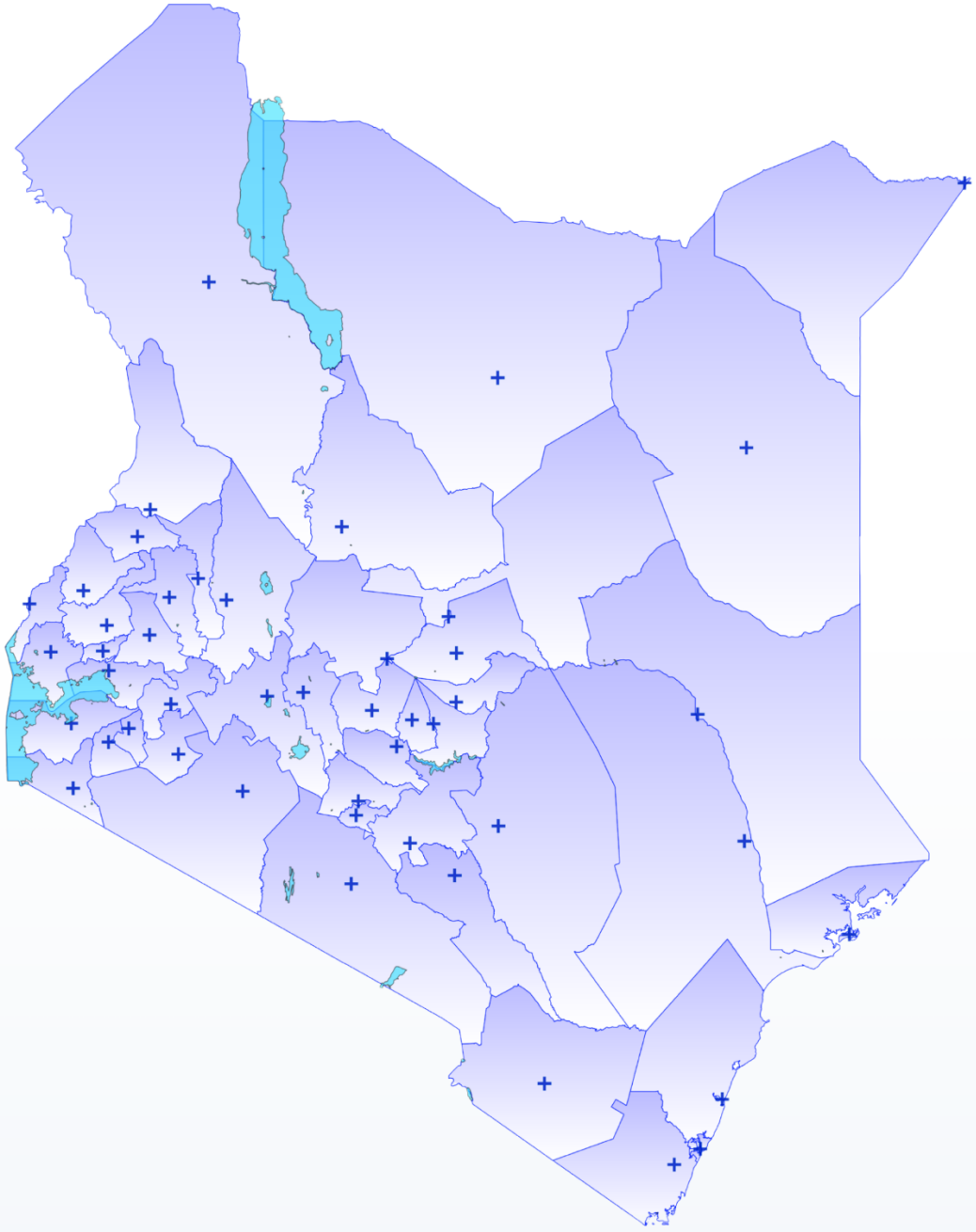
REPUBLIC OF KENYA

MINISTRY OF HEALTH



KENYA QUALITY OF CARE HEALTH FACILITY ASSESSMENT : SERVICE AVAILABILITY AND READINESS REPORT

Ministry of Health
Division of Health Sector Monitoring and Evaluation

POPULAR VERSION
2024

Preface

The Government of Kenya, through the Ministry of Health, remains steadfast in its commitment to achieving Universal Health Coverage (UHC) and delivering quality, equitable, and people-centered healthcare to all Kenyans. Central to this vision is the assurance that health services provided across all counties meet the highest standards of safety, effectiveness, and responsiveness.

This *Quality of Care Health Facility Assessment* represents a landmark effort to systematically evaluate the availability, readiness, and performance of health facilities in all 47 counties. The assessment provides critical insights into how our health system is functioning on the ground, highlighting both areas of excellence and those that require targeted investment and improvement.

The findings will serve as a guiding framework for policy formulation, resource allocation, and continuous quality improvement at all levels of the health system. They also reflect our commitment to accountability and transparency in ensuring that every Kenyan—regardless of location—has access to dignified, reliable, and high-quality health services.

I wish to recognize the invaluable contributions of our county governments, health workers, development partners, and communities whose collaboration has made this assessment possible. The Ministry will continue to strengthen such partnerships in order to drive progress towards a resilient health system that leaves no one behind.

It is my hope that this report will be used as a practical tool by policymakers, county leadership, facility managers, and frontline providers to accelerate improvements in service delivery. Together, we can transform Kenya's health sector into one that guarantees quality care for every citizen.

Hon. Aden Duale, EGH
Cabinet Secretary
Ministry of Health

Foreword

The Government of Kenya remains steadfast in its commitment to advancing Universal Health Coverage (UHC), ensuring that all citizens have access to safe, affordable, and high-quality healthcare. Quality of care is central to this vision—without it, expanded access alone cannot deliver better health outcomes or inspire the confidence of our people in the health system.

The **Quality of Care Health Facility Assessment (QOC-HFA)** represents an important milestone in our ongoing efforts to strengthen the health sector. By systematically assessing the availability, readiness, and performance of health facilities across all counties, this report provides robust evidence on what is working well, where critical gaps remain, and how resources can be deployed more effectively. The findings particularly highlight the central role of health workers, infrastructure, and essential supplies in shaping the patient experience and improving outcomes.

This assessment also complements Kenya's broader health sector reforms, including the Kenya Health Sector Strategic Plan and the Universal Health Coverage agenda. By linking service readiness data to financing frameworks such as the **Social Health Insurance (SHA),** we are able to not only measure inputs and outputs, but also ensure accountability, efficiency, and value for money in health investments.

I call upon national and county governments, healthcare providers, and our development partners to embrace the insights from this report as a shared platform for action. Together, we must translate evidence into policy and practice, drive targeted interventions, and strengthen coordination across all levels of the health system.

Let us commit to building a health system that is people-centered, resilient, and capable of delivering high-quality care for every Kenyan—today and for generations to come.

Mrs. Mary Muthoni Muriuki, CBS
Principal Secretary
State Department for Public Health and Professional Standards
Ministry of Health

Dr. Ouma Oluga, OGW
Principal Secretary
State Department for Medical services
Ministry of Health

Acknowledgment

The successful design, implementation, and completion of the **Quality of Care Health Facility Assessment (QoC-HFA)** would not have been possible without the invaluable contributions of many individuals and institutions. The Ministry of Health extends its sincere appreciation to all stakeholders whose collective efforts, technical expertise, and financial support were instrumental in realizing this important initiative.

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

Special commendation goes to the core team that steered the implementation of this work with dedication and commitment. In particular, we recognize the leadership of Dr. Charles Kandie and Dr. Helen Kiarie, as well as the contributions of 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. We also extend appreciation to all technical officers from the Ministry of Health, the Kenya National Bureau of Statistics, and the National Council for Population and Development (full list annexed) for their invaluable input.

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

We extend special thanks to healthcare providers and facility managers for their openness and participation, and to the clients who shared their experiences, reminding us of the importance of patient-centered care. We also commend the dedication of the research teams and data collectors, whose professionalism ensured the integrity and reliability of the findings.

Lastly, we acknowledge the Countdown to 2030 Kenya Country Collaboration Team—comprising the 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 gratitude for making this initiative a success.

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

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EXECUTIVE SUMMARY

Introduction

In 2024, the Ministry of Health, in collaboration with national and county stakeholders, undertook the Quality of Care-focused Harmonized Health Facility Assessment (QoC-HHFA) to evaluate the current state of healthcare services across Kenya. This assessment contributes to the country's efforts toward achieving Universal Health Coverage (UHC), as outlined in the Bottom-Up Economic Transformation Agenda (BETA). The findings serve as a foundation for evidence-based planning, resource allocation, and targeted health systems improvements.

Objectives of the Assessment

The QoC-HHFA was designed to:

- Assess the availability of essential healthcare services across the Kenya Essential Package for Health (KEPH) levels.
- Evaluate facility readiness to deliver quality services, including infrastructure, equipment, human resources, medicines, and guidelines.
- Identify gaps and barriers affecting service delivery and care outcomes.
- Inform national and county-level policy formulation and health sector investment.

Scope and Coverage

The assessment covered all 47 counties and included 13,361 health facilities across public, private, faith-based, and NGO sectors. The facilities were categorized into four KEPH levels: Level 2 (dispensaries), Level 3 (health centres), Level 4 (primary hospitals), and Level 5 (county referral hospitals). The survey assessed a wide range of service areas, including governance, quality assurance, infrastructure, workforce, and disease-specific services.

Key Findings

Service Availability

- Essential services such as outpatient care, maternal and child health, and communicable disease management were widely available.
- Services for non-communicable diseases (NCDs), cancer, mental health, and palliative care were limited, particularly in lower-level and rural facilities.

Service Readiness

- Higher-level facilities (Levels 4 and 5) demonstrated better service readiness across most domains compared to Levels 2 and 3.
- Public facilities generally performed better in readiness indicators compared to private facilities.

- Notable readiness gaps included staff availability, consistent supply of essential medicines, diagnostic capacity, and use of clinical guidelines.

Governance and Management

- Approximately 61% of facilities had functioning governance structures such as Health Management Teams and systems for performance appraisal.
- Mechanisms for engaging communities and conducting staff satisfaction surveys were present in 76% and 32% of facilities, respectively.
- Financial autonomy remained limited, with many public facilities lacking authority to plan and manage budgets.

Systems to Support Quality of Care

- More than two-thirds (63%) of facilities had systems for continuous medical education (CME) and fewer than 60% had active Quality Improvement Teams or Maternal and Perinatal Death Surveillance and Response (MPDSR) committees.
- Supportive supervision and mentorship mechanisms were inconsistently applied across facilities.

Health Products and Technologies

- Availability of tracer medicines, diagnostic supplies, and medical equipment varied across counties and facility levels.
- Facilities managed by NGOs and faith-based organizations generally reported higher levels of availability and stock consistency than public and private facilities.

Disease-Specific Services

- HIV and malaria services showed high availability and readiness across most counties and facility levels.
- Tuberculosis (including drug-resistant TB), sexually transmitted infections (STIs), and neglected tropical diseases (NTDs) had inconsistent service availability, particularly in lower-tier facilities.
- Services for diabetes, cardiovascular diseases, cancer, chronic respiratory diseases, and mental health were significantly underdeveloped in terms of both infrastructure and clinical capacity.

Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) and Nutrition

- Basic maternal and newborn care services were widely available across the country.
- Comprehensive Emergency Obstetric and Neonatal Care (CEmONC) services were mostly restricted to Level 4 and 5 facilities.

- Adolescent health services, postnatal care, and nutrition services were under-prioritized and under-resourced in most counties.

Conclusion

The 2024 QoC-HHFA reflects Kenya's continued progress toward Universal Health Coverage but also highlights persistent inequalities in access, quality, and readiness of healthcare services. To close these gaps, coordinated policy action, sustained investment, and multi-sectoral collaboration are required. The findings and recommendations of this report offer a strategic roadmap for strengthening the health system and improving health outcomes for all Kenyans.

INTRODUCTION

Background

The right to the highest attainable standard of health is enshrined in the Constitution of Kenya, 2010 (Article 43), and is further supported by national development frameworks such as Vision 2030 and the Kenya Kwanza Manifesto. These frameworks collectively prioritize the realization of Universal Health Coverage (UHC) through equitable access to quality, affordable, and responsive healthcare for all Kenyans.

As part of this national commitment, the Government of Kenya has implemented various reforms to improve the health system's capacity, structure, and responsiveness. Key reforms include legislative and institutional realignments, increased resource mobilization, and the integration of technology to improve service efficiency. The Ministry of Health, through the Department of Standards and Quality Assurance, has consistently undertaken facility-level assessments to monitor health service delivery and guide improvements.

In 2024, the Ministry of Health conducted the Quality of Care-focused Harmonized Health Facility Assessment (QoC-HHFA), building upon prior assessments such as the 2018 Kenya Harmonized Health Facility Assessment (KHHFA). This initiative aimed to evaluate both the availability and readiness of services offered across health facilities in all 47 counties. The 2024 assessment is a critical step toward achieving UHC by 2030 and supporting the national health policy and strategic frameworks.

Kenya's Health System Overview

Kenya's health system is organized into a six-tier framework under the Kenya Essential Package for Health (KEPH), ranging from community-based services to tertiary referral care. The system is decentralized, with county governments responsible for implementing health services while the national government handles policy formulation, regulation, and resource mobilization.

Over the years, Kenya has made significant gains in service coverage. According to the Kenya Demographic and Health Survey (KDHS) 2022:

- Skilled birth attendance improved from 66% in 2014 to 89% in 2022.
- Unmet need for family planning declined from 35% to 14%.
- At least one antenatal care visit from a skilled provider was reported by 98% of women, and 66% had four or more visits.
- Immunization coverage reached 80% for children aged 24 months.

Despite these achievements, challenges persist. Maternal mortality remains high, with the UN Maternal Mortality Estimation Interagency Group (UNMMEIG) reporting 379 maternal deaths per 100,000 live births for 2023. Neonatal and child mortality also continue to be areas of concern, particularly in underserved and remote counties.

Rationale for the Assessment

Although routine health information systems such as DHIS2 provide valuable data on health service utilization, they fall short in capturing information on the quality and readiness of services. The QoC-HHFA was designed to fill this gap by systematically assessing facility-level availability of services and their readiness to deliver quality care.

Key reasons for conducting the QoC-HHFA include:

- Evaluating structural and operational inputs required for effective service delivery.
- Assessing alignment with national guidelines and essential service packages.
- Identifying variations in service availability and readiness by county, facility level, and managing authority.
- Providing data to support planning, financing, and implementation of UHC priorities at both national and county levels.

Assessment Objectives

The specific objectives of the QoC-HHFA were to:

- Determine the availability of health services across KEPH levels.
- Assess the readiness of facilities to provide these services, including staffing, equipment, supplies, and adherence to clinical standards.
- Examine governance, management systems, and quality improvement mechanisms.
- Generate evidence for policymakers and stakeholders to guide investments, health system reforms, and quality enhancement strategies.

Structure of the Report

This report is organized into thematic sections focusing on specific service areas and health system functions. Each section presents findings on service availability, service readiness, and quality improvement systems. Relevant annex tables provide additional county, facility type, and ownership-specific data to support detailed interpretation and action planning.

METHODOLOGY

Study Design and Approach

The Kenya Quality-of-Care focused Harmonized Health Facility Assessment (QoC-HHFA) 2024 was designed as a multi-agency, collaborative initiative led by the Ministry of Health, in partnership with County Governments, the Council of Governors (CoG), the National Council for Population and Development (NCPD), the Kenya National Bureau of Statistics (KNBS), academic institutions, and development partners. The assessment applied a harmonized and consultative approach, leveraging technical expertise to design a comprehensive tool that integrates key quality and service readiness indicators.

The technical working group adapted and integrated indicators from existing assessment tools and frameworks, including:

- Health Facility Assessment (HFA)
- Service Delivery Indicators (SDI)
- Kenya Quality Model for Health (KQMH)
- Kenya Health Facility Census
- WHO Harmonized Health Facility Assessment (HHFA) methodology

The QoC-HHFA evaluated structures, processes, and outcomes of health services using the Donabedian model, which links health system resources (structure), delivery practices (process), and client outcomes (results). The model allowed for systematic evaluation of service delivery gaps and areas needing targeted improvement.

Assessment Modules and Focus Areas

The assessment addressed the following thematic modules:

- **Service Availability**: Physical presence of infrastructure, staff, essential services, and utilities.
- **Service Readiness**: Capacity to deliver services, including equipment, guidelines, staffing, and diagnostics.
- **Quality and Safety of Care**: Delivery of safe, effective, timely care, including adherence to standards, provider competence, and client experiences.
- **Management and Financing**: Supervisory structures, financial management practices, use of information for decision-making.
- **Human Resources for Health (HRH)**: Workforce capacity, training, deployment, and satisfaction.
- **Client Perspective**: Satisfaction with family planning services through exit interviews.

The following service areas were assessed;

Table 1: Assessed service areas

Area	Focus
County Health Department	Evaluated governance, leadership, and resource allocation at the county level.
Health Facility	Assessed available services and infrastructure, equipment, and commodities necessary to provide the services
Human Resources for Health	Assessed staffing levels, provider competency, and the work environment
Record Reviews	Assessed clinical and administrative records for service delivery trends and quality benchmarks.
Client Exit Interview	Collected client feedback on their experiences and satisfaction with family planning services.

Data Collection Tools

A total of seven tools were deployed through Computer-Assisted Personal Interviews (CAPI), using tablets programmed with CSPro software. Data collection was conducted electronically and securely uploaded to a centralized KNBS server. Each tool targeted a different respondent and assessment domain:

Table 2: QoC-HHFA 2024 survey tools

Survey tool	Main respondent	Description	Structure and Processes assessed
			Structure
1. County Health Department Questionnaire	County Director for Health	This tool focused on governance and management at the county level and had the following subsections. • Routine and Preventive Maintenance • Governance and Management • External Supervision • Health Financing and Accounting • Accountability Systems • Quality Assurance and Quality Improvement	• Management Systems (committees etc.) • Monitoring Systems • Supplies • Equipment • Certification and Standards

Survey tool	Main respondent	Description	Structure and Processes assessed
			Structure
2. Heath Facility Audit Questionnaire	In charge of the respective departments and service areas at the facility*	This tool sought information on each service area-specific topic/area for a defined set of indicators The modules included were; • Availability • Readiness • Governance and management structures • Practices • Quality & safety of healthcare	
3. Human Resource Roster	In charge/administrator in the health facility	Used to gather detailed information about the healthcare personnel providing medical services in health facilities. Collected line data of health workers from 22 cadres of interest and included the following details; • Name of the health workers • Cadre • Sex • Age • Highest level of education • Highest level of medical training • Trainings in last 2 years • Years worked	Health Workforce
			Process
4. Work Environment / Occupational Health and Safety	Health worker sampled for individual interviews	This tool assessed the following key elements. • Promotions in the last 3 years • Payment of salaries • Experience of assault (Physical, verbal, or any other) • Distribution of workload • • Satisfaction working at the health facility.	Health Workforce (through health worker interviews)

Survey tool	Main respondent	Description	Structure and Processes assessed
			Structure
		• Factors likely to improve ability to provide good quality of the ability to provide good quality care services.	
5. Diagnostic Accuracy/ Clinical Vignettes	Eligible health workers (medical officers, clinical officers, and nurses) who are sampled for interviews based on the eligibility criteria	• This tool assessed the clinical knowledge of the health workers on the diagnosis and management of six clinical cases • The eligibility criteria was health workers who conduct general out-patient consultations at least once a week and available on the day of the interview	
6. Record Review	Eligible clinical records	Review clinical records/files for completeness and accuracy documentation of care provided in specific service areas Target records were; • HIV-HTS records • HIV-ART records • TB records • Maternity records	Clinical records
7. Family Planning Client Exit Interview	Clients (men and women 18-54 years) 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	Tool sought to gauge the level of satisfaction and overall experience of clients with the services received	Patients/ Clients (through patient/client interviews)

Survey tool	Main respondent	Description	Structure and Processes assessed
			Structure
**Management and finance, Quality of care, Non-Communicable diseases, Communicable diseases, RMNCAH, Surgical Services, In-patient services (medical ward), Emergency Services, Laboratory Services and Diagnostics, Transfusion Services, Anti-Microbial Resistance (AMR)/ Infection Prevention Committee (IPC) /Patient Safety, Pharmacy Services*			

Sampling Strategy

The Kenya Health Master Facility Registry (KHMFR) and the 2023 Health Facility Census were used to construct the sampling frame. This provided a comprehensive and up-to-date database of all registered health facilities nationwide. While all Level 4 and 5 public facilities and port health facilities were assessed (census), Level 2 and 3 facilities were sampled to ensure representativeness across counties, ownership, and facility types.

Sampling was undertaken by a team of experts from the Kenya National Bureau of Statistics (KNBS). Required sample size for facilities was determined separately for each tool as follows;

- Total targeted facilities: 3,605
- Facility Audit: 3,530
- FP Client Exit Interviews: 806 facilities
- HR Roster data: 3,529 facilities
- Work Environment Interviews: 3,378 facilities
- Clinical Vignettes: 3,328 facilities
- Provider Availability: 3,412 facilities.

Table 3 below provides information on the targeted and the actual number of facilities included in the sample by county.

Table 3: Target and number of facilities assessed (unweighted)

County	Targeted	Assessed facilities				
		Facility Audit	FP	HR Roster	Work Environment / Clinical Vignettes	Provider Availability
Baringo	82	81	11	81	80	79
Bomet	72	71	28	71	71	69
Bungoma	80	75	18	75	73	73
Busia	68	67	16	67	67	65
Elgeyo Marakwet	63	61	20	60	58	56
Embu	74	73	13	73	71	72

County	Targeted	Assessed facilities				
		Facility Audit	FP	HR Roster	Work Environment / Clinical Vignettes	Provider Availability
Garissa	71	68	8	65	61	63
Homa Bay	85	85	20	85	83	80
Isiolo	42	41	6	41	41	41
Kajiado	87	85	16	85	84	85
Kakamega	87	87	40	87	81	85
Kericho	77	75	24	75	53	74
Kiambu	99	99	28	99	98	96
Kilifi	89	88	13	89	87	89
Kirinyaga	75	75	7	75	74	75
Kisii	82	82	19	82	80	81
Kisumu	90	89	24	90	84	88
Kitui	88	88	18	88	86	80
Kwale	81	80	20	80	77	76
Laikipia	74	70	16	70	67	66
Lamu	40	39	6	39	39	38
Machakos	90	87	21	87	85	83
Makueni	83	82	44	82	78	81
Mandera	72	71	5	72	66	72
Marsabit	62	52	1	55	49	47
Meru	92	92	16	92	91	81
Migori	84	84	10	84	84	82
County	**Targeted**	**Assessed facilities**				
		Facility Audit	FP	HR Roster	Work Environment / Clinical Vignettes	Provider Availability
Mombasa	87	82	22	81	79	82
Muranga	86	81	18	81	80	81
Nairobi	107	104	24	104	101	100
Nakuru	97	97	47	97	95	96
Nandi	77	77	21	77	74	77

County	Targeted	Assessed facilities				
		Facility Audit	FP	HR Roster	Work Environment / Clinical Vignettes	Provider Availability
Narok	74	72	8	71	69	62
Nyamira	75	75	16	75	73	75
Nyandarua	73	70	24	70	70	66
Nyeri	88	88	18	88	84	85
Samburu	61	60	6	60	56	60
Siaya	79	78	17	79	75	78
Taita/ Taveta	58	57	17	58	57	52
Tana River	52	44	3	44	42	32
Tharaka Nithi	72	72	13	72	70	71
Trans Nzoia	70	69	19	69	65	69
Turkana	78	78	8	77	60	76
Uasin Gishu	82	79	25	79	76	79
Vihiga	70	69	8	68	66	65
Wajir	66	66	5	65	54	65
West Pokot	65	65	19	65	64	64
Total	**3605**	**3530**	**806**	**3529**	**3378**	**3412**

Table 4 below provides a summary of the targeted facilities, number of facilities successfully involved in the survey, the weighted and unweighted number of providers or clients. The weighted data had a total of 13,361 facilities, 120,547 HR roster entries, 34,531 work environment, 34,712 for clinical vignettes and 99,773 for provider availability based on the respective unweighted data.

Table 4: Summary of the target, unweighted and weighted number of participants in the sample

		Number included in the sample					
	Targeted	Facility Audit	Client Exit (Interviews)	HR Roster	Work Environment (interviews)	Clinical Vignettes	Provider Availability
Facilities	3,605	3,530	806	3,529	3,378	3,328	3,412
Unweighted	3,605	3,530	1,600	60,933	5,449	5,507	19,054
Weighted		13,361		120,547	34,531	34,712	99,773

Data Analysis

Data was analyzed using:

- **Stata v17** for statistical analysis
- **Excel (SARA chartbook templates)** for indicator tables
- **QGIS v3.36.2** for spatial visualization and maps

Analysis was weighted to reflect true population and facility distribution, especially to correct for over or under-sampling of certain facility types. The core indicator framework used included WHO's SARA and HHFA indicator sets. Analysis was disaggregated by:

- County
- Facility level (KEPH)
- Ownership (public, private, FBO, NGO)
- Geographic location (urban vs. rural)

Ethical Considerations

All assessment participants, including facility managers, staff, and clients, participated voluntarily. Confidentiality and data privacy were assured. Ethical clearance and consent protocols were observed, and client-facing tools such as the FP exit interviews obtained informed verbal consent before proceeding.

Use of Findings

The results of the QoC-HHFA 2024 provide an evidence base to:

- Inform strategic investments and reforms aligned with UHC
- Guide the scale-up of Primary Health Care Networks (PCNs)
- Strengthen quality assurance mechanisms across facility levels
- Monitor alignment with national health sector targets
- Address disparities in service access and resource allocation

CHART INTERPRETATION

Purpose and Structure of Charts

The 2024 Quality of Care focused Harmonized Health Facility Assessment (QoC-HHFA) used various types of charts to summarize complex data across facilities, counties, and levels of care. These charts are designed to support data interpretation by health managers, policy-makers, and stakeholders for planning, decision-making, and health systems improvement.

There are two main categories of charts used in the report:

- **General Charts:** Illustrate overall availability and readiness of services or tracer items across all assessed facilities.
- **KEPH-Level Disaggregated Charts:** Show availability and readiness across different levels of the Kenya Essential Package for Health (KEPH), which includes Levels 2 through 5 facilities.

Each chart includes color-coded elements and is structured to highlight service coverage, tracer item availability, and overall system performance.

Components of a General Chart

Each general chart consists of three key components:

- **Chart Frame and Denominator:** This section defines the total number of facilities eligible to provide a given service or tracer item. For example, if 46% of the 12,113 facilities assessed offer cancer services, then the effective denominator becomes 5,577.
- **Tracer Item Availability:** This part of the chart shows the percentage availability of specific services or items, calculated against the eligible denominator. For instance, among the 5,577 facilities offering cancer services, 93% may offer cervical cancer screening.
- **Summary Metrics:** Two parameters are typically included here:
    1. The proportion of facilities offering all the tracer services.
    2. The average availability of all listed tracer items.

These elements help users quickly interpret service coverage and identify performance gaps.

The figure 1 below is an example of a general chart.

- The part marked **1** sets the frame for the chart and shows the proportion of facilities that should be included as well as the denominator. In the example below 46% of the 12,113 eligible facilities offer cancer services. This forms the denominator the rest of the chart (5,577)

- The part marked **2 –** This shows the percentage availability of each tracer service, based on the denominator set in **1** e.g. Of the 5,577 facilities offering cancer services, 93% offer cervical cancer services.
    - The part marked 3 summarizes the findings in this area using two parameters: the facilities with all services, and the average availability of all the tracer services in that area.

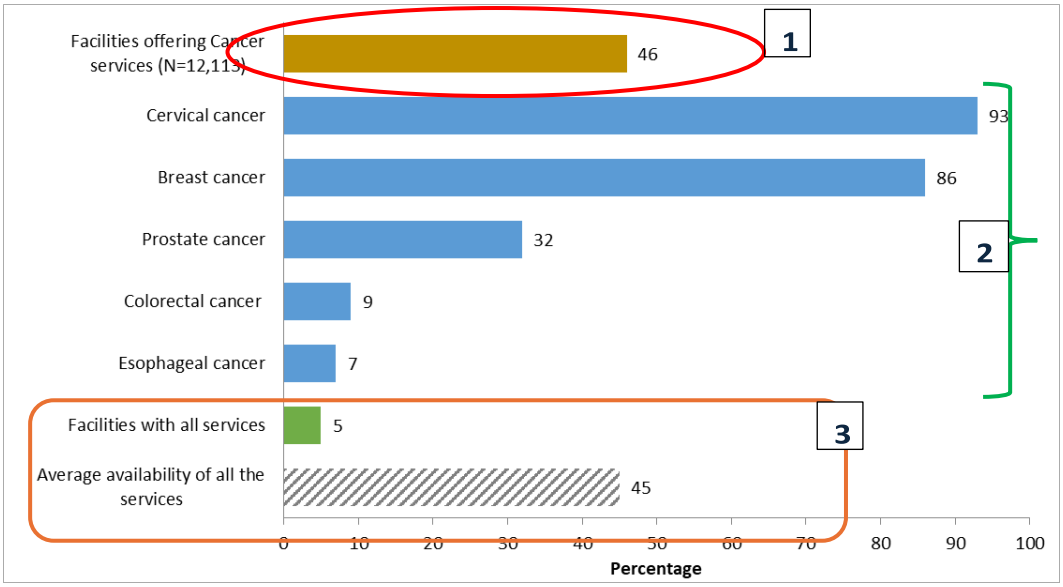

Figure 1 : Percent of health facilities that have select tracer cancer services (N=5,577)

Charts Disaggregated by KEPH Level

Given the stratified structure of the Kenyan healthcare system, KEPH-level disaggregation is essential for context-sensitive interpretation. Charts are color-coded by KEPH levels to show which services are expected at each level and how actual availability compares.

Description of the charts color scheme

1		The dark blue shade in the chart means that the drug/ medicine is available in **ALL** KEPH Levels
2		The orange shade in the chart means that the drug/ medicine is **ONLY** available from Level 3 and above
3		The grey shade in the chart means that the drug/ medicine is **ONLY** available from Level 4 and above
4		The light blue shade in the chart means that the drug/ medicine is **ONLY** available from Level 5 and above

The color-coded charts serve two main functions:

- **KEPH Expectations**: Show where services are expected (e.g., insulin syringes are expected from Level 2 upward).
- **KEPH Performance**: Show actual availability by level (e.g., insulin syringes may be available in 34% of Level 2, 55% of Level 3, 86% of Level 4, and 78% of Level 5 facilities).

This format highlights disparities in capacity and delivery of services across facility levels.

Interpreting County-Level Charts

County-level charts provide localized insights and enable benchmarking across Kenya's 47 counties. These charts are useful in:

- Assessing regional disparities in service availability and readiness.
- Identifying counties with exceptional performance or areas needing improvement.
- Supporting targeted resource allocation and decentralized decision-making.

County charts typically present average scores, percent of facilities with all tracer items, and comparisons against national performance.

Use of Color Codes

Standard color codes are used consistently throughout the report:

- Blue – Level 2
- Green – Level 3
- Yellow – Level 4
- Red – Level 5

These colours make it easier for readers to differentiate performance by facility level immediately.

Chart Utility in Health System Strengthening

The chart design in the QoC-HHFA enables:

- Rapid identification of service readiness gaps.
- Informed health planning and budgeting at county and national levels.
- Advocacy for underperforming services or regions.
- Monitoring of progress toward UHC targets using visual data representations.

Each chart is accompanied by interpretive text to contextualize the results and summarize implications for policy and service delivery.

COUNTY HEALTH MANAGEMENT

Overview of County Health Governance

The County Health Departments (CHDs) operate under the devolution framework established by the Constitution of Kenya 2010, the Health Act (2017), and the County Governments Act (2012). CHDs are responsible for coordinating the planning, management, and delivery of health services within their respective counties. Each CHD is led by a County Executive Committee Member (CECM) for Health, with technical guidance provided by the County Director of Health.

County health departments play a crucial role in translating national health policy into localized strategies, aligning resources with health needs, and ensuring accountability in service delivery. Their responsibilities span across infrastructure development, workforce deployment, health products management, and monitoring and evaluation of service outcomes.

Assessment Approach at County Level

The assessment tool for county-level governance and management was administered to County Directors of Health or their delegates in all 47 counties. The tool captured data on eight key thematic areas, which are mirrored at the facility level. Table 5 summarizes the assessment focus areas across both county and facility levels.

Table 5: County & Health Facility Level Assessment Areas

County Assessment	Health Facility Level Assessment
1. Governance and Management	
• Organograms approved by the county public service boards	• Health Management Team • Facility Management Team/ Board
2. Systems to support staff	
County Assessment	**Health Facility Level Assessment**
• Supportive supervision	• Staff appraisal system • External Supportive supervision • Continuous Medical Education (CME) • /Professional Development for medical staff
3. Health Products and Technologies	
HPT unit established Funding for supply chain activities	• Refer to the Pharmacy section of this report.
4. Health Information Systems	

County Assessment	Health Facility Level Assessment

Monitoring and Evaluation
• Functional M&E Units
  ○ AWP
  ○ APR
• Functional Research Units
	APR

5. Facility Use of Information	
• Employee satisfaction surveys • Customer satisfaction surveys	• Employee satisfaction surveys • Customer satisfaction surveys
6. Finance and Accounting systems	
Finance systems • Facility Improvement Fund (FIF) • Remuneration of Community Health Promoters (CHP's)	**Budget Allocation** • AWP • Autonomy to spend funds • Facility revenue streams • Budget 2023/2024 • Funding of budget
7. Service Delivery	
• Establishment of PCN's • Remuneration of CHP's • Referral services	• Refer to Specific service section of this report.
8. Systems to support quality	
• Quality Improvement mechanisms • IPC monitoring mechanisms • AMR mechanisms	• Refer to facility quality of care report section of this report
Maintenance of Infrastructure, Equipment	
Not assessed	

Key Findings

Among the 47 counties,

- Health Product and Technologies Units (HPTU) structures were the most common in county health departments; 89% of departments had HPTUs established while 70% had funding for supply chain activities.
- County health departments also had various service delivery tracers in place; referral services were implemented by 68%, 47% were remunerating CHPs and only 21% were linked to PCNs.
- The least implemented practice by the county health departments was employee satisfaction surveys at 19%.

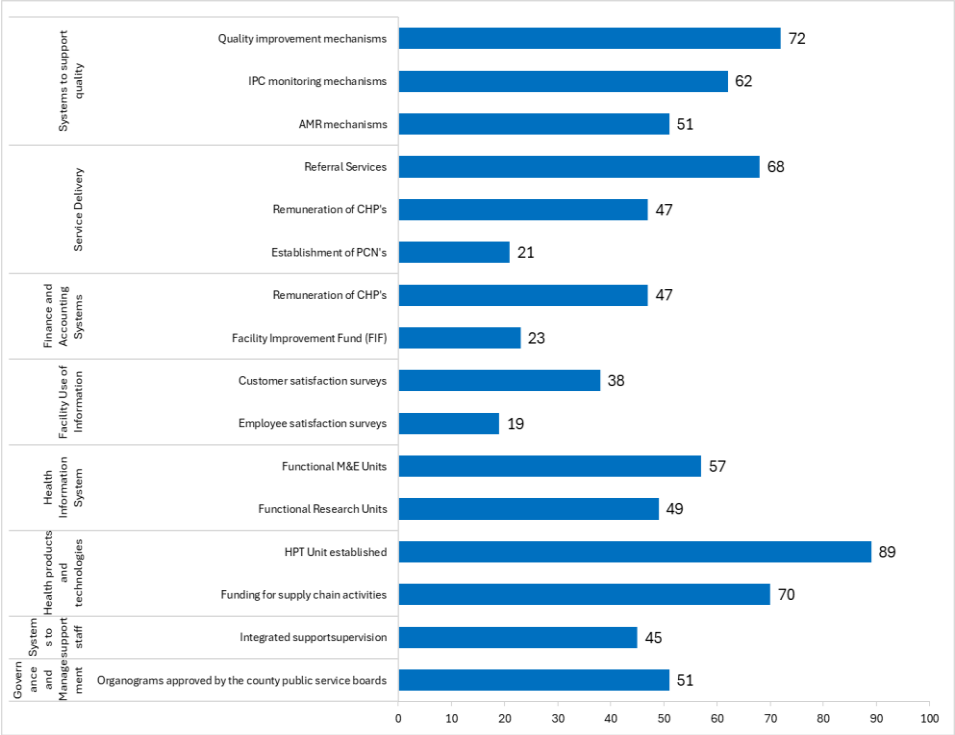

Figure 1: Percentage of counties with management structures and processes.

Governance and Organizational Structures

- Only 51% of counties had organograms approved by their respective County Public Service Boards.
- Most counties had functioning governance structures, but coordination mechanisms for quality and performance tracking varied widely.

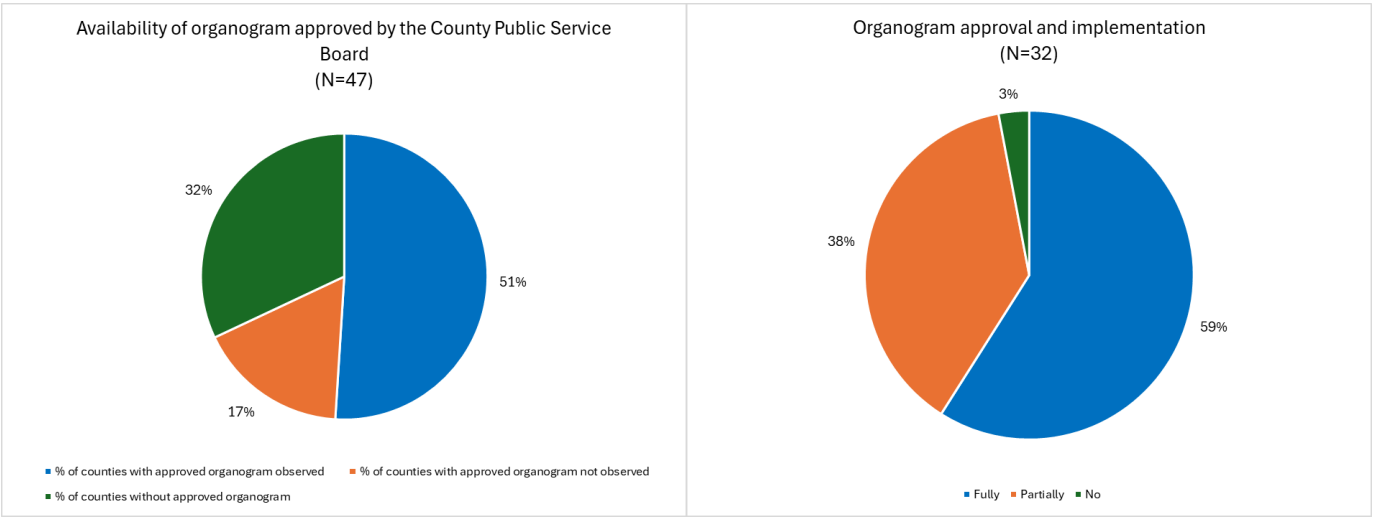

Figure 2: Availability of organogram and approval(left) and implementation as approved(right)

Health Products and Technologies

- 89% of counties had established Health Products and Technologies Units (HPTUs).
- 70% had designated budget allocations for supply chain functions.

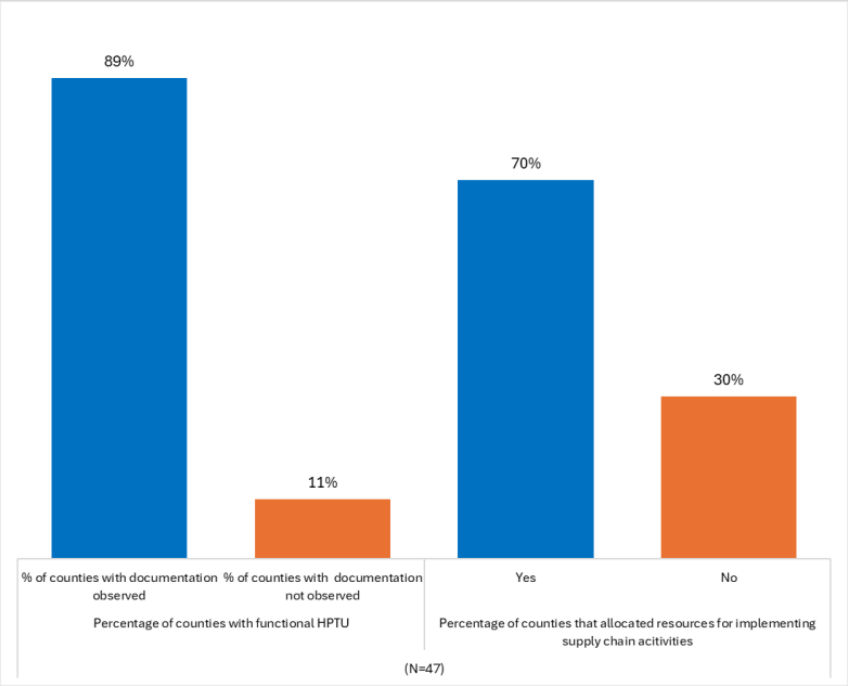

Figure 3: Counties with functional HPTU and counties that allocate resources for supply chain activities.

Primary Care Networks and Service Delivery

- Referral systems were functional in 68% of counties.
- Only 21% of counties had formally established and gazetted Primary Care Networks (PCNs).
- Less than half (47%) of counties reported implementing structured remuneration for Community Health Promoters (CHPs), limiting their integration into formal health delivery systems.

Monitoring, Evaluation, and Use of Data

- Fifty-seven percent (57%) of the counties provided documentary evidence of having functional M&E units established as per the M&E institutionalization guidelines.
- While 85% of the counties (85%) had approved Annual Work Plans (AWP) for the FY 2023/2024, 9% of all the counties did not have documentary evidence of the AWP.
- Three quarters of the counties (75%) had documentary evidence confirming that their health departments had developed Annual Performance Review (APR) reports for the FY 2022/2023.
- A limited number of counties had active research or learning units to inform policy development.
- Nearly half of the counties (49%) reported with documentary evidence that their health departments had functional research committee units.

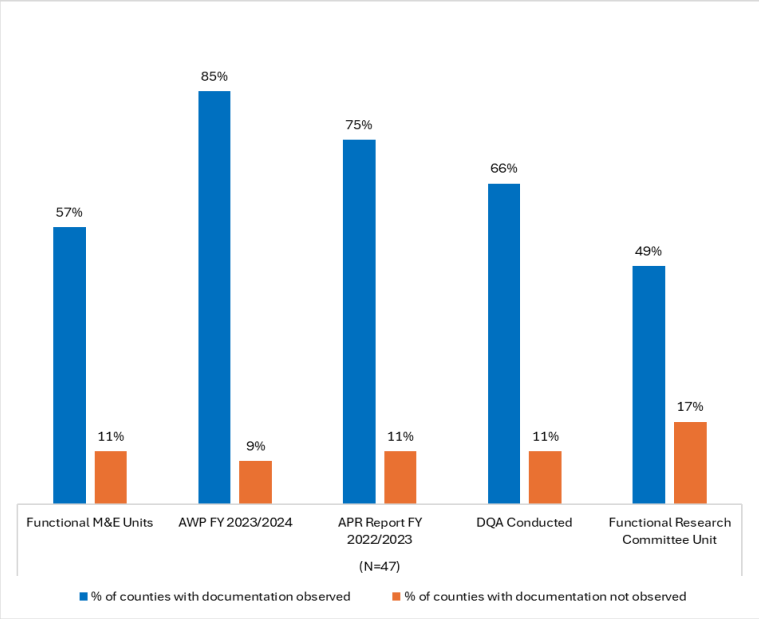

Figure 4: Percentage of counties that had M&E, Planning and Research mechanisms and documentation

Planning and Reporting Tools

The use of Annual Work Plans (AWPs) and Annual Performance Review (APR) reports serves as a benchmark for strategic planning and evaluation. The assessment found that:

- 85% of counties had approved AWPs for FY 2023/2024, indicating alignment with national planning guidelines.
- However, only 75% had developed APR reports for FY 2022/2023.
- 14% of counties had not prepared APRs, and 11% claimed to have them but could not provide documentation during verification.

The absence of documented performance reports in 25% of counties points to either weak reporting systems or gaps in institutional memory and data archiving.

Summary of Facility-Level Management Practices

Complementing the county findings, the assessment also highlighted critical insights from 13,361 health facilities nationwide:

- 61% had Facility Committees or Boards, and 56% had Health Management Teams (HMTs).
- 50% had implemented systems for staff performance management, and only 32% had conducted staff satisfaction surveys.
- 91% of facilities had received external supportive supervision in the preceding 12 months.
- 58% of facilities had developed Annual Work Plans, while 64% conducted routine performance reviews.

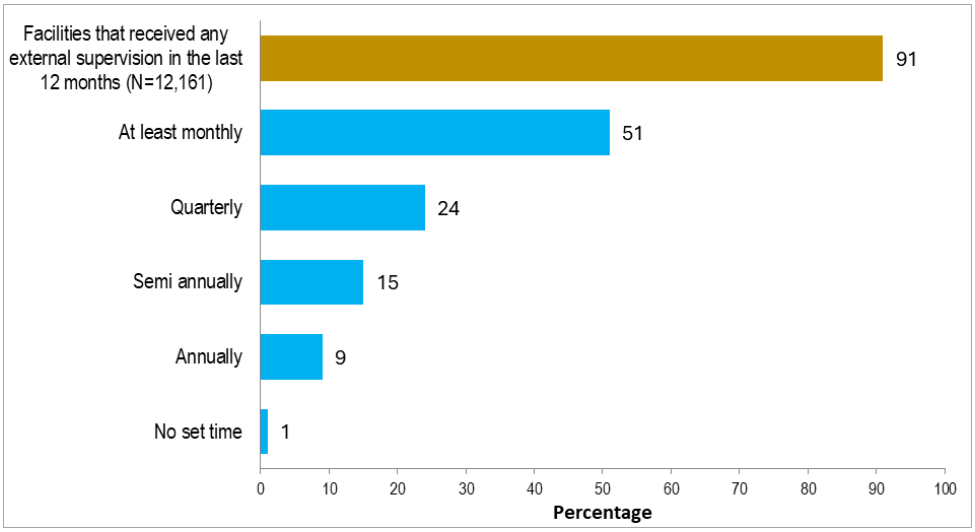

Figure 5: Percent of facilities with frequency of supportive supervision (N=12161)

Frequency of Health Facility Management Teams (HMTs)

Effective Health Facility Management Teams (HMTs) are critical for the success of healthcare facilities. They provide leadership, direction, and oversight, ensuring that the facility operates efficiently, delivers high-quality care, and meets the needs of the community. Strong HMTs contribute to improved patient outcomes, enhanced staff satisfaction, and the overall well-being of the community.

Findings of HMT performance showed that:

- Only 60% of facilities with HMTs held meetings in the month preceding the survey.
- Urban facilities (67%) were more likely to have recent HMT meetings than rural ones (53%).
- Level 5 facilities had the highest proportion of recent HMT meetings (86%) compared to Level 2 facilities (56%).

Financial Autonomy and Resource Allocation

- 73% of public health facilities reported having autonomy to plan and spend internally generated funds such as user fees or reimbursements.
- 51% of facilities relied on Facility Improvement Funds (FIF) as their main source of operational finance.
- Only 52% of the budgets for public facilities were funded during FY 2022/2023.

Funding support from national insurance schemes was reported as follows:

- 27% of facilities received reimbursements from the National Health Insurance Fund (NHIF).
- 20% received funding through the Linda Mama program under NHIF.

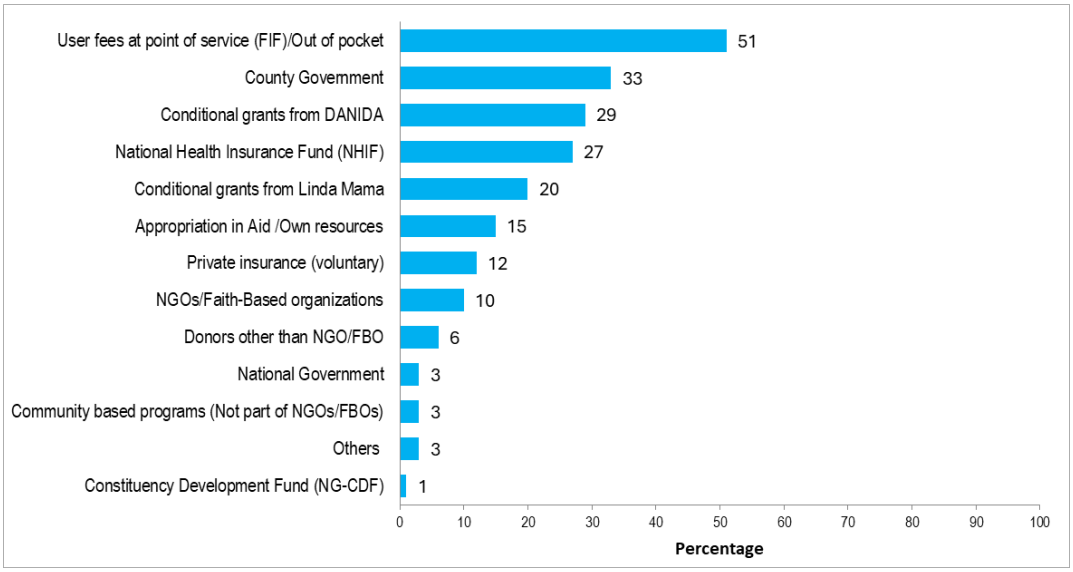

Figure 6: Percent of facilities with their sources of finance (N=13,361)

Disaggregation

By location:

- In urban areas, 68% of facilities relied on user fees, compared to 37% in rural areas.
- No urban facilities reported receiving NG-CDF support, suggesting inequity in the allocation of such funds.

By facility level:

- NHIF reimbursement was highest among Level 4 (83%) and Level 5 (81%) facilities.
- Only 17% of Level 2 facilities reported receiving NHIF funds, reflecting exclusion of primary care facilities from structured insurance payments.

By ownership:

- Public facilities were predominantly funded by county government allocations (69%).
- Private and NGO facilities reported greater reliance on NHIF and private insurance, though the use of private insurance remained low at 2%, indicating limited uptake of commercial health coverage.

Health Budget Expenditure (Public Facilities Only)

Among public facilities, the assessment found:

- On average, only 52% of the budgeted allocations for FY 2022/23 were funded.
- 73% of public facilities reported autonomy to plan and spend internally generated funds—often from FIF revenue.
- Urban public facilities had a higher budget fulfillment rate (58%) compared to 43% in rural areas.
- Level 2 facilities had the lowest proportion of budget funded (29%), exacerbating operational challenges such as commodity stockouts, poor infrastructure maintenance, and staff shortages.

These findings highlight not just underfunding but also delays and unpredictability in disbursement, which often interrupt service delivery and weaken facility planning.

Recent Policy Progress: FIF Act

The recently passed Facility Improvement Fund (FIF) Act represents a critical policy milestone aimed at enhancing financial autonomy for public health facilities. The Act mandates that funds collected by facilities (e.g., user fees) be ring-fenced and retained at the source to support:

- Day-to-day operational needs,
- Infrastructure and equipment maintenance,
- Commodity replenishment, and
- Emergency expenditures.

If fully implemented, the FIF Act will:

- Minimize service disruptions caused by delayed county disbursements,
- Enable facilities to respond to immediate needs without bureaucratic delays,
- Compel counties to respect facility financial autonomy while maintaining oversight.

However, implementation challenges remain, including lack of clear accountability frameworks, weak financial reporting systems, and inadequate training on public financial management (PFM) principles at the facility level.

Recommendations

To strengthen county health management:

- Standardize Governance Structures: Counties should finalize and approve organograms and align them with their health sector priorities.
- Strengthen PCNs and Referral Systems: Counties must prioritize the gazettement and operationalization of PCNs and ensure the functionality of referral networks.
- Institutionalize M&E and Data Use: All counties should establish and maintain functional M&E units, conduct performance reviews, and institutionalize staff and client satisfaction surveys.
- Enhance Quality Systems: County IPC and AMR committees should be formed and supported as outlined in the National Action Plan for AMR (2023–2027).
- Improve Financial Transparency: Guidelines for management and ring-fencing of FIF accounts should be implemented, including regular audits and transparent reporting mechanisms.
- Support CHPs: Counties should adopt and implement structured remuneration frameworks to motivate and retain CHPs as part of the formal health system.

GENERAL SERVICE AVAILABILITY AND READINESS

Overview

General service readiness refers to the capacity of health facilities to deliver essential health services. It includes the availability of infrastructure, equipment, staff, guidelines, diagnostics, essential medicines, and standard precautions for infection prevention. The readiness index was assessed across five main domains:

- Basic amenities
- Basic equipment
- Standard precautions for infection prevention
- Diagnostic capacity
- Essential medicines

Table 6 below shows the components used in the general service readiness index and the data sources.

Table 6: General Service Readiness index

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 pregnancy test (KHFC)
Essential Medicines	• 22 tracer medicines in stock for the last 7 days (KQoCHFA) • Facilities with essential medicines for maternal care (KQoCHFA)

General Service Readiness	Domains for Service Readiness
Standard precautions for infection prevention	• Sharps boxes (KQoCHFA) • Disposable syringes (KQoCHFA) • Hand-washing soap or alcohol-based hand rub (KQoCHFA) • Latex gloves (KQoCHFA) • Standard operating procedure (SOP) for waste management (KHFC) • Safe disposal of infectious/medical waste segregated into 3 color-coded bins (KHFC) • Evidence of disinfectant use in theatre (KHFC)

Data were drawn from both the Kenya Health Facility Census 2023 (KHFC) and the 2024 Kenya Quality of Care Health Facility Assessment (KQoCHFA) and analysed across facility levels, counties, and managing authorities.

National General Service Readiness

Nationally, the General Service Readiness Index (GSRI) stood at 67%, indicating moderate capacity of health facilities to provide general health services. The domain scores were as follows:

- Diagnostic capacity: 77%
- Basic equipment: 77%
- Basic amenities: 77%
- Standard precautions for infection prevention: 65%
- Essential medicines:41%

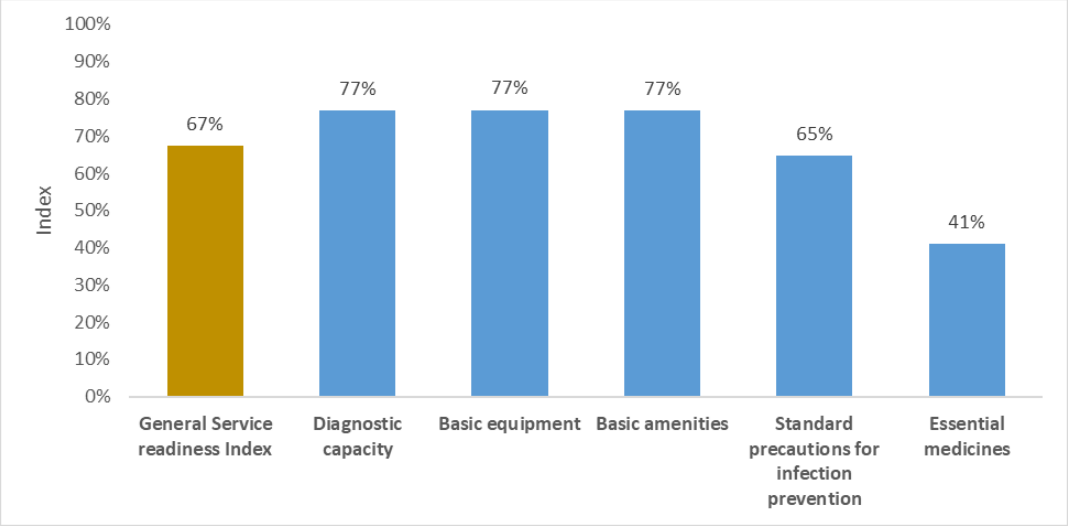

Figure 7: General service readiness index and domain scores

The highest performing domain was basic diagnostic capacity, while essential medicines and infection prevention systems showed the most significant gaps.

Domain Definitions and Tracer Items

The assessment used specific tracer items under each domain:

- Basic Amenities: Reliable power and water supply, room for client privacy, mobile signal access, and emergency transport services.
- Basic Equipment: Examination bed, stethoscope, thermometer, blood pressure machine, and light source.
- Standard Precautions: Availability of sharps boxes, disposable syringes, face masks, latex gloves, IPC guideline of hygiene protocol, SOPs for waste management, and proper waste segregation and disinfection practices.
- Diagnostic Capacity: Malaria, HIV, haemoglobin, urine dipstick for protein, pregnancy testing, blood glucose testing and Syphilis RDT.
- Essential Medicines: 22 tracer medicines (including those used for maternal and childcare, NCDs, and infections) and 23 non-pharmaceutical supplies.

Readiness by Facility Level

- The readiness score for basic amenities, standard precautions for IPC and diagnostic capacity increased as the KEPH level increased: Level 5 facilities had the highest readiness at 96%, 84% and 84% for the three domains compared to Level 2's readiness of 72%, 61% and 76% respectively.
- Level 3 facilities had the highest readiness score of 86% for basic equipment, followed by Level 5 at 85%, Level 2 at 80% and Level 4 facilities at 73%.
- Basic diagnostic capacity at level 2 facilities (76%) was higher than that at level 3 facilities (74%).

Readiness by Managing Authority

Variation was also observed by facility ownership:

- Readiness scores for basic amenities and equipment were higher in FBO, NGO, and private facilities compared to public facilities.
- The readiness score for standard precautions for IPC and diagnostic capacity stood at a minimum of 64% and 75%, respectively, across all facility ownership types.
- Public and private facilities recorded the lowest readiness score for essential medicines (38%), compared to NGO facilities (40%) and FBO facilities (56%).
- Overall, FBO facilities achieved the highest general service readiness score at 74%, followed by NGO facilities (69%), private facilities (68%), and public facilities at 64%.

County-Level Disaggregation

- Majority of the counties (85%) had a general service readiness score ranging from 61-75%.

- Kajiado County had the highest general service readiness score at 75% while West Pokot had the lowest at 56%.
- The counties with the lowest general service readiness of less than 60% were Nandi (59%), Turkana and Vihiga, both at 58%, and West Pokot (56%).

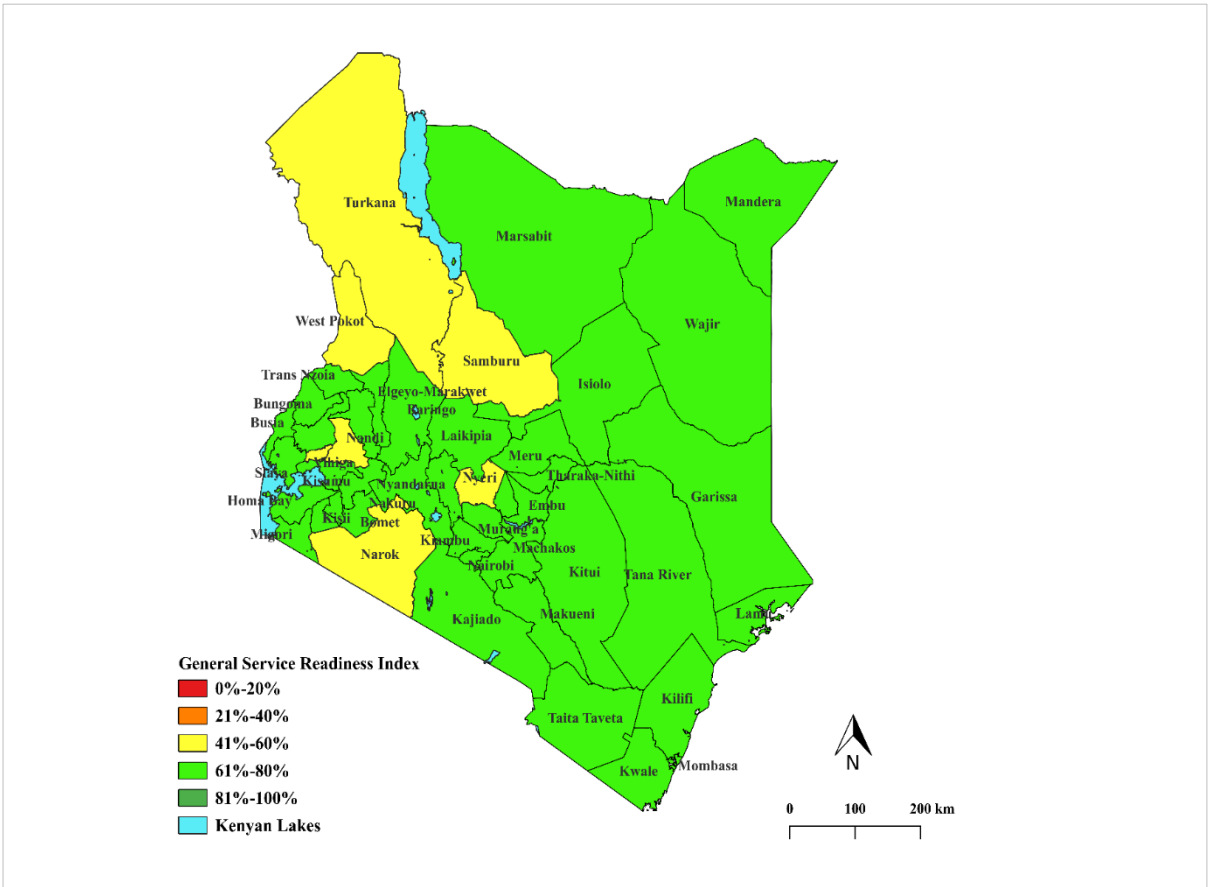

Figure 8: General Service Readiness Index by county

Domain-specific highlights included:

- Basic amenities: Highest in Mombasa (90%), lowest in Baringo (43%).
- Equipment: Highest in Samburu (92%), lowest in Nandi (64%).
- Infection prevention: Highest in Kajiado and Siaya counties, both at 75%, lowest in Turkana and Tana River counties at (44%).
- Diagnostics: Highest in Kajiado and Kiambu counties, both at 85%, lowest in Homa Bay (63%).
- Essential medicines: Only Mandera (77%), Tana River (67%), Wajir (66%) and Lamu (61%) scored above 60%. Five counties scored below 25%, including Nandi (23%), Bomet (22%), Nyeri (19%), Samburu, and Narok, both at 14%.

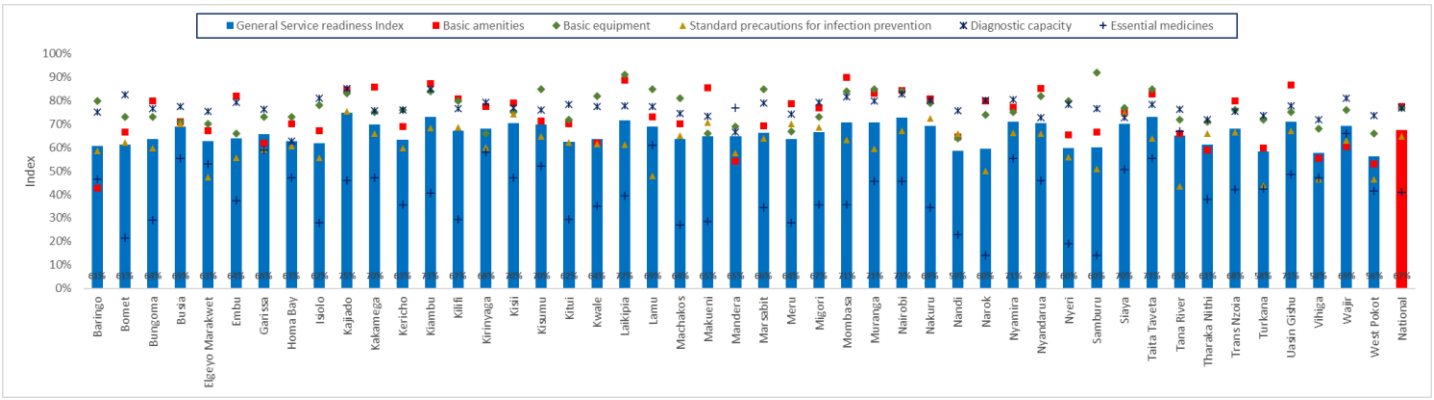

Figure 9: General service readiness domain and index by county, national

Key Gaps and Recommendations

Gaps Identified:

- Limited access to essential medicines and IPC supplies, especially in lower-tier and public facilities.
- Uneven readiness in counties with remote or under-resourced regions.
- Fragmentation in diagnostic services and inconsistent availability of clinical equipment.

Recommendations:

i. Invest in essential medicines supply chain systems, with a focus on rural and Level 2 facilities.

ii. Standardize infection prevention practices by supporting training and availability of SOPs and IPC materials.

iii. Scale up diagnostic and equipment access across all facility levels, especially those expected to manage NCDs and maternal-child health.

iv. Strengthen financial autonomy and planning at the facility level to enable timely procurement of readiness-critical items.

COMMUNICABLE DISEASES

Introduction

Communicable diseases continue to pose a significant burden on Kenya's health system, accounting for a large share of morbidity and mortality, particularly among vulnerable populations such as children under five, pregnant women, and immunocompromised individuals. The major communicable diseases of public health concern include HIV/AIDS, malaria, tuberculosis (TB), sexually transmitted infections (STIs), and neglected tropical diseases (NTDs). These diseases are not only highly prevalent but also intersect with broader issues of health equity, health system readiness, and public health emergency response.

The 2024 Quality of Care Health Facility Assessment (QoC-HFA) evaluated the availability and readiness of health facilities to deliver essential services for the prevention, diagnosis, treatment, and management of these five priority disease areas. The assessment provides a critical lens into Kenya's progress toward Universal Health Coverage (UHC) and highlights areas requiring investment and policy attention.

Service Availability

As illustrated in Figure 10, malaria services were the most widely available, present in 95% of health facilities. Over 80% of facilities provided HIV (83%) and STI (89%) services. TB services were available in just over half (58%) of facilities, while services for NTDs were the least available, present in only 34% of facilities. On average, 72% of facilities offered services for the five major communicable diseases, yet only 22% provided all five tracer services.

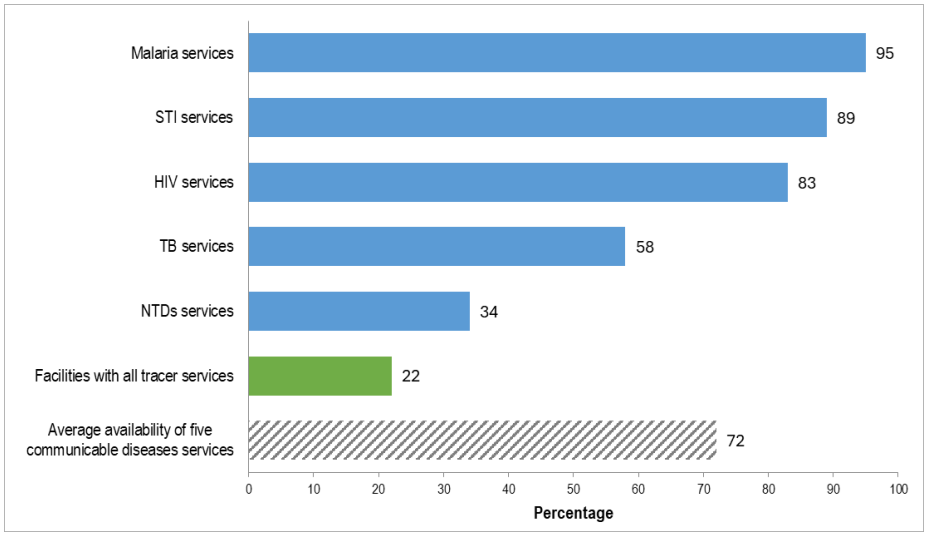

Figure 10: Availability of services for communicable diseases (N=13,361)

Service Readiness

Figure 11 shows that, among facilities offering communicable disease services, readiness was moderately high for HIV (63%), malaria and STIs (61%), and TB (57%). However, readiness for NTDs was low (28%) in counties where these diseases are endemic. Major barriers included

limited diagnostic capacity for TB and a lack of essential commodities for malaria. For HIV, shortages in medicines and guideline availability were significant weak points.

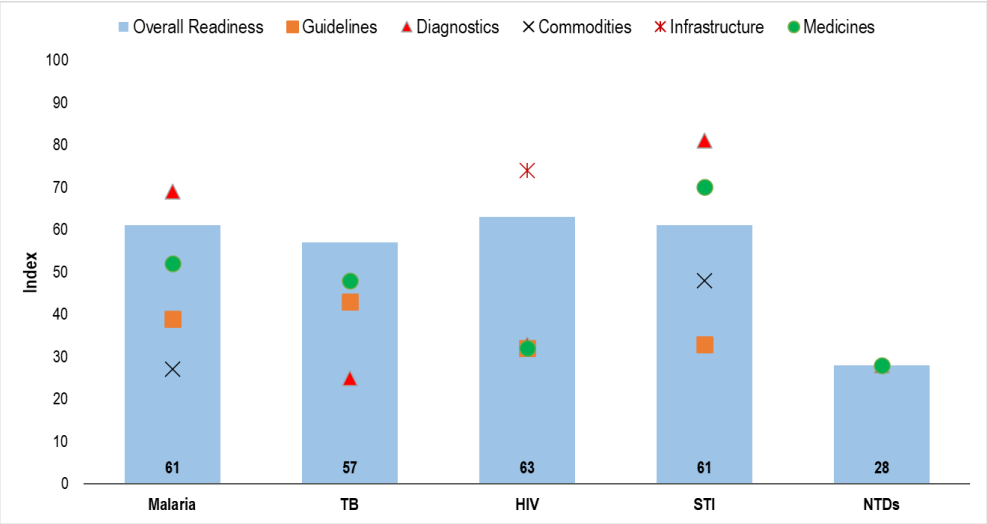

Figure 11:Availability of tracer items for communicable diseases

By Location, KEPH Level, and Ownership, there was little variation by location. Level 4 and 5 facilities offered more comprehensive services compared to levels 2 and 3. Private facilities had lower availability of TB and HIV services, while NGO facilities were less likely to offer malaria services.

By County, there were notable differences among counties in terms of service availability. Nyamira County led with an average availability of 84%, while Mandera County had the lowest at 50%. Seven counties scored at least 80% in average service provision, but no county had all communicable disease services available in every facility

Discussion

Generally, the readiness to provide communicable diseases services has declined slightly from the KHFA 2018. The overall readiness for facilities to provide Malaria services has remained unchanged at 61% from 62% in 2018, TB has declined somehow from 67% to 57%, STIs from 72% to 61% and HIV services from 69% to 63%. Similarly, readiness to provide NTD services has declined from 35% in KHFA 2018 to 28%.

MALARIA

Malaria remains a major public health challenge in Kenya. The 2020 Kenya Malaria Indicator Survey (KMIS) showed that about 70% of the population is at risk, with 13 million in endemic areas and 19 million in highland or seasonal risk regions. Treatment relies on artemisinin-based combination therapies, such as artemether-lumefantrine. Malaria vaccination is available in eight high-risk counties.

Service Availability

Malaria diagnostic and treatment services are widely accessible, offered in 95% of facilities. Nearly all facilities providing malaria services had both diagnostic and treatment options

available. However, intermittent preventive treatment for pregnant women and malaria vaccinations are limited to endemic areas.

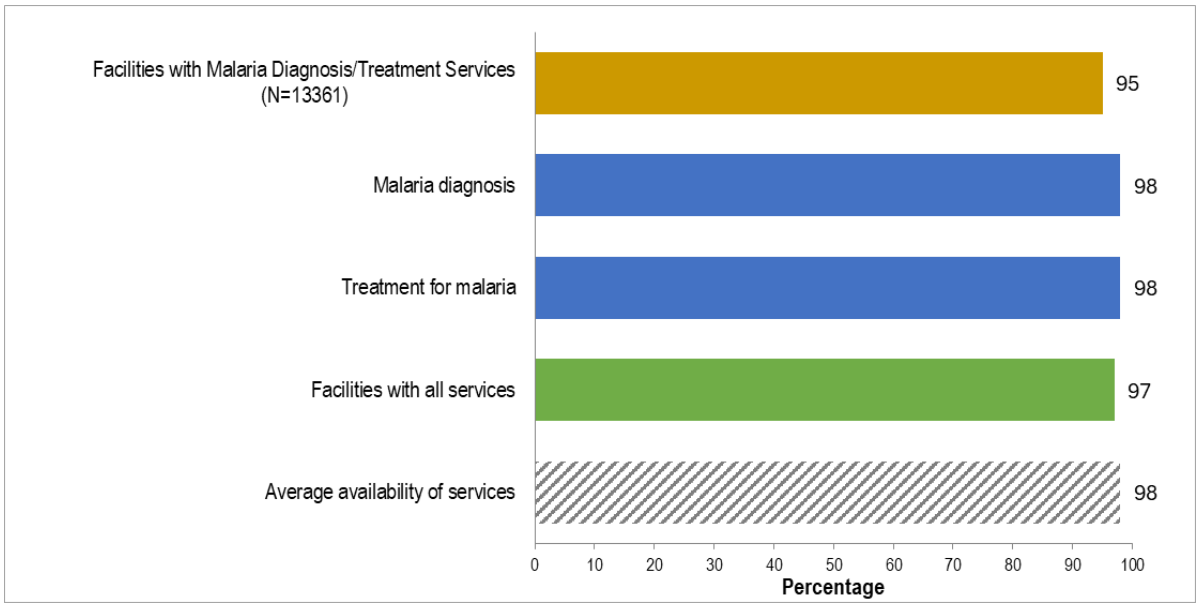

Figure 12: Percentage of facilities that have select tracer Malaria services (N=12,634)

County Distribution

Malaria service availability was high across most counties, ranging from 89% to 100%. However, tracer item availability varied, with Busia County at 85% and Makueni and Nyandarua at 43%.

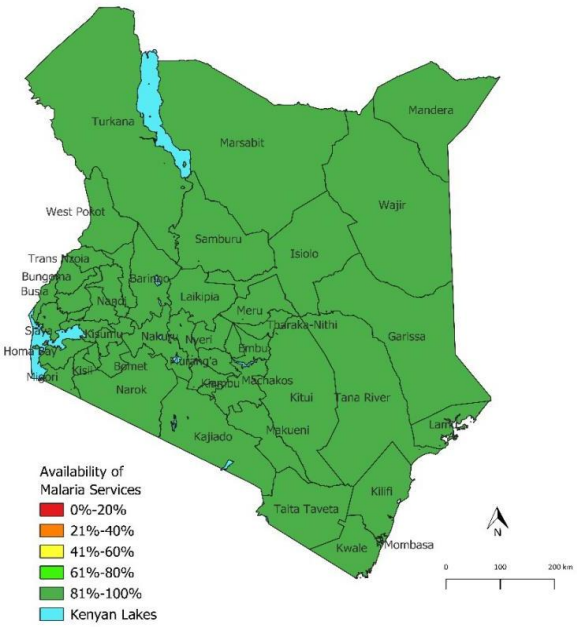

Figure 13: Average availability of Malaria services by county

Service Readiness

Among facilities providing malaria services, only 39% had up-to-date diagnostic and treatment guidelines. Rapid diagnostic test (RDT) services were available in 78% and microscopy in 60% of facilities. The average availability of the five tracer items for malaria was 61%, yet only 15% of facilities had all tracer items on hand at the time of survey

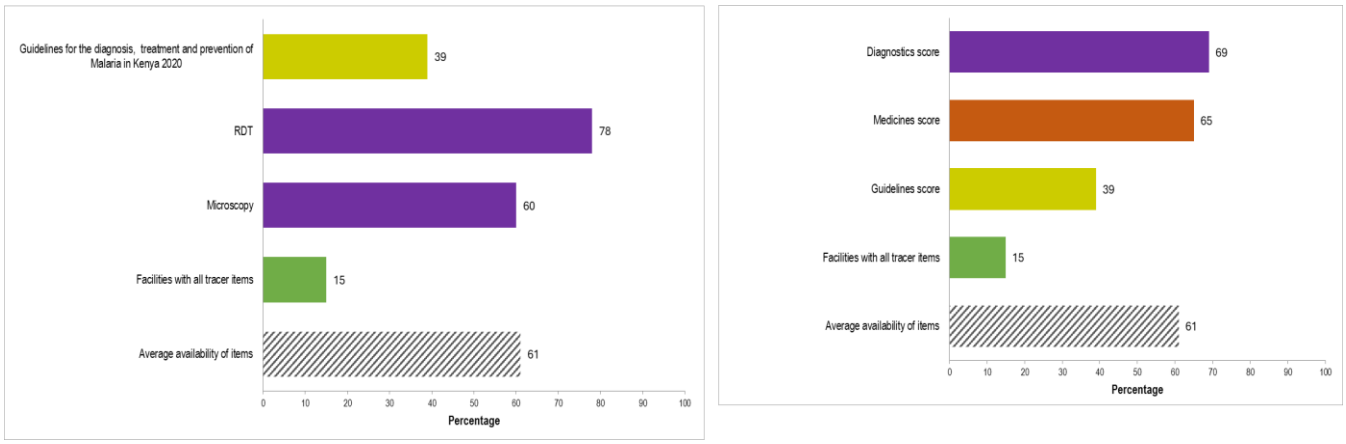

Figure 14: Percent of facilities that have select tracer items (N=12,634)

Malaria Vaccination Services

In the eight target counties, 64% of facilities offered malaria vaccination services. Public facilities were more likely to provide these services than private ones. Readiness, as measured by vaccine availability, was 61% in these counties.

Discussion

Availability of malaria diagnostic services improved from 89% in 2018 to 98% in 2024, and treatment availability rose from 45% to 98%. Availability of first-line medicines increased slightly. The focus now should be on enhancing quality.

Conclusions and Recommendations

Efforts should target counties and regions with lower availability, particularly for IPT and malaria vaccinations. Addressing declines in readiness and ensuring consistent supplies of essential commodities remain priorities.

TUBERCULOSIS (TB)

Kenya bears a high burden of TB, with an estimated 133,000 new cases in 2021. Standard treatment uses a combination of antibiotics, and GeneXpert is prioritized for diagnosis. 51% of facilities had microscopy services.

Service Availability

TB services are available in 58% of facilities, with screening, diagnosis, and treatment present in 94%, 88%, and 69%, respectively. More than half (62%) of facilities offered all TB services.

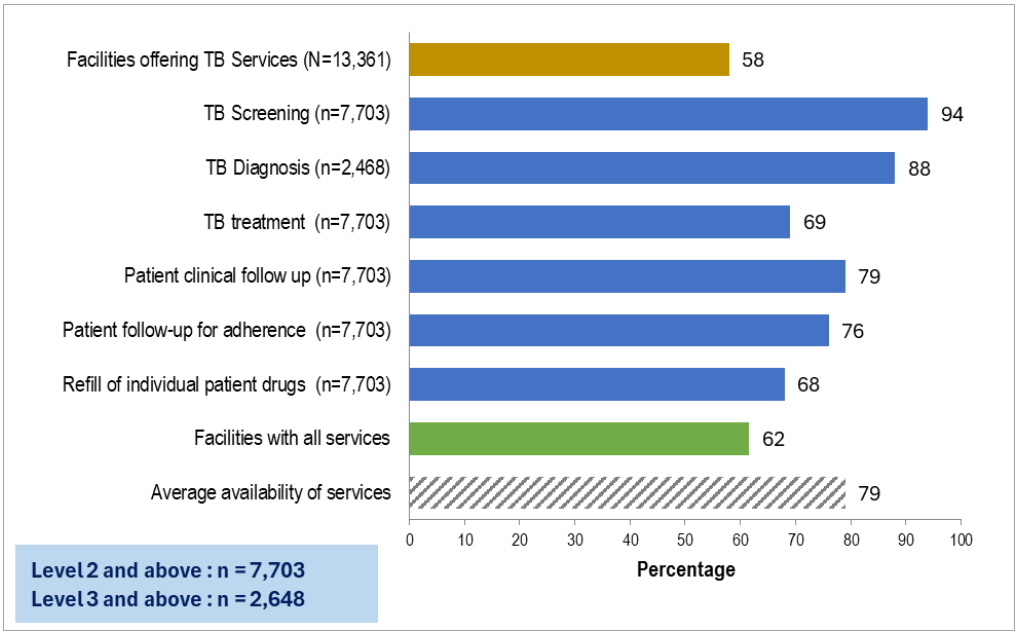

Figure 15: Availability of TB services in the country (N=7703)

County Distribution

TB service availability varied by county, with Siaya highest at 93% and Garissa lowest at 56%. Most counties had at least 60% availability.

Service Readiness

Overall readiness for TB services was 57%. GeneXpert diagnostic services were available in 88% of hospitals, while microscopy and chest X-ray were available in 53%and in 23% of Level 3,4 and 5 facilities, respectively.About two-thirds (67%) of facilities stocked essential TB medicines.

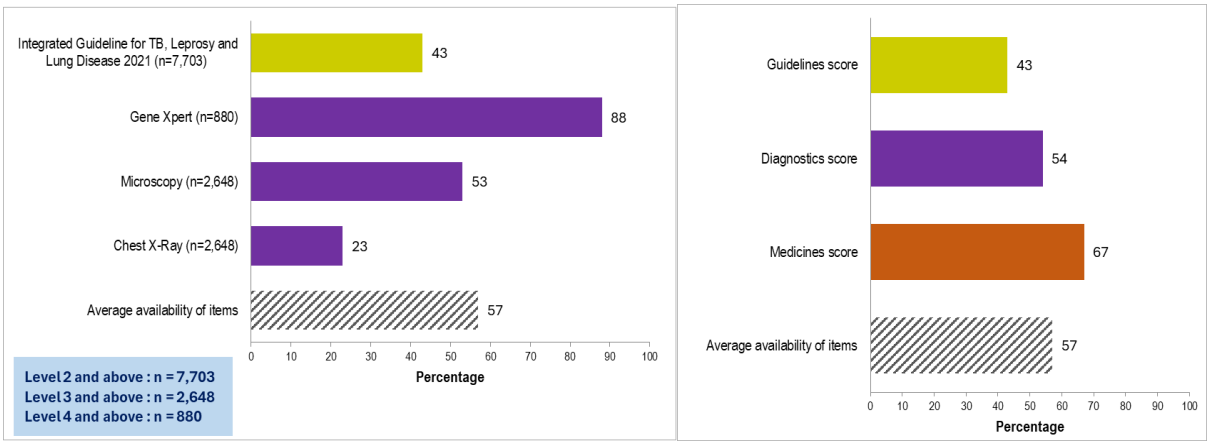

Figure 16: Availability of tracer items to offer TB Services

MULTI DRUG RESISTANT TB (MDR TB)

Service Availability

MDR TB service availability and readiness is generally low, with only 18% of facilities providing all DR TB tracer services while the average availability was at 34%. Diagnostic capacity and access to medicines require improvement,only 10% of facilities had Bedaquiline (the only DRTB tracer drug assessed) available.

- Diagnosis and treatment: About a quarter (26%) of facilities conducted DR-TB diagnosis and testing, and 30% offered treatment for DR-TB.
- Follow-up and adherence: Between 34% to 36% of facilities supported clinical follow-up, adherence monitoring, and drug refills for DR-TB patients.
- Supportive services: Around 36% to 38% of facilities provided contact tracing and social support for DR-TB patients, with overall average service availability at 34%.

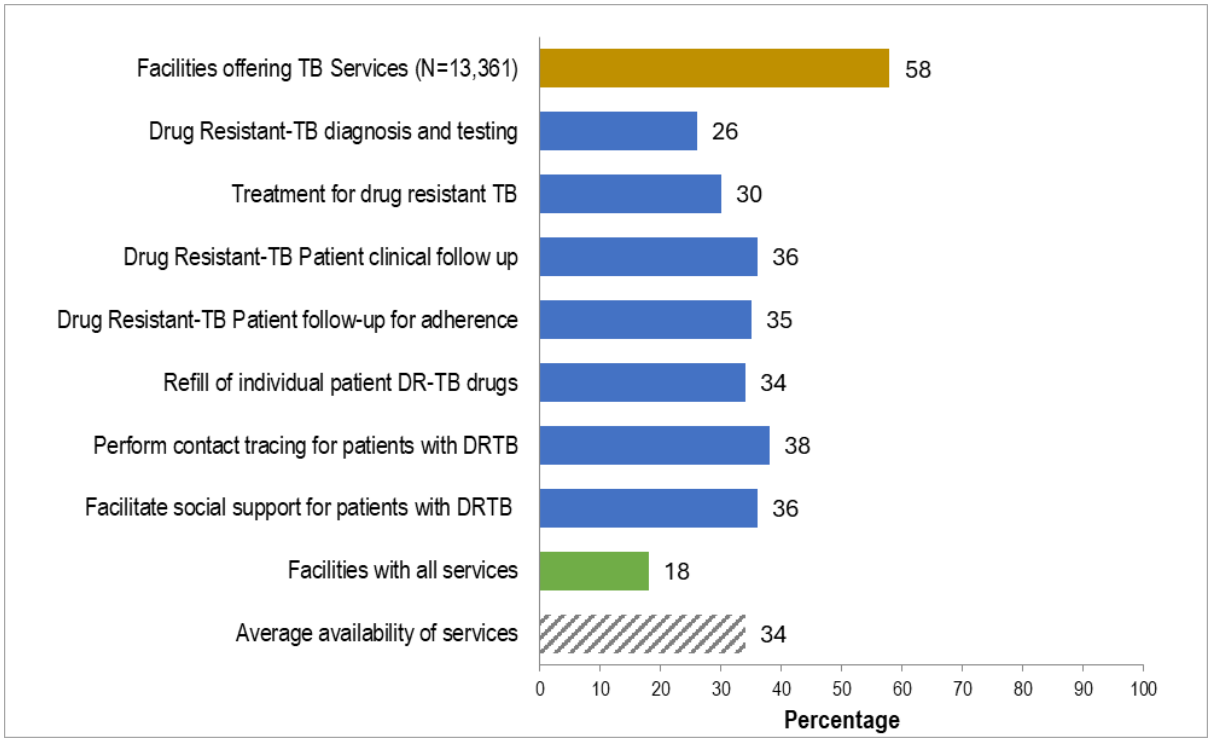

Figure 17: Percent of facilities that have select DR-TB tracer services (N=7703)

Service Readiness

Most hospitals had better diagnostic capacity than primary facilities. Readiness was lowest in rural and private facilities.

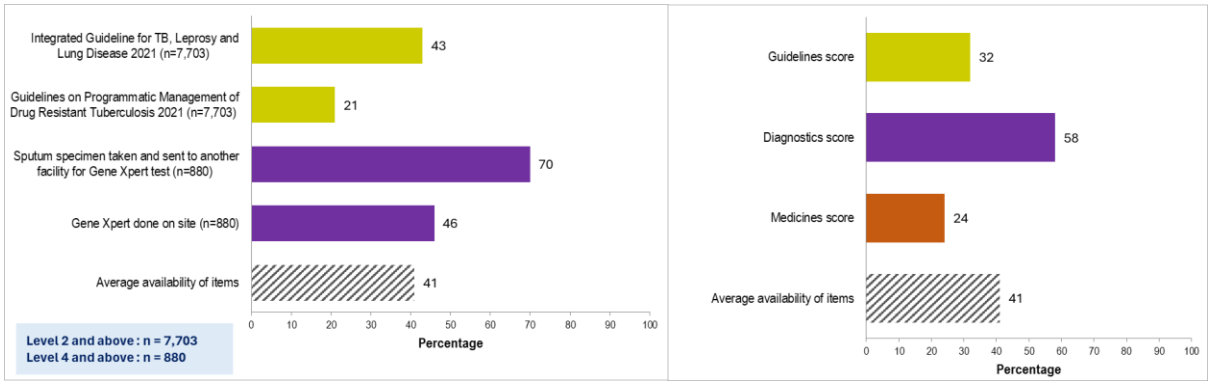

Figure 18:Readiness of health facilities to provide DR-TB services

County Distribution

Service availability for MDR TB was very low in Counties. It was highest in Lamu (72%) and Trans Nzoia (62%), and moderate in Bomet, Siaya, Vihiga, Embu and Laikipia counties which had a

score of at least 50% None of the counties had all the DR-TB services available in all their health facilities

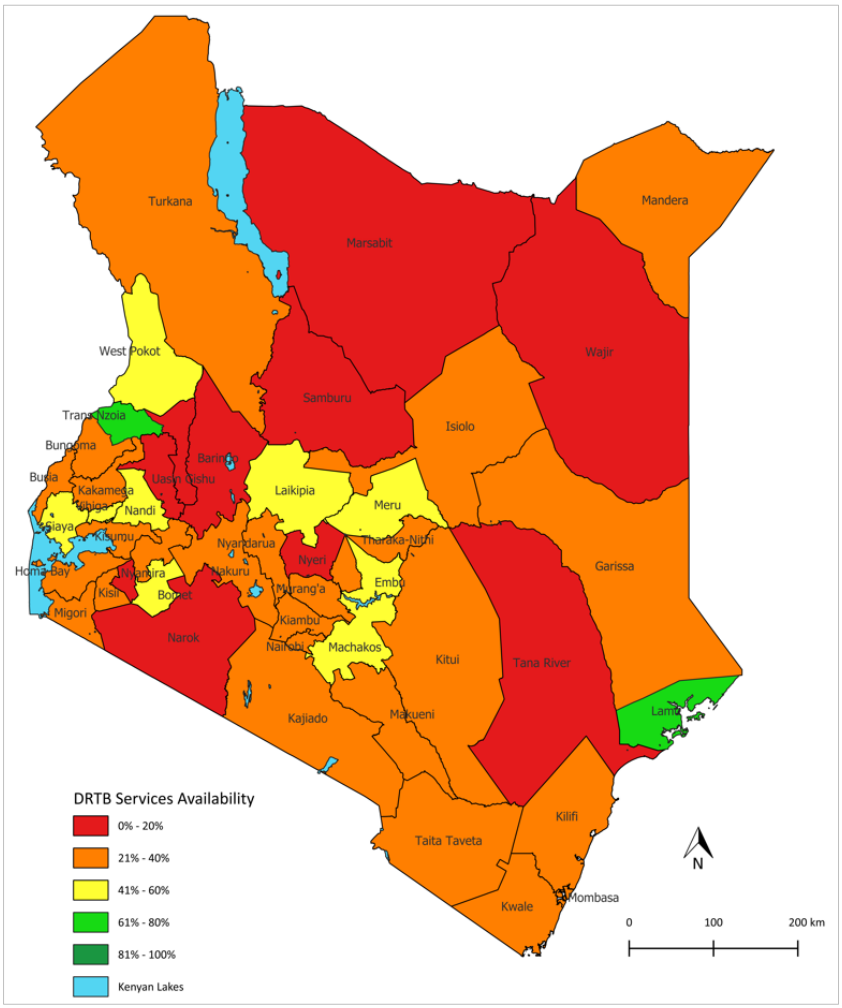

Figure 19: Average availability of DRTB Services by county

HIV/AIDS

HIV continues to be a significant health issue, with 1.4 million people living with HIV in Kenya as of 2020 (3.7% adult prevalence). ART adherence is vital to reaching the UNAIDS 95-95-95 targets.

Service Availability

HIV counselling and testing were available in nearly all facilities offering HIV services, but ART services were available in only 41%. PEP and elimination of mother-to-child transmission services were present in about half of the health facilities. Overall, 56% of facilities provided all five HIV tracer services, and just 34% had all services available at once.

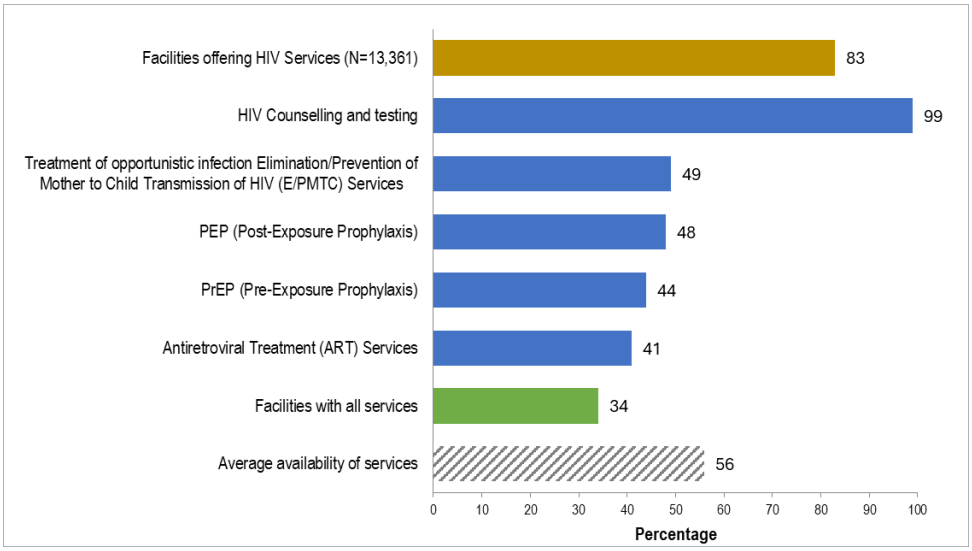

Figure 20: Percentage of facilities that have select HIV tracer services (N=11,071)

Service Readiness

Primary facilities had high availability of testing kits (94%) but low availability of guidelines (around one-third). Hospitals had better diagnostic readiness (up to 98% for testing kits) but only about half had guidelines. The average availability of items in primary facilities and hospitals was 60% and 66%, with a minority 18% and 16%) possessing all tracer items, respectively.

County Distribution

Service availability varied widely,Taita Taveta had the highest at 82%, while Wajir was lowest at 23%. No county had all HIV services available in every facility.

Discussion and Recommendations

While testing and counselling services are widely available, comprehensive HIV care—including medicines—remains inconsistent, especially in private and lower-level facilities. Investments should target counties with the lowest service availability.

SEXUALLY TRANSMITTED INFECTIONS (STIS)

STIs are a major public health concern, with significant impact on women and vulnerable populations.

Service Availability

- STI diagnosis and treatment services were available in 89% of facilities in Kenya; 96% provide diagnosis services for STIs while almost all (98%) treat
- Average availability of STI services was at 97%.

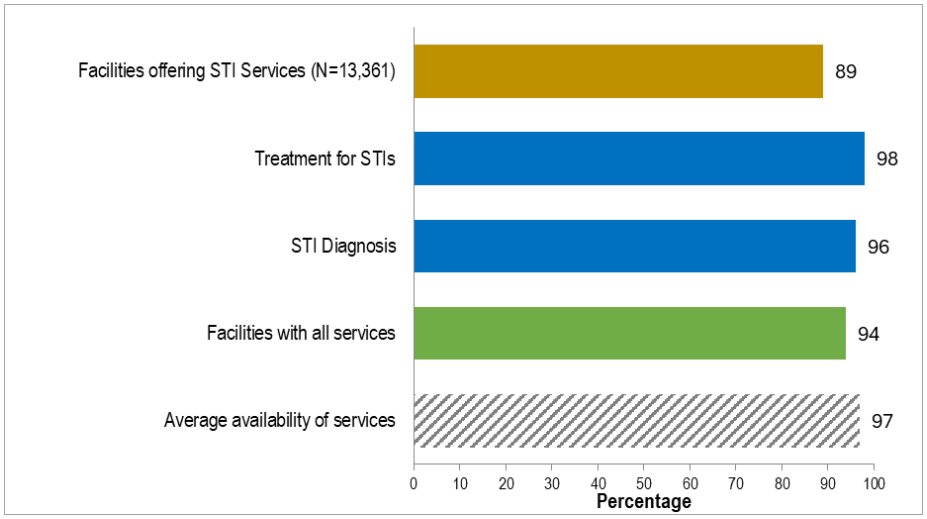

Figure 21: Percentage of facilities that have select tracer STI services (N=11,856)

Service Readiness

Readiness was moderate, with one-third of facilities having national guidelines and 77% and 20% stocking male and female condoms, respectively. Only 5% of facilities had all five tracer items.

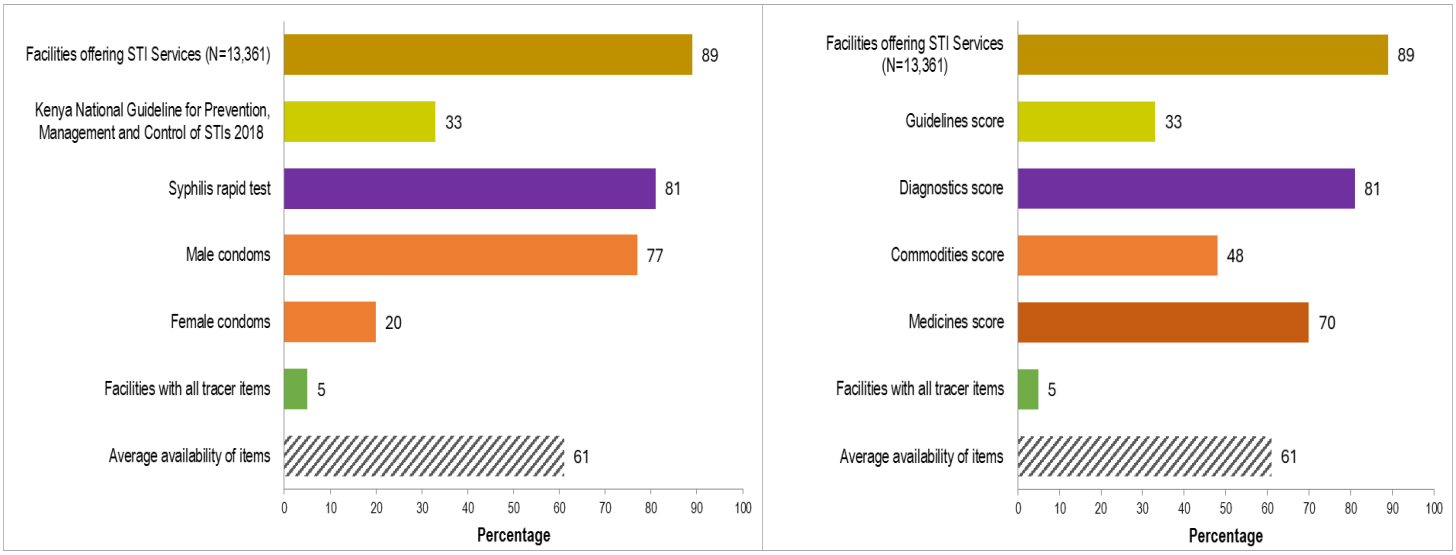

Figure 22: Readiness of health facilities to provide STI services (N=11,856)

County Distribution

There was high availability (81%-100%) of STI services across all counties.

Discussion and Recommendations

Low availability of STI commodities such as male condoms in FBO facilities and STI guidelines in lower-level facilities creates service inequalities. Ensuring equitable distribution of resources is essential.

NEGLECTED TROPICAL DISEASES (NTDS)

NTDs constitute a diverse range of conditions affecting marginalized communities. Availability and readiness of NTD services remain critically low, especially for Lymphatic Filariasis, Soil Transmitted Helminths, and Visceral Leishmaniasis

Service Availability

Service availability varied by disease and county, with the highest for schistosomiasis (61%) and dengue fever (60%).

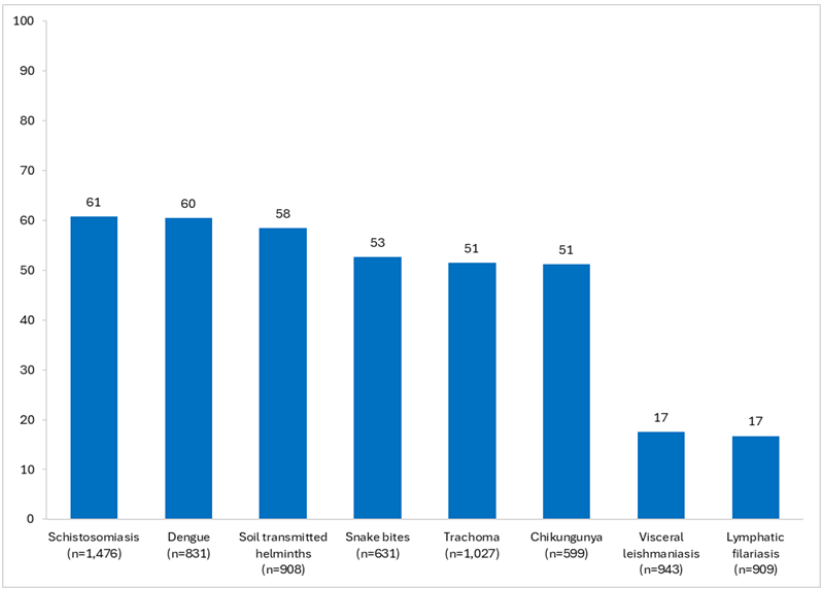

Figure 23: Percent of facilities that have select NTD tracer services

County Distribution

Mombasa County had the highest average availability of NTD services at 50% while Nyeri had the least at 12%.Only six counties (Mombasa, Taita Taveta, Kisii, Kajiado, Laikipia and Nyandarua) had an average score of more than 40% in the availability of NTD services.

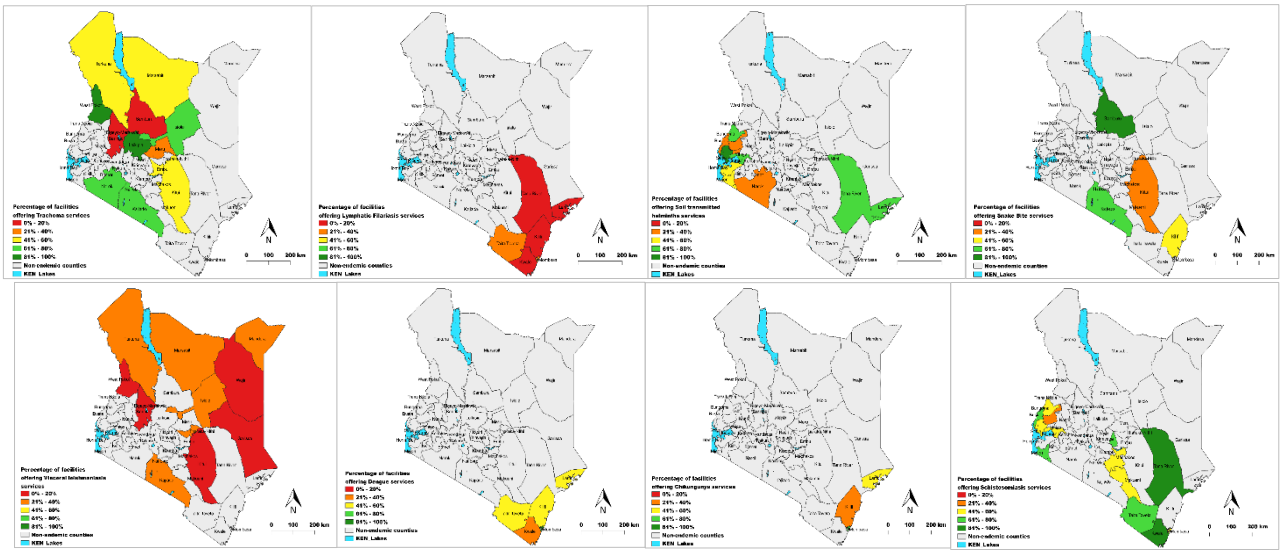

Figure 24: Average availability of NTD Services by county

Service Readiness

Readiness for NTD services was generally very low, particularly for diagnostics and medicines, both at 28%. Urban and high-level facilities had higher readiness. Most counties had 12–40% NTD service availability.

Medicines

Praziquantel, albendazole, and ivermectin were available in less than a third of facilities. Trachoma treatment was the most available at 76%

Discussion and Recommendations

Service and tracer item availability for NTDs remain limited, perpetuating health inequalities. Increased investments and programmatic support are necessary, especially in endemic counties.

Key Recommendations—Communicable Diseases

To address these challenges, the following recommendations are proposed:

- Targeted County Support: Counties such as Marsabit and Mandera should receive prioritized infrastructural, human resource, and commodity support to boost disease management capacity.
- Diagnostic Expansion: There is a need to expand the availability of diagnostic tools, particularly GeneXpert for TB and viral load testing platforms for HIV.
- Integrated Service Delivery: All facilities should be supported to provide a comprehensive communicable disease package, ensuring that clients can receive malaria, TB, HIV, STI, and NTD services under one roof.
- Healthcare Worker Capacity Building: Continuous training and mentorship in integrated management of communicable diseases are essential to maintain quality.
- Commodity Security: Strengthen national and county-level supply chain systems to ensure uninterrupted availability of medicines, diagnostics, and prevention tools.

NON-COMMUNICABLE DISEASES (NCDS)

Introduction

Kenya is currently grappling with a complex epidemiological transition marked by a triple burden of disease, communicable diseases, non-communicable diseases (NCDs), and injuries. Among these, NCDs are emerging as a leading cause of death and disability, reflecting changing lifestyles, aging populations, and urbanization. According to the Ministry of Health, the probability of dying prematurely from an NCD in Kenya is 21%, and without substantial intervention, NCD-related mortality is projected to rise by 55% by 2030.

The 2024 Quality of Care Health Facility Assessment (QoC-HFHA) focused on evaluating the availability and readiness of health facilities to deliver five priority NCD services: diabetes, cardiovascular diseases (CVD), chronic respiratory diseases (CRD), cancer, and mental health. These areas were selected based on national burden of disease estimates and strategic priorities outlined in the Kenya National Strategy for the Prevention and Control of NCDs.

Overall Service Availability

The assessment revealed that almost all (91%) of health facilities provided NCD services. However, only 28% of facilities offered all five NCD (CVD, Diabetes, CRD, mental health and cancer) services.

Disaggregated availability showed:

- Cardiovascular diseases: 92%
- Diabetes: 90%
- Chronic respiratory diseases: 88%
- Mental health services: 52%
- Cancer services: 46%

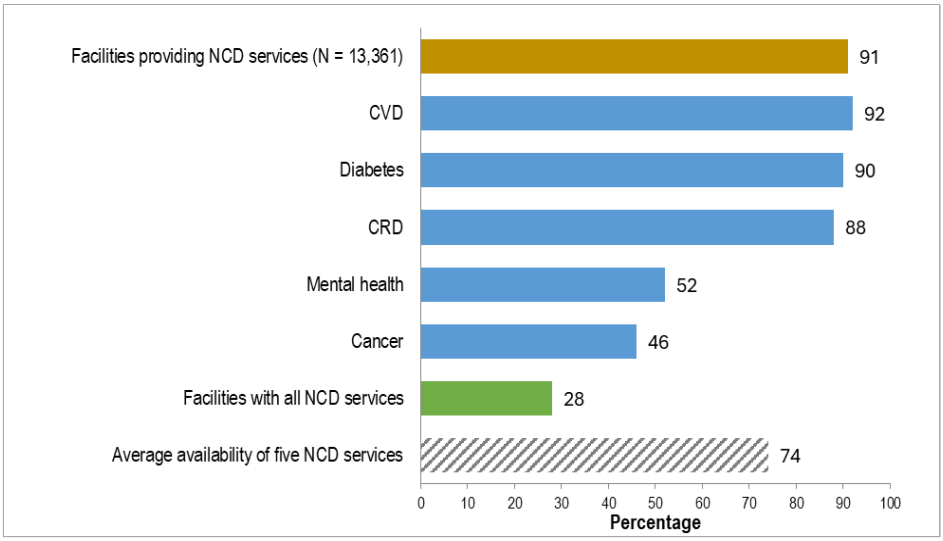

Figure 25: Availability of services for non-communicable diseases (N=12,113)

While CVD and diabetes services had relatively wide coverage, mental health and cancer services were considerably less available, particularly in counties with fragile health systems.

The average availability across the five disease categories stood at 74%, with lower-tier facilities (Levels 2 and 3) significantly lagging in cancer and mental health service provision.

Table 7: Percentage of facilities that have select NCD Services available

	NCDs	Diabetes	CVDs	CRD	Cancer	Mental health	Palliative care	Number of facilities
By County								
Baringo	78%	93%	89%	90%	24%	36%	41%	223
Bomet	97%	70%	93%	88%	58%	42%	27%	176
Bungoma	94%	85%	83%	92%	69%	57%	31%	253
Busia	87%	90%	88%	93%	69%	57%	22%	152
Elgeyo Marakwet	93%	74%	89%	95%	52%	83%	69%	136
Embu	89%	82%	91%	80%	34%	61%	24%	176
Garissa	85%	96%	95%	83%	19%	36%	19%	153
Homa Bay	90%	78%	98%	98%	53%	50%	12%	329
Isiolo	97%	93%	76%	69%	24%	24%	20%	71
Kajiado	93%	84%	95%	84%	32%	25%	20%	340
Kakamega	88%	82%	90%	88%	56%	58%	27%	319
Kericho	83%	88%	90%	78%	56%	48%	33%	196
Kiambu	98%	98%	97%	87%	52%	56%	24%	630
Kilifi	100%	94%	94%	96%	47%	60%	19%	409
Kirinyaga	89%	100%	87%	69%	24%	30%	11%	179
Kisii	92%	88%	100%	92%	61%	41%	14%	255
Kisumu	84%	79%	83%	75%	46%	40%	17%	336
Kitui	98%	97%	95%	91%	59%	81%	12%	363
Kwale	82%	89%	94%	90%	38%	24%	12%	227
Laikipia	91%	100%	95%	99%	75%	71%	37%	184
Lamu	100%	97%	97%	97%	48%	43%	18%	73
Machakos	91%	94%	92%	91%	38%	55%	18%	417
Makueni	95%	96%	98%	88%	39%	41%	8%	283
Mandera	95%	93%	83%	76%	4%	24%	15%	190
Marsabit	75%	79%	73%	77%	9%	27%	8%	105
Meru	100%	98%	99%	91%	40%	69%	39%	459
Migori	95%	82%	88%	85%	81%	38%	30%	306
Mombasa	93%	99%	94%	92%	45%	39%	19%	344
Muranga	99%	96%	93%	91%	39%	35%	7%	358
Nairobi	88%	96%	95%	88%	68%	58%	25%	1073
Nakuru	90%	90%	92%	90%	51%	37%	11%	543
Nandi	99%	80%	88%	85%	28%	53%	24%	231
Narok	83%	83%	73%	84%	21%	39%	14%	166
Nyamira	94%	81%	90%	88%	27%	77%	30%	195
Nyandarua	94%	89%	96%	96%	54%	91%	58%	199
Nyeri	98%	98%	97%	95%	27%	80%	11%	387
Samburu	79%	83%	94%	91%	14%	63%	8%	108
Siaya	88%	77%	82%	85%	50%	42%	25%	217

	NCDs	Diabetes	CVDs	CRD	Cancer	Mental health	Palliative care	Number of facilities
Taita Taveta	100%	89%	88%	93%	49%	49%	16%	113
Tana River	100%	100%	99%	89%	19%	18%	4%	97
Tharaka Nithi	96%	85%	96%	85%	19%	66%	10%	179
Trans Nzoia	94%	92%	98%	99%	74%	71%	21%	178
Turkana	65%	61%	80%	77%	35%	31%	7%	161
Uasin Gishu	83%	98%	100%	99%	43%	74%	26%	225
Vihiga	91%	84%	93%	82%	51%	33%	16%	163
Wajir	93%	85%	90%	82%	27%	58%	27%	151
West Pokot	54%	74%	80%	89%	35%	71%	34%	88
By type								
Level2	88%	87%	91%	86%	39%	48%	17%	8674
Level3	96%	95%	95%	92%	59%	57%	24%	2442
Level4	99%	99%	98%	96%	75%	73%	51%	960
Level5	100%	100%	100%	100%	95%	89%	84%	37
By managing authority								
FBO	92%	96%	94%	91%	49%	52%	25%	1445
NGO	74%	88%	85%	82%	71%	50%	17%	301
Private	92%	95%	94%	90%	34%	50%	26%	4967
Public	90%	84%	90%	86%	55%	53%	17%	5400
By location								
Rural	89%	86%	91%	87%	44%	49%	20%	6550
Urban	92%	94%	94%	90%	48%	55%	23%	5563
All	**91%**	**90%**	**92%**	**88%**	**46%**	**52%**	**22%**	**12113**

Overall Service Readiness

Service readiness was assessed based on six domains: trained staff, availability of clinical guidelines, diagnostic capacity, essential medicines, basic equipment, and supportive infrastructure. The findings showed that readiness across the five NCD service areas was suboptimal and uneven.

- Diabetes services had the highest readiness score at 71%; CVD services followed at 60%; Chronic respiratory diseases were at 55% and Mental health services at 54%
- Readiness for palliative services was 49%

Trained staff and access to updated clinical guidelines were consistently the weakest components across all disease areas, undermining service quality and patient safety.

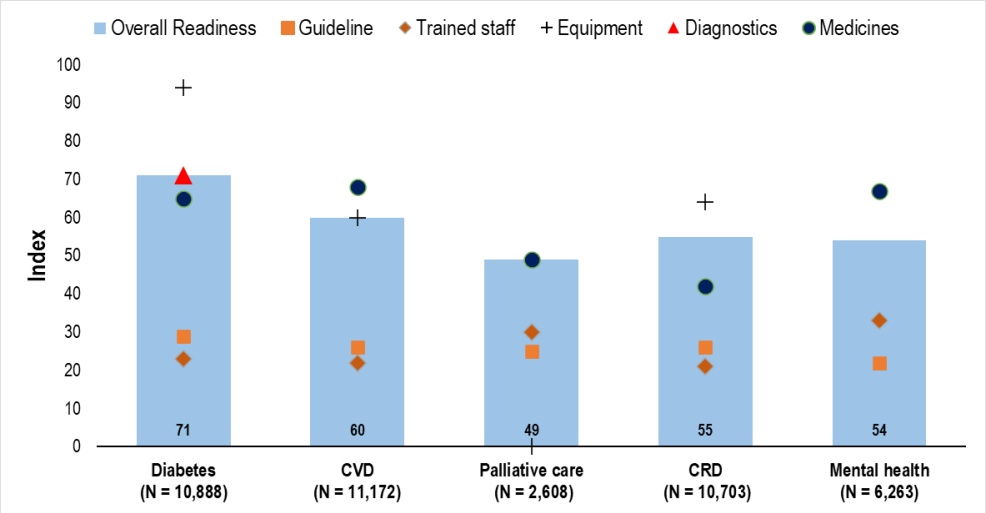

Figure 26: Readiness to provide select non-communicable diseases services (N=12,113)

DIABETES SERVICES

Diabetes care was reported in 90% of facilities that offered NCD services. High coverage was observed in various aspects of care:

- Screening: 94%
- Diagnosis: 90%
- Counseling: 91%
- Treatment: 86%
- Follow-up: 85%

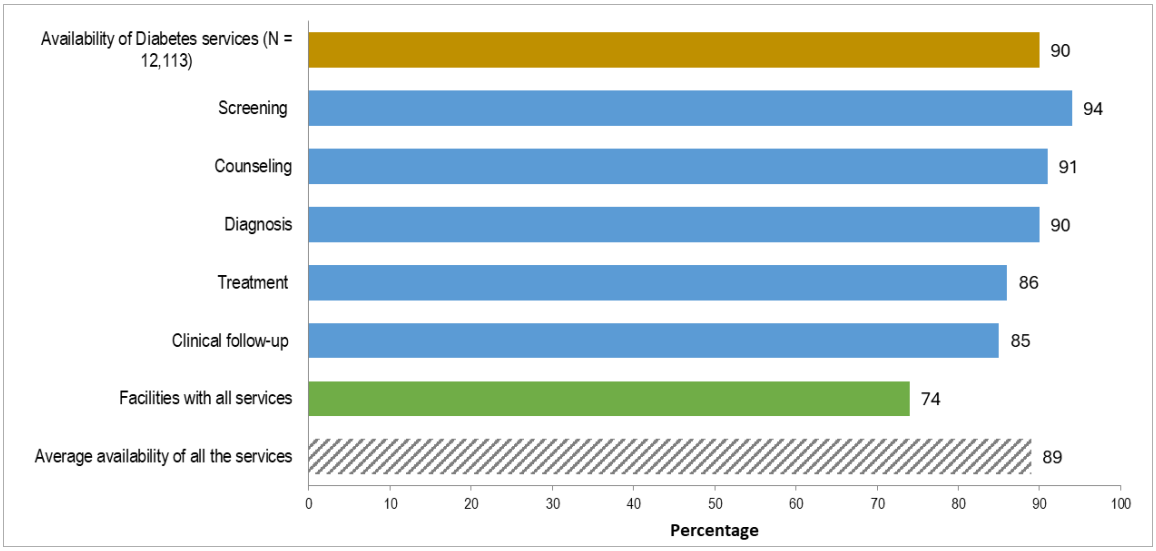

Figure 27: Percent of facilities that have diabetes services (N=10,888)

The readiness score for diabetes services was 71%, suggesting room for improvement, especially in lower-tier and rural facilities.

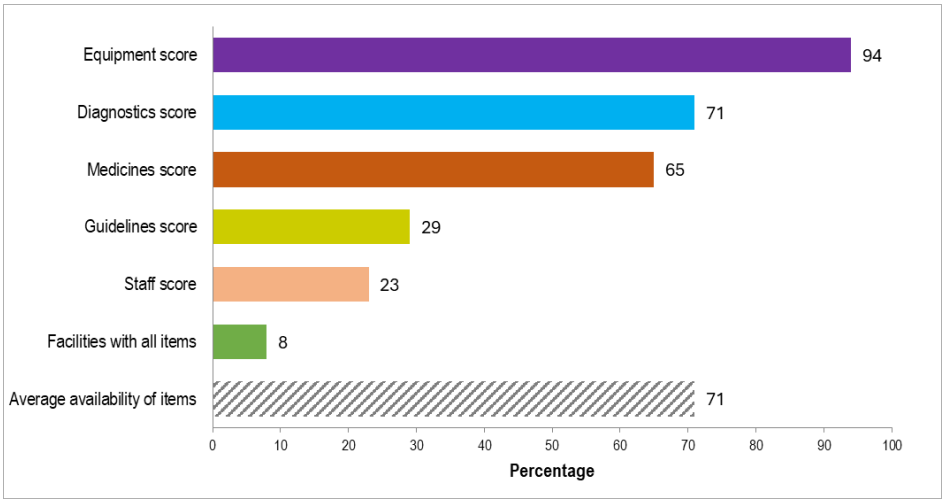

Figure 28: Readiness scores of diabetes services (N=10,888)

Only 8% of facilities had all required tracer items, such as glucometers, insulin, oral hypoglycemic agents, and test strips. Many facilities lacked HbA1c testing kits, with only 38% reporting availability. Additionally, only 29% of facilities had access to the National Clinical Guidelines for Diabetes Management, and just 23% of facilities had staff trained in diabetes care.

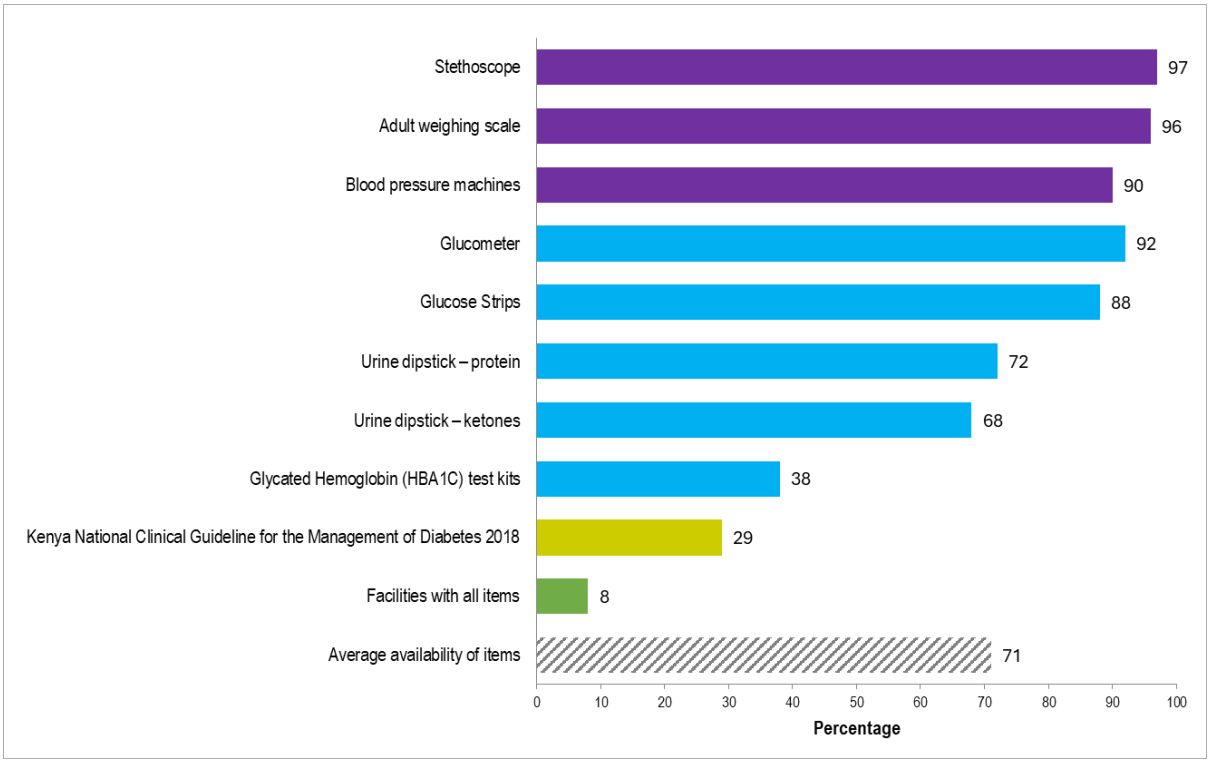

Figure 29: Percent of facilities that have select diabetes tracer items (N=10,888)

Key recommendations include:

- Expanding in-service training on diabetes management.
- Disseminating clinical guidelines more effectively.
- Investing in diagnostic infrastructure, especially for glycemia monitoring.

CARDIOVASCULAR DISEASE (CVD) SERVICES

Cardiovascular disease services were available in 92% of facilities offering NCD services, with strong performance in:

- Screening: 95%
- Diagnosis: 91%
- Counseling: 90%
- Treatment: 87%
- Follow-up: 86%

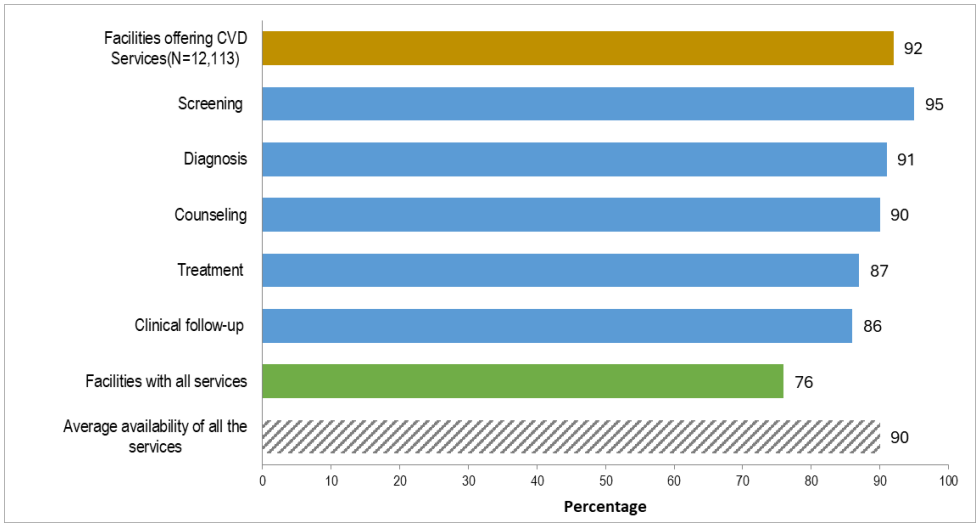

Figure 30: Percentage of facilities that have CVD services (N=11172)

Average availability of tracer items, such as sphygmomanometers, ECG machines, and antihypertensive medications was 60%. Critical gaps included lack of trained staff; and guidelines at 22% and 26% respectively. Low availability seen in lower level and rural facilities.

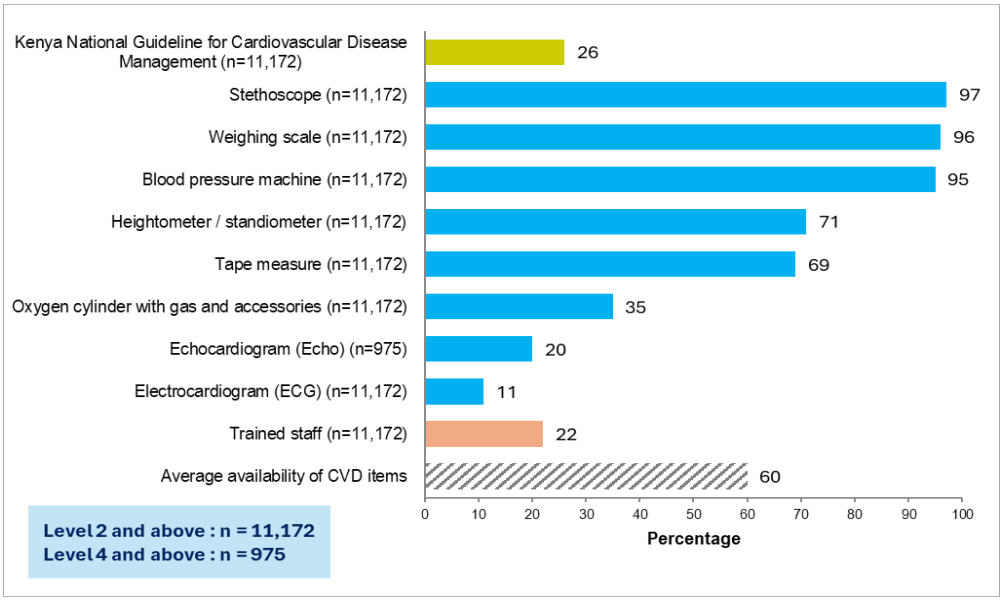

Figure 31: Percent of facilities that have select CVD tracer items (N=11172)

Recommendations include:

- Increase and sustain the supply of essential tracer elements, particularly in rural and lower-level facilities.
- Promote Access to Standardized Guidelines through nationwide dissemination.
- Leverage telemedicine to bridge the gap in healthcare access between rural and urban areas.

CHRONIC RESPIRATORY DISEASE (CRD) SERVICES

Service availability for chronic respiratory diseases, including asthma, bronchitis, and COPD, was 88%, but there were significant disparities:

- Asthma services were most common
- Bronchiectasis and cystic fibrosis were least available, with only 45% and 21% of facilities, respectively, reporting capacity to manage them.
- The average service availability for chronic respiratory diseases was at 62% with only 20% of facilities having all the services.

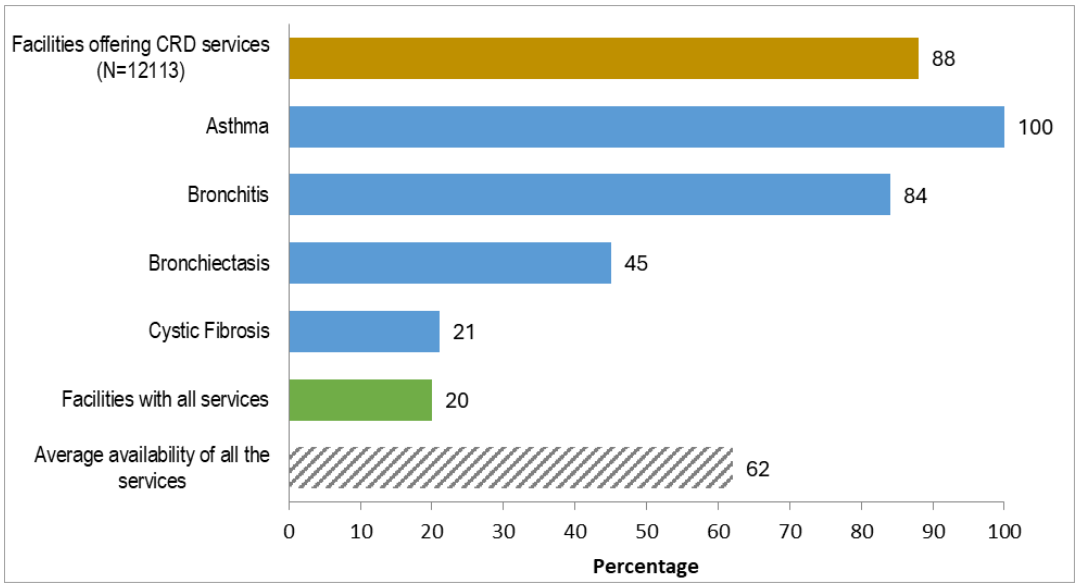

Figure 32: Percent of facilities that have CRD Services (N=10,703)

Readiness for CRD care was also poor:

- Average readiness index: 55%
- Trained staff and guidelines were the least available tracers at 21% and 26%, respectively.

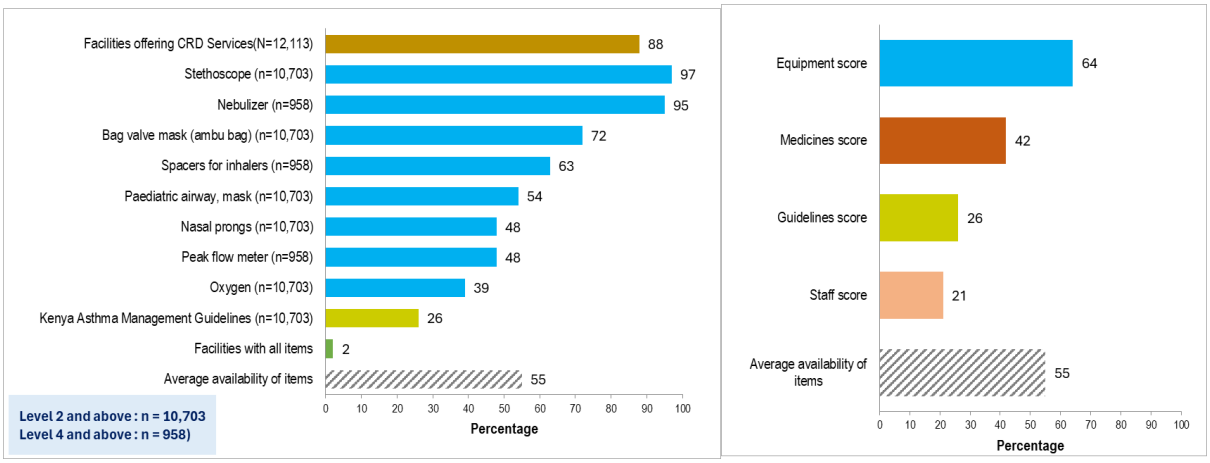

Figure 33: Percent of facilities that have tracer CRD items (N=10703)

- Availability of CRD tracer medicines in rural regions (32%) is lower compared to urban regions (50%).
- Majority of counties have a moderate average availability of CRD tracer items, falling within a range of 41% - 60%

The lack of diagnostic tools such as spirometers, coupled with inconsistent medication availability, limits the ability to provide standardized care.

Recommendations

- Increase investment to ensure adequate availability of essential equipment
- Training health workers on the management of asthma and COPD
- Establish public-private partnerships to expand service coverage and optimize resource allocation
- Disseminate the national guidelines

CANCER SERVICES

- Cancer services were offered in 46% of the health facilities
- The most available services included cervical cancer (93%) and breast cancer services (86%)
- The least available cancer services were oesophageal cancer (7%) and colorectal cancer (9%)
- Only 5% of facilities offered all five cancer services
- The readiness to offer cancer services was highest for colorectal cancer (43%), followed by oesophageal cancer (39%), breast cancer (37%), cervical cancer (36%) and prostate cancer (35%)

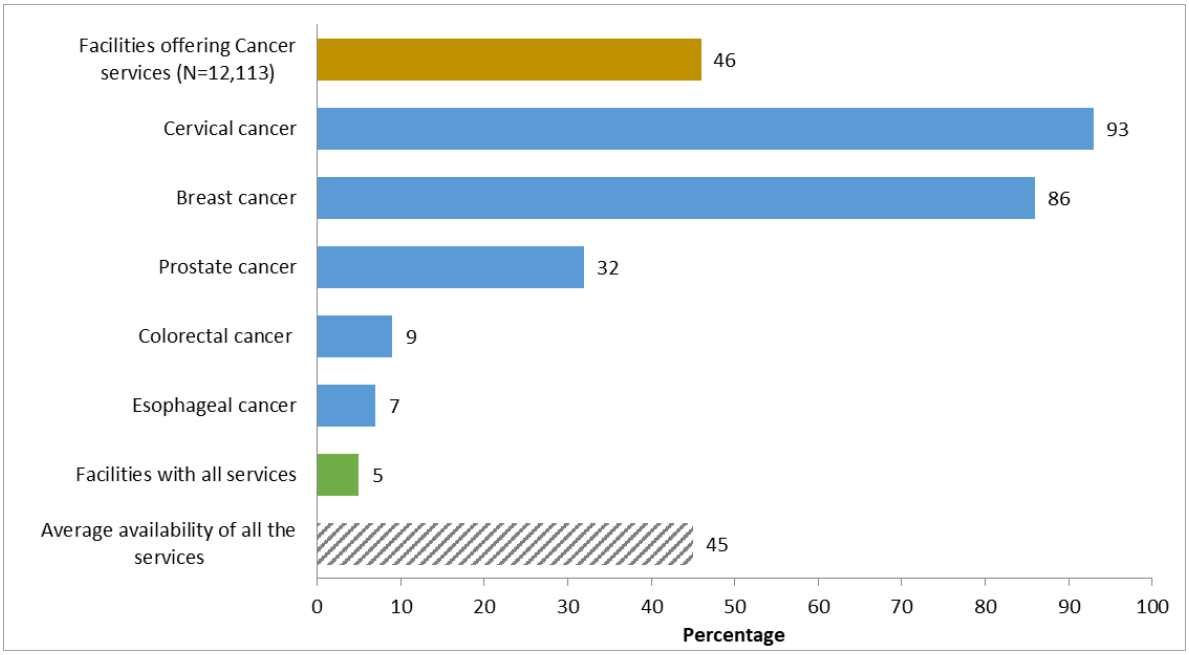

Figure 34: Percent of health facilities that have select tracer cancer services (N=5,577)

- Inadequate biopsy tools, imaging equipment (e.g., ultrasound, mammography), pathology support, cancer treatment drugs and trained oncology staff significantly constrain effective service delivery.

Recommendations

- Establishing regional cancer centres with referral linkages to improve access to quality cancer care
- Expanding investment in diagnostics, including imaging and laboratory services to ensure timely cancer diagnosis
- Improving on the availability of essential chemotherapy medicines, radiotherapy services, surgical cancer treatment and palliative care for improved patient outcomes

MENTAL HEALTH SERVICES

Mental health remains one of the most underdeveloped service areas in Kenya's health system. Only 47% of facilities reported offering mental health services, with most focused on basic counselling and provision of psychotropic drugs.

- Referral for further management, counselling and support services were the most readily available services at 87% and 86% respectively.
- Mental health services for those aged below 19 years were least readily available at 42%
- Availability of specialized services in level 4 and 5 facilities ranged between 66% (dementia) to 89% (epilepsy/seizures)

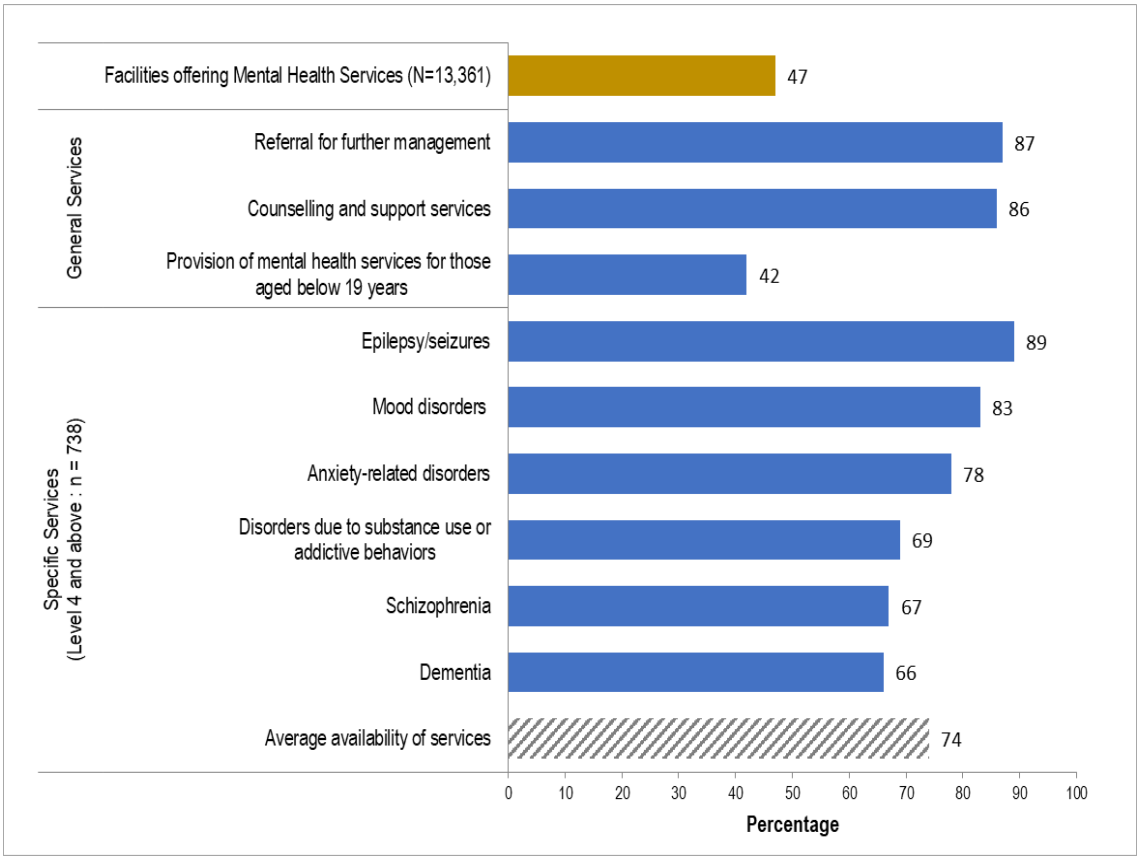

Figure 35: Percent of facilities that have select mental health services (N=6263)

However, readiness was low; the gaps included:

- Shortage of psychotropic medications-67%
- Absence of trained psychiatric staff or counsellors.
- Poor infrastructure for private consultation or inpatient psychiatric care.

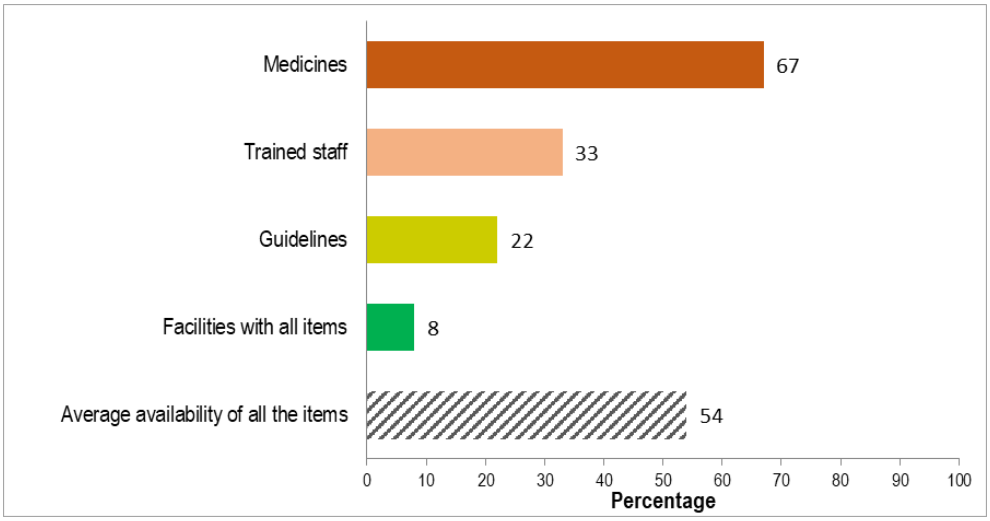

Figure 36: Percent of facilities that have select tracer mental health items (N=6263)

The stigma surrounding mental health further impedes service delivery and utilization. Recommendations include:

- Integrating mental health into primary care services and routine health screenings.
- Training frontline workers in psychological first aid and community mental health interventions.
- Strengthening medicine supply chains and mental health referral networks.
- Increase budget allocations for equipping mental health facilities with necessary tracer items.
- Collaboration between public institutions, private entities, and NGOs to expand service coverage.

PALLIATIVE CARE

Palliative care services were offered in 20% of health facilities. Outpatient care was the most common, available in 77% of these facilities, while inpatient services were highest in level 4 and 5 hospitals (85%). Home-based palliative care was least available (45%), and only 24% of facilities had linkages with external organizations. Urban facilities reported stronger linkages (30%) compared to rural (18%). County-level disparities were evident: Mombasa (79%), Narok (74%), and Kwale (71%) had the highest service availability, while Wajir (37%), Tana River (31%), and Lamu (27%) had the lowest.

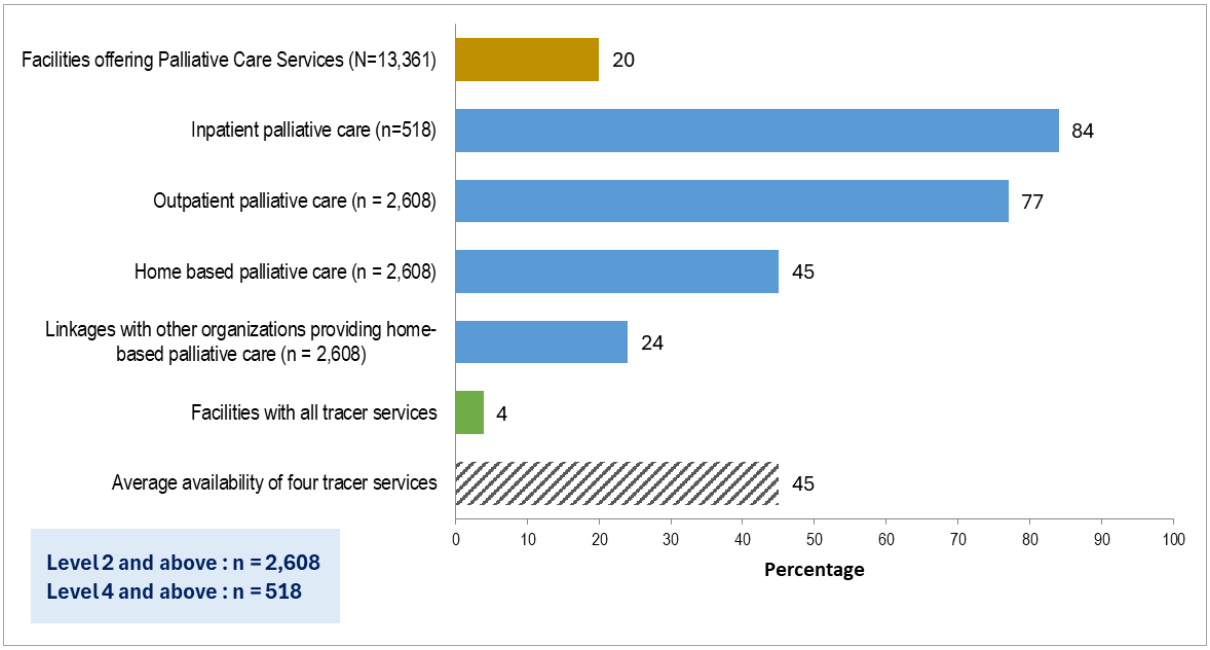

Figure 37: Percent of facilities that have select palliative care services (N=2608)

Readiness to provide palliative care was modest. Only 49% of tracer medicines and commodities were available, with common pain relievers, IV fluids, and iron/folic acid showing

relatively high availability (>70%), while opioid analgesics (25%) and oral food supplements (32%) were much lower

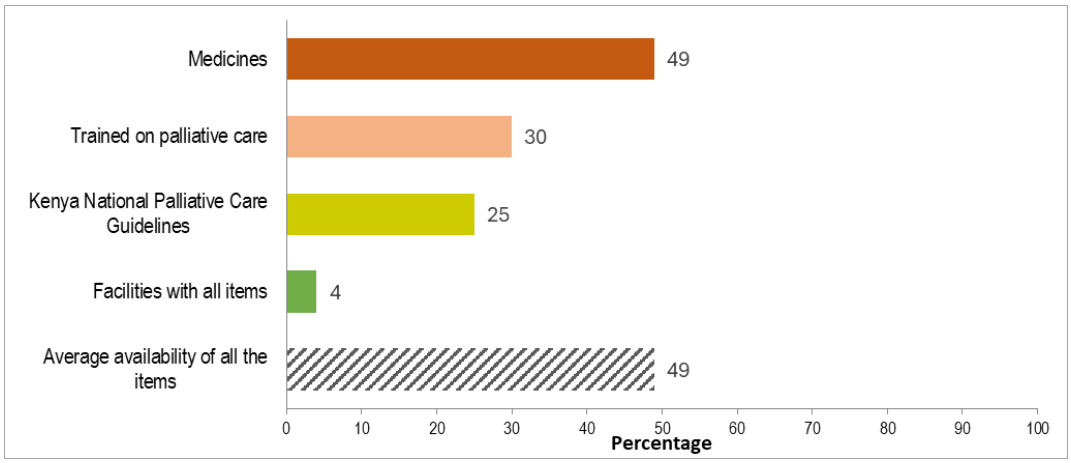

Figure 38: Percent of facilities that have tracer palliative care items (N=2608)

Recommendations

- Strengthen referral and linkages with home-based care providers to improve continuity of care.
- Build the capacity of palliative care workforce
- Improve dissemination of national guidelines and integrate them into healthcare curricula.
- Address geographic disparities by prioritizing support for rural and underperforming counties.
- Enhance access to essential medicines, particularly opioids and nutritional supplements, while ensuring safe prescribing and use.

Conclusion and Recommendations

The findings highlight critical gaps in Kenya's readiness to tackle the growing burden of NCDs. While availability has improved in several areas, readiness remains inadequate, particularly in rural, lower-tier, and public facilities. Cross-cutting recommendations include:

- Expand NCD integration into primary healthcare, ensuring that all facilities offer the services as per KEPH level.
- Invest in diagnostics and commodities, especially for diabetes, CVD, CRDs, and cancers.
- Strengthen training and clinical mentorship, focusing on guideline use and case management.
- Improve infrastructure for mental health and cancer services.
- Develop regional centres of excellence for oncology, CRD, and NCD diagnostics to decongest national referral hospitals.

Collectively, these efforts will strengthen Kenya's response to NCDs and advance the national UHC agenda.

REPRODUCTIVE, MATERNAL, NEWBORN, CHILD AND ADOLESCENT HEALTH (RMNCAH) AND NUTRITION

Introduction

Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCAH) is a cornerstone of Kenya's commitment to achieving Universal Health Coverage (UHC). The RMNCAH program aims to eliminate preventable deaths and ensure that women, children, and adolescents live healthy lives. Services span the continuum of care—from pre-pregnancy through pregnancy, childbirth, postpartum, infancy, and adolescence—covering preventive, promotive, curative, and rehabilitative interventions.

General Findings on Availability

According to the 2024 assessment, key findings across RMNCAH sub areas include:

- Child health services were the most available, with 90% of facilities offering these services.
- Basic Emergency Obstetric and Newborn Care (BEmONC) and nutrition services were less available, at 46% and 42% respectively.
- Only 2 in 10 facilities had all RMNCAH service components.

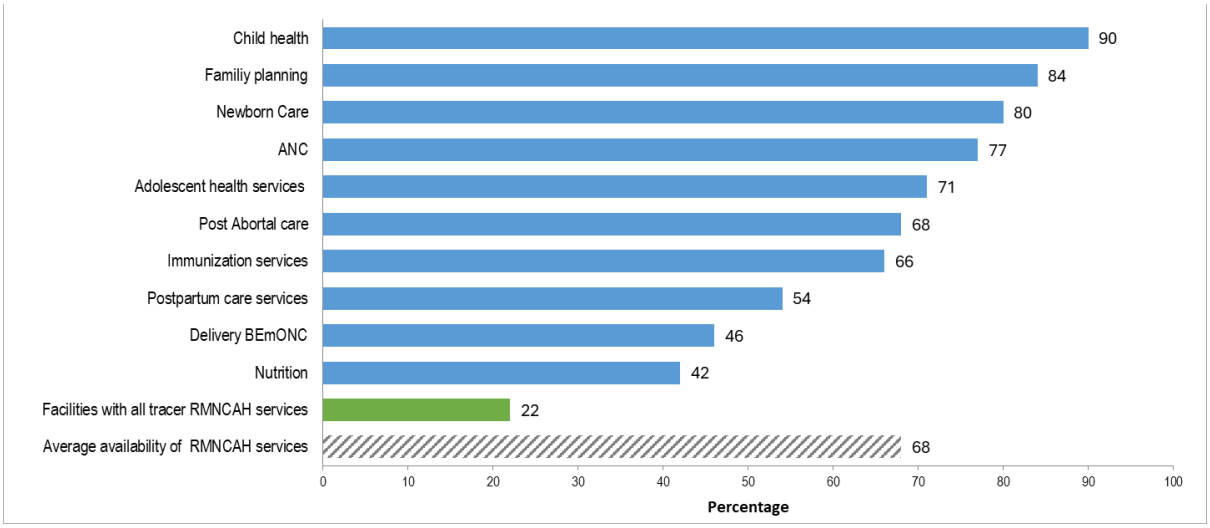

Figure 39: Percentage of facilities that have services available by RMNCAH subareas (N=13,361).

This disparity reflects both infrastructure and workforce limitations in some regions and levels of care.

FAMILY PLANNING

Access to quality family planning (FP) services is a key driver in improving reproductive health outcomes and empowering individuals to make informed choices about their reproductive lives. The quality of care survey assessed the state of family planning services across Kenya, focusing on two critical aspects: the supply-side factors, including the availability of family planning

services and the readiness to offer them, and the demand-side factors, including client experiences and satisfaction, at health facilities across various counties.

Service Availability

- Family Planning services were available in 85% of facilities nationally.
- Counseling was most common (95%), while surgical methods were least available (BTL at 41%, vasectomy at 21%).
- Average availability of the 14 tracer services stood at 58%.
- Urban facilities offered more long-term and surgical methods; rural facilities had better access to male condoms and emergency contraception.
- Higher-level facilities (Level 4 & 5) provided the widest range of FP services, especially IUCDs and implants; lower-level facilities had limited options, especially for DMPA-SC.
- NGO and FBO facilities reported higher availability of certain commodities, while public facilities showed strong coverage of essential FP services.
- County variation: Most counties had ≥80% of facilities offering FP; however, Mandera (35%) and Wajir (38%) had the lowest tracer service availability.

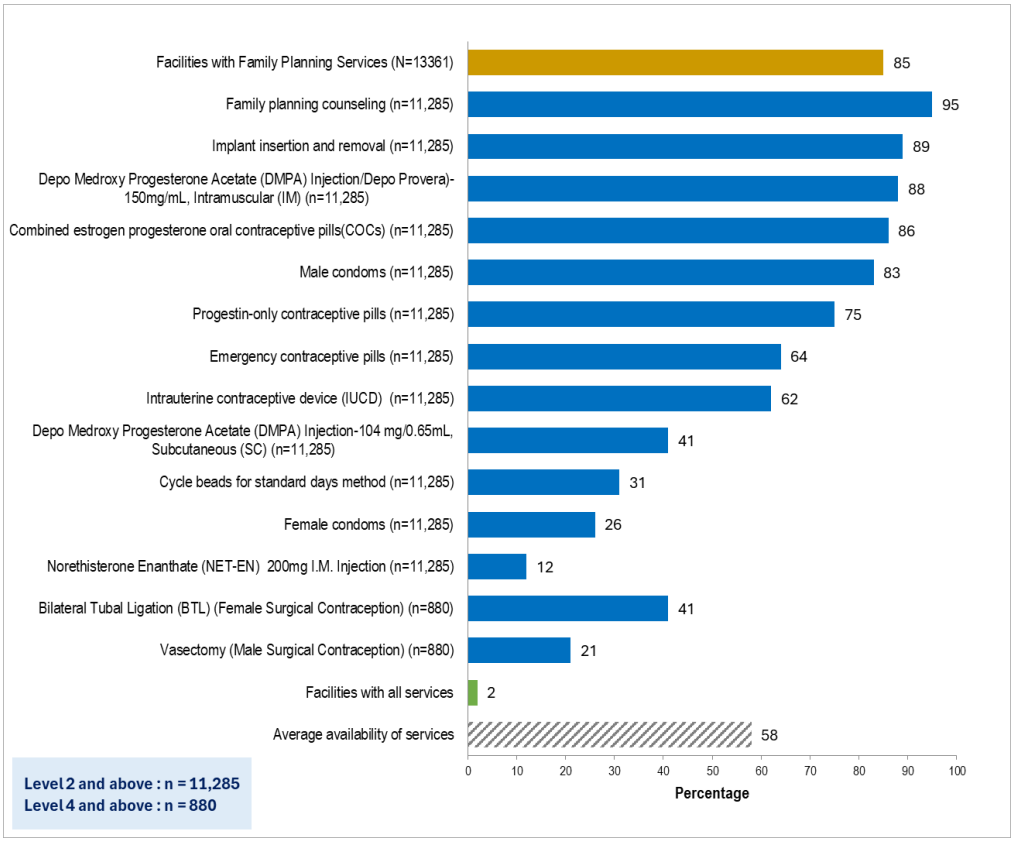

Figure 40: Percentage of facilities with family planning tracer services available N=11285

Service Readiness

- Average readiness score for FP tracer items was 52%.
- Commodities moderately available (54%) – COCs, DMPA injections, condoms, and 2-rod implants were widely stocked.

- Equipment availability was relatively high (70%), especially BP apparatus (86%) and designated FP rooms (77%).
- Guidelines were poorly available (27%), and only 31% of facilities had FP-trained providers in the past 2 years.
- Readiness was highest in Level 5 (71%) and lowest in Level 2 (49%).
- Public facilities scored better (54%) than private (49%); urban facilities outperformed rural on most tracer items.
- County disparities: readiness ranged widely, with Kakamega, Homa Bay, Migori, Narok, Nakuru, Kiambu, and Kajiado (61–80%) performing best, while Kericho (26%) and Mandera (22%) scored lowest.

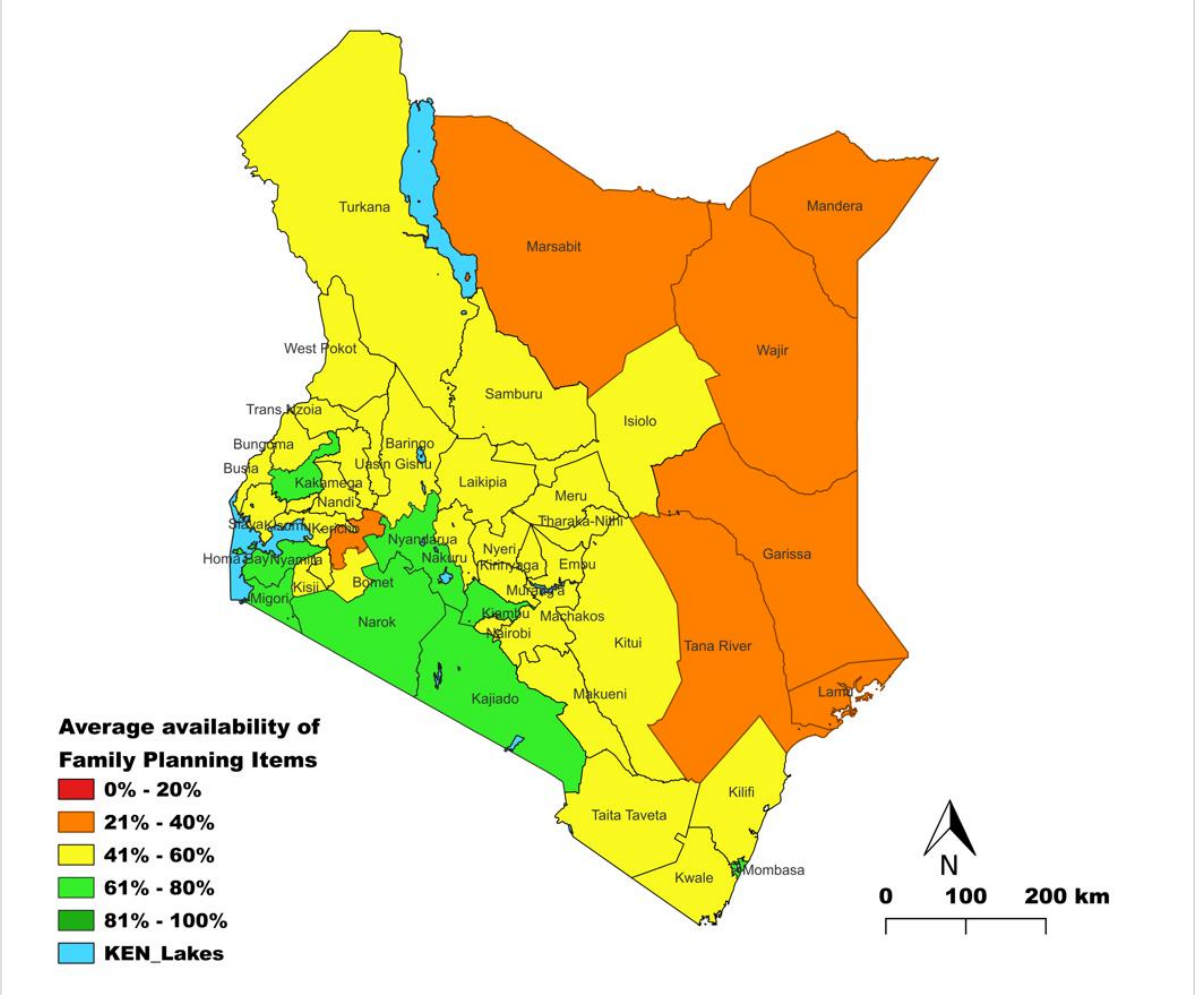

Figure 41: Average readiness to offer family planning services by county

ANTENATAL CARE (ANC)

Service Availability

- Slightly more than three-quarters (77%) of facilities provided ANC services.
- Tetanus toxoid vaccination; HIV test and IFAS had the highest availability
- Obstetric ultrasound was the least available service with less than a fifth of facilities providing it

- Only 7% of the facilities offered all the recommended ANC services.

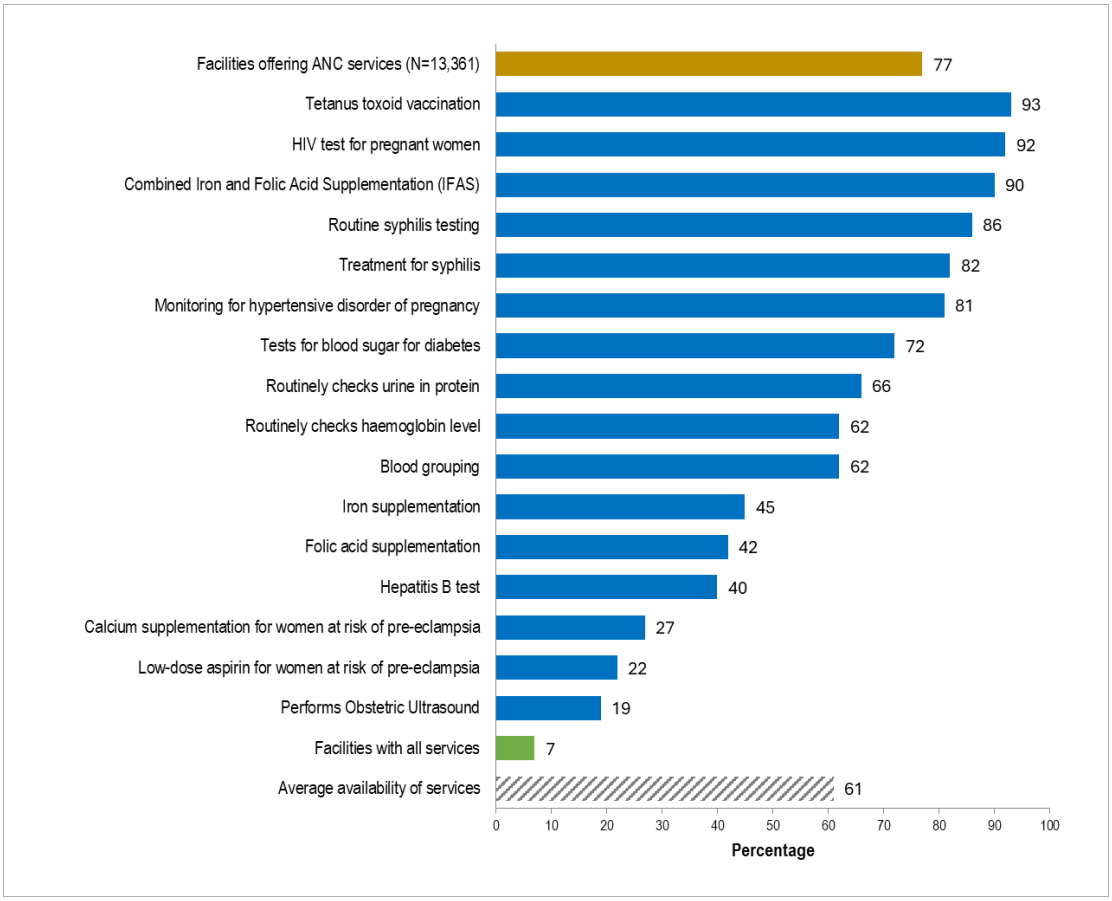

Figure 42: Availability of ANC tracer services

Service Readiness

- The average availability of ANC tracer items was 67%.
- Guidelines were the least available tracer items at 22% while commodities were the highest at 88%.

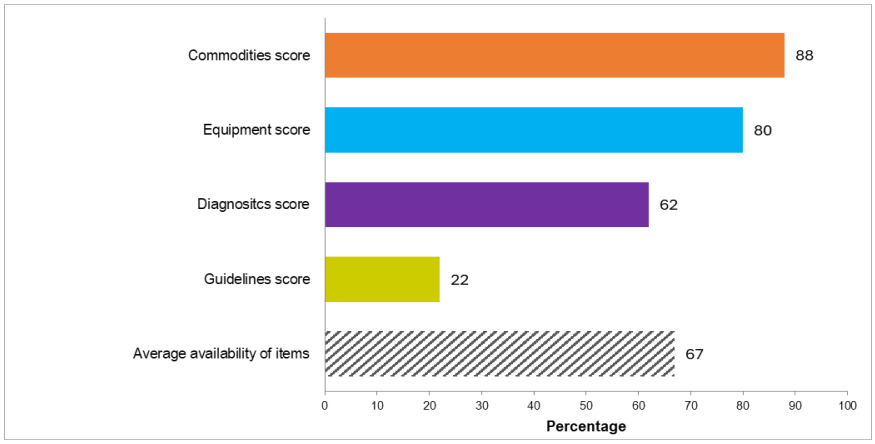

Figure 43: Average readiness score for ANC services (N=10,317)

- Generally higher availability of tracer items in urban, FBO/NGO and higher-level facilities

- Equipment such as adult weighing scales, examination couches and blood pressure apparatus were the most available tracer items at 96%, 96% and 95% respectively, while obstetric ultrasound was the least available equipment, with 37% of facilities having it.
- Two of every three facilities offering ANC services had urine dipstick protein test available while the availability of hemoglobin, blood grouping and rhesus tests were 62%, 62% and 58% respectively.

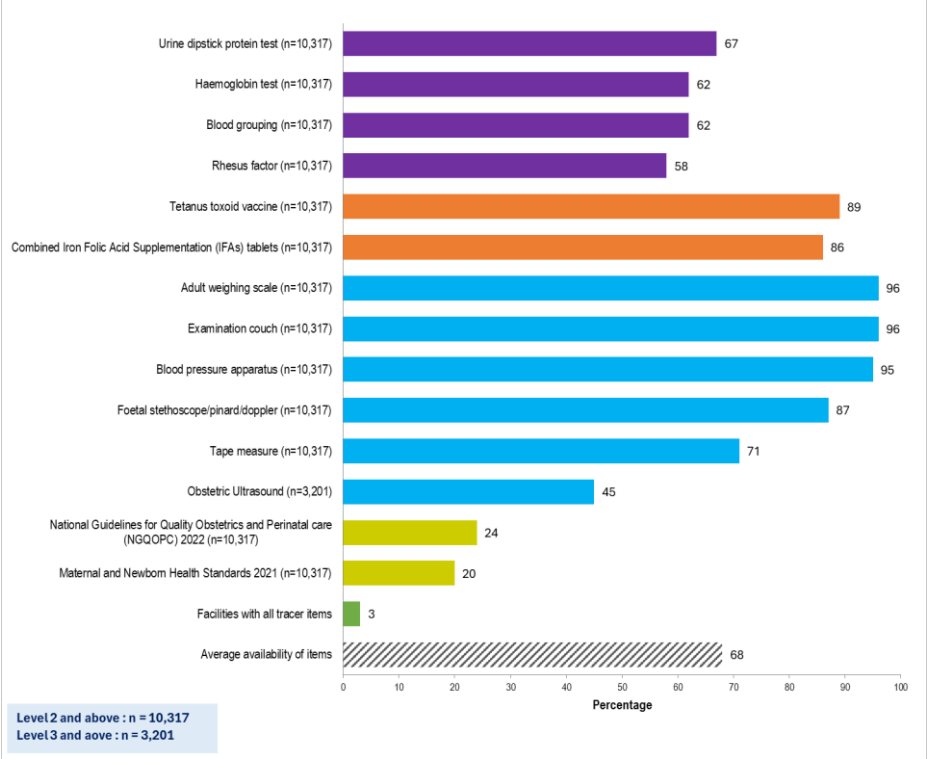

Figure 44: Average readiness to offer ANC services N=10,317

Recommendations

- Strengthen investments to ensure continuous availability of essential services and commodities at ANC facilities, preventing missed opportunities for care despite good client adherence.
- Address gaps in managing high-risk pregnancies by ensuring consistent availability of specialized services and required commodities, supported by ongoing monitoring and supply chain strengthening

Childbirth and Delivery Services

General Availability

- Only 46% were equipped to offer BEmONC signal functions.
- Comprehensive EmONC (CEmONC) services were largely limited to Level 4 and 5 hospitals.

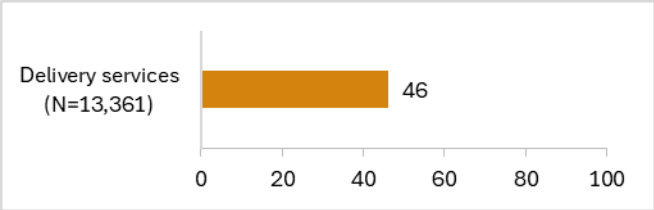

Figure 45: Percent of facilities that have select Delivery services(N=6132)

General Readiness

- Many facilities lacked 24-hour coverage, blood transfusion capacity, or surgical readiness.
- Readiness improved at higher-level facilities, but even some Level 4 facilities lacked essential commodities such as uterotonics or vacuum extractors.

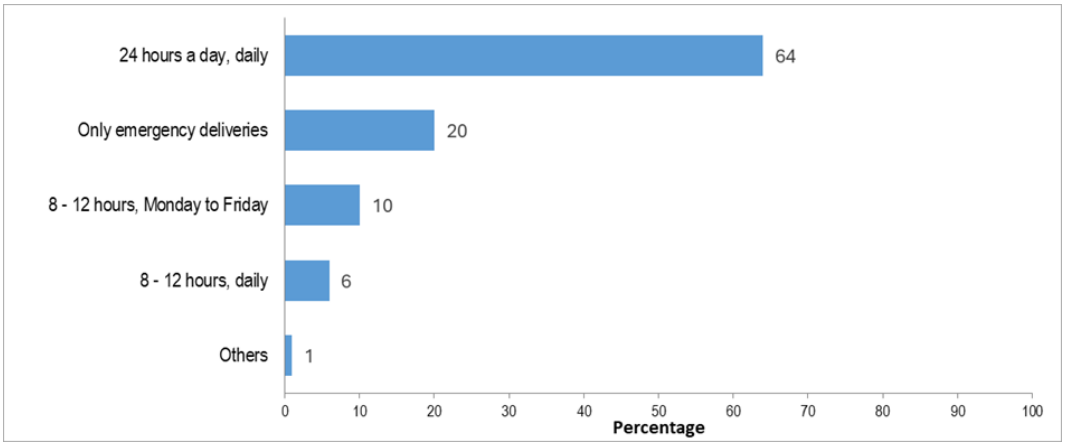

Figure 46: Percent of facilities offering delivery services operating hours(N=6,132)

BEmONC Availability

During the survey the following tracer items were checked to assess Basic Emergency Obstetric and Newborn Care services in hospitals with delivery services:

Table 8: BEmONC tracer services

Domain	Tracer services (7 signal functions)
Basic Emergency Obstetric Newborn Care and (BEmONC) services provided	Parenteral administration of antibiotics Parenteral administration of oxytocic drugs Parenteral administration of anticonvulsants Assisted vaginal delivery Manual removal of placenta Manual removal of retained products Neonatal resuscitation

Findings

Nationally, 46% of all health facilities offer delivery services, as shown in Figure 31 below. Further analysis of the availability of 7 BEmONC signal functions among the health facilities offering delivery services (N=6132) showed that;

- The full package of Basic Emergency Obstetric Newborn Care (BEmONC) services (7 signal functions) was available in 37% of facilities offering delivery services.
- The most available BEmONC services were manual removal of retained products (70%) and placenta (69%) as well as parenteral administration of both antibiotics (69%) and oxytocic drugs (69%.). Less than half the facilities (48%) conducted assisted vaginal delivery.

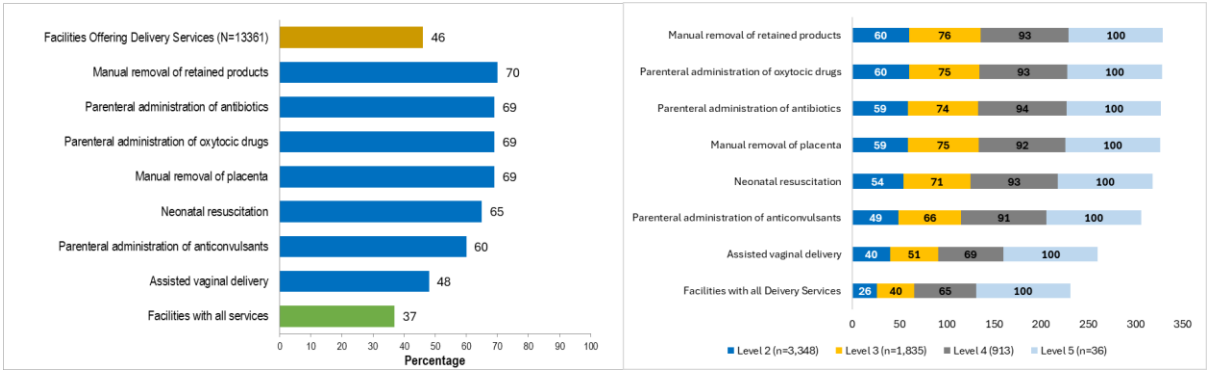

Figure 47: Percent of facilities that have select BEMONC tracer services (N=6132)

County Distribution

Figure 48 shows the average availability of BEmONC services disaggregated by county.

- In most counties, the percentage of facilities offering all BEmONC services ranged between 21% and 40%.
- Counties that had availability of above 61% were Meru (71%), Kajiado (68%), Nairobi (63%), Migori (66%) and Nyandarua (66%).

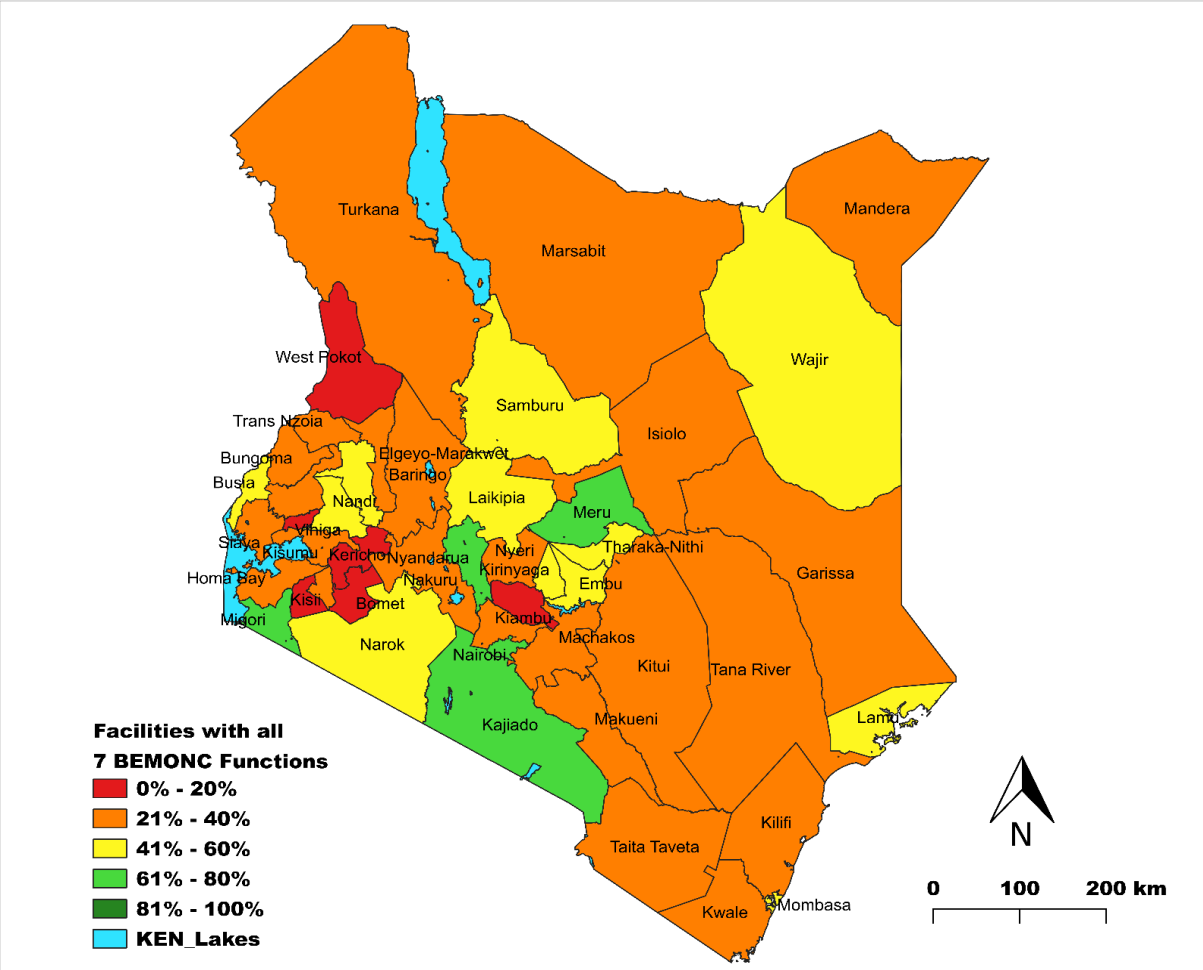

Figure 48: Availability of BEmONC Services by county

CeMONC Availability

The survey assessed availability of the nine CEmONC signal functions in levels 4 and 5 facilities offering delivery services.

Table 9: CEmONC tracer services

Domain	CEmONC tracers (9 signal functions)
Comprehensive Emergency Obstetric Newborn Care (CEmONC) services provided (Level 3,4 and 5)	1. Parenteral administration of antibiotics 2. Parenteral administration of oxytocic drugs 3. Parenteral administration of anticonvulsants 4. Assisted vaginal delivery 5. Manual removal of placenta 6. Manual removal of retained products 7. Neonatal resuscitation 8. Blood Transfusion 9. Caesarean Section

Findings

National:

Among the level 4 and 5 health facilities offering delivery services;

- The full package of (Comprehensive Emergency Obstetric Services) CEmONC was offered at 46% of the facilities.
- Most of the facilities offered parenteral administration of antibiotics (94%), oxytocic drugs (93%), manual removal of retained products of conception (93%) and neonatal resuscitation (93%).
- The least available CEmONC services were caesarean section (65%) and blood transfusion (67%) .

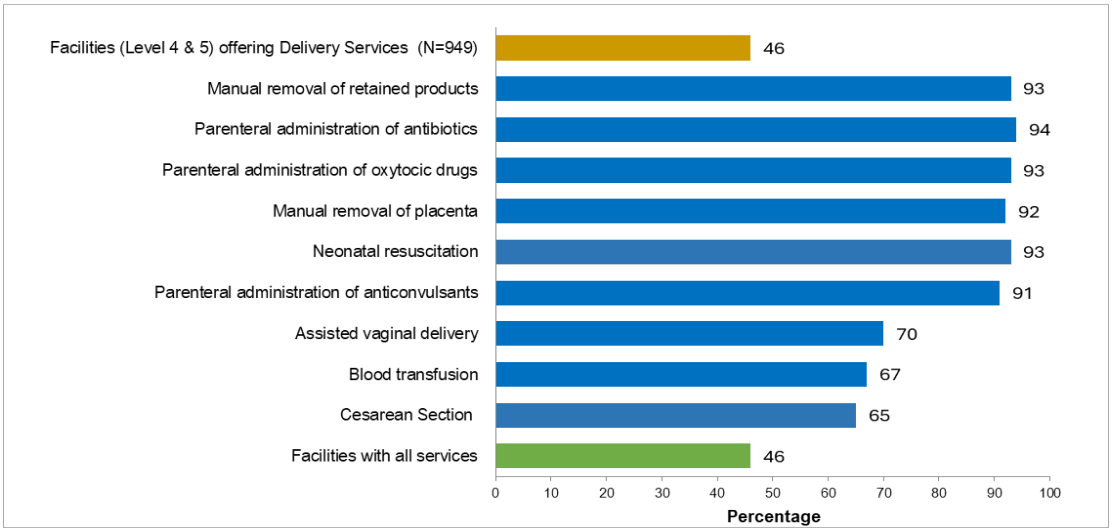

Figure 49: Percent of health facilities that offered CEmONC signal functions

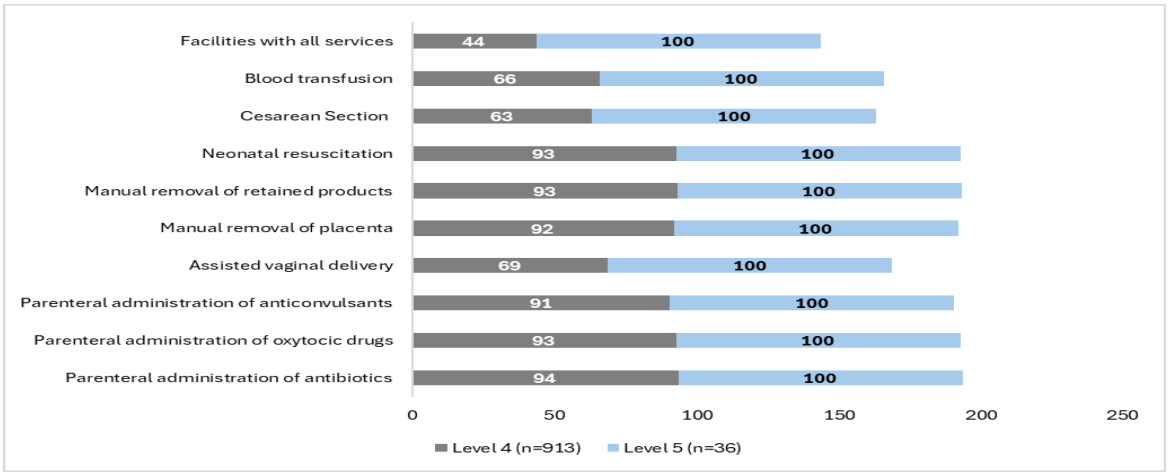

Figure 50: Percent of facilities (levels 4 and 5) that had CEmONC services (9 signal functions) by KEPH Level

Disaggregation by location, KEPH level and ownership

- The full CEmONC package was available in 55% of urban facilities and at only 28% of rural facilities.
- Caesarean section and blood transfusion were offered in 77% and 76% of urban facilities respectively compared to 41% and 49% of rural facilities respectively.

- All the level 5 facilities had full CEmONC package available compared to 44% of level 4 facilities.
- The least available signal function in level 4 facilities was caesarean section at 63%
- The full CEmONC package was most offered in FBO facilities (68%) followed by private facilities (56%), public facilities (34%) and NGO facilities (33%)
- All facilities in Lamu and Kwale counties offered the entire CEmONC package.
- None of the facilities in Elgeyo Marakwet county offered all the 9 CEmONC signal functions.
- Elgeyo Marakwet had the least proportion of facilities that provided both blood transfusion and caeserian section at 22% and 33%, respectively.

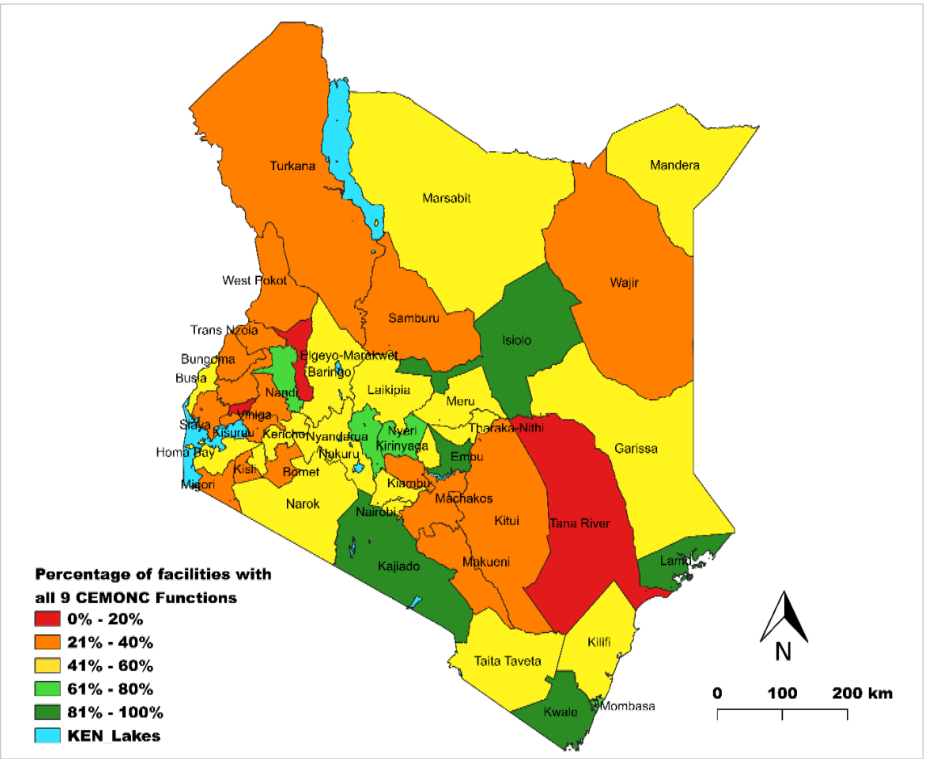

Figure 51: Availability of CEmONC services by county

Discussion

There is a slight decline in the proportion of facilities offering delivery services from 50% in 2018 KHFA to 46% in this survey. The proportion of facilities offering delivery services with all the 7 BEmONC signal functions had tripled to 37%, from 12% in 2018 KHFA. The full CEmONC package (9 signal functions) were offered in 46% of the hospitals (Level 4 and 5).

Conclusion

The availability and readiness to offer basic delivery services was generally low, with notable gaps in the availability of the tracer items. The readiness to provide comprehensive maternity services was also very low with a notable gap in the availability of Caesarean section and blood transfusion services especially in the level 4 facilities.

Table 10: Delivery recommendations

Findings	Recommendations
• Less than half of all facilities were offering delivery services with a disparity by location and KEPH level. • Almost two thirds of facilities conducting delivery services do not offer the entire BEmONC package. • Less than half of levels 4 and 5 facilities that offered delivery services had the full CEmONC package.	• There is an urgent need to make investments in expanding the service availability and readiness to offer both basic and comprehensive maternity services.
• Low availability of essential medical equipment (radiant warmer, resuscitation table and manual vacuum aspirator), medical oxygen and medicines.	• Health facilities offering childbirth services to ensure all the requisite equipment and medical supplies are availed to ensure provision of quality maternal and child health services.
• Low availability and use of partographs in monitoring labour during child birth.	• Ensure availability and utilization of partographs in monitoring of labour for better maternal and neonatal outcomes. Continuous training on partographs, including e-versions, should be embedded in all delivery curricula and CPD.

POSTNATAL CARE

Postnatal care services are a fundamental component of maternal and newborn health and also a key to achieving the Sustainable Development Goals (SDGs) on the reduction of maternal mortality rates and end preventable deaths of newborns.

Service Availability

- Slightly more than half (54%) of the facilities in Kenya provide postpartum care services.
- Among the facilities providing postpartum services, almost all (94%) provide outpatient postnatal services.
- Delivery services were available in 46% of facilities, with 84% of these providing inpatient postnatal services.

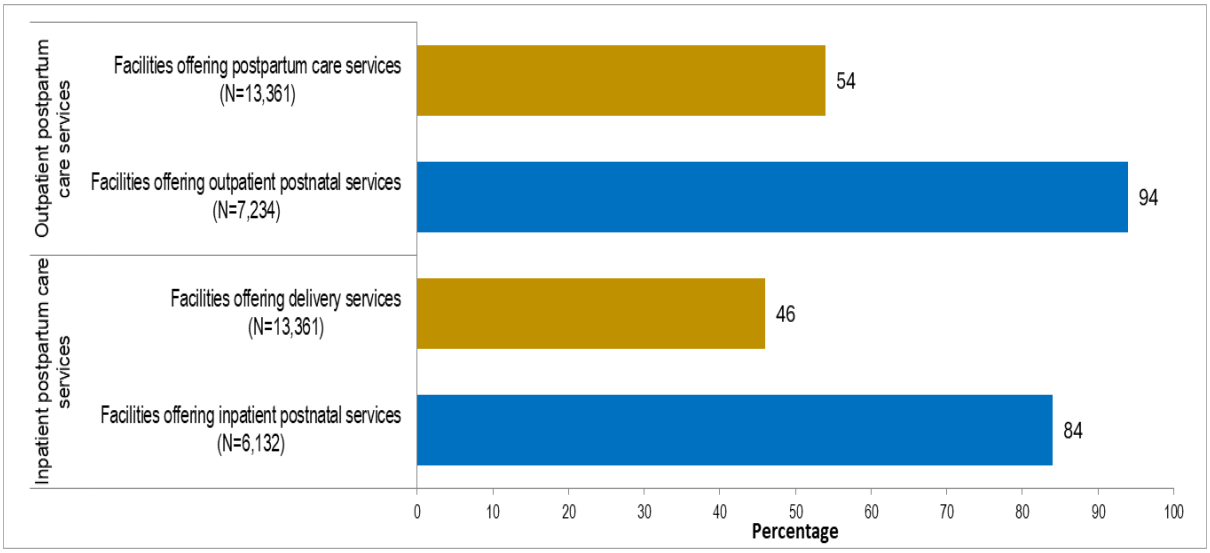

Figure 52: Availability of inpatient and outpatient postpartum care services

Service Readiness

- One third (34%) had all the tracer items available.
- The average availability of postnatal tracer items was 78%.
- There was varied availability of the tracer items; 89% equipment, 76% commodities and 73% infrastructure.
- Thermometer and infant weighing scale were the most available tracers at 90% and 89% respectively.

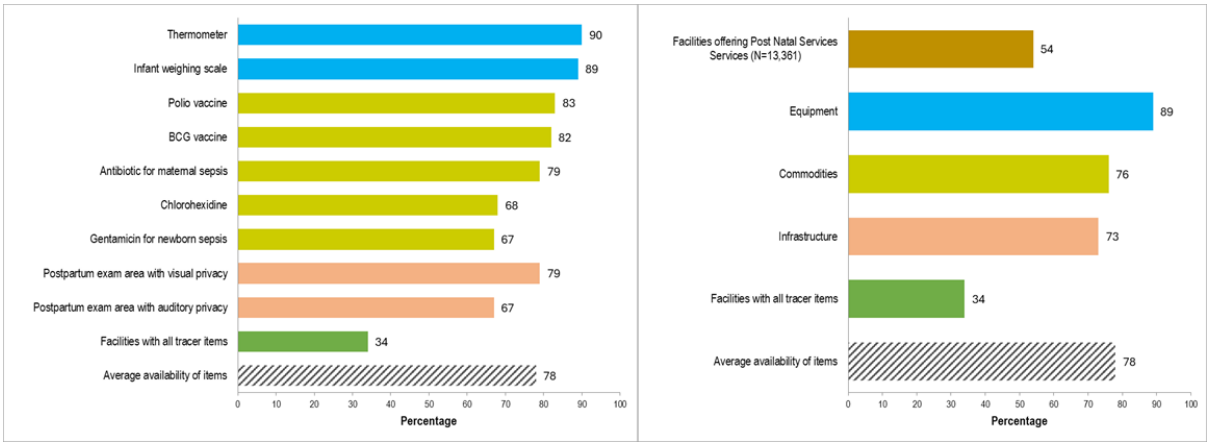

Figure 53: Percent of facilities that have select post-natal tracer items (N=7234)

Recommendations

- Interventions of prevent and manage PPH should be offered at all health facilities to ensure that maternal mortality as a result of this complication does not occur.
- The low availability and readiness of PNC services in level 2 facilities point towards a need to strengthen Primary Care Networks to achieve UHC.

There is a critical need for counties to review the findings of this assessment due to the low availability and readiness of several PNC tracer services that may hinder their achievement of good maternal and newborn health outcomes.

POST ABORTION CARE SERVICES

Unsafe abortions are the fifth leading cause of maternal death in Kenya. Post abortion care (PAC) is vital for treating complications from unsafe abortions and providing family planning. Quality PAC reduces health risks and lowers maternal mortality.

The Quality of Care (QOC) assessment evaluated both the availability of PAC services and the readiness of health facilities to deliver them. Only facilities providing postnatal services (N=7,234) were included in the assessment.

Service Availability

PAC services were available at 68% (n=4918) of facilities providing postnatal care. Nearly all facilities offered PAC counseling, but only 58% provided Dilatation and Curettage (D&C). The average availability of PAC tracer services was 77%.%.

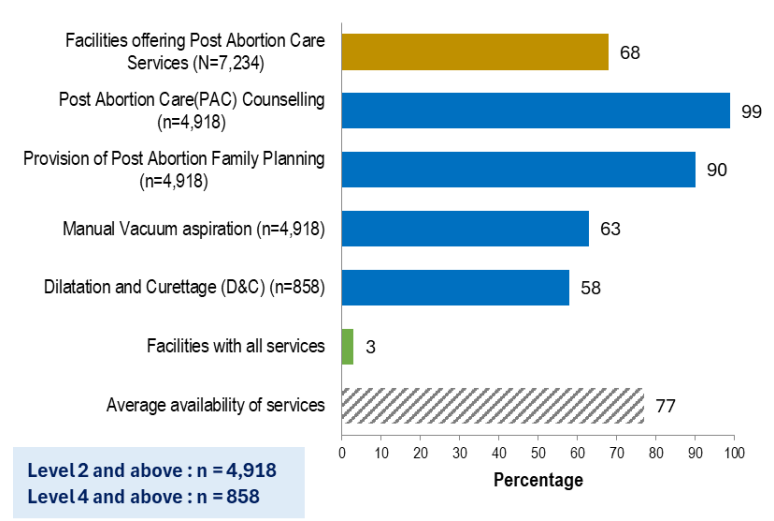

Figure 54: Availability of PAC services in facilities offering Postnatal Care

Disaggregation by location, KEPH level and ownership.

PAC service availability was higher in urban (82%) than rural areas (70%). Nearly all level 5 facilities (98%) offered PAC, compared to about 8 of every 10 level 2 facilities. PAC counseling and post-abortion family planning were accessible across all facility levels. Private facilities had the highest availability (86%), while FBO and public facilities reported lower rates at 74% and 72%, respectively.

By County,

- Figure 55 shows that majority of the counties had over 70%average availability of PAC services. On the other hand, The lowest average availability of PAC services were recorded in Nandi (65%), Kitui & Tharaka Nithi (66%), West Pokot (67%), Kisumu & Murang'a (68%) and Meru (69%).

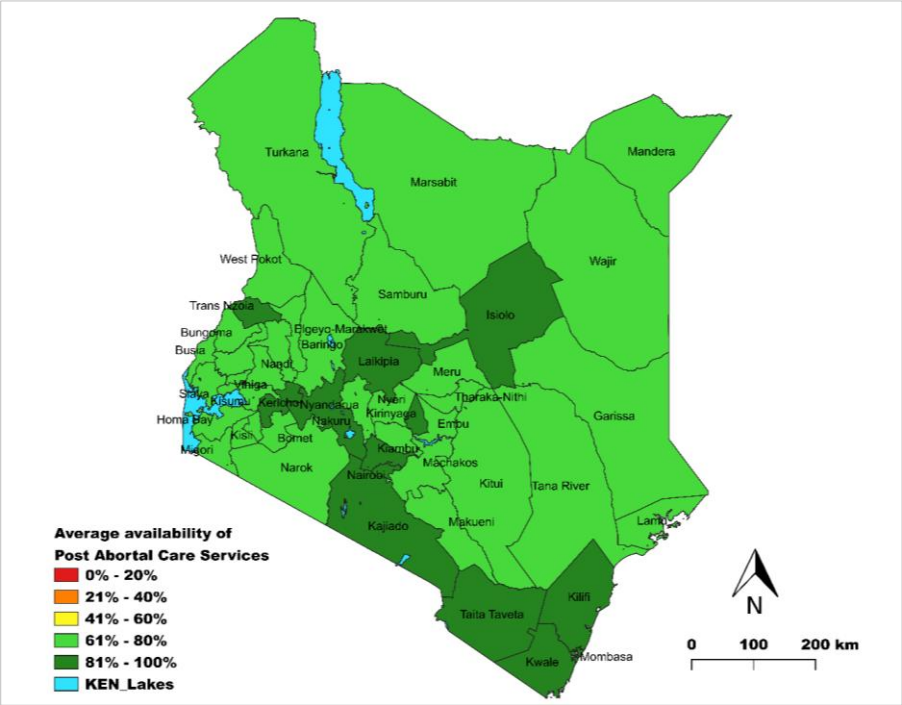

Figure 55: Availability of PAC tracer services disaggregated by county

Service Readiness

To assess the readiness of PAC services in the country, tracer equipment (2), guidelines (2) and medicines (3) were assessed, as detailed in the following table.

The availability of tracer items for PAC varied, with medicines at 74%, equipment at 58%, and guidelines at 21%. Vacuum aspirators were available in 56% of facilities, whereas D&C kits were present in 27%. Only 20% of facilities had PAC guidelines. The average availability of the PAC tracer items was at 47%.

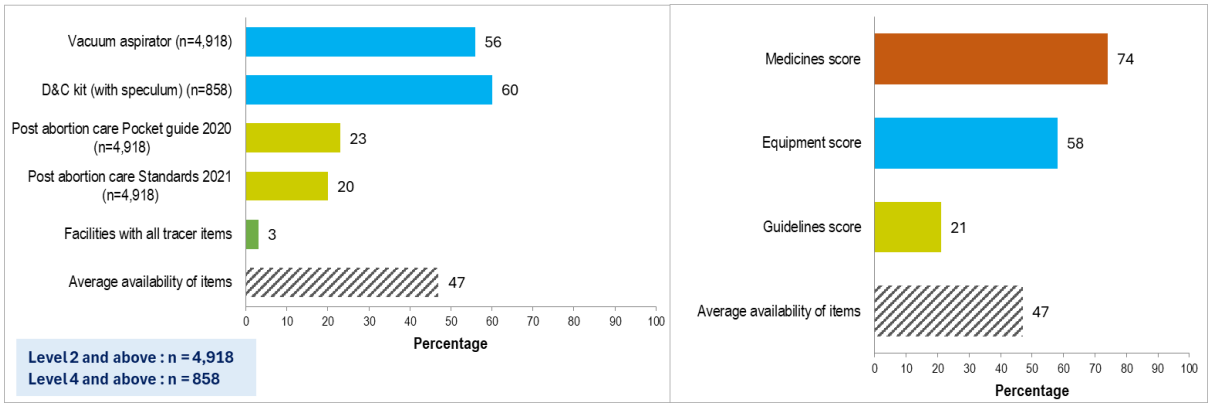

Figure 56: percent of facilities that have select PAC items(N=4918)

Disaggregation by location, KEPH level and ownership:

Readiness in urban facilities was 55% and 38% rural facilities. Level 4 and 5 have the highest availability of tracers. For instance, 92% of level 5 and 82% of level 4 facilities had vacuum aspirators, and 97% and 58% had D&C kits, respectively. In contrast, level 2 facilities had the

lowest availability of most items (42% for aspirators, and 16% for Post abortion care Pocket guide 2020).

NGOs and private sites were generally better equipped; NGOs led in PAC pocket guide access (43%).

County Distribution

Figure 57 shows PAC tracer item availability by county. Most counties had average availability of of PAC tracer items ranging from 41%–60%. The highest average availability of PAC tracer items was recorded in Nakuru (65%), Kajiado (64%), and Nairobi (61%) counties.

Six counties with the lowest average availability of PAC tracer items were Nandi (27%), Homabay & Nyamira (31% each) West Pokot (32%) and Kisumu (33%).

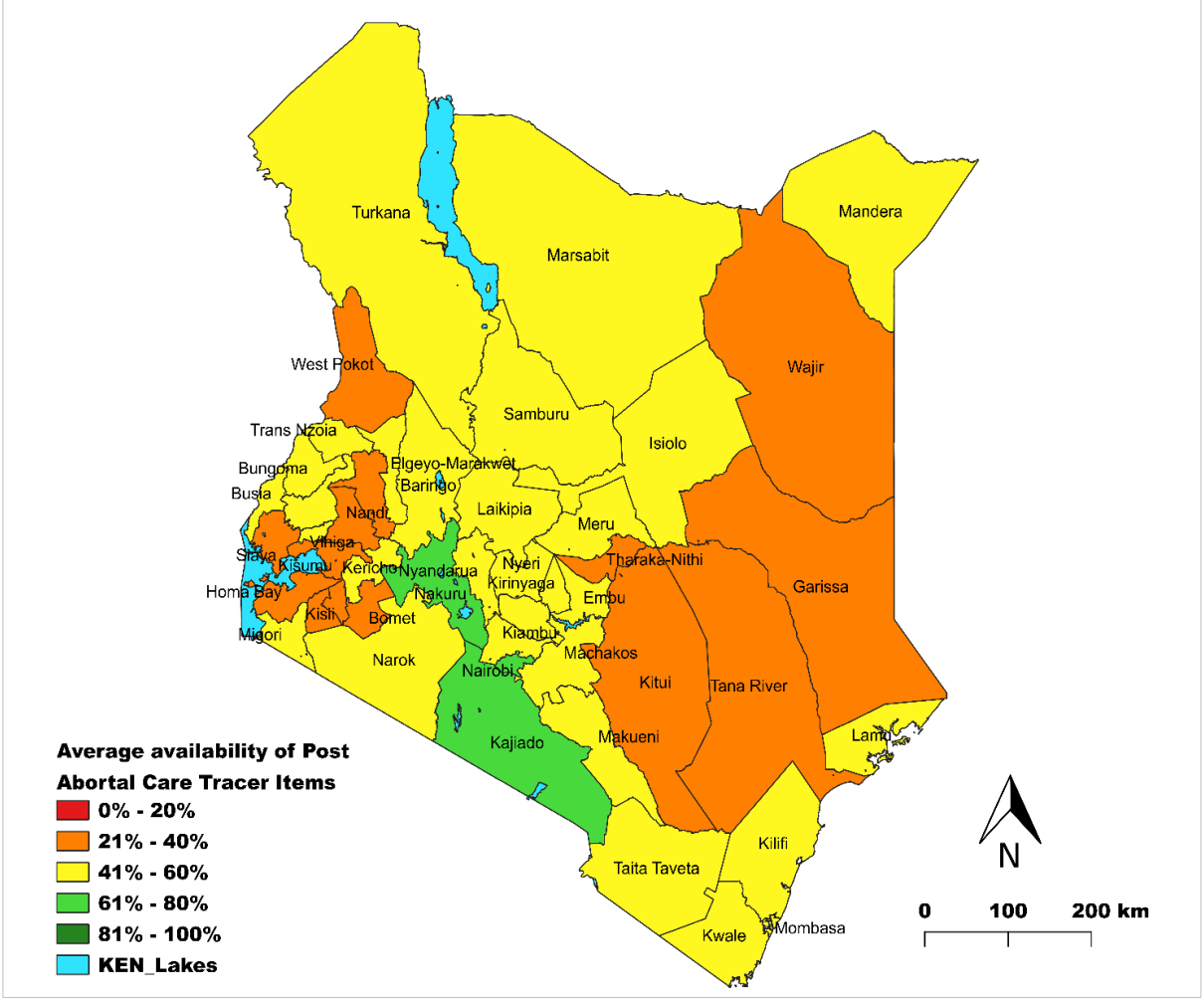

Figure 57: Average availability of post abortal care items by county

Discussion

PAC services are widely available in private and higher-level facilities, but limited in FBO and lower-level facilities. Availability rose from 27% in KHHFA 2018 to 68% in this assessment, which included only facilities offering postnatal care.

Recommendations

Expand PAC services at FBO and lower-level facilities to address unsafe abortions' impact on maternal mortality.

Strengthen Lower-level Facilities: Equip Level 2 and rural sites to deliver full PAC, including D&C, through targeted training, funding, and facility upgrades.

Enhance Public Sector Capacity: Invest in public facilities to lessen reliance on private providers and ensure equitable access, especially for low-income communities.

NEWBORN HEALTH SERVICES

Health services for newborns encompass a wide range of medical and support measures to ensure the health and well-being of newborns which include disease screening, vaccination, routine check-ups, intensive care, among others.

The QOC survey assessed essential newborn services (services immediately at birth) and comprehensive newborn services (essential services and services for the sick and premature newborns).

Key findings

- Nationally essential newborn health services were in 80% of facilities providing delivery services.
- Among the 8 essential newborn services assessed, availability ranged between 60%-99% except for Vitamin K injection which was at 58%.
- Average availability of essential newborn health services was 82% with 1 in 3 facilities having all the services
- However, advanced services for small and sick newborns, such as CPAP machines and incubators, were only available in a minority of Level 4 and 5 facilities.

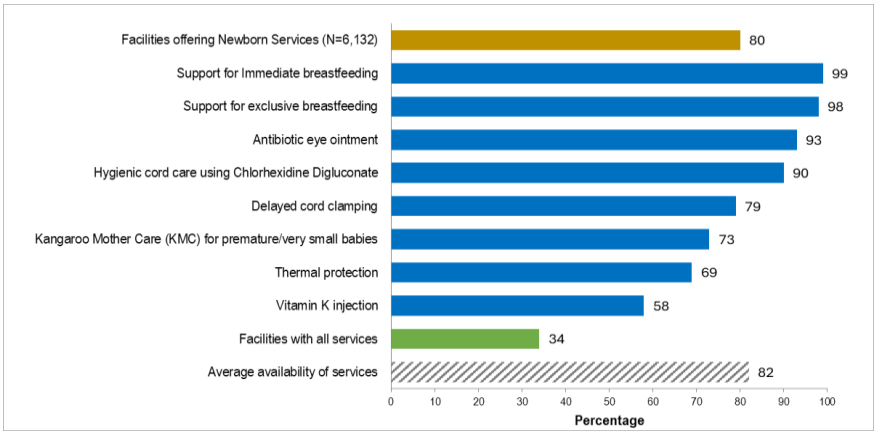

Figure 58: Availability of essential newborn health services (n=4876)

CHILD HEALTH AND IMMUNIZATION

Availability and access to ***comprehensive child health services*** ensure that children receive timely treatment, and routine vaccinations for their health and well-being in order to survive, thrive and reach their full potential.

The 2024 QOC assessed service availability and service readiness for child health based on two categories as follows:

- Preventive Curative and Rehabilitative Services for Children Under 5 Years.
- Immunization services for routine under 5 vaccinations.

Preventive Curative and Rehabilitative Services for Children Under 5 Years.

Service Availability

Preventive, curative, and rehabilitative services for children under five were widely available, offered in 90% of facilities, with an overall average availability of 88%.

High availability was recorded for diarrhea management (99%), growth monitoring (98%), pneumonia management (97%), Vitamin A supplementation (95%), malaria treatment (94%), developmental assessments (93%), malnutrition management (88%), and triage systems (83%).

Despite this, only 37% of facilities had **all** tracer services for under-fives, and just over half (57%) offered developmental delay and disability management.

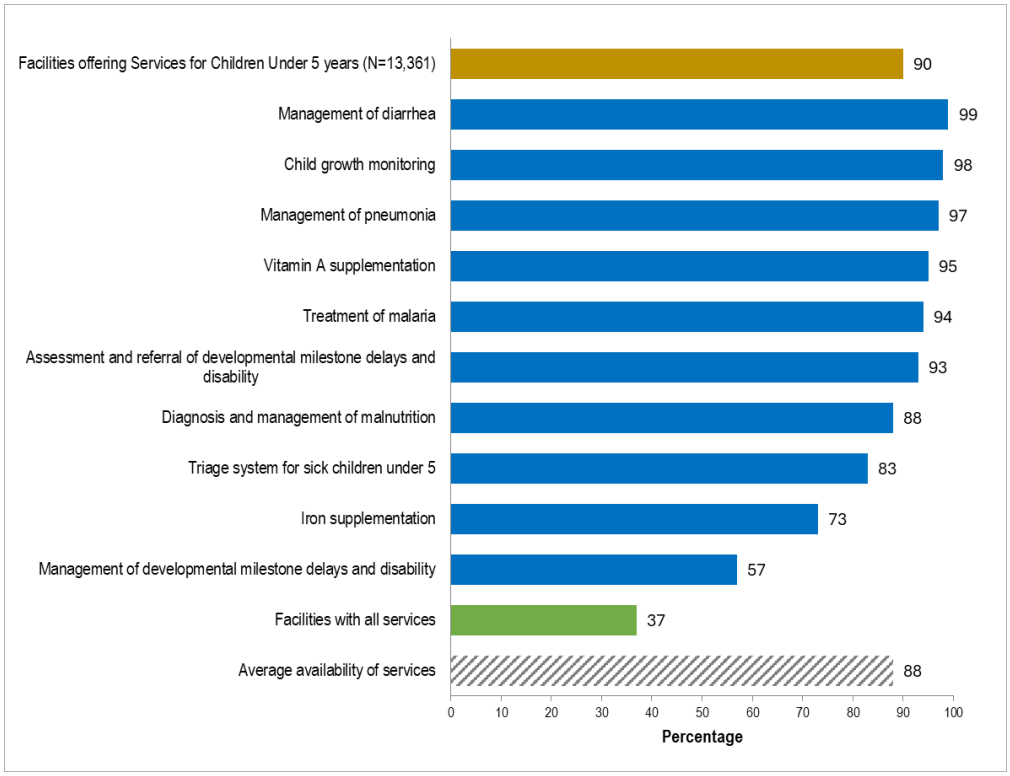

Figure 59: Availability of preventive, curative and rehabilitative services for children under 5. (N=11,997)

Service Readiness

- The average readiness to provide under-five health services was 67%, with high equipment availability (92%) but lower availability of diagnostics (66%), medicines (63%), guidelines (42%), and trained staff (33%); only 4% of facilities had all tracer items.
- Equipment availability was generally strong (86%–95%), while key diagnostic tests such as stool microscopy (59%) and hemoglobin (60%) were the least available.
- Availability of guidelines was uneven, with IMNCI relatively high (77%) compared to the Basic Pediatric Protocols 2022 (34%).

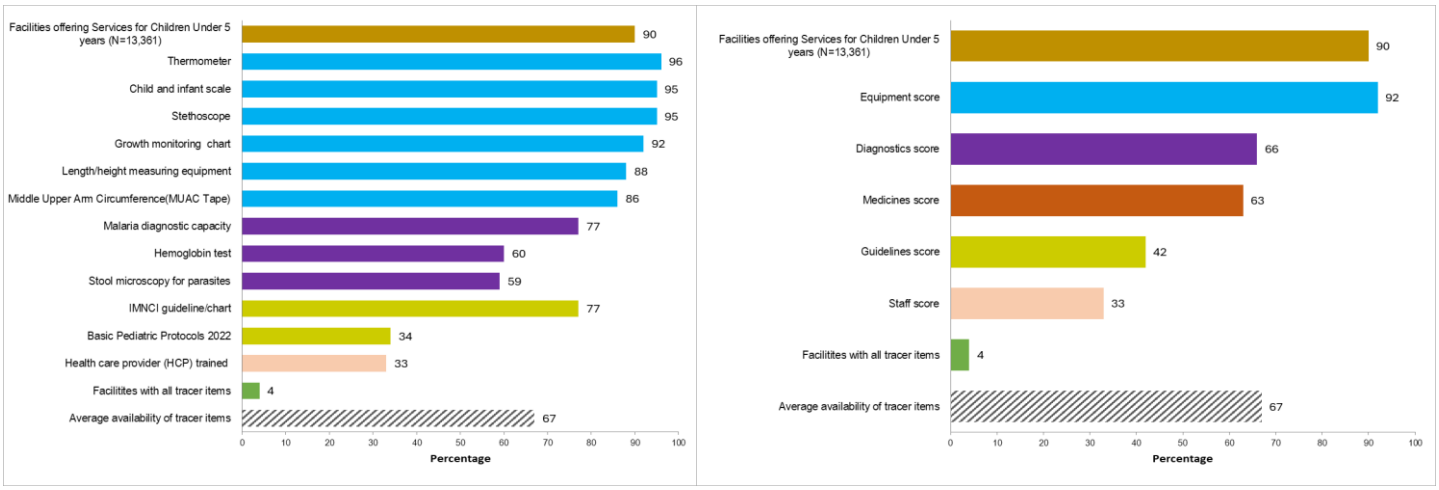

Figure 60: Readiness of preventive, curative and rehabilitative services for children under 5

Immunization services for routine under 5 vaccinations.

Service Availability

- Nationally, 66% (8819) of all health facilities offered child immunization services.
- Among facilities that offer child immunization, 65% provide immunization services five days a week (Mon-Friday), and 16% provide immunization services 7 days a week, while facilities scheduling on specific days (not daily) accounted for 19%.
- Immunization services offered as outreaches in only 1% of facilities.

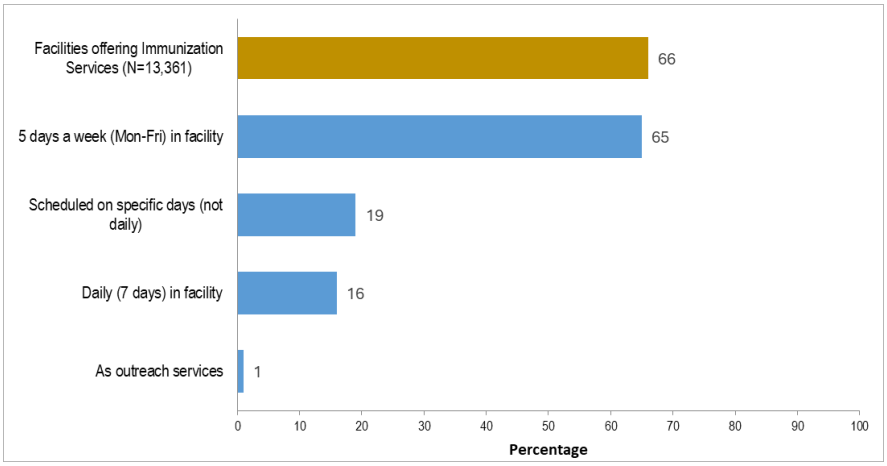

Figure 61: Availability of child immunization services by frequency

Service Readiness

- Readiness score**: 90%**, the highest among RMNCAH subareas.
- Cold chain capacity was generally strong in public and Level 3–5 facilities.

ADOLESCENT HEALTH SERVICES

Service Availability

- Nationally, 71% of facilities offered adolescent health services.
- Among facilities offering adolescent health services, HIV testing, counseling, and STI services were the most readily available at 94%. In comparison, the provision of substance abuse rehabilitation services (24%), antiretroviral therapy (ART) (41%), and mental health services (57%) to adolescents were the least available services.

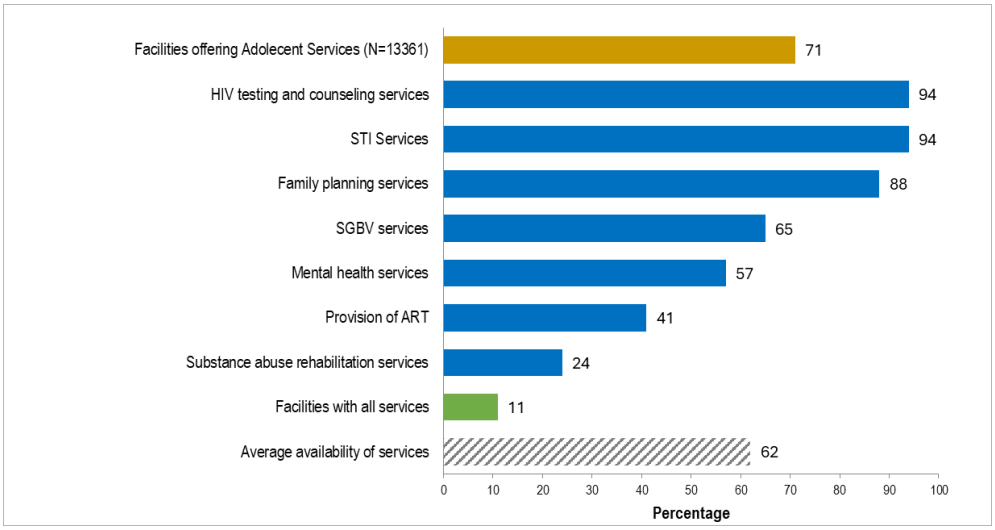

Figure 62: Percent of facilities with adolescent health services (N=9520)

Service Readiness

- Lowest among all RMNCAH subareas at **43%**.
- Gaps included lack of privacy, adolescent-friendly guidelines, and trained youth counsellors.

NUTRITION AND DIETETICS

Service Availability

- Nutrition services were available in **42%** of facilities.
- Services included growth monitoring, counselling for pregnant women, and therapeutic feeding for malnourished children.

Service Readiness

- Readiness score for Nutrition and Dietetics was **48%**.
- Challenges included inadequate supply of micronutrient supplements, limited availability of therapeutic food, and insufficient nutritionists in rural areas.

SURGICAL SERVICES

Surgical and inpatient services are essential components of a functioning health system. Surgical interventions address a wide range of critical conditions including obstetric complications, trauma, acute abdominal emergencies, and non-communicable diseases such as cancers. Meanwhile, inpatient services provide continuous clinical monitoring and treatment, especially for complex medical cases. Their availability and readiness have a direct impact on patient outcomes, morbidity, and mortality, particularly in emergencies. In Kenya, the KHFA 2024 assessed both minor and major surgical services alongside inpatient capacity, governance, and facility-level quality of care structures.

Minor Surgical Services

Service Availability

The services were widely offered in the health facilities at 86% (11,557 facilities).

- Common procedures: suturing (97%), incision & drainage (88%).
- Less available: wound debridement (65%), male circumcision (54%), chest tube insertion & lymph node/mass biopsy (53%).
- Availability increases with level of care (40% at Level 2 to 97% at Level 5).
- Higher in urban (78%) vs. rural (64%) facilities.
- Ownership: private & FBOs (78%) higher than public (65%).

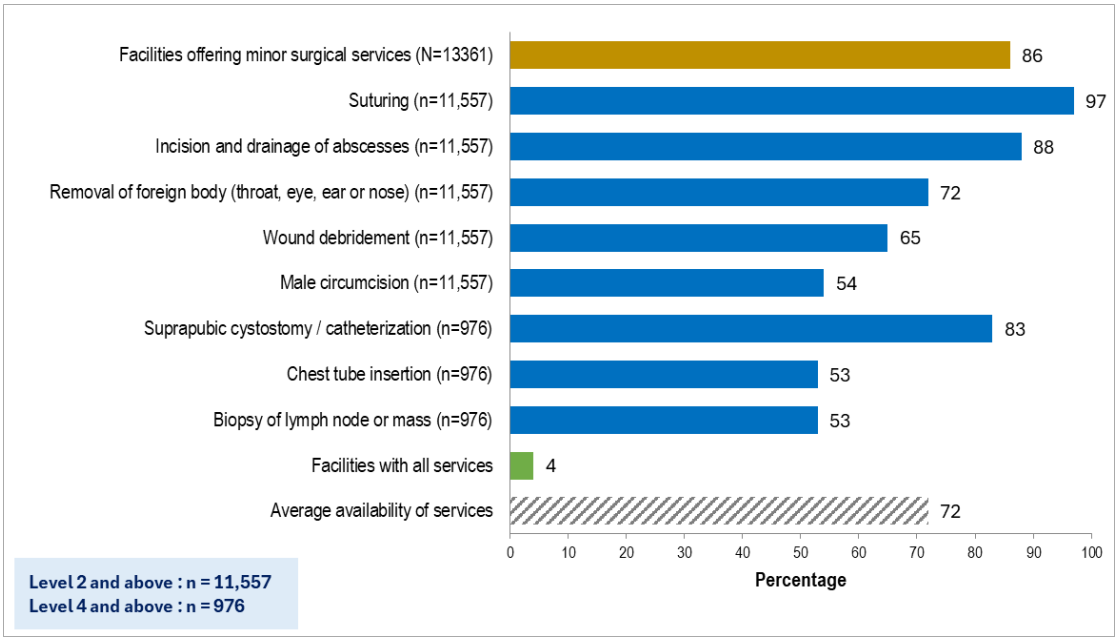

Figure 63: Percentage of facilities with select tracer minor surgical services. (N=11,557)

There was variation in the counties in the availability of surgical services, ranging from 57% (Homa Bay) to 88% (Kajiado).

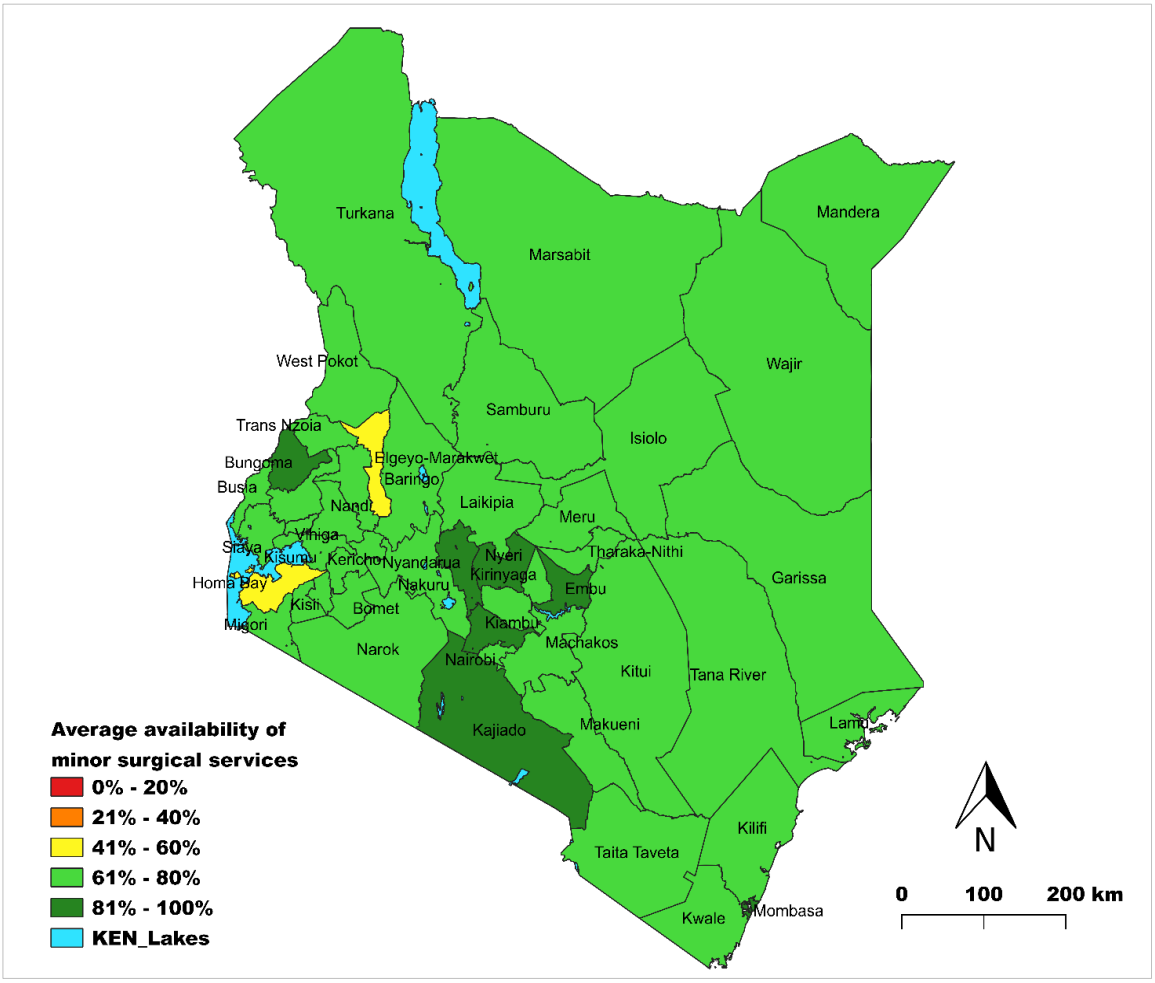

Figure 64: Average availability of minor Surgical Services by county

Service Readiness

Service readiness was measured using the availability of 11 minor surgery tracer items.

- Average availability of 11 tracer items: 78%.
- Well stocked: gauze, sutures, lidocaine (94–96%).
- Least available: oxygen (36%) and suction apparatus (49%).
- Only 23% of facilities had all tracer items.
- Readiness higher in hospitals (Level 4 and 5) than in lower-level (Level 2 and 3) facilities.
- Public facilities lag behind NGOs, FBOs, and private facilities.
- Urban readiness better than rural; county disparities noted (58% in Vihiga to 81–100% in 11 counties).

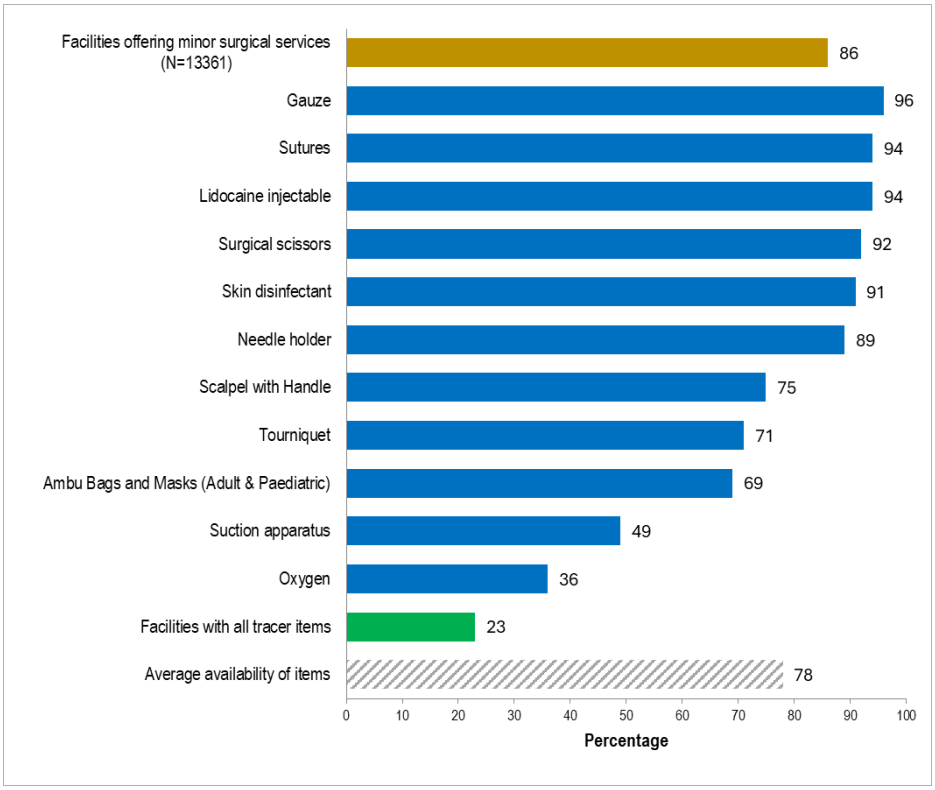

Figure 65: Percentage of facilities with select tracer items for minor surgical services. (N=11,557)

Major Surgical Services

Major surgical services were assessed only in Level 4 and 5 facilities.

Service Availability

- 60% of Level 4 and 5 facilities offer major surgery.
- Average availability of major surgical services was 68%.
- Common major surgical services: ectopic pregnancy surgery (92%), hernia repair (86%).
- Least available major surgical services: craniotomy (35%), cleft lip/palate repair (28%).
- Major surgical services are more available in Level 5 hospitals (89%) than Level 4 (67%).
- Ownership: NGO facilities least equipped (none offered craniotomy or cleft lip repair).
- Major surgical services are more available urban facilities (72%) than in rural (53%).
- County variation: high in Narok (88%), low in Samburu (40%).

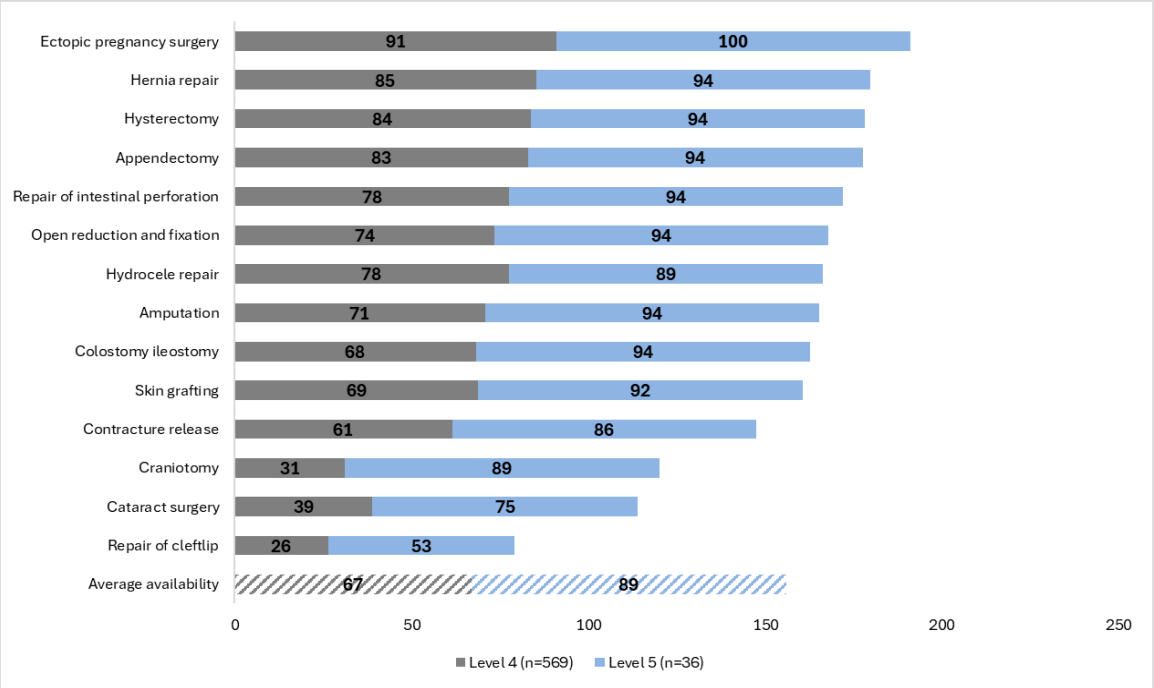

Figure 66: Percentage of facilities with select tracer major surgical services disaggregated by KEPH level

Service Readiness

The 2024 QOC assessed readiness to provide major surgical services based on medicines and Oxygen.

- Average availability of major surgical medicines was 84%.
- High readiness: diazepam & atropine (95%).
- Low readiness: thiopental powder (54%).
- Better readiness in Level 5, urban, FBO facilities; public lagging.
- County variation : 100% (Elgeyo Marakwet) vs. 67% (Garissa).

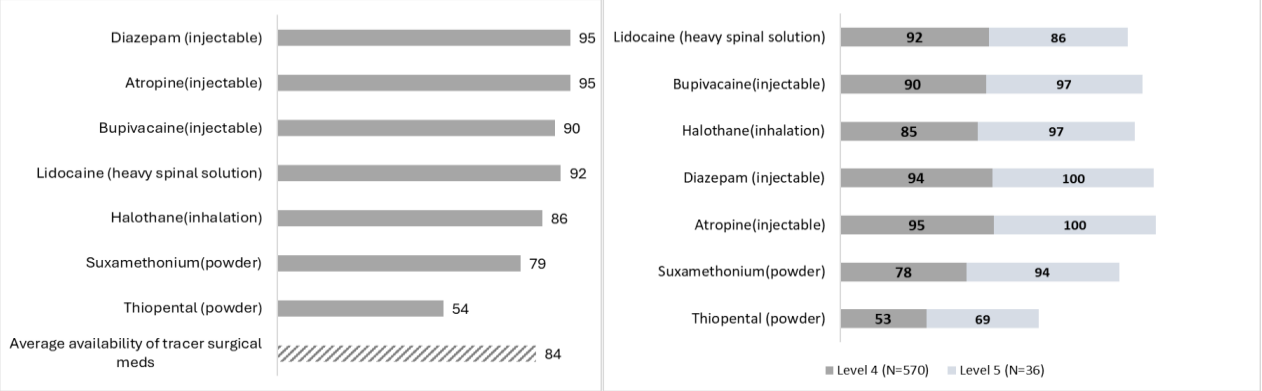

Figure 67: Percent of facilities that had select tracer medicines for major surgical services and by level of care (n=606)

- Oxygen supply:
  - Standalone cylinders dominant (90%).
  - Limited PSA plants (20%), liquid oxygen (20%), manifold systems (14%).
  - Distribution uneven across counties; higher in Level 5 and public hospitals.

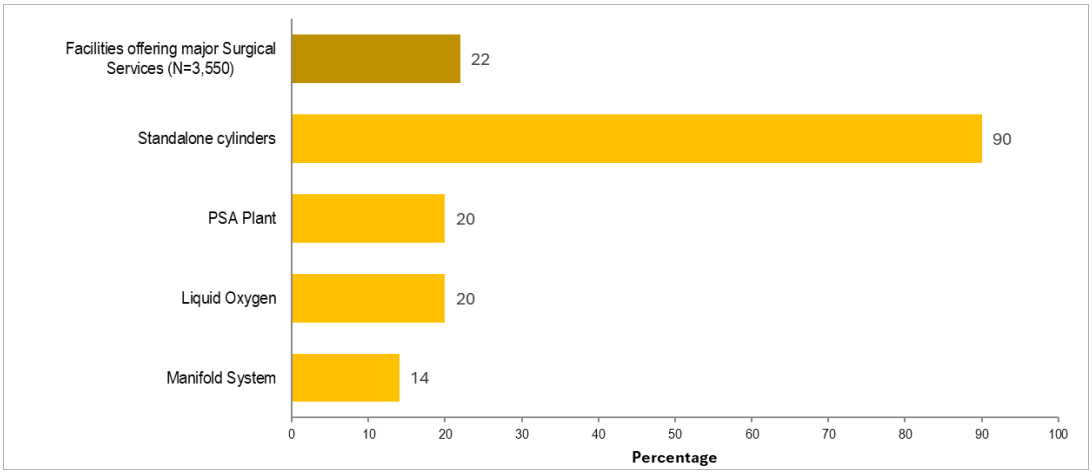

Figure 68: Percentage of facilities with various oxygen sources in theatre(N=773)

Theatre Systems And Governance

- Governance: only 44% of facilities had functional theatre users' committees.
  - Better in Level 5 (86%), urban (53%), FBO (65%).
  - Lowest in rural (27%) and public and NGO facilities at 31% and 30% , respectively.
  - Wide county disparities (Kwale 100% vs. Turkana 8%).

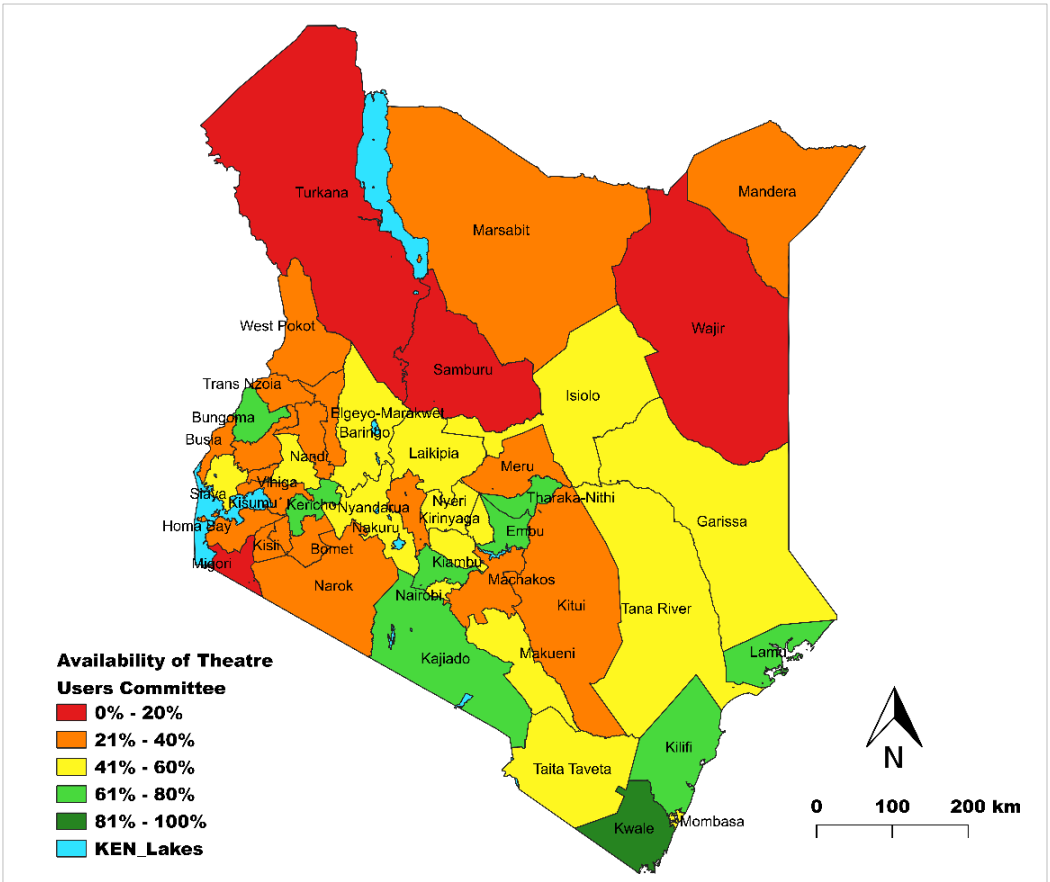

Figure 69: Availability of theatre users committee by county

INPATIENT SERVICES

Service Availability

Only 22% of all facilities offered general medical inpatient services, distributed as follows:

- Level 2: 741 facilities
- Level 3: 1,231 facilities
- Level 4: 946 facilities
- Level 5: 37 facilities

In total, 87,577 functional inpatient beds were reported:

- 43% were occupied during the assessment.
- Urban facilities accounted for 61,111 beds, compared to 26,466 in rural areas.
- By ownership:
  - Private: 42,240 beds
  - Public: 29,466 beds
  - FBOs: 14,925 beds
  - NGOs: 947 beds

This distribution illustrates significant inequalities, particularly in rural regions and public sector facilities that often cater to large, underserved populations.

Quality of Care Structures

Several quality metrics were assessed to determine the effectiveness of inpatient service delivery:

Table 11: QOC Structures

Indicator	Finding
Bed-sharing	4% of facilities reported patients sharing beds; highest in Level 5 (19%)
Daily ward rounds	75% conducted daily rounds; highest in Level 5 (92%), lowest in Level 2 (69%)
Multidisciplinary team rounds	74% overall; urban (80%), rural (65%)
Patient gown availability	51% had adequate stock; Level 5 (68%), Level 2 (46%)
Availability of mattress with mackintosh	83% overall; urban (86%), rural (78%)

These findings suggest that although some basic quality assurance practices are present, deficiencies persist in patient dignity (e.g., gowns), IPC (e.g., mattress protection), and clinical governance.

Challenges Identified

- Low availability of major surgical services in Level 3 public facilities, despite their importance in decentralizing emergency care.
- Limited access to specialized surgical procedures such as craniotomy and cleft lip repair, affecting surgical equity.
- Inadequate supply of basic equipment like oxygen and suction machines across many surgical units.
- Overcrowding and bed-sharing, particularly in high-volume urban referral facilities.
- Weak theatre governance, especially in rural and lower-tier facilities, impeding quality assurance and surgical audit practices.

Recommendations

Table 12: Recommendations

Issue	Recommended Action
Limited access to major surgeries	Scale up surgical capacity in Level 3 and 4 facilities, particularly in public and rural settings.
Lack of surgical supplies	Ensure continuous availability of oxygen, suction equipment, and emergency trays across all surgical sites.
Weak theatre governance	Institutionalize theatre user committees and integrate surgical audits into routine quality improvement systems.
Gaps in inpatient quality structures	Invest in essential items such as patient gowns, IPC supplies, and enforce structured ward round protocols.
County disparities	Prioritize counties like Vihiga, Turkana, and Samburu for targeted equipment, workforce, and governance support.

BLOOD TRANSFUSION SERVICES

In Kenya, the Kenya National Blood Transfusion Service (KNBTS) is responsible for ensuring a safe and sufficient blood supply, which is essential for surgeries, trauma care, childbirth, and treating conditions such as anemia, bleeding and bone marrow disorders, low platelet count, and severe infections. Although blood transfusion carries minimal risks, it is generally safe when conducted under national standards and guidelines that protect both donors and recipients. To guarantee safety, all donated blood is screened for infectious pathogens, including HIV, hepatitis B and C, and syphilis, before use, with lower-level facilities relying on regional blood centers for screened and distributed supplies.

Service Availability

The 2024 QOC assessed health level 3,4 and 5 facilities that offered blood transfusion services.

Only 22% of level 3,4 and 5 facilities reported offering blood transfusion services. This limited access is of significant concern, especially considering the country's burden of obstetric emergencies and trauma-related cases that require prompt transfusion support.

Among facilities offering blood transfusion services;

- Only 39% conducted screening of blood for transfusion-transmissible infections (TTIs).
- About 25% of these facilities reported experiencing interruptions in the availability of blood in the three months preceding the assessment, mainly due to stock-outs, lack of donor blood, or logistical delays in supply from regional blood banks.

Despite these challenges, 96% of transfusing facilities reported having mechanisms to maintain blood at the correct storage temperature (2–6°C), and 94% had functional temperature monitoring devices. These devices are critical in ensuring the viability and safety of stored blood.

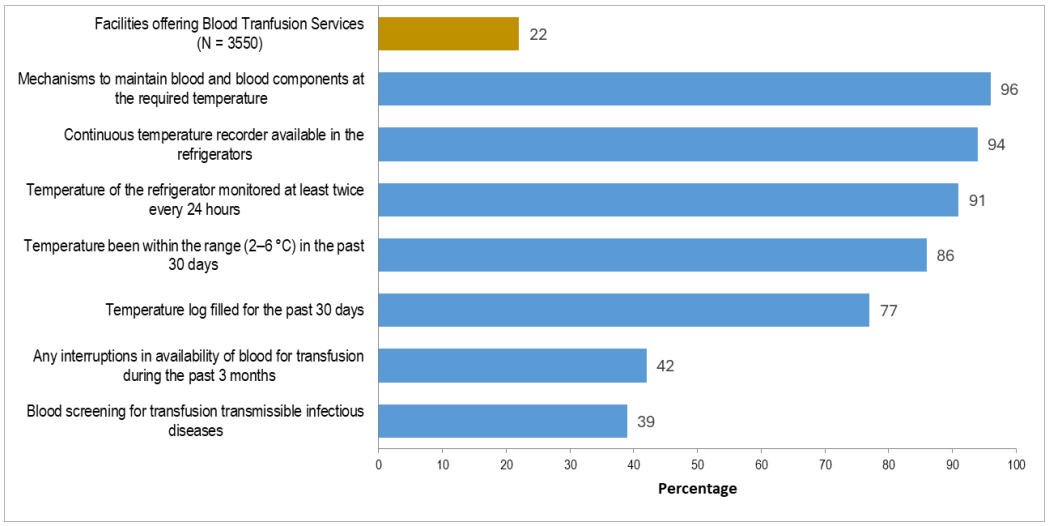

Figure 70: Proportion of facilities that offered blood transfusion tracer services (N=795)

Service Readiness

Readiness for blood transfusion services was assessed using a set of tracer items and procedures that reflect the facility's ability to store, screen, and administer blood safely. The 2024 KHFA also assessed facilities' compliance with national blood transfusion standards and guidelines.

Among facilities offering blood transfusion services;

- Availability of national guidelines and training for safe blood transfusion services in Kenya remains limited, with only 45% of facilities having the Kenya National Standards for Blood Transfusion Services (2022) and 47% having the Guidelines for the Appropriate Use of Blood, Blood Components and Products (2022), giving an average guideline availability score of 46%.
- The Kenya National Standards for Blood Transfusion Services, 2022 were least available at NGO at 30% compared to FBO at 43%, private at 45% and public at 47%.
- About half (49%) of facilities offering transfusion services had healthcare workers trained on safe blood transfusion within the past two years.
- Trained staff were most available at NGO facilities (67%) compared to private (58%), public (42%) and FBO (36%.)
- The average availability of tracer items was 46% while 27% of facilities had all items

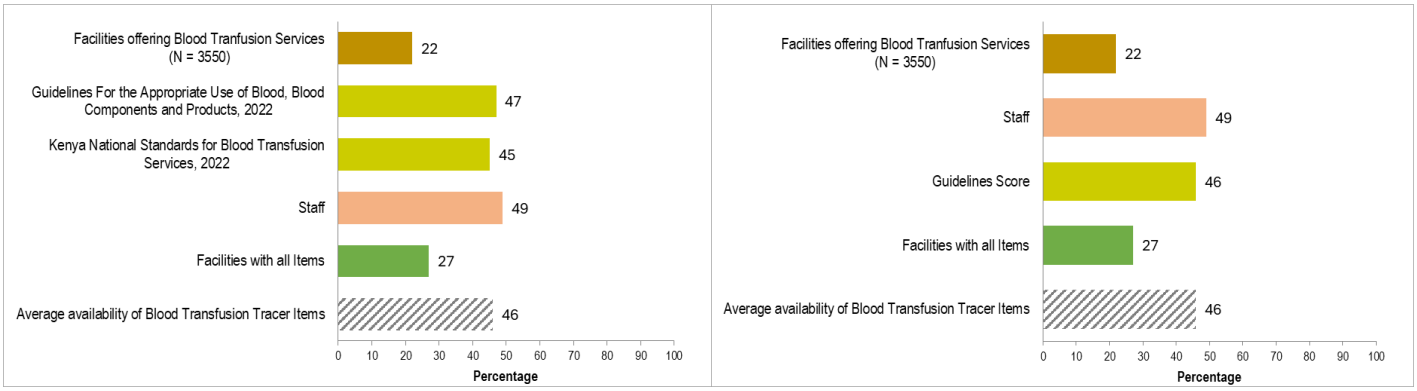

Figure 71: Proportion of facilities with blood tracer items (N=795)

Recommendations

- Expand access to blood transfusion by establishing blood banks in all primary and secondary hospitals and ensuring a reliable supply of blood and blood products.
- Assess level 3 facilities providing transfusion services to determine whether they are appropriately classified or offering services beyond their scope.
- Strengthen dissemination of national blood transfusion guidelines and protocols, coupled with regular training of healthcare workers on safe transfusion practices.
- Ensure all facilities offering blood transfusion consistently screen blood and blood products for transfusion-transmissible infections.
- Guarantee uninterrupted power supply and routine temperature monitoring in blood banks to maintain the safety and efficacy of blood and blood products.

LABORATORY SERVICES

Introduction

Laboratory services are a cornerstone of quality healthcare, providing essential support for diagnosis, treatment monitoring, disease surveillance, and public health decision-making. Globally, up to 75% of medical decisions depend on laboratory test results. In Kenya's pursuit of Universal Health Coverage (UHC), strengthening an accessible and quality-assured laboratory network is vital for accurate diagnosis, timely patient care, and epidemic preparedness. The 2024 KHFA assessed laboratory availability and readiness in Levels 3,4 and 5 facilities, focusing on diagnostic capacity, equipment, quality systems, and infrastructure to support continuous service delivery.

Service Availability

- Functional laboratories: 88% of Level 3, 4 and 5 facilities reported having functional laboratory services.
- Basic diagnostics: On average, 86% of tracer basic laboratory tests were available.
- High availability tests: Urinalysis (98%), blood glucose testing (97%), and VDRL testing (95%) were nearly universal.
- Low availability tests: TB microscopy was available in only 61% of facilities; GeneXpert machines were even less common.
- Advanced diagnostics: Inconsistent availability of liver/renal function tests, full haemogram, and electrolyte panels.

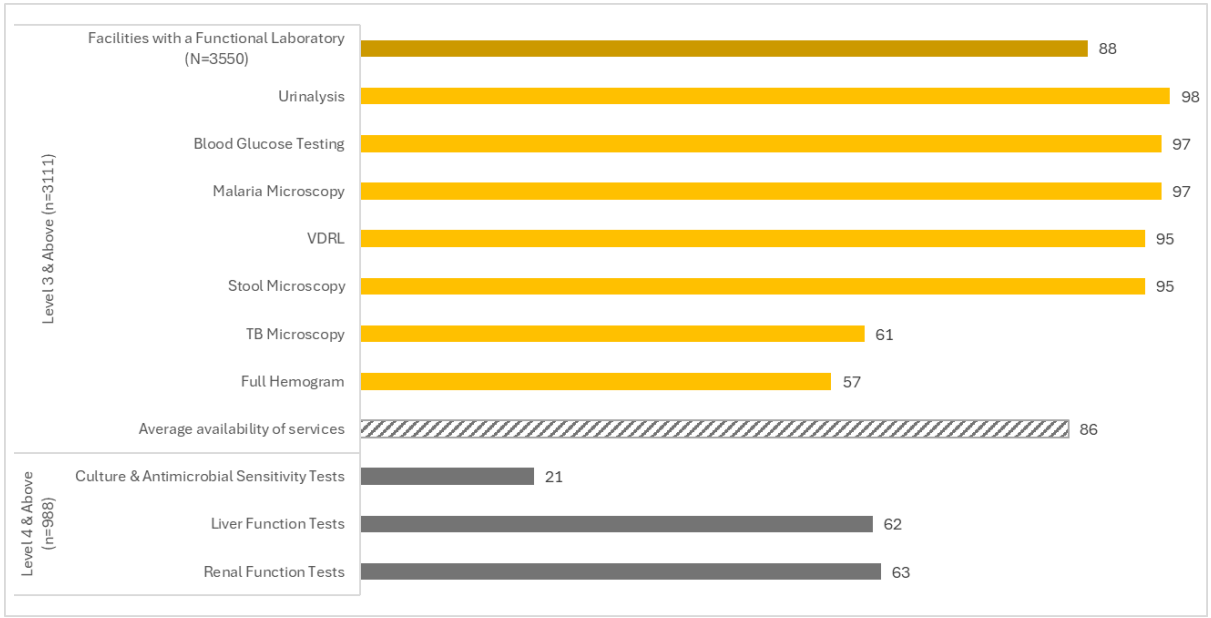

Figure 72: Availability of basic and advanced tracer laboratory services (N=3111)

- Nationally, 34% of facilities with functional laboratories experienced interruptions in laboratory services due to equipment breakdowns and/or reagent stockouts during the review period (October–December 2023), as shown in Figure 224 below.
- On average, laboratory tracer service interruptions occurred in 21% of facilities.

- Full Hemogram was the most frequently interrupted service (39%), while VDRL was the least interrupted (12%).
- Four out of ten Level 4 and 5 facilities experienced interruptions in Liver and Renal Function tests.

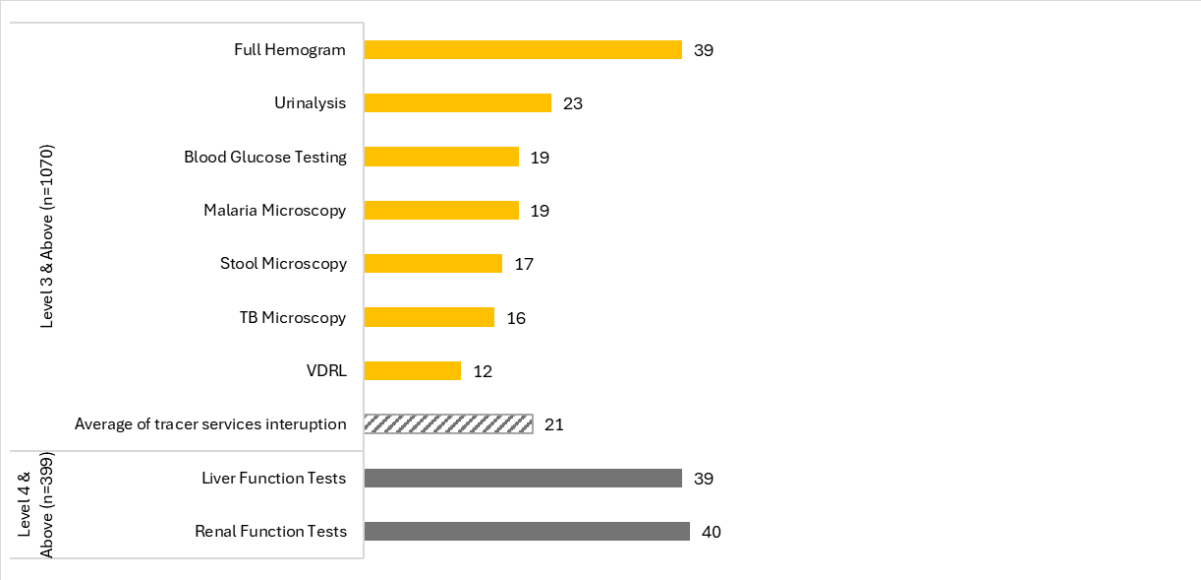

Figure 73: Percent of facilities that have services interrupted (N= 1070)

Service Readiness

- Only 43% of the required tracer equipment was available in Level 3 to 5 facilities.
- Standard Operating Procedures were available in 91% of facilities.
- Specimen tracking systems was present in 85% of facilities.
- EQA participation was reported in 68% of facilities, lower than previous assessments, raising concerns about test accuracy.
- Only 51% of facilities had a designated Quality Assurance officer.

Other readiness gaps include ;

- Inadequate cold storage for reagents
- Limited laboratory space
- Lack of regular equipment calibration

Disparities by County and Ownership

Substantial inequities were observed across regions and facility ownership:

- Counties such as Mandera, Wajir, and Marsabit recorded the lowest availability of services and EQA participation, reflecting persistent underinvestment.
- Urban facilities were more likely to offer advanced diagnostics, 40% had liver function tests compared to 23% in rural facilities.
- Public facilities experienced higher service interruptions (22%) than NGO facilities (12%), often due to delays in procurement and equipment servicing.

- Kajiado County recorded the highest average availability of laboratory tracer items at 59%, while Vihiga County had the lowest at 20%.
- Only two counties, Kajiado (59%) and Isiolo (51%), had at least 50% of their facilities equipped with laboratory tracer items.
- More than half of the counties (57%) had fewer than 40% of their health facilities with laboratory tracer items.

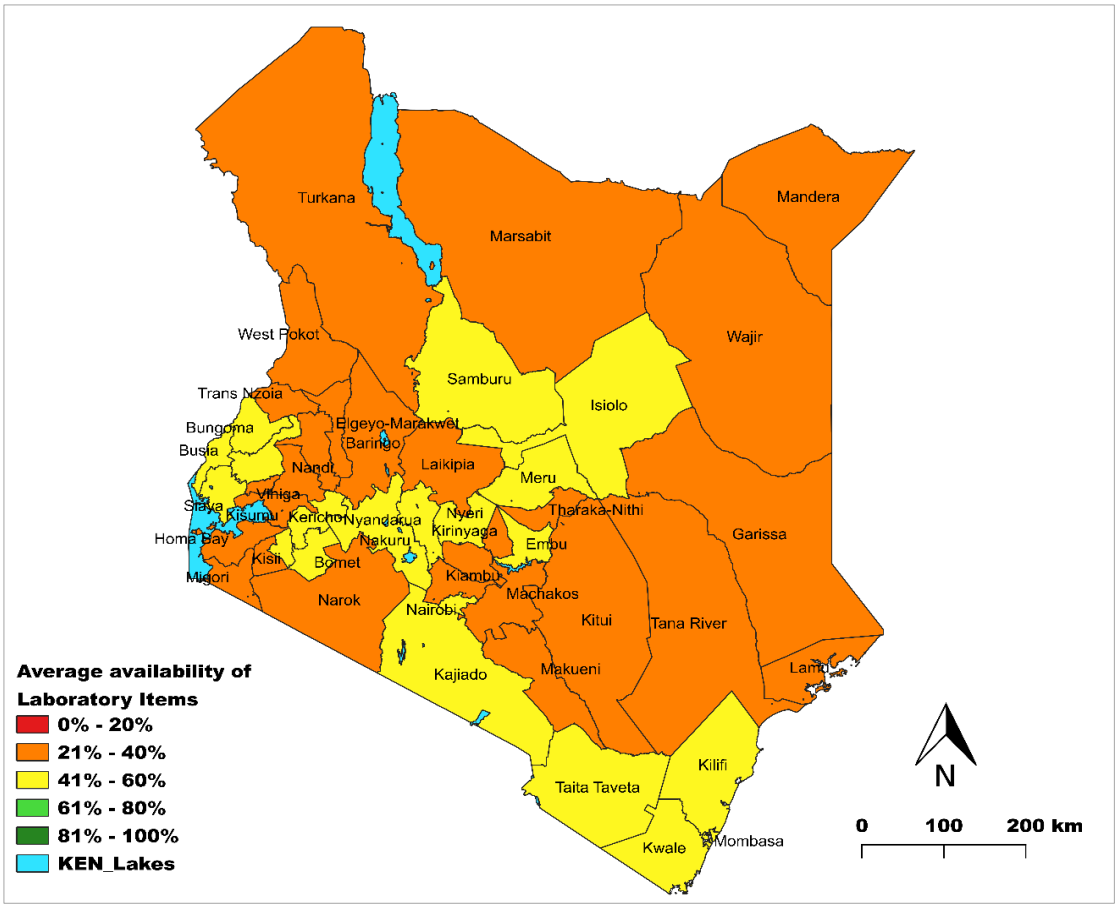

Figure 74: Average availability of laboratory tracer items by county

Recommendations

- Expand availability of advanced diagnostics at Level 3 and rural facilities through targeted investment and resource allocation.
- Strengthen supply chain management and preventive equipment maintenance to minimize service disruptions.
- Improve procurement and distribution of essential laboratory equipment, reagents, and guidelines, prioritizing low-performing counties.
- Scale up quality management systems, appoint QA focal persons in all facilities, and strengthen lot-to-lot testing capacity.
- Enforce EQA participation for all facilities, with special support to low-performing counties.
- Reduce inequities by prioritizing investments in rural and remote facilities.

PHARMACY SERVICES

Introduction

Pharmacy services are essential for ensuring access to medicines, promoting rational use, and supporting efforts against antimicrobial resistance (AMR). A resilient pharmaceutical system underpins Kenya's progress toward Universal Health Coverage (UHC), improving treatment outcomes, reducing mortality, and enhancing trust in the health system. The KHFA 2024 assessed pharmacy services across availability, readiness, stewardship, and regulatory compliance

Service Availability

Despite progress in procurement and distribution, stockouts of essential medicines remain widespread. On average, 33% of the 23 tracer medicines were out of stock in facilities during the seven days prior to assessment.

- Key drivers of stockouts: delayed deliveries from KEMSA, weak inventory planning at facility level, and inadequate storage and cold chain capacity.
- Private and NGO facilities reported lower stockout rates due to flexible procurement systems.
- Public facilities, especially rural ones, frequently lacked critical medicines such as antibiotics, antihypertensives, and pediatric formulations.

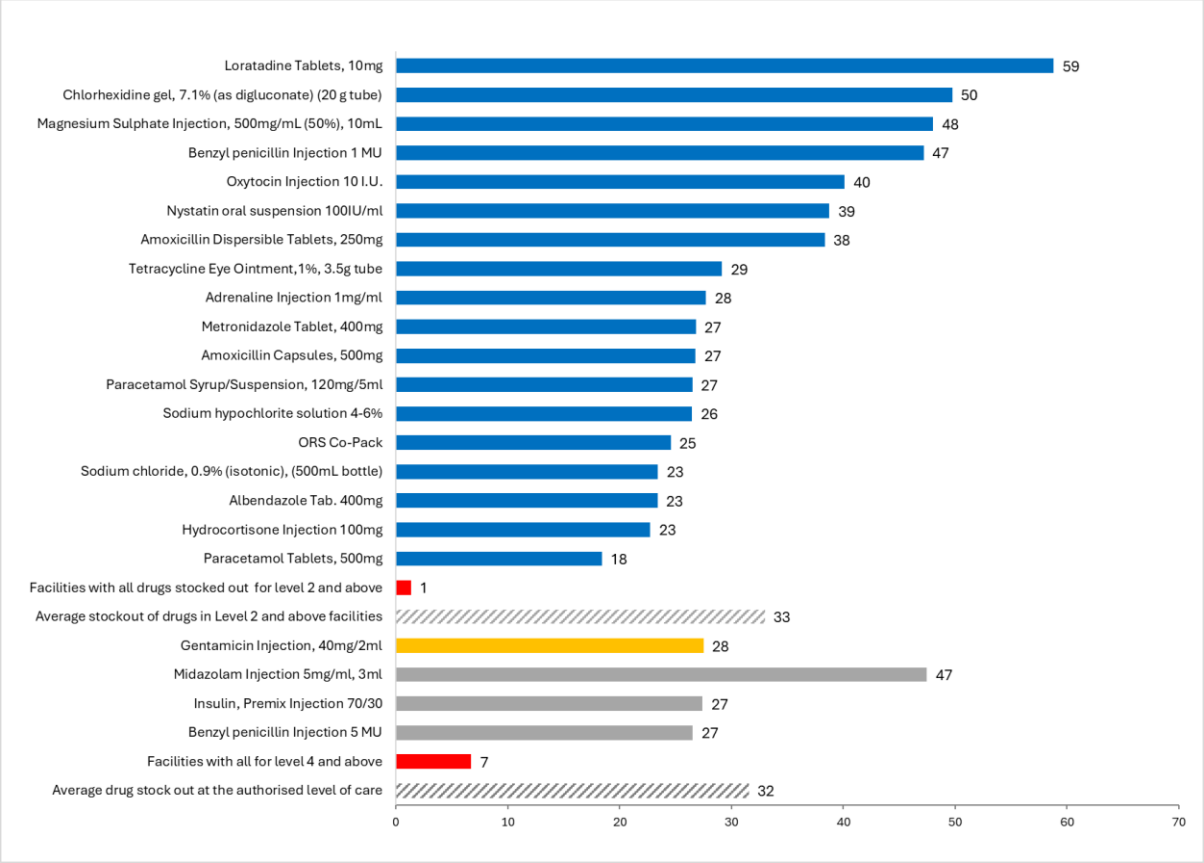

Figure 75: Average stock out of essential medicines at facilities 7 days prior to the assessment

Service Readiness

Pharmacy readiness was measured through governance, stock management, staffing, and regulatory compliance. Overall, readiness remained weak.

- Only 6% of facilities had all four essential pharmacy reference documents:
  - Kenya Essential Medicines List (KEML)
  - Standard Operating Procedures (SOPs)
  - Drug disposal protocols
  - Antimicrobial Stewardship (AMS) guidelines
- Many Level 2 and 3 facilities lacked pharmacists or pharmaceutical technologists.
- Stock management was inconsistent: stock cards were poorly maintained, and digital ordering systems were rarely used.
- Expired drug disposal was poorly managed, with few facilities using safe channels or conducting audits.

Antimicrobial Stewardship (AMS)

AMS implementation was limited outside higher-level facilities. Functional AMS committees were found mainly in Level 5 hospitals. Lower-level facilities rarely conducted prescription audits, drug-use evaluations, or antibiotic consumption tracking. Awareness of AMS guidelines among staff at Levels 2 and 3 was minimal, increasing risks of irrational prescribing, particularly for antibiotics and antimalarials.

Pharmacovigilance and Quality Systems

Pharmacovigilance systems remained weak. Only a small proportion of facilities reported adverse drug reactions (ADRs), while medication error reporting was negligible. Routine prescription audits and medicine-use evaluations were not institutionalized in most facilities.

Electronic Systems and Infrastructure

Adoption of electronic logistics management tools was low in lower-level facilities, limiting visibility of stock levels and expiry tracking. Infrastructure gaps, such as poorly ventilated and unorganized storage areas, further undermined medicine quality and safety.

Challenges Identified

- Inadequate drug forecasting and poor integration of morbidity data into quantification processes.
- Inefficient distribution practices, especially to remote counties where stock delivery may take several weeks.
- Limited infrastructure, including poorly ventilated and unorganized pharmacy storage areas.
- Weak pharmacovigilance systems, with low reporting of adverse drug reactions (ADRs) or medication errors.

Recommendations

To strengthen pharmacy systems, KHFA recommends:

- Improving supply chain resilience by digitizing procurement systems, enhancing data visibility, and improving delivery lead times.
- Expanding Medicines and Therapeutics Committees (MTCs) and AMS programs to Level 3 and 4 facilities to institutionalize rational drug use.
- Enforcing pharmacy SOPs and regulatory compliance, including regular inspections and licensing.
- Digitizing stock management, including mobile-based tools for order placement, stock visibility, and expiry tracking at primary care facilities.
- Investing in pharmacy infrastructure, including lockable storage, shelving, and cold chain capacity, particularly in public and rural facilities.

EMERGENCY AND REFERRAL SERVICES

Introduction

Emergency care is a cornerstone of a responsive and equitable health system. The Constitution of Kenya (2010) guarantees every person the right to emergency medical treatment, highlighting its critical role in protecting life and ensuring access to essential services regardless of socioeconomic status. Emergency services encompass the capacity to deliver time-sensitive interventions for conditions such as trauma, obstetric emergencies, respiratory distress, sepsis, and non-communicable disease exacerbations. A functional emergency and referral system requires trained personnel, established triage and referral protocols, reliable infrastructure, lifesaving equipment, and uninterrupted medicine supplies.

The KHFA 2024 assessed the availability, readiness, and equity of emergency and referral services across health facilities nationwide, covering infrastructure, governance, staffing, emergency preparedness drills, and adherence to constitutional principles such as non-payment before emergency care.

Service Availability

The assessment found that 89% of health facilities reported offering some form of emergency care. Among the facilities assessed:

- On average, 51% of facilities have the required emergency infrastructure, with the most available being access to an ambulance (69%) and the least being isolation rooms for infectious diseases (28%).
- Resuscitation areas (44%) and functional communication systems (55%) are moderately available, while designated triage areas are present in 57% of facilities.
- Only 13% of facilities have all the listed emergency infrastructures in place.

Many primary health care facilities lacked dedicated triage zones, often assessing patients at the outpatient department without a structured system for identifying emergency cases. Inadequate communication infrastructure (e.g., radio or mobile links for ambulance coordination) was also a limiting factor in effective emergency response.

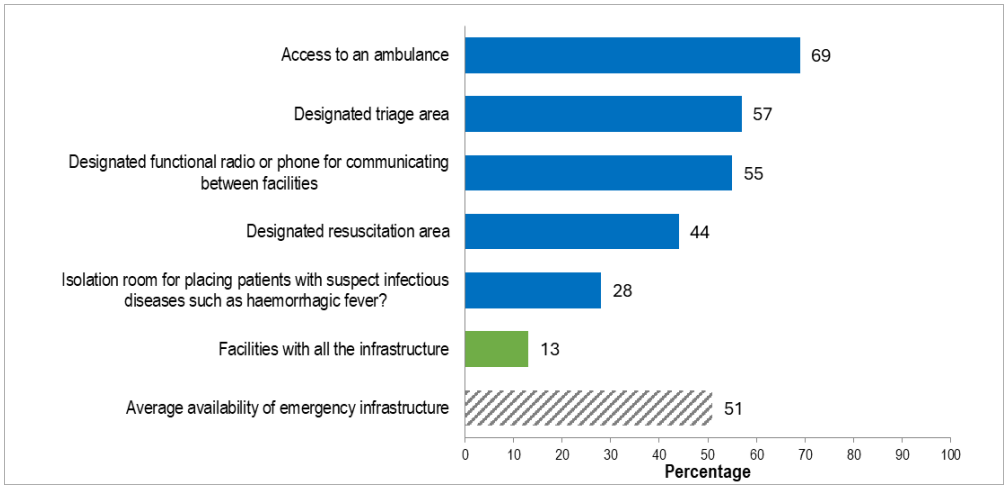

Figure 76: Percent of facilities that have infrastructure for emergencies (N=12039)

Equipment and Medication Availability

Availability of tracer Equipment in Facilities offering emergency services

- The average availability of emergency tracer items in facilities authorized to stock was 60% nationally.
- Less than half of all facilities had both oxygen face mask and suction machine (46% and 44% respectively)
- Pulse oximeters and nebulizers were available in 58% and 54% respectively in all health facilities as summarized in the figure 73 below.
- In hospitals, the most available tracer emergency services equipment were the patient monitors at 71% while the least available were CPAP machines at 28%.

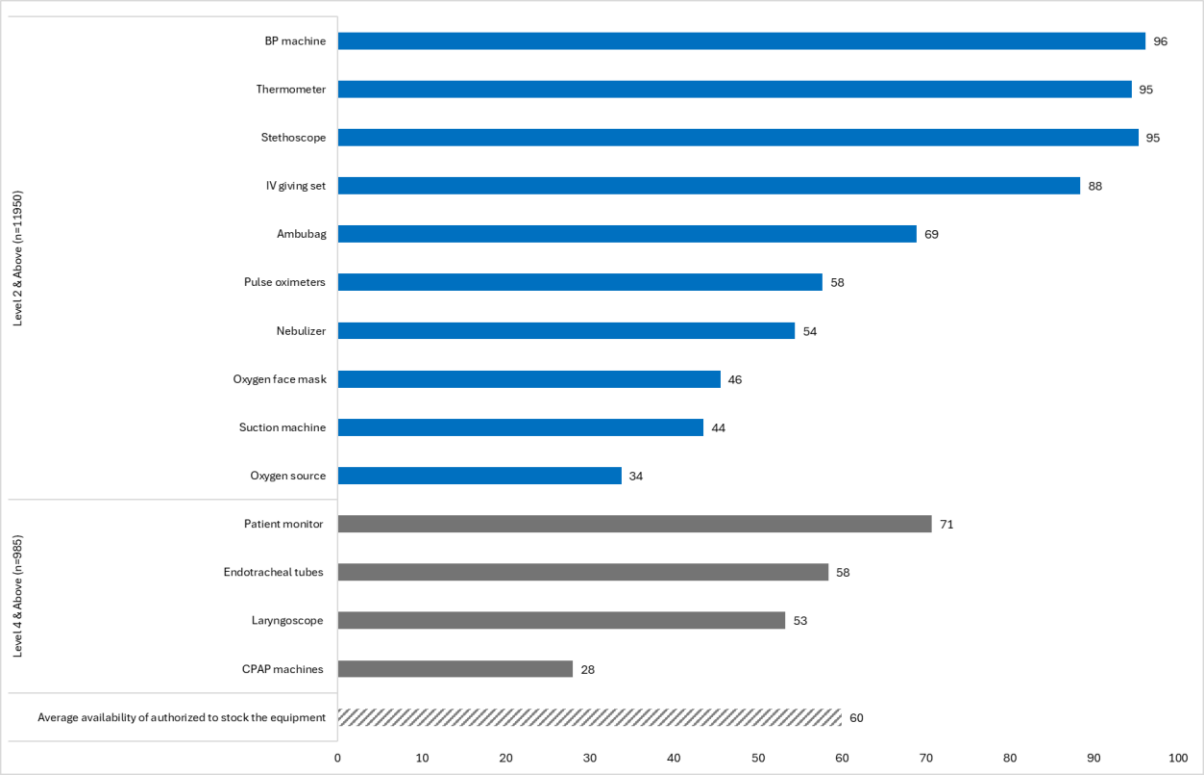

Figure 77: Percent of facilities with emergency tracer items (N=12,039)

Availability of emergency tracer supplies

Among the health facilities offering emergency services;

- The average availability of the tracer supplies was at 56%
- Only 9% of the facilities had all the tracer pharmaceutical items
- Normal saline was available in most of the health facilities at 90%, while anticoagulants such as heparin were found in only 19% of the facilities.
- Less than half of the facilities had atropine (48%), vitamin K (46%), medical oxygen (33%) and hydralazine (29%) as shown below.

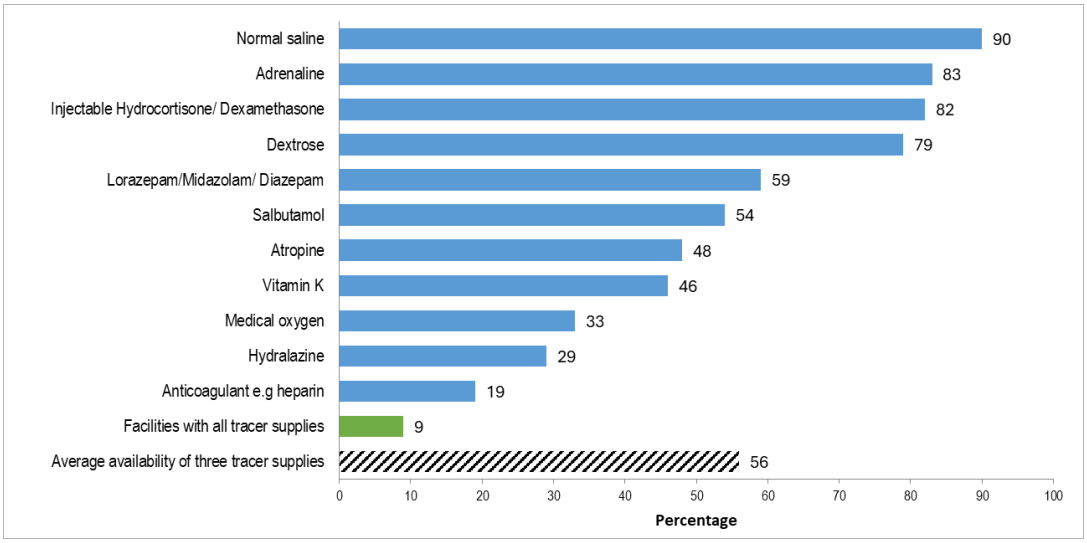

Figure 78: Percent of facilities that had tracer emergency supplies (N=12,039)

Medical Emergency Preparedness Systems

The survey aimed to assess facilities with emergency systems in place focusing on emergency preparedness protocols, emergency preparedness drills in case of Mass casualty events, and the requirement for payment prior to the provision of initial emergency care.

Findings

- 64% of health facilities providing emergency medical services had triage protocols in place, ensuring patients are prioritized based on the severity of their condition.
- Only 31% had emergency preparedness protocols, which are critical for coordinated responses during disease outbreaks or mass casualty events.
- Less than a fifth (15%) of facilities had conducted emergency drills in the 12 months preceding the assessment.

Additionally, 5% of facilities reported that patients were required to make upfront payment before receiving emergency care, contravening constitutional guarantees and increasing the risk of delayed treatment or preventable deaths. This barrier was more pronounced in private facilities, where 9% reported enforcing pre-payment, compared to 2% in public facilities.

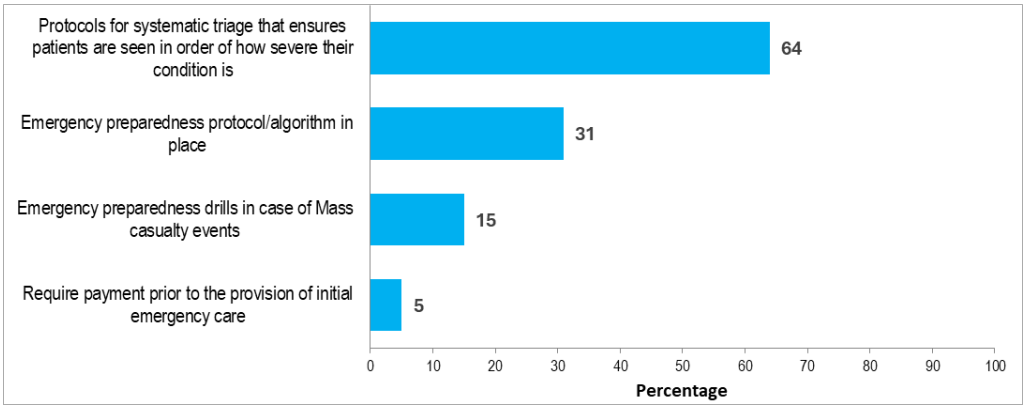

Figure 79: Percent of facilities that had emergency system (N=12,039)

Key Gaps Identified

The KHFA identified the following major gaps:

- Inadequate infrastructure, especially at Level 2 and rural facilities.
- Low frequency of emergency drills, affecting preparedness for real-life emergencies.
- Stockouts of essential medications and equipment.
- Lack of standard triage systems in lower-level facilities.
- Unconstitutional payment practices in some private and FBO-managed facilities.

Recommendations

To strengthen Kenya's emergency and referral systems, the following strategic actions are recommended:

- Equip all health facilities with core emergency infrastructure, including isolation areas, resuscitation bays, and communication systems for coordination.
- Institutionalize emergency preparedness drills, making them mandatory through national policy and linked to routine facility supervision.
- Improve emergency supply chains, ensuring uninterrupted availability of tracer medicines and equipment through buffer stocks, prepositioning, and digital inventory systems.
- Fully implement the Emergency, Chronic and Critical Illness Fund (SHIF) to eliminate financial barriers to emergency care.
- Prioritize capacity-building in low-performing counties such as Marsabit, Mandera, and Vihiga, including staff training, infrastructure upgrades, and governance oversight.

SUMMARY OF KEY RECOMMENDATIONS

General Services and Governance

To strengthen the foundation of Kenya's healthcare system, it is essential to address persistent gaps in service availability, particularly across Level 2 and Level 3 facilities. Scaling up infrastructure investment in lower-tier facilities will help ensure that all facilities meet minimum service standards and deliver equitable care. In parallel, county-level governance and coordination structures must be institutionalized. This includes ensuring the presence and functionality of key structures such as Monitoring and Evaluation (M&E) units, Infection Prevention and Control (IPC) committees, and quality improvement teams. Effective governance also requires that national health strategies are not only disseminated but actively enforced. Strengthening policy implementation and supervision mechanisms at both county and facility levels will help standardize care, monitor performance, and build accountability.

Service Delivery and Readiness

Despite progress, the availability of essential health services such as surgical care, emergency services, and cancer treatment remains suboptimal in many facilities. There is a pressing need to equip Level 3 and Level 4 facilities with core diagnostic tools, emergency response infrastructure, and basic surgical capacity. Equally important is ensuring that health workers adhere to clinical protocols and standard operating procedures (SOPs). National clinical guidelines should be widely disseminated and supported with practical, on-site training. Supply chain bottlenecks also require urgent attention. Health commodity forecasting, quantification, procurement, and distribution systems must be improved to ensure consistent availability of tracer medicines and medical supplies at all levels of care.

Emergency and Referral Services

Emergency preparedness and response remain weak in most facilities. Many lack dedicated triage areas, isolation rooms, and functioning ambulances. Facilities should be mandated to conduct regular emergency drills and invest in the necessary infrastructure to respond effectively to disease outbreaks and clinical emergencies. Additionally, financial access to emergency care remains limited, particularly in private facilities where pre-payment is often required. The government should accelerate the operationalization of the Emergency, Chronic and Critical Illness Fund under the Social Health Insurance Fund (SHIF) to ensure that all patients, regardless of socio-economic status, can access timely emergency services.

Maternal, Newborn, Child, and Adolescent Health (RMNCAH)

The availability of Basic Emergency Obstetric and Newborn Care (BEmONC) signal functions remains low in many health facilities. Efforts should focus on training healthcare providers and ensuring that essential equipment and medications are consistently available for the management of obstetric emergencies. Readiness for comprehensive newborn care also needs strengthening. This includes scaling up neonatal infrastructure, expanding paediatric training, and leveraging mobile health (mHealth) tools for early diagnosis and referrals. Additionally,

adolescent-friendly services are underdeveloped, and many facilities lack the necessary space and privacy to offer appropriate care. Investments should be made to develop adolescent-focused services and improve WASH (water, sanitation, and hygiene) infrastructure, especially in public and rural health facilities.

Non-Communicable Diseases (NCDs) and Cancer

The assessment revealed poor access to diagnostic and treatment services for non-communicable diseases, including cancer. To address this gap, the Ministry of Health and county governments should prioritize the establishment of regional cancer centres and scale up histopathology, chemotherapy, and radiotherapy capacity. The availability of essential cancer medicines remains inadequate, and supply chains for oncology drugs should be strengthened through centralized procurement and partnerships with the Kenya Medical Supplies Authority (KEMSA). Integration of NCD services into primary healthcare is also essential. Screening and treatment for conditions such as diabetes, hypertension, and mental health should be incorporated into routine services, supported by targeted training and the provision of essential supplies.

Blood Transfusion and Laboratory Services

Blood transfusion services continue to face multiple challenges, particularly in screening and safety practices. A nationwide rollout of transfusion safety training is needed, targeting healthcare workers in both public and private facilities. Additionally, every unit of blood must be screened for transfusion-transmissible infections before use. Laboratory capacity must also be enhanced, especially in rural and public sector facilities. External quality assurance (EQA) programs should be institutionalized, and all public laboratories must be equipped with SOPs and participate in regular proficiency testing to ensure accurate and reliable diagnostic results.

Pharmacy and Supply Chain

Frequent stockouts, inadequate pharmacy infrastructure, and weak inventory management systems were key issues identified in the assessment. There is a need to invest in electronic logistics management information systems (eLMIS) and digitize pharmacy operations to streamline stock control, improve ordering efficiency, and minimize losses. In addition, poor adherence to medication safety practices, including adverse drug reaction (ADR) monitoring, poses risks to patient safety. Pharmacy guidelines and pharmacovigilance procedures should be cascaded to facilities through county health management teams (CHMTs). To address the environmental and health risks posed by expired medicines, regional pharmaceutical waste disposal infrastructure should be established, alongside routine audits and tracking mechanisms.

Health Information and M&E Systems

The underutilization of data for planning and quality improvement remains a concern. Health workers and facility managers should be trained in data interpretation and encouraged to use

routine data for decision-making and performance monitoring. Regular data review meetings should be integrated into the facility quality improvement (QI) cycle. Digital infrastructure also needs to be scaled up. Access to DHIS2, EMR, and eCHIS systems must be expanded to Level 2 and rural facilities to improve data accuracy, reporting timeliness, and service tracking. Furthermore, staff and patient satisfaction surveys—critical feedback tools for service improvement—must be institutionalized and conducted annually in all facilities to ensure services are responsive to user needs.

Facility Finance and Management

Public facility financing remains fragile, with only 52% of budgets funded in FY 2022/23. Counties must prioritize timely disbursement of health budgets and comply with the Facility Improvement Fund (FIF) Act, which guarantees facility autonomy in retaining and using internally generated funds. This will minimize disruptions caused by funding delays and improve operational efficiency. To enhance financial protection and access to care, especially in rural areas, reliance on user fees should be phased out, and SHIF/NHIF reimbursements should be expanded to outpatient and primary care services. Finally, routine supportive supervision, quarterly performance reviews, and functional quality improvement committees should be institutionalized to strengthen accountability and improve health system responsiveness.

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