

Policy Brief I June 2026

Protecting Primary Health Care During Financing Transition in Kenya

Evidence for policymakers, county governments, and development partners

Key Messages

- Kenya's PHC facilities experienced a major financing shock when the User Fee Forgone (UFF) conditional grant was abruptly abolished in FY 2020/21, the DANIDA PHC support grant was phased out, and other time-limited external PHC support streams ended - all within the same transition period.
- Although the UFF and DANIDA grants represented only 0.3% to 3.71% of county health budgets, they were often the only predictable cash that reached PHC facilities directly and could be used for day-to-day operations, casual staff wages, outreach, and essential supplies.
- Withdrawal of direct PHC financing reduced facility autonomy, increased debts and payment delays, worsened commodity stockouts, weakened supervision and staff morale, and shifted costs back to patients through out-of-pocket spending - including asking mothers in labour to purchase disinfectants and basic consumables.
- Interrupted time series (ITS) analysis showed statistically significant immediate declines in outpatient visits (-480,401; $p=0.001$) and fourth antenatal care attendance (-2,838; $p=0.001$) after the July 2021 UFF withdrawal, with partial recovery in subsequent trends.
- Transition design matters profoundly: the abrupt UFF withdrawal was experienced as harmful, while the phased DANIDA co-financing model - with annual 25% step-downs and required county co-financing - gave counties more time to adapt and build capacity.
- Kenya's next-generation PHC financing under the Social Health Authority (SHA) represents an opportunity, but the Primary Healthcare Fund must be universal at a population level, predictable, and delivered with sufficient facility-level autonomy to avoid replicating the vulnerabilities of the transition period.

PHC Financing in Kenya

Kenya aims to achieve Universal Health Coverage (UHC) by 2030, with primary health care (PHC) as its central delivery strategy. PHC facilities - dispensaries (Level 2) and health centres (Level 3) - are the first and most accessible point of care for most Kenyans, particularly in rural and arid-semi-arid areas. Whether these facilities can deliver timely, affordable, and acceptable care depends critically on how they are financed^[1-5].

Kenya operates a devolved governance system in which 47 county governments are responsible for implementing and financing PHC services^[6]. The national government provides counties with an equitable share allocation and, historically, conditional grants earmarked for specific functions including PHC^[7]. Until 2020, two conditional grants were the principal direct financing channels reaching PHC facility bank accounts:

- **The User Fee Forgone (UFF) conditional grant:** introduced following the 2013 abolition of user fees at dispensaries and health centres. It was disbursed quarterly into ringfenced Special Purpose Accounts held by each facility, reimbursing them for foregone revenue and enabling discretionary spending on operational needs^[7].
- **The DANIDA PHC support grant:** provided direct operational financing to PHC facilities through the Health Sector Services Fund (HSSF), which DANIDA co-financed alongside the national government since 2010. Beyond operational funding, DANIDA's requirements also strengthened facility committees, internal accounting systems, and community accountability mechanisms^[7].

These two grants, along with other time-limited external support streams, were abolished or phased out in overlapping waves between 2020 and 2025. This policy brief presents evidence on how these transitions affected PHC facilities and what Kenya's next-generation financing architecture must learn from their design and implementation.

About this Study

This policy brief draws on a mixed-methods study conducted between July and December 2024 that examined the implementation experience of PHC financing transitions across three purposively selected counties representing diverse socioeconomic and geographic contexts.

Study Counties

- **County A:** High-income urban county, population ~1.8 million, central region. Health budget: KES 6–7.6 billion annually. Insurance coverage: 39.1%.
- **County B:** Middle-income rural county, population ~2.6 million, western region. Health budget: KES 1.8–2.4 billion annually. Insurance coverage: 18.1%.
- **County C:** Lower-income arid-semi-arid (ASAL) county, population ~185,000, eastern region. Health budget: KES 1.3–1.5 billion annually. Insurance coverage: 11.8%.

Methods

The study combined qualitative inquiry with quantitative interrupted time series (ITS) analysis:



Qualitative component: 23 in-depth interviews with national policymakers, county health and finance officials, donors, and PHC facility managers (see table 1 below), complemented by review of county budgets, Controller of Budget reports, and institutional documents. Framework analysis was used to identify themes linked to the study's conceptual framework.



Quantitative component: ITS analysis of monthly Kenya Health Information System (KHIS)/DHIS2 data from July 2020 to June 2022 (24 months), using outpatient visits and ANC4 attendance at public Level 2 and 3 facilities as utilisation indicators. July 2021 was set as the event month (first month following the UFF abolition).

Table 1: Study participants

Role	County A (urban, HIC)	County B (rural, MIC)	County C (ASAL, LIC)	National / Donors
Health facility managers	2	2	2	-
County health & finance officials	4	3	4	-
National policymakers / donors	-	-	-	6
TOTAL INTERVIEWS: 23				

Data collection period July–December 2024. ITS analysis not conducted for DANIDA withdrawal given phased design and insufficient post-withdrawal time points.

The Three PHC Financing Transitions

Kenya's PHC financing transition can be understood through three distinct but overlapping waves of funding withdrawal or exit (table 2). These transitions differed in source, design, and timing but together explain why facilities and counties experienced the period as a wider PHC financing shock rather than a single isolated grant change.

Table 2: Funding sources, role and transition model studied

Funding source	Source	Main role in PHC system	Why it ended	Transition model
User Fee Forgone (UFF) conditional grant	National Government of Kenya	Reimbursed facilities for free services; financed casual wages, utilities, drugs, supplies, and equipment. Disbursed quarterly to facility bank accounts - one of only two direct cash sources for PHC.	Reallocated into the general equitable share to counties - removing ring-fencing and facility-level control.	ABRUPT - Withdrawn in FY 2020/21 with no staggered timeline; counties had little time to adapt budgets.
DANIDA PHC support grant	DANIDA / Danish development support	Financed PHC facility operations, management, recurrent costs, and accountability capacity-building. Strengthened facility committees and internal accounting.	Denmark reoriented priorities away from health toward climate change and the blue economy.	PHASED - Annual 25% step-down over 4 years (FY 2022/23 to FY 2025/26), with county co-financing required to replace each tranche.
Other time-limited external support	Project-based external funding	Supported outreaches, selected service inputs, equipment, and capacity-building activities complementing routine PHC delivery.	Fixed-term or project-based; no domestic replacement plan designed before exit.	TIME-LIMITED - Ended on schedule; gaps emerged immediately because no successor domestic financing had been put in place.



“The money [UFF] was not taken away; it was made part of the equitable share. In theory we can assume that there was no loss, but once it is not a conditional grant you lose the potential positives of having conditionality and the facility may not receive what it used to get.”

- Development Partner



What the Evidence Shows

1. Financial resources became more constrained and less predictable

The UFF and DANIDA grants, while modest as a share of total county health budgets, were the only predictable cash resources that PHC facilities could control directly for non-salary recurrent spending. Most other county contributions arrived as in-kind inputs (salaries, infrastructure) through unpredictable county disbursement processes, or as social health insurance reimbursements that many facilities lacked the equipment or capacity to claim reliably.

The table below shows the grants' financial contribution to county health budgets across the three study counties. Despite representing a small percentage of total health allocations, the loss of these grants dramatically reduced usable facility-level cash

Table 3: PHC grants' financial contribution to county health budgets across the three study counties

County / Indicator	FY 2018/19	FY 2019/20	FY 2020/21	FY 2021/22	FY 2022/23
County A - High-income urban					
UFF grant (KES)	38,723,265	38,723,265	38,723,265	0	0
DANIDA grant (KES)	31,083,750	41,107,213	31,083,750	23,210,000	33,772,347
Grants as % of health budget	1.10%	1.15%	0.98%	0.30%	0.46%
County B - Middle-income rural					
UFF grant (KES)	37,789,290	37,789,290	37,789,290	0	0
DANIDA grant (KES)	33,311,250	30,843,750	29,610,000	23,070,000	33,447,791
Grants as % of health budget	3.71%	2.86%	3.20%	1.10%	1.87%
County C - Lower-income ASAL					
UFF grant (KES)	3,472,461	3,472,461	3,472,461	0	0
DANIDA grant (KES)	12,656,250	11,718,750	12,060,000	9,400,000	9,734,622
Grants as % of health budget	1.07%	1.10%	1.16%	0.65%	0.66%

Source: County budget documents reviewed as part of the study(2023).

Under the previous arrangement, quarterly disbursements flowed from the national government through the County Revenue Fund into ringfenced Special Purpose Accounts at each facility, giving managers a clear funding rhythm and discretionary access to operational budgets. Following UFF abolition and phased DANIDA withdrawal, facilities became dependent on unpredictable consolidated county equitable share disbursements.



“Our health budgets keep going down - at one point we were at KES 7.6 billion, we are now at 6 billion, and we are hoping this year we don't get to 5 point something billion.”

- County Official, County A

“The user fee forgone conditional grant played a very big role in the health facilities. It used to help us pay debts and casual worker salaries. We could even do some capital developments. We now have accumulating debts and pending salaries. Some activities have stalled because we don't have finances to go ahead with them.”

- PHC Facility In-Charge

2. Essential commodity availability deteriorated

Reduced direct funding meant PHC facilities lost their principal mechanism for topping up commodity supplies between KEMSA deliveries or procuring non-pharmaceutical consumables. The consequences were immediate:

- Drug and non-pharmaceutical **stockouts increased**, with County B's Head of Pharmacy reporting that hospitals were being asked to subsidise PHC facilities with commodities because the facilities could no longer supplement KEMSA supplies.
- **Infection prevention was compromised:** one facility manager described replacing disinfectants with ordinary soap because of inability to procure basic cleaning agents, directly affecting adherence to infection control standards.
- **Minor equipment procurement stalled:** blood pressure machines, weighing scales, and other small-value equipment that facilities could previously procure autonomously were no longer affordable given the loss of discretionary cash.



"We are no longer able to procure some non-

pharmaceuticals. While ideally, we would procure JIK [disinfectant] to disinfect hospital surfaces, now we just use ordinary soap. This is affecting our infection control."

- PHC Facility In-Charge, County B (PFT 108)

"The funding reduction has greatly affected our ability to procure key equipment. There are a few things we are allowed to procure - blood pressure machines, weighing scales. Now that we have none [of the grants], we are forced to work with what we have. We are stuck there until we get any form of funding."

- Level 3 Facility Manager, County A (PFT 101)

Respondents reported that persistent stockouts were eroding community trust in PHC facilities and shifting care-seeking behaviour toward higher-level hospitals or private providers - increasing both costs and distance for patients.

3. Governance, accountability, and staff motivation weakened

The financing transitions disrupted not only the material resources of the PHC system but also its 'software' - the governance practices, accountability systems, and motivational conditions that enable facilities to function effectively.

Accountability systems: partial institutionalisation

The DANIDA and UFF grants had embedded accountability requirements including facility committee oversight, internal accounting procedures, community representation, and transparent budget posting. These requirements strengthened facility governance, with some counties retaining the practices post-transition. County A, for instance, absorbed the accountants previously funded by DANIDA to support financial management, preserving the accountability capacity built under grant financing.



"These conditional grants strengthened the internal accountability capacity of the county. The practices that were reinforced were government procedures - so in terms of capacity for self-audit and self-regulation, that was really built up. At the facility level there is representation of the community through the facility committees, which play an oversight role."

- County Official, County A

However, the withdrawal of grant funding reduced the resources available to sustain facility committee activities, including the payment of committee member allowances that enabled participation from community representatives. Where these mechanisms survive, they do so despite reduced resources rather than because new funding has been secured.

Staff motivation: delayed salaries and resource frustration

The loss of direct PHC financing had a direct motivational impact on support staff, particularly casual staff whose salaries had been financed through the grants. Delayed payments, unmet requests for essential supplies, and the experience of being unable to provide quality care created frustration that respondents linked to reduced productivity and risks to patient-centred practice.



"PHC facilities were paying casual workers using this money - the security officer, the cleaner. Those people have not been paid because of reduced funding. So even though they continue coming to work, their productivity is reduced."

- County Official, County C

"When work becomes routine and you are not given time to refresh or the tools you need, you go into 'autopilot'... you start treating patients before you even get the story from them."

- MOH Official

4. Patients faced higher out-of-pocket costs and reduced access

The consequences of facility-level financing gaps were absorbed, in significant part, by patients - particularly the poorest households who depend most on public PHC.

- **Out-of-pocket costs re-emerged:** facility managers described asking patients to purchase drugs, wound-cleaning consumables, and delivery-related items (including disinfectants and cotton) that had previously been provided for free - directly reversing the gains of the 2013 user fee abolition policy.
- **Outreach activities declined:** both the UFF and DANIDA grants had funded community outreach for immunisation, antenatal care, and health promotion. Without this financing, outreach was reduced, limiting access for communities who cannot easily travel to facilities.
- **Care-seeking shifted upward:** drug stockouts and reduced quality at PHC level pushed patients toward sub-county and county hospitals or private facilities, increasing transport costs and patient charges.



“Maybe the client has a wound that needs to be cleaned on a daily basis, but we don’t have the commodities.

So we tell them: go and buy these commodities for us to clean your wound. Like those who are in the labour ward, the mother will be told, go and buy JIK, buy cotton, buy this, then come, we shall attend to you.”

- PHC Facility In-Charge, County B

5. Quantitative evidence: immediate decline in service utilisation

The interrupted time series analysis of national KHIS data between July 2020 and June 2022 provides quantitative corrob of the qualitative evidence on utilisation impacts. The findings are presented in the figure and table below.

Figure 1: Impact of UFF withdrawal on Outpatient visits (left) and ANC visits (right)

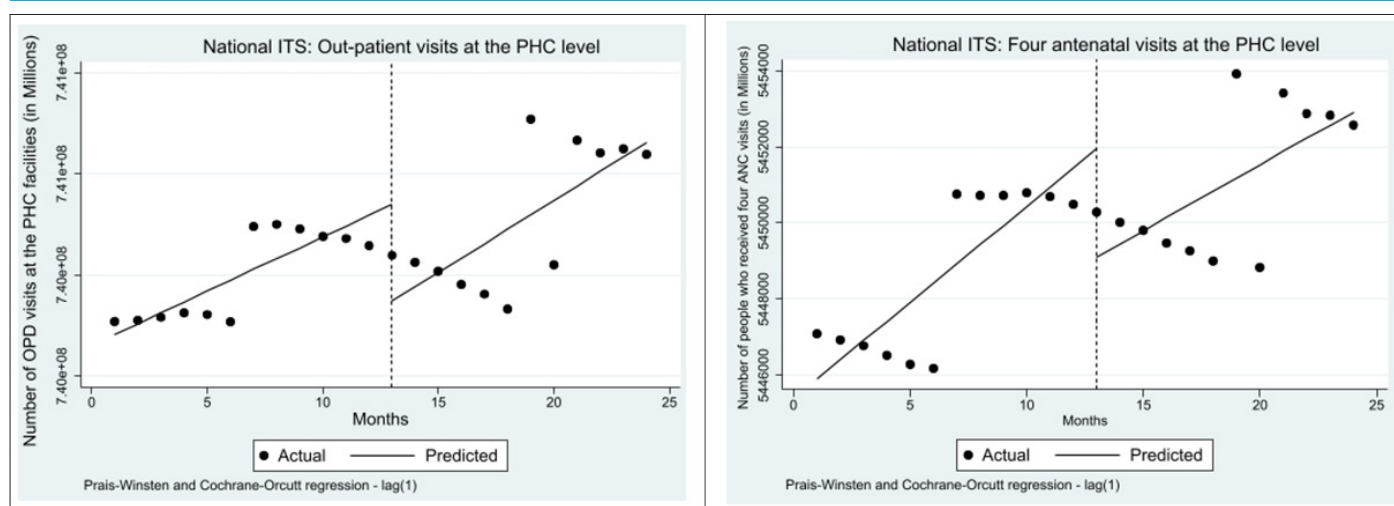


Table 4: Interrupted time series results

Indicator	Pre-intervention trend	Step-change (immediate)	Post-intervention trend change	Final post-intervention trend
Outpatient visits	+53,532/month *** (p=0.0001)	-480,401 *** (p=0.001)	+17,920/month (p=0.183, NS)	+71,452/month *** (p=0.0001)
4th ANC visits	+502/month *** (p=0.0001)	-2,838 *** (p=0.001)	-155/month (p=0.109, NS)	+347/month *** (p=0.0001)

Note: *** p<0.01. NS = not statistically significant. Source: KHIS monthly data, July 2020–June 2022. ITS analysis using Prais-Winsten estimation with AR(1) correction.

The analysis shows two key findings. First, before the UFF withdrawal (July 2020 to June 2021), both outpatient visits and ANC4 attendance were on statistically significant upward trends, indicating improving facility use during the pre-event period. Second, the July 2021 UFF abolition produced a statistically significant immediate step-down in both indicators - a loss of approximately 480,000 outpatient visits and 2,838 ANC4 visits in the month following withdrawal.

A subsequent upward trend in outpatient visits was observed, suggesting partial county adaptation - possibly including increased effort to register for and claim from the Social Health Authority. However, the initial step-change represents real disruption to service delivery that was not immediately recovered, and the observation window is too short to assess whether the full deficit was absorbed over time.

What the ITS evidence tells us

The ITS results are consistent with the qualitative accounts of reduced outreaches, stockouts, and patient dissatisfaction. They demonstrate that the financing transition had measurable population-level effects on care-seeking behaviour, not merely operational impacts on facility readiness. The partial recovery in utilisation trends suggests that counties did adapt, but adaptation took time and the interim harm was real. It also reinforces the importance of the manner of transition, not just the amount of financing lost.

Transition Design: The Critical Difference

The comparative experience of the UFF and DANIDA transitions provides one of the most policy-relevant insights from this study. The two grants were broadly similar in function - both provided direct, predictable operating cash to PHC facilities - but they ended in fundamentally different ways, with different consequences for counties' ability to adapt.

The abrupt UFF withdrawal: too fast for counties to absorb

The UFF conditional grant was abolished in FY 2020/21 as part of a national decision to rationalise intergovernmental transfers. No staggered withdrawal timeline was offered, no co-financing plan was established, and counties were given little advance notice to adjust their health budgets. The result was an immediate and unmanaged fiscal gap at facility level.



"I think the challenges were that the withdrawal of the user fee forgone conditional grant wasn't staggered. It was just withdrawn, and people had not yet gotten to master how to plan and budget. So it's been a challenge."

County Official, County A (PFT 103)

The phased DANIDA withdrawal: time to adapt, capacity to learn

DANIDA's withdrawal followed a deliberate four-year co-financing schedule in which donor funding was reduced by 25% annually while county governments were expected to step up corresponding domestic co-financing. This structured approach gave counties time to plan, allowed learning to accumulate across tranches, and created institutional conditions for absorbing accountability systems built under the grant.

The contrast between the two approaches illustrates that the impact of PHC financing transitions depends not only on the resources withdrawn, but on whether counties are given the time, planning support, and fiscal scaffolding to manage the transition without destabilising frontline services.



"The staggered withdrawal of the DANIDA funds taught us how to 'fish', because yes you have funds that are staggered... It would be great if donor funding withdrawal was staggered to ensure people now take up their mandate."

- County Official, County A

What This Means for Kenya's Emerging PHC Financing Architecture

Kenya's 2023 Social Health Insurance Act established the Social Health Authority (SHA) and introduced a tax-funded Primary Healthcare Fund (PHCF) intended to purchase PHC services through a blended capitation mechanism. These represent a significant step toward institutionalising PHC financing and have the potential to replace and improve on the conditional grants that were lost during the transition period.

However, the evidence from this study points to three design requirements that the new architecture must meet to avoid replicating the vulnerabilities exposed by the transition:

1. Universality: The UFF conditional grant was universal - every registered PHC facility received it regardless of enrolment status. The PHCF, by contrast, provides benefits only to SHA-registered members. Facilities serving unregistered or low-enrolment populations will struggle to generate capitation revenue and may face similar funding gaps to those that emerged after UFF abolition. The new architecture must ensure that PHC facilities receive baseline operational financing independent of registration rates, particularly in

rural and ASAL counties where registration remains low.

2. Predictability and facility-level control: The defining feature of the UFF and DANIDA grants was not their size but their disbursement model - quarterly transfers directly to facility bank accounts, giving managers discretionary control over operational spending. Consolidating PHC financing into broader county envelopes without ringfencing risks recreating exactly the problem that was solved by HSSF in 2010: facilities dependent on unpredictable, non-earmarked county transfers that compete with other county priorities.

3. Institutionalisation of governance gains: The accountability systems strengthened under DANIDA - facility committees, internal audits, community representation, financial reporting - represent public health infrastructure that should not be allowed to atrophy. Counties that invested in absorbing these systems have shown this is possible. The national government should make institutionalisation of these governance practices an explicit requirement within the SHA's facility contracting and quality standards.

Priority Actions

For National Government

- **Ensure the PHCF reaches PHC facilities as direct, usable cash.** Capitation-based payments are a step forward, but their effectiveness depends on timely disbursement, adequate registration coverage, and facility-level financial autonomy that mirrors what the UFF provided.
- **Build universality into the PHCF design.** Facilities serving large populations of unregistered or under-registered residents must receive baseline operational financing regardless of capitation revenue, to prevent a two-tier system in which urban registered populations access better-resourced facilities than rural unregistered ones.
- **Mainstream staggered transition as national policy for any future PHC grant changes.** The abrupt UFF withdrawal demonstrated the harm of unmanaged exits. Any future rationalisation of PHC financing streams should be subject to minimum notice periods, co-financing requirements, and county adaptation plans.
- **Ringfence PHC resources within county allocations.** When PHC funds are merged into broader county envelopes without protection, frontline services are crowded out by competing county priorities. Conditional transfer mechanisms or performance-linked disbursements should be maintained until county health financing systems are demonstrably strong enough to sustain PHC operations without ringfencing.

For County Governments

- **Map all PHC funding streams and plan for their transition proactively.** Counties should maintain a real-time picture of all direct PHC financing, including project-based external support, so that transition timelines are known in advance and domestic replacement financing can be planned before gaps emerge.
- **Sustain the governance and accountability infrastructure built under grants.** Facility committees, internal auditing practices, community oversight mechanisms, and accounting capacity represent lasting public goods. Counties that have absorbed these systems post-DANIDA should codify them in

standing operating procedures and budget for their continuation.

- **Prioritise PHC in county budget allocations.** Ensuring that PHC facilities receive sufficient and timely county financing - not just in aggregate budget figures but as usable cash at facility level - requires deliberate budget allocation and disbursement discipline.

For Development Partners

- **Use phased co-financing as the default exit model.** The DANIDA experience demonstrates that staggered withdrawal, with clear annual step-down tranches and required county co-financing at each stage, is substantially less damaging than abrupt exit and can actively build domestic financing capacity.
- **Align exit timelines with domestic institutional readiness.** Transition should be contingent not only on elapsed time but on verified county capacity to sustain financing flows, accountability systems, and service quality without donor support.
- **Map and communicate project-based support transitions early.** Short-term programmatic funding for outreach, equipment, and service inputs should be mapped against facility and county budgets at the design stage, with explicit domestic transition plans before project exit.

For Civil Society and Professional Bodies

- **Track whether 'free PHC' is genuinely free in practice.** The ITS evidence shows that financing gaps at facility level translate into real increases in patient out-of-pocket costs. Civil society organisations and community health advocates should monitor whether patients are asked to purchase drugs, consumables, or supplies that should be available without charge.
- **Advocate for the PHCF to be universal and well-funded.** The transition from a universal UFF grant to a registration-linked capitation creates equity risks. Civil society should engage national and county governments on the need to ensure that the most vulnerable communities - those with the lowest registration rates - are not left without funded PHC services.

Annex: Methods in Brief

This policy brief draws on a mixed-methods study of PHC financing transitions in Kenya, with ethics approval from KEMRI SERU (protocol: KEMRI/SERU/CGMR-C/294/4708) and NACOSTI (permit: NACOSTI/P/23/28111).

The qualitative component included 23 in-depth interviews (30–60 minutes each) conducted between July and December 2024 with national policy actors, development partners, county health and finance officials, and PHC facility managers across three purposively selected counties. Interviews were transcribed verbatim and analysed in NVivo 12 using a framework approach guided by a conceptual framework linking PHC financing changes to hardware and software health system outcomes.

The quantitative component used an interrupted time series (ITS) design, analysing monthly KHIS data on outpatient visits and ANC4 attendance at public Level 2 and 3 facilities from July 2020 to June 2022 (24 months). The model used Prais-Winsten estimation with a first-order autoregressive correction to account for serial correlation. July 2021 was designated the event month (first month following UFF abolition). ITS was not conducted for the DANIDA withdrawal given the phased design and insufficient post-withdrawal time points.

Evidence is strongest for identifying operational mechanisms and short-term utilisation effects. Limitations include three-county sample, reliance on routine KHIS data (with risks of underreporting), two utilisation indicators, and a short post-intervention observation window that precludes full long-term assessment.

Based on

Muthuri, R.N.D.K., Musiega, A., Maritim, B., Amboko, B., Nzinga, J., Mbau, R., Mugo, P., Tsofa, B., Musuva, A., Murira, F., Vilcu, I., Boxshall, M., and Barasa, E. Examining the Implementation Experience of Primary Healthcare Financing Transitions in Kenya (forthcoming).

KEMRI-Wellcome Trust Research Programme | Health Systems Insight

References

1. Ministry of Health. Kenya Health Facility Census Report. 2023 Sep.
2. KENYA COMMUNITY HEALTH POLICY. 2020.
3. Ministry of Health. Comprehensive National Health Policy Framework. 2011.
4. GOK. The Constitution of Kenya [Internet]. 2010. Available from: www.kenyalaw.org
5. Kairu A, Orangi S, Mbutia B, Barasa E. Examining Health Facility Financing in Kenya in the Context of Devolution [Internet]. doi:10.21203/rs.3.rs-501560/v1