



Health Financing in Kenya

THE CASE OF WAJIR, MANDERA, TURKANA, MERU AND BUNGOMA COUNTIES



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capacités
FOR HEALTH

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CONTENT

4	List of Abbreviations
5	Executive Summary
8	Introduction
8	Background
9	Method and Scope of Study
10	County Health Profiles and Fiscal Findings
10	Turkana
20	Wajir
27	Mandera
35	Meru
40	Bungoma
44	National Health Budget: Fiscal Facts
44	How much is available for 2013/14?
49	Conclusion & Recommendations
50	Additional References and Resource documents

LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
AIE	Authority to Incur Expenditure
AOP	Annual Operation Plan
CBO	Community Based Organization
CBHA	County Budget Health Analysis
DANIDA	Danish Aid National Development Agency
ESP	Economic Stimulus Program
FBO	Faith Based Organization
FP	Family Planning
GAM	Global acute malnutrition
GAVI	Global Alliance for Vaccines and Immunization
GDP	Gross Domestic Product
GOK	Government of Kenya
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HRH	Human Resources for Health
HSSP	Health Sector Service Fund
ICT	Information Communication Technology
IEC	Information Education Communication
KAIS	Kenya AIDS Indicator Survey
KEMSA	Kenya Medical Supplies Agency
KDHS	Kenya Demographic and Health Survey
KHPF	Kenya Health Policy Framework
KNH	Kenyatta National Hospital
MCH	Maternal Child Health
MDGs	Millennium Development Goals
MOMS	Ministry of Medical Services
MOPHS	Ministry of Public Health and Sanitation
MRTH	Moi Referral and Teaching Hospital
MTEF	Mid Term Expenditure Framework
MTP	Medium Term Plan
NACC	National AIDS Control Council
NCD	Non Communicable Disease
NGO	Non-Governmental Organization
NHA	National Health Accounts
NHSSP II	National Health Sector Strategic Plan II
OOP	Out-of-pocket
SAM	Severe Acute Malnutrition
SC	Save the Children
SWAp	Sector-Wide Approach
TB	Tuberculosis
WASH	Water and Sanitation Hygiene
WHO	World Health Organization

1. EXECUTIVE SUMMARY

The ushering in of the devolved system of governance, enshrinement of health rights in the constitution and reforms in public management financing, offer significant opportunities for the development and improvement of the health sector in Kenya. The national government is now mandated to play an oversight role in health policy formulation while the county governments are charged with health service provision. To improve equitable access to essential health care services, both the county and national governments must be dedicated to meet the international threshold of 15% of their expenditure as stipulated in the Abuja declaration on governments' health care financing, and as well meet the target of the social pillar of The Kenya Vision 2030 roadmap. Over the last decade, total health spending in the health sector has increased, and subsequently translated into better health outcomes, as reported in the 2008/09 Kenya Demographic Health Survey (KDHS).

1.1. Purpose of the County Budget Health Analysis

The National and County budget analysis exercise was purposed to ascertain the apportionment of different sector budgets by national and selected county governments in Kenya, with a special focus on health budgets. The review sought to find out the allocations per vote head (between recurrent and development expenditures), with the aim that the findings will bolster health advocacy initiatives, both at the counties and at the national level.

The budget analyses focused on four specific objectives;

1. Review the 2013/14 budgetary priorities and allocations of the National and 5 County Governments to the health sector in relation to other sectors, with reference to national, and international commitments and policy frameworks.
2. Review the 2013/14 specific budgetary priorities and allocations by National and 5 County Government to the health sector with emphasis on monies earmarked for development and recurrent expenditure.
3. Provide analysis on the implication of the 2013/14 budgetary priorities and allocations on the delivery of healthcare services both for the National and 5 County Governments, in view of the deliverables of the Child Survival and Development Strategy, Constitution of Kenya 2010, Vision 2030 and MDGs 4, 5 and 6.
4. Provide guidelines and recommendations on best practices on health financing mechanisms

1.2. Method and Scope of Analysis

The study sought to interrogate the respective County Health budgets using different methods and levels, the initial level was guided by the following key questions;

1. Health Budget Allocation by the National and County Governments
2. Health Budget Allocation by major Healthcare Stakeholders within the Counties: identifying the major health care stakeholders in the respective counties; their Health Budget contribution to the County and what their contribution pay for.
3. Budget Allocation by Priority Areas namely: Child Health, HIV/AIDS and Nutrition

Subsequently, the study sought to understand budget allocation proportions in select counties through budget analysis by first analysing the design and policy structures to establish where money was allocated and by whom. At this level, a desk review of policy documents and reports was undertaken to ensure existing health policies were backed by budget commitments. Second entry point was to provide essential data for optimising health resource allocation and mobilisation, for identifying and tracking shifts in resource allocations (e.g. from curative to preventive, or from recurrent to capital expenditure), and for assessing equity and efficiency in a dynamic health sector environment. The final analysed the adequacy of the County health budgets against burden of disease and global health norms and standards.

1.3. General Findings of County Budget Analysis

Total health expenditure (THE) in absolute value has continued to vary each year since the introduction of the National health budget allocation and review. The budget and analysis review established varied budget allocations in each of the five Counties. The findings are based on the overall National, County allocations and other key stakeholders' allocations towards health services with the focus on key priority areas, namely: Child Health, HIV/AIDS, and Nutrition.

The overall government budget allocation to the Ministry of Health accounted for 3%, while the rest of the Ministries allocation is 97%. According to the Ministry of Health recurrent and capital health expenditure allocations, 38.34 % is highest allocation to Kenyatta National Hospital, followed by 17.93% to Moi Referral and Teaching Hospital. The Ministry of Health's capital health expenditure allocation towards Family Planning and Maternal and Child Health is 29.12% being the highest allocation, followed by Rural Health Centers and Dispensaries accounting for 13.23%.

In terms of National allocations by CRA 2013, the following were the allocations per County towards health services, Mandera – KES 160,000,000, Turkana - KES 610,000,000, Meru - KES 420,000,000, Bungoma - KES 1,027,000,000, and Wajir - 235,000,000. On review of the Counties' capital and development expenditure, Mandera allocated 53%, Turkana 64%, Meru 5%, Bungoma 28% and Wajir 60% respectively. The percentage budget allocation to Health Care for each of the

counties was; Mandera 3.8%, Turkana 12%, Meru 6.4%, Wajir 5.6% and Bungoma 12%. According to the per capita health expenditure, Bungoma County was the 8th largest spender among the top 10 counties in the country and had allocated 28% to development.

Kenya's Health budget also benefits largely from the contribution of development partners, NGOs and the private sector.

1.4. Conclusions

The health sector has been identified as one of the key components addressing equity; it is essential to the socio-economic agenda of the Economic Recovery Strategy (ERS) for Wealth and Employment Creation as well as to the social pillar of the Kenya Vision 2030. The mandate of the sector is to ensure that access to basic health services continues to be given priority, with strong emphasis on reaching the poor. In order to ensure that the poor have access to quality health care, the sector continues to emphasize the importance of allocating more resources to health promotion and prevention, while at the same time strengthening hospitals so that they can adequately serve as referral centers for the primary health services. Some of the challenges facing the health sector include:

- i. Insufficient skilled human resources, exacerbated by mal-distribution of available health personnel, with some rural dispensaries left unstaffed. The doctor and nurse to patient population ration is far below those recommended by the Kenya Essential Package for Health Services (KEPHS)
- ii. Inadequate budgetary allocations and clarity of allocations and contribution by key stakeholders involved in health care service delivery within the Counties. The counties and the country therefore does not meet both the requirements of the Abuja Declaration of 15% of Total Government Budget, the Economic Recovery Strategy/Vision 2030 requirement of 12% of GDP, and the WHO - Commission on Macroeconomics and Health (CMH) recommendation of USD34 per capita.
- iii. Inadequate and poorly maintained health and public infrastructure such as roads, electricity, water points, etc. jointly minimizing access to health care and discouraging health seeking behaviors.
- iv. The separation of Health obligations between the National and County Governments with guiding policies yet to be put in place –which has been cause for labor conflicts between the government and health workers
- v. The inability to fully monitor the operations of non-profits, which eventually leads to duplication of efforts, and wastage of health resources.

2. INTRODUCTION

2.1. Background

African countries are recording economic growth rates of around 5 to 6% per annum – on par with the rest of the world¹ – and policy improvements have brought greater stability to many countries. These positive trends in economic growth and stability are good news for efforts to reduce poverty and improve health in Africa.

However, sub-Saharan Africa still faces a grim scenario with respect to the health of its people. The region – home to 12 percent of the world’s population – accounts for 22 percent of the total global disease burden and more than 68 percent of the people living with HIV/AIDS². The region’s poor health status is mirrored by crises in health financing and human resources for health. With only 2% of the global health workforce and only 1% of the world’s health expenditures, sub-Saharan African countries are ill-equipped to adequately address their health problems. Low per capita income, limited capacity for domestic revenue mobilization, and pervasive health systems bottlenecks complicate governments’ ability to respond effectively to the health challenges in their countries. Even with substantial external assistance, large gaps remain between available and needed resources.

In Kenya, The health sector continues to be financed from three primary sources: public, private including households (consumers), and donors. According to the National Health Accounts (NHA 09/10), the total health expenditure in Kenya was equivalent to about 4.8 percent of GDP at current market prices, which translates to per capita health spending of approximately Ksh 1,987 (\$27) – falling below the CMH target of \$34 per capita. Households remain the largest contributors of health funds, at 35.9 percent, followed by the government, and then donors, who contribute approximately 30 percent. The high out of pocket household expenditures and the dependency on donors, especially for priority interventions, has prompted the government to embark on developing a health financing strategy. In the short term, the National Hospital Insurance Fund (NHIF) is undergoing restructuring to play a bigger role in financing health and a review is currently underway.

The ushering in of the devolved system of governance, enshrinement of health rights in the Constitution of Kenya 2010, and reforms in public management financing, offer significant opportunities for the development and improvement of the health sector in Kenya. The national government is now mandated to play an oversight role and health policy formulation while the county governments are charged with health service provision. To improve equitable access to essential health care services, both the county and national governments must be dedicated to meet the international threshold of 15% of their expenditure as stipulated in the Abuja declaration³, or the CMH target of \$34 per capita⁴.

In this report we will present findings of an analysis of the Health Budgets for Wajir, Mandera, Turkana, Bungoma, and Meru Counties, clearly identifying gaps and opportunities in health financing within these counties.

¹ OECD (Organisation for Economic Co-operation and Development) Development Centre and the African Development Bank. African economic Outlook

² World Bank - World Development Indicators 2008 (Washington, DC: World Bank, 2008). <http://ddp-ext.worldbank.org>.

³ The Abuja Declaration on HIV/AIDS, Tuberculosis, and Other Related Infectious Diseases - African Summit on HIV/AIDS, Tuberculosis, and Other Related Infectious Diseases. Abuja, Nigeria. April 24-27, 2001. http://www.un.org/ga/aids/pdf/abuja_declaration.pdf. Accessed February 4, 2014; Omondi, Nduta *et al*

⁴ WHO - Macroeconomics and Health: Investing in Health for Economic Development. Report of the Commission on Macroeconomics and Health (Geneva: 2001)

2.2. Method and Scope of Analysis

This study sought to interrogate the respective County Health budgets by asking the following questions;

a. Health Budget Allocation by the National and County Governments

- What is the allocation of health resources from the national government to the specific counties?
- What is the amount of resources allocated to healthcare by the respective county governments?
- What do these resources pay for?
- What percentage of the total county budgets constitutes healthcare resources?
- How much of these resources have been allocated to capital and recurrent expense lines?
- What are the significant gaps in the County Health Budget Allocations?

b. Budget Allocation by Priority Areas

- What is the budget allocation towards Child Health? What does it pay for?
- What is the budget allocation towards HIV/AIDS? What does it pay for?
- What is the budget allocation towards Nutrition? What does it pay for?
- For Wajir, Turkana and Mandera: What is the allocation towards WASH? What does it pay for?
- For Bungoma: What is the allocation towards Malaria? What does it pay for?

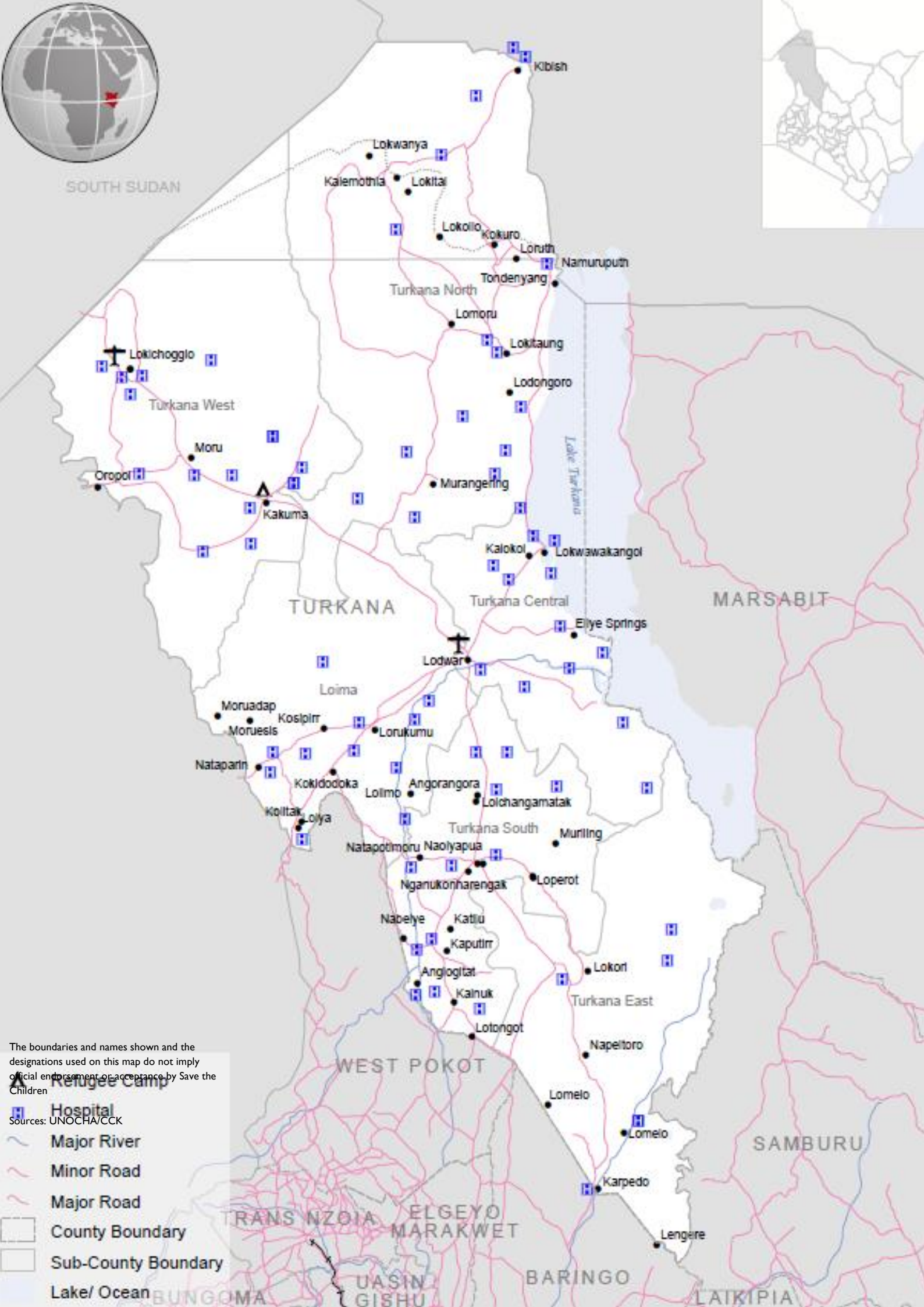
The study sought to understand budget allocation proportions in the select counties. The Analysis considered various levels or potential entry points for work. The **First level** of work was to analyse the design and policy structures, and look at where money is allocated and by whom. At this level, a desk review was undertaken to see whether the existing health policies were backed by budget commitments. A **Second entry** point was to provide essential data for optimising health resource allocation and mobilisation, for identifying and tracking shifts in resource allocations (e.g. from curative to preventive, or from recurrent to capital expenditure), and for assessing equity and efficiency in a dynamic health sector environment. And the **Third level** was to analyse the adequacy of the County health budgets against burden of disease and global health norms and standards.

The study results were derived from semi-structured interviews with key health officials at the Counties. The qualitative data derived from these interviews were supplemented by a survey of budget documentation, Health Situation reports, County Integrated Development Plans, Annual Health Work Plans, policy papers, and legislation, Health Surveys, County Appropriation Bills/Acts, and any similar past budget analysis reports. However, some government officials were reluctant to divulge budget information demanding that the study team seek a written authority from the Ministry of Health Head Quarters.

TURKANA COUNTY



SOUTH SUDAN



TURKANA

MARSABIT

WEST POKOT

SAMBURU

TRANS NZOIA ELGEYO MARRAKWET

UASIN GISHU

BARINGO

LATKIPIA

BUNGOMA

The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by Save the Children

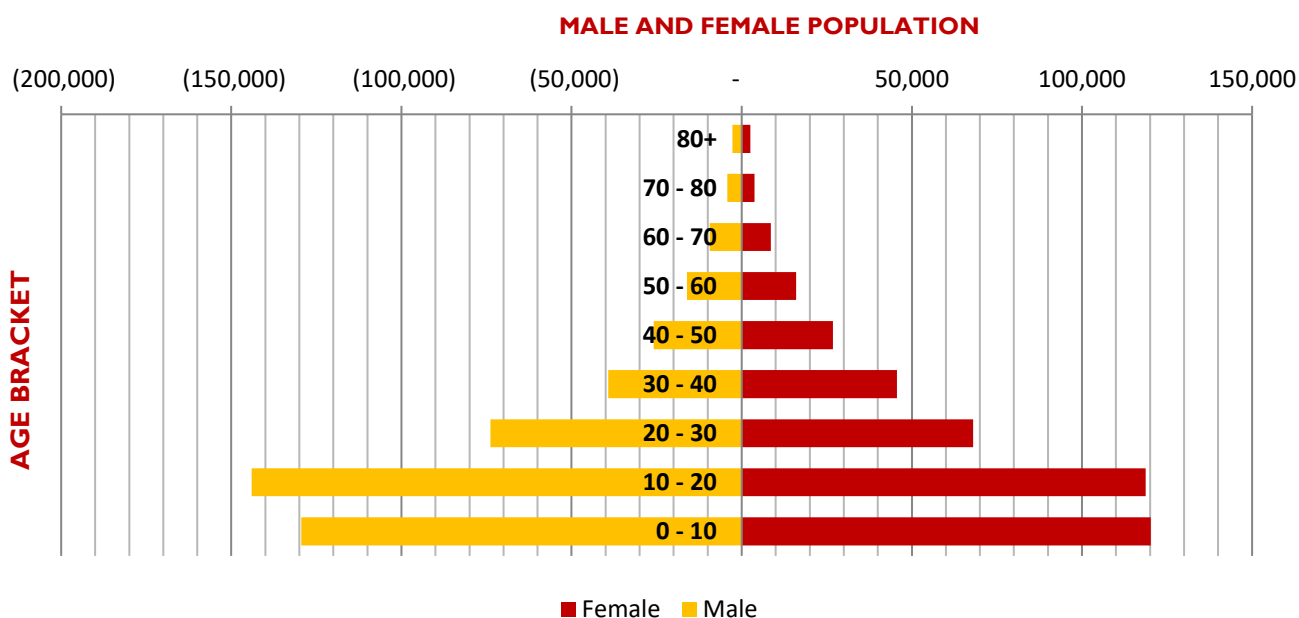
- Refugee Camp
- Hospital
- Major River
- Minor Road
- Major Road
- County Boundary
- Sub-County Boundary
- Lake/ Ocean

Sources: UNOCHA/CCK

HEALTH CONTEXT

Demographics

Turkana County has six constituencies and seven sub counties which are Turkana North, Kibish, Turkana Central, Loima, Turkana West, Turkana South and Turkana East, with a total population of 855, 399. The annual growth rate is 3.2% (KNBS 2009 census). The proportion of male to female is almost equal at 52:48 percentiles. There is marked population increase in the urban areas due to rural-urban migration, IDPs and the fact that a lot of people are choosing to drop pastoralism for commercial interests.⁵ The graph below shows the distribution of population, broken down by gender and age group.



Graph: Distribution of Population across gender and age groups;
Source: KNBS - Population Census 2009

Morbidity and Mortality

The common causes of morbidity and mortality are: Malaria, Respiratory Infections, Diarrhoeal diseases, Diseases of the skin, Eye infections, Pneumonia, Malnutrition, Urinary Tract Infections, and Ear Infections. Most communicable diseases are attributable to unsafe water, poor hygiene and sanitation, unsafe sex and malnutrition⁶.

The two tables below summarize how the county performs on critical (Impact Level) health indicators, and ranks the major causes of morbidity and mortality in the county.

⁵ Turkana County Integrated Development Plan 2013-2017

⁶ Turkana County Health Strategic and Investment Plan -2013/14-2017/18

Impact level Indicators	County Estimates
Life Expectancy at birth (years)	42
Annual deaths (per 1,000 persons) – Crude mortality	10.52
Client satisfaction Index	60%
Neonatal Mortality Rate (per 1,000 births)	31
Infant Mortality Rate (per 1,000 births)	60
Under 5 Mortality Rate (per 1,000 births)	74
Maternal Mortality Rate (per 100,000 births)	488
Adult Mortality Rate (per 100,000 births)	358
Total fertility rate (children per woman)	6

Table: Impact level Indicators.

Source: County Health Strategic Plan 2013-2017

Causes of Death				Causes of ill Health (disease or injury)			
National		County-specific		National		County-specific	
No	Condition	No	Condition	No	Condition	No	Condition
1	HIV/AIDS	1	Malaria	1	HIV/AIDS	1	Malaria
2	Perinatal conditions	2	Respiratory Diseases	2	Perinatal conditions	2	Respiratory
3	Lower respiratory infections	3	Diarrhoeal Diseases	3	Malaria	3	Diseases of respiratory infections
4	Tuberculosis	4	Diseases of skin	4	Lower respiratory infections	4	Diarrhoeal diseases
5	Diarrhoeal diseases	5	Eye infections	5	Diarrhoeal diseases	5	Malnutrition
6	Malaria	6	Pneumonia	6	Tuberculosis	6	HIV/AIDS
7	Cerebrovascular disease	7	Malnutrition	7	Road traffic accidents	7	Diseases of skin
8	Ischaemic heart disease	8	Urinary Tract Infections	8	Congenital anomalies	8	Accidents
9	Road traffic accidents	9	Accident including fractures	9	Violence	9	Eye infections
10	Violence	10	HIV/AIDS	10	Unipolar depressive disorders	10	Bites – Animal/human

Table: Causes of Mortality and Morbidity

Source: County Health Strategic Plan 2013-2017

Health Infrastructure

According to the County Health Strategic Plan, the 153 health facilities in Turkana County offer the following services: 63% offer services targeting elimination of Communicable diseases, 1.3% (2 facilities) services for halting, reversing the rise of Non Communicable diseases, 0.6% can offer services for Accident and Emergency Care, On Essential Health services-50% of the facilities can offer Integrated MCH/FP Services, 22% maternity services, 16% Laboratory services and 1.3% Imaging services among other essential services.

Facilities lack critical infrastructure like stores and Delivery rooms. Many facilities do not have sufficient waste disposal facilities as Incinerators, placenta pits. Only 10% of the facilities have access to computer services, 40% of the facilities have some source of power/electricity. Despite these significant gaps, 35% of the facilities have working service charters which demonstrate they are making efforts towards client satisfaction. There is need to improve on personnel, equipment and structures at level III downwards, in order to improve access to health services, and promote health seeking behaviours. This will also enable smooth functioning of community units.

Most health indicators in the county are lower than the national average and way lower than the WHO standards. The immunization coverage among < 5years stands currently at of 53%. Slightly over 20% of children under five have stunted growth and malnutrition. Family planning uptake is less than 20% and deliveries by skilled Birth attendants less than 9%. Unsafe water, poor hygiene and sanitation Latrine coverage is at 16%. Non Communicable Conditions are on the rise, increased Road Traffic Accidents, and Increased number of people on substance abuse and population growth straining the existing health system.

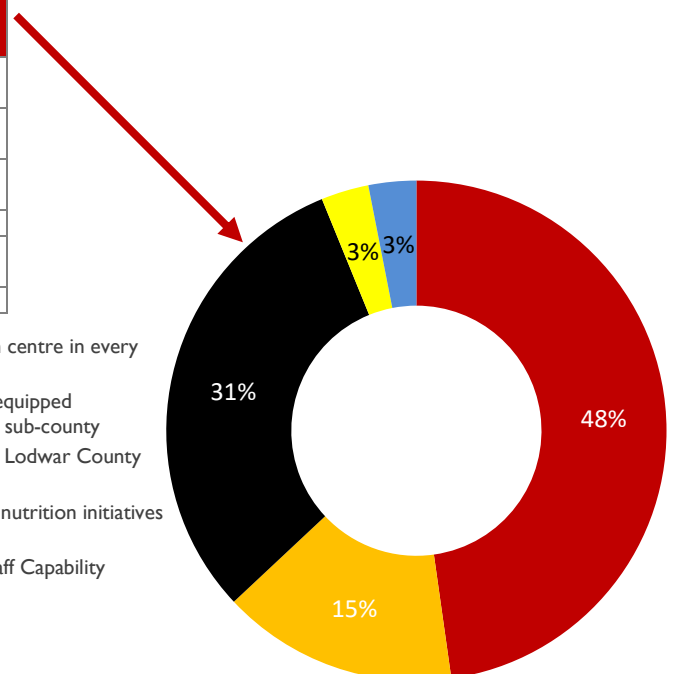
HEALTH BUDGET SUMMARIES & FINDINGS

According to the Turkana County Budget Estimates 203/2014, the priority of the county is to upgrade at least one health centre in each of the 10 sub-counties at a unit cost of Ksh. 10 million, which once completed will make up 48% of the Total Health Expenditure for the 2013/14 fiscal year. Lodwar County Hospital is allocated 31% of the total health development expenditure. Health emergency response is allocated 15 per cent, while the support for health and nutrition and medical staff capabilities contribute 3 per cent each.

Table & Chart: Breakdown of Turkana Health Development Budget |
Source: County Budget estimates 2013/14 fiscal year

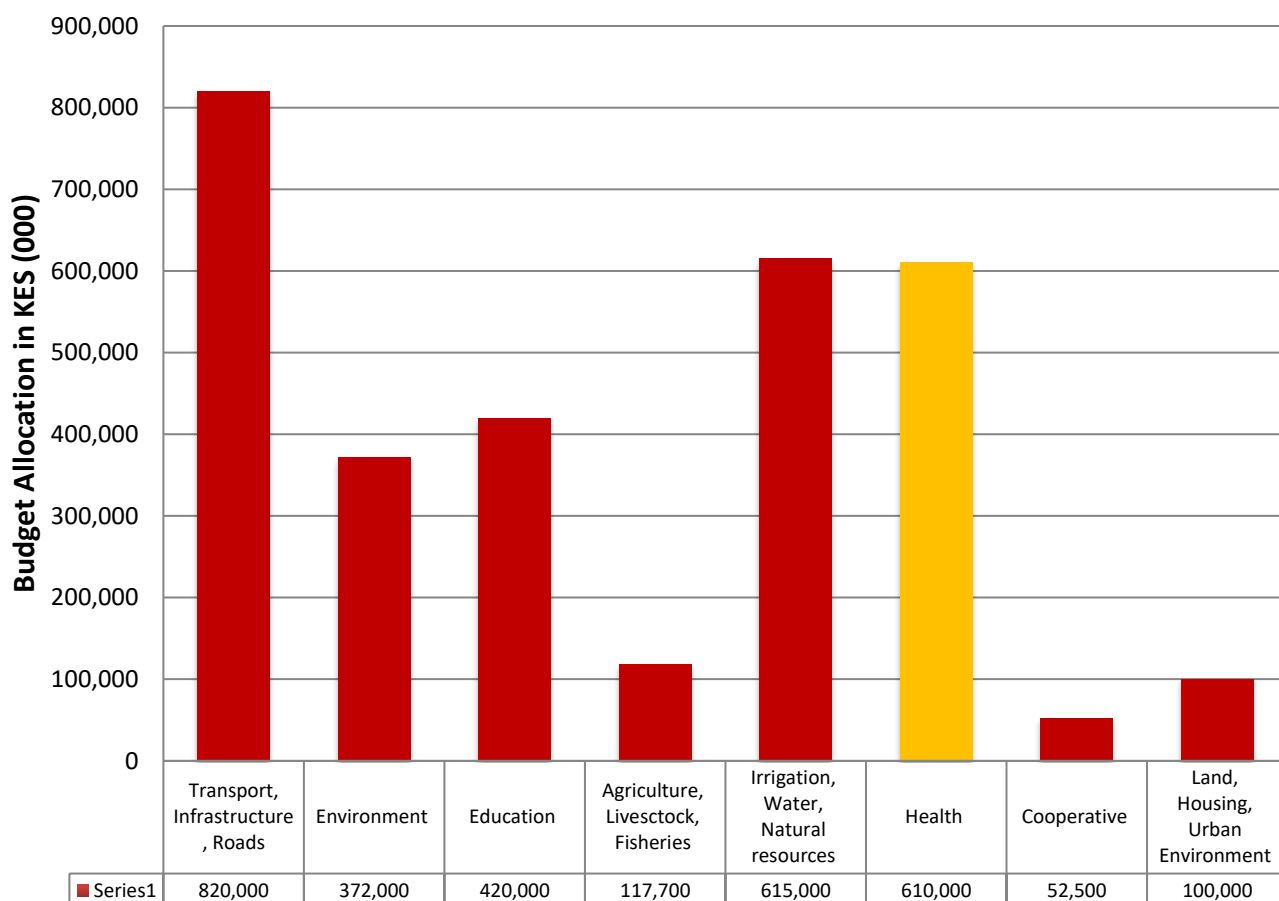
Turkana County Health Services and Sanitation	Allocation in KES	% Health Devt Budget
Upgrade at least one health centre in every Sub-county	310,000,000	47.77
Purchase of a fully equipped ambulance for each sub-county	99,000,000	15.25
Improve facilities in Lodwar County Hospital	200,000,000	30.82
Support health and nutrition initiatives	20,000,000	3.08
Support Medical Staff Capability initiatives	20,000,000	3.08
Total	649,000,000	100

- Upgrade one health centre in every sub-county
- Purchase of a fully equipped ambulance for each sub-county
- Improve facilities in Lodwar County Hospital
- Support health and nutrition initiatives
- Support Medical Staff Capability initiatives



Proportion of Budget from National Government

Turkana County was allocated a total of **KES 8,245,834,000**, by the Commission on Revenue Allocation for the 2013/14 Fiscal year. Of this allocation KES 5,275,000,000 (64%) was allocated to Capital/Development expenditure, and the rest went towards recurrent expenditure. Health Care took up **12%** of the Capital Expenditure budget and **7%** of the total County Budget.



Graph: Allocation of county development Budget Across sectors
Source: County Budget estimates 2013/14

Proportion of Health Service Expenditures vs. Management Support Expenditures

Based on the County Health Strategic plan, the county would require a total of KES 1,983,040,000 for Healthcare. This appropriation by far exceeds the GoK allocation of KES 610,000,000. However, the plan considers the contribution from User Fees, and the support of partners like WHO, UNICEF, MERLIN/SCI, EGPAF, WVK, USAID, GIZ, AMREF, IRC, APHIA Plus, DANISH AID, DFID, and UNFPA towards the budget deficit. These partners have been earmarked to support; the implementation of Community Strategy, Capacity Building, Food Program, Staff Employment, Infrastructure Development, HMIS, Health Products, and County Health Management. The study could not establish the exact amount of the Appropriations in Aid.

In the table below; the fact that security for health commodities and supplies has been projected to cost KES 860,000,000 while operations and other research have an allocation of KES 10,000,000 sure raises interests.

Domain	Area of Health	Sub-total in KES
Health Services	Eliminate Communicable conditions	573,480,000.
	Halt, and reverse increasing burden of Non communicable conditions	65,400,000.
	Reduce the burden of Violence & Injuries	155,000,000.
	Provide essential Medical services	143,400,000.
	Minimize exposure to health Risk factors	32,000,000.
	Strengthen collaboration with Health Related Sectors	0
SUB-TOTAL		969,280,000
Management support	Policy formulation and strategic planning	1,760,000.
	Ensuring security for commodities and supplies	860,000,000.
	Performance monitoring, and evaluation	122,000,000
	Capacity strengthening and retooling of Health Staff	0
	Resource mobilization and coordination of partners	20,000,000.
	Operations, and other research	10,000,000.
SUB-TOTAL		1,013,760,000.
OVERALL TOTAL		1,983,040,000.

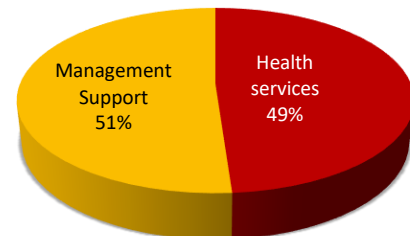


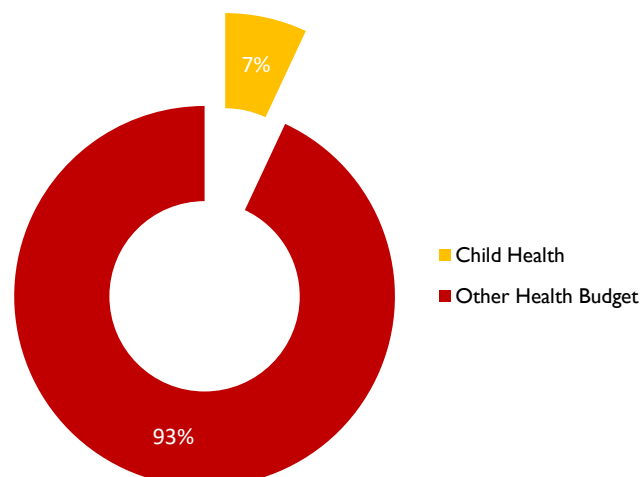
Table & Graph: Distribution of County Health Budget (Resource requirement)
Source: County Health Investment plan 2013/14

SUB-ACCOUNTS

CHILD HEALTH

The county has an estimated 167,327, children under the age of five, which makes up 17.3% of the total population. According to a review of the DHIS reports, the county has an infant Mortality rate of 60/1000 births, an under-five Mortality rate of 74/1000 births, A neonatal mortality rate of 31/1000births, a Maternal Mortality rate of 488/100,000 births, and a skilled delivery rate of 25%. Of these children, only 47% are fully immunized.⁷

The county health budget estimates indicate that a total of KES 138,000,000 was allocated towards Child Health Services. This makes up for 14.2% of the Health Services budget and 7% of the total county health budget for 2013/14 Fiscal year. A similar amount of money of allocated to providing Maternal and Newborn Services.



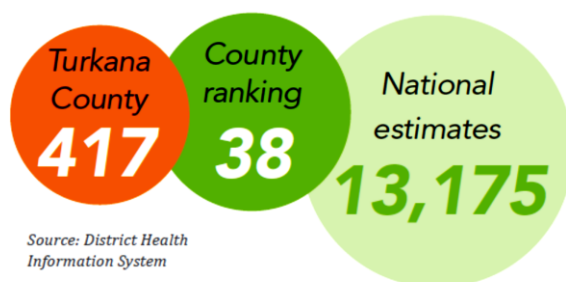
⁷ County Health Strategic Plan

HIV and AIDS

Accurately assessing the exact impact and prevalence and impact of HIV/AIDS in Turkana is a challenge due to the remoteness and vastness of the region, high mobility of the local population and security concerns. However, studies reveal that HIV awareness in Turkana has increased, with levels up to 98%, due to sustained national and regional HIV/AIDS information campaigns. However, the region has reported some of the highest HIV prevalence rates in the country in the last decade⁸.

Access to ARVs in Turkana is greatly hampered by the isolation and mobility of the nomadic community. According to the Kenya AIDS Indicator Survey of 2012, Turkana County has an HIV prevalence rate of 3.7% down from 4.1% recorded in 2007 and higher than the regional (North Rift) prevalence of 3.1%. There are approximately 51,214 people living with HIV in Turkana County, 13% of who are children. According to a 2011 County HIV Profile developed by NACC and UNAIDS, 97% of these children are in need of ARVs yet they are not under any treatment.

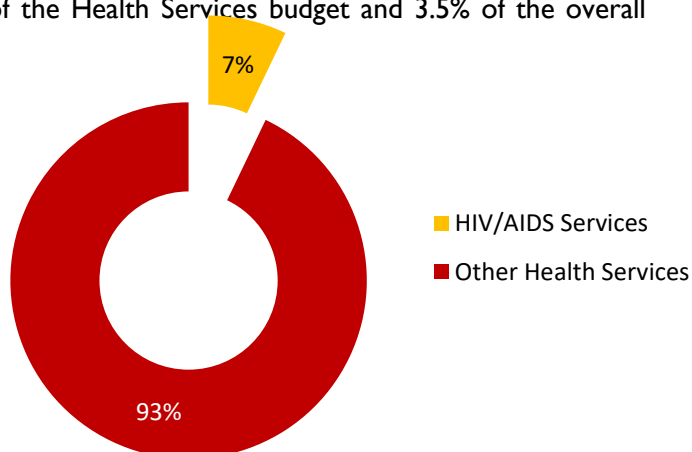
New HIV infections annually among children



Despite the huge importance of HIV testing as a way to increase prevention and treatment, about 68 per cent of people in Turkana County had never tested for HIV by 2009. There is a need to scale up HIV testing in the county, to counsel and reduce the risk for those who test negative, and to link those who test positive to care and treatment programmes. Few communities in Turkana County traditionally circumcise men, with only 25% of men who participated in a national survey in 2009 reporting that they had been circumcised. The practice should be scaled up, carried out under safe and hygienic conditions, and encouraged before sexual debut.

Kenya has committed to eliminating new HIV infections among children by 2015, while keeping their mothers alive. However, the challenge in Turkana is that 96% of HIV-positive pregnant women in Turkana County do not deliver in a health facility and Only 28 per cent of pregnant women attend the recommended four antenatal visits in Turkana County⁹.

The county health budget estimates indicate that a total of KES 69,000,000 was allocated towards HIV/AIDS Services. This makes up for 7.1% of the Health Services budget and 3.5% of the overall county health budget for 2013/14 Fiscal year.



⁸ IRC Report- AIDS in Turkana 2010

⁹ Turkana County HIV Profile-NACC/UNAIDS 2012

NUTRITION

According to Arid land resource management project (ALRMP), the County has four main livelihood zones. Nearly 60% of the population is considered pastoral, 20% agro pastoral, 12% fisher folks and 8% are in the urban/peri-urban formal and informal employments.

Turkana district requires continuous surveillance of nutrition situation due to its vulnerability to adverse climatic conditions such as drought and flooding. Malnutrition rates have significantly reduced in Turkana following heightened response in blanket supplementary feeding, nutrition and health outreach services, as well as general food distribution. Preliminary results of nutrition surveys released in December 2012 indicate that Global Acute Malnutrition (GAM) in Turkana has reduced from 37.4 per cent (in 2010) to 13.7 per cent, and Severe Acute Malnutrition (SAM) reduced from 9.4 per cent to 3.2 per cent within the same period.

The table below summarizes the County's Nutrition profile.

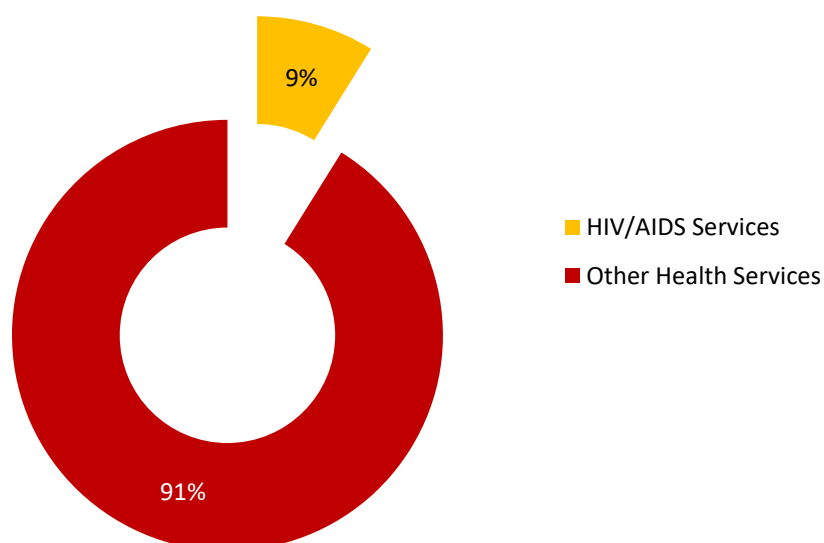
Table: County Nutritional Profile
Source: Inter-agency Nutritional Survey 2012 (WVK, MERLIN, UNICEF, GOK)

		Indicators used	Interpretation for Turkana County
Malnutrition		Children WHZ <-2SD	Critical
		Caretakers MUAC <23.0cm	High
Immediate causes			
	Food intake	Meal/day	Low
		Food diversity	Low
		Child milk consumption	Lower
	Diseases	Crude mortality rate	Emergency
		Under five mortality rate	Emergency
		Morbidity-High prevalence of Malaria, ARIs and Diarrhoea	High
Underlying causes			
	Current Household Food Security	Relief food distribution i-June 2012 BSFP Cycle 5- ended in April 2012	None None
		Milk availability	Lower than past months
		Pastoralist Purchasing power Agropastoral- Reduced harvests Fisheries- Markets migrated from Todonyang Casual Labour- Higher food prices	Decreased
		Income source	Shifted to temporary sources
		Livestock asset base	Fair/Good
		Coping strategies	Poor
	Health/Water/Sanitation	Sanitation	Poor
Inadequate Vit. A supplementation/Deworming		Poor	
Access to safe water		Medium/Low	
Health services/personnel/drugs		Inadequate	

HINI Implementation			
		Iron Supplementation for pregnant women	Poor
		Zinc Supplementation for diarrhoea	Poor
		Appropriate Handwashing practice	Poor
		Deworming for 12-59m	Poor
Underlying causes			
	Social Care Practices	Prelacteals	Poor
		Early introduction of complementary foods	Poor
		Timely initiation of breastfeeding	Poor
	Health/Water/Sanitation	Sanitation	Poor
		Vaccination coverage	Satisfactory
		Utilization of safe (treated) water	Medium/Low
		Water quantities/person	Inadequate

According to the 2013 Kenya Emergency Humanitarian Response Plan, the major Nutrition partners in the county are UNICEF, IRC, World Vision and MERLIN/SCI. Collectively these partners appropriated a total of **KES 740,865,040** although this analysis was unable to establish exactly how much was raised or expensed.

Regarding public allocations, the county health budget estimates indicate that a total of KES 86,000,000 was allocated towards Nutrition Services. This makes up for 8.8% of the Health Services budget and 4.3% of the overall county health budget for 2013/14 Fiscal year.



WAJIR COUNTY



ETHIOPIA



MANDERA

MARSABIT

Gurar
Danaba

Bur Mayo

Wajir North

Ajao

Buttelu

Buna

Eldas

Eldas

Tarbij

El Ben

Khorof Harar

Tarbij

Girifu

Wajir East

Wagalla

Wajir

Wajir West

WAJIR

SOMALIA

ISILOLO

Habaswein

Wajir South

Dif

Abakore

Sarif

Biyamathow

Sabuli

GARISSA

▲ Refugee Camp
The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by Save the Children

Hospital
Major River
Minor Road
Major Road
County Boundary
Sub-County Boundary
Lake/ Ocean

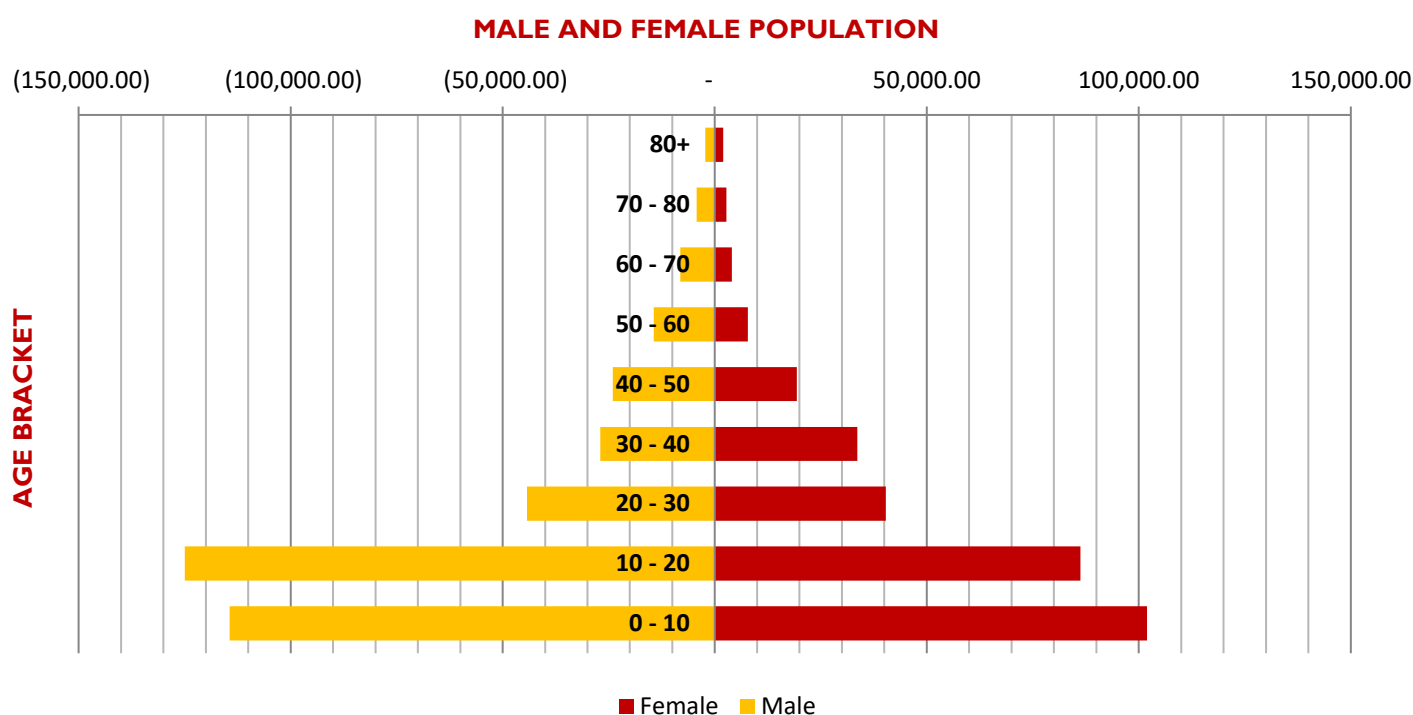
Sources: UNOCHA/CCK

HEALTH CONTEXT

Demographics

Wajir County comprises of six sub-counties namely Wajir East, Tarbaj, Wajir West, Eldas, Wajir North and Wajir South. These units are further divided into 28 divisions, 128 locations and 159 sub-locations.

Projections from the Kenya 2009 Population and Housing census indicate that the county has a total population of 727,965 which is projected to be 852,963 in 2017. Males comprise 55 per cent of the population whereas female population account for 45 per cent. The county has an inter-censal growth rate of 3.22 per cent which is higher than the national population growth rate of 3.0 per cent. The average county population density stands at 13 persons per square kilometre.



Graph: Distribution of Population across gender and age groups;
Source: KNBS - Population Census 2009

Morbidity & Mortality

The morbidity rate is 16.3% with men and women accounting for 14.4 per cent and 18.3 per cent respectively. The most five prevalent diseases are; Malaria 54.8 per cent, flu 7.2 per cent, diarrhoea 5.8 per cent, respiratory diseases 5.2 per cent, and stomach-ache 4.8 per cent¹⁰.

Health Infrastructure

There are 80 public health facilities, 27 private facilities and 2 facilities run by NGO/missions. The county has 10 level IV hospitals, 26 level III health centers, 46 level II health centers, 46 dispensaries and 24 clinics. According to the 2005/2006 KIHBS, 95.9 per cent of the population has to cover

¹⁰ County Health Sector Plan 2013/14-2022/23

more than 5 Km to access a health facility and only 4.1 per cent access a health facility within less than 1Km. The HIV prevalence rate is 0.9 per cent.

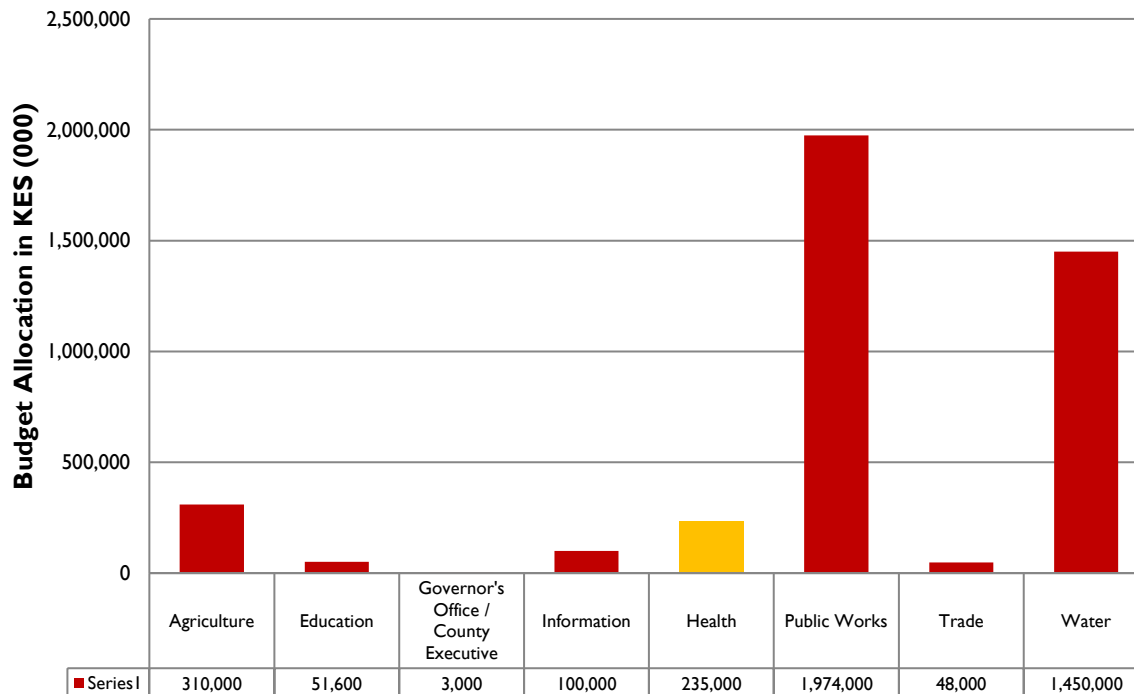
The county is served by 5 doctors, 175 nurses and 625 community health workers. The doctor patient ratio is 1:132,000 compared to internationally recommended standards of 1: 5,000. The nurse to patient ratio is 1:4,163¹¹. The County has a total bed capacity of 358.

Family planning and contraceptive prevalence is very low with only 4 per cent of married women using modern methods of family planning. This low uptake of family planning is attributed to cultural beliefs and practices in the community. This has led to high population growth and increase in poverty due to unplanned families which strain on the local resources. Efforts must be made to encourage uptake of family planning services in line with the national goal for population growth control.

HEALTH BUDGET SUMMARIES & FINDINGS

Wajir County was allocated a total of **KES 6,928,942,000** by the Commission on Revenue Allocation as the overall budget for the 2013/14 Fiscal year, out of which 60% (KES 4,171,600,000) was aligned for development expenses and the rest for recurrent expenses – read County Personnel and County operations. The Health Sector received an allocation of KES 235,000,000 which translates into **5.6%** of the Development budget and **3.4%** of the overall Public county budget.

Table below shows the allocation to the Health Sector in comparison to other sectors.



Graph: Allocation of county development Budget Across sectors
Source: County Budget estimates 2013/14

¹¹ County Health Sector Plan 2013-2023

Proportion of Health Service Expenditures vs. Management Support Expenditures

Table below is a summary of the Wajir Health sector resource requirement for the financial year under review. Please note that Capital Health expenses have only been allocated 16% compared to 58% on Maintenance and Operation. The study team was unable to obtain a breakdown of these Maintenance and Operation costs.

Particulars	Allocation in KES
Personal Emoluments and Related expenses for Departmental staff	372,140,000
Maintenance, Operation	812,054,000
Capital Expenditure for Health Services	218,700,000
Gross Health Resource Requirement FY2013/14	1,402, 894,000

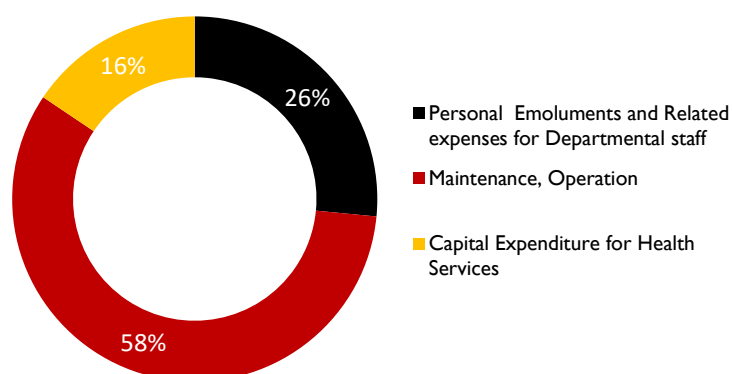
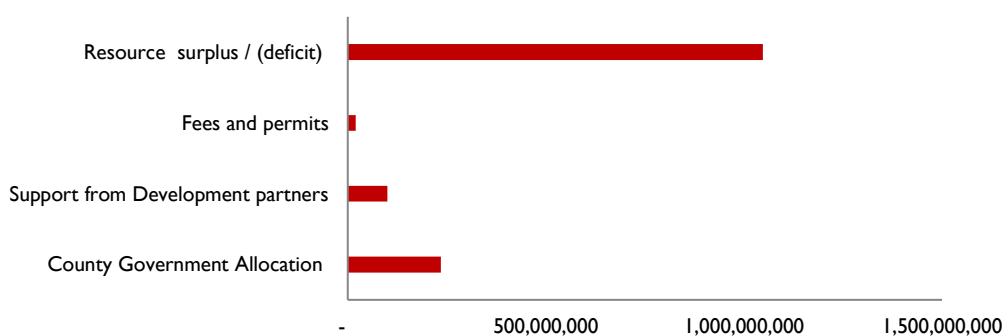


Table & Graph: Distribution of Health Resource requirements 2013/14
Source: County Health Sector Plan 2013-2023

This budget is certainly beyond the public allocation of KES 235,000,000 from the CRA. To address the extremely large deficit, it is expected that development partners will greatly supplement the health expenditure. Some little resources will also be raised from user fees and permits. Despite the projected contribution of partners there would still be a deficit of over KES 1 billion which then creates the need to interrogate the health planning and budgeting process.



County Government Allocation	235,000,000
Support from Development partners	100,000,000
Fees and permits	20,000,000
Gross Revenue	355,000,000
Resource Deficit	(1,047,894,000)

The major Health partners in the county are; Save the Children, Islamic Relief, WFP, ALDEF, WASDA, UNICEF, AMREF, APHIA Plus *Imarisha*, and World Vision Kenya.

In light of the deficit, the County's health department realigned the budget to limits that are achievable. The table below shows the 2013/14 working budget for Wajir County Health Department.

Table: Wajir County Health Budget
Source: County Budget Estimates

ITEM	AMOUNT in KES
Cleaning and Detergents	200,000
Refurbishment of buildings	500,000
HIV/AIDS Programs	1, 000,000
Care and Burial of Animals	500,000
Provision of litter bins	500,000
Drugs and Vaccines	200,000,000
Child Health	2,000,000
Maintenance of Dumpsite	5,000,000
Maintenance of Slaughter Slab	3,600,000
Maintenance of Cemetery	1,500,000
Maintenance of Public toilets	1,000,000
Sub Total – Recurrent	243,700,000
Construction of Dispensaries	75,000,000
Ambulances	150,000,000
Establishment of Dumpsite in Wajir for Biodegradable waste	10,000,000
Sub-Total - Capital	235,000,000
Total Budget (in KES)	478,700,000

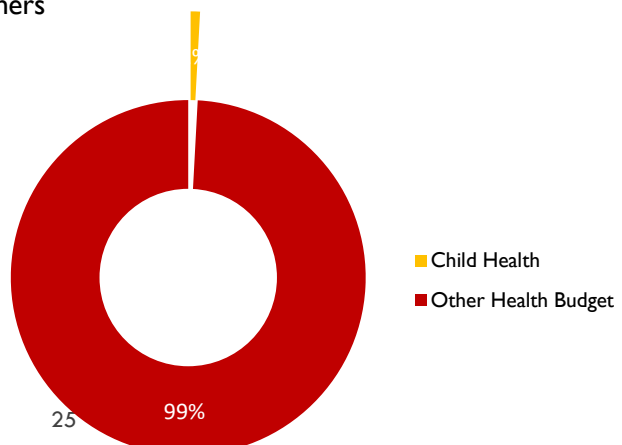
SUB-ACCOUNTS

The Health budget estimates for Wajir have been structured in a way that makes it difficult to establish the exact amounts of resources allocated to these priority areas, as a result some of the figures under the priority areas below may merely be indicative. Nonetheless, below is the summary of how the county performs on the various priority areas.

CHILD HEALTH

According to 2008-09 KDHS, 48 per cent of the children aged 12-23 months received all basic recommended vaccinations. This can be attributed to the long distance to the health facilities and the high illiteracy levels among the residents. There is therefore the need for initiatives towards providing immunization services closer to the people through mobile clinics and mass immunization campaigns. The DHIS projects and an immunization coverage of 56% for 2013/2014.

Child Health was allocated a total of KES 2,000,000 but it is important to note that this is a cohort that receives a lot of support from Health Partners



HIV and AIDS

By the end of 2011, there were 810 people living with HIV in Wajir County. Children constitute 13% of those living with HIV in the county.

Table: HIV Burden in Wajir
Source: NACC/UNAIDS County HIV Profiles

		Rank*
Total population (2009)	661,941	20
HIV adult prevalence (overall)	0.2%	1
Number of adults living with HIV	677	1
Number of children living with HIV	133	2
Total number of people living with HIV	810	1

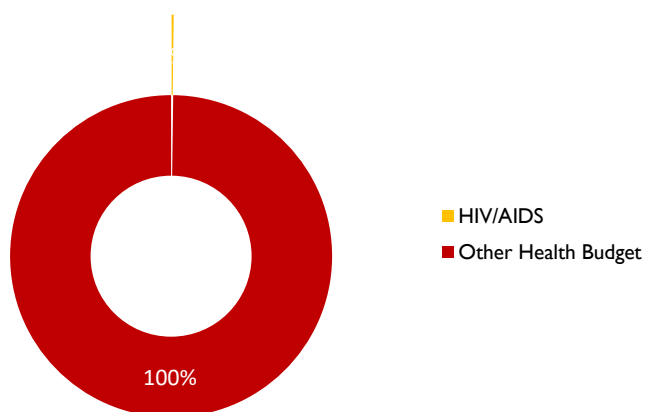
Over the years, very low levels of HIV infection have been reported for both men and women in Wajir County. In Kenya generally, women are more vulnerable to HIV infection than men.

There is a need to scale up HIV testing in the county, to counsel and reduce the risk for those who test negative, and to link those who test positive to care and treatment programmes. about 85 per cent of people in Wajir County had never

tested for HIV by 2009.

94% of HIV-positive pregnant women in Wajir County do not deliver in a health facility, and Only 44 per cent of pregnant women attend the recommended four antenatal visits. 92% of children living with HIV in Wajir County in need of antiretroviral therapy (ART) are not under treatment. Most communities in Wajir County traditionally circumcise men, with over 97 per cent of men who participated in the KAIS 2012 reported that they had been circumcised. Even in traditionally circumcising communities, the practice should be carried out under safe and hygienic conditions and encouraged before sexual debut.

The budget allocation to HIV/AIDS of KES 100,000,000 is less than one percent of the County Health budget was less



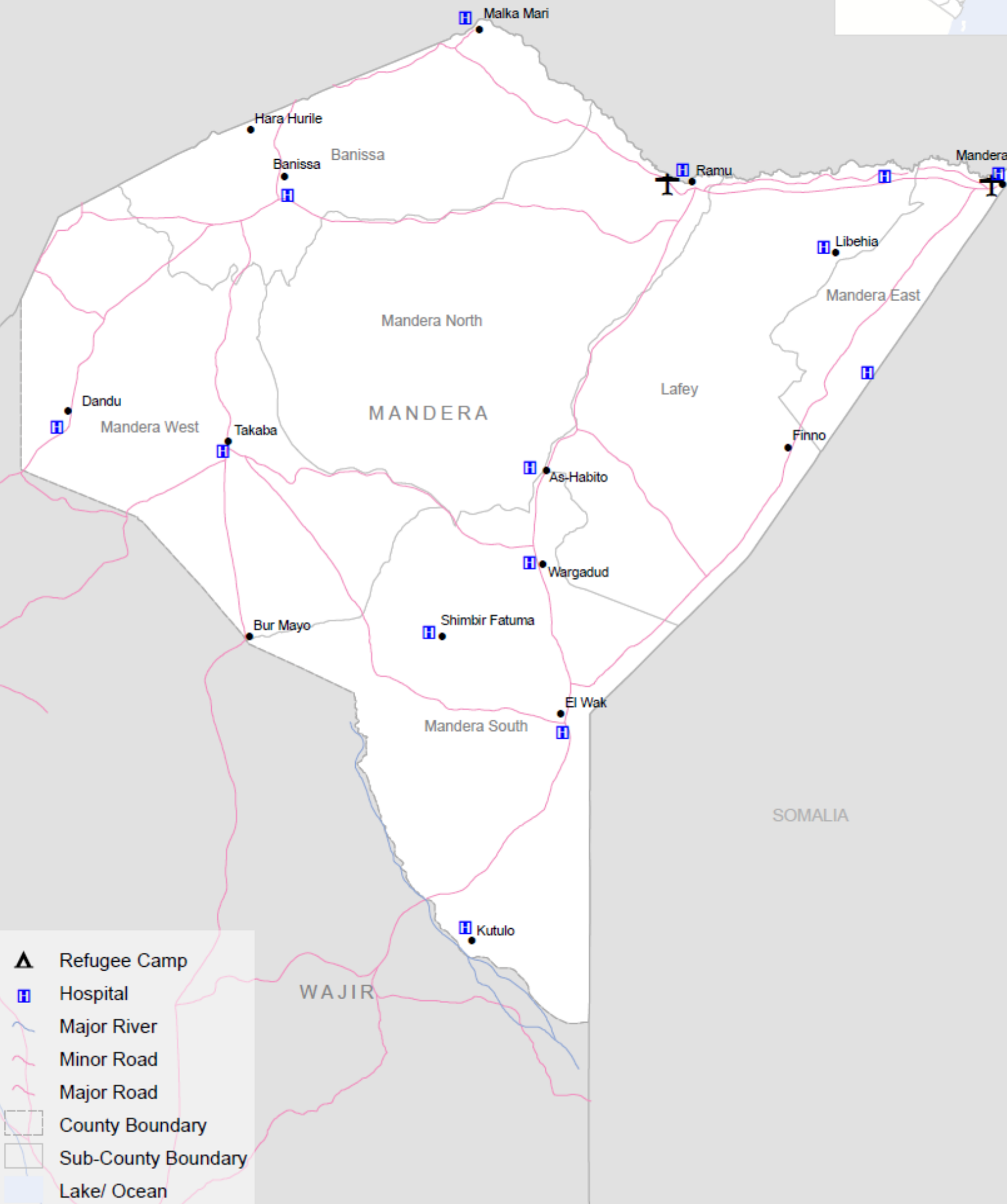
NUTRITION

The nutrition status is poor, which in turn reduces the residents' labour productivity and hence are subjected to a cycle of food insecurity and dependence on relief food. According to the KDHS (2008-09) 35 per cent of children under age five in the county are stunted. Stunting is a sign of chronic malnutrition. The 35 per cent is high and there is need for deliberate efforts to reduce this figure. The prevalence of acute malnutrition in wajir south district is considered "critical" with global acute malnutrition (GAM) of 23.1 (19.5-27.3 95% C.I.) and Severe Acute Malnutrition (SAM) rate of 4.6 % (3.5-6.2 95% C.I.). Compared with the survey undertaken in 2011 which indicated GAM of 28.5% (24.4-33.0 95% CI) and SAM of 4.5% (2.7-7.4), the acute malnutrition rates have reduced though not statistically significant due to overlapping confidence intervals.

MANDERA COUNTY



ETHIOPIA



Malka Mari

Hara Hurile

Banissa

Banissa

Ramu

Manderla

Libehia

Manderla East

Manderla North

Lafey

Dandu

Manderla West

Takaba

MANDERA

As-Habito

Wargadud

Finno

Bur Mayo

Shimbir Fatuma









Manderla South

El Wak

SOMALIA

Kutulo

WAJIR

-  Refugee Camp
-  Hospital
-  Major River
-  Minor Road
-  Major Road
-  County Boundary
-  Sub-County Boundary
-  Lake/ Ocean

HEALTH CONTEXT

Demographics

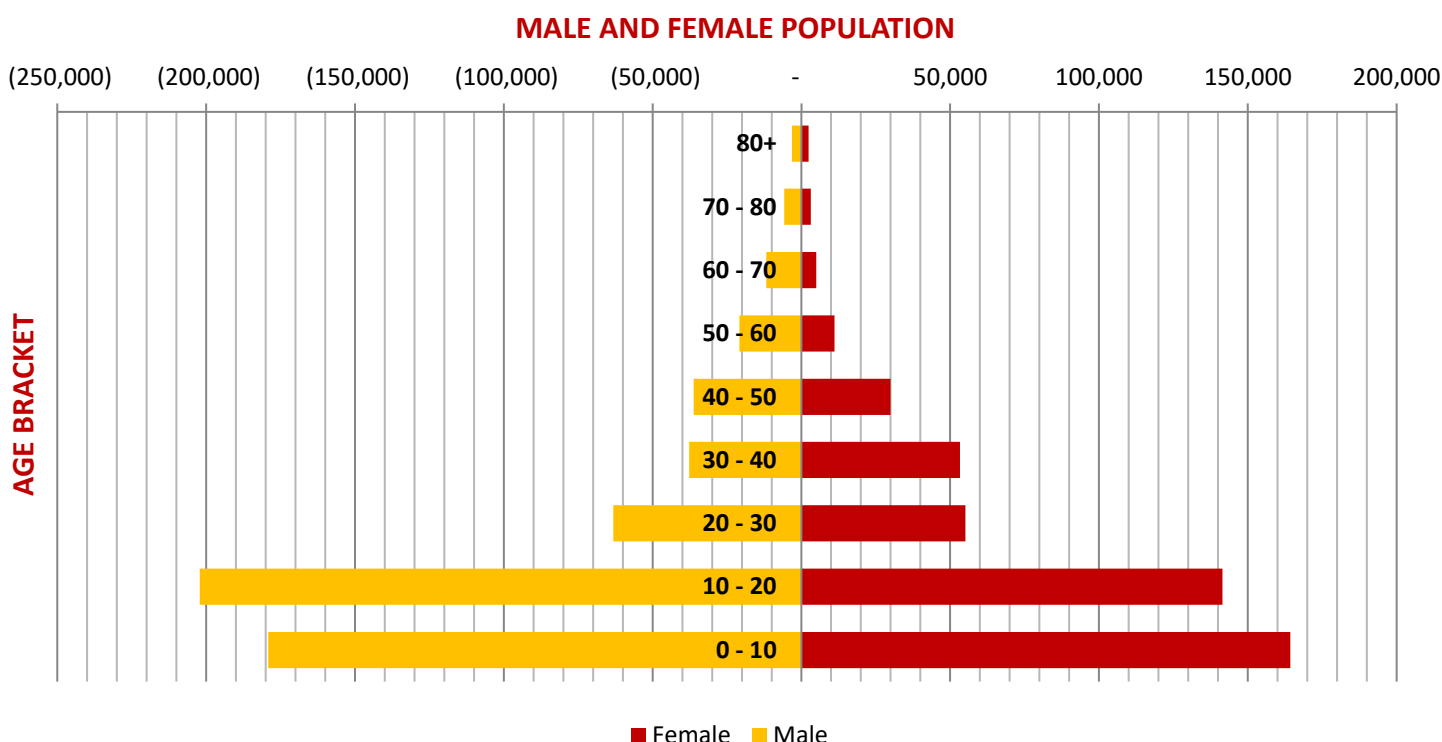
Mandera County covers 25,991 sqkm. Total population 1,025,756, (KNBS 2009), females account for 465,813 while males are 559,943. Mean annual rainfall of 255mm. Mean temperature is 28 degrees Celsius. Main residents are Somali Muslims, pastoral community; there are few urban centers at water points. The main economic activities are: livestock keeping, trade, agro pastoralism. The county has six sub counties and six parliamentary constituencies, 30 wards, 148 villages. It shares international borders with Ethiopia to the north, Somalia to the east and nationally borders with Wajir County to the south¹².

The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by Save the Children
Sources: UNOCHA/CCK

SUBCOUNTY	MALE	FEMALE	TOTAL
Mandera west	87249	74452	161,701
Banisa	87558	70516	158,074
Mandera east	123,626	102,264	225,890
lafey	35931	26866	62,797
Mandera central	147,085	129,199	276,284
Mandera north	78,354	62,516	140,930

Table: Population distribution by Sub-County
Source: Mandera County CIDP

This population is distributed across gender and age groups as indicated in the graph below.



¹² Mandera Country Integrated Development Plan

Morbidity and Mortality

The five most common diseases in order of prevalence are Perinatal conditions, Diarrhoeal diseases, Lower Respiratory Infections, Dengue fever and Tuberculosis.

The two tables below summarize how the county performs on critical (Impact Level) health indicators, and ranks the major causes of morbidity and mortality in the county.

Table: Causes of Morbidity and Mortality
Source: County Health Strategic Plan 2013-2017

Causes of death				Causes of ill health (disease or injury)			
National		County-specific		National		County-specific	
No	Condition	No	Condition	No	Condition	No	Condition
1	HIV/AIDS	1	Perinatal conditions	1	HIV/AIDS	1	Perinatal conditions
2	Perinatal conditions	2	Diarrhoeal diseases	2	Perinatal conditions	2	Diarrhoeal diseases
3	Lower respiratory infections	3	Lower respiratory infections	3	Malaria	3	Lower respiratory infections
4	Tuberculosis	4	Violence	4	Lower respiratory infections	4	Dengue fever
5	Diarrhoeal diseases	5	Obstetric complications	5	Diarrhoeal diseases	5	Tuberculosis
6	Malaria	6	Malnutrition	6	Tuberculosis	6	Urinary tract infection
7	Cerebrovascular disease	7	Cerebrovascular disease	7	Road traffic accidents	7	Ear infections
8	Ischaemic heart disease	8	Malaria	8	Congenital anomalies	8	Road traffic accidents
9	Road traffic accidents	9	Tuberculosis	9	Violence	9	Violence
10	Violence	10	Road traffic accident	10	Unipolar depressive disorders	10	Malaria

Table: Impact level Indicators.
Source: County Health Strategic Plan 2013-2017

Impact level Indicators	County estimates
Life Expectancy at birth (years)	60
Annual deaths (per 1,000 persons) – Crude mortality	57/1000
Neonatal Mortality Rate (per 1,000 births)	-
Infant Mortality Rate (per 1,000 births)	57/1000
Under 5 Mortality Rate (per 1,000 births)	74/1000
Maternal Mortality Rate (per 100,000 births)	488/100,000
Adult Mortality Rate (per 100,000 births)	■

Health Infrastructure

According to the County Health Investment plan, the County has 1 county referral hospital, 5 sub county hospital, 37 primary health care facilities including (3 model health centers). Two community unit in Mandera west and Banisa, 1 faith based organization facility, and 30 private facilities in the entire county (6 nursing homes and 24 clinics).

The county has a doctor/population ratio is 1:114,000 while the nurse/population ratio is 1:25,000, and evidently has a serious shortage of health personnel. The table below shows the available health staff against the number required based on KEPHS norms and standards.

STAFF CADRE	AVAILABLE	REQUIRED	STAFF CADRE	AVAILABLE	REQUIRED
Medical officers	7	30	Administrators	4	6
Dentists	0	6	Clinical Officers (specialists)	6	60
Dental Technologists	0	12	Clinical Officers (general)	17	120
Public Health Officers/ Technician	14	56	Nursing staff (KRCHNs)	67	300
Pharmacists	4	12	Nursing staff (KECHN)	15	45
Pharm. Technologist	4	18	Laboratory technicians	0	30
Lab. Technologist	19	54	Community Oral Health Officers	0	12
Orthopedic technologists	0	6	Secretarial staff / Clerks	6	18
Nutritionists	3	12	Attendants / Nurse Aids	0	100
Radiographers	2	12	Cooks	5	16
Physiotherapists	1	12	Cleaners	19	200
Occupational Therapists	2	12	Security	8	150
Plaster Technicians	2	12	Community Health Extension Workers (PHT's, social workers, etc)	30	90
Health Records & Information Officers	2	12	Community Health Workers	80	240
Medical engineering technologist	1	6	Other (specify)- Consultants - Radiographer Obs / Gyn, Surgeon, Physician	0	5
Medical engineering technicians	0	12	Drivers	6	18
Mortuary Attendants	1	12	Accountants	3	6

Table: Outlook of Health Personnel
Source: County Health Strategic Plan 2013-2017

The average facility coverage is 30kms and even then the roads are in deplorable state and means of transport is unreliable and unaffordable to many. 80% of the residents of the county live below poverty line

The quality of health care is generally poor due to the shortage of health care workers. The county has in the recent past had high staff turnover due to seasonal insecurity, poor transport network, climatic, inadequacy of essential social amenities.

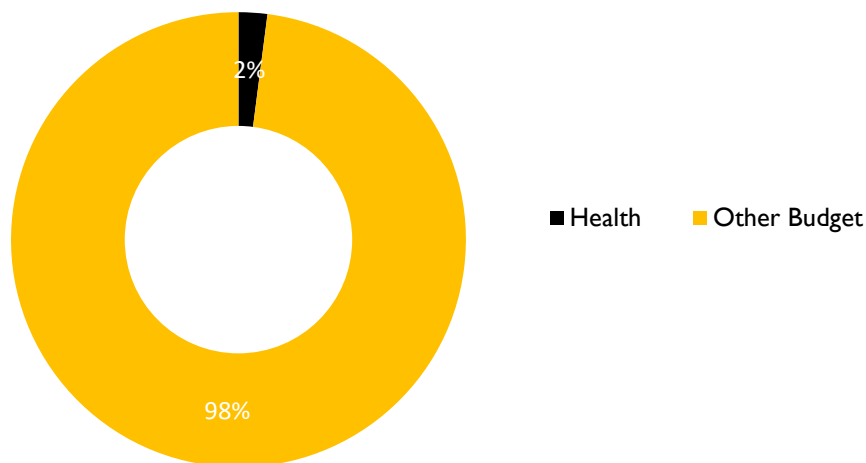
Lack of equipment and essential supplies has hampered provision of quality care across the health centers, dispensaries and referral hospitals, consequently resulting into poor health seeking behaviors by the communities of this county.

Poor health care financing in general has led to the deterioration of service delivery. The Poor social economic status and high level of illiteracy has worsened the situation.

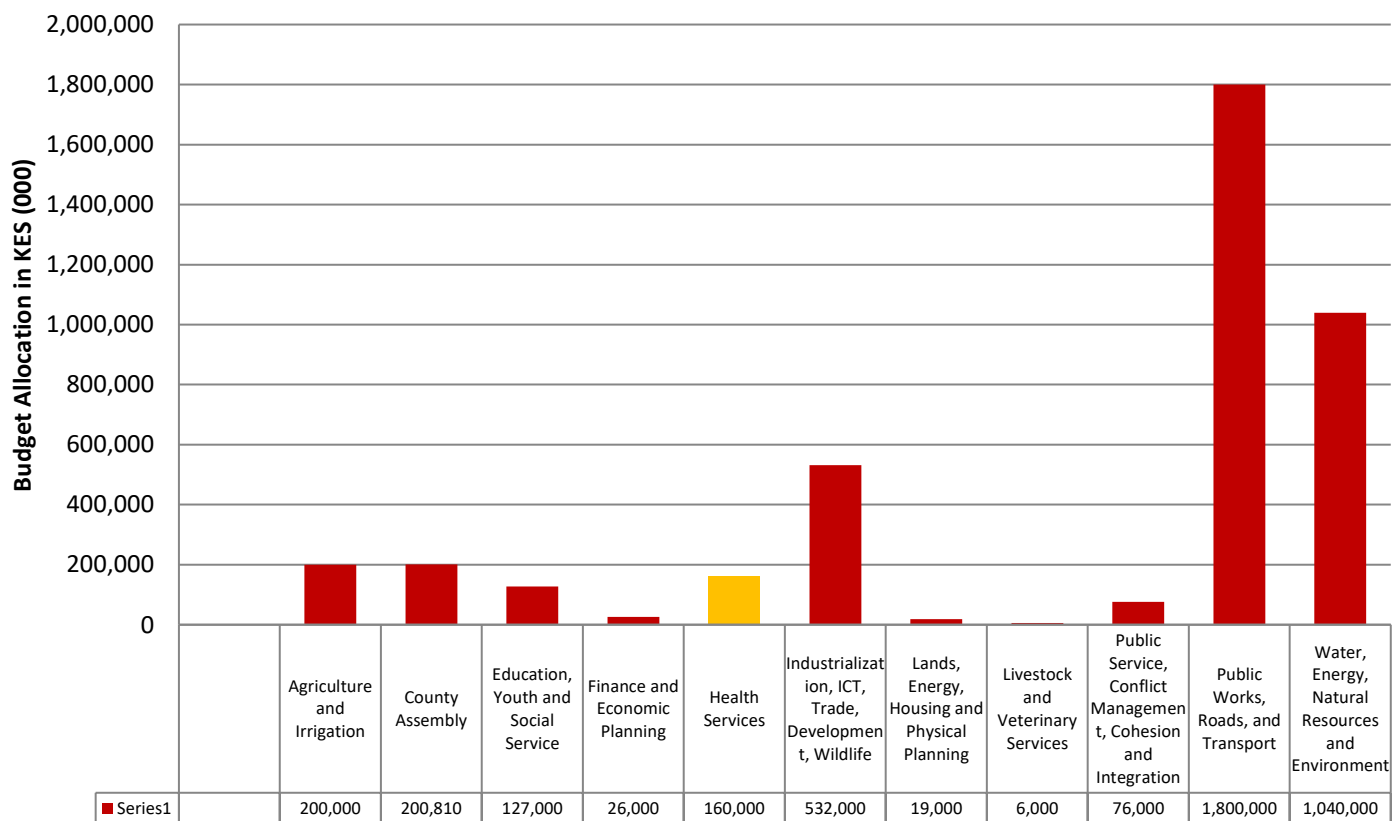
HEALTH BUDGET SUMMARIES & FINDINGS

Mandera County was allocated a total of **KES 7,842,858,000**, by the Commission on Revenue Allocation for the 2013/14 Fiscal year. Of this allocation KES 4,186,810,000 (53%) was allocated to Capital/Development expenditure, and the rest went towards recurrent expenditure. Health Care took up **3.8%** of the Capital Expenditure budget and **2%** of the total County Budget.

Chart: Proportion of Health Budget in the County Budget Estimates 2013/14



Graph: Proportion of Health Budget in relation to other Sectors



Proportion of Health Service Expenditures vs. Management Support Expenditures

The tables below summarize the overall Health Budget Appropriation for 2013/2014. As do the rest of the counties, there are certainly very wide financing gaps. This is one of the counties with the lowest county budget allocation to healthcare at only KES 160,000,000. In addition, they have an allocation of KES 28,800,000 from the Health Sector Service Fund (HSSF) and intend to raise KES 12,000,000 from user fees. It was not clear if they will receive any allocations from the various Constituency Development Funds.

Budget Area	Activity/Item	Amount in KES (000)
Service delivery	Community services	62,000
	Outreach services	30,080,
	Supportive supervision to lower units	12,000
	On the job training	12,000
	Emergency preparedness planning	16,000
	Patient Safety initiatives	6,000
	Therapeutic committee meetings and follow up	504
	Clinical audits (including maternal death audits)	864
	Referral health services	14,716
SUB-TOTAL-A		154,164

Health Infrastructure (physical infrastructure, equipment, transport, ICT)	Physical infrastructure: construction of new facilities	30,000
	Physical infrastructure: expansion of existing facilities	60,000
	Physical infrastructure: Maintenance	30,000
	Equipment: Purchase	75,000
	Equipment: Maintenance and repair	11,000
	Transport: purchase	42,000
	Transport: Maintenance and repair	6,000
	ICT equipment: Purchase	2,000
	ICT equipment: Maintenance and repair	1,000
SUB-TOTAL - B		157,000

Health Workforce	Recruitment of new staff	75,000
	Personnel emoluments for existing staff	230,000
	Pre-service training	6,000
	In service trainings	24,000
	Staff motivation	72,000
SUB-TOTAL - C		407,000

Leadership and Governance	Annual health stakeholders for a	900
	Quarterly Coordination meetings	300
	Monthly management meetings	864
	Annual Work Planning and reporting	2,400
SUB-TOTAL - D		4,364

Health information	Data collection: routine health information	1,200
	Data collection: vital events (births, deaths)	8,000
	Data collection: health related sectors	6,000
	Data collection: Surveillance	6,000
	Data collection: Research	1,000
	Data analysis	1,000
Information dissemination	500	
SUB-TOTAL - E		23,700

Health Products	Procurement of required health products	520,000
	Warehousing / storage of health products	5,000
	Distribution of health products	6,000
	Monitoring rational use of health products	2,000
SUB-TOTAL - F		533,000
Health Financing	Costing of health service provision	550
	Resource mobilization	712
	Health expenditure reviews	612
SUB-TOTAL - G		1,874

Total County Health Appropriation FY 2013/14
(A+B+C+D+E+F+G) = **KES 1,281,102,000**

Source: County Health Strategic and Investment Plan

The key International partners expected to contribute to the huge health budget deficit include, The Clinton Foundation, DANIDA, JICA, GIZ, DFID, UNFPA, UNICEF, UNAIDS, ECHO, ADB, Royal Dutch Government, Italian Government, WHO, World Bank, USAID/APHIA Plus, Save the Children, and Christian Aid. Local Health partners include the Kenya Episcopal Conference (KEC), The Christian Association of Kenya (CHAK), and SUPKEM among others.

SUB-ACCOUNTS

Just like in the case of Wajir, The Health budget estimates for Mandera have been structured in a way that makes it difficult to establish the exact amounts of resources allocated to these priority areas. Nonetheless, below is the summary of how the county performs on the various priority areas.

CHILD HEALTH

According to a 2013 SCI-MNCH Baseline Study, infant mortality rate in the county is at 72/1000 live births, which is 38% higher than the national average of 52/1000 live births (KNBS 2010). The under-five mortality rate (U5MR) of 128/1000 live births – 23% higher than the national average of 77 deaths /1000 live births

At least 25% of the children are either underweight or stunted. While 83% of children (9-23 months) have been fully immunized at the national level, only 53% in Mandera County are fully immunized. In 2012, only 35% of births were delivered in a health facility against a national average of 44%.

HIV/AIDS

By the end of 2011, there were 7,842 people living with HIV in Mandera County. Children constitute

		Rank*
Total population (2009)	1,025,756	38
HIV adult prevalence (overall)	1.3%	4
Number of adults living with HIV	6,555	8
Number of children living with HIV	1,287	9
Total number of people living with HIV	7,842	8

16% of those living with HIV in the county. Despite the huge importance of HIV testing as a way to increase prevention and treatment, about 68 per cent of people in Mandera County had never tested for HIV by 2009.

There were about 517 HIV-positive pregnant women in Mandera County in 2011.

*Table: Burden of HIV in Mandera County
Source: NACC/UNAIDS County HIV Profile*

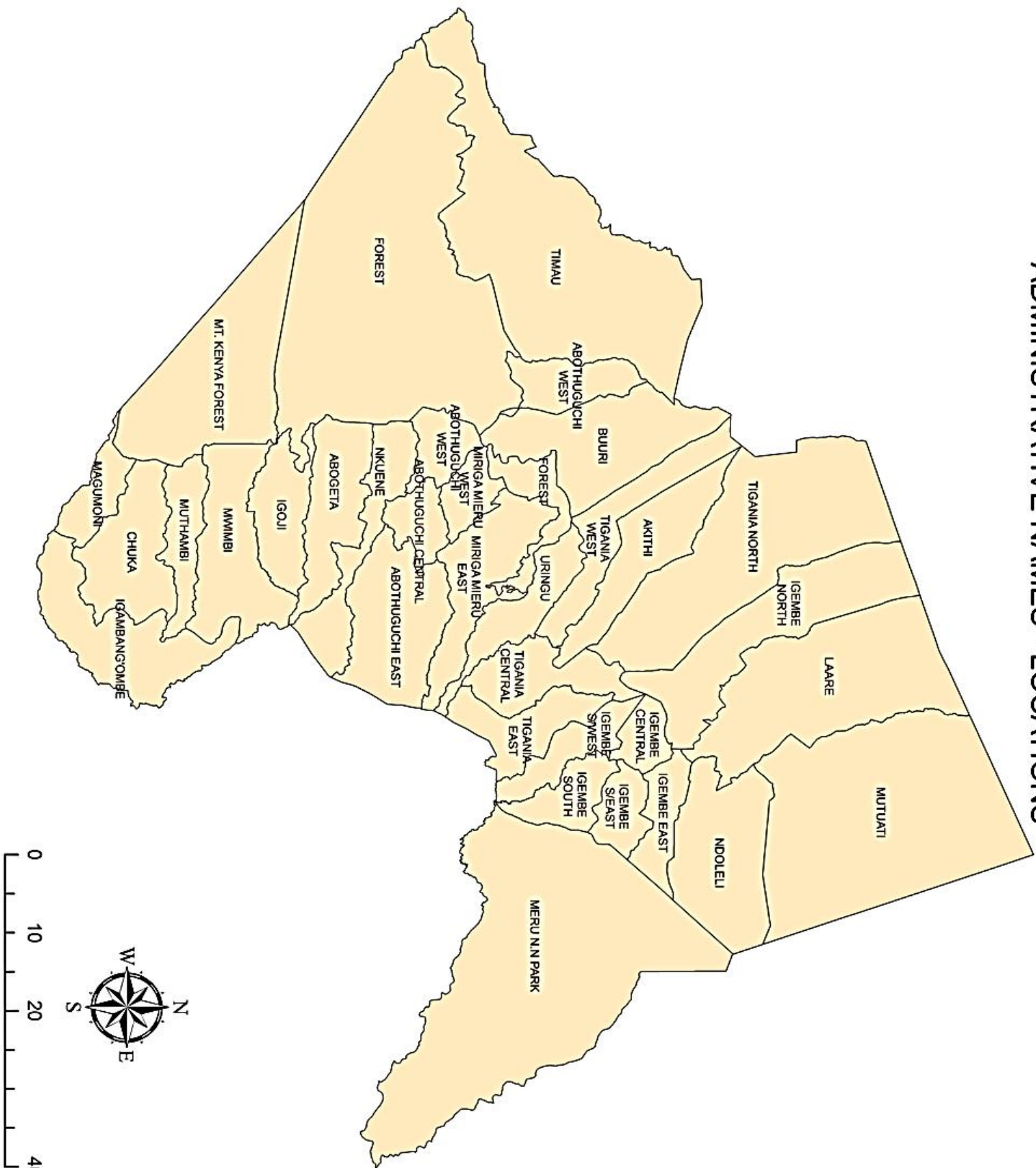
99% of HIV-positive pregnant women in Mandera County do not deliver in a health facility. Only 39% of pregnant women attend the recommended four antenatal visits in Mandera County

NUTRITION

Based on a Nutrition Survey conducted in Mandera in July 2013, The global acute malnutrition (GAM) prevalence among children aged under 5 shows that the situation is still serious in Mandera East at 14.6 percent, and is critical in both Mandera North at 16.8 percent and Mandera Central at 20.6 percent, despite an overall improved food security situation. The poor nutrition status in Mandera is mostly because of local tensions and insecurity, which has limited access to health facilities.

MERU COUNTY

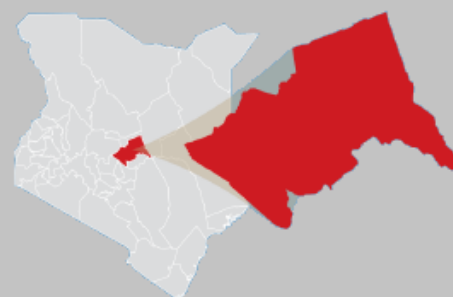
ADMINISTRATIVE NAMES - LOCATIONS



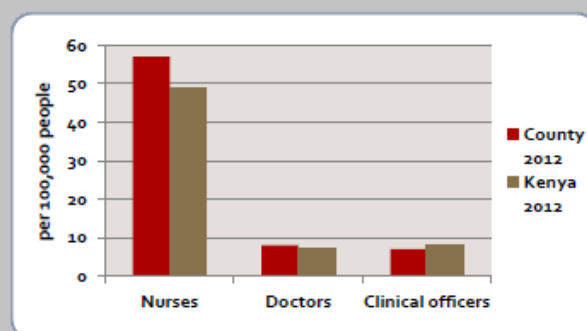
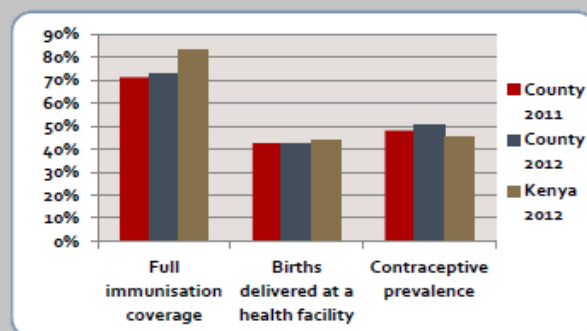
The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by Save the Children

Source: www.meru.go.ke

HEALTH CONTEXT



INDICATOR	2011	2012	Kenya 2012
POPULATION¹			
1 Total	1,443,374	1,488,984	42,387,216
2 Male	713,711	736,264	21,070,003
3 Female	729,662	752,720	21,317,213
4 Under Age 5	206,402	212,925	6,518,230
5 Under Age 1	40,414	41,692	1,339,775
NUTRITION²			
6 Underweight (weight for age) (%)	25.2	24.2	15.0
7 Stunted (height for age) (%)	32.8	27.8	30.0
CHILD HEALTH			
8 Full immunisation coverage (%) ³	71.3	72.5	83.0
MATERNAL HEALTH			
9 Births delivered at a health facility (%) ⁴	42.6	42.4	44.0
10 Contraceptive prevalence (%) ⁵	48.2	50.5	45.0
HIV/AIDS			
11 Number of people tested for HIV ⁶	170,544	194,268	6,952,636
12 Number of people living with HIV on antiretroviral treatment ⁶	7,797	10,319	524,010
13 Mother-to-child transmission of HIV (%) ⁷	8.5	10.0	8.5
14 Malaria test positivity rate (%) ⁸	46.3	43.7	30.0
15 Malaria cases ⁶ (per 100,000 people)	34,228	32,549	21,945
16 Malaria admission ⁶	437	161	19,308
17 Tuberculosis prevalence (per 100,000 people) ⁹	n/a	158	223
18 Tuberculosis incidence (per 100,000 people) ⁹	n/a	80	79
HEALTH PERSONNEL—PUBLIC¹⁰			
19 Nurses (per 100,000 people)	n/a	57	49
20 Doctors (per 100,000 people)	n/a	8	7
21 Clinical officers (per 100,000 people)	n/a	7	8
HEALTH FACILITIES¹¹			
22 Public	n/a	103	4,039
23 Nongovernmental	n/a	2	252
24 Faith-based	n/a	56	1,006
25 Private	n/a	204	2,721
HEALTH FINANCING			
26 Preventive services budget (per capita, KES) ¹²	647	n/a	669
27 Curative services budget (per capita, KES) ¹³	306	n/a	408
28 National Health Insurance Fund (NHIF) coverage county ¹⁴ (% of county population)	22.7	25.3	20.8



The county has one Level V hospital, 9 Level IV hospitals, 23 health centres, 102 dispensaries, 158 private medical clinics, 5 nursing homes and 3 maternity homes.

HEALTH BUDGET SUMMARIES & FINDINGS

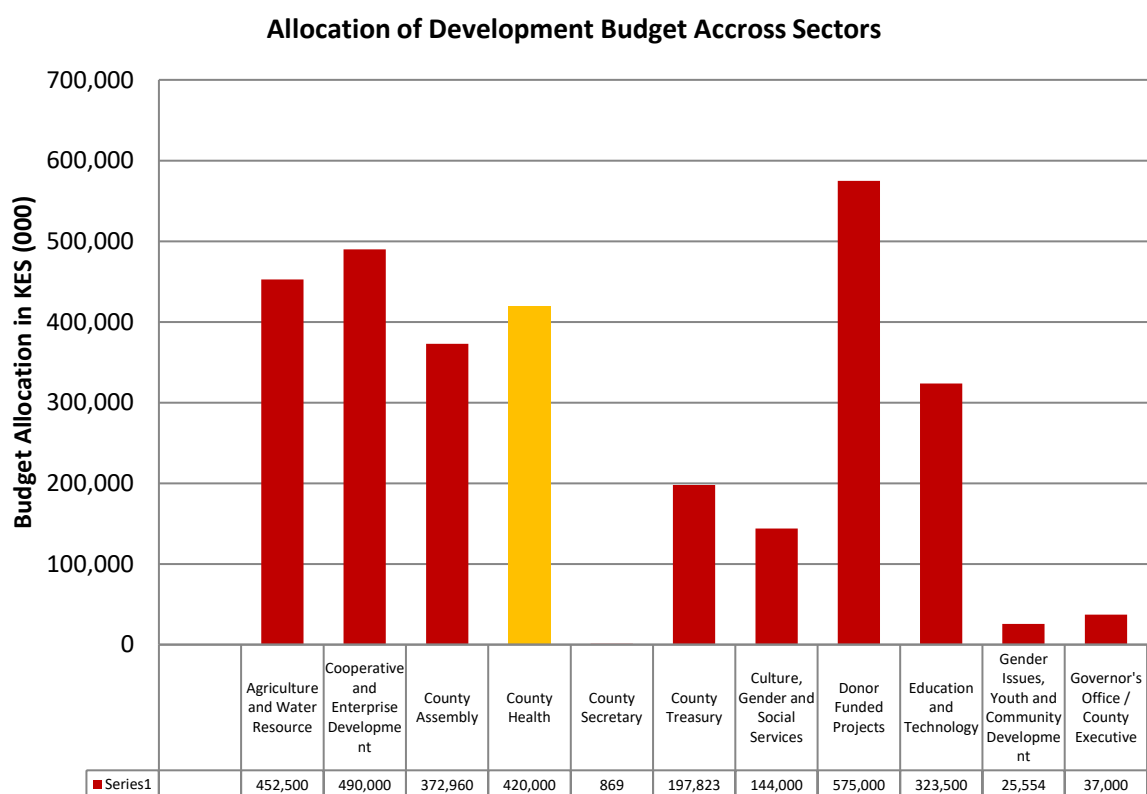
According to the Commission on Revenue Allocation, Meru County allocated a total of KES 420,000,000 to capital healthcare expenditure which is 6.4% of the County Development budget and 5% of the overall county budget.

The county budget estimates indicate that, KES 20 million will be used to buy a diagnostic imaging machine, and KES 70 million to fund the construction of two cancer treatment centres, to help in early cancer detection and improve treatment, care and management of cancer.

The county will use KES 6 million to buy medical equipment and KES 25 million to buy 10 fully-equipped ambulances which will be distributed to each of the 9 constituencies.

The county will spend KES 43 million to build level 2 and 3 hospitals, while KES 1.2 million will be used to buy medicine fridges. A renal dialysis unit will be put up at the Meru Level Five Hospital at KES 25 million while dispensaries, health centres and district hospitals will be refurbished at a cost of KES 47 million.

Each ward (political unit) has been allocated KES 3.5 million to finance various health development projects.



Efforts by the study team and SCI staff to obtain additional Health Budget Information, (and other relevant documents required for review) from the authorities in Meru County were unsuccessful. The study could therefore not provide further insights into the Meru Health Budget.

Recurrent and Capital Expenditure

The table below shows the Meru County Health Budget according to the County Budget Estimates 2013/14.

ITEM	AMOUNT in KES
PERSONNEL	
Salaries	7,036,560
Wages Occasional Workers	8,000,000
House Allowance	2,016,000
Leave Allowance	131,639
Commuter Allowances	360,000
Provident Fund Contribution	578,376
Gratuity	1,402,663
Computer Programming & Systems Support	800,000
Staff Training Contribution	9,825,000
Sub Total- Personnel	30,150,238
OPERATIONS	
Supply & Material(Cleaning Materials, etc.)	10,000,000
Office Supply & Printing (Stationery, Forms, etc.)	1,000,000
Books and publications	100,000
Newspapers and magazines	500,000
Computer & Office Equipment	10,000,000
DRUGS,MEDICAL EQUIPMENT AND TOOLS	141,000,000
Drinking Water & Sewerage	2,000,000
Travel and subsistence	1,500,000
Travel and subsistence(Overseas travel)	2,000,000
Board committee, conference and seminars	1,000,000
Postage & Communication(Telephone,Internet, etc.)	2,000,000
Catering & Entertainment	2,000,000
Baseline Surveys	6,100,000
Environment impact assessment	3,000,000
Health strategic plan	1,500,000
Health annual operation plan	1,100,000
Motor vehicle operations	2,000,000
HIV-AIDS Assistance Contribution	2,000,000
Monitoring and evaluation systems	4,850,000
Research and Development	5,150,000
catering services(food for admitted patient)	30,000,000
Advertisement & Publicity(Press/Radio/TV Ads, etc.)	1,300,000
Sub Total - Operations	230,100,000

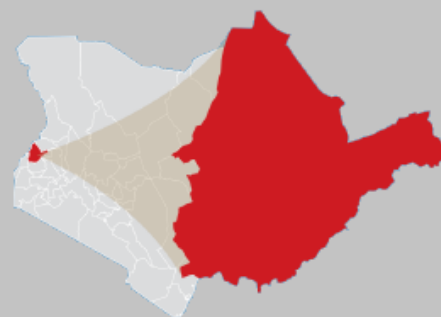
MAINTENANCE	
Computer & Office Equipment Maintenance & Repair	600,000
Vehicle Maintenance & Repair	3,000,000
Other Equipment &Tools Maintenance &Repair	3,000,000
Sub-total - Maintenance	6,600,000
CAPITALINVESTMENTS	
Purchase of 2X4 WD Double cabin Vehicles	9,000,000
Purchase of a Diagnostic Imaging Machine	20,000,000
Construction of two cancer treatment bunk	70,000,000
Purchase of Diagnostic Laboratory Equipment	15,000,000
Procure Clinical Equipment E.G BP	6,000,000
Procure 10 ambulances fully equipped	25,000,000
Build Level 2 & 3 Facilities	40,000,000
Racking/Shelfing of storage Facilities	700,000
Fortify Drug Strorage Rooms and Pharmacies	1,000,000
Procure Medicine Fridges	1,200,000
Procure Quality Movement Enhancing Equipment	1,700,000
Establish a renal unit/dialysis centre at meru county	25,000,000
Dispensary rehabilitation /healthcentre /district hospitals	47,900,000.00
health ward project (ksh 3.5 M per ward)	157,500,000.00
Sub total – Capital Investments	420,000,000.00

TOTAL COUNTY HEALTH BUDGET 2013/2014
KES 686,850,238

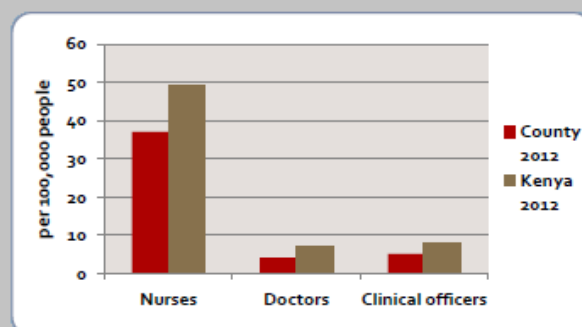
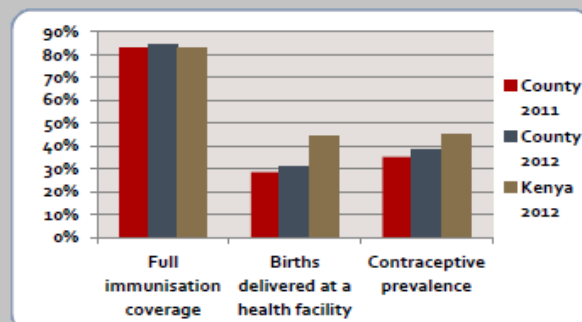
Table: Meru County Health Budget
Source: County Budget Estimates 2013/14

BUNGOMA COUNTY

HEALTH CONTEXT



INDICATOR	2011	2012	Kenya 2012
POPULATION¹			
1 Total	1,735,638	1,790,484	42,387,216
2 Male	846,671	873,426	21,070,003
3 Female	888,967	917,058	21,317,213
4 Under Age 5	303,737	313,335	6,518,230
5 Under Age 1	62,483	64,457	1,339,775
NUTRITION²			
6 Underweight (weight for age) (%)	14.8	13.8	15.0
7 Stunted (height for age) (%)	28.4	23.4	30.0
CHILD HEALTH			
8 Full immunisation coverage (%) ³	83.0	84.4	83.0
MATERNAL HEALTH			
9 Births delivered at a health facility (%) ⁴	28.5	31.1	44.0
10 Contraceptive prevalence (%) ⁵	35.1	38.5	45.0
HIV/AIDS			
11 Number of people tested for HIV ⁶	211,966	193,007	6,952,636
12 Number of people living with HIV on antiretroviral treatment ⁶	10,732	12,545	524,010
13 Mother-to-child transmission of HIV (%) ⁷	8.7	6.7	8.5
14 Malaria test positivity rate (%) ⁸	47.1	43.3	30.0
15 Malaria cases ⁶ (per 100,000 people)	33,534	24,506	21,945
16 Malaria admission ⁶	5,379	3,822	19,308
17 Tuberculosis prevalence (per 100,000 people) ⁹	n/a	127	223
18 Tuberculosis incidence (per 100,000 people) ⁹	n/a	39	79
HEALTH PERSONNEL—PUBLIC¹⁰			
19 Nurses (per 100,000 people)	n/a	37	49
20 Doctors (per 100,000 people)	n/a	4	7
21 Clinical officers (per 100,000 people)	n/a	5	8
HEALTH FACILITIES¹¹			
22 Public	n/a	94	4,039
23 Nongovernmental	n/a	4	252
24 Faith-based	n/a	18	1,006
25 Private	n/a	28	2,721
HEALTH FINANCING			
26 Preventive services budget (per capita, KES) ¹²	479	n/a	669
27 Curative services budget (per capita, KES) ¹³	247	n/a	408
28 National Health Insurance Fund (NHIF) coverage county ¹⁴ (% of county population)	11.7	13.1	20.8



Health Infrastructure

Bungoma County has 136 health facilities - 11 hospitals, 4 Nursing Homes, 16 health centres, 78 dispensaries, 27 clinics and 134 community units. The County has a fair distribution of facilities, though the facilities have inadequacies of essential equipment, personnel, health products, health information, and limited financing towards health. Only 16% of the population utilizes Bungoma's hospitals, which raises critical questions around health seeking behaviours¹³.

According to KDHS 2011, 8.6% of the communities reside within a distance of 0-1 km of a health facility, 49.1% within 1.14.9Km of a health facility and 48.4% within 5Kms and more. The County should establish and equip a multi-faceted referral Hospital to handle complex medical cases. There is need to have at least two well-equipped health centres in each sub-county and urban areas.

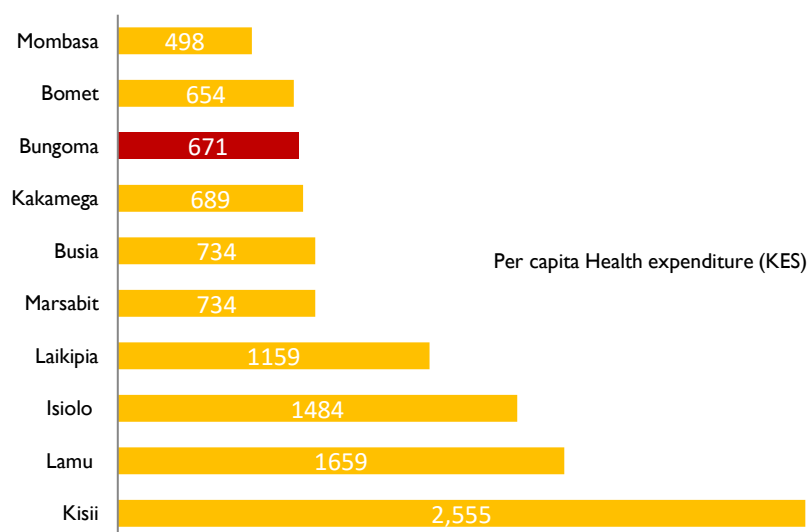
The five most common diseases in order of prevalence in the County include; malarial fever (40%), respiratory tract infection (19%), skin (7%) diseases, diarrhoea (4%) and typhoid (3%). - (SARAM 2013). According to KDHS 2011, 68.55% of children are vaccinated and have access to vaccination centres.

HEALTH BUDGET SUMMARIES & FINDINGS

A breakdown of the development budgets by the Commission on Revenue Allocation (CRA), County Budgets 2013-2014, shows that Kisii County will spend KES 2,555 on each of its residents to improve their health infrastructure. This is 10 times more than what the bottom five counties combined plan to spend per person in developing health services. Kisii County would be the highest spender on health with an allocation of KES 3.2 billion from its overall budget.

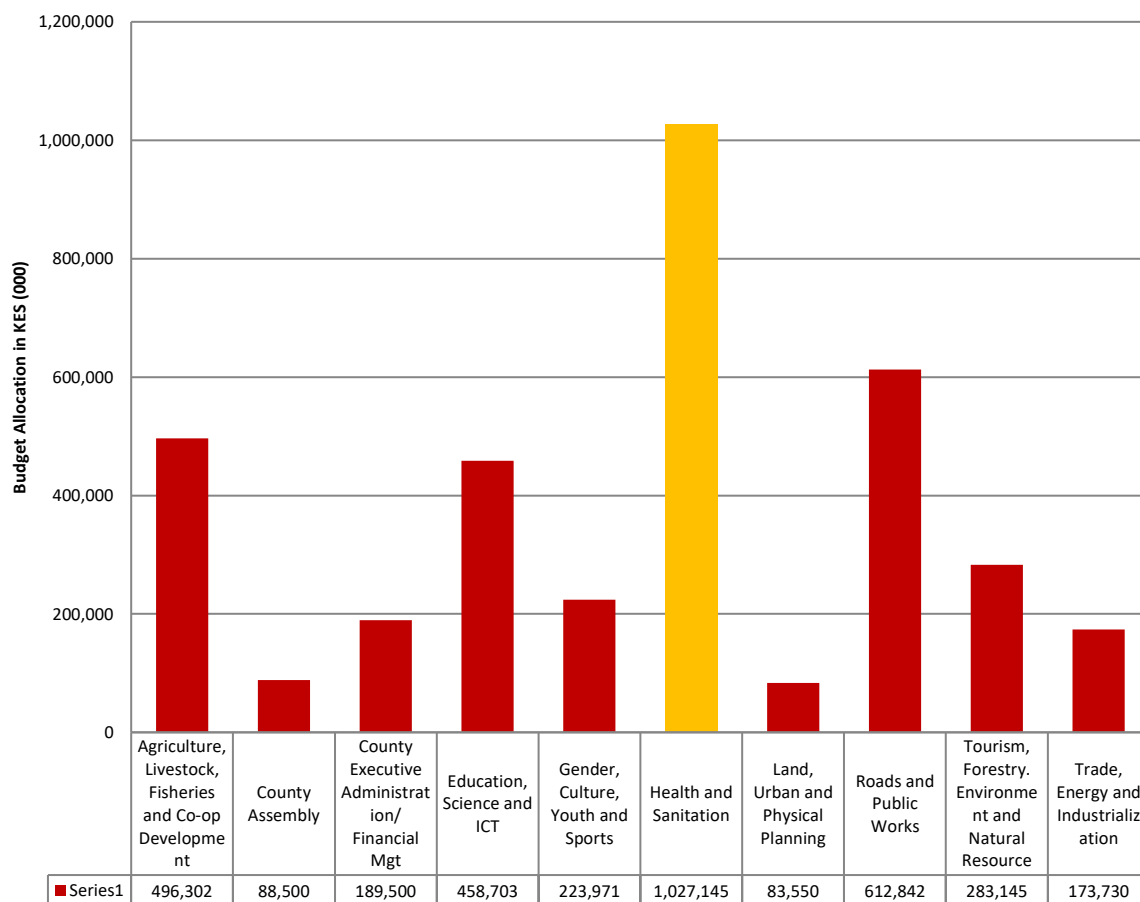
The report further indicates that Bungoma County is the 8th largest health spender with an allocation of KES 1,027,145,000 which is equivalent to KES 671 per citizen. This allocation amounts to 12% of the overall county budget, and 28% of the development budget.

Table: Per Capita Health Allocation for the top 10 counties
Source: CRA County Budget reports 2013/2014



¹³ Official County Website www.bungoma.go.ke, accessed February 2014, Omondi, Nduta et al

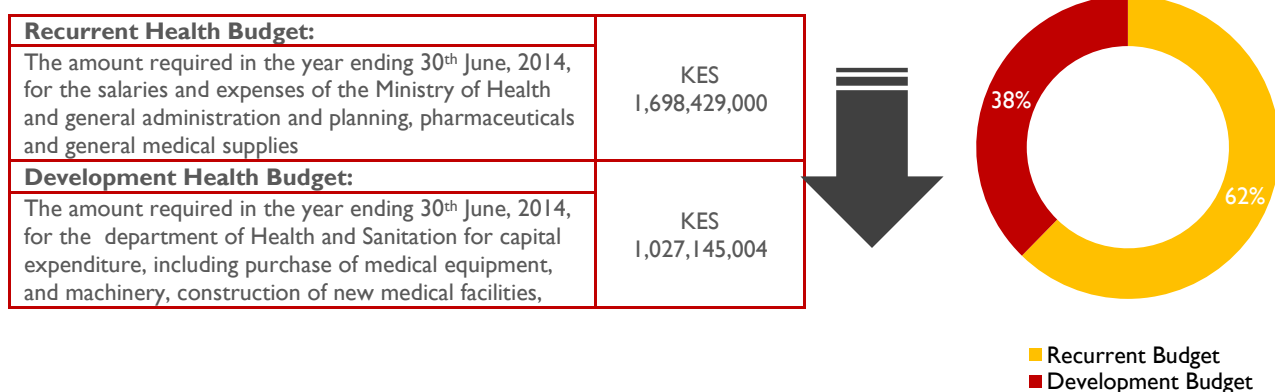
Table: Proportion of County Health Budget in relation to other sectors
 Source: Bungoma County Appropriations Act, July 2013



Proportion of Health Service Expenditures vs. Management Support Expenditures

The county will use the health budget allocation to improve preventive and promotive healthcare, increase access to healthcare and health facilities (by constructing new health facilities), to train medical personnel, improve and construct new medical training facilities, Expand HIV/AIDS services, to ensure that every homestead has access to clean, portable and sufficient water, and to improve sanitation and waste management.

According to the Bungoma County Appropriations Bill of 2013, the breakdown of the health budget into capital and recurrent expenditure is as indicated in the chart below.



THE NATIONAL HEALTH BUDGET

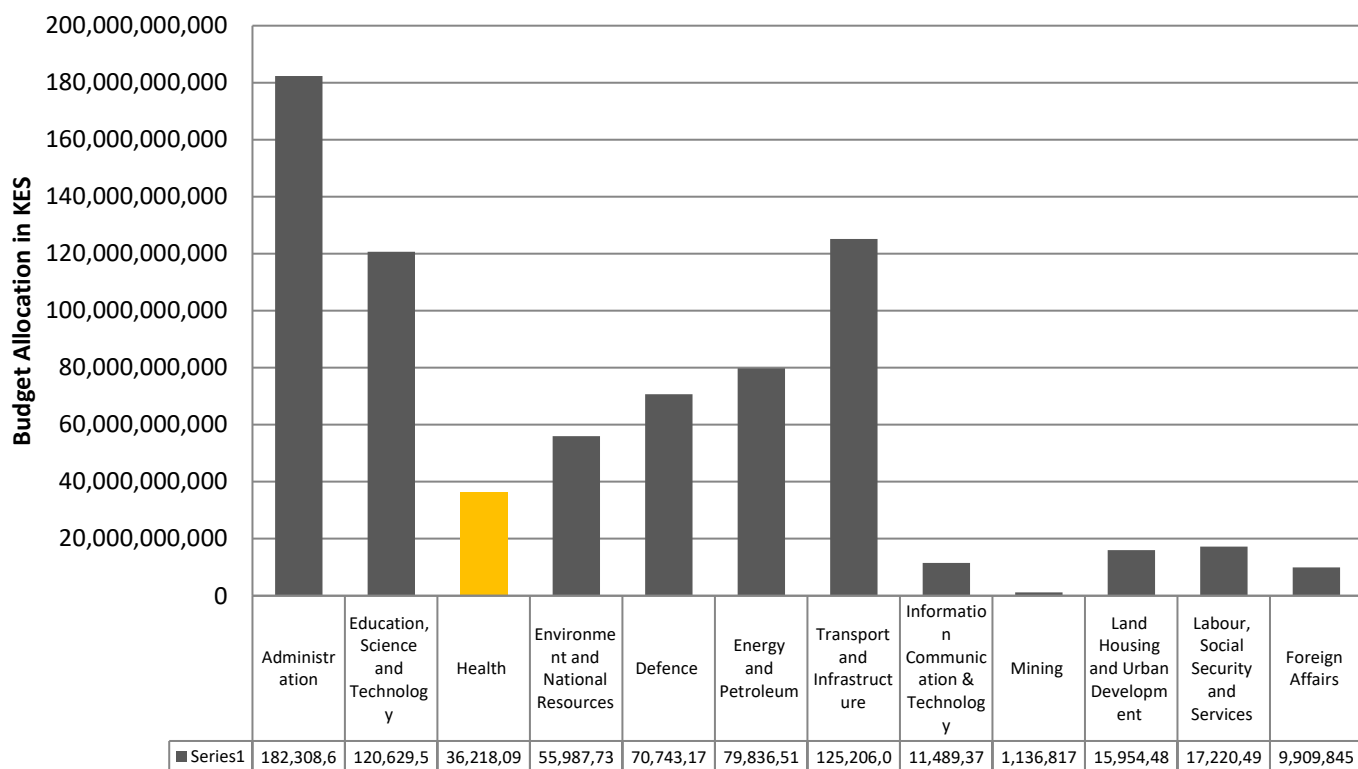
OVERVIEW

The National Health Accounts report for 2009/10, indicate that the Total Health Expenditure (THE) in absolute value has increased from Ksh 82.2 billion (US\$1,046 million) in 2001/02 to Ksh 122.9 billion (US\$1,620 million), an increase of 49%. THE per capita has also increased, from Ksh 2,636 (\$34) in 2001/02 to Ksh 3,203 (\$42) in 2009/10. THE as a percentage of the Gross Domestic Product (GDP) has remained nearly constant, at 5% since 2001/02. Government health expenditures as a percentage of total government expenditures declined from 8% in 2001/02 to 4.6% in 2009/10, which is under half of the Abuja declaration target of 15% and the Economic Recovery Strategy (ERS) target of 12% of total Government allocations. In the 2009/10, the public expenditure was 63.3 per cent which includes external (donor) support and health insurance which contributed 11 per cent of total health expenditure. The rest 36.7% was funded privately, with Out-Of-Pocket spending at the point of service being predominant. Private health insurance is limited but widely growing as more Kenyans enter the middle class.¹⁴

In the fiscal year 2013/14, the Health Ministry Government budget allocation was a total of KES 36 billion, and another 62billion as Appropriations in Aid which makes a total budget of **KES 98 billion**. Out of this KES 60 billion was allocated to the 47 counties for medical services while the headquarters retained KES 34 billion to support its policy formulation and oversight role. The ministry budget projection however was KES 160billion which means that there was a deficit of KES 62billion in the Health Budget.

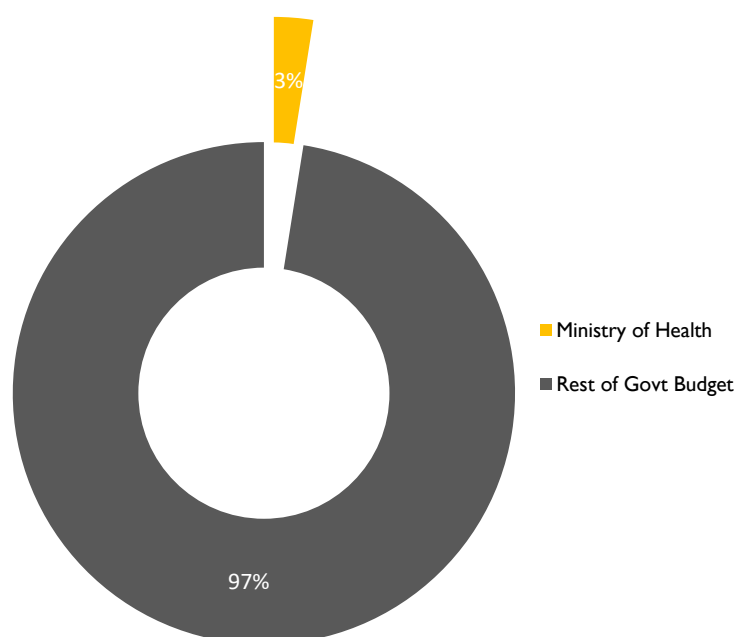
The tables and graphs below put into perspective various aspects of the Kenya National Health Budget for the FY 2013/14.

Graph: Budget Allocation to the Ministry of Health in comparison to other Ministries



¹⁴ The Kenya National Health Accounts 2009/2010

Chart: Government Health Budget as a portion of the Overall government Budget



Recurrent Vs. Capital Health Expenditure

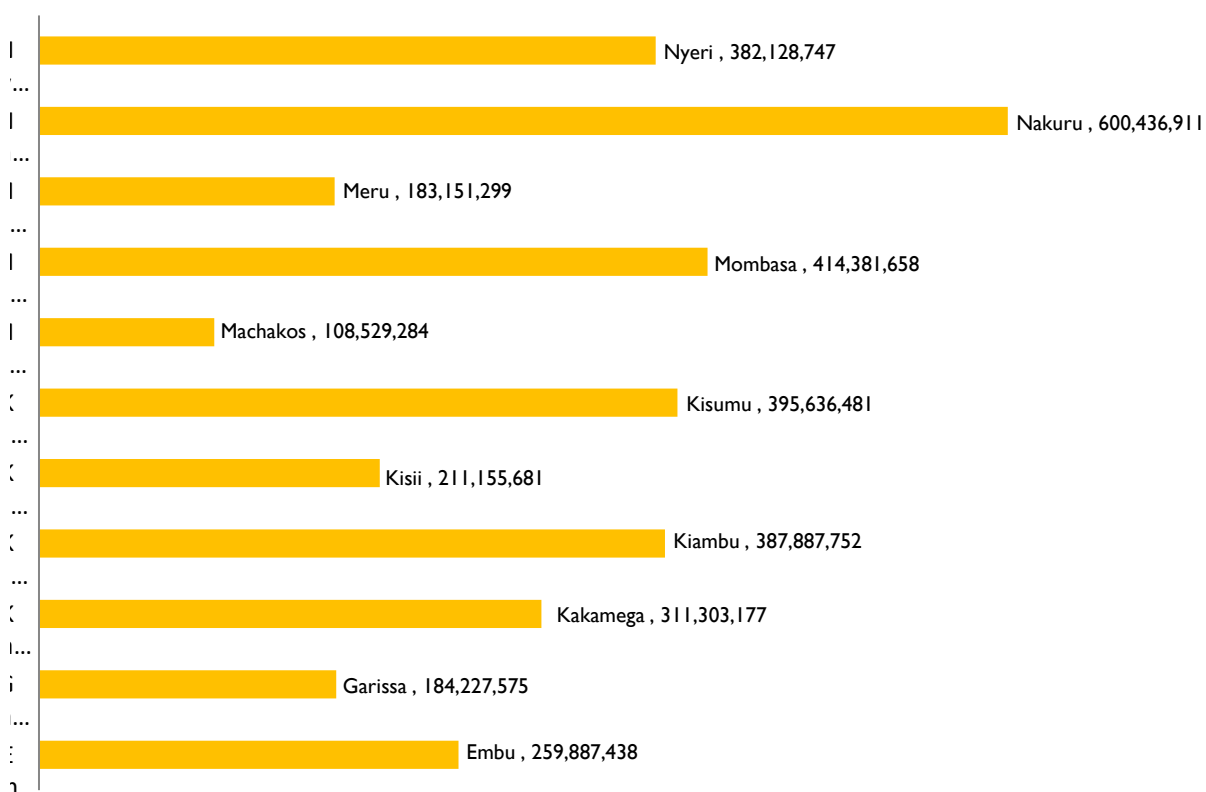
Recurrent Health Expenditure Estimates		Amount in KES (000)	%
1	Headquarters Admin (Tech Services)	557,110	2.74
2	Headquarters Admin (Professional Services)	355,108	1.75
3	Physiotherapy Services	769	0.004
4	Health Finance Secretariat	20,673	0.10
5	Planning and Feasibility Studies	15,230	0.07
6	National Aids Control Programmes	288,030	1.41
7	National Quality Control Laboratories	165,936	0.82
8	Nursing Services	35,764	0.18
9	Health Standards and Regulatory Services	18,426	0.09
10	District Health Services	20,000	0.10
11	Mental Health Services	510,927	2.51
12	Spinal Injury Hospital	221,343	1.09
13	Biomedical/Hospital Engineering	10,837	0.05
14	Health Services	17,211	0.08
15	Clinical Services	10,460	0.05
16	Division of Mental Health	41,243	0.20
17	Nutrition	525	0.003
18	Radiology services	1,773	0.01
19	Kenya Medical Training Colleges	2,850,784	14.03
20	Kenya Medical Supplies Agency	398,430	1.96
21	Pharmacy Services	106,167	0.52
22	Kenyatta National Hospital	7,793,642	38.34
23	Moi Referral and Teaching Hospital	3,643,670	17.93
24	Headquarters & Administrative Services	355,343	1.75
25	Kenya Medical Research Institute	1,249,000	6.14
26	Control of Malaria	59,476	0.29
27	Government Chemist	517,076	2.54
28	Rural Health Centres & Dispensaries	700,000	3.44
29	Radiation Protection Board	77,060	0.38
30	National Aids Council	282,720	1.39
Total Recurrent Vote - MOH		20,325,743	100

Capital Health Expenditure Estimates		Amount in KES (000)	%
1	National Quality Control Laboratory	30,556	0.19
2	Health Standards and Regulatory Services	13,311	0.08
3	District Health Services	1,000,000	6.30
4	Kenya Medical Training Centres	163,700	1.03
5	Kenya Medical Supply Agency	867,141	5.46
6	Kenya National Hospital	608,500	3.83
7	Moi Referral and Teaching Hospital	495,522	3.12
8	Wajir District Hospital	20,000	0.13
9	Headquarters and Administrative Services ⁴	347,025	2.18
10	Kenya Medical Research Institute	146,000	0.92
11	Environmental Health Services	349,772	2.20
12	Nutrition	806,985	5.08
13	Family Planning Maternal and Child Health	4,625,000	29.12
14	National Public Health Laboratory Services	581,000	3.66
15	Kenya Expanded Programme Immunization	387,526	2.44
16	Special Global Fund	685,569	4.32
17	Special Global Fund-TB	487,458	3.07
18	Special Global Fund-Malaria Control	1,187,392	7.48
19	Rural Health Centres and Dispensaries	2,101,000	13.23
20	National Aids Council	980,899	6.18
Total Capital Vote-MOH		15,884,356	100

Source: Ministry of Health Recurrent and Development expenditure estimates 2013

Allocation to Level 5 Hospitals

In addition to the health allocations by the county governments, the national government has allocated 10% (KES 3.4billion) of the national health budget to level 5 facilities to assist in the operations and facilitation of health care provision within the regions they are located. There is however disparity in allocations depending on demographics and other salient factors. Below is a summary of allocations to all the level 5 facilities.



Financing Gap

In the 2013/14 FY, the Ministry of Health has secured additional financing through foreign borrowing, grants and as support from foreign governments. These funds collectively will contribute to 22.39% of the gross capital health budget. The government will still need to raise about KES 60 billion to meet the National health resource requirements. The major partners include among others, UNICEF, WHO, WorldBank, ADB, GIZ, UNFPA, DFID, USAID, ECHO, ECO, OFDA, CDC, and Global Fund for AIDS, Tuberculosis and Malaria, amongst others. The funds have been secured for the following sub-sectors

Sub-Sector		Amount in KES (000)
1	Kenya Medical Supplies Agency	215,000
2	Kenyatta National Hospital	364,022
3	Moi Teaching and Referral Hospital	20,000
4	Wajir District Hospital	347,025
5	Kenya Medical Research Institute	86,038
6	Sanitation Services	86,038
7	Environmental Health Services	800,000
8	Nutrition	825,000
9	Rural Health Centres & Dispensaries	7,392
Total Foreign Borrowing/Grants		2,750,515

CONCLUSION

- In 2010, Kenya spent KSh. 7.20 for each KSh100 on healthcare. This fell to KSh6.10 in 2011 and was further cut to Sh5.9 in 2012. In 2013/14 financial year, the national and county governments plan to spend KSh5.70 per KSh100 on the sector, translating to 5.7 per cent of the total National Budget. The sector is running on less than a third of its recommended budget. The health sector has not been prioritized at the same level as education and infrastructure¹⁵.
- Development partners still fund a large portion of the health sector¹⁶. However, development partner contributions to the health sector are largely project-based and run outside the public health provision structures. The community level strategy, for example, is almost entirely donor funded. This initiative will not be sustained without increased financial commitment from the county governments.
- The Ministry of Health, and the Transition Authority needs to ensure functions are **properly** transferred to the counties in line with the Fourth Schedule of the Constitution so that the roles of county governments and national government on healthcare are clear, that funds follow the functions assigned to the two levels of government, and that the two levels of government interact effectively and efficiently.
- Counties like Wajir which has one of the lowest per capita expenditure on health in the country (at KES 114 per capita) and Mandera which has a health development budget of a mere KES 160,000,000 should be encouraged (through a range of advocacy processes) to prioritize healthcare. Their development budgets have been taken up by Infrastructure/Public works, and Water services, leaving the burden of health to NGOs and development partners.

¹⁵ World Vision County Budget Analysis 2013

¹⁶ Institute of Education and Democracy/DSW, Health Financing report 2010

- Health Sector Service Fund should be realigned to the county budgeting process so that funds meant for Community level interventions are clearly marked and factored into the County Health Budgets. Other than Turkana the rest of the counties were unable to establish exactly how much contribution they would expect from the HSSF. Most importantly, the county government and its stakeholders need to improve the understanding of communities on HSSF and the role they need to play in its implementation.
- The government should institute mechanisms of monitoring off-budget support both at national and county levels to ensure contribution to specific service provision sub-sectors are documented and factored into the respective budgets or health expenditure frameworks. All the counties surveyed reported difficulties in capturing NGO contributions. Such a mechanism should also ensure that only realizable Appropriations in Aid are reflected in the budget, to avoid cases like that of Wajir County that has over KES 1 billion deficit on the health budget.
- The County Health Strategic and Investment plans should be realigned with the Medium Term Expenditure Frameworks, to ensure that the targets of the plans are realizable.

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