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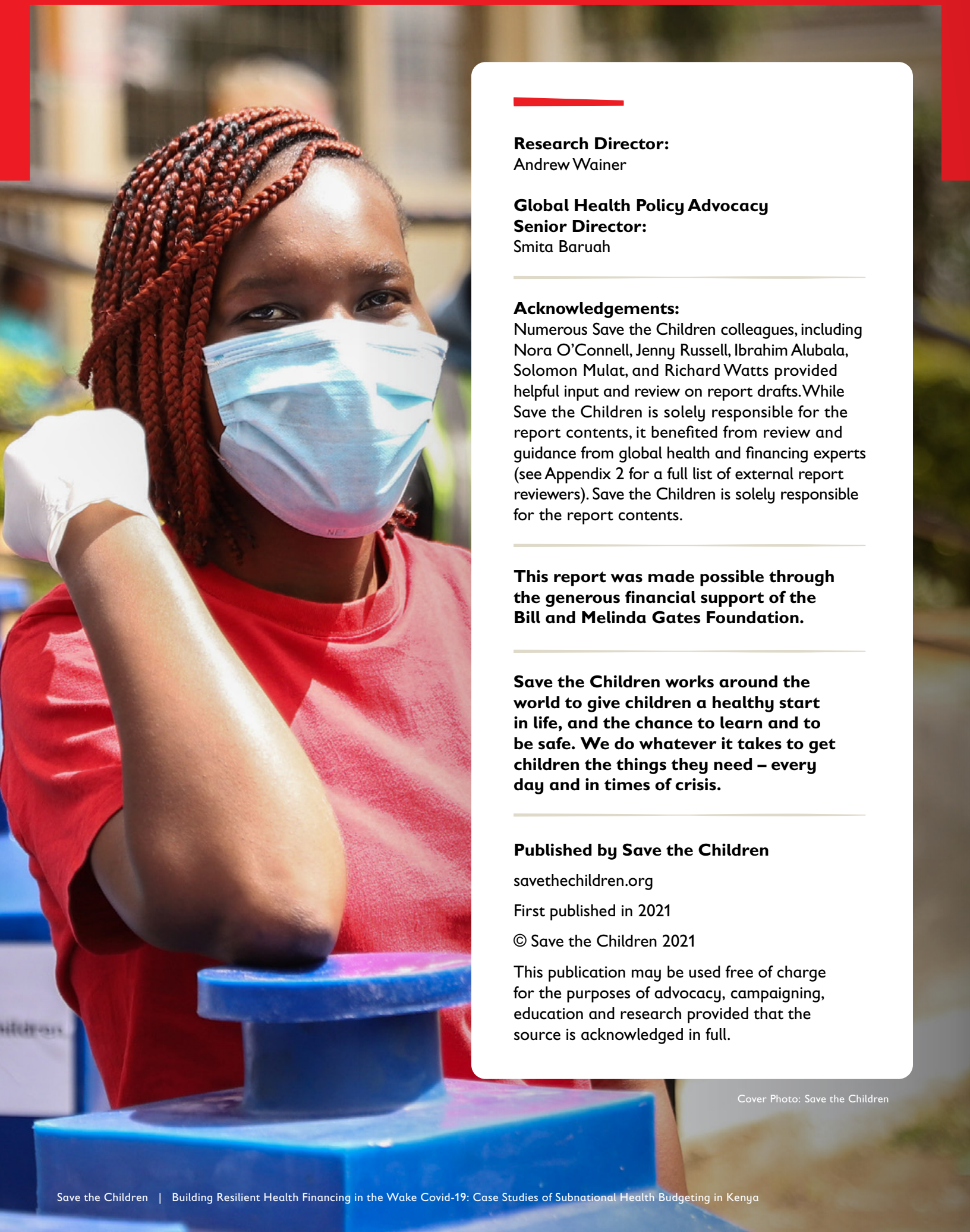
BUILDING RESILIENT HEALTH FINANCING IN THE WAKE OF COVID-19:

CASE STUDIES OF SUBNATIONAL HEALTH BUDGETING IN KENYA



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ACRONYM LIST

CRA	Commission on Revenue Allocation
DANIDA	Danish International Development Agency
DRM	Domestic Resource Mobilization
HERAF	Health Rights Advocacy Forum
HSSF	Health Sector Service Fund
IMF	International Monetary Fund
KSH	Kenyan Shillings
ODA	Official Development Assistance
OOP	Out-of-Pocket
OSR	Own Source Revenue
PFM	Public Financial Management
SDGs	Sustainable Development Goals
UHC	Universal Health Coverage

1. EXECUTIVE SUMMARY

BUILDING SUSTAINABLE HEALTH SYSTEMS POST-PANDEMIC

In 2020, the Covid-19 global pandemic illustrated like nothing else in recent history the importance of building resilient health systems. It also demonstrated the urgent need for sustainable health financing to develop and maintain those systems, and demonstrated the strong need for domestic financing to support a timely scale-up that is up to the task during a health crisis.

Without strong health systems, the impact is clear: as of early 2021, Covid-19 infected more than 100 million people and caused two million deaths globally, many of which could have been prevented with better health infrastructure. Maternal and child health gains have also been put at risk.[1] In spite of progress in recent decades, high-quality and timely maternal health care services were inaccessible for millions of women in low and middle-income countries even before the pandemic, and initial reports have found disruptions to routine family planning and contraception services in more than 100 nations surveyed.[2]

Health financing – "the mobilization, accumulation and allocation of money to cover the health needs of the people" – is a particularly urgent component of health systems in developing countries in the wake of Covid-19.[3] To bolster health systems, as of September 2020, governments globally committed $11.7 trillion USD to fighting Covid-19's impact, but the lion's share of government spending has been directed to advanced economies with low- and middle- income countries much more limited in their ability to spend due to high levels of existing debt.[4]

For its part, Kenya has made universal health coverage (UHC) one of its signature development goals in recent years, but financing it, even before the pandemic, has been a challenge. Achieving UHC can have enormous benefits, including ending preventable child and maternal deaths, but it requires strong domestic financing to be sustainable. Given the challenges of Covid-19, developing country governments such as Kenya need increased political will and technical capacity on domestic resource mobilization in order to deliver high-quality health services for their citizens.

ALL HEALTH CARE IS LOCAL

The Bill & Melinda Gates Foundation stated in its annual letter that 2021 is the "year global health went local."[5]

This report uses two counties in Kenya as cases by which to examine the challenges and best practices in increasing resource allocation for health at the subnational level. We have taken this approach, because counties in Kenya, in the wake of decentralization, are increasingly becoming pivotal health financing decision-makers. In fact, Kenya's county allocations to health nearly doubled in absolute terms between 2013 and 2017.[6]

While our analysis is primarily relevant to the Kenyan context and its 47 counties, determining the right balance for effective and equitable health financing in the midst of decentralization is a global challenge. And Kenya's story is not an isolated case: the World Bank found that 82% of African countries have decentralized health care functions and in most of those countries, the decentralization process is still underway.[7]

Within this context of a devolved Kenyan health financing system, our research is focused on Makueni and Nyeri Counties, two counties noted for their effective health financing and participatory budgeting policies and practices. Through our focus on these two counties, our research has unearthed effective health financing practices that may provide important lessons for USAID and other global donors, as well as local and national Kenyan policymakers which are discussed below.

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LOCAL HEALTH SYSTEMS MUST REFLECT LOCAL PRIORITIES

While we also touch upon subnational tax practices, the focus of the report is on health budgets and PFM practices, and how donors can best support these efforts to help countries like Kenya move toward financing the health needs of its own people.

Government-to-government support on subnational health finance is important, but subnational health financing should also include the active participation of citizens. To this end, we also analyze the role of local civil society in participatory budgeting in the health sector and in subnational health budget advocacy generally. Both Makueni and Nyeri Counties are noted internationally for their effective health financing and participatory budgeting policies and practices.

HOW GLOBAL DONORS AND COUNTY LEADERSHIP CAN STRENGTHEN SUBNATIONAL HEALTH SYSTEMS POST-COVID-19 AND BEYOND

Across the world, the Covid-19 pandemic has ravaged health systems, economies, and livelihoods, and has disrupted the delivery of routine health services. Because of the pandemic, decades of progress on child survival and other development gains for children risk unravelling.

The pandemic is a wake-up call for the investment needed to build strong and resilient health systems, and the need for public and political support for increasing resources for health has never been more urgent.

While research for this report was conducted just before and during the early days of the Covid-19 pandemic, the findings are applicable to donors and national and subnational governments as they build back better, stronger, and more resilient health systems.

This report draws lessons from two Kenyan counties to help inform and guide U.S. foreign assistance agencies and county leaders in Kenya to implement effective health budgeting policies, programs, and practices in concert with citizens. These recommendations are summarized here and outlined in greater details below.

RECOMMENDATIONS FOR COUNTY GOVERNMENTS

- **County governors should empower primary health facilities with more budgetary autonomy.** Post-devolution, without health financing decision-making authority, local health facilities largely lost the accountability that comes with it, which has impacted service delivery.[8] Makueni County, among others in Kenya, have enacted PFM reforms to re-empower facility managers to access county health funds more easily. This policy change should be considered across all 47 counties in Kenya.

- **County leadership should improve health facility revenue and cost tracking.** Program-based budgeting and linking county health facilities electronically to track costs in real time were some of the PFM enhancements USAID's Health Policy Plus program tried to implement at the subnational level, while some counties also took the initiative themselves to create or improve facility-level revenue and spending reporting systems. These reforms are direly needed as Kenya does not have a national system for tracking health facility revenue, costs, and transfers.[9]

- **County governors should expand their participatory budgeting processes and allow for more community engagement on health budgeting.** Kenya's 2012 Public Finance Management Act established County Budget and Economic Forums in every county as a platform for citizen engagement on budget matters, but these forums typically remain unknown by citizens and are often inoperative.[10] However, in some cases county leaders such as those in Makueni and Nyeri Counties along with local civil society organizations have taken the initiative to strengthen public engagement in health budgeting. Kenyan leaders at the national and local level should make a greater effort to involve women- and youth-led groups in particular to ensure a gender-responsive health budget that is in tune with the future of the community.

Photo: Save the Children

Photo: Save the Children

RECOMMENDATIONS FOR USAID

- **USAID should continue to support health budgeting at the subnational level in Kenya.** Counties are increasingly becoming important decision-makers on health finance. In fact, their health budget allocations increased 178% between 2013 and 2019, a larger percentage increase than at the national level.[11] As health budgeting decisions increasingly shift to counties, these subnational entities can serve as policy laboratories for effective health and participatory budgeting practices, and disseminate their best practices and lessons learned through organizations such as the Council of Governors to have a nationwide impact.

- **USAID should include and fund local civil society organizations and networks as part of its support for subnational health budgeting.** While government-to-government technical assistance helped counties increase budget allocations to health, our case studies found that civil society has an important role to play to ensure that county-level health budgeting accurately reflects citizens' needs. This kind of citizen engagement remains underdeveloped at the subnational level, and USAID's own research finds that "the lack of health related advocacy civil society organizations at county level limits the ability of civil society to effectively engage in the policy process."[12]

- **USAID should support counties' efforts to raise more own source revenue (OSR) after the country's economy recovers from the pandemic.** While this report is primarily focused on health budgeting and PFM, Kenya's journey to financial self-reliance requires increasing the amount of subnational domestic revenue. The World Bank identified a shortfall of $510 million USD in unmet revenue potential among counties and suggests there may be much more.[13] Tax was not part of USAID's Health Policy Plus program in Kenya, but support for progressive tax policy reform would enhance counties' financial autonomy and their ability to deliver services, including health services.

In 2020, the Covid-19 global pandemic illustrated like nothing else in recent history the importance of building resilient health systems. It also demonstrated the urgent need for sustainable health financing to develop and maintain those systems, and demonstrated the strong need for domestic financing to support a timely scale-up that is up to the task during a health crisis.

2. INTRODUCTION

In 2020, the Covid-19 global pandemic illustrated like nothing else in recent history the importance of building resilient health systems. It also demonstrated the urgent need for sustainable health financing to develop and maintain those systems, and demonstrated the strong need for domestic financing to support a timely scale-up that is up to the task during a health crisis.

Without strong health systems, the impact is clear: as of early 2021, Covid-19 infected more than 100 million people and caused two million deaths globally, many of which could have been prevented with better health infrastructure. Maternal and child health gains have also been put at risk.[14] In spite of progress in recent decades, high-quality and timely maternal health care services were inaccessible for millions of women in low and middle-income countries even before the pandemic, and initial reports have found disruptions to routine family planning and contraception services in more than 100 nations surveyed.[15]

Health financing – "the mobilization, accumulation and allocation of money to cover the health needs of the people" – is a particularly urgent component of health systems in developing countries in the wake of Covid-19.[16] To bolster health systems, as of September 2020, governments globally committed $11.7 trillion USD to fighting Covid-19's impact, but the lion's share of government spending has been directed to advanced economies with low- and middle- income countries much more limited in their ability to spend due to high levels of existing debt.[17]

The Center for Global Development calculates that during 2020-2024, domestic government health expenditure will be 6.3% lower in low-income countries and 4.1% lower in lower middle-income counties due to the fiscal impacts of Covid-19.[18] This constitutes the loss of billions of dollars for health care that will no longer be available to address citizens' health needs.

Foreign assistance will also not provide sufficient funding for developing nations' health financing responses to the Covid-19 pandemic. Even before the pandemic, foreign assistance funding globally was essentially flat and in Kenya – the focus of this report – it decreased 25% from its high of $3.3 billion USD in 2013 to $2.5 billion USD in 2018.[19] Further long-term decreases in foreign assistance are expected and global donors have been urging the Kenyan government to take on increased responsibility and additional co-financing, particularly in the country's health budget.[20]

Over the past decade in particular, the U.S. government – including USAID – has emphasized domestic resource mobilization (DRM) as a part of its global development agenda. President Obama's Global Development Policy included efforts to increase DRM through the Treasury Department's Office of Technical Assistance and the Millennium Challenge Corporation in addition to USAID. Furthermore, in 2015, the United States was one of the founding members of the Addis Tax Initiative, a global partnership of donors, civil society, and developing nations working to enhance and increase DRM in developing nations.

For his part, former USAID Administrator Mark Green also strengthened the role of DRM in USAID's development finance work through the Journey to Self-Reliance framework, which emphasizes a country's "ability to plan, finance, and implement solutions to its own development challenges.

Using a global lens, we are also mindful of the importance of domestic resource mobilization and effective budgeting in achieving the Sustainable Development Goals (SDGs) and the formidable ambition of Sustainable Development Goal 3 which aims by 2030 to "ensure healthy lives and promote well-being for all at all ages"[21] Even before Covid-19, Kenya needed to invest billions more annually to achieve the SDGs. Given the pandemic's strain on Kenya's health system, the need for additional domestic spending on health to achieve SDG 3 has become even more urgent.[22]

Given the urgency in responding to Covid-19 in the short-term and the goals of meeting SDG 3 and achieving fiscal self-reliance in the long-term, how can Kenya best finance its recovery from the pandemic and improve its health outcomes? That is the question this report intends to address by examining effective pre-pandemic health budgeting and PFM practices at the subnational level.[A] While we also touch upon revenue, the focus of the report is on health budgets and PFM. Kenya will certainly have to increase domestic revenue in coming years, but given the fiscal constraints imposed by Covid-19, enhancing budget and PFM practices will be most crucial in the coming years.

Photo: Save the Children


Photo: Save the Children

This report uses two counties in Kenya as cases by which to examine the challenges and best practices in increasing resource allocation for health at the subnational level. Within this context of a devolved Kenyan health financing system, our research is focused on two counties noted for their effective health financing and participatory budgeting policies and practices: Makueni and Nyeri Counties. Through our focus on these two counties, our research has unearthed effective health financing practices that may provide important lessons for USAID and other global donors, as well as local and national Kenyan policymakers which are discussed below.

While field research in Kenya was carried out at the beginning of the pandemic, the recommendations developed for Kenyan policymakers and international donors apply to efforts to build back from Covid-19 and to enhance domestic resource mobilization for health in a post-pandemic world.

Our main research question for this report was: given the urgency in responding to Covid-19 and with decreasing support from donors, how can Kenya best finance its recovery from the pandemic and improve its health indicators over the long-term, particularly for its vulnerable citizens?

Given the importance of counties to health service delivery, we decided to focus on local-level health budgeting with a focus on the following question:

What are effective health budgeting practices and lessons learned that can be applied at the local level in Kenya and in other countries as they fund the rebuilding of their health systems? These are two of the key questions this report intends to address through the two case studies.

[A] For this report, we use the World Health Organization's definition of the PFM system: "the set of rules and institutions governing all processes related to public funds."

We examine the subnational level, because counties in Kenya, in the wake of decentralization, are increasingly becoming pivotal health financing decision-makers. County allocations to health nearly doubled in absolute terms between 2013 and 2017.[23] And Kenya is not an isolated case: the World Bank found that 82% of African countries have decentralized health care functions and in most of those countries the decentralization process is still underway.[24] While our analysis is primarily relevant to the Kenyan context and its 47 counties, determining the right balance for effective and equitable health financing in the midst of decentralization is a global challenge.

We also look specifically at the role of donors such as USAID in supporting effective health budgeting policies, programs, and practices at the local level. USAID has a long history of global health investments in Kenya, especially through global maternal and child health programs, and is a key partner in the global effort to end preventable child and maternal deaths. Kenya is among USAID's twenty-five priority countries.

While we also touch upon subnational tax practices, the focus of the report is on health budgets and PFM practices, and how donors can best support these efforts to help countries like Kenya move toward financing the health needs of its own people.

Government-to-government support on subnational health finance is important, but subnational health financing should also include the active participation of citizens. To this end, we also analyze the role of local civil society in participatory budgeting in the health sector and in subnational health budget advocacy generally.

We focus on donor support for subnational health financing, because donors have traditionally played an important role in enhancing counties budgeting and PFM practices in the midst of devolution, particularly through USAID's Health Policy Plus program (see Text Box 6). And we focus on civil society organizations, because even as subnational health budgets increase, civil society organizations help ensure that taxpayer money is spent according to citizens' will and with transparency and accountability.

Following a brief description of the report research methods below, the report's Health Financing in Kenya section provides a brief overview of health financing trends, with a focus on Kenya, including Kenya's universal health coverage (UHC) initiative, the role of subnational units in health financing, and ongoing challenges for Kenya's health financing system. With the national health financing context set, the heart of the report then provides detailed analyses of effective health financing practices through our two case studies of Makueni and Nyeri Counties. As noted above these were analyzed with a particular focus on how USAID and other donors can most effectively empower county leaders and local civil society to enhance health budgeting and PFM. The report concludes with recommendations for donors such as USAID and county and national governments.

KENYA TRIPLED ITS TOTAL ALLOCATION TO HEALTH BETWEEN THE 2013/14 FISCAL YEAR AND 2018/19 FISCAL YEAR. THIS IS PRIMARILY DUE TO THE EXPANSION OF COUNTY HEALTH BUDGETS, PROVIDING ANOTHER REASON TO FOCUS ON THE ROLE OF COUNTIES IN HEALTH BUDGETING.

Photo: Save the Children

3. HEALTH FINANCING IN KENYA

GLOBAL HEALTH FINANCING: FROM ODA TO DRM

Even before the Covid-19 crisis, global health spending by governments was increasing faster than countries' gross domestic products. This was true more so in low- and middle- income countries where, between 2000 and 2016, health spending was increasing nearly 6% per year on average compared to 4% in high income countries.[25]

This increase in public health spending by developing country governments has been accompanied by a concurrent decline in official development assistance (ODA) for health in middle-income counties and this development assistance now represents only 1% of total global health spending for these nations.[26] Part of this reduction in global health ODA is attributed to its own successes – global health foreign assistance has contributed to historic reductions in maternal and child deaths, among other achievements.

As foreign assistance declines, governments must increase their domestic resource mobilization (DRM) for health and ensure that their health budgets emphasize their most vulnerable citizens. Political will is the greatest challenge to increased domestic health budget allocations, but countries also face technical challenges. As we outline below, donors such as USAID, as well as local budget advocacy groups can play an important role at the national and subnational level in generating political will and inculcating effective technical practices for equitable health budgets.

KENYA'S (SLOWLY) INCREASING HEALTH BUDGET

In 2015, following years of sustained, robust economic growth Kenya graduated from a lower-income to a lower-middle income country. As Kenya's economy grew and became East Africa's business hub, foreign assistance declined, and by 2018 it accounted for less than 3% of Kenya's gross national income, down from 6% in 2013.[27] While still an important support for the country's health sector, ODA for health is also declining in Kenya. In 2017, external aid accounted for 18% of Kenya's total health expenditures, down from 29% in 2009.[28] Further, PEPFAR's 2020 fiscal year budget request for Kenya was 44% lower than its budget for Kenya in 2017.[29]

Kenya's strong economic growth was not matched by an increase in its tax-to-GDP ratio, which increased only slightly from 17% in 2001 to 18% in 2017.[30] And in spite of sustained economic growth, Kenya's domestic public health expenditures amount to only about 2% of gross domestic product. Thus the health sector remains dependent on a combination of foreign assistance and Kenyan citizens' out-of-pocket payments which together, in 2017, amounted to 42% of Kenya's health expenditures.[31] Since 2010, about 62% of all U.S. bilateral foreign assistance to Kenya has been directed to health, much of it targeted toward programs on tuberculosis, malaria, maternal health, and HIV/AIDS.[32]

While Kenya is steadily increasing its health budget, its growth has been slow. During 2018/2019, Kenya allocated 9.2% of its total government budget to health, up from 7.8% in 2012/13 – the last year before devolution.[33] Kenya's allocations to its health budget have also consistently fallen short of Kenya's own estimated requirements for the sector and continue to fall short of the 15% of the government budget benchmark set by the Abuja Declaration.[34]

Viewed in absolute terms, Kenya's health funding looks much better. Kenya tripled its total allocation to health from 78 billion Kenyan Shillings (KSH) during the 2013/2014 fiscal year – the first year after devolution – to 207 billion KSH for the 2018/2019 fiscal year. This is primarily due to the expansion of county health budgets, providing another reason to focus on the role of counties in health budgeting.[35]

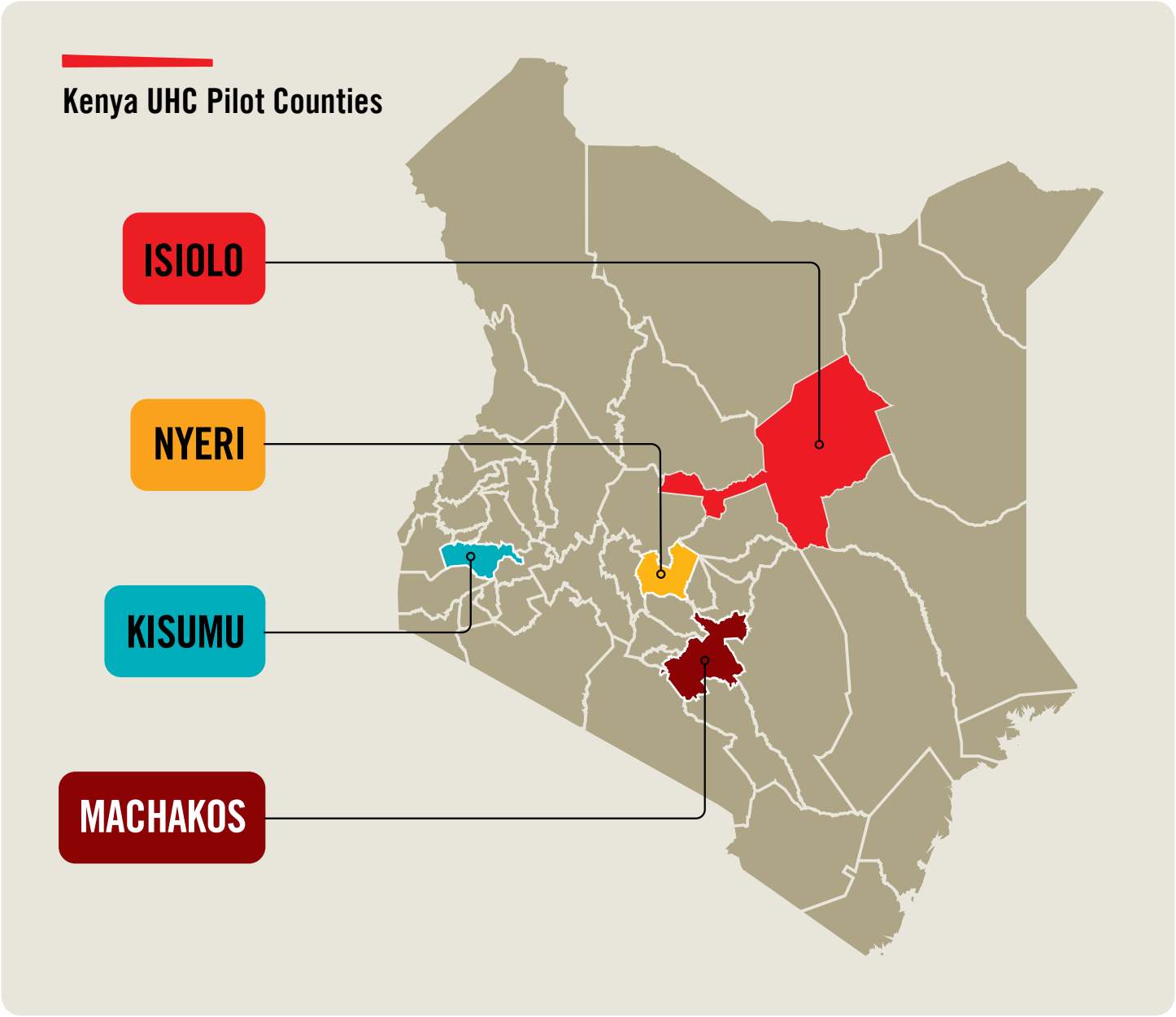
In the short term, given the economic impact of Covid-19, Kenya will not be able to rely on economic growth alone to continue to increase absolute budget resources for health. This means that as the Kenyan economy recovers in coming years and economic growth resumes, both public and private DRM and effective health budgeting will become even more urgent.

STRIVING FOR UNIVERSAL HEALTH COVERAGE

Any discussion of Kenya's health financing system must include the Kenyatta Administration's commitment to achieve universal health coverage (UHC) by 2022. The goal of UHC was first presented in the long-term national development framework, Kenya Vision 2030. This framework aimed to "transform Kenya into a newly industrializing, middle-income country providing a high quality of life to all its citizens."

President Uhuru Kenyatta's goal of health coverage for every Kenyan by the end of his term in 2022 is extremely ambitious – and following the Covid-19 crisis, extremely unlikely. Only 17% of Kenyans are currently covered by any form of pre-payment plan, leaving the majority of Kenyans vulnerable to out-of-pocket payments for health care.[36]

In 2019, the national government increased its health financing through the creation of a UHC conditional grant for counties. To be eligible, counties must allocate at least 20% of their budget to health care.[37] The early impact of Kenya's UHC initiative is analyzed below in the case study for Nyeri County, which was one of the four pilot counties for UHC (See UHC pilot county map below). Whether or not Kenya achieves UHC in 2022, 2030, or beyond, health financing will play a critical role in its success or failure.[38]

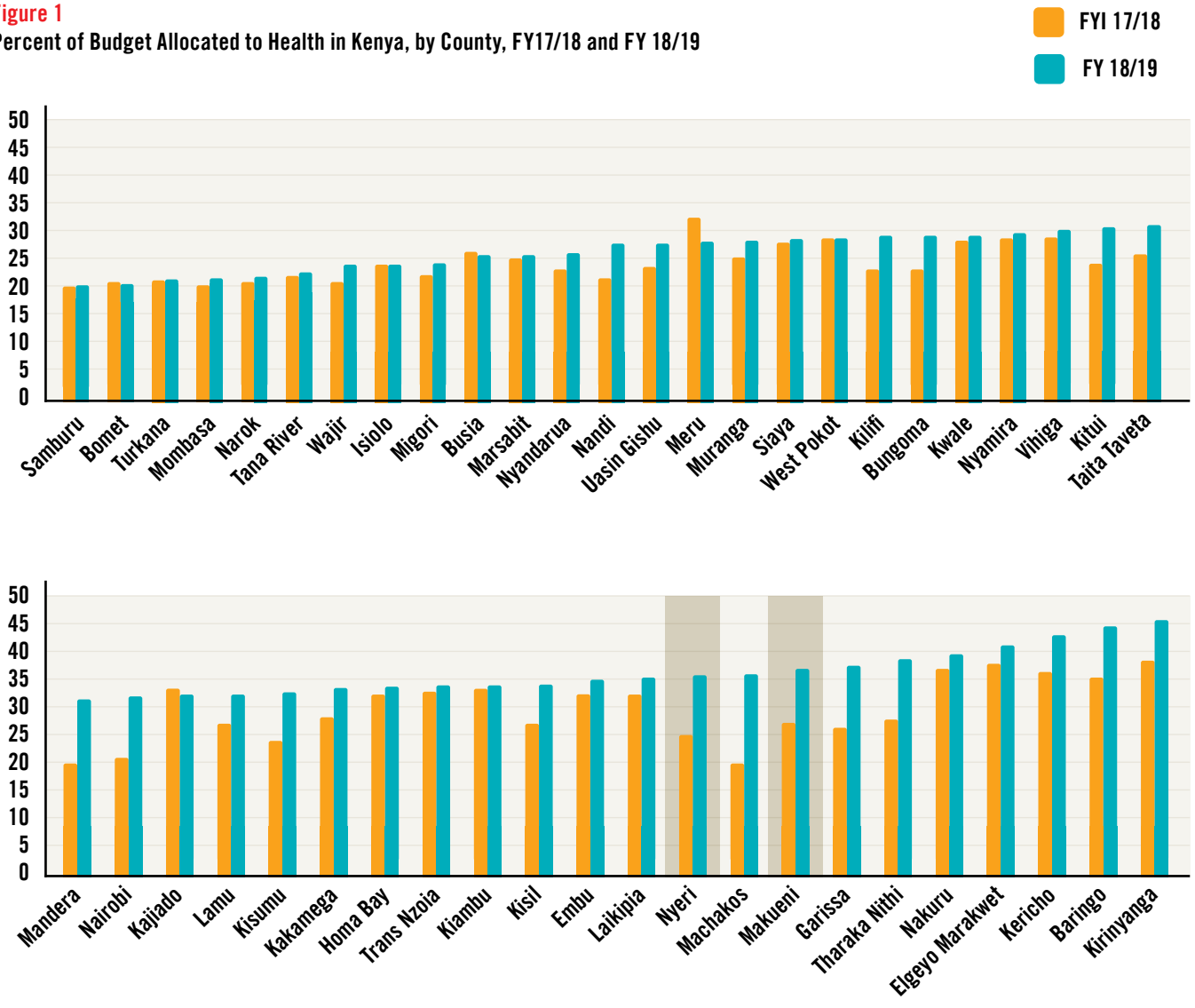


EMPOWERING COUNTIES: THE IMPACT OF DEVOLUTION ON HEALTH FINANCING

In 2013, Kenya transitioned to a devolved system of government under which the country's 47 newly created counties became the main providers of primary and secondary health care services.[39] The national government continues to play a leading role in developing health regulations and policy, and the majority of county health funds are still provided through grants from the national government through County Revenue Accounts. Kenya's national health funding system is complicated, but the country's constitution gives counties wide latitude on how to spend health funds, and, as discussed above, counties lead health service delivery and control the extent to which overall budget resources are allocated to health.

Since devolution, county budget allocations to health have nearly doubled in absolute terms, but this also masks significant variation among counties (See Figure 1). Several counties, including Nyeri, have prioritized health by allocating almost 40% of their total county government budget to the health sector in recent years.[40]

Figure 1
Percent of Budget Allocated to Health in Kenya, by County, FY17/18 and FY 18/19



Source: Global Financing Facility

Photo: Save the Children

EVEN AS HEALTH BUDGETS GROW, POOR BUDGET CREDIBILITY, SUBPAR PROCUREMENT PRACTICES, AND WEAK CASH MANAGEMENT REMAIN ONGOING CHALLENGES AT THE NATIONAL AND SUBNATIONAL LEVELS. EVEN WITH GROWTH IN OVERALL REVENUE, BAD PRACTICES IN THESE AREAS CAN LIMIT BUDGET SPACE FOR HEALTH.

CHALLENGES TO KENYA'S HEALTH CARE FINANCE SYSTEM

Kenya still faces obstacles to improving DRM for health both at the county and national levels. This section will briefly address some of the most pressing health finance challenges facing Kenya's counties.

Budget Credibility and Overemphasis on Recurrent Costs

Even as health budgets grow, poor budget credibility, subpar procurement practices, and weak cash management remain ongoing challenges at the national and subnational levels. Even with growth in overall revenue, bad practices in these areas can limit budget space for health. For example, the Center for Global Development finds that spending under the allocated budget can reduce future budget allocations by 20-40% in sub-Saharan Africa, while good PFM practices can lead to increases in health budgets as ministries of finance react to health budget effectiveness in determining future budgets for health.[41]

During fiscal year 2016/2017, actual expenditures by the Kenyan Ministry of Health were 20% below the ministry's budget allocation, reflecting the ongoing challenges of creating budgets aligned with programming goals, of ensuring timely transfer of funds from the national to the county level, and of creating an effective service delivery system that can absorb and spend allocated budgets.[42]

There are also major challenges of allocation within health budgets. The lion's share of health spending in Kenya is dedicated to recurrent expenditures – mostly salaries – while the amount dedicated to the development budget has decreased in some counties. Kenya's 2012 Public Finance Management Act recommends that counties allocate 70% of their budgets to recurrent expenditures.[43] But in recent years, 80% of counties (39) allocated more than 70% of their total health budget to recurrent expenditures.[44] The amount allocated to salaries and medical supplies leaves little left over for capital expenses and new health initiatives, and the overemphasis on recurrent expenses raises questions of efficiency in health service delivery.[45] We heard of this problem often during our research, and it is explored below in more detail in the Nyeri County case study.

Disorganized Transition to Devolution

While the devolution of health care brought funding and policymaking closer to citizens, it also created new problems. In many ways, the central government did not adequately plan the transition to devolution, and years later counties still face challenges in meeting the massive health care burdens, including financial budget management, that fell to them.

> **"WHEN DEVOLUTION CAME IT WAS LIKE ON-THE-JOB LEARNING, THERE WAS NOWHERE TO LEARN FROM…HOMEGROWN SOLUTIONS HAVE BEEN FOUND."**
>
> – Makueni County Chief Officer of Planning, Budgeting, and Revenue Eliud Ngela.

Particularly in the early days of devolution, devolved funds released to the county governments were not commensurate with the scope and magnitude of the devolved health functions they were mandated to execute. And paradoxically, decentralization – while empowering officials at the county level – reduced the autonomy of health facilities. As power was concentrated at the county leadership level following decentralization, facilities lost the financial autonomy they had before.

Edwine Barasa and his co-authors found that devolution "resulted in weakened hospital management and leadership, reduced community participation in hospital affairs, compromised quality of services, reduced motivation among hospital staff, non-alignment of county and hospital priorities, staff insubordination, and compromised quality of care."[46] The empowerment of health facility staff and the financial autonomy of health facilities is an important policy question that will be explored below.

USAID and other donors have been working with counties on program-based budgeting by linking social outcomes to funding, but there remains significant work to do.

> **"EVIDENCE-BASED DECISION-MAKING IS STILL VERY LIMITED, THERE IS A LOT OF SUPPORT FOR HISTORICAL SPENDING, BUT WHERE THE REAL PROBLEMS ARE, THERE'S NO SPENDING."**
>
> – WHO Social and Economic Policy Specialist Robert Simiya.

Photo: Save the Children

KENYA'S INCREASED HEALTH CARE SPENDING IS ONLY PARTIALLY ATTRIBUTABLE TO GOVERNMENT FUNDS. AS FOREIGN ASSISTANCE HAS DECLINED, GOVERNMENT SPENDING PICKED UP SOME OF THE COSTS OF HEALTH CARE, BUT THE REMAINDER OF THE FUNDING GAP HAS FALLEN TO KENYAN HOUSEHOLDS.

Photo: Save the Children

OUT-OF-POCKET COSTS

Kenya's increased health care spending is only partially attributable to government funds. As foreign assistance has declined, government spending picked up some of the costs of health care, but the remainder of the funding gap has fallen to Kenyan households. As noted above, more than 40% of Kenya's total health expenditures are paid for by a combination of external funding and Kenyan households. In 2017, out-of-pocket (OOP) spending for health care by Kenyan residents accounted for 24% of health expenditures in Kenya.[47] While Kenyans' OOP spending is decreasing as a percentage of total expenditures, in 2018 7% of Kenyans – most of them low-income, rural residents –fell victim to catastrophic health payments.[48]

Photo: Save the Children

4. SUBNATIONAL HEALTH FINANCING CASE STUDIES: MAKUENI AND NYERI COUNTIES

THE ROLE OF COUNTIES IN KENYA'S HEALTH FINANCING SYSTEM

Before diving into our analytical case studies of the effective health finance policies, programs, and practices in Makueni and Nyeri Counties, it is important to understand more about the role of counties in Kenya's complex, multilayered, devolved health system. Context is key, and this section provides a foundation for deeper analysis of the two case studies.

In Kenya, health provision is organized into six levels, five of them overseen by county governments (see Text Box 1).[49] But even as the Kenyan Constitution grants counties strong authority on how to operate their own health systems, including how to spend health care funds, counties are still dependent on the central government for those funds.[50] On average counties rely on the central government for more than 90% of their total funding with less than 10% generated through county-level revenue sources (see Figure 2).[51]

To manage the various sources of county revenue, each county operates a County Revenue Fund (CRF) that pools all the financing from different sources. This fund is controlled by the county treasury and includes four main sources of revenue:

- Block grants from the national government
- Own-source revenue generated by local taxes and user fees
- Conditional grants from the national government
- Loans and grants from development partners[52]

TEXT BOX 1. LEVELS OF HEALTH CARE PROVIDERS

Level 1: Community health units

Level 2: Dispensaries

Level 3: Health centers

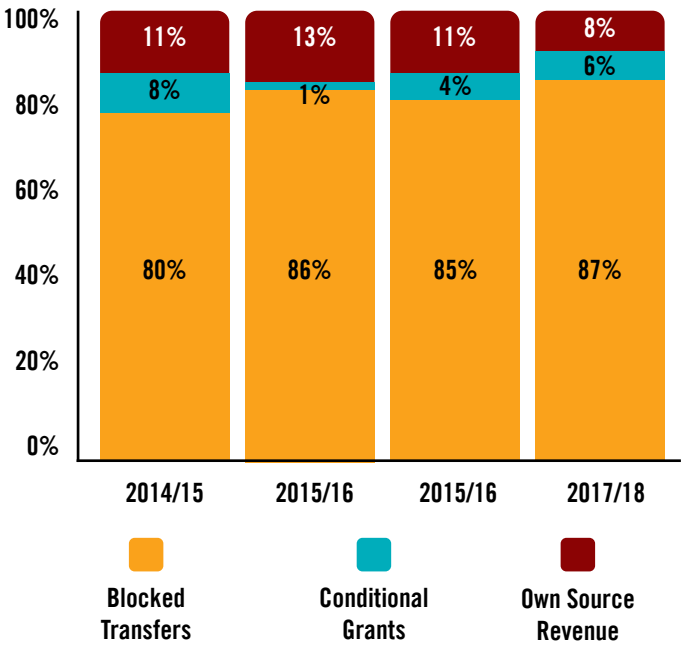
Level 4: Primary hospitals (previously district hospitals)

Level 5: County referral hospitals (previously provincial hospitals)

Level 6: National referral hospitals

Providers in levels 1-5 fall under the purview of county governments, while level 6 is managed by the national government. The levels also apply to private providers, but they are not listed here.

Figure 2:
Trends in Sub-National Revenue Source 2014/15 - 2017/18 (%)



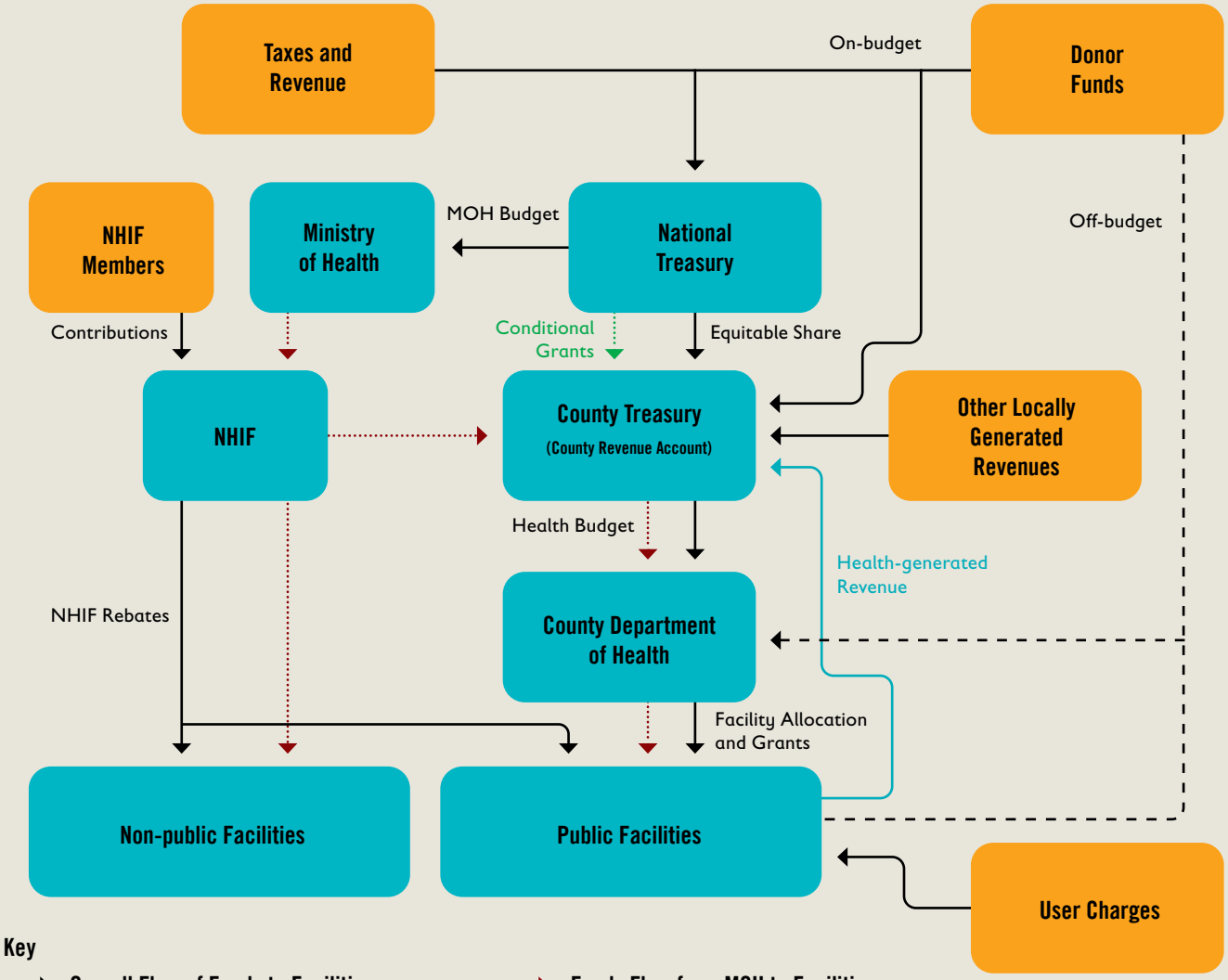
Source: Office of Controller of budget (2018)

THE EQUITABLE SHARE

The main source of revenue for county funds is a block grant from the central government called the equitable share. Kenya's Commission on Revenue Allocation (CRA) recommends the revenue allocation formula for how much each county shall receive from the equitable share, and the Senate of Kenya decides whether to reject or implement the CRA's recommendation.[53]

Per the Kenyan Constitution, the national government must transfer a minimum of 15% of national revenue to counties as part of the equitable share. The specific amount that the central government grants to each county is based on a series of factors that include county population, geographical size, and poverty level.[B] Counties receive these funds as block grants and have full control over how the resources are allocated.[54] For the 2017/18 fiscal year, the equitable share block grant accounted for an average of 78% of revenue across all 47 counties (see Figure 3).[55]

Figure 3
National- and Country-Level Flow of Health Funds Post Devolution



Source: HP+ Analysis

[B] As of August 2020, the Kenyan government is discussing and debating new parameters for an equitable share formula.

OWN-SOURCE REVENUE

Funds generated locally – called own-source revenue (OSR) – are the second largest source of county revenue. But this source is still far behind the amount transferred from the central government, and counties have struggled to increase OSR.[56] Own-source revenue includes funds generated locally through taxes, fees, and levies, including fees at health facilities. Each county creates its own OSR policy within the parameters set out in the Constitution. During the 2017/18 fiscal year counties collected only 66% of the targeted amount which accounted for an average of 8% of their total revenue for that year.[57]

Photo: Save the Children

Photo: Save the Children

CONDITIONAL GRANTS

Conditional grants from the national government are the third main source of financing for counties. Conditional grants are earmarked for specific purposes by the central government, and counties do not have a say in how they are spent. There are several health-related conditional grants for counties. One of the most recent is the 2019 UHC conditional grant that requires counties to direct at least 30% of their budgets to health care to be eligible for the transfer from the central government.[58] During the 2017/2018 fiscal year, conditional grants accounted for an average of 4% of total county revenue, but that is likely to change as larger portions of government budgets, including conditional grants, are channeled to UHC.[59]

FOREIGN ASSISTANCE

The final significant source of health financing for counties is foreign assistance in the form of on-budget grants and loans. While foreign assistance to Kenya is declining from its peak of $3.3 billion USD in 2013, in 2018 Kenya was still the fourth largest recipient of ODA on the continent, receiving $2.5 billion USD.[60] The United States is by far the largest donor to Kenya's health sector, providing $618 million USD in 2017.[61]

USAID, through its Health Policy Plus project, works at the county and national levels providing technical assistance to assist with Kenya's health financing system and strategy. The five-year $185 million USD project implemented by a consortium of partners, supports the Kenyan government's evolution to UHC through health budget advocacy and supporting linkages between county and national government stakeholders. It focuses primarily on health budgeting and PFM at the county level.[62]

The Danish International Development Agency (DANIDA) and the World Bank have also been important foreign sources of on-budget health financing for counties through the Health Sector Service Fund (HSSF) started in 2010. After devolution in 2013, the HSSF was adapted to engage the counties directly through the national Integrated Financial Management Information System (IFMIS). In the context of this report, the HSSF's goals of increasing resources for health facilities and integrating community input in identifying health priorities were particularly important. The important role of DANIDA and the World Bank in county-level health financing is discussed further below in the case studies.

MAKUENI COUNTY

Makueni County is a rural county of just under a million people about a three-hour drive southeast of Nairobi. The county has an average life expectancy of 67 years and an infant mortality rate of 45 per 1,000 births. The vast majority of people in Makueni work in agriculture, and the county has a 35% poverty rate. It has a young population: 75% of its residents are under 35 years of age.[63]

In many ways citizens in Makueni County live as generations before them had: depending on good rains – increasingly difficult due to climate change – in a semi-arid region pursuing subsistence farming, growing maize, mangos, and peas, and raising livestock including cows and chickens.

"Makueni was just farmlands and all the administrative offices were in Machakos [a neighboring county]," said County Director of Public Participation and Civic Engagement Dr. Zipporah Wambua. "Makueni was a backwater with no industry."

The county government – with the support of donors – is working to grow the county's manufacturing sector, but 78% of the population remains employed in agriculture.[64]

DONOR ASSISTANCE FOR HEALTH FINANCING IN MAKUENI COUNTY

In an era of an emphasis on increasing local ownership of foreign assistance, Makueni's success increasing health access and affordability while ensuring accountability and participation has attracted donors from across the globe looking for ways to reproduce positive results. USAID does not have as large of a presence in Makueni County as in Nyeri in terms of health financing assistance, but the World Bank's Kenya Accountable Devolution Program and DANIDA's assistance to health facilities in particular have contributed to Makueni's international reputation as a hub for health financing success, including as a model for participatory budgeting. Makueni's program provides an example that can be instructive to other donors, including USAID, that are seeking to improve health budgeting and PFM at the subnational level.

The World Bank became involved in Makueni's participatory budget program in 2015. Makueni County Director of Public Participation and Civic Engagement Dr. Zipporah Wambua said the Bank selected the county, because it had a history of participatory budgeting and a governor with a background in civil society (see Text Box 2 below). In addition to supporting the expansion of Makueni's citizen participation program, the World Bank is also studying the program's impact and limitations, providing a feedback loop for country leadership on fostering participatory budgeting. Makueni County's participatory budgeting project is discussed in further detail below.

World Bank Social Development Specialist Annette Omolo said the level of citizen enthusiasm and engagement in Makueni County's budgeting process are indicative of its success. "The rooms would be full, like over 200 people in a room and they've traveled distances and they've taken buses to get there," Omolo said. "Because they've begun to see the impact [of participation], because the county takes up what they said.'" Omolo attributed the county's citizen budgeting success to local government simply doing what they told citizens they were going to do "They do well because the projects that citizens selected are implemented," Omolo said. While the World Bank's formal evaluation of the Makueni project is ongoing, early findings show that citizen participation resulted in "budget allocation increasingly aligned with citizen priorities" rather than determined by battles between different sectoral departments intent on maximizing their own budget envelopes.[65] Makueni's participatory budget process will be analyzed in more detail below.

Denmark's foreign assistance agency, DANIDA, has also contributed to health financing best practices in Makueni and other counties by directly funding primary health facilities, thereby supporting counties' health finance autonomy. This direct, on-budget support helped facilities cope with the post-devolution challenge of health financing often being stuck at the county-leadership level and not being sent down to facilities. (Makueni's policy changes to empower health facilities is examined in more detail below.)

One community health care director in Makueni County said the direct DANIDA funding to health facilities was vital to the county's financing. "DANIDA has been there for the major priorities of the facility," the facility director said. "For example we have hired workers to register patients. The local running of the facility, DANIDA really takes care of them."

TEXT BOX 2: THE BENEFITS OF PARTICIPATORY BUDGETING

Government Officials	Politicians	Community/ Public
• Implementing Development Projects	• Closeness to the people	• Voice heard
• Generating reports	• Election pledges fulfiled	• Empowerment
• Evaluating social and economic impact	• Increased approval rating by the public	• Community cohesion
• Government closer to the people	• Improved communication Re-election	• Economic and Social benefits of the projects (employment, services)
• Credibility of government		• Sense of control and ownership

MAKUENI COUNTY HEALTH FINANCING EFFECTIVE PRACTICES

As we examine in greater detail below, the quality of leadership in both Makueni and Nyeri Counties attracted donor support and in both cases donors, including USAID, were often engaged with these local-level governments due to the success of programs already started by county leadership. This mode of donor engagement supports country ownership and alignment with the expressed needs of citizens and the priorities of subnational governments.

"Donors follow the lead of the government, so donors will give their opinion, they will mobilize their resources," said ThinkWell's Joanne Ondera. "[But] if the county government…makes a totally different decision, it doesn't really matter how much influence you donors have…Movement forward depends on the [county] leadership."

LEADERSHIP PRIORITIZING HEALTH CARE COVERAGE

When it comes to the creation of the innovative Makueni Care program and Makueni County's overall health care financing success, Save the Children interview respondents consistently mentioned one factor above others: leadership. Specifically, respondents pointed to the governor.

"It's predominantly due to the governor, it's a personality thing," said Joanne Ondera, former Kenya country lead for ThinkWell. For his part, Makueni County Budget Director Karanja Waigi also attributed the county's health care success to the county governor, "You have a very visionary governor who believes in people's power." Makueni County Governor Kivutha Kibwana won his first term in 2013 and was re-elected in 2017. He is now term-limited, and his current term will end in 2022. From the beginning of his term, Kibwana's leadership team recognized the harmful economic impacts that health care costs caused for Makueni's citizens.

"It was clear that many of the families were bankrupted by the money that they spent [on health care]. Most of them were not able to afford the national health insurance," Kibwana said. "They had to sell their land, sell their livestock. As a result, they would miss on school fees for their kids."

> **"Donors follow the lead of the government, so donors will give their opinion, they will mobilize their resources, but if the county government…makes a totally different decision, it doesn't really matter how much influence you donors have… Movement forward depends on the county leadership."**
>
> – Joanne Ondera, ThinkWell

These catastrophic health care costs can impact women and children in particular. In fact, more than five million families across Africa, Asia, Latin America, and the Caribbean spend at least 40% of their non-food annual household expenses on maternal health care.[66]

Given this scenario, and the inadequacy of Kenya's national health insurance scheme in Makueni, the county leadership team set out to 1) increase access to primary health care, and 2) provide Makueni citizens health care without them having to pay at the point of service. Today, Makueni County has one of the lowest incidences of catastrophic health expenditures of any county in Kenya.[67]

Makueni County's leadership started by taking on the issue of access. County leadership analyzed the overall health system and made investments in access to primary health care based on a gap analysis.

"We've more than doubled the staff in terms of doctors, nurses, the clinical officers, and so on," Kibwana said. The first round of investments in primary health increased the number of primary health care facilities in the county from 109 to 235.[68] Makueni County allocated 3.3 billion Kenyan Shillings (KES) – about $31 million USD – to health care during fiscal year 2018/2019 mostly through transfers from the national government. Health care allocations represented 32% of the total county budget – above the average 27% allocated to health by Kenya's 47 counties.[69]

After increasing access, the county also implemented a county-wide health insurance program, Makueni Care, to reduce costs for patients (see Text Box 4).

TEXT BOX 3: HOMEGROWN UHC: MAKUENI CARE

One thing that makes Makueni County remarkable is its locally-created and operated universal healthcare program called Makueni Care, the only of its kind in Kenya. Launched by Makueni County Governor Kivutha Kibwana at the end of 2016, Makueni Care now includes 45,000 Makueni households who pay 500 KES (about $4.70 USD) per year to enroll.[1] Makueni Care serves as a countywide UHC program: it essentially eliminates fees for members at public health facilities, and the evidence shows it works much better at local scale than Kenya's nationwide UHC efforts. During FY 2018/19 the program cost about 221.5 million KES ($2.1 million USD), 25% of which was covered by premiums, while the rest was paid for by the county government.[2]

Makueni Care is open to anyone who has lived in the county for at least six months. Residents older than 65 years of age pay no fees and also receive public healthcare for free through other county health programs.[3]

After Makueni Care was implemented, county officials reported a 91% enrollment rate among households, that the program has driven increased health access, and that the number of health facilities in the country has doubled from 22 to 47.[4]

Additionally, due in part to the Makueni Care program, in 2019 Makueni was named the county with the best managed health care system in Kenya by Amref Health Africa.[5] Makueni was also one of only two counties receiving the highest certification from the national Auditor-General, who stated the county showed "that all the money was accounted for with the proper documentation provided."[6]

Makueni Care has also facilitated community engagement in health care policy and financing including with representatives from marginalized groups such as women, people experiencing disabilities, and children.

"The Makueni Care program…led to improved service delivery in the county for the simple reason that households are able to voluntarily pay the premium and they are able to follow up through [public participation] committees…on how facilities are performing in meeting community needs," said Felix Murira, senior program analyst for health systems consulting firm ThinkWell. "The committees are able to report what they are feeling directly to…the county assembly which in turn goes to [the department of health]. These issues are promptly addressed."

[1] Philip Muasa, "Inside Makueni's universal Health Care Programme." The Standard, August 13, 2018. https://www.standardmedia.co.ke/health/article/2001291782/inside-makueni-s-universal-health-care-programme.
[2] F. Murira, I. Vîlcu, "A Review of Makueni Care." ThinkWell, 2019. https://thinkwell.global/wp-content/uploads/2020/02/Makueni-Care-Brief-2019_10_09-Final.pdf.
[3] Philip Muasa, "Inside Makueni's universal Health Care Programme." The Standard, August 13, 2018. https://www.standardmedia.co.ke/health/article/2001291782/inside-makueni-s-universal-health-care-programme.
[4] "Building Health: Kenya's Move to Universal Health Coverage." World Health Organization, December 12, 2018. https://www.afro.who.int/news/building-health-kenyas-move-universal-health-coverage.
[5] "Winners of Inaugural Quality Healthcare Kenyan Awards Named at Gala Dinner in Nairobi." Amref Health Africa press release, July 4, 2019. https://amref.org/kenya/news/winners-inaugural-quality-healthcare-kenyan-awards-named-gala-dinner-nairobi/.
[6] Kennedy Kimanthi, "Counties clean up audit mess as Ouko plans expansion." Kenya Tribune, April 7, 2019. https://www.kenyantribune.com/counties-clean-up-audit-mess-as-ouko-plans-expansion/.

In implementing this broad health service and financing reform, interview respondents said part of its success was attributable to the governor's leadership style of empowering county health and budget staff and delegating decision-making to experts in the county bureaucracy.

"What the [county] top leadership…does is to support the lower-level decisions that officials take," said ThinkWell Technical Advisor Boniface Mbuthia. "The members of his staff don't feel intimidated to make decisions, because they know that as long as they follow the…procedures, the governor will support them."

STRENGTHENING CITIZEN FISCAL ACCOUNTABILITY

Closely related to the county's leadership that emphasized health care access for Makueni's vulnerable citizens, the county also consistently invested in strong accountability for the health budget and service delivery. These accountability mechanisms ensure that the health care reforms are responsive to citizens' needs. Accountability strengthens the compact between citizens and the government, allowing the county to adjust health financing as community health needs evolve, and also ensures that citizens have a seat at the table – enhancing inclusiveness and credibility when determining health financing priorities.

While participatory budgeting does not necessarily directly increase the overall amount of health financing available in Makueni County, it channels taxpayer dollars to more community-level projects. For example, health facility community scorecards enable citizens to determine gaps and priorities, rather than elected officials determining health budgeting and spending based on vanity projects. Public input also shapes the county's long term health financing through the County Fiscal Plan which maps budgeting through 2025.[70]

Additionally, beyond engaging in budgeting, Makueni's community action planning enables communities to determine their own contributions toward the delivery of effective health care (See Text Box 4).

TEXT BOX 4: KEY ELEMENTS OF THE MAKUENI PB PROCESS

Public Forums, Selection of Projects, Priority Lists and Technical Evaluation

County people forum
1,000 delegates

Sub-County People's Forum
Elects a development committee of 11

Ward People's Forum
Development committee of 11

Sub-Ward People's Forum - 60 Units
Development committee of 11

Village Cluster People's Forum - 315 Units
Development committee of 11 from each village

Village People's Forum - 3455 Units
Elects a development committee of 11

While the county's collection and analysis of data helps determine the allocation of health financing, its citizen budget participation efforts are comprehensive and impactful. Makueni Director of Public Participation Dr. Zipporah Wambua said that citizen engagement on health financing organized alongside the county's administrative hierarchy allows for citizen input to be collected, consolidated, and discussed at the following levels:

6 sub-counties | **30** wards | **60** sub-wards

377 clusters | **3,643** villages

The extensive outreach to citizens on the budget has increased the representation of marginalized groups, including persons experiencing disabilities and women, and has allowed them to voice their concerns and preferences in terms of financing the local health system.[71]

The accountability and participation efforts go back to 2014, early in Kibwana's tenure. "When we started…we realized that there was little engagement of the youth, the women, the children…so we agreed on…specific sessions for those categories. Leaders are selected in each village, and they are trained by the county how to mobilize their community to contribute to the budget process. We want to make sure that this process is not a one-time event."

EMPOWERING HEALTH FACILITIES

Ultimately, health care is delivered to citizens at the facility level. Patients' experiences with their dispensary, community clinic, or hospital will most inform their experience with Kenya's health care system. Recognizing the need to incentivize performance at the facility level and empower health facility staff with more financial autonomy, Makueni County implemented an informal health financing policy directive – emanating from the Governor's office – to allow facilities to collect and keep more of the revenue they generate. This post-devolution health financing policy was key to empowering health facilities and deserves to be disseminated throughout the Kenya.

The implementation of devolution greatly empowered county governments and particularly governors, but health facilities have less financial autonomy under devolution.

"All the facilities are suffering because money is not flowing down," said Thomas Maina, who worked with the World Bank to assist counties with budgeting and planning following devolution. "Before devolution money used to flow directly to facilities...Now money is not flowing."

Before devolution health facilities had more autonomy in developing their own programs and policies, including budgeting. Now, much of that power lies with county governments who can slow and divert funding from facilities and hold onto revenues generated by facilities. County-level leaders have stepped in to change policies to re-empower health facilities so that these facilities are able to keep more of the money they earn. These policies typically enhance incentives for high-quality service and give health facilities autonomy to use funding resources in ways that are more responsive to the communities they serve.

Makueni County has taken the lead in implementing these types of policy changes.

> **"The leadership structure of Makueni has understood that you need to allow the small units within the county to make decisions that influence the quality of care as opposed to having those decisions being made at the top leadership level."**
>
> – Boniface Mbuthia, Technical Advisor, ThinkWell

"What the top leadership now does is to support the lower-level decisions that officials take…they have understood…the dynamics of different entities within a larger organization and the fact that needs vary depending on where you sit."

Makueni County officials said this health PFM policy change also allows facilities to react to emerging health needs in a timely manner, because more of their own financing is under their control rather than managed at the county leadership level.

"For health…there are critical services that need to be available without following the government bureaucracy," said Makueni Chief Officer of Planning Budgeting and Revenue Eliud Ngela. "A hospital is not like a school... If you go through the bureaucracy you will find that at some point you will not have any money in the account."

Among Kenyan counties, Makueni's policy change empowering health facilities is the exception, not the rule. Makueni's decision to keep financial decision-making at the facility level means that service providers are more accountable to patients, which improves service performance.[72]

"Most of the counties…ensured that that money is kept at the center and never flows to the health facilities," Mbuthia said. "That introduces a layer of bureaucracy in how to access public financial resources…Unless you are at the treasury you have no control of financial resources."

> **"Already there are discussions of what happens with a new governor, will all this new stuff be kept? If there's no legal basis, it could be cancelled or deteriorate. It goes beyond a donor or partner driving it."**
>
> – Nirmala Ravishankar, Program Director ThinkWell

MAKUENI'S HEALTH FINANCING CHALLENGES

Makueni County's health financing system, and particularly Makueni Care, is nationally recognized for providing health care to a low-income, mostly agricultural population despite inheriting a weak health system after devolution. But the county continues to face health financing challenges.

SUSTAINABILITY

While the main factor currently contributing to health financing success in Makueni County is its leadership's emphasis on health financing and innovations like Makueni Care, when the current leadership is gone, there is no guarantee that the next governor will sustain the health budgeting and financing policies implemented by the current administration. Accordingly, the main challenge facing Makueni County's health financing system is sustainability – both political and financial.

"Already there are discussions of what happens with a new governor," said ThinkWell Program Director Nirmala Ravishankar. "Will all this new stuff be kept? If there's no legal basis, it could be cancelled or deteriorate. It goes beyond a donor or partner driving it."

This demonstrates the perils of an over-personalized governance system without strong systems for institutional and policy coherence and continuity.

Stephen Muchiri of USAID's Health Policy Plus project also noted that county policy priorities can change quickly. "If you get another governor who says that health is not a priority, you lose all those gains."

Makueni Care also faces fiscal sustainability challenges as it is heavily subsidized by the government and its roughly $5 dollar USD annual premiums from program members are not nearly enough to cover it's the program's costs.

Even Governor Kibwana said the fees charged by the program are too low. "Even when you have subsidized medicine you need to have the people participate [financially] so that they don't get the wrong signal that…services are free."

Makueni County does have the advantage of the citizen accountability structures that at least ensure that its participatory budgeting and review of service delivery are grounded in citizens' expressed preferences which are not likely to change with political administrations.

"One thing they have going for them is that the citizens know the [budgeting] process," said the World Bank's Annette Omolo. "The level of awareness…is very high…and there is a very high level of support for participatory budgeting."

"DOING A PROPERTY TAX PROBABLY MEANS YOU ARE TAXING YOUR POLITICAL SUPPORTERS. COUNTY GOVERNORS ARE ESPECIALLY RISK AVERSE…ESPECIALLY SINCE 95% OR SO OF THEIR BUDGET COMES AS A GRANT THAT THEY DON'T HAVE TO PESTER THEIR LOCAL TAX PAYERS ABOUT."

– Jamie Boex, Senior Fellow at Duke Center for International Development

Photo: Save the Children

OWN SOURCE REVENUE

While health budgeting and PFM are the focus of this report, generating sufficient revenue is also important to ensure adequate health budgets. Like counties across Kenya, Makueni faces the challenge of generating sufficient own-source revenue (OSR) so that it is not overly-dependent on the central government and donors for financing. The national Equitable Share comprises about 80% of Makueni County's budget while OSR makes up about 6% of the county budget. The remaining budget is comprised of donor funding and conditional grants from the national government.[73]

Makueni County officials are well aware of the problem and say increasing OSR is a priority. "We have not performed well in OSR in part due to the way we estimate it," said Eliud Ngela, Makueni Chief Officer of Planning, Budgeting, and Revenue. "We have not been able to do a revenue mapping potential." Ngela said the county is aiming to increase local revenue generation to at least 10% of total county revenues.

To this end, the county is focusing on reforming property tax assessment, aiming to assess lands based on their value rather than their size, as is the current method. "Once you have the valuation rolls, you levy according to the value of the property which is one of the best practices in property taxation," Ngela said. "But it also means a lot of effort…it's a labor intensive activity." There is disagreement among experts on the extent to which counties can increase local revenue, given that most tax collection authority falls under the purview of the national government. But as noted above, research by the Kenyan National Treasury and the World Bank found potential increases in subnational revenue generation and identified property taxes as having the most potential.[74]

One additional challenge of reforming property taxes is a political one, as many large property owners at the local level wield political power. Jamie Boex, a Senior Fellow at Duke Center for International Development, said, "Doing a property tax probably means you are taxing your political supporters. County governors are especially risk averse…especially since 95% or so of their budget comes as a grant that they don't have to pester their local tax payers about." Nevertheless, ensuring that large property owners pay their fair share is a key part of increasing local revenue. And easing the burden for vulnerable groups, including women who are overrepresented in informal sector jobs but still often pay local fees, can strengthen citizen-state relations (See Text Box 6).

Photo: Save the Children

TEXT BOX 5: TAX AND GENDER IN KENYA

Makueni County's public budgeting process which is supported by the World Bank and the USAID-funded Health Policy Plus project in Nyeri County both explicitly call for engaging women and integrating gender principles into their work. But how do gender and tax intersect at the subnational level in Kenya?

There is a small but growing body of research on the impacts of gender on tax.[1] Research and analysis is limited by the lack of gender-disaggregated data, but tax provisions that explicitly disadvantage women and girls are increasingly rare.[2] Instead, most of the adverse impacts of tax codes on women usually come from implicit biases and differences in the socioeconomic statuses of men and women. For example, flat consumption taxations like the value added tax (VAT) are regressive and therefore place a larger burden on women and other marginalized groups in developing countries. Conversely, excessive tax incentives for corporations and elites erode the citizen-state compact and rob women and other marginalized groups of government revenue that could be used to provide critical services.

The International Center for Tax and Development (ICTD) states, "The effects of tax policy on gender relate mainly to implicit biases that are embedded in policies relating to small and micro businesses, informal taxes, and taxes on assets and property." In some cases these biases favor women and in others they work against them.

In Kenya, counties can play an important role in determining whether tax policies are gender sensitive. While counties – compared to the national government – do not have much constitutional authority to collect taxes, they are empowered to create user fees and levies including market fees and health care fees. These fees can have a significant impact particularly on informal vendors (disproportionately women), and especially during times of economic hardship such as during the Covid-19 pandemic.

The vast majority of employed women in East Africa are in the informal sector – 93% – a rate higher than men at 75%.[3] Given the outsized role of women as informal vendors and owners of small and micro-businesses, counties' determinations of market fees, for example, have a disproportionate impact on women in Kenya. The impact of these fees for basic services are often greater on women than the impact of national taxes. According to the ICTD, "User fees for essential services are much larger than formal taxes paid…and are the largest component of formal and informal payments for most taxpayers."[4]

And while large percentages of both men and women work in the informal sector in Kenya, labor experts say that women are usually in the most vulnerable informal sector jobs such as cleaning and street vending. The Kenyan national government has proposed a series of fiscal measures to help vulnerable Kenyan households to which counties can also contribute by shaping local tax regimes to the benefit of informal workers.[5] Particularly during times of crisis such as the Covid-19 pandemic – counties' fiscal policies can be changed to help women by lowering local fees for informal vendors at markets, lowering fees for boda-boda drivers, and lowing other user fees that informal workers are accustomed to paying to county officials.

[1] Anuradha Joshi, Jalia Kangave, and Vanessa van den Boogard, "Gender and Tax Policies in the Global South." International Center for Tax and Development / Institute of Development Studies, May 26, 2020. https://opendocs.ids.ac.uk/opendocs/bitstream handle/20.500.12413/15450/817_Gender_and_Tax.pdf.
[2] Michelle Harding, Grace Perez-Navarro, and Hannah Simon, "In Tax, Gender Blind is not Gender Neutral: why tax policy responses to COVID-19 must consider women." OECD Centre for Tax Policy and Administration, June 1, 2020. https://oecdecoscope.blog/2020/06/01/in-tax-gender-blind-is-not-gender-neutral-why-tax-policy-responses-to-covid-19-must-consider-women/
[3] Louise Donovan, April Zhu, "Kenya's Labor Market Wasn't Made for a Pandemic." Foreign Policy, April 10, 2020. https://foreignpolicy.com/2020/04/10/kenya-labor-coronavirus-pandemic-informal-workers-economic-crisis/.
[4] Anuradha Joshi, Jalia Kangave, and Vanessa van den Boogard, "Gender and Tax Policies in the Global South." International Center for Tax and Development / Institute of Development Studies, May 26, 2020. https://opendocs.ids.ac.uk/opendocs/bitstream/handle/20.500.12413/15450/817_Gender_and_Tax.pdf.
[5] Louise Donovan, April Zhu, "Kenya's Labor Market Wasn't Made for a Pandemic." Foreign Policy, April 10, 2020. https://foreignpolicy.com/2020/04/10/kenya-labor-coronavirus-pandemic-informal-workers-economic-crisis/.

NYERI COUNTY

Unlike Makueni County, which even its boosters describe as a "backwater," Nyeri County entered devolution with advantages. About a three hour drive north of Nairobi on the southwestern flank of Mount Kenya, Nyeri County inherited a strong health system constructed before devolution. The county has been a center of administration since the British Colonial period, and its prominence continued after independence.

NYERI'S SUCCESSES IN HEALTH CARE PROVISION – WHICH WE WILL EXAMINE IN GREATER DETAIL BELOW – ARE LINKED TO THE COUNTY HAVING THE HIGHEST LIFE EXPECTANCY RATE IN KENYA. BUT AS NYERI COUNTY SUCCESSFULLY CONTAINS COMMUNICABLE DISEASES AND RESIDENTS LIVE LONGER, THE COUNTY INCREASINGLY STRUGGLES WITH NON-COMMUNICABLE DISEASES (NCDS), WHICH ARE MORE EXPENSIVE TO TREAT.

Nyeri County has a population of 759,164 and while its total population is smaller than Makueni County, its geography is also smaller and is thus much more densely populated.[75] Nyeri's economy is focused on tea, dairy farming, and horticulture. Like Makueni County, Nyeri also has a young population with 60% of residents younger than age 30.[76]

Unemployment and the lack opportunities for youth are severe problems in Nyeri County, but its 19% poverty rate is lower than Makueni County's. Donor funding comprises about 4% of county revenue and county health expenditures. The amount the county spends on health– which change from year-to-year – is one of the proportions of the budget in Kenya at 34% of the total budget. Nyeri is also exceptional in raising revenue locally – with OSR making up 11% of its budget – one of the highest percentages among all counties in Kenya. This will be explored further below.[77]

Nyeri's successes in health care provision – which we will examine in greater detail below – are linked to the county having the highest life expectancy rate in Kenya. But as Nyeri County successfully contains communicable diseases and residents live longer, the county increasingly struggles with non-communicable diseases (NCDs), which are more expensive to treat.[78] This stands as a looming health care service and financing challenge for Nyeri County in particular and for Kenya generally as the prevalence of diseases such as cancer and diabetes increase. Nyeri County was chosen as one of Kenya's four pilot UHC counties in part because of its high burden of NCDs.

DONOR ASSISTANCE FOR HEALTH FINANCING IN NYERI COUNTY

Nyeri County Executive Member Rachael Kamau said that USAID's capacity building through the Health Policy Plus project helped Nyeri become one of the leading counties when it comes to health budgeting. "USAID is…training in terms of how to develop work plans, how to develop program-based budgets…It's very helpful."

The Health Policy Plus program also builds county capacity to advocate for increased health funding from the national government (See Text Box 6), and Nyeri has also been working with the World Bank's Kenya Devolution Support Program which cited Nyeri as one of the countries' leading counties in terms of PFM and civic participation, among other governance parameters.[79]

For his part, USAID Kenya Health Care Financing Specialist Dhim Nzoya said the country mission's emphasis on health financing is, as noted above, based on an abrupt devolution in 2013 that left counties without the capacity to plan and budget for health.

TEXT BOX 6: USAID'S HEALTH POLICY PLUS PROJECT

Makueni County relies on donors slightly more than Nyeri County (6% of the county budget versus 4% for Nyeri), but Nyeri is notable for the foreign assistance it receives specifically on health financing through the USAID and PEPFAR-funded Health Policy Plus project (HP+). Led by Palladium, HP+ works in 16 countries at the local, national, and global levels on health policy design, implementation, and financing. The project began in 2015 and ended in 2020

In Kenya, HP+ works in 26 counties to strengthen decentralized health service delivery and budgeting with a focus on the implementation of program-based budgeting. Among these 26 counties HP+ works in depth in nine counties, one of which is Nyeri.

The HP+ Kenya Country Director Stephen Muchiri said the project is focused on helping counties transition to more domestic funding as foreign assistance continues to decrease. "PEPFAR is the pilot for transitioning out of aid," he said. "You need to put concrete deadlines for transitioning out of aid. If you don't have that deadline, as the National Treasury, I would say, 'why [should I transition].'"

[1] "Budget Allocations for Health in 26 Kenyan Counties Increase by $98M Over 2 Years with USAID Planning and Budgeting Guidance." Health Policy Plus press release, December 15, 2017. http://www.healthpolicyplus.com kenyaCountyBudgeting.cfm.D. Khaoya, P. Abonyo, and S. Muchiri, "Kenya County Health Accounts: Summary of Findings from Nine Deep-Dive Counties." Health Policy Plus, July, 2019. http://www.healthpolicyplus.com/ns/pubs/13332-13607_KenyaCHASynthesis.pdf.

"We are focusing on aligning the annual workplans for counties to program-based budgeting which… makes sure that you show results for the money that you have been given," said Nzoya. "We've been able to work with counties and build their capacity [and] link their program to funding and results."

NYERI COUNTY HEALTH FINANCING EFFECTIVE PRACTICES

LEADERSHIP PRIORITIZING HEALTH CARE BUDGETS

Like Makueni County, Nyeri County has been cited nationally and internationally as a leader in health financing. Nyeri was ranked number two by the World Bank's Devolution Support Program which assesses counties' public financial management as well as their mechanisms for public participation in the budgeting process, among other factors.[80]

Leadership is also a key factor of Nyeri County's success. In Nyeri, this includes the governor and the county budget and health departments, and encompasses both the local political and technical leadership.

Interview respondents said that Nyeri Governor Mutahi Kahiga makes health care and health financing a priority. "The governor is so keen on health he visits the hospital every week," said County Executive Dr. Rachael Kamau. "On a weekly basis we write reports for him on health services and on what is happening in the health sector. He has an interest in health, so he gives us the biggest allocation."

Photo: Save the Children

For his part, USAID Kenya's David Nzoya said that health financing "is a political process [and] in Nyeri we have very good leadership."

Nelson Maina, a local civil society leader trained by Uraia Trust, also noted the governor advocated for the county to be more transparent with health budgeting information, and to facilitate accountability through citizen participation. "He's pushing everything to go digital. And it's bearing fruit, I must say, because we can access a lot of information online now, including on health."

Interview respondents also praised the county health and budget staff in particular, who they said are professional and have had long tenures in their positions and noted that these traits contribute to ensuring higher levels of health budgeting and PFM. "They are totally different than leaders from other departments," said Health Policy Plus Project Deputy Director David Khaoya. "They grasped the concepts of PFM quite early."

Khaoya said the longevity of the tenures of Nyeri's health and budget staff allowed them to better steer the health financing system through devolution. "Their leadership did not change. These are people who have been there right from the time of devolution, so they understand where the challenges have been," he said. "[In] other counties you'll find the chief officer has been there for one year or two, and before he finds out what he is supposed to be doing, he's transferred."

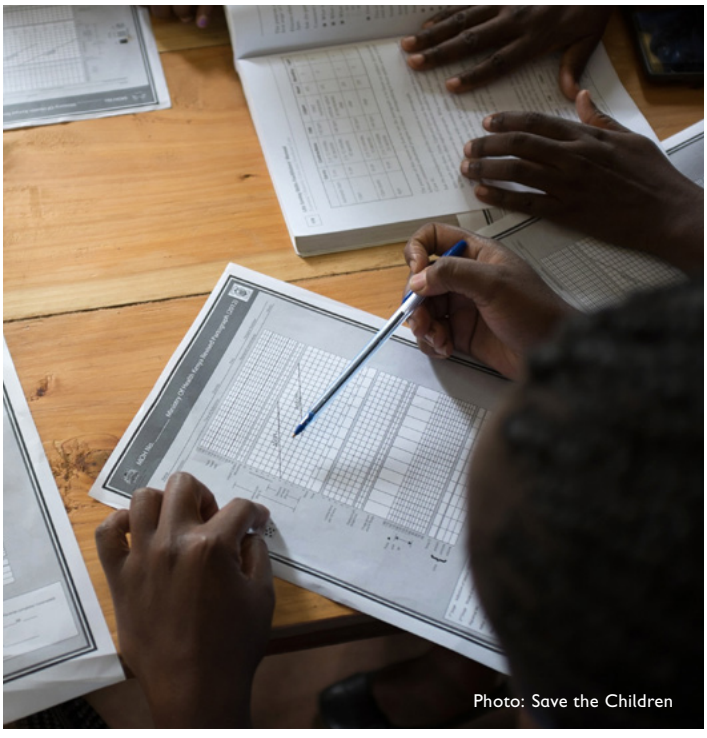


Photo: Save the Children

HIGH QUALITY DRM AND PFM FOR HEALTH

Nyeri County's respondents said that in addition to having leadership that prioritizes health care by dedicating large percentages of the county budget to it, Nyeri has also used its health budget wisely through PFM and DRM best practices, including implementing program-based budgeting and digitally linking health facilities to monitor revenues, stocks of health products, and other financial and health supply issues in real time.

Nyeri County was "amongst the first ones to be able to make…changes on PFM that helped define the role of health facilities and the county governments," said ThinkWell's Boniface Mbuthia. "They were proactive."

The county's PFM received high marks from fiscal governance civil society groups and donors alike. "They are able to prioritize what areas they are working on for the coming…year," said Thomas Maina of the World Bank. "Their program-based budget also aligns to the annual workplan to put more money on the priority areas."

In 2019, the Kenya's national Public Procurement Regulations Authority ranked Nyeri County at the top of all counties in terms of compliance with public procurement regulations.[81] Nyeri has also upgraded local tax collection to an electronic rather than manual paper-based system, making it less prone to corruption. Nelson Maina of the Uraia Trust said that this increased local revenue is being channeled to health facilities. "Before, revenue collection was more manual, so there was a lot of leakage," he said. "But now electronically, things are better, so we are seeing an upsurge in own-source revenue."

Nyeri has also shown good practices regarding property tax valuation and collection. Unlike many counties in Kenya, Nyeri has updated its valuation rolls so that property can be properly taxed at up-to-date rates. And while much of Kenya's land is communally owned and therefore, unregistered, Nyeri County land has been registered, making it more amenable to property levies.[82]

The electronic linking of health facilities, tracking of county revenue, and high-quality PFM practices mean that "the department of health is able to prepare… reports on time and the finance department is able to respond," said the World Bank's Thomas Maina.

Photo: Save the Children

CIVIL SOCIETY AND PUBLIC PARTICIPATION

Like Makueni, another strength of Nyeri County's health financing environment is a strong civil society cadre of budget advocates – through the Nyeri County Budget Coalition. The loose coalition of local civil society organizations ensures that local health financing is accountable to citizens and amplifies citizen voices in health financing citizens at the local level.

County officials acknowledge that organizations like the Uraia Trust, which is part of the coalition, have prompted health financing changes including making the county's budget information more accessible to the public and directing more financing to needs expressed by the community. Some of the coalition's notable achievements include that out of 17 proposals the coalition made to the county government for the fiscal year 2018/19 budget seven of them were approved, and that the county is now launching sub-county citizen budget forums for the first time.[83]

This small civil society consortium was able to develop its budget advocacy skills in part due to support and training by external donors including the Center for International Public Enterprise and the Health Systems Advocacy Partnership. Training has been provide to the local consortium on topics ranging from budget cycle tracking and evidence-based budget advocacy to understanding budget analysis and social accountability.[84]

Budget advocacy is highly technical, and the coalition sees itself in part as translators of local health financing issues to the public. "The more you educate the public here the more they champion for better services, better finances," said Nelson Maina of the Uraia Trust. "[The county uses] a lot of jargon, so we try, as much as possible, to simplify what they are saying. So we are seeing more participation, even the youth…We are seeing more demand for information – not just figures, people want justifications."

Jemima Muthoni of the Health Rights Advocacy Forum (HERAF) said the county's complicated health budgeting cycle makes it challenging to integrate public input at the right moment during the budgeting process. "The challenge of aligning what the community asks for in public participation to what was actually put in the annual work plan is now something we are trying to work [on]."

Maina added that it is not enough for the county to invite citizens to hearings on health finance issues – the citizens need to be trained and educated on how these budgets impact them and why their input is important. "There is no civic education to understand why they are here. They are not sure why they were asked to come...So there is an accountability gap…it's still a very political process."

NYERI COUNTY HEALTH FINANCING CHALLENGES

Over-budgeting Recurrent Expenditures and Underspending of Development Budgets

As discussed throughout this report, effective health budgeting requires spending of allocated budgets on health, not just increasing the total amount allocated for health. In terms of allocations, Nyeri places a high priority on health financing with more than one-third of the total county budget allocated to health care. However, a closer look reveals that most of the county's 2.6 billion KES ($24 million USD) health budget is spent on recurrent costs – and the vast majority on salaries – leaving little left to address community health needs as expressed by citizens.[85]

Recurrent costs can be defined as "those incurred for goods and services consumed in the course of a budget year, and which must be regularly replaced."[86] This includes salaries, medical supplies, health operations, and maintenance. In the health sector throughout Kenya, salaries comprise the lion's share of recurrent budget spending.

Kenya's 2012 Public Finance Management Act recommends that counties allocate 30% of their budgets to development and the remaining 70% to recurrent expenditures allowing them to balance current service provision with needs for expansion.[87] For fiscal year 2018/19, recurrent costs comprised 88% of the Nyeri's total health allocation. While not the highest in Kenya, this put Nyeri among the upper cohort of counties in terms of the proportion of their health allocations taken up by recurrent costs. (For context, Makueni County allocated 77% of its health budget to recurrent costs while another county was as low as 56%.)

Furthermore, Nyeri was among the top five counties in Kenya in terms of the percentage of its budget going to salaries.[88] To be sure, recurrent costs are the backbone of a health budget, but Nyeri's focus on salaries meant less resources were available for other inputs critical to delivery of health services.[89] This over-budgeting on health personnel costs has been identified as a challenge by county leaders and by USAID's Health Policy Plus project staff, and they are presently collaborating to reduce staff costs and redirect savings to other health needs.[90]

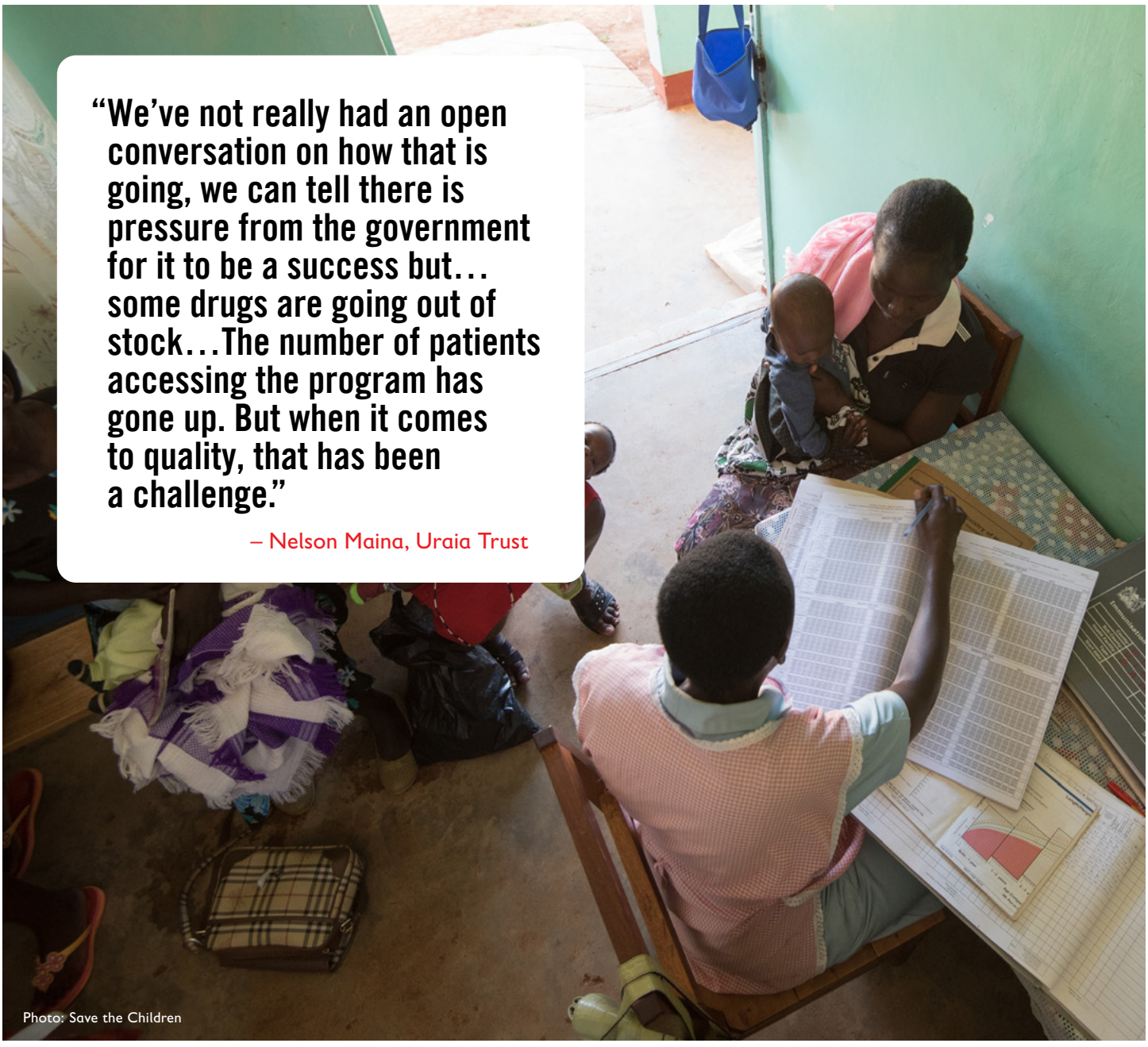
Photo: Save the Children

county health budget allocations and also found the county overly invested in recurrent costs. "With the bulk of the budget going to recurrent expenditure, the small asks may get overlooked. We want to see more money going into specific priority needs for the community."

On the other hand, Nyeri's development budget for health also has its challenges. Development budgets are used for capital expenditures including new health facilities and buildings, medical equipment, and capital transfers.[91] For fiscal year 2017/18, while Nyeri's recurrent budget allocation was almost 100% spent, the county was only able to spend 54% of its development budget allocation.[92]

This shortfall in spending not unique to Nyeri and is a problem across Kenyan counties that is indicative of systematic problems with county procurement processes and other PFM practices.[93]

Nyeri County civil society leaders said that these budget execution problems also reflect a continuing disconnect between citizen and county government health priorities. "The priority of the people is not necessarily the priority of the leaders," said Michael Ndegwa of KANCO, an NGO focused on HIV/AIDS. "So you find so many structures without doctors, without even nurses, without even supplies, but the structure is there."



"We've not really had an open conversation on how that is going, we can tell there is pressure from the government for it to be a success but… some drugs are going out of stock…The number of patients accessing the program has gone up. But when it comes to quality, that has been a challenge."

– Nelson Maina, Uraia Trust

Photo: Save the Children

UHC PILOT IMPLEMENTATION

As discussed above, Nyeri County is one of four counties in Kenya that was selected as a UHC pilot in 2018. Each of the four counties were chosen based on their unique characteristics, and Nyeri was selected due to its high burden of non-communicable diseases. While a noble idea, the implementation of UHC in Nyeri County has had mixed results – not so different from Kenya's other three pilot counties.

UHC pilot counties say the Ministry of Health did not give them adequate direction, and many respondents indicated that Kenya's UHC initiative was driven by politics as much as by development imperatives. For their part, Kenyan civil society and private sector organizations have also critiqued the government for the lack of guidance in implementing UHC and for not gathering and sharing lessons from the UHC pilot process. In May 2020, a coalition of civil society organizations submitted a letter to parliament stating that the Kenyan government "should ensure no more monies are allocated towards the full roll-out of the UHC phase until the report on lessons-learnt from the pilot counties is submitted."[94]

As the patient load escalated due to services being offered for free, and as patients from neighboring counties were increasingly referred to Nyeri County health facilities due to health sector labor disputes in other counties, Nyeri was not provided with commensurate financing from the national government to offset these increasing costs. By December 2019 when the pilot ended, Nyeri County received only half of its UHC budgetary allocation from the national government (See Text Box 7).

Makueni County Governor Kibwana, whose county was not part of the pilot, said, "The four pilot counties don't speak well of that [UHC] experience…My colleagues have told me that it was inflexible."

Civil society groups working on health budgeting in Nyeri have also seen problems in the UHC budget implementation. "We've not really had an open conversation on how that is going," said Nelson Maina. "We can tell there is pressure from the government for it to be a success but…some drugs are going out of stock…The number of patients accessing the program has gone up. But when it comes to quality, that has been a challenge."

Nevertheless, despite multiple implementation programs, the UHC pilot in Nyeri can count some successes – primarily increased health access. Newton Wambugu, chief health officer for Nyeri County, said the UHC pilot has been a success in terms of getting people into the system "instead of staying home because they couldn't afford it."

For her part, Dr. Rachel Kamau said that UHC resources allowed Nyeri to increase county health staff, set up quality improvement teams in hospitals, and expand the county's ICU bed capacity from three to six – particularly important as it was done before the onset of the Covid-19 crisis and therefore prepared the county for the pandemic's impact. UHC funding also helped the county respond to its growing burden of NCDs by expanding the renal and oncology units at the county referral hospital.[95]

TEXT BOX 7: THE CHALLENGE OF INTERGOVERNMENTAL TRANSFERS

Nyeri County faces a public financial management (PFM) challenge common to counties throughout Kenya – receiving funding transfers from the federal government on time. In the absence of significant local revenue generation, counties' heavy reliance on national funding means that their budgeting and program effectiveness depends on the vagaries of a sometimes inefficient national PFM system.

"Unfortunately, [the national government] brings the money a little late," said Nyeri County Executive Rachel Kamau. "[So] sometimes the money does not come on time to the health facility. You'd rather have your own money than the money you have to wait for someone else to give to you on their own timing."

These delays can have consequences for local health systems including delaying the purchasing of equipment and medicines, and the implementation of programs. These setbacks are part of a devolved health financing system that continues to experience power struggles between national and local government funding prerogatives.

5. CONCLUSION AND RECOMMENDATIONS

Across the world, the Covid-19 pandemic has ravaged health systems, economies, and livelihoods, and has disrupted the delivery of routine health services. Because of the pandemic, decades of progress on child survival and other development gains for children risk unravelling.

As discussed throughout this report, Kenya, among other nations, has committed to achieving universal health coverage and has translated this commitment into concrete action. As we have noted above, implementing UHC under normal conditions is a major challenge. But providing equitable, high-quality health care to citizens during a pandemic is a Herculean task, and Covid-19 poses a serious threat to progress toward UHC in A frica and across the globe.

The pandemic is a wake-up call for the investment needed to build strong and resilient health systems, and the need for public and political support for increasing resources for health has never been more urgent. Recognizing this, member states of the 73rd World Health Assembly in 2020 unanimously adopt a Covid-19 response resolution that included commitments to increase domestic financing and development assistance where needed toward achieving UHC.[96]

While research for this report was conducted just before and during the early days of the Covid-19 pandemic, the findings are applicable to donors and national and subnational governments as they build back better, stronger, and more resilient health systems. Improved budget allocation and execution, increased local ownership and engagement with civil society regarding local budgeting, and finding innovative means to increase own source revenue will be even more important now as donors, country, and county governments rebuild health systems.

How to do this is highly context specific and anything but direct. "There is no clear pattern across and within country income groups in what drives budget prioritization of the health sector," the World Health Organization states. "Higher income or higher general government revenue and spending do not necessarily imply higher priority on health. Prioritization is largely a collective choice made by societies, generally expressed by politicians empowered by their citizens."[97]

In Kenya, national leaders made health one of the country's top four development priorities, and development partners including USAID have responded in kind, providing health budgeting and PFM assistance with a focus on counties. At the same time, Kenyan citizens are also increasing their knowledge and skills to advocate for better and more representative budgets.

This report is intended to draw lessons from two Kenyan counties to help inform and guide U.S. foreign assistance agencies and county leaders in Kenya on best practices in effective health budgeting policies, programs, and practices with a focus on working with citizens. The following recommendations are based on our two exploratory case studies and focus on two key stakeholder groups.

Photo: Save the Children

RECOMMENDATIONS FOR COUNTY GOVERNMENTS

County governors should empower primary health facilities with more budgetary autonomy. Decentralization has been paradoxical for Kenya's health system – it empowered county-level leadership in terms of budgetary decisions, but health facility managers lost some of the budgetary autonomy they had prior to decentralization. Without health financing decision-making authority, health facilities largely lost the accountability that comes with it, which has impacted service delivery.[98] Makueni County, among others in Kenya, have enacted PFM reforms to re-empower facility managers to access county health funds more easily. This policy change should be considered across all 47 counties in Kenya, but developing laws is new terrain for county governments, and health departments lack capacity to take this on.[99]

More health facility budget responsibility comes with more accountability. Makueni County has created health facility management committees selected by citizens to ensure accountability for service delivery at the facility level – close to the communities that use them. While the responsibility for empowering health facilities with more budgeting input resides primarily with county leadership, the national government and donors can help with this rebalancing of health budgeting across counties.

Photo: Save the Children

County leadership should improve health facility revenue and cost tracking. Program-based budgeting and linking county health facilities electronically to track costs in real time were some of the PFM enhancements USAID's Health Policy Plus program tried to implement at the subnational level, while some counties also took the initiative themselves to create or improve facility-level revenue and spending reporting systems. These reforms are direly needed as Kenya does not have a national system for tracking health facility revenue, costs, and transfers.[100] While this health budgeting reform process has not yet been formally evaluated, local civil society interview respondents spoke highly of the effort, and Nyeri has received national attention within Kenya for its high quality procurement and PFM for health.

County governors should expand their participatory budgeting processes and allow for more community engagement on health budgeting. Kenya's 2012 Public Finance Management Act established County Budget and Economic Forums in every county as a platform for citizen engagement on budget matters, but these forums typically remain unknown by citizens and are often inoperative.[101] However, in some cases county leaders and/or local civil society organizations have taken the initiative to strengthen public engagement in health budgeting. For example, Makueni County has an extensive participatory budgeting program supported by the World Bank, which allocates a certain number of seats on local development committees for women. For its part, Nyeri County boasts an influential network of budget advocacy organizations including local women's groups, youth groups, and groups representing people who experience disabilities. Kenyan leaders at the national and local level should make an effort to involve women- and youth-led groups in particular to ensure a gender-responsive health budget that is in tune with the future of the community.

RECOMMENDATIONS FOR USAID

USAID should continue to support health budgeting at the subnational level in Kenya. Counties are increasingly becoming important decision-makers on health finance. In fact, their health budget allocations increased 178% between 2013 and 2019, a larger percentage increase than at the national level.[102] As health budgeting decisions increasingly shift to counties, these subnational entities can serve as policy laboratories for effective health and participatory budgeting practices, and disseminate their best practices and lessons learned through organizations such as the Council of Governors to have a nationwide impact.

USAID should include and fund local civil society organizations and networks as part of its support for subnational health budgeting.

While government-to-government technical assistance helped counties increase budget allocations to health, our case studies found that civil society has an important role to play to ensure that county-level health budgeting accurately reflects citizens' needs. This kind of citizen engagement remains underdeveloped at the subnational level, and USAID's own research finds that "the lack of health related advocacy civil society organizations at county level limits the ability of civil society to effectively engage in the policy process."[103]

Even as county health budgets increase, there is no guarantee that funding will be used to improve health care for the most vulnerable. The World Bank-supported participatory budgeting process in Makueni County is an example of how citizen engagement can shape health financing during a time of increasing subnational budgets. Makueni County also made efforts to ensure women and girls play a key role in health budgeting by reserving one-third of the participants in each of development committee for women. This policy move has led to a more gender-responsive health budget. Nyeri County also has a strong network of civil society health budget advocacy experts, including local women's organizations and groups representing people who experience disabilities, that has pushed the county to make heath budgeting more transparent and responsive. To be most effective and reflective of local needs, these budget advocacy groups and efforts should be based locally – and not parachuting into counties from Nairobi. USAID should work with national and county governments to ensure stakeholder consultations and participatory budgeting include local women's organizations, people experiencing disabilities, youth groups, and other marginalized groups.

USAID should support counties' efforts to raise more own source revenue (OSR) after the country's economy recovers from the pandemic.

While this report is primarily focused on health budgeting and PFM, Kenya's journey to financial self-reliance requires increasing the amount of subnational domestic revenue. The World Bank identified a shortfall of $510 million USD in unmet revenue potential among counties and suggests there may be much more.[104] Tax was not part of USAID's Health Policy Plus program in Kenya, but support for progressive tax policy reform would enhance counties' financial autonomy and their ability to deliver services, including health services.

Property tax provides the best opportunity for counties to raise additional local revenue progressively. Among its middle-income country peers, Kenya lags on the collection of property taxes. According to the IMF, Kenya's average revenues from property taxes were .15% of GDP, compared to .76% in other middle-income countries.[105] The Brookings Institution also found that Kenya has one of the least efficient property registration systems in Africa.[106] Tax policy and property tax policy in particular is certainly space for USAID and other donors to work with Kenya at the subnational level on increasing revenue as part of the nation's journey to financial self-reliance.

Photo: Save the Children

Photo: Save the Children

APPENDIX 1: RESEARCH METHODS

The primary data for this report was gathered through two exploratory case studies of Makueni and Nyeri Counties in Kenya. The two counties were selected based on a purposive sample in consultation with Save the Children and external experts inside and outside Kenya. The health financing qualities that set these two counties apart in the context of Kenya are explored in depth in the case study section.

Research was conducted in February and March 2020 during the early stages of the Covid-19 outbreak and thus, while the data was generally not collected and analyzed in the context of Covid-19, many of the findings are only reinforced by the increased health financing demands imposed by the pandemic.

Once these two counties were identified as case study sites, we employed a snowball sampling technique to gather qualitative data through remote and in-person semi-structured interviews. In addition to numerous Kenyan government officials at the local and national levels, we interviewed civil society leaders, bilateral and multilateral foreign assistance officials inside and outside of Kenya, and health and fiscal policy experts.

All interviews were conducted in English and transcribed prior to coding and analysis. A total of 49 interviews were conducted between October 2019 and April 2020. Some interviews were conducted individually with respondents, and others were conducted in groups of two or more as needed in terms of respondents' requests and time constraints. Each individual is treated as a different respondent even if they took part in a group interview.

Table 1: Geographic Location of Respondents

RESPONDENT LOCATION	# OF RESPONDERS
Makueni County	9
Nyeri County	9
Nairobi	23
Outside Kenya	8
Total	49

Tables 1 and 2 below provide a breakdown of the geographic locations and types of respondents interviewed for this report.

All research was conducted before the Covid-19 crisis significantly impacted Kenya, so all findings from this report reflect the views and opinions of the respondents prior to the need to divert health funding to address the pandemic. We have integrated research and analysis on the economic and health impact of the pandemic on Kenya's health financing system, but the overall thrust of the report's analysis is on Kenya's long-term health financing needs. The Covid-10 pandemic has simply made these needs more urgent.

Many of these interviews were conducted in person during February and March 2020 through field research in Nairobi, and Nyeri and Makueni Counties. Quotes from respondents are interspersed throughout the report.

Table 2: Type of Respondents[C]

RESPONDENT LOCATION	# OF RESPONDERS
Locally-based civil society	6
INGOs and program implementers[D]	15
Kenyan subnational and national government officials	12
Multilateral development officials	6
Bilateral development officials	6
University-based researchers and analysts	4
Total	49

[C] "Given that the designations for "Type of Respondent" included significant ambiguity and overlap between groups, the numbers presented in Table 2 are intended to provide a general sense of respondents interviewed rather than a strict delineation or grouping.
[D] This included officials based in Kenya and overseas.

DATA ANALYSIS

Information gathered was transcribed and coded thematically based on the health financing best practices and challenges mentioned by respondents. Samples from the codebook can be found below.

VERIFICATION

The simple counting procedure used to ascertain key themes from transcribed interviews was verified using the NVivo qualitative analysis program. While there was some overlap in both challenges and best practices between Makueni and Nyeri Counties we tried to highlight differences between the two counties so as to provide additional insights for readers. The validity of respondents' information was ensured through obtaining information from several respondents in the same organization and from a diversity of respondents at the local, national, and international levels. Conclusions were also reviewed by 22 external experts who provided feedback and critiques on the report's content and conclusions. Secondary desk research was also used to verify the insights and best practices identified by respondents.

We interviewed local government officials extensively, but also civil society and external analysts. For example, in the case of Makueni County we interviewed the governor to obtain a panoramic view of health financing system and the origin of Makueni Care, but also discussed these issues with Kenya officials at the national level and civil society and donor experts. This allowed researchers to assess the validity of assertions by respondents through triangulating our data gathering and analysis.

In addition to the interviews and focus groups providing the core data for analysis regarding local health financing best practices and challenges, we also used a wide range of secondary data on health financing at the global, national, and local level to provide context for our analysis.

CODEBOOKS SAMPLES: Makueni County

THEME	DEFINITION	INTERVIEW CONTENT EXAMPLE
Strong leadership	County leadership (primarily the governor) prioritizes health financing and health services	The biggest driver for success is leadership. It is difficult to quantify, but the governor is a powerful figure and he directly follows…outcomes.
Strong citizen participation	Citizens are important stakeholders in the health budgeting process and influence health financing decisions	Public participation processes here are continuous. There is an annual public participation plan…The idea is to deepen participation beyond just the mere numbers to synergies in thinking and bring suggestions together.
Empowering facilities	Policy is changed, informally or formally, to provide health facilities with more budget autonomy	Before, facilities were keeping revenues and that continued during the transition. We got the legal tool to facilitate that way later. Now the ministry of health would like that to happen for everyone.

CODEBOOKS SAMPLES: Nyeri County

THEME	DEFINITION	INTERVIEW CONTENT EXAMPLE
Strong leadership	County leadership that prioritizes health financing and health services	The governor is so keen on health he visits the hospital every week. On a weekly basis, we write reports for him on health services and on what is happening in the health sector.
Health PFM reform	Enhancing health budget cost and revenue tracking through digitization and other reforms	He's pushing everything to go digital. That is a long-term goal for the county government and it's bearing fruit I must say, because we can access a lot of information online now, including on health.
Influential civil society	Civil society advocacy has led to tangible improvements in county health budget transparency and accountability	Budget data is available on the Nyeri County website – in part due to advocacy by IBP.

APPENDIX 2:
EXTERNAL REVIEWERS

Richard Christel
Program Associate, Transparency & Accountability Initiative

Matthew Eldridge
Policy Program Manager
Urban Institute

Lisa Fleisher
Senior Public Finance Advisor
USAID

Sanjeev Gupta
Senior Policy Fellow
Center for Global Development

Michael Jarvis
Executive Director
Transparency & Accountability Initiative

Rachel Kamau
County Executive Council Member
Nyeri County

John Kinuthia
Senior Program Officer
International Budget Partnership

Nelson Maina
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Uraia Trust

Janine Mans
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ThinkWell

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Zipporah Wambua
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