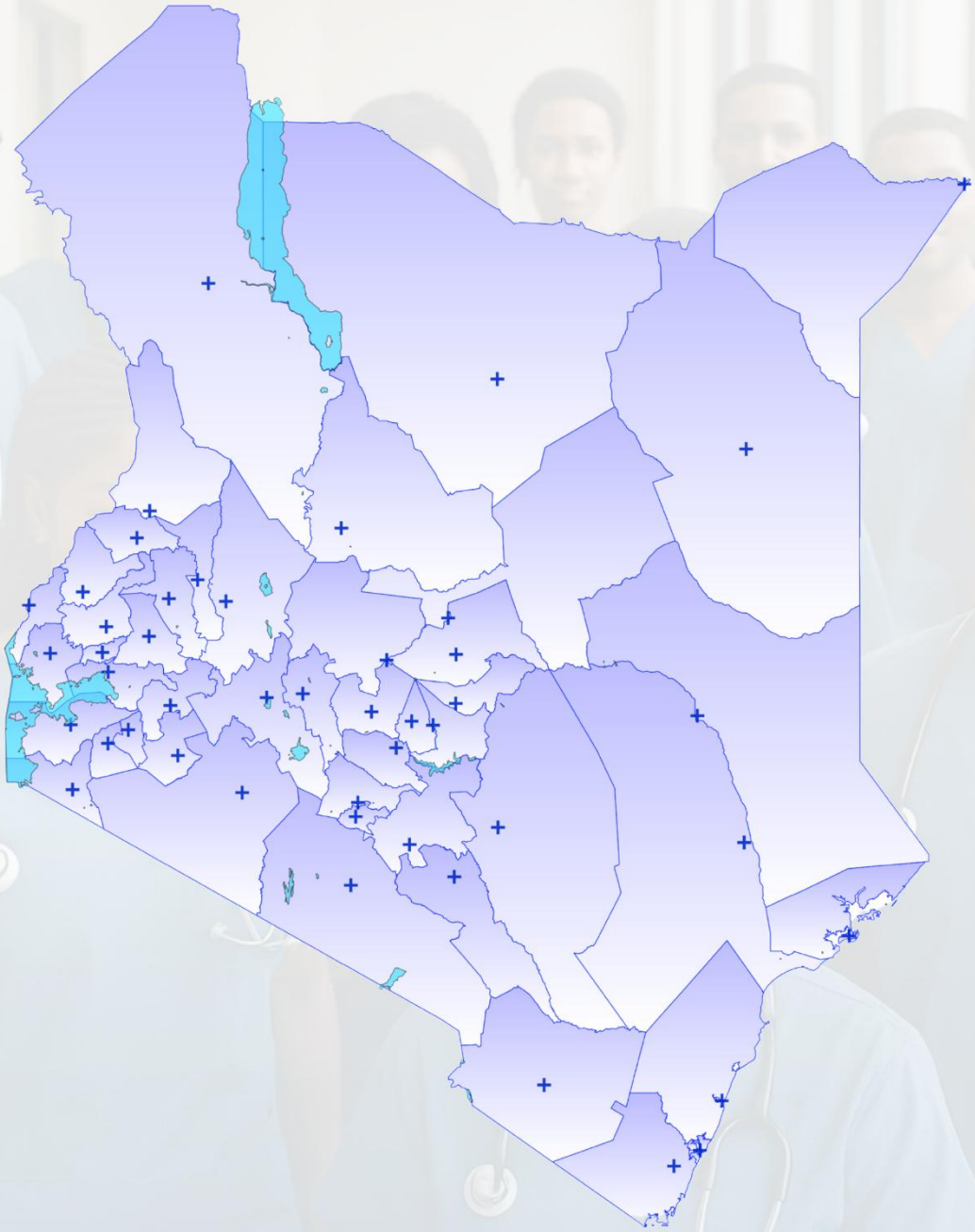
REPUBLIC OF KENYA

MINISTRY OF HEALTH



KENYA HEALTH FACILITY ASSESSMENT : QUALITY OF CARE AND HUMAN RESOURCES FOR HEALTH REPORT

Ministry of Health
Division of Health Sector Monitoring and Evaluation

POPULAR VERSION
2024

Preface

In the journey towards achieving Universal Health Coverage (UHC), the Government of Kenya reaffirms its commitment to providing equitable, affordable, and high-quality healthcare services to all citizens. Health is a key priority in the government's Bottom-Up Economic Transformation Agenda (BETA), which focuses on strengthening health systems, expanding access to care, reforming health financing, and advancing health innovations. This comprehensive approach ensures that all Kenyans, regardless of their socio-economic status or geographical location, have access to the highest quality healthcare without experiencing financial hardship. The quest for UHC is not merely a policy objective; it is a moral imperative that reflects our collective responsibility to ensure that every Kenyan has access to the healthcare they deserve.

This commitment is based on the principles outlined in the Constitution of Kenya 2010, which highlights health as a fundamental human right. Recent findings from the Kenya Demographic and Health Survey (KDHS) 2022 highlight significant progress in health coverage, such as more skilled birth attendance and a reduction in unmet family planning needs. However, despite these gains, challenges remain, especially in maternal and child health. The persistently high maternal mortality rates and stagnant childhood mortality figures reveal major gaps in care quality that need urgent attention.

This report summarizes key findings from the Human Resource module of the Quality of Care-focused Harmonized Health Facility Assessment (QOC-HFA). The evaluation aimed to determine the number and distribution of health workers, understand their work environment, and assess their capacity to manage common health conditions. The assessment was launched to obtain accurate data for guiding policy decisions and improving healthcare delivery. The insights gathered will be a vital tool for policymakers, health administrators, and stakeholders to identify service gaps, improve care quality, and ultimately enhance health outcomes for all Kenyans. The findings in this report are based on comprehensive data collection and analysis, capturing the experiences and views of county managers, healthcare providers, and clients. As we share these insights, we stress the importance of collaboration among all stakeholders to implement necessary changes for a more effective and equitable healthcare system. We believe this information will support decision-making and strategic planning, guiding us toward a healthier future for all Kenyans.

Together, we can build a healthcare system that is accessible, affordable, and of the highest quality.

Hon. Aden Duale, EGH
Cabinet Secretary
Ministry of Health

Foreword

The Government of Kenya is resolutely committed to achieving Universal Health Coverage (UHC), ensuring every citizen has access to high-quality, affordable, and equitable healthcare. While the 2022 Kenya Demographic and Health Survey (KDHS) reveals encouraging progress, such as more births attended by skilled professionals and greater access to family planning, our work is far from over. We must confront the significant challenges that remain, especially the unacceptable rates of maternal and child mortality. These persistent gaps in our healthcare system demand our immediate and focused attention.

To guide our path forward, this report details the findings from the Human Resource module of the Quality of Care-focused Harmonized Health Facility Assessment (QOC-HFA). This assessment provides the critical data and insights necessary to inform effective policy, optimize service delivery, and pinpoint where our efforts are most needed.

The path to a healthier Kenya requires collective action. I call upon all stakeholders, from national and county governments to healthcare providers and development partners, to utilize the findings within this report to drive evidence-based decisions and targeted interventions. By uniting our efforts around this shared data, we can forge a healthcare system that not only meets the highest standards of quality but also empowers every Kenyan to live a long, healthy, and fulfilling life.

Mrs. Mary Muthoni
Principal Secretary
Public Health and Professional Standards
Ministry of Health

Dr. Ouma Oluga
Principal Secretary
Medical services
Ministry of Health

Acknowledgment

The successful design, implementation, and completion of the Quality of Care Health Facility Assessment (QoCHFA) would not have been possible without the invaluable contributions of numerous individuals and institutions. The Ministry of Health extends sincere appreciation to all stakeholders whose collective efforts, technical input, and financial support were instrumental throughout the process.

We acknowledge the leadership of the Ministry for stewardship in advancing Universal Health Coverage (UHC) in Kenya through this assessment. Our gratitude also goes to county governments for their collaboration and support, which were essential for effective data collection and ensuring that the assessment captured realities on the ground.

We commend efforts by the core team that steered implementation of this work for their dedication and commitment. In particular, we acknowledge efforts by Dr Charles Kandie and Dr. Helen Kiarie for leading this work, Dr. Hannah Kagiri, Dr. Boniface Kimuyu, Anthony Komen, Rose Muthee, Dr. Beatrice Kariuki, Dr. Joseph Mung'atu, Dr. Susan Mambo, Dr. Henry Kissinger, Dr. Betsy Rono, Quintine Kinyanjui, Stella Mwangi, Boniface Muganda, Jackson Muhoro and Anne Nduta for their efforts. We additionally applaud all the technical officers from the Ministry of Health, The Kenya National Bureau of Statistics, and the National Council for Population and Development (full list annexed).

We recognize the invaluable contributions by our development partners and non-governmental organizations (NGOs), particularly the Global Fund (Dr. Bartilol Kigen), UNFPA (Charity Koronya, Ezekiel Ngure and Kigen Korir), UNICEF (Dr. Laura Onyiego and Camlus Odhus), CHAI (Rosemary Kihoto & Joshua Okeyo), WHO (Cosmas Leonard & Wendy Venter), and APHRC (Dr. Martin Mutua, Godfrey Adero and Diana Munjuri) whose technical assistance and funding made the KQOC/HFA 2024 possible. The technical and financial support you provided significantly strengthened the planning, execution, and overall success of the assessment.

Special thanks go to healthcare providers and facility managers for their openness and participation, offering critical insights into service delivery. We are equally grateful to the clients who participated in this assessment, whose voices emphasized the importance of patient-centered care.

We deeply appreciate the dedication of the research teams and data collectors, whose professionalism ensured the integrity of the findings. Our gratitude also goes to the Countdown to 2030 Kenya Country Collaboration Team (Ministry of Health-Division of Health Sector Monitoring and Evaluation, JKUAT and APHRC) for coordinating the process. To everyone who contributed in any way, we extend our heartfelt thanks for making this initiative a success.

Dr. Patrick Amoth, EBS.
Director General for Health
Ministry of Health

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About the QOC HFA 2024

This summary presents highlights from the Kenya Quality of Care Health Facility Assessment 2024 (KQOC-HFA) — a nationwide evaluation of how well health facilities in Kenya are delivering quality care. The assessment was conducted by the Ministry of Health, in collaboration with county governments, healthcare workers, technical partners, and development agencies. The initiative builds on the 2023 National Health Facility Census, and forms part of Kenya's renewed commitment to achieving Universal Health Coverage (UHC), a key pillar in the Bottom-Up Economic Transformation Agenda (BETA).

This comprehensive review reflects the country's recognition that it is not enough for people to simply access health services — the care they receive must also be safe, effective, equitable, and patient-centered.

Reasons for Undertaking the Assessment

Over the past decade, Kenya has made significant progress in expanding access to healthcare. National coverage indicators — such as skilled birth attendance, antenatal care, and immunization rates — have improved steadily. However, the gains in service access have not been fully matched by improvements in health outcomes.

Challenges remain across key areas:

- Maternal mortality and neonatal deaths remain high despite service availability.
- Infection prevention and control (IPC) practices are weak in many facilities.
- Antimicrobial resistance (AMR) is increasing due to poor prescribing practices and inadequate surveillance.
- Many facilities operate without standardized quality assurance systems.
- Health workers face limited opportunities for supervision, training, and support.

This assessment responds to the growing understanding that quality is the missing link between service coverage and actual impact. Kenya's ambition to accelerate progress toward UHC demands a strong, evidence-based understanding of the real conditions in health facilities and how they influence care delivery.

Key Questions the Assessment Sought to Answer

The KQOC-HFA was guided by several essential questions that go beyond infrastructure or staffing levels:

1. Are health facilities following the right standards and protocols to ensure patient safety and quality care?
2. Are healthcare workers equipped, both in knowledge and tools, to diagnose and manage the most common causes of illness and death?

3. Do health facilities have functional systems for quality improvement, regular supervision, and internal performance review?
4. Are patients treated with dignity, privacy, and respect during their healthcare journey?
5. Is the care experience improving over time, based on feedback and outcomes?

These questions aimed to capture not just what services are available, but how well those services are being delivered and experienced.

Goals and Objectives of the QOC-HFA

The overall goal of the QOC-HFA is to evaluate and improve the quality of health services in Kenya. The assessment was designed with the following specific objectives:

- To assess the quality-of-care structures and systems across different types and levels of health facilities.
- To generate data for use in planning, budgeting, and policy formulation, particularly for county health systems.
- To provide a baseline for monitoring progress toward UHC and key health sector strategies.
- To identify gaps and strengths in service readiness, staff competence, and patient experience.
- To promote learning and accountability, encouraging the adoption of quality-improvement measures at all levels.

By comparing findings across facilities, counties, and service areas, the Ministry of Health and its partners can better target investments, training, and reforms.

How the Assessment Was Carried Out

The 2024 QOC-HFA used a mixed-methods approach combining quantitative and qualitative data. The assessment was conducted in 3,605 health facilities, across all 47 counties.

Facility Sampling Strategy

- A census of all public Level 4 and Level 5 hospitals, as well as Port Health facilities, was conducted.
- For Level 2 and 3 public facilities, as well as private, faith-based (FBO), and NGO-run facilities, a stratified random sampling approach was used to ensure inclusion of all types and ownership structures.
- Facilities were sampled from the official Kenya Master Facility List (KMFL) — ensuring that the data reflected the national health facility landscape.

Data Collection Tools

Several specially designed tools were used to collect information across five broad areas:

1. **Quality Assurance Systems** – Do facilities have quality improvement teams, standards, and processes for internal review?
2. **Human Resource Availability and Knowledge** – Are staff available, properly distributed, and knowledgeable about evidence-based clinical practices?
3. **Patient Safety** – Are there systems to prevent and monitor medical errors, infections, or adverse events? Are deaths being reviewed and lessons implemented?
4. **Work Environment and Supervision** – Are staff supported through supervision, training, occupational safety, and career development?
5. **Patient Experience and Client Satisfaction** – Are patients given dignified care? Do they feel heard? Are feedback systems in place?

Other tools included:

- Clinical vignettes (to assess diagnostic knowledge),
- Case record reviews (to assess documentation and treatment decisions),
- Exit interviews with clients (for real-time feedback on service experience),
- Facility observation checklists (for IPC measures, equipment, etc.).

Data was collected using digital tools to ensure consistency and improve speed of analysis. All data collectors were trained and supported to uphold the highest ethical and quality standards.

Unique Features of the QOC-HFA Assessment

This 2024 round of the Quality-of-Care Assessment had several notable advances compared to previous efforts:

- It was fully aligned with global quality of care frameworks and Kenya's Quality Model for Health (KQMH).
- It built upon the 2018 Kenya Harmonized Health Facility Assessment (KHFA) and the Kenya Demographic and Health Survey (KDHS) 2022, allowing for richer comparisons.
- It integrated county-specific disaggregation, allowing local governments identify unique challenges and tailor solutions.
- It placed strong emphasis on client-centered care, including privacy, respectful communication, and satisfaction; dimensions that are often overlooked in service readiness assessments.

The QOC-HFA 2024 was more than a data collection exercise; it is a strategic instrument for improving the delivery, accountability, and equity of healthcare in Kenya. It provides

government, development partners, county health managers, and civil society with a reliable picture of the quality of services offered across different settings.

The insights from this assessment will guide:

- Health system reforms, including supervision and training models,
- Resource allocation, especially to underperforming counties or service areas,
- Policy development, including enforcement of national patient safety and quality standards,
- And community engagement efforts to ensure services are not just available, but acceptable and effective.

Ultimately, the 2024 KQOC-HFA reinforces one message: access is not enough. Quality must be placed at the center of Kenya's UHC journey if we are to save lives, build trust, and ensure that every Kenyan, regardless of where they live, receives the care they deserve.

1.0 General Service Readiness

General service readiness refers to the capacity of a health facility to provide essential health services safely and effectively. It encompasses the presence and functionality of core infrastructure, equipment, infection control mechanisms, diagnostic tools, and the availability of essential medicines. These components collectively determine whether a facility is prepared to deliver services under normal and emergency conditions.

The 2024 Kenya Quality of Care Health Facility Assessment (QOC-HFA) examined service readiness using a standardized approach, evaluating five key domains across public, private, faith-based, and NGO-managed facilities nationwide. The results highlight commendable progress and persistent systemic challenges in achieving universal readiness.

1.1 Basic amenities

Basic amenities are foundational elements that support daily operations and enable safe, respectful patient care. They include access to clean water, electricity, communication tools, functional toilets, waste disposal systems, emergency transport, and internet connectivity.

According to the 2024 QOC-HFA:

- The national mean availability of basic amenities was 77%, indicating that more than half of the country's health facilities had essential infrastructure components.
- Facilities in urban areas and at higher service levels (e.g., Level 4 and 5) performed better, while those in rural settings and lower-tier levels (Level 2 and 3) were the most affected by infrastructure gaps.
- Reliable electricity and water supply remained a challenge in arid and semi-arid counties, where geographic and climatic factors further exacerbate infrastructural vulnerabilities.

These findings raise concerns about the ability of many facilities to sustain critical services, such as infection prevention, maternity care, and safe storage of vaccines without dependable power and sanitation infrastructure.

1.2 Basic equipment

The availability of basic medical equipment such as thermometers, stethoscopes, blood pressure machines, and weighing scales is essential for diagnosis, treatment, and patient monitoring.

- The mean national availability of basic equipment stood at 77%, suggesting generally good access to essential tools.
- Level 5 and 3 facilities demonstrated the highest equipment readiness at 85% and 86% respectively, while Level 4 facilities lagged at 73%
- Equipment maintenance and calibration were not consistently assessed, but anecdotal reports indicated frequent downtime due to lack of technical support or spare parts.

This uneven distribution of tools undermines efforts to standardize care, especially in outpatient and maternal health settings where routine monitoring is vital.

1.3 Standard precautions for infection prevention

Effective infection prevention and control (IPC) measures are necessary to protect both patients and healthcare workers. The 2024 QOC-HFA assessed the presence of gloves, sharps disposal containers, hand-washing stations, disinfectants, and waste management systems.

Key findings include:

- The national mean availability of standard IPC items was 65%.
- Compliance was higher in Level 4 and 5 facilities, but Level 2 and 3 facilities in rural areas frequently lacked adequate hand hygiene materials and safe disposal systems.
- IPC committees, which are key to sustaining infection control practices, were absent in most lower-tier facilities; almost all Level 5 hospitals had them.

In the context of increased global attention on healthcare-associated infections (HAIs) and pandemic preparedness, these gaps pose significant risks to service continuity and patient safety.

1.4 Diagnostic capacity

Access to diagnostic tests is central to evidence-based care and timely treatment. The assessment evaluated the availability of tests for malaria, HIV, haemoglobin, blood glucose, and urine protein, among others.

- Overall diagnostic readiness was 77%
- HIV testing capacity was available in 97% of facilities, malaria diagnostics in 98% reflecting strong programmatic support for these diseases.
- About two thirds of facilities (62%) had haemoglobin testing and almost all facilities (97%) had urine protein testing
- Diagnostic capabilities were more comprehensive in urban settings, NGO-managed facilities, and higher level hospitals.

Despite high scores in some areas, the lack of point-of-care diagnostics in rural and low-resource settings limit accurate case detection for anaemia, pregnancy complications, and chronic illnesses.

1.5 Essential medicines

Availability of essential medicines is a key determinant of a facility's ability to provide continuous and effective care. The assessment focused on 22 tracer medicines

- The mean national availability of essential medicines was 41%.
- Frequent stock-outs were reported in Level 2 and 3 facilities, particularly for antihypertensives, antibiotics, and emergency obstetric drugs.
- Poor inventory management, delayed procurement cycles, and irregular supplies were identified as contributing factors.

These medicine gaps not only affect clinical outcomes but also erode patient trust and increase the risk of complications or readmissions.

General Service Readiness Indicators

Table 2 below shows the components used in the general service readiness index and the data sources.

Table 1: Components used in the general service readiness index and the data sources

General Service Readiness	Domains for Service Readiness
Basic Amenities	• Reliable Power Source (KHFC) • Reliable water source (KHFC) • Room with privacy (KQoCHFA) • Mobile signal availability (KHFC) • Emergency transportation (KQoCHFA)
Basic Equipment	(KHFC)
Basic Diagnostic Capacity	• Haemoglobin (tracer items for antenatal care services) (KQoCHFA) • Blood glucose (KQoCHFA) • Malaria diagnostic capacity (KQoCHFA) • HIV diagnostic capacity (KHFC) • Urine dipstick – Protein (KHFC) • Urine dipstick – Ketones (KQoCHFA) • Syphilis Rapid Diagnostic test (RDT) (KQoCHFA)
Essential Medicines	• Availability of 22 tracer medicines in health facilities (KHFC) • Availability of 23 non pharmaceutical in health facilities (KHFC)
Standard precautions for infection prevention	• Sharps boxes availability (KHFC) • Hand washing facility next to all toilets in the facilities (KQoCHFA) • Latex gloves availability (KQoCHFA) • Availability of face masks in health facilities (KHFC) • Standard operating procedure (SOP) for waste management (KHFC) • Safe disposal of infectious/medical waste segregated into 3 color-coded bins (KHFC) • Availability of disposable syringes (KHFC) • Availability of IPC guideline of hygiene protocol (KHFC)

Findings:

- Overall, the general service readiness was 67%.
- The domain with the highest average readiness was basic diagnostic capacity, basic equipment and basic amenities at 77%,
- The lowest average readiness was medicines at 41%.

Disaggregation by KEPH level and Ownership

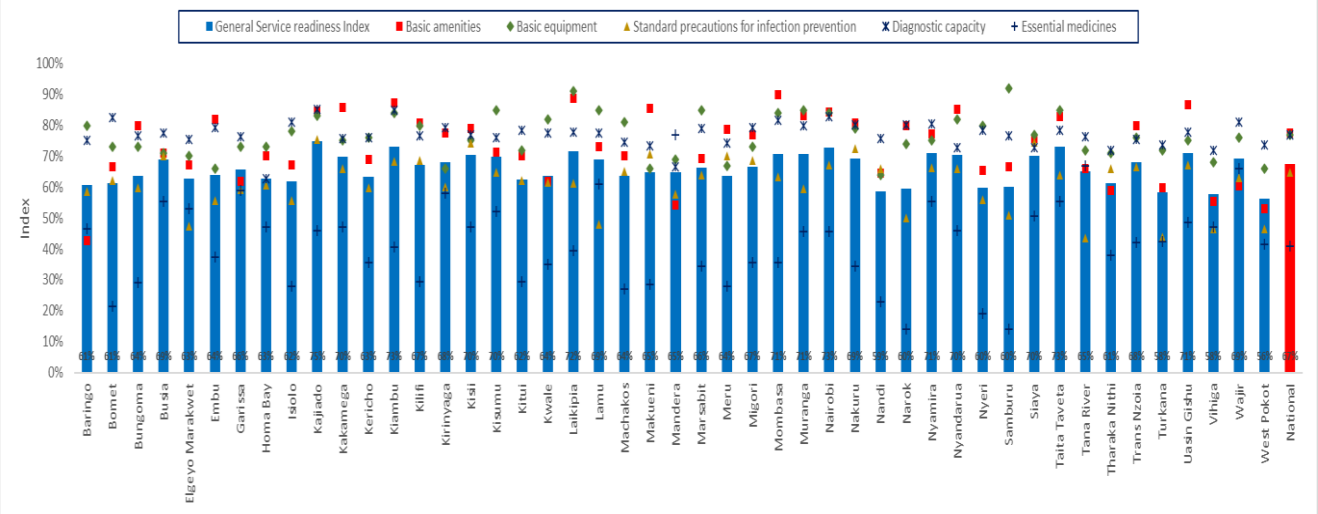
- The readiness score for basic amenities, standard precautions for IPC and essential medicines increased as KEPH level increased. Level 5's had the highest readiness at 96%, 84% and 84% for the three domains compared to Level 2's readiness of 72%, 61% and 31% respectively.

General service readiness distributed by county and disaggregated by domains

- Basic amenities average readiness was highest in Mombasa and Laikipia counties, both at 90% . Five counties with the lowest basic amenities readiness were Tharaka Nithi (59%), West Pokot and Mandera (53%), Vihiga (55%) and Baringo (43%).
- Samburu and Laikipia counties had the highest basic equipment average readiness at 92% and 91% respectively, while Nandi county had the lowest at 64%.
- Average readiness for standard precautions for infection prevention was highest in Kajiado and Samburu counties (75%) and lowest in Tana River and Turkana county (44%).
- Basic diagnostic capacity was highest in Kajiado and Kiambu counties at 85%, a contrast with Mandera (67%) and Homa Bay (63%) which had the lowest basic diagnostic capacity.

- Only 4 counties had an essential medicine readiness score greater than 60% - Mandera (77%), Tana River (67%), Wajir (66%) and Lamu (61%). Three counties had an essential medicine score of less than 20%: Nyeri (19%), Narok (14%) and Samburu (14%)

Figure 1: General service readiness domains and index by county, National



2.0 Systems to Support Quality Care

The provision of quality healthcare extends beyond the availability of infrastructure, medical supplies, and equipment. It requires robust systems and processes that promote safety, accountability, consistency, and continuous improvement. These systems include external evaluations, internal mechanisms for quality monitoring, supportive supervision structures, and capacity-building frameworks.

The 2024 Kenya Quality of Care Health Facility Assessment (QOC-HFA) examined the presence, functionality, and reach of these systems across various levels and ownership categories of health facilities in the country. The findings underscore the strengths and gaps of systems that influence the delivery of high-quality, equitable healthcare services nationwide.

2.1 External Assessments

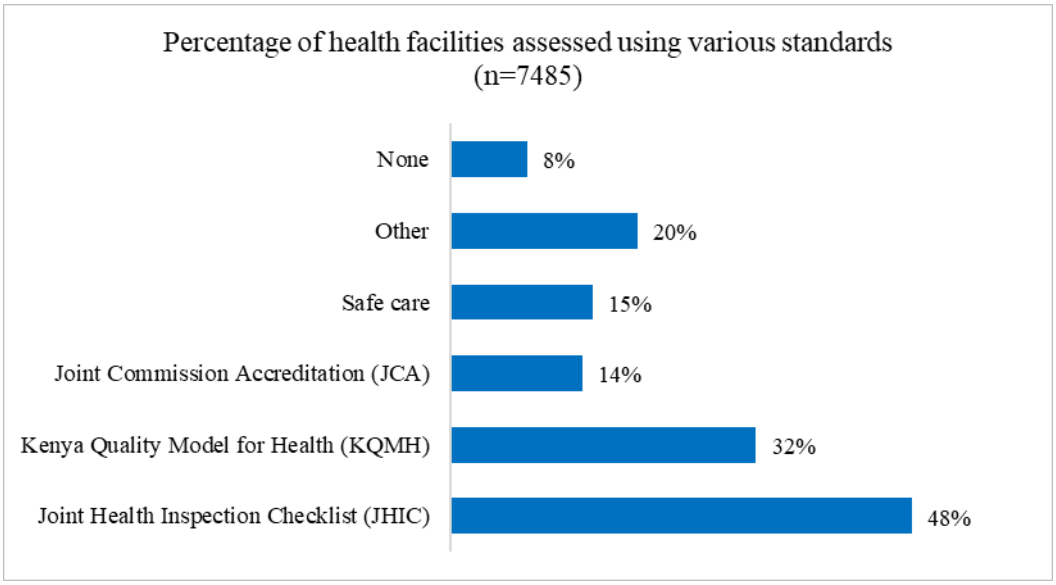
External assessments serve as a regulatory mechanism to ensure that health facilities comply with established standards and guidelines. They provide an objective evaluation of service delivery, infrastructure, infection prevention and control, patient safety protocols, staff qualifications, and legal compliance.

The 2024 assessment revealed that:

- Slightly more than half (56%) of all facilities had undergone at least one external assessment in the preceding year.

- Assessment coverage was highest among Level 5 hospitals (95%), followed by Level 4 (72%) facilities, with Level 2 facilities registering the lowest coverage at 53%.
- Among the assessment tools utilized:
    - About half of the facilities (48%) were evaluated using the Joint Health Inspection Checklist (JHIC):- Kenya's standardized tool for assessing compliance with legal and regulatory requirements.
    - About a third of the facilities (32%) of facilities were assessed against the Kenya Quality Model for Health (KQMH) standards, which offer a framework for institutionalizing continuous quality improvement.
    - The least proportion of facilities (14%) reported using international standards, including those issued by the Joint Commission International and other recognized global accreditation bodies.

Figure 2: Percentage of health facilities assessed using various standards



These findings indicate variations in the depth, comprehensiveness, and consistency of external assessments especially across facility levels and ownership. Notably, many lower-level and privately managed facilities had not undergone any external assessments potentially leaving quality lapses undetected and unaddressed.

2.2 Internal Quality Assurance and Improvement Mechanisms

Internal quality assurance systems are critical to embedding a culture of continuous improvement within health facilities. They involve systematic, self-led processes such as internal assessments, routine performance monitoring, peer review, and quality improvement initiatives. The establishment of Quality Improvement Teams (QITs) and Work Improvement Teams (WITs) is a central feature of these systems.

Key findings include:

- About seven in every ten health facilities (69%) had Quality Improvement Teams (QITs)

- The QITs were established in 90% of Level 5 and 85% of Level 4 facilities.
- Quality Improvement Teams (QITs) were reported in only 63% of Level 3 facilities, highlighting a significant gap at the primary care level.
- There was a disparity between urban and rural areas, with 76% of urban facilities reporting the presence of QITs, compared to only 62% of rural facilities.

In addition to team structures, training remains a foundational component for successful quality improvement. The assessment found that:

- Only 4% of health facilities had healthcare workers trained on quality improvement in the past 2 years.
- One in every four level 5 facility and one in every 10 level 4 facility had health care workers trained on quality improvement. These findings indicate a need to prioritize the decentralization of quality improvement training and team establishment, particularly in lower-tier and rural health facilities. Without a functioning internal quality improvement mechanism, these facilities are less equipped to identify service delivery gaps, implement corrective actions, or monitor progress.

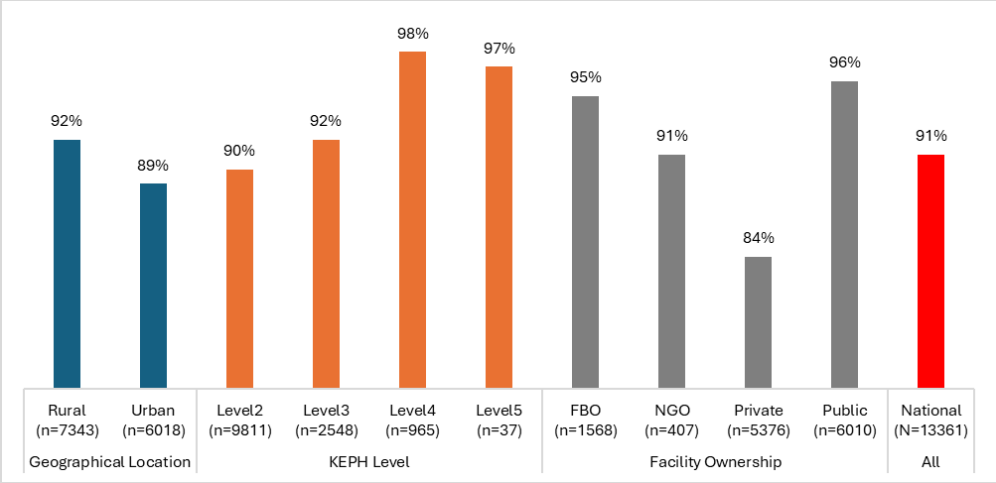
2.3 Supportive Supervision

Supportive supervision is a strategic and collaborative approach that focuses on mentorship, coaching, and professional development, rather than enforcement and punitive oversight. It plays a pivotal role in enhancing staff performance, morale, and adherence to clinical and operational standards.

According to the KQOC-HFA 2024:

- Almost all (91%) of facilities reported having received at least one external supportive supervision visit in the past 12 months
- Among these:
    - Nearly all levels 4 and 5 facilities reported recent supervision, 98% and 97% respectively.
    - About half of the facilities (51%) received monthly supervision visits, which is a recognized best practice in quality assurance
- Supervision coverage was significantly higher in public facilities (96%) compared to private facilities (84%).
- While the high availability of supportive supervision at the higher levels and public facilities is commendable, supervision was less consistent in lower-level and non-public facilities, which often serve the most vulnerable populations.

Figure 3: Percentage of facilities that received any external supervision within the last 12 months (N=13,361)



3.0 Patient Safety in Health Facilities

Ensuring the safety of patients is one of the most important responsibilities of the healthcare system. Patient safety means that people get the care they need without being harmed by avoidable mistakes, infections, or poor systems. The 2024 Quality of Care assessment took a close look at how health facilities across Kenya are doing in keeping patients safe.

3.1 Review of Deaths in Facilities

One key measure of patient safety is whether health facilities review deaths that happen to learn from them and prevent future harm.

- About seven in every ten health facilities (73%) that offer inpatient services conduct formal death reviews.
- Death reviews were most common in level 5 hospitals (100%) and NGO facilities (96%) compared to 70% of level 3 facilities and 64% of private facilities.
- Maternal and perinatal death reviews were the most common (84%), while surgical-related death reviews were the least conducted (35%).

In just 3 months (Oct–Dec 2023):

- 427 maternal deaths were reported, and 95% (407) were audited.
- 4,094 neonatal deaths were reported, and 76% (3,114) were audited.

This shows great progress in maternal & neonatal audits, but surgical death reviews still need more attention.

3.2 MPDSR Committees

Maternal and Perinatal Death Surveillance and Response (MPDSR) committees are key in coordinating review of maternal and perinatal death audits and putting in place measures to prevent such deaths.

- MPDSR committees were available in 63% of the facilities
- Two thirds (63%) of Faith-Based Organizations (FBOs) and 80% of public hospitals had these committees.
- Private facilities were the lowest at 48%.
- Some counties (like Mandera, Kilifi) had less than a fifth of their facilities with MPDSR committees.

3.3 Surgery-Related Adverse Events

Tracking problems that happen during or after surgery is key to improving surgical safety.

- Only 35% of facilities reviewed deaths that happened within 24 hours after surgery.
- These reviews were more common in private facilities (45%) and least conducted in NGO facilities (22%).
- Most level 5 hospitals (86%) reviewed surgical deaths, compared to 51% of level 4 and 22% of level 3 facilities.

3.4 Monitoring Surgical Errors and Infections

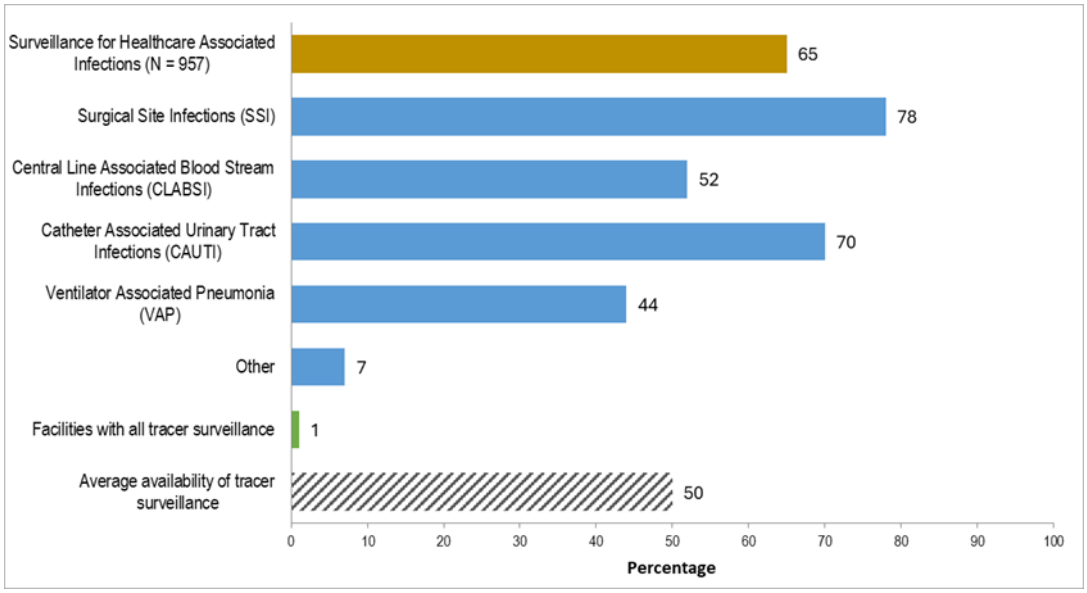
It's not enough to do surgery, facilities also need systems to detect and report when things go wrong.

- Only 28% of facilities had systems in place to monitor surgery-related complications.
- Majprity of Level 5 facilities (83%) monitored surgical errors and infections compared to 19% of Level 3 facilities.
- NGO-run facilities had the best monitoring systems overall (55%), while availability in public facilities was 25%.

3.5 Surveillance of Healthcare-Associated Infections (HAIs)

- About two thirds (65%) of level 4 and 5 facilities offering inpatient services conducted surveillance for healthcare associated infections.
- Majority of health facilities conducted surveillance for surgical site infections (78%) and catheter associated urinary tract infections (70%) while 44% conducted surveillance for ventilator associated pneumonia.

Figure 4: Percentage of Facilities offering in-patient services that conducted surveillance for specific HAI's



3.6 Infection Prevention and Control (IPC) Committees

Facilities with active IPC committees are better prepared to prevent infections before they happen.
Nationally, 40% of all facilities had an IPC committee.

These were common in higher level facilities; 95% and 76% in level 5 and 4 hospitals respectively compared to 26% of level 3 facilities.

- Nearly half (48%) of facilities with IPC committees met monthly, as expected.

3.7 IPC Policies and Guidelines

Kenya launched its national IPC guidelines in 2021, but not all facilities have adopted them.

- More than half (68%) of facilities had the IPC guidelines on the day of the assessment
- About eight in every ten level five facilities (81%) had the policy, compared to only 60% of level 2 facilities.

3.8 Antimicrobial Stewardship (AMS) and Resistance Surveillance

The misuse of antibiotics contributes to the global rise in antimicrobial resistance (AMR), posing a major threat to healthcare outcomes.

- Only 38% of facilities monitored antibiotic use and consumption while 32% conducted prescription audits.
- Only 46% of health facilities (level 4 and 5 had a functional Antimicrobial Stewardship (AMS) Committee.
- Level 5 facilities reported higher availability of AMS committee (54%) compared to Level 4 facilities at(46%). Private and FBO facilities were slightly behind Public and NGO institutions in AMS governance at 44% .

- Less than half (46%) of level 4 facilities reported AMR lab data to the National Central Data Warehouse.

3.9 General Patient Safety Incident Monitoring

- Only 26% of facilities conducted surveillance for general patient safety incidents.
- Medication errors were the most monitored (74%), while blood transfusion errors were the least (14%).
- Surveillance was significantly better in Level 5 hospitals (65%), with lower-tier facilities lagging behind.

3.10 Policies and Guidelines for Patient Safety

Availability of the National Policy on Patient Safety, Health worker safety and Quality of care, 2022 in health facilities was generally low, with wide variations in availability across the counties

- Nationally, about one in every four facilities (25%) had the National Policy on Patient Safety, Health worker safety and Quality of care 2022.
- Higher level facilities had a higher probability of having the policy ,51% for level 5 and 43% for level 4 compared to 21% and 33% for level 2 and 3 respectively.
- Public facilities had the least proportion of their facilities having the policy at 20% compared to 32% of faith-based facilities.

4.0 Human Resources: Availability, Work Environment, and Staff Wellbeing

Healthcare workers are the backbone of the health system. Without enough trained and motivated staff, no facility can offer safe, timely, and effective care. The 2024 Quality of Care assessment took a deep dive into staffing levels, training, safety at work, job satisfaction, and how staff are distributed across Kenya.

The assessment focused on the following areas;

Table 2: HRH assessment focus

Active Health Worker Stock	Medical Worker Density
• Medical: Non-Medical Ratio	

• Distribution
  ○ Gender
  ○ Cadre
  ○ Age
  ○ Terms of Engagement
	• Distribution
	  ○ Cadre
	  ○ KEPH Level
	  ○ Ownership

• Norms and Standards:	• Density

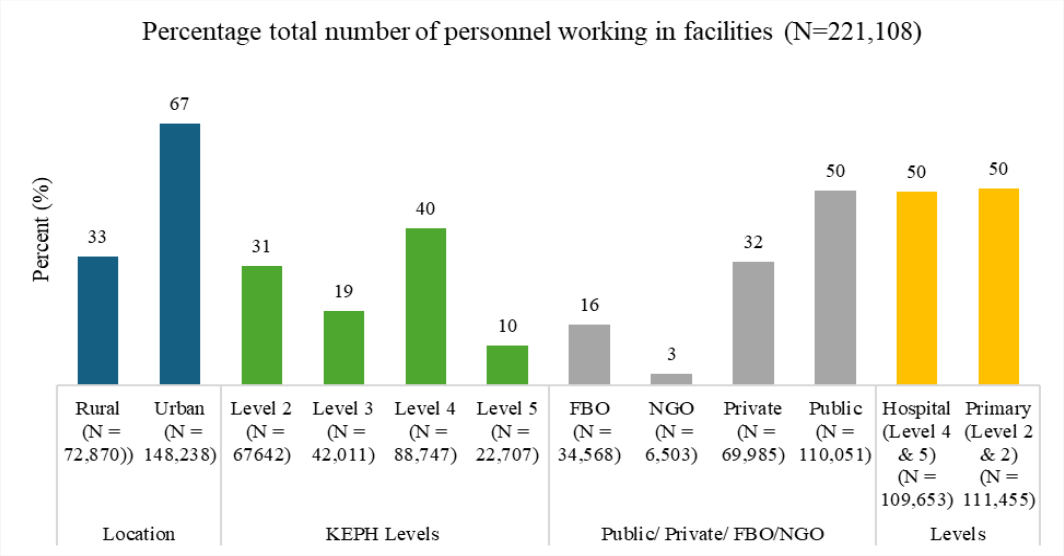
4.1 Active Health Worker Stock

The equitable distribution of health workers is critical to ensuring fair access to healthcare services across Kenya. An effectively distributed workforce helps reduce health disparities, improves health outcomes, strengthens health system efficiency, and ensures that healthcare services are accessible to all, regardless of income or location.

In the 2024 assessment,

- A total of 221,108 personnel across 13,320 health facilities were assessed.
- The majority of these workers were in Level 4 facilities, which accounted for 40%, followed by Level 2 facilities at 31%.
- In terms of ownership, public and private facilities employed the highest proportions of staff at 51% and 30% respectively.
- The analysis however revealed that 67% of health workers are concentrated in urban areas, highlighting a significant urban-rural imbalance that undermines equitable healthcare access.

Figure 5: Distribution of personnel in the health facilities



4.2 Health Worker Numbers and Distribution

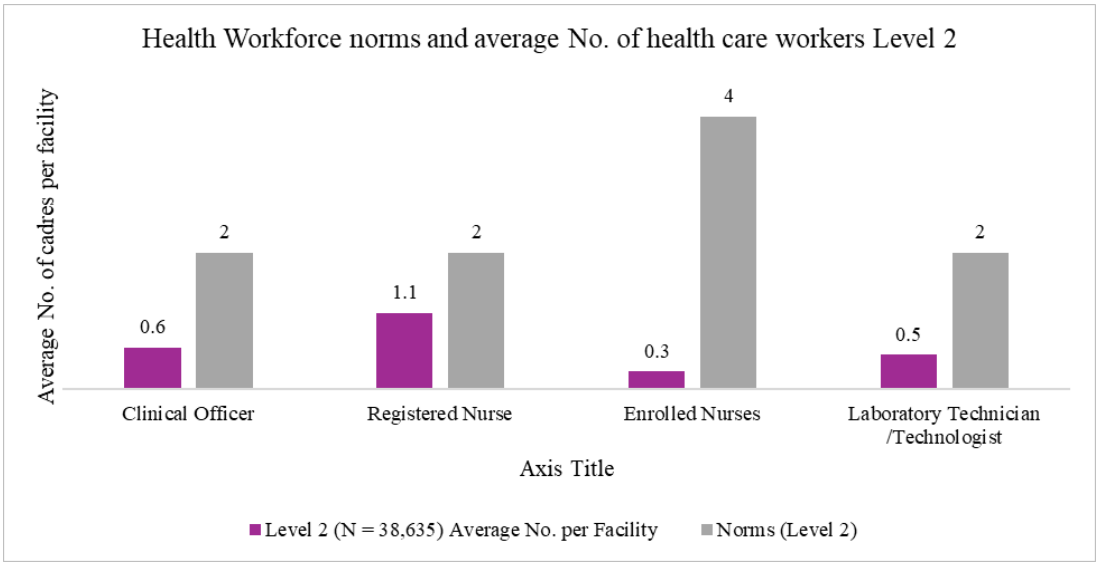
Despite policy efforts and workforce investments, the assessment found significant shortages in essential health worker cadres across all levels of the health system.

- According to the 2014 Human Resources for Health Norms and Guidelines, none of the facility levels assessed in 2024 met the required staffing thresholds.

Level 2 Facilities:

- Registered nurses stood at 1.1 per facility (against a norm of 2).
- Enrolled nurses were at 0.3 per facility (7.5% of the required number).
- Clinical officers averaged 0.6 (norm is 2).
- Laboratory personnel averaged 0.5 per facility (norm is 2).

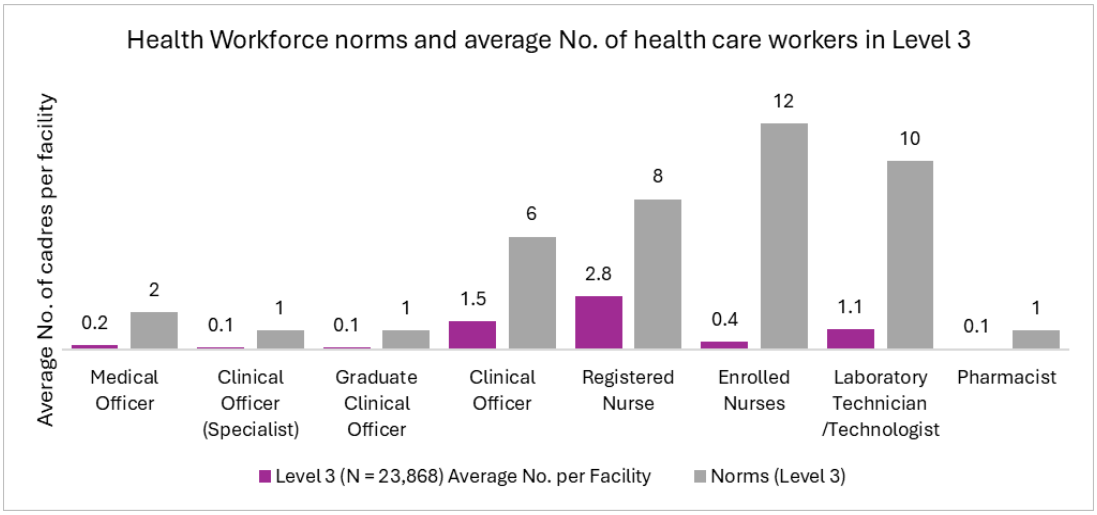
Figure 6: Staffing norms and Average Health Workers-Level 2 (N=38,635)



Level 3 Facilities:

- Severe shortages were observed across most cadres.
- Medical officers and clinical officer specialists averaged less than one per facility.
- Enrolled nurses stood at 0.4 per facility against a requirement of 12
- The picture remained consistent with the 2018 KHFA, with little improvement.

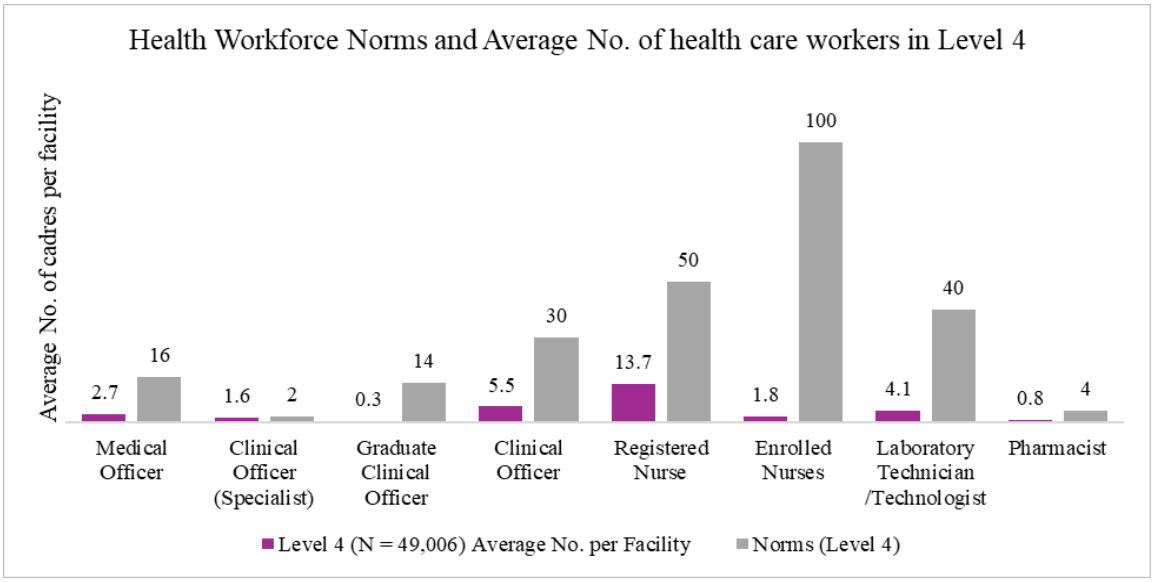
Figure 7: Staffing norms and Average Health Workers-Level 3 (n=23,868)



Level 4 Facilities:

- Enrolled nurses were critically low at 1.8 per facility (against a norm of 100).
- Registered nurses averaged 13.7 (required: 50).
- Clinical officers averaged 5.5 per facility (required: 30).
- Laboratory staff stood at 4.1 (against a requirement of 40).

Figure 8: Staffing norms and Average Health Workers-Level 4 (N=49,006)



These findings highlight critical staffing deficits across facility levels, significantly affecting the delivery of basic and specialized services, especially in primary and secondary care facilities.

4.3 Distribution of the Medical and Non-Medical Personnel in Kenya.

With respect to staff composition, the assessment applied the 2017 Norms and Standards for Management of Human Resources in the Public Service, which recommend a 70:30 ratio of medical (technical) to non-medical (support) staff.

- Nationally, only 61% of personnel were classified as medical, while 39% were non-medical indicating that the country has exceeded the recommended proportion of non-medical staff by 9%.
- This imbalance was consistent across KEPH facility levels, where non-medical personnel accounted for 44% in Level 2, 40% in Level 3, 35% in Level 4, and 38% in Level 5 facilities.
- NGO-owned facilities had the highest proportion of non-medical staff at 50%, followed by FBOs at 46%, private facilities at 41%, and public facilities at 35%, which had the lowest proportion.
- These findings highlight both a shortage and an inefficient distribution of health workers. Addressing this imbalance is essential to achieving equity in health service delivery across the country.

Figure 9: Distribution of the medical and non-medical personnel in Kenya

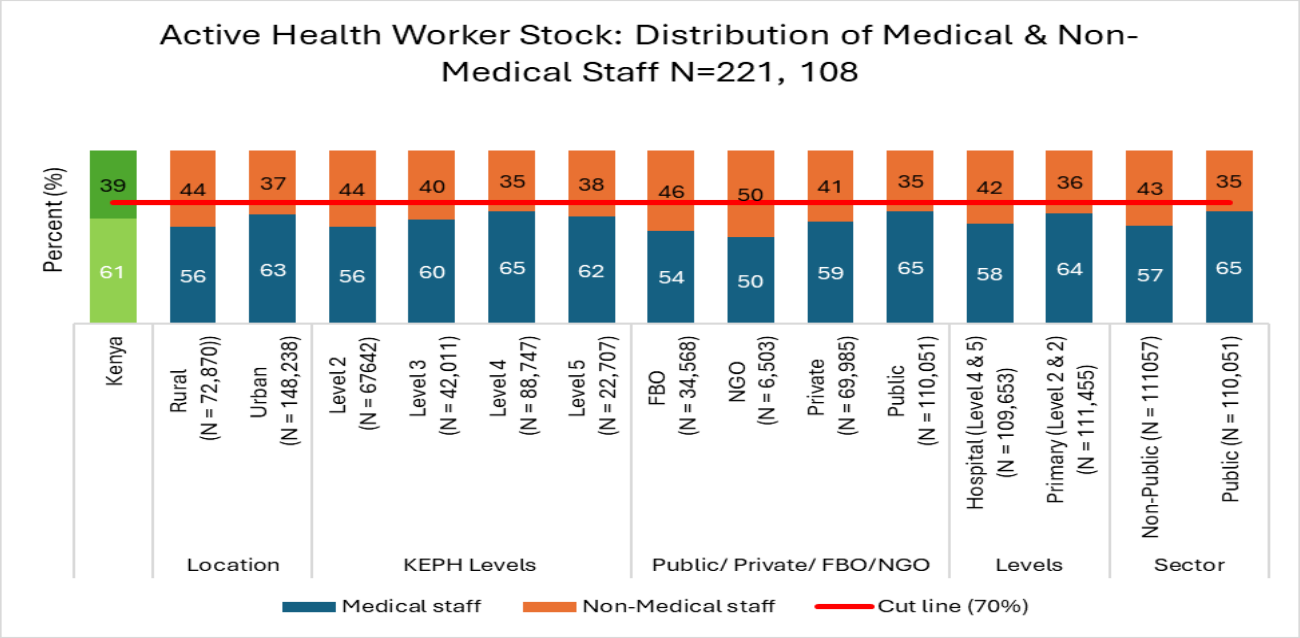
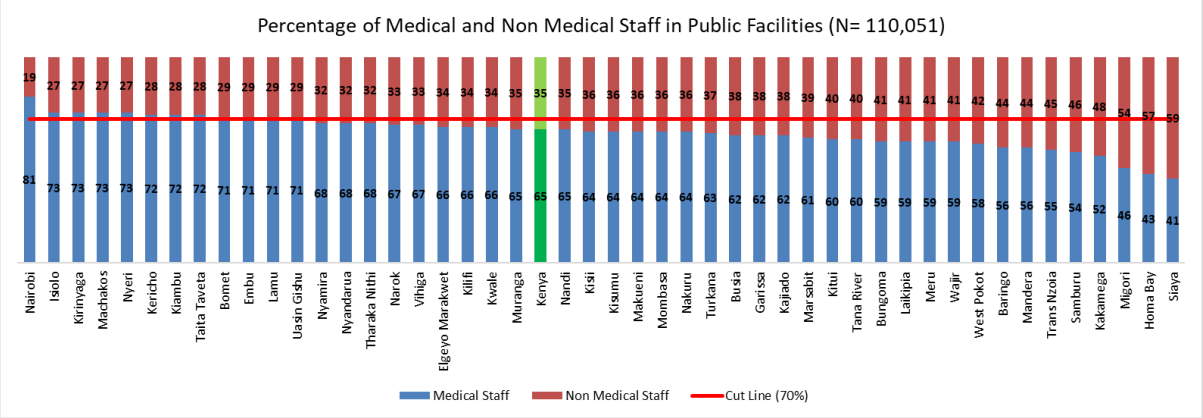


Figure 10: Distribution of the medical and non-medical personnels in the Counties among public facilities

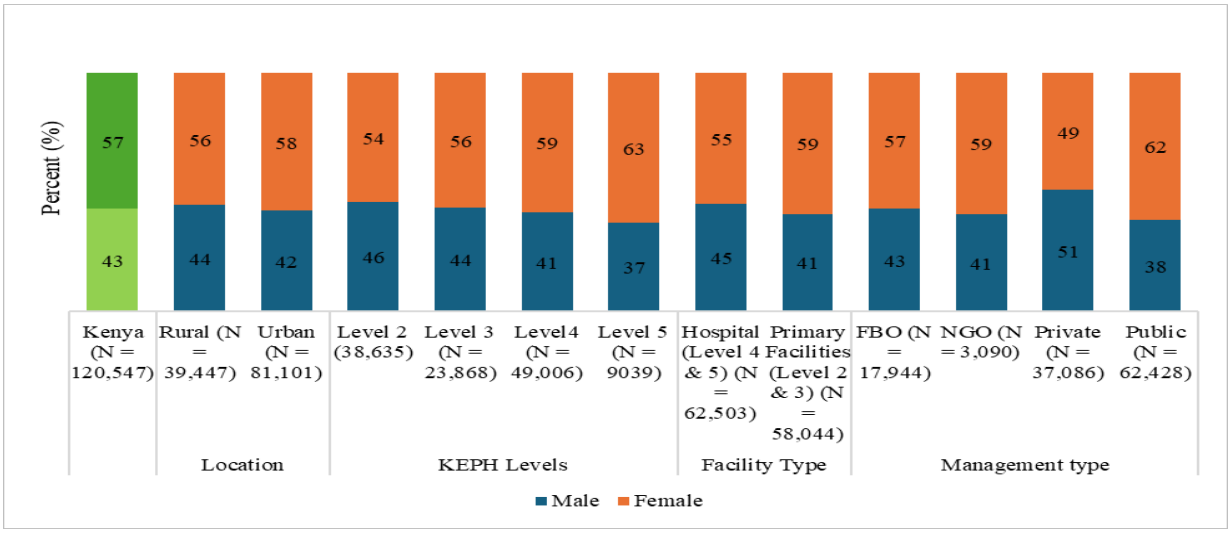


In public facilities Nationally 65% of staff in public facilities were medical while 35% were non-medical. Among Counties, Nairobi, Isiolo, Kirinyaga, Machakos, Nyeri, Kericho, Kiambu, Taita Taveta, Bomet, Embu, Lamu and Uasin Gishu Counties met the required 70:30 ratio of medical to non-medical workers. On the other hand, Migori, Homa Bay and Siaya had more than 50% of their staff being non-medical.

4.4 Distribution of Health Workers by Gender

- Female medical Health Workers comprised the majority (57%) nationally, which is replicated across the KEPH Levels.
- Level 5 had 63% female health workers while Level 4 had 59%. Level 2 had the least proportion of female health workers at 54%.
- The Public Health Facilities had their bulk of medical health workers as female (62%) while the Private facilities had 49% females.

Figure 11: Distribution of Health Workers by Gender (N=120,547)

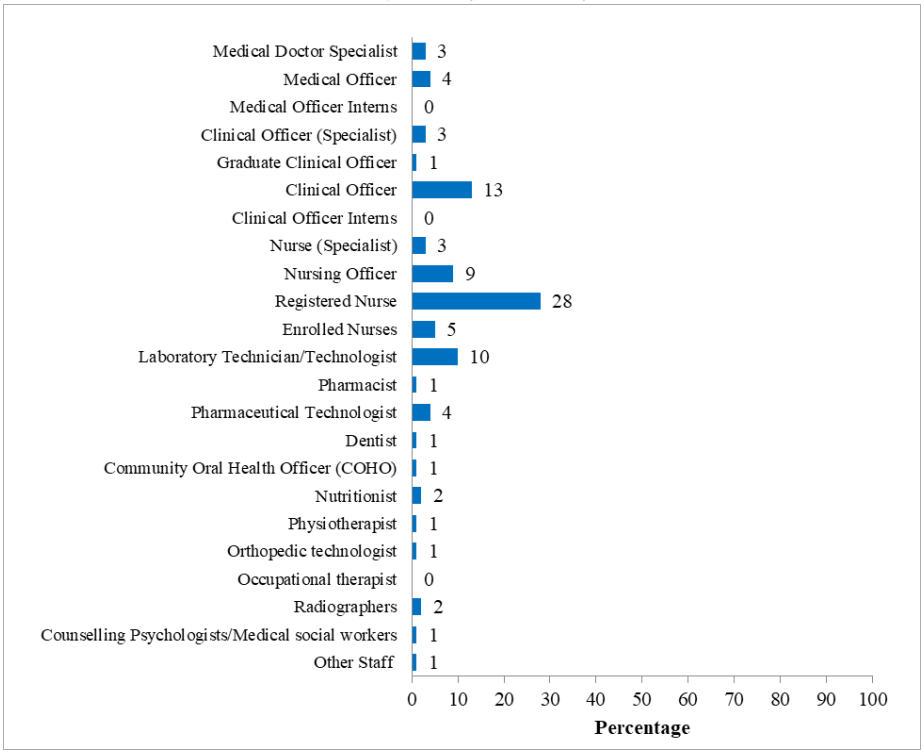


4.5 Distribution of Health Workers by Cadres

This survey collected data on 22 specified cadres. Medical doctors, clinical officers and nurses' cadres had multiple categories based on the role and qualification.

- A total of 120,547 health workers were assessed according to their cadres in the Kenya 2024 QOC Assessment.
- The cadres that had the highest proportion of the health workers were Registered nurses at 28%, Clinical Officers were 13%, and lab technicians/technologists at 10%. The Occupational therapists comprised 0.4% of all the health workers while medical Officers Interns comprised 0.1.

Figure 12: Distribution of Health Workers by Cadre (N=120,547)



Analysis of Education level,

- 67% of the health workforce held diploma qualifications, 13% had completed university degrees, and 8% had certificate-level training, primarily among enrolled nurses.

Terms of Engagement

- Less than half (49%) of health workers are on permanent terms of employment
- One third (33%) are on contracts, many under NGO, FBO, or county engagement.
- Others are engaged through local mechanisms or donor-funded projects.

Table 3: Percentage of staff terms of engagement

Permanent and pensionable	NGO/Faith-based	Contract	County	UHC Contract	Locum	Owner	Number of facilities
By location							
Rural	45%	5%	32%	3%	6%	2%	0%	39447
Urban	51%	3%	33%	1%	2%	4%	0%	81101
By type							
Level2	36%	5%	37%	1%	3%	6%	1%	38635
Level3	42%	2%	40%	2%	3%	4%	0%	23868
Level4	60%	3%	28%	2%	3%	2%	0%	49006
Level5	62%	6%	24%	2%	2%	1%	0%	9039
By managing authority							
FBO	14%	14%	61%	1%	0%	3%	0%	17944
NGO	15%	6%	62%	0%	0%	6%	0%	3090
Private	31%	3%	50%	0%	0%	9%	1%	37086
Public	71%	1%	13%	3%	5%	1%	0%	62428
All	**49%**	**4%**	**33%**	**2%**	**3%**	**4%**	**0%**	**120547**

4.6 Health workforce distribution by Age

The 2024 Kenya Quality of Care Focused Health Facility Assessment (KQOC) investigated the professional experience among the health workforce by looking at the age distribution and the median number of years of service in the current position among staff working at the facility.

- The distribution between the ages was as follows, 20-24 years (3%), 25-29 years (22%), 30 and 34 (26%), and 35-39 years (19%).

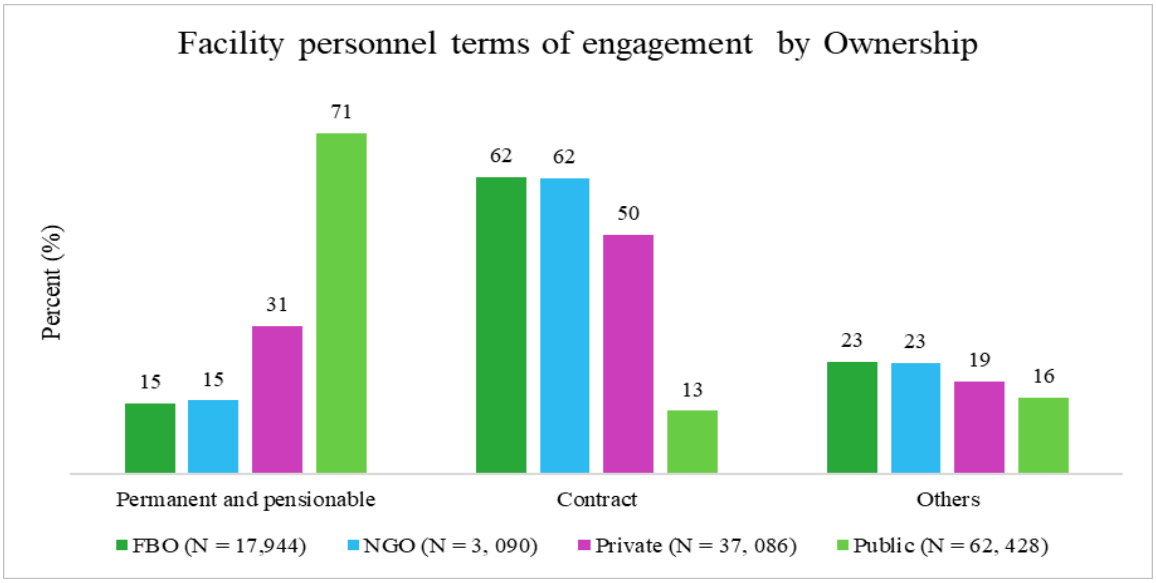
- The distribution for those above 40 years was 40-44 years at 12%, 45-49 years at 7%, 50-54 years at 5%, 55-60 years at 4% and those above 60 years at 2%

This indicates that most of the current workforce in Kenyan facilities comprises young healthcare providers. It is therefore important to institute measures to motivate and ensure retention of this work force.

4.7: Terms of engagement for Health workers by Ownership

- Most public employees were on permanent and pensionable terms (71%).
- Most medical personnels were on contract ,62% in FBO and NGO and Private (50%) institutions.

Figure 13: Distribution of Health Workers by their terms of engagement across Facilities by ownership (N=120,547)



4.8 Health Workforce Density

Workforce density, measured as the number of health workers per 10,000 population, remained below both national targets and WHO benchmarks required to support Universal Health Coverage (UHC). The overall HR density as per WHO standards is 44.5 health workers per 10,000 population

An analysis of densities across different cadres based on the QOC-HFA is summarized in the table below;

Table 4: HRH Densities

HRH Densities	Kenya QOC 2024	Current average regional (AFRO) density per 10,000 population	Requirement for population for at least 70% of UHC service index
Medical Doctors, all generalists and specialists	0.89	3.29	7.7
Clinical Officers	3.23	0.28	0.90
Nurses	10.14	13.99	58.64
Lab Technologists	2.31	1.25	14
Pharmacists	1.28	1.28	14.72
Dentists	0.14	0.74	5.28
Core cadres	14.25		23

- Counties such as Turkana, Wajir, Narok, and Tana River reported the lowest density of medical officers and nurses, while Nyeri and Kisumu demonstrated higher-than-average densities, especially for clinical officers.

Figure 14: Medical Officers density per 10000 population

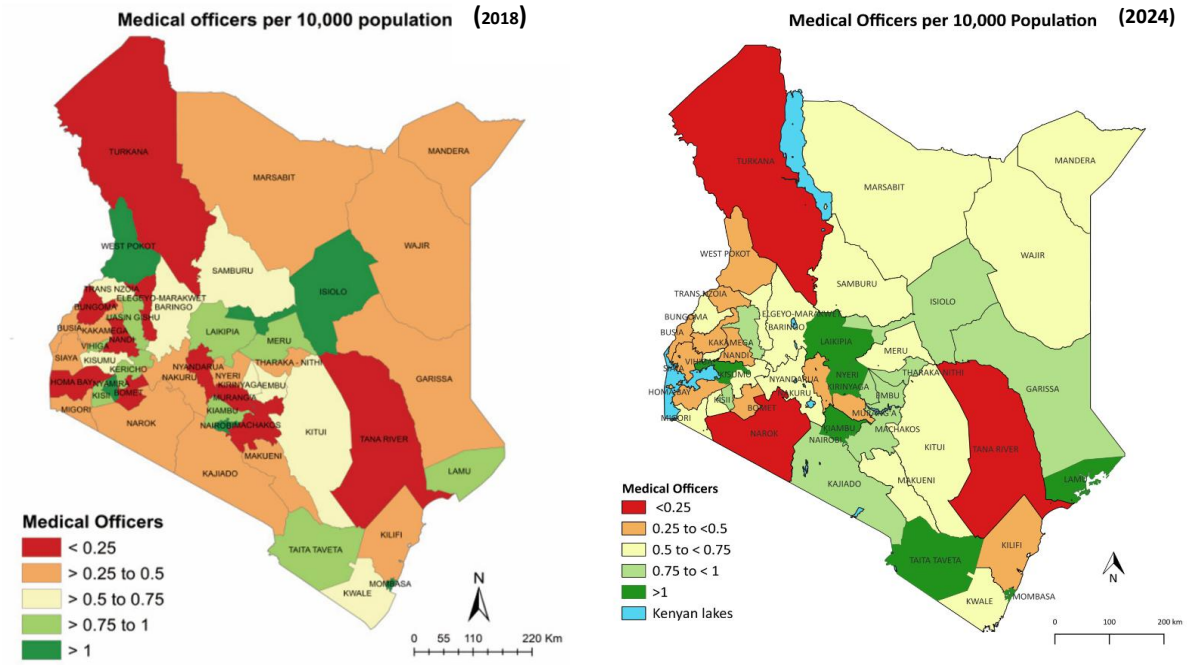
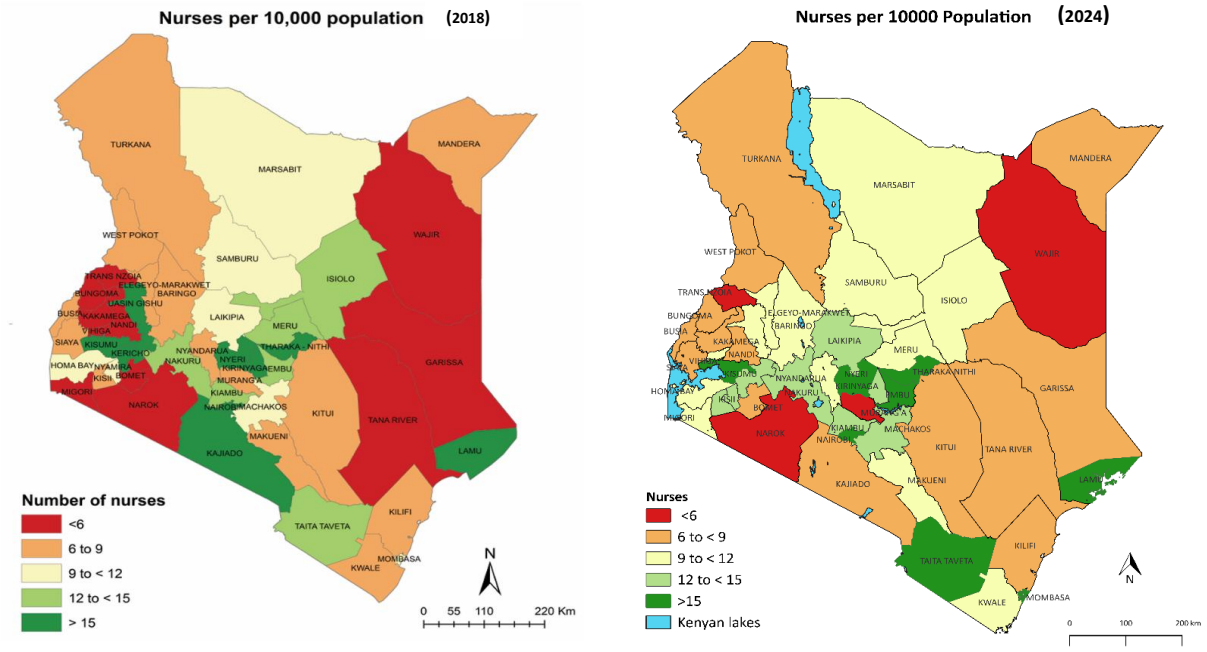


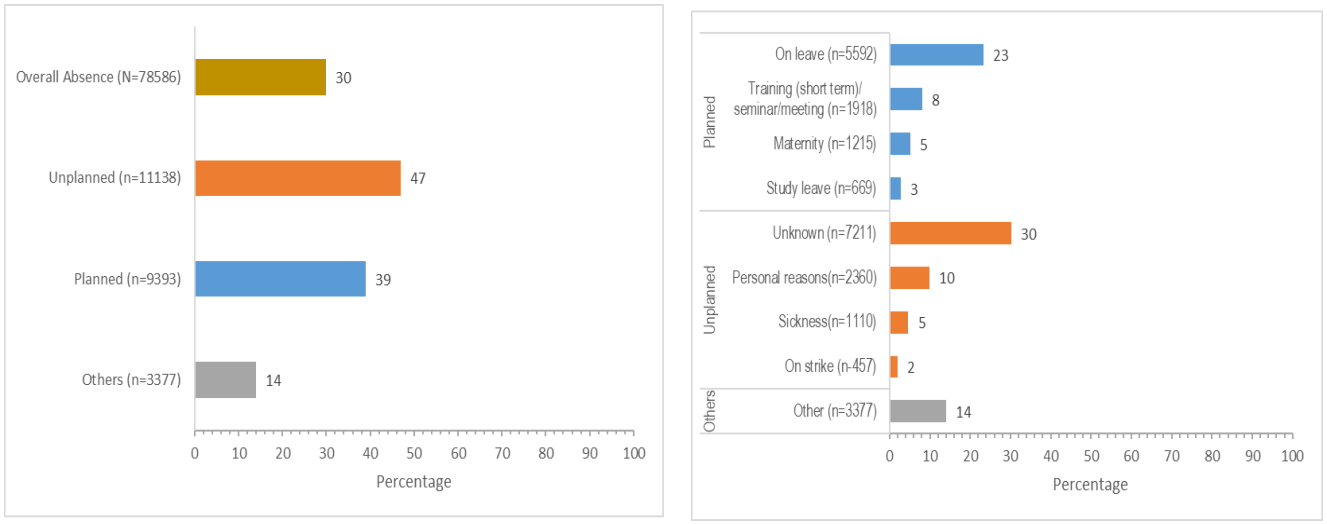
Figure 15: Nurses density per 10000 Population



4.9: Absenteeism

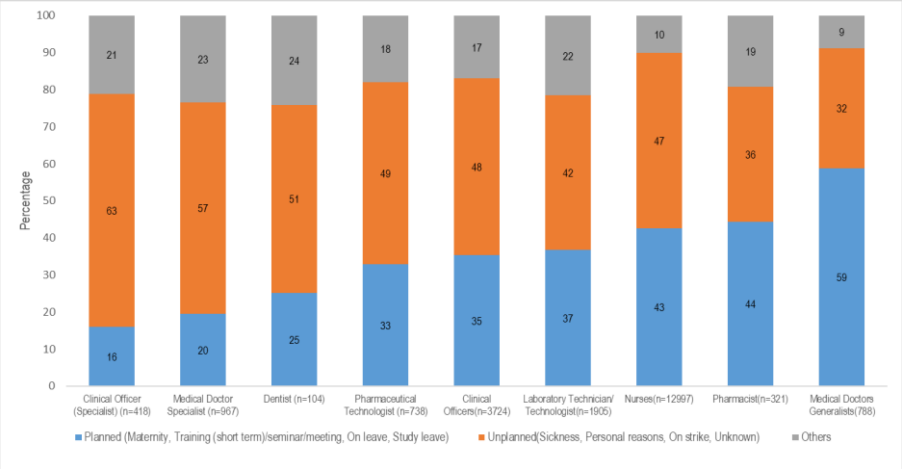
- Nationally, health worker absence in Kenya is 30% during the unannounced visit.
- Health worker absence can be categorized as either planned or unplanned.
- Unplanned reasons were the reason for absenteeism for majority of the health workers at 47%, while planned absenteeism, including training, study leave, and official duty, constituted 39% of total absences.
- Annual leave was the highest reason for planned absenteeism at 23%. For the unplanned absence, unknown reasons were highest at 30% while other reasons were at 14%. Any additional reasons were categorized as others.

Figure 16: Reasons for absenteeism by category (n= 78586)



- Clinical officer specialists had the highest unplanned absence (63%).
- Rural areas reported higher planned absenteeism (44%), while urban areas had more unplanned absences (50%).
- Public sector facilities were most affected, followed by private and NGO facilities.

Figure 17: Percentage of health worker availability by cadre

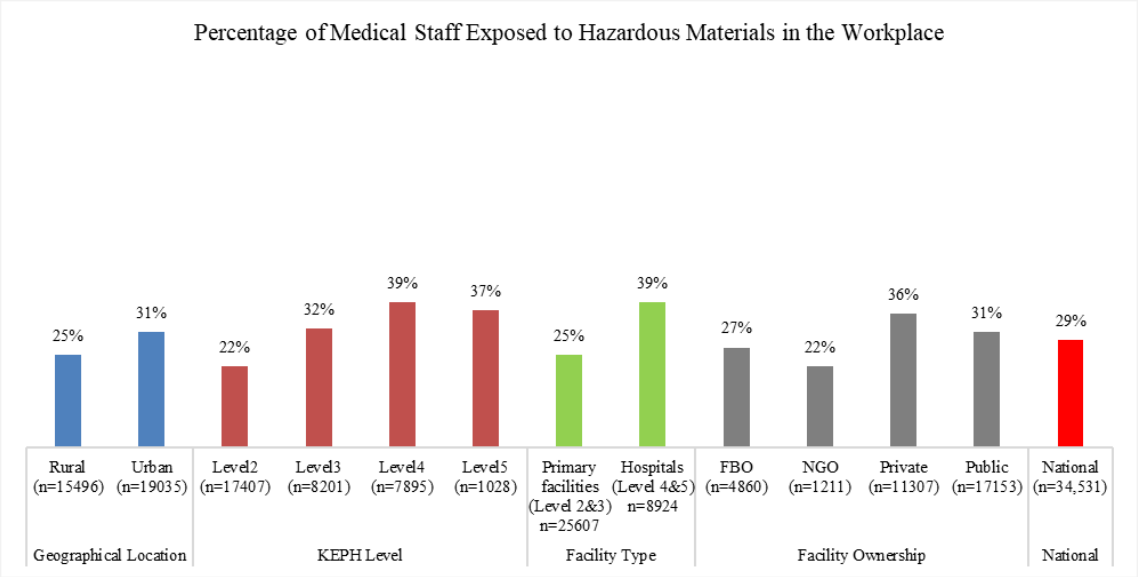


4.10: Occupational Health and Safety

Healthcare workers often face risks on the job, from infections to physical or verbal assault.

- Nationally, slightly more than a quarter (29%) of the medical staff reported having been exposed to hazardous materials in the workplace.
- A higher number of exposures was reported among medical staff working in level 4 and 5 facilities at 39% and 37% respectively compared to those working in level 2 facilities (22%).
- Three and four out of ten medical staff working in public and private health facilities respectively, had been exposed to hazardous materials compared two out of ten working in NGO facilities

Figure 18: Percentage of Workers Exposed to Hazardous Materials in the Workplace (n=34,531)



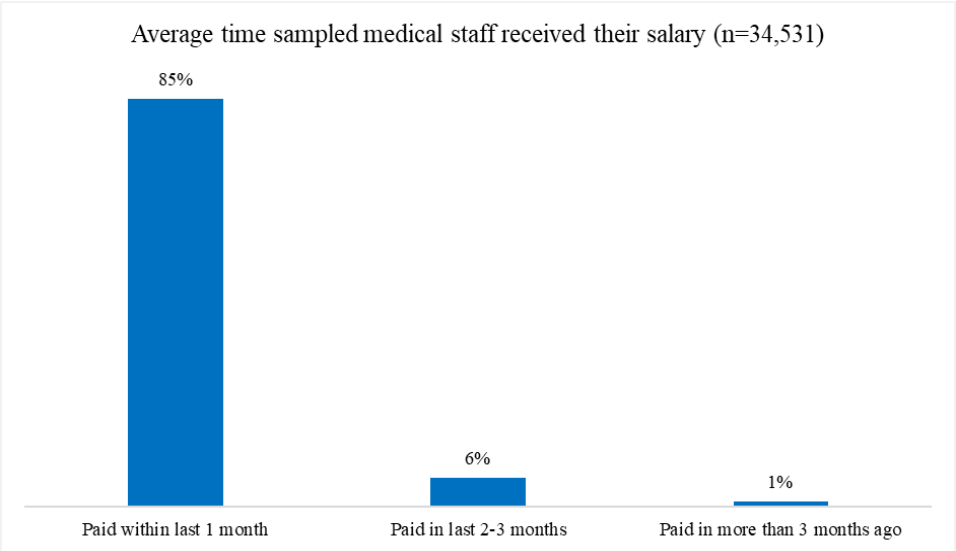
- About 96% had received vaccination against workplace-related infections; a strong positive sign.
- Only 24% of facilities had systems in place for staff safety surveillance.

4.11: Health Worker Environment and Satisfaction

Payment of Salaries

- Overall, salaries for medical staff were paid in a timely way with 85% of medical staff reporting having received their salaries within the previous month. That said, 1% of medical staff reported having been paid more than 3 months before the day of the survey.

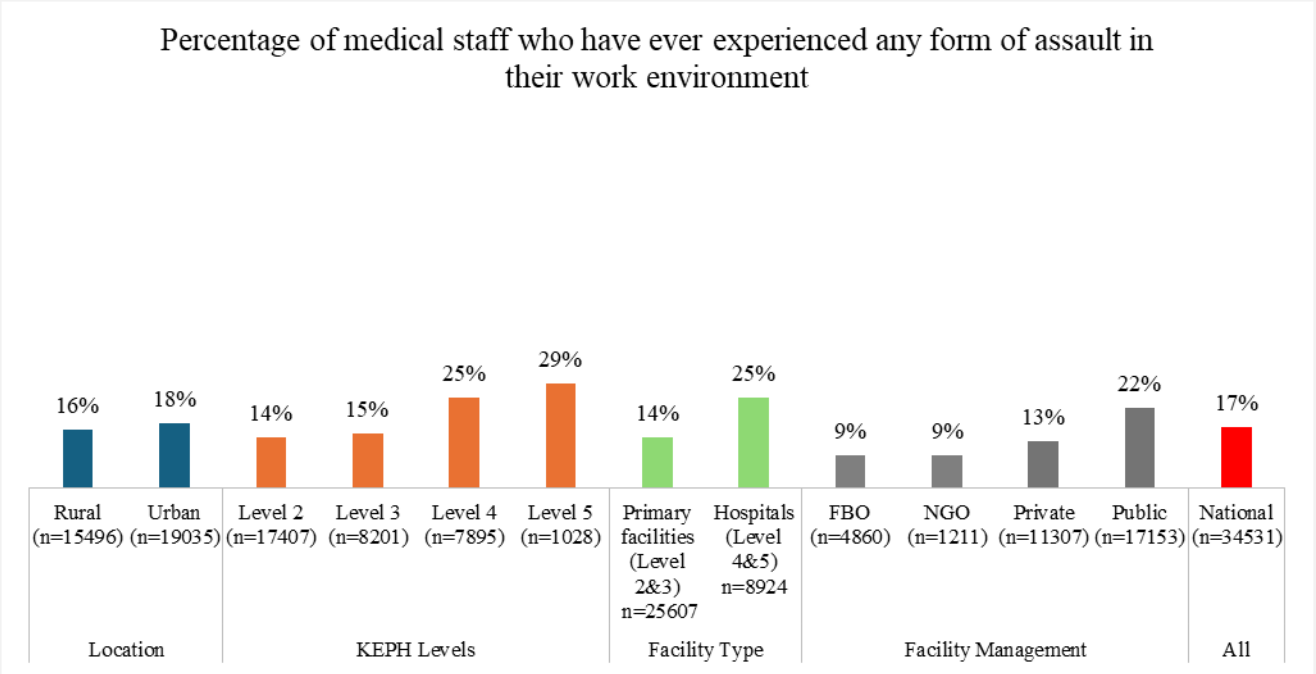
Figure 19: Average time sampled medical staff received their salary (n=34,531)



Workplace Violence and Assault

- 17% of healthcare workers reported being assaulted
- The majority of perpetrators were patients (77%) or their caregivers (22%).
- Busia County had the highest rate of reported assault (33%).

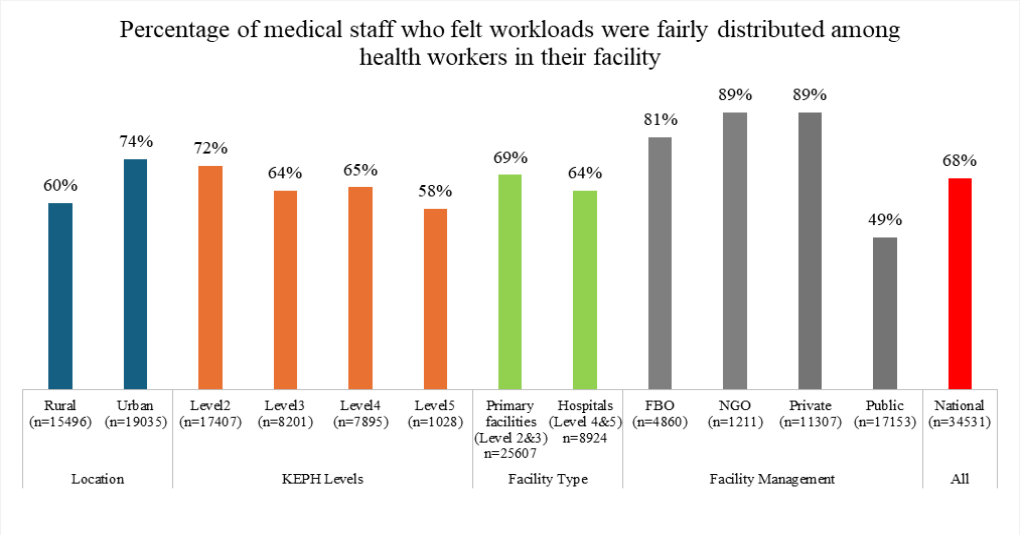
Figure 20: Percentage of medical staff who have ever experienced any form of assault in their work environment(n=34,531)



Job Satisfaction and Workload

- In Kenya, almost seven out of ten (68%) of medical staff felt that the workloads were fairly distributed among the health workers in their facilities.
- About three quarters (74%) of medical staff in the urban facilities felt the workloads were fairly distributed compared to 60% of staff in the rural facilities.
- More medical staff in Level 2 (72%) felt that the workloads were fairly distributed compared to staff Level 5 (58%) facilities.
- About half (49%) of the medical staff in public facilities felt the workloads were fairly distributed compared to more than 80% of staff in NGO, Private and FBO facilities.

Figure 21: Percentage of medical staff who felt workloads were fairly distributed among health workers in their facility



5.0: Human Resource Knowledge and Practice

Ensuring correct diagnosis is the first step in effective care, guiding proper case management and improving patient health and quality of life. The 2024 assessment tested how well health workers across Kenya diagnose illnesses, follow treatment guidelines, and keep accurate patient records.

Clinical Knowledge Assessment (Vignettes)

Health workers were tested using clinical case simulations (also called “vignettes”)
The findings were analyzed against the following indicators.

1. Correct diagnosis
2. Diagnostic accuracy
3. Adherence to clinical guidelines in diagnosis
4. Correct treatment based on clinical guidelines
5. Treatment accuracy
6. Health education

Each of the 5 indicators above was disaggregated by;

1. Cadre
2. KEPH Level
3. Facility ownership
4. Location (rural/urban)
5. Years of experience
6. County

What was assessed?

Six key conditions were used to evaluate knowledge:

1. Malaria

2. Pneumonia
3. Asphyxia of the newborn
4. Diarrhoea with severe dehydration
5. Postpartum haemorrhage
6. Hypertension

Key findings:

- Postpartum haemorrage was correctly diagnosed by 93% of the healthcare workers; an improvement in performance from the 90% that correctly diagnosed it in 2018 Service Delivery Indicator survey.
- A comparison of the performance in SDI 2018 and QoC 2024, showed a decrease in proportion of healthcare workers that correctly diagnosed birth asphyxia and pneumonia, from 88% to 76% and 82% to 79% respectively.

Correct Diagnosis

Across all cadres, 85% of the simulated cases were correctly diagnosed. Notably:

- Doctors had the highest diagnostic accuracy at 91%.
- Clinical officers followed at 87%, and nurses at 82%.

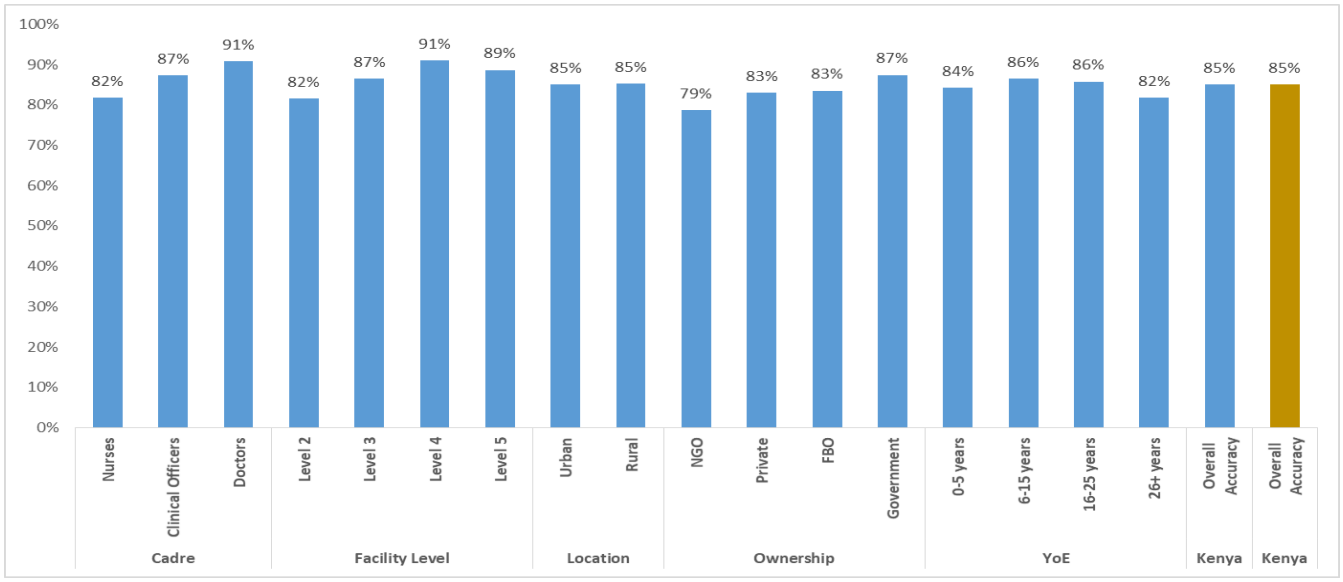
By condition, diagnostic accuracy was highest for:

- Hypertension and malaria (95%),
- Moderate for postpartum haemorrhage (93%), and
- Lowest for birth asphyxia (76%) and diarrhoea (76%).

Performance also varied by experience. Surprisingly, those with more than 26 years of experience were slightly less accurate (82%) compared to their less-experienced colleagues, suggesting potential gaps in the uptake of new clinical guidelines.

- Public sector workers had better diagnostic accuracy (87%) than those in NGO (83%), private, or faith-based organizations.

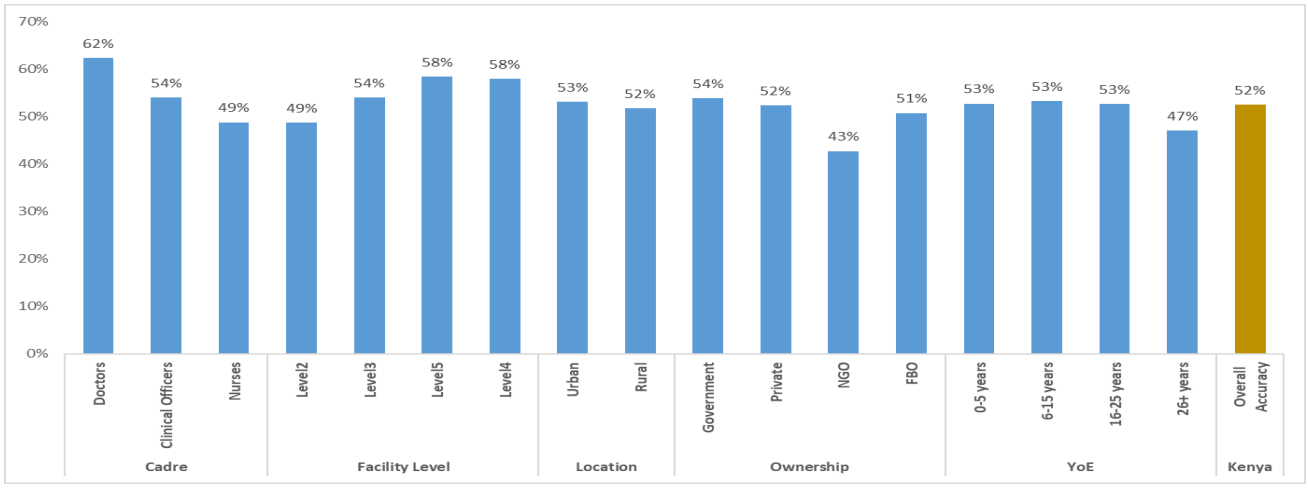
Figure 22: Proportion of six cases accurately diagnosed by healthcare providers by cadre; level of care; location; ownership and years of experience (N=34,712)



5.1 : Treatment accuracy:

- On average, slightly more than half (52%) of health workers gave the correct treatment across all six conditions.
- Enrolled nurses and junior clinical officers had the lowest accuracy rates.
- Medical officers and specialist providers were more likely to treat as per the follow national treatment guidelines

Figure 23: Treatment accuracy disaggregated by cadre, facility level, location, ownership and years of experience (N=34,712, (N=34,688 for years of experience))



An analysis of the average accuracy in the diagnosis of 5 clinical cases (malaria, diarrhoea, pneumonia, PPH and hypertension) and treatment of 6 cases (malaria, diarrhoea, pneumonia, PPH, birth asphyxia and hypertension by county is as shown in the table below;

Table 5: Accuracy in diagnosis vs treatment of the four cases by county

County	Diagnostic Accuracy	Treatment Accuracy	No. of Providers
Baringo	79%	43%	578
Bomet	76%	57%	487
Bungoma	89%	63%	840
Busia	86%	50%	522
Elgeyo-Marakwet	86%	51%	333
Embu	78%	39%	519
Garissa	94%	59%	323
Homa Bay	80%	42%	800
Isiolo	84%	44%	214
Kajiado	71%	44%	776
Kakamega	85%	53%	879
Kericho	77%	43%	564
Kiambu	71%	43%	1926
Kilifi	81%	63%	841
Kirinyaga	73%	39%	542
Kisii	93%	62%	981
Kisumu	88%	59%	1243
Kitui	87%	54%	689
Kwale	86%	54%	611
Laikipia	86%	51%	534
Lamu	89%	42%	194
Machakos	92%	51%	1208
Makueni	98%	59%	655
Mandera	98%	75%	447
Marsabit	94%	57%	313
Meru	83%	49%	1031
Migori	95%	52%	853
Mombasa	86%	54%	1029
Muranga	87%	53%	714
Nairobi	83%	48%	4648
Nakuru	82%	50%	1614
Nandi	86%	58%	581
Narok	95%	58%	385
Nyamira	98%	65%	477
Nyandarua	92%	52%	474
Nyeri	80%	52%	1043
Samburu	86%	54%	250
Siaya	92%	59%	534

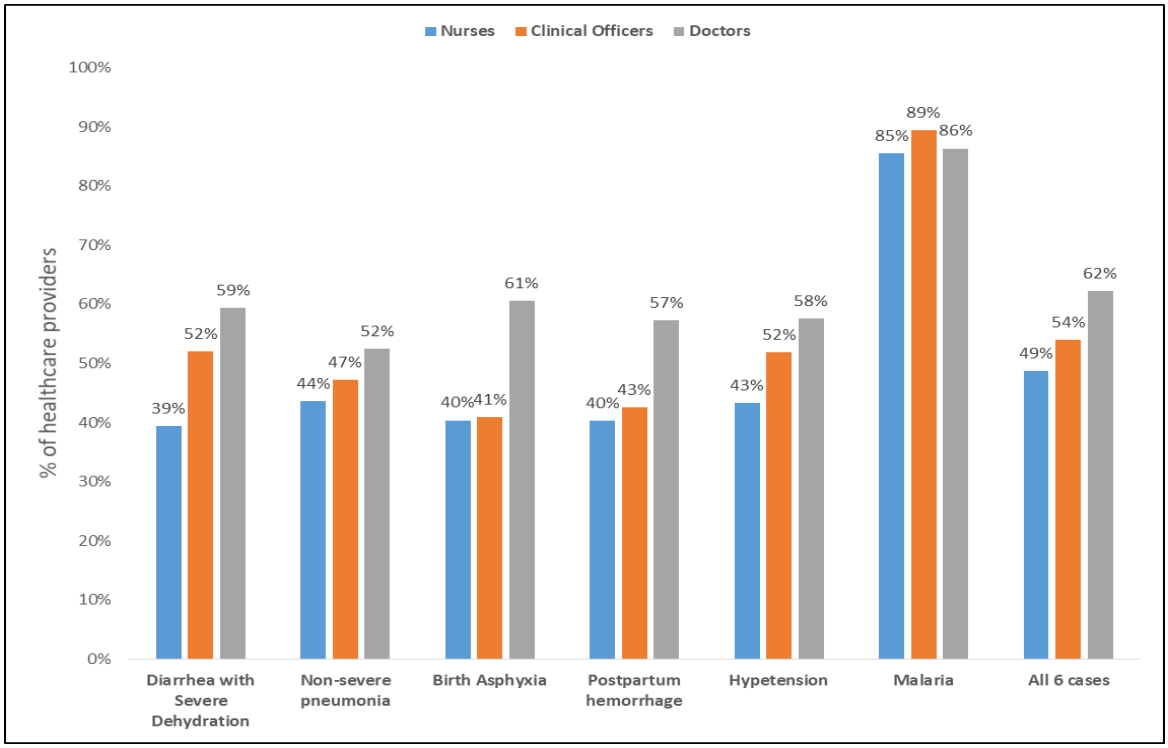
County	Diagnostic Accuracy	Treatment Accuracy	No. of Providers
Taita-Taveta	94%	68%	331
Tana River	80%	43%	159
Tharaka-Nithi	82%	49%	491
Trans-Nzoia	92%	47%	538
Turkana	80%	51%	602
Uasin Gishu	92%	61%	772
Vihiga	87%	60%	461
Wajir	98%	66%	403
West Pokot	100%	73%	303

5.2: Adherence to Guidelines

Even when diagnosis was correct, many providers did not follow the full clinical process, like checking vital signs or asking for relevant history.

- Health workers often skipped steps like using a partograph for labour monitoring or checking for danger signs in children.
- About two thirds of the doctors (62%) correctly managed all the six conditions compared to 54% and 49% of clinical officers and nurses respectively.
- Majority of clinical officers correctly managed malaria (89%) compared to 86% of doctors and 85% of nurses.
- The widest margin in correct management of the six conditions was for birth asphyxia which was correctly managed by 61% of the doctors compared to 40% of the nurses.

Figure 24: Proportion of healthcare workers who offered correct treatment by cadre (N=34,712)



Record-Keeping And Documentation

The survey reviewed patient files for delivery, HIV care, and TB treatment to see if important information was being recorded.

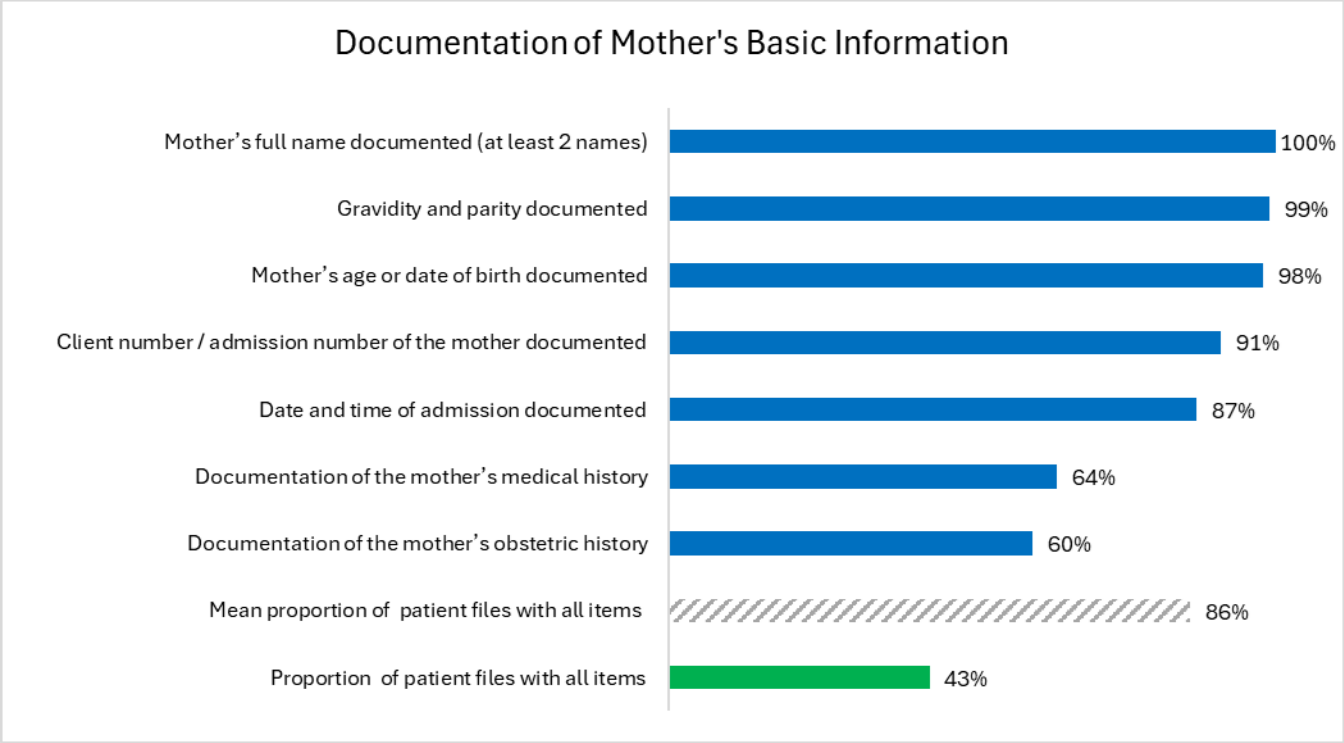
Delivery care records:

- Basic patient information was well-recorded in most files.
- However, partographs (used to monitor the mother and foetus during labour and also monitors progress of labour to allow for timely and effective decision making on the management of labour, complications and emergencies) were only completed in for a small number of cases.
- Postpartum checks for mother and baby were often missing in the records.

5.3: Documentation Of Mother's Basic Information

- Nationally, basic information of the mothers in the records were found to be well done with 100% of the records having at least 2 names of the mother documented, 98% of the records had either the age or date of birth of the mother, 99% had the gravidity and parity recorded and 91% had a client number or admission number.
- 87% of the records indicated the date and time of admission with lower proportion documenting the mothers' medical history (64%) and obstetric history (60%)
- Less than half of patient files (43%) had all seven parameters documented, despite an average of 86% per file

Figure 25: Documentation of Mother's Basic Information in patient files in maternity (n=7818)

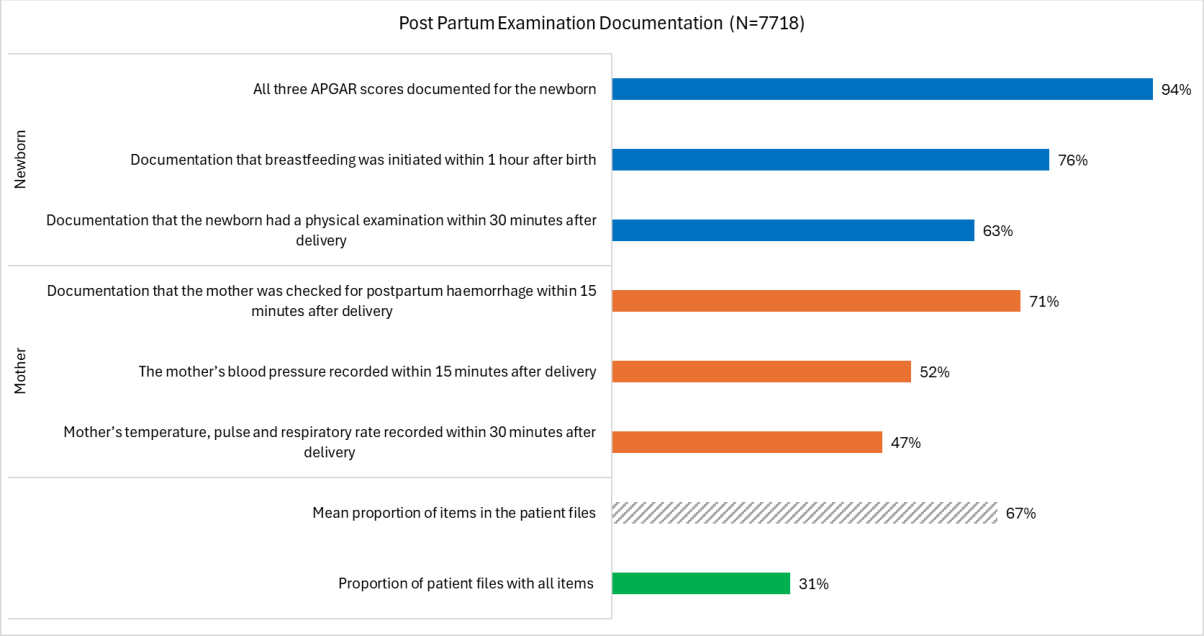


5.4 : Postpartum Examination

The assessment showed that postpartum monitoring for mothers was suboptimal.

- Only 47% of records documenting temperature, pulse, and respiratory rate within 30 minutes after delivery, and 52% recording blood pressure within 15 minutes.
- Documentation was better for checks on postpartum haemorrhage and initiation of breastfeeding, which were recorded in 71% and 76% of cases respectively.
- For newborns, APGAR scores were documented in 94% of records, while physical examinations within 30 minutes after birth were noted in 63% of cases.
- Nearly a third (31%) of the records had all six parameters documented.
- The mean proportion of items recorded in a file was 67% (four of the six parameters).

Figure 26: Documentation of postpartum examination of mother and newborn in patient files in maternity (n=7818)



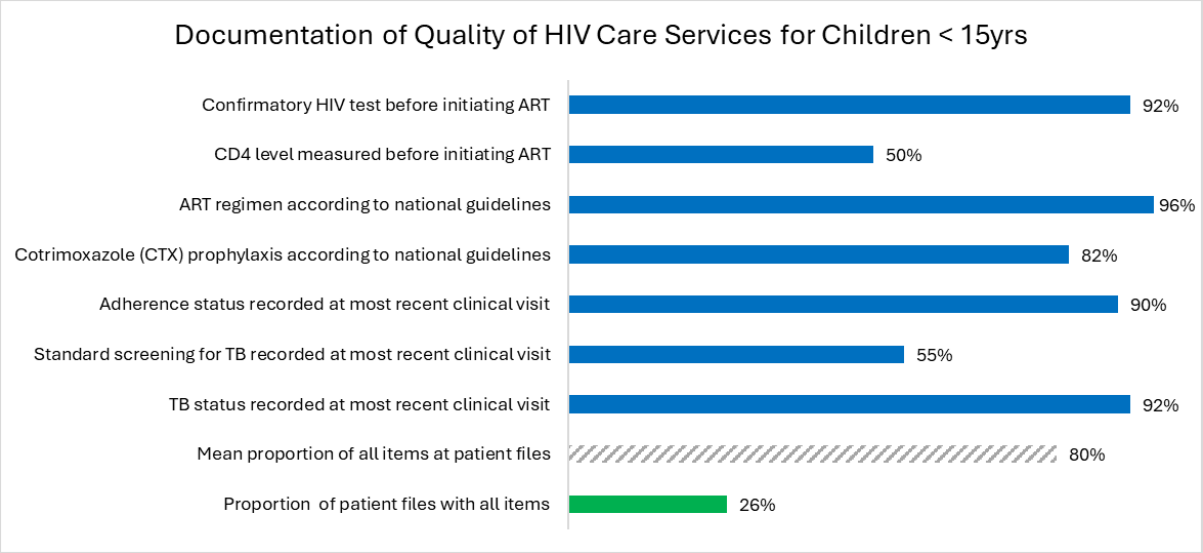
5.5: HIV Services:

- Most clients (92%) received a confirmatory HIV test before initiating ART, aligning with national guidelines for quality HIV testing services
- Only 50% of clients had CD4 testing at ART initiation, despite its recommendation for identifying advanced HIV disease
- A large proportion of clients (96%) were on ART regimens recommended by the national program, indicating effective treatment optimization efforts.
- Cotrimoxazole prophylaxis was provided to 82% of eligible clients, though uptake may have been affected by supply chain issues and unclear understanding of updated guidelines.
- Adherence status was recorded for most clients during recent visits.
- Whereas TB screening is recommended at every clinic visit, only 55% had this documented, suggesting a missed opportunity in TB case finding, even though 92% had their TB status recorded at the most recent visit.

- Only 26% of files had all items documented, though the mean completeness per file was 80%.

5.6: Documentation Of Select Services in Pediatric HIV Care

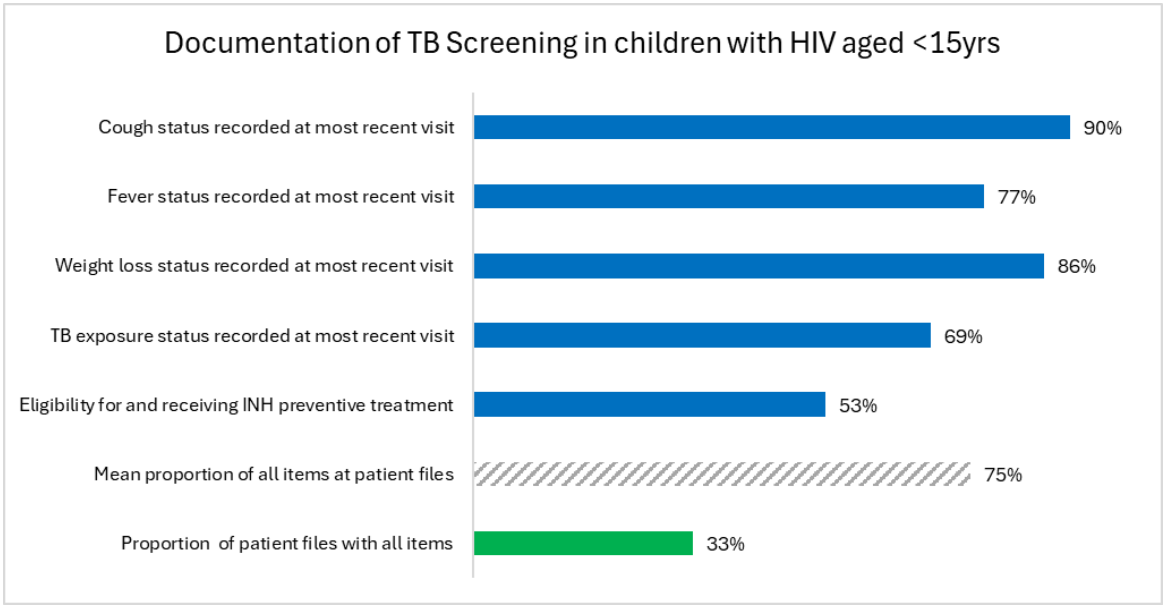
Figure 27: Documentation of select services in pediatric HIV Care (N=1734)



5.7 TB screening and treatment status in patient on ART

- Nationally, 90% of clients had their cough status recorded in line with TB screening and prevention guidelines, and 69% had their TB exposure status documented, as required during clinical visits for people living with HIV.
- Only 53% of clients eligible for isoniazid preventive therapy (INH) had records indicating they received the treatment, highlighting gaps in TB prevention efforts among patients on ART.
- The mean completeness was 75%, but only 33% of patient files contained all five items

Figure 28: TB screening and treatment status amongst patients on ART (N=1734)

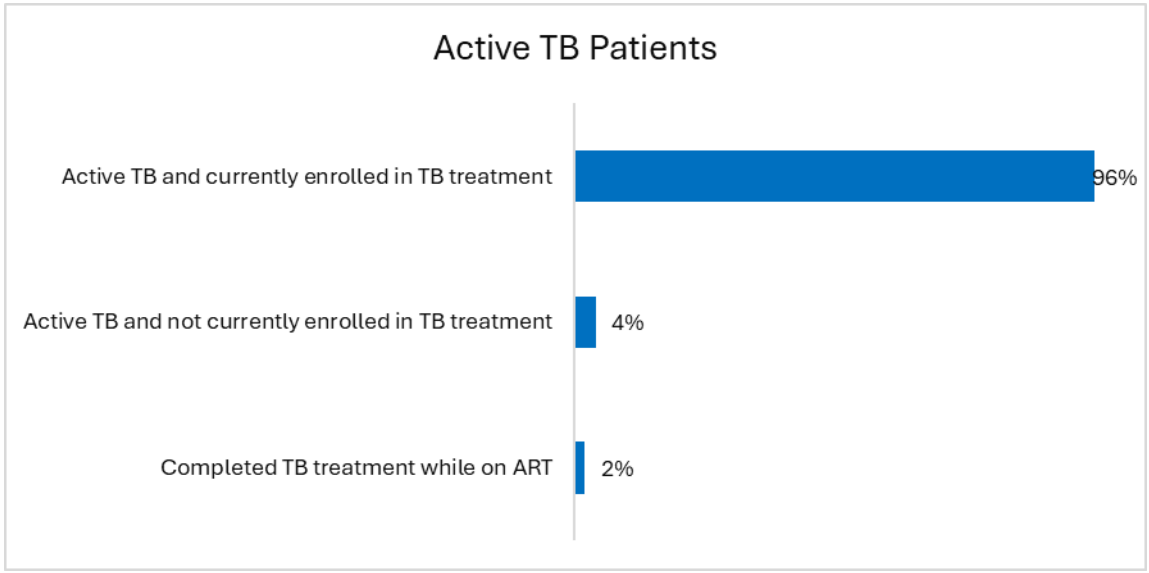


5.8: TB Treatment Status Amongst Active TB patients living with HIV

Of patients on ART with active TB,

- 96% were current on TB treatment while 4% were not. Those who had TB and had completed treatment while on ART were 2% and were not eligible for TB treatment.

Figure 29: Treatment Status for Active TB Patients on ART (N=59)



Tuberculosis (TB)

This quality-of-care assessment involved reviewing TB data from the TB4 Register, TB Record Card, and TPT/Contact Management Register to evaluate documentation.

The review focused on records of adult pulmonary TB clients (aged 15 and above) who had initiated treatment in the first six months of the prior year and remained on the national first-line TB treatment for at least six months.

Quality of TB Services

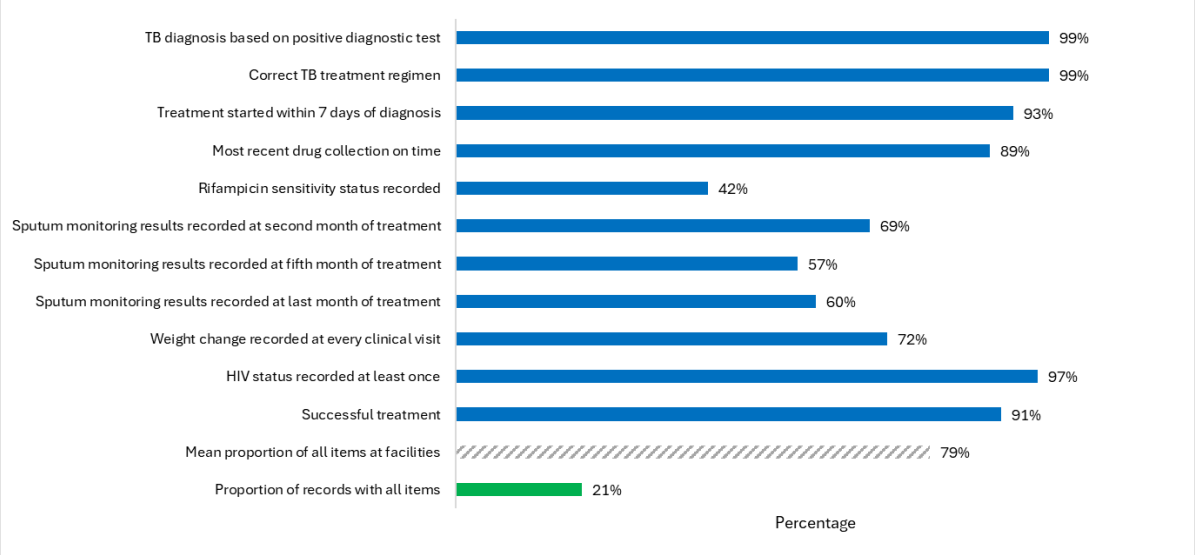
From the review of 4,999 records,

- There was high documentation of TB services, with 99% of clients diagnosed through positive diagnostic tests and started on the correct TB treatment regimen.
- Most clients were initiated on treatment within seven days of diagnosis and successfully completed their treatment.
- However, sputum monitoring at the fifth month of treatment was documented in only 57% of records.
- Despite the policy requiring Rifampicin resistance testing for all patients, only 42% had recorded results, likely due to limited access to GeneXpert testing.
- Less than 70% of clients had sputum monitoring documented at the 2nd, 5th, and 7th months of treatment. HIV test results were available in 97% of the records, 72% had

weight changes documented at each visit, and the overall treatment success rate was 91%.

- The average availability of services was at 79%, contrary to 21% of patient files containing all expected indicators

Figure 30: Percentage of TB clients with tracer quality indicators documented (N=4999)

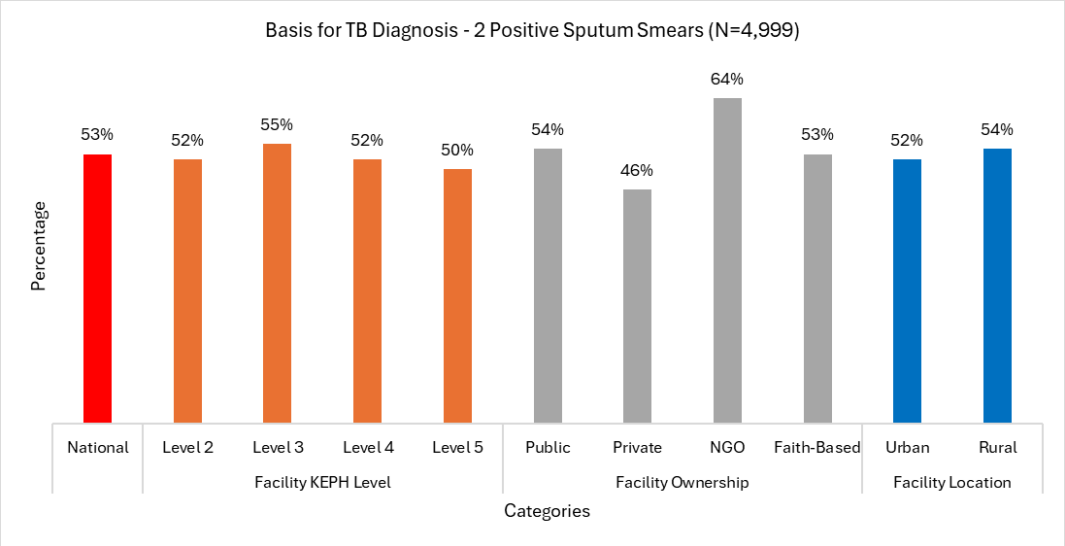


Documentation of Basis for TB diagnosis

The Kenya National Tuberculosis, Leprosy and Lung Disease Program (NTLD-P) Guidelines (2022) recommend that TB diagnosis by smear microscopy should include at least two positive sputum smears as part of bacteriological confirmation. Proper documentation of smear results is essential for accurate case classification, treatment initiation, and monitoring program quality. Of the 4,999 files reviewed, 53% of patients had two positive sputum smears documented.

- By ownership, NGO facilities had the highest docuwmentation of two positive smears at 64%, followed by public facilities at 54% and faith-based facilities at 53%. Private facilities reported the lowest performance at 46%.
- Documentation was comparable in urban (52%) and rural (54%) facilities while across facility levels, documentation of two positive sputum smears ranged from 50% at level 5 facilities to 55% at level 3 facilities

Figure 31: Percentage of TB clients with documented diagnosis based on various criteria (n=4,999)

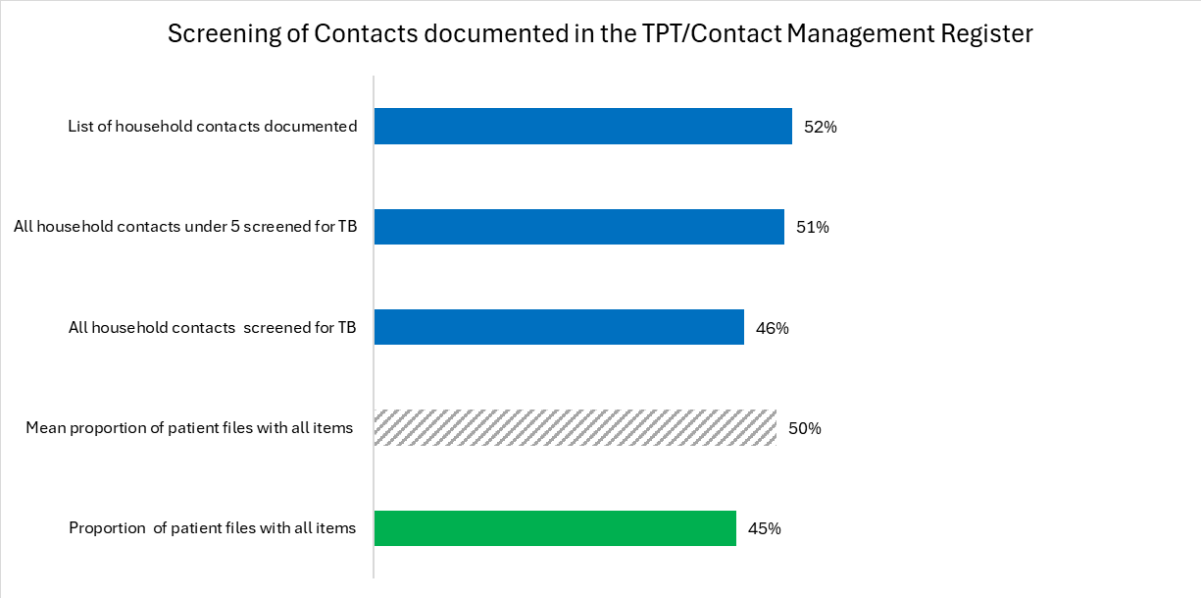


Documentation of screening of contact persons of TB patients

Out of 4,999 records reviewed,

- 52% had documented lists of household contacts, with 46% having all the contacts screened for TB and 51% all contacts under 5 screened.
- On average, 50% of items were documented, and 45% of patient files contained all required items.

Figure 32: Percentage of screening of contact persons of TB patients documented

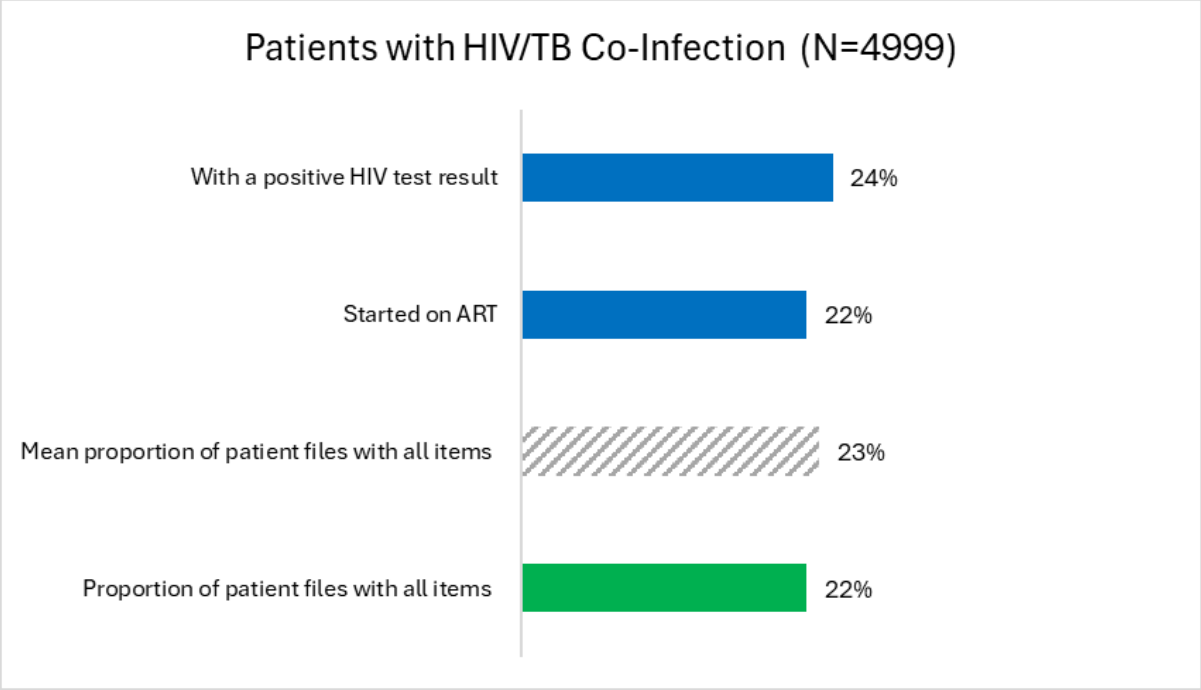


Documentation In Patients with Tb/ HIV Co-Infection

- Based on a review of 4,999 records in the TB treatment register (TB4) 24% of TB patients had a positive HIV test documented, and 22% were recorded as having been started on ART.

- The mean proportion of patient files with all items was 23%, and the proportion of files with all items documented stood at 22%.

Figure 33: : Percentage of TB clients tested for HIV and documented



6.0: Client-Centered Care

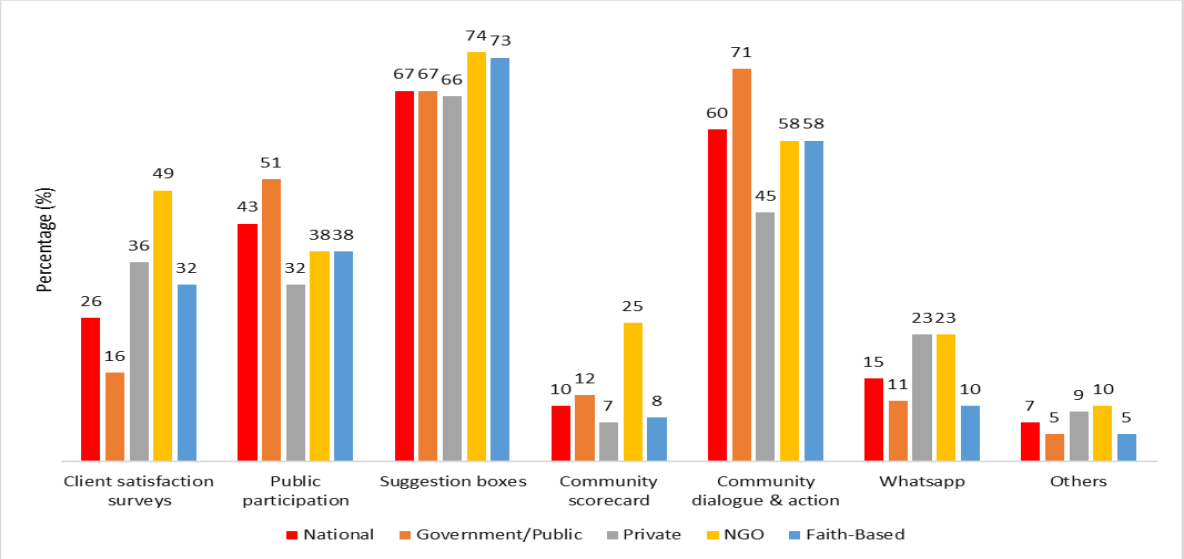
Quality health care services should be effective; safe, and Patient-centered (providing care that responds to individual preferences, needs and values). The Kenya Quality of Care Health Facility Assessment 2024 (QOC-HFA) evaluated how well facilities integrate the principles of client-centered care into service delivery. This included examining the extent to which patients' dignity, privacy, preferences, and feedback mechanisms are embedded in routine care processes.

The assessment's findings point to notable efforts in engaging clients, but also highlight systemic gaps that undermine the realization of respectful, responsive, and inclusive care especially at the lower levels of the health system.

6.1 Methods Used to Collect Client Feedback at Health Facility Level

- Suggestion boxes and Community dialogue and action were the most utilized mechanisms in engaging clients

Figure 34: Percentage of facilities implementing mechanisms to engage clients by ownership



6.2 Respectful And Dignified Care

Respectful maternity care and client dignity are at the core of universal health coverage.

- The assessment found that many facilities do not consistently adhere to standards of respectful care, particularly during sensitive services such as family planning, postnatal care, and maternal health.
- Despite growing awareness of patients' rights and advocacy efforts, a significant proportion of clients reported feeling rushed, inadequately informed, or not fully listened to during consultations.
- Patients in lower-level facilities and rural settings were more likely to experience breaches of confidentiality, limited interaction time with providers, and less counselling on available care options.

The findings emphasize the need to embed respectful care protocols, such as the Respectful Maternity Care Charter and Kenya's National Guidelines on Patient Rights and Responsibilities, into everyday health service delivery at all levels.

6.3 Privacy In Service Delivery

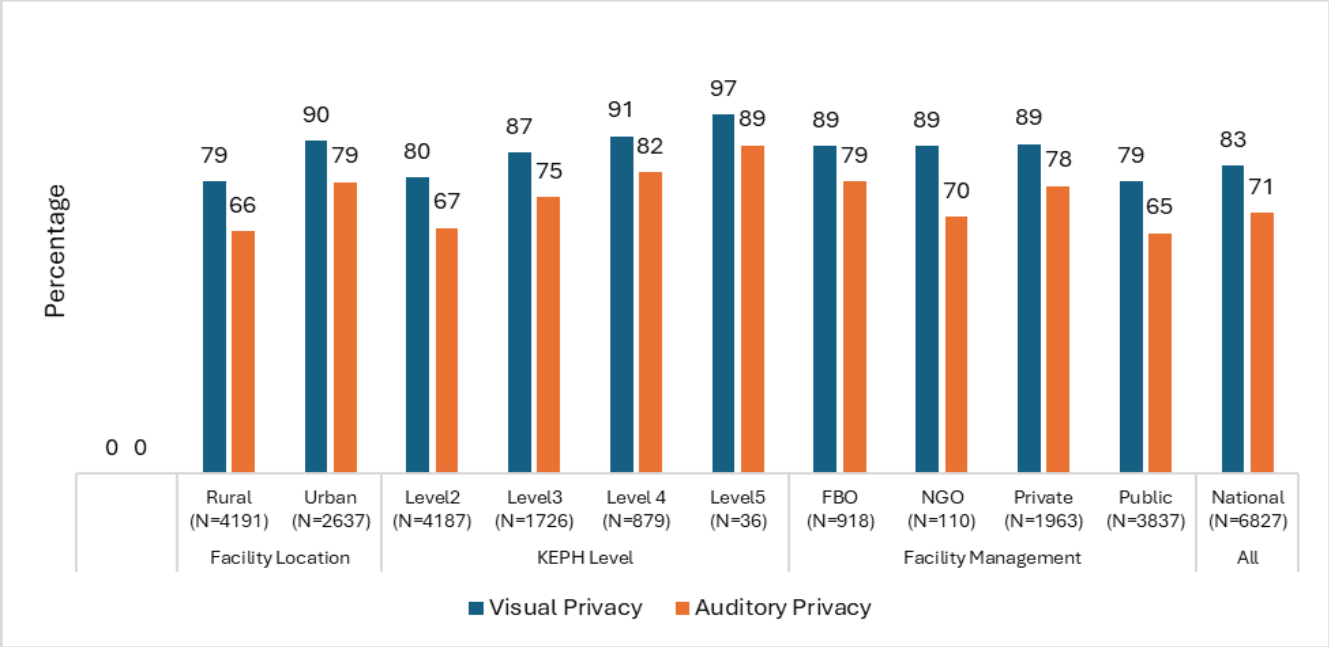
Privacy is a critical dimension of patient-centered care. It directly impacts how patients perceive their experience, particularly in services that involve personal or sensitive information, such as reproductive health, HIV services, mental health consultations, and maternal care.

The 2024 KQOC-HFA established that:

- Only about 60% of facilities offering family planning and postnatal care had dedicated consultation rooms that ensured both visual and auditory privacy.

- This figure was significantly lower in Level 2 and Level 3 facilities, where services were often delivered in open wards or partitioned spaces without doors or adequate soundproofing.
- Facilities in urban and private sectors generally performed better in privacy assurance than their rural and public counterparts.
- Of the 11,071 health facilities providing HIV services, 79% and 69% of the rooms used had visual and auditory privacy respectively. The highest privacy was provided at Level 5 facilities.
- Of the 6827 facilities providing post-partum services, 83% had visual privacy and 71% auditory privacy in the room used to deliver the services. Public health facilities had the least privacy with only 65% while level 5 facilities provided the highest level of privacy.

Figure 35: : Proportion of Facilities Providing Post-Partum Services with a Room with Visual and Auditory Privacy (n=6827)



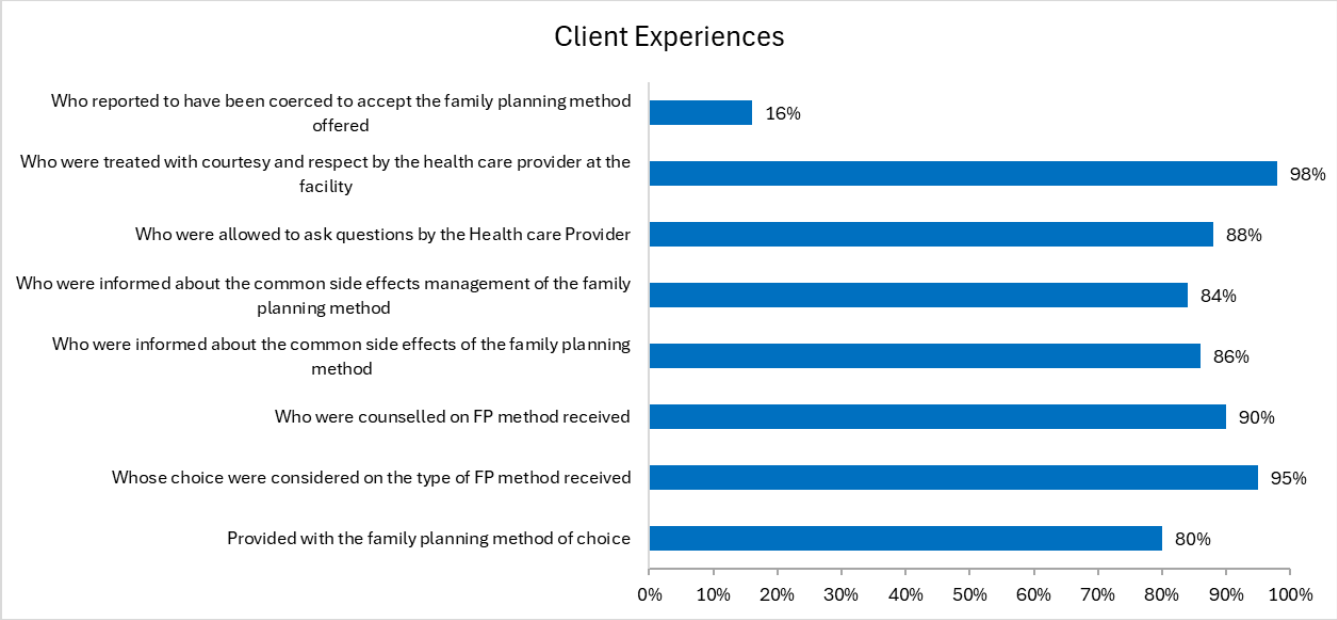
6.4 Family Planning Client Exit Interview

The FP interview was administered to clients who had visited the healthcare facility seeking FP services, including those receiving counseling for contraceptives, or any other reproductive health services related to family planning. The interview focused on the level of satisfaction and overall experience of clients with the FP services received.

6.4.1 Client experiences

- Of the sampled clients, 80% of were provided with their family planning method of choice, and 95% of clients felt their choice was considered in selecting the method.
- Clients receiving counselling remained high at 90%, with 86% being informed about common side effects and 84% being informed about managing these side effects.
- Notably, 88% of clients were allowed to ask questions, and 98% felt treated with courtesy and respect, while 16% of clients reported feeling coerced into accepting a family planning method.

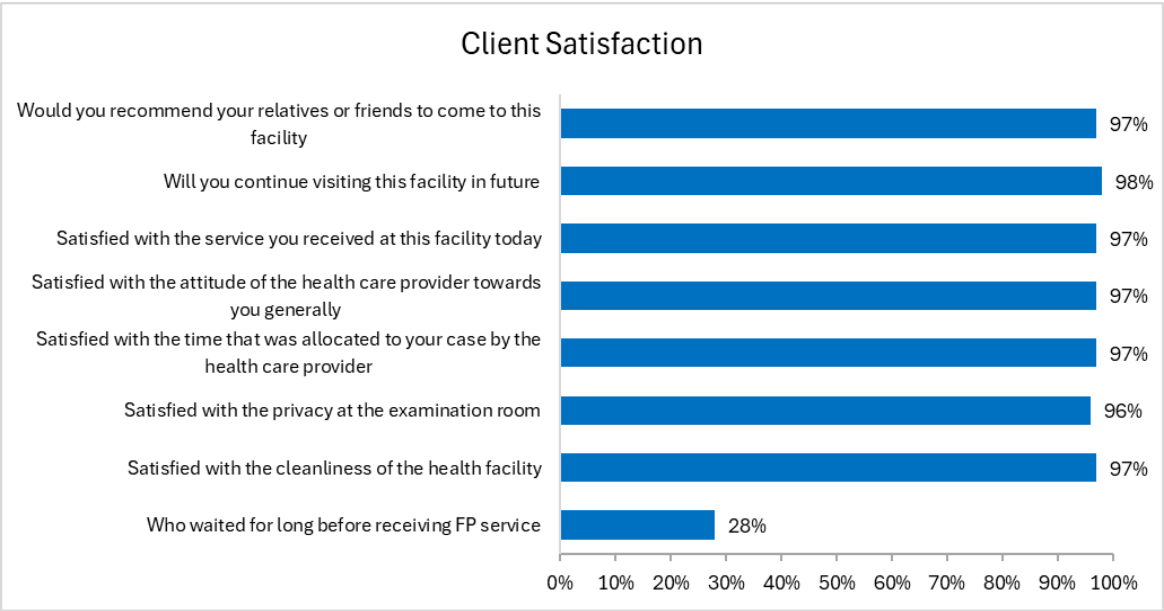
Figure 36: Percentage of FP client experiences on the FP services provided (n=1,601)



6.4.2 Client Satisfaction

- Almost all clients were satisfied with the quality of care provided, including cleanliness of the facility, time allotted to them by the healthcare provider and attitude of the healthcare providers towards them**.**
- Majority reported they would continue visiting the facility in the future and would recommend the facility to their relatives and friends. Satisfaction with the waiting time was however very low with 28% of the clients reporting having waited for long before receiving FP services.

Figure 37: Percentage of FP clients satisfied with the care provided (n=1,601)



6.4.3 Listening To Clients: Feedback And Engagement

An essential component of client-centered care is the systematic collection and use of patient feedback to improve service delivery. The QOC-HFA found that:

- Only 55% of facilities had a system in place to review performance based on client feedback or service data.
- Public (61%) and faith-based (68%) facilities were more likely to have such mechanisms compared to private facilities (36%).
- Even where systems existed, routine use of client data for decision-making was inconsistent, and often not linked to quality improvement plans.
- Regular community engagement platforms, such as health facility management committees or stakeholder forums, were absent in a significant number of facilities.
- Rural facilities were particularly constrained in mobilizing community participation due to limited staffing, logistical barriers, and weak linkages with county health departments.

These gaps present a missed opportunity to enhance transparency, build community trust, and create a culture of accountability. Facility-level planning and budgeting should be informed by patient voices, not just clinical metrics or external audits.

7.0 Quality of Care Index

Quality of Care: Structures and Processes Indices

This analysis evaluated the quality of healthcare using two frameworks: the Donabedian model (focusing on structures and processes) and the Institute of Medicine (IOM) quality domains (effectiveness, safety, and patient-centeredness).

Table 6: Indicators, data sources for structures & processes from the Kenya Health Facility QoC Assessment 2024 and the Kenya Health Facility Census 2023

Dimensions of Quality	Structures	Processes
Effectiveness	**Health Facility Level** ● General service readiness *(Basic amenities (QoC & KHFC), Basic equipment (KHFC), Standard precautions for infection prevention (QoC & KHFC) Diagnostic capacity (QoC), Essential medicines KHFC)* ● Service Specific Readiness (*NCD, CD, RMNCAH, Inpatient, Surgery, Emergency services) QoC* ● Availability of CMEs *(QoC)* ● Facility undergone external assessment *(QoC)* ● Quality improvement team in place *(QoC)*	● Patient Record Review (Overall score for Childbirth/Delivery, HIV and TB Care) *(includes documentation of files with All Mothers's biodata captured, All Partograph Documentation captured, All Post partum Documentation captured, files with CD4 level measured before initiating ART, files with ART regimen according to national guidelines, files with Cotrimoxazole (CTX) prophylaxis according to national guidelines, files with Adherence status recorded at most recent clinical visit, files with Standard screening for TB recorded at most recent clinical visit, files with TB status recorded at most recent clinical visit, files with all Quality of ART & HIV Clinical Care captured, files with all HIV Services for Children, files with Screening of contact persons, files with Basis for diagnosis, files with Quality of TB services) (QoC)* ● Daily Scheduled ward rounds in medical wards/cadres *(QoC)* ● Multidisciplinary ward rounds per week *(QoC)*

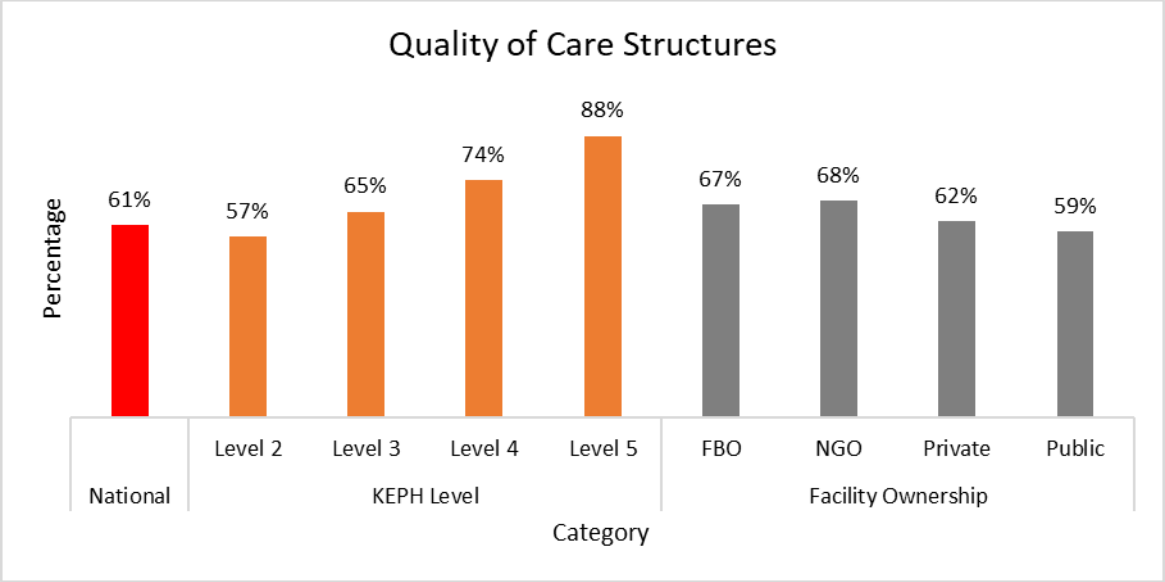
Dimensions of Quality	Structures	Processes
	• Percentage of public facilities budget funding (FY 2022/2023) above and equal to 75% *(QoC)* **Health workers** • Percentage of facilities that meet the HR norms (Levels 2 to 4) *(QoC)* • Health-provider (*knowledge and ability (mean score for diagnostic accuracy and correct treatment) QoC*	• Supportive supervision in the 12 months prior to the survey *(QoC)* • Use of electronic medical records or medication order entry systems in the pharmacy *(QoC)* • Adherence to Clinical Guidelines in Diagnostic Process *(QoC)*
Patient Safety	• Patient safety incidence monitored *(medication errors, surgical errors, HAIs, Blood transfusion Errors) QoC* • Mechanism for patient safety identification and management of adverse events *(QoC)* • IPC committees *(QoC)* • Functional waste segregation in the wards *(QoC)* • Have a National policy on patient safety *(QoC)* • Have a Laboratory system for documenting or tracking movement of specimen *(QoC)* • Have a functional MDT and Antimicrobial team for Antimicrobial stewardship activities *(QoC)*	• Have patient safety incidence monitored (medication errors, surgical errors, HAIs, Blood transfusion Errors) *(QoC)* • Conduct medication reviews on patients on chronic treatment *(QoC)* • Conduct surveillance for patient safety incidence *(QoC)* • Conduct Death reviews *(QoC)*
Patient Centeredness	• Protocol for systematic triage for patient in order of severity *(QoC)*	• Payment prior to the provision of emergency care isn't required *(QoC)* • Provision of health education for acute diarrhea with severe dehydration *(QoC)* • Provision of health education for hypertension *(QoC)*

Structures Index

The structures index quantifies the availability of necessary building blocks in health facilities for effective, safe, and patient-centered care.

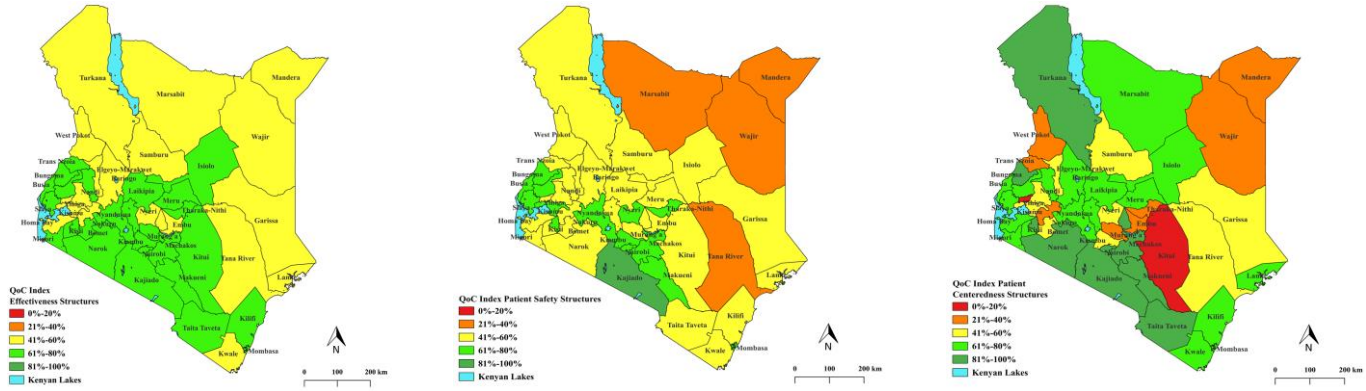
- Nationally, the overall structures index score is 61%. Hospitals (Level 5 at 88% and Level 4 at 74%) show higher scores compared to primary health facilities (Level 3 at 65% and Level 2 at 57%).
- Non-governmental Organization (NGO) owned facilities have the highest structures score at 68%, followed by FBO (67%), private (61%), and public facilities (59%).

Figure 38: Quality of care structures indices



- Among counties, the structures effectiveness index ranged from 41–80%, with most counties scoring 41–60%. The patient safety structures index ranged from 21% to above 80%, with Mandera, Wajir and Vihiga scoring below 41%. Patient-centeredness showed the widest variability, with nine counties scoring above 80% while Vihiga and Kitui scored below 20%.

Figure 39: Quality of care Structures indices by County

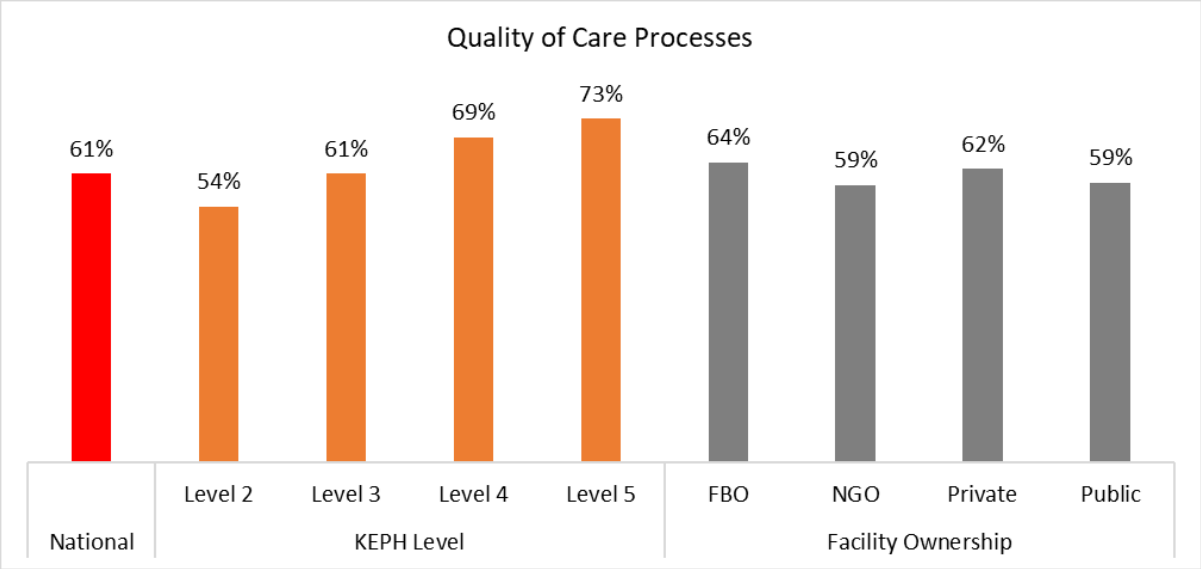


Process Index

The Processes Index measures the implementation of standardized, evidence-based clinical and administrative procedures to support consistent, high-quality service delivery aligned with the IOM principles.

- Nationally, the overall Processes Index score is 61%. Hospitals (both Level 4 and 5) have a much higher processes index compared to primary healthcare facilities (Level 2 at 54% and Level 3 at 61%).
- Among ownership the processes index varied fairly across with FBO (64%) and Private (62%) facilities having a slightly higher index that their counterparts NGO and Public at 59% .

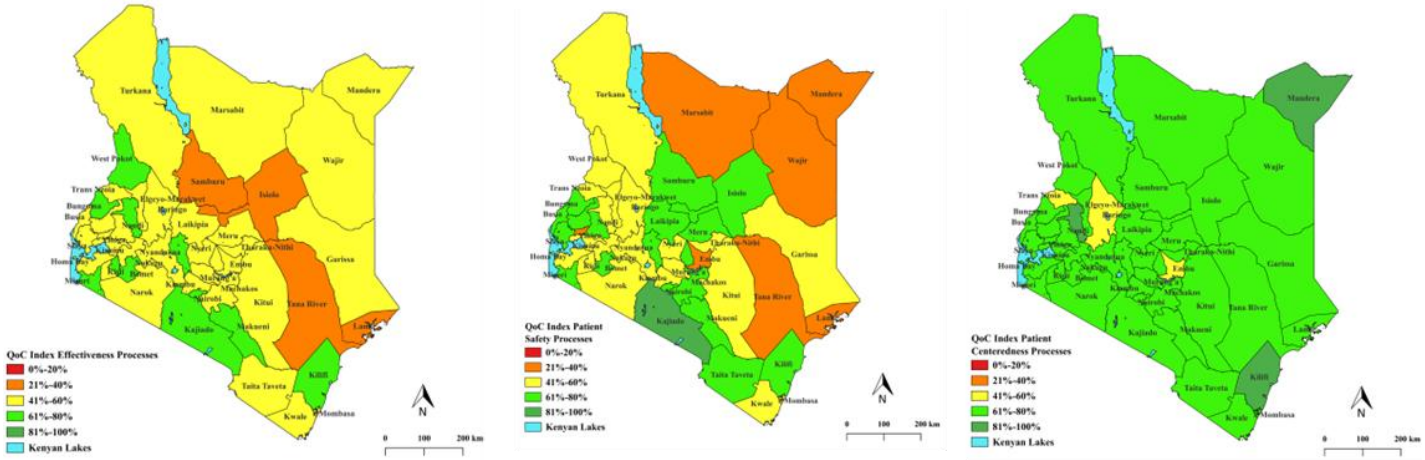
Figure 40: Quality of Care processes Indices



shows the county distribution of processes index score by IOM domain.

- Majority of the counties had an effectiveness process index ranging from 41% to 60%. Four counties namely Samburu, Isiolo, Tana River and Lamu had an index score below 41%.
- A largely average performance (21%-60%) was seen for patient safety processes index score across most counties
- Patient-centeredness processes index scores vary, with Mandera, Nandi, and Kilifi (81%) having the highest scores.

Figure 41: Quality of Care Processes indices by county



9.0 Contextual Report

While the 2024 Kenya Quality of Care Health Facility Assessment (KQOC-HFA) provided comprehensive and structured insights into the quality of healthcare across the country, it also uncovered critical contextual challenges that impact service delivery and quality of care. These issues were observed outside the scope of standard survey tools and methodologies but are essential in interpreting the performance of facilities, especially, in underserved and fragile contexts.

This section outlines the systemic, environmental, and governance-related barriers that were identified during fieldwork and interviews with facility staff and county representatives. Addressing these challenges is essential for realizing equitable and sustainable improvements in healthcare quality, particularly in counties facing prolonged underinvestment and insecurity.

9.1 Denied Access and Inaccessibility

Data collection teams reported difficulties in accessing specific facilities across counties due to a variety of administrative and security-related constraints:

- In Garissa County, Médecins Sans Frontières (MSF)-run facilities declined to provide human resource data, citing data protection policies. The facility in charge stated that such data could only be accessed through MSF's country office in Nairobi or the international headquarters in Geneva. This hindered the comprehensiveness of the national human resources dataset.
- In Uasin Gishu and Kisumu Counties, certain private facilities refused access to enumerators without providing justifications. This reflects a broader concern over private sector participation in public health assessments, particularly where regulatory compliance and accountability are weak.

- In Marsabit County, four health facilities could not be visited due to insecurity and logistical difficulties associated with remote and conflict-prone terrain.

These cases reveal a critical need for improved access protocols, stakeholder engagement, and security coordination, particularly for future assessments in high-risk or privately managed locations.

9.2 Facility Misclassification and Structural Gaps

Misclassification of health facilities undermines accurate assessment, planning, and resource allocation. The 2024 assessment identified instances where Level 4 designations were not matched by requisite staffing or infrastructure:

- Facilities in Wajir, Embu, Nyeri, and Trans Nzoia counties were flagged for being listed as Level 4 hospitals while lacking essential features, such as theatres or medical officers, contrary to national service delivery norms and KEPH standards.

Additionally, the assessment observed that:

- Several Level 2 and 3 facilities were offering services beyond their designated scope, including inpatient care, major surgeries, and caesarean sections — procedures that should be reserved for higher-level facilities. The majority of these facilities were privately owned, suggesting inconsistencies in regulatory classification and licensing criteria.

These misclassifications raise concerns about patient safety, regulatory compliance, and the equitable distribution of specialized care. There is an urgent need for the Ministry of Health, in collaboration with county departments and the Kenya Medical Practitioners and Dentists Council (KMPDC), to review and rectify facility classifications based on actual service capacity.

9.3 Staffing Shortages, Transfers, and Absenteeism

Workforce-related challenges remain one of the most significant barriers to the consistent delivery of quality care. Across several counties, data collectors reported:

- Persistent staff shortages, particularly in rural and semi-arid regions. In numerous facilities, only one nurse or clinical officer was available to serve large populations, including for maternity and emergency services.

- Frequent and unpredictable staff transfers disrupted service continuity and community trust in the healthcare system. In some counties, frontline health workers were redeployed without timely replacements.

- High levels of absenteeism, especially in public sector facilities. Disaggregated data indicated that absenteeism was more prevalent in rural areas due to long travel distances, lack of accommodation, and difficult working conditions.

These findings point to systemic weaknesses in human resource management, including recruitment, deployment, and retention mechanisms. They also highlight the need for strengthened accountability systems, incentives for rural service, and targeted capacity building.

9.4 Infrastructure Gaps in Hard-to-Reach Areas

In many remote and underserved regions, physical infrastructure and utilities remain suboptimal or entirely lacking, impeding service readiness and safe care delivery. Assessment teams documented the following:

- Lack of electricity and running water, especially in Level 2 and 3 facilities in counties such as Tana River, Turkana, and Mandera.
- Absence of basic amenities such as clean toilets, private consultation rooms, or waiting areas, which compromised infection prevention measures and patient privacy.
- Poor road networks that limited access to referral services, medical supplies, and supervisory visits.

Insecurity and climate-related disruptions (e.g. floods or droughts) further complicated access and service delivery. These issues emphasize the need for infrastructure investments tailored to fragile settings, and integration of climate resilience planning in healthcare infrastructure development.

9.5 Weak Facility-Level Governance and Accountability

In several instances, the assessment found that weak local leadership, poor coordination, and limited financial autonomy undermined the effectiveness of health facilities:

- Many facilities lacked operational budgets, making it difficult to procure essential supplies or conduct facility-level planning.
- Facility-in-charges reported minimal decision-making authority on critical matters such as staffing, equipment maintenance, or service expansion.
- Inadequate engagement of Facility Management Committees (FMCs) or Health Facility Boards, particularly in rural areas, led to reduced community oversight and feedback.

These governance issues are compounded by limited data use in local decision-making. While data was being collected through tools such as DHIS2, very few facilities used this data to review performance, plan services, or engage stakeholders in quality improvement.

9.6 Systemic Nature of Challenges

Importantly, the issues described in this section are not isolated or incidental. They reflect underlying systemic weaknesses that cut across counties, ownership types, and levels of care. Challenges such as misclassification, understaffing, infrastructure deficits, and limited

accountability mechanisms are symptoms of broader governance, financing, and policy enforcement gaps.

Improving the quality of healthcare in Kenya will therefore require:

- Coordinated national and county-level investment in health system building blocks, especially workforce, infrastructure, and governance.
- A renewed regulatory focus to ensure that facilities meet minimum operating standards before service expansion.
- Enhanced planning, budgeting, and monitoring mechanisms, aligned with UHC goals and community priorities.
- Deliberate efforts to strengthen fragile health systems, particularly in Arid and Semi-Arid Lands (ASALs), border counties, and informal urban settlements.

Conclusion

The contextual findings from the KQOC-HFA 2024 reveal that technical and structural interventions alone are insufficient to address quality-of-care challenges. Real progress requires tackling governance, accountability, resource equity, and stakeholder engagement.

These insights should inform not only quality improvement plans but also policy reforms and fiscal strategies at both national and county levels. Only through such a holistic and coordinated approach can Kenya build a health system that is not only accessible, but truly resilient, responsive, and equitable.

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