IPF
INSTITUTE OF PUBLIC FINANCE

# Are Counties Getting It Right?

## A Comparative Review of Facility Improvement Financing Legislation Across 12 Kenyan Counties.

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# A. Background

In 2023, Kenya's health sector underwent significant legislative reforms aimed at strengthening health system governance, financing and service delivery. Key among these reforms were the enactment of the Digital Health Act, the Social Health Insurance (SHI) Act, the Facilities Improvement Financing (FIF) Act, and the Primary Health Care (PHC) Act.

The FIF Act of 2023 marked a major shift in health facility financing by providing additional legal backing to the ability of public health facilities to generate and retain revenue at source, thereby enforcing their financial autonomy through the law. Previously, although counties collected revenue from health services provided in public facilities, there was no clear legal framework for safeguarding facilities' autonomy to retain and utilize the revenue collected.

While counties had the authority to permit revenue retention, implementation remained inconsistent and purely discretionary. This resulted in varied practice across the counties: some counties permitted full retention, others mandated partial transfers to the County Treasury, and some opted for centralized control by refusing to grant facilities any financial autonomy.[1]

The new FIF legislation replaces county level discretion with a mandatory national framework. Under this framework all public health facilities are granted financial autonomy, allowing them to collect, retain and manage all the revenue they generate. The national law ensures uniformity across all 47 counties.

The FIF Act empowers counties to enact complementary legislation and regulations to operationalize its provisions within their respective contexts. This creates an opportunity for counties to clarify ambiguities in the national law and tailor implementation to local realities. In practice, however, the task of interpretation has proven complex. Provisions that appear straightforward in the national framework have been interpreted differently at the county level, leading to inconsistencies in how the Act is operationalized.

Some of the areas where ambiguities and differences in interpretation exist include the meaning and scope of the term "other relevant entities" as a source of revenue, the definition of "all" in relation to monies raised or received and the exact role of counties in "facilitating" revenue collection. Additionally, the Act lacks guidance on whether revenue collected may be used for specific expenditure, such as Human Resources for Health (HRH). This is particularly significant given that facilities often incur substantial costs by hiring temporary or casual workers to address their staffing gaps and often use FIF for this purpose.

In the following sections, we explore these areas of ambiguities and divergence, drawing on specific provisions of the national FIF Act, and illustrate how different counties have interpreted and adapted the Act within their local contexts. This paper presents findings from the review and synthesis of the Facility Improvement Fund (FIF) legislation across 12 counties: Baringo, Busia, Embu, Garissa, Kirinyaga, Meru, Mombasa, Nakuru, Nyamira, Nyandarua, Taita Taveta, and Vihiga counties. We compare the provisions in these legislations with those of the national FIF Act and other relevant legislations, including the Public Finance Management (PFM) Act. We begin by providing an overview of the sections of acts that are similar across counties.

[1] *Prior to the enactment of the National FIF Act, 21 of the 47 counties required facilities to remit all their revenues to the County Revenue Fund (CRF), 10 counties allowed facilities to retain 100% of their revenues while 16 counties allowed the facilities to retain a portion of their revenues. See Facility Autonomy in the Age of Devolution: County-Level Arrangements for Managing Health Facility Revenue in Kenya*

# B. Findings

The FIF Act establishes a legal framework for financial autonomy in public health facilities, but it does not address all the key operational details specific to each county. For example, it does not fully define for each individual county the sources of revenue, scope of revenue retention, permissible uses of FIF funds, facility-level budgeting processes, penalties, or the number and management of bank accounts. To address these gaps, counties have enacted legislation to clarify revenue sources, fund use, budgeting, and financial management at the facility level, ensuring the national FIF framework works effectively locally.

A review of 12 county laws shows tight alignment between county legislation and the national act. Several of the counties reviewed in this paper have directly adopted sections of the National FIF Act into their Bills/Acts. Such alignment with the National FIF Act promotes the standardization of frameworks for Facilities Improvement Financing across counties. On the other hand, overuse of national language raises questions about the purpose of the county laws, which should rather clarify and expand on national law. The table below highlights the most common sections from the FIF Act that have been directly incorporated into the 12 county laws reviewed in this analysis.

*Table 1: Common Clauses Across the Counties*

| **Common Sections in County FIF Laws** | **Corresponding Section in the National FIF Act** | **Number of counties with the clauses** |
|---|---|---|
| Short Title | Section 1 | 11 |
| Interpretation | Section 2 | 11 |
| Objects and purposes of this Act | Section 3 | 12 |
| Application of this Act | Section 4 | 9 |
| Retention of public health facilities improvement financing | Section 5 | 8 |
| Sources of the public health facilities improvement financing | Section 6 | 8 |
| Uses of the finances retained by public health facilities | Section 7 | 2 |
| Annual reporting | Section 23 | 7 |
| Audit | Section 24 | 10 |
| Overdraft and continuity | Section 25 | 9 |
| Winding up of improvement Financing | Section 26 | 10 |
| Transitional provisions | Section 27 | 9 |
| Penalties | Section 28 | 9 |
| Regulations | Section 29 | 9 |

There are also differences observed across counties. Embu, Taita Taveta, Kirinyaga, Nyandarua, and Nyamira contain unique sections that are not reflected in the National FIF Act. These counties have introduced additional sections tailored to their respective local contexts.

*Table 2: Counties with distinct sections in their legislation*

| Counties with Sections in FIF Laws that are not included in the National FIF Act | Sections | Notes |
|---|---|---|
| **Embu**[2] | • Establishment and membership of the Fund Board<br>• Functions of the Fund Board | Embu has established the Embu County Health Facilities Improvement Fund Board, composed of chief officers, county directors, medical superintendents and representatives from Level 2 and 3 facilities. Its mandate is to oversee the administration of funds drawn from a pooled fund.<br><br>This contravenes the national FIF Act, which does not provide for 'Fund Boards' as the Act does not envision a pooled fund. |
| **Taita Taveta** | Functions of the Hospital Management Board | Taita Taveta provides for the Hospital Management Board in addition to the Hospital Management Team mentioned in Section 14 of the national FIF Act.<br><br>The Hospital Management Board in the Act refers to the administrative and oversight body of the facility, whose membership includes community representatives. The Hospital Management Team, on the other hand, is the operational management team responsible for the day-to-day running of the hospital and is comprised of hospital staff in leadership roles. |
| **Kirinyaga** | • The Kirinyaga County Health Facilities Improvement Fund Board.<br>• Membership of the Board.<br>• Qualification of Membership.<br>• Termination of Membership.<br>• Functions of the Board.<br>• Conduct of business and affairs of the Board. | Like Embu, Kirinyaga County has established the Kirinyaga County Health FacilitiesImprovement Fund Board to manage the Fund, contrary to the provisions of the national FIF Act. |

[2] *Embu County has established the provisions on FIF retention and management within the Embu County Health Services Act, 2024. It is unclear whether the county intends to develop a standalone FIF bill.*

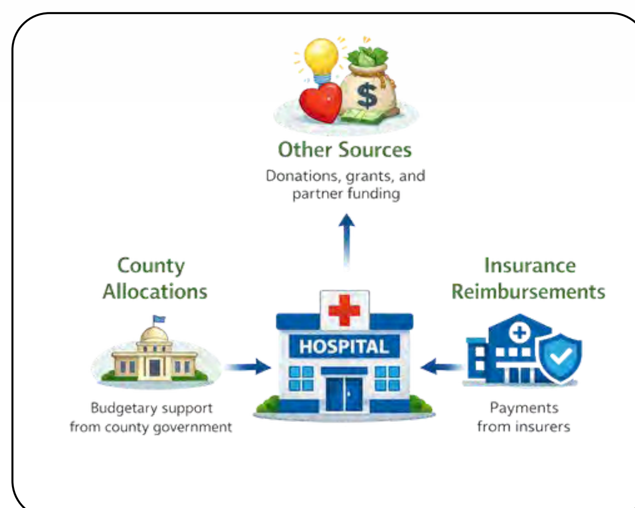
| Nyandarua | Nomination and role of the Hospital Management Board<br>Remuneration of members | Similar to Taita Taveta, the Act establishes a Hospital Management Board (oversight body with community representation) in addition to the Hospital Management Team responsible for day-to-day operations under Section 14 of the national FIF Act. |
|---|---|---|
| Nyamira | • Planning and budgeting<br>• Public participation<br>• Integrated Community Health Preventive Team<br>• Hospital Management Board<br>• Role of the Hospital Management Board<br>• Inclusivity<br>• Remuneration<br>• Vacancy in Membership<br>• Procuring entity<br>• Waivers<br>• Repeal | Notably, Nyamira County goes beyond the provisions of the national FIF Act by offering additional guidance on the functioning of the Health Facility Management Teams, by capping the number of payable sittings for the Health Facility Management Teams, Hospital Boards and Health Facility Committees (a maximum of four meetings per year). |

These variations in specific county acts are not all sensible attempts to fill gaps in the national FIF Act. In some instances, the additional provisions do not align with the national law, for example the establishment of "fund boards" to manage pooled FIF funds. Clearly, while counties can learn from one another, they should not necessarily adopt all of the provisions documented here.

### a. Sources of public health facilities improvement financing

Section 6(a) outlines that sources of revenues shall include 'own source revenues that include monies received as user fees, charges and monies paid as reimbursement for services received from insurance firms or other relevant entities.' The phrase 'other relevant entities' could reasonably be interpreted to mean any other entities that compensate facilities for services rendered. However, the phrase is open-ended, leaving room for different county level interpretations and classifications of FIF revenues.

Counties have interpreted the term 'other relevant entities' in varied ways. Some counties have effectively expanded the scope of FIF to include public health unit revenues. Counties such as Baringo, Busia, Meru, Mombasa, Taita Taveta, Garissa and Embu have incorporated fees from services such as licensing of food premises, liquor licensing, inspection of health facilities among others. This variation shows that counties are not only operationalizing retention at facility level, but also redefining what counts as health sector own-source revenue eligible for FIF, potentially increasing the size of the FIF pot considerably. In Embu County, for example, public health unit revenues accounted for approximately 12% of the total FIF revenue in FY 2024/25, highlighting their significance as a complementary source of facility financing.



**b. Retention of public health facilities improvement**

Section 5(1) of the National FIF Act stipulates that, 'There shall be retention of all monies raised or received by or on behalf of all public health facilities.' Such monies shall be deposited directly into a dedicated FIF account opened by the respective facility. However, counties have defined "all" in different ways, not all of which are consistent with the plain language of the national law.

*Table 4: Counties' provisions on retention of revenues*

| County | Provisions on Retention of Revenues | Remarks |
|---|---|---|
| **Vihiga** | *Section 9(1):* There shall be retention of all monies raised and received by or on behalf of all public health facilities except three percent operations purposes.<br><br>*Section 9(2):* Non-financial receivables and donations may be retained in whole or be re-donated to another public health facility upon full disclosure as provided for in relevant laws. | Section 9(1) mirrors past county practices where a portion of funds was retained to cover administrative costs under pooled FIF arrangements. However, since FIF revenues are not classified as public funds, for which the PFM Act provides for a maximum of 3 % deduction for administrative costs, the rationale for extending a similar provision to these revenues remains unclear.[3] |
| **Kirinyaga**[4] | *Section 5(1):* All revenue collected from the health facilities shall be deposited into the funds collections accounts of the collecting facility.<br><br>*Section5(2):* 80% of the money in the accounts shall be retained by the collecting facility and shall be transferred to the operations accounts to be utilized at the facility level.<br><br>*Section 5(3):* 20% of the money in the accounts shall be transferred into the Funds accounts at the CHMT level to be utilized in the county at large-targeting fund administration (to a maximum of 3%), rural health facilities, preventive health services that include, support to community, ambulance and supportive supervision and others as approved by the Chief Officer. | This provision on partial retention of revenues violates the national act that stipulates that all the collected, retained, planned and used resources should be used within a facility. The FIF Act does not mandate the utilization of FIF funds for services such as preventive and community services. |

[3] *Section 197 of the Public Finance Management (County Regulations), 2015, provides the criteria for the establishment of a county public fund. Specifically, Section 197(2) stipulates that 'the administration costs of the Fund shall be a maximum of 3% of the approved budgets of the Fund.*

[4] *Kirinyaga County has developed both legislation and accompanying regulations: The Kirinyaga County Health Facilities Improvement Fund Act, 2023, and The Public Finance Management (Kirinyaga County Health Facilities Improvement Fund) Regulations, 2024. Provisions regarding the retention of revenues are specifically detailed in the regulations.*

| Busia | *Section 9(2):* Of the monies collected and retained by the health facilities, 70% shall be retained and utilized at the County and Sub-County Hospitals and for public health services, 25% of the money collected shall be utilized for primary health care and 5% shall be utilized for administrative expenses.<br><br>*Section 9(3):* Level 2 and 3 facilities shall retain and utilize all the monies collected in the facilities. | The Busia FIF Act does not clearly indicate where the 30 percent is to be deposited or managed. This contrasts the approach adopted by Kirinyaga County, where the Act provides that 20 percent of the FIF collected shall be transferred to the CHMT level.<br><br>Further, while Kirinyaga makes an effort to specify the intended uses of the 20 percent revenues collected, the Busia FIF Act leaves the utilization of the 25 percent unclear by broadly referring to expenditures on primary health care. In addition, it is important to reflect on the rationale for setting aside this 25 percent, particularly given that the same facilities are already responsible for delivering primary health care services. |
|---|---|---|

The share of revenue not retained by facilities raises important operational questions that are not clearly addressed in any of the legislation. None of the county acts with these provisions indicate whether these funds should be transferred into specific accounts, the timeliness or frequency for such transfers and the processes for tracking and reconciliation. The absence of clear guidance on fund flow procedures is likely to result in inconsistent implementation and reporting challenges.

### c. Uses of the finances retained by public health facilities

Section 8 of the National FIF Act outlines the uses of retained revenues, focusing on sustaining operations, procurement of essential commodities, financing preventive services, ambulance transfers and sustaining daily operations. However, the section does not explicitly address Human Resources for Health (HRH) costs such as payments to casual or temporary staff, even though personnel costs are often facilities' largest and most recurrent costs. While one might interpret the language on 'supporting optimal operations' as implicitly covering HRH, explicitly including HRH would provide greater clarity.

Counties have generally not taken additional steps to clarify this in their own legislation or policy documents. In fact, most counties, such as Baringo, Garissa, Meru and Mombasa, omit the section on uses entirely, leaving facilities-in-charges without clear guidance and reliant on the national law. Nyamira County does include provisions on uses, but these are lifted directly from the national law without adding any nuance or clarification. The differences between the national law and Nyamira County provisions are minimal, consisting mainly in the omission of certain clauses, and the addition of a single clause on capacity building. rather than substantive adaptation.

*Table 5: Comparison of Fund Use Provisions: National FIF Act vs Nyamira County*

| National FIF Act | Nyamira County |
|---|---|
| The finances retained by Public Health Facilities shall be used to:<br>a. Support the respective public health facilities' optimal operations for effective service delivery throughout the financial year<br>b. Subject to applicable financial laws and regulations, ensure readily available financial resources for purchase and acquisition of urgent goods and services at the respective health facility.<br>c. Enhance, where applicable, the accessibility and predictability of finances for procurement of essential products, commodities and technologies<br>d. Ensure that health services are available, accessible, acceptable, affordable and of good quality and standard<br>e. Guarantee that health facilities are optimally resourced to offer quality care to all patients<br>f. Facilitate primary health care and preventive services at the community level<br>g. Sustain daily operations and promote improved access to health services to all residents in the Republic of Kenya<br>h. Fund ambulance services for the transfer of patients from one health facility to another. | The resources and monies retained at the county health facility shall be used for the following purposes:<br>a. Ensure readily available financial resources for purchase and acquisition of urgent goods and services at the respective health facility<br>b. Enhance, where applicable, the accessibility and predictability of finances for procurement of essential products, commodities and technologies<br>c. Guarantee that health facilities are optimally resourced to offer quality healthcare to all patients<br>d. Facilitate, primary healthcare and preventive services at the community level<br>e. Support capacity building in the management and provision of healthcare services<br>f. Sustain daily operations, maintenance, offset costs and for connected healthcare services |

*Note: Text highlighted in green indicates clauses drawn directly from the National FIF Act and reflected in the Nyamira County FIF Act.*

### d. Uses of the finances retained by public health facilities

One of the key provisions under the national act is the requirement for county governments to facilitate effective collection and retention of FIF revenue by public health facilities. However, the concept of 'facilitation' is ambiguous, raising important questions about the extent of county involvement in managing the facilities' revenues. An overly broad interpretation of 'facilitation' risks enabling centralization of revenue collection and retention.

The Vihiga County Act provides that all monies collected by public health facilities, or on behalf of facilities, shall be deposited into a special purpose account at the Central Bank of Kenya.[5] While this approach may be intended to enhance transparency and accountability by centralizing tracking of facility revenues, it reflects a county-level interpretation of 'facilitation' that runs contrary to the vision of the national FIF Act, which does not propose a pooled fund. In addition, to provide oversight, the county had introduced a new governance entity, the Public Health Facilities Improvement Financing Oversight Committee, not provided for in the national act.

A key drawback of the centralized approach is delays in the utilization of funds. Nakuru County, which has implemented a centralized revenue collection approach since 2024, has experienced such delays, with facilities waiting for approval processes before funds are reimbursed, even though facilities ultimately receive and retain the full amounts owed to them.

Although counties such as Vihiga and Nyamira have incorporated provisions on the role of county governments in facilitating effective collection and retention of facility revenues, these provisions largely duplicate the national Act and provide no additional clarification on the meaning or operational limits of this role. Conversely, counties such as Taita Taveta,

[5] *The committee comprises of the County Director for Health Services, County Nursing Officer, Department Director of Administration, Planning and Support, Departmental Accountant, Department Procurement Officer, County Pharmacist and the County Laboratory Coordinator.*

Nyandarua, Nakuru, Mombasa, Meru, Kirinyaga, Garissa, Busia and Baringo do not provide for this section of the Act in their county legislation.

To establish clarity around the county government's role in facilitating effective collection and retention of public health facility revenues, county legislation should explicitly define the scope, mechanisms and limits of this function. Importantly, any approach adopted should promote timely and efficient utilization of resources at the facility level, rather than creating procedural bottlenecks that undermine financial autonomy and responsive service delivery.

### e. Bank account for the Facility Improvement Financing

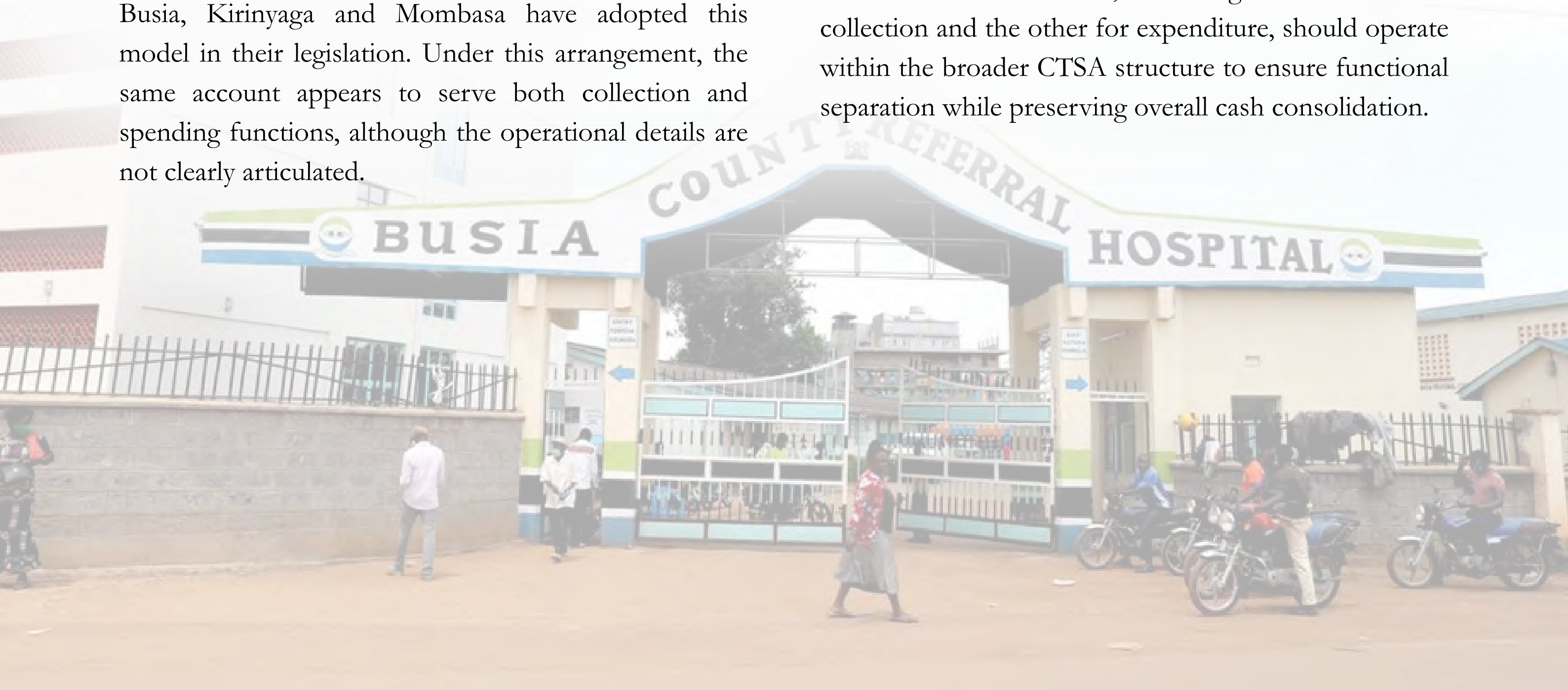
The national FIF Act requires every public health facility to open and manage a bank account into which all revenues collected by or on behalf of the facility are deposited. It further specifies the authorized signatories: for level 4 and 5 facilities, the medical superintendent and hospital administrator and for level 2 and 3 facilities, the facility in- charge and sub- county accountant. While the national act is clear on the establishment of a collection account and its signatories, it does not address whether facilities should operate a separate expenditure account or undertake spending directly from the same collection account.

As a result of this legislative silence, counties have adopted two distinct approaches to the operation of facility bank accounts. The first approach mirrors the national act by providing a single revenue collection account, without explicit provision for a provision for a separate expenditure account. Counties such as Baringo, Busia, Kirinyaga and Mombasa have adopted this model in their legislation. Under this arrangement, the same account appears to serve both collection and spending functions, although the operational details are not clearly articulated.

The second approach is a two-account model, where facilities operate one account for revenue collection and a separate expenditure account from which funds are accessed once an Authority to Incur Expenditure (AIE) is issued. Counties such as Nyamira and Taita Taveta have adopted this structure. While this model may enhance internal controls by separating receipt and spending functions, it may also introduce additional administrative steps that could affect the timeliness of fund utilization.

International best practice in PFM supports consolidating government cash through a Treasury Single Account (TSA).[6] Under this system, all receipts and payments are processed through a single account or a set of linked accounts operating as one consolidated structure. The operation of a TSA enhances oversight, reduces fragmentation and allows funds to be managed as a single, consolidated pool. In 2024, the Government of Kenya (GoK) approved a phased, three- year implementation of the TSA in line with Sections 28 (2) and 119 (2) of the PFM Act, 2012.[7]

At the county level, Section 96 of the PFM (County Governments) Regulations stipulates that bank accounts held by county departments or agencies for purposes of incurring expenditure must function as sub- accounts under the County Treasury Single Accounts (CTSA), except where County Treasury grants explicit approval for alternative arrangements. Consistent with this framework, counties maintain recurrent and development accounts into which funds are transferred from the County Revenue Fund (CRF) to facilitate spending. Accordingly, at the facility level, two linked sub- accounts, one designated for revenue collection and the other for expenditure, should operate within the broader CTSA structure to ensure functional separation while preserving overall cash consolidation.




[6] See Dimension 21.1 of the PEFA Handbook Volume II: PEFA Assessment Field guide.

[7] See page 54/178 of the 2025 Budget Policy Statement

### f. Authority to Incur Expenditure

The national Act requires the medical superintendents and facility in- charges to obtain AIEs from the Chief Officer following the development of facility budgets. However, the Act remains silent on the process for the development of these budgets. Counties such as Baringo, Busia, Garissa, Meru, Mombasa, and Taita Taveta have legislated clear facility budgeting processes (see Fig.1), providing guidance to medical superintendents and facility-in- charge on the steps to follow during budget preparation. In contrast, Kirinyaga, Embu, Nyamira, Nyandarua and Vihiga counties do not provide guidance on facility budgeting processes.

*Figure1: Meru County Health Facility Budgeting Process*

**Authority to Incur Expenditure**

**30.** (1) The Chief Officer shall be the accounting officer.

(2) The user departments at the health facility will identify their needs and submit their requests to the Management Team.

(3) Costing of the requirements will be established and requests evaluated by the County Facility Management Teams based on the available fiscal resources.

(4) The County Health Management Team shall determine the ceilings to allow respective health facility share the available fiscal resources.

(5) The health facility shall adjust their requirements according to the available fiscal resources.

(6) The Health Facility Management Team, through the facility in-charge, shall submit the proposed budgets for consideration by the Hospital Board/Health Facility Committees.

(7) Upon consideration, of the proposed budgets, the Hospital Board / Health Facility Committee shall submit the proposed budgets to the Chief Officer for approval and issuance of Authority to Incur Expenditures.

As part of the AIE process, some counties have introduced additional review structures beyond the Chief Officer's approvals, as outlined in the national Act. For example, in Kirinyaga County, the County Health Facilities Improvement Fund Board reviews facility AIE requests and provides recommendations to the Chief Officer.[8] While these measures aim to enhance oversight, they can delay approvals and may limit the financial autonomy of health facilities. Experiences in the education sector illustrate how minimizing review and approval AIE processes can enhance financial autonomy at the facility level. School in-charges serve as the accounting officer, with authority to spend funds in line with the approved budget once the quarterly AIE is issued by the county education department, enabling more timely and flexible use of resources.[9]

Notably, the national Act does not prescribe a specific timeline or frequency for the submission and approval of AIEs to the accounting officer. In practice, field experience reveals variation across counties, with some facilities submitting AIEs on a needs basis and others following the quarterly facility budget cycle. Given existing practices across departments, facilities should adopt a quarterly AIE submission schedule. This will provide a predictable and structured approach to financial management while reducing the administrative burden associated with monthly submissions. At the

[9] *Kenya's new facility autonomy bill: Can we make a good thing even better? https://thinkwell.global/kenyas-new-facility-autonomy-bill-can-we-make-a-good-thing-even-better/#:~:text=Kenya%20shifted%20to%20a%20devolved,still%20claim%20all%20facility%20revenue.*

same time, provisions should be made for emergency or urgent spending, recognizing the unpredictable nature of health service delivery and the need for facilities to respond promptly to critical situations.

To ensure clarity and efficiency, county legislations should explicitly outline the facility budgeting process, including a standard budget format. Counties should also avoid creating extra review or approval layers for AIEs that could delay expenditure at the facility level.

### g. Expenditure of the facility improvement financing

Section 22 (9) of the national Act provides that health facilities are required to file returns and financial accounts in the format as guided by county legislation for the preceding quarter to the chief officer before a new authority to incur expenditure is issued. However, most county legislations do not provide any reporting template. An exception is Taita Taveta County, which provides a performance reporting template on revenue and expenditure, serving as a good practice that other counties could adopt (Annex I). Key features of the Taita Taveta template that counties should consider drawing from include disaggregating revenue collection by streams and by month. The expenditure section also provides itemized categories and codes, facilitating easier consolidation of reports across facilities.

### h. Annual reporting

Section 23 of the National FIF Act stipulates that at the end of each financial year, the "accounting officer for a county health facility" shall submit the facility's financial statements to the Auditor General, Controller of Budget and the Commission on Revenue Allocation. However, earlier provisions of the Act designate only the Chief Officer as the accounting officer, without explicitly identifying them (or anyone else) as the accounting officer of 'a county health facility.' The hospital medical superintendents and facility-in-charges are only authorized to incur expenditure with approval from the Chief Officer and are not formally designated as the accounting officers of the facility. When considered alongside other county guidelines, this provision appears to imply that the reporting officer is the facility-in-charge.[10] The absence of clear designation creates ambiguity over who holds the formal responsibility for submitting financial statements at the facility level.

Some counties attempt to address this in their county legislation by explicitly delegating the reporting responsibility. In Meru County, for example, the proposed Meru County Facility Improvement Bill, 2024, stipulates that the hospital management board (in Level 4),health center management committee (Level 3) and dispensary management committee (Level 2) shall submit the statements of income and expenditure, as well as the statements of assets and liabilities, at the end of the financial year to the County Head of Audit and the Auditor General. This is despite the fact that only the Chief Officer is identified as the accounting officer within the county bill.

Taita Taveta County, in its 2024 bill, differentiates reporting requirements by level of care. For Level 4 and 5 facilities, it mirrors the national ambiguity by assigning reporting to an undefined accounting officer. For lower-level facilities, the reports are to be submitted to the sub-county accountant, who consolidates them and submits them to the Chief Officer, who then forwards them to the County Treasury.

### i. Penalties

The FIF Act, under Section 28, simply outlines that the penalties stipulated in the PFM Act and the Public Procurement and Asset Disposal Act and other written laws on misuse, misappropriation and other deviations shall apply. The relevant PFM Act provisions referenced in this context are Sections 197, 198 and 199, which deal with offences committed by public officers. Most counties have adopted this provision verbatim from the national act, without outlining how these penalties should be applied specifically in the context of health facilities.

Uniquely, Vihiga County has contextualized these national penal provisions to focus on facility-specific misconduct. For instance, while Section 197(1)(c) of the PFM Act broadly prohibits a public officer from 'lending money on behalf of the Government', Vihiga's legislation specifically prohibits the 'lending of money on behalf of a public health facility.' This localized adaptation closes interpretive loopholes and makes the provisions operationally relevant, directly linking the offence to health facilities.

[10] *See Section 3.3 of the Guidelines on Implementation of International Public Sector Accounting Standards (IPSAS Accrual) By Level 4 and 5 Hospitals in Kenya, which states that the Chief Executive Officer/Medical Superintendent is the accounting officer of the facility.*

# C. Conclusion

While counties have made efforts to align their legislation with the national FIF Act, several key gaps persist that counties should consider in the development of their acts. These include the need to provide clear guidelines on the budget formulation, explicitly clarifying whether facilities should have two bank accounts, specifying the scope of FIF expenditures allowed, and specifying the degree of county government involvement.

An emerging concern relates to the proposed broadening of FIF sources to include health- related revenues, including those collected from public health services. In some counties, these revenues represent a significant portion of total FIF collections. While including such revenues can improve facility liquidity, particularly when funds are retained at the facility level, it also raises concerns regarding the overall liquidity and fiscal stability of the county government, given its functions beyond the health sector. Moreover, current legislation provides limited guidance on the mechanisms for channeling these revenues to facilities. Counties must therefore weigh the potential benefits of enhanced facility- level financing against the implications for overall county fiscal stability when deciding whether to incorporate public health revenues into FIF.

Counties have also adopted questionable approaches regarding the retention of FIF revenues. While the national Act envisions full retention of these funds at the facility level, some counties permit facilities to retain only a portion, diverting up to 30% to other uses such as general operations and primary health care, which are often not clearly defined. Such diversion undermines the intent of the legislation, and counties should ensure that 100% of revenues are retained at the facility level as originally envisioned and as seen in Meru, Mombasa, Nyamira and Nyandarua counties.

At the same time, a number of good practices have emerged across counties regarding the management of FIF, offering valuable lessons for others. These include:

1. **Regular reporting on FIF management (quarterly basis):** Quarterly reporting on FIF management, aligned with facility budget cycles, promotes timely financial oversight, strengthens accountability and enables early identification and correction of discrepancies in fund utilization.
2. **Clear establishment of offences related to financial misconduct and associated penalties:** For example, Vihiga County has clearly outlined practices that constitute financial misconduct, together with corresponding penalties. This enhances compliance, deters misuse of funds and provides a structured framework for enforcement and corrective action.

In sum, while the national FIF Act of 2023 establishes an important foundation for restoring financial autonomy at the facility level, its effective implementation ultimately depends on how counties interpret and operationalize its provisions. The observed gaps and variations in county legislation highlight the risk of continued inconsistences that may undermine the intended benefits of the reform. Moving forward, there is a clear need for counties to provide more explicit guidance that is aligned with the national guidelines, to ensure consistent implementation and fully realize the FIF reform's potential to improve health system performance and outcomes.

## SCHEDULE 1: HIF Performance Reports

(a) Collection Summary for Health Facilities

| | DEPARTMENT | Quarter Target | MONTHLY COLLECTIONS (From cash Analysis Book) | | | | Monthly Total | Comments |
|---|---|---|---|---|---|---|---|---|
| | **Insurance Summary** | | | | | | | |
| 1. | Capitation | | | | | | | |
| 2. | Linda Mama | | | | | | | |
| 3. | Others (e.g AAR, AON) | | | | | | | |
| 4. | | | | | | | | |
| 5. | | | | | | | | |
| **I** | **Department Collections** | | **User-fees** | **Insurance** | **Waiver** | **Exemption** | | |
| 1. | Inpatient | | | | | | | |
| 2. | Maternity | | | | | | | |
| 3. | NBU | | | | | | | |
| 4. | Laboratory | | | | | | | |
| 5. | Ultrasound | | | | | | | |
| 6. | X-ray | | | | | | | |
| 7. | CT- Scan | | | | | | | |
| 8. | OPG | | | | | | | |
| 9. | Mammography | | | | | | | |

**(c)** Expenditure Summary – Guide (insert rows as necessary as guided by chart of accounts)

| **Facility/Unit** | | | **Month:** | | **Year:** |
|---|---|---|---|---|---|
| **Expense Item Code** | **Expense Item Description** | **New AIE's Received This Month** | **Cumulative AIE's Received This Financial Year** | **Payments made this Month** | **Cumulative Payment made this F/Y** |
| 2210201 | Telephone/telex | | | | |
| 2210302 | Accommodation | | | | |
| 2210203 | Courier & Postal services | | | | |
| 2210701 | Training Expenses | | | | |
| 2211101 | General Office Supply | | | | |
| 2211201 | Purchase of refined fuel & Lubricants | | | | |
| 2211102 | Accessories for computers | | | | |
| 3111002 | Purchase of computer & Printers | | | | |
| 2211004 | Cleansing materials | | | | |
| 2110202 | Casual Labour | | | | |
| 2210102 | Water and Sewerage | | | | |
| 2210101 | Electricity | | | | |
| 2210504 | PHC Activities | | | | |
| 2211103 | Purchase of | | | | |

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Fourth floor, Rosami Court, Muringa road, Kilimani.
P.O. Box 21753-00100, Nairobi, Kenya
Email: info@ipfglobal.or.ke
Tel:+254 758 728 882

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