REPUBLIC OF KENYA

Ministry of Health

NATIONAL CERVICAL CANCER ELIMINATION ACTION PLAN

2025-2030

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NATIONAL CERVICAL CANCER ELIMINATIONACTION PLAN

2025-2030

Vision

A Kenya free from the burden of cervical cancer.

Mission

To provide timely and equitable access to evidence-based, cost-effective, and quality HPV vaccination, cervical cancer screening, diagnosis, treatment, palliative care; and improve survivorship.

Goal

Achieve and sustain 90% HPV vaccination coverage, 70% screening coverage through HPV testing, and 90% treatment coverage for both precancer and invasive cancer by 2030.

Core Values

1. Integration
2. Collaboration
3. Sustainability
4. Governance
5. Advocacy and education
6. Capacity building
7. Coordination
8. Equity

Contents

Foreword

Kenya remains firmly committed to achieving the constitutional right of the highest attainable standard of health for all its people, guided by the Sustainable Development Goals and the country's pursuit of Universal Health Coverage. These aspirations reflect our national resolve to ensure that every Kenyan can access essential health services without financial hardship. Cervical cancer elimination stands as a critical pillar within this broader agenda, symbolizing our dedication to equity, dignity, and improved quality of life for women and girls across the country.

The global call to eliminate cervical cancer presents Kenya with a transformative opportunity to strengthen our health system. Achieving this goal requires a renewed focus on a resilient and motivated health workforce, the strengthening of primary health care as the foundation of service delivery, and sustainable domestic financing to ensure long-term continuity of lifesaving interventions. By embracing innovation, reinforcing health infrastructure, and ensuring the integration of preventive and treatment services, Kenya can build a system capable not only of combating cervical cancer but also of advancing broader health and development priorities.

Cervical cancer remains one of the leading causes of cancer-related illness and death among women in Kenya, disproportionately affecting those in low-resource settings. Its burden is particularly tragic because cervical cancer is highly preventable and treatable when detected early. Despite progress in vaccination, screening, and treatment, gaps in access, awareness, and timely care continue to undermine our national efforts and perpetuate avoidable suffering among Kenyan families.

This National Cervical Cancer Elimination Action Plan therefore provides a clear and coordinated pathway to accelerate progress toward a cervical cancer-free Kenya. I call upon all government entities, development partners, civil society organizations, the private sector, professional associations, communities, and individuals to take up their role in bringing this plan to life. Let us act boldly, invest wisely, and collaborate with unwavering commitment. Together, we can protect the lives of our women and girls and realize the vision of a healthier, more equitable future for our nation.

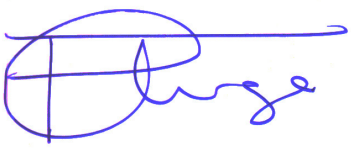
Hon. Aden Duale, EGH
Cabinet Secretary
Ministry of Health, Kenya

Preface

Cervical cancer remains a major public health challenge in Kenya, ranking as one of the leading causes of cancer-related illness and death among women. Yet, it is also one of the most preventable and curable cancers if vaccination against the human papillomavirus (HPV) and screening is scaled in the population, and if women are diagnosed early and treated effectively. This National Cervical Cancer Elimination Action Plan represents a significant step forward in Kenya's journey toward achieving the World Health Organization's (WHO) Global Strategy to Eliminate Cervical Cancer as A Public Health Problem. It outlines a coordinated national framework to accelerate prevention, early detection, treatment, and palliative care interventions, while ensuring equitable access for all women and girls, regardless of geography or socioeconomic status.

The development of this plan has been guided by Kenya's commitment to the Universal Health Coverage (UHC) agenda and the broader national health policy goals articulated in the Kenya Vision 2030. It builds upon the achievements and integrates lessons learned from the country's successful health programs, including immunization, HIV, and reproductive health strategies. Through multi-sectoral partnerships, community engagement, and investment in health system strengthening, this plan provides a roadmap for scaling up HPV vaccination, improving screening coverage, enhancing diagnostic and treatment capacity, and promoting public awareness and advocacy. By so doing, the action Plan furthers the aspirations of the National Cancer Control Strategy 2023-2027, of having a 'nation free from the preventable burden of cancer'.

The realization of cervical cancer elimination in Kenya will require the concerted effort of all stakeholders—national government, county governments, development partners, civil society, healthcare professionals, and communities. We are confident that the implementation of this Action Plan will not only save thousands of lives but also empower women and contribute to a healthier, more productive nation. Let us, therefore, commit to this collective vision and ensure that no woman in Kenya dies from a preventable disease like cervical cancer.



Dr Ouma Oluga,
Principal Secretary
State Department for Medical Services
Ministry of Health, Kenya

Executive Summary

Cervical cancer is the leading cause of cancer deaths among women in Kenya, despite it being very preventable and having effective management approaches. Approximately 6,000 women were diagnosed with cervical cancer in Kenya in 2022, and 3,600 died from the disease. The Global Strategy to Eliminate Cervical Cancer as A Public Health Problem requires countries to ensure at least 90% of girls are vaccinated against HPV by age 15 years, 70% of women are screened at least twice in a lifetime with a high-precision test and 90% of women with cervical precancer or invasive cancer receive treatment.

Kenya has experienced both successes and challenges in implementing cervical cancer elimination strategies. In 2024, 61% of girls received the first HPV dose. Although 48% of women targeted for screened in 2024 were actually screened, only 6% were screened using HPV testing. Of those eligible for treatment, only 43% were actually treated. These gaps underscore the need for accelerated action to put Kenya firmly on the path to cervical cancer elimination. OR
These gaps reveal that Kenya's journey toward cervical cancer elimination is still incomplete and requires focused attention.
This action plan, therefore, seeks to spur action to put Kenya on track to achieving the 2030 elimination interim targets. Through detailed situational, gap and root-cause analysis, a multi-stakeholder effort identified priority actions for spurring progress towards the 2030 targets. This action plan has 21 operational objectives, with specific actions under each, grouped into three key result areas, which are aligned to the three elimination targets. This is outlined in the table below:

Table 1: Operational objectives and targets

Key Result Area	Operational objectives	Target
HPV vaccination	Strengthen and expand equitable, timely, and integrated HPV vaccine delivery with the goal of achieving at least 90% coverage of girls by age 15 years, by the year 2030	HPV vaccination coverage among eligible girls is increased to at least 90%".
	Strengthen the capacity, motivation and availability of the health workforce to deliver HPV vaccines safely and effectively.	
	Strengthen the health information system to ensure complete, timely, and integrated data capture, reporting, and decision making on HPV vaccination across public and private sectors by 2030.	
	Strengthen the HPV vaccine supply chain through timely forecasting, equitable distribution and innovative delivery.	
	Secure long-term domestic and external financing for HPV vaccine procurement and delivery.	
	Promote strong political leadership, policy integration, and multi-sectoral coordination to support HPV vaccination.	
	Promote uptake of HPV vaccination through effective behavior change messages and interventions directed at caregivers, health care providers, religious leaders, and other community influencers.	
Screening and precancer treatment	Ensure health facilities have adequate capacity/service readiness for screening and precancer treatment.	At least 70% of women 30-49 years are screened using HPV testing; and at least 90% of those with precancer receive treatment
	Ensure quality assurance in cervical cancer screening and treatment.	
	Strengthen Health Care worker capacity for cervical cancer screening and treatment.	
	Increase community awareness and demand creation for screening.	
	Enhance data management and use in decision making.	
	Increase financial prioritization for cervical cancer screening and treatment in national and county health budgets, and other financing mechanisms (costs of tests, devices, consumables, maintenance, and provider payment mechanisms).	

Key Result Area	Operational objectives	Target
	Strengthen Leadership and Governance for cervical cancer screening and precancer treatment at both national and county level.	
	Ensure provision of quality cervical cancer screening and pre-cancer treatment services.	
Diagnosis, treatment, palliative and survivorship care for invasive cervical cancer	Strengthen infrastructural capacity of comprehensive specialized facilities offering diagnostic, treatment and palliative care for cervical cancer.	At least 90% of women with invasive cervical cancer receive comprehensive treatment, palliative and survivorship care.
	Strengthen the availability and capacity of a well-trained, multidisciplinary oncology workforce to support timely diagnosis and comprehensive treatment of cervical cancer.	
	Strengthen the capacity of the counties and regional cancer centers to avail Health product and technologies to deliver comprehensive cervical cancer diagnosis, treatment and palliative care.	
	Comprehensively provide financial cover for the diagnosis and treatment of cervical cancer.	
	Strengthen cervical cancer data systems for effective monitoring, planning, and quality improvement of diagnosis and treatment services across all levels of care.	
	Strengthen leadership and governance systems for effective policy implementation, coordination, and oversight of cervical cancer diagnosis and treatment.	

The implementation of the action plan will be undertaken by both national and county governments, in collaboration with other stakeholders. To achieve this, existing coordination mechanisms will require to be strengthened, including the school health TWG, county NCD and Immunization TWGs, National Cervical Cancer Elimination TWG, all reporting to the Council of Governors (CoG) and NCD Interagency Coordination Committee (NCD-ICC).

Resource requirements and justification

To implement the health system strengthening interventions proposed in this action plan, **KES 1.2 Billion** will be required over five years. Of this, 27% is for interventions to be implemented primarily by counties, 16% by national government and 57% is shared by the two levels of government. A proposal to establish two additional PET/SPECT centers at MTRH and Mombasa regional cancer center will require **KES 1.4 Billion.**

Cervical cancer elimination service provision components are comprehensively covered in the Social Health Insurance Funds (SHIF).

Primary Health Care Fund (PHCF)

- HPV immunization for levels 2 and 3
- HPV testing
- Cryotherapy
- Thermal ablation
- LEEP
- Cervical biopsy, if conducted at level 2 or 3

Social Health Insurance Fund (SHIF)

- Imaging (CT, MRI, PET, etc.)
- Chemotherapy
- Radiotherapy/ brachytherapy
- Surgery
- HPV immunization for levels 4-6

Emergency and Chronic Conditions Insurance Fund (ECCIF)

- Any treatment beyond SHIF
- Palliative care surgery

In conclusion, this Action Plan provides a clear roadmap for Kenya's journey toward cervical cancer elimination. With sustained commitment and collaborations, we can advance toward a cervical cancer-free kenya, safeguarding the health and well-being of women and girls across nation.

Dr. Patrick Amoth, EBS
Director General For Health
Ministry of Health, Kenya

Acknowledgements

The Ministry of Health extends its sincere appreciation to all individuals and organizations that contributed to the conception, development, and finalization of this Action Plan. We acknowledge the strategic guidance and support from the offices of the Cabinet Secretary, Principal Secretaries, Director General for Health, the Directorate of Family Health, and the Division of Non-Communicable Diseases. We also thank the Council of Governors and county governments for their active participation and insightful contributions.

We appreciate Health Systems Insight (HSI) and the Clinton Health Access Initiative (CHAI) for their financial and technical support. We further acknowledge the advisory role of the National STOP Cervical Cancer Committee under the Cancer Prevention & Early Detection Technical Working Group (TWG), which brings together diverse stakeholders in cervical cancer control, whom we thank for their critical input at various stages. Special appreciation goes to the core team comprising NCCP, NVIP, HSI, and CHAI, whose commitment and expertise were essential in driving this work.

We are grateful to the Heads of the National Cancer Control Programme (NCCP) and the National Vaccines and Immunization Programme (NVIP), Dr. Joan-Paula Bor and Dr. Rose Jalang'o, for their technical leadership and for ensuring timely completion of the document. We also thank all NCCP and NVIP program officers for their dedication, with particular recognition to Beatrice Ochieng and Dr. Elizabeth Namu for coordinating the development process.

Our gratitude extends to development partners and technical collaborators, including the World Health Organization (WHO) – global and Africa Regional Office and the International Agency for Research on Cancer (IARC), for their technical support and external review of the Action Plan.

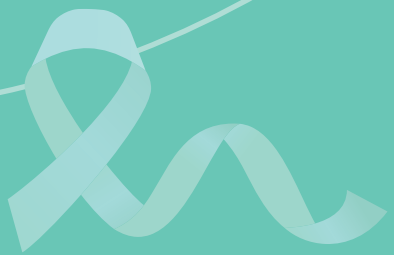
Finally, we appreciate the women, girls, and communities whose voices and experiences have informed this plan. We look forward to continued collaboration with all partners in the dissemination and implementation of this Action Plan to put Kenya firmly on the path to cervical cancer elimination.

Dr. Issak Bashir
Director – Directorate of Family Health
Ministry of Health, Kenya

Acronyms and Abbreviations

ABC:	Activity-Based Costing
AEFI	Adverse Event Following Immunization
ASAL	Arid and Semi-Arid Lands
CCE	Cervical Cancer Elimination
CHP:	Community Health Promoter
CRH:	County Referral Hospital
CTC:	Cancer Treatment Center
ECCIF:	Emergency, Chronic, and Critical Illness Fund
EHR:	Electronic Health Records
GAVI :	Global Alliance for Vaccines and Immunization
HCW:	Healthcare worker
HIV:	Human Immunodeficiency Virus
HPV:	Human papillomavirus
IARC:	International Agency for Research on Cancer
IBC:	Ingredients-Based Costing
IEC:	Information, Education and Communication
KEMSA:	Kenya Medical Supplies Authority
KENITAG:	Kenya National Immunization Advisory Group
KHIS:	Kenya Health Information System
KRA:	Ker Result Area
LIMS:	Logistics Information Management System
LMICs:	Low- and middle-income country
MDT:	Multi-disciplinary team
MOE	Ministry of Education
MOH	Ministry of Health
NCCEAP:	National Cervical Cancer Elimination Action Plan
NCCP:	National Cancer Control Program
NCCS:	National Cancer Control Strategy
NCD:	Noncommunicable disease
NGT:	Nominal Group Technique
NVIP:	National Vaccines and Immunization Program
OOP:	Out-of-pocket expenditure
PCL:	Precancerous lesion
PHC:	Primary Health Care
SHI:	Social Health Insurance
SHIF:	Social Health Insurance Fund
TWG:	Technical Working Group
UHC:	Universal Health Coverage
VIA:	Visual inspection with acetic acid
WHO:	World Health Organization

CHAPTER ONE: EPIDEMIOLOGY OF CERVICAL CANCER



CHAPTER ONE: EPIDEMIOLOGY OF CERVICAL CANCER

Overview

Cervical cancer is a leading cause of disease burden among women in many settings globally. Different populations are affected disproportionately, even in the same country. This chapter describes the burden of cervical cancer globally and in Kenya, and puts it into the context of the factors that drive disparities in both incidence as well as outcomes. A brief description of the justification and process followed in the development of the action plan is also presented.

1.1 Global burden of cervical cancer

Cervical cancer remains a significant global health concern, particularly in low- and middle-income countries (LMICs). Globally, it is the fourth most common cancer among women, with an estimated over 660,000 new cases and over 348,000 deaths annually, according to the International Agency for Research on Cancer (IARC) [1]. The primary cause of cervical precancerous lesions and cervical cancer is persistent infection with high-risk human papillomavirus (HPV) types. Cervical cancer is a preventable disease, HPV infection can be prevented by vaccination, and precancerous lesions arising from chronic HPV infection can be identified at cervical screening and treated to avoid progression to cervical cancer [2,3]. Despite advances in prevention and early detection, cervical cancer continues to pose a major public health challenge, especially in areas with limited access to healthcare services [4].

Regionally, the burden of cervical cancer varies widely (figure 1). Sub-Saharan Africa, South Asia, and parts of Latin America bear a disproportionate share of cases and deaths. In Sub-Saharan Africa, for example, cervical cancer is often the leading cause of cancer death among women due to inadequate screening programs and limited access to HPV vaccines [5]. In contrast, high-income regions such as North America and Western Europe have seen significant declines in incidence and mortality rates due to widespread screening and vaccination efforts. This regional variation highlights the importance of resource allocation and healthcare infrastructure in determining health outcomes.

Disparities in cervical cancer outcomes are influenced by multiple social, economic, and healthcare factors. Women from marginalized communities, including those with lower socioeconomic status, limited education, and restricted access to healthcare, are at greater risk of developing and dying from cervical cancer. Racial and ethnic disparities are also evident in many countries, reflecting systemic barriers to preventive care and treatment. Addressing these disparities requires a multifaceted approach that considers not only medical interventions but also broader social determinants of health.

Evidence-based strategies for reducing the burden of cervical cancer include HPV vaccination, regular screening using methods such as HPV testing, and timely treatment of precancerous lesions [6,7].

Women living with HIV are at significantly higher risk of developing cervical cancer due to their compromised immune systems, which make it more difficult to clear high-risk HPV infections—the primary cause of cervical cancer. Studies have shown that women with HIV are up to six times more likely to develop cervical cancer compared to HIV-negative women [8]. The progression from HPV infection to cervical precancer and cancer tends to be faster in this population, emphasizing the need for more frequent and earlier screening. In many low-resource settings where HIV prevalence is high, access to both antiretroviral therapy and cervical cancer prevention services remains limited, further compounding the risk. Integrating cervical cancer screening and treatment into HIV care programs is a crucial strategy to improve outcomes and reduce the dual burden of disease among women living with HIV [9,10].

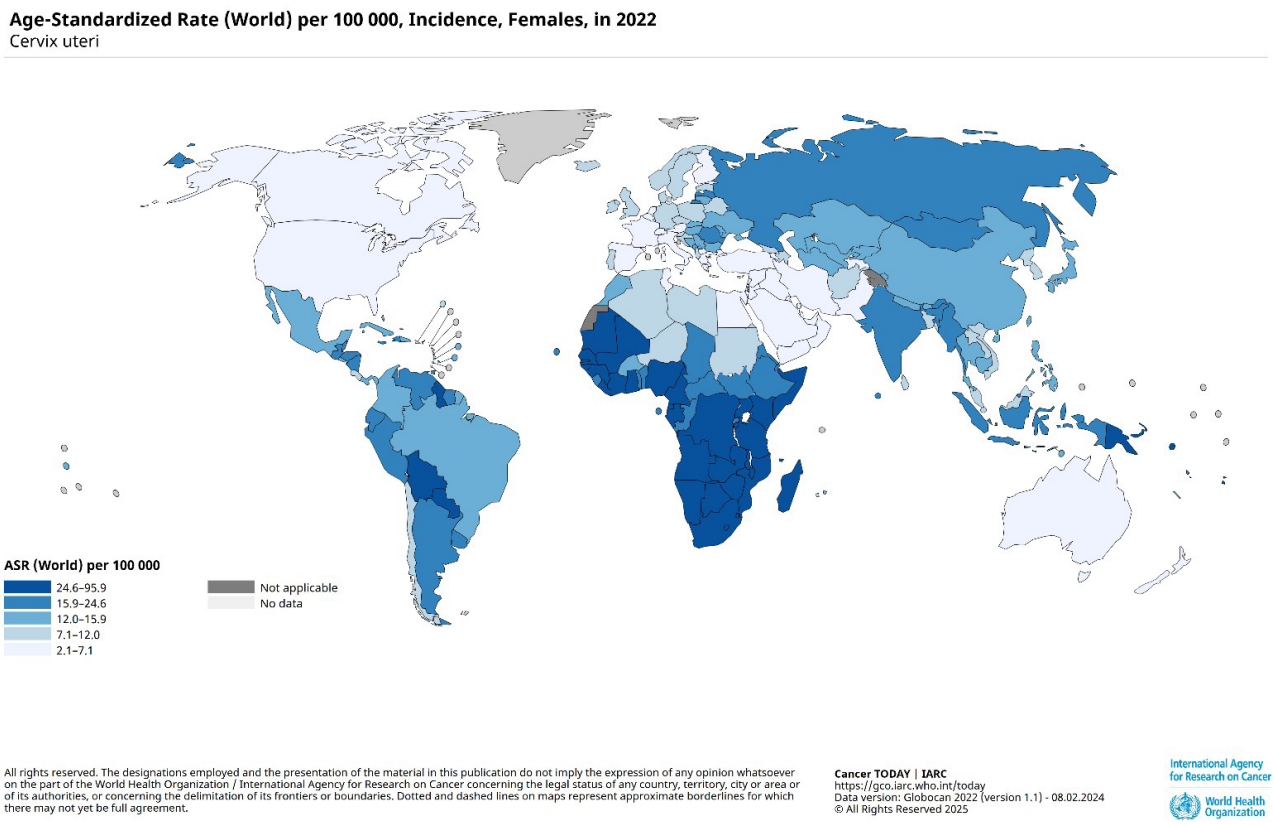
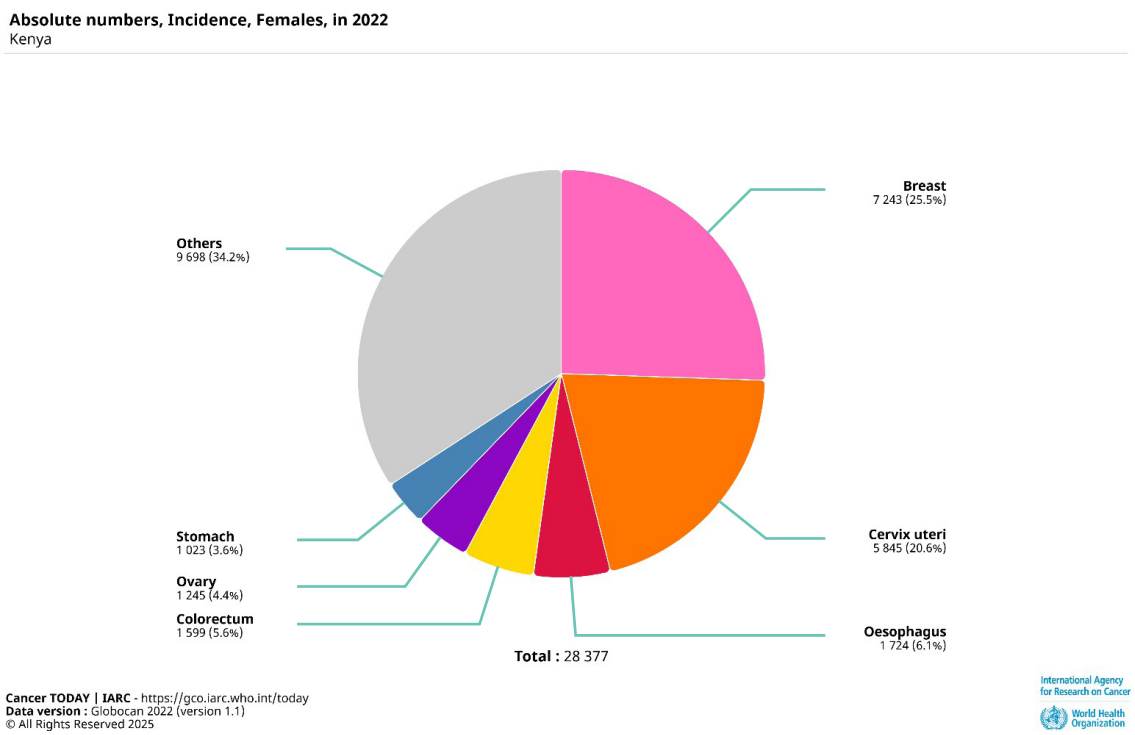


Figure 1: Global incidence of cervical cancer, 2022

1.2 Burden of cervical cancer in Kenya

Cervical cancer remains a significant public health issue in Kenya, ranking as the leading cause of cancer-related deaths among women. Annually, approximately 6,000 new cases are diagnosed, accounting for 21% of all new cancer cases in women, with nearly 3,600 deaths reported each year. Figure 2 shows the proportion of new cancers and deaths in 2022 among women in Kenya. Cervical cancer is the second most common cancer after breast among Kenyan women and both account for almost 50% of all cancers among women. The age-standardized incidence and mortality rates for cervical cancer in Kenya are 32.8 and 21.4 per 100,000 women-years, respectively. The high incidence is primarily driven by lack of screening through which precancerous lesions would be detected, treated and progression to cancer prevented. The high mortality rate is largely attributed to late-stage diagnoses and limited access to timely treatment.

Cervical cancer disparities in Kenya are shaped by a complex interplay of socioeconomic, geographic, and systemic factors that hinder equitable access to prevention, screening, and treatment services. Women residing in rural areas and resource-poor urban settings often face significant challenges, including limited availability of screening services, shortages of trained healthcare providers, and inadequate medical supplies [11]. Socioeconomic status further exacerbates these disparities. Women from poorer households are significantly less likely to undergo cervical cancer screening compared to their wealthier counterparts [12]. Additionally, lack of health insurance and financial constraints impede access to necessary medical care. Cultural and social factors, such as limited autonomy in healthcare decision-making and misconceptions about cervical cancer, also contribute to low screening uptake. Addressing these multifaceted barriers requires targeted interventions that enhance healthcare infrastructure [13], increase community awareness, and promote policies aimed at reducing financial and social obstacles to cervical cancer prevention and treatment.



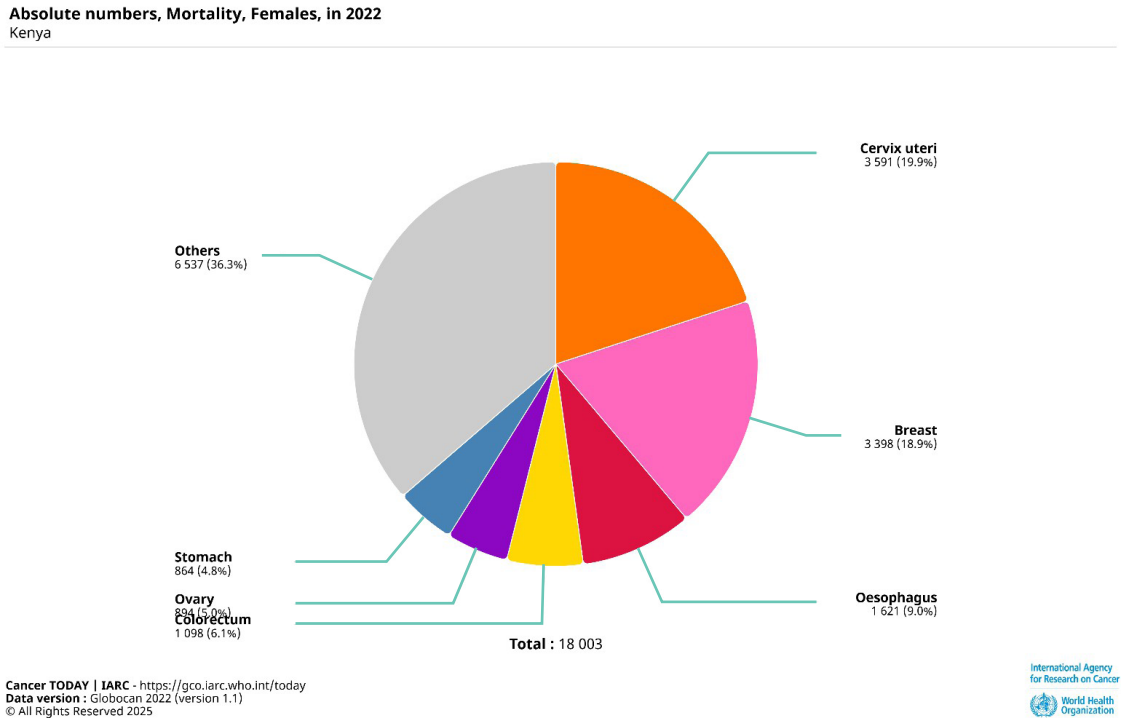


Figure 2: Cervical cancer burden in Kenya: a) Incidence; b) mortality

1.3 Global response to cervical cancer: the Global Elimination Initiative

In May 2018, the WHO issued a global call to eliminate cervical cancer, leading to the establishment of the Cervical Cancer Elimination Initiative and the adoption of a Global Strategy in 2020 [14–16]. The goal is to reduce incidence to below 4 cases per 100,000 women, based on three key targets by 2030: 90% of girls fully vaccinated against HPV by age 15, 70% of women screened by ages 35 and 45, and 90% of those with pre-cancer or cancer receiving appropriate treatment (figure 3). Achieving these targets will require strong political commitment, sustainable financing, community engagement, and integration of services into existing health systems. These efforts, if effectively implemented, can drastically reduce the incidence and mortality of cervical cancer worldwide [7].

The global strategy specifies the strategic action that every country should prioritize in order to be on the path to elimination. For HPV vaccination, these include securing affordable vaccine supplies through market

interventions and strengthen delivery systems using school programs and community outreach, especially for underserved populations. Additionally, evidence-based communication, social mobilization, and ongoing innovation are critical to improving vaccine uptake, addressing hesitancy, and ensuring efficient, high-quality delivery. For screening and precancer treatment, it is vital to understand and address social, cultural, and structural barriers by engaging communities—especially women—in designing accessible, context-specific services and increasing health literacy. Integrating screening and treatment into primary care, promoting single-visit screen-and-treat approaches, ensuring affordable access to quality-assured diagnostics, and strengthening laboratory capacity with robust quality assurance are key to delivering effective, people-centered care. Comprehensive care for cervical cancer cases requires implementing national guidelines, strengthening referral networks, expanding diagnostic and treatment capacities, including surgery, radiotherapy, and palliative care—while addressing workforce training, stigma reduction, and survivor support to ensure accessible, high-quality, people-centered care across the continuum.

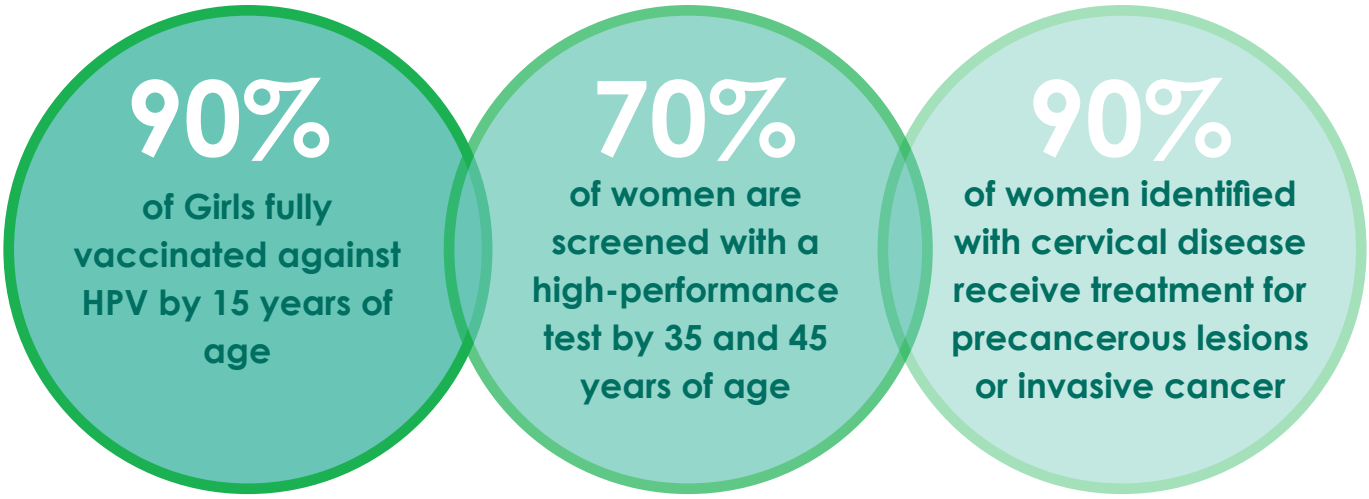


Figure 3: Global cervical cancer elimination 2030 interim targets

1.4 Justification and process of developing the action plan

Although cervical cancer elimination is one of the strategic interventions in the National Cancer Control Strategy 2023–2027, an operational implementation plan was necessary to accelerate progress toward the 2030 elimination targets. The National Cervical Cancer Elimination Action Plan (NCCEAP) therefore provides the focused, coordinated, and time-bound roadmap required to translate national priorities into concrete actions, clarify roles across stakeholders, and align investments along the entire prevention, screening, diagnosis, and treatment continuum. This dedicated plan positions Kenya to close existing gaps and move decisively toward cervical cancer elimination. The process of developing the action plan commenced in December 2024, with the formation of a governance mechanism, comprising the core team (NCCP, NVIP and Health Systems Insight/HSI) and an advisory team (the STOP cervical cancer TWG). Thereafter, a stakeholders co-creation and prioritization workshop was held in March 2025, with the aim of undertaking a performance review of the national cervical cancer program, undertake gap and root cause analysis, and suggest priority areas of focus for the action plan (figure 4). Subsequent technical workshops oversaw the development of the action plan draft, including costing and development of various learning and advocacy products. After external review and validation, the action plan will be launched, disseminated to all relevant stakeholders and implementation commenced.

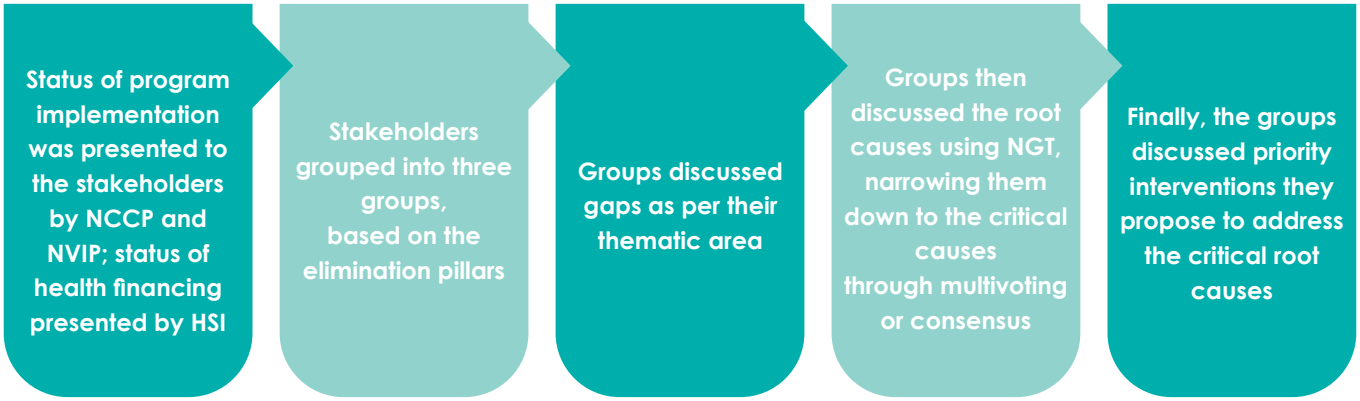
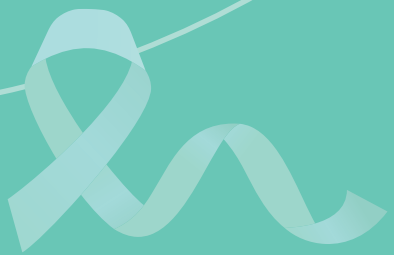


Figure 4: Information generation pathway during the co-creation workshop

CHAPTER TWO: STATUS OF CERVICAL CANCER ELIMINATION IN KENYA



CHAPTER TWO: STATUS OF CERVICAL CANCER ELIMINATION IN KENYA

Overview

In 2018, the WHO Director General issued a call for elimination of cervical cancer globally; this was followed by the launch of the Global strategy for elimination of cervical cancer in 2020. This chapter outlines the status of implementation of the elimination initiatives in the Kenyan context.

2.1 Review of the implementation of cervical cancer control strategies in Kenya

2.1.1 HPV vaccination

Since its 2019 rollout, Kenya's HPV vaccination program has remained low in coverage due to COVID-19 disruptions, limited access in marginalized communities, and systemic delivery and policy gaps; by 2023, only 54.7% of girls aged 10–14 had received one dose and 44.3% had completed two (figure 5). Challenges include weak school attendance by eligible girls in some regions, logistical constraints, poor integration into existing health systems, and delays in adopting a cost-effective single-dose regimen. Leadership and coordination issues, inadequate data systems, insufficient health worker support, misinformation, and minimal community engagement—especially among men and out-of-school youth—further impede uptake. The program remains heavily donor-dependent, with an unclear transition strategy post-Gavi support (full transition expected in 2029), budget cuts, and limited domestic financing threatening sustainability and scale-up, particularly as financial, operational, and accountability systems remain fragmented at both national and county levels.

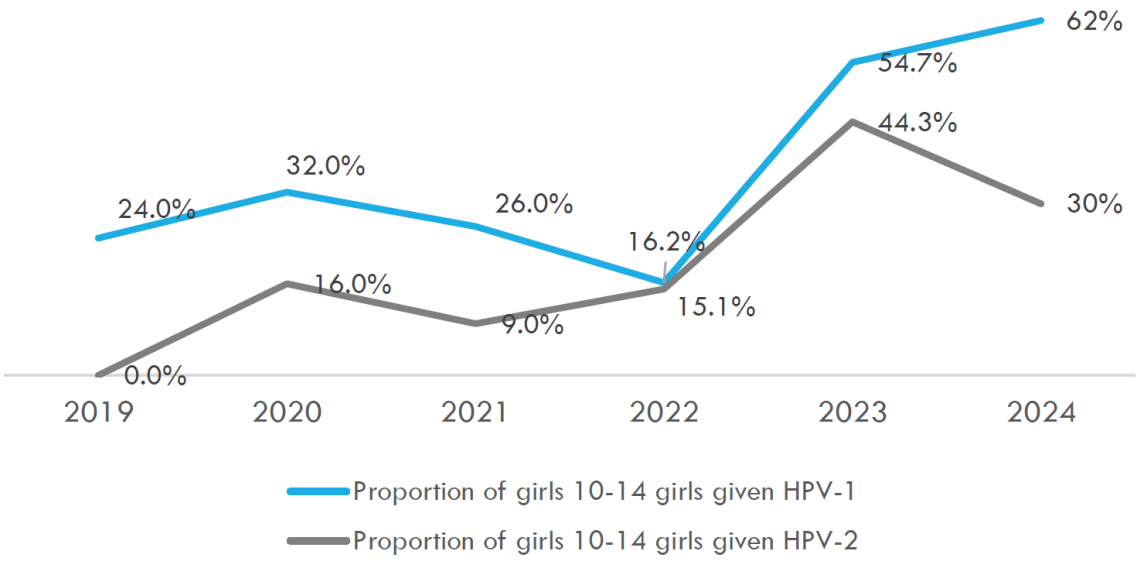


Figure 5: HPV vaccination coverage in Kenya, 2019-2024

2.1.2 Screening and treatment for cervical pre-cancer

Cervical cancer screening and treatment coverage in Kenya remains low, with significant disparities across counties. Despite efforts since 2011 using VIA and cryotherapy, coverage falls far below the 70% target, with most women screened using less accurate VIA instead of the recommended HPV testing (figure 6). Barriers include limited facility infrastructure, inadequate trained personnel, long distances to screening sites, and lack of integration of services. Though thousands of providers have been trained and equipment distributed, HPV testing still accounts for less than 6% of screenings due to lack of funding for commodity procurement and systems strengthening, logistical challenges, referral bottlenecks, and tracking issues. New guidelines promoting self-sampling and same-day treatment aim to improve uptake, but weak health systems, poor coordination, inadequate financing, and low public awareness continue to hinder progress. Treatment coverage for precancerous lesions is also low, with over half of eligible women not receiving care and major regional disparities. Issues such as workforce shortages, stockouts, misinformation, high costs, and loss to follow-up undermine the effectiveness of the cervical cancer prevention and treatment program.

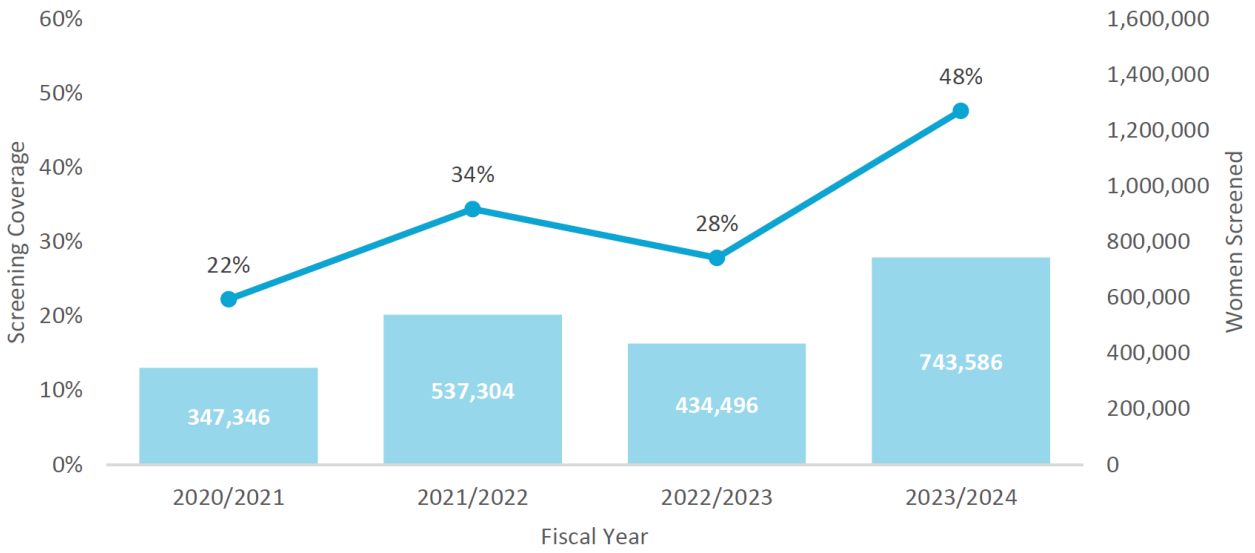


Figure 6: Cervical cancer screening (all methods) and precancer treatment coverage in Kenya, 2020-2024

2.1.3 Diagnosis and treatment of invasive cervical cancer

In 2019, aligning with the Universal Health Coverage agenda, the Ministry of Health and county governments decentralized cancer treatment by establishing regional cancer centers across the country. These centers integrated cancer services into existing facilities with capacities in pathology, radiology, palliative care, gynecology, pediatrics, and surgery among others. In addition to increasing radiotherapy capacity at the three national referral facilities, three additional radiotherapy facilities were set up in the regional centers, with brachytherapy capacity also available.

Even with these service availability investments, significant gaps hinder effective cervical cancer diagnosis, treatment, and care in Kenya, including inadequate equipment supply and maintenance, and weak referral systems, which contribute to poor access and high loss to follow-up rates. Specialized health professionals such as gynecological oncologists and pathologists are inadequate and unevenly distributed, while existing staff face heavy workloads, burnout, and limited training and supervision. Health informatics and supply chains are further constrained by costly imports, regulatory barriers, drug shortages, and fragmented data systems. Public awareness about available services is low, resulting in delayed care-seeking. At the policy level, gaps remain in achieving fully coordinated stakeholder efforts, sustaining consistent political commitment, and ensuring optimal implementation of national plans.

2.2 Strengths, Weaknesses, Opportunities and Threats (SWOT) Analysis.

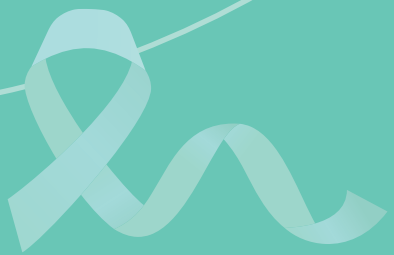
Table 2: SWOT analysis of the Kenya cervical cancer control program

Pillar	Strengths	Weaknesses
HPV vaccination	• Vaccination delivered through multiple strategies: facility-based and school-based primarily, with some community outreach. • Existence of an advisory committee on vaccination in Kenya - Kenya National Immunization Technical Advisory Group (KENITAG) • Robust community strategy where Community Health Promoters (CHPs) are leveraged for social mobilization, education and strengthening referral	• Low domestic funding for immunization • Lack of clear strategy to catch up missed girls in 10-14 yr age range • Strategies for reaching vulnerable and out-of-school girls not well defined • Persistent vaccine hesitancy among certain religious groups • Inadequate tracking of the financing transition roadmap for immunization services. • Inadequate engagement of guardians and schools, especially at subnational levels. • Myths and misconceptions

	Opportunities	**Threats**
	• More evidence available to support that cervical cancer prevention is one of the most cost-effective health interventions and should be prioritized • Recent switch to single-dose will free up resources to reinvest in HPV coverage improvements e.g., boosting single-dose coverage among 10–14-year-olds • Political momentum and policy framework are in place • Ongoing financing/UHC reforms/ implementation, such as the PHC Fund • Ongoing reforms in the school health program (integration of services and information systems) • Wider choice of HPV vaccines including lower priced products	• Donor dependency for health programs and foreign aid cuts • Gavi transition expected in 2029 • Worsening fiscal space and weak economic performance • Deficient technical planning, quantification and forecasting at the county level • Domestic health budget cuts,due to competing national priorities
Screening and precancer treatment	**Strengths**	**Weaknesses**
	• Political momentum and policy framework are in place • Existing coordination structures at national and subnational levels • Treatment of pre-cancerous lesions available; especially thermal ablation at PHC • HPV testing commodities now stocked by KEMSA • Screening guidelines available and updated (with screen, triage and treat in a single visit approach) • A national cancer reference laboratory exists to provide quality assurance and technical support to counties • Pre-service training on screening and treatment (KMTC tutor training, inclusion in curriculum)	• Low coverage of HPV testing as the recommended screening modality (low coverage with any modality) • High loss to follow-up from screening programs, hence low treatment coverage • No operational plan to drive progress towards elimination • Weak referral and linkages, especially for LEEP • and biopsy • Quality assurance: VIA positivity countrywide consistently below 5% • Frequent screening commodity stock-outs • No specific budget lines, therefore cannot track investment in screening and treatment
	Opportunities	**Threats**
	• The proposed PHC Fund benefit package encompasses cervical cancer screening and treatment • HPV self-sample collection can reduce stigma and other personal/cultural barriers to screening • Multiplex HPV testing platforms can enhance integration and health system efficiencies • Adoption of program-based budgeting • Male partner involvement • Integration of cervical cancer screening with other NCDS, reproductive health and HIV programs • Inclusion into performance appraisals • Pooled procurement and regional collaboration	• Lack of a robust coordination between all partners and the MoH and counties, for target-based planning on screening and treatment • Attrition of trained HCWs • Inadequate financing to scale and sustain HPV testing • Donor dependency and setbacks due to funding disruptions • Lack of prioritization and lean fiscal space in the counties • Treatment apathy among women • Language/cultural barriers to understanding of cervical cancer screening and treatment among the target population as well as healthcare providers • Equipment maintenance and consumable shortages

Diagnosis and treatment of invasive cervical cancer	**Strengths**	**Weaknesses**
	• Regional cancer centers have expanded radiotherapy and brachytherapy capacity and improved access • Local training programs in gyneoncology increasing number of specialists	• Diagnostic capacity still inadequate • Unstructured and inefficient referral system for suspected cervical cancer • Lack of robust cancer registration system to track progress • Long waiting times before having MDT care • Shortage of pathologists • High costs of radiotherapy & brachytherapy machine maintenance
	Opportunities	**Threats**
	• UHC implementation: SHIF and the ECCIF • Diagnosis covered under SHIF • Leveraging digital health solutions including telepathology can reduce turnaround times • Integration of palliative care services at all levels of care. • Public–private partnerships to expand imaging, radiotherapy capacity.	• Unpredictable financing for healthcare • Kenya servicing significant debt 70% of GDP affecting fiscal space for health

CHAPTER THREE: OPERATIONAL MODEL FOR CERVICAL CANCER ELIMINATION IN KENYA



CHAPTER THREE: OPERATIONAL MODEL FOR CERVICAL CANCER ELIMINATION IN KENYA

Overview

This chapter outlines the specific interventions that are proposed for implementation in the period 2025/26 to 2029/30, to put Kenya on the path to cervical cancer elimination.

3.1 Vision, mission, goal and core values

Vision

A Kenya free from the burden of cervical cancer.

Mission

To provide timely and equitable access to evidence-based, cost-effective, and quality HPV vaccination, cervical cancer screening, diagnosis, treatment, palliative care; and improve survivorship.

Goal

Achieve and sustain 90% HPV vaccination coverage, 70% screening coverage through HPV testing, and 90% treatment coverage for both precancer and invasive cancer by 2030.

Core Values

a. Integration

Deliberate alignment and incorporation of cervical cancer services—such as HPV vaccination, screening, diagnosis, and treatment—into existing health programs and platforms (e.g., PHC, maternal health, HIV, school health and community health) to ensure comprehensive and seamless delivery. This promotes efficiency, maximizes resource use, and improves outcomes by addressing women's health needs within a unified framework.

b. Collaborations

Strategic partnerships between stakeholders—including government agencies (Ministries of health, education, interior), civil society, health providers, development partners, county governments, faith-based facilities, private sector and communities—focused on cervical cancer prevention and control. These collaborations leverage shared resources, knowledge, and expertise to accelerate progress toward common elimination goals.

c. Sustainability

The ability of cervical cancer interventions (such as HPV vaccination, screening, and treatment) to maintain their impact and operations over time by building local capacity, securing long-term financing, institutionalizing practices within the health system, and ensuring community ownership to reduce dependency on external support. Examples include domestic financing (PHC benefits), local equipment maintenance plans, and workforce retention.

d. Governance

The systems, structures, and processes through which cervical cancer programs are led and managed—ensuring accountability, transparency, equity, and responsiveness. Strong governance ensures clear roles, effective oversight, and alignment with national health priorities and policies. The structures include the Non-communicable Disease Interagency Coordinating Committee (NCD- ICC), the National Cervical Cancer Elimination TWG, County NCD TWGs and School Health Coordination mechanisms.

e. Advocacy and education

Activities that influence policy, raise awareness, and empower individuals and communities with information about cervical cancer prevention. This includes addressing misinformation, social listening/ misinformation trackers and adverse event following immunization (AEFI) communication protocols (HPV vaccine confidence), promoting HPV vaccination and screening uptake, and mobilizing public and political support for cervical cancer elimination.

f. Capacity building

Efforts to enhance the knowledge, skills, systems, and infrastructure necessary for effective cervical cancer prevention and care. This includes competency-based curricula, training health workers, e-learning, certification, mentorship, improving supply chains, upgrading diagnostic capabilities, and strengthening data and referral systems.

g. Coordination

The systematic organization and harmonization of cervical cancer efforts across stakeholders and sectors for coherent planning, resource use, implementation, and monitoring. Strong coordination avoids duplication, enhances efficiency, and ensures alignment with national strategies.

h. Equity

Achieving equity in cervical cancer elimination requires ensuring that all women, especially those in underserved

and high-risk populations (rural, arid and semi-arid lands/ ASAL counties, informal settlements, women living with HIV, women with disabilities, migrants/refugees), have access to timely prevention, screening, and treatment services.

3.2 Key Result Areas (KRAs)

The operational focus of the elimination plan is structured around the three pillars of the cervical cancer elimination strategy, listed below. Interventions under each pillar are then grouped as per relevant health system building block. Cross-cutting issues including M&E/HIS, supply chain, financing, workforce, governance, community engagement, research/innovation are addressed specifically as they apply in each KRA.

Key Result Area 1: HPV vaccination

Key Result Area 2: Screening and precancer treatment

Key Result Area 3: Diagnosis, treatment, palliative and survivorship care for invasive cervical cancer.

3.3 Operational Objectives and Interventions

3.3.1 Key Result Area One: HPV vaccination

This is the first pillar of the elimination initiative, as well as the most impactful and cost-effective of the cervical cancer elimination interventions. This KRA seeks to ensure that over 90% of girls are vaccinated against HPV by the time they attain 15 years of age, through a combination of school- based, health facility and community strategies.

Operational objective 1: Strengthen and expand equitable, timely, and integrated HPV vaccine delivery with the goal of achieving at least 90% coverage of girls by age 15 years, by the year 2030

Actions:

- Institutionalize school-based HPV vaccination delivery through outreaches in all public and private primary schools
- Expand facility-based vaccination services to provide routine, accessible HPV vaccination services, including demand generation.
- Expand and institutionalize HPV vaccination outreaches to marginalized and underserved communities.
- Establish integrated mechanisms to track, follow-up, and improve school-based HPV vaccination outcomes.
- Increase vaccination coverage for 10-year-old girls to at least 90%, and conduct periodic catch-ups for girls 11-14 years to reach those missed at 10 years.
- Utilize innovative delivery approaches targeting missed opportunities plus zero dose girls.

Operational objective 2: Strengthen the capacity, motivation and availability of the health workforce to deliver HPV vaccines safely and effectively.

Actions:

- Strengthen the skills, motivation, and performance of healthcare workers and CHPs through structured, ongoing capacity-augmentation interventions.
- Establish an annual recognition and learning exchange platform to reward high-performing counties and promote best practice sharing.

Operational objective 3: Strengthen the health information system to ensure complete, timely, and integrated data capture, reporting, and decision making on HPV vaccination across public and private sectors by 2030.

Actions:

- Enhance adoption of vaccination modules into facility electronic health records systems (EHR) being rolled out countrywide, and their use at all vaccination points.
- Upgrade and integrate the Logistics Management Information System (LMIS) and make it end to end for utilization facility level.
- Enhance data quality to ensure consistency and accuracy between the source document /files and reporting including KHIS.
- Improve projection and forecasting of the number of in-school and out-of-school girls by county.
- Include HPV in coverage surveys to enable triangulation of administrative data on HPV

Operational objective 4: Strengthen the HPV vaccine supply chain for timely forecasting, equitable distribution and innovative delivery

Actions:

- Improve vaccine and related commodities forecasting and quantification
- Cold chain capacity mapping, distribution frequency, stockout thresholds/alarms, and reverse logistics.
- Strengthen last-mile delivery solutions (for example solar refrigerators, outreach carriers), and routine Wastage monitoring.

Operational objective 5: Secure long-term domestic and external financing for HPV vaccine procurement and delivery.

Actions:

- Advocate for implementation of HPV vaccination in the Health Benefits Package under Primary Health Care (PHC).
- Strengthen advocacy for HPV vaccination financing at national and county levels using evidence- based

tools.
- Develop a strong resource mobilization mechanism for HPV vaccines and its routine activities.

Operational objective 6: Promote strong political leadership, policy integration, and multi-sectoral coordination to support HPV vaccination.

Actions:
- Ensure policy integration across ministries , departments and health programs.
- Strengthen coordination across counties, ministries, and partners, including the National Immunization TWG, School Health Coordination Mechanisms and Regular Partner Mapping.

Operational objective 7: Promote uptake of HPV vaccination through effective behavior change messages and interventions directed at caregivers, health care providers, religious leaders, and other community influencers.

Actions:
- Facilitate participatory workshops where community members co-develop communication messages and tools that are locally relevant and culturally resonant.
- Optimize awareness among eligible girls, caregivers, and other trusted messengers in the community.
- Support caregiver decision-making to vaccinate eligible girls.
- Enhance capacity of HCWs to communicate better on HPV vaccination as trusted messengers by the community

3.3.2 Key Result Area Two: Screening and Treatment of Cervical Precancer Lesions

This KRA focuses on ensuring all eligible women are invited and offered screening with a high-precision method (HPV testing) and those with positive screening findings linked to further evaluation and/or treatment.

Operational objective 1: Ensure health facilities have adequate capacity/service readiness for screening and precancer treatment.

Actions:
- Carry out periodic assessment of the national cervical cancer screening and treatment program.
- Conduct quantification, forecasting and costing of all cervical cancer screening and pre-cancer treatment HPTs.
- Procure and equitably distribute the essential screening commodities and treatment devices.
- Upgrade primary health facilities to meet minimum infrastructure standards for cervical cancer screening and treatment.

Operational objective 2: Ensure provision of quality cervical cancer screening and pre-cancer treatment services

Actions:
- Scale up of HPV testing coverage from 6% to 50% in 2027 and to 70% in 2030.
- Scale up of treatment coverage of PCL from 43% to 70% in 2027 and 90% in 2030.
- Create a "call and recall" system for invitation and tracking for eligible women across the screen, triage and treat cascade.
- Implement a national HPV sample referral and testing cascade, including measures such as SOPs, courier schedules, barcoding, specimen rejection criteria, andlab information management system (LIMS) integration.

Operational objective 3: Strengthen Health Care worker capacity for cervical cancer screening and treatment

Actions:
- Identify health worker training gaps (pre-service and in-service).
- Support pre-service training on cervical cancer screening and treatment in universities and colleges.
- Continuous in-service training for HCW to update their knowledge and skills.

Operational objective 4: Increase community awareness and demand creation for screening

Actions:
- Review, print and disseminate IEC materials for key opinion leaders and general public.
- Create awareness on cervical cancer screening and treatment among HCWs and CHPs
- Enhance awareness creation throughout the year in line with the Cancer Communication Strategy

Operational objective 5: Enhance data management and use in decision making

Actions
- Support adoption of EHR systems in screening and treatment

Operational objective 6: Increase financial prioritization for cervical cancer screening and treatment in national and county health budgets, as well as other financing mechanisms (costs of tests, devices, consumables, maintenance, and provider payment mechanisms)

Actions:
- Advocacy, sensitization and resource mobilization from domestic sources.
- Engage private insurance companies to include HPV testing in their packages.

- Identify and engage development partners/donors to fund screening and treatment related interventions through existing health sector programs.
- Explore private lab partnerships with clear QA and capped tariffs.

Operational objective 7: Strengthen Leadership and Governance for cervical cancer screening and precancer treatment at both national and county level

Actions:
- Strengthen national level coordination of cervical cancer elimination interventions.
- Improve county level coordination of cervical cancer elimination interventions.
- Support counties leadership to implement cervical cancer elimination policies in their own context.
- Institute quarterly performance reviews with corrective action plans.

Operational objective 8: Ensure quality assurance in cervical cancer screening and treatment

Actions:
- Institutionalize a process of routine continuous quality improvement in the cervical cancer screening and treatment program in line with the Cancer MEAL framework.
- Develop an advisory framework (within the National Cervical Cancer Elimination TWG) to safeguard quality and ensure the country adopts clinically validated HPV tests and other screening technologies.

3.3.3 Key Result Area Three: Diagnosis, Treatment, Palliative and Survivorship Care of Invasive Cervical Cancer

This KRA focuses on women diagnosed with cervical cancer, and seeks to ensure that such women access timely diagnosis as well as all the treatment, follow-up, palliative and survivorship care services they need.

Operational objective 1: Strengthen infrastructural capacity of comprehensive specialized facilities offering diagnostic, treatment and palliative care for cervical cancer. (see appendix VIII).

Actions:
- Conduct a mapping assessment for cancer diagnostic services (laboratory and imaging), as well as treatment capacity (including service need mapping and HR capacity).
- Increase timely access to quality and accurate cervical cancer laboratory diagnosis and support within the county Referral Hospitals (CRHs) and Cancer Treatment Centers.
- Provide adequate and accurate imaging equipment for diagnosis of cervical cancer at the CRHs.
- Establish two additional nuclear medicine services to provide diagnostic and therapeutic radionuclide services.
- Enhance patient and laboratory test navigation by creating robust referral pathways within the regional hubs and county referral systems

Operational objective 2: Strengthen the availability and capacity of a well-trained, multidisciplinary oncology workforce to support timely diagnosis and comprehensive treatment of cervical cancer. (see appendices V-VII).

Actions:
- Strengthen availability and capacity of a skilled multi-disciplinary team of oncology human resources for health across all levels of care (e.g. Lab pathology , medicine/oncology ,nursing, imaging and palliative care).
- Ensure timely staging, multidisciplinary tumor boards, and patient navigation to reduce delays.
- Include personnel trained in sexual/reproductive health, fertility preservation counseling, psychosocial support, return- to-work/survivorship care in the multi-discplinary team.

Operational objective 3: Ensure availability of Health product and technologies to deliver comprehensive cervical cancer diagnosis, treatment and palliative care in counties and regional CTCs

Actions:
- Strengthen the Histopathology reagent supply, equipment purchase and maintenance within the counties and regional CTCs.
- Equip theatre services within the counties to support surgical intervention of early invasive cervical cancer.
- Ensure regular provision of safe chemotherapy at all CTCs.
- Increase capacity for radiotherapy/brachytherapy at CTCs.
- Strengthen provision of nuclear and radiation medical products and equipment within the CTCs for treatment of advanced cervical cancer.
- Ensure the availability of palliative commodities in all county referral facilities with linkages to primary and community home-based care, as per the NCCS 2023-2027.

Operational objective 4: Comprehensively provide financial cover for the diagnosis and treatment of cervical cancer.

Actions:
- Support sustainable Domestic financing for diagnosis and treatment of invasive cervical cancer, including

advocating for full information of the relevant SHI packages (especially SHIF and ECCIF).

Operational objective 5: Strengthen cervical cancer data systems for effective monitoring, planning, and quality improvement of diagnosis and treatment services across all levels of care.

Actions:

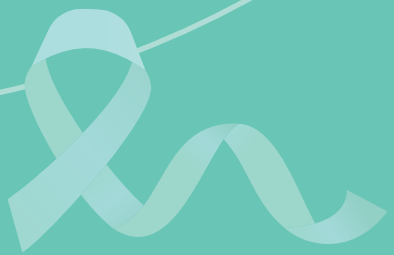
- Improve data collection, quality and reporting practices for cancer diagnosis and treatment, through adoption of EHR at CRHs and CTCs.
- Enhance real-time data use for clinical decision-making and service improvement, through linkage of facility EHR to KHIS and oncology dashboard.
- Generate and disseminate periodic data for policy advocacy, resource mobilization, and community feedback.
- Identify research priority areas and conduct research to guide cervical cancer diagnosis and treatment.

Operational objective 6: Strengthen leadership and governance systems for effective policy implementation, coordination, and oversight of cervical cancer diagnosis and treatment services at national and county levels.

Actions:

- Strengthen the cancer diagnosis and treatment coordination between national and county mechanisms.
- Monitor adherence to National Cancer Treatment Guidelines and Standards on cervical cancer.
- Build leadership capacity for evidence-based planning, implementation, and advocacy.
- Ensure cervical cancer elimination indicators are included in the government performance management system.

CHAPTER FOUR: COSTING OF THE NCCEAP



CHAPTER FOUR: COSTING OF THE NCCEAP

Overview

This chapter provides a breakdown of the cost estimates for the implementation of the NCCEAP, for the planning period 2025-2030. The costs estimates encompass all interventions spelt out in the action plan, across the three pillars: expanding HPV vaccination coverage, HPV testing, access to PCL treatment, diagnosis and treatment of invasive cervical cancer. A combination of Activity-based costing (ABC) and Ingredients-based costing (IBC) were applied, to enable tracking of the individual cost drivers for implementation. The goal of the costing exercise was to ensure that a detailed estimate of the cost of implementing the NCCEAP is obtained, while ensuring that efficiency and service integration are considered for optimal use of available resources. Several considerations and assumptions were made during the costing process:

1. **Any proposed activity, which was deemed to be part of the routine service provision, had no additional costs attached to it.** For example, while costs of training and mentorship for healthcare workers are included, their salaries are not. Therefore, the costs represents the additional investment for health system strengthening for an effective cervical cancer response.
2. **Items with an existing financing mechanism, such as through another domestic source were not costed.** For example, the cost of providing HPV testing is included in the Primary Health Care Fund, under the Social Health Insurance. Therefore, the cost of offering the service to all the eligible women was not costed separately. However, we estimated the initial costs of availing HPV testing commodities to health facilities countrywide, for them to start offering the service and therefore qualify to be reimbursed under the PHC Fund.
3. **The implementation of the NCCEAP is premised primarily on domestic financing.** Therefore, all effort was made to avoid duplicate costing, since the bulk of the resources will be from domestic public financing.
4. **The costing exercise was a multi-stakeholder effort,** including inputs from the Divisions of Health Financing and Planning (MoH), the Social Health Authority, and accounting officers from counties**.** Therefore, the cost estimates and resource mobilization strategies proposed are **based on in- depth analysis of the current health financing landscape in Kenya.**

4.1 Financial Resources Requirements

Table 3 shows the breakdown of the cost requirements for implementation of the NCCEAP in the five- year period till 2030. The costs are summarized by pillar, strategic objective and implementation year.

Table 3: Cost requirements for implementing the NCCEAP (KES)

Pillar	Stategic Objective	2025/26	2026/27	2027/28	2028/29	2029/30	TOTAL
1: HPV vaccination	SO1	56,721,418	56,721,418	56,721,418	56,721,418	56,721,418	
	SO2	1,263,511	1,263,511	1,263,511	1,263,511	1,263,511	
	SO3	0	2,432,465	2,432,465	2,432,465	0	
	SO4	1,597,643	1,597,643	1,597,643	1,597,643	1,597,643	
	SO5	0	2,545,386	2,545,386	2,545,386	2,545,386	
	SO6	0	5,771,937	5,771,937	5,771,937	5,771,937	
	SO7	0	18,974,834	18,974,834	18,974,834	18,974,834	
Subtotal		**59,582,572**	**89,307,193**	**89,307,193**	**89,307,193**	**86,874,728**	**414,378,879**
2: Screening and PCL treatment	SO1	0	12,269,134	12,269,134	0	0	
	SO2	0	8,023,579	8,023,579	8,023,579	8,023,579	
	SO3	0	29,009,896	29,009,896	29,009,896	29,009,896	
	SO4	0	15,427,920	15,427,920	15,427,920	15,427,920	
	SO5	0	317,153	317,153	317,153	317,153	
	SO6	0	998,877	998,877	998,877	998,877	
	SO7	8,136,279	8,136,279	8,136,279	8,136,279	8,136,279	
	SO8	0	11,905,734	11,905,734	11,905,734	11,905,734	

Subtotal		**8,136,279**	**86,088,572**	**86,088,572**	**73,819,438**	**73,819,438**	**327,952,300**
3. Diagnosis and treatment of cervical cancer	SO1	340,000	37,724,250	37,724,250	37,724,250	37,724,250	
	SO2	0	0	0	0	0	
	SO3	64,493,423	64,493,423	64,493,423	64,493,423	64,493,423	
	SO4	0	0	0	0	0	
	SO5	0	7,437,700	0	1,075,018	1,075,018	
	SO6	0	2,741,500	0	2,802,255	2,802,255	
Subtotal		**64,833,423**	**112,396,873**	**102,217,673**	**106,094,946**	**106,094,946**	**491,637,860**
GRAND TOTAL		**132,552,273**	**287,792,638**	**277,613,438**	**269,221,577**	**266,789,112**	**1,233,969,039**

This cost represents the additional investment required to strengthen the health system for an effective cervical cancer response, excluding activities considered part of routine service provision.

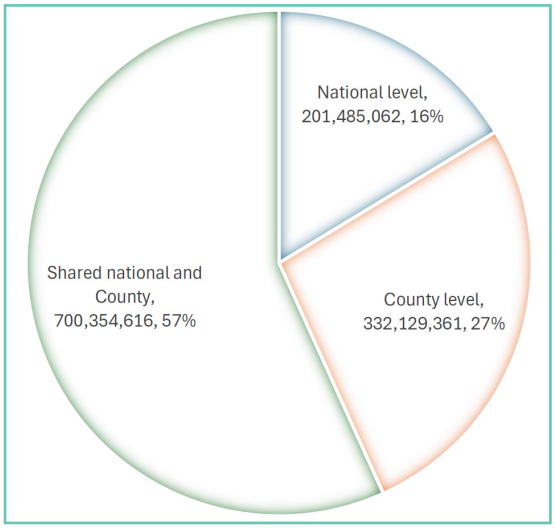


Figure 7: NCCEAP implementation cost, by level of government (KES)

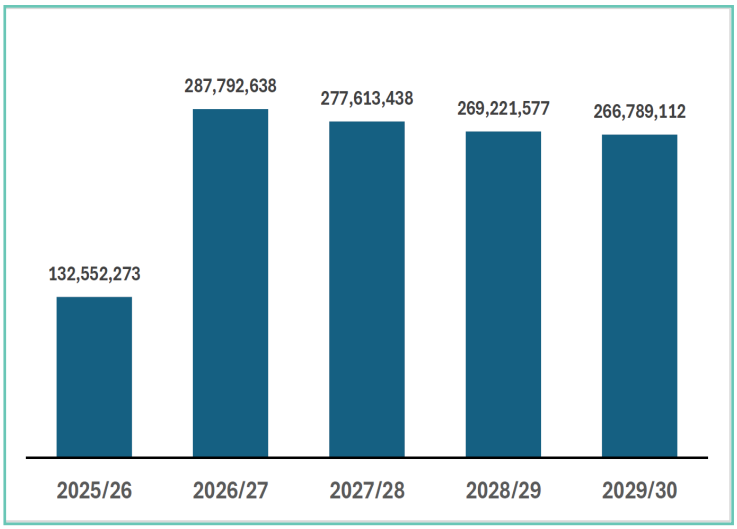


Figure 8: Cost of implementing the NCCEAP, by year (KES)

Notes:

1. **Additional Investments and Total Cost:** In addition to the implementation of the activities in the NCCEAP, expansion of PET/SPECT services by establishment of two units (MTRH and Mombasa cancer center) is estimated to cost KES 1,389,600,000. Therefore the total cost of implementation would be KES 2,623,569,039.
2. **Relative Cost and Context:** The average annual cost of implementing the NCCEAP represents 5.4% of the average cost of implementation of the NCCS 2023-2027, 0.7% of the cost of the annual cost of implementing the NCD strategic plan 2021-2025 and 0.4% of the total budgetary allocation to health in the fiscal year 2025/26. For context, cervical cancer represents 13.1% of all new cancer cases, and 12.2% of deaths. Cumulatively, cancer contributes 22.7% of the burden of catastrophic health expenditure in Kenya.
3. **Cross-Cutting Benefits:** Several investments proposed in the NCCEAP will be utilized beyond cervical cancer. These include diagnostic and treatment facilities. For instance, molecular diagnostic platforms can be utilized for other priority infectious agents like HIV and HBV.

4.2 Resource Mobilization Strategies

1. **Government-Led Approaches**
   a. **Social Impact Bonds (Outcome-Based Funding):** Funder pays only after agreed outcomes are achieved (e.g., Tiko, Kiambu Maternal Health). Key Action: Government agencies to sensitize counties and other implementing bodies on the model and its benefits.

   b. **Direct Public Funding:** Strengthen county and national government participation in the budget-making process. Support policy adjustments (e.g., adopting one-dose cervical cancer vaccine schedule instead of two). Ensure timely remittance of funds to SHA, indigent support programs, and county health accounts.

   c. **Operationalization of Laws and Funds:** Activate underutilized statutory funds such as the

Tobacco Fund and Sports Fund. Key Enabler: Political goodwill and stakeholder advocacy for enforcement.

d. **Enhance sensitization and capacity-building** on PPP frameworks for counties and health facilities.

e. **Equipment Leasing / Fee-for-Service Models:** Encourage leasing arrangements and pay-per-use models to ease capital expenditure burden and improve service availability.

f. **Strengthening Social Health Schemes:** for example, Introduce levies on selected goods/ services to boost SHA resources.

g. **Loans and Grants:** Mobilize concessional loans and research grants for cervical cancer elimination programs.

h. **County Government Contributions:** Utilize Facility Improvement Funds (FIF) to support local outreach programs, screening initiatives, and Health Products and Technologies (HPTs).

2. **Corporate Social Responsibility (CSR):** Engage corporates to fund awareness campaigns, screening drives, and vaccination programs as part of their CSR initiatives.

3. **Local Philanthropy:** Map and engage local philanthropists to align their giving with national and county cervical cancer elimination priorities.

4. **Community Resource Mobilisation:** Organize high-visibility fundraising events such as marathons, art auctions, and dinners to rally public support and raise funds.

5. **Private Health Insurance Expansion:** Advocate for private insurers to expand coverage to include cervical cancer vaccination, screening, and treatment.

6. **Development Partners and Civil Society Organizations (CSOs):** Strengthen partnerships for funding, capacity-building, and advocacy support.

7. **Unlock Technical Efficiencies:** Integrate service delivery across programs to reduce duplication. Automate and digitize processes to save time and costs. Implement pooled procurement to leverage economies of scale. Budget/ resource optimization of institutional funding for cervical cancer.

4.3 Resource management

The following measures will ensure prudent and efficient utilization of resources available for CCE in the country:

- **Digitisation of Manual Processes:** Shift from paper-based systems to electronic data capture and reporting.
- **Automation of Processes:** Use technology to streamline workflows, approvals, and payments.
- **System Optimisation:** Improve interoperability between health systems for better data sharing and decision-making.
- **Service Integration:** Deliver multiple services (e.g., screening, vaccination, treatment) in a single visit to increase efficiency.
- **Pooled Procurement:** Consolidate purchases across counties and programs to reduce costs.
- **Use of AI and Analytics:** Apply artificial intelligence for demand forecasting, disease surveillance, and program planning.
- **Social Accountability:** Engage communities to monitor service delivery and ensure transparency.
- **Resource Tracking and Audits:** Strengthen financial tracking, audits, and reporting for efficient use of funds.

4.4 Risk Analysis and Mitigation Measures

Table 4: Risks and mitigation measures

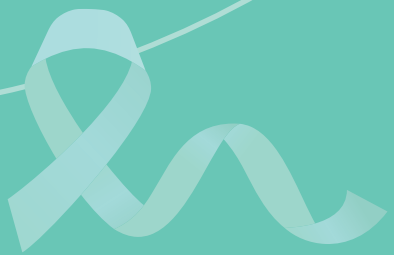
Risk Class/Category	Risk and Description	Likelihood (L/H/M)	Impact (L/H/M)	Overall Risk Level (L/H/M)	Mitigation Measure	Risk Owner
Leadership and Governance	Lack of political goodwill	H	H	H	• Sustained strategic targeted advocacy • Active engagement in decision making platform	MoH/counties
	Frequent change of senior MOH leadership	H	H	H	• Anchor NCCEAP implementation at the office of the Director General of Health	MoH

Risk Class/Category	Risk and Description	Likelihood (L/H/M)	Impact (L/H/M)	Overall Risk Level (L/H/M)	Mitigation Measure	Risk Owner
Human resource	Inadequate specialized HR	H	H	H	• Train and employand retain specialized staff	MOH/ Counties
	High staff turnover – migration	M	H	H	• Provide incentives to encourage staff retention	Counties
Financing	Competing health priorities – e.g. infectious diseases, pandemics or epidemics/ outbreaks, maternal health etc.	H	H	H	• Find points of integration • Prioritize interventions with highest impact e.g. vaccination and screening • Advocate for preventive and promotive interventions	MoH/counties
	Corruption and mismanagement of funds	H	H	H	• Enforcement of accountability	MoH/ Counties
	Diversion of funds	M	M	M	• Active involvement and monitoring of the budget making process.	MoH/ Counties
	Declining donor funding (Overseas development assistance)	H	H	H	• Progressive shift towards domestic funding. • Explore innovative financing mechanisms. • Prioritize cost-effective interventions	MoH/ Counties
	Limited private sector uptake of SHA	H	M	H	• Timely reimbursement of claims and continuous engagement.	MoH

Risk Class/Category	Risk and Description	Likelihood (L/H/M)	Impact (L/H/M)	Overall Risk Level (L/H/M)	Mitigation Measure	Risk Owner
Service delivery	Health emergencies – outbreaks	L	H	M	• Advocate for financing of the emergency fund for emergency preparedness such as ECCIF	MoH/ Counties
	Misinformation leading to low uptake of interventions	M	H	H	• Implement the cancer communication strategy.	MoH
	Global political changes	M	H	H	• Strengthen domestic resource mobilization.	MoH/ Counties
	Poor readiness of facilities for service provision – infrastructure,	H	H	H	• Increase investments in HR, equipment's and commodities	MoH/ Counties
	Bureaucratic delays affecting timely implementation	H	H	H	• System optimization, automation and digitization of processes.	MoH/ Counties
	Cultural barriers and Religious barriers	H	H	H	• Sustained awareness through opinion leaders.	MoH/ Counties
	Low literacy levels impacting health service seeking	M	M	M	• Customize IEC Material to target all levels literacy.	MoH/ Counties
	Lack of public trust occasioning poor uptake of services	H	H	H	• Community engagement and participation • Transparency and accountability • Culturally sensitive communication	MoH/ Counties
	Inadequate medical equipment management plan – e.g. Service Level Agreement for machines, HR, Reagents	H	H	H	• Proper planning and budgeting.	MoH/ Counties

L: Low; **H:** High; **M:** Medium

CHAPTER FIVE: IMPLEMENTATION, MONITORING, EVALUATION AND LEARNING FRAMEWORK



CHAPTER FIVE: IMPLEMENTATION, MONITORING, EVALUATION AND LEARNING FRAMEWORK

Overview

The implementation of the NCCEAP will be tracked through three key approaches, as guided by the National Cancer Monitoring, Evaluation, Accountability and Learning Framework 2023-2027.

First, the implementation framework in appendix 1 will be used to structure the proposed activities for every year into the annual workplans for all responsible agencies at national and county level. Second, various indicators will be monitored on a continuous basis, to inform stakeholders on performance of the elimination initiative, and informing decision-making. Lastly a mid-term evaluation will be conducted in 2028 and an end-term evaluation in 2031, to assess the extent of implementation and impact of the NCCEAP.

5.1 Monitoring

Monitoring NCCEAP will be integrated into the national surveillance platforms, and ride on the digital superhighway. Service provision modules integrated into Taifa Care and other EHR platforms will collect data on HPV vaccination, screening, precancer treatment, diagnosis, staging and treatment of invasive cervical cancer. This information will be aggregated and transmitted to the Kenya Health Information System (KHIS), where it will then be pulled into the National Oncology Dashboard. Therefore, both monitoring of the cervical cancer program and information dissemination will be a continuous process.

5.2 Evaluation

Both a mid-term (2028) and end-term (2031) evaluations will be conducted to assess the country's progress towards attainment of the set targets.

5.3 Learning

The revamped National Oncology dashboard will be made available and accessible to all relevant personnel, including the technical program implementers at national (relevant MoH divisions and agencies) and county (cervical cancer focal persons, NCD coordinators, EPI focal persons, facility in- charges, etc.), as well as decision-makers at national (DG, Principal Secretaries) and county (County Directors of Health, Chief Officers Health, County Executive Committee Members for Health and Governors) levels. A cervical cancer elimination report will be published and disseminated to all stakeholders, including the general public, every year.

5.4 Implementation Coordination and Governance

Implementation of the NCCEAP will be based on existing structures, including county NCD TWGs, county NCD and cancer focal persons, national TWGs under NCCP and NVIP, the NCD interagency coordination committee (NCD-ICC) and School Health coordination structures (see appendices III and IV).

NB: The outcome performance matrix is shown in Appendix II

Table 5: Key outcome indicators for the NCCEAP derived from the National cancer control MEAL Framework

Indicator	Baseline (2025)	2026	2027	2028	2029	2030
Percentage of girls who have received the HPV vaccine by the age of 15 years	54%	70%	80%	90%	90%	90%
Percentage of women aged 30– 49 who have been screened with a high-performance test for the first time	6%	30%	50%	60%	70%	80%
Percentage of women identified with having pre-cancerous lesions that receive treatment	43%	60%	70%	80%	90%	90%
Percentage of women identified with having invasive cervical cancer that receive treatment	58%	60%	70%	75%	80%	90%
Proportion of women with cervical cancer who are diagnosed at early stage (stage 1 and 2)	40%	50%	60%	65%	70%	80%

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Empowering and Enabling Access,
Eliminating Cervical Cancer:
Uniting for a Healthier Tomorrow!
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CERVICAL CANCER
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Appendices

Appendix I: Implementation Matrix

Key Result Area One: HPV vaccination

Strategic Objectives	Activities	Sub-activities	Lead Agency	2025/26	2026/27	2027/28	2028/29	2029/30
Strengthen and expand equitable, timely, and integrated HPV vaccine delivery with the goal of achieving at least 90% coverage of girls by age 15 years, by the year 2030.	Institutionalize school-based HPV vaccination delivery in all public and private primary schools	Hold dialogue meetings with county education and health officials especially in the underserved counties (low HPV vaccination coverage)	NVIP	X				
		Sensitize teachers and school administrators on HPV vaccination benefits and procedures	NVIP/Counties		X	X		
		Incorporate HPV and cervical cancer content into existing health education curricula.	NVIP		X			
		Adopt teacher job-cards/checklists for HPV vaccination facilitation and recordkeeping.	NVIP		X			
		Introduce self-populated school health registers to capture the eligible cohort by month	NVIP		X	X		
	Expand facility-based vaccination services to provide routine, accessible HPV vaccination services, including demand generation.	Deploy additional HPV IEC materials (e.g., posters, use of local radio spots) in outpatient departments to increase awareness.	NVIP	X	X			
		Facilitate quarterly coordination dialogues between schools and their linked health facilities.	NVIP	X	X	X	X	X
		Have a CHP HPV vaccination champion at the health facilities	Counities	X	X			
		Designate “HPV Vaccination Day” (e.g., first Saturday of each month) at all health facilities.	Counties		X			

	Expand and institutionalize HPV vaccination outreaches to marginalized and underserved communities.	Map underserved schools, communities, and facilities to guide mobile clinic deployment.	NVIP/Counties		X	X		
		Conduct targeted outreach to eligible girls, including those who are out-of- school, PLWHIV, people living with disabilities, refugee camps	NVIP/Counties	X	X	X	X	X
		Sensitize CHPs and community stakeholders on HPV vaccination benefits and delivery procedures.	NVIP/Counties	X	X	X	X	X
		Integrate HPV vaccination data capture in eCHIS	NVIP		X			
	Establish integrated mechanisms to track, follow-up, and improve school-based and school-based HPV vaccination outcomes.	Implement digital tools to track vaccine coverage and follow up on missed doses.	NVIP		X	X		
		Develop standard operating procedures for weekend/out-of-hours vaccination.	Counties	X				
		Leverage digital tools (e.g., SMS reminders or mobile apps) to schedule vaccination sessions and send follow-up dose reminders	NVIP/Counties		X	X		
	Increase vaccination coverage for 10-year-old girls to at least 90% and conduct periodic catch-ups for girls 11-14 years to reach missed opportunities	Develop and disseminate targeted advocacy materials to key decision-makers at national and county level	NVIP	X				
	Utilize innovative delivery approaches targeting missed opportunities plus zero dose girls	School-based catch-up campaigns in areas where girls missed doses due to school closures or disruptions	NVIP	X	X	X	X	X
		Introduce community-based mobile vaccination units in informal settlements and nomadic regions	NVIP/Counties		X	X	X	X
		Collaborate with CHPs to conduct door to door mobilization ahead of mobile vaccination days	Counties	X	X	X	X	X
Strengthen the capacity, motivation and	Strengthen the skills, motivation, and performance of healthcare workers and CHPs through structured, ongoing capacity- augmentation interventions.	Continuous knowledge and skills gaps assessment among healthcare workers and CHPs through structured needs	NVIP	X	X	X	X	X

availability of the health workforce to deliver HPV vaccines safely and effectively.		assessments and training evaluations. (Targeted training)						
		Design and implement targeted training plans based on identified gaps per cadre and county.	NVIP/Counties		X		X	
		Conduct structured training sessions for frontline health personnel on HPV vaccine delivery, safety, communication, and documentation.	NVIP/Counties		X	X	X	X
		Develop and disseminate standardized SOPs, job aids, and vaccination guidelines for facility and community-based service providers.	NVIP		X			
		Conduct supportive supervision and field mentorship visits to reinforce quality practices and address gaps in real-time.	NVIP/Counties	X	X	X	X	X
		Training and mentorship for all health care workers at level 2-4 health facilities offering HPV vaccination	NVIP/Counties		X	X	X	X
		Promote monthly Continuous Medical Education sessions to update healthcare workers on emerging HPV vaccination protocols and best practices.	NVIP/Counties	X	X	X	X	X
	Establish an annual recognition and learning exchange platform to reward high-performing counties and promote best practice sharing.	Hold annual performance recognition events to celebrate counties that excel in HPV vaccination coverage, innovation, and equity.	NVIP			X	X	X
		Develop standardized performance criteria and indicators to evaluate county-level progress on HPV vaccination (e.g., coverage rates, dropout rates, integration, data quality).	NVIP		X	X		
		Identify and profile county HPV vaccine champions, including healthcare workers, policymakers, CHPs, and CSOs who demonstrate exceptional leadership.	NVIP	X	X	X	X	X

		Facilitate cross-county learning exchanges through benchmarking visits, virtual forums, and case study presentations to share innovations and scalable practices.	NVIP		X	X		
Strengthen the health information system to ensure complete, timely, and integrated data capture, reporting, and decision making on HPV vaccination across public and private sectors by 2030.	Enhance adoption of vaccination modules into facility electronic health records systems (EHR) being rolled out countrywide, and their use at all vaccination points	Hold advocacy meetings with NVIP,HIS, DHA, counties to enhance the inclusion of the immunization module in the facility EHRs	NVIP		X	X		
		Train healthcare workers in all HPV vaccination facilities on EHR use for HPV vaccination data entry and reporting by 2027	NVIP, DHA			X		
		Link EHRs to the KENIS (in school) and eCHIS (out of school) to provide data of eligible girls	NVIP, DHA			X	X	
	Upgrade and integrate the Logistics Management Information System (LMIS) and make it end to end for utilization facility level.	Make the facility EHRs interoperable with Chanjo LMIS	NVIP/DHA			X	X	
	Enhance data quality to ensure consistency and accuracy between the source document / files and reporting including KHIS	Conduct Routine Data Quality Assessments (DQAs)	NVIP		X		X	
		Develop and Disseminate Data Quality SOPs and Guidelines	NVIP		X			
		Capacity build healthcare provider(e.g. HRIOs) and program staff on data management and quality	NVIP		X		X	
		Promote inclusion of HPV vaccine in the school health register	NVIP		X			
	Project and forecast the number of in-school and out-of-school girls by county	Support the ongoing integration of KHIS and KENIS for accurate numbers of eligible girls	NVIP	X	X	X	X	X
		Adopt the grade system to identify eligible girls for HPV vaccination	NVIP	X				

Strengthen the HPV vaccine supply chain for timely forecasting, equitable distribution and innovative delivery	Improve vaccine and related commodities forecasting and quantification	Sensitize and mentor county teams on relevant data reporting tools	NVIP		X		X	
		Train county teams on microplanning and supply chain management practices	NVIP	X		X		X
Secure long-term domestic and external financing for HPV vaccine procurement and delivery.	Advocate for implementation of HPV vaccination in the Health Benefits Package under Primary Health Care (PHC)	Hold dialogue meetings for modification of the system and contracts to allow for reimbursement HPV vaccination done both within facilities and school outreaches	NVIP	X				
		Disseminate updated Health Benefits Package guidelines to healthcare providers.	NVIP		X			
	Strengthen advocacy for HPV vaccination at national and county levels using evidence-based tools	Develop policy and evidence briefs demonstrating the return on investment (ROI), cost effectiveness and health impact for sustainability	NVIP		X		X	
		Build capacity of local advocates and CSOs, training work-shops and tool-kit for grassroot advocacy	NVIP		X	X	X	X
		Conduct targeted advocacy engagements with national policymakers and county assemblies, using tailored data driven resources (ROI, epidemiological impact, life saved estimates, modeling reports	NVIP		X		X	
	Develop a strong resource mobilization mechanism for HPV vaccines and its routine activities	Ensure a budget line for vaccines and delivery costs in National ,County and health facilities	NVIP/Counties		X	X	X	X
		Collaborate with Gavi, development partners, and private sector for co-financing and support	NVIP	X	X	X	X	X

Promote strong political leadership, policy integration, and multi- sectoral coordination to support HPV vaccination.	Ensure policy integration across ministries , departments and health programs	Integrate HPV vaccination into relevant health policies including adolescent health, school health, health promotion, community health policies and across sectors including education , gender ,interior and immigration (refugees)	NVIP			X	X	
	Strengthen coordination across counties, ministries, and partners	Identify and engage champions from diverse sectors including national and county leaders, social influencers, religious leaders and community leaders	NVIP		X	X	X	X
		Ensure HPV vaccination focal persons and agenda are included in the school health coordination framework at national and county levels in line with the school health policy.	NVIP		X	X	X	X
Promote accurate knowledge and positive attitudes on HPV vaccination by addressing stigma, misinformatio n, and harmful norms through inclusive, multi-stakeholder behavior change communication.	Facilitate participatory workshops where community members co-develop communication messages and tools that are locally relevant and culturally resonant.	Conduct rapid perception surveys or focus group discussions to surface common myths, beliefs, and misinformation gaps on HPV vaccination.	NVIP		X		X	
		Plan for regular review and adaptation of messages based on community feedback and emerging issues.	NVIP		X		X	
		Create a rollout plan with community stakeholders, identifying platforms (churches, barazas, schools, local media) and timelines for message deployment.	NVIP		X	X	X	X
	Optimize awareness among eligible girls	Adoption and adaptation of existing IEC materials targeting eligible girls	NVIP		X			
		Roll out targeted programs for eligible girls leveraging on existing groups e.g. scouts , school brigades and girl guides	NVIP		X	X	X	X
	Enhance awareness among caregivers for eligible girls	Equip CHPs with materials to increase awareness on HPV vaccination	NVIP/Counties		X		X	
		Conduct media engagements to ensure accurate and responsible reporting	NVIP/Counties		X	X	X	X

		(sensitization workshops , press releases, media briefings etc.)						
		Engage the parents through school PTA's	NVIP	X	X	X	X	X
		Increase HPV awareness through public campaigns on health days such as World Cancer Day, World immunization week, cervical cancer awareness month, day of the African Child and School Health Weeks.	NVIP		X	X	X	X

Key Result Area Two: Screening and treatment for cervical precancerous lesions

Strategic Objectives	Proposed Strategies/activities	Sub-activities	Responsible/ Lead Agency	2025/ 26	2026/ 27	2027/ 28	2028/ 29	2029/ 30
To ensure health facilities have adequate capacity/ service readiness for screening and precancer treatment.	Carry out periodic assessment of the national cervical cancer screening and treatment program	Review the existing cervical cancer baseline assessment tool	NCCP		X			
		Conduct the assessment in all the 47 counties including mapping of HPV testing capacity	NCCP		X			
		Disseminate the assessment findings to all stakeholders	NCCP		X			
		Establish a mechanism for routine tracking of cervical cancer screening and treatment service provision countrywide i.e. HR, Device utilization etc.	NCCP			X	X	X
	Conduct quantification ,forecasting and costing of all cervical cancer screening and pre-cancer treatment HPTs	Establish a national taskforce to do the quantification and costing through regular TWG meetings to establish national requirements.	NCCP		X			
		Present the quantification and costing (requirements) to MOH/MOF/ Treasury for adoption and financing	NCCP		X			

	Procure and equitably distribute the essential screening commodities and treatment devices	Support procurement of the quantified screening and treatment commodities by KEMSA	NCCP			X		
		MOH and counties develops a distribution list and shares with KEMSA	NCCP/counties			X		
		MoH and counties track distribution and utilization of commodities and devices	NCCP/counties			X		
	Upgrade primary health facilities to meet minimum infrastructure standards for cervical cancer screening and treatment.	Implement the standardized minimum requirements guidance for facilities, as detailed in the National Cancer Screening and Early Diagnosis Guidelines	NCCP		X			
		Counties to create a functional HPV Testing and pre-cancer treatment workflow, with defined service delivery Points (Level 2 and 3 conduct HPV self and clinician assisted sample collection; level 4 and 5 conduct the HPV sample processing and results transmission).	Counties		X			
		Progressively support recruitment and retention of the recommended human resource to support delivery of services according to the service expected at the facility level	Counties		X			
Ensure quality assurance in cervical cancer screening and treatment	Institutionalize a process of routine continuous quality improvement in the cervical cancer screening and treatment program	Present key performance and quality indicators at all coordination meetings at national (TWG, NCD- ICC) and county (NCD TWG, CHMT) levels	NCCP/Counties		X	X	X	X
		Plan, conduct regular DQAs and SQAs, and undertake actions based on the findings	NCCP/Counties			X		X
		Standardize HPV DNA testing SOPs based on the different platforms available	NCCP		X	X	X	X
		Implement HPV External Quality Assurance (EQA) testing and	NCCP		X	X	X	X

		standardize Internal Quality Assurance (IQA)						
		Integrate cervical cancer screening program quality as an agenda in the Quality Improvement structure at national, county and facility level as outlined in the National Cancer MEAL and KQMH frameworks	NCCP	X	X	X	X	X
	Develop an advisory framework (within the National Cervical Cancer Elimination TWG) to safeguard quality and ensure the country adopts clinically validated HPV tests and other screening technologies	Incorporate relevant experts on an ad-hoc basis to provide advisory to the TWG on new adopting technologies and approaches	NCCP		X	X	X	X
Strengthen Health Care worker capacity for cervical cancer screening and treatment	Identify health worker training gaps (pre-service and in-service)	Assess adequacy of existing curricula in colleges and Universities	NCCP		X			
		Conduct a needs assessment for the HCW training to determine skills requirements for the country from the county level	NCCP					
	Support pre-service training on cervical cancer screening and treatment	Develop advisories on inclusion of cervical cancer in the curricula for training institutions	MOH/NCCP/NCI		X	X		
		Support colleges and universities to create course content for cervical cancer screening and treatment for pre-service training						
	Continuous in-service training for HCW to update their knowledge and skills	Develop/review/update standardized training packages	NCCP		X	X	X	X
		Actual trainings conducted of the selected cadres in the counties	NCCP		X	X	X	X
		Quarterly mentorship from the national and county teams using e-learning platforms and OJTs.	NCCP/Counties		X	X	X	X

		Ensure counties maintain a database of those trained on cervical cancer screening and treatment and share semiannually with NCCP	NCCP/Counties		X	X	X	X
		Advocate through COG for adherence to the staffing norms and standards and KEPH	NCCP		X	X	X	X
Increase community awareness and demand creation for screening	Review, print and disseminate IEC materials for key opinion leaders general public.	Develop/review and translate IEC materials into local languages	NCCP	X				
		Pretest and validate the translated IEC materials	NCCP	X				
		Revision of the advocacy toolkit to fit all audiences	NCCP	X				
	Create awareness on cervical cancer screening and treatment among HCWs and CHPs	Dissemination of the 2023-2028 Cancer screening guidelines to the facilities	NCCP	X				
		Develop/revise job aids and disseminate to HCWS	NCCP					
	Enhance awareness creation during national month	Use survivors for lived experiences through weekly webinars	NCCE TWG		X	X	X	X
		Sensitization for media , national and county level opinion leaders on cervical cancer	NCCP		X	X	X	X
		Weekly radio and tv talk shows on cervical cancer	TWG		X	X	X	X
Enhance data management and use in decision	Support adoption of EHR systems in screening and treatment	Ensure inclusion of cervical cancer screening and treatment in the EHR systems	NCCP		X	X	X	X
		Support linkage of EHR to KHIS	NCCP		X	X	X	X
		Enhance the existing oncology dashboard and make it accessible to all relevant decision makers at national and county levels	NCCP		X	X	X	X
Increase financial prioritization for cervical cancer screening and treatment in national and county health budgets	Advocacy, sensitization and resource mobilization from domestic sources	Sustain advocacy for full implementation of cervical cancer benefits as outlined in the gazetted Tariffs	NCCP		X	X	X	X

		Utilize the annual national and county health budget analysis findings to guide financial prioritization for cervical cancer screening and treatment	NCCP					
		Engage The National Treasury, National assembly health committee for increased budget allocation for cervical cancer at national level	NCCP	X	X	X	X	X
		Engage the county assembly health committee and the Chief Officers for health and finance for creation of budget line for cancer and increased allocation for cervical cancer screening and treatment	NCCP	X	X	X	X	X
		Hold dialogues on CCE with counties during IGF and Devolution Conferences	NCCP	X	X	X	X	X
		Ensure cervical cancer is adequately captured in the planning and budgeting at national and county levels	NCCP/COG	X	X	X	X	X
	Engage private insurance companies to include HPV testing in their packages	Hold regular advocacy engagements with insurance players and their regulators on including HPV testing in their packages	NCCP	X	X	X	X	X
	Identify and engage development partners/ donors to fund screening and treatment related intervention through existing health sector programs.	Identify, map, and create a database of all the existing development donors/partners to avoid over funding in one specific area, and create harmonization of funds for a more targeted planning and management especially during the Annual Work Plan development.	Counties		X	X	X	X
		Explore and sustain alternative resource mobilizations alternatives at national and county levels including grants proposal, philanthropies, CSR, PPP	Counties		X	X	X	X

Strengthen Leadership and Governance for cervical cancer screening and precancer treatment at both national and county level	Improve national level coordination of cervical cancer elimination interventions	Annual review of TORs and membership of the National Cervical Cancer TWG	NCCP	X	X	X	X	X
		Quarterly reporting of the National Cervical Cancer TWG to the Noncommunicable Disease Interagency Coordination Committee (NCD ICC)	NCCP	X	X	X	X	X
		Quarterly reporting of the county NCD TWG to the National Cervical Cancer TWG, through the county cancer focal person/NCD coordinator	County focal person/ NCD coordinator	X	X	X	X	X
		Ensure adequate staffing at NCCP as per the staff establishment	MOH	X	X	X	X	X
		Annual leadership and technical training for the MOH National cervical cancer focal point	MOH	X	X	X	X	X
	Improve county level coordination of cervical cancer elimination interventions	Ensure full participation of the county cancer focal persons/NCD coordinator in the county NCD TWGs	County Director of Health	X	X	X	X	X
		Quarterly reporting of the county cancer focal person/NCD coordinator to the CHMT	County focal person/ NCD coordinator	X	X	X	X	X
	Support counties leadership to implement policies in their own context	Robust dissemination of Cervical cancer elimination action plan	NCCP	X	X			
		Hold annual policy dialogues on cervical cancer elimination with county leadership	NCCP					
Ensure provision of quality cervical cancer screening and pre-cancer treatment services	Scale up of HPV testing coverage from 6% to 50% in 2027 and to 70% in 2030	Map HPV testing sites and establishing the testing capacity in the regional and county labs	NCCP/COG		X			
		Develop county-to-county collaboration frameworks/agreements/memoran dums of understanding to facilitate optimal utilization of existing HPV testing capacity at regional	COG		X			

		laboratories (integrated sample referral system and results relay).						
		Counties ensuring HPV commodities availability through quantification, financing and procurement	County/COG		X			
	Scale up of treatment coverage of PCL from 43% to 70% in 2027 and 90% in 2030	Offer refresher training for HCWs involved in screening and PCL treatment	NCCP/Counties		X	X	X	X
		Provision of treatment devices to all level facilities and monitoring functionality and utilization of these devices.	NCCP		X	X	X	X
		Using CHPs for follow-up and patient navigation, linking them to further treatment.	Counties		X	X	X	X
	Create a "call and recall" system for invitation and tracking for eligible women across the screen and treat cascade	Work with relevant agencies to create a SMS- based system for individualized invitation to eligible women for screening	NCCP		X	X	X	X
		Utilize CHPs for community-based invitation for screening	Counties		X	X	X	X
		Use of patient navigators in the facilities to support referral and linkages to care	Counties		X	X	X	X
	Improve capacity of health facilities to meet minimum infrastructure standards for CaCx S&T services	Implement the standardized minimum requirements guidance for facilities, as detailed in the National Cancer Screening and Early Diagnosis Guidelines and HR norms and standards	NCCP		X			
	Implement a national HPV sample referral and testing cascade	Implement HPV sample collection at all health levels including self- sample collection	Counties			X	X	X
		Utilize integrated sample/specimen referral from collection points to testing labs	NPHLS			X	X	X
		Utilize centralized lab system, national and regional labs to process HPV samples as per the	Counties, NPHLS			X	X	X

Key Result Area Three: Diagnosis, treatment palliative care and survivorship of invasive cervical cancer

Strategic Objectives	Proposed Strategies/ activities	Sub-activities	Responsible/Lead Agency	2025/ 26	2026/ 27	2027/ 28	2028/ 29	2029/ 30
Strengthen infrastructural capacity of comprehensive specialized facilities offering diagnostic, treatment and palliative care for cervical cancer.	Conduct a mapping assessment for cancer diagnostic services (laboratory and imaging), as well as treatment capacity (including service need mapping and HR capacity)	Develop the assessment tool	NCCP	X				
		Conduct assessment						
		Process and disseminate findings						
	Increase timely access to quality and accurate cervical cancer laboratory diagnosis and support within the county Referral Hospitals (CRHs) and Cancer Treatment Centers (CTCs)	Review and disseminate cancer specimen guidelines (2020) guidelines, job aids and SOPs in CRHs and CTCs.	NCCP		X			
		Establish an integrated histology sample referral network to regional hubs for processing and reporting.	NCCP		X	X		
		Broaden the scope of SHA oncology package to include histology sample processing.	SHA		X			
		Support counties with no cancer diagnostic capacity to explore setting up the services including through Public Private collaborations	NCCP			X	X	X
		Advocate for utilization of FIF for regular supply of diagnostic commodities	NCCP	X	X	X	X	X
		Strengthen regular blood donor drives and blood donor awareness, as per the Intergovernmental Framework on Coordination of Blood Transfusion Services.	NCCP/Counties	X	X	X	X	X
	Provide adequate and accurate imaging equipment for diagnosis of cervical cancer at the CRHs	Support equipping eligible counties with multi-slice CT scan and minimum 1.5 Tesla MRI machines in every regional CTC and CRHs	NCCP	X	X	X	X	X
	Establish additional nuclear medicine services to provide diagnostic and therapeutic radionuclide services	Support two additional referral hospitals (MTRH, Mombasa) with PET and SPECT scans	NCCP		X	X	X	X

	Enhance patient and laboratory test navigation by creating robust referral pathways within the regional hubs and country referral systems	Avail county specific toll-free numbers to regional CTCs for ease of referral for treatment of cervical cancer.	NCCP	X	X	X	X	X
Strengthen the availability and capacity of a well-trained, multidisciplinary oncology workforce to support timely diagnosis and comprehensive treatment of cervical cancer.	Strengthen availability and capacity of a skilled multi-disciplinary team of oncology human resources for health across all levels of care (e.g. Lab pathology , medicine, nursing, imaging and palliative care)	Hire and train requisite HR based on the needs assessment (see annex v for relevant staffing)	NCCP/Counties	X	X	X	X	X
		Ensure regular in-service training and mentorship of the oncology workforce through mechanisms such as refresher courses, CMEs, MDT meetings and e-learning.	NCCP	X	X	X	X	X
Strengthen the capacity of the counties and regional cancer centers to avail Health product and technologies to deliver comprehensive cervical cancer diagnosis, treatment and palliative care	Strengthen the Histopathology reagent supply, equipment purchase and maintenance within the counties and regional cancer centers	Provide technical support to counties to undertake periodic forecasting and quantification of all essential cancer diagnostic supplies.	NCCP	X	X	X	X	X
		Provide regular maintenance of equipment through in-house user training.	Counties	X	X	X	X	X
		Ensure comprehensive service level agreements accompany all equipment purchases and installations covering the entire life span of the equipment.	NCCP/Counties		X	X	X	X
	Equip theatre services within the counties to support surgical intervention of early invasive cervical cancer	Avail the minimum list of theatre requirements for early cervical cancer surgical cancer management to at CRHs (see annex vi)	NCCP/Counties		X	X	X	X
	Ensure regular provision of safe chemotherapy at all CTCs	Ensure availability of the minimum requirements for chemotherapy at national and regional CTCs (see annex vi)	NCCP/Counties		X	X	X	X
	Strengthen provision of nuclear and radiation medical products and equipment within the CTCs for treatment of advanced cervical cancer	Ensure availability of the minimum requirements for radiotherapy and nuclear medicine at national and regional CTCs (see annex vi)	NCCP/Counties		X	X	X	X

	Ensure the availability of palliative commodities in all county referral facilities with linkages to primary and community home-based care, as per the NCCS 2023-2027	Ensure regular availability of morphine in level 3 facilities and above.	NCCP	X	X	X	X	X
Comprehensively provide financial cover for the diagnosis and treatment of cervical cancer	Support sustainable Domestic financing for diagnosis and treatment of invasive cervical cancer	Advocate for full implementation of SHIF and ECCF	SHA	X				
		Finalize ,disseminate and utilize the cancer treatment protocols to inform improvements on oncology benefits package	NCCP		X			
Strengthen cervical cancer data systems for effective monitoring, planning, and quality improvement of diagnosis and treatment services across all levels of care.	Improve data collection, quality and reporting practices for cancer diagnosis and treatment	Train data clerks and health records officers on cervical cancer specific data capture tools on diagnosis and treatment and protocols	NCCP/NCIK/ Counties		X		X	
		Implement regular data quality audits and feedback sessions at cervical cancer diagnostic and treatment service delivery points	NCCP/NCIK/ Counties		X		X	
		Avail data collection tools - cancer treatment registers and monthly summary tools	NCCP/Counties	X	X	X	X	X
	Enhance real-time data use for clinical decision-making and service improvement.	Ensure inclusion of cancer diagnosis and treatment modules into facility EHRs	NCCP/DHA		X	X		
		Ensure visibility of a revamped oncology dashboard at national and county level for facility managers and M&E teams.	NCCP		X	X		
		Integrate client follow-up alerts/reminders into EHRs and digital tools	NCCP			X	X	
		Incorporate telemedicine to support county hospitals in the diagnosis of cervical cancer	NCCP/NCIK/ DHA			X	X	
		Support linkage of facility EHRs to cancer registries	NCCP/NCIK/ DHA			X	X	
	Generate and disseminate periodic data for policy advocacy, resource mobilization, and community feedback.	Produce annual reports on cervical cancer diagnosis and treatment coverage, outcomes, and gaps.	NCCP		X	X	X	X
		Use data to support investment cases and partner engagement (e.g., for brachytherapy, radiotherapy and chemotherapy).	NCCP		X	X	X	X
		Share data through community forums, health stakeholder meetings, and scorecards.	NCCP		X	X	X	X

	Identify research priority areas and conduct research to guide cervical cancer diagnosis and treatment	Refine national cervical cancer diagnosis and treatment research agenda	NCIK/NCCP		X			
		Increase funding directed towards research on cervical cancer diagnosis and treatment	NCCP/NCIK			X	X	X
		Support creation of clinical drug trial sites within the CTCs to allow for treatment with newer therapies for cervical cancer patients	NCIK/NCCP				X	X
Strengthen leadership and governance systems for effective policy implementation, coordination, and oversight of cervical cancer diagnosis and treatment services at national and county levels.	Strengthen the cancer diagnosis and treatment coordination between national and county mechanisms.	Ensure presentation and discussion on progress of cervical cancer diagnosis and treatment at all relevant TWGs meetings at national and county levels	NCCP/Counties		X	X	X	X
	Monitor adherence to National Cancer Treatment Guidelines and Standards on cervical cancer.	Finalize and disseminate the National Cancer Treatment Guidelines and Standards	NCCP		X	X		
		Conduct quality of care survey/assessments with cervical cancer diagnosis and treatment indicators included.	NCCP			X		X
	Build leadership capacity for evidence-based planning, implementation, and advocacy	Mapping capacity gaps on evidenced based decision making at national and county levels	NCCP		X			
		Develop advocacy materials and toolkits for targeted sensitizations.	NCCP			X		
		Sensitize leaders on use of evidence for decision making.	NCCP	X	X	X	X	X
	Ensure cervical cancer elimination indicators are included in the government performance management system	Engage the national and county level planning officers to include cervical cancer elimination indicators in their performance contracts.	NCCP/CoG		X			

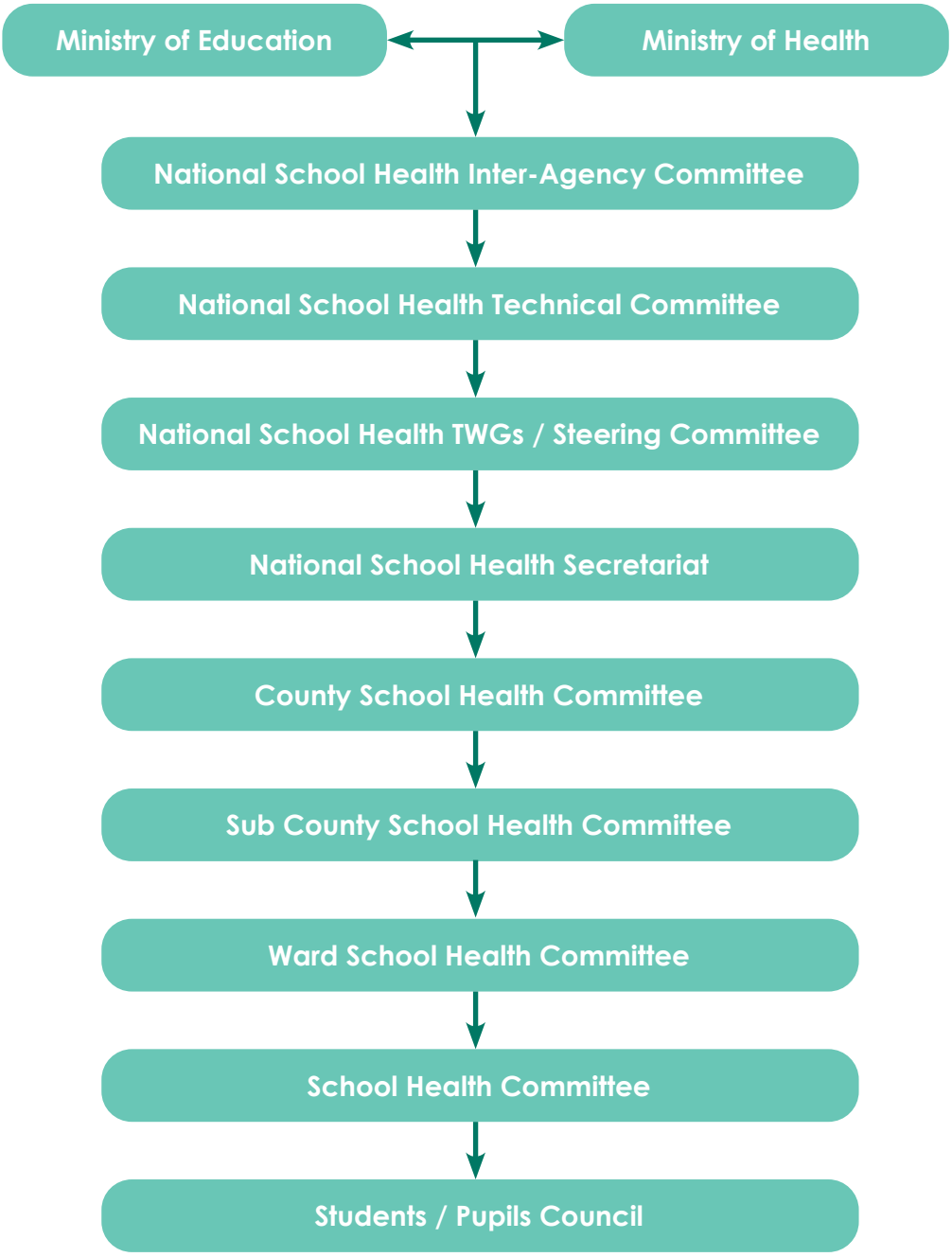
Appendix II: Outcome performance matrix (derived from the National cancer control MEAL Framework)

Key Result Area	Key Performance Indicator	Baseline		Target	
		Value	Year	Mid-Term Period Target (2028)	End of Plan Period Target (2030)
HPV vaccination	Proportion of schools with HPV vaccination days as part of their calendar	Not available	Not available	70%	90%
	Number of vaccine stock-outs per year by sub-county	4	2023	0	0
	Proportion of 10-year-old girls Vaccinated with HPV Vaccine	58%	2023	80%	90%
	Increased proportion of girls fully vaccinated against HPV by age 15 years	54%	2023	90%	90%
Screening and precancer treatment	Proportion of health facilities using the Kenya national cancer screening guidelines	Not available	Not available	80%	100%
	Proportion of trained TOTs active in the cervical cancer screening and treatment program	53%	2022	80	90%
	Proportion of health facilities with cervical cancer screening commodities	25%	2022	75%	90%
	Proportion of health facilities with cervical cancer precancerous treatment equipment	25%	2022	75%	90%
	Proportion of health facilities with key cervical cancer screening and treatment SOPs and Job aids	Not available	Not available	80%	90%
	Number of counties where HCW trainings on cervical cancer screening and treatment are regularly conducted at least every two years	Not available	Not available	30	47
	Number of counties where CHP trainings on cervical cancer early detection have been conducted	Not available	Not available	30	47
	Number of counties with a structured cervical cancer early detection mentorship and CQI program	Not available	Not available	30	47
	Proportion of health facilities offering cervical cancer screening	22%	2022	70%	90%
	Proportion of eligible (level 3-6) health facilities offering HPV molecular testing (either at facility lab or through sample referral)	2%	2022	50%	70%
	Proportion of primary healthcare workers trained on cervical cancer screening and treatment	12%	2022	50%	70%
	The proportion of persons invited for cervical cancer screening at least once in a given time frame (i.e. invitation coverage)	10%	2022	30%	70%

	Annual screening target coverage attainment	48%	2024	70%	90%
	Proportion of women 30-49 ever-screened for cervical cancer	N/A	N/A	70%	90%
	Proportion of women age 30-49 years screened for cervical cancer using HPV testing	6%	2024	50%	70%
	Proportion of women screened using HPV testing who had self-sample collection	N/A	N/A	30%	70%
	Proportion of women screened using HPV testing who had HPV test results and triage in less than 30 days	N/A	N/A	70%	90%
	Proportion of women screened using VIA/VILI with a positive screening result	4%	2022	5-10%	5-10%
	Proportion of women screened using HPV testing with a Positive screening result	14%	2022	5-25%	5-25%
	Proportion of women screened using pap smear positive results	2%	2022	1-5%	1-5%
	Proportion of women age 25-49 years with suspicious cancer lesions	0.8%	2022	0.5%	0.5%
	Proportion of women 25-49 years screened for cervical cancer with inconclusive/unsatisfactory results	Not available	Not applicable	1%	1%
	Proportion of women 25-49 years screened for cervical cancer with results unknown	Not available	Not applicable	<1%	<1%
	Proportion of women with abnormal cervical screening result, whose time period from getting results to final diagnosis is less than 60 days	Not available	Not applicable	90%	90%
	Proportion of women with cervical lesions treated using thermal ablation, cryotherapy or LEEP	43%	2024	70%	90%
	Proportion of women with precancer lesions, receiving same day treatment	Not available	Not applicable	30%	50%
	Proportion of HIV positive women 25 years and above screened for cervical cancer	30%	2022	70%	90%
	Proportion of level 4, 5 and 6 facilities adequately equipped for cancer diagnosis	55%	2023	70%	90%

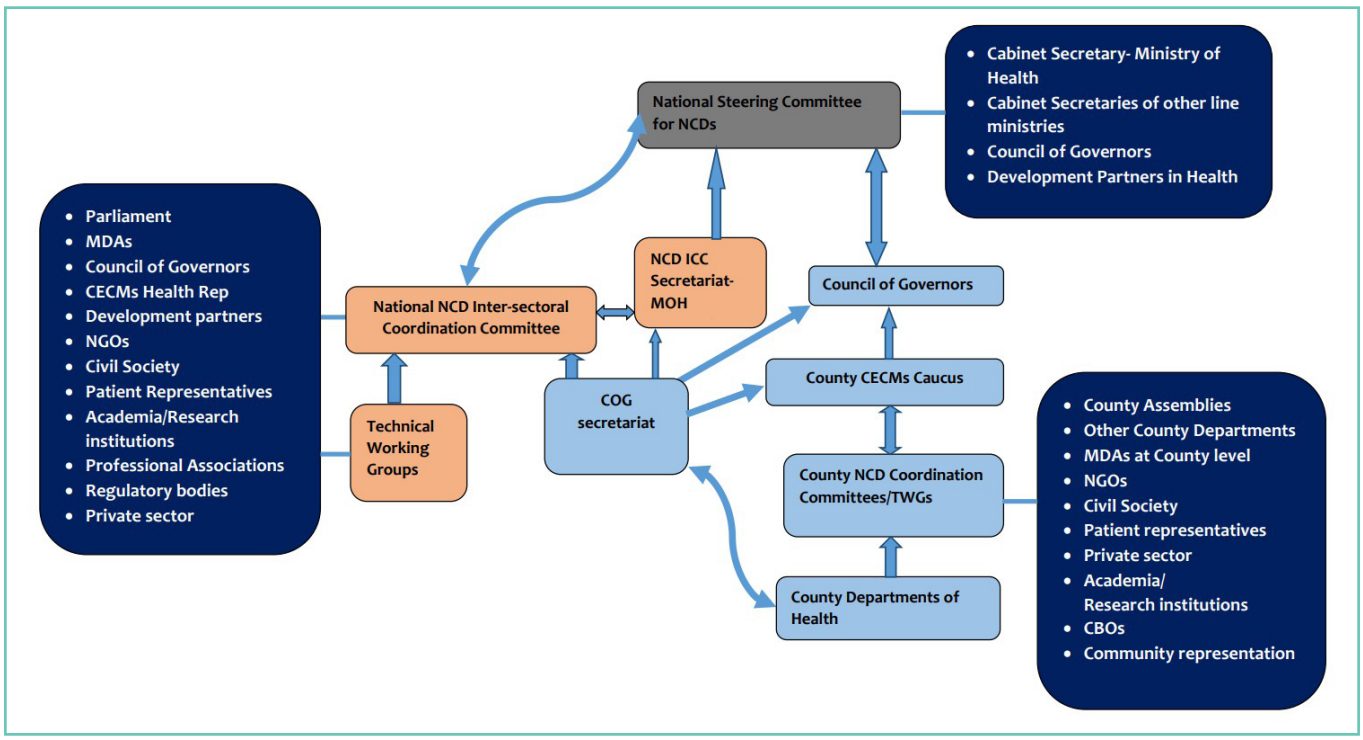
Diagnosis and invasive cancer treatment	Proportion of level 4 - 6 health facilities offering cancer imaging services	Not available	Not applicable	70%	90%
	Proportion of level 4 - 6 laboratories offering pathology cancer diagnostic services	Not available	Not applicable	70%	90%
	Average time (in days) from a patient's diagnosis (date of the pathology report) to first treatment	Not available	Not applicable	60	60
	Proportion of cancer tissue specimens withturnaround time of less than 21 days for histology and less than 7 days for cytology	Not available	Not applicable	70%	100%
	Proportion of cervical cancer patients undergoing imaging with TAT of <21 days	Not available	Not applicable	70%	100%
	Proportion of cervical cancer cases that are staged/have stage information documented	30%	2019	80%	100%
	Proportion of cervical cancers diagnosed in stage 1 or 2	30%	2022	60%	80%
	Proportion of patients who complete the full recommended course of cervical cancer treatment	Not available	Not applicable	90%	90%
	Proportion of patients received the recommended multi-modal treatment for their stage	Not available	Not applicable	90%	90%
	Proportion of eligible health facilities providing palliative care services	3%	2022	50%	90%
	Proportion of cervical cancer patients accessing palliative care	Not available	Not applicable	70%	90%
Financing	Percentage of total health expenditure allocated to NCDs control (including cancer control) at national and county levels				
	Number of county governments with specific budget line for cervical cancer control interventions	Not available	Not applicable	30	47
	Proportion of Total Health Expenditure allocated to immunization	2.0%	2022	3.5%	4.0%
Advocacy and awareness	Number of counties including cervical cancer control interventions in their CIDPs, CHSSPs and AWPs	10	2022	30	47
	Increased level of awareness on cancer control and prevention in the general population	30%	2022	80%	90%
Strategic information and research	Proportion of facilities adopting electronic health records systems in HPV vaccination, screening and treatment service provision	Not available	Not applicable	70%	90%

Appendix III: School Health coordination framework



(Adapted from the School Health Policy) second edition ,2018

Appendix IV: Noncommunicable disease coordination framework



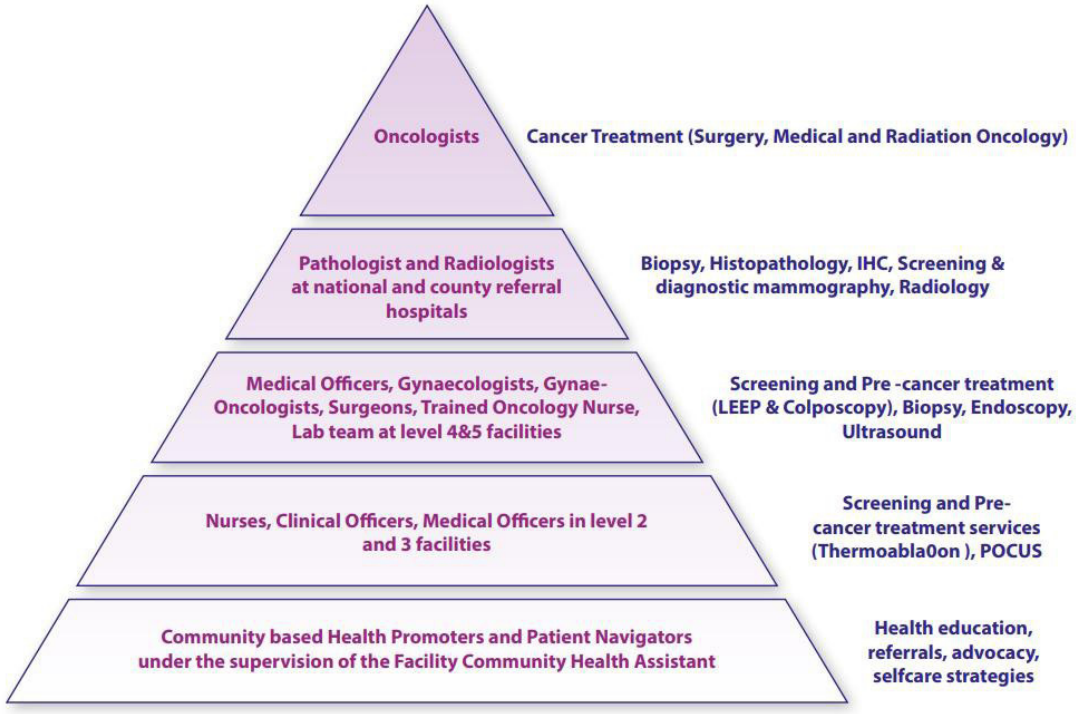
The TWGs included in the NCD coordination framework includes the county NCD TWGs, the national cervical cancer elimination TWG, as well as other national level cancer control TWGs mentioned in the action plan.

(Adapted from the National NCD Strategic Plan 2020/21-2025/26)

Appendix V: Minimum HR requirements for an effective cancer diagnostic service at CRH and treatment at CTC

2 gynae oncologists in every CRH	2 gynae oncologist in every CTC
2 pathologist in every CRH	2 pathologist in every CTC
2 histotechnicians in every CRH	4 histotechnicians in every CTC
2 radiographers in every CRH	1 Radio oncologist for every CTC
2 radiologists in every CRH	2 Medical engineer technologists for every CTC
2 trained medical officers for cervical biopsy collection in every CRH	12 Oncology nurses in every CTC
	4 physicists for every CTC
2 gynaecologists to enhance diagnosis in every CRH	6 Oncology clinical officers in every CTC
4 palliative care nurses	10 lay navigators in every CTC
2 palliative care clinical officer for every CRH	3 Counsellors in every CTC
6 nurse oncologists for every CRH	3 nutritionists for every CTC
3 clinical officer oncologists at the CRH	8 lay navigators in every CTC
2 oncology pharmacists in every CRH	3 HRIOs in every CTC
2 oncology pharmaceutical technologists in every CRH	2 oncology pharmacists in every CTC
2 Medical engineer technologists for every CRH	3 pharmaceutical technology oncologists in every CTC
4 lay navigators in every CRH	
2 HRIOs in every CRH	
2 Counsellors for every CRH	
2 nutritionists in every CRH	

Appendix VI: The role of the health workforce in cancer prevention and control across the care continuum from community to tertiary level



(Adapted from the National Cancer Control Strategy 2023-2027)

Appendix VII: Minimum equipment requirements for effective cervical cancer diagnosis and treatment

Service area	Minimum requirements
Histopathology	• Tissue processor • Microtome • Microscope • Water bath • Slides • Biosafety cabinet • Histology reagents • Centrifuge • Weighing balance (kedl 2023 specification)
Theatre	• Radical hysterectomy sets • Biopsy forceps • Trachelectomy sets
Chemotherapy	• Chemotherapy agents • Chemo mixing safety cabinets • Efficient supply chain • Nitrile gloves • Gowns • Headgears • Footwear • Syringes and needles (luer cap syringes) • Infusion drop sets • Hemo chairs and beds • Rip stands • Examination gloves • Spill kits (see appendix)
Radiation, nuclear medicine and Imaging	• Digital linear accelerator • Brachytherapy treatment • Anaesthetic machines • Brachytherapy table • General purpose suction unit • Led operation light) • Patient trolley • Emergency/resuscitation trolley

Appendix VIII: Minimum Human Resource requirements for Cancer Diagnosis by level of Care

LEVEL OF CARE	IMAGING	PATHOLOGY
Level 4	• 5 radiologists • 10 technologists • 4 sonographers • 1 biomedical engineer • 2 radiology nurses • 2 patient porters	• 5 pathologists (3 anatomic, 2 clinical) • 20 histocytotechnologists • 1 biomedical engineer • 1 ICT engineer • 2 medical records personnel • 2 administrative assistants
Level 5	• 10 radiologists (1 pediatric radiologist, 1 oncologic imaging) • 2 Interventional radiologists • 30 technologists • 10 sonographers • 1 medical physicist • 2 biomedical engineer • 4 radiology nurses • 4 patient porters • 1 ICT engineer	• 10 pathologists (6 anatomic, 4 clinical) • 40 histocyto technologists • 2 biomedical engineers • 1 ICT engineer • 4 medical records personnel • 3 administrative assistants
Level 6	• 40 Radiologists (general & all subspecialisation) • 6 Interventional radiologists • 60 technologists • 15 sonographers • 2 medical physicists • 2 biomedical engineers • 10 radiology nurses • 10 patient porters • 2 ICT engineers • 2 administrative assistants • 20 medical records personnel	• 14 pathologists (10 anatomic, 4 clinical) • 56 histocyto technologists • 3 biomedical engineers • 1 ICT engineer • 4 medical records personnel • 4 administrative assistants

(Adopted from the National Cancer Control Strategy 2023-2027)

Appendix IX: Sample list of essential requirements for cervical cancer screening, diagnosis and treatment

Screening
VIA
Bivalve speculums – medium and Large size (disposable)
Glacial acetic acid 5 ml
Distilled water 95 ml
Normal saline 0.9%
Orange sticks/ Applicator wooden sticks
Nonsterile gloves
Cotton Wool, 400g, Roll
Clear Spray Bottle (with trigger sprayer)
HPV testing
Bivalve speculums – medium and Large size (disposable)
HPV sample collection kit (Includes Copan FLOQSwab (Self-sampling device) 5E089N, sample collection media, pair of gloves)
Abbott Alinity
BD Viper
GeneXpert
Hologic
ROCHE C4800
ROCHE C6800
ROCHE C8800
Pap Smear testing
Bivalve speculums – medium and Large size (disposable)
Pap smear kit
Nonsterile gloves
Harris hematoxylin
glacial acetic acid
OG6
Eosin Azure
Eosin y
light green SF
Bismark brown
Acid fuchsin
Celestine Blue B
Alcian blue
Giemsa stain
Methylene blue
phosphotungstic acid
Congo red
Periodic Acid Schiff (PAS)
Masson trichrome stain
Diagnosis
Biopsy (Suspicious Lesions)
Punch Biopsy
Specimen container with lid and labels
Gauze Cotton 1500g 91M, Roll (BP)
Formalin (10% neutral buffered formal saline)
Normal saline 0.9%
Hibitane solution
Bivalve speculums – medium and Large size (disposable)
Histopathology
Ethyl alcohol
Isopropanol
Paraffin wax
Formaldehyde
Xylene
Tissue cassettes
Treatment
Thermal ablation
Cryotherapy
Nitrous oxide gas
Carbon dioxide gas
LEEP
Loops
15mm x12mm x11cm shaft
10mm x 10mm x11cm shaft
5mm ball, 11cm shaft
Electro surgery pens/ hand piece
Dispersive pads
Dispersive pad adapter (ES -3160C)
Smoke evacuator and filters
Speculum tubing
Internal Filter (replace annually) 1 per unit
1 -2% lignocaine with 1:100 000 Adrenaline
Spinal needles 22 -25-gauge x 90Mm
Syringe, Disposable, 10ml, Without Needle
Needles 18 – 20 gauge
Wooden Applicator Sticks (orange sticks)
Long needle holder
Long mayo scissors -straight
Long tissue forceps
Suture- Vicryl No. O on a taper cut needle
Sterile surgical gloves
Large Cotton swabs (Ob /Gyn or Proctology)
Cotton Gauze Plain L/Wvn Absorb-91Cmx91M 1500G Bp
Specimen containers with lid and labels
Monsel's paste 500mg
Glutaraldehyde Solution(Generic) 2.4%
Formalin (10% neutral buffered formal saline)
Lab equipment

Flow cytometer
Heating block
Barcode printer
barcode printer labels
100-1000 micropipette
Water distiller
Fine point alcohol resistance permanent marker
Biological waste bins
Biological waste bins
Biological waste bins
xpert compatible printer
LabXpert print cartridge
Sample racks
Laboratory registers
Request forms
Services
Gene xpert
Cobas systems (Cobas 4800,6800,8800,)
Abbott system (Alinity ,Architect immunoanalyser)
Viper BD
Grossing station
ATP 1020 tissue processor
ATP 300s tissue processor
leedo embedding station and freezing chamber
Leica embedding station and cooling chamber
Rotary microtome, manual strokes operation
automated rotary microtome with manual operation options
Autostainers 2
coverslipper
digital scanner
printers
cassette printer
scanner printer
Other equipment
Thermal ablation device with batteries
Colposcope
LEEP machine with probes and batteries
Speculums - reusable
Insulated speculums
Endocervical speculum
Sponge forceps
Gully pots
kidney dishes
Autoclave
Gynecology Examination Couch
Examination light (White light)
Instrument Tray
Instrument Trolley
Rotating stool
Privacy screen Adequate Coverage
Mackintosh
Infection prevention
Surgical Mask, Disposable, 3 Ply, Tie On, 50 Pack
Soap Anti-Bacterial Handwash 25%, 500ml
Sodium Hypochlorite 4-6%, 5 litres Generic
Hand Sanitizer 70% Alcohol
Waste segregation Polythene Bags / Liners Red
Waste segregation Polythene Bags / Liners Yellow
Waste segregation Polythene Bags / Liners Red

(Source: National Cancer Control Program)

Appendix X: Screening cascade for women 30-49 years by county, 2026-2030

County	30–49-year-old female population in 2030	Number to be screened per year	Expected number with HR HPV per year	Expected number to be treated for PCL per year	Expected suspicious lesions, needing diagnostic services
Nairobi	742,823	148,565	32,090	6,097	1,486
Nyeri	125,976	25,195	5,442	1,034	252
Marsabit	52,158	10,432	2,253	428	104
Isiolo	27,984	5,597	1,209	230	56
Kirinyaga	110,786	22,157	4,786	909	222
Bungoma	163,101	32,620	7,046	1,339	326
Nandi	114,730	22,946	4,956	942	229
Nakuru	308,657	61,731	13,334	2,533	617
Meru	233,063	46,613	10,068	1,913	466
Machakos	218,259	43,652	9,429	1,791	437
Kakamega	230,097	46,019	9,940	1,889	460
Nyamira	87,647	17,529	3,786	719	175
Makueni	139,792	27,958	6,039	1,147	280
Embu	95,321	19,064	4,118	782	191
Kiambu	413,005	82,601	17,842	3,390	826
Kisumu	146,180	29,236	6,315	1,200	292
Kitui	152,105	30,421	6,571	1,248	304
Kericho	115,125	23,025	4,973	945	230
Busia	104,786	20,957	4,527	860	210
Baringo	71,280	14,256	3,079	585	143
Homa Bay	133,534	26,707	5,769	1,096	267
Kisii	171,811	34,362	7,422	1,410	344
Murang'a	161,650	32,330	6,983	1,327	323
Laikipia	72,387	14,477	3,127	594	145
Kilifi	177,643	35,529	7,674	1,458	355
Keiyo-Marakwet	51,935	10,387	2,244	426	104
Siaya	120,550	24,110	5,208	989	241
Vihiga	72,135	14,427	3,116	592	144
Nyandarua	96,671	19,334	4,176	793	193
Bomet	105,635	21,127	4,563	867	211
Kwale	104,995	20,999	4,536	862	210
Tharaka	58,989	11,798	2,548	484	118
Migori	124,481	24,896	5,378	1,022	249
Trans Nzoia	120,190	24,038	5,192	987	240
Kajiado	158,326	31,665	6,840	1,300	317
Narok	122,053	24,411	5,273	1,002	244
Mombasa	194,026	38,805	8,382	1,593	388
Samburu	29,439	5,888	1,272	242	59
Turkana	96,974	19,395	4,189	796	194
Uasin Gishu	161,100	32,220	6,960	1,322	322
Garissa	83,917	16,783	3,625	689	168
Wajir	74,437	14,887	3,216	611	149
Lamu	17,672	3,534	763	145	35
Taita Taveta	47,772	9,554	2,064	392	96
West Pokot	59,029	11,806	2,550	485	118

Tana River	32,661	6,532	1,411	268	65
Mandera	70,621	14,124	3,051	580	141
National	**6,373,506**	**1,274,701**	**275,335**	**52,314**	**12,747**

The estimates are based on the latest population projections from the Kenya National Bureau of Statistics (KNBS), as well as other relevant sources listed below.

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62. Nurta Mohamed	Garissa County
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