WORKING PAPER

CONTRIBUTION STORIES REGARDING DANISH HEALTH SECTOR SUPPORT TO KENYA 2004-2024

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Responsibility for content and presentation of findings and recommendations rests with the authors.

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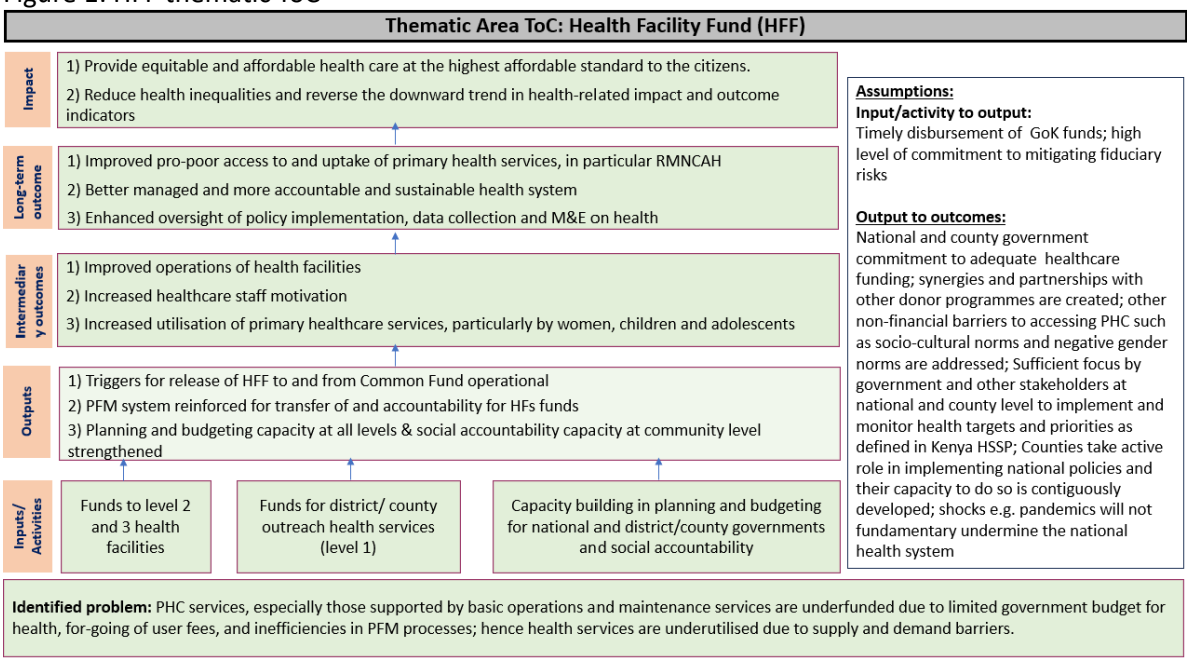
1. Denmark's Contribution to the Health Facility Fund (HFF) across Phases I-IV (2004–2024)

1.1 Introduction

This contribution analysis examines Denmark's long-term support to health facility funding in Kenya from 2004–2024, tracing contribution pathways across HSPS I–V and assessing their plausibility using the overarching and phase-specific ToCs as well as the HFF thematic ToC seen below.

Figure 1: HFF thematic ToC



Denmark has, since 2004, provided consistent support for direct health facility funding to health centres and dispensaries (Levels 2 and 3 in the current facility hierarchy). The intervention began as a pilot in Coast Province (2005–2010) and was subsequently scaled up nationwide in partnership with the World Bank (2012–2016). Following devolution in 2013, Denmark remained the sole development partner (DP) financing all Level 2 and 3 facilities across counties, a role it continues to play. The funding has primarily aimed to cover a portion of the basic recurrent costs at facility level, including cleaning, security, and essential maintenance.

In the most recent programme phase, sustainability has been a central focus, with counties expected to assume increasing responsibility for financing Levels 2 and 3, while Danish support has simultaneously piloted Level 1 funding for Community Health Unit (CHU) outreach activities in selected areas. The contribution analysis explores what changed during the evaluation period, what Denmark contributed, what other factors influenced outcomes, and how these link to the ToC pathways for health systems strengthening, PHC functionality, and equitable access to essential

services. The analysis focuses on the plausibility of Denmark's contribution to observed intermediary results, facility maintenance, staff support, community outreach, and fiscal transparency, and the extent to which these may have supported longer-term trends in Primary Health Care (PHC) service utilisation and system performance.

1.2 Context

Kenya's efforts to expand equitable access to primary health care have unfolded alongside major financing and governance reforms, including the 2004 "10/20 policy," which reduced primary-level user fees to mitigate financial barriers for poor households.[1] While the policy initially improved utilisation, concerns were expressed that it reduced facility-level revenue, limiting managers' ability to respond to problems and maintain operations. To address this gap, the Government piloted Direct Facility Funding (DFF) in Coast Province with Danish support, an approach later scaled nationally as the Health Sector Services Fund (HSSF) with World Bank and Danida backing in coordination with the Ministry of Health (MoH).[2] Under HSSF, funds were channelled directly to health centres and dispensaries through government Public Financial Management (PFM) systems, supported by detailed operational manuals and dedicated oversight structures within the MoH.[3]

The 2013 transition to devolution[4] reshaped health financing responsibilities, shifting authority over facility management and budgeting to 47 county governments. Early interpretations of PFM rules created uncertainty about whether facilities could continue to receive direct transfers, prompting the establishment of a conditional grant system that allowed funds to flow to counties and onwards to facilities.[5] This design balanced compliance with devolved PFM requirements while preserving the operational benefits of direct facility financing. It also enhanced fiscal transparency by applying CRA-recommended allocation formulas and fully integrating transfers into county budgets.[6] However, from FY2021/22 onwards, reliance on the County Governments Additional Allocations Act (CGAAA) introduced recurrent delays. The CGAAA for FY2023/24 was only agreed to in March 2024, with transfers disbursed just days before the end of the fiscal year,[7] while FY2024/25 disbursements were delayed until July 2025.[8] These delays significantly disrupted facility operations, forcing facilities to accumulate debts and counties to undertake supplementary budgeting before spending.[9]

Despite these challenges, the funding mechanism has matured into a key component of Kenya's PHC financing architecture. Counties have progressively increased their co-financing contributions,

[1] Opwora A, Waweru E, Toda M, Noor A, Edwards T, Fegan G, Molyneux S, Goodman C. Implementation of patient charges at primary care facilities in Kenya: implications of low adherence to user fee policy for users and facility revenue. Health Policy Plan. 2015 May;30(4):508-17. doi: 10.1093/heapol/czu026. Epub 2014 May 16. PMID: 24837638; PMCID: PMC4385819.
[2] Mbuthia, Boniface, Ileana Vîlcu, Anne Musuva, and Nirmala Ravishankar. 2023. "Facility Autonomy in the Age of Devolution: County-level Arrangements for Managing Health Facility Revenue in Kenya. Kenya Brief 12." Nairobi: ThinkWell. - https://thinkwell.global/wp-content/uploads/2023/05/Kenya-Brief-12_Facility-autonomy-2023.pdf
[3] Completion Report for Health Sector Program Support Phase II 2012.
[4] Mbuthia, Boniface, Ileana Vîlcu, Anne Musuva, and Nirmala Ravishankar. 2023. "Facility Autonomy in the Age of Devolution: County-level Arrangements for Managing Health Facility Revenue in Kenya. Kenya Brief 12." Nairobi: ThinkWell. - https://thinkwell.global/wp-content/uploads/2023/05/Kenya-Brief-12_Facility-autonomy-2023.pdf
[5] See e.g. County Governments Additional Allocatiosn Bill- Senate Bill no 19 of 2024.
[6] Use of CRA allocation formulas and integration of funds into county budgets.
[7] FY2023/24 CGAAA delays — Act assented to March 2024; disbursement on 25 June 2024.
[8] FY2024/25 CGAAA delays — approval in late April, gazettement 13 May 2025, disbursement on 10 July 2025.
[9] Facility and county coping mechanisms including debt accumulation and supplementary budgets.

from 25% in FY2021/22 to a planned 100% by FY2026/27[10], supported by the fiscal feasibility of integrating facility grants, which represent only 0.2% of total county revenues in FY 2024/25.[11] In parallel, the programme expanded to Level 1 funding in FY2022/23, enabling support to CHUs for outreach activities. For the last three years an annual amount of 127.5 million Kenyan shillings (KSH) has been allocated for CHUs.[12] Over time, the model has evolved from a provincial pilot to a nationally institutionalised system now reinforced by the 2023 Facilities Improvement Financing Act (FIF), which formalises facility autonomy and revenue retention.[13] This trajectory reflects steady progress toward a more sustainable and transparent framework for financing primary care facilities in Kenya.

1.3 Summary of findings

Overall contribution claim: Denmark made a catalytic and enabling contribution to the emergence and continuity of Kenya's primary-level facility-funding system. The evidence shows that Denmark' early piloting support, leadership during national roll-out, and continued engagement through devolution allowed the facility-funding modality to take root and function as a reliable source of operational financing for Level 2 and 3 facilities. By working consistently through government PFM systems, Denmark helped establish a mechanism that counties now rely on for basic maintenance and service continuity within the evolving PHC financing framework. Although Denmark's funding represented a small share of total health expenditure, it filled a critical operational gap often unmet by government or other partners. As such, Denmark's role should be understood as one part of a wider financing ecosystem, necessary for the model's establishment and persistence, but insufficient on its own to drive utilisation or outcome changes, which depend on broader system conditions.	
Rating of Strength of Evidence	**Findings on Govt of Denmark's contribution to the Kenyan Health Sector: Contribution to Facility Funding**
Strong	**1) Denmark contribution to the establishment of Kenya's facility funding system was catalytic.** Evidence strongly suggests that without Denmark, the system would not have emerged or persisted in its national form.
Strong	**2) Denmark played a central role in institutionalising and sustaining the HFF model within Kenyan PFM systems.** Although institutionalisation took time, particularly due to devolution, there is clear evidence that counties (and increasingly national government) are gradually taking over financing from their own revenues. Recent legal reforms have embedded the approach within national PFM rules. Denmark's patient, long-term (over 20 years), system-aligned support and capacity building, was central to this progress. However, ongoing health financing reforms (e.g., Social Health Authority (SHA)) mean the system is not fully entrenched.

[10] Annual inflation has ranged between 5% and 8% per year since 2020. https://www.centralbank.go.ke/inflation-rates/ Note that allocations have remained relative stable in nominal figures for a long period. In 2015, when Danida funding first is reported separately from the World Bank in County Allocation Revenue Act it was 844.7 million KHS, which in 2024 prices would amount to 1.35 billion KSHs – thus almost halved real value while population and number of facilities also increased in the same period

[11] GoK, Office of the Controller of Budget: County Budget Implementation Review Report for FY 2024/25: while Counties approved a combined budget of 600 billion KSH they received 533 billion KSH (summary analysis page iii).

[12] MoH PHC End Eval op.cit 2025.

[13] Facilities Improvement Financing Act, 2023 — establishment of a national framework for facility autonomy

Strong	**3) Denmark made a sustained contribution to the basic functioning of primary care facilities.** Facility funding made a significant and clearly evidenced contribution to the basic functioning/maintenance and physical upkeep of Level 2 and 3 facilities. Over the evaluation period, it has been the most reliable, and often the only, source of operational funding for the facilities.
Strong	**4) Denmark plausibly contributed to improved staff motivation and user experience in funded facilities.** Cleaner, safer and more functional facilities likely improved staff morale and client satisfaction, though systemic constraints, particularly HRH instability and commodity shortages, limited consistency.
Moderate	**5) Denmark made a plausible but non-attributable contribution to health outcomes through improved facility functioning.** Facility funding supported cost effective day-to-day service delivery, although its small share of county budgets (~0.3%) and reliance on other system inputs mean outcome effects cannot be attributed to Danish support alone.
TOC pathway assessment	The ToC assumed that ***IF*** direct funding was provided to primary-level facilities, ***THEN*** local management capacity, facility conditions and staff motivation would improve, enabling more reliable service readiness and contributing to increased utilisation and better outcomes. This was only partially realised. Facility funding clearly improved day-to-day functionality and enabled basic operational problem-solving at Level 2 and 3 facilities, but systemic constraints (HRH shortages/strikes, commodity gaps, supervision weaknesses and fiscal delays) frequently disrupted the link between improved readiness and higher utilisation. National and county commitment to the model strengthened over time, but full institutionalisation and sustainability remain uneven. Given Denmark's small share of total health financing, its contribution was necessary for the modality's existence, but outcome-level changes cannot be attributed to Danish support alone.

1.4 What happened / what changes were observed?

Phase I–II (2004–2010): User fee reform and pilot testing of DFF

- The 10/20 policy reduced financial barriers for patients but reduced facility-level operating revenue, leaving facilities unable to fund basic functions.[14]
- Government piloted DFF in Coast Province (with Danish support), introducing predictable operational grants to Level 2 and 3 facilities.[15]
- Early evidence indicated that DFF improved cleanliness and hygiene, security and safety for staff and patients, reliability of facility opening hours, ability to carry out small repairs and maintain functional space.
- Facility committees became more active in oversight and local management, increasing accountability and responsiveness.
- The pilot demonstrated that small, predictable operational funds could stabilise basic facility functioning and informed national policy thinking on facility autonomy[16] and financial reporting.

[14] Opwora A, Waweru E, Toda M, Noor A, Edwards T, Fegan G, Molyneux S, Goodman C. Implementation of patient charges at primary care facilities in Kenya: implications of low adherence to user fee policy for users and facility revenue. Health Policy Plan. 2015 May;30(4):508-17. doi: 10.1093/heapol/czu026. Epub 2014 May 16. PMID: 24837638; PMCID: PMC4385819.
[15] Completion Report for Health Sector Program Support Phase II 2012.
[16] Mbuthia, Boniface, Ileana Vîlcu, Anne Musuva, and Nirmala Ravishankar. 2023. "Facility Autonomy in the Age of Devolution: County-level Arrangements for Managing Health Facility Revenue in Kenya. Kenya Brief 12." Nairobi: ThinkWell. - https://thinkwell.global/wp-content/uploads/2023/05/Kenya-Brief-12_Facility-autonomy-2023.pdf

Phase III (2010–2013): National rollout through HSSF

- Government scaled the pilot nationally through the HSSF, supported by MoH guidance, manuals, and new financial management structures.
- Level 2 and 3 facilities began receiving operational funds, filling an important financing gap.
- Facilities reported improvements in general upkeep and cleanliness, ability to hire casual workers (cleaners, guards), routine maintenance tasks, and basic operational readiness.
- A dedicated HSSF Secretariat oversaw grant management, strengthening accountability and reporting.
- Predictable funding supported better planning of routine activities and reduced reliance on delayed or uncertain county/sub-county support.
- This period consolidated DFF as a national mechanism and improved transparency in facility management.

Phase IV (2013–2021): Devolution and reconfiguration of facility funding

- Devolution transferred responsibility for health service delivery to 47 counties, shifting decision-making, budgeting, and HRH management away from national structures.
- To safeguard continuity, Government introduced conditional grants for facility funding, aligning the mechanism with devolved PFM requirements while maintaining continuity of direct support.
- Integration of grants into county budgets improved transparency, oversight by the Controller of Budget and Auditor General, and visibility of allocations.
- Rapid expansion of facilities diluted the value of operational grants per facility, though overall service availability increased.
- Despite systemic shifts, facility managers consistently described the grants as the only predictable source of funding for routine operational needs.

Phase V (2021–2025): Funding delays, co-funding transition, and expansion to Level 1
Fiscal delays and operational disruptions

- Introduction of County Governments Additional Allocations Bill (CGAAB) and subsequent CGAAA's caused repeated and severe delays in the disbursement of facility grants.[17]
- In some years, funds arrived only at the very end of, or after, the fiscal year, undermining predictability and compressing spending into short windows.[18]
- Facilities accumulated arrears (cleaning, utilities, casual staff) and struggled to maintain stable operations.

Co-funding and transition to county financing

- Counties were required to progressively increase their share of financing, with most meeting co-funding requirements despite fiscal pressures.

[17] In the previous years after devolution (from FY2013/14) funds for both the large unconditional grants (the" equitable share") and the conditional grants (from both donors and government) were approved through one legal instrument: the County Allocation Acta (CARA), after 2022 the CARA only includes the unconditional grant.
[17] PHC Report FY 2023/24. Analysis of timeliness is also based on (i) The County Budget Reports by the Controller
[18] [18] PHC Report FY 2023/24. Analysis of timeliness is also based on (i) The County Budget Reports by the Controller of Budget- https://cob.go.ke/reports/consolidated-county-budget-implementation-review-reports/ (ii) Budget and Appropriation Committee of the National Assembly Reports- https://www.parliament.go.ke/the-national-assembly/committees/12/budget-an-appropriations-committee and (iii) Hansard Reports- https://www.parliament.go.ke/the-national-assembly/house-business/hansard

- Real grant value declined due to inflation and growth in the number of facilities, reducing operational purchasing power.[19]

Expansion to Level 1 (CHUs)

- Level 1 grants funded CHU outreach, referral strengthening and basic operational activities.
- Over the past three financial years, counties, following national advisories issued in 2022 and revised in 2024 that expanded the allowable number of supported CHUs from 10 to 20, selected 323, then 364 Community Health Units for Level 1 funding, yet only 289 and 294 CHUs respectively ultimately received support (due to counties not meeting minimum conditions), meaning that roughly 5% of facilities benefited and that the specific CHUs funded changed from year to year.[20]

Observed effects at facility level

- Facilities continued to rely on HFF for cleaning and waste management, security, utilities, small maintenance and repairs, and limited outreach support.
- Operational continuity improved where funds were timely, but disruptions (strikes, stockouts, insurance confusion) had pronounced effects on utilisation.

Cross-cutting changes observed across all phases

The facility level funding is widely considered (based on interviews during fieldwork at facility level, at county level and with national stakeholders, as well as reported in past reviews[21] as well as in academic studies[22]) to have contributed to the following **intermediary results** (based on the ToC) some of which are documented by researchers as far back as 2010[23].

- When funds were timely, facilities consistently maintained cleaner, safer and more orderly environments.
    - From our fieldwork it was found that most of the funding (DFF) was spent on salaries for casual labourers, followed by utilises (water and electricity) with limited funds available for repairs and maintenance[24]. MoH own assessments[25] indicated that most facilities spent funding on repair of buildings including paintings, plumbing, electrical work, floor tiling etc
- Most spending went to casual labour (cleaning, security) and utilities, with limited scope for repairs unless counties supplemented.
- Gradual improvements in transparency and governance occurred through facility committees and strengthened reporting systems.

[19] Annual inflation has ranged between 5% and 8% per year since 2020. https://www.centralbank.go.ke/inflation-rates/ Note that allocations have remained relative stable in nominal figures for a long period. In 2015, when Danida funding first is reported separately from the World Bank in County Allocation Revenue Act it was 844.7 million KHS, which in 2024 prices would amount to 1.35 billion KSHs – thus almost halved real value while population and number of facilities also increased in the same period.

[20] MoH PHC Annual Report 2024/25.

[21] Danida 2019: Review of the Effect of Danish Support for Operations & Maintenance to Level 2 & 3 Health Facilities in Kenya, Final Report December 2019 – by Dr Finn Schleimann. "KEMRI 2013: Review of Health Sector Services Fund – Implementation and Experience", KEMRI, May 2013 - https://assets.publishing.service.gov.uk/media/57a08a31e5274a27b2000495/HSSF.pdf

[22] Antony Opwora, Margaret Kabare, Sassy Molyneux, Catherine Goodman, Direct facility funding as a response to user fee reduction: implementation and perceived impact among Kenyan health centers and dispensaries, Health Policy and Planning, Volume 25, Issue 5, September 2010, Pages 406–418, https://doi.org/10.1093/heapol/czq009

[23] Ibid.

[24] These expenditure patterns are also largely confirmed by Opwora et al 2010 op cit.

[25] MoH 2025: Danida End Term Evaluation of PHC (preliminary draft final report October 2025); fieldwork for the study was undertaken in eight counties during 2025: Kitui, Kisumu, Tana River, Narok, Murang'a, Kakamega, Kilifi and Uasin Gishu

- The physical environment of PHC facilities improved incrementally (small scale renovations and better storage) but measurably, enhancing user experience when other system inputs were functional.
    - "the use of DFF funds to renovate buildings, create space for specific services such as laboratory and pharmacy, fence compounds, install security gates, and purchase doors, cabinets, cupboards and locks, was said to have improved storage of drugs, stationery and equipment, and provided more comfortable working conditions for staff and waiting bays for patients. Overall, the environment was felt to have become safer and more attractive for both clients and staff"[26]
- However, operational improvements were frequently overshadowed by shortages in HRH, drugs and equipment and utilization remained highly sensitive to external system shocks, showing the limits of operational grants alone.
- That said, over two decades, HFF evolved from a pilot to an integrated national instrument, reinforced by legislation (FIF Act 2023) and increasing county co-financing.

1.5 What did Denmark do?

Phase I–II (2004–2011): Establishing and testing the model

- Co-designed and piloted the Direct Facility Funding (DFF) model with the MoH in Coast Province, including development of facility-level funding rules and financial reporting templates.
- Provided TA for early system design as part of the wider SWAp, advising on financial flows, governance structures and accountability mechanisms including.
- Developed early versions of fund management manuals, including procurement guidance, financial controls, and facility committee roles, which later informed the national HSSF framework.
- Supported training in Navision accounting software as an interim financial management solution prior to the development and rollout of Government of Kenya (GoK) Integrated Financial Management Information System in counties.
- Funded establishment of the HSSF Secretariat and provided essential operational resources (e.g. 4WD vehicle and computers/printers for all 47 counties) allowing the MoH to manage grants nationwide.

Phase III (2012–2017): National Rollout of HSSF

- Co-financed national rollout of the HSSF with the World Bank, expanding direct transfers to all Level 2 and 3 facilities.
- Supported the establishment of a dedicated HSSF Secretariat responsible for fund flow management, reporting, and facility oversight.
- Funded capacity building for facility in-charges, committees and sub-county accountants on financial reporting and grant management.
- Provided technical support to MoH to develop national manuals, SOPs and supervision tools, strengthening accountability.
- Ensured that direct operational funding remained predictable and uninterrupted during the transition to national roll-out.

[26] Antony Opwora, Margaret Kabare, Sassy Molyneux, Catherine Goodman, Direct facility funding as a response to user fee reduction: implementation and perceived impact among Kenyan health centres and dispensaries, Health Policy and Planning, Volume 25, Issue 5, September 2010, Pages 406–418, https://doi.org/10.1093/heapol/czq009

- Shifted from a broader SWAp approach to an exclusive focus on facility-level operational financing, following the discontinuation of contributions to the EMMS basket (after KEMSA was recapitalised by the World Bank).
- Adapted support to a rapidly changing institutional context, including establishment of two separate Ministries of Health and early preparations for devolution.

Phase IV (2016–2020): Devolution and Transition to County-Based Facility Funding

- Supported the development and operationalisation of conditional grants for facility funding, enabling alignment with devolved PFM requirements while preserving direct support to facilities.
- Co-funded and maintained, with the World Bank, a joint project management unit (PMU) at MoH and the Council of Governors (CoG) to coordinate implementation, reporting and financial oversight across 47 counties.
- Supported counties to meet compliance requirements for banking arrangements, facility committee structures and financial reporting.
- Provided sustained technical assistance to MoH and counties on grant management, performance oversight and integration into county budgets.
- Maintained support during periods of fiscal uncertainty, enabling many facilities to function despite delays in county allocations.
- Did not require county co-funding during this period, acknowledging capacity constraints and allowing counties to stabilise their basic health financing functions.

Phase V (2021–2025): Support during financing reforms, co-funding Transition & expansion to Level 1

- Continued providing operational funding during the transition to the Facility Improvement Financing (FIF) system and amid delays related to new PFM Acts (CGAAB/CGAAA).
- Engaged in ongoing policy dialogue with MoH, Treasury and Council of Governors (CoG) to resolve CGAAA-related delays and promote long-term sustainability of facility financing.
- Supported co-funding arrangements, with counties gradually increasing their share of operational financing for Level 2–3 facilities from 25% to 60% (on track for 100% by FY2026/27).[27]
- Contributed to the expansion (pilot) of HFF to Level 1 (Community Health Units), enabling basic operational support for CHVs, referral strengthening and limited outreach activities.
- Provided technical guidance to national structures during the transition to the SHA and evolving PHC/UHC reforms.
- Became the sole development partner supporting the PMU after the closure of the World Bank's THS-UC project (2023), funding programme management positions at MoH and CoG.[28]
- Strengthened county-level coordination structures by enabling designation of facility-funding focal persons, county accountants, and reporting officers.[29]

[27] Refer to table 3 in the Annex

[28] https://www.oagkenya.go.ke/performance-audit-reports/ In addition to annual financial audit reports the office also undertakes specialised performance audits reports including several in the health and GBV sector. https://www.oagkenya.go.ke/2022-2025-performance-audit-reports/

[29] https://www.oagkenya.go.ke/performance-audit-reports/ In addition to annual financial audit reports the office also undertakes specialised performance audits reports including several in the health and GBV sector. https://www.oagkenya.go.ke/2022-2025-performance-audit-reports/

- Maintained consistency of support during a period of multiple shocks (PFM delays, insurance changes, pandemic disruptions) helping facilities stay functional.

Cross-Cutting Contributions Across All Phases

- Provided long-term, predictable operational financing for primary-level facilities, addressing routine but unfunded tasks essential for service continuity with facility funding being the single largest Danish health investment, amounting to over DKK 530 million (≈45% of all Danish health sector spending in Kenya over 20 years).[30]
- Worked through government PFM and accountability systems, strengthening national ownership and integration into public financing rules.
- **Developed and refined financial management systems** including fund management manuals, reporting tools, banking arrangements, verification processes, and facility committee operations thereby reinforcing transparency and compliance.
- Acted as the anchor DP especially during periods when other partners discontinued their support.
- Provided technical assistance at key transition points (pilot, national roll-out, devolution, conditional grants, FIF reforms), enabling adaptation and continuity across all HSPS phases.
- Supported broader systems strengthening, including supervision structures, use of IFMIS and county Treasury processes, and county-level PFM improvement through Kenya Accountable Devolution Programme (KADP – with World Bank)[31], as well as social accountability initiatives via URAIA (2016–2025 in 11 counties).[32]
- Helped institutionalise the facility-funding model through long-term engagement with MoH, Treasury, CoG, CRA and county health teams, reinforcing consistency across political and administrative transitions.

1.6 What other factors may have been influential in bringing about the observed changes?

Enabling:

- GoK's resource allocation for health rose substantially, both nominally and as a share of GDP (from ~1% to ~2%) and as a share of total public expenditure (from 7.5% to ~10%). From around 2010 onward, GoK funding surpassed development partner contributions.
- Counties consistently allocated around 30% of their expenditures to health, prioritizing recruitment of health workers, rapid expansion of Level 2 and 3 facilities (dispensaries increased from 3,127 in 2013 to 4,546 in 2018 to 10,677 in 2022[33]) and growth in county referral hospitals (17 in 2013 to 23 in 2022[34]).
- A sequence of reforms, including the **abolition of user fees**, **Linda Mama**, and the 2023–2025 UHC legislative package (PHC Act, FIF Act, SHI Act, Digital Health Act, Quality Healthcare and Patient Safety Bill (2025, pending)), created a broad enabling framework for service expansion and financial protection.

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[30] Danida programme documents and completion reports for each of the five program periods.

[31] https://documents.worldbank.org/en/publication/documents-reports/documentdetail/898461518702311127/kenya-accountable-devolution-program

[32] https://uraia.or.ke/about-us/

[33] Council of Governors (2023) Devolution in Kenya: A journey from centralised to devolved governance under the Constitution of Kenya 2010.

[34] ibid

- Danish facility funding constituted only ~0.5% of total county health spending but functioned within a context of rising domestic investment, improving the ability of facilities to make use of operational funds.
- Significant DP support across the health sector amounting to approximately USD 16.6 billion over the evaluation period. Although Denmark contributed only about 1.2%, other partners funded major off-budget inputs, training, equipment, supplies, medicines, vaccines, primarily through vertical programmes.

Constraining Factors

- Frequent health worker strikes, including prolonged national disruptions (e.g., the 2017 strike lasting over 300 days[35] in addition other strikes which occurred[36]), which heavily affected service delivery, staff morale, and continuity of care in addition to delayed salary payments for staff[37].
- Drug stockouts, reported widely during fieldwork and strongly associated with reduced utilization, even where facility conditions and staffing were otherwise adequate.
- The doubling of public facilities without matching staff growth stretched existing HRH across more sites, reducing operational effectiveness and service quality.
- Covid-19, major insurance transitions, and the 2025 USAID stop-work order created significant disruption to national systems (including Kenya health information system (KHIS) functionality), affecting utilisation and continuity of care.
- Late or end-year funding releases in FY2023/24 and FY2024/25 weakened the core ToC assumption of predictable operational funding, forcing facilities to accumulate arrears and limiting the intended improvements.

What the influencing factors mean for the contribution claims overall?

Overall assessment: Overall, the influencing factors indicate that Denmark's contribution to strengthening frontline primary care through Health Facility Funding (HFF) is credible, clearly additional, but inherently bounded. The mechanism Denmark supported—predictable operational funding for Level 2 and 3 facilities—addressed a gap that no other partner filled and became an integral part of Kenya's evolving PHC financing architecture. However, the scale and effects of Danish support were inevitably shaped by much larger forces, including major GoK investments, county-driven expansion of the health system, extensive off-budget vertical programme inputs, and periodic system shocks that directly affected facility performance. As such, Denmark's facility funding can be seen as a distinct and meaningful contributor to improved service readiness, but its influence on wider outcomes such as utilisation, staff motivation, and continuity of services is moderated by broader systemic dynamics that were far more powerful than the grant itself.

[35] Intrahealth Policy Note September 2021 Averting Public Health Sector Industrial Unrest In Kenya: Establishing Stakeholder Work Councils To Foster Harmonious Labor Relations, by Mathew Thuku, Mukami Kathambara, Ann Malubi, Jennifer Kiema, Linah Vihenda, Sarah Atieno, Anne Mungai, Rose Indah, Lulu Keeru, Lucy Njenga, Annette Murunga, Dr. Janet Muriuki, Esther Kariuki, Wycliffe Omanya https://www.intrahealth.org/resources/averting-public-health-sector-industrial-unrest-kenya-establishing-stakeholder-work

[36] Ong'ayo, Gerald et al. 2019. "Effect of strikes by health workers on mortality between 2010 and 2016 in Kilifi, Kenya: a population-based cohort analysis. The Lancet Global Health. DOI:https://doi.org/10.1016/S2214-109X (19)30188-3

[37] During fieldwork in Isilo it was also noted that health workers (like any other County employees) haven't received salaries for two months due to delays in fiscal transfers from central government to the county.

What strengthens Denmark's contribution claim:

- Denmark funded a gap no other development partner addressed, predictable operational resources for Level 2 and 3 facilities, making its contribution uniquely attributable.
- Two decades of continuous support helped institutionalise DFF into national and county systems, culminating in the FIF Act (2023).
- Rising domestic PHC investment increased the system's ability to absorb and use Danish-funded grants.
- Vertical programme inputs often amplified the impact of HFF-funded basic functioning.

What limits the contribution claim:

- Relatively small financial scale of HFF within overall PHC budgets.
- External shocks and HRH/commodity constraints overshadowed improvements HFF sought to support.
- Rapid facility expansion diluted grant value.
- Off-budget DP support and system transitions complicate attribution.

1.7 Plausibility and assessment of Denmark's contribution to HFF

Five main causal pathways, each supported by triangulated evidence across document review, KIIs and quantitative data analysis can be identified and map onto the TOCs developed for HSPS I, II, III.

Pathway 1 – Establishing and sustaining the modality for direct facility funding:
Causal step 1: Denmark played a catalytic and system-shaping role in creating and supporting the design, piloting, national rollout and continuity of DFF, enabling the establishment and sustained operation of a national modality for delivering operational funds to Level 2 and 3 facilities.

Supporting evidence / strong

- Denmark was the sole development partner supporting the initial DFF/HSSF pilot in Coast Province and funded the development of manuals, tools and governance arrangements used in national rollout.
- Denmark and the World Bank jointly led the move to nationwide HSSF, with Denmark providing the majority of external financing and supporting Secretariat functions, supervision tools and PFM compliance structures.
- After devolution, Denmark remained the only DP financing facility funding nationally, enabling continuity during the transition to county PFM systems while other partners' support was geographically limited or short-term.
- Long-term use of GoK systems strengthened institutionalisation, contributing to improved financial reporting, oversight processes (Treasury, CoB, OAG), county co-funding, and legal anchoring through reforms such as the FIF Act (2023).
- Consistent testimonies across government and partners emphasise that the modality "would not have happened" or would not have persisted without Denmark, given the absence of other long-term funders for operational grants.

Pathway 2 – Improving facility functioning and service readiness through operational funding:
Causal step 2: By providing predictable operational funds for Level 2 and 3 facilities (and later Level 1 CHUs), Denmark plausibly contributed to improved day-to-day facility functionality by

enabling routine operational activities (cleaning, utilities, minor maintenance, casual staff), thereby strengthening basic service readiness in Level 2 and 3 facilities.

Supporting evidence / moderate to strong

- Facility grants were frequently the most reliable source of operational funds, especially during periods of delayed county disbursements or limited O&M allocations.
- Use of funds followed consistent patterns across counties primarily cleaning/waste management, utilities, security, and small repairs, activities essential for maintaining a safe and functional service environment.
- For Level 1, allowances and operational funds for CHUs supported community outreach and referral[38], reinforcing links between households and facilities.
- Facility committees became more active and effective where predictable grants allowed them to plan, approve expenditures and exercise oversight.
- Earlier reviews found that DFF/HSSF contributed to "safer and more attractive" facilities, better storage, more usable space, and more comfortable waiting areas for patients.[39]
- Documentary evidence and county interviews confirm that without HFF, many facilities would have struggled to maintain even basic functionality, as county O&M budgets were often insufficient or delayed. They described HFF as more important 'than its 0.5% share' of county health expenditure would suggest.

PATHWAY 3 — Improving Staff Motivation and User Experience

Causal step 3: Facility funding improved the physical environment and operational functioning of Level 2 and 3 facilities, which plausibly contributed to improved staff motivation and more positive user experiences, though these effects were moderated by wider systemic constraints.

Supporting evidence / moderate

- Facilities reported improvements in cleanliness, safety, and general order, creating a more conducive working environment for staff and better waiting conditions for clients.
- Managers used grants to hire cleaners and security staff, supporting consistent hygiene and safety standards that staff viewed as important for morale.
- Predictable operational funds reduced frustration among facility in-charges, enabling them to address immediate operational problems without waiting for delayed county O&M allocations.
- Patient feedback from select counties noted improved waiting areas and general facility conditions, suggesting a positive influence on client experience.
- Qualitative evidence shows that increases in facility use and improvements in user experience were most visible where outreach and facility conditions improved, but these gains were highly sensitive to broader system constraints (e.g. drug stockouts, HRH shortages, salary delays, strikes, and insurance or financing disruptions) which frequently weakened staff motivation and interrupted the causal link between improved readiness and consistent utilisation[40].

[38] ibid

[39] Antony Opwora, Margaret Kabare, Sassy Molyneux, Catherine Goodman, Direct facility funding as a response to user fee reduction: implementation and perceived impact among Kenyan health centres and dispensaries, Health Policy and Planning, Volume 25, Issue 5, September 2010, Pages 406–418, https://doi.org/10.1093/heapol/czq009

[40] Interviews at Isiolo health centre, during the visit our team was shown electronic records of outpatients and took photos of records before and after drugs were availed. The drug stockout was according to interviews part a result of the delays fiscal transfers from ventral government (the equitable share).

Pathway 4 – Supporting RMNCAH and other outcomes as part of a broader system of complementary inputs

Causal step 4: By supporting basic facility functionality and more stable service environments, facility funding may have contributed to improved service utilisation and health outcomes, although these effects are influenced by wider system factors and cannot be attributed to Denmark alone.

Supporting evidence and limits / plausible but weakly evidenced

- HFF helped keep many Level 2 and 3 facilities operational during periods of delayed county funding, supporting continuity of basic services and, in some counties, stabilising client flow.
- Despite representing <1% of county health budgets, facilities consistently viewed HFF as disproportionately important for maintaining essential day-to-day operations.
- Some counties reported improved service availability and client flow when operational conditions stabilised, indicating a plausible contribution to utilisation under favourable circumstances.
- However, utilisation and outcomes were driven largely by broader system factors—HRH shortages, stockouts, salary delays, user fee policies, Linda Mama changes, and wider PHC/UHC reforms—limiting the strength of the HFF link.
- RMNCAH and service coverage trends over the 20 years were mixed and cannot be isolated to HFF's small-scale, operational inputs.
- Previous reviews highlight that attribution to HFF is not possible, given the absence of a counterfactual (all counties received HFF), rotating CHU selection, concurrent domestic and vertical programme investments, and repeated system shocks (strikes, stockouts, COVID-19, insurance disruptions, USAID stop-work order).[41].

Pathway 5 – Contributing (partly unintentionally) to legal and policy reforms for PHC and facility financing:

Causal step 5: Although Denmark did not explicitly aim to secure national legislation on facility financing, long-term implementation of a functioning facility-funding mechanism demonstrated the feasibility of direct transfers and facility autonomy, thereby contributing, alongside other partners, to the development of PHC and facility financing legislation, including the FIF Act and 2023 UHC legal reforms.

Supporting evidence / moderate

- Key informants credit Denmark with having "set the example" by demonstrating over many years that primary-level facilities could manage funds transparently and effectively.[42]
- National guidelines, manuals and oversight structures developed with Danish support provided administrative precedents for facility financial autonomy and informed later policy debates.
- The existence of an operational HFF mechanism shaped policy discussions during devolution on own-source revenue, facility bank accounts and direct transfers.

[41] Danida 2019: Review of the Effect of Danish Support for Operations & Maintenance to Level 2 & 3 Health Facilities in Kenya, Final Report December 2019 – by Dr Finn Schleimann.

[42] [42] In Homa Bay, the CECM-Health and a member of the CHMT reported that Danish support was instrumental in the preparation and passing of The Facility Improvement Fund (FIF) Act (approved and passed by the County Assembly, June 2023). Danish support used to facilitate public participation in developing the Act. HB County Government passed FIF legislation one year before The National Government (National FIF Act passed, August 2024).

- The FIF Act institutionalises many design features that mirror the long-standing Danish-supported HFF model (facility revenue retention, complementary county funding, PHC focus[43]). Counties that had earlier implemented facility funding bylaws, influenced by HFF practice, were often among those advocating for a national legal framework.

1.8 Theory of Change (ToC) assessment

The HFF thematic ToC assumes that **IF** direct operational funds reach Level 2 and 3 facilities and Level 1 CHUs, and **IF** national and county planning, budgeting and accountability capacities are strengthened, **THEN** facilities will function more effectively, staff will be better supported, and communities will face fewer barriers to accessing PHC services. Over time, these improvements are expected to contribute to more equitable PHC access and, ultimately, better health outcomes.

Overall, the observed results align well with the early and intermediate stages of this logic. Evidence from facilities and counties consistently shows that HFF filled a critical financing gap for basic operations (cleaning, security, utilities, minor repairs) and for CHUs, outreach activities. Counties progressively co-financed HFF and expanded PHC infrastructure and staffing, while national reforms, including the FIF Act, strengthened the institutional basis for facility-level financing.

However, the ToC's expectations for higher-level changes in utilisation and outcomes are only partially supported. While HFF helped keep facilities functional, trends in service use and outcomes were heavily influenced by factors outside the HFF pathway such as drug stockouts, HRH shortages and strikes, delayed CGAAA disbursements, insurance-related disruptions, and the USAID 2025 stop-work order. Given the small financial scale of HFF relative to county health spending and the absence of a counterfactual (coverage of all 47 counties), Denmark's contribution to outcome-level change is plausible but not directly attributable.

Table 1: Assessment of ToC assumptions for HFF

ToC Assumption	Extent to Which Assumption Held	Assessment Summary
Timely and predictable disbursement of HFF and GoK funds	Partially / Weak in later years	Early years saw manageable delays, but CGAAA-driven delays in FY2023/24–2024/25 severely disrupted predictability. Late and end-year disbursements undermined the core ToC mechanism of consistent operational funding.
Government commitment to using and strengthening PFM systems	Moderate to Strong	National and county actors, supported by Denmark, consistently used government PFM systems. Oversight by OCOB and the Auditor General largely maintained fiduciary standards.
Sustained GoK and county prioritisation of health financing and co-funding	Strong	GoK's health spending rose as a share of GDP and public expenditure. Counties consistently allocated

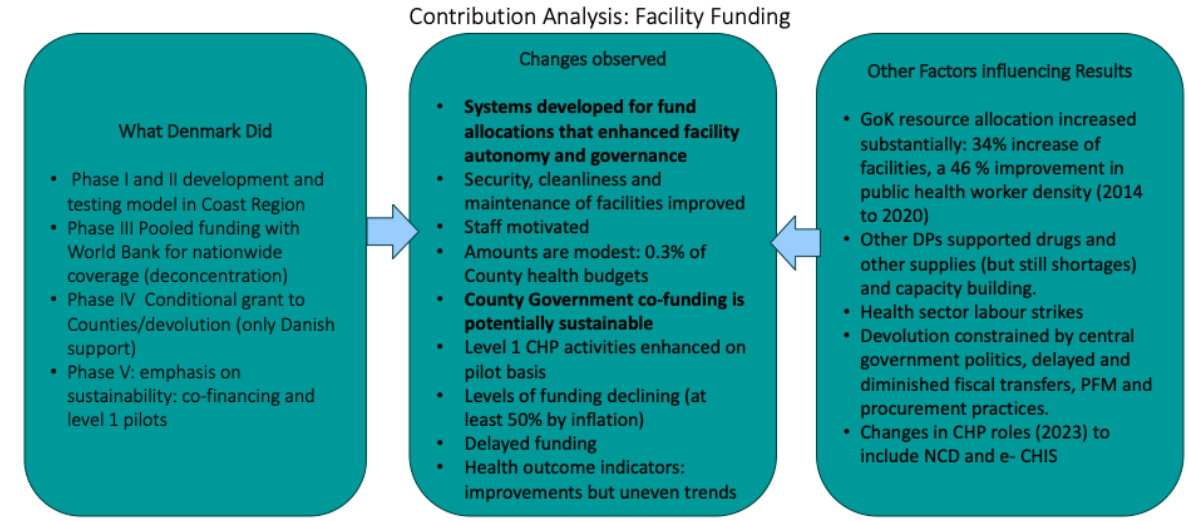
[43] In Homa Bay, the CECM-Health and a member of the CHMT reported that Danish support was instrumental in the preparation and passing of The Facility Improvement Fund (FIF) Act (approved and passed by the County Assembly, June 2023). Danish support used to facilitate public participation in developing the Act. HB County Government passed FIF legislation one year before The National Government (National FIF Act passed, August 2024).

		~30% of budgets to health and progressively increased HFF co-funding toward full financing.
Synergies with other development partner programmes	Moderate	Large-scale off-budget DP investments (HRH, commodities, training, outreach) complemented HFF and improved facility readiness. Synergies occurred but were largely indirect rather than formally coordinated.
Non-financial barriers to PHC (social norms, trust, demand factors) addressed by other actors	Weak	Persistent social, gender, and trust barriers—e.g., suspicion of new insurance enrolment—limited the translation of improved facility functioning into greater utilisation.
Counties develop capacity and take an active role in operationalising PHC reforms	Moderate	Many counties adopted bylaws, expanded PHC infrastructure, hired HRH and engaged with FIF and PHC reforms. However, performance remains uneven; some counties fail to meet HFF conditions or fully appreciate its strategic value.
Health system remains resilient to major shocks	Weak	Multiple shocks (Covid-19, HRH strikes, USAID 2025 stop-work, drug stockouts, insurance reform disruptions) repeatedly disrupted services, undermining the ToC expectation of stable progression from improved readiness to higher utilisation.
Complementary inputs (HRH, drugs, equipment, training) reliably provided by GoK and DPs	Partially	Complementary investments were substantial but inconsistent. Stockouts, staffing gaps and funding interruptions limited facilities' ability to leverage HFF for sustained service improvements.

Taken together, the assessment indicates that the core logic of the HFF ToC is directionally valid for early and intermediate results. Direct facility funding, embedded in government systems and supported by capacity-building, clearly strengthened basic operations and contributed to the ongoing institutionalisation of PHC financing.

However, several key assumptions, especially around timely disbursement, stability of complementary inputs and resilience to shocks, held only partially. These gaps help explain why Denmark's contribution to facility functioning and the financing architecture is strong and credible, while its contribution to utilisation and outcomes is more modest and cannot be isolated from broader system influences.

Figure 2: Summary of Contribution Analysis: Facility Funding



Assessment of strength of evidence : clear evidence for establishment of system, for facility O&M, staff and committee motivation, but moderate evidence for health sector outcomes or utilization ratios.

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2. Denmark's Contribution to Essential Medicines and Medical Supplies (2004 – 2013)

2.1 Introduction

This contribution analysis examines Denmark's support to the development, strengthening, and institutionalisation of Kenya's Essential Medicines and Medical Supplies (EMMS) system between 2004 and 2013. The analysis traces how Danish financial and technical support contributed to the shift from a fragmented and supply-driven medicines delivery system to a national demand-driven ("pull") system, and how this support interacted with wider pharmaceutical reforms and the evolution of the Kenya Medical Supplies Agency (KEMSA). While Denmark's direct support was concentrated in HSPS I -III, its influence continued through the systems and capacities it helped establish.

2.2 Context

Prior to HSPS I, Kenya faced major challenges in ensuring reliable availability of essential medicines. Persistent funding shortfalls, weak storage and distribution capacity, and fragmented supply chains meant medicines often failed to reach facilities[44]. The Kenya Health Policy Framework (1994–2010) aimed to strengthen pharmaceutical management and shift from a centrally determined push system to a demand-driven supply model[45]. This required legal and institutional reforms, leading to the creation of the Kenya Medical Supplies Agency (KEMSA) in 2001 to oversee central procurement and supply chain coordination. Facilities and districts were also expected to build capacity to plan, forecast, and manage their medicines needs within a given resource envelope[46]. At the same time, multiple donor-driven vertical supply chains (e.g. HIV, TB, immunisation) continued to operate outside KEMSA, partly reflecting concerns about its effectiveness[47].

2.3 Key Findings

Strength of Evidence	Key Findings on Govt of Denmark's contribution to the Kenyan Health Sector Contribution to: Essential Medicines and Supplies
Overall contribution claim: Denmark made a strong and catalytic contribution to establishing, institutionalising, and sustaining Kenya's essential medicines supply system, supporting the national transition to a demand-driven (pull) system and strengthening KEMSA's capacity to deliver essential medicines reliably[48].	

[44] Ministry of Health (1994). Kenya's Health Policy Framework, 1994 - 2010
[45] Ibid
[46] Ministry of Health (2004). National Health Sector Strategic Plan II, 2005-2010
[47] Aronovich, Dana Gelfeld, and Steve Kinzett. 2001. Kenya: Assessment of the Health Commodity Supply Chains and the Role of KEMSA. Arlington, Va.: DELIVER/John Snow, Inc., for the U.S. Agency for International Development (USAID)

[48] Reporting against HSPS phases and programme indicators has been inconsistent and often incomplete—particularly in HSPS I and II, though not limited to them. These gaps reduce confidence in the data and limit how reliably Denmark's contribution to improvements in essential medicines, PHC, and UHC can be assessed.

1	Denmark's early investment was essential in establishing and proving the feasibility and value of Kenya's EMMS pull system. Denmark was the only partner investing in system-wide medicines and supply chain reform at a time when other development partners supported parallel vertical procurement and supply systems.
1	Denmark played an instrumental role in embedding the EMMS pull system within national policies, guidelines, and facility-level practice, enabling its institutionalisation; the EMMS pull system remains Kenya's primary essential medical supply mechanism.
1	Denmark's financial and technical support strengthened capacity for commodity forecasting, quantification and ordering at all levels (from facility to national level), and logistical capacity to delivery supplies.
2	Denmark and World Bank's pooled financing and capitalisation of KEMSA improved the reliability of EMMS system by meeting the demand or orders from facilities.[49] This contributed to KEMSA's performance post devolution.
1	Systemic constraints - including early KEMSA capacity weaknesses, funding shortfalls, vertical supply chains,and slow policy implementation moderated the speed and consistency of results across HSPS I–III.
2	Increased EMMS availability contributed to enabling conditions that improved service utilisation, but gains were shaped by broader health system constraints beyond the EMMS programme.
TOC pathway assessment	**Causal Pathway Assumptions** The TOC underpinning Denmark's support assumed that if facilities were supplied with essential medicines through a functional pull system, and if KEMSA could procure and distribute effectively, then stockouts would reduce, wastage would decline, and health services availability and utilisation would increase. The assessment indicates that capacity building at facility and district levels improved forecasting, quantification, ordering, and medicines management. However, early assumptions about KEMSA's operational readiness were overly optimistic and KEMSA's effectiveness did not materialise until the latter part of HSPS II (2010-2012) when institutional transformation (largely funded by World Bank and USAID) began to show results. Prior to this governance, systems, human resources and systems and logistics capacity gaps remained, slowing pull system implementation. Continued existence of other supply chains for vertical donor funded programmes reduced KEMSA's viability as the leading medical supplies organisation. Combined, these factors impacted the timely achievement of HSPS I, II and III results.

2.4 What happened/what changes were observed?

HSPS I (2004-2006)

[49] The revolving funds is a system whereby an initial stock of essential medicines is obtained and then sold at a small mark-up price sufficient to replenish drug stock and ensure sustainability

- Essential medicines and medical supplies (EMMS) availability in rural facilities in pilot provinces North Eastern and Coast reached 86% against a target of 85%.[50]

HSPS II (2007–2011)

- The pull system was scaled up countrywide, based on HSPS I success.
- Pull system records showed significant improvements in the availability of low-cost EMMS.[51]

HSPS III (2012-2016)

- Denmark support EMMS for only one year (2012/2013) after which the support was stopped due to challenges in operationalising the EMMS fund under the devolved system of government[52]
- The pull system was operational in 65 districts against a target of 70 districts – a substantial achievement against the planned output targets.[53]
- Capacity of health facilities and districts to plan, manage and ensure proper (rational) use of medicines was also strengthened.
- KEMSA was fully capitalised to procure medicines and supplies to service demands from health facilities.

2.5 What did Denmark do?

HSPS I

- Denmark piloted the pull system in partnership with MoH and KEMSA. The pull system involved the allocation of drawing rights to individual facilities, and health facilities ordering and receiving quarterly EMMS from KEMSA based on allocated drawing rights.
- Denmark's support focussed on using government systems to procure EMMS and build capacity in procurement and supply at all levels. Specifically, Denmark provided a technical advisor to the MOH to develop pull system guidelines for medical supplies.
- Additionally, Denmark funded training on forecasting, quantification, ordering, storage, and rational drug use for MOH Health staff at national and sub-national levels (Division of Pharmacy, PHMTs and DHMTs, District Pharmacy Facilitators and Level 2 and 3 Health Facility Staff) and Facility Management Committees.
- Technical support and capacity building was extended to KEMSA to establish procedures and systems for implementing the pull system. However, activities were delayed until March 2005 due to a long programme planning period. Given these delays, Denmark supported procurement of 'drug kits' (distributed in North Eastern and Coast Provinces under the push system) to ensure continued availability of essential medicines as the pull system was established.[54]

[50] HSPS I completion report
[51] HSPS I completion report
[52] HSPS III completion report
[53] HSPS III Completion report
[54] HSPS I completion report and interviews with government officials

HSPS II

- Based on the success and lessons learnt from HSPS I, Denmark, in partnership with MOH and KEMSA supported the national roll out of the pull system.
- Denmark supported orientation and sensitisation of DHMTs pharmacy officers and training of health facility staff on the pull system and good medicines management practices and quantification and ordering.[55]
- Denmark, with the World Bank, co-financed the establishment of the EMMS and with the Government of Kenya, pooled funds to support EMMS procurement. Through this fund, Denmark capitalised KEMSA to ensure health facility orders were fulfilled.[56]
- Denmark supported the restructuring of the Division of Pharmaceutical Services, contributing to a comprehensive pharmaceutical sector review, the development of the Kenya National Pharmaceutical Policy (KNPP, 2006-2008) and the draft pharmaceutical master plan to implement the policy, developed in 2009-2010. The policy and master plan addressed organisational and institutional issues including the decentralisation of the Division of Pharmacy, autonomy of KEMSA, and strengthening of the Pharmacy and Poisons Board and the National Quality Control Laboratory. However, by 2012, limited progress had been made around policy implementation.[57]

HSPS III

- With the World Bank and Government of Kenya, Denmark continued supporting the joint funding basket modality to channel support through the EMMS Fund - reinforcing KEMSA's role as the main provider of essential medicines and medical supplies. Danish funds paid for facility EMMS and supported capacity strengthening of pharmacy and commodity management (through short and long-term assistance).[58]
- Support remained intensive in early HSPS III ceasing in late 2013, when changes, following devolution, made it impossible to use the joint basket fund support. By the time support ceased, most funds had been used and KEMSA was adequately capitalised by World Bank (US$75 million) and had become a sustainable business – hence Denmark's decision to discontinue EMMS funding.[59]

2.6 What other factors may have been influential in bringing about the observed changes?

Enabling factors

- Support from other development partners, mainly the World Bank and USAID, reinforced Danish support and helped drive KEMSA's transformation by establishing more efficient and effective KEMSA systems (planning and supply chain management, establishing a buffer stock, strengthening its governance and management systems, enhancing staff capacity, introducing new technologies including a logistics management information system, establishing a transport system and becoming a customer focused organisation).World Bank

[55] HSPS II achievements and lessons learnt, the pull system and appropriate medicines use
[56] HSPS II completion report and interviews with government key informants
[57] HSPS II achievements and lessons learnt, the pull system and appropriate medicines use
[58] HSPS II completion report and interviews with government key informants
[59] HSPS III Completion report

and USAID provided funding and technical advisors embedded within KEMSA to drive the transformation.

- The legal framework of KEMSA was improved through its establishment by an Act of Parliament (2013) which gave KEMSA institutional autonomy from the MoH enabling it to establish and control its own budget.[60]

Constraining factors

- Weak early legal and institutional frameworks for KEMSA (created via gazette notice rather than legislation). This weak legal framework meant KEMSA remained dependent on the MOH budgetary allocations for operational and staffing costs, resulting in lack of institutional autonomy. The relationship between KEMSA and MOH lacked clarity with MoH continuing to undertake KEMSA functions, further undermining KEMSA's effectiveness.[61]
- During HSPS II pull-system scale up was hampered by institutional and operational capacity challenges including warehouse constraints, lack of adequate materials and handling equipment, unreliable IT system and stock records. Inadequate KEMSA capacity (human resources, systems and overall governance and leadership weaknesses).
- Insufficient funding for EMMS procurement resulting in KEMSA inability to fulfil orders; drawing rights were not maintained or aligned with available funding; there were too many items included in the pull system; and there was also no safety stock kept at any level in the supply chain.[62] As a result, pull system scaled up was phased gradually to allow KEMSA capacity to develop (2004 to 2012).[63]
- Parallel medical supply chains serving vertical programmes arguably denied KEMSA access to financial resources that could have bolstered its capacity. Additionally, parallel systems meant that medicines and supplies reached health facilities through different channels burdening facility staff who tracked and report to multiple supply chains.[64]
- Devolution greatly disrupted established supply systems. County governments were no longer obliged to source medicines from KEMSA, which led to mismanagement and scarcity of drugs at health facilities.[65] Devolution was expected to be rolled out over a three-year period; instead, there was an immediate transition without enabling policy ecosystem in place.[66]

What do the influencing factors mean for the contribution claims?

The influencing factors demonstrate that Denmark's contribution claims remain plausible and well-supported, but that the magnitude and visibility of Denmark's effects were shaped - both positively and negatively - by dynamics largely outside its control. Enabling factors such as World Bank and USAID support to KEMSA, improved legal frameworks, and broader sector reforms amplified the

[60] Yadav, P. (014). Kenya Medical Supplies Authority: A case study of the on-going transition from an ungainly bureaucracy to a competitive and customer focused logistical organisation; and World Bank (2019) Health Sector Support Project Implementation Completion and Results Report

[61] HSPS II progress report, 2008 and Yadav, P. (014). Kenya Medical Supplies Authority: A case study of the on-going transition from an ungainly bureaucracy to a competitive and customer focused logistical organisation; HSPS II achievements and lessons learnt, the pull system and appropriate medicines use and interviews with government key informants

[62] HSPS II achievements and lessons learnt, the pull system and appropriate medicines use

[63] HSPS II progress report, 2008 and Yadav, P. (014). Kenya Medical Supplies Authority: A case study of the on-going transition from an ungainly bureaucracy to a competitive and customer focused logistical organisation.

[64] Aronovich, Dana Gelfeld, and Steve Kinzett. 2001. Kenya: Assessment of the Health Commodity Supply Chains and the Role of KEMSA. Arlington, Va.: DELIVER/John Snow, Inc., for the U.S. Agency for International Development (USAID)

[65] World Bank (2019) Health Sector Support Project Implementation Completion and Results Report

[66] HSPS III completion report

results of Denmark's early investments, strengthening the causal chain by accelerating KEMSA's institutional transformation and improving system efficiency. Conversely, constraining factors - including early KEMSA capacity weaknesses, fragmented vertical supply chains, funding shortfalls, and the disruptive effects of rapid devolution—moderated, the intended outcomes of Denmark's support. Taken together, these factors do not weaken the contribution claims; rather, they help explain variations in results across HSPS phases and clarify that Denmark's role was catalytic but embedded within a complex system where contextual constraints shaped the pace and extent of observable change.

2.7 Plausibility and assessment of Denmark's contribution

Three principle causal pathways, each supported by triangulated evidence across document review, KIIs[67] and quantitative data analysis can be identified that also map to the TOCs developed for HSPS I, II, III.

Causal Pathway: Denmark's contribution enabled the development of Kenya's EMMS pull system which is currently operational in Kenya's devolved health system.

Evidence: Strong

- Denmark was unique in supporting the establishment of the national EMMS pull system, while other donors continued to fund parallel vertical supply chains.
- HSPS I pilot achieved 86% availability of EMMS in rural facilities, confirming feasibility and value of the pull system.
- KEMSA's early legal and institutional weaknesses—including lack of autonomy, warehousing constraints, HR gaps, and unreliable IT systems—slowed early roll-out.
- Training improved forecasting, quantification, storage, and rational drug use at multiple system levels.
- Devolution caused major short-term disruption to procurement despite the system's underlying strength, illustrating contextual constraints on Denmark's contribution.
- Denmark's support to KEMSA contributed to the establishment of the pull system currently operational in Kenya's devolved health system. This system has been strengthened and expanded and now supplies medicines to county governments and facilities. Facilities are now able to quantify their needs. KEMSA's role is to supply based on demand and county governments pay KEMSA directly. This "supermarket model" builds on the elements of the pull system established with Danish support.[68]

Causal Pathway: Denmark's financial and technical support to EMMS and the pharmaceutical sub-sector, and the transition from the push to pull supply system, enabled increased availability of low cost and quality essential medicines in health facilities and improved management of medicines. [69]

[67] KIIs included KEMSA staff, most of whom had been in KEMSA since its formation and early HSPS Coordinator and programme officer

[68] Key informant interviews with government officials

[69] HSPS I, II and III completion reports and government key informant interviews

Evidence: Strong to Moderate

- EMMS funding shortages led to misalignment between drawing rights and available budgets.
- Denmark and the World Bank were central to capitalising KEMSA, enabling fulfilment of health facility orders.
- The KEMSA capitalisation – established through Denmark and World Bank support - improved KEMSA's financial sustainability after devolution, hence Denmark's withdrawal of funds.

Pathway three: Denmark contributed to the development of a stronger pharmaceutical ecosystem – policies, institutional reforms and capacity building – that enabled Kenya to implement and sustain the EMMS pull system. However, vertical/parallel procurement and supply systems limited realisation of a harmonised national system integration.

Evidence: Moderate/strong

- Denmark supported key pharmaceutical sector reforms and strategies including the KNPP (2006–2008) and the pharmaceutical master plan (2009-2010).
- The transition from the push to a pull supply systems contributed to increased availability of low-cost and quality essential medicines (levels 2 and 3 facilities) and improved supplies management, rational drugs use and reduced wastage (e.g. reduction in expired medicines).[70]
- Denmark's combined support for essential medicines and supplies and health facility funds, addressed two key determining factors linked to facility utilisation – availability of essential medicines and motivated health care workers and equipment**.**
- Parallel, development partner funded supply chains continued to by-pass the KEMSA system, limiting full integration and the performance of national systems supported by Denmark.

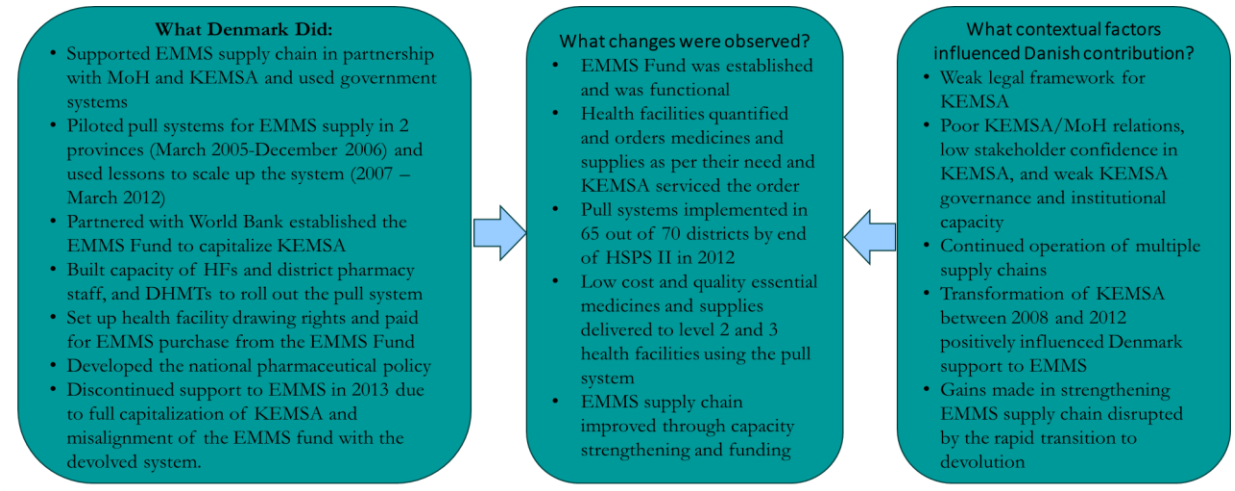
2.8 Theory of Change (TOC) assessment

The TOC assumed that if the pull system is successfully rolled out and KEMSA is capitalised to procure EMMS to meet demand, then essential medicines and medical supplies will be available at Level 2 and 3 facilities, and stock-out time will reduce. This will ultimately contribute to increased utilisation of health facilities which will in turn contribute to improved health outcomes. The contribution analysis demonstrates that several of these assumptions held: the pull system proved feasible and was institutionalised; facility and district capacity improved quantification, storage and rational drug use; and improved EMMS availability did contribute to some extent, to increased service utilisation. However, a key assumption was that KEMSA could play its role effectively. This assumption held true only in part since initially KEMSA's capacity was insufficient to effectively roll out the pull system countrywide. This meant a more gradual scale up was required Additionally,

[70] HSPS I, II and III completion reports and government key informant interviews

devolution and vertical supply chains weakened system performance. Overall, the timing and scale of expected outcomes were moderated by systemic constraints.

Figure 3: Summary of Contribution Analysis EMMS



3. Denmark's contribution to Health Management Information System (2004 - 2012)

3.1 Introduction

This contribution analysis examines Denmark's support to the development, strengthening and utilisation of the Health Management Information System (HMIS) in Kenya. While Denmark's direct financial and technical support to HMIS was concentrated in HSPS I and II (2004–2011), its influence continued into later phases through the systems it helped establish and the capacities it helped build. This contribution analysis traces causal pathways through the TOCs for HSPS I and II.

3.2 Context

Before Danish support began in 2004, Kenya's health sector had multiple, uncoordinated and poorly integrated health management information systems with no effective central coordination to ensure data was made available to all who needed it.[71] Information systems had evolved in a fragmented and ad-hoc manner to meet MoH, development partner, NGO and other reporting requirements.[72] Vertical programmes such as HIV, TB, and Malaria, operated separate systems which hindered the development of one unified national HMIS and repository of data.[73] A 2003 needs assessment found no overarching framework for health information requirements, widespread duplication of data collection, limited feedback of data analysis to facilities, low rates of reporting and inaccurate and incomplete data.[74]

Denmark's support to HIMS took place in the context of the decentralisation of the management of health services, with district health management teams (DHMTs) leading health planning from facility to district level. However, the availability of good quality, timely data was inadequate and hindered the data use for planning purposes. In addition, a national M&E policy and supervision guidelines were not yet in place, and core indicators for use by DHMTS had not been finalised.[75] [76] [77]

[71] Ministry of Health (1994). Kenya's Health Policy Framework

[72] Health Sector Support Programme phase 1 document and Aga Khan Health Service Kenya (2005). Community Health Department. Leading the Information Revolution in Kwale District, Policy Brief no. 5 Available at C:\Documents and Settings\kizit

[73] Health Sector Support Programme phase 1 document

[74] Aga Khan Health Service Kenya (2005). Community Health Department. Leading the Information Revolution in Kwale District, Policy Brief no. 5 Available at C:\Documents and Settings\kizit

[75] Health Sector Support Programme phase 1 document

[76] Denmark, Ministry of Foreign Affairs (2004). Appraisal of the Health Sector Programme Support to Kenya, Phase 1

[77] Ministry of Health (2004). National Health Sector Strategic Plan II

3.3 Key Findings

Strength of Evidence	Key Findings
Overall contribution claim: Denmark made a strong and catalytic contribution to the emergence, institutionalisation and sustained use of Kenya's HMIS	
1	**1. Denmark played a catalytic and foundational role in establishing Kenya's national HMIS.** Danish support was the only significant external investment in HMIS during the critical early years (HSPS I–II), enabling the development, piloting and national rollout of harmonised tools and reporting systems.
1	**2. Denmark's support enabled the transition from paper to digital HMIS platforms, including DHIS2.** Denmark supported the piloting and scale up of the Kwale Model and supported the MOH to adopt and scale up DHIS2 countrywide. The Kwale HMIS model, the unified reporting tools, and the DHIS2 platform still form the backbone of routine health information flows across the country.
1	**3. Danish support strengthened national and subnational leadership, capacity, and ownership of HMIS.** Working through MOH structures and systems, Denmark's support for training, supervision, and indicator harmonisation, contributed to government ownership and technical leadership, enabling the HMIS Division and District Health Management Teams to take increasing responsibility for data quality, reporting, and use.
2	**4. Danish support helped establish and operationalise the HMIS, but limited support to ensuring data use and monitoring, meant its practical contribution to decision-making is unclear.** Moreover, many vertical programmes continued to operate parallel data systems, reducing the effectiveness of 'one' HMIS.
TOC pathway assessment	The theory of change underpinning Danish support to HMIS assumed that the central level HMIS staff will be interested and support HMIS implementation and that the health facilities and districts effectively use the information and have resources to support decisions The **assessment** indicates that the HMIS staff at central level supervised the implementation the Kwale HMIS Model and the DHIS2; provided leadership in the revision and development of standardised indicators and definitions and managed the reporting from districts to national level (in the case of the Kwale HMIS model) and reporting through DHIS2. Health facilities and DHMTS were trained in data use but there is limited evidence to support the assessment of whether and how this data was used especially at facility and district levels. Despite national harmonisation efforts, Kenya's HMIS remains partially fragmented as several development partners continue to use parallel information systems, leading to duplicated reporting and limiting DHIS2's role as a fully unified platform.

3.4 What happened/what changes were observed?

HSPS I (2004-2006)

- The Kwale HMIS model was developed and piloted, providing a harmonised set of paper-based tools and district level aggregation and reporting framework[78].
- The model was rolled out to 16 districts (target was 15).
- Monthly data were aggregated using an Excel based system and transmitted via a File Transfer Protocol, enabling data from all districts to be available at the national level for the first time. This was a huge improvement from the past system of transmitting paper-based data by post from districts to national level[79],[80].
- Despite improvements, it was recognised that the Excel based system had limitations.[81] [82]

HSPS II (2007-2011)

- The Kwale Model was rolled out countrywide but was prone to data quality gaps due to lack of inbuilt quality control features; and could not undertake comparative analysis across facilities. Data management and analysis was also time consuming and labour intensive given the large amount of excel-based data that needed to be analysed to produce reports.[83]
- MOH initiated review of existing automated databases to address the Kwale Model limitations.[84] [85] [86] [87]
- MOH adopted DHIS2 based on University of Oslo model.
- DHIS2 was piloted in selected districts and rolled out countrywide by end of HSPS II[88].
- Number of active DHIS2 users and the volume of data entered into the system increased rapidly as shown in Figure 1 below.
- By the end of Danish support to HMIS in February 2012 a total of 81% of the districts were reporting through the DHIS in timely manner.[89]

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[78] Manya, A, et al. (2012). National Roll out of District Health Information Software (DHIS2) in Kenya, 2011 – Central Server and Cloud based Infrastructure. Available at ISTAfrica_Paper_ref_139_doc_4776 (2).pdf

[79] Manya, A, et al. (2012). National Roll out of District Health Information Software (DHIS2) in Kenya, 2011 – Central Server and Cloud based Infrastructure. Available at ISTAfrica_Paper_ref_139_doc_4776 (2).pdf

[80] Key informant interviews with Government officials.

[81] Karuri, J. et.al. 2014. DHIS 2 The tool to improve health data demand and use in Kenya. Available at DHIS2TheTooltoImproveHealthDataDemandandUseinKenya.pdf and the Appraisal of the Health Sector Programme Support to Kenya phase 1 report

[82] Karuri, J. et.al. 2014. DHIS 2 The tool to improve health data demand and use in Kenya. Available at DHIS2TheTooltoImproveHealthDataDemandandUseinKenya.pdf and the Appraisal of the Health Sector Programme Support to Kenya phase 1 report

[83] Key informant interviews with MOH HMIS staff

[84] Karuri, J. et.al. 2014. DHIS 2 The tool to improve health data demand and use in Kenya. Available at DHIS2TheTooltoImproveHealthDataDemandandUseinKenya.pdf and the Appraisal of the Health Sector Programme Support to Kenya phase 1 report

[85] Manya, A, et al. (2012). National Roll out of District Health Information Software (DHIS2) in Kenya, 2011 – Central Server and Cloud based Infrastructure. Available at ISTAfrica_Paper_ref_139_doc_4776 (2).pdf

[86] HSPS I and II progress and completion reports; and interviews with MoH HMIS staff and staff who participated in Danish HSPS I and II

[87] Key informant interviews with MoH HMIS staff and staff who participated in Danish HSPS I and II and review of documents

[88] Interviews with government officials

[89] HSPS II completion report

- Capacity built among healthcare staff, information and records officers and district health management teams due to prior training during the roll out of the Kwale HMIS Model facilitated the rapid scale up of DHIS2.

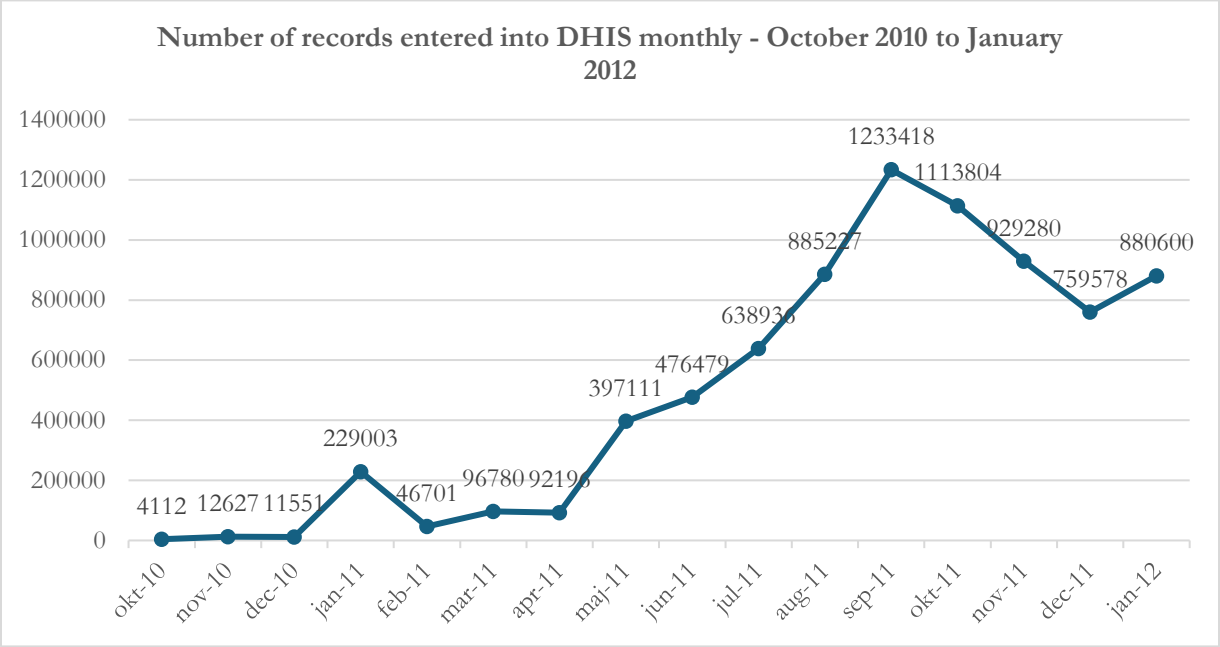

Figure 1: Trend in monthly data entry into DHIS Oct 2010-Jan 2012
Source: Manya, A, et al. (2012). National Roll out of District Health Information Software (DHIS2) in Kenya, 2011

3.5 What did Denmark do?

HSPS I: Foundational Investments

- Denmark provided financial support for the design and the scale up of the Kwale HMIS Model, through piloting the system in 16 districts covering two provinces (North Eastern and Nyanza). This was done in partnership with the Aga Khan Health Services and MOH.
- Financial and technical support for comprehensive analysis of country-wide HMIS to form a baseline; capacity building and training of PHMTs and DHMTs, health records and information officers at district level on computer and internet literacy and data management, training of healthcare providers in data recording and reporting[90].
- Development of standardised indicators and indicator definitions and development and distribution of data collection tools to all health facilities[91].
- Denmark provided financial support for the purchase of equipment (duplicators, computers and printers)[92].

[90] HSPS I progress and completion reports

[91] Ibid.
[92] Ibid.

- Financial and technical support to MOH Division of HMIS and provinces for coordination, supportive supervision and policy reform.[93]
- Denmark supported technical advisors placed in MOH and in Coast and North-Eastern Provinces to provide technical guidance and mentorship to the teams implementing the HMIS systems.

HSPS II (2007-2008) and HSPS III (2009-2012)

Denmark supported the scale up of the Kwale Model of HIMS countrywide. However, during this period, the limitations of this model emerged, and the country adopted DHIS.

- Denmark shifted its support to assist countrywide implementation of the DHIS, in partnership with the University of Oslo.
- The University of Oslo played a technical and mentorship role in the implementation of the DHIS.
- Denmark's support to University of Oslo supported more intensive capacity building of healthcare providers and health records and information officers, establishment of 'super-users' of the system, purchase of additional information technology (IT) equipment, testing of the DHIS system in pilot districts, countrywide implementation of the system, capacity building for the HMIS team.[94]

3.6 What other factors may have been influential in bringing about the observed changes?

The evolution of Kenya's HMIS was shaped by a range of system, contextual, institutional and political factors which interacted with Denmark's support, sometimes enabling or constraining progress.

Enabling

- Growing government ownership and technical leadership by the MOH to the development of a unified system.The Health Information Policy (2008) and the Strategic Plan for Health Management Information System (2009-2014) articulated a clear vision for integrated HMIS and created a supportive policy environment. The strategic plan recognised the gaps in the Kwale HMIS Model and prioritised the establishment of a web-based (automated) information system which formed the basis for the adoption and roll out of DHIS2.[95]
- Over time, the MOH HMIS Division increased its capacity to develop guidelines and supervise counties. Interviewees consistently noted that strong technical leadership, including regarding the adoption of DHIS2 was key to successful implementation of DHIS2 and contributed to sustaining its use beyond the programme period. Significant investment in health data systems including DHIS2 by USAID after Denmark's support ended, also likely enabled sustained use.
- Improved internet connectivity in the country and real-time utility of the software which made data accessible from anywhere and anytime.[96]

[93] Ibid

[94] Manya, A, et al. (2012). National Roll out of District Health Information Software (DHIS2) in Kenya, 2011 – Central Server and Cloud based Infrastructure. Available at ISTAfrica_Paper_ref_139_doc_4776 (2).pdf

[95] Usaid/Kenya (2010). Assessment of National Monitoring and Evaluation and Health Management Information Systems. Available at USAID/KENYA: ASSESSMENT OF NATIONAL MONITORING AND EVALUATION AND HEALTH MANAGEMENT INFORMATION SYSTEMS

[96] Manya, A, et al. (2012). National Roll out of District Health Information Software (DHIS2) in Kenya, 2011 – Central Server and Cloud based Infrastructure. Available at ISTAfrica_Paper_ref_139_doc_4776 (2).pdf

Constraining

- Continued creation of more districts affected data management and analysis while the split of MOH into two ministries (Ministry of Medical Services and Ministry of Public Health) following the post-election violence in 2008 weakened the leadership of the health sector and slowed the pace of programme implementation with most development partners adopting a 'wait and see' attitude.[97]
- Vertical programme investments reinforced fragmentation, pulled resources from one HMIS, and limited interest from some development partners to support a unified HMIS left Denmark as the sole funder in this area[98]. Parallel monitoring systems included the Malaria Information and Acquisition System, Community-Based Programme Activity Reporting, the Kenya HIV/AIDS Programme Monitoring System, and information systems for family planning, reproductive health, immunization, nutrition, tuberculosis.[99] Other development partners, mainly USAID,[100] took up the support to DHIS after Danish support ended in 2012.[101]
- DHIS had its own limitations. The system did not capture inpatient data and did not allow for individual patient monitoring. In addition, this system only captured the minimum core indicators, leaving out many other indicators for programmes to track on their own. Due to this, programme specific information systems have continued to exist alongside DHIS and Electronic Medical Records (EMR) systems have also been established to monitor patient treatment.[102]

What do the influencing factors mean for the contribution claims?

The enabling and constraining factors help explain why Denmark's contribution to Kenya's HMIS was both catalytic and yet partially limited. Enabling conditions such as growing MOH ownership, strong technical leadership, supportive national policies, improved connectivity, and later donor investments - strengthened the plausibility that Denmark's early foundational support directly enabled the emergence and institutionalisation of HMIS. At the same time, constraining factors - continued fragmentation from vertical programmes, political disruptions, structural limits of the Kwale model, and DHIS2's own constraints - explain why sustained data use for decision-making is weaker. Together, these factors reinforce the contribution claim by showing that Denmark's inputs were necessary and influential, but not sufficient to resolve broader systemic barriers that shaped how fully the HMIS could be unified and used across the system.

[97] HSPS II Programme Completion report
[98] HSPS II completion report and HSPS II achievements and lessons learnt: Health Management Information System
[9999] Usaid/Kenya (2010). Assessment of National Monitoring and Evaluation and Health Management Information Systems. Available at USAID/KENYA: ASSESSMENT OF NATIONAL MONITORING AND EVALUATION AND HEALTH MANAGEMENT INFORMATION SYSTEMS
[100] Centre for Health Solutions-Kenya, Overview of Afya Info Programme. Available at: https://chskenya.org/afya-info/#:~:text=Afya%2DInfo%20was%20a%20USAID%2Dfunded%20project%20that%20sought,Kenya%20for%20a%20strong%2C%20unified%20National%20Health
[101] HSPS II completion report and HSPS II achievements and lessons learnt: Health Management Information System; Karuri, J. et.al. 2014. DHIS 2 The tool to improve health data demand and use in Kenya. Available at DHIS2TheToolToImproveHealthDataDemandandUseinKenya.pdf and the Appraisal of the Health Sector Programme Support to Kenya phase 1 report; and interviews held with current and former HMIS managers
[102] Interviews with MoH HMIS staff, staff who participated in Danish HSPS I and II and county government staff

3.7 Plausibility and assessment of Denmark's contribution to the development and rollout of Kenya's HMIS

Two main causal pathways, each supported by triangulated evidence across document review, KIIs and quantitative data analysis can be identified and map onto the TOCs developed for HSPS I, II, III.

Pathway one: Denmark contributed to the development of HMIS which paved the way for DHIS and DHIS2

Evidence: Strong

- HSPS I – II (2004-2012): Strong and direct contribution, with HSPS I widely understood as Denmark's most direct and influential phase of contribution. MOH officials consistently stated that HSPS I marked the first time Kenya had a coherent model for routine health information reporting.
- Denmark, as sole and primary development partner, was instrumental to supporting the development of a national HMIS, while other development partners in health such as the Global Fund, GAVI, PEPFAR, supported separate programme specific information systems.
- Denmark's support to the piloting of the Kwale system and subsequent roll out meant Denmark had a direct contribution to making data available from all districts at the national level for the first time.[103]
- Denmark's support to the Kwale Model directly informed the adoption and implementation of the DHIS2 which addressed limitations of the Kwale HMIS. DHIS2 improved on the Kwale Model by producing a web-based solution but the foundations have remained the same i.e. data collected from facility level using standardised registers and reporting tools and guided by standardised core indicators.
- The DHIS2 system is still the core HMIS system in Kenya that provided data for core national indicators, while other systems exist to serve data needs for specific programmes.

Pathway 2: Denmark's approach of working through Government systems supported institutional capacity, and it is plausible that capacity was sustained after direct support ended.

Evidence: Moderate/strong

- Denmark's financial and technical support contributed to the leadership role that MOH played in rolling out DHIS2, strengthening government ownership of the system and contributing to the sustainability of the system to date.[104]
- Capacity building and DHIS2 enabled the health managers from facility to national level to make simple and customised data analysis. The system also improved dissemination of health data by allowing public access.[105]

[103] This is evidence from MOH HMIS staff, and staff of HSPS I and II and documents reviewed including the HSPS completion reports and surveys conducted on the HMIS in Kenya

[104] HSPS II completion report and HSPS II achievements and lessons learnt: Health Management Information System

[105] Karuri, J. et.al. 2014. DHIS 2 The tool to improve health data demand and use in Kenya. Available at DHIS2TheToolToImproveHealthDataDemandandUseinKenya.pdf and the Appraisal of the Health Sector Programme Support to Kenya phase 1 report; and interviews held with HSPS I and II staff

- Interviewees described the shift to DHIS as transformational, enabling central managers to access aggregated data without waiting for paper reports. Interviews cite Denmark's support as catalytic for HMIS reform.
- The adoption of DHIS2 built on earlier HMIS models, architecture and capacities previously supported by Denmark.

3.8 Theory of Change (TOC) assessment

The changes observed are in line with the Theory of Change (ToC): That IF the capacity and infrastructure for HMIS and supportive supervision is strengthened to successfully roll out the HMIS, THEN the system will make data available to decision-makers and inform planning and improvement of health services management. With Danish support, both the Kwale HMIS Model and DHIS2 were successfully rolled out countrywide, reports from health facility level were transmitted upwards to the national level and information was accessible to decision-makers.

Underlying assumptions for the ToC held true to a certain extent. The assumption that central-level staff were interested and motivated to implement M&E and HMIS held true. The Division of HMIS was involved in the supervision of the implementation of the Kwale HMIS Model and led the implementation and monitoring of DHIS.[106] The assumption that health facilities and districts effectively use the information and have resources to support decisions made held true to a lesser extent. Although Denmark supported the strengthening of DHMTs' capacity in planning and budgeting in the context of decentralisation, it did not support specific interventions related to data use such as data reviews and analysis.[107] The MOH ownership and leadership was a necessary condition but provide insufficient in establishing a truly unified HMIS as most development partners remained outside system.[108]

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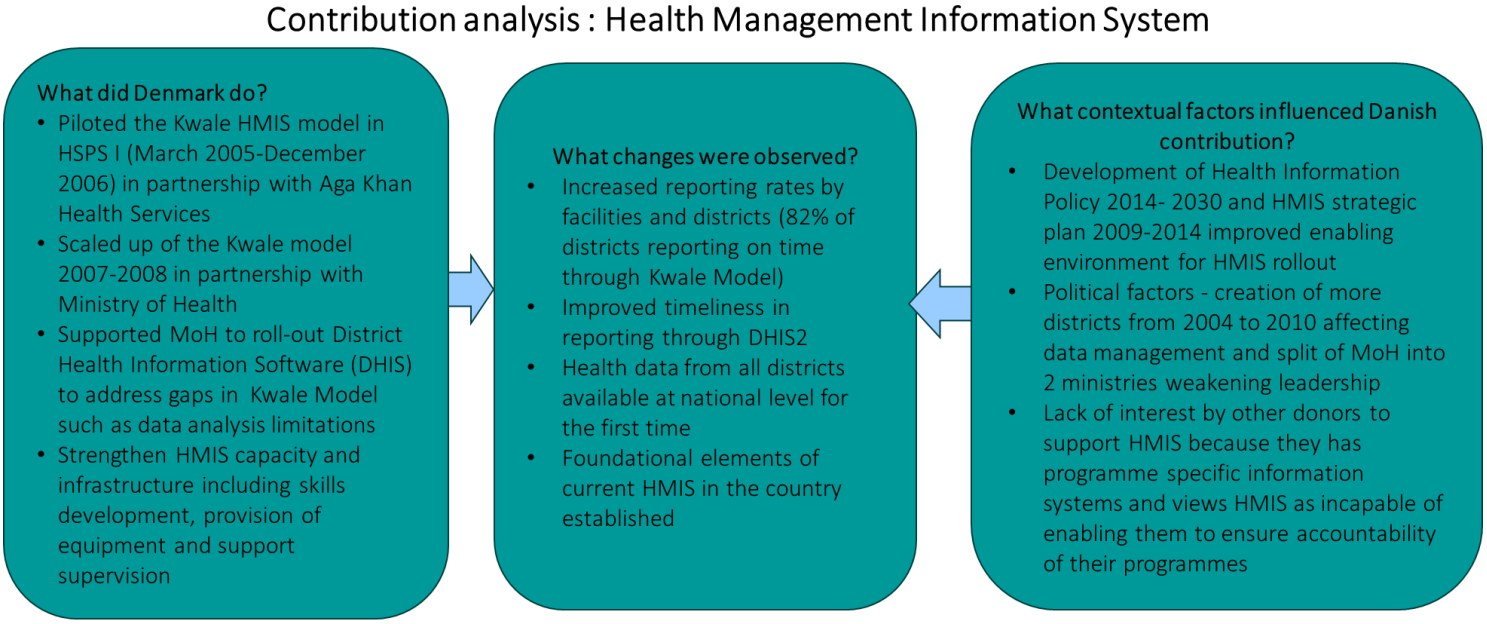
[106] Interviews with HSPS I and II staff and Manya, A, et al. (2012). National Roll out of District Health Information Software (DHIS2) in Kenya, 2011 – Central Server and Cloud based Infrastructure. Available at ISTAfrica_Paper_ref_139_doc_4776 (2).pdf

[107] Review of the Health Sector Programme Support documents for phase I and II and completion reports

[108] Key informant interviews with HMIS staff, staff of HSPS I and II and county health department staff

Figure 4: Summary of contribution analysis for Health Management Information System and monitoring and evaluation



Assessment of strength of evidence (clear evidence for)

- Establishment of the Kwale HMIS Model making data available from all districts at national level
- Established the foundational elements underpinning current HMIS in the country
- Denmark as the only main development partner that supported Kenya to roll out both Kwale HMIS model and DHIS

4. Denmark's contribution to RMNCAH/SRHR & GBV efforts and PHC/UHC reform priorities across Phases I-IV (2004–2024)

4.1 Introduction

This contribution analysis examines Denmark's support to Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH), Sexual and Reproductive Health and Rights (SRHR), and Gender-Based Violence (GBV) prevention and response in Kenya from 2004–2024. It traces plausible Danish contributions across HSPS phases I–V, focusing on system strengthening, service availability and utilisation, survivor-centred GBV response, and alignment with PHC and UHC reforms. The analysis uses document review, KIIs and routine data trends to assess causal pathways and the strength of evidence.

While RMNCAH/SRHR/GBV programming intensified from HSPS III onward, earlier phases contributed foundational investments in child health, outreach, facility financing and ASRH tools that shaped subsequent progress. Across all phases, Denmark represented approximately 1% of Kenya's ODA but maintained a consistent strategic focus on underserved ASAL counties and on GBV system institutionalisation.

Table 2: Overview of primary modalities of Danish support to RMNNCH

Phase	Primary modalities
HSPS I (2004–2006)	IMCI and adolescent SRH training; initial mobile services; start of health facility funding (HSSF pilot).
HSPS II (2007–2011)	Infrastructure & mobile clinics in North-East; housing for health workers; accelerated PHC fund rollout.
HSPS III (2012–2016/17)	Amref SRHR project in 5 ASAL counties; GVRC core funding; early GBV referral network formation.
HSPS IV (2017–2020)	UNFPA H6 RMNCAH (6 counties); scale-up of GBV clinical package and one-stop centres; PHC/UHC conditional grants.
HSPS V ACCELERATE (2021–2025)	Triple Zero agenda (zero unmet family planning need, zero preventable maternal deaths, zero GBV); inclusion of GBV DHIS2 indicator; ASRHR and county system strengthening.

4.2 Short context

Kenya has faced persistently high maternal and neonatal mortality for two decades, largely from preventable causes such as haemorrhage, hypertensive disorders, sepsis and unsafe abortion.[109] Access to timely, quality emergency obstetric and newborn care has been constrained by long distances, insecurity, limited transport, and weak referral systems, particularly in arid and semi-arid (ASAL) counties.[110] Structural gender inequalities, harmful practices (FGM/C, child marriage) and norms discouraging facility delivery further reduced SRHR/MNCH care-seeking and contributed to preventable deaths.[111] Although devolution opened space for county-led planning, uneven capacity, HRH shortages, recurrent strikes and commodity stock-outs constrained progress.[112]

[109] Kenya Confidential Enquiry into Maternal Deaths (CEMD) Reports; KDHS 2014/2022 MMR Trends.
[110] RMNCAH Contribution Analysis Context Review (barriers related to distance, referral, insecurity).
[111] National Adolescent Sexual and Reproductive Health Policy Analysis; FGM/C and HTP studies cited in RMNCAH CA.
[112] Health Sector Human Resources Assessment; HSPS IV Completion Report (industrial actions and system constraints).

Despite growing national policy attention to GBV, most survivors continued to face limited access to comprehensive health and justice services. Fragmented data systems, weak medico-legal capacity and poor coordination between health, police and prosecutorial services restricted accountability.[113] GVRC and later ACCELERATE programming highlighted persistent barriers, including low awareness, provider capacity gaps, stigma and fear of retaliation. Before GBV indicators were added to DHIS2 in 2023, national reporting relied on partial facility data and CSO systems, limiting visibility and resource allocation.[114] These constraints shaped service needs and underpinned the rationale for Danish-supported RMNCAH/GBV investments.

4.3 Summary findings

Overall contribution claim - Denmark plausibly contributed to improved availability and utilisation of essential RMNCAH/SRHR services and to strengthened GBV prevention and response, especially in underserved ASAL counties. This contribution is supported by a clear line of sight between Danish inputs and observed system changes across PHC financing, outreach, service readiness, GBV clinical pathways and survivor reporting. Progress occurred within a wider partner ecosystem and amid persistent systemic constraints—particularly HRH shortages, commodity insecurity, data limitations and sociocultural norms—that shaped the scale and sustainability of outcomes.	
Evidence Strength	**Consolidated Key Findings**
1	**1) Denmark's long-term and ASAL-focused engagement plausibly contributed to continuity in RMNCAH/SRHR service readiness and access.** Denmark's sustained presence in underserved ASAL counties, beginning with early infrastructure, training and mobile outreach under HSPS I–II and continuing through Amref, H6 and ACCELERATE, helped maintain essential service readiness through O&M support, outreach and foundational MNH system strengthening. Although modest in scale, this support filled critical gaps in remote counties with limited partner presence, aligned with Kenya's PHC and UHC equity agenda, and was valued by stakeholders facing persistent HRH shortages, infrastructure constraints and geographic isolation. **2) Denmark's programming reinforced national reforms and complemented larger partner investments.** Across HSPS phases, Danish support was well-aligned with major shifts in the health sector, including devolution, PHC network development and the UHC agenda. Danish-funded TA, systems support and community engagement complemented significant investments by DFID/FCDO, USAID, the World Bank/GFF and UN agencies. Its contribution was therefore one of strategic complementarity, helping counties operationalise national priorities and strengthening parts of the system that enabled wider reforms to take effect. **3) Denmark plausibly contributed to to strengthened GBV prevention and response and county-level stewardship of RMNCAH/GBV services, within a wider multi-actor ecosystem.** Support to GVRC, Amref and ACCELERATE strengthened GBV case management, documentation, medico-legal linkages and survivor services, while the contribution of the H6 project remains uncertain due to data quality gaps. Denmark's support sustained technical capacity, expanded good-practice models in counties with limited services, and strengthened planning, supervision and resource flows through HSSF/HFF mechanisms and TA to the MoH and counties. However, national adoption of tools, protocols and indicators, such as DHIS2 GBV updates, reflected collective action by government and other development partners. Denmark's role added coherence and continuity rather than driving system-wide change.
2	**4) — Improvements in RMNCAH/SRHR utilisation reflect multiple drivers, with Denmark contributing to enabling conditions despite documentation limitations**

[113] ACCELERATE Programme FGD and Survivor Pathway Assessment (2023–2025).
[114] DHIS2 GBV Indicator Integration Technical Notes (2023) and pre-DHIS reporting limitations.

	Positive trends in ANC visits, skilled deliveries, family planning uptake and EmONC readiness in supported counties emerged through a mix of national policies (e.g., Linda Mama, FP2020), devolution, PHC/UHC reforms, partner financing and sociocultural dynamics. Denmark contributed by strengthening enabling conditions, facility readiness, outreach, commodities and community awareness, within this broader landscape. Incomplete records in HSPS I–II, inconsistent project reporting and discrepancies with national sources reduce the precision of contribution estimates, but the consistency and systems-focused nature of Danish support across HSPS III–V provide credible evidence of a meaningful contribution to RMNCAH/SRHR access and GBV response capacity.
ToC pathway assessment	The ToC's core logic, that strengthening PHC capacity, outreach, referral and survivor-centred GBV services would increase RMNCAH utilisation and improve GBV reporting and care, is broadly supported by evidence. Improvements in family planning, FIC, ANC4+, SBA, GBV documentation and pathway navigation align well with the expected causal pathways. • Assumptions[115] that held strongly: policy alignment, partner complementarity, county leadership, and data system strengthening. • Assumptions that held partially: HRH availability, commodity security, and community norm change, each regularly constrained by strikes, stock-outs, insecurity, and entrenched harmful practices. • Assumptions with weakest evidence: translation of improved medico-legal services into sustained justice, protection and healing for survivors, due to limited outcome tracking and systemic barriers. Overall, the causal assumptions were realistic and directionally valid. However, bottlenecks in HRH and commodity stability, uneven community norm shifts, and incomplete survivor outcome data moderated causal strength. These areas represent recurring constraints observed across HSPS phases and help explain why some causal assumptions held only partially.

4.4 What happened / what changes were observed?

HSPS I (2004–2006)

- Large-scale IMCI training was delivered in North Eastern (65.5% of health workers trained) and to a lesser extent in Nyanza (26.9%), with some sensitisation on adolescent SRH.
- Direct funding to PHC facilities in Coast Province increased service utilisation by an estimated 40–50%, particularly measles immunisation through outreach.
- Surgical capacity was expanded in Garissa and Wajir hospitals in NE Province.
- Community engagement increased through strengthened Health Facility Management Committees, with female representation requirements
- National MDG-related ambitions guided the programme, though HSPS I reporting did not track progress against the MDG indicators themselves.

Overall, HSPS I laid the groundwork for later MNH system strengthening and PHC outreach approaches.

HSPS II (2007–2011)

- No endline reporting was provided for key HSPS II indicators (ANC coverage, skilled delivery, PMTCT, CPR), limiting assessment of progress.
- Danish support to pastoralist areas enabled major upgrades in North Eastern Province, including improved district hospitals, new labour and paediatric wards, and 54 staff quarters across Levels 2–4.
- Mobile clinics were established for pastoralist populations (12 in NEP, 2 in Tana River), extending basic services to hard-to-reach groups.

[115] Referring specifically to assumptions from the Thematic ToC for RMNCAH and GBV

- 1,120 nurses were contracted (2–3-year terms) to strengthen HIV care, with all contracts ending by mid-201

Early GBV response also began through support to the SGBV clinic at Coast General Hospital.

HSPS III (2012–2016 + 2017 no-cost extension)

- First major scaling of GBV programming through GVRC, expanding from 2 to 5 GBV Recovery Centres and embedding GBV in several County Integrated Development Plans.
- GVRC expanded multisectoral GBV case management, trained health workers and police, and strengthened county-level GBV coordination, though outcome data remained limited.
- Amref's SRHR project in five northern counties showed improvements in SBA, family planning use, and immunisation, supported by extensive health worker training, outreach clinics, and 10 maternal shelters.
- Project activities helped counties adjust to early devolution through technical assistance, HRH management training, and strengthened CHMT/sub-county teams.
- UNFPA led H6 RMNCAH phase 2 planning began in late 2017, though data quality issues later limited conclusions on RMNCAH outcomes.
- Evidence gaps persisted for key HSPS III outcome indicators (modern family planning use, ANC 4+, SBA, FIC, and GBV outpatient reporting).

Despite data limitations, HSPS III represents a pivotal phase where Denmark shifted more explicitly to RMNCAH and GBV system strengthening.

HSPS IV (2017–2020)

- The H6 RMNCAH project operated in six high-burden counties, aiming to improve access, demand, and quality of integrated RMNCAH/GBV services, supported by significant health worker training.
- Capacity-building for planning, budgeting, coordination, and M&E was strengthened at county and national levels.
- Overlap with earlier AMREF counties occurred, but no structured lesson-sharing was documented, limiting coherence.
- Data inconsistencies in H6 reporting made RMNCAH outcome improvements difficult to verify.
- GVRC expanded GBV programming in eight counties, establishing eight one-stop GBV Recovery Centres and scaling community and school-based prevention.
- GVRC's model became a national blueprint for comprehensive GBV services, though outcome data for HSPS IV indicators were unavailable.
- GVRC contributed to national policy processes, including discussions on integrating GBV services within Kenya's UHC programme, alongside other partners and government actors

The phase strengthened GBV institutionalisation but produced modest verified RMNCAH outcome results due to weak project-level data.

HSPS V (2021–2025, ongoing)

- The ACCELERATE programme expanded GBV and SRHR services across 13 underserved counties, reaching over 58,000 adolescents with youth-friendly SRHR services, including hard-to-reach LGBT+ groups and persons with disabilities.
- Community awareness of where to access GBV services rose sharply—from <30% (2021) to >70% in at least 7 ACCELERATE counties.

- A national GBV indicator was added to DHIS2 in 2023 with the support of other partners and MoH, enabling increased visibility and reporting of GBV cases; several counties saw notable rises in reported cases in 2024.
- Internal research (2022–2025) showed improvements in triple-zero indicators (family planning availability, GBV reporting pathways, some service-readiness measures) in four counties, though PEP readiness declined and half of survivors still arrive too late for emergency care.
- Under the national PHC Support Program, to which Denmark contributed financing, outreach and O&M support expanded across all 47 counties, including new funding to Community Health Units from 2022.
- Social Safety Nets during Covid-19 reached 7,620 vulnerable households and also supported 2,677 GBV survivors with cash transfers and linked services, based on inputs from GVRC.

Overall, HSPS V shows stronger evidence of GBV system gains and enhanced PHC readiness, with moderate RMNCAH improvements.

4.5 What did Denmark do?

HSPS I (2004–2006) – Foundations and child/youth health

- Focused support on achieving MDG-related child and adolescent health goals within the Kenya Essential Package for Health.
- Funded district-based health projects in North Eastern and Coast Provinces.
- Supported ASRH through development, printing, and dissemination of training manuals and youth-friendly service guidelines, plus fliers, posters, and ASRH/HIV "edutainment" radio content.
- Provided IMCI training support to health workers in NE and Nyanza, indirectly contributing to HIV/STI case management.
- Established the Health Facility Fund in Coast Province and developed operational guidelines, laying foundations for later HSSF support.
- Signed the SWAp MoU and piloted the Health Sector Services Fund in 2006 ahead of national rollout in HSPS II.

HSPS II (2007–2011) – System expansion and early GBV response

- Deepened the health SWAp, continuing to channel support through government systems, with the World Bank as the only other fully committed DP.
- Continued support to the SGBV clinic at Coast General Hospital and satellite sites, strengthening survivor care and multisectoral response.
- Supported KEPH implementation in PHC facilities and targeted pastoralist communities, including infrastructure improvements and mobile clinic deployment.
- Co-funded HIV nurse employment with CHAI, expanding public-sector HIV care capacity.
- Continued direct Health Facility Fund disbursements in Coast Province until HSSF became operational in 2010.
- Supported the introduction of the national HMIS and provided technical assistance through Euro Health Group and Niras.

HSPS III (2012–2016; extended to 2017) – ASRHR and GBV scale-up and devolution support

- Responding to DP and internal appraisal recommendations, Denmark prioritised ASRHR and GBV, funding two major initiatives:
  - Amref SRHR project in five northern counties (DKK 30M).
  - UNFPA-led H6 RMNCAH phase 2 in six counties (DKK 40M; 7.5% of total funding).
- Provided DKK 10M in core funding to GVRC, enabling national expansion of GBV services and contributing to development of GBV policy frameworks and the GBV "service package."
- Strengthened primary-level service delivery through the Health Sector Services Fund (HSSF) (DKK 210M), supporting 3,000 facilities and community engagement via HFMCs and CHUs.
- Supported governance and access-to-justice linkages through FIDA and IDLO, reinforcing GBV referral pathways.
- Played a key role in supporting counties during the early devolution transition, offering flexible technical assistance and financial oversight.
- Delivered support through government systems, NGOs, UN agencies, and continued core funding modalities.

HSPS IV (2017–2020) – Multisectoral GBV institutionalisation and UHC O&M support

- Enabled scale-up of GBV services by supporting GVRC's 2017–2021 strategic plan and rollout of the multisectoral GBV service package.
- Supported development of GBV clinical case management tools, referral pathways, and the MoH 365 post-rape form, and provided TA to county hospitals.
- Continued support to the UNFPA-led H6 RMNCAH phase 2 across six counties.
- Continued long-term investment in underserved northern counties, helping strengthen RMNCAH delivery despite weak H6 data.
- Disbursed DKK 169M in UHC conditional grants to counties for Level 2–3 O&M, filling key financing gaps.
- Used government systems for O&M support while engaging NGOs and UN agencies for targeted project implementation.

HSPS V (2021–2025, ongoing) – Triple zero and national PHC strengthening

- Funded and shaped the ACCELERATE programme, Kenya's primary national vehicle for advancing the "three zeros" (zero unmet need for family planning, zero preventable maternal deaths, zero GBV/harmful practices) in 13 counties.
- Continued Denmark's longstanding leadership in GBV system strengthening supporting multisectoral GBV approaches, increasing survivor reporting, and contributing to DHIS2's 2023 GBV indicator inclusion.
- Provided long-term, reliable funding that helped normalise GBV care-seeking and expand holistic survivor pathways nationally.
- Supported improvements in ACCELERATE's triple-zero indicators across counties through systems strengthening, community engagement, and health worker capacity-building.
- Implemented a nationwide Primary Health Care programme (DKK 140M), supplying conditional grants for Level 1–3 facilities and technical assistance to the MoH and Council of Governors.

- Delivered Covid-19 social protection support (DKK 20M) to vulnerable households and GBV survivors through Oxfam/IBIS, leveraging GVRC expertise.
- Used a mix of modalities: on-budget support to devolved county systems, technical assistance, and targeted NGO/UN project delivery.

4.6 What other factors may have been influential in bringing about the observed changes?

Kenya's progress in strengthening RMNCAH, SRHR and GBV systems was shaped by a mix of systemic, contextual, institutional and political factors that interacted with Denmark's support, at times enabling progress and at other times constraining it.

Enabling

- At the start of Danish support, early sector reforms, particularly the Health Information Policy, the HMIS Strategic Plan and the emerging SWAp, created a policy environment that prioritised harmonisation, system strengthening and coordinated RMNCAH investments. These frameworks signalled government commitment to reducing fragmentation and expanding essential services.
- As devolution took root, counties gained autonomy over planning and budgeting, enabling Danish PHC, outreach and GBV investments to align more closely with local priorities. Counties with stronger leadership and PFM capacity were able to translate support into improved O&M, staffing and emergency referral systems.
- Over time, increasing national momentum around UHC, RMNCAH and GBV reforms, including Linda Mama, adolescent SRHR policies, Anti-FGM initiatives and adoption of the MoH 365 form, reinforced incentives for counties to expand services and strengthen clinical and medico-legal pathways.
- Across HSPS phases, significant complementary investments by USAID, DFID/FCDO, UNICEF, UNFPA, the Global Fund and the World Bank supported commodities, HRH, EmONC and adolescent SRHR, amplifying potential gains in Danish-supported counties.
- Community-level engagement contributed to incremental shifts in some settings, though deeply entrenched patriarchal norms around early marriage, GBV, family planning and home delivery continued to inhibit access and remained a major barrier throughout HSPS I–V.

Constraining

- From the outset, persistent HRH shortages, uneven staff distribution and rising workloads limited the extent to which expanded RMNCAH and GBV services could translate into consistent quality of care. Recurrent health worker strikes, salary delays and absenteeism repeatedly disrupted service continuity across all phases.
- In the early and middle phases (HSPS II–III), governance disruptions were severe, including significant violence resulting in deaths and displacement during the 2007–2008 post-election crisis. These events, together with the temporary split of the MoH and slow devolution rollout, contributed to fragmentation, duplicated responsibilities and prolonged commodity stock-outs. In ASAL areas, insecurity, long distances and weak transport networks further constrained access to ANC, delivery and GBV services despite expanded outreach.
- Across HSPS I–IV, entrenched sociocultural norms, home births, TBA preference, FGM/C, child marriage, GBV stigma and family planning misconceptions, continued to affect service

uptake. Covid-19-related misinformation later compounded mistrust of the health system and contributed to declines in immunisation and care-seeking.

- Until 2023, fragmented GBV information and medico-legal systems, dominated by paper registers and parallel programme databases, limited visibility into survivor pathways and hindered outcome-level tracking. These gaps slowed institutionalisation of GBV response models before DHIS2 integration.
- In the later period (HSPS IV–V), wider shocks constrained progress well beyond the influence of any single development partners. Covid-19 reduced access to RMNCAH and GBV services and increased IPV. From 2021–2025, global aid cuts and the 2025 USAID Stop Work Order triggered widespread funding disruptions, commodity shortages and staffing gaps that affected service delivery nationwide.

What the influencing factors mean for the RMNCAH contribution claims overall?
Overall assessment: The contribution claims remain valid. Denmark's impact grew stronger from HSPS III onward, but outcomes were shaped by wider system constraints, sociocultural norms and external shocks outside its control.

What strengthens Denmark's contribution claim:

- Denmark consistently invested in underserved ASAL counties, filling PHC, BEmONC and GBV service gaps where few other partners operated.
- Long-term support to GVRC played a catalytic role in building Kenya's GBV system, including the national service model, medico-legal tools and DHIS2 GBV integration.
- Two decades of O&M financing through HSSF/HFF/PHC grants strengthened the county primary care platforms that now underpin RMNCAH and GBV service delivery.
- Danish support aligned closely with major health reforms UHC, Linda Mama/Linda Jamii and SRHR/GBV policies, helping accelerate uptake and institutionalisation.
- Investments in BEmONC skills, referral systems, youth-friendly services and county planning generated changes that continued beyond individual project cycles.

What limits the contribution claim:

- HRH shortages and recurrent strikes disrupted continuity of RMNCAH and GBV services, limiting the impact of Danish-funded training and facility upgrades.
- Commodity stock-outs across family planning, EmONC and GBV supplies constrained service readiness and often prevented full survivor pathway completion.
- Deep-rooted norms around home delivery, FGM/C, child marriage and GBV stigma continued to suppress service uptake even where access improved.
- Data gaps and inconsistencies, particularly within H6 reporting, restrict the precision with which Denmark's contribution to specific outcomes can be assessed.
- External shocks, including Covid-19, insecurity in ASAL counties and the 2025 USAID funding halt, disrupted service delivery and complicate attribution to any single partner.

While Denmark played a sustained and influential role in RMNCAH/SRHR and GBV system strengthening, its contribution should be understood within the broader donor landscape. Denmark consistently represented approximately 1% of Kenya's total ODA, and several major development partners, particularly DFID/FCDO, USAID, UN agencies and the World Bank, also made substantial, long-term investments in GBV prevention, RMNCAH service delivery, and health

systems strengthening. Denmark's contribution was therefore complementary rather than dominant; its added value lay in its continuity, geographic focus on underserved ASAL counties, and strategic support to GBV institutionalisation rather than in the overall scale of financing.

4.7 Plausibility and assessment of Denmark's contribution to RMNCAH/SRHR and GBV

Three main causal pathways, each supported by triangulated evidence across document review, KIIs and quantitative data analysis can be identified and mapped onto the thematic RMNCAH and GBV theory of change derived from ToCs by phase.

Pathway 1 – Strengthening RMNCAH and GBV Service availability, readiness and utilisation: Denmark's long-term investments in PHC O&M grants, BEmONC capacity, outreach, and GBV clinical services, particularly in underserved ASAL counties, plausibly strengthened service availability and readiness and contributed to observed increases in family planning, ANC4+, SBA, immunisation and GBV reporting.

Causal steps:

1. Danish inputs increased service availability and readiness through O&M/PHC/HSSF/HFF grants, BEmONC and youth-friendly training, infrastructure and staff housing improvements, outreach/mobile clinics, and long-term GVRC support that expanded One-Stop GBV Recovery Centres.[116]
2. Improved availability contributed to higher utilisation, reflected in increased ANC4+, SBA, modern family planning uptake and greater GBV reporting and care-seeking in underserved ASAL counties.[117]
3. Strengthened GBV clinical and medico-legal systems improved pathway completion, driven by standardised PRC forms, GBV registers, forensic tools and MoH 365.[118]
4. Enhanced service readiness supported sustained systems change, as counties embedded youth-friendly SRHR, family planning and GBV protocols into routine services following Amref, UNFPA, GVRC, PSI/PSK and ACCELERATE inputs.[119]

Supporting evidence: Moderate to strong (Strong triangulation across routine data, KIIs and evaluations; weakened by incomplete early-phase documentation and variable project data quality (e.g patchy reporting and limited baseline data)

- Modern family planning increased 22%→35.6%, FIC 52.6%→68.3%, ANC4+ in Mandera 35%→47%, and SBA increased in multiple target counties[120] , though data quality issues make magnitude uncertain.
- Knowledge of where to report GBV rose from <30% to >70% in seven ACCELERATE counties.[121]

[116] HSPS I–V documentation; stakeholder KIIs; Amref, GVRC, UNFPA project reports showing Danish support to PHC, BEmONC, outreach, infrastructure and GBV centres.
[117] Routine DHIS2 RMNCAH data; ACCELERATE monitoring; Amref and H6 trend reports showing ANC4+, SBA, family planning utilisation increases in supported counties.
[118] GVRC and ACCELERATE reports; MoH guidance; fieldwork findings on PRC forms, registers, and forensic exams.
[119] County supervision reports; Amref and UNFPA documentation of youth-friendly service integration.
[120] Aggregated RMNCAH indicator improvements from DHIS2 and programme reports (Mandera, Turkana, Marsabit).
[121] ACCELERATE 2022–2025 internal research and partner FGDs

- Documentation standards improved significantly: PRC 39.4%→61.5%, GBV register 33.3%→72%, forensic completeness 36.2%→51.3%[122] indicate stronger clinical processes, not necessarily broader survivor outcomes.
- Stakeholders often linked improved RMNCAH and GBV service readiness in ASAL counties to Danish-funded O&M, outreach and GBV services; however, the absence of systematic output and outcome reporting in earlier HSPS phases limits the strength of these associations.[123]

Pathway 2 – Strengthening county stewardship, referral systems and multisectoral coordination

By supporting counties through the devolution transition with financing, technical assistance and GBV multisectoral referral development, Denmark plausibly strengthened county leadership, planning, supervision and coordination, enabling more coherent RMNCAH and GBV service delivery models.

Causal steps:

1. Danish support helped counties operationalise devolved health responsibilities through TA, O&M grants, financial oversight and PHC strengthening, enabling counties to plan, budget and supervise RMNCAH/GBV services more effectively.[124]
2. Referral systems and community linkages improved, supported by investments in outreach, CHVs, community referral mechanisms and GBV multisectoral pathways spanning health, police and justice.[125]
3. Counties institutionalised RMNCAH and GBV priorities, integrating them into CIDPs, adopting GBV service packages and standardising tools such as MoH 365 and medico-legal protocols.[126]
4. Improved stewardship supported system performance, with counties increasingly owning functions initially supported by Amref, UNFPA and GVRC, reinforced by UHC reforms, although limited HSPS performance reporting constrains fully assessing the scale of these effects.[127]

Supporting evidence: Moderate (Consistent narratives across stakeholders, evaluations and programme reports with clear contributions to process strengthening, but referral functionality and coordination remain highly variable)

- County managers in Mandera, Wajir, Turkana and Marsabit described Danish O&M grants as indispensable for PHC continuity under devolution.[128]
- GVRC, FIDA and IDLO strengthened coordination across health, police, legal and psychosocial services in several countries. [14]
- National uptake of GBV service packages, referral pathways and medico-legal tools corresponded with Denmark-funded workstreams.[129]

[122] GBV pathway assessment from ACCELERATE research; facility-level MoH 365 data.
[123] KII testimonies from county health teams and health workers in ASAL counties.
[124] HSPS III–V documentation; TA deployment reports; devolution transition support records.
[125] GVRC, FIDA and IDLO documentation on multisectoral GBV referral systems.
[126] County Integrated Development Plans; MoH GBV policy adoption records.
[127] Evaluation fieldwork; stakeholder interviews; UHC policy documents
[128] County manager KIIs confirming reliance on Danish O&M funding.
[129] GBV multisectoral coordination meeting records and implementer reports.

- Strikes, insecurity and Covid-19 disrupted continuity, moderating attribution.[130]

Pathway 3 – Influencing national policy, norms and institutionalisation of SRHR and GBV systems

Through sustained support starting in 2012 to Amref, UNFPA, GVRC, PSI/PS Kenya and ACCELERATE, Denmark played a plausible and significant role in shaping RMNCAH/SRHR and GBV policy frameworks, contributing to standardised clinical tools, the MoH 365 PRC form, GBV service package and the 2023 integration of GBV indicators into DHIS2**.**

Causal steps:

1. Danish-funded partners helped shape national RMNCAH/SRHR and GBV policy frameworks, contributing to ASRHR tools, family planning guidelines, GBV protocols and medico-legal reforms including the MoH 365 form and forensic standards.[131]
2. Standardised tools strengthened national coherence and visibility, culminating in the 2023 integration of the GBV indicator into DHIS2.[132]
3. Community engagement has supported shifts in social norms and increased demand, through CHVs, religious leaders, male involvement, women's rights organisations and youth-friendly interventions.[133]
4. Policy and norm shifts strengthened institutionalisation, embedding GBV response and adolescent SRHR within national and county health systems and aligning with Linda Mama, Linda Jamii and UHC reforms.[134]

Supporting evidence: Moderate (Broad system influence and strong documentary alignment; Contributions are credible but diffuse, with outcomes shaped by broader national reforms and other partners' larger-scale inputs)

- National adoption of MoH 365 and medico-legal tools clearly linked to GVRC and ACCELERATE with Danish support.[135]
- Stakeholders widely recognised Denmark as the most reliable long-term system-builder in GBV response.[136]
- Increases in survivor reporting aligned with expansion of One-Stop Centres and community sensitisation.[137]
- Family planning, ANC and youth-friendly service adoption tracked with complementary RMNCAH/UHC policy reforms.[138]

4.8 Theory of Change (ToC) assessment

The changes observed broadly reflect the Theory of Change: **IF** primary-level service capacity, outreach, referral systems and GBV clinical processes are strengthened, **THEN** RMNCAH/SRHR

[130] National rollout documents for GBV service package and MoH 365.
[131] Covid-19 impact studies; insecurity reports; health worker strike analysis.
[132] Amref, UNFPA, GVRC policy contributions; MoH protocol development history
[133] MoH HMIS records; DHIS2 GBV integration process documentation.
[134] CHV/CHU community engagement reports; ACCELERATE and Amref demand-generation documentation.
[135] Alignment of Danish support with Linda Mama, Linda Jamii and UHC implementation documents.
[136] MoH GBV guidelines, medico-legal forms; GVRC technical assistance logs, government KIIs.
[137] Policy stakeholder interviews; GBV partner FGDs.
[138] DHIS2 and programme monitoring of GBV case trends; ACCELERATE outreach data. RMNCAH policy analyses; county adoption reports; UHC reform documentation.

utilisation and survivor access to care should improve. Danish support contributed to these intermediate shifts by funding basic service functionality, strengthening clinical capacity, and supporting GBV documentation and awareness efforts. These inputs plausibly supported increases in FP use, ANC attendance, skilled deliveries, immunisation and GBV reporting, though the scale of improvement is uncertain due to mixed data quality and shared contributions from other partners.

The assumption that counties would be motivated to strengthen RMNCAH/SRHR/GBV systems largely held; most counties adopted relevant priorities, used new tools and engaged in coordination efforts. However, the assumption that improved readiness would reliably translate into increased utilisation held only partially. Persistent HRH shortages, commodity gaps, insecurity and social norms limited uptake even where services expanded.

Similarly, the assumption that stronger GBV documentation and referral processes would significantly improve survivor pathways held only to a limited degree. While documentation became more consistent and reporting increased, many survivors still presented late, and weak justice-sector follow-up constrained more comprehensive outcomes. The assumption that national reforms would reinforce county-level gains was only partially met: Danish support aligned well with PHC/UHC and SRHR/GBV policies, but parallel systems and structural bottlenecks reduced coherence.

Overall, the ToC is valid and Denmark's contribution to intermediate system strengthening is plausible, but progress was uneven and constrained by longstanding systemic limitations.

Table 3: Select ToC assumptions – degree to which they held

ToC assumption	**Extent to which assumption held**	**Notes**
Counties show interest and leadership in strengthening RMNCAH/SRHR/GBV systems	Held	Counties generally adopted RMNCAH/GBV priorities, used new tools and engaged in coordination mechanisms, indicating motivation and willingness to implement reforms.
Improved service readiness leads to increased utilisation of RMNCAH/SRHR services	Partially held	Gains in availability did not always translate into higher uptake due to HRH shortages, commodity gaps, long distances, insecurity and entrenched norms.
Stronger GBV documentation and referral systems improve survivor pathway completion	Weak evidence	Documentation improved and reporting increased, but many survivors still presented late and follow-through across justice and protection systems remained inconsistent.
National reforms reinforce county-level RMNCAH/SRHR/GBV improvements	Paritally held	Danish support aligned with PHC/UHC and SRHR/GBV reforms, but parallel systems and wider structural bottlenecks reduced overall coherence and limited reinforcement of county progress.
System-strengthening inputs are sufficient to drive and sustain improvements in RMNCAH/SRHR/GBV outcomes	Partially held / constrained	Inputs improved processes and readiness, but core systemic constraints—HRH instability, financing gaps, supply-chain weaknesses, sociocultural norms and incomplete data—limited the extent to which strengthened services translated into sustained or widespread population-level outcomes.

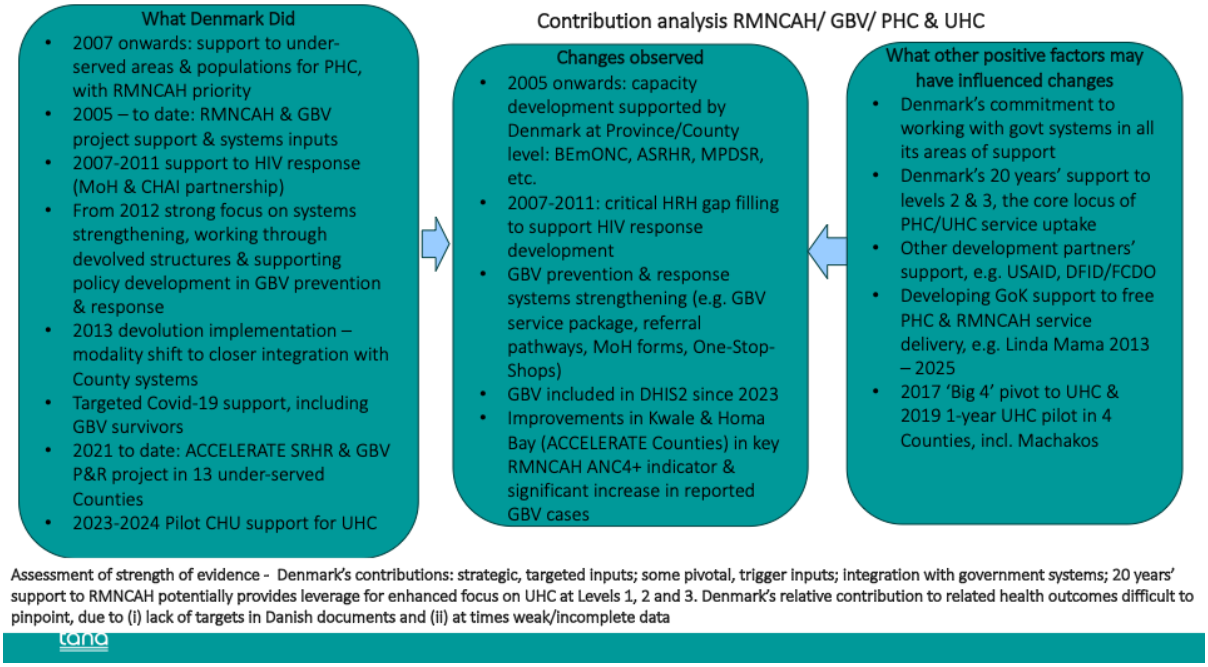
Denmark's contribution is most convincingly demonstrated in two areas where its long-term support aligned closely with government and partner priorities:

1. Expanded access to essential SRHR/MNCH services in underserved counties
   - Long-term support to PHC financing, outreach and ASAL systems produced sustained improvements.
2. Establishment and institutionalisation of Kenya's GBV clinical and medico-legal response model
   - Danish-funded work by GVRC and ACCELERATE **contributed to** the development and adoption of national medico-legal tools and standards, complementing broader government-led and partner-supported reforms.

A third, credible but more moderate contribution concerns:

3. County stewardship and evidence use, strengthened through DHIS2 integration, planning support and CHMT capacity building.

Figure 5: Summary of contribution analysis for RMNCAH



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6. Annex A: Key analytical tables

Table 4: Planned Facility Funding 2020 -2026

FY	L2/L3 Grant from Danida	L2/L3 Counterpart Funds from Counties	L1 Grant from Danida (Counterpart funds not required)
2020/21	900,000,000 (100%)	0	
2021/22	701,250,000 (75%)	198,750,000 (25%)	
2022/23	540,000,000 (60%)	360,000,000 (40%)	127,500,000
2023/24	450,000,000 (50%)	450,000,000 (50%)	127,500,000
2024/25	360,000,000 (40%)	540,000,000 (60%)	127,500,000
2025/26	360,000,000 (40%)	540,000,000 (60%)	352,500,000
2026/27	0	900,000,000 (100%)	

Source: "Danida (sic) Primary Health Care (PHC) Support Programme update status 3 October 2025"

Co-funding from counties has largely progressed well as summarised in the table below. Most counties have disbursed the expected or above the expected levels of co-funding.

Table 5: Summary of Performance in Disbursement of County Counterpart Funding.

Financial Year	No. of Counties which disbursed expected amounts of counterpart funding	No. of counties which disbursed amounts more than the expected	No. of Counties which disbursed less than was expected	No. of counties which did not disburse any amount
2021/2022	23	17	3	4
2022/2023	34	6	3	4
2023/2024	35	5	1	6

Source: Ministry of Health 2025: Evaluation of Danida Primary Health Care Support (draft dated 15 October 2025)

Table 6: Annual Indicator performance of the HSPS PHC Support program

Indicator	Baseline	2020/21	2021/22	2022/23	2023/24	2024/25	Target
Outcome Indicators							
Facility maternal mortality. Deaths per 100,000 deliveries (Ratio)	99	102	110	91	97	95	77
Births attended by skilled health staff (Percentage -%)	67.9%	78.1%	79.3%	76.0%	73.0%	69.3%	75%
Contraceptive Prevalence Rate (CPR)	16	24.1	15.2	12.4	15.6	14.7	18
Output Indictors							
Outpatient (OPD) Utilization Rate	1.5	1.4	1.6	1.5	1.4	1.2	2.5
Percentage of pregnant mothers completing 4th Antenatal Care (ANC) Coverage (%)	51.4%	50.3%	52.7%	52.3%	53.8%	49.1%	63%
Proportion of children under 1 year receiving Penta 3	81.1%	85.9%	87.9%	85.4%	82.4%	80.3%	95%
Women of Reproductive Age (15-49) currently using modern FP family planning methods (%)	43.9%	29.7%	36.8%	36.8%	40.4%	41.9%	64%
Facility Based neonatal mortality rate (per 1,000)	10	9	10	10	10	9	3

Source: MoH Danida PHC Annual Report 2024/25

While progress can be noted over the 20-year period, then there have also been periods where some indicators have stagnated or declined. In the current program phase, progress on health indicators is recognised by MoH as being very mixed, ref the table below from latest Danida PHC report that indicate some stagnation or regression

By the end of the FY2024/25, no (output or outcome) indicator had attained the program target. MoH indicated that "the performance may be attributed to the introduction (in October 2024) and transition to the new funding model in the health sector under the Social Health Authority (SHA). The Stop-Work order issued by the new government in the United States in January 2025, which halted funding from USAID for ninety days, affected the availability of the KHIS and might have

disrupted optimal data entry across the country". However, as can be seen from the table above, some indicators like "facility maternal mortality" performed poorly already from 2020.