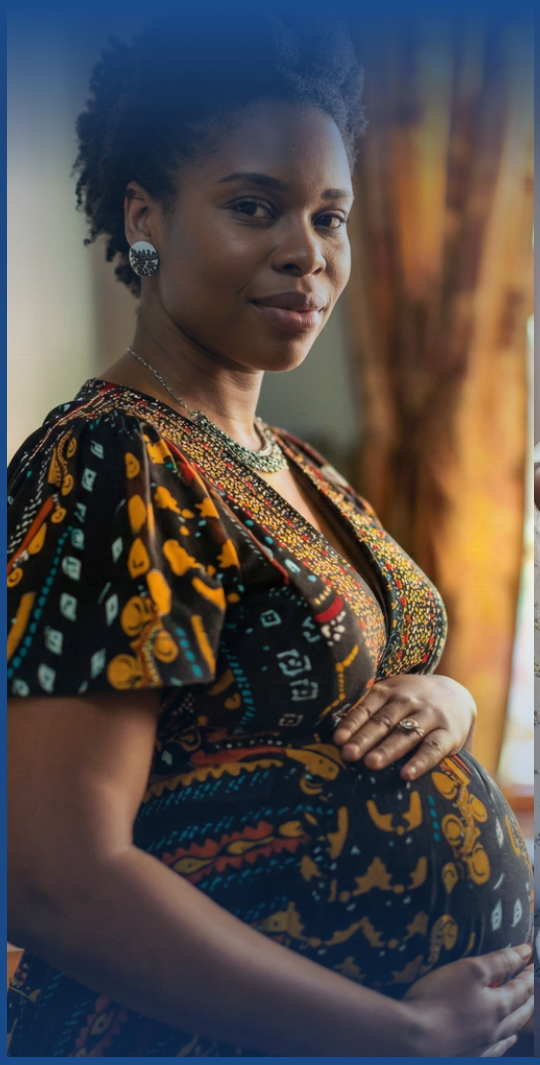
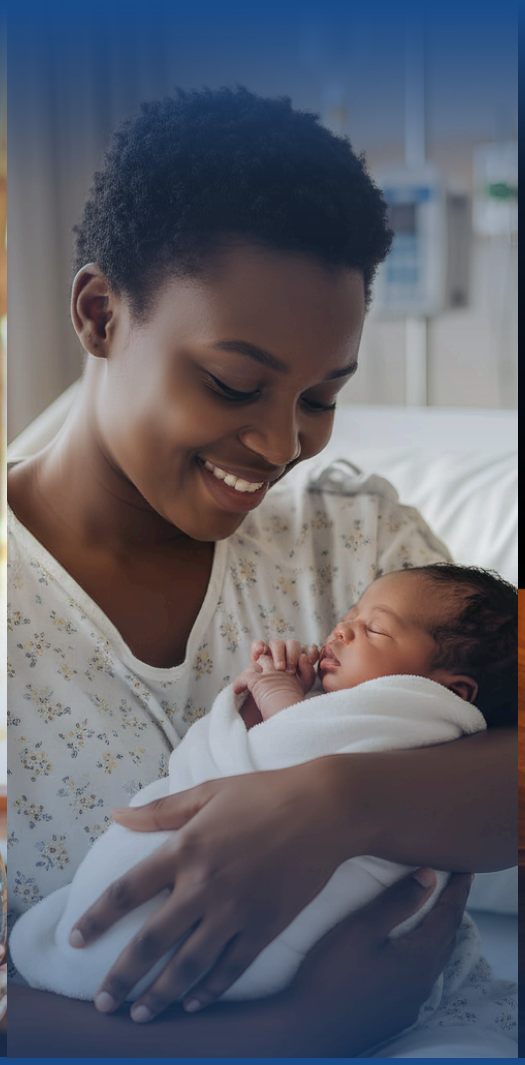
MINISTRY OF HEALTH

THE KENYA EVERY WOMAN EVERY NEWBORN EVERYWHERE (EWENE) ACCELERATION PLAN

2026 - 2028

Accelerating Reduction of Preventable Maternal and Newborn Deaths in Kenya







THE KENYA EVERY WOMAN EVERY NEWBORN EVERYWHERE (EWENE) ACCELERATION PLAN 2026-2028

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Developed by
The Division of Reproductive Maternal Newborn Child and Adolescent Health (DRMNCAH)

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ABBREVIATIONS

Abbreviation	Full Name
AI	Artificial Intelligence
ANC	Antenatal Care
AWP	Annual Work Plan
CBO	Community-Based Organization
CEMND	Confidential Enquiry into Maternal and Neonatal Deaths
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CHA	Community Health Assistant
CHP	Community Health Promoters
CHS	Community Health Strategy / Directorate
CHV	Community Health Volunteer
CIDP	County Integrated Development Plan
CPAP	Continuous Positive Airway Pressure
CSO	Civil Society Organisation
CQI	Continuous Quality Improvement
DHIS2	District Health Information System (version 2)
DQA	Data Quality Assessment
EMR	Electronic Medical Record
EmONC	Emergency Obstetric and Newborn Care
EPMM	Ending Preventable Maternal Mortality
EWENE	Every Woman Every Newborn Everywhere
FBO	Faith-Based Organization
FIF	Facility Improvement Fund
HDU	High Dependency Unit
HIS	Health Information System
HPT	Health Products and Technologies

HRH	Human Resources for Health
ICF	International Classification of Functioning, Disability and Health
ICT	Information and Communication Technology
IFA	Iron Folic Acid
KEML	Kenya Essential Medicines List
KEMSA	Kenya Medical Supplies Authority
KHFC	Kenya Health Facility Census
KHIS	Kenya Health Information System
KHP	Kenya Health Policy
KNBS	Kenya National Bureau of Statistics
KMC	Kangaroo Mother Care
LCG	Labour Care Guide
LMIS	Logistics Management Information System
MISP	Minimum Initial Service Package
MNH	Maternal and Newborn Health
MISP	Minimum Initial Service Package
MoH	Ministry of Health
MPDSR	Maternal and Perinatal Death Surveillance and Response
NICU	Neonatal Intensive Care Unit
NMR	Neonatal Mortality Rate
NGO	Non-Governmental Organization
ODEL	Open Distance and E-Learning
PCN	Primary Care Network
PFMA	Public Finance Management Act
PNC	Postnatal Care

PNC	Postnatal Care
PPH	Postpartum Haemorrhage
PPP	Public–Private Partnership
QA	Quality Assurance
QoC	Quality of Care
QI	Quality Improvement
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
RMNCAH+N	Reproductive, Maternal, Newborn, Child, Adolescent Health + Nutrition
SDG	Sustainable Development Goal
SHA	Social Health Authority
SHIF	Social Health Insurance Fund
SOP	Standard Operating Procedure
SSNB	Small and Sick newborns
TXA	Tranexamic Acid
TWG	Technical Working Group
UHC	Universal Health Coverage
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization

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FOREWORD



It gives me great pleasure to present the Kenya EWENE Acceleration Plan 2026–2028, a bold and focused roadmap to accelerate our national efforts in reducing preventable maternal and newborn deaths in Kenya.

Every mother and every newborn have the right to survive, thrive and transform. Yet, too many lives continue to be lost due to causes that are both preventable and treatable.

This Plan represents our renewed commitment to addressing these challenges head-on by scaling up proven, cost effective, high-impact interventions and strengthening the systems that deliver them. Anchored in Every Woman Every Newborn Everywhere (EWENE) framework and aligned with the Sustainable Development Goals, this Plan prioritizes high-impact interventions, strong partnerships, and enhanced accountability to ensure that all women and newborns in Kenya have equitable access to quality care.

Key priorities include:

- Strengthening resilient, responsive, and inclusive health systems.
- Ensuring the availability and equitable distribution of skilled birth attendants.
- Improving financial access to care through the Social Health Authority (SHA).
- Promoting respectful, dignified, and high-quality maternity and newborn care.
- Leveraging innovation in equipment, medicines, and service delivery; and
- Raising public awareness and increasing demand for essential services.

This is a national call to action. I urge all stakeholders, across government, the private sector, development partners, and communities to align efforts and resources with this plan. Let us work together to accelerate progress, foster accountability and champion innovations that put women and newborns at the center of our health and development agenda.

Every life counts.

Hon. Aden Duale,EGH
Cabinet Secretary Health

PREFACE

The Kenya EWENE Acceleration Plan 2026–2028 is anchored on strengthening the core building blocks of Kenya's health system to accelerate the reduction of preventable maternal and newborn deaths. Despite progress, challenges remain across service delivery, workforce capacity, data use, access to essential commodities, financing and governance.



This plan provides a structured framework to address these gaps while scaling up high-impact and evidence-based interventions. It emphasizes improving service delivery to ensure women and newborns receive timely, quality and respectful care. Investments in the health workforce will focus on training, deployment and retention of competent, motivated and skilled personnel at all levels. Strengthening health information systems will enhance the generation and use of quality data for planning, monitoring and accountability.

Reliableaccess to essentialmedicines, commodities, and technologies will be prioritized to address leading causes of maternal and newborn deaths.

Sustainable health financing will be advanced to reduce financial barriers to care, while strong leadership and governance will drive coordination, accountability, and partnerships at both national and county levels.

The Ministry of Health is committed to leading the implementation of this plan in close partnership with all stakeholders. Together, we can accelerate progress to ensure that every woman and every newborn in Kenya not only survives but thrives.

Dr. Ouma Oluga, OGW
Principal Secretary
State Department for Medical Services

ACKNOWLEDGEMENT

The Kenya EWENE Acceleration Plan 2026–2028 plan was developed through a consultative and participatory process that brought together representatives from National and County governments, development partners and health-care professionals, supporting Every Woman Every Newborn Everywhere (EWENE) commitments.

The process was spearheaded by a team from the Division of Reproductive Maternal Newborn Child and Adolescent Health (DRMNCAH) led by the head of division Dr. Serem Edward, Maternal Newborn Health section Lead, Dr. Jeanne Patrick, EWENE planning committee chairperson Dr. Julliet Omwoha and EWENE Advocacy and communication committee chair Mary Magubo.



The Ministry of Health wishes to acknowledge the invaluable contributions of all stakeholders who participated in the development of the Kenya EWENE Acceleration Plan 2025–2027.
We extend our appreciation to all the technical experts led byProf. Peter Gichangi and Ms. Mercylyn Mokeira, who provided the evidence base and guidance necessary to identify priority interventions.

We also appreciate the technical contributions from stakeholders drawn from Ushiriki Wema, AMREF Health Africa, Clinton Health Access Initiative, OMMI consortium, Council of Governors, CPHD, EPN, FERRING, Gates Foundation, Global Financing Facility, HENNET, International Centre For Reproductive Health Kenya, Jacaranda Health, Jhpiego, Kenya Medical Training College, Kenya Obstetrical and Gynaecological Society, Kenya Paediatric Association, Kenyatta University, Technical University of Mombasa, Living Goods, Lwala Community Alliance, MCGL, MEDS, Midwives Association of Kenya, MPESA Foundation, NEST 360, Nursing Council of Kenya, Options Consultancy Services Ltd, PATH, Shina Foundation, Touch a Life Foundation, UNFPA, UNICEF, University of Nairobi , Wanahabari, Women Engaged in Development and WHO.

We acknowledge with gratitude the Gates Foundation for their financial contribution, through Ushiriki Wema, towards the development of the Kenya EWENE Acceleration Plan 2026–2028.

Above all, we recognize the resilience of Kenyan women, newborns, and families, whose voices continue to inspire our efforts to ensure health, dignity, and equity for all.

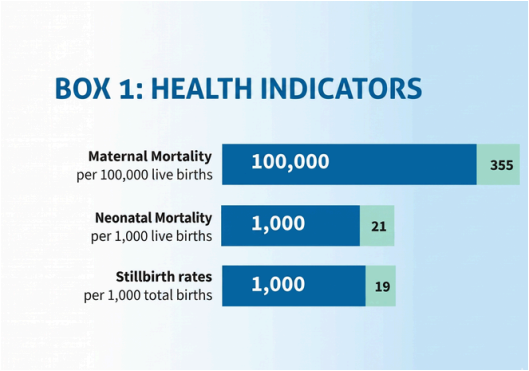
Dr. Patrick Amoth, EBS
Director General for Health

EXECUTIVE SUMMARY

The Kenya Every Woman Every Newborn Everywhere (EWENE) Acceleration Plan 2026–2028 is a targeted, high- impact roadmap designed to rapidly close the gaps in maternal, newborn, and stillbirth outcomes and deliver on national commitments under the Sustainable Development Goals (SDGs), the Kenya Health Policy (KHP), and the global EWENE platform.

Despite notable progress in-facility deliveries and skilled birth attendance, maternal mortality (355 per100,000), neonatal mortality (21 per1,000), and stillbirth rates (15 per1,000) remain stubbornly above national and global targets. These deaths are largely driven by postpartum hemorrhage (PPH), hypertensive disorders, prematurity, Intrapartum asphyxia, and sepsis-conditions that are largely preventable with timely, high-quality care.

This Acceleration Plan focuses on women and newborns who already reach health facilities, where the potential for rapid and measurable impact is greatest. It is grounded in WHO normative guidance, Kenya's EWENE scorecard priorities, and recent performance reviews, and identifies quick wins and catalytic reforms to close the most urgent gaps in quality, readiness, and equity of care.



It is organized around 10 pillars: Policy and Planning; Quality of Care, Gender & Equity, Data, Monitoring & Evaluation, Financing & Investment, Maternal Newborn Health Workforce, Response & Resilience, Commodities & Technologies, Accountability & Community Engagement, Research, Innovation and Knowledge Exchange. Each pillar defines county and national roles, ensuring coordinated, multi-level implementation. Enablers for success include strong political leadership, targeted investments in high-burden counties, integration of digital health solutions, gender- responsive programming, and sustained community engagement.

For the Acceleration Plan to succeed, Kenya will implement five game-changing delivery mechanisms designed to ensure speed, consistency, and accountability:

a) National EWENE Delivery Unit within the Ministry of Health
b) Ring-fenced last-mile fund for commodity security and infrastructure
c) Encourage and embed a readiness and drill culture for high-risk events
d) Promote PremPrep5 interventions for premature babies: administration of antenatal corticosteroids, administration of Mg SO4, delayed cord clamping, early initiation of breastfeeding and KMC as standard practice
e) Promote utilization of information from the live MNH scorecard to sustain political and community accountability.

Kenya has five years to meet its Sustainable Development Goals (SDGs) and Kenya Health Policy targets for maternal and newborn health. This Acceleration Plan serves as both a technical blueprint and a delivery contract, anchored in WHO guidance, EWENE scorecard priorities and Kenya's health policy framework. With political will, social accountability and disciplined execution, it can save thousands of mothers and newborns each year, securing a healthier future for the next generation.

1.INTRODUCTION

Background

Kenya has made steady progress in maternal and newborn health over the past two decades. Skilled birth attendance has increased to 89%, surpassing the global average of 84% (UNICEF, 2023). About 88% of births now occur in health facilities and almost all pregnant women (98%) receive at least one antenatal care visit (KNBS & ICF, 2023). Postnatal care coverage within 48 hours is also approaching global benchmarks, with 78% of mothers and 83% of newborns receiving early follow-up (KNBS & ICF, 2023). The rate of early initiation of breastfeeding has slightly declined from 62% to 60%, while exclusive breastfeeding rates have also dropped from 61% to 60%. Moreover, bottle feeding rates have increased from 22% to 34%, suggesting a shift toward artificial feeding. Although the coverage of Iron Folic Acid Supplement is 98%, only 35% of women adhered to the full recommended dose of iron and folic acid supplementation (IFAS) throughout pregnancy (Alemu et al 2025).

Box 2: Current progress

Indicator	Current Progress (Kenya)	Kenya Target
Maternal mortality	355/100,000	70/100,000
Stillbirths	15/1,000	≤12/1,000
Neonatal mortality	21/1,000	≤12/1,000
ANC: Four or more antenatal care	66%	90%
Births attended by skilled health personnel	89%	90%

Policy frameworks have reinforced these gains. The National Guidelines for Quality Obstetrics and Perinatal Care (2020), the Maternal and Newborn Health Standards for improving quality of care in health facilities, and the institutionalization of Maternal and Perinatal Death Surveillance and Response (MPDSR) demonstrate Kenya's leadership in aligning national systems with global evidence. Women's relatively high autonomy in health decision-making (86%) and the rollout of universal health coverage further strengthen the enabling environment.

Additionally, access to basic and comprehensive delivery of obstetrics and neonatal care and ambulance services is linked to robust community health promoters that link and refer women, newborn and dads from the community to the health facilities. These milestones position Kenya among the countries with strong foundations for achieving global maternal and newborn health targets.

Despite these advances, progress has not been fast enough to meet the Sustainable Development Goals (SDGs) and the Kenya Health Policy (KHP) objectives by 2030. The Sustainable Development Goal (SDG) target for maternal mortality is fewer than 70 per 100,000 live births, yet Kenya remains at 355—five times higher. The SDG neonatal mortality target is ≤12 per 1,000 live births; Kenya stands at 21. Similarly, stillbirths remain at 15 per 1,000, far above the global target of ≤12 (KNBS & ICF, 2023).

While access to services is improving, the rate of reduction in mortality lags behind what is required. UNICEF estimates that Kenya needs a fivefold acceleration in interventions to reach the neonatal target (UNICEF, 2023). This mismatch between progress achieved and progress required underscores the urgency for focused, catalytic action.

Kenya continues to experience a triple burden of malnutrition, characterized by persistent undernutrition and widespread micronutrient deficiencies, alongside a growing prevalence of overweight, obesity, and diet-related non-communicable diseases (NCDs). Approximately 7% of women of aged 15–49 years are undernourished, reflecting ongoing challenges in food security, dietary diversity, and access to essential nutrition services. At the same time, 45% of women are overweight, demonstrating the coexistence of both undernutrition and overweight within the same demographic groups.

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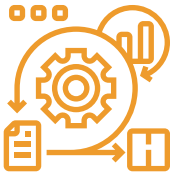
Target audience

The Acceleration Plan is intended for health leaders at national and county levels, including management teams, development partners, faith-based organizations, professional associations, training institutions, and regulatory bodies. It also applies to healthcare providers, policy makers, and frontline workers delivering maternal and newborn care.



Scope of the Acceleration Plan

Recognizing the complexity of maternal and newborn health, the Plan narrows its focus to women and newborns who access health facilities where quick wins are most achievable. It is designed for use by national and county governments, health providers, EWENE partners, and program managers to accelerate reductions in morbidity and mortality.



Development of the Acceleration Plan

The Plan was developed through a consultative, participatory process involving government, stakeholders, professional bodies, and partners. Key steps included: identifying priority questions, retrieving and synthesising evidence, formulating recommendations, and planning for dissemination, implementation, monitoring, evaluation, research, and learning. The development of this Plan was validated by EWENE stakeholders.



Rationale for the Acceleration Plan

Maternal, newborn, and stillbirth rates in Kenya have stagnated, leaving the country off-track to achieve SDG and Kenya Health Policy targets within the next five years.To rapidly achieve the SDGs and KHP goals, Kenya must employ focused, urgent, and coordinated course-correcting and catalytic actions, thus the need for this Acceleration Plan. With strong political leadership, adequate resources and accountability, the Acceleration Plan provides a pathway for transformative progress



Methods

The Acceleration Plan draws on the WHO handbook for guideline development (WHO, 2014) and the MOH's policies and procedures. In summary, the process included: (i) identification of the priority question and outcomes; (ii) retrieval of the evidence; (iii) assessment and synthesis of the evidence; (iv) formulation of the Acceleration Plan; and (v) planning for the dissemination, implementation, and impact evaluation.



Evidence Synthesis

Members of the Acceleration Plan Writing Group reviewed available publications and data to inform decisions. Publications from MOH and stakeholders were identified to inform the literature review. Given the existence of normative recommendations, MOH and WHO guidelines, and short lead time, it was considered sufficient to consult available literature rather than undertake a full systematic review

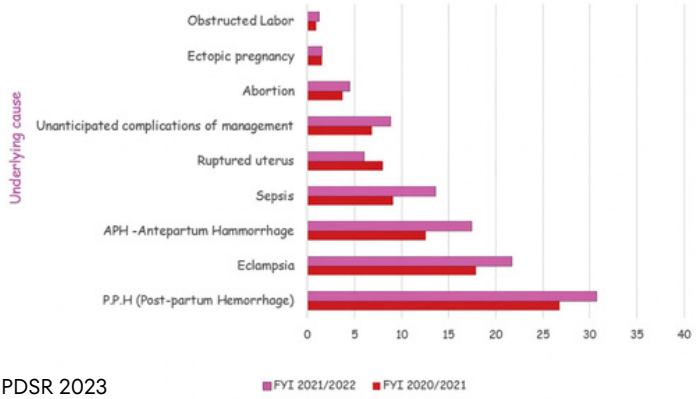
2. PROBLEM STATEMENT

This section highlights gaps in maternal, newborn health and nutrition indicators indicators as well as systemic factors using data from the Kenya Health Information System (KHIS), published reports, and relevant literature that contribute to poor outcomes. It also draws on global, regional, and national normative recommendations to inform the priorities of the Acceleration Plan.

2.1. MATERNAL HEALTH

Kenya's population based maternal mortality ratio remains high at 355 per 100,000 live births, far above the SDG target of fewer than 70 per 100,000. The leading direct causes are postpartum haemorrhage, hypertensive disorders, sepsis, and obstructed labor

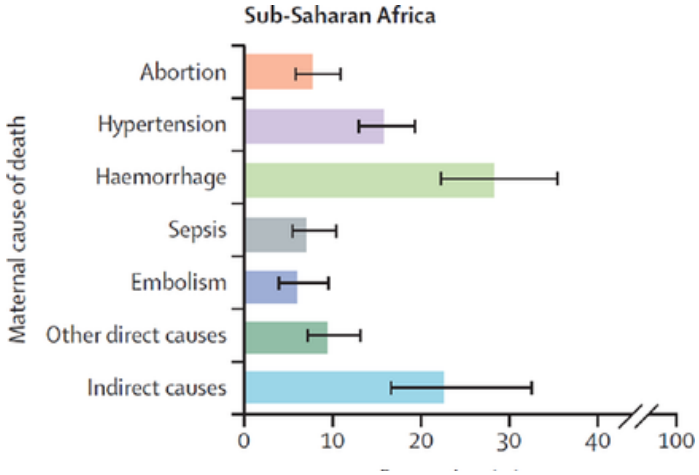
Figure 1. Direct causes of maternal mortality in Kenya, MPDSR 2023



Source: MoH, MPDSR 2023

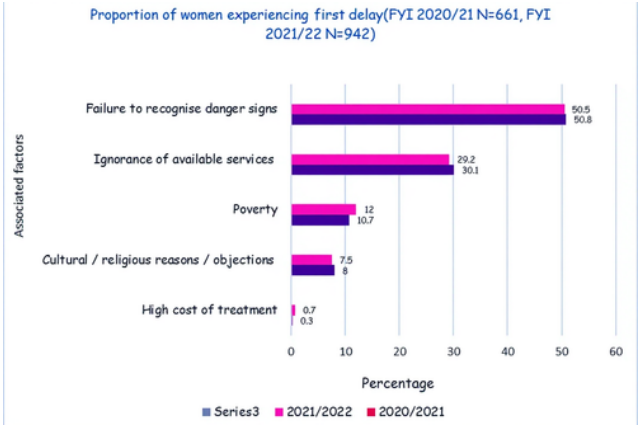
Figure 2. Causes of maternal mortality in Sub-Saharan Africa

Regional evidence confirms a similar pattern across Sub-Saharan Africa, where haemorrhage and hypertensive disorders dominate (Cresswell et al, 2025).



Source: Cresswell et al, 2025

Indirect causes of Maternal Death

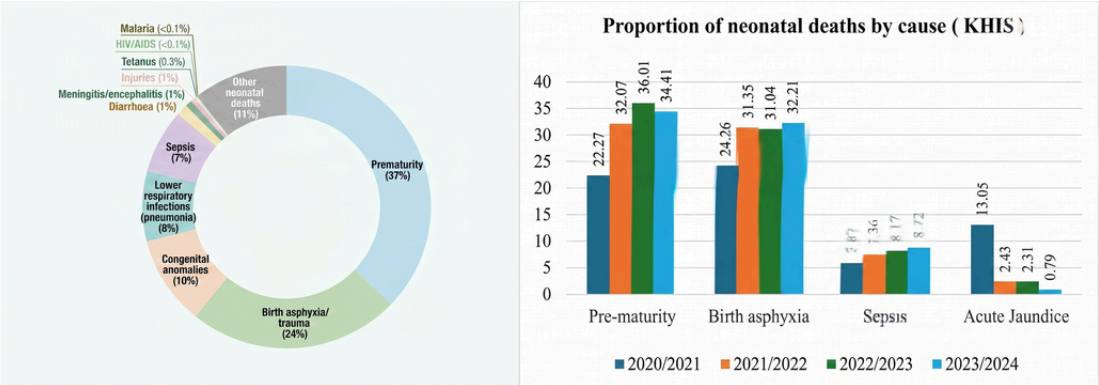


Anemia has consistently been the major indirect cause of maternal deaths in the two fiscal years under review at 58% and 60% respectively as shown in figure 17, followed by cardiovascular diseases at 19% in FY 2020/2021 and HIV/AIDS 19% in FY 2021/2022 while malaria is the least indirect cause of maternal deaths at 7 % in the two fiscal years.

2.2. NEWBORN HEALTH

The neonatal mortality rate (NMR) is21 per1,000 live births, almost double the SDG target of ≤12per 1,000 by 2030. Progress has stagnated over the past decade, with prematurity, intrapartum asphyxia, sepsis, and pathological jaundice as the leading causes. The comparative burden of neonatal causes in Kenya and globally is shown in Figure 3.

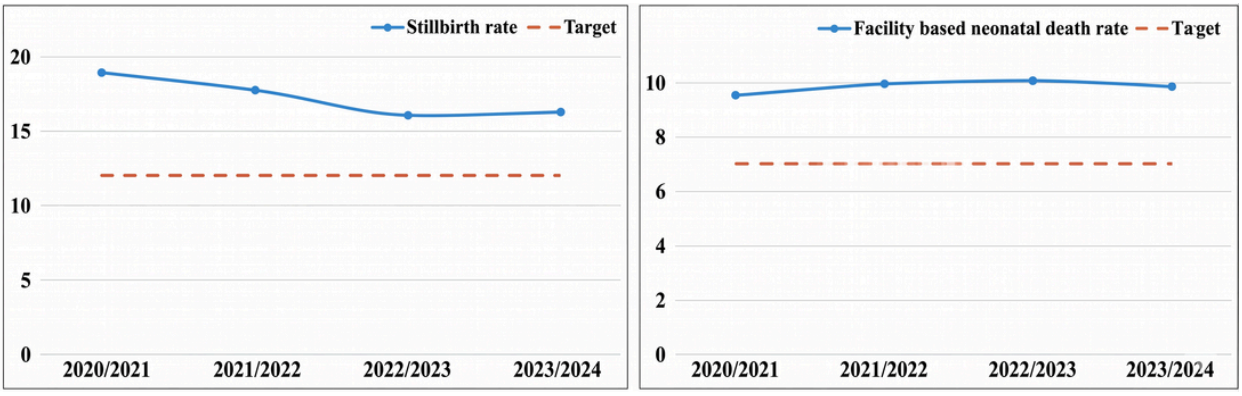
Figure 3. Leading causes of neonatal mortality: Kenya and global comparison



United Nations Inter-Agency Group for Child Mortality Estimation. Levels and Trends in Child Mortality: Report 2024. The World

Kenya also records approximately 30,400 stillbirths annually ((15 per 1,000 births). Of these, over 40% are intrapartum deaths, babies alive at labour onset but lost during delivery, reflecting deficiencies in intrapartum monitoring and timely emergency response. Trends in neonatal mortality and stillbirths against 2030 targets are shown in Figure 4, while the timing of perinatal deaths is summarised in Figure 5.

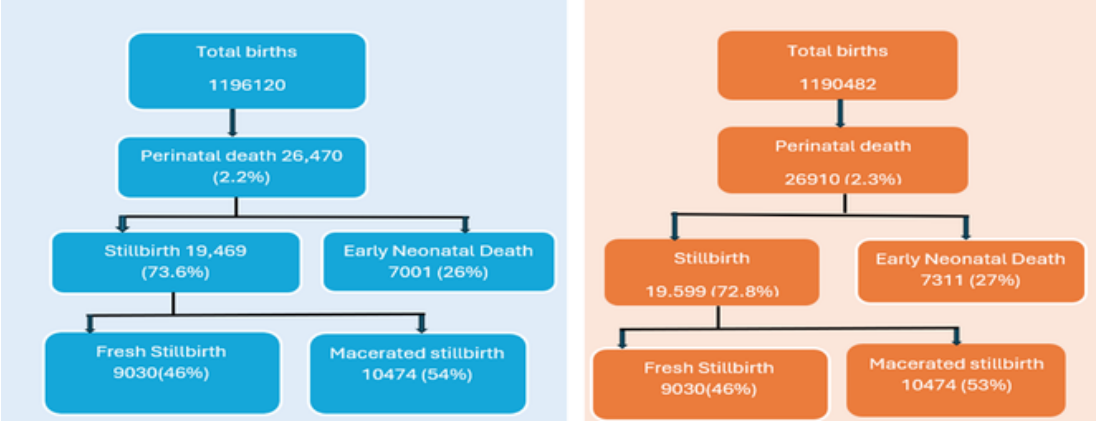
Figure 4. Facility based mortality and stillbirth rates versus 2030 target



Source : MOH KHIS

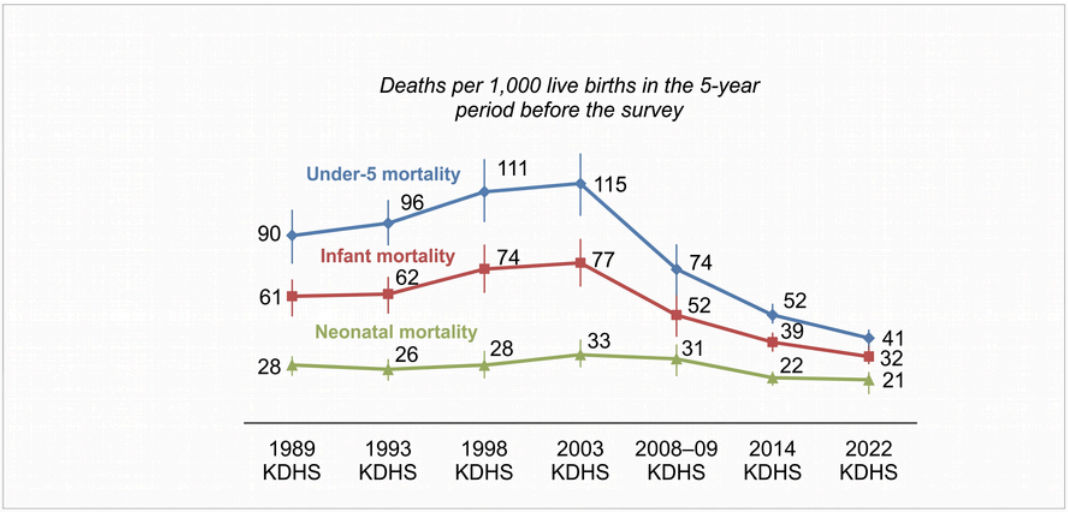
The stillbirth rate in Kenya is 19/1000 live births, which translates to approximately 30,400 stillbirths annually (an average of 83/day), contributing over 70% of the perinatal deaths (MOH KHIS 2022/2023 - 2023/2024). Nearly half (42%) of these babies were alive at the onset of delivery but succumbed during the process due to complications, Figure 5. Figure 6 shows declining early childhood mortality trends since 1989.

Figure 5. Timing of perinatal deaths in Kenya



Source: MOH KHIS 2022/2023- 2023/2024 report

Figure 6. Trends in early childhood mortality rates

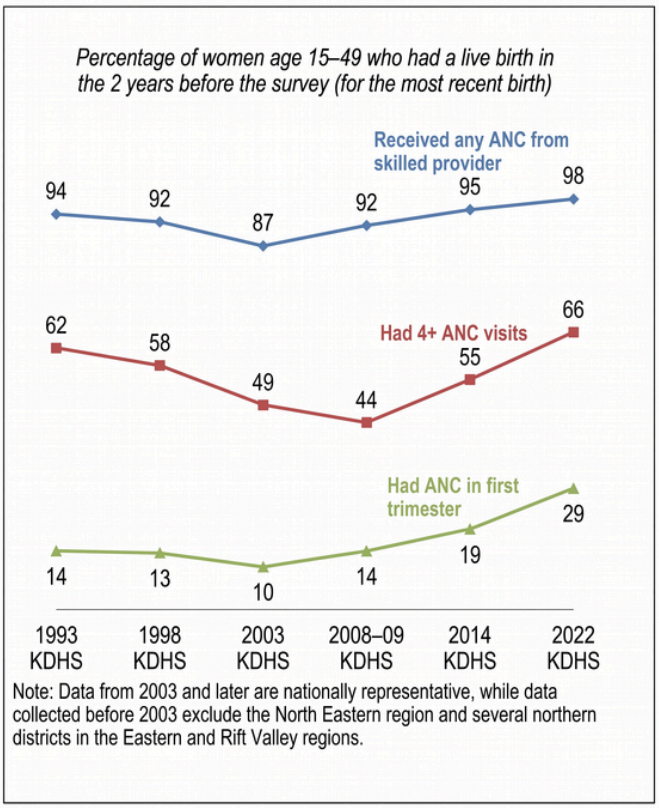


2.3. SERVICE COVERAGE AND UTILISATION

Antenatal care contacts

Almost all pregnant women (98%) receive at least one antenatal care (ANC) visit. However, only 66% achieve four visits and just 4% complete the recommended eight contacts. This indicates missed opportunities for high risk detection and timely intervention. Trends in ANC utilisation are shown in Figure 7.

Figure 7. Trends in ANC services utilisation

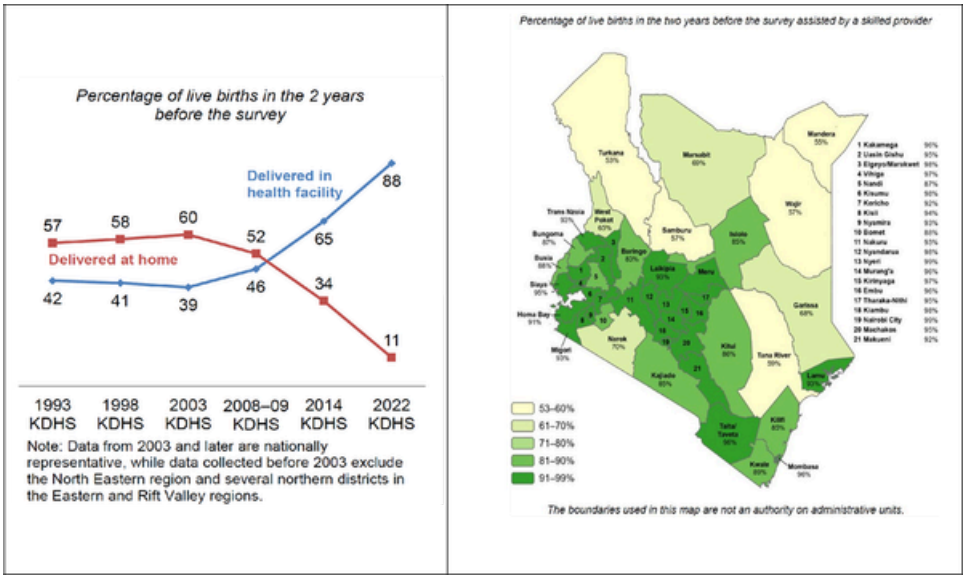


Place of birth

Coverage of skilled birth attendance is high, at 89% of deliveries, with 81% occurring in facilities. Although 89% of the mothers are delivered by a skilled birth attendance, only 62% are supported for early initiation of breastfeeding. Despite this, maternal and neonatal outcomes remain poor, demonstrating systemic gaps in facility readiness and quality. This is illustrated in Figure 8a. Figure 8 also shows the trends in skilled delivery and early initiation of breastfeeding in Kenya across KDHS survey years from 1989 to 2022. Skilled delivery has steadily increased over time, rising from about 52% in 1989 to 89% in 2022.

Early initiation of breastfeeding also improved, though more gradually, increasing from around 56% in 1989 to 60% in 2022, with notable dips in earlier years (1993 and 1998). The gap between skilled delivery and early initiation widened in recent years, indicating that improvements in health-facility births have not translated proportionally into immediate breastfeeding practices. Overall, the graph highlights progress in maternal health services but persistent challenges in newborn care practices.

Figure 8a. Trends in the place of birth



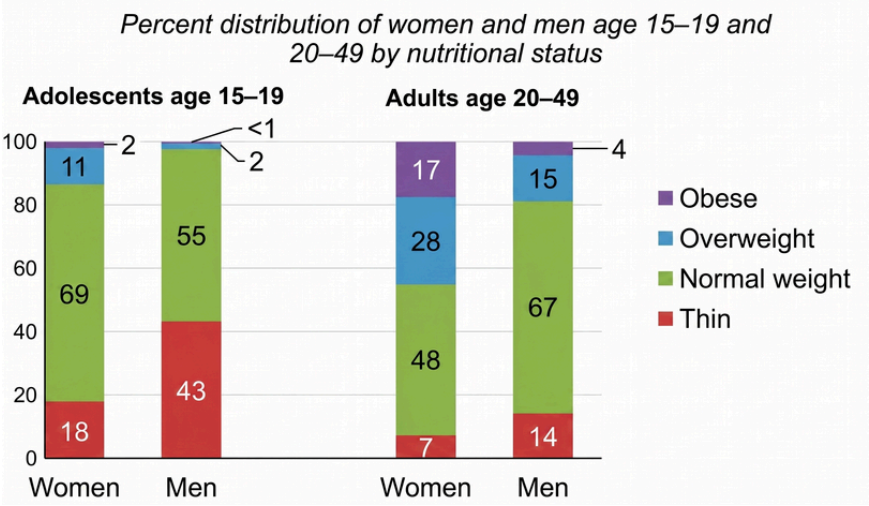
Source: KNBS and ICF 2023

Outcomes vary significantly across counties, with preventable maternal and newborn deaths continuing to occur even in facilities with skilled staff. Contributing factors include inadequate availability of life-saving commodities (e.g., uterotonic drugs), shortages of essential supplies and equipment (such as calibrated drapes to measure blood loss), and delays in timely referral during obstetric emergencies.

Beyond commodities and infrastructure, the quality of intrapartum care is also affected by adherence to recommended practices. For example, although national policy documents encourage midwives to support various birthing positions that promote safe and respectful care, most women continue to deliver in the lithotomy position. The limited uptake of evidence-based, woman-centred practices points to gaps in provider training, supervision, and accountability.

Micronutrient deficiencies remain a major public health concern in Kenya, with anaemia affecting 30% of women of reproductive age. Despite the high burden of anaemia, coverage of iron and folic acid (IFA) supplementation for at least 90 days remains low at 8%, indicating a significant gap in service delivery. This low uptake is inconsistent with the relatively higher ANC 1 and ANC 4 coverage, highlighting missed opportunities to provide essential micronutrient supplements during routine antenatal care. The rate of early initiation of breastfeeding has declined slightly from 62% to 60%, and exclusive breastfeeding has decreased from 61% to 60%. At the same time, bottle- feeding has risen sharply from 22% to 34%, indicating a growing shift toward artificial feeding practices. Iron and folic acid (IFA) supplementation uptake also remains low at 62%, despite the high ANC 1 coverage of 98%, reflecting significant missed opportunities within routine maternal care. The average national figures provide an overview of the situation, they mask significant counties disparities, with some counties facing far more severe levels of malnutrition, Figure 8b. These regional variations highlight the need for targeted, context-specific interventions to address the unique drivers of malnutrition and improve nutrition outcomes, figure 8b.

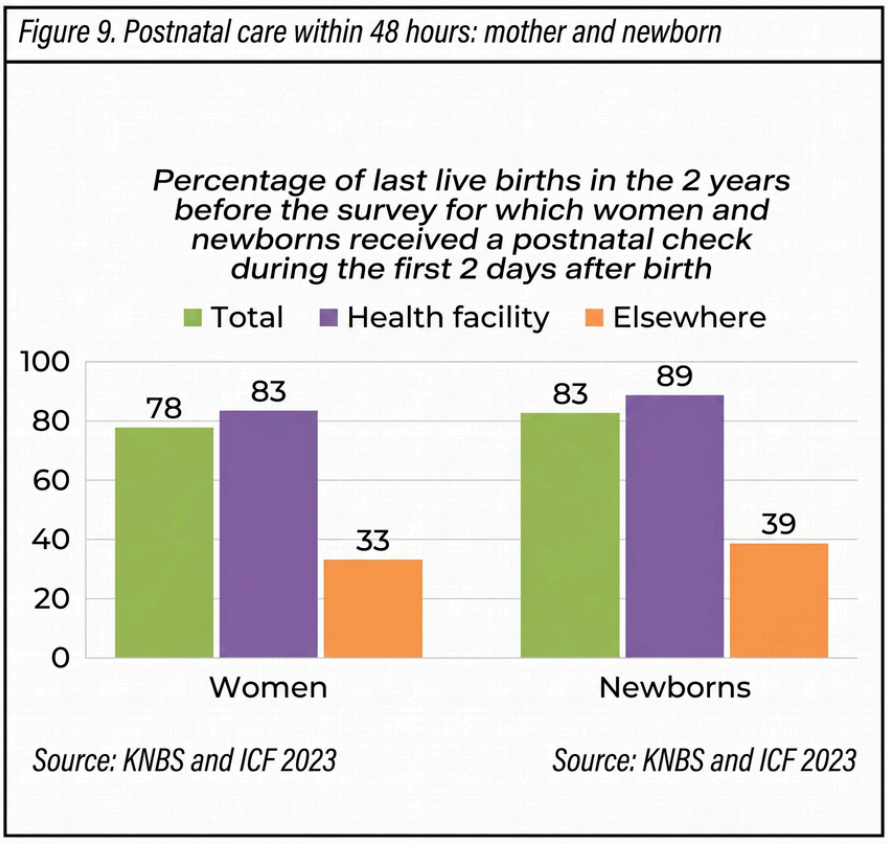
Figure 8b. Nutritional status of adolescent and adult women and men



Source: KNBS ICF Micro 2023

Postnatal Care

Within 48 hours of delivery , 78% of mothers and 83% of newborns receive postnatal care. While coverage is relatively high, continuity of care for the mother–newborn dyad remains suboptimal. These findings are shown in Figure 8.

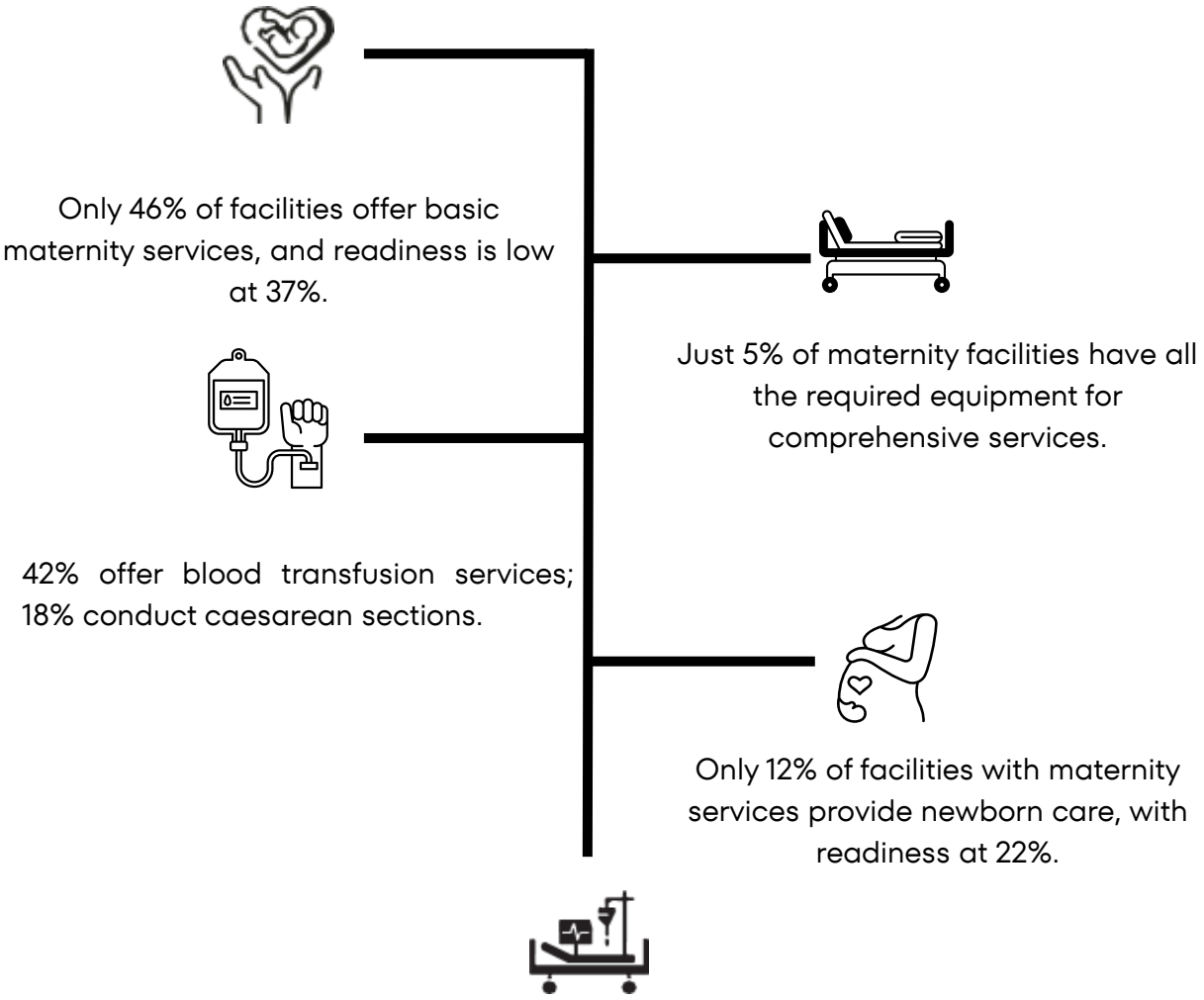


2.4. FACILITY READINESS

Basic Maternity Services Availability and Readiness

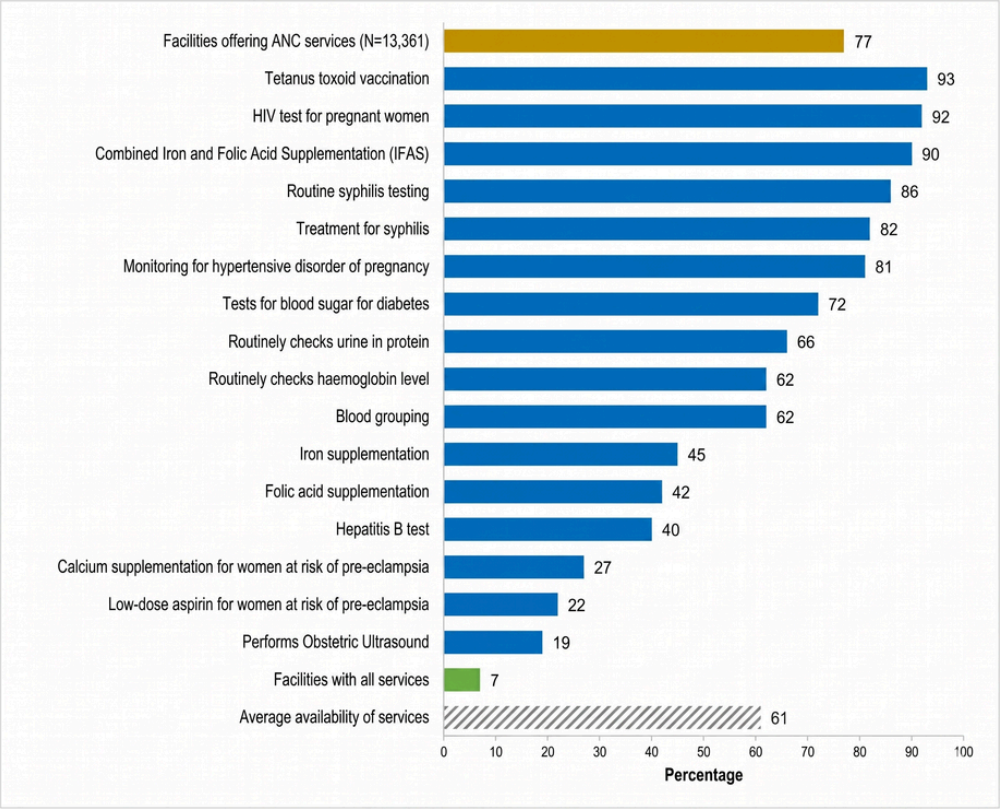
The Kenya Health Facility Census (KHFC) 2023 highlights significant gaps:

BOX 3: Key highlights from Service Availability and Readiness Report



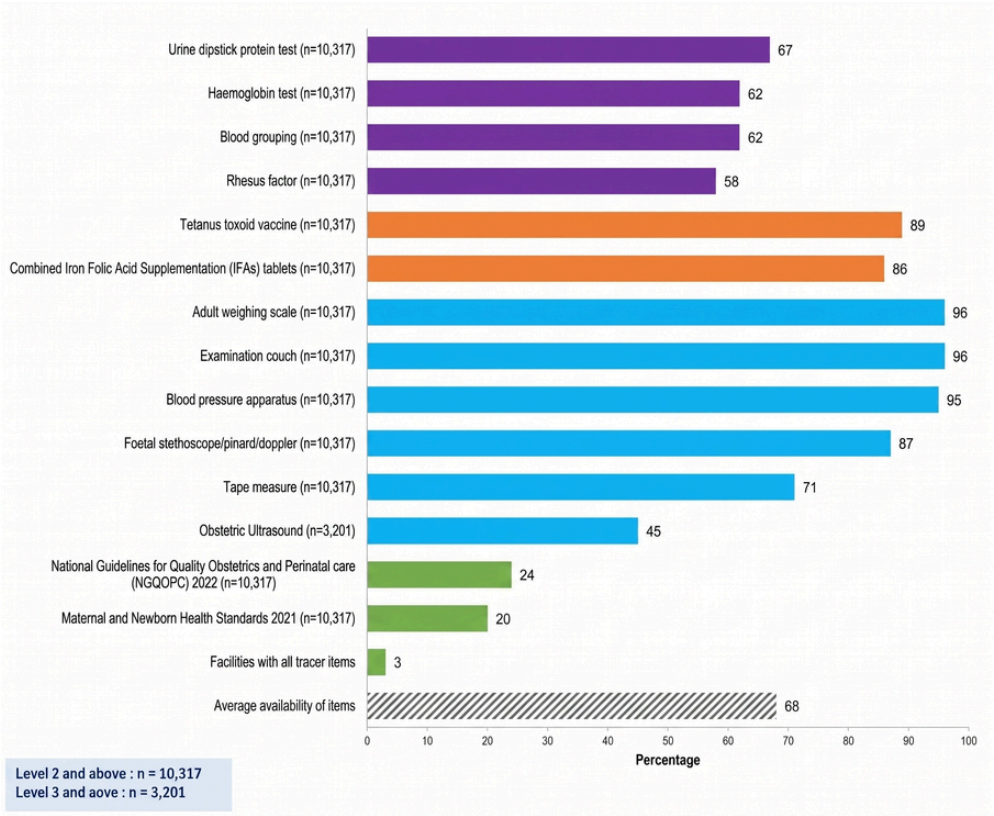
Effective antenatal care can improve the outcomes for both the mother and newborn. At least eight contact visits are recommended due to the benefits they offer, including early identification of and timely, appropriate care for mothers, as well as enhanced interpersonal communication between healthcare providers. From MOH SARA 2024, 77% of facilities nationally offer ANC services with average availability of 61%, Figure 10. Only 7% have all tracer ANC services (MOH SARA 2024). Only 3% of the facilities have all the ANC tracer items, Figure 11.

Figure 10. Availability of ANC tracer services



Source: MOH SARA 2025 (fig141)

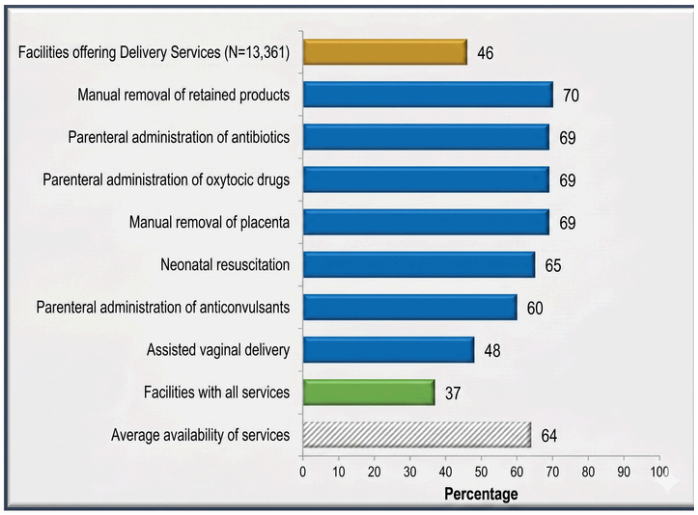
Figure 11. Average readiness to offer ANC services N=10,317



Source: MOH SARA 2024

Basic service readiness is shown in Figure 12, while newborn service capacity is detailed in Figure 13 and 14. Over 54% facilities from level 3 have neonatal resuscitation services. Critical care capacity is presented in Table 1. Of the 6132 facilities offering delivery services nationally, 37% have all 7 BEmONC signal functions, Figure 12. Average availability of essential newborn health services was 82%,Figure 13 while for tracer services for the sick and small newborns was 78%, figure 14.

Figure 12. Percent of facilities that have select BEMONC tracer services (N=6132)



Source: MOH SARA 2024

Figure 13. Availability of essential newborn health services (n=4876)

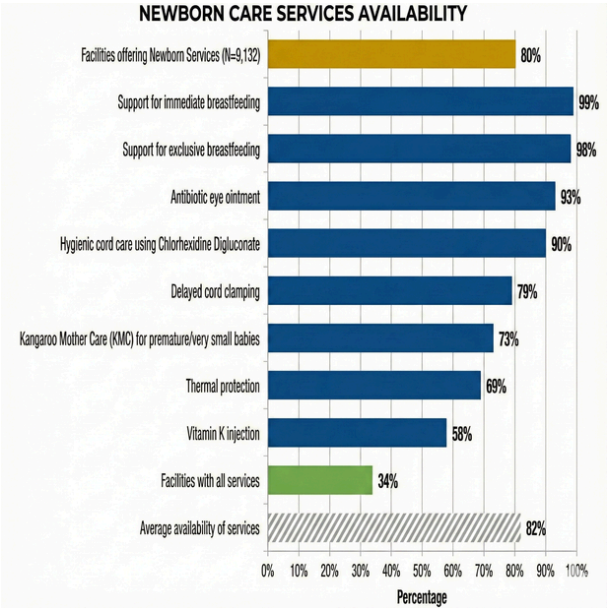


Figure 14. Availability of comprehensive newborn health tracer services in Kenya (n=598)



Source: MOH SARA 2024

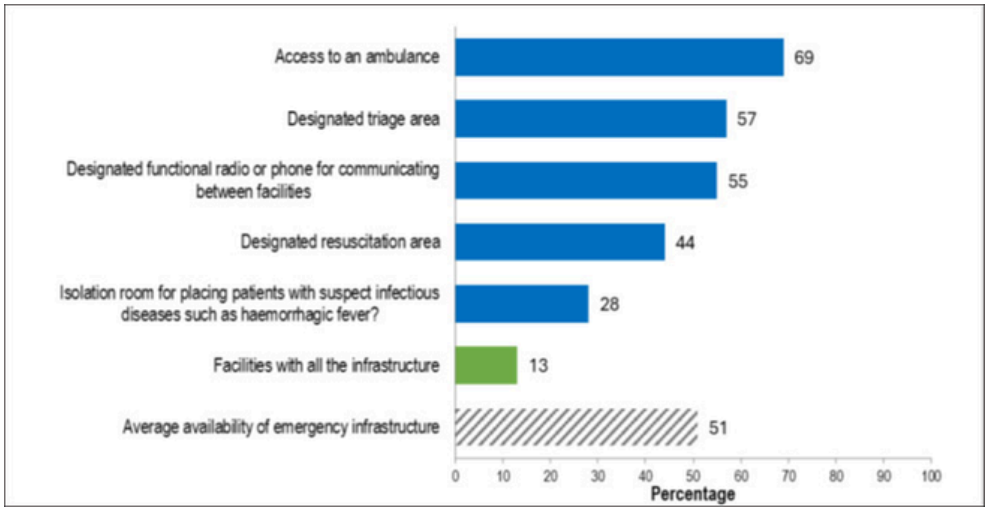
Table 1. Critical beds in government facilities and expected targets

No of HDU beds	Level 4		Level 5		Level 6	
	Current	Target per facility	Current	Target per facility	Current	Target per facility
HDU Adult beds	154	12	41	24	31	24
HDU cots	23		9		6	
ICU Adult beds	104	12	120	24	166	24
ICU paediatric beds	12	12	16	24	32	24
ICU Neonatal beds	2	3-4 / 1000 LVB	17	2/1000 LVB	46	1/1000 LVB
Total	295		203		281	
Grand Total					779	

Source: MOH 2023-KHFC/norms and standards for care of the newborn - Kenya 2025

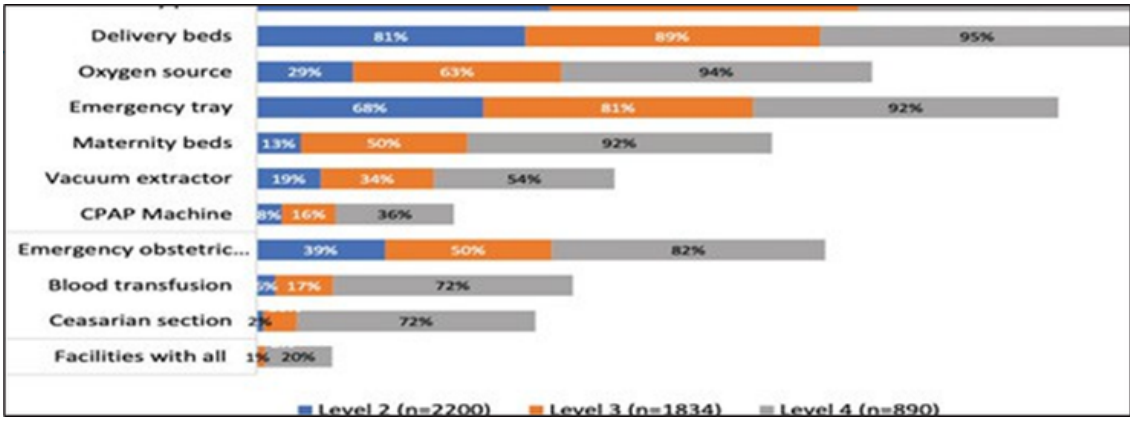
The most available emergency infrastructure (Isolation room, Triage area, Resuscitation area, Functional phone for communication, and Access to an ambulance) item was access to an ambulance at 69% while the least available was an isolation room at 28%, Figure 15, (MOH SARA 2024).

Table 15. Percent of facilities that have infrastructure for emergencies (N=12039)



The preparedness of primary healthcare facilities in Kenya for providing oxygen and CPAP for neonates is critically low. Only 1% of level 3 and 20% of level 4 have all what is required to provide oxygen and CPAP, Figure 16.

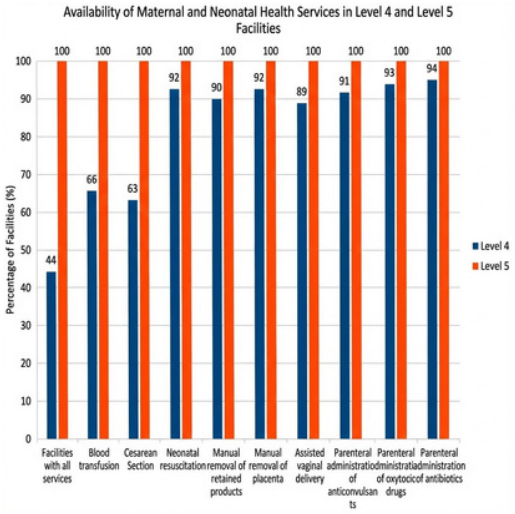
Figure 16. Facility preparedness for neonatal oxygen and CPAP



Source: MOH 2023-KHFC

Comprehensive maternity care capacity remains constrained. Figure 17 shows overall availability of comprehensive services. Of the 2784 level 3, 4 and 5 facilities offering delivery services, 46% had all 9 CEmONC signal functions. Figure 18 shows proportion of healthcare providers giving correct diagnosis, correct treatment for all the six for cases. Only 40% of the health care providers made correct diagnosis and gave treatment for postpartum haemorrhage.

Figure 17. Percent of facilities (levels 4 and 5) that had CEmONC services (9 signal functions) and by KEPH level



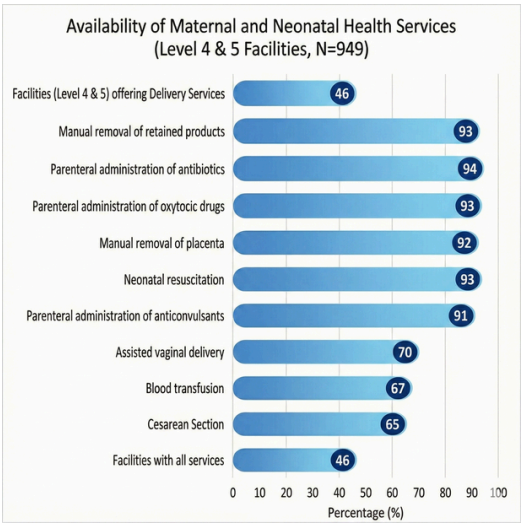
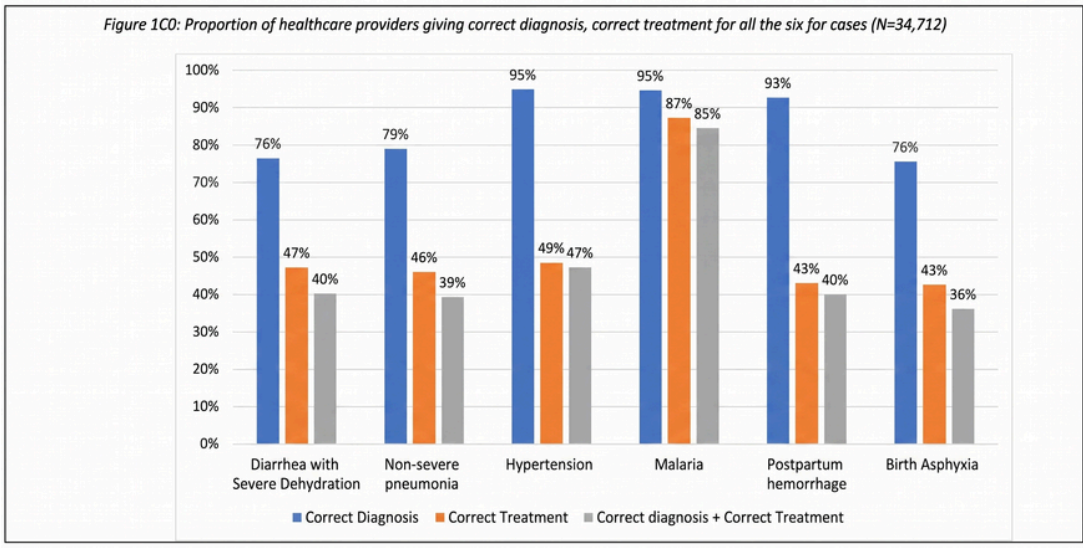


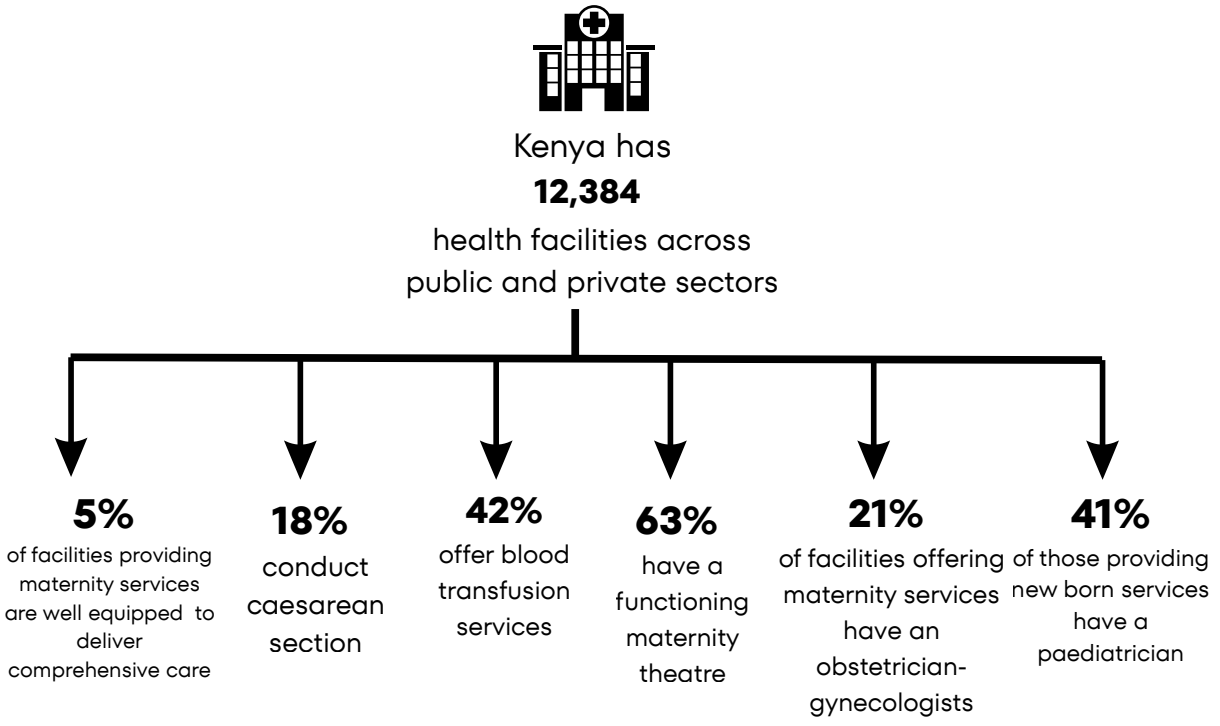
Figure 18. Proportion of healthcare providers giving correct diagnosis, correct treatment for all the six for cases (N=34,712



Source: MOH QC&HR 2024

For postpartum haemorrhage, 93% received correct diagnosis while only 43% got correct treatment with only 40% receiving correct diagnosis and treatment. Even when women get to medical facilities risk of death, though reduced, more than 60% of the women could die from not receiving correct treatment and diagnosis.

From Figures 10–18, it is evident that while women are increasingly accessing health facilities and interacting with qualified professionals. The readiness of these facilities remains critically low, undermining progress toward EWENE targets. Diagnosis and correct treatment remain a problem. Implementation of needed nutrition interventions are not matching contact with skilled professionals.



2.5. NUTRITION STATUS

Kenya continues to experience a substantial burden of maternal and neonatal complications, including anemia, low birth weight, preterm birth, and early neonatal morbidity. These challenges are closely linked to gaps in the integration of essential nutrition interventions within routine antenatal, postnatal, referral, and community platforms. Although national policies and guidelines exist, implementation at county level remains uneven, with many counties lacking a prioritized and well-coordinated package of evidence-based nutrition actions across the continuum of care.

These system gaps contribute to missed opportunities for early screening, prevention, and timely management of key nutrition-related risks during pregnancy and the postnatal period. Weaknesses in service delivery such as inadequate micronutrient supplementation, insufficient screening for maternal nutrition risks, suboptimal counselling practices, and limited follow-up at community level further exacerbate poor pregnancy and neonatal outcomes. Moreover, limited integration of initiatives such as the Baby-Friendly Hospital Initiative (BFHI) reduces the quality of breastfeeding support and undermines early initiation and exclusive breastfeeding, both of which are critical for reducing neonatal illness and mortality.

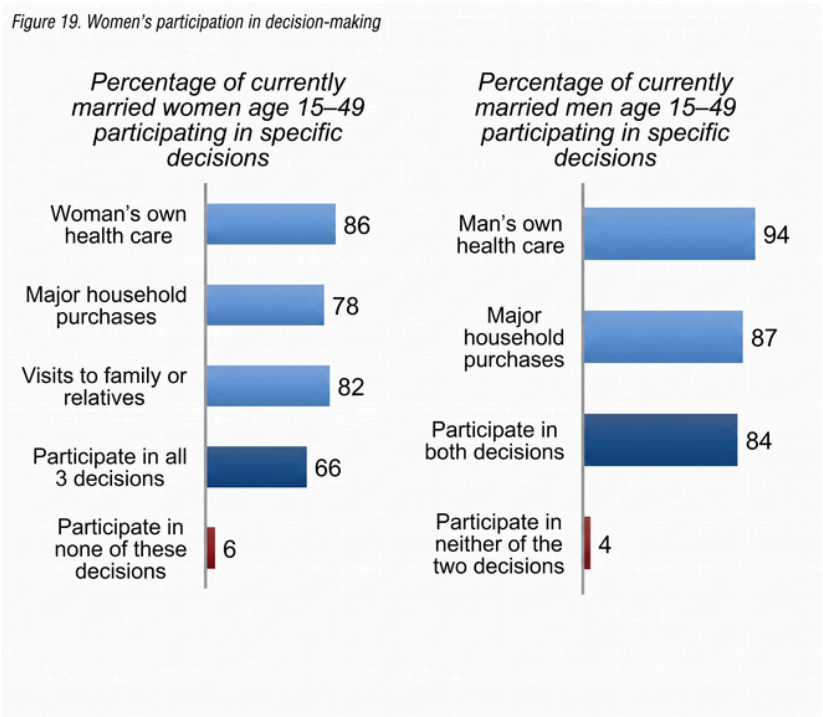
Given the persistently high rates of maternal anemia, preterm births, and neonatal complications, there is an urgent need to strengthen and integrate targeted nutrition interventions across antenatal care, facility-based referral systems, and community health structures. A coordinated, evidence-driven approach embedded within routine maternal and newborn health services and reinforced through BFHI will be essential to reducing preventable adverse outcomes and improving overall maternal.

2.6 PARTICIPATION IN DECISION MAKING

Women's empowerment in health decision-making is comparatively high, with 86% reporting autonomy over their own health. This supports the potential impact of demand-side and behavioural interventions. This data is presented in Figure 13.

Kenyan women report comparatively high levels of autonomy in health-related decision-making, with 86% indicating that they can make choices about their own health (Figure 19). This suggests that demand-side barriers may be less about permission to seek care and more about broader behavioural, cultural, or informational factors. Interventions should therefore build on this existing empowerment by promoting behaviour change, strengthening health literacy, and ensuring that services are responsive to women's choices and needs.

Figure 19. Women's participation in decision-making

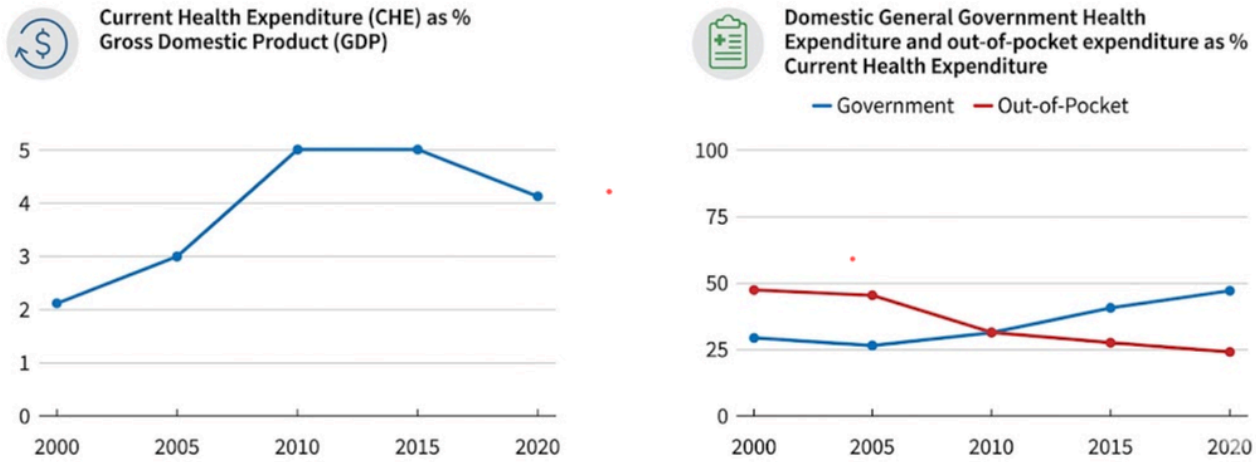


Source: KNBS and ICF 2023

2.7. FINANCING AND SYSTEMIC BARRIERS

Despite strong policy frameworks, maternal and newborn health remains underfunded. Budget allocation to health falls short of the Abuja Declaration target (15%), while donor support is declining. Households continue to face a high financial burden, with out-of-pocket expenditure at 25%. Figure 20 shows the current health expenditure profile.

Figure 20. Health expenditure and out-of-pocket expenditure



Source: Kenya EWENE Country profile 2025

From the foregoing, systemic causes underpinning these outcomes include:



- Low facility readiness – only 27% of facilities meet basic maternity service standards.
- Commodity stockouts – life-saving drugs such as TXA, oxytocin, $MgSO_4$, ACS, and surfactant are not reliably available.
- Human resource gaps – critical shortages of neonatal nurses and skilled birth attendants, especially in hard-to-reach areas and during nights/weekends.
- Weak referral systems – inadequate ambulances, delayed transfers, and lack of integrated mother-newborn referral pathways.
- Fragmented data and accountability – absence of a live MNH scorecard limits rapid detection of underperformance and corrective action.
- Financing constraints – limited, inflexible funds for last-mile readiness, with donor support often fragmented.
- Slow adoption of technology in MNH, such as Obstetric Point of Care Ultrasound (O-POCUS), rapid diagnostic tests, wearable devices and telehealth\telemedicine

Kenya's maternal and newborn health challenge is no longer primarily about access. It is about quality and consistency of care inside facilities, backed by system readiness and accountability.

Therefore, the EWENE Acceleration Plan 2025–2027 is timely and will address these gaps, prioritising the interventions and delivery mechanisms that can shift indicators from red to green and save thousands of lives each year. It aims to:

- Break the stagnation in maternal and newborn outcomes by focusing on facility-based women and
- newborns, where the most significant and fastest gains are possible.
- Align Kenya's interventions with WHO normative guidance and global EWENE priorities to address both clinical and system-level gaps.
- Introduce game-changing delivery mechanisms including a national delivery unit, last-mile funding, readiness and drill culture, and a public scorecard to ensure interventions are implemented consistently and monitored in real time.
- Leverage quick wins and medium-term reforms to build momentum toward the SDG 2030 targets while strengthening systems for long-term sustainability.

3. VISION TO ACTION

3.1 GOAL, STRATEGIC OBJECTIVES AND EXPECTED OUTCOMES



Goal

To accelerate the reduction of preventable maternal and newborn mortality and stillbirths in Kenya by 2027 through full implementation of EWENE/WHO high-impact interventions; facility readiness; and strengthened accountability systems; ensuring that every woman and every newborn everywhere receive timely, respectful, and high-quality care.



Strategic Objectives

By 2028, Kenya will:

1. Achieve universal coverage of WHO-recommended quality care standards for Prenatal care, labour care and birth companionship, childbirth and newborn care, in all facilities conducting deliveries.
2. Expand access to Level-2 small and sick newborn care to all 315 Primary Care Network hubs, with functional referral pathways ensuring access within two hours.
3. Increase ANC coverage to ≥8 contacts for at least 75% of pregnant women, with integrated

PNC follow-up for mother–baby pairs within 48 hours.

4. Attain ≥90% compliance with the WHO postpartum haemorrhage (PPH) first-line treatment bundle, including tranexamic acid within 3 hours.
5. Institutionalize immediate Kangaroo Mother Care (KMC) for all eligible preterm and low- birth-weight newborns.
6. Ensure 85% appropriate use of antenatal corticosteroids and administration of MgSO4 for eligible women in preterm labour.
7. Embed a real-time RMNCAH scorecard for monthly county-level performance review and corrective action.
8. Achieve high-level political stewardship and commitment to accelerate the reduction of maternal and newborn mortalities.
9. Improve access and utilization of quality maternal and newborn health services across the continuum of care, ensuring equitable coverage for all populations by 2027.

10. Enhance timely and appropriate referral for mothers and newborns.
11. Strengthen community maternal and newborn health activities.
12. Mainstream gender and equity in MNH services.
13. Improve data quality, collection, dissemination and utilization for maternal and newborn health to drive evidence-based decision-making, learning and research.
14. Increase funding and ring-fencing resources for maternal and newborn Health

Expected Outcomes



1. Maternal mortality ratio reduced from 355 to ≤140 per 100,000 live births.
2. Neonatal mortality rate reduced from 21 to ≤12 per 1,000 live births.
3. Stillbirth rate reduced from 19 to ≤12 per 1,000 births.
4. 100% of counties implement monthly readiness drills for obstetric and newborn emergencies.
5. 100% of maternity facilities are stockout-free for priority life-saving commodities
(uterotonics, tranexamic acid, magnesium sulfate, ACS, surfactant).
6. Reduction of county disparities in NMR so no county exceeds twice the national average.
7. Reduction by 50% of the maternal deaths directly related to PPH among women accessing health services from facilities by 2028.
8. Reduction by 50% of the neonatal deaths directly related to prematurity, infection, intrapartum asphyxia, and neonatal jaundice among neonates accessing medical facilities by 2028.

3.2. KENYA'S EWENE SCORECARD VERSUS 2030 GLOBAL TARGETS

Table 2. Kenya EWENE score card June 2025

Indicator	Category	Global Target	Kenya Target	Current achievement	Deficit to target	Rate of change required
Population based Maternal mortality	Mortality	Reduce the global maternal mortality ratio to less than 70 per 100,000 live births.	140/100,000	355/100,000	285	72/100,000
Hospital based Maternal Mortality	Mortality		140/100,000	100/100,000	40	10/100,000
Stillbirths	Mortality	12 or fewer stillbirths per 1000 total births	≤12/1,000	19/1,000	7/1,000	9.20%
Neonatal mortality	Mortality	12 or fewer neonatal deaths per 1000 live births	≤12/1,000	21/1,000	9/1,000	10.80%
ANC: Four or more antenatal care contacts	Coverage	90% global coverage of four or more antenatal care contacts	90%	66%	24	6.00%
Births attended by skilled health personnel	Coverage	90% global average coverage of births attended by skilled health personnel	90%	89%	1	Achieved-maintain
Early routine postnatal care (within two days) - Woman	Coverage	80% global coverage of early postnatal care	80%	77.60%	2.4	Achieved-maintain

Early routine postnatal care (within two days) - Woman	Coverage	80% global coverage of early postnatal care	80%	77.60%	2.4	Achieved-maintain
Early routine postnatal care of the newborn (within two days)	Coverage	There is currently no target for early routine postnatal care of newborns due to a lack of data to set a target.	No target	82.10%	100%	17.90%

RED - Not Achieved | YELLOW On Target | GREEN - Achieved

3.3. TRANSLATING GOALS INTO MEASURABLE RESULTS

Through the Kenya EWENE Acceleration Plan 2025-2027, direct causes of maternal and newborn morbidity and mortality and stillbirths among women who access medical facilities will be addressed. This will include the prevention of PPH antenatally and the active management of the third stage of labour, ensuring that the "first response PPH bundle"- comprising uterotonics, isotonic crystalloids, tranexamic acid, and uterine massage is available in all facilities providing basic maternity services. In the event of refractory PPH, these women should be offered compressive measures (aortic or bimanual uterine compression), the non-pneumatic antishock garment, and intrauterine balloon tamponade (WHO, 2023), and ensure the availability blood, blood products and care bundles for other maternal and neonatal complications.

Ensure newborn care units are available and functional to reduce greatest risk of death and disability among newborns who are born too soon or too small or who become sick. Thus, this Acceleration Plan will ensure that newborns with complications of prematurity, intrapartum brain injury, severe bacterial infection or pathological jaundice and those with congenital conditions receive inpatient care delivered via a resilient health system, multidisciplinary teams and use of innovative technologies buy:

1. Addressing the quality of care in Maternal health services across the continuum of care package: preconception, antenatal, intrapartum and postnatal.
2. Management of complications of pregnancy and childbirth by addressing appropriate care for PPH, infection treatment and hypertensive disorders management.
3. Provision of quality neonatal care in all hospitals that have a maternity and scaling up the care for the small and sick newborn.
4. Making available, appropriate and timely referral of mother and newborn.
5. Ensuring adequate, competent and motivated Human Resource for Health (HRH) staff with the right attitude.
6. Efficient labour management with timely interventions and sufficiently skilled birth attendants to prevent intrapartum asphyxia and other critical newborn interventions (neonatal intensive care unit, CPAP).
7. Operationalize Standard Operating Procedures (SOPs for in-facility management of the woman and newborn).
8. To address maternal and newborn interventions and accountability.
9. Invest in monitoring and evaluation for maternal health and use data in quality improvement.
10. Leverage emerging technology for EWENE.
11. Mobilize resources for EWENE.
12. Enhance political buy-in for EWENE.

The goal and strategic objectives of the Acceleration Plan set the direction: reducing preventable maternal and newborn deaths, ensuring equitable access, and delivering consistently high-quality care across Kenya. Achieving this vision depends on translating commitments into targeted, measurable, and time-bound actions that are implemented at the facility, county, and national levels.

To achieve this, the Acceleration Plan is organized around 10 strategic pillars:

1. Policy & Planning
2. Quality of Care
3. Gender & Equity
4. Data, Monitoring & Evaluation
5. Financing & Investment
6. MNH Workforce
7. Response & Resilience
8. Commodities & Technologies
9. Advocacy, Public Awareness and Community Engagement
10. Research, Innovation and Knowledge Exchange

Each pillar addresses the systemic and clinical gaps revealed by Kenya's EWENE Scorecard, backed by SWOT analysis, and proposes solutions with clear lines of responsibility. The summary table 3 below serves as a roadmap to the detailed action plan.

Table 3. Summary of the acceleration road map

Gap	Pillar	Selected Priority Interventions
Shortages and uneven distribution of skilled providers	MNH Workforce	Recruit and equitably deploy skilled midwives and neonatal nurses Establish mentorship hubs and continuous training
Weak adherence to standards and inconsistent quality of care	Quality of Care	Enforce clinical guidelines and audits Establish facility QI teams and neonatal health awards
Inadequate and unsustainable financing	Financing & Investment	Integrate MNH into SHIF/SHA to essential and emergency health services Implement the RMNCAH investment case and ring-fence county MNH budgets
Limited data quality and weak accountability	Data, Monitoring & Evaluation	Digitise MNH data dashboards Regular MPDSR reviews with national scorecards Ensure there is real time data capture
Gender inequities and harmful norms	Gender & Equity	Implement male involvement and empowerment interventions Ensure gender-responsive resource allocation
Weak community engagement and accountability	Accountability & Community Engagement	Establish community scorecards and dialogue forums Support CSO advocacy and confidential enquiries into maternal deaths

Fragmented policies and weak planning linkages	Policy & Planning	Align county annual work plans/CIDPs with national MNH frameworks Institutionalise peer review and accountability mechanisms
Fragile referral and emergency systems	Response & Resilience	Equip enhanced care units in maternity wards Ensure functional ambulances and oxygen supply Revise the 2014 referral guidelines
Commodity stock-outs and weak supply chain	Commodities & Technologies	Ensure PPH bundles, oxygen, and NICU supplies Update KEML and digitise LMIS with dashboards Ensure adoption of emerging technologies.
Limited translation of evidence into practice	Research, Innovation & Knowledge Exchange	Develop MNH & newborn research agenda Hold annual research and learning fora

4. STRATEGIC PILLARS

This section describes 10 strategic pillars and ends with game changer interventions.

4.1. PILLAR 1: POLICY AND PLANNING

Effective policy and planning are the foundation of a coherent national response to maternal and newborn health challenges. Kenya benefits from a supportive policy environment, including the Kenya Health Policy, RMNCAH Investment Framework, and existing MNH quality standards. However, weak alignment between national policies and county implementation, inadequate prioritisation of MNH in county planning and budgeting, and limited accountability mechanisms continue to undermine progress. This pillar, therefore, seeks to institutionalise evidence- based, harmonised, and participatory policy and planning processes that ensure MNH is consistently prioritised and financed at both national and county levels.

Table 4. SWOT analysis for interventions to address policy and planning gaps



Strengths

- Kenya Health Policy (KHP) and RMNCAH Investment Framework provide a supportive policy environment.
- Existing national MNH guidelines, including
- Maternal and Newborn Quality of Care Standards.
- EWENE commitments already endorsed at the national level.
- ANC≥8 contacts standardized in policy or widely adopted in practice
- MPDSR and TWG institutionalized.
- Existing Technical Working Groups (TWGs) and MNH subcommittees at national and county levels foster multisectoral collaboration. Availability of information systems that enable tracking of MNH indicators and support evidence- based planning.



Weaknesses

- Low implementation of immediate KMC, companionship in labour, and standardized PPH bundle.
- Weak linkage between national policy and county-level implementation.
- Weak linkage between national policies and county-level implementation.
- Lack of integration of climate and disaster resilience planning.
- Poor policy dissemination
- Weak linkage between national policies and county-level execution leads to variation in MNH service delivery



Opportunities

- MOH 2023–2025 guidelines provide clear technical standards for ANC, intrapartum care, PPH, newborn care and SSNC.
- EWENE scorecard offers a political platform for accelerating action.
- Potential to integrate MNH priorities into the new Universal Health Coverage (UHC) agenda.
- Inter-sectoral linkages.
- Public-Private partnerships
- Digital health and innovations



Threats

- Frequent policy changes can delay county adoption.
- Donor dependency risks the sustainability of high-impact interventions.
- Shifts in national and county leadership disrupt policy continuity.
- Pandemics, economic downturns, and climate- related disasters (e.g., floods, droughts) can divert resources away from MNH priorities.
- Conflicts between national and county mandates slow policy harmonization and accountability.
- Shifts in national and county leadership disrupt policy continuity.

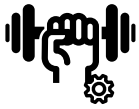
Table 5. Priority interventions to address policy and planning gaps

Objective	County Interventions	National Interventions	Expected Outcomes
Integrate MNCH into county planning and budgeting	Mainstream MNH into CIDPs, AWPs, and budgets Allocate and ringfence funds for MNH Build the capacity of county leadership to prioritise MNH in planning and resource allocation	Develop and disseminate national MNH planning guidelines aligned with UHC and EWENE Monitor county plans to ensure MNH is prioritised	MNH consistently prioritised and financed in county plans and budgets
Strengthen policy alignment and intergovernmental coordination	Align county MNH plans with national frameworks (ENAP/EPMM, EWENE, UHC Participate in inter-county peer learning and review platforms	Harmonise MNH policy frameworks at the national level Convene intergovernmental forums (summits, TWGs) for alignment	Reduced fragmentation; harmonised MNH policies across national and county levels
Enhance the enforcement and accountability of MNH policies	Enforce compliance with MNH standards and guidelines in facilities Establish county MNH accountability forums	Institutionalise MNH accountability within national review processes (Joint Health Sector Reviews, Annual Reports) Publish annual national scorecards on MNH policy implementation	Stronger accountability for MNH policy enforcement at the national and county levels
Foster inclusive and participatory MNH policy processes	Engage CSOs, professional associations, and communities in county MNH policy development Disseminate county MNH policies widely	Institutionalise CSO, academia, and partner participation in national MNH policy development and review	Inclusive MNH policy processes with a stronger citizen and professional voice
Build evidence-based policy and planning capacity and Strengthen policy communication, dissemination, and implementation support	Use MNH data (DHIS2, MPDSR, scorecards) to inform county plans Conduct county-level data- to-action forums to guide planning Strengthen policy communication and dissemination	Provide tools and technical support for evidence-based MNH planning Develop a national framework for translating evidence into MNH policies	Evidence-driven MNH policies and plans, improving effectiveness and resource use.

4.2. PILLAR 2: QUALITY OF CARE

The Government of Kenya recognizes that the quality of care is central to achieving reductions in maternal and newborn mortality and ensuring equitable access to services. Despite the availability of national guidelines and standards, gaps in adherence, variability in service delivery, and limited accountability mechanisms persist, compromising outcomes. Strengthening the quality of care requires the institutionalization of evidence-based standards, Continuous capacity building of healthcare providers within MNH, structured quality improvement systems, and mechanisms for regular monitoring and accountability. This pillar, therefore, focuses on enhancing quality standards, embedding and enhancing quality improvement processes at all levels, and ensuring that all women receive respectful, evidence-based, and equitable care.

Table 6. SWOT analysis for interventions to address quality of care gaps



Strengths

- National QoC standards for maternal and newborn care exist.
- 89% skilled birth attendance, high facility delivery coverage.
- Ongoing MPDSR process provides case-based learning and care networks.
- Government commitment to implementing quality standards by adapting the MOH QoC standards for SSNB.
- MNH Standards QoC and SSNB into the KHIS platform.
- Updated quality standards and EmONC checklists.



Opportunities

- Upscaling rollout of MOH 2023 PPH recommendations and labour monitoring tools.
- Digital tools for labour management.
- Potential to integrate mentorship hubs for SSNB and EmONC.
- Institutionalize clinical governance mechanisms.
- Community access to services and referral across level of care.
- Rollout of Baby-friendly Hospital Initiative BFHI).
- Partnerships with Medical Training Institutions and Professional Societies/bodies for Quality Improvement capacity building.



Weaknesses

- Low compliance with the WHO Labour Care Guide.
- PPH bundle incompletely applied; objective blood-loss tools absent.
- ACS used inconsistently and sometimes unsafely in low-readiness settings.
- Incomplete application of PPH bundle
- Irregular supportive supervision



Threats

- HR attrition and uneven skill mix.
- Commodity stock outs undermine quality interventions.
- Insufficient quality improvement teams.
- High cost of training and retaining health care workers.
- Competing emergency priorities.

Table 7. Priority interventions to address quality of care gaps

Objective	County Interventions	National Interventions	Expected Outcomes
Ensure adherence to clinical standards and guidelines	Disseminate MNH guidelines, SOPs, and job aids to facilities Enforce compliance through facility managers	Develop, validate, and disseminate updated MNH guidelines, SOPs, and protocols Standardise clinical practice nationally	Uniform evidence-based MNH care across all facilities
Strengthen clinical audits, quality assurance, and accountability	Ensure all maternal and neonatal deaths are audited as per the prevailing national guidelines Conduct routine CQI meetings at the facility/ county level	Disseminate and train on death audit guidelines and monitor compliance Strengthen national QA systems Provide supportive supervision and oversight	≥90% of deaths reviewed monthly; accountability culture institutionalised
Promote respectful maternity and newborn care	Train all MNH providers on respectful care Implement respectful maternity and newborn care charters at the facility level Monitor client experiences and feedback mechanisms	Develop and disseminate national respectful maternity and newborn care guidelines and standards Integrate respectful maternity and newborn care into national MNH policies and accountability frameworks	Dignified, respectful, and client-centred MNH care in all facilities
Strengthen supportive supervision, mentorship, and provider capacity	Implement facility-based mentorship and supportive supervision Budget for training and mentorship costs in county AWP	Institutionalise national mentorship programmes Provide funding and technical support for county mentorship hubs	A skilled and confident MNH workforce is continuously supported

Objective	County Interventions	National Interventions	Expected Outcomes
Improve infrastructure, readiness, and clinical protocols	Ensure functionality of equipment, water, electricity, oxygen, and supplies in MNH units Prioritise care for mothers and babies during the first 28 days of life in all facilities	Procure anddistribute standardised MNH equipment Develop infrastructure standards Develop protocols for nurse- midwife to paediatrician consultations Develop obstetric care protocols	Functional, well-equipped facilities prioritising survival in the first 28 days
Enhance community engagement and accountability for quality of care	Establish facility quality committees with community representation Conduct community dialogues and implement scorecards Disseminate and operationalise the Community Health Strategy for MNH linkages	Institutionalise community accountability frameworks for MNH quality Publish/disseminate national MNH quality of care performance reports	Increased trust and accountability; community voice embedded in quality improvement
Institutionalise a culture of quality improvement and motivation	Establish QIteams inall MNH facilities Conduct regular QI cycles and assessments	Provide QI frameworks, standards, and tools Monitor QI implementation nationally Introduce annual maternal and neonatalhealth awards Establish reward systems for best-performing MNH teams/facilities Publish/disseminate national MNH quality of care performance reports	Continuous quality improvement embedded in all facilities, supported by recognition and motivation
Strengthen supportive supervision, mentorship, and provider capacity	Implement facility-based mentorship and supportive supervision Budget for training and mentorship costs in county AWP	Institutionalise national mentorship programmes Provide funding and technical support for county mentorship hubs	A skilled and confident MNH workforce is continuously supported

4.3. PILLAR 3: GENDER & EQUITY

Kenya has made progress in promoting gender-responsive programming, and women report high levels of autonomy in health decision-making. Despite the progress, there are disparities between counties, different populations and resource allocation. Adolescents, youth, and women in marginalised settings, still face barriers to accessing timely and respectful care. Male involvement in maternal health also remains limited. With frameworks such as the WHO's equity agenda and the national UHC reforms, there is an opportunity to close these gaps. This pillar focuses on mainstreaming gender and equity into planning and service delivery, addressing harmful norms, and ensuring equitable access for all women and newborns.

Table 8. SWOT analysis for interventions to address gender and equity gaps

Strengths

- Commitment to gender-responsive programming in RMNCAH policies Community health strategy supports CHP engagement.
- Equity data available from KDHS and DHIS2 National government has established institutions to address gender and equity.

Weaknesses

- Persisting disparities in NMR and maternal outcomes between counties (e.g., NMR up to 37/1,000 in some counties).
- Gender-based barriers to care seeking not systematically addressed
- Limited male involvement in MNH services.
- Weak enforcement of gender-responsive and anti-discrimination policies at facility and community levels
- Limited gender responsive budgets
- Limited capacity for gender mainstreaming
- Weak enforcement of gender-responsive and anti-discrimination policies at facility and community levels.

Opportunities

- WHO and EWEC frameworks on gender and equity in MNH.
- Community scorecards and social accountability tools.
- Growing advocacy around respectful maternity care.
- Use of technology and data science to inform programs and for modeling.
- Leveraging digital tools to amplify gender and youth voices in MNH advocacy and accountability

Threats

- Cultural norms that delay care-seeking.
- Resource allocation skewed toward higher-performing counties.
- Risk of weaponisation of gender and equity by politicians.
- Unaddressed social determinants of health and emerging commercial determinants.
- Weak coordination among actors.
- Socioeconomic inequalities
- Weak coordination among actors
- Continued marginalization of adolescent mothers, persons with disabilities, and people living with HIV limits access to quality care

Table 9. Priority interventions to address gender and equity gaps

Objective	County / Community Interventions	National Interventions	Expected Outcomes
Integrate gender and equity into MNH policy, planning, and service delivery	Mainstream gender and equity into county MNH workplans and budgets Design, implement, and monitor MNH services through a gender-responsive lens Allocate resources to gender- and equity-responsive MNH interventions	Disseminate national gender and equity guidelines Provide technical support for gender-responsive planning, budgeting, and monitoring Track national and county resource allocations to ensure equity	Gender and equity considerations institutionalised in MNH programming, with resources committed
Strengthen collection and use of disaggregated MNH data	Collect and report sex, age, disability, and socioeconomic disaggregated MNH data	Revise and disseminate MNH data tools to capture gender/equity indicators- Monitor and publish disaggregated MNH data nationally	Improved evidence on inequities to guide planning and corrective action
Promote equitable access for adolescents, youth, men, and marginalised groups	Establish and scale up adolescent- and youth-friendly MNH services Conduct targeted outreach to marginalised and vulnerable groups Implement interventions promoting male involvement, challenging harmful gender norms, and empowering women in MNH decision-making	Develop/adapt national guidelines and communication strategies on male engagement, gender norm change, and women's empowerment Institutionalise indicators on male involvement and women's empowerment within MNH M&E systems	Increased uptake of MNH services by adolescents, youth, men, and marginalised groups More gender-equitable household and community decision-making
Build capacity for gender-responsive MNH service delivery	Train CHVs, health providers, and county managers on gender- and equity-sensitive MNH care Conduct whole-facility sensitisation sessions on gender, rights, and equity	Develop and roll out gender/equity training modules Integrate gender and equity competencies into pre-service curricula Provide national sensitisation packages and monitor compliance	Skilled, sensitised workforce delivering gender and equity responsive MNH care
Strengthen accountability for gender and equity in MNH	Establish county gender/ equity accountability forums Engage communities in monitoring gender and equity in MNH. Introduce citizen feedback mechanisms (SMS platforms, suggestion boxes) on respectful care and service access.	Institutionalise gender and equity accountability within national MNH review processes Publish annual gender and equity MNH reports	Transparent, accountable MNH system addressing gender and equity gaps

4.4. PILLAR 4: DATA, MONITORING, AND EVALUATION

Reliable data and robust monitoring systems are crucial for informed decision-making, effective resource allocation, and accountability in maternal and newborn health. Kenya has established strong health information systems, including DHIS2 and LMIS, but challenges persist with data completeness, timeliness, accuracy, and utilization for planning. Limited integration of digital innovations and weak feedback loops between national, county, and facility levels further constrain performance. This pillar, therefore, prioritises the institutionalization of digitalized, harmonised data systems, regular performance reviews, and accountability mechanisms that drive continuous improvement.

Table 10. SWOT analysis for interventions to address data, monitoring and evaluation gaps



Strengths

- DHIS2 and KHIS are established national data systems.
- MPDSR process institutionalized in most counties.
- Kenya has begun using scorecard approaches for MNH and RMNCAH+N.
- National commitment to the digitization of services in Kenya.



Weaknesses

- No real time, public-facing MNH scorecard updated monthly.
- Inconsistent definitions and tracking for key interventions (ANC≥8, PPH bundle, immediate KMC, ACS, neonatal and child health indicators).
- Delays in data aggregation and feedback to facilities.
- Slow rollout of the electronic medical records (EMR) system.
- Lack of gadgets for data collection e.g. electronic medical records, digital partographs.
- Weak MPDSR feedback dissemination to counties



Opportunities

- EWENE scorecard platform can integrate facility and county-level indicators.
- Digital health innovations for real-time data capture.
- Peer-learning through public dashboards candrive healthy competition.
- High penetration of the internet.
- Existence of Mother–baby pair tracking system.



Threats

- Data quality gaps at the facility level reduce decision-making accuracy.
- Weak interoperability between EMRs and national reporting systems.
- Weak data security measures leave personal health information vulnerable to breaches and leakage.

Table 11. Priority interventions to address data, monitoring and evaluation gaps

Objective	County Interventions	National Interventions	Expected Outcomes
Improve MNH data quality, timeliness and completeness	Ensure timely, complete and accurate DHIS2 reporting	Revise, validate and disseminate MNCH data tools to include EWENE indicators	High-quality MNH data available for monitoring and planning
	Participate in monthly data audits and address discrepancies	Conduct national DQAs and provide feedback	
Strengthen MPDSR and Confidential Enquiry systems	Undertake MPDSR and NCA death audits as per the national guidelines Track and implement recommendations within 3 months	Strengthen bi-annual the National MPDSR Committee Publish annual MPDSR & CEMND reports Establish accountability and follow-up mechanisms by developing MPDRS action tracker	≥90% of MPDSR recommendations implemented; improved maternal and neonatal mortality response
Institutionalise the use of MNH scorecards and dashboards	Develop and apply county MNH scorecards Share results with community and county leaders	Develop and disseminate national MNH scorecards and dashboards	Counties and national levels use performance data for accountability and improvement
Build capacity for RMNCAH data analysis, use and learning, linking with CRVS	Train health workers and managers in data analysis Establish county M&E units Hold annual targeted county review meetings on MNH performance	Develop and roll out national training for MNH data Provide mentorship and supportive supervision	Counties and facilities routinely analyse and use data for decision-making
Increase accountability and transparency in MNH data use	Present MNH data in community forums and county assemblies Participate in operational/ research activities to generate MNH evidence	Institutionalise annual national MNH data review conferences with counties, CSOs, academia, and partners	Greater transparency and stronger evidence base for MNH interventions
Scale up digitalisation and innovation for MNH data	Adopt digital data solutions (EMRs, e-registers) in MNH units Support and maintain digital infrastructure Train staff to effectively use digital platforms	Develop a national framework for EMR systems in collaboration with ICT and other government institutions Expand DHIS2 functionality to cover EWENE indicators Support e-/m-Health innovations for real-time data	Scaled-up use of digital platforms; timely and accurate data for accountability and decision-making

4.5. PILLAR 5: FINANCING & INVESTMENT

Adequate and predictable financing is crucial for sustaining and expanding maternal and newborn health services. Kenya has developed strong health financing frameworks, but dependency on external funding, limited fiscal space, and inefficiencies in resource utilisation threaten progress (AFIDEP 2025). County allocations for MNH remain inconsistent, and there is a weak alignment between national priorities and local budgeting. This pillar focuses on mobilising domestic resources, strengthening efficiency and accountability, and operationalising innovative financing mechanisms to guarantee sustainable investments in MNH.

Table 12. SWOT analysis for interventions to address financing and investment gaps



Strengths

- Kenya's UHC rollout includes MNH in the benefits package.
- RMNCAH+N Investment Framework exists.
- Existence of maternal, newborn and child health advocacy strategy.
- Support to increase MNH funding at national and county levels with national leaders, governors and MCAs.
- Existence of an investment case for maternal, newborn and child health.



Opportunities

- Political will for targeted financing mechanisms.
- Potential for PPPs in ambulances, equipment, and NICU expansion.
- Efficiency gains from pooled procurement and digital stock management.
- Existence of a total market approach guidelines.
- Leveraging Kenya's commitments to the Maputo and Abuja Declarations to mobilise increased domestic financing for health and ensure maternal and newborn health (MNH) receives dedicated prioritisation.
- Targeted investments in neonatal ICU/HDU beds, equipment, and workforce training to address critical gaps in newborn intensive and high-dependency care (MoH KHFC, 2023).
- Expanding maternal HDU capacity with equipment and skilled workforce training to strengthen readiness for obstetric emergencies and reduce preventable maternal deaths.
- Operationalising a functional Social Health Insurance system to provide financial protection and reduce the burden of out-of- pocket expenditure on households.
- Allocating and ring-fencing specific budgetary resources for MNH at both national and county levels to ensure predictable and sustainable financing.
- Improving coordination of donor and partner investments to reduce fragmentation and create synergistic approaches that maximise the impact of MNH programs.



Weaknesses

- Low budgetary allocation to health.
- Low contribution of the health sector to GDP
- (MOH Health labour market analysis 2023).
- Funding often insufficient and fragmented across donors.
- No dedicated last-mile fund for commodities and readiness.
- Limited fiscal flexibility at the facility level to respond to emergencies.
- Low comprehensive care readiness: Only 5% of facilities offering maternity services have all the required equipment for comprehensive care (MOH 2023-KHFC).
- Inadequate ambulance access: >51% of facilities lack functional ambulances (MOH 2023-KHFC).



Threats

- Donor funding volatility and risk of gaps if partners withdraw.
- Inflation and currency fluctuations affecting procurement costs.
- Underprioritisation of MNH.
- Lack of targeted financial allocation for MNH.
- Persistent poverty.

Table 13. Priority interventions to address financing and investment gaps

Objective	County Interventions	National Interventions	Expected Outcomes
Increase domestic financing for MNH	Allocate adequate county MNH budgets Ringfence allocations for MNH Ensure timely disbursement to facilities Build the capacity of county leadership to prioritise MNH and allocate resources effectively	Increase national health budget allocations earmarked for MNH Integrate MNH into SHIF/SHA benefit packages Enforce PFMA compliance to protect MNH allocations Develop a national investment case for newborns to guide resource prioritisation	Increased and predictable MNH funding at the county and national levels, with improved prioritisation and accountability
Improve efficiency and accountability in MNH spending	Strengthen county-level PFM systems Improve absorption and reduce wastage Audit MNH expenditures at the facility/county level Generate reliable MNH data for investment planning Conduct annual efficiency reviews of MNH funds utilisation at the county level	Develop and enforce efficiency benchmarks Monitor MNH budget absorption Publish annual MNH financial reports and reviews Use consolidated MNH data for costed investment cases Ensure annual national-level review of efficiency and effectiveness of MNH fund utilisation	Improved value for money, reduced wastage, and better accountability for MNH financing
Leverage private sector, FBOs, and PPPs for MNH investment	Partner with private providers and FBOs to expand maternity infrastructure and services Ensure public, private, and FBO facilities adopt and implement similar MNH service standards	Engage private and FBO facilities to standardise service delivery nationwide Operationalise the PPP framework to support the delivery of high-quality MNH services Advocate for incentives (tax waivers, subsidies) for private investment in MNH	Standardised, high-quality MNH services across public, private, and FBO sectors; expanded investment through functional PPPs

Plan for donor transition and innovative financing	Mobilise county assemblies and communities for local resource mobilisation Conduct rapid assessments of MNH infrastructure, HRH gaps, and financing needs	Develop donor transition strategy and co-financing mechanisms Explore innovative financing instruments (sin taxes, bonds, diaspora, impact investments) Provide technical support and tools for rapid assessments and integrate findings into national strategies	Reduced reliance on donor funds; sustainable and diversified MNH financing base
Strengthen accountability and transparency in MNH resource use	Institutionalise public expenditure tracking at the facility and county levels	Publish and disseminate national MNH expenditure reviews Strengthen oversight through parliamentary committees, the Controller of Budget, and the Auditor General Employ MNH sub-specialists (e.g., neonatologists, obstetric anaesthetists) to strengthen accountability for quality outcomes	Transparent and accountable MNH financing; strengthened citizen and political trust; specialist expertise integrated into oversight and service delivery
Expand financial protection for households	Enrol mothers into SHIF/SHA at ANC and maternity Provide support for indigent/ vulnerable mothers	Expand the SHIF benefit package to cover maternal and newborn services fully Design and fund subsidy schemes for poor households	Reduced out-of-pocket costs; universal financial protection for MNH

4.6. PILLAR 6: MATERNAL NEWBORN HEALTH WORKFORCE

A motivated, skilled workforce is the backbone of high-quality MNH care. While Kenya benefits from a national HRH policy and active CHP networks, shortages of neonatal nurses and midwives, inequitable staff distribution, and limited mentorship undermine care quality, especially in high-burden counties. Challenges in motivation, career progression, and retention further weaken service delivery. This pillar seeks to expand workforce capacity by scaling up pre-service and in-service training, having specialised cadres, and improving recruitment, deployment, and retention mechanisms to ensure that all counties have the required human resources to provide comprehensive MNH care.

Table 14. SWOT analysis for interventions to address MNH workforce gaps

Strengths

- National HRH policy in place to guide workforce planning and deployment
- Ongoing EmONC and newborn care training initiatives improving provider competencies
- Strong CHP network supporting community-based MNH
- Existing pool of trained health professionals across cadres
- The health sector contributes approximately 2.04% of GDP, with trends ranging between 1.95% and 2.18% (3-year moving averages, MoH–KHLMA 2023).

Weaknesses

- Severe shortage of neonatal nurses and midwives with advanced skills [Only 10% of facilities have a clinician, 21% have access to obstetrician-gynaecologist, and 41% have paediatricians; overall human resource availability is 63% (MOH-KHFC 2023).
- Gaps in night/weekend coverage in high- volume maternity units.
- Weak human resource for health coordination among county governments and between national and county
- levels of government, with inadequate management and leadership capacity.
- Inequitable distribution of health workers across geographical and levels of care.
- Financial constraints affecting remuneration, absorption of skilled professionals, and recruitment of additional staff due to rigid county budget ceilings (MoH–KHLMA 2023).
- Severe shortage of midwives.

Opportunities

- Potential to develop MNH Centres of
- Excellence for continuous mentorship.
- Use of e-learning platforms and ODeL for rapid refresher training and scale-up of competencies.
- Incentive schemes to attract and retain staff in hard-to-reach areas.
- Inclusion of the required skills and competencies in pre-service curricula.
- Evidence shows a strong correlation between workforce density and health outcomes: for every 5,400 health workers employed, there is at least one additional year of life expectancy gained (R^2=0.8698, p<0.001) and reduced risk of maternal mortality (R^2=0.9253, p<0.001) (MoH– KHLMA 2023).
- Existence of a digital learning platform for tracking performance.
- Availability of simulation mentorship models and interprofessional training.

Threats

- Attrition due to burnout, migration, and poor working conditions.
- Limited budgetary space for new hires.
- Persisting preventable maternal and neonatal deaths from causes such as PPH, hypertensive disorders, prematurity, intrapartum asphyxia, and sepsis despite increased facility deliveries (KNBS & ICF 2023; WHO & UNICEF 2020).
- Chronic challenges, including inadequate numbers of health workers and specialists, low morale, prolonged strikes, and variable competence levels (MoH–KHLMA 2023).
- Disparities in remuneration between national government and county governments.
- Nurse midwives change overs and transfers despite mentorship on EMONC.

Table 15. Priority interventions to address MNH workforce gaps

Objective	County Interventions	National Interventions	Expected Outcomes
Ensure an adequate, competent, and motivated MNH workforce	Report staffing needs Employ more healthcare providers Implement staff motivation schemes	Recruit & deploy staff per MOH norms Set staffing standards and incentives	Adequate and distributed MNH staff across facilities
Strengthen MNH training, skills, and competencies	Ensure providers attend yearly EmONC & newborn care refreshers Facilitate logistics for training and mentorship. Implement on-the-job EmONC/ newborn training with online ODEL Conduct skills/competency evaluations	Develop, review & accredit EmONC/newborn care curricula Provide virtual learning platforms Support training in specific competencies required for EWENE Revise HRH plans to include training time	Providers trained, retrained, and assessed regularly on core MNH/EWENE skills
Institutionalise mentorship and continuous learning	Participate in county referral hospital learning hubs for mentorship & drills Apply lessons from hub-to-facility networks	Fund, operationalise & provide technical support for skills-based learning hubs Establish national mentorship networks	Sustained mentorship, peer learning, and continuous quality improvement
Ensure dissemination and compliance with MNH guidelines & SOPs	Enforce guideline/SOP use in daily practice Integrate SOPs into routine service delivery	Develop, update & disseminate national MNH guidelines/SOPs Monitor adherence	Standardised evidence-based MNH care nationwide

Objective	County Interventions	National Interventions	Expected Outcomes
Introduce the neonatal nursing cadre and enforce staffing ratios	Apply WHO-recommended neonatal nurse-to-patient ratios	Introduce neonatal nursing cadre into HRH norms Define & enforce staffing ratios nationally	Safer newborn care, reduced overload on staff.
Improve workforce planning and productivity	Conduct on-the-job evaluation of skills and productivity Include productivity in appraisals	National HRH pipeline planning (training → deployment → retirement) Equitable maternity/neonatal workforce planning Employ MNH sub-specialists (e.g., neonatologists, obstetric anesthetists) to strengthen accountability for quality outcomes	Efficient, equitable workforce deployment with accountability for productivity
Strengthen pre- service and academic training for MNH	Match pre-service training with service needs, including online classes	Orient pre-service lecturers on MNH global targets and EWENE/ ENAP/EPMM Advocate for integration of newborn care training into paediatrics/child health curricula	Future workforce trained on MNH standards and EWENE competencies from the start
Promote motivation, retention, and recognition	Implement local rewards (certificates, recognition)	Establish national incentive frameworks for hard-to-staff counties Provide housing and hardship allowances	Improved morale and retention, especially in underserved counties

4.7. PILLAR 7: RESPONSE & RESILIENCE

The capacity to respond rapidly to obstetric and newborn emergencies determines survival in critical moments. Kenya has referral guidelines and some ambulance capacity, but delays in transfer, lack of neonatal-specific transport, and weak coordination remain major contributors to preventable deaths. Embedding referral timeliness KPIs, equipping ambulances for neonatal care, and operationalising county-level referral coordination will strengthen system resilience and save lives during emergencies.

Table 16. SWOT analysis for interventions to address response and resilience gaps

Strengths	Weaknesses
• Strong national commitment to strengthening the health system to ensure responsiveness and resilience e.g. existing referral guidelines. • Infrastructure availability: 80% of facilities have reliable power and water, with 87% connected to the national grid and 45% accessing piped/municipal water (MoH–HFC 2023). • Existence of national preparedness plans. • Policy framework: Kenya Emergency Medical Care Policy (2020-2030) and Kenya Emergency Medical Care Strategy (2020- 2025): that outlines emergency response, training, and infrastructure. • Devolved health systems: County Departments of Health mandated to provide emergency services, emergency infrastructure, and ambulance services. • Community-based health systems/ structures: that can rapidly mobilize during emergencies and provide timely referrals. • Public-Private Partnership: NGOs and private hospitals to enhance emergency response capabilities. • Health financing: Emergency and critical care fund within Social Health Authority (SHA). • Political will: Emergency medical care in the Constitution, Health Act (2017) and Emergency and Critical Care Fund.	• Limited budget allocation for essential medical products and technologies to support resilience. • Space constraints in some facilities limit service expansion. • Weak referral systems: Poor linkages between lower-level and referral facilities, as well • as limited communication mechanisms for consultations. • Emergency and transport gaps: Insufficient ambulances and poor inter-county coordination for neonatal emergencies. • Fragmented coordination across counties and between the public and private sectors. • Knowledge gaps: 50.5% of maternal and 64.8% of neonatal deaths due to failure to recognise danger signs; 29.2% of maternal deaths linked to lack of awareness of available services (MPDSR 2024). • Lack of National coordination mechanism: to link the three stages of emergency responses; at the scene of incident, ambulance transportation, and health facilities. • Fragmented referral pathways: due to lack of standardized protocols and poor coordination between facilities leading to delays and inefficiencies. • Insufficient number of health-care providers trained on emergency care to respond effectively and efficiently. • Infrastructural gaps: facilities lacking essential emergency equipment, medications, trauma care units, and limited ambulance coverage. • Real-time data system: for urgent response, decision making and resource mobilization. • Communication gaps: poor inter-facility communication compromise decision-making and coordination. • Low public awareness on emergency response: e.g., lack of knowledge on danger signs on obstetric and neonatal emergencies, to necessitate timely response and referral.



Opportunities

- Existing infrastructure base can be expanded to improve service delivery.
- Facility Improvement Fund can incentivise counties to invest in neonatal services and reward performance; inclusion of neonatal services in UHC packages can reduce household costs.
- Infrastructure investment opportunities to scale up neonatal ICUs and HDUs across counties.
- County-level planning offers scope to tailor
- EWENE implementation to local needs.
- Bundled newborn care approaches can integrate affordable essential interventions.
- Private sector engagement, including CSR initiatives, can drive innovation and recognition (e.g., newborn awards).
- Adoption of emerging digital technologies, including AI and large language models, to strengthen data, referral, and clinical decision support systems.
- Digital Health integration: Mobile apps and digital referral tracking to streamline emergency responses and referrals.
- Decentralization of services: strengthening county-level emergency systems to reduce burden on national referral hospitals.
- Training and capacity building: scaling up emergency medicine and simulation-based training for healthcare providers.
- Global support: donor funding and technical assistance from global health organizations.
- Public-private partnerships: collaborations with private ambulance services, telecoms, and logistics firms can enhance reach and efficiency.
- Community engagement: empowering community members and CHPs to improve early detection, triage, and referralcompliance
- Review of Emergency and Referral Guidelines, protocol and tools: To incorporate the updates on MNH.
- Establish Counties Emergency and rescue and support (E&RS) command/call center: for efficient coordination and timely execution.



Threats

- Persistently high out-of-pocket costs for households.
- Inadequate public budget allocations to health and MNH specifically.
- Variations in health outcomes across counties highlight inequities in access and quality (KNBS & ICF 2023).
- Weak health system capacity undermines resilience to shocks and sustainability of services.
- Funding gaps of the national preparedness and resilience plans (MOH 2022 to2026 plan).
- Political and bureaucratic delays: policy implementation can be slowed by administrative bottlenecks.
- Inadequate emergency-fund allocation by the national and county governments: inconsistent budget allocations threaten implementation and sustainability.
- Urban-Rural disparities: rural populations often lack access to timely emergency care due to geographic and infrastructural barriers.

Table 17. Priority interventions to address MNH Resilience and response workforce gaps

Objective	County Interventions	National Interventions	Expected Outcomes
Ensure MNH resilience and preparedness are integrated in national disaster and preparedness plan	Adapt national disaster and preparedness plans to produce resilience and preparedness plans informed by local context.	Revise national disaster preparedness plans to integrate MNH resilience and preparedness plans	≥90% of MNH services are available and sustained during disaster and emergencies.
Expand and strengthen facility readiness for critical maternal & newborn care	Adapt national disaster and preparedness plans to produce resilience and preparedness plans informed by local context.	Fund & equip HDUs/NICUs Include newborn care equipment in procurement plans Provide technical specifications for equipment Equip L5/L6 hospitals with NICUs (1–2 beds/1000 LVB)	Expanded access to critical care for mothers & newborns Reduction in preventable deaths from prematurity, asphyxia, and PPH
Institutionalise risk management and clinical governance	Implement facility-level risk management and governance systems Conduct supportive supervision	Develop tools for risk management and clinical governance tools Link funding to the achievement of targets with an enabling environment assured	Safer MNH services Improved compliance with national standards
Strengthen resilience during emergencies	Develop facility-specific preparedness & rapid response teams Train counties on minimum initial service package (MISP)	Finalise and integrate MISP into national disaster response frameworks	MNH services integrated into emergency preparedness & disaster response
Increase enrolment and financial protection under SHA/ SHIF	Enroll mothers at ANC Confirm via digital communication (SMS)	Develop rebate/reward systems for ANC first-trimester attendance and eight visits	Higher financial coverage for MNH Improved ANC uptake

Objective	County Interventions	National Interventions	Expected Outcomes
Assure patient safety through infection prevention and control	Implement IPC protocols Display SOPs at service points Conduct audits Enforce SOP use	Ensure enforcement and resourcing of IPC measures Disseminate IPC guidelines Provide technical support	Reduced infections, safer facilities for mothers and newborns
Promote early and consistent ANC attendance	Develop tracking tools. Map all pregnant women at the community level Establish tracking systems	Develop and disseminate national tools for ANC tracking	Increased ANC coverage, early risk detection, improved maternal– newborn outcomes

4.8. PILLAR 8: COMMODITIES & TECHNOLOGIES

Lifesaving MNH commodities eg. oxytocin, tranexamic acid, magnesium sulphate, corticosteroids, and surfactant are on Kenya's essential medicines list; however, stockouts, poor supply chain responsiveness, and suboptimal maintenance of critical equipment (CPAP, phototherapy, incubators) compromise care. By establishing a predictive stock management system, securing ring-fenced financing for essential supplies, and maintaining sustained equipment contracts, Kenya can ensure that every facility is ready to save lives every day.

Table 18. SWOT analysis for interventions to address the commodities and technologies gaps

Strengths

- National Essential Medicines List includes MNH life-saving commodities.
- Commodity logistics systems already in place via KEMSA.
- Introduction of CPAP and oxygen plants in some counties.
- Expand digital logistics monitoring and digitization in all counties.

Weaknesses

- Frequent stockouts of oxytocin, TXA, $MgSO_4$, ACS, caffeine citrate and surfactant.
- Poor maintenance of equipment; lack of calibration.
- Uneven access to essential newborn technologies (CPAP, phototherapy, pulse oximeters).

Opportunities

- MOH has a list of life-saving commodities for MNH
- Digital stock management tools to predict shortages.
- Public–private partnerships for equipment supply and maintenance.
- Staff capable of quantification and projections are available at the national and county levels.
- Pooled ordering of commodities.
- Operationalization of the Social Health Insurance Fund (SHIF) and Primary Health Care (PHC) Fund provides a new window to ring-fence financing for MNH commodities and equipment maintenance.

Threats

- Limited budget allocation for commodities and technologies.
- Procurement delays due to bureaucratic bottlenecks.
- Inflation affecting commodity costs.

Table 19. Priority interventions to address the commodities and technologies gaps

Objective	County Interventions	National Interventions	Expected Outcomes
Strengthen forecasting and quantification	Conduct annual county MNH quantification Train county/facility staff on forecasting	Develop a national framework for MNH quantification Provide training and mentorship	Accurate, evidence-based forecasts that reduce stock-outs and overstocks
Standardise commodities through KEML	Use KEML specifications for procurement	Update and expand KEML with maternal and newborn commodities Incorporate a comprehensive MNH commodities list into KEML Disseminate KEML nationally	Standardised and quality-assured MNH commodities across all counties
Ensure continuous availability and quality of lifesaving commodities	Provide PPH bundles (uterotonics, tranexamic acid, balloons, IV fluids) in all facilities Maintain oxygen supply and essential newborn commodities (chlorhexidine, KMC items, surfactant) Monitor commodity quality for NICU supplies	Include PPH bundles and newborn commodities in KEML/essential lists Enforce QA through PPB/ KEMSA Support local manufacturing and quality assurance	Uninterrupted supply of safe and lifesaving maternal and newborn commodities
Improve procurement, warehousing and last- mile delivery	Strengthen county procurement and warehousing Share stock and delivery data with national HPT teams	Expand KEMSA/national warehouse capacity Coordinate last-mile delivery through national HPT teams	Reliable and efficient delivery of commodities to facilities
Strengthen stock management and reporting	Train staff on LMIS Conduct routine stock audits Submit monthly stock reports	Strengthen national LMIS Aggregate/analyse county data and provide feedback	Timely, accurate stock data supporting supply decisions
Promote rational and prudent use of commodities	Enforce rational-use protocols at facilities Strengthen accountability to prevent misuse or theft	Issue national guidelines on prudent use Monitor adherence via audits	Reduced misuse, wastage, and theft of MNH commodities

Objective	County Interventions	National Interventions	Expected Outcomes
Expand access to MNH equipment and emergency transport	Procure lifesaving equipment (resuscitation kits, CPAP, incubators) Equip enhanced care units in maternity wards Procure and maintain ambulances with oxygen, resuscitation kits, and staff Report ambulance functionality regularly	Set standards for emergency transport (ambulances, staff, equipment) Procure/distribute standardised equipment and ambulances Provide national kits for enhanced care units Review and revise the 2014 referral guidelines	Facilities and referral systems fully equipped for maternal and newborn emergencies
Digitise MNH supply chain management	Use e-LMIS/digital tools for forecasting and reporting Input county data into dashboards	Develop and maintain a national MNH commodities dashboard -Digitally monitor commodity flows, warehousing, and last-mile delivery	Real-time visibility enabling proactive supply chain management
Secure sustainable financing	Allocate and ringfence county budgets for commodities Advocate with assemblies for MNH commodity funding	Mobilise domestic/partner financing Advocate for Treasury allocations for MNH commodities Integrate MNH commodities into SHIF/SHA packages	Sustainable financing ensuring commodity security
Promote innovations and scale-up	Pilot and adopt proven MNH technologies Document county-level innovations	Map MNH innovations nationally Support innovation hubs, PPPs, and accelerators Facilitate national scale-up of proven technologies	Evidence-based MNH innovations scaled to improve outcomes
Strengthen governance and coordination	Participate in county commodity TWGs Provide data to national HPT structures	Use national HPT platforms to harmonise partner support and oversee last- mile delivery	Strong national–county coordination ensuring a harmonised MNH supply chain

4.9. PILLAR 9: ADVOCACY, COMMUNICATION, ACCOUNTABILITY, AND COMMUNITY ENGAGEMENT

Advocacy, communication and community engagement are the backbone of sustained MNH. Advocacy influences political will, policies, and resources to ensure supportive systems and funding for MNH, while communication empowers individuals, families, and communities with knowledge and motivation to adopt healthy practices such as skilled birth attendance, breastfeeding, and family planning and community engagement ensures full ownership of MNH services, willingness to use them.

For successful MNH campaign like EWENE require strong Advocacy, communication and community engagement strategies for political commitment, adequate funding, integration of the campaign priorities into health policies for sustainability, community awareness, participation and adoption of MNH practices like skilled birth attendance and antenatal care and inspired lasting behaviour change with a full community ownership

Table 20. SWOT analysis for interventions to address Advocacy, communication and community engagement



Strengths

- Good political will from GOK and policy enviroment for MNH
- Existing community health structures (CHCs, CHPs, HFCs) trained on MNH modules and involved in implementation
- The MPDSR and Neonatal Child Death Audit process has created a culture of case review.
- Well trained skilled birth attendants on EMONC
- Digitization- E-CHIS/KHIS to integrate data and timely reporting.
- Existing community scorecard and public barazas to collect feedback on EWENE/MNH implementation.
- Community Health Promoters engaged in MNH activities
- Some counties use community scorecards for health services.
- Media coverage and CSOs actively engaged in health advocacy ,public awareness and social mobilization
- Supportive legal and policy framework (PHC Act 2023, Health Act 2017)
- Existence of national MNH policies, strategies, and frameworks (e.g. Kenya Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCAH) policy).



Weaknesses

- Low prioritization of allocation of funds for MNH at national and county levels
- HFMCs are incapacitated in financial management literacy
- Poor coordination of MPDSR reporting and monitoring
- Limited public access to MNH performance data.
- Community engagement is often ad-hoc, not systematically linked to quality improvement.
- Fragmentation of efforts and resources from partners with multiple civil society organizations working independently and without strong coordination mechanisms.
- Capacity gaps in social accountability mechanisms
- Inconsistent representation of women and youth in CHS
- Poor and inconsistent remuneration of CHPs
- Fragmented advocacy and communication efforts with limited coordination among stakeholders.
- Low male involvement and cultural barriers affecting uptake of MNH services.
- Poor response on maternal and newborn deaths from the licensing bodies(KMPDC and NCK)



Opportunities

- Community/EWENE scorecards can be made public to drive social accountability.
- RMNCAH Advocacy and communication Strategy
- Vibrant ecosystem players in the MNH space that are pushing for accountability, including CSOs, donors, and other institutions.
- media can be partners in amplifying public awareness on MNH
- Global push for respectful maternity care and patient rights.
- Scaling up community-linked interventions across antenatal, labour, delivery, and newborn care could prevent up to 61% of neonatal deaths and 50% of maternal deaths by 2030 (WHO & UNICEF)
- There is a national focus on social accountability and good governance Devolution of health services allows county-level advocacy tailored to local needs.
- Use of mobile technology and social media to reach wider audiences such as , SMS PROMPT messages)



Threats

- Political sensitivity around poor-performing counties/facilities.
- Community mistrusts if feedback is not acted on.
- Disregard for community input in planning and implementation processes.
- Weak accountability mechanisms of civil society organizations, including the absence of champions or oversight bodies at the county and sub-county levels.
- Limited sustainability once partner funding ends
- Economic constraints limiting health budgets and community outreach.

Table 21. Priority interventions to address Advocacy, communication and community engagement gaps

Objective	County Interventions	National Interventions	Expected Outcomes
Enhance coordination mechanisms at all levels with civil society and stakeholders locally and at the global level	Map all stakeholders, including civil society, and develop a repository. Launch the RMNCAH coordination hub and adolescent platform Domesticate a public participation framework on MNH implementation strengthen TWGs Leverage on existing GOK structures to action Treasury and counties to prioritize MNH Financing while prioritizing EWENE pillars	Review community governance guidelines to reinforce accountability of MNH interventions. Disseminate the revised national guideline on community governance. Roll out the training of the CHCs across the nation using the revised guidelines.	Functional CHC Governance structures
To strengthen the financial literacy levels of Health Facility Management committees	Build the Capacity of the Community Committee Audits on MPDSR & Neonatal Child Audit Develop and disseminate bi-annual MPDSR reports to county executives Establish Community audit committees Activate Community QITs and WITs	Dissemination and availability of the MPDSR /Neonatal Child audit tools. Support the digitization of MPDSR Disseminate the revised KQMCH to the counties Develop an MPDSR/Neonatal Child Health audit tracker	Functional and responsive community-based MPDSR systems
Strengthen MNH information Visibility accessibility, coordination and feedback mechanisms at all levels	Develop RMNCAH advocacy and Communication plans- Revive the RMNCAH websites to strengthen visibility of MNH information and updates Scale up and regularize the community scorecards, linking facility performance with community feedback and partner commitment Utilize EWENE champions to discuss key MNH messages and priority areas Sensitize Media practitioners and champions on MNH Issues	Support oversight on the quality of MNH services through ensuring compliance with standards. Explore mechanisms of accreditation of health facilities based on standards and levels of care Timely dissemination and interpretation of survey results Develop an advocacy and Media kit related to EWENE	Effective MNH Data access, visibility, and feedback mechanism framework

Expected Outcomes	Expected Outcomes	Expected Outcomes	Expected Outcomes
Enhance coordination mechanisms at all levels with civil society and stakeholders locally and at the global level	Map all stakeholders, including civil society, and develop a repository Launch the RMNCAH coordination hub and adolescent platform Facilitate regular RMNCAH stakeholders' meetings Domesticate a public participation framework on MNH implementation strengthen TWGs Leverage on existing GOK structures to action Treasury and counties to prioritize MNH Financing while prioritizing EWENE pillars	Map all stakeholders, including civil society, and develop a repository Support the digitization of social accountability; and coordination etc Facilitate regular stakeholders' meetings Develop and disseminate a public participation framework on MNH implementation Spearhead social accountability ahead and capacity building of CSOs. Institutionalize partnerships with academia, the private sector, and global networks Hold stakeholder meetings with policy makers on drivers and barriers on MNH implementation Leverage international collaborations for MNH innovation and adoption of best practices.	Strong collaborative ecosystem advancing MNH at the community, national, and global levels.
Advocate for increased allocation, ring-fencing, and utilization of funds for MNH at national and county levels.	Ring-fence county-level MNH funds within County Integrated Development Plans (CIDPs) and annual budgets. Strengthen financial tracking systems for MNH spending. Advocate for county assemblies to protect MNH allocations.	Integrate MNH as a budget line in the National Treasury and Ministry of Health (MoH) budget. Develop national MNH investment case and financing strategy.	Increased and sustained MNH funding.
Conduct high level advocacy with key policy and decision makers at national and sub-national levels (the Executive, Legislature, Media and donor) for leadership, commitment, and accountability on maternal and newborn health	Engage Governors, County Executives, and Assemblies through county MNH forums. Create county-level MNH champions (political, faith-based, community leaders)	Engage the Executive, Parliament, development partners, and media on MNH priorities. Institutionalize annual national MNH advocacy and accountability forum.	Increased political will and visibility of MNH.

Expected Outcomes	Expected Outcomes	Expected Outcomes	Expected Outcomes
Increase public awareness and education campaigns to amplify the importance of timely identification and response to danger signs for maternal and newborn deaths for positive behavior change	Conduct national wide mass media campaign on EWENE use of both national TV and local radio stations, Social media ,community drama and art. Conduct community sensitization forums, such as barazas, chief's meetings, and women's group sessions, to educate families on MNH danger signs. Establish community-based surveillance, emergency response, and referral systems for rapid action when complications occur.	Campaigns on maternal and newborn danger signs and prevention of deaths Finalize and implement a national RMNCAH advocacy and social behavior change communication (BCC) strategy Partner with national media houses to run Integrate MNH communication into existing UHC and RMNCAH frameworks and national health promotion policies. Collaborate with faith-based organizations, private sector, and influencers to amplify public messages.	Increased public knowledge on maternal and newborn danger signs.
To capacity build CHPs to dispel myths and misconceptions on MNH	Train CHPs and community health assistants (CHAs) on accurate MNH information and effective community engagement. Conduct refresher trainings and mentorship sessions to strengthen CHPs' capacity to address myths and misconceptions in their communities. Provide CHPs with culturally appropriate IEC materials (posters, flip charts, visual aids) in local languages.	Review and update national CHP training curricula and guidelines to include modules on MNH myths, misconceptions Partner with national training institutions and MoH divisions to institutionalize continuous professional development (CPD) for CHPs on MNH communication	Improved CHP knowledge, confidence, and communication skills on MNH. Increased community trust and reliance on CHPs for accurate MNH information.

Expected Outcomes	Expected Outcomes	Expected Outcomes	Expected Outcomes
To Advocate for infrastructural investment to improve access to better road networks, especially in rural and underserved areas, to ensure year-round accessibility to health facilities.	Identify and map priority health facility access roads requiring construction or rehabilitation. Engage community leaders to support road maintenance through local initiatives. Establish partnerships with local transport providers to strengthen emergency transport availability	Engage the National Government Ministries (Transport, Roads, Planning, and Health) to prioritize road improvement in health access corridors. Integrate MNH-access roads into national infrastructure plans, Vision 2030, and UHC agendas. Advocate for inclusion of "health facility access roads" in national annual development budgets	Reduced delays in reaching care (Second Delay)..
Budget allocation for accelerating innovative approaches like SMS PROMPTS, and toll-free emergency helplines for timely communication and monitoring of MNH.	Allocate county-level funds to implement and sustain digital MNH refer SMS follow-ups, and emergency toll-free lines Collaborate with mobile service providers to ensure network access in rural areas.	IIntegrate digital health innovations SMS alerts, and toll-free hotlines into national MNH and RMNCAH strategies Establish national public–private partnerships (PPPs) to scale up successful digital MNH models. Allocate funding within the national health and ICT budgets to support innovation in emergency referral and communication systems	Improved real-time communication and referral during maternal and newborn emergencies. Increased use of digital tools for MNH monitoring and follow-up.
Engaging male partners and family decision-makers in maternal health discussions to promote shared responsibility.	Organize community dialogue sessions and couple-focused education on shared decision-making for birth preparedness and complication readiness. Promote male-friendly health facility services (e.g., flexible clinic hours, joint counseling sessions). Train CHPs and health workers to actively engage male partners and family influencers during ANC, delivery, and postnatal visits.	Integrate male engagement strategies into national RMNCAH, UHC, and community health policies Conduct national campaigns and media programs highlighting men's roles in supporting maternal and newborn health. Include male involvement indicators in national MNH and CHS monitoring frameworks.	Increased male and family participation in maternal health care and decision-making.

Expected Outcomes	Expected Outcomes	Expected Outcomes	Expected Outcomes
Advocate for engagement of the private sector at all levels of the MNH spectrum including but not limited to data mainstreaming and management; implementation of national MNH policies, guidelines and standards; MNH health finance allocation;	Create county-level PPP coordination platforms for joint MNH planning, implementation, and data review. Build capacity of private facilities to adopt and implement national MNH standards, guidelines, and quality-of-care protocols. Advocate for private sector co-investment in county-level MNH financing and service delivery initiatives.	Establish incentive models (e.g., tax benefits, performance-based contracts) to encourage private investment in MNH infrastructure and innovation. Develop a national MNH public–private partnership (PPP) framework to guide collaboration in financing, service delivery, data sharing, and quality assurance. Institutionalize mechanisms for private sector representation in national MNH technical working groups, policy development, and accountability forums.	Strengthened partnerships and alignment between public and private health sectors in MNH delivery.
Review SHA benefit package for comprehensive MNH care to include better care for Anti-D serum, management of complications and ANC Profile a. Strengthen public and private sector collaboration to accelerate the efficient implementation of SHA for MNH b. public awareness and social mobilization of uptake, utilization and optimization of SHA and other health insurance packages on MNH..	Engage county health departments and health facilities to identify service gaps and unmet needs within the current SHA package. Strengthen linkages between public, private, and faith-based facilities to ensure smooth claims processing and service delivery under SHA.	Conduct a national review of the SHA benefit package to assess coverage gaps in essential MNH services, including Anti-D serum, ANC profile, emergency obstetric and newborn care, and postnatal services. Develop costed proposals to include management of obstetric and neonatal complications (e.g., eclampsia, PPH, neonatal sepsis) in the SHA benefit package. Strengthen monitoring and accountability mechanisms to ensure timely reimbursement and service quality across accredited facilities. Develop and implement a national communication and advocacy strategy to promote SHA enrollment and awareness of MNH benefits. Establish a national monitoring framework to track MNH service utilization trends under SHA.	Comprehensive MNH coverage within SHA, reducing out-of-pocket expenses for women and families. Higher enrollment and utilization rates of maternal and newborn health services under SHA.

4.10. PILLAR 10: RESEARCH, INNOVATION & KNOWLEDGE EXCHANGE

Kenya has a vibrant research community and has piloted promising MNH innovations. Yet, the absence of a national innovation pipeline, weak policy–research linkages, and limited dissemination mean that proven solutions often remain in the pilot phase (UNICEF 2025). Establishing an MNH Innovation Taskforce, creating a national repository of proven interventions, and hosting annual evidence-to-policy forums will accelerate the adoption of effective innovations at scale.

Table 22. SWOT analysis for priority interventions to address research, innovations and knowledge exchange gaps



Strengths

- Research institutions and universities actively engaged in MNH studies.
- Kenya has piloted innovations such as CPAP, digital ANC tracking, and Uterine Balloon Tamponade.
- Some counties open to piloting new approaches.
- Many health workers hold master's degrees, equipping them with the capacity to undertake research and contribute to evidence generation.
- Strong research infrastructure supported by networks of scientific and ethical research committees.



Weaknesses

- Limited budget allocation from the national level to support health research and innovation activities.
- Weak integration of research findings into policy and practice.
- Lack of central repository for MNH innovations and evaluations.



Opportunities

- Potential to scale proven pilots nationally.
- Leveraging Kenya's governance framework for research and innovation to drive improvements in maternal and newborn health outcomes.
- Existence of government-facilitated research agencies, institutes, and regulatory bodies to strengthen evidence generation and application.
- Potential to expand partnerships and collaborations with academia, the private sector, and development partners to scale up impactful innovations.



Threats

- Risk of fragmented, short-term pilots without sustainability planning.
- Innovation fatigue can occur among facilities when change is constant.
- Failure to implement research findings and recommendations, limiting the translation of evidence into policy and practice.

Table 23. Priority interventions to address research, innovations and knowledge exchange gaps

Objective	County Interventions	National Interventions	Expected Outcomes
Set and coordinate MNH research priorities	-Identify county-specific MNH research priorities -Align county research with national RMNCAH and newborn & child health agenda.	-Develop and disseminate a national MNH research agenda, including a newborn & child health research agenda -Disseminate the RMNCAH research agenda to all stakeholders -Support county research (funding, mentorship, technical guidance)	Harmonised national and county MNH research priorities aligned to EWENE, ENAP, EPMM.
Build capacity and an enabling environment for operational and implementation research	Train county/facility staff in operational and implementation research Institutionalise protected time for staff to undertake research Facilitate evidence generation to fill knowledge gaps in service areas	-Develop HRH policies mandating protected time for research -Partner with universities, research institutions, and development partners -Develop regulatory and ethical frameworks for MNH clinical research.	Strengthened national and county capacity to generate and apply MNH evidence.
Promote translation of research into policy and practice	-Apply research findings in county MNH plans and service delivery -Institutionalise journal clubs at the facility/county level -Hold annual targeted meetings with CHMTs to review and apply research findings.	-Institutionalise national knowledge translation platforms (policy briefs, technical dialogues) -Ensure integration of evidence into MNH policies and guidelines.	Research systematically translated into MNH policies and practice.
Strengthen knowledge management and exchange	-Document and share best practices at the county/facility level -Hold county learning and best practice forums -Participate in inter-county learning visits.	-Facilitate national fora to document and disseminate best practices -Establish national MNH knowledge hubs and digital repositories -Hold annual MNH research forums with academia and partners -Convene inter-county and national peer learning platforms.	Institutionalised platforms for continuous MNH learning and exchange across counties..
Promote, finance and scale up MNH innovations	--Adopt and pilot local innovations in service delivery -Document innovations for potential scale-up.	-Conduct mapping of existing MNH innovations for national scale-up -Support innovation hubs, accelerators, and PPPs.	Scaled-up innovations improving efficiency, access, and quality of MNH services.
Enhance collaboration with academia, the private sector and global partners	-Collaborate with universities, FBOs, and the private sector to conduct applied/operational research.	-Institutionalise partnerships with academia, the private sector, and global networks -Leverage international collaborations for MNH innovation and evidence generation.	Strong collaborative ecosystem advancing MNH research, innovations, and knowledge exchange.

Figure 21. Game Changer (Interventions)

National EWENE Delivery Unit
A dedicated unit within the Ministry of Health, empowered to track KPIs weekly, resolve bottlenecks in real time, and enforce accountability from facility to county to national level.

Ring-fenced Last-Mile Fund
A rapid-release financing mechanism to guarantee uninterrupted availability of life-saving commodities, prevent stockouts, and maintain constant service readiness in all facilities

Readiness & Drill Culture
Standardised, colour-coded emergency sets trays for PPH, pre-eclampsia, and sepsis in every maternity unit, reinforced through mandatory monthly simulation drills to keep teams prepared for high-risk events.

Immediate Kangaroo Mother Care (KMC) as Standard Practice
Institutionalised for all eligible newborns, supported by redesigned ward spaces, integrated mother–newborn care teams, and staff training to make immediate KMC the norm rather than the exception.

Real time MNH Scorecard
A transparent, public-facing dashboard updated monthly at the county level to monitor progress, drive peer learning, encourage healthy competition, and sustain political and community accountability







GAME CHANGER DELIVERY MECHANISMS





5. FRAMEWORK FOR IMPLEMENTING THE EWENE ACCELERATION PLAN

This section outlines the coordination and administration mechanisms for the EWENE Acceleration Plan.

5.1 Coordination framework and administrative mechanisms

The Rapid Response Initiative (RRI) will be delivered through a coordinated national–county governance structure to ensure strong political leadership, technical oversight, and effective day-to-day execution. The National and County Governments will implement this Acceleration Plan using existing coordination and administrative mechanisms.

At national level, the National Steering Committee (NSC) chaired by the Cabinet Secretary for Health and co-chaired by the Chair of the CoG Health Committee will provide policy direction, mobilize resources, review national performance, and resolve cross-cutting system bottlenecks. It will align partner support through strengthened MNH coordination platforms and report RRI performance and key decisions to the Office of the President. The National Technical Committee (NTC), chaired by the Director-General for Health, will provide technical leadership, validate guidance, conduct advanced data analysis, and coordinate surge support and partner alignment through sub-committees for M&E, Service Delivery, and Advocacy.

An RRI Secretariat housed in the RMNCAH Division/Directorate of Family Health will manage day-to-day coordination, documentation and communication, provide direct county support, and produce concise, data-driven performance briefs for executive leadership.

Counties will elaborate on their acceleration activities and annual work plans, as detailed in this National EWENE Acceleration Plan, following a rapid assessment to identify their needs. At county level, a County RRI Steering Committee chaired by the CECM Health (co-chaired by the Chief Officer) will lead implementation and resource stewardship, with the CECM reporting to the Governor and through CoG mechanisms. A County RRI Technical Committee chaired by the County Director of Health will coordinate operational plans and performance monitoring with CHMT, SCHMT, high-volume facilities, and partners. Designated national officers will support counties to strengthen reporting and communication between national and county levels.

5.2 Legal and regulatory framework

As this is an extract from reports and guidelines, the following documents legal, policy, guidelines, and manuals-should be read in conjunction with the Acceleration Plan.



- Constitution of Kenya 2010
- Kenya Health Sector Strategic Plan 2023-2028
- The National Reproductive Health Policy 2022 -2032
- RMNCAH investment case 2025
- National Guidelines on Quality Obstetrics and
- Perinatal care, 2020
- National RMNCAH Advocacy and Communication and Social Mobilization Strategy 2025 - 2030
- Comprehensive Newborn Care Protocols: Integrating Technologies with Clinical Pathways 2022
- Core Standards for Quality Healthcare
- Health Labour Market Analysis for Kenya 2023
- Kenya Norms and standards for care of the newborn 2025
- Basic paediatric protocol
- Kenya Health Sector Referral Implementation Guidelines
- Human Resources for Health Norms and Standards Guidelines for The Health Sector
- Newborn investment case – 2025
- National. Infection Prevention and Control Guidelines for Health Care Services in Kenya

5.3 Funding arrangements

The funding for the national and county level activities shall be funded through the national treasury and included in the annual work plans and budgeting cycles at county and national level. Partners shall be engaged for additional resource mobilization to enact interventions as envisioned in this acceleration plan, with indicative costs based on the KHSSP 2023-2028 costed plan and the RMNCAH investment case.

5.4 Implementation, Monitoring, and Evaluation

Since this Acceleration Plan is an extract from existing documents, as detailed under the legal and regulatory frameworks, the monitoring indicators are abstracted from the respective documents' M&E frameworks, Among them being the Kenya Health sector strategic plan, and the global EWENE monitoring indicators, and other process-level indicators to monitor implementation of key interventions. The M&E plan to monitor this acceleration plan over 2 years is included in Table 24. The Division of Reproductive and Maternal Health will be responsible for reporting and documentation of learnings.

5.5 Impact Indicators

Result Area	Indicator	Baseline 2022/23	Target 2027/28	Data Source
Reduction of maternal mortality ratio	Maternal mortality ratio	355	175	Population Census/KDHS
Reduce perinatal deaths	Perinatal mortality rate	32	17	KDHS
Reduction of neonatal mortality rate	Neonatal mortality rate	21	15	KDHS
Reduction in still-birth Rate	Still birth rate	15	12.5	KDHS
Reduction in total fertility rate	Total fertility rate	3.4	3	KDHS
Reduction in teenage pregnancies	Teenage pregnancy rate	15	12	KDHS

5.6 Outcome Indicators

Key Result Area	Output/ Outcome Indicator	Baseline	Data source			Data Source
		24/25	25/26	26/27	27/28	
ANC 4	4th Antenatal Care (ANC) Coverage (%)	49.04%	65%	70%	75%	KHIS
ANC 8	Proportion of 8th contact Antenatal Care (ANC) Coverage (%)	5.66%	30%	40%	50%	KHIS
Skill Birth Attendance	(%) of Deliveries conducted by Skilled Birth Attendants	69.09%	90%	95%	100%	KHIS
Caesarean section	Caesarean section rate	18.97%	13%	12%	12%	KHIS
Post Natal Care-Mother	PNC within 48 hours (mother)	66.55%	70%	80%	95%	KHIS
Post Natal Care-Newborn	PNC within 48 hours (infants)	68.40%	70%	80%	95%	KHIS
Fresh still birth	Fresh still Birth Rate	7.64%	5%	4%	3%	KHIS
Facility Maternal Deaths	Facility Maternal Mortality Ratio (per 100,000 live births)	91	70	50	30	KHIS

5.7. Output Indicators

Policy and Planning						
Key Result Area	**Output/ Outcome Indicator**	**Baseline**	**Targets**			**Data Source**
		24/25	**25/26**	**26/27**	**27/28**	
Policies and Guidelines	% of counties with an EWENE steering committee (established)	0	100	100	100	County
	% of counties holding at least one quarterly EWENE Technical Committee (functionality)	NA	100	100	100	County
	% of counties that held monthly MPDSR committee meeting	41%	100	100	100	HFA-QOC/County records
	% of facilities with maternal and newborn health standards 2021	20%	30%	50%	60%	HFA-QOC
	Proportion of facilities with maternal and perinatal death surveillance committees (MPDSR)	63%	80%	90%	90%	HFA-QOC
	% of facilities with functional newborn child adolescent death audit committee(NCA)	20%	30%	40%	50%	HFA-QOC

MNH Financing						
Key Result Area	**Output/ Outcome Indicator**	**Baseline**	**Targets**			
		24/25	**25/26**	**26/27**	**27/28**	**Data Source**
Domestic financing for health and RMNCAH-National	Amount of national health budget allocated for payment of premiums for indigent /vulnerable women for maternal and newborn SHA cover	910 million	3Billion	6 Billion	6 Billion	MOH
Domestic financing for health and RMNCAH-County	% of counties that have ring-fenced MNH budgets	ND	100%	100%	100%	County
Social Health Insurance	% of county population registered on SHA	??	40%	60%	80%	SHA

Quality of Care						
Key Result Area	**Output/ Outcome Indicator**	**Baseline**	**Targets**			
		24/25	**25/26**	**26/27**	**27/28**	**Data Source**
Availability of national guidelines	% of facilities with National guideline for quality obstetric and perinatal care 2022	24%	40%	70%	90%	HFA-QOC
Availability of national guidelines	% of facilities with comprehensive newborn care protocols 2022	ND	60%	70%	80%	HFA-QOC
Review of maternal deaths	Proportion of Maternal death audited	105.82%	100%	100%	100%	KHIS
Review of neonatal deaths	Proportion of Neonatal Deaths Audited	66.76%	80%	87%	100%	KHIS
Dignified, respectful, and client-centered MNH care	% of clients reporting receiving person-centered maternity care	ND	-	60%	80%	Client exit Survey
% of facilities meeting staffing standards for MNH by level of care	% of level 4 facilities meeting staffing norms for MNH	ND	-	70%	80%	Facility assessment/BEmONC Report
	% of level 3 facilities meeting staffing norms for MNH	ND	-	70%	80%	Facility assessment/BEmONC Report

Gender and Equity

Key Result Area	Output/ Outcome Indicator	Baseline	Targets			
		24/25	25/26	26/27	27/28	Data Source
Gender and Equity	% of women who make their own informed decisions about sexual relations, contraceptive use, and reproductive health care.	64.80%	75%	80%	90%	KDHS
	% of facilities offering adolescent health services	71%	75%	80%	90%	HFA-QOC

Maternal newborn health workforce						
Key Result Area	**Output/ Outcome Indicator**	**Baseline**	**Targets**			
		24/25	**25/26**	**26/27**	**27/28**	**Data Source**
Training of health workers	% of facilities with staff trained on EMONC within the last 2 years	28%	35%	60%	90%	HFA-QOC
	Number of Health workers trained on EMONC (Since 2024)	4000	6000	7000	8000	MOH
	Number of Health workers trained on PAC (Since July 2025)	42	1000	2000	2000	MOH
	Number of Health workers trained on Comprehensive New-born Care	892	1160	1500	1952	MOH
	Number of level 4 and 5 facilities conducting Maternal care mentorship program	0	50	100	150	MOH
	Number of level 4 and 5 facilities conducting newborn care mentorship program	0	50	100	150	MOH
	Correct diagnosis and treatment (PPH)	40%	50%	60%	70%	HFA-QOC
	Correct diagnosis and treatment (Asphyxia)	36%	50%	65%	80%	HFA-QOC

Response and Resilience

Key Result Area	Output/ Outcome Indicator	Baseline	Targets			
		24/25	25/26	26/27	27/28	Data Source
Emergency Services	Availability of a national Emergency transport system for (Y/N)	N	N	Y	Y	MOH
	Proportion of counties with an Emergency operations /referral center	ND	60%	80%	100%	MOH/County
	Proportion of counties with a dedicated referral coordinator	ND	60%	100%	100%	MOH/County

Service Delivery

Key Result Area	Output/ Outcome Indicator	Baseline	Targets			
		24/25	25/26	26/27	27/28	Data Source
Availability of basic Emergency Obstetric and Newborn Care	% of facilities providing delivery services with all 7 Basic Emergency Obstetric and Newborn Care signal functions	37%	50%	60%	80%	HFA-QOC
Availability of comprehensive Emergency Obstetric and Newborn Care	% of level 4 & 5 facilities providing delivery services with all 9 Comprehensive Emergency Obstetric and Newborn Care signal functions	46%	60%	70%	80%	HFA-QOC
Availability of services for small and sick newborn	% of level 4 and 5 facilities providing comprehensive newborn care for the small and sick newborns	60%	75%	90%	100%	HFA-QOC
	% of level 4 and 5 facilities providing management of pre term respiratory distress with CPAP or other ventilation services	52	67%	82%	90%	HFA-QOC

Key Result Area	Output/ Outcome Indicator	Baseline	Targets			
		24/25	25/26	26/27	27/28	Data Source
Availability of Essential newborn services	% of facilities providing delivery services offering all essential newborn health services (immediate breastfeeding; exclusive breastfeeding; antibiotic eye treatment; chlorhexidine cord care; delayed cord clamping; KMC; thermal protection & vitamin K)	34%	40%	50%	70%	HFA-QOC
Availability of Essential newborn services	% of facilities providing delivery services offering KMC for premature/small babies	73%	82%	92%	100%	MOH
Access to emergency and obstetric care	Proportion of the population living within 60 minutes' travel time to a functional BeMONC facility	ND	-	70%	80%	MOH
Post abortion Care Services	% of facilities providing postnatal services offering post abortion care services	68%	70%	70%	75%	HFA-QOC
Chlorhexidine use on the newborn	Proportion of newborns who received chlorhexidine digluconate 7.1% for umbilical cord care at birth	65%	70%	75%	80%	KHIS
Kangaroo Mother Care for the infants with LBW	Proportion of preterm/ LBW babies initiated on Kangaroo Mother Care	54%	60%	64%	70%	KHIS

Commodities & Technologies

Key Result Area	Output/ Outcome Indicator	Baseline	Targets			
		24/25	25/26	26/27	27/28	Data Source
Availability of essential Maternal Health drugs	% of facilities that had all the 4 tracer MNH drugs (oxygen, heat stable carbetocin, oxytocin, dexamethasone and magnesium sulphate)	ND	50%	60%	70%	HFA-QOC
Availability of essential Newborn Health drugs	% of facilities that had all the 4 tracer MNH drugs (oxygen, heat stable carbetocin, oxytocin, dexamethasone and magnesium sulphate)	ND	50%	60%	70%	HFA-QOC
	Stock out rate for Mgso4	48%	20%	10%	5%	HFA-QOC
	stock out rate for oxytocin	40%	20%	10%	0%	HFA-QOC
	stock out rate for carbetocin	ND	40%	70%	90%	HFA-QOC
	Stock out for Benzyl Penicillin	47%	40%	70%	90%	HFA-QOC
Blood Availability	% of Level 4 facilities offering Delivery services offering blood transfusion services	66%	75%	80%	90%	HFA-QOC
	% of blood requirement collected yearly	-	80%	90%	100%	KNBTS Report
Diagnostics	% of facilities with Full Hemogram (Level 3-5)	57%	65%	70%	80%	HFA-QOC
	% of facilities with obstetric ultrasound (level 3-5)	45%	55%	65%	75%	HFA-QOC

Monitoring and evaluation						
Key Result Area	**Output/ Outcome Indicator**	**Baseline**	**Targets**			
		24/25	**25/26**	**26/27**	**27/28**	**Data Source**
Reporting	Functional real time EWENE Dashboard (Y/N)	N	Y	Y	Y	Dashboard
	Community reporting of maternal and newborn deaths (eCHIS)(Y/N)	N	Y	Y	Y	ECHIS/KHIS
	% of counties reporting on the EWENE dashboard	N/A	47	47	47	County reports

Advocacy, Communication, Accountability & Community Engagement						
Key Result Area	**Output/ Outcome Indicator**	**Baseline**	**Targets**			
		24/25	**25/26**	**26/27**	**27/28**	**Data Source**
Advocacy and public awareness	Number of EWENE mass media campaigns conducted(Radio and TV	ND	4	4	4	Media Performance Reports
	Number of digital social media campaigns conducted	ND	4	4	4	Social Media Analytics
	Number of EWENE media training conducted	1	5	5	5	MOH
	Number of MNH IEC materials printed and displayed correctly	ND	50%	70%	100%	MOH
Community Engagement	Number of community dialogues / town-halls held	0	47	47	47	ECHIS
	Number of facilities that conducted maternity open days	0	50%	70%	100%	MOH

ROAD MAP FOR IMPLEMENTATION

Road map for implementation

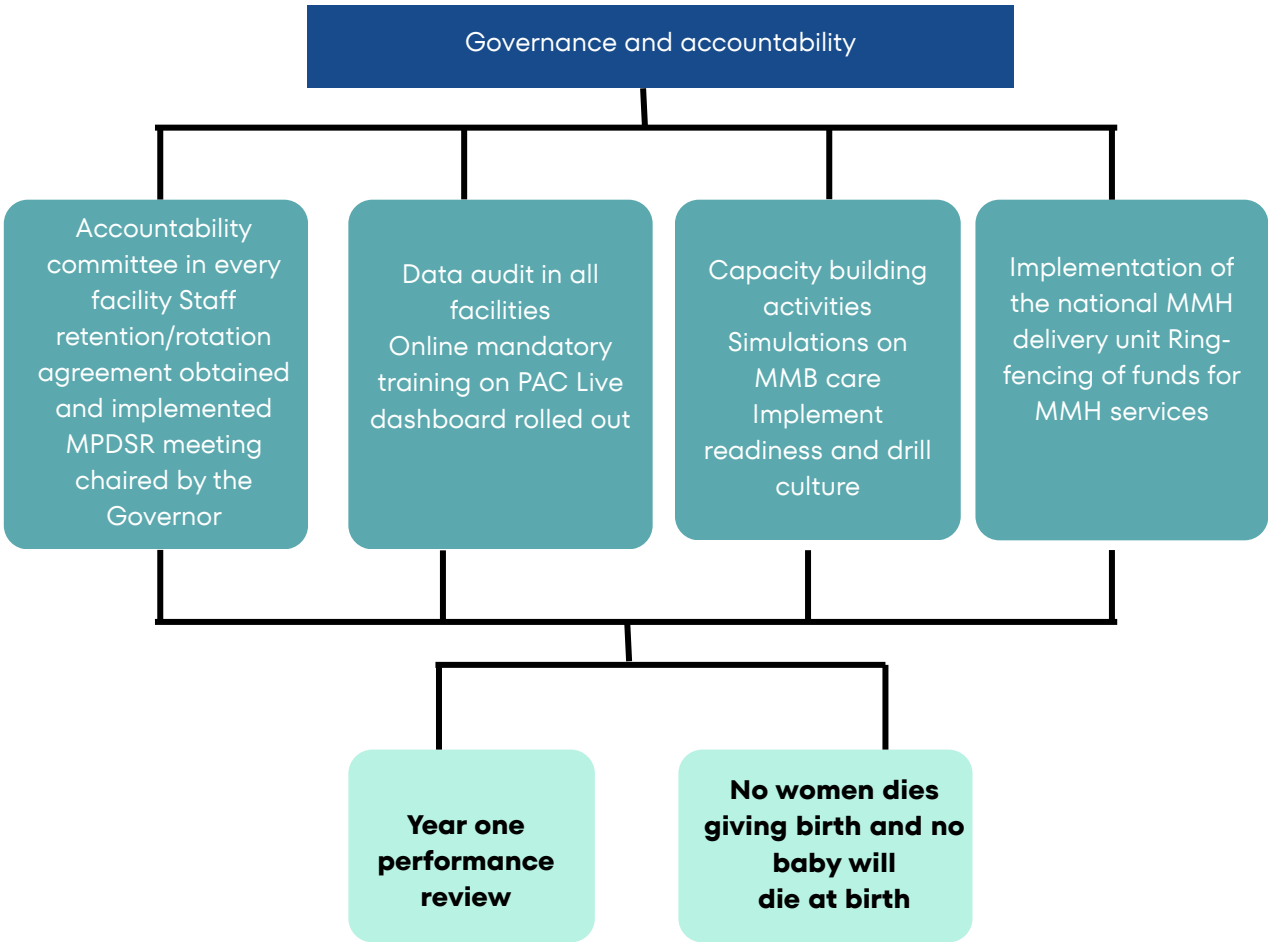
This acceleration plan will be implemented via a series of rapid response approach/initiative (RRA/I) focusing on achievable results in three months and creating momentum for the next cycle of RRA/I. Four RRA/I will be implemented in year 1 and year 2. Figure 21 shows the envisioned pathway.

Road map for No Woman Should Die While Giving Life

This road map considers mother and baby as a dyad to ensure no woman or baby should die. Key domains to be addressed

1. Administration and governance
2. Data Management
3. Service Delivery – mother and newborn quality of care
4. Capacity Building
5. Health Products and Technology Services
6. Advocacy and public awareness on danger signs

Figure 22. Road map for rapid response initiative implementation



Acceleration Plan review interval

This Acceleration Plan is a rapid initiative to address the causes of deaths of mothers and their newborns who have accessed medical facilities. It is meant to last for 24 months. The plan can be reviewed at any time if emerging solutions address the primary focus.

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WOMEN ENGAGED IN DEVELOPMENT
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MINISTRY OF HEALTH



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