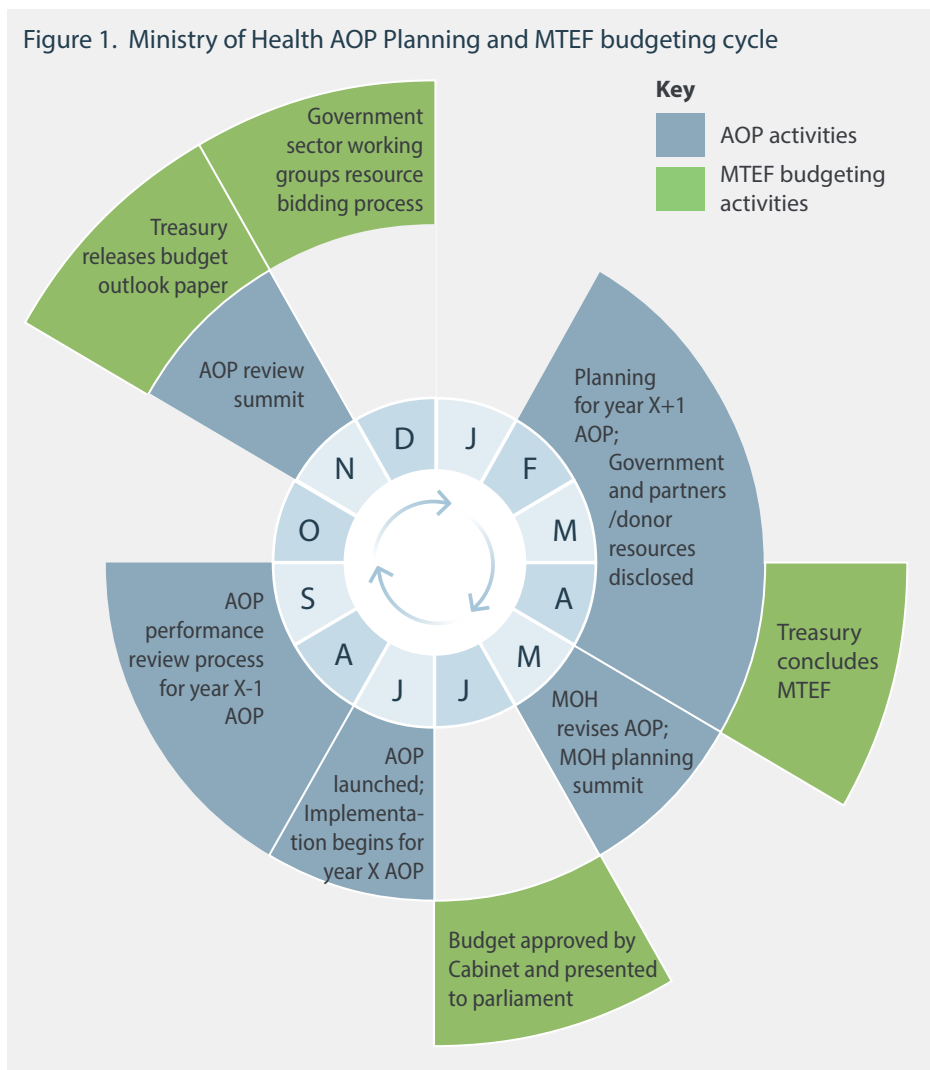


Health sector planning and budgeting in Kenya: recommendations to improve alignment

Operational planning is an important tool for translating government policies and strategic objectives into day-to-day management activities. Since 2005 the Ministry of Health (MOH) in Kenya has used Annual Operation Plans (AOP) to harmonise planning and budgeting across the health sector, and to integrate plans with the Government-wide Medium Term Expenditure Framework, which was implemented in 2000.

Overview of the AOP process

Figure 1 shows how the AOP process is supposed to be conducted and link with Treasury announcements and MTEF activities. The AOP process is led by the MOH but also aims to involve stakeholders at key points of the cycle, e.g. to identify health sector priorities and to assist in planning activities across different levels of the health sector (community, facility, district, and national MOH departments).



Despite these well-defined processes for planning and involving stakeholders in the MOH policies and guidelines, the Kenyan Health sector continues to suffer from misalignment between sector policies, priority setting and budgeting. In 2012/2013, researchers from KEMRI-Wellcome Trust Research Programme conducted a detailed examination of the planning processes in the health sector to establish the reasons for this misalignment.

Key points

- Kenya, like many developing countries, suffers from a persistent misalignment between policy, planning and budgeting; resulting in a failure of the government to achieve public sector targets and respond to changing population needs.
- To address this misalignment, the government has incorporated the World Bank's Medium Term Expenditure Framework (MTEF) into its national planning, and the Ministry of Health has used Annual Operation Plans (AOP) to facilitate sector planning and budgeting alongside the MTEF.
- Research conducted by KEMRI-Wellcome Trust Research Programme has found that several years after the adoption of these planning and budgeting tools, the desired linkage between policy, planning and resource allocation in the health sector is far from being realised.
- Several factors contributed to this delink, these include: weak stewardship and coordination of the AOP and budgeting processes in the health sector, the rapidly changing institutional and planning environment, a lack of reliable data to inform priority setting, and poor stakeholder participation.
- There is a need for stronger commitment and stewardship for the planning and budgeting process by senior MOH officials, and for institutional integration of the planning and budgeting processes at national and sector levels through a common cycle and framework.

The planning and budgeting process in practice

In Fiscal Year 2012/13 the AOP process was significantly delayed and some key activities, such as the review of the previous year's plan to inform priority setting, were not done. As a result the planning process became misaligned with the government-wide MTEF process. In addition, there was no link made between resource availability and the targets set, and there was no participation of non-government actors in the planning. By the beginning of July 2013, when AOP implementation was supposed to begin, the health sector had a budget but no AOP.

Causes of misalignment in the planning and budgeting process

Several factors contributed to the delays in the AOP process and ensuring misalignment with the MTEF.

Stewardship of the AOP process

The Health Sector Coordinating Committee (HSCC), which was responsible for leading the planning process, did not function well – there was poor attendance at meetings, and a lack of follow up on issues agreed at the meetings. Further, the Core planning team, which worked below the HSCC to coordinate the planning process also lacked clear leadership and explicitly defined terms of reference.

Institutionalised separation between health sector planning and the MTEF process

Within the MOH, the Economic Policy and Planning department that coordinated the MTEF budgeting was accountable to the Treasury. Meanwhile, the Technical Planning department that coordinated the AOP was accountable to the Technical Director of the MOH. This separation has hampered planning and efforts to harmonise budgets, with the MTEF seen as an externally driven process.

Rapidly changing organisational and planning environment in the health sector

Since 2008 the MOH has undergone significant changes including being split in two, a proposed merger back to one Ministry, and the devolution of the health system. These changes have created major challenges for stewardship and coordinating the AOP process. For example, the finalisation of planning tools and templates were delayed in 2012 because the MOH did not know how health services would be organised as part of the National Health Policy and Strategic Plan.

Data use in priority and target setting

The quality of data collected to monitor AOP implementation and then inform priority areas and targets was unreliable, for example, many of the indicators had no baseline data to assess progress.

Uptake and participation by planning units

Submission of AOPs by planning units was very low across all levels of the health system (community units, dispensaries, health centres, country hospitals and District Health Management Teams). At the national level only 3 of the 17 technical departments of the MOH had submitted plans. This is partly due to a lack of technical support by Core AOP team members to peripheral sites.

Recommendations to improve alignment

The Kenyan health sector is far from achieving planning and budgeting alignment several years after the adoption of MTEF and AOP tools to address this. The MOH should consider the following recommendations to enhance alignment between planning and budgeting, so as to enhance rational prioritisation of the limited resources available for better health outcomes.

- Integrate the MTEF budgeting processes into internal MOH planning systems. This will require institutional integration of the teams undertaking technical planning for the AOP and those undertaking budgeting or economic planning for the MTEF under one unit, with a common cycle and framework and common reporting lines.
- High level support and commitment for these structures and their systematic functioning is required from both senior MOH and Treasury officials, and from key donors and partners including the WHO and World Bank country officials.
- Ensure that accurate data are available to inform target setting, together with input from local planning units to inform the feasibility of target achievement – these steps will be essential if realities in the health sector are to inform policy and planning, and if planning is to inform sector budget information.
- County Health Management Teams should continue to use the revised planning tool developed by the MOH which reflects a continuum from review of previous year's AOP, through to technical priority setting, planning and budgeting for the coming year's AOP.

About the research

This brief is based on a study which assessed the degree to which the health sector AOP process in Kenya has achieved alignment between planning and budgeting, using document reviews, participant observation and key informant interviews. The research was conducted as part of the RESYST (Resilient and Responsive Health Systems) Research Consortium.

Related publication

Tsofa B, Molyneux S, Goodman C (2015) **Health sector operational planning and budgeting processes in Kenya – “never the twain shall meet”** *Int J Health Plann Mgmt*

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