World Health Organization

Country Cooperation Strategy *at a glance*

Kenya

http:// www.who.int/countries/en/

WHO region	Africa
World Bank income group	Lower-middle-income
Child health	
Infants exclusively breastfed for the first six months of life (%) (2008-2009)	32
Diphtheria tetanus toxoid and pertussis (DTP3) immunization coverage among 1-year-olds (%) (2015)	89
Demographic and socioeconomic statistics	
Life expectancy at birth (years) (2015)	63.4 (Both sexes) 65.8 (Female) 61.1 (Male)
Population (in thousands) total (2015)	46050.3
% Population under 15 (2015)	41.9
% Population over 60 (2015)	4.5
Poverty headcount ratio at $1.25 a day (PPP) (% of population) ()	
Literacy rate among adults aged >= 15 years (%) (2007-2012)	87
Gender Inequality Index rank (2014)	126
Human Development Index rank (2014)	145
Health systems	
Total expenditure on health as a percentage of gross domestic product (2014)	5.72
Private expenditure on health as a percentage of total expenditure on health (2014)	38.75
General government expenditure on health as a percentage of total government expenditure (2014)	12.8
Physicians density (per 1000 population) (2013)	0.198
Nursing and midwifery personnel density (per 1000 population) (2013)	0.863
Mortality and global health estimates	
Neonatal mortality rate (per 1000 live births) (2015)	22
Under-five mortality rate (probability of dying by age 5 per 1000 live births) (2015)	49.4 [38.0-64.0]
Maternal mortality ratio (per 100 000 live births) (2015)	362
Births attended by skilled health personnel (%) (2014)	61.8
Public health and environment	
Population using improved drinking water sources (%) (2015)	63.2 (Total) 81.6 (Urban) 56.8 (Rural)
Population using improved sanitation facilities (%) (2015)	30.1 (Total) 29.7 (Rural) 31.2 (Urban)

Sources of data:
Global Health Observatory May 2016
http://apps.who.int/gho/data/node.cco

HEALTH SITUATION

Life expectancy at birth in Kenya had improved from a low of 45.2 years in the 1990s, to an estimated 63.4 years by 2015. According to latest figure, infant and under-5 mortality improved from 77 and 115 in the 1990s to 39 and 52 per 1000 live births respectively in 2014. Maternal and neonatal mortality, on the other hand, had shown stagnation since 1993 but in the recent past have showed marked decreasing trend reaching 362/100,000 and 22/1,000 respectively in 2015. There are wide disparities in health status across the country, closely linked to underlying socio-economic, gender and geographical disparities. Immunization coverage was high (KHSSP MTR, 2016) with 83% of infants receiving 3 doses of pentavalent and measles vaccines. Full immunization coverage was 79%, which is far below the KHSSP target for full immunization coverage. The trend showed a modest decline between 2013/14 and 2015/16.

Infectious diseases are the leading causes of morbidity and mortality in Kenya. In children, measles cases remained few, malaria prevalence declined by more than one-third but diarrhoea and pneumonia were (KHSSP MTR 2016) still leading causes of childhood morbidity, particularly in areas where there are shortages of safe drinking water, adequate sanitation, malnutrition, and pollution of food sources. HIV/AIDS is responsible for up to 29.3% of all deaths and 24.2% of all disability in the country and it is estimated that 1.6 million people in Kenya are living with HIV; respiratory (chest) infections including tuberculosis cause14.4% of deaths while malaria contributes 16% of the total outpatient visits, and is the leading cause of mortality amongst under 5's.

Coverage of HIV, TB and malaria interventions all showed recent positive trends. Major increases are found in number of people benefitting from PMTCT (from 67% to 80%), ART (from 35% to 56% for adults), LLIN use rates, in especially endemic counties (increasing to 74% of children), and high levels of TB treatment completion and cure rates. In addition, coverage of HIV counselling and testing, HIV-TB interventions, and ACT treatment for malaria were all very high. Kenya has recently experienced outbreaks of new/re-emerging conditions such viral haemorrhagic fevers (e.g. dengue chikungunya) as well as other emergencies. Neglected tropical diseases such as lymphatic filariasis also remain a burden.

Non-Communicable Diseases (NCDs) accounted for more than 50% of total hospital admissions and over 55% hospital deaths in Kenya (HMIS 2012) and they pose a greater social and economic burden to the economy. According to HMIS, cardiovascular diseases and cancers are the second and third leading causes of death respectively. Prevalence of diabetes in persons aged between 20-79 years is 4.7%.

HEALTH POLICIES AND SYSTEMS

The Kenya Health policy (2014-2030) defines the Country' long term intent in health. The target of the policy is to attain a level and distribution of health at a level commensurate with that of a middle income country, with specific impact targets of attaining a 16% improvement in life expectancy; a 50% reduction in annual mortality from all causes; and a 25% reduction in time spent in ill health.

Governance structures fundamentally changed in 2013 from a previously centralized structure to a two-tier system comprising the National Government and 47 devolved County Governments. The counties are the units of service delivery and resource allocation, while the national government has the core functions of health policy and support to the counties. These constitutional imperatives, plus the emerging global orientations such as the Sustainable Development Goals (SDG), require restructuring of health governance and the healthcare delivery system. To this end, under the devolved health services, there are opportunities to improve delivery of primary health care (PHC). A key focus is consolidating, harmonizing and updating health related legislation in a Health Bill, in order to integrate and strengthen service delivery and enhance governance for health.

Kenya had also ratified the FCTC and made some inroads in its implementation, especially in the areas of control of smoking in public places, and advertising, sponsorship and promotion. A STEPs Survey and a global youth tobacco survey have been concluded. The surveys showed that 13%t of Kenyans currently consume some form of tobacco products with a significantly higher prevalence among men (23 %) than women (4.1%). While approximately 19% of Kenyans currently drink alcohol, 13% these consuming alcohols on a daily basis. Kenya has a Cancer Prevention and Control Act and has established a National Cancer Institute on the basis of this Act. Further, a National Mental Health Policy is currently being implemented.

Towards strengthening national capacitates for International Health Regulations(IHR, 2005), the country inaugurated the first Public Health Emergency Operations Centre (PHEOC) in 2016 to better coordinate activities of relevant stakeholders involved in prevention, detection and response to public health events (PHEs). It is expected that when PHEOC is fully operationalized, it will enhanced public health emergency preparedness and response for PHEs in the country.

COOPERATION FOR HEALTH

The Government of Kenya has highlighted the need to adhere to aid effectiveness and partnership principles. The health sector in the country currently has a number of active partners supporting interventions, including international and a large number of non-state actors mostly involved in supporting delivery of health services in vaccine preventable diseases, health systems pillars, HIV, TB and malaria related interventions.

The country has in the past experienced relatively unpredictable flows of international aid. The increasing aid assistance since 2008/09 is not just a result of resumption of support from existing partners, but also a reflection of increasing support from non-traditional sources of aid, such as China, and other emerging economies.

The United Nations presence in the country is extensive, with a number of agencies having Headquarters, Regional and Country presence in Kenya. The Delivering as One approach has been adopted for the implementation of the UNDAF (2014-2018). WHO support is guided by the strategic priorities and main focus areas as contained in the third generation of CCS for the period 2014-2019.

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WHO COUNTRY COOPERATION STRATEGIC AGENDA (2014–2019)

Strategic Priorities	Main Focus Areas for WHO Cooperation
STRATEGIC PRIORITY 1: Reduce the burden of communicable diseases, including HIV/AIDS, tuberculosis, malaria, neglected tropical diseases and vaccine-preventable diseases, using disease control strategies including, prevention, treatment, elimination and eradication	• **HIV:** Support the development and implementation of national policies, strategies and programmes for HIV prevention, testing, treatment and care services towards universal access to HIV services. • **Neglected Tropical Diseases (NTDs):** Support Elimination or Eradication of selected NTDs by 2019 and beyond. • **Vaccine Preventable Diseases (VPDs):** Support efforts to increase coverage of vaccination services • Tuberculosis (TB): Support Stop TB Strategy in detection and successful treatment of tuberculosis including drug-resistant tuberculosis, multidrug-resistant tuberculosis, through integrated services, community, civil society and private sector engagement. • **Malaria:** Support development and implementation of national policies, strategies and approaches on malaria prevention, control and elimination including the generation and use of strategic information for anti-malaria agenda setting and evidence-based targeting of anti-malaria interventions towards a malaria free Kenya.
STRATEGIC PRIORITY 2: Halt / stabilize and reverse the rising burden of non-communicable conditions, injuries violence and disability through comprehensive sector wide evidence-based policy options and strategies coupled with robust monitoring and evaluation systems informed by a continuous research agenda	• **Non Communicable Diseases (NCDs):** Support the development and implementation of sector-wide policies, strategies and programmes including research & evidence generation, monitoring and assessing the health situation and trends to prevent and control non-communicable conditions together with their risk factors. • **Mental Health:** Support the development and implementation of strategies including early diagnosis and data systems which ensures access to services for mental health and substance use disorders. • **Violence and Injuries:** Support development and implementation of comprehensive multi-sectoral national policies, strategies and plans on violence & injury prevention and control, including the generation and utilisation of research and information for violence & injury prevention agenda setting and evidence-based options to reduce the burden of injuries and violence in Kenya. • **Disabilities and Rehabilitation:** Support the development and implementation of evidence-based policies, legislations and strategies to increase access to services for people with disabilities by provision of norms and standards on rehabilitative services and monitoring access to services. • **Nutrition:** To improve nutrition & food safety throughout the life-course for public health and sustainable development
STRATEGIC PRIORITY 3: Improve health outcomes and embrace healthy lifestyles in a supportive and enabling risk mitigating environment through the course of life for improved quality of health and increased health adjusted life expectancy	• **Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH):** Support the national governments to build capacity to expand the access to quality evidence-informed interventions to improve maternal, newborn, child, adolescent, and reproductive health, whilst securing the health of older people through healthy behaviours. • **Health Promotion:** To support health and development, and prevent or reduce risk factors for health conditions using evidence-based and ethical policies, strategies, recommendations, standards, guidelines at national/sub-national levels. • **Social Determinants of Health (SDH):** To facilitate the development and implementation of policies and programmes to enhance health equity through strengthened inter-sectoral collaborations and partnerships for coordinated actions addressing Social Determinants of Health (SDH).
STRATEGIC PRIORITY 4: By 2019, the Country has a responsive, client-centred, technologically driven and sustainable health system that is facilitating movement towards universal health coverage with defined quality health and related services, with protection from catastrophic health expenditures	• **Organization of Service Delivery**: Support the National and County Governments in efforts to improve organization of devolved service delivery to improve physical, financial and socio-cultural access to health and related services, with a focus on organization of the health service package, the health system, health infrastructure, community health, facility management, emergency / referral, outreach, and supervision services. • **Health Workforce**: Support National and County Governments efforts to improve the production, productivity, motivation retention and distribution of the health workforce required to attain universal health coverage. • **Health Information**: Support National and County Governments efforts to generate, analyse, disseminate and use of comprehensive health information from routine health statistics, vital statistics, surveys, census, and research. • **Essential Health Products and Technologies**: Support the National and County Governments to improve access to essential medicines and health technologies; and to strengthen national and regional regulatory capacity. • **Health Financing**: Facilitate the country in defining, applying and monitoring approaches to assure efficient and equitable use of health finances, in a manner that assures social protection. • **Health Leadership**: Support National and County Governments to build capacity for leading the health agenda, in line with attaining the policy and strategic objectives for health.
STRATEGIC PRIORITY 5: Have adequate capacity for disaster preparedness, surveillance, and effective response to disease outbreaks, acute public health emergencies and the effective management of health-related aspects of humanitarian disasters to contribute to health security.	• **Disaster risk management:** Support the development of national capacities for disaster risk management, including the effective management of health related aspects of humanitarian disasters. • **Alert and response capacities**: Support will continue towards developing, maintaining and exercising policy, strategies and technical guidance, information management, communication and operational systems needed at all levels to detect, verify, assess /coordinate the response to important public health hazards , risks and events according to 2005 IHR requirements. • **Epidemic pandemic and crisis response:** Focused support towards (i) implementation of relevant international frameworks for Pandemic Influenza Preparedness Framework for the sharing of influenza viruses and access to vaccines and other benefits (ii) Establishing mechanisms of response for emerging, re-emerging and established epidemic-prone diseases /conditions. • **Polio eradication:** To support complete eradication of polio and attain polio free certification status.