

**RELATIONSHIP BETWEEN PUBLIC SPENDING BY LOCAL
GOVERNMENT AND HEALTH STATUS IN KENYA**

By

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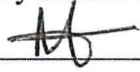


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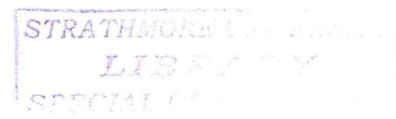
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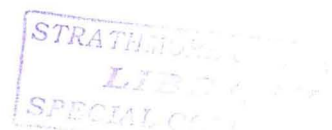
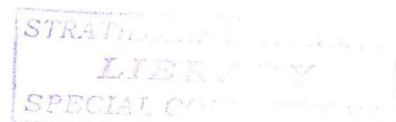
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ABSTRACT

Public spending by Kenyan government in the health sector has been dogged by misallocation of resources, untimely disbursement of funds, under-spending, many medical facilities constructed and not in use and medical supplies purchase being damaged and expired. As a result a child's chance of survival is as low as 73 children dying before their 5th birthday in Kenya. 28,000 children died in 2012 of either pneumonia or diarrhoea which are diseases with both preventive and curative solutions.

This study evaluated whether a relationship exists between public spending in health by Kenya's local government and health status. Further, it establishes factors that affect public spending ability to improve health status. Using regression analysis this study modeled the relationship between aggregate annual public spending in health by local government and annual child mortality rate which is the number of children that die after their first birthday and before their fifth birthday per 1000 live births between 1978 and 2008. The study analysed a similar relationship between aggregate annual development spending in health by local government and annual child mortality between 2003 and 2008 across the 175 local authorities.

The results of this study reveal that a significant and positive relationship exists between public spending in health by local government and national health status. However there is an insignificant and small relationship between development spending by local government in health and sub national health status. Local governments have constructed frequently health facilities near the population and have spent more in curative primary health care. These two factors strength ability of public spending improve health status.. However rarely are capital expenditures matched to future running cost of facilities, spending is significantly below the budgeted in the health sector and spending in non-budgeted items is a common phenomenon.

To accelerate the achievement of Kenya's goal in improving health status, this study recommended increased spending by county government in the areas where previously spent on by local government. Additionally practice of the fundamental principles of public spending would improve the ability of public spending in improving health status further accelerating the achievement of improved health status in Kenya.

Key words: effectiveness, public spending, health status, good planning, expenditure control, untimely disbursement, unbiased projection, appropriate policy.

TABLE OF CONTENTS

DECLARATION	ii
ACKNOWLEDGEMENT	iii
ABSTRACT.....	iv
TABLE OF CONTENTS.....	v
LIST OF FIGURES	viii
LIST OF TABLES.....	ix
LIST OF ABBREVIATION	x
CHAPTER 1: INTRODUCTION.....	1
1.1: Introduction to the Study.....	1
1.2: Background of the study.....	2
1.3: Problem Statement	6
1.4: Research Objectives	7
1.4.1: Main Objective	7
1.4.2: Specific Objectives	7
1.5: Research Questions	7
1.6: The Scope of the Study	7
1.7: Justification for the study	8
CHAPTER 2: LITERATURE REVIEW.....	9
2.1: Introduction	9
2.2: Public Spending Principles.....	9
2.3: Factors that affect public spending's ability to improve health status	10
2.4: Measures of factors that affect health impacting public spending.....	14
2.5: Public spending and health status relationship evaluation	17
2.6: Conceptual Framework	19
CHAPTER 3: RESEARCH METHODOLOGY	21
3.1: Introduction	21
3.2: The Research Design.....	21
3.3: Population and Sampling.....	21
3.4: Data description and collection method	22
3.5: Data Analysis	24

3.6: Research Quality	26
3.6.1: Reliability	26
3.6.2: Validity	27
3.7: Ethical Consideration	27
CHAPTER 4: PRESENTATION OF RESEARCH FINDINGS.....	28
4.1: Introduction	28
4.2: Demographic characteristics of the respondents	28
4.3: Relationship between public spending and national health status	29
4.1: Relationship between development spending and sub-national health status	32
4.2: Factors that affect ability of public spending to improve health.....	33
4.2.1: Comprehensiveness	33
4.2.2: Discipline.....	35
4.2.3: Honesty.....	36
4.2.4: Predictability	36
4.2.5: Contestability.....	37
CHAPTER 5: DISCUSSION	39
5.1: Introduction	39
5.2: Relationship between public spending and national health status	39
5.3: Relationship between development spending and sub-national health status	40
5.4: Factors that affect public spending ability to improve health	40
5.4.1: Comprehensiveness	40
5.4.2: Discipline.....	41
5.4.3: Honesty.....	41
5.4.4: Predictability	41
5.4.5: Contestability.....	42
CHAPTER 6: CONCLUSION ANDRECOMMENDATION	43
6.1: Introduction	43
6.2: Conclusion.....	43
6.3: Recommendation.....	43
6.4: Area of further Research	44

6.5: Limitation of the Study.....	44
REFERENCE	45
APPENDIX A	49
INTERVIEW	49
INTRODUCTORY GUIDE	49
APPENDIX B.....	53



LIST OF FIGURES

Figure 1.1: Central and Local Governments Public Spending in Health.....	1
Figure 1.2: Public Spending in Kenya in Billions of Shillings.....	4
Figure 1.3: Percentage of health spending by development partners and Government	5
Figure 1.4: Local Revenue Performance after independence and Pre-LATF	6
Figure 2.1: Public Spending on health in Kenya by functional Composition.....	13
Figure 2.2: Conceptual Framework.....	20
Figure 4.1: Profession of Respondents	28
Figure 4.2: Public spending in health by local government in Kenya shillings millions.....	30
Figure 4.3: Responses on matching decisions of health facilities construction to future running costs	34
Figure 4.4: Frequency of responses on cause of primary health facilities being operational	35
Figure 4.5: Frequency of the response on untimely disbursement of funds.....	37
Figure 4.6: Frequency of response on primary health facilities constructed far from the population ...	38

LIST OF TABLES

Table 4.1: Respondents years of experience in Kenya's local government	29
Table 4.2: Respondents' years of experience in the local government interviewed about.....	29
Table 4.3: Comparison of changes in LGPS against changes CMR	30
Table 4.4: Comparison of directional changes in LGPS and CMR.....	31
Table 4.5: Goodness of fit result for $\ln NHSt = \delta_0 + \delta_1 \ln PSLGt + \epsilon_t$	31
Table 4.6: Analysis of Variance of $\ln NHSt = \delta_0 + \delta_1 \ln PSLGt + \epsilon_t$	31
Table 4.7: Results of $\ln NHSt = \delta_0 + \delta_1 \ln PSLGt + \epsilon_t$	32
Table 4.8: Goodness of fit result for $\ln SNHSt_i, t = \delta_0 + \delta_1 \ln PSLGi, t + \epsilon_{i, t}$	32
Table 4.9: Analysis of Variance of $\ln SNHSt_i, t = \delta_0 + \delta_1 \ln PSLGi, t + \epsilon_{i, t}$	33
Table 4.10: Results of $\ln SNHSt_i, t = \delta_0 + \delta_1 \ln PSLGi, t + \epsilon_{i, t}$	33
Table 4.11: Mean and standard deviation of responses on matching health facilities construction costs and future running costs.....	34
Table 4.12: Means and standard deviations of responses on causes of primary health facilities not being operational.....	35
Table 4.13: Mean and Standard Deviation of the Response on untimely disbursement of fund.....	36
Table 4.14: Descriptive Statistics on the proportion of curative spending in total public spending in health.....	37
Table 4.15: Mean and Standard deviation of Response on far constructed primary health facilities ...	38

LIST OF ABBREVIATION

AIDS	Acquired Immune Deficiency Syndrome
CGPSH	Central Government Public Spending in Health
CMR	Child Mortality Rate
GDP	Gross Domestic Product
GoK	Government of Kenya
HIV	Human Immunodeficiency Virus
KNBS	Kenya National Bureau of Statistics
KDHS	Kenya Demographic and Health Survey
LA	Local Authority
LATF	Local Authority Transfer Fund
LGPS	Local Government Public Spending
LG	Local Government
LASDAP	Local Authority Service Delivery Action Plan
LGA	Local Government Act
MDA	Ministries Departments and Agencies
MDG	Millennium Development Goals
MSPNDV	Ministry of State for Planning, National Development and Vision 2030
OECD	Organisation for Economic Cooperation and Development
OLS	Ordinary Least Square
PEFA	Public Expenditure Financial Accountability
UNDP	United Nations Development Programme
WHO	World Health Organisation

CHAPTER 1: INTRODUCTION

1.1: Introduction to the Study

In 2000, during the United Nation summit in New York all the national leaders in the world pledged in writing to eight development goals (United Nations Millennium Declaration, 2000). They targeted to achieve them by 2015. The goals had specific, measurable development status for each of them. The nations pledged to eradicate extreme poverty and hunger, provide universal primary education, health, promote gender equality and empower women. They set three development goals on health which included: reducing child mortality, improving maternal health and combating HIV/AIDS, Malaria & other diseases (UNDP, 2000). Ensuring environmental sustainability and developing a global partnership for development were the last two goals. Governments have been either increasing their spending on certain interventions or begun new interventions to achieve the set targets.

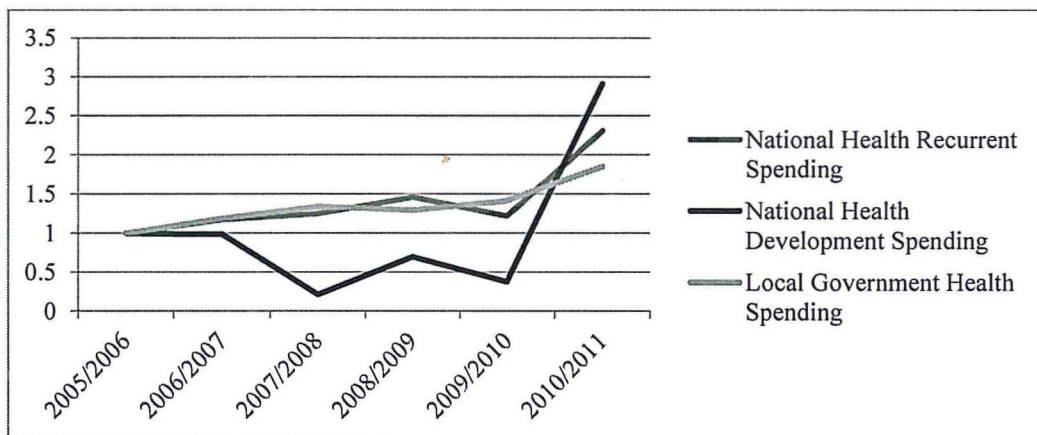


Figure 1.1: Central and Local Governments Public Spending in Health

Source: Public expenditure financial accountability assessment 2008 and 2012

Observing the public spending on health sector over the period 2005/2006 to 2010/2011 in Kenya, it is clear that the patterns varied by type and level of government. Central and local level of governments spent in varying proportions on both recurrent and development expenditure as a means of achieving the set health objectives as pledged by the central government. Development spending as a proportion of 2005/2006 central government development spending is below one for three years out of the five years observed. Central government's recurrent spending progressively grew over the five-year period and local government's health spending also slowly grew as shown in figure 1.1.

1.2: Background of the study

Local governments in Kenya were established in 1902 and repealed in 2013. It is only until 1977 that the Local Government Act (LGA) is enacted to govern their operation and organization (Mboga, 2009). Their role in the delivery of local health services is noticeably different from that of the central government. During the period, they were in operation they primarily focused on preventive health services. They provided: clean water; sewerage and sanitation; garbage collection; and constructed public toilets and cemeteries (The World Bank, 2002). They were also involved in preventive health education activities with the majority of the local governments carrying out HIV/AIDS public awareness campaigns. Although their primary focus is on preventive health services, they also carried out curative health services. They worked with the community to contribute towards building and maintaining health centres, clinics and dispensaries while providing supplies and medicines (The World Bank, 2002).

However, in 2011 the Urban Areas and Cities Act repealed local governments in March 2013 (Gok, 2011). The repeal is to give effect to the provisions of the constitution which established county governments. They collect the same revenues as them, while providing public services that were somewhat similar (GoK, 2011). The distinct difference is that the county governments have more power and autonomy to raise revenue and provide public services without supervision from the central level. Although the structure of operation and organization has changed, the goal of effectively spending public resources has not changed.

Relationship between public spending and health status is described by Baldacci, Guin-Siu, & Mello (2003) as the association between the two variables and specifically the relationship between public spending and health status. Rajkumar & Swaroop (2007) describe the relationship as the impact of public spending on health status. Since the relationship between two variables only illustrates the association between them and not the cause-effect, this study will use the relationship between public spending and health status definition of Baldacci, Guin-Siu & Mello (2003).

Since governments enter into social programmes like health care to improve human development, researchers studied the association between public spending and health

status (Rajkumar & Swaroop, 2007). The study investigated the relationship between public spending and health status. The study of that relationship has also been used to investigate the effectiveness of public spending. Although not a conclusive assessment of the concept of effectiveness, it has illustrated whether public spending changes has any association with health outcomes.

Governments face several challenges in their spending, and Kenya is no exception (The World Bank, 1998). Government Ministries, Departments and Agencies' (MDAs') are unable to spend within the planned budget and have either been under-spending or overspending against the budgeted (GoK, 2010b). The World Bank(1998) mentions that these problems of public spending could affect the association between public spending and health status.

Ministry of State for Planning, National Development and Vision 2030[MSPNDV] 2010 report on public expenditure review, cited causes of weak relationship between public spending and health outcomes. The report cited overspending, under-spending, poor costing of projects and programmes and fiscal indiscipline. It explained that under spending mainly affected development expenditure in Kenya. Further that it causes of under-spending were: poor design of projects, long procurement process, late approval of supplementary budgets, shortage of technical personnel and untimely exchequer release during the fiscal year (GoK, 2010b). Given the myriad problems in public spending, the question is to what extent do these problems explain the relationship between government spending in health programs and health status in Kenya?

Another challenge of public spending is allocating resources to functions that are less efficient in achieving health status (GoK, 2010b). High proportion of spending in curative care is considered by public health specialist as inappropriate in achieving improved health status (Filmer, Hammer, & Pritchett, 2002 and Gupta, Clements & Tiongson, 1998). The public health specialists consider preventive health care more appropriate. At the central government level in Kenya, the government spending is skewed more towards curative compared to preventive health care as observed in Figure 1.2. Exacerbating the challenge is poor accountability of the spending. In the 2011/2012 report of the Auditor General, there were only 15 out of 252 financial statements of MDA's that were unqualified (GoK, 2014). The other MDAs had either a

qualified, adverse or disclaimer of opinion given by the Auditor General. Reason for not having unqualified financial statement included: unsupported expenditure; non-surrender of imprest; unauthorized expenditure; excessive expenditure; misallocation of expenditure item; lack of adequate disclosures; and exclusion of expenditure from the appropriation accounts.

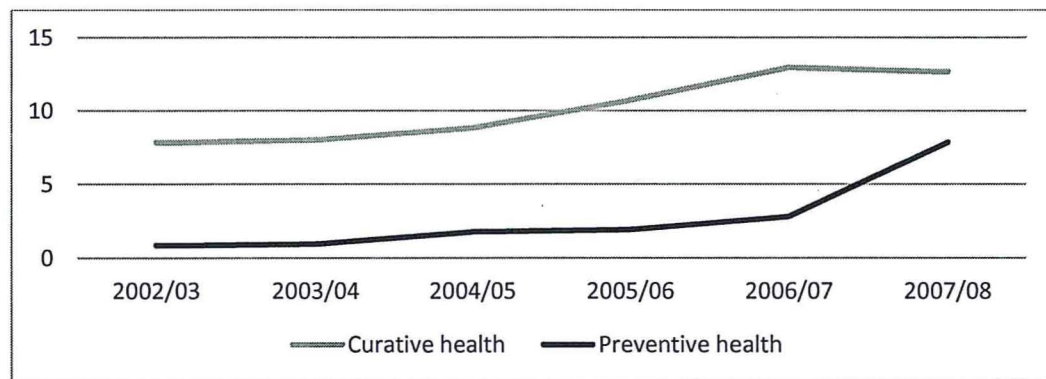


Figure 1.2: Public Spending in Kenya in Billions of Shillings
Source: Public Expenditure Review 2010

The basic unit is local government level to understand public spending in health in Kenya. There were only five out of the 175 local governments that ran curative health services, which were: Nairobi, Mombasa, Kisumu, Eldoret and Nakuru (GoK, 2010b). Other than Nairobi, which runs a maternity hospital, the other local governments ran health centers and dispensaries. Although the other local governments were not mandated to run curative health service, if health projects were identified by the community they would carry them out (The World Bank, 2002). Communities identified projects during the Local Authority Service Delivery Action Plan (LASDAP). In the health sector, local government's spending is very minimal constituting 1 per cent of the total health spending in 2010 (Gok, 2010b).

Public spending in Kenya is categorized into recurrent and development spending (GoK, 2010b). Since all spending for development partners are included in development spending, the recurrent component is also included. In the health sector, expenditure by function is categorized into curative health spending and preventive health spending (GoK, 2010b).

Public spending on health has been declining over the period 2001/02 to 2005/06 while that of development partners has been increasing as observed on figure 2.1 (GoK, 2010b). Although it is critical to understand whether this trend continued after

2005/06 to 2013/2014, this data is not available. Government only accounted for a third of total spending on health care annually (GoK, 2010b). Households direct spending on health care accounted for 36 per cent while government accounted for 29 per cent. External development partners accounted for 30 per cent and private expenditure financed by employer the remaining 3 per cent (GoK, 2010b).

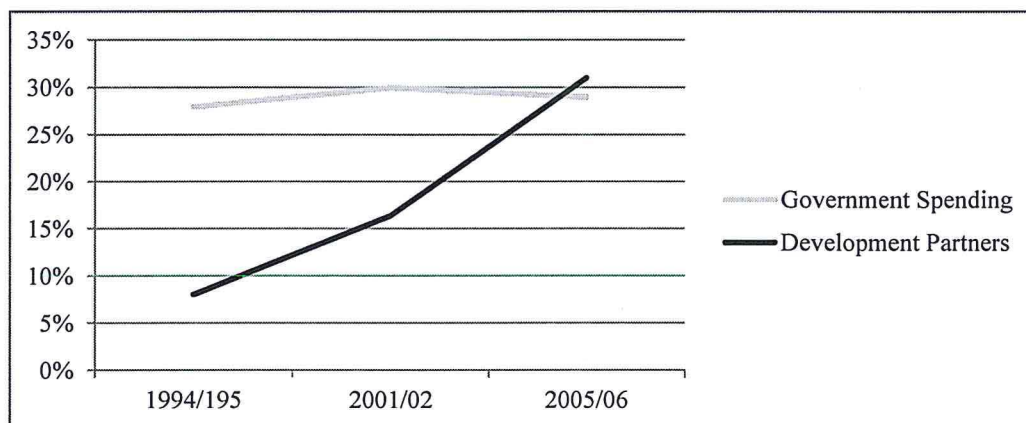


Figure 1.3: Percentage of health spending by development partners and Government
Source: WHO (2009)

The composition of public spending in health by both local and central governments is 70 per cent recurrent in 2007/2008. The Spending fell from 90 per cent in 2002/2003 and is estimated to account for 60 per of total public spending in health by 2009/2010 (GoK, 2010b). The composition of recurrent expenditure implies that development spending constituted the smaller position of the public spending in health. Although development spending in health has increased it is dogged by low execution rates (GoK, 2010b).

Local government financial performance after independence to pre-LATF period had been fluctuating. After independence in 1963, local governments reported budget surplus on aggregate for more than a decade (The World Bank 2002). Beginning from 1986, they started reporting a series of perennial budget deficit extending all the way to the year 1999(The World Bank, 2002). The financial performance of a government determines its ability to provide public services that could improve health status.

One cause of the perennial budget deficits had been described as declined sources of revenue by the local government (The World Bank, 2002). In the Financial Year 1969-70(see figure 1.4), local government's revenue were 17.1 per

cent of government total current revenue and 3.26 per cent of Gross Domestic Product (GDP). However, in the financial year 1970-71 the central government abolished Graduated Personal Tax (GPT) in rural local governments. Consequently, the share of local government's revenue declined to 11.30 per cent of current revenue and 2.38 per cent of GDP. The abolishment of GPT extended to municipal councils in 1974-75 exacerbating the problem.

In the same period of 1969-70 to 1999-00, although local government's revenues had declined, expenditure continued to surge, yet public service quality and accessibility declined during the period of 1970 to 1999 (The World Bank, 2002). Health status had deteriorated. Specifically, life expectancy had declined, while infant and child mortality had risen. This poor health status is worse in rural areas and urban informal settlement.

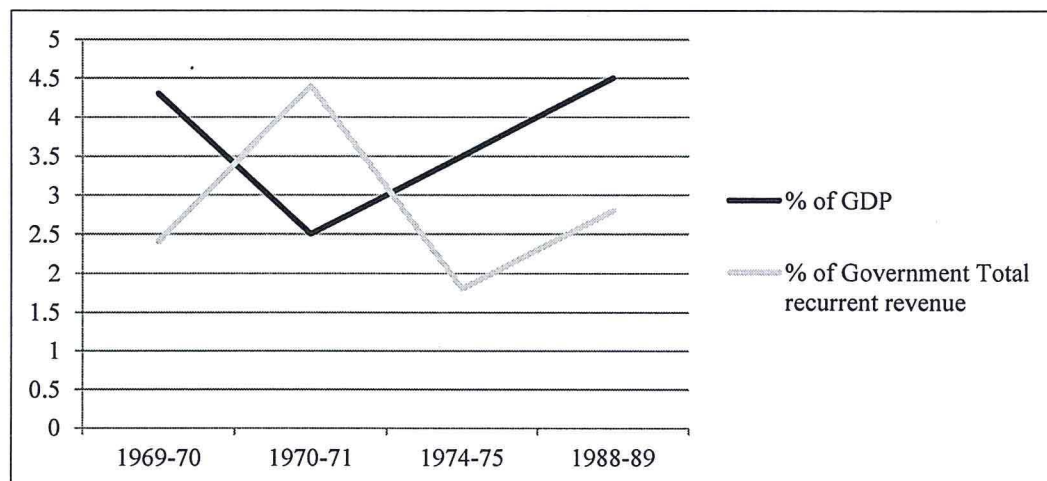


Figure 1.4: Local Revenue Performance after independence and Pre-LATF
Source: World Bank (2002)

1.3: Problem Statement

Under the Constitution of Kenya 2010, attainment of health has become a human right for all Kenyans, and this has shifted from being the responsibility of central government to being that of county government. County governments are a new level of government that came into operation in March 2013.

Although county governments are new institutions, it is their responsibility to improve the health status of its people. This is a challenge given that Kenya is reported as having the lowest survival rate for children with 73 out of 1000 children

who have reached one year likely to die before reaching their 5th birthday (UNICEF, 2013). Additionally 28,000 children died of either pneumonia or diarrhoea in 2012 (UNICEF, 2013). Further in 2010, 5500 women died while pregnant or shortly thereafter in Kenya (WHO, UNICEF, UNFPA, & World Bank, 2010).

An understanding of the association between past public spending by local government and the health status in Kenya would enrich the budgeting and spending of county governments with the aim of improving public spending's impact and effectiveness.

1.4: Research Objectives

1.4.1: Main Objective

This study aims to evaluate the association between public spending by Kenya's local governments and health status.

1.4.2: Specific Objectives

1. To evaluate the relationship between public spending in health by local government and health status in Kenya
2. To establish the factors that affect public spending's ability to improve health status.

1.5: Research Questions

1. What is the relationship between aggregate annual public spending in health by local government and national health status in Kenya?
2. What is the relationship between aggregate development spending in health by local government and sub national health status in Kenya?
3. What are the factors that affect public spending's ability to improve health status.

1.6: The Scope of the Study

This study concentrated on Kenya's 175 local governments over 30 year's period from 1978 to 2008. The choice of this period is constrained by availability of data on public spending and health status. The study looked at health which under the new constitution is a devolved function to be carried out by county governments. Although different in the level of power and functions, county governments and the

previous local governments are both local level of government. Hence, the choice to study local government as opposed to central government.

1.7: Justification for the study

It is the right of all Kenyan citizens to enjoy health care services in order to attain the highest attainable standard of health (GoK, 2010a). Since health care services are a right enshrined in the Kenyan constitution, the citizens are also empowered to take part in government policy making and financial planning process through public participation. It is therefore paramount for the citizens to understand what has been deterring or spurring the government's effort in achieving its set health status. An identification of factors that affect the strength of the association of spending by local government and health status may enable the citizen engage better with the county governments. The engagements during identification and prioritisation of projects could yield better choice of projects. Those projects that are strongly associated with improving health status (GoK, 2010a).

Additionally, government's policy needs to achieve the set objective of improving health care services to Kenyan citizens. In order to do so, they would require an understanding of its predecessor's public spending and health status relationship prior to devolution. The results of this study would highlight association between public spending by local government to health status at the national and sub-national level. This information may enable the county governments chose better policies for the accelerated improvement of Kenya's health status.

The literature on the relationship between public spending and health status has extended only to look at the effect of governance on that relationship. Other than governance, previous studies have seldom identified factor that affect the strength of public spending in determining health status. This study sought to extend the literature by identifying factors that affect public spending's ability to improve health status. Additionally the study will evaluate the relationship between public spending at local government and aggregate national health status as well as sub-national health status. The university may use the study to obtain extensive information on the relationship.

CHAPTER 2: LITERATURE REVIEW

2.1: Introduction

This chapter begins by defining public spending principles, how their practice or non-practice affects the strength of public spending in determining health status. The chapter further describes how the factors affect the ability of public spending to improve health status have been measured in the literature. Finally, how to evaluate the relationship between public spending in health and health status is explained.

2.2: Public Spending Principles

Fundamental principles guide public spending. These principles of sound public spending include: comprehensiveness, discipline, honesty, predictability, and contestability (The World Bank, 1998).

Comprehensiveness requires complete coverage of government operation in the budget and discipline calls for policy, planning and budgeting decision to be made within hard budget constraint. Hard budget constraint is the revenue projected to be collected by government (The World Bank, 1998). On the other hand, honesty necessitates unbiased revenue projections, while predictability entails stable funding of existing government projects (The World Bank). Finally, the World Bank describes contestability principle as reviewing and evaluating performance of policies.

The practices of comprehensiveness will result to capital projects being well matched to future running cost of operating those facilities (The World Bank, 1998). The World Bank, explain that practice of discipline principle would yield minimal variation between the budget and actual expenditure. Honesty practice would reduce the occurrence of expenditure cuts caused by lower revenue collection than projected (The World Bank). When the revenue projections are realistic, and discipline is exercised in budget execution then predictability principle can be adhered to resulting in timely disbursement of funds to projects (The World Bank). When contestability is practiced together with the discipline principle government can identify appropriate policy instrument that are effective at achieving the set goals (The World Bank).

2.3: Factors that affect public spending's ability to improve health status

Government practice of public spending principles' affects its ability to improve health status (The World Bank, 1998). Exclusive or combined practices of those principles cause public spending to strengthen its ability to improve health status.

Practice of the comprehensiveness principle strengthens public spending ability to improve health status. In a bid to improve access to health care, the government may set up new health facility for the surrounding population. Practice of the comprehensive principle would require linking the decision of building the health facility to that of running it after it is complete (The World Bank, 1998). The result would be a new health facility opening its doors to the surrounding population for delivery of health care services. Since the cost of medical staff, medical drugs and medical supplies were budgeted for and disbursed for use on completion of the health facility construction. Assuming the health service provided by the health facility is of the quality, quantity and price demanded by the population, then its presence is expected to improve the health status of the people (Filmer, Hammer & Pritchett, 2000).

Sometimes the comprehensiveness principle is not practiced and this causes public spending to be weak or insignificant in improving health status. In the same example of constructing a health facility, when the comprehensiveness principle is not practiced then decision to construct the health facility is delinked from that of operating it. In this case, the completed health facility remains unused because of lack of funds to operate it. Since the public spending on construction has not yielded an operational health facility then the additional spending is not expected to influence improvement of health status (Filmer, Hammer & Pritchett, 2000). According to the 2010 public expenditure review report by GoK (2010b), decisions of constructing health facilities by many Constituency Development Fund (CDF) boards were delinked from those of funding their running on completion. As a result about 900 dispensaries constructed by CDF were reported as non-operational due to lack of medical staff, medical equipment, medical supplies and medical drugs (GoK).

The review further revealed that the 900 non-operational dispensaries were caused by delinked decisions making (GoK, 2010b). The institutions that made the decision to construct the dispensary was different from that operated it. The legal framework in Kenya mandated CDF boards to construct health facilities and vested the decision of running health facilities on Ministry of health and Ministry of medical services (GoK).

Practice of discipline principle during budget execution strengthens public spending's ability to improve health status. Practice of discipline principle during budget execution results to resource allocation to projects within the budgeted period as per the budgeted amount (The World Bank, 1998). Receipt of budgeted resources for projects results to their execution and completion. Assuming the projects have the ability of improving health of the people on execution; public spending in these projected would be expected to improve health status (Filmer, Hammer, & Pritchett, 2000).

A reverse result from the practice of discipline principle is expected when discipline is not practiced. Indiscipline during budget execution is in the form of misallocation of resources to other projects. Misallocation of resources to other projects causes stalling of projects budgeted for and aimed at improving health status. Stalling of these projects reduces the magnitude of health services intend to be provided. Reduced health services growth slows down rate of improvement of health status. Although spending is budgeted for in health and may be spent still in the health sector, the misallocation weakens public spending's ability to explain changes in health status (The World Bank, 1998).

Whenever honesty principle is practiced during revenue forecasting, it is expected to cause public spending to be stronger at improving health status. Practice of honesty principle during revenue forecasting yields realistic and unbiased revenue estimation. Realistic and unbiased revenue estimates enable governments to spend within their resource envelope, avoiding the problem of the budget deficit. When spending is within the resource envelope, planned health programs and activities are executed. Assuming the planned health programs and activities are expected to result to health services that would be demanded by the population. Then practice of

honesty principle during budget making safeguards execution of budgeted health programs during the financial year.

However, if honesty principle is not practiced, and instead dishonesty practiced then unrealistic and biased revenue projections are done. A phenomenon of unrealistic and biased revenue projections observed in developing countries is that of optimistic forecasting (The World Bank, 1998). According to the World Bank (1998), these revenue forecasts are optimistic as they require legislation to increase taxes. However, since legislators are politician and habitually avoid legislating tax increases these optimistic targets are not achieved (The World Bank). Whenever revenue targets are not achieved, then, to maintain fiscal balance government cut on expenditure (The World Bank). Dishonesty during budget making result to expenditure cuts during budget execution a factor that weakness public spending's ability to improving health status.

Gok (2010b) reported that dishonesty in budget making where optimistic revenue forecasts are made is evidenced in Kenya's central government. Kenya experienced a similar result as that described by the World Bank (1998) of expenditure cuts in order to maintain the budget balance. Specifically expenditure cuts were first made on capital projects, followed by operation and maintenance (Gok). In the health sector capital projects experiencing expenditure cuts implies construction of health facilities come to a halt. On the other hand, expenditure cuts on operation and maintenance results to inadequate medical drugs, medical supplies and any repairs of equipment were frozen. This action of expenditure cuts reduces the quality of health service delivered to the citizens. Poor quality services are not well demanded by citizens making public spending weaker at improving changes in health status (Filmer & Pritchett, 1999).

Predictability principle is practiced from budget making to budget execution in order to be a factor that affects public spending's ability to improve health status (The World Bank, 1998). The principle is practiced during budget making by preparing a clear cash flow statement indicating when each project will receive what amount (The World Bank). Thereafter on budget execution the principle of predictability is practiced whenever funds are received on time for each project.

Timely receipt of funds facilitates timely execution of planned projects within their stipulated timeframe. Whenever health care related projects are executed within their stipulated timeframe then the population demanding the service is expected to receive it may result to improve health status of that population.

When predictability principle is not practiced, then although clear cash flow statement may be prepared during the budgeting stage, the funds would be received after the planned date. When funds for capital projects are not received when planned then we have a problem of untimely disbursement of funds which affects the completion of capital projects. The problem is exacerbated by bureaucratic procurement process in the case of Kenya's health sector funded by central government (Gok, 2010b). When funds are received late then this will affect the ability of the government to complete capital project as planned hence affecting the actualization of service delivered. This negatively affects the ability of public spending in health to determine changes in health status positively

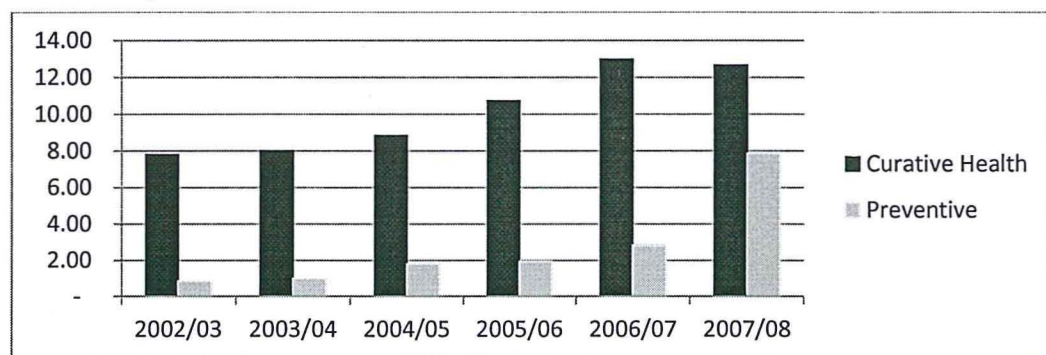


Figure 2.1: Public Spending on health in Kenya by functional Composition
Source: Public Expenditure Review policy for prosperity 2010

Practicing contestability during a budget cycle strengthens the ability of public spending to determine changes in health status (The World Bank, 1998). Practice of this principle involves reviewing and evaluating the results and outcomes of projects and programs undertaken (The World Bank). This review is used to influence subsequent projects by making them more appropriate (The World Bank). Expenditure on more appropriate projects and programs is expected to improve the ability of public spending to improve health status (Filmer, Hammer, & Pritchett, 2000).

However, contestability sometimes is not practiced hence negatively affecting the ability of public spending improve health status. Non-practice means programs and projects are not reviewed and evaluated. As a result their effect on improving health status remains unknown. Since the effect of projects and programs is unknown then, it is expected that health projects, and programs implemented are those that are less likely to improve health status. Gupta, Benedict, & Erwin (1998) reckon curative health care is less likely to improve changes in health status compared to preventive. Filmer, Hammer, & Pritchett (2000) adds that in curative health care delivered at primary health facilities is more likely to cause public spending to improve health status than if delivered at secondary and tertiary health facilities.

At the central government level as report in GoK (2010b), public health spending is more on curative health care than on preventive health care as observed on figure 2.2. If the composition of spending is also similar at the local government, this could cause their public spending to be weaker or insignificant in determining changes in health status.

2.4: Measures of factors that affect health impacting public spending

Organisation for Economic Cooperation and Development [OECD] (2001), in a bid to investigate whether the comprehensive principle is being practiced, asked respondents whether recurrent and capital investment budget were integrated into one single process. The respondents were working in public finance sphere in its transition countries. Specifically, they inquired whether the recurrent cost implication of investment were calculated and included in the medium term budget framework. In these two questions asked, the expected answers were either yes or no (OECD).

The World Bank (2003) investigated whether MDAs in developing countries were practicing discipline principle by measuring magnitude of misallocation. The magnitude of misallocation is measured as the proportion of spending that is misallocated over the total public spending. The frequency of misallocation is measure by the number of projects planned whose funds were misallocated. They further argued that the more the frequency of misallocation the higher the probability

that public spending may not yield the desired outcome which is improved health status of the country's population.

The World Bank (1998) investigated the practice of discipline principle in Ugandan Government's Priority Program Area. The Priority Program Area is a program of Ugandan government set up in 1996 which identified some programs that were to receive resources prior to other programs. A review of this program revealed that discipline is not practiced as the priority programs were subjected to large amounts of supplementary expenditure. Further, the supplementary expenditures resulted to proportion of spending against the budgeted ranging between 170 and 690 per cent.

To investigate practice of predictability, GoK (2010b) measured it as timely disbursement of funds to projects. Its presence or absence is all that is measured for individual projects. Thereafter the frequency of this phenomenon is measured and categorised.

To investigate practice of honesty principle, Public Expenditure Financial Accountability (PEFA) measured the proportion of aggregate expenditure against the approved budget. The aim is to identify whether the proportions were below 100 percent. The proportion below 100 per cent implied under-spending which could be caused by expenditure cuts. The measure is a proxy because under-spending is not necessarily caused by expenditure cuts. It could occur as a result of misallocation that causes actual expenditure to be lower than planned expenditure. Public Performance Measurement Framework developed by PEFA secretariat measured the proportion of aggregate expenditure against approved budget for a period of three years (PEFA, 2011). The aggregate expenditure excluded debt repayment and donor funded expenditure. In their approach, the government would be rated on a scale of A to D with A being the lowest level of under-spending. A score is awarded when actual expenditure varies from the approved budget by less than or equal to 5 per cent. B is awarded when actual expenditure varies from the approved budget by less than or equal to 10 per cent but more than 5 percent. C is awarded when actual expenditure varies from the approved budget by less than or equal to 15 per cent but more than 10 per cent. Finally, D is awarded when actual expenditure varies from the

approved budget by more than 15 percent. This variation they measured over a period of three years to give the grade. Given the cross-sectional nature of this study, the grading system for a period of one year is used.

Niger, a country in Africa to the west, on practice of discipline is scored C in 2008 and this score worsen to D in the 2012 assessment (IMF, 2013). In fact for 2006, 2007 and 2008 the variation of the aggregate spending from the approved budget were 20.8%, 12.7% and 12.3% respectively leading Niger to score a C in 2008 (IMF). For 2010, 2011, and 2012 the variation of the aggregate spending from the approved budget were: 17%, 18.6% and 16.5% leading Niger to score D in the 2012 assessment.

Liberia is another county where practice of discipline principle is assessed. In 2007 they scored B which meant for the three-year period the variation of the aggregate spending from the approved budget did not exceed 10% for more than one year (IMF, 2012). However in 2008/09, 2009/10 and 2010/11 public spending variation from budgeted were: 19%, 19.8% and 8.4% respectively. This performance caused the score to decline for Liberia from B to D. Although Niger and Liberia both deteriorated in score, Liberia's decline rate is higher from 2007 to 2012 assessments.

Uganda, a neighbouring country to Kenya when assessed on practice of discipline principle had scored B in 2008 and C in the 2012(the Republic of Uganda, 2012). The reason for the deterioration is in 2010/11 the expenditure variation is 28.7% which is above the 15% compared to 1.1% in 2008/09 and 2.5% in 2009/10. At the central government level in Kenya, the government maintained the score of B between the period of 2008 and 2012(GoK, 2012).Although this tool has been used to measure the practice of discipline principle by government, it has mainly been at the central level, yet little has been done at the local level.

To measure contestability, Gupta, Benedict, & Erwin (1998) had investigated whether appropriate health projects were executed in 33 countries. Gupta et al. sampled 33 countries from: Sub-Saharan Africa; Asia; Latin American and Caribbean; and Transition countries. Appropriate health project is defined as spending in preventive health services and curative health services at primary health facilities (Gupta, Benedict & Erwin). Gupta et al. found out that the average

proportion of spending on curative health services compared to total public spending on health is 60 per cent (Gupta, Benedict & Erwin). Sub-Saharan Africa's and Asia's averages proportion of spending on curative health services were about 65 per cent each. Transition countries had an average proportion of spending on curative health services at 50 per cent while Latin America and Caribbean is at 60 per cent average proportion. Gupta et al. concluded that because of this large proportion of public spending in health on inappropriate project, this is a factor that caused public spending to be weak or even insignificant at explaining the changes in health status.

2.5: Public spending and health status relationship evaluation

Rajkumar & Swaroop (2008) conducted a study that sought to evaluate the relationship between public spending in health and education; and health and educational status. They evaluated the relationship between public spending in health and health status by using a regression model which measured the significant and magnitude of the coefficient of public spending in health as a determinant of health status. The model they used is as follows:

$$\ln(HS_{i,t}) = \delta_0 + \delta_1 \ln(PCGDP_{i,t}) + \delta_2 \ln(PHSGDP_{i,t}) + \delta_3 G_{i,t} + \delta_4 G_{i,t} * \ln(PHSGDP_{i,t}) + BX_{i,t} + \varepsilon_{i,t} \quad (2.1)$$

where

i represented the country and t the year and $\ln(HS_{i,t})$ is the natural logarithm of health status measure by the child mortality rate. $\ln(PCGDP_{i,t})$ represent income which is measured by per capita GDP in purchasing power parity adjusted dollars. PHSGP- represented share of public spending in GDP. The public spending included both recurrent and development; both local and central and both external borrowing and grants. G represented governance measured by quality of bureaucracy or Index of Corruption. X represented non-health country specific related factors and B is the co- efficient of X and ε is the error term.

The study sampled 91 countries around the world over three years 1990, 1997 and 2003 (Rajkumar & Swaroop, 2008). The study used Ordinary Least Square (OLS) regression to investigate the relationship between public spending and health status. The results were income is significant in improving health status. Public spending is insignificant and the magnitude of its coefficient small at -0.37.

However, the other non-health factors other than income were insignificant in explaining the changes in health status. The income explained 88 per cent of the variation in health status. Public spending interacted with corruption had a significant negative effect on health status measured by child mortality. Additionally, public spending interacted with quality of bureaucracy is significant and negatively affected variation in health status.

Filmer & Pritchett (1999) also estimated the effect of public spending on health status using a similar OLS model as Rajkumar & Swaroop (2008). However, they opined there could be three issues that arise from estimating using OLS: reverse causality and measurement error. On reverse causality, if a country with higher child mortality rates devote larger amounts of public spending on health then the regression coefficient is likely to be small or even negative, but consistent with a powerful positive impact on public spending. Measurement error would occur due to the different accounting systems that track public spending on health. The systems were not co-ordinated hence different countries measured different concepts.

The results of Filmer & Pritchett(1999) were female education significantly affect health status with roughly 10 per cent lower rates of child mortality per additional year of female schooling. Additionally 1 per cent increase in income inequality is associated with half a per cent increase in child mortality a relationship that is also significant. Ethnolinguistic diversity also significantly and negatively affected health status. Ethnolinguistic diversity measured the probability that two citizens spoke different native language. The coefficient of predominantly Muslim is not significant in explaining variation in health status. Urbanisation, population with access to safe water, and tropical climate were also not significant in explaining variation in health status.

Farahani, Subramanian, & Canning (2010) also model the relationship between public spending in health and health status and used Probit model. They found public spending in Indian State is significant in explaining changes in health status, and the relationship is negative. A 10% increase in per capita health spending in an average state with all variables at their mean value decreases mortality by 0.0004.

2.6: Conceptual Framework

On the left top side of figure 2.2 is a box representing public spending by local government in health. That is the Kenya shillings aggregate annual amount of money that the 175 local governments in Kenya spent in health between the year 1978 and 2008. The spending in health as described by Mboga (2009) and World Bank (2002) are on construction of health facilities, construction of pit latrines and toilets, construction of wards within health facilities and salary remuneration of health workers and purchase of medical drugs, supplies and equipment.

Public spending in health by local government is followed by an arrow facing the right which shows that it is public spending in health by local government that improves changes in health status.

The strength of public spending to improve changes in health status is also influenced by some factors. Those factors are outlined in the box at the bottom of figure 2.2. Those factors affect the strength of public spending to improve changes in health status.

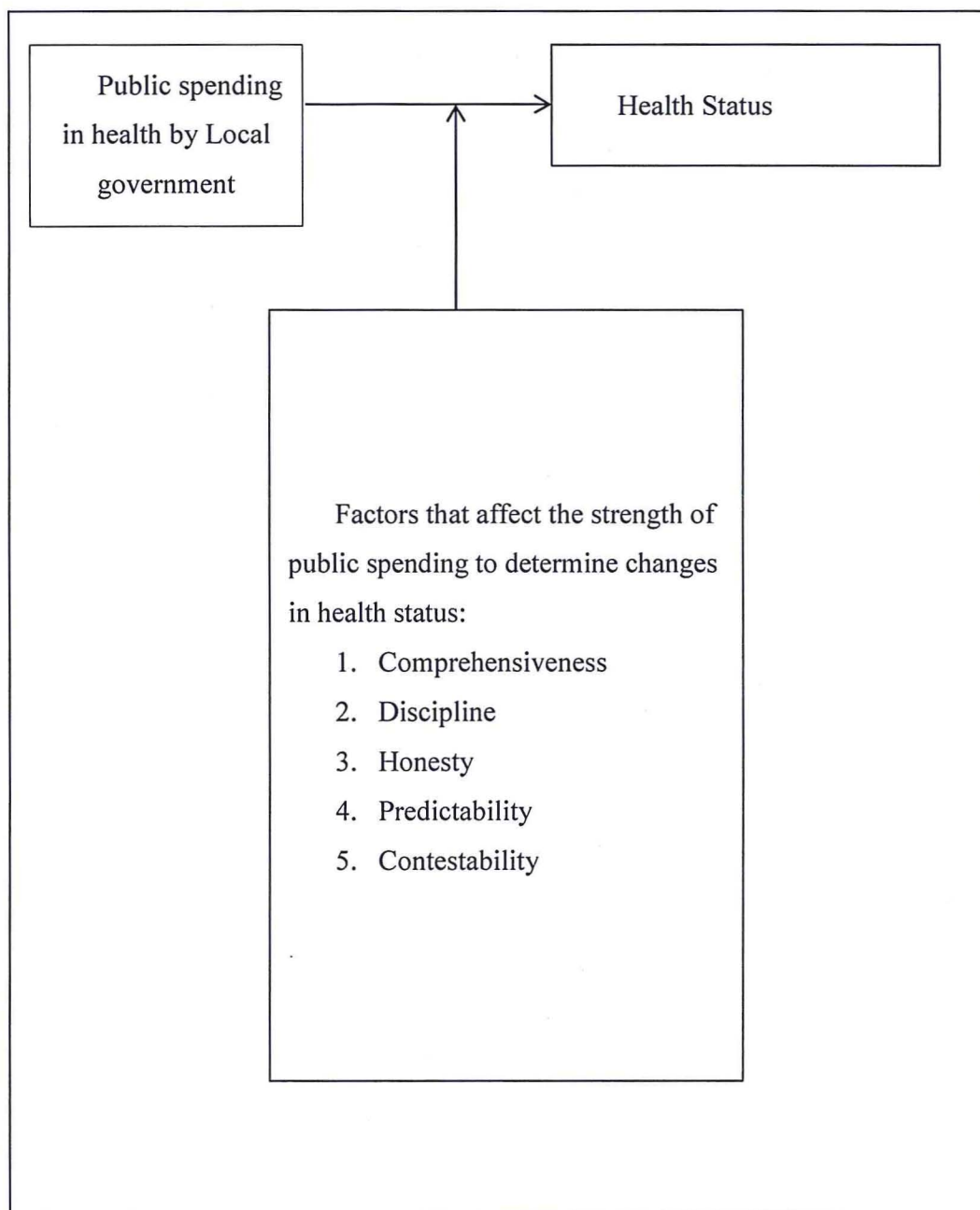


Figure 2.2: Conceptual Framework

CHAPTER 3: RESEARCH METHODOLOGY

3.1: Introduction

This chapter explains how the study is carried out. Beginning with the research design selected for the study, the chapter describes how the population is sampled, and the instruments used in collecting the data. The data is described together with the research instrument in section 3.4 and the final section discusses the data analysis techniques employed.

3.2: The Research Design

In order to describe the characteristic of public spending and health status this study evaluated how the two variables related in the case of Kenya. The study also identified factors that affect the strength of public spending to improve health status in Kenya. To achieve these objectives, the study used a descriptive research design. Linear regression analysis is used to evaluate the link between public spending and health status. The study used record review and personal interview to collect data on public spending, health status and factors that affect the strength of public spending by local government to improve health status.

3.3: Population and Sampling

The study population is local governments in Kenya, which were also referred to as local authorities. Local governments were established by the Local Government Act of 1977, and were repealed by the Urban Areas and Cities Act of 2012. As at 2000, the Ministry of Local Government had 175 local Authorities under them, which were classified into city, municipal, town and county councils. The composition is: 1 City Council, 45 Municipal Councils, 62 Town Councils and 67 County Councils. Beginning March 2013, Local Authorities were repealed but were put under the county government. County governments are 47 and established by the Constitution of Kenya in 2010 (GoK, 2010c). Given the small size of local governments, the study conducted a census instead of sampling to collect the quantitative data.

3.4: Data description and collection method

The data collected for public spending in health at the local government are two folds. One is the aggregate annual spending of both recurrent and development expenditures over the period 1978 to 2007. The expenditure is the aggregate of all the 175 local government for one year over a period of 30 years. Public spending in health by local government data is used achieve objective one. The data on public spending in health by local government between the periods of 1978 to 2007 was collected via document review of annual economic survey over this period.

On the other hand, development spending in health by local government represents annually aggregate development expenditure for each local government over a five years period of 2003 and 2008. Specifically, the development spending is on construction and rehabilitation of health facilities, construction and rehabilitation of public toilets, construction of staff quarters for health workers, and construction of wards within a health facility. This definition of public spending is taken from the World Bank (2002).The data on development spending in health by local governments is collected by document reviewing the Local Authority Transfer Fund Report of 2003,2004,2005,2006,2007 and 2008.Given this voluminous data already available on the entire population, this study choose document review. This data is in Kenya Shillings and contained both actual and budgeted expenditure. Data on approved budget is contained in a previous years report and the actual spending on the next years report.

Since the data on recurrent expenditure is not itemized and only that on development is, then this study is limited to the development expenditure of local government. The development expenditure per local government is aggregated to the counties which are 47.

Health status is measured by child mortality rate which is the number of deaths of children before reaching their 5th birthday per 1000 children who survived to one year of age. The data is collected from the Kenya Health and Demographic Survey Report (KDHS) which were carried out in 1993, 1998, 2003 and 2009. The 2009 data has been disintegrated to the county level by the by the Ministry of Devolution and Planning in their publication of County Profile.

To further evaluate the relationship between development spending in health by local government over the period of 2003 to 2008 and sub-national health status, the study used child mortality data per province and equated it to county for the counties that form a region. Then for the annual change in child mortality per region the study used the growth rate indicated by Kenya demographic and health survey which showed the trend as linear.

The study used public spending in health by local government in development expenditure obtained from LATF report for the period 2003 and 2008. The local government's development spending is aggregated to the county level for comparison which the child mortality data

The Study had used personal interviews to collect quantitative data on factors that affect the ability of public spending to improve health status in Kenya. The study had interviewed government officers and civil society organisation representatives. The government officers included health professionals, accountants, administrators and economists. Civil society organisations were only those that were involved in the public finance at the local government level who were interviewed.

To collect data on factors that affect health impacting public spending, the study collected data on practice or non-practice of public finance principles at the local government level.

To collect data on practice of comprehensive principle, the study measured it by the extent to which construction of health facilities were matched to their future running cost. The study asked respondent to rate the occurrence of the event where projects to construct health facilities were matched to their future running costs at the planning stage. The respondents were given a Likert scale of 5 to rate the occurrence of that event. On the Likert scale 1 represents very frequent, 2 frequent, 3 occasional, 4 rare 5 very rare. Thereafter the study asked the respondent to rate using the same Likert scale the occurrence of health facilities not being in used because they lacked medical staff. They were also asked to rate the occurrence of health facilities being operational after construction. Finally they were asked to rate the occurrence of the events that health facilities are have medical equipment to operate the facility, that

they have the medical staff to operate the facility and they have medical drugs to operate the facility.

To collect data on practice of discipline principle, the study measured the number of times a budget item is not spent on. When an item is budgeted for and spent on then discipline had been practiced, and it is measured as zero otherwise it is measured as 1. Additionally practice of discipline or non-practice is measured by the proportion by which the budgeted item is overspent on. This information is collected from document review of LATF report between the period 2000 and 2008.

To measure practice of the other factors that affect health impacting public spending, the questions asked are contained in Appendix A.

3.5: Data Analysis

To evaluate the relationship between public spending in health by local government and national health status in Kenya the study compared the trend of annual public spending in health by local government. The study also evaluated the trend in annual national child mortality over a 30 years period between 1978 and 2008. Where an increase in public spending in health had a corresponding decline in child mortality, public spending was described as having a positive association to national health status. Further, the study modeled child mortality over the 30 years period against public spending in health by local government. Then the study compared the difference in goodness of fit of the model, correlation, significant of the coefficient, and the magnitude of the coefficient. The model was estimated as follows:

$$\ln(NHS_t) = \delta_0 + \delta_1 \ln(PSLG_t) + \varepsilon_t \quad (3.1)$$

Where:

t represents the year, NHS represents annual National Health Status which is the annual child mortality rate. Child Mortality Rate is the number of children that die after their first birthday before reaching their fifth birthday per 1000 children between one and five years.

$PSLG$ represents annual public spending by local government in health

ε_t is the error term

To estimate the values of the parameters that measures the extent to which change in one of the independent variable by one is associated with changes in the depend variable (health status), the study used Ordinary Least Square (OLS) method compute as:

$$\frac{\partial S}{\partial \delta_2} = \sum_{t=1}^T 2(\ln(NHS_t) - \delta_0 - \delta_1 \ln(PSLG_t)) \quad (3.3)$$

To evaluate the relationship between public spending on health and health status, the study calculated coefficient of determination given by:

$$R^2 = \frac{\sum_{t=1}^T (NHS_t - \widehat{NHS})^2}{\sum_{t=1}^T (NHS_t - \overline{NHS})^2} \quad (3.4)$$

To evaluate the relationship between development spending in health by local government and sub-national health status in Kenya the study modeled child mortality rate against public spending in health on development by local government over the 6 years period between 2003 and 2008 across 47 counties which represent the sub-national level of government. Then the study compared the difference in goodness of fit of the model, correlation, significant of the coefficient, and magnitude of the coefficient. The model is estimated as follows:

$$\ln(SNHS_{i,t}) = \delta_0 + \delta_1 \ln(DPSLG_{i,t}) + \varepsilon_{i,t} \quad (3.1)$$

Where

t represents the year and i the subnational (county) government

SNHS represents annual Sub-national Health Status which is the annual child mortality rate. Child Mortality Rate is the number of children that die after their first birthday before reaching their fifth birthday per 1000 children between one and five years.

DPSLG represents annual public spending in health on development by local government

$\varepsilon_{i,t}$ is the error term

To estimate the values of the parameters that measures the extent to which change in one of the independent variable by one is associated with changes in the depend variable (health status), the study used Ordinary Least Square (OLS) method compute as:

$$\frac{\partial S}{\partial \delta_2} = \sum_{i=1}^n \sum_{t=1}^T 2(\ln(NHS_{i,t}) - \delta_0 - \delta_1 \ln(PSLG_{i,t})) \quad (3.3)$$

To evaluate the relationship between public spending in health and health status, the study calculated coefficient of determination given by:

$$R^2 = \frac{\sum_{i=1}^n \sum_{t=1}^T (NHS_{i,t} - \widehat{NHS}_{i,t})^2}{\sum_{i=1}^n \sum_{t=1}^T (NHS_{i,t} - \overline{NHS})^2}$$

To identify the factors that affect public spending's ability to improve health status in Kenya, the study used descriptive statistics to analyse the respond. The responds analysed were on question eight in the questionnaires..

3.6: Research Quality

In order for this study to generalize on its finding of local government public spending the data collected should be of good quality. The data collected should be consistent when repeatedly collected so that the results of the study can in as much as possible representative local government's public spending in health in Kenya. To do so, the study maximized reliability and validity of the data.

3.6.1: Reliability

The study has tried to avoid errors arising from inaccurate coding; ambiguous instructions to the interviewee; interviewee and interviewer fatigue; and interview basis in as much as possible. To test the extent to which the data collect is reliable, the study used the Cronbach coefficient of Alpha. The Cronbach Coefficient of Alpha is computed as follows((Kothari, 2004):

$$KR_{20} = \frac{(K)(S^2 - \sum s^2)}{(S^2)(K-1)} \quad (3.5)$$

Where:

KR_{20} is the reliability coefficient of internal consistency

K is the number of items used to measure the cause of effective public spending on health

S^2 is the variance of the all scores

s^2 is the variance of individual items

The study carried out Cronbach Alpha reliability test on the responds provided

by the respondents in the questionnaire. Question 5, 7, 8 and 9 were expected to produce highly related results. Since question 5 asked whether capital expenditure is matched to future running cost of the health facilities, then it is expected that the responses to question 7, 8 and 9 were similar. Since question 7, 8 and 9 asked whether primary health facilities were not operational due to lack of medical staff, medical equipment or medical drugs. The result of Cronbach Alpha is 0.83 which indicates a high level of reliability.

3.6.2: Validity

To ensure the result of the study evaluates the relationship between public spending in health by local government and national health status and local health status, in Kenya the study identified from the literature other variables that could cause health status to change other public spending in health. The study controlled for these extraneous variables in order to differentiate the extent to which this variable cause a change in health status and the extent to which public spending cause changes in health status. The control is to maximize the internal validity of the study. To ensure external validity is also maximising, the study used all the items in the population for representation.

3.7: Ethical Consideration

To address confidentiality of the information provided by the respondent the study begins by promising confidentiality to the respondent in the interview guide. Thereafter the study used numbers to represent the local government instead of the name of the local government. Further, where information about the local government needed to be disclosed for the purpose of achieving the objective the name of the local government is not mentioned.

The study wrote to relevant government institutions that are the custodians of the data required for this study in order to obtain the data. Further in conducting the interview the interviewer introduces herself and the purpose of the interview before seeking the consent of the interviewee to participate in an interview.

CHAPTER 4: PRESENTATION OF RESEARCH FINDINGS

4.1: Introduction

This chapter presents the finding of this research and is divided into three sections. The second section presents the results of the regression equations that sought to evaluate the relationship between public spending by local government in health and national health status. Secondly, the relationship between development spending by local government in health and sub-national health status. The third section presents the results of the third objective which is to identify of factors that affect public spending's ability to improve health status.

4.2: Demographic characteristics of the respondents

The study collected primary data through telephone interviews, to identify factors that affect local government public spending's ability to improve health status in Kenya. The respond rate is 36/47 which equals 77 per cent. Of the 36 respondents one did not have the experience of working in local government, therefore, is omitted from the analysis. The other 35 respondents consisted of eight respondents from civil society organisation. The eight were involved in oversight of public finances at the local government level. The other respondents were: one health professional, twelve administrators, one planner, and fourteen accountants

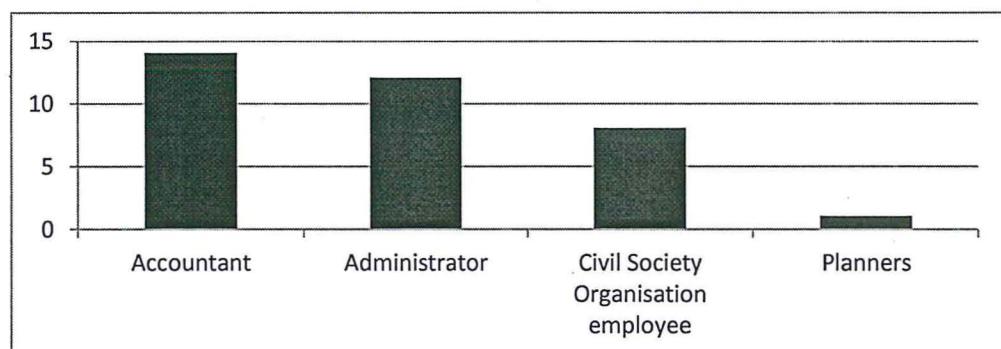


Figure 4.1: Profession of Respondents

Table 4.1: Respondents years of experience in Kenya's local government

	Number of respondents
Less than 5 years	8
Between 5 and 10 years	5
More than 10 years	22
Total	36

All the respondents had a university degree as the highest level of educational attained, and they were 10 females and 26 males.

Table 4.2: Respondents' years of experience in the local government interviewed about

	Number of respondents
Less than 5 years	22
Between 5 and 10 years	5
More than 10 years	8
Total	36

4.3: Relationship between public spending and national health status

The relationship between the two variables, public spending in health by local government and health status can either be positive or negative. The study first determines whether there was any association between them, then whether the relationship was significant. Finally, the magnitude of the relationship.

Public spending in health was the expenditure incurred by local government in health which was both recurrent and development aggregate. It was an annual aggregate of all the 175 local government over a 30 years period. Health status was measured as child mortality rate which is the number of deaths of children before reaching their 5th birthday per 1000 children who survived to one year of age.

Figure 4.2 Illustrates that public spending in health by local government had overall increased over the 30 years period between 1978 and 2007. The overall increase had been described by declined spending in some period and increased spending in others. In ten years of the 30-year period, public spending by local government in health declined from the previous period as observed in table 4.3. The trend indicates consistent commitment to increase spending in health by local government over the 30 years period.

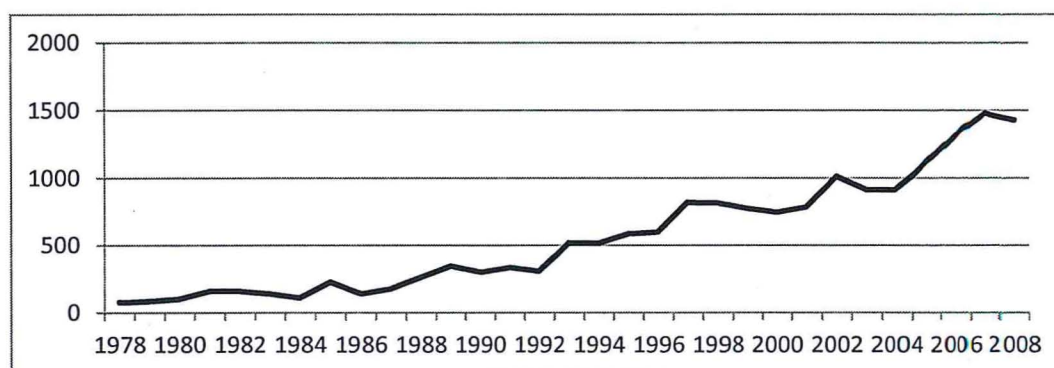


Figure 4.2: Public spending in health by local government in Kenya shillings millions

Observing from table 4.3 in thirteen years public spending in health by local government increase coincided with a decrease in child mortality. That is in less than half of the period under study which is 43 per cent of the time; more commitment of resources by local government had been associated with improved health status. There are six years when increase spending by local government in health was associated with increased child mortality. Meaning in 20% of the period under study more commitment by government was associated with worsening health status.

There were periods when government declined commitments towards the health sector was associated with a reduction in child mortality which was also 13% of the time.

Table 4.3: Comparison of changes in LGPS against changes CMR

	CMR Increase	CMR decrease
LGPS increase	6 years	13 years
LGPS decrease	4 years	6 years

government ended at construction of these primary health facilities as demanded by the local communities through the local government's participatory budget making process. Comprehensive principle is not well practiced in the case of local governments in Kenya.

5.4.2: Discipline

As illustrated in Uganda, by World Bank (1998) spending on non-budgeted items results to overspending, the results of this study are similar. In the case of local governments in Kenya spending on non-budgeted items was practiced by a majority, who are 69 percent of all local government that spent in health. The total spending on non-budgeted items range was wider than that of Uganda. It rated between zero and 3817 per cent in the case of Kenya's local government. This illustrates that the phenomenon is of a higher magnitude in Kenya's local government. Practice of discipline principle was lacking in the case of local governments in Kenya.

5.4.3: Honesty

On average spending as a proportion of budgeted is at 64 per cent in the case of public spending in health by local government. This is above 15 per cent and is rated D which is the lowest rank. Of the 19 local government that spend below the budgeted only one was ranked at B for a variation of 9 per cent from the budgeted. A score of D is similar to that of Niger and Liberia in 2013 although they were measured over a period of 3 years. Kenya's local government's spending as a proportion of budgeted was rated below that of Uganda's national government in 2012 when it is rated as C. The other governments compared to Kenya are at the national level not local level although the results are not significantly different except for the case of Uganda.

5.4.4: Predictability

As described by the GoK (2010) that untimely disbursement of funds is a major cause of low absorption rate in development expenditure. This phenomenon of untimely disbursement is also evident at the local government level. The respondents rated timely disbursement of funds to projects as a very rarely occurring event.

5.4.5: Contestability

Public spending in health on average was 78 per cent on curative health care. According to Gupta, Benedict, & Erwin (1998) about two thirds of public spending in health is on curative health care. For Kenya's local government a proportion of 78 per cent is high than the average of Sub-Saharan Africa which is 65 per cent. This proportion is higher than all the other average proportion calculated for the various regions in the world and the overall average of 60 per cent for all the 33 countries sampled by Gupta, Benedict & Erwin(1998). Given that the proportion of public spending is more than what was computed by Gupta, Benedict & Erwin(1998) who mention the high proportion of 60 per cent caused public spending in health to be weak at determining changes in health status.

Filmer, Hammer, & Pritchett(2000) contends with Gupta, Benedict & Erwin(1998) theory that curative health spending causes public spending to be weak in determining changes in health status. Filmer et al. mentioned that weakness of public spending to determine changes in health status occurred when curative spending was more on secondary and tertiary health facilities. In fact, curative spending in primary health care was strong at determining changes health status. Kenya's local government spending in curative health includes construction of health facilities, health centres, clinics, and wards in primary health facilities.

Results of the respondent on the frequency of health facilities being constructed by local government being situated near where the population lived was on average a rare occurrence and a majority of the respondents rated it as very rare. This indicates that primary health facilities were where the people need it. This could be as a result of participatory budgeting where the community identifies the project they need. As Filmer, Hammer, & Pritchett (2000) described that in many developing countries the cause public spending being weak in determining changes in health status was health facilities are constructed far from where the population lives. This phenomenon is not the same in as far as primary health facilities constructed by local government in Kenya. This factor contributes to improving effectiveness of public spending in health.

CHAPTER 6: CONCLUSION ANDRECOMMENDATION

6.1: Introduction

In this chapter, the conclusion, recommendation and areas of further studies are discussed sequentially.

6.2: Conclusion

The relationship between local government public spending and national health status is significant and positive between the period of 1978 to 2007. However, that between development spending and sub national health status is not significant over the period of 2003 and 2008 across the 175 local governments. This could be as a result of the minimal amount of development spending in health by local government as a comparison to the local government spending in health.

Contestability principle is the one principle well practiced by local government in Kenya in as far as public spending in health is concerned. They construct health facilities near the population and spending more on curative primary health care. The other four principles of sound public spending are not practiced in Kenya. Capital expenditure are unmatched to future running cost, spending is on unbudgeted items, items budgeted are not fully spent on during the year and funds are rarely received in a timely manner. Finally health facilities very rarely have medical staff, equipment and drugs to operate them.

6.3: Recommendation

To improve health status in Kenya the study recommends to county governments to increase spending in health in the areas that the former local government spent in. These areas are curative health care at primary health facilities and preventive health care. This is likely to improve health status in Kenya and accelerate the rate of reducing of child mortality to reach the two-third target and beyond.

To improve the strength of public spending in health in determining changes in health status, this study recommends to county government to link capital spending to future running cost of health facilities. Additionally, ensure the health facilities already completed have the medical equipment, staff and drugs required to

be operation this will increase quickly increase the magnitude of public health services provided. As a result increase the strength of public spending to improve health status.

6.4: Area of further Research

The study found development spending in health by local government to be insignificant in determining health status. The study recommended further research to investigate significant of development spending in health in determining changes in health status by obtaining additional data.

The study used past data and with the change to new structure of devolved governance it is this studies recommendation that a similar study is carried out using county government public spending data to investigate strength of public spending in health in determining changes in health status after devolution. This could illustrate the change in this phenomenon as this study illustrates the situation before devolution.

6.5: Limitation of the Study

In evaluating the relationship between public spending and health status, the study looked at changes in public spending in one year and compared it to changes in health status in the same year. For development projects which take several years to complete spending in one year may not result to improve health status in the same year.

To compare local government public spending effect on sub-national health status the study could not obtain individual local government recurrent spending in health. The study was limited to development expenditure on health by local government.

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APPENDIX A

INTERVIEW

INTRODUCTORY GUIDE

I want to thank you for taking the time to meet with me today. My name is Meimuna Mohammed, Pursuing a Master of Commerce at Strathmore University and my research topic is Effectiveness of public spending on health by local governments in Kenya. As part of my research work, I would like to inquire about your experience working in Kenya's health sector at the local level. Specifically, what your views are on public spending in Kenya's health sector. The interview should take less than an hour. The information give shall be treated with utmost confidentiality and shall be used solely for the purpose of achieving the objectives of this study.

1. Name of the
County

2. What is your professional experience in the health sector in
Kenya?

- ☐ Health Worker
- ☐ Accountant/ Finance officer
- ☐ Planner/Economist
- ☐ Administrator

3. How long have you worked in the health sector in
Kenya?

- ☐ Less than 5 years
- ☐ Between 5 to 10 years
- ☐ More than 10 years

4. What is your education
attainment?

- ☐ Primary education

☐ Secondary Education

☐ College/University

5. What is your
Gender?

☐ Female

☐ Male

6. How long have you been in this
county?

☐ Less than 5 years

☐ Between 5 to 10 years

☐ More than 10 years

7. When categorising public spending in health, it is grouped into:

a. Recurrent expenditure

b. Development expenditure

c. Curative health care

d. Preventive health care

Please select the option that applies to your county

☐ a & b only

☐ c & d only

☐ all of the above

☐ None of the above

8. The following are suggested to reduce government's ability to improve health status through its spending in the health sector. Rate these causes by ticking to indicate the extent to which it applies in your county(select one option)

1- Very frequent(Occurred five or more times)

2- Frequent(Occurred four times)

3- Occasionally(Occurred 3 times)

4- Rarely(Occurred 2 times)

5- Very rarely(Occurred once)

No	Cause	1	2	3	4	5
1.	There is timely disbursement of funds					
2.	Public spending is more on curative than preventive health care					
3.	Capital expenditure is matched to future running cost of new health facilities					
4.	Primary health facilities(<i>Dispensaries, health centres and sub-county hospitals</i>) are situated far from where the population lived					
5.	Capital expenditure is matched to future running cost of new health facilities					
6.	Primary health facilities(<i>Dispensaries, health centres and sub-county hospitals</i>) are situated far from where the population lived					
7.	Primary health facilities(<i>Dispensaries, health centres and sub-county hospitals</i>) have medical staff to operate the facilities					
8.	Primary health facilities(<i>Dispensaries, health centres and sub-county hospitals</i>) have medical drugs and supplies to operate the facilities					
9.	Primary health facilities(<i>Dispensaries, health centres and sub-county hospitals</i>) have equipment required to operate the facilities					

APPENDIX B

List of Counties and Local Governments under them

COUNTY	LOCAL GOVERNMENT
BARINGO	BARINGO COUNTY COUNCIL
BARINGO	KOIBATEK COUNTY COUNCIL
BARINGO	ELDAMA
BARINGO	RAVINE TOWN COUNCIL
BOMET	KABARNET MUNICIPAL COUNCIL
BOMET	BOMET COUNTY COUNCIL
BOMET	BOMET MUNICIPAL COUNCIL
BOMET	LITEIN TOWN COUNCIL
BOMET	SOTIK TOWN COUNCIL
BOMET	BURETI COUNTY COUNCIL
BUSIA	TESO COUNTY COUNCIL
BUSIA	MALABA TOWN COUNCIL
BUSIA	NAMBALE TOWN COUNCIL
BUSIA	FUNYULA TOWN COUNCIL
BUSIA	PORT VICTORIA TOWN COUNCIL
ELGEYO/MARAKW ET	ITEN-TAMBACH TOWN COUNCIL
ELGEYO/MARAKW ET	MARAKWET COUNTY COUNCIL
ELGEYO/MARAKW ET	KEIYO COUNTY COUNCIL
EMBU	EMBU COUNTY COUNCIL
EMBU	EMBU MUNICIPAL COUNCIL
EMBU	RUNYENJES MUNICIPAL COUNCIL
HOMA BAY	SUBA COUNTY COUNCIL
ISIOLO	ISIOLO COUNTY COUNCIL
KAJIADO	KAJIADO TOWN COUNCIL
KAJIADO	OLKEJUADO COUNTY COUNCIL
KAKAMEGA	KAKAMEGA COUNTY COUNCIL
KAKAMEGA	KAKAMEGA MUNICIPAL COUNCIL
KAKAMEGA	LUGARI COUNTY COUNCIL
KAKAMEGA	BUTERE- MUMIAS COUNTY COUNCIL
KAKAMEGA	MUMIAS TOWN COUNCIL
KAKAMEGA	MALAVA TOWN COUNCIL
KERICHO	KERICHO TOWN COUNCIL
KIAMBU	THIKA MUNICIPAL COUNCIL
KILIFI	KILIFI COUNTY COUNCIL
KILIFI	KILIFI TOWN COUNCIL
KILIFI	MALINDI COUNTY COUNCIL
KILIFI	MALINDI MUNICIPAL COUNCIL

COUNTY	LOCAL GOVERNMENT
KILIFI	MARIAKANI TOWN COUNCIL
KIRINYAGA	KIRINYAGA COUNTY COUNCIL
KIRINYAGA	SAGANA TOWN COUNCIL
KIRINYAGA	KERUGOYA/KUTUS MUNICIPAL COUNCIL
KISII	KISII MUNICIPAL COUNCIL
KISII	NYAMARAMBE COUNCIL
KISUMU	MUHORONI TOWN COUNCIL
KISUMU	AHERO TOWN COUNCIL
KITUI	KITUI COUNTY COUNCIL
KITUI	KITUI MUNICIPAL COUNCIL
KITUI	MWINGI COUNTY COUNCIL
KITUI	MWINGI TOWN COUNCIL
KWALE	KWALE COUNTY COUNCIL
KWALE	KWALE TOWN COUNCIL
LAIKIPIA	LAIKIPIA COUNTY COUNCIL
LAIKIPIA	RUMURUTI TOWN COUNCIL
MAKUENI	MTITO ANDEI TOWN COUNCIL
MANDERA	MANDERA COUNTY COUNCIL
MANDERA	MANDERA TOWN COUNCIL
MARSABIT	MARSABIT COUNTY COUNCIL
MARSABIT	MOYALE COUNTY COUNCIL
MERU	MERU COUNTY COUNCIL
MERU	MERU MUNICIPAL COUNCIL
MERU	NYAMBENE COUNTY COUNCIL
MERU	MAUA MUNICIPAL COUNCIL
MIGORI	MIGORI MUNICIPAL
MURANG'A	KANDARA TOWN COUNCIL
MURANG'A	MAKUYU TOWN COUNCIL
NAIROBI	NAIROBI CITY COUNCIL
NAKURU	NAKURU COUNTY COUNCIL
NAKURU	NAKURU MUNICIPAL COUNCIL
NAKURU	MOLO TOWN COUNCIL
NAKURU	NAIVASHA MUNICIPAL COUNCIL
NANDI	NANDI COUNTY COUNCIL
NANDI	NANDI HILLS TOWN COUNCIL
NANDI	KAPSABET MUNICIPAL COUNCIL
NAROK	NAROK COUNTY COUNCIL
SAMBURU	SAMBURU COUNTY COUNCIL
SAMBURU	MARALAL TOWN COUNCIL
SIAYA	SIAYA COUNTY COUNCIL

COUNTY	LOCAL GOVERNMENT
SIAYA	SIAYA MUNICIPAL COUNCIL
SIAYA	BONDO COUNTY COUNCIL
SIAYA	BONDO TOWN COUNCIL
SIAYA	YALA TOWN COUNCIL
SIAYA	UGUNJA TOWN COUNCIL
SIAYA	UKWALA TOWN COUNCIL
TAITA TAVETA	TAITA/ TAVETA COUNTY COUNCIL
TAITA TAVETA	TAVETA TOWN COUNCIL
UASIN GISHU	ELDORET MUNICIPAL COUNCIL
UASIN GISHU	WARENG COUNTY COUNCIL
UASIN GISHU	BURNT FOREST TOWN COUNCIL
VIHIGA	VIHIGA COUNTY COUNCIL
VIHIGA	VIHIGA MUNICIPAL
BUNGOMA	BUNGOMA COUNTY COUNCIL
BUNGOMA	BUNGOMA MUNICIPAL COUNCIL
BUNGOMA	WEBUYE MUNICIPAL COUNCIL
BUNGOMA	MOUNT ELGON COUNTY COUNCIL
BUNGOMA	KIMILILI MUNICIPAL COUNCIL
BUNGOMA	MALAKISI TOWN COUNCIL
BUNGOMA	SIRISIA TOWN COUNCIL
BUSIA	BUSIA COUNTY COUNCIL
BUSIA	BUSIA MUNICIPAL COUNCIL
EMBU	MBEERE COUNTY COUNCIL
GARISSA	GARISSA COUNTY COUNCIL
GARISSA	GARISSA MUNICIPAL COUNCIL
GARISSA	IJARA COUNTY COUNCIL
HOMA BAY	HOMA BAY COUNTY COUNCIL
HOMA BAY	HOMA BAY MUNICIPAL COUNCIL
HOMA BAY	OYUGIS TOWN COUNCIL
HOMA BAY	KENDU BAY TOWN COUNCIL
HOMA BAY	RACHUONYO COUNTY COUNCIL
HOMA BAY	MBITA POINT TOWN COUNCIL
KERICHO	KIPKELION TOWN COUNCIL
KERICHO	LONDIANI TOWN COUNCIL
KERICHO	KIPSIGIS TOWN COUNCIL
KIAMBU	KIAMBU COUNTY COUNCIL
KIAMBU	KIAMBU MUNICIPAL COUNCIL
KIAMBU	KIKUYU TOWN COUNCIL
KIAMBU	RUIRU MUNICIPAL COUNCIL
KIAMBU	KARURI TOWN COUNCIL

COUNTY	LOCAL GOVERNMENT
KIAMBU	LIMURU MUNICIPAL COUNCIL
KIAMBU	THIKA COUNTY COUNCIL
KISII	GUCHA COUNTY COUNCIL
KISII	SUNEKA TOWN COUNCIL
KISII	KEROKA TOWN COUNCIL
KISII	TABAKA TOWN COUNCIL
KISII	OGEMBO TOWN COUNCIL
KISII	GUSII COUNTY COUNCIL
KISII	NYAMACHE TOWN COUNCIL
KISII	MASIMBA TOWN COUNCIL
KISUMU	KISUMU COUNTY COUNCIL
KISUMU	KISUMU MUNICIPAL COUNCIL
KISUMU	NYANDO COUNTY
LAIKIPIA	NANYUKI MUNICIPAL COUNCIL
LAIKIPIA	NYAHURURU MUNICIPAL COUNCIL
LAMU	LAMU COUNTY COUNCIL
MACHAKOS	KANGUNDO TOWN COUNCIL
MACHAKOS	MACHAKOS MUNICIPAL COUNCIL
MACHAKOS	MASAKU COUNTY COUNCIL
MACHAKOS	MATUU TOWN COUNCIL
MACHAKOS	MAVOKO MUNICIPAL COUNCIL
MAKUENI	MAKUENI COUNTY COUNCIL
MAKUENI	WOTE TOWN COUNCIL
MIGORI	AWENDO TOWN COUNCIL
MIGORI	MIGORI COUNTY COUNCIL
MIGORI	KENHACHA MUNICIPAL COUNCIL
MIGORI	RONGO TOWN COUNCIL
MOMBASA	MOMBASA MUNICIPAL COUNCIL
MURANG'A	MURANG'A COUNTY COUNCIL
MURANG'A	MURANG'A MUNICIPAL COUNCIL
MURANG'A	MARAGUA COUNTY COUNCIL
MURANG'A	MARAGUA TOWN COUNCIL
MURANG'A	KANGEMA TOWN COUNCIL
NAROK	NAROK TOWN COUNCIL
NAROK	TRANS MARA COUNTY COUNCIL
NYAMIRA	NYAMIRA COUNTY COUNCIL
NYAMIRA	NYAMIRA TOWN COUNCIL
NYAMIRA	NYANSIONGO TOWN COUNCIL
NYANDARUA	NYANDARUA COUNTY COUNCIL
NYANDARUA	OL'KALOU TOWN COUNCIL

COUNTY	LOCAL GOVERNMENT
NYERI	NYERI COUNTY COUNCIL
NYERI	NYERI MUNICIPAL COUNCIL
NYERI	OTHAYA TOWN COUNCIL
NYERI	KARATINA MUNICIPAL COUNCIL
TAITA TAVETA	VOI MUNICIPAL COUNCIL
TANARIVER	TANA RIVER COUNTY COUNCIL
THARAKA NITHI	MERU SOUTH COUNTY COUNCIL
THARAKA NITHI	THARAKA COUNTY COUNCIL
THARAKA NITHI	CHOGORIA TOWN COUNCIL
THARAKA NITHI	CHUKA MUNICIPAL COUNCIL
TRANS NZOIA	KITALE MUNICIPAL COUNCIL
TRANS NZOIA	NZOIA COUNTY COUNCIL
TURKANA	TURKANA COUNTY COUNCIL
TURKANA	LODWAR COUNCIL
VIHIGA	LUANDA TOWN COUNCIL
WAJIR	WAJIR COUNTY COUNCIL
WEST POKOT	CHEPARARIA TOWN COUNCIL
WEST POKOT	KAPENGURIA MUNICIPAL COUNCIL
WEST POKOT	POKOT COUNTY COUNCIL