IMMEDIATE IMPACT OF EXTERNAL FUNDING WITHDRAWAL ON KENYA'S HEALTH SECTOR

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PREPARATION OF THIS DOCUMENT

The opinions expressed in this document are those of the authors and do not necessarily reflect the views of the donors or any organization.

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ABBREVIATIONS

AIA	Appropriations in Aid
ARV	Antiretrovirals
BADEA	Arab Bank for Economic Development in Africa
CEMA	Center for Epidemiological Modelling and Analysis
COP	Country Operational Plan
COG	Council of Governors
FCDO	Foreign, Commonwealth & Development Office
FIF	Facility Improvement Financing
FY	Financial Year
GAVI	Global Alliance Vaccine Initiative
GF	Global Fund
GoK	Government of Kenya
HIV	Human Immuno-deficiency Virus
HPTs	Health Products and Technologies
KIPPRA	Kenya Institute for Public Policy Research and Analysis
KHIS	Kenya Health Information System
KPs	Key Populations
LMICs	Lower Middle-Income Countries
MoH	Ministry of Health
NATO	Non-Aligned Trade Organization
OVCs	Orphaned and Vulnerable Children
PEPFAR	Presidents Emergency Programme for Aids Relief
RMNCH	Reproductive Maternal Neonatal Child Health
TB	Tuberculosis
WHO	World Health Organization

EXECUTIVE SUMMARY

Kenya's health sector has long relied on a mix of government, private, and external funding, with development partners playing a critical role in financing commodities, human resources for health (HRH), and health information systems for strategic programs such as HIV, TB, malaria, Reproductive, Maternal, Neonatal and Child Health (RMNCH). In 2018/19, external funders contributed approximately 18% of total health expenditure, with the US Government alone accounting for over 60% of all external health funding. Recent abrupt shifts in US foreign aid policy, alongside reductions from other development partners, have created a substantial and immediate financing shock, with far-reaching implications for service continuity, equity, and health system resilience.

This report provides a comprehensive analysis of the scale, structure, and allocation of external funding for health in Kenya over the period FY 2019/20–2025/26, with a particular focus on the impact of the withdrawal of US Government funding. Using national approved budgets, donor reports, commodity quantification data, and PEPFAR HRH and beneficiary data, the analysis tracks on-budget and off-budget flows, disaggregates funding by source and disease area, and estimates the monetary gaps created in commodities, HRH, and health information systems.

Total external funding for health in Kenya is estimated at KES 54 billion in FY 2025/26, a sharp decline from KES 126 billion in FY 2024/25. This decline is driven primarily by the withdrawal of US Government support and reductions in Global Fund and World Bank allocations. Off-budget funding, which previously formed the largest share of external health resources, fell from KES 87 billion in FY 2024/25 to KES 26 billion in FY 2025/26, reflecting the heavy reliance on US off-budget channels such as PEPFAR. On-budget external funding also decreased from KES 39 billion to KES 28 billion over the same period, although the composition shifted towards a higher proportion of grants (68.6% in FY 2025/26) relative to loans.

The donor landscape has also shifted. Historically, the US Government has been the dominant external funder of health in Kenya, contributing more than half of total

external health funding prior to FY 2024/25. Its withdrawal has coincided with reductions among multilateral agencies that themselves depend on US contributions, including the Global Fund, World Bank, GAVI, and WHO. At the same time, new and expanding partners have emerged, such as the Susan Thompson Buffet Foundation, which contributed KES 3.8 billion for RMNCH in FY 2025/26, and the Gates Foundation, now among the largest external contributors to the sector. Nevertheless, these additional investments are insufficient to offset the scale of the US funding gap.

Disease-specific analyses show that external funding remains heavily concentrated in a few strategic programs. In FY 2025/26, RMNCH received the largest share of external support (32%), boosted by new funding, while HIV, TB, and malaria collectively account for around 20% of external resources. However, budgets for all three strategic disease programs have declined due to both reduced external funding and lower domestic allocations, raising serious risks of reversal in previously hard-won gains in incidence, treatment coverage, and mortality. RMNCH funding has increased overall due to the new external investment, but this appears to have been accompanied by a reduction in government contribution, suggesting a potential crowding-out effect.

Beyond program envelopes, the report quantifies the impact of the withdrawal of US Government support on key health system inputs. For commodities, the funding gap across HIV, TB, malaria, vaccines, and nutrition is estimated at KES 34.7 billion in FY 2025/26 (excluding the overfunded RMNCH programme). For HRH, PEPFAR supported more than 41,000 health workers across cadres in 2024, including clinical officers, nurses, pharmacists, laboratory staff, and large numbers of lay and community-based cadres who are not formally recognized in MoH staffing norms. If counties were to absorb all PEPFAR-supported staff at government pay scales, the additional annual wage bill would be approximately KES 47.8 billion, with the largest HRH liabilities in high-burden counties such as Nairobi, Kisumu, Homa Bay, and Migori. Health information systems, including EMRs, KHIS2, Chanjo KE, Damu KE, and HIV data platforms also depend heavily on external funding, with PEPFAR allocation of around KES 513 million for maintenance and support in FY 2024/25.

External funding also highlights a wide range of beneficiary-focused interventions, especially for vulnerable and high-risk groups. PEPFAR resources support livelihoods and services for orphaned and vulnerable children (OVCs), pregnant and

breastfeeding women, children and adolescents living with HIV, key populations, and adolescent girls and young women. The withdrawal of funding threatens to disrupt these targeted programs, widen existing inequities in access to prevention and treatment services, and reduce the scale-up of proven interventions in populations that already face disproportionate risk.

Overall, the analysis highlights three critical findings. First, Kenya's health sector is highly exposed to external funding shocks, particularly in HIV, TB, malaria, RMNCH, commodities, HRH, and data systems. Second, the current domestic budget response in FY 2025/26 is not sufficient to bridge the gaps created by donor withdrawal, raising immediate risks for service continuity and longer-term risks for health outcomes and financial protection. Third, the structure of external financing, characterized by a mix of loans and grants, a dominance of off-budget flows, and donor-driven prioritization, has created vulnerabilities that must now be addressed through deliberate transition planning.

The report concludes with a set of policy recommendations. In the short term, the national government should reprioritize and increase health allocations in FY 2025/26 to cover strategic commodities and maintain critical information systems, while working with the Council of Governors to support counties in absorbing essential HRH previously funded by donors. In the medium term, Kenya should develop a fully costed transition roadmap for programs supported by multilateral partners, improve efficiency through service integration and IT system consolidation, leverage Facility Improvement Financing (FIF), and create a more enabling environment for private sector participation in health financing and supply chains. The report also brings out the need to explore innovative financing mechanisms such as sin taxes, hypothecated levies, impact bonds, and debt swaps, and to negotiate for more grant financing and better alignment of external support with unfunded national priorities.

Finally, this assessment is intended as both an immediate guide for policy and a foundation for subsequent work. It will inform deeper modelling of the impact of external funding cuts on health outputs, outcomes, and the broader economy, and support Kenya's efforts to build a more self-reliant, equitable, and resilient health system in the face of shifting global development assistance.

01 Introduction & Background

Image source: unsplash.com

1. INTRODUCTION AND BACKGROUND

Changes in foreign development assistance, such as the ones occasioned by the recent abrupt shift in US foreign aid policy, can have significant impact on health provision, outputs, and outcomes in countries with a substantial dependence on external assistance. Recent analysis of the impact of aid withdrawal in multiple low-income or middle-income countries (LMICs) showed sanction episodes lasting 5 years could negate 30% of overall progress in reducing child mortality and 60% of gains in reducing maternal mortality. In Kenya, the United States of America (US) government has been a key funder of the health sector, supporting many aspects including commodities, health workforce training and deployment, public health research, HIV, tuberculosis, malaria, immunization, nutrition, and reproductive health services, and the development of health policies and systems. The abrupt halt in US government funding has created significant financial shortfalls, which threaten healthcare service delivery, workforce stability, commodity security and public health research.

Kenya's health sector relies on three major sources of funding: the government, the private sector (private firms and households) and external funding. In the most recent national health accounts for 2018/19, the government contributed 53%, private sector sources 23% while external funders contributed 18% of the country's total health expenditure. In the same year, the US government contributed over 60% of all external funding to the overall health sector. Strategic and priority diseases such as HIV, TB and malaria are heavily reliant on external funding. For example, external funders contributed 62% of HIV health expenditure in 2018/19 and financed 86% of antiretroviral agents (ARVs), 50% of which came from the US government funding.

Despite contributing close to 20% of total health care expenditure, external sources are neither predictable nor sustainable. The recent sudden funding withdrawal by the US government is a testimony of the uncertainty of donor funding. On January 20, 2025, the US President signed an executive order that transformed the US foreign aid policy to gravitate around "America First". The order suspended American foreign assistance globally for a period of 90 days pending review to establish whether such assistance is aligned to their foreign aid policy that seeks to fulfil three conditions, (1) making America safer, (2) stronger and (3) more prosperous.

This sudden change in the US government foreign aid policy also reduced funding commitments to multilateral organizations such as the World Bank, WHO, GAVI and Global Fund (GF). This affects disbursements from these organizations to support healthcare as they seek to enhance efficiencies due to the shrinking resource envelope. For instance, the GF has announced a reduction in the current grant (GC7) of between 13% and 15%. The GF has initiated a process where countries are required to submit revised requests of their reprioritized activities that fit within the reduced budget. Other external funders such as the United Kingdom (UK) through their development agency, the Foreign, Commonwealth & Development Office (FCDO) have announced a reduction in foreign aid budget to Kenya and other African countries by 12% in this financial year. This decision is informed by the UK government change in policy to cap international aid spending at 0.3% of Gross National Income down from the internationally recommended 0.7%.

Due to international outcry, the US government approved an "Emergency Humanitarian Waiver" to allow continued access to HIV treatment funded by PEPFAR (the U.S. President's Emergency Plan for AIDS Relief) across 55 developing countries including Kenya. The waiver ensures that life-saving HIV medication and related services can continue to be provided. The withdrawal of funding by the US government has nevertheless negatively affected the health sector in Kenya due to their support to the other components of health care provision such as human resources for health (HRH) and data systems.

Despite the funding cuts for health from external sources, the government has not adequately increased budgetary allocations in the current financial year 2025/26 to bridge the gap created by the funding cuts. There has not been a commensurate commitment from existing or new external funders to fill the gap created by the US government withdrawal of funding. A recent rapid assessment by the Ministry of Health (GOK 2025) estimated that Kenya requires KES25 billion to fund the commodity budget left by the US government funding cuts. However, this was not informed by the most up to date commodity quantification and forecasting and the approved national government budgets with donor commitments. Furthermore, the medium-to-long-term impact will be felt after a lag in funding especially when commodities run out of stock due to lack of replenishment and when staff supported by the US government eventually stop working.

To better understand policy actions that must be taken by the Kenyan government and other external funders to bridge the financing gap and ameliorate the effects of the funding withdrawal, there is need for a comprehensive analysis of the financial effects of the withdrawal of the US government funding of Kenya's health sector. This assessment seeks to provide an updated assessment of the impact of external funding withdrawal through a comprehensive analysis of external funding landscape and tracking the funds within the health care system to understand areas that will be hit the most. The overall objective of this analysis is to estimate the immediate impact of the external funding cuts to the health sector in Kenya. This will focus on service disruptions, equity in service access, workforce implications and impact on supply chain and infrastructure.

Specifically, this analysis will:

i) Estimate the size, trends, ways through which external funding flows, and the relative contributions of external funders to Kenya's health sector.

ii) Determine the diseases factors of provision, geographical coverage, services, and special groups benefiting from external funding.

iii) Estimate immediate impacts of external funding cuts on service delivery, equity in access, workforce, supply chain and infrastructure to inform mitigation strategies.

This analysis focuses on external funding for Kenya's health sector. The readers are encouraged to take note of the upcoming national health accounts estimates for information about other sources of health care funding.

The intention of this analysis is to inform policymakers about the scale of external funding for health in Kenya and the specific health sector areas to which these funds are directed. This analysis will be useful for advocacy in resource mobilization efforts to fill the gap resulting from the withdrawal of the US government support and reduction in funding from other donors. In addition, this report highlights other external donors such as the Global Fund that have announced plans to reduce funding for health, making the report timely for informing donor transition planning.

The government and development partners can also use this report to identify priority areas for increased funding following the withdrawal of US government funding. Researchers can also utilize findings to examine trends in external development assistance to the health sector and the correlation between health budgets and health outcomes with a view of informing their efficiency and return on investment.

It will also inform the subsequent comprehensive analysis on the impact of the suspension of US foreign development assistance on health outputs, outcomes and on the wider economy.

02 External Funding Channels in Kenya

2. THE EXTERNAL FUNDING CHANNELS IN KENYA

The Government of Kenya receives funding through both on-budget and off-budget support from external sources. The on-budget support is provided in the form of grants or concessional loans and is recorded in the national budget as either Appropriations-in-Aid or as direct revenue to finance government expenditure (KIPPRA[1] Macro-model). Although all foreign aid is intended to align with the government's national development priorities, some donors, such as PEPFAR (prioritizing HIV), and Thomson Susan Buffet (prioritizing RMNCH), prioritize their own programmatic areas. This donor driven focus can create imbalances in resource allocation across Ministry of Health programs.

The on-budget foreign assistance is typically recorded under development vote-heads of the Ministry of Health (MOH) budget. In exceptional cases such as the Global Fund (GF) grant, the National Treasury is the principal recipient of the grant hence it is recorded under the development vote head in the budget of the National Treasury. However, the execution of this component of the budget is initiated by the Ministry of Health.

The current geopolitics (such as the wars between Ukraine and Russia as well as the Middle East conflicts) have also contributed to the reduction in resources available for foreign development assistance (Hideaki S. et al 2025). In particular, the recent agreement among NATO member states to allocate at least 5% of GDP to defence, is expected to further constrain development assistance from European countries (NATO 2025).

[1] KIPPRA is a state corporation public policy institute with a mandate of providing quality policy advice to the government.

03 Methods

Image source: pexels.com

3. METHOD OF ANALYSIS

Sources of data for this analysis include Ministry of Health (MoH) approved budgets, commodity quantification reports, human resources (HRH) budgets and donor specific annual reports, development partners' operational and grant reports. Approved health budget data for the last seven years (2019/20-2025/26) was used to generate a comprehensive on-budget external funding landscape. Budget data was used since expenditure data was not available for all the years. In addition, the available expenditure data was not disaggregated into categories relevant for this analysis. We also note that on-budget external funding is likely to be spent in full due to the Appropriations in Aid (AIA) component, guided by contractual obligation and the more enhanced monitoring and evaluation requirements of external funders.

The on-budget external funding for health was obtained from the annual national approved budgets published by the National Treasury. The off-budget data was sourced from the published budgets and reports from external funders. For the US Government, the health investments budget data was obtained from published annual country operational plans (COP). Data on commodity requirements was obtained from commodity quantification reports and a recent rapid assessment report by the MoH. The off-budget data provided in foreign currency was converted to Kenya Shillings using average annual exchange rates sourced from the central bank of Kenya.

Human Resources for Health data was obtained from PEPFAR for PEPFAR supported staff. The payroll cost of PEPFAR supported staff was computed using government remuneration rates. Additional PEPFAR supported health input budgets (commodities and infrastructure support) and support to beneficiaries was obtained from the country operational plan (COP) report for year 2023.

The major limitation of the data sources was incompleteness of the data. For example, some of the data did not have information for the entire period of analysis, 2019/20-2025/26. For this, additional information was obtained from published budgets. The data was summarized in charts and tables for visualization and ease of interpretation.

04 Findings & Discussion

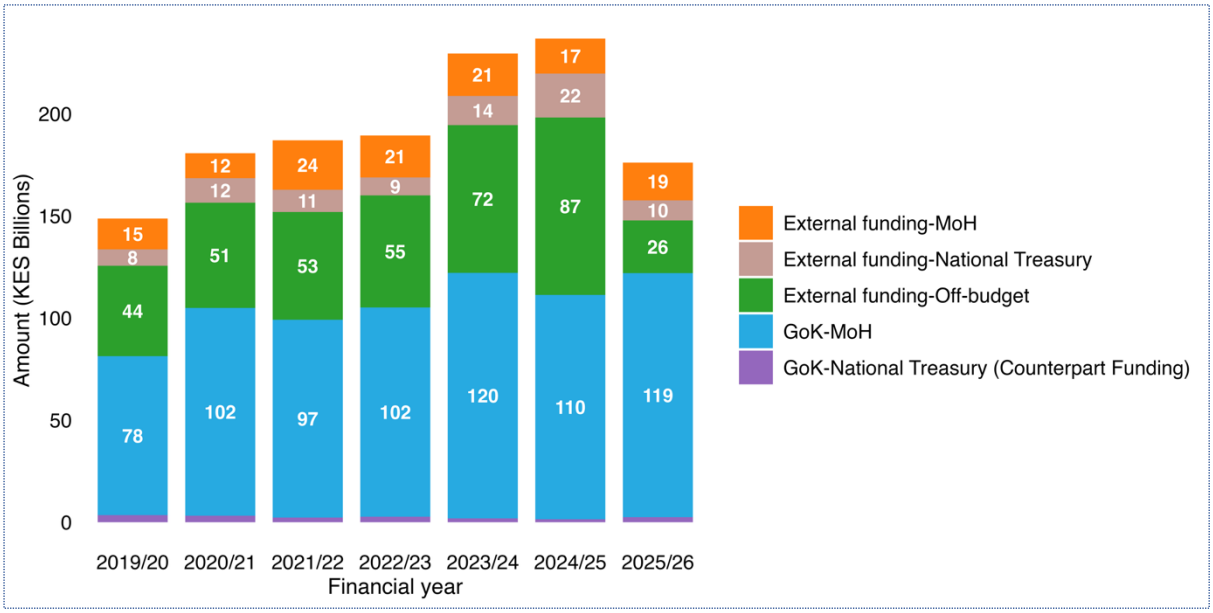

Image source: unsplash.com
Spending in Billions U.S. dollars
0
5
10
15
20
25
30
35
40
45
$10
$40
$10
$40
$7
$40
$5
$25
$5
$16
$4
$15
$3
$12
$2
$12
$5
$2
$5
$8
Discrete manufacturing
Transportation and logistics
Utilities
B2C
Healthcare
Process
Energy and natural resources
Retail
Government
Insurance
Other

4. FINDINGS AND DISCUSSION

In this section, summarised data is presented, and findings are organized according to the specific objectives.

Figure 1 shows that the Ministry of Health (MoH) budget allocation for FY 2025/26 is KES138 billion, up from KES127 billion in FY 2024/25.

Figure 1: Total Government and external funding for health



Kenya's total health budget includes both government and external funding. For the Financial Year 2025/2026, the funding is estimated as follows:

a) Government contribution through the Ministry of Health: **KES 119 billion**.

b) On-budget external funding directly to the Ministry of Health: **KES 19 billion**.

c) Additional on-budget external funding through the National Treasury: **KES 12.3 billion** (This includes KES 9.83 billion mainly from the Global Fund, and KES 2.47 billion as government counterpart funding).

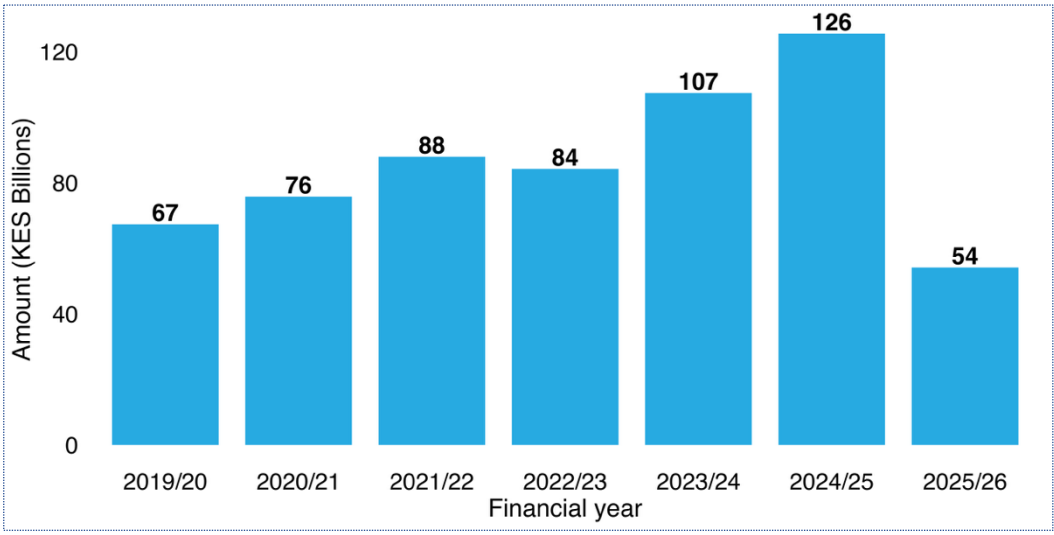
d) Off-budget external funding: **KES 26 billion**.

In total, the external funding for health in Financial Year 2025/2026 is estimated at **KES 54 billion**, a significant decline from **KES 126 billion** in the Financial Year 2024/25.

Figure 2 shows the annual trend in total external funding with a clear upward trend prior to FY 2025/26. However, in FY 2025/26, the total external funding has severely declined to KES 54 billion down from KES 126 billion in the previous year largely due

to the withdrawal of funding by the US government in 2025 and the decline in GF and World Bank support.

Figure 2: Total External Funding for Health in Kenya (KES)



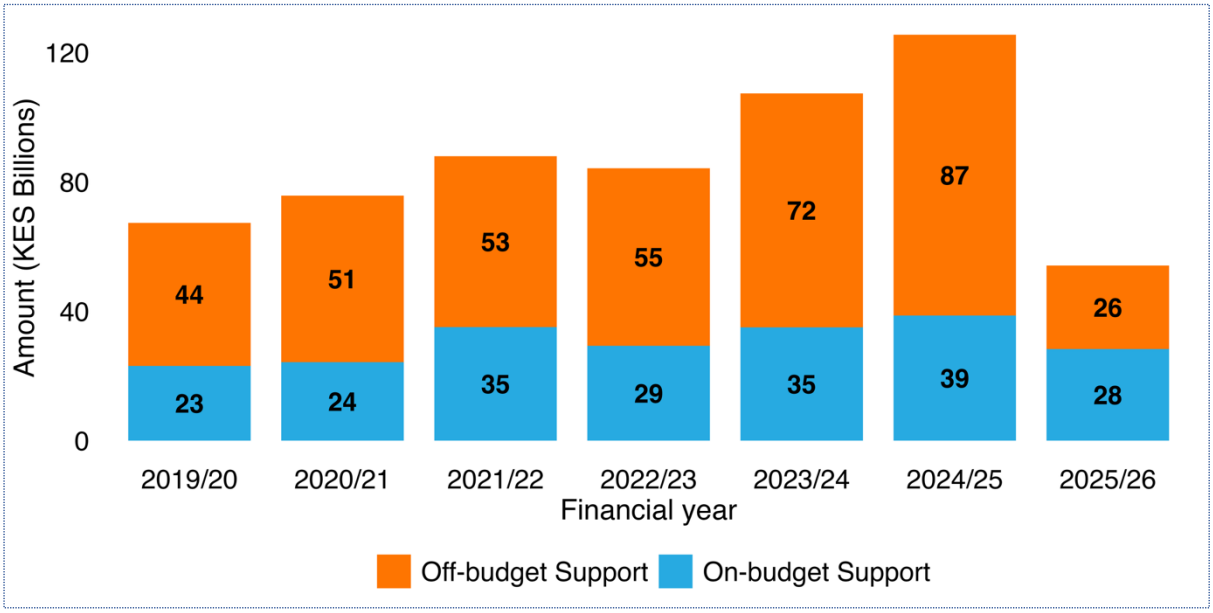
Source: Authors computations from national approved budgets and donor funding reports

On-budget and Off-budget External Funding for Health

The total external funding for health comprises both on-budget (MoH and National Treasury budgets) and off-budget support. For all the years analyzed except Financial Year 2025/26, the off-budget support made up the larger share of external health funding. As shown in Figure 3, the off-budget support dropped sharply from KES 87 billion in FY2024/25 to KES 26 billion in FY2025/26 due to the withdrawal of funding from the US government which primarily supports through off-budget. The key challenge with off-budget support is that the government has limited control over these resources and cannot easily direct them to address emerging or shifting national health priorities.

On-budget total external funding also declined from KES 39 billion in FY2024/25 to KES 28 billion in FY2025/26. The largest reductions were from the Global Fund (KES 11.6 billion) and the World Bank (KES 1 billion). However, this drop was partially offset by the contributions from new external funders to the health sector.

Figure 3: On-budget and Off-budget total external funding for health



Source: Authors computations from national approved budgets

The on-budget external funding comes into the country as grants or concessional loans. Table 1 shows that for the period 2019/20-2025/26, the country cumulatively received more loans than grants in external funding for health through on-budget support. The highest proportion of loans of 83.2% of on-budget external funding was in FY 2021/22, while the highest proportion of grants of 68.6% of external funding is reported in FY 2025/26.

Table 1: Proportion of Loans vs Grants in On-budget External Funding

Year	On-budget KES billions	% Loan	% Grant
2019/20	23.12	45.83%	54.17%
2020/21	24.28	64.00%	36.00%
2021/22	35.13	82.86%	17.14%
2022/23	29.35	60.00%	40.00%
2023/24	35.04	60.00%	40.00%
2024/25	38.69	53.85%	46.15%
2025/26	28.33	32.14%	67.86%

Source: Own computations from national approved budgets

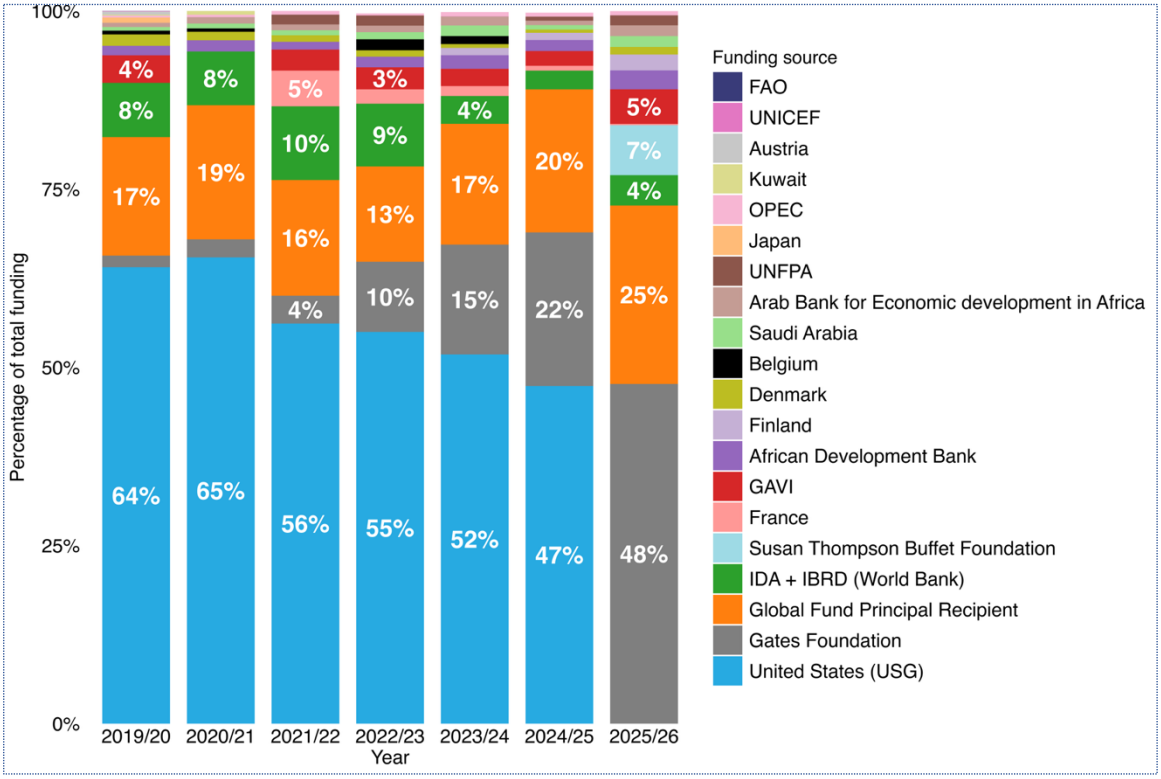
Loans increase Kenya's public debt and the attendant challenges of increasing debt to GDP ratio, a key indicator used to assess the risk and the country's credit worthiness on the international financial market. For this reason, the preferred situation is to have more grants rather than loans. Furthermore, loans borrowed to invest in healthcare do not have a direct and immediate return on borrowed money invested. Access to grants is however hampered by the categorization of the country into a lower middle-income country (LMIC) which implies that the country is expected to finance its healthcare through more loans than grants.

A further disaggregation of on-budget external funding shows that more on-budget external funding comes into the country as appropriations in aid (AIA) as opposed to revenue. This points to the disproportionate influence of external funders on the sourcing of donated products; in most cases these products are procured externally denying the local manufacturers the opportunity to build capacity to supply the required inputs.

Sources of External Funding for Health

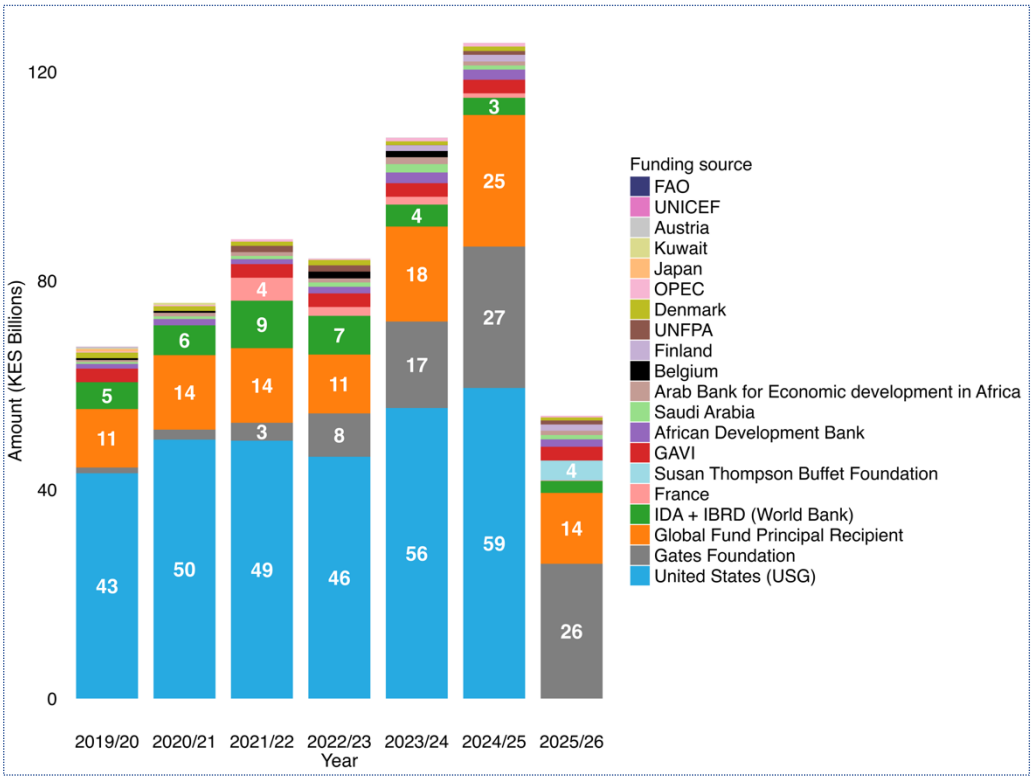
As shown in figure 5 and 6, the US Government has been the major external funding source for the health sector in Kenya, constituting over 50% of total external funding prior to FY2024/25 on average. The withdrawal of US government funding therefore deals a big blow to the country's ability to bridge the wide gap created. In addition, the multilateral external funders are also affected by the change in the US government foreign aid policy. Global Fund, World Bank, WHO and GAVI are recipients of the US government funding. A cut in their global budgets may lead to a reprioritization of their interventions in the country to fit within their resource envelopes. External funding data shows that these multilateral agencies had already started to reduce their on-budget support to the health sector prior to the US funding withdrawal. The analysis has also revealed the entry of new external funders; Susan Thompson Buffet Foundation is now among the major external funders of health in Kenya. In FY 2025/26 Susan Thompson Buffet Foundation donated KES3.8 billion grant to support reproductive, maternal, neonatal and child health (RMNCH) programme in Kenya. The Gates Foundation is now the highest contributor of external funding to the health sector in Kenya.

Figure 4: Relative total external funding by source



Source: Author's computation from national approved budgets

Figure 5: Total External Funding for Health by Source in Kenya (KES)

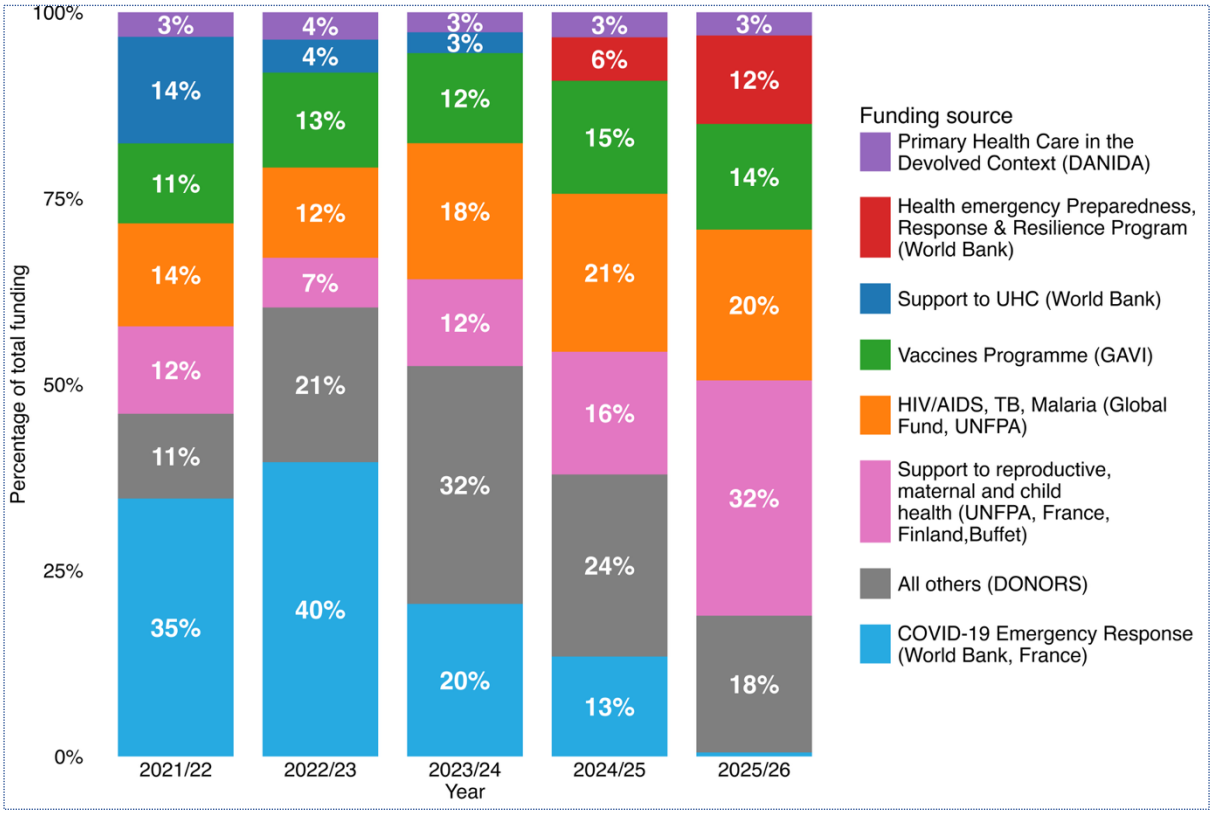


Source: Author's computation from national approved budgets

Total External Funding by Disease

Figure 6 shows the diseases where the external funding was directed. In FY 2025/26, reproductive, maternal, neonatal and child health (RMNCH) was the most funded program by external sources with 32% of all external funding going to this programme. This proportion is boosted in FY 2025/26 by the withdrawal of US government funding that was directed to HIV, TB and Malaria that changed the relative funding of diseases. Strategic and priority diseases of HIV, TB and malaria continued to attract a sizeable proportion of external funding (20% of external funding), mainly from Global fund and UNFPA. All the other diseases not listed in the chart attracted 18% of external funding.

Figure 6: Total On-budget External Funding by disease

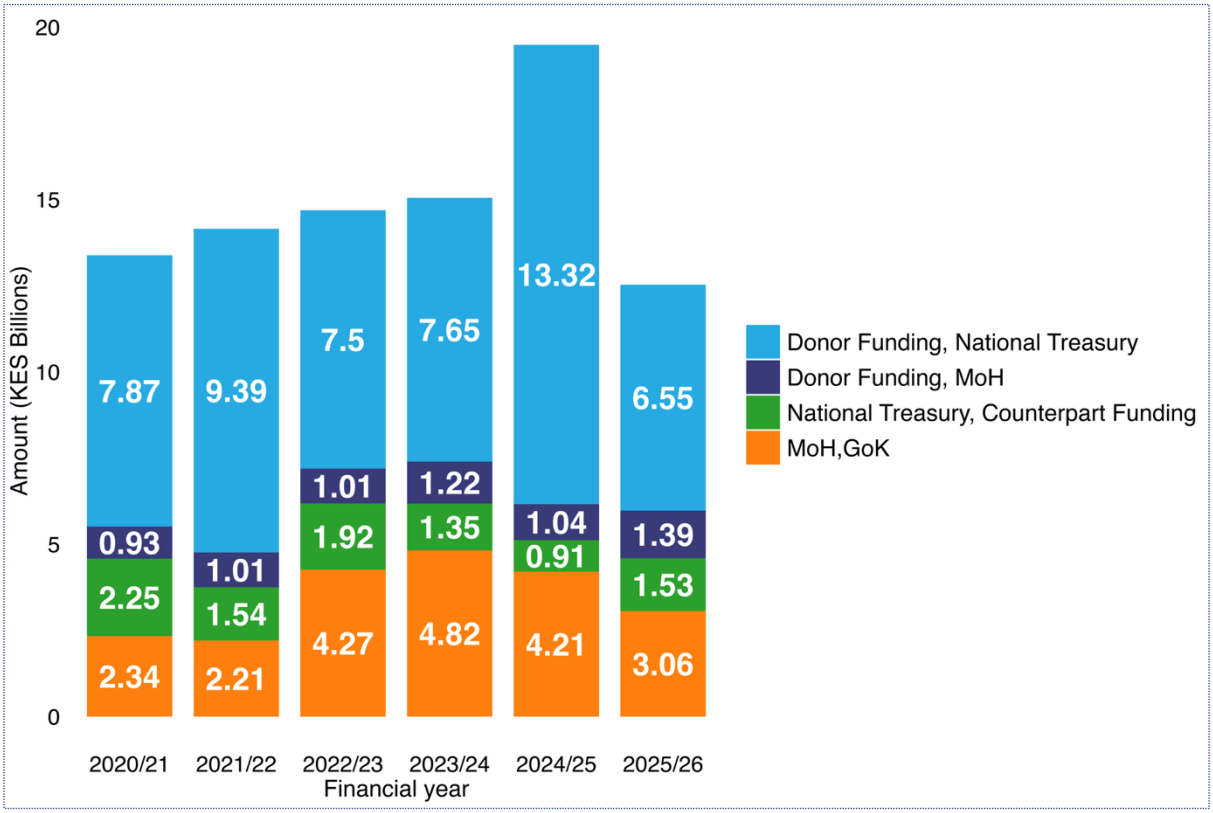


Source: Author's computation from national approved budgets

Further analysis of funding for strategic disease programmes show that these disease programs are heavily donor reliant. The extent of funding from the government either as counterpart funding or through the MoH budget allocation is minimal. Furthermore, despite the funding cuts by the US government and the decline in funding from Global Fund, the government also cut the budget for strategic disease programs substantially in FY 2025/26 as shown in figures 6, 7 and 8. All the three

strategic disease programs budgets, HIV, TB, and Malaria, have declined in both the total external funding and from government funding. This decline in funding, if not addressed soon, will likely reverse the gains made over the years in these disease programs. For example, the sustained low level of HIV incidence in different groups can be reversed. The RMNCH program budget has been boosted by a new external funder but also had their government contribution cut in the FY 2025/26 budget as shown in figure 8.

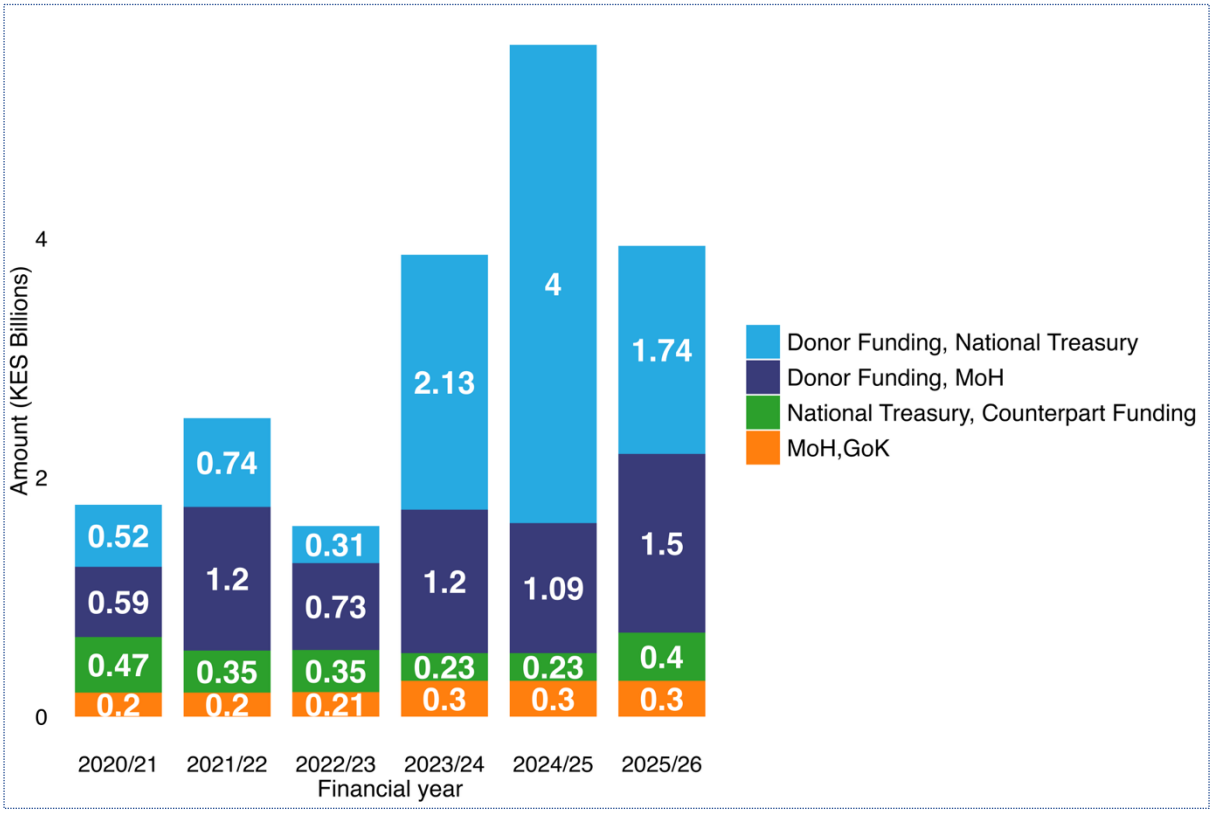
Figure 7: Budget for HIV



Source: Author's computation from national approved budgets

The budget amounts combine the budget for HIV in MoH and National Treasury budgets. Overall, there is a decline in both external funding (GF) and government contribution towards HIV budget in FY 2025/26.

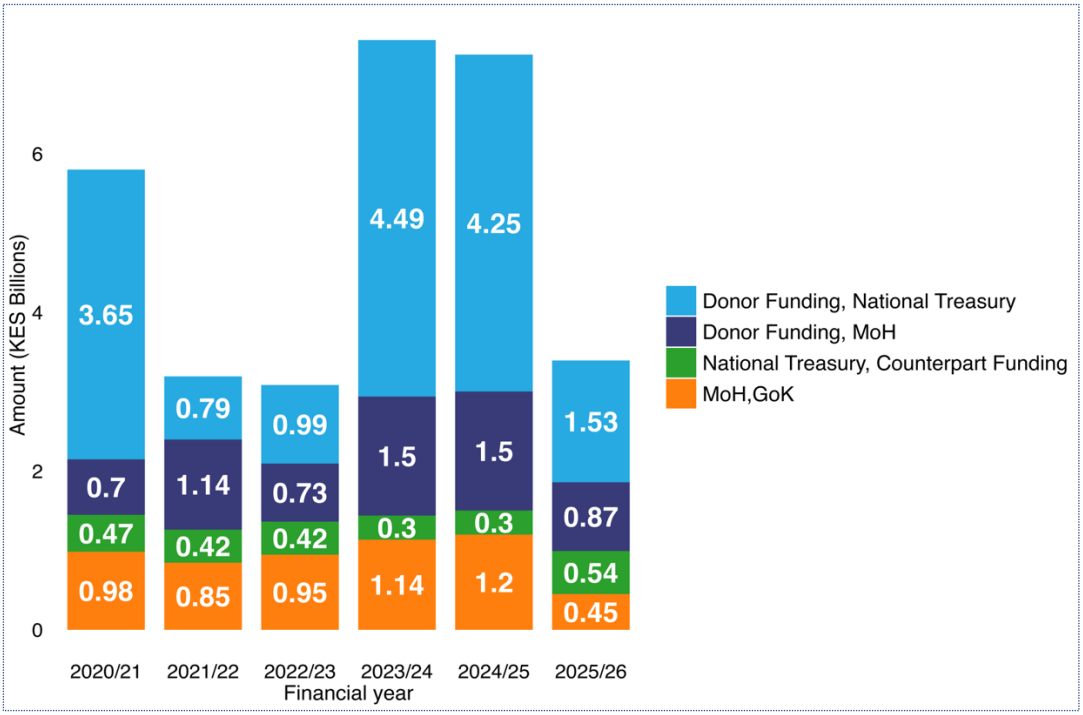
Figure 8: Budget for TB



Source: Author's computation from national approved budgets

The external funding from GF for TB has been reduced substantially in FY2025/26 budget from KES 4 billion in FY2024/25 to KES 1.74 billion in FY 2025/26.

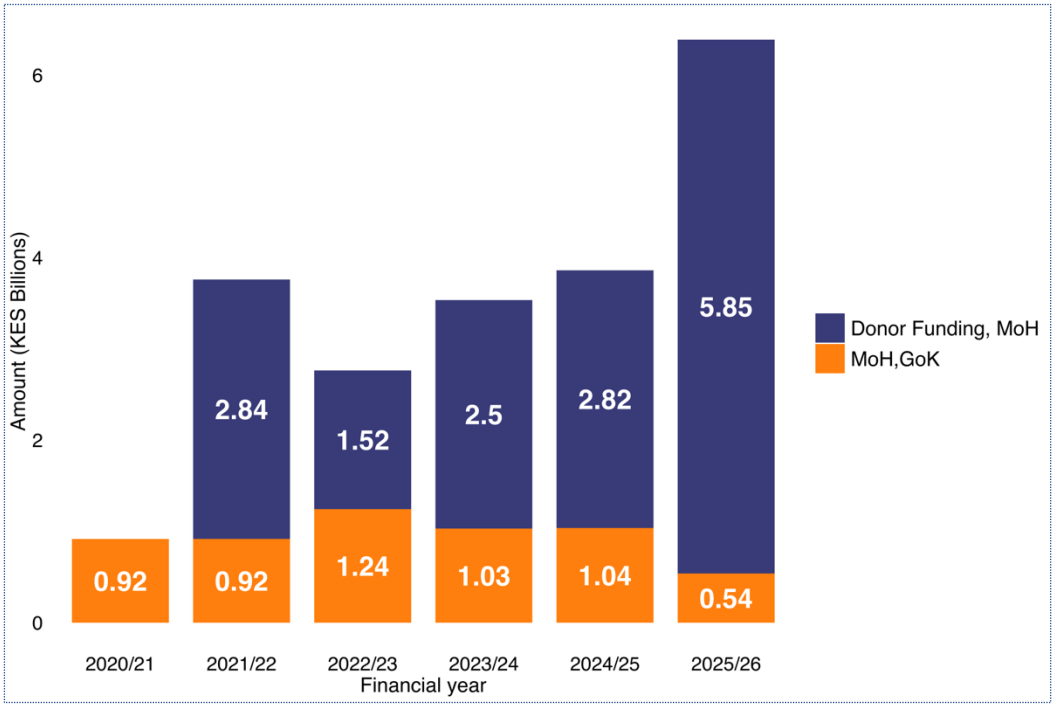
Figure 9: Budget for Malaria



Source: Author's computation from national approved budgets

External funding and government contribution for Malaria have reduced. Global fund has budgeted for KES 1.53 billion for Malaria in FY2025/26 down from KES 4.25

Figure 10: Budget for RMNCH



Source: Author's computation from national approved budgets

The RMNCH programme received KES 5.85 billion in external funding in FY2025/26 up from KES 2.82 billion in FY 2024/25. However, the government contribution was reduced from KES 1.04 billion in FY 2024/25 to KES 0.54 billion in FY 2025/26 suggesting crowding out effect of external funding.

Factors of Provision Supported by External Funding Sources

External funding is used to buy commodities, pay for deployment and strengthen capacity of human resources for health, pay for installation and maintenance of information systems and generally strengthening of health systems building blocks (governance, financing, and service delivery). An analysis was conducted on each factor of provision individually to establish the resources directed to these factors by source of funding.

Commodities

Table 2 shows the funding for health care commodities in Kenya by source of funding. The annual requirements are obtained from the quantification reports. The withdrawal of funding by the US government has widened the commodity funding gap to KES 34.655 billion in FY 2025/26.

Table 2: Health Care Commodity Funding by Source of funding 2025/26

HPTs	Resource requirements KES billion	KES billion	KES billion	KES billion	KES billion	KES billion
		USG**	Other donors	Global Fund	GOK (CPF)	GAP
HIV	27.11			7.94	4.59	14.47
TB	17.75			3.24	0.7	13.81
Malaria	3.81			2.41	0.99	0.41
Vaccines	11.585		6.50		2	3.085
RMNCH/FP	2.47		5.85	-	0.54	(3.92)
Nutrition	4.96			-	2.08	2.88
Total (excluding RMNCH/FP)						**34.655***

** This total does not include the overfunding in RMNCH programme*
*** At the time of writing this report, the USG had not made a commitment*

Source: From quantification reports, own computation from national approved budgets, adaptation from MOH reports.

Human Resources for Health

The US government through the President's Emergency Programme for AIDS Relief (PEPFAR) supports different cadres of human resources for health in Kenya to work in public facilities. Table 3 shows a summary of some of the US government supported cadres.

Table 3: Number of PEPFAR Supported healthcare Workers by cadres in Kenya, 2024

HRH Cadre	Number of USG supported staff
Clinical Officers	1,973
Doctors	26
Epidemiologists	8
HIV Diagnostic Assistants	661
Laboratory Technologists/Technicians	649
Medical Assistants	5
Nurses	1,249
Pharmacists	45
Pharmacy Technicians	385
Others	36,537
Grand Total	41,538

Source: Authors computation from PEPFAR reports

Most of the US government supported staff cadres are however not aligned with the MoH staff cadres. For example, community health promoters (6390), DREAM mentors (5335), lay workers (1222), mother mentors (1010), peer educators (6252) and testing and counselling providers (3453) are not classified in the MoH staff cadres. These workers provided services in the vertical programs of HIV, TB and Malaria.

The withdrawal of funding has occasioned staff layoffs, further weakening the operational backbone required for service delivery. Table 4 shows the number of PEPFAR supported staff cadres by county at the end of September 2024 which includes the cost of staff if the government were to absorb them at government rates. HRH deployment is a county function, in which the county governments would collectively require KES 47.8 billion annually to absorb all the 41,170 PEPFAR staff. Counties that have a higher HIV burden had more PEPFAR supported staff resulting in a higher annual wage bill. For example, Nairobi County will have an additional annual wage bill of KES10 billion if the county absorbs all the PEPFAR supported staff. Additionally, among the PEPFAR supported staff were regional coordinators who may not be required when the counties hire directly. As such, this analysis generates an upper bound budget if the counties absorb all the PEPFAR supported staff. Counties can undertake a workload indicator survey to determine the optimal number of staff and decide on the number of essential staff to absorb, and this will be lower than what this analysis has shown

Table 4: Number of PEPFAR Supported healthcare Workers by counties in Kenya, 2024

County	PEPFAR Supported staff	Funding Gap for Government to Assume (KES)	County	PEPFAR Supported staff	Funding Gap for Government to Assume (KES)
Baringo County	89	154,843,971	Meru County	452	535,586,558
Bomet County	214	276,185,864	Migori County	3267	3,873,997,436
Bungoma County	783	905,297,369	Mombasa County	2292	2,564,686,421
Busia County	857	926,016,335	Muranga County	437	500,963,683
Elgeyo-Marakwet County	68	87,063,365	Nairobi County	8803	10,158,406,590
Embu County	227	263,216,648	Nakuru County	1407	1,756,472,256
Homa Bay County	3282	3,823,427,809	Nandi County	165	190,354,386
Kajiado County	394	457,896,046	Narok County	333	467,213,586
Kakamega County	1070	1,258,360,961	Nyamira County	291	379,804,965
Kericho County	335	399,391,007	Nyandarua County	171	210,687,997
Kiambu County	2982	3,357,754,325	Nyeri County	265	321,404,597
Kilifi County	1110	1,224,038,733	Samburu County	56	94,469,418
Kirinyaga County	332	378,614,148	Siaya County	2490	2,841,996,369
Kisii County	979	1,090,518,776	Taita Taveta County	144	159,635,689
Kisumu County	3758	4,437,453,148	Tharaka Nithi County	217	252,819,064
Kitui County	571	633,785,468	Trans-Nzoia County	325	366,025,033
Kwale County	252	283,707,140	Turkana County	477	563,734,879
Laikipia County	121	168,620,865	Uasin Gishu County	579	668,353,492
Machakos County	745	845,331,645	Vihiga County	294	350,295,765
Makueni County	475	526,740,610	West Pokot County	57	69,125,071
			Total	**41170**	**47,824,297,487**

Source: authors computation from PEPFAR and MOH reports

The PEPFAR supported healthcare workers include staff providing critical services such as clinical officers, nurses, pharmacists, epidemiologists, data and records staff. The abrupt withdrawal of funding will likely disrupt critical services supported by the above staff. It turns out that the amount required by government to compensate PEPFAR supported staff is far lower than the PEPFAR budget, pointing to the high cost of providing services by donors.

Health Information Systems

Health information systems used to collect, analyze, and disseminate health information in Kenya are highly dependent on external funding. These systems include the EMR systems (Kenya EMR, Chanjo KE, Damu KE, KHIS2 and HIV data systems). These systems are also used for surveillance, monitoring and evaluation of programme implementation. External funders support system upgrades, maintenance, training of human resources, and security. Most of these systems are supported off-budget and therefore requires an in-depth assessment to establish the cost of government taking them over. In COP23, the annual budget for health information systems maintenance for FY 2024/25 was KES513 million.

Direct Beneficiaries of External Funding for Health

Part of the PEPFAR budget supports livelihoods for orphaned and vulnerable children (OVCs), nutrition for HIV positive breast-feeding women, HIV services for key populations etc. The COP23 budget highlights and focuses on areas in which the country still lags in identification and retention of paediatric patients living with HIV disease (COP23). The US government's withdrawal of support implies that interventions on pregnant and breastfeeding women (PBFW), children, and adolescents may not be implemented to scale hence increasing inequities in HIV services access. The other special groups affected by the withdrawal are adolescent girls and young women (AGYW) who are disproportionately vulnerable to HIV and have reported persistent gaps in knowledge of HIV status and limited understanding of associated risks. The withdrawal of PEPFAR resources means that there will be no scale-up of impactful HIV prevention interventions among this group. The PEPFAR budget for these beneficiaries is shown in table 5 below.

Table 5: PEPFAR Budget for Beneficiaries

Beneficiaries	Budget (KES)		
Year	2023	2024	2025
Adolescent Girls and Young Women	4,630,194,000	4,463,528,000	4,131,078,000
Children	525,335,706	955,811,304	921,048,282
Key Populations	3,089,927,000	3,122,892,000	921,048,282
Orphaned and Vulnerable Children	2,205,154,000	2,051,099,000	1,872,320,000
Pregnant and Breast-Feeding Women	1,191,190,000	1,218,453,000	1,126,075,000

Source: Adapted from COP23

Summary of Financial Implications of US Government Funding Withdrawal that need to be Plugged

Analysis of the funding data shows that the withdrawal of the US Government support has created a major funding gap in three broad areas of the healthcare system, health commodities, human resources, and information systems. These three inputs have the most direct impact on health service delivery and outcomes. Table 6 below provides an annual monetary value of the inputs in KES. It is worth noting that the HRH deployment is a devolved function of county governments hence the amounts shown in the table would ideally need to be supported by county government budgets.

Table 6: Summary of funding gap for factor inputs procured at National level

Description	US Government funding withdrawn (KES)
Commodities	34, 655, 498, 268
Human Resources for Health	45, 450, 187, 270
Health information systems support	513, 842, 810

05 Conclusion & Recommendations

Image source: unsplash.com

5. CONCLUSION AND RECOMMENDATIONS

The suspension of US government foreign assistance presents both challenges and opportunities for Kenya's healthcare sector. While the immediate funding shortfall is substantial, it highlights the need for Kenya to build a more self-reliant and resilient health system. This can be achieved by increasing domestic resources mobilization from both public and private sources, gradually integrating donor-funded programs into routine services, and exploring innovative financing mechanisms. This transition, although difficult, can strengthen long-term sustainability and national ownership of Kenya's health system.

The following policy recommendations are proposed for consideration by stakeholder to bridge the funding gap and ensure program continuity:

1) Immediate funding response:

i) The national government should reprioritize and appropriate additional funds for health in FY 2025/26 to bridge the funding gap created by the withdrawal of funding by the US government for strategic commodities (HIV, TB, & Malaria) and maintenance of health information systems.

ii) Since human resources for health (HRH) and health service delivery are devolved county functions, the national government should liaise with Council of Governors secretariat to assist to coordinate and support the county governments in taking over county-related activities that were previously funded by the US government. This includes absorbing the salaries and emoluments of essential frontline staff who were on donor payroll.

2) Medium-term transitioning plan

i) The government should develop a fully costed, time-bound transition roadmap for programs supported by multilateral agencies (Global Fund and WHO) who have announced reductions in their budgets

ii) The government should enhance efforts to increase efficiency in service delivery, supply chain, human resources, and in health information systems to save on cost. This can be achieved through integration of siloed services such as HIV services as well as consolidation of IT systems into an integrated health care system to ensure efficiency in resource use.

iii) The government should initiate discussions with private sector to create a conducive policy environment for the private sector, to enhance their role in unlocking private capital to support service delivery and financing of health care. One such discussion would be to invoke the KEMSA supplementary supplies division (SSD) window to procure commodities on behalf of the private sector to benefit from KEMSA's economies of scale.

iv) The government should leverage the funds flow to facilities through the facility improvement financing (FIF) to fund non-pharmaceutical inputs and improve services as envisaged.

v) The government should explore non-traditional funding sources such as debt swaps, health and impact bonds as well as sin and hypothecated taxes on alcoholic and sugary items. This should be preceded by a review of success stories for these funding models to prepare the ground for adoption and adaptation to local contexts.

vi) The government should initiate discussions with alternative and existing external funders and negotiate for more grants as opposed to loans. In addition, the government should negotiate for external funders to plug into government unfunded priorities preferably through on budget support.

vii) The government in collaboration with development partners should fast track a costed donor transitioning framework that covers the entire health sector.

viii) Leverage Social Health Authority to cover commodities and specialized services for vertical programs previously funded by donors. A detailed assessment of the impact of this policy action to the sustainability of SHA should precede this decision.

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