Country Cooperation Strategy 2024-2030

Kenya

World Health Organization
African Region

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Abbreviations

ASAL	Arid and semi-arid lands
CCS	Country Cooperation Strategy
CPCP	Core predictable and country presence
CVC	Cardiovascular disease
DALY	Disability-adjusted life year
DPHK	Development Partners of Health in Kenya
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
EPR	Emergency preparedness and response
FAO	Food and Agricultural Organization of the United Nations
HWF	Health workforce
IDSR	Integrated Disease Surveillance and Response
IHME	Institute of Health Metrics and Evaluation
IHR (2005)	International Health Regulations (2005)
KDHS	Kenya Demographic and Health Survey
KHHFA	Kenya Harmonized Health Facility Assessment
KNBS	Kenya National Bureau of Statistics
NCD	Noncommunicable disease
NHIF	National Health Insurance Fund
NPO	National Professional Officer
PHC	Primary health care
SDG	Sustainable Development Goal
UHC	Universal health coverage
UN	United Nations
UNSSDCF	United Nations Sustainable Development Cooperation Framework
WCO	WHO Country Office
WHO	World Health Organization
WR	WHO Representative

Message from the Cabinet Secretary for Health

As Cabinet Secretary for Health of the Republic of Kenya, it is with great pride and a sense of profound responsibility that I present the Kenya-WHO Country Cooperation Strategy (CCS) for 2024–30. This strategy is a beacon of our shared vision and commitment as the Government of Kenya and the World Health Organization (WHO) towards a healthier, more equitable future for all Kenyans.

This CCS is the culmination of an extensive consultative process that brought together the Government of Kenya, WHO and a diverse array of stakeholders. It is a testament to the power of collaboration and collective expertise, which were pivotal in shaping a responsive and forward-looking strategy. It reflects our mutual dedication to forging a robust health system in Kenya. The CCS lays out a clear vision for health in Kenya aligned with both our national aspirations and global health goals. It aims to address the multifaceted challenges of our health care system, from enhancing primary health care services to tackling emerging health threats.

This strategy aligns with the Bottom-up Economic Transformation Agenda's focus on empowering Kenyans at the grassroots level. By ensuring access to quality health care, we are investing in a healthier, more productive citizenry. This focus on universal health coverage (UHC), as envisioned by the agenda, tackles financial barriers and prioritizes preventive care. A robust health care system is not only the foundation for individual well-being but also a cornerstone of a thriving economy, as envisaged by the bottom-up approach to national development.

On behalf of the Government of Kenya and in partnership with WHO, I extend my heartfelt gratitude to all national counterparts, staff members and other stakeholders who have contributed their insights, expertise and unwavering support to the CCS. Your invaluable input has been instrumental in shaping a strategy that is both ambitious and attainable. As we embark on this six-year journey of implementing this CCS, I am inspired by the spirit of partnership and solidarity that has characterized its development. This strategy is more than a road map; it is a pledge to work hand-in-hand with all stakeholders to realize the health aspirations of the Kenyan people.

Looking forward to implementing this WHO Country Cooperation Strategy we are not only enhancing the health of our nation but also contributing significantly to the global health landscape. Through our concerted efforts, shared goals and enduring partnership with WHO, I am confident that we will achieve remarkable progress and set new standards in health systems excellence. I call upon all stakeholders within Kenya and the broader international community to join us in this noble endeavour. Together, we can transform our health landscape and create a legacy of health and well-being for future generations.

Finally, I pledge the unwavering commitment of the Government of Kenya to this strategy. We are dedicated to working alongside WHO and all our partners to bring this vision to fruition. Through our collective effort and shared responsibility, we will strive to achieve the goals set forth in this CCS, improving health outcomes for all Kenyans and contributing to global health progress. Let us embark on this transformative journey together to realize a healthier, more prosperous Kenya.

Honourable Dr Deborah M. Barasa
Cabinet Secretary for Health, Kenya.

Foreword

The World Health Organization's (WHO) Fourth Generation Country Cooperation Strategy (CCS) crystallizes the major reform agenda adopted by the World Health Assembly to strengthen WHO capacity and ensure that its delivery better meets the needs of countries. It reflects the Transformation Agenda of WHO in the African Region, as well as the key principles of the WHO Thirteenth General Programme of Work 2019–2025 (GPW 13) at the country level. It aims to increase the relevance of WHO's technical cooperation with Member States and focuses on identifying priorities and effectiveness measures in implementing WHO's programme budget. The role of different partners, including non-State actors, in supporting governments and communities is highlighted. It builds on lessons learnt from implementing the earlier generations of the country cooperation strategies. Its implementation will be measured using the regional key performance indicators, which reflect the WHO country focus policy.

We note that the recommendations and lessons from the evaluation of CCS 2014–2019 and insights from engagements with the Government and other health sector stakeholders informed the priorities of this CCS. I commend the Government of Kenya and its partners for the significant achievements in improving the health and well-being of its citizens. The country has made considerable investments in health financing and strengthening the health system components, including the innovative use of digital health. The Government's devolution policy, focus on quality and equity and adoption of primary health care are the right approaches that will lead to the desired universal health coverage.

Kenya's commitment to achieving the health-related Sustainable Development Goals (SDGs) by 2030 is poised to substantially impact the country's overall health status. Progress has been made in health impact indicators, as evidenced by the decline in child mortality indicators. Significant challenges remain, however, including the double burden of communicable and noncommunicable diseases. WHO is committed to collaborating closely with the Government and key stakeholders in health to surmount these challenges and enhance achievements before 2030.

I call on all WHO staff to redouble their efforts to ensure the effective implementation of the programmes described in this document to improve the population's health and well-being, which are essential elements for Africa's economic development. For my part, I can reassure you of the total commitment of the WHO Regional Office for Africa and WHO headquarters to provide the necessary technical and strategic support for the achievement of CCS 4 objectives with a view to achieving the Triple Billion Goals and the SDGs.

Dr Matshidiso Moeti
WHO Regional Director for Africa

Preface

In the evolving landscape of global health, the WHO Country Cooperation Strategy (CCS) for Kenya, 2024–2030 is a testament to our unwavering commitment to advancing health and well-being in Kenya. This strategy reflects WHO's significant reform agenda, as endorsed by the World Health Assembly, aimed at bolstering WHO's capacity to better meet the dynamic health needs of the Kenyan population.

This CCS is harmoniously aligned with the Transformation Agenda of the WHO Secretariat in the African Region and is grounded in the principles of the **WHO Thirteenth General Programme of Work 2019–2025** (GPW 13) and the forthcoming Fourteenth General Programme of Work 2025–2028 (GPW 14). At its core, this strategy aims to magnify the impact of WHO's technical cooperation with Kenya, focusing sharply on priority identification and programme implementation efficacy. The role of diverse partners, including civil society and the private sector, is paramount in this collaborative effort, supporting governments and communities in their pursuit of health and wellness.

Reflecting upon the evaluation of **CCS 2014–2019**, we acknowledge both the strides made and the challenges encountered. This CCS is built upon these invaluable lessons, the articulated priorities of Kenya's health-related national policies, strategies and plans and the **United Nations Sustainable Development Cooperation Framework, 2022–2026**. It is a strategy designed to align with global, continental and regional health contexts and actively drive progress towards universal health coverage (UHC).

In our pursuit of UHC, we emphasize an approach that enhances service quality, integrates interventions, centres on people's needs and ensures the affordability and accessibility of health services. The implementation of this CCS will be meticulously monitored, employing global and regional key performance indicators that resonate with Kenya's policy focus, aiming to fortify national health leadership and institutions. This strategic blueprint is a catalyst for operational planning, advocacy and fostering of partnerships.

I extend my deepest gratitude to the Government of Kenya for its leadership and diligence in developing this CCS, including in the comprehensive evaluation of the Kenya CCS 2014–2019. I urge all WHO staff, particularly the WHO Country Office team, to intensify their efforts towards effectively implementing this strategy, thereby enhancing the health and well-being of the Kenyan populace, which are pivotal for the nation's socioeconomic development.

Through strong leadership and transparent and committed collaboration with non-State actors, the United Nations Country Team and development partners, we can collectively achieve our national, regional, continental and international health development goals. I reaffirm WHO's commitment to providing the necessary technical and strategic support to realize the objectives of GPW 13 and GPW 14 and the United Nations Sustainable Development Goals in Kenya.

Dr Abdourahmane Diallo
WHO Country Representative in Kenya

George receives his oral polio vaccine on 5 October 2024.

He is one of 3.8 million children that got his vaccination as part of a 5-day vaccination campaign supported by WHO.

Community Health Promoter checks the blood pressure of a 100-year-old man in a remote village in Laikipia County, Kenya, 2024.

Health promoters can use this data to track community health trends, identify emerging issues, and guide targeted interventions that improve access to care and support better health outcomes in remote areas.

Executive Summary

The World Health Organization (WHO) Country Cooperation Strategy (CCS) for Kenya, 2024–2030, delineates the collaborative framework for WHO and the Kenya government aligned with the **National Health Policy (2014 – 2030)**, **Kenya Vision 2030**, **the United Nations Sustainable Development Cooperation Framework (2022 – 2026)**, **the 13th General Programme of Work**, and **the Sustainable Development Agenda** in line with the Government's **Bottom Up Economic Transformation Agenda 2022 – 2027**. This strategy, pivotal in the lifecycle of the Sustainable Development Goals (SDGs), aims to provide essential support for achieving these goals.

Under the guiding principles of **13th General Program of Work (2019 - 2025)**, WHO's strategic thrust encompasses achieving universal health coverage (UHC), addressing health emergencies and promoting overall healthier populations. This strategic orientation operates at global, regional and national levels, focusing on amplifying public health impact through policy dialogue, strategic support, technical assistance and necessary service delivery.

The development of this CCS was informed by evaluations of **CCS 2014 – 2019** and consultations with the Ministry of Health (MoH), development partners and other essential health sector stakeholders. It seeks to build country capacity and promote self-sustenance, with WHO transitioning from certain work areas as Kenya's capacity strengthens.

Key considerations underpinning the WHO's collaboration with the Kenyan Government include:

1. **Adapting** to the government's devolution policy, offering targeted support to both the central and subnational levels, particularly in capacity development;
2. **Emphasizing** health promotion and disease prevention as essential strategies to reduce the health burden and promote healthy living;
3. **Addressing** the increasing burden of noncommunicable diseases (NCDs) and the role of various sectors in mitigating social determinants of health and facilitating access to health services. This entails promoting intersectoral collaboration;
4. **Making** concerted efforts to identify and reach underserved populations, addressing gender equity and human rights issues, which are crucial for achieving health and development goals;
5. **Leveraging data**, analytics and evidence for policy planning and implementation, recognizing the significant role of digital health in advancing health service delivery. This involves prioritizing data generation and the application of technology and innovation.

1 The elements of the agenda are investing in the HWF with a focus on community health promoters who are well trained, fit for purpose and motivated to deliver health services at community level; reviewing the health financing architecture to ensure sustainable financing through Social Health Insurance, while prioritizing vulnerable and marginalized populations; strengthening health commodity security by investing in local manufacturing to increase access and affordability of essential health commodities; and leveraging integrated digital technologies to deliver efficient health care services, while ensuring end-to-end visibility and accountability in the supply chain system.

Strategic Agenda

The strategic agenda, comprising the mission, vision, strategic priorities and critical strategic deliverables, is aligned with GPW 13 and GPW 14. The mission of WHO is a Kenya in which all people attain the highest possible level of health and well-being and strive to achieve the goals of the Kenya National Health Policy 2014–2030 and the SDGs.

The vision of this CCS is one in which the people of Kenya, especially children, women and the most vulnerable groups benefit from UHC, enjoy better protection from health emergencies and have better health and well-being everywhere in the country.

The strategic priorities identified for WHO work in Kenya during the period 2024–2030 are as follows:

1. **Strengthening** health systems for accelerating progress towards UHC and addressing priority communicable, noncommunicable diseases;
2. **Protecting** the population from and reducing the impact of health emergencies;
3. **Promoting** healthy living and accelerating actions to address determinants of health;
4. **Strengthening** the country's leadership and stewardship of health.

The strategic deliverables for each strategic priority are shown in Table 1.

This CCS outlines a comprehensive approach to implementing the strategic priorities that involves capacity building, technical support and a robust M&E framework to assess progress and adapt strategies as needed. WHO will seek synergies with other UN agencies and development partners in the country, based on their comparative advantages. Particular attention will be given to ensuring adequate engagement of the health-related government sectors, as the agenda to tackle the social determinants of health is critical in these last seven years of the Sustainable Development Agenda timeline. This CCS also articulates the implications for the WHO Country Office (WCO) in Kenya, WHO Regional Office for Africa and WHO headquarters.

A robust M&E framework is integral to this CCS, ensuring accountability and facilitating continuous improvement. In this regard, the framework includes clear performance indicators and targets, allowing for regular assessment of the strategy's impact and effectiveness.

This CCS represents WHO's commitment to supporting Kenya in its journey towards sustainable health improvements and overall population well-being. It is a strategic document that aligns with global health priorities while being tailored to Kenya's specific needs and context. As the strategy unfolds, it will serve as a dynamic blueprint for health sector development, adaptable to changing circumstances and emerging health challenges, to enhance health and well-being in Kenya, which are crucial for the nation's socioeconomic development.

Table 1: WHO Country Cooperation Strategic Agenda for Kenya, 2024 – 2030:
Strategic priorities and strategic deliverables

1 Strengthening health systems for accelerating progress towards **universal health coverage** and addressing priority communicable and noncommunicable diseases.

- (a) Increasing access to and reducing inequities in health services, financing and interventions across the life course.
- (b) Improving the quality, utilization and responsiveness of health services and interventions and health workforce (HWF) capacity across the life course.
- (c) Strengthening delivery of disease-specific service coverage and disease elimination initiatives.

2 Protecting the population from and reducing the impact of **health emergencies.**

- (a) Strengthening health emergency preparedness capacities to prevent and mitigate emerging health risks due to epidemics and other hazards, including climate change.
- (b) Reimagining integrated disease surveillance and response (IDSR) to enable rapid detection and monitoring of disease of outbreaks and other emergencies
- (c) Enhancing health emergency response and building health systems' resilience.

3 Promoting **healthy living** and accelerating actions to address determinants of health.

- (a) Reducing exposure to health risks by addressing social, economic and commercial determinants of health
- (b) Strengthening capacities to tackle risk factors for communicable and noncommunicable diseases
- (c) Promoting healthy settings and addressing environmental determinants of health, including climate change

4 Strengthening the country's **leadership and stewardship** of health.

- (a) Strengthening the country's capacity for data and digitalization, research, innovations and use of evidence for policy and planning
- (b) Strengthening partnerships and whole-of-government engagement
- (c) Strengthening WHO country presence and leadership, resource mobilization and strategic communications to drive health impact in Kenya

1. Introduction

The World Health Organization's (WHO) Country Cooperation Strategy (CCS) for Kenya covering the period 2024–2030 represents a pivotal framework for health sector collaboration and development. This strategy is not merely a road map; it embodies a shared vision for health and well-being in Kenya, aligning with the national ambitions and WHO's global and regional health mandates. It is a testament to WHO's commitment to supporting Kenya in navigating the multifaceted health challenges and opportunities that lie ahead.

CCS 2024–2030 articulates how WHO will collaborate with the Government of Kenya to support the implementation of the Kenya Health Policy 2014–2030 in the context of the Kenya Vision 2030, the United Nations Sustainable Development Cooperation Framework (UNSDCF) 2022–2026 and the Sustainable Development Agenda. This is the last WHO CCS for the period up to 2030, the end of the timeline for the Sustainable Development Goals (SDGs) and, therefore, it endeavours to make available the support to significantly accelerate progress toward attaining the goals.

The main goals of GPW 13, which currently guides WHO work, are achieving UHC, addressing health emergencies and promoting healthier populations. The target is to have an additional one billion people benefiting from UHC, one billion more protected from health emergencies and one billion more enjoying better health and well-being. This strategic framework guides WHO's work at the global, regional and country levels. WHO aims to drive public health impact by stepping up its leadership and focusing global public goods – that is normative guidance and agreements, data, research and innovation – on influence through policy dialogue, strategic support, technical assistance and service delivery, where necessary.

Kenya, located in the heart of eastern Africa, has a diverse geographical landscape ranging from coastal beaches to arid deserts and highland regions. This geographic diversity presents unique health challenges and opportunities, influencing the health needs and services across different counties. Kenya has 47 counties, 29[2] of which are described as arid and semi-arid lands (ASALs) and are prone to climate emergencies.

With a population estimated at 51.5 million in 2019 that is projected to reach 57.8 million by 2030, Kenya is experiencing rapid demographic changes. These changes include urbanization, an increase in the elderly population and varying health needs across age groups, all of which have significant implications for health policy and planning.

Kenya has demonstrated strong economic resilience and growth, particularly marked by its transition to a lower-middle-income country. The country was one of the fastest-growing economies in Africa, with an annual average growth of 5.9%, between 2010 and 2018. With a GDP of US$ 95 billion and a GDP per capita of US$ 2081.80 (World Bank, 2021), Kenya reached lower-middle income status in 2014 and has successfully established a diverse and dynamic economy (USAID, 2023).

2 https://www.asals.go.ke/asal-info/

Irene and her 13-month-old baby Shanyl at the Homa Bay County Teaching and Referral Hospital in western Kenya.

In February 2023, WHO's Malaria Vaccine Implementation team took part in a 3-day visit across government offices, health facilities and homes in western Kenya to understand how the RTS,S/AS01 malaria vaccine was being implemented into the national immunization program, and how individuals at all levels were responding to it.

Kenya's economic progress has been uneven, however, with disparities in income, access to health services and quality of life. The COVID-19 pandemic accentuated these challenges, disrupting economic stability and exacerbating health inequalities. Nonetheless, real GDP increased by 7.5% in 2021, following the recovery of the services sector and expansion in industrial output (World Bank, 2020; 2022). Kenya's government elected into office in August 2022 has clear priorities for the health sector. It is within this context and in line with the commitments already made by the country in global, regional and national policies and strategies that WHO intends to anchor its cooperation with the government.

Development of this CCS

This CCS draws from the evaluations and recommendations of CCS 2014–2019, incorporating insights from engagements with MoH, development partners and critical health sector stakeholders. A major thrust is to build Kenya's capacity in the health sector and promote self-sustenance, preparing for a gradual WHO transition from certain areas as the country's capacity develops. It highlights the importance of the country's health care leadership and ownership, and hence its role is facilitatory, including in strengthening the country's capacity in the context of the Kenya devolved health systems strengthening framework anchored on the Devolution Policy, the Kenya Health Policy, 2014–2030, and the Kenyan partnership framework.

This document presents an analysis of information on Kenya's health and development context, its path towards the realization of the SDGs and WHO's current collaboration with the country. It also outlines WHO's strategic agenda for 2024–2030, including the strategic priorities and deliverables and key outputs, and it identifies their implications for the work of WHO at the Country Office, Regional Office for Africa and headquarters toward contributing to better health and well-being in Kenya.

With the approaching of the 2030 deadline for achieving the SDGs, this strategy is not intended to be just a plan for the immediate future but a commitment to the long-term health and well-being of the Kenyan people. It represents a collective effort to build a healthier, more equitable and sustainable future for all Kenyans.

During a severe drought in 2022, a mobile team provides nutrition screening and other health services under a the shade of a tree in Korr, Marsabit.

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2. Health and Development Context

2.1. Health systems in the country

The Kenya National Health Policy, 2014–2030, gives directions to ensure significant improvement in the country's overall health status in line with the Constitution of Kenya 2010, the country's long-term development agenda, Vision 2030 and global commitments. The policy thus demonstrates the health sector's commitment to ensuring that the country attains the highest possible health standards responsive to the population's needs under the government's stewardship. Specific focus is placed on eliminating communicable diseases, halting and reversing the rising burden of noncommunicable conditions, reducing the burden of violence and injuries and mental health conditions, minimizing exposure to health risk factors and strengthening collaboration with the private sector and other health sectors. In addition, various national strategies are in place to guide the development of all health system pillars. Similarly, regulations provide parameters for producing and delivering health services, including the overall National Health Act No. 21 of 2017. This act aims to establish a unified health system, coordinate the inter-relationship between national and county government health systems and regulate health care services and providers, health products and health technologies, as well as managing the connected responsibilities.

With the creation of devolution by the Constitution of 2010 (fourth schedule), a two-tier health system was established where the national level was responsible for the functions of health policy, national referral hospitals, capacity building and technical assistance to counties, while the county governments took over the mandate for the rest of the subnational health services.
Kenya's health care system consists of six levels. Level 1, with community health services, level 2, with dispensaries, level 3, with health centres, and level 4, with primary referral facilities, constitute primary health care. Level 5 consists of the secondary referral facilities and level 6 the tertiary referral facilities. The first five levels fall under the mandate of the counties while level 6 facilities are under the national government. There are 14 378 health facilities, 46% of which are owned by the public sector and the rest by the private sector, which includes faith-based organizations and nongovernmental organizations (MoH).

The Government of Kenya has prioritized primary health care (PHC) and developed the Kenya Primary Health Care Strategic Framework that spells out the UHC implementation pathway and how primary health services will be management. In that vein, primary care networks are being established at level 4 primary hospitals with links to the levels 2 and 3 health facilities connected to community units to realize UHC. 86 000 community health promoters are being trained, and the government will deploy about 100 000 in communities, targeting at least one for every 1000 people. During the financial year 2020/2021, MoH undertook routine maintenance of 54 dialysis sites; set up 219 new theatres, 14 intensive care facilities and state-of-the-art radiology equipment in 98 hospitals; and established a regional cancer centre in each of Meru, Nakuru, Mombasa, Garissa, Kisumu, Embu, Kakamega, Nyeri and Machakos towns.

With respect to HWF developments and initiatives in Kenya, in October 2023 the government launched the Kericho Declaration on HRH in Kenya, a 17-point set of commitments for the government and partners to address Kenya's most pressing HRH priorities. The health labour market analysis for Kenya was also launched in September 2023. Its set of actions and recommendations

called for (i) multisectoral HWF governance, planning and investment to meet health needs and absorb and retain health care workers, (ii) optimizing the quantity and quality of HWF education and supply, (iii) improving HWF regulation, and (iv) strengthening data use for policy and decisions. The 2023 Kenya budget statement prioritized the employment of 20 000 health care workers of all cadres, representing a significant increase in Kenya's nearly 180 000 HWF stock, which was essential. Also, the United Kingdom launched the bilateral Global HWF Programme support for Kenya, providing US$ 2 million in HWF support to the Kenya WCO over two years (2023/2024) and a further US$ 3 million in partnership grants to support the strengthening of HWF capacity and retention.

The government has prioritized digital health and it developed the Kenya National eHealth Policy, 2016–2030, with the aim to achieve the highest health standards through adopting and using information and communication technologies. The country enacted the Digital Health Act in 2023 that established a digital health agency responsible for developing, operationalizing and maintaining a comprehensive integrated health information system to manage the core digital systems and the infrastructure for its seamless health information exchange.

Kenya has doubled its health workforce in the last 10 years to almost 190 000 active health workers.

Nurse Esther Omagwa from Railways Health Clinic in Kisumu is one of many health workers who have noticed a big difference.

"5 years ago, I used to be 1 of 2 nurses working at this facility. I remember when some clients would come and I used to turn them down because I was too tired. These days, we are a team of 4 so I am able to respond to my patients efficiently.".

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2.2. Universal health coverage

The government committed to attaining UHC by enacting the UHC Policy, 2020–2030. This policy aims to ensure all people's access to quality health services while protecting them from the risk of financial hardship when accessing care.

Through the bottom-up Economic Transformation Agenda, 2022–2027, the current Government has prioritized achieving UHC with a focus on PHC, based on three pillars:

1

Publicly funded primary healthcare services, including preventive, promotive, palliative, rehabilitative, and curative services, are anchored on primary care networks and community health promoters.

2

A mandatory social health insurance system (with private insurance as complementary) for coverage of secondary and tertiary services.

3

A national fund to cover the catastrophic cost of chronic illnesses, injuries, and emergencies that are not covered or restrictively covered by insurance.

Providing universal access to affordable, quality health services is critical in achieving the goal of ending extreme poverty and it lays the foundation for economic growth and competitiveness grounded in the principles of equity and sustainability. The Kenya UHC programme began in 2018 as a pilot programme in four of Kenya's 47 subnational governments (MoH, 2018). The UHC model adopted a two-phase medium-term approach. The first phase was expected to abolish all user fees at the primary or local health centres and the secondary or county referral hospitals. The second phase was the rollout of the national health insurance scheme through the National Health Insurance Fund (NHIF). In this second phase contributions will be mandatory for all Kenyans above the age of 18 years, while the government will complement the scheme by paying for people experiencing poverty.

Progress has been made in increasing coverage of essential health services. By 2020 the programme had enlisted more than 200 community health units with community health volunteers reaching 86 423 by 2023, plus over 700 other health workers. Between 2018 and 2019, the project supported 3.2 million Kenyans accessing critical health care services (MoH, 2019). The UHC service index rose marginally from 54.3 in 2015 to 55.9 in 2019 (WHO, 2019, 2022) and the health facility density and distribution per 10 000 population reached 2.7 in 2020, exceeding the WHO target of 2.5 (MoH, 2021). The government health expenditure as a proportion of total government expenditure improved from 6.3% in 2015 to 8.3% in 2019 (WHO, 2018, 2022) and the proportion of households spending over 10% of their income on health, that is what is termed catastrophic expenditure, reduced from 12.7% in 2013 to 5.2% by 2021 (MoH, 2014; WHO, 2023).

Household out-of-pocket expenditure on health reduced from 29.22% in 2014 to 24.3% in 2019.

Patients wait at reception in Rumaruti Level 4 hospital in Laikipia to settle payments and file claims through their health insurance.

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However, this is still relatively high, and at least 5% of households experience catastrophic health-related expenditure. The number of outpatient visits per person per year demonstrated a marginal increase from one visit in 2017/2018 to two visits in 2019/2020, but were below the target of three (MoH, 2020). The national average inpatient bed density is 13.3, which is below the target of 25, and the national average inpatient bed occupancy rate is 46%, which is below the target of 80%. The national maternity bed density is 13.8 per 1000 population, which is above the target of 10, while the national core HWF density is at 15.6 per 10 000 population, which is below the set target of 23 (MoH, 2018b). Whereas infrastructure scores high with the index score of 100, service utilization is very low and has an index score of 31.2 (MoH, 2018b).

Kenya had a density of 30 doctors, nurses, midwives and clinical officers per 10 000 population in 2021. It has engaged extensively with various stakeholders to strengthen and improve the understanding of the HWF situation by implementing the national HWF accounts process and health labour market analysis. However, a recent health labour market survey found that, although the overall stock of health workers is increasing, their distribution across the counties could be more equitable if the counties' share of the national population is considered.

According to the Kenya harmonized health facility assessment of 2018, the service readiness index of the health facilities was at 59%, indicating that six out of 10 health facilities were ready to provide their defined set of health services. However, only 17% of the health facilities had all the basic diagnostic testing capacity and 44% had the essential medicines.

In a remote part of Laikipia not all facilities have laboratories. George Metto picks up samples from Ipolei dispensary to take to a larger facility with a laboratory. Patients could wait up to 1 week for their results.

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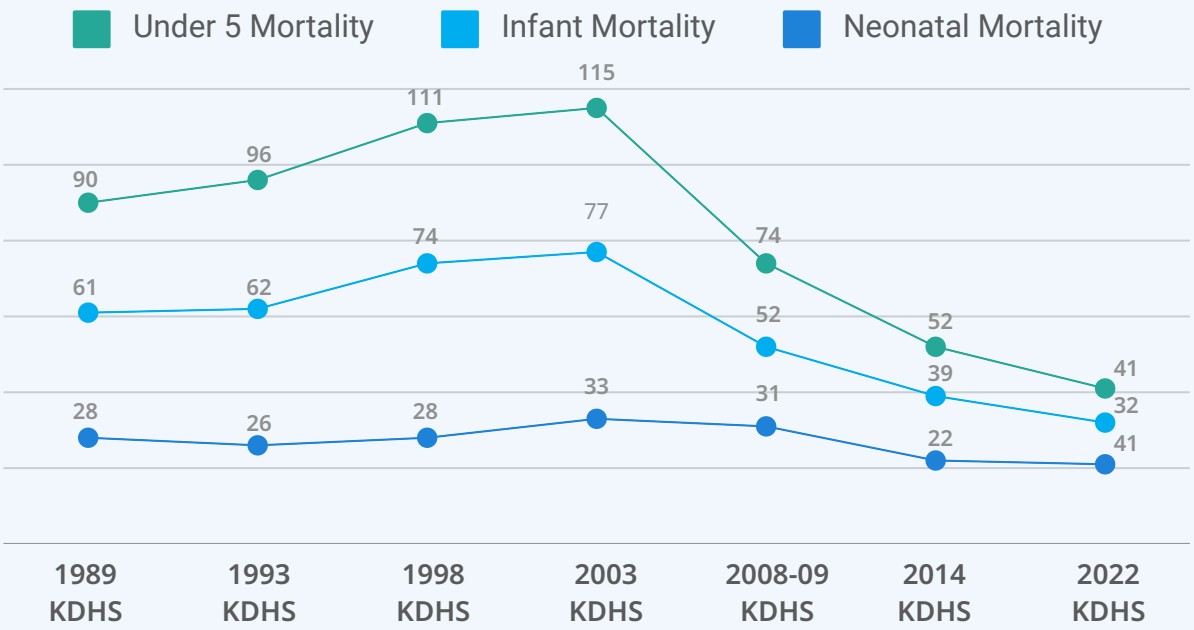
From a mid-term review of the Kenya Health Sector Strategy and Investment Plan, 2018–2023, upper respiratory tract infections, malaria, diarrhoea and diseases of the skin remain responsible for a high proportion of all cases in under-five children, while for the population older than five years, malaria and diseases of the skin have exchanged positions over the past four years as the leading cause. Upper respiratory tract infections lead at 20% in this age group. Over half of the health facility deaths were caused by communicable diseases, while over time the deaths attributed to NCDs and injuries are on the increase. As of 2020/2021, the top five leading causes of death were lower respiratory infections, cancers, hypertensive diseases, HIV and birth asphyxia (MoH, 2022).

Progress has been made in maternal, child and newborn health. Mortality rates for newborns, infants and under-five children have continued to decline, although they started to plateau from 2018. The under-five mortality rate is on track for its SDG target, but not the neonatal mortality rate (see Figs 1 and 2).

FIGURE 1: Child mortality trends in Kenya, KDHS 1989 to KDHS 2022

Source: KDHS 2022
Data source: WHO Global Health Observatory



Note: Data from 2003 and later are nationally representative, while data collected before 2003 exclude the North Eastern region and several northern districts in the Eastern and Rift Valley regions.

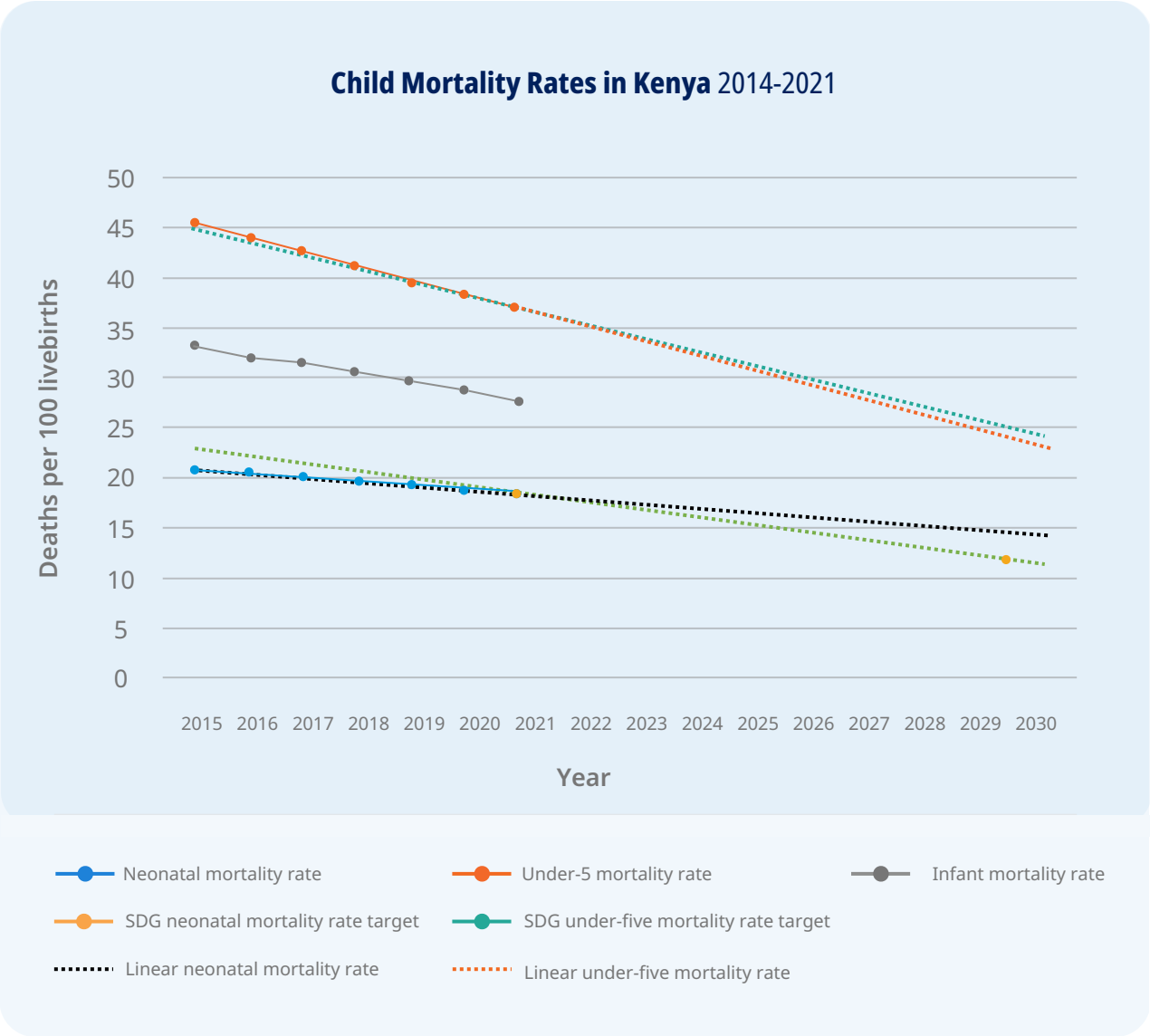


FIGURE 2: Child mortality trends in Kenya, 2014-2021 and progress towards SDG targets.

In 2019, Kenya attained the maternal and neonatal tetanus elimination status. The proportion of mothers attending at least four antenatal care sessions rose from 38.3% in 2013/2014 to 66% in 2022 and deliveries assisted by a skilled provider increased to 89% in 2022 from 66% in 2014, but the proportion of women aged 15–49 years using modern methods of contraception had not changed, standing at 56.3% in 2013/2014 and 57% in 2022. Notably, the maternal mortality ratio has stagnated over the years, with levels of 362 deaths per 100 000 live births in 2014 (KDHS, 2014) and 355 deaths per 100 000 live births in 2019 (Kenya Population and Housing Census, 2019). The facility maternal mortality ratio declined slightly between 2018/2019 and 2022/2023 from 19 to 94 deaths per 100 000 live births, while the proportion of low-birth-weight children increased from 4.7% in 2015 to 5.3% in 2023 (MoH, 2023).

The current Kenya government is committed and determined to realize the constitutional right to health for its people in the shortest time possible by delivering a UHC system **built on three pillars:**

1

Fully publicly financed primary healthcare encompassing preventive, promotive, outpatient and essential diagnostic services and that gives patients a choice among public, faith-based and private health care providers based on a regulated tariff.

2

Universal seamless health insurance system comprising mandatory national insurance as the principal cover (in the sense of primary coverage) and an aligned voluntary health insurance as complementary cover.

3

A national fund for chronic and catastrophic illness and injury costs not covered by insurance or with very restrictive cover such as cancer, diabetes, stroke and accident rehabilitation and pandemics to be funded by a combination of an insurance levy and government funding.

2.3. Health and equity

Significant inequality and inequity exist in the use of all types of health care services favouring the more affluent population groups, with particularly pronounced disparity levels in preventive and inpatient care services. This is driven primarily by differences in living standards and educational achievement, but the region of residence also is a crucial driver for inequality, though only in preventive care use (Iinca et al., 2019). Inequities exist across the counties. For example, there is less than one health facility per 10 000 population in Bungoma county compared with over 3.5 health facilities per 10 000 population in Mombasa county (McCollum, n.d.). Mothers with no education and the poorest mothers were less likely to deliver with a skilled provider, with the levels at 54.6% and 69.3%, respectively, compared with mothers with primary education and mothers in the second wealth quintile, with their levels at 87.2% and 89%, respectively.

Extreme weather events due to climate change affect East and southern African countries. The events include extreme heat spells, droughts and floods, all with consequences for lives and livelihoods, with pregnant women, neonates, children and the elderly among the most vulnerable to these conditions. The health sector has a vital role in institutionalizing strategies to mitigate climate change and make adaptations to deal with its effects. Although the UHC initiative may play a role in reducing disparities in health care utilization, achieving equity in health and access to care will require multisectoral approaches to address all critical drivers of inequity (linca et al., 2019).

For equity in health financing and expenditures, the country is currently implementing profound health financing reforms by establishing social health insurance for Kenya. This reform aims to increase financial risk protection and ensure equitable access to health services for all citizens. In 2023, the country enacted four health-related laws, that is the Social Health Insurance Act, the Primary Health Care Act, the Digital Health Act and the Facility Improvement Financing Act. The Social Health Insurance Fund and the Chronic-Illness and Emergency Fund, providing financing for a unique benefit package at all levels of care for all Kenyans. Social health insurance represents a fundamental shift from the previous scheme-based approach and is a move to a more system-based financing approach that reduces the fragmentation in the health financing arrangements. Social health insurance will be introduced in 2024, and work is going on to develop the regulations for each act. Some of the challenges anticipated relate to the need to leverage data and information systems across the funds and to develop strategic purchasing mechanisms to enhance the efficiency and overall quality of care. Moreover, improving public financial management within the health sector will also be necessary, focusing on better resource allocation and utilization of funds. All these aspects are crucial for building a robust health financing system through this reform.

Jamila and a neighbour fetch untreated water from the Tana River, Kenya.

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2.4. Emergency Preparedness and Response

The WHO Health Emergencies Programme works with MoH systems and structures in both the national and devolved systems and with partners to ensure the country is better prepared for all-hazards health emergencies threatening global health security. The programme prioritizes research to prevent and manage epidemic- and pandemic-prone diseases; to strengthen and expand systems to rapidly detect, investigate and assess potential threats to public health; and to immediately respond and systematically manage acute emergencies during some conflict-affected and humanitarian settings, where WHO staff and operational partners act as health-care providers of last resort.

WHO in Kenya, working with other partners, supports preparedness and response to outbreaks and emergencies. In 2014, Ebola preparedness and response training was conducted in all 47 counties, targeting 60% of the health personnel at health facilities, airports and ground border crossings. In 2015 MoH published the standard case definitions for priority diseases as part of the IDSR system. In 2016 Kenya moved from the standalone, web-based surveillance system to DHIS2. Community event-based surveillance was piloted and rolled out in some counties in 2019, while health facility event-based surveillance was piloted in 2021. In 2020 COVID-19 call centres and hotlines were established at the county level, and in 2021 event-based surveillance was established in schools.

WHO Kenya Emergency team and WHO trained Rapid responders assess the aftermaths of a **flash flood in Mai Mahiu** April 2024, during heavier than normal March-April-May rains.

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The country undertook an independent joint external evaluation of the International Health Regulations (IHR (2005)) core capacity in 2017 and scored 58%, which is level 3 preparedness, but in 2019 the score had fallen to 41% or level 2 preparedness. Following the joint external evaluation, the country developed and implemented the National Action Plan for Health Security,2019–2023. From the analysis of the most recent State Party Self-Assessment annual report for Kenya on IHR (2005) capacities for 2023, despite the significant improvement in the capacities that year compared to the 2022 scores, which had gone from 47% to 51%, there was an overall need to strengthen the capacities to match regional and global thresholds. The country demonstrated strengths in surveillance, laboratory, health emergency response, and risk communication and community engagement indicators.

Along with the National Disaster Operations Centre, the country established the national and county public health emergency operation centres in 2016 and 2021, respectively. The country adopted the One Health approach to address the threat and challenge of zoonotic disease outbreaks, resulting in the development of the One Health strategic plans for 2012–2017 and 2021–2025. There were improvements in the joint rapid response to the Rift Valley fever and anthrax outbreaks in 2018 and 2019, respectively.

The WHO African Region launched its flagship initiative for health security in July 2022 to ensure that one billion Africans were better protected from health emergencies by the end of 2025. Accordingly, Kenya developed a road map for the flagship programmes over 2022–2024. The road map focuses on (i) ensuring the availability of dedicated, trained and ready-to-deploy, multidisciplinary HWF at national and county levels, (ii) improving planning and cohesiveness across ministries, partner agencies and civil society organizations, (iii) ensuring timely and effective deployment of emergency supplies and human resources, as well as the transportation, procurement and distribution of supplies at national and county levels, and (iv) conveying information on public health threats transparently and in a timely and coordinated manner through mechanisms built into the national action plans for health security. Other areas of focus include strengthening existing structures and ensuring human and material resources are available, capable and organized to deal with a wide range of hazards that result in health emergencies, strengthening national capacities for implementation/scale-up of the third edition of IDSR and improving existing laboratory infrastructure and systems for efficient disease detection and response.

2.5. Promoting healthier populations

Approximately 39% of all deaths in the country are attributable to NCDs (Vos et al., 2020) and up to 57% of NCD deaths are caused by cardiovascular diseases (CVDs), cancers, diabetes and chronic respiratory diseases. In addition, 53% of the NCD disability-adjusted life years (DALYs) and 72% of injury DALYs occur among persons aged 40 years or younger (MoH, 2018a). Kenya had a premature (among people 30–70 years old) CVD mortality rate of 8% in 2019, while the total CVD mortality rate was 13.8%, contributing 6.3% of DALYs (IHME, 2019; Mbau et al., 2021).

The prevalence of diabetes among adults in Kenya was estimated at 3.1% in 2019, while by 2021, 43.7% of the people were found to be undiagnosed for diabetes. Kenya's mortality rate due to hypertensive heart disease was 1.7% in 2019, lower than the global rate of 2.05%. For the period 2012–2018, the annual incidence of cancer increased from 37 000 to 47 887 cases and the mortality due to cancer increased from 28 500 to 32 987 deaths. By 2020, the five-year prevalent cases were 82 620. In October 2019, Kenya introduced the human papillomavirus vaccine against cervical cancer into the routine immunization schedule.

In 2017 the country developed and launched the national guidelines for tobacco dependence treatment and cessation, and in 2018 it launched the guidelines for the prevention and management of cardiovascular diseases. A national anti-smoking mass media campaign was launched in 2014, and tobacco use declined from 23% to 18.8% for male adults and from 4.1% to 2.3% for women between 2015 and 2019. In 2020, the Protocol to Eliminate Illicit Trade in Tobacco Products was ratified. Furthermore, a joint initiative of the Ministry of Agriculture, World Food Programme, FAO and WHO on the Tobacco-Free Farms project focusing on replacing tobacco farming with food crops was launched in Migori county in 2021 and scaled to Meru, Bungoma and Busia counties in 2022. Migori was the Global No Tobacco Day venue on 31 May 2023. Road traffic injuries accounted for 0.2% of all outpatient visits in fiscal year 2019/2020, going down from 1% in 2015/2016. However, road traffic fatalities increased by 47%, from 2695 in 2016 to 3975 in 2020. Between 2010 and 2019 there was a significant decline in sexual, physical and emotional violence among youths aged 13–24 years.

The WHO report on the basic hygiene and hand washing facilities in 91 health facilities in seven counties revealed that fewer than 50% of the facilities had functional hand hygiene stations within five metres of a latrine. WHO has worked with the Ministry of Water to promote access to water for health facilities and supported the development of guidelines for breast milk supplements. The Kenya Parliament passed the Food Safety Bill, and the Food and Feed Bill is being developed. To reduce air pollution, the Clean Cook initiative was upgraded to Clean and Safe Cook initiative, and the policy guidance on zero-rating gas was passed by parliament, leading to increased gas uptake. WHO supported the domestication of the global guideline on particulate matter. In the last two to three years, WHO has supported MoH in reducing pollution, with the target of zero carbon monoxide emissions by 2030.

Tobacco farmers attend a sensitisation meeting by WHO and partners to learn about the health benefits of farming beans rather than tobacco.

Bungoma County, Kenya.

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Tobacco farmer Mary and her grandson listen carefully to learn about the health, financial and environmental benefits of growing beans.

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3. Kenya's Path to Sustainable Development Goals

Kenya's commitment to the SDGs is demonstrated by its development of a comprehensive road map following the introduction of the 2015 Sustainable Development Agenda. This road map intricately integrates the SDGs into the nation's planning processes at both the national and county levels, aligning them with sectors' strategic plans and county-integrated development plans. This alignment ensures that Kenya's development priorities resonate with sustainable and long-term goals.

Central to Kenya's development is its Vision 2030, an ambitious framework aiming to transform the country into a newly industrialized middle-income nation offering a high-quality of life to all its citizens by 2030. Implemented through successive five-year medium-term plans, Vision 2030 is built upon three pillars, that is the economic, social and political pillars, with health being a critical component under the social pillar. This pillar strives for a just society where equitable social development thrives in a clean and secure environment.

In this context, the health sector aims to provide an efficient and high-quality health care system. This goal is reflected in the Kenya National Health Policy, 2014–2030, which aims for universal coverage of essential services, contributing to the highest standard of health. These efforts align with Vision 2030's long-term development agenda, focusing on high-quality health services to maintain a healthy and productive population.

The Kenya government's commitment to health system reforms, particularly to UHC, underscores its dedication to realizing the constitutional right to health. These reforms are geared towards providing equitable, accessible and affordable health care, pivoting from curative to preventive care. Notably, the Bottom-Up Economic Transformation Agenda, 2022–2027, incorporated into the fourth medium-term plan (2023–2027) reflects this shift, emphasizing provision of UHC through the PHC approach.

Kenya has made significant strides towards key health-related SDGs, such as (i) the rise in life expectancy at birth, which has increased to 60 for males and 66.3 for females (KNBS, 2019), (ii) the rise in the UHC service coverage index from 28% in 2000 to 53% in 2021 and (iii) the improvements in facility density, which reached 2.7 per 10 000 population in 2020, exceeding the WHO target of 2 (MoH, 2018b). These are testament to progress. The proportion of government health expenditure has improved and there has been a notable reduction in household out-of-pocket health expenditure. The government's health expenditure as a proportion of the total government expenditure improved from 7.5% in 2014 to 8.3% in 2019 and the proportion of households spending over 10% of their income on health reduced from 12.7% in 2013 to 5.1% in 2022. Household out-of-pocket expenditure on health reduced from 29.22% in 2014 to 24.3% in 2019, but this is still relatively high. The Kenya Demographic and Health Survey (KDHS) of 2022 showed the adolescent fertility rate to be 73 per 1000 women aged 15–19 years, and the proportion of deliveries attended by health personnel to be 89.3% (see Fig. 2 and Annex 1 for crucial progress indicators).

SDG3 – Good health and well-being	Value	Year	Rating	Trend
Maternal mortality rate (per 100 000 live births)	342	2017	🔴	→
Neonatal mortality rate (per 1000 live births)	20.5	2020	🔴	↗
Mortality rate, under-5 (per 1000 live births)	41.9	2020	🟠	↗
Incidence of tuberculosis (per 100 000 population)	259.0	2020	🔴	↗
New HIV infections (per 1000 uninfected population)	0.7	2020	🟠	↑
Age-standardized death rate due to cardiovascular disease, cancer, diabetes, or chronic respiratory disease in adults aged 30–70 years (%)	21.0	2019	🟠	→
Age-standardized death rate attributable to household air pollution and ambient air pollution (per 100 000 population)	78	2016	🟡	●
Traffic deaths (per 100 000 population)	28.3	2019	🔴	↓
Life expectancy at birth (years)	66.1	2019	🔴	→
Adolescent fertility rate (births per 1000 females aged 15 to 19)	96.0	2014	🔴	●
Births attended by skilled health personnel (%)	61.8	2014	🔴	●
Surviving infants who received 2 WHO-recommended vaccines (%)	88	2020	🟡	→
Universal health coverage (UHC) index of service coverage (worst 0–100 best)	56	2019	🔴	↗
Subjective well-being (average ladder score, worst 0–10 best)	4.5	2021	🔴	→

Dashboards: SDG achieved 🟢 **Challenges remain** 🟡 **Significant challenges remain** 🟠 **Major challenges remain** 🔴
Trends: On track or maintaining SDG achievement ↑ **Moderately improving** ↗ **Stagnant** → **Decreasing** ↓

FIGURE 3: SDG performance per indicator

Significant progress has been made in reducing mortality rates for newborns, infants and under-five children. Still, more effort is needed to ensure the attainment of the SDG targets, especially for neonatal mortality rate and maternal mortality ratio. Noteworthy progress has also been made in (i) reduction of morbidity and mortality from HIV/AIDS with the attaining of high routine vaccine coverage, (ii) introduction of new vaccines, including those for rubella, bivalent inactivated poliovirus, human papillomavirus and malaria, and (iii) elimination of some diseases like maternal and neonatal tetanus and wild polio. However, the agenda remains unfinished, and to sustain progress, partner alignment, integration of health insurance, person-centred care and linkages with NCDs will need focus. Additionally, the child mortality agenda relating to eliminating mother-to-child transmission of HIV needs to be addressed. Ensuring the sustainability of the HIV response is critical, especially as large donors such as the United States President's Emergency Plan for AIDS Relief and the Global Fund to Fight AIDS, Tuberculosis and Malaria are requesting a higher share of domestic investments from countries for these efforts.

Malaria prevalence declined from 27% in 2015 to 19% in 2020 in the high burden, endemic lake zone and from 8% in 2015 to 5% in 2020 in the endemic coast area. Malaria incidence declined from 113 cases per 100 000 population in the financial year 2016/2017 to 79 per 100 000 population in the financial year 2020/2021 (MoH, 2022).

Kenya achieved the End TB Strategy milestone for 2020 with a 34% reduction in TB incidence compared to 2015 and against the target of 20% reduction. It also achieved a 44% reduction in TB deaths compared to 2015 (WHO TB Programme). The number of people co-infected with TB and HIV declined from 70 000 in 2014 to 35 000 in 2020.

Kenya was certified for Guinea worm-free status in 2018. It reduced the prevalence of lymphatic filariasis in its endemic coast region to less than 1%, for which it is awaiting validation and certification, and it lowered endemicity of trachoma by 80%. Onchocerciasis is no longer endemic in the country.

There was a reduction in tobacco use with the prevalence declining from 23% to 18.8% for male adults and from 4.1% to 2.3% for women from 2015 and 2019 (MoH, 2015; IHME 2019). Kenya's mortality rate due to hypertensive heart disease was 1.7% in 2019, lower than the global one of 2.05% (Mbau et al., 2021). Road traffic injuries accounted for 0.2% of all outpatient visits in fiscal year 2019/2020, down from 1% in fiscal year 2015/2016 (MoH, 2020).

Despite these accomplishments, several challenges hinder the acceleration of SDG progress. NCDs are becoming more prevalent, with incidences and mortality rates rising for conditions such as cancer. For instance, annual cancer cases increased from 37 000 to 47 887 and cancer-related deaths rose from 28 500 to 32 987 between 2012 and 2018. Road traffic fatalities surged by 47% from 2695 in 2016 to 3975 in 2020. Disparities in disease prevalence, like the variance in HIV rates across the counties, underscore the necessity for targeted efforts in specific areas. HIV prevalence ranges are significant, going from as high as 20.1% in Homa Bay county to as low as 0.2% in Mandera and Wajir counties (MoH, 2021). Also, despite the increase in the prevention of mother-to-child transmission of HIV from 8.3% to 10.8% between 2015 and 2020 (EGPAF, 2021) and a high national prevention of mother-to-child transmission coverage of 94% by 2020, targeted interventions are still required. Additional challenges include insufficient human, finance and supplies resources, limited service coverage, service quality issues, restricted community engagement, minimal private sector involvement, and ineffective cross-sector collaboration.

WHO Country Representative in Kenya, Dr Diallo (left) hands over Neglected Tropical Disease (NTD) medicines and Mpox diagnostic kits to Kenya's Cabinet Secretary for Health, Dr. Debra Mulongo Barasa (right).

This initiative aimed to support Kenya's goal of eliminating NTDs by 2030 and enhancing it's response to the Mpox outbreak.

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4. WHO and Kenya: A Collaborative History

WHO has a longstanding collaborative relationship with the Government of Kenya, primarily orchestrated through the CCS. The most recent CCS, which was for 2014–2019, set the tone for an inclusive partnership jointly formulated by MoH and WHO, reflective of the priorities outlined in the Kenya Health Sector Strategic and Investment Plan, 2023–2027.

This collaboration is governed by national and United Nations partnership frameworks, notably the Health Sector Partnership and Coordination Framework (2020–2030). This framework emphasizes aligning partner support with a joint work plan, implementation strategy and investment plan led by the government. It aims to enhance aid effectiveness through a sector-wide approach to health service delivery, acknowledging the diverse range of partners involved in Kenya's health sector at various levels and capacities. It proposes a harmonized approach to coordinate and optimize the use of all resources, addressing sector goals and priorities and achieving tangible results.

At its core, the Partnership and Coordination Framework incorporates structures that unify different stakeholders. The Health Sector Advisory and Oversight Committee operates at the highest level of this structure, providing strategic leadership and governance oversight towards the realization of UHC and the objectives set in the Kenya health sector strategic and investment plans. It is a pivotal forum for aligning developmental efforts, chaired by the Cabinet Secretary for Health and co-chaired by the chairperson of the Council of Governors' Health Committee and the chairperson of the Development Partners of Health in Kenya (DPHK). WHO, a permanent member of its executive branch, also hosts the office of the DPHK coordinator.

WHO Country Representative in Kenya, Dr Diallo and Kenya's Director General for Health, Dr. Amoth, during the launch of the Health Labour Market Analysis Tool (Beta 3.0), 2024.

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The Health Sector Interagency Steering Committee serves as the second tier, bringing together crucial health sector partners for strategic leadership and direction and fostering coordinated technical support and policy dialogue on strategic issues with government, donors, development partners, the private sector and civil society. The Health Sector Intergovernmental Consultative Forum is an active partnership forum with WHO as a prominent participant. The Interagency Coordinating Committee facilitates joint planning, coordination and monitoring of specific health sector investments. It is chaired by the MoH Director General, has representatives of the designated heads directorates for the respective thematic committees, and is co-chaired by a designated county's Executive Committee member for health and a development partners' representative, currently WHO. WHO is also represented in the technical working groups of the Interagency Coordinating Committee.

A partnership framework, the United Nations Sustainable Development Cooperation Framework (UNSDCF), previously called the United Nations Development Assistance Framework, has always coordinated the UN partner support to the government. The current UNSDCF framework is for 2022–2026, and WHO is the Lead Agency for Health. WHO's close relationship with MoH as a trusted partner has been critical in providing policy and technical guidance, norms and standards, particularly during public health crises like the COVID-19 pandemic. In addition, WHO has supported Kenya in various ways in strengthening the public health supply chain. This included updating of the essential medicines list, provision of technical

support for the Kenya Medical Stores reform in 2021, assessment of the pharmaceutical situation as was done for the for UHC pilot counties in 2018 and development of pharmaceutical policies and regulations.

Despite these strong ties, challenges still need to be addressed in WHO's engagement with other government departments to effectively address the social determinants of health and its involvement at the subnational level, given Kenya's operation through its devolution policy. To enhance effectiveness, WHO, through MoH, is exploring mechanisms to address these issues, ensuring a more integrated and comprehensive approach to health and well-being across Kenya.

Kenya has played a prominent role in health, catalysing work beyond the its borders. Kenya has been a member of the WHO Executive Board for three years since 2019 and took the helm at the Board as Vice Chair and Chair in 2020 and 2021, respectively, during the COVID-19 pandemic. Kenya was also among the first countries in Africa to pilot UHC as a national priority. The country was vital to cross-border collaboration for polio elimination in the Horn of Africa under the Intergovernmental Authority on Development in Eastern Africa.

In summary, this section outlines the historical and ongoing collaboration between WHO and the Kenya government, highlighting the frameworks and structures facilitating this partnership. It also identifies the challenges in devolution and the areas for improvement in the partnership to address broader social determinants of health and well-being. WHO has a longstanding collaborative relationship with the Government of Kenya, primarily orchestrated through the CCS. The most recent CCS, which was for 2014–2019, set the tone for an inclusive partnership jointly formulated by MoH and WHO and reflective of the priorities outlined in the National Health Sector Plan.

WHO Country Representative in Kenya, Dr Diallo visits Laikipia County Governor Joshua Irungu to understand the health system in the county, successes and gaps.

5. Strategic Agenda

The WHO cooperation strategy for Kenya articulates the organization's key areas of support to the Government of Kenya toward achieving its priorities as laid out in the Kenya National Health Policy, 2014– 2030, and in the context of the Kenya Vision 2030 and the Sustainable Development Agenda. It is also guided by the government's Bottom-Up Economic Transformation Agenda, 2022–2027[3], which calls for moving from a focus on curative to preventive and promotive services.

Mission, Vision and Strategic Priorities

WHO cooperation with the Government of Kenya takes into consideration the following guiding principles and critical considerations:

1. In line with the Government's devolution policy with mandates devolved to the county governments, the cooperation between the government and WHO needs to adjust to offer appropriate support to MoH and the subnational level, especially for capacity development.
2. With the increasing burden of noncommunicable conditions and with the role played by other sectors in addressing social determinants and facilitating access to health services, the cooperation will promote collaboration across the different government sectors.
3. Greater emphasis is placed on the health promotion and prevention of health conditions as a critical pathway to minimizing the disease burden and promoting healthy living.
4. Data and evidence are critical for technical guidance, policy, planning and strategy implementation, and digital health plays a significant role in facilitating and advancing health service delivery. Consequently, promoting data and evidence generation and using and applying technology and innovation to increase health service delivery will be vital components of the cooperation.
5. Efforts must be made to identify those populations left behind and ensure mechanisms to reach them are put in place. The issue of addressing inequality and equity should be high on the cooperation agenda.
6. To optimize the effectiveness and efficiency of the cooperation in the context of limited resources, the cooperation should prioritize areas where WHO has a comparative advantage and maximize synergy with other partners and other health sector stakeholders.
·Further strengthening the country's capacity for health emergency preparedness, readiness and timely response is essential.

3 The elements of the agenda are investing in HWF, with a focus on community health promoters who are well trained, fit for purpose and motivated to deliver health services at community level; reviewing the health financing architecture to ensure sustainable financing through Social Health Insurance while prioritizing vulnerable and marginalized populations; strengthening health commodity security by investing in local manufacturing to increase access and affordability of essential health commodities; and leveraging on integrated digital technologies to deliver efficient health care services while ensuring end to end visibility and accountability in the supply chain pipeline system.

WHO's mission is a Kenya in which all people attain the highest possible level of health and well-being and strive to achieve the goals of the Kenya Health Policy, 2014–2030, and the SDGs.

The vision of this CCS is one in which the people of Kenya, especially children, women and the most vulnerable groups,[1] benefit from UHC, enjoy better protection from health emergencies and have better health and well-being everywhere in the country.

The strategic priorities of the previous CCS that were found to be still relevant were retained with adjustments, while the new aspects necessary to build capacity for strong leadership and stewardship of health were considered critical for ensuring the success of the traditional strategic priorities for the three goals of GPW 13. These aspects relate to data, evidence and technology application on the one hand and broadening partnerships and promoting all-of-government engagement on the other.

This CCS, therefore, focuses on the following strategic priorities:

1. **Strengthening** health systems for accelerating progress towards UHC and addressing priority communicable and noncommunicable diseases;
2. **Protecting** the population from and reducing the impact of health emergencies;
3. **Promoting** healthy living and accelerating actions to address determinants of health;
4. **Strengthening the country's leadership and stewardship of health.**

For each of these strategic priorities, the strategic deliverables and key outputs of WHO's work are outlined below (see also Fig. 4).

4 These include those living in ASAL counties and informal settlements.

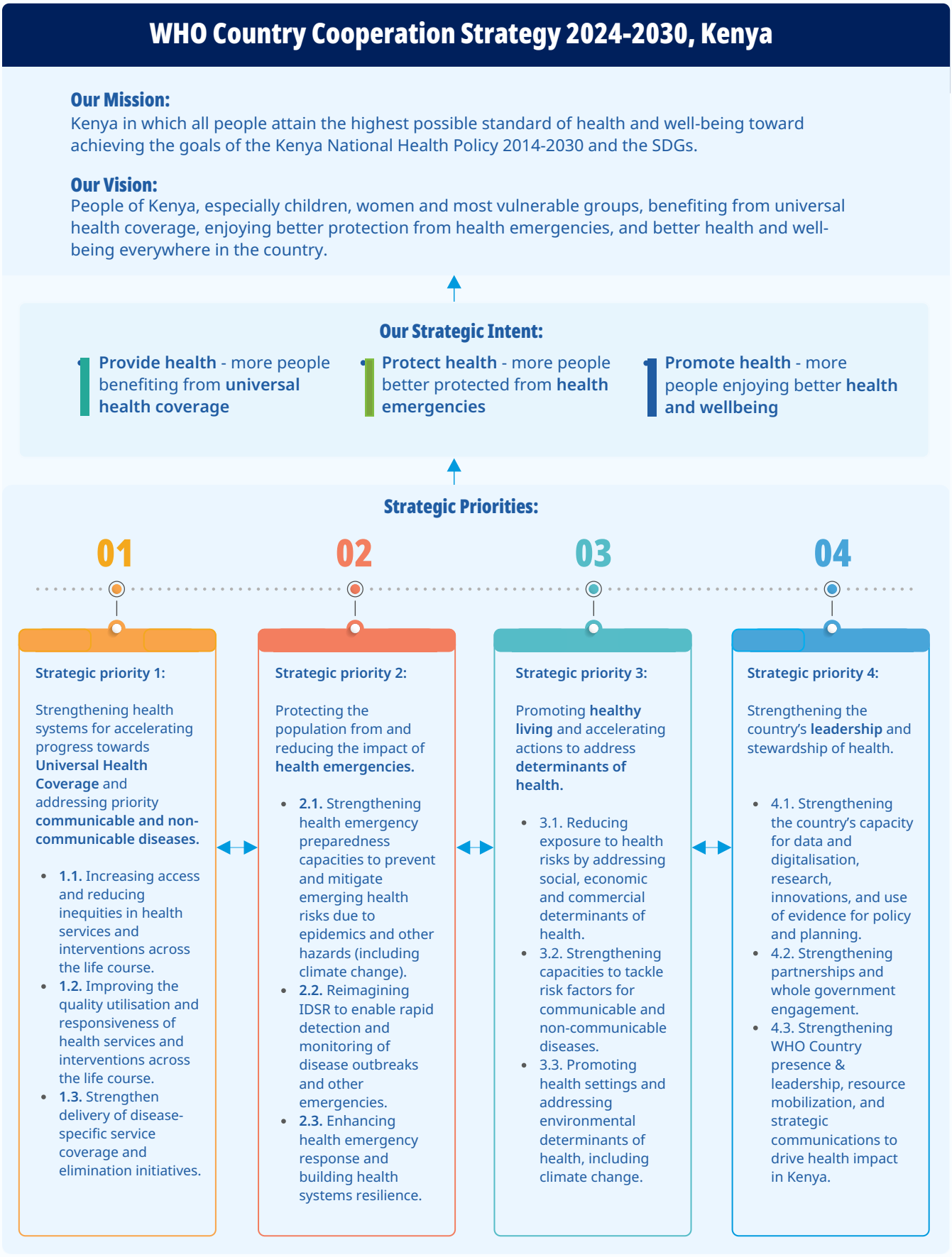


Fig. 4. Strategy logic map for the WHO Country Cooperation Strategy, 2024-2030, Kenya

Strategic Deliverables and Key Outputs

5.1 Strategic Priority 1:
Strengthening health systems for accelerating progress towards UHC and addressing priority communicable and noncommunicable diseases

A. Deliverable 1.1: Increasing access to and reducing inequities in health services, financing and interventions across the life course

(a) Reinvigorating PHC with strong and effective PHC networks that link communities to the different levels of service and health facilities, and strengthening their capacities. The capacity of community health will also be enhanced through established community health promoters with at least one per 1000 population. The community health promoters are part of a PHC team, and the overall PHC teams' capacity will be enhanced. This will include reinforcing technical guidance on the most appropriate model of UHC and developing appropriate essential health care packages, including health benefits packages that integrate communicable, noncommunicable and mental health conditions. In this regard, WHO will also support strengthening of effective and efficient supply chain management to ensure that affordable and quality essential medicines and other health commodities are available. Significant effort will be put into supporting local production with international standards. In addition, WHO health systems/UHC coverage will emphasize the interrelated nature of strengthening of the workforce, the supply chain and essential medicines and commodities.

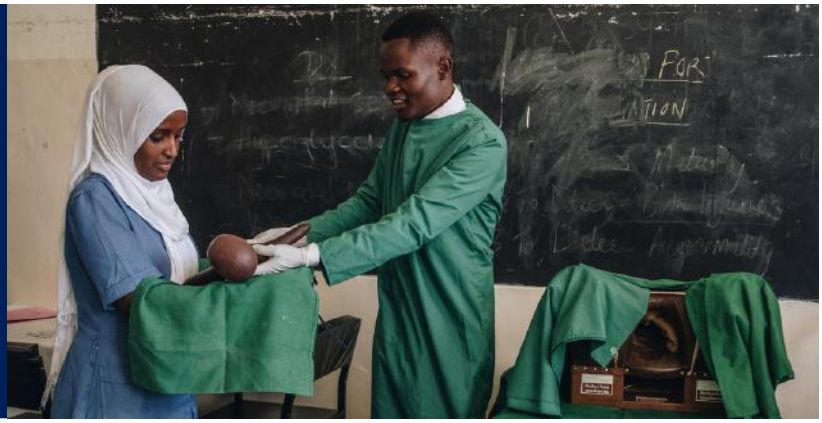
(b) Ensuring sustainable health financing with increased domestic financing, less dependency on external funding, increased efficiency in utilization of funds and repurposing of the hospital insurance fund to social health insurance that meets the needs of all Kenyans. The support will also include implementing the new policy, identifying those getting subsidized services and digitalizing NHIF processes.

(c) Ensuring that adequate, motivated, quality and fit-for-purpose HWF, including multidisciplinary PHC teams and community health promoters, is in place at all levels, guided by appropriate, evidence-based policies and strategies.

Ifra Barrow and Stanley Simwa practice delivery techniques in the Kenya Medical Training College Skills Lab.

Nairobi, Kenya.

© WHO / Khadija Farah



Community health promoters in a remote part of Laikipia are visiting a Masai Manyatta to ensure their families are healthy.

If any of them seem unwell or might need medical assistant they refer them to the closest health facility.

© WHO / Genna Print

Mark from the WHO Country Office in Kenya conducts a training with healthcare workers from Lamu County to improve **response to and prevention of cholera.**

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B. Deliverable 1.2: Improving the quality, utilization and responsiveness of health services and interventions and HWF capacity across the life course

(a) Strengthening continuous quality improvement, regulatory frameworks and accreditation of health services in line with the Kenya Quality Model for Health (2018) and the Quality-of-Care Certification Framework for the Kenyan Health Sector (2020).

(b) Digitalizing and integrating health information management systems to ensure the availability and use of real-time data for UHC and strengthened disease-specific health response.

(c) Addressing the life-course health conditions, particularly for sexual, reproductive, maternal, newborn, child and adolescent health, and healthy ageing.

C. Deliverable 1.3: Strengthening delivery of disease-specific service coverage and disease elimination initiatives

(a) Strengthening effective implementation of interventions to control and eliminate HIV/AIDS, TB, viral hepatitis and sexually transmitted infections.

(b) Strengthening strategies, guidelines, governance and disease intervention packages to control and eliminate malaria, neglected tropical diseases, Dengue fever and other priority tropical and vector-borne diseases.

(c) Sustaining high coverage of essential and new vaccines and the elimination of targeted vaccine-preventable diseases and polio eradication status.

5.2 Strategic Priority 2:
Protecting the population from and reducing the impact of health emergencies

To protect the population from health emergencies and reduce their impact, the country needs to have the capacity to predict, detect and respond timeously to any health or humanitarian emergency and ensure that there is no or only minimal disruption of the provision of essential health services. Hence, emphasis will be placed on emergency preparedness, emergency response and health system resilience.

The identified priority strategic deliverables under emergency preparedness and response (EPR) are (i) health emergency preparedness to prevent and mitigate emerging health risks due to epidemics and other hazards, including climate change, (ii) reimagining IDSR to enable rapid detection and monitoring of disease outbreaks other emergencies, and (iii) enhancing health emergency response and building health systems' resilience (see Figs 5 and 6). The strategic deliverables and expected key outputs are outlined Fig. 5. Strategic deliverables on emergency preparedness and response.

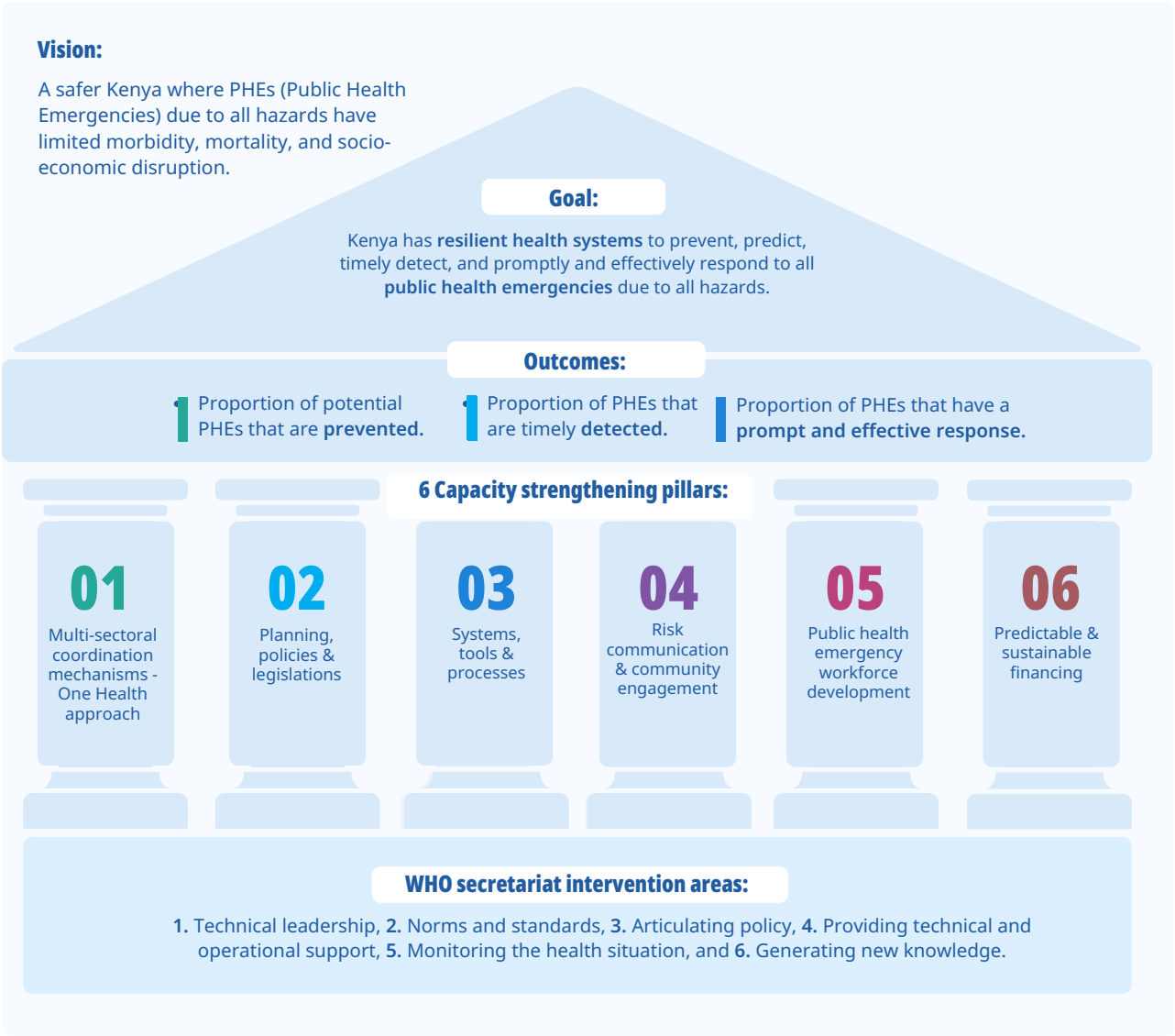

Fig. 5. Strategic deliverables on emergency preparedness and response.

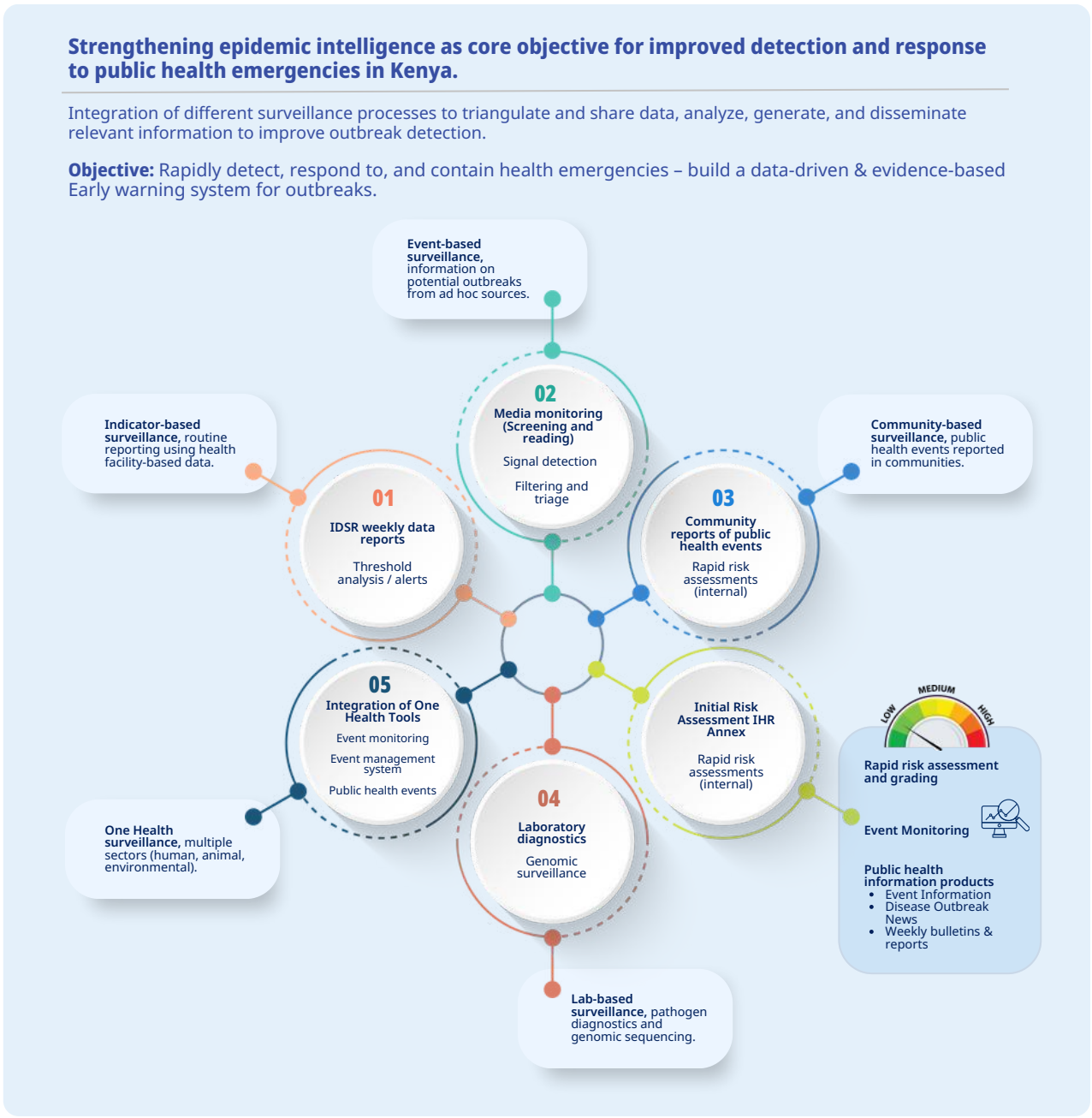

Fig. 6. Detection of public health emergencies in Kenya.

A. Deliverable 2.1: Strengthening health emergency preparedness capacities to prevent and mitigate emerging health risks due to epidemics and other hazards, including climate change

(a) Strengthening infectious disease outbreak preparedness and utilization of the One Health approach in Kenya. This will include strengthening and tracking IHR (2005) core capacities and conducting gender-based vulnerability assessments, identifying groups disproportionately affected by emergencies such as pregnant women and single mothers and tailoring preparedness and response plans accordingly.

(b) Resource mobilization for repositioning strategic information and generation of improved quality health metrics for scaling up and better preparedness for outbreak monitoring and response;

(c) Enhancing governance and stewardship to combat antimicrobial resistance, strengthening surveillance and infection control and ensuring accessible, quality-assured and responsibly used medicines.

B. Deliverable 2.2: Reimagining IDSR to enable rapid detection and monitoring of disease outbreaks and other emergencies

(a) Strengthening integrated disease surveillance and bolstering data and information systems and their applications both at national and subnational levels for enhanced public health intelligence;

(b) Institutionalizing integrated multidisciplinary performance and data reviews at all levels for improved outbreak monitoring and response;

(c) Improving systems for multidisciplinary and multisectoral M&E of IDSR performance.

C. Deliverable 2.3: Enhancing health emergency response and building health systems' resilience

(a) Strengthening and building the legal framework and capacity for core IHR (2005) competencies and strengthening sectoral and intersectoral coordination and collaboration for better alignment, complementarity and synergy of strategies and their operationalization at national and subnational levels;

(b) Enhancing disaster risk management, ensuring effective engagement with set multi-stakeholder disaster management structures. This will include ensuring equitable access to emergency services and addressing potential gender disparities in access to vaccines, personal protective equipment and other essential interventions during emergencies; promoting gender-inclusive communication, that is the use of clear and inclusive language in awareness campaigns and information dissemination to reach all populations effectively; and mitigating gender-based violence during emergencies through integrating measures to prevent and respond to gender-based violence in emergency response protocols.

(c) Promoting health systems resilience for emergencies and enhancing knowledge synthesis, knowledge translation and knowledge exchange to deliver on the research and innovation agenda for outbreak preparedness and response, emerging best practices and lessons learned at both national and subnational levels. This includes enhancing risk communication and community engagement to empower communities to cope with public health emergencies.

After a flash flood in Mai Mahiu 2024, displaced families were housed in a school where they slept in classrooms. During response, women and men were divided to sleep in different locations as a gender - based violence prevention method during the response.

Beatrice who lost her house stand in the classroom that she has been sleeping in.

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5.3 Strategic Priority 3:
Promoting healthy living and accelerating actions to address determinants of health

While recognizing that health services need to be comprehensive to include promotive, preventive, curative, rehabilitative and palliative care, low attention has been given to promoting health and well-being. The Government of Kenya has prioritized promotive and preventative health care, significantly contributing to a healthier population.

The Healthier Population Billion target aims to address the factors influencing people's health that are outside the direct control of the health sector, focusing on:

1. **Healthier environment,** that is air, water, roads etc.
2. **Healthier eating** to reduce wasting, stunting, overweight etc.
3. **Healthier life choices,** for example not smoking or using alcohol
4. **More beneficial relationships,** for example stopping violence against women and children.

The CCS priority deliverables under strategic priority 3 are: (i) reducing exposure to health risks by addressing social, economic and commercial determinants of health, (ii) strengthening capacities to tackle risk factors for communicable and noncommunicable diseases (iii) promoting healthy settings and addressing environmental determinants of health, including climate change.

The WHO collaboration will prioritize technical support for the following areas:

A. Deliverable 3.1: Reducing exposure to health risks by addressing social, economic and commercial determinants of health

(a) Assessing and monitoring health risks;

(b) Strengthening health promotion approaches, including health education and communication to reduce risk factors for NCDs (including harmful use of alcohol, substance abuse, physical inactivity, obesity, tobacco use, raised blood pressure etc.) and road traffic accidents and for effective implementation of cost-effective interventions to tackle priority NCDs, that is cardiovascular disease, chronic respiratory disease, cancer, diabetes and mental disorders.

(c) Promoting personal hygiene, cleaner and safer environments (including at the workplace), air, water, sanitation, recreation areas and radiation locations and anticipating and mitigating effects of climate change through a climate-resilient health system.

B. Deliverable 3.2: Strengthening capacities to tackle risk factors for communicable and noncommunicable diseases

(a) Assessing and monitoring health risks

(b) Strengthening health promotion approaches to reduce risk factors for NCDs (including harmful use of alcohol, substance abuse, physical inactivity, obesity, tobacco use, raised blood pressure) and road traffic accidents) and effective implementation of cost-effective interventions to tackle priority NCDs (CVD, CRD, Cancer, diabetes, and mental disorders)

(c) Promoting cleaner and safer environments, including workplace, air, water, sanitation, recreation, radiation, and anticipating and mitigating effects of climate change through a climate-resilient health system

C. Deliverable 3.3: Promoting healthy settings and addressing environmental determinants of health, including climate change

(a) Health governance and leadership capacity to advance the promotion of health and well-being;

(b) Integration of mental health into routine health services and enhanced multisectoral approach to ensure mental health in all sectors;

(c) Strengthening equitable access to safe, healthy and sustainably predicted foods and reducing the burden of all forms of malnutrition and foodborne diseases through the life course for better health and well-being.

The key outputs of this work will include (i) supporting the development of policies and providing regulatory systems guidance to promote, protect and support the consumption of safe and healthy diets throughout the life course; (ii) strengthening health systems' capacities in the prevention and management of all forms of malnutrition in all settings, including during emergencies; (iii) strengthening the capacities to monitor nutrition status indicators across the lifecycle and foodborne diseases to improve availability, quality and concurrency of nutrition data for planning prioritization and decision-making; (iv) supporting national food systems, aligning with WHO global strategies on food safety; and (v) improving participation in contribution to national and international codex standards to ensure food safety standards are met, and fostering partnerships and collaborations with different stakeholders to enhance multisectoral actions towards nutrition and food safety through a one-health approach.

5.4 Strategic Priority 4:
Strengthening the country's leadership and stewardship of health

The strategic priorities tied to strengthening the country's leadership and stewardship of health sector programming will focus on (i) strengthening the country's capacity for data and digitalization, research, innovations and use of evidence for policy and planning, (ii) strengthening partnerships and whole-of-government engagement and (iii) strengthening WHO country presence and leadership, resource mobilization and strategic communications to drive health impact in Kenya.

WHO will work with MoH to ensure that there is data and reliable evidence to guide policy, planning and implementation. Evidence will be critical in policy dialogue, considering ethical and evidence-based options, providing standards and technical guidance, and setting the research agenda. Given the nature of the country's set-up, there will be a need to strengthen partnerships across other government sectors and between the public and private sectors, both at national and sub-national levels. **The focal areas and the key outputs of WHO collaboration will include the following:**

A. Deliverable 4.1: Strengthening the country's capacity for data and digitalization, research, innovations and use of evidence for policy and planning

(a) Strengthening capacities of counties and national government for digitalization, real-time data management, analytics and application of health information systems and technological advances to improve service delivery and inform policies;

(b) Generation of evidence, enhancement of knowledge management and sharing of best practices while enhancing internal capacity for technology uptake and promotion of innovation;

(c) Setting the health research agenda and strengthening capacities for innovations and use of technology.

B. Deliverable 4.2: Strengthening partnerships and whole-of-government engagement

(a) Enhancing intersectoral collaboration at both national and county levels through the partnership framework and engagement with intergovernmental forums, parliamentarians and Council of Governors;

(b) Strengthening partnerships between the public sector and both for-profit and not-for profit private sector and engagement with the other UN agencies;

(c) Enhancing regional collaboration through multi-country cooperation and sharing of experiences.

C. Deliverable 4.3: Strengthening WHO Country presence & leadership, resource mobilisation, and strategic communications to drive health impact in Kenya

(a) Enhanced strategic communications and visibility of the WHO Country Office, building on WHO's convening role

(b) Institutionalising advocacy and resource mobilisation across programs

(c) Enhancing WHO Country Office capacities for efficient & effective administration, human resources, procurement, logistics, and financial management to ensure effective delivery and impact

5.5 Linkages of the strategic agenda with the Government and UNSDCF's priorities

This CCS is rooted in WHO policies and strategies and is aligned with national and global policies and procedures. The strategic priorities have strong links with the national health priorities of Kenya's government. They also have strong links with GPW 13, UNSDCF and the SDGs, as shown in Table 2.

CCS strategic priority	GPW 13	National Health Policy (2014–2030)	UNSDCF	SDGs
1. Strengthening health systems for accelerating progress towards UHC and addressing priority communicable and non-communicable diseases	**Achieving UHC** One billion more people benefitting from UHC	**Main objective:** Attain universal coverage of critical services that positively contribute to the realization of the policy goal **Policy objective 1:** Eliminate communicable conditions **Policy objective 2:** Halt and reverse the rising burden of noncommunicable conditions and mental disorders **Policy objective 4:** Provide essential health care	**Output 1.2.1:** Enhanced systems and capacity of the national and county governments, non-state institutions and communities to efficiently deliver to women, girls, children and youth inclusive, accessible and equitable health care, including reproductive, maternal, newborn, child and adolescent health; HIV; water, sanitation and hygiene; and food and nutrition services	**Target 3.8:** UHC **Target 3.1:** Maternal mortality **Target 3.2:** Neonatal and child mortality **Target 3.3:** Infectious diseases **Target 3.4:** Non-communicable diseases **Target 3.7:** Sexual and reproductive health
2. Protecting the population from and reducing the impact of health emergencies	**Addressing health emergencies** One billion more people better protected from health emergencies	**Policy objective 4:** Provide essential health care		**All SDG 3 targets;** **Target 11.5** (reduction of economic losses caused by disasters) **Target 16.1:** Reduce violence everywhere
3. Promoting healthy living and accelerating actions to address determinants of health	**Promoting healthier populations** One billion more people enjoying better health and well-being	**Policy objective 3:** Reduce the burden of violence and injuries **Policy objective 5:** Minimize exposure to health risk factors		**Target 3.4:** Noncommunicable diseases **Target 3.5:** Substance abuse **Target 3.6:** Road traffic accidents **Target 3.9:** Environmental health
4. Strengthening the country's leadership and stewardship of health	**More effective and efficient WHO** providing better support to countries	**Policy objective 6:** Strengthen collaboration with private and other sectors that have an impact on health		

Data manager, Flavia Naudi shows the tablet she uses to record digital data at Railways Health Clinic in Kisumu, April 2024.

At the end of every month, the clinic is able to efficiently analyze patient trends, track inventory, and quickly share accurate health records, improving overall patient care and decision-making.

6. Implementing the Strategic Agenda

This CCS will be implemented through four consecutive WHO biannual programme budgets and work plans. This section articulates the approaches for effectively implementing the strategic priorities of this CCS, which aligns with the WHO constitutional mandate and core functions. It also outlines the implications for the three levels of the organization, that is WCO, the WHO Regional[3] Office for Africa and the WHO headquarters.

6.1 Implementation Approaches

The approaches to implement this CCS will be guided by the WHO values and principles set out in the WHO constitution. These values include the regard of the enjoyment of the highest attainable standard of health as one of the fundamental rights of every human being without distinction of race, religion, political belief or economic or social condition. They also include a commitment to health universality and equity. WHO will leverage its comparative strengths and core functions to ensure a significant public health impact in Kenya. These strengths include the organization's global mandate and platform, the combined expertise of its three organizational levels, its reputation as an impartial convener, its stewardship of global standards and conventions, its role as a trusted and authoritative source of health information, and its technical and policy expertise. In addition, the approaches to translate this CCS into action will be anchored in the organization-wide strategic and organizational shifts articulated in GPW 13, including the organization's stepping up in leadership, driving public health impact in every country and focusing global public goods on impact, **all which reflect WHO's six core functions, as outlined.**

1. **Stepping up leadership.** In implementing this CCS, WHO will pursue its work on healthy lives and well-being – including UHC, health emergencies and healthier populations – and will leverage its diplomacy, advocacy and convening roles to support national health leadership in aligning this broad array of health actors with national priorities and systems. WHO will also engage with the political level and various non-state actors to support Kenya's health and development agenda.

2. **Strategic policy dialogue.** WHO will focus the strategic policy dialogue on Kenya's needs and the pertinent resolutions and decisions of the WHO governing bodies, that is the World Health Assembly, WHO Executive Board and the WHO Regional Committee Africa. The dialogues will be anchored on WHO's science, evidence-based policy briefs and normative guidance documents. As a trusted source of knowledge and data, WHO will effectively support and advocate for policy actions in line with GPW 13 and GPW 14 priorities.

3. **Strategic support.** To strengthen Kenya's national health system's performance in terms of health coverage and equity, responsiveness, financial risk protection and efficiency, WHO strategic support will include the provision of advice on various aspects of health system building blocks and UHC, as well as reviewing the global and regional policies and actions agreed at the World Health Assembly and the WHO Regional Committee for Africa.

3

4 **Technical assistance.** Technical cooperation between WHO and Kenya will strengthen individual and institutional capacity and allow provision of technical assistance. WHO provides integrated and coordinated technical guidance through contextualizing norms, standards and guidelines and the coordination and translation of research into health interventions.

5 **Service delivery.** WHO will provide the required service functions that may be needed during acute emergencies for which the country might require catalytic support, including technical expertise, equipment, kits, medicines, vaccines or supplies to augment the capacities existing in the country.

Jackton, a worker at the Cholera Treatment Unit in Nairobi, demonstrates how he mixes chlorine for cleaning. The treatment unit was set us as part of Kenya's emergency response to a cholera outbreak, first reported in October 2022.

© WHO / Billy Miaron

6.2 Implications for the WHO Country Office: Core Competencies and Capacities

The strategic agenda and the strategic approach for delivering the WHO core functions have significant implications for the competencies and capacities needed at WCO in Kenya to implement this CCS efficiently and effectively and drive impact in Kenya. Building on the WHO/AFRO functional review conducted in 2018, the approved organogram version of 7 March 2022 and the WHO core predictable and country presence (CPCP) recommendations, the shifts in human resource allocation, the staff profiles and the new capacities required at the Kenya WCO to successfully deliver the results envisaged by this CCS are as follows:

6.2.1 Strategic and empowered office of the WHO Country Representative

In line with the CPCP recommendations that categorized the WHO Country Office Kenya in Group E (full country support, including field operations), a new position of Deputy WHO Representative will be established. Under the WHO Representative's leadership, the this position will mainly provide oversight and coordination of the WHO Country Office technical teams.

The Programme Management Officer and the External Relations and Resource Mobilization function will be maintained to enhance the WHO Country Office programme planning and management capacities and to accentuate WHO's partnerships and resource mobilization drive and capacities to engage with government departments, development partners, nongovernmental and civil society organizations, the private sector and other stakeholders in Kenya.

With the increasing demand of and higher capacities required to support the WHO Representative's office, a senior administrative assistant National Officer Level A is required. An additional administrative assistant (G6) will be needed to support the office of the Deputy WHO Representative.

WHO Country Office Representative in Kenya, Dr Diallo addresses delegates from across the African continent during the launch of the Health Labour Market Analysis Tool (Beta 3.0) in Nairobi, 2024.

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6.2.2 Robust cross-cutting functions team

To enhance WHO's critical role in health leadership, WHO Country Office's visibility, internal and external communications, programme support and the representative's office, the communications team needs to be strengthened and at least an additional communications expert, a national programme officer (NPO) recruited. This position will add value to WHO work in the country through media relations and engagement, advocacy, event organizing, social media content and constant engagement with the public using different channels, including social media.

Efforts will be made to mobilize the resources required to fill the health information officer (international) position recommended by the functional review. In addition, a new position to support research and innovation will be needed to advance this critical and relevant agenda.

As the location of the WHO Regional Emergency and Logistics Hub, the Multi-country Assignment Team and more than 100 staff members and special service agreement contract holders, WHO Country Office in Kenya requires a dedicated expert to focus on preventing and responding to sexual exploitation, abuse and harassment. This will ensure the effective implementation of initiatives and activities to mitigate reputational risks to the Organization.

WHO collaborated with Busia's local radio and TV stations to promote its initiative helping farmers switch from tobacco to bean farming. The photos capture farmers who have successfully made the transition, sharing their testimonials.

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6.2.3 Strengthened UHC life course team

Resource mobilization efforts will be enhanced to fill the positions of health financing (international), health systems (NPO) and essential drugs and medicines/health tech regulation (NPO), possibly combined with the laboratory (NPO) post, four of the five positions approved during the functional review. In addition, efforts will be made to fill the posts of family and reproductive health lead (international), sexual, reproductive and maternal health NPO, nutrition NPO and neonatal, child and adolescent health NPO as soon as possible. The currently funded NPO posts, two programme assistants and the health policy, planning, coordination and governance position (international) will be retained.

6.2.4 Enhanced UHC communicable and noncommunicable diseases team

The critical positions recommended during the functional review are filled currently. These include the HIV/AIDS/lead (international); NPO positions on malaria, TB, neglected tropical diseases, NCD and Expanded Programme on Immunization/routine immunization and a programme assistant. Given that Kenya has been categorized as a high-risk country for poliomyelitis, human resource capacities will be required to heighten surveillance and conduct supplemental immunization activities. A post for the coordinator for vaccine-preventable diseases (international) will be established to lead the polio/ Expanded Programme on Immunization interventions, based on resource availability. As the Malaria Vaccines Programme winds down, discussions will continue regarding the resources to sustain at least one of the two currently filled positions. The public health and environment post also will be filled based on the availability of funds.

6.2.5 Responsive EPR team

The increasing requests for WHO support to protect the population from and reduce the impact of health emergencies necessitate a more responsive EPR team. Accordingly, when funding becomes available, WHO will establish additional NPO positions for health operations, health information, health logistics, M&E and epidemiologists and a programme assistant (G6). Also, the EPR team lead post will be upgraded to grade P5, per the CPCP recommendations. These will be in addition to the four currently approved posts on health risk management (international), IDSR/IHR, infectious hazard management and programme assistance.

6.2.6 Efficient and resourceful country support unit

The currently approved operations officer and general service posts will be maintained. Resource mobilization efforts will be enhanced to fill the four approved international positions for ICT, programme budget and finance, logistics, procurement and travel, and HR officers. With the increasing financial resources managed by WCO and the need to ensure accountability, efficiency and effectiveness, the finance officer post (NOA) will be retained and possibly upgraded to National Officer, Level B grade.

As the workforce expands, encompassing temporary and short-term staff, consultants and those on special service contracts, WCO in Kenya recognizes the imperative to build a robust HR team. This

Stephen Ntoburi, a Field Officer in the WHO Country Office in Kenya visits a remote Maasai community to monitor and support immunization efforts in the area.

reinforced HR team plays a pivotal role in bolstering business operations, ensuring regulatory compliance, shaping policies and safeguarding the welfare of both the staff and the organization. Additionally, ensuring HR operational effectiveness will facilitate the strategic orchestration of HR activities, including the annual HR rhythm, fostering enhanced leadership, heightened employee engagement and more robust career development. To support these efforts, WCO will establish two human resources officer (NOA) positions when funding becomes available, further solidifying the HR function's foundation. The strengthened HR team will contribute to improved performance management and cultivate an environment characterized by trust, transparency and open communication among staff, along with staff and organizational well-being, thereby fostering a culture conducive to organizational growth and excellence.

6.2.7 Sustained district health systems team

Kenya's focus on devolution requires a robust team at WHO Country Office under the WHO Country Office Representative to support the policy and strategic guidance in the devolution of health actions and strategic field-based operations. Provided the resources are available, efforts will be made to sustain the profile and team composition approved by the functional review, comprising five district health systems officers, a district surveillance/information NPO, a programme assistant and five drivers.

Shem Kiptoon, District Health Systems officer sits with colleagues during a field visit to the Lunga Lunga community in Nairobi.

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6.3 Implications for the WHO Regional Office for Africa and WHO Headquarters

Implementing this CCS involves a coordinated effort across the three levels of WHO. The critical aspects of this collaborative approach are as follows:

6.3.1 Optimized expertise and support

WCO will strategically utilize the expertise and resources from across the organization's three levels. This includes tapping into specialized teams and institutions such as the Multi-country Assignment Teams and the WHO Emergency Hub in Nairobi.

The Multi-country Assignment Team based in Kenya, along with one of the 11 embedded teams in the African Region established in 2021, supports the WCOs in Kenya, Mauritius, Rwanda and Seychelles. It provides continuous and integrated high-level strategic and technical support for programmatic priorities.

The WHO Emergency Hub in Nairobi, one of the modern storage centres for essential medical equipment and consumables, is crucial in ensuring timely logistical support to countries facing emergencies in eastern and southern Africa. The hub also houses a centre of excellence specializing in capacity building in health and crisis emergency management. It offers crucial support to countries in responding to outbreaks and emergencies from a closer range and in real time. This arrangement enhances the ability of WHO to provide immediate and effective assistance during health crises, leveraging its proximity and specialized expertise.

6.3.2 Local collaboration for capacity building

WHO will enhance collaboration with local institutions in Kenya to build sustainable country capacity. This will involve working closely with national health authorities, research institutions and other stakeholders to ensure that the support provided is tailored to Kenya's specific needs and context. Such collaboration will address the immediate health challenges and build long-term capacity and resilience in the Kenyan health system.

6.3.3 Collaborative planning and budgeting

Within the framework of the one WHO country plan and budget, based on this CCS the details on the support from the Multi-country Assignment Team, Regional Office and headquarters will be consolidated in the biennial country support plans. This collaborative planning ensures the strategies and actions are well coordinated and aligned with the CCS's overarching goals.

These approaches underscore the importance of a cohesive and integrated process involving various WHO levels and local stakeholders in implementing the CCS. By leveraging resources and expertise from the Regional Office and headquarters and closely collaborating with local partners, WHO aims to make a significant and sustainable impact on the health sector in Kenya.

6.4 Financial implications and budget

Implementing this CCS requires an estimated budget of US$ 152.5 million (Table 3). This financial projection reflects the imperative to secure catalytic funding that aligns with the strategic priorities outlined within this document.

This budget estimate does not account for major event-based interventions associated with disease outbreaks and other health emergencies that may occur during the period. To address such potential exigencies and other required needs, WHO will proactively mobilize additional resources at both local and international levels. This effort will be complemented by leveraging resources from other United Nations agencies and various partners and stakeholders within the health sector.

WHO's strategic approach to resource mobilization will involve a multifaceted strategy aimed at ensuring the financial sustainability and effectiveness of this CCS' initiatives. This includes establishing robust partnerships, advocating for increased investment in health and optimizing the use of available resources to maximize health outcomes for the people of Kenya.

The commitment to transparency and accountability in the management of these resources will be paramount. This will ensure that funds are utilized efficiently and effectively to achieve the intended health improvements and to support Kenya in its journey towards achieving the health-related SDGs. This financial framework underscores WHO's dedication to fostering a collaborative and well-funded approach to health development in Kenya, ensuring that the strategic goals of this CCS are met with the necessary financial backing.

Strategic priority	Budget (US$)
1. Strengthening health systems for accelerating progress towards UHC and addressing priority communicable and noncommunicable diseases.	57 000 000
2. Protecting the population from and reducing the impact of health emergencies.	27 000 000
3. Promoting healthy living and accelerating actions to address determinants of health	40 000 000
4. Strengthening the country's leadership and stewardship of health	28 000 000
Total	**152 500 000**

Table 3. Budget by Strategic Priorities

7. Monitoring and Evaluation

This CCS will be monitored and evaluated based on the WHO impact and accountability framework. As an element of the WHO results-based management system, the framework, which aligns with the impact- and outcome-focused approach of GPW 13, articulates the health impact and outcomes resulting from the programme outputs, activities and inputs. While WHO will be accountable for the inputs, activities and outputs, the Government of Kenya and WHO will take joint responsibility for the outcomes and impact. This section outlines the M&E approaches, including performance monitoring, performance targets and the evaluation mechanisms that will be adopted to track impact and accountability for this CCS.

7.1 Performance Monitoring

The biennial programme of action that will be developed to translate this CCS into action will include a robust monitoring framework of intervention-specific indicators that jointly contribute to the planned outputs and outcomes. The status of these indicators will be assessed and tracked to determine their outcomes and impact on Kenya's national health development using the regular WHO semi-annual monitoring of work plan implementation.

Each two years the CCS performance will be monitored and assessed using performance monitoring reports as follows:

1. **First semi-annual performance monitoring report at six months**
2. **Mid-term performance monitoring report at 12 months (for each biennium)**
3. **Second semi-annual monitoring report at 18 months**
4. **End of biennium performance report at 24 months**

The semi-annual monitoring and assessments will aim to achieve the following goals:

1. **To establish that the focus of WCO programmes and resources is on implementing the CCS strategic agenda;**
2. **To assess progress in implementing planned activities and expected outputs that contribute to achieving the performance targets of the strategic priorities and strategic deliverables;**

3. **To determine whether the activities related to the CCS's strategic priorities are being implemented timeously and efficiently, that is without waste of inputs or resources vis-à-vis the completed planned activities;** [3]
4. **To identify, analyse and fix process bottlenecks in implementing the planned activities, contributing to attaining of the strategic priorities;**
5. **To identify the strategic priorities, strategic deliverables and key outputs related to the activities that should be reprogrammed in the biennial operational work plans.**

The biennial programme of action that will be developed to translate this CCS into action will include a robust monitoring framework of intervention-specific indicators that jointly contribute to the planned outputs and outcomes. The status of these indicators will be assessed and tracked to determine their outcomes and impact on Kenya's national health development using the regular WHO semi-annual monitoring of work plan implementation.

7.1.1 Reprogramming and adaptation

Based on the monitoring outcomes, activities related to the strategic priorities may be reprogrammed to adapt to evolving health needs or operational challenges. This flexible approach ensures that the CCS will remain dynamic and responsive to the changing health landscape in Kenya.

7.1.2 Joint responsibility and accountability

While WHO is accountable for the inputs, activities and outputs, the outcomes and impact are the joint responsibility of WHO and the Government of Kenya. This collaborative approach reinforces both parties' commitment to achieving the goals set out in this cooperation strategy.

7.1.3 Learning and improvement

The M&E process is designed not only for accountability but also as a learning tool. The insights gained from M&E will inform future WHO strategy adjustments, policy development and implementation of health programmes in Kenya.

7.2 Performance Targets

The overall measurement of the impact of this CCS will be tracked using the healthy life expectancy (HALE) achieved in Kenya, the UHC index, the Better Protected Index and the Healthier Population Index, as defined in the GPW 13 results framework. The outcomes of implementing this CCS will be tracked using the GPW 13 outcome indicators and the SDG targets and indicators, especially given that the CCS end date aligns with that of the Sustainable Development Agenda and the SDGs. These indicators also align with the Kenya Health Sector Strategic Plan, 2023–2027, M&E plan. The SDG targets related to each strategic priority are shown in Table 4. In addition, the output performance targets/indicators (see Annex 1) will be assessed and reported in biennial performance reports, with balanced scorecards that track the performance of each strategic priority articulated in this CCS.

Strategic priority	SDG 3 targets	Other health-related SDG targets
Strengthening health systems for accelerating progress towards UHC and addressing priority communicable and noncommunicable diseases	**3.8** Universal health coverage **3.b** Provide access to medicines and vaccines for all, support R&D of vaccines and medicines for all. **3.c** Increase health financing and health workforce in developing countries. **3.3** End the epidemics of HIV, TB, malaria and NTDs and combat hepatitis and waterborne and other communicable diseases. **3.4** Reduce mortality from NCDs and promote mental health.	**2.2** End all forms of malnutrition, including achieving by 2025 the internationally agreed targets on stunting and wasting in children under five years of age and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons. **5.2** Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation.

Continued...

Strategic priority	SDG 3 targets	Other health-related SDG targets
	3.6 Halve global deaths and injuries from road traffic accidents. **3.1** Reduce maternal mortality.	**5.3** Eliminate all harmful practices such as child, early and forced marriage and female genital mutilation.
Strengthening health systems for accelerating progress towards UHC and addressing priority communicable and noncommunicable diseases	**3.2** End preventable newborn and child deaths. **3.7** Ensure universal access to sexual and reproductive health care services.	**5.6** Ensure universal access to sexual and reproductive health and reproductive rights.
Protecting the population from and reducing the impact of health emergencies	**3.d** Strengthen capacity for early warning, risk reduction and management of health risks.	
Promoting healthy living and accelerating actions to address determinants of health	**3.5** Strengthen prevention and treatment of substance abuse. **3.9** Reduce deaths from hazardous chemicals and air, water and soil pollution and contamination. **3.a** Strengthen implementation of framework convention on tobacco control.	
Strengthening the country's leadership and stewardship of health		**10.2** Empower and promote the social, economic and political inclusion of all, irrespective of age, sex, disability, race, ethnicity, origin, religion and economic or other status. **17.17** Encourage and promote effective public, public–private and civil society partnerships, building on the experience and resources strategies of partnerships.

7.3 CCS Evaluation

This CCS will be evaluated for its relevance, effectiveness, efficiency and overall impact on the health system and population health in Kenya. The evaluation process will also consider the concurrence of the CCS with the broader health and development agendas. In this regard, WHO will evaluate the outcomes and impact of this CCS at its mid-term and at the end of its period in 2030. In addition, periodic, in-depth evaluations of selected programmes may be conducted to determine their outcomes and impact on national health development. Thematic evaluation of some key areas will also be undertaken when necessary.

7.3.1 Mid-term Evaluation

WHO will conduct a mid-term evaluation to assess the results, that is the outcomes and impact achieved by 2027. This will generate evidence that may be used to accelerate the trajectory towards achieving the CCS' strategic priorities and strategic deliverables, to reprogramme the subsequent biennium(s) and to enhance learning and mutual accountability. Besides, the mid-term evaluation will contribute to the final evaluation of the CCS.

The specific objectives of the mid-term evaluation will be as follows:

1. **To gauge** against the set milestones the progress towards achieving the expected effectiveness and impact of implementing the CCS's strategic priorities and strategic deliverables (objectives);
2. **To determine** whether there is a need to reprogramme the successive biennial work plans;
3. **To identify** any challenges that might hamper relevance, coherence, effectiveness, efficiency, equity and impact of implementing the CCS's strategic agenda;
4. **To initiate** actions to resolve identified challenges and ensure the attainment of the targets and goals of the CCS's strategic priorities.

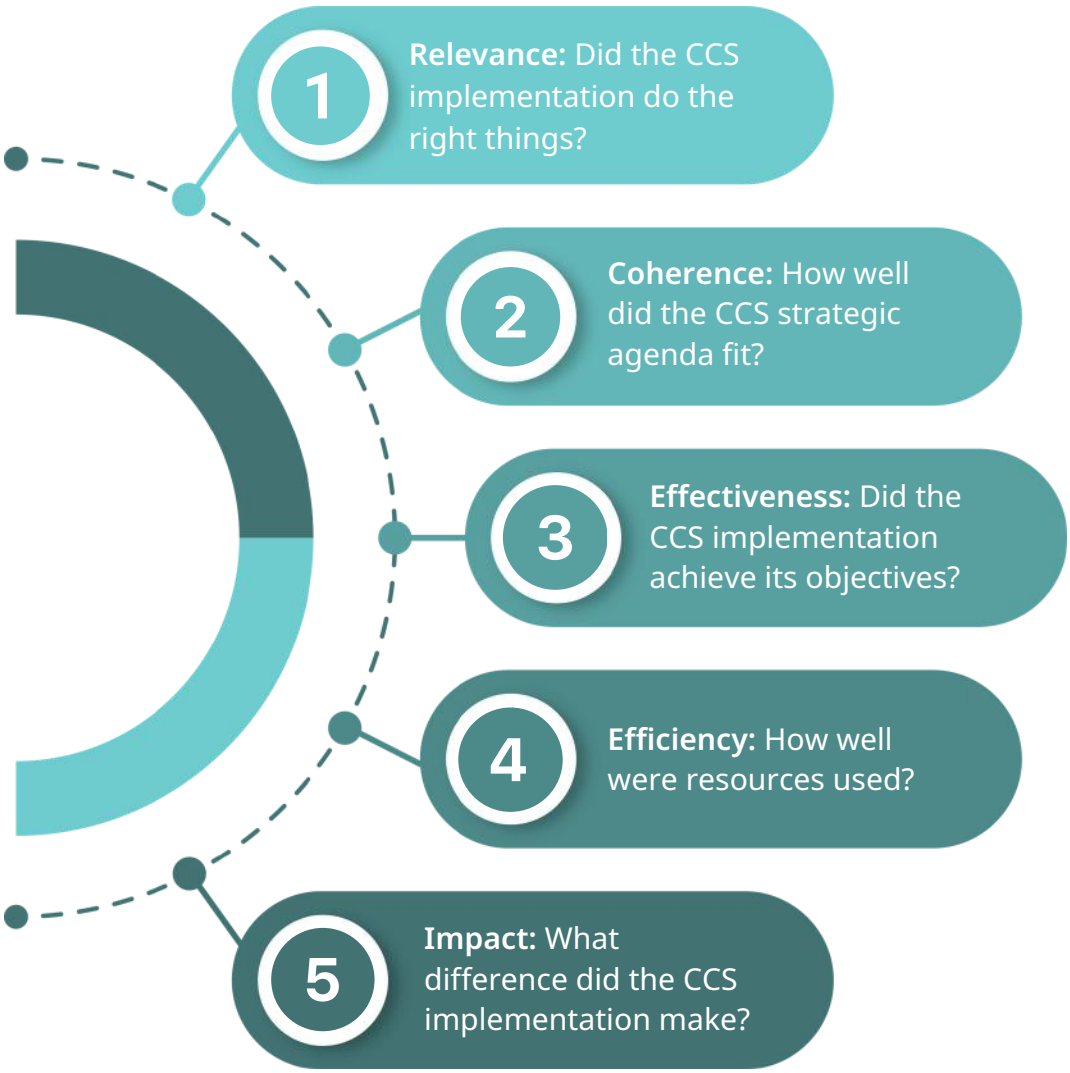
7.3.2 Final Evaluation of the CCS

WHO will conduct a mid-term evaluation to assess the results, that is the outcomes and impact achieved by 2027. This will generate evidence that may be used to accelerate the trajectory towards achieving the CCS' strategic priorities and strategic deliverables, to reprogramme the subsequent biennium(s) and to enhance learning and mutual accountability. Besides, the mid-term evaluation will contribute to the final evaluation of the CCS.

An independent final or summative evaluation of the outcomes and impact of this CCS will be conducted in 2030. The assessment will determine the contribution of WHO toward achieving of

Kenya's national health development targets as indicated in the Kenya Health Sector Strategic Plan and the goals of this cooperation strategy. The summative evaluation will assess the relevance, coherence, effectiveness, efficiency, equity, sustainability and impact of WHO's work in Kenya.

The key questions to be addressed will include the following:



The summative evaluation will identify vital SDG-related achievements, critical enabling and constraining factors, gaps, lessons learned and missed opportunities. The findings and recommendations will inform the development of the next CCS and aim to enhance the collaboration between WHO and Kenya. The robust monitoring and evaluation framework for this CCS is integral in ensuring that the strategic objectives are met effectively, leading to meaningful improvements in the country's health outcomes.

Annex

Annex 1: CCS Monitoring Framework (Targets and Indicators)

SDG target	Indicators	Baseline	2030 targets
3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births	**3.1.1** Maternal mortality ratio per 100,000 live births	355 (2019) (KNBS, 2019)	140 (UN)
	3.1.2 Proportion of births attended by skilled health	89.3% (2022) (KNBS, 2023)	
3.2 By 2030, end preventable deaths of newborns anD children under 5 years, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births	**3.2.1** Under-five mortality rate per 1000 live births	41 (2018–2022) (KNBS, 2023)	<25 (UN)
	3.2.2 Neonatal mortality rate per 1000 live births	21 (2018–2022) (KNBS, 2023)	<12 (UN)
3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases	**3.3.1** Number of new HIV infections per 1,000 uninfected population, by sex, age and key populations	0.73 (2021) (WHS 2023)	0.02 (UNAIDS global target)
	3.3.2 Tuberculosis incidence per 1 000 population	251 (2021) (WHS 2023)	20 (Stop TB Partnership global target)
	3.3.3 Malaria incidence per 1 000 population	64.5 (2021) (WHS 2023)	9 (WHO Global Technical Strategy)

	3.3.4 Hepatitis B incidence per 100 000 population	1834 (2019) (WHS 2023)	
	3.3.5 Number of people requiring interventions against neglected tropical diseases	10 649 944 (2021) (WHS 2023)	
3.4 By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being	**3.4.1** Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease per 100 000 population	21 (2019) (WHS 2023)	Reduce by 1/3
	3.4.2 Suicide mortality rate per 100 000 population	6.1 (2019) (WHS 2023)	
3.5 Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol	**3.5.1** Coverage of treatment interventions for substance use disorders	24% (2019)	
	3.5.2 Harmful use of alcohol, defined according to the national context as alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol	2.9 (2019) (WHS 2023)	
3.6 By 2020, halve the number of global deaths and injuries from road traffic accidents	**3.6.1** Death rate due to road traffic injuries per 100 000 population	28.3 (2019) (WHS 2023)	Halve the deaths and injuries
3.7 By 2030, ensure universal access to sexual and reproductive health care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes	**3.7.1** Proportion of women of reproductive age (aged 15–49 years) who have their need for family planning satisfied with modern methods	74.7 (2019) (WHS 2023)	100
	3.7.2 Adolescent birth rate (aged 10–14 years; aged 15–19 years) per 1000 women in that age group	**73** (2018–2022) (KDHS 2022)	
3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all	**3.8.1** Coverage of essential health services (as a component of the UHC service coverage index).	**53** (2021) (WHS 2023)	100
	3.8.2 Number of people covered by health insurance or a public health system per 1000 population (effort will be made to differentiate this indicator along various dimensions (income quintiles, formal versus informal sector, sex, rural/remote areas versus urban, etc. and track the percentage of households spending more than 10% of household income on health, which is a strong measure of financial protection)	**26%** (2022)	

3.9 By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination	**3.9.1** Mortality rate attributed to household and ambient air pollution per 100 000 population	1319 (2019) (WHS 2023)	
	3.9.2 Mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene per 100 000 population	29 (2019) (WHS 2023)	
	3.9.3 Mortality rate attributed to unintentional poisoning per 100 000 population	24 (2019) (WHS 2023)	
3a Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate	**3a.1** Age-standardized prevalence of current tobacco use among persons aged 15 years and older	11.1% (2020) (WHS 2023)	
3b Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health	**3b.1** Proportion of the population with access to affordable medicines and vaccines on a sustainable basis		**100** (universal)
3c Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States	**3c.1** Health worker density and distribution	30.2 (2021)	
3d Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks	**3d.1** International Health Regulations (IHR) capacity and health emergency preparedness	45 (2020) (WHS 2023)	

SDG target	Indicators	Baseline	2030 targets
5.2 Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation	5.2.1 Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age (%)		
	5.2.2 Proportion of women and girls aged 15 years and older subjected to sexual violence by persons other than an intimate partner in their lifetime (%)		
5.3 Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation	5.3.1 Proportion of women aged 20–24 years who were married or in a union before age 15 and age 18		
	5.3.2 Proportion of girls and women aged 15–49 years who have undergone female genital mutilation/cutting		
5.6 Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences	5.6.1 Proportion of women aged 15–49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health car		
	5.6.2 Number of countries with laws and regulations that guarantee women aged 15–49 years access to sexual and reproductive health care, information and education		

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