MINISTRY OF HEALTH

RAPID RESULTS INITIATIVE TO ADDRESS MATERNAL & NEWBORN MORTALITY IN KENYA

Every Woman Every Newborn Everywhere

2026

Developed by

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

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Foreword

> **Over 6 months**, the RRI will focus on strengthening health care across all the building blocks... and deepening community engagement to ensure timely, quality care for every woman and newborn

Kenya stands at a defining moment in its commitment to safeguard the lives of mothers and newborns. Despite notable progress in expanding access to essential health services, maternal and newborn mortality remain unacceptably high, signaling systemic challenges that demand urgent and coordinated action. With facility deliveries at an all-time high and strengthened national investments such as Social Health Insurance Fund, national clinical guidelines, Emergency Obstetric Newborn Care(EmONC) scale-up, and Maternal Perinatal Death Surveillance and Response(MPDSR), and Newborn Child and Adolescent Death Audit(NCA) institutionalization, Kenya has built a strong foundation for improved outcomes. Yet preventable deaths continue to occur, exposing critical gaps in service readiness, adherence to evidence-based practice, functionality of referral systems, and timeliness of emergency response.

The Maternal and Newborn Health Rapid Results Initiative (MNH RRI) provides a decisive, time-bound mechanism to rapidly reverse these trends. Anchored within the Kenya Every Woman Every Newborn Everywhere (EWENE) Acceleration Plan 2026–2028 .This initiative represents the first, high-intensity implementation phase designed to drive measurable reductions in

maternal deaths, neonatal deaths, and fresh stillbirths—particularly across 26 high-burden counties. It brings together political leadership, technical expertise, and operational discipline through a whole-of-government approach, underpinned by strong data, accountability, and evidence-based interventions. Over 6 months, the RRI will focus on strengthening health care across all the building blocks including health workforce capacity, enhancing availability of life-saving commodities and blood products, strengthening referral systems, leveraging digital health platforms for efficiency , and deepening community engagement to ensure timely, quality care for every woman and newborn. This document sets out the roadmap for that accelerated action and signals a renewed national commitment to protect the lives and dignity of Kenya's mothers and babies.

Hon. Aden Duale, EGH.
Cabinet Secretary for Health
Ministry of Health, Kenya

Preface

> “In the survival of mothers and newborns, we find the truest measure of our health system’s integrity, our government’s accountability, and our nation’s commitment to those who depend on us most.”

Maternal and neonatal mortality remain the most unforgiving measures of health system performance. Unlike indicators permitting incremental improvement, these deaths demand immediate, coordinated excellence across every component of the health ecosystem. When a mother or newborn dies from preventable causes, the failure is systemic.

Kenya has invested substantially in health system transformation—establishing the Social Health Authority, developing comprehensive clinical guidelines, building digital health infrastructure, and training health workers. Yet with facility deliveries at 89% and first antenatal care coverage approaching universal levels, our maternal mortality ratio of 355 per 100,000 live births signals that access without quality remains an empty promise.

This Maternal and Newborn Health Rapid Results Initiative represents a fundamental departure from conventional implementation strategies. It is the inaugural demonstration of the Health Policy Platform—a governance innovation that transforms policy from aspiration to accountable execution through surgical precision in targeting systemic bottlenecks, real-time monitoring, and fortnightly performance reviews at the highest levels of government.

We deliberately employ maternal and neonatal health as the test case for health system transformation. Success here requires functional governance, adequate financing, competent workforce, reliable commodities, robust data systems, and quality service delivery—the building blocks upon which all health outcomes depend. If we create conditions for every woman and every newborn to survive and thrive, we will have built a health system capable of addressing any challenge our nation faces.

This six-month intensive implementation establishes precedents for how government functions;replacing rhetoric with results, fragmented efforts with coordinated action, and elevating data-driven accountability above all considerations. The world will watch not what we promise, but what we achieve.

Dr. Ouma Oluga, OGW
Principal Secretary
State Department for Medical Services
Ministry of Health, Kenya

Executive summary

> **As a strategic addendum to the Kenya EWENE Acceleration Plan 2026–2028, the RRI is a focused, time-bound delivery mechanism engineered to fast-track high-impact interventions, strengthen accountability, and drive an immediate decline in maternal and newborn fatalities."**

Kenya stands at a critical inflection point. Despite decades of investment and significant strides in expanding health service coverage, the maternal mortality ratio and newborn mortality rate remain stubbornly stagnant, rivaling the high burden of geographies worldwide and reflecting a profound and unacceptable failure to safeguard the country's most vulnerable citizens. With a Maternal Mortality Rate (MMR) of 355 per 100,000 live births, a Neonatal Mortality Rate (NMR) of 21 per 1,000 live births, and more than 30,000 stillbirths annually, Kenya is off track to meet the Vision 2030 and the SDGs targets. These preventable deaths persist even as the vast majority of Kenyan women access essential health services in facilities for antenatal, delivery, and early postnatal care.

The Maternal and Newborn Health Rapid Response Initiative (MNH RRI) has been mobilized to address this stagnation decisively. As a strategic addendum to the Kenya EWENE Acceleration Plan 2026–2028, the RRI is a focused, time-bound delivery mechanism engineered to fast-track high-impact interventions, strengthen accountability, and drive an immediate decline in maternal and newborn fatalities. Its mandate is to reduce preventable maternal deaths, neonatal deaths, and fresh stillbirths by reinforcing governance and financing, building frontline workforce capacity, securing commodities and blood, improving data and accountability systems, and elevating the quality of care across facilities and communities. Kenya has significantly expanded maternal and newborn health service coverage where facility deliveries have risen from 62% in 2014 to 89% in 2022; 98% of pregnant women attend at least one ANC visit, and 73% of mothers and newborns receive a postnatal check within 48 hours.

Initiatives such as Linda Mama, the Beyond Zero campaign, national clinical guidelines, scale-up of EmONC training, and institutionalization of MPDSR underpin these gains. Yet mortality has not declined as expected. Neonatal deaths account for two-thirds of infant deaths and half of all under-five deaths, while still births, half of which occur during the labour process, remain high. These patterns expose deep systemic deficiencies in facility readiness, adherence to evidence-based practice, the functionality of referral systems, and the timeliness of emergency response.

The leading causes of maternal mortality are hemorrhage, hypertensive disorders, sepsis, obstructed labour, anaemia; and the leading causes of newborn mortality are prematurity, birth asphyxia, respiratory distress, neonatal sepsis, and pathological jaundice. These conditions are well known, preventable, and treatable with affordable and available high impact interventions. Their persistent toll highlights serious gaps in readiness, adherence to clinical protocols, and timely recognition and escalation of complications. Workforce shortages and skills gaps, frequent stock-outs of essential commodities, weak diagnostics, inconsistent data use, and the persistent divide between policy and implementation continue to fuel preventable deaths. Counties often under-prioritize MNH in budgets, and MPDSR follow-through is uneven. Incremental improvements will not suffice.

Against this backdrop, the MNH RRI is positioned to break the stagnation and serve as a launch pad to accelerate the reduction of maternal and neonatal mortality. Over a 6 month push in 26 high burden counties, it targets measurable reductions in facility maternal deaths, neonatal deaths, and fresh stillbirths while strengthening leadership, financing, commodities, data systems, workforce capacity, and quality of care. The initiative is organized around six key results areas.

1. **Governance and financing,**
2. **Human Resources for Health,**
3. **Health Products and Technologies and blood availability**
4. **Data, Monitoring & Evaluation, Accountability and Learning**
5. **Service delivery**
6. **Advocacy Communication and Community Engagement**

A layered governance structure, from the President and Cabinet Secretary to county steering teams, ensures tight coordination and rapid problem-solving. Implementation progresses through four phases: preparation, national launch, intensive action, and transition into routine EWENE systems. The RRI requires a National budget of KES 1,029,259,400.00 that is mainly directed toward workforce training and capacity building and essential lifesaving commodities to achieve the RRI aims and rapidly shift performance trajectories while laying the foundation for sustained improvements in maternal and newborn health, as part of implementing the Kenya Every Woman Every Newborn Everywhere Acceleration Plan.

Dr. Patrick Amoth, CBS
Director-General for Health
Ministry of Health, Kenya

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With an MMR of 355 per 100,000 live births, an NMR of 21 per 1,000 live births, and more than 30,000 stillbirths annually, Kenya is off track to meet the Vision 2030 and SDG targets

1.0 BACKGROUND

1.1 Kenyan context

Kenya has indeed made significant strides in Maternal and Newborn Health (MNH) service coverage with facility deliveries increasing from 62% (KDHS 2014) to 88% (KDHS 2022). Almost all pregnant women have access to at least one antenatal care clinic at 98%, and nearly four out of five mothers and newborns receive a critical postnatal check within the first 48 hours.

Trends in Antenatal Care and Skilled Birth Attendance

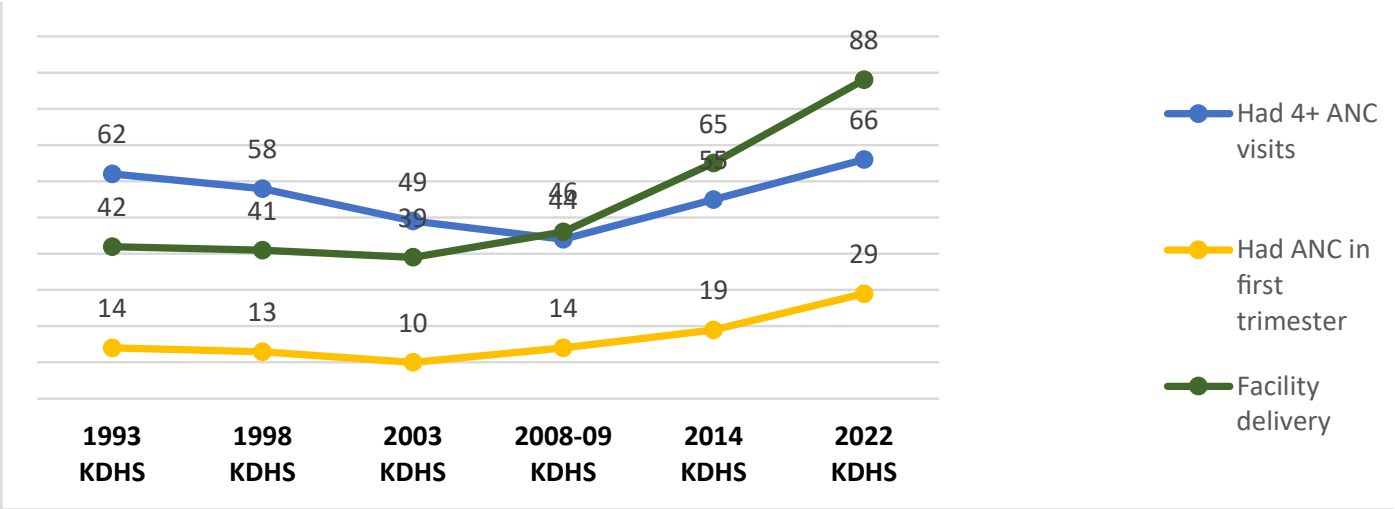


Figure 1: Trends in Antenatal Care and Skilled Birth Attendance; KDHS 1993 to 2022

These gains are the direct result of dedicated national investments into maternal and newborn health, including flagship programs like Linda Mama, the Beyond Zero campaign, the development of the National Guidelines for Quality Obstetric and Perinatal Care and scale up of Emergency Obstetrics and Newborn Care training and the strengthening of accountability mechanisms through Maternal and Perinatal Death Surveillance and Response (MPDSR) systems. However the corresponding impact on maternal and neonatal mortality has not been realized.

Kenya's Maternal Mortality Ratio (MMR) of 355 per 100,000 (KHPC, 2019) translates into approximately 5,000 mothers dying due to pregnancy related causes every year .

Trends in Antenatal Care and Skilled Birth Attendance

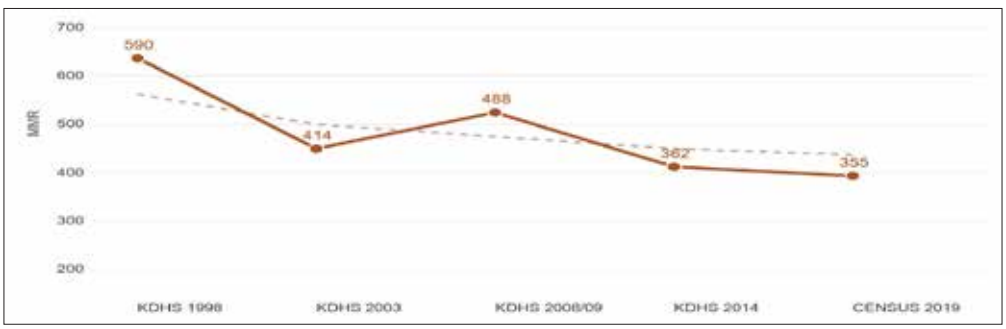


Figure 2: Trends in Maternal Mortality in Kenya

5,000

Kenya's Maternal Mortality Ratio (MMR) of 355 per 100,000 translates into approximately 5,000 mothers dying due to pregnancy-related causes every year

A similar trend is evident in newborn survival, with the Neonatal Mortality Rate (NMR) which has remained high, at 21 per 1,000 live births (KDHS, 2022), which translates into approximately 42,000 deaths per year. Neonatal deaths account for 66% of infant deaths and 51% of total under 5 deaths. Kenya's stillbirth rate stands at a sobering 19.2 per 1,000 births, with nearly half of these devastating losses occurring during the intrapartum period. The majority of neonatal deaths and stillbirths are preventable and occur due to preventable and/or treatable causes.

Trends in Childhood Mortality

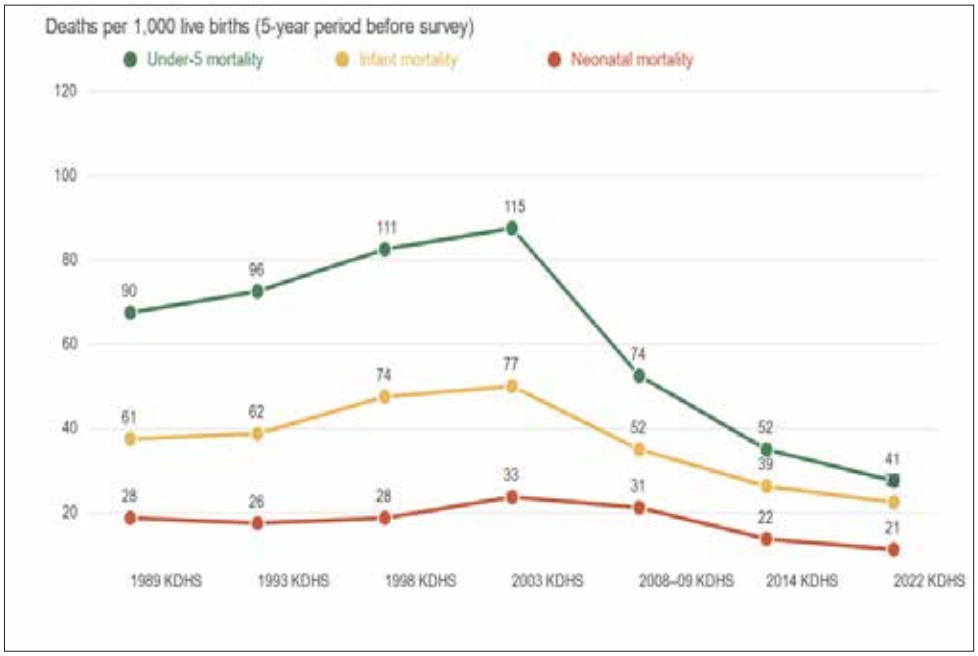


Figure 3: Trends in Child Mortality in Kenya

These preventable deaths point to systemic deficiencies across the health system with poor facility readiness, lack of adherence to evidence based clinical practice, the functionality of referral systems, and the critical response time for emergencies; the quality of services through the continuum of care is insufficient to save lives.

66%

Neonatal deaths account for 66% of infant deaths and 51% of total under-5 deaths.

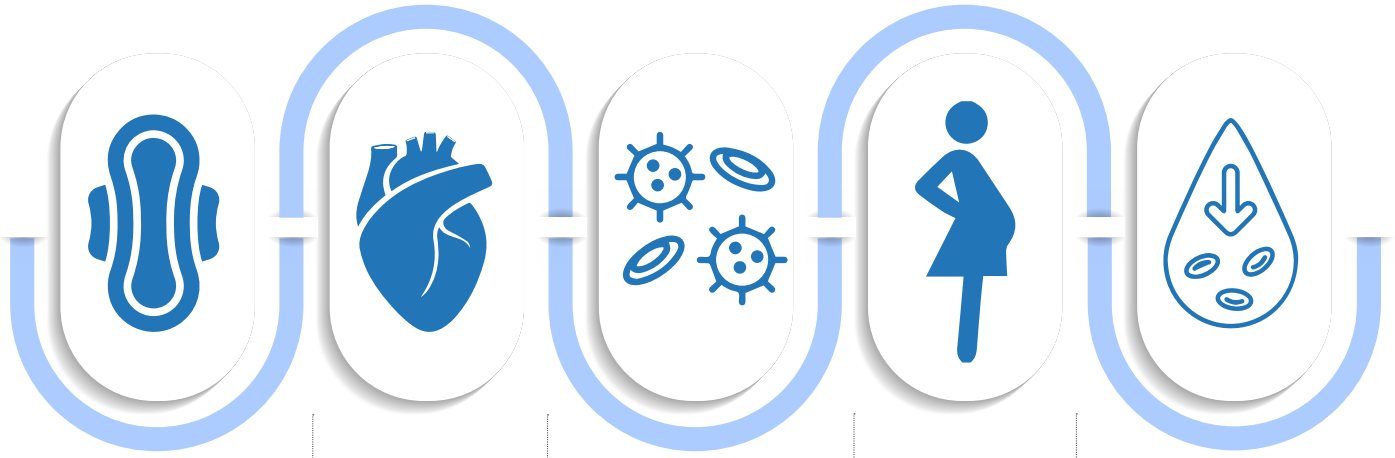
Kenya's stillbirth rate stands at a sobering 19.2 per 1,000 births, with nearly half of these devastating losses occurring during the intrapartum period.

1.2 The Causes of Maternal and Neonatal Mortality

The causes of maternal and newborn deaths across Kenya are preventable and treatable using readily available and affordable high impact interventions. This knowledge base provides a clear mandate for targeted intervention.

Causes of maternal deaths (source MPDSR report 2024)

Hemorrhage, hypertensive disorders in pregnancy, sepsis and obstructed labour are the leading direct causes of maternal deaths. Anaemia in pregnancy is the leading indirect or underlying cause of maternal mortality.

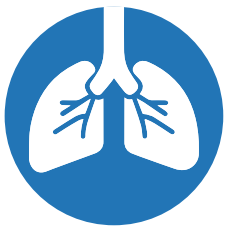


Obstetric Hemorrhage (Postpartum hemorrhage- **37%,** Antepartum haemorrhage-**14%**)	Hypertensive Disorders in Pregnancy- **22%**	Sepsis in pregnancy- **12%**	Obstructed Labour – **8%**	Anaemia in pregnancy- **60%** of indirect causes

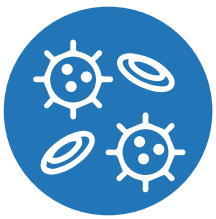
Causes of Newborn Deaths (Data Source: KHIS 2023)

Newborn mortality is precipitated mainly by critical conditions requiring intensive, specialized care:

1. **Prematurity:** Complications arising from being born too soon. **(37%)**



2. **Intrapartum Asphyxia and Respiratory Distress:** Failures of the baby to initiate or sustain breathing at birth. **(33%)**



3. **Neonatal Sepsis:** Life threatening infections in the first weeks of life. **(9%)**

These identified causes represent clinical emergencies demanding immediate, uncompromising, high-quality care. Their continued, devastating prevalence not only signifies a failure of care but lays bare profound, critical shortcomings in fundamental facility readiness, the fidelity of adherence to established clinical protocols, and the ability to timely recognize, escalate, and competently manage complications.

1.3 Systemic Barriers Sustaining High Mortality

Beyond the immediate clinical causes, persistent systemic and institutional gaps constitute the fundamental challenges that continue to drive unacceptable MNH outcomes. These gaps nullify the potential gains of expanded service access.

Critical Bottlenecks and Deficiencies (Data Source: Kenya Quality of Care Report 2024)

1. Policy, Financing and Implementation Gap: Although national MNH policies are strong, county level execution remains fragmented and uneven. Prioritization of maternal and newborn health has also declined, weakening consistent implementation.

2. Health Workforce Capacity Deficits: Staffing shortages are widespread, with only 12 counties meeting minimum staffing thresholds. Nurse-to-patient ratios remain unsafe, and key competencies are low as only 40% of providers correctly manage conditions like PPH and severe dehydration, and just 36% accurately diagnose birth asphyxia. Monitoring is also weak, shown by only 52% of mothers having blood pressure checked within 15 minutes postpartum.

3. Commodity insecurity and Infrastructure challenges: Stockouts of essential MNH medicines are common, including $MgSO_4$ (48%), Benzyl Penicillin (47%), and Oxytocin (40%). Critical lab diagnostics are inconsistently available, and only 5% of maternity facilities have full obstetric and newborn care equipment, limiting readiness and emergency response.

4. Low utilization and data analytics: Routine reporting remains inconsistent, and data is underused for decision-making. Despite long-standing MPDSR implementation, weak follow-through on recommendations restricts timely corrective action.

5. Sub Optimal Quality of Service Delivery: Only 37% of facilities meet all BEmONC standards, and 46% of Level 4 and 5 facilities deliver all CEmONC signal functions. Chronic underinvestment in MNH, especially in frontline workers and facility readiness, continues to undermine service quality and community engagement.

These interlinked systemic failures definitively demonstrate why high service coverage alone is an insufficient condition to achieve mortality reduction targets. The Rapid Results Initiative (RRI) is therefore strategically engineered to dismantle these chronic bottlenecks head-on.

1.4 The Rationale for the MNH Rapid Response Initiative

The Maternal and Newborn Health Rapid Response Initiative (RRI) is strategically anchored within the framework of the EWENE Acceleration Plan 2025-2027, serving as the critical launch pad for its first implementation phase. It is fundamentally designed as a concentrated, time-bound execution aimed at unlocking rapid, measurable progress in areas where the potential for life-saving gains is demonstrably highest. The timing is in alignment with the current political momentum and technical capabilities, as well as with the global movement on EWENE.

2.0 GOALS, OBJECTIVES, AND EXPECTED OUTCOMES

2.1 Goal:

To accelerate the momentum to reduce preventable maternal deaths, neonatal deaths and fresh stillbirths in Kenya over a 6 months period (February to July 2026), with a primary focus on 26 high-burden counties, while laying the foundation for sustained system transformation through the EWENE Acceleration Plan.

2.2 Objectives:

Objectives to achieve the goal include

1. To strengthen the leadership governance and financing for maternal and new-born health with increased government and county allocation of funds to maternal and new-born care
2. To improve the skills and capacity of frontline health workforce to provide MNH services through in service skills-based training and mentorship
3. To strengthen the supply chain for essential MNH health products and technologies to ensure zero stock out of prioritised essential MNH commodities
4. To build a culture of strong data analytics for program decision making through digital health platforms, and visualisation dashboards in order to promote accountability for maternal and new-born health services
5. To improve quality of MNH services through institutionalisation of MPDSR structures and implementation of responses identified to correct gaps in MNH service delivery, and community awareness to increase community demand for quality MNH services

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By the end of 6 months RRI period, Kenya aims to achieve:

2.3 RRI Outcome Targets:

By the end of the 6-month RRI period, Kenya aims to achieve the outcomes below, with implementation of prioritised interventions per key result area.

Table 1: Rapid Results Initiative Outcome Targets

Indicator	Baseline FY2024	Target (After RRI)
4th ANC	52%	70% (18% increase projection)
Skilled Birth Attendance	70%	90% (20% increase projection)
Facility Maternal Mortality Ratio	98/100,000 live births	83/100,000 live births (15% reduction)
Facility Neonatal Mortality Rate	9.4/1,000 live births	8 /1,000 live births (15% reduction)
Facility Stillbirth Rate	16.44/1,000 live births	13/1,000 live births (15% reduction)

The specific key output indicators per key result area are outlined in Chapter 5: table 12

2.5 Targeted counties

All counties have preventable maternal and new-born mortality. The RRI will put in place national and county level interventions in all counties. 26 counties were identified using thecriteria below.

1. Counties meeting 3 of the below criteria using the KHIS 2024 annual data (20 counties)

Top absolute number of facility maternal deaths

Top facility maternal mortality ratio

Top number of still births

Top number of neonatal deaths

Table 2: Targeted 20 counties with high burden of maternal and new - born deaths.

	County	2024 Facility Maternal Mortality Ratio	2024 Number of Maternal Deaths reported in health facilities_Rev2020	MOH 711 Neonatal deaths 0-28 Days	2024 MOH 711 Fresh Still Birth
1	Migori	261	23	143	283
2	Garissa	228	59	243	361
3	Mombasa	157	41	312	181
4	Kisumu	129	31	440	258
5	Kisii	129	29	271	111
6	Kitui	128	28	240	242
7	Nairobi	122	165	1533	766
8	Machakos	104	23	212	172
9	Nakuru	102	56	801	355
10	Trans Nzoia	101	22	340	202
11	Bungoma	95	47	425	333
12	Homa Bay	94	29	210	165
13	Kwale	91	22	258	197
14	Siaya	86	18	264	216
15	Kilifi	83	27	496	328
16	Kakamega	82	37	539	317
17	Kajiado	78	25	199	261
18	Uasin Gishu	77	21	462	222
19	Meru	76	21	257	285
20	Samburu	208	13	47	80
21	Elgeyo Marakwet	34	4	69	99
22	West Pokot	61	12	170	319
23	Tana River	103	7	37	110
24	Mandera	46	12	56	229
25	Turkana	63	18	181	193
26	Wajir	92	13	68	101

2. Counties with under reporting of maternal deaths (3 counties)

21. Elgeyo Marakwet
22. West Pokot
23. Tana River

3. Equity consideration counties(2 counties)

24. Turkana
25. Mandera
26. Wajir

TARGETED PRIORITY 26 COUNTIES

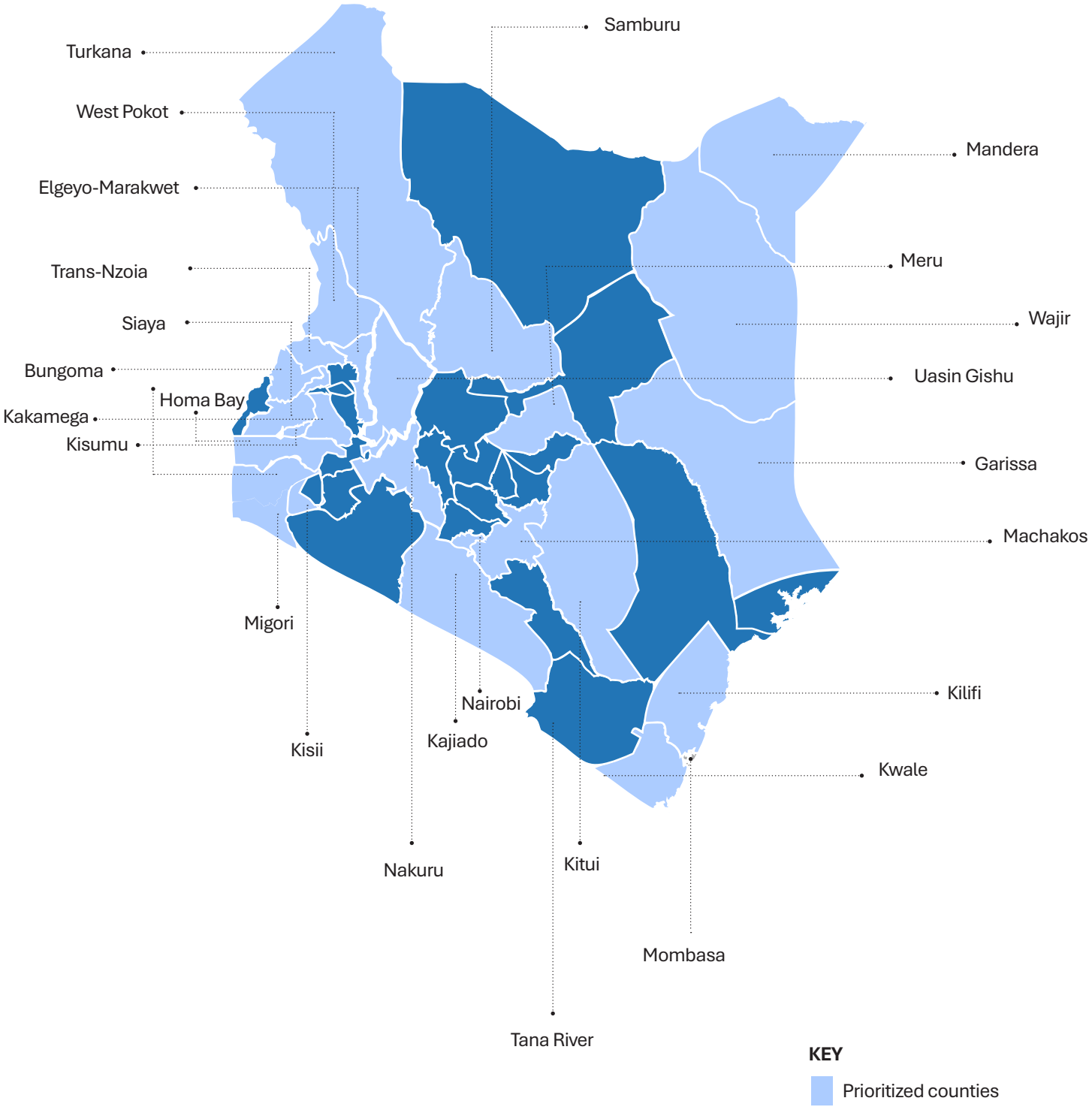

Figure 4: Targeted priority 26 counties

3.0 KEY RESULTS AREAS AND PRIORITY INTERVENTIONS

3.1 Implementation of the RRI- Key result areas and priority interventions

This Rapid Results Initiative (RRI) is strategically structured around five critical Key Result Areas (KRA). These key result areas represent the essential pillars required to drive significant and measurable improvements in MNH outcomes. By targeting Financing and Governance, Human Resources for Health, Data, Monitoring, Evaluation, Research and Learning, Commodities and Health Products and Technologies (HPT), and Service Delivery, we ensure a comprehensive approach that addresses systemic challenges at both the national and county levels. The interventions outlined within each KRA have been carefully selected for their potential to deliver high-impact results within the six-month period, promoting accountability and fostering an environment of accelerated progress.

I. Finance and Governance

a. Governance

Table 3: Governance - Interventions and Expected Outputs

Inventions	Output	Responsible
Establish RRI coordinating team	Established RRI coordinating team	National
Fortnightly RRI National–County coordination meetings	RRI coordination meetings held	National MOH and COG
Engagement with CECs, Chief Officers & CDH Caucus on MNH & RRI implementation status	Engagement forum with CECs, Chief Officers & CDH Caucus on MNH & RRI implementation status held	National MOH and COG
EWENE Forum – High-level engagement with Governors & partners, and Launch of EWENE acceleration plan and RRI plan	EWENE acceleration plan and RRI plan launched	National MOH and COG
	Signed commitment to EWENE Acceleration plan	National
Hold National MPDSR review with all counties	National MPDSR review held with all counties in (February)	National MOH and COG
County specific EWENE/RRI plan with integration of MNH actions and budget lines in county AWPs (aligned to EWENE)	County EWENE plans endorsed by County Leadership	COG and County
Establish and operationalize County MNH RRI coordination teams led by CHMT	Weekly County MNH RRI coordinating meetings	County
Weekly County MPDSR committees meeting (with feedback to CECs & Governors) in the RRI period	County weekly MPDSR meetings	County
Governors to receive and review monthly MNH reports and address gaps	Monthly RRI review reports submitted to the governor	National MOH, COG and County
Committee (National & County) impromptu supervisory visits at service delivery points	Joint COG-MOH supervision visits to counties on MPDSR	National MOH and COG

b. Advocacy for Financing

Table 4: Advocacy for Financing: Interventions and Expected Outputs

Inventions	Output	Responsible
Advocacy towards ring-fencing MNH funds within existing UHC/SHIF allocations	Number of counties with ring-fenced MNH budgets	County
Accelerate review of SHA benefit package for RMNCAH by Benefit Package and Tariffs Advisory Panel (BPTAP)	Comprehensive RMNCAH SHA Package	National MOH and SHA
Advocate for allocation/ spending at least 30% of county budget to health, prioritizing high-impact maternal and newborn services, including budget reallocation to MNH	Number of counties allocating at least 30% of their budget to health	County
Increase registration of individuals to SHA and payment of premiums	Increased coverage of county population registered to SHA	National MOH and SHA
Track expenditure on essential MNH supplies and equipment	Monthly tracking of commodity availability and spending	Counties

II. Human Resources for Health

Table 5: Human Resources for Health - Interventions and Expected Outputs

Inventions	Output	Responsible
Train counties on EMONC (under-served prioritised)	Healthcare workers trained on EmONC in 26 target counties	National
Train counties on PAC (under-served prioritised)	Healthcare workers trained on PAC in 26 target counties	National
Train counties on Essential Newborn Care	Healthcare workers trained on Essential Newborn Care in 26 target counties	National
Train counties on Comprehensive Newborn Care	Healthcare workers trained on Comprehensive Newborn Care in 26 target counties	National
Develop Kenya Simulation-Based Training Plan	Guidelines on simulation-based training developed	National
Conduct readiness assessment for simulation-based training	Report on readiness assessment for simulation-based training in health facilities published	National
Rapid assessment of KMTC campuses and county refferal hospitals for readiness to provide MNH simulation training	Report on readiness assessment for MNH simulation-based training in KMTC campuses published	National
Equip Skills corner in 10 high volume facilities per county(26 counties) with EMONC bundle of equipment	260 skills corner established in target 26 counties (10 High volume facilities per county)	National
Train TOTs to conduct regional EmONC & Comprehensive Newborn Simulation Refreshers	120 trainers for EmONC and CNC Simulation based training	National
Conduct monthly EmONC emergency drills (PPH, eclampsia, neonatal resuscitation)	Monthly drills on EmONC in all facilities with skill corner	County
Conduct on-site mentorship/supervision for EmONC	Monthly mentorship sessions on MNH for all facilities	National
Develop short videos on lifesaving MNH procedures, commodities and equipment via MoH Virtual Academy	1 video per EmONC skill produced and published	National

Inventions	Output	Responsible
Develop short videos on lifesaving MNH procedures, commodities and equipment via MoH Virtual Academy	1 video per MNH commodities and equipment orientation produced and published	National
Advocate for MNH nurses/midwives' recruitment to balance staff turnover through COG/Caucus engagement meetings	Meeting of key stakeholders on recruitment of MNH staff in county facilities	County
Ensure 24-hr skilled coverage in maternity units	Maternity units attain 24hr service coverage	County
Hire and retain trained midwives and nurses in maternity and newborn units	Recruit /post 3 additional nurses to maternity, and 3 additional neonatal nurses to NBUs in top 5 high volume facilities	County
Prioritise health worker training in EmONC and Comprehensive Newborn Care within county health budgets	County funded EmONC and CNC training sessions	National
MDT sensitisation on RMNCAH services (scale up remaining 32 counties)	32 counties with MDTs sensitized on RMNCAH package of services	National

III. Data, Monitoring & Evaluation, Accountability and Learning

Table 6: Data, Monitoring & Evaluation, Accountability and Learning- Interventions and Expected Outputs

Inventions	Output	Responsible
2 dedicated technical officers to analyse MPDSR data, conduct DQAs, and feedback to counties	2 data technical MEL officers recruited/ posted	National
Deploy live MNH RRI /MPDSR scorecard on KHIS dashboard	Deployed MNH RRI dashboard in KHIS	Counties
Develop RRI dashboard on maternal & neonatal deaths	Live RRI Dashboard at OP, COG, CS, PS, DG Levels	National (MOH) and COG
Bi-weekly RRI reports	Bi- Weekly RRI reports	National (MOH)
Accelerate MPDSR tools digitization	Digitized MPDSR tools	National
Develop & circulate MPDSR Action Tracker Tool	MPDSR Action tracker developed	National
Accelerate finalisation and digitization of maternity file and roll-out	Digitized maternity file launched by May 2026	National
Finalise and update MNH registers including KHIS updates	Updated MNH reporting tools and Summery tools	National
Prioritise digitalization of MNH patient records in Taifa Care	Incorporation of MNH patient record in Taifa care	National
Strengthen eCHIS to report all pregnancies, maternal & neonatal deaths	eCHIS upgraded to include pregnancy & death reporting;	County
Ensure accurate KHIS data entry completion & upload of maternal death audits	Monthly maternal and neonatal death data verification by national to all counties	County
Convene county monthly MPDSR review meetings & track implementation	Monthly County MPDSR data review meetings held	County

IV. Commodities & Health Products and Technologies (HPT)

Table 7: Commodities & HPTs - Interventions and Expected Outputs

Inventions	Output	Responsible
Procure MNH commodities (Carbetocin, Caffeine citrate)	1.5 Million Heat Stable Carbetocin procured	National (KEMSA)
	1.5 Million V calibrated delivery drapes procured	
	1.5 million doses of Caffeine Citrate	
Advocate for EMOTIVE bundle (Early Detection, Massage, Oxytocics, Tranexamic acid, IV fluids, Examination and Escalation) in high-volume facilities (push model)	2 advocacy forums for PPH Bundle adoption and procurement with KEMSA,COG and relevant stakeholders to develop PPH Packaged Bundle guide for procurement and distribution in counties	KEMSA/ Counties
Strengthen use of the Logistics Management Information System (LMIS) dashboard for MNH commodities tracking	National LMIS dashboard with all 47 counties active	National and Counties
Train MoH and county staff on LMIS	10 National and 98 county staff trained on LMIS	National
Advocacy campaign to increase county uptake of MNH commodities from KEMSA, including evidence generation on essential MNH commodities	Commodities advocacy brief completed	National
	Increased uptake of essential MNH commodities from KEMSA	
Advocacy for funding for key MNH commodities by the national government	Essential National MNH commodities budget line established	National
National blood drive campaign to build up stocks at RBTCs	Monthly regional blood drives conducted to mobilize blood across all RBTCs with link counties	KNBTS County
	Blood screening reagents available in RBTCs	KNBTS
Monitor stock levels of blood and blood products monthly using LMIS app; trigger redistribution through RBTUs/ DHMT/HPTUs	Weekly blood and blood products availability reports	County
Forecasting, quantification, and procurement of MNH commodities in all county facilities	47 county MNH commodities forecasting and quantification reports	County
Ensure allocation of adequate resources to procure MNH commodities as per quantification and forecasting process	≥80% of budgeted MNH funds committed allocated to procure essential MNH commodities	County
Ensure availability of essential lifesaving maternal and newborn commodities (oxytocin, carbetocin, TXA, vaginal drapes, NASG)	Essential maternal and newborn health commodities stocked and available across 95% of county facilities (oxytocin, HSC, TXA, Caffeine citrate, Drapes)	County
Ensure availability of family planning commodities to prevent unwanted pregnancies	Family planning commodities consistently available in county facilities	County
Counties to procure supplies for transfusion(transfusion sets)	Blood transfusion supplies (Blood giving sets etc.) available in health facilities	County
Strengthen logistics to ensure blood availability in needed facilities	Improved logistics and efficient distribution system for timely blood availability	County
Conduct assessment of available equipment and functionality against launched norms and standards for newborn care	Newborn equipment dashboard functional	County

V. Service Delivery

This key result area focuses on the critical interface between the healthcare system and the community, emphasizing respectful, people-centered care and system resilience while reinforcing quality improvement through the active establishment and function of MPDSR and Quality Improvement (QI) teams.

a) Community Engagement, respectful and people centered care, advocacy

Table 8: Community Engagement- Interventions and Expected Outputs

Inventions	Output	Responsible
Engage media in RRI / EWENE accountability campaign	National EWENE Media campaign engagement through various channels	National
Conduct community dialogues and maternity open days to promote uptake of maternal health services	Community dialogues on maternal new-born health Maternity open days held in target county health facilities	County
Maternity open days held in target county health facilities	County	
Community health outreaches to far-flung populations and Community Health Promoters (CHPs) follow-up to increase ANC, SBA and PHC fund registration	50 outreaches conducted on MNH RRI counties	County

b) Response & Resilience

Table 9: Response & Resilience- Interventions and Expected Outputs

Inventions	Output	Responsible
Operationalize national referral system and hotline with SHA	National SHA referral system operationalized	National (SHA)
Map and functionalize ambulance referral networks (maternal/newborn)	47 Functional EOCs equipped to manage MNH emergencies	County
	Appointment of a county referral coordinator	County
	47 Monthly county referral performance reports submitted	County
Implement 24-hour call-on referral system	≥90% of maternity facilities with 24-hour call referral system operational with duty roster	County
Ensure functional ambulances and a referral coordinator to streamline referrals between facilities	Functional ambulances per referral network in all 47 county	County

c. Maternal and Perinatal Death Surveillance and Response

Table 10: Maternal and Perinatal Death Surveillance and Response - Interventions and Expected Outputs

Inventions	Output	Responsible
Complete MPDSR sensitization to counties,	47 counties sensitized on MPDSR and NCA guidelines	National
Train counties on MPDSR and establish com-mitees	26 counties sensitized on MPDSR & newborn death audit	National
Train & establish Newborn and child audit com-mittees at community and facility level	26 Newborn and Child death Audits functional com-mittees	County
Establish/activate MPDSR/QI teams in all mater-nity facilities for weekly audits	100% Facilities conducting weekly MPDSR/QI review Meetings	National
Support Supervision to counties on MPDSR meetings, and coordination	18 targeted joint support supervision	National

In conclusion, successful execution of the interventions detailed across these five key result areas is paramount to achieving the ambitious goals set for this RRI. These key result areas are landmarks of an actionable roadmap, specifying responsible parties and measurable output indicators to ensure there are measures of accountability at every level of implementation

4.0 IMPLEMENTATION MECHANISMS

Incremental, conventional approaches risk prolonged stagnation. The RRI provides a strategic launch pad to urgently accelerate mortality reduction and restore progress toward national and SDG commitments. The MNH RRI relies on a whole-of-government approach, driven by strong leadership from H.E. the President and the C.S for Health.

4.1 Governance, Coordination, and Management

i. National Steering Committee (NSC)

Chair: Cabinet Secretary for Health

Co-Chair: Chair Health Committee of the Council of Governors

Membership: Senior MoH leadership, Office of the President - Council of Economic Advisors, the Council of Governors (CoG) including the CEO, the COG health director and caucus chairs. Representation from Parliament, The National Treasury, key development partners, and professional bodies.

Functions: Guide policy direction, mobilize requisite resources, execute high-level review of national performance, and adjudicate cross-cutting systemic bottlenecks, establish or strengthen MNH Partner Coordination Platforms at national and county levels to align technical and financial support across the key result areas.

ii. National Technical Committee (NTC)

Chair: Director General for Health

Membership: MoH Directorates including Family Health (DFH), Health Products & Technologies (HPT), Human Resources for Health (HRH), Health Financing, Digital Health, MOH technical agencies, COG and supporting partners

Functions: Provide authoritative technical oversight, develop and validate operational guidance, conduct advanced data analysis, and ensure seamless coordination of surge support and partner alignment.

These functions will be executed through the following sub-committees:

1. **M&E Subcommittee-**Tracks data, compiles dashboards, and provides monthly progress updates to the Steering Committee and the Office of the President.
2. **Service Delivery subcommittee-** Provides technical assistance and supervision to counties through maternal and newborn focal points and partner support. 2 national officers per county
3. **Advocacy subcommittee-** develops all advocacy material and oversees all advocacy engagements at national level and supports county.
4. **Secretariant-** ensures cordinating scheduling documentation and reporting to the Director General

iii. RRI Operational Committee

Chair: Director Family Health

Membership: Head Division of RMNCAH, with Divisions of Primary Health Care (PHC), Community Health, Health Financing, Intergovernmental, Health Promotion, Nutrition and Dietetics, Nursing & Midwifery, Health Information Systems (HIS), Health Products and Technologies (HPTs), Human Resource for Health (HRH), National Blood Transfusion Services(KNBTS), Social Health Authority (SHA), Digital Health Agency (DHA), Kenya Essential Medical Supplies Authority (KEMSA) and Council of Governors representative.

Functions: Operational committee to execute day-to-day coordination, rigorous documentation, effective communication, and provision of direct support to counties. Prepare concise, data-driven national RRI performance briefs and high-stakes presentations for executive leadership.

iv. County Governance Structure

a. County RRI Steering Committee

Chair: The CECM for Health providing strategic leadership to the county steering committee.	**Co-Chair:** The Chief Officer resource mobilizing and steering resources for the county RRI activities	**Members:** County Director of Health (CDH), County Health Management Team (CHMT),Partners, Representatives from key Ministries

b. County RRI Technical Committee -Chair CDH

Members: CHMT, Sub- County Health Management teams, key high-volume facility in-charges, and county partners.	**Functions**: Deliver county-level political endorsement, provide technical guidance, ratify county RRI operational plans, authorize resource allocation, coordination and conduct local performance stewardship. There will be linkage between National and county facilitated by national level officers supporting each county through the CDH. The national level officers will follow up on reports and create seamless communication flows between the two levels of Government.

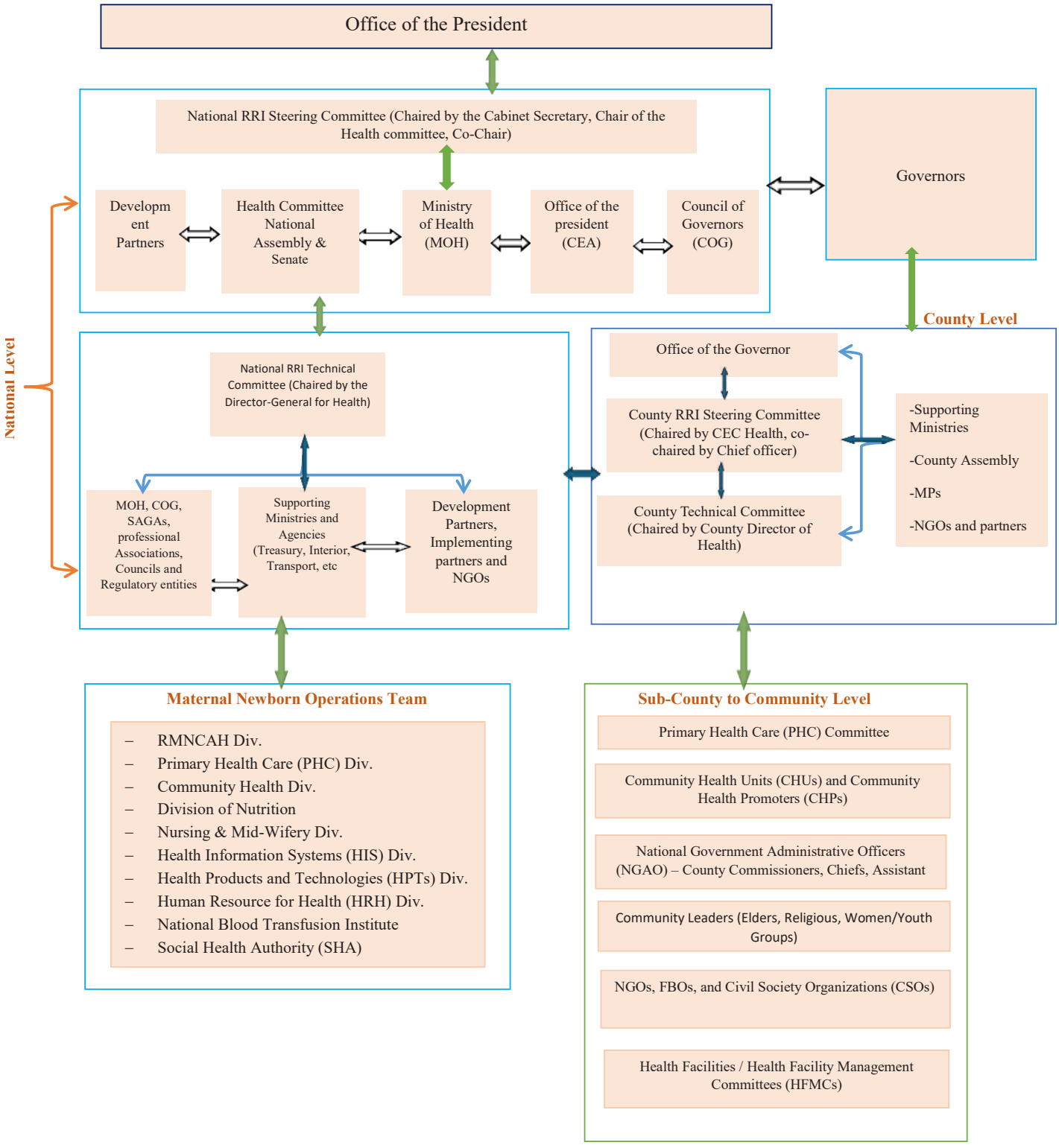

Figure 5: MNH RRI Coordination structure at National and County Levels

4.2 RRI IMPLEMENTATION PHASES:

i) Preparation (Pre-Launch)

This phase secures institutional commitment and finalizes core operational tools, including the RRI Action Plan and Scorecard. Steering and Technical Committees are formally established, and baseline assessments in 26 counties guide targeted resource deployment. Counties also convene preparatory meetings to align leadership and ready teams for launch.

ii) Launch and Initial Surge

This phase is marked by the Presidential Launch of the EWENE Acceleration Plan positions the MNH RRI as the flagship, high-urgency first phase. Immediately thereafter, all counties and facilities receive clear operational guidance to accelerate readiness. The focus is a rapid, targeted surge of essential resources such as life-saving commodities, critical equipment, and priority staffing, to close the most urgent service-delivery gaps at frontline facilities.

iii) Intensive Implementation (Core 175 Days)

This phase is marked by full implementation of clinical care bundles, Quality Improvement (QI) cycles, strengthened MPDSR systems, and rigorous data-driven reviews. Weekly county and national coordination meetings to ensure real time analysis and rapid problem solving. Structured peer learning enables high performers to spread effective practices quickly.

iv) Consolidation and Transition

The final phase ensures sustainability and begins with a comprehensive end-line performance review and documentation of key lessons. Proven interventions are integrated into routine EWENE activities, embedded in County Annual Work Plans, and supported through ongoing budgets. The phase ends with agreed monitoring and accountability mechanisms to maintain gains and reinforce a high-performance culture.

Table 11: Phases of RRI implementation

Phase	Period	Milestones
Pre-RRI Preparations	Oct–Dec 2025	Establish coordination teams; validate EWENE; COG, DPHK, Partner engagement finalize tools/dashboards; launch logistics.
launch	Feb 2026	National launch by H.E. the President/CS; county activations; EWENE communications rollout; dashboards operational.
Rapid implementation	Feb to July	Deliver interventions; monthly RRI and MPDSR reviews; continuous dashboard reporting.
Mid Term Review	April 2026	National–county hybrid review; support lagging counties; media updates.
Final consolidation and recognition	June to July 2026	Validate dashboards; document best practices; Presidential recognition of top counties.
Post RRI integration	July to Sept	Integrate into 2026–27 County AWPs and KHSSP; sustainability and accountability framework.

5.0 MONITORING AND EVALUATION

The RRI M&E framework will serve as the core accountability tool, systematically measuring progress, identifying bottlenecks, and ensuring data-driven decision-making across all levels of the initiative. Monitoring is primarily based on output indicators provided by CDHs on a bi-weekly basis. These indicators are crucial input for review during the bi-weekly Rapid Results Initiative (RRI) review meetings.

The CDHs are also responsible for submitting comprehensive County Reports. Conversely, outcomes are systematically monitored by the national level using KHIS data. Nationally, the Ministry of Health (MOH) compiles a comprehensive report from all counties every two weeks, with the key findings and progress reflected directly on the dedicated RRI dashboard.

5.1 Key Outcome Indicators and Targets

The targeted outcomes of the RRI are illustrated in Table 1.

5.2 Key Output Indicators and Targets (Full List attached as Annex 3)

Table 12: Key Output Indicators and targets

MNH RRI Intervention	Target
1. Health Financing and Governance	
Ksh 5 Billion allocated annually to paying premiums for indigent /vulnerable mothers	K5 billion allocated for SHA premiums – Announced at the launch
Number of County MPDSR Meetings held monthly	4(virtual or physical)
Number of Governor led monthly MPDSR review meetings	1 monthly high level MPDSR review meetings
Proportion of county population registered to SHA	50%
2. Human Resources for Health	
No of HCWs trained on EMONC	900 in 26 counties
No of HCWs trained on Comprehensive new-born care	500 in 26 counties
Number of EMONC drills conducted weekly	10(at least one per 10 highest volume facilities per county)
Number of maternity and newborn care health care workers recruited or re deployed to maternity and NBU per county	30(at least an additional 3 Maternity, 3 Newborn unit, in the top 5 high volume facilities per county)
3. Health Products and Technologies	
Procurement of 1.5 million doses of carbetocin	1,500,000 doses of carbetocin procured and distributed to counties
Procurement of 1.5 million doses of caffeine citrate	1,500,000 doses of caffeine citrate procured and distributed to counties
Procurement of 1.5 million Calibrated V drapes	1,500,000 million Calibrated V drapes procured and distributed to counties and health facilities
Heat Stable Carbetocin use in Active Management of Third Stage of Labour job aid and SOPs developed and disseminated	47 virtual dissemination meetings on Heat Stable Carbetocin use in Active Management of Third Stage of Labour
KNBTS conduct monthly regional blood drives in collaboration with counties	7 regional blood drives

MNH RRI Intervention	Target
	Target collection of 47,000 units of blood collected per month(requirement is 1% of population estimated at 564,000 units per year(estimated 47,000 per month)
Advocate for inclusion of reimbursement of blood transfusion services to KNBTS	SHA package reimbursing blood logistics and blood transfusion services to KNBTS
Counties, ensure no stock out of essential MNH commodities	zero stock outs for tracer commodities- Oxytocin, heat stable carbetocin, mgso4, Benzyl penicillin, caffeine citrate, oxygen , tranexamic acid, calibrated V delivery drapes
Counties to procure essential PPH commodities	V drapes, UBT balloon tamponade, NASG
4. Digital Platforms and data	
RRI Dashboard	Functional RRI dashboards at OP, CS,PS, DG office
MPDSR Dashboard	Functional MPDSR dashboard with realtime reporting of maternal and new-born deaths
DHA reporting of all claim outcomes , starting with maternal and new-born outcomes	Reporting of maternal and newborn outcomes for mother and baby for all claims
Counties reporting all maternal and new-born deaths in all facilities within 24 hours	Functional MPDSR dashboard with real-time reporting
5. Service Delivery	
a) MPDSR	
Conduct MPDSR trainings for county and facility committees	At least 26 counties trained on MPDSR / Neonatal child and adolescent (NCA) death audits
Conduct NCA death audit trainings for county and facility committees	At least 26 Number of MPDSR training sessions conducted nationally
Counties hold monthly MPDSR and NCA death audit review meetings	At least 26 Number of NCA death audit training sessions conducted nationally
Counties hold monthly MPDSR and Neonatal death audit review meetings	47 (100%) of counties submitting monthly MPDSR &NCA death audit meeting summaries
Counties hold monthly MPDSR and Neonatal death audit review meetings	Number of systemic gaps action points logged
Counties hold monthly MPDSR and Neonatal death audit review meetings	Number of systemic action points resolved from previous month county MPDSR tracker(80% target)
b) Emergency and referral services	
Roll out SHA emergency Response Ambulance Reimbursement Mechanism	Functional reimbursement mechanisms and guidelines established by January 15th and launched

MNH RRI Intervention	Target
Strengthen referral services through Emergency Operation Centres to provide maternal and new-born care emergency and referral services	1. Full time EOC/referral coordinator 2. At least 2 functional ambulances, with at least 2 dedicated drivers 3. At least 2 dedicated EMT staff 4. Fuel budget for emergency services 5. Linkage to the SHA ambulance system
c) Community engagement and awareness and education	
Engage media in RRI / EWENE accountability campaign	EWENE engagement toolkits developed / materials disseminated
	Media spots aired –TV, National radio and local stations
	Media articles published –print, digital/social media
Conduct community dialogues & maternity open days to promote uptake of maternal health services	Number of community dialogue days held monthly Number of health facilities that conduct maternity open days monthly
Community outreaches to reach those in underserved areas	47 counties conducting at least 2 integrated outreach services per month
Community health outreaches to far-flung populations and CHP follow-up to increase ANC, SBA and PHC fund registration	50 outreach services conducted per county

6.0 BUDGET

Table 13: RRI Implementation Budget

Budget source	Total Amount (KSh.)	Remarks
National Budget	1,016,463,324	(excludes 5B to SHA, 1B for MNH commodities)
County Budget (all 47 counties)	159,030,000	
Total Budget	1,175,493,324	

The County budget caters for all 47 counties, hence estimated cost per county is 3.4 million per county for coordination and stakeholder engagement activities, including virtual and physical MPDSR meetings, and governor-led Response review meetings.

However, this excludes county cost of hiring 30 extra staff annually, and cost of procuring commodities, training health care workers of buying any equipment, ensuring functional facilities , or ambulances and community mobilization at county level. Each county is to cost its specific RRI plan

Table 14: Budget proposal for the RRI

Focus Area	TOTAL	National	All 47 counties	Total	Largest Cost Drivers
MNH Financing and Leadership	80,679,400	35,589,400	45,090,000	7%	SHA maternity package
MNH Workforce	513,600,000	485,800,000	27,800,000	44%	At National, EMONC Training, PAC Training, ENC training, CNC Training, Setting up simulation corners(500k per facility)
Data, Monitoring & Evaluation, Accountability and Learning	102,000,000	91,300,000	10,700,000	9%	Digitising the MPDSR tools, including piloting, setting up MNH Dashboard, develop MPDSR action tracker, Digitisation of MNH tools in Taifa care, strengthen ECHIS
Comodities & Technologies (HPT)	168,440,000	135,040,000	33,400,000	14%	procurement of carbetocin, caffeine citrate & V-drapes
Service Delivery - MPDSR, Response and Resilience	95,440,000	75,300,000	20,140,000	8%	Stregthening Quality improvement through MPDSR and newborn death audit response measures, stregthening referral services.
Advocacy, Communication and Community engagement	215,333,924	193,433,924	21,900,000	18%	Mass media and digital media campaigns, national and local level vernacular stations
Total Budget	1,175,493,324	1,016,463,324	159,030,000	100%	

6.2 Focus Area by % Cost Estimate

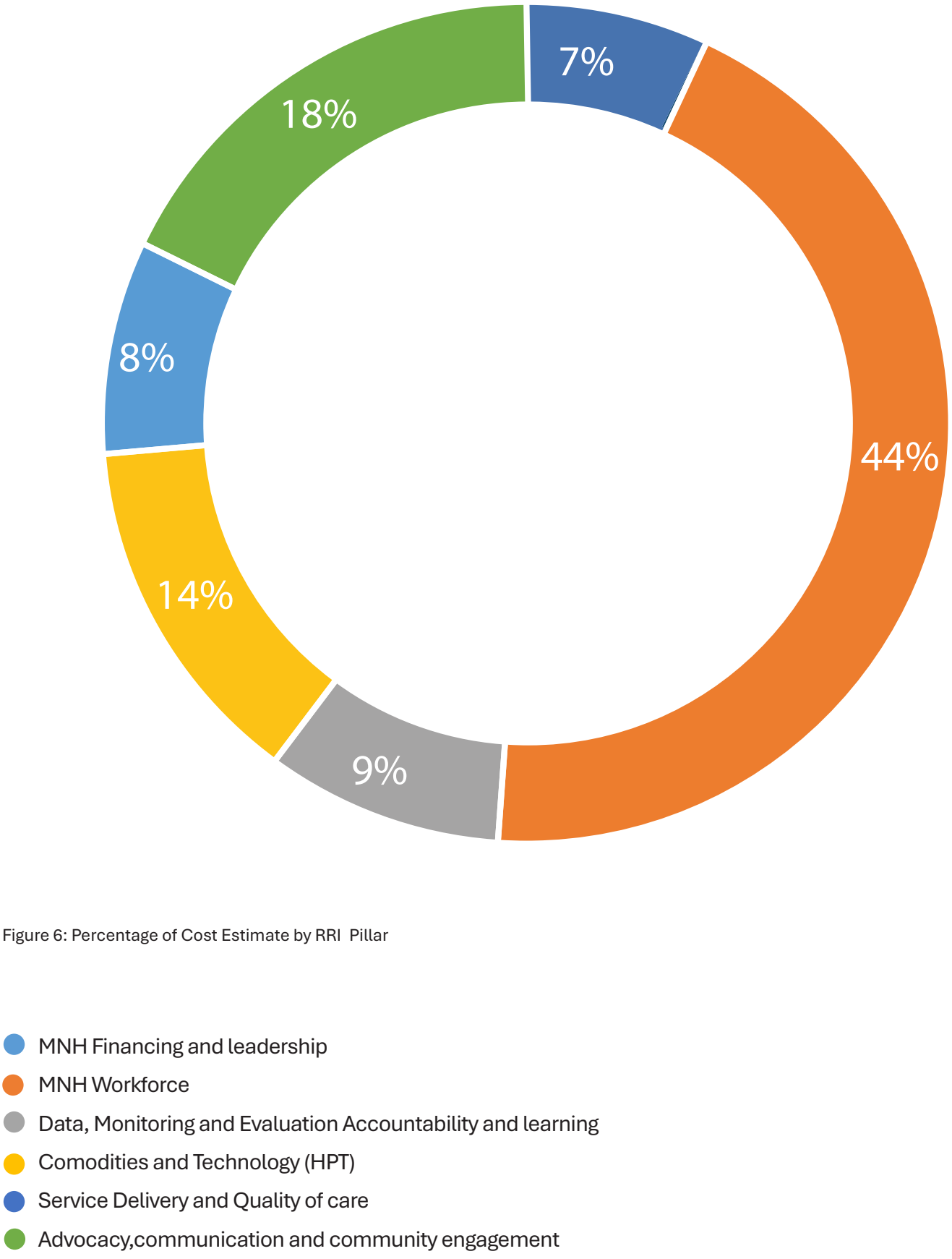

Figure 6: Percentage of Cost Estimate by RRI Pillar

Acknowledgements:

The development of the Maternal and Newborn Health Rapid Results Initiative (MNH RRI) has been made possible through the collective leadership, technical expertise, and commitment of institutions and individuals across the health sector. The Ministry of Health acknowledges the stewardship provided under the leadership of the Cabinet Secretary for Health, whose guidance shaped the vision and ambition of this initiative. Appreciation is also extended to the Director-General for Health for providing overall leadership to the process.

The Ministry of Health recognizes the contributions of the Director of Family Health, Dr. Bashir Issak, the Head of the Division of Reproductive, Maternal, Child and Adolescent Health, Dr. Edward Serem, and their teams, as well as other Ministry of Health Divisions whose technical input and coordination were instrumental in the development of this initiative.

The Ministry further appreciates the Council of Governors, County Executive Committee Members for Health, Chief Officers, and County Directors of Health for their collaboration and commitment to implementation at county and facility levels. Appreciation is also extended to development partners, civil society organizations, and community structures whose partnership strengthens Kenya's collective resolve to end preventable maternal and newborn deaths. Special appreciation to the contributors listed below

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