development initiatives

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Progress of health and WASH in Kenya's poorest ASAL counties

In-depth analysis of 10 arid and semi-arid land counties

Factsheet

Contents

Key findings

This factsheet looks at the progress in the water, sanitation and hygiene (WASH) and health sectors in 10 of the poorest[1] arid and semi-arid land (ASAL) counties including Garissa, Isiolo, Kitui, Mandera, Marsabit, Samburu, Tana River, Turkana, Wajir and West Pokot between 2009 and 2019.

It looks at two major indicators: 1) access to clean water and improved sanitation, and 2) proportion of births in health facilities between 2009 and 2019. It reviews investment, actual spending, absorption rates[2] and the gaps in these sectors over the last five years.

The factsheet begins with an overview of access to clean water and improved sanitation, and the proportion of births in health facilities in the 10 counties. Next, we analyse investment in health and WASH sectors at the county level, and finally we look at the critical financial gaps in the two sectors.

Key findings from the analysis include:

- Household access to safe water sources increased in eight of the ten counties between 2009 and 2019, except Garissa and Mandera where it decreased.
- Access to improved sanitation facilities increased by at least eight percentage points in each of the ten counties between 2009 and 2019.
- The proportion of births in health facilities across the 10 counties increased by between 12 and 30 percentage points between 2015 and 2019, but the figures remain lower than the national average.
- Investment in water, sanitation and hygiene across the 10 counties has improved year on year during the period under review, dipping slightly in 2017/18 before a substantial increase in 2018/19.
- Absorption rates in the health sector averaged 84.3% between 2014/15 and 2018/19.

Introduction

According to Article 43 of the Constitution of Kenya 2010, access to quality healthcare and clean water, sanitation and hygiene services (WASH) are basic human rights.[3] These rights are also included in Goal 3 (ensure healthy lives and promote wellbeing for all at all ages) and Goal 6 (ensure availability and sustainable management of water and sanitation for all) of the UN's Sustainable Development Goals, which Kenya ratified in 2015.[4]

To meet this commitment, it is important that the Kenyan government continuously improves access to healthcare and WASH through robust investments. This is particularly true in the marginalised arid and semi-arid lands (ASAL) of north-eastern Kenya where inequalities in both health and WASH sectors are prominent.

Currently, access to improved WASH facilities and quality healthcare are crucial to stopping the spread of Covid-19, which has hit Kenya the hardest in East Africa. Cumulative cases in the poorest ASAL counties were 654 out of the national total of 35,460.[5] This underpins the need to scale up both health and WASH facilities in these counties to reduce the rising number of cases in the region.

Improved access to WASH facilities is linked to better health outcomes. By increasing investments in clean water and improved sanitation, the government will be protecting its citizens from contracting waterborne and hygiene-related infections, which increase health-related expenses and susceptibility to Covid-19. Commitments by both the national and county governments to improve investments in, and access to, WASH and healthcare in these counties will be critical in the fight against the pandemic and in improving the general wellbeing of citizens.

Having a devolved system of government, Kenya has designated part of the responsibilities both under WASH and healthcare to specific tiers of the government. County governments now have the responsibility of water supply and sanitation provision, as well as essential health service delivery. National government, on the other hand, retains responsibility for the management and use of international waters and water resources, health policy, technical assistance to counties and management of national referral health facilities.

Legislation promoting access, oversight and management of WASH and healthcare resources has been developed over time. The Health Act 2017 formalises intergovernmental collaboration between county and national governments, and establishes structures for providing oversight, regulatory services and promotion of healthcare services.[6] The Water Act of 2016 provides a legal basis for regulation, management, and development of water and sewerage services.[7] Other legislation and policies promoting provision of health and WASH services include the Public Health Act 2012,[8] Kenya Environmental, Sanitation and Hygiene Policy (KESHP) 2016–2030,[9] the National Water Master Plan 2030[10] and the Kenya Vision 2030.[11]

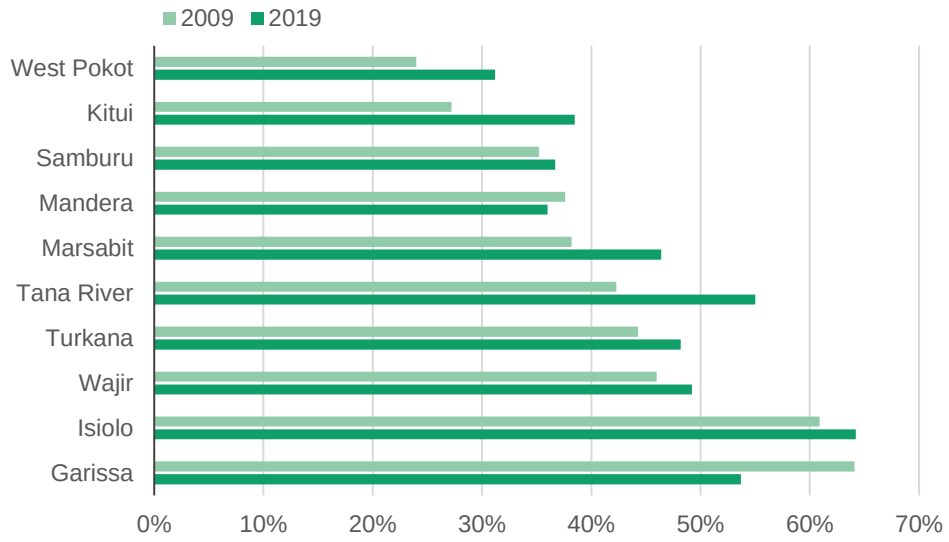
Progress in WASH and health in the 10 poorest ASAL counties

Water, sanitation and hygiene (WASH)

Household access to safe water sources increased in eight of the ten counties between 2009 and 2019, except Garissa and Mandera.

Access to safe water sources has substantially improved in eight of the ten counties within the last decade. Increases have been attributed to improved investments in water resources and rehabilitation of obsolete water points in the arid and semi-arid land (ASAL) region. Besides Garissa and Mandera, where access has decreased by 10.4 and 1.6 percentage points respectively between 2009 and 2019, the rest of the counties have increased access by at least 3 percentage points. Highest increases were seen in Tana River (13 pp) and Kitui (11.3 pp). The remaining counties have increased between 1.5 and 8.2 percentage points (Figure 1).[12]

Figure 1: Households with access to safe water sources in 10 of the poorest ASAL counties



Source: Development Initiatives based on Kenya Population and Housing Census reports in 2009 and 2019.[13]
See the differing levels of access to safe water across counties on the Spotlight on Kenya.

Analysis reveals household access to safe water sources has at least kept pace with the growing population in all the 10 counties, except in Garissa. Garissa's gains in population in the last decade has not translated to increased access to safe water sources. This highlights the need for increased investment in water resources to ensure the majority of the residents have access.

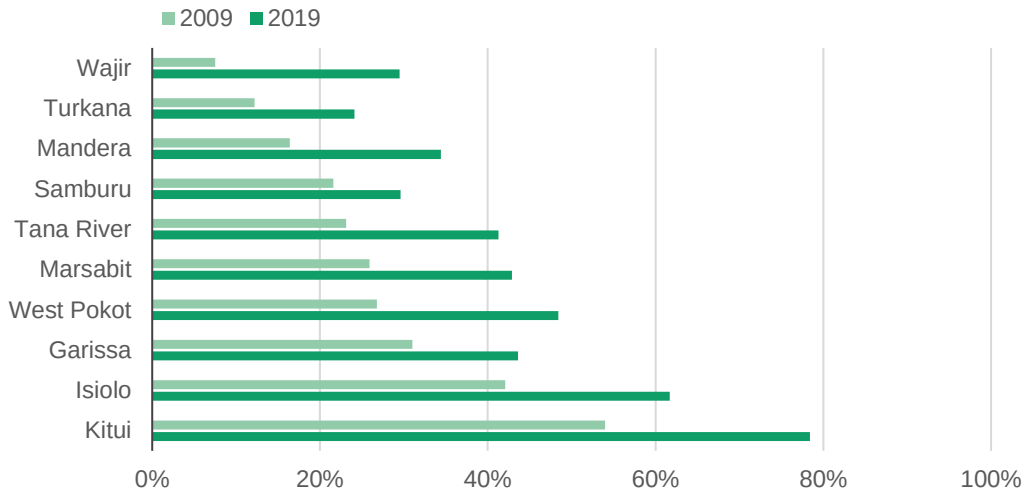
Though substantial progress has been made, only two counties in 2009 and one in 2019 had a percentage of access higher than the national average. In 2009, only Garissa and Isiolo had a higher percentage access than the national average of 56.1%. In contrast, in 2019, only Isiolo had a higher percentage than the national average of 64.8%. Increased investment in water resources and development of efficient structures and legislation to ensure increased access to water resources is crucial for achievement of both county and national targets.

Household access to improved sanitation facilities has increased by at least 8 percentage points in each of the 10 counties between 2009 and 2019.

A comparison between 2009 and 2019 census figures on sanitation reveals an increase of at least eight percentage points in the proportion of households accessing improved sanitation facilities. The highest increases were seen in Kitui (24.4 pp), Wajir (22 pp) and West Pokot (21.6 pp) (Figure 2).[14] The increase is attributed to improved investment by both the government and the private sector. Despite the increase, only two counties – Kitui and Isiolo – have over half of their households accessing improved sanitation facilities.

A comparison of access to improved sanitation facilities in ASAL counties against the national averages in 2009 and 2019 highlights the inequality of access in the ASAL counties. In both years, the national averages are higher than the county with the highest level of access, Kitui. In 2009, the national average was 65%, while Kitui had 54%. In 2019, the national average was at 82.2%, while Kitui had 78%. From this analysis, we can conclude that although the counties have witnessed increased access to improved sanitation facilities with the increasing population, they are still far behind the national average. This can be attributed to the slow progress in scaling up sanitation services in response to the needs of the population.

Figure 2: Household access to an improved sanitation facility in 10 of the poorest ASAL counties between 2009 and 2019



Source: Development Initiatives based on Kenya Population Housing Census reports in 2009 and 2019.[15]
See the differing levels of access to improved sanitation facilities across counties on the Spotlight on Kenya.

Health

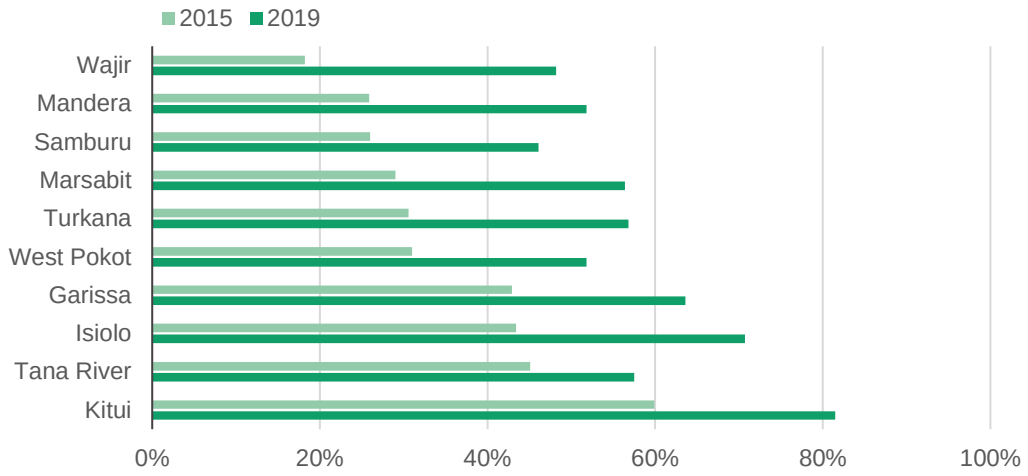
The proportion of births in health facilities increased by between 12 and 30 percentage points between 2015 and 2019, but the figures are lower than the national averages in both years.

Childbirth in hospital is of primary importance for the survival of both the mother and the child. Health facilities offer both the mother and the child pre and postnatal care which is important for the early growth and maturity of the baby.[16]

The proportion of births in health facilities have increased by between 12 and 30 percentage points in the counties under review between 2015 and 2019 (Figure 3).[17] This can be attributed to the free maternity programme, launched in 2013, that abolished delivery fees in all public health facilities countrywide. The programme aimed to promote the use of health facility delivery services nationally. Additionally, low National Hospital Insurance Fund (NHIF) fees have also increased the number of women attending pre and postnatal care in health facilities countrywide.

However, despite the increase, analysis shows that in both 2015 and 2019, the figures for all the 10 counties were lower than the national average of 65.3% in 2015 and 85.7% in 2019. There is need for improvement in not only funding to the health sectors in these counties, but also access to quality data on the health needs and resource requirement for decision makers. Moreover, high levels of poverty in these counties mean that households require improved allocation to pro-poor health insurance to subsidise the insurance cost.

Figure 3: Proportion of births in health facilities in 10 of the poorest ASAL counties between 2015 and 2019



Source: Development Initiatives based on Kenya Population and Housing Census report 2019[18] and 2015/16 Kenya Integrated Household Budget Survey.[19]
See the differing proportion of births in health facilities across counties on the Spotlight on Kenya.

Investment in health and WASH sectors at the county level

Data on county budgets and expenditure is only available up to the department level, this makes it difficult to determine spending on health or water, sanitation and hygiene (WASH) where the two have been combined, or where health or WASH sectors have been combined with other departments. Therefore, for the purposes of analysis, we will limit our analysis to eight rather than ten counties because the Kitui and Tana River have their health and WASH budgets and expenditure combined with other departments.

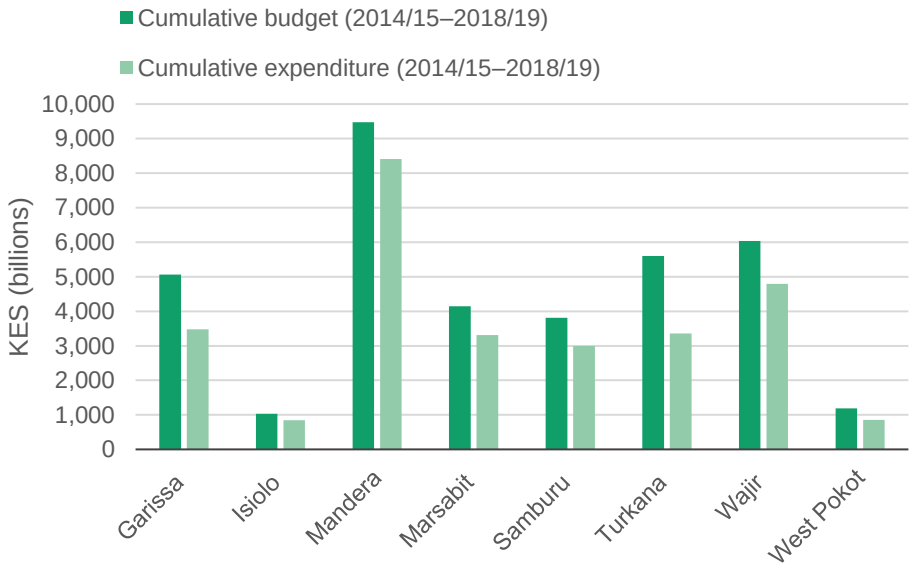
Investment in WASH has improved year on year during the period under review, dipping slightly in 2017/18 before a substantial increase in 2018/19.

Cumulative WASH budget and expenditure for all the eight counties has increased year on year, decreasing in 2017/18 before an increase in 2018/19. Analysis reveals the combined WASH budget increased by 16% between 2014/15 and 2015/16. A marginal increase of 6.4% was witnessed in 2016/17, followed by a decrease of 24.4% in 2017/18. The budget increased to the highest in 2018/19 by 36% to KES 8.2 billion.[20] In the five years under review, Mandera had the highest combined budget while Isiolo county had the least (Figure 4). However, it should be noted that Isiolo county had the least population of all the 10 counties under review.

Similarly, combined expenditure on WASH has consistently increased in the years under review except in 2017/18. A reduction of 44.7% was witnessed in 2017/18 from KES 6.8 billion in 2016/17 to KES 3.8 billion in 2017/18. The rest of the years were characterised by increases of 7.7% to 5.9 billion in 2015/16, followed by another increase of 14.8% in

2016/17 to 6.8 billion then a slump of 44.7% in 2017/18. Expenditure increased by the largest margin in 2018/19 (58%) to KES 6 billion.[21]

Figure 4: Cumulative WASH budget and expenditure between 2014/15 and 2018/19

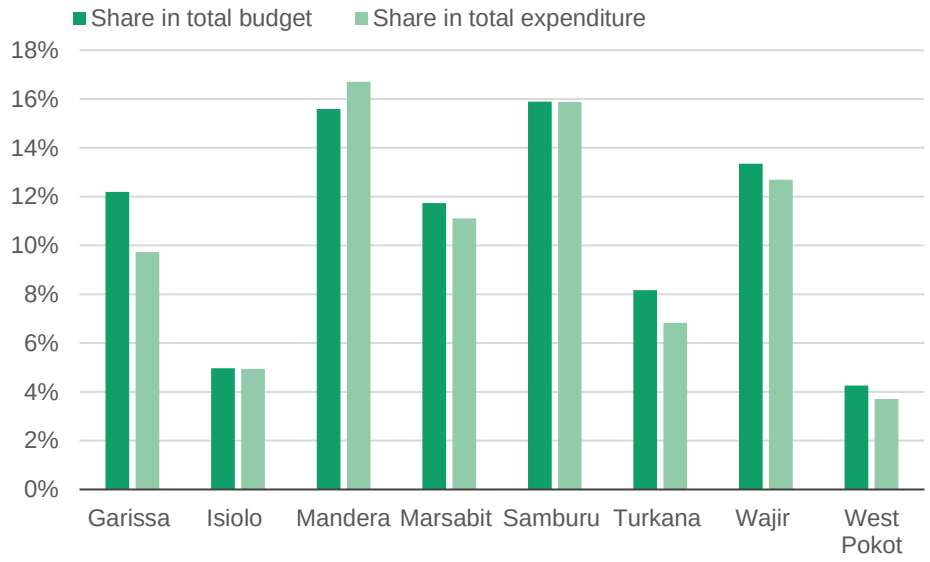


Source: Development Initiatives based on Controller of Budget reports.[22]
See the proportion of total county government expenditure allocated to water (which includes sanitation and hygiene) on the Spotlight on Kenya.

The reduction in actual expenditure in 2017/18 is explained by the decrease in absorption rates of funds[23] earmarked for water and sanitation in the ASAL counties. Absorption rates reduced slightly in 2015/16 to 79% up from 85.1%. The rates picked up in 2016/17 increasing slightly to 85.3%. The rates reduced drastically to 62.4% in 2017/18 before picking up in 2018/19 to 72.5%. The low absorption rate in 2017/18 is attributed to the delays in disbursement of funds from the national government and lengthy procurement processes associated with county tenders and purchases.

Cumulative share of WASH budget in the total budget for all the eight counties is slightly higher than the share of WASH expenditure in total expenditure underscoring the importance of high absorption rates of funds. While the share of WASH budget stood at 11.2%, the share of WASH in total expenditure was 10.7%. The highest share of WASH in the total budget was witnessed in Samburu at 15.9%, while the lowest was West Pokot at 4.3%. Mandera had the highest share of WASH in total expenditure accounting for 16.7%, while the lowest was West Pokot at 3.7%. The share of WASH in both budget and expenditure in Samburu and Mandera indicates the level of prioritisation and commitment to enhance access to WASH resources in these counties. Increasing the WASH share will improve resources available for investment and rehabilitation of WASH projects.

Figure 5: Share of water (including sanitation and hygiene) in total budget and expenditure between 2014/15 and 2018/19



Source: Development Initiatives based on Controller of Budget reports.[24]
See the differing shares of water (including sanitation and hygiene) in total budget and expenditure across counties on the Spotlight on Kenya. The data tool also shows per person spending on WASH.

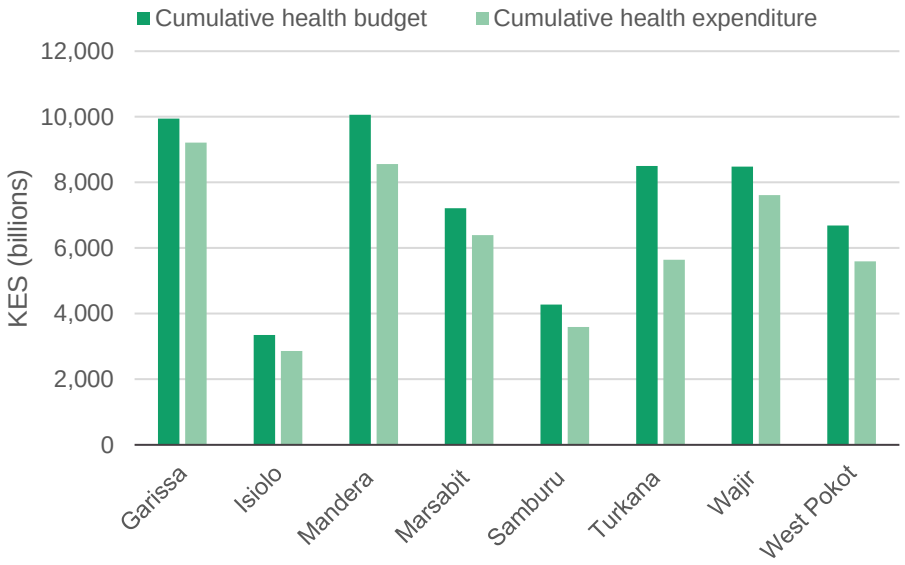
Absorption rates in the health sector averaged 84.3% between 2014/15 and 2018/19.

The combined health budget for all the eight counties increased by 79.1% between 2014/15 and 2018/19. Actual expenditure on the other hand increased by 53.8% between 2014/15 and 2016/17 but reduced in 2017/18 before increasing in 2018/19.

Health, being one of the critical sectors, has seen its budget increase consistently by double digits, with the exception of 2015/16. The health budget increased by 1.4% between 2014/15 and 2015/16, 18.4% in 2016/17, 20% in 2017/18, and 24.2% in 2018/19 to KES 16.2 billion (Figure 6).

Expenditure similarly increased by 19.7% in 2015/16 and 28.5% in 2016/17 before decreasing by 0.3% in 2017/18. The highest increase was witnessed in 2018/19 to KES 14.2 billion (37.8%).

Figure 6: Cumulative health budget and expenditure between 2014/15 and 2018/19 in eight ASAL counties

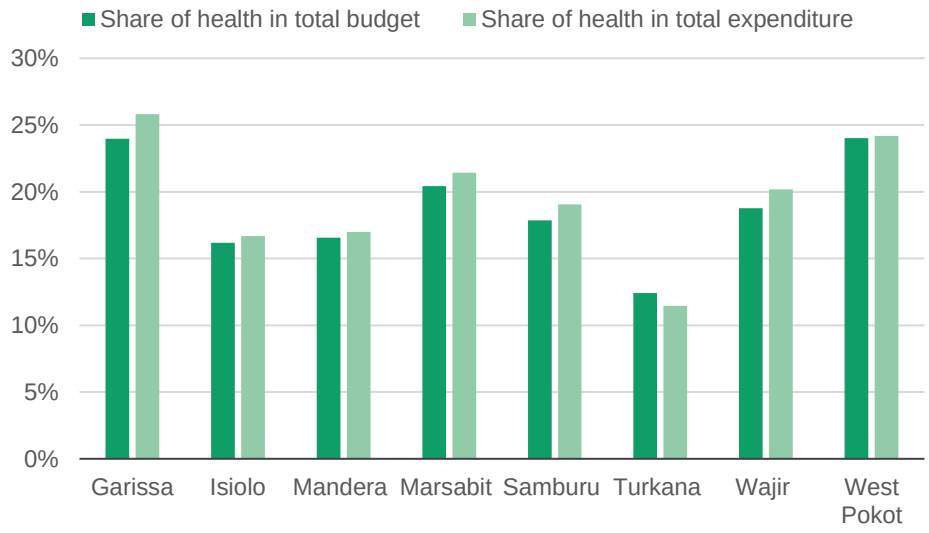


Source: Development Initiatives based on Controller of Budget reports.[25]
See the differing shares of health in total budget and expenditure across counties on the Spotlight on Kenya.
The data tool also shows per person spending on health.

As in the WASH sector, the reduction in expenditure in 2017/18 is explained by a decrease in absorption rates. Absorption rates decreased by 16 percentage points from 94.6% in 2016/17 to 78.6% in 2017/18. The absorption rates increased in 2018/19 to 87.1%.

The share of health in the total budget and expenditure for the eight counties is almost the same. While the share of health in the total budget was 18.1%, share of health in total expenditure was 18.9%. The highest budget share was witnessed in Garissa and West Pokot with 24%, while the lowest was Turkana at 12.4%. Analysis of expenditure reveals Garissa had the highest share of health expenditure at 25.8%, while the lowest was Turkana county at 11.5% (Figure 7).

Figure 7: Share of health in total budget and expenditure between 2014/15 and 2018/19



Source: Development Initiatives based on Controller of Budget.[26]
See the differing shares of health in total budget and expenditure across counties on the Spotlight on Kenya. The data tool also shows per person spending on health.

Critical financing gaps in WASH and health sector

Access to safe water and sanitation, and the proportion of births in health facilities in the ASAL counties are still below the national averages as shown in Figures 1, 2 and 3.

Information on county sector resource requirements versus allocation would give a picture of the financial gaps at the county level. Unfortunately, this information is not available for the ASAL counties. We will instead focus on the national sector reports and other national documents and link these reports to the county-level situation.

According to the national water master plan, Kenya requires KES 1.76 trillion to provide universal access to safe water and improved sanitation by 2030. The current government can only provide funding up to 56.1% of the funds. This leaves a huge resource gap that can only be filled by donors and the private sector.[27]

The financial gaps are evident when looking at the national sector reports on health and WASH sectors. Huge differences exist between the resources required and the resources allocated to both WASH and health sectors. This trend has been seen consistently in the last five years. For instance, in 2020/21 WASH sector reports, it was reported that only 66.7% of the resources required were available.

The financial situation is further worsened by high levels of non-revenue water[28] supplied which currently stands 42.1%. This is attributed to the illegal connections or damages of water supply meters in residential homes.[29]

Historical analysis shows both tiers of government have consistently underfunded the health sector. This is evidenced by the huge variations between the resources required and resources allocated. Competition from other key sectors, coupled with low absorption rates, have meant reduced funding to the health sector which has negatively impacted on the achievement of targets.

Dependence on donors in the health sector has also contributed to the financial challenges faced by the sector, as it may not be sustainable long-term due to Kenya's debt situation. Overdependence on compulsory payments by the employed to NHIF as a pathway to finance Universal Health Coverage is also a contributing factor.[30] At the core of the financial challenges is poverty. Currently poverty averages 64.4% across all 10 counties. Payments of NHIF will either be very poor or intermittent, since residents have to choose between food and access to health services.

Conclusion

Arid and semi-arid land (ASAL) counties have made substantial progress in both health and water, sanitation and hygiene (WASH) sectors. A comparison between 2009 and 2019 reveals these counties have made significant steps to increase both access to water and sanitation, and the proportion of births in health facilities.

However, comparing the changes to the national averages negates the progress. National averages are higher than the county percentages, which highlights the inequalities they face.

Unlike the health sector which is given priority in all the 10 counties each year, the WASH sector is not. The WASH sector has the third or fourth largest budget each year. This points to a lack of commitment in the ASAL counties to improve access to water and sanitation.

Even with the prioritisation of the health sector, serious resource gaps still exist in both the health and WASH sectors. This will negatively impact the achievement of Kenyan government's aim of meeting the Social Development Goals (SDG) 3 (ensure healthy lives and promote wellbeing for all at all ages) and 6 (ensure availability and sustainable management of water and sanitation for all) by 2030.

Existing financial gaps have been worsened by the reliance of the sectors on donor funds. Long-term borrowing has also become unsustainable due to the debt situation in the country. The scaling up of health and WASH services has been further constrained by high incidences of poverty and inadequate data to assist with the budgeting process. Addressing these challenges must be prioritised to meet the goal of access to WASH and healthcare for all.

Notes

[1] Levels of poverty per county are based on 2015/16 Kenya Integrated Household Budget Survey poverty headcount figures. Available at: https://www.knbs.or.ke/?wpdmpro=basic-report

[2] Absorption rates refers to the share of the actual expenditure out of the budgeted expenditure.

[3] Constitution of Kenya, 2010. Available at: http://kenyalaw.org:8181/exist/kenyalex/actview.xql?actid=Const2010 (accessed 4 September 2020)

[4] Sustainable Development Goals. Available at: https://www.un.org/development/desa/disabilities/envision2030.html (accessed 4 September 2020)

[5] RCMRD, 6 September 2020. Kenya counties coronavirus total cases, demographic and social profile. Available at: https://opendata.rcmrd.org/datasets/be00cde34b0346cb98491176939074d8 (accessed 4 September 2020)

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[11] Government of the Republic of Kenya, 2007. Kenya Vision 2030. Available at: http://vision2030.go.ke/inc/uploads/2018/05/Vision-2030-Popular-Version.pdf (accessed 4 September 2020)

[12] Water data used for this analysis is available in the Spotlight on Kenya. Available at: https://www.devinit.org/data/spotlight-kenya/?t=kenya_water_and_sanitation&i=spotlight_on_kenya_2017.kenya_household_san_fac&y=2019 (accessed 4 September 2020)

[13] Kenya National Bureau of Statistics, 2019. Kenya population and housing census report volume four. Available at: https://www.knbs.or.ke/?wpdmpro=2019-kenya-population-and-housing-census-volume-iv-distribution-of-population-by-socio-economic-characteristics (accessed 4 September 2020)

[14] Data on improved sanitation facilities is available in the Spotlight on Kenya. Available at: https://www.devinit.org/data/spotlight-kenya/?t=kenya_water_and_sanitation&i=spotlight_on_kenya_2017.kenya_household_san_fac&y=2019 (accessed 4 September 2020)

[15] Kenya National Bureau of Statistics, 2019. Kenya population and housing census report volume four. Available at https://www.knbs.or.ke/?wpdmpro=2019-kenya-population-and-housing-census-volume-iv-distribution-of-population-by-socio-economic-characteristics (accessed 5 September 2020)

[16] Health Policy project Kenya, 2013. Maternal and newborn health care in Kenya. Available at: https://www.healthpolicyproject.com/ns/docs/MaternalNewbornHealthCare_Kenya_Oct2013.pdf (accessed 5 September 2020)

[17] Data on proportion of births in health facilities is available in the Spotlight on Kenya. Available at: https://www.devinit.org/data/spotlight-kenya/?t=kenya_health&i=spotlight_on_kenya_2017.kenya_births_attendance&y=2016 (accessed 5 September 2020)

[18] Kenya National Bureau of Statistics, 2019. Kenya population and housing census report volume four. Available at https://www.knbs.or.ke/?wpdmpro=2019-kenya-population-and-housing-census-volume-iv-distribution-of-population-by-socio-economic-characteristics (accessed 7 September 2020)

[19] Kenya National Bureau of Statistics, 2015/16. Kenya Integrated Household Budget Survey. Available at https://www.knbs.or.ke/?wpdmpro=basic-report (accessed 28 September 2020)

[20] Office of the Controller of Budget, County budget implementation review reports (2014/15–2018/19). Available at: https://www.cob.go.ke/ (accessed 8 September 2020)

[21] Office of the Controller of Budget, County budget implementation review reports (2014/15–2018/19). Available at: https://www.cob.go.ke/ (accessed 8 September 2020)

[22] Office of the Controller of Budget, County budget implementation review reports (2014/15–2018/19). Available at: https://www.cob.go.ke/ (accessed 8 September 2020)

[23] Absorption rates refers to the share of the actual expenditure out of the budgeted expenditure.

[24] Office of the Controller of Budget, County budget implementation review reports (2014/15–2018/19). Available at: https://www.cob.go.ke/ (accessed 8 September 2020)

[25] Office of the Controller of Budget, County budget implementation review reports (2014/15–2018/19). Available at: https://www.cob.go.ke/ (accessed 8 September 2020)

[26] Office of the Controller of Budget, County budget implementation review reports (2014/15–2018/19). Available at: https://www.cob.go.ke/ (accessed 8 September 2020)

[27] Development Initiatives, 2018. Enhancing access to safe water and improved sanitation in Kenya. Available at: http://devinit.org/wp-content/uploads/2018/12/Enhancing-access-to-safe-water-and-improved-sanitation-services-in-Kenya.pdf (accessed 9 September 2020)

[28] Water that has been produced but is lost before it reaches the customer.

[29] Development Initiatives, 2018. Enhancing access to safe water and improved sanitation in Kenya. Available at: http://devinit.org/wp-content/uploads/2018/12/Enhancing-access-to-safe-water-and-improved-sanitation-services-in-Kenya.pdf (accessed 8 September 2020)

[30] Households pay monthly NHIF premiums in exchange for subsidised universal healthcare coverage.

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