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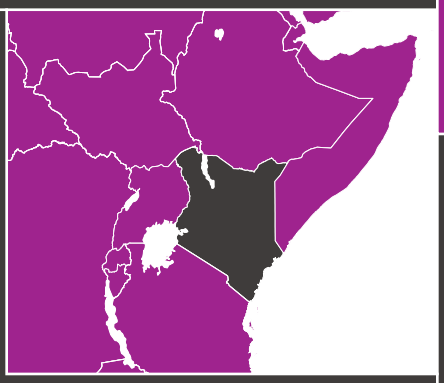
ANNUAL EVALUATION OF THE ABOLITION OF USER FEES AT PRIMARY HEALTHCARE FACILITIES IN KENYA



This publication was prepared by Thomas Maina of the Health Policy Project and Doris Kirigia (independent consultant).

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EXECUTIVE SUMMARY

Background

Abolition of user fees in primary healthcare facilities is now widely considered by developing countries as one of the key policy options to address access to healthcare services by the poor and vulnerable. User fees, introduced in Kenya and many other low-income countries in the late 1980s, have failed to achieve the intended objective of improving access to healthcare. Instead, user fees have imposed a barrier to accessing health services by the poor and vulnerable and have contributed to inequalities in access to healthcare. In response, many African countries introduced partial or total elimination of user fees in the 2000s (Meessen et al., 2011).

In 2004, Kenya followed suit, removing all user fees at public dispensaries and health centers, except for a minimum registration fee of 10 or 20 Kenya shillings (KShs).[1] Commonly referred to as the 10/20 policy, children under age five and clients with specific health conditions, including malaria and tuberculosis, are also exempted from registration fees. Still, there was low adherence to the policy and facilities continued to charge higher fees to clients seeking care (Chuma et al., 2009; Onsomu et al., 2014). In response, the government abolished all user fees in public dispensaries and health centers in 2013 and allocated KShs 700 million for compensation to lower-level facilities for providing free services.

This study is the first attempt to generate evidence on the effects of removing user fees at primary-level facilities in Kenya. It is a nationally representative survey of dispensaries and health centers, and includes a sample of 250 lower-level facilities. These were selected using a multistage cluster sampling strategy, and were drawn from 15 randomly selected counties. The sample also included a representative number of faith-based health facilities to enable monitoring of changes in public facilities vis-à-vis those run by faith-based facilities, and to reduce confounding due to other policy changes affecting all health services. Data were collected through document reviews, key informant interviews, and extraction from health facilities records. The objective of the study was to document the effects of the removal of user fees on health utilization patterns, facilities' adherence to the policy, health workers and clients' perceptions of the policy, and the quality of service provided before and after its introduction.

Results

Percentage change in utilization of health services

The study assessed the utilization patterns for different health services and age groups before and after the policy change. Key services covered included outpatient services, antenatal care, immunization, family planning, HIV testing, and post-natal care, among others. These data were extracted from facility records for all years from 2011–2014. Results were compared between government and faith-based facilities. Both public and faith-based facilities reported a modest increase in utilization of outpatient services.

For instance, total outpatient services (visits and re-attendance) delivered in public facilities—for both children five years and under and for the total population over age five—increased by 25 percent and 37 percent, respectively. In faith-based facilities, total outpatient visits for children five years and under decreased by 25 percent, while visits for the population over age five increased by a statistically significant 19 percent. Both public and faith-based facilities recorded modest increases in utilization of all other outpatient services, with the exception of the number of clients counselled and tested through the prevention of mother-to-child transmission, the number of children receiving the first dose of measles vaccine, and the number of children fully immunized, all of which decreased during

[1] US$1 = KShs 95 in July 2015.

the policy implementation period. However, for both types of facilities, these decreases were not statistically significant.

Adherence to user fees removal

Study findings indicated high levels of adherence to the abolition of user fees policy (85% of all facilities). However, about 15 percent of respondents in the exit interviews reported having paid for the services they received. Clients paid an average of KShs 91.3 (US$0.96) and KShs 50 (US$0.53) at public health centers and public dispensaries, respectively. Those who sought care at faith-based facilities indicated having paid an average of KShs195 (US$2.1) and KShs 104 (US$1.1) at health centers and dispensaries, respectively. The median amount of money paid by clients who reported having paid for services was KShs 50 (US$0.53) for public health centers, KShs 30 (US$0.32) for public dispensaries, KShs 150 (US$1.58) for faith-based health centers, and KShs100 (US$1.05) for faith-based dispensaries. About four percent of clients/patients who sought care from public facilities and six percent who sought care from faith-based facilities reported that they owed the facilities some additional money.

The policy implementation process

The study found a number of important shortcomings in the policy implementation process. These included limited consultation with stakeholders during the policy design, planning, and implementation process, and the use of a circular by the Ministry of Health to communicate the policy to county health management teams and health workers. The circular did not clarify the population categories that could access free care or whether health centers/dispensaries under other government departments (e.g., prisons and city and municipal councils) were covered by the policy.

Flow of abolition of user fees funds and reimbursement mechanisms

The findings of this study show that abolition of user fees faces a challenge similar to that faced by Kenya's Health Sector Services Fund (HSSF): frequent delays in the disbursement of funds attributed to liquidity-related problems at the national level. Devolution further complicated the HSSF's model of disbursing funds, with county governments insisting that reimbursements be made to county revenue accounts instead of being paid directly to health facilities.

Patients' perceptions of the quality of healthcare after removal of user fees

Overall, there was little evidence to suggest that staff attitudes, registration services, or cleanliness of facilities visited had deteriorated after user fees were abolished. However, nearly 30 percent of patients stated that drug availability had worsened following the removal of user fees.

Patient's perceptions of the availability of drugs and other medical supplies

Close to 34 percent and 26 percent of patients who received healthcare at public health centers and dispensaries, respectively, reported that they were asked to buy drugs or other medical supplies elsewhere. Major items that clients had been asked to buy included drugs, cards/registration books, and non-pharmaceuticals, including syringes. Key informants also reported long delays in receiving medical supplies.

Health workers' perceptions of user fees removal

Most health workers interviewed felt that fee removal had changed patients' situations for the better, especially the poor who could now access healthcare with no financial hardships. However, health workers cited shortage of drugs and long wait times as some negative effects for patients of the removal of user fees.

Health workers' perceptions of the working environment

Issues of major concern raised by the majority of the health workers included increased workload (78%), fewer resources for essentials in facilities (76%), and long spells of drug shortages (74%). The

health workers interviewed reported that these issues had made their jobs more difficult and had a negative impact on patients.

Loss of health workers and support staff

Key informants indicated that some support staff (e.g., cleaners, clerks, and some health workers, notably laboratory technicians) had been laid off in part because of the loss of revenue resulting from the removal of user fees and delays in the receipt of HSSF funds. This loss has had a number of negative effects. For instance, the absence of laboratory technicians contributed to the closing of some facilities' laboratory units and patients being forced to seek laboratory tests elsewhere.

Conclusion and Recommendations

Given sustained budget support from national and county governments to health facilities, Kenya's health system should be able to achieve improved health outcomes without relying on user fees. The analysis highlights the need to (among other actions) guarantee adequate funding; ensure adequate drug supplies and health workers; redesign the reimbursement mechanism, especially in the context of devolution and alignment with the constitution; and strengthen existing national monitoring and evaluation instruments and systems to provide detailed data on a timely basis. For instance, the national and county governments, in consultation with key stakeholders, should redesign the reimbursement mechanism to ensure that health facilities are adequately and promptly reimbursed for providing free healthcare.

ABBREVIATIONS

ANC	antenatal care
FBO	faith-based organization
FY	fiscal year
HPP	Health Policy Project
HSSF	Health Sector Services Fund
KShs	Kenya shilling
NGO	nongovernmental organization
MOH	Ministry of Health
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PETS-Plus	*Public Expenditure Tracking Survey, 2012*
USAID	United States Agency for International Development

BACKGROUND

Abolition of user fees in primary healthcare facilities is now widely considered by many low-income countries to be a key policy option to address access to healthcare services by the poor and other vulnerable groups. User fees, introduced in many low-income countries in the late 1980s, have failed to achieve their intended goals. Instead, they have imposed financial barriers to accessing health services, thereby contributing to inequalities in access to healthcare. Even where user fee policies were accompanied by exemption policies to protect some specific groups—such as children, the poor, and pregnant women—they were found to reduce demand for health services (Ridde and Morestin, 2011). In response to these challenges related to user fees, many African countries introduced partial or total elimination of user fees in the 2000s (Meessen et al., 2011).

Like many African countries, Kenya also introduced user fees in public health facilities to raise additional revenue to finance healthcare services. The introduction of user fees was occasioned by declining health budget allocations resulting from poor economic performance, and was part of a structural adjustment program prescribed by the international community (GOK, 2001). The user fee policy included a waiver and exemption policy to protect the poor and other vulnerable groups. In addition, children under age five were exempted from all charges. However, the waiver and exemption mechanism remained ineffective and was administratively difficult to implement. This resulted in undeserving cases benefiting from manipulation of the waiver and exemption system. The declining central government allocations also forced managers of public health facilities to limit those eligible for waivers and exemptions. Because of this, the waiver and exemption mechanism failed to protect the poor and the vulnerable. Evidence on user fees and other out-of-pocket spending in Kenya revealed that user fees are significant barriers to access, especially among the poorest populations (GOK and Health Systems 20/20, 2009).

To increase access to healthcare, especially by the poor and the vulnerable, the government reduced user fees at lower-level facilities (i.e., health centers and dispensaries) in 2004, to a maximum of 10 Kenya shillings (KShs) and KShs 20, respectively, to cover registration. Under this policy, commonly referred to as the 10/20 policy, children under age five and those with specific health conditions, such as malaria and tuberculosis, were exempted from payment. In July 2007, all fees for deliveries in public health facilities were also abolished to further increase access to maternal healthcare services.

Still, low adherence to the 10/20 policy was reported at public primary health facilities, with facilities charging higher fees to clients seeking care (Onsomu et al., 2014; Chuma et al., 2009). This was despite the introduction of the Health Sector Service Fund (HSSF) in 2007, which was meant to compensate these facilities for the lost revenue. When asked, the reasons given for charging higher fees were that lower-level facilities were not compensated enough for the loss of revenue, and that facilities needed to meet ever-increasing demand for healthcare services (Chuma et al., 2009).

Even though fees at primary-level facilities were low, there was widespread evidence to show that such fees could encourage self-treatment and generate very little revenue for health facilities. In some countries, the fees acted as a barrier to the timely use of health services or led to non-utilization of health services, resulting in increased morbidity and mortality (Russell, 2004).

In response, the newly elected Jubilee government abolished user fees in all public dispensaries and health centers on June 1, 2013. To address the challenges experienced during the first attempt to reduce fees, the government allocated funds to compensate health facilities for revenue loss arising from the removal of user fees. The national government set aside KShs 700 million in the fiscal year (FY) 2013/2014 budget for this purpose, channelling the funds through the HSSF. This report presents findings from the first evaluation of the abolition of user fees at primary healthcare facilities in Kenya.

Rationale of the Study

Previous experiences with removal of user fees in Kenya and elsewhere indicate limited impact in terms of the utilization of health services (Schneider and Gilson, 1999; Wilkinson et al., 2001). Evaluations have also shown that the removal of user fees is only effective in the first year of implementation and that the majority of facilities reintroduce fees later for various reasons, including lack of supplies and medicines, delays in fund reimbursement, and the need to hire additional support staff whose salaries are not covered in the normal allocations (Chuma et al., 2009). Continuous monitoring and evaluation of the new policy in Kenya is therefore important, not only to ensure that the intended goals are achieved, but also to identify potential challenges in the process early on and make recommendations on how these can be addressed.

The Kenya Ministry of Health (MOH), with support from the USAID- and PEPFAR-funded Health Policy Project (HPP), commissioned a study to document the impact of the user fee removal on healthcare utilization patterns, costs of treatment, and communities' understanding of the policy. The study assesses the key drivers and impact of the removal of user fees since June 2013 and documents health workers' experiences in the implementation process. The MOH set up a technical working group, which included key stakeholders, to guide the implementation of the study and ensure that it captured issues of interest and value to the health sector. In 2013, HPP conducted a baseline assessment using data drawn from the District Health Information System.[2]

This evaluation will facilitate monitoring of the impact of the policy and the extent to which the policy is meeting its objectives. The results were compared with the baseline to show patterns of change in the key variables identified through the technical working group. These variables include

- Extent to which health facilities are adhering to user fees removal
- Extent to which the poor and vulnerable populations are benefiting from free health services
- Revenue collection patterns
- Changes in patterns of health service utilization
- Perceptions of the quality of care
- Increased public funding
- Availability of medicines and related supplies
- Staff attitudes

Study Objectives

The overall aim of the evaluation was to assess the impact of the removal of user fees at primary public healthcare facilities in Kenya. Specifically, it aimed to

- Determine health facilities' adherence to the user fees removal policy after 19 months of implementation (June 2013–March 2015)
- Assess the impact of the free primary healthcare policy on access to and utilization of health services among the poor and vulnerable
- Document service users' perceptions of the policy design and implementation, and its impact on the quality of care
- Document the extent to which facilities have essential commodities and supplies, and assess the impact of the free primary healthcare policy on the availability of these essential commodities

[2] Chuma, J. and T. Maina. 2013. *Free Maternal Care and Removal of User Fees at Primary-Level Facilities in Kenya: Monitoring the Implementation and Impact—Baseline Report.* Washington, DC: Health Policy Project, Futures Group. Available at http://www.healthpolicyproject.com/index.cfm?id=publications&get=pubID&pubID=400.

METHODOLOGY

Study Design

The study adopted a multiple methods design, which included both quantitative and qualitative methods. The use of multiple methods was necessary so that one method could address the weaknesses associated with the others.

Target population

Following discussions between the MOH and HPP, the study team agreed to design the annual evaluation to allow for a comparison of findings with other key studies conducted in the country that had provided some baseline data, especially on quality of care. One such survey is the *Public Expenditure Tracking Survey in Kenya, 2012 (PETS-Plus)*, conducted in 2012 and supported by HPP and the World Bank (Onsomu et al., 2014). The research team adopted the sampling strategy used in the *PETS-Plus* survey to select a nationally representative sample of facilities. The sample was comprised of both public and faith-based dispensaries and health centers. Multiple units of analysis, each related to the key objectives, were used as follows:

1. Individuals: for indicators related to understanding the policy, service utilization patterns, and cost burdens
2. Health facility: for document reviews and indicators related to outpatient utilization patterns, facility income and expenditure, and inputs (including commodities and supplies)
3. Health workers: for those indicators measuring providers' perceptions of the policy
4. Health facility committees and county health managers: for indicators related to these groups' perceptions of the policy implementation process, impact, and cost burden

Sampling size and strategy

Using a multistage cluster sampling strategy, the study team selected 250 health facilities to be surveyed. The study was designed to include faith-based facilities to allow for comparison. The sampling strategy was designed to produce nationally representative estimates, having a minimum power of 80 percent with a 0.05 level of significance, and allow for disaggregation by geographic location (rural/urban), provider type (public/private), and facility type (dispensary/health center). Based on the hypothesis, increased utilization of public facilities occurred following the removal of user fees, which may have led to a decline in the number of visits made to faith-based dispensaries and health centers. Drawing from the *PETS-Plus* experience, some strata were over-sampled to allow for meaningful analysis at that level.

Fifteen out of the 47 counties were selected, after which health facilities were randomly selected by strata within each sampled county (i.e., four strata capturing ownership [public/private] by facility type, dispensaries or health centers). Of the 15 counties, five were pre-selected: Nairobi and Mombasa, the most populous cities; and Nyandarua, Nyamira, and Siaya, because of their baseline poverty rates (Table 1) and service delivery outcomes. To select the other 10 counties, the study team first stratified the counties by above- or below-median urbanization, and then by above- or below-median poverty; the team then randomly selected the 10 counties with probability in proportion to their population size. Appendix 1 shows the distribution of facilities in the sample across the selected counties.

Table 1. Counties Included in the User Fees Removal Study

County	Poverty levels (%)
Bungoma	52.2
Homa Bay	43.1
Kilifi	66.9
Kirinyaga	25.6
Kitui	62.5
Makueni	63.8
Nairobi	22.0
Nakuru	41.8
Nyamira	46.3
Nyandarua	49.8
Siaya	35.6
Trans Nzoia	50.1
Uasin Gishu	44.6
West Pokot	68.7
Mombasa	37.6
National level	**45.9**

Data Collection Methods

Data were collected through document review and key informant interviews. The data collection methods are described in more detail below:

1. **Exit interviews:** Exit interviews were conducted with 7–10 clients at each participating health facility using a semi-structured questionnaire to capture data on socioeconomic characteristics, service users' perceptions of service availability, quality of care (i.e., illness patterns, utilization, attitude of health workers, interaction with health workers, medicine availability, health facility cleanliness, and maintenance) and levels of fees charged, if any.
2. **Facility record reviews:** Health facilities records were reviewed to extract data on utilization patterns for FYs 2011/2012–2013/14. The data was collected by age and gender for all services offered at dispensaries and health centers, including but not limited to outpatient services, laboratory, antenatal care (ANC), HIV and AIDs counselling and testing, and deliveries.
3. **In-depth interviews:** Interviews were conducted with MOH representatives, health workers, and representatives from the sampled counties' health management teams. Researchers interviewed all officers in charge of facilities (in-charges) and a selected number of health workers in the sampled facilities to document their experiences with policy implementation. The study also sought to establish interviewees' perceptions of the impact of the removal of user fees on facilities' ability to operate. They were also asked whether facilities received revenue compensation in a timely manner and what, if any, coping strategies had been adopted to allow the facilities to offer services effectively. Table 2 summarizes the data sources and the kind of information gathered from each source.

Table 2. Data Sources and Range of Information Collected

Data Source	Type of Information	Description of Information Collected
National level	Quantitative	• Issues related to the flow of resources from government to lower-level facilities
	Qualitative	• Key informant interviews with senior MOH managers on implementation of the policy change and challenges experienced
County level	Quantitative	• Overall allocations to each county • Allocations attributed to the policy change for each policy orientation • Changes in amount of revenues from user fees collected
	Qualitative	• Key informant interviews with decisionmakers on implementation of the policy change
Primary healthcare facilities	Quantitative	• Records review for utilization of healthcare services relating to outpatient department and other services (e.g., maternal deliveries, etc.) • Records review for trends in access and quality of care • Records review for specific utilization of services from households in the selected catchment area, profile users by social economic characteristics • Review of financial records
	Qualitative	Key informant interviews with facility in-charges on issues related to the implementation of the policy
Patient exit interviews	Qualitative	Patient exit interviews to collect information at the household level on utilization of healthcare by socioeconomic groups

Data Management and Analysis

Quantitative data were entered into fox-pro® and transferred to STATA® 11 for analysis. Analysis of the qualitative data was conducted throughout the study to prevent backlogs and to ensure that the instruments and approaches were amended based on emerging findings. Detailed notes were taken for all in-depth interviews, typed into Microsoft Word®, and analyzed manually using the thematic framework approach. A code book was developed with deductive codes based on the interview and focus group discussion guides, using the list of topics identified.

Survey Respondents

The survey obtained information form health workers and clients/patients. The section below provides the characteristics of the respondents interviewed.

Characteristics of Facility In-charges, Health Workers, and Clients/Patients Interviewed

A total of 225 lower-level facilities participated in the survey. These included,98 public health centers, 35 public dispensaries, 39 health centers run by faith-based organizations (FBOs)/nongovernmental organizations (NGOs), and 53 FBO/NGO-run dispensaries. In-depth interviews were conducted with health facility in-charges and health workers. Patient exit interviews were also conducted in all participating health facilities. Interviews were conducted with 225 facility in-charges, 557 health workers, and 2,159 facility clients/patients through exit interviews. Table 3 shows the number of health facilities included in the study and the number of respondents for in-depth interviews and patient exit interviews.

Table 3. Numbers of Facilities and Respondents

Interviews	Public Facilities		Faith-based Facilities		
	Health Centers	Dispensaries	Health Centers	Dispensaries	Total
Facility in-charges	98	35	39	53	225
All health workers (including in-charges)	263	65	108	121	557
Client/patient exit interviewees	1,002	326	442	386	2,159

Table 4 shows the characteristics of the in-charges for public and faith-based facilities. The results show that about 61 percent of the facilities' in-charges were female and 39 percent were males. The majority were registered nurses (56%). Others were clinical officers (30%), enrolled nurses (11%), and those with health-related qualifications (3%). In-charges at health centers were mainly registered nurses (58%) and clinical officers (40%), while 77 percent of all public dispensaries were managed by registered nurses. Only 15 percent and 9 percent of public dispensaries were managed by clinical officers and enrolled nurses, respectively. A similar pattern was observed in faith-based facilities, with registered nurses managing 57 percent of the participating health centers, followed by clinical officers at 25 percent and enrolled nurses at 14 percent. Registered nurses managed 40 percent of faith-based dispensaries, while enrolled nurses and clinical officers managed an equal proportion of 26 percent each.

Table 4. Distribution of Facility In-charges Interviewed by Qualification and Facility Type and Ownership

	Public Facilities		Faith-based Facilities		
	Health Centers	Dispensaries	Health Centers	Dispensaries	Overall
Clinical officers	40%	15%	25%	26%	30%
Registered nurses	58%	77%	57%	40%	56%
Enrolled nurses	2%	9%	14%	26%	11%
Others	0%	0%	5%	8%	3%
Total	**100% (98)**	**100% (35)**	**100%(39)**	**100% (53)**	**100% (225)**

In terms of the health workers who participated in this study, 44 percent were registered nurses, 18 percent clinical officers, 14 percent enrolled nurses, and 14 percent laboratory technicians. Two percent of all health workers were community health workers, with the remaining 8 percent belonging to other cadres that also included support staff.

Table 5. Distribution of Health Workers Interviewed by Qualification and Facility Type and Ownership

	Public health centers	Public dispensaries	FBO health centers	FBO dispensaries	Overall
Clinical officers	18%	12%	19%	21%	18%
Registered nurses	51%	60%	39%	22%	44%
Enrolled nurses	11%	17%	14%	20%	14%
Lab technicians	11%	8%	16%	21%	14%
Community health workers	2%	2%	0%	3%	2%
Others	6%	2%	12%	14%	8%
Total	**100% (263)**	**100% (65)**	**100%(108)**	**100% (121)**	**100% (557)**

Overall, 65 percent of exit interview participants had come for treatment services for themselves or their child, 8 percent for immunizations, 9 percent for ANC services, and 2 percent for family planning and post-natal care.

RESULTS

Utilization Patterns Before and After Policy Change

This section presents data on utilization patterns for different services and age groups before and after the policy change. Key services covered included outpatient services, ANC, immunization, family planning, HIV testing, and post-natal care, among others. These data were extracted from the facility records. Results were compared between government and faith-based facilities. The hypothesis is that utilization in public facilities increased following the removal of user fees and that this increase may have led to a decline in the number of visits made to faith-based dispensaries and health centers.

Utilization of outpatient services

The percentage change in utilization of health services was computed by comparing data from facility records 19 months before and 19 months after the user fees removal. Table 6 shows the mean monthly total outpatient visits for both first visits and re-attendances for children under age five and for the population over age five, for public and faith-based health centers and dispensaries.

Table 6. Public Health Centers and Dispensaries Utilization

Factor	Time Period	Total*	Total Months	Average per Months	P <0.05	% Increase*
Public health centers and dispensaries						
Total outpatient visits (under age 5)	Before	767,289	19	40,384	Yes	124.9%
	After	958,385	19	50,442		
Total outpatient visits (over age 5)	Before	1,433,433	19	75,444	Yes	137.0%
	After	1,958,190	19	103,063		
FBO health centers and dispensaries						
Total outpatient visits (under age 5)	Before	310,491	19	16,342	No	-125.0%
	After	233,468	19	12,288		
Total outpatient visits (over age 5)	Before	525,859	19	27,677	Yes	119.0%
	After	626,855	19	32,992		

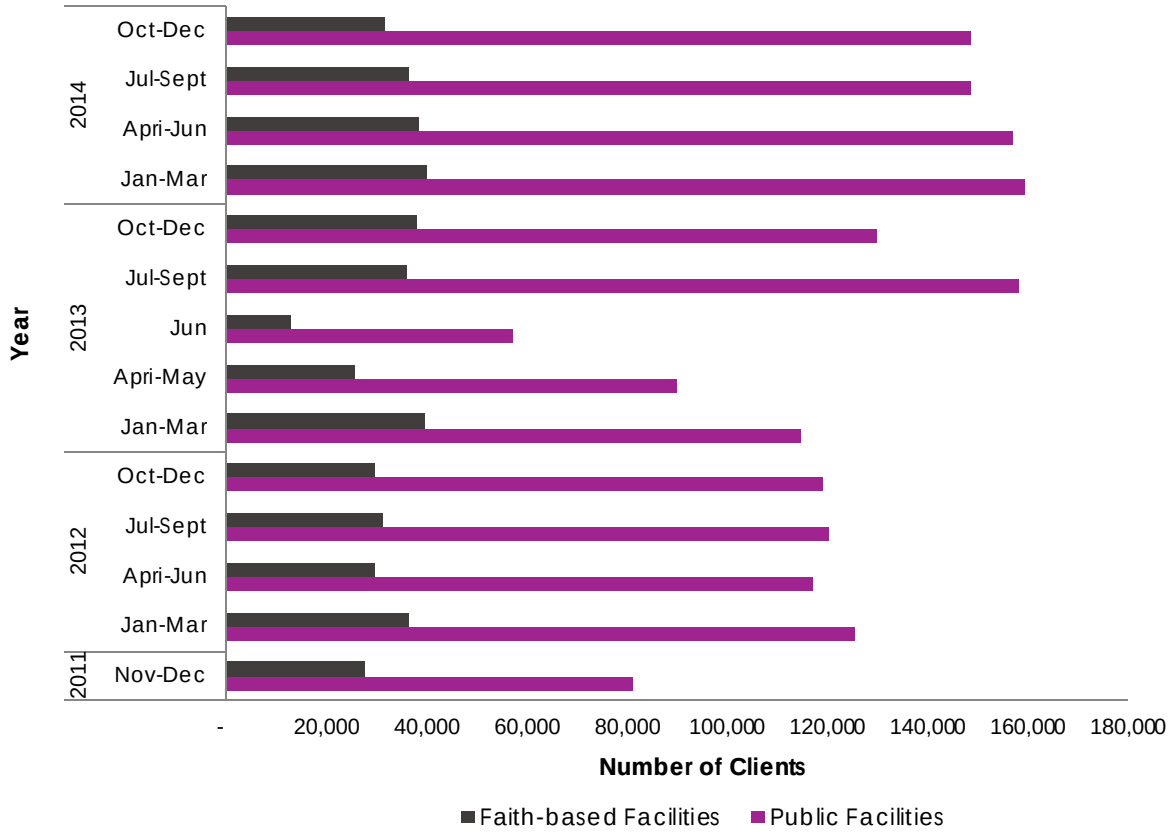
*Total is the sum across all facilities of either FBO or public facilities.

Utilization of outpatient services among children under age five

Figure 1 and Table 6 demonstrate the changes in healthcare utilization 19 months before and after the implementation of the user fee removal policy for both public and faith-based health facilities. For public health centers and dispensaries, total outpatient visits for children under age five increased by 24.9 percent. The increase was statistically significant ($p<0.05$). For the faith-based facilities, total attendances for children under age five decreased by 25 percent. For the period before the policy was introduced, the average monthly utilization of outpatient services for the entire sample of public health centers and dispensaries for those under age five was 40,384. Between June 2013 and December 2014 (the intervention period), the average monthly utilization of outpatient services for the entire sample of public health centers and dispensaries increased to an average of 50,442. For faith-based facilities, the average monthly utilization rate before the policy was introduced was

16,342. After the policy was introduced, the utilization rate reduced to an average of 12,288. This may imply that patients were opting instead to consume free care at public health facilities.

Figure 1. Outpatient Utilization, Under Age Five (first visit and re-attendance)



Utilization patterns among individuals over age five

Figure 2 and Table 6 show the utilization of health services in public and faith-based lower-level facilities for the population over age five. Study results showed that utilization among this population in public health facilities increased by 37 percent following the user fees removal. This increase was statically significant ($p<0.05$). Utilization of outpatient services for those over age five at faith-based facilities also slightly increased by about 19 percent—also statistically significant ($p<0.00$)—implying that the implementation of user fees removal had no major impact on patients' choice of healthcare provider between public and faith-based facilities for the population over age five. The mean total monthly outpatient visits for public health centers and dispensaries was 75,444, and increased to 103,063 after the policy was introduced. For faith-based lower-level facilities, the mean total monthly visits for outpatient services were 27,677 before the policy, and rose to 32,992 after the policy was introduced.

Figure 2. Outpatient Utilization for Population over Age Five (first visit and re-attendance)

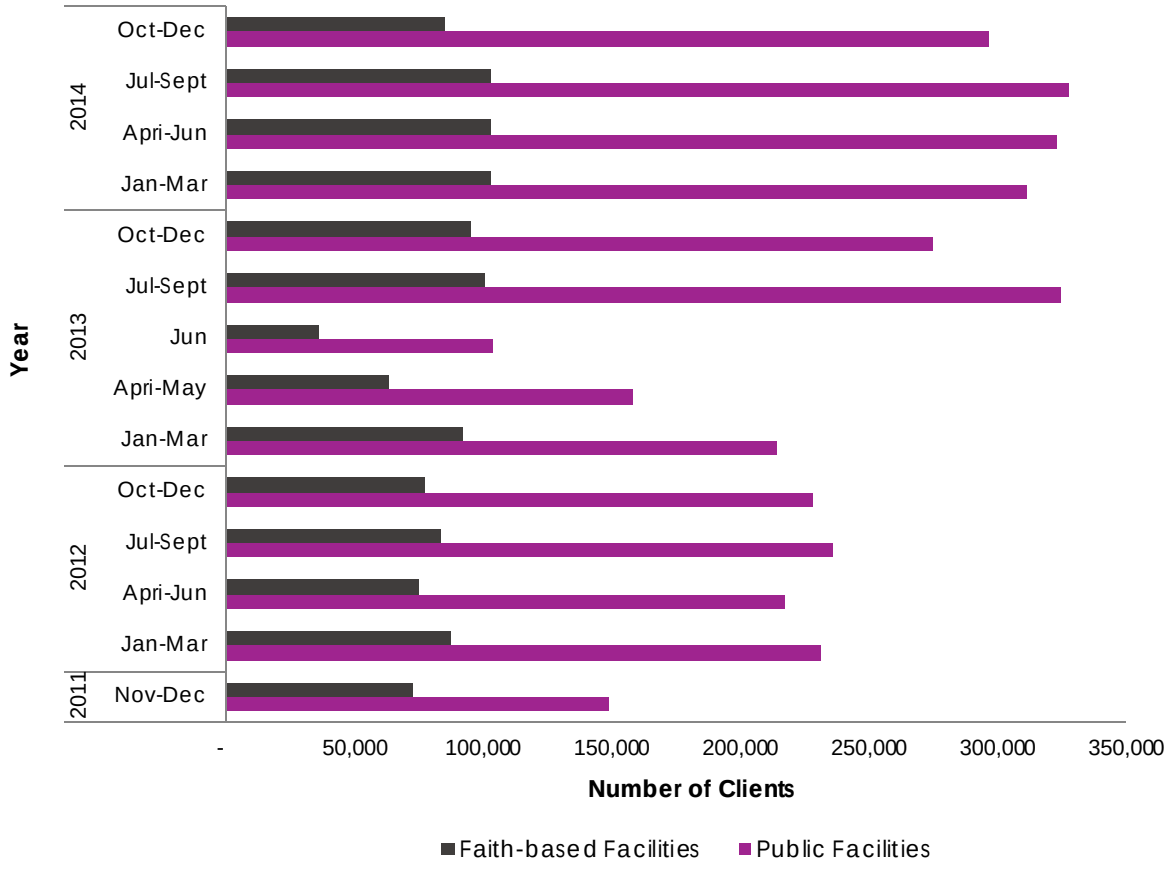


Figure 2 shows a massive increase from July–September 2013 in utilization of health services in public health facilities, which then dropped in October–November 2013 due to a health worker strike. The strike affected the provision of services in all public facilities throughout the country. Despite this drop, there was an overall increase in utilization of health services that can be attributed to the abolition of user fees at public primary health facilities. At faith-based health facilities, utilization by those age five and younger reduced marginally by about 25 percent. The conclusion is that the user fees removal in public primary health facilities had a negative impact on faith-based primary health facilities, with the possibility that users migrated to public health facilities.

Utilization pattern of other outpatient services

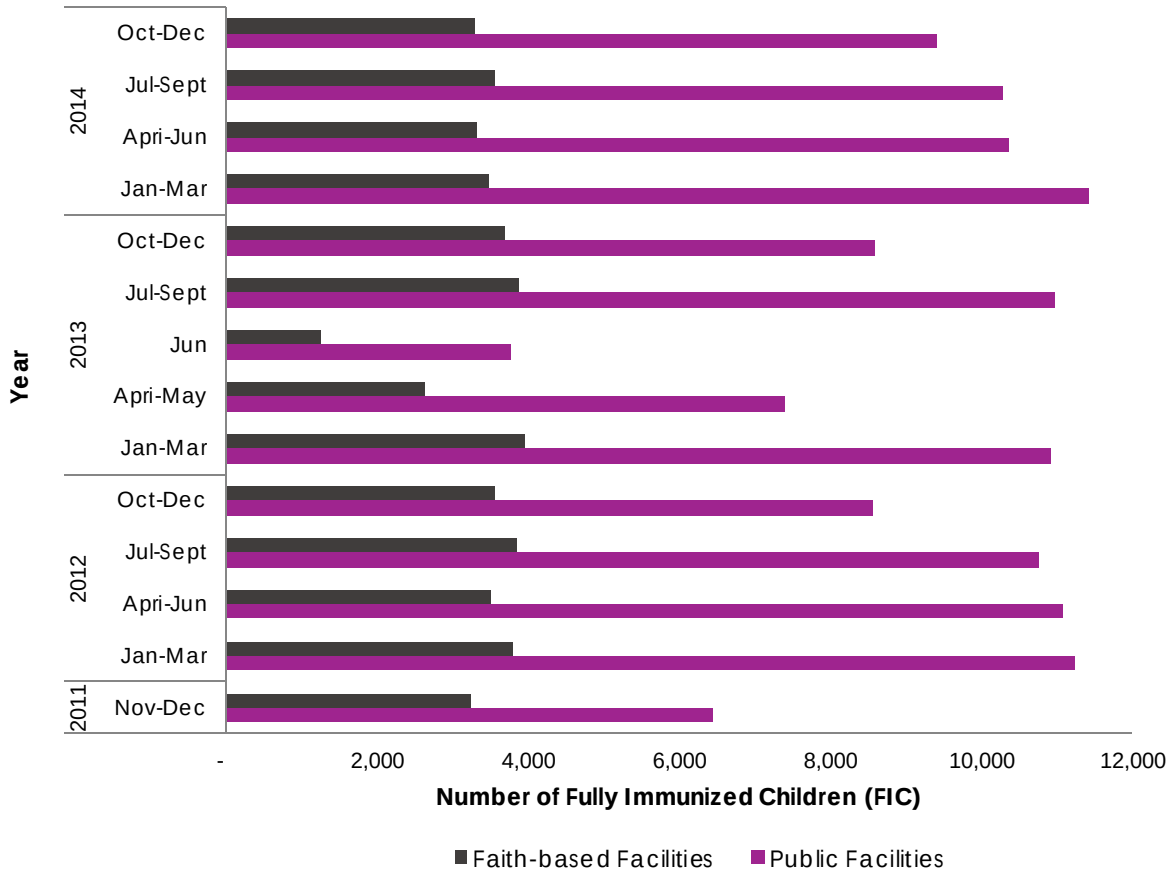
Overall, there was minimal change in the number of children fully immunized in both public and faith-based facilities pre- and post- policy implementation. The minimal change in uptake of

immunization services in public health facilities was expected considering that such services were free in these facilities prior to implementation of the user fees removal policy. Table 7 and Figure 3 show that, in general, there was a slight decrease of about 7 percent in the number of children fully immunized in public health centers and dispensaries, which was not statistically significant. Faith-based facilities also recorded a slight decline (about 3%) in the number of children fully immunized, which was also not statically significant (p=0.00). Interestingly, in the first quarter (July–September 2013) of policy implementation, public health facilities experienced a slight increase, compared to the first and second quarters.

Table 7. Public Health Centers and Dispensaries Utilization of Immunization and ANC Services

Factor	Time Period	Total	Total Months	Average per Month	P <0.05	% Increase
Public health centers and dispensaries						
Fully immunized children	Before	66,382	19	3,494	No	-107%
	After	61,480	19	3,236		
Laboratory (routine and special)	Before	888,631	19	46,770	Yes	147%
	After	1,307,340	19	68,807		
FBO health centers and dispensaries						
Fully immunized children	Before	23,356	19	1,229	No	-103%
	After	22,454	19	1,182		
Laboratory (routine and special)	Before	582,076	19	30,636	Yes	130%
	After	759,330	19	39,965		

Figure 3. Fully Immunized Children



Routine and special laboratory tests

The number of routine and special laboratory tests performed increased after the removal of user fees (Table 7 and Figure 4). Increases were recorded in both public and faith-based facilities, with the highest peaks recorded in July–September 2013 and April–June 2014. The mean total monthly number of laboratory tests before the policy was introduced was 46,770 tests, but this increased to 68,807 tests after the policy was introduced, an increase of about 47 percent. The increase was statistically significant (p-value <0.00). Faith-based facilities also reported an increase in the number of routine and special tests (30%).

Figure 4. Number Routine and Special Laboratory Test

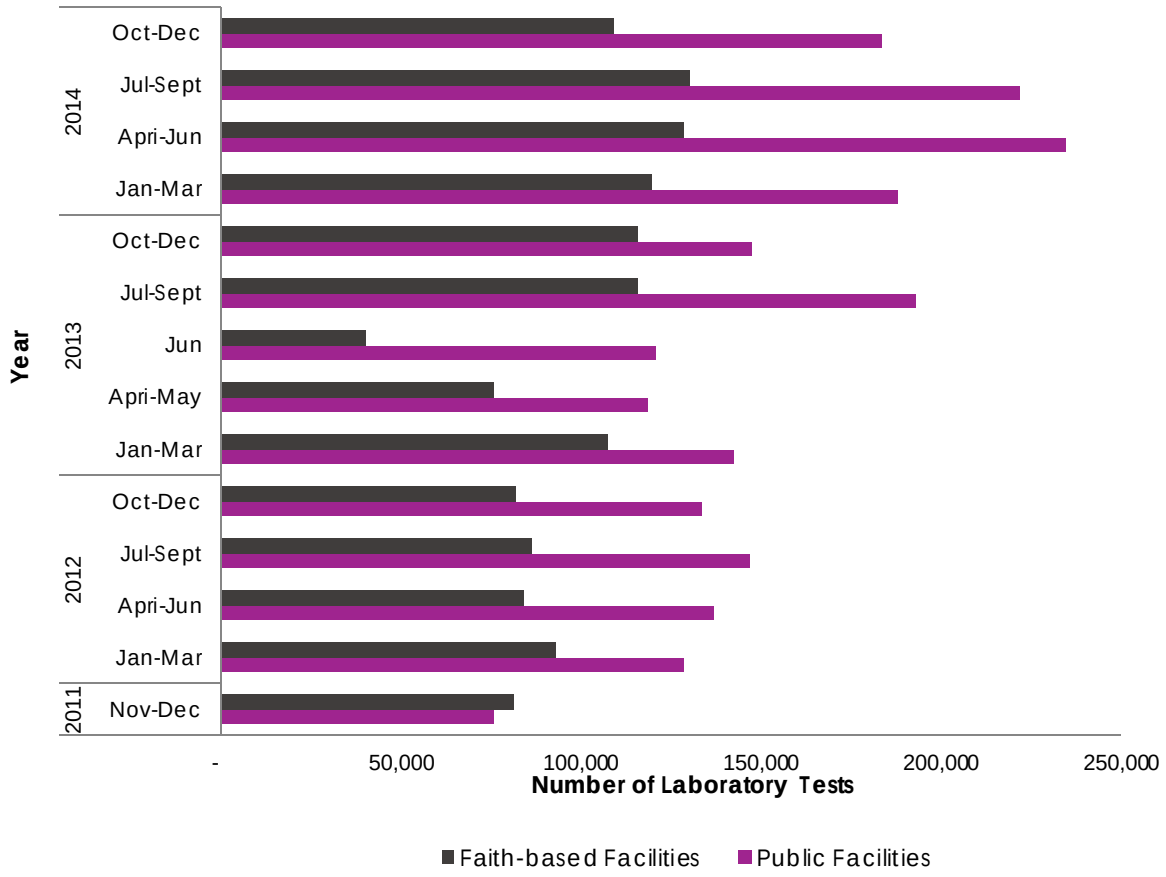


Table 8. Utilization of ANC and Delivery Services in Public and FBO Facilities

Factor	Time Period	Total	Total Months	Average per Month	P <0.05	% Increase
Public health centers and dispensaries						
ANC (1st and 4th visit)	Before	126,878	19	6,678	Yes	175%
	After	221,826	19	11,675		
Deliveries	Before	25,248	19	1,329	Yes	126%
	After	31,822	19	1,675		
FBO health centers and dispensaries						
ANC (1st and 4th visit)	Before	37,482	19	1,973	No	103%
	After	38,532	19	2,028		
Deliveries	Before	10,954	19	577	No	102%
	After	13,282	19	699		

Utilization of ANC services, first and fourth visit

Table 8 and Figures 5 and 6 show the number of pregnant women who utilized ANC services (first and fourth visits). The results show an increase of about 75 percent (Table 8) in the uptake of ANC

services (both first and fourth visits) at public health facilities, following the policy change. The increase was statistically significant ($p<0.01$), implying that the removal of user fees had a positive impact on the utilization of ANC services. For faith-based facilities, the uptake of ANC services increased marginally by 3 percent, which was not statistically significant. Clearly, public health facilities were preferred for ANC services after the policy was introduced.

Figure 5. Number of Pregnant Women Making First ANC Visit

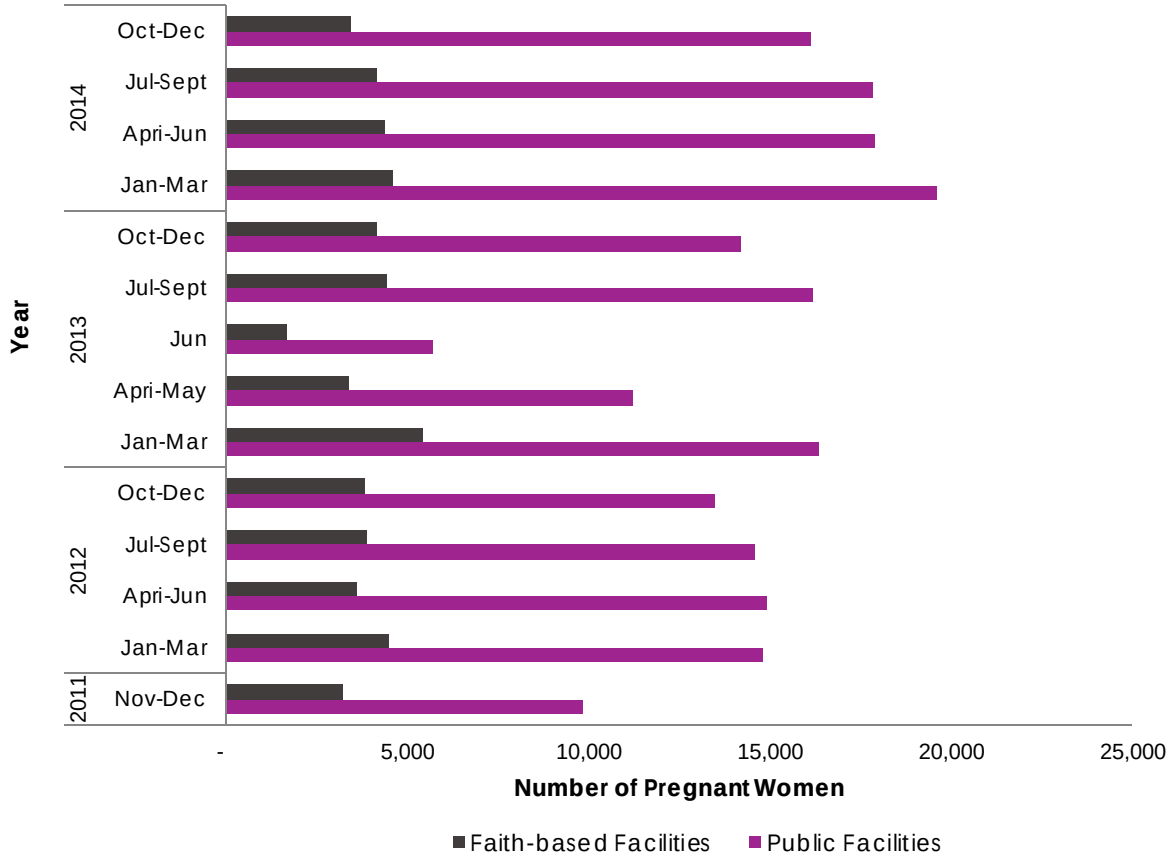
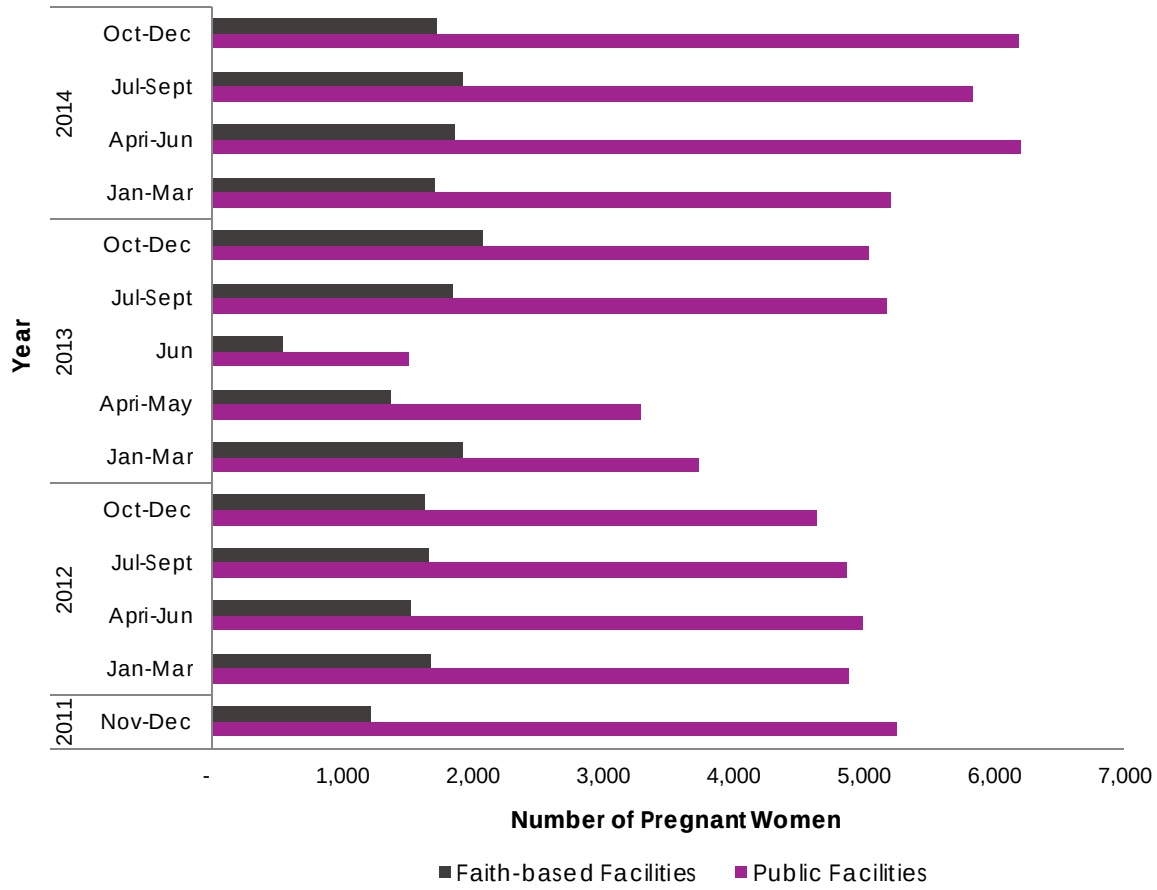


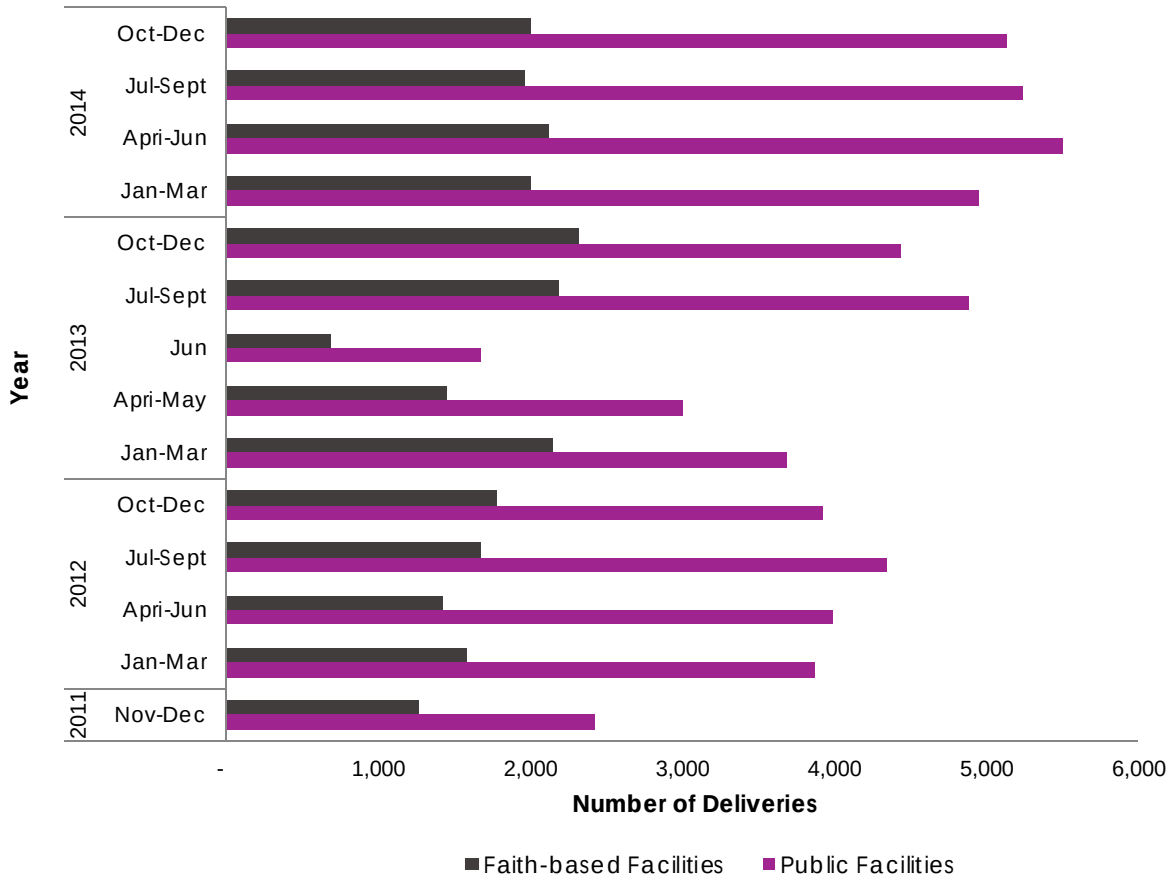
Figure 6. Number of Pregnant Women Making >= 4 Visits



Utilization of delivery services

Table 8 and Figure 7 show the number of mothers delivering at public and faith-based health centers and dispensaries. Table 8 (p. 13) shows a significant increase in the total number of deliveries in public health centers and dispensaries, a statistically significant increase of about 26 percent ($p<0.00$). The fact that maternal health services were also free may have contributed to the significant increase in deliveries in public, lower-level facilities. Faith-based facilities also recorded a slight increase of about 2 percent, which was not statistically significant.

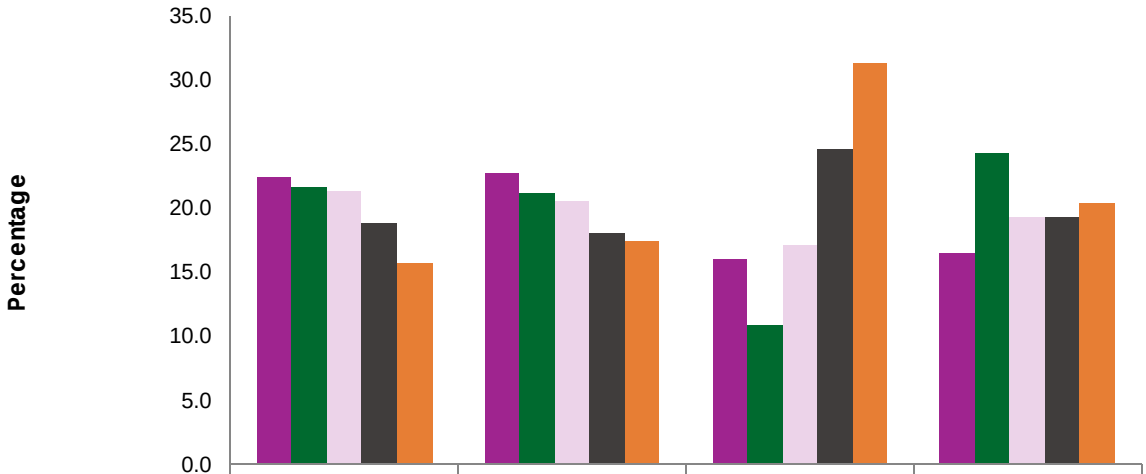
Figure 7. Total Number of Deliveries in Health Centers and Dispensaries



Utilization of outpatient health services by socioeconomic groups

The socioeconomic status of clients seeking outpatient health services was measured using a wealth ranking technique developed by the Kenya National Bureau of Statistics. The technique uses various household amenities, convenience facilities, and other socioeconomic and asset characteristics. This method was adopted so that the study's findings would be consistent with other local, household-based surveys (e.g., the *Kenya Health Demographic Survey* and the *Kenya Household Health Expenditure and Utilization Survey)* that use the same wealth index. The index categorized the clients and their households into five quintiles: 1) poorest, 2) second poorest, 3) middle, 4) fourth richest, and 5) richest. Outpatient utilization rates for key outpatient services were then linked to the socioeconomic categories to determine the utilization of outpatient services by wealth categories. Using these data, Figure 8 shows the utilization of outpatient services by socioeconomic category.

Figure 8. Utilization of Outpatient Services by Socioeconomic Category



	Public Health Centres	Public Dispensaries	FBO Health Centres	FBO Dispensaries
Poorest	22.5	22.7	16.1	16.5
Second poorest	21.7	21.2	10.9	24.3
Middle	21.4	20.6	17.1	19.4
Fourth richest	18.9	18.1	24.6	19.4
Richest	15.7	17.5	31.4	20.4

The results reflect a pro-poor trend after the abolition of user fees policy was introduced, with about 44.2 percent of the consumers of outpatient services in public health centers and dispensaries coming from the poorest and second poorest wealth quintiles. However, the reverse is observed among faith-based health centers, and to some extent among faith-based dispensaries. The possibility that the poorest and the second poorest switched from faith-based to public health facilities may explain this trend. However, the results should be interpreted with a good deal of caution as the sample size is not large enough to make generalizations. In order to confirm it, the potential pro-poor trend would need to be investigated further through a household survey drawing upon a larger sample size.

Adherence to the Removal of User Fees Policy

Individuals who sought healthcare on the day of the survey were asked during exit interviews if they had paid any money for services they received that day and, if so, how much. Table 5 shows the distribution of reported responses by facility type and ownership. The results indicated that 14 percent of patients seeking care in public health centers and dispensaries and 80 percent of those seeking care in faith-based facilities had paid some money for services received.

Table 9. Payment Responses by Facility Type and Ownership (N=2,159)

Patients/clients who confirmed making payment for services they had consumed (%)				
	Public		FBO/NGO facilities	
	Health centers	Dispensaries	Health centers	Dispensaries
Paid any fees for services received?	14%	15%	81%	80%
Had debts/balances to be paid to the facility later	2%	6%	5%	8%

Patients/clients paid an average of KShs 91.3 (US$0.96) at public health centers and KShs 50 (US$0.53) at public dispensaries. At faith-based facilities, patients said they paid an average of KShs 195 (US$2.1) at health centers and KShs 104 (US$1.1) at dispensaries. The median amount of money

paid by clients who reported having paid for services was KShs 50 (US$0.53) for public health centers, KShs 30 (US$0.32) for public dispensaries, and KShs 150 (US$1.58) and KShs 100 (US$1.05) for faith-based health centers and dispensaries, respectively.[3] About 4 percent of interviewees who received care from public health centers and dispensaries—and 6 percent who received care from faith-based equivalents—owed the facilities some additional money for the services they had received that day.

An interesting finding from exit interviews was that many facilities continued to charge patients KShs 10 or 20 for registration/card books, or asked patients to buy a card/book for registration elsewhere before receiving free health services. About 10 percent of respondents who reported being asked to buy drugs or other items to facilitate treatment also reported that they had been asked to buy a card/registration book from other sources outside the facility.

Interviews with facility in-charges and other key informants confirmed that patients paid for some services, including issuance of registration card/book, drugs for some illnesses, laboratory services, and injections. The explanation given was that the reimbursement for free services was insufficient and could not fully cover operational costs, such as support staff and laboratory services. There were reports that facilities also used the money to buy drugs because shortages were common, a practice that had been endorsed by county health officials.

> *"What do you expect us to do when the money they are reimbursing us is not enough to meet the salaries of our support staff like clerks and watchmen. Our laboratory department was constructed by the community and the laboratory technician is paid through cost sharing revenues. The reimbursement grant even come[s] late, sometimes after six month[s]. Can you imagine?"*
>
> ~Health worker, Kitui County

The Policy Implementation Process

This section describes the implementation process of the removal of user fees in health centers and dispensaries. A critical review of the implementation process enables the identification of the factors that may have contributed to the outcome observed.

Stakeholders' involvement and consultation

Stakeholders' involvement and consultation is critical to ensuring ownership of a policy and to rally support for it. Interviews with key stakeholders at the national and county level indicated limited stakeholder consultation during the policy formulation and implementation phases. Health workers and facility in-charges interviewed as part of the study also expressed concern that they were neither consulted during the design and planning phase of the policy, nor supported during the initial implementation phase. Following the immediate removal of user fees, facilities did not have sufficient revenue to meet the operating costs.

> *"We were left on our own to figure out where drug supplies will come from due to the anticipated increase in utilization."*
>
> ~Health worker, Nyandarua County

However, the lack of consultation was attributed partly to the fact that the policy followed a directive by the president, which required instantaneous removal of user fees.

> *"The implementation of the policy was rushed and gradual implementation was not followed because immediate abolition of user fees was a presidential decree that required immediate implementation."*
>
> ~MOH official

[3] Exchange rate: US$1 is equivalent to KShs 95

Health workers' awareness of the user fees abolition policy

There was universal awareness of the abolition of user fees policy among health workers (100%), an indication that the president's announcement in June 2013, which was supplemented by the MOH through a circular, was effective in reaching all intended audiences. Key informants said they received information on the free primary healthcare policy through the president's announcement on June 1, 2013. In addition, health workers interviewed for the study reported that the cabinet secretary for health issued a circular communicating the presidential directive to county health officials, who cascaded the communication to the health centers and dispensaries. However, the circular was not clear on what services were to be free, and therefore caused confusion within the facilities.

> *"Since the presidential directive was to become effective immediately, the MOH did not have time to prepare guidelines to clarify what services were free, who was to benefit, and the reimbursement modalities."*
>
> ~MOH official

According to the health workers interviewed, the circular also did not clarify which categories of the population, in terms of gender and age, were expected to access free healthcare. In particular, it was unclear whether the policy also covered health centers/dispensaries operated by other government departments, including prisons and city and municipal councils. The lack of clarity might explain why health facilities in former municipalities—like Mombasa, Nairobi, Kisumu, and Nakuru counties—were initially reluctant to remove user fees. By the time of this study, the circular by the cabinet secretary remained the only policy document on the removal of user fees.

Reimbursement rates and mechanisms

Key informants at the national level reported that the reimbursement rate was based on historical data of revenue collected from user fees reported by each health facility, figures that were adjusted by 10 percent to account for expected increases in service utilization. This approach was not popular among county government officials and health facility in-charges, who felt that the historical data did not capture the utilization rates, leading to the insufficient allocation of funds.

> *"These funds do not match the utilization levels and are therefore inadequate to compensate facilities for lost revenue."*
>
> ~Key informant, health center, Homa Bay County

Reimbursement funds are channeled through the HSSF. This mechanism was set up in June 2010 to facilitate the transfer of funds directly from the National Treasury to primary healthcare facilities' bank accounts. The HSSF provided a platform to channel funds from different sources to dispensaries and health centers, without creating additional parallel structures. In so doing, facilities could receive consolidated funds for the implementation of a unified annual work plan. However, key informants interviewed felt that using this platform to channel user fee compensation funds was not clarified, leading to confusion regarding whether the funds were to be accounted for separately or as part of the HSSF funds, as stipulated by the HSS guidelines (MOPHS, 2010).

Interviews with health facility in-charges indicated a state of confusion, with many unable to differentiate between HSSF funds and user fee reimbursement funds. This may largely be because all funds come through the HSSF mechanism. For instance, health centers were receiving multiple funds through the HSSF, including user fee reimbursements, compensation for free maternity services, and the original HSSF funds. It was not easy for health workers to isolate any of these funds in their bank statements. Key informants reported that health facilities would prefer funds for free maternity services and the reimbursement of abolished user fees to be channeled into one stream to avoid the confusion:

"Why two reimbursement funds when maternal health services are part of the free primary healthcare package provided by health centers and dispensaries?"

~Key informant, health center, Nakuru County

Health facility in-charges also reported lengthy delays in receiving reimbursements, which they attributed to the HSSF and devolution. It was also reported that since health centers and dispensaries are under their docket, county governments insisted that HSSF funds should first be channeled directly to the common county revenues account before being transferred health centers and dispensaries. This caused lengthy delays in disbursing funds.

Interviews with key informants also indicated the existence of two parallel models of reimbursement. The first sends funds from the national level directly to county-level accounts, after which counties are expected to trigger the flow of monies to the respective lower-level health facility accounts. The second model circumvents the county revenue accounts and sends reimbursements directly to health facility accounts from the national level.

Patients' Perceptions of the Quality of Care Following the Removal of User Fees

This section presents information, collected through exit interviews, about the perceptions of clients/patients regarding changes in the quality of care. Respondents were sampled from patients/clients who had direct contact with the health centers and dispensaries before and after the removal of user fees, and who were asked to describe the changes they had observed over the two periods. Table 10 summarizes the results of the quality of services, as reported by the clients.

Table 10. Clients' Perceptions of Changes in Healthcare After the Removal of User Fees (N=2,159)

Services	No Change (%)	Improved Significantly (%)	Improved Slightly (%)	Declined Slightly (%)	Declined Significantly (%)
Reception/registration	35.4	25.9	32.4	4.74	1.5
Waiting time at facility	24.7	22.0	27.0	18.0	8.4
Time spent with health worker	30.0	33.3	32.2	7.2	2.3
Availability of drugs	22.4	24.8	24.2	16.6	12.0
Staff attitude	28.0	33.1	32.1	5.1	1.6
Cleanliness of facility	29.0	35.8	31.3	3.2	0.8

Overall, about one-third of the clients interviewed at both public and faith-based facilities indicated that services related to the registration of patients had either improved slightly (32.4%) or significantly (25.9%) since the implementation of policy, while roughly 35 percent reported that there had been no change. Overall, there was little evidence to suggest that either staff attitude or the cleanliness of facilities had deteriorated after user fees were abolished. Of the patients interviewed, 28 percent reported that there was no change in staff attitude, while approximately 33 percent reported that services had improved significantly and 32 percent that services had improved slightly. Regarding the availability of prescribed drugs, about 22 percent reported no change, while nearly 25 percent reported a significant increase and just over 24 percent reported a slight increase in availability of prescribed drugs. Nearly 30 percent of patients stated that drug availability had worsened following the removal of user fees.

Patients' perceptions of availability of drugs and other medical supplies

In-depth discussions with key informants and health workers indicted that user fees generated by lower-level facilities, though small in absolute terms, are important sources of discretionary funds and are used to pay for temporary health staff, drugs, and non-pharmaceuticals not supplied by the Kenya Medical Supply Authority.

Table 11 shows client responses to questions about the availability of drugs and other medical supplies in the facility. Close to 69 percent and 85 percent of those who sought care at public health centers and dispensaries, respectively, reported having received drugs from the facilities. This compares to 75 percent and 79 percent of those attending faith-based health centers and dispensaries, respectively. About 34 percent and 26 percent of clients who sought care from public health centers and dispensaries, respectively, reported that they were asked to buy drugs or other medical supplies elsewhere.

> *"Medical care is far from being totally free despite the government assurance as clients come here for the medical services which at times are also not free as we are in most cases asked to go and buy medicine that is not available here."*
>
> ~Exit interview respondent, Nyandarua County

Table 11. Clients' Perceptions of Availability of Drugs and Other Medical Supplies (N=2,159)

	Type of Health Facilities and Ownership			
	Public health centers (%)	Public dispensaries (%)	FBO health centers (%)	FBO dispensaries (%)
Have you been given any drugs today?	69.0	84.6	75.0	79.0
Are there any drugs/items for treatment that the doctor said you must buy elsewhere?	34.1	25.8	7.0	4.0
If yes, what have you bought or are you expected to buy?				
Drugs	48.2	35.0	11.0	6.0
Syringes	2.4	0.5	0.0	0.4
Bandage/gauze	0.1	0.9	0.0	0.4
Card/registration book	2.3	7.7	0.0	0.9

In-charges and other health workers interviewed reported that facilities experienced long delays in receiving supplies, which meant that they were unable to provide high-quality healthcare. The reports of missing critical medical supplies and frequent stock-outs were corroborated by interviews with county-level health officials. Health workers described the situation as leading to not only sub-optimal care for patients, but also additional workloads for health workers, who are forced to make unnecessary referrals and "borrow" critical out-of-stock supplies from neighboring hospitals.

> *"We keep on moving from one facility to another looking to borrow from these facilities some critical medical supplies that are missing in our facility are available. This is not good for us as we are at times accused by patients of "creating" an artificial shortage ourselves"*
>
> ~Dispensary health worker, Uasin Gishu County

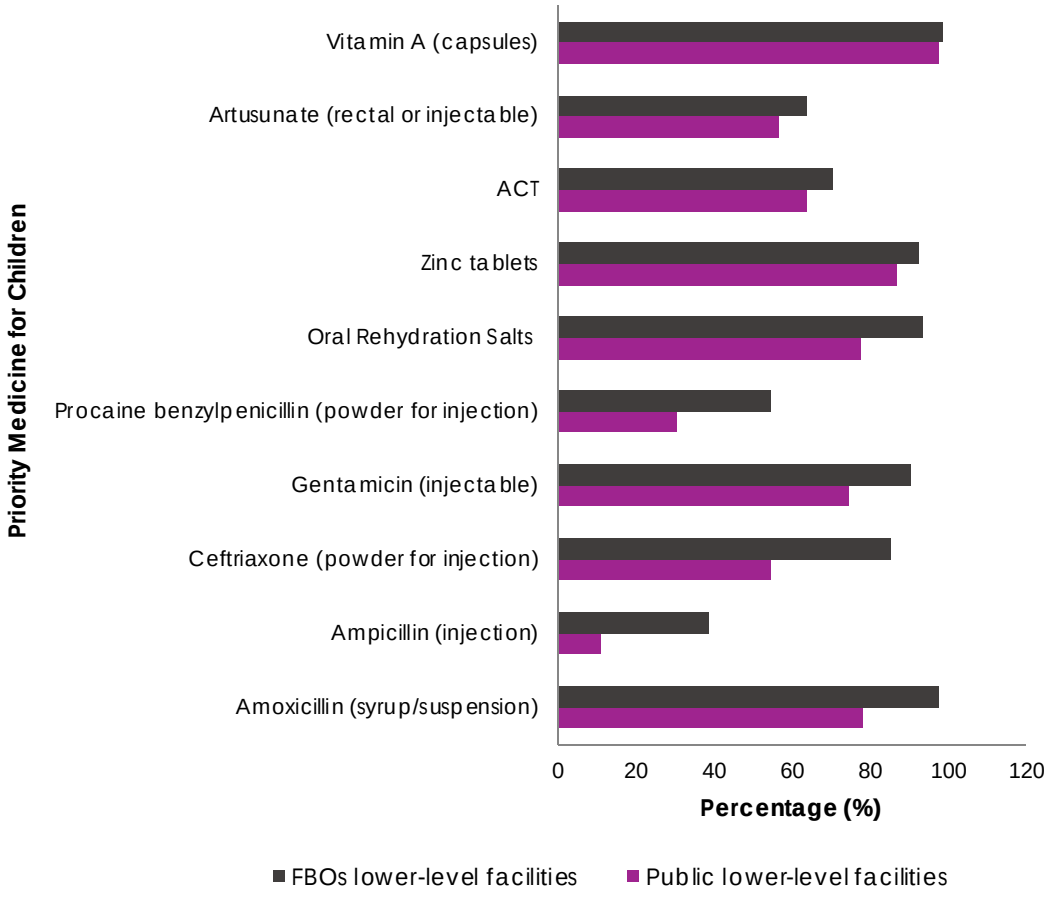
Availability of Key Health Inputs: Basic Infrastructure, Medical Equipment, and Essential Medicines for Mothers and Children

Access to essential health services depends on the availability of high-quality, essential health inputs such as infrastructure, medical equipment, and medicine. Inadequate and dilapidated infrastructure and non-functioning medical equipment generally leads to poor-quality health services. A set of service delivery-related indicators used in the *PETS-Plus* 2012 survey[4] was used to assess the availability of key inputs that include basic infrastructure and medical equipment and essential medicines for mothers and children. The following section summarizes the findings.

Essential medicines for mothers and children

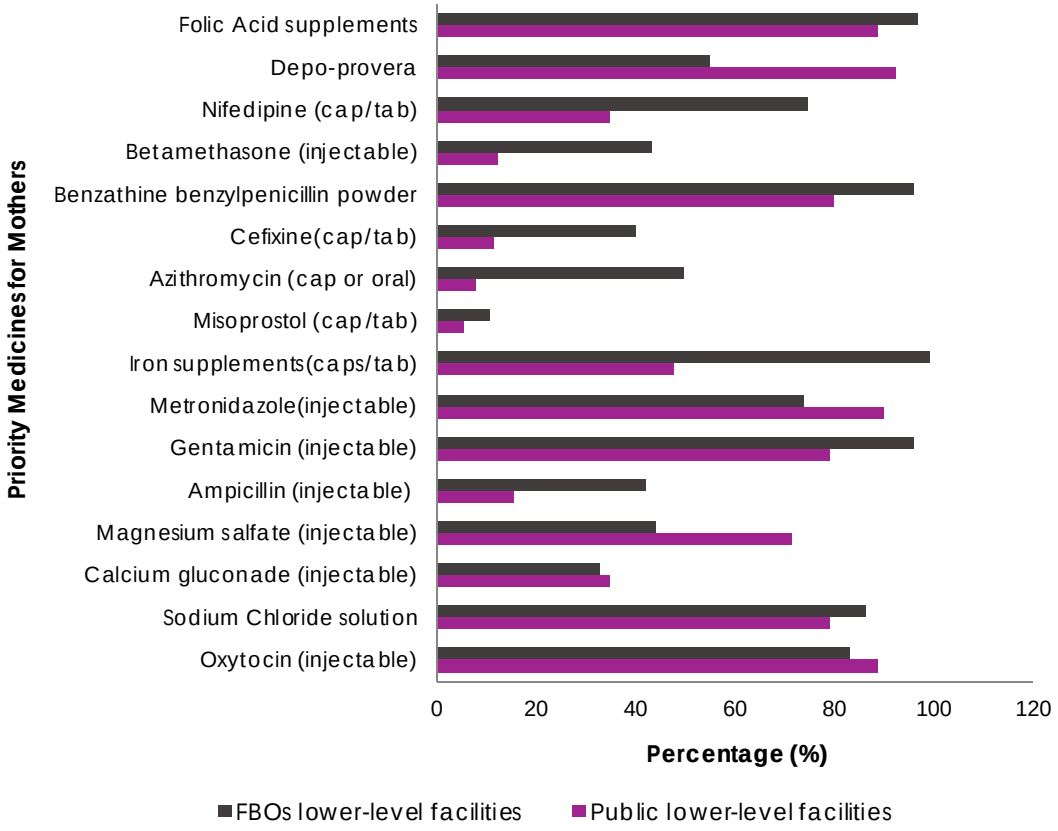
As shown in Figure 9, the availability of tracer drugs for children was relatively higher in faith-based health centers and dispensaries (78.7%) than in public health centers and dispensaries (63.3%). Figure 10 shows that public facilities (e.g., health centers and dispensaries) had 54 percent of the tracer/priority drugs for mothers' available while faith-based health centers and dispensaries had approximately 65 percent.

Figure 9. Availability of Priority Medicine for Children



[4] These include availability of essential medicine for mothers and children (15 tracer drugs for mothers and 10 tracer drugs for children), basic infrastructure (e.g., toilets, electricity, and clean water), and medical equipment (e.g., weighing scale, stethoscope, thermometer, and sphygmomanometer).

Figure 10. Priority Medicine for Mothers

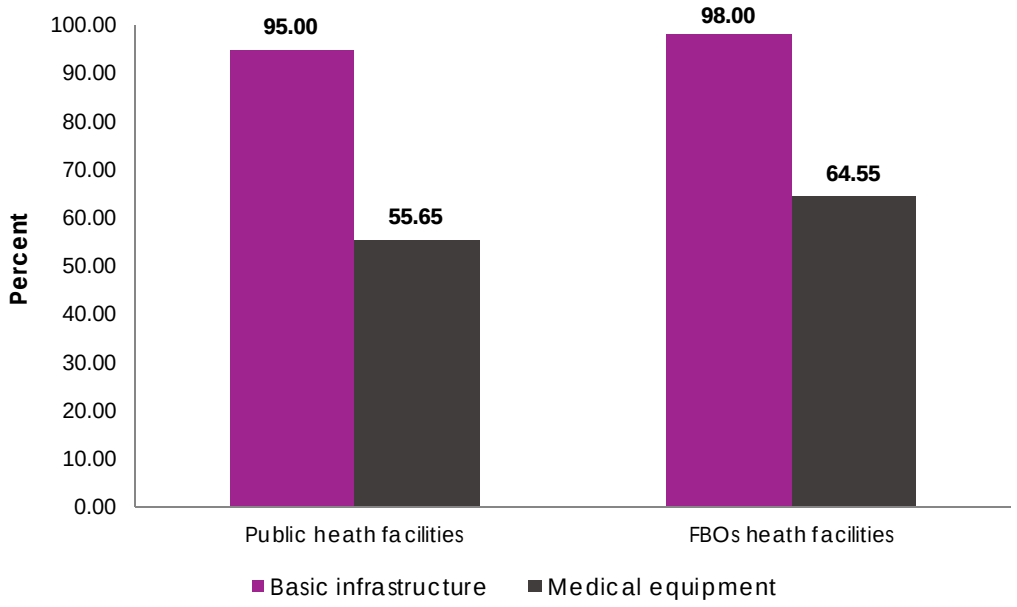


Infrastructure and medical equipment

The infrastructure availability indicator is an unweighted average of three items that measure the availability of clean water, toilets, and electricity. Access to these items ensures that health facilities are able to provide a certain level of health services. Using this indicator, approximately 95 percent of public health centers and dispensaries had basic infrastructure. The majority of faith-based health centers and dispensaries (98%) had basic infrastructure (Figure 11).

The medical equipment indicator shows the availability of basic medical equipment necessary to provide essential health services. The findings show that approximately 56 percent of public health centers and dispensaries had the medical equipment necessary to provide basic health services, compared with nearly 65 percent of faith-based health centers and dispensaries (Figure 11).

Figure 11. Infrastructure and Medical Equipment Availability, by Facility Ownership



Health Workers' Perceptions of the Removal of User Fees

This study examined health workers' perceptions of the removal of user fees and its impact on the working environment and quality of care for patients/clients.

Perceptions of the effect on patient situation

The findings show that most health workers interviewed agreed that patients were better off with the removal of user fees given that the poor could now access healthcare even for minor ailments. However, patients also faced drug shortages and long waiting times before they were attended to. Table 12 summarizes the responses to the most frequent issues raised by health workers.

Table 12. Issues Mentioned by Health Workers About Fee Removal That Has Changed Their and Their Patients' Situations (n=557)

	Yes	No
Has enabled poor clients to be provided with healthcare	92.2%	7.8%
The poor can now come with minor complaints	92.9%	7.1%
Has encouraged poor mothers to deliver in health facilities	92.0%	8.0%
Long waiting times	57.9%	42.1%
Worse for patients because of the persistent drug shortages	66.3%	33.7%

Most of the health workers interviewed said that the fee removal had changed the patients' situation for the better, especially for the poor, for whom the previously charged fees had been a major barrier to accessing healthcare. Over 90 percent of the health workers interviewed said that the poor now come for services, even for minor complaints.

> *"The free services have made it easy for patients who are poor to seek care at the right time. Fees removal has also encouraged poor pregnant women to come and deliver at health facilities, unlike in the past when they used to come when it was already too late when they see a serious complication."*
>
> ~Key informant/health worker, health center, Makueni County

"They wait to see any incoming truck that brings medicine to this facility from [the Kenya Medical Supply Authority] and then come and register to just collect drugs … they have forgotten [that] the importance of health matters now that healthcare is free."

~Key informant/health worker, dispensary, Nakuru County

The majority of health workers described long waiting times and persistent drug shortages as some of the negative effects occasioned by the removal of user fees on patients' situations.

Perceptions on the effect of the working environment

The significant increase in workloads in public health centres and dispensaries was a major concern to health workers and was raised by the majority of those interviewed. Seventy-eight percent said that removal of user fees had significantly increased the number of patients/clients they saw per day (Table 13). Thirteen percent reported some minimal increase and 10 percent reported no increase at all.

"User fee removal has increased the workload for us as the patients can come in any time of the hours and you are expected to attend to them."

~Nurse, health center, Bungoma County

Table 13: Has removal of user fees at public lower-level facilities increased the number of patients/clients seen by providers each day?

	Public	FBO/NGO
Yes, significant increase	77.61%	20.54%
Yes, some minimal increase	12.58%	26.79%
No increase at all	9.82%	52.68%

Health workers also reported that the policy change had worsened working conditions that were already challenging. For example, 76 percent of health workers indicated that the policy had led to fewer resources for essential commodities in the facility (Table 14). The revenues from user fees were seen as critical for buying essential items like supplementary drugs and non-pharmaceutical items such as laboratory reagents, cleaning material, and stationary. These revenues were also used to pay for the salaries of certain staff, such as laboratory technicians and cleaners. The majority of respondents (74%) thought that the policy change had led to long spells of drug shortages, making their own jobs more difficult and having a negative impact on patients who are then forced to go to the chemist where drugs are expensive.

"User fees were used to help us to get the necessary things (e.g., supplementary drugs that are not found in the drug kits). How can I treat a patient when I cannot give him the right drugs? Sometimes the reimbursement comes too little or comes at a time when you have waited for too long."

~In-charge, health center, Bungoma County

Table 14: Dimensions of the Impact of Free Healthcare on the Working Conditions of Health Workers

Questions Related to Working Conditions	Responses	
	Yes	No
Fewer resources for essentials in facility	76.0%	34.0%
We no longer have money to buy critical medicine not listed in the Kenya Essential Medical Supply Agency/Mission for Essential Medicine list	75.5%	24.5%
We no longer enjoy a cup of tea	47.8%	52.2%
We no longer have money to pay for transport allowances	51.8%	48.2%
More drug shortages	73.6%	26.4%
Long waiting time	59.2%	40.8%
Higher job satisfaction	38.0%	61.0%

Interviews with in-charges and county health officials indicated that some support staff—namely cleaners, clerks, and some technical staff, most notably laboratory technicians—had been laid off because of the removal of user fees and the delay in disbursement of HSSF funds. The absence of critical staff like laboratory technicians contributed to a human resource crisis, which manifested itself in a decline of health workers' morale and attitudes toward their work. In some counties, respondents felt that this crisis had led to health workers feeling overworked. In some facilities, the absence of critical staff contributed to the closing of some facilities' laboratory units and patients being forced to seek laboratory tests elsewhere.

DISCUSSION

This study set out to assess the impact of the removal of user fees in public, primary healthcare facilities in Kenya on service delivery, service uptake, and the perceived quality of care. Observed patterns in public, primary healthcare facilities were compared with those reported in faith-based facilities. Here the results are discussed in more detail and compared with the literature on the impacts of user fee removal in low- and middle-income countries.

The user fee removal policy was poorly communicated and hurriedly implemented.

Literature on a variety of health system reforms in developing countries, including the abolition of user fees, shows that the process of policy change—usually depicted by the interaction between actors, processes, design features, and context—determines the outcome of the policy change (Gilson and McIntyre, 2005). Experiences have shown the importance of the implementation process, which if carefully planned, leads to the achievement of the desired results reflected by the expected outcomes of the policy. Implementing the abolition of user fees policy and achieving the anticipated increase in the utilization of healthcare requires the mobilization of adequate resources. This ensures that adequate drugs are available, averting repeated stock-outs; that critical health workers are hired to meet the increased workload; and that prompt and adequate reimbursements are made to participating health facilities.

In Kenya, the decision to implement the policy to eliminate user fees was made swiftly, without adequate planning and consultation. In addition, health workers were not informed of the change and there was no related policy document in place to guide policy implementation. Consequently, the policy is subject to different interpretations. Some facilities charge for services, such as laboratory tests, that they consider separate from the free primary healthcare services covered under the policy.

Levels of policy adherence are high, but a few facilities continue to charge user fees.

The findings presented in this report show that the majority of individuals seeking care were not charged any fees. However, about 15 percent of respondents paid for the services they received, which means that not all facilities are adhering to the user fees removal policy; even in facilities that do adhere, there is ambiguity in terms of what is free and what should be paid for. Therefore, a package of health services that are free at the point of consumption needed to be clarified to avoid the kind of confusion experienced when the 10/20 policy was introduced (Onsomu et al., 2014). The MOH could also have issued policy guidelines or appropriate materials to explain changes in user fees to the lower-level health facilities that implemented the policy.

Previous evidence on removal of user fees in Kenya reported much lower levels of adherence to the policy. Chuma et al. (2008) reported that the reduction of user fees in Kenya was a policy on paper, but hardly adhered to in practice, with over half of participating facilities charging fees beyond the recommended 10/20 for dispensaries and health centers. This study showed much higher levels of adherence to the newer 2013 policy. These high levels reflect the important role of compensating facilities for revenue lost from user fees removal.

For the first time, the government set aside dedicated funds (KShs 700 million) for reimbursing health facilities for their provision of free services.

Although the flow of funds has faced several challenges and health workers expressed concerns that the funds were not sufficient, these resources play an important role and the government should be commended for their commitment. Moving forward, however, it will be important that these allocations are reviewed and that the funding arrangements are harmonized with the broader health system financing structure, which is currently being designed as part of the heath financing strategy.

The reimbursement system is facing challenges and should be redesigned.

This study shows that abolition of the user fees is facing challenges similar to the ones faced by the HSSF funds—frequent delays in disbursement that can be attributed to liquidity-related problems at the national level. Some facilities report delays of up to six months. Moreover, the policy was introduced while Kenya's government was implementing devolution. Under devolution, roles previously performed by the national government were transferred to county governments. Devolution introduced new dynamics in the way healthcare was delivered and financed in Kenya, and affected the execution of the HSSF model of disbursing funds directly to facilities. County governments claimed that they should be the ones receiving the funds and transferring them to facilities. Two parallel models have emerged during the implementation of the policy: one aligned to the principles of devolution, channeling funds directly to county revenue accounts; and a parallel one that sends money directly to health facilities' bank accounts from the national government. To harmonize the financing flows, the MOH is considering using the National Hospital Insurance Fund as a vehicle for reimbursing facilities for providing free services in the future.

There was a significant increase in the utilization of health services for all services reviewed.

In countries where user fees have been abolished, the expected result was an increase in the utilization of health services, at least in the short term. The results presented in this report show significant increases in utilization for all services, ranging from outpatient care for children age five and below to services for those over age five. However, increases in the utilization of healthcare services may not necessary translate to improved health outcomes. Although other countries like Uganda, Zambia, and South Africa reported very high increases in healthcare utilization following the removal of user fees (Schneider and Gilson, 1999; Wilkinson et al., 2001; Xu et al., 2006), the case of Kenya is different. This is largely because the level of charges at dispensaries and health centers were already low following the 10/20 policy, and removing these small charges did not significantly increase the affordability of services.

The significant rise in healthcare utilization is a positive outcome, especially considering all of the challenges surrounding the implementation of the policy. The challenges, however, are threatening the reliability and sustainability of the policy.

Health facilities do not have adequate medicines and supplies.

About one-third of patients interviewed did not get prescribed medicines at the facility they attended and had to buy them elsewhere. Health workers interviewed also reported medicine shortages as a frequent occurrence, adding they did not have any buffer money to buy medicines, particularly during the six-month period when they received no funds from the national government to compensate for the revenue loss associated with the removal of user fees. The availability of drugs and other medical supplies is essential for health centers and dispensaries to provide high-quality, primary healthcare services. The fact that patients are resorting to buying drugs and other medical supplies elsewhere is a major concern, as this negates the objectives of removing user fees. Health workers interviewed also reported long delays in receiving supplies, which meant they were unable to provide high-quality healthcare. The reports of missing critical medical supplies like laboratory reagents and frequent stock-outs were corroborated by key informant interviews.

The situation described by health workers not only resulted in sub-optimal care for patients, but also additional workload for health workers who were forced to undertake unnecessary referrals and "borrow" out-of-stock, but critical, medical supplies from neighboring hospitals. These resourceful practices by health workers who struggled to provide healthcare in this context can have negative impacts on their productivity and staff morale.

CONCLUSION AND RECOMMENDATIONS

The experiences in the first few months following the removal of user fees at public, primary healthcare facilities shows that the policy can be implemented successfully. However, it appears that the situation during this period was characterized by high expectations, with patients flocking to facilities expecting to find available drugs and enough health workers to attend to their needs. As a result, facilities soon experienced inadequate supplies of critical medicines and delays in reimbursement funds (which were also considered inadequate). The findings of this study highlight the need to guarantee adequate funding, drug supplies, and health workers to support the successful implementation of such a policy.

Accordingly, the study team makes the following recommendations:

- The existing national monitoring and evaluation instruments and systems should be strengthened to provide detailed data on a timely basis about the impacts of the removal of user fees policy on the levels of utilization, quality, referral patterns, and other factors.
- Address supply and drug stock-outs through increased budgetary allocations to medicine and other medical supplies.
- Redesign the reimbursement mechanism, especially in the context of devolution, to ensure that it aligns with the constitution. Allocations should also be reviewed and funding arrangements aligned with the broader thinking on health financing.
- Ensure adequate supply and optimal use of health workers at the county level. More importantly, ensure that incentives are provided to health workers to motivate them in situations where workloads have increased without corresponding increases in human resources.
- Removal of user fees should be a starting point toward universal health coverage, with the ultimate objective being a redesigned healthcare financing system that encourages prepayment.

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APPENDIX 1: DISTRIBUTION OF FACILITIES IN THE STUDY SAMPLE

County	Facility Type and Ownership	Facility Name	Region	Sub-county
WEST POKOT	Dispensary (Public)	Kanglikwan Dispensary	Rift Valley	West Pokot
WEST POKOT	Health Center (Public)	Turkwel Health Centre	Rift Valley	West Pokot
WEST POKOT	Health Center (Public)	Alale Health Centre	Rift Valley	North Pokot
WEST POKOT	Health Center (Public)	Tamough Health Centre	Rift Valley	West Pokot
WEST POKOT	Health Center (Public)	Keringet Health Centre	Rift Valley	West Pokot
WEST POKOT	Health Center (Public)	Serewo Health Centre	Rift Valley	West Pokot
WEST POKOT	Dispensary (Nonprofit)	FBO Dispensary	Rift Valley	West Pokot
WEST POKOT	Dispensary (Nonprofit)	Chepnyal Dispensary	Rift Valley	West Pokot
WEST POKOT	Health Center (Public)	Kabichbich Health Centre	Rift Valley	Pokot Central
WEST POKOT	Dispensary (Nonprofit)	Kabichbich Miss Dispensary	Rift Valley	Pokot Central
WEST POKOT	Dispensary (Nonprofit)	Nasolot Dispensary	Rift Valley	Pokot Central
WEST POKOT	Dispensary (Public)	Annet Dispensary	Rift Valley	Pokot Central
WEST POKOT	Dispensary (Nonprofit)	Marich Dispensary	Rift Valley	Pokot Central
TRANS NZOIA	Dispensary (Public)	Grassland Dispensary	Rift Valley	Trans Nzoia West
TRANS NZOIA	Health Center (Public)	Kiminini Health Centre	Rift Valley	Trans Nzoia West
TRANS NZOIA	Health Center (Public)	Kaplamai Health Centre	Rift Valley	Trans Nzoia East
TRANS NZOIA	Health Center (Public)	Suwerwa Health Centre	Rift Valley	Trans Nzoia East
WEST POKOT	Health Center/Med Clinic/Nursing Home (Nonprofit)	Alale (AIC) Health Centre	Rift Valley	North Pokot
WEST POKOT	Dispensary (Nonprofit)	Amakuriat Dispensary	Rift Valley	North Pokot

County	Facility Type and Ownership	Facility Name	Region	Sub-county
WEST POKOT	Dispensary (Nonprofit)	Korokou Dispensary	Rift Valley	North Pokot
BUNGOMA	Health Center/Med Clinic/Nursing Home (Nonprofit)	Kibabii Health Centre	Western	Bungoma South
BUNGOMA	Health Center (Public)	Ndalu Health Centre	Western	Kimilili Bungoma
BUNGOMA	Health Center (Public)	Tongaren Health Centre	Western	Kimilili Bungoma
BUNGOMA	Health Center/Medical Clinic/Nursing Home (Nonprofit)	Dreamland MC Health Centre	Western	Kimilili Bungoma
BUNGOMA	Dispensary (Nonprofit)	Kamukuywa (ACK) Dispensary	Western	Kimilili Bungoma
BUNGOMA	Health Center (Public)	Chwele Health Centre	Western	Bungoma West
BUNGOMA	Health Center (Public)	Malakisi Health Centre	Western	Bungoma West
BUNGOMA	Health Center/Medical Clinic/Nursing Home (Nonprofit)	St. Damiano Nursing Home	Western	Bungoma South
BUNGOMA	Dispensary (Public)	Machwele Dispensary	Western	Bumula
BUNGOMA	Health Center/Medical Clinic/Nursing Home (Nonprofit)	Khasoko Health Centre	Western	Bumula
BUNGOMA	Health Center (Public)	Webuye Health Centre	Western	Bungoma East
BUNGOMA	Health Center (Public)	Milo Health Centre	Western	Bungoma East
BUNGOMA	Health Center/Medical Clinic/Nursing Home (Nonprofit)	Kaptama (Friends) Health Centre	Western	Mt. Elgon
TRANS NZOIA	Health Center (Public)	Tulwet Health Centre	Rift Valley	Trans Nzoia West
BUNGOMA	Health Center/Medical Clinic/Nursing Home (Nonprofit)	Kipsigon (FGC) Health Centre	Western	Mt. Elgon
TRANS NZOIA	Health Center (Public)	Bikeke Health Centre	Rift Valley	Trans Nzoia West
TRANS NZOIA	Dispensary (Nonprofit)	Marie Stopes Clinic (Trans Nzoia West)	Rift Valley	Trans Nzoia West
TRANS NZOIA	Dispensary (Nonprofit)	Kapkoi Mission Dispensary	Rift Valley	Trans Nzoia West
TRANS NZOIA	Dispensary (Nonprofit)	St. Brigids Girls High School Dispensary	Rift Valley	Trans Nzoia West
TRANS NZOIA	Dispensary (Nonprofit)	St. Raphael Dispensary	Rift Valley	Trans Nzoia West

County	Facility Type and Ownership	Facility Name	Region	Sub-county
TRANS NZOIA	Dispensary (Nonprofit)	St. Ursula Dispensary	Rift Valley	Trans Nzoia West
TRANS NZOIA	Dispensary (Nonprofit)	Maridadi RCEA Medical Centre	Rift Valley	Kwanza
TRANS NZOIA	Dispensary (Public)	Kobos Dispensary	Rift Valley	Kwanza
TRANS NZOIA	Health Center (Public)	Cherangany Health Centre	Rift Valley	Trans Nzoia East
TRANS NZOIA	Dispensary (Nonprofit)	Makutano (PCEA) Medical Clinic (Trans Nzoia East)	Rift Valley	Trans Nzoia East
TRANS NZOIA	Dispensary (Nonprofit)	Kitale Mobile Clinic	Rift Valley	Trans Nzoia West
UASIN GISHU	Health Center (Public)	Soy Health Centre	Rift Valley	Eldoret West
UASIN GISHU	Health Center (Public)	Turbo Health Centre	Rift Valley	Eldoret West
UASIN GISHU	Health Center (Public)	Kipsigak Health Centre	Rift Valley	Eldoret West
UASIN GISHU	Health Center (Public)	Kabobo Health Centre	Rift Valley	Eldoret West
UASIN GISHU	Health Center/Medical Clinic/Nursing Home (Nonprofit)	Moi's Bridge Catholic	Rift Valley	Eldoret West
UASIN GISHU	Health Center/Medical Clinic/Nursing Home (Nonprofit)	Mercy Health Centre	Rift Valley	Eldoret West
UASIN GISHU	Health Center/Medical Clinic/Nursing Home (Nonprofit)	Marie Stopes Health Centre (Eldoret West)	Rift Valley	Eldoret West
UASIN GISHU	Dispensary (Nonprofit)	Jumia Medical Clinic	Rift Valley	Eldoret West
UASIN GISHU	Health Center (Public)	Chembulet Health Centre	Rift Valley	Eldoret East
UASIN GISHU	Health Center (Public)	Ainabkoi (RCEA) Health Centre	Rift Valley	Eldoret East
UASIN GISHU	Dispensary (Nonprofit)	St. Mary's Kapsoya Dispensary	Rift Valley	Eldoret East
UASIN GISHU	Dispensary (Public)	Katuiyo Dispensary	Rift Valley	Eldoret East
UASIN GISHU	Health Center/Medical Clinic/Nursing Home (Nonprofit)	Langas Rcea	Rift Valley	Wareng
UASIN GISHU	Dispensary (Public)	Biseria	Rift Valley	Wareng
UASIN GISHU	Health Center/Medical Clinic/Nursing Home (Nonprofit)	St. Brigitas Health Centre	Rift Valley	Wareng

County	Facility Type and Ownership	Facility Name	Region	Sub-county
UASIN GISHU	Dispensary (Nonprofit)	Assururiet (SDA) Dispensary	Rift Valley	Wareng
NAKURU	Health Center (Public)	Lare Health Centre	Rift Valley	Njoro
NAKURU	Health Center (Public)	Keringet Health Centre (Kuresoi)	Rift Valley	Kuresoi
NAKURU	Dispensary (Public)	Gerol	Rift Valley	Kuresoi
NAKURU	Health Center (Public)	Upper Solai Health Centre	Rift Valley	Subukia
NAKURU	Health Center (Public)	Nku West Health Centre	Rift Valley	Nakuru
NAKURU	Health Center/Medical Clinic/Nursing Home (Nonprofit)	Nakuru West (PCEA) Health Centre	Rift Valley	Nakuru
NAKURU	Health Center (Public)	Mogotio RHDC	Rift Valley	Rongai
NAKURU	Health Center/Medical Clinic/Nursing Home (Nonprofit)	Family Health Options Kenya (Nakuru)	Rift Valley	Nakuru
NAKURU	Health Center/Medical Clinic/Nursing Home (Nonprofit)	St. Francis Health Centre (Nakuru Central)	Rift Valley	Rongai
NAKURU	Health Center (Public)	Ol-Jorai Dispensary	Rift Valley	Naivasha
KIRINYAGA	Dispensary (Public)	Karima-ini Dispensary	Central	Kirinyaga Central
KIRINYAGA	Health Center (Public)	Mutithi Health Centre	Central	Kirinyaga South
NYANDARUA	Dispensary (Public)	Nandarasi Dispensary	Central	Nyandarua South
NYANDARUA	Health Center/Medical Clinic/Nursing Home (Nonprofit)	Njabini Catholic Nursing And Maternity	Central	Kinangop
NYANDARUA	Dispensary (Nonprofit)	Rurii (ACK) Dispensary	Central	Nyandarua North
NYANDARUA	Health Center (Public)	Njabini Health Centre	Central	Kinangop
NYANDARUA	Health Center (Public)	Wanjohi Health Centre	Central	Kipipiri
NYANDARUA	Health Center (Public)	Shamata Health Centre	Central	Nyandarua North
NYANDARUA	Dispensary (Nonprofit)	Mukeu (AIC) Dispensary	Central	Kinangop
NYANDARUA	Dispensary (Nonprofit)	Passenga Dispensary	Central	Nyandarua North

County	Facility Type and Ownership	Facility Name	Region	Sub-county
NYANDARUA	Dispensary (Nonprofit)	Oljororok Catholic Dispensary	Central	Nyandarua North
NYANDARUA	Dispensary (Nonprofit)	Kahuho I (AIC) Dispensary	Central	Nyandarua North
NYANDARUA	Dispensary (Nonprofit)	Holy Family Dispensary	Central	Nyandarua North
NYANDARUA	Dispensary (Public)	Mbuyu Dispensary	Central	Nyandarua North
NYANDARUA	Health Center (Public)	Kahembe Health Centre	Central	Nyandarua North
NYANDARUA	Health Center (Public)	Kasuku Health Centre	Central	Nyandarua North
NYANDARUA	Health Center (Public)	Maina & Mwangi Health Centre	Central	Nyandarua North
NAKURU	Dispensary (Nonprofit)	Huruma Mobile Clinic	Rift Valley	Njoro
NYANDARUA	Dispensary (Nonprofit)	St. Mary's Catholic Dispensary (Olkalau)	Central	Nyandarua North
NAKURU	Dispensary (Nonprofit)	St Martin De Porres (Static)	Rift Valley	Kuresoi
NAKURU	Dispensary (Public)	Teret Dispensary	Rift Valley	Njoro
NAKURU	Health Center/Medical Clinic/Nursing Home (Nonprofit)	Holy Spirit Health Centre	Rift Valley	Naivasha
NAKURU	Health Center/Medical Clinic/Nursing Home (Nonprofit)	Holy Trinity Health Centre (Mai Mahiu)	Rift Valley	Naivasha
NAKURU	Health Center/Medical Clinic/Nursing Home (Nonprofit)	Naivasha (AIC) Medical Centre	Rift Valley	Naivasha
NAIROBI	Health Center (Public)	Eastleigh Health Centre	Nairobi	Kamukunji
NAIROBI	Dispensary (Public)	Upendo Dispensary	Nairobi	Kamukunji
NAIROBI	Health Center (Public)	Umoja Health Centre	Nairobi	Embakasi
NAIROBI	Health Center (Public)	Dandora II Health Centre	Nairobi	Embakasi
NAIROBI	Health Center (Public)	Nairobi Remand Prison Health Centre	Nairobi	Makadara
NAIROBI	Health Center (Public)	Makadara Health Centre	Nairobi	Makadara
NAIROBI	Health Center (Public)	NSIS Health Centre (Ruaraka)	Nairobi	Kasarani

County	Facility Type and Ownership	Facility Name	Region	Sub-county
NAIROBI	Dispensary (Public)	Prescort Dispensary	Nairobi	Kasarani
NAIROBI	Health Center (Public)	PSTC Health Centre	Nairobi	Kasarani
MAKUENI	Other Hospital (Nonprofit)	Suleman Farooq Memorial Centre	Eastern	Kibwezi
MAKUENI	Dispensary (Nonprofit)	Kambu Catholic Dispensary	Eastern	Kibwezi
MAKUENI	Health Center/Medical Clinic/Nursing Home (Nonprofit)	Kasikeu Catholic Health Centre	Eastern	Nzaui
MAKUENI	Dispensary (Nonprofit)	Makindu Catholic Dispensary	Eastern	Kibwezi
MAKUENI	Dispensary (Nonprofit)	Kibwezi Catholic Dispensary	Eastern	Kibwezi
MAKUENI	Health Center (Public)	Masongaleni Health Centre	Eastern	Kibwezi
MAKUENI	Health Center (Public)	Mbenuu H. Centre	Eastern	Nzaui
MAKUENI	Dispensary (Nonprofit)	Kithituni Health Clinic	Eastern	Nzaui
MAKUENI	Dispensary (Nonprofit)	Mbyani Catholic Dispensary	Eastern	Nzaui
MAKUENI	Dispensary (Nonprofit)	Salama (Baptist) Nursing Home	Eastern	Nzaui
MAKUENI	Health Center (Public)	Kathonzweni Health Centre	Eastern	Makueni
MAKUENI	Health Center (Public)	Nziu Health Centre	Eastern	Makueni
MAKUENI	Health Center (Public)	Kanzokea Health Centre	Eastern	Makueni
MAKUENI	Health Center/Medical Clinic/Nursing Home (Nonprofit)	Mumo (AIC) Health Centre	Eastern	Makueni
MAKUENI	Dispensary (Public)	Mutulani Dispensary	Eastern	Makueni
MAKUENI	Dispensary (Public)	Mangala Dispensary	Eastern	Makueni
MAKUENI	Health Center (Public)	Kaliani Health	Eastern	Mbooni West
NAIROBI	Health Center (Public)	Kahawa West Health Centre	Nairobi	Kasarani
NAIROBI	Health Center/Medical Clinic/Nursing Home (Nonprofit)	Vision Peoples Inter Health Centre	Nairobi	Kasarani

County	Facility Type and Ownership	Facility Name	Region	Sub-county
NAIROBI	Health Center/Medical Clinic/Nursing Home (Nonprofit)	Provide International Health Care (Mathare)	Nairobi	Kasarani
NAIROBI	Health Center (Public)	Kahawa Garrison Health Centre	Nairobi	Kasarani
NAIROBI	Health Center/Medical Clinic/Nursing Home (Nonprofit)	Soweto Kayole PHC	Nairobi	Embakasi
NAIROBI	Health Center/Medical Clinic/Nursing Home (Nonprofit)	Provide International Kayole Clinic	Nairobi	Embakasi
NAIROBI	Health Center (Public)	Mukuru Health Centre	Nairobi	Embakasi
NAIROBI	Health Center (Public)	Dandora I Health Centre	Nairobi	Embakasi
NAIROBI	Health Center/Medical Clinic/Nursing Home (Nonprofit)	St. Joseph Nursing Home	Nairobi	Kamukunji
NAIROBI	Health Center (Public)	Waithaka Health Centre	Nairobi	Dagoretti
NAIROBI	Health Center/Medical Clinic/Nursing Home (Nonprofit)	Kabiro Medical Clinic	Nairobi	Dagoretti
KITUI	Dispensary (Nonprofit)	Kyome (AIC) Dispensary	Eastern	Mwingi West
KITUI	Health Center (Public)	Winzyeei Health Centre	Eastern	Mwingi West
KITUI	Health Center (Public)	Waita Health Centre	Eastern	Mwingi Central
KITUI	Health Center (Public)	Kavindu Health Centre	Eastern	Mwingi East
KITUI	Health Center/Medical Clinic/Nursing Home (Nonprofit)	Tei Wa Yesu Health Centre	Eastern	Kyuso
KITUI	Dispensary (Nonprofit)	Kimangao Dispensary	Eastern	Kyuso
KITUI	Health Center (Public)	Mathuki Health Centre	Eastern	Mwingi East
KITUI	Health Center (Public)	Mbitini Health Centre	Eastern	Kitui Central
KITUI	Dispensary (Nonprofit)	Mbitini (ACK) Dispensary	Eastern	Kitui Central
KITUI	Dispensary (Nonprofit)	Mutune Dispensary	Eastern	Kitui Central
KITUI	Dispensary (Nonprofit)	Zombe (AIC) Dispensary	Eastern	Kitui Central
KITUI	Dispensary (Nonprofit)	Mutito Dispensary	Eastern	Kitui Central

County	Facility Type and Ownership	Facility Name	Region	Sub-county
KITUI	Dispensary (Public)	Kyangunga Dispensary	Eastern	Kitui Central
KITUI	Dispensary (Public)	Kalulini Dispensary	Eastern	Kitui Central
KITUI	Dispensary (Nonprofit)	Zombe Catholic Dispensary	Eastern	Kitui Central
KITUI	Health Center (Public)	Yatta Health Centre	Eastern	Kitui West
MOMBASA	Health Center (Public)	Magongo (MCM) Dispensary	Coast	Changamwe
MOMBASA	Health Center/Medical Clinic/Nursing Home (Nonprofit)	Mother Amadea	Coast	Changamwe
MOMBASA	Dispensary (Nonprofit)	Holy Ghost Dispensary	Coast	Changamwe
MOMBASA	Dispensary (Nonprofit)	Mikindani Catholic Dispensary	Coast	Changamwe
MOMBASA	Dispensary (Public)	Moi Airport Dispensary	Coast	Changamwe
MOMBASA	Health Center (Public)	Jomvu Model Health Centre	Coast	Changamwe
MOMBASA	Dispensary (Nonprofit)	Ukumbusho Dispensary	Coast	Mvita
MOMBASA	Dispensary (Nonprofit)	Family Health Options Kenya (FHOK) Mombasa	Coast	Mvita
MOMBASA	Dispensary (Public)	Railway Dispensary	Coast	Mvita
MOMBASA	Dispensary (Public)	State House Dispensary (Mombasa)	Coast	Mvita
MOMBASA	Dispensary (Public)	Mwembe Tayari Staff Clinic	Coast	Mvita
MOMBASA	Health Center (Public)	Mlaleo Health Centre (MOH)	Coast	Kisauni
MOMBASA	Dispensary (Public)	NYS Dispensary (Kilindini)	Coast	Likoni
MOMBASA	Health Center (Public)	Shimo-La Tewa Health Centre (GK Prison)	Coast	Kisauni
KILIFI	Dispensary (Public)	Midoina Dispensary	Coast	Bahari
KILIFI	Health Center (Public)	Vipingo Rural Demonstration Health Centre	Coast	Bahari
KILIFI	Health Center (Public)	Chasimba Health Centre	Coast	Bahari

County	Facility Type and Ownership	Facility Name	Region	Sub-county
KILIFI	Health Center (Public)	Matsangoni Model Health Centre	Coast	Bahari
KILIFI	Health Center (Public)	Kizingo Health Centre	Coast	Bahari
KILIFI	Health Center (Public)	Municipal Health Centre	Coast	Malindi
KILIFI	Dispensary (Public)	Roka Maweni Dispensary	Coast	Bahari
KILIFI	Dispensary (Nonprofit)	Watanu SDA dispensary	Coast	Malindi
KILIFI	Dispensary (Nonprofit)	Malanga (AIC) Dispensary	Coast	Malindi
KILIFI	Dispensary (Nonprofit)	NAWACO Clinic	Coast	Malindi
KILIFI	Dispensary (Nonprofit)	St Anne Mida Catholic Dispensary	Coast	Malindi
KILIFI	Health Center (Public)	Ganze Health Centre	Coast	Ganze
KILIFI	Dispensary (Nonprofit)	St. Marys Msabaha Catholic Dispensary	Coast	Malindi
KILIFI	Dispensary (Nonprofit)	Ramada Dispensary	Coast	Magarini
KILIFI	Health Center/Medical Clinic/Nursing Home (Nonprofit)	Bomu Medical Centre (Mariakani)	Coast	Kaloleni
KILIFI	Dispensary (Nonprofit)	Union Medical Dispensary	Coast	Kaloleni
SIAYA	Health Center (Public)	Rwambwa Health Centre	Nyanza	Siaya
SIAYA	Health Center (Public)	Kadenge Ratuoro Health Centre	Nyanza	Siaya
SIAYA	Health Center (Public)	Hawinga Health Centre	Nyanza	Siaya
SIAYA	Health Center/Medical Clinic/Nursing Home (Nonprofit)	Ng'iya Health Centre	Nyanza	Siaya
SIAYA	Health Center/Medical Clinic/Nursing Home (Nonprofit)	Nyang'oma Mission Health Centre	Nyanza	Bondo
SIAYA	Dispensary (Nonprofit)	Aro (SDA) Dispensary	Nyanza	Bondo
SIAYA	Dispensary (Public)	Usenge Dispensary	Nyanza	Bondo
SIAYA	Dispensary (Public)	Got Osimbo Dispensary	Nyanza	Ugenya

County	Facility Type and Ownership	Facility Name	Region	Sub-county
SIAYA	Health Center (Public)	Ukwala Health Centre	Nyanza	Ugenya
SIAYA	Health Center/Medical Clinic/Nursing Home (Nonprofit)	Sega Dispensary	Nyanza	Ugenya
SIAYA	Health Center/Medical Clinic/Nursing Home (Nonprofit)	Nyambare Health Centre	Nyanza	Ugenya
SIAYA	Health Center/Medical Clinic/Nursing Home (Nonprofit)	Rangala Health Centre	Nyanza	Ugenya
SIAYA	Dispensary (Nonprofit)	Matibabu Nzoia	Nyanza	Ugenya
SIAYA	Health Center (Public)	Ndere Health Centre	Nyanza	Gem
SIAYA	Health Center/Medical Clinic/Nursing Home (Nonprofit)	Aluor Mission Health Centre	Nyanza	Gem
SIAYA	Health Center (Public)	Manyuanda Health Centre (Rarieda)	Nyanza	Rarieda
SIAYA	Other Hospital (Nonprofit)	Dolphil Nursing & Maternity Home	Nyanza	Gem
HOMA BAY	Health Center (Public)	Nyagoro Health Centre	Nyanza	Homa Bay
HOMA BAY	Health Center (Public)	Got Kojowi Health Centre	Nyanza	Ndhiwa
HOMA BAY	Health Center (Public)	Tom Mboya Memorial Health Centre	Nyanza	Mbita
HOMA BAY	Health Center (Public)	Sena Health Centre	Nyanza	Mbita
HOMA BAY	Health Center (Public)	Usao Health Centre	Nyanza	Mbita
HOMA BAY	Health Center/Medical Clinic/Nursing Home (Nonprofit)	St. Mary's Health Centre (Mbita)	Nyanza	Mbita
HOMA BAY	Health Center (Public)	Homa Lime Health Centre	Nyanza	Rachuonyo South
HOMA BAY	Dispensary (Public)	Nyangiela Dispensary	Nyanza	Rachuonyo South
HOMA BAY	Health Center/Medical Clinic/Nursing Home (Nonprofit)	Mangima SDA Health Centre	Nyanza	Rachuonyo South
BUNGOMA	Dispensary (Nonprofit)	Mission of Mercy Clinic	Western	Bungoma South
BUNGOMA	Dispensary (Public)	Kibuke Dispensary	Western	Bumula
HOMA BAY	Health Center/Medical Clinic/Nursing Home (Nonprofit)	Raruowa Health Centre	Nyanza	Rachuonyo South

County	Facility Type and Ownership	Facility Name	Region	Sub-county
HOMA BAY	Health Center/Medical Clinic/Nursing Home (Nonprofit)	Tonga Health Centre	Nyanza	Suba
HOMA BAY	Health Center/Medical Clinic/Nursing Home (Nonprofit)	Homa Hills Health Centre	Nyanza	Rachuonyo South
HOMA BAY	Health Center/Medical Clinic/Nursing Home (Nonprofit)	Atemo Health Centre	Nyanza	Rachuonyo South
HOMA BAY	Dispensary (Nonprofit)	Ogande Dispensary	Nyanza	Homa Bay
HOMA BAY	Dispensary (Nonprofit)	Nyagowa ELCK Dispensary	Nyanza	Rachuonyo South
HOMA BAY	Dispensary (Public)	Lambwe Dispensary	Nyanza	Mbita
NYAMIRA	Dispensary (Public)	Nyambari Geke Dispensary	Nyanza	Manga
NYAMIRA	Health Center (Public)	Riakinaro Health Centre	Nyanza	Nyamira
NYAMIRA	Health Center (Public)	Gesure Health Centre (Manga)	Nyanza	Manga
NYAMIRA	Health Center (Public)	Nyangweta Health Centre	Nyanza	Nyamira
NYAMIRA	Health Center (Public)	Riechieri Health Centre	Nyanza	Nyamira
NYAMIRA	Health Center (Public)	Isoge Health Centre	Nyanza	Borabu
NYAMIRA	Health Center (Public)	Kiang'inda Health Centre	Nyanza	Nyamira
NYAMIRA	Health Center/Medical Clinic/Nursing Home (Nonprofit)	St Joseph's Nyansiongo Health Centre	Nyanza	Borabu
NYAMIRA	Health Center/Medical Clinic/Nursing Home (Nonprofit)	Eronge Health Centre	Nyanza	Borabu
NYAMIRA	Health Center/Medical Clinic/Nursing Home (Nonprofit)	Nyamira Adventist Dispensary	Nyanza	Nyamira
NYAMIRA	Health Center/Medical Clinic/Nursing Home (Nonprofit)	Itibo Mission Health Centre	Nyanza	Nyamira
NYAMIRA	Health Center/Medical Clinic/Nursing Home (Nonprofit)	Kebirigo Mission Health Centre	Nyanza	Nyamira
NYAMIRA	Health Center/Medical Clinic/Nursing Home (Nonprofit)	Matongo Health Centre	Nyanza	Nyamira
NYAMIRA	Dispensary (Nonprofit)	Matutu Dispensary	Nyanza	Borabu
NYAMIRA	Dispensary (Nonprofit)	Kemera Dispensary (Manga)	Nyanza	Manga

County	Facility Type and Ownership	Facility Name	Region	Sub-county
NYAMIRA	Dispensary (Nonprofit)	Nyabikomu Dispensary	Nyanza	Nyamira
NYAMIRA	Dispensary (Public)	Igena-Itambe Dispensary	Nyanza	Nyamira
NAIROBI	Health Center/Medical Clinic/Nursing Home (Nonprofit)	St. Francis Health Centre (Nairobi North)	Nairobi	Kasarani
NAIROBI	Dispensary (Public)	Babadogo Health Centre	Nairobi	Kasarani
NAIROBI	Dispensary (Nonprofit)	EDARP Donholm	Nairobi	Embakasi
NAIROBI	Health Center/Medical Clinic/Nursing Home (Nonprofit)	Imara Health Centre	Nairobi	Embakasi
NAIROBI	Dispensary (Public)	Ngaira Rhodes Dispensary	Nairobi	Kamukunji
NAIROBI	Health Center/Medical Clinic/Nursing Home (Nonprofit)	Marie Stopes Nursing Home (Eastleigh)	Nairobi	Kamukunji
NAIROBI	Dispensary (Nonprofit)	Kibera South (MSF Belgium) Dispensary	Nairobi	Langata
NAIROBI	Dispensary (Nonprofit)	Kibera Chemi Chemi ya uzima clinic	Nairobi	Langata
NAIROBI	Health Center/Medical Clinic/Nursing Home (Nonprofit)	Revival Home Based Care Clinic	Nairobi	Langata
NAIROBI	Dispensary (Nonprofit)	Cotolengo Center	Nairobi	Langata
NAIROBI	Health Center/Medical Clinic/Nursing Home (Nonprofit)	St. Angela Merici Health Centre (Kingeero)	Nairobi	Westlands
NAIROBI	Health Center/Medical Clinic/Nursing Home (Nonprofit)	Mercy Mission Health Centre	Nairobi	Dagoretti
KIRINYAGA	Health Center (Public)	Kangaita Health Centre	Central	Kirinyaga West
KIRINYAGA	Health Center (Public)	Ucheru Community Health Centre	Central	Kirinyaga West
KIRINYAGA	Health Center/Medical Clinic/Nursing Home (Nonprofit)	Mt. Kenya (ACK) Hospital	Central	Kirinyaga West
KIRINYAGA	Health Center/Medical Clinic/Nursing Home (Nonprofit)	Kianyaga Catholic Health Centre	Central	Kirinyaga North
KIRINYAGA	Dispensary (Nonprofit)	St. Mary Magdalene Medical Centre	Central	Kirinyaga North
KIRINYAGA	Dispensary (Nonprofit)	Mutira (ACK) Dispensary	Central	Kirinyaga Central
KIRINYAGA	Dispensary (Public)	Gathambi Dispensary	Central	Kirinyaga Central

County	Facility Type and Ownership	Facility Name	Region	Sub-county
KIRINYAGA	Health Center (Public)	Baricho Health Centre	Central	Kirinyaga Central
KIRINYAGA	Health Center/Medical Clinic/Nursing Home (Nonprofit)	Baricho Catholic Health Centre	Central	Kirinyaga Central
KIRINYAGA	Health Center (Public)	Sagana Rural Health Demonstration Centre	Central	Kirinyaga Central
KIRINYAGA	Dispensary (Nonprofit)	St. Teresa Catholic Dispensary	Central	Kirinyaga South
KIRINYAGA	Health Center (Public)	Murinduko Health Centre	Central	Kirinyaga South
KIRINYAGA	Dispensary (Nonprofit)	Christian Community Services Wang'Uru Dispensary	Central	Kirinyaga South
KIRINYAGA	Dispensary (Nonprofit)	Difathas Catholic Dispensary	Central	Kirinyaga South

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