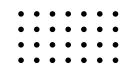


BUDGET TREND ANALYSIS REPORT FOR SRH/RMNCAH PROGRAMS IN ISIOLO, MARSABIT AND MANDERA COUNTIES(FY 2022/23-FY 2024/25)

FEBRUARY 2026



1. INTRODUCTION



1.1 Background

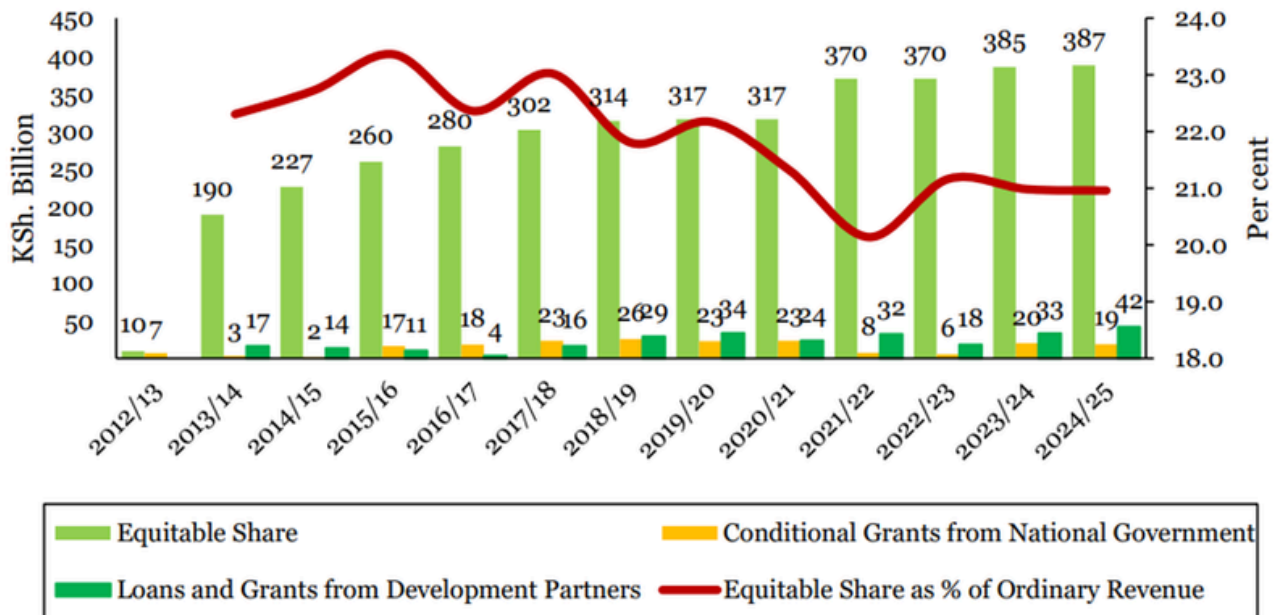
In the Kenyan context, Devolution is presented as a system of multi-level government under which the Constitution creates two distinct and inter-dependent levels of government that conduct their mutual relations in a consultative and cooperative manner. There have been experts who have identified several factors determining the efficiency of decentralization and in this case devolution. They include the establishment of the Constitution and a legal framework that highlights the specific role of each level of government including the regulations governing fiscal arrangements and public service delivery, and mechanism for conflict resolution (Azfar et al, 2004). There is also the political framework governing the electoral process at the sub-national level that facilitates the direct participation of the users of the services in the elections of political leaders. Fiscal decentralization framework; information sharing; and adequate capacity in the form of human capital, essential equipment and technology are also key factors.

According to Kenya's Reproductive, Maternal, Newborn, Child, Adolescent Health and Nutrition (RMNCAH-N), the Investment Framework of 2016-2020 reports significant outcomes. It however highlights that expanding the coverage of RMNCAH-N services still remain a challenge. A key example is that, the maternal mortality ration which is an important indicator of maternal status, remains high in Kenya despite slight improvements over the recent years, from 363 per 100,000 live births in 2014 to 355 in 2019. Additionally, stillbirth rates have substantially fallen from 23 to 15 deaths per 1,000 total births from 2014 to 2022/2023. Neo-natal mortality rates have also declined, but marginally over the last decade with the neonatal mortality rate decreasing from 22 deaths per 1,000 live births in 2014 to 21 deaths in 2022 while stillbirth decreased.

It has been noted that in summary as a country, Kenya has made significant progress in maternal and child health status, with substantial declines in mortality rates over the last twenty years. Kenya is also noted to have made notable progress in improving family planning services, achieving a modern contraceptive prevalence rate of 57% among married women as of 2022.

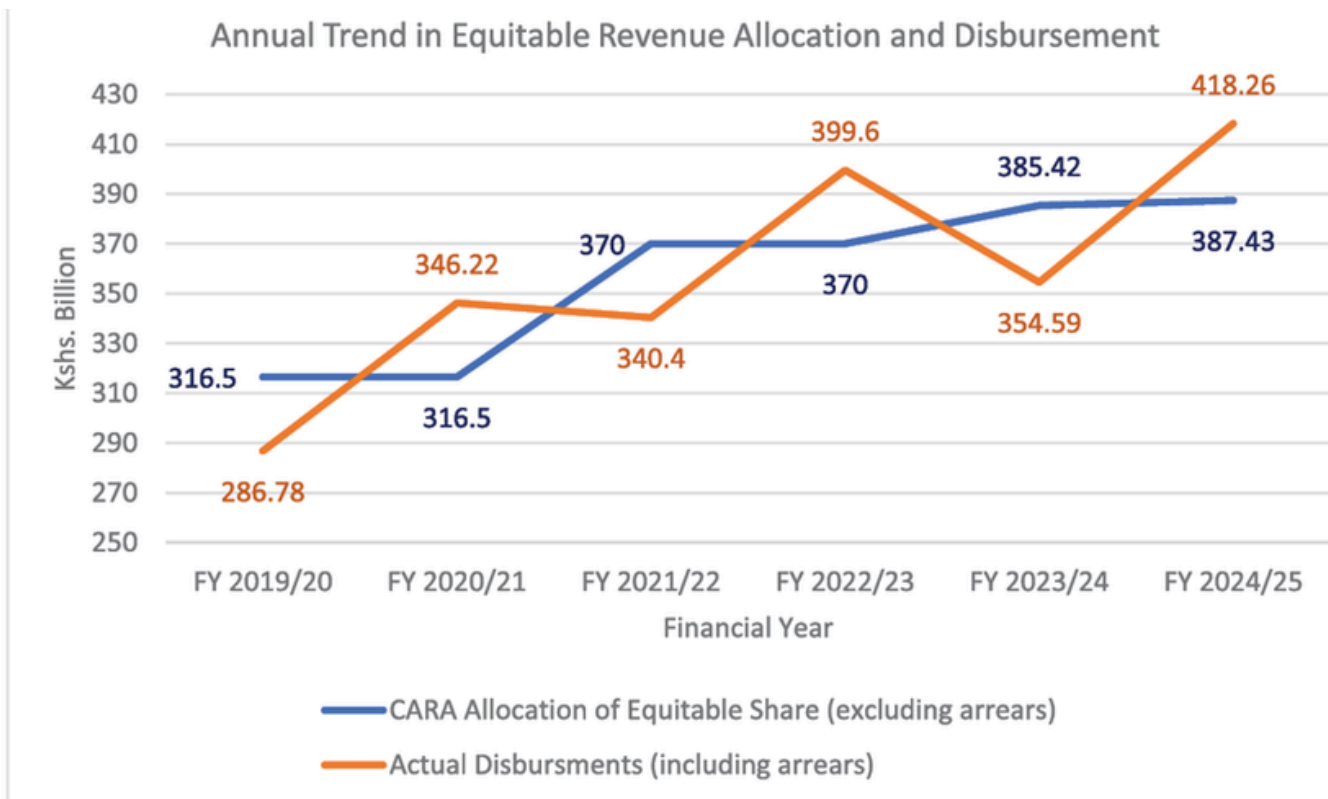
To understand the county governments contribution towards the related reforms. It is important to put into perspective the cumulative resource envelope available to the counties. The forty-seven county governments have since 2013 been allocated revenues amounting to Ksh.4,208.71 billion to 2023/2024 financial year. The related equitable share amounts to Ksh.3,741.1 billion with conditional grants from the national government amounting to Ksh.193.55 billion, and loans and grants from development partners amounting to Ksh.274.12 billion.





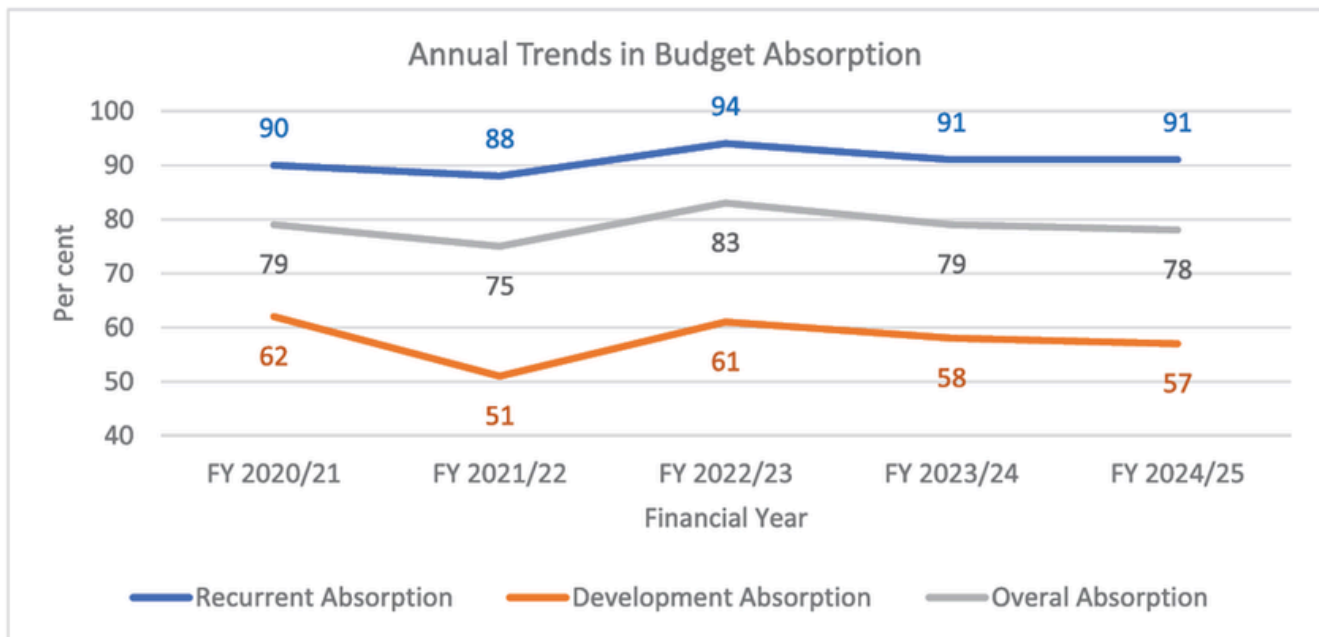
Source of Data: Controller of Budget

While it is important to note the respective allocation to the county governments since the rollout of devolution to build a perspective, it is critically important to correlate these allocations to the exchequer releases over the period.



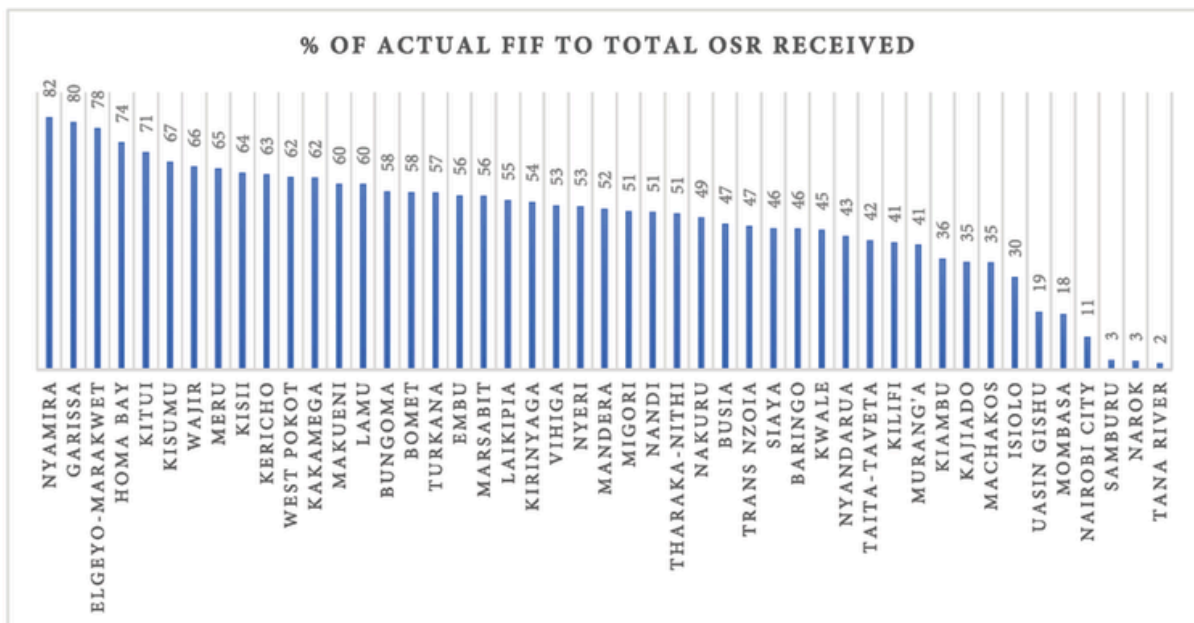
Source: County Treasuries

A constructed budget absorption over a defined period of time also provides a greater understanding of the overall planning, budgeting and implementation status of the three county governments under the review.



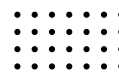
Source: County Treasuries

The counties equally continue to raise own source revenues with a significant percentage relating to Facility Improvement Funds. For the counties under focus, it has been noted that they are striving to generate FIFs to complement their rather progress equitable share of allocations from the national transfers.



Source: County Treasuries

Due to the fact that Kenya has been recognized to have made significant progress in maternal and child health status, with substantial declines in mortality rates over the last twenty years, including notable progress in improving family planning services, achieving a modern contraceptive prevalence rate of 57% among married women as of 2022, this assignment is expected to provide a platform to assess the level of county governments contribution towards the national indicators. With the national outlook already provided, it would be critical to assess the level of counties investment, especially the three counties under focus.



2. APPROACH AND METHODOLOGY

Reducing maternal and child morbidity and mortality and improving reproductive, maternal, newborn, and child health (RMNCH) have become key priorities of the global health agenda, particularly for low- and middle-income countries (LMICs). It was considered that during the period of the Millennium Development Goals (MDGs) between 1990 and 2015, the coverage of effective RMNCH interventions to reduce maternal and child morbidity and mortality was scaled up in LMICs.

Kenya has been considered to be lagging far behind on key SDG indicators, and the nation will not achieve its target unless concerted efforts are undertaken to increase access to and utilisation of RMNCAH-N services.

SDGs Targets by 2030-relevant to the analysis

- Reducing the global maternal mortality ratio to less than 70 per 100,000 live births
- Ending preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1000 live births and under 5 mortalities to at least as low as 25 per 1000 live births
- Strengthening the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol
- Ensuring universal access to sexual and reproductive health care services including family planning information and education and the integration of reproductive health into national strategies and programs
- End all forms of malnutrition, including achieving, by 2025 the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons.
- The Global strategy also includes the target of reducing still births to 12 or less per 1000 total births

The 2024 Kenya SDG report noted that maternal mortality remained unchanged, neonatal mortality stagnated, and under-five mortality improving—but the progress slower. This underscored the urgent need for RMNCAH-N IC to accelerate progress toward SDG targets on maternal, newborn, child, and adolescent health and nutrition. The end-term review of the RMNCAH Investment Framework (2016–2020) called for a new strategy to guide National and County Governments, donors, and stakeholders in scaling up investments. In response, the Ministry of Health, in collaboration with the RMNCAH-N Multi-stakeholder Country Platform, developed the second RMNCAH-N IC to drive coordinated action and improve health outcomes across all levels.



2.3 Limitations of the Assessment



As in every exercise, the assignment has experienced certain limitations. This section highlights some of those foreseen limitations and proposes some initial mitigation measures to deal with any possible shortage of information.

Table 2: Limitations of data collection and proposed mitigation strategy

Risk	Probability	Mitigation
Un-availability of the reference documents on public platforms	High	Engage with key intergovernmental institutions to source for the documentations.
Lack of uniformity in budgeting for the related programmes by the three county governments.	High	Consolidate the related programmes allocations to provide a fair view to generate a trend analysis.

3. SPECIFIC FINDINGS

It was noted that access to the related reference materials have been a challenge throughout the course of this assignment however available materials have provided a snapshot of the required information. The basis of the analysis was therefore based on available information provided in the respective counties' programme based budgets; Controller of Budget County Budget Implementation Reports; and the Counties Integrated Development Plans.

The table below shows related available information package used to arrive at the analysis carried out.

County	CIDP	Programme Based Budget	Annual Development Plan/Work Plan	County Budget Implementation Report	Data on RMNCAH
Isiolo	Available	Available	Not available	Available	Not available
Mandera	Available	Available	Not available	Available	Not available
Marsabit	Available	Available	Not available	Available	Not available

While the publicly available information did not provide for specific allocations towards RMNCAH, the information provided an indication of the related allocations towards the health sector in the counties as well as a consolidated amount on preventive healthcare which is inclusive of allocations towards RMNCAH.

It is noteworthy to highlight that in all instances across the three counties, the respective County Integrated Development Plans (CIDPs) and the Program Based Budgets identified four key programs that could be presumed to be related to RMNCAH.

- 1.Reduction of the burden of preventable diseases and promote healthy lifestyles among communities.
- 2.Reduction of maternal and new-born mortality.
- 3.Increment of community health units to cover 100% of the county villages.
- 4.Improvement of coverage of facilities offering adolescent and youth friendly service.

To provide the comparative analysis, the table below highlights the associated allocations and expenditures across the three counties with relation to the health sector and RMNCAH respectively.

		Allocations (Ksh billions)			Expenditures (Ksh billions)		
		2022/23	2023/24	2024/25	2022/23	2023/24	2024/25
Mandera	Total Health	2,840,787,296	2,648,252,262	2,648,252,262	2,620,733,589	2,499,180,000	2,575,744,815
	RMNCAH	131,186,458	211,914,813		84,826,152	172,055,555	
Isiolo	Total Health	1,465,600,000	1,509,197,581	1,628,740,000	1,424,530,000	1,180,260,000	1,354,460,000
	RMNCAH		113,730,224			37,551,515	
Marsabit	Total Health	1,859,990,000	2,029,160,000	2,223,330,000	1,668,730,000	1,841,370,000	2,051,390,000
	RMNCAH	425,991,493	503,182,283		253,651,618	338,331,782	10,000,000

With the highlighted data related challenges, the analysis provided may to a large extent be unreliable. The related analysis is as provided in the below:

3.1 Trend analysis on the allocations against the related expenditures

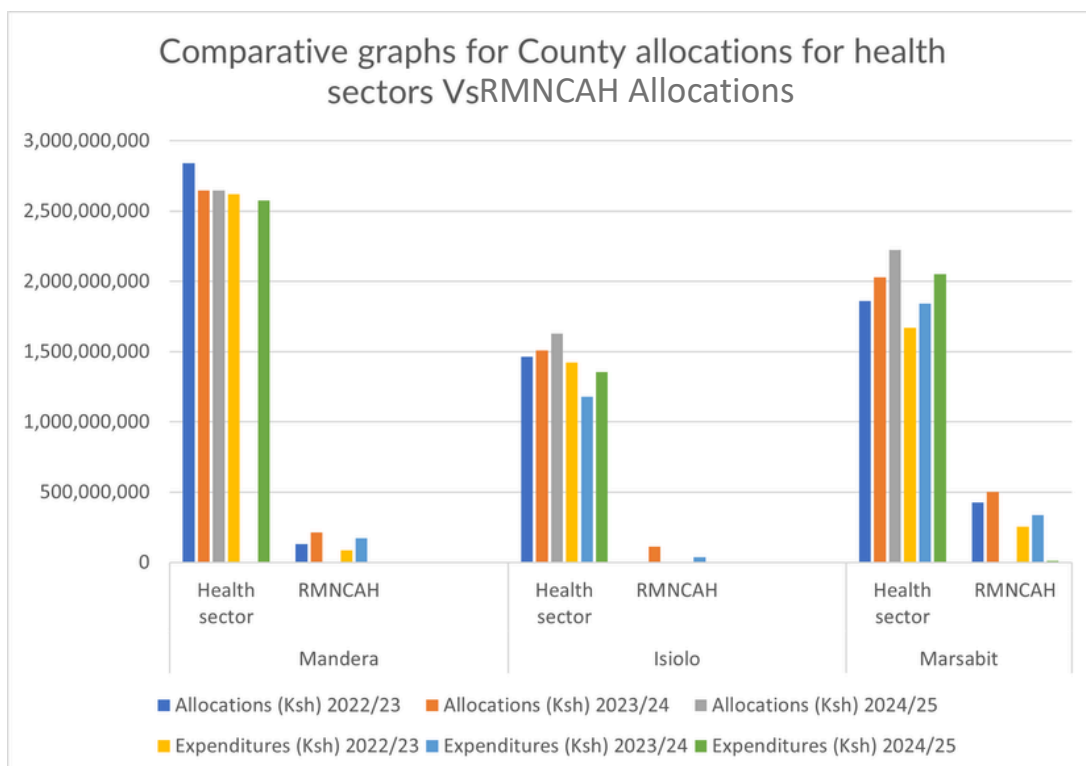


Fig1.0: Comparative graphs for County allocations for health sector Vs RMNCAH allocations

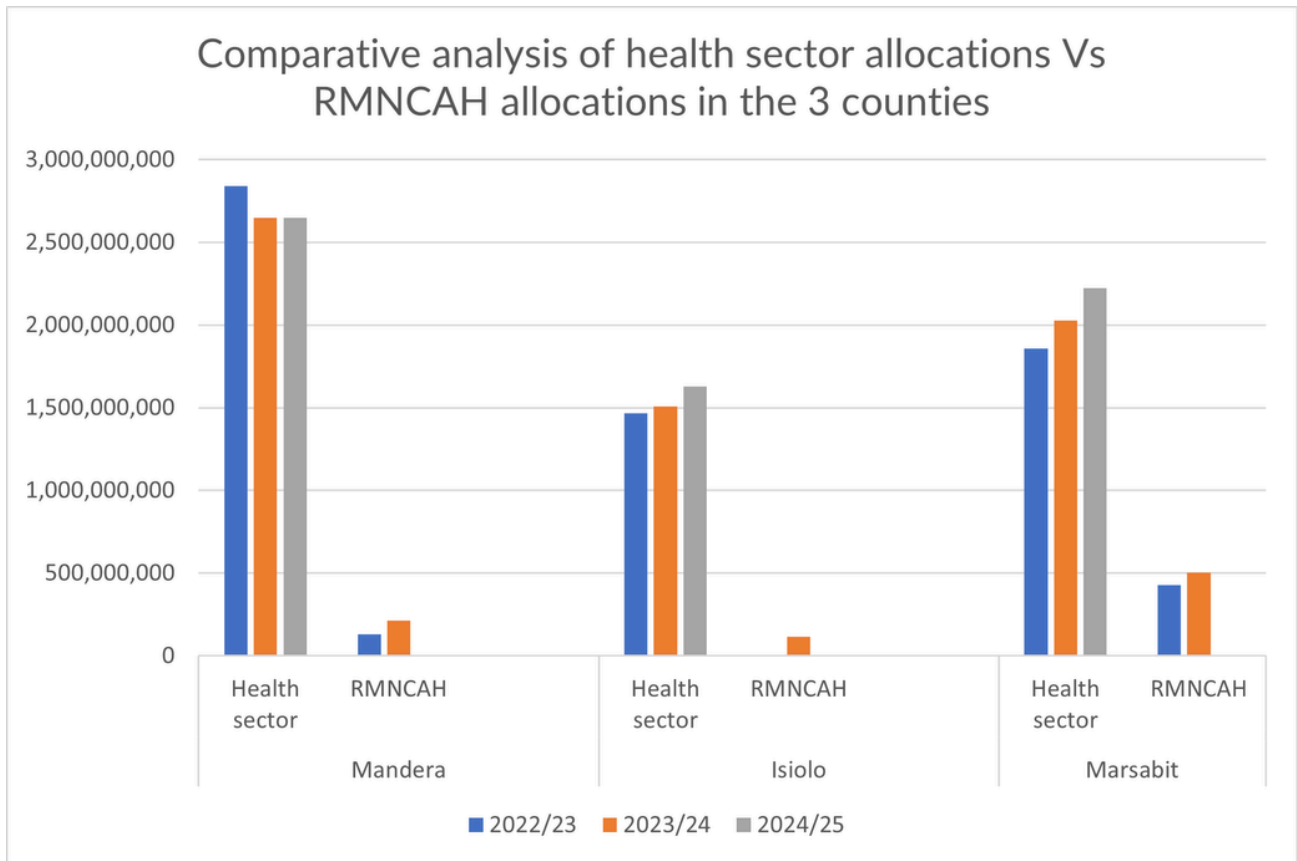


Fig 1.1: Comparative analysis of health sector allocations Vs RMNCAH allocations in the 3 counties

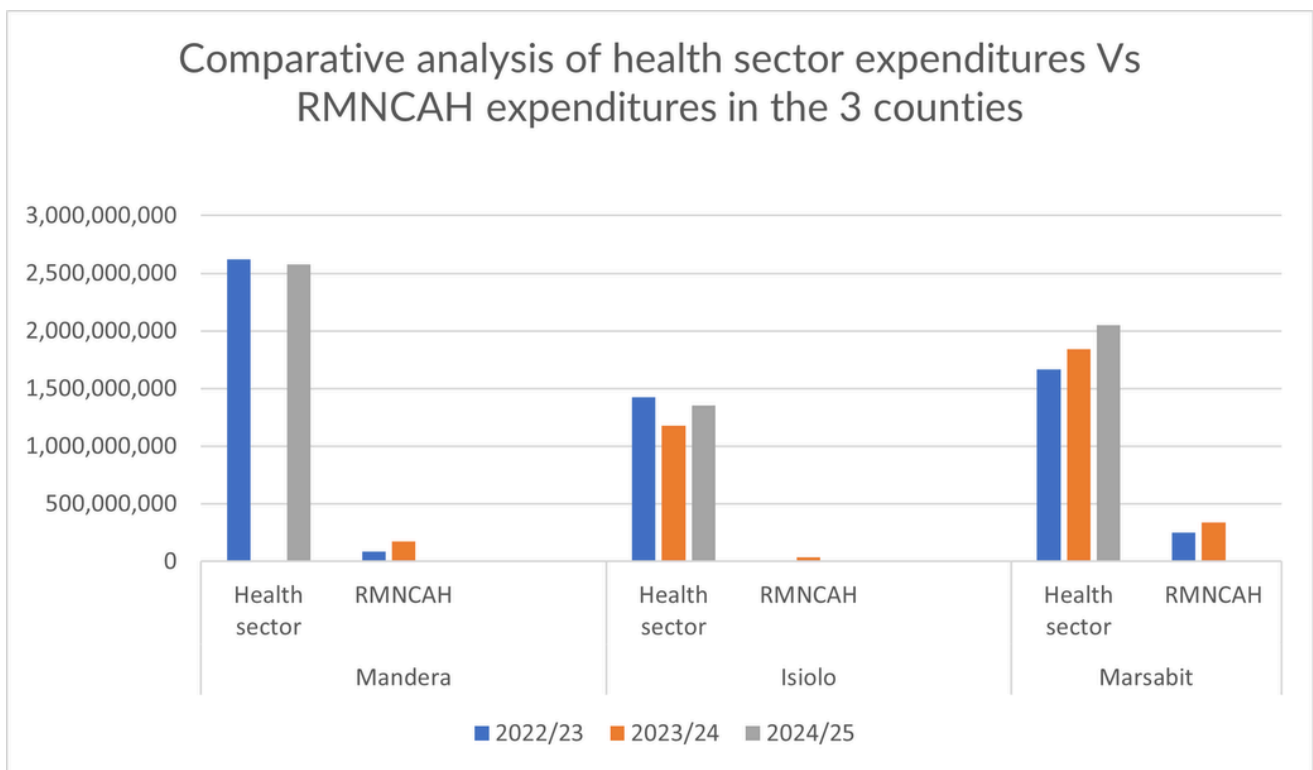
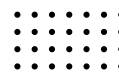


Fig 1.2: Comparative analysis of health sector expenditures Vs RMNCAH expenditures in the 3 counties



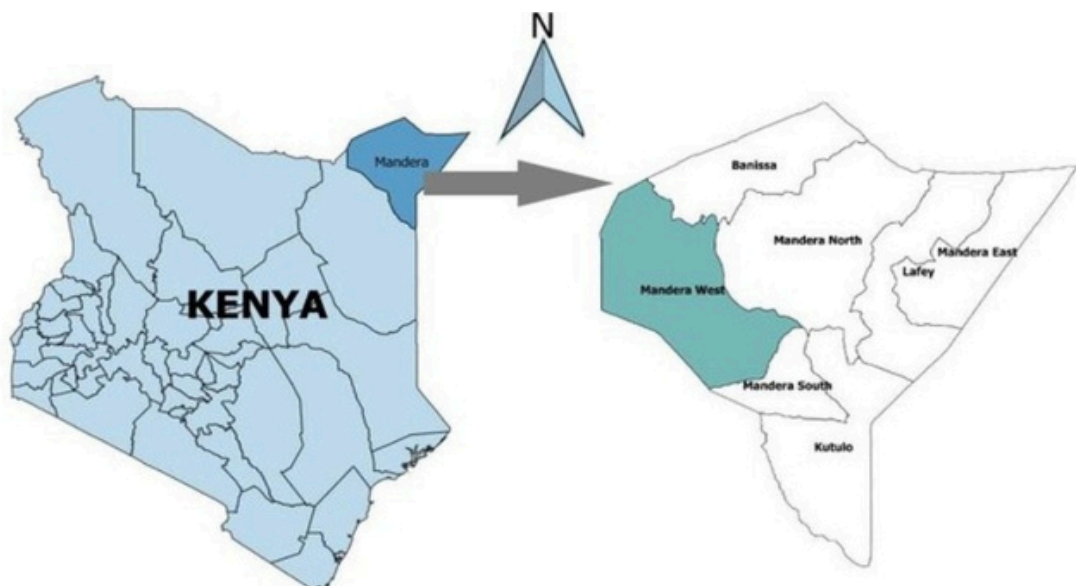
From the provided data, the following can be noted across each county government:

a. Mandera County

There is no data available for both allocations and expenditures related to both RMNCAH and RSRHR for the 2024/2025 financial year. Mandera County has demonstrated a strong commitment to health, with expenditures to the health sector increasing to almost 21% of the overall budget by 2021, according to current budgeting documents and studies on the health sector. Through targeted, high-value initiatives, the County has given priority to RMNCAH (Reproductive, Maternal, Neonatal, Child, and Adolescent Health) and RSRHR (Reproductive and Sexual Health Rights) in 2024–2025.

RMNCAH Allocations in Mandera (FY2023-2025) were:

- Integrated Reproductive Health Program: A total of **KES 710 million** was set aside for this program's development in 2024; by 2025, that amount had increased to **KES 750 million**.
- Maternal and Newborn Unit Upgrades: A significant **KES 1.2 billion** expenditure was recorded for the improvement
- Family Planning/Maternal & Child Health: **KES 38.5 million** has been set aside for some FP/MCH initiatives.
- High Absorption Rate: The Mandera health sector's budget absorption rate increased from **85% in FY 2022–2023** to **90.2% in FY 2024–2025**.
- Funding Sources: RMNCAH services are still largely reliant on national government funding (amounting to more over **Ksh 400 million** in 2024–2025) and development partner support, notwithstanding the county's growing local, own-source earnings.



b. Isiolo County

In Isiolo county, there is no data available for both allocations and expenditures related to both RMNCAH and SRHR for the 2022/2023 and 2024/2025 financial years.

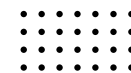


RMNCAH Allocations in Isiolo (FY2023-2025) were:

- Total Health Budget: The Health and Sanitation department receives a significant portion of the county budget, and the sector was expected to spend amount of money in FY 2024–2025 (some reports even approach **2.9 billion KES**).
- RMNCAH initiative Allocation: With help from USAID-UNICEF, the County had started a **three-year** initiative (October 2023–September 2026) to improve RMNCAH, with an emphasis on sanitation, immunisation, and maternal/newborn care.
- Community Health Promoters (CHPs): CHP services, which are essential for RSRHR and RMNCAH outreach, are funded with about **21 million KES** a year.
- UNFPA Support: For reproductive health initiatives, specific grants from partners such as UNFPA (about **9.6 million KES**) are provided.
- Budgetary Restrictions: The full implementation of RMNCAH initiatives is impacted by low own-source revenue and delays in the availability of national government funds.
- Reproductive Rights & FGM: The County Integrated Development Plan (**CIDP 2023-2027**) includes measures to end female genital mutilation (FGM) and promote SRHR.
- Key Spending Areas: In order to lower maternal and newborn mortality, spending is concentrated on modernising facilities, purchasing medical equipment, and educating healthcare professionals.

RMNCAH Allocations in Marsabit (FY2023-2025) were

- In Marsabit county, there is no data available for the allocations related to both RMNCAH and RSRHR for the 2024/2025 financial year.
- Budgeting for Maternal and Child Health (MCH): The Programme Based Budget (PBB) for 2025–2026 allocates funds specifically for Integrated MCH and Family Planning services, including specialised care in maternity wards.
- Health Sector Expenditure: From Ksh 0.7 billion in 2014–15 to over Ksh 1.5 billion in 2017–18, Marsabit's total health sector budget increased, with a large amount going towards infrastructure and staff. According to recent budget forecasts for 2025–2026, health spending will amount more than KSh 1 billion, with significant sums going towards "Use of Goods and Services" and personnel remuneration.
- Conditional Grants: Maternal health care (e.g., KSh 25 million in 2020/21) and World Bank-supported initiatives (e.g., KSh 34 million in 2020/21) have received substantial funding from both domestic and foreign partners.
- Nutrition Integration: By utilising current RMNCAH personnel and resources, funding for the treatment of severe childhood wasting is incorporated into the MCH program.



3.2 FIF Performance: The Engine for Sustainable SRH -strategic Benchmarking (FIF as % of Total OSR)

The findings indicate that these counties are utilizing FIF to complement their equitable share from the national government.

- Marsabit: Shows strong potential with FIF accounting for 54% of its Own Source Revenue (OSR).
- Mandera: Utilizes FIF as a significant portion of OSR, currently at 51%.
- Isiolo: Records the lowest utilization of FIF among the three, at 30% of total OSR.

To increase RMNCAH and SRH increments, the following model is proposed based on the report's analysis; Ringfencing Model.

- Revenue Collection: Fees collected from services (Facility Improvement Fund).
- 100% Retention: Policy recommendation to allow facilities to retain these funds locally rather than remitting to the County Revenue Fund.
- Automated Restocking: Direct reinvestment into SRH/RMNCAH commodities and essential medical supplies.

3.3 General Challenges in the budget analysis process

The comprehensive budget analysis for Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCAH) in Isiolo, Marsabit, and Mandera counties was significantly hampered by systemic data limitations. The primary challenge was the acute lack of disaggregated, accessible, and timely financial data at both county and sub-county levels. This manifested in several ways:

1. **Limited Access to Information:** Budget documents (Annual Development Plans, County Fiscal Strategy Papers, Program-Based Budgets) often lacked specific RMNCAH line items, with related expenditures buried within broader health program budgets. Internal county health management financial reports were not readily available for public or stakeholder scrutiny.
2. **Severe Lack of Disaggregation:** Available data was rarely disaggregated by:
 - Activity: Making it impossible to distinguish allocations and expenditure for specific RMNCAH components (e.g., antenatal care vs. adolescent health services).
 - Geographic Location: Concealing disparities in resource distribution between sub-counties and health facilities.
 - Funding Source: Blending funds from the County Revenue Fund, national government conditional grants (including the Free Maternity Services/FIF), and development partners, obscuring accountability for each stream.
 - Gender and Age: Budgets were not analyzed through a gender or age lens, contradicting the principles of equitable RMNCAH service provision.
3. **Opacity in Financial Flows:** The tracking of the Facility Improvement Fund (FIF) from collection at facility level to its utilization was particularly challenging. There was no clear, standardized reporting mechanism to show how FIF revenues were reinvested in the originating facilities to improve RMNCAH services.

Consequences: These gaps made it difficult to assess budget adequacy, track efficiency, measure equity in resource allocation, and hold departments accountable for RMNCAH commitments. The analysis risked being inconclusive on whether investments matched county RMNCAH burden and priorities





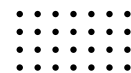
3.4 Specific Challenges related to analysis of budgets and allocations for SRH/RMNCAH Programs

- 1. Heavy Reliance on External Funding:** SRH and RMNCAH services remain disproportionately dependent on support from the national government (over Ksh 400 million in Mandera for 2024-2025) and development partners like USAID, UNICEF, and UNFPA. This creates a high risk of service disruption if donor priorities shift.
- 2. Persistent Data Gaps and Lack of Transparency:** There is a critical shortage of publicly available data. For example, Isiolo and Mandera lack allocation and expenditure data for RMNCAH in the 2024/2025 financial year. This "information black hole" makes it difficult for stakeholders to track progress or advocate for more funds.
- 3. Low Allocation Relative to General Health:** Across all three counties, RMNCAH allocations are significantly lower than general health sector budgets. In some years, these critical programs recorded zero allocations despite their high priority status in national frameworks.
- 4. Administrative Overheads "Crowding Out" Services:** County health budgets are often skewed toward administrative functions (system-wide support), which can account for up to 75% of spending, leaving as little as 1% for direct primary care services like RMNCAH.
- 5. Fluctuating Budget Execution:** While Mandera has shown a high absorption rate (up to 90.2%), budget execution in other areas is inconsistent due to delays in exchequer releases from the national government and low own-source revenue (OSR) generation.

3.5 Key observations

1. The RMNCAH allocations are significantly low compared to the health sector allocations in all the 3 counties.
2. Comparatively, Marsabit County has the highest RMNCAH allocations and expenditure, followed by Mandera, with Isiolo recording the least allocations and expenditures.
3. Generally, Mandera County has the highest health sector allocations compared to the other two counties.
4. All the Counties have recorded fluctuating allocations and expenditure across the financial years, with RMNCAH recording zero allocations and expenditure in some financial years.





4. POLICY RECOMMENDATIONS

To strengthen RMNCAH financing, transparency, and ultimately health outcomes, the following recommendations are made to the County Department of Health and the County Assembly:

To the County Department of Health:

➤ Enhance Budget Transparency and Access to Information:

- Develop and publicly share a simplified RMNCAH Budget Brief annually, alongside main budget documents, highlighting allocations by key program areas (e.g., maternal health, family planning).
- Establish a public portal or regular publication of quarterly financial execution reports for the health sector, with a dedicated section for RMNCAH.
- Proactively disclose internal health financing reports to authorised stakeholders, including the County Assembly Health Committee and civil society.
- Update and display service charters at all health facilities indicating all services provided at the particular facility to enhance efficiency and accountability e.g. FP services, HIV and STI testing and treatment, SGBV PEP and PREP etc

➤ Institutionalize Budget Disaggregation:

- Strengthen the Program-Based Budgeting (PBB) framework to include clear, discrete budget lines for core RMNCAH activities within the county health budget.
- Implement a mandatory reporting template that requires financial data to be disaggregated by program, sub-county, and facility level (where applicable).
- Introduce gender and age-responsive budgeting tools to ensure RMNCAH allocations specifically address the needs of women, adolescents, and children.

➤ Ensure Transparent and Accountable FIF Utilization:

- Institutionalize Ring-Fencing of Health Funds: Counties should implement legislative frameworks to ring-fence Facility Improvement Funds (FIF) and a specific percentage of the health budget for RMNCAH services. This prevents funds intended for maternal and reproductive health from being diverted to administrative overheads.
- Create a transparent FIF management system: Require health facilities to develop micro-plans for FIF expenditure focused on RMNCAH service improvement (e.g., equipment, waiting bays, water/sanitation) and publicly display these plans and subsequent expenditure at the facility.
- Under the second point on create.... In brackets replace with (youth friendly rooms, condom dispenser, equipment like ANC Profile testing, commodities etc)

➤ Transition from Donor Reliance to Domestic Resource Mobilization:

- Incremental OSR Reinvestment: Counties should commit to reinvesting a fixed portion of their increasing Own Source Revenue—such as the FIFs they are already generating—directly back into SRH commodity procurement.
- Mainstreaming Commodities: Shift the procurement of family planning and reproductive health products from donor-funded projects to the county's core "Use of Goods and Services" budget line.

➤ Strengthen Primary Healthcare (PHC) and Community Outreach:

- Invest in CHPs: Secure permanent funding for Community Health Promoters (CHPs), who are essential for SRH/RMNCAH outreach in marginalized areas. Isiolo's current investment of 21 million KES annually serves as a baseline that should be scaled.
- Infrastructure Upgrades: Prioritize the modernization of maternal and newborn units to ensure that increased budget allocations translate into improved quality of care and higher facility delivery rates.



To the County Assembly :

- **Enhance Budget Transparency and Access by improving oversight for Information access and disaggregation:** This "information black hole" makes it difficult for stakeholders to track progress or advocate for more funds.
 - Mandate, through County legislation or Standing Orders, that the Department of Health submits RMNCAH-specific budget proposals and reports, as part of the annual budget approval process.
 - Conduct pre-budget and post-budget hearings focused on RMNCAH, detailing financial data from the Department of Health to inform allocation decisions.
- **Advocate for and Safeguard Budget Increments:**
 - Based on the County RMNCAH needs and burden, establish a benchmark for the minimum percentage of the county health budget that should be allocated to RMNCAH program and advocate for its annual increase.
 - Protect RMNCAH allocations during budget negotiations and ensure any cuts are justified and minimal.
 - Scrutinize the absorption and utilization rates of RMNCAH funds; poor utilization should not be an excuse for reduced future allocations but a trigger for targeted support and accountability.
- **Legislate for Transparency in FIF and Other Resources:**
 - Enact or amend a County Health Financing Act that legally provides for the ring-fencing, retention, and transparent management of FIF at facility level.
 - Require the Department of Health to table quarterly FIF implementation reports before the Assembly for scrutiny.
 - Link facility performance assessments, partly, to the transparency and effectiveness of FIF use in improving RMNCAH services.
- **Enhance Data Accountability and Public Transparency**
 - **Digital Budget Portals:** Establish and maintain public-facing county treasury portals where Annual Development Plans (ADPs) and Program-Based Budgets (PBBs) are published in a timely manner to facilitate social accountability.
 - **Standardized Budget Coding:** Adopt uniform budgeting codes for SRH/RMNCAH across the three counties to allow for accurate trend analysis and comparative performance tracking.





To the Parliamentarians:

➤ Ring-fencing FP Budgets:

- Legislate a dedicated, nondiscretionary budget line for FP commodities within the State Department for Medical Services to fill the gap left by donor exit and fully fund FP Commodities as a strategy to mitigate teenage pregnancies, maternal mortality and enhance child spacing.

➤ Zero-Rating SRH Commodities

- Enact tax exemptions on all imported Reproductive Maternal, Newborn, Child, and Adolescent Health commodities to lower procurement costs for KEMSA and private providers as well as raw materials to enhance and increase the local production of these commodities as part of ensuring our nations commodity security and sovereignty.

➤ Incentivize County Matching:

- Develop a conditional grant framework where the National Government matches county-level allocations for FP service delivery (e.g., a 2:1 ratio) to encourage domestic resource mobilization.

➤ Policy directive to subsidize all SRH commodities in public facilities remain free at the point of use, fully subsidized through the Social Health Authority (SHA). As a key driver to mitigate declining skilled births, low ANC and PNC visits, early detection of pregnancy risks and complications.

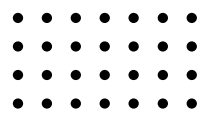
➤ Mandate Adolescent-Friendly Services (AFS):

- Amend the Health Act to require all Level 2& 3 facilities to provide confidential, integrated "one-stop" desks for HIV testing, counseling, life skills and SGBV post-trauma care for adolescents and young people.

➤ Enhance collaborative equipping models by utilizing the NG-CDF to fund









- While NG-CDF currently focuses on KMTCS and "National Functions," MPs should leverage the Constituency Oversight Committee (COC) to prioritize the upgrading and equipping of Level 3 laboratories and maternity wings as "complementary infrastructure" to ensure Primary Health Care for Universal Health Coverage.
- MPs can utilize NG-CDF to fund the "hardware" (maternity wards, solar power, water tanks, and medical equipment) while signing MOUs with County Governments to provide the "software" (staffing and commodities)
- Allocate NG-CDF funds for the digitization of Level 3 facilities to support the national rollout of the Integrated Healthcare Information Technology System (IHITS), ensuring accurate RMNCAH data for better planning and ability to upload data for SHA registration and claim management to ensure optimal reimbursements are done.

Conclusion: Addressing these data and transparency challenges is not merely an academic exercise. It is a fundamental prerequisite for evidence-based policymaking, equitable resource allocation, and effective oversight. By implementing these recommendations, the County Government can ensure that every shilling allocated to RMNCAH is tracked, accounted for, and utilized to maximize impact for the women, newborns, children, and adolescents of **Isiolo, Marsabit, and Mandera.**



FOR MORE INFORMATION:



-  +254 737 108 766
-  www.atmplatformkenya.org
-  info@atmplatformkenya.org
-  @MeTAKenya2018
-  @MeTAKenya
-  Access to Medicines Platform
-  @ProjectSHARP
-  @projectsharp_ke