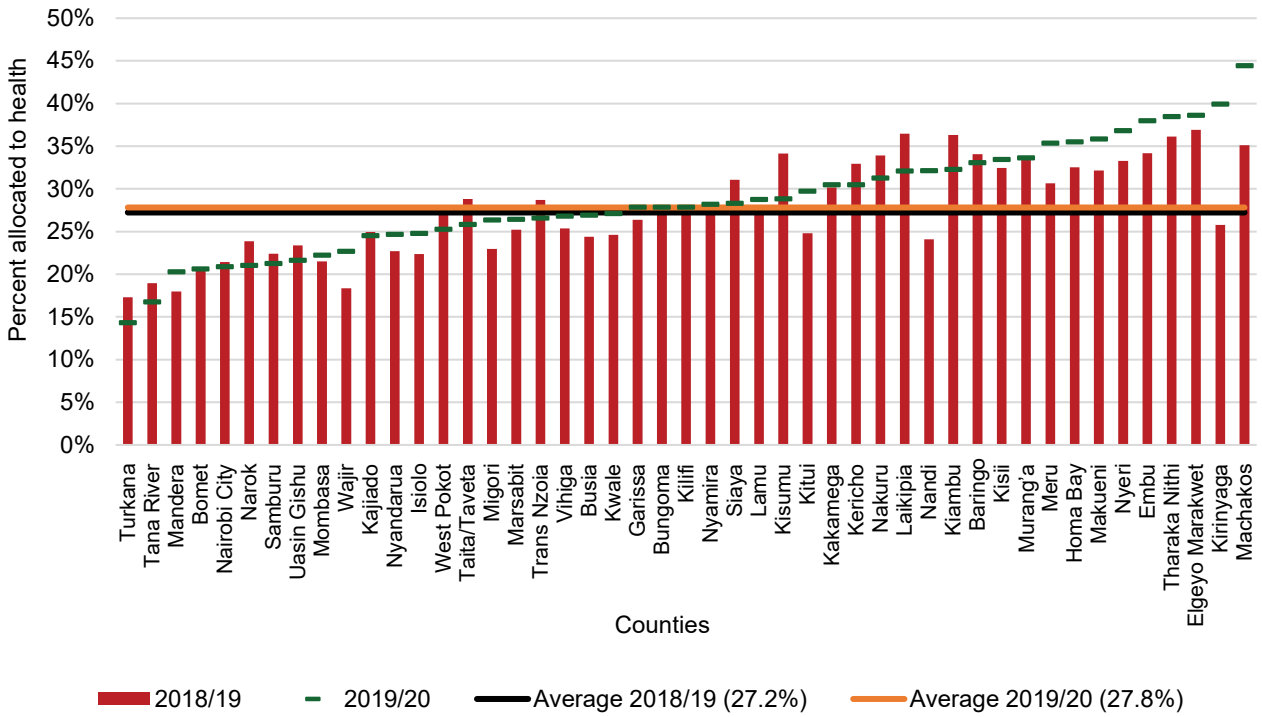
Counties' budgets expanded from Ksh 388 billion in FY 2017/18 to Ksh 445 billion in FY 2018/19 and Ksh 457 billion in FY 2019/20, representing an increase of 18 percent over the three-year period (and a slight increase of 3 percent between FY 2018/19 and FY 2019/20). Allocations to health increased slightly faster than overall growth in county government budgets, from Ksh 105 billion in FY 2017/18 to Ksh 121 billion in FY 2018/19 and Ksh 127 billion in FY 2019/20. The expansion in health funding represents 21 percent growth from FY 2017/18 through FY 2019/20 and an increase of 5 percent from the second to the third year.

Figure 13 also shows that, despite this growth, the county governments' allocations to the health sector as a percentage of total county governments budgets increased only marginally over the period, from 27.0 percent in FY 2017/18 to 27.2 percent in FY 2018/19 and 27.8 percent in FY 2019/20. Even with this marginal increase, on average, health remains a priority sector for the county governments.

Allocations to Health by County

Figure 14 indicates that counties on average increased their absolute funding and as well as the proportion of the budget allocated to health during FY 2017/18–FY 2019/20. However, different counties performed differently. Figure 14: Allocation to health as a percent of total county budget by county, FY 2018/19 and FY 2019/20 shows the percentages of the budgets allocated to health by county and compares them with averages across all 47 counties during FY 2018/19–FY 2019/20.

Figure 14: Allocation to health as a percent of total county budget by county, FY 2018/19 and FY 2019/20



Source: Republic of Kenya, 2018/19–2019/20

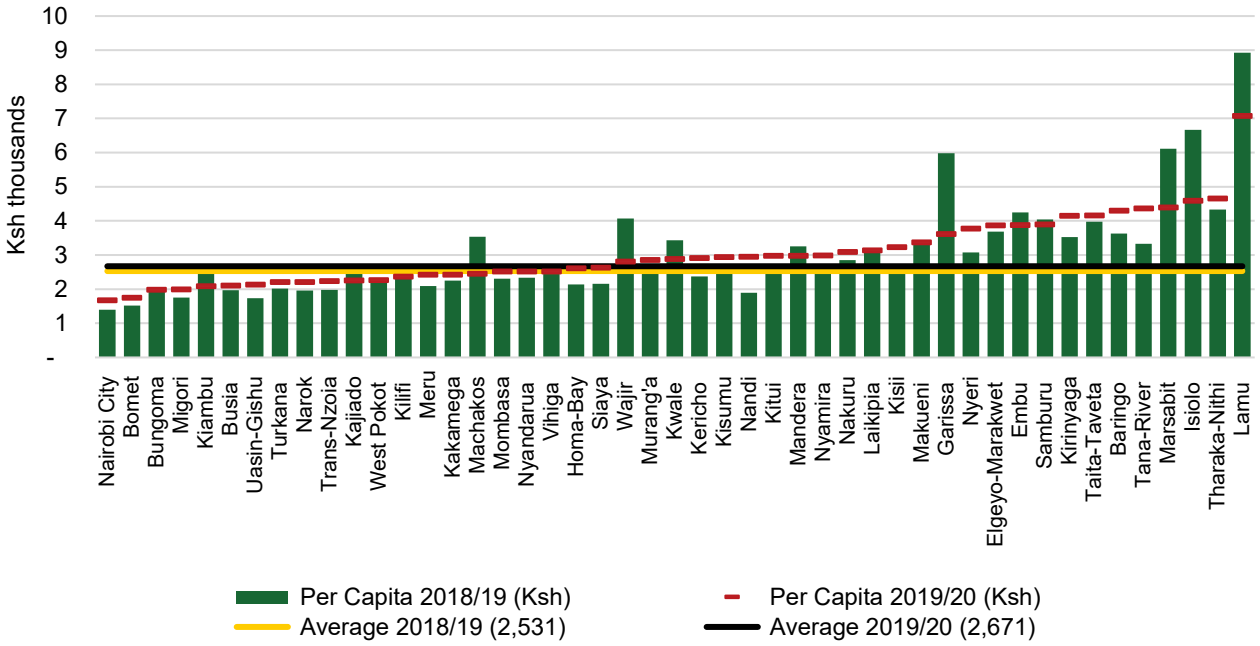
The aggregate proportion of counties' budgets dedicated to health increased from 27.2 percent in FY 2018/19 to 27.8 percent in FY 2019/20, with most counties (28 of 47) increasing the proportionate budget over the two fiscal years. The allocation decreased in the remaining 19 counties. Nine counties achieved or surpassed the estimated pre-devolution allocation of 35 percent in FY 2019/20

as compared to only two the previous year. The data in Figure 14 do not suggest any particular differences between high-performing and low-performing counties, meaning that low-performing counties have the potential to increase their proportional allocations to health.

Per Capita Allocations to Health by County, FY 2018/19 and FY 2019/20

Per capita allocations provide a valuable measure of a county's commitment to the health sector. Figure 15 provides per capita health budget allocations by county for FY 2018/19 and FY 2019/20.

Figure 15: County per capita health budget allocations, FY 2018/19–2019/20



Sources: Republic of Kenya, 2018/19–2019/20; Republic of Kenya (Kenya National Bureau of Statistics), 2009

Figure 15 shows that counties collectively increased their per capita budget allocation to health 5.5 percent between FY 2018/19 to FY 2019/20, from Ksh 2,531 to Ksh 2,671. The per capita allocation varied across counties; the range in FY 2019/20 was Ksh 1,676 in Nairobi County to Ksh 7,080 in Lamu County. Most counties (34 out of 47) maintained or increased the health budget per capita allocation; 13 decreased the allocation.

County Health Budget Allocations to Recurrent and Development

County governments determine the proportion of funds to be allocated to recurrent and development activities. The PFMA 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, so as to consistently invest in expansion and yet maintain the provision of services. This section analyses how counties allocated funding for recurrent and development activities during FY 2017/18–FY 2019/20.

Overall Health County Recurrent and Development Expenditure Allocations

Table 2 presents counties' absolute and relative allocations for recurrent and development activities.

Table 2: Recurrent and development allocations, health sector, FY 2017/18–FY 2019/20, Ksh billions

Budget category	FY 2017/18	FY 2018/19	FY 2019/20
Recurrent	85.8 (81.9%)	95.3 (78.7%)	104.5 (82.3%)
Development	19.0 (18.1%)	25.8 (21.3%)	22.5 (17.7%)
TOTAL	104.8 (100%)	121.1 (100%)	127.1 (100%)

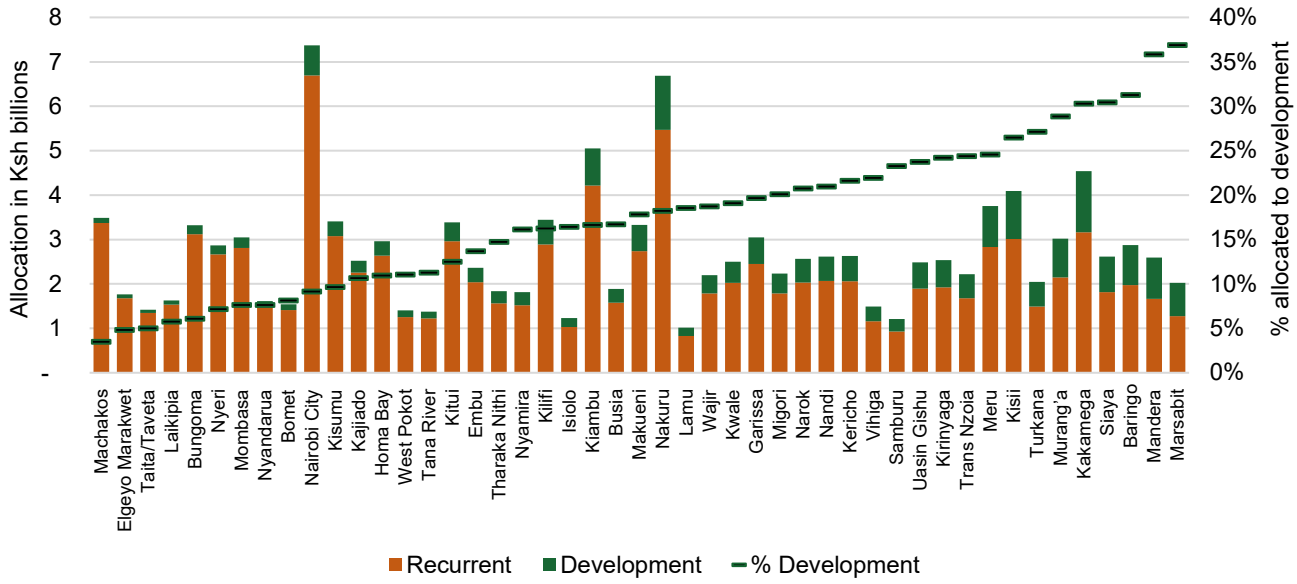
Source: Republic of Kenya, 2017/18–2019/20b

Table 2 shows that counties' health sector budgets continued to be dominated by recurrent activities, making up 81.9 percent of all county health budgets in FY 2017/18, 78.7 percent in FY 2018/19, and 82.3 percent in FY 2019/20. The trend represents an overall increase in proportion of the budget allocated for recurrent expenditures, and thus an overall decrease in development expenditure allocations. Absolute allocations for recurrent expenditures increased from Ksh 85.8 billion in FY 2017/18 to Ksh 95.3 billion in FY 2018/19 and to Ksh 104.5 billion in FY 2019/20, while allocations to development expenditures increased from Ksh 18.9 billion in FY 2017/18 to Ksh 25.8 billion in FY 2018/19 before decreasing to Ksh 22.5 billion in FY 2019/20. The increasing budget allocations for health are disproportionately channelled toward recurrent expenditures, even as the aggregate proportion allocated to development remains well below the 30 percent recommended by the PFMA of 2012.

Proportion of Budget Allocations to Recurrent and Development Budgets by County, FY 2019/20

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 budget allocations to development, regardless of the absolute amounts allocated to health. Figure 16 presents recurrent and development allocations by county for FY 2019/20, ranked by percent of budget allocated to development.

Figure 16: Allocation to recurrent and development activities by county, FY 2019/20



Source: Republic of Kenya, 2019/20b

The health budget allocations ranged from Ksh 1.02 billion in Lamu to Ksh 7.37 billion in Nairobi City, and the proportion allocated for development ranged from 3.5 percent in Machakos to 36.9 percent in Marsabit. Table 3 lists 42 counties that allocated less than 30 percent of the health budgets to development expenditures (i.e., more than 70 percent to recurrent) and thus below the recommended threshold; five counties met that threshold.[10] These five counties show no common characteristic, indicating that other counties have the potential to allocate a higher proportion of funds to the development budget.

Table 3: Proportion of counties' health allocation dedicated to recurrent activities, FY 2019/20

61–70%	71–80%	80–90%	Over 90%
Marsabit: 63.1% Mandera: 64.2% Baringo: 68.7% Siaya: 69.6% Kakamega: 69.7%	Murang'a: 71.1% Turkana: 72.9% Kisii: 73.5% Meru: 75.4% Trans Nzoia: 75.6% Kirinyaga: 75.8% Uasin Gishu: 76.3% Samburu: 76.7% Vihiga: 78.0% Kericho: 78.4% Nandi: 79.0% Narok: 79.2% Migori: 79.9%	Garissa: 80.3% Kwale: 80.9% Wajir: 81.3% Lamu: 81.4% Nakuru: 81.8% Makueni: 82.2% Busia: 83.3% Kiambu: 83.4% Isiolo: 83.6% Kilifi: 83.8% Nyamira: 83.9% Tharaka Nithi: 85.3% Embu: 86.3% Kitui: 87.5% Tana River: 88.7% West Pokot: 89.0% Homa Bay: 89.0% Kajiado: 89.3%	Kisumu: 90.3% Nairobi City: 90.9% Bomet: 91.8% Nyandarua: 92.4% Mombasa: 92.4% Nyeri: 92.8% Bungoma: 93.9% Laikipia: 94.2% Taita/Taveta: 95.0% Elgeyo Marakwet: 95.2% Machakos: 96.5%

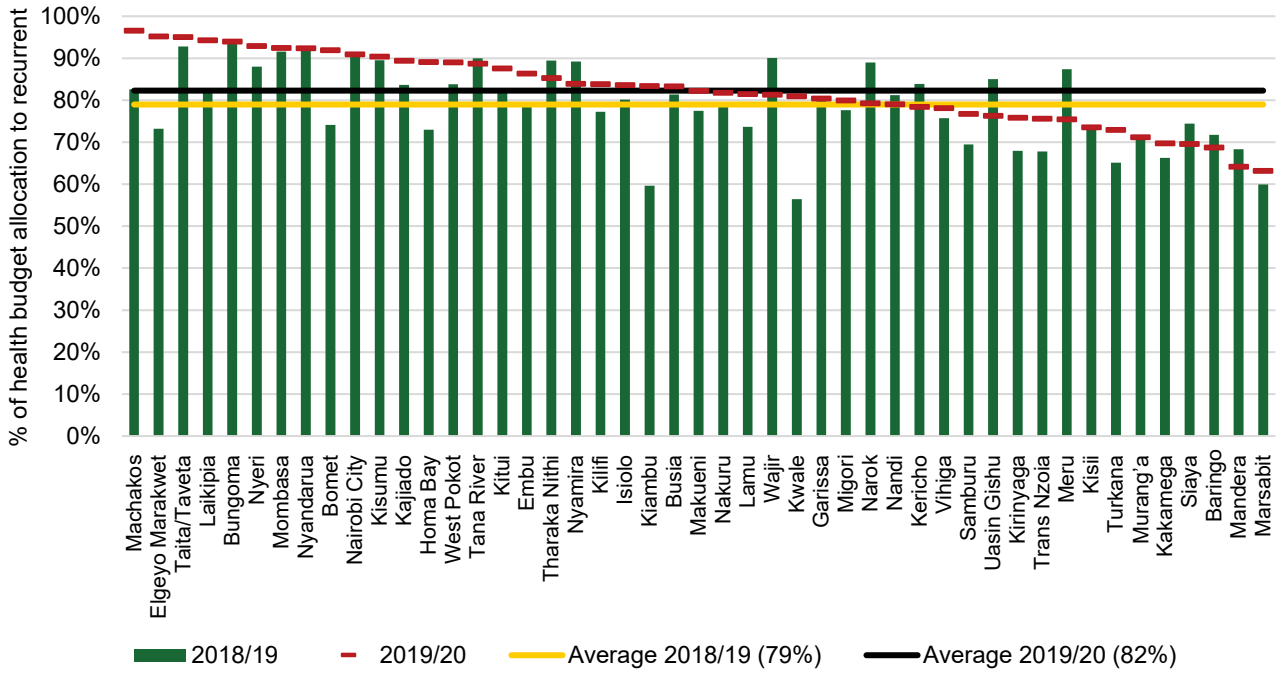
Source: Republic of Kenya, 2019/20b

[10] Kenya's Public Financial Management Act of 2012 recommends that counties' development expenditures over the medium term are not less than 30 percent of total county expenditures.

Trends in Recurrent versus Development Allocations by County, FY 2018/19–FY 2019/20

Figure 17 presents recurrent health budget allocations as a percentage of total health allocations during FY 2018/19–FY 2019/20 by county.

Figure 17: Recurrent allocations as a percentage of health allocations by county, FY 2018/19–2019/20



Source: Republic of Kenya, 2019/20b

Figure 17 shows that, on average, the proportion of county health budgets allocated to recurrent increased from 79 percent in FY 2018/19 to 82 percent in FY 2019/20, leaving fewer resources for development activities. The proportion of the total health budget dedicated to recurrent activities increased in Bomet, Homa Bay, Elgeyo Marakwet, Embu, Kiambu, Kirinyaga, Kwale, Laikipia, Lamu, Machakos, Samburu, Trans Nzoia, and Turkana counties. Substantial decreases in recurrent allocations between FY 2018/19 and 2019/20 were observed for Meru, Narok, Uasin Gishu, Wajir, Kericho, Nyamira, Siaya, Tharaka Nithi, Mandera, and Baringo. On the whole, counties do not seem to be succeeding in containing recurrent allocations in their budgets.

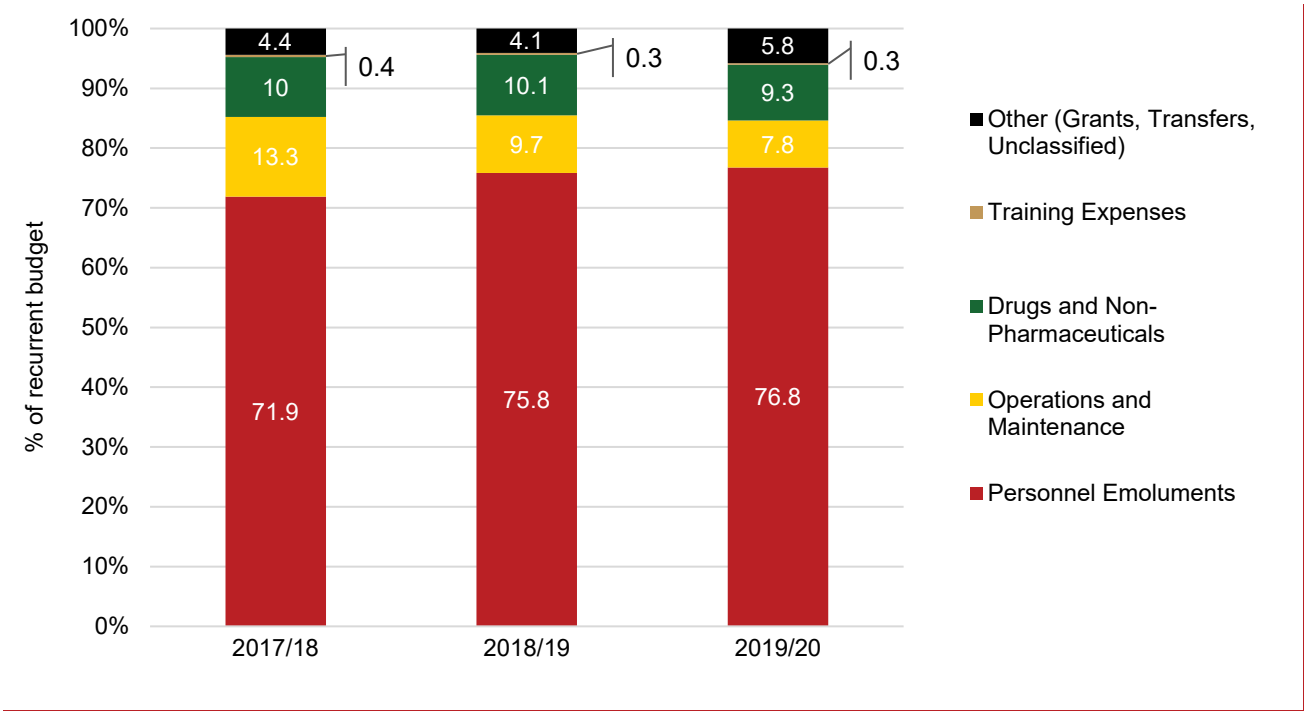
County Health Budget Allocations by Economic Category

As counties move toward implementing programme-based budgeting, it is prudent to analyse budget allocations by key health inputs. Programme-based budgeting classifies allocations according to specific programs, disaggregated into sub-program economic categories. The formatting of programme-based budgeting provides an assessment of whether health inputs are balanced and positioned to achieve technical and operational efficiency in service delivery. This section examines how counties allocated their recurrent and development budgets by economic categories.

Health Recurrent Budget Allocations by Economic Category

Programme-based budgeting guidelines propose the disaggregation of the recurrent budget into the four economic categories—personnel emoluments, operations and maintenance, acquisition of non-financial assets, and "others including transfers." However, health sector budgets are more informative if inputs critical for service delivery are identified and separated from the operations and maintenance category to demonstrate the priority in allocation given by counties to key inputs. Figure 18 presents the pattern in counties' health recurrent budget allocations by economic categories relevant in the health sector.

Figure 18: County health recurrent budget allocations (%) by economic category, FY 2017/18–FY 2019/2011



Source: Republic of Kenya, 2017/18–2019/20b

Figure 18 shows that allocations for the personnel emoluments category take up the largest share of the recurrent budget, accounting for 71.9 percent in FY 2017/18, increasing to 75.8 percent in FY 2018/19 and 76.8 percent in FY 2019/20. Figure 18 also shows a decrease in the proportion of budgets allocated to operations and maintenance, from 13.3 percent in FY 2017/18 to 9.7 percent in FY 2018/19 and 7.8 percent by FY 2019/20. Allocations for drugs and non-pharmaceutical supplies, considered essential health inputs, have been decreasing, dropping from 10.0 percent in FY 2017/18 to 9.3 percent by FY 2019/20. Allocations for other recurrent expenses, including grants and transfers, decreased slightly, from 4.4 percent in FY 2017/18 to 4.1 percent in FY 2018/19 before increasing to 5.8 percent in FY 2019/20. It appears that broadly speaking, growth in budget allocations for personnel emoluments over the period is constraining other essential inputs.

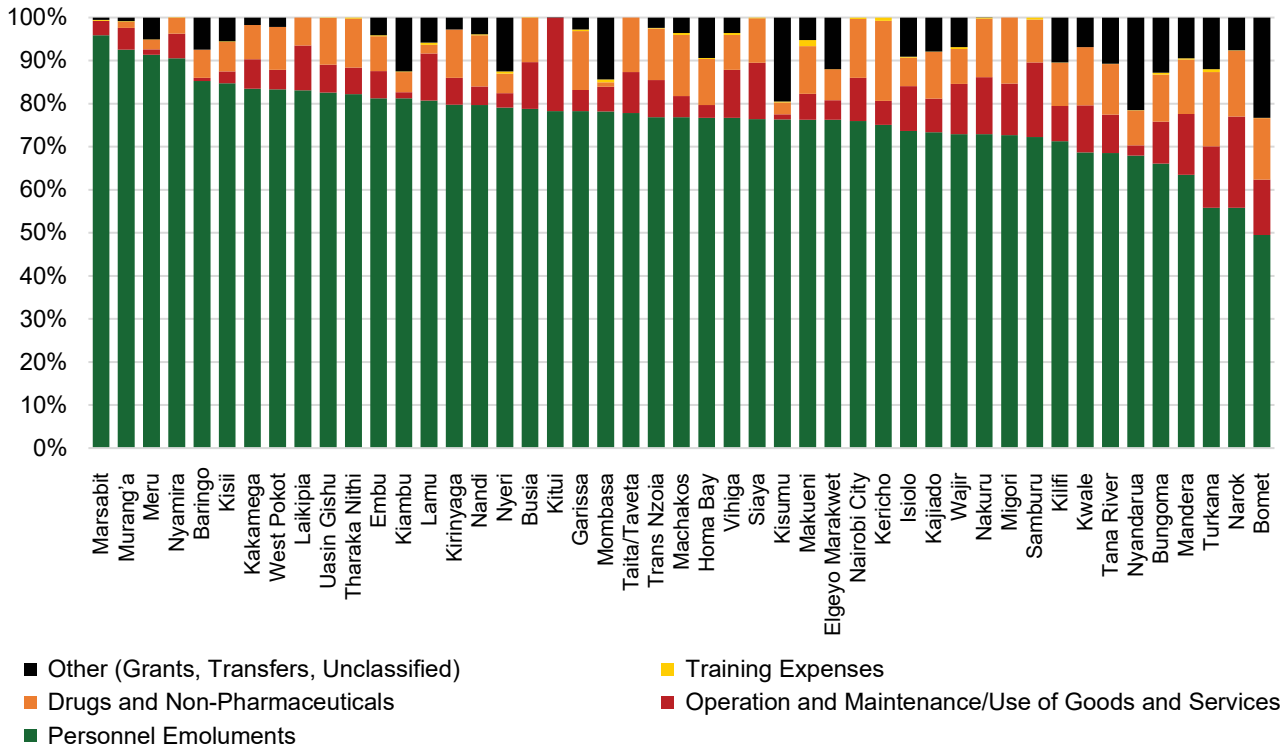
Health Recurrent Budget Allocations by Economic Category by County, FY 2019/20

Individual counties varied in how they allocated their FY 2019/20 recurrent budgets. Figure 19 shows individual counties' allocations to personnel emoluments; drugs and non-pharmaceuticals;

[11] Figures may not add to 100 percent due to rounding.

training; operations, and the "other" category, which includes grants, transfers, and unclassified expenditures.

Figure 19: Health recurrent budget allocations (%) by economic category by county, FY 2019/20



Source: Republic of Kenya, 2019/20b

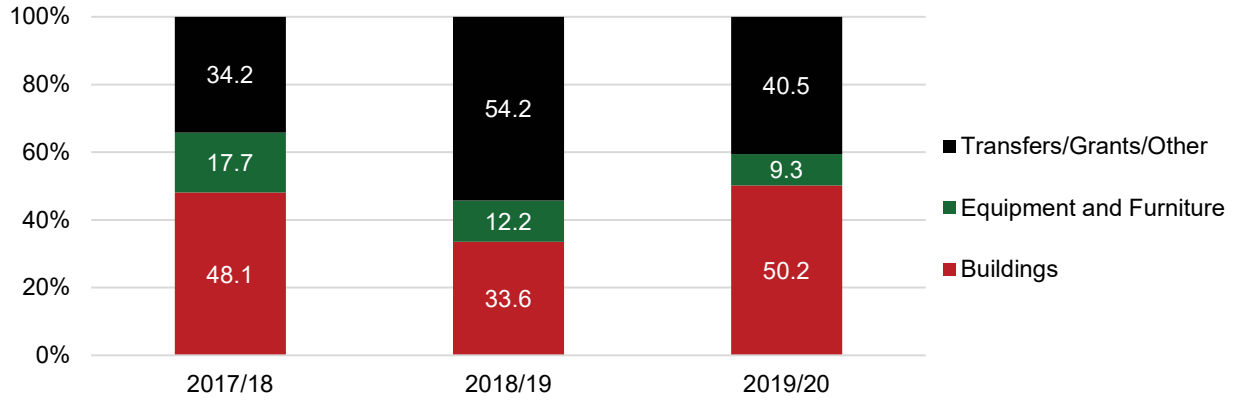
Figure 19 shows that during FY 2019/20, Bomet, Narok, and Turkana counties allocated less than 60 percent of their recurrent budgets to personnel emoluments, a level that allows sufficient resources for other critical health inputs. At the other extreme, Marsabit, Murang'a, and Meru allocated more than 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 (76.8 percent) for 30 out of the 47 counties.

Health Development Budget Allocation by Economic Category

As noted previously in Table 2, counties are gradually decreasing the absolute amount and proportion of their health budgets allocated to development. Figure 20 shows the trend in development budget allocation by category over a three-year period.

The highest proportion of expenditures in FY 2017/18 was investment in construction projects. The category accounted for about 48.1 percent, declining to 33.6 percent in FY 2018/19 and increasing to 50.2 percent in FY 2019/20. Construction plus equipment and furniture totalled 65.8 percent in FY 2017/18, 45.8 percent in FY 2018/19, and 59.5 percent in FY 2019/20. The proportion of funds allocated to transfers, grants, and other development increased from 34.2 percent in FY 2017/18 to 54.2 percent in FY 2018/19 and decreased to 40.5 percent in FY 2019/20.

Figure 20: County health services development budget allocations (%) by economic category, FY 2017/18–FY 2019/20

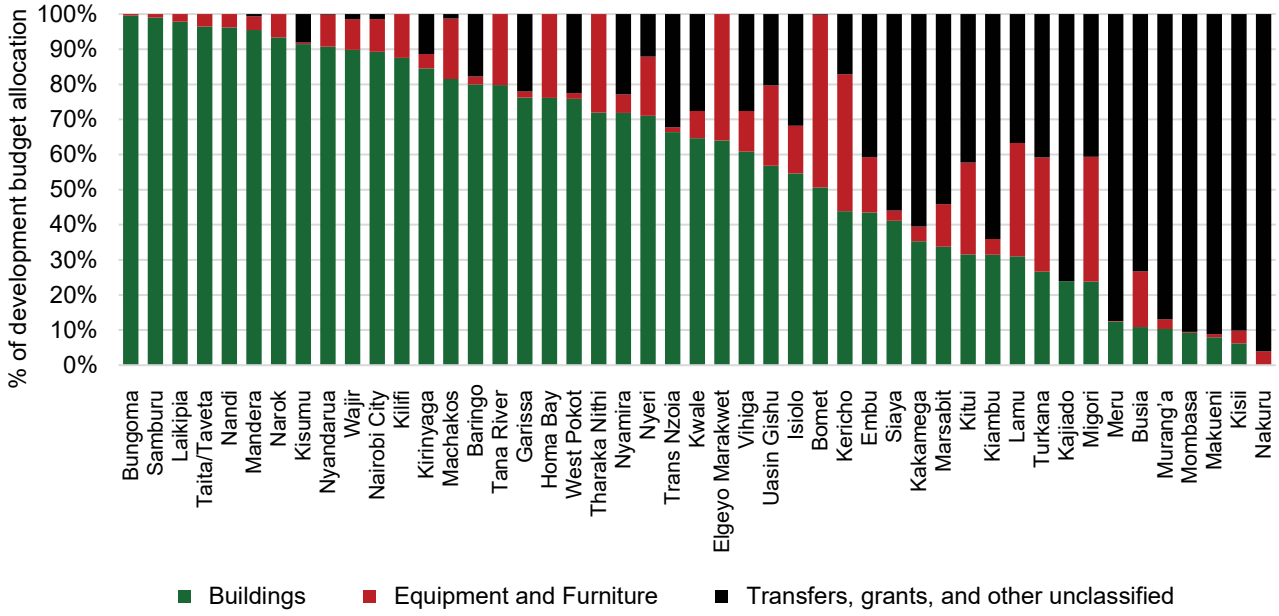


Source: Republic of Kenya, 2017/18–2019/20b

Health Development Budget Allocation by Economic Category by County, FY 2019/20

Individual counties varied in how they allocated their FY 2019/20 development budgets. Figure 21 shows individual counties' allocations for FY 2019/20 to buildings; equipment and furniture; and grants, transfers, and other development expenditures not classified among these categories.[12]

Figure 21: Individual counties' health development budget allocations (%) by economic category, FY 2019/20



Source: Republic of Kenya, 2019/20b

Figure 21 shows that more than half of the counties are expanding their physical infrastructure by allocating more than 50 percent of their development budget to buildings. However, counties that seem to allocate little or no funds reported the highest allocation of the development budget under

[12] Counties apportion part of their development budget as bulk grants and transfers to their owned institutions and facilities that are semi-autonomous and who independently budget and incur expenditures out of the grant or transfers provided.

the category of transfers, grants, and unclassified, which may incorporate elements of other categories, including buildings and equipment. If that is the case, it suggests counties are preferring to implement infrastructure expansion through grants and transfers.

CONCLUSIONS AND RECOMMENDATIONS

This study sought to explore Kenya's budget allocations to the MOH. The question is whether these resources were allocated appropriately during FY 2017/18–FY 2019/20 to achieve the country's intended health priorities with a view to inform resource allocation policies in the health sector. The study findings lead to the following conclusions and recommendations.

Conclusions

- The proportion of the national government budget allocated to health increased from 3.7 percent in FY 2017/18 to 5.1 percent in FY 2018/19 and decreased slightly to 4.8 percent in FY 2019/20. The national government increased the absolute allocation between FY 2017/18 and 2018/19 by 48 percent, while increasing it in FY 2019/20 by only 3 percent. The relatively smaller increase in FY 2019/20 may indicate a saturation in national government resource allocations to the MOH.
- Even though the MOH has reinstated Ksh 900 million in the budget for free services at primary health facilities, the funding is not guaranteed to directly benefit the facilities. The actual reimbursement is either channelled to a county's general revenue account or not provided by the counties as an addition to health facilities' allocation.
- Although the proportion of donors' contribution to the development budget declined from 63 percent in FY 2017/18 to 44 percent by FY 2019/20, donors remain the main support for core programmes such as HIV, tuberculosis, and malaria. A high dependence on donors for financing key programmes persists, raising issues of ownership and sustainability.
- The proportion of the MOH budget allocated for Preventive, Promotive, Reproductive, Maternal, Newborn, Child, and Adolescent Health Services has been gradually declining over the last three years, from a high of 14 percent in FY 2017/18 to 10 percent in FY 2019/20. The MOH allocation to this category is insufficient to meet its policy objectives in eliminating preventable diseases and conditions.
- The budget allocation for the Free Maternity Health Programme increased from Ksh 3.9 billion in FY 2017/18 to Ksh 4.1 billion in FY 2019/20. It is expected that the change of the funding mechanism for free maternity services from MOH disbursement to the use of the National Hospital Insurance Fund mechanism will be innovative, efficient, and effective in reaching nongovernmental providers.
- County governments are committed to increasing—in absolute and relative terms—their budgetary allocations to health. Overall county health sector budgets have been increasing gradually over the last three years. Counties are prioritizing health in their budgets with proportional allocations of 27.0 percent in FY 2017/18 and 27.8 percent in FY 2019/20. Although there were noticeable variations among counties, the allocations reflect the high priority given to health.
- The number of counties allocating more than 30 percent of their budgets to the health sector remained flat—19 counties in FY 2017/18 and 18 counties in FY 2019/20. County governments must continue prioritizing the health sector in budget allocations to successfully implement their planned projects.
- Most counties increased their relative contributions to recurrent categories compared to development over the period studied. This trend in the counties' recurrent budget allocations

suggests that counties continue to increase allocations to personnel emoluments instead of shifting resources to other critical inputs. The aggregate percentage allocated to personnel emoluments among counties remains high at 77 percent, in contrast to the recommended 50 to 60 percent.

- Counties' allocations for medical drugs and non-pharmaceuticals supplies, considered essential health inputs, continues to decrease.
- Study results show the predominance of recurrent over development expenditure estimates across counties. Counties are allocating less than adequate resources for development expenditures. This is especially true for Kisumu, Nairobi, Bomet, Nyandarua, Mombasa, Nyeri, Bungoma, Laikipia, Taita/Taveta, Elgeyo Marakwet, and Machakos, which are allocating less than 10 percent for development expenditures.
- County development budgets are allocated mostly to new infrastructure, whereas only a minimal amount is allocated to rehabilitation. Rapid expansion of facilities demands more allocations to the recurrent budget in the future and thus less funding for development.

Recommendations

In the light of these findings, this study makes the following recommendations:

- The MOH budget must be expanded for two reasons:
    - To reduce over-reliance on donor resources for key programmes, including those for HIV, tuberculosis, and malaria, and to enhance domestic resource mobilisation for key programmes
    - To extend coverage and access to priority national-level programmes, such as maternity care, immunisation, family planning, and subsidies for free care at primary care facilities
- The MOH needs to align resource allocation to policy priorities, especially in funding for Preventive, Promotive, Reproductive, Maternal, Newborn, Child, and Adolescent Health Services, whose proportion of allocation is comparatively low.
- The MOH should immediately develop the mechanisms stipulated in the recently enacted Kenya Health Law 2017 to ensure that resources disbursed for free care at primary care facilities are ring-fenced and used to increase access to and quality of services at those facilities.
- As budgets expand, counties should allocate resources more efficiently by directing allocations to critical health inputs, especially drugs and related supplies. Counties should also seek to contain unsustainable allocations to personnel emoluments.
- The MOH and its partners should provide more technical support to counties, given that budget allocations for health remain below the proportion allocated for such services before devolution, now five years after devolution.
- Given that a large portion of county health allocations go to personnel emoluments, it is important that rational deployment plans as well as initiatives to enhance productivity are enacted.
- There is a need to ensure that over the medium term, a minimum of 30 percent of county governments' budgets is allocated to development expenditures, as recommended in the

PFMA of 2012. However, unless counties receive sufficient allocations for health, it will remain difficult for them to allocate to their development budgets before meeting the needs of their recurrent budgets.

- The constitutional obligation of delivering most healthcare services rests with counties, and thus counties should continue increasing the amount they allocate to health, as they are yet to realise the recommended 35 percent average. Counties ranked lowest in allocating funds to health should be encouraged and given the capacity to increase these allocations. Planning, budgeting, and advocacy capacities for those counties should be enhanced.

REFERENCES

Republic of Kenya. 2008. *Kenya Vision 2030*. Nairobi, Kenya: Republic of Kenya.

Republic of Kenya (Kenya National Bureau of Statistics). 2009. *Kenya Population and Housing Census 2009*. Nairobi, Kenya: Kenya National Bureau of Statistics, Republic of Kenya.

Republic of Kenya (National AIDS Control Council (NACC). 2012. *Kenya AIDS Indicator Survey 2012*. Nairobi, Kenya: Republic of Kenya.

Republic of Kenya. 2012/13–2019/20. *Estimates of Recurrent and Development Expenditures,* Nairobi, Kenya. Republic of Kenya.

Republic of Kenya. 2013/14–2019/20. *County Budget Estimates*. Nairobi, Kenya. Republic of Kenya.

Republic of Kenya (Ministry of Health). 2014. *Kenya Health Sector Strategic Plan 2014–18*. Nairobi, Kenya: Republic of Kenya.

Republic of Kenya. 2017/18–2019/20a. *Estimates of Recurrent and Development Expenditures*. Nairobi, Kenya. Republic of Kenya.

Republic of Kenya. 2017/18–2019/20b. *County Budget Estimates*. Nairobi, Kenya. Republic of Kenya.

Republic of Kenya (National AIDS and STI Control Programme (NASCOP)). 2018. *Kenya HIV Estimates, Report 2018*. Nairobi, Kenya: Republic of Kenya.

Republic of Kenya (Ministry of Health). 2018. *National and County Health Budget Analysis 2018/19*. Nairobi, Kenya: Republic of Kenya.

Republic of Kenya. 2018/19–2019/20. *County Budget Estimates*. Nairobi, Kenya. Republic of Kenya.

Republic of Kenya (National Bureau of Statistics). 2019. *Economic Survey 2019*. Nairobi, Kenya: Kenya National Bureau of Statistics, Republic of Kenya.

Republic of Kenya. 2019/20a. *Estimates of Recurrent and Development Expenditures*. Nairobi, Kenya. Republic of Kenya.

Republic of Kenya. 2019/20b. *County Budget Estimates*. Nairobi, Kenya. Republic of Kenya.

Republic of Kenya (National Bureau of Statistics) and ICF. 2015. *Kenya Demographic and Health Survey (KDHS) 2014*. Nairobi, Kenya, and Rockville, MD, USA: Kenya National Bureau of Statistics, Republic of Kenya, and ICF.

Kenyatta, U. 2017. "Speech by His Excellency Hon. Uhuru Kenyatta, C.G.H., President and Commander in Chief of the Defence Forces of the Republic of Kenya during the 2017 Jamhuri Day Celebrations at the Moi International Sports Centre, Kasarani, on 12th December, 2017. Republic of Kenya. Available at https://www.president.go.ke/2017/12/12/speech-by-his-excellency-hon-uhuru-kenyatta-c-g-h-president-and-commander-in-chief-of-the-defence-forces-of-the-republic-of-kenya-during-the-2017-jamhuri-day-celebrations-at-the-moi-international/.

World Health Organization (WHO). 2011. *The Abuja Declaration: 10 Years On*. Geneva, Switzerland: World Health Organization. Available at: http://www.who.int/healthsystems/publications/abuja_declaration/en/.

ANNEX 1: COUNTY HEALTH BUDGET ALLOCATION FY 2019/20

Total budget and health allocation (Ksh)

County	Total Budget	Health Allocation Total	Health Allocation Recurrent	Health Allocation Development
Baringo	8,681,521,003	2,871,336,831	1,973,041,805	898,295,026
Bomet	7,462,094,406	1,539,197,227	1,413,634,727	125,562,500
Bungoma	11,921,532,499	3,323,533,969	3,121,507,658	202,026,311
Busia	7,014,506,252	1,889,674,598	1,574,019,963	315,654,635
Elgeyo Marakwet	4,557,445,040	1,761,616,831	1,676,916,831	84,700,000
Embu	6,217,459,024	2,363,109,690	2,039,538,410	323,571,280
Garissa	10,930,462,277	3,045,589,455	2,446,674,561	598,914,894
Homa Bay	8,337,787,696	2,961,654,513	2,637,334,323	324,320,190
Isiolo	4,968,602,389	1,232,150,569	1,029,553,060	202,597,509
Kajiado	10,286,441,043	2,524,446,135	2,255,046,135	269,400,000
Kakamega	14,872,045,379	4,535,606,497	3,161,606,497	1,374,000,000
Kericho	8,611,379,022	2,626,450,263	2,058,605,579	567,844,684
Kiambu	15,638,800,000	5,052,933,672	4,211,716,907	841,216,765
Kilifi	12,361,738,785	3,447,218,718	2,887,561,155	559,657,563
Kirinyaga	6,338,812,666	2,533,092,065	1,919,821,863	613,270,202
Kisii	12,238,790,961	4,093,880,441	3,010,432,308	1,083,448,133
Kisumu	11,805,545,842	3,407,328,051	3,078,107,649	329,220,402
Kitui	11,378,500,249	3,385,625,718	2,963,019,360	422,606,358
Kwale	9,220,842,555	2,501,998,638	2,024,299,741	477,698,897
Laikipia	5,067,875,000	1,627,195,326	1,533,520,215	93,675,111
Lamu	3,541,578,961	1,018,897,235	829,797,235	189,100,000
Machakos	7,850,709,245	3,490,596,994	3,368,590,374	122,006,620
Makueni	9,286,317,262	3,331,726,419	2,737,446,594	594,279,825
Mandera	12,763,400,807	2,590,423,258	1,661,900,338	928,522,920
Marsabit	7,641,139,415	2,022,535,525	1,276,514,381	746,021,144
Meru	10,607,744,925	3,752,612,454	2,830,686,250	921,926,204
Migori	8,462,640,607	2,232,317,637	1,783,356,079	448,961,558
Mombasa	13,679,368,038	3,045,477,310	2,813,285,534	232,191,776
Murang'a	8,967,803,594	3,019,534,506	2,148,210,297	871,324,209
Nairobi City	35,283,295,889	7,369,000,001	6,695,744,601	673,255,400
Nakuru	21,377,017,362	6,687,894,142	5,468,058,130	1,219,836,012
Nandi	8,133,676,476	2,614,143,072	2,065,779,557	548,363,515
Narok	12,169,977,930	2,562,176,843	2,030,447,832	531,729,011
Nyamira	6,428,365,421	1,813,703,086	1,521,137,865	292,565,221
Nyandarua	6,521,891,236	1,610,119,476	1,487,216,976	122,902,500
Nyeri	7,787,075,422	2,869,352,371	2,664,135,137	205,217,234
Samburu	5,682,188,870	1,209,750,378	928,255,484	281,494,894
Siaya	9,223,350,139	2,612,860,606	1,817,358,172	795,502,434
Taita/Taveta	5,478,701,636	1,417,323,931	1,346,223,931	71,100,000

County	Total Budget	Health Allocation Total	Health Allocation Recurrent	Health Allocation Development
Tana River	8,224,541,330	1,379,137,966	1,223,471,966	155,666,000
Tharaka Nithi	4,766,155,422	1,834,043,792	1,563,628,898	270,414,894
Trans Nzoia	8,336,783,996	2,216,617,567	1,675,750,748	540,866,819
Turkana	14,267,747,812	2,048,338,814	1,493,035,859	555,302,955
Uasin Gishu	11,470,437,174	2,483,543,599	1,894,155,122	589,388,477
Vihiga	5,556,670,244	1,489,861,964	1,162,760,426	327,101,538
Wajir	9,666,416,131	2,196,003,588	1,785,013,588	410,990,000
West Pokot	5,563,994,018	1,407,403,130	1,251,903,130	155,500,000
Total	456,651,171,451	127,049,034,871	104,539,823,251	22,509,211,620

Recurrent and development budget analysis

County	Recurrent					Development		
	Personnel Emoluments	Operations and maintenance	Drugs and medical supplies	Training expenses	All other recurrent	Buildings	Equipment and furniture	Grants, transfers, and other unclassified
Baringo	1,682,043,481	14,148,802	129,221,141	0	147,628,381	718,080,132	20,300,000	159,914,894
Bomet	700,000,000	181,860,397	201,390,000	828,590	329,555,740	63,520,000	61,864,500	178,000
Bungoma	2,062,278,181	303,297,382	341,857,270	13,379,582	400,695,243	201,171,463	854,848	0
Busia	1,240,079,554	170,374,459	163,176,095	389,855	0	34,272,414	50,182,540	231,199,681
Elgeyo Marakwet	1,278,939,851	75,341,681	121,250,000	600000	200,785,299	54,200,000	30,500,000	0
Embu	1,657,613,479	128,556,546	164,984,159	4,800,000	83,584,226	140,840,039	50,816,347	131,914,894
Garissa	1,914,642,287	121,123,759	333,500,000	9,268,000	68,140,515	456,500,000	10,500,000	131,914,894
Homa Bay	2,022,307,105	79,038,686	282,000,000	6,000,000	247,988,532	247,000,000	77,320,190	0
Isiolo	758,539,267	107,079,950	68,276,350	2,200,000	93,457,493	110,626,563	27,597,509	64,373,437
Kajiado	1,655,120,934	174,722,286	244,485,732	3295794	177,421,389	64,400,000	0	205000000
Kakamega	2,638,954,674	215,638,635	251,867,770	0	55145418	485,000,000	57,000,000	832,000,000
Kericho	1,545,933,689	114,443,507	382,208,383	16,020,000	0	248,882,313	221,889,358	97,073,013
Kiambu	3,420,539,179	60,589,186	196,000,000	6,517,000	528071542	264,461,500	38,038,500	538,716,765
Kilifi	2,057,764,197	237,292,648	289,143,280	1476272	301,884,758	489,800,000	69,857,563	0
Kirinyaga	1,531,030,613	119,510,000	215,717,430	0	53563820	518,420,202	24,850,000	70,000,000
Kisii	2,550,908,407	82,625,000	207,000,000	4200000	165,698,901	67,520,000	39,500,000	976,428,133
Kisumu	2,348,978,658	36,640,000	85,000,000	8,000,000	599,488,991	301,145,552	1,500,000	26,574,850
Kitui	2,318,797,163	644,072,197	0	0	150000	133,277,399	110,707,118	178621841
Kwale	1,389,966,114	220,908,678	274,616,328	0	138,808,621	308,720,003	37,064,000	131,914,894
Laikipia	1,274,520,215	159,000,000	100000000	0	0	91675111	2,000,000	0
Lamu	669,674,837	90,827,614	16,500,000	4,750,000	48044784	58650000	60,950,000	69,500,000
Machakos	2,589,438,553	165,206,336	478490601	13775000	121,679,884	99471620	21035000	1,500,000
Makueni	2,088,353,638	164,392,956	302,000,000	40,500,000	142200000	46,968,139	5,500,000	541,811,686
Mandera	1,055,504,798	234,413,592	210,000,000	4,831,949	157,149,999	886,404,040	36,018,880	6,100,000
Marsabit	1,223,770,667	43,100,000	0	3000000	6643714	251660000	90300000	404,061,144
Meru	2,586,850,000	33,980,000	65,200,000	750,000	143,906,250	114,750,000	1,050,000	806,126,204

County	Recurrent					Development		
	Personnel Emoluments	Operations and maintenance	Drugs and medical supplies	Training expenses	All other recurrent	Buildings	Equipment and furniture	Grants, transfers, and other unclassified
Migori	1,296,360,000	214,061,800	272,934,279	0	0	107,000,000	159,664,894	182,296,664
Mombasa	2,200,062,875	160,370,384	29,730,375	18,585,462	404,536,438	21,468,774	550,000	210,173,002
Murang'a	1,988,634,799	107,919,248	31,000,000	2,000,000	18,656,250	90,000,000	24,000,000	757,324,209
Nairobi City	5,087,730,251	669,888,460	918,529,500	19,596,390	0	601,000,000	62,255,400	10000000
Nakuru	3,985,708,169	726,795,541	741,047,580	14,406,840	100000	0	48,042,120	1,171,793,892
Nandi	1,645,975,952	89,343,806	245,000,000	5,000,000	80,459,799	527,363,515	21,000,000	0
Narok	1,133,838,363	429,759,435	310,409,479	2,262,591	154,177,964	496,599,780	35,129,231	0
Nyamira	1,377,308,326	87,301,539	55,808,000	720000	0	210216000	15385000	66,964,221
Nyandarua	1,009,910,640	36,248,820	120,600,000	159,200	320,298,316	111,500,000	11,202,500	200,000
Nyeri	2,107,360,734	88,938,912	120,398,621	13,432,000	334004870	145,831,902	34,570,531	24,814,801
Samburu	670,863,550	160,814,301	92000000	4577633	0	278614894	2880000	0
Siaya	1,389,018,575	237,339,597	188,000,000	3,000,000	0	327,094,294	23,232,109	445,176,031
Taita/Taveta	1,047,722,124	127,584,597	170,917,210	0	0	68,600,000	2,500,000	0
Tana River	838,486,220	109,253,663	143,300,000	1,500,000	130,932,083	124,200,000	31466000	0
Tharaka Nithi	1,285,658,898	95,770,000	178,000,000	4,200,000	0	194,414,894	76,000,000	0
Trans Nzoia	1,288,418,388	143,496,195	200,750,000	3,000,000	40,086,165	359,227,953	7,000,000	174,638,866
Turkana	833,900,000	213,143,719	256,867,573	10,450,000	178,674,567	148,014,968	180,514,894	226,773,093
Uasin Gishu	1,564,659,111	121,501,011	205,995,000	2,000,000	0	335,015,622	134,858,041	119,514,814
Vihiga	891,550,356	130,064,560	93,800,000	5,800,000	41545510	199,000,000	37,800,000	90,301,538
Wajir	1,301,959,144	207,672,068	144,670,000	8,000,000	122,712,376	369,000,000	35,990,000	6,000,000
West Pokot	1,042,985,810	56,711,800	125,358,287	0	26,847,234	117,950,000	2,550,000	35,000,000
Total	72,273,045,067	9,208,771,516	10,168,877,983	317,734,133	3,327,510,089	8,661,723,620	3,142,619,649	13,989,084,484