
# MINISTRY OF HEALTH

## KENYA REPRODUCTIVE, MATERNAL, NEWBORN, CHILD, ADOLESCENT HEALTH, AND NUTRITION

## AN INVESTMENT CASE

*2025/26 – 2029/30*

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## ABBREVIATIONS AND ACRONYMS

| | |
|---|---|
| ACS | Adolescent Communication Strategy |
| ACSM | Advocacy, Communication, and Social Mobilisation |
| AIDS | Acquired Immunodeficiency Syndrome |
| ANC | Antenatal Care |
| ARI | Acute Respiratory Infection |
| ASAL | Arid and Semi-Arid Lands |
| AWPs | Annual Work Plans |
| AYSRH | Adolescent and Youth Sexual and Reproductive Health |
| BEmONC | Basic Emergency Obstetric and Newborn Care |
| BFCI | Baby Friendly Community Initiative |
| BFHI | Baby-Friendly Hospital Initiative |
| BMS | Breast Milk Substitutes |
| CBAs | Collective Bargaining Agreements |
| CBD | Community-Based Distribution |
| cBFCI | Community Baby Friendly Community Initiative |
| CEmONC | Comprehensive Emergency Obstetric and Newborn Care |
| CHAK | Christian Health Association of Kenya |
| CHAs | Community Health Assistants |
| CHEWs | Community Health Extension Workers |
| CHMT | County Health Management Team |
| CHPs | Community Health Promoters |
| CHVs | Community Health Volunteers |
| CIP | Costed Implementation Plan |
| CMNC | Common Childhood Diseases and Community Newborn Care |
| CoP | Community Practice |
| CORPs | Community Own Resource Persons |
| CPAP | Continuous Positive Airway Pressure |
| CQI | Continuous Quality Improvement |
| CSOs | Civil Society Organisations |
| CWC | Child Welfare Clinic |
| DHIS | District Health Information Software |
| DMPA | Depot Medroxyprogesterone Acetate |
| DPHK | Development Partners in Health Kenya |

| | |
|---|---|
| DQA | Data Quality Assessment |
| ECDS | Early Childhood Development Schools |
| e-CHIS | Electronic Community Health Information System |
| EENC | Early Essential New-born Care |
| ENAP | Every Newborn Action Plan |
| EOC | Emergency Operations Centre |
| EPMM | Ending Preventable Maternal Mortality |
| ETAT | Emergency Triage Assessment and Treatment |
| EWENE | Every Woman Every Newborn Everywhere |
| FBOs | Faith-Based Organisations |
| FGM | Female Genital Mutilation |
| FIF | Facility Improvement Financing |
| FP | Family Planning |
| GFF | Global Financing Facility for Women, Children and Adolescents |
| GBV | Gender-based Violence |
| GDP | Gross Domestic Product |
| H-IUD | Hormonal Intrauterine Device |
| HALE | Healthy Life Expectancy |
| HCP | Health Care Providers |
| HCW | Health Care Workers |
| HIS | Health Information System |
| HIV | Human Immunodeficiency Virus |
| HLMA | Health Labour Market Analysis |
| HMIS | Hospital Management Information System |
| HPAC | Health Promotion and Advocacy Committees |
| HPTs | Health products and Technologies |
| HPV | Human Papillomavirus |
| HRH | Human resources for health |
| HRIO | Health Records and Information Officer |
| HTS | HIV Testing Services |
| IC | Investment Case |
| ICCM | Integrated Community Case Management |
| ICPD | International Conference on Population and Development |
| IF | Investment Framework |

| | |
|---|---|
| IFAS | Iron and Folic Acid Supplement |
| iLMIS | Integrated Logistics Information Management System |
| IMAM | Integrated Management of Acute Malnutrition |
| IMNCI | Integrated Management of Newborn and Childhood Illnesses |
| IPC | Infection Prevention and Control |
| IPT | Intermittent Preventive Treatment |
| IRA | Insurance Regulatory Authority |
| IUCD | Intrauterine Contraceptive Device |
| IUD | Intrauterine Device |
| IYCF | Infant and Young Child Feeding |
| IYCN | Infant & Young Child Nutrition |
| KCCB | Kenya Conference of Catholic Bishops |
| KDHS | Kenya Demographic and Health Survey |
| KEMSA | Kenya Medical Supplies Authority |
| KENPHIA | Kenya Population-based HIV Impact Assessment |
| KEPH | Kenya Essential Package for Health |
| KHFA | Kenya Health Facility Assessment |
| KHFS | Kenya Health Financing Strategy |
| KHIS | Kenya Health Information System |
| KHSSP | Kenya Health Sector Strategic Plan |
| KMPDC | Kenya Medical Practitioners and Dentists Council |
| KNBS | Kenya National Bureau of Statistics |
| LLINs | Long-lasting Insecticide-treated Nets |
| LMIS | Logistics Management Information System |
| MAM | Moderate Acute Malnutrition |
| MCH | Mother and Child Health |
| MCP | Multi-stakeholder Country Platform |
| mCPR | Modern Contraceptive Prevalence Rate |
| MDD-W | Minimum Dietary Diversity for Women |
| MEL | Monitoring, Evaluation, and Learning |
| MIYCN-E | Maternal, Infant and Young Child Feeding Nutrition in Emergencies |
| MMR | Maternal Mortality Ratio |
| MMS | Multiple Micronutrient Supplements |
| MNCH | Maternal, Newborn, and Child Health |

| | |
|---|---|
| MNH | Maternal and Newborn Health |
| MNPs | Micronutrient Powders |
| MoE | Ministry of Education |
| MoH | Ministry of Health |
| MPDSR | Maternal Perinatal Death Surveillance Response |
| NBU | Newborn Unit |
| NCH | Neonatal and Child Health |
| NCPD | National Council for Population and Development |
| NGAO | National Government Administrative Officers |
| NHA | National Health Accounts |
| NHIF | National Health Insurance Fund |
| NHWA | National Health Workforce Accounts |
| NICHE | Nutrition Improvements through Cash and Health Education |
| NICU | Neonatal Intensive Care Unit |
| OAG | Office of the Attorney General |
| OOP | Out of Pocket |
| OPD | Outpatient Department |
| ORS | Oral Rehydration Solution |
| OTP | Outpatient Therapeutic Programme |
| PHC | Primary Healthcare Fund |
| PLW | Pregnant and Lactating Women |
| PSEAH | Protection from Sexual Exploitation, Abuse and Harassment |
| QA | Quality assurance |
| QI | Quality Improvement |
| QOC | Quality of Care |
| RH | Reproductive Health |
| RMNCAH | Reproductive, Maternal, Newborn, Child and Adolescent Health |
| RMNCAH-N | Reproductive, Maternal, Newborn, Child, and Adolescent Health and Nutrition |
| RUPHA | Rural & Urban Private Hospitals Association of Kenya |
| SAM | Severe Acute Malnutrition |
| SBBC | Safer Birth Bundle of Care |
| SBC | Social Behaviour Change |
| SBCC | Social and Behaviour Change Communication |
| SBNP | School-based Nutrition Package |

| | |
|---|---|
| SDG | Sustainable Development Goal |
| SEAH | Sexual Exploitation, Abuse and Harassment |
| SGBV | Sexual and Gender-based Violence |
| SHA | Social Health Authority |
| SHIF | Social Health Insurance Fund |
| THE | Total Health Expenditure |
| TNT | The National Treasury |
| TOTs | Training of Trainers |
| TWG | Technical Working Group |
| UHC | Universal Health Coverage |
| UNESCO | United Nations Educational, Scientific and Cultural Organization |
| UNICEF | United Nations International Children's Emergency Fund |
| USAID | United States Agency for International Development |
| UNFPA | United Nations Population Fund |
| WHO | World Health Organization |
| WIFAS | Weekly Iron and Folic Acid Supplementation |
| WRA | Women Reproductive Age |

## FOREWORD

Kenya has made commendable strides in improving the health outcomes of women, newborns, children, and adolescents. Building on this progress, the Government of Kenya—through the Ministry of Health—continues to develop robust policies and strategies aimed at strengthening health financing and service delivery. These efforts are central to advancing the well-being of the population and accelerating national development.

In this context, the Ministry of Health has developed the second Kenya Reproductive, Maternal, Newborn, Child, Adolescent Health and Nutrition (RMNCAH-N) Investment Case (IC) for the period 2025/26–2029/30. This Investment Case outlines the strategic direction, priority investment areas, implementation framework, and resource requirements for RMNCAH-N. It is aligned with key national and global commitments, including the Kenya Health Sector Strategic Plan (KHSSP) 2023–2027, Every Woman Every Newborn Everywhere (EWENE) (previously Every Newborn Action Plan (ENAP) /Ending Preventable Maternal Mortality (EPMM)/, ICPD25, FP2030, and the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030). These frameworks collectively aim to enhance access to and improve the quality of health services at all levels.

The RMNCAH-N Investment Case serves two primary purposes. First, it is a tool for mobilising public and private resources—both domestic and external—to expand access to quality health services for women, children, and adolescents. Second, it provides a policy framework to guide the programming and implementation of cost-effective RMNCAH-N interventions across all counties in Kenya. As an advocacy instrument, it supports the Government's health financing reforms, particularly the rollout of Social Health Insurance under the Universal Health Coverage (UHC) agenda.

The Ministry of Health believes that collaborative investment in RMNCAH-N services by all stakeholders will significantly reduce maternal, neonatal, infant, and child mortality and stillbirths. The successful implementation of this Investment Case will lead to improved health outcomes for women, newborns, children, and adolescents—ultimately contributing to a healthier, more prosperous Kenya. This document is a call to action for national and county governments, development partners, implementing agencies, the private sector, non-state actors, and civil society. Together, we must work in partnership to achieve our shared national and global goals for the health and well-being of the citizens of Kenya.

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We thank the RMNCAH-N Task Team comprising Multi-County Stakeholders for their commitment to gathering insights, engaging with diverse contributors, and drafting this comprehensive document. We are especially grateful to representatives from County Departments of Health, adolescent advocates, Health NGOs Network (HENNET), and Development Partners in Health Kenya (DPHK) , as well as our development partners—The United States Agency for International Development (USAID), United Nations International Children's Emergency Fund, (UNICEF), United Nations Population Fund (UNFPA), and World Health Organization (WHO)—for their meaningful contributions throughout the stakeholder consultations. The Ministry also recognises the officers from the RMNCAH, Nutrition, Planning and Policy, and Monitoring and Evaluation units for their technical input and support in shaping this Investment Case.

We are deeply appreciative of the technical and financial support provided by the Global Financing Facility for Women, Children, and Adolescents (GFF), World Bank, which was instrumental in the development of this document. Special thanks to Program for Appropriate Technology in Health (PATH) for facilitating key meetings and engagements during the process. The successful implementation of this Investment Case will require coordinated action and sustained collaboration among all stakeholders. It will serve as a guiding tool for joint annual planning, county-level implementation, and enhanced sectoral coordination, partnerships, and monitoring efforts.

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## EXECUTIVE SUMMARY

The implementation of the Kenya Reproductive, Maternal, Newborn, Child, Adolescent Health and Nutrition (RMNCAH-N) Investment Framework (IF) 2016-2020 yielded positive health outcomes. However, expanding the coverage of RMNCAH-N services still remains a challenge. For instance, the maternal mortality ratio, an important indicator of maternal health status, remains high in Kenya despite slight improvements over recent years, from 362 deaths per 100,000 live births in 2014 to 355 in 2019. Additionally, stillbirth rates have fallen substantially from 23 to 15 deaths per 1,000 total births from 2014 to 2022/23. Neonatal mortality rates have also declined, but marginally, over the last decade, with the neonatal mortality rate decreasing from 22 deaths per 1,000 live births in 2014 to 21 deaths in 2022, while stillbirths decreased (KDHS, 2022). In summary, Kenya has made significant progress in maternal and child health status, with substantial declines in mortality rates over the last twenty years.

Kenya has also made notable progress in improving family planning services, achieving a modern contraceptive prevalence rate (mCPR) of 57% among married women as of 2022. However, the unmet need for family planning remains high due to social, cultural, and religious barriers. Disparities exist in family planning accessibility across different user groups and counties. Furthermore, despite the country's emphasis on adolescent health, challenges persist, including high teenage pregnancy rates, mental health issues, substance abuse, and overall adolescent health concerns.

In the realm of child nutrition, Kenya has significantly reduced malnutrition among children under five years. The prevalence of stunting decreased from 36% in 2003 to 17.6% in 2022, and the rate of underweight children dropped from 19% in 1993 to 10% in 2022. Additionally, the rate of wasting declined from 7% to 5% during the same period. Nevertheless, micronutrient deficiencies continue to affect all segments of the population, thus increasing the risk of morbidity and mortality and negatively impacting child development, education, and productivity. Gender-based violence is also a concern, with 16% of females and 10% of males reporting having experienced physical violence (KDHS, 2022).

While Kenya has made strides in maternal, newborn, child, and adolescent health and nutrition, there still remains much work to be done to reach nationally agreed goals and improve the overall health outcomes. This situation underlines the necessity for a fresh RMNCAH-N investment case to steer National and County Governments, Development Partners, and other stakeholders in directing resources to bolster health services and outcomes for mothers, newborns, children, and adolescents. Consequently, the Ministry of Health, together with the RMNCAH-N Multi-stakeholder Country Platform, undertook the development of this RMNCAH-N Investment Case 2025/26-2029/30.

This RMNCAH-N Investment Case 2025/26-2029/30 is aligned with the Kenya Health Sector Strategic Plan 2023-2027, which aims to enhance access to and improve the quality of health services at all levels. Among its key priorities is ensuring quality RMNCAH-N health services.

The RMNCAH-N Investment Case identifies challenges that affect the delivery of the services, including:

- **Inadequate Capacity**: Health facilities do not have adequate capacity to provide quality RMNCAH-n services.
- **Insufficient Provider Knowledge and Skill**: Some healthcare providers do not have the necessary knowledge and skills to deliver quality RMNCAH-N services.
- **Referral System Challenges**: Referral systems between health facilities are inefficient.
- **Limited Emergency Services**: Few facilities offer emergency services for women, newborns and children, including essential equipment and drugs.
- **Delays in Emergency Obstetric and Newborn Care:** Delays in providing emergency care leading to neonatal asphyxia, contributing to a significant portion of newborn mortality and infant/ child morbidity.
- **Limited facilities offering youth-friendly services**: a major challenge in adolescent health.
- **Low Uptake of Services**: The uptake of RMNCAH-N services is low due to inadequate demand creation initiatives.
- **Access to Family Planning**: Women of reproductive age often lack access to high-quality family planning services.
- **Limited Nutritional Services**: The provision of nutritional services for women, newborns, children, and adolescents is limited.
- **Human Resource Challenges**: There is an inadequate human resource for health and an uneven distribution of skilled health workers, with some areas experiencing significant shortages while others have a surplus.
- **Limited Domestic Funding**: Government funding for RMNCAH-N services is low at both the national and county levels, with no dedicated funding for these services.
- **Donor Dependency**: There is an over-reliance on donor funding for RMNCAH-N health products and technologies.
- **Commodity Stock-outs**: There are frequent stock-outs of RMNCAH-N commodities.
- **Supply Chain Issues**: Limited capacity in supply chain management for maternal, newborn, and child health commodities.

Addressing these challenges is crucial for improving the health outcomes for women, newborns, children, and adolescents and to end preventable stillbirth. The RMNCAH-N Investment Case 2025/26-2029/30 addresses these challenges through increased funding for the various interventions, with the ultimate objective of enhancing the quality of life for women, newborns, children, and adolescents. The following outcomes are expected to drive this overall impact: The following outputs and outcomes are expected to drive this overall impact:

**Outputs**

a) Health facilities are equipped and staffed to consistently provide high-quality RMNCAH-N services.
b) Healthcare providers demonstrate improved knowledge, skills, and competency in delivering RMNCAH-N services.
c) Efficient and coordinated referral systems are established, ensuring timely access to appropriate levels of care.
d) Health facilities offer comprehensive emergency obstetric and newborn services with essential equipment and drugs readily available.
e) Obstetric emergencies are managed promptly and effectively, reducing newborn morbidity and mortality caused by asphyxia.
f) Adolescents access youth-friendly RMNCAH-N services in an environment that meets their unique needs and respects their confidentiality.
g) Increased uptake of RMNCAH-N services through strengthened demand creation and community engagement strategies.
h) Increased rates of literacy on prevention and management of malnutrition.
i) Nutritional services for women, newborns, children, and adolescents are strengthened and integrated into RMNCAH-N platforms.
j) Dedicated and sustainable government funding is allocated for RMNCAH-N services at national and sub-national levels.
k) RMNCAH-N commodities are consistently available through improved forecasting, procurement, and inventory management.

**Outcomes**

l) Improved coverage of high-impact interventions for women, newborns, children and adolescents.
m) Reduced unmet need for family planning.
n) Reduced teenage pregnancy.
o) Eliminated gender-based violence and other harmful practices.

These outcomes will be realised through the delivery of high-impact, evidence-based maternal, newborn, child health and nutrition services across all counties in Kenya, including:

- Emergency obstetric care with an emphasis on the management of post-partum haemorrhage.
- Essential newborn care, including introducing the Safer Birth Bundle of Care approach.
- Nutrition services to address stunting among children and adolescents, and anaemia in pregnant women.
- Quality of antenatal care and postnatal care services, including post-partum family planning.
- Quality family planning services at all service delivery points.
- Expanded provision and use of adolescent-friendly health services.
- Strengthened gender-based violence and gender-equity response services.
- High availability and readiness of services for RMNCAH at all levels.

The delivery of these services will be bolstered through:

1. Development and dissemination of standards, guidelines, standard operating procedures, and job aids for effective service delivery.
2. Strengthening the capacity of frontline healthcare workers.
3. Procurement of relevant essential medicines and commodities.
4. Support for relevant quality of care committees, especially the Maternal and Perinatal Death Surveillance and Response (MPDSR) committees.
5. Availability of youth-friendly services/ adolescent facility-friendly services.
6. Enhanced demand generation activities.
7. Support for quality monitoring and evaluation activities.

These services and activities will require robust financing. The total estimated investment financing required will increase over time as the RMNCAH-N services are scaled up in accordance with the Kenya Health Sector Strategic Plan's expected coverage for the various services. The total estimated investment will grow annually, starting at KSh 79,586 million (US$612 million) in 2025/26 and reaching KSh 105,790 million (US$814 million) by 2029/30. Over the five-year period, the cumulative investment required is estimated at KSh 460 billion (US$3.54 billion), with contributions expected from the National and County Governments, Social Health Insurance, Private Sector, and Development Partners.

In terms of programmes, Maternal and Newborn Health (MNH) accounts for the largest share each year, making up over 40% of the total investment. This is followed by immunisation (18%), child health (over 12%), GBV/GER (8%), and family planning (6.7%). A considerable part of the budget—over 31% annually—will be directed towards human resources for health (HRH). Other recurrent expenses, including training, capacity building, facility operations and maintenance, advocacy and demand creation, and monitoring and evaluation (M&E), will also constitute a significant portion of the expenditure needed to implement the RMNCAH-N Investment Case 2025/26-2029/30. Additionally, medicines, supplies, family planning commodities, and vaccines absorb a substantial part of the investments.

However, the financial projections reveal a significant funding gap. The estimated available resources are KSh 49.92 billion (USD 384 million) in 2025/26, rising to KSh 53.57 billion (USD 412 million) in 2026/27, KSh 53.78 billion (USD 414 million) in 2027/28, KSh 56.32 billion (USD 433 million) in 2028/29 and KSh 52.47 billion (USD 404 million) in 2029/30. The funding gap is expected to increase over time, from approximately KSh 29.67 billion ($228 million) in 2025/26 to KSh 53.32 billion (USD 410 million) in 2029/30. The summary is provided in Table S1.

Table S1: Estimated investment, available resources and funding gap

| Year | Investment (KSh million) | Investment (USD million) | Available Resources (KSh million) | Available Resources (USD million) | Funding Gap (KSh million) | Funding Gap (USD million) |
|---|---|---|---|---|---|---|
| 2025/26 | 79,586 | 612 | 49,920 | 384 | 29,666 | 228 |
| 2026/27 | 85,167 | 655 | 53,570 | 412 | 31,597 | 243 |
| 2027/28 | 90,580 | 697 | 53,780 | 414 | 36,800 | 283 |
| 2028/29 | 98,744 | 760 | 56,320 | 433 | 42,424 | 326 |
| 2029/30 | 105,790 | 814 | 52,470 | 404 | 53,320 | 410 |
| **Total** | **459,867** | **3,537** | **266,060** | **2,047** | **193,807** | **1,491** |

**In conclusion**, investing in RMNCAH-N interventions will be transformative for Kenya. Over five years, this investment could save an estimated **27,995 child lives**, **4,611 maternal lives**, and prevent **11,071 stillbirths**—a powerful impact on national health. These lives saved translate into significant productivity gains: healthy adults contribute immediately, while children promise future economic productivity. The estimated **KSh 565 billion** boost to GDP underscores this potential. With a **return on investment of KSh 12.50** for every shilling spent, the benefits are not only financial but deeply human—each life saved represents hope, potential, and a brighter future for families, communities, and the nation.

# INTRODUCTION

## 1.1 Overview

The Kenya Reproductive, Maternal, Newborn, Child, and Adolescent Health and Nutrition (RMNCAH-N) Investment Case (IC) builds upon the previous Kenya Reproductive, Maternal, Newborn, Child, and Adolescent Health Investment Framework (RMNCAH-IF) 2016-2020. RMNCAH-N IC 2025/26-2029/30 details Kenya's roadmap to achieve the vision of ensuring and guaranteeing universal access to RMNCAH-N services as espoused in various Government policies and guided by the Kenya Constitution 2010, Vision 2030 and Health Policy 2014-2030. Furthermore, in pursuance of Sustainable Development Goal (SDG) 3, Kenya is committed, under the United Nations Global Strategy for Women's, Children's and Adolescents' Health (2016–2030)[1], to improve the health of women, children and adolescents by accelerating the coverage and improving the quality of health services. In this regard, Kenya developed and implemented its first RMNCAH investment case in 2016.

Kenya's RMNCAH Investment Framework (2016–2020) drove notable health gains. Maternal mortality dropped slightly—from **362 to 355 deaths per 100,000 live births** between 2014 and 2020—but remains high. Stillbirth rates have fallen substantially from 23 to 15 deaths per 1,000 total births from 2014 to 2022/23. Neonatal mortality rates have also declined, but marginally, over the last decade, with the neonatal mortality rate decreasing from 22 deaths per 1,000 live births in 2014 to 21 deaths in 2022, signalling progress yet highlighting the need for deeper investment. Child survival has steadily improved over two decades, but **micronutrient deficiencies** still threaten development and future productivity. **Modern contraceptive use** is rising, yet unmet needs persist. Adolescents face pressing issues—**teenage pregnancy**, **mental health challenges**, and **substance abuse**—demanding urgent action. **Gender-based violence and other harmful practices** also remain a critical concern. Expanding access to RMNCAH-N services is essential to sustain and accelerate these gains.

## 1.2 RMNCAH Investment Framework 2026-2020

In 2016, the Government of Kenya developed the first Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) Investment Framework through the Ministry of Health and stakeholders. Although it was an investment case (IC), it was referred to as an investment framework (IF). The IF envisioned a situation in Kenya where there are no preventable deaths of women, newborns or children, and no preventable stillbirths; where every pregnancy is wanted, every birth is celebrated and accounted for, and where women, babies, children, and adolescents are free of HIV/AIDS, survive, thrive and reach their full social and economic potential.[2]

The RMNCAH IF outlined three broad strategies for implementation, including (a) addressing disparities and increasing equitable coverage through prioritised investments in underserved counties and accelerating action for underserved and marginalised populations; (b) addressing prioritised demand-side barriers to increase utilisation, coverage and affordability of RMNCAH services, and (c) addressing prioritised supply-side bottlenecks in the health system

to improve access to high impact interventions delivered efficiently and effectively, while ensuring financial protection for the poor.[2]

The Kenya RMNCAH IF ended in 2020, and its end-term evaluation noted the following:[3]

1. The process of its development, though consultative, was not sufficiently inclusive. The end-term report indicated limited dissemination and inadequate awareness by various stakeholders at the county level, which could have affected ownership and implementation in some counties.
2. Notwithstanding the above, counties implemented the framework activities in various ways, including through county-level specific RMNCAH plans or through integrating RMNCAH into annual work plans (AWPs). In addition, resources were allocated to support systems strengthening for RMNCAH, mainly through external funding.
3. Improvements in the supply of and demand for RMNCAH services in many counties resulted from strengthening capacity building for RMNCAH service providers at facility and community levels, infrastructure development, improved referral systems, and provision of commodities and supplies. As a result, there were general improvements in RMNCAH health indicators.
4. RMNCAH financing improved throughout implementation, with the National and County Governments, as well as the Development Partners, increasing funding and exceeding the framework's financing targets. However, out-of-pocket RMNCAH expenditure also rose during implementation.
5. There was a good and supportive policy environment for implementing RMNCAH activities, with the devolution enabling prioritisation of RMNCAH in integrated county planning and improved resource allocation as well as overall coordination and implementation of key evidence-based interventions at the county level. Furthermore, Civil Society Organisations (CSOs) provided strong advocacy for improvements in financing and indicators at the National and County levels.

## 1.3 Rationale for the New Investment Case

Despite progress, challenges remain in increasing coverage of RMNCAH services, nutritional services, and health outcomes. The end-term review of RMNCAH IF 2016-2020 showed that ten of the indicators on reduced mortality and morbidity of women, children and adolescents in the IF met set targets, while six indicators stagnated or worsened compared to the baseline. Moreover, resources for implementation were insufficient despite the increased funding for RMNCAH, where some counties were noted to continue to experience health system gaps such as inadequate infrastructure, commodities, human resource challenges and gaps in RMNCAH commodities and supplies, like family planning commodities and drugs.[3] Equity concerns have been raised due to increased out-of-pocket expenditure for RMNCAH services.

Besides, Kenya is lagging far behind on key SDG indicators, and the nation will not achieve its target unless concerted efforts are undertaken to increase access to and utilisation of RMNCAH-N services.

Box 1: The SDG indicators include by 2030

- reducing the global maternal mortality ratio to less than 70 per 100,000 live births.
- ending preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1000 live births and under-5 mortality to at least as low as 25 per 1000 live births.
- strengthening the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol.
- ensuring universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.
- and end all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons.
- The Global Strategy also includes the target of reducing stillbirths to 12 or less per 1000 total births

The 2024 Kenya SDG report shows maternal mortality remains unchanged, neonatal mortality has stagnated, and under-five mortality is improving—but too slowly. This underscores the urgent need for RMNCAH-N IC to accelerate progress toward SDG targets on maternal, newborn, child, and adolescent health and nutrition. The end-term review of the RMNCAH Investment Framework (2016–2020) called for a new strategy to guide National and County Governments, donors, and stakeholders in scaling up investments. In response, the Ministry of Health, in collaboration with the RMNCAH-N Multi-stakeholder Country Platform, developed the second RMNCAH-N IC to drive coordinated action and improve health outcomes across all levels.

## 1.4 Alignment with KHSSP and Other Commitments

This investment case (RMNCAH-N-IC) draws from and aligns with the current Kenya Health Sector Strategic Plan (KHSSP) 2023-2027. The priorities in this RMNCAH-N-IC are to align with the KHSSP Strategic objectives, which are: (a) increasing access to and availability of quality and affordable essential health services for all, (b) building and strengthening partnerships and collaboration, and (c) strengthening the health systems for effective and efficient delivery of health services.

The performance indicators for the RMNCAH-N are also drawn from the KHSSP 2023-2027 and extended to cover the period up to 2030. Notwithstanding this alignment, the specific strategic interventions and activities were also derived from the national strategic plans of the various programmes from which RMNCAH-N are included. These were the Newborn and Child Health Strategic Plan 2022–2026[4], Draft Adolescent Health Strategic Plan 2023/24–2027/28, and the Kenya Nutrition Action Plan 2023–2027[5].

Apart from drawing from the various strategic plans, stakeholder consultation yielded valuable information that shaped the RMNCAH-N priorities.

The RMNCAH-N IC is aligned with Kenya's commitments, especially Every Woman Every Newborn Everywhere (EWENE) (previously Every Newborn Action Plan (ENAP) /Ending Preventable Maternal Mortality (EPMM), ICPD25[6,7], and FP 2030 Commitment[8]. Every Newborn Action Plan (ENAP)[7], launched in 2014 and signed by Kenya, provides a road map of strategic actions for ending preventable newborn mortality and stillbirth and contributing to reducing maternal mortality and morbidity**.** The strategies for ending preventable maternal mortality (EPMM) established objectives for the SDGS and comprehensive approaches to enhancing the maternal health initiative. This RMNCAH-N IC priority interventions aim to improve nutritional and health status for women, newborns, children, and adolescents and reduce the unmet need for family planning and teenage pregnancy. Furthermore, it is aligned with the FP2030 objective of increasing the modern contraceptive prevalence rate (mCPR) for married women from 58% in 2022 to 64% by 2030.

## 1.5 RMNCAH-N IC Development Process

The development of the RMNCAH-N IC 2025/26–2029/30 was led by the Ministry of Health (MOH), in collaboration with RMNCAH-N multi-stakeholders, with technical support from the Global Financing Facility (GFF), World Bank. The process began in April 2024 and concluded in July 2025. It involved a rapid review of relevant documents alongside extensive stakeholder consultations. The Task Team and key stakeholders convened eight technical workshops to develop the IC. A draft version was shared with stakeholders for feedback, and the comments received were incorporated into the final document.

Key stakeholders included the MOH RMNCAH Division, County Government representatives, HENNET, and development partners such as the DPHK Secretariat, UNFPA, UNICEF, WHO, and USAID. Adolescents and youth representatives also actively participated as integral members of the Task Team responsible for the technical development of the IC. The RMNCAH-N IC 2025/26–2029/30 was validated on 30 June 2025 and submitted to a select group of three external technical experts for review. The feedback from the external experts was incorporated into this final document.

## SITUATION ANALYSIS

### 2.1 Country Context

Kenya is located in the East African region and spans a total surface area of 581,309 square kilometres. It shares borders with Tanzania to the south, Uganda to the west, South Sudan to the northwest, Ethiopia to the north, and Somalia to the northeast. According to the Kenya National Bureau of Statistics[9], the projected population in 2023 was approximately 51.5 million, with females accounting for 50.4% and males 49.6%.

Kenya's population is growing rapidly at an annual rate of 2.2% and is projected to reach 57.8 million by 2030. The population is predominantly young: individuals under 25 years constitute about 59%, children under five years account for 13%, and adolescents aged 10–19 years make up 12%. Women of reproductive age represent approximately 26% of the population. This demographic profile underscores the critical importance of prioritising Reproductive, Maternal, Newborn, Child, and Adolescent Health and Nutrition (RMNCAH-N) in the delivery of health services.

The country experienced sustained economic growth over the last three years, following a negative growth rate of Kenya's Gross Domestic Product (GDP) of -0.3% in 2020 as a result of COVID-19. The real GDP grew by 4.9% in 2022 and 5.7% in 2023. The Gross Domestic Product (GDP) per capita at current prices improved to KSh 293,229 in 2023 from KSh 266,473 in 2022. The GDP per capita at constant prices stood at KSh 194,627 in 2022 and 201,841 in 2023, reflecting the country's lower middle-income status.7 This situation has implications for health care financing, with development partners' funding expected to flatten or gradually decrease over time. Furthermore, the poverty headcount ratio indicates that about 39% of Kenyans live below the absolute poverty line, suggesting that a significant portion of the population may not be able to afford to pay for healthcare. The situation is exacerbated by the high disease burden in the country and inadequate funding for the health sector. The implication is that there is a greater need to continue mobilising resources for RNMCAH-N.

The Kenya health care system is organised around the two levels of government as enshrined in the Kenya Constitution 2010. The national level has the responsibility for policy, oversight of referral hospitals, and capacity building, while the county level is responsible for service delivery, mainly through primary health facilities and secondary-level hospitals. The Ministry of Health, therefore, provides overall leadership and regulatory and policy guidance for service delivery in the country.

Kenya is committed to achieving Universal Health Coverage (UHC) by 2030 to allow all Kenyans to access quality and affordable services without experiencing financial hardships. In this regard, the Government of Kenya is currently focused on advancing key health financing initiatives to strengthen the allocation of resources in the Kenyan health sector, improve efficiencies, and advance insurance coverage.

## 2.2 Health Status, Burden of Disease, and Trends

### *2.2.1 Maternal health status*

The maternal mortality ratio (MMR), a key indicator of maternal health, remains high in Kenya, although there have been modest improvements in recent years. It declined slightly from 362 deaths per 100,000 live births in 2014 to 355 deaths per 100,000 live births in 2019. The facility-based maternal mortality ratio reflects a similar trend, as illustrated in Figure 2.1. Despite this progress, the MMR is still considered unacceptably high, highlighting the urgent need for sustained technical and financial investments to improve maternal health outcomes.

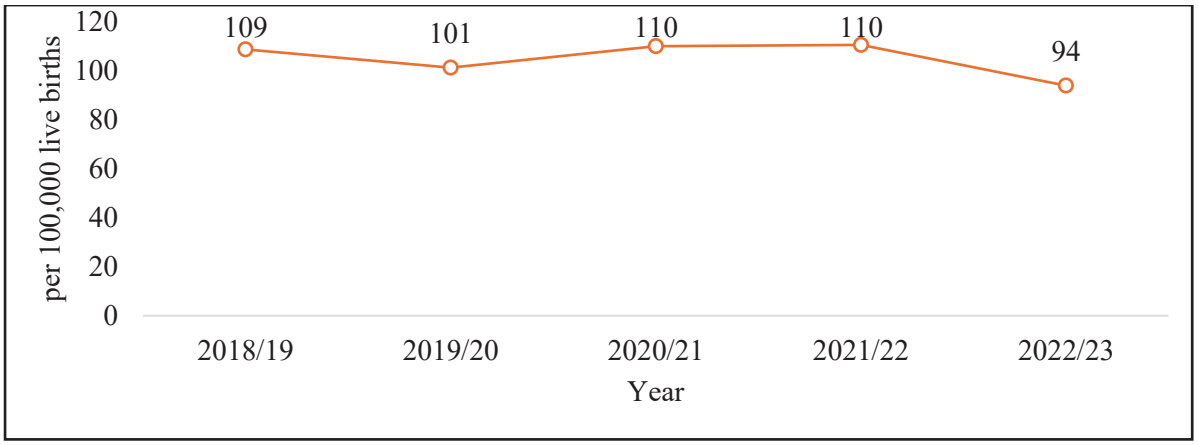
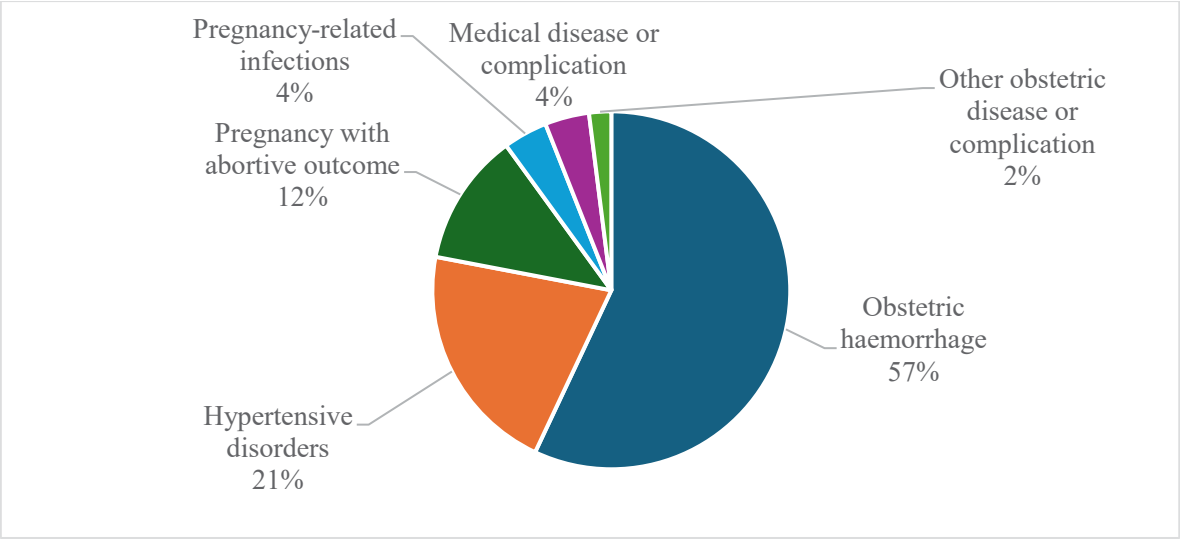



*Figure 2.1: Trend in facility maternal mortality ratio*
*Source*: Adopted from KHSSP 2023-2027

The leading causes of maternal mortality in Sub-Saharan Africa are obstetric haemorrhage, hypertensive disorders in pregnancy, non-obstetric complications and pregnancy-related infections.[11] In Kenya, similar causes have been documented, and the percentages of each contributing to maternal mortality are presented in Figure 2.2.[12]



### *2.2.2 Newborn, infant and child health status and trends*

Data from the Kenya Demographic and Health Surveys (KDHS) 2022 show that stillbirth and neonatal mortality rates have also declined, but marginally, over the last decade. Neonatal mortality declined from 22 deaths per 1,000 live births in 2014 to 21 deaths in 2022, while stillbirths decreased more substantially from 23 deaths per 1,000 total births in 2014 to 15 deaths per 1,000 total births in 2022/23.

Kenya has made significant progress in child health status, with infant mortality and child mortality rates steadily declining over the last twenty years (Figure 2.3).

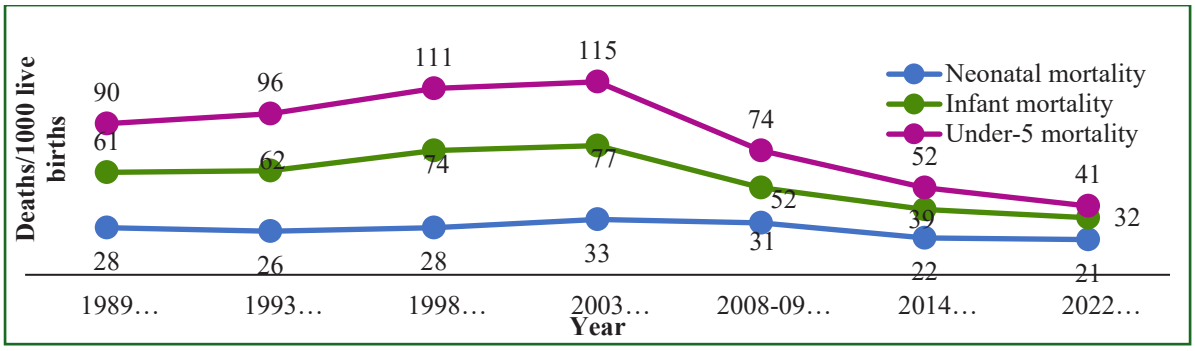



*Figure 2.2: Trend in child mortality rates*
*Source*: Kenya Demographic and Health Survey 2022 and KHSSP 2023-27

These mortality rates vary depending on several determinants, notably characteristics of the mothers and families. In general, under-five mortality rates declined as the level of education of the mother increased. For example, the child mortality rate was 49 deaths per 1,000 live births for children of mothers with primary education, reduced to 42 for children of mothers with secondary education, reaching a significantly lower rate of 32 deaths per 1,000 live births for children whose mothers have a post-secondary level of education. The child mortality rate has generally been shown to decline with the increase in income. However, no substantial differences exist in neonatal and infant mortality by income quintiles (Figure 2.4)

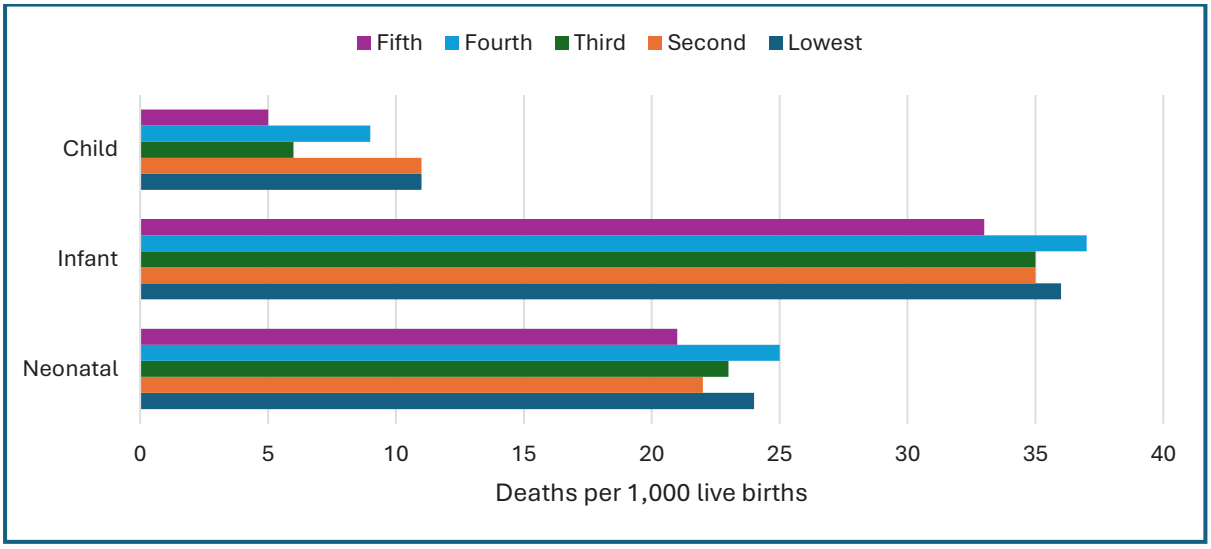



*Figure 2.3: Mortality rates by income quintile*
*Source*: Kenya Demographic and Health Survey 2022

### *2.2.3 Family planning situation*

Kenya has made substantial progress in improving family planning services and indicators. There has been a steady rise in the use of modern contraceptives among married women, which stood at 57% in 2022 (Figure 2.5).

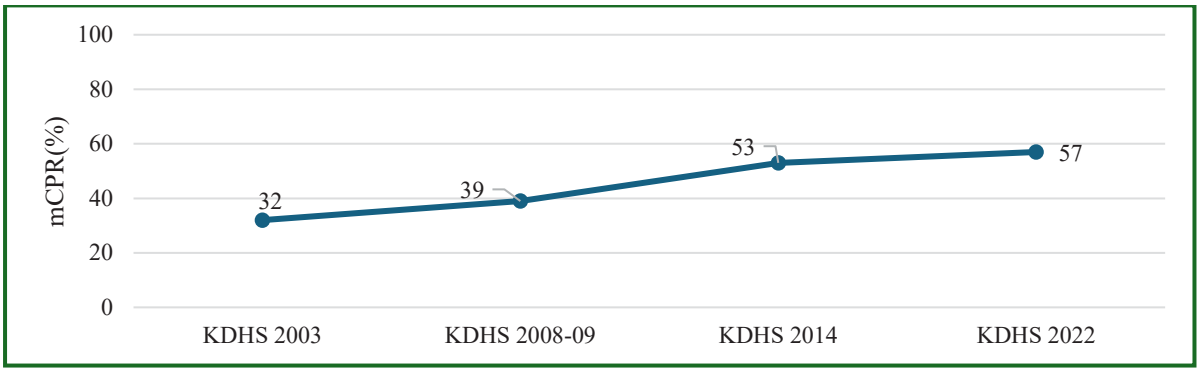



*Figure 2.4: Trend modern contraceptive prevalence rate*
*Source*: Data from KDHS 2022

Over the years, the modern contraceptive prevalence rate (mCPR) method mix in Kenya has shifted notably, with increasing acceptability and use of long-acting reversible contraceptives (LARCS). Injectable remain the most used method among married women. However, there has been a steady and significant rise in the use of implants—from just 1.7% in 2003 to 18.5% in 2022. Other methods, such as pills, IUCDs, and male condoms, have shown relatively stable usage, while female sterilisation has declined. These trends, as presented in Table 2.1, highlight evolving preferences and the importance of ensuring a diverse and accessible contraceptive method mix.

Table 2.1: Method mix by percentage of married women

| Method | KDHS 2003 | KDHS 2008-09 | KDHS 2014 | KDHS 2022 |
|---|---|---|---|---|
| Injectable | 14.3 | 21.6 | 26.4 | 19.9 |
| Implant | 1.7 | 1.9 | 9.9 | 18.5 |
| Pill | 7.5 | 7.2 | 8 | 8.1 |
| IUCD | 2.4 | 1.6 | 3.4 | 4.4 |
| Female sterilization | 4.3 | 4.8 | 3.2 | 2.3 |
| Other | 0.1 | 0.5 | 0.1 | 1.9 |
| Male condom | 1.2 | 1.8 | 2.2 | 1.8 |
| Total | 31.5 | 39.4 | 53.2 | 56.9 |

*Source*: Data from KDHS 2022

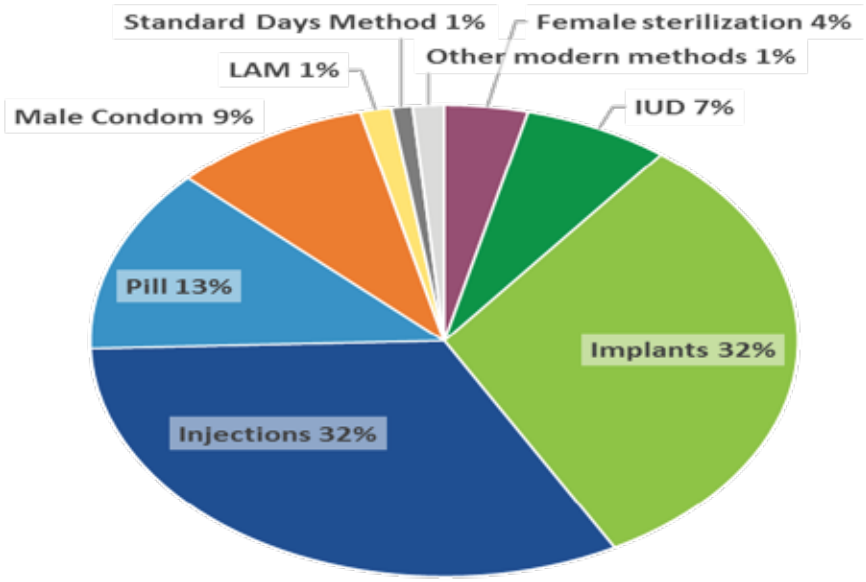



*Figure 2.5: 2022 KDHS Percentage method mix*

Despite this progress made in mCPR, the unmet need for family planning, though on a declining trend, is still high, and hence, some women are unable to access FP services for various reasons, including social, cultural and religious barriers. Figure 2.7 shows the trend in the unmet need for family planning in the last ten years.

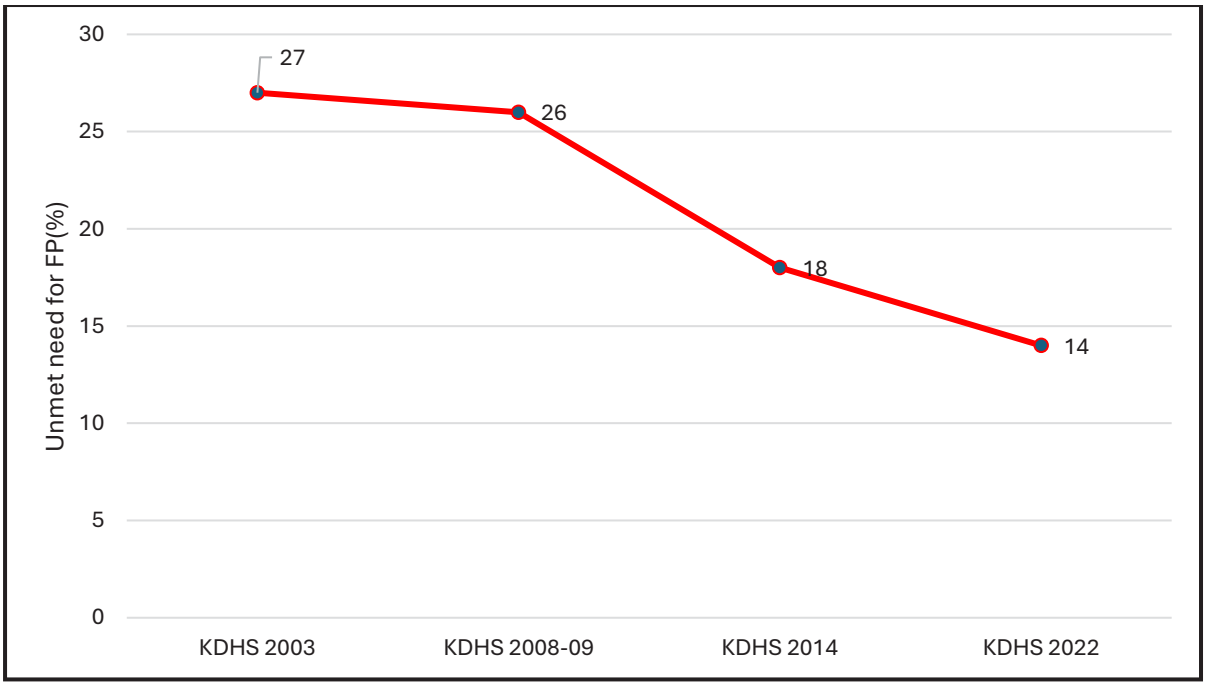



*Figure 2.6: Trend unmet need for family planning in Kenya*
*Source*: Data from KDHS 2022

There is inequity in the unmet need for family planning with respect to the various characteristics of the potential users. The unmet need declines in level of education with those with no education at 23%, primary education (15%), secondary education (13%) and post-secondary education (10%). Income is also an important factor in reducing unmet need for FP (Figure 2.8).

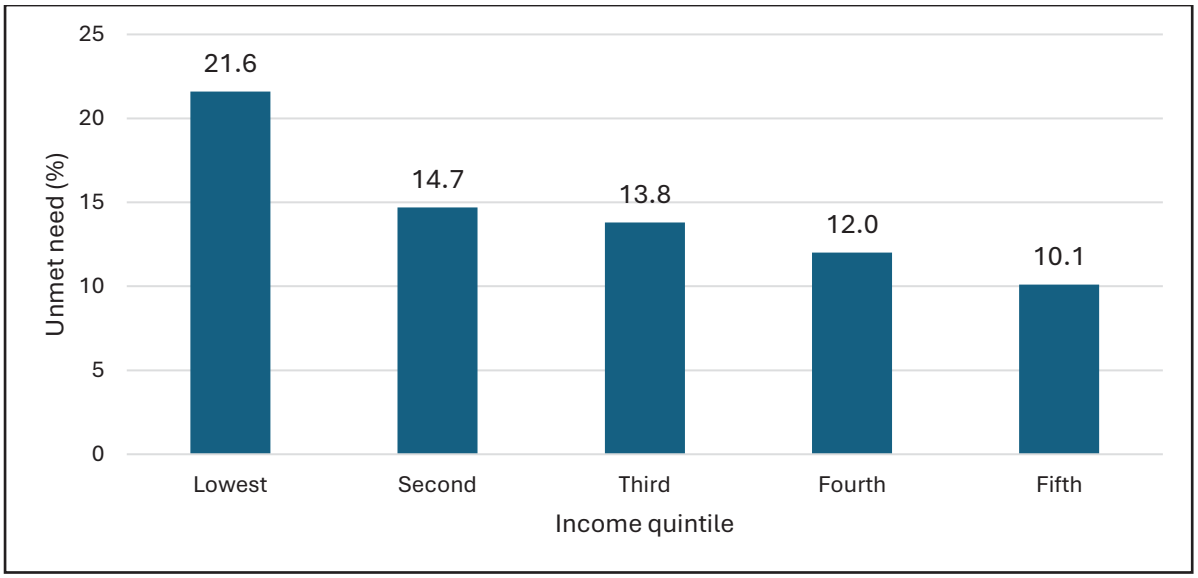



*Figure 2.7: Unmet need for FP by rates by income quintile*
*Source*: Kenya Demographic and Health Survey 2022

Substantial disparities exist in the unmet need for family planning among the Kenyan counties, as shown in Figure 2,9.

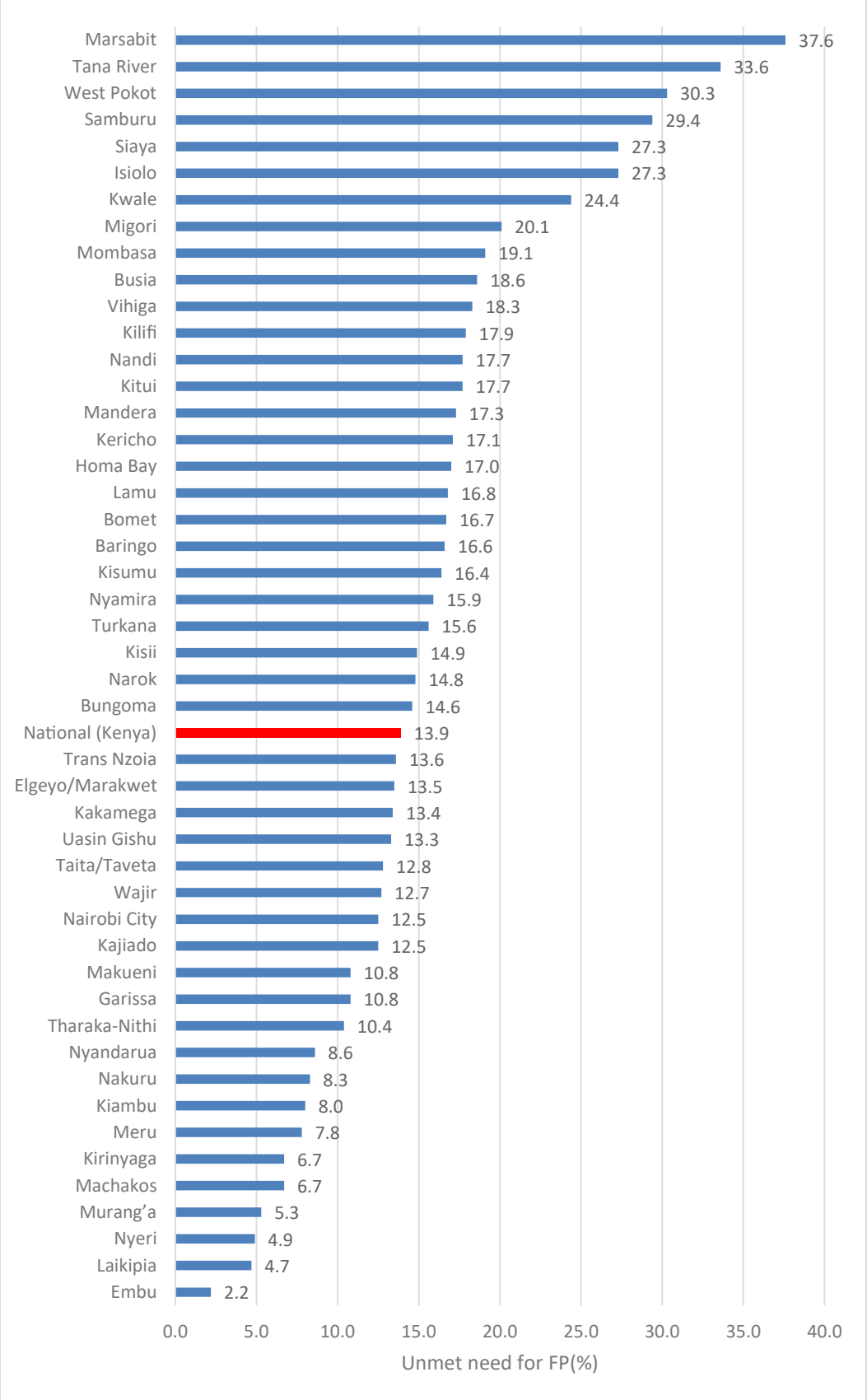



*Figure 2.8: Unmet need for family planning in counties in 2022*
*Source*: Data from KDHS 2022

### *2.2.4 Adolescent health status*

Kenya places a strong emphasis on the health of its adolescent population to build a strong human resource base for development. The KHSSP 2023-2027 provides the health situation of adolescents in terms of teenage pregnancy, mental health, and general health. Figure 2.10 shows that teenage pregnancy is an important issue in the country.

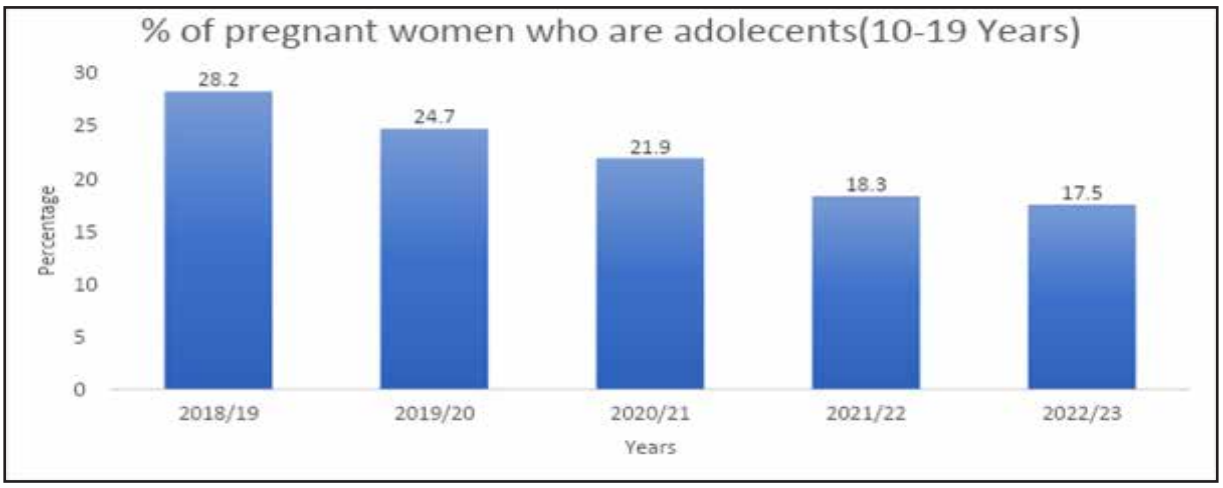



*Figure 2.9: Trend in teenage pregnancy rate*
*Source*: Adopted from KDHS 2022

The teenage pregnancy rates, as analysed by different variables, are shown in Table 2.2.

Table 2.2: Teenage pregnancy differentials

| Background characteristic | Percentage of women age 15–19 who: Have ever had a live birth | Have ever had a pregnancy loss[1] | Are currently pregnant | Have ever been pregnant |
|---|---|---|---|---|
| **Age** | | | | |
| 15 | 2.1 | 0.0 | 0.8 | 2.7 |
| 16 | 4.2 | 0.3 | 1.2 | 5.5 |
| 17 | 10.0 | 1.2 | 2.4 | 12.8 |
| 18 | 16.4 | 1.1 | 5.3 | 20.9 |
| 19 | 27.4 | 1.6 | 5.0 | 31.1 |
| **Residence** | | | | |
| Urban | 9.7 | 0.7 | 2.9 | 12.1 |
| Rural | 13.3 | 0.9 | 3.0 | 16.0 |
| **Education[2]** | | | | |
| No education | 30.8 | 3.9 | 9.6 | 37.8 |
| Primary | 16.3 | 1.4 | 4.4 | 19.8 |
| Secondary | 9.9 | 0.5 | 2.1 | 12.0 |
| More than secondary | 4.0 | 0.0 | 0.8 | 4.8 |
| **Wealth quintile** | | | | |
| Lowest | 17.8 | 1.6 | 4.0 | 21.1 |
| Second | 14.9 | 0.6 | 3.4 | 17.5 |
| Middle | 10.6 | 1.1 | 2.6 | 13.4 |
| Fourth | 10.0 | 0.4 | 3.0 | 12.9 |
| Highest | 6.0 | 0.4 | 1.6 | 7.1 |
| Total | 12.2 | 0.9 | 3.0 | 14.8 |

Source: Adopted from KDHS 2022

Adolescents and young people in Kenya continue to engage in risky sexual behaviours, leading to high rates of unplanned pregnancies, unsafe abortions, and sexually transmitted infections (STIs), including HIV/AIDS. Evidence from across the Sub-Saharan African region shows that teenage pregnancy is closely linked to several factors, including a woman's level of education, occupation, marital status, wealth quintile, knowledge of modern contraceptive methods, and unmet need for family planning.[13] These interconnected factors highlight the importance of targeted interventions to address the sexual and reproductive health needs of adolescents and young people.

According to the Kenya population situation analysis in 2024, adolescents aged 10-19 make up 11.6 million (22.2%) of the total population. Over 40% of adolescents have had at least one mental health issue, with 1 in 8 (12.5 %) of adolescents meeting criteria for a mental disorder. In addition, 2.4% of adolescents have more than one mental disorder, and suicidal thoughts and self-harm significantly affect adolescents with mental health disorders.

### *2.2.5 Nutrition status*

Breastfeeding practices remain strong, with 98% of children born in the two years preceding the survey having been breastfed, and 60% of children aged 0–5 months exclusively breastfed. However, only 31% of children aged 6–23 months receive a minimum acceptable diet.

There is evidence of improved nutritional status among children in Kenya. Currently, 5% of children are wasted (too thin for their height), 10% are underweight (too thin for their age), and 3% are overweight (heavy for their height). The prevalence of stunting among children under five years decreased from 26% in 2014 to 18% in 2022, nearing the national target of 17%. Among older children, 7% are thin and 17% are obese, indicating emerging concerns around both undernutrition and overnutrition.[14]

Micronutrient deficiencies remain a concern across all age groups in Kenya. Anaemia is a severe public health problem among pregnant women, with a prevalence of 41.6%. Rates are lower among non-pregnant women (21.9%), preschool children (26.3%), and school-age children (6.5%). Pregnant women in rural areas exhibit significantly higher anaemia rates (50.8%) compared to those in urban areas (29.5%). Folate deficiency is also widespread, affecting 32.1% of pregnant women and 30.9% of non-pregnant women, with higher prevalence in rural areas (36%) than in urban areas (25%).

Among adolescents aged 15–19, 18% of females and 43% of males are classified as thin, indicating undernutrition or inadequate food intake. Among adults aged 20–49, 7% of women are classified as thin, while 28% are overweight, reflecting a growing issue of overnutrition. Overall, while significant strides have been made, Kenya still faces challenges related to both undernutrition and overnutrition, as well as micronutrient deficiencies, which impact health, growth, and productivity.

## 2.3 Social Determinants of Health

Social determinants of health are non-health factors that significantly influence population health outcomes. Education—particularly for women—plays a critical role in shaping health status. In Kenya, the adult literacy rate is relatively high, at 83% overall and 80% among adult women. However, gender disparities persist, with young women from poor and rural households facing greater educational disadvantages compared to the national average. These disparities in education contribute to broader inequalities in health outcomes, reinforcing the importance of addressing social determinants as part of comprehensive health strategies.[15]

Poverty has been shown to negatively impact population health, as individuals living in poverty often face limited access to healthcare and social protection. Gender inequality further compounds these challenges, particularly for poor women and girls, who are disproportionately disadvantaged in terms of access to assets, entitlements, and decision-making power both within households and in society. As a result, gender inequality remains a major driver of both poverty and poor health outcomes.

According to the Kenya National Bureau of Statistics (2024), the overall poverty rate in Kenya stood at 38.6% in 2021, affecting 19.1 million individuals and 34.7% of households (equivalent to 4.4 million households).[16] This high level of poverty significantly limits access to essential health services and undermines efforts to improve the overall health and well-being of the population.

The overall poverty in Kenya is largely driven by food poverty, which stood at 30.5% in 2021.[16] This high level of poverty contributes to a relatively high prevalence of undernourishment. According to Kenya's 2023 Position Paper on the implementation of Sustainable Development Goals, the prevalence of undernourishment in the population was 30.5% in 2021, with higher rates observed in rural areas (32.2%) compared to urban areas (26.8%). These figures highlight the persistent challenges in achieving food security and equitable nutrition across different population groups.[17]

Access to and utilisation of water and sanitation services play a critical role in improving health outcomes. In 2019, 62.9% of the population had access to safely managed drinking water services, increasing to 67.9% by 2022. The availability of clean and safe water also improved significantly: from 60% in 2019 to 72.2% in 2020, 74% in 2021, and reaching 90.6% in 2022 among the urban population. In contrast, rural areas saw more modest gains, with access rising from 50.2% in 2019 to 55.6% in 2020, 61.5% in 2021, but slightly declining to 56.3% in 2022. Additionally, 90% of the population had access to basic sanitation services in 2022, although urban sewerage coverage remained relatively low at 32%.[17]

Gender-based violence remains a significant concern in Kenya. According to the Kenya Demographic and Health Survey (KDHS) 2022, 16% of females and 10% of males reported experiencing physical violence in the 12 months preceding the survey. Additionally, 13% of women have experienced sexual violence at some point in their lives, while 7% reported experiencing sexual violence within the 12 months prior to the survey. These figures highlight the urgent need for strengthened prevention and response mechanisms to address gender-based violence across the country.[14]

Early marriage and female genital mutilation/cutting (FGM/C) remain prevalent in Kenya, despite gradual progress. Child marriage, although steadily declining, still affects 25% of women and men aged 25–49 years who were married before the age of 18. Among women aged 20–24 years, 4.4% were in a union before age 15, and 22.9% before age 18.[14]

The prevalence of FGM/C among girls and women aged 15–49 years has also declined, dropping from 21% in 2014 to 15% in 2022. This positive trend reflects ongoing efforts to combat harmful practices and protect the rights and well-being of girls and women.[14]

## 2.4 Health and Climate Change

According to the WHO, climate change has a profound impact on health through its effects, such as frequent extreme weather events—including heatwaves, storms, and floods—and the disruption of food systems.[18] These impacts contribute directly to increased illness and mortality. Moreover, climate change undermines key social determinants of health, such as livelihoods, equality, access to healthcare, and social support systems. It disproportionately affects the most vulnerable and disadvantaged populations, including women, children, ethnic minorities, low-income communities, migrants and displaced persons, older adults, and individuals with underlying health conditions.

The World Bank further highlights that climate change alters disease burdens by increasing heat-related illnesses and deaths, shifting patterns of infectious disease transmission—thereby raising the risk of major outbreaks and pandemics—and negatively affecting maternal and child health outcomes.[19]

Although climate change disproportionately impacts women, newborns, stillbirths and children, the effects of climate events on maternal and child health have been neglected, underreported and underestimated.[19] This notwithstanding, the WHO proposes three broad areas of responses to climate change, consisting of (a) promoting actions that both reduce carbon emissions and improve health, (b) building better, more climate-resilient and environmentally sustainable health systems, and (c) protecting health from the wide range of impacts of climate change.[18] While all these areas of action are relevant to RMNCAH-N, the last two are particularly important, especially ensuring environmental sustainability and climate resilience as central components of universal health coverage (UHC) and primary health care (PHC) in which RMNCAH-N services are core services. Furthermore, continuous assessment of the RNMCAH-N services' vulnerabilities, developing health plans that integrate climate risk, and implementing climate-informed surveillance and response systems for key risks.

The World Bank outlines actions it has supported in several countries to mitigate climate change impacts on the health sector, which can be adopted for the Kenya RMNCAH-N IC. They include strengthening health systems to predict, detect, prepare, and respond to climate risks and disasters, by, for example, building climate-informed surveillance and early-warning systems, transitioning health systems to low-carbon, high-quality service delivery, and addressing the root causes of climate change and its impacts on health by working across sectors to scale up efforts.[19]

## 2.5 Emerging Technologies

Kenya has made significant progress in establishing the foundations for digital and emerging technologies to support RMNCAH-N service delivery. Systems like Kenya EMR are used in many public health facilities and contribute to improved documentation, continuity of care, and monitoring.

Telemedicine could play an increasing role in extending specialist care to underserved areas, supported by reliable diagnostic data and integration into facility workflows. Social media channels could be more systematically leveraged for targeted health promotion and countering misinformation, while digital pharmacies, if appropriately regulated, could become part of an integrated supply chain for RMNCAH-N commodities. Emerging applications of artificial intelligence, such as predictive analytics for maternal complications, diagnostic tools, such as AI-powered ultrasounds, and chatbots leveraging large language models, could support more responsive and efficient service delivery if developed and deployed in line with national priorities, equity considerations, and ethical safeguards.

To achieve this vision, Kenya will need to invest in robust digital infrastructure, strengthen governance and regulatory frameworks, and build health worker capacity to effectively use new tools. Prioritising interoperability, data security, and equitable access will ensure that future digital investments directly contribute to improved coverage, quality, and outcomes for RMNCAH-N services.

## 2.6 Health System Building Blocks Context

### *2.6.1 Service delivery*

Access to and improvement of the quality of health services at all levels is a core objective of the Kenya Health Sector Strategic Plan (KHSSP) 2023–2027. A key priority for the Government of Kenya under this plan is the provision of high-quality reproductive, maternal, newborn, child, adolescent, and nutrition (RMNCAH-N) health services. To achieve this key priority, the KHSSP emphasises strengthening the health system to ensure effective service delivery and improved service quality.

The RMNCAH-N services are delivered through a range of mechanisms, including public and private health facilities, pharmacies, and community-based platforms. Health facilities—particularly government and faith-based institutions—remain the primary sources of these services.

Maternal and newborn health services include comprehensive antenatal care (ANC), with prevention, detection and management of complications, high-quality facility-based intrapartum care, postnatal care, and management of complications across the continuum of care. In 2022, the first ANC visit coverage was approximately **98%**, while coverage for the recommended four ANC visits stood at **66%**, indicating that a significant proportion of pregnant women do not receive the full continuum of antenatal care. Additionally, **88%** of deliveries at health facilities, leaving about **12%** of births for home delivery, with the majority without skilled attendance.

Delivery at health facilities increased with the level of education and the income quintile of the households. Low accessibility of health facilities contributed to home deliveries. Other factors that acted as barriers to accessing services included obtaining permission to go to the facilities and obtaining money.

Trends from KDHS, illustrated in Figure 2.11, show steady progress in maternal health indicators over time.

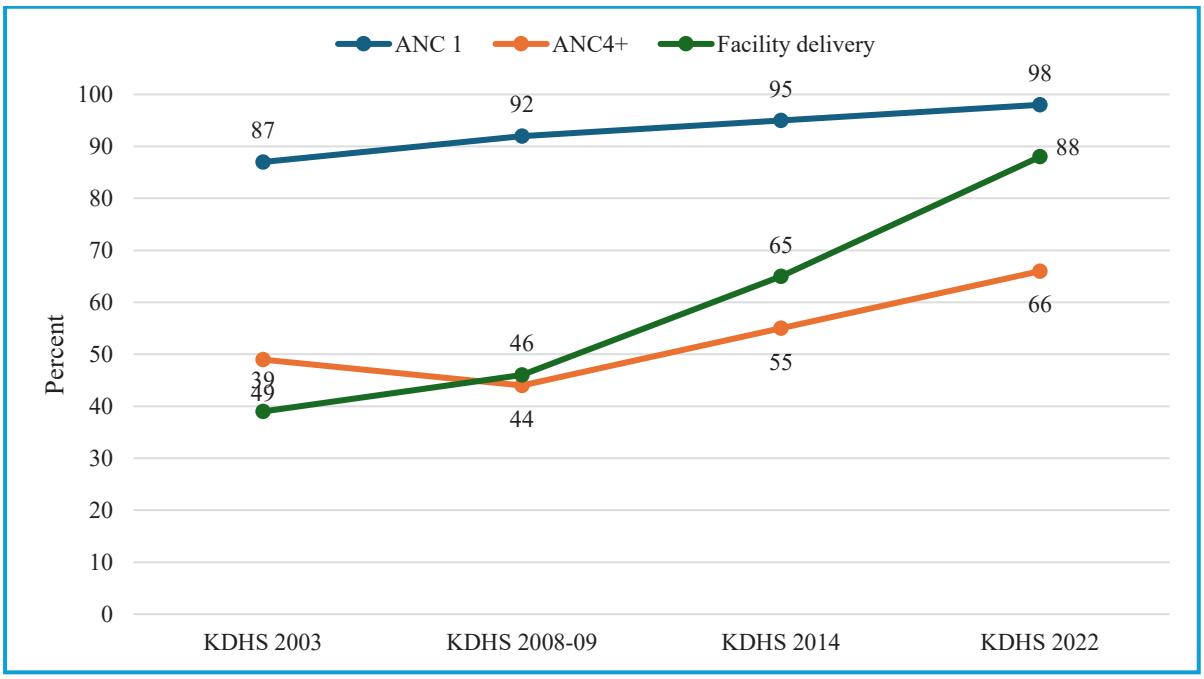



*Figure 2.10: Trends in coverage of maternal care services*

A similar trend is apparent in post-natal care services, as summarised in Figure 2.12.

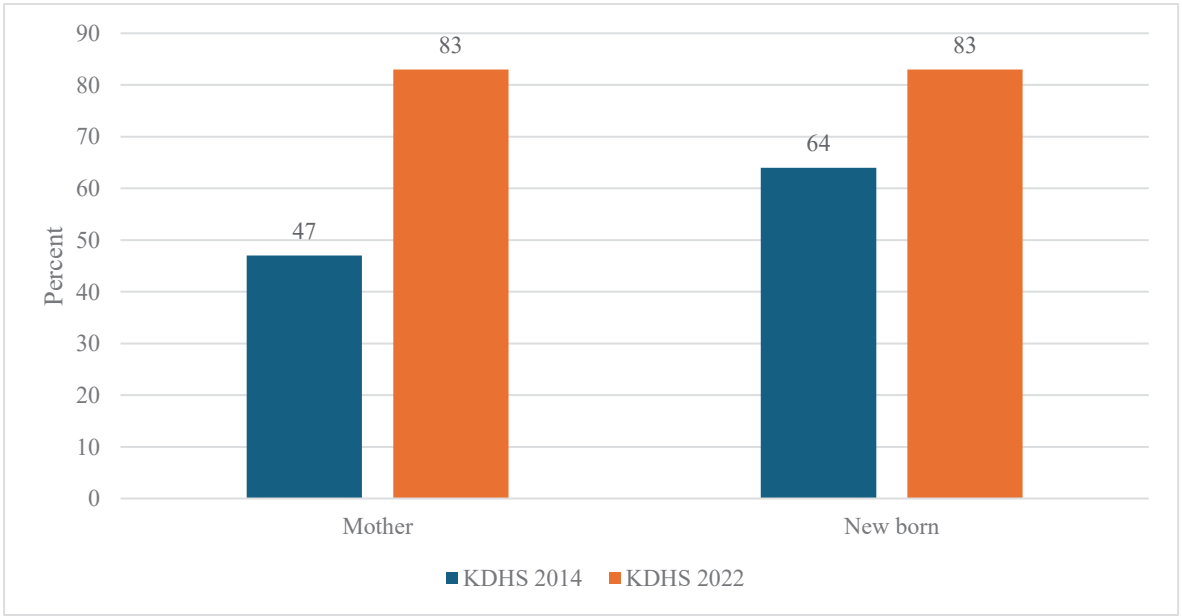



*Figure 2.11: Mothers and newborn who received postnatal care within 2 days*

Reducing stillbirths and newborn mortality requires a strengthened health system capable of delivering both basic and comprehensive emergency obstetric and newborn care (CEmONC), as well as ensuring safe deliveries. A major contributor to newborn deaths—such as asphyxia—often results from delays in responding to intrapartum foetal distress, highlighting the need for timely and effective interventions. However, the quality of health personnel, interventions and equipment remains low, even in referral (Level 4) public and private hospitals. The most limited resources include assisted feeding support for infants to establish breastfeeding (50%), incubators (58%) and ventilation support (34%). These gaps significantly hinder the ability to provide life-saving care for newborns in critical condition.

The country has made significant progress in meeting EPMM Target 4, including putting in place policies and guidelines for access to emergency obstetric care (EmOC), including a national strategy/implementation plan for scale-up, specific budget lines in the national plans and county plans), EmOC facility mapping showing geographical distribution, standardised designs and floor plans for the basic EmOC health facilities, defined minimum number of midwives to be staffed in an EmOC health facility for providing all-around the clock care, a defined list of essential equipment needed for basic and comprehensive EmOC, country capacity to provide yearly data on the performance of EmOC signal functions for measuring the availability of EmOC. However, ENAP Target 4 on scaling up small and sick newborn care had not been comprehensively addressed by considering the above indicators under EmOC. [20]

Figure 2.13 and Figure 2.14 show disparities in service availability across different levels of facilities.

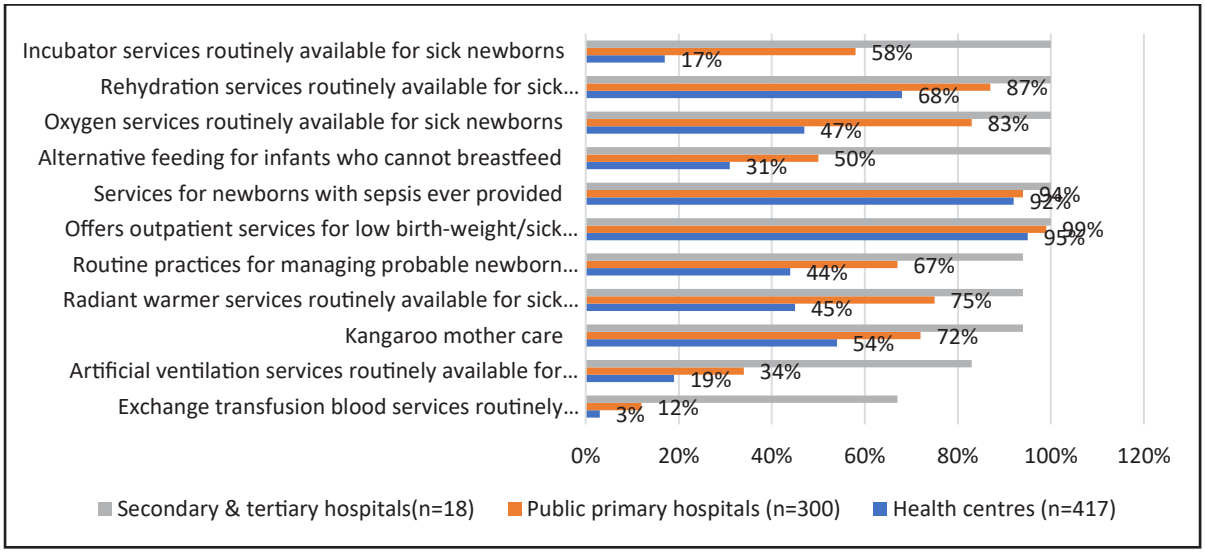



*Figure 2.12: Availability of newborn services*
Source: Adapted from Kenya health facility census, Ministry of Health, 2023.[21]

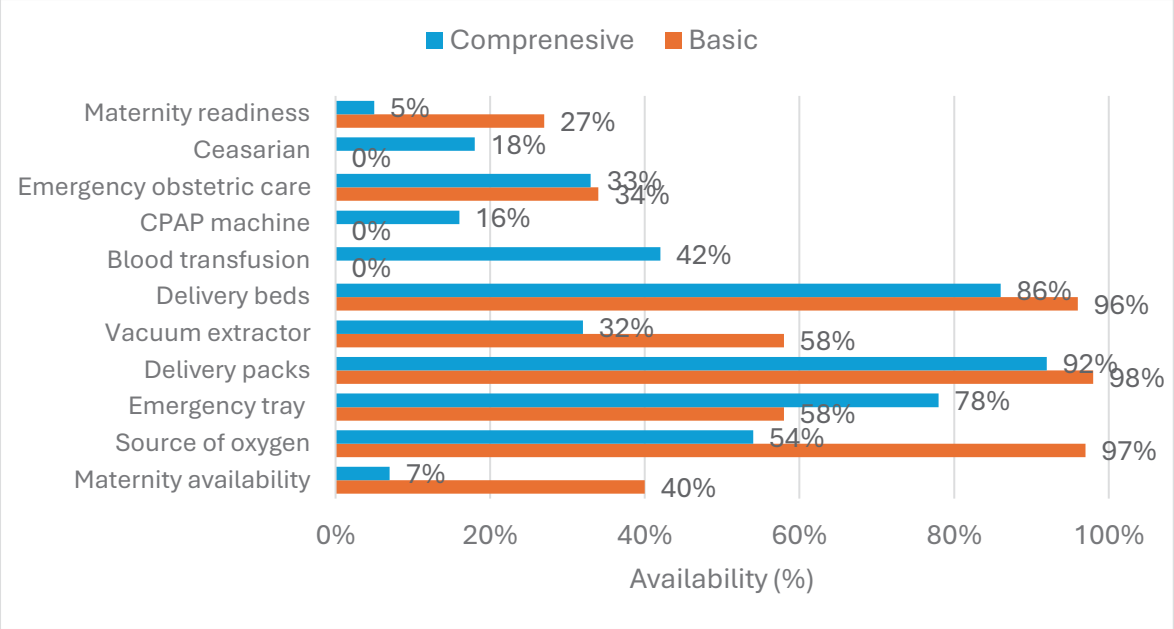



*Figure 2.13: Maternity care service availability and readiness*
Source: Adapted from Kenya health facility census, Ministry of Health, 2023.

The coverage of child health services remains uneven. According to the KDHS 2022, a high proportion of caregivers (87%) sought medical attention for children exhibiting symptoms of acute respiratory infection (ARI). However, only 43% did so on the same day or the following day, indicating delays in care-seeking that could impact health outcomes.

For children with diarrhoea, 58% of caregivers sought advice or treatment—unchanged from 2014—highlighting a stagnation in progress for this key indicator. While child immunisation coverage is generally strong, with 80% of children aged 12–23 fully vaccinated against all basic antigens, there is a need to sustain current levels and scale up efforts for specific vaccines to ensure comprehensive protection for all children.

Quality of care has been enhanced, and actions have been put in place under EWENE[20]. The achievements include the development of

- National quality of care standards for MNH.
- National quality of care standards for small and sick newborn care.
- National quality of care plan included community participation in MNH for priority setting and planning.
- National quality of care plan included community participation in MNH for monitoring and evaluation.
- Set of quality-of-care indicators.
- Maternal and perinatal death surveillance system in place for maternal deaths.
- Maternal and perinatal death surveillance system in place for neonatal deaths.
- Maternal and perinatal death surveillance system in place for stillbirth.
- Integration of maternal and perinatal death surveillance system data and the routine health information system

The challenges facing RMNCAH-N services are outlined in the KHSSP 2023/24-2027/28, and the various programme strategic plans are presented in Table 2.3.

Table 2.3: Challenges and root causes in service delivery

| Number | Challenges | Root cause analysis |
|---|---|---|
| 1. | Health facilities do not have adequate capacity to deliver quality (RMNCAH-N) maternity care services. | • Inadequate capacity strengthening in maternal care among health workers,<br>• Low ratio of health workers to clients.<br>• Insufficient life-saving commodities and Health Products and Technologies (HPT) for quality RMNCAH-N health services.<br>• Sub-optimal strengthening of outreach RMNCAH-N services.<br>• Inadequate quality Adolescent and Youth Friendly RMNCAH-N services, especially for men.<br>• Inadequate capacity to use service delivery data for decision-making (e.g. budgeting, planning, programming). |
| 2. | Poor quality of care at facilities. | • RMNCAH-N QI standards and guidelines have not been disseminated to all counties.<br>• Inadequate CQI mechanisms (QITs) in community and health facility settings.<br>• Insufficient supervision and mentorship for health workers providing RMNCAH-N services.<br>• Insufficient provider knowledge and skill |
| 3. | Low government funding for newborn and child health services at the National and county levels, with no vote head for newborn and child health at the National level. | • Reliance on donor funding leads to inadequate budgeting for RMNCAH-N by Governments.<br>• Budget allocation for RMNCAH-N services not disbursed to County Health Departments.<br>• Inadequate advocacy for domestic resources towards RMNCAH-N services at the county level. |
| 4. | Poor referral systems between health facilities. | • Inadequate ambulances.<br>• Emergency care and referral policy /strategy for RMNCAH-N has not been disseminated at the county level. |

| Number | Challenges | Root cause analysis |
|---|---|---|
| | | • Referral systems require strengthening at all levels of the health system, including the distribution of specialists. |
| 5. | Low availability of facilities offering comprehensive obstetric and newborn emergency services, including newborn resuscitation equipment and drugs. | • Low funding for capacity strengthening on EmONC.<br>• Inadequate staffing in RMNCAH-N service delivery points. |
| 6. | Delays in providing emergency obstetric services cause asphyxia, which contributes to about 15.2% of newborn mortality. | • Inadequate health care workers numbers.<br>• Inconsistent supply of critical care commodities and equipment.<br>• Inadequate NICU and NBU in many parts of Kenya.<br>• Inadequate referral and emergency systems. |
| 7. | The organisation of service delivery in community and facility settings is not optimal. | • Primary Care Networks are not fully functionalised in the context of RMNCAH-N at scale.<br>• Lack of guidelines and strategies on quality RMNCAH-N services to include the principles of continuity, coordination and comprehensive care.<br>• Inadequate performance-based incentives for health workers providing RMNCAH-N services. |
| 8. | Low uptake of RMNCAH-N services | • Insufficient health education/promotion to communities on the importance of RMNCAH-N services. |
| 9. | Women of reproductive age do not have access to quality family planning services. | • Erratic contraceptive health products and technologies (HPTs) and related supplies.<br>• Capacity gaps in some providers to deliver FP services in some facilities that can provide services due to a lack of or obsolete equipment.<br>• Inadequate number of trained health workers for family planning service provision remains a critical challenge, highlighting the |

| Number | Challenges | Root cause analysis |
|---|---|---|
| | | need for sustained efforts in workforce development.<br>• Youth-friendly services are not widely available.<br>• Limited mentorship and supervision at all levels.<br>• Low uptake in arid and semi-arid (ASAL) counties.<br>• Information gaps: Challenges persist in providing adequate information to communities on family planning services.<br>• Inadequate advocacy and sensitisation efforts for community gatekeepers such as religious leaders.<br>• Inadequate funding: The program faces consistent challenges due to inadequate funding for national strategic commodities, hindering the optimal execution of service delivery. |
| 10. | Limited availability of health services for adolescents. | • The health needs of adolescents have largely not been prioritised.<br>• Limited number of facilities providing adolescent-friendly services.<br>• There is limited continuous professional education for primary health care clinicians and nurses to receive specific training on adolescent health.<br>• The absence of national standards for the delivery of health services for adolescents.<br>• There is no enabling legal framework for the legal age of married adolescents to give consent to access health services, including reproductive health interventions and mental health services.<br>• Limited data collection and reporting tools on adolescents in service delivery.<br>• Sub-optimal training of life skills in schools.<br>• Limited budget allocation to support school health and adolescent health activities since the division does not have a vote head. |

| Number | Challenges | Root cause analysis |
|---|---|---|
| 11. | Limited provision of nutritional services for mothers, children and adolescents | • Lack of a holistic approach to nutrition issues for all population groups.<br>• Limited platforms in place to deliver nutrition services.<br>• Inadequate provider capacity to deliver quality nutrition services.<br>• Inadequate funding for nutrition services |

### *2.6.2 Health workforce*

According to the Ministry of Health's 2021 Health Labour Market Analysis (HLMA), Kenya's health workforce is predominantly composed of nurses, clinical officers, and medical doctors, who together account for 77.8% of the total health personnel. The density of doctors, nurses, midwives, and clinical officers stands at approximately 30.14 per 10,000 population—representing 68% of the SDG threshold indicator.[22] While the number of health workers continues to grow through recruitment in both the public and private sectors, significant gaps remain in the availability, distribution, and capacity of the health workforce (Table 2.4).

Table 2.4: HRH challenges and gaps

| Number | Challenges | Root causes |
|---|---|---|
| 1 | Inadequate number and mix of human resources for health. | • Freeze on public sector employment.<br>• Employment inconsistent with HRH norms and standards in line with KEPH level.<br>• Inadequate budget allocations.<br>• Absenteeism. |
| 2 | Skewed distribution of skilled health workers, with some areas of the country facing significant shortages while others have optimum/surplus numbers. | • Tendency to deploy more staff to higher-level (level 4 and above) facilities often located in urban and peri-urban areas. |
| 3 | Ageing health workforce in the public health sector | • Inconsistency in the timely replacement of HRH attrition.<br>• Freeze on public sector employment. |
| 4 | Frequent industrial action. | • Demotivated HRH.<br>• Delayed salary payments<br>• Delayed HRH promotions.<br>• Inadequate budgeting allocations.<br>• Contractual engagement is demotivating. |

| Number | Challenges | Root causes |
|---|---|---|
| | | • Poor working environment, low remuneration, and non-implementation of CBAs. |
| 5 | Inadequate capacity-building activities. | • Inadequate training funds for general capacity building<br>• Inadequate provision of training funds to develop human resources for health in key specialities to meet the health sector demands in the country.<br>• Contractual employment |
| 6 | Inefficiency in HRH use, | • Maldistribution of HRH across counties and levels of health facilities.<br>• Absenteeism. |

These challenges impact the provision of RMNCAH-N services. The shortage of key HRH, especially doctors, has implications for the provision of comprehensive obstetric care, which is not universally provided at higher levels of facilities. According to the Kenya Health Labour Market Analysis Report of 2023, the share of the county health workforce adjusted for the county's share of the population, for doctors, nurses, and clinical officers among key clinical workers, showed an overall distribution skewed by 7.31-fold, such that some counties are more than seven times better off than others. For example, Lamu and Taita Taveta counties have respectively 4.3-folds and 2.7-folds relatively better off in the aggregate distribution of health professionals in the public sector as compared to Kajiado, Narok and Trans Nzoia. About 40% (n = 19) of counties do not have an equitable share of the health workforce when compared with their share of the population.[22] The skewed distribution of HRH across the counties undermines the provision of essential RMNCAH-N services in some counties and rural areas. Besides, the capacities of the available workers need to be updated regularly to ensure quality RMNCAH services are available at different levels of the facility.

### *2.6.3 Health products and technologies*

The Health Products and Technologies (HPT) Supply Chain Strategy 2020-2025 provides the roadmap for a steady supply of quality and affordable HPT through a functional supply chain system. Availability of HPT has improved significantly in the public sector. The mean availability of non-pharmaceuticals in the 2023 health facility census was 76%. However, the country still faces several challenges in ensuring HPT availability at the last mile or at health facilities. The challenges are presented in Table 2.5.

Table 2.5: Challenges and root causes for HPT

| Number | Challenges | Root causes |
|---|---|---|
| 1. | Overreliance on donor funding for RMNCAH-N HPT. | • Inadequate funding for RMNCAH-N HPT by the National and County Governments.<br>• Budget is consolidated with all other health budgets, limiting prioritisation of lifesaving RMNCAH HPT.<br>• Inadequate coverage of RMNCAH-N products in insurance. |
| 2. | Stock-out of RMNCAH-N commodities. | • Inadequate forecasting and quantification at the national, county and facility levels.<br>• Inadequate HRH at the facility level.<br>• Delayed disbursement of funds to KEMSA and other suppliers by the Ministry of Health (MoH) and the counties.<br>• Non-pooled national procurement of strategic essential commodities.<br>• There is an inadequate budgetary provision for the procurement and distribution of strategic commodities.<br>• Delayed payment of funds owed to KEMSA and other suppliers by the Ministry of Health and the counties.<br>• Inadequate infrastructure (stores, storage equipment, cold chain) for effective HPT management. |
| 3. | Limited supply chain management capacity for maternal, newborn and child health commodities. | • Inadequate capacity building of health workers in supply chain management.<br>• Poor data quality with challenges in identifying and managing the supply chain. |
| 4. | Inadequate LMIS. | • Insufficient investment.<br>• Limited accountability.<br>• Limited use due to the shift from manual to digital systems.<br>• Limited use of ICT in most health facilities for effective supply chain management (commodity inventory management, dispensing and linkages to clinical modules and systems such as KHIS). |
| 5. | Limited control of quality for procurement done by the counties. | • Lack of implementation of guidelines for quality control, e.g., post-market surveillance and good distribution practices.<br>• Limited funding for monitoring quality and market surveillance of quality testing. |

| Number | Challenges | Root causes |
|---|---|---|
| | | • Limited post-market surveillance of RMNCAH-N commodities in the counties.<br>• Fragmented pooled procurement of Strategic RMNCAH-N at the county levels |

These challenges continue to hinder the effective delivery of RMNCAH-N services. In particular, inadequate budgetary allocations for the procurement and distribution of strategic public health commodities have constrained KEMSA's ability to implement proposed structural reforms. Additionally, delays in disbursing funds owed to KEMSA and other suppliers by both the Ministry of Health and county governments disrupt procurement processes and supplier payments, often resulting in stock-outs of essential RMNCAH-N health products and technologies (HPTs). Unlike other program-based HPTs, RMNCAH-N products have not benefited from robust market-shaping interventions. Yet, such interventions are critical for rationalising product selection, reducing costs, ensuring quality, improving efficiency, and enhancing availability. Strengthening market-shaping strategies for RMNCAH-N commodities is therefore essential to improving access and sustainability.

Health commodities play an essential role in health service provision, including RMNCAH-N services. However, strategic commodities have been left to the development partners and national government, with minimal or no contribution from the county governments, For instance, the counties do not budget for FP commodities and reproductive health commodities.

### *2.6.4 Health financing*

The Kenya Health Financing Strategy (KHFS) 2020-2030, while recognising that health financing is inadequate in the country, sets three objectives: (a) to mobilise resources required to provide the essential high-quality health services that the people of Kenya need; (b) to maximise efficiency and value for money in the management and utilisation of available health resources; and (c) to ensure equity in the mobilisation and allocation of health funds to guarantee fairness in use. The KHFS sets five targets in its implementation consisting of the attainment of a progressive increase in the total National and County Government allocation to health for Kenya to meet UHC and the SDG targets; instituting mandatory prepayment revenue generation; developing specific programmes best suited for external funding and focused on innovations in service delivery; facilitating functional non-public prepayment mechanisms that are linked to mandatory prepayment mechanisms; and eliminate direct out-of-pocket payments at point of use for essential services.[23]

Over the years, RMNCAH-N services in Kenya have received funding from various sources (see Figure 2.15). The Kenya Health Financing Strategy (KHFS) has played a key role in shaping the current health financing architecture, with a strong emphasis on transitioning towards prepayment mechanisms.

As illustrated in Figure 2.15, the national and county governments collectively represent the largest source of financing for reproductive health services, which are a core component of RMNCAH-N. However, households continue to bear a significant financial burden, with out-of-pocket (OOP) expenditure accounting for 32% of total spending in 2018/19.[24] Reducing this burden is a central objective of the KHFS, which aims to eliminate OOP payments and promote financial risk protection for all.

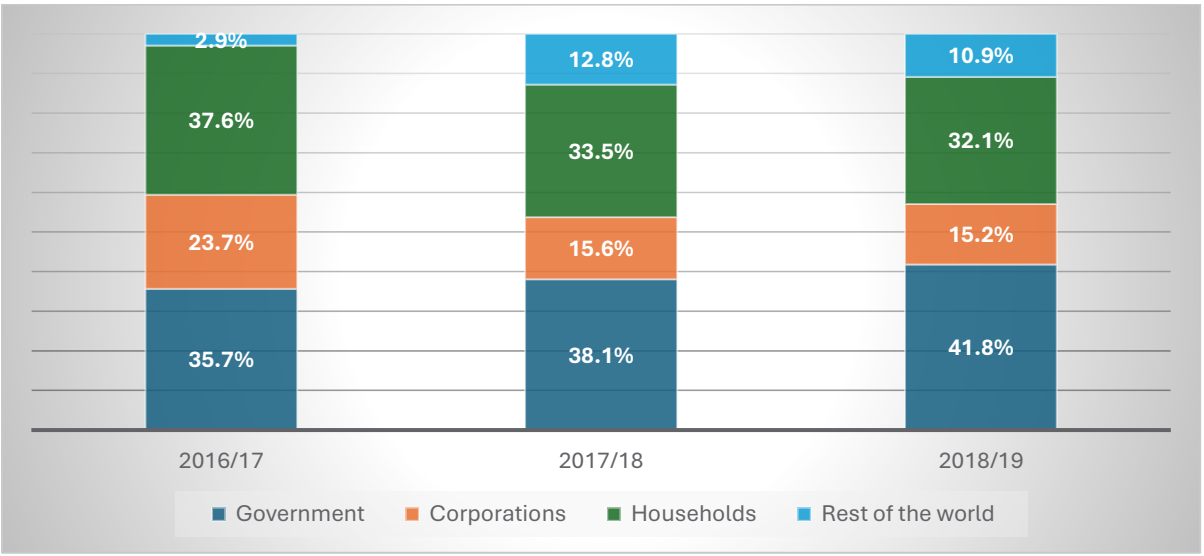



*Figure 2.14: Institutional units providing revenues for financing schemes, CHERH*
*Source*: Adopted from Kenya National Health Accounts Report 2021.

In line with the KHFS 2020-2030 and UHC Policy 2020–2030, the Government of Kenya is currently undertaking health financing reforms to ensure social health insurance coverage for the population. The financing reforms captured in the Social Health Insurance Act[25], the Facility Improvement Financing Act[26], and the Digital Health Act[27], aim to strengthen the financing of universal health coverage in Kenya. Maternity and child health services packages are prominently featured in the new financing, where the package is covered under both the Primary Healthcare (PHC) Fund and the Social Health Insurance Fund (SHIF).

According to the Social Health Insurance Act, the PHC Fund shall be used to purchase primary healthcare services from primary healthcare facilities, pay health facilities for the provision of quality primary healthcare services, and establish a pool for receipt and payment of funds for primary healthcare in the country. The PHC approach prioritises community-level health services through Community Health Units and PHC Networks, structured as hubs (level 4 referral hospitals) and spokes (levels 2 and 3 facilities) to ensure seamless referrals. The FIF Act provides a framework for financing, managing, and administering revenues generated by public health facilities. This Act supports health reforms by improving public health facilities' financial autonomy and resource management. Some delivery services (some normal and assisted delivery) are provided through the PHC fund, which is non-contributory. The challenges are shown in Table 2.6.

Table 2.6: Challenges and root causes for financing

| Number | Challenges | Root causes |
|---|---|---|
| 1. | Unsustainable financing | • Overreliance on donor funding for RMNCAH-N in general.<br>• Low insurance coverage of the population. |
| 2. | Inadequate funding | • Counties experience delays in the flows of funds (equitable share).<br>• Inadequate funding for RMNCAH-N from the National and County Governments.<br>• Limited advocacy for the justification of funding family planning services by the Government. |
| 3. | Equity concerns | • Out-of-pocket health expenditures remain significant, posing a barrier for many households. |

### *2.6.5 Health Information Systems (HIS)*

Data availability and use are critical for systematically tracking progress in the implementation of RMNCAH-N services. Kenya has made notable progress by establishing various platforms within the Kenya Health Information System (KHIS). The Ministry of Health has also prioritised digital health as a key enabler of Universal Health Coverage (UHC), and RMNCAH-N services are expected to leverage this digital infrastructure.

Despite these advancements, several challenges persist that hinder the effective use of health information systems for RMNCAH-N. These include:

- Inadequate government funding for health information systems.
- Over-reliance on donor support at both national and county levels, leading to fragmentation.
- Under-prioritisation of Health Information Systems Monitoring and Evaluation (HISM&E) activities.
- Irregular data review meetings due to limited funding
- Inadequate data collection and reporting tools at service delivery points
- Significant capacity gaps among HMIS staff
- Limited use of data for planning and decision-making
- Persistent issues with data quality

Addressing these gaps is essential to strengthening evidence-based planning and improving the delivery of RMNCAH-N services across the country.

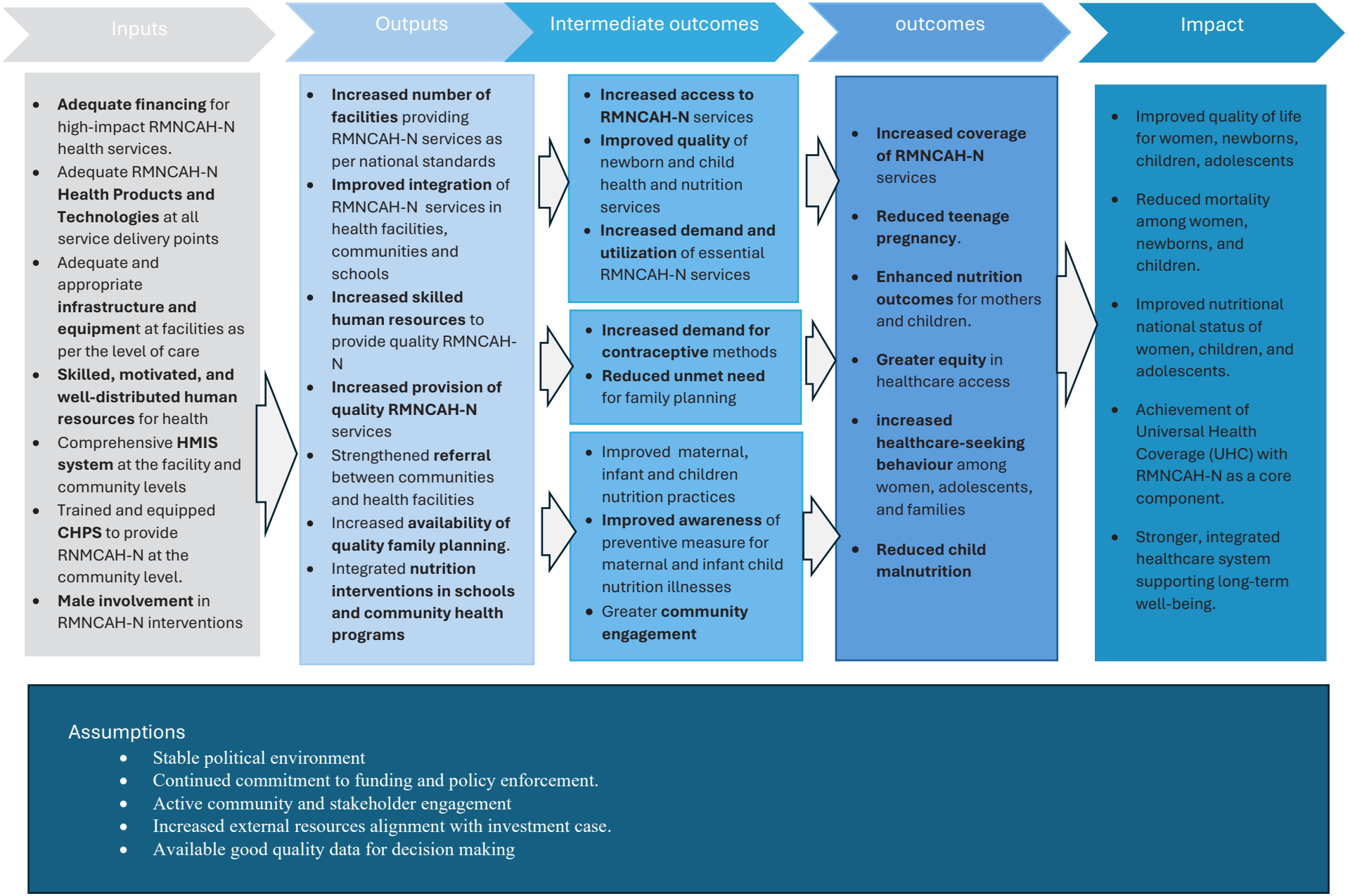
## 2.7 Theory of Change

Strengthening the health system's capacity to deliver RMNCAH-N services, including upgrading facility infrastructure, expanding the pool of skilled healthcare professionals, and streamlining referral networks, can significantly improve service delivery. Expanding access to comprehensive emergency obstetric and neonatal care is crucial to reducing preventable maternal and newborn mortality. Prioritising adolescent health and intensifying demand creation efforts, including family planning outreach, will boost service uptake. Addressing disparities through enhanced nutritional support and equitable distribution of health personnel can fill existing service gaps. Furthermore, increasing and diversifying funding at national and county levels will stabilise commodity supply and improve supply chain performance, ultimately leading to better health outcomes for women, newborns, children, and adolescents.

The key outcomes contributing to this impact include reduced unmet need for family planning, reduced incidence of teenage pregnancy, eliminated gender-based violence and other harmful practices, and improved health and nutritional status for women, newborns, children, and adolescents. These outcomes will be driven by the following key strategic interventions:

1. Provision of high-impact, evidence-based, and quality maternal, newborn, child, and adolescent health and nutrition services across all counties
2. Increased access to and utilisation of quality maternal and newborn services
3. Availability of quality family planning services at all service delivery points
4. Increased demand for family planning services
5. Expanded availability and uptake of adolescent-friendly health services.
6. Robust GBV and GER response services.

Various health inputs will be used to deliver the RMNCAH-N services, generating outputs that will produce the expected outcomes as outlined above. At a broader level, the inputs will include adequate financing, adequate HPT, appropriate infrastructure and equipment, adequate, skilled, and motivated human resources for health, a comprehensive HMIS system at the facility and community level, and increased CHPS trained and equipped to provide RNMCAH-N at the community level.




Assumptions

- Stable political environment
- Continued commitment to funding and policy enforcement.
- Active community and stakeholder engagement
- Increased external resources alignment with investment case.
- Available good quality data for decision making

# PRIORITISED INTERVENTIONS

## 3.1 Introduction to Interventions

This RMNCAH-N IC advocates for the prioritisation of interventions and the removal of barriers to service accessibility, with a focus on optimising both the supply and demand for RMNCAH-N services—particularly among marginalised and vulnerable women, children, and adolescents.

A gender-responsive and respectful approach is essential, aligning with both global and national health priorities, including Kenya's commitment to achieving Universal Health Coverage (UHC). The investment case also addresses immediate and long-term cross-cutting priorities, including:

- Enhancing demand for RMNCAH-N services.
- Improving access to high-quality care.
- Ensuring service quality and responsiveness.
- Promoting integration across health programmes.

Together, these efforts aim to drive better health outcomes for women, children, and adolescents across Kenya.

## 3.2 Maternal, Newborn and Child Health Interventions

**Strategic intervention 1: Strengthen the Maternal and Perinatal Death Surveillance and Response System (MPDSR) to address the quality of care for maternal and perinatal health.**

Key actions:

1. Institutionalise MPDSR at all levels: Mandate routine maternal and perinatal death reviews within health facilities and at the county level.
2. Build the capacity of health workers and administrators to conduct no-blame, action-oriented reviews.
3. Provide technical support to the counties.
4. Roll out national MPDSR tools for case identification, classification, analysis, and recommendation tracking.
5. Ensure Real-Time Reporting: Deploy digital platforms for timely data capture, analysis, and feedback loops.
6. Link MPDSR to Quality Improvement (QI): Ensure that findings directly inform facility-based QI plans and clinical audits.
7. Monitor Implementation of Recommendations: Track progress on corrective actions from death reviews and measure impact over time.
8. Build the capacity of community-based workers, such as CHA and CHPs, to conduct no-blame, action-oriented reviews.
9. Community engagement and surveillance: Include community-level reporting of maternal deaths to capture underreported cases and promote accountability.

**Strategic intervention 2: Improve the quality of basic, comprehensive and intensive Emergency Obstetric and Newborn Care (EmONC) services at primary health centres and hospitals at basic (BEmONC), comprehensive (CEmONC) and intensive (IEmONC) levels as appropriate.**

Key actions:

1. Scale up the provision of high-quality BEmONC at designated primary health facilities.
2. Scale up the provision of high-quality CEmONC services in all hospitals.
3. Scale up implementation of the QoC Standards for MNH in all 47 counties.
4. Bolster consultations at the counties on MNH.
5. Enhance the quality of care during childbirth to prevent any complications.
6. Introduce the Safer Birth Bundle of Care (SBBC) in high-volume facilities.
7. Scale up high-quality Kangaroo Mother Care.
8. Strengthen the neonatal nurse workforce.
9. Enhance community structures in relation to newborn care.
10. Strengthen follow-up of newborns discharged after inpatient care.
11. Develop, launch and disseminate a costed MNCH acceleration plan as well as county-specific costed acceleration plans.

**Strategic intervention 3: Enhance access and utilisation of maternal services.**

Key actions:

1. Capacity building of healthcare providers on the continuum of care package.
2. Capacity building of HCP on self-care.
3. Enhance the service preparedness of health facilities to screen, diagnose, and rehabilitate ROCs.
4. Create awareness and management of maternal mental health at the facility and community level.
5. Enhance post-abortion care services at all levels.
6. Map and review existing facility and community-level data and identify gaps to establish what additional data is needed to inform the prioritisation of interventions.

**Strategic intervention 4: Empower communities to demand respectful maternal care.**

Key actions:

1. Strengthen social accountability mechanisms for maternal health services.
2. Capacity building for community actors in maternal health services

**Strategic intervention 5:** Promote and enhance availability and access to high-impact, evidence-based interventions for the management of all newborns, including small and sick newborns.

*Key actions*:

1. Scale up the provision of comprehensive and essential newborn care services.
2. Scale up the Safer Birth Bundle of Care (SBBC).
3. Enhance community structures in relation to newborn care.

**Strategic Intervention 6: Strengthen referral and linkages to deliver improved quality maternal and newborn services as per the KEPH.**

*Key actions*:

1. Functionalise ambulances, including mobile clinics.
2. Timely referral of clients, including specimen.

**Strategic intervention 7: Promote access to and uptake of preventive interventions for childhood illnesses.**

*Key actions*:

1. Enhance capacity for health care workers on notifiable diseases and community health promoters (CHPs) on Integrated Community Case Management (ICCM) guidelines on common childhood diseases and Community Newborn Care (CMNC).
2. Ensure effective utilisation of the Mother and Child Health (MCH) Handbook
3. Promote uptake of childhood vaccines.

**Strategic intervention 8: Promote access to timely and quality treatment for common childhood illness-major killers (Scale iMNCI and ETAT+).**

*Key actions*:

1. Scale up iMNCI and ETAT+.
2. Promote and strengthen implementation of IMNCI and ETAT+ to address leading causes of child morbidity and mortality and improve the management of severely sick children.

**Strategic intervention 9: Promote access to high-quality and comprehensive early childhood development (ECD) interventions for all children eight years and below, especially nurturing care during the first 1000 days of life.**

*Key actions*:

1. Establish national and county-level multi-sectoral governance mechanisms with decision-making authority to coordinate early childhood development interventions across relevant sectors and stakeholders.
2. Define ECD-specific interventions to be delivered, and existing platforms and contact points into which they can be integrated (e.g. ANC, postnatal care, well child/immunisation visits, etc.).
3. Develop and roll out a training and capacity-building plan for ECD interventions, including service providers and managers.
4.

**Strategic intervention 10: Strengthen the health sector's capacity for identification and appropriate and timely referrals for children with developmental delays, difficulties or disabilities.**

*Key actions*:

1. Introduce/strengthen scheduled well-childcare visits.
2. Strengthen community health promoters (CHPs), ECD teachers and religious leaders' capacity to identify and refer children with challenges to link health facilities.

3. Strengthen intra- and inter-county linkage among health facilities and rehabilitation centres.
4. Enhance the capabilities of health care workers on appropriate and timely referrals.

## 3.3 Family Planning Strategic Interventions

**Strategic intervention 1: Strengthen the capacity of all market segments to deliver quality FP services.**

*Key actions:*

1. Review the National Costed Implementation Plan (CIP) to include the total market approach (TMA) strategy.
2. Build the capacity of healthcare providers to provide quality family planning (FP) services.
3. Strengthen the capacity of private providers, including community pharmacists and pharmaceutical technologists, to provide quality FP services.
4. Integrate FP services in health facilities.
5. Implementation of RH/FP self-care interventions.
6. Promote post-pregnancy family planning intervention in the health care facilities.
7. Strengthen the capacity of community-based distribution of FP commodities per the FP policy.
8. Enhance the quality of family planning services.
9. Provide the required FP methods with the emphasis on long-term methods.
10. Increase awareness creation for DMPA-SC, especially self-injection, by systematically engaging community volunteers for wider coverage and involving men as well as religious and cultural leaders in DMPA-SC programming.
11. Distribute written guidance on DMPA-SC and self-administration to all counties to promote ownership of the self-administered DMPA-SC programme.

**Strategic intervention 2: Increase the availability of quality FP commodities, health products, and technologies at all service delivery points**.

Key actions:

1. Strengthen capacity for selection, quantification and supply chain management for FP HPT at all levels to inform needs and ensure efficient use.
2. Digitise the quantification processes for FP HPT.
3. Enhance supply chain management and distribution of the DMPA-SC commodities by strengthening monitoring of procurement and distribution of the DMPA-SC commodities to health facilities to ensure timely requests of DMPA-SC commodities to meet client choice and needs.

**Strategic intervention 3: Implement quality monitoring and reporting mechanisms for FP HPT.**

**Key actions:**

1. Monitor the FP supply chain, including enhancing supply chain management and distribution of the DMPA-SC commodities by strengthening monitoring of procurement and distribution of the DMPA-SC commodities to health facilities to ensure timely requests of DMPA-SC commodities to meet client choice and needs.

2. Roll out standardised training on FP iLMS to all the counties.
3. Conduct quality assurance/improvement spot checks for FP quality services at the county/facility level for users' safety.
4. Enhance FP supply chain visibility and quality data for efficiency, accountability and informed decision-making.
5. Procure and distribute FP commodities to all service delivery points.

## 3.4 Adolescent Health Strategic Interventions

**Strategic intervention 1: Improve adolescent healthcare-seeking behaviour.**

*Key actions*:

1. Develop appropriate information for improved adolescent health-seeking behaviour.
2. Capacity build adolescents with information for increased healthcare-seeking behaviour.

**Strategic intervention 2: Strengthen community engagement in promoting adolescent health and rights.**

*Key actions*:

1. Build the capacity of CHPs on adolescents' health and rights.
2. Institute community structures to promote adolescent health and rights.

**Strategic intervention 3: Promote awareness of mental health and the harmful effects of substance abuse among adolescents, young people, and communities.**

*Key actions*:

1. Adapt the existing Kenya Mental Health Policy (2015-2030) for adolescents.
2. Enhance mental health awareness in communities.
3. Promote adolescents and young people's awareness of the harmful effects of alcohol, tobacco and other substances.

**Strategic intervention 4: Strengthen service delivery through the provision of inclusive guidelines and service packages.**

*Key actions*:

1. Strengthen service delivery through the provision of guidelines and service packages.
2. Provide quality and comprehensive care for all adolescents, including those with disabilities.
3. Facilitate meaningful adolescent involvement in interventions tailored to address their health needs and well-being.
4. Capacity building for adolescents on life skills to prioritise their health.
5. Improve access to quality health services and information among vulnerable adolescents and those in humanitarian and fragile settings.

**Strategic intervention 5: Promote initiatives that address social risks and deterrence of harmful socio-cultural practices among adolescents.**

*Key actions*:

1. Create initiatives that address harmful and risky socio-cultural practices among adolescents.
2. Strengthen community-based initiatives challenging social norms and attitudes that perpetuate health-related harmful practices.

## 3.5 Nutrition Strategic Interventions

**Strategic intervention 1: Strengthen the policy, legal, and regulatory environment for nutrition.**

*Key actions*:

1. Bolster the policy environment.
2. Disseminate & Implement the KNAP 2023-2027.

**Strategic intervention 2: Increase access and utilisation of comprehensive nutrition services.**

Key actions:

1. Improve capacity for maternal, infant and young child nutrition initiatives.
2. Deliver quality nutrition services.
3. Promote growth monitoring, nutrition education and counselling for infants and young children on optimal breastfeeding and complementary feeding.

**Strategic intervention 3: Strengthen the nutrition environment in the education and health sectors.**

Key actions:

1. Integrate nutrition interventions within the education sector.
2. Mainstreaming nutrition interventions across the private health sector.

**Strategic intervention 4: Strengthen the integrated supply chain management system for nutrition health products and technologies (HPT).**

Key actions:

1. Strengthen capacity on nutrition health products and technologies (HPT).
2. Conduct training and mentorship on nutrition health products and technologies (HPT) management.

## 3.6 Gender-Based Violence, and Gender and Equity Response Interventions

**Strategic Intervention 1: Promote and strengthen GBV prevention through policy development, community engagement, and awareness campaigns.**

*Key actions*:

1. Develop, disseminate, and implement a GBV health sector policy, SEAH policy, and workplace GBV policy.
2. Review and update community GBV packages and IEC materials to ensure inclusivity (e.g., braille, sign language, voiceovers).
3. Develop targeted GBV prevention messages, men, men groups, children and other vulnerable groups.
4. Build the capacity of Community Health Promoters (CHPs) and community Own Resource persons (CORPs) on GBV prevention.
5. Conduct nationwide campaigns to raise awareness about GBV and engage champions to advocate for its elimination.
6. Undertake national campaigns to promote positive attitudes, beliefs and norms, especially for men and boys.
7. Conduct male engagement forums and community dialogues.
8. Provide technical support to the counties.

**Strategic Intervention 2: Ensure comprehensive, survivor-centred, and timely response services for GBV survivors**.

*Key actions*:

1. Bolster the capacity of healthcare workers on clinical management of GBV survivors, forensic sample collection, psychosocial support, and court etiquette.
2. Advocate for the inclusion of GBV supplies in essential commodities and ring-fenced funding for GBV at the county level.
3. Strengthen child-friendly GBV services by providing technical support and monitoring the quality of service.
4. Improve psychosocial support by training health providers and advocating for the employment of more psychologists.
5. Promote self-care among GBV service providers by disseminating self-care handbook and building their capacity on self-care practices.
6. Promote and strengthen GBV prevention.
7. Strengthen the provision of comprehensive, survivor-centred, and timely response services for GBV survivors.
8. Strengthen intersectoral actions, including women empowerment interventions, safe environments, including schools, workplaces, and other public spaces, transport interventions, and technology-facilitated GBV, including cyberbullying.
9. Incorporate care for mental health, including basic psychosocial support, strengthening positive coping methods and treatment for moderate-severe depressive disorder, including post-traumatic stress disorders.

**Strategic Intervention 3: Bolster gender-responsive interventions under the GER.**
*Key actions:*

1. Undertake advocacy and policy dialogues focused on GER challenges.
2. Build the capacity of RMNCAH program managers and health providers on GER integration.
3. Conducting targeted intersectional analyses (gender, equity, barrier, and vulnerability assessments) to guide strategic planning.
4. Ensuring diversity of women, girls, children, adolescents, and older people when defining strategic objectives and target audiences.
5. Prioritise men's and older persons' sexual and reproductive health needs.
6. Expanding RMNCAH services in public health and humanitarian emergencies to all at-risk groups.
7. Establishing a balanced mix of process, outcome, and impact indicators stratified by age, sex, socio-economic status, migration status, etc., including qualitative measures of attitudes, perceptions, and enabling environments
8. Embedding community-led monitoring with equal representation of men, women, and other vulnerable groups

**Strategic Intervention 4: Strengthen national and county-level coordination mechanisms for effective GBV program implementation.**
*Key actions*:

1. Support national GBV health sector Technical Working Group (TWG) meetings and participate in national gender sector working groups.
2. Advocate for counties to establish quarterly GBV prevention and response TWGs and appoint GBV focal persons at the facility, sub-county, and county levels.
3. Promote GBV quality assurance by sensitising providers, building capacity on digitised GBV QA tool, and monitoring service delivery.
4. Establish and coordinate inter-county learning exchange forums for continuous improvement among key stakeholders.
5. Advocate for healthcare providers to participate in the court users committee.
6. Establish or enhance web-based platforms (e.g., national GBV MIS or GBVIMS) to improve data quality, cross-sectoral consolidation, and real-time information sharing to facilitate holistic services for survivors.

## 3.7 RMNCAH-N and Climate Change Interventions

**Strategic Intervention 1: Integrate Climate Change into RNMCAH-N policies and budgets.**
*Key actions*:

1. Build national and county-level capacity on climate change and RMNCAH-N.
2. Include climate change activities in the counties' RMNCAH-N workplans.
3. Mobilise funds for RMNCAH-N services for climate funds.
4. Ensure health, gender, education and youth ministries are involved in project proposals to mobilise climate funds.

5. Scale up public-private partnerships to increase policies and investments for climate change interventions for RMNCAH-N.

**Strategic Intervention 2: Bolster visibility of climate change and RMNCAH-N.**
*Key actions:*

1. Engage women, children, and adolescents in climate change and health issues.
2. Strengthen community awareness of the impacts of climate change.
3. Increase awareness of the impacts of climate change among policymakers.

**Strategic Intervention 3: Evaluate climate change and RMNCAH-N interventions.**
*Key actions*:

1. Support piloting and evaluating health and climate co-financing initiatives.
2. Advance research on the intersectional impacts of climate change on women, children, and adolescents.

## 3.8 Emerging Technology Interventions

**Strategic Intervention 1: Strengthen RMNCAH-N service delivery through the use of emerging technology.**
*Key actions*:

1. Build the capacity of healthcare workers and policy makers in emerging technologies for RMNCAH-N services.
2. Invest in healthcare infrastructure to support technology deployment.
3. Promote public-private partnerships for technology adoption.
4. Monitor and evaluate the impact of technologies on RNMCAH outcomes.

## 3.9 RMNCAH-N Advocacy, Communication and Social Behaviour Change

**Strategic intervention 1: Increase awareness for RMNCAH-N through accurate information to the target audience for positive social behaviour change.**
*Key actions*:

1. Develop RMNCAH-N SBC strategy.
2. Implement a sustained, comprehensive, and targeted family planning social and behaviour change campaign.
3. Identify behavioural patterns, motivations, and barriers among priority populations.

**Strategic intervention 2: Bolster advocacy for increased financing for RMNCAHN services at the national and county levels.**
*Key actions*:

1. Advocate for increased domestic financing for RMNCAH-N.
2. Advocate for continued development partners' funding.
3. Advocate for the retention of trained staff in GBV clinics and structured on-the-job training for new staff.

**Strategic Intervention 3: Enhance male involvement in RMNCAH-N.**
*Key action*:

1. Generate and/or customise guidelines on male involvement in RMNCAH-N.

**Strategic Intervention 4: Enhanced coordination and documentation of RMNCAH-N information.**
*Key actions*:

1. Strengthen documentation of RMNCAH-N information.
2. Increase the visibility of RMNCAH-N.

**Strategic Intervention 5: Strengthen the capacity of RMNCAH-N personnel and media at the national and county levels on Social Behaviour Change (SBC).**
*Key actions*:

1. Enhance the capacities of RMNCAH-N officers.
2. Increase community capacity for RMNCAH-N advocacy.

**Strategic Intervention 6: Integrate RMNCAH-N needs of vulnerable populations.**
*Key action*:

1. Bolster advocacy efforts for service integration.

**Strategic Intervention 7: RMNCAH-N IC dissemination**
*Key action*:

1. Launch and disseminate RMNCAH-N IC widely.

## 3.10 Monitoring and Evaluation Research and Learning Priorities

**Strategic Intervention 1. Strengthen monitoring and evaluation for RMNCAH-N**
*Key actions*:

1. Developing standardised indicators and harmonised data collection tools aligned with global standards.
2. Optimise electronic health information systems (like DHIS2) for real-time data and improving interoperability with other systems.
3. Ensuring data quality via regular audits, supervision, and triangulation methods.
4. Building the capacity of health workers and M&E staff in data analysis, visualisation, and use.
5. Promoting data-driven decision-making through review meetings and dashboards with performance metrics.
6. Engaging communities in monitoring and feedback to foster accountability.
7. Strengthening research and evaluations to assess service coverage, equity, and impact, and to scale effective practices.

**Strategic Intervention 2: Enhance research capacity and learning.**
**Key actions:**

1. Promote the implementation of research and data to innovate and improve the provision of quality evidence-based services.
2. Operationalise reproductive health and other programs.
3. Conduct surveys on various RMNCAH-N issues.

## RMNCAH-N IMPACT ANALYSIS

### 3.1. Health Benefits from RMNCAH-N Investment

The impact of this RMNCAH-N Investment Case was estimated using two modelling tools: the Lives Saved Tool (LiST) module within the Spectrum suite for maternal, newborn, and child health, and the ImpactNow model for family planning. Coverage targets for various services, as outlined in the Kenya National Health Sector Strategic Plan 2023–2027, were used to project the expected health outcomes. Specifically, reproductive, maternal, newborn, child, and adolescent health and nutrition intervention targets—detailed in the monitoring and evaluation indicators in Appendix C—were incorporated into the LiST module for impact analysis.

The analysis was based on several baseline coverage assumptions. Additionally, assumptions regarding the percentage of deaths by cause were integrated into the Spectrum model to estimate the number of deaths that could be averted through the scale-up of services proposed in this investment case (see Tables 4.1, 4.2, and 4.3).

Table 4.1: % of maternal deaths by proximate causes

| Cause | Percent |
|---|---|
| Antepartum haemorrhage | 8.5% |
| Intrapartum haemorrhage | 0.8% |
| Postpartum haemorrhage | 47.8% |
| Hypertensive disorders | 21.0% |
| Sepsis | 4.0% |
| Abortion | 12.0% |
| Embolism | 1.0% |
| Other direct causes | 3.0% |
| Indirect causes | 2.0% |
| **Total** | **100%** |

Source: Guttmacher Institute, 2024.

Table 4.2: % of neonatal deaths by proximate causes

| Cause | Percent |
|---|---|
| Neonatal - Diarrhoea | 0.78% |
| Neonatal - Sepsis | 5.37% |
| Neonatal - Pneumonia | 7.39% |
| Neonatal - Asphyxia | 23.75% |
| Neonatal - Prematurity | 42.75% |
| Neonatal - Tetanus | 0.12% |
| Neonatal - Congenital anomalies | 8.65% |
| Neonatal - Other | 11.09% |
| **Total** | **100%** |

*Source*: World Health Organisation

Table 4.3: % of postnatal deaths by proximate causes

| Cause | Percent |
|---|---|
| Diarrhoea | 15.67% |
| Pneumonia | 20.94% |
| Meningitis | 2.55% |
| Measles | 0.02% |
| Malaria | 9.97% |
| AIDS | 3.68% |
| Injury | 14.89% |
| Other - Infectious Diseases | 25.72% |
| Other - NCD | 6.55% |
| **Total** | **100%** |

*Source*: World Health Organization

The maternal mortality ratio (MMR) for the baseline year was estimated using the Spectrum model, starting from 2019, the year in which the MMR was recorded at 355 deaths per 100,000 live births, as reported in the 2019 Kenya Population Census. Using this figure, along with observed coverage levels for prenatal and delivery services, the model generated an estimated MMR, with results presented in Table 4.4.

For the purposes of this investment case, an MMR of 269 per 100,000 live births for the year 2024/25 was calculated and adopted as the baseline. The projected impact of scaling up RMNCAH-N services, as outlined in this investment case, is reflected in a further reduction in the maternal mortality ratio, as shown in Table 4.5.

Table 4.4: Estimated MMR trend for impact analysis

| Year | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 |
|---|---|---|---|---|---|---|---|
| Maternal mortality ratio (deaths per 100,000 live births) | 355 | 338 | 321 | 304 | 289 | 275 | 262 |

Table 4.5: Impact of the investment on key indicators

| **Year** | **2024/25 (Baseline)** | **2025/26** | **2026/27** | **2027/28** | **2028/29** | **2029/30** |
|---|---|---|---|---|---|---|
| Maternal mortality ratio (deaths per 100,000 live births) | 262 | 240 | 220 | 200 | 181 | 164 |
| Neonatal mortality rate (deaths per 1,000 live births) | 18 | 17 | 17 | 16 | 16 | 15 |
| Infant mortality rate (deaths per 1,000 live births) | 26 | 25 | 24 | 24 | 23 | 22 |
| Under-five mortality rate (deaths per 1,000 live births) | 34 | 33 | 31 | 30 | 29 | 28 |

In addition, the estimated health benefits of all interventions—including maternal, newborn, child, adolescent, family planning, and nutrition—are presented in Table 4.6, in terms of lives saved relative to the 2024/25 baseline.

Table 4.6: Additional lives saved by investment in RMNCAH-N

| Category | 2024/25 (Baseline) | 2025/26 | 2026/27 | 2027/28 | 2028/29 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|
| Additional children lives saved from all RMNCAH-N interventions | 0 | 1,895 | 3,751 | 5,610 | 7,462 | 9,277 | 27,995 |
| Stillbirths prevented by maternal and newborn interventions | 0 | 717 | 1,452 | 2,203 | 2,968 | 3,731 | 11,071 |
| Additional maternal lives saved from RMNCAH-N interventions | 0 | 529 | 838 | 1,245 | 1,753 | 2,130 | 6,495 |
| Total additional lives saved | 0 | 3,141 | 6,041 | 9,058 | 12,183 | 15,138 | 45,561 |

The table above provides compelling evidence of the substantial health benefits achieved through the provision of nutrition, maternal, newborn, and child health (MNCH), and family planning (FP) services. The most critical impact is the prevention of premature deaths among children and pregnant women. Additionally, the investment in family planning contributes to reducing maternal mortality by preventing unsafe abortions.

Beyond health outcomes, the RMNCAH-N investment also yields substantial economic benefits. These are reflected in increased productivity among the population reached by these services, as illustrated in Table 4.7.

Table 4.7: Return on Investment

| Year | Incremental productivity benefits (KSh million) | Incremental cost of RMNCAH-N (KSh million) | Return on Investment |
|---|---|---|---|
| 2025/26 | 37,918 | 4,648 | 8.16 |
| 2026/27 | 75,491 | 5,983 | 12.62 |
| 2027/28 | 113,255 | 8,082 | 14.01 |
| 2028/29 | 151,024 | 11,854 | 12.74 |
| 2029/30 | 188,117 | 14,693 | 12.80 |
| Total | 565,805 | 45,261 | 12.50 |

Investing in maternal, newborn, child, and adolescent health—as well as in family planning and nutrition—offers substantial returns. For every shilling invested, Kenya is projected to gain KSh 565 billion in productivity returns. Over the period 2025/26 to 2029/30, each shilling invested is expected to yield KSh 12.50 in productivity gains.

While the rate of return varies depending on the level of additional investment required for each intervention, all returns are significant. This impressive return on investment (ROI) highlights the immense value of RMNCAH-N interventions. An ROI exceeding KSh 1 confirms that the investment is not only worthwhile but also transformative. Improved health and well-being translate into powerful economic gains, creating a virtuous cycle of prosperity and sustainable development for the nation.

### 3.2. GBV Impact

The government of Kenya has set the elimination of GBV by 2030 as its target. Two scenarios are presented: one with no scale-up of GBV interventions and another with scale-up of the interventions. In this investment case, the impact and costing tools provided by the UNFPA Impact40 were used. The unit costs used in the analysis were based on the local data; hence, default ones were not used. The incremental coverage used from the baseline of 2024/25 is presented in Table 4.8.

Table 4.8: Incremental coverages used

| Intervention | Target population | Baseline 2024/25 | Target for 2030 |
|---|---|---|---|
| Couples counselling and therapy | couples | 0 | 90 |
| Empowerment training for women and girls, including life skills, safe spaces, and mentoring | married women | 2 | 30 |
| Life-skills/school-based curriculum, rape and dating violence prevention training | children | 0 | 90 |
| Community mobilization | Women and men | 0 | 90 |
| Group education with men and boys to change attitudes and norms | men | 0 | 90 |

The result is a decline in the percentage of the population experiencing GBV, as shown in Figure 4.1.

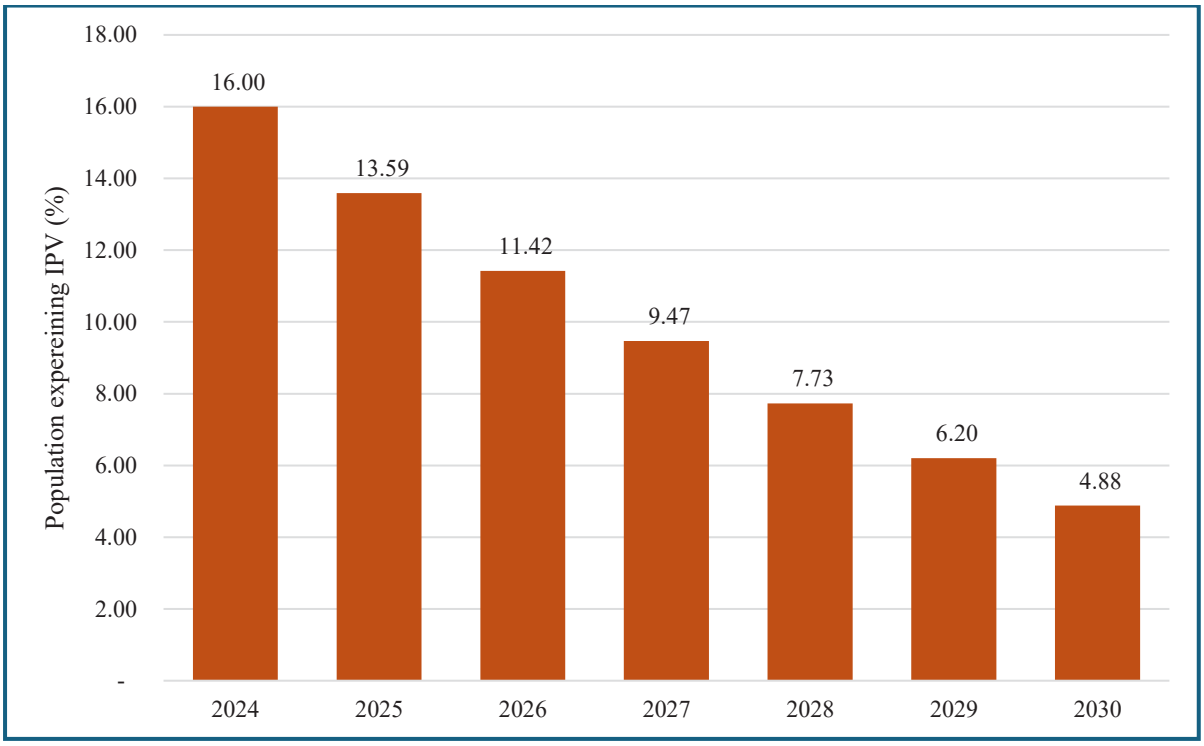



*Figure 4.1: Trend in % of GBV prevalence*

# RESOURCE REQUIREMENTS AND FINANCIAL GAP ANALYSIS

## 5.1 Overall RMNCAH-N Resource Requirements

The financial resource requirements for this RMNCAH-N investment case were estimated using an activity-based approach. The trend in the estimated total financial resources is shown in Figure 4.1. The total investment required will increase over time as the RMNCAH-N services are scaled up in accordance with the KHSSP's expected coverage for the various services. The total investment is estimated at KSh 79,586 million (US$612 million)[1] in 2025/26, KSh 85,167 million (US$655 million) in 2026/27, KSh 90,580 million (US$697 million) in 2027/28, KSh 98,744 million (US$760 million) in 2028/29 and KSh 105,790 million (US$814 million) in 2029/30. The required investment in the five years is estimated at KSh 460 billion (US$3.54 billion). The investment requires contributions from all sources, including the National Government, County Government, social health insurance, the domestic private sector, and international Development Partners.

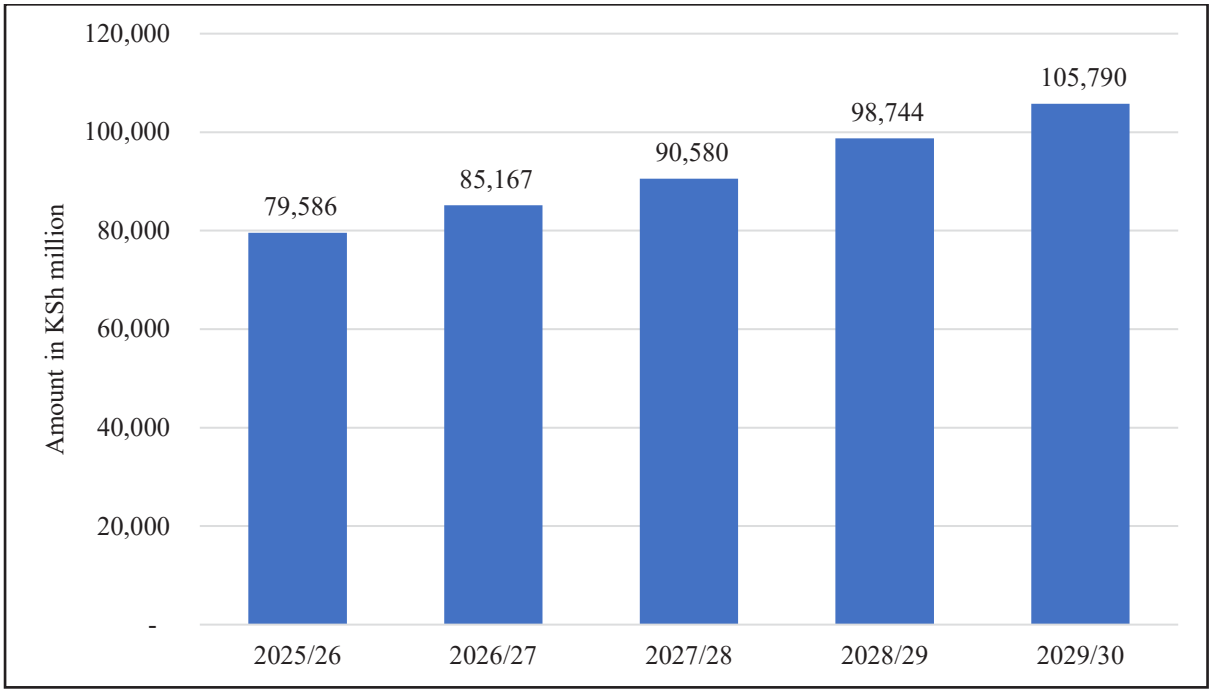



*Figure 5.1: Trends in total investment (KSh million)*

Table 5.1 shows the investment as distributed by the RMNCAH-N programme areas. Maternal and Newborn Health (MNH) take the largest investment each year. For instance, as shown in Table 5.2, MNH accounts for over 40% of the total investment cost in each, followed by immunisation (18%), child health (over 12%), GBV/GER (8%), and family planning (over 6.7%). Although the percentage of estimated resources for adolescent interventions looks small, it is important to note that adolescents will also benefit from other services, whose costs encompass all the users irrespective of age.

[1] An exchange rate of KES 130 per 1US$1 is used for all the five years of the IC.

Table 5.1: Required investment by programme area (KSh million)

| Programme Area | 2025/26 | 2026/27 | 2027/28 | 2028/29 | 2029/30 | Total |
|---|---|---|---|---|---|---|
| Adolescent Health (excluding service delivery) | 307 | 826 | 433 | 379 | 315 | 2,261 |
| Advocacy communication, and SBC | 912 | 1,171 | 1,065 | 1,111 | 1,220 | 5,479 |
| Child Health | 9,673 | 11,331 | 13,164 | 15,146 | 17,372 | 66,686 |
| Climate Change and RNMNCAH-N | 323 | 319 | 337 | 422 | 400 | 1,800 |
| Emerging Technologies | 4,047 | 4,274 | 4,540 | 5,010 | 5,310 | 23,181 |
| Family planning | 5,764 | 5,945 | 6,125 | 6,433 | 6,618 | 30,885 |
| GBV | 4,023 | 5,750 | 7,509 | 9,214 | 10,883 | 37,379 |
| Immunisation (vaccines and related supplies) | 15,753 | 15,869 | 16,564 | 17,535 | 18,437 | 84,158 |
| M&E | 1,089 | 1,100 | 1,177 | 1,246 | 1,246 | 5,858 |
| Maternal and newborn | 36,988 | 37,599 | 38,722 | 41,406 | 43,302 | 198,017 |
| Nutrition | 707 | 984 | 943 | 842 | 685 | 4,161 |
| **Total** | **79,586** | **85,167** | **90,580** | **98,744** | **105,790** | **459,867** |

Table 5.2: Required investment by programme area (% per year)

| Programme Area | 2025/26 | 2026/27 | 2027/28 | 2028/29 | 2029/30 | Total |
|---|---|---|---|---|---|---|
| Adolescent Health (excluding service delivery) | 0.4% | 1.0% | 0.5% | 0.4% | 0.3% | 0.5% |
| Advocacy communication and SBC | 1.1% | 1.4% | 1.2% | 1.1% | 1.2% | 1.2% |
| Child Health | 12.2% | 13.3% | 14.5% | 15.3% | 16.4% | 14.5% |
| Climate Change and RNMNCAH-N | 0.4% | 0.4% | 0.4% | 0.4% | 0.4% | 0.4% |
| Emerging Technologies | 5.1% | 5.0% | 5.0% | 5.1% | 5.0% | 5.0% |
| Family planning | 7.2% | 7.0% | 6.8% | 6.5% | 6.3% | 6.7% |
| GBV | 5.1% | 6.8% | 8.3% | 9.3% | 10.3% | 8.1% |
| Immunisation (vaccines and related supplies) | 19.8% | 18.6% | 18.3% | 17.8% | 17.4% | 18.3% |
| M&E | 1.4% | 1.3% | 1.3% | 1.3% | 1.2% | 1.3% |
| Maternal and newborn (MNH) | 46.5% | 44.1% | 42.7% | 41.9% | 40.9% | 43.1% |
| Nutrition | 0.9% | 1.2% | 1.0% | 0.9% | 0.6% | 0.9% |
| Total | 100% | 100% | 100% | 100% | 100% | 100% |

Human Resources for Health (HRH) will account for the largest share of the cost, at over 36% each year. The Government is assumed to bear this cost, mainly from the county governments. Other recurrent costs, which include training, capacity building, facility operations and maintenance, advocacy and demand creation, and M&E, will account for the second largest share of the costs of implementing the RMNCAH-N Investment Case. Medicines, supplies, FP commodities and vaccines will constitute a significant portion of the total costs. The investment categorised by type of input is shown in Table 5.3.

Table 5.3: Investment by input category (KSh billion, %)

| Year | Unit of measurement | Emerging Technologies | FP commodities and supplies | Human Resources for Health | Medicines and Supplies | Other Recurrent costs, including training and capacity building | Vaccines | Total |
|---|---|---|---|---|---|---|---|---|
| 2025/26 | KSh billion | 3,790 | 2,392 | 27,702 | 9,824 | 23,120 | 12,758 | 79,586 |
| | % | 4.8% | 3.0% | 34.8% | 12.3% | 29.1% | 16.0% | 100% |
| 2026/27 | KSh billion | 4,056 | 2,451 | 28,939 | 10,727 | 26,209 | 12,784 | 85,167 |
| | % | 4.8% | 2.9% | 34.0% | 12.6% | 30.8% | 15.0% | 100% |
| 2027/28 | KSh billion | 4,313 | 2,511 | 30,300 | 11,718 | 28,351 | 13,388 | 90,580 |
| | % | 4.8% | 2.8% | 33.5% | 12.9% | 31.3% | 14.8% | 100% |
| 2028/29 | KSh billion | 4,702 | 2,572 | 31,807 | 12,792 | 32,602 | 14,269 | 98,744 |
| | % | 4.8% | 2.6% | 32.2% | 13.0% | 33.0% | 14.5% | 100% |
| 2029/30 | KSh billion | 5,038 | 2,635 | 33,398 | 13,916 | 35,723 | 15,080 | 105,790 |
| | % | 4.8% | 2.5% | 31.6% | 13.2% | 33.8% | 14.3% | 100% |

## 5.2 Available Resources and Funding Gap

The estimation of available resources for the RMNCAH-N Investment Case was informed by data from multiple sources. County government expenditure figures were obtained from budget implementation review reports prepared by the Controller of Budget and supplemented with county-level expenditure reports. Using data on spending for medicines, reagents, medical supplies, and operations and maintenance, projections were made based on a 5% annual growth rate—aligned with Kenya's projected economic growth, which directly influences government revenue.

It was assumed that RMNCAH-N services account for approximately 30% of total county health expenditures, based on utilisation data. Further assumptions included that the National Government would cover 50% of programme costs, while county governments would finance all Human Resources for Health (HRH) related to RMNCAH-N service delivery. Additionally, the National Government is expected to maintain its current level of funding for family planning commodities and continue contributing to Universal Health Coverage (UHC), from which RMNCAH-N services benefit. National Government commitment for vaccines procurement, according to budget estimates up to 2027/28, was used and extrapolated to 2029/30. These assumptions were integral to estimating the financial resources available to support the implementation of the investment case.

Data on development partners' contributions were sourced from the Development Partners for Health in Kenya (DPHK) survey report and the World Bank/GFF Kenya country commitment for the period under review. The planned contribution from USAID was excluded from the analysis. Table 5.4 presents the estimated available resources from the three primary sources, totalling approximately KSh 49.92 billion (US$384 million) in 2025/26, KSh 53.57 billion (US$412 million) in 2026/27, KSh 53.78 billion (US$414 million) in 2027/28, KSh 56.32 billion (US$433 million) in 2028/29, and KSh 52.47 billion (US$404 million) in 2029/30.

Table 5.4: Estimated available resources by source (KSh million)

| Source | 2025/26 | 2026/27 | 2027/28 | 2028/29 | 2029/30 | Total |
|---|---|---|---|---|---|---|
| County Government | 33,465 | 34,990 | 36,653 | 38,478 | 40,403 | 183,989 |
| National Government | 5,900 | 6,745 | 7,450 | 8,165 | 8,890 | 37,150 |
| Development Partners | 10,552 | 11,830 | 9,679 | 9,679 | 3,179 | 44,917 |
| **Total** | 49,916 | 53,565 | 53,782 | 56,321 | 52,472 | 266,056 |

Figure 5.2 illustrates the projected funding gap, calculated as the difference between available resources and the total investment required for RMNCAH-N services. This gap is expected to widen over time, starting at approximately KSh 29.67 billion (US$228 million) in 2025/26 and increasing to about KSh 53.32 billion (US$410 million) by 2029/30. This growing shortfall highlights the urgent need for strategic resource mobilisation and sustainable financing mechanisms to ensure the successful implementation of the investment case.

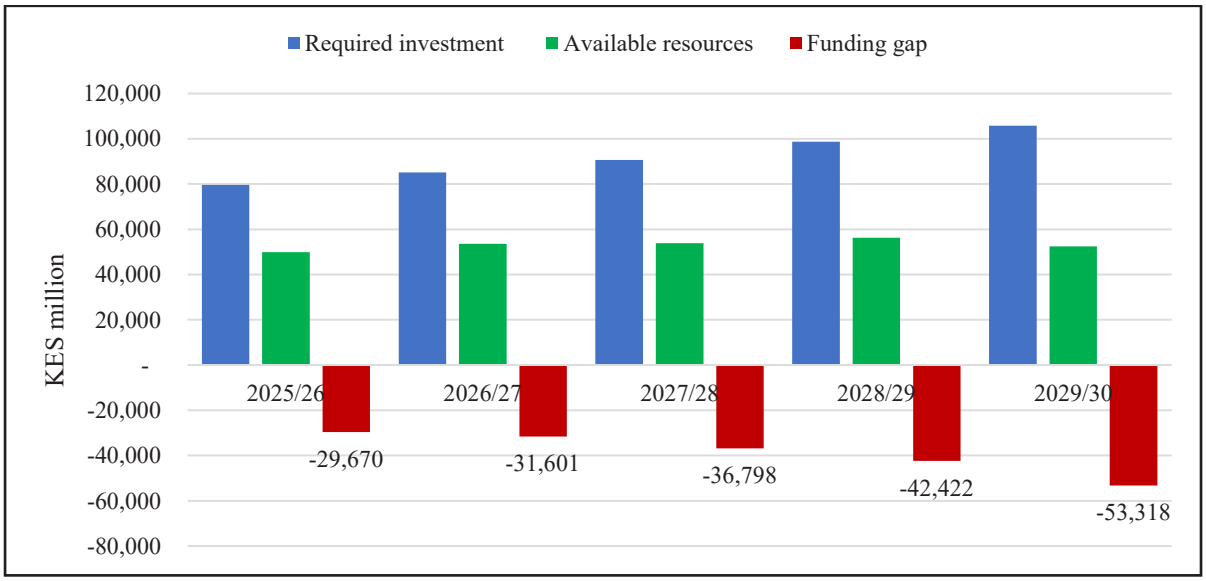



*Figure 5.2: Estimated total funding gap (KSh million)*

## INSTITUTIONAL IMPLEMENTATION ARRANGEMENTS

Leadership and governance encompass the provision of strategic direction, the formulation of appropriate policies and plans, and the establishment of effective oversight, regulation, motivation, and partnerships. These elements are essential for integrating all health system building blocks to achieve desired health outcomes. The development and implementation of the RMNCAH-N IC is a country-led process anchored in the RMNCAH-N Multistakeholder Country Platform at the national level. This platform's primary objective is to provide advisory, oversight, coordination, guidance, advocacy, and accountability for Kenya's ongoing and planned efforts to improve RMNCAH-N services and health outcomes.

The platform aims to strengthen coordination and implementation of RMNCAH-N services, mobilise resources, and enhance accountability for health outcomes for women, children, and adolescents. Its guiding principles align with globally recognised development effectiveness standards and the Kenya Health Sector Partnership and Coordination Framework. These principles emphasise government leadership, inclusive and meaningful participation, transparency, open communication, and mutual accountability.

The National RMNCAH-N Multistakeholder Country Platform will be chaired by the Government Focal Point for Kenya and co-chaired by a representative from the County Health Forums. Membership will include representatives from the Ministry of Health, relevant enabling ministries, county governments, development partners, civil society, the private sector, professional associations, and youth organisations. The platform will convene quarterly meetings, with outcomes presented at the Health Sector Intergovernmental Consultative Forum by the chair or co-chair. Policy issues will be escalated to the Health Sector Advisory/Oversight Committee (HSAOC) and the Health Summit. The chair will ensure that RMNCAH-N remains a standing agenda item at all meetings and may call special sessions as needed. A dedicated secretariat—comprising the Ministry of Health, Government of Germany (GoG), HENNET, and DPHK—will support the platform by organising meetings, preparing agendas and reports, and managing communications. Existing RMNCAH-N technical working groups will continue their regular meetings, with their deliberations presented to the country platform through their respective leadership.

At the county level, implementation will be integrated into existing county engagement forums. The national platform will support these forums to carry out similar functions—advisory, oversight, coordination, guidance, advocacy, and accountability—tailored to the specific RMNCAH-N priorities and outcomes of each county.

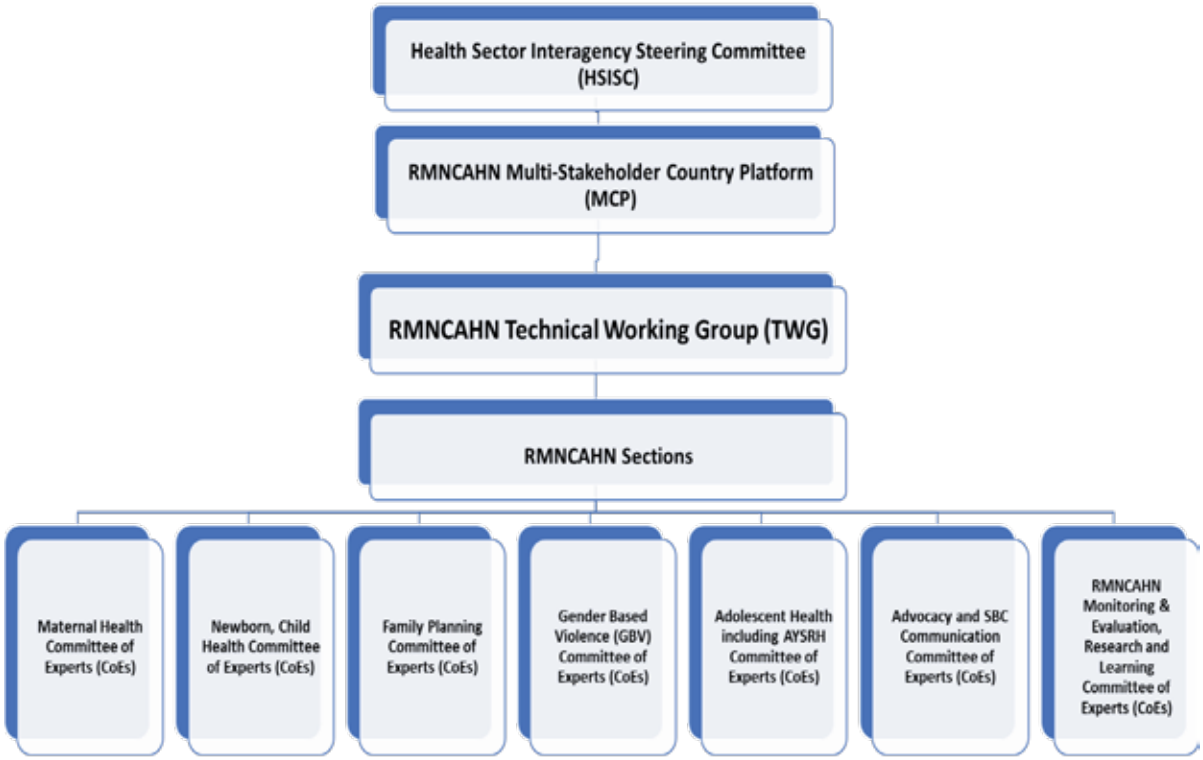



*Figure 6.1: Institutional arrangement for RMNCAH-N implementation*

Table 6.1: Roles and responsibilities of stakeholders

| **Institution** | Roles and Responsibilities |
|---|---|
| Ministry of Health | • Provides leadership and stewardship, including convening members of the country platform.<br>• Purchasing and/or providing RMNCAH-N services with a focus on reducing inequities and improving quality.<br>• Fostering an enabling environment, including clear accountability<br>• Domestic resource mobilisation.<br>• Leading annual progress reviews, including the necessary data collection and analysis (HMIS, surveys, etc.) to allow for monitoring progress.<br>• Technical advisory to the Cabinet Secretary on RMNCAH-N matters.<br>• Provide technical and logistical support to ensure that there is adequate capacity for the implementation of the RMNCAH-N Investment Case.<br>• Coordination of partnerships and collaborations for implementation of RMNCAH-N Investment Case |
| County Governments | • Provide equitable access to high-quality, affordable RMNCAH-N services.<br>• Mobilise and allocate resources for RMNCAH-N service delivery in the county.<br>• Promote the uptake of RMNCAH-N services through community health strategy structures. |

| Institution | Roles and Responsibilities |
|---|---|
| | • Adopt and/or customise national government policies and guidelines for RMNCAH-N |
| Other Ministries | • Mainstream and advocate for RMNCAH-N in their strategies and programming activities.<br>• **Participate effectively in the RMNCAH-N Multistakeholder Country Platform meetings** |
| The Multi-Stakeholder Country Platform at the National and County Level | • Set strategic directions (policy, technical, and financial) for the national and county approach to RMNCAH-N investments and financing.<br>• Strengthen collaboration, coordination, and facilitate dialogue among government ministries at national and county levels, civil society, development partners, academia, private sector, and communities supporting implementation and monitoring of RMNCAH-N services.<br>• Mobilize resources to ensure complementary financing to support the implementation and monitoring of the national RMNCAH-N Investment Case; this includes domestic and/or external resources and others.<br>• Support the development and implementation of the RMNCAH-N Investment Case linked to health financing reforms.<br>• Monitor implementation progress of the investment framework (monitoring and evaluation), including data use and resource flows for key RMNCAH-N priorities, and facilitate discussion with country stakeholders to address challenges.<br>• Advocate for appropriate evidence-based implementation research for RMNCAH-N<br>• Foster mutual accountability in the implementation and monitoring of the RMNCAH-N investment framework; and<br>• Align platform activities with the growing momentum on strengthening PHC and progress towards the achievement of UHC. |
| Parliament | • Support resource allocation for ensuring high and sustained RMNCAHN coverage and equity and implementation of the RMNCAHN IC.<br>• Enact relevant legislation anchoring RMNCAHN policy into law.<br>• Support policy implementation in their areas of jurisdiction |
| Pharmacy and Poisons Board | • Ensure all RMNCAH-N high HPT are registered for use.<br>• Periodically assess all RMNCAH-N HPT in the country for conformity to desired quality standards and potency. |
| KEMSA | • Facilitate storage and distribution of essential RMNCAH-N commodities and technologies identified by the Ministry for effective implementation of this Investment Case. |
| Professional associations, regulatory and statutory bodies | • Advocate for, regulate and enforce policy aspects related to their respective bodies.<br>• Advocacy for and provision of guidance on RMNCAH-N to other stakeholders as per policy. Participate in policy formulation, implementation, and monitoring.<br>• Adaptation and dissemination of standards and guidelines.<br>• Pre- and in-service training.<br>• Voicing health workforce challenges and developing effective strategies to address them. |

| Institution | Roles and Responsibilities |
|---|---|
| Academic, Research and Health Training Institutions | • Enhance RMNCAH-N training and capacity building.<br>• Conduct research to inform and guide policy on RMNCAH-N.<br>• Support awareness creation on RMNCAH-N |
| Development partners | • High-level advocacy to build commitment to RMNCAH-N issues.<br>• Strengthen the capacity of in-country partners through coordinated policy, technical and financial assistance.<br>• Foster cross-country sharing of knowledge, best practices, and country experiences.<br>• Donor coordination – reinforce existing coordination mechanisms.<br>• Aligning ongoing investments in TA and service delivery with the Investment Case.<br>• Ensure adherence to aid effectiveness principles.<br>• Foster pooling or shared management of complementary financing as envisioned by the Investment Case. |
| Non state actors | • Support for country planning and implementation, including both the investment framework and county investment cases, health financing strategies; and technical assistance.<br>• Voicing priorities and supporting the development of effective strategies for reaching affected communities intended to benefit from investments in RMNCAH-N, including women, youth, and religious groups.<br>• Advocacy for domestic and external resource mobilisation and policies.<br>• Service delivery and demand generation, particularly in hard-to-reach areas, vulnerable populations, and fragile settings.<br>• Independent monitoring and accountability to strengthen national and county responses; support for tracking and transparency of financial flows.<br>• Enhancing communication and transparency with large and diverse networks of civil society and with communities. |
| Youth/Adolescent – Male and Female | • Voicing priorities of affected communities intended to benefit from investments in RMNCAH-N.<br>• Supporting the development of effective strategies for reaching youth populations.<br>• Advocacy, education, and social mobilisation to strengthen youth awareness and participation, including building budget literacy among young people. |
| Private Sector | • Service delivery strengthening, manufacturing, commodity distribution, etc., including through public-private partnerships.<br>• Leveraging new technologies and innovations to improve and strengthen RMNCAH-N services. |
| Media | • Advocate and administer quality reporting on RMNCAH-N.<br>• Dissemination of accurate information on RMNCAH-N initiatives to create public awareness. |
| Individuals and communities | • Adopt appropriate healthy lifestyles and healthcare-seeking behaviours and participate actively in RMNCAH-N demand generation forums.<br>• Participate in RMNCAH-N decision-making at all levels.<br>• Provide oversight on the delivery of quality or RMNCAH-N services. |

## MONITORING AND EVALUATION OF THE RMNCAH

The Monitoring and Evaluation (M&E) plan will play a critical role in tracking the implementation of the interventions outlined in the RMNCAH-N IC. It will enable the systematic assessment of their effectiveness, efficiency, relevance, and sustainability. This will be achieved through regular and structured monitoring of key performance indicators related to service delivery, providing evidence to guide improvements and inform timely corrective actions.

This chapter outlines the core indicators that will be monitored throughout the implementation of the Investment Case. These indicators are categorised into three levels: impact, outcome, and output, ensuring a comprehensive evaluation of progress and results.

### 6.1 Assumptions

- Stable political environment.
- Interventions will transform into expected results.
- Funding will be available for the outlined interventions.
- Programme will align efficiently with the investment case.
- Counties will align their strategies and interventions with the investment case.
- Good quality data will be available for decision-making.

### 6.2 Expected Result (Impact) Indicators

Impact indicators will inform the overall result of the interventions outlined in the investment case in relation to improving the health and well-being of mothers, children, and adolescents. Table 7.1 presents the expected result (impact) indicators and targets of this RMNCAH-N Investment Case.

Table 0.1: Expected impact of RMNCAH

| Indicator | Baseline-2024/25 | Midterm Target-2027/28 | Endline Target 2029/30 | Data source | Frequency of data collection |
|---|---|---|---|---|---|
| Life expectancy at birth (years) | 66 | 71 | 72 | KDHS | periodic |
| Maternal Mortality Ratio (MMR) per 100,000 live births | 355 | 230 | 113 | Census | periodic |
| Perinatal mortality rate per 1000 live births | 13.2 | 12 | 10 | KDHS | periodic |
| Neonatal mortality rate per 1000 live births | 21 | 15 | 13 | KDHS | periodic |
| Infant Mortality Rate per 1000 live births | 32 | 22 | 20 | KDHS | periodic |
| Under Five Mortality Rate per 1000 live Births | 41 | 30 | 24 | KDHS | periodic |

| | | | | | |
|---|---|---|---|---|---|
| Stillbirth rate per 1000 live births | 15 | 10 | 10 | KDHS | periodic |
| Adolescents birth rate | 15 | 10 | 8 | KDHS | periodic |
| Prevalence of stunting amongst under 5 children | 18 | 12 | 7 | KDHS | periodic |
| Prevalence of underweight amongst under 5 children | 10 | 7 | 4 | KDHS | periodic |
| Exclusive breastfeeding rate (0-<6 months) | 60 | 80 | 85 | KDHS | periodic |
| Prevalence of cervical cancer screening among women aged 25-49 | 30.9 | 70 | 90 | STEPS/ KDHS | periodic |
| Prevalence of overweight-obese and obese among adolescent girls (15-19) (%) | 13 | 10 | 7 | KDHS | periodic |
| Prevalence of overweight-obese and obese among women of WRA (20-49) (%) | 45 | 32 | 20 | STEPS/ KDHS | periodic |
| Prevalence of overweight-obese and obese among adolescents aged 10-14 (%) | 9.5 | | 5 | Kenya Adolescent Health Survey | periodic |
| Prevalence of FGM among women 15-49 years | 15 | 11 | 8 | KDHS | periodic |
| Total fertility rate | 3.4 | 3.1 | 2.6 | KDHS | periodic |
| Proportion of Neonatal deaths due to pre-maturity | 35 | 24 | 16 | KHIS | Routine |
| Proportion of neonatal deaths due to birth asphyxia | 30 | 20 | 14 | KHIS | Routine |
| Proportion of neonatal deaths due to sepsis | 10 | 5 | 3 | KHIS | Routine |

## 6.3 Outcome and Output Indicators

Outcome indicators will measure the resultant effect of interventions in the medium term, while the output indicators will measure the short-term results of an intervention. In this M&E framework, these indicators are organised into the following programme areas: Maternal, Newborn and Child Health, Family Planning, Adolescent Health, and Nutrition. Appendix C provides the details for each of these programme areas.

## 6.4 Monitoring and Evaluation Processes

The monitoring measures will ensure the Investment Case is implemented as per the plan and the goals are achieved. The team will work towards a robust monitoring system through effective policies, tools, processes, and systems to meet the information stakeholders' needs. This will be through collecting, tracking and analysing data to determine what is happening, where, and to whom to guide in decision-making.

Implementation of the RMNCAH-N Investment Case 2025/26 – 2029/30 in Kenya is intended to improve access to quality health services for mothers, newborns, children, and adolescents without suffering financial catastrophe. It is anticipated that there will be improvements in health outcomes. This evaluation is designed to assess whether the implementation of the Investment Case would have achieved the intended goals of improving the health and well-being of the targeted population. The evaluation is intended to provide evidence-based policy-making relating to strategic objectives by ensuring that there is robust and credible evidence on performance and documenting what worked and what did not work.

## REFERENCES


1. United Nations. The Global Strategy for Women's, Children's and Adolescents' Health (2016-2030). New York: UN. 2016.
2. Ministry of Health. Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) Investment Framework. 2016.
3. Ministry of Health. End-Term Evaluation of The Kenya Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) Investment Framework 2016-2020. 2023.
4. Ministry of Health. Newborn and Child Health Strategic Plan 2021 - 2026. Nairobi: MoH. 2022.
5. Ministry of Health. Draft Kenya Nutrition Action Plan 2023-2027. Nairobi: MoH. 2024.
6. National Council for Population and Development. Action Plan for Implementation of ICPD25 Kenya Country Commitments 2020 - 2030. Nairobi: NCPD. 2020.
7. Every Newborn Action Plan [Internet]. [cited 2025 Feb 10]. Available from: https://www.who.int/initiatives/every-newborn-action-plan
8. National Council for Population and Development. FP2030 Kenya Government Commitment. Nairobi: NCPD. 2021.
9. Kenya National Bureau of Statistics. Economic Survey 2024. Nairobi: KNBS. 2024.
10. Kenya National Bureau of Statistics. Economic Survey 2025. Nairobi: KNBS. 2025.
11. Musarandega R, Nyakura M, Machekano R, Pattinson R, Munjanja SP. Causes of Maternal Mortality in Sub-Saharan Africa: A Systematic Review of Studies Published from 2015 to 2020. J Glob Health. 2021;11.
12. Guttmacher Institute. Severe Maternal Outcomes and Obstetric Care in Kenya | Guttmacher Institute [Internet]. 2024 [cited 2024 Jun 7]. Available from: https://www.guttmacher.org/fact-sheet/severe-maternal-outcomes-and-obstetric-care-kenya
13. Asmamaw DB, Tafere TZ, Negash WD. Prevalence of Teenage Pregnancy and its Associated Factors in High Fertility Sub-Saharan Africa Countries: A Multilevel Analysis. BMC Women's Health [Internet]. 2023;23(1):1–10. Available from: https://doi.org/10.1186/s12905-023-02169-7
14. KNBS and ICF. Kenya Demographic and Health Survey 2022: Main Report Volume 1. Nairobi, Kenya, and Rockville, Maryland, USA: KNBS and ICF. 2023.
15. UNESCO. Global Education Monitoring Report 2023: Technology in Education: A Tool on Whose Terms? UNESCO. [Internet]. GEM Report UNESCO; 2023 Jul. Available from: https://unesdoc.unesco.org/ark:/48223/pf0000385723
16. Kenya National Bureau of Statistics. The Kenya Poverty Report Based on the 2021 Kenya Continuous Household Survey. Nairobi: KNBS. 2023.
17. Government of Kenya. Country Position Paper on Implementation of Sustainable Development Goals. Nairobi: National Treasury. 2023.
18. World Health Organization. Climate Change [Internet]. 2023 [cited 2025 Jul 19]. Available from: https://www.who.int/news-room/fact-sheets/detail/climate-change-and-health

19. World Bank. Health and Climate Change [Internet]. 2024 [cited 2025 Jul 19]. Available from: https://www.worldbank.org/en/topic/health/brief/health-and-climate-change

20. EWENE.Org. Kenya ENAP and EPMM Country Profile | Progress to meet ENAP EPMM Coverage Targets. 2023 [cited 2025 Oct 8]; Available from: https://www.who.int/publications/i/item/9789240068759,

21. Ministry of Health. Kenya Health Facility Census Report: Towards Achievement of Universal Health Coverage, Nairobi: MOH.REPORT. 2023.

22. Ministry of Health. Health Labour Market Analysis for Kenya: Nairobi: MOH. [Internet]. 2023. Available from: http://www.health.go.ke

23. Ministry of Health. Kenya Health Financing Strategy 2020–2030. Nairobi: MOH. Kenya Health Financing Strategy. 2020.

24. Ministry of Health Kenya. Kenya National Health Accounts 2016/17_2018/19. Nairobi: MoH; 2021.

25. Republic of Kenya. The Social Health Insurance Act. Nairobi: Government Printer. 2023.

26. Republic of Kenya. The Facilities Improvement Financing Act. Nairobi: Government Printer. 2023.

27. Republic of Kenya. The Digital Health Act. Nairobi: Government Printer. Nairobi: Government Printer; 2023.

## APPENDIX A: IMPLEMENTATION MATRIX

This implementation matrix outlines the specific activities across the various programme areas that will be carried out during the investment period. The matrix will inform the different stakeholders and implementers of the activities' expected timing and estimated costs.

### Maternal Health

Table A1: Implementation matrix for maternal health interventions

| Strategy/ Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 |
|---|---|---|---|---|---|---|---|---|
| Strengthen the maternal death surveillance and response (MPDSR) system to address the quality of care for maternal and perinatal health | Strengthen MPDSR at the health facilities | Establish and functionalise MPDSR committees in all health facilities | One-day sensitisation meeting of 40 participants in each of the 47 counties, TA from the national level | X | | | | |
| | Build the capacity of health workers and administrators to conduct no-blame, action-oriented reviews | Train HCPs and managers on MPDSR and use the lessons to improve healthcare | 5-day training on MPDSR guidelines, two trainings per quarter (35 participants and 5 trainers) | X | X | X | X | X |
| | Provide technical support to the counties | Conduct technical support visits to counties on MPDSR | 5-day technical support to the counties annually (5 people from the national team to each county) | X | X | X | X | X |
| | Roll out national MPDSR tools for case identification, classification analysis, and recommendation tracking | Disseminate the MPDSR guidelines and tools | One-day sensitisation meeting of 40 participants per county in all 47 counties, TA from the National level. | X | | | | |
| | | Disseminate the MPDSR guidelines and tools | Printing every 2 years | X | | X | | X |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | Disseminate the MPDSR guidelines and tools | Printing every 2 years | **X** | | **X** | | **X** |
| | Ensure Real-Time Reporting: Deploy digital platforms for timely data capture, analysis, and feedback loops | Data are routinely captured | Internal activity. No additional cost attached | **X** | **X** | **X** | **X** | **X** |
| | Link MPDSR to Quality Improvement (QI): Ensure that findings directly inform facility-based QI plans and clinical audits. | Hold an annual meeting at the county level to ensure findings are included in the planning and audits | 1 workshop of 40 participants for 2 days in every county | **X** | **X** | **X** | **X** | **X** |
| | Track progress on corrective actions from death reviews and measure impact over time. | Implement confidential inquiry on maternal deaths | One day meeting for confidential report feedback at the National level | **X** | **X** | **X** | **X** | **X** |
| | | | One day sensitisation meeting in all 47 counties for the implementation of confidential inquiry, TA from the National level | **X** | **X** | **X** | **X** | **X** |
| | | Hold quarterly MPDSR meetings | By CHMT, internal (no cost attached) | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | Create awareness within the community regarding the importance of maternal and perinatal deaths, notification and reviews during action days | One-day meeting per quarter in every sub-county, 40 participants per county and in all the 47 counties, quarterly | **X** | **X** | **X** | **X** | **X** |
| | Strengthen MPDSR at the community level | Training CHPs/ CHAs on verbal autopsy | Five-day training for CHPs, 40 participants per county, and in all 47 counties, twice a year | **X** | **X** | **X** | **X** | **X** |
| | Scale up the provision of BEmONC and CEmONC services, including SBBC, at all health facilities | Training of HCW on EmONC (complications: eclampsia, Antepartum and postpartum haemorrhage, obstructed labour, sepsis) as per national guidelines | 5-day training for health care workers, 40 participants in each county, four times per year or quarterly in the years indicated | **X** | **X** | | | |
| | | Offer mentorship package to HCWs on EmONC | Five-day training for health care workers 40 participants per county, and in all the 47 counties, quarterly in the years indicated | **X** | **X** | | | |
| | | Provision of TA on EMONC | Four-day technical support per county by five people from the national level | **X** | **X** | **X** | **X** | **X** |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | Procure MNH commodities and supplies | Total commodity costed under service below | **X** | **X** | **X** | **X** | **X** |
| | | Advocate for an increase in regional blood banks | No cost attached, under the general advocacy and SBC section | | | | | |
| | | Scaled-up implementation of the PPH Bundle approach, including EMOTIVE, as per the guidelines | Virtual meeting (no cost attached) | **X** | **X** | **X** | **X** | **X** |
| | | Provide maternal and newborn health services | Service delivery at health facilities | **X** | **X** | **X** | **X** | **X** |
| | Scale up implementation of the QoC Standard for MNH in all 47 counties, scale up SBBC | Develop MNH QOC eKQMH guidelines | 5 development workshops with 30 pax for 5 days, requiring transport, conference and DSA, External validation of 50 Pax( 20 National, 10 counties rep and 20 partners ) requiring Conference, Transport and DSA | **X** | | | | |
| | | Train healthcare workers on MNH QOC standards | Two classes, each of 35 participants plus 5 facilitators per class, monthly for the years indicated | **X** | **X** | | | |
| | | Provide QOC TA to counties facilities | 5 people from the national level and 5 from the county level | **X** | **X** | **X** | **X** | **X** |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | Link MNH QOC in eKQMH and KHIS platform | 2 workshops of 5 days each and 40 participants to functionalise the system for 5 days each | | X | | | |
| | | Conduct annual quality of care audits (MNH ) at the facility and provide technical support to counties on QOC. | 5 people from the national level and 10 from the county level for 5 days of work at each county | X | X | X | X | X |
| | Bolster consultations in the counties on MNH | Learning best practices forum in all 47 counties | 5-day residential meeting once per year, with 40 participants in every county | X | X | X | X | X |
| | | Document and disseminate best practices | One meeting in a quarter (internal cost) | X | X | X | X | X |
| | Enhance the quality of care during childbirth to prevent any complications | Conduct routine on-the-job training | Carried out by 5 county-based staff, 5 days per month | X | X | X | X | X |
| | Scale up high-quality Kangaroo Mother Care | Conduct routine on-the-job training | Carried out by 5 county-based staff 5 days per month | X | X | X | X | X |
| | Strengthen the neonatal nurse workforce | Employ more workers | Under county HRH development (cost included here) | X | X | X | X | X |
| | Enhance community structures in relation to newborn care | Train CHPs/ CHAs on newborn care | 5-day training of 35 CHPs/CHAs and 5 facilitators, every month | X | X | X | X | X |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Strengthen the follow-up of newborns discharged after inpatient care | Carry out follow-up at the household level by CHPs and make referrals where necessary | Routine work. No additional cost | **X** | **X** | **X** | **X** | **X** |
| | Develop, launch and disseminate a costed MNCH acceleration plan as well as county-specific costed acceleration plans | Develop a national accelerated plan at the national level | 2 five-day technical meetings of 20 participants, at the national level | **X** | | | | |
| | Develop, launch and disseminate a costed MNCH acceleration plan as well as county-specific costed acceleration plans | Counties adapt the national plan and develop county plans | One-week plan development workshop in each county of 30 participants, one consultant per county for 30 days | **X** | | | | |
| | Develop, launch and disseminate a costed MNCH acceleration plan as well as county-specific costed acceleration plans | Annual review of county acceleration plans | 3-day workshop of 30 participants from each county | **X** | **X** | **X** | **X** | **X** |

**Newborn and Child Health**

Table A2: Implementation matrix for newborn and child health interventions

| Strategy/Intervention | Activity | Sub-activity | 2025/26 | 2026/27 | 2027/28 | 2028/29 | 2029/30 |
|---|---|---|---|---|---|---|---|
| Promote and enhance availability and access to high-impact, evidence-based interventions for the management of all newborns, including small and sick newborns. | Scale up the provision of comprehensive and essential newborn care services, including SBBC | Dissemination of a comprehensive essential newborn care guideline. | X | | | | |
| | | Procurement and distribution of essential newborn care equipment to all facilities, including but not limited to oxygen, CPAP, radiant warmers, and incubators | X | X | X | X | X |
| | | Monitor stock out of essential newborn commodities in the counties and take mitigating measures, i.e. Tetracycline, Chlorhexidine, Vitamin K | X | | | | |
| | | Procure caffeine citrate and train healthcare workers on its use. | X | X | X | X | X |
| | | Capacity building of health care workers on management of preterm and or low birth weights on resuscitation, cord care, IPC, feeding and KMC | X | | | | |
| | | Roll out newborn, child and adolescent death surveillance response guidelines | X | X | X | X | X |
| | | Training of HCWs and OJT on resuscitation procedures-ABCD | X | X | X | X | X |
| | | Sensitise health workers on early essential new-born interventions | X | X | X | X | X |
| | | Deliver quality maternal and newborn services | X | X | X | X | X |

| Strategy/Intervention | Activity | Sub-activity | 2025/26 | 2026/27 | 2027/28 | 2028/29 | 2029/30 |
|---|---|---|---|---|---|---|---|
| | Enhance community structures in relation to newborn care | Train CHAs and CHPs on CMNC, Nurturing Care, integrated ICCM/ SAM/ MAM and other maternal newborn interventions | X | | | | |
| Promote access to and uptake of preventive interventions for childhood illnesses | Enhance capacity for HCWs on notifiable diseases and CHPs on Integrated Community Case Management (ICCM) guidelines on common childhood diseases and Community Newborn Care (CMNC). | Training TOTs and HCPs | X | | | | |
| | Ensure effective utilisation of the Mother and Child Health (MCH) Handbook | Sensitisation of HCWs on the mother-child handbook | | X | | | |
| | Promote the uptake of childhood vaccines | Procure and distribute vaccines | X | X | X | X | X |
| Promote access to timely and quality treatment for common childhood illnesses - major killers (Scale iMNCI and ETAT+). | Scale up iMNCI and ETAT+ | Train at least 60% of HCWs in every facility on IMNCI and ETAT | X | X | X | X | X |
| | | Conduct quarterly targeted supportive supervision and data quality audit on infant and child morbidity | X | X | X | X | X |
| | | Integrated supportive supervision-quarterly | X | X | X | X | X |
| | | Establish and/or strengthen ORT corners | X | X | X | X | X |
| | | Equip Emergency Trays with appropriate child-friendly supplies: Ambu bags | X | X | X | | |

| Strategy/Intervention | Activity | Sub-activity | 2025/26 | 2026/27 | 2027/28 | 2028/29 | 2029/30 |
|---|---|---|---|---|---|---|---|
| | | Develop an emergency preparedness checklist for paediatrics. | | **X** | | | |
| | | Conduct oxygen administration and newborn resuscitation training for HCWs working on NBUs | **X** | | | | |
| | | Avail treatment guidelines and protocols | **X** | **X** | **X** | **X** | **X** |
| | | Strengthen the availability of key commodities to manage major childhood illnesses. | | **X** | | | |
| | Promote and strengthen the implementation of IMNCI and ETAT+ to address the leading causes of child morbidity and mortality and improve the management of severely sick children. | Incorporate ETAT and IMNCI data classifications into routine HIS/digital tools | | | **X** | | |
| | | Increase the number of TOTS in iCCM at all levels | | **X** | | | |
| | | Integrated outreach services to the difficult-to-reach populations | | | | | |
| Promote access to quality and comprehensive early childhood development interventions for all children eight years and below, especially nurturing care during the first 1000 days of life. | Establish national and county-level multi-sectoral governance mechanisms with decision-making authority to coordinate early childhood development interventions across relevant sectors and stakeholders. | Development of TOR for the multi-sectoral coordinating committee/TWGs for ECD interventions | **X** | | | | |
| | | Establishment of national and county-level multi-sectoral TWGs for ECD interventions (MOH, MOE, Social Services, NGAO, implementing partners) | **X** | **X** | **X** | **X** | **X** |

| Strategy/Intervention | Activity | Sub-activity | 2025/26 | 2026/27 | 2027/28 | 2028/29 | 2029/30 |
|---|---|---|---|---|---|---|---|
| | | Development of a national and county-level implementation framework for ECD interventions. | X | | | | |
| | | Lobby political leadership at the national, county and sub-county levels for resource allocation for ECD interventions. | | X | | X | |
| | Develop and roll out a training and capacity-building plan for ECD interventions, including service providers and managers. | Development and roll-out of a training and capacity building plan for ECD interventions to include service providers and managers | X | | | | |
| Strengthen the health sector's capacity for identification and appropriate and timely referrals for children with developmental delays, difficulties or disabilities. | strengthen CHPs, ECD teachers and religious leaders' capacity to identify and refer children with challenges to link to the health facility | Conduct residential training per county | X | X | X | X | X |
| | Strengthen intra- and inter-county linkage among health facilities and rehabilitation centres. | Hold consultative meetings between county teams and rehabilitation management | X | | X | | |
| | | Sensitisation of healthcare providers on identification and referral of children with disabilities and special needs at all levels of care (including specialised therapists) | X | | | | |
| | Enhance the capabilities of HCW on appropriate and timely referrals | Review existing guidelines for service providers and caregivers on early identification and referrals of children with developmental delays or disabilities. | X | | | | |

**Family Planning**

Table A3: Implementation matrix for family planning interventions

| Strategy/Intervention | Activity | Sub-activities | 2025/26 | 2026/27 | 2027/28 | 2028/29 | 2029/30 |
|---|---|---|---|---|---|---|---|
| Strengthen the capacity of all market segments to deliver quality FP services | Review the National CIP to include the TMA strategy | Review the National CIP to include the TMA strategy | X | X | | | |
| | Roll out the TMA strategy in both the public and private sectors | Validation and launch meeting ((Printing of 400 copies, dissemination and distribution) | | X | | | |
| | Build the capacity of healthcare providers to provide quality FP services | Training of healthcare providers on national family planning guidelines for the provision of quality services | X | X | X | X | X |
| | | Promote post-pregnancy family planning intervention in healthcare facilities | X | X | X | X | X |
| | | Build capacity to roll out the FP mentorship package. | X | X | X | X | X |
| | | Roll out of Hormonal IUD and DMPA SC orientation package | X | X | X | X | X |
| | Strengthen the capacity of private providers, including community pharmacists and pharmaceutical technologists, to provide quality FP services | Train private providers on FP for the provision of quality services | X | X | X | X | X |
| | | Roll out the FP mentorship package to the private providers | X | X | X | X | X |
| | Integrate FP services in health facilities | Develop guidelines on integrating FP services in health facilities | X | | | | |
| | | Sensitisation meetings for the integration of FP services (county level) | X | X | X | X | X |

| Strategy/Intervention | Activity | Sub-activities | 2025/26 | 2026/27 | 2027/28 | 2028/29 | 2029/30 |
|---|---|---|---|---|---|---|---|
| | Implementation of RH/FP self-care interventions | Dissemination of self-care interventions in RH/FP | X | X | | | |
| | | Training of Healthcare providers on RH/FP self-care interventions | X | X | X | X | X |
| | Promote post-pregnancy family planning intervention in the health care facilities | Training of Healthcare providers on post-pregnancy family planning, Module 2 | X | X | X | X | X |
| | Strengthen the capacity of community-based distribution of FP commodities as per the FP policy | Sensitisation of CBD and CHPs on FP services and commodities | X | X | X | X | X |
| | | Train CBD on FP in the selected Counties | X | X | X | X | X |
| | Enhance the quality of family planning services | Dissemination of FP QA standards in all counties | X | | X | | |
| | | Train HCWs on FP QA standards training in all counties | X | X | X | X | X |
| | | Conduct Quality Assurance and (Technical Assistance ) for FP services delivery | X | X | X | X | X |
| | | Train three county TOTs per county on Hormonal IUD. | X | X | X | X | X |
| | | Train experienced IUCD providers on H-IUD. | X | X | X | X | X |
| | Provide the required FP methods with an emphasis on long-term methods | Procure and distribute | X | X | X | X | X |
| | Increase awareness creation for DMPA-SC, especially self-injection, by systematically engaging community volunteers for wider | Undertake various awareness activities | X | X | X | X | X |

| Strategy/Intervention | Activity | Sub-activities | 2025/26 | 2026/27 | 2027/28 | 2028/29 | 2029/30 |
|---|---|---|---|---|---|---|---|
| | coverage and involving men as well as religious and cultural leaders in DMPA-SC programming. | | | | | | |
| | Distribute written guidance on DMPA-SC and self-administration to all counties to promote ownership of the self-administered DMPA-SC programme | Print and distribute | X | X | X | X | X |
| Increase the Availability of Quality FP Commodities, health products and Technologies at all service delivery points | Strengthen capacity for selection, quantification and supply chain management for FP HPT at all levels to inform needs and ensure efficient use. | Train TOTs in the RH HPT management course | | X | X | X | X |
| | | Training of Healthcare providers on forecasting and supply planning for FP HPT | X | X | X | X | X |
| | | Forecasting and supply planning | X | X | X | X | X |
| | | Sensitise counties and other stakeholders on the introduction and scale-up plan for Hormonal IUDs. | X | X | X | X | X |
| | | Digitise the quantification processes for FP HPT | X | | | | |
| | Ensure sustained availability of FP commodities, including DMPA SC and H-IUD, in all service delivery points | Training healthcare workers on supply chain management and an online learning integrated supply chain curriculum. | X | X | X | X | X |
| Implement quality monitoring and reporting mechanisms for FP HPT. | Monitoring FP supply chain | Conduct quarterly logistics working group meetings | X | X | X | X | X |
| | | Hold a 3-day bi-annual technical Review meeting | X | X | X | X | X |

| Strategy/Intervention | Activity | Sub-activities | 2025/26 | 2026/27 | 2027/28 | 2028/29 | 2029/30 |
|---|---|---|---|---|---|---|---|
| | Roll out standardised training on FP iLMS to all counties | Roll out standardised training on FP iLMIS to all counties | **X** | **X** | **X** | **X** | **X** |
| | Conduct quality assurance/improvement spot checks for FP quality services at the county/facility level for users' safety. | Conduct routine last-mile assurance for FP commodities | **X** | **X** | **X** | **X** | **X** |
| | | Conduct routine Post Market Surveillance | | **X** | | **X** | |

**Adolescent Health**

Table A4: Implementation matrix for adolescent health interventions

| Strategy/ Intervention | Activity | Sub-activity | 2025/26 | 2026/27 | 2027/28 | 2028/29 | 2029/30 |
|---|---|---|---|---|---|---|---|
| To improve adolescent healthcare-seeking behaviour | Develop appropriate information for improved adolescent health-seeking behaviour | Review and design appropriate health information on risk factors for communicable and non-communicable diseases to be integrated into the school curriculum. | X | X | | | X |
| | | Develop and disseminate a sensitisation package for the inclusion of adolescent awareness programs among stakeholders | | X | X | | |
| | | Develop and disseminate a guideline for Adolescent peer-to-peer engagement in healthcare-seeking behaviour | | | | X | X |
| | Capacity build adolescents with information for increased healthcare-seeking behaviour | Conduct adolescent and youth-specific outreaches and mobile clinics in communities to promote service utilisation among adolescents | | X | | | X |
| Strengthen community engagement in promoting adolescent health and rights. | Build the capacity of CHPs on adolescents and rights | Develop a Community Health Promoters health module on adolescents and rights | X | X | | | X |
| | | Conduct sensitisation of Community Health Promoters on the adolescent health module. | | X | | | X |
| | | Conduct sensitisation of Community Health Promoters | | X | X | X | |

| Strategy/ Intervention | Activity | Sub-activity | 2025/26 | 2026/27 | 2027/28 | 2028/29 | 2029/30 |
|---|---|---|---|---|---|---|---|
| | | on the adolescent health module. | | | | | |
| | Institute community structures to promote adolescent health and rights. | Develop platforms that provide access to resources and support for adolescents, parents/caregivers, and community leaders | | **X** | **X** | **X** | |
| | | Develop a community sensitisation package for adolescents and their influencers. | | | **X** | **X** | **X** |
| | | Develop a positive parenting and community leaders' program as a social asset for adolescents and young people's health | | **X** | **X** | | **X** |
| Promote awareness of mental health and the harmful effects of substance abuse among adolescents, young people, and communities. | Adapt the existing Kenya Mental Health Policy (2015-2030) for adolescents | Develop an implementation plan that encompasses adolescent mental health within its framework, aiming to provide access to comprehensive mental health services for adolescents and youth nationwide. | **X** | | | | |
| | | Disseminate the implementation plan to health care providers, CSOs, community leaders, and parents to support and raise awareness of mental health | | **X** | | | |

| Strategy/ Intervention | Activity | Sub-activity | 2025/26 | 2026/27 | 2027/28 | 2028/29 | 2029/30 |
|---|---|---|---|---|---|---|---|
| | Enhance mental health awareness in communities | Develop age-appropriate content for awareness of mental health and the harmful effects of substance abuse, considering the needs of out-of-school adolescents | | X | | | |
| | | Sensitise adolescents and communities on mental health issues | X | X | X | X | X |
| | Promote adolescent and young people's awareness of the harmful effects of alcohol, tobacco and other substance use. | Disseminate the national guidelines for aftercare and reintegration for persons with drug and substance abuse disorders among health workers, community leaders, teachers and other relevant stakeholders at the community level. | | | | | X |
| | | Develop age-appropriate content for awareness creation sessions on the harmful effects of alcohol, tobacco, and other substance use, considering the needs of out-of-school youth. | X | X | | | |
| Increase access and utilisation of comprehensive health services, including referrals to one-stop centres and providers of other social services | Strengthen service delivery through the provision of guidelines and service packages | Conduct a baseline survey to ascertain the number of facilities providing responsive adolescent health services according to national standards. | X | X | | | |
| | | Hold a two-day stakeholder meeting for 47 county adolescent health focal persons to aggregate their reports. | X | | | | |

| Strategy/ Intervention | Activity | Sub-activity | 2025/26 | 2026/27 | 2027/28 | 2028/29 | 2029/30 |
|---|---|---|---|---|---|---|---|
| | | Develop and disseminate a comprehensive service package, including QOC for adolescent health services | X | X | | | |
| | | Develop and disseminate guidelines on the provision of adolescent-responsive healthcare services (safe, confidential, equitable, non-discriminatory) and assistive devices for those with disabilities. | | X | X | X | |
| | | Develop and disseminate telemedicine guidelines for adolescent health in Kenya. | | | X | X | |
| | | Develop and disseminate recommendations for adolescent health in learning institutions. | | | X | | |
| | | Develop and deploy an adolescent health module in the Community Health package (e-CHIS). | | | X | X | X |
| | | Development and implementation of guidelines on iron and folic acid supplementation package for adolescents | | X | X | | |
| | Provide quality and comprehensive care for adolescents | Set up peer-led adolescent health hubs in schools and community spaces to provide SRHR education, counselling, and referrals. | X | X | | | |

| Strategy/ Intervention | Activity | Sub-activity | 2025/26 | 2026/27 | 2027/28 | 2028/29 | 2029/30 |
|---|---|---|---|---|---|---|---|
| | | Develop anonymous digital platforms (mobile apps, SMS services, AI chatbots) for confidential SRHR information and reporting. | X | X | | | |
| | | Ensure youth-friendly health services at county and sub-county health facilities by training healthcare providers on adolescent care | X | X | X | X | X |
| | Facilitate meaningful adolescent involvement in interventions tailored to address their health needs and well-being | Develop and disseminate a framework that guides the participation of adolescents in interventions affecting their health | X | X | X | X | X |
| | | Hold leadership forums for adolescents to engage on matters related to their health and well-being | X | X | X | X | X |
| | Capacity build adolescents on life skills to prioritise their health. | Develop and disseminate self-care guidelines for adolescent health. | | X | X | X | |
| | | Develop and disseminate an adolescent health-related life skills package to be integrated into the school curriculum and other adolescent fora. | X | X | X | X | X |
| | | Conduct high-level engagements with national and county leaders to advocate for adolescent-centred programs related to health interventions | | X | X | X | X |

| Strategy/ Intervention | Activity | Sub-activity | 2025/26 | 2026/27 | 2027/28 | 2028/29 | 2029/30 |
|---|---|---|---|---|---|---|---|
| | Improve access to quality health services and information among adolescents in humanitarian and fragile settings. | Map out the humanitarian adolescent populations for adolescent health provision | X | X | X | X | X |
| | | Analyse key stakeholders providing services to the marginalised and vulnerable adolescent populations. | X | X | X | X | X |
| | | Develop and disseminate a guideline on the provision of health services among adolescents in humanitarian and fragile settings, including defining how to report adolescent health indicators in humanitarian response structures | X | X | | | |
| | | Develop a natural and human-made emergency preparedness plan for adolescents in humanitarian and fragile settings | | X | X | | X |
| | | Train HCWs on the protocol for service provision to adolescents in humanitarian and fragile settings. | | X | | | |
| Promote Initiatives That Address Social Risks and Deterrence of Harmful Socio- | Create initiatives that address harmful and risky socio-cultural practices among adolescents | Develop and disseminate standardised guidelines for the management of health issues arising from harmful cultural practices ( alternative rites of passage) | X | X | | | |

| Strategy/ Intervention | Activity | Sub-activity | 2025/26 | 2026/27 | 2027/28 | 2028/29 | 2029/30 |
|---|---|---|---|---|---|---|---|
| Cultural Practices Among Adolescents | | Develop and disseminate a behaviour change communication package on reducing harmful social-cultural practices among adolescents and the community | X | X | X | X | |
| | | Establish adolescent peer networks to support peer learning and experience sharing against harmful social and cultural practices | | X | X | | |
| | Strengthen community-based initiatives challenging social norms and attitudes that perpetuate health-related harmful practices. | Build the capacity of adolescent peer networks to support peer learning and experience sharing against harmful social and cultural practices | | X | | X | |
| | | Conduct hybrid social events for adolescents to sensitise them on health-related harmful practices. | | X | X | X | X |
| | | Sensitise the communities on health-related harmful practices. | | X | | | |
| | | Develop and disseminate IEC materials targeting parents/caregivers, adolescents and community leaders on harmful social-cultural practices | X | X | | | |
| | | Conduct sensitisation meetings on reducing harmful social and cultural practices to HCWs, CHPs, opinion leaders and teachers | | X | X | X | X |

**Nutrition**

Table A5: Implementation matrix for nutrition interventions

| Strategy/ Intervention | Activity | Sub-activity | 2025/26 | 2026/27 | 2027/28 | 2028/29 | 2029/30 |
|---|---|---|---|---|---|---|---|
| Strengthen policy, legal and regulatory environment | Bolster policy environment | Develop/review maternal nutrition-related guidelines in line with international standards, conventions and global commitments, including maternal mental health, adolescent girls and disabled pregnant and breastfeeding mothers. (MMS, SOPs, training manual) | X | | | | |
| | | Review the BMS Act, 2012, to contextualise and update in line with the new WHO recommendations | X | X | | | |
| | | Advocate for the enactment of the Breastfeeding Mothers Bill. | X | X | | | |
| | | Review the workplace support implementation framework and guidelines | | X | | | |
| | | Review BFCI implementation package | X | | | | |
| | | Develop BFHI implementation package, including mentorship (guideline, training package, pocket guide) | X | X | | | |
| | | Review the human milk bank implementation framework | | X | | | |
| | | Develop MIYCN-E operational guidelines and training package | X | X | | | |
| | | Review the National Guidelines for Healthy Diets and Physical Activity | X | X | X | X | X |
| | | Develop the Food-Based Dietary Guidelines for Kenya | | X | X | | |
| | | Develop policy frameworks for fiscal policies for healthy diets | | X | X | | |
| | | Develop food procurement guidelines for healthy diets in public institutions | | X | X | | |

| Strategy/ Intervention | Activity | Sub-activity | 2025/26 | 2026/27 | 2027/28 | 2028/29 | 2029/30 |
|---|---|---|---|---|---|---|---|
| | | Develop guidelines on healthy eating for food outlets and eateries | | | X | X | |
| | | Develop a transfats regulation | | X | X | X | |
| | | Develop a sodium reduction framework | | | X | X | X |
| Increase access and utilisation of comprehensive nutrition services | Improve capacity for maternal, infant and young child nutrition initiatives. | Develop and disseminate SOPs for nutrition service delivery | X | X | X | | |
| | | Train TOTs on MIYCN initiatives (BFCI/cBFCI, BFHI, BMS Act, MIYCN, MIYCN-E, Vitamin A + D,MNPs, IFAS and MMS | X | X | X | X | X |
| | | Train health care workers on MIYCN initiatives (cBFCI/BFCI, BMS Act, BFHI, MIYCN, MIYCN-E, Vitamin A + D, MNPs, IFAS and MMS | X | X | X | X | X |
| | | Conduct MIYCN Capacity assessment using available MIYCN assessment tools for BFCI/BFHI | X | X | X | X | X |
| | | Provide MIYCN TA to counties, including Mentorship, OJT, support supervision, and assessment for MIYCN initiatives | X | X | X | X | X |
| | Build capacity among key stakeholders in healthy diets and physical activity | Conduct capacity analysis for the implementation of healthy diets and physical activity | X | X | | | |
| | | Develop a training and sensitisation package for healthy diets and physical activity | X | X | | | |
| | | Develop a training and sensitisation package on the enforcement of food environment policies | X | X | | | |
| | | Conduct sensitisation sessions for healthy diets and physical activity | X | X | X | X | X |

| Strategy/ Intervention | Activity | Sub-activity | 2025/26 | 2026/27 | 2027/28 | 2028/29 | 2029/30 |
|---|---|---|---|---|---|---|---|
| | | Develop SBC activities for healthy diets and physical activity within the RMNCAH-N SBC strategy. | X | X | X | X | X |
| | | Sensitise stakeholders on healthy foods, physical activities, and marketing of unhealthy foods. | X | X | X | X | X |
| | Deliver quality nutrition services. | Promote maternal nutrition assessment, education and counselling on dietary diversity, healthy eating and meal frequency among PLWs. | X | X | X | X | X |
| | | Promote supplementation of IFAS and/or MMS and deworming among pregnant women | X | X | X | X | X |
| | | Design intervention targeting mothers in vulnerable circumstances (adolescent pregnant and breastfeeding girls, disabled pregnant mothers) | X | | | | |
| | | Support for Community-Led Nutrition Initiatives | X | X | X | X | X |
| | | Provide technical support to counties to conduct community outreach and education | X | X | X | X | X |
| | Promote growth monitoring, nutrition education and counselling for infants and young children on optimal breastfeeding and complementary feeding | Technical assistance and mentorship to counties. | X | X | X | X | X |
| | | Procure Vitamin A supplements for children 6 to 59 months of age. | X | X | X | X | X |
| Strengthen the nutrition environment in the | Integrate nutrition interventions | Development of policies, strategies and guidelines (Tuckshop guidelines, Teacher | | X | X | X | |

| Strategy/ Intervention | Activity | Sub-activity | 2025/26 | 2026/27 | 2027/28 | 2028/29 | 2029/30 |
|---|---|---|---|---|---|---|---|
| education and health sectors. | within the education sector | reference manual, School menu guides, School health policy) | | | | | |
| | | Develop school-based nutrition package (school meals menu guide, Reference manual on Food and Nutrition for teachers, School Gardening Guideline, School Health and Nutrition Service Delivery Package) | X | X | X | X | X |
| | | Promote Weekly Iron and Folic Acid Supplementation (WIFAS) for adolescent girls | X | X | X | X | X |
| | | Advocate with stakeholders for the local sourcing of food commodities for school meals among national and county stakeholders | | | X | X | |
| | Mainstreaming nutrition interventions across the private health sector. | Advocate for the mainstreaming of nutrition interventions across RHUPA, CHAK and KCCB health facilities | | | X | | |
| | | Train RHUPA, CHAK and KCCB leaders on nutrition mainstreaming. | | | X | | |
| | | Annual forums to appraise nutrition mainstreaming across RHUPA, CHAK and KCCB health facilities | X | X | X | X | X |
| | | Strengthen nutrition partnerships with the private sector | X | | X | | X |
| Strengthen Integrated Supply Chain Management System for Nutrition Health Products and Technologies (HPT). | Strengthen capacity on Nutrition Health Products and Technologies (HPT) | Conduct training and mentorship on Nutrition Health Products and Technologies (HPT) management. | X | X | X | X | X |

**Gender-Based Violence**

Table A6: Implementation matrix for GBV interventions

| Strategy/Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 |
|---|---|---|---|---|---|---|---|---|
| Promote and strengthen GBV prevention through policy development, community engagement, and awareness campaigns | Develop and disseminate GBV management SOPs, Psychosocial support and GBV prevention management guidelines, Healthcare providers Court guide, SEAH (sexual exploitation and harassment policy, and workplace GBV policies | Develop, disseminate, and implement a GBV health sector policy, SEAH policy, and workplace GBV policy. | 5 development workshops with 30 pax for 5 days, requiring transport, conference and DSA | X | X | | | |
| | | Review and update community GBV packages and SBC materials to ensure inclusivity (e.g., braille, sign language, voiceovers) | 3 development workshops with 30 participants for 5 days | X | | | | |
| | | Develop targeted GBV prevention messages for children and other vulnerable groups. | 3 development workshops with 30 pax for 5 days | | X | | | |
| | | Conduct nationwide campaigns to raise awareness about GBV and engage champions to advocate for its elimination | Under RMNCAH-N SBCC | X | X | X | X | X |
| | | Build the capacity of Community Health Promoters (CHPs). CHAs and Community Own Resource persons | 47 counties with 40 people per month (35 participants and 5 facilitators) | X | X | X | X | X |

| Strategy/Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 |
|---|---|---|---|---|---|---|---|---|
| | | (CORPs) on GBV prevention | | | | | | |
| | | Conduct male engagement forums and community dialogues | One meeting of 50 community participants per sub-county, quarterly, refreshments provided and facilitator's fee | X | X | X | X | X |
| Ensure comprehensive, survivor-centred, and timely response services for GBV survivors | Build the capacity of healthcare workers on clinical management of GBV survivors, forensic sample collection, psychosocial support, and court etiquette | Conduct training of county TOTs health workers in 10 regions, once every two years | TOT- regional training of 5 days for 8 participants from each county by a national team of 6 Trainers | X | | X | | X |
| | | Conduct training of HCW in counties | 5-day training workshop conducted within a county by TOTs, 40 participants, including facilitator TOTs | X | X | X | X | X |
| | Advocate for the inclusion of GBV supplies in essential commodities and ring-fenced funding for GBV at the county level. | Advocate for the inclusion of GBV supplies in essential commodities and ring-fenced funding for GBV at the county level | No cost | | | | | |
| | | Hold stakeholder collaboration meetings with training institutions for the inclusion of | Meetings with representatives from institutions, 30 participants for a one-day meeting | | X | X | | |

| Strategy/Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 |
|---|---|---|---|---|---|---|---|---|
| | | GBV in basic curricula | | | | | | |
| | Strengthen child-friendly GBV services by providing technical support and monitoring the quality of service | Hold annual meetings in counties, attended by 5 staff from the national level | Meeting of 3 days of 40 participants, including 5 national staff | X | X | X | X | X |
| | Improve psychosocial support by training health providers and advocating for the employment of more psychologists. | Conduct training in the regions for the TOTs on psychosocial support | TOT- regional training 8*5*47 counties, DSA county 14000 transport 3,000, conference 2500. Training for 5 days. national team 10,500*3*6 regional *6days, Driver | X | | X | | X |
| | | Conduct training in the regions for the HCW on psychosocial support | 5-day training workshop conducted within a county by TOTs, 40 participants, including facilitator TOTs | X | X | X | X | X |
| | Promote self-care among GBV service providers by disseminating self-care handbook and building their capacity on self-care practices | Develop the handbook and distribute | 3 workshops for 30 people for 5 days for development out of the city, two validation meetings. Print 500 copies every year and distribute | X | X | X | X | X |
| | Strengthening the provision of comprehensive, | Provide comprehensive, survivor-centred, | Under service delivery costs | X | X | X | X | X |

| Strategy/Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 |
|---|---|---|---|---|---|---|---|---|
| | survivor-centred, and timely response services for GBV survivors | and timely response services for GBV survivors | | | | | | |
| | Incorporate care for mental health, including basic psychosocial support, strengthening positive coping methods and treatment for moderate-severe depressive disorder, including post-traumatic stress disorders. | Provide related services | Under service delivery costs | X | X | X | X | X |
| Bolster gender-responsive interventions under the GER | Undertake advocacy and policy dialogues focused on GER challenges. | Conduct advocacy activities | Under SBC | X | X | X | X | X |
| | Build the capacity of RMNCAH program managers and health providers on GER integration | Conduct training | 5-day training (35 participants and 5 trainers) | X | X | | | |
| | Conduct targeted intersectional analyses (gender, equity, barrier, and vulnerability assessments) to guide strategic planning. | Undertake the analysis and produce a report for use | Hold 2 technical workshops to review results and report, 30 participants per workshop and a consultant for 60 days | | X | | X | |
| | Ensure diversity of women, girls, children, adolescents, and older people when defining | Undertake gender balanced engagements in policy processes | No additional cost | X | X | X | X | X |

| Strategy/Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 |
|---|---|---|---|---|---|---|---|---|
| | strategic objectives and target audiences. | | | | | | | |
| | Expand RMNCAH-N services in public health and humanitarian emergencies to all at-risk groups. | Expand RMNCAH-N services in public health and humanitarian emergencies to all at-risk groups. | No additional cost | X | X | X | X | X |
| | Establishing a balanced mix of process, outcome, and impact indicators stratified by age, sex, socio-economic status, migration status, etc., including qualitative measures of attitudes, perceptions, and enabling environments | Build the capacity of M&E officers at the county level on GER indicators | 5-day training, two training courses per quarter (35 participants and 5 trainers) | | X | | | |
| | | Build the capacity of M&E at the national level on GER indicators | | | X | | | |
| | Embed with equal representation of men, women, and other vulnerable groups. | Ensure equal representation of men, women, and other vulnerable groups in community-led monitoring structures | | X | X | X | X | X |
| Strengthen national and county-level coordination mechanisms for effective GBV program implementation. | Support national GBV health sector Technical Working Group (TWG) meetings and participate in national gender sector working groups. | Hold national GBV health sector Technical Working Group (TWG) meetings and participate in national gender sector working groups. | 2 participants from every county for national meetings - annual, and 30 from the national level | X | X | X | X | X |

| Strategy/Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 |
|---|---|---|---|---|---|---|---|---|
| | | Hold quarterly TWG meetings at the counties to track progress on the delivery of responsive gender-based violence services at the county level | | X | X | X | X | X |
| | Advocate for counties to establish quarterly GBV prevention and response TWGs and appoint GBV focal persons at the facility, sub-county, and county levels. | Conduct advocacy | Under the advocacy section | X | X | | | |
| | Promote GBV quality assurance by sensitising providers, building capacity on the digitised GBV QA tool, and monitoring service delivery | Mentoring of HCW | Routine- no cost | X | X | X | X | X |
| | Establish and coordinate intercounty learning exchange forums for continuous improvement among key stakeholders. | Undertake coordination | Under M&E | X | X | X | X | X |
| | Advocate for healthcare providers to participate in court users committee | Undertake advocacy through various forums | No cost | X | X | X | X | X |

**Climate Change and RMNCAH-N**

Table A7: Implementation matrix for climate change interventions

| Strategy/ Intervention | Activity | Sub-activities | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 |
|---|---|---|---|---|---|---|---|
| Integrate Climate Change into RNMCAH-N policies and budgets | Build national and county-level capacity on climate change and RMNCAH-N | Hold meetings to review and validate materials developed by a consultant | X | | | | |
| | | Hold a meeting to update the training materials | | | | X | |
| | | Conduct training of national TOTs on climate change and RMNCAH-N | X | | X | | X |
| | | Conduct training of county healthcare workers on climate change and RMNCAH-N | X | X | X | X | X |
| | | Include climate change activities in the counties' RMNCAH-N workplans. | X | X | X | X | X |
| | Mobilise funds for RMNCAH-N projects for climate funds | Allocate domestic funds for climate change activities. | X | X | X | X | X |
| | | Develop funding proposals and projects for climate funds. | X | X | X | X | X |
| | Provide technical support to counties and monitor implementation of climate change interventions | Undertake support at the county level by the national-level staff | | X | X | X | X |

| Strategy/ Intervention | Activity | Sub-activities | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 |
|---|---|---|---|---|---|---|---|
| | Ensure health, gender, education and youth ministries are involved in project proposals to climate funds | Include them in the meetings | X | X | X | X | X |
| | Scale up public-private partnerships to increase policies and investments for climate change interventions for RMNCAH-N. | Hold annual meeting | X | X | X | X | X |
| Bolster the visibility of climate change and RMNCAH-N | Engage women, children, and adolescents in climate change and health issues | Undertake BCC activities | X | X | X | X | X |
| | Strengthen community awareness of the impacts of climate change | Hold male engagement forums and community dialogues | X | X | X | X | X |
| | Increase awareness of the impacts of climate change among policymakers | Hold annual awareness meetings with policymakers at the national level | X | X | X | X | X |
| | | Hold annual awareness meetings with policymakers at the county level | X | X | X | X | X |
| Evaluate climate change and RMNCAH-N interventions | Support piloting and evaluating health and climate co-financing initiatives. | Conduct technical meetings at the national level | | | X | 0 | X |

| Strategy/ Intervention | Activity | Sub-activities | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 |
|---|---|---|---|---|---|---|---|
| | Advance research on the intersectional impacts of climate change on women, children, and adolescents | Hold technical review meetings at the national level | | X | | | X |
| | | Undertake survey | | X | | | X |

**Emerging Technologies**

Table A8: Implementation matrix for emerging technologies

| Strategy/ Intervention | Activity | Sub-activities | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 |
|---|---|---|---|---|---|---|---|
| Strengthen RMNCAH-N service delivery through the use of emerging technology | Build capacity for healthcare workers in emerging technologies for RMNCAH-N services | Hold meetings to review and validate materials developed by a consultant | X | | | | |
| | | Hold a meeting to update the training materials | | | | X | |
| | | Conduct training of national TOTs on emerging technologies | X | | X | | X |
| | | Conduct training of county TOTs on emerging technologies | X | | | X | |
| | | Training of HCWs in counties | x | x | x | x | x |
| | Invest in healthcare infrastructure to support technology deployment | | X | X | X | X | X |

| Strategy/ Intervention | Activity | Sub-activities | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 |
|---|---|---|---|---|---|---|---|
| | Promote public-private partnerships for technology adoption | Conduct annual meetings of | X | X | X | X | X |
| | Monitor and evaluate the impact of technologies on RNMCAH outcomes. | Conduct one technical meeting at the national level of 30 participants | | X | | | X |
| | | Undertake survey | | X | | | X |

**Advocacy Communication, and Social Behaviour Change**

Table A9: Implementation matrix for advocacy and SBC

| Strategy/Intervention | Activity | Sub-activities | 2023/24 | 2024/25 | 2025/26 | 2026/27 | 2027/28 |
|---|---|---|---|---|---|---|---|
| Increase awareness for RMNCAH-N through accurate information to the target audience for positive social behaviour change. | Develop SBC strategy | Develop, launch, and disseminate the RMNCAH-N advocacy and social behaviour strategy and IEC materials for social behaviour change. | | X | | | |
| | | Launch and disseminate the AYPSRH SBC Strategy. | | X | | | |
| | A sustained, comprehensive, and targeted family planning social and behaviour change campaign implemented at scale | Conduct the annual national RMNCAHN *Tujulishane* Campaign through various channels: radio activations, TV shows, town hall discussions, call centres, print media, social media, influencers, and community engagements. | X | X | X | X | X |
| | | Print launch and disseminate "Understanding Adolescents: Guide for Parents, Teachers and Caregivers'' 24/25 | X | X | X | X | X |

| Strategy/Intervention | Activity | Sub-activities | 2023/24 | 2024/25 | 2025/26 | 2026/27 | 2027/28 |
|---|---|---|---|---|---|---|---|
| | | Print and disseminate "Understanding Adolescents: Guide for Adolescents'' | X | X | X | X | X |
| | | Hold high-level advocacy forums (the executive, parliament, private sector, governors, county first ladies, KEWOPA) for leadership, commitment, buy-in and accountability for RMNCAH-N. | X | X | X | X | X |
| | | | X | X | X | X | X |
| | | Develop, print and disseminate advocacy and media kits for RMNCAH-N. | X | X | X | X | X |
| Bolster advocacy for increased financing for RMNCAHN services at the national and county levels | Advocate for increased domestic financing | Conduct advocacy meetings with the parliamentary health and budgetary committee to safeguard funding allocation for RMNCAH-N. | X | X | X | X | X |
| | | Conduct annual advocacy meetings with decision-makers at the National Treasury and Economic Development Planning to ensure Government RMNCAH-N, FP and immunisation, both at national and county, co-financing commitments are fulfilled | X | X | X | X | X |

| Strategy/Intervention | Activity | Sub-activities | 2023/24 | 2024/25 | 2025/26 | 2026/27 | 2027/28 |
|---|---|---|---|---|---|---|---|
| | | Conduct forums with the SHA Benefits Package Advisory Panel to advocate a comprehensive benefits package for RMNCH-N under SHA, including, but not limited to, the addition of the ANC profile in the benefits package and management of complications post-delivery. | X | X | X | X | X |
| | | Hold bi-annual meetings with insurance regulators to advocate for the integration of RMNCAH-N in private insurance schemes. | X | X | X | X | X |
| | | Hold meetings with the county FIF implementation task team to advocate for the allocation of a percentage of county FIF resources allocation towards RMNCAH-N interventions. | X | X | X | X | X |
| | | Advocate for clear budget lines for RMNCAH-N HPT and not lumped up in health budgets. | X | X | X | X | X |
| | | Advocate for adequate financing, timely disbursement and procurement of essential HPT for RMNCAH-N | X | X | X | X | X |
| | | Advocate for adequate infrastructure (stores, storage equipment, cold chain) for effective HPT management | X | X | X | X | X |

| Strategy/Intervention | Activity | Sub-activities | 2023/24 | 2024/25 | 2025/26 | 2026/27 | 2027/28 |
|---|---|---|---|---|---|---|---|
| | | Track national RMNCAH-N expenditures and advocate for the timely disbursement of elimination of linkages and increased utilisation of available resources for specified RMNCAH-N interventions. | | | X | | X |
| | Advocate for continued development partners' funding | Host an annual roundtable meeting with development partners of health in Kenya to advocate for continued development partners' funding with clearly outlined, gradual transition plans towards self-sufficiency. | X | X | X | X | X |
| Enhance male involvement in RMNCAH-N | Generation and/or customisation and implementation of guidelines on male involvement in RMNCAH-N | Generate a Male Engagement in RMNCAH-N. Couple Counselling guide for service providers | | X | | | |
| | | Generate and disseminate information on fathers' and men's contributions to healthy families through nurturing care, through all stages of the continuum of RMNCAH-N care | | X | | | |
| | | Conduct community and media dialogues for enhanced male involvement in RMNCAH-N | X | X | X | X | X |
| Enhanced coordination and documentation of RMNCAH-N information | Strengthen documentation of RMNCAH-N information | Review and update the existing MOH Family Health /RMNCAH-N Website and social media sites. | X | X | X | X | X |
| | | Document and compile country and county successes, best practices, and lessons | X | X | X | X | X |
| | | Develop and maintain the AYP interactive platform. | X | X | X | X | X |
| | Increase the visibility of RMNCAH-N | Conduct national forums to recognise, celebrate and mark key important RMNCAH-N days. | X | X | X | X | X |

| Strategy/Intervention | Activity | Sub-activities | 2023/24 | 2024/25 | 2025/26 | 2026/27 | 2027/28 |
|---|---|---|---|---|---|---|---|
| | | Host an annual RMNCAH-N Conference to outline progress, gaps and showcase best practices for enhanced awareness | X | X | X | X | X |
| | | Hold RMNCAH-N TWG quarterly meetings at the national and county levels | X | X | X | X | X |
| | | Conduct disseminations for the RMNCAHN Investment Case 2023/4-2027/8 in all economic blocs, bringing together top health leadership in each county | | X | X | X | X |
| | | Monitoring of the RMNCAH-N SBC activities at the national and county levels | X | X | X | X | X |
| Strengthen the capacity of RMNCAH-N personnel and media at the national and county levels on SBC | Enhance the capacities of RMNCAH-N officers | Develop and implement the national RMNCAH-N SBC training manual. | | X | | | |
| | | Capacity building of RMNCAH-N officers and call centre experts on SBC (Annual basis) | | X | X | X | X |
| | Increase community capacity for RMNCAH-N advocacy | Conduct training of RMNCAH_N advocacy champions, including CSOs and FBO influencers, on enhanced capacity for RMNCAH_N advocacy at the national and county levels. | X | X | X | X | X |
| | | Develop and implement a peer educator manual for young people on RMNCAH-N | | X | | | |
| | | Media sensitisation for health auditors and journalists on RMNCAH-N | X | X | X | X | X |
| | | Procure laptops and a video camera for communication for RMNCAH-N | | X | | | |

| Strategy/Intervention | Activity | Sub-activities | 2023/24 | 2024/25 | 2025/26 | 2026/27 | 2027/28 |
|---|---|---|---|---|---|---|---|
| Integration of the RMNCAH-N needs of vulnerable populations. | Bolster advocacy efforts for service integration | Advocate for improved access to RMNCAH-N services for persons living with disabilities, such as ramp infrastructure and the availability of service providers with knowledge of sign language. | X | X | X | X | X |
| | | Advocate for national recognition and resolution of RMNCAH-N challenges faced by vulnerable mothers, newborns, children, and adolescents in refugee camps | X | X | X | X | X |

**Monitoring and Evaluation**

Table A10: Implementation matrix for M&E

| Strategy/Intervention | Activity | Sub-activities | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 |
|---|---|---|---|---|---|---|---|
| Strengthen Monitoring & Evaluation for RMNCAH-N | Improve the quality and capacity of routine data collection and reporting systems | Develop RMNCAH-N M&E Strategy and an M&E Action Plan | | | X | | |
| | | Develop RMNCAH-N Annual Work Plans (AWP) based on the implementation matrix | | X | X | X | X |
| | | Generate and disseminate annual RMNCAH-N Implementation Progress Report (APIR) | | X | X | X | X |
| | | Capacity build of health care workers on the use of digitised reporting (online tools) | | X | X | X | X |
| | | Revise RMNCAH-N data collection and reporting tools | | X | X | X | X |
| | | Sensitise and capacity build health workers on the revised tools | | X | X | X | X |
| | | Conduct training on the revised scorecard for accountability and tracking program performance meetings | | X | X | X | X |
| | | Conduct RMNCAH-N scorecard dissemination meetings at all counties | | X | X | X | X |
| | | Print and distribute the revised data collection and reporting tools | | X | X | X | X |
| | | Provide resource materials for monitoring and evaluation | X | X | X | X | X |
| | Enhance Data Quality Assurance mechanisms | Conduct quality assessments (QAs) to improve service delivery | X | X | X | X | X |
| | | Develop Data Quality Audit (DQA) guidelines | | X | | | |
| | | Conduct quarterly data quality audits (DQAs) to improve routine data | | X | X | X | X |
| | | Conduct bi-annual technical and support supervision of RMNCH-N implementation by the national team and quarterly technical and support supervision by county teams to improve the quality of care. | | X | X | X | X |

| Strategy/Intervention | Activity | Sub-activities | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 |
|---|---|---|---|---|---|---|---|
| | | Train data program managers on data validation | | X | X | X | X |
| | Bolster data utilisation for evidence-based decision-making | Conduct regular data reviews to promote the culture of utilising routine-generated data at all levels | | X | X | X | X |
| | | Generate data sources outside the routine KHIS data, like programme assessments, periodic surveys and special studies, to facilitate the end-line program review | X | X | X | X | X |
| | | Quarterly RMNCAH-N reports (RMNCAH-N Score Card/ presentation at the RMNCAH-N Multi-stakeholder Country Platform | | X | X | X | X |
| | | Annual and Bi-Annual RMNCAH-N performance reports, (countdown) communication briefs and policy briefs | X | X | X | X | X |
| | Strengthen collaborations and partnerships | Conduct partner mapping for the RMNCAH-N Division | | X | X | X | X |
| | | Coordinate RMNCAH-N technical work groups (TWGs) and staff meetings | | X | X | X | X |
| | | Conduct RMNCAH-N quarterly coordination meeting with key stakeholders using the implementation progress report and Scorecard | X | X | X | X | X |
| | | Promoting accountability through periodic performance monitoring | | X | X | X | X |
| | | Annual review of the RMNCAH-N implementation plan and course correction | | X | X | X | X |
| Enhance Research Capacity and Learning | Promote the implementation of research and the use of data to innovate and improve the provision of quality | Scale up the implementation of digital innovation | | X | X | X | X |
| | | Capacity building of HCPs on digital platforms | | X | X | X | X |
| | | Train HCPs on research methodologies at all levels | | X | X | X | X |
| | | Conduct an assessment on adolescents and youth-friendly services | | X | | | |

| Strategy/Intervention | Activity | Sub-activities | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 |
|---|---|---|---|---|---|---|---|
| | evidence-based services | | | | | | |
| | Operationalise the reproductive health and other programs | Implement research findings for learning, disseminate and document research best practices | | X | X | X | X |
| | | Strengthen the RMNCAH-N documents repository for research and learning | | X | | | |
| | Conduct surveys on various RMNCAH-N issues | Conduct RMNCAH-N priority research | X | X | X | X | X |

## APPENDIX B: DETAILED COSTING ANALYSIS

### Maternal Health

Table B1: Estimated costs of activities for maternal health interventions

| Strategy/ Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| Strengthen the maternal death surveillance and response (MPDSR) system to address the quality of care for maternal and perinatal health | Strengthen MPDSR at the health facilities | Establish and functionalise MPDSR committees in all health facilities | One-day sensitisation meeting of 40 participants in each of the 47 counties, TA from the national level | 47,324,902 | 0 | 0 | 0 | 0 | 47,324,902 |
| | Build the capacity of health workers and administrators to conduct no-blame, action-oriented reviews | Train HCPs and managers on MPDSR and use the lessons to improve healthcare | 5-day training on MPDSR guidelines, two trainings per quarter (35 participants and 5 trainers) | 70,705,600 | 75,654,992 | 80,950,841 | 86,617,400 | 75,401,181 | 389,330,015 |
| | Provide technical support to the counties | Conduct technical support visits to counties on MPDSR | 5-day technical support to the counties annually (5 people from the national team to each county) | 46,397,554 | 49,645,383 | 53,120,560 | 56,838,999 | 60,817,729 | 266,820,224 |

| Strategy/ Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | Roll out national MPDSR tools for case identification, classification analysis, and recommendation tracking | Disseminate the MPDSR guidelines and tools | One-day sensitisation meeting of 40 participants per county in all 47 counties, TA from the National level. | 47,324,902 | 0 | 0 | 0 | 0 | 47,324,902 |
| | Roll out national MPDSR tools for case identification, classification analysis, and recommendation tracking | Disseminate the MPDSR guidelines and tools | Printing every 2 years | 5,136,000 | 0 | 5,880,206 | 0 | 6,732,248 | 17,748,455 |
| | Ensure Real-Time Reporting: Deploy digital platforms for timely data capture, analysis, and feedback loops. | Data are routinely captured | Internal activity. No additional cost attached | 0 | 0 | 0 | 0 | 0 | 0 |
| | Link MPDSR to Quality Improvement (QI): Ensure that findings directly inform facility-based | Hold an annual meeting at the county level to ensure findings are included in | 1 workshop of 40 participants for 2 days in every county | 110,638,000 | 118,382,660 | 126,669,446 | 135,536,307 | 145,023,849 | 636,250,263 |

| Strategy/ Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | QI plans and clinical audits. | the planning and audits | | | | | | | |
| | Track progress on corrective actions from death reviews and measure impact over time. | Implement confidential inquiry on maternal deaths | One-day meeting for confidential report feedback at the National level | 272,850 | 291,950 | 312,386 | 334,253 | 357,651 | 1,569,089 |
| | Track progress on corrective actions from death reviews and measure impact over time. | | One day sensitisation meeting in all 47 counties for the implementation of confidential inquiry, TA from the National level | 43,625,676 | 46,679,474 | 49,947,037 | 53,443,329 | 57,184,362 | 250,879,878 |
| | Track progress on corrective actions from death reviews and measure impact over time. | Hold quarterly MPDSR meetings | By CHMT, internal (no cost attached) | 0 | 0 | 0 | 0 | 0 | 0 |

| Strategy/ Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | Strengthen MPDSR at the community level | Create awareness within the community regarding the importance of maternal and perinatal deaths, notification and reviews during action days | One-day meeting per quarter in every sub-county, 40 participants per county and in all the 47 counties, quarterly | 28,162,400 | 30,133,768 | 32,243,132 | 34,500,151 | 36,915,162 | 161,954,612 |
| | Strengthen MPDSR at the community level | Training CHPs/ CHAs on verbal autopsy | Five-day training for CHPs, 40 participants per county, and in all 47 counties, twice a year | 80,464,000 | 86,096,480 | 92,123,234 | 98,571,860 | 105,471,890 | 462,727,464 |
| Improve the quality of basic and comprehensive emergency obstetric and newborn care (EmONC) services at primary health centres and hospitals | Scale up the provision of BEmONC and CEmONC services, including SBBC, at all health facilities | Training of HCW on EmONC (complications: eclampsia, antepartum and postpartum haemorrhage, obstructed labour, sepsis) as | 5-day training for health care workers, 40 participants in each county, four times per year or quarterly in the years indicated | 129,940,800 | 139,036,656 | 0 | 0 | 0 | 268,977,456 |

| Strategy/ Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | | per national guidelines | | | | | | | |
| | | Offer mentorship package to HCWs on EmONC | Five-day training for health care workers 40 participants per county, and in all the 47 counties, quarterly in the years indicated | 43,313,600 | 46,345,552 | 0 | 0 | 0 | 89,659,152 |
| | | Provision of TA on EMONC | Four-day technical support per county by five people from the national level | 30,978,640 | 33,147,145 | 35,467,445 | 37,950,166 | 40,606,678 | 178,150,074 |
| | | Procure MNH commodities and supplies | Total commodity costed under service below | 0 | 0 | 0 | 0 | 0 | 0 |
| | | Advocate for an increase of regional blood banks | No cost attached, under general advocacy and SBC section | 0 | 0 | 0 | 0 | 0 | 0 |

| Strategy/ Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | | Scaled-up implementation of the PPH Bundle approach, including EMOTIVE, as per the guidelines | Virtual meeting (no cost attached) | 0 | 0 | 0 | 0 | 0 | 0 |
| | | Provide maternal and newborn health services | Service delivery at health facilities including health commodities | 32,916,793,477 | 32,952,927,408 | 33,837,346,765 | 35,550,126,211 | 36,464,911,660 | 171,722,105,521 |
| | Scale up implementation of the QoC Standard for MNH in all 47 counties | Develop MNH QOC eKQMH guidelines | 5 development workshops with 30 pax for 5 days, requiring transport, conference and DSA, External validation of 50 Pax( 20 National, 10 counties rep and 20 partners ) requiring Conference, Transport and DSA | 71,018,853 | 0 | 0 | 0 | 0 | 71,018,853 |

| Strategy/ Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | | Train healthcare workers on MNH QOC standards | Two classes, each of 35 participants plus 5 facilitators per class, monthly for the years indicated | 117,614,400 | 125,847,408 | 0 | 0 | 0 | 243,461,808 |
| | | Provide QOC TA to counties facilities | 5 people from the national level and 5 from the county level | 185,590,216 | 198,581,531 | 212,482,238 | 227,355,995 | 243,270,915 | 1,067,280,895 |
| | | Link MNH QOC in eKQMH and KHIS platform | 2 workshops of 5 days each and 40 participants to functionalise the system for 5 days each | 0 | 10,487,284 | 0 | 0 | 0 | 10,487,284 |
| | | Conduct annual quality of care audits (MNH ) at the facility and provide technical support to counties on QOC. | 5 people from the national level and 10 from the county level for 5 days of work at each county | 67,519,354 | 72,245,709 | 77,302,908 | 82,714,112 | 88,504,100 | 388,286,183 |

| Strategy/ Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | Bolster consultations at the counties on MNH | Learning best practices forum in all 47 counties | 5-day residential meeting once per year, with 40 participants in every county | 222,281,800 | 237,841,526 | 254,490,433 | 272,304,763 | 291,366,097 | 1,278,284,618 |
| | | Document and disseminate best practices | One meeting in a quarter (internal cost) | | | | | | - |
| | Enhance the quality of care during childbirth to prevent any complications | Conduct routine on-the-job training | Carried out by 5 county-based staff, 5 days per month | 72,417,600 | 77,486,832 | 82,910,910 | 88,714,674 | 94,924,701 | 416,454,717 |
| | Scale up high-quality Kangaroo Mother Care | Conduct routine on-the-job training | Carried out by 5 county-based staff 5 days per month | 72,417,600 | 77,486,832 | 82,910,910 | 88,714,674 | 94,924,701 | 416,454,717 |
| | Strengthen the neonatal nurse workforce | Employ more workers | Under county HRH development (cost included here) | 0 | 0 | 0 | 0 | 0 | 0 |

| Strategy/ Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | Enhance community structures in relation to newborn care | Train CHPs/ CHAs on newborn care | 5-day training of 35 CHPs/CHAs and 5 facilitators, every month | 58,807,200 | 62,923,704 | 67,328,363 | 72,041,349 | 77,084,243 | 338,184,859 |
| | Strengthen the follow-up of newborns discharged after inpatient care | Carry out follow-up at the household level by CHPs and make referrals where necessary | Routine work. No additional cost | 0 | 0 | 0 | 0 | 0 | 0 |
| | Develop, launch and disseminate a costed MNCH acceleration plan as well as county-specific costed acceleration plans | Develop a national accelerated plan at the national level | 2 five-day technical meetings of 20 participants, national level | 9,737,000 | 0 | 0 | 0 | 0 | 9,737,000 |
| | Develop, launch and disseminate a costed MNCH acceleration plan as well as county-specific costed | Counties adapt the nation y, and develop county plans | One-week plan development workshop in each county of 30 participants, one consultant | 250,192,750 | 0 | 0 | 0 | 0 | 250,192,750 |

| Strategy/ Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | acceleration plans | | per county for 30 days | | | | | | |
| | Develop, launch and disseminate a costed MNCH acceleration plan as well as county-specific costed acceleration plans | Annual review of county acceleration plans | 3-day workshop of 30 participants from each county | 110,135,100 | 117,844,557 | 126,093,676 | 134,920,233 | 144,364,650 | 633,358,216 |
| Enhance access and utilisation of maternal services | Capacity build healthcare providers on the continuum of care package | Develop RMC training package for HCPs | Five development workshops with 30 participants for 5 days, requiring transport, conference and DSA | 0 | 18,377,250 | 0 | 0 | 0 | 18,377,250 |
| | Capacity building of healthcare providers on the continuum of care package | Train health care providers on respectful maternity care | Five-day training for healthcare workers, two classes of 35 participants and 5 trainers each, every month for the years indicated | 117,614,400 | 125,847,408 | 134,656,727 | 144,082,697 | 154,168,486 | 676,369,718 |

| Strategy/ Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | Capacity building of HCP on self-care | Train HCPs on self-care | Five-day training for health care workers, two classes, each of 35 participants plus 5 facilitators per class, monthly | 117,614,400 | 125,847,408 | 134,656,727 | 144,082,697 | 154,168,486 | 676,369,718 |
| | Enroll pregnant women in the household on the SHA/ SHIF | Engage CHAs/ CHPs for demand creation | Non-residential training of 35 participants plus 5 facilitators per county, once every year | 8,046,400 | 8,609,648 | 9,212,323 | 9,857,186 | 10,547,189 | 46,272,746 |
| | Enhance the service preparedness of health facilities to screen, diagnose, and rehabilitate RCs | Train HCWs to screen and diagnose reproductive cancers | Five-day training for the healthcare workers, two classes, each of 35 participants plus 5 facilitators per class, monthly | 117,614,400 | 125,847,408 | 134,656,727 | 144,082,697 | 154,168,486 | 632,121,232 |
| | Create awareness and management of maternal mental health at the facility and | Train HCPs on maternal mental health at all levels as per the continuum | Five-day training for healthcare workers, two classes, each of 35 participants | 117,614,400 | 125,847,408 | 134,656,727 | 144,082,697 | 154,168,486 | 632,121,232 |

| Strategy/ Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | community level | of care guidelines | plus 5 facilitators per class, monthly | | | | | | |
| | Enhance the quality of care during childbirth to prevent any complications | Mentoring of healthcare providers on partograph use to prevent obstetric fistulas and other complications | Carried out by county-based staff 5 days per month | 72,417,600 | 77,486,832 | 82,910,910 | 88,714,674 | 94,924,701 | 389,210,016 |
| | Enhance the quality of care during childbirth to prevent any complications | Promote timely referral of pregnant women from the community to health facilities for skilled birth attendance | No cost attached | 0 | 0 | 0 | 0 | 0 | 0 |
| | Enhance the quality of care during childbirth to prevent any complications | Sensitise community health promoters on danger signs before, during and after childbirth | 3-day non-residential meeting of 35 participants plus 5 facilitators, monthly | 265,531,200 | 284,118,384 | 304,006,671 | 325,287,138 | 348,057,237 | 1,427,103,393 |

| Strategy/ Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | Bolster the availability and utilisation of fistula services at the facility | Conduct community dialogue and action days to demystify myths and misconceptions on fistula | No additional cost. Integrated into existing dialogue and action days | 0 | 0 | 0 | 0 | 0 | 0 |
| | Bolster the availability and utilisation of fistula services at the facility | Provide fistula management | Service delivery | 385,200,000 | 770,400,000 | 963,000,000 | 1,348,200,000 | 1,733,400,000 | 5,200,200,000 |
| | Bolster the availability and utilisation of fistula services at the facility | | | | | | | | |
| | Enhance post-abortion care services at all levels | Create awareness on the availability of Post Abortion Care (PAC) services at all levels | 3-day non-residential meeting of 40 participants in every county on a quarterly basis | 81,268,640 | 86,957,445 | 93,044,466 | 99,557,579 | 106,526,609 | 436,780,129 |
| | Enhance post-abortion care services at all levels | Capacity building of HCPs on PAC service | Five-day training for health care workers, two classes, each of 35 participants | 117,614,400 | 125,847,408 | 134,656,727 | 144,082,697 | 154,168,486 | 632,121,232 |

| Strategy/ Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | | | plus 5 facilitators per class, monthly | | | | | | |
| | Map and review existing facility and community-level data, and identify gaps to establish what additional data is needed to inform the prioritisation of interventions | Undertake the mapping exercise | Technical meetings and consultation for 30 days | 0 | 5,117,703 | 0 | 0 | 0 | 5,117,703 |
| Empower communities to demand respectful maternal care | Strengthen social accountability mechanisms for maternal health services. | Conduct client exit interviews and surveys | No cost attached | 0 | 0 | 0 | 0 | 0 | 0 |
| | Strengthen social accountability mechanisms for maternal health services. | Conduct community dialogue and open days | Under advocacy | 0 | 0 | 0 | 0 | 0 | 0 |
| | Strengthen social accountability mechanisms for maternal health services. | Train CHPs/ CHAs on community scorecards | Five-day non-residential training of 35 participants plus 5 facilitators per class, monthly | 58,807,200 | 62,923,704 | 67,328,363 | 72,041,349 | 77,084,243 | 316,060,616 |

| Strategy/ Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | Capacity building for community actors on maternal health services | Train community health actors on maternal health (CHAs and CHPs) | Three-day training of 35 participants plus 5 facilitators per class, monthly | 265,531,200 | 284,118,384 | 304,006,671 | 325,287,138 | 348,057,237 | 1,427,103,393 |
| Strengthen the referral and linkages to deliver improved quality maternal services as per the KEPH. | Functionalize ambulances, including mobile clinics | Procure equipped ambulances (as per the national guidelines. | Cost not attached to RMNCAH-N | 0 | 0 | 0 | 0 | 0 | 0 |
| | Functionalize ambulances, including mobile clinics | Train the personnel on emergency health services | Five-day training of 2 classes per quarter, 35 participants plus 5 facilitators per class, | 39,204,800 | 41,949,136 | 44,885,576 | 48,027,566 | 51,389,495 | 210,707,077 |
| | Timely referral of clients, including specimen | Advocacy for the demand creation of services | No cost here, but part of the advocacy costed under Advocacy and SBC | 0 | 0 | 0 | 0 | 0 | 0 |
| | Timely referral of clients, including specimen | Adequate distribution of specialists and experts nationwide | No cost required | 0 | 0 | 0 | 0 | 0 | 0 |

| Strategy/ Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | Timely referral of clients, including specimen | Quality handling and movement of specimen | No cost attached and assumed as part of the general health services | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total** | | | | **36,602,889,314** | **36,828,382,376** | **37,759,259,105** | **40,058,070,592** | **41,568,690,957** | **192,390,059,361** |

## Newborn and Child Health

Table B2: Estimated costs of activities for newborn and child health interventions

| Strategy/ Intervention | Activity | Sub-activity | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| Promote and enhance availability and access to high-impact, evidence-based interventions for the management of all newborns, including small and sick newborns. | Scale up the provision of comprehensive and essential newborn care services | Dissemination of comprehensive essential newborn care guidelines | 8 one-day regional meetings, each county having 3 participants, DSA, transport reimbursement, conference package, 145 participants | 3,651,165 | 0 | 0 | 0 | 0 | **3,651,165** |
| | | Procurement and distribution of essential newborn care equipment to all facilities, including but not limited to oxygen, CPAP, | No additional cost for RMNCAH-N | 0 | 0 | 0 | 0 | 0 | 0 |

| Strategy/ Intervention | Activity | Sub-activity | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | | radiant warmers, and incubators | | | | | | | |
| | | Monitor stock out of essential newborn commodities in the counties and take mitigating measures, i.e. Tetracycline, Chlorhexidine, Vitamin K | One day, a meeting of 20 persons | 1,001,700 | 0 | 0 | 0 | 0 | **1,001,700** |
| | | Procure caffeine citrate and train healthcare workers on its use. | Costed as part of the commodities and included in other trainings | 0 | 0 | 0 | 0 | 0 | 0 |
| | | Capacity building of health care workers on management of preterm and or low birth weights on resuscitation, Cord Care, IPC, feeding and KMC | TOT- 10 regional training of 5 days for 8 persons per county, national team 3 persons per region and driver | 17,857,350 | 0 | 0 | 0 | 0 | **17,857,350** |

| Strategy/ Intervention | Activity | Sub-activity | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | | Roll out Newborn, Child and Adolescent Death Surveillance Response Guidelines | 10 regional training of 5 days for 8 persons per county, national team 3 persons per region and driver, annually | 17,857,350 | 17,857,350 | 17,857,350 | 17,857,350 | 17,857,350 | **89,286,750** |
| | | Training of HCWs and OJT on resuscitation procedures-ABCD | 24 HCWs per county for 3 days<br>Conference package and DSA<br>Facilitators-4 from the national level, annually | 10,991,400 | 10,991,400 | 10,991,400 | 10,991,400 | 7,693,980 | **51,659,580** |
| | | Sensitise health workers on early essential newborn interventions | Two workshops per county annually-25 participants for 5 days, 4 facilitators from the national governments per county, annually | 191,527,350 | 191,527,350 | 191,527,350 | 191,527,350 | 191,527,350 | **957,636,750** |
| | Enhance community structures in relation to newborn care | Train CHAs and CHPs on CMNC, Nurturing Care, integrated ICCM/ SAM/ | Regional training of 20 participants per county | 58,455,075 | 0 | 0 | 0 | 0 | **58,455,075** |

| Strategy/ Intervention | Activity | Sub-activity | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | | MAM and other maternal newborn interventions | | | | | | | |
| Promote access to and uptake of preventive interventions for childhood illnesses | Enhance capacity for HCWs on notifiable diseases and CHPs on Integrated Community Case Management (ICCM) guidelines on common childhood diseases and Community Newborn Care (CMNC). | Training TOTs and HCPs | Training of trainers (TOT) meeting at the county level, 1 TOT per county for 35 participants per county for 10 days | 240,976,050 | 0 | 0 | 0 | 0 | **240,976,050** |
| | Ensure effective utilisation of the Mother and Child Health (MCH) Handbook | Sensitisation of HCWs on the Mother-Child Handbook | 1 training workshop per county for five days - 35 participants | 0 | 127,791,825 | 0 | 0 | 0 | **127,791,825** |
| | Promote the uptake of childhood vaccines | Procure and distribute vaccines | Vaccines as per requirements | 6,258,384,437 | 6,431,213,052 | 6,606,115,804 | 6,746,932,171 | 6,888,832,323 | 32,931,477,788 |
| | | Deliver immunisation services | Actual service provision in facilities | 2,994,317,158 | 3,084,634,682 | 3,176,366,440 | 3,266,219,474 | 3,357,334,656 | 15,878,872,410 |
| Promote access to timely and quality treatment for common childhood | Scale up iMNCI and ETAT+ | Train at least 60% of HCWs in every facility on IMNCI and ETAT | Two workshops per county annually-25 participants for 5 days, 4 facilitators | 191,527,350 | 191,527,350 | 191,527,350 | 191,527,350 | 191,527,350 | **957,636,750** |

| Strategy/ Intervention | Activity | Sub-activity | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| illnesses - major killers (Scale iMNCI and ETAT+). | | | from the national governments per county, annually | | | | | | |
| | | Conduct quarterly targeted supportive supervision and data quality audit on infant and child morbidity | Average consumption of 10km/litre. Assumed that 10 counties will be visited annually (national level only) | 1,249,920 | 1,249,920 | 1,249,920 | 1,249,920 | 1,249,920 | **6,249,600** |
| | | Integrated supportive supervision- Quarterly | Quarterly integrated supportive supervision, 2-national and 2 county - field activity-4 people for 5 days in each of 47 counties, fuel- 130 X 200 km/day X 5 days X 20km/litre | 53,771,760 | 53,771,760 | 53,771,760 | 53,771,760 | 53,771,760 | **268,858,800** |
| | | Establish and/or strengthen ORT corners | Evenly across the five years (1455 facilities per year) | 276,319,050 | 276,319,050 | 276,319,050 | 276,319,050 | 276,319,050 | **1,381,595,250** |
| | | Equip Emergency Trays with appropriate | Each facility is to receive three sets spread | 27,448,575 | 27,448,575 | 27,448,575 | 0 | 0 | **82,345,725** |

| Strategy/ Intervention | Activity | Sub-activity | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | | child-friendly supplies: Ambu bags | across 3 years, 7275 per year | | | | | | |
| | | Develop an emergency preparedness checklist for paediatrics. | 3 workshops at the national level for 5 days, 30 participants | 0 | 2,504,250 | 0 | 0 | 0 | **2,504,250** |
| | | Conduct oxygen administration and newborn resuscitation training for HCWs working on NBUs | Regional training sessions for 25 participants for 3 days, and facility-level training | 21,484,300 | 0 | 0 | 0 | 0 | **21,484,300** |
| | | Avail treatment guidelines and protocols | 10000 copies per year of paediatric protocols, 5000 copies of quality of care handbook per year, 2500 copies of ICCM guidelines per annum, 1000 copies of ETAT training manuals and materials per year, purchase of 192 mannequins in year 2, dissemination | 55,035,475 | 58,667,350 | 49,667,350 | 49,667,350 | 49,667,350 | **262,704,875** |

| Strategy/ Intervention | Activity | Sub-activity | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | | | meetings (year 1)-5 regional meetings-94 people--2 per county- 20 persons per meeting-facilitators-3 from the national level | | | | | | |
| | | Strengthen the availability of key commodities to manage major childhood illnesses. | Workshop at the national level- 30 participants for 5 days | 0 | 2,504,250 | 0 | 0 | 0 | **2,504,250** |
| | Promote and strengthen implementation of IMNCI and ETAT+ to address leading causes of child morbidity and mortality and improve the management of severely sick children. | Incorporate ETAT and IMNCI data classifications into routine HIS/digital tools | 5-day workshop at the national level – 35 participants | 0 | 0 | 2,921,625 | 0 | 0 | **2,921,625** |
| | | Increase the number of TOTS in iCCM at all levels | Train HCWs and CHPs on iCCM, 100 participants per county for 5 days | 0 | 58,455,075 | 0 | 0 | 0 | **58,455,075** |
| | | Integrated outreach services to the difficult-to-reach populations | Integrated outreach at the county level (costed above) | 0 | 0 | 0 | 0 | 0 | 0 |

| Strategy/ Intervention | Activity | Sub-activity | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | | Provide health services for common childhood illness | Service provision at health facilities (medicines, HRH, operations) | 9,672,729,959 | 11,330,858,301 | 13,164,169,860 | 15,146,089,578 | 17,371,806,239 | **66,685,653,937** |
| Promote access to quality and comprehensive early childhood development interventions for all children eight years and below, especially nurturing care during the first 1000 days of life. | Establish national and county-level multi-sectoral governance mechanisms with decision-making authority to coordinate early childhood development interventions across relevant sectors and stakeholders. | Development of TOR for the multi-sectoral coordinating committee/ TWGs for ECD interventions | Non-residential TWG at the national level for 10 participants | 75,000 | 0 | 0 | 0 | 0 | **75,000** |
| | | Establishment of national and county-level multi-sectoral TWGs for ECD interventions (MOH, MOE, Social Services, NGAO, implementing partners) | Quarterly TWG at the county level, 1-day with 20 participants per county | 17,857,350 | 17,857,350 | 17,857,350 | 17,857,350 | 17,857,350 | **89,286,750** |
| | | Development of a national and county-level implementation framework for ECD interventions. | Consultancy for 30 days | 900,000 | 0 | 0 | 0 | 0 | **900,000** |
| | | Lobby political leadership at the national, county and sub-county levels for | Regional meetings of 5 persons per county for 2 days | 0 | 15,069,600 | | 15,069,600 | 0 | **30,139,200** |

| Strategy/ Intervention | Activity | Sub-activity | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | | resource allocation for ECD interventions. | | | | | | | |
| | Develop and roll out a training and capacity-building plan for ECD interventions, including service providers and managers. | Development and roll-out of a training and capacity-building plan for ECD interventions to include service providers and managers | National TWG meeting for 1 day, 20 participants | 17,907,350 | 0 | 0 | 0 | 0 | **17,907,350** |
| Strengthen the health sector's capacity for identification and appropriate and timely referrals for children with developmental delays, difficulties or disabilities. | strengthen CHPs, ECD teachers and religious leaders' capacity to identify and refer children with challenges to link to the health facilities | Conduct residential training per county | 1-day non-residential training per county of 100 participants | 13,423,200 | 13,423,200 | 13,423,200 | 13,423,200 | 13,423,200 | **67,116,000** |
| | Strengthen intra- and inter-county linkage among health facilities and rehabilitation centres. | Hold consultative meetings between county teams and rehabilitation management | Regional meetings of 3 persons per county for 2 days, 25 persons per region | 5,836,950 | 0 | 5,836,950 | 0 | 0 | **11,673,900** |
| | | Sensitisation of healthcare providers on identification and referral of children with disabilities and special needs at | National workshop for 30 people for 5 days | 2,504,250 | 0 | 0 | 0 | 0 | **2,504,250** |

| Strategy/ Intervention | Activity | Sub-activity | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | | all levels of care (Including specialised therapists) | | | | | | | |
| | Enhance the capabilities of HCWs on appropriate and timely referrals | Review existing guidelines for service providers and caregivers on early identification and referrals of children with developmental delays or disabilities. | Workshop at the national level- 30 participants for 5 days | 2,504,250 | 0 | 0 | 0 | 0 | **2,504,250** |
| **Grand Total** | | | | **20,155,593,774** | **21,913,671,690** | **23,807,051,334** | **25,998,502,903** | **28,438,867,877** | **120,313,687,580** |

**Family Planning**

Table B3: Estimated costs of activities for family planning interventions

| Strategy/ Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/29 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| Strengthen the capacity of all market segments to deliver quality FP services | Review the National Costed Implementation Plan (CIP) to include the total market approach (TMA) strategy | Review the National CIP to include the TMA strategy | Conduct 5 workshops for 5 days each to review and develop FP CIP, including TMA strategy | 18,375,645 | 19,661,940 | 0 | 0 | 0 | **38,037,585** |
| | | Validation and launch meeting ((Printing of 400 copies, dissemination and distribution) | To be done in 47 counties with 5 persons (235) per county meeting to be done in 9 clusters, 10 national officers and 5 partners per cluster | 0 | 21,259,400 | 0 | 0 | 0 | **21,259,400** |
| | | | DSA, conference hall and transport required | | | | | | |
| | Build the capacity of healthcare providers to provide quality FP services | Training of healthcare providers on national family planning guidelines for the provision of | Hold 5-day meeting of 400 TOTs training in FP services | 43,544,720 | 46,592,850 | 49,854,350 | 53,344,154 | 56,288,197 | **249,624,271** |

| Strategy/ Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/29 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | | quality services | | | | | | | |
| | | Promote post-pregnancy family planning intervention in healthcare facilities | Hold 5-day training for 200 TOTS on post-pregnancy family planning and 5-day training for 200 TOTS in Voluntary Surgical contraception | 16,169,412 | 17,227,224 | 18,285,036 | 19,342,848 | 20,400,660 | **91,425,180** |
| | | Build capacity to roll out the FP mentorship package. | Hold 5-day training for 2000 FP mentors | 27,257,180 | 29,165,183 | 31,206,745 | 33,391,218 | 35,234,065 | **156,254,391** |
| | | Roll out of Hormonal IUD and DMPA SC orientation package | Conduct 3-day training of 400 TOTS on H-IUD and DMA SC in the counties, orient 5000 Healthcare workers on hormonal IUD and DMPA SC and hold a 1-day sensitisation meeting for | 181,515,121 | 194,221,179 | 207,816,662 | 214,167,683 | 228,079,081 | **1,025,799,727** |

| Strategy/ Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/29 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | | | CHPs and CHAs | | | | | | |
| | Strengthen the capacity of private providers, including community pharmacists and pharmaceutical technologists, to provide quality FP services | Train private providers on FP for the provision of quality services | 200 per year for 5 days, as in the above | 20,392,060 | 21,819,504 | 23,346,869 | 24,981,150 | 26,359,850 | **116,899,434** |
| | | Roll out the FP mentorship package to the private providers | Use the TOTs to do mentorship in the private sector. One week per 5 days quarterly by 2 TOTs to the private sector facilities ( transport allowance per day, lunch allowance per day | 25,680,000 | 27,477,600 | 29,401,032 | 31,459,104 | 33,195,319 | **147,213,056** |
| | Integrate FP services in health facilities | Develop guidelines on integrating FP services in health facilities | Workshop to develop guidelines-5 days-30 ppts | 3,675,450 | 0 | 0 | 0 | 0 | **3,675,450** |
| | | Sensitisation meetings for the integration of | No cost attached, routine | 0 | 0 | 0 | 0 | 0 | 0 |

| Strategy/ Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/29 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | | FP services (county level) | | | | | | | |
| | Implementation of RH/FP self-care interventions | Dissemination of self-care interventions in RH/FP | Print 1000 copies of the National Guideline on self-care intervention in RH and hold 1 1-day dissemination meeting at the National and county levels | 1,430,000 | 535,000 | 0 | 0 | 0 | **1,965,000** |
| | | Training of Healthcare providers on RH/FP self-care interventions | Hold 5-day TOTs Training for 175 healthcare providers on National self-care guidelines for RH, 5 days training of 2000 Health care providers on self-care guidelines for RH, 1 day training of CHAs and CHPs on self-care guidelines for RH | 75,059,002 | 80,313,132 | 83,072,371 | 85,824,369 | 90,692,967 | **414,961,840** |

| Strategy/ Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/29 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | Promote post-pregnancy family planning intervention in the health care facilities | Training of Healthcare providers on post-pregnancy family planning, Module 2 | hold 5 days training of 200 TOTs on post pregnancy Family planning and 2000 Healthcare providers on post pregnancy Family Planning | 45,784,872 | 48,989,813 | 52,419,100 | 56,088,437 | 61,053,375 | **264,335,597** |
| | Strengthen the capacity of community-based distribution of FP commodities as per the FP policy | Sensitisation of CBD and CHPs on FP services and commodities | Covered under other trainings | 0 | 0 | 0 | 0 | 0 | 0 |
| | | Train CBD on FP in the selected Counties | Covered under other trainings | 0 | 0 | 0 | 0 | 0 | 0 |
| | Enhance the quality of family planning services | Dissemination of FP QA standards in all counties | 6 regional meetings with 3 participants per county for 3 days, 25 participants | 6,205,600 | 0 | 7,104,791 | 0 | 8,134,276 | **21,444,667** |
| | | Train HCWs on FP QA standards training in all counties | 400 pax per year for 2 days (within county – conference, transport reimbursement | 5,050,400 | 5,403,928 | 5,782,203 | 6,186,957 | 6,528,413 | **28,951,901** |

| Strategy/ Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/29 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | | Conduct Quality Assurance and (Technical Assistance)for FP services delivery | 5 parsons from the national level quarterly for 5 days, 1 driver, fuel, per diem for 6 days | 25,436,682 | 27,217,250 | 29,122,457 | 31,161,029 | 32,880,794 | **145,818,212** |
| | | Train three county TOTs per county on Hormonal IUD. | Train 3 county TOTs per county on Hormonal IUD | 1,765,500 | 1,889,085 | 2,021,321 | 2,147,790 | 2,275,700 | **10,099,396** |
| | | Train experienced IUCD providers on H-IUD. | Hold 3-day training for 2000 Healthcare providers on H-IUD in county and facility | 37,878,000 | 40,529,460 | 43,366,522 | 46,079,850 | 48,824,111 | **216,677,943** |
| | Provide the required FP methods with an emphasis on long-term methods | Provide the required FP methods | Service at delivery (HRH and operations, excluding commodities which are costed below in commodity security) | 2,401,872,152 | 2,448,661,059 | 2,535,296,268 | 2,728,421,871 | 2,778,628,106 | **12,892,879,456** |

| Strategy/ Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/29 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | Distribute written guidance on DMPA-SC and self-administration to all counties to promote ownership of the self-administered DMPA-SC programme | Provide the guidelines to the counties | Print 1000 copies of every year | 15,000,000 | 15,750,000 | 15,750,000 | 15,750,000 | 15,750,000 | **62,250,000** |
| | Increase awareness creation for DMPA-SC, especially self-injection, by systematically engaging community volunteers for wider coverage and involving men as well as religious and cultural leaders in DMPA-SC programming | Undertake demand creation | Cost under SBC | 0 | 0 | 0 | 0 | 0 | 0 |

| Strategy/ Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/29 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| Increase the Availability of Quality FP Commodities and health products and technologies at all Service Delivery Points | Strengthen capacity for selection, quantification and supply chain management for FP HPT at all levels to inform needs and ensure efficient use. | Train TOTs in RH HPT management course | Hold 5-day training 400 TOTs in RH HPT management course | 13,113,920 | 14,031,894 | 15,014,127 | 16,065,116 | 17,015,219 | **75,240,277** |
| | | Training of Healthcare providers on forecasting and supply planning for FP HPT | Hold 5-day training of 2000 healthcare workers on forecasting and quantification tools and methods on FP HPT and develop and maintain a live database of healthcare providers trained. | 40,784,120 | 43,639,008 | 46,693,739 | 49,962,301 | 48,719,700 | **229,798,868** |
| | | Forecasting and supply planning | hold 5 days stakeholder workshop for forecasting and supply planning (30 pax outside of city) | 3,306,300 | 3,537,741 | 3,785,383 | 4,050,360 | 4,273,897 | **18,953,681** |
| | | Sensitise counties and other stakeholders on the | Conduct training sessions for stakeholders with | 10,902,872 | 11,666,073 | 12,482,698 | 13,356,487 | 14,093,626 | **62,501,756** |

| Strategy/ Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/29 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | | introduction and scale-up plan for Hormonal IUDs. | subsequent post-training evaluations. (one-day meeting at county, 2 persons from national level, 30 pax from county, conference, transport allowance, national level persons 2 days of per diem and transport reimbursement ) | | | | | | |
| | | Digitise the quantification processes for FP HPT | No cost is attached. To be supported by the Ministry of ICT | | | | | | - |
| | Ensure sustained availability of FP commodities , including DMPA SC and H-IUD, in all service delivery points | Training healthcare workers on supply chain management and online learning integrated supply chain curriculum. | Training 2000 healthcare workers on supply chain management | 37,878,000 | 40,529,460 | 43,366,522 | 46,402,179 | 48,963,096 | **217,139,257** |

| Strategy/ Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/29 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| Implement quality monitoring and reporting mechanisms for FP HPT. | Avail FP commodities at all service delivery points | Procure and distribute FP commodities | As per national requirements | 2,391,931,668 | 2,450,533,633 | 2,510,571,338 | 2,572,079,957 | 2,635,095,529 | 12,560,212,125 |
| | Monitoring FP supply chain | Conduct quarterly logistics working group meetings | Meeting of 30 pax per county, 2-day meeting, per diem for 3 days, meeting in the county | 281,221,680 | 300,907,198 | 321,970,701 | 344,508,651 | 363,521,943 | **1,612,130,172** |
| | | Hold 3 3-day bi-annual technical Review meetings | National level of 50 pax, per diem for 4 days | 8,774,000 | 9,388,180 | 10,045,353 | 10,748,527 | 11,341,734 | **50,297,794** |
| | Roll out standardised training on FP iLMS to all counties | Roll out standardised training on FP iLMIS to all counties for 1000 HCWs | 5-day training | 18,446,800 | 19,738,076 | 21,119,741 | 22,598,123 | 23,845,304 | **105,748,045** |
| | Conduct quality assurance/improvement spot checks for FP quality services at the county/ facility level for users' safety. | Conduct routine Last-mile assurance for FP commodities | | 3,700,761 | 3,979,313 | 4,278,831 | 4,600,894 | 4,600,894 | **21,160,694** |
| | | Conduct routine Post Market Surveillance | | 1,877,850 | 0 | 2,149,950 | 0 | 2,579,941 | **6,607,741** |

| Strategy/ Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/29 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| **Grand Total** | | | | **5,764,029,767** | **5,944,664,183** | **6,125,324,110** | **6,432,719,055** | **6,618,375,797** | **30,869,362,916** |

**Adolescent Health**

Table B4: Estimated costs of activities for adolescent health interventions

| Strategy/ Intervention | Activity | Sub-activity | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| To improve adolescent healthcare-seeking behaviour | Develop appropriate information for improved adolescent health-seeking behaviour | Review and design appropriate health information on risk factors for communicable and non-communicable diseases to be integrated into the school curriculum. | • 5 development workshops in 2023/24 with 30 people for 5 days, internal validation meeting of 30 participants, external validation meeting with 50 participants (20 national, 10 counties and 20 partners), printing 50 copies,<br>• 47 county dissemination meetings for 1 day in 2024/25 and 2027/28 | 19,241,000 | 34,701,983 | 0 | 0 | 32,431,760 | **86,374,743** |
| | | Develop and disseminate a sensitisation | Same assumption as above, with inflation factored. | 0 | 20,587,870 | 21,371,574 | 0 | 0 | **41,959,444** |

| Strategy/ Intervention | Activity | Sub-activity | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | | package for the inclusion of adolescent awareness programmes among stakeholders | Development and validation in 2024/25 and dissemination in 2025/26 | | | | | | |
| | | Develop and disseminate a guideline for adolescent peer-to-peer engagement in healthcare-seeking behaviour | 5 development workshops, each of 5 days in 2026/27, with 30 people, internal validation meeting of 30 participants, external validation meeting with 50 participants (20 national, 10 counties and 20 partners), printing 50 copies, 47 county dissemination meetings for 1 day in 2024/25 and 2027/28 | 0 | 0 | 0 | 23,571,052 | 18,666,760 | **42,237,812** |
| | Capacity build adolescents with information | Conduct adolescent and youth-specific outreaches and mobile clinics | Hold adolescent and youth-specific outreaches and | 0 | 33,876,350 | 0 | 0 | 31,660,140 | **65,536,490** |

| Strategy/ Intervention | Activity | Sub-activity | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | for increased healthcare-seeking behaviour | in communities to promote service utilisation among adolescents | mobile clinics in 47 counties, 3-day event for 30 adolescents per county, 4 national officers and 4 officers per County requiring transport reimbursement and conference package | | | | | | |
| Strengthen community engagement in promoting adolescent health and rights. | Build the capacity of CHPs on adolescents and rights | Develop a Community Health Promoters Health Module on Adolescents and Rights | 5 Workshop to develop a Community Health Promoters Health Module on Adolescents and Rights (same assumptions as above on document development) | 17,175,000 | 40,497,103 | 0 | 0 | 19,606,760 | **77,278,863** |
| | | Conduct sensitisation of Community Health Promoters on the adolescent health module. | Training of TOTs | 0 | 6,738,325 | 0 | 0 | 6,297,500 | **13,035,825** |
| | | Conduct sensitisation of Community Health | Training of CHPs in 47 counties, training of 18 National TOTs | 0 | 70,817,287 | 75,774,497 | 81,078,711 | 0 | **227,670,495** |

| Strategy/ Intervention | Activity | Sub-activity | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | | Promoters on the adolescent health module. | and 27 County TOTs by 10 National trainers | | | | | | |
| | Institute community structures to promote adolescent health and rights. | Develop platforms that provide access to resources and support for adolescents, parents/caregivers, and community leaders | Develop SRQ as per user, 3 workshops of 30 people for 5 days each, consultancy for 40 days, | 0 | 4,927,350 | 1,339,533 | 14,057,368 | 0 | **20,324,251** |
| | | Develop a community sensitisation package for adolescents and their influencers. | 5 workshops (same assumptions as above on document development) | 0 | 0 | 19,663,658 | 20,720,328 | 14,997,960 | **55,381,946** |
| | | Develop a positive parenting and community leaders' program as a social asset for adolescents' and young people's health | 5 workshops (same assumptions as above on document development) | 0 | 18,441,450 | 31,231,109 | 0 | 25,268,460 | **74,941,019** |
| Promote awareness of mental health and the harmful | Adapt the existing Kenya Mental | Develop an implementation plan that encompasses | 3 development workshops with 30 participants | 17,811,220 | 0 | 0 | 0 | 0 | **17,811,220** |

| Strategy/ Intervention | Activity | Sub-activity | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| effects of substance abuse among adolescents, young people, and communities. | Health Policy (2015-2030) for adolescents | adolescent mental health within its framework, aiming to provide access to comprehensive mental health services for adolescents and youth nationwide. | and internal validation | | | | | | |
| | | Disseminate the implementation plan to health care providers, CSOs, community leaders, and parents to support and raise awareness of mental health | Launch of the strategy, 150 pax at the national level, in 47 counties, with 235 participants from counties, in 9 clusters, with 10 national officers and 5 partners per cluster | 0 | 46,639,517 | 0 | 0 | 0 | **46,639,517** |
| | Enhance mental health awareness in communities | Develop age-appropriate content for awareness of mental health and the harmful effects of substance abuse, | Costed under SBC | 0 | 0 | 0 | 0 | 0 | 0 |

| Strategy/ Intervention | Activity | Sub-activity | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | | considering the needs of out-of-school adolescents | | | | | | | |
| | | Sensitise adolescents and communities on mental health issues | Conduct training for healthcare workers and teachers on mental health and well-being among adolescents and community awareness. Training of 235 HCWs in 9 clusters, 10 national staff, and similarly 235 teachers | 4,563,200 | 81,673,228 | 5,224,408 | 5,590,116 | 4,563,200 | **101,614,152** |
| | Promote adolescent and young people's awareness of the harmful effects of alcohol, tobacco and other | Disseminate the National guidelines for aftercare and reintegration for persons with drug and substance abuse disorders among health workers, | Conduct county-based workshops to disseminate national guidelines, a total of 235 participants (5 per county) in 9 clusters and 10 | 0 | 0 | 0 | 0 | 19,606,760 | **19,606,760** |

| Strategy/ Intervention | Activity | Sub-activity | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | substance use. | community leaders, teachers and other relevant stakeholders at the community level | national officers and 5 | | | | | | |
| | | Develop age-appropriate content for awareness creation sessions on the harmful effects of alcohol, tobacco, and other substance use, considering the needs of out-of-school youth. | Costed under RMNCAH-N SBC | 0 | 0 | 0 | 0 | 0 | 0 |
| Increase access and utilisation of comprehensive health services, including referrals to one-stop centres and providers of other social services | Strengthen service delivery through the provision of guidelines and service packages | Conduct a baseline survey to ascertain the number of facilities providing responsive adolescent health services according to national standards. | Costed under M&E | 0 | 0 | 0 | 0 | 0 | 0 |

| Strategy/ Intervention | Activity | Sub-activity | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | | Hold a two-day stakeholder meeting for 47 county adolescent health focal persons to aggregate their reports | Meeting of 50 participants (10 adolescent focal persons, 15 partners and 25 national staff) | 2,012,000 | 0 | 0 | 0 | 0 | **2,012,000** |
| | | Develop and disseminate a comprehensive service package, including QOC for adolescent health services | 5 workshops (4 development and 1 finalisation 30 pax for 5 days (assumptions same as for development, validation and county dissemination) | 34,350,000 | 60,899,328 | 0 | 0 | 0 | **95,249,328** |
| | | Develop and disseminate guidelines on the provision of adolescent-responsive healthcare services (safe, confidential, equitable, non-discriminatory) and assistive devices for those with disabilities. | Workshops of 235 participants (5 from each county), in 9 clusters and 10 national officers and 5 partners | 0 | 20,587,870 | 11,896,519 | 10,138,309 | 0 | **42,622,697** |

| Strategy/ Intervention | Activity | Sub-activity | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | | Develop and disseminate telemedicine guidelines for adolescent health in Kenya. | 5 workshops (4 development and 1 finalisation 30 pax for 5 days (assumptions same as for development, validation and county dissemination) | 0 | 0 | 9,831,829 | 37,419,257 | 0 | **47,251,086** |
| | | Develop and disseminate recommendations for adolescent health in learning institutions. | Conduct 3 workshops | 0 | 0 | 35,535,131 | 0 | 0 | **35,535,131** |
| | | Develop and deploy an adolescent health module in the Community Health package (e-CHIS). | Conduct workshops (3 development and 1 finalisation) of 30 pax for 5 days, and engage a consultant, (assumptions same as for development, validation and county dissemination) | 0 | 0 | 23,974,206 | 11,433,792 | 9,333,380 | **44,741,378** |

| Strategy/ Intervention | Activity | Sub-activity | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | | Development and implementation of guidelines on iron and folic acid supplementation package for adolescents | 5 workshops (4 development and 1 finalisation 30 pax for 5 days (assumptions same as for development, validation and county dissemination) | 0 | 19,179,750 | 21,240,734 | 0 | 0 | **40,420,484** |
| | Provide quality and comprehensive care for adolescents | Set up peer-led adolescent health hubs in schools and community spaces to provide SRHR education, counselling, and referrals. | No cost to RMNCAH-N | 0 | 0 | 0 | 0 | 0 | 0 |
| | | Develop anonymous digital platforms (mobile apps, SMS services, AI chatbots) for confidential SRHR information and reporting. | Cost for the Ministry of ICT | 0 | 0 | 0 | 0 | 0 | 0 |

| Strategy/ Intervention | Activity | Sub-activity | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | | Ensure youth-friendly health services at county and sub-county health facilities by training healthcare providers on adolescent care | 5-day training in 9 clusters of 235 HCWs (5 from each county) and 10 national staff as facilitators | 36,823,460 | 39,401,102 | 42,159,179 | 45,110,322 | 36,823,460 | **200,317,523** |
| | Facilitate meaningful adolescent involvement in interventions tailored to address their health needs and well-being | Develop and disseminate a framework that guides the participation of adolescents in interventions affecting their health | Conduct 5 (4 development and 1 day for finalisation) five-day workshops | 18,330,000 | 19,746,850 | 21,371,574 | 0 | 12,600,000 | **72,048,424** |
| | | Hold leadership forums for adolescents to engage on matters related to their health and well-being | Conduct leadership forums for adolescents to engage on matters related to their health and well-being at the county level | 18,342,760 | 19,626,753 | 21,000,626 | 22,470,670 | 18,342,760 | **99,783,569** |
| | Capacity build adolescents on life skills to prioritise their health. | Develop and disseminate self-care guidelines for adolescent health. | Hold four 5-day workshops | 0 | 16,932,750 | 2,365,363 | 23,054,427 | 0 | **42,352,541** |

| Strategy/ Intervention | Activity | Sub-activity | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | | Develop and disseminate an adolescent health-related life skills package to be integrated into the school curriculum and other Adolescent fora. | Hold four, 5 day workshops t | 37,366,780 | 23,213,950 | 22,473,563 | 24,046,712 | 19,629,280 | **126,730,284** |
| | | Conduct high-level engagements with national and county leaders to advocate for adolescent-centred programs related to health interventions | Conduct a one-2-day high-level meeting annually | 0 | 288,900 | 309,123 | 330,762 | 270,000 | **1,198,785** |
| | Improve access to quality health services and information among adolescents in humanitarian | Map out the humanitarian adolescent populations for adolescent health provision | Hold biannual meetings with stakeholders and conduct landscape analysis | 4,320,000 | 577,800 | 618,246 | 661,523 | 540,000 | **6,717,569** |
| | | Analyse key stakeholders providing services to marginalised | Hold biannual meetings with stakeholders | 9,743,650 | 10,606,268 | 3,293,477 | 5,378,625 | 3,467,800 | **32,489,819** |

| Strategy/ Intervention | Activity | Sub-activity | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | and fragile settings. | and vulnerable adolescent populations. | | | | | | | |
| | | Develop and disseminate a guideline on the provision of health services among adolescents in humanitarian and fragile settings, including defining how to report adolescent health indicators in humanitarian response structures | 5 workshops | 42,802,760 | 63,149,003 | 0 | 0 | 0 | **105,951,763** |
| | | Develop a natural and human-made emergency preparedness plan for adolescents in humanitarian and fragile settings | Hold 5 workshops, engage a consultant and disseminate | 0 | 41,646,818 | 24,535,779 | 0 | 17,491,760 | **83,674,358** |
| | | Train HCWs on the protocol for service | Train 5 TOTs in each of the 47 counties | 0 | 39,401,102 | 0 | 0 | 0 | **39,401,102** |

| Strategy/ Intervention | Activity | Sub-activity | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | | provision to adolescents in humanitarian and fragile settings. | | | | | | | |
| Promote initiatives that address social risks and deterrence of harmful socio-cultural practices among adolescents | Create initiatives that address harmful and risky socio-cultural practices among adolescents | Develop and disseminate standardized guidelines for the management of health issues arising from harmful cultural practices ( alternative rites of passage) | 5 workshops to develop standardized guidelines | 16,575,000 | 18,888,325 | 0 | 0 | 0 | **35,463,325** |
| | | Develop and disseminate behaviour change communication package on reducing harmful social-cultural practices among adolescents and the community | 5 workshops | 7,699,820 | 28,384,767 | 8,815,524 | 9,432,611 | 0 | **54,332,722** |
| | | Establish adolescent peer networks to support peer learning and experience | Conduct three 3-day workshops to sensitise county adolescent focal persons on the establishment of | 0 | 2,038,350 | 2,181,035 | 0 | 0 | **4,219,385** |

| Strategy/ Intervention | Activity | Sub-activity | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | | sharing against harmful social and cultural practices | adolescent peer networks | | | | | | |
| | Strengthen community-based initiatives challenging social norms and attitudes that perpetuate health-related harmful practices. | Build the capacity of adolescent peer networks to support peer learning and experience sharing against harmful social and cultural practices | Train 94 adolescent peer networks | 0 | 13,530,150 | 0 | 15,490,669 | 0 | **29,020,819** |
| | | Conduct hybrid social events for adolescents to sensitise them on health-related harmful practices. | Conduct one annual social event per county to sensitise adolescents on health-related harmful practices | 20,000,000 | 21,400,000 | 22,898,000 | 24,500,860 | 20,000,000 | **108,798,860** |
| | | Sensitise the counties on health-related harmful practices. | Hold one- 3-day sensitisation meetings for CAHCO on health-related harmful practices. | 0 | 4,029,620 | 0 | 0 | 0 | **4,029,620** |

| Strategy/ Intervention | Activity | Sub-activity | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | | Develop and disseminate IEC materials targeting parents/caregivers, adolescents and community leaders on harmful social-cultural practices | 5 workshops to develop standardised guidelines for the management of health issues arising from harmful cultural practices ( alternative rites of passage) | 0 | 0 | 0 | 0 | 0 | 0 |
| | | Conduct sensitisation meetings on reducing harmful social-cultural practices to HCWs, CHPs, opinion leaders and teachers | Hold one, 3-day sensitisation meeting per county to sensitise on reducing harmful social, cultural practices to HCWs, CHPs, opinion leaders and teachers | 0 | 4,029,620 | 4,311,693 | 4,613,512 | 3,766,000 | **16,720,825** |
| **Grand Total** | | | | **307,156,650** | **826,459,540** | **433,416,378** | **379,099,626** | **315,363,740** | **2,261,495,934** |

**Nutrition**

Table B5: Estimated costs of activities for nutrition interventions

| Strategy/Intervention | Activity | Sub-activity | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| Strengthen policy, legal and regulatory environment | Bolster policy environment | Develop/review maternal nutrition-related guidelines in line with the international standards, conventions and global commitments, including maternal mental health, adolescent girls and disabled pregnant and breastfeeding mothers. (MMS, SOPs, training manual) | Develop MMS guideline and SOPs package | 15,455,000 | 0 | 0 | 0 | 0 | **15,455,000** |
| | | Review BMS Act, 2012 to contextualise and update in line with the new WHO recommendations | Planning and dissemination meetings | 5,822,500 | 5,972,500 | 0 | 0 | 0 | **11,795,000** |
| | | Advocate for the enactment | No cost | 0 | 0 | 0 | 0 | 0 | 0 |

| Strategy/Intervention | Activity | Sub-activity | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | | of the Breastfeeding Mothers Bill. | | | | | | | |
| | | Review the workplace support implementation framework and guidelines | Planning and dissemination meetings | 0 | 4,900,000 | 0 | 0 | 0 | **4,900,000** |
| | | Review BFCI Implementation package | 4 development workshops and disseminations | 2,540,000 | 0 | 0 | 0 | 0 | **2,540,000** |
| | | Develop BFHI Implementation package, including mentorship (guideline, training package, pocket guide) | 4 development workshops and disseminations | 4,690,000 | 4,690,000 | 0 | 0 | 0 | **9,380,000** |
| | | Review Human Milk Bank Implementation Framework | 4 development workshops and disseminations | 0 | 4,690,000 | 0 | 0 | 0 | **4,690,000** |
| | | Develop MIYCN-E operational guidance and training package | 3 development workshops and disseminations | 3,560,000 | 3,560,000 | 0 | 0 | 0 | **7,120,000** |
| | | Review the National Guidelines for | 20 Planning meetings | 300,000 | 9,595,000 | 14,441,400 | 300,000 | 300,000 | **24,936,400** |

| Strategy/Intervention | Activity | Sub-activity | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | | Healthy Diets and Physical Activity | | | | | | | |
| | | Develop the Food-Based Dietary Guidelines for Kenya | 20 Planning meetings, hiring a consultant and stakeholder workshops | 0 | 17,860,000 | 4,826,400 | 0 | 0 | **22,686,400** |
| | | Develop policy frameworks for fiscal policies for healthy diets | 20 Planning meetings, hiring a consultant and stakeholder workshops | 0 | 9,495,000 | 8,695,000 | 0 | 0 | **18,190,000** |
| | | Develop food procurement guidelines for healthy diets in public institutions | 20 Planning meetings, hiring a consultant and stakeholder workshops | 0 | 18,190,000 | 25,936,400 | 0 | 0 | **44,126,400** |
| | | Develop guidelines on healthy eating for food outlets and eateries | 20 Planning meetings, hiring a consultant and stakeholder workshops | 0 | 0 | 9,845,000 | 16,091,400 | 0 | **25,936,400** |
| | | Develop a transfats regulation | 20 Planning meetings, hiring a consultant and stakeholder workshops | 0 | 7,826,000 | 5,619,500 | 4,744,500 | 0 | **18,190,000** |
| | | Develop a sodium reduction. framework | 20 Planning meetings, hiring a consultant and stakeholder workshops | 0 | 0 | 8,176,000 | 10,553,400 | 5,007,000 | **23,736,400** |

| Strategy/Intervention | Activity | Sub-activity | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| Increase access and utilisation of comprehensive nutrition services | Improve capacity for maternal, infant and young child nutrition initiatives. | Develop and disseminate SOPs for nutrition service delivery | Planning meetings, writing workshop and dissemination. | 25,597,300 | 16,936,000 | 26,943,300 | 0 | 0 | **69,476,600** |
| | | Train TOTs on MIYCN initiatives (BFCI/cBFCI, BFHI, BMS Act, MIYCN, MIYCN-E, Vitamin A + D,MNPs, IFAS and MMS | Train 250 TOTs on BFHI, 90 TOTs on BFCI, 188 TOTs on BMS, 188 TOTs on MIYCN -E and 188 TOTs on MMS | 42,976,640 | 36,763,480 | 18,639,480 | 18,639,480 | 18,639,480 | **135,658,560** |
| | | Train health care workers on MIYCN initiatives (cBFCI/BFCI, BMS Act, BFHI, MIYCN, MIYCN-E, Vitamin A + D, MNPs, IFAS and MMS | Train 60 HCWs on each initiative | 27,309,600 | 27,309,600 | 27,309,600 | 27,309,600 | 27,309,600 | **136,548,000** |
| | | Conduct MIYCN Capacity assessment using available | Conduct external assessment for BFCI | 3,990,000 | 3,045,000 | 3,990,000 | 3,990,000 | 3,045,000 | **18,060,000** |

| Strategy/Intervention | Activity | Sub-activity | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | | MIYCN assessment tools for BFCI/BFHI | | | | | | | |
| | | Provision of MIYCN TA to counties, including Mentorship, OJT, support supervision, and assessment for MIYCN initiatives | Conduct MIYCN mentorship, OJT and supportive supervision | 0 | 0 | 0 | 0 | 0 | **0** |
| | Build capacity among key stakeholders in healthy diets and physical activity | Conduct capacity analysis for the implementation of healthy diets and physical activity | 10 Planning meetings | 7,970,000 | 0 | 0 | 0 | 0 | **7,970,000** |
| | | Develop a training and sensitisation package for healthy diets and physical activity | 10 Planning meetings, hiring a consultant and 2 stakeholder workshops | 11,388,000 | 7,095,000 | 0 | 0 | 0 | **18,483,000** |
| | | Develop a training and sensitisation package on the | Planning sessions | 4,044,100 | 3,924,100 | 0 | 0 | 0 | **7,968,200** |

| Strategy/Intervention | Activity | Sub-activity | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | | enforcement of food environment policies | | | | | | | |
| | | Conduct sensitisation sessions for healthy diets and physical activity | Sensitisation of managers on the guidelines in 6 clusters | 0 | 14,292,690 | 18,145,190 | 16,496,720 | 0 | **48,934,600** |
| | | Development of SBCC activities for healthy diets and physical activity within the RMNCAH-N SBCC strategy. | 20 Planning meetings | 13,975,500 | 13,975,500 | 0 | 0 | 11,523,400 | **39,474,400** |
| | | Sensitisation of stakeholders on healthy foods, physical activities, and marketing of unhealthy foods. | Stakeholder sensitisation forums | 5,586,768 | 5,586,768 | 5,586,768 | 5,586,768 | 5,586,768 | **27,933,840** |
| | Deliver quality nutrition services. | Promote maternal nutrition assessment, education and counselling on | Conduct TA/Mentorship | 902,000 | 902,000 | 902,000 | 902,000 | 902,000 | **4,510,000** |

| Strategy/Intervention | Activity | Sub-activity | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | | dietary diversity, healthy eating and meal frequency among PLWs. | | | | | | | |
| | | Promote supplementation of IFAS and/or MMS and deworming among pregnant women | Conduct TA/Mentorship | 28,952,000 | 28,952,000 | 28,952,000 | 28,952,000 | 28,952,000 | **144,760,000** |
| | | Design intervention targeting mothers in vulnerable circumstances (Adolescent pregnant and breastfeeding girls, disabled pregnant women) | 3 meetings with 30 pax | 675,000 | 0 | 675,000 | 0 | 0 | **1,350,000** |
| | | Support for Community-Led Nutrition Initiatives | Sensitization meetings | 0 | 2,832,000 | 0 | 2,832,000 | 0 | **5,664,000** |
| | | Provide technical support to counties to conduct | Training sessions | 0 | 36,012,000 | 0 | 36,012,000 | 0 | **72,024,000** |

| Strategy/Intervention | Activity | Sub-activity | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | | community outreach and education | | | | | | | |
| | Promote growth monitoring, nutrition education and counselling for infants and young children on optimal breastfeeding and complementary feeding | Technical Assistance and mentorship to counties | Conduct TA/Mentorship | 904,000 | 904,000 | 904,000 | 904,000 | 904,000 | **4,520,000** |
| | | Procure Vitamin A supplements for children 6 to 59 months of age | Procure Vitamin A supplements for children 6 to 59 months of age | 174,189,000 | 315,629,500 | 296,612,300 | 217,281,500 | 154,932,500 | **1,158,644,800** |
| Strengthen the nutrition environment in education and health sectors. | Integrate nutrition interventions within the education sector | Development of policies, strategies and guidelines (Tuckshop guidelines, Teacher reference manual, School menu guides, School health policy) | Finalisation writing workshop | 0 | 5,586,768 | 39,094,672 | 38,664,672 | 0 | **83,346,112** |
| | | Develop School-based Nutrition package (School meals menu guide, Reference | Stakeholder meetings | 3,203,400 | 3,203,400 | 3,203,400 | 3,203,400 | 3,203,400 | **16,017,000** |

| Strategy/Intervention | Activity | Sub-activity | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | | manual on Food and Nutrition for teachers, School Gardening Guideline, School Health and Nutrition service delivery package) | | | | | | | |
| | | Promote Weekly Iron and folic acid supplementation (WIFAS) for adolescent girls | Development of a WIFAS Framework | 18,399,300 | 18,399,300 | 18,399,300 | 23,484,200 | 29,030,600 | **107,712,700** |
| | | Advocate with stakeholders for Local sourcing of food commodities for school meals among national and county stakeholders | 20 Planning meetings, hiring a consultant and stakeholder workshops | 4,641,800 | 4,641,800 | 0 | 0 | 0 | **9,283,600** |
| | Mainstreaming nutrition interventions across the private health sector. | Advocate for the mainstreaming of nutrition interventions across | One day meeting with 30 pax and facilitators | 0 | 3,500,000 | 0 | 0 | 0 | **3,500,000** |

| Strategy/Intervention | Activity | Sub-activity | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | | RHUPA, CHAK and KCCB health facilities | | | | | | | |
| | | Train RHUPA, CHAK and KCCB leaders on nutrition mainstreaming. | Hold 3 days workshop | 0 | 19,241,000 | 0 | 0 | 0 | **19,241,000** |
| | | Annual forums to appraise nutrition mainstreaming across RHUPA, CHAK and KCCB health facilities | Hold 1-day annual forums | 3,500,000 | 3,500,000 | 3,500,000 | 3,500,000 | 3,500,000 | **17,500,000** |
| | | Strengthen nutrition partnerships with the private sector | Hold two meetings | 10,900,000 | 0 | 10,900,000 | 0 | 10,900,000 | **32,700,000** |
| To Strengthen the Integrated Supply Chain Management System for Nutrition Health Products and Technologies (HPTs). | Strengthen capacity on Nutrition Health products and Technologies (HPTs) | Conduct training and mentorship on Nutrition Health Products and Technologies (HPTs) management. | Training workshops and mentorship sessions | 233,120,000 | 233,120,000 | 233,120,000 | 233,120,000 | 233,120,000 | **1,165,600,000** |

| Strategy/Intervention | Activity | Sub-activity | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| **Grand Total** | | | | **654,591,908** | **892,130,406** | **814,416,710** | **692,567,640** | **536,855,748** | **3,590,562,412** |

### Gender-Based Violence

Table B6: Estimated costs of activities for GBV

| Strategy/Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| Promote and strengthen GBV prevention through policy development, community engagement, and awareness campaigns | Develop and disseminate GBV management SOPs, Psychosocial support and GBV prevention management guidelines, Healthcare providers Court guide, SEAH (sexual exploitation and harassment policy, and workplace GBV policies | Develop, disseminate, and implement a GBV health sector policy, SEAH policy, and workplace GBV policy. | 5 development workshops with 30 pax for 5 days, requiring transport, conference and DSA | 9,576,000 | 43,417,133 | 0 | 0 | 0 | 52,993,133 |
| | | Review and update community GBV packages and SBC materials to ensure inclusivity (e.g., braille, sign language, voiceovers) | 3 development workshops with 30 participants for 5 days | 12,371,000 | 0 | 0 | 0 | 0 | 12,371,000 |
| | | Develop targeted GBV prevention messages for children and other vulnerable groups. | 3 development workshops with 30 pax for 5 days | 0 | 11,090,550 | 0 | 0 | 0 | 11,090,550 |

| Strategy/Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | | Conduct nationwide campaigns to raise awareness about GBV and engage champions to advocate for its elimination | Under RMNCAH-N SBCC | 0 | 0 | 0 | 0 | 0 | 0 |
| | | Build the capacity of Community Health Promoters (CHPs). CHAs and Community Own Resource persons (CORPs) on GBV prevention | 47 counties with 40 persons per month (35 participants and 5 facilitators) | 248,160,000 | 265,531,200 | 284,118,384 | 304,006,671 | 248,160,000 | 1,349,976,255 |
| | | Conduct male engagement forums and community dialogues | One meeting of 50 community participants per sub-county, quarterly, refreshments provided and facilitator's fee | 20,221,600 | 21,637,112 | 23,151,710 | 24,772,330 | 20,221,600 | 110,004,351 |

| Strategy/Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| Ensure comprehensive, survivor-centred, and timely response services for GBV survivors | Build the capacity of healthcare workers on clinical management of GBV survivors, forensic sample collection, psychosocial support, and court etiquette | Conduct training of county TOTs health workers in 10 regions, once every two years | TOT- regional training of 5 days for 8 participants from each county by a national team of 6 Trainers | 49,262,960 | 0 | 56,401,163 | 0 | 49,262,960 | 154,927,083 |
| | | Conduct training of HCW in counties | 5-day training workshop conducted within a county by TOTs, 40 participants, including facilitator TOTs | 215,260,000 | 230,328,200 | 246,451,174 | 263,702,756 | 215,260,000 | 1,171,002,130 |
| | Advocate for the inclusion of GBV supplies in essential commodities and ring-fenced funding for GBV at the county level. | Advocate for the inclusion of GBV supplies in essential commodities and ring-fenced funding for GBV at the county level | No cost | 0 | 0 | 0 | 0 | 0 | 0 |
| | | Hold stakeholder collaboration meetings with training institutions for the inclusion | Meetings with representatives from institutions, 30 participants for one day meeting | 0 | 1,605,000 | 1,717,350 | 0 | 0 | 3,322,350 |

| Strategy/Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | | of GBV in basic curricula | | | | | | | |
| | Strengthen child-friendly GBV services by providing technical support and monitoring the quality of service | Hold annual meetings in counties, attended by 5 staff from the national level | Meeting of 3 days of 40 participants, including 5 national staff | 34,968,100 | 37,415,867 | 40,034,978 | 42,837,426 | 34,968,100 | 190,224,471 |
| | Improve psychosocial support by training health providers and advocating for the employment of more psychologists. | Conduct training in the regions for the TOTs on psychosocial support | TOT- regional training 8*5*47 counties, DSA county 14000 transport 3,000, conference 2500. Training for 5 days. national team 10,500*3*6 regional *6days, Driver | 48,418,760 | 0 | 55,434,638 | 0 | 48,418,760 | 152,272,158 |
| | | Conduct training in the regions for the HCW on psychosocial support | 5-day training workshop conducted within a county by TOTs, 40 participants, including | 215,260,000 | 230,328,200 | 246,451,174 | 263,702,756 | 215,260,000 | 1,171,002,130 |

| Strategy/Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | | | facilitator TOTs | | | | | | |
| | Promote self-care among GBV service providers by disseminating self-care handbook and building their capacity on self-care practices | Develop the handbook and distribute | 3 workshops of 30 persons for 5 days for development out of the city, two validation meetings. Print 500 copies every year and distribute | 11,135,000 | 342,400 | 366,368 | 392,014 | 320,000 | 12,555,782 |
| | Strengthen the provision of comprehensive, survivor-centred, and timely response services for GBV survivors | Provide comprehensive, survivor-centred, and timely response services for GBV survivors | Under service delivery costs | 2,815,926,687 | 4,390,702,033 | 5,975,296,728 | 7,570,594,744 | 9,176,971,529 | 29,929,491,720 |
| | Incorporate care for mental health, including basic psychosocial support, strengthening positive coping methods and | Provide related services | Under service delivery costs | 225,824,856 | 376,374,760 | 526,924,665 | 677,474,569 | 828,024,473 | 2,634,623,323 |

| Strategy/Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | treatment for moderate-severe depressive disorder, including post-traumatic stress disorders. | | | | | | | | |
| Bolster gender-responsive interventions under the GER | Undertake advocacy and policy dialogues focused on GER challenges. | Conduct advocacy activities | Under SBC | 0 | 0 | 0 | 0 | 0 | 0 |
| | Build the capacity of RMNCAH program managers and health providers on GER integration | Conduct training | 5-day training (35 participants and 5 trainers) | 70,705,600 | 75,654,992 | 0 | 0 | 0 | 146,360,592 |
| | Conduct targeted intersectional analyses (gender, equity, barrier, and vulnerability assessments) to guide | Undertake the analysis and produce a report for use | Hold 2 technical workshops to review results and report, 30 participants per workshop and a consultant for 60 days | 0 | 8,731,200 | 0 | 9,996,351 | 0 | 18,727,551 |

| Strategy/Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | strategic planning. | | | | | | | | |
| | Ensure diversity of women, girls, children, adolescents, and older people when defining strategic objectives and target audiences. | Undertake gender balanced engagements in policy processes | No additional cost | 0 | 0 | 0 | 0 | 0 | 0 |
| | Expand RMNCAH-N services in public health and humanitarian emergencies to all at-risk groups. | Expand RMNCAH-N services in public health and humanitarian emergencies to all at-risk groups. | No additional cost | 0 | 0 | 0 | 0 | 0 | 0 |
| | Establishing a balanced mix of process, outcome, and impact indicators stratified by age, sex, socio-economic status, migration status, etc., | Build the capacity of M&E officers at the county level on GER indicators | 5-day training, two trainings per quarter (35 participants and 5 trainers) | 0 | 4,579,600 | 0 | 0 | 0 | 4,579,600 |
| | | Build the capacity of M&E at the national level on GER indicators | 3-day training, two trainings | 0 | 2,707,100 | 0 | 0 | 0 | 2,707,100 |

| Strategy/Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | including qualitative measures of attitudes, perceptions, and enabling environments | | | | | | | | |
| | Embed with equal representation of men, women, and other vulnerable groups. | Ensure equal representation of men, women, and other vulnerable groups in community-led monitoring structures | Routine | 0 | 0 | 0 | 0 | 0 | 0 |
| Strengthen national and county-level coordination mechanisms for effective GBV program implementation. | Support national GBV health sector Technical Working Group (TWG) meetings and participate in national gender sector working groups. | Hold national GBV health sector Technical Working Group (TWG) meetings and participate in national gender sector working groups. | 2 participants from every county for national meetings - annual, and 30 from the national level | 9,490,000 | 10,154,300 | 10,865,101 | 11,625,658 | 9,490,000 | 51,625,059 |
| | | Hold quarterly TWG meetings at the counties to track progress on the delivery of responsive | | 36,660,000 | 39,226,200 | 41,972,034 | 44,910,076 | 36,660,000 | 199,428,310 |

| Strategy/Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | | gender-based violence services at the county level | | | | | | | |
| | Advocate for counties to establish quarterly GBV prevention and response TWGs and appoint GBV focal persons at the facility, sub-county, and county levels. | Conduct advocacy | Under the advocacy section | 0 | 0 | 0 | 0 | 0 | 0 |
| | Promote GBV quality assurance by sensitising providers, building capacity on the digitised GBV QA tool, and monitoring service delivery | Mentoring of HCW | Routine- no cost | 0 | 0 | 0 | 0 | 0 | 0 |
| | Establish and coordinate intercounty learning exchange forums for | Undertake coordination | Under M&E | 0 | 0 | 0 | 0 | 0 | 0 |

| Strategy/Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | continuous improvement among key stakeholders. | | | | | | | | |
| | Advocate for healthcare providers to participate in court users committee | Undertake advocacy through various forums | No cost | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total** | | | | **4,023,240,563** | **5,749,825,848** | **7,509,185,466** | **9,214,015,350** | **10,883,017,422** | **37,379,284,649** |

## Climate Change

Table B8: Estimated costs of activities for climate change

| Strategy/ Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| Integrate Climate Change into RNMCAH-N policies and budgets | Build national and county-level capacity on climate change and RMNCAH-N | Hold meetings to review and validate materials developed by a consultant | 2 one-day technical meetings at the national level and 1 meeting outside the city for 3 days | 6,210,000 | 0 | 0 | 0 | 0 | 6,210,000 |

| Strategy/ Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | | Hold a meeting to update the training materials | 5-day meeting | 0 | 0 | 0 | 4,532,659 | 0 | 4,532,659 |
| | | Conduct training of national TOTs on climate change and RMNCAH-N | 5-day training out of city | 3,755,000 | 0 | 4,299,100 | 0 | 4,922,039 | 12,976,139 |
| | | Conduct training of county TOTs on climate change and RMNCAH-N | | 53,450,760 | 0 | 0 | 65,479,479 | 0 | 118,930,239 |
| | | Conduct training of county healthcare workers on climate change and RMNCAH-N | 5-day training facilitated by county TOTs | 193,640,000 | 207,194,800 | 221,698,436 | 237,217,327 | 253,822,539 | 1,113,573,102 |
| | | Include climate change activities in the counties' RMNCAH-N workplans. | No cost | 0 | 0 | 0 | 0 | 0 | 0 |
| | Mobilise funds for RMNCAH-N | Allocate domestic funds for climate | No cost | 0 | 0 | 0 | 0 | 0 | 0 |

| Strategy/ Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | projects for climate funds | change activities. | | | | | | | |
| | | Develop funding proposals and projects for climate funds. | 5-day meeting out of the city to develop proposals annually | 5,190,000 | 5,553,300 | 5,942,031 | 6,357,973 | 6,803,031 | 29,846,335 |
| | Provide technical support to counties and monitor the implementation of climate change interventions | Undertake support at the county level by the national-level staff | 5 National level staff travel to counties to provide TA, 3 days per county, quarterly | 0 | 29,972,840 | 32,070,939 | 34,315,905 | 36,718,018 | 133,077,702 |
| | Ensure health, gender, education and youth ministries are involved in project proposals to climate funds | Include them in the meetings | No cost attached | 0 | 0 | 0 | 0 | 0 | 0 |
| | Scale up public-private partnerships to increase policies and investments for climate change interventions | Hold annual meeting | Annual one-day meeting of 40 participants at the national level | 340,000 | 363,800 | 389,266 | 416,515 | 445,671 | 1,955,252 |

| Strategy/ Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | for RMNCAH-N. | | | | | | | | |
| Bolster the visibility of climate change and RMNCAH-N | Engage women, children, and adolescents in climate change and health issues | Undertake BCC activities | Under RMNCAH-N SBC | 0 | 0 | 0 | 0 | 0 | 0 |
| | Strengthen community awareness of the impacts of climate change | Hold male engagement forums and community dialogues | One per sub-county quarterly | 50,993,600 | 54,563,152 | 58,382,573 | 62,469,353 | 66,842,207 | 293,250,885 |
| | Increase awareness of the impacts of climate change among policymakers | Hold annual awareness meetings with policymakers at the national level | Meeting of 20 participants | 231,663 | 247,879 | 265,231 | 283,797 | 303,663 | 1,332,233 |
| | | Hold annual awareness meetings with policymakers at the county level | | 8,695,000 | 9,303,650 | 9,954,906 | 10,651,749 | 11,397,371 | 50,002,676 |

| Strategy/ Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| Evaluate climate change and RMNCAH-N interventions | Support piloting and evaluating health and climate co-financing initiatives. | Conduct technical meetings at the national level | | 0 | 0 | 4,465,108 | 0 | 5,112,104 | 9,577,212 |
| | Advance research on the intersectional impacts of climate change on women, children, and adolescents | Hold technical review meetings at the national level | Technical meetings at the national level | 0 | 625,950 | 0 | 0 | 766,816 | 1,392,766 |
| | | Undertake survey | | 0 | 10,700,000 | 0 | 0 | 13,107,960 | 23,807,960 |
| **Total** | | | | **322,506,023** | **318,525,371** | **337,467,590** | **421,724,757** | **400,241,419** | **1,800,465,160** |

## Emerging Technologies

Table B9: Estimated costs of activities for climate change

| Strategy/ Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| Strengthen RMNCAH-N service delivery through the use of emerging technology | Build the capacity of healthcare workers in emerging technologies for RMNCAH-N services | Hold meetings to review and validate materials developed by a consultant | 2 one-day technical meetings, national, and 1 meeting out of the city for 3 days, each with 20 participants | 6,210,000 | 0 | 0 | 0 | 0 | 6,210,000 |

| Strategy/ Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | | Hold a meeting to update the training materials | 5-day meeting | 0 | 0 | 0 | 4,532,659 | 0 | 4,532,659 |
| | | Conduct training of national TOTs on emerging technologies | 5-day training out of the city | 3,755,000 | 0 | 4,299,100 | 0 | 4,922,039 | 12,976,139 |
| | | Conduct training of county TOTs on emerging technologies | TOT- regional training of 5 days for 8 participants from each county by a national team of 6 Trainers | 53,450,760 | 0 | 0 | 65,479,479 | 0 | 118,930,239 |
| | | Training of HCWs in counties | 5-day training facilitated by county TOTs | 193,640,000 | 207,194,800 | 221,698,436 | 237,217,327 | 253,822,539 | 1,113,573,102 |
| | Promote public-private partnerships for technology adoption | Conduct annual meetings of | One-day meeting of 40 participants | 180,000 | 192,600 | 206,082 | 220,508 | 235,943 | 1,035,133 |
| | Monitor and evaluate the impact of technologies on RNMCAH outcomes. | Hold one technical meeting at the national level with 30 participants | One day meeting of 30 participants | 0 | 625,950 | 0 | 0 | 766,816 | 1,392,766 |
| | Monitor and evaluate the impact of technologies | Undertake survey | Survey at KSh 10 million | 0 | 10,700,000 | 0 | 0 | 13,107,960 | 23,807,960 |

| Strategy/ Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/28 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | on RNMCAH outcomes. | | | | | | | | |
| | Promote the use of technologies | Fund technologies for use in RMNCAH-N | Estimated at 5% of service costs | 3,811,782,242 | 4,009,235,719 | 4,270,684,182 | 4,643,384,959 | 4,958,444,583 | 21,693,531,685 |
| **Total** | | | | **4,069,018,002** | **4,227,949,069** | **4,496,887,800** | **4,950,834,932** | **5,231,299,880** | **22,975,989,682** |

## Advocacy, Communication and Social Behaviour Change

Table B10: Estimated costs of activities for advocacy and SBC

| Strategy/ Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/29 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| Increase awareness for RMNCAH-N through accurate information to the target audience for positive social behaviour change. | Develop SBC strategy | Develop, launch, and disseminate the RMNCAHN advocacy and social behaviour strategy and IEC materials for social behaviour change. | 5 development workshops with 30 participants for 5 days and dissemination to the counties | 0 | 59,354,398 | 0 | 0 | 0 | **59,354,398** |
| | | Launch and disseminate the AYPSRH SBC Strategy | Launch of the strategy, 150 participants requiring conference and printing, to be done in 47 counties, targeting 5 participants per county (per diem for national and county personnel, driver and fuel) | 0 | 43,503,418 | 0 | 0 | 0 | **43,503,418** |

| Strategy/ Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/29 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | A sustained, comprehensive, and targeted family planning social and behaviour change campaign implemented at scale | Conduct the annual national RMNCAHN *Tujulishane* Campaign through various channels: radio activations, TV shows, town hall discussions, call centres, print media, social media, influencers, and community engagements. | Conduct one radio advert per month, two media campaigns each year, one hour town hall via TV, and 40-second classified adverts. | 251,000,000 | 268,570,000 | 287,369,900 | 307,485,793 | 329,009,799 | **1,443,435,492** |
| | | Print launch and disseminate "Understanding Adolescents": Guide for Parents, Teachers and Caregivers 24/25 | Printing of 200,000 copies per year | 64,000,000 | 68,480,000 | 73,273,600 | 78,402,752 | 83,890,945 | **368,047,297** |
| | | Print and disseminate "Understanding Adolescents": Guide for Adolescents | Printing of 50,000 copies per year | 16,000,000 | 17,120,000 | 18,318,400 | 19,600,688 | 20,972,736 | **92,011,824** |

| Strategy/ Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/29 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | | Hold high-level advocacy forums (the executive, parliament, private sector, governors, county first ladies, KEWOPA) for leadership, commitment, buy-in and accountability for RMNCAHN. | 5 meetings per year of 20 participants, breakfast meetings, conference and transport | 450,000 | 481,500 | 515,205 | 551,269 | 589,858 | **2,587,833** |
| | | | | 400,000 | 428,000 | 457,960 | 490,017 | 524,318 | **2,300,296** |
| | | Develop, print and disseminate advocacy and media kits for RMNCAH-N. | Printing of brochures, posters, promotional stickers, and newspaper publications | 151,875,000 | 162,506,250 | 173,881,688 | 186,053,406 | 199,077,144 | **873,393,487** |
| Bolster advocacy for increased financing for RMNCAHN services at the national and county levels | Advocate for increased domestic financing | Conduct advocacy meetings with the parliamentary health and budgetary committee to safeguard funding allocation for RMNCAH-N | 2-day meeting outside town. 20 MPs | 1,800,000 | 1,926,000 | 2,060,820 | 2,205,077 | 2,359,433 | **10,351,330** |
| | | Conduct annual advocacy meetings with decision-makers at the National T | Breakfast meeting of 20 participants, conference and transport | 90,000 | 96,300 | 103,041 | 110,254 | 117,972 | **517,567** |
| | | Treasury and Economic Development | | 80,000 | 85,600 | 91,592 | 98,003 | 104,864 | **460,059** |

| Strategy/ Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/29 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | | Planning to ensure Government RMNCAHN, FP and Immunisation, both at national and county, co-financing commitments are fulfilled | | | | | | | |
| | | Conduct forums with the SHA Benefits Package Advisory Panel to advocate a comprehensive benefits package for RMNCHN under SHA, including, but not limited to, the addition of the ANC profile in the benefits package and management of complications post-delivery. | Breakfast meeting of 20 pax, conference and transport | 90,000 | 96,300 | 103,041 | 110,254 | 117,972 | **517,567** |
| | | | | 80,000 | 85,600 | 91,592 | 98,003 | 104,864 | **460,059** |
| | | Hold bi-annual meetings with insurance regulators to advocate for the integration of RMCAH N/FP in private insurance schemes. | Meeting of 20 participants, conference and transport | 340,000 | 363,800 | 389,266 | 416,515 | 445,671 | **1,955,251** |

| Strategy/ Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/29 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | | Hold meetings with the county FIF implementation task team to advocate for the allocation of a percentage of county FIF resources allocation towards RMNCAHN interventions. | 5 from national, 1 driver,1 day per county, fuel (280km per county), 20 per county, transport and conference. | 13,630,000 | 14,584,100 | 15,604,987 | 16,697,336 | 17,866,150 | **78,382,573** |
| | | Advocate for clear budget lines for RMNCAHN HPTs and not lumped up in health budgets. | Covered under advocacy for resource mobilization. | 0 | 0 | 0 | 0 | 0 | 0 |
| | | Advocate for adequate financing, timely disbursement and procurement of essential HPTs for RMNCAHN | Covered under advocacy for resource mobilization. | 0 | 0 | 0 | 0 | 0 | 0 |
| | | Advocate for adequate infrastructure (stores, storage equipment, cold chain) for effective HPT management | Covered under advocacy for resource mobilisation. | 0 | 0 | 0 | 0 | 0 | 0 |

| Strategy/ Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/29 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | | Track national RMNCAHN expenditures and advocate for timely disbursement of elimination of linkages and increased utilisation of available resources for specified RMNCAH-N interventions. | Consultant for 90 days,30 RAs for 30 days, 3 meetings each 1 day,2 meetings for 5 days for data cleaning and analysis, 1 meeting for 5 days for report writing. 30 participants | 0 | 0 | 26,825,007 | 0 | 30,711,951 | **57,536,958** |
| | Advocate for continued development partners' funding | Host an annual roundtable meeting with development partners of Health in Kenya to advocate for continued development partners' funding with clearly outlined gradual transition plans towards self-sufficiency. | Breakfast meeting, 30 participants, conference and transport | 195,000 | 208,650 | 223,256 | 238,883 | 255,605 | **1,121,394** |
| Enhance male involvement in RMNCAH-N | Generation and/or customisation and implementation of guidelines on male | Generate a Male Engagement in RMNCAH) Couple Counselling Guide for service providers | 2 meetings for 5 days, internal validation, printing (500 copies), 30 participants, outside town and internal | 0 | 7,104,800 | 0 | 0 | 0 | **7,104,800** |

| Strategy/ Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/29 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | involvement in RMNCAH-N | | validation of 30 participants | | | | | | |
| | | Generate and disseminate information on fathers' and men's contributions to healthy families through nurturing care, through all stages of the continuum of RMNCAH-N care | Covered within the media campaigns. | 0 | 0 | 0 | 0 | 0 | 0 |
| | | Conduct community and media dialogues for enhanced male involvement in RMNCAH-N | 40 participants per quarter per sub-county, venue and transport allowance of KSh 500, 314 sub-counties. | 150,720,000 | 161,270,400 | 172,559,328 | 184,638,481 | 197,563,175 | **866,751,384** |

| Strategy/ Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/29 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| Enhanced coordination and documentation of RMNCAH-N information | Strengthen documentation of RMNCAH-N information | Review and update the existing MOH Family Health /RMNCAH-N website and social media sites. | Internal cost | 0 | 0 | 0 | 0 | 0 | 0 |
| | | Document and compile country and county successes, best practices, and lessons | Internal cost | 0 | 0 | 0 | 0 | 0 | 0 |
| | | Develop and maintain the AYP interactive platform. | Internal cost | 0 | 0 | 0 | 0 | 0 | 0 |
| | Increase the visibility of RMNCAH-N | Conduct national forums to recognise, celebrate and mark key important RMNCAH-N days | 5 national events | 2,000,000 | 2,140,000 | 2,289,800 | 2,450,086 | 2,621,592 | **11,501,478** |
| | | Host an annual RMNCAHN | 3-day meeting, outside town, | | | | 14,221 | 14,353,216 | **62,970,592** |
| | | | | | | | 91,513 | 76,602,919 | **336,073,188** |

## APPENDIX D: Participants for RMNCAH-N Investment Case Development

| No. | Name | Job Title | Organization or Facility |
|---|---|---|---|
| 1 | Dr. Edward Serem | Head, Division of RMNCAH | MOH |
| 2 | Dr. Hellen Kiarie | Head M&E | MOH/M&E |
| 3 | Nancy M. Njeru | DDPS | MOH-DHPT |
| 4 | Dr. Juliet Omwoha | Head NCH | MOH/DRMNCAH |
| 5 | Peris Murethi | PM | MOH/DRMNCAH |

| Strategy/ Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/29 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | | Conduct disseminations for the RMNCAHN Investment Case 2023/4-2027/8 in all economic blocs, bringing together top health leadership in each county | 5 development workshops with 30 participants for 5 days and dissemination to the counties | 0 | 68,820,688 | 515,205 | 551,269 | 589,858 | **70,477,021** |
| | | Monitoring of the RMNCAH-N SBC activities at the national and county levels | Internal cost | 0 | 0 | 0 | 0 | 0 | 0 |
| | Disseminate RMNCAH-N IC | Present of the Final IC within RMNCAH N Division | Half a day Meeting of 30 participants | 135,000 | 0 | 0 | 0 | 0 | 0 |
| | | Present of Final IC with MOH Leadership | Half a day Meeting of 40 participants | 180,000 | 0 | 0 | 0 | 0 | 0 |
| | | Launch the RMNCAH IC (nationally and regionally) | Half a day Meeting of 60 participants | 975,000 | | | | | |
| | | Launch the RMNCAH IC (nationally and regionally) | Half a day Meeting of 50 participants nationally and 235 participants in regions | 18,971,760 | 0 | 0 | 0 | 0 | 0 |

| Strategy/ Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/29 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | | Sensitise CECs, COs and CDHs | Half a day Meeting of 60 participants | 6,315,000 | 0 | 0 | 0 | 0 | 0 |
| | | Present to NGOs | Half a day Meeting of 60 participants | 390,000 | 0 | 0 | 0 | 0 | 0 |
| | | Present to DPHK | Half a day Meeting of 60 participants | 270,000 | 0 | 0 | 0 | 0 | 0 |
| | | Dissemination with Health Committees (Parliament, COG, Country Assembly Health Committees) | Separate meetings with the various committees | 6,285,000 | 0 | 0 | 0 | 0 | 0 |
| Strengthen the capacity of RMNCAH-N personnel and media at the national and county levels on SBC | Enhance the capacities of RMNCAH-N Officers | Develop and implement the national RMNCAH-N SBC training manual. | 3 meetings for 5 days, out of town, up to internal validation, 30 participants | 0 | 10,368,300 | 0 | 0 | 0 | **10,368,300** |
| | | Capacity building of RMNCAH-N officers and call centre experts on SBC (Annual basis) | 5 per county for 5 days, per diem, 5 facilitators from national, driver and fuel in 10 regions. | 0 | 29,967,490 | 32,065,214 | 34,309,779 | 36,711,464 | **133,053,947** |

| Strategy/ Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/29 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | Increase community capacity for RMNCAH-N advocacy | Conduct training of RMNCAH_N advocacy champions, including CSOs and FBO influencers, on enhanced capacity for RMNCAH-N advocacy at the national and county levels. | National: 2-day meeting, out of town, 30 participants. County: within the county, 2-day meeting, per diem, conference and transport. | 75,000,000 | 80,250,000 | 85,867,500 | 91,878,225 | 98,309,701 | **431,305,426** |
| | | Develop and implement a peer educator manual for young people on RMNCAHN | 3 meetings for 5 days, out of town, up to internal validation, 30 participants | 0 | 10,304,100 | 0 | 0 | 0 | **10,304,100** |
| | | Media sensitisation for health auditors and journalists on RMNCAHN | Two classes, each of 35 participants plus 5 facilitators per class, 25 participants per class, with a class of 3 facilitators | 67,080,000 | 71,775,600 | 76,799,892 | 82,175,884 | 87,928,196 | **385,759,573** |
| | | Procure laptops and Video cameras for communication for RMNCAH-N | 5 laptops, 2 video cameras | 0 | 1,712,000 | 0 | 0 | 0 | **1,712,000** |

| Strategy/ Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/29 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| Integration of the RMNCAH-N needs of vulnerable populations. | Bolster advocacy efforts for service integration | Advocate for improved access to RMNCAHN services for persons living with disabilities, such as ramp infrastructure and the availability of service providers with knowledge of sign language. | 2 meetings, 30 participants in each, for 1 day | 14,100,000 | 15,087,000 | 16,143,090 | 17,273,106 | 18,482,224 | **81,085,420** |
| | | Advocate for national recognition and resolution of RMNCAHN challenges faced by vulnerable mothers, newborns, children, and adolescents in refugee camps | 1 national meeting of 30 participants | 255,000 | 272,850 | 291,950 | 312,386 | 334,253 | **1,466,438** |
| Grand Total | | | | **912,096,760** | **1,171,210,444** | **1,065,285,944** | **1,111,153,202** | **1,219,645,877** | **5,445,870,467** |

## Monitoring and Evaluation

Table B11: Estimated costs of activities for M&E

| Strategy/Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/29 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| Strengthen Monitoring & Evaluation for RMNCAH-N | Improve the quality and capacity of routine data collection and reporting systems | Develop RMNCAH M&E Strategy and an M&E Action Plan | 5 development workshops with 30 pax for 5 days and dissemination to counties | 61,714,003 | 0 | 0 | 0 | 0 | 61,714,003 |
| | | Develop RMNCAH Annual Work Plans (AWP) | Hold 5-day workshop for 50 pax at the national level, hold 5 5-day workshops for 35 participants in each of 47 counties | 168,900,228 | 180,723,244 | 193,373,871 | 204,810,152 | 204,810,152 | **952,617,646** |
| | | Generate and disseminate Annual RMNCAH-N Implementation Report (APIR) | hold two meetings for 5 days per meeting | 7,350,258 | 7,864,776 | 8,415,310 | 8,912,998 | 8,912,998 | **41,456,341** |
| | | Capacity build health care workers on the use of digitised reporting (online tools) | QA-5 days, MPDSR-5 days, KHIS-5 days, HPT-5 days, scorecard-5 days, both national | 180,808,333 | 193,464,916 | 207,007,460 | 219,250,043 | 219,250,043 | **1,019,780,794** |

| Strategy/Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/29 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | | | (50pax) and county level (300 pax) | | | | | | |
| | | Revise RMNCAH-N data collection and reporting tools | 5 development workshops with 30 pax for 5 days and dissemination to counties | 7,442,995 | 7,964,005 | 8,521,485 | 9,025,452 | 9,025,452 | **41,979,389** |
| | | Sensitise and capacity-build health workers on revised tools | 5 days for national and county meetings. 300 pax county and 50 pax for national | 36,161,667 | 38,692,983 | 41,401,492 | 43,850,009 | 43,850,009 | **203,956,159** |
| | | Conduct training on the revised scorecard for accountability and tracking program performance meetings | 5 days for national and county meetings. 300 pax county and 50 pax for national | 36,161,667 | 38,692,983 | 41,401,492 | 43,850,009 | 43,850,009 | **203,956,159** |
| | | Conduct RMNCAH-N scorecard dissemination meetings in all counties | 10 regional meetings for 3 days each (with 5pax from each county) | 16,543,805 | 17,701,871 | 18,941,002 | 20,061,188 | 20,061,188 | **93,309,055** |
| | | Print and distribute the revised data | printing of 2500 reporting tools | 1,431,125 | 1,531,304 | 1,638,495 | 1,735,397 | 1,735,397 | **8,071,718** |

| Strategy/Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/29 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | | collection and reporting tools | | | | | | | |
| | | Provide resource materials for monitoring and evaluation | 10 laptops for RMNCAH M&E officers, 2 printers and stationaries | 2,461,535 | 2,633,842 | 2,818,211 | 2,984,883 | 2,984,883 | **13,883,354** |
| | Enhance Data Quality Assurance mechanisms | Conduct quality assessments (QAs) to improve service delivery | Quarterly QAs at selected facilities by the national team in 47 counties. 5-day activity with 4 participants in one county, County-level QAs by county teams at their sub-counties | 134,081,529 | 143,467,236 | 153,509,942 | 162,588,640 | 162,588,640 | **756,235,987** |
| | | Develop Data Quality Audit (DQA) guidelines | 5 development workshops with 30 pax for 5 days and dissemination to counties | 0 | 0 | 0 | 0 | 0 | 0 |
| | | Conduct quarterly data quality audits (DQAs) to improve routine data | Quarterly QAs at selected facilities by the national team in 47 | 134,081,529 | 143,467,236 | 153,509,942 | 162,588,640 | 162,588,640 | **756,235,987** |

| Strategy/Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/29 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | | | counties. 5 days activity with 4 pax in one county level QAs by county teams at their sub-counties | | | | | | |
| | | Conduct bi-annual technical and support supervision of RMNCH-N Implementation by the national team, and quarterly technical and support supervision by county teams to improve the quality of care. | National level: Bi-annual 5-day activity of the national 4 officers to visit each county for supportive supervision at selected facilities in all 47 counties. County-level quarterly 5-day supportive supervision activity by county teams in selected facilities. | 56,835,584 | 60,814,075 | 65,071,060 | 68,919,413 | 68,919,413 | **320,559,545** |
| | | Train data program managers on data validation | A 4 day training of 30 pax for national and 300 pax county teams | 28,027,152 | 29,989,053 | 32,088,286 | 33,986,013 | 33,986,013 | **158,076,516** |

| Strategy/Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/29 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | | | (CHRIOs &SCHRIOs) | | | | | | |
| | Bolster data utilisation for evidence-based decision-making | Conduct regular data reviews to promote the culture of utilising routine-generated data at all levels | National level : Bi-annual 3-day meetings in each of the 10 national regions with 4 national officers (facilitators) in each region and with 5 CHMT members from each county. County Level- Quarterly 3-day county-level data reviews by county teams. | 43,598,937 | 46,650,862 | 49,916,423 | 52,868,519 | 52,868,519 | **245,903,260** |
| | | Generate data sources outside the routine KHIS data, like program assessments, periodic surveys and special studies, to facilitate the end-line | Cost covered under surveys | 0 | 0 | 0 | 0 | 0 | 0 |

| Strategy/Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/29 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | | program review | | | | | | | |
| | | Quarterly RMNCAH-N reports (RMNCAH-N Score Card/ presentation at the RMNCAH-N Multi-stakeholder Country Platform | National level: Quarterly 1-day meetings of 50 pax for RMNCAH-N scorecard report sharing at the national stakeholders' forum. County level: Quarterly 1-day meeting of 40 pax RMNCAH-N scorecard report sharing for county stakeholders . | 2,862,250 | 3,062,608 | 3,276,990 | 3,470,794 | 3,470,794 | **16,143,435** |
| | | Annual and Bi-Annual RMNCAH-N performance reports, (countdown) communication briefs and policy briefs | 5 days meeting of 40 pax (national) to develop RMNCAH-N communication briefs and policy briefs | 5,243,642 | 5,610,697 | 6,003,446 | 6,358,494 | 6,358,494 | **29,574,773** |
| | Strengthen Collaborations | Conduct partner mapping for | 3 day meeting to develop a national | 1,459,748 | 1,561,930 | 1,671,265 | 1,770,105 | 1,770,105 | **8,233,152** |

| Strategy/Intervention | Activity | Sub-activities | Budget Assumptions | 2025/26 | 2026/27 | 2027/28 | 2028/29 | 2029/30 | Total |
|---|---|---|---|---|---|---|---|---|---|
| | and Partnerships | the RMNCAH-N division | partner data base | | | | | | |
| | | Coordinate RMNCAH-N technical work groups (TWGs) and staff meetings | 1-day program-specific Quarterly TWG meetings: Child Health, MNH, SRH, GBV, Family Planning and Nutrition | 1,373,880 | 1,470,052 | 1,572,955 | 1,665,981 | 1,665,981 | **7,748,849** |
| | | Promoting accountability through periodic performance monitoring | Bi-annual periodic performance monitoring for 5 days of 35 pax each | 9,176,374 | 9,818,720 | 10,506,030 | 11,127,365 | 11,127,365 | **51,755,853** |
| | | Annual review of the RMNCAH-N implementation plan and course correction | 5-day review meeting of 40 Pax | 5,243,642 | 5,610,697 | 6,003,446 | 6,358,494 | 6,358,494 | **29,574,773** |
| Total | | | | **1,089,416,808** | **1,099,621,002** | **1,176,573,472** | **1,246,139,204** | **1,246,139,204** | **5,857,889,691** |

## APPENDIX C: OUTCOME AND OUTPUT INDICATORS BY PROGRAMME AREA

***Maternal Newborn and Child***

Table C1: Maternal, newborn, and child health outcome indicators

| Indicator | Baseline-2022/23 | 2024/25 | 2025/26 | 2026/27 | 2027/28 | 2028/29 | Endline Target-2029/30 | Indicator Type | Data source | Frequency of data collection |
|---|---|---|---|---|---|---|---|---|---|---|
| Facility maternal deaths per 100,000 deliveries | 90 | 85 | 80 | 75 | 70 | 65 | 60 | Outcome | KHIS | Routine |
| Facility neonatal mortality rate (per 1000 live Births | 10 | 8 | 7 | 6 | 5 | 4 | 3 | Outcome | KHIS | Routine |
| Fresh stillbirth rate per 1,000 births in institutions | 75 | 70 | 65 | 60 | 55 | 50 | 45 | Outcome | KHIS | Routine |
| Proportion of maternal deaths audited | 90 | 95 | 97 | 98 | 99 | 99 | 99 | Output | KHIS | Routine |
| Proportion of perinatal death audits | 20 | 35 | 40 | 45 | 50 | 55 | 60 | Output | KHIS | Routine |
| Proportion of child deaths audited | ND | 15 | 20 | 25 | 30 | 35 | 40 | Output | KHIS | Routine |
| Proportion of neonatal deaths audited | 20 | 30 | 35 | 40 | 45 | 50 | 55 | Output | KHIS | Routine |
| Proportion of pregnant women attending 8 ANC contacts | 4 | 15 | 25 | 30 | 35 | 40 | 50 | Output | KHIS | Routine |
| Proportion of skilled deliveries conducted in health facilities | 70 | 80 | 82 | 85 | 88 | 90 | 93 | Output | KHIS | Routine |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Proportion of mothers receiving postpartum care within 48 hours | 63 | 69 | 70 | 75 | 80 | 85 | 90 | Output | KHIS | Routine |
| Proportion of infants receiving postpartum care within 48 hours | 62 | 69 | 70 | 75 | 80 | 85 | 90 | Output | KHIS | Routine |
| Proportion of hospitals providing CEmONC services | 5 | | 8 | | 10 | | | Output | KHFA | Periodic |
| Fully immunized child coverage | 72 | 80 | 85 | 90 | 95 | 97 | 99 | Outcome | KHIS | Routine |
| Proportion of newborns applied chlorhexidine for umbilical cord care | 60 | 70 | 75 | 80 | 85 | 90 | 95 | Output | KHIS | Routine |
| Proportion of newborns who received vitamin K at birth | 40 | 50 | 55 | 60 | 65 | 70 | 75 | Output | KHIS | Routine |
| Proportion of babies initiated on Kangaroo Mother Care | 50 | 60 | 65 | 70 | 75 | 80 | 85 | Output | KHIS | Routine |
| Proportion of children under 5 with diarrhoea taken to a health facility or provider for advice or treatment | 57 | | 65 | | 70 | | 75 | Output | KDHS | Periodic |
| Proportion of children under five with diarrhoea treated with ORS and Zinc | 50 | 60 | 65 | 70 | 75 | 80 | 85 | Output | KHIS | Routine |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Proportion of children under five years with pneumonia treated with Amoxil DT | 60 | 70 | 75 | 80 | 85 | 90 | 95 | Output | KHIS | Routine |
| Proportion of children under five years with severe pneumonia treated with oxygen therapy | 5 | 15 | 20 | 25 | 30 | 35 | 40 | Output | KHIS | Routine |
| Proportion of children under five with delayed developmental milestones assessed | 20 | 30 | 35 | 40 | 45 | 50 | 55 | Output | KHIS | Routine |
| Proportion of children under five years dewormed | 50 | 60 | 65 | 70 | 75 | 80 | 85 | Output | KHIS | Routine |
| Proportion of children under five years who have their births registered | 70 | | 75 | | 80 | | 85 | Output | KNBS | Periodic |

***Family Planning***

Table C2: Family planning outcome indicators

| Indicator | Baseline-FY 2022/23 | 2023/24 | 2024/25 | 2026/27 | 2027/28 | 2028/29 | Endline Target-2020/30 | Type of the Indicator | Data source | Frequency of data collection |
|---|---|---|---|---|---|---|---|---|---|---|
| Percentage of women of reproductive age (15−49 years) who have their need for family planning satisfied with modern methods. | 53 | - | - | - | 57 | | 60 | Output | KDHS | every 5 years |
| % of women of reproductive age with unmet needs for family planning | 14 | 14 | 13 | 12 | 11 | 11 | 10 | Output | KDHS | every 5 years |
| Modern Contraceptives Prevalence Rate (mCPR) -married women | 57 | 60 | 61 | 62 | 62 | 63 | 64 | Outcome | KDHS | every 5 years |

***Adolescent Health***

Table C3: Adolescent health outcome indicators

| Indicator | Baseline-2022/23 | 2023/24 | 2024/25 | 2026/27 | 2027/28 | 2028/29 | Endline Target-2029/30 | Type of indicator | Data source | Frequency of data collection |
|---|---|---|---|---|---|---|---|---|---|---|
| Percentage of adolescents (10-19 years) being pregnant/ % reduction in Teenage Pregnancy | 15 | 15 | 14 | 11 | 10 | 9 | 8 | Output | KHIS | Routine |
| % reduction in teenage pregnancy | 0.15 | 0.15 | 0.14 | 0.11 | 0.1 | 0.1 | 0.1 | Outcome | KHIS | Routine |
| Proportion of facilities offering adolescent and youth-friendly services | 62 | 70 | 78 | 85 | 90 | 93 | 97 | Output | KENPHIA/KDHS | Every five years |
| Proportion of adolescents 10-19 years of age equipped with knowledge for decision making participation in the implementation of health intervention (disaggregated by age 10-14,15-19 and sex) | 30 | 45 | 60 | 70 | 80 | 90 | 95 | Output | KENPHIA | Every five years |
| Proportion of adolescents (10-19) reached with key health messages on prevention and management | 30 | 45 | 55 | 65 | 80 | 90 | 95 | Output | KENPHIA | Every five years |
| Proportion of 10-14yrs girls given HPV1 | 16.21 | | 40 | 55 | 70 | 85 | 90 | Output | KHIS | |
| proportion of 10-14yrs girls given HPV2 | 15.12 | | | 40 | | | 80 | Output | KHIS | |
| HPV coverage (10-14 yrs) | 7 | | 31 | 40 | | | 80 | Outcome | KHIS | |
| (%) of pregnant women who are adolescents (10-19 years)/adolescent pregnancy rates | 17.5 | 16.8 | 16.4 | 15.25 | 14.7 | 14.15 | 13.6 | Output | KHIS | |
| (%) of pregnant women who are adolescents (10-19 years) | 17.4 | 16.5 | 15.6 | 13.8 | 12.9 | 12 | 11.1 | Output | KHIS | |
| Proportion of adolescents (10-19) reached with key health messages on prevention and management | 30 | | | | 55 | | 65 | Output | KAHS | |

***Nutrition***

Table C4: Nutrition outcome indicators

| Indicator | Baseline-2022/23 | 2023/24 | 2024/25 | 2026/27 | 2027/28 | 2028/29 | Endline Target-2029/30 | Type of indicator | Data source | Frequency of data collection |
|---|---|---|---|---|---|---|---|---|---|---|
| Proportion of children 6-59 months supplemented with two (2) age-appropriate doses of vitamin A | 72 | 85 | 85 | 87 | 88 | 89 | 90 | Output | KHIS/KDHS | Annually/ periodic 5 years |
| Proportion of children 6–23 months achieving minimum acceptable diet | 30 | 45 | 50 | 50 | 60 | 65 | 70 | Output | KHIS/KDHS | Annually/ periodic 5 years |
| Proportion of women (15-49) who meet minimum dietary diversity MDD-W | 50 | | | | 70 | | 80 | Output | KDHS | |
| Proportion of the adult population consuming at least 5 servings of fruit and vegetables per day | 6 | 10 | 15 | 25 | 35 | 40 | 45 | Output | STEPS Wise survey | periodic |
| Proportion of defaulters among children 6-59 months with Severe Acute Malnutrition (SAM) on treatment in the OTP program (OTP Default rate - Nutrition) | 11 | 10 | 8 | 6 | 5 | 4 | 3 | Output | KHIS | annually/ periodic |
| IMAM cure rate among children 6-59 months enrolled in the OTP programme | 84 | | | | 88% | | 90% | Outcome | | |
| Proportion of low birth weight in health facilities (less than 2500 grams) | 6 | 6 | 5 | 5 | 4 | 4 | 3 | Output | KHIS | |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Proportion of low birth weight (less than 2500 grams)-Reduce by 10% | 9 | | | | 8 | | 7 | Output | KDHS | |
| Percentage of children 0-5 (<6 months) months who were exclusively breastfed | 60 | 65 | 70 | 80 | 80 | 83 | 85 | Output | KHIS | |
| Early initiation of breastfeeding | 60 | | | | 80 | | 85 | Output | KDHS | |
| Proportion of children under 5 attending CWC who are underweight | 5% | | | | 4 | | 3.5 | Output | KHIS | Annually |
| Proportion of counties benefitting from NICHE program | 11% | | | | 23% | | 23% | Output | | |
| Proportion of health facilities (levels 4, 5 and 6) stocking parental feeds | | 20 | 40 | 80 | 100 | 100 | 100 | Output | | |
| Regulation for restrictions of marketing of unhealthy foods and non-alcoholic beverages to children developed | | | | | 1 | | 1 | Outcome | Regulation | |

## APPENDIX D: Participants for RMNCAH-N Investment Case Development

| No. | Name | Job Title | Organization or Facility |
|---|---|---|---|
| 1 | Dr. Edward Serem | Head, Division of RMNCAH | MOH |
| 2 | Dr. Hellen Kiarie | Head M&E | MOH/M&E |
| 3 | Nancy M. Njeru | DDPS | MOH-DHPT |
| 4 | Dr. Juliet Omwoha | Head NCH | MOH/DRMNCAH |
| 5 | Peris Murethi | PM | MOH/DRMNCAH |
| 6 | Dr. Jane Koech | S.P.O | MOH/DRMNCAH |
| 7 | Richard Kimenye | P.O | MOH/DRMNCAH |
| 8 | Tracey Lnziani | P.O | MOH/DRMNCAH |
| 9 | Brian Ondigo | P.O | MOH/DRMNCAH |
| 10 | Caroline Thuo | P.O | MOH/DRMNCAH |
| 11 | Tabitha Njoki | P.O | MOH/DRMNCAH |
| 12 | Hambulle Mohamed | S.P.O | MOH/DRMNCAH |
| 13 | Dr. Nancy Njeru | SDDPS | MOH-DHPT |
| 14 | Joyce Onyango | P.M | MOH/DRMNCAH |
| 15 | Bwasu Petronilia | P.O | RMNCAH/Adolescent Health section |
| 17 | Dr. Annah Nyaboke | Paediatrician | KPA Representative |
| 18 | Julius Korir | Consultant | Consultant |
| 19 | Sheila Chepkirui | Programs Coordinator | Organization of African Youth |
| 20 | Jackson Kipruto Cheruiyot | County Child Health Focal Person | MOH/Dept. of Health Services |
| 21 | Jane Owuor | County Reproductive Health Coordinator/Chair, CRHCs Caucus | MOH/Dept. of Health Services |
| 22 | Pasqueline Njau | Senior Advocacy and Policy Officer | PATH |
| 23 | Meboh Abuor | Snr. Program Advisor | COG |
| 24 | Dr. Owino Robert | PM | MOH/DRMNCAH-AH |
| 25 | Esther Kamau | Liaison Officer | GFF |
| 26 | Dr. Gordon Okomo | CDH//Chair, CDH's Caucus | MOH/Dept. of Health Services |
| 27 | Dr. Albert Ndwiga | PM | MOH/DRMNCAH-RMH |
| 28 | Caroline K. Kathiari | MIYCN | MOH-/Division of Nutrition & Diadetics |
| 29 | Sharon Musakali | Programs | HENNET |
| 30 | Dr. Mary Magubo | PM | MOH/DRMNCAH |

| | | | |
|---|---|---|---|
| 31 | Dr. Loise Nyanjau | ADMS | MOH/DRMNCAH-NCH |
| 32 | Charity Koronya | FPI RMCS Specialist | UNFPA |
| 33 | Alice N. Mwangangi | P.O | MOH/DRMNCAH |
| 34 | Jackson Cheruiyot | CCH | Nakuru county |
| 35 | Vincent Ibworo | DPHK Secretariat | DPHK |
| 36 | Sharon musakali | programs | HENNET |
| 37 | Naomy Arrussey | P.O | MOH/DRMNCAH |
| 38 | Achieng Victor | WHO SRH | WHO Kenya |
| 39 | Doddy Collince Okelo | Communication | Organization of African Youth - Kenya |
| 40 | Jane Owuor | CRHC | MOH Kisumu |
| 41 | Dr. David Njuguna | Health Economist | MOH |
| 42 | Dr. Chris Masila | Consultant | Practhealth |
| 43 | Esther Kamau | Liaison Officer | GFF |
| 44 | Kolum Cosmas | P.O | MOH/RMNCAH |
| 45 | Dalmas Aiyeko | AD/ICT | MOH/DRMNCAH |
| 46 | Margaret Lumbale | ED | HENNET |
| 47 | Dr Milka Choge | Country Coordinator | GFF |


# MINISTRY OF HEALTH