Situational Analysis Report on Community Engagement in Pandemic Prevention, Preparedness, and Response (PPR) in Kenya

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This report provides an in-depth situational analysis of current community engagement in Pandemic Prevention, Preparedness, and Response (PPR) in Kenya, including stakeholder mapping, gap analysis, and an overview of decision-making fora at national and sub-national levels.

Contents

List of Abbreviations

AMR	Antimicrobial Resistance
CDC	Centers for Disease Control and Prevention
CHC	Community Health Committee
CHP	Community Health Promoter
CHU	Community Health Unit
COHU	County One Health Unit
CSO	Civil Society Organization
EOC	Emergency Operations Centre
GHSA	Global Health Security Agenda
HENNET	Health NGOs Network
IHR	International Health Regulations
JEE	Joint External Evaluation
MoH	Ministry of Health
NAPHS	National Action Plan for Health Security
NPHI	National Public Health Institute
PHEOC	Public Health Emergency Operations Centre
PHC	Primary Health Care
PPR	Pandemic Preparedness and Response
SPAR	State Party Annual Reporting
TB	Tuberculosis
UHC	Universal Health Coverage
WHO	World Health Organization
ZDU	Zoonotic Disease Unit

1. Introduction

The COVID-19 pandemic underscored global and national challenges in health system responsiveness, equity, and resilience. One of the most critical lessons learned was the indispensable role that communities play in pandemic preparedness, response, and recovery. Globally, there is a growing consensus that effective Pandemic Preparedness and Response (PPR) must be inclusive, participatory, and community-led—particularly to ensure that public health measures address the needs of the most vulnerable and marginalized populations.

In Kenya, the health system has made significant progress in strengthening institutional mechanisms for emergency preparedness and response. A major milestone is the establishment of the National Public Health Institute (NPHI)**,** a centralized body designed to coordinate surveillance, research, policy development, and public health emergency management. The NPHI provides a unique opportunity to institutionalize robust stakeholder engagement frameworks, including mechanisms for community involvement in public health governance.

Despite these advances, community engagement in PPR remains fragmented, inconsistent, and often ad hoc**.** Marginalized and key populations — including people living with HIV, TB survivors, sex workers, people who use drugs, LGBTQ+ individuals, and residents of informal settlements — continue to experience exclusion from critical decision-making spaces such as technical working groups (TWGs), emergency coordination platforms, and preparedness planning committees. Where engagement does occur, it is frequently tokenistic and lacks transparency, accountability, and sustainability.

Communities possess valuable contextual knowledge, leadership, and social capital that are critical for developing inclusive, equitable, and effective preparedness and response strategies. However, Kenya currently lacks a national stakeholder engagement framework that clearly defines the roles, responsibilities, and modalities for community and civil society participation in PPR. There are also no standardized tools or guidelines to facilitate structured inclusion of community actors in formal health governance processes, such as TWGs or policy development forums.

This situational analysis and technical assistance initiative aim to address these gaps by informing the development of comprehensive frameworks and tools to strengthen and institutionalize community representation in Kenya's PPR architecture. Specifically, the process seeks to:

- Develop national guidelines for community and civil society representation in PPR governance;
- Design context-specific community engagement strategies;
- Draft Standard Operating Procedures (SOPs) for operationalizing community participation; and
- Recommend structured inclusion of community actors in TWGs and policy decision-making bodies.

Communities target to operationalize a whole-of-society approach to health security — building a more inclusive, resilient, and responsive PPR system that recognizes communities as central partners in preparedness and response.

2. Methodology

This situational analysis employed a mixed-methods approach, combining a desk review of relevant policy documents with primary qualitative consultations through Key Informant Interviews (KIIs) and a stakeholder consultative meeting. The objective was to obtain a comprehensive understanding of community engagement in Pandemic Preparedness and Response (PPR) in Kenya — including current practices, governance structures, stakeholder dynamics, and existing gaps.

2.1. Desk Review

The analysis began with an extensive review of key national and global health security documents, which provided the contextual and institutional basis for understanding Kenya's PPR architecture. These included:

- Kenya National Action Plan for Health Security (NAPHS 2019–2023) – Ministry of Health
- Kenya Joint External Evaluation (JEE) Report (2024 Draft)
- Kenya Global Health Security Country Page (CDC/USG, 2023)
- Community Health Policy (2020–2030) and Community Health Strategy (2020–2025)
- National Public Health Institute (NPHI) Concept Paper and Strategic Framework (2024 Draft)
- Relevant literature, policy briefs, and technical reports from development partners, civil society organizations (CSOs), and community networks involved in health governance and pandemic preparedness

The desk review focused on identifying the policy provisions, institutional frameworks, and operational mechanisms guiding community engagement in PPR. It also mapped out decision-making fora at both national and county levels and reviewed lessons from previous public health emergencies such as COVID-19, cholera, and Rift Valley Fever.

2.2. Key Informant Interviews (KIIs)

A total of 15 Key Informant Interviews were conducted with individuals representing government institutions, civil society, development partners, and community networks. The KIIs were semi-structured to allow in-depth exploration of perspectives on community engagement in health security and PPR governance.

Categories of respondents included:

- Officials from the Ministry of Health, particularly from the Directorate of Health Security, Division of Disease Surveillance and Response (DDSR), and Zoonotic Disease Unit (ZDU)

- Representatives from the National Public Health Institute (NPHI) Secretariat and selected County Health Departments
- Members of civil society organizations and networks, including Stop TB Partnership Kenya, HENNET, NEPHAK, and community-based organizations involved in community-led monitoring and advocacy
- Development and technical partners such as WHO, CDC Kenya, and USAID, who support PPR and health security initiatives
- Community leaders and peer networks working on HIV, TB, and other health priorities at grassroots level

The KIIs explored several dimensions, including:

- Existing platforms for community participation in PPR decision-making
- Institutional and operational challenges affecting meaningful community engagement
- Capacity needs, coordination gaps, and feedback mechanisms
- Opportunities to institutionalize community representation in national and county PPR structures

2.3. Stakeholder Consultative Meeting

Following the KIIs, a national stakeholder consultative meeting was convened to validate and enrich the findings from the desk review and interviews. The meeting brought together over 25 participants representing government agencies, county officials, civil society organizations, development partners, and community networks.

The session, organized in collaboration with Stop TB Partnership Kenya, served several objectives:

1. To present preliminary findings of the situational analysis for feedback and validation
2. To facilitate dialogue among stakeholders on current challenges, opportunities, and best practices in community engagement in PPR
3. To collect inputs on the design of a stakeholder engagement framework for the NPHI and broader PPR coordination mechanisms
4. To identify priority areas for technical assistance and capacity-building interventions to enhance community participation in health security governance

Discussions were conducted through plenary sessions and breakout groups, enabling participants to provide practical insights on policy gaps, representation mechanisms, and operational bottlenecks. The consultative meeting also promoted collective ownership and alignment among key stakeholders.

2.4. Data Analysis and Synthesis

Information from the desk review, KIIs, and the stakeholder consultative meeting was triangulated to ensure accuracy and comprehensiveness. Themes were analyzed around key pillars of PPR — governance, coordination, capacity, inclusivity, and sustainability — and aligned with Kenya's NAPHS, JEE indicators, and One Health frameworks.

Findings were synthesized to highlight:

- The current landscape of community engagement in PPR and PHC governance
- Key actors and institutional linkages
- Gaps in policy, coordination, and representation
- Opportunities to strengthen and institutionalize community participation

This multi-method approach ensured that the analysis reflects both policy realities and lived community experiences, providing a credible evidence base for policy and programmatic recommendations.

3. Overview of Kenya's PPR Framework

3.1. Governance and Institutional Architecture

Kenya's Pandemic Preparedness and Response (PPR) system operates within a devolved health governance framework established under the Constitution of Kenya (2010). The national government retains the mandate for policy formulation, coordination, and international health regulation (IHR 2005) compliance, while county governments are responsible for service delivery, surveillance, and community-level implementation.

The country's overarching vision for health security, articulated in the National Action Plan for Health Security (NAPHS 2019–2023), aspires to achieve "a nation free and secure from all public health risks and hazards." The NAPHS operationalizes the Joint External Evaluation (JEE) and State Party Annual Reporting (SPAR) recommendations, focusing on strengthening institutional capacities to prevent, detect, and respond effectively to public health emergencies.

Key coordination mechanisms include the Ministry of Health Directorate of Health Security and Emergencies, the National Public Health Institute (NPHI), and the National Emergency Operations Centre (EOC). The NPHI serves as a centralized body to coordinate surveillance, research, emergency response, and policy development, while the EOC provides a command structure for multi-sectoral response. At the county level, County EOCs (20 established to date) support localized emergency preparedness and response, covering over half of Kenya's population.

3.2. Strategic Pillars of the PPR Framework

Kenya's health security capacities are organized around four strategic pillars that reflect the IHR core competencies and the One Health approach.

a) **Prevention**
This pillar focuses on mitigating risks before outbreaks occur through robust legal, policy, and financing mechanisms. Prevention strategies include:

- Strengthening legal frameworks and national coordination for IHR implementation.
- Expanding immunization coverage and infection prevention and control measures.

- Implementing the National Multi-Sectoral Cholera Elimination Plan.
- Enhancing antimicrobial resistance (AMR) surveillance through development of the National Medicines Formulary and antibiotic stewardship programs.
- Advancing zoonotic disease surveillance and control through the Zoonotic Disease Unit (ZDU), which links human, animal, and environmental health.

b) Detection

Detection capacity has improved markedly through investments in laboratory networks, surveillance systems, and workforce development.

- Kenya has implemented genomic sequencing capacity in four national reference laboratories and molecular diagnostic capabilities in seven regional laboratories.
- Nine laboratories (six human and three animal) have achieved international accreditation
- The country has established a comprehensive surveillance network integrating population-based, facility-based, and community-based surveillance systems that generate actionable data for public health decision-making.
- Kenya has achieved the WHO benchmark of one trained field epidemiologist per 200,000 people, underscoring national investment in public health intelligence.

c) Response

The response pillar aims to ensure timely and coordinated action during public health emergencies.

- The National Emergency Operations Centre (EOC) and its 20 county branches are guided by a national EOC framework and strategy.
- Multi-sectoral coordination for outbreak management operates under the IHR Inter-Ministerial Coordination Committee (IMCC), supported by rapid response teams at both national and county levels.
- Kenya continues to strengthen systems for logistics, medical countermeasures, and risk communication to ensure coherent and transparent information flow during crises.

d) One Health Coordination

Kenya's PPR architecture is strongly aligned with the One Health approach, recognizing the interconnectedness of human, animal, and environmental health.

- The Zoonotic Disease Unit (ZDU)—a joint platform between the Ministries of Health and Agriculture, Livestock and Fisheries—coordinates zoonotic surveillance and response activities.
- County One Health Units (COHUs) are being established to facilitate collaboration across sectors at the local level.
- Cross-sectoral initiatives such as the joint Infectious Disease and Global Health Master of Science program at the University of Nairobi and Moi University build the workforce needed for integrated health security operations

3.3. Community Engagement and Risk Communication

The NAPHS identifies risk communication and community engagement (RCCE) as a cross-cutting priority area. Kenya's recent investments have improved communication capacity across national and county levels, including the development of standardized tools for rumor management and public messaging. However, the involvement of communities in governance and oversight remains weak, often limited to health promotion and outbreak response rather than structured participation in preparedness and policy development.

The 2023 SPAR and 2024 Draft JEE both highlight that while Kenya has established community-based surveillance systems, structured mechanisms for consistent, resourced, and institutionalized community engagement are still lacking. Civil society organizations, community-based networks, and vulnerable populations remain underrepresented in decision-making platforms such as Technical Working Groups (TWGs) and EOCs, despite their critical role in building trust and ensuring equitable access to information and services.

3.4. Key Achievements and Emerging Opportunities

Kenya has made notable progress in health security with support from international partners, particularly the United States Government (USG) Global Health Security (GHS) program, WHO, and Africa CDC. Key achievements include:

- Establishment of 20 county EOCs covering more than 50 percent of the population.
- Accreditation of laboratories and expansion of genomic sequencing capacity.
- Implementation of multi-sectoral coordination through the ZDU and One Health platforms.
- Development of the National Medicines Formulary and the National Cholera Elimination Plan.
- Enhanced epidemiological workforce development through field training programs.

The ongoing operationalization of the NPHI and the strengthening of county One Health platforms present an opportunity to embed community engagement as a core component of national PPR governance, ensuring that local knowledge and networks contribute meaningfully to health emergency preparedness, response, and recovery.

4. Current Status of Community Engagement in PPR

4.1. Policy Recognition

Community engagement is formally acknowledged across Kenya's national health and development frameworks as an essential pillar for achieving health security and resilience. The

policy environment provides a strong normative basis for participation, though implementation remains inconsistent and under-resourced.

a) Community Health Policy and Strategy

The *Community Health Policy (2020–2030)* and *Community Health Strategy (2020–2025)* recognize communities as the foundation of Kenya's health system. They define the structure and mandate of Community Health Units (CHUs), Community Health Promoters (CHPs), and Community Health Committees (CHCs) as key vehicles for health promotion, surveillance, and accountability at the household and community level. The CHPs are the first point of contact for households, linking communities with primary health care facilities and reporting on public health events, including outbreaks and unusual occurrences.

The policy further promotes community participation in governance through CHCs, which are expected to engage in decision-making, social accountability, and community-led monitoring (CLM) processes. These structures serve as the entry point for pandemic preparedness activities and play an integral role in early warning systems, behavior change communication, and local-level health governance.

b) Integration within National Action Plans and Health Security Frameworks

The *National Action Plan for Health Security (NAPHS 2019–2023)* explicitly recognizes community engagement and participation as a core component of health emergency preparedness and response. It outlines communities as the "first line of defense" in detecting outbreaks and mobilizing preventive actions. The NAPHS encourages the establishment of community-based surveillance systems, training of CHPs on disease detection, and integration of community data into the national surveillance system.

Similarly, the *Joint External Evaluation (JEE) 2024 Draft* underscores the importance of community involvement in strengthening the "Prevent–Detect–Respond" continuum. It highlights Kenya's progress in training CHPs, expanding One Health structures, and promoting community-based risk communication. However, the evaluation also identifies significant disparities across counties, with varying levels of functionality, coordination, and inclusion of marginalized communities.

c) Alignment with Universal Health Coverage (UHC) and Vision 2030

Kenya's UHC agenda, embedded within Vision 2030, links health security and pandemic preparedness to broader efforts to achieve equitable access to quality health services. Under UHC, community health systems are critical for bridging the gap between national health programs and local populations. The policy encourages the inclusion of community feedback and participation in planning and implementation of emergency preparedness programs, though practical integration into pandemic-related planning remains limited.

Despite the policy recognition, community engagement in PPR is still largely project-based and dependent on donor funding, with limited domestic resources allocated to sustain participation mechanisms. This has led to fragmentation, weak institutional linkages, and inconsistent representation in governance processes.

4.2. Operational Mechanisms

a) Community Health Structures

Kenya's community health system provides a robust foundation for pandemic preparedness and response. All 47 counties have established Community Health Units (CHUs), each served by trained Community Health Promoters (CHPs). As of 2023, over 90,000 CHPs have been deployed nationwide, supported by the Ministry of Health and county governments.

CHPs are responsible for conducting household visits, mobilizing communities for immunization and screening, and identifying unusual health events for rapid reporting. During the COVID-19 pandemic, CHPs were instrumental in case detection, contact tracing, and risk communication. Their role in pandemic surveillance is further reinforced by the integration of community-level reporting into the *Electronic Community Health Information System (eCHIS)*, which feeds directly into national health data platforms such as DHIS2.

However, the functionality of CHUs varies widely across counties. Some counties have fully digitized systems and receive regular stipends and supervision, while others face funding shortages, delayed remuneration, and irregular data reporting. The *Kenya JEE (2024)* notes that community reporting mechanisms require sustained financial investment and improved linkages with county health departments to enhance accountability and data reliability.

b) Community-Based Surveillance Systems

Kenya's *Integrated Disease Surveillance and Response (IDSR)* system integrates data from communities through CHPs, health volunteers, and informal community reporters. Community-Based Surveillance (CBS) and Event-Based Surveillance (EBS) are now implemented in all 47 counties.

Community members report suspected outbreaks or unusual events to CHPs, who escalate alerts through the sub-county disease surveillance coordinators for verification. Counties such as Kisumu, Machakos, and Garissa have adopted digital tools like *mDharura* and *EBS mobile reporting systems*, allowing real-time alert tracking and verification.

Despite this progress, surveillance effectiveness is constrained by several challenges:

- Uneven functionality of CBS across counties due to limited integration of digital tools.
- Weak feedback mechanisms, where alerts raised by communities are not followed by visible action or feedback.
- Limited training for CHPs and community leaders on event verification and reporting protocols.
- Insufficient integration of CBS data into One Health surveillance systems, hindering cross-sectoral collaboration between human and animal health sectors.

c) Risk Communication and Social Mobilization

Risk communication and community engagement (RCCE) have evolved significantly, particularly after the COVID-19 pandemic. The Ministry of Health has developed a national risk communication strategy, established a Risk Communication Technical Working Group (TWG), and deployed county-level communication focal points. These structures aim to coordinate timely dissemination of health information, rumor management, and mobilization during public health emergencies.

Community engagement under the RCCE framework often involves:

- Mobilization of CHPs, religious leaders, and traditional healers to promote preventive behaviors.
- Partnerships with civil society organizations, such as Stop TB Partnership Kenya, NEPHAK, and Kenya Red Cross, for awareness campaigns.
- Deployment of social media and SMS platforms for risk communication.

However, engagement often remains one-directional and reactive. Many risk communication activities are led by technical experts with minimal participation from community representatives in message design. The JEE 2024 notes the absence of a standardized mechanism for collecting and integrating community feedback into communication planning. Moreover, while counties have developed risk communication plans, their implementation is often dependent on external funding, and coordination with national-level Emergency Operations Centres (EOCs) is weak.

d) Community Role in One Health Platforms

Kenya has made strides in operationalizing the One Health approach through the Zoonotic Disease Unit (ZDU) and County One Health Units (COHUs). These structures facilitate cross-sectoral collaboration between the human, animal, and environmental health sectors.

At national level, the ZDU coordinates surveillance and response to zoonotic diseases such as anthrax, rabies, Rift Valley fever, and brucellosis. At county level, COHUs provide platforms for joint outbreak investigation and coordination. However, community participation in these mechanisms remains minimal.

Most COHUs lack structured engagement with community-based organizations, indigenous networks, and local leaders. Communities are often involved only during outbreak response rather than in planning and prevention. This limits the potential of the One Health approach to harness community knowledge for early detection and cross-sectoral action at grassroots level.

4.3. Key Challenges and Gaps

Despite policy commitments and operational frameworks, several structural and systemic gaps continue to hinder meaningful community engagement in PPR:

a. **Weak institutionalization:** There is no national framework that clearly defines the modalities for community participation in PPR decision-making structures.

b. **Limited representation:** Community and civil society organizations are underrepresented in high-level coordination mechanisms such as the National Emergency Operations Centre (EOC), Technical Working Groups (TWGs), and One Health committees.
c. **Fragmented coordination:** Multiple actors engage communities during emergencies, but coordination across sectors and levels of government is weak.
d. **Insufficient resources:** Most community-level activities depend on donor funding, with minimal domestic budget allocation for surveillance, risk communication, or community training.
e. **Inadequate feedback mechanisms:** Data shared by communities often lacks feedback loops, undermining trust and sustained participation.
f. **Capacity limitations:** Many CHPs lack continuous training in PPR concepts, surveillance tools, and digital data systems.
g. **Limited inclusion of vulnerable groups:** Marginalized populations, including people living with HIV, TB survivors, and informal settlement residents, are not systematically included in decision-making processes.

4.4. Emerging Opportunities

Kenya's ongoing health reforms present significant opportunities to strengthen and institutionalize community engagement in PPR. The establishment of the National Public Health Institute (NPHI) provides a framework for integrating community participation into formal governance systems. By linking the NPHI with community health structures and One Health platforms, Kenya can operationalize a bottom-up approach to health security.

The digital transformation agenda under the *Kenya Health Information System (KHIS)* and eCHIS also presents opportunities to enhance real-time community reporting and feedback. Additionally, the growing network of civil society organizations—such as Stop TB Partnership Kenya, HENNET, and NEPHAK—provides an existing foundation for structured advocacy and accountability.

Finally, global funding opportunities through the Global Fund's Community Engagement (CE) Strategic Initiative and Pandemic Fund grants offer a chance to align community-led interventions with national and regional PPR priorities, ensuring that community engagement is institutionalized, sustainable, and adequately financed.

5. Stakeholder Mapping

Kenya's Pandemic Preparedness and Response (PPR) ecosystem is multi-sectoral, encompassing government ministries, county administrations, technical partners, civil society, academia, and community-based structures. This mapping provides an overview of the key institutions and actors engaged in PPR and community engagement (CE), their respective roles, and coordination linkages.

Category	Institutions / Actors	Roles in PPR and Community Engagement
National Government	Ministry of Health (DMS, DPH, DVS, ZDU), National Public Health Institute (NPHI) Secretariat	Provides national leadership, develops policy and coordination frameworks, ensures IHR (2005) compliance, oversees surveillance, and leads multi-sectoral emergency response.
	Directorate of Health Security and Emergencies (DHSE)	Leads preparedness and response planning, oversees risk assessment, and coordinates outbreak management.
	Division of Disease Surveillance and Response (DDSR)	Manages Integrated Disease Surveillance and Response (IDSR), verifies community alerts, and coordinates Rapid Response Teams (RRTs).
	Zoonotic Disease Unit (ZDU) – Joint MoH & Ministry of Agriculture	Coordinates One Health collaboration, joint zoonotic surveillance, and inter-sectoral outbreak investigations.
County Governments	County Health Departments, County Disease Surveillance Units, County Emergency Operations Centres (EOCs)	Manage sub-national preparedness, lead surveillance, and coordinate community-based response mechanisms.
	Sub-County Health Management Teams (SCHMTs)	Supervise Community Health Units (CHUs), guide CHPs, and coordinate reporting to national systems.
Community Structures	Community Health Promoters (CHPs), Community Health Committees (CHCs)	Serve as frontline agents in health promotion, surveillance, household disease detection, and community feedback.
	Faith-Based Organizations (FBOs), Youth Networks, CBOs	Mobilize communities for awareness, advocacy, and behavioral change during public health emergencies.
Civil Society and Networks	Stop TB Partnership Kenya, HENNET, NEPHAK, AMREF Health Africa, Kenya Red Cross	Conduct community-led monitoring (CLM), advocacy, capacity building, and accountability for equitable service delivery.
	Other networks (e.g., Women Fighting AIDS in Kenya, LVCT Health, KANCO)	Promote inclusion of marginalized populations, strengthen gender-responsive and key population-led engagement.

Development and Technical Partners	World Health Organization (WHO), CDC Kenya, USAID, FAO, Africa CDC, World Bank, Global Fund	Provide technical assistance, capacity building, policy guidance, and funding for health security, surveillance, and community systems strengthening.
	EANNASO / Anglophone Africa Learning Hub	Regional coordination, peer learning, and dissemination of good practices in community engagement for PPR.
Academic and Research Institutions	Kenya Medical Research Institute (KEMRI), University of Nairobi, Moi University, JKUAT, Technical University of Kenya	Conduct operational research, build workforce capacity, support laboratory analysis and innovation for health security.
Private Sector	Pharmaceutical companies, MEDS, transport and logistics providers, Safaricom, Airtel	Ensure continuity of supply chains, logistics support, and digital innovations for surveillance and risk communication.
Multisectoral Mechanisms	One Health Platforms (National and County levels)	Facilitate cross-sectoral coordination among human, animal, and environmental health actors; strengthen joint surveillance and response.
Community Networks	Community Health Units (CHUs), Peer Networks, Indigenous and Women's Groups	Engage in risk communication, advocacy, early detection, and feedback mechanisms linking grassroots voices to policy processes.

6. Gap Analysis

Kenya has made significant progress in establishing a pandemic preparedness and response (PPR) framework aligned with international standards. However, several structural, institutional, and operational gaps continue to constrain the effective integration of communities into national and sub-national health security systems.
This gap analysis identifies weaknesses across key thematic areas — governance and coordination, capacity and resources, information flow, policy and institutionalization, and One Health inclusion — and examines their implications for resilience and sustainability of community engagement in PPR.

6.1. Governance and Coordination

Despite Kenya's robust PPR architecture, community engagement remains weakly institutionalized within governance and coordination mechanisms. The IHR Inter-Ministerial Coordination Committee (IMCC) and National Public Health Emergency Operations Centre (EOC) largely comprise government and development partners, with minimal representation from civil society or community networks.

At the county level, County EOCs exist in 20 counties, but their operations are predominantly technocratic, lacking formal community representation or mechanisms for integrating community priorities into preparedness planning. The County Health Management Teams (CHMTs) engage CHPs and CBOs primarily as implementers rather than governance actors, limiting their role in policy feedback or decision-making.

Key drivers of this gap include absence of community representation guidelines in PPR governance frameworks, lack of structured engagement platforms linking grassroots actors to national decision-making bodies, and insufficient budgetary provision for participatory governance. This results in limited accountability, weak bottom-up feedback, and low ownership of preparedness interventions at the community level.

6.2. Capacity and Resources

Although community health systems are central to Kenya's health security response, resource constraints significantly affect their functionality and sustainability. The **Community Health Promoters (CHPs)** operate largely as volunteers, with limited or inconsistent stipends across counties. Financing for community surveillance, risk communication, and emergency response depends heavily on donor projects and humanitarian funding, creating a cycle of short-term engagement.

Civil society organizations and community-based organizations (CBOs) working on health security — including Stop TB Partnership Kenya, NEPHAK, and faith-based networks — face similar challenges. Their participation in surveillance or advocacy activities is often limited to project-funded periods, reducing continuity in engagement.

Moreover, capacity gaps exist in data literacy, surveillance reporting, and familiarity with PPR frameworks such as the JEE, SPAR, and NAPHS. Without dedicated training programs and sustained financial support, community actors cannot meaningfully contribute to national health security objectives.

The implication is a dependency on external funding, limited institutional memory, and vulnerability to disengagement once donor support phases out.

6.3. Information Flow and Feedback Mechanisms

Kenya's surveillance system integrates data from community sources through the Integrated Disease Surveillance and Response (IDSR) platform and the Electronic Community Health Information System (eCHIS). However, weak vertical and horizontal linkages impede timely flow of information between communities, counties, and national structures.

Community-based alerts often experience delays in verification due to limited human resources at sub-county levels. Furthermore, communities seldom receive feedback once alerts are submitted, undermining trust in the reporting process. The Kenya JEE (2024) noted that while community-based surveillance (CBS) and event-based surveillance (EBS) systems are operational nationwide, only a fraction function optimally due to inadequate supervision, lack of digital tools, and weak inter-sectoral data integration.

This results in delays in outbreak detection, fragmented response, and loss of local accountability. Strengthening two-way feedback loops, digital reporting tools, and cross-sector data sharing mechanisms remains critical to building confidence and responsiveness within communities.

6.4. Policy and Institutionalization

Kenya lacks a formalized policy or legal framework that clearly defines the role of communities and civil society in PPR beyond the health sector. While the Community Health Policy (2020–2030) and Community Health Strategy (2020–2025) outline community roles in disease surveillance and promotion, these are not explicitly linked to broader emergency management structures such as the NPHI or the National Disaster Management Authority (NDMA).

There is no dedicated national community engagement framework for health security, resulting in fragmented and ad hoc participation. In practice, most engagement is event-driven — during outbreaks or emergencies — rather than institutionalized as part of continuous preparedness planning.

Furthermore, coordination between government, development partners, and community actors is not standardized; different sectors and donors apply varying engagement models and tools, leading to duplication and inconsistent outcomes.

This absence of clear institutional pathways leads to fragmented engagement, policy incoherence, and weak sustainability of community contributions to PPR processes.

6.5. One Health and Multi-sectoral Inclusion

Kenya has made significant progress in operationalizing the One Health approach through the Zoonotic Disease Unit (ZDU) and County One Health Units (COHUs). However, community participation in One Health governance remains limited. Most community-level engagement focuses on awareness creation and outbreak response rather than structured inclusion in planning or surveillance.

The ZDU's multisectoral coordination meetings often exclude community-based organizations or indigenous knowledge networks, despite their critical role in zoonotic disease control and environmental monitoring. The Kenya NAPHS identifies this as a priority gap, emphasizing the need to institutionalize community participation in One Health committees and expand COHUs to sub-county level.

Without structured inclusion, Kenya risks missing opportunities to harness community knowledge for early detection, cross-sectoral collaboration, and sustainability of PPR interventions.

6.6. Summary of Identified Gaps

Thematic Area	Key Gaps Identified	Implications
Governance & Coordination	Communities not represented in national and county PPR governance structures such as IMCC, NPHI Steering Committees, and County EOCs.	Weak accountability, limited community ownership, and top-down decision-making in preparedness planning.
Capacity & Resources	Inconsistent funding for CHPs and CBOs; limited training on surveillance, data systems, and PPR frameworks.	Dependency on donor funding; uneven implementation across counties; reduced sustainability of engagement.
Information Flow & Feedback	Weak data linkage between eCHIS, IDSR, and national PPR dashboards; limited feedback to communities after alerts.	Delays in outbreak verification, reduced trust, and inefficient response coordination.
Policy & Institutionalization	No formal national framework defining community roles in PPR across sectors; fragmented coordination between health and non-health actors.	Disjointed engagement, duplication of effort, and poor integration into broader disaster risk management.
One Health Inclusion	Community representation not institutionalized in ZDU or COHU coordination; limited awareness of One Health principles among local actors.	Missed opportunities for multisectoral collaboration and local leadership in zoonotic disease prevention.
Sustainability and Ownership	Engagement remains project-based and reactive; absence of budget lines for community participation in PPR.	Inconsistent continuity of engagement, weak institutional memory, and limited resilience in future outbreaks.

7. Overview of Decision-Making Fora

Kenya's pandemic preparedness and response (PPR) governance is layered across national and county levels, with newly established NPHI structures anchoring coordination and Public Health Emergency Operations Centres (PHEOCs) providing the incident management backbone. While formal decision-making largely sits with government bodies, multiple platforms interface with counties, partners, and—more intermittently—community and civil society actors.

7.1. National Level

a. IHR Inter-Ministerial Coordination Committee (IHR-IMCC)

The IMCC provides high-level, multi-sector policy direction for IHR (2005) implementation, aligning human, animal, and environmental sectors. It sets national priorities, clears major response policies, and guides cross-government action during public health events. Community participation is typically indirect—channeled through civil society seats in technical forums rather than as standing members of the IMCC itself. (Inference based on Kenya's IHR architecture and MoH communications on cross-sector JEE follow-up.)

b. Kenya National Public Health Institute (NPHI)

Established in 2022, the NPHI consolidates fragmented public health functions and now serves as the central coordination hub for preparedness, surveillance, and emergency response. Within NPHI, the Directorate of Public Health Emergency Preparedness & Response develops and reviews policies, guidelines, and frameworks; establishes and oversees PHEOCs and emergency referral systems; manages strategic emergency health commodities; leads risk communication and community engagement; and coordinates field support and post-emergency recovery. This Directorate is organized into divisions (Public Health Preparedness, Emergency Response, Disaster & Risk Management, and National Strategic Stockpiles & Product Safety).

c. National (Public Health) Emergency Operations Centre (EOC/PHEOC)

The national PHEOC applies incident management system (IMS) principles to coordinate multi-hazard responses, aggregate situation awareness, and task operational pillars (surveillance, case management, logistics, RCCE, etc.). It serves as the primary conduit between technical programs, counties, and partners, while maintaining links to strategic stockpiles and specimen referral systems to accelerate surge operations. Direct, routine integration of community-generated data and representation remains limited and is an area flagged for strengthening.

d. Zoonotic Disease Unit (ZDU) and One Health Coordination

The ZDU (a joint platform of MoH and the agriculture/livestock portfolio) leads multi-sectoral zoonotic surveillance, prioritization, and joint outbreak investigation. It convenes technical forums that feed into national decision-making, with county linkages through emerging County One Health Units (COHUs). Community representation within these coordination spaces is not yet institutionalized, despite the value of local knowledge for early signals of zoonotic threats. (Synthesis from NPHI and national health security materials.)

e. National Risk Communication and Community Engagement (RCCE) Functions

NPHI's preparedness/response directorate explicitly includes risk communication and community engagement in its remit—standardizing guidance, coordinating national messaging, and supporting rumor management and feedback. This creates a formal "home" for RCCE at national level and an avenue to institutionalize community input loops across preparedness and response cycles.

f. National Learning and Coordination Platforms

Kenya participates in structured learning exchanges that connect national and county authorities to share operational lessons (e.g., five national sessions convened by JLN Kenya during COVID-19), helping to translate national guidance into county action and surface local feedback for policy refinement.

7.2. Sub-National (County) Level

a) County Emergency Operations Centres (County EOCs/PHEOCs)

Several counties operate EOCs that mirror national IMS structures, coordinate county-level response pillars, and escalate information to the national PHEOC. They interface with County Health Management Teams (CHMTs), Sub-County Health Management Teams (SCHMTs), and program leads (surveillance, case management, logistics) to manage local events and resource deployment. While counties routinely engage Community Health Units (CHUs) operationally, formalized community seats within County EOCs are uncommon, limiting structured community influence on preparedness planning. (Synthesis informed by NPHI role descriptions and Kenya's devolved response set-up.)

b) Technical and Advisory Groups

Counties convene technical groups (e.g., surveillance and laboratory TWGs, RCCE sub-groups) that provide advice to CHMTs and County EOCs. These fora are critical for turning national guidance into local SOPs and mobilizing partners. Civil society is sometimes invited ad hoc, but standing participation and feedback mechanisms vary across counties. (Derived from national coordination narratives and JLN documentation on county-national collaboration).

c) County One Health Units (COHUs)

COHUs provide a platform for joint human-animal-environmental assessments and action (e.g., for anthrax, RVF). Their maturation—and the inclusion of community actors—remains uneven, but they are the logical county-level venue to institutionalize community surveillance inputs (e.g., animal die-off reports) and indigenous knowledge for early warning. (One Health roles inferred from ZDU coordination mandate.).

7.3. Interfaces, Data Flows, and Escalation

Decision-making is supported by a multi-tier information flow: CHUs/CHPs and community reporters feed signals (IBS/EBS) to sub-county surveillance, which verifies and escalates to County EOCs and the national PHEOC. Strategic stockpile management, specimen referral, and workforce surge are triggered through NPHI divisions. The NPHI's focus on building and coordinating PHEOCs, strategic stockpiles, and referral systems is intended to shorten the "signal-to-action" timeline; strengthening structured community feedback loops into this chain is a priority.

7.4. Community Entry Points into Decision-Making

Although communities have long contributed to surveillance and RCCE, formal seats in decision-making fora remain limited. The NPHI mandate now explicitly references leading RCCE and supporting counties during crises—creating an institutional window to embed civil society and community representatives in RCCE groups, County EOCs, and COHUs, and to standardize mechanisms for two-way feedback and participatory message design. Lessons from Kenya's COVID-19 learning exchanges—where national and county teams co-problem-solved operational issues—illustrate how structured platforms can bring local experience into policy and operational decisions.

7.5. Recent Momentum and Next Steps

Since the 2024 JEE, the Ministry of Health and NPHI have emphasized operationalizing NPHI and closing coordination gaps identified during the evaluation, with partners committing technical and financial support to strengthen PPR governance. Ongoing efforts to develop NAPHS II (2025–2029) through multi-stakeholder processes further signal an opportunity to codify community participation within national and county decision-making architectures.

8. Progress and Best Practices

Kenya has demonstrated steady and measurable progress in strengthening its Pandemic Preparedness and Response (PPR) architecture, anchored in the International Health Regulations (IHR, 2005) and the One Health framework. The following thematic areas capture key achievements and emerging best practices:

8.1. Strengthened Governance and Coordination Mechanisms

The establishment of the National Public Health Institute (NPHI) and operationalization of 20 county-level Emergency Operations Centres (EOCs) has enhanced multisectoral coordination and decentralized response capacity, covering over 50% of the national population

The National Emergency Response Framework and approved National Health Emergency Response Operations Plan (NHEROP) provide structured guidance for incident management, resource mobilization, and coordination across the Ministry of Health, county governments, and partners

8.2. Surveillance, Laboratory, and Information Systems

Kenya has established comprehensive surveillance systems integrating community, facility, and national levels. The Integrated Disease Surveillance and Response (IDSR) and Event-Based Surveillance (EBS) mechanisms operate across all 47 counties.
The expansion of genomic sequencing capacity in four reference laboratories and molecular diagnostic capacity in seven regional labs has significantly improved early pathogen detection. Moreover, six human health and three animal health laboratories have achieved international accreditation, demonstrating a functional cross-sectoral laboratory network

8.3. Workforce Development and Field Epidemiology

Kenya has achieved the WHO benchmark of one trained field epidemiologist per 200,000 population, bolstered by the Field Epidemiology and Laboratory Training Program (FELTP) and the Joint Master's Degree in Infectious Disease and Global Health offered by the University of Nairobi and Moi University. These programs have produced a multidisciplinary workforce capable of managing complex outbreaks and conducting rapid response deployments

8.4. Advancements in One Health Implementation

The Zoonotic Disease Unit (ZDU), jointly managed by the Ministry of Health and the Ministry of Agriculture, has strengthened human-animal interface coordination. Kenya's ZDU has guided development of contingency plans for zoonotic diseases such as Rift Valley Fever, anthrax, and rabies, while supporting the operationalization of County One Health Units (COHUs)

This integrated approach has enhanced joint surveillance, risk mapping, and research across human, animal, and environmental sectors.

8.5. Community Engagement and Civil Society Participation

Active engagement by civil society and community networks — notably HENNET, NEPHAK, and Stop TB Partnership Kenya — has advanced community-led surveillance, accountability, and advocacy for pandemic preparedness and primary health care (PHC).

These networks have contributed to the Community-Led Monitoring (CLM) model and the COPPER Global Fund Community Engagement Project, illustrating how community data can inform national health security decision-making and improve response equity.

8.6. Partnerships and Regional Collaboration

Kenya continues to benefit from partnerships under the Global Health Security Agenda (GHSA) and Africa CDC's Regional Collaborating Centres (RCC). These alliances have supported multisectoral simulation exercises, antimicrobial resistance (AMR) stewardship, and biosafety training initiatives.

International collaborations with WHO, CDC, USAID, and FAO have provided critical technical and financial support for strengthening preparedness, while joint exercises with security agencies have enhanced cross-sectoral emergency response readiness

In summary, Kenya's progress reflects a maturing health security ecosystem characterized by decentralized coordination, multisectoral collaboration, and growing community involvement. The challenge ahead lies in institutionalizing these gains through sustainable financing, robust data-sharing systems, and formal mechanisms for community inclusion in PPR governance and oversight.

9. Recommendations

To enhance the effectiveness, inclusivity, and sustainability of Kenya's Pandemic Preparedness and Response (PPR) architecture, this situational analysis proposes a set of strategic, actionable recommendations that prioritize institutionalization, financing, capacity building, coordination, and accountability for community engagement.

9.1. Institutionalize Community Participation

- Establish formal mechanisms for community representation within national and county PPR governance structures, including the Inter-Ministerial Coordination Committee (IMCC), the National Public Health Institute (NPHI) stakeholder forums, and County Emergency Operations Centres (EOCs).

- Integrate Community-Based Organizations (CBOs), Faith-Based Organizations (FBOs), Community Health Committees (CHCs), and civil society networks into national and sub-national decision-making frameworks, ensuring they have defined roles, representation criteria, and feedback responsibilities.
- Review the IHR coordination framework to include structured participation of community representatives as observers or advisory members, enhancing bottom-up accountability in pandemic planning and response.

This institutionalization will ensure that community actors are recognized as legitimate partners and contributors to PPR decision-making, not just implementers.

9.2. Invest in Community Health Systems

- Secure dedicated and predictable financing for community health workers (CHPs), surveillance networks, and local emergency preparedness structures through the Universal Health Coverage (UHC) financing framework and county health budgets.
- Advocate for inclusion of community surveillance and response activities within the national and county Medium-Term Expenditure Frameworks (MTEFs) to guarantee sustainability.
- Mobilize pooled donor support to strengthen community-level outbreak detection, logistics, and emergency response, while aligning funding to Kenya's national PPR priorities.

Sustained investment will empower communities to play continuous roles in preparedness, rather than episodic participation during outbreaks.

9.3. Strengthen Feedback Loops and Information Systems

- Establish two-way communication and data feedback mechanisms between Community Health Units (CHUs), County Disease Surveillance Coordinators, and the National PHEOC through digital platforms such as the Electronic Community Health Information System (eCHIS) and mDharura.
- Develop standardized feedback protocols so that alerts raised by CHPs and CBOs receive timely verification and response communication from county and national surveillance units.
- Integrate community-generated data into the Integrated Disease Surveillance and Response (IDSR) system and ensure that outputs are accessible to community structures for transparency and learning.

Strengthening these data linkages will increase trust, accelerate response actions, and enhance the quality of surveillance intelligence.

9.4. Integrate One Health at the Community Level

- Establish and operationalize County One Health Committees (COHUs) with representation from community actors across the human, animal, and environmental sectors.
- Facilitate community-level joint risk mapping and outbreak simulations to strengthen multi-sectoral preparedness, including livestock farmers, local environmental groups, and indigenous knowledge networks.
- Develop and disseminate community-friendly One Health education materials to enhance public understanding of zoonotic and environmental health risks.

Embedding One Health at the community level will strengthen surveillance and response to zoonotic threats, enabling early detection and coordinated mitigation across sectors.

9.5. Capacity Building and Training

- Develop a national training curriculum on PPR and One Health tailored for Community Health Promoters (CHPs), local leaders, CBOs, and CSOs, aligned with the State Party Annual Reporting (SPAR) and Joint External Evaluation (JEE) tools.
- Institutionalize continuous professional development (CPD) programs for CHPs and community leaders on surveillance, outbreak response, and emergency communication.
- Engage academic and research institutions such as KEMRI, University of Nairobi, and Moi University in co-designing training modules and evaluating capacity outcomes.

A structured training framework will build a critical mass of skilled community actors able to participate meaningfully in preparedness, surveillance, and response governance.

9.6. Enhance Risk Communication and Community Engagement (RCCE)

- Shift from traditional, top-down Information, Education, and Communication (IEC) campaigns to participatory co-creation of messages with communities, ensuring they are culturally sensitive, gender-responsive, and contextually appropriate.
- Strengthen RCCE coordination units within the NPHI and counties to include CSOs, media, and youth networks in message development and rumor management.
- Integrate social listening and community feedback mechanisms into national and county RCCE plans to inform adaptive communication during health emergencies.

By embedding communities in the design and delivery of communication strategies, Kenya can foster public trust, counter misinformation, and improve adherence to public health measures.

9.7. Monitor, Evaluate, and Learn from Community Engagement

- Incorporate community engagement indicators into the NAPHS monitoring and evaluation framework, including metrics on participation, feedback, representation, and impact.
- Conduct annual community engagement performance reviews involving government, partners, and community representatives to assess progress and share lessons.
- Utilize platforms such as the Anglophone Africa Learning Hub and EANNASO to facilitate cross-country learning on community engagement models and outcomes.

Monitoring and learning will enable Kenya to track the effectiveness of engagement mechanisms, identify bottlenecks, and continually refine strategies for inclusivity and accountability.

9.8. Promote Sustainable Partnerships and Resource Mobilization

- Leverage the Global Fund Community Engagement Strategic Initiative, Pandemic Fund, and Africa CDC initiatives to expand investment in community-driven preparedness.
- Foster public-private partnerships (PPPs) with technology firms, logistics providers, and media networks to support digital surveillance tools, emergency supply chains, and communication infrastructure.
- Advocate for the inclusion of community engagement financing in all future national health security strategies and donor compacts.

Sustained partnerships and resource mobilization will ensure long-term resilience and autonomy of Kenya's community systems in health security governance.

Summary

In essence, Kenya's PPR system will only reach full maturity when communities are recognized not merely as beneficiaries but as co-creators and custodians of health security. Institutionalizing their participation, investing in their systems, and embedding their voices across One Health and PPR platforms will foster a truly inclusive, equitable, and sustainable model of pandemic preparedness and response.

10. Conclusion

Kenya has made significant strides in strengthening its Pandemic Preparedness and Response (PPR) architecture through deliberate policy reforms, strategic investments, and strong partnerships at national, regional, and global levels. The establishment of the National Public Health Institute (NPHI), operationalization of 20 county Emergency Operations Centres (EOCs), and expansion of genomic sequencing and surveillance systems reflect Kenya's commitment to

fulfilling the International Health Regulations (IHR 2005) obligations and enhancing its national health security capacities.

These advancements have been further supported by sustained collaborations with development partners such as WHO, CDC, USAID, FAO, and Africa CDC, as well as regional mechanisms under the Global Health Security Agenda (GHSA) and Africa CDC Regional Collaborating Centres. Collectively, these efforts have improved national coordination, strengthened technical expertise, and enhanced multisectoral collaboration across human, animal, and environmental health sectors.

However, despite these commendable achievements, community engagement remains one of the weakest pillars of Kenya's PPR framework. While community structures — including Community Health Units (CHUs), Community Health Promoters (CHPs), and Community Health Committees (CHCs) — play a vital role in surveillance, health promotion, and outbreak response, their inclusion in higher-level governance and decision-making processes remains inconsistent and largely ad hoc. Community-led and civil society organizations often participate in response activities but are rarely involved in planning, policy formulation, or monitoring of preparedness actions.

The fragmented and project-based nature of community engagement, compounded by limited financing and unclear institutional mandates, undermines Kenya's ability to sustain a "whole-of-society" approach to health security. The lack of a national framework for structured community participation in PPR and One Health processes leads to duplication of efforts, gaps in coordination, and insufficient integration of community data into surveillance and response systems.

To achieve a resilient and people-centered health security system, Kenya must move beyond policy recognition to operational institutionalization of community engagement. This includes:

- Establishing formal mechanisms for community representation in PPR governance structures such as the NPHI, Inter-Ministerial Coordination Committee, and County EOCs.
- Developing and implementing national guidelines and standard operating procedures (SOPs) for community participation in PPR, aligned with the One Health approach.
- Investing in sustained financing and capacity building for community and civil society actors to enable consistent, meaningful engagement.
- Enhancing data integration and feedback loops between community health systems, county surveillance teams, and national PHEOCs.
- Institutionalizing accountability frameworks to ensure that community-generated evidence informs policy and resource allocation decisions.

Ultimately, Kenya's progress toward a resilient, equitable, and people-centered PPR system will depend on its ability to leverage community structures not only as implementers but as co-leaders and decision-makers in health security governance. Institutionalizing community engagement—through policy, practice, and financing—will ensure that preparedness and response efforts are grounded in local realities, inclusive of marginalized populations, and capable of sustaining national resilience in the face of future pandemics and health emergencies.