Mapping the Financial Flow and Expenditures for Select MNCH Medicines in Kenya

August 2017

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This document is made possible by the generous support of the American people through the US Agency for International Development (USAID), under the terms of cooperative agreement number AID-OAA-A-11-00021. The contents are the responsibility of Management Sciences for Health and do not necessarily reflect the views of USAID or the United States Government.

About SIAPS

The goal of the Systems for Improved Access to Pharmaceuticals and Services (SIAPS) Program is to ensure the availability of quality pharmaceutical products and effective pharmaceutical services to achieve desired health outcomes. Toward this end, the SIAPS result areas include improving governance, building capacity for pharmaceutical management and services, addressing information needed for decision-making in the pharmaceutical sector, strengthening financing strategies and mechanisms to improve access to medicines, and increasing quality pharmaceutical services.

Recommended Citation

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Sheena Patel. 2017. Mapping the Financial Flow and Expenditures for Select MNCH Medicines in Kenya. Submitted to the US Agency for International Development by the Systems for Improved Access to Pharmaceuticals and Services (SIAPS) Program. Arlington, VA: Management Sciences for Health.

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ACRONYMS

ADP	annual development plan
BROP	Budget Review and Outlook Paper
CFSP	County Fiscal Strategy Paper
CHD	county health department
CHMT	County Health Management Team
CoG	Council of Governors
CRA	Commission for Revenue Allocation
DHS	Demographic and Health Survey
KEMSA	Kenya Medical Supplies Authority
KES	Kenyan shillings
MDG	Millennium Development Goals
MEDS	Mission for Essential Drugs and Supplies
MMR	Maternal mortality rate
MNCH	Maternal, newborn, and child health
MoH	Ministry of Health
NMR	neonatal mortality
PFM	Public Finance Management Act
SIAPS	Systems for Improved Access to Pharmaceuticals and Services
UNCoLSC	United Nations Commission on Life-Saving Commodities for Women and Children
USAID	US Agency for International Development

INTRODUCTION

As countries work to meet the targets for maternal, newborn, and child health (MNCH) established under Sustainable Development Goal 3, they need to ensure continuous availability of essential medicines and supplies to prevent and treat the conditions that cause morbidity and mortality in women and children.

Since the report of the United Nations Commission on Life-Saving Commodities for Women and Children (UNCoLSC) was published in 2012, much has been done to highlight the challenges countries face in ensuring the availability of essential commodities and to create resources to assist countries in this endeavor. Procurement was identified as a major challenge by the UNCoLSC, and accurate forecasting was identified as a weak point. Despite the development of guidance on forecasting for the commodities prioritized by the UNCoLSC, in the absence of reliable data on morbidity or consumption, procurement is likely to remain an issue.

Another identified issue is financing these life-saving commodities. In most settings, these commodities are procured with government funds, but there is a lack of documented evidence as to how decisions regarding financing for these commodities are made and executed. An understanding of the financial flows for MNCH commodities is critical as countries pursue the goals of ending preventable child and maternal deaths and of universal health coverage and as many go through the process of decentralization. Understanding financial flows for MNCH commodities may also assist the donor community in making smarter investments and assisting countries in mobilizing additional resources.

The US Agency for International Development (USAID)-funded Systems for Improved Access to Pharmaceuticals and Services (SIAPS) Program conducted an assessment of subnational procurement practices in Kenya. One component of that assessment is related to understanding the financial flows for MNCH commodities. The financing section was expanded to incorporate portions of the data collection tools that were developed and used for mapping MNCH financial flows in Bangladesh, Nepal, and Uganda.

BACKGROUND

Maternal, Newborn, and Child Health in Kenya

The 2014 Kenya Demographic Health Services (DHS) and recent Countdown to 2015 reports found that while Kenya has made progress over the last decade to reduce maternal and child mortality, it was not enough to meet the country's Millennium Development Goals (MDGs) for reducing the mortality rates for mothers (MDG 5) and children (MDG 4).[1] According to the 2014 DHS, there has been a considerable increase in the utilization of maternal and child health services. Approximately 60% of women have four or more antenatal care visits, 61% deliver in a health facility, and 62% of deliveries are attended by a skilled birth attendant.[2] Decreases in child and infant mortality rates have been largely attributed to the enhanced use of mosquito nets, increases in antenatal care, skilled attendance at childbirth, postnatal care, contraceptive use, exclusive breastfeeding practices, and a decrease in unmet family planning needs, as well as overall improvements in other social indicators, such as education and access to water.[3,4]

Despite the increase in the utilization of MNCH services, Kenya was unable to meet its MDG 4 and 5 targets. The 2014 Kenya DHS found the maternal mortality rate (MMR) to be 362 per 100,000 in 2014, providing no indication that the MMR has declined in recent years.[5, 6] Estimates from the 2015 WHO MDG report placed the MMR at 510 per 100,000. From 2009 to 2014, the infant mortality rate declined from 52 to 39 per 1,000 live births, while the child mortality rate declined from 74 to 52 per 1,000 live births during the same period.[7] Neonatal mortality (NMR) had the slowest decline during those years, from 31 to 22 deaths per 1,000 live births; further decreasing infant and child mortality rates will require steeper declines in the NMR, which is linked to maternal health services.

There are considerable geographic variations in maternal and child mortality rates among counties in Kenya and also disparities in access to MNCH services. For example, the MMR ranges from as high as 3,795 in Mandera County to less than 300 in other counties, and the percentage of births attended by a skilled birth attendant ranges from 39% in Mandera to more than 80% in other counties.[8,9] Challenges to improving access to MNCH services include

[1] Countdown to 2015. 2015. A Decade of Tracking Progress for Maternal, Newborn and Child Survival: The 2015 Report. New York: UNICEF and World Health Organization.
[2] National Bureau of Statistics-Kenya and ICF International. 2015. 2014 KDHS Key Findings. Rockville, MD, USA: KNBS and ICF International.
[3] Ibid.
[4] Ministry of Health, Kenya. 2016. Kenya reproductive, maternal, newborn, child and adolescent health (RMNCAH) investment framework. Kenya: Government of Kenya.
[5] World Health Organization. *Trends in maternal mortality: 1990 to 2015: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division*. (Geneva: World Health Organization, 2015).
[6] National Bureau of Statistics-Kenya and ICF International. 2015. 2014 KDHS Key Findings. Rockville, MD, USA: KNBS and ICF International.
[7] KDHS and ICF-Macro. Kenya Demographic and Health Survey 2014. Calverton, MD: Kenya National Bureau of Statistics and ICF Macro, 2014. KDHS 2014. Available at: http://dhsprogram.com/pubs/pdf/PR55/PR55.pdf
[8] UNFPA. (13 August 2014). Counties with the Highest Burden of Maternal Mortality. Available at: http://kenya.unfpa.org/news/counties-highest-burden-maternal-mortality.

inequitable coverage and demand-side barriers that limit access to essential services, such as geographic barriers, out-of-pocket expenses, religious and sociocultural beliefs and practices, education, and the low status of women.[10]

The availability of essential MNCH commodities is also an issue. The 2013 Kenya Service Availability and Readiness Assessment Mapping report found that maternal health medicines were the least available among the other tracer medicines, which included medicines for national health programs, with the mean availability of maternal health commodities at primary care facilities and hospitals being 24% and 29%, respectively.[11] Among all health facilities that were assessed, only 51%, 26%, and 10% had oxytocin, magnesium sulfate, and misoprostol available, respectively.[12] When comparing counties, the mean availability of the tracer medicines among all health facilities ranged from 18% to 39%.[13] Major supply-side barriers that hamper the availability of essential MNCH commodities include funding gaps and weak supply chain management, poor health information systems that limit evidence-based decision making, and ineffective use of resources from both domestic and international partners due to capacity challenges and weak coordination at the national and county levels.[14]

Health System Structure

In 2010, the majority of Kenyans (67%) voted on and approved a new Constitution based on the concept of devolution of political and economic power to 47 newly formed counties to bring more ownership and decision making power to the local level.[15] For health service delivery, primary and secondary health services were devolved to the counties, and the Ministry of Health (MoH) provides policy support and technical guidance for national programs and is responsible for human resources for health, such as teaching hospitals, public universities, and medical schools. The purpose of the devolution was to enhance equity in resource allocation and improve service delivery, particularly for those in rural areas.

In addition to creating new counties, devolution also included the creation of new administrative systems that absorbed some, if not all, of the previous systems of administration, including local, district, and provincial level administrations. Under this devolved system, counties are responsible for county legislation, executive functions, responsibilities transferred from the national government and those agreed upon with other counties, and establishing and staffing public service.[16]

[9] KDHS and ICF-Macro. Kenya Demographic and Health Survey 2014. Calverton, MD: Kenya National Bureau of Statistics and ICF Macro, 2014. KDHS 2014.
[10] Ministry of Health, Kenya. 2016. Kenya reproductive, maternal, newborn, child and adolescent health (RMNCAH) investment framework. Kenya: Government of Kenya.
[11] Government of Kenya, 2014: Kenya Service Availability and Readiness Assessment Mapping (SARAM). Ministry of Health, Nairobi Kenya.
[12] Ibid.
[13] Ibid
[14] Ministry of Health, Kenya. 2016. Kenya reproductive, maternal, newborn, child and adolescent health (RMNCAH) investment framework. Kenya: Government of Kenya.
[15] KPMG Africa. 2013. Devolution of Healthcare Services in Kenya: Lessons learnt from other countries. South Africa: KPMG.
[16] Ibid.

The Kenya Health Policy, 2014–2030, provides guidance to the health sector in identifying and outlining activities needed to meet the country's health goals. It is aligned with the 2010 Constitution and Kenya's Vision 2030 (Kenya's national development agenda) and also with global commitments for health, such as the Sustainable Development Goals.[17] The policy further delineates the roles and responsibilities of the national and county governments and provides guidance in implementing activities and achieving the health goals under the devolved system.

Service Delivery

Under the devolved health care system, there are clear distinctions in the roles and responsibilities of the MoH and County Health Departments (CHDs). Figure 1 illustrates the devolved service delivery system and the relationship between the national and county level governments and service delivery points.

At the national level, in additional to managing service delivery at tertiary referral hospitals and institutions, the MoH has a leadership role and is responsible for:

- Developing national policy and legislation, such as standards setting, national reporting, sector coordination, and resource mobilization
- Offering technical support with an emphasis on planning, development, and monitoring of health service delivery quality and standards throughout the country
- Providing guidelines on tariffs for health services
- Promoting mechanisms for improving administrative and management systems, including conducting appropriate studies
- Building the capacity of county governments to effectively deliver high-quality and culturally responsive health services[18]

In addition to these activities, the MoH is also in charge of financing; mobilizing resources; health information; communication and technology; public-private partnerships; and planning and budgeting for national health services and for services provided by the Kenya Medical Supplies Authority (KEMSA), National Hospital Insurance Fund, Kenya Medical Training College, Kenya Medical Research Institute, and national health programs for major diseases, such as HIV/AIDS, malaria, and tuberculosis.[19]

[17] Ministry of Health, Kenya. 2014. Kenya Health Policy 2014–2030. Nairobi: Ministry of Health, Kenya.
[18] Ibid.
[19] Ibid.

The county government is responsible for managing services at county health facilities and pharmacies, ambulatory services, disease surveillance and response, disaster management, and other public health and sanitation related services.[20] The CHD is also responsible for three levels of care:

- *Community health services*: Includes all community-based demand creation activities, including the identification of cases that need to be managed at higher levels of care
- *Primary care services*: Includes all dispensaries, health centers, and maternity homes for both public and private providers
- *County referral services*: Includes county referral hospitals comprising the former level-four and district hospitals in the county, both public and private

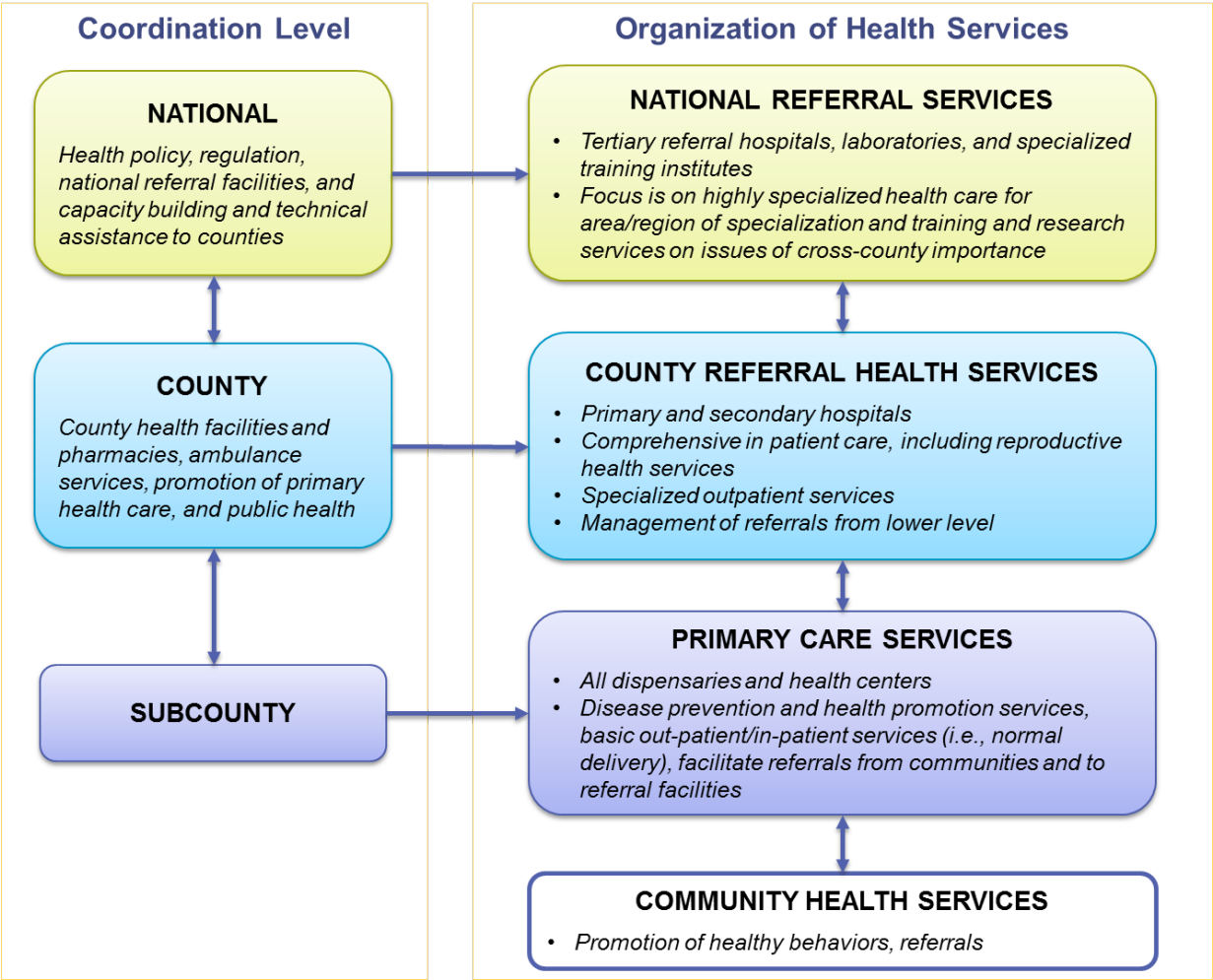

Figure 1. Organization of Kenya's health delivery system[21]

[20] KPMG Africa. 2013. Devolution of Healthcare Services in Kenya: Lessons learnt from other countries. South Africa: KPMG.
[21] Ministry of Health, Kenya. 2014. Kenya Health Policy 2014–2030. Nairobi: Ministry of Health, Kenya.

Supply Chain System

Prior to devolution, the supply chain system in Kenya was centralized and was a combination of a kit-based push system and an inventory-based ordering (pull) system. The pull model was gradually scaled up, and medicines were supplied based on the requisitions received by the health facilities. KEMSA was established in 2001 as a state corporation to improve the availability of medicines and supplies. The agency is mandated to manage procurement, warehousing, and distribution for the public sector health care supply chain. It is the largest purchaser of medicines in the country; uses both government and donor funds, undifferentiated; and distributes them to public medical institutions.

After devolution, the pull system remained; however, procurement of medicines was decentralized to the newly formed counties, with KEMSA becoming the primary supplier of medicines in the public health sector. According to the Kenya National Pharmaceutical Policy, medicines must be procured from KEMSA as the primary supplier. If KEMSA cannot supply the medicine, counties can procure it from the Mission for Essential Drugs and Supplies (MEDS), which is the primary supplier in the private sector, or the commercial sector as a last resort. All suppliers distribute medicines directly to health facilities; some counties have regional warehouses where medicines can be stored and then delivered to the health facility.

METHODOLOGY

Purpose and Objectives

SIAPS assessed subnational procurement practices of maternal and child health commodities in three counties in Kenya in October 2016. Information on financial flows could easily be collected because the tools already included a section on budgeting and financing of MNCH medicines. Kenya was of particular interest in the mapping of financial flows due to its level of devolution and decentralization.

The purpose of mapping financial flows for maternal and child health medicines is to inform the development of strategies and interventions to improve the availability of these commodities. For Kenya, the main objectives are to track the budgeting process, including development, approval, and timelines, and track the flow of funding, disbursements, and expenditures; this information was collected from two of the three counties selected for the sub-national procurement assessment.

Data Collection

Tracer Medicines

As in Bangladesh, Nepal and Uganda, three tracer medicines were selected to map financial flows for first-line MNCH medicines used to treat the leading causes of maternal, newborn, and child deaths, as indicated in the National Essential Medicines List and Standard Treatment Guidelines. These medicines include oxytocin for the management and treatment of postpartum hemorrhage, gentamicin for the treatment of neonatal sepsis, and zinc sulfate for the management of diarrhea. Table 1 indicates the tracer medicines and formulations that were selected.

Table 1: Tracer Medicines for Mapping Financial Flows of MNCH Medicines

Category	Medicine and Formulation
Maternal Health	Oxytocin, 10 IU
Newborn Health	Gentamicin, 10 mg/ml in 2ml vial Gentamicin, 40 mg/ml in 2ml vial
Child Health	Zinc sulfate, 20 mg dispersible tablet

Selected Sites and Respondents

Three counties were selected in consultation with the Kenya MoH and the Reproductive Health Division for the subnational procurement assessment. As part of the assessment, follow-up visits were conducted in two of the counties—Elgeyo-Marakwet and Kakamega. During these visits, additional budgeting information was collected. In these counties, discussions were held with personnel responsible for budgeting at the county finance departments and county health departments and with county pharmacists responsible for developing the medicines budget.

At the national level, discussions were also held with the reproductive health division to better understand the budgeting processes at the national level. Table 2 indicates the stakeholders interviewed at the national and county levels.

Table 2: Institutions and Key Stakeholders Visited at the National and County Levels

National level	County level
Family Health Division/Reproductive Health Division	County Health Department (CHD)
	CHD Accountant
	County Finance Department
	County Pharmacist

Data Collection

Data were collected through in-depth interviews with key personnel responsible for not only developing the budget for medicines but also managing the budgeting process at the county level. Data on financing were also collected during the subnational procurement assessment in October 2016 and were extracted and consolidated into this report. Data were collected only at the county level.

In addition, budget documents posted on county websites and national and county health budget analysis reports were reviewed to assess health expenditures.

The data collection focused on the following areas:

- Budget development for medicines, including quantification
- Budget approval process
- Financial flow (disbursement of funds)
- Expenditures and procurement

RESULTS

The scope of the data collection was limited and primarily focused on documenting the budgeting process with an emphasis on health commodities and mapping the financial flows for maternal and child health medicines. The budget process is how the budget is developed for the county, including the CHD, and how the budget line item for medicines is determined, including quantification. Data on how the budget translated to the health facility level were also collected. While counties determine their budgets independently, the national level has a role in determining the budget ceilings for each county; however, the national level does not determine how the funds are distributed within the county or approve the county budgets.

Key Institutions/Departments

The Kenyan fiscal year runs from July to June with the budget development process beginning at the end of August for the next fiscal year. The structure of the county government largely corresponds with that of the national government and has similar institutions that are responsible for the budgeting process. The roles and responsibilities of each institution are defined in the Public Finance Management (PFM) Act of 2012. The PFM also lays out the budgeting process for the national and county levels post-devolution. Table 3 lists key institutions at the national and county levels and their primary responsibilities during the budgeting process.

Both the national and county governments have a treasury that is responsible for resource mobilization, budget preparation, coordination and review, budget implementation, capacity building, and reporting. The National Treasury is headed by the Cabinet Secretary of Finance, while the County Treasury is headed by the County Executive Committee Member of Finance. At the county level, there is also the County Executive Committee headed by the governor that is responsible for reviewing and approving the budget prior to it being submitted to the County Assembly.

Table 3. Key Institutions at the National and County Levels Responsible for the Budgeting Process

Budget Process	National Government	County Government
Development and approval	National Treasury • *Cabinet Secretary for Finance*	County Treasury • *County Executive Committee Member for Finance*
		County Executive Committee
Development and approval	Sector Working Groups • *MoH*	Departments/Sector • *CHD* • *County pharmacists for medicines budget*
Development	Commission for Revenue Allocation	County Budget and Economic Forum
Approval	Parliament	County Assembly

At the national level, Sector Working Groups are responsible for developing the budget for their respective sectors, such as the MoH. As mentioned previously, the role of the MoH in Kenya is to provide technical guidance to county departments of health and manage national health programs—HIV/AIDS, TB, malaria, the free maternity health program, immunizations, and other health system strengthening programs—and national-level facilities, such as KEMSA, national hospitals, and teaching and referral hospitals. While there is the national free maternity health program, it currently only provides maternal health services and does not include the provision of medicines.[22] Therefore, MNCH medicines are only financed and procured at the county level and are included in county budgets.

While the MoH budget does not include the CHD budgets, a major source of funding for the counties is national revenue. The national government provides guidance on priority issues, but it does not dictate how the county should use its funds. Rather, it determines the budget ceiling for each county through the Commission for Revenue Allocation.

At various stages in the budget development process, discussions and forums are held to invite public participation. At the county level, the County Budget and Economic Forum ensures public participation in public finances to improve accountability and public participation at the county level. Finally, Parliament and the County Assembly are responsible for approving the budget papers and the final budget at the national and county levels, respectively.

Key Documents

During the budget development process, key documents are produced to help guide the process, some of which are required for public funds to be appropriated. Guidelines for developing the budget and timelines for submission of the related documents and budgets are detailed in the PFM Act.

Table 4 describes the documents that are developed during the budgeting process at both the national and county levels.

Table 4: Essential Documents in the Budgeting Process[23]

Document	Description
Budget circulars	• Included information on the budget calendar; procedures for the review and projection of revenues and expenditures; key policy areas and issues guiding budget formulation; procedures for public participation; and budget formats
Annual development plan (ADP)	• Developed at the county level as a key planning document that guides the budgeting process for the next year. It is a one-year extract of the five-year County Integrated Development Plan. • Program/sector priorities, targets, and overall budget and estimated costs (projected costs) for major programs and projects • Each county must have an ADP to receive public funds

[22] Ministry of Health, Kenya. 2015. National and County Health Budget Analysis Report, FY 2014/15. Nairobi: Ministry of Health, Kenya.
[23] George B. 2017. Key documents essential to the budget process in Kenya. Available at: https://www.politicalkenyan.com/key-documents-essential-to-budget-process-kenya/.

Document	Description
Budget Review and Outlook Paper (BROP)/County BROP	• Review of the previous year's budget performance (year-end review), which is updated for the current year's economic expectations (i.e., inflation, growth) • Proposed distribution of the coming year's budget across key sectors like health or "provisional ceilings" for each sector
Budget policy statement	• National level • Indicates the broad strategic priorities and policy goals that will guide the national government and the county governments in preparing their budgets both for the following financial year and over the medium term (three years) • Included financial projections (proposed expenditures), ceilings, and priorities
Division of revenue bill and county allocation revenue bill	• National level • Divides the national revenue between national and county governments • Divided the national revenue allocated to the county governments among the counties using the revenue allocation formula
County Fiscal Strategy Paper	• County level • Similar to the budget policy paper at the national level • Outlook on expenditures, revenues, and borrowing for the upcoming year and medium term
Finance bill	Revenue raising measures for national and county governments and a policy statement.
Audit reports	Confirms whether public funds have been used lawfully and effectively

Budget Development

Because MNCH commodities are only budgeted and procured at the county level, this section will focus on the budget development processes at that level and touch on national-level processes that impact county budgets, such as setting the county budget ceilings. While discussions were held with county budgeting representatives, further information was gathered through literature and budget document and guideline reviews.

Determining County Budget Ceilings

According to policy, at least 15% of the national revenue must be allocated for the counties. The Commission for Revenue Allocation (CRA) is an independent commission responsible for determining the budget ceiling for each county. The budget ceiling is based on a standard formula that takes into consideration population, poverty gap, land area, basic equal share (amount shared equally among all counties), and fiscal responsibility, with weights attached to each parameter.

Actual expenditure and need is not taken into consideration when determining budget ceilings, and the MoH has a limited role in advocating on behalf of the counties for additional resources. The Council of Governors (CoG), which brings together governors from each of the 47 counties to work collectively on issues related to public policy and governance at the county and national levels, has tried to advocate for changes in the formula used by the CRA and negotiate for additional funds for the counties, but without success. The CoG also has subcommittees within the Council for various sectors, including health and biotechnology, and the MoH has created an MNCH Commodity Working Group. Both are still relatively new, but discussions held with a representative of the MoH's family health division indicated that they can be used to advocate for more resources for health.

County-level Process and Timeline

The annual budgeting processes at the national and county levels are done concurrently. The budget development process begins on August 30 of each year for the upcoming year. The final budget must be approved by Parliament and the County Assembly no later than June 30. The County Finance and Treasury representatives interviewed in the two counties visited stated that these timelines are always adhered to and did not mention any challenges or issues faced in meeting any of the deadlines.

The process at the county level largely mimics that at the national level with the exception of the ADP, which is specific to counties. At the national level, the equivalent document that provides the framework for the national budget is the country's long term development plan, called Vision 2030.[24]

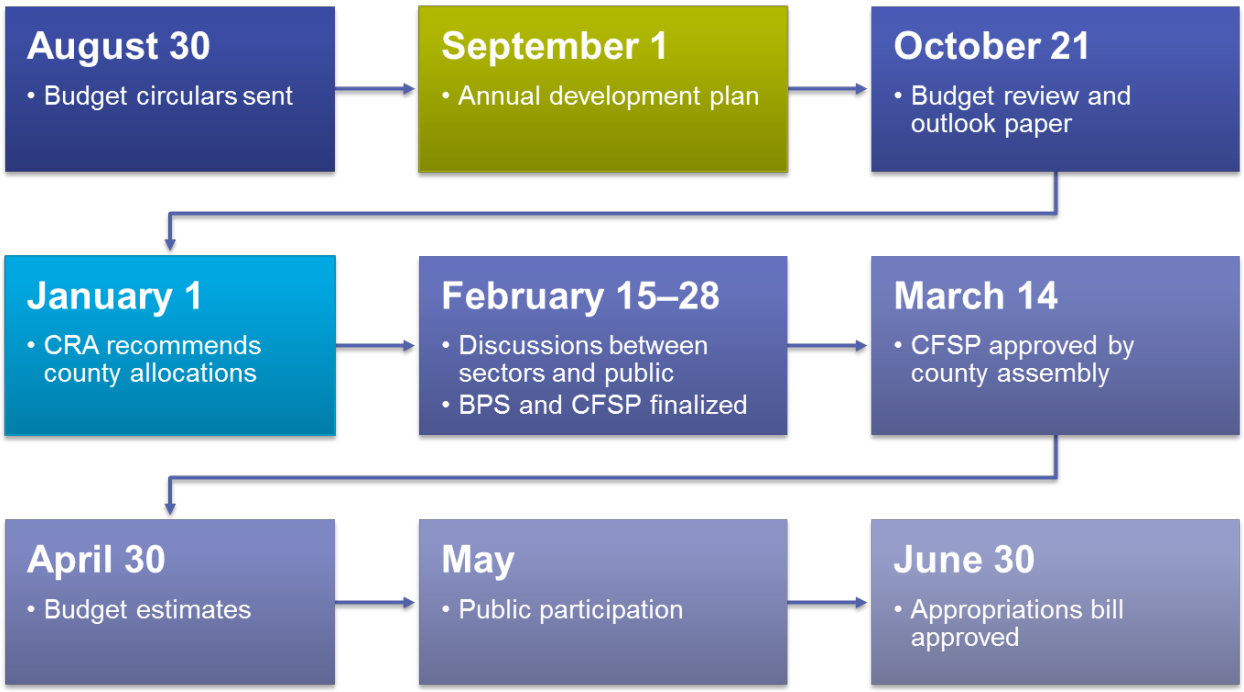

Figure 2. Summary of budgeting process and timeline at the national and county levels

Budget circulars sent to county departments. The budget cycle begins when the national and county treasuries send budget circulars to their respective ministries, departments, and agencies on August 30. The budget circulars outline the guidelines for the budget process for the coming fiscal year and the procedures to be followed to involve the public in the budget process. The budget circulars contain the priorities for the counties, deadlines for key documents to be submitted and approved, and budget formats to be used.

[24] Government of the Republic of Kenya. 2007. Kenya Vision 2030. Nairobi: Government of Kenya.

County treasury submits annual development plan for approval. By September 1, the County Executive Member, Finance, must submit the ADP, which is a one-year extract from the county's five-year integrated development plan, to the County Assembly. The ADP is the key planning document that guides the budgeting process for the next year and includes strategic priorities for the upcoming year and medium term; programs to be delivered; significant capital expenditures; and grants, transfers, and subsidies to be made on behalf of the County Government.

Determine county department ceilings. After the budget circulars are sent to each department and the ADP is approved, meetings are held between the County Treasury and the department to determine individual budget ceilings. The overall county budget is estimated based on the previous year's budget and expenditures.

BROP is developed and submitted by October 21. Once the department ceilings are finalized and approved, the CHD begins developing the detailed department budget to align with the ceiling. Discussions held with Kakamega County's budgeting representatives indicated that a three-day workshop is held with all ministries/departments to develop the county BROP. This will include a review of the previous year's budget performance, update the economic and financial forecast, identify the policy priorities across sectors, and propose budget ceilings for key sectors such as health and education.

Commission for Revenue Allocation determines county budget ceilings by January 1. Until this point, county governments are estimating what the expected overall budget will be. Once the budget ceiling is determined, adjustments are made to the budget projections.

Public participation at various points in the process. Hearings and discussions are held with the public, including nongovernmental organizations, advocacy groups, civil society, and other professional institutions, to gather further input on the budget and promote transparency.

County Fiscal Strategy Paper (CFSP) submitted for approval by February 28. The CFSP includes input from the public and takes into consideration the county budget ceiling finalized by the CRA. This is the final draft of the budget that is submitted to the County Assembly for approval by mid-March. It includes the final budget and distribution across each sector and is accompanied by other budget documents, such as the Debt Management Strategy Paper.

Detailed program budgets submitted for approval by April 30. The county budget estimate is the detailed budget for programs within each sector. The total budget and sector distribution should not be changed at this stage, but funds may be moved between programs. Final changes can be made to the budget and submitted for approval. This will also include public participation until the end of May.

Approval of the Appropriations Bill by June 30. Once the budget is finalized, the County Assembly can then pass the Appropriations Bill, which authorizes the government to release the funds.

County Health Budget

This section will focus on the budgeting process done within CHDs with a focus on developing the budget for medicines. The County Health Management Team (CHMT) and the subcounty health management teams within the CHD are responsible for ensuring that health policies are implemented and regulations and standards for health care delivery are adhered to. The CHMT also includes the CHD accountant responsible for coordinating the budget development process.

Figure 3 summarizes the process for budget development for the CHD and for medicines as part of the overall budget development process. As the various departments meet with the County Treasury to determine the department ceilings, the CHD collects information on health facility needs, including medicines. This information is used to help the CHD advocate for additional resources in determining the department ceiling. Once the department ceiling is determined, subcounty pharmacists generate a standard list of requirements and forward it to the county pharmacist to aggregate into a standard template. This is done between November and December as part of the BROP. The county pharmacist further amends the budget based on the previous year's budget/estimated budget and sends it to the CHMT accountant to submit to the County Treasury. Once the County Treasury adjusts the department ceilings based on the county budget ceiling determined by the CRA, the county pharmacists develop another draft of the budget that is submitted to the County Treasury to incorporate into the CFSP by February 28.

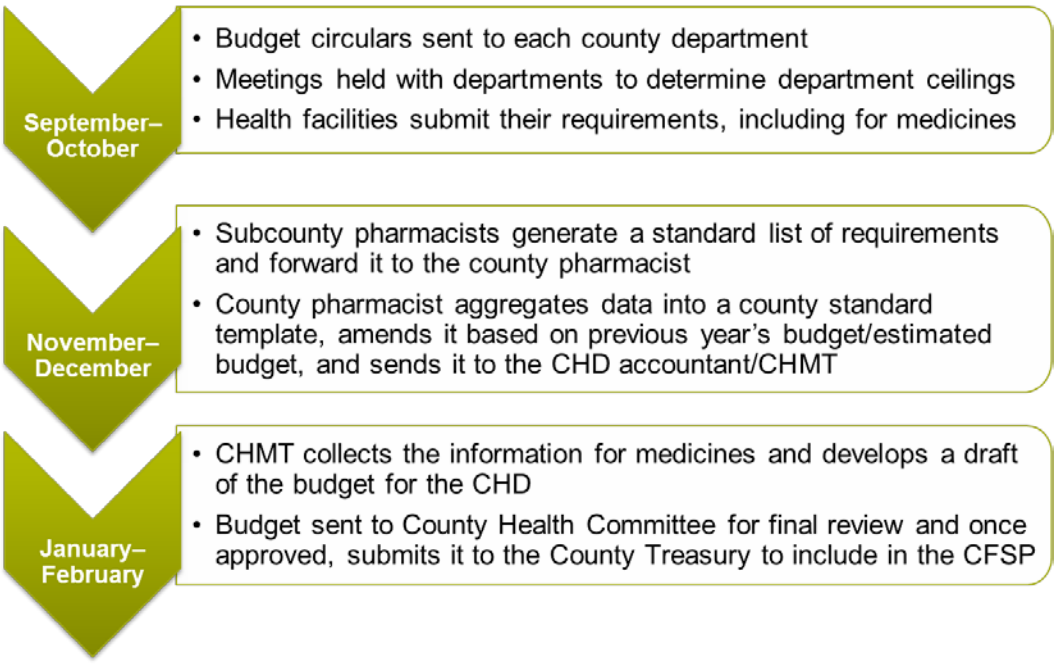

Figure 3. Summary of the budget development process for CHDs

Discussions with county pharmacists indicated that while information on health facility and medicine needs is collected, it is not used to inform the budget because the financial resources are insufficient. The department budget is largely based on the previous fiscal year's

expenditures with a standard percent increase (used for all departments); one county reported an increase of 1.8%. In addition, while the general process for budgeting is standard across the two counties visited and follows the guidelines in the budget circulars, within the CHD, differences arise on how the budget is developed for medicines and how drawing rights against the budget health facilities have for medicines are determined. There are no standardized guidelines or procedures on how this is done, and it is left entirely up to the CHD and the county pharmacist.

Quantification of Medicine Needs

The SIAPS subnational procurement assessment collected data from county pharmacists on how medicine needs are quantified across three counties (Elgeyo-Marakwet, Kakamega, and Kwale). It should also be noted that the last quantification in the three counties was conducted during the 2014–2015 fiscal year with the assistance of the Health Commodities and Services Management Project of Management Sciences for Health. Since the project stopped supporting the counties before capacity could be built for quantification, none of the selected counties have undergone a formal quantification to determine medicine needs and have been referring back to the last quantification that was done.

The assessment also found that while medicine needs are calculated differently across counties, they are primarily based on past consumption and past distribution. One county indicated that it calculates the need based on the previous year's expenditure on medicines with a standard percentage increase.

Finally, while all three counties indicated using stock data to inform medicine needs (i.e., stock on hand, stock-outs, and buffer stock), upon further investigation, it was found that availability data are neither submitted to the county nor tracked, particularly for MNCH commodities. The medicine needs are adjusted based on the budget available and the line item for medicines, which includes pharmaceuticals and non-pharmaceuticals, is determined.

Determining Health Facility Drawing Rights

Drawing rights refers to the budget that each health facility has for medicine, which is tracked by subcounty through the county pharmacists to ensure that expenditures for medicines do not exceed what is allocated. Discussions with the county pharmacists found that there are no standard guidelines or procedures on how this is done and it is left to county pharmacists to determine.

One county pharmacist indicated that he determines the health facility drawing rights based on the work load data (i.e., number of patients per facility) plus a standard increase across all facilities and divides the medicine budget proportionally among facilities. He indicated that he adds a standard of 3,000 patients per facility to ensure that smaller facilities have enough funds for medicines.

The second county visited indicated that the needs for each facility are estimated and used to determine the drawing rights. Procurement data are further reviewed to ensure that essential

medicines are being procured. Within this county, there is a policy that allows health facilities to have a small budget (approximately 5%–10%) for emergency procurement if there is a stock-out.

Supplemental Budget

Nine months into the fiscal year, current expenditures are reviewed. During this time, the county has the opportunity to reallocate funds among departments or line items in the budget based on under- or over-expenditures. A supplemental or revised budget is developed in April of the current fiscal year and submitted to the County Assembly for review. This is primarily done to compensate for any over-spending, particularly for medicines. While the approved funds can be reallocated, the overall budget must remain within the county ceiling. Counties are not allowed to transfer funds between approved development and recurrent allocations.[25]

Discussions with CHDs and county pharmacists indicated that over-expenditures are fairly common for medicines and that during the time when the supplemental budget is being developed, the over-expenditure is compensated for. For example, in Elgeyo-Marakwet, during the 2014–2015 fiscal year, the CHD originally requested a budget of 100,000,000 Kenyan shillings (KES) but was approved for only 70% of the requested amount (table 5). The actual expenditure for medicines that year was 106,000,000 KES (153% of which was approved). Through the reallocation of approved funds, a supplemental budget to increase the line item for medicines by 36,000,000 KES to compensate for the total expenditure was subsequently approved by the County Assembly.

Table 5. County Budget for Medicines for Elgeyo-Marakwet, FY 2014–2015

	Amount (KES)	Amount (USD)	Percent
Total County Budget	**2,995,655,205**	**28,901,662**	
Amount disbursed by national level	2,845,235,405	27,450,433	95% of total budget
County revenue	132,000,000	1,273,518	4.4% of total
Grants	18,420,000	177,714	0.6% of total
Amount requested by CHD	895,293,662	8,637,668	
Amount approved by CHD	895,293,662	8,637,668	100% of request
Amount requested for medicines	100,000,000	964,786	
Amount approved for medicines	70,000,000	675,350	70% of request
Total expenditure for medicines	106,000,000	1,022,673	153% of approved amount
Supplemental/revised budget for medicines	106,000,000	1,022,673	36,000,000 KES reallocated to medicines line item to compensate for over-expenditure

Financial Flow

County funds include national revenue disbursed quarterly by the National Treasury, revenue accrued by the county, and donor funds. The funds remain at the County Treasury, and all

[25] Ministry of Health, Kenya. 2017. National and County Health Budget Analysis, FY 2016/17. Nairobi: Ministry of Health, Kenya.

payments are made directly by the county accountant. The county budget does not differentiate the source of the funds (national, donor or county revenue), and therefore it was not possible to extract data by funding source. The county budget must be broken down by recurrent (70%) and development (30%) costs. The line item for medicines includes both pharmaceuticals and non-pharmaceuticals and is categorized as a recurrent cost. The county pharmacist develops and submits the budget for the medicine line item; however, the budget is not broken down by specific medicines and it was not possible to extract what was budgeted for the MNCH tracer medicines. Figure 4 illustrates how funds for MNCH commodities flow through the system in Kenya.

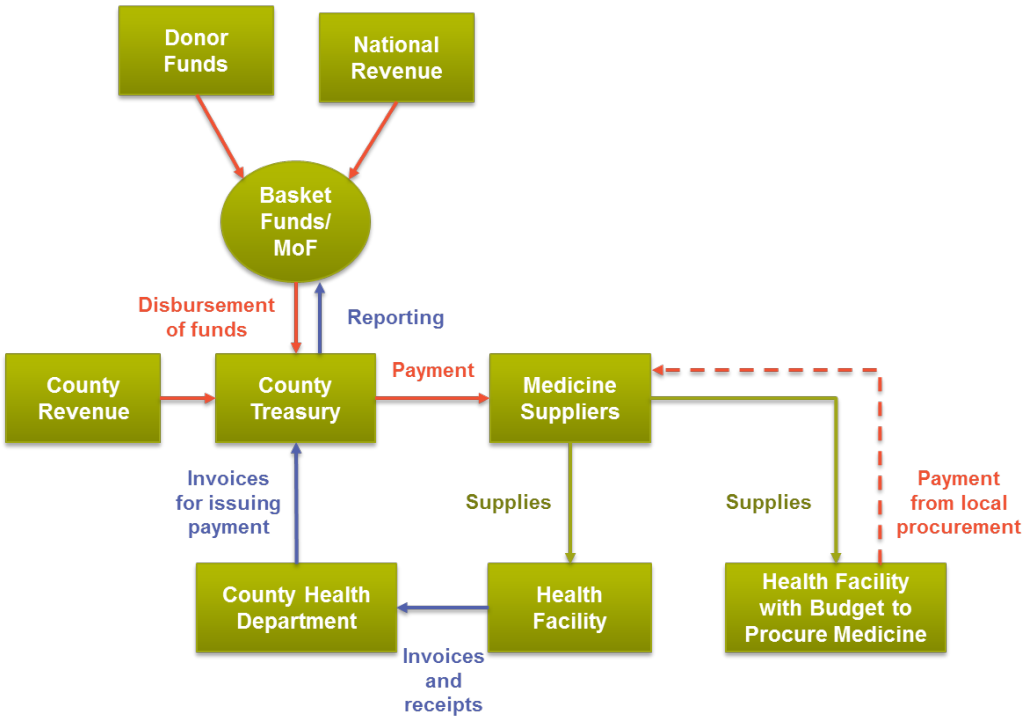

Figure 4. Financial flow for MNCH commodities in the Kenyan decentralized system

County pharmacists from both counties visited indicated that because medicines are categorized as recurrent costs and that most of the budget for recurrent costs is allocated for wages and salaries, there are limited financial resources for medicines. Once this is taken into account, the remaining budget is not sufficient to cover the costs of medicines, which leads the county to reject the requested amount and wait for the supplemental budget to approve over-expenditures.

Medicine procurement is done by the county procurement department, which procures all public goods and services, and payment to the supplier is made directly by the county accountant/treasury. As mentioned earlier, the policy in Kenya states that medicines must first be procured from KEMSA. In cases where KEMSA cannot supply the medicines, counties and health facilities can procure from MEDS (which serves the faith-based and the private sectors) or the commercial sector as the third option. In cases where counties must resort to procuring

medicines from the commercial sector, none of the county pharmacists indicated having issues related to the quality of medicines. Each county has a list of approved suppliers that they can procure medicines from and, in some cases, established contracts with suppliers that include medicine prices. However, the prices of medicines procured from the commercial sector are much higher than those from either KEMSA or MEDS. Table 6 indicates the procurement prices for maternal and newborn heath medicines.

Table 6. Tracer Medicine Procurement Prices per Unit, FY 2014–2015

Tracer Medicine	Unit	Medicine Procurement Price per Unit (USD)			
		KEMSA	***MEDS***	***Commercial sector***	***International median price***
Oxytocin 10 IU	Amp	0.12	0.14	0.24	0.17
Gentamicin 10 mg/ml	Amp	0.09	0.09	N/A	0.09
Gentamicin 40 mg/ml	Amp	0.09	0.12	0.82	0.06
Zinc sulfate 20 mg DT	Tab	*Not able to collect this information as it was being procured as ORS-zinc co-packs.*			

Health facilities order medicines from KEMSA via an electronic system. All orders must first be approved by the county pharmacist before KEMSA can fill them. Orders are placed directly with MEDS and submitted to county pharmacists. Medicines are then supplied directly to the health facilities by the suppliers and invoices are sent to the county pharmacist to submit to the county accountant at the treasury for payment.

One of the major challenges indicated by county pharmacists is delay in payment to the suppliers (KEMSA or MEDS), which leads to delays in commodities reaching health facilities. This is in part due to delays in the disbursement of funds from the national level or because the amount requested is more than what was budgeted for or exceeds the health facility's drawing rights. The county pharmacist in one county indicated that KEMSA will usually supply the medicines despite delays in payment due to disbursement of funds because the county has a strong relationship with the company and usually pays on time. However, this is not true across all the counties, and more research needs to be done to identify the specific bottlenecks causing delays in both payment to suppliers and disbursement of funds to the county level.

County Budget Allocations for Health and Medicines

As mentioned earlier, the budget for medicines is not broken down by medicine and is lumped together under the line item for medicines, which includes pharmaceuticals and non-pharmaceuticals. Since the 2013–2014 fiscal year—the first year devolution was completely rolled out—USAID's Health Policy Plus project has been conducting annual national and county health budget analyses. These reviews, along with the county health budget documents available on the county website and procurement data collected through the subnational procurement assessment for Elgeyo-Marakwet, were reviewed to better understand health expenditures, particularly for medicines.

The national and county health budget analysis reports found that while the health budgets for the MoH and allocations for health combined for MoH and counties remained more or less the same, the average percentage of county budgets allocated for health has been gradually increasing over the last three years. However, budget allocations specifically for medicines have been inconsistent at the county level. While the average percentage of the county budgets allocated for medicines increased from 7.8% to 10.5% between FY 2014–2015 and FY 2015–2016, the budget allocation for FY 2016–2017 decreased to 9.6%.

Data submitted by the finance department from Elgeyo-Marakwet County for FY 2014–2015 and 2015–2016 indicated that despite an increase in the percentage of the county budget allocated for health (30% to 32%), the final amount allocated specifically to medicines, taking into consideration the supplemental budget, decreased from 11.8% to 9.5%.

Table 7. Average Percentage of the Total National and County Budgets Allocated to Health and Medicines[26]

	2012–2013 *(pre-devolution)*	**2013–2014**	**2014–2015**	**2015–2016**	**2016–2017**
Average percentage of the national budget allocated to health (national and county)	7.8%	5.5%	7.5%	7.7%	7.6%
Percentage of health budget allocated to MoH (national)	*Not applicable*	3.4%	4.0%	3.9%	3.7%
Average percentage of county budgets allocated for health	*Not applicable*	13.5%	21.5%	23.4%	25.2%
Elgeyo-Marakwet		23.0%	30.0%	32.0%	*Not available*
Total county budget for medicines and supplies	*Not applicable*	11.1%	7.8%	10.5%	9.6%
Elgeyo-Marakwet	*Not applicable*	*Did not collect*	11.8%	9.5%	*Did not collect*

Note: Table includes data from the National and County Health Budget Analysis reports developed by the Health Policy Plus project as well as data collected from Elgeyo-Marakwet as part of the subnational procurement assessment.

[26] http://www.healthpolicyplus.com/ns/pubs/6138-6239_FINALNationalandCountyHealthBudgetAnalysis.pdf

SUMMARY OF KEY FINDINGS

While progress has been made in the last few years in ending preventable child and maternal deaths, there are still challenges to improving access to medicines and health services. A major challenge, which has been highlighted by the Global Financing Facility and many donors, including USAID, is financing and how that affects the procurement and availability of MNCH medicines.

In Kenya, the purpose of devolution, particularly for the health sector, was to increase transparency; enhance equity in resource allocation; and improve service delivery, particularly for those in rural areas. However, challenges continue to inhibit progress in achieving the country's goal of reducing maternal and child deaths. Maternal and child mortality rates remain too high in many counties, and access to essential MNCH medicines is limited. While the country has invested heavily in improving the supply chain for medicines, disparities continue to exist between counties. One of the major challenges counties face is adequate financing for MNCH medicines based on actual need and efficient financial systems to ensure continuous availability of medicines. Since the new, devolved system is still progressing, there is an opportunity to streamline and enhance processes to ensure access to essential MNCH commodities, particularly with regard to financing and the factors that affect it.

This report has identified key bottlenecks related to budgeting and the financial flow of MNCH medicines at the county level. The budgeting process for the national and county levels is clearly defined in the budget circular, with guidelines and clear deadlines for each step in the process. While no issues were identified regarding meeting the budgeting timelines, there are challenges and weaknesses in developing the budget line item for medicines.

No guidelines for developing the budget for medicines. While the development of the overall county budget is clearly indicated in policy documents and national guidelines, there are no standardized guidelines or tools specifically for county pharmacists and health departments on how the budget should be developed, including guidelines for quantification and determining health facility drawing rights or a budget for medicines. Quantification handbooks exist at the national level and counties can adapt them for their own quantification at the county level. A major factor in developing the medicines budget is quantification and identifying the actual need, but this is largely based on past consumption, past distribution, and/or previous year's expenditures. Despite estimating the medicine needs, albeit inaccurately, the requested budget is often less than what is needed as county pharmacists expect that the approved and allocated amount will be less. Similarly, for health facility drawing rights, there are no standardized guidelines or operating procedures across counties on how this is determined in each facility, and it is not based on what is actually needed per facility.

Approved and allocated budget is often less than requested. During the budget development process, there are multiple times when departments and public organizations (e.g., nongovernmental organizations, professional institutions) can comment and advocate for additional resources. Despite this, both counties visited indicated that the budget that is finally approved and allocated is less than what is requested. This can be due to limited financial resources due to the ceiling cap for the county, a lack of data for decision making, or limited capacity for the CHD to advocate for more resources.

Little is known about how the formula that CRA uses to allocate funds impacts the budget for medicines. It is recommended to research this further by comparing budget ceilings verses county needs and evaluating the reality of expenditures and stock-outs of medicines.

However, there are certain coping mechanisms instituted at the county level to compensate for both under- and over-expenditures by certain departments or line items. These include the process for developing the supplemental budget or the reallocation of approved funds between departments and line items and the provision of emergency procurement funds to health centers and hospitals, as done in one county. While the supplemental budget is done across all counties and is mandated at the national level, the provision of funds to health facilities for procurement is a mechanism devised by that county. Other counties may have developed other coping mechanisms to ensure the needed amount of medicines is procured.

Limited availability and visibility of logistics data needed for decision making. Key logistics data, such as stock status and days of stock-out, for MNCH commodities are not being tracked, monitored, or reported at either the county or the national level. Currently, the District Health Information System used in Kenya has a logistics module only for malaria commodities. As a result, critical data that can be used to inform the budget for medicines and even advocate for additional financial resources are not available or used. Although one county indicated that it collects and uses these data to determine the budget, this does not seem to be uniform across counties.

Disbursement of funds often not done on time, leading to delays in payment of suppliers. A major reason indicated for the delay in payment to suppliers and subsequent late or limited supplies of medicines is delays in the disbursement of funds from the national to the county level. More research needs to be done at the national level as to the reasons for the delays, which hinder payment to suppliers such as KEMSA and MEDS. While those counties with a strong relationship with KEMSA are not affected by minor delays because KEMSA will continue to honor orders, other counties are more vulnerable. MEDS, because it is a private-sector supplier, will withhold supplies until previous balances are paid.

Monitoring expenditures for medicines is limited and not done at the subcounty level. While annual audits of expenditures are routinely done, monitoring or analyzing the budget for medicines and correlating it to availability is not. This is due in part to limited accessibility of the data and to limited capacity at the county level. It was found that at the health facility level, some facilities have a small budget to conduct emergency procurement of medicines; however, this is not reported to county pharmacists or tracked at the county level so that it can be taken into account during the budget development process.

Lack of coordination between the national and county levels and among counties. Finally, a major bottleneck identified is the lack of coordination between the national level, such as the MoH, MNCH Commodity Working Group, health and biotechnology subgroup of the CoG, and the CHDs. While the MoH and the CHD have clear and distinct roles under the devolved system, the coordination between the two is limited, particularly with regard to commodities. Similarly, although the MNCH commodity security working groups and the CoG's health and biotechnology subgroup are new, it is unclear as to their respective roles and how the groups can

be utilized to advocate for more financial resources for medicines or to strengthen county-level processes and systems that can inform the medicines budget.

As previously mentioned, challenges vary across counties, and how these challenges are addressed or circumvented is entirely up to county governments. Counties should coordinate and share experiences on what mechanisms have been instituted to ensure that medicines are continuously available.

Kenya has made considerable progress given that it is in the early stages in devolution. Systems and processes are evolving and lessons are being learned at both the national and county levels. Given that devolution is only in its fourth year, there are great opportunities to strengthen and institutionalize guidelines and procedures for improving capacity at the county level to adequately budget for and provide continuous availability of MNCH commodities. Addressing these key bottlenecks will be essential moving forward to ensure proper allocation and efficient use of funds for health commodities.