REPUBLIC OF KENYA

NATIONAL AND COUNTY HEALTH BUDGET ANALYSIS

FY 2023/24

MINISTRY OF HEALTH

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NATIONAL AND COUNTY HEALTH BUDGET ANALYSIS

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Foreword

National and county budgets are a direct reflection of policy priorities and resource allocation decisions, shaping the activities, programs, and services provided each year. Analysing these allocations provides insights into government spending patterns and assesses how well these align with stated health policy goals.

This report, building on the National and County Health Budget Analysis, 2022/23, gives a detailed examination of how public health sector resources were distributed in the 2023/24 fiscal year, comparing this to the previous two years. This analysis, produced annually, aims to inform and strengthen future health budgeting processes in the sector.

The findings within serve as valuable evidence for decision-makers at both national and county levels in public health budget planning and allocation. This information can be leveraged for advocacy efforts to secure additional funding and optimize resource utilization. Policymakers can also use these insights to evaluate the cost-effectiveness of programs and activities and ensure compliance with program-based budgeting as mandated by the Public Finance Management Act of 2012.

This analysis further enables benchmarking Kenya's health spending against international standards like the Abuja Declaration targets. Additionally, it encourages counties to assess their health allocations relative to each other, promoting increased investment in health. This work contributes to improved health financing, with the goal of achieving better health outcomes for all.

ACKNOWLEDGEMENTS

The Ministry of Health (MOH) expresses its sincere gratitude to all institutions that provided data for this study. The MOH appreciate the financial and technical support provided by U.S. Agency for International Development (USAID) through PROPEL Health Project.

This report was made possible by analysing data from various sources, including past budget analyses, the Office of the Controller of Budget, the National Treasury, the MOH, and county governments. The MOH appreciates all those who assisted in gathering this information, especially county health officials who provided crucial raw data without which this analysis would not have been possible.

A team from the MOH, led by Stephen Macharia, Director of Planning, and assisted by Terry Watiri, Senior Economist, conducted the analysis, with valuable technical guidance from PROPEL Health Project through Caroline Njoroge and Abhigale Muthami. Final reviews were done by Stephen Macharia (MOH), Dr David Khaoya (PROPEL Health) and Nzoya Munguti (USAID Kenya Mission). The MOH is grateful to everyone who contributed to this effort.

The MOH looks forward to continued collaboration in future budget analyses and welcomes suggestions on how to improve the activity.

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
KES	Kenya Shilling
MOH	Ministry of Health
MTRH	Moi Teaching and Referral Hospital
PFMA	Public Finance Management Act of 2012
RMNCAH	Reproductive, Maternal, Newborn, Child, and Adolescent Health

EXECUTIVE SUMMARY

Tracking allocations to health in the national and county budgets is critical in assessing whether resources allocated to the health sector are aligned to key policy objectives as articulated in policy documents. In Kenya, the budget process is defined by the country's constitution and elaborated in the Public Finance Management Act of 2012.

The Kenya Constitution of 2010 introduced devolution, with health functions shared between the national and 47 county governments. Prior to devolution, resources flowed directly from the National Treasury to the Ministry of Health (MOH) to finance health activities in the country. With devolution, the National Treasury now sends funds directly to counties, which then individually and independently determine how much to allocate for health services, according to their priorities. The transfer of functions and funding to the counties began in fiscal year (FY) 2013/14.

The ministries, departments, and agencies of national and county governments develop budgets following set guidelines, which are then approved by the respective legislative bodies. This report examines the trend in fiscal allocations by health sector priority areas from FY 2020/21 to FY 2023/24. All Kenya Shilling (KES) values reported are in nominal terms. The findings provide evidence that can help national, and county policymakers understand allocation patterns by different economic and functional areas.

Main findings

Combined national and county health budget allocations: The combined health budget (national and county) expanded from KES 94 billion (7.8% of the total government budget) in FY 2012/13 (pre-devolution) to KES 280 billion in FY 2023/24 (79.7% of the total government budget) —a three-fold expansion. Health as a proportion of total government budget has increased steadily since FY 2013/14, reaching 11.1 percent in FY 2020/21 before dropping to 9.7 percent in FY 2023/24. The proportion remains lower than the 15 percent recommended in the Abuja Declaration.

Analysis of national level health budget allocations:

- The Ministry of Health budget allocation for FY 2023/24 was KESs 141 billion, constituting 6 percent of the national budget, compared to 5.8 percent in FY 2022/23. The KES 141 billion budget allocation included contributions by government and development partners for one year. Overall, the Ministry of Health FY 2023/24 budget allocations increased by 15 percent from what was reported in FY 2022/23. The development health budget for FY 2023/24 accounted for 43 percent of the total Ministry budget, a marginal decrease from what was reported in FY 2022/23 (44%). The recurrent health budget in FY 2023/24 accounted for 57 percent of the total budget, compared with 56 percent in FY 2022/23.
- Development partners accounted for 35 percent of the total development budget in FY 2023/24, compared with 38 percent in FY 2022/23. A disaggregation of the recurrent health budget for 2023/24 shows that total grants/ transfers to semi-autonomous government agencies, which includes their own locally generated revenues (user fees and sales of goods) accounted for about 72 percent of the total Ministry of Health recurrent budget while personnel emoluments accounted for 11 percent of the total recurrent health budget. Operations and maintenance and universal health coverage accounted for nine and eight percent respectively.
- Overall, funding allocations to HIV, TB, Malaria and RMNCH by the government of Kenya through the MOH budget has increased, with respect to FY 2020/21. In the period under review, funding for HIV increased by 106% (KES 2,487 million) between FY 2020/21 and

FY 2023/24, for TB by 49% (KES 98 million), for malaria by 16% (KES 153 million) and RMNCH by 12% (KES 115 million).

Analysis of county level health budget allocations

- The counties' health sector budgets decreased from 29 percent of total counties' budget in FY 2020/21 to 27 percent in FY 2023/24. However, substantial variations between counties are also noted. In FY 2022/23, 19 counties allocated at least 30 percent of their budget to health, compared with 15 counties in FY 2023/24. The split between recurrent and development health budgets remained fairly constant at 83 percent and 17 percent in FY 2023/24 compared to 84 percent and 16 percent in FY 2022/23. In FY 2023/24, 77 percent of the recurrent health budget was allocated to personnel emoluments, while 9 percent went to finance operations and maintenance. Drugs and non-pharmaceuticals received 10 percent of the recurrent budget.
- Investment in the construction and refurbishment of buildings was the largest expenditure category in the development budget in FY 2022/23, with an allocation of 46 percent of the total county health development budget. During FY 2023/24, construction of facilities was allocated 57 percent of the total county health budget. A further 29 percent was allocated to equipment and furniture. Transfers/grants and other development expenditures were allocated 14 percent.
- Overall, the county health budget per person was KES 2,715 (US$19) in FY 2023/24 compared to KES 2,620 (US$21) in FY 2022/23. However, there was a wide variation in per capita health budget allocations between counties in FY 2023/24, ranging from KES 8,668 (US$60 per capita) in Lamu County to KES 1,157 (US$8) per capita in Nyandarua.

Recommendations

- To align resource allocations to achieve health sector policy priorities and achieve the 15 percent of government resources to health recommended by the Abuja Declaration, the Kenyan health sector requires additional domestic financing, both at the national and county levels. The MOH and the Ministry of Finance need to work together to enhance and explore additional resources of domestic funding, including allocating an increased share of government tax revenue to the health sector and scaling up insurance coverage, thus adequately mobilizing funds from both mandatory and voluntary contributor segments. More immediately, maximizing efficient targeting and spending, prioritizing coordination across government and development partners, and fully executing health resources could yield considerable gains and value for money, and reduce resource wastage.
- Increased resource allocations should be prioritized efficiently to target donor-dependent health initiatives, including HIV, TB, and malaria. Secondarily, the ministry should prioritize areas that have received inadequate budget allocations, like preventive, promotive, and reproductive, maternal, neonatal, child, and adolescent health. Policies that help mobilize private investment in healthcare services can serve to drive economic growth in addition to helping supplant reduced donor funding. The MOH can encourage growth in resources directed to the health sector by pursuing policies to catalyse private investment, such as reducing regulations, expanding the contracting capabilities of private health providers, and actively encouraging local private institutions to invest in the health sector.
- Because SAGAs account for a significant portion of its budget, the MOH should explore innovative resource mobilization concepts such as increasing their budget from user fees and expanding the adoption and uptake of insurance coverage to partially shift the cost of healthcare coverage.

- Although advocating for additional resources for health at the county level is warranted, counties need to ensure resources are allocated more efficiently to health priority areas that increase value for money, including directing more resources to cost-effective preventive and promotive health services. Additionally, counties should enhance advocacy efforts to ensure key disease programmes like HIV, malaria, and TB are prioritized during the planning and budgeting processes. To accomplish such advocacy, counties need to capitalize on the evidence from county-specific budget and expenditure analyses.
- Counties need to reduce their overreliance on the national government's shareable revenue by enhancing collection of revenue from local taxes. They also need to increase and streamline revenue collection by expanding the population covered by insurance and focusing on promoting primary care as a more cost-effective means of delivering care.
- Counties must prioritize rationalizing staffing plans and exploring strategies to ensure budget allocations to personnel are needs-based and informed by evidence and to ensure that resource allocations are adequate for other key health inputs. Effectively using data and greater in-depth analysis is needed to understand the underlying drivers in personnel budgets and determine how best to allocate resources to meet Kenya's increasing need for skilled health personnel.
- Counties should invest in technical capacity strengthening in planning and budgeting to effectively adopt the programme-based budgeting approach in their planning and budgeting processes. This budget approach has been proven to increase efficiency in resource allocations and link inputs with programme outcomes.

INTRODUCTION

The Kenyan Constitution and other pivotal national policy documents such as Kenya Vision 2030 and the Kenya Health Policy (2014–2030), establish health as a fundamental human right and a cornerstone of economic development. This commitment translates into a mandate for both national and county governments to prioritize health investments and ensure the provision of equitable, high-quality health services for all citizens with respect to geography, gender, and economic conditions. Financial resources are essential to the successful implementation of health policies and strategies at both the national and county levels. Budgetary allocations for both national government and counties are expected to align with the policy commitments outlined in the respective guiding documents. At the national level, the 2023 Budget Policy Statement (BPS), Kenya Health Sector Strategic Plan 2023-2027, and Medium-Term Expenditure Framework for the FY 2021/22 – FY2023/24 prioritize key sectors such as infrastructure, education, health, and social safety nets. The 2023 BPS was prepared with consideration of Medium Term IV that captures the government Bottom-up Economic Transformation Agenda (BETA). This is a comprehensive economic development plan aimed at transforming Kenya's economy and promoting inclusive growth. Its main pillars are agricultural transformation and inclusive growth, micro, small, and medium enterprise economy, housing and settlement, healthcare and digital superhighway, and creative economy (Republic of Kenya, National Treasury and Planning 2023).

The Health Sector Strategic Plan 2023-2027 specifically articulates the government's commitment to continue increasing health sector funding to achieve the Abuja Declaration target of allocating at least 15% of the annual budget to health (Republic of Kenya, 2018; WHO, 2011). Counties usually align their respective medium-term planning and budgeting frameworks to national strategies while also considering localised priorities.

This analysis of national and county health budgets compares the respective budgets against national and county governments' priorities and compares trends over the last four years (FY 2020/21 to FY2023/24). It also examines how the national and county governments allocate their health budgets. The analysis briefly reviews the health policy priorities that the various governments intend to address, as well as the macroeconomic settings in which these governments operate. It reviews data on Ministry of Health (MOH) and county health allocations from FY 2020/21 to FY 2023/24 to assess how financing aligns with health priorities. The study also includes a trend analysis to show investments in the public health sector and progress towards increasing domestic resources for health. In addition, it analyses the health budgets by recurrent and development categories; economic categories; the seven programmes identified by the MOH under the programme- based budgeting (PBB) approach; and by MOH strategic programmes that include HIV, malaria, and tuberculosis (TB). The analysis concludes with recommendations to guide policy- and decision-makers in ensuring that budgets are better aligned to sector priorities. The findings offer valuable evidence to empower health sector actors to advocate for the necessary resources to achieve national health goals.

Macroeconomic Context

Kenya's economic growth varied over the three years of analysis, from 0.3% in 2020, to 7.6% in 2021, and 4.8% in 2022 (Republic of Kenya, National Bureau of Statistics,2021-2023). The economy recovered from the crippling effects of COVID-19 pandemic to expand at 7.6% in 2021, compared to a contraction of 0.3% in 2020. The recovery was driven by resumption of most economic activities

after the lifting of the COVID -19 containment measures instituted in 2020 to curb the spread of the virus and prompt Government interventions. In 2022, the economy posted decelerated growth due to the significantly high growths attained in 2021 and suppressed agricultural production owing to adverse weather conditions during the year.

According to the Budget Review and Outlook Paper, the economy is projected to expand further by 5.5% in 2023 and maintain a strong momentum over the medium-term, supported by the strong recovery in agriculture and resilient services sector that will both drive the industrial sector, and broad-based private sector growth (Republic of Kenya, National Treasury and Planning,2023). The BETA framework, geared towards economic turnaround and inclusive growth, is expected to reinforce the growth outlook. Table 1 shows Kenya's economic outlook, including projections for 2024/25.

Table 1:Kenya's economic outlook FY 2021/22-FY2024/25

Indicator	2021/22	2022/23	2023/24	2024/25	Change
Gross domestic product (GDP) growth	7.6	4.8	5.5	5.7	▲
Fiscal deficit as a % of GDP	6.2	5.6	5.4	4.4	▼
Real GDP	6.2	5.2	5.6	5.9	▲
Total revenue as % GDP	17.3	16.5	18.6	18.9	▲
% of nominal debt to GDP	64.7	68	65.5	63.1	▼
Health sector growth, in KES millions	121	123	141	164	▲

Performance of Selected Health Priority Areas

The health sector is a key component of Kenya Vision 2030, the longer-term development agenda. Its social pillar envisions a healthy and productive population able to fully participate in and contribute to other sectors of the economy. The District Health Information Survey and the 2022 Kenya Demographic and Health Survey (KDHS) document improved performance in key health indicators. For instance, KDHS notes remarkable declines between 2014 and 2022 in under-five mortality, from 52 to 41 per 1000 live births, and in infant mortality rates, from 39 to 32 per 1,000 live births (KNBS, 2023).

After close to four decades of intervention, the country has made significant progress. HIV prevalence among adults (15-49 years) in the general population has declined from 9.1% in 2000 to 4.3% in 2021. New HIV infections reduced from about 101,448 in 2013 to 34,540 in 2021, while annual AIDS-related deaths declined from 52,964 in 2010 to 22,373 in 2021. (https://nsdcc.go.ke/event/world-aids-day-2022).

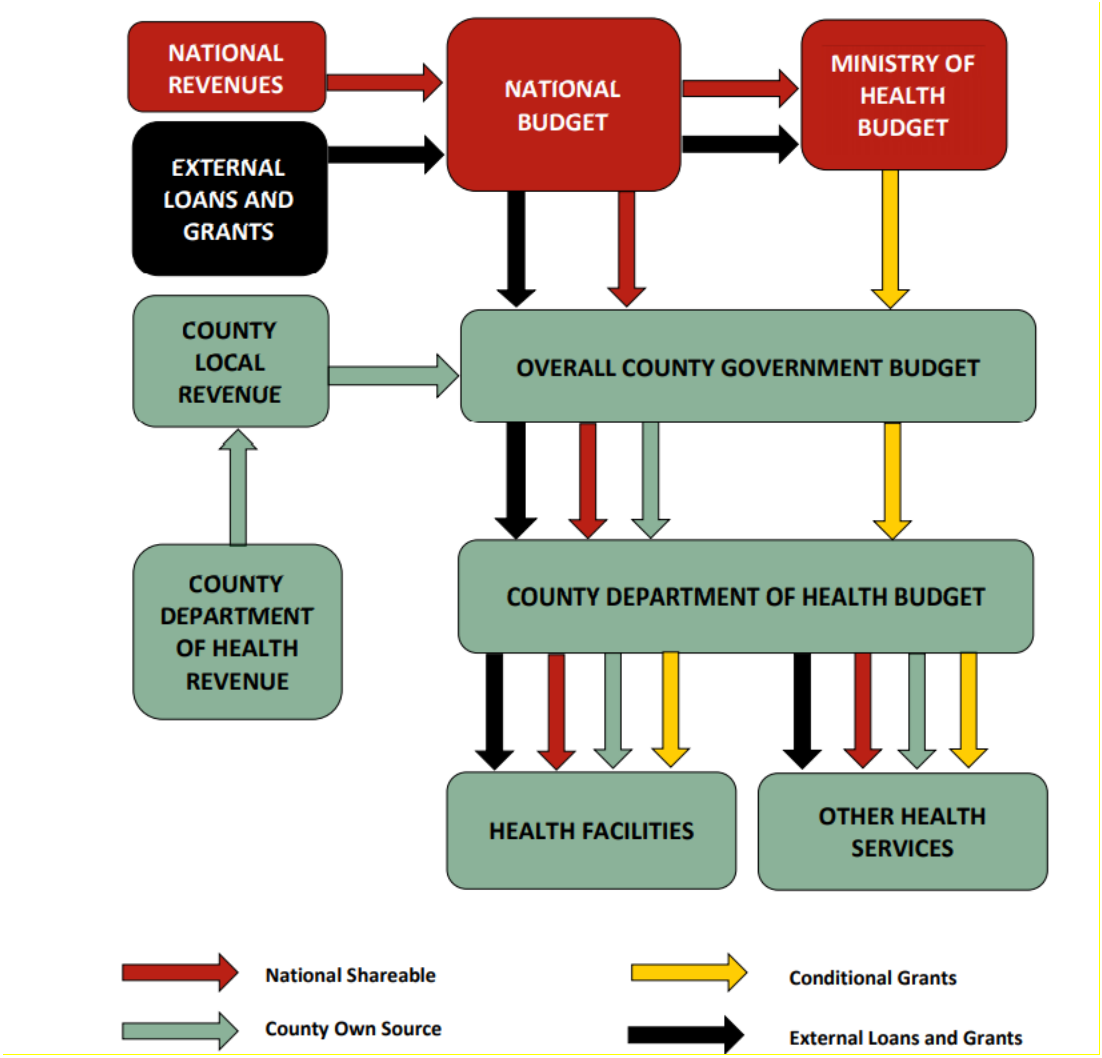
The 2022 KDHs also shows that contraceptive prevalence rate has increased steadily over time, from 32% in 2003 to 39% in 2008–09, 53% in 2014, and 57% in 2022. However, it is still far below the Family Planning 2020 target of 70%. Nearly all women (98%) reported receiving antenatal care from a skilled provider in 2020. Moreover, the percentage of live births that were assisted by skilled providers increased markedly over the past two decades, from 41% in 2003 to 89% in 2022 (KNBS, 2023)

Budgeting Process

According to the Public Finance Management Act of 2012, the National Treasury issues aggregate budget ceilings for national spending. These ceilings are based on the economic outlook, projected tax revenue, donor commitments, and other government income such as user fees. After setting aside payments for consolidated fund services (i.e., pensions, national debt, and related expenses), the Intergovernmental Budget and

Economic Council develops budget allocation proposals for the national and county governments and other independent constitutional bodies. The budget proposals are adopted after approval by Parliament. National and county governments are provided with notional budget targets to allocate among sectors and institutions under their authority, including health. Inter-county allocations are determined by a formula proposed by the Commission on Revenue Allocation and approved by Parliament every five years. In this process, as outlined in Figure 1, the National Treasury allocates a lump sum amount to counties, which individually and independently determine budget allocations for health services according to their priorities and mandates.

Figure 1: Kenya's financial resources- sharing arrangement



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

The process of allocating budget resources to the respective sectors is the same at the national and county levels. The county and national treasuries communicate the budget ceilings to the various sectors through the Budget Review and Outlook Paper or the County Budget Review and Outlook Paper, which are normally released in September and must be approved by the cabinet and legislative assembly at each level of government. Although the Budget Review and Outlook Paper provides the initial indication of the amount the

health sector might receive, interventions and advocacy for more health funding should be done before its release.

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

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

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

Programme-Based Budgeting

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

a) To improve the prioritization of expenditures in the budget to help allocate limited county government resources to those programmes of greatest benefit to the community.

b) To encourage county government departments to improve the efficiency and effectiveness of service delivery by changing the focus of public spending from inputs to outputs and outcomes.

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

Study Objectives

The main objective of this analysis is to characterize national and county government budget allocations to the health sector and provide the necessary evidence that can effectively inform healthplanning and budgeting at national and county levels. Specifically, the study examines four allocations:

a) Total government budget allocation to health

b) National and county budget allocations to health

c) Comparisons/trends of county budget allocations to health

d) National and county budget allocations to health by key economic inputs

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

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

1. It will enable the health sector to absorb the impact of the expanded administrative costs of devolution while still providing the level of service that existed before devolution.
2. It will allow Kenya to move more quickly towards the national goal of universal health coverage.
3. It will promote progress towards achieving the Abuja Declaration commitment of allocating 15% of the public budget to health.
4. It will provide a measure of sustainability in delivery of health services, especially if expansion comes from domestic sources.

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

METHODS

This study analysed initial MOH and county budget allocations to the health sector for FY 2020/21, FY 2021/22, FY 2022/23 and FY 2023/24 in nominal terms. MOH data were obtained from the budget estimates issued by the National Treasury for every fiscal year. County budget data were obtained from various sources: the Commission for Revenue Allocation, the Office of the Controller of Budget, and, in some instances, county treasuries.

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

Limitations

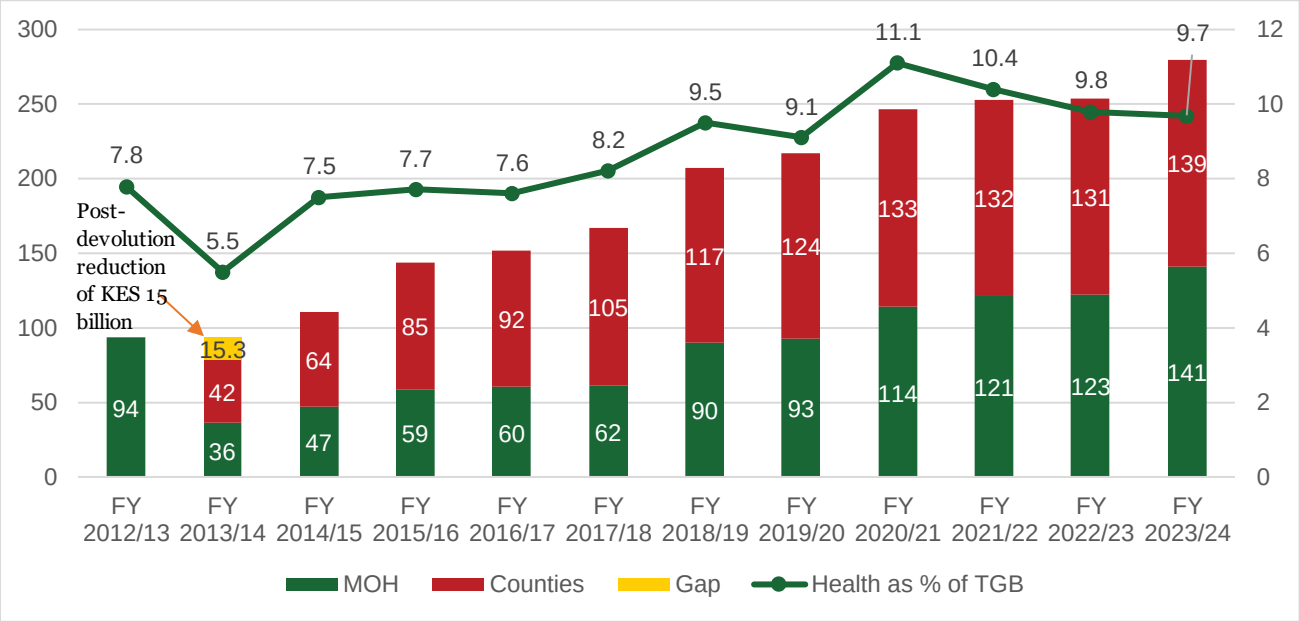
Data from the Office of the Controller of Budget have not been audited by the Office of the Auditor-General as of the time of writing the report, thus allowing some inconsistencies with final county budgets. The authors of this study note that, in some instances, the budget format was inconsistent and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

KEY FINDINGS

Government Budget Allocations to Health Pre- and Post-devolution

The Kenya Constitution of 2010 introduced devolution, defined as the sharing health functions and resources between the national and 47 county governments. Devolution was implemented after the general elections in March 2013, and the transfer of functions and funding to the counties began in the budget for FY 2013/14. **Error! Reference source not found.** shows the proportion of the government budget allocated to health by the national and county governments for the period FY 2012/13 through 2023/24.

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



Sources: Republic of Kenya. 2012/13—2023/24, Republic of Kenya, 2013/14—2023/24

Since devolution, national and county governments have continued to increase their allocations to health, both in absolute and as a proportion of the total government budget (see Figure 2). In absolute terms, the combined budget allocations to health continued to expand gradually, from KES 78 billion in FY 2013/14 to KES 280 billion in FY 2023/24 (258% expansion). In nominal terms, the MOH increased its contribution from KES 36 billion to KES 141 billion and county contributions increased from KES 42 billion to KES 139 billion.

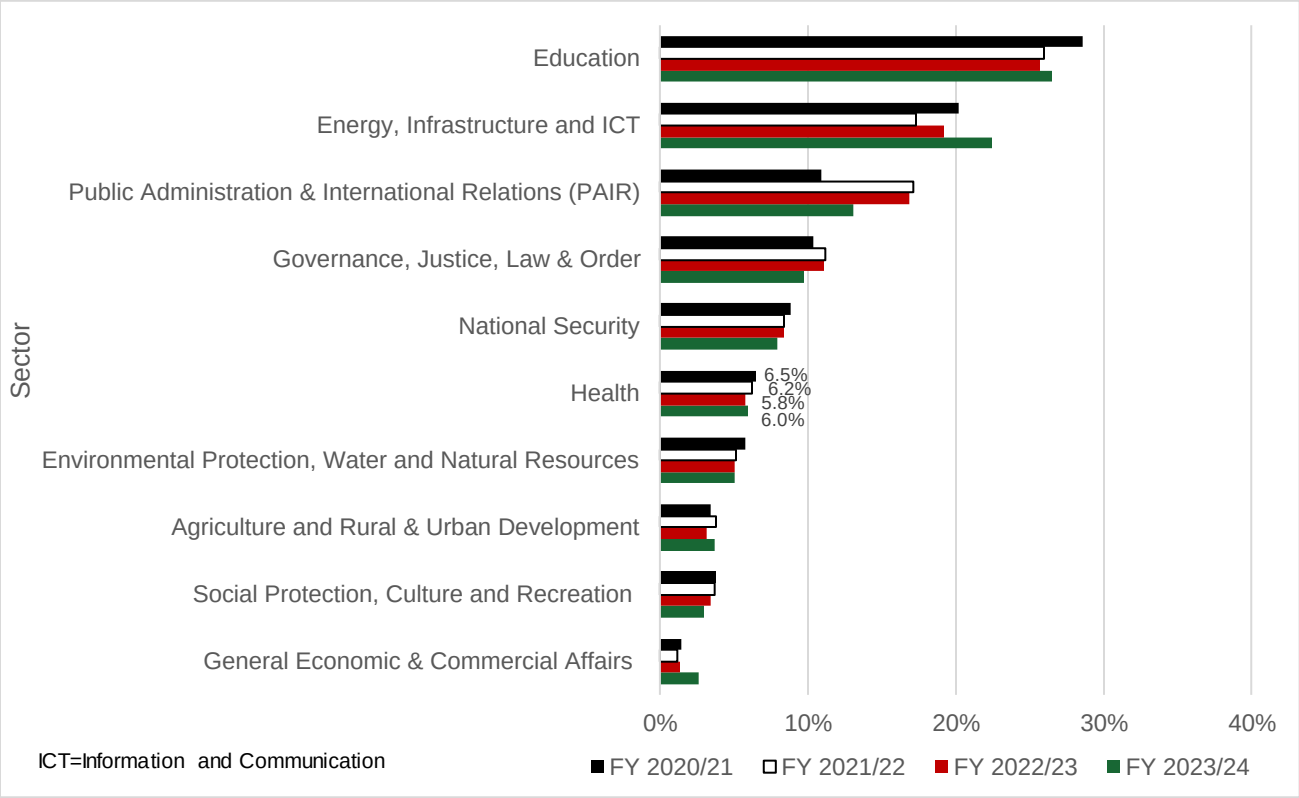
The combined proportion of the total government budget allocated to health by national and county governments also has increased but has not yet reached the government's target of 15%, in accordance with the Abuja Declaration. Combined budget allocations to health by national and county governments as a proportion of the total government budget increased from 5.5% in FY 2013/14 to 11.1% in FY 2020/21 before decreasing to 9.7% by FY 2023/24.

Disaggregating the proportional increases at the national (MOH) and county level reveals the priority given to health at each level of government. The national health budget allocation as a proportion of the total government budget has decreased, from 6.5 to 6.0% in the past four fiscal years. The health sector ranks sixth in budget allocations, as discussed in the next section.

National Government Budget Allocation by Sector

The national budget is allocated among 10 sectors, as defined in the respective National Treasury circulars (Republic of Kenya, 2018/19–2020/21a). In the clustering of sectors, most clusters subsume more than one ministry or state department. The ministries of health and education are the only ones in their respective sectors. Figure 3 shows the proportion allocated to the 10 sectors at the national level for FY 2020/21 through FY 2023/24.

Figure 3: Proportion of national government budget allocation by sector



Source: Republic of Kenya, 2020/21-2023/24a

The top three sectors in budget allocation are (1) education; (2) energy, infrastructure, and information and communications technology (ICT); and (3) public administration and international relations. These three sectors received more than half of the total national government budget allocation in the analysis period. The health sector (MOH) was allocated 6.5% of the national budget in FY 2020/21, 6.2% in FY 2021/22, 5.8% in FY 2022/23 and 6.0% in FY 2023/24. The sector's ranking did not change for four consecutive years.

Ministry of Health Allocations to Recurrent and Development Budgets

MOH allocations to the recurrent budget increased from KES 64.5 billion in FY 2020/21 to KES 64.9 billion in FY 2021/22, KES 68.5 billion in FY 2022/23 and further expanded to KES 80.6 billion in FY 2023/24 (see Table 2). As a proportion of the MOH budget, allocation to recurrent expenditures decreased from 57% in FY 2020/21 to 54% in FY 2021/22 before increasing to 56% in FY 2022/23 and 57% in FY 2023/24. The government—through the recurrent budget—is the main contributor to increases in the health budget, which expanded by 17.7% from FY 2022/23 to FY 2023/24. Allocation to the development budget increased from KES 49.6 billion in FY 2020/21 to KES 56.2 billion in FY 2021/22, decreased to KES 54.0 billion in FY 2022/23 before expanding to KES 60.6 billion by FY 2023/24. The proportional

allocation to development over the four years was 43% and 46% in FY 2020/21 and FY 2021/22, and 44% in 2022/23 and 43% in 2023/24 (Table 2). The development budget, which includes donor on-budget resources, increased by 12.1% between FY 2022/23 to FY 2023/24.

Table 2: MOH allocations to recurrent and development budgets, FY 2020/21-FY 2023/24

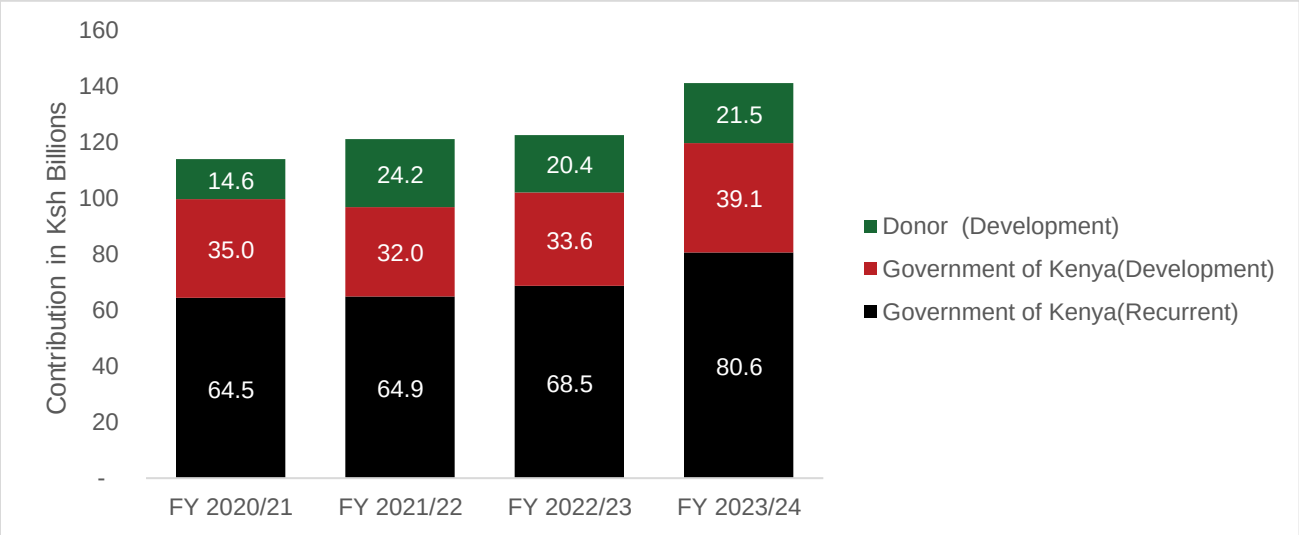
Budget	2020/21	2021/22	2022/23	2023/24	Percentage change, 2022/23-2023/24
Recurrent	KES 64.5 billion (57%)	KES 64.9 billion (54%)	KES 68.5 billion (56%)	KES 80.6 billion (57%)	+17.70%
Development	KES 49.6 billion (43%)	KES 56.2 billion (46%)	KES 54.0 billion (44%)	KES 60.6 billion (43%)	+12.1%

Source: Republic of Kenya, 2020/21-2023/24a

Contribution to MOH Budget by source, FY 2020/21 – FY 2023/24

The MOH budget comprises both allocations from the government and grants and loans from donors. Figure 4 presents the trend in MOH recurrent and development financing as well as donor contributions (loans and grants) allocated to the development budget, under which funding for national strategic programmes for HIV, TB, malaria, medical commodities/drugs, and vaccines is provided. The donor component of the budget increased from KES 14.6 billion in FY 2020/21 to KES 24.2 billion in FY 2021/22 before declining to KES 21.5 billion by FY 2023/24. In this fiscal year, the government of Kenya increased its allocation to the MOH's development budget by KES 4.1 billion. However, the government's increased contribution to the development budget is not strategically targeted to make up for the declining donor support that funds the MOH's key strategic programmes. The largest share of this increase is allocated to universal health coverage (to cover transfers to government agencies and hospitality supplies) and capital grants to SAGAs.

Figure 4:MOH budget allocation in KES billions, FY 2020/21-2023/24



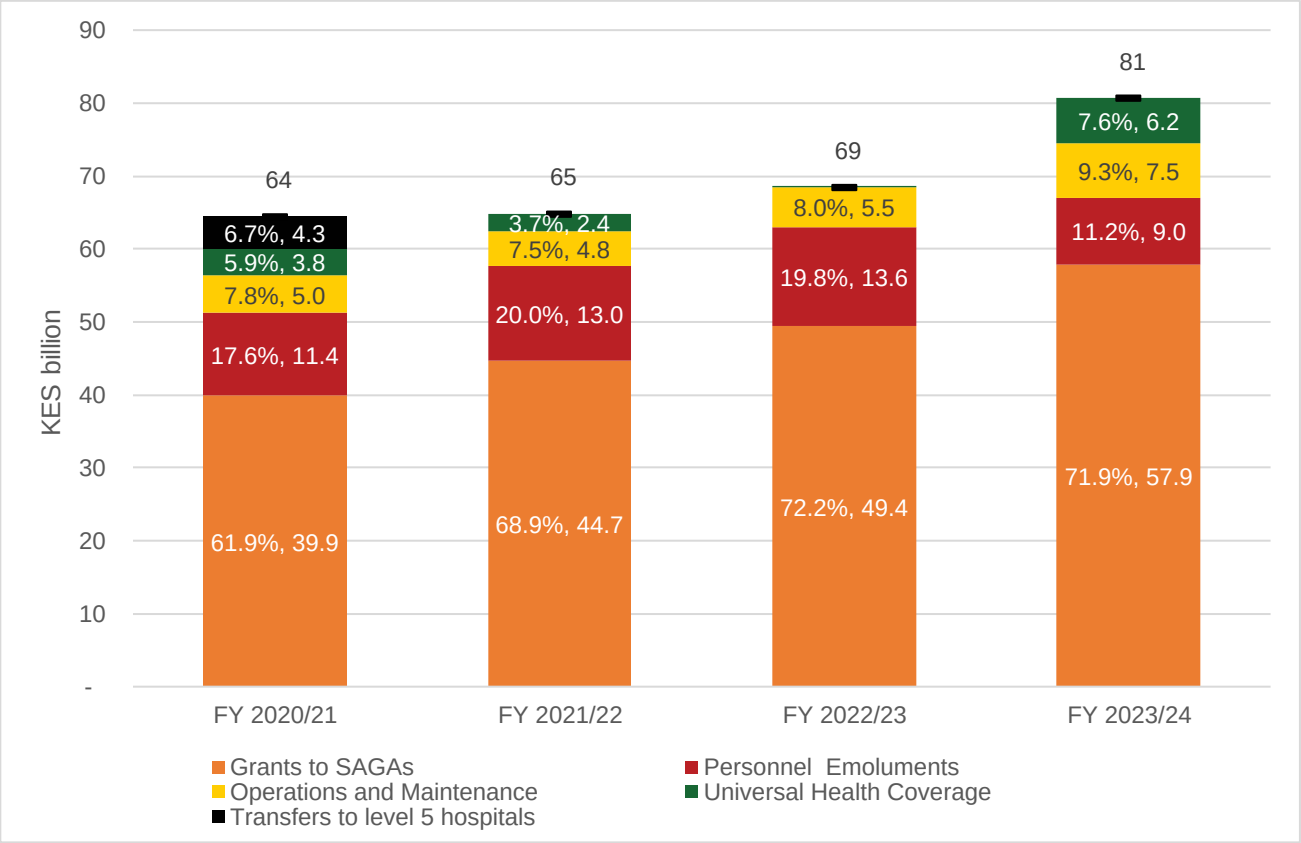
Source: Republic of Kenya, 2020/21-2023/24a

Ministry of Health Recurrent Budget by Spending Classification

Figure 5 presents a breakdown of the recurrent budget across the key spending categories under the MOH from FY 2020/21 to FY 2023/24. They are (1) grants to the eight semi-autonomous government agencies

(SAGAs)[1]; (2) personnel emoluments; (3) reimbursements for removal of user fees at facilities, which have been combined with universal health coverage grants; (4) transfers to level 5 hospitals; and (5) operations and maintenance. The rapid expansion of the MOH recurrent budget has been driven by increases in budget allocations to SAGAs, which increased from KES 39.9 billion in FY 2020/21 to KES 57.9 billion in FY 2023/24, and operations and maintenance, which increased from KES 5 billion in FY 2020/21 to KES 7.5 billion by FY 2023/24. Figure 5 also shows that during FY 2023/24, the MOH allocated KES 6.2 billion, or 7.6% of the MOH recurrent budget to universal health coverage. This amount was an increase from the budget of KES 3.8 billion in FY 2020/21 and KES 2.4 billion in FY 2021/22. Commensurate increases were observed under the development budget for UHC, indicating the MOH's prioritization for financing universal health coverage.

Figure 5:MOH recurrent budget allocations by major classification, FY 2020/21-2023/24



Source: Republic of Kenya, 2020/21-2023/24a

Proportion of Ministry of Health Recurrent Budget Allocations to SAGAs

As of FY 2023/24, eight SAGAs were under MOH administration and funded through grants as well as their own revenue generated through user fees and the sale of goods and services. Figure 6 shows the breakdown of MOH recurrent budget allocations to the eight SAGAs in FY 2020/21–FY 2023/24. Of

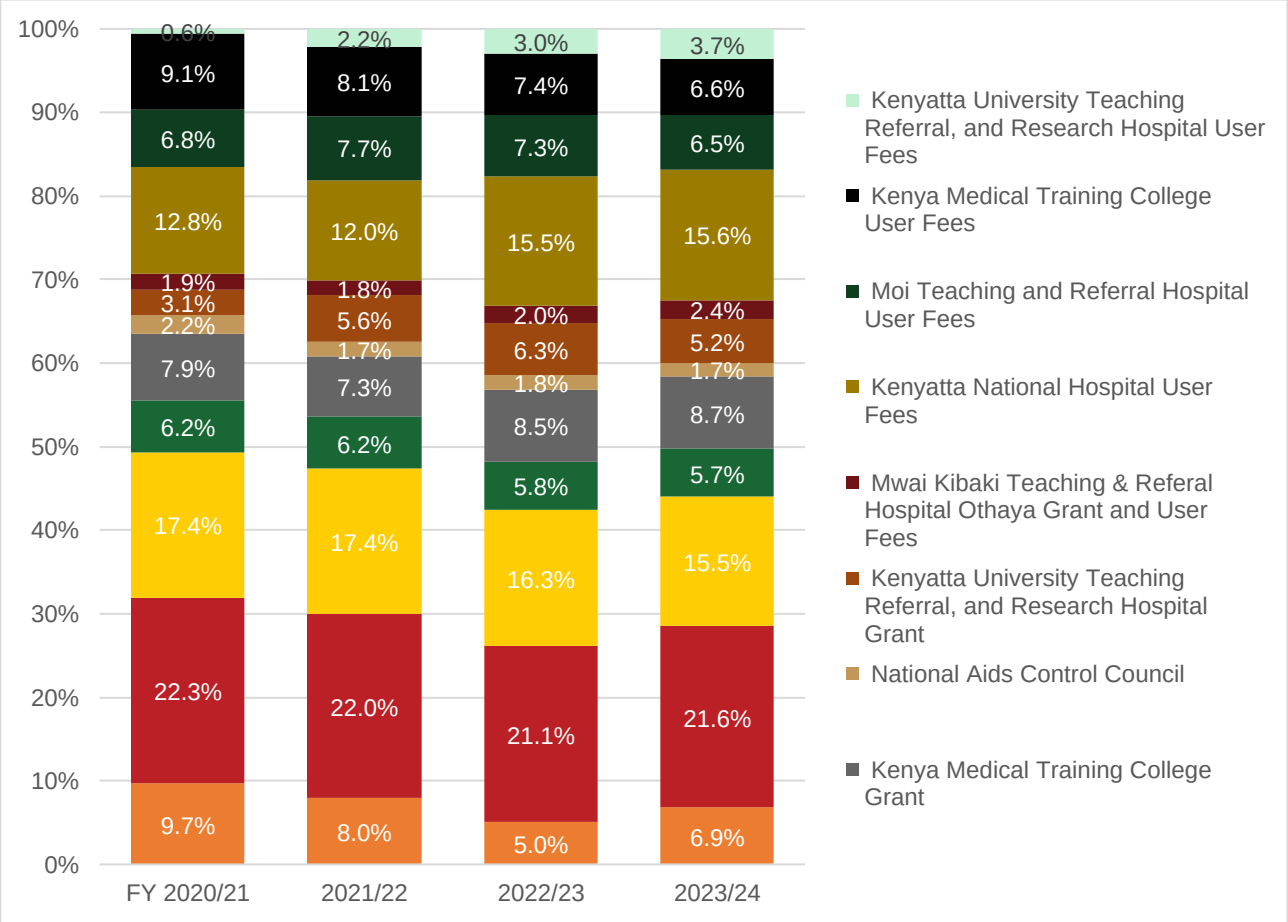
[1] SAGAs are publicly funded institutions with the autonomy to manage and account for their budget and operations independent of the mother ministry; they usually are governed by distinct legislation, but their funding is channeled through the mother ministry. The MOH has eight such institutions.

the KES 57.9 billion that the MOH allocated to SAGAs in FY 2023/24, 60% was in the form of government grants, and 40% was from revenue generated internally by the institutions through user fees and the sale of goods and services. Allocation to SAGAs increased in FY 2023/24, up from KES 39.9 billion in FY 2020/21, KES 44.7 billion in FY 2021/22 and KES 49.4 billion in FY 2022/23. The budget expansion in FY 2020/21 was driven by increases in grant allocations to most of the agencies.

As shown in Figure 6, four hospitals—Kenyatta National Hospital, Moi Teaching and Referral Hospital, Kenyatta University Teaching, Referral, and Research Hospital, and Mwai Kibaki Teaching and Referral Hospital, Othaya—accounted for about 70% of MOH recurrent budget allocations to SAGAs in FY 2023/24, up from 65% in FY 2020/21.

In the FYs 2020/21, 2021/22 and 2023/24, Kenyatta National Hospital received the largest grant allocation, at 22%, with a slight decrease from 21% in FY 2022/23; followed by Moi Teaching and Referral Hospital, at 16% in both FYs 2023/24 and 2022/23, down from 17% in both FYs 2021/22 and 2020/21.Kenyatta University Teaching, Referral, and Research Hospital and Mwai Kibaki Teaching and Referral Hospital, Othaya received a combined 6% of the MOH recurrent budget grant allocations to SAGAs in FY 2023/24, an decrease from 8% in FY 2022/23. The Kenya Medical Training College was allocated 9% in grants in both FYs 2023/24 and 2022/23, an increase from7% in FY 2021/22 and 8% in FY 2020/21. The Kenya Medical Supplies Authority was allocated about 1% in grants in FY 2023/24, an increase from 0.2% in FY 2022/23.

Figure 6: MOH recurrent budget allocations to SAGAs, FY 2020/21- FY 2023/24

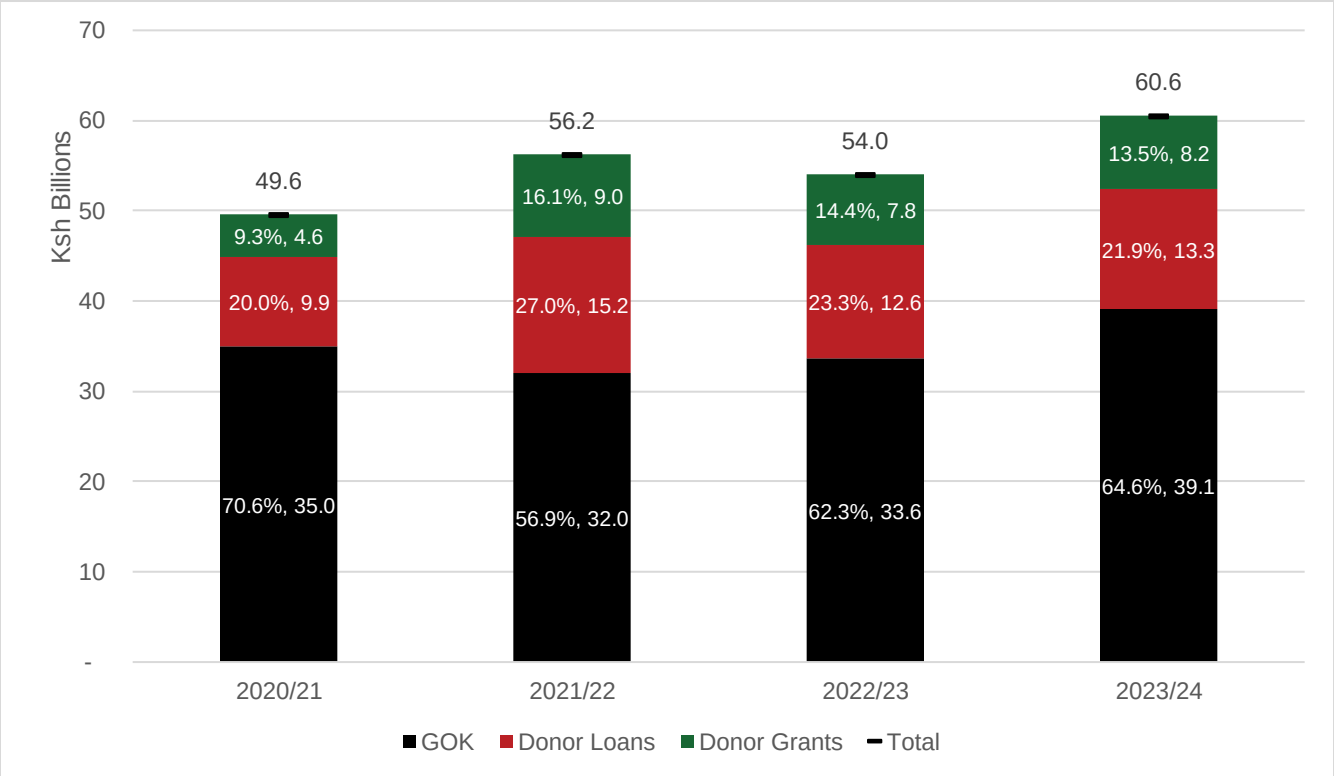


Source: Republic of Kenya, 2020/21-2023/24a

Ministry of Health Development Budget

The MOH's development budget includes funds provided by the national government and from donors through loans and grants. The amounts and share contributed from each of the sources for FY 2020/21 through FY 2023/24 are presented in Figure 7. In FY 2023/24, the budget increased to an all-time high of KES 60.6 billion. This increase was significantly different from the three previous fiscal years, especially FY 2020/21. In absolute terms, the government's contribution increased from KES 35.0 billion (70.6%) in FY 2020/21 to KES 39.1 billion (64.6%) by FY 2023/24. Donor loans have declined as a proportion of the total development budget in the last three fiscal years from 27.0% in FY 2021/22 to 21.9% by FY 2023/24. Similarly, the proportion of donor grant contributions decreased, from 16.1% in FY 2021/22 to 13.5% in FY 2023/24. This pattern shows that the government is gradually transitioning from a donor-dependent development budget to domestic public financing, offsetting its reliance on declining donor funds. If this trend is maintained, the government is on track to improve development budget predictability and expand investment in the health sector to advance universal health coverage.

Figure 7:Composition of MOH development budget, FY 2020/21-FY 2023/24

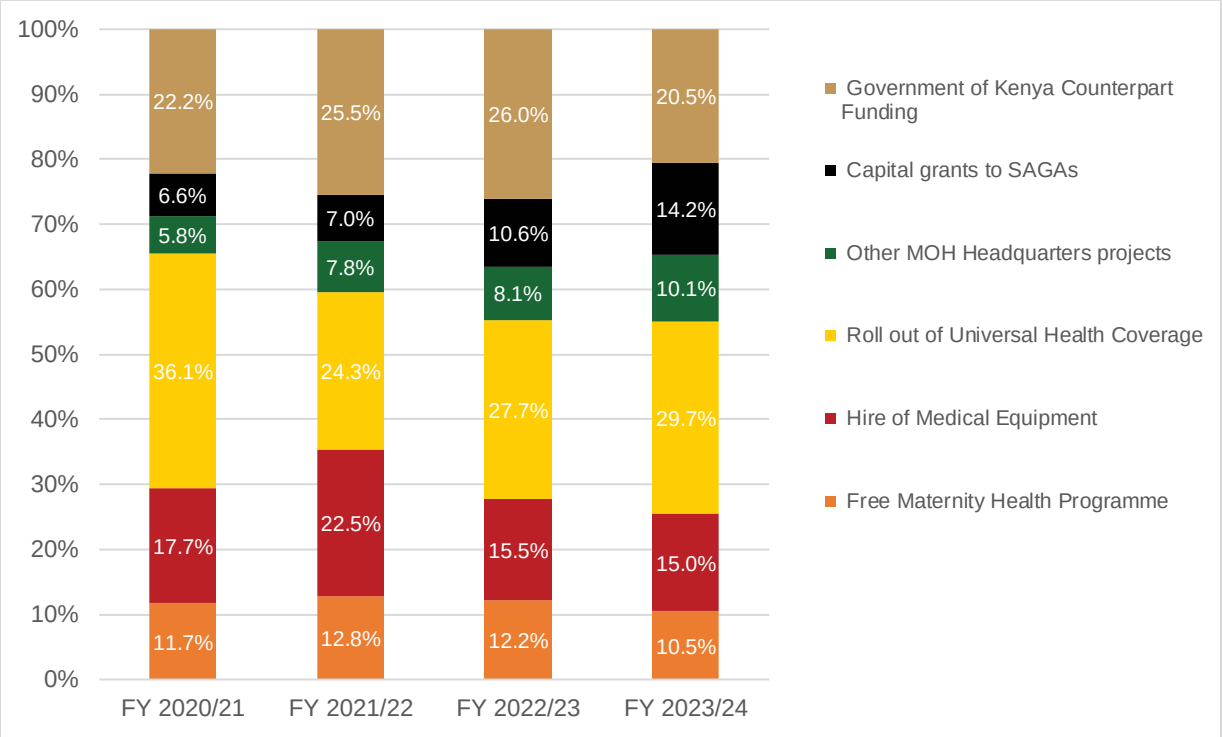


Source: Republic of Kenya, 2020/21-2023/24a

Ministry of Health Development Budget by Spending Classification

Figure 8 shows the distribution of the MOH development budget provided by the national government for FY 2020/21-FY 2023/24 by key programme area. As illustrated, MOH development budget allocations to the key programme areas have shifted over the past four fiscal years. Some areas have had significant increases, whereas others have decreased. Allocation to the rollout of universal health coverage has seen a significant decrease, from 36.0% (KES 12.6 billion) in FY 2020/21 to 29.7% (KES 11.6 billion) in FY 2023/24. This, however, comprises the highest proportion of the development budget and an indication that the MOH is prioritizing financing universal health coverage through the development budget as opposed to the recurrent budget (as previously shown in Figure 5).

Figure 8: Allocation of government of Kenya development budget to key programme areas, FY 2020/21-FY 2023/24



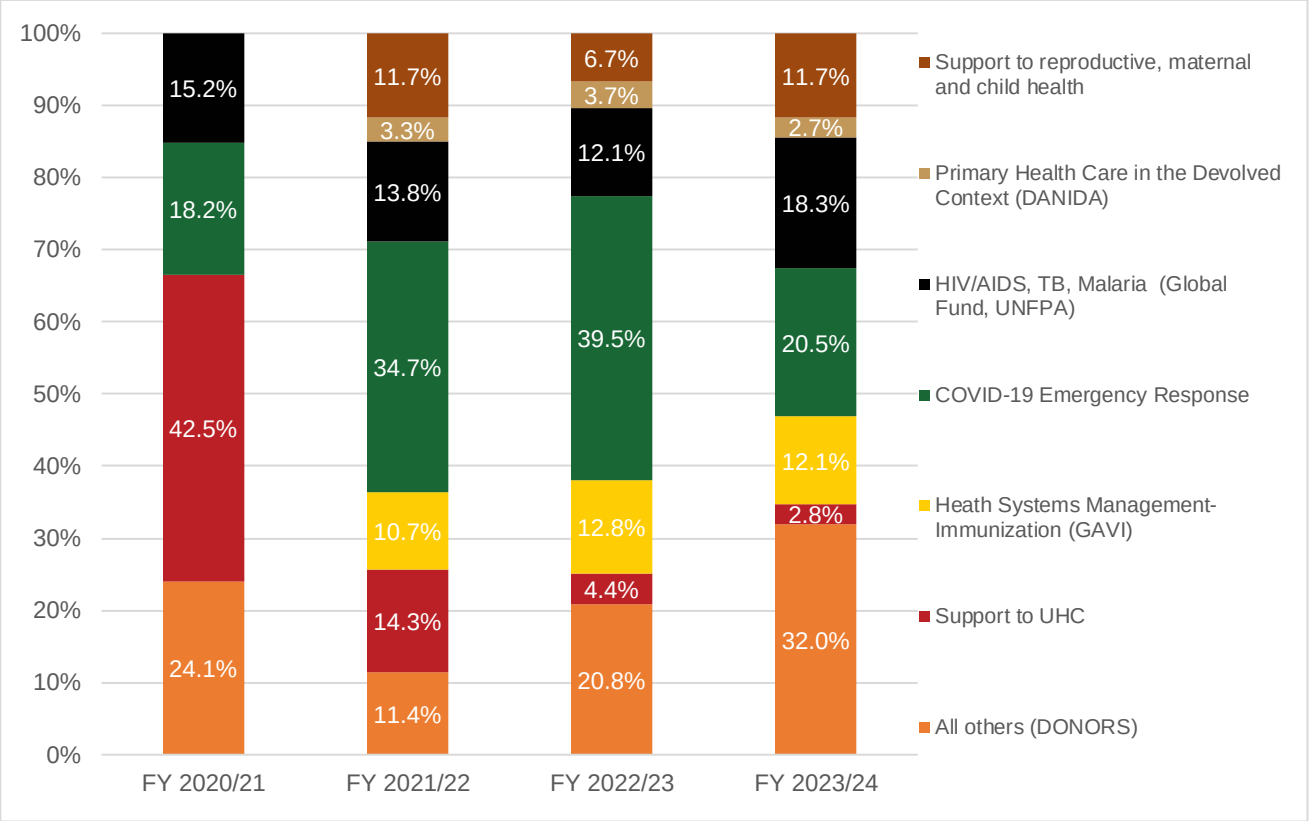
Source: Republic of Kenya, 2020/21-2023/24a

The government counterpart funding, which is the government's contribution to donor-funded programmes on HIV, TB, malaria, clinical waste management, the Kenya COVID-19 Emergency Response, nutrition, and vaccines and immunisation, increased from 22.2% (KES 7.8 billion) in FY 2020/21 to 26% (KES 8.8 billion) in FY 2022/23 before decreasing to 20.5% (KES 8 billion) in FY 2023/24. Consequently, allocation to hire of medical equipment has dropped from 17.7% (KES 6.2 billion) in FY 2020/21 to 15% (KES 5.9 billion) by FY 2023/24. Allocations to capital grants to SAGAs and other MOH headquarters projects have increased from 6.6% (KES 2.3 billion) and 5.8% (KES 2 billion) in FY 2020/21 to 14.2% (KES 5.6 billion) and 10.1% (KES 4 billion) by FY 2023/24, respectively. Financing of the Free Maternity Care Programme has remained constant over the past four fiscal years. This fund covers reimbursement to facilities providing free maternity care through the National Health Insurance Fund.

Ministry of Health Development Budget from Donor Sources, by Spending Classification

Donors support several key health programmes in Kenya through loans and grants, with financing channelled through the MOH development budget. In FY 2023/24, donor allocations through the MOH's development budget to the COVID-19 Emergency Response received the bulk of donor contributions at 20.5% (World Bank -16.8%; DANIDA-3.7%), down from 39.5% in the previous year (World Bank-32%; DANIDA-7.6%). Figure 9 presents a summary of the contributions by spending classifications in the four financial years.

Figure 9: Proportion of the MOH development budget from donor sources by programme, FY 2020/21-FY 2023/24



Source: Republic of Kenya, 2020/21-2023/24a

The proportion of donor contributions to strategic services (i.e., disease programmes), including the HIV, TB, and malaria programmes, was 18.3%, which was provided by the Global Fund and the United Nations Population Fund (UNFPA). Contributions slightly increased from KES 2.2 billion in FY 2020/21 to KES 3.9 billion in FY 2023/24. These disease programmes receive additional technical and financial support from donors, notably the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). However, this support is expended directly through USAID implementing partners.

Donor funding to immunisation and related health systems support was 10.7%, 12.8%, and 12.1% from Gavi, the Vaccine Alliance, for FY 2021/22, FY 2022/23 and FY 2023/24 respectively, with no allocation in FY 2020/21. Support to reproductive, maternal and child health programmes was 11.7% (UNFPA-3.3%; France-3.2%; Finland-5.1%) in FY 2023/24 an increase from 6.7% (UNFPA-5.9%; France-0.8%) in the previous year. In FY 2023/24, support to universal health coverage and primary health care was 2.8% and 2.7% respectively). The remaining 32% was allocated to other programmes, including Clinical Waste disposal and Clinical laboratory and Radiology services Improvement.

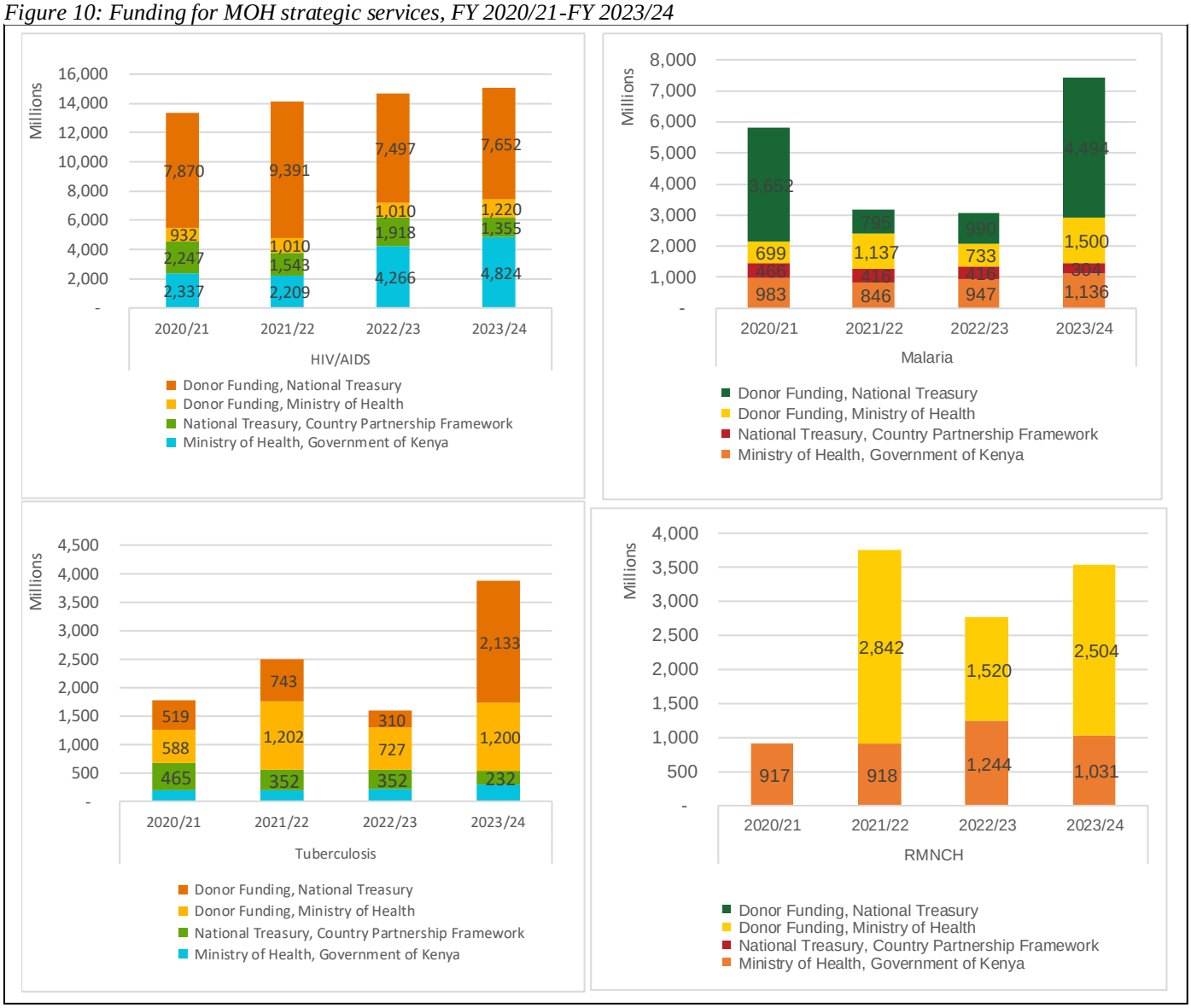
Ministry of Health and Donor Allocation to Strategic Services

Figure 10 summarises government and on-budget donor contributions to MOH strategic services (HIV, TB, Malaria and RMNCAH). The assessment shows trends in allocations to each of these strategic services and highlights how resource allocation has shifted between the government of Kenya and donors over the past four fiscal years. Donors provide on-budget support to key strategic services using two government budget streams: the MOH and the National Treasury for key commodities. In the last four fiscal years, donor contributions to these services through the MOH budget have been unpredictable, except for HIV,

where donor support consistently increased. Funding through the National Treasury budget was also unpredictable for HIV, TB and malaria. There were relatively high allocations to malaria during the years designated for mass net distribution.

Overall, funding allocations to HIV, TB, Malaria and RMNCH by the Government of Kenya through the MOH budget increased in FY 2020/21. In the period under review, funding for HIV increased by 106% (KES 2,487 million) between FY 2020/21 and FY 2023/24, for TB by 49% (KES 98 million), for malaria by 16% (KES 153 million) and RMNCH by 12% (KES 115 million). It should be noted, however, that due to a multilateral funding agreement with the Global Fund through the Country Partnership Framework, additional allocations were made available and spent directly under the National Treasury budget; these amounts are presented in Figure 10.

Figure 10: Funding for MOH strategic services, FY 2020/21-FY 2023/24



Source: Republic of Kenya, 2020/21-2023/24a

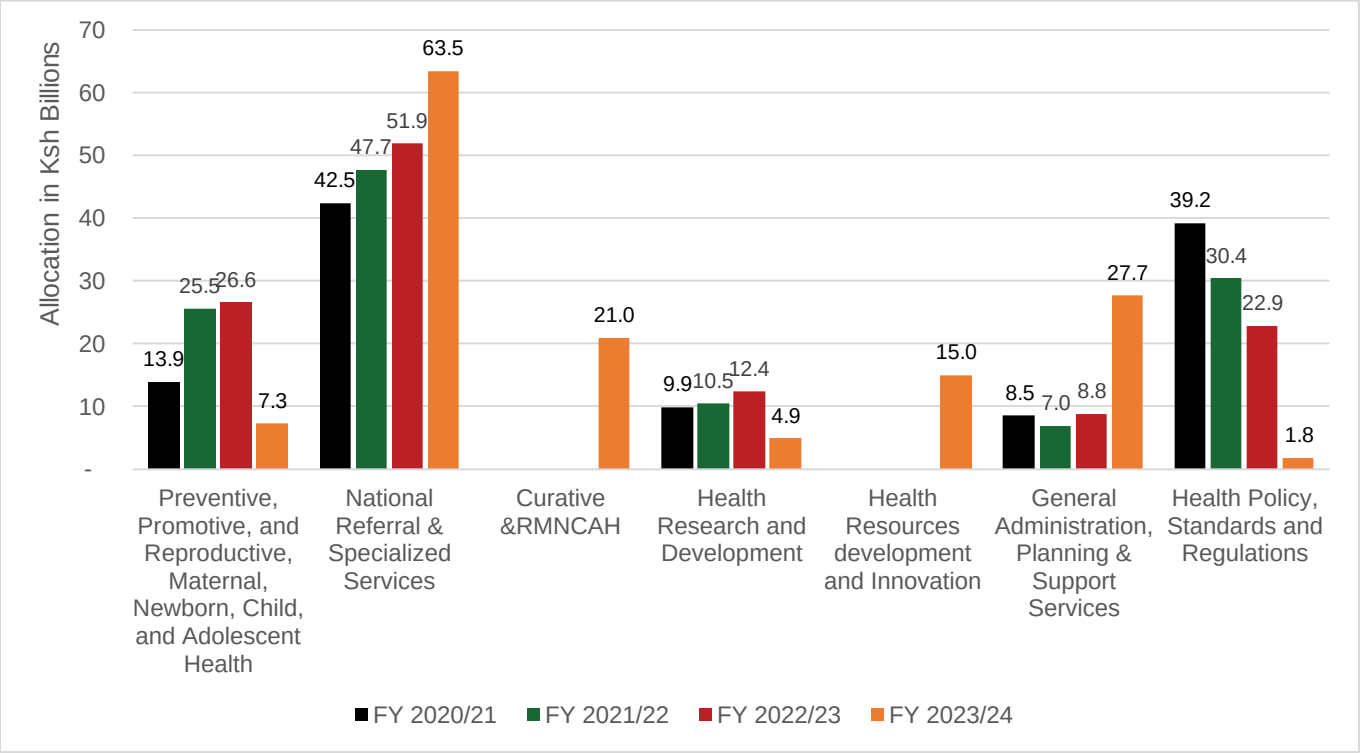
Note: Allocation data only include budget provisions that are directly identifiable as targeted funding for the specific facilities providing the services. The figures also exclude allocations to other ministries that undertake in-kind interventions related to the four programmes and exclude items funded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

Ministry of Health Allocations to PBB Programmes

Figure 11 illustrates health budget allocations (both recurrent anddevelopment) from the perspective of the MOH's seven designated programmes, through which all health services and the health mandate is delivered (programme-based budgeting (PBB)). This section highlights how health resources are distributed across these programmes - preventive and promotive RMNCAH; national referral and specialised services; curative and RMNCAH; health research and development; health resources development and innovation; general administration, planning and support services; and health policy, standards and regulations.

Although increases can be observed across most of these programmes, the MOH has prioritized national referral and specialized services and Curative & RMNCAH. These two programmes received 60% (KES 85 billion) of the MOH's entire budget for FY 2023/24. The reproductive, maternal, newborn, child,and adolescent health services programme saw a decrease between FY 2020/21 and FY 2023/24 and received only 5% (KES 7.3 billion) of the MOH budget.

Figure 10: MOH budget allocations to PBB programmes, FY 2020/21-FY 2023/24



Source: Republic of Kenya, 2020/21-2023/24a

County Allocations to Health

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

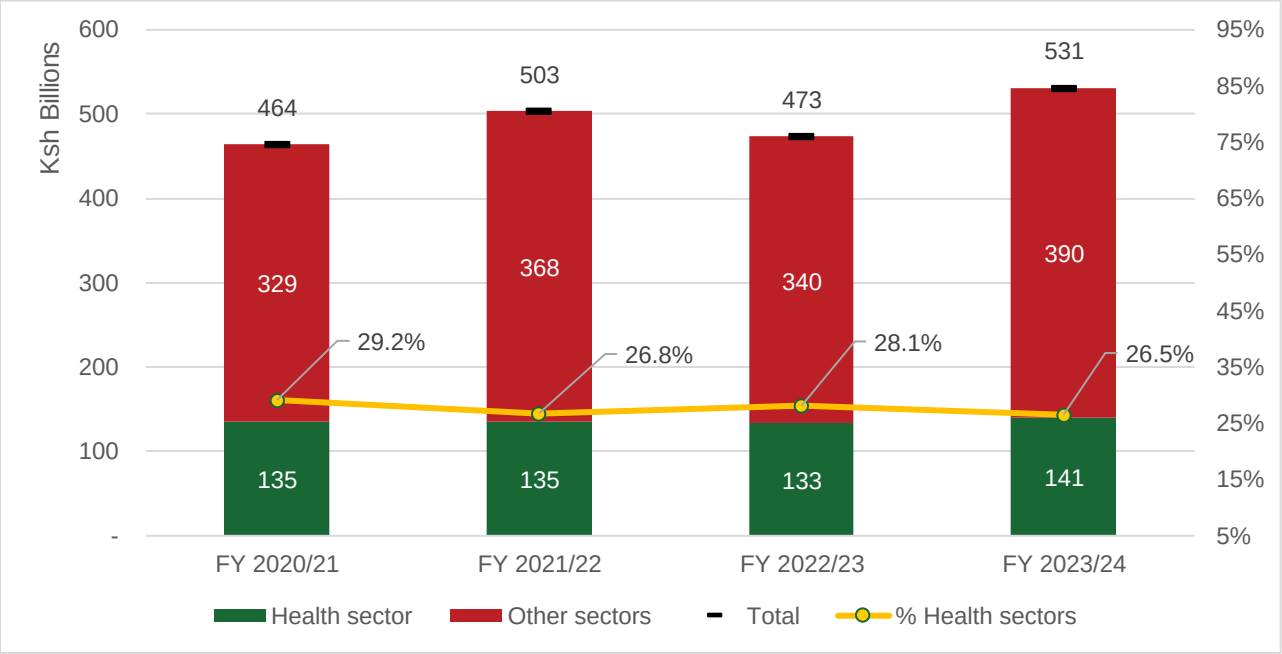
Overall Allocations to Health by County Governments

The proportion of counties' health budgets in relation to their total county government budgets indicates the priority level that county governments place on the health sector. Figure 12 shows counties' budget

allocations to health during FY 2020/21-FY 2023/24. County budgets expanded from KES 464 billion in FY 2020/21 to KES 503 billion in FY 2021/22, decreased to KES 473 billion in FY 2022/23 before increasing again to KES 531 billion in FY 2023/24, representing an increase of 14% over the four-year. Proportional allocations to health increased significantly less than overall growth in county government budgets, representing four percent growth from FY 2020/21 through FY 2023/24.

Figure 12 also shows that county government allocations to the health sector as a percentage of total county government budgets decreased over the period, from 29.2% in FY 2020/21 to 26.5% in FY 2023/24. This finding is an indication that health sector is not prioritized in the county governments.

Figure 11: County governments' allocations to health and all other sectors, FY 2020/21-FY 2023/24



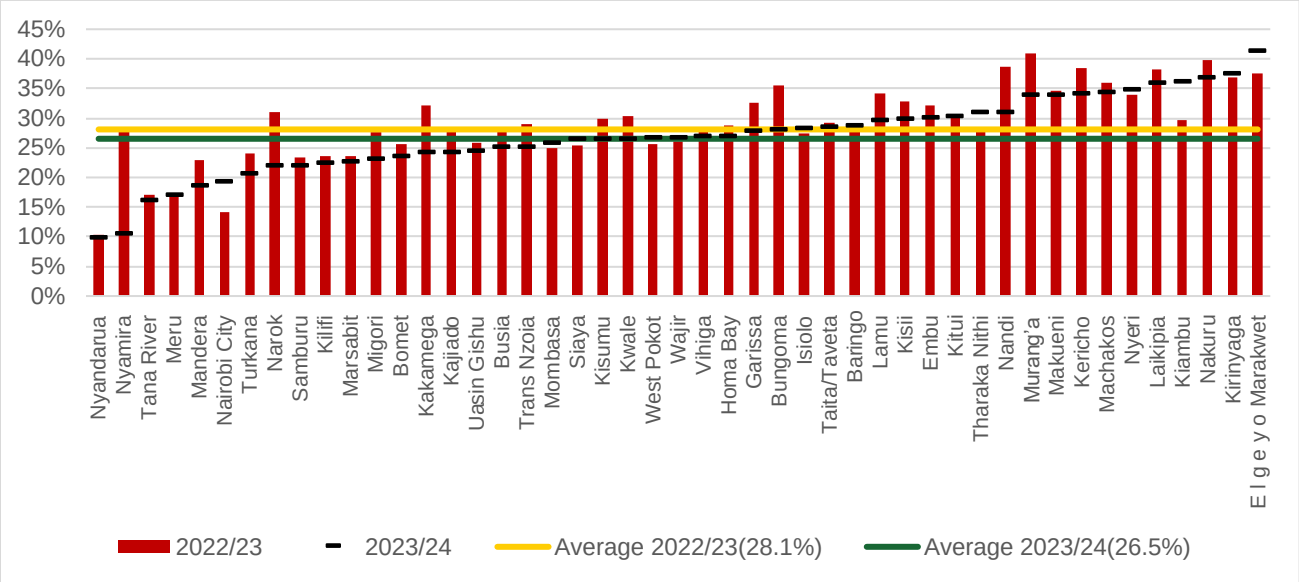
Source: Republic of Kenya, 2020/21-2023/24b

Note: For FY 2023/24, the KES 141 billion for county health budgets differs from the KES 139 billion presented in Figure 2 because it includes additional transfers received from the MOH that counties have discretion to allocate

Allocations to Health by County

As Figure 13 shows, counties on average decreased the proportion of their budgets allocated to health during FY 2022/23–FY 2023/24. However, decreases in allocation to health were not uniform across all counties. The aggregate proportion of county budgets dedicated to health decreased from 28.1% in FY 2022/23 to 26.5% in FY 2023/24, with only 13 of the 47 counties increasing the proportion of their budgets to health over the two fiscal years. Five counties achieved and surpassed the estimated pre-devolution allocation of 35% in FY 2023/24, compared to nine in the previous year. However, the data in Figure 14 do not suggest any apparent uniqueness between counties allocating a higher proportion to health and those allocating a lower proportion; low-performing counties have the potential to increase their proportional allocations to health.

Figure 12: Allocations to health as a percentage of total county budget, FY 2022/23 and FY 2023/24

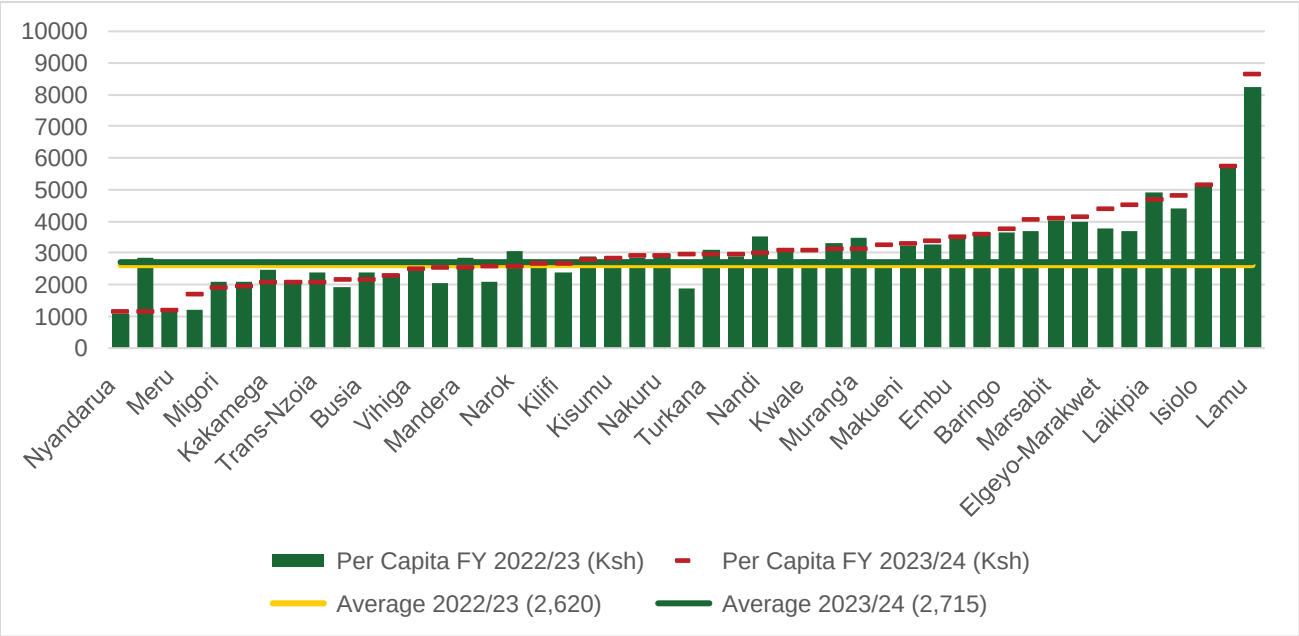


Source: Republic of Kenya, 2020/21-2023/24b

Per Capita Allocations to Health by County

Per capita allocations provide a valuable measure of a county's commitment to the health sector. Figure 14 provides per capita health budget allocations by county for FY 2022/23 and FY 2023/24. Counties collectively increased their per capita budget allocations to health 3.6% between FY 2022/23 to FY 2023/24, from KES 2620 to KES 2,715, in nominal terms and adjusted for population. Per capita allocations varied across counties in FY 2023/24, ranging from KES 1157 in Nyandarua County to KES 8,668 in Lamu. More than half of the counties (24 out of 47) increased their health budget per capita allocations. However, 23 counties decreased their per capita allocations in FY 2023/24.

Figure 13:County per capita health budget allocations, FY 2022/23 and FY 2023/24



Source: Republic of Kenya, 2020/21-2023/24b

County Health Budget Allocations to Recurrent and Development

County governments determine the proportion of funds to be allocated to their recurrent and development activities. The Public Finance Management Act of 2012 recommends that over the medium term, counties allocate at least 30% of their budgets to development activities and 70% or less to recurrent activities. The intent is to consistently invest in expansion and yet maintain provision of services. This section analyses how counties allocated funding for recurrent and development activities during FY 2020/21–FY 2023/24.

Overall Allocations to Recurrent and Development Expenditure

Table 3 shows that counties' health sector budgets continued to be dominated by recurrent activities, making up 81.5% in FY 2020/21, 81.9% in FY2021/22, 83.8% in FY 2022/23 and 82.5% in FY 2023/24. This trend represents an overall increase in the proportion of these budgets allocated for recurrent expenditures, and thus an overall decrease in development expenditure allocations. Absolute allocations for recurrent expenditures increased from KES 110.3 billion in FY 2020/21 to KES 110.6 billion in FY 2021/22, KES 111.4 billion in FY 2022/23 and 111.6 in FY2023/24. Allocations to development expenditures decreased from KES 25.1 billion in FY 2020/21 to KES 24.5 billion in FY 2021/22 and KES 21.6 billion in FY 2022/23 before increasing to 24.6 billion in FY 2023/24. The increasing budget allocations for health are disproportionately channelled towards recurrent expenditures, even as the aggregate proportion allocated to development remains well below the 30% recommended by the Public Finance Management Act of 2012.

Table 3: Recurrent and development health sector allocations, FY 2020/21-FY 2023/24, KES billions

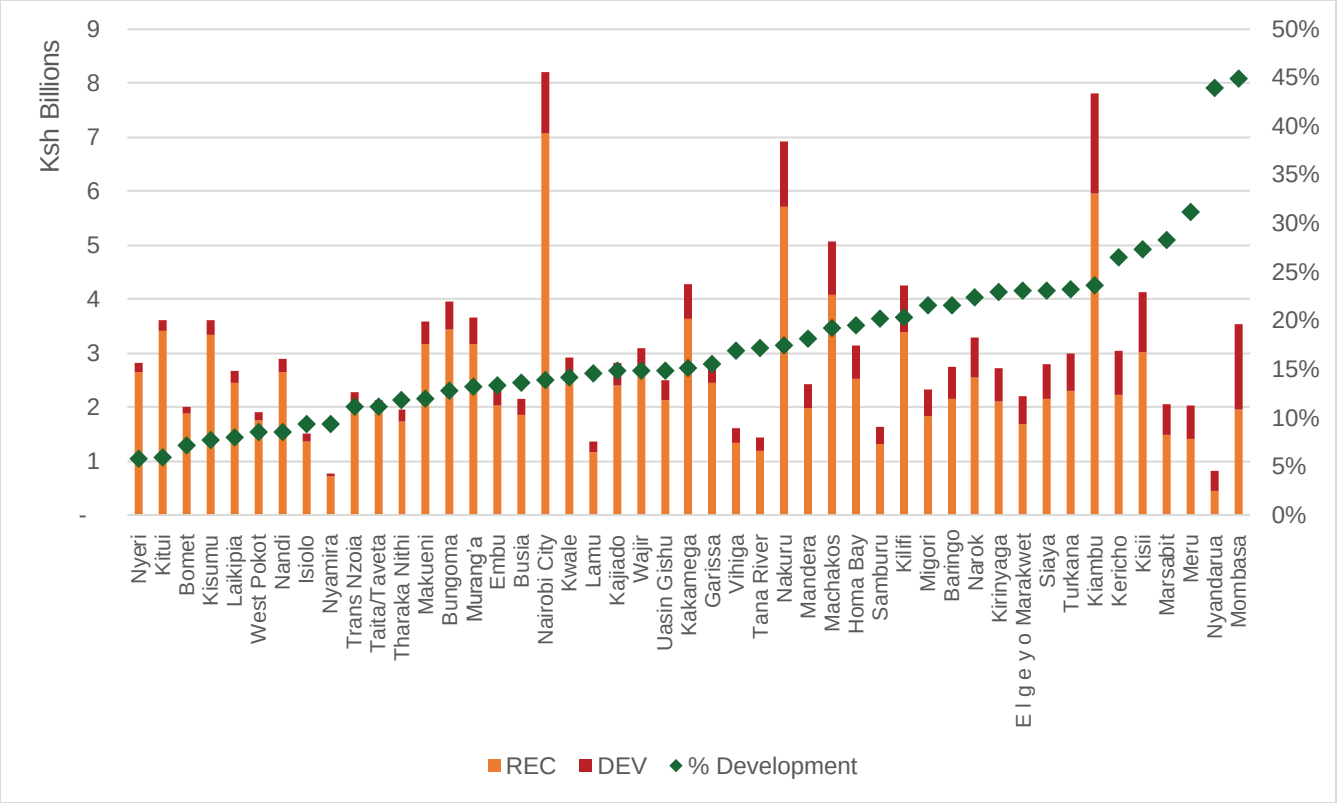
Vote				
	FY 2020/21	**FY 2021/22**	**FY 2022/23**	**FY 2022/24**
Recurrent	110.3 (81.5%)	110.6 (81.9%)	111.4 (83.8%)	111.6 (82.5%)
Development	25.1 (18.5%)	24.5 (18.1%)	21.6 (16.2%)	24.6 (17.5%)
TOTAL	135.4 (100%)	135.0 (100%)	133.0 (100%)	140.9 (100%)

Source: Republic of Kenya, 2020/21-2023/24b

Proportion of Budget Allocations to Recurrent and Development Budgets by County

The level of funding for development and its proportion of the total health department's budget indicates the level of capital investment in the health sector and the overall expansion of longer-term infrastructure. There are significant variations among counties in the proportion of their development budget allocations, regardless of the absolute amounts allocated to health. Figure 15 presents recurrent and development allocations by county for FY 2023/24, ranked by percentage of budget allocated to development. The proportion allocated for development ranged from less 6% in Nyeri and Kitui to 44.9% in Mombasa.

Figure 14: Allocations to recurrent and development activities by county, FY 2023/24



Source: Republic of Kenya, 2020/21-2023/24b

Table 4 lists 44 counties that allocated less than 30% of their health budgets to development expenditures (i.e., more than 70% to recurrent), which is below the recommended threshold; three counties met that threshold. These three counties show no common characteristic, indicating that other counties have the potential to allocate a higher proportion of funds to their development budgets.

Table 4:Proportion of counties' health allocations dedicated to recurrent activities, FY 2023/24

51–70%	70–80%	80–90%	Over 90%
Mombasa : 55.1%	Marsabit :71.7%	Homa Bay :80.5%	Nyamira : 90.6%
Nyandarua : 56.0%	Kisii : 72.7%	Machakos : 80.8%	Isiolo : 90.7%
Meru : 68.8%	Kericho : 73.5%	Mandera : 81.9%	Nandi : 91.5%
	Kiambu : 76.4%	Nakuru : 82.6%	West Pokot : 91.5%
	Turkana : 76.8%	Tana River : 82.8%	Laikipia : 92.1%
	Siaya : 76.9%	Vihiga : 83.1%	Kisumu : 92.3%
	E l g e y o Marakwet : 76.9%	Garissa : 84.4%	Bomet : 92.9%
	Kirinyaga : 77.1%	Kakamega : 84.9%	Kitui : 94.2%
	Narok : 77.6%	Uasin Gishu : 85.1%	Nyeri : 94.2%
	Baringo:78.4%	Wajir : 85.1%	
	Migori : 78.4%	Kajiado : 85.2%	
	Kilifi : 79.7%	Lamu : 85.5%	
	Samburu : 79.8%	Kwale : 85.8%	
		Nairobi City : 86.1%	
		Busia : 86.4%	
		Embu : 86.7%	

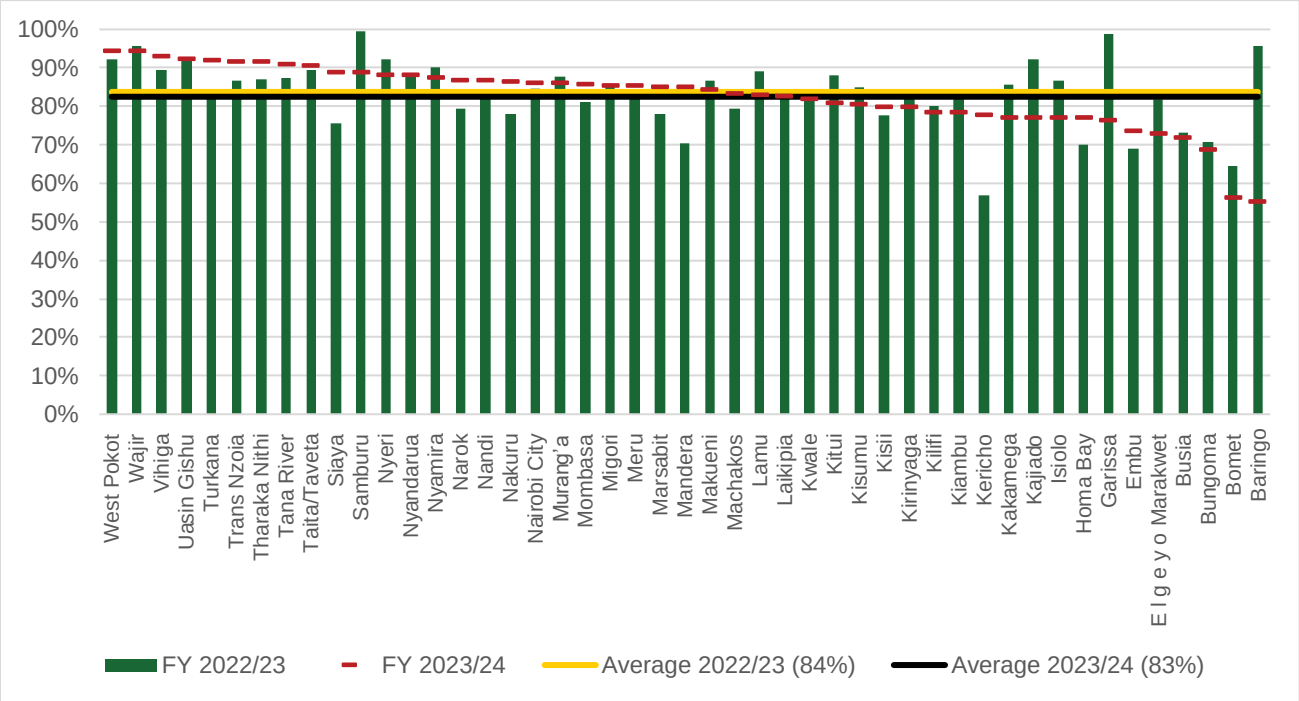
51–70%	70–80%	80–90%	Over 90%
		Murang'a : 86.8% Bungoma : 87.3% Makueni : 88.0% Tharaka Nithi : 88.2% Taita/Taveta : 88.8% Trans Nzoia : 88.9%	

Source: Republic of Kenya, 2020/21-2023/24b

Trends in Recurrent versus Development Allocations by County

Figure 16 presents recurrent health budget allocations as a percentage of total health allocations during FY 2022/23 and FY 2023/24 by county. On average, the proportion of county health budgets 23 allocated to recurrent decreased slightly from 83.8% in FY 2022/23 to 82.5% in FY2023/24. The proportion of the total health budget dedicated to recurrent activities increased in 22 counties (Kericho, Mandera, Siaya, Nakuru, Turkana, Marsabit, Narok, Homa Bay, Trans Nzoia, Tharaka Nithi, Mombasa, Embu, Machakos, Vihiga, Tana River, Nandi, Kisii, West Pokot, Nairobi City, Taita/Taveta, Meru and Uasin Gishu). The analysis showed substantial decreases in recurrent allocations between FY 2022/23 and 2023/24 in 13 counties (Nyeri, Kisumu, Kiambu, Lamu, Kitui, Bomet, Kakamega, Elgeyo Marakwet, Isiolo, Samburu, Kajiado, Garissa and Baringo). Overall, this trend suggests that counties are not limiting recurrent allocations in their budgets.

Figure 15: Recurrent allocations as a percentage of health allocations by county, FY 2022/23, and FY 2023/24



Source: Republic of Kenya, 2020/21-2023/24b

County Health Budget Allocations by Economic Category

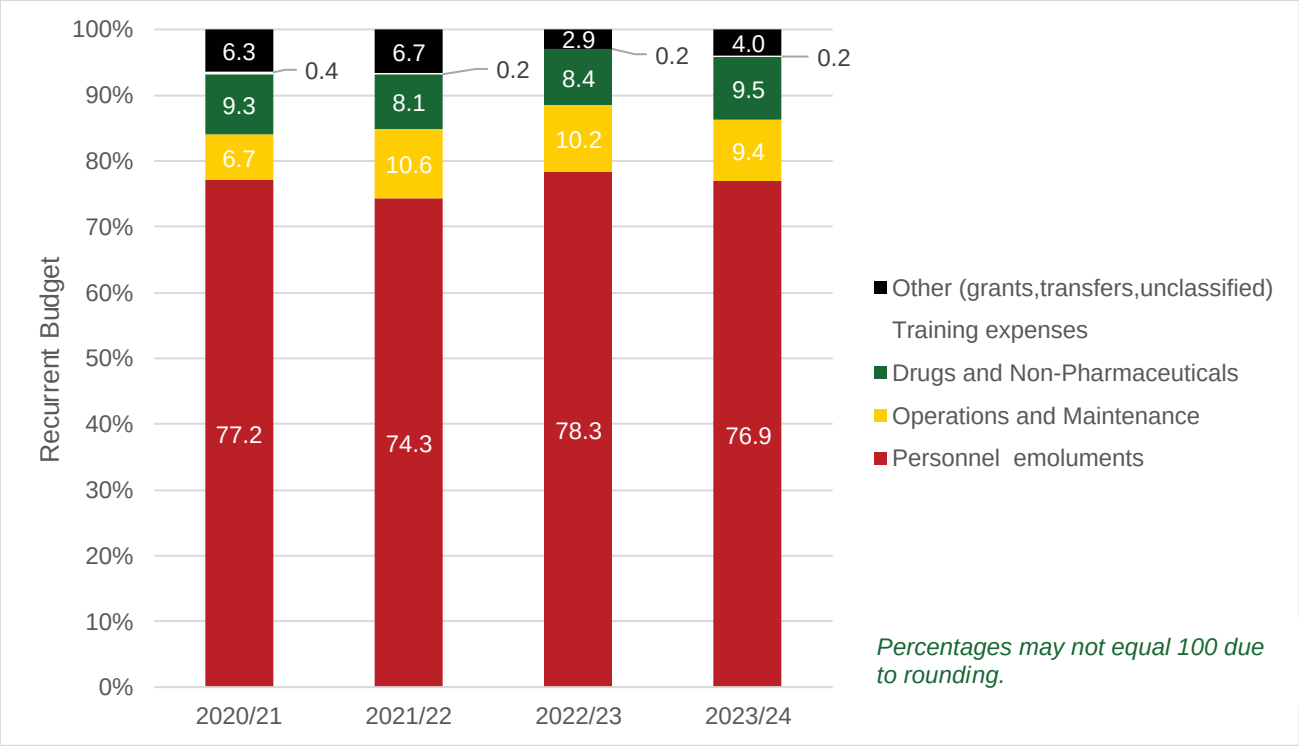
As counties move towards implementing PBB, it is prudent to analyse budget allocations by key health inputs. Programme-based budgeting classifies allocations according to specific programmes, disaggregated into sub-programme and economic categories. Programme-based budgeting guidelines propose disaggregation of the recurrent budget into four economic categories: personnel emoluments; operations and maintenance; drugs and

non-pharmaceuticals; and training and other, including grants and transfers. However, health sector budgets are more informative if critical service delivery inputs are identified and separated from the operations and maintenance categories. This separation enables counties to demonstrate allocations to priority key inputs. The development budget is disaggregated into three economic categories: transfers, grants, and other development expenditures; equipment and furniture; and buildings. The following two sub-sections examine how counties allocated their recurrent and development budgets by economic categories.

Health Recurrent Budget Allocations by Economic Category

Figure 17 presents the trend in counties' health recurrent budget allocations by health sector economic category. Allocations for personnel emoluments comprised the largest share of the recurrent budget, decreasing from 77.2% in FY 2020/21 to 74.3% in FY 2021/22 before increasing to 78.3% in FY 2022/23 and then decreasing again to 76.9% in FY 2023/24. The growing increase of the proportion of the health budgets allocated to personnel emoluments is gradually crowding out much-needed resources for other key recurrent inputs. Budget allocations to operations and maintenance increased from 6.7% to 10.6% in FY 2021/22 and has gradually decreased to 10.4% in FY 2022/23 and 9.4% in FY 2023/24. Drugs and non-pharmaceuticals decreased from 9.3% in FY 2020/21 to 8.1% in FY 2021/22 and gradually increased in the subsequent years to 8.4% and 9.5% in FY 2022/23 and FY 2023/24 respectively.

Figure 16: County health recurrent budget allocations by economic category, FY 2020/21-FY 2023/24

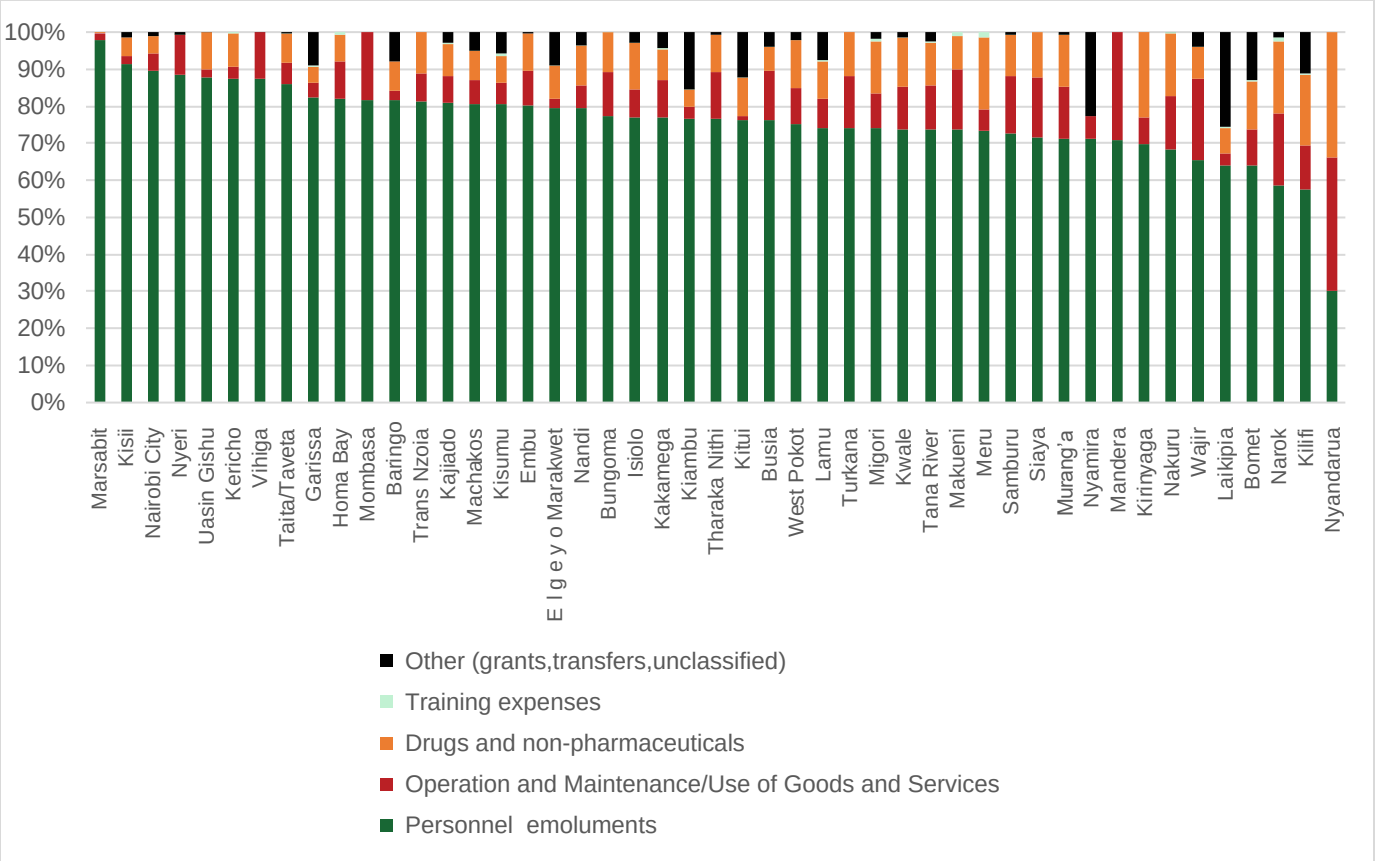


Republic of Kenya, 2020/21-2023/24b

Health Recurrent Budget Allocations by Economic Category by County

FY 2023/24 recurrent budget allocations varied across counties. Figure 18 shows individual counties' allocations to personnel emoluments; drugs and non-pharmaceuticals; training; operations and maintenance; and other, including grants, transfers, and unclassified expenditures.

Figure 17: Health recurrent budget allocations by economic category by county, FY 2023/24



Republic of Kenya, 2020/21-2023/24b

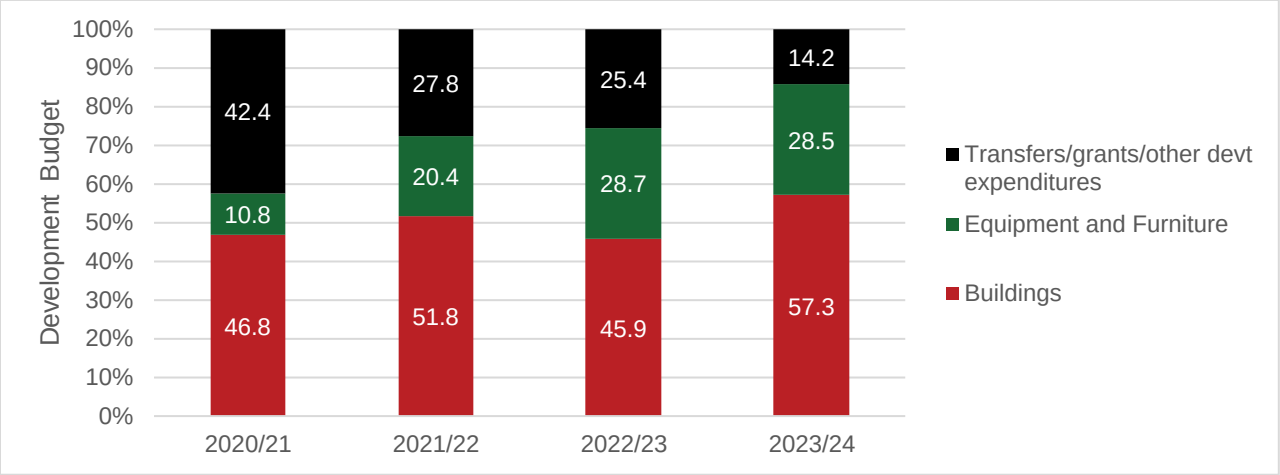
As shown in Figure 18, during FY 2023/24, Narok, Kilifi and Nyandarua counties allocated less than 60% of their recurrent budgets to personnel emoluments, freeing up fiscal space for other critical health inputs. At the other extreme, Marsabit and Kisii counties allocated more than 90% of their recurrent budgets to personnel emoluments, leaving less than 10% for other critical inputs. Allocations to personnel emoluments exceeded the average (76.9%) for 22 out of the 47 counties.

Health Development Budget Allocation by Economic Category

As noted in Table 3, there was an overall decrease in counties' allocation to development budgets, both as an absolute amount and as a proportion of their health budgets. Figure 19 shows the trend in development budget allocations by economic category over the four-year period. The proportion of expenditures allocated to investment in construction projects (buildings) increased from 46.8% in FY 2020/21 to 51.8% in FY 2021/22, declined to 45.9% in FY 2022/23 before increasing to 57.3% in FY2023/24. Construction plus equipment and furniture totalled 57.6% in FY 2020/21, 72.2% in FY 2021/22, 74.6% in FY2022/23, and 85.8% in FY 2023/24. The proportion of funds allocated to transfers, grants, and other development decreased from 42.4% in FY 2020/21, 27.8% in FY 2021/22, 25.4% in FY 2022/2023 and to 14.2% in FY 2023/24.2

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

Figure 18: County health development budget allocations by economic category, FY 2020/21-FY 2023/24

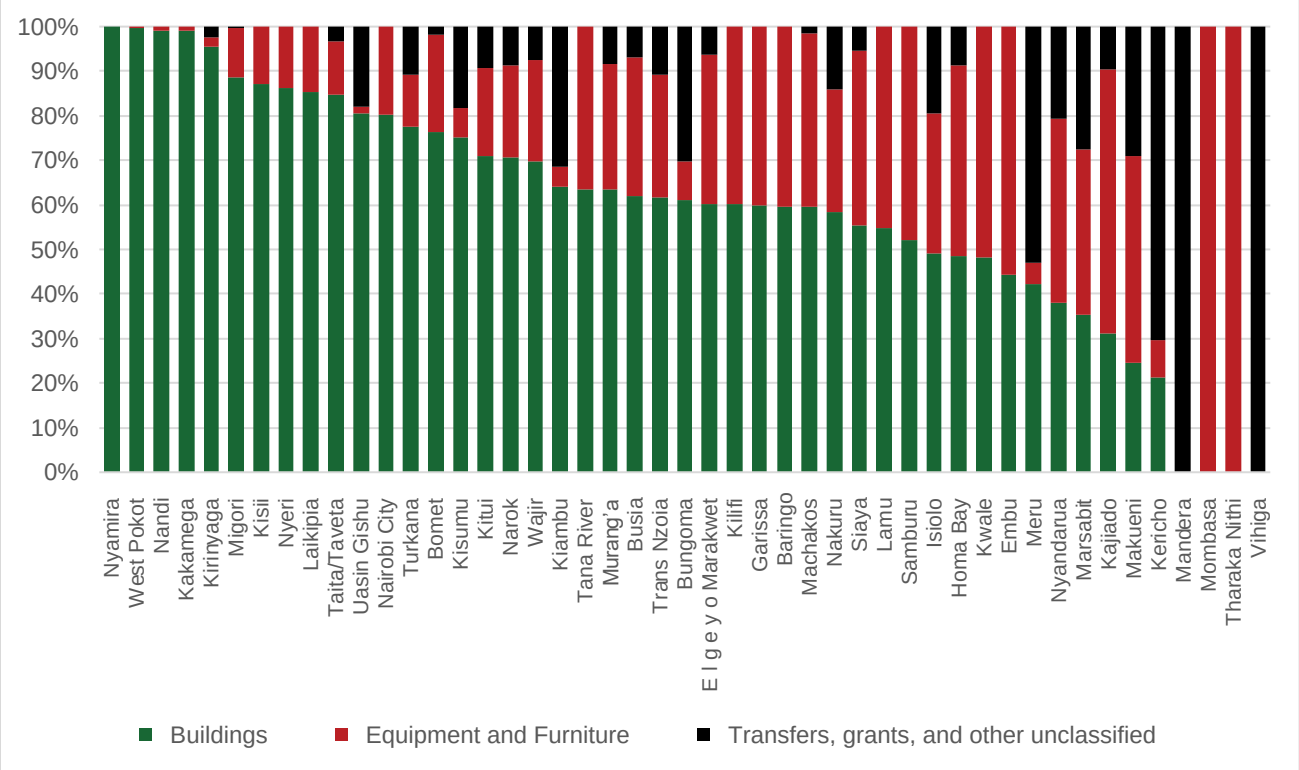


Republic of Kenya, 2020/21-2023/24b

Health Development Budget Allocation by Economic Category by County

Like recurrent budget allocations, FY 2023/24 development budget allocations also varied across counties. Figure 20 shows individual counties' allocations for FY 2023/24 to buildings; equipment and furniture; and grants, transfers, and other development expenditures not classified among these categories. Almost half of the counties have expanded their physical infrastructure by allocating more than 50% of their development budgets to buildings. However, counties that seem to allocate little or no funds to buildings reported the highest allocation of the development budget under the categories of equipment and furniture and transfers, grants, and unclassified. This suggests that those counties are preferring to implement infrastructure expansion through grants and transfers and equip existing and any new infrastructure.

Figure 19: County health development budget allocations by economic category, FY 2023/24



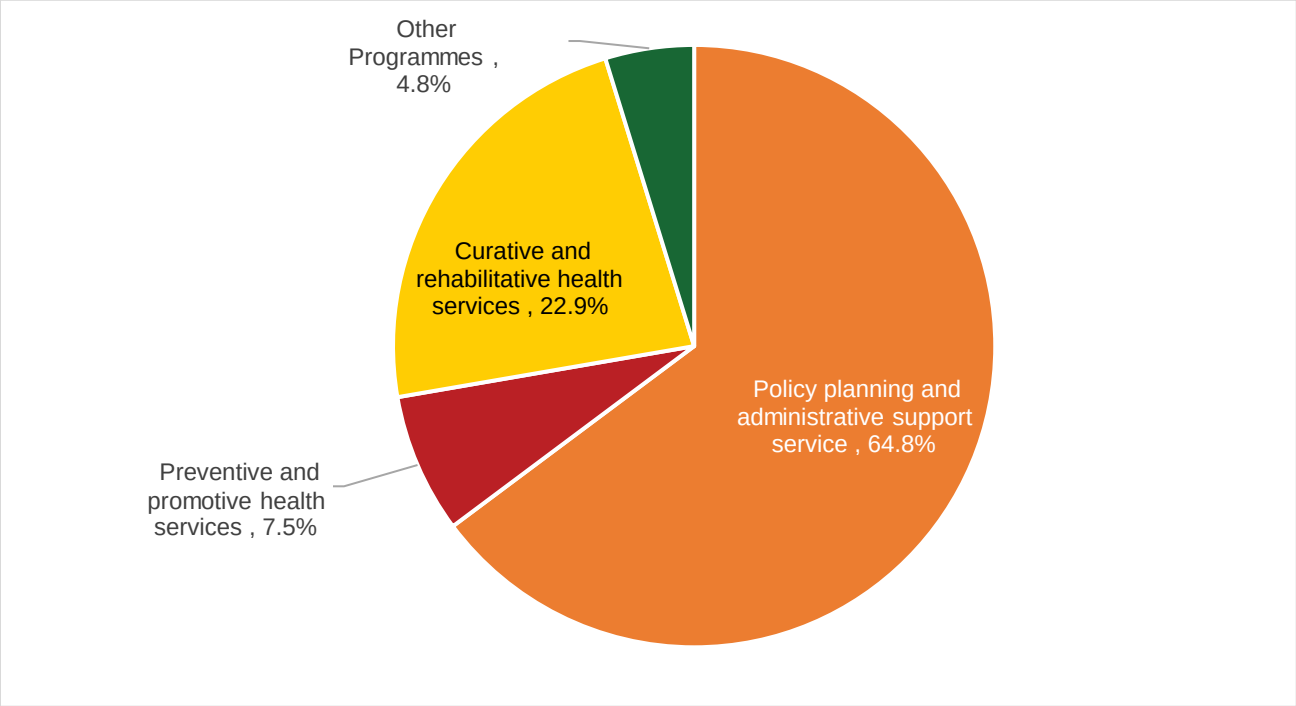
Republic of Kenya, 2020/21-2023/24b

County Health Allocations to Programmes

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

Figure 21 shows the overall county budget allocations to these programmes for FY 2023/24. Among all the 47 counties, 32 reflect all three programmes in their budgets while the rest either do not or have only one or two. In the analysis, "Other" programmes refer to those that were not categorized under the three major programmes. Based on the available data, inefficiencies in county resource allocations are clear, with more funding going towards curative care as opposed to preventive and promotive care, increasing the demand for curative care as a result. Furthermore, inefficient allocations are seen in the large amount going to policy planning and administrative support, which funds personnel emoluments in counties.

Figure 20:County budget allocations to programmes, FY 2023/24



Republic of Kenya, 2023/24b

CONCLUSIONS AND RECOMMENDATIONS

This study sought to explore Kenya's budget allocations to health, and whether these resources were allocated appropriately during FY 2020/21-FY 2023/24 to achieve the country's intended health priorities. The study findings lead to the following conclusions and related recommendations.

Conclusions	Recommendations
• Kenya allocated budget share to health was 9.7% of the total government budget in FY 2023/24. Despite the significant increase, the overall budget allocation to the health sector falls short of the 15% of government resources to health recommended by the Abuja Declaration and the government's own commitment. • The health sector continues to fall behind other sectors, ranking sixth in government allocation priorities. Over the last four fiscal years, proportional budget allocations to the MOH at the national level have increased marginally, from 6.5% in FY 2020/21 to 6.0% in FY 2023/24.	• The MOH and the Ministry of Finance need to work together to enhance and explore additional resources of domestic funding, including allocating an increased share of government tax revenue to the health sector and scaling up insurance coverage, thus adequately mobilizing funds from both mandatory and voluntary contributor segments. More immediately, maximizing efficient targeting and spending, prioritizing coordination across government and development partners, and fully executing health resources could yield considerable gains and value for money, and reduce resource wastage.
• Both donor on-budget funding and government funding for donor-supported strategic services, especially for HIV/AIDS and malaria, have increased in absolute terms in the four years of the review. However, government expenditures have traditionally fallen short of initial allocations, leaving uncertainty as to the resources that will be strategically targeted and expended in full. Core disease programmes, such as HIV/AIDS, TB, and malaria, remain dependent on donor funding. • Looking at the MOH's budget allocations through the seven PBB programmes, national referral and specialized services has dominated the MOH's overall budget in the last four fiscal years, leaving limited resources for preventive, promotive, and reproductive, maternal, neonatal, child, and adolescent health.	• Increased resource allocations should be prioritized efficiently to target donor-dependent health initiatives, including HIV, TB, and malaria.Secondarily, the ministry should prioritize areas that have received inadequate budget allocations, like preventive, promotive, and reproductive, maternal, neonatal, child, and adolescent health. • Policies that help mobilize private investment in healthcare services can serve to drive economic growth in addition to helping supplant reduced donor funding. The MOH can encourage growthin resources directed to the health sector by pursuing policies to catalyse private investment,such as reducing regulations, expanding the contracting capabilities of private health providers, and actively encouraging local privateinstitutions to invest in the health sector.
• Grants to SAGAs have dominated the MOH's recurrent budget, averaging close to 70% for the past four fiscal years, with user fees from these agencies contributing a portion towards total allocation. Such inefficiencies significantly limit the fiscal space for the MOH to sufficiently allocate to other priority programmes.	• Because SAGAs account for a significant portion of its budget, the MOH should explore innovative resource mobilization concepts like increasing SAGAs budgets from user fees and expanding the adoption and uptake of insurancecoverage to partially shift the cost of healthcare coverage. Expanding greater adoption of health insurance schemes will require strong political will from local governments and the MOH.

Conclusions	Recommendations
• The combined proportional allocation to health has been fluctuating at the county level, albeit with noticeable inter-county variations. On average, counties allocated 26.5% of theirbudgets to health in FY 2023/24, a decrease from 29.2% in FY 2020/21. This level of resource allocation still falls below the estimated 35% the national government was spending in counties before devolution. • Some counties (13 of 47) increased their proportionate health budgets over the last two fiscal years, whereas 34 counties experienced decreases in their allocations. Five counties achieved and surpassed the estimated pre-devolution allocation of 35% in FY 2023/24, compared to nine in the previous year.	• Although advocating for additional resources for health at the county level is warranted, counties need to ensure resources are allocated more efficiently to health priority areas that increase value for money, including directing more resources to cost-effective preventive and promotive health services. Additionally, countiesshould enhance advocacy efforts to ensure key disease programmes like HIV, malaria, and TB are prioritized during the planning and budgetingprocesses. To accomplish such advocacy, counties need to capitalize on the evidence fromcounty-specific budget and expenditure analyses. • Counties need to reduce their overreliance on the national government's shareable revenue by enhancing collection of revenue from local taxes. They also need to increase and streamline revenue collection by expanding the population covered by insurance and focusing on promoting primary care as a more cost- effective means of delivering care.
• County health sector budgets continue to be dominated by recurrent expenses, most of which are allocated to personnel emoluments. In 2023/24, average recurrent budget constituted 82.5% of county overall budgetsan increase from 81.5% in FY 2020/21. Although inter-county variations do exist, 44 out of 47 counties allocated more than 70% of their budgets to recurrent activities, crowding out resources for key development investments. As a result, allocations to county development budgets havebeen in decline, reaching a low of 17.5% in FY 2023/24. The Public Finance Management Act of 2012 recommends a threshold of 30% for development budgets, which is not being met by most counties. • The high allocation to personnel emoluments across counties is a concerning trend. Counties allocated 76.9% of their resources to personnel emoluments in FY 2023/24, a slight decrease from 77.2% in FY 2020/21. Although this assessment did not conduct an in- depth analysis of personnel budgets and resource needs, the high allocations might be a response to accommodating the acute need for health personnel in Kenya. A study in 2021 found that Kenya employs 17 health workers per 10,000 population, falling short of the World Health Organization recommended minimum of 23 per 10,000 population (Milo et al., 2021).	• Counties must prioritize rationalizing staffing plans and exploring strategies to ensure budgetallocations to personnel are needs-based and informed by evidence and to ensure that resource allocations are adequate for other keyhealth inputs. Effectively using data and greater in-depth analysis is needed to understand the underlying drivers in personnel budgets and determine how best to allocate resources to meet Kenya's increasing need for skilled health personnel. • Counties need to ensure sufficient resources are available for critical health inputs, such as drugs, non- pharmaceuticals, and operations.

Conclusions	Recommendations
• Findings show that adherence and capacity to adopt the PBB approach to planning and budgeting varies among counties.The three most common programmes instituted in 32 counties were preventive and promotive health, curative health, and policy, planning, andadministrative support services. Preliminary findings show inefficiencies in county resource allocations, with more funding going towards curative care (23%) as opposed to preventive care (8%). The main cost driver, accounting for 65%, is policy planning and administrative support budgets, which include personnel emoluments in counties.	• Counties should invest in technical capacity strengthening in planning and budgeting to learnto effectively adopt the PBB approach in their planning and budgeting process. The PBB approach has proven to increase efficiency in resource allocations and link inputs with programme outcomes.

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For more information, contact:

Ministry of Health
Afya House, Cathedral Road
P.O Box 30016 – 00100 Nairobi, Kenya
Phone: +254-20-2717077
Email: mohcommunication@health.go.ke