REPUBLIC OF KENYA

MINISTRY OF HEALTH

KENYA HEALTH SECTOR STRATEGIC PLAN (KHSSP)

Transforming Health Systems to Achieve Universal Health Coverage

July 2023 - June 2027

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FOREWORD

This strategic plan has been aligned with the Kenya Constitution 2010 (Article 43 (a) and the Fourth Schedule, Vision 2030, Kenya Health Policy 2014-2030, Bottom-up Economic Transformation Agenda (BETA) and Global and regional health agenda. It builds on the progress Kenya has made toward the achievement of the Sustainable Development Goals (SDGs) and the World Health Organization (WHO) Global Programme of Work (GPW13), which assigns member states priority to achieve Universal Health Coverage (UHC), enhance emergency response, and encourage a healthier populace.

The Strategic Plan also aims to accelerate the aspiration of Vision 2030 as outlined in the Social pillar to facilitate the implementation of the Medium-Term Plan (MTP) IV health agenda that aims to strengthen healthcare by delivery of Universal Health Coverage (UHC) through the implementation of a fully public-funded primary healthcare (preventive, promotive, outpatient and basic diagnostic services); a universal seamless health insurance system; establishing a national fund for chronic and catastrophic illness and injury costs not covered by insurance; scaling up manufacturing of essential medical supplies; strengthening human resource for health; expanding healthcare infrastructure; and enhancing supply chain management for health commodities.

The Kenya Health Sector Strategic Plan (KHSSP) 2023-2027 strategic objectives align with the Government Transformation Agenda under BETA and are focused on improving health service delivery across all levels of healthcare, community involvement, emergency response, lowering the burden of diseases (communicable and non-communicable), adopting a holistic life course approach, and addressing critical areas for strengthening the health system. It will act as a guiding document that outlines strategic goals, objectives and directions to improve the health, well-being and quality of life of the Kenyan population.

In the context of changing global trends and increasing innovations in the health sector, this Strategic plan aims to further strengthen the pillars of the health system: Leadership and governance; Service delivery; Health system financing; Human Resources for Health; Health Products and technologies; and Health information systems. The interventions outlined are all-inclusive and specially designed to handle the main health issues in Kenya, the rapid adoption of new technologies for the delivery of effective healthcare, and the possibility of emerging and reemerging diseases. It therefore offers a comprehensive set of actions to re-engineer and revamp the healthcare services delivery.

The Ministry is committed to fully realizing this plan by harnessing resources; promoting partnerships and collaborations; leveraging innovation and technology, as well as monitoring and evaluating to track the achievement in a responsive and accountable manner. The directorates will create annual operating plans, link the strategic plan to the budget, and offer an open procedure for tracking and reporting progress regularly. Further, a collaborative approach will be strengthened amongst the National and county Governments and all stakeholders to ensure its successful implementation.

The goal of this strategic plan will only be achieved through the commitment of all stakeholders in health, and I firmly believe we can achieve it. I call for continued support from the entire health sector community and partners to make the implementation of this plan a success.

Hon. Aden Duale, EGH
Cabinet Secretary
Ministry of Health

ACKNOWLEDGEMENT

This Strategic Plan outlines the health sector's strategic directions, investment areas, implementation & monitoring and evaluation framework and the resource requirements for the fourth Strategic Plan 2023 - 2027 under the Kenya Health Policy 2014 - 2030.

The development of this sector strategic plan was led by the office of the Cabinet Secretary and coordinated through the office of Director of Planning - Central Planning and Project Monitoring Department. It was formulated following a comprehensive analysis of the health systems conducted through an inclusive and participatory methodology to ensure involvement and contributions from a wide range of key health stakeholders, including Ministry of Health, County Governments, Semi-Autonomous Government Agencies (SAGAs), United Nations agencies, development partners, private sectors, civil society and community organizations.

We recognize the contribution of the Office of the Director General (DG) for technical guidance and support, the Council of Governors, the County Executive Committee Members for Health Caucus and the SAGAs for coordinating participation of their officers in the realization of this strategic plan. We also recognize the contribution of the Technical Working Group (TWG) and technical officers drawn from the Ministry of Health for their dedication to the development of this strategic plan.

The Ministry of Health is forever grateful to the World Health Organization (WHO), The United Nations Children's Fund (UNICEF), the African Medical and Research Foundation (AMREF), the United States Agency for International Development (USAID), the United Nations Population Fund (UNFPA) for their financial and technical support in the development of the five-year Strategic Plan. Special recognition to the members of the Futures Health Economic Metrics (FHEM) consultants for their invaluable support and contribution.

There is no doubt that this plan will significantly improve health outcomes in our country and thus we call for a coordinated and collaborative approach in the implementation of this strategic plan.

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

Ms. Mary Muthoni, MBS
Principal Secretary,
State Department for Public Health and Professional Standards,
Ministry of Health

EXECUTIVE SUMMARY

The "Vision" of the KHSSP 2023-2027 is to ensure the country is a healthy, productive, and globally competitive nation. Driven by a "Mission" To build a progressive, responsive, and sustainable Health care system for accelerated attainment of the highest standard of health to all people living in Kenya. The "Goal" is to attain Equitable, affordable, accessible, and quality health care for all, with an overarching "Theme" to accelerate the attainment of Universal Health Coverage.

The KHSSP is anchored on the following policies and Agenda: The Constitution of Kenya - 2010, Vision 2030; Kenya Health Policy 2014 – 2030; Bottom-up Economic Transformation Agenda (BeTA) and UHC agenda. It has considered the global and regional health agenda (Agenda 2063 of the African Union the Sustainable Development Goals (SDGs) and the East Africa Community (EAC) Vision 2050). The plan seeks to refocus attention from curative health care to preventive and promotive healthcare at the primary care level and highlights the significance of enhancing healthcare services, outcomes, and infrastructure.

Six policy objectives that were defined in the Kenya Health Policy 2014-2030, have been used to guide the development of interventions and strategies. These objectives are: Eliminate communicable conditions; Halt and reverse the rising burden of non-communicable conditions and mental disorders; Reduce the burden of violence and injuries; Provide essential healthcare; Minimize exposure to health risk factors and Strengthen collaboration with private and other sectors that have an impact on health.

Situation Analysis shows that the country faces significant disparities in access to healthcare services, with rural areas and marginalized communities being particularly underserved. There is a growing burden of non-communicable diseases such as cancers, heart disease diabetes and related complications, that if not addressed urgently, will become a threat not just to health but to the socio-economic well-being of the country. Kenya is also grappling with a high burden of communicable diseases, which are largely preventable, including malaria, HIV/AIDS, tuberculosis, and diarrhea and the covid 19 pandemic exposed weaknesses in the healthcare infrastructure, supply chain management, and emergency response capabilities. The highest causes of death in the past five years include Upper respiratory tract infections (URTI), Diarrhea, Diseases of the skin, Malaria, Arthritis, Hypertension, and Injuries. Other diseases of the ear, nose and throat continue to contribute to the burden of diseases in Kenya. The country is still grappling with the need to meet the growing need for children under 5 years, adolescents and women of reproductive age.

The situation analysis also portrays that there is government goodwill and a strong enabling environment to drive the healthcare agenda. However, the country needs to allocate and utilize its healthcare resources more strategically, intentionally, and ambitiously if it is to fulfil present and future demands.

The six strategic objectives of the current KHSSP will be achieved through the implementation of key action as identified in the Key Strategic Focus Areas outlined as follows: Strengthening access to and quality of health services at all levels and enhancing service delivery through an integrated and responsive primary healthcare approach. and Building resilience of health systems including climate change adaptations and health security.

The health systems investment areas include Health Leadership and Governance; to improve health system stewardship and social accountability at all levels. Service delivery: To strengthen access to quality health services at all levels of care, including emergency care to accelerate attainment of universal health coverage. This will be through enhancing an integrated and responsive primary healthcare approach and building a resilient health system. Human Resources for Health; to ensure adequate, appropriate, and equitable distribution of HRH. Health Products and Technologies; To ensure efficient HPT management, and security for all health products and technologies, while strengthening Traditional and Alternative Medicines (TAM).

Health Financing: To mobilize resources and ensure equitable allocation of funds while maximizing efficiency and value for money. Health Infrastructure: to expand and enhance physical health infrastructure; improve management of medical devices and equipment as well as enhance ICT Infrastructure and strengthen the existing transport services and referral system. Health Information Systems and M&E; This focuses on digitizing the health ecosystem, and strengthening health data quality, governance and use. It also focuses on enhancing the monitoring and evaluation of health sector performance, and coordination of strategic partnerships and collaborations for digitization. Health Research and Development; To strengthen research coordination, establishm meıh of rqpsindn ınt researion management information systems and eexpand research and evidence translation. It also focuses on enhancing sustainable and Innovative research funding for strengthenning health innovations and technology transfer.

Resources needed and the financial gaps to actualize the plan have been outlined in Chapter five (Resources Requirements), a costed budget provided, and sources of funds identified. The Ministry of Health will take lead in the implementation of this Strategic plan in Collaboration with other stakeholders. The implementation matrix outlines who, where (level), when and how the interventions will be actualized in the next five years. A common communication and risk mitigation strategy has been outlined.

In the five-year period from 2023/24 to 2027/28, the total costs for health services and the health system The One Health model was used to provide cost estimates by the KHSSP strategic objectives and orientations. From the costing, KES 4.8 trillion is required to finance the strategy over the plan period. Overall, a total of KES 2.85 trillion is available to support the KHSSP over the next five years leaving a funding gap of KES 1.97 trillion for the five years, indicating a significant shortfall in financial resources for the health sector.

To keep track on the progress with what is envisioned to take place in the next five years a monitoring, evaluation, accountability, and learning will be closely followed up hence in place are outlined performance outputs and timelines for each. Changes always arise hence posing unpredictable risks hence possible mitigating strategies are also in place to guard this plan. Every player in the health sector must develop a contingency plans, Effective communication will be enhanced throughout the five years and lessons learned will be documented for purposes of learning and growth.

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

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ACRONYMS AND ABBREVIATIONS

AAALAC	American Association for Assessment and Accreditation of Laboratory Animal Care
ACEs	Adverse Childhood Experiences
AMREF	African Medical and Research Foundation
ANC	Antenatal Care
ART	Antiretroviral Therapy
ASAL	Arid And Semi-Arid Lands
AU	African Union
AYP	Annual Year Plan
AYSRH	Adolescents Youths Sexual Reproductive Health
BAT	Best Available Technologies
BCG	Bacillus Calmette Guerin
BEP	Best Environmental Practices
BETA	Bottom-Up Economic Transformation Agenda
BLS	Basic Life Support
BPFA	Beijing Declaration and Platform of Action
CABG	Coronary Artery Bypass Graft Surgery
CANECSA	College Of Anesthesiologists of East, Central and Southern Africa
CBRNE	Chemical, Biological, Radiological and Nuclear Explosives
CDC	Center For Disease Control
CECM	County Executive Committee Members for Health
CEDAW	Convention On the Elimination of All Forms of Discrimination Against Women
CEMONC	Comprehensive Emergency Obstetric and New-Born Care
CEWAS	Commodity Early Warning and Alert System
CHAS	Community Health Assistants
CHERP	Covid-19 Health Emergency Response Project
CHMT	County Health Management Teams
CHP	Community Health Promoters
CHRIOS	County Health Records Information Officers
CHUS	Community Health Units
CLTS	Community Lead Total Sanitation
CNAP	County Nutrition Action Plan
COECSA	College Of Ophthalmology of Eastern Central and Southern Africa

COHOS	Community Oral Health Officers
COHVP	National Committee of Human Vaccine Production
COM	College Of Medicine
COSECSA	College Of Surgeons of East, Central and Southern Africa
CPSB	County Public Service Boards
CRC	Child Rights Convention
CRRT	Continuous Renal Replacement Therapy
CSOS	Civil Society Organizations
CSR	Cataract Surgical Rate
CVDS	Cardiovascular Diseases
D&EC	Disciplinary And Ethics Committee
DASH	Directorate of Adolescent and school health
DG	Director General
DHA	Demographic And Health Survey
DMH	Division Of Mental Health
DR	Diabetic Retinopathy
DR TB	Drug Resistant Tuberculosis
DRM	Disease Related Malnutrition
DRMH	Department of Reproductive maternal Health
DSRU	Disease Surveillance and Response Unit
E-CHIS	Electronic Community Health Information Systems
EAC	East Africa Community
ECSACOP	East And Central Africa College of Physicians
EHC	Ear And Hearing Care
EMONC	Emergency Obstetrics and Newborn Care
EMRS	Electronic Medical Records System
EMTCT	Elimination Of Mother to Child Transmission of HIV
ENT	Ear, Nose & Throat
EPOD	Electronic Proof of Delivery
ETR	End-Term Review
FBOS	Faith-Based Organizations
FHEM)	Futures Health Economic Metrics
FP	Family Planning

GFGP	Good Financial and Grant Practices
GHSA	Global Health Security Agenda
Global	Programme of Work (GPW)
GOK	Government Of Kenya
GOPC	Dermatology, Ophthalmology, Psychiatry, Endocrinology Clinic
GPC	Global HIV Prevention Coalition
GPW	Guinea Worm Disease
HAPCA	HIV And AIDS Prevention and Control Act
HBV	Hepatitis B Vaccine
HISP	Health Insurance Subsidies Program
HIV/AIDS	Human immunodeficiency virus
HMIS	Hospital Management Information System
HPS	Health Promoting Schools
HPT	Health Products and Technologies
HPV	Human papillomavirus infection
HRH	Human Resources for Health
HRIOS	Health Records Information Officers
ICPD	International Conference on Population and Development
ICT	Information Communication Technology
ICU	Intensive Care Unit
IHC	Immunohistochemistry
IHP	International Health Partnerships
IHR	International Health Regulations
IHRIS	Integrated Human Resource Information System
ILMIS	Integrated Logistics Management System
IMAM	Integrated Management of Acute Malnutrition
IMIC	Integrated Molecular Imaging Center
IPTp	Intermittent Preventive Treatment in Pregnancy
ITNS	Insecticide Treated Nets
IUD	Intrauterine device
JICA	Japan International Cooperation Agency
KBI	Kenya Biovax Institute
KEML	Kenya Essential Medicines List

KEMRI	Kenya Medical Research Institute
KEMSA	Kenya Medical Supplies Authority
KEPH	Kenya Essential Package of health
KHHFA	Kenya Harmonized health facility assessment for UHC
KHHRAC	Kenya Health Human Resource Advisory Council
KHIS	Kenya Health Information System
KHP	Kenya Health Policy
KHPOA	Kenya Health Professions Oversight Authority
KHSSP	Kenya Health Sector Strategic Plan
KIPRE	Kenya Institute of Primate Research
KM	Knowledge Management
KMC	Kangaroo Mother Care
KMPDC	Kenya Medical Practitioners and Dentists' Council
KMTC	Kenya Medical Training College
KNAP	Kenya Nutrition Action Plan
KNBTS	Kenya National Blood Transfusion Services
KNH	Kenya National Hospital
KNRA	Kenya Nuclear Regulatory Authority
KPS	Key Populations
KQMH	Kenya Quality Model for Health
KRA	Key Result Area
KUTRRH	Kenyatta University Teaching, Referral and Research Hospital
LAN	Local Area Network
LBW	Low Birth Weight
LF	Lymphatic Filariasis
LLINS	Long-lasting insecticidal nets
LMIS	Logistics Management System
LPM	Litres Per Minute
LSM	Larval Source Management
M & E	Monitoring And Evaluation
MCPR	Modern Contraceptive Prevalence Rate
MDA	Mass Drug Administration
MDGS	Millennium Development Goals

MDTS	Multidisciplinary Teams
MEAL	Monitoring, Evaluation, Accountability, and Learning
MHGAP	Mental Health Gap Action Program
MIP	Malaria In Pregnancy
MIPA	Meaningful Involvement of People Living with HIV
MIYCN	Mother Infant Young Child Nutrition
MMR	Maternal Mortality Ratio
MMUH	Mama Margaret Uhuru Hospital
MOUS	Memorandum Of Understanding
MRIS	Magnetic Resonance & Imaging Equipment
MTP	Medium Term Plan
MTR	Mid-Term Review
MTRH	Moi Teaching & Referral Hospital
NASCOP	National AIDS and STIs control programme
NBU	Newborn Unit
NCCQIF	National Coordination Centre for Quarantine and Isolation Facilities
NCCS	National Cancer Control Strategy
NCD	Non-Communicable Diseases
NGCDF	National Government Constituency Development Fund Board
NGOS	Non-Governmental Organizations
NHIF	National Health Insurance Fund
NHWA	National Health Workforce Accounts
NICC	Nutrition interagency coordinating committee
NICHE	Nutrition Improvements Through Cash and Health Education
NICU	Neonatal Intensive Care Unit
NITAG	National Immunization Technical Advisory Group
NMR	Neonatal Mortality Rate
NOFBI	National Optic Fiber Backbone Infrastructure
NQCL	National Quality Control Laboratory
NSBD	National School Based Deworming Program
NSDCC	National Syndemic Diseases Control Council
NTDS	Neglected Tropical Diseases
NUPI	National Unique Patient Identifier

ODF	open defecation free
PCNS	Primary Care Networks
PCV	Pneumococcal conjugate vaccine
PFM	Public Finance Management
PHC	Primary Health Care
PHOTC	Public Health Practitioners and Technicians' Council
PLHIV	People Living with HIV/AIDs
PMTCT	Prevention of Mother to Child Transmission
POPC	Pediatric Outpatient Clinic
PPB	Poisons and Pharmacy Board
PREP	Pre-Exposure Prophylaxis
PWIDS	People Who Inject Drugs
QMS	Quality Management System
R&D	Research And Development
RDT	Rapid Diagnostic Tests
RH	Reproductive Health
ROP	Retinopathy of Prematurity
SAFCEI	Surgery, Antibiotic Facial Cleanliness, And Environmental Improvement
SAGA	Semi- Autonomous Government Agencies
SCAC	State Corporations Advisory Council
SCHRIOS	Sub-County Health Records Information Officers
SDGS	Sustainable Development Goals
SHI	Social Health Insurance
SO	Strategic Objective
SOPC	Surgical Outpatient Clinic
SOPS	Standard Operating Procedures
TAM	Traditional and Alternative Medicine
TB	Tuberculosis
TCTP	Third Country Training Programme
TD	Tetanus-Diphtheria
TISN	Training Institute of Specialized Nursing
TMA	Total Market Approach
TSR	TB Treatment Success Rate

TT	Tetanus Toxoid
TT	Trachoma Trichiasis
TWG	Technical Working Group
UHC	Universal Health Coverage
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children emergency fund
URTI	Upper respiratory tract infections
URTI	Upper Respiratory Tract Infections
USAID	United States Agency for International Development
VMMC	Voluntary Medical Male Circumcision
WASH	Water, Sanitation, and Hygiene
WHO	World Health Organization
WISN	Workload Indicators for Staffing Needs
WRA	Women Of Reproductive Age
YLDS	Years Lived with Disability
ZN-ORS	Zinc and Oral Rehydration Solution

CHAPTER 1: BACKGROUND AND INTRODUCTION

1.1 Background

The Government of Kenya is committed to attaining her health agenda guided by Constitution 2010, Vision 2030 and Health Policy 2014 – 2030. The Kenyan constitution Article 43 (1) (a) provides that every person has the right to the highest attainable standard of health. The aspirations of Kenya's Vision 2030 are to provide equitable, affordable and quality healthcare to all citizens as embedded in the Universal Health Coverage agenda. The goal of the health policy 2014–2030 is to attain the highest health standards that respond to the population's needs. The health sector aims to achieve this goal by supporting equitable, affordable, and high-quality health standards and related services.

The main objective of the Kenya Health Policy 2014–2030 is to attain the highest possible standards of health in a responsive manner, which will be achieved by supporting equitable, affordable, and high-quality health and related services for all Kenyan. It outlines six Policy Objectives which includes: Accelerate Reduction of the Burden of Communicable Diseases; Halting and reversing the trends of non-communicable diseases; Reducing the burden of violence and injuries; Provide personal cantered essential health services; Minimize exposure to health risk factors; Strengthen collaboration with private and other health-related sectors.

To actualize the policy objectives, a 5-year strategic plan is required to make sure the sector is headed toward achieving this initiative through the following investment areas which includes policy objectives are Service delivery systems, health leadership and governance, health infrastructures, human resources for health, health products and technologies, health management information systems and Monitoring and Evaluation (M&E), health financing; and health research and development. The plan seeks to refocus attention from curative healthcare to preventive and promotive healthcare and highlights the significance of enhancing healthcare services, outcomes, and infrastructure.

The plan offers a comprehensive road map for the sector's investments and strategic priorities, ensuring its alignment with the medium-term plan IV and its integration into the Bottom-up Economic Transformation Agenda (BETA). The MTP IV implementation, monitoring and evaluation framework guides each government ministry to develop a strategic plan as per the State Department for Economic Planning guidelines to enhance service delivery, advance good governance, maintain accountability and transparency and accomplish socioeconomic development goals.

1.2 Global and Regional Health Commitments

1.2.1 Global commitments

Global commitments to public health are essential for improving the health and well-being of people worldwide. These commitments come in the form of agreements, treaties, and declarations that outline goals, strategies, and targets for addressing health challenges. These global commitments provide a framework for international cooperation and action to improve public health. They guide the work of governments, international organizations, and civil society to address health challenges, promote healthy lifestyles, and ensure equitable access to healthcare services for all. They require sustained efforts, resources, and political good will to translate them into tangible improvements in people's health. Several global commitments have enhanced the focus and priorities of the KHSSP 2023-2027 and are integrated as follows:

1.2.1.1 Sustainable Development Goals (SDGs)

SDGs are a focus of global efforts to improve health standards by implementing a Universal Health Coverage agenda in health. Therefore, the creation of the 17 Sustainable Development Goals (SDGs), provides a shared blueprint for peace and prosperity for people and the planet, now and into the future. The SDGs are interlinked, integrated, indivisible and are universally applicable, considering different national realities, capacities and priorities. SDG Goal 3 on Good Health and Well-being aims to ensure healthy lives and promote well-being for all, at all ages. It addresses all major health priorities: reproductive, maternal, newborn, child and adolescent health; communicable and non-communicable diseases; universal health coverage; and access for all to safe, effective, quality and affordable medicines and vaccines.

Figure 1. 1: SDG 3 and health-related linkages with the other SDGs

(WHO, 2021; Monitoring of Health-Related SDGs)

Kenya's Progress in adoption and implementation of SDG 3

Kenya adopted the SDGs into the national and county level context by reviewing existing plans/strategies, identifying areas of change and criteria for prioritizing and identifying synergies and linkages across all sectors. The country developed robust monitoring and reporting systems to ensure indicators are localized to fit into the national context.

Kenya initiated the following interventions/strategies to implement SDG3 targets: -

i. Accelerating UHC through enhancing efficiency in the provision of health services; improving availability of essential health services; ensuring equity in access to essential health services; and enhancing human resource capacity for health service provision.
ii. To accelerate the reduction in maternal and child mortality the government has prioritized a few interventions. These include Linda mama/ free Maternity services in public and faith-based health facilities; adaptation of the World Health Organization (WHO) Quality of Care Guidelines on Maternal and Newborn Health; advocacy and Awareness of adolescent youths Sexual Reproductive Health (AYSRH) policy; and implementation of Community Based Family Planning.
iii. Interventions to prevent new HIV infections include Integrated prevention being implemented countrywide (Structural, Behavioral, and Bio-medical – Voluntary Medical Male Circumcision (VMMC), Prevention of mother-child transmission (PMTCT), and Condom programming). Increase Antiretroviral Therapy (ART) uptake: development of policies to address stigma and violence, scaling up interventions targeting key populations, roll out of point of care, and review and implementation of guidelines.
iv. Implementation of TB priority interventions among them: development of the National Strategic Plan, Increase in the number of GeneXpert machines; and introduction of shorter-term regimen for management of drug-resistant TB.
v. Routine distribution of long-lasting insecticidal nets (LLINs), intermittent preventive treatment in pregnancy (IPTp), and scaling up diagnosis and management of malaria cases.
vi. Undertaking recruitment of more human resources for health and conducting routine capacity building for healthcare workers as per the Kenya Health Act 2017.

1.3 Universal Health Coverage (UHC)

The United Nations (UN) is committed to achieving UHC, which aims to ensure that everyone has access to essential quality healthcare services without financial hardship. The Government of Kenya has committed to accelerating the attainment of Universal Health Coverage (UHC) as one of the BETA Agenda for enhancing socio-economic development. UHC aims to ensure that all Kenyans access and receive essential quality health services without suffering financial hardship.

1.4 International Health Regulations (IHR)

Implementation of the International Health Regulations is to guide the country on key actions needed to assure adherence to international health regulations. The Regulations aim to prevent, protect against, control, and provide a public health response to global health risks. Kenya is implementing several International Human Rights agreements such as the International Declaration for Human Rights, the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the Child Rights Convention (CRC), the International Conference on Population and Development (ICPD) programme of action and the Beijing Declaration and Platform of Action (BPFA).

1.5 Global Health Security Agenda (GHSA)

GHSA was Launched in 2014, to strengthen global health security by improving preparedness for and response to public health emergencies. Ensuring health security at all levels of society relies on coordinated multi-sectoral action and investment to build consolidated emergency preparedness. When prepared, responses are timelier and more effective, and the human, economic and societal consequences of emergencies can be significantly limited.

Achieving international public health security is one of the main challenges arising from the new and complex landscape of public health. Shared vulnerability implies shared responsibility. Strengthening the countries' disease surveillance and response systems is central to improving public health security nationally and in each county. International public health security relies on the appropriate and timely management of public health risks, which in turn depend on effective inter-sectoral, national capacities and internationals. Collaboration.

Ensuring health security at all levels of society relies on coordinated multi-sectoral action and investment to build consolidated emergency preparedness. When prepared, responses are timelier and more effective, and the human, economic and societal consequences of emergencies can be significantly limited.

1.6 International Health Partnerships (IHP+) on Aid Effectiveness

The IHP+ approach included providing support to strong and comprehensive country and government-led national health plans in a well-coordinated way. It focuses on improving the effectiveness of health aid through enhanced coordination and alignment of international assistance with national health strategies.

1.6.1 Regional commitments

Regional commitments to public health are crucial for addressing specific health challenges and tailoring interventions to the unique needs of different populations. These commitments often build upon global frameworks, but they also incorporate regional priorities and contextual factors. They provide a platform for collaboration, resource sharing, and knowledge exchange among countries within a region as they help tailor public health interventions to the specific needs and challenges of the region, ultimately contributing to improved health and well-being for all.

1.6.2 Africa Union Agenda 2063

The agenda 2063 is a strategic framework for the socio-economic transformation of the continent. It builds on and seeks to accelerate the implementation of past and existing continental initiatives for growth and sustainable development. Within the Africa region, the nature and focus of required health services has evolved significantly. While communicable diseases continue to be a major problem in many countries, additional challenges are emerging to which changes in policy are needed to address them urgently.

The Africa Union Agenda 2063 aspires that every African citizen will have full access to affordable and quality health care services, including sexual and reproductive health services for vulnerable groups. Africa also aims to eradicate neglected tropical diseases and control infectious diseases like Ebola. Robust systems will be put in place to halt and reverse non-communicable diseases and reduce deaths from HIV/AIDS, malaria, and tuberculosis to zero. Comprehensive health services and infrastructure will ensure accessibility, affordability, acceptability, and quality of care for all.

1.6.3 Primary Health Care and Health Systems

Ouagadougou Declaration on Primary Health Care and Health Systems – a re-iteration of the principles of the PHC approach, within the context of an overall health system strengthening approach.

1.6.4 Abuja Declaration

The Declaration seeks to support improvements of health systems in the country by domesticating the provisions through national legislation, the country commitment in the Abuja Declaration that calls for allocation of 15% of the government budget for health.

1.6.5 East Africa Community Vision 2050

The EAC Vision 2050 articulates the dreams and aspirations of the East African peoples and makes a commitment to what they will do to achieve these dreams. It follows closely on the development of the African Union Agenda 2063 which articulates the aspiration of all the people of the African continent. It lays out a broad perspective in which the region optimizes the utilization of its resources to accelerate productivity and the social wellbeing of its people.

The knowledge and management of health has changed because of significant shifts in how people live, work, and interact. Continued investments will be made in both health infrastructure systems as well as building capacities of health personnel. Both preventive and curative approaches will be enhanced to ensure a healthy and productive sub region that is free from diseases and pandemics EAC Partner States will enhance collaboration and cooperation to strengthen health systems through increased health financing, recruitment, development and training and retention of the health workforce. This will be achieved through improved distribution and access to safe, affordable, effective and quality medicines, vaccines and medical technologies, through improving access to health services and infrastructure.

During the implementation of the Vision 2050, the following will be undertaken:

- Strengthened collaboration among health sectors and health related institutions in the region.
- Strengthened and harmonized health and health related policies, strategies and plans.
- Harmonized health and health related legislations and regulations.
- Common and uniform standards of services, products and technologies; and
- Strengthened coordination of development support.

Successful implementation of the goals and the achievement of Vision 2050 requires an enabling environment. The presence of effective institutions is inextricably linked with economic transformation and growth. It is therefore imperative to invest in human capital and establish the necessary institutions to uphold the Vision.

1.6.6 African Health Strategy 2016-2030

This strategy aims to achieve universal health coverage, improve health outcomes, and strengthen health systems in Africa. It prioritizes areas like maternal and child health, infectious diseases, and non-communicable diseases.

1.7 Kenya Health Development Agenda

1.7.1 The Kenya Constitution

The Constitution of Kenya 2010 provides an overarching conducive legal framework for ensuring a more comprehensive and people-driven health services, and a rights-based approach to health is adopted and applied in the country.

Citizen's high expectations are grounded on the fact that the Constitution states that every citizen has a right to life, right to the highest attainable standard of health including reproductive health and emergency treatment. Other human rights as stipulated in the constitution are to be free from hunger and to have food of acceptable quality, right to clean, safe and adequate water and reasonable standards of sanitation and the right to a clean healthy environment.

Kenya has a devolved system of governance, with health functions largely devolved under the Fourth Schedule of the Constitution, and the national and county governments having their clear specific function.

1.7.2 Kenya Health Policy 2014-2030

The Government is implementing the Kenya Health Policy 2014-2030. The policy goal is to 'attain the highest possible health standards in a manner responsive to the population needs,' while its aim is to support provision of equitable, affordable, and quality health and related services at the highest attainable standards to all Kenyans. The policy has six objectives: Eliminate communicable conditions; Halt and reverse the rising burden of non-communicable conditions; Reduce the burden of violence and injuries; Provide essential healthcare; Minimize exposure to health risk factors; and Strengthen collaboration with private and other health-related sectors.

The Kenya Health Policy 2014-2030 demonstrates the Government's commitment towards improvement in the overall status of health in Kenya in line with the Constitution, Vision 2030, and global commitments. The policy goals are achieved by addressing all health system building blocks, namely: health financing, leadership, product and technologies, health workforce, infrastructure, information, and service delivery systems.

1.7.3 Vision 2030

Kenya's Vision 2030 identifies the health sector as an essential component to national development. One of the goals of Vision is to improve the overall health outcomes and indicators by shifting focus from curative health care to preventive and promotive health care.

The vision aims to tackle health disparities and reverse the negative trends observed in health outcomes and impact indicators. To achieve this, specific strategies have been formulated under Vision 2030. These strategies include establishing a robust network of health infrastructure, enhancing the quality of healthcare services to meet the highest standards, and fostering partnerships with the private sector. Furthermore, the government is committed to ensuring access to healthcare for those who are financially strained and prioritizing the needs of women, girls, and individuals in vulnerable situations.

1.7.4 Bottom-up Economic Transformation Agenda (BeTA) and Medium-Term Plan (MTP) IV

The Bottom-Up Economic Transformation Agenda (BETA) being implemented through MTP IV 2023-2027 has identified gaps in Kenya's healthcare system. The gaps include Service delivery, UHC, Triple burden of disease, Human Resources for Health, Governance and Leadership in Health, Ineffective supply chain of HPTs for and Inefficient and fragmented healthcare financing system.

Health as captured in VISION 2030 falls under the social pillar that aims at "building a just and cohesive society that enjoys equitable social development in a clean and secure environment". The Government aim in MTP IV is to strengthen healthcare by delivery of Universal Health Coverage (UHC) through the implementation of a fully public-funded primary healthcare (preventive, promotive, outpatient and basic diagnostic services); a universal seamless health insurance system; establishing a national fund for chronic and catastrophic illness and injury costs not covered by insurance; scaling up manufacturing of essential medical supplies; strengthening human resource for health; expanding healthcare infrastructure; and enhancing supply chain management for health commodities.

BETA aims to have a more creative, deliberate and ambitious utilization of resources to address old and emerging challenges after the COVID-19 pandemic to build a resilient and transformative health system. BETA is committed and determined to realize the constitutional right to health in the shortest time possible by delivering Universal Health Coverage (UHC) through the following:

- Provide Social Health Insurance Fund coverage for all Kenyans without exclusion in the policy of "Leaving No One Behind".
- Employ and initiate payment for community health promoters who shall form part of the Primary Health Care system.
- Prioritize employment of healthcare workers to bridge the gap according to WHO recommendations of 23 HC per 10,000 population.
- Set up an emergency medical treatment fund to cater for emergency, cancer treatment and referrals.
- Establish a commission for the management of human resources for health without undermining devolution.
- Set aside Sh50 billion for Kenya Association of Retired Officers medical schemes.
- Harmonize the terms of employment for all healthcare workers in the spirit of equal work for equal pay.
- Integrate preventive and promotive services/establish MDT (a primary healthcare approach) as envisioned in our Afya Bora Mashinani.
- Allocate Sh100 billion into co-funding the strategic programs for HIV, tuberculosis, blood transfusion, malaria, family planning and reproductive health.
- Ring-fence funds for healthcare under facility improvement funds and increase allocations from the National Treasury in collaboration with county governments.
- Reduce the cost of treatment which includes drugs, consultation, laboratory services,and imaging services.
- Build up the supply chain management system (KEMSA) to ensure efficiency and accountability in the medical supplies to all health facilities.
- Integrate Information Communication and Technology systems to enhance telemedicine and health management information systems. Immediately operationalize a National Health Information System for Electronic Health Records (EHR) to standardize and ensure the portability of patient data.

1.7.5 Universal Health Coverage (UHC)

UHC aims to provide individuals with the healthcare they need without facing financial difficulties. It is a priority both nationally and globally. In Kenya, UHC is a crucial part of the country's health policy, aiming to ensure that all Kenyans can access quality healthcare services in areas such as promotion, prevention, treatment, rehabilitation, and palliative care. The achievement of UHC requires a progressive approach and collaboration across different sectors. UHC's thematic areas include health service coverage, financial risk protection, health workforce, health systems strengthening, governance and accountability, and partnerships and coordination.

The government of Kenya has focused on advancing key health financing initiatives to strengthen the allocation of resources in the Kenyan health sector, to improve efficiencies, and to advance insurance coverage. The government through the Bottom- up Economic Transformation Agenda (BETA) has a shift to achieve UHC with a focus on primary healthcare (PHC) based on three pillars.

- Publicly funded primary healthcare services that include preventive, promotive, palliative, rehabilitative, and curative services; are anchored on primary care networks and community health promoters.
- A mandatory social health insurance system (with private insurance as a complementary) for coverage of secondary and tertiary services.
- A National fund to cover the catastrophic cost of chronic illnesses, injuries and emergencies not covered or restrictively covered by insurance.

1.8 Process of Development of the KHSSP 2023-2027

The development of the KHSSP 2023-2027 was carried out through a comprehensive consultative process, following the established procedure for developing strategic plans outlined in the Quality Management System (QMS) of the Ministry of Health. A Technical Working Group (TWG) was established, with members chosen from key stakeholders and provided with clear Terms of References (TORs), to ensure broad representation and collaboration. The TWG conducted its work based on the investment areas outlined in the Kenya Health Policy (KHP) 2014-2030 and was divided into groups, each focusing on a specific aspect of the Policy. It is informed by several documents which include the Universal Health Coverage Policy, the Kenya Essential Package for Health, Health Sector Norms and Standards, the Partnership Framework, M&E framework including County Specific Health Strategies, Service delivery program specific strategies, and SAGA specific strategies. The sector priorities will time to time guide the allocation of resources in the MTEF process, for both levels of Government and partners. This resource allocation will inform annual planning, and therefore the performance contracting in the health sector.

The drafting process involved multiple identified thematic groups, each responsible for specific areas. A structured and inclusive approach was adopted for the consultative process, which took place at various levels:

- National
- Counties
- Health related Ministries
- Key health sector partners

The Draft KHSSP was subjected to an external expert joint assessment (JANS) after which stakeholders validated. The final document was endorsed by the Cabinet Secretary ready for dissemination and implementation.

CHAPTER TWO: SITUATION ANALYSIS

2.1 Introduction

This chapter highlights the performance of the health sector within the Monitoring and Evaluation framework for the Kenya Health Policy (2014-2030) and the Kenya Health Sector Strategic Plan (2018-2023). A detailed analysis is based on the Policy Strategic objectives and the investment areas defined in the Kenya Health Policy. The situation analysis was informed by a comprehensive review of the KHSSP through KHIS reports, periodic surveys and facility assessments.

2.2 General Health Status

The life expectancy at birth improved from 64.2 to 66.1 years against the KHSSP target of 68 years. A reduction in under five mortality rate, infant mortality rate and neonatal mortality rate was recorded within the review period though the targets were not achieved. Under five mortality rates reduced from 52/1,000 Live births in 2018 to 41/1,000 live births in 2023 against a target of 40/1,000 live births. The infant mortality rate reduced from 39 in 2018 to 32 per 1,000 live births against a target of 28. Neonatal mortality rate reduced from 22/1,000 live births to 21/1,000 LB falling below the KHSSP target of 15/1,000 LB. Maternal Mortality Ratio decreased from 362 per 100,000 live births in 2014 (KDHS) to 355 in 2019 (Census)

2.3 Morbidity patterns

The ten leading causes of under-five morbidity included upper respiratory tract infections; diarrhoea; other diseases of the respiratory systems; skin diseases; malaria; pneumonia; tonsilitis; ear infections, eye conditions and intestinal worms. Upper respiratory tract infections remained the leading cause of morbidity in children under five years accounting for over 29% of all conditions within the review period.

Table 2.1: Summary of the top ten causes of morbidity for under 5 years in the Country as from FY (2018/2019 to FY 2022/2023)

No.	2018 – 2019		2019 – 2020		2020 – 2021		2021 –2022		2022 –2023	
	Disease	%	Disease	%	Disease	%	Disease	%	Disease	%
1	URTI	29	URTI	30	URTI	34	URTI	38.4	URTI	31.7%
2	Diarrhea	7.7	Diarrhea	7.5	Diarrhea	8.4	Diarrhea	9.7	Diarrhea	8.1%
3	Other Dis. of Respiratory System	6.1	Disease of the skin	6.7	Disease of the skin	7.6	Disease of the skin	5.8	Disease of the skin	o4.8%
4	Disease of the skin	5.5	Confirmed Malaria	6.1	Confirmed Malaria	4.8	Confirmed Malaria	5.5	Confirmed Malaria	4.8%
5	Confirmed Malaria	5.5	Other Dis. of Respiratory System	5.9	Other Dis. of Respiratory System	6.7	Pneumonia	4	Pneumonia	3.5%

6	Pneumonia	3.2	Pneumonia	3.5	Pneumonia	6.4	Tonsilitis	3.3	Lower Respiratory Tract Infections	2.9%
7	Tonsillitis	2.3	Tonsillitis	2.5	Tonsillitis	3.9	Lower Respiratory Tract Infections	3.2	Tonsilitis	2.8%
8	Ear Infections/ Conditions	1.7	Ear Infections/ Conditions	1.9	Eye Infections	3.8	Eye Infections	2.5	Eye Infections	1.8%
9	Eye Infections	1.5	Eye Infections	1.6	Lower Respiratory Tract Infections	2.6	Ear Infections/ Conditions	1.8	Ear Infections/ Conditions	1.5%
10	Intestinal worms	1.4	Intestinal worms	1.5	Intestinal worms	2.1	Intestinal worms	1.5	Intestinal worms	1.3%

Source: KHIS 2023

Table 2. 2: Summary of the top ten causes of morbidity for over 5 years in the Country from FY9 2018/2019 to FY 2022/2023

Disease	2018-2019	2018-2020	2018-2021	2018-2022	2018-2023
URTI	19	18	21	21.6	19.5
Arthritis, Joint pains etc.	3.7	3.2	4.5	2.9	2.7
Confirmed Malaria	5.3	5.5	6.5	5.2	5.4
Diarrhea	3	2.6	2.9	2.5	2.5
Disease of the skin	5.6	5.5	6.4	4.1	3.9
Hypertension	2.6	2.5	3.1	2.4	2.3
Other Dis. of Respiratory System	4.5	3.9	3.8	2.8	3.1
Pneumonia	2	2	2.8	2.2	2.1
Urinary Tract Infection	4	3.9	4.6	3.9	3.9
Other injuries	0	0	3	2.1	2.1
Intestinal worms	1.6	1.5	0	0	0

Source: KHIS 2023

The top ten leading causes of morbidity for over five-year-olds within the period under review included upper respiratory infections, diseases of the skin, malaria, other respiratory diseases, urinary tract infections, arthritis, diarrhoea, hypertension, pneumonia and intestinal worms. Upper respiratory tract infections accounted for most of the conditions, with over 18% of all conditions from 2018/19-2022/23 FYs.

Table 2. 3: Summary of the top ten causes of morbidity for over 5 years in the Country from FY9 2018/2019 to FY 2022/2023

No.	2018-2019		2019 – 2020		2020 –2021		2021 –2022		2022 –2023	
	Disease	%	Disease	%	Disease	%	Disease	%	Disease	%
1	URTI	19	URTI	18	URTI	21	URTI	21.6	URTI	19.5
2	Disease of the skin	5.6	Confirmed Malaria	5.5	Confirmed Malaria	6.5	Confirmed Malaria	5.2	Confirmed Malaria	5.4
3	Confirmed Malaria	5.3	Disease of the skin	5.5	Disease of the skin	6.4	Disease of the skin	4.1	Urinary Tract Infection	3.9
4	Other Dis. of Respiratory System	4.5	Other Dis. of Respiratory System	3.9	Urinary Tract Infection	4.6	Urinary Tract Infection	3.9	Disease of the skin	3.9
5	Urinary Tract Infection	4	Urinary Tract Infection	3.9	Arthritis, Joint pains etc.	4.5	Arthritis, Joint pains etc.	2.9	Other Dis. of Respiratory System	3.1
6	Arthritis, Joint pains etc.	3.7	Arthritis, Joint pains etc.	3.2	Other Dis. of Respiratory System	3.8	Other Dis. of Respiratory System	2.8	Arthritis, Joint pains etc.	2.7
7	Diarrhea	3	Diarrhea	2.6	Hypertension	3.1	Diarrhea	2.5	Diarrhea	2.5
8	Hypertension	2.6	Hypertension	2.5	Other injuries	3	Hypertension	2.4	Hypertension	2.3
9	Pneumonia	2	Pneumonia	2	Diarrhea	2.9	Pneumonia	2.2	Pneumonia	2.1
10	Intestinal worms	1.6	Intestinal worms	1.5	Pneumonia	2.8	Other injuries	2.1	Other injuries	2.1

Source: KHIS 2023

2.4 Underlying Causes of Death

In 2022/23 FY, the leading cause of death for all ages were conditions arising during the perinatal period accounting for 13.2% of all deaths, that occurred in health facilities followed by cancer (12.2%), lower respiratory infections (9.8%) and endocrine disorders (7.6%).

Table 2. 4: Leading causes of death for all ages

No.	Causes	% of total deaths
1	Conditions arising during the perinatal period	13.2%
2	Cancer	12.2%
3	Lower respiratory infections	9.8%
4	Endocrine disorders	7.6%
5	Digestive diseases	7.4%
6	Cardiovascular diseases	6.2%
7	Genito-urinary diseases	5.8%
8	HIV	4.9%
9	Respiratory diseases	4.4%
10	Road traffic accidents	3.9%
11	Tuberculosis	3.8%
12	Diabetes mellitus	3.4%
13	Meningitis	2.9%

No.	Causes	% of total deaths
14	Nutritional deficiencies	2.0%
15	Diarrhea diseases	1.8%
16	Malaria	1.5%
17	Maternal conditions	1.2%
18	Homicide	1.2%
19	Alcohol use disorders	1.0%
20	Skin diseases	0.9%

Source: KHIS Tracker 2023

The leading cause of death for under 5-year-olds during 2022/23 FY was birth asphyxia and birth trauma accounting for 28.4% of all deaths, followed by prematurity/Low birth weight and lower respiratory tract infections at 19.9% and 15.1% respectively.

Table 2. 5: Top 10 leading causes of death, under five-year - 2022/2023

No.	Causes	% of all <5 Deaths
1	Birth asphyxia and birth trauma	28.4%
2	Prematurity and low birth weight	19.9%
3	Lower respiratory infections	15.1%
4	Endocrine disorders	6.4%
5	Nutritional deficiencies	4.5%
6	Diarrhea diseases	3.4%
7	Malaria	3.2%
8	Meningitis	3.2%
9	Respiratory diseases	3.2%
10	Congenital anomalies	2.9%

Source: KHIS Tracker 2023

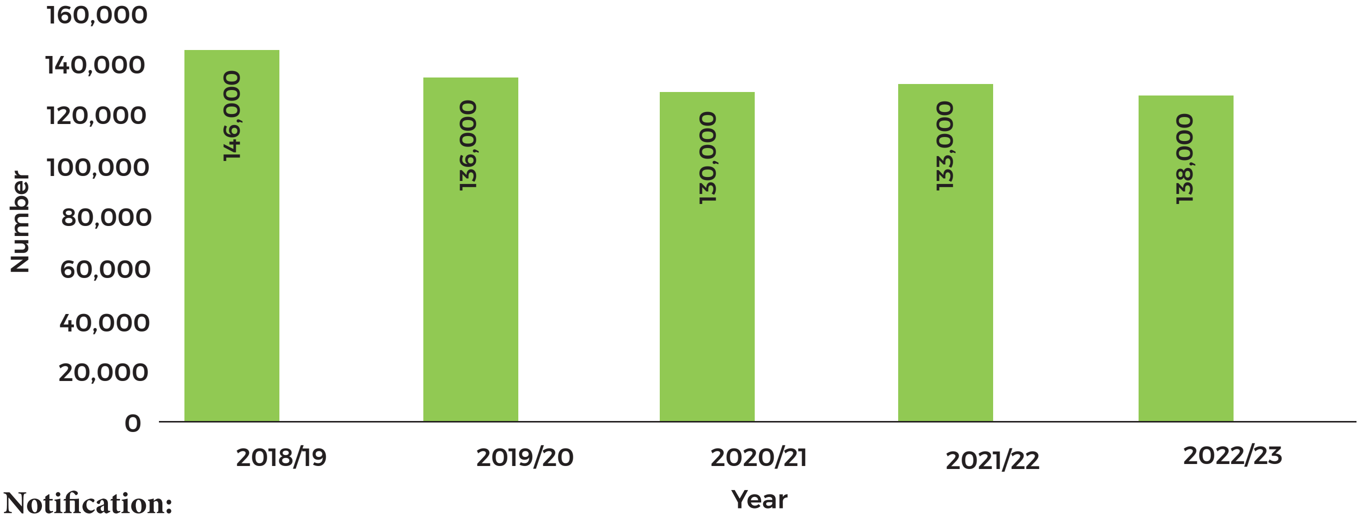
2.5 SO1: Accelerate Reduction of the Burden of Communicable Diseases

This section highlights progress made in reducing the burden of communicable conditions, which include:

- Tuberculosis, leprosy and lung disease`
- HIV/AIDS
- Malaria
- Neglected tropical diseases.
- Vaccine preventable diseases
- Tuberculosis, Leprosy and Lung Diseases

Kenya is listed by WHO among 30 high burden countries for TB and TB/HIV that contribute over 80% of the global TB burden (WHO report 2022), with a prevalence of 426 per 100,000 and an incidence 146,000 per year (TB Prevalence survey 2017). The incidence has however reduced over the past 5 years by 12% to 128,000 new and relapse cases in 2022.

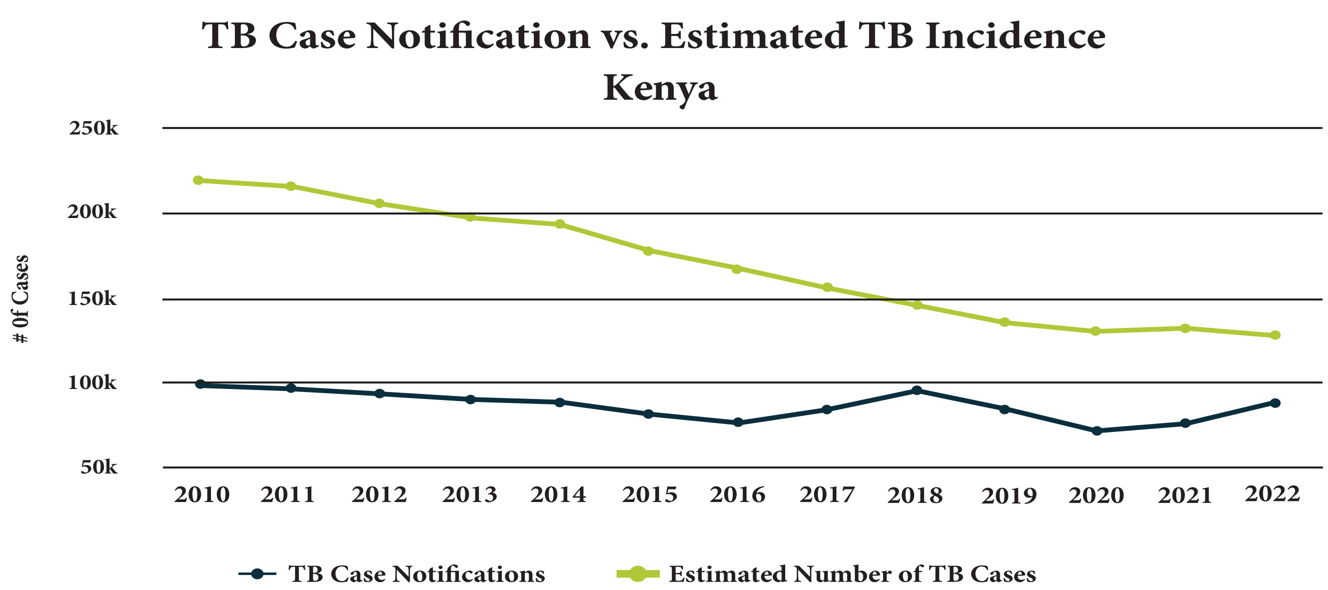
Figure 2. 1: Trends in TB incidence (source: WHO TB estimates)



Notification:

TB incidence has been on a downward trend over the past 10 years. However, the notification of TB cases has remained relatively constant over the past 10 years, constantly below the targeted number of incident cases. In 2022, a total of 88,690 cases were notified against a target of 128,000, translating to a 69% notification rate.

Figure 2. 2: Trends of TB notification rates (source; hub.tbdiah.org).



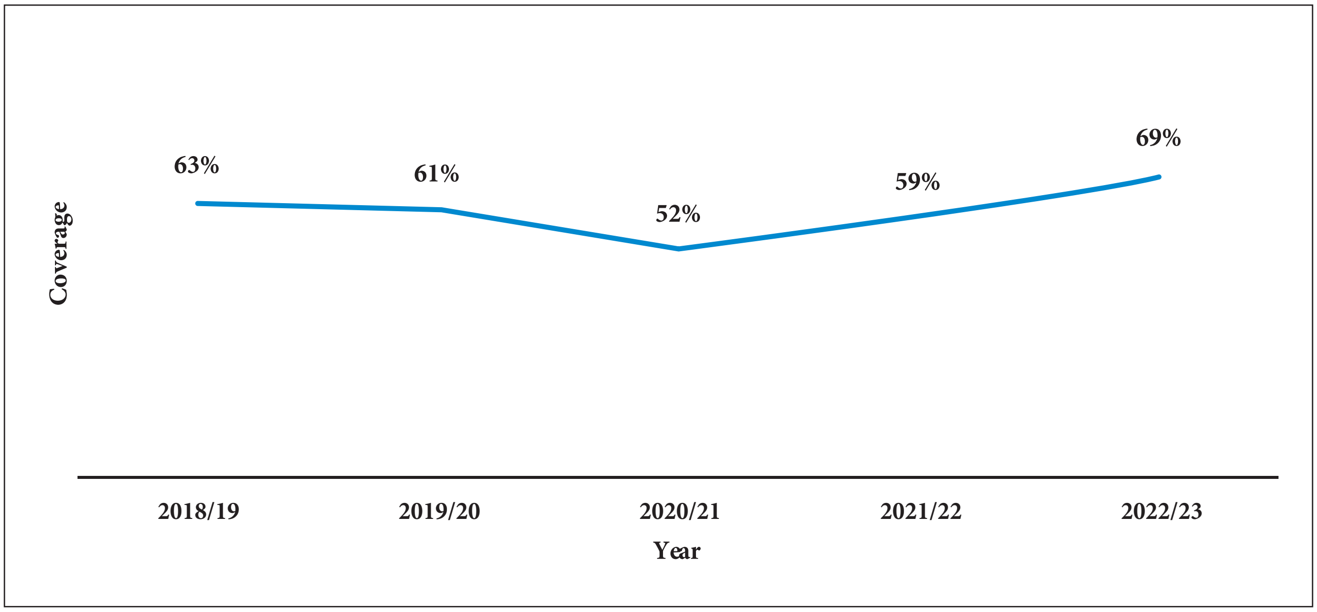
The decline in TB incidence is attributed to the strengthening of TB prevention among high risks groups; contacts of TB patients, PLHIV, prisoners, and health care workers by adopting shorter term preventive therapy, the adoption of active case finding in health facilities, and of continuous quality improvement and engaging all care providers, including the private sector.

Number of TB cases notified has also been on an upward trend due to; adoption of new diagnostic technologies, including WHO rapid diagnosis; by expanding availability of molecular testing, strengthening sample referral for TB specimen for early diagnosis and treatment, and expansion of TB culture labs with 3 more labs in Kitale, Machakos and Malindi.

TB Treatment coverage:

As the TB incidence declines, the country has made notable progress in reaching the unreached, and the treatment coverage has risen over time from 61% in 2019 to 69% in 2022, with a decline in 2020 and 2021

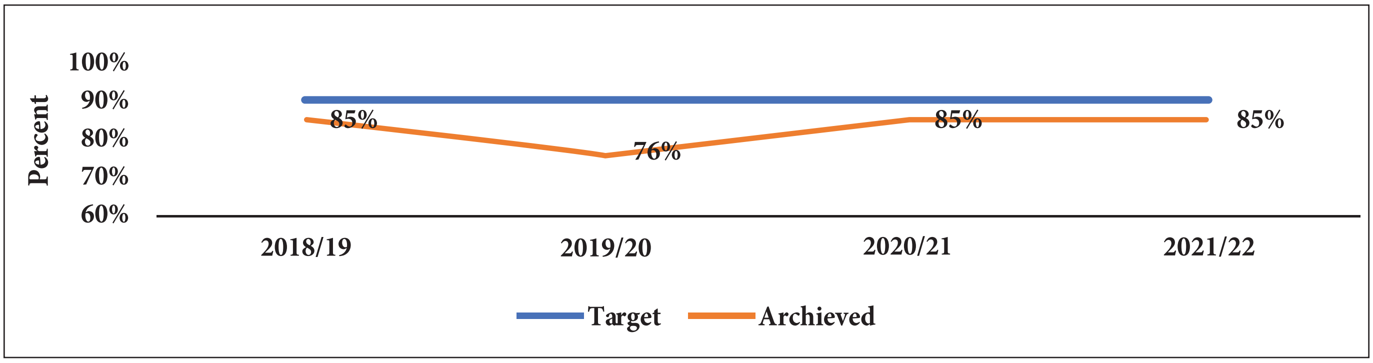
Figure 2. 3: Trends in TB treatment coverage (Source, WHO TB Global reports)



TB treatment success rate:

The annual target treatment success rate is 90% for all people diagnosed with TB and started on treatment for both drug susceptible and drug-resistant TB. Kenya has not achieved the treatment success rate targets over the last five years with the success rate stagnating at 85% from 2018/19 to 2021/22 FY. The figure below shows trends in treatment success rate against targets.

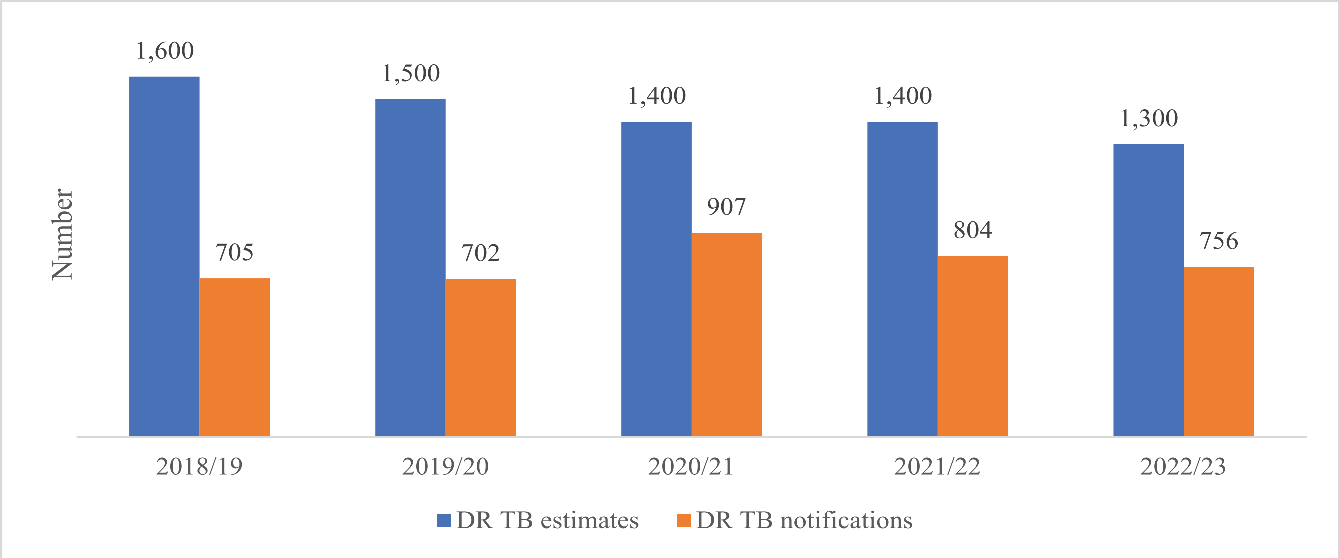
Figure 2. 4: Trends in TB treatment success rate



Source: TIBU

Drug-resistant tuberculosis (DR TB) remains a challenge and a threat to gains made in tuberculosis control over the years, with a notable decline in the estimated number of Drug-Resistant TB cases from 1,600 in 2018 to 1,300 in 2022. DR TB case identification has been a challenge, at less than 65% over the past five years, due to logistical challenges; stock out of testing commodities and sub optimal functionality of the national reference laboratory.

Figure 2. 5: Trends in DR TB estimates and notifications

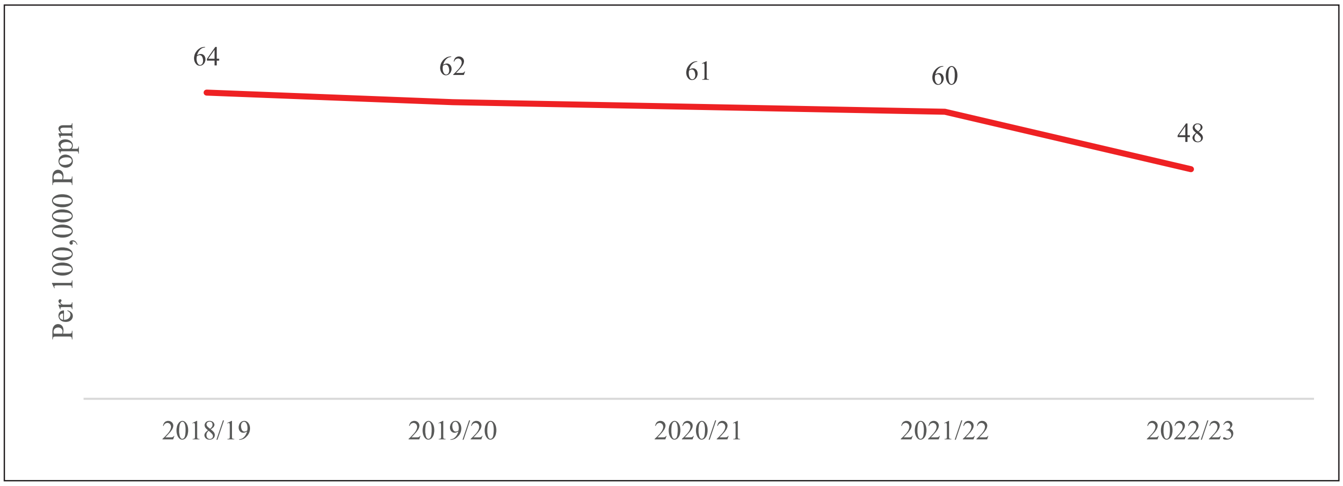


Source: (WHO TB global reports)

TB mortality:

Mortality attributed to TB has significantly reduced over time, with a decline in mortality from 64 in 2018 to 48 per 100,000 in 2022. In Terms of absolute numbers there is a decline in mortality from 32,000 to 25,900 people.

Figure 2. 6: Trends in TB mortality



Source: (WHO TB Global reports)-Deaths per 100,000

Some of the main challenges in TB management includes:

- Inadequate management of other comorbidities including malnutrition since up to 50% of TB patients are malnourished at treatment initiation. TB/HIV death rate has also risen in the recent past.
- Delayed TB diagnosis results in poor treatment outcomes
- Health system challenges including health care worker capacity, poor referral and patient linkages to treatment and sub optimal integration of services.

HIV/AIDs

- Kenya faces the fourth largest HIV epidemic globally, with 1.4 million people living with HIV and 1.33 million receiving antiretroviral therapy (ART). Kenya has committed to meeting global targets, aiming for 95% of people living with HIV to know their status, 95% of them to be on treatment, and 95% to achieve viral suppression by 2030. The current progress towards these targets stands at 97-97-94. New HIV infections have dropped from overs. Despite these achievements, HIV remains a public health threat in Kenya.

HIV Identification Rate

- Currently, the identification rate for adults, adolescents and children stands at 98%, 85% and 80% respectively. These figures fall below the set targets of 95%, indicating a need to close the gap and improve performance for these population groups. Efforts should be focused on ensuring that children and adolescents receive timely and accurate HIV testing and diagnosis, enabling them to access the necessary treatment and prevention services.

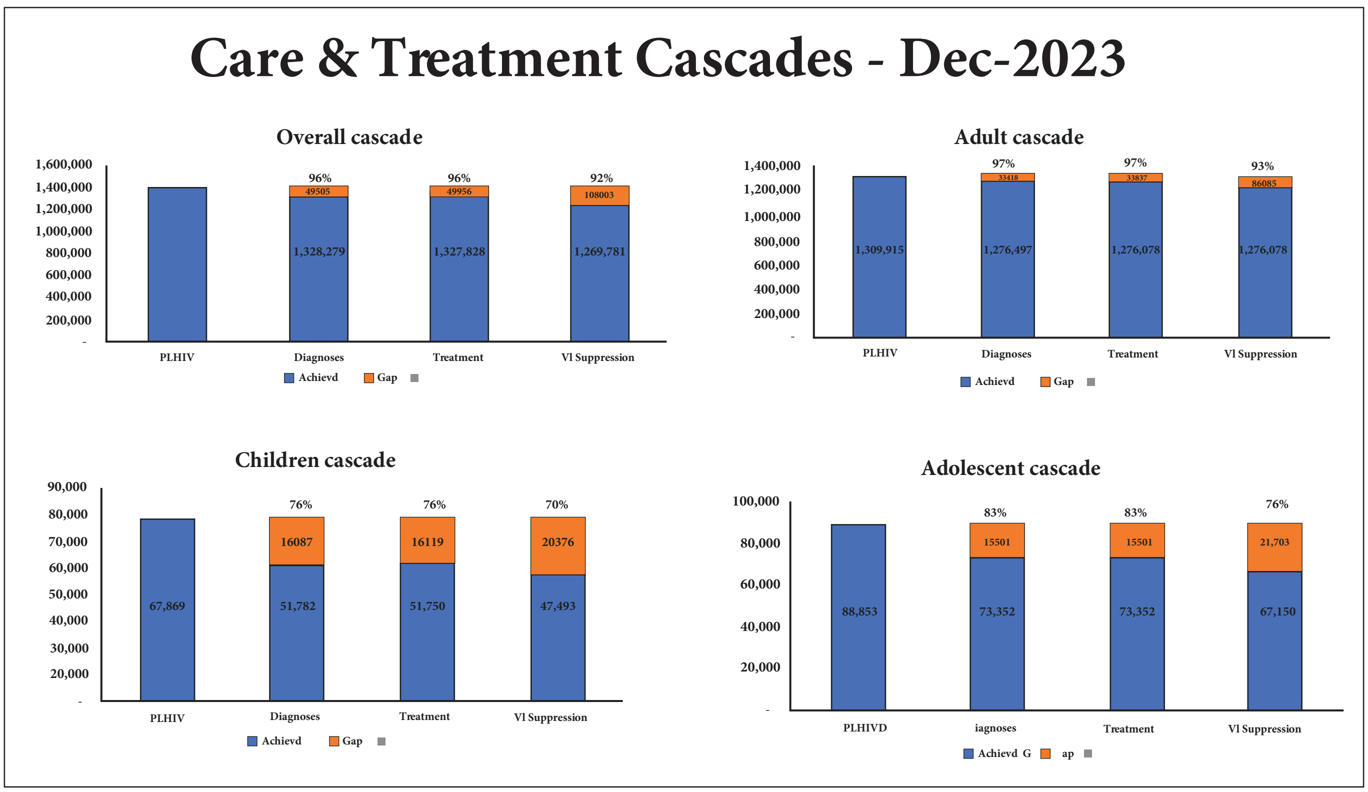
Treatment:

ART coverage improved during the review period with children ART coverage improving from 61% in 2018 to 80% in 2023, adolescent ART coverage improving from 58% in 2018 to 85% in 2023 and adult ART coverage improving from 70% in 2018 to 97% in 2023. The ART coverage for children and adolescents within the review period fell below the target of 95%.

Viral Load suppression:

Viral suppression signifies effective treatment and plays a crucial role in reducing the risk of HIV transmission. Between 2018 and 2023, there has been an increase in viral load suppression among children, adolescents, and adults in the country. Viral load suppression for children, adolescents and adults improved from 45%, 43% and 67% in 2018 to 65%, 73% and 93% in 2023 respectively.

Figure 2. 6: Care and Treatment cases



Source: HIV estimates 2023, and KHIS

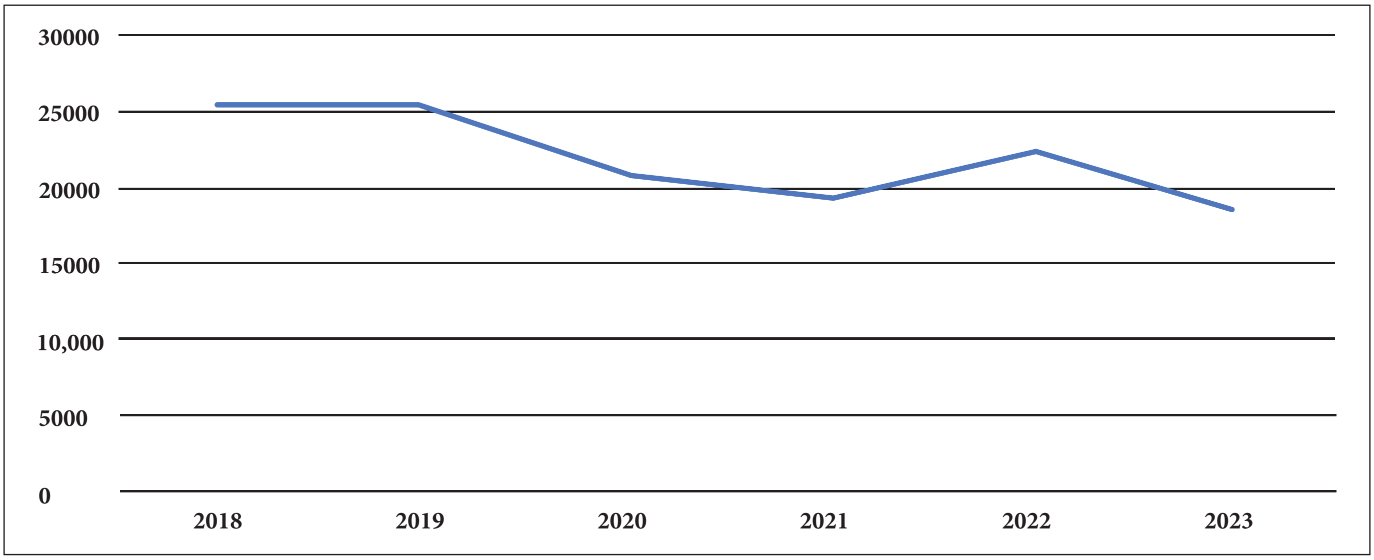
Elimination of Mother to child transmission of HIV (eMTCT)

Mother-to-child HIV transmission rate declined from 10.8% in 2019 to 8.6% in 2023. Although the MTCT rate has been declining over the last 5 years, the Country has not attained its set targets of <5%. The HIV program has declared a fight toward ending HIV and AIDS in children by 2027 and strategic shifts have been put in place to accelerate attainment of this goal.

HIV related deaths

HIV/AIDS-related deaths reduced from about 25,000 in 2018 to 18,000 in 2023.

Figure 2. 7: HIV Related deaths



Pre-Exposure Prophylaxis (PrEP)

The uptake of Pre-Exposure Prophylaxis (PrEP) among eligible individuals in Kenya increased from 29% in 2020 to 64% in 2022, across all population groups. However, there are variations in PrEP initiation among different populations. The general population and discordant couples have shown high uptake rates at 62.1% and 54.2%, respectively, while People Who Inject Drugs (PWIDs) have the lowest uptake at 11.6%. Despite the overall increase in PrEP uptake, there is still a need to further scale up its utilization, particularly among Key Populations (KPs), to ensure broader coverage and effective HIV prevention strategies.

Key and Vulnerable Populations

Key and vulnerable populations continue to be the primary drivers of the HIV epidemic in Kenya. Despite efforts to combat the spread of HIV, these populations, which include men who have sex with men, Female sex workers, transgender individuals, and people who inject drugs, face significant challenges in accessing prevention, treatment, and care services. Their marginalized status, stigma, discrimination, and limited access to healthcare contribute to their heightened vulnerability to HIV infection. Addressing the specific needs and rights of these populations is crucial to effectively reduce HIV transmission and achieve epidemic control in Kenya.

Triple Elimination of HIV, Syphilis and Hepatitis B.

Kenya is committed to the 'triple EMTCT initiative' to simultaneously micro-eliminate mother-to-child transmission of HIV, syphilis, and HBV. In this regard, in 2018, Kenya adopted dual rapid testing of HIV and syphilis at 1st ANC, later scaled up to repeat testing in the 3rd trimester. This increased syphilis screening among pregnant women and a decline in syphilis positivity (1.2% in 2020 to 0.9% in 2022). Screening for Hepatitis B increased by 80% from 179,332 in 2019 to 323,659 in 2022, while that for Hepatitis C increased by 40% from 63,353 in 2019 to 88,398 in 2022.

Achievements

- The HIV program has put on treatment more than 97% of all PLHIV in Kenya by doubling the people on ART to 1.35M
- Mother to child transmission of HIV has reduced in the last 5 years from 10.5% to 8.6% in 2023.
- Reduction in HIV infection and HIV related mortality by 78 and 68 respectively over the last decade

Malaria

Malaria remains a major public health issue in Kenya, responsible for approximately 16% of outpatient consultations. Over 70% of the population is continuously at risk, particularly vulnerable groups such as children and pregnant women.

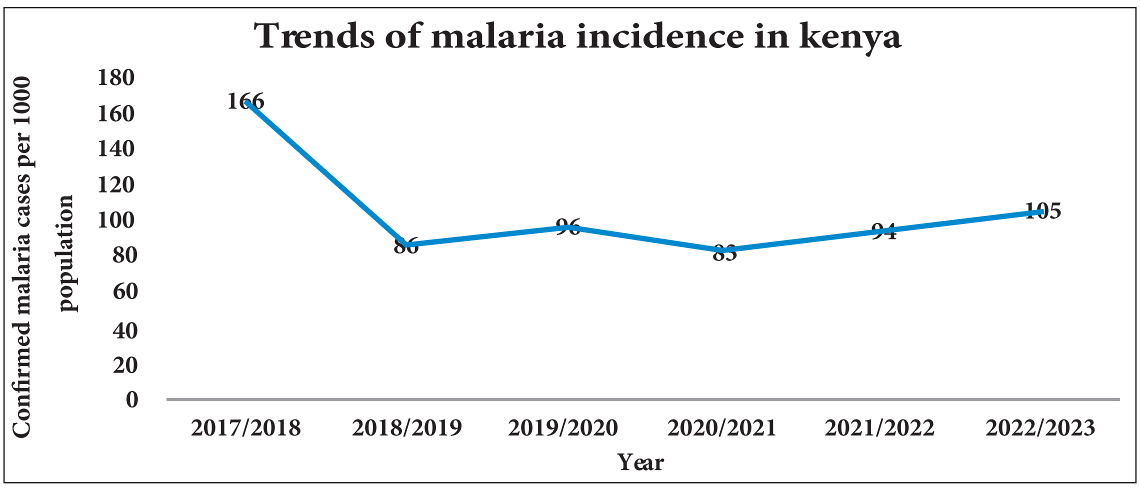
Progress and Performance

Malaria Prevalence, incidence, mortality and use of insecticide treated nets (ITNs). The national malaria prevalence decreased from 11% in 2010 to 8% in 2015, and further to 6% in 2020. There were variations in incidence across the country over the 2019-2023 KMS period, with a significant decrease in 2020/21 but increased again in 2022/23. Usage of long-lasting insecticide-treated nets (LLINs) among children under one year increased from 56% in 2017-2018 to 95.8% in 2022.

Malaria Incidence

There were variations in incidence across the country over the 2019-2023 KMS period, with a significant decrease in 2020/21 but increased again in 2022/23.

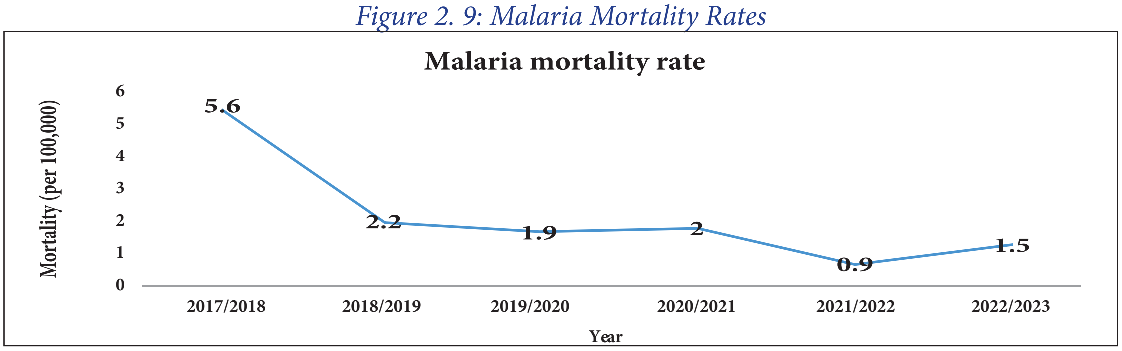
Figure 2. 8: Malaria trends in Kenya



Malaria Mortality

Inpatient malaria deaths decreased by more than 50% between 2018/19 and 2021/22 but rose to 1.5 per 100,000 persons in 2022/23 due to the COVID-19 pandemic and reduced efficacy of ITNs. Malaria incidence showed a significant decrease in 2020/21 but increased again in 2022/23.

Figure 2. 9: Malaria Mortality Rates



Achievements

1. Successful distribution of insecticide treated nets (ITNs) through mass campaigns and routine channels, reducing parasite prevalence significantly
2. Improved visibility of malaria commodities and data through the KHIS malaria dashboards, with strengthened reporting rates.
3. Updated malaria surveillance curriculum and trained 7,600 health workers across 47 counties.
4. Conducted the Kenya Malaria Indicator Survey and post-distribution LLIN survey in 2020 and 2022 respectively.
5. Expanded partnerships, including the establishment of the End Malaria Council and the Zero Malaria Campaign Coalition.

Challenges

1. Inadequate funds to operationalize Kenya Malaria Strategy
2. The Biological threats to interventions: Drug and insecticide resistance
3. Emergence of new malaria vectors
4. Regulatory concerns restricting malaria testing by non-laboratory personnel

Recommendations

1. Increase budgetary allocations and actual disbursements towards malaria by national and county governments and optimize the use of available resources.
2. Implement resistance management plans, promote research and development, and enhance surveillance systems
3. Invest in vector surveillance and control, integrated vector management, and community education
4. Review & amend regulations, and training and certification of CHPs

National Vaccines and Immunization Program

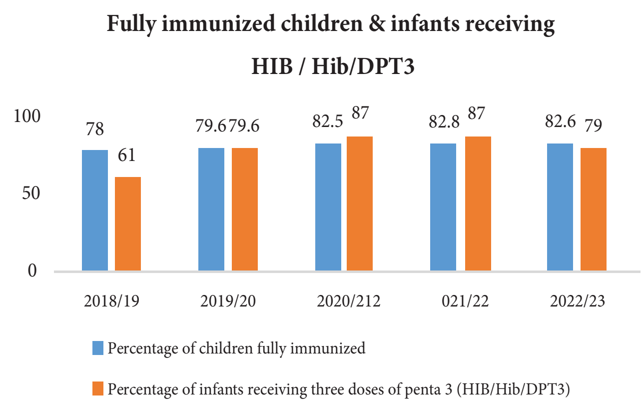
The National Vaccines and Immunization program is responsible for the forecasting of vaccines, procurement of vaccines, storage of vaccines at the national and regional store, and distribution of vaccines to the regional store. The vaccines that are currently on the immunization schedule are Measles, BCG, Tetanus Toxoid, Polio vaccines, Hepatitis B, PCV, Rotavirus vaccines, Pentavalent, Yellow Fever, HPV and Malaria Vaccine. Also included is Typhoid vaccine and biological sera such as anti-snake venom, anti-rabies antibodies and Covid Vaccine.

Immunization has managed to reduce the burden of vaccine preventable diseases by more than 70% over the last two decades. The Country is focusing on improving and sustaining immunization coverage and equity by increasing access to immunization services through procurement and installation of specialized vaccine storage equipment and assuring uninterrupted supply of vaccines at all service delivery points through timely procurement and distribution of all childhood vaccines, to avoid stock outs.

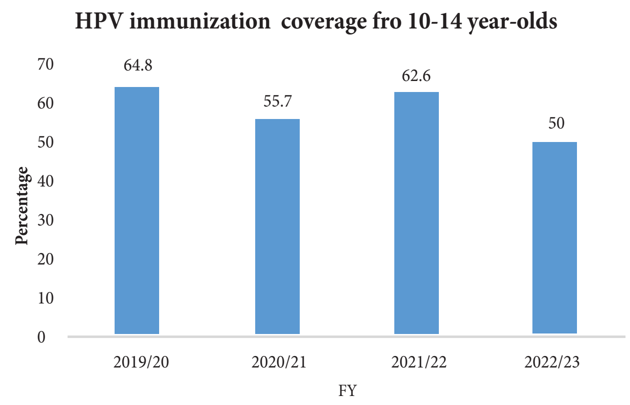
The WHO Africa Regional Strategic Plan for Immunization 2014 – 2020 sets a national target for immunization coverage for specific antigens at 90%. The graph below shows that the national targets of 90% have not been achieved for the selected indicators from the year 2018/19 to the year 2022/2023.

During the period under review, percentage of fully immunized children improved from 78% in 2018/19 FY to 82.6% in 2022/23 FY while the percentage of children receiving 3 doses of Penta 3/HiB/DPT3 improved from 61% in 2018/19 FY to 79% in 2022/23 FY. However, there was a decline in HPV immunization coverage for 10–14-year-old girls from 64.8% in 2018/19 FY to 50% in 2022/23 FY.

Figure 2. 10: shows the percentage of children fully immunized and % of infants receiving three doses of penta 3 (HIB/ Hib/DPT3)



Source; KHIS



Source, NVIP

Achievements

i. Introduction of vaccines into the country

- National HPV vaccine introduction to vaccinate all 10-year-old girls in the country
- MenAfrivac vaccination which prevents meningitis has been introduced in 5 high risk counties
- Malaria vaccine introduction in eight selected counties
- Scale-up of yellow fever in 2 more risk counties of West Pokot and Turkana

ii. Guidelines

- Finalization of National Immunization communication strategy
- Review of Monitoring and Evaluation Framework and SOPs

iii. Vaccinations

- Polio supplementary immunization activity was conducted in 11 Counties
- National switch of PCV 10 from 2 to 4 doses
- Replacement of tetanus toxoid (TT) with tetanus-diphtheria (TD)vaccine to offer dual protection

Challenges

- Underfunding and low prioritization of immunization services thus contribute to weak coordination of the program, delayed procurement (injection devices and documentation tools) weak or no supervision, suboptimal training of health workers and poorly implemented service delivery strategies, (e.g. outreaches and mobile clinics), especially in hard-to-reach populations.
- Immunization services have been adversely affected by the numerous industrial actions by health workers since the advent of devolution almost every year there are several health worker's industrial actions in several counties.
- Not all health facilities optimally offering immunization services- A few Health facilities (6.6%) are not offering services, while a significant number schedule immunization
- Competing priorities both at county and National making it impossible to complete scheduled activities.

Neglected tropical Diseases (NTDs)

Neglected Tropical Diseases (NTDs) present a significant public health challenge in Kenya, particularly affecting individuals living in poverty and marginalized communities. Kenya is endemic to 16 out of the 20 listed NTDs, with diseases such as schistosomiasis (bilharzia), soil-transmitted helminthiasis (intestinal worms), leishmaniasis (kala-azar), dengue, chikungunya, and snakebite envenoming having the most substantial impacts on communities. If left untreated, these diseases can lead to severe morbidity, disabilities, and even death.

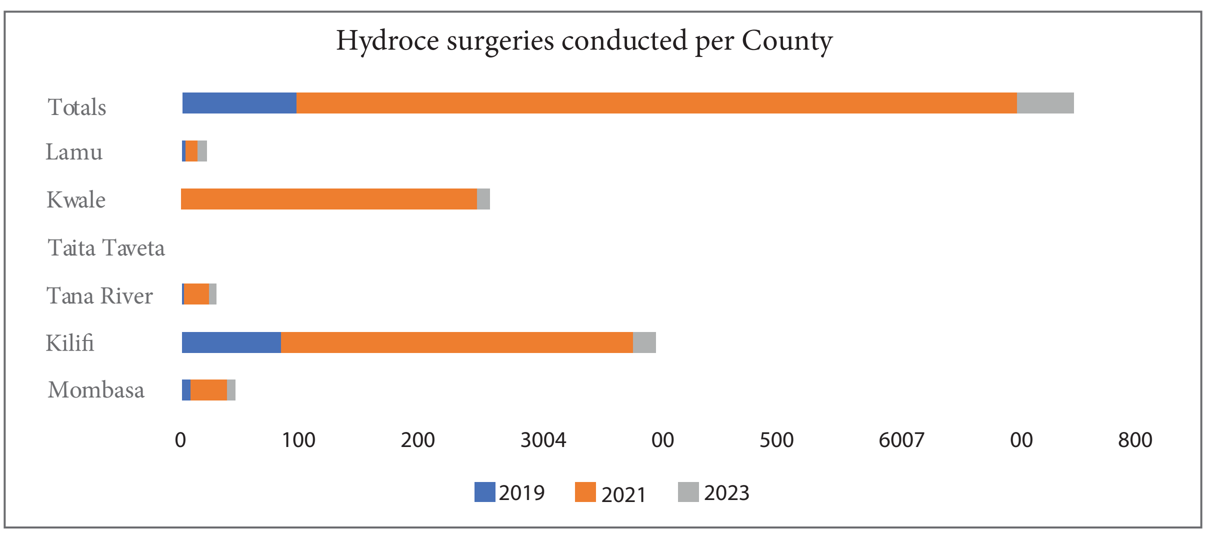
The impact of NTDs extends beyond physical suffering and has adverse effects on socio-economic development. These diseases contribute to decreased productivity, school absenteeism, and increased healthcare costs, thereby perpetuating the cycle of poverty within affected communities.

- Kenya has achieved significant success in controlling and eliminating several Neglected Tropical Diseases (NTDs).
- The country has been certified free of guinea worm and has finalized the elimination dossier for Human African Trypanosomiasis (sleeping sickness), while also preparing a dossier towards the elimination of onchocerciasis (river blindness).
- Additionally, the mass drug administration (MDA) of trachoma, a leading cause of blindness, and lymphatic filariasis (elephantiasis) have been scaled down, with a focus on morbidity management and disability prevention.
- These achievements position Kenya in line with global commitments that require NTD-endemic countries to eliminate at least one NTD by 2030, aligning with SDG3. Despite the progress made in NTD control efforts in Kenya, several challenges hinder the interventions.
- These challenges primarily revolve around limited resources, including financial resources, personnel, medical supplies, and logistical complexities. areas.

Lymphatic Filariasis (LF)

Over the years, the Program collected data to inform the situation on Morbidity Management and Disability Prevention (MMDP) status in the country. Hydrocelectomies were performed between 2019 and 2023 across the six coastal counties.

Figure 2. 11: Number of hydrocele surgeries conducted by county from 2019-2023.



Capacity Building: In collaboration with the Department of Surgery, University of Nairobi, training was conducted for healthcare workers on the management of hydroceles. A total of 108 healthcare workers, consisting of urologists, surgeons, medical officers, anesthetists, theatre nurses, physicians, and clinical officers, were trained.

Trachoma

- Kenya is a trachoma-endemic nation, and substantial efforts have been made to combat this disease and reduce its prevalence in arid and semi-arid areas where the disease is of public health importance. Trachoma has been confirmed as endemic in twelve (12) counties within Kenya.
- The period from 2019 to 2022 witnessed significant efforts in treating trachoma through preventive chemotherapy with a total of 5,172,944 individuals having received treatment for trachoma through preventive chemotherapy.
- Trachoma trichiasis surgeries
- The Trachoma trichiasis (TT) surgeries conducted between 2018 and 2023 were 17,564 as shown in the table below.

Table 2. 7: Number of TT surgeries performed 2018 – 2023.

Year	TT Surgeries Performed
2018	8,996
2019	3,585
2020	2,004
2021	755
2022	416
2023	1,808
TOTAL	17,564

Leishmaniasis

- Visceral leishmaniasis is endemic and reported in 11 of the 47 counties in Kenya namely, Turkana), West Pokot Baringo, Wajir t) Mandera Garissa Kitui, Isiolo, Marsabit Tharaka Nithi and Kajiado) Counties while cutaneous form occurs mainly in Nakuru and Nyandarua counties.
- The National Strategic Plan for Control of Leishmaniasis 2021-2025 was launched in 2021 and prioritizes disease ecology, case management, surveillance, and vector control.
- Respiratory tract infections
- There should be a write–up on this as it is the highest burden of disease (morbidity and mortality)

2.6 SO2: Halting and Reversing the Trends of Non-Communicable Diseases

NCDs are imposing a growing burden on public health and the economy in the country, accounting for 41% of national deaths in 2022 compared to 33% in 2017. They also result in reduced household income due to decreased productivity, premature mortality, and healthcare expenses. To address the surge in NCDs, policy documents such as the NCD Strategic Plan, Cancer Policy, and National Cancer Control Strategy have been formulated.

The Ministry of Health and stakeholders have also utilized data tools, digital health solutions, and collaborations across sectors to implement innovative interventions. Examples include the piloting of integration interventions like the HIV/Hypertension and Cancer screening module to enhance NCD service accessibility, and collaborative projects like the Primary Health Integrated Care Project for Chronic Conditions (PIC4C) in Busia and Trans Nzoia counties, which focus on scaling up screening, early detection, and treatment of hypertension, diabetes, cervical, and breast cancer at the community level.

These initiatives have demonstrated success in integrating NCD service delivery at the primary healthcare level, with the implementation of the SPICE electronic medical records system being a notable component. Inadequate data tools, interdependent NCD Indicators, limited health worker capacity on NCDs (number and skill set) and suboptimal funding remain major barriers to NCD programming. As per the previous Kenya Health Sector Strategic Plan, the baseline indicators were derived from several sources including the Stepwise Survey of 2015 and KHIS.

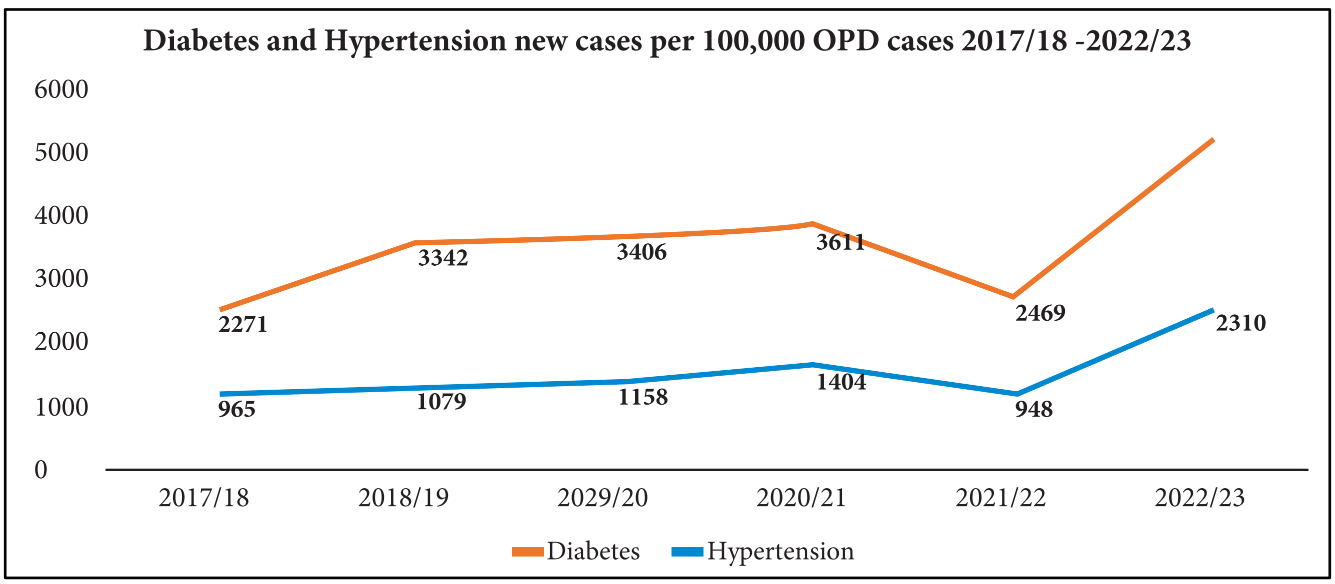
The high-burden NCDs include:

1. Diabetes and hypertension
2. Cancer
3. Mental illness
4. Renal disease
5. Diabetes and Hypertension

According to the 2015 Stepwise survey, the prevalence of diabetes was estimated at 1.9%, but the International Diabetes Federation projected a higher prevalence of 4.0% in 2021. The incidence rate of diabetes increased from a baseline of 921/100,000 in 2018/19 to 958/100,000 in 2022/23, This increase in incidence could be attributed to intensified community screening efforts. Enrolment in the Changing Diabetes in Children Program also saw significant growth, with the number of children enrolled surpassing 4,500 in 2022/23 from an initial 175 in 2011.

Healthcare worker training, particularly at the primary healthcare level, has been intensified. 2015 STEPwise survey reported a hypertension baseline adult prevalence of 23.8%, with only 8% diagnosed and receiving therapy, and 4% having satisfactory blood pressure control. The targeted incident rate for hypertension in 2018/19 was 2,583/100,000, but the achieved performance was slightly lower at 2,784/100,000 in 2022/23, missing the target by 9%.

Figure 2. 12: New hypertension and diabetes cases per 100,000 new OPD visits trends-2017/18 –2022/23



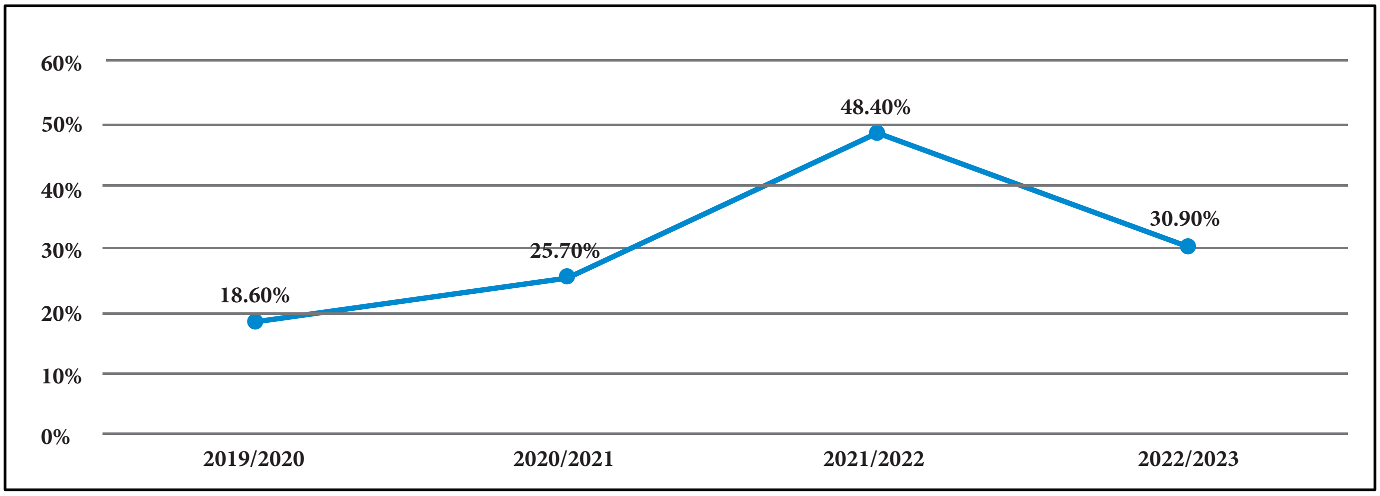
Cancer

Cancer is a significant contributor to NCD deaths in Kenya, with over 42,000 new cases and almost 27,000 cancer-related deaths recorded in 2020. While the cervical cancer elimination target of 90:70:90 has not yet been attained, the program has achieved 50% vaccination on HPV, 31% screening coverage and 29% treatment coverage. Approximately 46% of the facilities out of 7,850 provide screening services and report on the Kenya Health Information System. Additionally, the Global Breast Cancer Initiative has been adopted, and a Breast Cancer Screening and Early Diagnosis Action Plan is currently being implemented.

Cervical Cancer Screening and Treatment Program

The National Cancer Screening Guidelines are being implemented nationally and recommend screening for women between 25 to 49 years. A total of 343,576 women were screened in FY 2022/2023 as compared to 670,019 women who were screened for cervical cancer in FY 2021/2022.

Figure 2. 13: National cervical cancer annual screening target attainment from FY 2019/20 to FY 2022/23, Source KHIS (MOH 745)



Mental Health

The burden of Mental Health and neurological disorders is widespread. At least 25% of patients and 40% of in-patients in different health facilities have a mental illness and the estimated prevalence of psychosis is 1% of the general population. The common mental illnesses in Kenya are depression and suicide, substance use disorder, bipolar disorder, schizophrenia and other psychoses. Indicator: cases of mental health per 1,000 OPD visits

Achievements

- Capacity building of healthcare workers
- The ministry developed an online self-paced mental health gap action program (MH GAP) (training module for healthcare workers to equip them with knowledge on the management of various mental health conditions at the primary healthcare level.
- Finalization and Launch of National Guidelines on Workplace Mental Wellness
- The ministry developed the National Guidelines on Workplace Mental Wellness in FY2022/2023 which provide direction to organizations on how to promote mental wellness, prevent mental health conditions and support those affected employees.
- Monitoring and evaluation: Review of mental health reporting tools and indicators to be integrated into HIV program and KHIS
- The ministry developed, piloted and validated the Mental health morbidity summary tool to address the gap of the scarcity or lack of county data on mental health.

Challenges and Recommendations

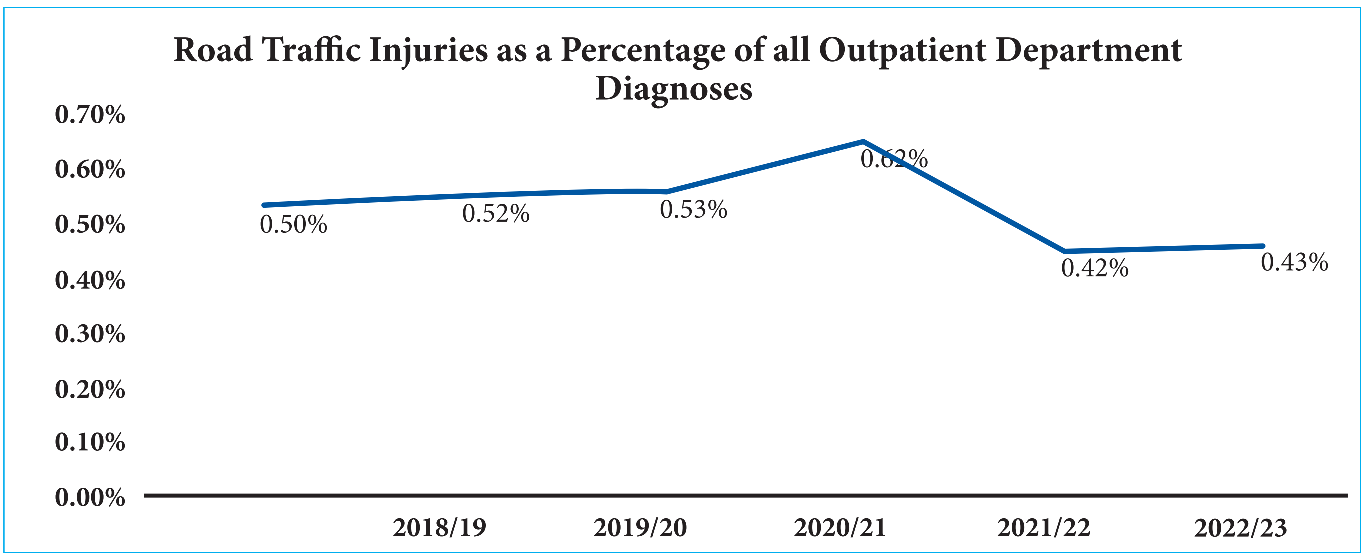
Challenge/Gap	Recommendation
Insufficient health care financing for mental health	Advocate for funding allocation by national government and continue mobilizing for partnerships through the national mental health forum
Poor Mental health Leadership and governance structures at county level	Support counties to establish Mental Health Councils and County MH Technical Working Groups
Inadequate human resource for mental health	Build capacity of the existing multidisciplinary clinical teams in management of common mental health conditions through training and mentorship and integrate mental health in Primary Health Care
Lack of national guidelines on management of mental health conditions leading to disparities in patient care	Finalize and support implementation of National Guidelines and Standards on Management mental health conditions. Develop and disseminate IEC materials and Algorithms on mental health care
Poor referral and linkage pathways for mental health services	Establish clear referral pathways for mental health at the various levels of the health care system
Poor Monitoring and Evaluation Framework for Mental Health	Develop a national Monitoring, Evaluation and Learning framework for Mental Health

2.7 SO3: Reducing the Burden of Violence and Injuries

Road Traffic Accidents

Road traffic injuries (RTI) accounted for 0.43% of cases presented to the Outpatient Department (OPD) in 2022/23, from 0.42% recorded in the previous year which could be attributed to increased motorcycle crashes (boda-boda).

Figure 2. 14: Trends of road traffic injuries as a proportion of all OPD diagnoses, 2017/18-2022/23.



Road traffic fatality rate increased from 6.6 per 100,000 in 2018/19 to 8.7 per 100,000 in 2022/23 with a peak in 2021/22 at 9.2 per 100,000.

Figure 2. 15: Road traffic injuries 2021/22- 2022/23

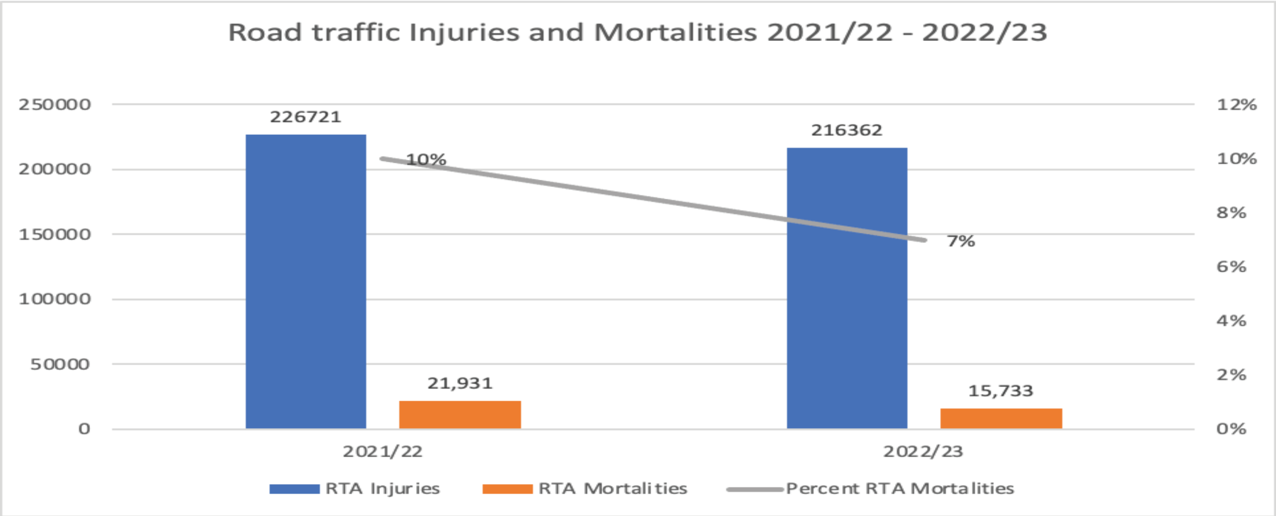
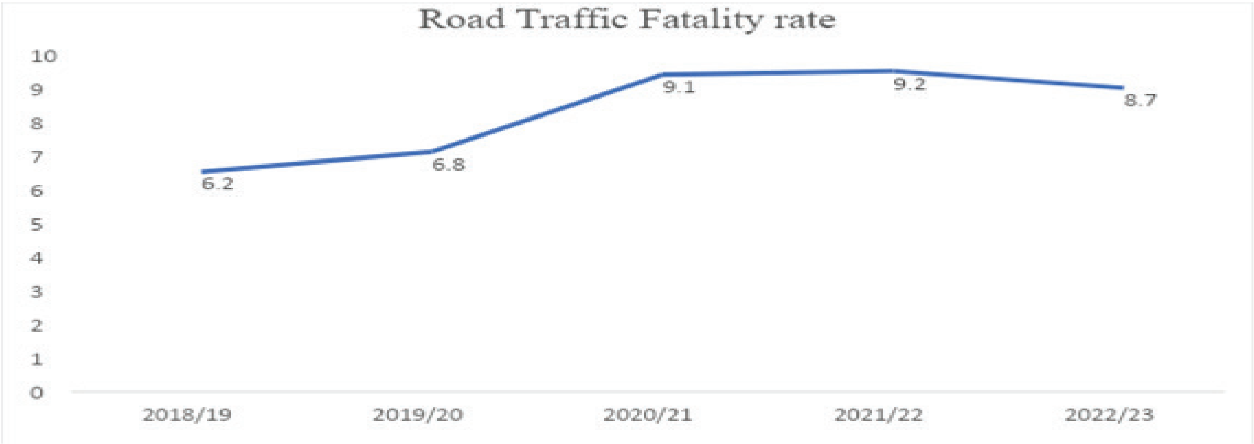


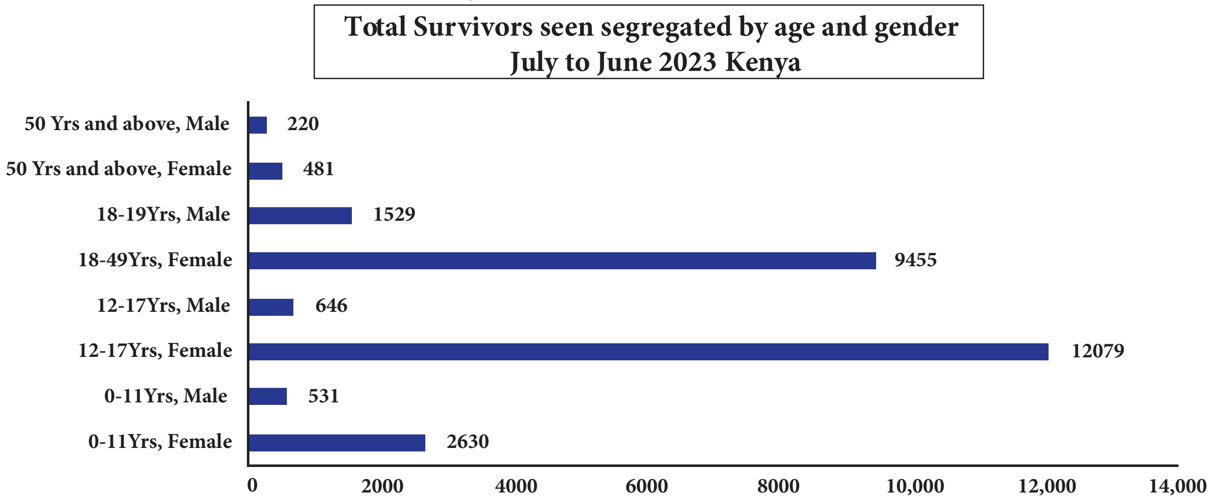
Figure 2. 16: Road Traffic Fatality Rate 2018-2023



Gender-based Violence

Gender-based violence is defined as any act of violence that results in physical, sexual, economic, or psychological harm or suffering to women, girls, men, and boys, as well as threats of such acts, coercion, or the arbitrary deprivation of liberty. A total of 27,571 survivors of sexual violence were reported to the health care facility for care, and only 68% (18625/27,571) were seen within 72 hours. Disaggregated by gender, 26,645 females and 2926 males were victims of SGBV. Most survivors were female between the ages of 16 to 17 years, a total of 12,079. Among the survivors, 24,849 were tested for HIV.

Figure 2. 17: GBV Survivors



2.8 SO4: Provide Person-Cantered Essential Health Services

Reproductive Health, Maternal, Neonatal and Child Health Services

The Ministry of Health is mandated to ensure the universal provision of quality and comprehensive Reproductive Health (RH) services to all persons in need of these services to attain the highest standard of reproductive health as provided in the Kenya Constitution. DRMH Program is a technical unit of the Ministry of Health that ensures best practices by giving technical support to the country on matters concerning reproductive Health.

Priority RH interventions included.

- Reduction of unmet family planning needs, reduction of maternal, perinatal, and neonatal morbidity and mortality, and reduction of teenage pregnancies
- The progress of RH interventions is monitored with a focus on critical areas including Fertility matters for both men and women, Antenatal care, Skilled birth attendance, Postnatal care, Newborn care, Family planning, and Adolescent reproductive health.
- Reproductive health
- The percentage of women of reproductive age (15–49 years) who have their need for family planning satisfied with modern methods was 57% in 2022.
- Percent of women of reproductive age with unmet needs for family planning reduced from 18% in 2014 to 13% in 2022.

The total fertility rate (TFR) from KDHS 2014 was 3.9 in 2018 and has declined to 3.4 in 2022 (KDHS 2022).

Maternal health

Maternal Mortality Ratio (MMR): MMR was 362 deaths per 100,000 live births (KDHS 2014) with a marginal reduction seen in the 2019 census at 355/100,000 live births. The facility maternal deaths per 100,000 live births dropped notably from 110/100,000 in 2021/2022 to 94/100,000 in 2022/2023. The set target was 200 deaths/100,000 live births.

In the 2019 census reported a maternal mortality ratio of 355/100,000 live births. Failure to achieve this target may be attributed to poor Quality of Care in the provision of maternal and newborn services. This is evidenced in the Confidential Enquiry into maternal death where over 99% of maternal deaths were attributed to suboptimal care.

Neonatal and child health

Neonatal Mortality rate (NMR):

According to a report from KDHS 2014, NMR was 22 per 1000 live births. The KHSSP 2018/23 midterm target was 17 and the end term was 15. The current neonatal death rate stands at 21/1000 live births, (KDHS 2022). Failure to achieve the target is attributed to poor quality of care and inadequate staff-patient ratio in maternity and labor ward units.

Stillbirth rates:

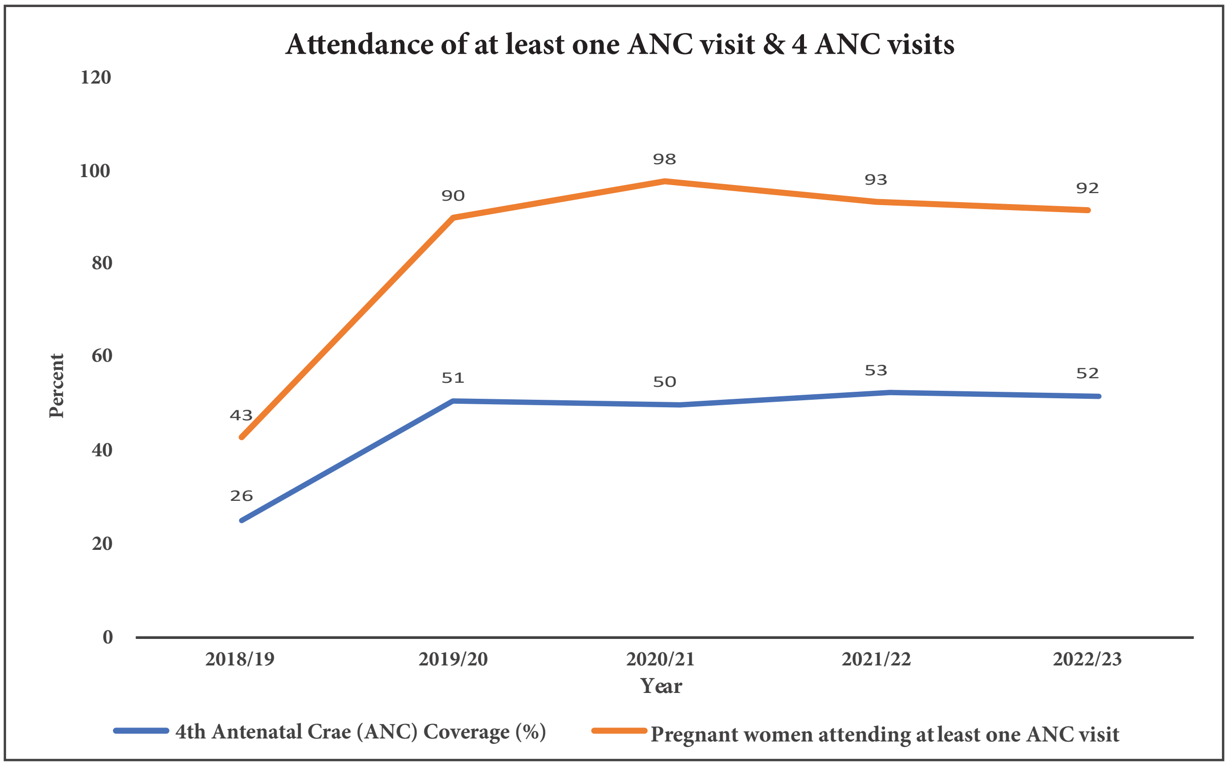
The baseline (KDHS 2014) was 23 per 1000 live births while in 2022/23 it was 15, meeting the set target for 2023. Routine health facility data indicates that 9.8/1000 live births (2018/19), 10 /1000 live births (2019/20), 9.2/1000 live births (2020/21) and 83/1000 live births (2021/22) and 7.5 (2022/23) were stillbirths. In 2018 it was 23 against the KHSSP 2018/22 set target of 17, while by 2022/23 it was 15 against the set target of 15. The target was achieved. The KDHS reported a stillbirth rate of 15 per 1000 pregnancies of 28 weeks duration or more weeks and an early neonatal deaths rate of 17 per 1000 live births, this is a perinatal mortality of 32 deaths per 1000 pregnancies of 28 or more weeks duration.

Essential Services

Percentage of Pregnant women who completed four or more ANC visits.

There was a slight drop in 4th antenatal care (ANC) coverage to 51.9% in 2022/23 from 52.5% in 2021/22 according to Kenya Health Information System (KHIS). There was great improvement reported in the KDHS 2022, reporting 4th ANC at 66% from 57% in the 2014 KDHS report. According to KHIS, the proportion of pregnant women who attended at least one ANC visit also dropped to 93.5% from 90.5% in the same period but the KDHS survey reported a great improvement of 98% for the two years before the survey.

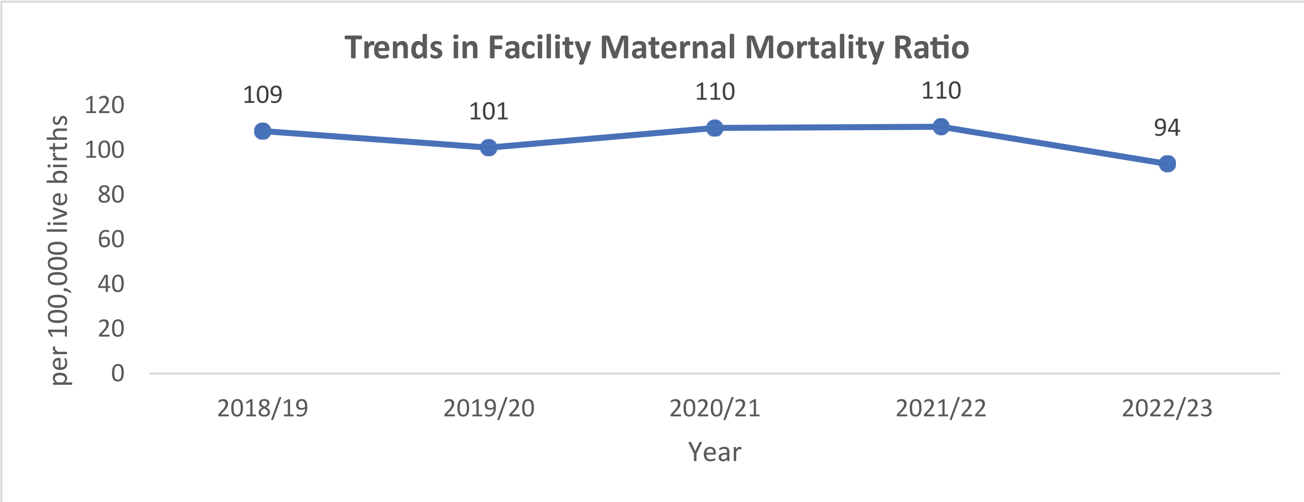
Figure 2. 18: (%) of pregnant women attending at least one ANC visit and those attending 4 ANC visits.



Maternal Mortality

Facility maternal deaths per 100,000 live births dropped notably from 110/100,000 in 2021/2022 to 94/100,000 in 2022/2023. This drop was also noted in the census report 2019, where a maternal mortality rate recorded was 355 deaths/100,000 live births from the 362 deaths/100,000 live births in KDHS, 2014. This may be attributed to improved quality of maternal health across the continuum of care due to various interventions such as increased access to free maternal health services through the Linda Mama initiative, training of health care providers in routine and emergency obstetric care, in-depth interrogation of gaps in quality of care through the MPDSR process, Quality of Care assessments and awareness creation at community level on the maternal health services

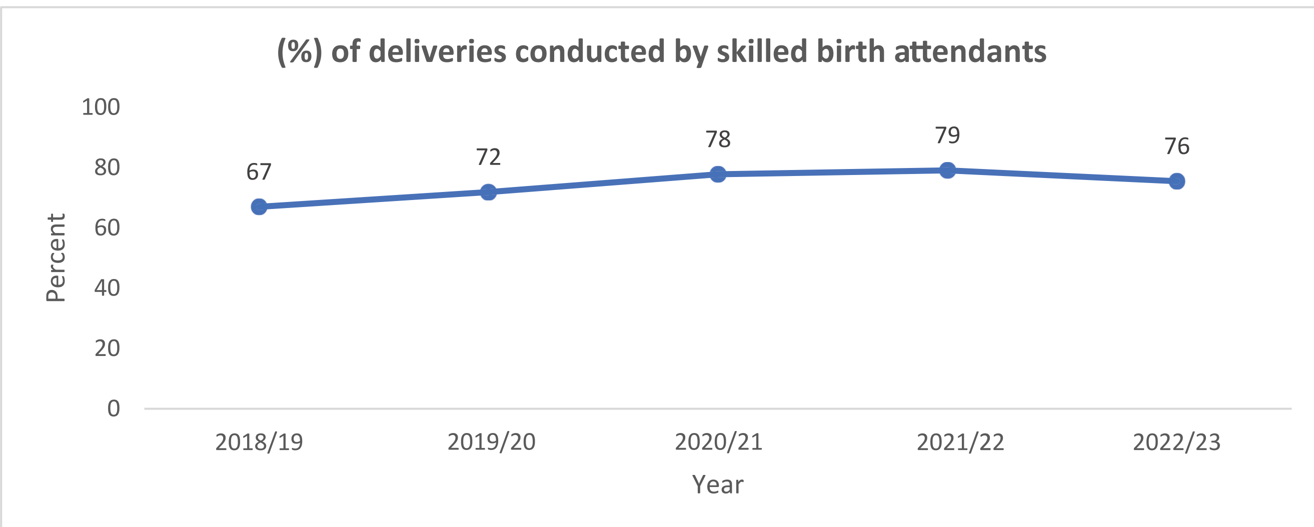
Figure 2. 19: Facility Maternal Mortality Ratio



Skilled Birth Attendance

Skilled birth attendance has been increasing steadily over the last 5 years from 57% in 2017/18 to 79% in the FY 2021/22. This has been attributed to the free maternity services under the Linda Mama insurance scheme initiative. However, there was a drop in FY 2022/23 to 76% from 79% in FY 2021/22. Despite the drop experienced in FY 2022/23, there was an increase to 89% in the period covered by the KDHS 2022 from 66% in the KDHS 2014.

Figure 2. 20: % of Deliveries conducted by skilled birth attendants.



Fresh stillbirth (FSB) rate per 1,000 births in institutions

KHSSP 2018/23 targets for Facility FSB was 7/1000 births. However, the following performance 9.8/1000 live births (2018/19), 10 /1000 live births (2019/20), 9.2/1000 live births (2020/21) and 8.3/1000 live births (2021/22) and 7.5 (2022/23)

Challenges

- Facilities offering these services do have not enough capacity to ensure quality maternity care.
- Family Planning
- Under the FP2030 framework, Kenya has set ambitious yet attainable goals for the Family

Planning program. These objectives include:

- Increased mCPR: A commitment to elevate the modern Contraceptive Prevalence Rate (mCPR) for married women from 58% to 64% by 2030.
- Reduced Unmet Need: A pledge to decrease unmet family planning needs for all women from 14% to 10% by 2030, emphasizing inclusivity in service provision.
- Last Mile Accessibility: Ensuring sustained availability of family planning commodities to the last mile, promoting equitable access to reproductive health services. Capacity Building: Enhancing the capacity of Human Resources for Health (HRH) to provide comprehensive family planning information and services, reinforcing the healthcare system's ability to meet growing demands.
- Adolescent Pregnancy Reduction: Targeting a reduction in pregnancies among adolescent girls (15-19 years) from 14% to 10% by 2025, with a focus on promoting sexual and age-appropriate reproductive health education.
- Gender Norm Transformation: Initiating efforts to transform social and gender norms to improve male engagement in family planning, fostering a more inclusive and supportive environment.
- Data Utilization: Improving the availability and utilization of quality family planning data for informed decision-making, ensuring that strategies remain evidence-based and responsive to evolving needs.
- Financial Sustainability: Committing to increased domestic financing for family planning commodities, to cover 100% of the requirements (currently at USD 30M) by 2026, ensuring the program's financial sustainability.
- Over the past few years, the Family Planning (FP) program in Kenya has witnessed significant progress in key indicators, reflecting a commendable commitment to improving reproductive health services. These include enhanced accessibility to modern contraceptive methods, increased contraceptive prevalence rates, and a reduction in unmet family planning needs.

Key Achievements

1. Percentage of women of reproductive age (WRA) (15–49 years) who have their need for family planning satisfied with modern methods.
2. According to KHSSP 2018/232, the set target was 65% of WRA with needs satisfied by modern methods. According to KDHS, by 2022, there are 57% of WRA had their family planning needs satisfied by modern methods. The target was not achieved, this could be attributed to periodic commodity supply gap stockouts of contraceptive options in health facilities.
3. Reduction in Unmet Needs: The percentage of women with unmet family planning needs decreased from 23.3% in 2014 to 14% in 2021 (KDHS), signifying a substantial improvement in addressing the reproductive health needs of the population.
4. Logistical Enhancements: the Ministry of Health (MOH), in collaboration with KEMSA and partners, introduced an integrated logistics management information system (iLMIS). This system includes a Commodity Early Warning and Alert System (CEWAS), Logistics Management Information System (LMIS), and electronic Proof of Delivery (ePOD). These improvements have enhanced visibility of commodities in the supply chain, ensuring the efficient flow of family planning resources.

Challenges

- Inadequate Funding: The program faces consistent challenges due to inadequate funding for national strategic commodities, hindering the optimal execution of planned initiatives.
- Low Uptake in ASAL Counties: Low uptake in Arid and Semi-Arid Lands (ASAL) counties poses a significant challenge, necessitating targeted interventions to address regional disparities in family planning utilization.

- Information Gaps: Challenges persist in providing adequate information to communities, emphasizing the need for enhanced communication strategies to promote awareness, and understanding of family planning services.
- Health Worker Shortages: The inadequate number of trained health workers for family planning service provision remains a critical challenge, highlighting the need for sustained efforts in workforce development.

Nutrition

Kenya is still grappling with the triple burden of malnutrition, (underweight, overweight and micronutrient deficiencies). Malnutrition has a significant impact on a country's economic development. In Kenya, the economic loss due to child undernutrition was estimated at Ksh 373.9 billion (US$4.2 billion) equivalent to 6.9 percent of the GDP in 2014 (COHA study, 2019).

All these three forms of malnutrition affect individuals, households, and populations, and can be manifested throughout the life course. The KHSSP 2018-2023 was a call to rally different actors and sectors to take up their role in addressing the challenges of malnutrition.

Obesity and Overweight Among Adults

KHSSP 2018-2023 set to reduce the prevalence of obesity among adults from 28% in 2018 to 20% in 2023, however, the prevalence of overweight and obesity among adults aged 20-49 has increased over time, where 45% of women and 19% of men are obese or overweight (KDHS 2022).

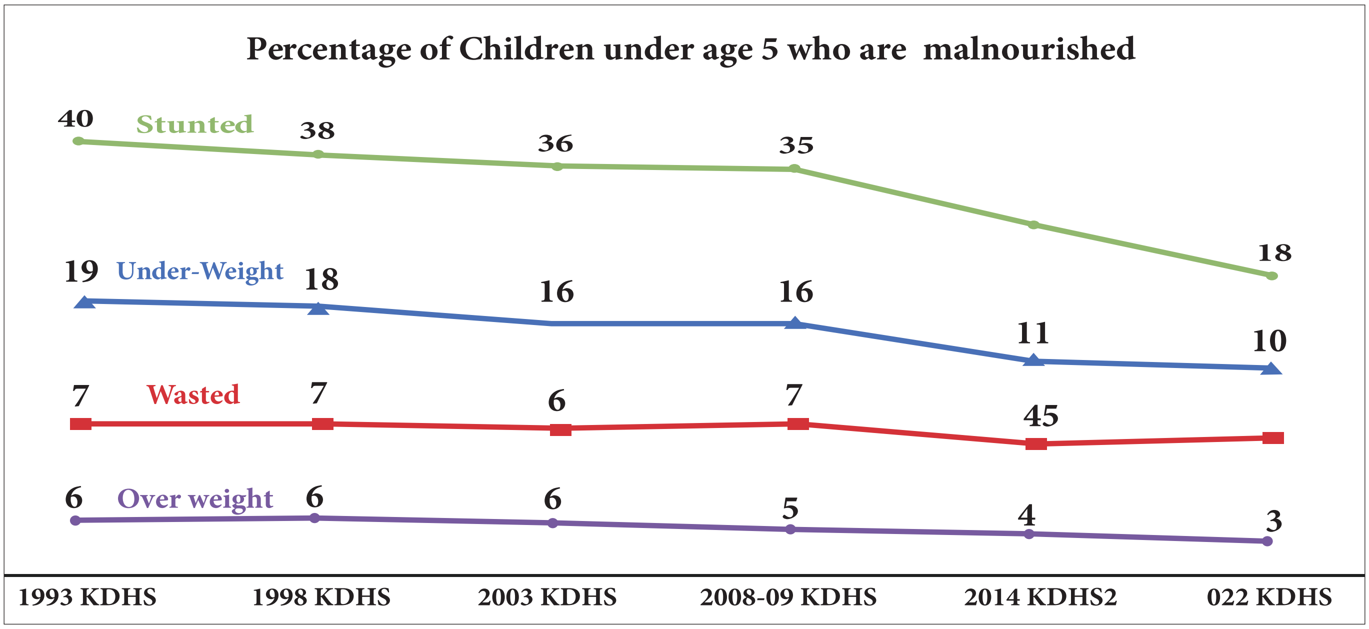
Stunting

Stunting is defined as a height that is more than two standard deviations below the WHO child growth standards median. It is one of the most significant impediments to human development, largely an irreversible outcome of inadequate nutrition and repeated bouts of infection during the first 1000 days of a child's life According to KDHS 2022, the prevalence of stunting for children under the age of 5 dropped from 26% in 2014 to 18% in 2022, against a target of 17%. The prevalence of stunting was reported to be high in the following counties: Kilifi (37%), West Pokot (34%), Samburu (31%), Meru (25%) and Kitui (25%). Counties with the lowest prevalence were Kisumu (9%), Garissa (9% each), Murang'a (10%), Nairobi City (11%), and Kirinyaga (11%).

Underweight

According to KDHS 2022, 10% of children are underweight (too thin for their age), against a target of 7%. The non-achievement could be attributed to persistent drought and increased burden of diseases. Around 22% of children whose mothers had no education were underweight compared to 5% of children whose mothers have more than secondary education. Also, 19% of children in the lowest wealth quintile are underweight compared with 4% of children in the highest wealth quintile.

Figure 2. 21: Summarizes the key nutrition indicators among children under five years.



Source: KDHS 2022

Vitamin A supplementation

The country data on Vitamin A supplementation shows that we are in progress towards achieving the global target of 80% among children 6 to 59 months. The Vitamin A supplementation routine data shows that the country is at 83.7% (KHIS 2022). This achievement was a result of investment by the government and partners, better facilitation in utilization of existing health structures and other initiatives like Malezi Bora.

Clinical Nutrition

Nutrition management during illness has been shown to contribute to improved clinical outcomes, reduced length of hospital stays and reduced medical cost. Worldwide the prevalence of disease related malnutrition ranges from 20% to 70% in hospital admissions. KHSSP 2018-2023 set a target to increase the proportion of hospitals in level 4 ,5 and 6 with parenteral feeds from 20% in 2018 to 80 % in 2023. Availability of parenteral feeds is an indicator of facility readiness to offer specialized nutrition services. However, the health facility assessment report for 2022 revealed that only Nairobi County reported availability of parenteral feeds in at least two hospitals assessed. Twenty-one (21) counties reported at least 1 hospital having parenteral feeds while 25 counties reported no parenteral feeds in all hospitals assessed. This indicates very low performance of below 3% which can be attributed to a high cost of the feeds, inadequate capacity to offer specialized nutrition and dietetics services, and inadequate data investment in this area.

Key achievements in nutrition sector

During the implementation of the KHSSP 2018-2022, Kenya realized the following achievements.

- Introduction of social safety nets programs in counties with high burden of malnutrition such as Nutrition Improvements through Cash and Health Education (NICHE).
- Multisectoral approach in addressing the burden of malnutrition. The Nutrition Interagency Coordinating Committee (NICC) played a key role in coordinating and harnessing the partners efforts throughout the 5 years.
- Capacity development on high impact nutrition interventions
- Development of strategic documents and guidelines in integrated management of acute malnutrition (IMAM), mother infant young child nutrition (MIYCN) and healthy diets among others
- Development and implementation of the Kenya Nutrition Action Plan (KNAP) and 23 counties developed the county nutrition action plan (CNAP)

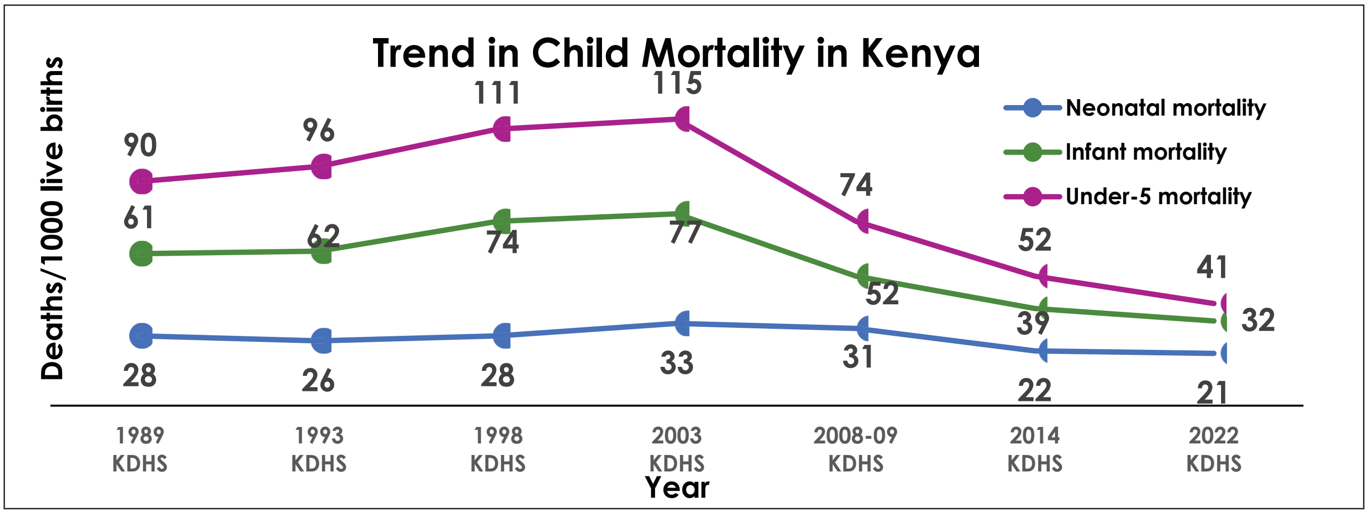
- Implementation of nutrition-sensitive activities
- Continued monitoring and surveillance for nutrition interventions.

New-born and Child Health

The Ministry of Health set out to reduce childhood morbidity and mortality to achieve the SDG 2030 goals. The 2030 goal is to reduce under-5 mortalities to less than 25 per 1000 live births and reduce neonatal mortality to less than 12 per 1000 live births.

The under-five mortality rate decreased from 52 to 41 deaths per 1,000 live births between 2014 and 2022. The infant mortality rate decreased from 39 to 32 deaths per 1,000 live births. However, the reduction in neonatal mortality rate was slow, with 21/1000 live births in 2022 compared to 22/1000 live births in 2014 (KDHS). Neonatal mortality accounted for 51% of under-5 deaths.

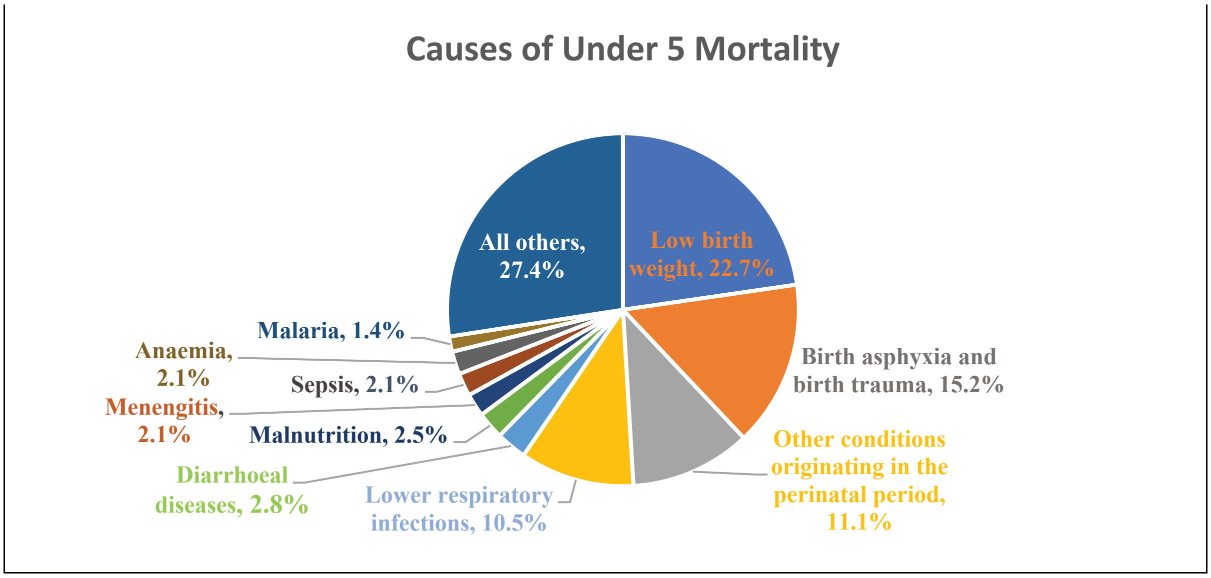
Figure 2. 22: Trends in Child Mortality in Kenya, Source KDHS 2022



Causes of Under-5 Mortality

According to the KHIS 2022 data, the leading causes of under 5 deaths were predominantly neonatal causes with low birth weight and prematurity leading (23%), followed by asphyxia (15%), and other perinatal conditions. The leading causes of death in the post-neonatal period were lower respiratory conditions, diarrhea and malnutrition.

Figure 2. 23: Top causes of under 5 mortalities in Kenya, Source HIS 2022



Achievements/Performance

- Areas of focus which have contributed to the reduction of under-5 mortalities have included the use of vaccinations which reduced frequency and severity of pneumonia. However, Pneumonia remained a leading cause of OPD visits accounting for 4.5% of the OPD visits for children under 5 in FY 2022/23.
- Dispersible Amoxicillin DT was introduced in 2018 and it's the use for management of pneumonia has increased from 43% in 2021/22 to 58% FY 2022/23
- The introduction of the rotavirus vaccine also led to reduction in diarrheal cases and resultant mortality. Diarrhea accounted for 9.1% of OPD visits among the under 5 in FY 2022/23. The KDHS 2022 showed that among Children with diarrhea, advice or treatment was sought for 58% which remained constant compared to 2014. There was an increased proportion of under 5 presenting in facilities managed with Combination Zn-ORS from 7% in 2014 to 32% in the 2022 KDHS. s.
- Use of corticosteroids to promote lung maturity in preterm and investment in newborn equipment for respiratory support, warmth, feeding and phototherapy.
- The Ministry of Health has developed several clinical guidelines to direct the delivery of quality new-born and child health services. These include.
- Comprehensive newborn care guidelines for 2022, along with the New-born ETAT Plus Training Curriculum.
- Basic Pediatric Protocols 2022 edition
- Guidelines for the use of Chlorhexidine for cord care to reduce sepsis. (2022)
- The Pediatric Quality of Care Standards including small and sick new-born (2023)
- Development of the Kenya Action Plan for Pneumonia and Diarrhea
- OH has supported equipping 13 hospitals in 10 out of the 14 counties with specialized newborn units to meet the global ENAP target of having 80% of counties with at least one specialized newborn unit. These new-born units can provide comprehensive new-born care functions like alternative feeding, ventilatory support through continuous positive airway pressure, and phototherapy for the management of jaundice.
- The above efforts have contributed to increased uptake of chlorhexidine for cord care from 46% in FY 2020/21 to 72% in FY 2022/23 and increased coverage of Kangaroo mother care (KMC) from 44% in FY 2020/21 to 63% among low-birth-weight babies.

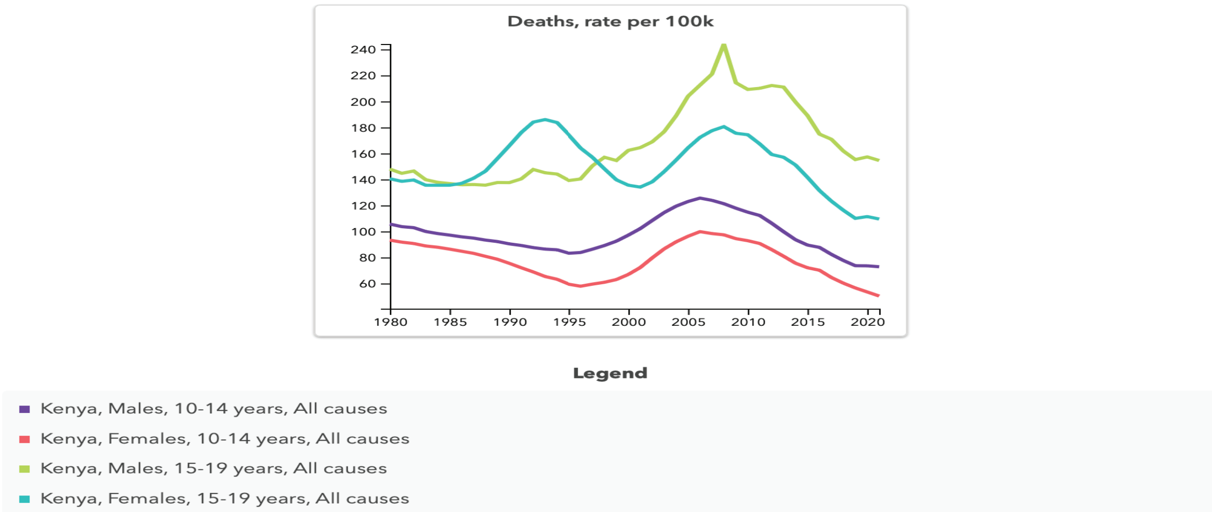
Challenges

- Low government funding for new-born and child health at the National and county levels with no vote head for New-born and child health at the National level
- Poor quality of care at facilities due to inadequate provider knowledge and skill
- Poor referral systems between health facilities
- Low availability of facilities offering comprehensive obstetric and new-born Emergency services including new-born resuscitation equipment and drugs (KHHFA 2018)
- Delays in providing emergency obstetric services cause asphyxia which contributes to about 15.2% of newborn mortality.
- Adolescent Health

Adolescent Mortality

According to the Global Burden of Disease Estimates 2021, adolescent mortality has declined since 2005. Mortality among older adolescents 15-19 years of age is, however, much higher (Male and female at 182/100,000 and 132/100,000 respectively) than that of younger adolescents 10-14 years of age (Male and female at 80/100,000 and 60/100,000 respectively).

Figure 2. 24: Adolescent Mortality 10-14, 15-19, Kenya (GBD 2021 estimates)



Diarrheal diseases and lower respiratory tract infections persist from childhood as leading causes of mortality in this population. TB, HIV, Malaria, and infectious causes of maternal conditions (in 15-19-year-old females) are also among the top 5 communicable disease causes of mortality in the adolescent population. Road injury and maternal conditions like post-partum hemorrhage and other non-infectious causes of maternal death are significant non-communicable conditions that need to be addressed to reduce mortality in this population.

Adolescent Morbidity (DALYs)

TB, HIV, Malaria, diarrheal diseases, and some maternal conditions like STIs in 15-19-year-old females are among the top 5 communicable disease-causing morbidities (Disability Adjusted Life Years) in the adolescent population. Road injury, childhood behavioral disorders, and maternal conditions like post-partum hemorrhage and other non-infectious causes of maternal death are significant non-communicable conditions that need to be addressed to reduce morbidity in this population.

Kenya Adolescent Health Survey (KAHS) 2020

The KAHS 2020 reported that three-quarters of adolescents had a normal BMI, with 1 in ten being malnourished (mostly from the ASAL counties) and one in 10 being obese (mostly from Urban centers). Only a third of adolescents 10-14 had adequate dietary diversity, while adolescents 15-19 years reported 46% having adequate dietary diversity as reported in the KDHS 2022. The KAHS 2020 also reported one-third of adolescents live a sedentary lifestyle. Only half of the adolescents 10–14-year-olds reported brushing at least once a day and three-quarters of 15–19-year-olds brushed at least once a day. The KAHS 2020 reported that about 95% and 99% of adolescents do not wear seatbelts in cars and helmets when on a bicycle or motorbike, respectively.

KAHS 2020 reported alcohol use and cigarette smoking in 10-14-year-olds as 2% and 0.7%, respectively, and in 15-19-year-olds as 9% and 3%, respectively. The KDHS 2022 reports alcohol use among 15-19-year-olds as 3% among females and 6% among males, and tobacco use among 15-19-year-olds as 1% for females and 12% for males. Slightly more than half of all adolescents (54.5%) are reported to have experienced 1/> adverse childhood experiences (ACEs). These adolescents reporting ACEs have a higher incidence of suicidal ideation and attempts, depression, and anxiety than those who did not. The adolescent fertility rate has reduced by more than half, from 153 pregnancies per 100,000 adolescent population in 1989 to 73 pregnancies per 100,000 adolescent population, as reported in the KDHS 2022.

School Health

The National School Health Program is a collaboration between the Ministry of Health and the Ministry of Education to promote learners' health, as articulated in the National School Health Policy 2018. The School Health Implementation Guidelines outline the 8 thematic areas of focus as: Values and life skills, Gender, Growth, and Development, Child Rights and Responsibilities, Water, Sanitation, and Hygiene, Nutrition, Disease prevention and control, Special needs, disabilities, and rehabilitation, School infrastructure and environmental health safeguards, Other Cross-cutting issues.

Kenya Adolescent Health Survey (KAHS) 2020 School Health Data

The KAHS 2020 reported that 94% of adolescents had ever attended school, which is consistent with the findings of the KDHS 2022, which reported that 92% of adolescents had ever attended school. The KAHS 2020 further reported that 60% of adolescents had missed 1-5 school days in the last 3 months, mostly due to health-related issues. Nine out of ten schools had improved water sources, seven out of ten schools provided sanitary towels, only 15% of schools had any healthcare personnel, 10% of schools had sanatoriums/ sick bays, and of these, only 3% had them within the school compound. Only a third of schools sampled had disability access, and 32% of schools sampled had functional school health clubs, with 90% of them managed by teachers.

The National School-Based Deworming Program (NSBD)

The National School-Based Deworming Program (NSBDP) is a long-standing government-led initiative currently implemented by the Ministry of Health and the Ministry of Education. It maintains the goal of eliminating soil-transmitted helminths (STH) and schistosomiasis (SCH) as a public health problem for school-age children in Kenya. It is aligned with the disease-specific targets within the WHO's Road Map for Neglected Tropical Diseases 2021 - 2030. Since 2012, the NSBDP has conducted annual mass deworming across 27 at-risk counties of Kilifi, Kirinyaga, Kitui, Kwale, Machakos, Mombasa, Taita Taveta, Bomet, Busia, Homa Bay, Kericho, Kisumu, Lamu, Nandi, Tana River, Bungoma, Kakamega, Migori, Nyamira, Siaya, Vihiga, Garissa, Kisii, Narok, Trans Nzoia, Makueni, and Wajir.

Achievements

- Conducting the 1st ever National Adolescent Health Survey.
- Development of the Adolescent Health Policy and Strategy in response to the evidence generated in the KAHS 2020 and KDHS 2022.
- Development and launch of the Community Handbook for Engaging Adolescents, Parents, and Community Leaders on Adolescent Health.
- Interoperability of NEMIS and KHIS in data management to ensure data flow from NEMIS to KHIS on school-based deworming.

Challenges

- Limited budget allocation to support Adolescent Health activities.
- Limited data collection and reporting tools on adolescent health in service delivery, e.g., at the OPD register.
- Inadequate deworming medicines.
- Challenges in the school calendar due to COVID-19 adjustments.
- A limited number of facilities provide adolescent-responsive services.
- Early Sexual debut among adolescents leading to teenage pregnancies and sexually transmitted diseases.
- Sub-optimal training of life skills in schools.

Oral Health Services

Oral health services range from basic services offered at the primary healthcare level to more specialized services offered at level 5 and 6 KEPH levels. These include dental extractions, fillings, full mouth scaling, root canal treatment and dentures among others. The availability of these services is low across the different KEPH with only 13% of health facilities providing these services. This is reflected more so in the primary healthcare facilities where basic services like dental extractions are only available in 6% and 16% of level 2 and 3 facilities respectively. Furthermore, there is a skewed distribution of these services, with most being available in urban areas. Only 2% of health facilities offer specialized oral healthcare. Source of the data

Burden of oral diseases and conditions

The oral diseases and conditions of public health concern are dental caries, periodontal disease, or-facial trauma, fluorosis, congenital malformations such as cleft lip and palate, oral cancer, and oral manifestations of HIV. These are largely preventable and account for a global prevalence of 45% which is higher than the prevalence of any other non-communicable disease (NCD). The relationship between oral diseases and conditions and NCDs goes beyond sharing modifiable common risk factors. A two-way relationship has been shown between oral diseases and some NCDs. In addition, oral diseases and conditions have a detrimental social and economic impact, leading to productivity loss and school children's learning disruption due to pain, discomfort, and dysfunction.

Table 2. 8: Disease magnitude

DISEASE	MAGNITUDE	
	CHILDREN	ADULTS
Dental caries (tooth decay)	23.9%	34.3%
Periodontal (gum) diseases	75.7%	98.1%
Dental Fluorosis	41.4%	27%
Oral Cancer	-	0.3%

Source: Kenya National Oral Health Survey 2015

There is a paucity of current data on oral health as the last national oral health survey was done in 2015, and there are no data collection tools and indicators integrated in KHIS. In addition, oral health services did not feature in KHSSP (2018-2023).

Human resource for oral health

Access to oral health professionals remains a challenge with the current dentist-to-population ratio standing at 0.27 per 10,000 population (Health Facility Census Report, 2023). Availability of oral health professionals is low in primary healthcare facilities accounting for 9% and 19% in level 2 and 3 facilities.

Table 2. 9: Health Professionals distribution in primary healthcare facilities 2019-2023

CADRE	2019	2022	2023
Dentists	1288	1344	1395
Community Oral Health Officers	1300	N/D	1193
Dental Technologists	1100	987	N/D

Source: Kenya Medical Practitioners and Dentists Council

Achievements

- The Kenya National Oral Health Policy (2022-2030) and the Kenya National Oral Health Strategic Plan (2022-2026) were developed and launched in 2022.
- To increase knowledge on oral health issues at the community level, a competence-based e-learning course for community health promoters on oral health (WHO, Harvard University and MOH) is being piloted in November 2023.

Challenges

- Additionally, limited resources, insufficient oral health workforce and inadequate integration into primary health care contribute to its neglect.
- Oral health curative services have for a long time been the focus at the expense of preventive and promotive services.
- Curative services are capital intensive and with dental technologies, equipment and commodities being primarily imported, the cost of these services remains high.
- Currently, there is inadequate oral health data and disease surveillance systems as well as low funding for oral health research.
- There are no data collection tools for oral health and no indicators integrated within KHIS. This data would inform the development of evidence-based policies, strategies, and targeted interventions to meet the needs of the population.

Ear and Hearing Care (EHC) Services

The World Health Organization (WHO) estimates that there are 466 million people with disabling hearing loss globally with 80% of this global burden in low to middle-income countries. By 2050 nearly 1 in every 4 people globally will have some degree of hearing loss and out of every 2 young people 1 will be having a degree of hearing loss. Out of these 1 in every 3 people globally will require ear and hearing care services with 1 out of every 14 requiring hearing rehabilitation services. The global number of years lived with disability attributed to hearing loss by 2019 was 43.5 million (95%UI 29.7 61.8) with age-related hearing loss being the third leading contributor to Years Lived with Disability (YLDs).

In Kenya, there is no timely and accurate data on Ear and Hearing care conditions because the indicators in hearing health are not integrated into the KHIS data collection tool. The KHIS 2021 reported a total of 899,654 ear diseases per annum in the country with 264,789 cases being children under 5 years with the rest aggregated as individuals above 5 years. This is not considered a true picture of the state of hearing loss or ear-related conditions as the country lacks proper accurate data on prevalence. Otitis media, the commonest cause of preventable hearing loss in childhood, is estimated to have a prevalence of 12 to 24 per 1000 among school-going children in rural Kenya. Infections causing acute febrile illnesses such as bacterial meningitis contribute to the bulk of hearing loss with their interventions mainly use of antibiotics being ototoxic and thus increasing the burden. The prevalence of hearing loss among children treated for bacterial meningitis is 44% based on a study done in Kenyatta National Hospital (. Which year)

Noise-induced hearing loss both in the formal and informal sectors and recreational noise exposure in the country is a rising prevalent issue due to inefficient implementation of rules and regulations on safety and effective noise reduction measures. Noise reduction measures should not only be implemented in occupational settings but also social and entertainment venues to effectively employ hearing conservation measures that cut across the life course. Ototoxic exposure to medications and chemicals together with a rise in the burden of Chronic diseases such as diabetes and cancer directly or indirectly affect an individual's hearing throughout their life course.

Achievements

- Development of a costed Kenya National Ear and Hearing Care Strategic Plan (2023-2028).
- Development of Kenya Ear and Hearing Care Guidelines 2023
- In collaboration with the EHC partners Health centre EHC Otology unit in Nairobi was built and equipped with basic ear and hearing care equipment and instruments in 2020.

Challenges

- Kenya has no Ear and hearing care data/Statistics MOH only collects ear diseases aggregated as under 5 and above 5 years in outpatient 705 A and B
- Not all EHC facilities are sufficiently equipped to provide services according to their KEPH level.
- Inadequate resources to fund activities Inadequate EHC data and disease surveillance systems for planning.
- Inadequate numbers and skewed distribution of human resources for EHC
- Hearing care technologies, equipment and commodities are primarily imported due to limited domestic manufacturing of these items, limited technical capacity and inadequate access to raw materials leading to the high cost of these supplies.
- Limited Health insurance coverage of Ear hearing care healthcare services

Eye Health Services

With the increasing burden of NCDs, diabetes is now an emerging cause of blindness. Eye conditions that can cause vision impairment and blindness are, with good reason, the focus of prevention and intervention. On the other hand, many eye conditions do not cause visual impairment, yet they are the leading reasons for presentation to eye care services and can lead to personal and financial hardships in addition to absence from school or work. Such conditions include conjunctivitis, lid abnormalities, pterygium, and dry eye syndrome.

Table 2. 10: Eye Disease Magnitude

SNO	DISEASE	MAGNITUDE
1.	Cataract	43% of all the Blinding conditions
2.	Glaucoma (Among those aged 50 years and above)	4.3%
3	Refractive Errors (among School children)	0.73%
4.	Prevalence of Diabetic retinopathy	35.9%
5.	Refractive Errors (including difficult in reading.>50yrs	51.7%
6.	Allergic Conjunctivitis (as % of All outpatients' visits)	27%

Source of data KHIS 2023

Cataract: In Kenya, the estimated cataract surgical rate (CSR) in 2019 was 800. This is low compared to the WHO-recommended CSR target of 3000 by 2020. With the increasing prevalence of cataracts and number of cataract surgeries, there is a need to promote high-quality surgery with a good visual outcome (visual acuity of 6/18 or better) from the current 65% to 70% by 2023 through routine cataract surgical outcome monitoring, and CSC of 80% by 2025.

Diabetic Retinopathy (DR): The country is experiencing a rise in diabetes owing to demographic, nutritional and social changes such as urbanization. The Kenya National Stepwise survey on non-communicable diseases 2015 found the prevalence of diabetes to be 2% for the age group between 18-69 years and over 50% of cases are undiagnosed.

Glaucoma: It is estimated to affect 2% of patients attending eye clinics and accounts for 6% of blindness in the country.

Childhood blindness: The main causes of childhood blindness include, congenital cataracts, retinopathy of prematurity corneal diseases (including those associated with nutritional deficiencies), congenital glaucoma, trauma, cortical blindness, tumours like Retinoblastoma and hereditary retinal diseases. With the persistently high poverty level and lack of access to pediatric eye care services, childhood blindness is expected to increase.

Retinopathy of prematurity (RoP): An eye disease that can happen in premature and low birth weight babies, is one of the leading causes of blindness in children. As neonatal services continue to improve, more premature and low birth weight babies are surviving, therefore the babies at risk of ROP are on the rise.

Refractive error and Low vision: In Kenya magnitude and pattern of refractive errors are hampered by a lack of data from locally done population-based studies. It is estimated that there are about 840,000 people with low vision from different causes. Almost 60 % of persons with visual impairment are due to refractive errors (short sight or long sight).

Allergic conjunctivitis: According to the Ministry of Kenya Health Information Systems data, Allergic conjunctivitis is the leading cause of presentation to eye care services and accounts for 27% of all outpatient visits in eye clinics across the country. Standard, evidence-based (Kenyan) and Simplified Ocular Clinical Grading and Guide 2016, of the Ministry of Health will be used to ensure quality of care for patients with Ocular allergies.

Achievements

- In collaboration with the county governments and eye care partners 7 new eye units were built and equipped with basic eye equipment and instruments.
- Ophthalmic tools are in place for reporting on KHIS.
- developed ophthalmic indicators and have been integrated into the KHIS.
- Ophthalmic commodities have been integrated into KEMSA system LMIS and KHIS.

Challenges

- Not all eye care facilities are sufficiently equipped to provide services according to their KEPH level.
- Huge challenges with equipment maintenance led to difficulties in maintaining equipment in good working order.
- Generally, the numbers of eye health workers are not adequate and are unevenly distributed.
- Insufficient financing for eye care services

2.9 Primary Health Care, community health and Primary Healthcare Networks

Primary healthcare has been acknowledged by the World Health Organization as the gateway to achieving UHC. Kenya has renewed its focus on a people-centered approach to healthcare delivery, which will be realized by strengthening community health systems.

The Government has shifted service delivery interventions to focus on primary health care, through the formation of primary care networks as stated in the primary health care strategic framework. Guidelines were developed that outline the steps in the establishment of PCNs. Over the period in review, 10 counties had established PCNs out of a possible 315. In 2023, the Primary Health Care Act came into force. It provides a framework for the delivery of community-based healthcare services.

The Community Health

Globally, the community health approach is recognized as an effective way of improving healthcare delivery and addressing the burden of disease, contributing to health and socioeconomic development. The community health approach is based on the Primary Health Care (PHC) concept that focuses on the principles of equity, community participation, intersectoral action appropriate technology and a decentralized role played by the health system.

The Kenya Health Policy 2014-2030 re-emphasizes the importance of the community (level 1) of care as the entry point to the health system and whose focus is demand creation activities for health services as defined in the community health strategy. The community health strategy inaugurated in 2007 focuses on improving community awareness and health-seeking behaviors and taking defined interventions and services closer to the households.

Policy, legal context: Since 2018, the Ministry of Health has prioritized strengthening community health systems through the development of Community health policy which was first of its kind launched in 2020. This was followed by the review and development of the 3rd edition of the community health strategy 2020-2025 which was to operationalize the strategy launched in 2020.

The Digitization Landscape Assessment Report and National Community Health Digitization strategy 2020-2025 were also developed. Other national documents developed to operationalize the community health strategy included the Community Health Committee training manual, the Guidelines on Community Scorecard for Social Accountability of Primary Health Care and the Kenya Quality Model for Community Health.

Maintain a motivated, trained, and supported Community health workforce: There are 107,831 CHPs in the 47 counties who provide preventive, promotive, and basic health care hence bringing health services closer to where Kenyans live. The National Government has committed funds for payment of stipends to 100,000 CHPs on a matching basis with the County Government. However, only 3250 of the 10,000 community health units have a community health assistant. The national government in FY 2019/2020 supported counties in training 400 community health assistants at Kenya Medical Training College.

Strengthen the delivery of comprehensive preventive, promotive, rehabilitative, and basic health care at the community level: The Community health service delivery is guided by a prescribed service package for delivery to households by the CHPs. The aim is to ensure that there is a reduction in the burden of disease in communities and prompt referral of sick patients to the health facility. There is a need to ensure that the community health services are delivered by well-trained CHPs and that they are provided the personal protective equipment (PPE), identification badges and jackets and the CHP kit that facilitates the delivery of services.

In FY 2023/24, the National government procured and distributed 100,000 CHP kits to the 47 counties. Scale up community health digital tools by rolling out electronic Community Health Information Systems e-CHIS: Quality community health data is essential for the planning, resource allocation and monitoring progress toward Universal Health Coverage. However, paper-based tools are still in use despite their myriad challenges. With the advancement in digital health and wide mobile network coverage as well as smartphone penetration, the Ministry of Health has developed an electronic community health information system (e-CHIS) to improve real-time data availability, and accuracy of community health data. A mobile health application has been developed and tested among CHPs and it is simple and user-friendly. In FY 2023/2024, the national government procured and distributed 100,000 smart phones for use by CHPs for routine data collection using the e-CHIS.

Implement the community scorecard as a feedback mechanism for Primary Health Care by citizens – People-centered delivery: In line with the Governments' Afya Nyumbani agenda, community participation and feedback to the formal health system must be provided in a structured manner. The Ministry of Health has developed guidelines on the "Community Scorecard for social accountability of primary health care". This is a citizen-led governance tool that assesses various quality aspects in the delivery of primary health care services. It also enables joint action planning and execution of interventions between facility staff and the community. All the 47 counties have been trained on Community Score card.

2.10 S05: Minimize Exposure to Health Risk Factors

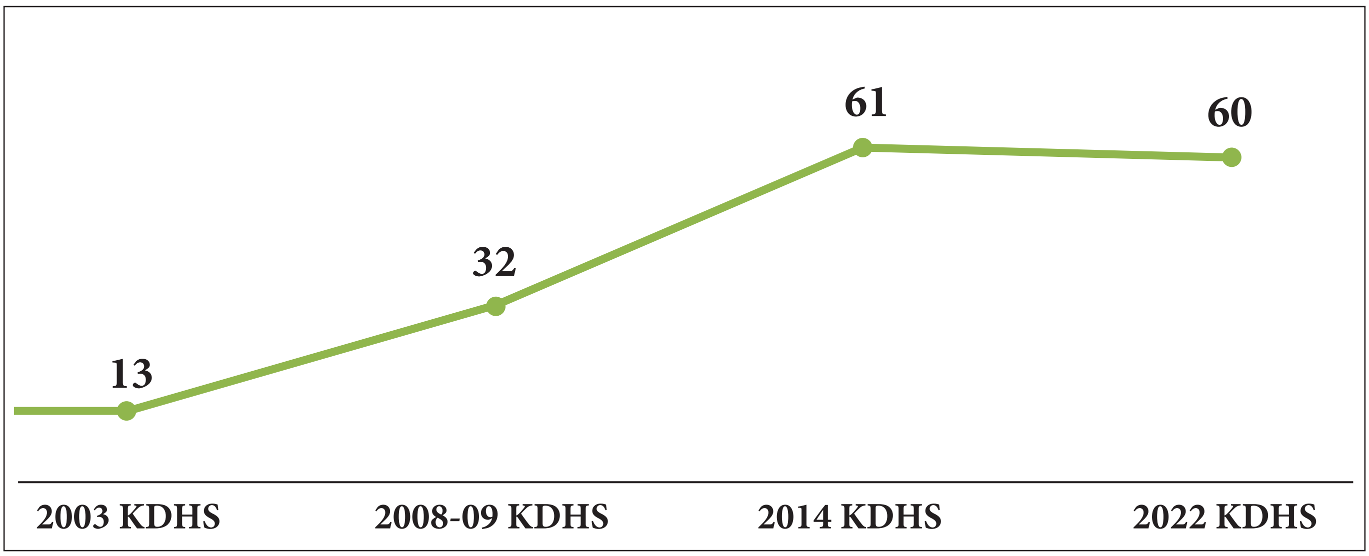
Risk factors to health in Kenya include unsafe sex, suboptimal breastfeeding, alcohol and tobacco use, obesity and physical inactivity, amongst others. People are increasingly embracing safe sex practices, attributed to steady improvements in knowledge and attitudes of communities regarding sexually transmitted infections and conditions.

On the prevalence of NCD risk factors, tobacco use remains high, particularly among productive populations in urban areas and among males. The same pattern is seen in the use of alcohol products, especially the impure alcohol products mainly found in the rural areas.......

2.10.1 Exclusive Breastfeeding

Exclusive breastfeeding rate in the country remained unchanged at 60% between 2014 and 2022. The percentage of children exclusively breastfed between 4-5 months, sharply declines to 38% with the majority receiving liquids or foods other than breastmilk. This was below the target of 70% set out in KHSSP 2018-2023. The non-achievement was attributed to limited implementation of Breast Milk Substitute Regulation 2021.

Figure 2. 25: Trends in Exclusive Breastfeeding (0 – 6 Months)



Source: KDHS 2022

2.10.2 Obesity and Overweight Among Adults

KHSSP 2018-2023 set to reduce the prevalence of obesity among adults from 28% in 2018 to 20% in 2023, however, the prevalence of overweight and obesity among adults aged 20-49 has increased over time, where 45% of women and 19% of men are obese or overweight (KDHS 2022). This brings the overall rate to around 32%. The variance could be due to increased access and intake of unhealthy food products such as sugar sweetened beverages, fast foods, lack of awareness of healthy diets, lack of physical activity among, inadequate implementation of healthy diets and physical activity guidelines, lack of regulations/policies that support healthy diets and physical activity among others.

There was also disparity among women aged 20-49 living in urban and rural areas where 53% of women aged 20–49 in urban areas is overweight or obese compared with 39% in rural areas. Among men, 25% of men aged 20–49 in urban areas is overweight or obese compared with 14% in rural areas. In the County context, Turkana County has the highest percentage of women aged 20–49 who are thin (44%), while Kirinyaga County has the highest percentage of women aged 20–49 who are overweight or obese (65%). Also, Turkana County has the highest percentage of men aged 20–49 who are thin (54%), while Kajiado County had the highest percentage of men aged 20–49 who are overweight or obese (31%).

2.10.3 Tobacco Use

In Kenya, the high prevalence of tobacco uses among adults aged 15 and above is a significant public health concern, with 11.6% reported as tobacco users. Men have a much higher rate of tobacco use at 19.1% compared to women at 4.5%. Among adults, 7.8% smoke tobacco while 4.5% use smokeless tobacco. Among youth aged 13 to 15, 9.9% use tobacco products, with boys having a higher prevalence at 12.8% compared to girls at 6.7%. Similarly, 4.9% of youth in this age group smoke cigarettes, with boys again showing a higher rate at 7.4% vs 2.6% for girls. Smokeless tobacco use is at 3.9% among youth, with a slightly higher prevalence among boys at 4.3% compared to 3.3% for girls.

2.10.4 Alcohol use

According to the "Status of Drugs and Substance Use (DSU) in Kenya, 2022" national survey by NACADA, the average age for the initiation of tobacco, alcohol, khat, cannabis, prescription drugs, cocaine, and heroin was 16 to 20 years. The minimum age of initiation for various substances was found to be 6 years for tobacco, 7 years for alcohol, 8 years for cannabis, 9 years for khat, 8 years for prescription drugs, 18 years for heroin, and 20 years for cocaine. The survey revealed that one in every 8 Kenyans aged 15 to 65 years (3,199,119 individuals) were current alcohol users, with 1 in every 5 males (2,511,763) and 1 in every 20 females (687,356) in this age group using alcohol. The Western region had the highest prevalence of current alcohol use at 23.8%, followed by the Coast (13.9%) and Central (12.8%). In terms of manufactured legal alcohol use, Nairobi region had the highest prevalence at 10.3%, followed by Central (10.0%) and Eastern (8.4%). When it comes to the consumption of Changa, the Western region had the highest prevalence at 11.4%, followed by Nyanza (6.3%) and Rift Valley (3.6%). Additionally, the Western region had the highest prevalence of current traditional liquor use at 12.9%, followed by Coast (7.4%) and Nyanza (2.2%). Central region had the highest prevalence of potable spirits (4.1%) followed by Coast (3.2%) and Rift Valley (3.1%).

2.11 SO6: Strengthen Collaboration with Health-Related Sectors

Environmental Health Services

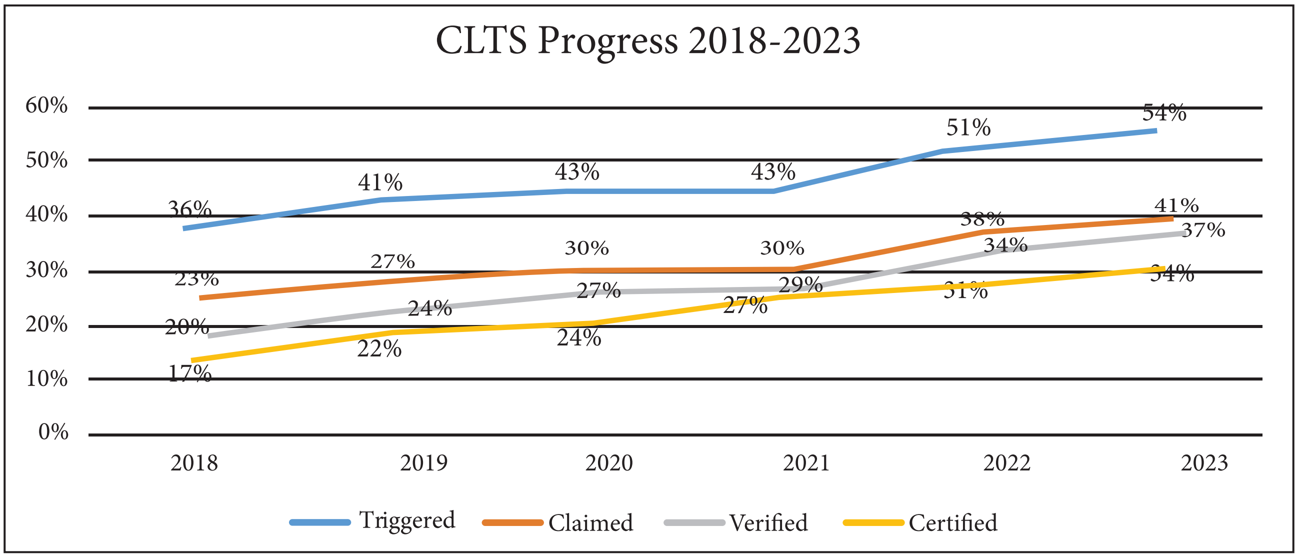
The aim of Environmental health practice is to assess, correct, control, and prevent factors in the environment that can potentially affect adversely the health of present and future generations. It comprises Water, hygiene & sanitation, vector control, healthcare waste management, climate change & pollution, occupational safety and health and food safety quality control.

Water, Sanitation, and Hygiene (WASH)

Access to sanitation and hygiene services is not only key to disease prevention and good health but it is also essential in achieving human rights and dignity. WASH in the health sector addresses Global commitments, like the sustainable development goal 6.2 which states; "By 2030, achieve access to adequate and equitable sanitation and hygiene for all and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations. During the period the Ministry prioritized to increase the proportion of villages certified as open defecation free from 17% in 2018/2019 to 31% in 2022/2023

Nationally by 2023, 27,851 villages were declared open defecation free amounting to (34%) coverage. This translates into 6,962,750 people living in ODF communities (based on the assumption that 1 village has 50 households, and each household has 5 people). This achievement has been brought about by implementation of Community Led Total Sanitation (CLTS). CLTS strategy involves triggering villages to initiate digging and construction of latrines, the village members then claim what they have constructed which is then verified by the local health officials, the last process is certification of villages as open defecation free by external certifiers. The figure below compares the progress of the CLTS process across five years 2018 – 2023.

Figure 2. 26: CLTS Progress 2018-2023



There has been an upward trend in the number of villages certified as Open defecation free across all the five years with a cumulative 17% increase from 2018 -2023.

Vector and vermin control.

The Public Health Act Cap 242 part XII stipulates the requirements on vector control with emphasis on mosquito control. The control of other vectors of public health importance is also critical in the reduction of the burden of vector borne diseases including ectoparasites. The Ministry distributed Vector control Commodities to 9 Counties with High burden of Vector infestation - Kisumu, Busia, Kakamega, Mombasa, Taita Taveta, Migori, Trans Nzoia, Homa Bay and Embu.

Health care Waste Management and climate change

The MOH strategic focus is to establish efficient, effective, and sustainable health care waste management and infection prevention and control systems that reduce patient management costs, and environmental impact caused by the generation and poor disposal of waste. Further by ensuring the use of the Best Available Technologies (BAT) and Best Environmental Practices (BEP) which contributes to reduction of impacts of climate change on health. During the period under review a total of 10 microwaves were installed in ten facilities namely Kisii level 5, Moi Teaching and referral Hospital, Kakamega County Referral Hospital, Jaramogi Oginga Odinga Teaching and Referral Hospital, Nakuru Provincial General Hospital, Kenyatta National Hospital, Machakos County Referral Hospital, Embu County Referral Hospital, Nyeri County Hospital and Port Reitz Hospital

The Ministry also established household air pollution center of excellence for air quality monitoring in collaboration with KEMRI and clean Air Africa. With support from KEMRI and Clean Air Africa the sector Developed short courses curriculum on HAP, HIA and health journalism (Target for health journalism is to enhance communication on HAP by journalists).

Food Safety and quality control

An estimated 600 million people, almost 1 in 10 people in the world, fall ill annually form consuming contaminated food, with diarrheal diseases being the most common form of these illnesses.420 million die annually with Africa bearing the brunt of 127000 deaths. -Kenyan stats? Food borne disease outcomes vary by pathogen and differ in severity from a few days of diarrhea to chronic conditions and even death. The diseases often are undiagnosed and underreported especially when it presents with mild diarrhea. Monitoring trends is key for appropriate food control interventions all through the food chain for sustainable management of food safety events.

In the last KHSSP the targets for foods meeting safety standards were 100% however the achievement was 85% in 2021/22. Foods including maize flour require to be satisfactory with no aflatoxin contamination and there are efforts of monitoring quality of informal milling including retail posho mills. In addressing malnutrition, the ministry enacted legislation providing for mandatory fortification of maize flour. There are enforcement guidelines in efforts to ensure compliance by small scale millers, medium scale and large-scale millers who are at 245,46% and 80% respectively.

Occupational Health and Safety

Occupational health and safety aim at minimizing work-related injuries and occupational diseases by ensuring a safe and healthy work environment, work practices and procedures for all staff in the health sector. To achieve this, all health facilities need to have well trained Occupational Health and Safety Committees in line with the requirements of Occupational Safety and Health Act 2007. Building on the experiences and lessons learnt during COVID-19 pandemic and its devastating effects on health workers, more focus needs to be placed on occupational safety and health of the health workers.

During the period under review, the Ministry had prioritized establishing Occupational Health and Safety Committees in 55 level 4 and 5 health facilities and achieved 45 translating to 81.8% coverage. This was achieved with support from partners however the project supporting this came to an end early 2023/24 financial year.

Disease Surveillance

The Division of Diseases Surveillance and Response oversees surveillance and response for public health events, including cross-border, laboratory, and sentinel surveillance. Kenya adopted integrated disease surveillance and response (IDSR) to improve surveillance and response for priority diseases and events at national and subnational levels. IDSR promotes efficient use of resources by integrating common activities.

The detection rate of non-polio acute flaccid paralysis (AFP) declined from 4.06 to 3.14 per 100,000. Despite the drop in 2022/23, the detection rate for the past three years remained above 2. (a rate below 2 means that the surveillance system is not efficiently working). The performance over the three years was a result of system-strengthening approaches like performance-based reimbursements, supportive supervisory activities, and guidance from Polio expert committee members. There was significant support from partners both at the National and County levels. Globally, there is a reduction in donor support for Polio activities and there is a need to transition to government funding to ensure a polio-free status.

Measles surveillance is conducted through case-based surveillance within the WHO AFRO Integrated Disease and surveillance approach. Under case-based surveillance, all suspected measles cases are investigated using an individual case investigation form and that a blood specimen is collected for serologic confirmation of measles infection at the time of initial contact with the case.

Various measles surveillance indicators are tracked by the country. The performance on the two main indicators is shown table. There has been improvement on the performance especially in 2022 and 2023.

Table 2. 11: The detection rate of non-polio acute flaccid paralysis (AFP)

Indicator	year					
	2018	2019	2020	2021	2022	2023
Non measles febrile rash illness rate: (target: at least 2 per 100,000 population)	1.6	2.0	0.7	1.8	2.52	2.32
Proportion of sub counties reporting at least 1 suspected case of measles with a blood specimen per year: (Target: at least 80%)	52%	69%	45%	71%	78%	72%

Achievements

- In 2022/23, the Division developed the 3rd IDSR guidelines edition and conducted sensitization in all 47 counties.
- Strengthened surveillance for Acute Flaccid Paralysis?
- The Division also finalized the Cholera Elimination Plan 2022-2026 and Cholera Treatment Guidelines 2023.

2.12 Semi-autonomous government agencies

SAGA	Achievements	Challenges
KEMRI	KEMRI provided to the public specialized laboratory services totaling Earned President award for its contribution to diagnostics and research in human health KEMRI further plays a regional lead in research as it hosts regional reference laboratories for Polio, Arbovirus and Malaria diagnostics Through studies it has supported the establishment of Kenya Biovax Institute mandated to produce vaccines for local use and export Established a Centre of excellence in stem cell research, synthetic biology and regenerative medicine developed and continues to manage Health and Demographic Surveillance Systems (HDSS) targeting population dynamics	Inadequate human resource Sub-optimal data management systems Over dependence on donor funding Inadequate knowledge translation Inadequate publicity of KEMRI services and research work Weak legal framework
Kenya Biovax Institute	KBI is actively engaged with AU and Africa CDC in discussions on Vaccine Market Shaping Two staff have been trained in Biomanufacturing at International Vaccine Institute, S. Korea and capacity building for staff is ongoing	Resource constraints Lack of high-end expertise in vaccine and biopharmaceuticals manufacturing
Kenyatta University Teaching, Referral &Research Hospital,	Hospital operationalized a total of 27 Specialized Outpatients Clinics Total number of patients attended by June 2023 are 28243 inpatients and 142,908 outpatients Surgeries done withing the past five years; minor 3037 and major 3693 Total of 12 heart surgeries Operationalized Critical Care services with 72 Beds ICU and 15 bed Neonatal Intensive Care Unit Comprehensive Breast Care Centre established	Inadequate resources i.e. human, financial, information and physical Patients related issues, e.g. lack of payment for services offered Changes in government policies require adapting strategies to the new policy e.g. access to emergency care.

SAGA	Achievements	Challenges
	The Integrated Molecular Imaging Center (IMIC) and IMIC Hospitality Centre at KUTRRH established Specialized cancer equipment's established Training on medical education	
Kenyatta National Hospital	Specialized surgeries - 32 major liver resection Capacity building to counties Infrastructure upgrade	
Mama Margaret Uhuru Hospital	Medical camps and outreaches Renal Dialysis Services Oxygen Plant	
Moi Teaching and Referral Hospital	Established Chandaria Cancer and Chronic Disease Centre Highly Specialized Surgical Services Done Medical Oxygen Investments Data Centre, ICT Network Upgrade, and High-Definition	limited funding for Capital Development
National Health Insurance Fund	23 % members growth for the last five years 42%-member retention for the past 5 years financial performance has been stable over the past five years Legislative Milestone Technological Advancements Digitization and Member Empowerment	Disruptions Caused by the Covid-19 Pandemic Slower registration rates and reduced premium payments Delays in Sponsor Remittances Impact of Inflation on Premium Payments Rising Healthcare Costs Combatting Medical Fraud and low utilization of digital platforms
The Kenya Health Professions Oversight Authority	Regulatory policies are now in place County Health Inspectors were trained and have continued to carry out health facility inspections within their respective counties for continuous quality improvement and pre-registration of new health facilities 1,200 health facilities closed due to non-compliance	Some health regulatory laws overlap/ conflict with the mandate of the Authority, necessitating a need for review of the existing regulatory framework. The Authority is currently accommodated at the Medical Practitioners and Dentist Plaza. The Country lacks a legislative framework to regulate some health professional cadres, thus posing a risk to patient safety and quality of care.

SAGA	Achievements	Challenges
Kenya Health Human Resource for Health Advisory Council	HR Instrument Development Health Workforce Data Improvement Governance Enhancement Data Analytics Training on Integrated Human Resource Information System Workload Planning implementing Workload Indictors Staffing Needs	Staff shortage Inadequate infrastructure Budget Constraints The Council is not yet categorized
Kenya Institute of Primate Research	29 candidate drugs and vaccines for major infectious diseases were preclinically evaluated for efficacy and safety Registration of animal care and use program by the American Association for Assessment and Accreditation of Laboratory Animal Care (AAALAC) Acquired certification for Good Financial and Grant Practices Snake Bite Research and Intervention Center to address snakebite envenomation Phage Research Program towards production of alternative antimicrobials to treat and mitigate AMR/MDR	COVID-19 resulted in disruption of research activities and funding from external donors Inadequate funding to initiate and implement research projects to address national health agenda. Internal resources from GoK for research diversion to mitigate COVID-19
Kenya Medical Practitioners and Dentists' Council	The ratio of licensed medical practitioners per 10,000 increased from a baseline of 1.5 in 2017 to 1.87 in 2022 The ratio of registered health facilities to 10,000 population rose from a baseline of 2.4 in 2017 to 3.01 in 2022 The total number of local registered medical and dental practitioners increased from 12,911 in 2018 to 16,213 by the end of 2022. There was a 32.7% increase in the total number of health facilities registered by KMPDC between 2018 and 2023	
Kenya Nuclear Regulatory Authority	Processed and approved license applications for two cyclotron medical facilities Processed and approved ten license applications for installations of linear accelerators Conducted Chemical Biological Radiological and Nuclear (CBRN) explosives training for forty officers from the National Police Service Operationalized the Central Radioactive Waste Management Facility	Public perception: The perception that nuclear technology involves nuclear weapons. Threat: the risk that nuclear material could fall into wrong hands, for instance, terrorists Nuclear Instrumentation: Lack of modern and adequate equipment Inadequate resourcing

SAGA	Achievements	Challenges
Public Health Practioners and Technicians' Council	Conducted 1st ever 1st Public Health Scientific Conference Inspected 80% of public Health programme training institutions Digitalized 75% of council business process Inspected and approved internship centers for training.	Untested systems, processes and procedures Limited human resources, working tools and office space Inadequate enforcement of the act Hosted by KMTC yet we are supposed to regulate their training
The National Quality Control Laboratory (NQCL)	NQCL has conducted quality control tests of pharmaceuticals and medical devices several equipment was procured within the period NQCL maintained its WHO prequalification status through two inspections by the WHO	NQCL operates in a competitive, complex and dynamic environment NQCL operates with limitations in key resources NQCL is not financially sustainable in the current model
Nursing Council of Kenya	The Council Conducted 15 National licensure exams with average pass rate of 75 The number of students who were indexed during the period rose by 30% The average annual retention rate stood at 48%, implying that most nurses and midwives were practicing without a valid license. The average compliance levels in nursing and midwifery training institutions were 88%, The Council successfully reviewed the Nurses and Midwives Act Cap the Council coordinated recruitment and exporting of 145 nurses in UK for employment.	Highly skilled nurses leaving the country to seek better employment opportunities in other countries. Emergence of pandemic/epidemic in the country, for example Covid 19 variants Inadequate staff capacities; Emergence of unqualified health practitioner
National Syndemic Diseases Control Council	Development, Implementation and Review of the Kenya AIDS Strategic Framework (KASF) and its supportive documents Coordination, development, and implementation of sectoral and population-based policies	Lack of an agreed coordination and accountability framework for partners and stakeholders in the HIV response Poor utilization of data to inform programming and policy at all levels of government.

SAGA	Achievements	Challenges
Kenya Medical Training College	Quality Training Staff Development Research, innovation and consultancy Linkages, collaboration, and partnerships Development of infrastructure and other facilities	The demand for courses is much higher than the training capacity Inadequate succession planning The demand for courses is much higher than the training capacity Slow adoption of new technologies Unforeseen external factors
Kenya National Blood Transfusion Services	Increase the number of blood and blood components made available Number of whole blood units collected Number of blood and blood components made available for transfusion	

CHAPTER THREE: STRATEGIC DIRECTION OF KHSSP 2023-2027

3.1 Goal of the Kenya Health Strategic Plan 2023-2027

This Kenya Health Sector Strategic Plan (KHSSP) 2023-2027 provides a comprehensive roadmap that outlines the goals, and strategies for the health sector in Kenya. It also provides a framework for guiding the development, implementation, and monitoring of health programs and policies in the country. The overall goal of this strategic plan will be "Acceleration of achievement of Universal Health Coverage through the Primary Health Care Approach".

3.2 Strategic Direction

Overall vision, mission, goal and objectives of KHSSP:

VISION

A healthy, productive and globally competitive nation

MISSION

To build a progressive, responsive and sustainable health-care system for the accelerated achievement of the highest standard of health for all people in Kenya

GOAL

To achieve equitable, affordable, accessible and high-quality health care for all

THEME

Accelerated achievement of universal health coverage

3.3 Strategic Objectives

The strategic plan will aim to achieve the following strategic objectives: -

1. Reinforce and improve access to people-centered essential primary health services.
2. Increase access and availability to quality & affordable essential health services for all.
3. Institutionalize emergency preparedness and response, early recovery and resilience.
4. Build and strengthen partnerships and collaboration.
5. Strengthen the health systems for effective and efficient delivery of health services.
6. Advocate and mobilize for adequate financing for health at all levels.

Strategic Objectives 1: Reinforce and improve access to people-centered essential primary health services.

This Strategic Plan prioritizes Primary Health Care (PHC) as the core foundation for Universal Health Coverage (UHC) to ensure access to affordable, quality and equitable primary health care services of the highest standard for all Kenyans. This will be achieved through the following interventions as outlined in the Primary Healthcare Strategic Framework.

- Secure and strengthen political leadership and commitment to achieve the Primary Health Care targets.
- Build a strong workforce for health services at all PHC levels.
- Increase access to functional Primary Health Care Networks available to provide Primary Health Care services.
- Enhance Financing for Primary Health Care.

- Improve systems for the Supply Chain, Medical Devices and Infrastructure.
- Improve the capacity to use data, research evidence and innovations for decision-making.

Strategic Objectives 2: Increase access to and availability of quality & affordable essential health services for all

The Government aims to strengthen healthcare by delivering Universal Health Coverage (UHC) through the implementation of a fully public-funded primary healthcare (preventive, promotive, outpatient and basic diagnostic services); a universal seamless health insurance system; establishing a national fund for chronic and catastrophic illness and injury costs not covered by insurance; scaling up manufacturing of essential medical supplies; strengthening human resource for health; expanding healthcare infrastructure; and enhancing supply chain management for health commodities.

Universal Health Coverage (UHC) is expected to: increase the proportion of persons covered under Social Health Insurance; promote access to affordable and quality essential health products and technologies; digitize health services and records; and expand health infrastructure and personnel.

Strategic Objectives 3: Strengthening capacity for emergency preparedness and response, early recovery and resilience

The health sector aims to enhance its capacity at all levels to prepare for, respond to, and recover from emergencies, ensuring the protection of Kenyans' health and well-being. This is part of the country's ongoing efforts to bolster its Public Health Emergency Surveillance & Response Capacity in delivering on IHR2005 to better detect and respond to Public Health Events (PHEs).

This will be achieved through strengthening structures for a multi-sectoral response and cross-border surveillance to disasters & public health threats in line with the International Health Regulations (IHR 2005) and the National Action Plan for Health Security (NAPHS).

The country has established and continues to strengthen the National Public Health Institute (NPHI) to play a leading and coordinating role of public health efforts in Kenya. The institute tackles public health challenges and strengthens disease surveillance, prevention, and response.

Strategic Objectives 4: To build and strengthen partnerships and collaboration.

With numerous and different types of partners supporting the health sector in Kenya at multiple levels and capacities, coordinating and harmonizing the investments and actions of all partners is critical to ensure the most effective utilization of all available resources to address sector priorities and achieve results.

Strategic Objectives 5: strengthen the health systems for effective and efficient delivery of health services.

Strengthening health systems is critical to the supply and delivery of quality, affordable healthcare services and to the achievement of universal health coverage. Health systems strengthening (HSS) includes the strategies, responses, and activities that are designed to sustainably improve the performance of a country's health system. Strong health systems can flexibly adjust resources and priorities to address emerging health needs while maintaining essential services. Efforts are focused on reorienting health systems towards re-engineering PHC for accelerated progress on UHC attainment.

Strategic Objectives 6: To advocate and mobilize for adequate financing for health at all levels.
Advocating for and mobilizing adequate financing for health involves raising awareness, building coalitions, and engaging stakeholders at multiple levels. Public awareness campaigns and educational initiatives can inform the general public and policymakers about the critical need for health financing. Advocacy efforts should focus on policy change, pushing for increased health budgets, equitable resource distribution, and integrating health financing into broader economic policies. Utilizing data and research to highlight the return on investment in health and leveraging media to amplify messages are also crucial steps.

3.4 Health Priorities

The Bottom-up Economic Transformation Agenda (BeTA and MTP IV)
The Bottom-Up Economic Transformation Agenda (BeTA) being implemented through MTP IV 2023-2027 has identified gaps in Kenya's healthcare system. The gaps include Service delivery, ripple burden of disease; increasing prevalence of non-communicable diseases, violence and injuries while still having high incidence of communicable diseases., Human Resources for Health, Leadership and Governance in Health, ineffective supply chain of HPTs for commodity security and Inefficient and fragmented healthcare financing system. To address these gaps under: -

Human Resource for Health: The aim is to transform Human Resource for Health (HRH) systems to efficiently support quality service delivery. This will entail Matching stipends for 100,000 existing Community Health Volunteers (CHVs) with what is paid by counties; extending of contracts for 8,550 UHC staff under existing terms for 3 years; and posting of 1,200 medical interns to the internship training centers; work with counties to fill the existing HRH gaps in lower-level facilities including recruiting of 20,000 human resource for health (11,621 for Primary Health facilities and 8,379 for Hospitals). Further, other areas of intervention include training of specialized and sub-specialized healthcare workers; capacity building of health workforce; strengthening health regulatory framework and governance to regulate unregulated health professional cadres; and development of a policy, guidelines and framework on export of health care workers for international recruitment.

Health Financing: The programme aims to increase the number of Households with health insurance under the new Social Health Insurance (SHI) Package. The SHI package will focus on the Afya bora Mashinani (Primary Health Care) model targeting 80% (8.2 million) of Households in the informal sector. SHI will ensure the indigents have an insurance cover paid for by National and county governments. A health benefit package will also be defined for the new SHI product. This will entail consolidation of the fragmented insurance pools and funds covering indigents in the informal sector and reforming the National Health Insurance Fund (NHIF) to make it more responsive to the health financing needs of Kenyans.

Health Commodity Security: The pillar aims to achieve sustainable access and affordability of quality essential health products and technologies (HPT) towards UHC, and to expand and diversify local production of essential HPT for domestic and export markets. This will be achieved through development of incentives to boost local manufacturing of HPTs, holding local manufacturing Expos to showcase country production capacity, reforms at KEMSA to streamline warehousing and distribution of HPTs with a 24-48 hr turnaround time. The National Health commodity supply plan proposes to Establish a National Health Procurement Board for bulk purchasing of health products and technologies with the aim of lowering cost of healthcare products through economies of scale.

Integrated Health Management Information System (IHMIS): The objective of the pillar is to fully digitize health services in Kenya to drive patient centric services, prevent fraud, improve responsiveness, efficiency, transparency and sharing of health data between health providers by setting up a fully integrated and interoperable health information ecosystem. The IHMIS will provide interconnectivity in the health sector through end-to-end visibility of the whole ecosystem as well as enable Kenyans to access health records and all other health services information with ease.

Community Health High Impact Interventions: The pillar aims at scaling up high-impact interventions in primary health care by promoting health and wellness, disease prevention and the underlying social determinants of health at the community level. It entails operationalization of all 315 primary healthcare networks (PCNs) through the establishment of the governance, coordination and financial structures for PCNs and mapping of the community health units (CHUs) to the PCNs; setting up of multi-disciplinary teams for each PCN; establishment and equipping of an additional 850 CHUs; procurement of CHPs kits; roll out of the community health information system; training of community health assistants (CHAs) and CHPs; conducting community engagements for CHPs; and enhancing behavior change, and communication.

Health infrastructure: The aim is to increase access to health services and ensure quality of healthcare is maintained. This will be achieved through making sustained investment in health infrastructure across the country to equip and improve the infrastructure of existing facilities and setting up regional specialized health facilities among other interventions.

Integration of Palliative Care in Kenya Health Care System: In Kenya, the increasing burden of non-communicable diseases including late diagnosis, treatment of cancers, the prevalence and rising persistent communicable diseases make palliative care an essential part of health care services. The Kenya Palliative Care Policy, launched in October 2021, provides a legal framework within which holistic and well-coordinated palliative care services are made available and accessible to everyone. About 800,000 Kenyans need palliative care every year. Unfortunately, only about 14,552 Kenyans are accessing these services. Access to palliative care is even more limited among children with less than 5% of pediatric patients having access. The previous KHSSP prioritized access to health promotion, disease prevention, diagnosis, treatment, disease management, rehabilitation and palliative care services.

In 2023, the approved organization structure of the Ministry of Health established the Aging-Palliative Care & Older Persons Division within the Directorate of Curative Services. Much of the palliative care services in Kenya have been provided by Non-Governmental Organizations (NGOs) with an emphasis on integrating palliative care as a priority need in National and County hospitals since 2012. Through the partnership with the Kenya Hospices and Palliative Care Association (KEHPCA) as an NGO mandated to coordinate palliative care services in the country, to date, 110 facilities are providing palliative care in 42 out of the 47 counties in Kenya. There have been initiatives to advocate for the inclusion of palliative care in undergraduate training curricula in nursing and medical schools.

Priorities.

- Mainstreaming palliative care in all levels of health and across facilities including hospices, government, private sector, community and home-based facilities.
- Palliative care services should be accessible to all in need (adults and children) including vulnerable populations, persons in humanitarian settings, prisoners, adolescents, and emergency and disaster situations among others

Indicators to track.

1. Established and coordinated palliative care services at the county level
2. Increased access for oral morphine solution for palliative care
3. Availability of specialist palliative care professionals

3.5 Policy Principles

The principles aim to guide investments, set targets, and assess the performance of the sector towards attaining its overall aspirations. These principles are based on an interpretation of primary health care principles. They include:

1. Equity in the distribution of health services and interventions: There will be no exclusion or social disparities in the provision of healthcare services. Services shall be provided equitably to all individuals in a community, irrespective of their gender, age, colour, geographical location, tribe/ethnicity, and socioeconomic status. The focus shall be on inclusiveness, non-discrimination, social accountability, and gender equality.
2. People-centered approach to health and health interventions: Health care services and health interventions will be based on people's legitimate needs and expectations. This necessitates community involvement and participation in deciding, implementing, and monitoring interventions.
3. Participatory approach to delivery of interventions: The different actors in health will be involved in the design and delivery of interventions to attain the best possible outcomes. A participatory approach should be applied when potential for improved outcomes exists. The private sector shall be seen as complementary to the public sector in terms of increasing geographical access to health services and the scope and scale of services provided.
4. Multisectoral approach to realizing health goals: A multisectoral approach is based on the recognition of the importance of the social determinants of health in attaining the overall health goals. A 'Health in all Policies' approach will be applied in attaining the objectives of this policy. The relevant sectors include, among others, agriculture—including food security; education—secondary-level female education; roads—focusing on improving access among hard-to-reach populations; housing—decent housing conditions, especially in high-density urban areas; and environmental factors— focusing on a clean, healthy, unpolluted and safe environment.
5. Efficiency in the application of health technologies: This aims to maximize the use of existing resources. The health sector will choose and apply technologies that are appropriate (accessible, affordable, feasible, and culturally acceptable to the community) in addressing health challenges.
6. Social accountability: Health care service delivery systems will be reoriented towards the application of principles and practices of social accountability, including reporting on performance, creation of public awareness, fostering transparency, and public participation in decision making on health-related matters.

3.6 KHSSP Priority Key Outputs

The key health outputs in the KHSSP relate to efforts to improve access to services, quality of services, and demand for services. These represent the expected implications of any investments in health, which when attained should provide the necessary service delivery outcomes the sector desires. Improvements in access to care will target physical, financial, socio-cultural issues, demand for services and quality as outlined:

1. Improvements in physical access will focus on improving availability of KEPH services in hard-to-reach areas, upgrading dispensaries to functional primary care facilities, improving functionality of health centers and addressing facility readiness challenges (for example, ensuring availability of electricity, water).
2. Improvements in financial access will focus on ensuring the following services are available free at the point of use: Maternity services, primary care services, emergency services, and specific services for HIV, TB, Malaria, plus neglected tropical conditions.

3. Improvements in socio-cultural barriers will focus on ensuring KEPH services are available for populations with known barriers to accessing routine services. These populations are cultural barriers – women, persons with disability, elderly, children, youth, marginalized groups (cultural barriers); health workers and commercial sex workers (social barriers); and prisons, IDP camps, schools, refugee camps, army barracks (congregate settings).
4. Improvement in demand for services will focus on improving the awareness of individuals, households and communities of the health problems they are facing and available services to solve these problems, and Improving health seeking behaviors, so that individuals, households and communities undertake action to protect their own health and make the best use of available health promotive, preventive and curative health services.
5. Finally, improvements in quality of care will be viewed from improving client experiences with care, assuring patient safety during access and use of services, and ensuring effectiveness of care provided.
6. Improving client experiences will focus on ensuring regular monitoring of client perceptions with different services to continually align care to client expectations.
7. Assuring patient safety will focus on scaling up infection prevention interventions, and institutionalizing mortality audits.
8. Ensuring effectiveness of care will focus on ensuring regular monitoring of care outcomes, with an aim to assure continued improvements are attained by the sector.
9. The Kenya Quality Model for Health (KQMH) would serve as the vehicle for improving care quality in the sector.

CHAPTER FOUR: HEALTH SYSTEM INVESTMENT AREAS, STRATEGIES, OUTPUTS AND KEY ACTION AREAS

4.1 Introduction

This section provides a brief description of each investment area reinforcing the need for the identification strategic output /objective, and action plan. The indicator and target for each investment area is annexed in the monitoring and evaluation plan document for the plan period.

4.2 Health Service Delivery: Focus Areas and Major Actions

4.2.1 Organization of service delivery

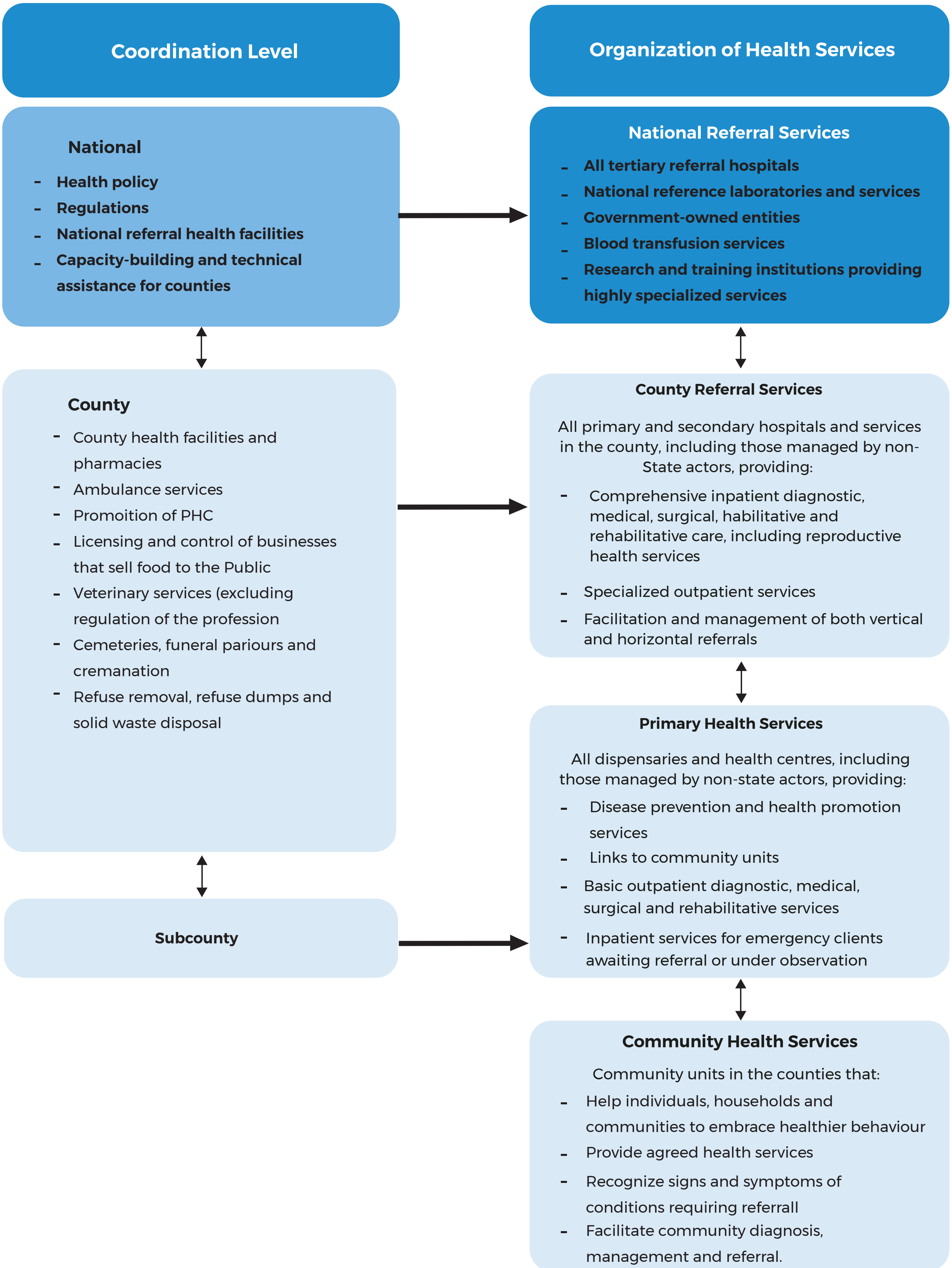
Health service delivery is an immediate product of the inputs into the health system, such as the health workforce, commodities, supplies and technologies, infrastructure and equipment, and finances. It is the coming together of health inputs to provide responsive, timely health services to patients or clients. Quality service delivery comprises timeliness, accessibility, safety, patient- or client-centeredness, effectiveness, efficiency and equitable coverage. Ensuring availability of health services that meet a minimum quality standard and securing access to them are key functions of a health system.

The Kenyan health system is organized in six levels and, as such, it is important to have a proper referral system to ensure efficient passage along and good-quality services at each stage of the continuum of care. These services need to include health promotion, prevention of diseases, injuries and conditions, diagnostics and treatment, disease management, rehabilitation and palliative care. Health service delivery also provides the necessary national framework for the prevention, detection and assessment of events that might constitute public health emergencies, including those of international concern, and the provision of a coordinated response.

Currently, the public health system consists of the following six levels with the national and county governments having different roles as shown in Figure 4. 1.

- Level 1: Community.
- Level 2: Dispensaries.
- Level 3: Health Centers.
- Level 4: Primary health care referral facilities at County and Sub- County.
- Level 5: Secondary/ regional referral facilities.
- Level 6: Tertiary Referral hospitals.

Figure 4. 1: Organization of service delivery



Kenya Health Policy, 2014-2030.

Table 4. 1: Areas of intervention in Organization of Service Delivery (KHP, 2014-2030)

Service Area	Description	Scope and Focus
i. Organization of the health service package	What the services that will be provided are, and their linkages	Identification and monitoring of the health interventions to be provided
		Organization of interventions by life cohorts and service areas
ii. Organization of the health system	How the health system is to be structured to deliver desired services	Levels of care for provision of services
iii. Organization of community services	How communities are able to engage in improving their health	Comprehensive community strategy to build demand for services through improving community awareness and health-seeking behaviors
		Programme-targeted community services to improve supply of services by taking services to the community
iv. Organization of facility services	How the facility organizes itself internally, to provide and manage delivery of care	Micro-planning for service delivery to reach under-served communities
		Epidemic preparedness and planning
		Therapeutics management and monitoring
		Patient safety initiatives
		Developing long-term facility master plans for long-term development
v. Organization of emergency and referral services	How services are planned and delivered across different levels of facilities The focus is on ensuring holistic delivery of services	Physical client movement (physical referral)
		Patient parameters movement (e-health)
		Specimen movement (reverse cold chain and reference laboratory system)
		Expertise movement (reverse referral)
		Formulation of National referral strategy and guidelines
		Formulation of an Emergency Medical Services (EMS) policy
vi. Coordination of national disasters, emergencies, and disease outbreaks	How services will be organized to respond to national disasters, emergencies, and disease outbreaks	Coordinated by the national government in line with the disaster risk management policy and legislation; management of cross-border outbreaks will also be carried out through intergovernmental mechanisms
		Outreaches by facilities to under-served communities

Service Area	Description	Scope and Focus
vii. Organization of outreach services	How services (preventive and curative) are supplied to communities, as per their needs	Mobile clinics in hard-to-reach areas
viii. Organization of supervision and mentorship services	How health workers are mentored and supported to continually improve their competences, skills and expertise in providing high-quality services	Integrated facilitative supervision
		Emergency supervision
		Technical supervision and coaching

This strategic plan places integrated people-centered approach to service delivery. This encompasses clinical encounters that include attention to the health of people in their communities, and their crucial role in shaping health policy and health services they receive. These services include but not limited to promotive, preventive, curative, rehabilitation and palliative health services.

4.2.2 Service Delivery Focus Areas

In terms of service delivery, the Strategic Plan focuses on the following areas:

Focus Areas 1: Strengthening access to and quality of health services at all levels, including emergency care to accelerate attainment of universal health coverage

Focus Areas 2: Enhancing service delivery through an integrated and responsive primary healthcare approach.

Focus Areas 3: Building resilience of health systems including disaster management and response, climate change adaptations and health security

Focus areas with their associated actions.

Focus Area 1: Strengthening access to and quality of health services at all levels, including emergency care to accelerate attainment of universal health coverage

1. Adopt a harmonized continuous quality improvement framework to guide all actors to include Quality-of-Care certification & Accreditation framework for Kenya health sector.
2. Ensure the provision of health care services that meet quality standards and enhance patient safety.
3. Sustain implementation of the infection prevention control (IPC) policy, standards and guidelines at all levels
4. Promote antimicrobial stewardship to optimize the use of antimicrobials and diagnostics at all levels and sectors.
5. Scale up innovative digital technologies to strengthen integrated and comprehensive service delivery. Bolster environmental health services health care waste management and water hygiene and sanitation services in all health facilities and institutions at all levels.
6. Strengthen occupational health and safety activities at all levels.
7. Disability mainstreaming to increase access to health services to address needs of people with disabilities.
8. Integrate mental healthcare services at all levels of care
9. Improve access and the quality of care for Reproductive, maternal, newborn, child, adolescent health and nutrition service delivery.
10. Strengthen delivery of forensic and pathology, ear and hearing, eye care, oral health, geriatric, rehabili-

tative and palliative services at facility level

11. Improve access and quality of care for communicable and non-communicable diseases
12. Strengthen a tiered and optimized laboratory network for both public health and diagnostic laboratories.
13. Implement the referral strategy and guidelines including sample referral, ambulance services in a coordinated manner across all levels of service delivery for emergency response
14. Strengthen emergency and critical care services at all levels.
15. Strengthen capacity and sustainability of interventions for neglected tropical diseases at both levels of government.

Focus Area 2: Enhancing service delivery through an integrated and responsive primary healthcare approach.

1. Establish and scale up target Primary care networks in all the counties as per the Kenya Primary Health Care Strategic Framework
2. Establish the target number of community health units per county and strengthen them with all the necessary inputs.
3. Review and operationalize the Kenya Essential Package for Health to align with UHC aspirations.
4. Screening and early detection of communicable and non-communicable conditions and related risk factors at all ages.
5. Integrate the delivery of NCDs management, forensic and pathology, ear and hearing, eye care, oral health, geriatric, rehabilitative, palliative services and mental health services at PHC level
6. Scaling up of services related to reproductive, maternal, newborn, child and adolescent health, and nutrition at the community and health facility levels
7. Strengthening control and elimination of endemic neglected tropical diseases of public health importance in the country
8. Strengthen advocacy, health promotion and social behavior change for health.
9. Strengthen One Health about the prevention and management of zoonotic and neglected tropical disease conditions.
10. Collaboration with health-related sectors and advocacy to address the social determinants of health.

Focus Area 3: Building resilience of health systems including disaster management and response, climate change adaptations and health security

1. Conduct vulnerability and risk assessment for disaster management purposes.
2. To conduct vulnerability and adaptation assessment at population level and health facility level
3. Energy transition to renewable energy sources to power health facilities
4. Expansion of community-based disease surveillance (event-based surveillance).
5. Implementation of the National Action Plan for Health Security 2019–2023.
6. Mainstreaming climate change interventions in the health sector to sustain low carbon emission
7. Strengthen port health services at points of entry.
8. Strengthening of early-warning, surveillance and monitoring systems for epidemics, disease outbreaks, antimicrobial resistance and other public health events.
9. Strengthening of the National Public Health Emergency Operations Centre at all levels

4.3 Health Leadership and Governance

Leadership and governance entail provision of strategic direction, and developing appropriate plans and policies with effective oversight, regulation, motivation and essential partnerships that integrate all health systems building blocks to achieve the desired results. Leadership and governance have been grouped into domains that include stewardship, governance arrangements, health partnerships, planning, monitoring and evaluation as well as advocacy.

This Strategic Plan aims to improve effective leadership, good governance and social accountability at all levels in the health sector.

Focus Areas and Interventions

The following are the Strategic focus areas for this Strategic Plan.

a. **Focus Area 1:** Strengthen health sector coordination and partnerships

b. **Focus Area 2:** Strengthen social accountability at all levels

c. **Focus Area 3:** Capacity building on leadership management and governance

d. **Focus Area 4:** Advocacy for support and investment in the health system at all levels among policy makers

e. **Focus Area 5:** Promote performance-based management for health

f. **Focus Area 6:** Streamline policy and legal environment in the health sector to support seamless service delivery

Focus Area 1: Strengthen health sector coordination and partnerships

The key interventions that will be undertaken to achieve this strategic focus area includes.

1. Strengthen coordination and strategic partnerships in alignment with the Kenya Health Sector Partnerships and Coordination Framework 2018-2030, Public-Private Collaboration Strategy 2020-2030 and the Intergovernmental Relations Act 2012 among others.
2. Harmonization of planning tools, one sector monitoring and evaluation,
3. Optimization of available resources towards common sector goals through mapping and tracking of resources to limit duplication and wastage

Focus Area 2: Strengthen Stewardship and social accountability at all levels

1. Development of appropriate organizational structures and management processes at all levels of function and provide optimal financial and human resource at each level of function
2. Generation of evidence and policy briefs for decision making
3. Adoption of social accountability approaches at all levels of service delivery to address efficiency, transparency and participation in the use of resources
4. Analysis of and response to gender related considerations at different levels of planning and service delivery
5. Succession management

Focus Area 3: Capacity building on leadership, management and governance

1. The key interventions that will be undertaken to achieve this strategic focus area includes.
2. Establishment of a Centre of Excellence in Leadership, Management and Governance in Health at KMTC.
3. Annual sensitization of SAGAs/CHMT/MOH heads of directorates/divisions on Mwongozo.
4. Review and harmonize guidelines and core curricula for health leadership, management and governance training during pre-service and in-service training
5. Develop an accreditation framework for health leadership, management and governance training during pre-service and in-service training.
6. Review and implementation of the norms and standards on Leadership and Governance.

Focus Area 4: Advocate for support and investment in the health system at all levels among policy makers

1. Advocacy among policy makers, legislators and development partners aimed at bringing about increased and sustained investment in health sector, protected budgetary allocation and strengthening of systems using analysis of national health accounts, public expenditure reviews, public expenditure tracking surveys and medium-term expenditure framework

Focus Area 5: Promote performance-based management for health

1. Conduct sensitization and training for National and County officials on AWP and Program Based Budgeting
2. Organize technical support to various planning units at National and County level during development of AWP and PBB.
3. Plan and conduct health sector performance reviews

Focus Area 6: Streamline policy and legal environment in the health sector to support seamless service delivery

1. Development, implementation and review of strategic policies, guidelines, applicable norms and standards at all levels.
2. Development and enactment of legislation related to health.
3. Review and development of relevant regulations for various legislations.
4. Advocate for political commitment and budgetary allocations at all levels for improved service delivery.

4.4 Human Resources for Health

To achieve its goals, the health sector requires adequate numbers of well-trained, knowledgeable, competent and equitably distributed human resources for health. A motivated, well trained and compensated workforce is required in attaining a healthy nation. Robust institutional capacity coupled with Human Resource for Health (HRH) systems efficiently support quality service delivery.

Human Resource Focus Areas

The Strategic Plan focuses on the following areas:

a. **Focus Area 1:** To ensure the health workforce is adequately skilled, appropriately and equitably distributed.

b. **Focus Area 2:** To strengthen institutional capacity for HRH management

c. **Focus Area 3:** To capacity build and develop Health care workers to provide quality health services

d. **Focus Area 4:** To develop a sustainable Community level Health workforce in line with the Primary Health Care agenda.

Interventions per focus area

Focus Area 1: To ensure the health workforce is adequately skilled, appropriately and equitably distributed

1. Recruit additional health care workers including interns to fill the existing HRH gaps at all facility levels
2. Strengthen use of the integrated health resource information system (IHRIS)
3. Develop mechanisms to attract and retain health workers in all regions of the country

Focus Area 2: To strengthen institutional capacity for HRH management

1. Strengthen the regulatory framework and governance to regulate health professionals including the unregulated cadres
2. Review and develop and implement HRH policy, strategies and guidelines
3. Increase capacity of human resource management teams at national and county level to manage HRH
4. Strengthen performance management systems to optimize HRH output and job satisfaction

Focus Area 3: To capacity build and develop health care workers to provide quality healthcare services

1. Implement the Ministry of Health training policy for Health care workers
2. Collaborate with training institutions and relevant stakeholders to ensure continuous review of curriculums to respond to emerging issues
3. Institutionalize continued in-service training to ensure provision of quality health services
4. Leverage mentorship and support supervision as key strategies to capacity building for health workforce

Focus Area 4: To develop a sustainable Community level Health workforce in line with the Primary Health Care agenda.

1. Train community health promoters on the basic and technical modules to be able to provide community health services as per the PHC ACT
2. Train and recruit of community health assistants at county level to supervise and mentor CHPs as per the community health strategy
3. To have an updated register/database of CHPs

4.5 Health Products and Technologies

Health-commodity security is very critical as no services can be rendered without the necessary health products and technologies. Thus, effective and efficient public-health supply chains as well as delivery of good-quality health products and technologies will ensure achievement of UHC.

Health Products and Technologies Focus Areas

The Strategic Plan focuses on the following areas:

a. **Focus Area 1:** Strengthen Governance, Regulation and Quality Assurance of HPTs

b. **Focus Area 2:** Strengthen HPT Management

c. **Focus Area 3:** Scale up Capacity for Local Production of Health Products and Technologies

d. **Focus Area 4:** Ensuring adequate, safe and equitable supply of blood, blood components, cells, tissues and organs

e.Focus Area 5: Mainstream Traditional and Alternative Medicine (TAM)

Health Products and Technologies Focus Area Interventions

Focus Area 1: Strengthen Governance, Regulation and Quality Assurance

1. Review and harmonize Health Products and Technologies supply chain related legislations, regulations and policies
2. Strengthen governance structures for HPT at MOH and County Departments of Health (CDOH) for effective leadership and stewardship.
3. Establish a National Regulatory Authority
4. Strengthen Pharmacovigilance and Post Market Surveillance
5. Institutionalize Health Technology Assessment (HTA) in HPT management.
6. Undertake structural reforms to improve affordability of health products and technologies

Focus Area 2: Strengthen HPT Management

1. Regularly review the essential HPT lists to ensure that all health products and technologies for the health system are responsive to the priority needs
2. Establish and sustain a system for timely and accurate quantification of health products and technologies at all levels of the health system
3. Ensure essential Health Products and Technologies are sourced in a cost effective and efficient manner
4. Strengthen the distribution network to the last mile based on sector needs
5. Strengthen prompt and safe disposal of HPT waste across all levels of the supply chain
6. Ensure equitable, affordable, accessible and quality Assistive Technology Devices for all
7. Adopt Information Communication Technology in all aspects of supply chain for HPT
8. Adopt the Global Standards for track and trace in the supply chain for HPT
9. Strengthen the logistics management information system

Focus Area 3: Scale up Capacity for Local Production of Health Products and Technologies

1. Lead stakeholder engagement to define and provide incentives for promoting local production of HPT
2. Accelerate the full exploitation of Trade Related Intellectual Property Rights (TRIPS) Flexibilities

Focus Area 4: Ensuring adequate, safe and equitable supply of blood, blood components, cells, tissues and organs

1. Strengthen advocacy and awareness interventions for voluntary regular non-remunerated blood, cells, tissues and organ donors
2. Increase collection of blood, components preparation, cells, tissues and organs in line with current technologies
3. Enhance the use of modern methods in processing, banking, Testing and distribution of blood, blood components, cells, tissues and organs.
4. Strengthen reporting of biovigilance activities in blood and transplant service
5. Maintenance of national and/or international blood and transplant service standards

Focus Area 5: Strengthen Traditional and Alternative Medicine (TAM)

1. Development of the Traditional and Alternative Medicine Policy
2. Capacity building for healthcare workers on integration of Traditional and Alternative medicine with Conventional medicine
3. Development of a database for TAM products and technologies
4. Optimize the contribution of Traditional and Alternative Medicines while protecting the public from any negative effects

4.6 Health Financing: Focus Areas and Interventions

Health Financing aims to ensure that there are adequate resources for the operation of the health system and increase the number of households with health insurance to minimize direct out-of-pocket payment at point of use for essential health services.

The Strategic Plan focuses on the following areas:

a. **Focus Area 1:** To increase funding for the health sector

b. **Focus Area 2:** Increasing the number of households with health insurance

Focus Area 1: To increase funding for the health sector

1. Mobilize resources required to provide the essential health services
2. To maximize equitable, efficient and value for money in the management and utilization of available health resources through effective resource mobilization, risk pooling and strategic purchasing.
3. accountability and appropriate use for sustainability
4. Develop specific programs that are best suited for external funding and are focused on innovations in service delivery.

Focus Area 2: Increasing the number of households with health insurance.

1. Sign up households under the new Social Health Insurance Fund (SHIF) scheme by ensuring 85 per cent (11.2 million) households are enrolled under the SHI scheme focusing on Afya Bora Mashinani (primary and community-based health care) to ensure indigents have an insurance cover paid for by national and county governments.
2. Institute mandatory prepayment revenue generation from the population, replacing out-of-pocket payments, guided by fairness and affordability for different income levels. (Mandatory Social Health Insurance)

3. Facilitate functional non-public prepayment (insurance) mechanisms that are linked to mandatory pre-payment mechanisms and provide clearly defined complementary services
4. Defining health benefit package for the new SHI product.
5. Consolidation of the fragmented insurance pools and funds covering indigents in the informal sector (UHC allocations, Linda Mama, Edu Afya, Health Insurance Subsidy Programme)
6. Establishment of Health Benefit Package and Tariffs Authority to revise benefits package biennially
7. Establishment of the Primary Health Care Fund
8. Establishment of the Health Emergency and Chronic Disease Fund.

4.7 Health Infrastructure: Focus Areas and Interventions

Health infrastructure is the foundation for planning, delivering, evaluating, and improving public health. The country requires massive investments in the health infrastructural system that supports the sustainable functionality of health care services by the national and county governments. These are related to all the physical aspects of health facilities construction, renovations, equipment, and information communication technology (ICT) required for the effective delivery of services at all levels

The Strategic Plan focuses on the following areas

a. **Focus Area 1:** Expand and enhance physical infrastructure of healthcare facilities (buildings) in line with the set norms and standards for improved services delivery.

b. **Focus Area 2:** Improve management of medical devices and equipment to meet set standards

c. **Focus Area 3:** Enhance ICT Infrastructure, networks and internet connectivity to digitize and improve health information management systems for delivery of UHC

d. **Focus Area 4:** Strengthen the existing transport services and referral system (ambulances, utility motor vehicles, unmanned aerial vehicles, courier services and others) to enhance service delivery.

Focus areas with their associated actions

Focus Area 1: Expand and enhance physical infrastructure of healthcare facilities (buildings) in line with the set norms and standards for improved services delivery.

1. Complete and operationalize all ongoing and stalled health infrastructural works
2. Develop a framework to guide establishment of new facilities to ensure that construction and distribution as per norms and standards and be compliant with disability inclusion, occupational health and safety laws and other relevant applicable Laws.
3. Develop and implement routine preventive and corrective maintenance for infrastructure across all health systems levels.
4. Establish and expand the existing specialized health facilities through private–public partnerships.
5. Installation of new and improvement of existing utilities (electricity, medical gas piping system, water and Oxygen tank/ PSA system)
6. Institute mechanisms to ensure physical infrastructure is climate resilient and mitigate against climate change impacts.
7. Review the health Infrastructure norms and standards.

Focus Area 2: Improve management of medical devices and equipment to meet set standards

1. Develop and implement guidelines and standards for management of medical devices and equipment to operationalize the Medical Devices Management Policy.
2. Digitalization of medical devices management system
3. Enhance and expand local equipment assembly and repair industry to accommodate technology changes
4. Ensure affordability and continuity in the maintenance and repair of equipment

Focus Area 3: Enhance ICT Infrastructure, networks and internet connectivity to digitize and improve health information management systems for delivery of UHC

1. Develop and utilize a standard hospital management software to enhance service delivery at health facilities
2. Enhance networks, internet connectivity and communication equipment for healthcare facilities
3. Collaborate with relevant stakeholders to improve ICT infrastructure in all levels of care
4. Maintain a master register of inventories of all major equipment and machines in the KMHFR.

Focus Area 4: Strengthen the existing transport services and referral system (ambulances, utility motor vehicles, unmanned aerial vehicles, courier services and others) to enhance service delivery.

1. Develop guidelines for health sector transport (ambulance, vehicles, boats, unmanned aerial vehicles and courier services) operation and maintenance.
2. Establish and operationalize a healthcare referral, transport and logistic services system.

4.8 Health Information Systems/ Health Digitization and M&E: Focus Areas and Interventions

This aims to enhance access to health information through the digitization of the health services. The Integrated Health Management Information System (IHMIS) provides interconnectivity in the health sector through end- to-end visibility of the whole ecosystem.

The Strategic Plan focuses on the following areas:

a. **Focus Area 1:** Digitize the health ecosystem.

b. **Focus Area 2:** Strengthen health data quality, governance and use at all levels of the health ecosystem.

c. **Focus Area 3:** Enhance monitoring and evaluation for health sector

Focus areas with their associated interventions.

Focus Area 1: Digitize the health ecosystem

1. Operationalize regulatory, institutional and policy framework for digitization.
2. Operationalize the Health Information Exchange (HIE)Promote, identify and scale up appropriate digital health innovations.
3. Digitization of health facilities and services
4. Integration of all existing health systems in the Ministry of Health (Human Resources, Social Health Insurance Fund, KEMSA, county and national referral hospitals, regulatory bodies and community-based health systems) using the Fast Health Interoperability Resource Standard
5. Operationalization of electronic health records to standardize data for patients
6. mplementation of Kenya Integrated Health Resource Information System to track and manage the health workforce, and operationalization of telemedicine.

7. Development of high-level dashboard to track key achievements of Afya Bora Mashinani on a real time basis.
8. Enhancement of National Health Data Centre to cater for increasing data traffic over time
9. Linking all level 4 and 5 facilities through National Optic Fibre Backbone Infrastructure (NOFBI) to a respective level 6 facility for telemedicine services.

Focus Area 2: Strengthen health data quality, governance and use at all levels of the health ecosystem

1. Develop and revise Guidelines and Sop's for data quality, governance and use.
2. Institutionalize data quality assessments and improvement.
3. Strengthen health workers and managers' capacity on data analytics and data synthesis.
4. Enhance security, confidentiality and privacy of Digital Health solutions (Conduct Data Protection Impact Assessments (DPIAs) for Digital health solutions with individual level data, certify systems security against the Kenya health Certification Framework, Develop Data Sharing Agreement/Protocol)

Focus Area 3: Enhance monitoring and evaluation for the health sector.

1. Strengthen Health Sector performance monitoring.
2. Conduct evaluations and assessments for the health sector
3. Promote use of M&E for learning and decision making in the health sector

4.9 Health Research and Development

The aim is to achieve structured coordination of research and translation of the findings into policy and products.

Focus Areas and Interventions

The Strategic Plan focuses on the following areas:

a. **Focus Area 1:** Establish and sustain research management information systems.

b. **Focus Area 2:** Expand research and knowledge translation.

c. **Focus Area 3:** Strengthen research capacity at all levels.

d. **Focus Area 4:** Sustainable and Innovative research funding

e. **Focus Area 5:** Strengthen health innovations and technology transfer through research.

Focus areas with their associated actions.

Focus Area 1: Establish and sustain research management information systems

1. Develop and advocate for enactment of a National Research & Development for Health Bill
2. Implement guidelines for health research data capture, data sharing, data ownership and research data security
3. Set up a national research-for-health management information system.
4. Strengthen mechanisms to track foreign-funded research outputs and innovations.

Focus Area 2: Expand research and evidence translation.

1. Establish a framework for research, evidence and knowledge translation for health sector
2. Map existing health research products through periodic assessments
3. Maintain a repository of systematic reviews and evidence synthesis at all levels.
4. Strengthen capacity for research and evidence translation.

Focus Area 3: Strengthen research capacity at all levels.

1. Strengthen human resource capacity in research-for-health.

Focus Area 4: Sustainable and Innovative research funding

1. Develop a resource mobilization strategy for health research.
2. Advocate for increased allocation in the research and for health development budget

Focus Area 5: Strengthen health innovations and technology transfer through research.

1. Establish end-to-end national innovation platforms.
2. Strengthen governance for innovation.
3. Improve innovations through partnerships across health systems pillars.
4. Scale up needs-driven scientific and technological innovations for health.
5. Localize innovations for sustainability.

CHAPTER FIVE: RESOURCE REQUIREMENTS

5.1 Resource Requirements for KHSSP Implementation

This section outlines the annual resource requirements for implementing the KHSSP 2023-2027, as well as strategic intervention and programs identified by the Ministry of Health, partners and stakeholders. Costing is the process of quantifying in monetary terms the value of inputs needed to produce a specific output. It involves estimating the quantity of inputs required by an activity or program. The cost data provided here offers a comprehensive insight into the financial resources needed for KHSSP 2023-2027 implementation, facilitating efficient resource allocation and budgeting. Moreover, cost data aids in recognizing potential funding gaps and challenges, allowing for the development of proactive solutions. It also supports the prioritization of interventions by ensuring that resources are directed toward activities with the most significant impact. Overall, this information on cost is expected to assist stakeholders in developing realistic annual health budgets without which annual operational plans cannot be designed or implemented in a more effective way. The cost data will help health program implementers, policymakers, and funders generate evidence to support advocacy efforts and resource mobilization, planning, and budgeting.

5.2 Costing methodology

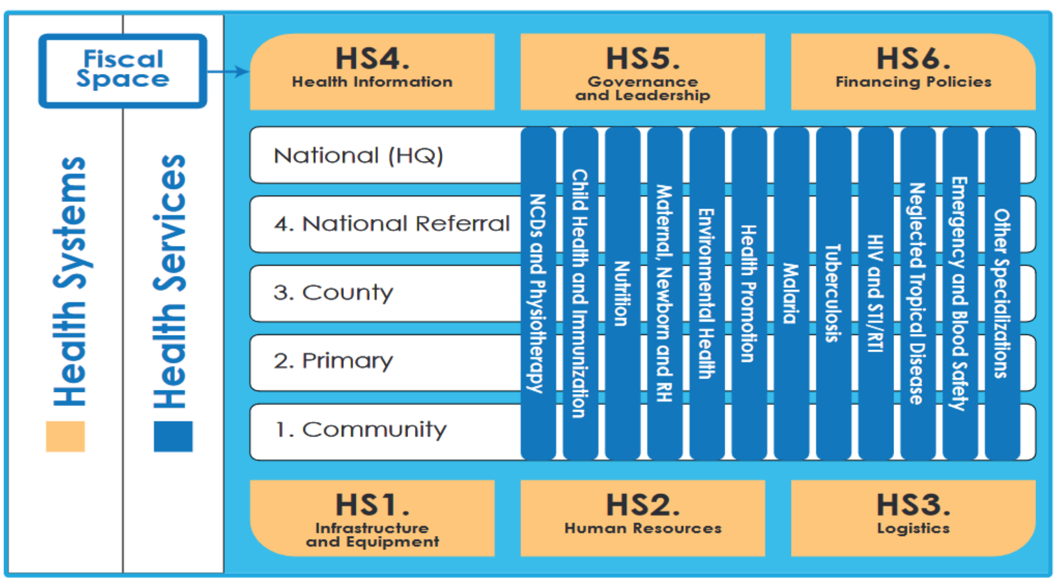
The costing approach for the KHSSP 2023-2027 integrated both One Health and Activity-Based Costing models.

One Health Model

The estimates of resource needs are calculated using the One Health Tool, which is a model designed for medium to long-term strategic planning for the health sector. It estimates the costs of health programs, including service delivery and above-service delivery costs (e.g., program-specific management, training, and supervision costs), as well as the resource requirements for the health system (represented by the health system investment areas including infrastructure, human resources for health, health information systems, health financing, leadership and governance, and health products and technology).

The One Health Model serves as a tool for medium to long-term (3-10 years) strategic planning in the health sector at the national level. It functions as a unified tool in two keyways: facilitating joint planning, costing, budgeting, impact, and financial space analysis; and integrating disease programs with health systems. The tool is also organized into three components: health systems, health services delivery, and impact module.

Figure 5. 1: One Health Tool Framework



Activity-based Costing

The programme management and the health systems component of the KHSSP was costed using Activity-based costing (ABC). This is a method that allocates costs to products and services based on each intervention and activity, aiming to achieve specific goals and results. It emphasizes a bottom-up approach and is commonly used as a tool for planning. In ABC, all costs of activities are traced to the product or service for which the activities are performed. While direct labor and materials can be easily traced directly to products, allocating indirect costs to products can be more challenging. When products use common resources differently, some form of weighting is necessary in the cost allocation process.

Within ABC, each activity requires inputs, such as labor and the use of conference halls, which are needed in specific quantities and frequencies. The total input cost is determined by the sum of the product of the unit cost, the quantity, and the frequency of the input. The unit cost represents the value of resources needed to provide a service to one unit/person (client or patient). All the components required to provide a service to one person are clearly defined in activity-based costing, including the quantity of each input and its cost per unit.

ABC is significant in performance budgeting for two main reasons:

Improved Expenditure Prioritization: It enables enhanced program costing, providing a systematic method for determining how to allocate limited resources to the appropriate activities to achieve the desired results and improve the quality of expenditure.

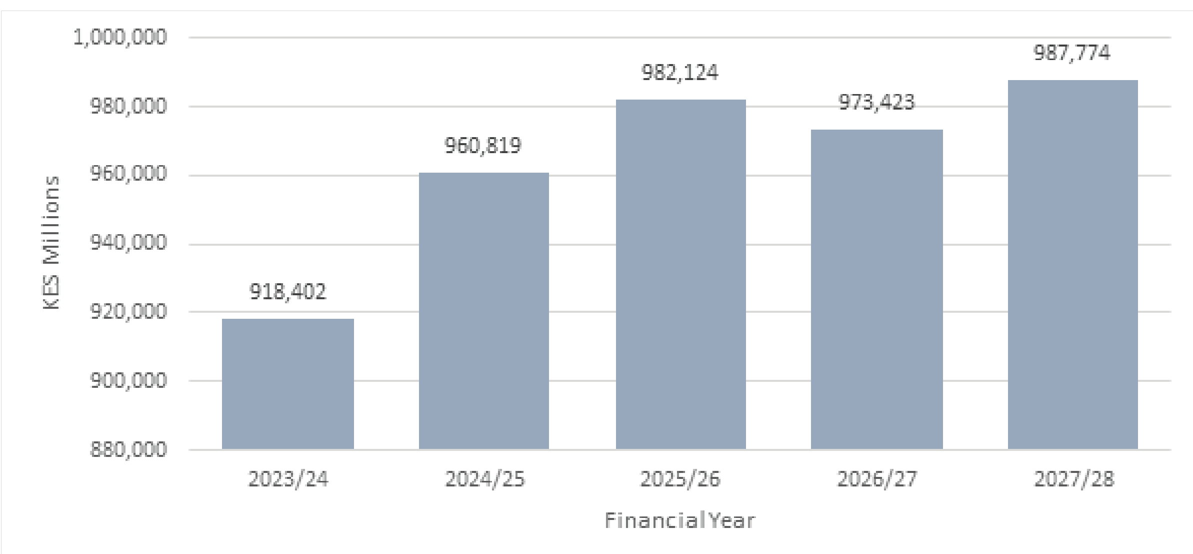
Enhanced Alignment between Planned Outputs and Funding: It helps in determining the costs of the activities necessary for generating the planned outputs, thereby creating a tighter linkage between planned outputs and funding.

5.3 Total Resource Requirements for KHSSP 2023-2027

This section describes in detail the level of resource requirements for the strategic plan period, the available resources and the gap between what is anticipated and what is required. The estimates will help guide and inform the annual planning, but also prepare the country to ensure that resource mobilization.

The One Health model was used to provide cost estimates by the KHSSP strategic objectives and orientations. The table below therefore provides summary costs estimates by intervention areas and health systems. From the costing, KES 4.8 trillion is required to finance the strategy over the plan period.

Figure 5. 2: Total KHSSP Cost Requirements (KES millions)



The Table below shows breakdown of costs by intervention areas and health systems. The cost shows heavy initial investment on health services and subsequent reduction which could be a result of stabilization of disease burden. The investment needs shift to health system maintenance and improvement.

Table 5. 1: Total costs by intervention areas and health systems (KES millions)

Total costs	2023/24	2024/25	2025/26	2026/27	2027/28	Total (KES)
Total Health Services costs	437,103	453,097	444,326	401,840	377,774	2,114,139
Total Health System costs	481,299	507,722	537,798	571,584	610,000	2,708,403
Grand Total	918,402	960,819	982,124	973,423	987,774	4,822,543

Source: One Health Model

Table 5. 2: Total costs by health systems (KES million

Total costs	2023	2024	2025	2026	2027	Total
Total Programme Costs	150,444	157,274	165,694	169,520	175,364	818,297
Total Human Resources	280,215	301,631	327,469	357,911	393,529	1,660,754
Total Infrastructure	91,160	91,674	91,780	91,162	89,792	455,570
Total Logistics	15,519	16,905	17,628	18,165	19,068	87,287
Total Medicines, commodities, and supplies	286,658	295,823	278,632	232,320	202,410	1,295,843
Total Health Financing	63,961	66,440	68,994	71,629	74,133	345,158
Total Health Information Systems	17,790	18,314	19,061	19,737	20,383	95,286
Total Governance	12,653	12,758	12,866	12,978	13,094	64,348
Grand Total	918,402	960,819	982,124	973,423	987,774	4,822,543

Source: One Health Model

Table 5. 3: Total costs by Recurrent and Development Expenditures (KES millions)

Metrics	2023/24	2024/25	2025/26	2026/27	2027/28	Total
Recurrent expenditures	827,241	869,145	890,344	882,261	897,981	4,366,973
% of Total	90.1%	90.5%	90.7%	90.6%	90.9%	90.6%
Capital expenditures	91,160	91,674	91,780	91,162	89,792	455,570
% of Total	9.9%	9.5%	9.3%	9.4%	9.1%	9.4%
Total cost of plan	918,402	960,819	982,124	973,423	987,774	4,822,543

Source: One Health Model

5.3.1 Cost estimates for the KHSSP by health programme areas

Cost analysis of implementing KHSSP by health programme areas include Sexual Reproductive Health (Maternal/newborn and FP); Child health; Immunization; Malaria; TB; HIV/AIDS; Nutrition; WASH including Environmental health; non-communicable diseases; Mental, neurological, and substance use disorders; Adolescent health; Neglected tropical diseases and Basic & Emergency Medical Services were also generated, in addition to the health system investment areas.

Figure 5. 3: Total costs of the KHSSP by disease programmed areas

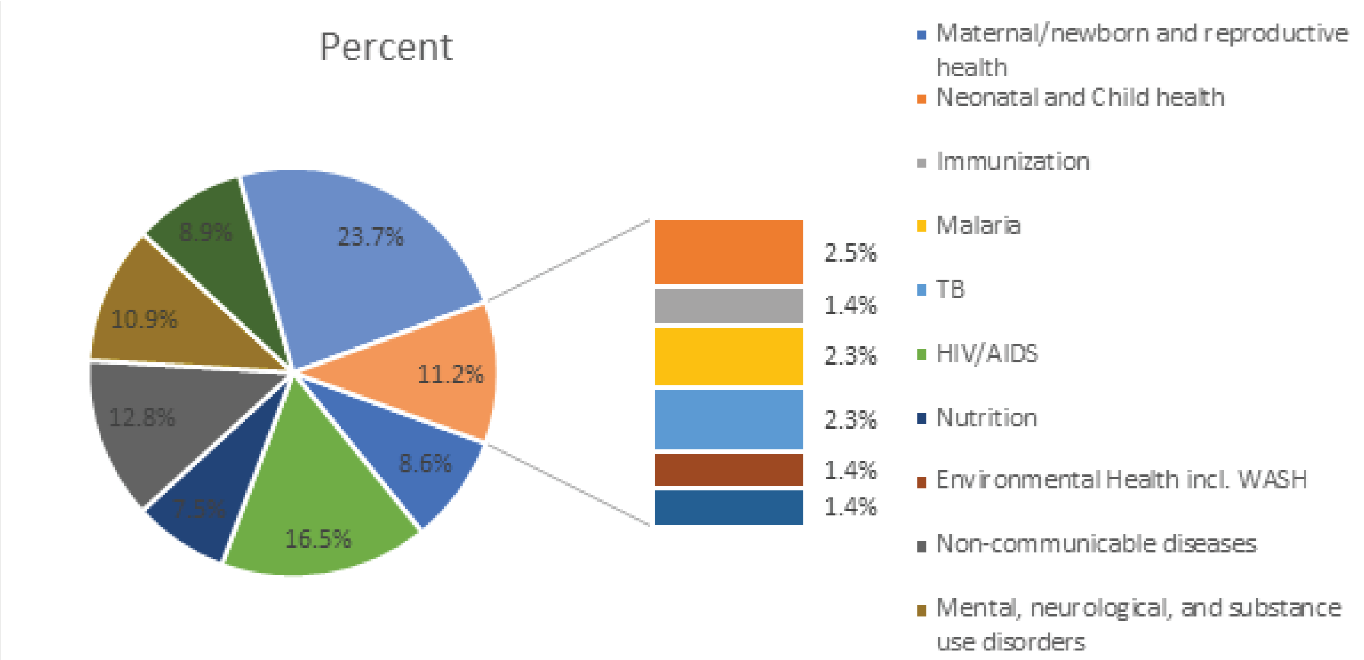


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Table 5.4 : Total costs of the KHSSP by disease programmed and health system investment areas (KES millions)

Programme area	**2023**	**2024**	**2025**	**2026**	**2027**	**Total**	**Percent**
Maternal/newborn and reproductive health	95,340	96,838	90,593	75,382	56,204	414,356	8.6%
Neonatal and Child health	29,336	28,505	25,841	21,081	15,683	120,445	2.5%
Immunization	11,436	13,203	13,452	14,483	13,205	65,780	1.4%
Malaria	21,237	20,171	21,355	23,774	24,776	111,314	2.3%
TB	26,237	25,220	23,373	20,015	14,777	109,621	2.3%
HIV/AIDS	151,363	154,530	159,341	158,022	172,978	796,235	16.5%
Nutrition	88,628	86,362	78,503	63,165	46,301	362,959	7.5%
Environmental Health incl. WASH	13,233	14,102	14,050	12,874	11,119	65,379	1.4%
Non-communicable diseases	135,542	135,328	123,718	102,247	118,620	615,456	12.8%
Mental, neurological, and substance use disorders	62,682	74,925	95,369	136,521	156,118	525,615	10.9%
Adolescent health and School Health	7,381	10,117	12,891	15,946	19,805	66,139	1.4%
Neglected tropical diseases	76,809	89,740	96,395	86,878	77,775	427,597	8.9%
Basic & Emergency Health care	199,178	211,778	227,242	243,035	260,412	1,141,646	23.7%
Grand Total	918,402	960,819	982,124	973,423	987,774	4,822,543	100.0%

Source: One Health Model

5.4 Available Resources

Secondary data sources were used to establish the available financial resources. Government financial commitments were obtained from the Fiscal Space as captured in the MOH budget (Budget Framework Paper) to establish resource availability. Planning assumptions were made about future contributions available each year of the planning period. Support from the Development Partners was estimated from Donor tracking reports and repository while private contribution was extrapolated from existing reports like National Health Accounts (NHA).

Overall, a total of KES 2.85 trillion is available to support the KHSSP over the next five years. Table 5. 5 shows the total available resources by year and source to support the implementation of the KHSSP over the short-term.

Table 5. 5: Estimated and projected financial resources available by source (KES millions)

Source	2023	2024	2025	2026	2027	Total	Percent
Government	292,187	313,699	339,118	361,909	398,100	1,705,012	60%
Development Partners	88,500	97,350	107,085	107,085	107,085	507,105	18%
Private Sources	117,795	129,575	129,575	129,575	129,575	636,095	22%
Total Available	498,482	540,624	575,778	598,569	634,760	2,848,212	100%

5.5 Financial Gap Analysis

The funding gap was computed as the difference between the resource requirements and the available resource-based budgets, provides a measure of the gap in funding which exists if full implementation is not done. The starting point for estimating resources available was based on budgets and budget projections as well as other financing sources for the plan reflecting the total amount of resources available. The identification of the funding gap provides an opportunity for potential stakeholders to see when additional resources is most useful. Further a Funding Gap will be computed as the difference between the resource requirements and the available resource, based budgets provides a measure of the gap in funding which exists if the action plan is to be fully implemented.

The financing gap was estimated by generating the difference between the available resources and the cost of implementing the KHSSP. The health sector requires KES 1.97 trillion to reduce the funding gap.

Table 0.1 summarizes the available resources and costs from the previous sections, to provide an estimate of the KHSSP funding gap by year.

Table 5.5: Financial gap analysis for the health sector (KES millions)

Metric	2023	2024	2025	2026	2027	Total
Total Requirement	918,402	960,819	982,124	973,423	987,774	4,822,543
Total Available	498,482	540,624	575,778	598,569	634,760	2,848,212
Funding Gap	(419,920)	(420,196)	(406,347)	(374,855)	(353,014)	(1,974,330)

Resources to bridge the gap could be mobilized from other sources like donors and the private sector including the households.

5.6 Strategies to ensure available resources are sustained.

Bridging the funding gap is critical to ensure that implementation of the strategic interventions in this strategy is not hampered by lack of resources. There is need for innovative strategies to mobilize and sustain funding including from non-traditional sources. Advocacy and lobbying will be undertaken for increased budget allocations. Additionally, partners and stakeholders will be identified, mapped, and continuously engaged for support towards implementation of this strategy.

CHAPTER SIX: IMPLEMENTATION ARRANGEMENT

6.1 KHSSP Implementation Plan

The KHSSP 2023–2027 implementation plan will engage multiple stakeholders within the health sector, each with distinct roles, and will establish partnership arrangements, as well as planning and budgeting processes, and communication strategies. These efforts will be conducted within the framework of devolved governance as mandated by the Constitution.

The Ministry of Health will drive the execution of the strategic plan, working in close collaboration with stakeholders at both national and county levels. At the national level, the Ministry of Health will work closely with relevant government agencies to align the strategic plan with national health policies and priorities. This collaboration will ensure that the plan complements and contributes to broader health initiatives at the national level. Moreover, the Ministry will engage with professional associations, research institutions, and non-governmental organizations to leverage their expertise and resources in the implementation process. Given the constitutional framework of devolved governance, the involvement of county governments and their respective health departments is crucial.

The Ministry of Health will establish collaborative mechanisms to engage county-level stakeholders, recognizing their autonomy in health service delivery. This will involve fostering partnerships, sharing best practices, and providing technical support to ensure effective alignment and integration of efforts across different counties.

6.2 Health sector stakeholders and their roles

There are four main categories of stakeholders, each with distinct roles in the delivery, management, and oversight of healthcare. These categories include:

1. Clients - are the core of the healthcare delivery system, seeking care, accessing services, and being the beneficiaries of health services and they include individuals, households, and communities.
2. State actors - national, county governments as well as health-related sectors, play a critical role in governance, policymaking, regulations and the provision of essential healthcare services,
3. Non-state actors - They include implementing partners such as faith-based organizations (FBOs), non-governmental organizations (NGOs), civil society organizations (CSOs), and the private sector who contribute and actively participate in service delivery, advocacy, and resource mobilization.,
4. External actors - This may include international organizations, donor agencies, and foreign entities involved in providing support, funding, or technical assistance to the health sector. They provide additional support, expertise, and resources to strengthen healthcare systems and address specific health challenges, contributing to the overall improvement of health outcomes.

6.3 Partnership Arrangement

The successful implementation of KHSSP 2023–2027 relies on collaborative efforts from all health stakeholders, guided by the Kenya Health Sector Partnership and Coordination Framework 2018–2030. This framework enhances aid effectiveness by adopting a sector-wide approach to health service delivery and establishes structures and mechanisms to facilitate collaboration among key partners at various levels. It defines partnership structures, roles, and responsibilities for different actors within the government and outlines expectations for partners. The effective coordination and harmonization of investments and actions from the diverse range of partners supporting Kenya's health sector are essential to ensure optimal resource utilization, address sector priorities, and achieve desired outcomes including

- Coordination and harmonization of investments and actions to eliminate duplication of efforts and identify critical gaps that need to be addressed
- Reduction of transaction costs for the government and partners
- Enhanced efficiency of support to the health sector
- Promotion and facilitation of mutual accountability for results
- Improved resource allocation and utilization through synchronized efforts
- Strengthened capacity for addressing health sector priorities
- Increased transparency and communication among stakeholders
- Improved sustainability of health interventions through unified strategies

The principles of the sector-wide approach align with those outlined in the 2005 Paris Declaration on Aid Effectiveness, emphasizing the adoption of a unified approach that includes a single planning, budgeting, and monitoring/evaluation framework. This approach requires all stakeholders in the health sector to operate within this unified framework, promoting a cohesive and integrated strategy for planning, budget allocation, and assessment of outcomes. This coordinated approach ensures that resources are directed toward addressing critical health priorities and that the impact of interventions can be consistently monitored and evaluated to drive continuous improvement.

6.4 Cross-cutting Sectors

6.4.1 Energy, Infrastructure and ICT Sector

Expansion, modernization, and efficient operation of health infrastructure to meet evolving healthcare needs rely heavily on the energy, infrastructure, and ICT sectors. The health sector's structured and deliberate engagement with these sectors is crucial to achieving its goals swiftly. Reliable infrastructure is essential for improving health outcomes by facilitating access to healthcare facilities and emergency services nationwide. Additionally, as the health sector increasingly adopts ICT for enhanced healthcare delivery, internet connectivity becomes a vital resource for implementing e-health, telemedicine, and training. Prioritizing collaboration with the ICT sub-sector will ensure the establishment of sectoral standards, cost efficiency, data reliability for national planning, and facilitate the creation of web portals, national e-health hubs, and health facility-based e-health hubs across the country in consultation with county governments.

6.4.2 Environmental Protection, Water and Natural Resources Sector

Unsafe environments, including air pollution and exposure to second-hand smoke, significantly contribute to public health issues such as increased cancer risk and respiratory infections. Access to clean water is essential in preventing waterborne diseases, particularly among young children. Additionally, controlled management and extraction of natural resources are crucial in protecting the population against environmental hazards, ultimately contributing to overall public health. The health sector aims to collaborate with relevant sectors in policy and regulatory dialogue to ensure that environmental, water, and sanitation facilities meet established standards and regulatory requirements, thereby promoting a safe and healthy environment for all.

6.4.3 Social Protection, Culture and Recreation Sector

The Health Sector plans to collaborate with the labor, social security, and services sub-sector to address international recruitment and integrate occupational safety and health into management systems. Additionally, the sector will play a part in reviewing policies and legislation related to occupational safety and health. Furthermore, the Health Sector is dedicated to fostering industrial peace and harmony and ensuring the socioeconomic rights of workers to enhance the productivity and performance of healthcare workers.

6.4.4 Public Administration and International Relations

The success of health sector programs relies on securing adequate funding and ensuring timely disbursement. The sector is committed to providing essential data to facilitate the prompt allocation of funds by the National Treasury in alignment with national and sectoral policies. The restructuring of public expenditure to be more growth and pro-poor-oriented, as outlined in Vision 2030, will greatly benefit the sector, emphasizing the importance of investing in human capital. Resource allocation will prioritize promotive and preventive healthcare while maintaining attention to curative care.

Furthermore, the sector will address the impact of national disasters and other challenges, such as road traffic accidents, fires, and acts of terrorism, which significantly affect referral hospitals. To this end, the sector will allocate funds for disaster preparedness, response, and recovery, and will develop guidelines for use by county governments. Additionally, the sector will focus on institutionalizing and strengthening public-private partnerships as a resource mobilization strategy to address budgetary deficits in accordance with the Public-Private Partnership Act (2013).

6.4.5 Education Sector

The connection between education and positive economic development, leading to improved health outcomes, is widely recognized. The education sector's initiatives prioritize delivering accessible, equitable, and high-quality education and training to enhance efficiency. Comprehensive, high-level education can notably contribute to improved health-seeking behavior through the implementation of health education and outreach programs. Collaboration between national teaching and referral hospitals and higher education institutions will continue to facilitate the training of medical and paramedical students. Moreover, the health sector will work with institutions in the basic education sub-sector to implement impactful health interventions, including deworming programs, eye screening in schools and HPV programs.

6.4.6 Governance, Justice, Law and Order Sector

The health sector operates under constitutional provisions that guarantee the right to the highest quality of healthcare, particularly Chapter Four, Article 43. This is supported by relevant legislation and regulatory mechanisms such as the Public Health Act, Research Ethics and Standards, and the Food and Drug Administration. The sector is currently working on finalizing the Health Bill to make it into law, and the effective enforcement of this law and related legislation will necessitate close cooperation between various entities including the Offices of the Attorney General.

6.4.7 General Economic and Commercial Affairs

The health sector aims to enhance its specialized healthcare services by drawing on best practices from middle-income countries such as India, Thailand, and South Africa. This initiative is designed to position Kenya as a global hub for medical tourism, attracting clients from the local, regional, and global levels and contributing significantly to economic growth. Priority areas for this endeavor include advocating for Kenya as a medical tourism destination, defining the roles of different sectors of the economy in supporting this vision, setting international quality standards, developing human resource capacity, establishing necessary infrastructure, creating financing mechanisms, and devising a marketing strategy through relevant sectors.

6.4.8 Agriculture, Rural and Urban Development

The Health Sector is focused on strengthening platforms for policy dialogue related to nutrition, housing, water, and environmental factors to enhance the quality of services accessible to the people of Kenya. Notably, there is a specific emphasis on prioritizing the nutritional needs of women of reproductive age and children under five years old. This includes a concerted effort to jointly implement the National Nutrition Action Plan to address the specific needs of these demographic groups. Through this collaborative approach, the sector reaffirms its dedication to advancing the overall well-being and healthcare services of the population.

6.4.9 County Governments

County governments in Kenya are pivotal in the administration of critical healthcare services as they are responsible for various aspects such as planning, budgeting, financial management, human resources, and ensuring the availability of emergency medicines and medical supplies. Moreover, they act as the crucial intermediary between local communities and primary healthcare networks, as well as the referral to higher-level health facilities. Through sustained collaborative initiatives between the County and National governments, tangible advancements in health indicators have been observed, underscoring the positive influence of their unified efforts on the broader healthcare framework. This collaboration has been instrumental in improving the overall accessibility and quality of healthcare services for the population, contributing to positive health outcomes and well-being.

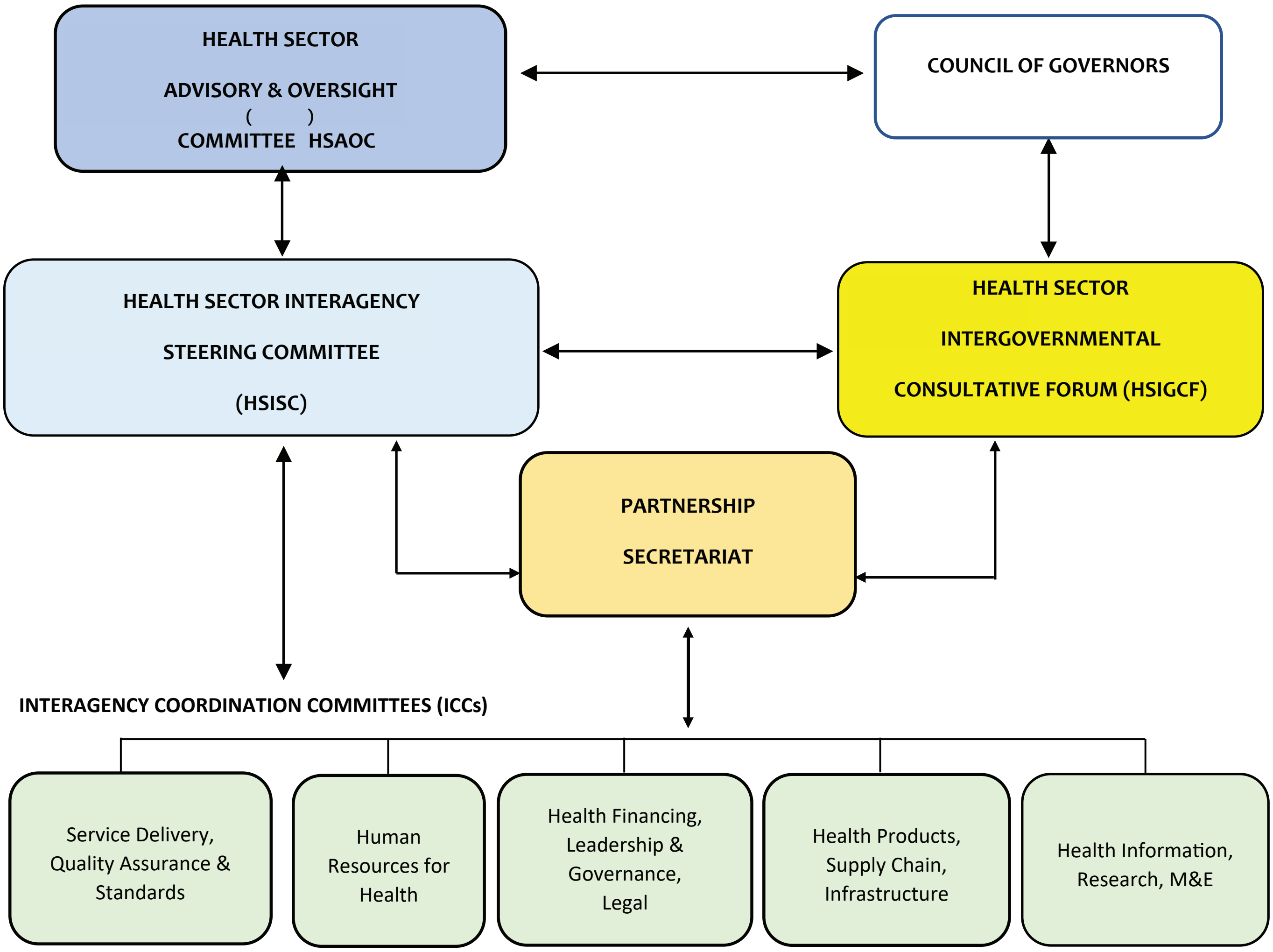
6.4.10 Development Partners

Development partners have collaborated with the government to support the country's health agenda, providing substantial financial and technical investment in various programs such as immunization, nutrition, HIV, TB, malaria, and research. Given the significant financial and technical requirements of health services against limited domestic resources, development partners and international non-governmental organizations have historically played a crucial role in providing resources for the health sector. Their involvement is structured around principles of aid effectiveness, emphasizing government ownership, alignment, harmonization, mutual accountability, and managing for results. Additionally, international collaboration in public health is vital for disease prevention, sharing best practices, and partnering on public health matters, leading the health sector to collaborate with international bodies with mandates related to containing, researching, or disseminating findings on health issues.

6.5 Health Sector Partnership Structures

The partnership structures elaborated below will guide the sector in the implementation of the health sector partnership and coordination framework. The terms of reference, membership and functions for each structure are detailed in the Health Sector Partnership Framework 2018-2030 document. Also, the different sector partners structures established by various constituencies to promote coordination and harmonization of work, and to guide their engagement with other GOK and to monitor adherence to their sector commitments are well elaborated in the framework.

Figure 6. 1: Health Sector Partnership Coordination Framework



Source: Kenya Partnership and Co-ordination Framework 2018-2030.

6.6 Priorities for Implementation

6.6.1 Common Planning Framework

A common planning framework establishes a structured approach to setting goals, defining strategies, and outlining activities across the health sector. It provides a unified platform for various stakeholders, including government agencies, development partners, and non-governmental organizations, to collaborate and align their efforts. It outlines key priorities, targets, and strategies for improving healthcare delivery, public health initiatives, and health system strengthening. By establishing a common planning framework, the health sector can ensure that all stakeholders are working towards shared objectives, thereby minimizing duplication of efforts and maximizing the impact of interventions.

The common planning framework in Kenya is set by the Kenya Health Policy 2014-2030, Kenya Health Sector Strategic and Investments Plans, Annual Work Plans, County Integrated Development Plans, and the National Program Plans.

6.6.2 Common Budgeting Framework

An established budgeting framework is crucial for aligning financial resources with important programs and investment areas. This framework is designed to simplify the distribution of financial resources, ensuring that investments are targeted toward priority areas identified in the strategic plan for the health sector. It entails creating a unified budgeting process that considers the resource requirements for key health programs, infrastructure development, capacity building for human resources, and other essential interventions. Furthermore, the common budgeting framework promotes transparency, accountability, and efficient resource utilization, thereby improving the overall effectiveness of investments in the health sector.

All partners are expected to utilize the common budgeting framework when providing details about their planned support over a specific period. Through this framework, stakeholders can specify the resources they are making available for implementation in order of priority areas. It also captures partner resources that have not been specified.

6.7 Communication Strategies

Article 35 of the Constitution 2010 grants all citizens the right to access information held by the State, while the County Governments Act 2012 mandates county governments to establish mechanisms for public communication and information access. Effective and timely communication of targeted messages through suitable channels is crucial for driving change. This section offers guidance on creating a communication strategy for the Strategic Plan with the aim of garnering increased support from key stakeholders, including the public.

The communication strategy will primarily focus on:

- Ensuring stakeholders' understanding of the Kenya Health Sector Strategic Plan 2018–2023 and the ongoing health reform process
- Ensuring stakeholders are fully informed about and comprehend their roles and responsibilities in plan implementation
- Improving agency consultation to achieve desired outcomes.

The communication plan should identify:

- The key messages for key stakeholders
- The methods by which those key messages are to be communicated to key stakeholders
- The actions required for the implementation of the strategy and fulfillment of related communication roles
- The resources needed to be able to undertake the communication tasks
- Communication risks
- The methodology and time frame for evaluating the effectiveness of the communication activity.

6.8 Communication risks

The methodology and time frame for evaluating the effectiveness of the communication activity.

Figure 6. 2: Focus of communication efforts, by stakeholder

Stakeholder		Communication focus
Clients	Individuals Households Communities	• Their role in adopting appropriate healthy and health- seeking behavior • Their active participation in the management of local health services • Their ownership of and commitment to good health through implementation of the strategic plan

Stakeholder		Communication focus
State actors	National and county governments	• Their leadership and stewardship role within the sector, across other sectors and among partners • Their role in contributing to national health outcomes and the need to strengthen intersectoral work and mechanisms
	Semi-autonomous government agencies	• Their role in providing specialized health services
	Ministry responsible for devolution	• Its role in ensuring that quality health care services are provided at all levels, including in urban areas
	Regulatory bodies and professional bodies/ associations with a health-related mandate drawn the State	• Their regulatory function in implementation of the strategic plan
Non-State/ external actors		• Their adherence to the Kenya health sector wide approach: Code of Conduct (Ministry of Health, 2007) incorporating • Their adherence to the common management arrangements • Their adherence to the quality standards • The need to ensure harmonized collaboration

6.9 Risk and Mitigations in the Implementation of KHSSP

During the implementation of KHSSP 2023-2027, the sector may encounter risks that impede achievement of results. It is therefore crucial that a deliberate effort be made to predict these risks and identify mitigation measures early enough to ensure that implementation continues smoothly. Adoption of a "Health in All Policies" approach the health sector involves all other relevant ministries and stakeholders in the achievement of its goals, it is therefore important to ensure that there is continuous support when mitigation measures.

Table 6.1 shows the risks identified through PESTEL and stakeholder analysis, and the strategies identified to address or mitigate them.

Table 6. 1: Implementation risks and their mitigation

Type of Risk	Specific Nature	Mitigation
Political	The country currently has a strong political commitment to delivering good-quality health care services to its citizens. This is reflected in the Constitution 2010 and the drive to achieve UHC under the "BETA" agenda and the Kenya Vision 2030, there by fostering an enabling environment for implementation of health-related policies and receipt of funding.Internal and external political and economic enthusiasm may, however, be affected by a change in country's leadership and the waning of buy-in/ commitment from county leaders.	Continuously involve the county leadership in decision-making and implementation of strategies aimed at achieving UHC
Economic	The strategies to be implemented under the Strategic Plan require sufficient and sustainable financial and human resources. Investment in the health sector, however, is not currently commensurate with economic growth. This may be attributed to the prioritization of investment in other sectors and leads to uneven investment in the sector itself owing to limited resources. There is a risk that the number of health personnel will prove inadequate for achievement of targets and that as a result tasks will be shifted to less qualified personnel.	Emphasize performance and social accountability, with a focus on prioritization of and efficiency in implementation of the strategies outlined in the Plan • Conduct annual reviews of the funding gap to track progress and inform resource mobilization strategies • Develop and introduce resource mapping and tracking at the national and county levels • Advocate the allocation of greater resources at the National and county level • Enhance performance management systems especially at the subnational level • Employ and deploy adequate numbers of health-care personnel across all levels of responsibility • Implement the strategy for enhancing community access to health care to improve their general health and reduce patient numbers at higher-level facilities

Type of Risk	Specific Nature	Mitigation
Social	The Plan emphasizes a people-centered approach to health care. Lack of community involvement may lead to implementation of strategies that do not respond fully to the community's needs	• Improve managerial processes at the county and sub county levels to ensure community involvement in implementation of the strategy • Promote social accountability at all levels with the aim of increasing demand for health-care services • Introduce/enhance peer-to-peer approaches at the community level
	Situations of instability, such as ethnic clashes, lead to violence and injuries, but also to displacement, which means that people are not able to access health care services as they would in normal circumstances	• Through the emergency preparedness and response measures and strategic repositioning, ensure that there are adequate supplies, commodities and equipment to cater for displaced populations and large numbers of casualties and ensure the continuity of service provision
	Unhealthy lifestyles are reported to have led to an increase in non-communicable conditions in the country. This trend is unfortunately increasing further, causing morbidity and mortality in an otherwise healthy population	Implement the strategy relating to non-communicable conditions at all levels
Technological	The delivery and management of services may be affected by poor network coverage in some areas, in ability to use e-health system and weak ICT infrastructure The country has not adopted a uniform electronic health record system or a telemedicine system to facilitate real-time data and remote patient management. This can also affect patient referrals	Connect health facilities with fibre optic technology Provide adequate infrastructure for ICT e.g., computers, telephones, mobile-health technology • Conduct training in the use of ICT and in preventive maintenance • Design a standardized electronic health record system for adoption by and use in all public health facilities for real-time data and information exchange
Environmental	The country has recently experienced epidemics such as cholera, chikungunya and polio. This results in the reallocation of funds to curb the outbreaks when they occur. Deforestation contributes to climate change and increased drought, which affects access to safe water and causes disease outbreaks.	• Set aside adequate resources for emergency preparedness and response • Institutionalize campaigns by individuals and organizations to plant trees

Type of Risk	Specific Nature	Mitigation
Legal	There remains the risk of poor implementation of health sector reforms and the use of resources allocated to health care for other purposes	• Enhance implementation of the health sector reforms through consultation and the reinforcement of mutual accountability • Amend the Public Finance Management Act 2012 to allow ring- fencing of the resources allocated to health

CHAPTER SEVEN: MONITORING AND EVALUATION

7.1 Monitoring and Evaluation

This Monitoring and Evaluation Plan is a guide to the steps employed to determine progress towards achieving the set goals and objectives for KHSSP 2023-2027. Regular and systematic tracking of the progress of the KHSSP 2023-2027 implementation is essential to assess the performance of the health sector and adjust accordingly. The M&E plan lists the goals and targets in the strategic plan, both short and medium term, and provides a framework to link interventional activities under the various thematic areas to these targets and goals. Implementation of these selected activities will be tracked continuously over the five-year duration of the strategic plan using output and outcome indicators listed in M&E framework and will enable achievement of the set goals and objectives. Tracking of these indicators will help in determining progress and guide on any necessary reprogramming needed to enable achievement of the set goals and objectives.

This M&E plan will:

1. Foster implementation of effective cross-sectoral mechanisms for data and performance assessment
2. Establish robust institutional capabilities for data collection through a unified data architecture, management, analysis, utilization, and dissemination.
3. Promote accountability through tracking of contributions to joint results achieved through the various interventions outlined in this strategic plan, promote enhanced multi-stakeholder coordination mechanisms. And consequently, lead to development of well-founded policies in the health sector.

The progress and performance of the KHSSP 2023-2027 will be evaluated through a well-articulated country-led review process at mid and end terms, that will incorporate all stakeholders and define actions to bridge identified gaps. A selected set of key performance indicators with defined baselines and targets, as well as enhanced information systems and capacity for data collection, management, and analysis will be used to effectively track results.

7.2 KHSSP Monitoring

The KHSSP 2023-2027 is dynamic and responsive to the evolving needs and challenges within the health sector. Recognizing the fluid nature of healthcare services and the continual advancements in clinical practice, it is imperative to acknowledge that the longer-term targets outlined in the strategic plan will necessitate regular review to remain abreast with progress on a shorter duration. A Common M&E Framework will outline key result areas, process indicators and monitoring processes that will form the primary basis of regular monitoring of the KHSSP. The monitoring process will involve the following steps:

A unified monitoring process that will ensure regular joint review of progress and linkages with programs, counties and other systems that have different M&E systems. This will involve deciding which data will be collected, when, and how. The monitoring process will be linked to the data sources such as the Kenya Health Information System, population-based surveys, surveillance systems, etc. Key stakeholders at national and county levels will need to jointly engage during this process development and updating of data collection and monitoring tools: It is essential to collect high-quality data on the indicators outlined in the KHSSP M&E framework, using appropriate tools and methods. The M&E teams will ensure that various data collection tools, such as those for routine data and population-based surveys, are current and relevant for the data needed to track progress of the KHSSP. The performance review guidelines will be updated and aligned with both KHSSP information needs as well as global standards, such as WHO core indicators, Joint program monitoring frameworks defined by government and implementing partners among others.

Data collection and analysis: Data collection will be based on the indicators outlined in the results framework and limited to those where there's technical capacities to collect at the national and county levels. Data quality will be assessed based on criteria established in national data quality guidelines before conducting analysis. Data analysis will be guided by the MOH performance review guidelines, the Annual performance review template, the data analytics guidelines as well as other relevant technical manuals relevant to each process. Data analysis will integrate gender disaggregation, equity, spatial distribution, and disability to the extent possible. Reporting and communication of findings: Monitoring will be aligned with annual performance review process, with the APR as the output at both National and County levels. To enhance uptake of the findings, user-friendly products such as short visual synopses, digital versions of the report and policy briefs will be created and distributed through available channels.

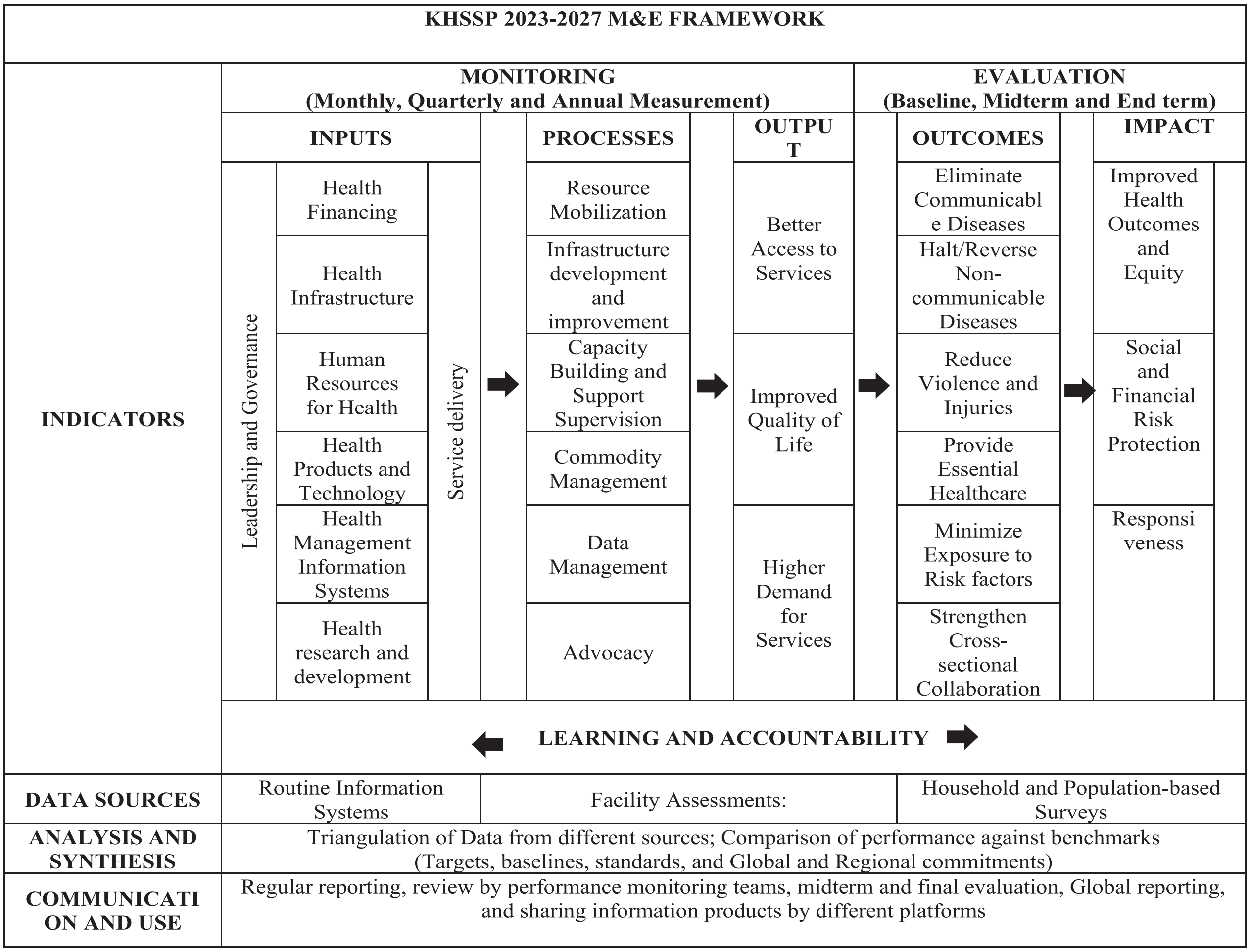
Corrective action: The evidence generated will guide the type of corrective action to be taken by various programs and stakeholders to promote accountability and achieve results. Corrective actions may include revising current activities and processes, such as scaling up or scaling down of activities, allocating resources more effectively to address emerging needs, enhancing capacity in various technical areas and reorienting advocacy and policy influencing efforts.

Quarterly and Annual multisectoral and multi-stakeholder review meetings: These reviews will focus on the progress of activities, processes, and outputs outlined in the annual work plans. Quarterly and annual performance review reports will be discussed in these meetings to where stock taking of implementation progress will be done. These review meetings will involve representation from various stakeholders and will provide a mechanism for feedback from technical working groups at both national and county levels., Recommendations will be implemented with follow-up conducted at both national and county levels.

7.3 KHSSP M&E Framework

This M&E framework provides guidance for monitoring and evaluating the implementation of the KHSSP 2023-2027. It outlines the logical progression from health system inputs to outputs to outcomes, culminating in impact. The framework encompasses domains at the input, output, outcome, and impact levels. See Figure 7.1 below. The logical framework, along with indicator performance tables, offer comprehensive information on the chosen indicators for monitoring. These indicators are carefully selected, considering global and regional commitments, as well as the priorities of the country and regional reporting requirements. They have been carefully chosen in a well-balanced manner, employing clearly defined selection criteria that include relevance, availability of data sources, measurability, and alignment with national and international health priorities and standards. The timeframes for data collection and analysis vary for each indicator. The selection process was collaborative, involving iterative and consultative engagement with program experts and stakeholders. Drawing from the lessons of KHSSP 2018-2023, M&E team endeavored to set realistic targets.

Figure 7. 1: KHSSP Framework for Implementation



Source: KHP 2014-2030

7.3.1 Indicators

The indicators were determined in consultation and technical inputs from the various programs and drafters of the strategic plan. and other key stakeholders. The key principles that guided the selection of indicators included:

1. Selecting indicators that are specific, measurable, achievable, results-oriented, time-bound, and relevant to the Kenya Health Policy 2014–2030 and program requirements.
2. Choosing indicators that can effectively demonstrate the accomplishments of the health sector, acknowledging that long-term impact indicators also mirror broader socio-economic development.
3. Ensuring a balanced set of indicators that covers inputs, processes, outputs, outcomes, and impact, with a focus on outcomes to evaluate performance at the service delivery level in alignment with the priorities of the Kenya Health Policy 2014–2030.
4. Ensuring alignment and conformity with globally and regionally endorsed indicators, particularly those related to the Sustainable Development Goals (SDGs) and Universal Health Coverage (UHC), to facilitate international comparisons and fulfil reporting obligations.
5. Selecting indicators that leverage established sources of information whenever possible to reduce reporting burdens and enhance data quality.

The indicators are categorized by thematic areas and objective, and are classified according to type (input, process, output, outcome, and impact). To determine the type of indicator, a sector-level perspective was adopted. Furthermore, details such as disaggregation, data sources, reporting frequency, responsible entity for data collection, reporting level, national baselines, and targets are provided for each indicator. Annual targets for the indicators were established in alignment with the goals, objectives, and targets of existing national strategic focus for various health programs. The indicators outlined in the Framework will undergo regular reviews throughout the implementation period to ensure their continued relevance, feasibility of collection, and alignment with the needs of diverse stakeholders in the health sector for performance measurement. During these reviews, indicators may be adjusted or eliminated based on monitoring and evaluation requirements.

7.3.2 Data Sources

Data for indicators outlined in the KHSSP 2023-2027 Framework, including baselines, will be collected based on quantitative and qualitative methodologies. Key sources are:

- Routine information systems
- Health-facility assessments
- Program evaluation or independent review reports that provide information on the implementation of activities and outputs and outcomes achieved.
- Operational research and special studies undertaken by programs and research institutes such as the Kenya AIDS indicator surveys.
- Population-based surveys such as the national population census, national household surveys, and the Demographic and Health Survey (DHS) that report data on health outcomes and impact

7.3.3 Data Management

The Monitoring and Evaluation division and the M&E TWG will provide oversight and coordinate initiatives aimed at supporting efficiency and effectiveness of data management, including ensuring data quality, timeliness and accuracy and appropriate analysis. Regular data quality audits and data and performance review forums will be conducted to track indicator performance at all levels. The data management hierarchy for the KHSSP 2023-2027 M&E framework presented in the table 3.1, outlines a structured system for M&E processes across different levels of the health system. At the national level, data collection involves developing activity indicators and tools, with the M&E division Head being responsible. Data will be compiled, aggregated, and analyzed for national, county and health sector reports to inform policy formulation and resource management., At the county level, a similar process will occur, with the County M&E/HIS focal person and the TWG responsible for coordinating the quarterly and annual performance reviews through data aggregation, and analysis to support policy formulation and resource allocation at the county level. Subsequently, the hierarchy extends to the sub-county, facility, and community levels, where data, entry, verification storage, analysis, and reporting are carried out by various responsible individuals, such as County Health Records Information Officers (CHRIOs), Sub-County Health Records Information Officers (SCHRIOs), Health Records Information Officers (HRIOs), and Community Health Assistants (CHAs). This structured data management hierarchy aims to facilitate collection of good quality data for evidence-based decision-making, resource allocation, and policy development throughout the health system, from the community level to the national level.

7.3.4 Data Analysis, Dissemination and Use

Analysis, dissemination and use of data generated from M&E is essential for informing program planning and implementation, as well as policymaking. Analysis of data from various sources, will be promoted and strengthened at the Community, health-facility, Sub-County, County and National levels through mechanisms such as facility audits or assessments, and development of quarterly and annual performance reports. Additionally, dissemination is a crucial aspect of the M & E process as it fosters a culture of learning and utilizing evidence in decision-making. Internally, the dissemination will contribute to organizational learning, strategic planning, and evidence-informed decision-making.

At the programmatic level, the information will facilitate program learning and the sharing of best practices. Externally, dissemination will ensure donor accountability, compliance with legal and regulatory requirements, and foster stakeholder understanding and support. This will be particularly beneficial for strengthening partnerships and collaborations. Timely reports will be produced upon validation of findings. The findings will be validated first at the county and finally at the national level. To ensure improved uptake of findings, user friendly products such as short visual synopses will be produced and disseminated using effective channels of communication. Data use involve integrating M&E with planning and performance cycles. Steps will be taken to synchronize the M&E Framework indicators with Annual Implementation Plans, and to align operational indicators in these plans with the M&E Framework.

Additionally, systems will be put in place to provide consistent feedback from the national level to the county, sub-county, health facilities, and community levels on reported data. This will ensure that all stakeholders appreciate the significance of data and understand how it is being utilized.

7.3.5 Data Quality

Data quality ensures quality of products from the M&E processes for evidence-based decision making at all levels. Data validation, cleaning and interpretation will be done.by adhering to the 6 principles of data, namely, precision, reliability, validity, integrity, completeness, and timeliness. Data quality will thus be maintained throughout the data collection and processing cycle via supportive supervision, routine data quality assessment, data reviews, and capacity building of staff. The National and County M&E teams will ensure that all programs and levels of service delivery generate and disseminate quality data to support informed decision-making.

7.4 KHSSP Evaluations

The purpose of an evaluation is to assess the significance, influence, efficiency, effectiveness, and durability of interventions, as well as the program's contribution to outcomes. It delivers trustworthy, evidence-based information to assist the nutrition sector in continuously enhancing its performance, learning, and accountability. The key evaluations for KHSSP 2023-2027 will include the Mid-Term Review (MTR), and the End-Term Review (ETR).

The Mid-Term Review (MTR) will assess the progress made during the first two years of implementation and recommend adjustments to the strategy or targets if necessary. It will encompass a subset of the targets outlined in the M&E plan, focusing mostly on r outcome indicators. The findings will be used to review overall progress on implementation of the strategies, priorities, and targets of KHSSP 2023-2027, and inform any mid-cycle adjustments.

End-Term Review (ETR) - The ETR will appraise the overall performance of KHSSP 2023-2027 and apply the lessons learned to shape the subsequent KHSSP, while also evaluating the sector's final accomplishments against the planned objectives. It will involve a comprehensive analysis of progress and performance throughout the entire duration of the plan.

The evaluations (MTR and ETR) will be structured to leverage multiple data sources in terms of timing and type to ascertain the overall impact of the strategy. Descriptive statistics will be employed to take stock of results and impact of the strategy. Moreover, the evaluation will include a review of policies formulated during the KHSSP 2023-2027 period to gauge the progress in implementation. To carry out these evaluations, a technical team will be constituted under the leadership of the head, M&E division; This team will be tasked with a clearly defined scope of work and will further refine the evaluation objectives, guiding questions, evaluation methodology, budget, as well as the anticipated outcomes and impact of the evaluations

7.4.1 What Will Be Evaluated

Relevance: The extent to which the interventions align with the priorities of the KHSSP 2023-2027 and the KHP 2014-2030.

Effectiveness: A measure of the extent to which the KHSSP 2023-2027 six priority objectives are achieved. These six priority objectives include:

- Eliminate Communicable Conditions
- Halt, and or reverse the rising burden of non-communicable conditions
- Reduce the burden of violence and injuries
- Minimize exposure to health risk factors
- Provide essential health services
- Strengthen collaboration with health-related sectors

Efficiency: Efficiency measures the outputs in relation to the inputs. This signifies that the KHSSP 2023-2027 implementation will use the least costly resources possible in order to achieve the desired results.

Impact: The positive and negative changes brought about by health interventions, whether direct or indirect, intentional or unintentional. This includes the primary impacts and effects resulting from the implementation of interventions on health indicators.

Sustainability: Sustainability assesses whether the benefits arising from KHSSP 2023-2027 implementation are likely to persist once external funding is withdrawn. Interventions or projects should be both environmentally and financially sustainable.

Innovations: Innovations evaluate the functionality and efficacy of innovation platforms in enhancing policy and practice, building capacity, and strengthening connections among stakeholders. The information it gathers will be used to change policies and promote larger scale changes.

7.5 Stakeholders Roles and Responsibilities

Actor	Responsibilities
Ministry of Health Division of monitoring and evaluation	• Provide overall leadership, coordination and stewardship of the M&E implementation • Resource mobilization (financial and technical) for M&E. • Develop a data analytics and utilization plan to ensure the use of reports from M&E systems and research to guide programme interventions, policies and budgets and routine decision making • Preparation of national performance reports • Formulation of HIS/M&E guidelines and policies and supporting counties to implement them • Building strong institutional collaboration/relationships critical for the success of M&E
The County Government	• Establish and equip strong Monitoring and Evaluation (M&E) units in alignment with their respective departmental structures. • Assemble a dedicated staff team comprising a comprehensive mix of M&E professionals required for implementing this scope, including M&E officers, HRIOs, statisticians, planners, economists, and epidemiologists. • This team will be responsible for coordinating and supervising the implementation of all M&E activities at the county, subcounty, and facility levels.
Development partners	• Provide significant technical and financial support to ensure functional systems. • Align their reporting requirements and formats with the indicators outlined in the M&E framework. • Coordinate efforts with existing development partners and stakeholders based on an agreed-upon country-level M&E system. • Utilize reports for decision-making, advocacy, and engaging with other partners for resource mobilization.
Health Facilities	• Collect data • Generate reports and disseminate for use by the implementers to monitor trends in supply of basic inputs, routine activities, and progress made to make regular adjustments and informed decisions about the program • Use data and reports generated to inform decision making
Community Health Units	• Identify and notify to the health personnel including the community health promoters of all health and demographic events E that occurs in the community

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LIST OF CONTRIBUTORS

MINISTRY OF HEALTH

S/NO.	PARTICIPANT NAME	INSTITUTION	DUTY STATION
1.	Stephen Macharia	MOH	Headquarters
2.	Dickson Sikuku	MOH	Headquarters
3.	Dr David Soti	MOH	Headquarters
4.	Dr David Njuguna	MOH	Headquarters
5.	Agatha Savini	MOH	Headquarters
6.	Agnes Kithinji	MOH	Headquarters
7.	Aiban Ronoh	MOH	Headquarters
8.	Amos Oyoko	MOH	Headquarters
9.	Anitha Kiptum	MOH	Headquarters
10.	Anne Marimbet	MOH	Headquarters
11.	Annet Simayo	MOH	Headquarters
12.	Anthony Komen	MOH	Headquarters
13.	Beryl Olilo	MOH	Headquarters
14.	Branice Kisali	MOH	Headquarters
15.	Brendah Obura	MOH	Headquarters
16.	Brian Kimathi	MOH	Headquarters
17.	Christopher Munyinyi	MOH	Headquarters
18.	Cyril Keah	MOH	Headquarters
19.	Daniel Otieno	MOH	Headquarters
20.	Denis Osiago	MOH	Headquarters
21.	Dr Beatrice Machini	MOH	Headquarters
22.	Dr Benard Wambu	MOH	Headquarters
23.	Dr Boniface Kimuyu	MOH	Headquarters
24.	Dr Christine Wambugu	MOH	Headquarters
25.	Dr Dipti Bhausar	MOH	Headquarters
26.	Dr Elizabeth Wangia	MOH	Headquarters
27.	Dr Esther Muinga	MOH	Headquarters
28.	Dr Evelynn Chege	MOH	Headquarters
29.	Dr Gladwell Gathecha	MOH	Headquarters
30.	Dr Hannah Kagiri	MOH	Headquarters
31.	Dr Helen Kiarie	MOH	Headquarters
32.	Dr Janette Karimi	MOH	Headquarters
33.	Dr Jonah Maina	MOH	Headquarters
34.	Dr Juliet Omwoha	MOH	Headquarters
35.	Dr Keziah Njonjo	MOH	Headquarters
36.	Dr Lilly Nyaga	MOH	Headquarters
37.	Dr Maureen Kimani	MOH	Headquarters
38.	Dr Mercy Kimani	MOH	Headquarters
39.	Dr Nazila Ganatra	MOH	Headquarters
40.	Dr Rachael Githiomi	MOH	Headquarters
41.	Dr Robert Owino	MOH	Headquarters

S/NO.	PARTICIPANT NAME	INSTITUTION	DUTY STATION
42.	Dr Rose Wafula	MOH	Headquarters
43.	Dr Stephen Muleshe	MOH	Headquarters
44.	Dr Stephen Mutiso	MOH	Headquarters
45.	Dr Stephen Njuguna	MOH	Headquarters
46.	Dr Thomas Gachuki	MOH	Headquarters
47.	Dr Tracey John	MOH	Headquarters
48.	Dr Tracy Njonjo	MOH	Headquarters
49.	Dr Wycliff Omondi	MOH	Headquarters
50.	Dr. Jacqueline Kisia	MOH	Headquarters
51.	Dr. Peter Mbugua	MOH	Headquarters
52.	Elizabeth Wainaina	MOH	Headquarters
53.	Elizabeth Wayua	MOH	Headquarters
54.	Elvis Kirui	MOH	Headquarters
55.	Emmanuel Kibet	MOH	Headquarters
56.	Eng Martin Owino	MOH	Headquarters
57.	Esther Kathini	MOH	Headquarters
58.	Faith Kaingu	MOH	Headquarters
59.	Francis Ondicho Motiri	MOH	Headquarters
60.	Fredrick Omiah	MOH	Headquarters
61.	Gamaliel Omondi	MOH	Headquarters
62.	Geoffrey M. Kebaki	MOH	Headquarters
63.	Grace Tarbei	MOH	Headquarters
64.	Henry Onyiego	MOH	Headquarters
65.	Jane Nyakio	MOH	Headquarters
66.	Japheth Athanasio	MOH	Headquarters
67.	Lance Dudah	MOH	Headquarters
68.	Lenson Kariuki	MOH	Headquarters
69.	Leonard Kimtai	MOH	Headquarters
70.	Lucy Mwangi	MOH	Headquarters
71.	Lucy W Maina	MOH	Headquarters
72.	Majid Mohamed	MOH	Headquarters
73.	Marcyline Mokua	MOH	Headquarters
74.	Mary Mwangangi	MOH	Headquarters
75.	Maureen Kang'ee	MOH	Headquarters
76.	Max Mutuku	MOH	Headquarters
77.	Mercy Irene Kimani	MOH	Headquarters
78.	Merina Lekorere	MOH	Headquarters
79.	Milka Kubai	MOH	Headquarters
80.	Mohamed Dawe Chute	MOH	Headquarters
81.	Moses Juma	MOH	Headquarters
82.	Naomi Mutie	MOH	Headquarters
83.	Nathaniel N. Mulekwa	MOH	Headquarters
84.	Ngotho Nyathira	MOH	Headquarters
85.	Nicholas Nyamweya	MOH	Headquarters

S/NO.	PARTICIPANT NAME	INSTITUTION	DUTY STATION
86.	Ongaki Dominic	MOH	Headquarters
87.	Penny Muange	MOH	Headquarters
88.	Priscilla Nyambura	MOH	Headquarters
89.	Rasma Mwachupa	MOH	Headquarters
90.	Robert Mwaura	MOH	Headquarters
91.	Robina Mwenesi	MOH	Headquarters
92.	Rose Muthee	MOH	Headquarters
93.	Samuel Cheburet	MOH	Headquarters
94.	Samuel Mwangi	MOH	Headquarters
95.	Samuel N. Kariuki	MOH	Headquarters
96.	Sharon Gisore	MOH	Headquarters
97.	Stella Wanja	MOH	Headquarters
98.	Stephen Bitok	MOH	Headquarters
99.	Stephen Kaboro	MOH	Headquarters
100.	Stephen Khaemba	MOH	Headquarters
101.	Tecla Kogo	MOH	Headquarters
102.	Terry Chelimo	MOH	Headquarters
103.	Terry Watiri	MOH	Headquarters
104.	Victor Mugendi	MOH	Headquarters
105.	Winfred Wanjiku	MOH	Headquarters
106.	Wycliffe Wanyang	MOH	Headquarters
107.	Zachary Ndegwa	MOH	Headquarters

SAGA AND REGULATORY BODIES

S/N	NAME OF PARTICIPANT	ORGANIZATION
1)	Amos K.O. Ragang	HRIM BOARD
2)	Bosben Kibet	KNRA
3)	Carol Langat	KNH
4)	Daniel Kimondo	KUTRRH
5)	Dr Daniel Mulinge	SHA
6)	Dr Murugi Micheni	NSDCC
7)	Dr. Cecilia Wanjala	BIOVAX
8)	Dr. Matthew Ngwena	NQCL
9)	Dr. Philip Melly	KEMRI
10)	Dr. Stella Kanja	KMPDC
11)	Dr. Onyimbo Kerama	KUTRRH
12)	Florence Bongei	KEMRI
13)	Hillary Barmasai	KTTA
14)	Hope Kwena	NQCL
15)	Jillani Ngalla	KIPRE
16)	John Anyira	KMTC
17)	John Mwihia	KNPHI

S/N	NAME OF PARTICIPANT	ORGANIZATION
18)	Judy Sirima	PPB
19)	Kelvin Okile	NCK
20)	Muthoni Karanja	KHHRAC
21)	Nancy Maiyo	KEMSA
22)	Nancy Thuita	NHIF
23)	Nick Kiptanui	KTTA
24)	Ruth Muia	NCI
25)	Sophie Ngugi	KHPOA
26)	Stanley Kulei	MTRH
27)	Stella Nyabange	KIPRE
28)	Thomas Maera	PHOTC
29)	Vincent Chagara	KNH

COG

S/N	NAME OF PARTICIPANT	COUNTY	ORGANISATION
1	Dr. Emmanuel Hillary Wamalwa	Nairobi	CoG
3	Mebor Abour	Nairobi	CoG
2	Peris Njibu	Nairobi	CoG

CECm

S/N	NAME OF PARTICIPANT	COUNTY	ORGANISATION
7	Alex Lechinka Kilowua	Kajiado	Health
3	Andrew Wamalwa	Bungoma	Bungoma County
18	Anthony Namunkuk	Narok	Narok county
4	Beatrice Nakholi	Busia	Busia County
8	Brenda Bill Bii	Kericho	Kericho County
24	Claire Parklea	W. Pokot	West Pokot County
5	Dr. Ndwiga Benson	Embu	Embu County
13	Dr. George Mungania	Meru	Meru County
22	Dr. Gichuyia M'riara	Tharaka Nithi	CEC Member of Health
2	Dr. Joseph K. Sitonik	Bomet	Bomet County
10	Dr. Mbarak Mohamed	Lamu	Lamu County
20	Dr. Nassir Lekudere	Samburu	Samburu County
19	Dr. Ombati T. Mokua	Nyamira	Nyamira County
12	Dr. Paul Musila	Makueni	Makueni County
23	Dr. Pepela Wanjala	Trans Nzoia	Trans Nzoia
17	Dr. Philemon Bureti	Nandi	Nandi County
1	Dr. Solomon Sirma	Baringo	Baringo County
15	Dr. Swabah A. Omar	Mombasa	Mombasa County
6	Hon. James Lowasa	Isiolo	Isiolo County
14	Hon. Julius N Awuor	Migori	Migori County

S/N	NAME OF PARTICIPANT	COUNTY	ORGANISATION
16	Jacqueline Osoro	Nakuru	Health
21	Joshua Jara	Tana River	Tana River County
11	Julius Kasanga	Machakos	Machakos County
9	Leah Ogega	Kisii	Health

CDOH

S/N	NAME OF PARTICIPANT	COUNTY	ORGANISATION
1.	Abubakar Baasba	COH-Lamu	DOH
2.	Aden Hussein	Garissa	Garissa County
3.	Augustine Lkeitan	Samburu	MoH
4.	Biwot Kevin	Elgeyo Marakwet	MoH
5.	David Kiuluku	Makueni	MoH
6.	Dr. Boru Ali	Marsabit	MoH
7.	Dr. Caro Ngunu	Nairobi	MoH
8.	Dr. Chepkwony Richard	Nandi	MoH-County
9.	Dr. Esborne Gakuo	Kirinyaga	CG-Kirinyaga
10.	Dr. Eunice Fwaya	Siaya	MoH
11.	Dr. Festus Kigen	Busia	MoH/GCB
12.	Dr. Francis K. Kiio	Narok	MoH
13.	Dr. Geofrey Nyambuti	Nyamira	MoH
14.	Dr. Induswe Benjamin	Vihiga	MoH
15.	Dr. Kigen Taabukk	Kericho	MoH-County
16.	Dr. Kokwo Solomon	West Pokot	MoH
17.	Dr. Koome Muthuri	Meru	CG-Meru
18.	Dr. Lucina Koyio	Nairobi	MoH
19.	Dr. Nyachae Micheal	Migori	MoH
20.	Dr. Onkware Richard	Kisii	MoH
21.	Dr. Philip Kamau	Baringo	MoH
22.	Dr. Ronald Kibet	Bomet	MoH
23.	Dr. Sarah J. Kipkulei	Uasin Gishu	MoH
24.	Dr. Sharon Mweni	Machakos	MoH
25.	Dr. Wainaina Daniel	Nakuru	MoH
26.	Dr. Waringa Vincent	Homabay	CG-Homabay
27.	Dr. Wayambisi Caleb	Bungoma	MoH
28.	Elvis Mwandawiro Mbatia	Taita Taveta	CDoH
29.	John M. Mbogo	Tharaka Nithi	Health
30.	Martha Mwathi	Nyandarua	MoH
31.	Oscar Okong'o	Tana River	MoH
32.	Paul Ngari	Embu	MoH
33.	Samson Saigilu	Kajiado	MoH
34.	Stephen Musyoka	Kiambu	Kiambu County
35.	Tom Alunga	Kisumu	MoH-Kisumu
36.	Zaietuni A. Mulaa	Trans Nzoia	MoH

PARTNERS

S/N	NAME OF PARTICIPANT	ORGANISATION
1.	Dr Cosmas Otieno	WHO
2.	Anabay Mamo	WHO
3.	Ann Simiyu	WHO
4.	Dr Mona Al-Mudhwahi	WHO
5.	Dr Valerie Obare	USAID
6.	Peter Waithaka	USAID
7.	Wairimu Gakuo	USAID
8.	Washington Omwamo	USAID
9.	Camlus Odhus	UNICEF
10.	Jimmy Kariuki	UNICEF
11.	Sicily Matu	UNICEF
12.	Charity Koronya	UNFPA
13.	Dan Okoro	UNFPA
14.	Zipporah Gathiti	UNFPA
15.	Elijah Kinyangi	JICA
16.	Sharon Musakali	HENNET
17.	Esther Olan	GFF
18.	Kipruto Chesang	CDC
19.	Deborah Ikhonge	AMREF
20.	Vayonda Ongaya	AMREF

CONSULTANTS

S/N	NAME OF PARTICIPANTS	ORGANISATION
1.	Dr Caroline Kawila	FHEM
2.	Easter Olwanda	FHEM
3.	Ednah Mwangi	FHEM
4.	Wesley Rotich	FHEM

ANNEX 1: M&E INDICATORS

Expected Results (Impact) Indicators and Targets

Expected Result (Impact)	Indicators	Targets						Data Source
Mortality by age and sex	**Indicators**	**Baseline 2022/23**	**2023/24**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	
Increase the overall life expectancy by 5 years	Life expectancy at birth	66			69		71	KDHS
Increase the overall healthy life expectancy by 5 years	Healthy Life Expectancy (HALE)	63			64		66	Global Health Observatory
Reduction of under 5 mortality rates by 27%	Under Five Mortality Rate	41			33		30	KDHS
Reduction of infant mortality rate by 31%	Infant Mortality Rate	32			27		22	KDHS
Reduction of neonatal mortality rate by 29%	Neonatal mortality rate	21			17		15	KDHS
Reduction in still-birth Rate by 17%	Stillbirth rate	15			13.5		12.5	KDHS
Mortality by cause								
Reduction of maternal mortality ratio (per 100,000 live births) by 51%	Maternal Mortality Ratio (MMR)	355			247		175	KDHS/Census/RAMOS
Reduce perinatal deaths by 47%	Perinatal mortality rate	32			23		17	KDHS
Reduction in AIDS related Deaths by 35%	Number of AIDS related Deaths	18473			14295		12000	KENPHIA/ Annual HIV estimates
Reduction in deaths from TB by 41%	TB mortality rate	32			23		19	KHIS Tracker/WHO estimates
Reduction of Malaria Mortality Rate by 91%	Total malaria deaths (per 100,000 persons per year)	1.08			0.5		0.1	KHIS Tracker
Proportion of deaths due to NCDs (Cardiovascular, Cancer, Diabetes, Chronic Respiratory Diseases) by 31%	NCDs Mortality Rate	39			30		27	KHIS Trackers/ GBD and WHO NCD progress monitor
Reduction of deaths due to NCDs by 33%	Probability of premature mortality from NCDs	21			17		14	WHO progress monitor
Reduction of cancer mortality rate by 11%	Cancer mortality rate (deaths per 100,000)	103			96		92	National cancer Registry, Global Cancer Observatory
Increase 5-year survival for childhood cancers by 150%	Childhood cancer five-year survival rate	20%			40%		50%	National cancer Registry

Expected Result (Impact)	Indicators	Targets						Data Source
Reduction of mortality due to road traffic injuries by 44%	Deaths due to road traffic injuries per 100,000 population	8			5.3		4.4	NTSA
Reduce mortality due to dietary risk factors by 7%	Mortality attributable to dietary risk factors (per 100,000)	28			25		26	IHME/ KNAP
Morbidity								
HIV Prevalence	HIV prevalence	3.7%			3.7		4	HIV Estimates/KENPHIA
Reduce HIV Incidence by 33%	HIV incidence rate (%)	0.598			0.4		0.4	HIV estimates/KENPHIA/KHIS
Reduction in prevalence of diabetes by 28%	Diabetes prevalence rate (per 100,000)	3.6			2.8		2.6	STEPS
Prevalence of hypertension	Hypertension prevalence rate (per 100,000)	23.8			24		25	
Reduce MTCT rate by 100%	PMTCT rate	8.6			3		0	HIV Estimates
Reduce TB Incidence by 17%	TB incidence rate per 100,000 population	237			230		196	WHO estimates/KHIS tracker
Reduction in Malaria Incidence among the population at Risk by 80%	Total malaria cases (per 1,000 persons per year)	105.2	73.8	58	42.2	31.6	21.1	KHIS
Malaria Prevalence	Malaria prevalence rate	6	-	-	5	-	-	KMIS
Risk factors								
Reduction of stunting in children by 20%	Prevalence of stunting amongst under 5 children	18			16		14.4	KDHS
Reduce the prevalence of underweight among children under 5 years by 30%	Prevalence of underweight amongst under 5 children	10			8.5		7	KDHS
Increase the exclusive breastfeeding rate by 8 %	Exclusive breastfeeding rate (0-6 months)	60			63		65	KDHS
Reduce harmful use of alcohol by 17%	Prevalence of harmful use of alcohol	12.7			11.5		10.5	STEPS
Reduction of tobacco use by 28%	Prevalence of current tobacco use in persons 15+ years	13			9.7		9.3	STEPS

Expected Result (Impact)	Indicators	Targets						Data Source
Reduce the suicide rate by 56%	Age standardized suicide rate (%) per 100,000	5			2.8		2.2	WHO progress monitor
Reduce early child marriages by 99%	Proportion of women aged (25-49) married by age 18	15			6		0.15	KDHS
Reduction of Female Genital Mutilation/Cutting Incidence by 33%	Prevalence of FGM among women 15-49 years	15			12		10	KDHS
Reduction in Physical and/or Sexual Based Violence prevalence rate by 22%	Physical and/or Sexual Violence prevalence rate in the last 12 months	41			35		32	KDHS
Fertility								
Reduce teenage pregnancy rate by 20 %	Teenage pregnancy rate	15			13		12	KDHS
Reduction of total fertility rate by 12%	Total fertility rate	3.4			3.1		3	KDHS
Financial Risk Protection								
Reduction in population incurring catastrophic health expenditures by 40%	% of population incurring catastrophic health expenditures	6.20%			4.71%		3.72%	KHHEUS
Reduction of out-of-pocket expenditure on health as a share of total health expenditure by 38%	Out-of-pocket expenditure on health (%) as a share of total health expenditure	24.30%			18.72%		15.00%	KHHEUS
Ensure healthy lives and promote well-being for all at all ages*	UHC Service Coverage Index for essential health services	75			81		85	HHFA/QOC

* The UHC Service coverage index includes the following indicators: Percentage of women of reproductive age receiving family planning services (using FP methods); percentage of infants receiving three doses of Penta (containing vaccine (HIB/Hib/DPT3); percentage of pregnant women who completed four or more ANC visits; percentage of skilled deliveries conducted in Health facilities; percentage of Children under five with diarrhoea treated with ORS & Zinc; TB treatment success rate (all forms of TB) ; proportion of HIV positive pregnant women who are currently on ART; percentage of women aged 15–49 years screened for cervical cancer; Diabetes incidence rate (per 100,000 OPD cases); and Hypertension incidence rate (per 100,000 OPD cases). A score is calculated for each indicator as 1 - ((end term target - current performance) / end term target). The score for the composite index is the average of all indicator scores.

Indicators by Strategic Objectives

Strategic Objective 1: Accelerate Reduction of the Burden of Communicable Diseases

Table 2: Accelerate reduction of the burden of communicable diseases	**Baseline**	**Targets**					**Data Source**
Indicator	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	
Proportion of under 1 year receiving DPT/ Hep+HiB1	87.8	90	92	93	94	95	KHIS
Proportion of under 1 year receiving DPT/ Hep+HiB3	84	87	90	91	92	93	KHIS
Proportion of under 1 year receiving vaccine against Measles and Rubella 1	84.2	85	86	86	87	90	KHIS
Proportion of under two years receiving vaccine against Measles and Rubella 2	59.7	65	74	78	80	82	KHIS
Proportion of 10-year-old girls receiving dose one of HPV Vaccine	33	40	55	60	70	80	KHIS
Proportion of 10-year-old girls receiving dose two of HPV Vaccine	27	35	40	45	50	60	KHIS
Proportion of under 1 year receiving IPV	84.7	90	90	90	90	90	KHIS
TB treatment success rate (all forms of TB) (%)	85	88	90	92	94	95	TIBU
TB Treatment Coverage	69	72	75	78	60	80	TIBU
TB case notification rate (per 100,000 Population)	179	185	185	179	168	156	TIBU
Proportion of HIV positive pregnant women who are currently on ART	90	95	97	98	100	100	KHIS
Antiretroviral therapy coverage (Adults)	97	99	99	99	99	99	KHIS
Antiretroviral therapy coverage (Children)	80	85	90	95	95	95	KHIS
Viral load suppression (adults)	91	92	98	98	99	100	EID/Database
Viral load suppression (children)	61	70	74	80	95	95	EID/VL Database
Advanced HIV disease screening (newly initiated on ART/RTT/CTF)	61	70	80	90	95	100	NDWH
Children under five with diarrhoea treated with ORS & Zinc (%)	55.3	60%	65%	70%	75%	80%	KHIS/KDHS
Total confirmed malaria cases [per 1,000 persons per year]	105	73.8	58	42.2	31.6	21.1	KHIS
Proportion of pregnant women in malaria-endemic areas who slept under LLIN	98	70	75	80	85	90	KDHS/ KMIS/PMLLIN
Proportion of children in malaria-endemic areas who slept under LLIN	51	75	78	80	85	90	KDHS/ KMIS/PMLLIN
Proportion of households with universal coverage of LLINs in malaria risk areas	48%	80%	70%	60%	80%	70%	KDHS/KMIS
Proportion of eligible women and adolescents who receive 3 or more doses of IPTp -SP	48%	54%	61%	67%	74%	80%	KHIS / KMIS
Proportion of suspected malaria cases presenting to public health facilities tested with mRDT or microscopy	89%	100%	100%	100%	100%	100%	KHIS
Proportion of people living with HIV receiving nutrition assessment,							

Table 2: Accelerate reduction of the burden of communicable diseases	Baseline	Targets					Data Source
counselling and support	50	55	60	65	70	0.75	KHIS
Proportion of people on TB treatment receiving nutrition assessment,							
counselling and support	50	55	60	65	70	0.75	KHIS
Proportion of travellers screened for notifiable diseases at all points of entry	77	79	81	83	85	100	POES Monthly report
Proportion of conveyances disinfected and/ or issued with certificates	84	85	86	87	88	100	POES Monthly report
Proportion of designated health facilities providing travel related vaccination services	70	75	80	85	90	100	POES Monthly report

Strategic Objective 2: Halt and Reverse the Burden of Non-Communicable Conditions

Indicators	Baseline	Targets					Data Source
	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	
Incidence of hypertension per 100,000 OPD Cases	2, 784	2645	2513	2387	2268	2154	KHIS
Incidence of diabetes per 100,000 OPD Cases	1,158	1100	1045	993	943	896	KHIS
Proportion of persons living with hypertension achieving control (<140/90)	59%	62%	66%	70%	75%	80%	KHIS
Proportion of people screened for hypertension at the community who are successfully linked to care	18%	23%	28%	33%	38%	45%	KHIS and SPICE
Proportion of adults (18-69 years) with raised blood glucose and currently on medication for diabetes	1.9	1.9	1.85	1.8	1.75	1.7	STEPS
Proportion of persons living with diabetes achieving control (HbaIC <7)	53%	58%	65%	70%	75%	80%	KHIS
The proportion of health facilities that have capacity to offer cardiovascular disease services (readiness)	55	73	75	85	90	95	KHFA/QOC
Proportion of outpatient clients with mental health conditions	-	-	25%	23%	21%	19%	KHIS
Percentage of women aged 25–49 years screened for cervical cancer							
30.9	30	45	50	55	60	KHIS	
Proportion of cancers diagnosed in early stages	-	35%	40%	45%	50%	60%	National cancer Registry
Number of days from diagnosis to initiation of cancer treatment	-	100	90	80	70	60	National cancer Registry
Proportion of women 25- 74 years undergoing clinical breast examination	-	10%	15%	30%	50%	70%	KHIS

Indicators	Baseline	Targets					Data Source
Age-standardized prevalence of raised blood pressure among adults aged 18+ (Hypertension)	-	30	28	26	24	22	STEPS and WHO
Prevalence of dental caries in adults	0.343			0.2575		0.193	Kenya Oral Health Survey
Prevalence of dental fluorosis among children	0.414			0.3105		0.233	Kenya Oral Health Survey

Strategic Objective 3: Reduce the Burden of Violence and Injuries

Table 4: Reduce the burden of violence and injuries	Targets					Data Source
Indicator	2023/24	2024/25	2025/26	2026/27	2027/28	
Road traffic injuries, per 1,000 OPD visits	2.2	2.1	2.0	1.9	1.8	KHIS
Number of SGBV survivors seen	3833	3200	2700	2500	2300	KHIS
Proportion of SBGV survivors presenting to facility within 72 hours	59	64	69	75	80	KHIS
Percentage of women aged 15-49 years who experienced gender-based violence	32	27	22	17	12	KHIS
Number of snake bites cases seen in OPD	17,567	15810	14229	12806	11526	KHIS
Number of dog bites cases seen in OPD	66,439	59795	53816	48434	43591	KHIS

Strategic Objective 4: Improve Persons Centred Essential Health Services

Indicator	Baseline	2023/24	2024/25	2025/26	2026/27	2027/28	Data source
Proportion of hospitals providing CEmONC services (public, private, primary, secondary & Tertiary)	16.2	23	30	37	44	50	HHFA/ QOC
Percentage of Pregnant women who completed 8 ANC contacts	4	8	12	16	20	24	KHIS
Percentage of Low birth weight in health facilities	6	6	5	4	4	4	KHIS
Proportion of children under five years whose developmental milestones are on track.	78%	79%	80%	81%	82%	83	KHIS
Proportion of children under five with diarrhoea treated with Zinc/ORS combined (Copack) in the facility	32%	35%	40%	45%	50%	55%	KHIS
Proportion of children under five with diarrhoea treated with Zinc/ORS Copack in the community	85%	87	88%	90%	91%	91%	KHIS
proportion of children under 5 years with pneumonia treated with amoxicillin DT(Facility)	58%	60%	65%	70%	75%	80%	KHIS/ KDHS
Proportion of Low birth weight /preterm babies put on Kangaroo Mother Care	60%	65%	68%	70%	73%	75%	KHIS/ KDHS

Indicator	Baseline	2023/24	2024/25	2025/26	2026/27	2027/28	Data source
Proportion of newborns applied chlorhexidine for umbilical cord care at birth	72%	73%	74%	75%	76%	80%	KHIS
Proportion of skilled Deliveries conducted in Health facilities	73	74	75	76	77	78	KHIS
Modern Contraceptives prevalence rate (mCPR) all women)	57	58	59	60	61	62	KDHS
% of women of reproductive age (cMWRA) with unmet needs for family planning	14	13.5	13	12.5	12	11.5	KDHS
Fresh stillbirth rate per 1,000 births in facilities	10.6Percentage of Low birth weight in health facilities	6	6	6	6	5	5
Number of maternal deaths in health facilities per 100,000 deliveries	90	87	84	81	78	75	KHIS
(%) maternal Deaths Audited	93	94.4	95.8	97.2	98.6	100	KHIS
Caesarean Birth rate (%)	17	17	15	14	13	12	KHIS
Proportion of facilities providing oral health services	13	13	18	25	35	50	Health Facility Census report, KHIS
The proportion of discharges from Outpatient Therapeutic Program (OTP) who have recovered. [6-59 months with Severe Acute Malnutrition (SAM) on treatment -OTP Cure rates]	82	82	82	83	83	84	KHIS
Proportion of facilities complying with the inpatient feeding guidelines	ND	ND	ND	60	80	100	MOH/ Clinical nutrition program reports
Proportion of pregnant women attending ANC who received combined iron and folate supplements	75	75	78	80	82	82	KHIS
Proportion of new ANC clients with low Hb <11mg/dl	25	23	22	20	18	15	KHIS
Proportion of brands of maize flour compliant to fortification standards	46	48	50	52	53	55	MoH-DND Industrial Survey reports
Proportion of facilities offering adolescent and youth friendly services	62	70	78		85	90	KAHS/ KDHS
Proportion of adolescent 10-19 years of age equipped with knowledge for decision making participation in the implementation of health intervention (disaggregated be age 10-14,15-19 and sex)	30	45	60		70	80	KAHS
Proportion of adolescents (10-19) reached with key health messages on prevention and management	30	45	55		65	80	KAHS

Indicator	Baseline	2023/24	2024/25	2025/26	2026/27	2027/28	Data source
Proportion of facilities providing Ear and Hearing care services	-	-	20%	30%	40%	50%	Health Facility Census reports, KHIS
Schistosomiasis MDA Treatment coverage in endemic sub-counties (%)	60	75	85	100	100	100	Programme reports, historical and current epidemiological analyses
Soil Transmitted Helminths MDA Treatment coverage in endemic sub-counties (%)	75	90	95	100	100	100	Survey Reports
Trachoma MDA Treatment coverage in endemic sub-counties (%)	80	85	90	100	100	100	Survey Reports
Proportion of Villages certified as open defecation free	30	37	49	55	60	65	KRTMS-CLTS
Proportion of health facilities implementing occupational health and safety standards	25	30	40	50	60	80	Program reports/surveys /KHIS
Number of hospitals with waste treatment equipment that is compliant to climate change and health requirements	16	20	40	55	60	65	Program report/Surveys/KHIS

Strategic Objective 5: Minimize Exposure to Health Risk Factors

Indicator	Baseline	2023/24	2024/25	2025/26	2026/27	2027/28	Data Source
Proportion of children 6-59 months supplemented with Two doses of Vitamin A	83.7	84	84	84	84	85	KDHS/KHIS
Proportion of children 6–23 months achieving Minimum Dietary Diversity	39	40	42	43	45	50	KDHS/KHIS
Proportion of the Adult population consuming 5 servings of fruit and vegetable per day	6	10	15	20	25	35	STEPS survey
Prevalence of raised total cholesterol in adults	13.30%	13.30%	11%	9%	7%	5%	STEPS
Prevalence of overweight and obesity among adults aged 18+ (%)	27.9	28	28.2	28.4	28.6	28.8	STEPS
Percentage of population with low level of total physical activity	6.50%	6.5%	6.3%	6.1%	5.9%	5.8%	STEPS
Prevalence of current tobacco use among adults (%)	13.3			11		9.7	STEPS
Prevalence of harmful use of alcohol(%)	12.7			11.5		10.5	STEPS
Prevalence of physical violence among women	16			14		10	KDHS
Percentage of women who have experienced intimate or sexual violence	7			5		2	KDHS
Percentage of households using improved sanitation facilities	41	48	55	62	69	76	KDHS

Indicator	Baseline	2023/24	2024/25	2025/26	2026/27	2027/28	Data Source
Percentage of households using improved safe water facilities	68	71	74	77	80	83	KDHS

Strategic Objective 6: Strengthen Collaboration with Health-Related Sectors

Indicator	Baseline	2023/24	2024/25	2025/26	2026/27	2027/28	Data Source
Percentage of households using improved sanitation facilities	41	48	55	62	69	76	KDHS
Percentage of households using improved safe water facilities	68	71	74	77	80	83	KDHS
Percentage of Health facilities with access to a reliable Power source	89	93	94	96	98	100	Health facility Census
Percentage of Health facilities with access to reliable water source	ND	83	88	93	97	100	Health facility Census
Percentage of facilities with an electronic health information system(any form)	ND	31	70	80	90	100	Health facility Census
Percentage of women completed secondary education	12.9	-	-	20	-	40	KDHS
Proportion of health facilities with access to a road all year round	84	87	94	96	98	100	Health facility Census
Number of workplaces/organizations established with lactation spaces	10	10	15	30	40	300	MoH/DND program reports
Proportion of school going children dewormed	84.7		100	100	100	100	KHIS
Number of community health promoters trained on Household Air pollution (HAP)	2668	20000	20000	20000	30000	18000	Program report/KHIS
Proportion of households using clean fuels and technologies as the main source of heating and cooking	21	23	25	27	29	30	KDHS
Reduction of ambient concentration of air pollutants from industrial/ power plants in urban areas (Pm 2.5 ug/m3)	13	12	11	10	9	8	WHO air quality database
Total number of dialogue days held	43237	43500	44000	45000	46000	47000	KHIS
Total number of community action days conducted	50864	53400	60000	65000	70000	80000	KHIS

Improving Access to Services and Demand of Care

Indicator	Baseline	2023/24	2024/25	2025/26	2026/27	2027/28	Data source
Service Availability and Readiness Index	-	85		90		95	HHFA/QOC
OPD per capita utilization rate	1.56	1.43	2	3	4	5	KHIS
% Bed occupancy	65.3	70	75	80	85	85	KHIS
% of health facilities with availability of tracer essential medicines	62	62	70	80	90	100	HFFA/QOC
Availability to specialized health care in management of NCDs (Mental, Cancer, Diabetes and Cardiovascular Diseases)	45	50	55	60	65	70	HHFA/QOC

Indicator	Baseline	2023/24	2024/25	2025/26	2026/27	2027/28	Data source
Percentage of delivery facilities providing all 7 Basic Emergency Obstetric Care (BEmONC) services	55%	74.20%	79.20%	84.60%	89.80%	100%	KHFA/QOC
Proportion of hospitals providing CEmONC services (public, private, primary, secondary & Tertiary)	16	23	30	37	44	50	KHFA/QOC
Caesarean section rate (%)	17	16	15	13	12	12	KHIS
Average distance to Nearest Health Facility(Km)	8	5	5	5	5	5	KNBS
Core Health Worker density per 10,000 Population (Nurses, Doctors, RCOs	26	28.1	30.5	33	35.8	38.9	HHFA/QOC/HLMA
Number of Doctors per population ratio (per 10,000 population)	1.82	2	2.1	2.3	2.5	2.7	Economic Survey/MOH
Number of Nurses per population ratio (per 10,000 population)	20.7	22.4	24.4	26.3	28.5	31	Economic Survey/MOH
Inpatient beds per capita, relative to a maximum threshold of 18 per 10,000 population	21	20	15	16	17	18	Health Facility Census
% of persons enrolled into an insurance scheme	26	70	72	73	74	75	NHIF, KHHEUS, KDHS

Quality System Indicators and Targets

Indicator	Baseline	2023/24	2024/25	2025/26	2026/27	2027/28	Data source
Average length of stay (ALOS)-medical ward	3.1	3	3	3	3	3	KHIS
Proportion of maternal deaths audited	93	95	96	97	98	100	KHIS
Proportion of neonatal deaths audited	62	68	75	80	87	100	KHIS
Facility maternal deaths per 100,000 deliveries	90.8	89	88	85	80	70	KHIS
Fresh stillbirth rate per 1,000 births in institutions	7.5	7.3	7	6.5	6	5	KHIS
ART Retention Rate	79	82	85	90	93	95	National Data warehouse
TB Treatment Success Rate	86	88	90	92	94	95	TIBU
Proportion of health facilities (level 4 and above) with surveillance system for Healthcare Associated Infections (HAIs)		65%	70%	75%	80%	85%	HHFA/QOC; MOH 749
Surgical site infection rate (Incidence rate)	25	23	20	15	12	10	Patient safety program reports/ KHIS
Client satisfaction	97	100	100	100	100	100	qoc
Proportion of healthcare workers exposed to occupational hazards in the workplace	29	35	40	50	45	60	QOC

Service delivery indicators and targets

Indicator	Baseline 2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	Data Source
Proportion of Community Health Units Established			96%	100%	100%	100%	KHIS
Proportion of Fully functional Community Units			75%	80%	85%	90%	Assessment Reports
No of community units linked to Primary Health facilities		2000	4000	6000	8000	10000	KHIS
Proportion of Healthcare facilities that provide KMC services		40	60	60	80	100	KHFA
Total Number of PCNs established		60	120	180	240	300	PCN Dashboard
Proportion of functional primary care networks (PCNs)		40	60	80	100	100	PCN Dashboard, Routine Report
Number of Smart PCNs (Digitized PCNs)		60	120	180	240	300	Digitization report
Number of PCNs with functional referral mechanisms		-	20	70	90	100	County report
Proportion of PCNs offering integrated primary health service - In reach		-	30	70	90	100	County report
Number of PCNs conducting at least 1 population based integrated intervention outreach		63	126	189	252	315	County report
Proportion of Level 2&3 facilities offering laboratory services		58	60	65	68	70	Census/ HFFA/QOC
Proportion of level 4-6 facilities offering rehabilitation services		65	70	70	80	100	Health Facility Census
Proportion of level 2 and 3 facilities offering radiology services (x-ray)		43	48	52	55	60	Health facility Census
Proportion of hospitals (level 4, 5 and 6) providing parenteral services		73	75	80	85	90	HFA/QOC
Proportion of hospitals with functional facility quality improvement team		60	70	80	90	100	HFA
Number of counties with Emergency Operations Centre (EOCs)	25	35	42	47	47	47	DDSR
Number of people screened for diabetes by CHPs			24,100,100	28,000,000	32,000,000	35,441,323	eCHIS
Number of diabetes referrals			284,000	868,000	992,000	1,098,681	eCHIS
Number of hypertension screenings done by CHPs			16,300,000	18,000,000	21,000,000	23,970,588	eCHIS
Number of people referred for hypertension by CHPs			616,000	693,000	808,000	885,000	eCHIS
Number of children <5 assessed for common illnesses			6,110,000	7,000,000	8,000,000	8,985,294	eCHIS
Number of pregnant women identified and attended to by CHPs			340,000	380,000	450,000	500,000	eCHIS

Indicator	Baseline 2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	Data Source
Number of expectant mothers referred to health facilities for ANC			133,000	150,000	180,000	195,588	eCHIS
Proportion of suspected malaria cases presenting to facilities tested with RDT or microscopy	53.7	60	70	80	90	95	KHIS
Proportion of Health facilities offering immunization services	61	66	70	74	78	82	HHFA/QOC
Proportion of facilities with capacity to provide CEmONC services	62	66	70	74	78	82	HHFA/QOC
Proportion of facilities with capacity to provide BEmONC services	70	74	78	82	86	90	HHFA/QOC
Proportion of health facilities with coordination mechanisms for quality							
improvement initiatives (QIT or CQI focal persons)		47%	50%	55%	60%	65%	HFA/QOC
Proportion of facilities meeting minimum quality and safety standards		80	85	90	95	100	HFA/QOC
Proportion of health facilities with coordination mechanisms for							
Infection Prevention and Control		62%	65%	70%	75%	80%	HFA-QoC
Proportion of health facilities (level 4 and above) with surveillance							
system for Healthcare Associated Infections (HAIs)		65%	70%	75%	80%	85%	HFA, MOH 749
Number of functional AMR One Health coordination structures at							
national and county levels of government		15	20	30	40	48	Patient Safety Unit Annual reports
Number of human microbiology laboratories collecting and reporting AMR data to the central data warehouse	20	21	22	23	24	25	Patient Safety Unit Annual reports
Percentage of hospitals (Level 4 and above) with functional antimicrobial							
stewardship (AMS) programmes		32%	40%	45%	50%	55%	Patient Safety Unit Annual reports
Proportion of clinicians who adhere to clinical guidelines in							

Indicator	Baseline 2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	Data Source
diagnosis and treatment of tracer health conditions	ND	68	100	100	100	100	HHFA/QOC
Proportion of antibiotics consumed belonging to the ACCESS category	50	55	60	65	68	70	Annual AMU/AMC reports
Hand hygiene compliance rate	50	55	60	63	65	70	KHIS
% of HC providers thar provided correct diagnosis and Correct Treatment for Uncomplicated malaria		85%	87%	89%	91%	93%	HFA
% of HC providers thar provided correct diagnosis and Correct Treatment for hypertension	ND	85	100	100	100	100	HFA
% of HC providers thar provided correct diagnosis and Correct Treatment for Post-partum haemorrhage	ND	40	100	100	100	100	HFA
% of HC providers thar provided correct diagnosis and Correct Treatment for Non severe pneumonia	ND	39	100	100	100	100	HFA
% of HC providers thar provided correct diagnosis and Correct Treatment for Birth asphyxia							HFA

Health workforce Indicators and Targets

Indicator	Baseline	2023/24	2024/25	2025/26	2026/27	2027/28	Data Source
Core Health Worker density per 10,000 Population (Nurses, Doctors, RCOs	26	28.1	30.5	33	35.8	38.9	Economic Survey/MOH
Number of Doctors per population ratio (per 10,000 population)	1.82	2	2.1	2.3	2.5	2.7	Economic Survey/MOH
Number of Nurses per population ratio (per 10,000 population)	20.7	22.4	24.4	26.3	28.5	31	Economic Survey/MOH
Density of community health volunteers (per 5 000 population)	9	9.3	9.6	9.9	10.3	10.7	KMCUL/ APRS
Number of CHPs in the country	90,637	101,070	107,134	113,562	120,376	127,599	KHIS tracker/ KMCUL
Staff attrition rate	1.70%	1.70%	1.70%	1.70%	1.70%	1.70%	HLMA
Proportion of interns placed by cadre							
Number of Intern Medical officers placed	ND	1214	1005	1055	1150	1200	iHRIS/MOH
Number of Dental officer interns placed	ND	25	45	52	80	100	iHRIS/MOH
Number of Pharmaceutical interns placed	ND	496	500	502	550	580	iHRIS/MOH
Number of Clinical officer interns placed (Diploma)	ND	1930	1683	1597	1800	1850	iHRIS/MOH
Number of Clinical officer interns placed (Degree)	ND	506	467	469	500	550	iHRIS/MOH
Number of Nursing officer interns placed	ND	874	805	1000	1300	1450	iHRIS/MOH

Indicator	Baseline	2023/24	2024/25	2025/26	2026/27	2027/28	Data Source
Proportion of level 2 facilities complying with human resource for health norms	ND	1	20	50	75	100	Health facility Census
Proportion of level 3 facilities complying with human resource for health norms	ND	2	20	50	75	100	Health facility Census
Proportion of level 4 facilities complying with human resource for health norms	ND	36	50	75	85	100	Health facility Census
Health workers satisfied with work environment	ND	71	80	85	90	95	QOC

Health Care Financing Indicators and Targets

Key Performance Indicators	Baseline (2022/23)	2023/24	2024/25	2025/26	2026/27	2027/28	Data Source
Government allocation to health as % of total government budget	7.80%	9.24%	10.68%	12.12%	13.56%	15.00%	Budget estimates, County Health Budget Analysis 9 (Revised estimates in the supplementary budget)
Government spending on health as % of total government spending	5.90%	6.92%	7.94%	8.96%	9.98%	11.00%	Audited financial reports of OAG
Government spending on health as % of Total Health Expenditure (THE)	52.30%	52.84%	53.38%	53.92%	54.46%	55.00%	National Health Accounts
Government spending on health as percentage of GDP	2.50%	2.80%	3.10%	3.40%	3.70%	4.00%	National Health Accounts
Government per capita health spending (US$)	48	55.80	63.60	71.40	79.20	87.00	National Health Accounts
Percentage of total health expenditure contributed to by donors	17.80%	16.24%	14.68%	13.12%	11.56%	10.00%	National Health Accounts
Out of pocket expenditure as % of total health expenditure	24.30%	22.44%	20.58%	18.72%	16.86%	15.00%	National Health Accounts
Percentage of population covered under any insurance	26	70	72	74	76	80	KHHEUS, KDHS
Percentage of population covered under SHA	22	66	68	70	72	76	SHA/KHHEUS
Number of counties allocating at least 30% of their health budget to development	7	47	47	47	47	47	COB Reports

Health Infrastructure Indicators and Targets

Indicator	Baseline (2022/23)	2023/24	2024/25	2025/26	2026/27	2027/28	Data Source
Expanded and improved physical infrastructure – buildings, plants, utilities, energy sources and others							
Proportion of level 2 and 3 health facilities complying with health infrastructure norms and standards	-	85	90	95	100	100	KHFA
Proportion of level 4 health facilities complying with health infrastructure norms and standards	ND	ND	100	100	100	100	KHFA
Proportion of the population within 5 km distance to a health facility	-	95	96	97	99	100	CEMA database
Percentage of health facilities implementing preventive and corrective maintenance on systems such as electrical, water, sanitation, sewerage or ventilation	81	85	90	95	100	100	QOC/KHFA
Percentage of health facilities implementing preventive and corrective maintenance on medical equipment such as Oxygen equipment, X-ray machine,	55	65	75	85	95	100	QOC/KHFA
Percentage of health facilities implementing preventive and corrective maintenance on small medical equipment such as stethoscopes	65	75	85	95	100	100	QOC/KHFA
Percentage of health facilities implementing preventive and corrective maintenance on equipment related to infrastructure such as Generator, Water pump	57	65	75	85	95	100	QOC/KHFA
Proportion of health facilities with Electronic Health management information system(any)	ND	31	70	80	90	100	Facility Census 2023
Medical equipment and devices							
Percentage of level 2 and 3 health facilities with tracer basic medical equipment*		39	46	54	64	75	Health Facility Census
Percentage of level 4 to 6 health facilities with tracer medical equipment**	N/A	40	43	46	49	52	KHFA
ICT infrastructure							
Number of health facilities end to end electronic health systems		153	1000	5000	7000	10,000	DHA/facility assessment
Percentage of health facilities with reliable internet connectivity.	31	50	70	80	90	100	DHA/facility assessment
Ambulance services							
Proportion of level II health facilities with access to a functional ambulance	65	70	80	90	100	100	QOC/KHFA
Proportion of level III health facilities with access to a functional ambulance	74	80	85	95	100	100	QOC/KHFA
Proportion of level IV health facilities with access to a functional ambulance	90	95	100	100	100	100	QOC/KHFA
Availability of disability friendly infrastructure							

Indicator	Baseline (2022/23)	2023/24	2024/25	2025/26	2026/27	2027/28	Data Source
Proportion of facilities with ramps /lifts		81.9	90	95	100	100	Health facility Census
Proportion of facilities with disability friendly washrooms		14.8	25	30	35	40	Health facility Census
Proportion of facilities with disability friendly maternity beds		6.9	25	35	45	55	Health facility Census
Proportion of facilities with wheelchairs		54.1	65	70	75	80	Health facility Census
Access and Demand for Healthcare Services							
Number of operational health facilities per 10,000 population	2.3	2.3	2.3	2.3	2.3	2.3	KHMFR/Census
Inpatient beds density (beds per 10,000 population)	26.5	26.5	29	31	35	40	KHMFR
Licenced facilities							
Number (%) of licenced health facilities	ND	100	100	100	100	100	KMPDC,COC,NCK
Number (%) of laboratories licenced	ND	100	100	100	100	100	KMLTTB
Number (%) of Pharmacies licenced	ND	100	100	100	100	100	PPB
Number (%) of Diagnostic centers licenced	ND	100	100	100	100	100	KMPDC
List tracer equipment							

Health products and Technologies Indicators and Targets

Indicator	Baseline	2023/24	2024/25	2025/26	2026/27	2027/28	Data Source
To expand current capacity for access to health care commodities							
Order fill rate of the 22 tracer medicines by quantity per item as (%) *	64	80	90	95	100	100	KEMSA
Order fill rate of the 23 tracer non-pharmaceutical commodities by quantity per item as (%) *	63	80	90	95	100	100	KEMSA
Percentage of health facilities with no stock out for any of the 22 tracer medicines for 7 consecutive days in a month*	ND	6	20	30	40	50	KHFA
Percentage of health facilities with no stock out for any of the 23 tracer medical supplies for 7 consecutive days in a month*	ND	15	25	40	45	50	KHFA
Mean availability of the 22 tracer medicines (%) *	ND	62	70	80	90	100	KHFA
Mean availability of the 23 tracer medical supplies (%) *	ND	76	80	90	100	100	KHFA
Proportion of essential HPT procured from local manufacturers (%)	20	25	30	40	50	60	KEMSA, SAGAs

Indicator	Baseline	2023/24	2024/25	2025/26	2026/27	2027/28	Data Source
% contribution of government in co-financing for public health commodities in public health programs (HIV, TB, Malaria, Nutrition, Vaccines & FP products)	10	10	100	100	100	100	MOH
To assure quality of all health commodities							
Proportion of hospitals (level 4 to 6) facilities with functional Medicines and Therapeutic Committees (MTC)	ND	61	70	80	90	100	Annual County reports (APRs) & Surveys
Proportion of health facilities with digitized HPT management systems (integrated end-to end)	ND	62	72	82	92	100	KHFA, Counties
Adequate safe and equitable supply of blood and blood products							
Proportion of safe blood available for transfusion	89	90	100	100	100	100	KTTA/KNBTS

Health Information Systems Indicators and Targets

Indicator	Baseline 2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	Data source	Frequency
Percentage of health facilities submitting timely information (timeliness of reports)	92	100	100	100	100	100	KHIS	Monthly
Percentage of community units submitting timely information (timeliness of reports)	85	100	100	100	100	100	KHIS	Monthly
Percentage of health facilities submitting complete information (completeness of reports)	95	100	100	100	100	100	KHIS	Monthly
Percentage of community units submitting complete information (completeness of reports)	85	100	100	100	100	100	KHIS	Monthly
Percentage of hospital deaths having certified cause of death	80	100	100	100	100	100	CDH KHIS	Annually
Number of counties with completed annual health performance review Reports	47	47	47	47	47	47	KHF/ reports	Yearly
Percentage of deaths (health facility and community) registered	45	50	55	60	65	70	CRVS Report	Annually
Percentage of hospitals reporting on inpatient morbidity and mortality	70	100	100	100	100	100	KHIS Tracker	Monthly
Number of counties conducting quarterly data review meeting	47	47	47	47		188	MOH/ County reports	Annually

Health research and development Indicators and Targets

Indicators	Baseline 2022/2023	2023/24	2024/25	2025/26	2026/27	2027/28	Data Source
Number of counties with operational health research and development working committees	ND	10	20	30	40	47	National and County Progress reports
Proportion of foreign-funded research outputs and innovations tracked on the research management information system	ND	10%	15%	20%	30%	50%	Progress reports
Number human resource capacity built in research-for-health	130	135	140	145	150	155	Training Reports
Number of counties with a dedicated budget for research	ND	5	10	15	20	25	Progress Reports
Number of counties with functional authorization committees for research	ND	47	47	47	47	47	County Annual Reports/ KHFA
Proportion of approved health research findings disseminated	ND	100	100	100	100	100	County Annual Reports/ KHFA

Leadership and Governance Indicators and Targets

1. Improve health system stewardship, public and social accountability at all levels	**Target**						**DATA SOURCE**
	Baseline 2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	
Number of planning units with annual work plans developed on time (30th June)*	53	54	54	54	54	54	National annual work Plan
Number of planning units with annual performance reports*	53	54	54	54	54	54	APR Report
Number of planning units conducting Annual customer satisfaction surveys	No Data	54	54	54	54	54	County APRs/PC/ KHFA
Number of planning units conducting at least one annual client, employee and work environment satisfaction surveys	No Data	54	54	54	54	54	County APRs/PC/ KHFA
Number of Intergovernmental Consultative Forum held in a reporting year	1	4	4	4	4	4	IGF Report
Number of health sector stakeholder consultative health meetings held. (Annual Health Convections)	1	1	1	1	1	1	Annual Health Convection Report
Number of new or reviewed legislation related to health	4(new)	2	2	2	2	2	MOH/ KLR (Kenya Law Reform)
Number of health policies reviewed (National MOH and National programmes)	ND						
Number of health policies developed (National MOH and National programmes)	ND						
Number of health strategies reviewed (National MOH, counties, SAGAs and National programmes)	ND	TBD	TBD	TBD	TBD	TBD	County / National records

* Planning unit -Counties & 7 national referral facilities

UHC Impact-level Indicators

Expected Result (Impact)	Indicator	Data source	Baseline	Mid Term	End Term	Freq. Data collection
Mortality by age and sex			2022/23	2025/26	2027/28	
Increase the overall life expectancy by 5 years	Life expectancy at birth	KDHS	66	69	71	5 years
Increase the overall healthy life expectancy by 5 years	Healthy Life Expectancy (HALE)	GHO				5 years
Reduction of under 5 mortality rate by 23%	Under Five Mortality Rate	KDHS	41	33	30	5 years
Reduction of infant mortality rate by 28%	Infant Mortality Rate	KDHS	32	27	22	5 years
Reduction of neonatal mortality rate by 32%	Neonatal mortality rate	KDHS	21	17	15	5 years
Reduction in still-birth Rate by 35%						
	Stillbirth rate	KDHS	15	13.5	12.5	5 years
Mortality by cause						
Reduction of maternal mortality ratio (per 100,000 live births) by 45%	Maternal Mortality Ratio (MMR)	KDHS	355	247	175	5 years
Reduction in AIDS related Deaths	Number of AIDS related Deaths		18,473	14,295	12,000	5 years
Reduction in deaths from TB by 50%	TB Mortality rate	Annual WHO Global	32	23	19	Annually
Reduction of Malaria Mortality Rate by 30%	Malaria Mortality rate	KHIS	1.08	0.5	0.1	5 years
Proportion of deaths due to NCDs (Cardiovascular, Cancer, Diabetes, Chronic Respiratory Diseases) by 64%	NCDs Mortality Rate	STEPS	39	30	27	5 years
Reduction of mortality due to road traffic injuries by 55%	Death rate due to road traffic injuries	NTSA	7.9	5.3	4	Yearly
Morbidity						
Reduce HIV Prevalence by 14%	HIV prevalence rate (%)	KENPHIA	3.7%	3.5%	4%	Yearly
Reduce HIV Incidence by 47%	HIV incidence rate (%)	KENPHIA	0.598	0.4	0.4	5 years
Reduction in prevalence of diabetes by 58%	Diabetes Disease Prevalence Rate (per 100,000)	STEPS	3.6	2.8	-	5 years
Reduce TB Incidence by 50%	TB incidence rate	WHO Global Annual Report	237	230	196	Annually
Reduction in Malaria Incidence among the population at Risk by 22%						
	Malaria incidence rate	KHIS	105.2	42.2	21.1	3 years
Fertility						

Expected Result (Impact)	Indicator	Data source	Baseline	Mid Term	End Term	Freq. Data collection
Reduce adolescent birth rate by 10%	Adolescent birth rate	KDHS	15	12	10	5 years
Reduction of total fertility rate by 21%	Total fertility rate	KDHS	3.4	3.1	3	5 years
Financial Risk Protection						
Reduction in population incurring catastrophic health expenditures by 60%	% of population incurring catastrophic health expenditures	KHHEUS	6.20%	4.71%	3.72%	5 years
Reduction of out of pocket expenditure on health as a share of total health expenditure by 52%	Out-of-pocket expenditure on health (%) as a share of total health expenditure	KHHEUS	24.30%	18.72%	15%	3 years
Ensure healthy lives and promote well-being for all at all ages	UHC Service Coverage Index of essential health services	HHFA	-	81	85	Annually

ANNEX: EHC INDICATORS

Outcome	Key performance Indicator	Frequency of data collection	Baseline	Target
Strategy 1: To improve access and coverage for ear and hearing care services in the delivery of UHC				
Readiness of EHC services	Proportion of EHC facilities equipped to offer comprehensive EHC services	Yearly	TBD(n)	n+20%
Availability of comprehensive EHC services	Proportion of facilities with available comprehensive EHC services	Yearly	TBD(n)	n+20%
Uptake of EHC services	Proportion of patients utilizing EHC services	Monthly	TBD(n)	n+20%
Strategy 2: To Integrate ear and hearing care in school health programs				
EHC school-based health coverage enhanced	Proportion of school coverage with Integrated ear and hearing care programs	Quarterly	TBD(n)	n+20%
	Proportion of school-going children with delayed speech for age	Quarterly	TBD(n)	n+20%
Strategy 3: To strengthen habilitation and rehabilitation services by leveraging on technology				
Accessibility of rehabilitative EHC services	Proportion of the population with congenital cases who accessed Cochlea habilitative services	Quarterly	TBD(n)	n+20%
Strategic4: To operationalize monitoring and evaluation mechanisms for Routine evidence-based decision-making				
Enhanced quality data collection through electronic records Management				
(Data disaggregated by age, adults, by sex,)	Proportion of health			
facilities submitting timely EHC data (%)	Quarterly	TBD(n)	n+20%	
	Proportion of newborns undergoing newborn hearing screening	Monthly	TBD(n)	n+20%
	Proportion of Population diagnosed with Acute Otitis media	Monthly	TBD(n)	n+20%
	Proportion of Population diagnosed with Chronic Otitis media	Monthly	TBD(n)	n+20%
	Proportion of Population with Impacted wax	Monthly	TBD(n)	n+20%
	Proportion of the population fitted with hearing Aids	Monthly	TBD(n)	n+20%
	Proportion of the population fitted with hearing Cochlear implants	Monthly	TBD(n)	n+20%
	Proportion of the Population with noise-induced hearing l loss Presbycusis(Age-related hearing loss)	Monthly	TBD(n)	n+20%
	Proportion of thE Population with Presbycusis (Age-related) hearing loss	Monthly	TBD(n)	n+20%

NTD INDICATORS

Indicators for various NTDs (in yellow has been selected for consideration in the KHSSP 2023-2027)

1. Guinea Worm Disease
Global Target: Eradication
National Target: Zero report of confirmed GWD cases

Indicators	Baseline	2023	2024	2025	2026	2027	Data Source	Frequency
Investigate rumors within 24hrs		100	100	100	100	100		
Conduct annual support supervision in at least 4 counties		4	4	4	4	4		
Train 50 health care workers per county on GWD in at least 4 counties		4	4	4	4	4		

2. SCHISTOSOMIASIS
Global Target: Eliminate SCH as a public health concern.
National Target: Elimination of SCH as a public health concern.

Indicators	Baseline	2023	2024	2025	2026	2027	Data Source	Frequency
Completed mapping of schistosomiasis and determined areas above intervention threshold and the endemic populations.		15(32%)	32-(69%)	-	-	-	Program	Annual
Implementation community-based treatments in endemic sub-counties.		93 (32%)	290 (100%)	290 (100%)	290 (100%)	290 (100%)	Program, KHIS	Annual
Achievement of 100% geographical coverage in schistosomiasis endemic sub-counties.		93 (32%)	290 (100%)	290 (100%)	290 (100%)	290 (100%)		
Proportion of sentinel site survey conducted		1 (100%)	1 (100%)	2 (100%)	3 (100%)	4 (100%)	Program, KHIS	Annual
Proportion of health care workers trained on Malacology		150 (100%)	150 (100%)	150 (100%)	150 (100%)	150 (100%)	Program, KHIS	Annual
Proportion of Malacological surveys conducted			1 (100%)	2 (100%)	4 (100%)	5(100%)	Program, KHIS	Annual

3. **SOIL TRANSMITTED HELMINTHS**
Global Target: Eliminate STH as a public health concern by 2030
National Target: Eliminate STH as a public Health concern 2030

Indicators	Baseline	2023	2024	2025	2026	2027	Data Source	Frequency
Complete mapping of STH at sub-county level and determined areas above intervention threshold and the endemic population.		290 (100%)	-	-	-	-	Program, KHIS	Annual
Implementation of community-based treatments in endemic sub-counties (290).		93(32%)	290 (100%)	290 (100%)	290 (100%)	290 (100%)	Program, KHIS	Annual
Achieve 100% geographical coverage in STH endemic sub-counties.		93(32%)	290 (100%)	290 (100%)	290 (100%)	290 (100%)	Program, KHIS	Annual

Conduct 3-5 years of treatments in all endemic sub-counties with Sub- County coverage more than 75%.		57(19%)	-	93(32%)	290 (100%)	-	Program, KHIS	Annual
Conduct first impact assessment activities in at least 50% of STH endemic sub-counties after at least 3 years of consecutive treatments.		-	57 (100%)	-	290 (100%)	-	Program, KHIS	Annual
Achieve a prevalence rate of less than <2% in endemic sub counties		-	56 (19%)	-	290 (100%)	-	Program, KHIS	Annual
No of new and re-trained healthcare workers on drug administration and supervision		27,300	52,500	52,500	52,500	52,500	Program, KHIS	Annual

4. **LYMPHATIC FILARIASIS**
Global Target: Eliminate LF as a public health problem
National Target: Elimination of LF as a public health problem by 2027

Indicators	**Baseline**	**2023**	**2024**	**2025**	**2026**	**2027**	**Data Source**	
Proportion of IUs that stop MDA after TAS1	18 (78.3%)	23 (100%)	-	-	-	Program, KHIS	Annual	
Proportion of IUs for which TAS1 survey is successfully conducted after at least 5 rounds of MDA.	18 (72%)	23 (100%)	-	-	-	Program, KHIS	Annual	
Proportion of IUs for which TAS2 survey is done two years after TAS1	7 (30.4%)	11 (47.8%)	5 (21.7%)	-	-	Program, KHIS	Annual	
Proportion of IUs for which TAS3 survey is done two years after TAS2	-	-	7 (30.4%)	11 (47.8%)	5 (21.7%)	Program, KHIS	Annual	
Proportion of IUs in which passive surveillance and vector control activities are implemented	7 (30.3%)	12 (52.2%)	18 (78.3%)	23 (100%)	-	Program, KHIS	Annual	
Percentage of LF elimination dossier completed	50% complete	75% complete	100% complete	-	-	Program, KHIS	Annual	
Proportion of IUs which have a minimum package of care for morbidity-management and disability prevention (MMDP) provided	5 (22%)	10 (44%)	15 (65%)	20(87%)	23 (100%)	Program, KHIS	Annual	
The proportion IUs where at least 75% of hydrocele cases have been operated	5 (22%)	10 (44%)	15 (65%)	20 (87%)	23 (100%)	Program, KHIS	Annual	

5. TRACHOMA
Global Target: Eliminate blinding trachoma as a public health problem by 2030
National Target: Elimination of blinding trachoma as a public health problem by 2027

Indicators	**Baseline**	**2023**	**2024**	**2025**	**2026**	**2027**	**Data Source**	

Mapping of trachoma conducted to determine IUs that need interventions (surgery and MDA)	54 (100%)	-	-	-	-	Program, KHIS	Annual	
Number and proportion of target counties where there is full geographical coverage of TT case-management services	12 (100%)	-	-	-	-	Program, KHIS	Annual	
Number and proportion of IUs implementing community-based TT surgery	52 (100%)	-	-	-	-	Program, KHIS	Annual	
Number and proportion of IUs where implementation of community-based MDA treatments have been conducted	24 (100%)	-	-	-	-	Program, KHIS	Annual	
Number and proportion of IUs that do not require further MDA	19 (79%)	24 (100%)	-	-	-	Program, KHIS	Annual	
Number and proportion of IUs which require 1 round of MDA	5 (21%)	0(0%)	-	-	-	Program, KHIS	Annual	
Number of IUs under surveillance	14	5	0	-	-	Program, KHIS	Annual	
Number and proportion of IUs that have achieved elimination of blinding trachoma	24 (44%)	30 (56%)	48 (88%)	54 (100%)		Program, KHIS	Annual	
Compile dossier for verification of elimination	20% complete	50% complete	80% complete	100% complete	-	Program, KHIS	Annual	

6. LEISHMANIASIS

Global Target: Control morbidity.

National Target: Reduction of morbidity in endemic areas to levels where they are no longer a public health problem.

Indicators	Baseline	2023	2024	2025	2026	2027	Data Source	
Proportion of healthcare workers trained on case management (target 1000)	200 (20%)	200 (40%)	200 (60%)	200 (80%)	200 (100%)	Program, KHIS	Annual	
Percentage of health facilities* managing leishmaniasis cases that are collecting and reporting leishmaniasis data	75%	100%	100%	100%	100%	Program, KHIS	Annual	
Proportion of CL & VL treatment Facilities* with updated treatment guidelines	100%	100%	100%	100%	100%	Program, KHIS	Annual	
Proportion of recovered cases* after initial management	95%	95%	95%	95%	95%	Program, KHIS	Annual	
Proportion of PKDL cases identified and appropriately managed	25%	50%	75%	100%	100%	Program, KHIS	Annual	
Number/proportion of healthcare workers trained on commodity management & reporting (target 100)	20 (20%)	20 (40%)	20 (60%)	20 (80%)	20 (100%)	Program, KHI	Annual	

Proportion of treatment facilities providing monthly consumption reports	25%	75%	100%	100%	100%	Program, KHIS	Annual	
Targeted sentinel site surveillance in all of target counties for vectors control activities. (Target 14)	3 (25%)	4 (50%)	4 (75%)	3 (100%)	(100%)	Program, KHIS	Annual	
Development of CL guidelines & tools	1 (100%)	-	-	-	-	Program, KHIS	Annual	
Number of suspected CL & VL counties mapped	3	3	3	3	3	Program, KHIS	Annual	
Proportion of VL/CL endemic sub- Counties with CHVs trained on active case finding	25%	50%	75%	100%	100%	Program, KHIS	Annual	
Leishmaniasis data incorporated into the national surveillance system	100%	-	-	-	-	Program, KHIS	Annual	
Number of health workers trained on leishmaniasis surveillance (target 400 HCW)	80 (20%)	80 (40%)	80 (60%)	80 (80%)	80 (100%)	Program, KHIS	Annual	
Number of county governments in leishmaniasis endemic areas allocating funding for leishmaniasis control activities (Target 14 Counties)	3	5	10	14	-	Program, KHIS	Annual	
IEC materials developed and distributed to leishmaniasis endemic counties	50%	75%	100%	-	-	Program, KHIS	Annual	
Number of Counties with an established & functional coordination mechanism	50%	100%	-	-	-	Program, KHIS	Annual	
Proportion of people with knowledge on leishmaniasis in endemic sub-Counties	25%	50%	75%	100%	-	Program, KHIS	Annual	

7. SNAKEBITE ENVENOMING

Global Target: 50% reduction in SBE associated deaths and disabilities.

National Target: Reduction of snakebite burden in endemic areas to levels where they are no longer a public health problem.

Indicators	Baseline	2023	2024	2025	2026	2027	Data Source	
Mapping of snakebite incidences in 16 high risk counties	4 (25%)	8 (50%)	12 (75%)	16 (100%)	Program, KHIS	Annual		
Clinical audits of health facility capacity for case management in 16 endemic counties	20%	40%	60%	80%	100%	Program, KHIS	Annual	
Conducted needs assessment on SBE diagnosis		4 (80%)	1 (20%)			Program, KHIS	Annual	
Proportion of communities sensitized in 60 SBE endemic sub-Counties	15 (25%)	6 (10%)	6 (10%)	6 (10%)	27 (45%)	Program, KHIS	Annual	
Assessed capacity of the 16 SBE endemic counties to purchase antivenoms		16 (100%)	16 (100%)			Program, KHIS	Annual	

8. ONCHOCERCIAIS

Global Target: Elimination of Transmission of Onchocerciasis

National Target: Eliminate Onchocerciasis as a public health problem

Indicators	Baseline	2023	2024	2025	2026	2027	Data Source	
Capacity building of health-care workers on clinical and laboratory diagnosis, case management and recognition of onchocerciasis in the 6 formerly endemic counties	450	500	500			Program	Annual	
Human and vector surveillance of onchocerciasis in the 6 formerly endemic counties (Epidemiological and entomological assessment)	50%	90%	100%	-	-	Program	Annual	
Present the "dossier" for in-country verification of absence of onchocerciasis transmission.	30%	50%	100%	-	-	Program	Annual	
Post elimination surveillance activities for Onchocerciasis	-	-	-	50%	50%	Program	Annual	
Post elimination advocacy and awareness creation	-	-	-	50%	50%	Program	Annual	

9. HUMAN AFRICAN TRYPANOSOMIASIS

Global Target: Elimination as a public health problem by 2020 and interruption of transmission (zero cases) by 2030

National Target: Validation for the elimination of rhodesiense HAT as a public health problem (less than 1 case per year per 10,000 human population)

Indicators	Baseline	2023	2024	2025	2026	2027	Data Source	
Identified and equipped target counties' health facilities	75%	100%	100%	-	-	Program	Annual	
Trained technical staff on Human African Trypanosomiasis (HAT)	75%	100%	100%	-	-	Program	Annual	
Conducted Active Surveillance of Human African Trypanosomiasis (HAT)	75%	100%	100%	-	-	Program	Annual	
Conduct Passive Surveillance of Human African Trypanosomiasis (HAT)	75%	100%	100%	100%	100%	Program	Annual	
To conduct Surveillance of African Animal Trypanosomiasis (AAT)	75%	100%	100%	100%	100%	Program	Annual	
To conduct Mapping and Surveillance of Vectors of HAT pathogens	75%	100%	100%	100%	100%	Program	Annual	
Submitted Dossier indicating the Post validation Surveillance Plan to WHO	-	100%	-	-	-	Program	Annual	

10. DENGUE FEVER

Global Target: To reduce the burden of dengue and chikungunya incidence burden by 25%

National Target: To establish a robust dengue and chikungunya surveillance and control

Indicators	Baseline	2023	2024	2025	2026	2027	Data Source	

Capacity building at the national level of both scientists and laboratory technicians on laboratory diagnosis(national) and vector surveillance	50	50	50	50	50	Program	Annual	
Procurement of equipment and materials for dengue and chikungunya surveillance	National	County 50%	County 50%			Program	Annual	
Capacity building at the counties for vector surveillance and laboratory surveillance		50	100	100	100	Program	Annual	
Proportion of entomological surveillance conducted in the counties	20%	40%	60%	80%	100%	Program	Annual	

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Afya House, Nairobi, Kenya.