Hennet
Health NGOs' Network

Civil Society Position Paper: Kenya Health Summit 2026

Towards a Joint Health Compact for Financing, Delivery and Accountability

Submitted to the Cabinet Secretary, Ministry of Health, Republic of Kenya, as a technical input for the design and drafting of the Joint Health Compact | Nairobi, Kenya | August 2026 |

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EXECUTIVE SUMMARY

Kenya stands at a defining moment in the transformation of its health system. The transition from NHIF to the Social Health Authority (SHA), the Primary Health Care Act and Facility Improvement Financing Act, the expansion of Primary Care Networks, and the deployment of more than 107,000 Community Health Promoters represent a genuine, significant reform effort. The question before the Kenya Health Summit 2026 is no longer whether Kenya has the right reforms on paper, but whether they can be financed, implemented, governed and sustained in a fiscal environment the Government's own 2026 Budget Policy Statement describes as being at high risk of debt distress.

This Paper is offered as technical input to the Joint Health Compact the Ministry of Health is developing, providing evidence, analysis and a proposed architecture of commitments that civil society believes can anchor the Compact and make it operational. It sets out the fiscal context, positions civil society's core arguments within that context, and closes with ten proposed Compact commitments organized under three pillars: Financing; Delivery and Quality; and Accountability and Partnership. The central argument is that Kenya currently finances roughly 6.9% of its national budget on health (national and county combined) against a 15% Abuja Declaration commitment. That gap shows up as a reported contraction in county health workforce numbers, SHA claims backlogs, and commodity stock-outs. For the Compact to be credible, this gap must be costed and funded so that Kenya's reform agenda remains a delivery agenda.

Purpose and Context

Civil society offers this paper as a technical partner to the Ministry's own drafting process. We stand ready to work with the Ministry of Health, county governments, Parliament, development partners, the private sector and communities to help build a Joint Health Compact for delivery, financing, accountability and trust. The Paper builds on consultations with CSOs across Kenya and submissions from member organisations. The Ministry has framed the Summit as an opportunity to take stock of Kenya's health reform journey and build consensus on priorities for the next phase of transformation. Civil society welcomes this framing and proposes the Compact go further than stock-taking by asking not only what reforms have been introduced, but whether they are reaching the Kenyan household, whether they are financially sustainable, whether they protect the poorest, whether resources are reaching the front line, and who is accountable when they do not.

KENYA'S HEALTH REFORM JOURNEY: WHAT HAS BEEN ACHIEVED

Civil society recognises the scale of reform already under way. For instance; The Government has deployed more than 107,000 Community Health Promoters nationally, explicitly positioning preventive and promotive health as central to the UHC agenda; SHA has expanded registration, contracted facilities and begun processing claims at scale.Current reports indicate that SHA is operating on a 90-day payment timeline with a 74% settlement rate; Kenya is also entering a fundamentally different financing environment, with Government-to-Government (G2G) arrangements, including the Kenya–US health cooperation framework, structured around government-led investment in primary health care, disease programmes, and maternal and newborn health. This is real progress, and the The task now is to match this architecture with four conditions on which this Position Paper is built namely; predictable financing, effective implementation, accountable institutions and meaningful citizen participation.

A QUICK LOOK AT CIVIL SOCIETY'S PRIORITIES FOR THE JOINT HEALTH COMPACT

PILLAR A — FINANCING

A1. Protect and Grow Primary Health Care Financing
Establish and enforce a protected PHC financing floor across national and county budgets, with a published, costed roadmap to close the gap between current combined health financing (~6.9% of the budget) and the Abuja commitment (15%).

A2. Institutionalise Community Health Financing
Adopt and finance a multi-year national community health financing framework covering CHPs, supervision, commodities, equipment, digital tools, referral and community engagement, jointly implemented by national and county governments.

A3. Address Health-Sector Debt
Publish verified health-sector arrears and a time-bound settlement plan, and put in place mechanisms that prevent new arrears from accumulating.

PILLAR B — DELIVERY AND QUALITY

B1. Restore Confidence in SHA
Publish quarterly, county-disaggregated SHA financing and claims data and establish enforceable standards for claims processing, tariff-setting transparency and payment timelines.

B2. Protect Essential Commodities
Ring-fence essential commodity financing and publish a domestic transition plan for externally financed commodities, with published stock-availability indicators.

B3. Strengthen the Health Workforce
Recognise Community Health Promoters and other community cadres as part of the formal health workforce establishment, with equitable distribution, retention and continuous professional development addressed as financing, not only policy, questions.

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Recognize Community Health Promoters and other community cadres as part of the formal health workforce establishment, with equitable distribution, retention and continuous professional development addressed as financing, not only policy, questions.

B5. Harness Kenya's Demographic Dividend
Invest in adolescent and youth health, particularly addressing the triple threat of teenage pregnancy, HIV and SGBV, while securing family planning commodities, youth-friendly services and meaningful youth and CSO participation so that young people can grow into a healthy, productive generation.

B6. Deliver Integrated, Patient-Centred Quality of Care
Ensure coordinated, respectful and quality care that responds to patients' needs and preferences, with meaningful patient participation, continuity of care, effective follow-up and referral, and accessible mechanisms for patient feedback and accountability.

PILLAR C — ACCOUNTABILITY AND PARTNERSHIP

C1. Make G2G Financing Accountable
Ensure government-managed external financing includes structured civil society participation in community engagement, independent monitoring, evidence generation and social accountability.

C2. Institutionalise Civil Society Participation
Formally recognise and resource a Civil Society Health Accountability and Partnership Mechanism within the national health-sector coordination framework.

C3. Establish a Compact Accountability Framework
Create an annual public review of the Joint Health Compact, with measurable indicators, institutional responsibilities, timelines, an equity impact assessment requirement, and citizen feedback.

1. The Role of Civil Society in Kenya's Shifting Health Financing

Kenya is entering a fundamentally different health financing environment, marked by greater domestic financing and increasing use of G2G financing. This presents an important opportunity to strengthen national ownership, align resources with priorities and build a more sustainable health system. Civil society supports government leadership and ownership of health financing — but this must be accompanied by public accountability for that financing. The movement of resources through government systems should not exclude civil society from programme design, implementation monitoring, community engagement, social accountability, evidence generation and independent oversight. The old model, in which CSOs were primarily donor-funded project implementers, is becoming less relevant; Kenya needs a partnership model built on civil society's comparative strengths in implementation reach, community access, evidence, accountability, innovation and policy feedback.

We propose the Compact explicitly recognize civil society as integral to the implementation and accountability architecture of G2G and domestic health financing, with defined roles in:

- Community engagement — helping ensure national investments are understood and translated into locally responsive services;
- Independent monitoring — tracking whether resources, commodities, services and commitments reach intended beneficiaries;
- Social accountability — through community scorecards, social audits and structured citizen feedback;
- Reaching underserved populations — informal settlements, ASAL counties, mobile populations, adolescents and persons with disabilities;
- Evidence generation — identifying implementation bottlenecks not visible through routine administrative systems;
- Policy dialogue — aggregating community and implementation evidence into national and county policy processes; and
- Accountability of the Compact itself — tracking implementation and publicly reporting progress.

We welcome the recognition of HENNET as the one source of truth for civil society health accountability, partnership and structured participation within the Ministry's sector coordination architecture. HENNET will provide an organized interface for CSO participation, maintain an up-to-date picture of CSO actors and their areas of operation, consolidate community and CSO-generated evidence, and support coordinated monitoring of health financing and implementation — giving the Ministry a credible, structured and accountable channel through which civil society evidence, contributions and concerns inform policy, planning and implementation.

2. HARNESSING KENYA'S DEMOGRAPHIC DIVIDEND: PROTECTING THE HEALTH OF A YOUNG NATION

Kenya's youthful population is one of the country's greatest development assets and yet one of its greatest responsibilities. More than 75% of Kenyans are below the age of 35, while the 2025 UNFPA population estimate puts Kenya's population at approximately 57.5 million, with 36% aged 0–14. Kenya has a narrow but significant opportunity to convert this youthful population into a demographic dividend through deliberate investment in health, education, skills, employment and economic opportunity. The dividend is not automatic; it depends on young people surviving, staying healthy, completing education, avoiding preventable pregnancies and HIV infection, and entering productive adulthood. Kenya's own population analysis recognises that the dividend will require sustained investment in human capital, including universal health coverage and youth empowerment.

The health dimension of this opportunity is particularly urgent because adolescent girls and young women continue to face an interconnected "triple threat" of teenage pregnancy, HIV and sexual and gender-based violence (SGBV). Kenya's 2022 KDHS found that 15% of girls aged 15–19 had ever been pregnant, with enormous county variation from 50% in Samburu to 5% in Nyeri and Nyandarua. More than 232,000 pregnancies among girls aged 10–19 were reported in 2025, while an estimated 5,720 new HIV infections occurred among adolescent girls and young women aged 15–24 in 2022. These are not isolated indicators: teenage pregnancy can interrupt education and economic participation; HIV creates lifelong health and financial consequences; and SGBV is both a cause and consequence of vulnerability to pregnancy and HIV. The situation is compounded by family planning stock-outs and weaknesses in the reproductive health information and supply environment. The recent Pharmacy and Poisons Board alert on a falsified batch of Postinor-2 illustrates the risks: for a young woman seeking emergency contraception, unreliable access or a falsified product can translate into unintended pregnancy, disrupted education and livelihoods, and increased vulnerability to unsafe abortion and SGBV.

The Every Woman Every Newborn Everywhere (EWENE) Acceleration Plan 2026–2028 provides an important platform for Government and partners to translate this demographic opportunity into measurable health gains. The Compact should build on EWENE rather than create parallel structures, linking its investments in maternal and newborn survival, health workers, commodities, quality of care, financing and accountability to the wider adolescent and reproductive health agenda. Government and partners should protect and finance a comprehensive package of adolescent- and youth-responsive services, including reliable access to quality-assured family planning, HIV prevention and testing, STI services, maternal health, mental health and GBV prevention and response.

This requires zero tolerance for contraceptive and essential medicine stock-outs, stronger pharmaceutical quality surveillance, timely and accurate public information, and youth-friendly services that protect confidentiality and dignity. Counties and the national government should use routine data to identify geographic and population-level gaps and direct resources accordingly.

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Civil society recognises its responsibility to build demand, trust and sustained SHA enrolment, particularly among informal-sector populations affected by weak means testing and limited information on eligibility and benefits. We commit to working with SHA and counties to drive informed enrolment through community mobilisation, registration support, accurate information and identification of barriers, using community health promoters, youth and women's networks, faith-based organisations and other trusted structures. The Compact should recognize and resource this through a CSO–SHA demand-generation and accountability partnership, while preserving CSOs' independent role in monitoring whether SHA delivers for citizens.

3. THE FISCAL CONTEXT: FINANCING HEALTH IN AN ERA OF DEBT DISTRESS

The 2026 Budget Policy Statement recognises fiscal consolidation, constrained revenues and elevated debt-service pressures, and identifies debt sustainability as a continuing concern. Kenya cannot assume additional external resources will indefinitely compensate for weaknesses in domestic financing; equally, calling for higher allocations without addressing efficiency, prioritization and accountability is unlikely to be sufficient. The table below sets out where Kenya stands against its own Abuja Declaration commitment.

Financing Indicator	FY 2026/27 Figure	Share / Benchmark
Total National Budget	Ksh 4.82 trillion	100%
National Health Allocation	Ksh 177.2 billion	~3.7% of total budget
Abuja Declaration Commitment	—	15.0% of national budget
Financing Gap to Abuja Commitment	—	~11.3 percentage points

Sources: *National Treasury FY 2026/27 Budget Statement; National Treasury/Parliamentary Budget Office FY 2026/27 total expenditure.*

With KSh 177.2 billion allocated to national health (~3.7% of the KSh 4.82 trillion national budget), the allocation remains well below the 15% Abuja benchmark. This calls for a deliberate shift from incremental annual budgeting towards a credible, multi-year health financing strategy. We recommend the Ministry: (i) develop and publish a costed pathway towards the Abuja benchmark with annual milestones; (ii) ring-fence financing for primary health care, community health, immunisation and other high-impact preventive services; (iii) strengthen domestic resource mobilisation, including strategic health taxes; (iv) improve expenditure efficiency by addressing fragmentation, duplication and under-execution of approved budgets; and (v) institutionalise transparent public and civil society participation in budget tracking and expenditure accountability.

Civil society proposes the Compact adopt a "protect, prioritise and account" approach: protect essential services and high-impact PHC interventions from disproportionate budget reductions; prioritise resources towards interventions with the greatest impact on mortality, morbidity, equity and household financial protection; and account for every major health financing stream, from allocation and disbursement to expenditure and outcomes, in a form Parliament, county assemblies, civil society and citizens can understand, scrutinize and monitor.

4. TRANSFORMING A REFORM AGENDA TO A DELIVERY COMPACT

Kenya's current reforms provide an important architecture for UHC that will only succeed if matched by predictable financing, effective implementation, accountable institutions and meaningful citizen participation. There is a real risk that fiscal pressure will cause Kenya to protect the most visible parts of the health system such as hospitals and tertiary care while under-investing in the less visible but highly consequential parts: prevention, community health, health promotion, disease surveillance, nutrition and social accountability. This would be a false economy: underfinanced prevention means the system pays more for treatment later; a weak Level 1 pushes avoidable demand onto referral hospitals; unavailable commodities push costs onto households; unpaid providers undermine service continuity. Kenya needs a financing model that follows the health needs of the population, not simply the institutional structure of the health system and this is the logic the Compact should encode.

5. PRIMARY HEALTH CARE AS THE PROTECTED FOUNDATION OF UHC

Primary health care cannot remain a policy aspiration while financing continues to favour curative and facility-based services. Kenya's most important health system asset is the system that prevents people from becoming seriously ill, identifies risk early, and connects households to appropriate care. The Community Health Promoter platform is the first level of Kenya's health system and should be financed and managed accordingly. Civil society is concerned that the financing architecture still does not adequately reflect Level 1's economic and public-health value, and proposes for the Compact:

- A clearly defined and protected financing envelope for Level 1/community health within Kenya's PHC financing framework;
- A costed, multi-year national community health financing framework, jointly implemented by national and county governments, covering CHP stipends, training, supervision, commodities, digital tools, referral support, data management and community engagement;
- A financing mechanism recognising prevention and health promotion as health-system outputs, not only clinical encounters;
- Integration of community health indicators into the national health financing and performance framework; and
- A requirement that national and county health plans demonstrate how financing reaches Level 1.

6. THE SOCIAL HEALTH AUTHORITY

6.1. Must Become a Source of Confidence

Civil society recognises the progress reported on SHA, including expanded registration (32.2 million as at August 2026), facility contracting, claims payments and settlement of verified claims inherited from the defunct NHIF. However, public and provider confidence will ultimately be determined by lived experience. Delayed claims, unclear processing procedures, tariff uncertainty, provider cash-flow challenges, unauthorized out-of-pocket payments and accumulated health-sector arrears remain significant concerns, when providers are not paid, commodities are not replenished, suppliers restrict deliveries and facilities accumulate liabilities. Patients ultimately bear the cost. The Compact should make SHA transparency, timely payment and financial accountability standing commitments:

- Publish quarterly, county-disaggregated SHA performance data e.g. contributions, claims received, approvals, rejections, pending claims, payment amounts and processing times.
- Make the reported 90-day payment timeline and 74% settlement rate independently verifiable, with regular public reporting.
- Publish the basis for SHA tariff and benefits-package decisions, including evidence and criteria used.
- Undertake independent actuarial and financial reviews of SHA and make findings publicly accessible.
- Publish a verified health-sector arrears position, including inherited NHIF liabilities, and a time-bound settlement plan.
- Establish safeguards against new arrears, including early-warning mechanisms and routine public reporting.
- Strengthen grievance redress and enforcement against unauthorized out-of-pocket payments.
- Institutionalise structured civil society and provider participation in reviewing SHA benefits, tariffs and wider financing reforms.

SHA must not only expand coverage on paper; it must become a predictable, transparent and trusted purchaser of health services whose commitments are honored and whose performance can be independently scrutinized by Parliament, providers, civil society and citizens.

6.2. MAKING SHA ENROLMENT AND RETENTION WORK FOR EVERY HOUSEHOLD.

Civil society recognises the Government's intention to use means testing to ensure that public subsidies are targeted to households that need them most. However, the current means-testing approach is becoming a significant barrier to SHA enrolment, retention and continuity of coverage, particularly for households in the informal sector whose incomes are irregular and difficult to assess. The Compact should therefore move from a binary approach to means testing towards a simpler, progressive and citizen-centred subsidy model that protects the principle of targeting while reducing administrative barriers. Government should simplify and speed up the assessment process, establish transparent and predictable contribution/subsidy bands, allow provisional enrolment while eligibility is being verified, provide accessible channels for households to challenge or update their assessment, and use interoperable administrative data to progressively improve targeting rather than repeatedly placing the burden of proof on citizens. No household should lose access to essential health services simply because its ability to pay has not yet been accurately determined. CSOs can support this transition by helping communities navigate enrolment and assessment, identifying exclusion and retention barriers, monitoring who is being left out, and bringing evidence from informal-sector communities into the continuous improvement of the SHA financing model.

Civil society also recognises its responsibility to build demand, trust and sustained enrolment in SHA. Kenya's large informal sector remains a particular challenge, alongside weaknesses in means testing and limited public understanding of eligibility and benefits. CSOs have a comparative advantage in reaching communities through community health promoters, faith-based organisations, youth and women's networks, informal-sector associations, employers, CBOs and trusted local leaders. We commit to working with SHA and county governments to drive informed enrolment and retention by taking accurate information to communities, supporting registration and identifying barriers to enrolment, mobilising informal-sector populations, and generating community-level feedback while retaining our independent role in monitoring whether SHA delivers on its promises.

7. Integrated People–Centred Health Services.

Civil society supports the transition from disease-specific, vertically financed programmes towards integrated, people-centred primary health care. However, integration must not become a euphemism for withdrawing resources or weakening programmes that have delivered major gains. HIV, TB and malaria remain major public health priorities placing significant demands on Kenya's health system. As external financing changes, the Compact should guarantee a country-led, country-owned transition that protects access to prevention, diagnosis, treatment,

commodities, community services and continuity of care, while progressively embedding these programmes within routine PHC planning, budgeting, workforce, procurement, supply chains, information systems and accountability. Communities and CSOs must be part of monitoring whether integration improves access and quality or inadvertently creates new gaps for populations that have historically depended on dedicated programmes.

At the same time, Kenya's health system must respond to the growing burden of non-communicable diseases (NCDs) and the reality of people living with multiple conditions. The Compact should accelerate integration of NCD prevention, screening, diagnosis, treatment, rehabilitation and palliative care into PHC, alongside HIV, TB, malaria and maternal, newborn, child and adolescent health services covering hypertension, diabetes, cardiovascular disease, cancers, mental health and other priority NCDs, with attention to early detection, continuity of care and access to affordable medicines and diagnostics. CSOs and communities should have a defined role in demand generation, prevention, community-based screening, treatment literacy, adherence support, stigma reduction, referral and accountability, so integration is measured not just by administrative consolidation but by whether people receive comprehensive, continuous and quality care across the life course.

8. Cross-Cutting Priorities for the Compact

Commodity Security: SHA coverage has little meaning if patients cannot find essential medicines and commodities. The Compact should ring-fence financing, strengthen forecasting and national pooled procurement to secure quality, economies of scale and reliable supply; establish time-bound domestic transition plans for donor-supported HIV, TB, malaria, vaccines, family planning, maternal and newborn commodities and essential diagnostics; and publish stock-availability indicators. CSOs should monitor the transition, procurement and distribution.

Human Resources for Health: Financing reform requires an adequate, equitably distributed and motivated workforce. The Compact should address health worker-to-patient ratios, inequitable distribution and missing cadres; recognize Community Health Workers and Promoters as integral to the workforce; and improve working conditions, retention, professional development and supportive supervision. FIF should only complement government responsibility for workforce financing, with public reporting on staffing gaps and vacancies.

Digital Health and Data Governance: Civil society supports digitization and responsible AI, provided technology strengthens rather than replaces the human relationship with communities. The Compact should ensure interoperability, data protection, inclusive data governance, safeguards against bias and exclusion, and accessible, anonymized health financing and service data. CSOs should help communities exercise their data rights and independently monitor whether digitization improves equity, quality and accountability.

Equity in Health Financing. UHC cannot be measured by national averages alone. Every major health financing reform should undergo an equity impact assessment and be accountable for those left behind such as people living in poverty, informal-sector workers, women and girls, persons with disabilities, older persons, and populations in ASAL and other underserved counties.

9.From Compact to Action: Implementing Kenya's Health Commitments

The immediate priority after the launch should be to translate the Compact from a statement of intent into a shared implementation and accountability agenda, with Government, counties, SHA, civil society and partners clear on their respective roles and how progress will be tracked. This should include establishing the necessary coordination and accountability arrangements, agreeing a results framework, improving visibility of health financing flows, strengthening community and civil society participation, and creating accessible mechanisms for public feedback and monitoring. We recommend that the Compact be reviewed annually at a high-level health-sector accountability forum.

Champions of the cause

Stronger Systems.
Stronger Partnerships.
Better Health for All.

Civil society remains committed to advancing equitable, people-centred, accountable and sustainable health systems through partnership, evidence, advocacy and community engagement.

PEOPLE CENTRED

ACCOUNTABILITY & TRANSPARENCY

PARTNERSHIP & COLLABORATION

HEALTH EQUITY & INCLUSION

STRONG SYSTEMS BETTER OUTCOMES

A stronger health system is built not only through financing and policy, but through accountable partnerships that place people at the centre of healthcare.

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