JOINT RIGHT TO HEALTH THEMATIC GROUP SHADOW REPORT SUBMITTED TO THE AFRICAN COMMISSION ON HUMAN AND PEOPLES' RIGHTS (ACHPR)

ON THE 87TH ORDINARY SESSION OF THE REVIEW OF THE 14TH PERIODIC STATE REPORT & THE 2ND REPORT ON THE PROTOCOL TO THE AFRICAN CHARTER ON HUMAN AND PEOPLES' RIGHTS ON THE RIGHTS OF WOMEN IN AFRICA (MAPUTO PROTOCOL)

OF THE REPUBLIC OF KENYA

REPORTING PERIOD: 2022 – 2025

SUBMITTED ON 11 APRIL 2026 BY:

KENYA LEGAL & ETHICAL ISSUES NETWORK ON HIV & AIDS (KELIN)
RAISE YOUR VOICE
NETWORK FOR ADOLESCENTS AND YOUTH OF AFRICA (NAYA) KENYA
TRANS*ALLIANCE KENYA (TAK)
WESTERN KENYA LBQT FEMINIST FORUM (WKLFF)
GLOBAL INITIATIVE FOR ECONOMIC SOCIAL AND CULTURAL RIGHTS
ZAMARA FOUNDATION
AFRICAN GENDER AND MEDIA INITIATIVE TRUST (GEM TRUST)
AFYAFRIKA
HEALTH OPTIONS FOR YOUNG MEN ON HIV/AIDS & STIS (HOYMAS)
UNDUGU FAMILY OF HOPE
HEALTH RIGHTS ADVOCACY FORUM (HERAF)
LVCT HEALTH
CENTRE FOR THE STUDY OF ADOLESCENCE (CSA)
REPRODUCTIVE HEALTH NETWORK KENYA (RHNK)

ON BEHALF OF THE RIGHT TO HEALTH THEMATIC GROUP

Abbreviations and Acronyms

ACHPR:	African Charter on Human and Peoples' Rights
ACHPR :	African Commission on Human and People's Rights
KELIN:	Kenya Legal and Ethical Issues Network
UCH:	Universal Health Coverage
PHC:	Primary Health Care Fund
FIF:	Facility Improvement Fund
SHA:	Social Health Authority
RMNCAH:	Reproductive Maternal Neonatal Child and Adolescent Health
CSO:	Civil Society Organisations
MoH:	Ministry of Health
PHCF:	Primary health Care Fund
ECCIF:	Chronical and Critical Illnesses
RMNCAH:	Reproductive, Maternal, Child and Adolescent Health
SHIF:	Health Insurance Fund
NHIF:	National Health Insurance Fund
PCN:	Primary Care Networks
CHP:	Community Health Promoters
KNBS:	Kenya National Bureau of Statistics
GOK:	Government of Kenya
KHIS:	Kenya Health Information System
SRHR:	Sexual and Reproductive Health and Rights
SRH:	Sexual and Reproductive Health

LEGAL & REGIONAL FRAMEWORKS

- African Charter on Human and People's Rights (Banjul Charter) on the Right to Health (Art.16)
- Maputo Protocol

Executive Summary

During the 2022–2025 reporting period, Kenya continued to demonstrate progress in fulfilling its commitments under the African Charter on Human and Peoples' Rights (ACHPR) and the Maputo Protocol. Notably, the country advanced the realization of Universal Health Coverage (UHC) through key health sector reforms. These included the enactment of the Social Health Insurance Act, which established the Social Health Authority (SHA) and the Social Health Insurance Fund, aimed at reducing out-of-pocket expenditure. Additional efforts focused on expanding primary healthcare and increasing investment in digital health systems.These efforts have contributed to expanded population health insurance coverage, improved access to essential services, and strengthened community-level healthcare delivery in line with ACHPR Resolution 141(XXXXIV)08, on Access to Health and Needed Medicines in Africa. Significant gains are also evident in maternal and child health outcomes, as well as the scale-up of specialised care through new financing mechanisms. Collectively, these developments reflect a strong policy commitment to advancing the right to health and improving health system performance. Despite these significant structural reforms, Kenya is at risk of undermining the right to health due to weak implementation, inadequate financing, and systemic governance failures, which are already resulting in inequitable access and the exclusion of vulnerable populations.

Despite significant structural UHC reforms, Kenya is at risk of undermining the right to health due to weak implementation, inadequate financing, and systemic governance failures.

This Shadow Report underscores that, notwithstanding notable progress, persistent shortcomings in implementation indicate gaps in Kenya's compliance with its immediate obligations.

However, the implementation of these reforms continues to face structural and systemic challenges that risk undermining equity and sustainability. Persistent underfunding, health workforce shortages, and imbalances in infrastructure limit service availability, particularly in rural and marginalised areas. Digitalisation efforts, while promising, raise concerns around the exclusion of vulnerable populations and data privacy. In addition, governance gaps, including inconsistencies in health data and weak coordination across levels of government, affect accountability and effective planning. Without strengthened domestic financing, inclusive policies, and robust oversight mechanisms, these challenges may lead to service disruptions, increased out-of-pocket costs, and continued disparities in access to quality healthcare. These challenges are already being reflected in reported cases of patients being unable to access services due to uncertainty around SHA coverage, informal sector workers experiencing lapses in financial protection, and adolescents facing barriers to confidential and youth-friendly services.

This Shadow Report underscores that, notwithstanding notable progress, persistent shortcomings in implementation indicate gaps in Kenya's compliance with its immediate obligations, including the provision of minimum essential levels of care and the guarantee of non-discriminatory access to health services, particularly for adolescents. While efforts to reduce teenage pregnancy and integrate adolescent health within RMNCAH reflect strong policy intent, implementation remains inconsistent at the county level, with limited availability of adolescent- and youth-friendly services and weak intersectoral coordination. Inadequate attention to underlying structural determinants, including poverty, gender-based violence, and school dropout, further compounds these barriers. In addition, inadequate domestic health financing, continued reliance on donor-supported programmes, and gaps in financial risk protection under current insurance mechanisms continue to restrict equitable access for adolescents.

In line with its obligations under Article 16 of the African Charter on Human and Peoples' Rights, Article 14 of the Maputo Protocol as well as the Abuja Declaration, Kenya is required to take deliberate, concrete, and targeted steps to ensure the full realisation of the right to health. This includes strengthening accountability and oversight mechanisms, prioritising adequate and sustainable domestic financing, and ensuring the meaningful participation of adolescents in the design, implementation, and monitoring of health policies and programmes. Kenya ought to prioritize effective implementation, strengthen accountability, and ensure meaningful public participation in health policy and programming.

Methodology

This Shadow report covers both Part A and Part B of Kenya's State Report Submission under the right to health in the 14th Periodic Report on ACHPR and Second Periodic Report on the Maputo Protocol (2022 – 2025), which makes reference to Article 16 of the Banjul Charter on the Right to Health, and states that "Every individual shall have the right to enjoy the best attainable state of physical and mental health''. The observations and findings are grounded in a participatory and evidence-based approach, drawing on contributions from multiple stakeholders engaged in advancing the right to health. Through collaborative convenings and interactive dialogues, these actors shared pertinent information in line with the reporting standards of the African Commission on Human and Peoples' Rights (ACHPR).

The contributing actors form part of a network of national organizations that has convened since 2024 to advance the right to health and has previously contributed to the Universal Periodic Review (UPR) process. Each organisation's submission was grounded in evidence generated primarily through desk reviews of national laws, policies, strategic plans, research studies, and national progress reports. This was complemented by primary lived-experience data, which was analysed and synthesised into four thematic clusters: health financing, Universal Health Coverage (UHC), sexual and reproductive health and rights, and health systems strengthening. Contributors included health economists, social scientists, legal experts, and media and communications practitioners.

Introduction

This Shadow Report is submitted to the African Commission on Human and Peoples' Rights (ACHPR) ahead of its 87th Ordinary Session. It provides an evidence-based assessment of Kenya's 14th Periodic Report from the perspective of civil society organizations (CSOs), grounded not only in documented evidence but also in the lived realities of communities.

Drawing on a range of reports, studies, official state documents, and community-level experiences, CSO actors have undertaken a critical and objective analysis of the Government's submissions, comparing stated progress with the realities observed on the ground by different communities. While the State's report demonstrates progress and optimism—particularly in advancing health financing under Universal Health Reforms and advancing sexual and reproductive health and rights—it insufficiently addresses the persistent and emerging challenges that undermine these gains. Its focus on health infrastructure and human resources for health, to the exclusion of other essential health system building blocks, presents an incomplete picture of the system's overall functionality and equity.

Under ACHPR Resolution 446 (LXVI) 2020 on conducting a study on the right to health for all and its financing in Africa, the Commission affirms that access to healthcare is a fundamental right and a public good that must be guaranteed through sustained public investment. Kenya is therefore obligated to ensure universal access to healthcare and to allocate adequate resources toward this end. In this context, the transition from the National Hospital Insurance Fund (NHIF) to the Social Health Authority (SHA) represents a significant structural reform in health financing. This reform is central to the country's UHC agenda and seeks to enhance equity, efficiency, and financial protection. Notably, the reform introduces three financing mechanisms: the Primary Health Care Fund (PHCF), the Social Health Insurance Fund (SHIF), and the Emergency, Chronic and Critical Illnesses Fund (ECCIF). This report critically examines the available evidence to assess progress while identifying key implementation challenges.

Further, ACHPR Resolution 141(XXXXIIII)08 on Access to Health and Needed Medicines in Africa calls upon States, including Kenya, to meet their minimum core obligations in ensuring the availability and affordability of essential medicines—an indispensable component of achieving UHC. While Kenya has made commendable progress in strengthening primary healthcare through initiatives such as setting up Primary Care Networks and the deployment of Community Health Promoters, this report adopts a balanced approach by examining both achievements and emerging serving delivery gaps, including unintended negative effects arising from ongoing health reforms.

This Shadow Report also commends Kenya for establishing a progressive policy and financing framework for adolescent sexual and reproductive health, in line with ACHPR Resolution 110(XXXXI)07 on the Health and Reproductive Rights of Women in Africa. These efforts are aligned with the broader UHC agenda and are supported by reforms such as the Social Health Authority. Despite strong policy intent—evidenced by efforts to reduce teenage pregnancy and integrate adolescent health within RMNCAH— persistent challenges remain as implementation is uneven across counties. Key gaps include limited availability of youth-friendly services, weak intersectoral coordination, and insufficient attention to structural drivers such as poverty, gender-based violence, and school dropout.

Recent shifts in donor funding, particularly reductions and realignments by the United States government, further threaten the sustainability of these gains. To fully meet its obligations under the African human rights system, Kenya must prioritize effective implementation, strengthen accountability mechanisms, and ensure meaningful participation of young people in health policy development and programming.

Chapter 1: Social Health Insurance and Health Financing in Kenya

Part A: Assertions from Kenya's 14th Periodic Report to the ACHPR

- The Social Health Insurance (SHI) Act 2023 became operational in October 2023, repealing the NHIF Act of 1998. Consequently, the Social Health Authority (SHA) was established by the SHI Act 2023 to manage three primary funds, namely: Primary Health care (PHC) Fund, Social Health Insurance Fund (SHIF) and Emergency, Chronic and Critical Illness Fund to enhance healthcare financing in Kenya. The commencement date for the Act was 22nd November 2023, after gazettement by the Cabinet Secretary for Health, with a one-year transition which ended on 21st November 2024.
- Registration of citizens to SHA began on 1st July 2024 while the roll out was from 1st October 2024. Central to SHA is Taifa Care towards Universal Health Coverage (UHC). Over 15 million Kenyans have enrolled in Taifa Care, with more than 60% of employers transitioning. However, NHIF debts, estimated at Ksh. 30 billion (USD 232.2M) hinders the rollout, prompting the 28 Government to allocate Ksh. 8.7 billion (USD 67.3M) in 2024 to offset debts. The Social Health Authority (SHA) rollout has also faced system and training challenges. Multi-Sectoral Steering Committees and partnerships are enhancing coordination, and the Government plans to distribute 65,000 tablets, with 5,000 already deployed, to improve onboarding processes.
- In FY 2023/24, the National Government allocated 3.3% of its total expenditure to health, with a projected increase to 3.5% in FY 2024/25. At the county level, the Expenditure was 22.2% in FY 2022/23, decreased to 21.6% in FY 2023/24, and is expected to increase to 22.4% in FY 2024/25.
- The Facilities Improvement Financing (FIF) legislation, now adopted by 44 counties up from 27 in F/Y 2024/25 has increased health facilities autonomy to plan, generate, and manage resources. Primary Care Networks (PCNs) expanded by 24% during the reporting period, from 151 to 227. Counties with operational PCNs have seen notable improvements in health indicators. Additionally, 36 counties consistently pay stipends to CHPs, who conducted over 4.1 million household visits 91% of the CHPs (98,780) reporting key community health data and supporting informal sector registration with the National Health Insurance Fund.

Part B: Submissions on Social Health Insurance and Health Financing in Kenya by the Right to Health thematic group

- The Right to Health Thematic Group acknowledges the ongoing efforts undertaken by the Government of Kenya during this reporting period. We commend the Government of Kenya in its boldness to undertake significant reforms in its health financing framework through the establishment of the Social Health Authority (SHA), marking a transition from the National Health Insurance Fund (NHIF). These reforms are central to the State's commitment to the progressive realization of the right to health, as enshrined in Article 16 of the African Charter on Human and Peoples' Rights.
- The introduction of SHA represents a shift towards a more comprehensive and inclusive health financing system. The State Party has made notable progress in expanding the scope of healthcare services through an enhanced benefits package that includes preventive, promotive, rehabilitative, and palliative care, including mental health services, which had previously been under-

emphasized (Willow Health Media, 2026). The adoption of both digital and in-person registration mechanisms has improved enrolment processes, resulting in approximately 24.7 million individuals being registered under SHA; with over 60% of employers transitioning their workforce to the new system. These reforms and measures reflect a positive and deliberate commitment to strengthening access to healthcare at the national level.

- However, the Thematic Group notes with concern that, despite high levels of registration, effective coverage remains limited. As of early 2026, only approximately 4.9 million individuals are actively contributing to the Social Health Insurance Fund (SHIF), with the majority of contributions originating from the formal sector (Institute of Economic Affairs [IEA], 2026). Informal sector participation remains significantly lower, with only 437,000 households up to date on contributions, representing a decline from previous NHIF levels (Auditor-General, 2025; IEA, 2026). This raises concern regarding the inclusivity and sustainability of the scheme.
- The Thematic Group is further concerned that persistent geographic inequities remain evident, with marginalised counties such as Turkana, West Pokot, Garissa, and Samburu recording lower levels of enrolment and participation. Such disparities risk deepening existing inequalities in access to health services and are inconsistent with the State's obligation to guarantee non-discrimination and equitable access to healthcare as envisioned in resolution 446 (LXVI) 2020, on conducting a Study on the right to health for all and its financing in Africa.
- The Thematic Group further observes that the transition to SHA has been characterised by governance and implementation challenges. Limited public awareness of the operational structure of the Primary Health Care Fund, SHIF, and the Emergency, Chronic and Critical Illness Fund (ECCIF), coupled with insufficient clarity regarding the benefits package, has led to confusion among beneficiaries and service providers (IEA, 2026). These governance and implementation gaps are reflected in reported cases during the transition period where patients were unable to access services due to uncertainty around SHA registration status and benefit entitlements, including instances where facilities could not verify coverage. Additionally, the benefits package remains insufficiently defined, potentially undermining transparency and accountability. Further, weak regulatory and oversight mechanisms in the registration and accreditation of individuals and health facilities have also been reported, creating opportunities for inefficiencies and system leakages (Auditor-General, 2025). These governance gaps highlight the need for strengthened institutional accountability frameworks to safeguard public resources and ensure equitable access.
- The implementation of SHIF has demonstrated both progress and systemic vulnerabilities. The Thematic Group expresses serious concern regarding reported financial irregularities, including fraudulent claims and payments to uncontracted or non-compliant facilities, which raise questions about the adequacy of accountability mechanisms. On the one hand, SHA reportedly disbursed approximately KSh 18.2 billion in claims between October 2024 and January 2025, indicating operational functionality in service reimbursement (Auditor-General, 2025). On the other hand, significant financial irregularities have been documented. An estimated KSh 11 billion was allegedly lost through fraudulent claims, including duplicate billing practices, while additional payments were made to uncontracted or non-compliant facilities (Auditor-General, 2025; Citizen Digital, 2026). These findings raise serious concerns regarding financial governance, fraud prevention, and oversight capacity. It also undermines public trust and threatens the financial sustainability of the scheme.
- The Thematic Group further notes with concern that SHIF is operating within a constrained fiscal environment, with identified funding gaps and contribution rates perceived as unaffordable for low-

income and informal sector populations. These challenges are further reflected in reported experiences of informal sector workers who, due to irregular incomes and contribution requirements, experience lapses in coverage, effectively limiting their access to healthcare services. The Auditor-General Report (2025) identified a substantial financing gap, with SHIF operating at a deficit relative to contributions. Contribution rates have also been perceived as burdensome, particularly for low-income and informal sector workers, many of whom contribute irregularly due to economic constraints. The current means-testing framework lacks transparency and has not achieved adequate coverage of vulnerable groups, thereby limiting the effectiveness of financial protection mechanisms ((IEA, 2026).

- The Thematic Group recognises that the Primary Health Care (PHC) Fund remains a central pillar in Kenya's efforts to strengthen preventive and community-based healthcare, with notable progress including a 24% expansion of Primary Care Networks and service access reaching approximately 4.5 million individuals. These gains reflect a policy shift towards prioritising PHC as the foundation of universal health coverage. However, persistent underfunding—below the 15% benchmark set by the African Union Abuja Declaration—continues to constrain effective implementation. This has contributed to shortages of healthcare workers, weak infrastructure, and supply chain inefficiencies, particularly affecting rural and underserved populations and supply chain challenges limiting equitable access to essential services particularly in rural and underserved areas.
- The Thematic Group also notes that, while the Emergency, Chronic and Critical Illness Fund (ECCIF) and the Facility Improvement Fund (FIF) have expanded access to specialised care and enhanced facility-level financial autonomy for over 2.2 milllion individuals, its roll out remains uneven. Coordination gaps between national and county governments and the absence of robust oversight mechanisms undermine efficiency and accountability in resource distribution. The FIF, now adopted by most counties, offers potential for improved responsiveness but carries risks of misallocation in the absence of strong oversight, potentially widening inter-county inequalities.
- Similarly, the Thematic Group expresses concern that broader health financing trends reflect persistent underinvestment relative to international commitments, compounded by declining donor support, including the significant contributions previously provided by USAID. In the absence of robust, predictable, and sustainable domestic financing mechanisms, these gaps are likely to result in service disruptions, increased out-of-pocket expenditures, and a deepening of existing inequities in access to healthcare.

Key Questions for Kenya	Recommendations
What measures are in place to sustain gains made with declining donor funding without increasing out-of-pocket expenditure?	The proposed budget allocation for 2026/27 of 3.5% translates to very slow progress to the targeted 15% (Abuja Declaration). With SHA premiums, consider higher allocations for health.
How will ECCIF flow from SHA to the County Government who are responsible for emergency response?	Strengthen oversight, auditing, and fraud prevention mechanisms within SHIF and ECCIF to safeguard public resources
Can you review the Means Testing Framework for SHA to increase equitable contributions, especially among informal sector populations?	Introduce an equity-based financing formula to address disparities across counties, particularly in marginalised regions.

In summation, the Right to Health Thematic Group recommends that the State Party strengthen equity, transparency, governance, coordination, and sustainability within the health financing system by ensuring inclusive and affordable coverage for vulnerable and informal sector populations, improving public awareness and clarity of benefits, addressing geographic disparities through targeted investments, reinforcing accountability and fraud prevention systems, increasing domestic health financing in line with the Abuja Declaration, strengthening primary health care, improving intergovernmental coordination in the management of health funds, and enhancing financial protection through more affordable contributions and stronger risk pooling mechanisms.

Chapter 2: Health Infrustructure and Human Resources for Health

PART A: Submissions by Kenya on Health Infrastructure and Human Resources for Health

- According to the Ministry of health (2023), Kenya's Counties hosted 13,190 Health Facilities, including 6 level 6 referral hospitals, 22 level 5 county hospitals, and 9,945 dispensaries.17 More recently, the Kenya National Bureau of Statistics (KNBS) reported that the total number of operational health facilities increased by 6.1 per cent to 15,984 in 2024. This increase was majorly attributed to the number of level 3 health facilities which rose by 611 facilities. approximately 226,434 healthcare workers, with 66% employed in public facilities, including Community Health Promoters (CHPs). The core workforce includes 34,220 nurses, 4,651 medical doctors, 7,877 clinical officers, 4,686 laboratory technicians and technologists, and 1,942 nutritionists.
- In 2024, the GOK expanded its health workforce, strengthening key professional cadres: diploma clinical officers increased by 30.7% to 28,712; medical doctors by 21.9% to 12,244; diploma registered nurses by 16.2% to 57,951; and laboratory technologists by 4.7% to 14,257. These gains in human resources were complemented by progress in civil registration and maternal health, where a total of 1,110,600 births registered an improvement in efficiency compared to 1,192,900 in 2023. 98.6% of these births occurred at health facilities.

PART B: Submissions on Health Infrastructure and Human Resources for Health by the Right to Health thematic group

a) Health Infrastructure

- Kenya has made measurable progress in expanding health facilities and workforce capacity; having recorded an increase in the number of health facilities, with the total rising to approximately 15,984 facilities as reported in the Economic Survey 2024 (Kenya National Bureau of Statistics [KNBS], 2024). This expansion reflects continued efforts to improve geographical access to healthcare services.
- Despite this progress, the Thematic Group expresses concern that significant structural and systemic challenges continue to constrain equitable access to quality healthcare services. Available data from the Kenya Health Information System (KHIS) Master Facility List (2023) indicates discrepancies in facility reporting, with lower figures than those submitted by the State, raising concerns regarding data consistency and reliability for planning and accountability.
- Furthermore, beyond numerical expansion, the distribution of health facilities remains heavily skewed towards lower-level care. Dispensaries (Level 2 facilities) constitute approximately 78% of all health facilities (KHIS, 2023), while higher-level referral capacity remains limited, with only six Level 6 national referral hospitals and 22 Level 5 county referral hospitals. This imbalance continues to undermine the referral system and constrain access to specialised and emergency care, particularly in underserved and rural areas.

b) Human Resource For Health

- Kenya's health workforce has expanded in aggregate terms, with estimates indicating approximately 226,434 personnel,

including community health promoters (Ministry of Health, 2023). The majority of the workforce is employed within the public sector, reflecting the central role of government in service provision.

- Nevertheless, closer examination reveals persistent shortages of skilled health professionals. Some reported figures—particularly for doctors and clinical officers—appear to be overstated when compared with official workforce reports. Current estimates suggest approximately 4,651 doctors and 7,877 clinical officers in active service. This gap highlights a critical human resource challenge. Kenya's doctor-to-population ratio remains significantly below the World Health Organization (WHO) recommended threshold, with approximately one doctor serving over 11,000 individuals.
- Despite the progress made in promoting facility-based deliveries, which are essential for improving maternal and neonatal health outcomes, with official reports indicating high levels of institutional births; significant discrepancies between administrative data and survey findings—particularly between the *Kenya Demographic and Health Survey (KDHS) 2022* and government estimates—raise concerns about data accuracy and reliability. These variations suggest inconsistencies in definitions and reporting methodologies, including the possible conflation of facility notifications with actual population-level outcomes. Such gaps underscore the need for harmonised health information systems to ensure accurate monitoring, strengthen accountability, and support evidence-based policy decisions.

Key Questions for Kenya	Recommendations
How does the State plan to address the shortage of skilled health workers while ensuring the absorption of trained professionals into the public health system?	Develop and implement a comprehensive workforce strategy to address shortages, improve distribution, and ensure the timely absorption of trained health professionals.
What steps are being taken to harmonise health data systems and address discrepancies across official reports?	Establish a unified health information framework to improve data accuracy, consistency, and interoperability across institutions.

In summary, the Right to Health Thematic Group recommends that the State address persistent gaps in both health infrastructure and human resources for health by ensuring a more equitable distribution of health facilities, with strengthened investment in higher-level referral services, and by establishing a unified and harmonised health information system to improve data consistency, reliability, and accountability. In addition, the Group recommends the development of a comprehensive health workforce strategy to address shortages and maldistribution of skilled health workers, ensure their timely absorption and retention within the public health system, and align training and deployment with national health service delivery needs.

Chapter 3: Universal Health Coverage (UHC)

PART A: Kenya's Submission on Universal Health Coverage

- Kenya has implemented significant interventions to achieve Universal Health Coverage (UHC), including public financing for primary health care, the establishment of emergency treatment and health insurance funds, and investments in digital health management systems. The health sector budget rose to Ksh. 127 billion (USD 985.5M) in FY 2024/25 from Ksh. 47.7 billion (USD 370.1M) in FY 2021/22, allocating Ksh. 2 billion (USD 15.5M) for free maternity care and Ksh 4.6 billion (USD 35.6M) for specialized medical equipment and stipends for 100,000 community health promoters, who serve as grassroots medical responders.

PART B: Submissions on Universal Health Coverage (UHC) by the Right to Health thematic group

- Kenya has made significant policy and legislative advancements towards achieving Universal Health Coverage (UHC), with a particular emphasis on strengthening primary health care (PHC), expanding community-based services, and digitising health systems. The rollout of the Community Health Promoter (CHP) programme represents a key achievement in this regard. Approximately 100,000 CHPs have been deployed nationwide, conducting over 4.1 million household visits as of 2025. In parallel, Primary Care Networks (PCNs) have expanded by approximately 24%, reaching 227 operational units. These efforts reflect the State's commitment to the progressive realisation of the right to health under Article 16 of the African Charter on Human and Peoples' Rights, as well as obligations under the Protocol to the African Charter on the Rights of Women in Africa (Maputo Protocol).
- The enactment of the Primary Health Care Act (2023) and the prioritisation of PHC within national development frameworks have elevated preventive and promotive healthcare as central pillars of UHC. Dedicated public financing mechanisms have been introduced to support PHC delivery, signalling a strategic shift towards community-based care.
- While these reforms demonstrate important progress, emerging gaps in implementation raise concerns regarding equity, sustainability, inclusivity, and the protection of human rights within the health system. It is estimated that approximately 9.1 million households are yet to be reached by PHC services. Achieving full population coverage would require an expanded workforce of approximately 221,000 CHPs, more than double the current number. Moreover, concerns persist regarding the sustainability of the programme. County-level financing remains inconsistent, with only 36 out of 47 counties regularly providing stipends to CHPs. Furthermore, primary-level facilities (Levels 2 and 3) continue to face chronic underfunding, leading to frequent medicine stockouts and limited-service capacity. These constraints suggest that while PHC has been prioritised at the policy level, financial commitments at sub-national levels have not fully aligned with national objectives.
- Kenya has taken important steps to strengthen digital health governance through the enactment of the Digital Health Act (2023), alongside efforts to modernise health information systems through large-scale deployment of digital tools. Reliance on digital platforms for accessing services—including registration under the Social Health Authority (SHA)—raises concerns about the exclusion of populations with limited digital literacy, connectivity, or access to technology. In addition, data privacy

concerns remain significant, as fears of confidentiality breaches and the potential misuse of sensitive health data for non-clinical purposes highlight the need for stronger safeguards to uphold privacy, informed consent, and trust in the system.

Key Questions for Kenya	Recommendations
How will the State address digital exclusion and ensure that non-digital pathways exist for accessing healthcare services and SHA registration?	Promote Digital Inclusion: Establish alternative, non-digital pathways for health system access to ensure that vulnerable populations are not excluded.
What strategies are being developed to address discrimination and ensure inclusive healthcare services for marginalised populations and older persons?	Advance Inclusive Health Service Delivery: Develop targeted strategies to address the health needs of underserved populations, including older persons and SGM individuals, and strengthen anti-discrimination measures within healthcare settings.

In conclusion, the Right to Health Thematic Group recommends that the State consolidate gains in Universal Health Coverage by ensuring adequate and equitable financing and scaling up primary health care through the full operationalisation of Primary Care Networks and expansion of the Community Health Promoter programme, while addressing existing coverage gaps and workforce deficits. The State is further urged to strengthen county-level financing commitments to ensure the sustainability of PHC services, particularly at Levels 2 and 3, and to address persistent challenges such as medicine stockouts and limited-service capacity. In addition, the Group recommends the establishment of inclusive, rights-based digital health systems through the provision of non-digital access pathways for vulnerable populations and the strengthening of data protection safeguards to guarantee privacy, informed consent, and public trust. Finally, the State is encouraged to adopt targeted measures to promote equitable and non-discriminatory access to healthcare for marginalised groups, including older persons, persons with disabilities and sexual and gender minorities.

Chapter 4: Sexual and Reproductive Health Rights

PART A: Kenya's Submission on Sexual Reproductive Health & Rights

- In addressing adolescent health, the Ministry of Health (MOH) is implementing strategies to reduce the national teenage pregnancy rate, currently at 15%. Through the Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCAH) program, the MOH has ensured that all reproductive health services for adolescents and youth are covered under SHA, aligning with Universal Health Coverage goals and including comprehensive Adolescent and Youth Sexual and Reproductive Health and Rights (SRHR) services.

PART B: Submissions on Sexual Reproductive Health & Rights (SRHR) by the Right to Health thematic group

- Kenya has demonstrated a strong policy commitment to advancing adolescent health within the broader framework of Universal Health Coverage (UHC), including the integration of Adolescent and Youth Sexual and Reproductive Health and Rights (AYSRHR) into national strategies and the adoption of multi-pronged service delivery approaches. These include community-based outreach, clinic-based services, school-based programmes, and digital platforms, reflecting a comprehensive and rights-oriented effort to address teenage pregnancy and improve access to sexual and reproductive health (SRH) services. The incorporation of adolescent health within the framework of the Social Health Authority further signals progress toward institutionalising these services within national systems. Policy instruments such as the Newborn, Child and Adolescent Health Policy (2018) also demonstrate alignment with national and international commitments to reduce adolescent health risks and improve outcomes.
- Despite these advances, the Thematic Group notes concern that significant gaps remain in implementation, equity, and service delivery. Access to adolescent-friendly services is inconsistent across counties, with persistent challenges related to quality of care, confidentiality, and provider attitudes. Structural and socio-cultural barriers, including stigma, restrictive norms, and limited awareness, continue to hinder service uptake. These barriers are reflected in community and civil society reports indicating that adolescents are, in some instances, unable to access confidential and youth-friendly services due to fear of stigma, lack of privacy, and inconsistent service delivery practices at facility level. In addition, adolescent health programming remains narrowly framed within maternal and child health interventions, with insufficient attention to mental health and broader psychosocial needs. Weak coordination between the health and education sectors undermines the effective delivery of comprehensive sexuality education, while limited youth participation reduces the responsiveness of programmes to adolescents' needs. In addition, adolescent health remains narrowly framed within maternal and child health programming, with insufficient attention to mental health and broader psychosocial needs. Systemic weaknesses in data collection, including limited disaggregation, inadequate staffing, and weak referral systems, further constrain effective service delivery and continuity of care.
- Furthermore, financing constraints further limit the effectiveness and sustainability of adolescent health interventions. Although the inclusion of adolescent SRH services within the SHA framework

and the Primary Health Care Fund has improved access to essential outpatient services, overall health sector funding remains below the 15% target set by the African Union Abuja Declaration, with recent allocations estimated at under 10% of the national budget. Access to more comprehensive services under the Social Health Insurance Fund remains contingent on household contributions, creating inequities for adolescents from low-income or vulnerable households. Continued reliance on donor funding and the phased implementation of SHA further raise concerns about long-term sustainability. Addressing these gaps will require increased domestic investment, strengthened accountability, and deliberate efforts to remove structural barriers in order to fully realize adolescents' right to health.

Key Questions for Kenya	Recommendations
How will the State ensure equitable access to quality adolescent-friendly services across all counties?	Strengthen equitable service delivery and standardise adolescent-friendly services nationwide, improve provider training on confidentiality and non-discrimination, and ensure consistent quality of care across counties
How is the State addressing stigma, weak intersectoral coordination, and limited youth participation in adolescent health programming?	Remove structural barriers by implementing stigma-reduction interventions, strengthen health–education coordination for comprehensive sexuality education, and institutionalise meaningful youth participation in programme design and monitoring.
How will the State close financing gaps and ensure sustainable, equitable access to adolescent health services under SHA?	Strengthen financing and sustainability of adolescent health services, particularly, increase domestic health budget allocations in line with the Abuja Declaration, ensure full integration and prioritisation of adolescent health within SHA and the Primary Health Care Fund, and reduce financial barriers by expanding risk pooling and subsidy mechanisms for adolescents from low-income and vulnerable households.

In conclusion, the Right to Health Thematic Group acknowledges progress in integrating Adolescent and Youth Sexual and Reproductive Health and Rights (AYSRHR) within Universal Health Coverage reforms, including through SHA and expanded service delivery platforms. However, concerns remain regarding persistent structural barriers and inequities in service quality and access. The Thematic Group therefore recommends that the State Party undertakes measures that will expand friendly services, addressing structural barriers through stigma reduction and improved intersectoral coordination with meaningful youth participation, and enhancing sustainable financing through increased domestic allocations, full integration within SHA and primary health care systems, and expanded subsidies and risk pooling for vulnerable adolescents.

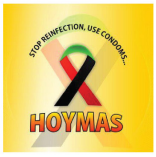
References

- AMREF Health Africa. (2025). Community health promoters and data privacy in Kenya.
- Government of Kenya. (2023). Digital Health Act.
- Government of Kenya. (2023). Primary Health Care Act.
- Government of Kenya(2023). The Social Health Insurance Act
- HelpAge International. (2025/2026). Exploring barriers to social protection and wellbeing of older persons in rural Kenya.
- KELIN. (2023). Digital health in Kenya: Addressing human rights concerns.
- KELIN. (2025). Press release on Auditor-General's findings on the Social Health Authority. Nairobi, Kenya.
- Kenya Healthcare Federation. (2025). Stakeholder perspectives on the implementation of the Social Health Authority. Nairobi, Kenya.
- Kenya Health Information System (KHIS). (2023). Master Facility List 2023
- Kenya National Bureau of Statistics (KNBS) & ICF. (2023). Kenya Demographic and Health Survey 2022.
- Kenya National Bureau of Statistics (KNBS). (2024). Economic Survey 2024.
- Kenya National and County Budget Analysis Dec 2024
- Kenya Universal Health Coverage Policy 2020 - 2030
- National Adolescent Sexual and Reproductive Health Policy 2015
- National Guidelines of Provision of Youth Friendly Services
- Management Sciences for Health (MSH) & Results for Development (R4D). (2025/2026). The costs and financing needs of delivering Kenya's PHC service package
- Ministry of Health. (2023). Kenya Health Workforce Report 2023. Government of Kenya.
- Ministry of Health. (2025). Social Health Authority implementation progress report. Government of Kenya.
- Ministry of Health. (2026). Strategic engagement with WHO to accelerate universal health coverage.
- Office of the Auditor-General. (2025). Audit report on the Social Health Authority. Nairobi, Kenya.
- Parliament of Kenya. (2025). Report of the Departmental Committee on Health on the assessment of Social Health Authority (SHA) fund utilization and challenges faced by health facilities. Nairobi, Kenya.
- Scholarnest Publishers. (2025). Implementation challenges of social health insurance reforms in Kenya. International Journal of Innovative Research in Economics and Social Sciences.
- SPARC. (2025). Kenya social health insurance policy brief. Strategic Purchasing Africa Resource Centre.
- The Kenya Times. (2025). System outages and service disruptions in SHA implementation. Nairobi, Kenya.
- UNAIDS. (2025). HIV progress report.
- Willow Health Media. (2025). Kenya's Social Health Authority: A healthcare revolution? Nairobi, Kenya.
- World Health Organization (WHO). (n.d.). Health workforce requirements for universal health coverage.


AfyAfrika

CENTRE FOR THE STUDY OF ADOLESCENCE

ZAMARA
FOUNDATION
Voice. Choice. Agency

Global Initiative
for Economic, Social
& Cultural Rights

STOP REINFECTION. USE CONDOMS.
HOYMAS

KELIN

GEM
African Gender and Media Initiative Trust

lvct
health
healthy societies

RHN
Reproductive Health Network Kenya

RAISE YOUR VOICE
EMPOWERED. ACTIVATED. ENGAGED

TA
TRANS* ALLIANCE

UNDUGU FAMILY OF HOPE

Western Kenya
LBQT Feminist Forum