GOVERNMENT EXPENDITURE ON RMNCAH IN NAIROBI & BUNGOMA COUNTIES AND THE EFFECT OF THE COVID-19

EXECUTIVE SUMMARY

The Evidence for Action (E4A)-MamaYe project works in two counties in Kenya, Bungoma and Nairobi. The project supports coalitions of civil society organisations and the media to strengthen accountability and support county health officials to improve planning and decision-making as a way of removing the bottlenecks in the budgeting process which include low budget allocations for healthcare, partial and late release of allocated resources and weak use of evidence to direct investments.

Kenya has a devolved health system, with the national Ministry of Health responsible for training and policy functions, and 47 semi-autonomous regions (counties) offering healthcare service delivery. The devolution of health services and a growing economy has enabled Kenya to increase its investment in healthcare. However, Kenya's maternal and child mortality rates remain among the highest in the world. Bottlenecks in health financing have been cited as the major contributor to the suboptimal return on investment for reproductive, maternal, neonatal, child and adolescent health (RMNCAH). These include low budget allocations for healthcare, partial and late release of allocated resources and weak use of evidence to direct investments.

This case study is an evaluation of the status of the health financing and budget process in the two counties, and explores ways in which the two could be optimised to reduce the number of deaths of mothers and children.
In both Nairobi and Bungoma, the proportion of the county budget allocated to healthcare has been between 20% and 30%, with an upward trend seen over the past five financial years (FYs). The two counties have had distinct budget lines for the allocation of the RMNCAH budget since FYs 2016/17 and 2019/20, respectively. Nairobi has increased its RMNCAH budget sevenfold over this period, while Bungoma’s budget has been reduced by more than 70% compared with the first and the second years of the RMNCAH budget line’s existence. Human resources for health (HRH) account for up to 75% of the health budget allocation in both counties, constricting the fiscal space for RMNCAH among other areas of the healthcare sector.

The RMNCAH budget for the two counties is heavily reliant on external funding. The World Bank’s Transforming Health Systems for Universal Care (THS-UC) project has been financing up to 75% of the RMNCAH programme in the counties, resulting in volatility where conditions attached to this fund have not been met.

On average, over the past four financial years, the rate of release of the annual health budget was 78% in Nairobi and 80% in Bungoma. Budget release data is not disaggregated into programmes and sub-programmes, so it is not possible to tell how much of these releases were intended for RMNCAH. A disproportionate amount of the budget funds was released in the second half of the financial year in both counties. The release of the health budget was negatively impacted in FY 2020/21 in Nairobi, which could be due to governance changes in the county and the Covid-19 pandemic.

The data shows that there have been no significant challenges to health budget utilisation in the two counties, with the absorption rate (expenditure to allocation) being comparable to the release rate in both counties in previous years. However, the prioritisation of RMNCAH within the funds released has varied between the counties. In FY 2019/20, the RMNCAH sub-programme had an absorption rate of 13% and 98%, in Bungoma and Nairobi respectively, compared to 77% and 81% for the health sector. The Covid-19 pandemic appears to have to RMNCAH being deprioritised in both counties, with neither county spending any monies allocated to RMNCAH in the first half of FY 2020/21.

To optimise the budget available for health in the counties, advocates should work towards leveraging other domestic funding sources and domestic investment in universal health coverage to improve funding for RMNCAH and push for reforms to improve efficiency: ensuring more funding reaches the facility level. Advocates should continue to adapt their advocacy engagements to the political context, and push for routine monitoring and evaluation of budget performance in collaboration with the county.
INTRODUCTION

E4A-MamaYe has been working in Bungoma and Nairobi counties since 2017 to build coalitions of CSOs, the media and county governments to promote RMNCAH.

We have supported coalitions to conduct strategic, evidence informed advocacy. These coalitions generate political commitment, strengthen accountability, and promote the inclusion of RMNCAH priorities in county plans and budgets.

Kenya is a lower-middle-income country (World Bank, 2015) in East Africa, with a population of about 50 million (KNBS, 2019). Administratively, the country has a devolved governance system and health is one of the functions that has been devolved to county government.

The sources of finance for a county’s health services are national revenue (through general taxes), allocated directly to the County Treasury or through the National Ministry of Health), as well as donors, implementing partners and households. The county’s budget is allocated by the National Treasury on an annual basis, based on a set of criteria laid out in law, in accordance with Kenya’s fiscal year, which runs from 1 July to 30 June. Each county determines how it will use its allocation, setting budgets and plans for each of the devolved sectors, including health.

Kenya’s budget is programme based: the budget lines are tied to programme and sub-programme areas, with outputs and activities under each. Both Nairobi and Bungoma have adopted programme-based budgeting and go through an iterative process to align the activities included in the
Annual Work Plan with the programme-based budget. Activities related to the health of mothers, children aged under five years and adolescents, including reproductive health, are contained in the RMNCAH sub-programme, under the Preventative and Promotive Health Services programme.

Kenya’s national health expenditure per capita grew from USD 51.2 to USD 78.6 between FYs 2001/02 and 2015/16 (MoH, 2019), and to USD 88.4 in 2018/19 (World Bank, 2018). Despite this 73% increase in expenditure, Kenya remains among the countries with high maternal and child mortality ratios (UNICEF, 2021), with challenges in the budgeting cycle being one of the most significant reasons for this (Tsofa et al., 2017). Economic decline, exacerbated by the covid-19 pandemic, alongside reduced overseas development assistance, have increased the need for funding to be used efficiently and effectively to achieve health outcomes.

METHODOLOGY

This case study used primary and secondary data sources of information. Primary data was collected though key informant interviews with county government officials in Bungoma and Nairobi counties, in the weeks of 15–19 March and 22–26 March 2021, respectively. Informants were purposely selected based on their knowledge, experience and involvement in planning, budgeting, and financing for health and RMNCAH in the two counties. Informed consent was obtained before the interviews, with participation being fully voluntary. Interviews were recorded and transcribed, analysed into themes and weaved with the quantitative data to inform this case study.

Secondary data was obtained through a desktop review of data on budget allocation, release and expenditure as published by the Controller of Budget’s County Governments Budget Implementation and Review Reports. Quantitative data from these reports was recorded into and analysed using Microsoft Excel. The data was analysed in financial years (July to June of each calendar year) and quarters (three-month periods starting from 1 July), in line with Kenya’s fiscal policy.

The themes of the report were based on the three stages of budget evaluation: allocation, release and expenditure. Examples of E4A support are provided throughout the case study to indicate how E4A, and the coalitions it supports, have improved the financing context in Bungoma and Nairobi counties. While it is not possible to determine the extent to which E4As or other partners’ interventions were successful, these examples are intended to demonstrate the holistic support provided throughout the health budgeting cycle.
Figures of inconsistent data in published sources and limited availability of government officials during the interviewing period were among the limitations of the case study. This analysis focused on funds for the overall health sector, and those that are directed to the RMNCAH sub-programme in each county. This sub-programme includes activities regarding preventive and promotive services specific to RMNCAH clients (WRA and children under five), such as training on emergency obstetric care, provision of family planning, respectful maternity care, and maternal and perinatal surveillance and response. It is important to note that this does not include other funds which benefit RMNCAH services, including purchase of health commodities, payment for HRH, infrastructure development and health promotion services. These and other budgets that indirectly benefit the RMNCAH sub-programme were excluded from the analysis.

**FINDINGS & DISCUSSION**

**Nairobi county is among the counties that have allocated the least proportion of their budget to health over the past five years.**

In FY 2020/21, Nairobi county allocated 22% of its budget to health (Figure 1), compared to an average of 29% across all counties and the nationally agreed target of 30% (GFF, 2019). Despite Nairobi’s gross county product (GCP) being three times that of the Kenya’s second wealthiest county, it has consistently allocated lower per capita budgets to health than other counties.

**Bungoma county allocates close to the national target of 30% to health.**

In FY 2020/21, Bungoma county allocated 29% of its budget to health. Since FY 2016/17, Bungoma has progressively increased both the per capita budget and the proportion of the county budget allocated health each year (Figure 1). However, there is room for improvement as Bungoma’s per capita allocation to health was lower than the average for comparable counties (by GDP) for the years in consideration.
The proportion of the health budget allocated to RMNCAH remains low in both counties

Nairobi county was one of the first counties to introduce a dedicated budget line for RMNCAH, in FY 2017/18, while Bungoma did not create a dedicated budget line until 2019/20. Nairobi county has progressively increased the proportion of its health budget that is allocated to RMNCAH from 0.5% in FY 2017/18 to 3.1% in FY 2020/21, presenting a more than sixfold increase in the RMNCAH budget over the past five years. However, in Bungoma, the proportion of the health budget allocated to RMNCAH has declined dramatically since it was created. This is due to the 80% decrease in funding received by Bungoma from the THS-UC programme.
Both Nairobi and Bungoma counties remain heavily reliant on external funding.

In previous years, up to 73% and 63% of Nairobi and Bungoma’s respective RMNCAH budgets have been sourced from THS-UC funds. The proportion funded by THS-UC funds has increased in the previous three financial years in Nairobi. In Bungoma, the dedicated budget line has enabled analysis on the extent to which domestic and external sources are funding RMNCAH. For 2021/22, the proportion of the RMNCAH sub-programme funded by THS-UC is projected to increase from the previous year.

E4A supports CSOs to engage in public participation. Public participation is a process to gain citizen engagement in the annual budget and is a legal requirement in Kenya. E4A worked with coalitions to develop written memos to present during this process. In 2019/20, E4A worked with the Bungoma chapter of the Health NGOs Network (HENNET) to highlight that Bungoma was at risk of losing THS-UC funds due to a proposed decrease in the proportion of the county budget being allocated to health (thus failing to meet one of the THS-UC conditions). Their memo highlighted the consequences of this, which influenced the county to increase its planned allocation to health from KES 3.08 billion to KES 3.2 billion and thereby secure the THS-UC funds for the year.
 Counties receive less than the amount they are allocated in any given budget year.

On average, Nairobi and Bungoma counties received 78% and 80% of their allocated health budget from the exchequer in the four years of 2016/17 to 2019/20, respectively, despite low releases to the county exchequer (Table 1). This suggests that, in the context of poor release to the county, the health sector has been prioritised when it comes to allocating the limited release to the sectors. As release data is not disaggregated by sub-programme, it is not possible to quantify the amount of funding released for RMNCAH services.

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Table 1: Proportion of allocated county and health budgets that is released from the national exchequer to Nairobi and Bungoma counties

In FY 2020/21, the release of the budget for RMNCAH activities in Nairobi county was negatively impacted by administrative changes.

The changes included shifts in leadership, with the Executive Office of the President assimilating some functions of the county, including healthcare, through a new entity: Nairobi Metropolitan Services (NMS) (Nation Media, 2020).

The changes mean that health finances to the department of health are channelled through NMS, rather than the County Department of Health. This has come with power and authority shifts, such as changes to the account signatories, which have impacted the ability of the county to access THS-UC funding (which accounted for 65% of the RMNCAH budget in 2019/20).

We have not accessed or even utilised Transforming Health Systems (THS) money for 2019/2020 because, in Nairobi county, we have been having issues with the political system.

(Nairobi City County Government respondent)
The proportion of the health budget released declined between 2019/20 and 2020/21 in Nairobi but remained consistent in Bungoma.

The decline in Nairobi is likely to be due to the administrative changes in Nairobi county exacerbated by the effects of Covid-19. In Bungoma, Covid-19 does not appear to have affected the proportion of the budget released in FY 2020/21, but releases were reported by respondents to have been more erratic than prior to the pandemic. (Illustrated in figure 4)

The timing [of release] is not consistent because before COVID we had three releases of funds but with COVID we have only two releases of funds to the county government in a month.

(Nairobi City County Government respondent)

Nairobi and Bungoma counties both spend almost all of the funds that are released for health services in each financial year.

However, because the amounts released have been less than the amounts allocated (Table 2), expenditure has remained below the allocated amounts. This has resulted in both counties’ health departments spending more in some years than the funds released to them.
Prioritisation of RMNCAH varies by county.

Since budget release is not disaggregated into programmes and sub-programmes, the evaluation of budget expenditure for RMNCAH can only be based on the allocated RMNCAH budget. In FY 2019/20, the absorption rate (the proportion of the allocated funds that were spent) for the RMNCAH budget in Bungoma county was significantly lower than the absorption rate for the overall health budget. In contrast, in Nairobi County the absorption rate for RMNCAH was higher than for health (Figure 5). This suggests that Nairobi has prioritised RMNCAH within the funds released to the health sector, whereas Bungoma has prioritised other sub-programmes within the health sector.

Improved planning can increase the absorption of funds and justify increased investment in health and RMNCAH.

The amounts allocated to health and RMNCAH services are influenced by the absorption rate in the previous year. In Bungoma, this effect was exacerbated by the conditions attached to the THS-UC funding. The low absorption rate in Bungoma in FY 2019/20 resulted in the budget allocation from the THS-UC project reducing from KES 191 million (USD 1.76 million) to KES 61 million (USD 0.56 million) in FY 2021/22.

RMNCAH budget expenditure does not always lead to the implementation of interventions contained in the Annual Work Plan (AWP), as reallocation to other sub-programmes often happens. E4A has worked with both counties to introduce health financing scorecards. Scorecards not only measure the extent to which the allocated budget is released to health and RMNCAH, but also the degree to which the released budget is used to implement activities as planned per the AWP. A completed scorecard is used to reach out to the key players in planning, budgeting and financing departments, to advocate for better budget performance for RMNCAH indicators.
Low capacity in health financial management is one of the causes of poor expenditure.

Counties do not have a full understanding of the financial guidelines and regulations of the various sources of finances and as a result are limited in their ability to plan and execute the budget.

The absorption of the [KES] 100 million was only [KES] 27 million, and this was because the World Bank have a guideline on how their resources are to be spent and we as the county were not really aware of these guidelines.

(Nairobi City County Government respondent)

The lack of capacity, along with a cycle of poor planning, allocation and execution, has resulted in a lack of budget monitoring. For example, rarely do the counties manage to hold four quarterly review meetings in a year. This means that bottlenecks in implementation are not identified or removed, restricting budget expenditure over the year.

There is a shortage of officers with capacity and institutional memory on budget implementation for RMNCAH services. This leads to turbulence whenever there are personnel transitions – with officers new to budget implementation positions being unskilled in this area and unable to isolate challenges in various aspects of the programme. Some implementing officers could not tell if the Annual Work Plan had been implemented, or whether there were differences in implementation between government- and donor-funded RMNCAH activities.

Another issue is that the actual implementation is carried out by departmental heads and if they delay in requisition then the entire system will delay automatically. We have worked on this challenge by advising the departmental heads to do requisition early enough so that the money is absorbed before the end of that financial year.

(Nairobi City County Government respondent)

E4A has worked with the MTEF TWG in Nairobi and HF SWG in Bungoma to map out budget calendars, showing who needs to do what and when, in accordance with the Public Financial Management Act. The calendars are now available to county officials and members of these groups, to institutionalise knowledge beyond any one official's tenure.
Neither Nairobi nor Bungoma spent anything on RMNCAH services in Q1 and Q2 of FY 2020/21. By the end of the second quarter of FY 2019/20, Nairobi and Bungoma had spent 17% and 37% of their RMNCAH budgets, respectively, compared with 0% in both Q1 and Q2 of FY 2020/21. Respondents from both counties noted that expenditure was halted due to a decline in the implementation of RMNCAH activities because of the shift of attention to the Covid-19 pandemic.

Most of the RMNCAH activities were postponed and some delayed due to delayed funding during the pandemic.

(Nairobi City County Government respondent)

In Bungoma, priority was given to expenditure for the Covid-19 response. The supplementary budget occasioned by receipt of emergency Covid-19 funding did not include RMNCAH. However, allocations for personal protective equipment (PPE) and improving health facility readiness for Covid-19 are likely to have had an indirect impact on RMNCAH expenditure. Although both counties received emergency financing due to the pandemic, they did not use any of it to mitigate the effect of Covid-19 on RMNCAH service delivery.

The effects of the Covid-19 pandemic will have long-term implications for planning and budgeting in Bungoma and Nairobi. The low absorption of finances as a result of Covid-19 has impacted the THS-UC allocation for 2020/21. In addition, other donors are scaling back or changing support in response to their own political and economic situations. With economic decline and a reduction in external funding, non-committed budgets, such as RMNCAH services, are at risk.
The fiscal space for RMNCAH remains low, due to low levels of health budget release in these counties and limited funding being allocated to HRH and development expenditure. Budget implementation bottlenecks further hinder the implementation of health and RMNCAH budgets. There is also poor use of evidence on budget performance in the planning and implementation of interventions and limited institutional memory.

External financing of RMNCAH services has potentially caused budget dependence, and a lack of awareness regarding the conditions attached to some of this external funding has led to volatility in the amounts received. With external funding declining, and the THS-UC project about to end its investments, counties are threatened with further disruption to funds and, therefore, services. This will exacerbate the turbulence already created through the Covid-19 pandemic and, in Nairobi, recent political and administrative changes.

E4A, along with other partners working in the health sector in Nairobi and Bungoma, has contributed to an improvement in the health financing context. Coalitions are now able to track budget performance – not only allocations – and are playing a role in government working groups by providing evidence, having an awareness of the political context, and knowing what decisions need to be made by when and what conditions are attached to external financing. While these budget advocates will continue to ensure health remains high up on the agenda and that priority issues are considered during the planning and budget process, this study demonstrates the importance of addressing the key bottlenecks identified here.

CONCLUSION & LEARNING

Budget performance monitoring should be integrated in routine performance evaluation. E4A has introduced a health financing scorecard for each county. The next step will be to work with the HF SWG in Bungoma and the MTEF TWG in Nairobi to conduct regular reviews of the scorecards (which include data on release and expenditure) alongside RMNCAH indicators, in order to identify and unlock bottlenecks and inform future implementation and planning.

NEXT STEPS

There should be a more holistic approach to health financing, aimed at increasing the fiscal space for RMNCAH. In addition to increasing budget accountability, E4A can support advocates to direct more effort into attracting additional resources for RMNCAH by leveraging other sources of finance through a focus on Primary Health Care, such as the UHC programme and the National Health Insurance Fund. The use of maternal, perinatal, death surveillance and response data could support the strengthening of financial management for facilities receiving funds through these national programmes.

External funding should be conditional on RMNCAH budget performance. E4A can support national and county advocates to engage in future discussions on external funding. With the THS-UC funding up for renewal this year, there is an opportunity for advocates to influence the conditions attached to funding, pegging external funding to improved budget performance of domestically-funded RMNCAH activities. This will decrease donor dependency and incentivise domestic resource mobilisation.

Advocacy should align with politics. E4A should continue to support coalitions to engage the most significant players in the budget process: the members of the county assembly and the office of the governor. This could be through increased multi-sectoral collaboration, increased awareness of the roles that entities outside of the department of health play in financing health, and in packaging evidence for these decision-makers, who may have different incentives to those in the health sector.
For raw data used in this study-including financial data, please contact the E4A team at info@evidence4action.net

More case studies are available on the mamaye.org website

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