



Kenya's health transitions

Country profile

June 2021

In this profile, we examine the impact of four transitions on Kenya's health system: a rapidly changing demography, a disease transition, changing patterns in domestic financing, and shifts in donor financing levels and priorities. These transitions affect whether Kenya will be able to achieve its ambitious goal of achieving universal health coverage (UHC) for its population. Our goal is to understand both the challenges these transitions present and the opportunities that can be harnessed to build a more equitable health system.

1 Demographic transition

Kenya's demographic makeup is rapidly changing. To achieve UHC, annual health spending per person needs to grow faster than the rapidly growing population. Kenya will need to address the concerns of its youth. Youth face high unemployment rates, work disproportionately in the informal sector (thereby leaving them unqualified for employer-provided insurance), and are at higher risk of non-communicable diseases and injuries (NCDIs). Healthcare in Kenya will need to evolve to tackle the increasing burden of risk factors associated with a rapidly urbanizing population and the changing geographic distribution of health service needs. See the [demographic transition section](#) for more details.

2 Disease (epidemiological) transition

Kenya, like many lower-middle income countries (LMICs), faces a double burden of disease—battling communicable diseases amidst a rising burden of NCDIs. As its NCDI burden continues to grow, Kenya must ensure NCDI service access and affordability; currently, services are costly, tend to be regressive, and are inadequately available in facilities. Kenya must also continue to improve and expand access to communicable disease care and essential services like maternal and child health (MCH), while accounting for regional and socio-economic disparities. See the [disease transition section](#) for more details.

3 Domestic finance transition

Kenya's domestic financing for healthcare is showing positive trends: domestic financing is increasing as a share of total health spending while external financing and out-of-pocket payments (OOPs) are declining. However, the COVID-19 pandemic has strained Kenya's economy, leading to budget cuts for key initiatives like the Big Four Agenda (job creation, UHC, affordable housing, and food security). Achieving UHC by 2022 in the current economic climate remains a herculean task. Kenya's domestic revenue mobilization and budget execution capacity will need to improve to sustainably achieve UHC. See the [domestic finance transition section](#) for more details.

4 Donor health aid transition

Donor aid continues to play an important role in Kenya's health financing landscape, particularly for HIV/AIDS financing. However, Kenya is facing several key donor transitions in the near-term future. Kenya's concentrated aid climate may exacerbate some challenges it faces during transition; transitions could in particular have a negative impact on HIV/AIDS services and services for key populations. Kenya will face the challenge of absorbing donor-funded programs and services if it wants to avoid potential backsliding. See the [donor health aid transition section](#) for more details.



Background

Kenya is the largest economy in eastern Africa. Its economy has grown in recent decades and it graduated from low-income country (LIC) status to LMIC status in 2014.¹ However, over one-third of the population (35.8%) still lives below the international poverty line of US\$1.90 per day.² Kenya's current population of 51.4 million is young, with more than half of its population currently below the age of 24.^{3,4} The country's population is expected to more than double in size by 2100.⁴ Kenya has seen significant improvement in health outcomes and economic development in recent decades (see Table 1 for an overview of key health and development indicators). The performance of Kenya's economy, like most economies all over the world, will largely be determined by the extent to which COVID-19 has disrupted life and economic activities. More action is needed to accelerate progress to achieve the Sustainable Development Goals (SDGs) and to meet the needs of its expanding population.

In 2017, the president of Kenya launched a development priority list called the 'Big Four Agenda', placing social and economic interests at the forefront of his administration's effort.⁶ The Big Four include:

1. expanding job creation in the manufacturing industry,
2. achieving UHC,
3. improving access to affordable housing, and
4. ensuring food security.⁶

This profile focuses on the second agenda item: achieving UHC. The UHC initiative in Kenya started in 2018 with a one-year pilot across four counties and was designed

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to generate lessons for scaling up across all 47 counties.⁷ Under the pilot, user fees were abolished at public health facilities and replaced with direct reimbursement to the counties from the national government.⁸ The pilot was funded through loans from the World Bank and the government of Japan.⁹ The aim was to determine:

1. whether the removal of user fees would improve service use and financial risk protection,
2. the cost of providing essential health services,
3. the ability of counties to respond to rising demand,
4. the effectiveness of public facilities in managing finances and service delivery,
5. the effectiveness of the referral system, and
6. the ability of the Kenya Medical Supplies Authority (KEMSA) to effectively supply affordable and quality products amidst increased demand.

Table 1. Overview of key health and development indicators^{4,5}

Development indicators		Health statistics	
Gross domestic product (2018)	\$US87.9 bn	Life expectancy at birth (2018)	67
Gross national income per capita (2018)	\$1,620	Infant mortality rate, per 1000 live births (2019)	35
Domestic public health expenditure % GDP (2017)	2.2%	Maternal mortality ratio, per 100,000 live births (2017)	342
Adult literacy rate (2018)	81.5%	Number of physicians per 1,000 population (2018)	.157
Human development index (2019)	0.579 Rank: 147	Health expenditure % GDP (2017)	5.2%

Source: World Bank Development Indicators



While the Big Four Agenda shows Kenya's great political commitment towards strengthening the Kenyan health system and achieving UHC, it is greatly affected by four major transitions:

- a rapidly changing **demography**
- a **disease** (epidemiological) transition
- changing patterns in **domestic financing**, and
- **donor financing** transitions.

In this profile, we examine the impact these four transitions have on Kenya's health system and on Kenya achieving UHC. Our goal is to understand the challenges Kenya faces in achieving UHC and the opportunities that it can harness in managing the challenges.

Demographic transition

Situational summary: Kenya's demographic landscape is undergoing rapid changes. Improvements in health care are resulting in Kenyans living longer: life expectancy at birth rose from 51 years in 1999 to 66 years in 2018.¹⁰ More children are also living beyond their fifth birthday: under five mortality per 1,000 live births dropped from 110 in 1999 to 41 in 2018.¹¹ Despite its declining fertility rate (5.2 births per woman in 1999 to 3.5 in 2018)¹², Kenya's population continues to expand. According to data from the World Bank, Kenya's population was 51.4 million in 2018, a 65% increase since 1999.¹³ The population is projected to rise further to 67 million by 2030¹⁴, and could potentially surpass 200 million by the close of the century (Figure 1).

Despite increased life expectancy, Kenya remains a largely young population, with a median age of 20 years and more than 60% of the population under the age of 24.¹⁵ This

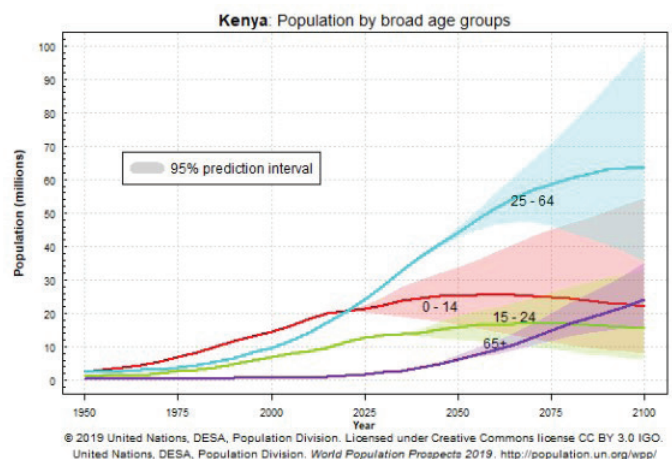
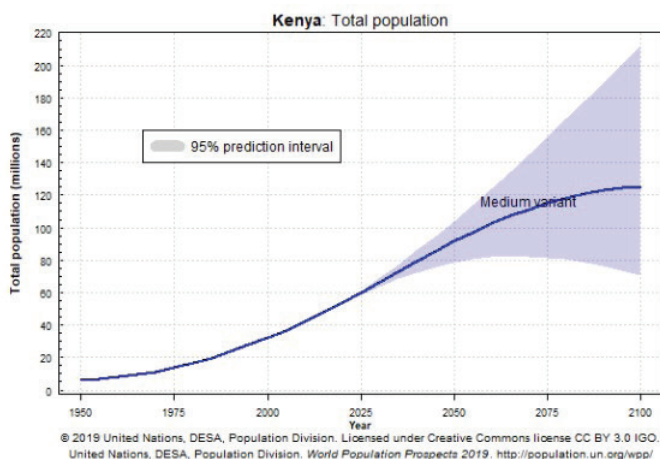
Demographic transition takeaways

- Kenya's demographic makeup is rapidly changing, presenting key challenges that must be addressed.
- To achieve UHC, annual health spending per person needs to grow faster than the rapidly growing population.
- Kenya will need to address the concerns of its youth. Youth face high unemployment rates, work disproportionately in the informal sector (thereby leaving them unqualified for employer-provided insurance), and are at higher risk of NCDIs.
- Healthcare in Kenya will need to evolve to tackle the increasing burden of risk factors associated with a rapidly urbanizing population and the changing geographic distribution of health service needs.

phenomenon, referred to as a "youth bulge", translates into a high dependency ratio (Figure 1).¹⁶ In addition to changes in the age makeup of its society, Kenya, like many LMICs, is experiencing a population shift from rural to urban settings (Figure 2). While three-quarters of Kenyans still live in rural areas, it is projected that nearly half of the country's population will live in cities by 2050.¹⁷

As the demographic makeup changes, the Kenyan health system will need to adapt to ensure the changing needs of its population are met. Several challenges will need to be addressed to achieve UHC in the midst of these demographic changes.

Figure 1. Total population and population age group growth¹⁸



Challenge: Meeting health needs of a growing and young population

Kenya's rapidly growing population creates a challenge for health policymakers working to achieve UHC. In the face of financial challenges and tight budgets, policymakers need to ensure that the annual growth in public health spending outpaces annual population growth. In addition, Kenya's young population faces barriers that affect their health and health seeking behavior; high unemployment, high informal sector participation, and high risk of non-communicable diseases and injuries (NCDIs).

- 1. High youth unemployment:** Youth unemployment is exceptionally high, estimated to have been 22% in 2016.¹⁵ As a result, a large portion of the youth do not have employer provider insurance through the National Hospital Insurance Fund (NHIF). The NHIF is the only mandatory coverage in Kenya, primarily insuring those with formal-sector employment whose contribution can be deducted directly. Additionally, a lack of income can lead to poverty and other adverse health outcomes related to social determinants of health.
- 2. Large share of informal sector workers:** Among those youth with employment, the majority work in the informal sector.¹⁵ Although able to voluntarily opt in to the NHIF, enrollment statistics show this is generally not an attractive option for informal workers, perhaps due to a preference found in Kenya for non-contributory financing schemes.²⁰
- 3. High risk for costly NCDIs:** A recent study found that in Kenya, "NCDIs occur at younger ages and affect those in the productive years of life, with over half of the NCDI disease burden and almost three-quarters of injuries occurring before the age of 40."²¹ Access to NCDI care is currently not meeting demand, and NCDI care is costly in general. With so many young members of the population uninsured, expenditures for NCDI services could cause significant financial hardship among youth.

Challenge: Preparing for the changing health needs of a rapidly urbanizing population

Although nearly three-quarters of Kenyans currently live in rural areas, it is projected that nearly half of the country's population will live in cities by 2050.¹⁷ This shift is likely to expose increasing numbers of Kenyans to the risk factors associated with urbanization, such as high caloric intake, excessive alcohol consumption, physical inactivity, and/or air pollution.^{22,23} However, Kenyans are already exhibiting a number of these risk factors, which may only be further exacerbated with a move to an urban setting: in 2015 27% of the population was overweight/obese, with the proportion of obese women being significantly higher than men (39% compared to 18%).²²

Figure 2. Urban and rural population growth²⁹

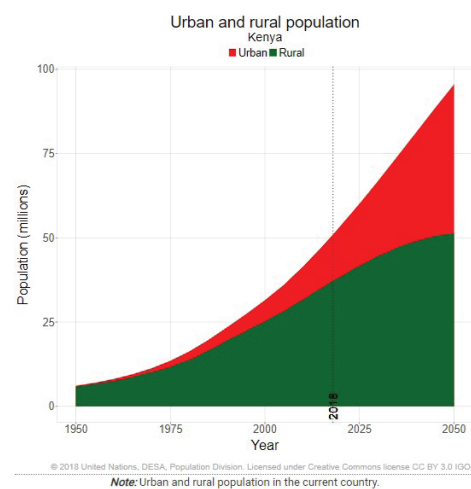
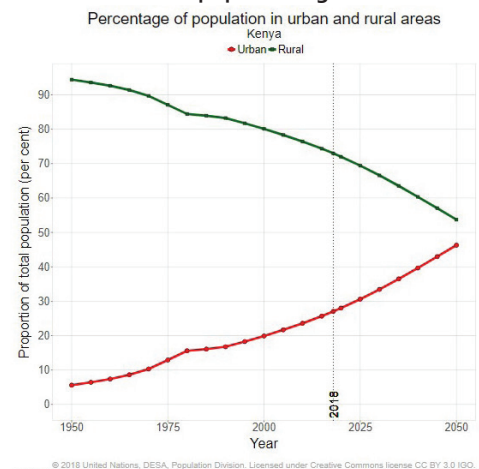
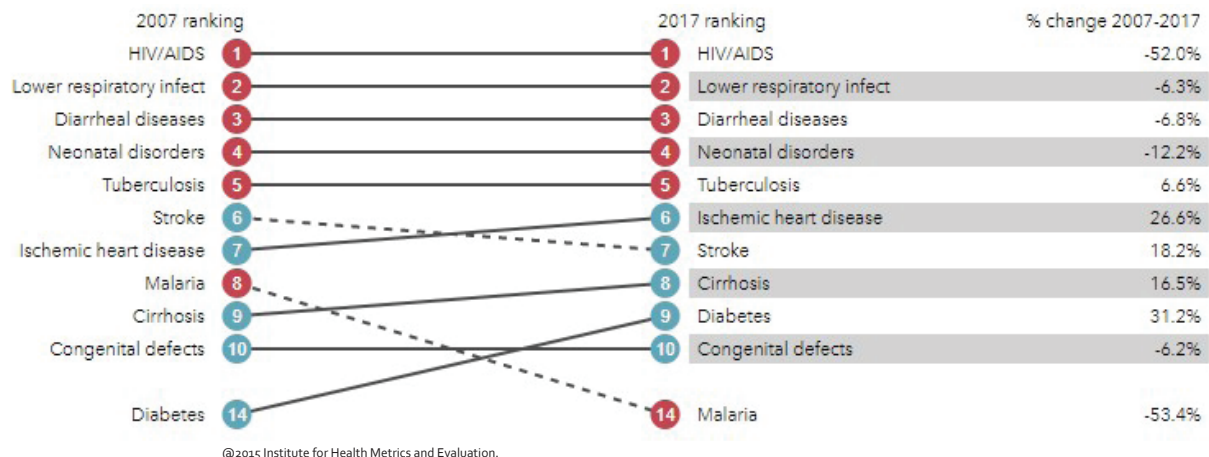


Figure 3. Top causes of death, 2007 and 2017²⁴

Disease (epidemiological) transition

Situational summary: Kenya, like many LMICs, faces a double burden of disease—battling communicable diseases amidst a rising burden of NCDs. Despite a fall in the annual mortality rate from communicable diseases, communicable diseases continue to make up the greatest number of deaths in Kenya (54%).²⁴ In 2017, communicable diseases were the top five causes of death (Figure 3) in Kenya.^{22,24}

Mortality from NCDs is on the rise in Kenya. NCDs are projected to overtake communicable diseases as the primary cause of death by 2030.²² In 2017, they made up 39% of all deaths (up from 29% in 1990) while injuries made up 8%.²⁵ In particular, ischemic heart disease, stroke, cirrhosis, diabetes, and congenital defects caused the greatest number of NCDI deaths in 2017.²⁴ Between 2007 and 2017, diabetes saw the greatest increase of deaths at 31%, followed closely by ischemic heart disease at 27% and stroke at 18% (Figure 3).²⁴ NCDs will in particular need to be managed carefully given Kenya's increasing life expectancy.

Given Kenya's changing demographic makeup, attention must also be paid to how disease patterns will evolve. Several challenges will need to be effectively addressed to achieve UHC amidst these shifts in the disease burden.

Challenge: Sustaining and expanding access to prevention and treatment for communicable diseases and essential maternal and child health services

Communicable diseases, while on the decline, are still a major cause of death in Kenya. Although NCDs also need to be tackled, Kenya must sustain services for communicable diseases and maternal and child health (MCH) to ensure the country does not backslide. Kenya must also

expand access to existing services if it is to tackle its significant communicable disease burden.

The Kenya Essential Package for Health (KEPH) outlines minimum entitlements to services for all Kenyans. It is an aspirational requirement for services set at the national level, although not all services outlined are necessarily covered under the NHIF.²⁶ For example, a recent comparative review of the KEPH and the NHIF found that while HIV testing and counseling are included in the NHIF package, prevention methods are not, even though all are outlined in the KEPH.²⁶ Despite the major role communicable diseases continue to play in causing mortality in Kenya, there remains a gap between policy guidance in the KEPH and implementation in terms of communicable disease prevention and treatment. Communicable diseases will not be brought fully under control without sufficient prevention and treatment.

Although maternal and child care is clearly outlined in the KEPH, there are several areas of misalignment between the aspirational services and the reality of what is included in the NHIF.²⁶ Newborn services are completely missing from the benefits package, as are key services like management of complicated deliveries.²⁶ For children, immunization is included in the NHIF package but other critical services, such as deworming and pneumonia management, are excluded.²⁶

Compounding the above-mentioned limitations, there remains significant inequality in access to MCH and key preventative measures for communicable diseases (e.g., vaccines).²⁷ Disparities are most stark in the northern and eastern regions, as well as among the rural and urban poor.²⁷



Challenge: Ensure availability of NCDI care and services

The rising NCDI burden means that there is an increasing demand for NCDI services. However, according to a Kenya ministry of health 2013 assessment on service readiness and availability, on average, Kenyan facilities are only able to provide 37% of NCDI services that should be provided.²⁸ The alignment between stated entitlements in the KEPH and what's provided through the NHIF is even wider for NCDIs than it is for communicable diseases: 63% of services that are included in the KEPH, particularly NCDIs and emergency care, are not included in the current NHIF health benefits package, meaning that even those with insurance will not be covered for such services.²⁶

Additionally, there is considerable variation in access to NCDI services between *counties* (depending on their poverty level), *facilities* (public versus private), and *rural versus urban settings*.²² Several priority NCDIs have specific coverage issues:

Diabetes: limited/infrequent routine monitoring tests (e.g., lipid tests); half of patients with diabetes are not adherent to medication, for reasons including challenges in accessing medicine and shortcomings of care.²⁹

Cardiovascular disease, hypertension, and stroke: a 2015 study found that only 2.7% of men and 6.9% of women with hypertension were receiving treatment.³⁰

Cervical cancer: only 4% of rural women get screened and most patients present with advanced stages of the disease (81%).^{31,32}

Injuries are increasingly contributing to overall mortality, and along with NCDs, are expected to overtake communicable diseases in terms of overall annual mortality by 2030.³³ Traffic crashes make up the majority of injuries and are on the rise: the number of reported traffic crashes increased by 39% between 2018 to 2019 alone (from 5,200 to 7,200) with a 22% increase in reported casualties.³⁴ However, services for emergency care, and specialized services like x-ray, laboratory, and rehabilitation, are currently limited.²⁸ Insufficient coverage of these services will leave certain populations, like the young and unemployed (and therefore likely uninsured), particularly vulnerable.

Challenge: Ensure affordability of NCDI care and services NCDI treatment is costly and regressive.³⁵ According to a recent study, households affected by NCDIs are 30%

Disease transition takeaways

- While communicable diseases remain the largest driver of Kenya's disease burden, NCDIs are rising.
- Since the NCDI burden continues to grow, Kenya must ensure NCDI service access and affordability; currently, NCDI services are costly, tend to be regressive, and are inadequately available in facilities.
- Kenya must continue to improve and expand access to communicable diseases and essential services, like MCH, while accounting for regional and socio-economic disparities; the NHIF does not cover comprehensive services for these areas, as recommended in the KEPH.

more likely to be impoverished than households with communicable diseases.³⁰ Treatment of NCDIs is primarily financed via out-of-pocket expenditures (OOPs) (81%).³⁵ NCDI spending only makes up 6.5% of total government health expenditures.³⁰ NCDIs are chronic illnesses, and yet for many Kenyans drug prices for long-term treatment are unaffordable. According to a recent study that collected data from 2010-2015, "crude death rates among the poor were more than double for NCDIs and triple for injuries than those among the wealthier populations", signaling that the poor disproportionately suffer from NCDIs.³⁰

A recent qualitative study exploring experiences of community members in accessing emergency care found cost to be the most commonly mentioned barrier, particularly at private facilities.³⁶ Private facilities were specifically mentioned because they are often "regarded as providing higher quality emergency care, but cost substantially more than government facilities."³⁶ Additionally, most acutely ill and injured patients self-present at hospital, in part due to the lack of ambulances in Kenya and therefore an inability to pay the high cost to access a private ambulance.³⁶

Domestic financing transition

Situational summary: Health financing in Kenya comes primarily from four key sources: the government, external development partners, health insurance, and OOPs. Overall, trends for these sources are heading in a positive direction (Figure 4). Domestic government expenditures for health have been increasing as a share of total health



spending in recent years (up from 29% in 2000 to 43% in 2017).³⁷ External aid as a share of total health spending is on the decline (down from 28% in 2006 to 18% in 2017).³⁷ OOPs have also fallen significantly (47% in 2000 to 24% in 2017).³⁷ Kenya's NHIF currently supports 16% of the population, although enrollment is primarily among formal sector workers since it is compulsory for employers and financed through payroll deductions.³⁸

Despite progress across the above mentioned indicators, domestic health spending as a share of general government expenditures, a measure of health sector prioritization, has remained fairly stagnant since 2005 (7% in 2005, 8% in 2017).³⁷ The story is similar for domestic health expenditures as a share of GDP (1.5% in 2005 and 2.1% in 2017), which is low when compared to other LMICs.³⁷ These figures suggest low prioritization of health within the domestic budget. Prioritization may be further complicated following enactment of a new constitution in 2010 that devolved provision of health services to the counties. As a result, health financing drastically changed as county-level governments took on significantly more financial responsibility.³⁹

Challenge: Achieving the promise of UHC by 2022 given the challenging macroeconomic environment

While Kenya continues to perform relatively well in containing the COVID-19 disease, the pandemic has put a major strain on the economy. The World Bank projects that the country's GDP per capita will drop substantially because of the pandemic.⁴⁰ Contributory factors include

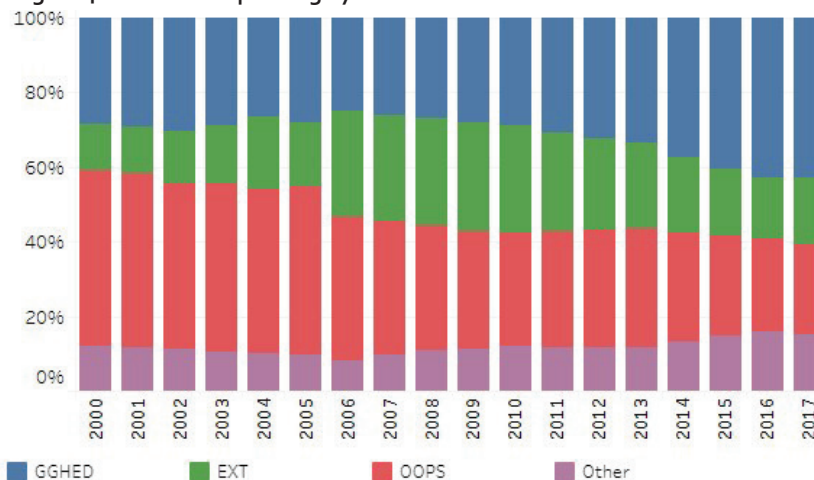
reduced global trade, investment, and tourism.⁴⁰ At the same time, a drop in domestic tax revenue is expected. Kenya took action to generate additional revenues in an attempt to close the gap.⁴¹ For example, the government reduced tax incentives and exempt income and increased the tax scope.⁴¹ Kenya's domestic finances are expected to continue to dwindle as the country's borrowing increases. In May 2020, the IMF raised Kenya's risk of debt distress from moderate to high, although the IMF noted that as exports revert back to normal levels, the scenario is likely to improve.⁴²

Prior to the COVID-19 pandemic, the Kenyan President launched the Big Four Agenda, which included achieving UHC by 2022. The economic strain from the pandemic has resulted in reductions in the Big Four budget allocations. Less than one-third of the current budget year's support for the initiative will be available in the upcoming year (127.3 billion shillings compared to 450.9 billion shillings).⁴³ The national rollout of UHC was intended for 2020; however this has been delayed.

Challenge: Expanding health services with limited domestic revenue mobilization and budget execution capacity

During a four-county pilot of UHC in 2019, the government removed all user fees for services provided in public facilities. If this action was extended to all 47 counties, Kenyans could significantly benefit: a 2014 report from Kenya's Ministry of Health found that "83% of Kenyans

Figure 4. Healthcare spending by source³⁷



Key: GGHE-D (domestic general government health expenditure); EXT (external health expenditure); OOPS (out-of-pocket expenditure)



lack financial protection from health care costs, and about 1.5 million Kenyans are pushed into poverty each year as a result of paying for health care."⁴⁴ However, given the constrained economic environment and limited resources for the initiative, it will be even more difficult to balance the ambitions of UHC with current domestic financial capacity.

Decentralization is still in its infancy in Kenya. Currently, county health allocations are via block grants (i.e., lump sum amounts where discretion for their application is not determined by the central level.)⁴⁵ Although such grants provide autonomy to the counties to determine health funding priorities, funding delays from the national to county level are common and affect access across all population groups. Additionally, the national government's capacity to execute has been limited: for example, only 68% of the total budget was spent in the 2015-2016 financial year.³⁹ The UHC pilot relied on reimbursements from the national level to the four pilot counties for forgone revenues from user-fees in public hospitals; however, the funds used for reimbursements came from external funders (the World Bank and the government of Japan). The capacity to execute such budget reimbursement across all 47 counties and the sustainability of financing hospitals in each county when donor funds are unavailable remains unclear.

Domestic finance transition takeaways

- Kenya's sources of financing for healthcare are showing positive trends: domestic financing is increasing as a share of total health spending while external financing and out-of-pocket payments are declining.
- However, the COVID-19 pandemic has strained Kenya's economy, leading to budget cuts for key initiatives like the Big Four Agenda. Achieving UHC by 2022 in the current economic climate remains a herculean task.
- Kenya's domestic revenue mobilization and budget execution capacity will need to be improved in order to sustainably achieve UHC.

Donor health aid transition

Situational summary: External donor funding as a share of Kenya's current health expenditures is on the decline (down from 28% in 2006 to 18% in 2017).³⁷ However, this proportion is still higher than fellow LMICs: on average, 11% of LMICs current health expenditures come from ex-

ternal sources.⁴⁶ The top external providers of official development assistance (ODA) for health in Kenya are split between bilateral and multilateral sources: the United States (US), the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund), the United Kingdom (UK), the World Bank International Development Association (IDA), and Gavi, the Vaccine Alliance (Gavi). According to data from the OECD CRS database, these donors have been the largest total contributors of funds since 2002 and were the top five donors in 2018. Most health ODA to Kenya supports STD control, including for HIV/AIDS.⁴⁷ Kenya is expected to transition from donor support from several of these top donors in the near future.

Gavi: Kenya is expected to enter the accelerated transition phase for Gavi in 2022, meaning that during this five-year phase, Kenya will be expected to gradually increase its investment as Gavi support decreases, ideally leaving Kenya in a position to fully-self finance its vaccine program at the end of the phase.⁴⁸

World Bank IDA: Kenya is currently an IDA-blend country, meaning that it is not quite credit-worthy enough to become fully eligible for IBRD-lending, but it is on a pathway to transition to IBRD-only support.⁴⁹

Global Fund: Transition from Global Fund support is not anticipated before 2025 given Kenya's high burden of disease across each of the three diseases – HIV/AIDS, tuberculosis, and malaria.⁵⁰ However, the Global Fund, through its Sustainability, Transition, and Co-financing Policy, notes that lower-middle income countries with a low-disease burden should begin to focus on transition preparedness.⁵⁰

Bilateral external aid: The US and the UK do not have as clear transition approaches as the above mentioned multilateral agencies. However, both have transitioned countries in the past either due to improvements in economic and/or health outcomes or as a means to prioritize their country portfolios.⁵¹⁻⁵³

Given Kenya's changing aid landscape, several challenges will need to be overcome to continue the health gains achieved with donor support.

Challenge: Managing a concentrated donor landscape
Kenya faces a very concentrated aid environment across several dimensions. First, most ODA for health is channeled to HIV/AIDS.⁴⁷ Second, two-thirds of all HIV/AIDS financing comes from external funders.⁴⁶ Third, the US is



by far the largest health ODA donor, making up an overwhelming majority (84%) of ODA for STI control, including HIV/AIDS.⁴⁷ Additionally, the share of ODA for health from other donors has been declining over time, potentially in part due to the rising share of funds from the US or key health multilaterals (Figure 5). Therefore, the US and HIV/AIDS funding portfolios have a disproportionate influence on Kenya's health financing landscape. A change to external funding levels for HIV/AIDS or a shift in US policy could have a significant negative impact on Kenya's domestic HIV/AIDS response.

The US President's Emergency Plan for AIDS Relief (PEPFAR)—the US aid program focused on HIV/AIDS—and the Global Fund both target key or vulnerable populations, such as orphans, vulnerable children, men who have sex with men, persons who inject drugs, and sex workers. While these affected populations may benefit from external support, they are also potentially the most vulnerable if Kenya were to experience a change in donor funding or donor priority areas.

Nearly half of Kenya's support from PEPFAR is still funding direct service delivery for HIV.⁵⁴ US financial support for HIV services primarily targets antiretrovirals (ARVs) (15% of total PEPFAR funds for Kenya in 2019) and infrastructure development such as disease surveillance systems and laboratories (30% of total PEPFAR funds for Kenya in 2019.) Across donors, roughly 90% of Kenya's ARV needs are provided from external funders.⁵⁴ A disruption to ARV funding or critical infrastructure, like surveillance, could be

catastrophic for HIV prevention and treatment.

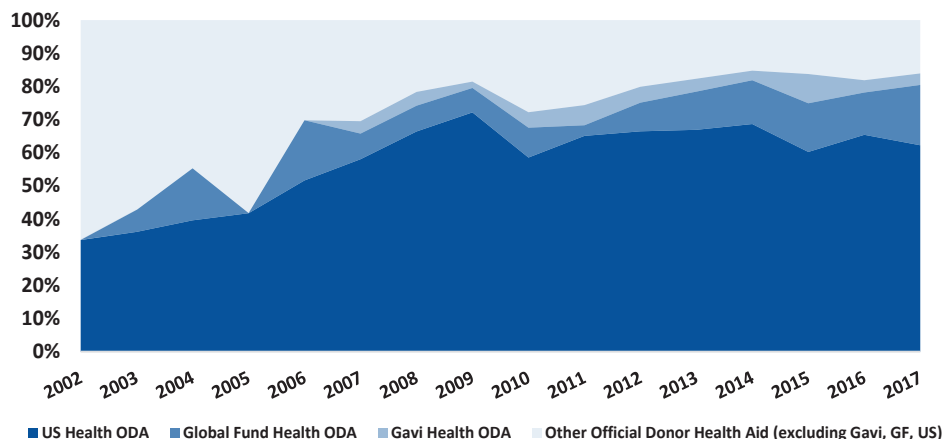
Challenge: Identifying pathways to absorb funding for donor-funded services and programs

While it is a positive trend that aid as a share of current health expenditures is declining in Kenya, a key issue may be overlooked: *Kenya receives a significant amount of capital investment from external donors.*^{47,55} Across current and capital expenditures, external aid makes up closer to 40% of Kenya's total government allocations to health, indicating a much larger dependence on donor aid.⁵⁵

The government will face reductions in key sources of health aid in the coming years. For example, Kenya is expected to be able to fully finance its routine immunization program at the end of its accelerated transition phase, in approximately 2027. However, as of 2020, Kenya only funds 23% of its routine immunization program.⁴⁸ If Kenya needs to mobilize resources for its immunization program, where will these funds come from? Funds could come from additional revenues dedicated to the health sector. However, if additional funds are unavailable, funds from one program area (e.g., HIV) may need to be redirected to routine immunization. This redirection could place a strain on the financial sustainability of certain program areas within the health sector.

If the government cannot absorb primarily donor funded programs/populations in light of a donor transition or policy change, this could add to the already high OOPs faced by many Kenyans. In particular, OOPs may affect those in the informal sector without insurance coverage or vulner-

Figure 5. US share of health aid in Kenya⁴⁷



able populations who may not receive services/commodities they need affordably. For example, 93% of the costs of antiretrovirals for HIV patients are covered by PEPFAR and the Global Fund.⁵⁴ If either donor reduced its support for ARVs without additional domestic funding mobilized for ARVs, these populations could be forced to pay for these commodities through out-of-pocket payments, potentially leading to catastrophic health expenditures. Unfortunately, this predicament could be a reality: a recent paper by Haakenstad et al. found that along with several other LMICs, Kenya has “little capacity to fill a substantial financial void left by development assistance” for HIV/AIDS.⁵⁶

Conclusion

Kenya has made significant progress in improving health outcomes and health financing in recent years, and the government’s prioritization of health and other social and economic issues is admirable. However, to achieve UHC and the SDGs, Kenya will need to navigate rapidly evolving situations to its demographic makeup, disease burden,

Development assistance transition takeaways

- Donor aid continues to play an important role in Kenya’s health financing landscape. However, Kenya is facing several key donor transitions in the near-term future.
- Kenya’s concentrated aid climate may exacerbate some challenges it faces during transition; effects of transitions may be especially acute among HIV/AIDS services and among key/vulnerable populations.
- Kenya will face the challenge of absorbing donor-funded programs and services if it wants to avoid potential backsliding.

and financing portfolio (both from domestic and external sources). On top of these transitions, Kenya will need to manage the economic impact of the COVID-19 pandemic and balance implications with the ambitious Big Four Agenda.

Resources

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Funding and Authorship

This profile was funded through a grant from the Bill & Melinda Gates Foundation to the Duke Center for Policy Impact in Global Health, with a subcontract to Strathmore University's Institute for Healthcare Management. The Foundation played no role in writing the profile. The profile was written by authors at Strathmore University (**Dosila Ogira, Joseph Onyango, Francis Wafula, and Gilbert Kokwaro**) and the Duke Center for Policy Impact in Global Health (**Kaci Kennedy McDade, Wenhui Mao, Gavin Yamey, and Osondu Ogbuoji**). This profile was designed by **Heather Hille**.

Methods

Our research included a desk-based review of websites, strategy documents, grey literature reports, and academic literature. We triangulated the findings of our desk review with key informant interviews with high-level policy personnel within each of the donor agencies. This project was screened for exemption by the Duke University Institutional Review Board as part of the study 'Driving health progress during disease, demographic, domestic finance and donor transitions (the "4Ds"): policy analysis and engagement with transitioning countries.'

