REPUBLIC OF KENYA

Ministry of Health

NEWBORN AND CHILD HEALTH STRATEGIC PLAN

2022 - 2026

Division of Newborn & Child Health

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ACRONYMS AND ABBREVIATIONS

ACSM	Advocacy Communication and Social Mobilization
ACT	Artemisinin-Based Combination Treatment
AH	Adolescent Health
AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Treatment
ASAL	Arid and Semi-Arid Lands
BEmONC	Basic Emergency Obstetric Newborn Care
BFCI	Baby Friendly Community Initiative
BFHI	Baby Friendly Hospital Initiative
BMS	Breast Milk Supplementation
CEmONC	Community Emergency Obstetric And Newborn Care
CHA	Community Health Assistant
CHEW	Community Health Extension Worker
CHP	Community Health Promoter
CMNC	Community Based Maternal Newborn Care
CSDS	Child Survival and Development Strategy
DPT3	Diphtheria-Tetanus-Pertussis Vaccine
ECD	Early Childhood Development
EmONC	Emergency Obstetric and Newborn Care
EMTCT	Elimination of Mother to Child Transmission of HIV
EMTCT	Elimination of Mother To Child Transmission
ETAT+	Emergency, Triage, Assessment and Treatment Plus
HCP	Health Care Provider
HIV	Human Immunodeficiency Virus
iCCM	Integrated Community Case Management
IMNCI	Integrated Management of Newborn and Childhood Illnesses
IPC	Infection Prevention and Control
KAP	Knowledge Altitude and Practice
KDHS	Kenya Demographic and Health Survey
KHSSP	Kenya Health Sector Strategic Plan
KMC	Kangaroo Mother Care
LLINs	Long Lasting Insecticide Nets
MCH	Maternal & Child Health
MDG	Millennium Development Goals
MIYCN	Maternal Infant & Young Child Nutrition
MNCH	Maternal Newborn Child Health
MOE	Ministry of Education
MOH	Ministry of Health
NBU	Newborn Unit
NCAHP	Newborn, Child and Adolescent Health Policy
NCAHU	Neonatal, Child and Adolescent Health Unit
NCH	Newborn & Child Health
NGAO	National Government Administration Officer
NHCA	Newborn Health Care Assistant
NHIF	National Health Insurance Fund
ORS	Oral Re-Hydration Salts
PMTCT	Prevention of Mother To Child Transmission
PNC	Post-Natal Care
PSPI	Possible Serious Bacteria Infection
SDGs	Sustainable Development Goals
SOPs	Standard Operating Procedures
TWG	Technical Working Group
UHC	Universal Health Coverage
UNICEF	United Nations International Children's Emergency Fund
WASH	Water Sanitation and Hygiene
WHO	World Health Organisation

DEFINITIONS

Adolescent	Any person between ages 10 and 19
Infant	The term "infant" is typically applied to young children under one year of age; however, definitions may vary and may include children up to two years of age.
Intrapartum	The time period spanning childbirth, from the onset of labor through delivery of the placenta. Intrapartum can refer to both the woman and the fetus.
Neonate	An infant less than 28 days.
Peripartum	The period shortly before, during, and immediately after giving birth.
Child	A person aged 2 months upto 10 years.

FOREWORD

Kenya has made great strides in improving child health indicators but child deaths remain unacceptably high with 52 out of 1,000 children born dying every year. Unfortunately, 70% of these deaths are attributed to preventable and treatable childhood illnesses such as diarrhoea, pneumonia (acute respiratory infections), malnutrition, anaemia, malaria, measles, HIV and tuberculosis. Additionally, a significant proportion of deaths in children under-five (46%) occur in the neonatal period due to infections such as sepsis, complications of pregnancy and childbirth including birth asphyxia, prematurity, low birth weight and other congenital anomalies.

While the country's under-five mortality has decreased by over 50% since 2003, neonatal mortality has decreased at a much slower rate of 33%.

The development of the Newborn and Child Health Strategic Plan is a major milestone in the heath sector's efforts to increase equitable access to health services, improve efficiency and effectiveness in service delivery, increase health financing as well as enhance partnerships. The strategy will contribute significantly to the achievement of the country's newborn commitments. The strategy provides a framework that can be supported by all partners to accelerate the achievement of better health for children. It will be guided by the National Health Strategic Plan 2018-2023, National Primary Health Care Strategic Framework 2019-2024, RMNCAH Investment Framework among other policy documents.

The implementation of the strategy will be structured along the three principles of SURVIVE, THRIVE and TRANSFORM. The strategy draws a link to the Kenya Community Health Strategy 2020-2025 whose scale up will serve to bring quality health services closer to communities and enhance the participation of families at household level.

The Ministry of Health renews its commitments to creating an enabling environment for the implementation of the strategy in partnership with the communities, development partners, private sector and other stakeholders, to reduce under- five mortality and improve the health of the children of Kenya.

Dr. Patrick Amoth, EBS Ag.
Director General Ministry of Health.

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Dr. Mulwa A. M.
Ag. Director Of Medical Services/Preventive & Promotive Health

EXECUTIVE SUMMARY

In 2013, the Neonatal, Child and Adolescent Health Unit - NCAHU (then the Division of Child and Adolescent Health - DCAH) initiated the process of the development of a National Child Health Policy (CHP) later named the **Newborn, Child and Adolescent Health (NCAH)** Policy reflecting the expanded mandate of the Neonatal, Child and Adolescent Health Unit. The policy, launched in November 2018, provides a unified framework and response to planning, prioritization and implementation of newborn, child and adolescent health programs at national and county level. It is linked to the Sustainable Development Goals (SDGs), Kenya's commitment to Universal Health Coverage (UHC), and the Kenya RMNCAH Investment Framework under the GFF (Global Financing Facility) platform which provides direction on national newborn, child and adolescent health priorities, interventions, partnerships and investments. With the policy developed and adopted, the division of newborn and child health initiated the development of the **Newborn and Child Health Strategic Plan (2022-2026)**, a document that will provide strategic implementation direction for the policy, outlining priority programming themes, expected results, outputs, interventions, activities, costing, and provide an M&E framework to guide monitoring and evaluation of the policy and strategy.

This strategic plan is anchored in a number of international and Kenya policy, strategy and guidance documents including the Kenya Health Policy 2012 – 2030, Kenya Health Sector Strategic Plan 2018–2022, Kenya Primary Healthcare Strategic Framework 2019-2024, Roadmap, M&E Framework and Operational guidelines towards implementing Universal Health Coverage (UHC) in Kenya 2018–2022, Kenya Reproductive, Maternal, Newborn, Child and Adolescent (RMNCAH) Investment Framework 2016–2020 and Kenya Framework for Elimination of Mother-To-Child Transmission of HIV and Syphilis 2016-2021.

Learning from previously implemented and ongoing newborn and child health programs, the document maps out challenges and opportunities for achieving NCH outcomes through a situation and health system bottleneck analysis. The strategic plan emphasizes the critical role that the health sector is uniquely positioned to provide for children in the earlier years of their lives through enhanced Early Childhood Development and Nurturing Care programs.

While acute malnutrition (wasting or low weight-for-height) among children under 5 years is relatively low in Kenya (4 percent), there are regional variations with North-Eastern having almost 14 percent. This document outlines proven strategies to address that. And, to implementation of the plan, effects of communicable diseases including COVID-19 have been taken into consideration. In addition, critical social determinants of health of newborns and children in Kenya include water, sanitation and hygiene, education, wealth and other socio-economic factors have also been analyzed.

The document follows the guiding principles embedded in the NCAH Policy 2018 which are: Alignment with Global and National policies and strategies; Gender, equity, access, and respect for child health rights; Life cycle approach; Evidence-based interventions; Integration; Multisectoral approach and Centered on the health systems blocks. As such, health systems strengthening will be a key priority area in its implementation.

The strategic plan's vision, mission, goal and objectives are aligned first to the Kenya National Health policy and the Newborn, Child and Adolescent Health (NCAH) policy. It is a direct progression from the Child Survival and Development Strategy 2008-2015, which guided the previous decade's newborn and childhood programming. It takes as its model, the Global Strategy for Women's, Children's and Adolescents' Health 2016-2030 which is structured along the three principles of ***SURVIVE, THRIVE and TRANSFORM***.

With a strategic goal of **"accelerating efforts to reduce newborn and child mortality in Kenya and equitably promoting their health, development and wellbeing",** this plan takes as its framework four specific policy objectives translated into strategic interventions, with an expansion of the enabling environment objective into its many components which include several cross- cutting issues. The document highlights the most critical indicators that will be used to measure attainment of the strategic goal at the end of the five-year strategic period. The targets are aligned to the country's commitment to the attainment of national and SDG goals with a consideration of the historical annual rates of reductions.

The components of this plan are based on the three principles of ***Survive, Thrive and Transform***, but also organized according to the four objectives of the NCAH Policy which apply to newborns and children, with the fifth strategy covering objective six of the policy (creating an enabling environment for provision of quality newborn, child and adolescent health services, which covers the range of health systems and health sector strengthening and capacity building).

To support in the monitoring and evaluation of this document, a monitoring and evaluation framework outlining the indicators, baseline values, targets for the five-year period, sources of data and frequency of data collection form part of it. To the extent possible, the strategy envisions using existing reporting, monitoring and evaluation structures like the national DHIS 2. And finally, the strategic plan is costed for ease of actualizing its implementation.

Dr. Isaak Bashir
Head, Department of Family Health

1.0 INTRODUCTION

The Process to Date

In 2013, the Neonatal, Child and Adolescent Health Unit - NCAHU (then the Division of Child and Adolescent Health- DCAH) initiated the process of the development of a National Child Health Policy (CHP) later named the **Newborn, Child and Adolescent Health Policy (NCAHP)**, reflecting the expanded mandate of the Neonatal, Child and Adolescent Health Unit. The Policy, launched in November 2018, provides a unified framework and response to planning, prioritization and implementation of newborn, child and adolescent health programs at national and county level. It is linked to the Sustainable Development Goals (SDGs), Kenya's commitment to Universal Health Coverage (UHC), and the Kenya RMNCAH Investment Framework under the GFF (Global Financing Facility) platform which provides direction on national newborn, child and adolescent health priorities, interventions, partnerships and investments.

Newborn, child and adolescent health is a priority for the Republic of Kenya. The Kenya Health Policy and the Health Sector Investment Plan identify newborn and child health as a priority for the government. Although there have been improvements in key newborn and child health indicators over the past decade, much remains to be done to meet the SDG targets.

With the NCAHP developed and adopted, the unit initiated the development of the **NCAH Strategy (2022-2026),** a document that will provide strategic implementation direction for the national policy, outlining priority programming themes, expected results, outputs, interventions, activities, costing, and provide an M&E framework to guide monitoring and evaluation of the policy and strategy.

Since the formulation of the NCAH Policy, the units have now split, with the Adolescent Division separated. Thus, this strategy is now a Newborn and Child Health (NCH) Strategy only. It has been developed in a consultative process with stakeholders, donors as well as regional input, and has resulted in this document which will guide the activities of the program for the next five years.

2.0 GLOBAL OVERVIEW OF MATERNAL, NEWBORN AND CHILD HEALTH

Substantial global progress has been made in reducing child deaths since 1990. In 2019 an estimated 5.2 million children under 5 years, died mostly from preventable and treatable causes. Children aged 1 to 11 months accounted for 1.5 million of these deaths while children aged 1 to 4 years accounted for 1.3 million deaths. Newborns (under 28 days) accounted for the remaining 2.4 million deaths. An additional 500,000 older children (5 to 9 years) died in 2019.[1] This is a marked decline from the total of 12.6 million deaths in under-5's in 1990. Older children (5-9 years) had one of the largest declines in mortality since 1990 (61%), due to a decline in infectious diseases. Injuries (including road traffic injuries and drowning) are the leading causes of death among older children.[2]

Since 1990, the global under-5 mortality rate has dropped by 59%, from 93 deaths per 1,000 live births in 1990 to 39 in 2018.[3] Sub-Saharan Africa remains the region with the highest under-5 mortality rate in the world, with 1 child in 13 dying before his or her fifth birthday, 15 times higher than in high income countries.

The under-5 mortality rate in Eastern and Southern Africa has fallen from 185 per 1000 live births in 1980 to 57 in 2018., Two regions, Sub-Saharan Africa and Central and Southern Asia, account for more than 80 per cent of the 5.3 million under-five deaths in 2018, while they account for only 52 per cent of the global under-five population.[4] With an under-5 mortality rate of 41 per 1000 live births, Kenya ranked 22nd globally.[5] This compares favourably with the rates reported by Uganda (46), United Republic of Tanzania (53) and Ethiopia (55), while the rates in South Sudan (99) and Somalia (122) reflects those countries' underdevelopment and internal insecurities.[6]

The leading causes of death among children under five globally in 2019 were preterm birth complications, acute respiratory infections, intrapartum-related complications such as birth asphyxia, congenital anomalies, diarrhoea and malaria.[7] Neonatal deaths accounted for 47% of under-five deaths in 2018.[8] Each year over 2 million babies die during labour, childbirth or on the first day of life (1.3 million intrapartum stillbirths; 1 million newborn deaths in the first 24 hours). Another million newborns die before reaching the first week of life.[9] More than half of these early child deaths are preventable or can be treated with simple, affordable interventions including immunization, adequate nutrition, safe water and food and appropriate care by a trained health provider when needed:

- The proportion of the world's children who receive recommended vaccines has remained the same over the past few years. During 2018, about 86% of infants worldwide (116.3 million) received 3 doses of diphtheria-tetanus-pertussis (DTP3) vaccine, with 129 countries reaching at least 90% coverage of DTP3 vaccine, leaving , an estimated 19.4 million infants worldwide not reached with routine immunization services.[10]
- The Global Action Plan for Pneumonia and Diarrhoea (GAPPD) Monitoring Visualisation Tool (launched by WHO and UNICEF in November 2016) presents data on 24 key indicators related to the protection, prevention and treatment of diarrhoea and pneumonia in children under 5 years of age and two indicators on mortality due to the two diseases. See Annex 2 for a list of these indicators.
- Nutrition-related factors contribute to about 45% of deaths in children under-5 years of age.[11] Globally, at least

10 WHO; **Immunisation coverage**; accessed at https://www.who.int/news-room/fact-sheets/detail/immunization-coverage

11 WHO; (Sept 19, 2019). **Children Reducing Mortality,** Accessed at https://www.who.int/news-room/fact-sheets/detail/children-reducing-mortality

1 in 3 children under 5 is not growing well due to malnutrition in its more visible forms: stunting, wasting and overweight, while at least 1 in 2 children under 5 suffers from hidden hunger due to deficiencies in vitamins and other essential nutrients.

- Globally, only 2 in 5 infants under six months of age are exclusively breastfed, as recommended, while sales of milk-based formula continue to grow. UNICEF estimated that in East and Southern Africa in 2018 the prevalence of children under 5 who are not growing well (stunted, wasted or overweight) was 42.1%, with 33.6% stunted (as compared to the global prevalence of 21.9%) and 6.2% wasted.[12] Data from Kenya in the 2013-2018 period reported a prevalence of moderate or severe stunting in all children to be 26%, ranging from 14% in the richest cohort to 36% in the poorest, with a 1% prevalence of severe wasting and 4% moderate wasting.[13]

The Sustainable Development Goals (SDGs) adopted by the United Nations in 2015 were developed to promote healthy lives and well-being for all children. The SDG Goal 3 is to end preventable deaths of newborns and under-5 children by 2030. There are two targets:

- Reduce newborn mortality to at least as low as 12 per 1,000 live births in every country (SDG 3.2); and
- Reduce under-five mortality to at least as low as 25 per 1,000 live births in every country (SDG 3.2).

These have been translated into the new "Global Strategy for Women's, Children's and Adolescent's Health", which calls for ending preventable child deaths while addressing emerging child health priorities. Meeting the SDG target would reduce the number of under-5 deaths by 10 million between 2017 and 2030. Focused efforts are still needed in Sub-Saharan Africa and South East Asia to prevent 80 per cent of these deaths.[14]

Congenital anomalies, injuries, and non-communicable diseases (chronic respiratory diseases, acquired heart diseases, childhood cancers, diabetes, and obesity) are the emerging priorities in the global child health agenda. Congenital anomalies affect an estimated 1 in 33 infants, resulting in 3.2 million children with disabilities related to birth defects every year. The global disease burden due to non-communicable diseases affecting children in childhood and later in life is rapidly increasing, even though many of the risk factors can be prevented.[15]

Similarly, the worldwide number of overweight children increased from an estimated 31 million in 2000 to 42 million in 2015, including in countries with a high prevalence of childhood undernutrition.[16]

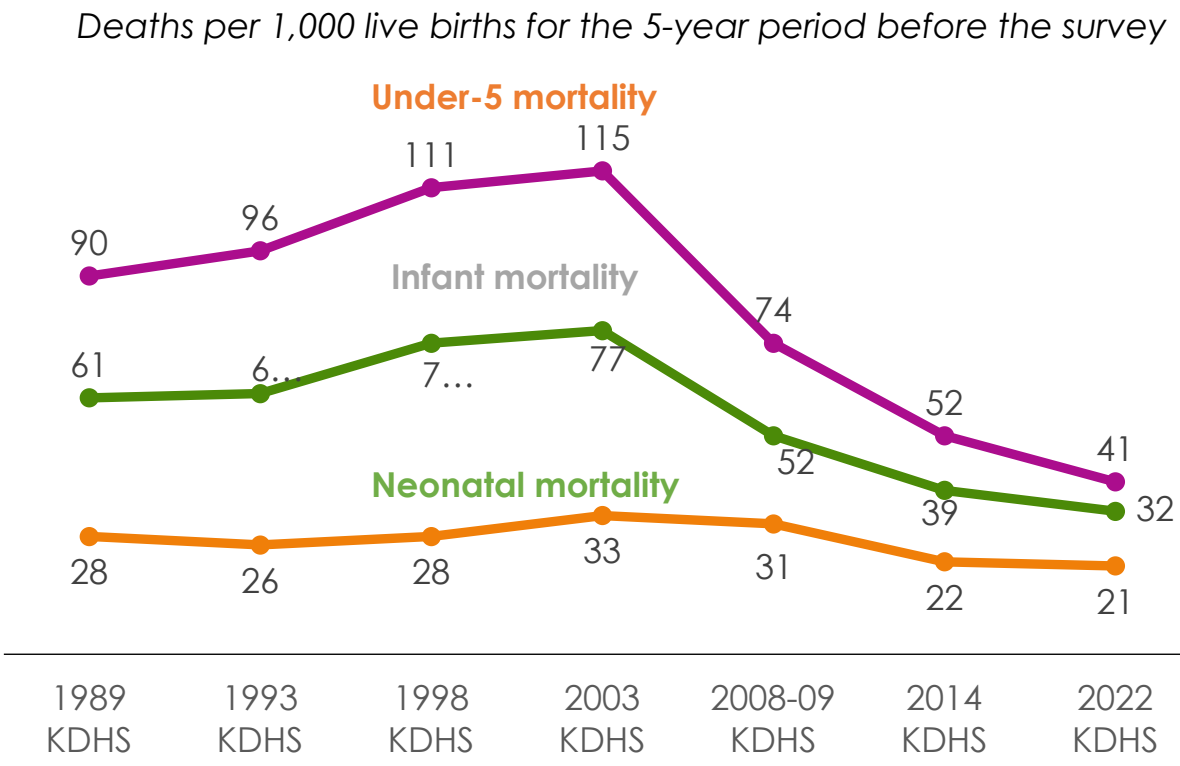
12 UNICEF. (2019). **State of the world's children 2019 - Children, food and nutrition: Growing well in a changing world;** UNICEF
13 ibid
14 WHO. (Sept 19, 2019). **Children Reducing Mortality.** Accessed at https://www.who.int/news-room/fact-sheets/detail/children-reducing-mortality
15 ibid
16 ibid

3.0 SITUATION ANALYSIS

KENYAN MATERNAL, NEWBORN AND CHILD HEALTH DATA, INCLUDING REGIONAL AND SUB-REGIONAL VARIATIONS, ISSUES AND OTHER LOCAL FACTORS

Despite not reaching her MDG child health targets, Kenya has made significant improvements in newborn and child health. The Kenya Demographic Health Survey (KDHS 2022) shows that since 2003, Kenya decreased its under-five mortality rate from 114 to 52 deaths per 1,000 live births, and decreased infant mortality rate from 77 to 39 deaths per 1,000 live births.[17] This has reduced further in the past seven years (see figure1). The neonatal mortality rate has decreased at a slower rate, and currently stands at 20 deaths per 1,000 live births. The SDG target is a reduction in the neonatal mortality rate to 12 per 1,000 live births by 2030. A total of 51,000 infant deaths were reported in 2017 representing a decrease from 64,000 in 1990. The under-5 deaths decreased from 110,000 in 1990 to 69,000 in 2017.

Figure 1: Trends in Child Mortality – Kenya 1989-2022



*Data from 2003 and later are nationally representative while data collected before 2003 exclude North Eastern region and several northern districts in the Eastern and Rift Valley regions.

Source: KDHS 2022

17 Kenya National Bureau of Statistics (2015); **Kenya Demographic and Health Survey 2022;** accessed at https://dhsprogram.com/publications/ publication-fr308-dhs-final-reports.cfm

These decreases are a result of critical high impact interventions and improvements to quality of care, including increased antenatal care (ANC) and postnatal care (PNC), exclusive breastfeeding practices and improved nutritional status of children, elimination of user fees for primary health care including immunization, scale up on the uptake of recommended child health commodities like oral rehydration salts (ORS) and zinc for the management of diarrhoea, use of amoxicillin DT for the treatment of non-severe pneumonia, accelerated introduction of new life saving vaccines and other socioeconomic factors such as access to clean water and education.

Shortly after independence, one in every seven Kenyan children born alive, died before the age of five, 49 years later, mortality has declined significantly, but remains high, with one in every 19 children not reaching their fifth birthday. The progress towards improving child survival has been uneven, with high rates of reduction in some areas and slow progress in others. Inequalities continue to persist with substantial gaps between the best and worst performing counties.[18]

This strategic plan will highlight the high impact interventions necessary to address the leading causes of morbidity and mortality among newborns and children in Kenya, as presented in the NCAH policy 2018.[19]

3.1 Newborn Health

In 2022, newborn deaths in Kenya accounted for approximately 51% of all under-5 deaths, with intra birth complications at 32%, prematurity at 25% and sepsis at 16% as the leading causes of neonatal mortality. While under-five mortality has decreased by over 50% since 2003, Kenya's neonatal mortality has decreased at a far slower rate, from 33 deaths per 1,000 live births in 2003 to 21 deaths per 1,000 live births in 2022[20].

A recent review of over 90,000 paediatric admissions in 2018-2020 in fourteen Kenyan public hospitals found that neonates (aged 0–28 days) accounted for almost half the admissions but two-thirds of the deaths. Neonatal fatality rate in newborn units (NBUs) were high and variable across hospitals and birth weight categories. But lack of standardized diagnostic criteria and procedures made meaningful comparisons of neonatal morbidity and mortality difficult across the different hospitals.[21]

Kenya developed a three-year Maternal, Newborn Health Scale-up Strategy (2015-2018), which aimed to tackle the three leading causes of death in newborns. Addressing birth asphyxia, prematurity, and neonatal sepsis could avert over 80% of newborn deaths.

Key factors contributing to newborn health outcomes include the following:

- **Access to quality maternal and newborn health services:**
  Increases in the uptake of ANC and PNC services, skilled birth attendants, increase in health facility births, exclusive breastfeeding practices and initiatives such as the Linda Mama Program have all contributed to the

18 Macharia, P.M., Giorgi, E., Thuranira, P.N. et al. **Sub national variation and inequalities in under-five mortality in Kenya since 1965.** BMC Public Health 19, 146 (2019). https://doi.org/10.1186/s12889-019-6474-1

19 Ministry of Health (2018); **Newborn, Child and Adolescent Health (NCAH) Policy 2018.**

20 **KIR KDHS 2022**

21 Irimu G, Aluvaala J, Malla L , et al; **Neonatal mortality in Kenyan hospitals: a multisite, retrospective, cohort study;** BMJ Global Health 2021;6:e004475. Accessed at https://gh.bmj.com/content/6/5/e004475

improvements in newborn health. However, geographical access to facilities remains a challenge, particularly in the Arid and Semi-Arid Lands (ASAL) regions.

The Kenya Harmonised Health Facility Assessment 2018 (KHFA)[22] noted that 81% of facilities in the country were offering antenatal care services (although only 4% of the facilities had all of the tracer items available). Half the facilities offered delivery services, but only 25% of the hospitals could offer comprehensive emergency obstetric and neonatal care (CEmONC). The mean availability of essential medicines for mothers nationally was 40%. Facilities in urban settings had a higher mean (45%) compared to those in rural setting (38%).

An objective of both neonatal and maternal strategies should be the greater integration at the county level of the two services, especially in the peripartum period. All facilities offering basic obstetric care should be providing the recommended essential package of care for mother and baby at the time of birth (e.g. resuscitation, thermal care, immediate breast feeding, cord care), but assessments show that only 3% of facilities are equipped to deal with emergency obstetric and newborn care (EmONC) and referral systems remain inadequate.

Even with the elimination of user fees for maternity and primary health care, financial constraints affecting transport, and payment for certain drugs and commodities still negatively affect women and children's access to care.

There are global recommendations on adequate space for delivery and neonatal facilities, that babies should not share incubators/cots, that mothers of sick newborns have beds and do not sleep on the floor or share beds with mothers on post-natal wards, that mothers can wash/bathe, and that they can visit at any time, all of which should be present for a facility to be classified as "equipped as per norms".

- **Access to quality services for sick newborns:**

  It is estimated that only 25% of sick newborns are cared for in a facility able to provide a basic minimum package of services.[23] The KHFA noted 93% of facilities offered outpatient services for low birth weight (LBW) and sick newborns. But for those who offer in-service care for LBW and sick newborns, only 29% had a bed for caregiver providing KMC.[24]

  Even in facilities that are equipped to deal with neonatal health issues, bed occupancy is often above recommended norms (with babies sharing incubators / cots), nurse-to- baby ratios are often very high (typically 1 nurse to 12 to 15 sick babies and even higher ratios on night shifts) and much of the needed nursing care such as feeding, comforting and maintaining hygiene is not done because staff are overburdened and on occasions work may be poorly organised. Private hospitals capable of providing high quality care are unaffordable to the vast majority of the population and low cost, small private facilities often provide care of poorer quality than the public sector.

22 Kenya Ministry of Health (2019). **Kenya Harmonised Health Facility Assessment (KHFA) 2018/2019 Main Report**

23 Kenya Paediatric Association, KEMRI, Wellcome Trust, Min. Health (2018); **Draft Report of a Workshop on Improving Inpatient Neonatal Care Services 15th & 16th February 2018, Nairobi, Kenya.**

24 Kenya Ministry of Health (2019). **Kenya Harmonised Health Facility Assessment (KHFA) 2018/2019 MAIN REPORT**

- **Lack of appropriately skilled staff:**

  More women are accessing ANC services and giving birth in health facilities (62%).[25] However, continuing staff shortages and an inadequate workforce in the health sector in general (occasioned by high turnover, poor motivation and remuneration, and lack of resources for capacity building) has been deeply felt in obstetric and neonatal units, with gaps in available appropriately trained staff who can provide quality newborn health services including Emergency Obstetric and Newborn Care (EmONC), and Early Essential Newborn Care (EENC).

  A cross sectional study in Kenya demonstrated that private sector facilities had a median ratio of babies to nurses of 3, with a maximum of 7 babies per nurse, while in the public sector, the median ratio was 19 babies and a maximum exceeding 25 babies per nurse. On analysis, ratios of 12 or more babies per nurse were associated with significant reductions in several indicators of quality of care compared with ratios of 3 or fewer babies per nurse.[26]

  There are discussions on relieving the pressure on obstetric and neonatal nursing staff through task-shifting or even the creation of a new cadre of Newborn Health Care Assistant (NHCA).[27] Such a cadre would be under the supervision of a qualified nurse and the tasks that might be undertaken in the delivery room would be restricted and supervised, but NHCAs might also provide useful inputs to basic care for babies who are less severely ill especially as they approach discharge when they may usefully support the professional staff in helping the family prepare for the baby's transition to care at home and in basic health promotion for baby and mother.[28]

  But it is also recognised that the number of staff, both professional nurses and lower-level clerical and support staff, need to be increased, and their roles better defined. A recent survey revealed that of the the 305 practising paediatricians in the country, only 94 are in public sector, non-tertiary county hospitals. There is either no paediatrician at all or only one paediatrician in 21/47 Kenyan counties that are home to over a quarter of a million under 19 years of age.[29]

- **Availability to essential MNH commodities, supplies and equipment:**

  Many MNH commodities, supplies and equipment are unavailable at dispensaries and health centres (levels 2 and 3) or restricted to specialist use at higher levels of care. While the Kenya Service Provision Assessment (KSPA 2010) showed that only 25% of facilities had adequate stocks of ANC supplies, and this varied across the levels of care[30], the mean availability of tracer items for ANC in the KHFA 2018 had risen to 61%, but only 4% of the facilities had all the tracer items available.[31]

25 Kenya National Bureau of Statistics. (2015); **Kenya Demographic and Health Survey 2014**; accessed at https://dhsprogram.com/publications/ publication-fr308-dhs-final-reports.cfm

26 Gathara D, Serem G, Murphy GAV, Obengo A, Tallam E, Jackson D, Brownie S, English M. (2019). **Missed nursing care in newborn units: a cross-sectional direct observational study;** BMJ Qual Saf 2019;0:1–12. doi:10.1136/bmjqs-2019-009363

27 Kenya Paediatric Association; **Draft Report Follow Up Workshop on the possible scope of work and training needs for a Neonatal Health Care Assistant to support nurses in providing improved inpatient neonatal care; 5th April 2018, Nairobi, Kenya**

28 ibid

29 English M, Strachan B, Esamai F, et al; **The paediatrician workforce and its role in addressing neonatal, child and adolescent healthcare in Kenya; Archives of Disease in Childhood 2020;105:927-931;** accessed at https://adc.bmj.com/content/105/10/927

30 Kenya **- Kenya Service Availability and Readiness Assessment Mapping (SARAM) report, 2013.** http://apps.who.int/healthinfo/systems/datacatalog/index.php/catalog/4

31 Kenya Ministry of Health (2019). **Kenya Harmonised Health Facility Assessment (KHFA) 2018/2019 Main Report**

3.2 Child Health

Since 2000, acceleration in the reduction of under-five mortality has resulted globally in an additional 18 million more children surviving to their 5th birthday.[32] While the KDHS 2022 shows that both infant mortality and under-5 mortality have steadily decreased, there has only been minimal improvement of other key indicators for child health including the percentage of children who have been fully vaccinated (80%), and stunting (18%). The KDHS 2022 did show that exclusive breastfeeding for 6 months had decreased by 1% point from 61% in 2014 to 60% in 2022. Additionally, combined uptake of ORS & Zinc for the management of diarrhoea increased from 8% in 2014 to 32% in 2022. The leading causes of child morbidity and mortality are familiar and are: Pneumonia (16%), diarrhoea (11%), malaria (4%), HIV (4%), and other non-communicable diseases (26%).[33, 34]

Inequities in health outcomes in Kenya for both children and adults are inextricably tied to wealth. A recent review[35] found significant inequality and inequity in the use of all types of care services in Kenya favouring richer population groups, with particularly pronounced levels for preventive and inpatient care services. These are driven primarily by differences in living standards and educational achievement, while the region of residence is a key driver for inequality in preventive care use only.

The main driving factors of socio-economic inequality in health care use in Kenya are total household expenditure, educational achievement, household characteristics and living standards, all disproportionately distributed in favour of richer individuals and better off households.

Key factors contributing to child health outcomes include the following:

- **Access to appropriate treatment for common childhood illnesses:**
  Kenya has put in place systems that support the delivery of evidence-based, high impact interventions including: low-cost life-saving antibiotic treatment (specifically Amoxicillin-DT) for pneumonia; combined uptake of ORS and Zinc for the management of diarrheoa, immunization against vaccine preventable diseases including pneumonia and measles; long lasting insecticide nets (LLINs) and artemisinin-based combination treatment (ACT) for malaria; exclusive breastfeeding and young infant feeding support and counselling; Vitamin A supplementation for children; interventions for those with special needs and disabilities; stimulation for optimal development through play and communication activities. Optimal realization of child health outcomes have been hampered by issues related to variances on coverage, equity, and quality of care across the country, as well as the chronic problem of an insufficient and inadequately trained workforce.

  The KHFA 2018 showed that the national average percentage of facilities offering immunization services is 71%, but only 3% of facilities had all of the essential tracer elements. Similarly, while 89% of the health facilities sampled

32 WHO; **Levels and trends in child mortality 2015;** http://www.who.int/maternal_child_adolescent/documents/levels_trends_child_ mortality_2015/en/

33 Kenya National Bureau of Statistics; **Kenya Demographic and Health Survey 2014;** accessed at https://dhsprogram.com/publications/ publication-fr308-dhs-final-reports.cfm

34 Kenya National Bureau of Statistics; **Kenya Demographic and Health Survey 2023;** accessed at https://dhsprogram.com/publications/ publication-fr308-dhs-final-reports.cfm

35 Ilinca S, Di Giorgio L, Salari P, Chuma J; **Socio-economic inequality and inequity in use of health care services in Kenya: evidence from the fourth Kenya household health expenditure and utilization survey;** International Journal for Equity in Health; Vol18: 196 (2019) accessed at https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-019-1106-z

nationally offered preventive and curative care for under 5 years old children, the mean availability of all tracer items was 68% with only 2% of the facilities nationally having all the tracer items needed for child preventive and curative care services. The mean availability of essential medicines for children nationally was only 56%.[36]

- **National policies, strategies, and guidelines on child health:**
  All the above interventions have been anchored on national policy frameworks such as the Child Survival and Development Strategy (CSDS 2008-2015) whose objective was to accelerate progress towards achievement of the MDGs on child health. Implementation of critical child health platforms such as Integrated Management of Newborn Childhood Illness (IMNCI), Emergency, Triage, Assessment and Treatment plus (ETAT+), the Kenya Action Plan for Pneumonia and Diarrhoea (KAPPD) and the Integrated Community Case Management (iCCM) programs, and national flagship programs such as Malezi Bora all contributed to these achievements in child health.

- **Elimination of user-fees for primary health care services:**
  Universal Health Coverage (UHC) is a key tenet within the KHSSP, and elimination of user fees for primary health care and maternity services is a great step towards achieving this milestone. Additional social protections, such as the NHIF increase access to essential services and unblock bottlenecks connected to access and availability of services.

- **The impact of violence against children:**
  The various forms of violence and abuse against children, including violent discipline, witnessing domestic violence at home, and violence against women (especially pregnant and lactating women) are key factors affecting the health and development of children.

- **Lack of data on 5-9 age group:**
  While data exists for newborn and infant health cohorts, information on the health status on the 5-9 age cohort is often not collected, or collapsed into other age cohorts. This is a critical data gap which affects formulation of policy guidance and programming that should address the needs of this age cohort.

3.3 Early Childhood Development and Nurturing Care

The Early childhood years are critical for human development. The time from pregnancy to age three marks the period of most rapid brain development, with marked neural pathway connections development. This period lays the foundation for health, well-being, learning and productivity throughout a person's whole life, and has an impact on the health and well-being of the next generation. After this period, delays in physical growth, cognitive and executive functions, and social and emotional connectivity are often irreversible. Enabling young children to achieve their full developmental potential is a human right and a critical requisite for sustainable development. Nevertheless, traditional Early Childhood Development (ECD) services tend to provide preschool interventions targeting older children (3–5 years) which misses the critical window of opportunity in child development. In these earliest years, the health sector is uniquely positioned to provide support for early childhood development.

Globally, of the recently published Nurturing Care Framework the Nurturing Care Framework (NCF) was

36 WHO, UNICEF, World Bank Group. (2018). **Nurturing care for early childhood development: a framework for helping children survive and thrive to transform health and human potential.** Geneva: World Health Organization;

launched at the World Health Assembly in May 2018, (Kenya is a signatory). Subsequently, Kenya adopted the NCF and regional launch of this strategy was conducted the same year. The NCF[37] which draws on state-of-the-art evidence on how early childhood development unfolds to set out the most effective policies and services that will help parents and caregivers provide nurturing care for babies. The framework is designed to serve as a roadmap for action, helping mobilise a coalition of parents and caregivers, national governments, civil society groups, academics, the United Nations, the private sector, educational institutions and service providers to ensure that every baby gets the best start in life. The Framework builds on the foundation of universal health coverage, with primary care at its core, as essential for all sustainable growth and development. The 2022 KDHS included The DHS Program's disability module, a series of questions based on the Washington Group on Disability Statistics (WG) questions, which in turn are based on the framework of the World Health Organization's International Classification of Functioning, Disability, and Health. The questions address six core functional domains (seeing, hearing, communication, cognition, walking, and self-care) which provide basic necessary information on disability. This information is comparable to that collected worldwide via the WG disability tools. Functional domains Seeing, hearing, communicating, remembering or concentrating, walking or climbing steps, and washing all over or dressing.

As per the sampling, it only included household population age 5 or above. Consequently, the data for children aged below 5 years were not captured hence leaving a gap. Similarly, the key findings don't give percentage for children 5 – 8 years rather they are only captured as females or males.

Children are considered to be developmentally on track if they have achieved the minimum number of milestones expected for their age group. Each of the three general domains is composed of a set of core subdomains: Health subdomains: gross motor development, fine motor development, and self-care. Learning subdomains: expressive language, literacy, numeracy, pre-writing, and executive functioning. Psychosocial well-being subdomains: emotional skills, social skills, internalizing behavior, and externalizing behavior.

Early childhood development is a multidimensional process that involves an ordered progression of motor, cognitive, language, socioemotional, and regulatory skills and capacities across the first few years of life (UNICEF 2016). While these are distinct domains of early childhood development, they are interconnected.

On the Early Childhood Development Index 2030 (ECDI2030) module, which captures the achievement of key developmental milestones by children between age 24 months and age 59 months, was included in the 2022 KDHS. It focused on the way children behave in certain everyday situations and the skills and knowledge they have acquired, reflecting the increasing difficulty of the skills children acquire as they grow, organized according to the three general domains of health, learning, and psychosocial well-being.

As per the 2022 KDHS findings on developmental growth among children age 24–59 months:

- Seventy eight percent (78%) of children are developmentally on track in health, learning, and psychosocial well-being.

37 **Kenya National Bureau of Statistics (2015). Kenya Demographic and Health Survey 2014**; accessed at *https://dhsprogram.com/publications/publi cation-fr308-dhs-final-reports.cfm*

- The percentage of children who are developmentally on track decreases with age; 83% of children age 24–35 months are developmentally on track, as compared with 74% of children age 48–59 months.
- A higher percentage of children in urban (87%) than rural (73%) areas are developmentally on track.

3.4 Nutrition

Kenya continues to face severe food insecurity with 3.4 million people in 2017 suffering from acute food insecurity.[38]

The prevalence of stunting nationally has fallen from 26 percent in 2014 to 18 percent in 2022[39], and is highest in the Coast, Eastern, and Rift Valley regions with the most prevalence among children 18–23 months, indicating that poor

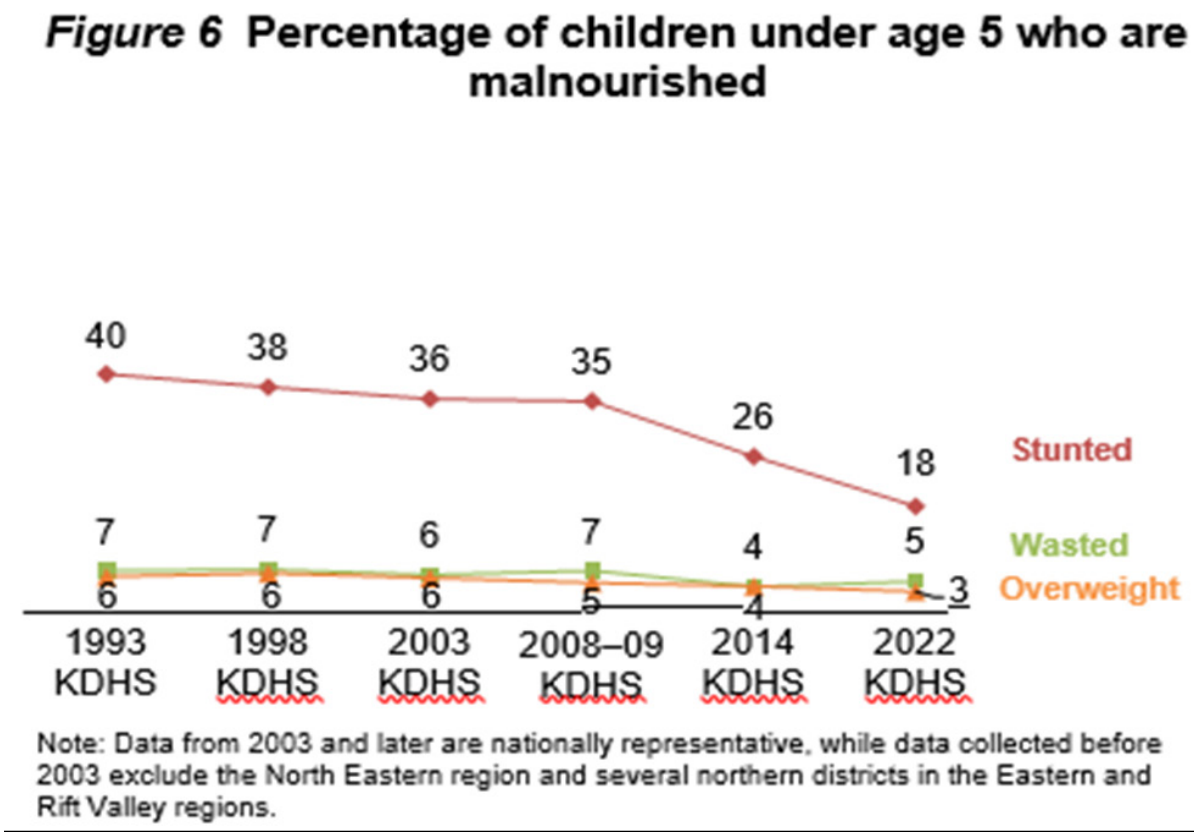
complementary feeding and hygiene and sanitation practices are likely contributors to stunting in that age group. Children under age 5 should have anthropometric measurements used to measure nutritional status. Anthropometric measurements are used to report on child growth indicators. Three indices—height-for-age (stunting), weight-for-height (wasting), and weight-for-age (underweight)—can be expressed in standard deviation units (z scores) from the median of the reference population. Values that are greater than two standard deviations below the median of the WHO Child Growth Standards are used to define malnutrition. Nutrition is one of the critical sectors key to the Early Childhood Development (ECD) Policy important to the survival and thriving of young children.

Data from the Kenya Demographic and Health Survey (KDHS), 2022 on a sampled 20,319 children under age 5 (unweighted), shows that 18% of children under age 5 are stunted, or too short for their age. This is a sign of chronic undernutrition. Five percent of children under age 5 are wasted (too thin for their height), which is a sign of acute undernutrition, while 3% of children under age 5 are overweight, which is a sign of overnutrition. Ten percent of children are underweight, or too thin for their age.

The prevalence of stunting has decreased markedly since 1993, with the greatest decrease between 2008–09 (35%) and 2022 (18%). Over this same time period, changes in the prevalence of wasting and overweight have been small, although the prevalence of each is at its lowest point since 1993 (Figure 2 – Below)

38 **USAID ibid**
39 **KDHS 2022**

Figure 2: Percentage of children under age 5 who are malnourished



- Stunting is higher among children in rural areas (20%) than children in urban areas (12%)
- Stunting decreases with increasing wealth, from 28% in the lowest quintile to 9% in the highest quintile.
- Twenty-two percent of children born to mothers with no education are stunted, as compared with 9% of children born to mothers with more than a secondary education.
- There are wide variations in stunting across counties. The highest percentages are in Kilifi, West Pokot, and Samburu (37%, 34%, and 31%, respectively) and the lowest in Kisumu and Garissa (9% each).

It is estimated that from 2010–2030 undernutrition will cost Kenya approximately US$38.3 billion in GDP due to losses in workforce productivity[40]. While acute malnutrition (wasting or low weight-for-height) among children under 5 years is relatively low nationally (4 percent)[41], it reaches almost 14 percent in Northeastern region. Children of mothers who did not complete primary school or who have no education are more likely to be stunted (34 percent and 31 percent respectively) than children of mothers with a secondary or higher education (17 percent). Fourteen percent of children in the highest wealth quintile are stunted, compared to 36 percent of children in the lowest wealth quintile.

Vitamin D deficiency, resulting in rickets, also shows wide regional variation. A survey of paediatric hospital admissions in three regions demonstrated a prevalence of rickets in Nairobi of 4.01%, with Central Region at 0.92%, but only one case out of 9756 admissions was diagnosed in the Western Region. General malnutrition

40 USAID (2017); Country Profile: Kenya; 2017; Available at: http://www.feedthefuture.gov/country/kenya

41 UNICEF; **Situation Analysis of Children and Women in Kenya 2017;** UNICEF, 2018, Nairobi, Kenya.

was associated with rickets, but this association also varied regionally[42].

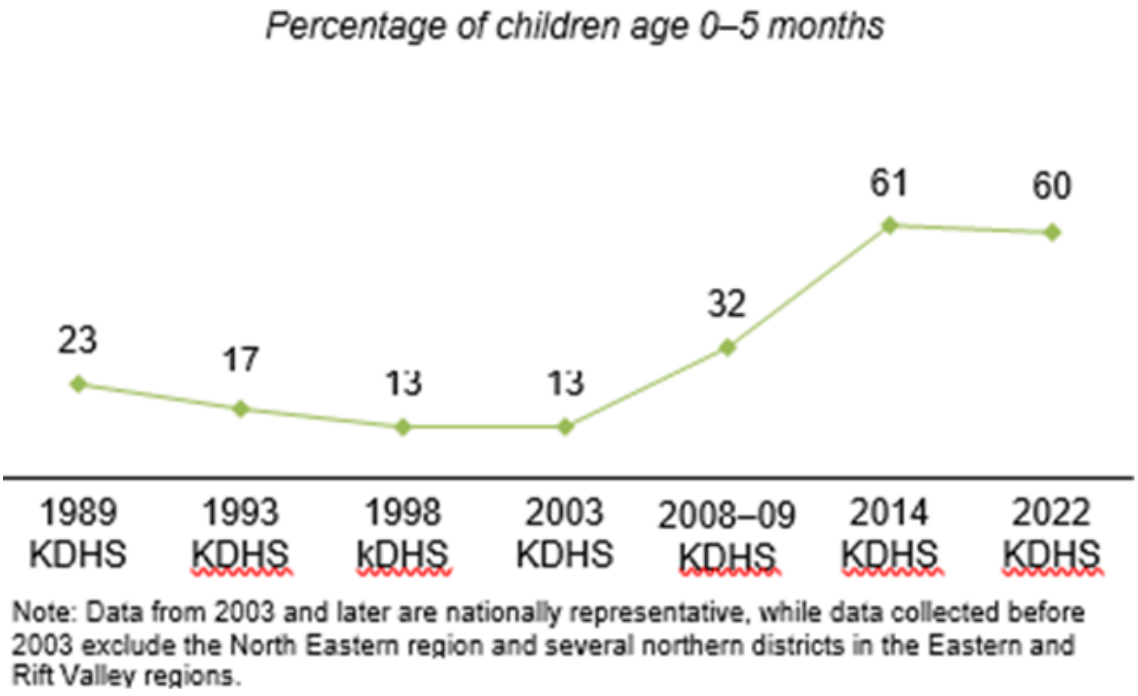
UNICEF's State of the World's Children Report 2019 states that only 11% of newborns in Kenya are underweight but also notes that one-third (34%) of newborns are not weighed45. Inadequate infant and young child feeding practices contribute to high rates of malnutrition in the country. Exclusive breastfeeding practices have increased dramatically, from 32 percent in 2008 to 61 percent in 2014, but only 42 percent of infants 4–5 months of age are still exclusively breastfed and only 62 percent of mothers initiate breastfeeding within an hour of birth.

Optimal infant and young child feeding (IYCF) practices are critical to the health and survival of young children. Recommended IYCF practices include early initiation of breastfeeding (within the first hour of life), exclusively breastfeeding for the first 6 months of life, and feeding children a diet that meets a minimum diversity standard (WHO and UNICEF 2021).

Early initiation of breastfeeding also encourages bonding between the mother and her newborn, especially through skin-to-skin contact, which facilitates the production of breast milk. In the first 6 months, children should be exclusively breastfed, meaning that they should be given nothing but breast milk. Exclusive breastfeeding for 6 months lowers the risk of infections that can lead to diarrhea and respiratory illnesses and provides all of the nutrients and liquid an infant requires for optimal growth and development (WHO and UNICEF 2021).

There has been a substantial increase in exclusive breastfeeding since 2003 (from 13% to 60%) following a decline between 1989 and 2003. Exclusive breastfeeding is essentially unchanged between 2014 and 2022 (Figure 3 – below)

Figure 3: Trends in exclusive breastfeeding



42 Karuri SW, Murithi MK, Irimu G et al. Using data from a multi-hospital clinical network to explore prevalence of pediatric rickets in Kenya; Wellcome Open Res 2017, 2:64 accessed at https://doi.org/10.12688/wellcomeopenres.12038.2

In addition, complementary feeding practices are poor, as only 22 percent of breastfed children 6–23 months received a minimum acceptable diet. Vitamin A deficiency is relatively low at 9 percent in children under 5 years, but only 35 percent of children 6–23 months consumed vitamin A-rich foods and 16 percent consumed iron-rich foods in the past day. Maternal and child anemia are widely prevalent, with 36 percent of children under 5 years and 42 percent of pregnant women suffering from anemia.[43]

The high prevalence of adolescent pregnancy has serious consequences because, relative to older mothers, adolescent girls are more likely to be malnourished and have a low birth weight baby who is more likely to become malnourished, and be at increased risk of illness and death than those born to older mothers. The risk of stunting is 33 percent higher among first-born children of girls under 18 years in Sub-Saharan Africa, and as such, early motherhood is a key driver of malnutrition.[44]

3.5 Communicable diseases

3.5.1 HIV and AIDS

Of the estimated 52,800 new HIV infections in Kenya in 2018, 8,000 were in children under 14, which is a 41% decline from the 13,500 new infections in children in 2010.[45] These 8,000 new infections constituted about 15% of all total new HIV infections in Kenya, and more than half of them (51%) occurred in eight high prevalence counties.[46] In comparison, the Kenya Population-Based HIV Assessment Survey (KENPHIA) in 2019 estimated 36,000 new HIV infections per year in adults, but did not estimate the number of new cases in children under 14.[47]

Approximately 69,500 HIV positive pregnant women required PMTCT services in 2017 compared to 73,800 in 2010.[48] Of these, about 53,236 received PMTCT services, making the PMTCT coverage about 77%. The 2019 KENPHIA reported that among women aged 15-49 years who delivered within the three years preceding the survey, 97.3% had attended at least one ANC visit for their most recent birth.[49] However, the target of 90% ANC attendance was not achieved in five counties (Mandera, Wajir, Garissa, Samburu, and Marsabit). There has been a significant decline in EMTCT rate (final transmission rate including breastfeeding) from about 29.7% in 2005 to 11.5% in 2017. As a result of the scale up of this program since 2004, about 132,300 child HIV infections have been averted through 2017.

Of the approximately 1.5 million people living with HIV in Kenya in 2017, 105, 200 (7%) were among children 0-14 years of age, of whom 50% were from seven counties and 84% (86,300) HIV-positive children were on ART. According to the KDHS 2022 key indicator report, a greater percentage of women (85%) than men (73%) have ever been tested for HIV and an average numbers of sexual partners are 2.3 among women and 7.4 among men[50].

43 Reported in the DHS as well as National Malaria Control Programme (NMCP) Kenya, Kenya National Bureau of Statistics (KNBS) and ICF International. Ministry of Health; National Malaria Control Program (2016). **Kenya Malaria Indicator Survey 2015.**

44 Fink, G., Sudfeld, C.R., Danaei, G., Ezzati, M., and Fawzi, W.W. (2014). **Scaling-Up Access to Family Planning May Improve Linear Growth and Child Development in Low and Middle-Income Countries;** PLoS ONE 9(7): e102391. Doi: 10.1371/journal.pone.0102391, cited in USAID; Kenya Nutrition Profile.

45 Unless otherwise noted, all the data in this section is from: Kenya MoH, NACC. (October 2018). Kenya HIV Estimates Report 2018

46 Homa Bay (700), Nairobi (660), Siaya (620), Kisumu (616), Kakamega (437), Migori (432), Nakuru (325), and Busia (318)

47 Kenya Ministry of Health, National AIDS and STI Control Programme (NASCOP), **Preliminary KENPHIA 2018 Report.** Nairobi: NASCOP; 2020.

48 The decrease in the number of HIV+ pregnant women is likely to be a function of several factors; reduced transmission (incidence) in young women leading to an aging of the HIV-infected population into lower-fertility age groups and perhaps increased knowledge of status leading to better fertility choices

49 Kenya Ministry of Health, National AIDS and STI Control Programme (NASCOP), **Preliminary KENPHIA 2018 Report.** Nairobi: NASCOP; 2020.

50 Kenya National Bureau of Statistics (KNBS)2022. **Kenya Demographic and Health Survey, key indicator report 2022**

In 2016, Kenya adopted "Test and Treat" a strategy under which those diagnosed with HIV start antiretroviral therapy (ART) as soon as possible towards epidemic control on the UNAIDS 90-90-90 targets. The KENPHIA 2019 survey estimated the HIV prevalence among children to be 0.7%, which translates to approximately 139,000 children living with HIV in Kenya, with no difference between girls and boys: HIV prevalence was 0.7% among girls and 0.8% among boys. HIV prevalence among children was between 0.4% among children aged 0-4 years,0.8% among children aged 5-9 years, and 1.1% among young adolescents aged 10-14 years. Among HIV-positive children (ages 0-14 years), 78.9% had a known HIV-positive status, based on parent-guardian report and the detection of ARVs in blood. Those on ART were 93.2% of those who were known to be HIV positive based upon parent-guardian report and detectable ARVs in blood. The prevalence of viral load suppression (VLS) in children (0-14years) was 48.3% with no significant difference observed between boys and girls, with boys at 43.8 and girls at 53.5%[51].

Deaths in children under the age of 15 from AIDS-related causes were estimated at 4,300 in 2017, a marked reduction from the 10,200 deaths recorded in 2010. Again, more than half (56%) of these deaths occurred in nine high prevalence counties.[52]

The number of total orphans is estimated to have slightly declined from 2.3 million children in 2010 to 2.0 million orphans in 2017. The number of all AIDS orphans also declined from 998,000 children in 2010 to 581,400 in 2017.

The Kenya Health Facility Assessment (KHFA) 2018 found that six in ten facilities in Kenya offer any paediatric HIV services or referral of children to HIV care and treatment services elsewhere. Nearly one-third of the facilities in Kenya that offer paediatric HIV services or referrals are ready to provide paediatric HIV services, while but only 3% of health facilities have all paediatric HIV tracer items.[53]

3.5.2 Tuberculosis (TB)

According to the Division of National Tuberculosis, Leprosy and Lung Disease program (DNTLDP) Annual Report 2021, Kenya continues to make progress towards achieving end TB targets of elimination of Tuberculosis, reduction of mortality and catastrophic costs to patient who fall ill due to the epidemic. The efforts saw the country surpass the 2020 milestones for the global targets; 32% Percentage Tuberculosis incidence rate reduction, against a target of 20%; and 38% Percentage mortality rate reduction, against a target of 35%. In spite of these achievements, the country still faces high burden of Tuberculosis, HIV and TB/HIV[54].

In 2021, a total of 7,491 childhood TB cases were notified to the National TB Program. This achievement represented 9.6% of all notified cases against the 10 – 15% national target. This rate was a massive improvement compared to 2020, as the Country witnessed a 32.2% increase[55].The increase can be attributed to a drop in COVID-19 cases and the normalization of services in the health facilities. However, the over 40% missed cases among all forms indicates a detection gap in pediatric TB. The reasons for this gap included challenges with specimen collection and bacteriological confirmation of TB in young children, due to the paucibacillary nature of TB disease in this age group. The treatment success rate(TSR) among children 0 – 14 years was 87.4% for the 2020 cohort, slightly above that of the 2019 cohort,

51 Kenya Ministry of Health, National AIDS and STI Control Programme (NASCOP), **Preliminary KENPHIA 2018 Report.** Nairobi: NASCOP; 2020.

52 Homa Bay [420], Nairobi [380], Siaya [372], Kisumu [369], Migori [259], Kakamega [195], Nakuru [174, Busia [142] and Mombasa [124]

53 Kenya Ministry of Health (2019). **Kenya Harmonised Health Facility Assessment (KHFA) 2018/2019 Main Report.**

54 Ministry of Health (2021). **Division of National Tuberculosis, Leprosy and Lung Disease program (DNTLDP) Annual Report 2021.**

55 Ministry of Health (2021). **Division of National Tuberculosis, Leprosy and Lung Disease program (DNTLDP) Annual Report 2021.**

86.6%. Cure rates among this age group remain low at 72.1% because of the low coverage of sputum testing during follow-up. The death rate was 5.5%, slightly above the national target of 5%. Comparing the treatment outcomes for the TB/HIV coinfection for the cohort 2020, the performance is dismal, with a TSR of 80%, which is way below the national target of 90%. The death rate is high at 13% against the national target of 5% and lost to follow up of 3.8%. In 2021, among the children TB/HIV among children Testing rate was at 94.4% with a co-infection rate of 11.5% and 100% ART uptake[56].

3.5.3 Diarrhoeal diseases

In 2018 in Kenya, 1,499,146 cases of diarrhoea were reported among children under five years.[57] A recent study in the Mathare slums of Nairobi found a prevalence of diarrhea of 18.7% among children under five years in the selected households.[58] Several factors such as number of people in a household, number of children under five years in a household, relationship and level of education of the primary caregiver, presence of flies, presence of open garbage, presence of faeces, and immunization practices of the child were found to be associated with diarrhoea prevalence.

These results were similar to the 2014 DHS which asked mothers about episodes of diarrhoea in their infants and children in the two weeks preceding the survey. Overall, 15 percent of children under the age of five had experienced diarrheoa, 2% being bloody diarrhoea. Half the episodes of diarrheoa were in children between the ages of 6 months and 2 years. Children who had access to improved or private toilet facilities had a reduced prevalence of diarrhea (11 percent versus 16 percent). The Western, Coastal and Nyanza regions had the highest prevalence of diarrhea (18-20 percent) while Northeastern had the lowest (8 percent). Treatment seeking was inversely proportional to the education level of the mother.[59]

A comparison between the 2008/09 and the 2014 DHS demonstrates a number of improvements:

- The proportion of children with diarrheoa taken to a health care provider for advice or treatment increased from 49 to 58 percent
- The proportion of children treated with ORS increased from 39 to 54 percent
- Use of zinc increased from less than one per cent to eight percent.

However, the proportion of children who received no treatment increased from 13 to 18 percent, and there was no change in the number of children who were given increased fluids.

3.5.4 Pneumonia and Acute Respiratory infections

The 2014 DHS[60] asked mothers about episodes of cough, shortness of breath or other respiratory difficulties in their infants and children in the two weeks preceding the survey – all symptoms of pneumonia. The results across the country were 9 percent of children with those symptoms, ranging from 4 percent in those under six months to 11 percent in infants aged 6-11 months, with the highest regional prevalence seen in the Western Region (13

56 Ministry of Health (2021). **Division of National Tuberculosis, Leprosy and Lung Disease program (DNTLDP) Annual Report 2021**.

57 The District Health Information Software. **Diarrhea among under five children. Nairobi:** DHIS; 2019.

58 Guillaume D, Justus O, Ephanus K; **Factors influencing diarrheal prevalence among children under five years in Mathare Informal Settlement, Nairobi, Kenya;** J Public Health Afr. 2020 Apr 29; 11(1): 1312. doi: 10.4081/jphia.2020.1312

59 Kenya National Bureau of Statistics. (2015). **Kenya Demographic and Health Survey 2014;** accessed at https://dhsprogram.com/publications/publication-fr308-dhs-final-reports.cfm

60 ibid

percent) and lowest in Northeastern (4 percent). Two-thirds of the children were taken to be seen at a health facility (an increase from the 56 percent seen in the 2004 DHS), and about half were treated with antibiotics. Treatment with antibiotics ranged from 34 percent in Northeastern to 62% in Nyanza. The DHS also noted that pneumonia was responsible for about 16% of the deaths in the under-five age group.

A more recent review of 1832 cases of pneumonia in children over five in 13 Kenyan hospitals found a high mortality rate of 7.9%, but also noted that "the WHO criteria for classification of severity for children under 5 years do not appear to be a valid tool for risk assessment in this older age group, indicating the urgent need for evidence-based clinical guidelines for this neglected population."[61]

The Kenya Action Plan Against Pneumonia and Diarrhoea (KAPPD) which is based on the Global Plan (GAPPD) is the platform upon which the National Pneumonia Control Strategy for Kenya is based. The GAPPD's global target is that by 2025 the mortality rate from pneumonia for under- fives is reduced to 3 per 1000 live births. In 2018, the under-five mortality rate due to pneumonia in Kenya was 6 per 1000. A list of the indicators for Child survival for pneumonia and diarrhea is listed in Annex 2. Countries seeking to achieve UHC must ensure that more than 90% of children with Pneumonia symptoms are taken to an appropriate healthcare provider. In Kenya it was 66% in 2014.

3.5.5 Febrile infections including malaria

The 2014 DHS[62] asked mothers about episodes of fever in their infants and children in the two weeks preceding the survey, and if so, whether any treatment was sought. Almost one-quarter (24 per cent) of the children had been feverish in the two weeks, ranging from 17 percent in infants less than six months to 30 percent in children aged six months to two years. The prevalence of fever was highest in Nyanza and Western (37 and 36 percent respectively). Treatment was sought in 63 percent of the cases (an increase from the 49 percent reported in the 2008 survey). One quarter of the children with fever were treated presumptively with antimalarials, with another 40 percent treated with antibiotics.

Household surveys show a reduction in malaria parasite prevalence from 11 percent in 2010 to 8 percent in 2015 nationwide, and from 38 percent in 2010 to 27 percent in 2015 in the endemic area near Lake Victoria. The mortality rate in children under five years of age has declined by 55 percent, from 115 deaths per 1,000 live births in the 2003 Kenya Demographic and Health Survey (DHS) to 52 deaths per 1,000 live births in the 2014 DHS.[63]

However, despite the overall declines in malaria prevalence, it remains an important health issue for children in endemic areas. A recent survey on the Kenyan coast[64] showed parasite prevalence gradually increased in childhood, reaching 12% by 9 years of age then declining through adolescence into adulthood. The incidence of hospitalized malaria was concentrated among children aged 6 months to 4 years (64% and 70% of all hospitalized

61 Macpherson L, Ogero M, Akech S et al; **Risk factors for death among children aged 5–14 years hospitalised with pneumonia: a retrospective cohort study in Kenya;** BMJ Global Health 2019;4:e001715. Accessed at https://gh.bmj.com/content/4/5/e001715

62 Kenya National Bureau of Statistics. (2015). **Kenya Demographic and Health Survey 2014;** accessed at https://dhsprogram.com/publications/ publication-fr308-dhs-final-reports.cfm

63 President's Malaria Initiative Report, 2019; accessed at https://www.pmi.gov/docs/default-source/default-document-library/country-profiles/kenya_profile.pdf?sfvrsn=22

64 Kamau G, et al.; **Malaria infection, disease and mortality among children and adults on the coast of Kenya Malaria Journal (2020)** 19:210 https://doi.org/10.1186/s12936-020-03286-6

and severe malaria). Malaria mortality was low but was highest among children aged 6 months–4 years (0.57 per 1000 person-years). Severe malaria and death from malaria were negligible above 15 years of age. Similarly, a survey of more than 5,700 hospitalised childhood malaria cases in Western Kenya[65] demonstrated a 3.7% mortality rate, with the median age for fatal cases being 33 months, but with increasing numbers of children older than 5 years admitted with malaria.

3.5.6 Hepatitis B

An analysis of samples from the Kenya AIDS Indicator Survey (2007) demonstrated a prevalence of chronic Hepatitis B infection in Kenya of 2.1%, representing approximately 398,000 persons.[66] Hepatitis B is a well-established precursor of hepatocellular carcinoma and cirrhosis, and it is also known that while most hepatitis B transmission is horizontal, vertical transmission to a neonate from an HbSAg positive mother carries a much higher risk of the more severe long-term sequelae. However, it has also been found that treating mothers with Tenofovir and immunizing the neonate against Hepatitis B, with the first dose given within 24 hours of birth, essentially protects against vertical transmission.[67] For the past several years, WHO has been recommending that "all infants should receive their first dose of vaccine as soon as possible after birth. Delivery of hepatitis B vaccine within 24 hours of birth should be a performance indicator for all immunization programmes".[68] While this may not be regarded as an immediate priority in Kenya, it is an additional immunisation practice that should be integrated into standard practice during the lifetime of this Strategic Plan.

3.5.7 COVID-19

The global pandemic of SARS-Covid-2 virus (COVID-19) that has swept the globe in 2020-2021 has affected Kenya like most other countries in the region. As of mid-May 2021, the country had recorded approximately 160,000 cases with 3,097 deaths,[69] of which 4,535 were in children under 10 years of age, with 27 deaths. Forty percent of those cases were in children under 5 years, but they accounted for 19 (70%) of the deaths. As can be seen from Table 2, almost half (46%) of the cases in the country have been reported from Nairobi, as well as 40% of the deaths.

Table 1: Kenya COVID-19 cases and deaths in children – as of May 13, 2021

UNDER 10 YEARS COVID 19 CASES AS OF 13TH MAY 2021			UNDER FIVE YEARS COVID 19 CASES AS OF 13TH MAY 2021		
County	Cases	Deaths	County	Cases	Deaths
Nairobi	2091	11	Nairobi	845	8
Kiambu	267	2	Mombasa	109	
Mombasa	260		Kiambu	104	1
Nakuru	225	1	Nakuru	90	1
Turkana	147	2	Turkana	82	2
Kisumu	137		Kisumu	62	
Kajiado	130		Kajiado	50	

65 Akech et al; **The Clinical Profile of Severe Pediatric Malaria in an Area Targeted for Routine RTS,S/AS01 Malaria Vaccination in Western Kenya;** Clinical Infectious Diseases, Volume 71, Issue 2, 15 July 2020, Pages 372–380, https://doi.org/10.1093/cid/ciz844

66 Ly KN, Kim A, Umuro M et al (2016). **Prevalence of Hepatitis B Infection in Kenya 2007;** Am J of Trop Med and Hygiene; 95(2): 348-353

67 WHO data

68 WHO; **Vaccines and Injectables, 2018;** accessed at: https://www.who.int/immunization/diseases/hepatitisB/en/#:~:text=WHO%20recommends%20that%20all%20infants,indicator%20for%20all%20 immunization%20programmes.

69 Accessed on May 27, 2021 at https://www.google.com/

Uasin Gishu	116	2	Uasin Gishu	50	1
Machakos	114	2	Machakos	48	1
Kilifi	104	1	Kilifi	33	1
51-100 cases*	418	4		174	2
20-50 cases**	366	2		133	2
1-19 cases ***	160			59	
TOTAL	4535	27		1863	19

*Siaya, Migori, Laikipia, Kisii, Kitui, Kericho, Nyeri
**Embu, Nyamira, Garissa, Kakamega, Meru, Nandi, Busia, Taita Taveta, Kirinyaga, Bungoma, Murang'a, Trans Nzoia
***Makueni, Baringo, Homa Bay, Nyandarua, Tharaka Nithi, Bomet, Narok, Tana River, Vihiga, Lamu, Kwale, Isiolo, Mandera. West Pokot, Elgeyo Marakwet, Marsabit, Samburu

Although the number of cases and deaths in children is small as compared to the total numbers, it must be remembered that this is a large underestimate of the actual number of cases, as most cases in children are asymptomatic. However, it has been demonstrated that asymptomatic children can acquire and transmit the virus to adults, and so children need to be considered in the implementation of quarantining, sanitation and social distancing control measures.

More importantly, it has not yet been determined the number of excess deaths that have occurred in young children in the past year because of the closure of facilities, parents being fearful of taking sick infants and children to health centres or hospitals because of fear of COVID transmission, or being unable to take children for care because of curfews or other travel restrictions.

Another aspect of the COVID-19 pandemic is the pressure it has put on the health care system, with instances reported of oxygen being in short supply, which would affect the ability of facilities to provide neonatal resuscitation or other services that require intensive and critical care resources. Further, the social and psychological effects it may be having on children who have been confined at home and unable to attend school and social events has yet to be measured.

It is also evident that the COVID pandemic will not be resolved quickly, and its current and aftereffects will need to be taken into account in health planning for the coming years covered by this Strategic plan.

3.6 Birth defects and congenital abnormalities

In Kenya, WHO estimates that 6,626 deaths are attributable to congenital anomalies in children aged less than five years of age each year which equates to 6.3% of all deaths in children aged less than five years. As the infant mortality rate due to infectious diseases among children declines in Kenya, the proportionate contribution of birth defects to childhood mortality and morbidity is expected to increase.

Birth defects surveillance was established in Kenya in 2016. A program has been put in place to establish a scalable surveillance system to systematically identify, code, report, and monitor select birth defects; determine the birth prevalence of the selected birth defects; describe the main sociodemographic and clinical characteristics of children with the selected defects; and use the data generated through birth defects surveillance to inform existing prevention policies, increase awareness of proven prevention methods, and improve referral to services for affected individuals in order to reduce the burden of birth defects in the region. There are currently fifteen sites collecting routine data on neonates born with congenital anomalies.

3.7 Social determinants of health

Critical social determinants of health of newborns and children in Kenya include water, sanitation and hygiene, education, wealth and other socio-economic factors. Education, especially for girls, is also an important factor in influencing sexual and reproductive health rights among adolescents.

Some of the key social determinants of health relevant to child health include:

- **Water, sanitation and hygiene** - has improved significantly in the past ten years. The most recent Kenya Integrated Household Budget Survey (KIHBS)[70] in 2015/2016 reported that:
  - The majority of households (72.6%) obtain drinking water from an improved source (piped; protected wells and springs; boreholes), while 27% use non-improved sources, a marked improvement from the 2005/06 KIHBS or the 2008 DHS when 58.9% and 63% of households respectively obtained drinking water from an improved source.
  - In rural areas, 61.8 per cent of households have access to improved sources of drinking water compared to 86.7 per cent of the households in urban areas (Nairobi City had the highest proportion [97.1%] as compared to Turkana County [63.3%], Wajir [44.7%] or West Pokot [37.2%]. Nationally, a majority of households (59%) do not use any method to make water safe for drinking, and this is true in both urban and rural areas.
  - 65.2 per cent of households have access to improved methods of human waste disposal. About half of the households (50.8%) in rural areas used unimproved sanitation compared to 13.2 per cent of their counterparts in urban areas. 8.4 percent of households had no toilet facilities. Lack of toilet facilities was more pronounced among households in rural areas (13.9%) than those in urban (1.4%).
  - Nearly 80 per cent of households had no place for hand washing in or near the toilet. The proportion of households with a place for washing hands is higher in urban areas (30.2%) than in rural areas (13.2%). Across counties, Kisii, Wajir, West Pokot and Makueni had less than 5 per cent of households each with a place for washing hands.[71] However, it should not be forgotten that water and sanitation issues also still exist within health facilities. A recent survey in fourteen Kenyan public hospitals (covering 116 wards) looking at factor promoting antibiotic resistance and using an aggregate score for some 34 WASH indicators found that the aggregate hospital performance ranged between 47 and 71% with five of the 14 hospitals scoring below 60%.[72]

- **Wealth** - three-quarters of urban residents (75%) are in the two highest wealth quintiles, while more than three-quarters of rural residents (78%) are in the lowest three quintiles (and are nearly equally distributed across these quintiles). Regional differences however exist, 9 in 10 people in Nairobi are in the two highest wealth quintiles, and 7 in 10 people in North Eastern are in the lowest wealth quintile. The recently released Kenya Gross County Report 2019 (based on 2017 data)76[73] noted that the GDP per capita in the four poorest

70 Kenya National Bureau of Statistics. (2018). 2015/16 **Kenya Integrated Household Budget Survey (KIHBS), Basic Report**

71 According to the KDHS 2014, a place for hand washing was observed in about 4 in 10 urban households (43%) and fewer than 3 in 10 rural households (27%).

72 Maina M, Tosas-Auguet O, McKnight J, Zosi M, Kimemia G, Mwaniki P, et al.; **Evaluating the foundations that help avert antimicrobial resistance: Performance of essential water sanitation and hygiene functions in hospitals and requirements for action in Kenya (2019);** PLoS ONE 14(10): e0222922. https://doi.org/10.1371/journal.pone.0222922

73 Kenya National Bureau of Statistics. (2019); **Gross County Product Report 2019;** Accessed through Wikipedia https://en.wikipedia.org/wiki/List_of_counties_of_Kenya_by_GDP

counties (Wajir, Turkana, West Pokot, Mandera) was KES 1,500 or less. Not surprisingly, these four counties are also among those showing the least advances in improved health of neonates and children. However, there also exist great disparities within urban areas, most notably in access to health services by the urban poor.

- **Educational levels of women** have strong correlation to the health of the child. The literacy rate in Kenya of approximately 81.5% (78.5% females, 85% males) has not changed significantly in twenty years, after experiencing a slight decrease in 2005-2008.[74]

3.8 Disasters and emergencies

The frequency and scope of emergencies and disasters have been increasing in recent years in Kenya, largely due to the effects of environmental factors often related to global warming, with consequent emerging and re-emerging vector-borne, communicable and epidemic diseases which pose challenges to child survival and development. The COVID-19 pandemic in 2020-2021 has been an additional unexpected emergency situation for which Kenya, like most countries, was ill-prepared to confront.

The coronavirus COVID-19 pandemic in 2020-2021 has been an unprecedented emergency, which has taxed the health system, but also had the effect of reducing uptake of services. The disruption in international air travel has had the effect of creating shortages of immunisation supplies, and by May 2020, almost one hundred countries had suspended their immunisation campaigns.[75] More seriously, there is widespread evidence that people were not accessing health care services, even in emergencies, for fear of they or their children contracting infection at the health centre. Data on under five services is being affected.

The effects of adverse environmental and weather conditions vary in severity in different areas of the country, with the arid and semi-arid regions of Northern Kenya, which historically have had weak health systems, bearing much of the burden, with recurrent and severe droughts or flooding during heavy seasonal rains being complicated by reported outbreaks of diseases including cholera, measles and malaria, among others. In addition, these are also areas prone to clashes during raids and cattle rustling in the pastoralist communities, as well as disturbances in regions close to border areas.

The consequences of such situations are a disruption in normal services, reduced food production with destruction or inadequate growth of food crops, increased incidence of disease such as diarrhoea and malaria, internal displacement and insecurity. Women and children are most at risk during these instances. Children often experience food deprivation, suffer deteriorating health and nutritional status, have an increased incidence of common diseases and have little or no access to health, education, water and sanitation or other services. They may also be prone to bodily harm and abuse and be denied their rights as children, as stipulated in the CRC. Often the mechanisms put in place to respond to the emerging or emergency situations are inadequate and not timely, so many children may succumb before assistance is forthcoming.

Although the Ministry of Health has developed the All Hazard Plan, Emergency Medical Policy, Ebola Virus Disease Contingency Plan and drafted a multi-sectoral Cholera Prevention and Control Plan, these documents have not been implemented by counties to shape up preparedness, preventive response and control interventions as part of systems

74 Accessed at https://www.macrotrends.net/countries/KEN/kenya/literacy-rate and https://countryeconomy.com/demography/literacy-rate/kenya

75 UNICEF. (2020). **Impact of COVID-19 on vaccine supplies;** Accessed at https://www.unicef.org/supply/stories/impact-covid-19-vaccine-supplies

strengthening and resilience building. It is not clear whether these plans have components for the under-five population. Additionally, mechanisms that are put in place by counties and communities during times of emergencies and disasters to ensure continuity of essential Reproductive, Maternal, Child and Adolecent Health services during emergencies/ disasters are more often short term, which do not translate into systems strengtheing and resilience building. Moreover, most of the prepar- edness and response interventions have not been harmonized, with funding gaps often experienced. In 2018/2019, UNICEF supported four counties in the capacity-building, mapping and ranking of priority hazards and risks, this needs to an annual exercise as part of bottleneck analysis for annual operational planning and implementation.

Before and after the 2008, 2013 and 2017 presidential elections Kenya witnessed varying levels of disorder and the subsequent displacement of populations, a large majority of whom were children and women who required continuity in the provision of essential health services. In an- ticipation of the repetition of such events, coordination mechanisms need to be put in place to ensure that not only will the maternal, neonatal and child service needs of displaced populations be maintained, but that psychosocial support to affected communities also be made available even in the absence of routine services, as stipulated in the Convention of the Right of Children and other human rights documents.[76]

3.9 High impact interventions

3.9.1. High impact interventions in the newborn period can be categorised under three levels:

- Immediate essential newborn care
  - Thermal care for all newborn
  - Early initiation to breastfeeding
  - Hygenic cord and skin care
  - Stimulation: communication and play
  - Newborn immunisation
  - Interventions for pmtct

- Neonatal infection management
  - Presumptive antibiotic therapy for newborns at risk of bacterial infection
  - Adherence to WASH and infection control measures in facilities
  - Case management of neonatal sepsis, asphyxia, prematurity, management of newborns with jaundice
  - Initiation of ART in babies born to HIV infected mothers

- Interventions for ill and small newborns
  - Kangaroo Mother Care (KMC) and extra support for feeding the ill and small babies
  - Continuous positive airway pressure (CPAP) to manage preterm babies with respiratory distress syndrome80[77]
  - Provision of human milk for small babies
  - Management of newborns with jaundice

76 UNICEF. (2010). **Core Commitments for Children in Humanitarian Action**

77 This should be oxygen primarily with CPAP in facilities with appropriate staffing; it is not an intervention that can be done by people not skilled and babies must be adequately monitored

Although the interventions listed above only include those directly linked to the newborn, this strategy recognizes the need to ensure implementation of high impact maternal health interventions in the antenatal and intrapartum periods for the best health outcomes of the newborn.

3.9.2 High impact interventions under the child health domain focus on addressing the leading direct and indirect causes of under-five morbidity and mortality in Kenya which include pneumonia, diarrheoa, malaria, malnutrition and other preventable diseases. Additionally, high impact interventions that ensure children not only survive but also thrive and transform such as those for care for child development (CCD) are also included. The interventions are delivered through three tested strategies, which include Integrated Management of Newborn and Childhood illnesses (IMNCI), Emergency Triage Assessment and Treatment (ETAT+) and Integrated Community Case Management (iCCM) for children under five years of age. The high impact interventions under the child health domain include:

- Routine Immunization as well as introduction of new childhood vaccines
- Oral rehydration salts and zinc for diarrhea treatment
- Amoxicillin Dispersible Tablets (DT) for treatment of childhood pneumonia
- Oxygen for severe pneumonia
- Interventions for detection of hypoxaemia in children under 5 years – pulse oximetry
- Blood transfusion for severe anaemia
- Long-lasting insecticidal nets (LLINs) and artemisinin-based combination treatment (ACT) for malaria
- Infant and young child nutrition including promotion of exclusive and continued breastfeeding, complementary feeding counseling and support and management of moderate and severe acute malnutrition
- Child care and development
- Deworming of pre and school aged children
- Vitamin A and Zinc supplementation and food fortification
- Screening and treatment of childhood TB
- Interventions for EMTCT for HIV exposed and children living with HIV
- Birth registration
- WASH interventions for promoting infection control and disease prevention.

3.10 Bottleneck analysis of health system issues

As part of the development of this strategic plan, a bottleneck analysis of the remaining challenges in access to and utilisation of high impact newborn and child health services was undertaken, analyzing some of the newborn and child health indicators in the context of:

- Supply side: % of target facilities/services points that have commodities, human resources
- and services
- Demand side: % of target population that is reached
- Quality: % of target population reached with effective service

3.10.1 Case Management of Pneumonia

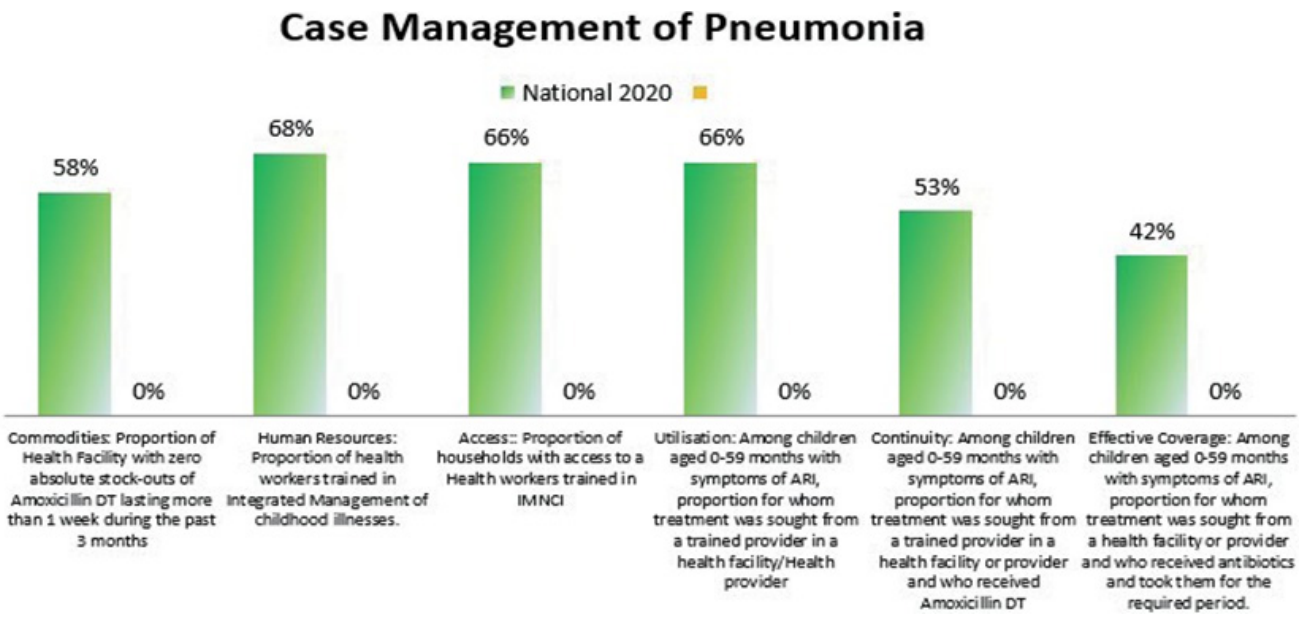
The latest data[78]indicates that only 35% of children under 5 years with pneumonia are being treated with the recommended amoxicillin DT. As an indicator, it cuts across the health system (both community and facility factors

78 DHIS2

contribute to its execution), and it is an effective way of gauging quality of health care.

It can be seen from Figure 2 that the performance of the supply side indicators - commodities, human resource, and geographic access – are 58%, 66%, and 66% respectively, meaning that commodities were the weak point. 42% of health facilities experienced a stock out of Amoxicillin DT lasting more than a week in the preceding 3 months. On the side of demand, initial utilization was at 66% but dropped to 53% for continuous utilization, meaning that 47% of Children aged 0-59months with symptoms of ARI did not seek treatment from a health facility, leaving a quality indicator for effective coverage at a mere 42%.

Figure 4: Bottleneck analysis of case management of Pneumonia



It was suggested the stockout issues could be rectified though capacity building on quantification and forecasting, advocating for a steady supply of Amoxicillin DT, proper documentation of its consumption at the clinic level and advocating at the Count level to ensure a constant supply.

On the demand side, the reasons for non-attendance at the clinic are more complex, and include issues of distance to the clinic, the cost of services, cultural beliefs and attitudes of health care providers. A possible solution would be to sensitise both caregivers and the community on the need to seek care at the health facility within 24 hrs, SBBC activities at the community level to demystify myths and misconceptions and carrying out some IPC activities in the community to strengthen customer care relations.

A recent analysis of pneumonia in three counties in Kenya documented the major policy and imple- mentation barriers at the national, county and health facility level in executing the protect, prevent and treat pneumonia strategy.[79] Their findings could apply more broadly to more general issues of delivery of health care in Kenya to the under-five population. The implementation barriers included:

79 Kenya Ministry of Health, Save the Children International. (2019). **Cross-sectional Survey of the Pneumonia Situation in Three Selected Counties in Kenya: Bungoma, Nairobi & Wajir**

Inadequate coordination at the national and county levels, affecting the quality and monitoring of the programme, delays in implementing and disseminating new policies and guidelines.

- Inadequate budgets allocation to purchase essential medicines such as Amoxicillin DT, injectable antibiotics and oxygen along with essential diagnostics such as pulse oximeters. The low availability & use pulse oximetry in the assessment of hypoxaemia in children under 5 years and the low availability and use of oxygen for the management of severe pneumonia
- - a critical component in the management of severely sick children – is especially relevant in the context of COVID 19.
- Insufficient capacity building, mentorship and on-job training of health workers on
- pneumonia diagnosis and treatment.
- Inadequate use of child health data for evidence-based program planning due to poor capacity of health information records officers and health providers.
- Low numbers of health providers and high staff turnover.
- Insufficient number of functional community units and community health volunteers (CHPs) not specifically trained in pneumonia prevention, protection and referral.
- Caregivers health seeking behaviour for pneumonia is affected by various factors such as cultural and social practices, long distance to health facilities, economic challenges and poor knowledge of pneumonia symptoms.
    - In the semi-arid area, the pastoralist/nomadic lifestyle of the community coupled with long distances to health facilities impose an economic burden, resulting in communities resorting to traditional medicines,
    - In the peri-urban and low-income areas, pneumonia and child health programming faces challenges in reaching unique hard-to-reach populations such as immigrants and and under five children.
- Lack of water and poor sanitation and waste disposal in the low-income areas in Nairobi County predispose residents and under-five children to various preventable illnesses including pneumonia.
- Weak roll-out of demand generation interventions that provide information and raise awareness of prevention measures, reduce misconceptions and improve care seeking practices in communities, based on formative research into the barriers and other relevant factors.
- Despite the introduction of PCV10 vaccine against pneumonia, there is a need to increase coverage to meet the GAPPD goal.

One of the report's[80] recommendations that is already being implemented is to strengthen the role of community health volunteers – training them in the pneumonia protect, prevent and treat strategy such as identifying underlying causes of pneumonia, the symptoms and referral.

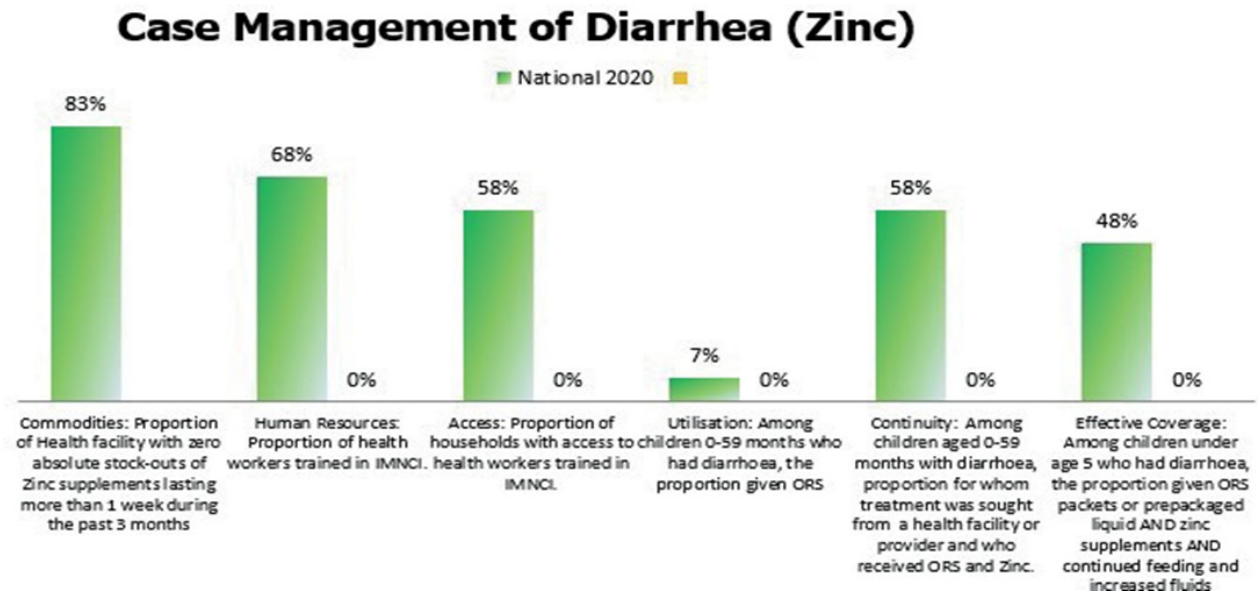
3.10.2 Case Management of Diarrhoea

The latest data indicate that only 32% of children under 5 years with diarrhoea are treated with zinc and ORS. Like pneumonia the indicators for diarrhea cut across the health system and are an effective way of gauging quality of health care. As can be seen in Figure 3 the main issue on the demand side is the geographic accessibility of the health centre. However, unlike pneumo- nia, it can be seen that while there are plenty of commodities available, there is a very low rate of utilization of services, with only 7% of infants and children with diarrheoa actually being treated with ORS. However, the management of diarrhea is not limited to health facility level access – as the com- modities are available

80 ibid

in the community level (kiosks, chemists, retail outlets, CHPs, etc.), the low utilization of commodities could be a result of other factors such as myths and misconceptions around diarrhea management in children, use of herbs, water & salt etc.

Figure 5: Bottleneck analysis of case management of diarrheoa



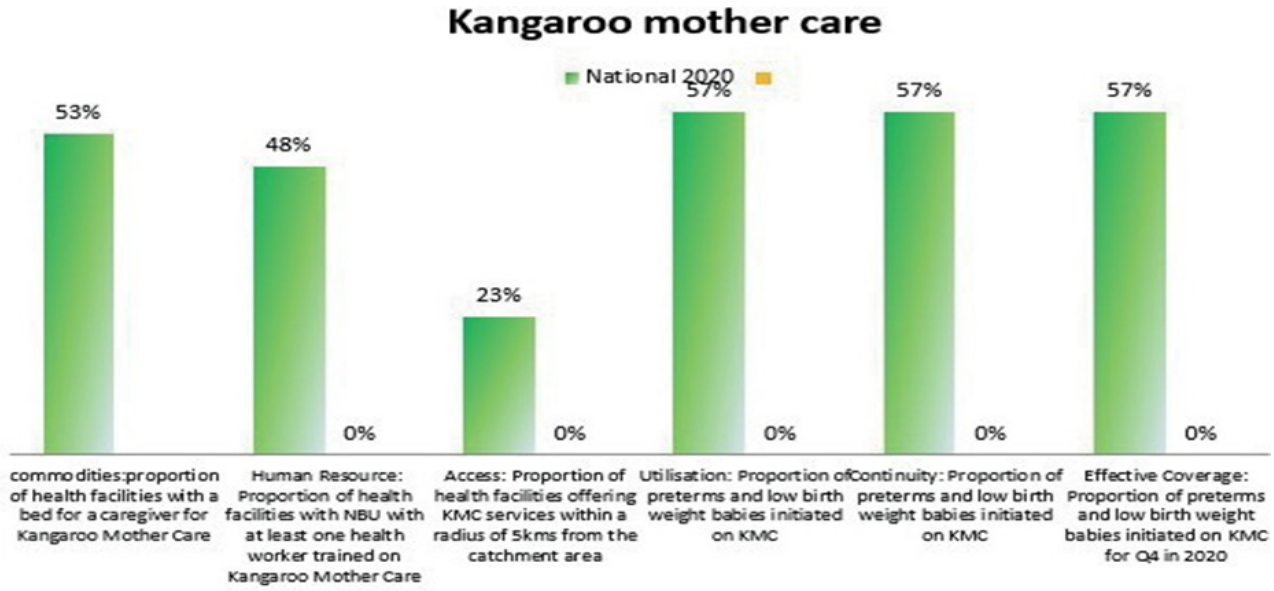
3.10.3 Case management and health of newborns

Two indicators to measure newborn care, both of which have low coverage, are:

- Percentage of preterm/low birth weight babies initiated on Kangaroo mother care (KMC) (13.5%)
- Proportion of babies applied chlorhexidine for cord care (13%)

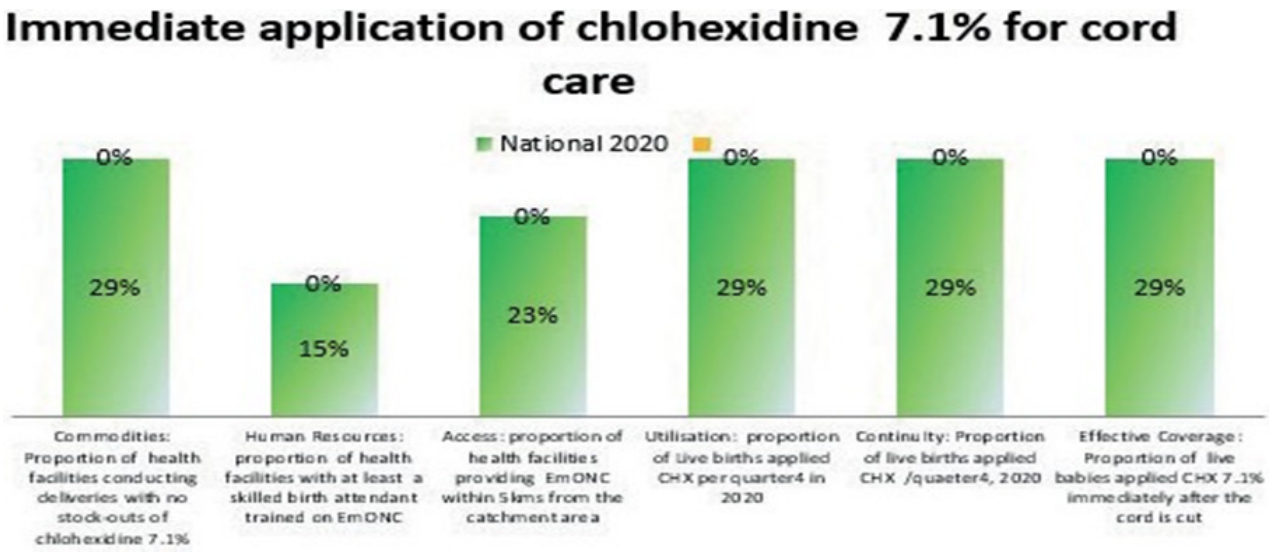
As can be seen from Figure 4, the main impediment to uptake of KMC is geographic access to a facility that offers the service. Once KMC is available, it is well-utilised.

Figure 6: Kangaroo mother care



However, as seen in Figure 5 the issue with chlorhexidine application is one of human resources – the number of skilled birth attendants who have been trained in EmONC.

Figure 7: Immediate application of chlorhexidine for cord care



Suggested solutions to improve uptake and access to KMC included:

- Scaling up of the KMC champion network, while simultaneously engaging counties and creating awareness on the importance of KMC network champions.
- Ensuring that adequate space is available in neonatal units for mothers and babies in KMC.
- Changing attitudes and increasing KMC knowledge through formation of social platforms for knowledge and experience sharing
- Inclusion of KMC services into pre services training, engaging learning institutions and regulatory bodies, and participating in learning institutions curriculum reviews
- Integrating the KMC package into the MCH handbook and ANC health messages
- Increasing the number of health workers trained in KMC by developing and disseminating a KMC mentorship package for use in facilities

A recent five-country randomized clinical trial of KMC was stopped early owing to the finding of significant reduced mortality among infants receiving immediate kangaroo mother care (p=.006).85[81]

81 WHO Immediate KMC Study Group; **Immediate "Kangaroo Mother Care" and Survival of Infants with Low Birth Weight;** N Engl J Med 2021; 384:2028-2038; DOI: 10.1056/NEJMoa2026486; accessed at https://www.nejm.org/doi/full/10.1056/NEJMoa2026486

4.0 The NCAH Policy and other policy / guidance documents

Although Kenya has several vertical programs and strategic documents on newborn, child and adolescent health thematic areas, the country has never had an overarching policy providing a holistic view and unified approach to newborn, child and adolescent health and development. **The Newborn, Child and Adolescent Health (NCAH)** Policy reflects the health goals of the **Strategic Development Goals (SDGs)** and provides direction on national child health priorities, interventions, investments, and partnerships.

The NCAH Policy outlines a vision, mission and goal, with six policy objectives:

- **Objective 1:** Reduce newborn, child and adolescent morbidity and mortality due to preventable communicable diseases
- **Objective 2:** Reduce newborn, child and adolescent morbidity and mortality due to non- communicable diseases and conditions
- **Objective 3:** Promote access to quality and comprehensive early childhood development interventions for all children up to eight years old, but especially in the first 1000 days of life
- **Objective 4:** Promote interventions to end all forms of malnutrition, and address the nutritional needs amongst newborns, children and adolescents
- **Objective 5:** Promote universal access to adolescent responsive health care services
- **Objective 6:** Create an enabling environment for provision of quality newborn, child and adolescent health services

The Policy then details policy domains and thematic areas under newborn, child and adolescent health, listing some 12-14 topics under each, as well as listing a dozen cross-cutting themes, each of which contain a list of activities that also need to be addressed:

- Health Systems Strengthening - leadership and governance, service delivery, financing,
- human resources, information systems, vital statistics
- Policies, strategies, plans and legal documents
- Early childhood development
- Water, hygiene, sanitation and other social determinants of health
- Advocacy, communication and social mobilisation
- Newborn and child health in emergencies
- Collaboration with professional, academic, regulatory and registration bodies
- Research and innovations
- Public/private partnership
- Special needs and disabilities

The Policy document then concludes with a discussion of Implementation Arrangements, including the roles and responsibilities of the National and County governments, academic and regulatory authorities, communities and individuals.

Besides the Newborn, Child and Adolescent Health (NCAH) Policy, this Strategy is also anchored in a number of international and Kenya policy, strategy and guidance documents. These are described briefly in **Annex 1**, and

include:

- **Kenya Health Policy 2012 – 2030**
- **Kenya Health Sector Strategic Plan 2018–2022**
- **Kenya Primary Healthcare Strategic Framework 2019-2024**
- **Roadmap, M&E Framework and Operational guidelines towards implementing Universal Health Coverage (UHC) in Kenya 2018–2022**
- **Kenya Reproductive, Maternal, Newborn, Child and Adolescent (RMNCAH) Investment Framework 2016–2020**
- **Kenya Framework for Elimination of Mother-To-Child Transmission of HIV and Syphilis 2016-2021**

5.0 Strategic framework – Survive, Thrive and Transform

The Newborn and Child Health Strategy Vision, Mission, goal and objectives are aligned first to the Kenya National Health policy and the Newborn, Child and Adolescent Health (NCAH) policy. It is a direct progression from the Child Survival and Development Strategy 2008-2015, which guided the previous decade's newborn and childhood programming.[82] The Strategic Framework takes as its model the Global Strategy for Women's, Children's and Adolescents' Health 2016- 2030[83] which is structured along the three principles of **SURVIVE, THRIVE and TRANSFORM**.

The Global Strategy approach aims for the highest attainable standards of health and well-being— physical, mental and social— at every age. A person's health at each stage of life affects health at other stages and also has cumulative effects for the next generation. The Strategy adopts an integrated and multisector approach, recognizing that health-enhancing factors including nutrition, education, water, clean air, sanitation, hygiene and infrastructure are essential to achieving the SDGs. Critically, the survival, health and well-being of women and children are essential to ending extreme poverty, promoting development and resilience, and achieving the SDGs. On a global level, implementing the Global Strategy, with increased and sustained financing, would yield tremendous returns by 2030:

- An end to preventable maternal, newborn, child and adolescent deaths and stillbirths
- At least a 10-fold return on investments in the health and nutrition of women, children and adolescents through better educational attainments, workforce participation and social contributions
- At least US$100 billion in demographic dividends from investments in early childhood and adolescent health and development
- A "grand convergence" in health, giving all women, children and adolescents an equal chance to survive and thrive

The global objectives of this strategy which will be applied to Kenya include:

- **Survive – end preventable deaths**
  - Reduce maternal mortality
  - Reduce stillbirths
  - Prevent perinatal and neonatal deaths
  - Ensure universal immunisation against preventable diseases
  - Reduce under-five mortality
  - End epidemics of HIV, tuberculosis, malaria, neglected tropical diseases and other communicable diseases
  - Reduce premature mortality from non-communicable diseases and promote mental health and well-being

- **Thrive – ensure health and well-being**
  - End all forms of malnutrition and address the nutritional needs of children and pregnant and lactating women
  - Ensure universal immunisation against preventable diseases

82 Kenya Ministry of Public Health. (2008). **Child Survival and Development Strategy 2008-2015**

83 WHO (2015). **The Global Strategy for Women's, Children's and Adolescents' Health (2016-2030) - Survive, Thrive, Transform**

- Ensure early identification of ill health, timely and appropriate management
- All children receive comprehensive nurturing care for early childhood development in the first 1000 days of life.
- Ensure that all girls and boys have access to good-quality care and nurturing care for early childhood development even in hard-to-reach areas
- Support community-based prevention, early identification and response to violence against children and pregnant and lactating women, with meaningful involvement and engagement of men, youth and extended families
- Substantially reduce pollution-related deaths and illnesses
- Achieve universal health coverage,including financial risk protection and access to quality essential services, medicines and vaccines
- Engage fathers and male guardians in early childhood development activities

- **Transform – expand enabling environments**
  - Eradicate extreme poverty
  - Ensure that all girls and boys complete free, equitable and good-quality pre-primary, primary and secondary education
  - Achieve universal and equitable access to safe and affordable drinking water and to adequate and equitable sanitation and hygiene
  - Enhance scientific research, upgrade technological capabilities and encourage innovation
  - Provide legal identity for all, including birth registration
  - Health system strengthening, including infrastructure, human resources, management, information systems and leadership
  - Enhance partnerships for sustainable development

Guiding Principles

The NCAH Policy lists a number of Guiding Principles, stating that they will be upheld in the implementation of the Policy, and therefore implicit in the Implementation Strategy that follows:

- **Alignment with Global and National policies and strategies:** mainly the 2010 Kenya Constitution, The Kenya Vision 2030, Kenya Health Policy (2014-2030) and the Kenya Health Sector Strategic and Investment Plan (2013-2017). Additionally, the policy aligns to relevant global commitments and obligations such as the Sustainable Development Goals and the Global Strategy for Women's, Children's Adolescents' Health 2016-2030.
- **Gender, Equity, Access, and Respect for Child Health Rights:** Newborns and children will have access to health services without discrimination based on ethnicity, gender, disability, religion, political belief, economic or social condition, or geographical location. Special attention will be given to reduce disparities, including those directly related to disabilities, and ensure equity.
- **Life Cycle Approach:** recognizes the interconnectedness of the different life stages from
- pregnancy, child birth, newborn, child, adolescent and through to adulthood. The policy will utilize the life course approach in its implementation.
- **Evidence-based interventions:** activities and programs under the different domains are based on evidence

generated in Kenya, regionally and globally; focus on proven interventions with the highest impact on newborn and child health.

- **Integration:** Recognizing the benefits including ensuring no missed opportunities and the possibility to increase coverage; activities to promote integration of newborn and child health services in planning, programming, implementation and monitoring and evaluation.
- **Multisectoral approach:** Newborn and child health is a facet of many factors, including the social determinants of health. Implementation will require multi-sector and cross-sector strategic partnerships.
- **Centered on the health systems blocks:** Functional health systems are critical to delivery of quality high impact interventions for newborns and children. As such, health systems strengthening will be a key priority area in the implementation of this policy.

5.1 Vision

A Kenya where all newborns and children survive, thrive and live to their fullest potential.

5.2 Mission statement

To ensure survival, health, development, and wellbeing of all newborns and children in Kenya, through promoting implementation of evidence-based high impact interventions, and creating an enabling environment for effective development and delivery of quality health services at all levels of service delivery.

5.3 Strategic goal

To accelerate efforts to reduce newborn and child mortality in Kenya and equitably promote their health, development and wellbeing.

5.4 Strategic Objectives

The objectives of the NCAH Policy are aligned with the newborn and child targets of the SDG Goal 3: "Ensure Healthy Lives and Promote Well-being for all at all ages", and these policy objectives are easily translatable into strategic objectives. Four of the five policy/strategic objectives outlined above are targeted at specific health issues – communicable diseases, non-communicable diseases, early childhood development in the first 1,000 days of life and nutrition, with the fifth advocating the creation of an "enabling equitable environment for provision of quality newborn and child health services".

The strategic plan that follows takes as its framework these four specific policy objectives translated into strategic interventions, with an expansion of the enabling environment objective into its many components, which includes a number of cross-cutting issues.

5.5 Impact targets

The following will be the most critical indicators that will be used to measure attainment of the strategy goal at the end of the five-year strategic period. The targets are aligned to the Kenya health policy and the country's commitment to the attainment of the sustainable development goals (SDG goals). Historical annual rates of reductions were considered in the development of the targets:

- Reduce neonatal mortality ratio from 22 to 16 per 1,000 live births by 2022 and 12 by 2025
- Reduce under five mortality rate from 52 to 45 per 1,000 live births by 2022 and 40 per 1,000 by 2025
- Reduce still birth rate from 12 to 9 per 1000 live births by 2022 and 7 per 1,000 by 2025

6.0 Detailed strategy and implementation matrix – interventions and activities

The components of the Strategic Plan which follows are based on the three principles of Survive, Thrive and Transform, but also organized according to the four objectives of the NCAH Policy which apply to newborns and children, with the fifth strategic covering Objective Six of the NCAH Policy - creating an enabling environment for provision of quality newborn, child and adolescent health services, which covers the range of health systems and health sector strengthening and capacity building.

6.1 Survive - GOAL – reduction of neonatal and child mortality and morbidity

6.1.1 Strategic Objective 1: Reduce neonatal mortality and morbidity

6.1.2 Strategic Objective 2: Reduce morbidity in infants and children (4 weeks – 10 years)

6.2 Thrive - GOAL – a healthy, well-nourished and well-protected childhood for all Kenyan children

6.2.1 Strategic objective 3: Promote access to quality and comprehensive early childhood development interventions for all children especially in the first 1,000 days of life

6.2.2 Strategic objective 4: Promote interventions to end all forms of malnutrition, and address the nutritional needs amongst newborns and children

6.3 Transform - GOAL – the provision of quality newborn and child health services in all counties of Kenya

6.3.1 Strategic objective 5: Create an enabling environment for provision of quality newborn and child health services

- **Strategy 5.1 Leadership and Governance -** Strengthen leadership and governance systems that are responsive and accountable in provision of health services to newborns and children at national and county levels
- **Strategy 5.2 Infrastructure -** Promote availability of adequate and appropriate infrastructure at both community and facility levels to enable provision of comprehensive and quality newborn and child health services.
- **Strategy 5.3 Service delivery and community health systems -** Support establishment and strengthening of community health systems to increase demand and utilisation, and to ensure delivery of community-based newborn and child health services in collaboration with the community health services unit as per national guidelines. These community systems to be supported by Level 4 hospitals and strengthened referral systems.
- **Strategy 5.4 Human resources -** Support interventions to ensure availability of adequate, skilled and motivated human resources for health for provision of quality high impact newborn and child health services at all levels of service delivery
- **Strategy 5.5 Quality improvement -** Put in place and/or strengthen systems including policies, standards, guidelines and programs to ensure quality improvement in provision of newborn and child health services as well as improve client experiences to ensure dignified care at all levels of delivery platforms.
- **Strategy 5.6 Health care financing -** Ensure availability of adequate financing for delivery of high impact and quality newborn and child health services
- **Strategy 5.7 Health commodities and supplies -** Strengthen systems including for procurement, supply

and management to ensure availability of essential lifesaving medicines, commodities, equipment and technologies for provision of newborn and child health services.

- **Strategy 5.8 Health information systems, monitoring and evaluation, research -** Strengthen health information systems to ensure collection, management and use of disaggregated data at the various levels of health service delivery to inform newborn, child and adolescent health programming; strengthened partnerships and linkages with the research community.
- **Strategy 5.9 Water, hygiene and sanitation and other social determinants of health -** Identify social determinants to child health including socioeconomic conditions, education, housing and environmental conditions and develop strategies to engage in strategic partnerships to address these determinants; improved WASH in health facilities.
- **Strategy 5.10 Special needs and disabilities -** Strengthen strategies for prevention and early detection, assessment and screening of developmental delays, special needs and disabilities and support to those affected
- **Strategy 5.11 Public private partnerships -** Develop strategies and approaches to strengthen resource mobilization for newborn and child health services and programs through public private partnerships.
- **Strategy 5.12 Child health in emergencies -** Support effective response to newborn and child health in disasters and emergency situations
- **Strategy 5.13 Advocacy, communication and social mobilisation -** Support development and implementation of newborn and child advocacy and communication strategic framework at national and county levels.

The following pages provide the detailed implementation matrix for the newborn and child strategy. The detailed plan presents activities by actions and by period of implementation. As part of the implementation, each county will develop their county specific plans to support the roll out of the national NCH strategic plan. Indicators to measure the outputs and outcomes under each of these activities are listed in the Monitoring and Evaluation Matrix – *section 9*.

6.1 Survive - GOAL –Reduction of neonatal and child morbidity and mortality

6.1.1 Strategic Objective 1: Reduce newborn and neonatal morbidity and mortality

KEY ACTIONS	DETAILED ACTIVITIES	2022	2023	2024	2025	2026	KEY IMPLEMENTORS
Promote and enhance availability and access to high impact evidence-based interventions for the management of all newborns including small and sick newborns	Development of a comprehensive essential newborn care guideline	x					National/Partners
	Dissemination of a comprehensive essential newborn care guideline.		x	x			National/Partners
	Create awareness to increase uptake of early antenatal care as per the national guidelines on quality obstetrics and perinatal care,early recognition of danger signs during pregnancy, and importance of skilled birth through Advocacy, Communication and social mobilization strategies including male involvement	x	x	x	x	x	National, County
	Capacity building of health care providers on management of all newborns especially small and sick newborns	x	x	x	x	x	National, County medical training institutions and implementing partners
	Strengthen perinatal ad neonatal Death Surveillance and Response)	x	x	x	x	x	National, County
	included in the NGQOPC	x	x	x	x	x	County
	Scale up Kangaroo mother care atall levels of care	x	x	x	x	x	National/county
	Scale up kangaroo mother care in all levels of care	x	x	x	x	x	National County
Promote evidence-based community maternal and newborn interventions as per national guidelines.	Train CHEWs, CHAs and CHPs on ICCM, CMNC, Nurturing Care, integrated ICCM/ SAM/ MAM and other maternal newborn interventions	x		x		x	County
	Community sensitization and support for initiation on the importance of early start of ANC services	x	x	x	X	x	County
	Train CHPs on Community Maternal Newborn Care	x	x	x	x	x	County
	Male involement maternal and newborn health	x	x	x	x	x	County, community
	Train CHEWs, CHAs and CHPs on utilization of the digitized tools for community maternal newborn child health interventions		x	x	x	x	National/ County
	Increase skilled birththrough community initiatives like maternity open days at ward levels, mother to mother support group, provision of newborn essential starter pack	x		x		x	County
	Strengthen linkages as per primary health care guidelinies	x	x	x	x	x	County/ Partners, commuity
	Conduct community dialogue and action days	x	x	x	x	x	County

KEY ACTIONS	DETAILED ACTIVITIES	2022	2023	2024	2025	2026	KEY IMPLEMENTORS
	Train the community health workforceon ICCM quality improvement		x	x	x	x	County/Partners
Put in place systems and programs to ensure access to and utilization of quality essential newborn care services at all levels of service delivery.	Support mothers in initiating breastfeeding within 1 hour of birth	x	x	x	x	x	National, County
	Implemetation of respectful newborn care at all levels of service delivery	x	x	x	x	x	National, County
	Strengthening community outreach programs	x	x	x	x	x	County
	Strengthen communication and social mobilization systems by use of technologies, IEC Materials and targeted advocacy, use of IEC materials in local language and service messaging	x	x	x	x	x	National, County
Support implementation of interventions that promote hygienic cord and skin care as per national guidelines	As per the national guidelines for quality obstetric and perinatal care	x	x	x	x	x	National and County
	Sensitization of CHP on the use of CHX for cord care	x	x	x	x	x	County
	Community sensitization on use of CHX and its benefit on cord care.	x	x	x	x	x	County
	Training of HCP and mothers/ caregivers on use of Chlorhexidine for cord care.	x	x	x	x	x	County/National
	Maintenance of acceptable standards of WASH/IPC in health facilities	x	x	x	x	x	County
Support implementation of interventions to address asphyxia including but not limited to promoting neonatal resuscitation	Promote quality management of pregnant and labour through use of partograph/labour care guide	x	x	x	x	x	National
	Support early identification and follow up of high risk pregnancies	x	x	x	x	x	County
	Provide guidelines on resuscitation	x	x	x	x	x	National
	Training of HCPs on new born resuscitation(golden minute)	x	x	x	x	x	National/County
	Support supervision and mentorship	x	x	x	x	x	National/County
	Supply oxygen and oxygen delivery units in all delivery rooms	x	x	x	x	x	National County
	Ensure all levels of health facilities meet criteria for CEMONC/ BEMONC	x	x	x	x	x	National County
	Timely management of complications in facility and timely referral	x	x	x	x	x	National County

KEY ACTIONS	DETAILED ACTIVITIES	2022	2023	2024	2025	2026	KEY IMPLEMENTORS
Support interventions that ensure emergency care for newborns including supporting functionality of emergency obstetric and newborn care services (EmONC)	Advocate obstetric emergency units including maternity theatres	x	x	x	x	x	County
	Advocate Increase of regional satellite blood banks including screening of blood	x	x	x	x	x	National (National Blood Transfusion Centre)
	Training of HCP On EmONC and essential new-born care.	x	x	x	x	x	National County
	Continuous mentorship of the HCps o EMONC and early essential newborn care	x	x	x	x	x	National County
	Provide standardized architectural designs for NBU	x				x	County
	Construct and renovate NBU according to the design provided in levels 4 & 5			x			County
	Construction/renovation of newborn units at sub counties facilities as per the architectural designs provided in National guidelines	x		x			Country
	Operationalise nonfunctional newborn units	x	x	x	x	x	County
	Training and retention of HCP eg neonatal nurses and pediatric neonatologist	x	x	x	x	x	National/County
	Disseminate guidelines to health workers	x	x	x	x	x	County
	Sensitize CHPs/community on PMTCT congenital syphilis and tuberculosis	x	x	x	x	x	County
	Promote implementation of national EMTCT guidelines	x	x	x	x	x	County
	Promote implementation of TB/ HIV and syphilis guidelines.	x	x	x	x	x	National County
	Provision of antimalarial to mothers	x	x	x	x	x	National County

KEY ACTIONS	DETAILED ACTIVITIES	2022	2023	2024	2025	2026	KEY IMPLEMENTORS
Promote access to evidence- based interventions for effective infection prevention and management among newborns.	Provide IPC guidelines for use in labor ward	x	x	x	x	x	National County
	Provide hand hygiene facilities at all service delivery points as part of larger WASH standards compliance	x	x	x	x	x	County
	Early identification and treatment of infections using existing protocols	x	x	x	x	x	County
	Procure commodities for diagnosis and treatment of any possible bacterial infection	x	x	x	x	x	County
	Ensure mothers get 2 doses, at least 80% coverage	x	x	x	x	x	County National
	Support administration of tetanus toxoid as per national schedule	x	x	x	x	x	County National
	Promote early ANC visits	x	x	x	x	x	National County
Introduction of Hepatitis B immunization at birth	Advocate for introduction of Hepatitis B immunisation at birth			x	x	x	National/Partners
Implement IMNCI guidelies recommendations on treatment of possible serious bacterial infections (PSBI) in infants and children.		x	x	x	x	x	National
	Dissemination of protocols and guidelines to health facilities and teaching institutions- Use the guidelines for training	x	x	x	x	x	National County
	Supply of commodities for management of PSBI	x	x	x	x	x	National County

6.1.2 Strategic Objective 2: Reduce morbidity and mortality in infants and children (4 weeks – 10 years)

KEY ACTIONS	DETAILED ACTIVITIES	2022	2023	2024	2025	2026	KEY IMPLEMENTORS
Promote access to and uptake of preventive interventions for childhood illnesses.	Train HCPs and CHPs on notifiable diseases, Integrated Management of Neonatal and Childhood Illnesses (IMNCI) guidelines, Trauma and Non Communicable Diseases (NCDs)		x	x	x	x	National County
	Sensitise MCH HCPs effective utilization of the Mother and Child Health (MCH) Handbook		x	x	x	x	National County
	Health educate caregivers/ mothers on effective utilization of the Mother and Child Health (MCH) Handbook		x	x	x	x	County
	Provide Immunization services to all children.		x	x	x	x	County
	Promote exclusive breastfeeding (6months)		x	x	x	x	County

KEY ACTIONS	DETAILED ACTIVITIES	2022	2023	2024	2025	2026	KEY IMPLEMENTORS
	Check for missed opportunities on immunization in sick children	x	x	x	x	x	County
	Enhance nurturing care of early childhood development upto 8 years (nurturing care)		x	x	x	x	County
Promote availability of and access to timely, comprehensive services for treatment, care and support for children infected with or exposed to HIV and TB.	Counselling, testing/re-testing of mothers in antenatal and postnatal period. HIV-positive mothers to be started on maternal HAART		x	x	x	x	County
	DNA PCR at birth and at 6 weeks for exposed infants and antibody test at 18 months – all exposed infants begun on ART prophylaxis; treatment and care to infected children		x	x	x	x	County
	Promote Linkage to care and treatment for all HIV/TB infected or exposed		x	x	x	x	County
	Counsel and encourage exclusive breastfeeding up to six months with infant prophylaxis.		x	x	x	x	County
	Offer complementary feeds after 6 months		x	x	x	x	National and county govt
	Isoniazid Preventive Therapy (IPT) Care.		x	x	x	x	County
	Linkage of Children with HIV/ TB to Primary Health networks to improve Compliance.		x	x	x	x	County
	Routine weighing and screening for malnutrition		x	x	x	x	County
	Screen for TB for all HIV infected children at every visit		x	x	x	x	County
	Offer IPT to children with open TB contacts		x	x	x	x	County
	Establish children-friendly comprehensive HIV/TB clinics		x	x	x	x	National/County
	Timely procurement of antivirals, anti-TBs, nutritional commodities and other supplies		x	x	x	x	National
	Intensify community defaulter tracing for both exposed and confirmed children		x	x	x	x	County
	Health education to caregivers on the importance of adherence of ARVS and Anti TB		x	x	x	x	County
	Conduct Data Quality Audit (Infant and Children morbidity). move to M&E		x	x	x	x	National/County

KEY ACTIONS	DETAILED ACTIVITIES	2022	2023	2024	2025	2026	KEY IMPLEMENTORS
Promote access to timely and quality treatment for common childhood illness-major killers (Scale iMNCI and ETAT+)	Train at least 60% of HCPs in every facility on IMNCI and ETAT+		x	x	x	x	National County
	Timely procurement, ordering and distribution of essential commodities, equipment and technologies (antimalarials, antibiotics, ORS, zinc, pulse oximeters, etc.)		x	x	x	x	County
	Conduct quarterly targeted supportive supervision		x	x	x	x	National/County
	Establish and/or strengthen ORT corners		x	x	x	x	County
	Equip Emergency Trays with child-appropriate supplies:		x	x	x	x	County
	Advocate for oxygen supply at all levels of health facilities		x	x	x	x	National/county
	Conduct Oxygen administration training for heathcare workers in the pediatric units.		x	x	x	x	National/county
	Advocate for inclusion of oxygen therapy as a thematic area in pre-service academic curriculum.			x		x	National
	Avail updated treatment guidelines and protocols		x	x	x	x	National
	Advocate for establishment of pediatric acute rooms in health facilities (inpatient and out patient)		x	x	x	x	National/County
	Advocate for Hiring of HCP's across different facility levels as per established norms and deploy appropriatel infrastructure		x	x	x	x	County
	Advocate for development of appropriate infastructure for enhanced service delivery		x	x	x	x	National County
	Advocate for Implementation of referral strategy		x	x	x	x	County
	Media/ local radio enhance advocacy on key childhood illnesses Take to ACSM		x	x	x	x	National/County
	Develop under five vitamin A supplementation and deworming guidelines	x	x				National County
	Advocate for Establishment of regional pediatric centre of excellence (National Children Referral Hospital)			x	x	x	National/county
	Strengthen monitoring and evaluation activities at all levels Take to M&E		x	x	x	x	National/County
	Advocate forIntegrated outreach services to the hard -to-reach populations		x	x	x	x	County

KEY ACTIONS	DETAILED ACTIVITIES	2022	2023	2024	2025	2026	KEY IMPLEMENTORS
Promote and strengthen implementation of integrated management of newborn and childhood illnesses (IMNCI) and Emergency Triage Assessment and Treatment (ETAT+) to address leading causes of child morbidity and mortality and improve the management of severely sick children.	Incorporate ETAT+ and IMNCI data in routine documentation tools		x				National county
	Provision of IMCNI & ETAT+ guidelines to health Workers		x	x	x	x	National/County
	Train HCPs on IMNCI and ETAT+& ETAT+		x	x	x	x	National County
	Review of pediatric data collection tools	x	x				National/County
	Integrate ETAT+ /IMNCI into digital medical records,		x	x			National
	Increase the number of ToTs		x	x	x	x	National/county
	Integrate IMNCI, ETAT and iCCM trainings in medical institution curriculums	x	x				National/KMTC
	Availability of rapid test kits(equipments and supply)		x	x	x	x	County
	Improve disease surveillance at all levels		x	x	x	x	National/County
Strengthen routine immunization programmes and support new vaccines' introduction for existing and emerging vaccine preventable diseases among children.	Quantification and timely procurement of all antigens		x	x	x	x	National
	Have annual immunization target for each facility		x	x	x	x	National/County
	Provision and maintenance of cold chain equipment (Fridges and vaccine carriers)		x	x	x	x	National/County
	Launching of new vaccines at the county and sub county level after the national launch.		x	x	x	x	County
	Conduct regular targeted immunization outreaches		x	x	x	x	County
	Strengthen advocacy at all levels on importance of immunization		x	x	x	x	National/county
	Identify and ensure proper follow up on immunization defaulters		x	x	x	x	County
	Ensure proper documentation of immunization services,		x	x	x	x	County
	Advocacy to key stakeholders on importance of vaccine preventable diseases (Tetanus, HPV, Malaria, COVID-19)		x	x	x	x	National/County
	Regular data reviews on performance		x	x	x	x	National/County
	Provide special vaccine programs for eligible populations (SCD, Trauma, Anti snake venom, Dog Bites, etc)		x	x	x	x	National/County
	Sensitize CHPs on the importance of immunisation		x	x	x	x	County
	Mop up in hot spots		x	x	x	x	National/County
	Health promotion on immunization especially MR2 (Measles Rubella 2)		x	x	x	x	County

KEY ACTIONS	DETAILED ACTIVITIES	2022	2023	2024	2025	2026	KEY IMPLEMENTORS
Support interventions on eradication, elimination and control of vaccine preventable diseases including polio and measles	Training HCPs and CHPs on case identification and reporting		x	x	x	x	County
	Strengthen advocacy at all levels		x	x	x	x	National/county
	Conduct mass/targeted populations immunization campaigns		x	x	x	x	National/County
	Specimen collection, referral and testing of suspected Acute Flaccid Paralysis(AFPs) and Measles		x	x	x	x	County
	Weekly reporting on notifiable conditions and disease.		x	x	x	x	County
	Multi-sectoral collaborations with relevant stakeholders e.g Ministry of Education, Religious Organizations, Ministry of Interior and Community.		x	x	x	x	National/county
	Integrate outreach to hard-to-reach populations to prevent outbreak.		x	x	x	x	County
Strengthen implementation of mother, child and nutrition Malezi Bora activities	Review 'Malezi Bora' strategy		x	x	x		National/county/ partners
	Advocate for 'Malezi Bora' implementation/county ownership		x	x	x	x	National
	Integration with other health programs-community outreach & ECDS		x	x	x	x	County

6.2 Thrive - GOAL – a healthy, well-nourished and well-protected childhood for all Kenyan children

6.2.1 Strategic objective 3: Promote access to quality and comprehensive early childhood development interventions for all children eight years and below especially nurturing care in the first 1000 days of life

KEY ACTIONS	DETAILED ACTIVITIES	2022	2023	2024	2025	2026	KEY IMPLEMENTORS
Establish national and county level multi-sectoral governance mechanism with decision making authority, to coordinate early childhood development interventions across relevant sectors and stakeholders.	Development of TORs for the multi sectoral coordinating committee/TWGs for ECD interventions	X	X				National
	Establishment of national and county level multi sectoral TWGs for ECD interventions (MOH, MoE, Social Services, NGAO, implementing partners)		x				National/County
	Advocacy meetings with political leadership at national, county and sub county level for resource allocation for ECD interventions	X	X				National and county
	Development of a national and county level implementation framework for ECD interventions.			x	x		MOH, MoE, Social ser- vices, NGOs, partners, county govt.

KEY ACTIONS	DETAILED ACTIVITIES	2022	2023	2024	2025	2026	KEY IMPLEMENTORS
	Sensitization of political leaders, NGAO teams and county executives on ECD and nurturing care conduct a country wide training gap analysis. level for resource allocation for ECD interventions.		x	x	x	x	National/County/ Partners
	Strengthening of community health units through provisions of CHP KITs and trainings		x	x	x		County/Partners
Develop an integrated plan of action (national roadmap) to ensure coordinated implementation of early childhood development interventions	Advocate for Implementation of County nutrition action plan	x	x	x	x		County/Partners
	Integrated plan should be included in annual work plans at county levels roll down to sub county, facility and community levels		x	x	x		County/Partners
	Training of political leaders & Executives on Science for ECD		x	x			National/Partners
	Sensitization of NGAO Team on nurturing Care				x		National/Partners
Build workforce capacity by conducting pre-service and in- service training on nurturing care for early child development	Conduct a countrywide training gap analysis			x			National/Partners
	Review of existing training curricula to ensure that interventions for nurturing care for ECD are included		x	x			KICD/Partners
	Development and roll out of a training and capacity building plan for ECD interventions to include service providers and mangers			x	x		National/Partners
	Development of a monitoring and evaluation framework for training and capacity building for ECD.			x			National/County
Support identification of national and local champions to catalyze change and drive the early childhood development agenda in the community	Identification of ECD champions at the national, county and sub-county level.	x	x	x	x		National/County
	Involvement of key political leadership to patronize ECD activities in the Counties.		x	x	x		County/Partners
	Resource mobilization for champions' activities		x	x	x		County/Partners
	Identify mentor mothers		x	x			County/Partners
	Request the County First Lady to be the patron			x			National/County
Strengthen and integrate nurturing care into service delivery provision at all levels of the health system	Identify existing gaps at all levels of the healthcare system		x				National/County
	Development and adoption of integrated nurturing care protocols.			x			National/County/ Partners
	Inclusion of nurturing care indicators to the M&E framework			x			National/County

KEY ACTIONS	DETAILED ACTIVITIES	2022	2023	2024	2025	2026	KEY IMPLEMENTORS
	Integrating nurturing care into other service delivery areas (ANC, delivery, PNC, immunization, Nutrition, paediatric inpatient care, IMNCI and iCCM).				x		National/County
	Development of a package on male involvement in ECD and nurturing care		x	x	x	x	County/Partners
	Development of a package on male involvement in ECD and nurturing care		x				County/Partners
Promote growth and development monitoring of children by building health worker capacity and strengthening appropriate use of growth monitoring tools	Conduct inventory of available growth monitoring tools (service delivery tools and M&E tools) and conducting procurement.				x		County/Partners
	Training of service providers on use of growth monitoring tools in the context of existing guidelines.				x		County/Partners
	Promote use of Mother Child Passport and progressive improvement in the use of family health records			x	x		County/Partners
Strengthen health sector capacity for identification and appropriate and timely referrals for children with developmental delays, difficulties or disabilities	Identify Institutional and personnel gaps in identification of children with developmental delays		x	x	x	x	County/Partners
	Review existing guidelines for service providers and caregivers on early identification and referrals of children with developmental delays or disabilities.		x				National/Partners
	Caregivers engagement and sensitization on identification and appropriate, timely referrals for children with developmental delays.		x	x	x	x	County/Partners
	Strengthen CHPs, ECD teachers and religious leaders' capacity to identify and refer children with challenges to link health facility			x	x	x	County/Partners
	Establishment of centres for comprehensive management of children with developmental delays and disabilities at county level.				x		County/Partners
	Educate the public through outreaches, media, public barazas on needs of children with developmental delays and disabilities in order to address stigma in the community.			x	x	x	County/Partners
	Strengthen intra and inter-county linkage among health facilities and rehabilitation centres.			x	x	x	County/Partners

KEY ACTIONS	DETAILED ACTIVITIES	2022	2023	2024	2025	2026	KEY IMPLEMENTORS
Promote support for vulnerable populations especially in need of nurturing care, particularly children born low birth weight or premature; malnourished and chronically ill children; those with developmental difficulties and disabilities, and children affected by HIV	Develop policy and guidelines on waiver of medical fee for vulnerable children at all levels of care.		x				National/County
	Map out and link vulnerable children to CSOs/NGOs and government services for vulnerable children (cash transfer program).		x	x	x		National/County/ Partners
	Mainstream provision of KMC services at all levels of care for access by vulnerable children.	x	x	x	x	x	County
	Identification and linkage of children with developmental delays and disabilities to NHIF enrolment.			x	x	x	County/Partners
	All children enrolled in NHIF	x	x	x	x	x	County/Partners
Identify salient indicators for tracking progress in early childhood development including indicators on responsive caregiving and	Develop indicators to be tracked		x				County
	Agree on indicator monitoring times		x				County
Promote implementation research and use of data to innovate and improve provision of quality evidence based	Conduct regular operational research on factors affecting implementation of ECD activities in the County.		x	x	x		National/County/ Partners

6.1.2 Strategic objective 4: Promote interventions to end all forms of malnutrition, and address the nutritional needs amongst newborns and children

KEY ACTIONS	DETAILED ACTIVITIES	2022	2023	2024	2025	2026	KEY IMPLEMENTORS
Put in place interventions to ensure early immediate initiation of breastfeeding within the first hour of birth and encourage exclusive breastfeeding for the first 6 months of life	Avail contextualized breastfeeding reference material to all the levels of care from the community up to the hospitals		x		x		National/County
	Sensitize health workers on early essential new-born interventions		x	x	x	x	National and county
	Scale up of early essential new-born care interventions that encourage bonding of mother and baby (e.g. skin to skin contact, early initiation of breastfeeding)		x	x	x	x	County/Partners
	Establishment of functional KMC rooms for the preterm neonates	x	x	x	x	x	County/ Partners

KEY ACTIONS	DETAILED ACTIVITIES	2022	2023	2024	2025	2026	KEY IMPLEMENTORS
	Educate and counsel mothers and their families on management of breastfeeding during ANC and post-natal follow ups.	x	x	x	x	x	County/Partners
	Advocate and develop standards to encourage mother friendly care at facility	x	x	x	x	x	County/Patner
	Develop and adopt standardised algorithms in form of posters and job aids within labour ward and ANC to guide health workers on skin to skin contact procedures		x	x			National/County
	Advocate for establishment of donor human milk banks for neonates who may temporarily or permanently not access their own mothers milk in level 4 and aboves.		x	x	x	x	National/County
Strengthen systems and programs to promote and support appropriate infant and young child feeding practices.	Advocate for development and operationalization of costed County Nutrition Action Plans (CNAP	x	x	x	x	x	County/ Partners
	Advocate for establishment of breastfeeding corners for mothers as needed and lactational rooms for staff in the workplace	x	x	x	x	x	County/ Partners
	Scale up of Baby Friendly Hospital Initiative (BFHI) in collaboration with nutrition	x	x	x	x	x	National/County
	Scale up of Baby Friendly Community Initiative (BFCI)	x	x	x	x	x	County/ Partners
	Advocacy for oversight, monitoring and enforcement of Breast Milk Substitute (BMS) Act, 2012	x	x	x	x	x	County Partners
	Promote complementary feeding initiatives at community level		x	x	x	x	County/Partners
	Advocate for allocation of funds to strengthen ECDE feeding programmes .		x	x	x	x	County/Partners
	Advocacy for, procurement and distribution of anthropometric and Information, Education and Communication (IEC) materials.	x	x	x	x		County/Partners
	Advocate for adequate supply of nutrition related commodities at the facility and community level.		x	x	x	x	National/County

KEY ACTIONS	DETAILED ACTIVITIES	2022	2023	2024	2025	2026	KEY IMPLEMENTORS
Put in place systems to ensure availability of and access to services for prevention and management of all forms of malnutrition at facilityand community level	Conduct screening for malnutrition at Community level and link with the health facility		x	x	x	x	County/Partners
	Conduct nutritional screening of all the children in all the service delivery pointsat the health facility		x	x	x	x	County/National
	Conduct growth monitoring and promotion at the health facilities	x	x	x	x	x	County/Partners
	Strengthen integration of SAM/ MAM into ICCM at community level		x	x	x	x	County/National
	Collaborate with other sectors such as Agriculture, Education, gender and social services to put interventions in place to address food and nutrition security.		x	x	x	x	National/County
	Conduct Bi-annual integrated MNCH services during child health days such as Malezi Bora outreaches in all Counties and sub-counties	x	x	x	x	x	National/County/ Partners
	Collaborate with private sector to promote infant and young child feeding practices	x	x	x	x	x	National/County/ Private Sectors/ Partners
	Collaborate with private sector to promote infant and young child feeding practices	x	x	x	x	x	National/County/ Private Sectors/ Partners
	Advocate to develop capcity of health workers and community health promoters on MIYCN interventions and mainstreaming of MIYCN in youth friendly initiatives,BFHI,BFCI,BMS act,workplace support for brestfeeding and WHO growth charts.	x	x	x	x	x	National/county

6.3 Transform - GOAL – the provision of quality newborn and child health services in all counties of Kenya

6.3.1 Strategic objective 5 - Create an enabling environment for provision of quality newborn and child health services

Strategy 5.1 Leadership and Governance - Strengthen leadership and governance systems that are responsive and accountable in provision of health services to newborns and children at national and county levels

KEY ACTIONS	DETAILED ACTIVITIES	2022	2023	2024	2025	2026	KEY IMPLEMENTORS
Strengthen coordination for delivery of newborn and child health services at all levels	Strengthen the linkage between National and county level in offering newborn & child health services		x	x	x	x	National/County
	Strengthen Maternal newborn and child health TWG at all levels	x	x	x	x	x	County/national
	Customize the national newborn communication strategy		x				County/Partners
	Ensure availability of functional maternity units	x	x	x	x	x	National/County
Ensure availabliyy of functional maternal and child	Ensure availability of MCH services	x	X	x	x	x	National/County
	Conduct quarterly child health TWG meeting at all levels	x	x	x	x	x	
Enhance leadership and governance for newborn and child health managers at all levels	Disseminate relevant policies through workshops at all levels		x	x			National/County
	Disseminate TORs for County and Sub-County newborn and child health focal persons	x	x	x	x	x	National / county
	Ensure all counties have newborn/child health focal persons	x	x	x	x	x	County
	Domestication and dissemination of policy guidelines on newborn and child health	x	x	x	x	x	National/County
	The interagency committee on Newborn Child Health and Adolescent Health to align their activities to address the needs of the county.		x				County
	Develop/revise relevant policy/ strategic documents		x	x			National Government
	Printing and distribution of the policy documents, strategies and job aids		x	x	x		National/County
Strengthen legal environment for implementation of newborn child health services including at the community level	Advocacy meetings with county executive and legislative arms		x	x	x	x	Department of Family Health and CHMT
	Sensitize service providers and key stakeholders on existing laws aimed at promoting child health		x	x	x	x	National/county/ Partners
	Conduct Community Engagement meeting with local leaders on Child Health rights		x	x	x	x	County/Partners

KEY ACTIONS	DETAILED ACTIVITIES	2022	2023	2024	2025	2026	KEY IMPLEMENTORS
	Advocate for Enacting of laws promoting and protecting child health interventions		x	x			National/County. County Executive/ Assembly
	Scale up on interventions of child health rights at the community level	x	x	x	x	x	National/County/ Partners
Enhance responsive accountability systems for newborn and child health outcomes at national, county and community level	Conduct integrated quarterly support supervision/TA	x	x	x	X	x	National/County
	Develop/review support supervision tools for NCH	x	x				National/county
	Ensure availability of a budget for support supervision/TA	x	x	x	x	x	National/County
	Establishment of mentorship program newborn and child health at county/ sub-county level		x				County/national
	Strengthen MPDSR perinatal and neonatal audits and implementation of its reccommendations	x	x	x	x	x	National/County
	Strengthen Community MPDSR / verbal autopsy /perinatal and neonatal audits and implementation of its recommendations	x	X	x	x	x	National/county/ partners

Strategy 5.2 Infrastructure - Promote availability of adequate and appropriate infrastructure at both community and facility levels to enable provision of comprehensive and quality newborn and child health services.

KEY ACTIONS	DETAILED ACTIVITIES	2022	2023	2024	2025	2026	KEY IMPLEMENTORS
Advocate for Conducting renovations/ construction in health facilities to ensure provision of quality high impact newborn and child health interventions	Resource mobilization through: • Proposal writing to partners / donors/GOK	x	x	x	x	x	National/ County
	Line item budget for construction in county AWP	x	x	x	x	x	County
	Provide space for high impact intervention services e.g. ORT, Breastfeeding corners and KMC	x	x	x	x	x	County
	Improve paediatric clinics to make them more child- friendly – attractive painting, play spaces and toys.	x	x	x	x	x	County
	Input into Public Works Dept to ensure standards are followed and maintained	x	x	x	x		National/ County
Advocate to ensure health facilities are connected to electricity grid or solar/green energy to ensure all time provision of quality new born	Connection of all health facilities to the main grid	x	x	x	x	x	County
	Put in place maintenance plans for the generators and solar panels	x	x	x	x	x	County
	Equip all facilities providing newborn and child health services with standby generators / solar systems	x	x	x	x	x	County

KEY ACTIONS	DETAILED ACTIVITIES	2022	2023	2024	2025	2026	KEY IMPLEMENTORS
Advocate for adequate and quality water, hygiene and sanitation facilities for infection prevention and provision of quality Newborn and Child health services	Develop and implement water, sanitation & Hygiene protocols (WASH) and standards in all newborn and health service delivery points.	x	x	x	x	x	National/County
	Conduct supportive supervision and hand hygiene quality audits	x	x	x	x	x	National / county

Strategy 5.3 Service delivery and community health systems – Support establishment and strengthening of community health systems to increase demand and utilization of community-based newborn and child health services

KEY ACTIONS	DETAILED ACTIVITIES	2022	2023	2024	2025	2026	KEY IMPLEMENTORS
Promote implementation of integrated community case management (iCCM) for children age 2months upto 5 years & CMNC for mothers and newborns and Mother Child Booklet	Sensitize community members on availability, importance & utilization of NCH services:		x	x	x	x	County
	Support capacity building of CHPs, and CHAs to support implementation of , newborn child health intervention at community level			x	x	x	National/County
	Support implementation of Integrated Community Case Management (iCCM)		x	x	x	x	Health Dept
	Promote implementation of Community Maternal Newborn Care (CMNC)		x	x	x	x	MOH/National/ County
	Strengthen quarterly support supervision at community level for NCH		x	x	x	x	County
Promote implementation of integrated community case management (iCCM) for children age 2months upto 5 years & CMNC for mothers and newborns	Support Counties on training of TOTs, link health facility staff, CHPs, CHAs, health facility CHEWs on iCCM		x	x	x		National/County
	Advocate and support capacity building including innovative approaches for implementation iCCM such as use of the simplified Sick Child Recording Form, use of the digitized iCCM tools (Sick Child Recording Form and Newborn Danger Signs check list)		x	x	x	x	National/County
	Support Counties on training of TOTs, link health facility staff, CHPs, CHAs, on CMNC		x	x	x	x	National/County
	Advocate for provision of supplies and commodities (medicines, and supplies) working in close collaboration with Division of Community Health (DCH),		x	x	x	x	National/CHMCT, SCHMT, County

KEY ACTIONS	DETAILED ACTIVITIES	2022	2023	2024	2025	2026	KEY IMPLEMENTORS
	Advocate for inclusion of iCCM and CMNC implementation through the PHC networks		x	x	x	x	National/County/ Sub County
Implement innovative interventions to address barriers to access and utilization of high impact interventions for Newborn, child health	Advocate to counties to conduct ICCM and CMNC gap analysis and development of investment cases		x	x	x	x	County
	Advocate for integrated outreaches with counties		x	x	x	x	County
	Promote uptake of insurance schemes such as National Health Insurance Fund (NHIF, Linda Mama	x	x	x	x	x	County/Partners
	Advocate for County Governments to initiate interventions that will provide financial cushion to MNCH services		x	x	x	x	County/Partners
	Advocate for expansion/ enhancement of social insurance packages to include NCH up to nine years		x	x	x		National/County
	Advocate for allocation and ringfencing of County health resources towards MNCH at health facility and community levels.		x	x			National/County
	Link CHPs and caregivers with organizations for capacity building on entrepreneurship such as Savings and loans, table banking, merry-go-rounds		x	x	x	x	County
Increase access to integrated community case management (iCCM) of common child illnesses as per the national guidelines	Disseminate iCCM training guidelines		x				National/County
	|Timely procurement and replacement of iCCM commodities		x				National/County
	Train HCP and Community Health Promoters on ICCM	x	x	x	x	x	National/County
	Advocate for facility – community linkage		x	x			National/County
	Identify facility based community focal person	x	x	x	x	x	County
	Increase number of Tots in iCCM at all levels	x	x	x	x	x	National/County

Strategy 5.4 Human resource - Support interventions to ensure availability of adequate, skilled and motivated human resources for health for provision of quality high impact newborn and child health services at all levels of service delivery

KEY ACTIONS	DETAILED ACTIVITIES	2022	2023	2024	2025	2026	KEY IMPLEMENTORS
Strengthen the capacity of the county governments in planning, recruitment and deployment of critical health care providers for provision of newborn and child health services	Advocate and budget for the recruitment of critical health care providers for provision of newborn and child health services including Paediatricians, Neonatologists, Nurse specialists, Clinical officer specialists, etc)		x	x	x	x	National/County/ Partners
	Create awareness of service need of critical health care providers through sensitization of county public service board, county assembly and county executives		x	x	x	x	National/CHMT
	Advocate for the inclusion of critical health care providers service providers in the HR policy for planning, recruitment and deployment		x	x	x	x	National/county
Ensure retention and motivation of critical cadres for provision of high impact newborn and child health services	Advocate for the proper implementation of the Human Resource Health policy	x	x	x	x	x	National/County
	Advocate for adequate compensation and motivation of critical care health workers	x	x	x	x	x	National/County
	Advocate for recognition of community health volunteers in maternal, newborn and child health activities in collaboration with the division of community health	x	x	x	x	x	National/County
Strengthen integration of competency-based training on high impact newborn and child health interventions into health workers pre-service training programs	Involvement in development of curriculum in the pre & in-service institutions		x	x	x	x	National and Medical Training Institutions
	Integrate IMNCI, Newborn, ETAT,EENBC, KMC,CHX, in the development of curriculum in the pre abd inservice institution		x				National
	Advocate through relevant regulatory bodies the implementation of competence-based pre-service training (short courses)		x	x	x	x	National/County
Advocate for Implementing evidence-based in-service training on high impact newborn and child health interventions	Advocate for / conduct of on-job evidence-based training, mentorship, classroom training and CMEs on high impact new-born and child health interventions at facility level, including support supervision	x	x	x	x	X	National/County
	Advocate for establishment of skills labs for newborn and child health interventions at facility level for facility based mentorship	x	x	x	x	x	National/County
	Development of skills lab operational guidelines and assessment tool	x	x				National

Strategy 5.5 Quality improvement – Put in place and/or strengthen systems including policies, standards, guidelines and programs to ensure quality improvement in provision of newborn and child health services as well as improve client experiences to ensure dignified care at all levels of delivery platforms.

KEY ACTIONS	DETAILED ACTIVITIES	2022	2023	2024	2025	2026	KEY IMPLEMENTORS
Advocate for establishing and strengthening of functional newborn and child health responsive quality improvement structures and policy environment	Advocate for strengthening of perinatal deaths audits in MPDSR Committees at all levels		x	x	x	x	County Government and partners
	Review the 2016 National Guidelines for Maternal and Perinatal Death Surveillance and Response (MPDSR) to include guidance for perinatal and neonatal death audits.		X	x	x	x	National County Government and partners
	Develop and disseminate the National Guidelines for Pediatrics Death Audits		x	x			National County Government and partners
	Conduct quarterly integrated support supervision	x	x	x	x	x	County Government and partners
	Development, dissemination and implementation of small and sick newborn and paediatric quality of care standards and tools guidelines	x	x	x	x	x	County Government and partners
	Develop/review guidelines , policies, SOPs, job aids at all levels for NCH.	X	x	x	x	x	County Government and partners
	Advocate to Strengthen coordination at national level for MPDSR through the DFH	x	x	x	x	x	County Government and partners
	Strengthen MPDSR committees at the community that will include perinatal death audits.	X	x	x	x	x	County Government and partners
	Advocate to establish and operationalize NCH dashboard and scorecard in all delivering facilities		x	x			County Government and partners
	Advocate for Conducting NCH client satisfaction surveys in all facilities conducting deliveries in collaboration with counties.	X	x	x	x	x	County Government and partners
	Advocate for strengthening of clinical and non- clinical committees to include the neonatal and child health agenda (IPC committees, quality of care committees etc.)	x	x	x	x	x	County Government and partners
	Advocate for Establishment and operationalizing of the DNCH structure for coordination of child health services.	X	x	x	x	x	County Government and partners

KEY ACTIONS	DETAILED ACTIVITIES	2022	2023	2024	2025	2026	KEY IMPLEMENTORS
Establish and ensure functionality of national and county quality improvement mentors to ensure provision of quality high impact newborn and child health interventions	Train and deploy prospective PQC CQI mentors and mentees in collaboration with the Department of Quality, Standards and Regulations.	X	x	x	x	x	County, national gov- ernment and partners
	Establish and integrate an MNCH mentorship model	x	x	x	x	x	National/County
Strengthen use of quality improvement tools for provision of quality newborn and child health services	Roll out of assessment tools for pediatrics. Quality Standards for small and sick newborns and paediatrics.	X	x	x	x	x	National/County/ Partners
	Capacity building for health care providers including health records officers at all levels on use of MPDSR and other neonatal and child health reporting tools		x	x	x	x	National, County gov- ernment and partners
	Advocate/strengthen data quality audits and support supervision and promote benchmarking at all levels	x	x	x	x	x	National/County and partners
Support utilization of quality of care data for provision of newborn and child health services.	Support Training of community health workers CORPS including CHPs and provincial administration on measurements and Reporting of NCH indicators at community level	x	x	x	x	x	National, County gov- ernment and partners
	Advocate for national, counties and partners to Conduct in depth data review meetings	x	x	x	x	x	National/County
	Capacity build for managers, HRIO and county/ sub county managers on KHIS, dashboard and scorecard-score card	x	x	x	x	x	National

Strategy 5.6 Health care financing – Ensure availability of adequate financing for delivery of high impact and quality newborn and child health services

KEY ACTIONS	DETAILED ACTIVITIES	2022	2023	2024	2025	2026	KEY IMPLEMENTORS
Promote development and strengthening of strategies to ensure effective mobilization, equitable allocation, and accountability in management of financial resources for newborn and child health at both national and county levels.	Lobby/advocate for allocation for increased domestic financing funding and resource allocation for NCH activities at national and county level	x	x	x	x	x	National County government and partners
	Resource mobilization through proposal development for public private and non-profit funding including donations and proposal writing						
	Advocate for strengthening of existing health care financing initiatives for NCH.	x	x	x	x	x	National County government and partners
	Advocate for Participation at national and county level through partnership for resource mobilization through public-private funding mechanisms, donations and proposal writing,etc	x	x	x	x	x	National County government and partners
	Inclusion of NCH into the Medium-Term Plan (MTP), County Integrated Development Plans (CIDP), Mid Term Expenditure Framework (MTEF), and Annual Work plans		x	x			National County government and partners
	Advocate for social insurance for households NHIF		x	x	x	x	National County government and partners
	Hold annual stakeholders' forum with health partners for increased funding for NCH	x	x	x	x	x	National County government and partners
	Development of costed implementation plan for newborn and child health at all levels	x	x	x	x	x	National County government and partners
Advocate for strengthening financial accountability and control of MNH programmes	Monitoring and tracking of resources allocated for NCHA and advocate for strengthening of facility management committees/ boards		x	x	x	x	National County government and partners County/ Partnerss
	Capacity building on health budgeting at national and county level including sensitizing the county assembly on health priorities		x	x	x	x	National County government

Strategy 5.7 Health commodities and supplies - Strengthen systems including for procurement, supply and management to ensure availability of essential medicines, commodities, equipment and technologies for provision of newborn and child health services.

KEY ACTIONS	DETAILED ACTIVITIES	2022	2023	2024	2025	2026	KEY IMPLEMENTORS
Build capacity of county and sub-county health management teams in procurement, supply and management of essential newborn and child health services	Advocate capacity-building of CHMT/health care providers (HCP) at all levels on child health services (incl. commodities, guidelines, policies, etc.)	x	x				National/County
Procurement of essential medicines, commodities and equipment for delivery of quality newborn and child health services	Forecasting and quantification of essential NCH meds, commodities and equipment at national and county levels	x	x	x	x	x	Child Health Focal Person/ County
	Regular facility based deworming during CWCs, OPD	x	x	x	x	x	County/ Subcounty
	Advocate for inclusion of NCH essential medicines and equipment into the county procurement list as per the national Guidelines and standards; incl oxygen	x	x				National
	Generate evidence on CHX use at community level		x				National/County
	Advocate for proper utilization and accountability of all procured and donated equipment and commodities at all levels.	x	x				County
	Advocate for purchase of paediatric-size equipment, medicine and supplies, as per national guidelines	x	x			x	National/County
Strengthen equipment maintenance and repair in health facilities for delivery of quality newborn and child health services	Advocate for review of essential equipment list to include pediatric-specific items.	x	x				National/County
	Advocate for establishment of pediatric equipment maintenance plan	x	x				National/county
Promote all time availability of blood and laboratory services for provision of emergency high impact interventions for newborns and child.	Advocate and lobby for establishment of count blood banks	x	x	x	x	x	National/County
	Advocate for integrated lab services and give priority to NCH samples.		x	x			National/County
	Advocate fro paediatric size packaging of blood and blood products and testing equipment.		x	x	x		National/County
	Advocate for the increase in the number of health facilities offering accredited lab services		x	x	x		National/County
	Advocate for steady supply of lab supplies and commodities through timely ordering and supply	x	x	x	x	x	National/County

Strategy 5.8 Health information systems, monitoring and evaluation, research - Strengthen health information systems to ensure collection, reporting, quality management and use of disaggregated data at the various levels of health service delivery to inform newborn and , child and adolescent health programming.

KEY ACTIONS	DETAILED ACTIVITIES	2022	2023	2024	2025	2026	KEY IMPLEMENTORS
Strengthen data quality and use in routine monitoring and evaluation for decision-making	Advocate for availability and utilization of newborn and child health collection/ reporting tools.	x	x	x	x	x	National/County
	Periodically review new born and child health data collection/ reporting tools		x	x	x	x	National/County/ partners
	Hold regional data review meetings at national and county levels and develop action plans	x	x	x	x	x	National/County/ partners
	Advocate and conduct quarterly routine data quality audits for Newborn and child health at service delivery units in collaboration with the counties	x	x	x	x	x	National/County/ partners
	Digitize ICCM and other newborn & child health data collection/ reporting tools and MNCH to improve data demand and use for decision making at National, County and community levels	x	x	x	x	x	National/County/ partners
	Analysis and use of NCH available routine health information to inform decision making	x	x	x	x	x	National/County/ partners
	Advocate to establish and operationalize NCH dashboard and strengthen the utilization of the scorecard in all levels	x	x	x	x	x	National/County/ partners
	Performance tracking of the child health indicators in the RMNCAH scorecard	x	x	x	x	x	National/County/ partners
	Training of healthcare workers at all levels on newborn and child health data collection and reporting tools	x	x	x	x	x	National/County/ partners
	Monitoring AWP/interventions performance for NCH targets	x	x	x	x	x	National/County/ partners
	Monitoring and evaluation of the implementation of the strategic plan 2022-2026			x		x	National/County/ partners
Strengthen birth and death registration for newborns and children	Strengthen collaboration Support and conduct SBCC activities in collaboration with civil registration department at community level to promote timely registration of children as soon as they are born and notification of deaths		x	x	x	x	National/county

KEY ACTIONS	DETAILED ACTIVITIES	2022	2023	2024	2025	2026	KEY IMPLEMENTORS
Support interventions to build capacity of national and county governments to conduct newborn and child health research.	Carry out situation analysis to identify research gaps that will inform the research priority agenda		x	x	x	x	National/County/ Partners
	Support identification of research agenda, implementation research, evaluation and dissemination of emerging best practices and evidence.		x	x	x	x	National/County/ Partners
	Hold meetings/workshops to strengthen strategic partnerships and networks to support the national research agenda	X	X	X	X	X	National/County/ Partners
	Hold quarterly Strengthen the M&E research Committee of Experts for NCH	x	x	x	x	x	National/County/ Partners
	Establish a joint working framework between the national and counties on research	x	x	x	x	x	National/County/ Partners
	Establish a research linkage mechanism with academic and research institutions	x	x	x	x	x	National/County/ Partners
	Advocate for evidence informed findings to guide policy development and review	x	x	x	x	x	National/County/ Partners
	Utilize the research findings to generate policy brief(s)	x	x	x	x	x	National/County/ Partners
	Advocate for implementation / operational research for NCH at county level	x	x	x	x	x	National/County/ Partners
	Hold learning exchange / benchmarking visits and share best practices	x	x	x	x	x	National/County/ Partners
	Build capacity in the counties to drive the NCH research agenda	x	x	x	x	x	National/County/ Partners
	Advocate for dissemination and implementation of research findings	x	x	x	x	x	National/County/ Partners
Support and strengthen integrated supervision	Conduct integrated quarterly support supervision	x	x	x	x	x	National/County/ Partners
	Develop/review, and validate support supervision tools for NCH	x	x	x	x	x	National/County/ Partners
	Ensure availability of a budget for support supervision	x	x	x	x	x	National/County/ Partners
	Establishment of mentorship program at county/sub-county level	x	x	x	x	x	National/County/ Partners

Strategy 5.9 - Water, hygiene and sanitation and other social determinants of health – Identify social determinants to child health including socioeconomic conditions, education, housing and environmental conditions and develop strategies to engage in strategic partnerships to address these determinants.

KEY ACTIONS	DETAILED ACTIVITIES	2022	2023	2024	2025	2026	KEY IMPLEMENTORS
Support utilization of safe water and sanitation and improved hygienic practices by caregivers and children at households, communities, learning institutions and other congregate settings in collaboration with the WASH program.	Advocate for sensitizing HC providers and CHPs and equip them with skills to support the households, communities, learning institution including schools on utilization of clean safe water, hand washing facilities and their uses, provision and use of washrooms/cloak room/ personal hygiene	x		x		x	Ward PHO's CHA's
	Advocate for Sensitizing the households, community, learning institutions, churches, mosques on water treatment techniques through community barazas and community dialogue days	x	x	x	x	x	Ward public health officers Community health volunteers

Strategy 5.10 – Special needs and disabilities - Strengthen strategies for prevention and early identification of developmental delays, special needs and disabilities

KEY ACTIONS	DETAILED ACTIVITIES	2022	2023	2024	2025	2026	KEY IMPLEMENTORS
Early identification (detection, assessment, screening) and referral of children with developmental delays, disabilities and special needs	Training/Sensitization of staff on early detection identification, screening, and assessment of developmental delays, disabilities and special needs;	x	x	x	x	x	County director of health services/ CHMT
	Strengthen/scale up community-based rehabilitation (CBR).	x	x	x	x	x	MOH/APDK
	Advocate for establishment and equipping of comprehensive rehabilitation facilities	x	x	x	x	x	County director of health services/ CHMT
	Advocate for ANC scale up of second trimesters scans of congenital defects	x	x	x	x	x	National/ County/ Subcounty
	Advocate for provision outreach disability services	x	x				CHMT
	Advocate for creating awareness at all levels of community and the health service on prevention, identification, early intervention and referral.	x	x	x	x	x	County/Partners
	Harmonizing/development of uniform tools and, a system of referral	x	x				MOH NATIONAL/ COUNTY/ PARTNERS
	Review existing guidelines for service providers and caregivers on early identification and referrals of children with developmental delays or disabilities.		x				National/Partners
	Educate care givers the public on identification linkage and needs of children with developmental delays and disabilities in order to address stigma in the community through outreaches, media, public barazas .			x	x	x	County/Partners
	Develop guidelines on children with special needs and disabilities that incorporates waiver of medical fees.		x				National/County
Promote mainstreaming of special needs and disabilities into all child policies and programs	Review of the existing child policies and programs to identify and fill any existing gaps	x					Child health focal per- son ETAT champions Rehabilitative focal person

KEY ACTIONS	DETAILED ACTIVITIES	2022	2023	2024	2025	2026	KEY IMPLEMENTORS
Support child health rights and children with special needs and disabilities.	Advocate or create awareness for child health rights and seeking of health services appropriately	x	x	x	x	x	County and sub county health promotion officers Health teachers
	Map all partners supporting child health activities at all levels	x	x	x	x	x	National/ County/ Subcounty
	Participate in commemorating world child days	x	x	x	x	x	County and sub county health pro-motion officers Health teachers

Strategy 5.11 Public private partnerships - Develop strategies and approaches to strengthen resource mobilization for newborn and child health services and programs through public private partnerships.

KEY ACTIONS	DETAILED ACTIVITIES	2022	2023	2024	2025	2026	KEY IMPLEMENTORS
Establish functional multisectoral fora at national and county levels for enhanced provision of newborn and child health high impact interventions Harness private sector for improved public private coordination, collaboration and accountability for results	Map all the partners supporting child health activities at national and county level	x		x		x	National/County/ partners
	Strengthen role in high level multi sectoral PPP stakeholder's forum for newborn and child health		x	x	x	x	National/County/ partners
	Inclusion of private sector in scale-up of newborn and child health interventions		x	x	x	x	National/County/ partners
	Reinforce capacity for health care providers in private facilities			x	x	x	National/County/ partners
	Advocate for inclusion of private sector into the various TWGs	x	x				National/County/ partners
	Advocate and promote reporting by private sector into the DHIS2	x	x	x	x	x	National
	Disseminate newborn and child health national guideline and policies at the TWGs	x	x	x	x	x	National/County/ partners
Strengthen capacity of the private sector in implementing high impact newborn and child health interventions	Advocate for training and mentorship of healthcare providers in private facilities	x	x	x	x	x	National/County/ partners
	Distribute guidelines and monitoring tools to private facilities	x	x	x	x	x	Sub county medical of- ficers-health services/ SCHMT
	Advocate for provision of essential drugs and commodities/ supplies to private facilities as per MoH guidelines(timely forecasting and quantification)		x	x	x	x	National/County/ partners
	Establish and implement mechanisms for continued quality improvement focused on private facilities.	x	x				National/County/ partners

KEY ACTIONS	DETAILED ACTIVITIES	2022	2023	2024	2025	2026	KEY IMPLEMENTORS
Strengthen engagement with and coordination of the private sector to promote implementation of this policy and ensure availability and provision of quality newborn	Joint planning and M&E activities (quarterly/bi annual national and county performance review meeting, quarterly data quality audit, quarterly service quality assessment)		x	x	x		National/County/ partners

Strategy 5.12 Child health in emergencies - Support effective response to newborn and child health in disasters and emergency situations

KEY ACTIONS	DETAILED ACTIVITIES	2022	2023	2024	2025	2026	KEY IMPLEMENTORS
PHASE 1 : Strengthen coordination, partnership, advocacy, quality & standards for effective newborn and child health emergency prepraedness and response at the national and county levels	Advocate for stakeholders meeting to review/include Newborn and Child Health interventions in emergencies through capacity building at all levels	x	x	x	x	x	County director of health services
	Training of national officers on management and coordination of newborn and child health emergencies and disasters	x		x			National Gov.
	Establish an Emergency Rapid Response Committee (ERRC) at DNCH incorporating DNCH stakeholders (NB: The ERRC will also liaise with National Health ERRC and County NCH ERRM committees).	x					County Government and Partners
	Advocate for the establishment of ERRC in the county level	x	x				County Government and Partners
	Advocate for representation of newborn and child health officers in the health sector emergency committee.	x		x		x	Sub county medical of- ficers-health services/ SCHMT
	Advocate for inclusion of County Child Health focal persons into the County Emergency Rapid Response Committee (CERRC)	x	x	x	x	x	County Government and Partners
	Review Emergency Response Kit for Kenya on Child Health in Emergencies (With reference to existing MOH Policies and Guidelines)		x	x			National Government
	Develop action plan on emergency preparedness and response to newborn and child health in humanitarian situations		x				National Government
	Strengthen surveillance of Newborn and Child Health indicators in emergency settings (With reference to existing MOH Policies and Guidelines)		x				National/County

KEY ACTIONS	DETAILED ACTIVITIES	2022	2023	2024	2025	2026	KEY IMPLEMENTORS
	Monitoring and Evaluation of the surveillance system on Newborn and ChildHealth in Emergencies	x	x	x	x	x	National/County
	Establishment and operationalization of the Monitoring, Evaluation, and Accountability and Learning System (MEAL) system for the newborn and child health in emergency and disasters	x	x	x	x	x	National/County
	Participate in National Emergency Committee Activities	x	x	x	x	x	National Government
	Foster/Integrate multisectorial response to child emergencies with other sectors (e.g. WASH, Education, Protection and Community Engagement for Behaviour & Social Change etc.)	x	x	x	x	x	National Government
PHASE 2: Enhance newborn and child health emergency preparedness and response	Train ToTs on newborn and child health emergencies and disasters		x		x		National/County/ partners
	Support implementation of priority interventions on emergency and disasters by training of healthcare providers on high impact interventions	x	x				National/County/ partners
	Collaborate with EOC to ensure that data on critical Neonatal and Child health interventions is up to date, strengthen and/ or establish pre-emergency tracking system	x	x	x	x	x	National Government
	Develop appropriate health education and promotion messages for all levels for implementing behavior change activities.		x				National Government
	Strengthen coordination mechanisms within the health sector at national and county levels to ensure strategic, coherent and effective implementation of NCH and nutrition responses to emergencies	x	x	x	x	x	National/County
	In collaboration with the emergency committee, develop NCH response plan- life saving interventions	x	x	x	x	x	National/County
	Ensure the re-establishment of disrupted essential care services for NCH, including reassessment of the newborn and child health kits;	x		x		x	National/County

KEY ACTIONS	DETAILED ACTIVITIES	2022	2023	2024	2025	2026	KEY IMPLEMENTORS
	Ensure provision of clinical and psychosocial services for victims of sexual violence and/or child abuse.		x				National/County/ Partners
	Ensure continuous monitoring and evaluation of available supplies		x				National/County/ Partners
	Ensure continued health coordination and action links to recovery and long-term development	x	x	x	x	x	National/County/ Partners
	Conduct a gap analysis of local and national capacities in Newborn and Child health ensuring integration of capacity strengthening in early recovery and transition plans, with a focus on risk reduction.	x	x	x	x	x	National/County/ partners
PHASE 3: Facilitate newborn and child health recovery and rehabilitation services following emergenncies	Hold review meetings on the use of the emergency response as a platform for sustainable scale-up of critical Newborn and Child health interventions at all levels.	x			x		National/County/ partners
	National sharing on newborn and child health in emergency and disaster situations	x	x	x	x	x	National/County/ partners

Strategy 5.13 Advocacy, communication and social mobilization (ACSM) - Support development and implementation of newborn and child advocacy and communication strategic framework at national and county levels.

KEY ACTIONS	DETAILED ACTIVITIES	2022	2023	2024	2025	2026	KEY IMPLEMENTORS
Develop advocacy strategies for buy in and support for implementation of neonatal and child health high impact Interventions at national and county level	Develop and disseminate NCH Advocacy communication and SBCC	x		x		x	County director of health services/CHMT
	Develop advocacy toolkits for Newborn	x	x	X	x		National/County Gov- ernment and Partners
	Develop advocacy toolkit for Children 2months upto 10 years		x	x			National/County
	Develop advocacy toolkit for nurturing care		x				National/County/ Partners
	Develop advocacy toolkit for iCCM		x				National/Partners
	Advocate for support for commemoration of world child health days	x	x	x	x	x	National/County/ Partners

KEY ACTIONS	DETAILED ACTIVITIES	2022	2023	2024	2025	2026	KEY IMPLEMENTORS
Develop Communication strategies to support creating awareness on NCH high impact interventions	Develop IEC materials with key messages on newborn high impact intervention	x	x				National/County/ Partners
	Develop IEC materials with key messages on children 2 up to 10-year-old high impact intervention	x	x				National/County/ Partners
	Develop IEC materials with key messages on nurturing care high impact intervention	x	x				National/County/ Partners
	Develop IEC materials with key messages on iCCM impact intervention			x			National/County/ Partners
	Develop a communication plan to disseminate IEC Materials with key messages through media engagement (print, electronic and social media)			x	x		National/County/ Partners
Research for NCH ACSM Activities	Conduct caregiver KAP survey on newborn and Child health high impact interventions Hire a consultant, field work		x			x	National/County/ Partners
Coordination and Partnerships for ACSM	Hold one quarterly ACSM TWG meetings for coordination of stakeholders	x	x	x	x	x	National/County/ Partners
Develop Social Mobilization strategies for Community engagement for NCH high impact interventions	Nominate newborn and child health community champions		x				National/County/ Partners
	Hold community dialogue and action days targeting NCH interventions for positive behavior change	x	x	x	x	x	National/County/ Partners
Inclusion of NCH in the existing ACSM/ HPAC at national and county level for coordinated ACSM activities, planning implementation and monitoring	Advocate for inclusion of NCH representative on county ACSM committees	x	x	x	x	x	County director of health services/CHMT
	Support and Capacity build ACSM/ (health promotion and advocacy committees at county level on NCH activities	x	x	x	x	x	County Government and Partners
Build capacity at national and county for Advocacy on Resource mobilization and support of NCH programme	Advocate for Establishment of resource mobilization committees on NCH advocacy at county level		x	x			County Directors
	Lobby for advocacy meetings with CHMT, County Assembly, local Media houses			x	x		County Directors/ Partners

7.0 IMPLEMENTATION

ROLES AND RESPONSIBILITIES

The Cabinet Secretary responsible for Health shall have the overall responsibility for the implementation of this Strategic Plan. The Division of Neonatal and Child Health within the Department of Family Health supported by the various technical working groups (TWG) shall be responsible for the day-to-day support to the Cabinet Secretary responsible for Health in ensuring the implementation of the plan. At County level, the Governor with the support of the County Health Management Teams (CHMT) shall be responsible for ensuring the implementation and financing of the strategic plan. The aspirations of this plan shall be captured in the County Integrated Development Plans (CIDP) at the county level and in the Medium Term Plan (MTP) at the national level.

All the counties (through the County Department of Health) shall be expected to develop annual implementation work plans that are aligned to this Newborn and Child Health (NCH) strategic plan. To ensure joint planning, financing and monitoring, all partners shall be required to align their support for newborn and child health response to this plan.

Roles and Responsibilities

Division of Neonatal and Child Health (NCH) and National Level TWGs

- Launch and dissemination of the NCH strategic plan for national level stakeholders as well as county health management teams
- Support county governments to develop county specific costed implementation plans for NCH
- Resource mobilization for implementation of the costed newborn and child health strategic planProvide technical leadership in the development of newborn and child health guidelines, SOPs, job aids and other technical documents necessary for the implementation of the proposed strategies
- Capacity build counties on matters relating to NCH
- Mobilise and engage in strategic partnerships with other government relevant ministries that impact on delivery of newborn and child health services, including but not limited to the Ministries of Agriculture, Education, Water and Interior
- Provide leadership in coordination towards implementation of this NCH strategic plan
- Provide leadership in monitoring and evaluation of the NCH strategic plan
- Together with county governments and other stakeholders provide leadership for documentation and scale up of emerging best practices in the newborn and child health response
- Formulation of the relevant guidelines and standards
- Lead in the development of research agenda for newborn and child health

County Governments

- Develop county-specific costed implementation plans and monitoring and evaluation frameworks.
- Provide leadership in dissemination of the NCH strategic plan to county level stakeholders including health service providers
- Coordinate and mobilize County level stakeholders including the private sector towards implementation

of the County specific costed implementation plan for NCH

- Provide leadership for resource mobilization for the implementation of the county costed implementation plan
- Provide leadership for monitoring, evaluation and reporting of the county costed implementation plan
- Provide technical assistance including support supervision to health service providers at both public and non public health facilities involved in the provision of high impact newborn and child health interventions
- Participate in the development of research agenda for newborn and child health

Development and or implementing partners and private sector players

- Participate in joint planning, financing and monitoring of priorities to the implementation of the newborn and child health strategic plan
- Supplement government resources in the implementation of the newborn and child health strategic plans
- Complement the government in the implementation and provision of newborn and child health services
- Advocate for the implementation of the newborn and child health strategic plan
- Hold the government accountable in the implementation of the newborn and child health strategies
- Participate in coordination meetings for monitoring, review and evaluation of the newborn, and child strategic plan national and county level
- Participate in the development of research agenda for newborn and child health

Academic, professional and regulatory authorities

- Provide technical assistance including in human resource development for the implementation of the newborn and child health strategic plan
- Facilitate in registration, regulation and licensing of service providers for newborn and child health services both in public and non public facilities
- Support in upholding ethics in the provision of newborn and child health services
- Participate in joint monitoring and evaluation of the newborn and child health strategic plan
- Support in identification of a research agenda for newborn and child health, ensure implementation of the research agenda, documentation of emerging best practices and promote scale up.
- A role in ensuring development and proper training of the health workforce
- Participate in the development of research agenda for newborn and child health

Communities and individuals

- Access and utilize newborn and child health services at all levels of service delivery
- Advocate with county and national governments for provision of comprehensive and quality newborn and child health services at all levels
- Hold the government both at national and county levels and other actors accountable in provision of newborn and child health services
- Engage in positive behaviors and practices for promotion and uptake of quality newborn and child health services
- Participate in monitoring and implementation of the newborn and child health strategy
- Ownership by the community
- Participate in research agenda for newborn and child health

8.0 RESOURCE REQUIREMENTS

The implementation of the New-born and Child Health Strategic Plan requires that all interventions or activities per thematic area, are costed. The estimates that appear in this Chapter will help guide and inform the annual planning, but also prepare the country to ensure that resource mobilization is planned ahead for each year, by the government as well as health sector development partners. This chapter describes in detail the level of resource requirements for the strategic plan period, the available resources and the gap between what is anticipated and what is required. In the first section, cost estimates are tabulated. In the second section, the available resources are tabulated and discussed. Finally, in the third section, the resource gaps for the plan period are provided by comparing resources required (cost estimates) with the resources available. Overall, this information on costs, resources available, and the financing gap will assist stakeholders to develop realistic annual budgets, without which annual operational plans cannot be designed or implemented in a more effective way.

Costing is a process of determining in monetary terms, the value of inputs that are required to generate a particular output. It involves estimating the quantity of inputs required by an activity/programme. Costing may also be described as a quantitative process, which involves estimating both operational (recurrent) costs and capital costs of a programme. The process ensures that the value of resources required to deliver services are cost effective and affordable.

Resource Requirements for New-born and Child Health Strategic Plan Implementation

The New-born and Child Health Strategic Plan was costed using the Activity-Based Costing (ABC) approach. **Activity-based costing (ABC)** is a method of allocating costs to products and services based on each intervention and activity with an aim of achieving set goals /results. It focusses on the bottom-up approach. ABC generally used as a tool for planning and control. All costs of activities are traced to the product or service for which the activities are performed. Direct labor and materials are relatively easy to trace directly to products, but it is more difficult to directly allocate indirect costs to products. Where products use common resources differently, some sort of weighting is needed in the cost allocation process.

In ABC, each of the **activities** require **inputs**, such as labor, conference hall etc. These inputs are required in certain **quantities**, and with certain **frequencies**. The summation of the **product** of the **unit cost,** the **quantity,** and the **frequency** of the input that will give the **total input cost**. Unit cost refers to value of resources to provide a service to one unit/person (client or a patient). In activity-based costing all the ingredients to provide a service to one person are clearly defined. The quantity of each input (ingredient) in the provision of the service is required. The cost price of a unit of the input is also required for calculation of the unit cost

ABC is relevant to performance budgeting in two ways.

i. As a tool for better expenditure Prioritization: It permits much improved program costing, hence it provides a **systematic way** of determining how to apply **limited resources** to the **right activities** to produce the **right results** (Improve quality of expenditure)
ii. As a means of developing a tighter linkage between **planned outputs and funding**. Determining cost of the activities that are required to produce the planned outputs.

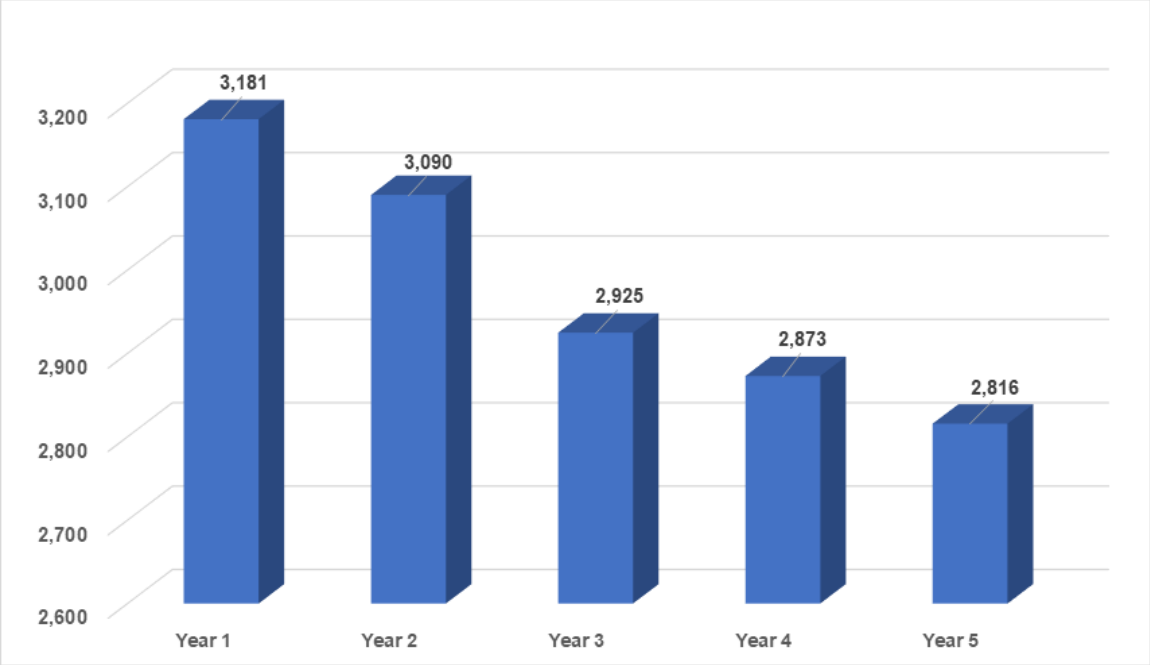
The costing of New-born and Child Health Strategic Plan employed the following steps:

i. Identified activities
ii. Determined cost for each activity
iii. Determined cost drivers
iv. Collection of activity data
v. Calculation of product cost

Summary cost estimates for the New-born and Child Health Strategic Plan

The figure below provides summary costs estimates by categories. From the costing, KES 14.2 billion is required to finance the strategy over the plan period.

Figure 8: New-born and Child Health Strategic Plan Resource needs in KES Millions



Source: ABC Costing

From the costing, Strategic Objective 5 on creating enabling environment for provision of quality Newborn and Child health services comprises the largest amount of resource requirement utilizing 66 percent followed by Strategic Objective 2 on reducing morbidity in infants and children with 17 percent as shown.

Figure 9: Breakdown of New-born and Child Health Strategic Plan Resource by Strategic Objectives

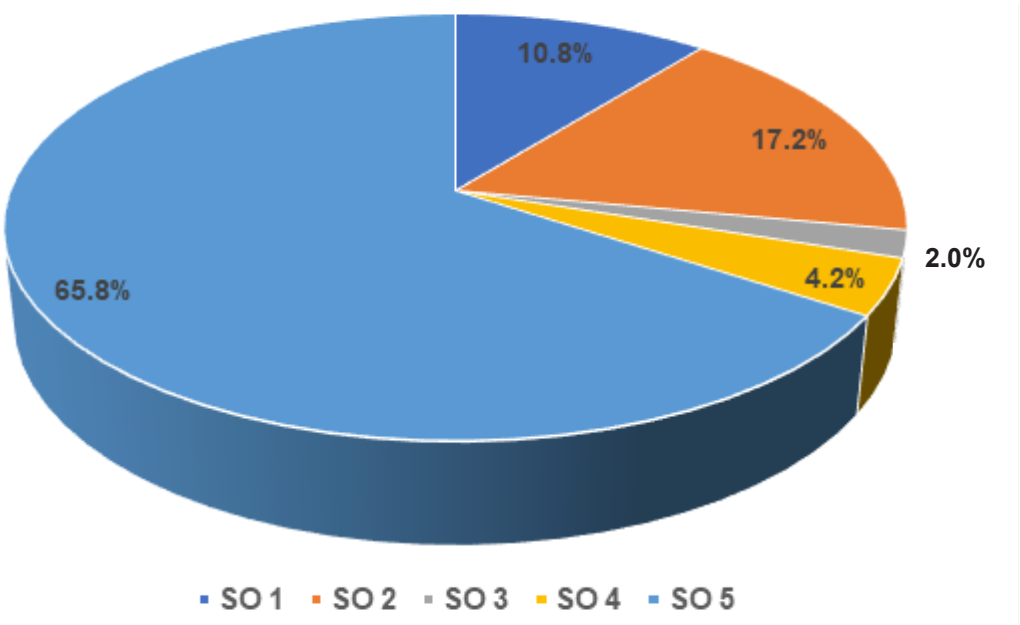


Table 2: Cost estimates for the New-born and Child Health Strategic Plan by Strategic Objectives (KES Millions)

Strategic Objectives	Year 1	Year 2	Year 3	Year 4	Year 5	Total	Percent
SO 1	465.2	303.7	298.5	269.0	267.0	1,603	10.8%
SO 2	447.4	535.2	525.4	524.7	524.7	2,557	17.2%
SO 3	101.5	69.0	47.8	39.5	46.6	304	2.0%
SO 4	215.8	104.5	104.5	104.5	98.8	628	4.2%
SO 5	1,951.0	2,077.6	1,948.7	1,935.1	1,878.6	9,791	65.8%
Grand Total	3,181	3,090	2,925	2,873	2,816	14,884	100.0%

Source: ABC Costing

Available Resources

A good health system raises adequate revenue for service provision, enhances the efficiencies of management of resources and provides the financial protection to the poor against catastrophic and impoverishing situations. Understanding how the health systems and services are financed, programmed, and resourced is important in strategic mobilization of resources, advocating for financing of priority actions, and supporting populations to access available health services. Estimation of resources is a critical component towards sustainable financing, and mobilisation on the funding in needed to implement the interventions outlined in the strategy.

With an understanding of how the health systems and services are financed, programmes and resources can be better directed to strategically complement the health financing already in place, advocate for financing of health priorities, and aid populations to access available health services.

Secondary data sources were used to establish the available financial resources for the New-born and Child Health Strategic Plan. Government financial commitments were obtained from the Fiscal Space as captured in the MOH budget. Planning assumptions have been made about future contributions available in each year of the planning period.

Table 3: Estimated and projected financial resources available by Funding source (KES millions)

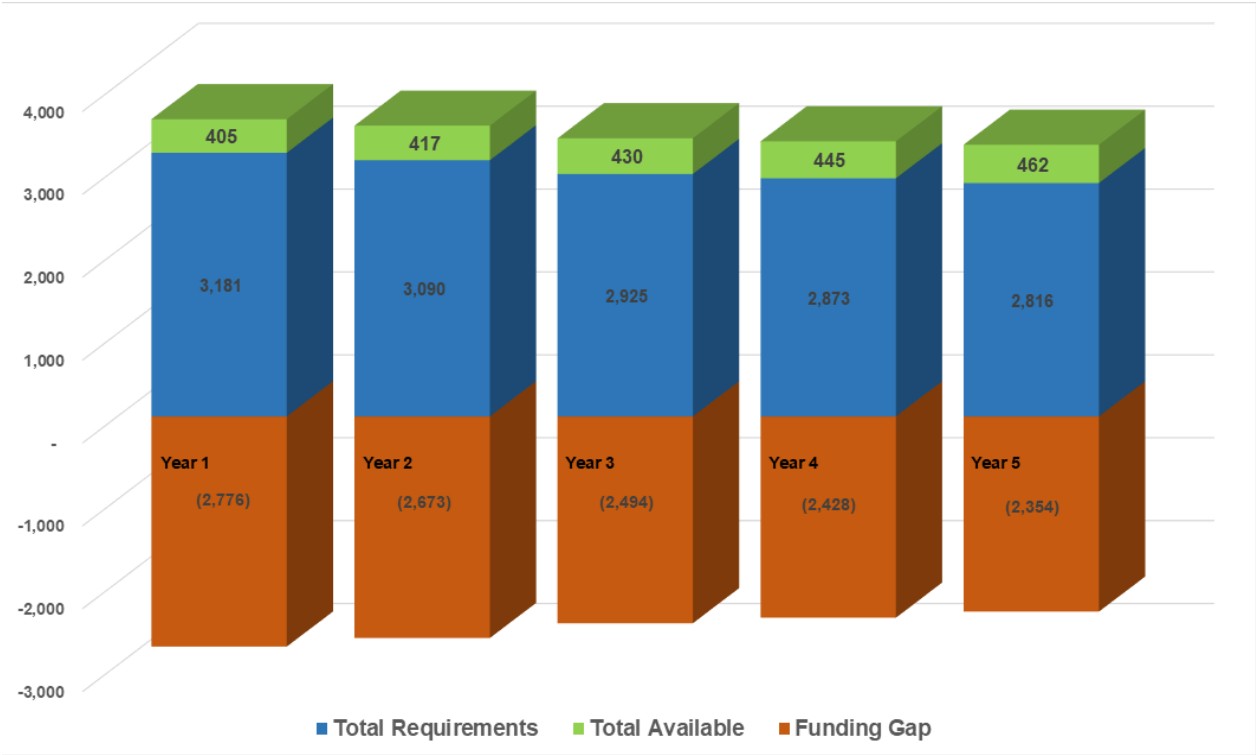
Funding Source	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Government	122,600,000	134,860,000	148,346,000	163,180,600	179,498,660	**748,485,260**
Partners	282,129,750	282,129,750	282,129,750	282,129,750	282,129,750	**1,410,648,750**
Total	404,729,750	416,989,750	430,475,750	445,310,350	461,628,410	**2,159,134,010**

Source: NCH Division

Financial Gap Analysis

The difference between the resource requirements and the available resource-based budgets provides a measure of the gap in funding that exists and can impede the full implementation of the New-born and Child Health Strategic Plan. The identification of the funding gap provides an opportunity for potential stakeholders to see where additional resources will be most useful.

Figure 10: Financial gap analysis for New-born and Child Health Strategic Plan (KES millions)
Financial gap analysis for New-born and Child Health Strategic Plan (KES millions)



The health sector requires KES 1.2 billion to reduce the funding gap. Table 4 summarizes the available resources and costs requirements from the previous sections. This provides an estimate of the New-born and Child Health Strategic Plan funding gap by year.

Table 4: Financial gap analysis for New-born and Child Health Strategic Plan (KES millions)

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Total Requirements	3,181	3,090	2,925	2,873	2,816	14,884
Total Available	405	417	430	445	462	2,159
Funding Gap	(2,776)	(2,673)	(2,494)	(2,428)	(2,354)	(12,725)

Bridging the Funding Gap

Bridging the funding gap is critical to ensure that implementation of the strategic interventions in this strategy is not hampered by lack of resources. There is need for innovative strategies to mobilize and sustain funding including from non-traditional sources.

A two-pronged approach will be adopted. First, by ensuring that resources projected as available are made available and prudently utilized. Advocacy and lobbying will be undertaken for increased budget allocations. Additionally, partners and stakeholders will be identified, mapped, and continuously engaged for support towards implementation of this strategy.

Second, appreciating that a critical ingredient to the continuity of support is transparency and accountability-implementation of this strategy will be closely monitored to ensure that resources are optimally utilized and that funders receive accountability reports that are accurate and timely. An annual report documenting the progress of achievements made in implementation of this strategic plan should be prepared and shared with stakeholders to sustain commitment.

Monitoring and Evaluation

As part of the NCH strategic plan, a monitoring and evaluation framework outlining the indicators, baseline values, targets for the five-year period, sources of data and frequency of data collection is included. The monitoring and evaluation framework shall utilize the already existing reporting platforms including Kenya Health Information System (KHIS). To ensure inequities are identified and addressed data disaggregation shall be done by counties and other equity variables, including age, gender, wealth, etc. The selected impact and coverage indicators are aligned to the other national and global documents such as the indicator and monitoring framework for children's health and the Every Newborn Action Plan.

For purposes of evaluating implementation of the strategic plan, an internal mid-term review shall be conducted at the end of the second year of the strategic plan implementation. This shall guide the revision/update of the set targets and implementation strategies where necessary. An independent end term evaluation of the plan shall be done at the end of year five to assess the achievements against set targets.

Monitoring and Evaluation Framework

Indicator	Targets (%)			Data Sources	Frequency of Data collection
	2022 (Base line)	2024 (Mid Term)	2026 (End Term)		
GOAL – reduction of newborn and child mortality and morbidity					
Neonatal mortality rate per 1,000 live births	21	15	12	KDHS	Periodic
Under five mortality rate per 1,000 live births	41	45	40	KDHS	Periodic
Infant Mortality Rate per 1,000 live births	32	31	28	KDHS	Periodic
Stillbirth rate per 1,000 births	23	17	10	KDHS	Periodic
Fresh stillbirth rate per 1,000 births in institutions	9	8	7	KHIS	Routine
Facility Neonatal mortality rate per 1,000 live births	10	7	5	KHIS	Routine
Strategic objective 1: Reduce newborn and neonatal mortality and morbidity					
Proportion of children 0-5 (<6 months) months who were exclusively breastfed	60	69	70	KHIS	Routine
Proportion of children fully immunized	80	82	85	KDHS	Survey
Proportion of infants receiving three doses of Penta3 (HIB/Hib/DPT3)	89	92	95	KDHS	Survey
Proportion of newborns applied chlorhexidine for umbilical cord care	63	60	80	KHIS	Routine
Proportion of neonates given vitamin K	65	75	90	KHIS	Routine
Proportion of Low birth weight in health facilities (less than 2500 grams)	6	6	5	KHIS	Routine
Proportion of preterm/Low birth weight babies initiated on Kangaroo Mother Care	42	50	80	KHIS	Routine
Proportion of neonatal deaths audited within 7 days	9	30	50	KHIS	Routine
Proportion of neonatal deaths due to Prematurity	25	20	15	KHIS	Routine
Proportion of neonatal deaths due to Asphyxia	36	26	21	KHIS	Routine
Proportion of neonatal deaths due to Sepsis	16	11	6	KHIS	Routine
Proportion of 4+ antenatal care visits	66	70	75	KDHS	Survey
Proportion of deliveries in a health facility	82	85	90	KDHS	Survey
Proportion of hospitals providing BEmONC services (public, private, primary, secondary & Tertiary)	50	55	60	KHFA	Annually
Proportion of hospitals providing CEmONC services (public, private, primary, secondary & Tertiary)	25	30	35	KHFA	Annually
Proportion of healthcare facilities that provide functional Kangaroo Mother Care	40	60	80	KHFA	Annually
Strategic objective 2: Reduce morbidity in infants and children (4 weeks – 10 years)					
Proportion of children under 5 with acute respiratory infection (ARI) symptoms in the last 2 weeks for whom advice or treatment was sought from a health facility or provider	82	75	80	KDHS	Periodic
Proportion of children under 5 with diarrhea taken to a health facility or provider for advice or treatment	57	65	70	KDHS	Periodic

Indicator	Targets (%)			Data Sources	Frequency of Data collection
	2022 (Base line)	2024 (Mid Term)	2026 (End Term)		
Proportion of children under five with diarrhea treated with ORS and Zinc	49	50	80	KHIS	Routine
Proportion of Health Facilities with functional Oral Rehydration Therapy corner	45	60	80	KHIS	Routine
Proportion of Health Facilities with up-to-date ORT/Zinc register	45	60	80		Routine
Proportion of children under 5 years with severe pneumonia	6	4	2		Routine
Proportion of children under five years with fast-breathing /pneumonia treated with Amoxil DT	53	50	80		Routine
Proportion of Children under five years with severe pneumonia treated with oxygen therapy	5	10	20	Survey	Periodic
Proportion of of children under five years dewormed	56	65	75		
Proportion of 6-59 months Vit A supplementation	82	85	90		
Proportion of infants in malaria-endemic areas who slept under LLIN	75	80	85		
Strategic objective 3: Promote access to quality and comprehensive early childhood development interventions for all children especially in the first 1000 days of life					
Proportion of children under five years who's developmental milestones are on track. (Learning, Health and psychosocioal well being)	78	80	85	KDHS	Survey
Proportion of children under five years checked for the four IMNCI general danger signs	25	40	60	Facility assess-ments	Periodic
Strategic objective 4: Promote interventions to end all forms of malnutrition, and address the nutritional needs amongst new- borns and children					
Proportion of stunted children aged 0-59 months	18	15	10	KDHS	Periodic
Strategic objective 5: Create an enabling environment for provision of quality newborn and child health services					
Strategy 5.1 Leadership and Governance - Strengthen leadership and governance systems that are responsive and accountable in provision of health services to newborns and children at national and county levels					
Proportion of counties with functional RMNCAH and coordination structure	60	65	70	Facility assess-ments	Periodic
Proportion of Community Health Units Established	55	80	90	KHIS	Annually
Proportion of Fully functional Community Units	66	90	95	KHIS	Annually

Indicator	Targets (%)			Data Sources	Frequency of Data collection
	2022 (Base line)	2024 (Mid Term)	2026 (End Term)		
Strategy 5.2 Infrastructure - Promote availability of adequate and appropriate infrastructure at both community and facility levels to enable provision of comprehensive and quality newborn and child health services.					
Proportion of health facilities complying with medical equipment and devices norms and standards	51	68	85	KHFA	Annually
Average distance to Nearest Health Facility	9.8	7	6	KHHEUS, KDHS	3-5 Years
Proportion of the population within 5 km distance to a health facility	62 (2018)	75	95	AccesMod - Modelling	Annually
Strategy 5.3 Service delivery and community health systems – Support establishment and strengthening of community health systems to increase demand and utilization , and to ensure delivery of community based newborn and child health services in collaboration with the community health services unit as per national guidelines.					
Proportion of health facilities using guidelines, SOPs and job aids for provision of RMNCAH interventions	60	80	95		
Proportion of health facilities providing integrated NCH services by level of service delivery (national county, facility)	60	80	95		
Number of health workers with knowledge, skills and competence to support KMC	5	20	50	KHFA	Annually
KMC beds available as a percentage of the recommended number	2	10	20	KHFA	Annually
Strategy 5.4 Human resources - Support interventions to ensure availability of adequate, skilled and motivated human resources for health for provision of quality high impact newborn and child health services at all levels of service delivery					
Core Health Worker density per 10,000 Population (Nurses, Doctors, RCOs	15.4	21.6	23.5	Emory/ IHRIS Report	Yearly
Number of Doctors per population ratio (per 10,000 population)	1.5	3.5	4	Emory/ IHRIS Report	Yearly
Number of Nurses per population ratio (per 10,000 population)	11.3	13.5	14	Emory/ IHRIS Report	Yearly
Proportion of health worker training colleges (universities and MTCs) that have a core curriculum that includes the most up to date NCH guidelines as examinable subjects	0	2	5		
Strategy 5.5 Quality improvement - Put in place and/or strengthen systems including policies, standards, guidelines and programs to ensure quality improvement in provision of newborn and child health services as well as improve client experiences to ensure dignified care at all levels of delivery platforms					
Existence and use of NCH dashboards and scorecards by level	50	60	80	KHIS	Routinely
Proportion of counties with functional MPDSR committees by level of service delivery	10	20	40	KHIS	Routinely
Proportion of maternal deaths audited within 24 hours	95	100	100	KHIS	Routinely
Proportion of perinatal deaths audited within 7 days	30	40	60	KHIS	Routinely

Indicator	Targets (%)			Data Sources	Frequency of Data collection
	2022 (Base line)	20244 (Mid Term)	2026 (End Term)		
Strategy 5.6 Health care financing - Ensure availability of adequate financing for delivery of high impact and quality newborn and child health services					
% of out of pocket expenditure of the total health budget spent on neonatal, infant and child health.					
Out of pocket expenditure as % of total health expenditure	25		15	National Health Accounts	Every 3 Years
Government spending on health as % of total government spending	11	13	15	National Health Accounts	Every 3 Years
Percentage of health expenditure specifically for NCH as part of the overall health budget	11	13	15		
Percentage of population covered under NHIF	30	35	40	NHIF/KH-HEUS	Annually
Strategy 5.7 Health commodities and supplies - Strengthen systems including for procurement, supply and management to ensure availability of essential lifesaving medicines, commodities, equipment and technologies for provision of newborn and child health services.					
Percentage of Health facilities with stock out on any of the 20 tracer non-pharm for 7 consecutive days in a month	20	10	5	KHFA	
% of health facilities reporting no stock out of essential NCAH commodities	20	10	5		
% of time out of stock for Essential Medicines and Medical Supplies – days per month					
Strategy 5.8 Health information systems, monitoring and evaluation, research - Strengthen health information systems to ensure collection, reporting, and use of disaggregated data at the various levels of health service delivery to inform newborn and child health programming					
% of children under five years who have their births registered	65	70	90		
Proportion of maternal deaths registered					
Proportion of neonatal deaths registered.					
% of county hospitals who submit 12 months of data for inpatient pediatric and neonatal admis sions and mortality each year	5	10	20	CIN	Annually
% of county hospitals that produce an annual report that describes their Newborn mortality rate stratified by birthweight, and their Paediatric Ward mortality rate stratified by age (<1 month; 1-11month; 12-59 month; and 5 – 14 years).	5	10	20	CIN	Annually
Percentage of health facilities submitting timely information (timeliness of reports)	87	90	92	KHIS	Monthly
Percentage of community units submitting timely information (timeliness of reports)	75	80	85	KHIS	Monthly

Indicator		Targets (%)					Data Sources	Frequency of Data collection
		2022 (Base line)		20244 (Mid Term)		2026 (End Term)		
Strategy 5.9 - Water, hygiene and sanitation and other social determinants of health – Identify social determinants to child health including socioeconomic conditions, education, housing and environmental conditions and develop strategies to engage in strategic partnerships to address these determinants.								
% Population using safely managed sanitation services including a hand washing facility with soap and water								
% of population using clean and safe drinking water								

9.0 REFERENCES

Akech et al; **The Clinical Profile of Severe Pediatric Malaria in an Area Targeted for Routine RTS,S/AS01 Malaria Vaccination in Western Kenya;** *Clinical Infectious Diseases,* Volume 71, Issue 2, 15 July 2020, Pages 372–380, https://doi.org/10.1093/cid/ciz844

English M, Strachan B, Esamai F, et al; **The paediatrician workforce and its role in addressing neonatal, child and adolescent healthcare in Kenya;** *Archives of Disease in Childhood 2020;105:927-931;* accessed at https://adc.bmj.com/content/105/10/927

Fink, G., Sudfeld, C.R., Danaei, G., Ezzati, M., and Fawzi, W.W. (2014). **Scaling-Up Access to Family Planning May Improve Linear Growth and Child Development in Low and Middle- Income Countries;** PLoS ONE 9(7): e102391. Doi: 10.1371/journal.pone.0102391, cited in USAID; **Kenya Nutrition Profile.**

Gathara D, Serem G, Murphy GAV, Obengo A, Tallam E, Jackson D, Brownie S, English M (2019). **Missed nursing care in newborn units: a cross-sectional direct observational study;** BMJ Qual Saf 2019;0:1–12. doi:10.1136/bmjqs-2019-009363

Guillaume D, Justus O, Ephanus K; **Factors influencing diarrheal prevalence among children under five years in Mathare Informal Settlement, Nairobi, Kenya;** J Public Health Afr. 2020 Apr 29; 11(1): 1312. doi: 10.4081/jphia.2020.1312

Ilinca S, Di Giorgio L, Salari P, Chuma J. (2019). **Socio-economic inequality and inequity in use of health care services in Kenya: evidence from the fourth Kenya household health expenditure and utilization survey;** International Journal for Equity in Health; Vol18: 196 accessed at https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-019-1106-z

Irimu G, Aluvaala J, Malla L , et al; **Neonatal mortality in Kenyan hospitals: a multisite, retrospective, cohort study;** BMJ Global Health 2021;6:e004475. Accessed at https://gh.bmj. com/content/6/5/e004475

Kamau G, et al.; **Malaria infection, disease and mortality among children and adults on the coast of Kenya Malaria Journal (2020)** 19:210 https://doi.org/10.1186/s12936-020-03286-6

Karuri SW, Murithi MK, Irimu G et al. **Using data from a multi-hospital clinical network to explore prevalence of pediatric rickets in Kenya;** Wellcome Open Res 2017, 2:64 accessed at https://doi.org/10.12688/wellcomeopenres.12038.2

Kenya Ministry of Health. (2013). **Kenya Service Availability and Readiness Assessment Mapping (SARAM) report, accessed** at http://apps.who.int/healthinfo/systems/datacatalog/ index.php/catalog/4

Kenya Ministry of Health (2018). **Newborn, Child and Adolescent Health (NCAH) Policy 2018.**

Kenya Ministry of Health (2016). **Basic Paediatric Protocols 4th Edition**

Kenya Ministry of Health, Save the Children International. (2019). **Cross-sectional Survey of the Pneumonia Situation in Three Selected Counties in Kenya**: Bungoma, Nairobi & Wajir

Kenya Ministry of Health, National AIDS and STI Control Programme (NASCOP) (2020), **Preliminary KENPHIA 2018 Report.** Nairobi: NASCOP

Kenya Ministry of Public Health. (2008). Child Survival and Development Strategy 2008-2015

Kenya National Bureau of Statistics. (2015). **Kenya Demographic and Health Survey 2014;** accessed at https://dhsprogram.com/publications/publication-fr308-dhs-final-reports.cfm

Kenya National Bureau of Statistics (March2018); 2015/16 **Kenya Integrated Household Budget Survey (KIHBS), Basic Report;**

Kenya National Bureau of Statistics. (2019). **Gross County Product Report 2019;** Accessed through Wikipedia https://en.wikipedia.org/wiki/List_of_counties_of_Kenya_by_GDP

Kenya National Bureau of Statistics, National Malaria Control Programme (NMCP) Kenya, ICF International, Ministry of Health. (2016). **Kenya Malaria Indicator Survey 2015**

Kenya Paediatric Assocation, KEMRI, Wellcome Trust, Min. Health; **Draft Report of a Workshop on Improving Inpatient Neonatal Care Services 15th & 16th February 2018, Nairobi, Kenya.**

Kenya Paediatric Association; **Draft Report Follow Up Workshop on the possible scope of work and training needs for a Neonatal Health Care Assistant to support nurses in providing improved inpatient neonatal care;** 5th April 2018, Nairobi, Kenya

Ly KN, Kim A, Umuro M et al. (2016). **Prevalence of Hepatitis B Infection in Kenya 2007;** Am J of Trop Med and Hygiene 95(2): 348-353

Macharia, P.M., Giorgi, E., Thuranira, P.N. et al. **Sub national variation and inequalities in under-five mortality in Kenya since 1965.** BMC Public Health 19, 146 (2019). https://doi. org/10.1186/s12889-019-6474-1

Macpherson L, Ogero M, Akech S et al; **Risk factors for death among children aged 5–14 years hospitalised with pneumonia:** a retrospective cohort study in Kenya; BMJ Global Health 2019;4:e001715. Accessed at https://gh.bmj.com/content/4/5/e001715

Maina M, Tosas-Auguet O, McKnight J, Zosi M, Kimemia G, Mwaniki P, et al.; **Evaluating the foundations that help avert antimicrobial resistance:** Performance of essential water sanitation and hygiene functions in hospitals and requirements for action in Kenya (2019); PLoS ONE 14(10): e0222922. https://doi.org/10.1371/journal.pone.0222922

President's Malaria Initiative Report, 2019; accessed at https://www.pmi.gov/docs/default- source/default-document-library/country-profiles/kenya_profile.pdf?sfvrsn=22

UNICEF. (2010); **Core Commitments for Children in Humanitarian Action**

UNICEF (2018); **Situation Analysis of Children and Women in Kenya 2017;** UNICEF, Nairobi, Kenya.

UNICEF. (2019) **State of the world's children 2019** - Children, food and nutrition: Growing well in a changing world; UNICEF

USAID; **Country Profile: Kenya; 2017;** available at: http://www.feedthefuture.gov/country/kenya

USAID; **Kenya Nutrition Profile, Updated February 2018;** accessed at https://www.usaid. gov/sites/default/files/documents/1864/Kenya-Nutrition-Profile-Mar2018-508.pdf

WHO; **Global health observatory;** available at: https://www.who.int/gho/child_health/mortality/causes/en/

WHO (Sept 19, 2019). **Children Reducing Mortality,** accessed at https://www.who.int/news- room/fact-sheets/detail/children-reducing-mortality

WHO (September 20, 2020); **Children: improving survival and well-being factsheet;** accessed at https://www.who.int/news-room/fact-sheets/detail/children-reducing-mortality

WHO. (2015). **The Global Strategy for Women's, Children's and Adolescents' Health (2016-2030) - Survive, Thrive, Transform;**

WHO; **Immunisation coverage;** accessed at: https://www.who.int/news-room/fact-sheets/ detail/immunization-coverage

WHO; **Levels and trends in child mortality 2015;** accessed at: http://www.who.int/maternal_child_adolescent/documents/levels_trends_child_mortality_2015/en/

WHO, UNICEF, World Bank Group. (2018). **Nurturing care for early childhood development: a framework for helping children survive and thrive to transform health and human potential.** Geneva: World Health Organization;

WHO. (2016). **Global Action Plan for Pneumonia and Diarrhoea (GAPPD).** Accessed at https://www.who.int/maternal_child_adolescent/epidemiology/gappd-monitoring/en/

ANNEX 1: OTHER RELEVANT GLOBAL AND KENYAN POLICY AND PROGRAM DOCUMENTS

Besides the Newborn, Child and Adolescent Health (NCAH) Policy, this Strategy is anchored in a number of international and Kenya policy and strategy documents, including:

- **WHO; Nurturing Care for Early Childhood Development: A Framework for Helping Children Survive and Thrive to Transform Health and Human potential; 2018** – The Nurturing Care Framework builds on state-of-the-art evidence about how early childhood development unfolds and how it can be improved by policies and interventions. The Framework describes how a whole-of government and a whole-of-society approach can promote nurturing care for young children. It outlines guiding principles, strategic actions, and ways of monitoring progress.
- **International guidance documents** published by WHO, UNICEF, UNFPA, UNAIDS, etc. on newborn health, breastfeeding, nutrition, infection control, health promotion, early infant diagnosis and treatment of HIV, immunisation, etc.
- **Kenya Health Policy 2012 – 2030** – this document, developed in 2011, is a general policy document and does not mention the specific health needs of children or women, but it does recognize four tiers of the health system: community, primary care, primary referral and tertiary referral services. Within it are contained six policy objectives:
  - **Objective 1:** Eliminate communicable conditions
  - **Objective 2:** Halt and reverse the rising burden of non-communicable conditions
  - **Objective 3:** Reduce the burden of violence and injuries
  - **Objective 4:** Provide essential health care
  - **Objective 5:** Minimize exposure to health risk factors
  - **Objective 6:** Strengthen collaboration with other sectors that have an impact on health

It should be noted that objectives 1, 2, and 4 of the Kenya Health Policy are reflected in objectives 1, 2 and 6 of the 2018 NCAH Policy (communicable and non-communicable diseases and access to health care) so this Strategy will be both a reflection and a manifestation of the larger Kenya Health Policy.

- **Kenya Health Sector Strategic Plan 2018–2022:** This is the key sector document which has outlined key strategies that the sector will focus on over the next five years. It is based on the following principles:
  - **Equity** in the distribution of health services and interventions
  - **People-centered** approach to health and health interventions
  - **Participatory** approach to delivery of interventions
  - **Multi-sectoral approach** to realizing health goals
  - **Efficiency** in the application of health technologies
  - **Social accountability**

The Plan is structured on a health systems approach, with the following sections as "Health System Investment Areas", each with its own strategies, outputs and key actions:

- Health Service Delivery
- Health Leadership and Governance
- Human Resources for Health
- Health Products and Technologies

- Health Financing
- Health Infrastructure
- Health Research and Development

This is followed by discussion on resource requirements, an implementation framework, and the roles of the various stakeholders.

- **Kenya Primary Healthcare Strategic Framework 2019-2024 -** acknowledges global changes and dynamics in the public health sector, which include an increased burden on non-communicable diseases and severe resource constraints. It proposes a number of primary health care strategic objectives and interventions with regard to the provision of health care services, leadership and governance, drugs and other medical supplies,financing of primary health care delivery, the relative roles of each of the main stakeholders involved as well as other health support systems. As well, the strategic framework calls for greater participation of the communities in the provision of health care services, the decisions on their priority health issues and getting involved in the implementation of essential clinical and public health packages. The framework includes a stepwise implementation plan which covers the induction of health related staff on PHC as well as advocacy and communication. Each primary care facility will organize its primary health care services in a people centered model. In the people centered model, a team of health workers (the multidisciplinary team– MDT) will be prescribed a population in a predetermined geographical area (The Community PHC zone).

- **Roadmap, M&E Framework and Operational guidelines towards implementing Universal Health Coverage (UHC) in Kenya 2018–2022 –** itemize the UHC goals and aspirations for the country and provides strategic interventions and priority areas of implementation towards achieving UHC, describing the role of the different players/enablers in achieving UHC. In addition, it details the monitoring and evaluation plan as well as the communication plan for UHC. The plan is for a phased approach (the first phase focusing on four counties – Kisumu, Isiolo, Machakos and Nyeri), with priorities and targets for the next four years focusing on population coverage, improving access to quality essential health services, and finding protection. The UHC Phase I will run for a period of one year, during which the other 43 counties will primarily focus on improving their health systems in preparation for the country scale-up. That includes recruiting additional health workers, ensuring adequate medicines and medical supplies in health facilities, training the health workers, improving the health infrastructure and medical equipment, with full scale-up by 2021.

- **Reducing Maternal and Neonatal Mortality in Kenya: Scaling up Effective Interventions in Maternal and Newborn Health: An Implementation Plan for the period 2016–2018 -** This document represents a strategic plan to scale-up the reduction of maternal and neonatal mortality within three years (2016-2018). The Ministry of Health (MoH) will aggressively target leading drivers of both maternal and neonatal mortality namely: postpartum hemorrhage (PPH), hypertension in pregnancy (eclampsia), maternal and neonatal sepsis, prematurity and birth asphyxia. These conditions will be used as entry points to address issues of demand generation, QoC, commodity availability and management and high impact interventions in the continuum of care. County Health Management Teams should be able to use these guidelines to realign their annual operational plans, intervention programs, costing, budgeting and financing. The document is also intended to guide collaborative networks towards positively impacting MNH within the broader framework of national development.

- **Kenya Reproductive, Maternal, Newborn, Child and Adolescent (RMNCAH) Investment Framework; 2016–2020 -** presents a prioritized set of smart interventions that could be scaled up during the next five years to rapidly improve the health outcomes of Kenyan women, children and adolescents. A useful guidance for counties to set priorities relevant for their context and mobilize collective effort involving both levels of government, development partners, civil society and private sector to enhance maternal, child and adolescent health. The RMNCAH investment framework focuses on translating political commitment into sustainable results. It recommends approaches and innovations relevant to the Kenyan context to address prioritized bottlenecks. The main assumption is that supply side interventions to improve service delivery and strengthen the health system need to be effectively coupled with innovative demand side approaches for scaling up coverage and utilization for high impact RMNCAH interventions. The framework also highlights the need for a multi-sectoral approach to address key social determinants that impact RMNCAH.

The RMNCAH investment framework prioritizes investments in 15 counties with high burden of poor maternal and child health outcomes, low coverage rates, and large underserved populations. In addition, five additional marginalized counties with underserved populations were selected for accelerated action and investment to improve national impact within the next five years.

Table 5: Counties Prioritized for Investment

Kakamega	West-Pokot	Marsabit
Nairobi	Samburu	Isiolo
Bungoma	Migori	Kitui
Turkana	Trans-Nzoia	Wajir
Nakuru	Garissa	Tana River
Mandera	Kilifi	Lamu
Narok	Homa Bay	

- **Integrated Management of Newborn and Childhood Illnesses (IMNCI) A guide for healthcare workers 2018 EDITION –** a comprehensive manual for healthcare workers for use in clinics, outpatient departments or at the bedside – a section for infants up to 2 months, other section for 2 months – 5 yrs.

- **Kenya Framework for Elimination of Mother-To-Child Transmission of HIV and Syphilis 2016-2021 –** takes the lessons learned from the first framework, and carries on the work with a goal of eliminating both MTCT and syphilis in children by 2021. Among the components of the framework are:
  - Shared responsibility of parents in elimination of new HIV infections and Syphilis in children
  - Focus on adolescent girls and young women
  - Syphilis diagnosis and treatment
  - Intensified response to address HIV stigma and discrimination
  - Strengthened community responsive programming, accountability and partnerships
  - Intensified private sector partnerships for service delivery and financing
  - Strengthened coordination mechanisms and programming driven by county governments
  - Robust strategic information systems and processes granulated to the ward and facility levels
  - Increased decentralization of diagnostics and treatment sites
  - Swift adoption of emerging technologies for diagnosis and treatment

ANNEX 2: COST REQUIREMENT BY DETAILED ACTIVITIES (KES MILLION)

Strategic Objectives and Detailed Activities	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Strategic Objective 1: Reduce new born and neonatal morbidity and mortality	465.2	303.7	298.5	269.0	267.0	1,603.4
Advocate for establishment and capacity building of the quality of care improvement teams	146.4	5.2	3.1	-	-	154.7
Capacity building of health care providers on management of all new-borns including small and sick newborn	21.3	21.3	18.3	-	-	61.0
Conduct Continuous mentorship of the HCP on essential newborn care	18.3	18.3	18.3	18.3	18.3	91.5
Conduct support supervision and mentorship	131.2	131.2	131.2	131.2	117.5	642.3
develop guidelines on respective newborn care	0.4	0.4	0.4	0.4	0.4	2.1
Development of a comprehensive newborn care protocol	3.0	3.0	3.0	3.0	3.0	15.0
Disseminate respective newborn care guidelines at national and county level	5.5	5.5	5.5	5.5	5.5	27.4
Dissemination of a comprehensive newborn care protocol	11.0	-	-	-	-	11.0
Implement respective newborn care at all levels of service delivery	11.3	11.3	11.3	11.3	11.3	56.4
Print 2000 copies of respective newborn care guidelines	-	-	-	-	3.0	3.0
Review and strengthen national perinatal and neonatal Death Surveillance and Response	18.3	18.3	18.3	18.3	18.3	91.5
Scale up Kangaroo mother care in all levels of care	56.4	56.4	56.4	56.4	56.4	282.0
Support breathing of pre-terms through administration of CPAP and surfactant	26.0	16.6	16.6	12.6	21.2	93.0
Training of HCP and mothers/caregivers on use of Chlorhexidine for cord care.	4.0	4.0	4.0	-	-	12.1
training of health care providers on respective new born care guidelines	12.1	12.1	12.1	12.1	12.1	60.4
Strategic Objective 2: Reduce morbidity in infants and children	447.4	535.2	525.4	524.7	524.7	2,557.5
Advocate for 'Malezi Bora' implementation/county ownership	-	83.5	83.5	83.5	83.5	334.0
Advocate for establishment of regional paediatric centre of excellence (National Children Referral Hospital)	6.1	-	-	-	6.1	12.2
Advocate for Implementation of referral strategy	-	6.1	-	6.1	-	12.2
Advocate for inclusion of oxygen therapy as a thematic area in pre-service Medical Training Curriculum.	-	-	1.7	-	-	1.7
Advocate for Integrated outreach services to the hard -to-reach populations	2.0	2.0	2.0	2.0	2.0	10.0
Avail updated treatment guidelines and protocols	6.1	6.1	6.1	6.1	6.1	30.6
Conduct Oxygen administration training for healthcare workers in the paediatric units.	196.0	196.0	196.0	196.0	196.0	980.2
Dissemination of printed paediatric protocols	6.1	-	-	-	-	6.1
Hire a consultant to review malezi bora strategy	-	1.2	-	-	-	1.2

Strategic Objectives and Detailed Activities	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Print and disseminate under five vitamin A supplementation and deworming guidelines	-	2.5	-	-	-	2.5
Review 'Malezi Bora' strategy	-	5.1	5.1	-	-	10.1
Review MCH handbook orientation package	-	1.7	-	-	-	1.7
Sensitise MCH HCPs to ensure effective utilization of the Mother and Child Health (MCH) Handbook	8.8	8.8	8.8	8.8	8.8	43.8
Train at least 60% of HCPs in every facility on IMNCI and ETAT+	196.0	196.0	196.0	196.0	196.0	980.2
Train HCPs and CHPs on notifiable diseases, Trauma and Non-Communicable Diseases (NCDs)	26.2	26.2	26.2	26.2	26.2	130.9
Strategic Objective 3. Promote access to quality and comprehensive early childhood developments interventions for all children especially in the first 1000 days of life	101.5	69.0	47.8	39.5	46.6	304.4
Advocacy meetings with political leadership at the national, county and sub-county level for resource allocation for ECD interventions.	14.9	14.9	-	-	-	29.8
conduct a country wide training gap analysis	-	-	-	-	-	-
Conduct regular operational research on factors affecting implementation of ECD activities in the County.	1.2	-	1.2	-	1.2	3.6
Develop indicators to be tracked	2.5	-	-	-	-	2.5
Develop nurturing care M&E framework	-	5.6	-	-	-	5.6
Development and adoption of integrated nurturing care protocols.	-	1.9	-	-	-	1.9
Development and incorporation of preservice training curriculum on nurturing care for ECD.	0.6	0.6	0.6	-	-	1.7
Development and maintenance of a Data base for nurturing care for ECD training.	12.5	-	-	-	-	12.5
Development of a national and county level implementation framework for ECD interventions.	10.1	-	-	-	-	10.1
Development of a package on male involvement in ECD and nurturing care	4.6	-	-	-	-	4.6
Development of TORs for the multi sectoral coordinating committee/TWGs for ECD interventions	0.6	0.6	-	-	-	1.1
Educate the public through outreaches, media, public barazas on needs of children with developmental delays and disabilities in order to address stigma in the community.	9.4	9.4	9.4	9.4	9.4	47.0
Establishment and operationalization of national and county level multi sectoral TWGs for ECD interventions (MOH, MoE, Social Services, NGAO, implementing partners)	17.3	17.3	17.3	17.3	17.3	86.6
Identify existing gaps at all levels of the healthcare system	1.2	-	-	-	-	1.2
Identify Institutional and personnel gaps in identification of children with developmental delays	1.2	-	-	-	-	1.2
Involvement of political leadership to patronise ECD activities in the counties	-	0.6	0.6	-	-	1.2
Review existing guidelines for service providers and caregivers on early identification and referrals of children with developmental delays or disabilities.	2.5	-	-	-	-	2.5

Strategic Objectives and Detailed Activities	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Scale up in-service training on nurturing care for ECD	4.2	4.2	-	-	-	8.3
sensitization of political leaders, NGAO team & county Executives on Science of ECD and Nurturing Care	-	1.2	-	-	-	1.2
strengthen CHPs, ECD teachers and religious leaders' capacity to identify and refer children with challenges to link health facility	12.8	12.8	12.8	12.8	12.8	63.9
strengthen intra and inter-county linkage among health facilities and rehabilitation centres.	5.9	-	5.9	-	5.9	17.7
Strategic Objective 4: Promote interventions to end all forms of malnutrition and address the nutritional needs amongst new born and children	215.8	104.5	104.5	104.5	98.8	628.1
Advocate for adequate supply of nutrition related commodities at the facility and community level	0.1	-	-	-	-	0.1
Advocate for establish breastfeeding corners for mothers as needed and lactational rooms for staff in the workplace	0.3	-	-	-	-	0.3
Advocate for establishment of donor human milk banks for neonates who may not temporarily or permanently access their own mothers' milk	32.2	32.2	32.2	32.2	32.2	161.2
Avail contextualised breastfeeding reference material to all the levels of care from the community up to the hospitals	0.6	-	-	-	-	0.6
Collaborate with private sector to promote infant and young child feeding practices	0.1	0.1	0.1	0.1	0.1	0.5
Collaborate with other sectors such as Agriculture, Education, gender and social services to put interventions in place to address food and nutrition security.	0.5	0.5	0.5	0.5	0.5	2.4
Conduct Bi-annual integrated MNCH services during child health days such as Malezi Bora outreaches in all Counties and sub-counties	56.9	56.9	56.9	56.9	56.9	284.4
Conduct growth monitoring and promotion at the health facilities	-	-	-	-	-	-
Develop and adopt standardised algorithms in form of posters and job aids within labour ward and ANC to guide health workers on skin-to-skin contact procedures	98.2	-	-	-	-	98.2
Develop capacity of Health Workers and Community Health Volunteers (CHPs) on MIYCN; integration of MIYCN interventions in youth friendly services; BFHI, BFCI, BMS Act, Workplace support for breastfeeding and WHO Growth Charts	5.7	5.7	5.7	5.7	-	22.6
Scale up of Baby Friendly Hospital Initiative (BFHI) in collaboration with nutrition	9.2	9.1	9.1	9.1	9.1	45.7
Scale up of early essential new-born care interventions that encourage bonding of mother and baby (e.g. skin to skin contact, early initiation of breastfeeding)	12.0	-	-	-	-	12.0
Strategic Objective 5: Creating enabling environment for provision of quality Newborn and Child health services	1,951.0	2,077.6	1,948.7	1,935.1	1,878.6	9,791.0
advocate for the Strengthening of perinatal death audits in MPDSR Committees at all levels	10.6	10.6	10.6	10.6	10.6	53.0

Strategic Objectives and Detailed Activities	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Capacity build CHMT/health care providers (HCP) at all levels on child health services (including. commodities, guidelines, policies, etc.)	3.6	3.6	3.6	3.6	3.6	17.9
Review the 2016 National Guidelines for Maternal and Perinatal Death Surveillance and Response (MPDSR) to include guidance for perinatal and neonatal death audits.	10.6	10.6	10.6	10.6	10.6	53.0
Advocate and conduct quarterly routine data quality audits (DQAs) for new born and child health at service delivery units in collaboration with counties	1.1	1.1	1.1	1.1	1.1	5.7
Advocate and lobby for establishment of county blood banks	214.4	214.4	214.4	214.4	214.4	1,071.8
Advocate and promote reporting by private sector into the DHIS2	2.5	2.5	2.5	2.5	2.5	12.7
Advocate and support capacity building including innovative approaches for implementation of iCCM such as use of the simplified Sick Child Recording Form, use of the digitized iCCM tools (Sick Child Recording Form and Newborn Danger Signs check list)	10.6	10.6	10.6	10.6	10.6	53.0
Advocate for increased domestic financing/funding, and ring fence funding for NCH activities at the national and county level.	17.3	17.3	17.3	17.3	17.3	86.5
Advocate for stakeholders meeting to review/ include Newborn and Child Health interventions in emergencies through capacity building at all levels	1.1	1.1	1.1	1.1	1.1	5.4
Advocate for / conduct of on-job evidence-based training, mentorship, classroom training and CMEs on high impact new-born and child health interventions at facility level, including support supervision	520.0	520.0	520.0	520.0	520.0	2,600.0
Advocate for availability and utilization of newborn and child health collection/ reporting tools	40.8	40.8	40.8	40.8	40.8	204.0
Advocate for counties to conduct iCCM and CMNC gap analysis and development of investment cases	-	-	65.3	-	-	65.3
Advocate for creating awareness at all levels of community and the health service on prevention, identification, intervention, referral and eliminate stigma in the community	7.6	7.6	7.6	7.6	7.6	38.0
Advocate for enacting of laws promoting and protecting child health interventions	0.0	0.0	0.0	0.0	0.0	0.0
Advocate for establishment of skills labs for newborn and child health interventions at facility level for mentorship	13.2	13.2	-	-	-	26.3
Advocate for inclusion of County Child Health focal persons into the County Emergency Rapid Response Committee (CERRC)	4.6	4.6	4.6	4.6	4.6	23.0
Advocate for inclusion of NCH essential medicines and equipment into the county procurement list as per Kenya essential medicine list (KEML); including oxygen	-	3.6	-	3.6	-	7.2
Advocate for inclusion of paediatric specific items into essential equipment list.	3.6	3.6	3.6	3.6	3.6	17.9
Advocate for integrated lab services and give priority to NCH samples	3.6	3.6	3.6	3.6	3.6	17.9
Advocate for National, counties and partners to Conduct in depth data review meetings	2.9	2.9	2.9	2.9	2.9	14.3

Strategic Objectives and Detailed Activities	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Advocate for proper utilisation and accountability of all procured and donated equipment and commodities at all levels.	4.0	4.0	4.0	4.0	4.0	20.0
Advocate for provision of essential drugs and commodities/supplies to private facilities as per MoH guidelines (timely forecasting and quantification)	2.5	2.5	2.5	2.5	2.5	12.7
Advocate for purchase of paediatric-size equipment, medicine and supplies, as per national guidelines	3.6	3.6	3.6	3.6	3.6	17.9
Advocate for representation of newborn and child health officers in the health sector emergency committee.	5.1	5.1	3.7	5.1	3.7	22.7
Advocate for strengthening of clinical and non-clinical committees to include the neonatal and child health agenda (IPC committees, quality of care committees etc.)	1.2	1.2	1.2	1.2	1.2	6.0
Advocate for support for commemoration of world child health days	0.8	0.8	0.8	0.8	19.2	22.4
Advocate for the establishment of ERRC in the county level	0.2	2.5	-	-	-	2.8
Advocate Forecasting and quantification of essential NCH medicines, commodities and equipment at national and county levels	-	3.6	-	3.6	-	7.2
Advocate or create awareness for child health rights and seeking of health services appropriately	2.5	2.5	2.5	2.5	2.5	12.7
Advocate through relevant regulatory bodies the implementation of competence-based pre-service training (short courses)	0.1	0.1	0.1	0.1	0.1	0.4
Advocate/strengthen data quality audits and support supervision and promote benchmarking at all levels	0.2	0.2	0.2	0.2	0.2	0.9
Analysis and use of NCH available routine health information to inform decision making	2.5	2.5	2.5	2.5	2.5	12.7
Capacity build the national DNCH team, HRIOs, and county/ sub-county managers on KHIS, dashboard, and scorecard	4.6	4.6	4.6	4.6	4.6	23.2
Capacity build health care workers (TOTs), health care workers, CHPs, CHAs on high impact MNCH strategies and interventions according to existing guidelines	14.7	14.7	14.7	14.7	14.7	73.7
Capacity building for health care providers including health records officers at all levels on use of neonatal and child health reporting tools	20.5	20.5	20.5	20.5	20.5	102.6
Capacity building on health budgeting at national and county level including sensitizing the county assembly on health priorities	37.2	37.2	37.2	37.2	37.2	186.2
Carry out situation analysis on new-borns and child health to identify research gaps that will inform the research priority agenda	-	1.8	-	-	1.8	3.6
Clinical and psychosocial services for victims of sexual violence and/or child abuse.	4.6	4.9	4.6	4.6	4.6	23.1
Collaborate with EOC to ensure that data on critical Neonatal and Child health interventions is up to date, strengthen and/or establish pre-emergency tracking system	1.9	1.9	1.9	1.9	1.9	9.6

Strategic Objectives and Detailed Activities	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Conduct a gap analysis of local and national capacities in Newborn and Child health ensuring integration of capacity strengthening in early recovery and transition plans, with a focus on risk reduction.	1.1	1.1	1.1	1.1	1.1	5.4
Conduct caregiver KAP survey on newborn and Child health high impact interventions	-	4.9	4.9	-	4.9	14.8
Conduct integrated quarterly support supervision	15.0	15.0	15.0	15.0	15.0	74.9
Conduct NCH annual client satisfaction surveys in all facilities conducting deliveries in collaboration with counties.	11.4	11.4	11.4	11.4	11.4	57.2
Conduct quarterly child health TWG meeting at all levels	0.6	-	-	-	-	0.6
Conduct quarterly integrated support supervision on quality of care for newborn and child health	16.0	16.0	16.0	16.0	16.0	80.0
Create awareness of service need of critical health care providers through sensitization of county public service board, county assembly and county executives	1.1	1.1	1.1	1.1	1.1	5.7
Develop a communication plan to disseminate IEC Materials with key messages through media engagement (print, electronic and social media)	4.0	4.0	4.0	4.0	4.0	20.0
Develop action plan on emergency preparedness and response to newborn and child health in humanitarian situations	-	8.0	-	-	-	8.0
Develop advocacy toolkit for Children 2months up to 10 years	-	10.1	-	-	-	10.1
Develop advocacy toolkit for iCCM	-	-	-	-	-	-
develop advocacy toolkit for nurturing care	-	6.0	-	-	-	6.0
Develop advocacy toolkits for Newborn health	-	10.1	-	-	-	10.1
Develop an advocacy plan for all NCH program interventions	-	7.6	-	-	-	7.6
Develop and disseminate NCH Advocacy communication and SBCC	-	6.0	16.0	16.8	-	38.8
develop and disseminate the National Guidelines for Paediatrics Death Audits	42.9	42.9	42.9	42.9	42.9	214.6
Develop appropriate health education and promotion messages for all levels for implementing behavior change activities.	-	7.5	4.3	4.3	4.3	20.3
Develop guidelines on children with special needs and disabilities that incorporates waiver of medical fees.	-	2.5	-	-	-	2.5
Develop/review, validate and launch support supervision tools for NCH	5.1	5.1	-	-	-	10.1
Develop/revise relevant policy/strategic documents	16.4	13.9	13.9	13.9	13.9	71.9
develop IEC materials with key messages on children 2 up to 10 year old high impact intervention	5.1	-	-	-	-	5.1
develop IEC materials with key messages on iCCM high impact intervention	-	-	-	-	-	-
develop IEC materials with key messages on newborn high impact intervention	-	5.1	2.5	-	-	7.6
develop IEC materials with key messages on nurturing care high impact intervention	-	6.0	-	-	-	6.0
development of community-based rehabilitation policy	-	13.1	-	-	-	13.1
Development of costed implementation plan for newborn and child health at all levels	6.2	6.0	6.0	6.0	6.0	30.3

Strategic Objectives and Detailed Activities	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Development of policy briefs	2.5	2.5	2.5	2.5	2.5	12.7
Development of skills lab operational guidelines and assessment tool	10.1	-	-	-	-	10.1
Development, dissemination and implementation of community newborn and paediatric quality of care guidelines	2.5	2.5	2.5	2.5	2.5	12.7
Development, dissemination and implementation of newborn and paediatric quality of care guidelines	3.1	3.1	3.1	3.1	3.1	15.4
Disseminate iCCM training guidelines	9.1	-	-	-	-	9.1
Disseminate IEC materials with key messages on NCH high impact interventions through interpersonal communication	-	-	-	16.0	-	16.0
Dissemination of skills lab operational guidelines and assessment tools	11.9	-	2.5	-	2.5	17.0
Dissemination of relevant policies through workshops at all levels	8.0	8.0	-	-	-	16.0
Dissemination of research findings	16.8	16.8	16.8	16.8	16.8	83.8
Distribute guidelines and monitoring tools to private facilities	1.3	1.3	-	-	-	2.6
Ensure all data collection/reporting tools and indicators are updated and embedded in the national EMR system for new born & child health to improve data demand and use for decision making at National, County and community levels. Support counties to adopt and update the data in the EMR system	13.0	13.0	13.0	13.0	13.0	65.0
Ensure continued health coordination and action links to recovery and long-term development	0.5	0.5	0.5	0.5	0.5	2.7
Ensure continues monitoring and evaluation of available supplies	-	9.6	-	-	-	9.6
Ensure the re-establishment of disrupted essential care services for NCH, including reassessment of the newborn and child health kits;	1.4	1.4	1.4	1.4	1.4	6.9
Establish a joint working framework and linkages between the national, counties, academic, and research institutions to harmonize research for Newborn and child health agenda	10.9	10.9	10.9	10.9	10.9	54.5
Establish an Emergency Rapid Response Committee (ERRC) at DNCH incorporating DNCH stakeholders (NB: The ERRC will also liaise with National Health ERRC and County NCH ERRM committees).	0.2	-	-	-	-	0.2
establish and implement mechanisms for continued quality improvement focused on private facilities	-	2.5	2.5	-	-	5.1
Establishment and operationalization of the Monitoring, Evaluation, and Accountability and Learning System (MEAL) system for the newborn and child health in emergency and disasters	3.2	10.4	3.2	10.4	3.2	30.3
Establishment of NCH mentorship program at county/ sub-county level	202.3	203.2	202.3	202.3	203.2	1,013.2
Foster/Integrate multisectoral response to child emergencies with other sectors (e.g. WASH, Education, Protection and Community Engagement for Behaviour & Social Change etc.)	1.9	1.9	1.9	1.9	1.9	9.6
Generate evidence on CHX use at community level	-	1.2	-	-	-	1.2

Strategic Objectives and Detailed Activities	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Harmonising/development of uniform tools and, a system of referral Hospital	2.5	2.5	-	-	-	5.1
Hold annual meetings to strengthen use of quality improvement tools for provision of quality newborn and child health services	2.5	2.5	2.5	2.5	2.5	12.7
Hold annual stakeholders' forum with health partners for increased funding for NCH	0.4	0.4	0.4	0.4	0.4	1.8
Hold bi annual review meetings at DNCH to advocate for Strengthening coordination at national level for MPDSR through the DFH	0.1	0.1	0.1	0.1	0.1	0.7
Hold learning exchange / benchmarking visits and share best practices	3.4	3.4	3.4	3.4	3.4	16.8
hold one quarterly ACSM TWG meetings for coordination of stakeholders	0.8	0.8	0.8	0.8	7.2	10.4
Hold quarterly M&E and research Committee of Experts for NCH	0.1	0.1	0.1	0.1	0.1	0.4
Hold regional meetings to advocate for establishment and strengthening of MPDSR committees at the community that will include perinatal death audits.	2.1	2.1	2.1	2.1	2.1	10.6
Hold review meetings on the use of the emergency response as a platform for sustainable scale-up of critical Newborn and Child health interventions at all levels.	4.6	4.6	4.6	4.6	4.6	22.8
In collaboration with the emergency committee develop NCH response plan- life saving interventions	0.2	0.2	0.2	0.2	0.2	0.8
Inclusion of NCH into the Medium-Term Plan (MTP), County Integrated Development Plans (CIDP), Mid Term Expenditure Framework (MTEF), and Annual Work plans	38.6	38.6	38.6	38.6	38.6	192.8
Integrate IMNCI , Newborn ETAT,EENBC, KMC,CHX in development of curriculum in the pre & in-service institution	2.5	-	-	-	-	2.5
Mobilize resources and advocate for availability of a budget for technical working group meetings	9.6	9.6	9.6	9.6	9.6	47.8
Monitoring of the AWP/High impact interventions performance for NCH targets	-	3.9	-	3.9	-	7.8
Monitoring and evaluation of the implementation of the strategic plan 2022-2026	-	-	1.2	-	1.2	2.4
Monitoring and Evaluation of the surveillance system on Newborn and Child Health in Emergencies	7.9	7.9	7.9	7.9	7.9	39.4
Monitoring and tracking of resources allocated for NCH	66.1	66.1	66.1	66.1	66.1	330.7
National sharing on new born and child health in emergency and disaster situations	4.5	4.5	4.5	4.5	4.5	22.4
Nominate newborn and child health community champions	-	2.4	-	-	-	2.4
Performance tracking of the child health indicators in the RMNCAH scorecard	16.0	16.0	16.0	16.0	16.0	80.0
Periodically review new born and child health data collection/ reporting tools as per HIS guidelines	9.1	-	-	9.1	-	18.1
Provide space for high impact intervention services e.g., ORT, Breastfeeding corners/space and KMC	6.1	6.1	6.1	6.1	6.1	30.6

Strategic Objectives and Detailed Activities	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Regional county annual data review meetings and develop action plans	55.7	55.7	55.7	55.7	55.7	278.4
Regular facility-based deworming during CWCs, OPD	16.7	16.7	16.7	16.7	16.7	83.3
Resource mobilisation through proposal development for public-private and non-profit funding mechanisms including donations and proposal writing, etc	5.9	5.9	5.9	5.9	5.9	29.6
Review Emergency Response Kit for Kenya on Child Health in Emergencies (With reference to existing MOH Policies and Guidelines)	1.9	4.3	3.5	1.9	1.9	13.6
Review existing guidelines for service providers and caregivers on early identification and referrals of children with developmental delays or disabilities.	-	1.2	-	-	-	1.2
Review of the existing child policies and programs to identify and fill any existing gaps	1.2	-	-	-	-	1.2
Review of the existing child policies and programs to identify any existing gaps	2.5	2.5	-	-	-	5.1
Roll out of the assessment tools for paediatrics Quality of care Standards	3.5	3.5	3.5	-	-	10.6
Strengthen collaboration with civil registration department at community level to promote timely registration of children as soon as they are born and notification of deaths	2.1	2.1	2.1	2.1	2.1	10.6
Strengthen MPDSR perinatal and neonatal audits and implementation of its recommendations	2.3	2.3	2.3	2.3	2.3	11.5
Strengthen Community MPDSR /verbal autopsy / perinatal and neonatal audits and implementation of its recommendations	24.0	24.0	24.0	24.0	24.0	120.0
Strengthen coordination mechanisms within the health sector at national and county levels to ensure strategic, coherent and effective implementation of NCH and nutrition responses to emergencies	4.6	4.6	4.6	4.6	4.6	22.8
Strengthen Maternal new born and child health TWG at National, county and sub county level	42.9	42.9	42.9	42.9	42.9	214.6
Strengthen quarterly support supervision at community level for NCH	3.4	3.4	3.4	3.4	3.4	17.1
Strengthen role in high level multi sectoral PPP stakeholder's forum for new born and child health	0.6	0.6	0.6	0.6	0.6	3.0
Strengthen surveillance of Newborn and Child Health indicators in emergency settings (With reference to existing MOH Policies and Guidelines)	3.2	-	-	-	-	3.2
Strengthen the linkage between national and county level in offering newborn & child health services	8.0	-	-	-	-	8.0
Support capacity building of CHPs, and CHAs to support implementation of, new born and child health intervention at community level	57.3	58.6	60.0	61.3	57.5	294.7
Support Counties on training of TOTs, link health facility staff, CHPs, CHAs, health facility CHEWs on iCCM	2.6	2.6	2.6	2.6	2.6	12.8
Support identification of research agenda, implementation research, evaluation and dissemination of emerging best practices and evidence.	3.4	3.4	3.4	3.4	3.4	16.9
Support implementation of Integrated Community Case Management (i CCM)	7.6	7.7	7.9	8.1	8.3	39.6

Strategic Objectives and Detailed Activities	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Support implementation of priority interventions on emergency and disasters by training of healthcare providers on high impact interventions	12.0	-	-	12.0	-	24.0
Support Training of community health workers including CHPs and provincial administration on Reporting of NCH indicators at community level	12.8	12.8	12.8	12.8	12.8	63.9
The interagency committee on NC & AH to align their activities to address the needs of the county	0.1	-	-	-	-	0.1
Timely procurement and replacement of iCCM commodities	1.2	1.3	1.3	1.3	1.4	6.5
Timely procurement, ordering and distribution of essential commodities, equipment and technologies (antimalarials, antibiotics, ORS, zinc, pulse oximeters, etc.)	69.9	69.9	69.9	69.9	69.9	349.3
To establish and operationalize NCH dashboard and strengthen the utilization of the RMNCAH scorecard in all levels	-	10.1	-	10.0	-	20.1
Train and deploy prospective PQoC QI mentors and mentees in collaboration with the Department of Quality, Standards and Regulations.	17.3	17.3	17.3	17.3	17.3	86.4
Train HCPs and CHPs on iCCM	-	55.7	-	-	-	55.7
Train ToTs on newborn and child health emergencies and disasters	-	2.1	-	2.1	-	4.2
Training of healthcare workers at all levels on newborn and child health data collection and reporting tools	8.7	8.7	8.7	8.7	8.7	43.6
Training of national officers on management and coordination of new born and child health emergencies and disasters	0.5	-	0.5	-	-	1.0
Training/Sensitization of healthcare providers on identification and referral of children with disabilities and special needs at all levels of care (Including specialized therapists)	2.5	6.1	6.1	6.1	2.5	23.3
Utilize the research findings to generate policy brief(s)	1.7	1.7	1.7	1.7	1.7	8.5
Grand Total	**3,180.9**	**3,090.0**	**2,924.8**	**2,872.9**	**2,815.7**	**14,884.3**

ANNEX 3 - GLOBAL ACTION PLAN FOR PNEUMONIA AND DIARRHOEA INDICATORS[79]

INDICATORS	TARGET	TARGET YEAR
Pneumonia mortality among children less than 5 yearsof age	3 deaths per 1000live births	2025
Diarrhoea mortality among children less than 5 years of age	1 death per 1000 live births	2025
Hib immunization coverage	90%	2025
Measles immunization coverage	90%	2025
DTP3 immunization coverage	90%	2025
PCV3 immunization coverage	90%	2025
Rotavirus immunization coverage	90%	2025
Exclusive breastfeeding of children aged 0-5 months	50%	2025
ORS treatment for diarrhoea	90%	2025
Care seeking for pneumonia	90%	2025
Antibiotic treatment for suspected pneumonia	90%	2025
Access to improved drinking water at household	90%	2030
Access to hygienic sanitation facility at household	90%	2040
Access to hand washing facilities at household	90%	2030
Access to clean and safe fuel used for cooking in thehousehold	90%	2030

79 Accessed at https://www.who.int/maternal_child_adolescent/epidemiology/pneumonia-diarrhoea-monitoring/en/

ANNEX 4 - MINISTRY OF HEALTH DIVISION OF NEONATAL AND CHILD HEALTH CHILD HEALTH EQUIPMENT AND SUPPLIES [92]

INDICATORS	TARGET	TARGET YEAR
Pneumonia mortality among children less than 5 years of age	3 deaths per 1000 live births	2025
Diarrhoea mortality among children less than 5 years of age	1 death per 1000 live births	2025
Hib immunization coverage	90%	2025
Measles immunization coverage	90%	2025
DTP3 immunization coverage	90%	2025
PCV3 immunization coverage	90%	2025
Rotavirus immunization coverage	90%	2025
Exclusive breastfeeding of children aged 0-5 months	50%	2025
ORS treatment for diarrhoea	90%	2025
Care seeking for pneumonia	90%	2025
Antibiotic treatment for suspected pneumonia	90%	2025
Access to improved drinking water at household	90%	2030
Access to hygienic sanitation facility at household	90%	2040
Access to hand washing facilities at household	90%	2030
Access to clean and safe fuel used for cooking in the household	90%	2030

General Infrastructure	
Electricity supply (with Back up)	
Functional cell phone	
Internet connection (wired or wireless)	
Functional Ambulance	
Water supply (Tap, Roof catchment, protected shallow wells)	

Oxygen therapy
Oxygen sources (Concentrators in Level 2, Cylinders in Levels 3 and above, Plant/ Piped in levels 4 and above
Diagnostics for childhood illnesses
Lab Support
Lab with capacity to do tests according to level of care:
At Level 2 and 3 MPS, HB, Urinanalysis, Blood sugar, HIV test, VDDL, Blood group
At level 4 and above: Haematological and Biochemical analysis according to level of care
Specialized services offered in level 4 and above:
Mechanical ventilation
Exchange transfusion
Dialysis
Blood transfusion Whole blood (Level 3) Whole blood and blood products (Level 4 and above)
Paediatric Surgical and Theatre services
Imaging and Ultrasound services/ equipment
Rehabilitative Services, equipment (Physiotherapy, Occupational therapy and

Special Pediatric Clinics (Offered in Level 4 and above)
ENT Clinics & Equipment
Ophthalmic Clinic & equipment
POPC
Dental Clinic & Equipment
Orthopedic Clinic & Equipment

Case management of children under five years
Outpatient department including MCH
Separate area for sick children under 5 years
Integrated services in MCH (REFER INTEGRATED MCH FLOW CHART) to include basic lab and Pharmacy services
Triaging Equipment
Weighing scales (Salter and Bathroom)
Height/length board
Weighing pants
MUAC tape
Family MUAC tape
Digital Thermometer
Respiratory timer
Pulse Oximeter with Paediatric and Neonatal probes
Wrist watches for counting Pulse rate
Paediatric admission record (PAR) forms
ORT corner space and equipment
ORT corner equipment (REFER ORT CORNER GUIDELINE/ EQUIPMENT)
Oxygen sources (Concentrators in Level 2, Cylinders in Levels 3 and above, Plant/ Piped in levels 4 and above
Emergency tray (REFER EMERGENCY TRAY LIST)
M&E/ Health Reporting Tools/ EHR/EMR
IMCI Recording Forms
MOH 204A Under 5 Register
MOH 510 Immunisation Register
MOH 216 Mother Child Handbook
MOH 511 CWC Register
MOH 701A Under five Morbidity Tally Sheet
MOH 705A Under 5 Morbidity Summary
MOH 711 Integrated Program Summary Sheet
MOH 717 Service Workload
Referral Forms
ORT Corner register
Paediatric Admission Record Forms (PAR)
Inpatient department
Oxygen sources/ supply (Concentrators in Level 2, Cylinders in Levels 3 and above, Plant/ Piped in levels 4 and above
Oxygen splitters
Pulse Oximeter with Paed and Neonatal probes
Oxygen delivery devices (Nasal prongs -Infant, Child, Nasal catheter Infant, Child, Non Rebreather masks, Oxygen masks Infant, Child sizes
ORT corner equipment (REFER ORT CORNER GUIDELINE/ EQUIPMENT)

Emergency tray (REFER EMERGENCY TRAY CHECKLIST)
Resuscitation couch
Ambu Bags 500ml
Ambu Bag 300ml
Functional Suction machine
Suction tube size 10
Heater
Height/ Length Measurement boards
Respiratory timer
M&E/ Health Reporting Tools/ EHR/EMR
Vital signs monitoring charts
Feeding charts
Paediatric Admission Record Forms (PAR)
Death notification Forms (D1)

Referral systems
Facility initiated means of transport
Functional Ambulance (REFER CHECKLIST FOR FUNCTIONAL AMBULANCE)
Facility Ambulance (Level 4 and above)
Sub-County ambulance (for use by Dispensaries and Health centers)

Essential Child Health Equipment list 1

Equipment
ORT Corner Equipment
Thermometers
Infant / Baby Weighing scale
Salter Scales
Weighing pants
Bathroom Weighing scale
Nebulization Equipment
Oxygen Cylinders & oxygen delivery sets
Oxygen Concentrators
Oxygen splitters
Oxygen Masks (circle if available) Infant, Child sizes
Nasal catheter, Infant, Child
Nasal prongs, Infant, Child
Ambu Bags 500ml
Ambu Bag 300ml
Functional Suction machine
Suction tube size 10
Heater
functional 500 ml self-inflating bag
Resuscitation table/couch
Height/ Length Measurement boards
Pulse oximeter
Respiratory rate timer

Essential Child Health Medicines
M&E/ Health Reporting Tools/ EHR/EMR
Antibiotics Register
Narcotics register
Drugs
Artesunate inj. 60mgs
Artemether lumefantrine 20/120mgs
Quinine 300 mg per ml
Amoxycillin Dispersible Scored Tabs 250 Mg.100 Pack
Amox + Clav 375mg
Gentamicin (40mg/1ml) inj.
Crystalline Penicillin 1,000,000 units vials
Benzathine inj.
Ceftriaxone 250mgs
ORS/ Zinc Co- pack
Ringers lactate infusion
Ciprofloxacin (250mg tabs)
Metronidazole tablet 200mgs
Ceftazidime (250mg tabs)
Metronidazole inj.
Metronidazole oral liquid 200mg/5ml
Erythromycin (250mg tabs)
Albendazole (400mg)
Iron tabs (200mg)
Folic Acid tabs (5mg)
Syr Cotrimoxazole 240mg/5ml
Tab Paracetamol tabs 250mg
Nystatin oral drops 20mls
Lorazepam inj
10% Dextrose 500 ml bottle
Salbutamol Inhalers (200 doses)
Salbutamol Nebulization solution (50ml) bottle
Adrenaline Inj.
Vitamin A (soft gelatinous capsules) 200,000 IU
Vitamin A (soft gelatinous capsules) 100,000IU
Vitamin A (soft gelatinous capsules) 50,000IU (therapeutic)
Clotrimazole cream
Hydrocortisone cream
Hydrocortisone injection 100mg
Griseofulvin tablets 125mg
Benzyl Benzoate ointment
Furosemide injection 40mg
Insulin inj.
ReSoMal
F75
F100

Essential Child Health Medicines
RUTF
Digoxin oral
Anti- TB drugs
ART drugs
Anti- cancer drugs
Vaccines
Anti- rabies
Anti- snake venom
Blood and blood products
Povidone iodine solution/Betadine solution

ANNEX 5: NCH Strategy Costing Matrix

Strategic Objective 1: Reduce newborn and neonatal morbidity and mortality															
Key actions	**Detailed activities**	**Task Description**	**Quantities and unit costs**	**Year of implementation**	**Item Description**	**Assumptions/Comments from James**	**Quantity**	**Unit Cost**	**Frequency**	**Amount**	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Promote and enhance availability and access to high impact evidence- based interventions for the management of preterm and/ or low birth weight (LBW) babies	Development of a comprehensive newborn care protocol	printing,editing and graphics design	Printing 2000 copies per year@1500	year 1	Printing of guidelines		2,000	1,500	1	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	15,000,000
	Dissemination of a comprehensive newborn care protocol	National level launch	8 one day regional meetings, each county having 3 pax= total of 141paxs *8400*2 nite DSA, transport 4000/=, conference package 2500*145 pax	yr 2	Regional dissemination meetings		1	3,654,300	1	3,654,300	3,654,300					3,654,300
		County level launch		yr 2	1 day launch at the county level	Assumed to have 50 participants per county. Transport and lunch provided	47	155,750	1	7,320,250	7,320,250					7,320,250
	Capacity building of health care providers on management of all newborns including small and sick newborns	Train National ToTs	47 counties put in clusters of 8. TOT- regional training 8*5*47 counties, DSA county 8400 transport 3,000, conference 2500. Training for 5 days. national team 10,500*3*6 regional *6days, Driver	yr 2, 3, 4	Training of trainers at the regional level		1	3,049,500	1	3,049,500	9,148,500	9,148,500	6,099,000			24,396,000
		Train County ToTs	10 clusters (regions)	yr 2, 3, 5	County TOTs	Assumed to be done in 10 clusters of 40 participants' each	1	3,049,500	1	3,049,500	12,198,000	12,198,000	12,198,000			36,594,000

	Review and strengthen national perinatal and neonatal Death Surveillance and Response	Training and facility mentorship of HCPs on PNDSR , work together with division of reproductive health and train on EMNOC, Newborn ETAT+,Community PNDSR, Early essential newborn care	Training on perinatal and neonatal death audits 5 ppts per county* 47 at the regional level-Annually 3 facilitators from national level 3 days training	yr 1, 2,3, 4, 5	Regional training on perinatal and neonatal death audits-Annually		6	3,049,500	1	18,297,000	18,297,000	18,297,000	18,297,000	18,297,000	18,297,000	91,485,000
	Scale up Kangaroo mother care in all levels of care	trainings	30conference package,DSA for 27pax 5trainings per county for entire 5 years,transport for 27 pax	yr 1, 2,3, 4, 5							56,400,000	56,400,000	56,400,000	56,400,000	56,400,000	282,000,000
	Conduct support supervision and mentorship	Working with the counties for integrated newborn support supervision and mentorship within the facilities	Quarterly supervision-4*10500*5*47, National driver, county team 2*8400*5	yr 1, 2,3, 4, 5	Integrated newborn support supervision		47	398,400	4	74,899,200	74,899,200	74,899,200	74,899,200	74,899,200	74,899,200	374,496,000
		Master ToT training on KMC at national level and county level	Train ToTs 5 per couty x 47, 3 days conference packagex , transport reimbursement 5 pax per county x 47x 2, National DSA x 4pax x 4 days, transport reimbursement national x days,	yr 1, 2,3, 4, 5	Regional training of trainers on KMC		8	1,326,000	1	10,608,000	10,608,000	10,608,000	10,608,000	10,608,000	10,608,000	53,040,000
			County level training on KMC	yr 1, 2,3, 4, 5	County level training on KMC	50 participants for 3 days. 10 counties trained in years 1-4 and 7 in year 5	1	245,000	1	245,000	2,450,000	2,450,000	2,450,000	2,450,000	1,715,000	11,515,000

		National govt to provide technical assistance during county KMC trainings	National DSA x 2 pax x 4 daysx 47 counties,transport reimbursement national level x 2 days x 47 counties	yr 1, 2,3, 4, 5	2 staff from national government to support county KMC trainings-DSA		94	10,500	4	3,948,000	39,480,000	39,480,000	39,480,000	39,480,000	27,636,000	185,556,000
					2 staff from national government to support county KMC trainings-transport reimbursement		94	4,000	1	376,000	3,760,000	3,760,000	3,760,000	3,760,000	2,632,000	17,672,000
	Support breathing of pre-terms through administration of CPAP and surfactant	Working with counties to ensure availability of CPAP machines in all level 6,5,4 across the country	10 CPAP level 6 (4 facilities),5 CPAP level 5 (47 facilities), 4 level 4, (100 facilities) * 50,000 Each CPAP costs between 50000-100000	yr 1, 2,3, 4, 5	Procurement of CPAP machines	Procurement to be done over the 5 years	675	75,000	1	50,625,000	10,125,000	10,125,000	10,125,000	10,125,000	10,125,000	50,625,000
		Training of national CPAP master ToT			Training of national CPAP master ToT	40 participants for 3 days	1	2,013,500	1	2,013,500	4,027,000	4,027,000	4,027,000			12,081,000
		Training of County CPAP master ToT			Training of County CPAP master ToT	50 participants for 3 days. 10 counties trained in years 1-4 and 7 in year 5	1	245,000	1	245,000	2,450,000	2,450,000	2,450,000	2,450,000	1,715,000	11,515,000
					Training of healthcare workers on newborn referral		2,350	2,000	2	9,400,000	9,400,000				9,400,000	18,800,000
	Advocate for establishment and capacity buiding of the quality of care improvement teams	Training tools-5 modules @ 5 pages X 1 per facility Lunch and transport -2000 for 10 staff per facility	5 modules @ 5 pages per facility	yr 5	Printing of training modules	Assumed that there are 7275 health facilities	181,875	5	1	909,375	909,375					909,375
					Training of health workers	Assumed that there are 7275 health facilities. To be implemented in Year 1	72,750	2,000	1	145,500,000	145,500,000					145,500,000

		Finalization of pediatric quality of care standards	National level workshop of 30 participants for 5 days	yr 2	Workshop to finalize the small and sick newborn quality of care standards	National level workshop of 30 participants for 5 days	1	2,535,000	1	2,535,000		2,535,000				2,535,000
		Finalization of the pediatric quality of care assessment tool	National level workshop of 30 participants for 5 days-	yr 2	Workshop to finalize the small and sick newborn assessment tool	National level workshop of 30 participants for 5 days	1	2,535,000	1	2,535,000		2,535,000				2,535,000
		Validation of the pediatric quality of care standards	1 days' validation meeting of 50 participants	yr 2	Meeting at national level to validate the small and sick newborn care standards	1 days' validation meeting of 50 participants	50	3,500	1	175,000		175,000				175,000
		Anchor critical pediatric quality of care in to the Kenya Quality Model for Health (KQMH)	National level workshop of 30 participants for 5 days	yr 3	Workshop to anchor critical standards in Kenya Quality Model for Health (KQMH)	National level workshop of 30 participants for 5 days- This assumption can be reviewed	1	2,535,000	1	2,535,000			2,535,000			2,535,000
		Dissemination of thepediatric quality of care standards	1 days' validation meeting of 50 participants-20 county participants	yr 3	Meeting to disseminate small and sick newborn standards	1 days' validation meeting of 50 participants-20 county participants	1	551,000	1	551,000			551,000			551,000
Support implementation of interventions that promote hygienic cord and skin care as per national guidelines	Implement respectful newborn care at all levels of service delivery	Adaptation/ adoption of the WHO guidelines	quartely meetings with CHMT /facility/community on RNC 30 PAX * 1day	yr 1, 2,3, 4, 5	Quarterly CHMT/facility/community meetings on respectful newborn care	Assumed that the participants will receive lunch and transport allowance	1,410	2,000	4	11,280,000	11,280,000	11,280,000	11,280,000	11,280,000	11,280,000	56,400,000
	Develop guidelines on respectful newborn care		4 meetings * 30/ pax/meeting	yr 1, 2,3, 4, 5	Four TWG meetings to develop guidelines on respectful newborn care	Assumed to occur in Year 1	30	3,500	4	420,000	420,000	420,000	420,000	420,000	420,000	2,100,000

	Disseminate respectful newborn care guidelines at national and county level	Dissemination of Respectful Newborn Care guidelines	10 regions * 1 day conference package , transport reimbursement 4 pax per county x 47 county ,DSA 4 pax per county x47counties x2 days, national DSA x 2pax x 2 days x 10 regions. Printing 2000 copies x 1500, DSA driver x 10 x 2days, Fuel average 600kms x unit costs	yr 1, 2,3, 4, 5	Five regional meetings of 40 participants for 1 day		5	1,096,000	1	5,480,000	5,480,000	5,480,000	5,480,000	5,480,000	5,480,000	27,400,000
	Print 2000 copies of respeciful newborn care guidelines			yr 5	Printing 2000 copies of guidelines		2,000	1,500	1	3,000,000					3,000,000	3,000,000
	training of health care providers on respectiful newborn care guidelines	Workshop to train health care workers	Train ToTs 5 per couty x 47, 3 days conference packagex , transport reimbursement 5 pax per county x 47x 2, National DSA x 4pax x 3 days, transport reimbursement national x days,	yr 1, 2,3, 4, 5	Training of trainers at the regional level-40 pax for 3 days-6 regions and 3 facilitators		6	2,013,500	1	12,081,000	12,081,000	12,081,000	12,081,000	12,081,000	12,081,000	60,405,000
	Training of HCP and mothers/caregivers on use of Chlorhexidine for cord care.	Essential newborn training	Train ToTs 5 per couty x 47, 3 days conference package , transport reimbursement 5 pax per county x 47x 2 days, National DSA x 4 pax x 3 days, transport reimbursement national x days,	yr 1, 2,3, 4, 5	Training of trainers at the regional level-40 pax for 3 days-6 regions and 3 facilitators		1	2,013,500	1	2,013,500	4,027,000	4,027,000	4,027,000			12,081,000

	Conduct Continuous mentorship of the HCP on essential newborn care	Mentors at the county level to mentor mentees at facility level	Regional TOTs-5 ppts per county-5 days-4 facilitators annual County TOTs conduct 5 trainings in each county per year Cost- County TOTs-per-diem but facility level lunches-1000 for approximately 5 staff at the facility for 3 days	yr 1, 2,3, 4, 5	Regional TOTs-40 participants per region for 5 days-6 regions		6	3,049,500	1	18,297,000	18,297,000	18,297,000	18,297,000	18,297,000	18,297,000	91,485,000
Total											**465,211,625**	**303,672,700**	**298,464,200**	**269,027,200**	**266,985,200**	**1,603,360,925**

Strategic Objective 2: Reduce morbidity in infants and children															
Key actions	**Detailed activities**	**Task Description**	**Quantities and unit costs**	**Years of Implementation**	**Item Description**	**Assumptions**	**Quantity**	**Unit Cost**	**Frequency**	**Amount**	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Promote access to and uptake of preventive interventions for childhood illnesses.	Train HCPs and CHPs on notifiable diseases, Trauma and Non Communicable Diseases (NCDs)	one 5 day training workshop per county for 47 counties.	DSA - @ KSH10500 for 6 days Training days-5 days 4 facilitators Conference package 3500 per pax Transport@ 2000, Airtime for coordination 1000	Year 1, 2, 3, 4, 5	Training of trainers (TOT) meeting at the county level (5 days-35 participants)	That the TOTs will train others at the facility level and that the trainings will be implemented over 5 years	47	2,784,500	1	130,871,500	26,174,300	26,174,300	26,174,300	26,174,300	26,174,300	130,871,500
	Review MCH handbook orientation package	1 National 3 day workshop to review MCH orientation package 30 pax	DSA - @ KSH10500 for 4 days Conference package 3500 for 30 pax Transport@ 2000, Airtime for coordination 1000	Year 2	One 3-day workshop at the national level to review the MCH handbook		1	1,695,000	1	1,695,000		1,695,000				1,695,000
	Sensitise MCH HCPs to ensure effective utilization of the Mother and Child Health (MCH) Handbook	8 regional 1 day meetings		Year 1, 2, 3, 4, 5	Eight 1-day regional meetings of 40 pax		8	1,096,000	1	8,768,000	8,768,000	8,768,000	8,768,000	8,768,000	8,768,000	43,840,000
Promote access to timely and quality treatment for common childhood illness-major killers (Scale up iMNCI and ETAT+)	Train at least 60% of HCPs in every facility on IMNCI and ETAT+	Training of trainers- 2 workshops per county 25pax per training/county-5 days 4 facilitators Conference, DSA (6 days) -Annually	(Multiply by 2 for ETAT and IMCI annually) DSA - @ KSH8400 for 6 days Training days-5 days 4 facilitators Conference package 2500 per pax Transport@ 2000, Airtime for coordination 1000)	Year 1, 2, 3, 4, 5	Two workshops per county-25 participants per training for 5 days		47	2,085,500	2	196,037,000	196,037,000	196,037,000	196,037,000	196,037,000	196,037,000	980,185,000
	Conduct Oxygen administration training for heathcare workers in the pediatric units.	Training of trainers- 2 workshops per county 25pax per training/county-5 days 4 facilitators Conference, DSA (6 days) -Annually	DSA - @ KSH10500 for 3 days Training days-2 days 2 facilitators Conference package 3500 per pax Transport@ 2000, Airtime for coordination 1000)	Year 1, 2, 3, 4, 5	2 workshops per county per year		47	2,085,500	2	196,037,000	196,037,000	196,037,000	196,037,000	196,037,000	196,037,000	980,185,000

	Advocate for inclusion of oxygen therapy as a thematic area in pre-service Medical Training Curriculum.	Annual meeting for curriculum update	DSA - @ KSH10500 for 2 days Training days-1 day 2 facilitators Conference package 3500 per pax Transport@ 2000, Airtime for coordination 1000)	Year 3	Workshop at the national level for curriculum update	30pax for 3 days	1	1,695,000	1	1,695,000			1,695,000			1,695,000
	Avail updated treatment guidelines and protocols	8 regional meetings one day meeting	8 regional meetings, 1 day meetings DSA for National 3 officers - @KSH10500 for 2 days DSA for Driver @ 4900 for 2 days, DSA for 2 County Officers(CEC & CDH) @ 8, 400 for 94 pax, County Drivers 4900 for 2 days @ for 37 pax, Airtickets for 20 OfficersDissemination 1 day Conference package 3500 per pax Transport@ 2000, Airtime for coordination 1000.	Year 1, 2, 3, 4, 5	Annual meeting with county leadership(CDH &CECM) for 1 day		1	6,115,800	1	6,115,800	6,115,800	6,115,800	6,115,800	6,115,800	6,115,800	30,579,000
	Advocate for Implementation of referral strategy	8 regional meetings	8 regional meetings, 1 day meetings DSA for National 3 officers - @KSH10500 for 2 days DSA for Driver @ 4900 for 2 days, DSA for 2 County Officers(CEC & CDH) @ 8, 400 for 94 pax, County Drivers 4900 for 2 days @ for 37 pax, Airtickets for 20 OfficersDissemination 1 day Conference package 3500 per pax Transport@ 2000, Airtime for coordination 1000.	Year 2, 4	Annual meeting with county leadership(CDH &CECM) for 1 day at regional level		1	6,115,800	1	6,115,800		6,115,800		6,115,800		12,231,600

	Print and disseminate under five vitamin A supplementation and deworming guidelines	3 workshops (National officers - MOH/ DNCH), 25 participants	DSA - @ KSH10500 for 5 days Conference package 3500 for 30 pax Transport@ 2000, Airtime for coordination 1000	Year 2	Workshop at the national level to develop vitamin A and deworming guidelines	30 pax for 5 days	1	2,535,000	1	2,535,000		2,535,000				2,535,000
	Advocate for establishment of regional pediatric centre of excellence (National Children Referral Hospital)	8 regional meetings	8 regional meetings, 1 day meetings DSA for National 3 officers - @KSH10500 for 2 days DSA for Driver @ 4900 for 2 days, DSA for 2 County Officers(CEC & CDH) @ 8, 400 for 94 pax, County Drivers 4900 for 2 days @ for 37 pax, Airtickets for 20 OfficersDissemination 1 day Conference package 3500 per pax Transport@ 2000, Airtime for coordination 1000.	Year 1, 5	Annual meeting with county leadership(CDH &CECM) for 1 day at regional level for establishment of regional center of excellence		1	6,115,800	1	6,115,800	6,115,800				6,115,800	12,231,600
	Advocate for Integrated outreach services to the hard -to-reach populations	Printing of ETAT Training manuals and materials	ETAT-1000 copies per year @ 2000 per copy/set	Year 2, 4	Printing of ETAT training manuals	To be printed annually	1,000	2,000	1	2,000,000	2,000,000	2,000,000	2,000,000	2,000,000	2,000,000	10,000,000
	Dissemination of printed pediatric protocols	8 regional meetings 1 day workshop	8 regional meetings, 1 day meetings DSA for National 3 officers - @KSH10500 for 2 days DSA for Driver @ 4900 for 2 days, DSA for 2 County Officers(CEC & CDH) @ 8, 400 for 94 pax, County Drivers 4900 for 2 days @ for 37 pax, Airtickets for 20 OfficersDissemination 1 day Conference package 3500 per pax Transport@ 2000, Airtime for coordination 1000.	Year 1	Annual meeting with county leadership(CDH &CECM) for 1 day at regional level for establishment of regional center of excellence		1	6,115,800	1	6,115,800	6,115,800					6,115,800

Strengthen implementation of mother, child and nutrition Malezi Bora activities	Review 'Malezi Bora' strategy	3 workshops (National officers - MOH/ DNCH), 30 participants	DSA - @ KSH10500 for 5 days Conference package 3500 for 30 pax Transport@ 2000, Airtime for coordination 1000	Year 2, 3	Two workshops at the national level with 30 participants for 5 days		1	2,535,000	2	5,070,000		5,070,000	5,070,000			10,140,000
	Advocate for 'Malezi Bora' implementation/county ownership	Regional meetings-3 ppts per county for 5 days	Malezi bora done 2round annualy. support logistics fuel 200km*-7days*47*2 rounds. DSA 10500* 10 officers/Lunch for health workers @ 1500*100*47. CHMT supportive supervision 4*47*8400* 3 days. Fuel @32perkm*150km*3days	Year 2, 3. 4. 5	Two Malezi bora weeks per annum per county		47	888,200	2	83,490,800		83,490,800	83,490,800	83,490,800	83,490,800	333,963,200
	Hire a consultant to review malezi bora strategy	Hire a consultant		Year 2	Consultancy to review Malezi bora strategy	30 days consultancy	30	40,000	1	1,200,000		1,200,000				1,200,000
Total											**447,363,700**	**535,238,700**	**525,387,900**	**524,738,700**	**524,738,700**	**2,557,467,700**

Strategic Objective 3. Promote access to quality and comprehensive early childhood developments interventions for all children especially in the first 1000 days of life																
Key actions	**Detailed activities**	**Task Description**	**Quantities and unit costs**	**Year of implementation**	**Item Description**	**Assumptions**	**Quantity**	**Unit Cost**	**Frequency**	**Amount**	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Establish national and county level multi-sectoral governance mechanism with decision making authority, to coordinate early childhood development interventions across relevant sectors and stakeholders.	Development of TORs for the multi sectoral coordinating committee/ TWGs for ECD interventions	Workshop at national level to develop the TORs. 3 days for 10 participants-Non-residential Conference package of 3500/ppt	DSA-10500 for 4 nights,Transport 200x2 Conference pax-3 days @ 3500 Drivers-1 driver -4000x2,	yr 1 & 2	Residential TWG at the national level for 10 participants-3 days		1	565,000	1	565,000	565,000	565,000				1,130,000
	Establishment and operationalization of national and county level multi sectoral TWGs for ECD interventions (MOH, MoE, Social Services, NGAO, implementing partners)	At national level-Quarterly meetings of 20 participants for 1 day-Conference package-Similar for each county	DSA-10500 for 2 nights.Transport-2000x2,-conference pax1 day-3500,1 Driver-4000x2	yr 1, 2, 3, 4 & 5	Quarterly TWG at the national level-1 day		1	570,000	4	2,280,000	2,280,000	2,280,000	2,280,000	2,280,000	2,280,000	11,400,000
			Transport 1000 Lunch-1000 Hall-3000-Community Halls Facilitators-3 people- DSA-10500	yr1, 2, 3, 4 & 5	Quarterly TWG at the county level-1 day-20 participants		940	4,000	4	15,040,000	15,040,000	15,040,000	15,040,000	15,040,000	15,040,000	75,200,000
		County level-Quarterly meetings of 20 participants for 1 day-Conference package-Similar for each county														
	Advocacy meetings with political leadership at the national, county and sub-county level for resource allocation for ECD interventions.		DSA-10500 for 3 nights for 3 National officers, DSA for Driver @ 4000 for 3 nights Conference pax-2 days @ 4000 Drivers-1 driver per county Facilitators-3 facilitators- 2022 and 2024	yr 1 & 2	Regional meetings of 5 ppts per county for 2 days		6	2,482,000	1	14,892,000	14,892,000	14,892,000				29,784,000

	Development of a national and county level implementation framework for ECD interventions.	4 Workshops at national level to develop a national and county implementation framework for ECD interventions	DSA 10500 for 6 nights x 30 pax x 4 workshops, Transport-2000 x2, Conference pax- @ 3500, 1 driver -4000x8	yr 1	4 Residential Workshops at national level 30 pax for 20 days		1	2,535,000	4	10,140,000	10,140,000					10,140,000
	sensitization of political leaders, NGAO team & county Executives on Science of ECD and Nurturing Care conduct a country wide training gap analysis	Consultancy for 30 days	National consultancy for 30 days @ 40000	yr 2	National consultancy		1	40,000	30	1,200,000		1,200,000				1,200,000
	Development and incoopperation of pre service training curriculum on nurturing care for ECD.	At national level,1day meeting of 20 pax for 1 day-conference package-similar for each county	DSA-10500 for 2 nights,Transport-200x2,-conference pax 1 day@3500,1 driver-4000x2	yr 1, 2 & 3	1 day meeting to review and map out develpment and incoperatio of preservice training curriculum on nurturing care for ECD		1	570,000	1	570,000	570,000	570,000	570,000			1,710,000
	Scale up inservice training on nurturing care for ECD	At national level, 2 training workshops each 5 days of 25 pax for TOTs.	DSA-10500 for 6 nights,Transport-200x2,-conference pax @3500,1 driver-4000x2	yr 1 & 2	Training of trainers at the regional level-5 partitipants per county for 5 days		2	2,085,500	1	4,171,000	4,171,000	4,171,000				8,342,000
	Development and mentainance of a Data base for nurturing care for ECD training.	5 worksops of 25pax@5 days to develop and maintain data base	DSA-10500 for 6 nights,Transport-200x2,-conference pax @3500,1 driver-4000x2	yr 1			6	2,085,500	1	12,513,000	12,513,000					12,513,000
Support identification of national and local champions to catalyze change and drive the early childhood development agenda in the community	Involvement of political leadership to patronise ECD activities in the counties	Hold one stakeholders meeting for resourse mobilization	DSA-10500 for 20 pax for 2 nights, conference-3500 for 30 pax for 1 day,Transport-2000x2 for 20pax.1 driver-4000x2	yr2, 3,4	Stake holders meeting		1	613,000	3	613,000		613,000	613,000			1,226,000

Strengthen and Integrate nurturing care into other service delivery provision at all levels of health care system	Identify existing gaps at all levels of the health-care system	Consultancy for 30 days	National consultancy for 30 days @ 40000	yr1,	consultancy for 30 days		1	40,000	30	1,200,000	1,200,000				1,200,000
	Development and adoption of integrated nurturing care protocols.	1 worksops of 30pax@5 days to develop and maintain data base	DSA-10500 for 6 nights, 20 pax,Transport-2000x2,-conference pax @3500,1 driver-4000x2	yr 2	development and mentainance of data base		1	1,873,000	1	1,873,000		1,873,000			1,873,000
	Develop nurturing care M&E framework	Hold 3 workshops@5 days to develop the M&E framework	DSA-10500 for 6 nights, conference @ 3500 for 5 days, Transport 2000x2, 1Driver 4000x2	yr2,	development and mentainance of data base		1	1,873,000	3	5,619,000		5,619,000			5,619,000
	Development of a package on male involvement in ECD and nurturing care	2 worksops of 30pax@5 days to develop and maintain data base	DSA-10500 for 6 nights-20 pacs,Transport-2000x2,-conference pax @3500,1 driver-4000x2	yr1,			1	1,873,000	2	3,746,000	3,746,000				3,746,000
		1 day key stakeholders/health service delivery persons sensitization workshop for 30 pax	DSA-10500 for 20 pax for 2 nights, conference-3500 for 30 pax for 1 day,Transport-2000x2 for 20pax.1 driver-4000x2	yr 1.	1 day key stakeholders/ health service delivery persons sensitization workshop for 30 persons		1	855,000	1	855,000	855,000				855,000
Strengthen health sector capacity for identification and appropriate and timely referrals for children with developmental delays, difficulties or disabilities	Identify Institutional and personnel gaps in identification of children with developmental delays	Consultancy for 30 days	Consultancy fees @ 30000 per day	yr 1	Consultancy for 30 days		30	40,000	1	1,200,000	1,200,000				1,200,000

	Review existing guidelines for service providers and caregivers on early identification and referrals of children with developmental delays or disabilities.	Workshop to review guidelines-5 days-30 ppts	DSA-10500 for 6 nights, conference @ 3500 for 5 days, Transport 2000x2, 1Driver 4000x2	yr 1	Workshop at the national level-30 participants for 5 days		1	2,535,000	1	2,535,000	2,535,000					2,535,000
	strengthen CHPs, ECD teachers and religious leaders' capacity to identify and refer children with challenges to link health facility	1 days' non-residential training per county-100 ppts Lunch-1000 Hall-3000-Community Halls Facilitators-3 people- DSA-10500	Transport 1000 Lunch-1000 Hall-3000-Community Halls Facilitators-3 people- DSA-10500	yr 1 & 2	1 day's non-redisential training per county of 100 participants	Annual meeting	47	272,000	1	12,784,000	12,784,000	12,784,000	12,784,000	12,784,000	12,784,000	63,920,000
	Educate the public through outreaches, media, public barazas on needs of children with developmental delays and disabilities in order to address stigma in the community.	Media engagements - Ksh. 200,000* 47 per year	Media engagement- Ksh. 200,000/=	yr 1, 2, 3, 4 & 5	County media engagements		47	200,000	1	9,400,000	9,400,000	9,400,000	9,400,000	9,400,000	9,400,000	47,000,000
	strengthen intra and inter-county linkage among health facilities and rehabilitation centres.	Meetings between county teams and rehab mgt	Regional meetings - 3 per county- for 2 days	yr 1, 2, 3, 4 & 5	Regional meetings of 3 ppts per county for 2 days-25 ppts per region	Every 2 years	6	982,500	1	5,895,000	5,895,000		5,895,000		5,895,000	17,685,000

Identify salient indicators for tracking progress in early childhood development including indicators on responsive caregiving and opportunities for early learning	Develop indicators to be tracked	Workshop for 5 days-30 ppts	DSA-10500 for 6 nights, Transport 2000x2, Conference @3500 for 5 days, 1 Driver 4000x2	yr 1	Workshop at the national level-30 participants for 5 days		1	2,535,000	1	2,535,000	2,535,000					2,535,000
Promote implementation research and use of data to innovate and improve provision of quality evidence based early childhood development interventions	Conduct regular operational research on factors affecting implimentation of ECD activities in the County.	Consultancy for 30 days	Consultalncy fees for 30 days @ 30,000 per day	yr 1	Consultancy for 30 days	To be conducted after every two years	30	40,000	1	1,200,000	1,200,000		1,200,000		1,200,000	3,600,000
Total											**101,521,000**	**69,007,000**	**47,782,000**	**39,504,000**	**46,599,000**	**304,413,000**

Strategic Objective 4: Promote interventions to end all forms of malnutrition and address the nutritional needs amongst newborn and children																
Key actions	Detailed activities	Task Description	Quantities and unit costs	Year of implementation	Item Description	Assumptions	Quantity	Unit Cost	Frequency	Amount	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Put in place interventions to ensure early initiation of breastfeeding within the first hour of birth and encourage exclusive breastfeeding for the first 6 months of life	Avail contextualised breastfeeding reference material to all the levels of care from the community up to the hospitals	Mapping existing nutrition materials, Sensitizing the relevant stakeholders on the materials and their usage	1 orientation meeting at the national for 1 day conference for 40pax @4000 3 virtual meetings targeting all 47 counties each receiving an airtime of 1000 for 47pax *3	2023	One days' physical meeting of 40 participants		40	3,500	1	140,000	140,000					140,000
				2023			141	1,000	3	423,000	423,000					423,000
	Scale up of early essential new-born care interventions that encourage bonding of mother and baby (e.g. skin to skin contact, early initiation of breastfeeding)	Training	8 five day regional workshop, each county having 3 pax= total of 141paxs *8400*5 nite DSA, transport 3000/=, conference package 2500*141 pax Facilitators-4 from national level (DSA-10500, transport reimbursement-3000)	2023	Six regional workshops of 25 participants each		6	2,001,000	1	12,006,000	12,006,000					12,006,000
	Develop and adopt standardised algorithms in form of posters and job aids within labour ward and ANC to guide health workers on skin to skin contact procedures	Sensitization at the ANC, Maternity	"1 meeting 20 participants-5 days-4 facilitators from national govt For county teams-DSA-8400, conference package-3000 transport-2000 Facilitators-10500, Fuel-300km/county-Driver-5000 DSA" 3 working meeting for 20pax who will require airtime @1000 virtual disemination meeting for 3pax per county 47 counties who will require airtime @1000		Workshop of 20 participants for 5 days		47	2,085,500	1	98,018,500	98,018,500					98,018,500
					3 working meetings for 20 pax	To be held virtually	20	1,000	1	20,000	20,000					20,000
					Virtual dissemination meeting for 3 pax per county (47 counties)		141	1,000	1	141,000	141,000					141,000

	Advocate for establishment of donor human milk banks for neonates who may not temporarily or parmanently access their own mothers milk	Advocate for establishment of milk banks in county referral hospitals	1 meeting with county leadership per annum 20 participants-2 days-4 facilitators from national govt For county teams-DSA-8400, conference package-2500 transport-2000 Facilitators-10500, Fuel-300km/county-Driver-5000 DSA	yr 1, 2,3, 4, 5	Annual meeting with county teams for 2 days-20 ppts		47	686,000	1	32,242,000	32,242,000	32,242,000	32,242,000	32,242,000	32,242,000	161,210,000
Strengthen systems and programs to promote and support appropriate infant and young child feeding practices.	Advocate for establish breastfeeding corners for mothers as needed and lactational rooms for staff in the workplace	Advocacy	1 day confrerence package for 30 pax national @4000, printing of 100 copies of BMS act@1000, Virtual orientation of county departments 3 pax per each of 47 county @1000 each airtime		1 day conference of 30 pax at the national level		30	3,500	1	105,000	105,000					105,000
					Printing 100 copies of BMS Act		100	1,000	1	100,000	100,000					100,000
					Virtual orientation of county departments (3 pax per county)		141	1,000	1	141,000	141,000					141,000
	Scale up of Baby Friendly Hospital Initiative (BFHI) in collaboration with nutrition	Sensitization of decision makers and training of maternity staff	I meeting with heads of relevant divisions in MOH 30 participants 1 day Conference package @4000x30pax 4 workshops per year for 5 days, DSA for 6 nights @10500 for 25pax, and 12600 for 2 facilitators for 6 nights per each workshop, DSA for driver 4 times per year for 6 nights @4900 per day, transport 2000, fuel at 160 per litre each litre going 7km workshop venue in Nakuru and Naivasha. Conference package @3000 per workshop for 5 days, 4 workshops per year	yr 1, 2,3, 4, 5	4 workshops per year of 25pax plus 2 facilitators		1	2,281,500	4	9,126,000	9,126,000	9,126,000	9,126,000	9,126,000	9,126,000	45,630,000
					1 day conference of 30 pax at the national level		30	3,500	1	105,000	105,000					105,000

	Advocate for adequate supply of nutrition related commodities at the facility and community level	Sensitization on the existing commodities and supply chain	I meeting for 30pax who will require confirence package @4000		1 day's meeting of 30 pax		30	3,500	1	105,000	105,000					105,000
Put in place systems to ensure availability of and access to services for prevention and management of all forms of malnutrition at facility and community level	Conduct growth monitoring and promotion at the health facilities	Training of national and county managers on the revised growth standards	"I meeting with heads of relevant divisions in MOH 30 participants 1 day Conference package @4000x30pax 4 workshops per year for 5 days, DSA for 6 nights @10500 for 25pax, and 12600 for 2 facilitators for 6 nights per each workshop, DSA for driver 4 times per year for 6 nights @4900 per day, transport @2000, fuel at 160 per litre each litre going 7km workshop venue in Nakuru and Naivasha. Conference package @3000 per workshop for 5 days, 4 workshops per year"	yr 1												-
	Collaborate with with other sectors such as Agriculture, Education, gender and social services to put interventions in place to address food and nutrition security.	Quarterly TWGs	Conference package-3500 , 30ppts Bundles-1000* 15 ppts	yr 1, 2,3, 4, 5	Quarterly TWGs with other sectors-30 participants and 15 joining virtually		30	3,500	4	420,000	420,000	420,000	420,000	420,000	420,000	2,100,000
					Airtime for virtual meeting		15	1,000	4	60,000	60,000	60,000	60,000	60,000	60,000	300,000
	Collaborate with private sector to promote infant and young child feeding practices	Advocate meeting	Confrence package of 30 pax@4000	yr 1, 2,3, 4, 5	This will be carried every year to review progress		30	3,500	1	105,000	105,000	105,000	105,000	105,000	105,000	525,000
	Conduct Bi-annual integrated MNCH services during child health days such as Malezi Bora outreaches in all Counties and sub-counties	56870000 per annum	Itemised budget incorporated	yr 1, 2,3, 4, 5	Malezi bora outreaches		1	56,870,000	1	56,870,000	56,870,000	56,870,000	56,870,000	56,870,000	56,870,000	284,350,000

	Develop capacity of Health Workers and Community Health Volunteers (CHPs) on MIYCN; integration of MIYCN interventions in youth friendly services; BFHI, BFCI, BMS Act, Workplace support for breastfeeding and WHO Growth Charts	workshop to develop	"6 days training, 240 participants to be trained (60 participants divided into 2 sessions per year) Conference package @2500 per pax for 5days for 30 pax per session, transport reimbursement return @2000 per pax for 30, DSA 8400 per pax for 7 days for 30 pax session, DSA for 2 National ToT 10,500 per pax for 7 days for 8 sessions, 2 county ToT @7000 per day, lumpsum Stationaries, manuals @15,000 per training.	yr 1, 2,3, 4, 5			2	2,829,600	1	5,659,200	5,659,200	5,659,200	5,659,200	5,659,200		22,636,800
Total											**215,786,700**	**104,482,200**	**104,482,200**	**104,482,200**	**98,823,000**	**628,056,300**

Creating enabling environment for provision of quality Newborn and Child health services															
Stretegic Objective 5.1: Leadership and governance - Strengthen leadership and governance systems that are responsive and accountable in provision of health services to newborn and children at all levels															
Key actions	Detailed activities	Task Description	Quantities and unit costs	Year of implementation	Item Description	Assumptions	Quantity	Unit Cost	Frequency	Amount	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Strengthen coordination for delivery of newborn and child health services at all levels	Strengthen the linkage between national and county level in offering newborn & child health services	Hold Regional meetings 3 ppts per county for 3 days-4 facilitators and driver	Conference package for 3 days for 10 Regional meetings of 3 pax per county ,4 facilitators and driver, DSA for 3 pax per county(47) transport for 3 pax per county DSA for 4 National facilitators,fuel for 10 regions avarage 600km	Yr 1	Regional meetings for 3 days	6 regional meetings of 25 participants each	6	1,326,000	1	7,956,000	7,956,000					7,956,000
	Strengthen Maternal newborn and child health TWG at National, county and sub county level	Conduct technical working group quarterly	Quarterly-Conference package-20 participants	4 Meetings yearly from year 1 to 5	Quarterly TWG meeting at the subcounty level	20 participants per subcounty for 295 subcounties-transport and lunch allowance provided	4,425	2,000	4	35,400,000	35,400,000	35,400,000	35,400,000	35,400,000	35,400,000	177,000,000
		295 sub-counties	refreshments of 15 pax per subcounty to be done quarterly	Meetings yearly from year 1 to 5	Quarterly TWG meeting at the county level	1 day's meeting	940	2,000	4	7,520,000	7,520,000	7,520,000	7,520,000	7,520,000	7,520,000	37,600,000
	Conduct quarterly child health TWG meeting at all level	Launch -Meeting of 50 people for 1 day			Launch of the communication strategy		1	551,000	1	551,000	551,000					551,000
Enhance leadership and governance for newborn and child health managers at all levels	Dissemination of relevant policies through workshops at all levels	Regional meetings-4 ppts per county for 5 days-4 facilitators and driver	Regional meetings-4 ppts per county for 5 days-4 facilitators and driver	1 &2	8 regional meetings of 25 participants		8	2,001,000	1	16,008,000	8,004,000	8,004,000				16,008,000

	The inter-agency committee on NC & AH to align their activities to address the needs of the county	1 day meeting at national level for 30 participants			1 day's meeting at the national level		30	3,500	1	105,000	105,000					105,000
	Develop/revise relevant policy/strategic documents	Workshop to develop AWP-1 for developing and another for review-twice a year	Conference package for 40 participants-DSA for 30 participants for 5 days				1	2,535,000	2	5,070,000	5,070,000	5,070,000	5,070,000	5,070,000	5,070,000	25,350,000
		KAPPD workshop-30 ppts- DSA, transport, conference package	Consultancy for 30days		Consultancy for 30days		30	40,000	1	1,200,000	2,535,000					2,535,000
			Add consultancy for 30 days		KAPPD workshop for 30 participants		1	2,535,000	1	2,535,000	2,535,000	2,535,000	2,535,000	2,535,000	2,535,000	12,675,000
		ECD Policy	30 participants for 5 days		5-day workshop to develop ECD policy		1	2,535,000	1	2,535,000	2,535,000	2,535,000	2,535,000	2,535,000	2,535,000	12,675,000
		Nurturing care framework	Consultancy for 30days		Consultancy for 30days		30	40,000	1	1,200,000	1,200,000	1,200,000	1,200,000	1,200,000	1,200,000	6,000,000
			30 participants for 5 days		5-day workshop to develop nurturing care framework		1	2,535,000	1	2,535,000	2,535,000	2,535,000	2,535,000	2,535,000	2,535,000	12,675,000
Enhance responsive accountability systems for newborn and child health outcomes at national ,county and community level	Strengthen MPDSR perinatal and neonatal audits and implementation of its recommendations	Hold monthly MPDSR and peadiatric death audits	48 meetings x 12x 20,000= (for teas and snacks)	1, 2, 3, 4, & 5	MPDSR and peadiatric death audits meetings		48 meetings	960,000	monthly	11,520,000	2,304,000	2,304,000	2,304,000	2,304,000	2,304,000	11,520,000
	Strengthen Community MPDSR /verbal autopsy /perinatal and neonatal audits and implementation of its recommendations	Hold monthly verbal MPDSR and peadiatric death audits	6000 cus x20,000x12	1, 2, 3, 4 & 5	Community verbal MPDSR meetings		6000 Cus, 12 meetings	120,000,000	monthly	120,000,000	24,000,000	24,000,000	24,000,000	24,000,000	24,000,000	120,000,000

Strengthen legal environment for implementation of newborn child health services including at the community level	Development of policy briefs	Workshop for 5 days-30 ppts annually	Five-day workshop per annum		Five-day workshop per annum		1	2,535,000	1	2,535,000	2,535,000	2,535,000	2,535,000	2,535,000	2,535,000	12,675,000
	Advocate for enacting of laws promoting and protecting child health interventions	Breakfast meeting with parliamentarians (Health committees-NA and Senate)-30 ppts Conference package-5000				Assumed to be an annual event	30	5,000	r	5,000	5,000	5,000	5,000	5,000	5,000	25,000
Strategy 5.2 Infrastructure - Promote availability of adequate and appropriate infrastructure at both community and facility levels to enable provision of comprehensive and quality newborn and child health services.																
Key actions	Detailed activities	Task Description	Quantities and unit costs	Year of implementation	Item Description	Assumptions	Quantity	Unit Cost	Frequency	Amount	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Advocacy for conducting renovations/ construction in health facilities to ensure provision of quality high impact newborn and child health interventions	Provide space for high impact intervention services e.g. ORT, Breastfeeding corners/space and KMC			Year 1, 2, 3, 4, 5			1	6,115,800	1	6,115,800	6,115,800	6,115,800	6,115,800	6,115,800	6,115,800	30,579,000
Total																**30,579,000**

Strategy 5.3 Service delivery and community health systems – Support establishment and strengthening of community health systems to increase demand and utilisation , of community based newborn and child health services																
Key actions	Detailed activities	Task Description	Quantities and unit costs	Year of implementation	Item Description	Assumptions	Quantity	Unit Cost	Frequency	Amount	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Promote implementation of integrated community case management (iCCM) for children age 2months upto 5 years & CMNC for mothers and newborns and Mother Child hand book	Support capacity building of CHPs, and CHAs to support implementation of , newborn and child health intervention at community level	Already costed above		5	iCCM Implementation framework	iCCM Implementation framework				-	57,300,000	58,617,900	59,966,112	61,345,332	57,499,205	294,728,549
	Support implementation of Integrated Community Case Management (i CCM)			5	Already costed	Costed in the iCCM Implementation framework		7,560,000		-	7,560,000	7,733,880	7,911,759	8,093,729	8,279,875	39,579,243
	Strengthen quarterly support supervision at community level for NCH	National,County (1), subcounty (1) and facility teams (1) and driver to supervise CHPs, CHEWs- 5 days per quarter- DSA for county person and driver Lunch of 2000 for the subcounty and facility person	Quarterly supervision 4 *10,500*5*47 National driver County team 2*8400*5	5	Quarterly supportive supervision at the community level		47	90,900	4	17,089,200	3,417,840	3,417,840	3,417,840	3,417,840	3,417,840	17,089,200

	Support Counties on training of TOTs, link health facility staff, CHPs, CHAs, health facility CHEWs on iCCM	Technical Assistance for TOTS training in the Counties using the 2022 iCCM guidelines for 14 days (5 days TOTs training and 7days teach back in a CHPs training)	National TOTS training *10,500*5*47, National driver, 1*6,300*14. County team Conference package 15pax 3,500*5days. Transport 10pax*2,000*-5days*47	1,2, 3,4 & 5	Technical Assistance for TOTS training in the Counties			2,555,700	1	-	2,555,700	2,555,700	2,555,700	2,555,700	2,555,700	12,778,500
	Advocate and support capacity building including innovative approaches for implementation of iCCM such as use of the simplified Sick Child Recording Form, use of the digitized iCCM tools (Sick Child Recording Form and Newborn Danger Signs check list)	Annual regional meeting in 8 regions to share best practices on iCCM-4 participants per county for 3 days-4 facilitators from the national level	8 regions 4 pax per county x 47 Counties (188 pax) Number of days (4) National facilitators 3000 per pax(4 per region 32) DSA for County participants 8400 per pax (188 pax X 3 days) Transport reimbursement for County officers (188 pax x 2 way) DSA for National facilitators 10500 per pax (4 pax X 4 days)	1	8 regional meetings of 25 participants each for 3 days		8	1,326,000	1	10,608,000	10,608,000	10,608,000	10,608,000	10,608,000	53,040,000

Implement innovative interventions to address barriers to access and utilization of high impact interventions for Newborn, child health	Advocate for counties to conduct iCCM and CMNC gap analysis and development of investment cases	Hire consultant for 5 days per County	1 consultant / consulting firm Duration (5 days)	3	A consultant or consulting firm for 5 days per County		235	40,000	1	9,400,000			9,400,000			9,400,000
		Conduct gap analysis data collection for 5 days per County	47 Counties 2 National x 47 Counties (188 pax) Number of days (4) National Facilitators (4 pax) per region (24) DSA 188 pax Transport reimbursement	3	Data collection at county level--5 days per county		47	297,600	4	55,948,800			55,948,800			55,948,800
Increase access to integrated community case management (iCCM) of common child illnesses as per the national guidelines.	Disseminate iCCM training guidelines	Regional dessemination of 47 counties								-						-
				1	Disseminate iCCM training guidelines		8	1,137,500		9,073,120	9,073,500					9,073,500
	Timely procurement and replacement of iCCM commodities	Support Counties to timely and regularly procure and replenishment of iCCM commodities		5 years	procurement and replacement of iCCM commodities					-	1,234,520	1,262,914	1,291,961	1,321,676	1,352,075	6,463,146
	Train HCPs and CHPs on iCCM	100 CHPs per county at Ksh. 2000 per day for 5 days	Annual training Hall hire-Ksh. 3000 per hall Facilitators-DSA-8400 transport reimbursement Facilitation allowance-2500		Training of CHPs on ICCM-5 days per county		47	1,184,500	1	55,671,500		55,671,500				55,671,500
Total											**10,308,020**	**56,934,414**	**1,291,961**	**1,321,676**	**1,352,075**	**71,208,146**

Strategy 5.4 Human resource - Support interventions to ensure availability of adequate, skilled and motivated human resources for health for provision of quality high impact newborn and child health services at all levels of service delivery																
Key actions	Detailed activities	Task Description	Quantities and unit costs	Year of implementation	Item Description	Assumptions	Quantity	Unit Cost	Frequency	Amount	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Strengthen the capacity of the county governments in planning, recruitment and deployment of critical health care providers for provision of newborn and child health services	Create awareness of service need of critical health care providers through sensitization of county public service board, county assembly and county executives	Hold regional sensitization meetings	47 Counties 2 National x 47 Counties (188 pax) Number of days (4) National Facilitators (4 pax) per region (24) DSA 188 pax Transport reimbursement	1	regional sensitization meetings		2 National x 47 Counties (188 pax)	1,137,500	1	1,137,500	1,137,500	1,137,500	1,137,500	1,137,500	1,137,500	5,687,500
Strengthen integration of competency-based training on high impact newborn and child health interventions into health workers pre-service training programs	Integrate IMNCI , Newborn ETAT,EENBC, KMC,CHX in development of curriculum in the pre & in-service institution	Workshop to incorporate Newborn ETAT,EENBC, KMC,CHX in development of curriculum in the pre & in-service institution	5 days conference package for 30 pax, DSA 25@6 days ,Transport reimbursement		Workshop at the national level for 5 days		1	2,535,000	1	2,535,000	2,535,000					2,535,000
	Advocate through relevant regulatory bodies the implementation of competence-based pre-service training (short courses)	Advocacy meeting	1 Meeting for every year for 20 pax, 1 day conference package, transport for 15 pax		Conference package for 20 pax for 1 day	No additional cost	20	3,500	1	70,000	70,000	70,000	70,000	70,000	70,000	350,000

Advocate for Implementing evidence-based in-service training on high impact newborn and child health interventions	Advocate for / conduct of on-job evidence-based training, mentorship, classroom training and CMEs on high impact new-born and child health interventions at facility level, including support supervision	Facility based activity	Refreshments for 10 pax for 13000 health facilities every quarter		Refreshments for 10 pax for 13000 health facilities every quarter	No additional cost	130,000	1,000	4	520,000,000	520,000,000	520,000,000	520,000,000	520,000,000	520,000,000	2,600,000,000
	Advocate for establishment of skills labs for newborn and child health interventions at facility level for mentorship	4 Consultative meeting 20 pax	1 day conference package for 20 pax, Transport reimbursement for 10 MOH Officers,		1 day conference package for 20 pax, Transport reimbursement for 10 MOH Officers,	Assumed to occur in Year 1 & 2 in all counties	940	3,500	4	13,160,000	13,160,000	13,160,000				26,320,000
	Development of skills lab operational guidelines and assessment tool	4 Workshops to develop the guideline, 1 Validation meeting	30 pax conference package DSA for 25, Transport for 25 Pax		Workshop at the national level for 5 days-30pax		1	2,535,000	4	10,140,000	10,140,000					10,140,000
	Dissemination of skills lab operational guidelines and assessment tools	National launch, county regional disseminations	100 pax for national launch 1 day conference package,printing 2000 copies 60- 100pages,2 banners, decor: county regional dissemination;national DSA 2pax for 2 days COUNTY DSA for 4Pax for 2 days @47 counties , Driver DSA 2days for 10 regions,fuel -unit cost for 600kms		Conference package for the national launch-100 pax		100	3,500	1	350,000	350,000					350,000
					Printing of 2000 copies of 100 page document		2,000	5	100	1,000,000	1,000,000					1,000,000
					Printing of 2 banners		2	35,000	1	70,000	70,000					70,000
					Event decoration		1	100,000	1	100,000	100,000					100,000
					Regional dissemination meeting for county level staff for 2 days-25 pax		8	982,500	1	7,860,000	7,860,000					7,860,000
					Training of skills lab faculty	30 pax for 5 days-every 2 years	1	2,535,000	1	2,535,000	2,535,000		2,535,000		2,535,000	7,605,000
Total											**558,957,500**	**534,367,500**	**523,742,500**	**521,207,500**	**523,742,500**	**2,662,017,500**

Strategy 5.5 Quality improvement: Put in place and/or strengthen systems including policies, standards, guidelines and programs to ensure quality improvement in provision of newborn and child health services as well as improve client experiences to ensure dignified care at all levels of delivery platforms.																
Key actions	Detailed activities	Task Description	Quantities and unit costs	Year of implementation	Item Description	Assumptions	Quantity	Unit Cost	Frequency	Amount	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Advocate for establishing and strengthening of functional newborn and child health responsive quality improvement structures and policy environment	Advocate for the Strengthening of perinatal death audits in MPDSR Committees at all levels	Regional meetings with 3 pax per county for 3 days: one national workshop with 30paxs for 1day 4 facilitators; communication for coordination-airtime,4 drivers	8 regional meetings with 3 participants per county for 3 days-25 participants ;20paxs for 1 day workshop;4facilitators;communication for coordination(DSA,transport reimbursement,conference package,airtime,	Yr 1, 2, 3, 4, 5	Regional meeting of 25 pax for 3 days	Assumed to be held annually	8	1,326,000	1	10,608,000	10,608,000	10,608,000	10,608,000	10,608,000	10,608,000	53,040,000
	Review the 2016 National Guidelines for Maternal and Perinatal Death Surveillance and Response (MPDSR) to include guidance for perinatal and neonatal death audits.	Regional meetings with 3 pax per county for 3 days 4 facilitators	8 regional meetings with 3 participants per county for 3 days-25 participants	Yr 1, 2, 3, 4, 5	Regional meetings for 3 days-25 pax	Hold regional meetings to Review the 2016 National Guidelines for Maternal and Perinatal Death Surveillance and Response (MPDSR) to include guidance for perinatal and neonatal death audits.	8	1,326,000	1	10,608,000	10,608,000	10,608,000	10,608,000	10,608,000	10,608,000	53,040,000
	Develop and disseminate the National Guidelines for Pediatrics Death Audits	5 Workshops at national levels-5 days-30 pax	DSA, conference package for 30paxs,, print 35 copies of perinatal death audit guidelines,airtime	Yr 1, 2, 3, 4, 5	5 workshops at the national level-1 workshop per annum	Hold workshops to develop and disseminate the National Guidelines for Pediatrics Death Audits	1	2,535,000	1	2,535,000	35,400,000	35,400,000	35,400,000	35,400,000	35,400,000	177,000,000
					Printing of 35 copies of perinatal death audit guidelines		35	1,500	1	52,500	7,520,000	7,520,000	7,520,000	7,520,000	7,520,000	37,600,000

	Development, dissemination and implementation of newborn and paediatric quality of care guidelines	6 Workshops at national levels-5 days-30 pax	30 Participants x 5 days 2 Drivers x 6 days;5workshops(DSA,airtime,conference package)	Yr 1, 2, 3	5 Workshops at the national level-30pax for 5 days	2 workshops in Y1 & Y2 and 1 workshop in Y3	1	2,535,000	1	2,535,000	2,535,000	2,535,000	2,535,000	2,535,000	2,535,000	12,675,000
		Regional meetings with 3 pax per county for 3 days 4 facilitators	30 Participants x 3 days 10 Drivers x 3 days, conference package, transport reimbursement,airtime)	Yr 1, 2, 3, 4, 5	Regional meeting with 3 participants per county-25 pax for 5 days	Hold Regional meetings with 3 participants per county-25 pax for 5 days	8	1,326,000	1	10,608,000	551,000	551,000	551,000	551,000	551,000	2,755,000
	Conduct quarterly integrated support supervision on quality of care for newborn and child health				Quarterly support supervision from national level to counties	Conduct quarterly support supervision by national team (4 staff from national level and driver- 5 days per county)	47	297,600	4	55,948,800	16,008,000	16,008,000	16,008,000	16,008,000	16,008,000	80,040,000
	Development, dissemination and implementation of community newborn and paediatric quality of care guidelines	6 Workshops at national levels-5 days-30 ppts	30 Participants x 5 days 2 Drivers x 5 days;6workshops(DSA,airtime,conference package,transport reimbursement)	Yr 1, 2, 3	Workshop at the national level	Hold 6 workshops for Development, dissemination and implementation of community newborn and paediatric quality of care guidelines	1	2,535,000	1	2,535,000	2,535,000	2,535,000	2,535,000	2,535,000	2,535,000	12,675,000
	Hold bi annual review meetings at DNCH to advocate for Strengthening coordination at national level for MPDSR through the DFH	Two meetings 20paxs per year to review the MPDSR (perinatal audits)bottle necks	Tea and snacks for 20paxs twice a year	Yr 1, 2, 3, 4, 5	Conference package for 20 pax for 1 day twice a year	No additional cost(consider costing for tea&snacks	20	3,500	2	140,000	140,000	140,000	140,000	140,000	140,000	700,000

	Hold regional meetings to advocate for estab-lishment and strengthening of MPDSR committees at the commu-nity that will include peri-natal death audits.	Regional meetings with 3 pax per county for 3 days 4 facilitators; communi-cation for coordina-tion-airtime	8 regional meetings with 3 participants per county for 3 days-16 national pax, (DSA, con-ference pack-age, airtime, transport -8 air travel with air-port transfers, road fares)	Yr 1, 2, 3, 4, 5	8 regional meetings with 3 participants per county for 3 days-with 4 national staff	To be held annually	8	1,326,000	1	10,608,000	2,121,600	2,121,600	2,121,600	2,121,600	2,121,600	10,608,000
	Conduct NCH annual client satisfaction surveys in all facilities conducting deliveries in collaboration with counties.	Consultan-cy-10 days to digitize client satis-faction ques-tionnaire	10-day consul-tancy(local)	Yr 1, 2, 3, 4, 5	10 days' consul-tancy	Per annum	10	40,000	1	400,000	105,000	105,000	105,000	105,000	105,000	525,000
		Regional meetings with 3 ppts per county for 3 days 4 facilitators	8 regional meetings with 3 participants per county for 3 days-16 national pax, (DSA, con-ference pack-age, airtime, transport -8 air travel with air-port transfers, road fares)	Yr 1, 2, 3, 4, 5	8 regional meetings with 3 participants per county for 3 days-with 4 national staff		8	1,326,000	1	10,608,000	5,070,000	5,070,000	5,070,000	5,070,000	5,070,000	25,350,000
		Sample 1000health facilities,-200paxs lunch allow-ance-super-visors&re-search assis-tants;driv-ers lunch allowance;-fuel ksh42/ km;commu-nication for coordina-tion-airtime for 200paxs)	200paxs lunch allowance-su-pervisors & research assis-tants;drivers lunch allow-ance;fuel ksh42/ km;communica-tion for coordi-nation-airtime for 200paxs) for 10days	Yr 1, 2, 3, 4, 5	Lunch allowance for 200 pax for 10 days		200	1,000	10	2,000,000	1,200,000	1,200,000	1,200,000	1,200,000	1,200,000	6,000,000
					Communication allowance for 200 pax for 10 days		200	1,000	10	2,000,000	2,535,000	2,535,000	2,535,000	2,535,000	2,535,000	12,675,000
					Fuel for field-work	Assumed that each vehicle would cover 300km per day per county. Used Ksh.32 per km	14,100	32	10	4,512,000	2,535,000	2,535,000	2,535,000	2,535,000	2,535,000	12,675,000

	Advocate for strengthening of clinical and non-clinical committees to include the neonatal and child health agenda (IPC committees, quality of care committees etc.)	Refresher 5day training workshop for 20 officers per county,16 facilitators(-conference package,D-SA,Transport reimburse-ment&air-port transfers-air+road, air-time)	5day training workshop for 20 officers per county,16 facilitators/train-ing (conference package,D-SA,Transport reimburse-ment&air-port trans-fers-air+road ,airtime)	Yr 1, 2, 3, 4, 5	5-day training at the county level-20 par-ticipants and 4 facilitators from the national level		47	1,568,000	1		1,200,000	1,200,000	1,200,000	1,200,000	1,200,000	6,000,000
Establish and ensure functionality of national and county quality improvement mentors to ensure provision of quality high impact new born and child health interventions	Train and de-ploy prospec-tive PQoC QI mentors and mentees in collabora-tion with the Department of Quality, Standards and Regula-tions.	Train na-tional and county QI mentors on PQoC	18 National QI mentors 5-day training workshops 5day training workshop for 20 officers per county,16 facilitators/ training (confer-ence package, DSA, Transport reimburse-ment&airport transfers-air+ road, airtime)	Yr 1, 2, 3, 4, 5	18 national QI mentors work-shop-5 days		1	1,690,000	1	1,690,000	2,535,000	2,535,000	2,535,000	2,535,000	2,535,000	12,675,000
					5-day training at the county level-20 par-ticipants and 4 facilitators from the national level		47	1,568,000	1		14,739,200	14,739,200	14,739,200	14,739,200	14,739,200	73,696,000
	Roll out of the assessment tools for pedi-atrics Quality of care Stan-dards	Regional meetings with 3 pax per county for 3 days 4 facilitators; communi-cation for coordina-tion-airtime	8 Regional meetings with 3 pax per county for 3 days,16na-tional facilita-tors, communication for coordina-tion-airtime;air tickets and transfers for 8 pax,road trans-port reimburse-ment,confer-ence package,)	Yr 1, 2, 3	Regional meet-ing-25pax for 3 days		8	1,326,000	1	10,608,000	3,536,000	3,536,000	3,536,000			10,608,000

	Capacity build health care workers (TOTs), health care workers, CHPs, CHAs on high impact MNCH strategies and interventions according to existing guidelines	Train national and county QI mentors on PQoC	Train 20 pax national and 3paxs per county QI mentors on PQoC for 5 days (DSA, conference package, transport reimbursement)	Yr 1, 2, 3, 4, 5	Training at the county level-20 pax for 5 days		47	1,568,000	1		14,739,200	14,739,200	14,739,200	14,739,200	14,739,200	73,696,000
Strengthen use of quality improvement tools for provision of quality newborn and child health services	Hold annual meetings to strengthen use of quality improvement tools for provision of quality newborn and child health services	Hold 1 national level meeting per year of 50pax for quality improvement (DSA, Fuel, Transport, airtime, Conference)	50pax, 5days, conference, DSA, Fuel5vehicles, Transport, coordination airtime	Yr 1, 2, 3, 4, 5	National level meeting on quality improvement-50 pax for 5 days		1	1,815,000	1	1,815,000	2,535,000	2,535,000	2,535,000	2,535,000	2,535,000	12,675,000
	Capacity building for health care providers including health records officers at all levels on use of neonatal and child health reporting tools	1 workshop per county per annum-30 ppts for 5 days 4 facilitators	47 workshops, 5days, 30ppl, lunch, DSA4 facilitators, conference	Yr 1, 2, 3, 4, 5	County level workshop-30pax for 5 days-5 facilitators		47	2,183,000	1	20,520,200	20,520,200	20,520,200	20,520,200	20,520,200	20,520,200	102,601,000
	Advocate/ strengthen data quality audits and support supervision and promote benchmarking at all levels	Conduct routine data quality assessments in 10 counties	200km per day, 3 officers (1 national, 2 county, 1 subcounty) for 5 days per annum + driver and fuel	Yr 1, 2, 3, 4, 5	Routine data quality audits per annum-3 officers for 5 days		10	90,900	1	909,000	181,800	181,800	181,800	181,800	181,800	909,000

Support utilization of quality of care data for provision of newborn and child health services.	Support Training of community health workers including CHPs and provincial administration on Reporting of NCH indicators at community level	Train CHAs,CHPs and county commissioner administration on NCH indicators reporting-3000 pax per county for 1 day	1-day training of 3000 participants per county,5facilators (Hall hire, Lunch allowance, transport reimbursement, facilitation fee,printing)	Yr 1, 2, 3, 4, 5	1-day training of 3000 participants per county		47	272,000	1	12,784,000	12,784,000	12,784,000	12,784,000	12,784,000	12,784,000	63,920,000
	Advocate for National, counties and partners to Conduct in depth data review meetings	Hold national-level meeting per year of 30pax for 10 days for in-depth data review, Counties 3pax/county for 5 days annually (DSA, Fuel, Transport, airtime, Conference)	Hold 1 national-level meeting per year of 30pax for 10 days for in-depth data review, Counties 3pax/county for 5 days annually (DSA, Fuel, Transport, airtime, Conference)	Yr 1, 2, 3, 4, 5	1 national level meeting of 30 pax for 5 days pa		1	864,000	1	864,000	864,000	864,000	864,000	864,000	864,000	4,320,000
					Regional meetings of 25 participants for 5 days-3 pax per county		8	2,001,000	1	2,001,000	2,001,000	2,001,000	2,001,000	2,001,000	2,001,000	10,005,000
	Capacity build the national DNCH team, HRIOs, and county/ sub-county managers on KHIS, dashboard, and scorecard	Hold Regional training meetings for county for 3 days with national facilitators; train national team for 5 days on KHIS,dashboard and scorecard	8 Regional training meetings-5paxs per county for 3 days-16 national facilitators; national team 20paxs for5 days,4facilitators(DSA,fuel,transport(air with airport transfers & road,conference package,airtime ,facilitation fee)	Yr 1, 2, 3, 4, 5	Regional meetings of 25 participants for 3 days-3 pax per county		8	1,326,000	1	2,121,600	2,121,600	2,121,600	2,121,600	2,121,600	2,121,600	10,608,000
					National workshop of 20 pax for 5 days facilitators		8	1,568,000	1	12,544,000	2,508,800	2,508,800	2,508,800	2,508,800	2,508,800	12,544,000
Total											**179,737,400**	**179,737,400**	**179,737,400**	**176,201,400**	**176,201,400**	**891,615,000**

Strategy 5.6 Health care financing - Ensure availability of adequate financing for delivery of high impact and quality newborn and child health services																
Key actions	Detailed activities	Task Description	Quantities and unit costs	Year of implementation	Item Description	Assumptions	Quantity	Unit Cost	Frequency	Amount	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Promote development and strengthening of strategies to ensure effective mobilization, equitable allocation, and accountability in management of financial resources for newborn and child health at both national and county levels	Advocate for increased domestic financing/ funding,and ring fence funding for NCH activities at the national and county level.	Hold annual senior level meetings to advocate for NCH financing	20 Participants x 3 days 10 Drivers x 3 days	Yr 1, 2, 3, 4, 5	Annual senior level NCH financing advocacy meetings. 20 pax for 3 days		1	1,500,000	1	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	7,500,000
		Convene an annual County Health Executive Team and County Assembly Health Committee Meeting and use the RMNACH scorecard to advocate for financing of NCH activities	30 Participants x 2 days x 47 Counties 20 Drivers x 2 days x 47 Counties	Yr 1, 2, 3, 4, 5	Annual County Health Executive Team and County Assembly Committee Meeting		47	1,680,000	1	78,960,000	15,792,000	15,792,000	15,792,000	15,792,000	15,792,000	78,960,000
	Resource mobilisation through proposal development for public-private and non-profit funding mechanisms including donations and proposal writing,etc	Convene bi-annual proposal writing workshops	30 Participants x 6 days 10 Drivers x 6 days	Yr 1, 2, 3, 4, 5	Bi-annual proposal writing workshop-30pax for 6 days		1	2,955,000	2	5,910,000	5,910,000	5,910,000	5,910,000	5,910,000	5,910,000	29,550,000

	Inclusion of NCH into the Medium-Term Plan (MTP), County Integrated Development Plans (CIDP), Mid Term Expenditure Framework (MTEF), and Annual Work plans	Participation of the DNCH during the development of MTP, CIDP and MTEF: Participation of 4 DNCH Officers in 2 Consultative Meetings for MTP Participation of 4 DNCH Officers in 2 Consultative Meetings for CIDP in 47 Counties Participation of 4 DNCH Officers in 2 Consultative Meetings for MTP	4 Participants x 5 days x 2 meetings (MTEF) - National 4 Participants x 5 days x 47 meetings (MTEF) - Counties 4 Participants x 5 days x 2 meetings (MTP) 4 Participants x 5 days x 47 meetings (CIDP)	Yr 1, 2, 3, 4, 5	4 Participants x 5 days x 2 meetings (MTEF) - National		1	338,000	2	676,000	676,000	676,000	676,000	676,000	676,000	3,380,000
					4 Participants x 5 days x 47 meetings (MTEF) - Counties		47	279,600	2	26,282,400	5,256,480	5,256,480	5,256,480	5,256,480	5,256,480	26,282,400
					4 Participants x 5 days x 2 meetings (MTP)		47	338,000	2	31,772,000	6,354,400	6,354,400	6,354,400	6,354,400	6,354,400	31,772,000
					4 Participants x 5 days x 47 meetings (CIDP)		47	279,600	2	26,282,400	26,282,400	26,282,400	26,282,400	26,282,400	26,282,400	131,412,000
	Hold annual stakeholders' forum with health partners for increased funding for NCH	Annual stakeholders meeting to take stock of current financing for NCH and Conduct stakeholder mapping and joint planning	Annual meeting with 100 stakeholders (national, COG, partners) for 2 days. requires conference package	Yr 1, 2, 3, 4, 5	Conference package for 2 days. Annual activity		100	3,500	2	700,000	350,000	350,000	350,000	350,000	350,000	1,750,000

	Development of costed implementation plan for newborn and child health at all levels	Workshops to develop the costed plan. 2 workshop to develop, 1 meeting internal validation, 2 workshop finalization, external validation, editing, printing and dissemination	1. Development workshops for 30 pax for 5 days who require conference, transport and DSA 2. Internal validation. Meeting at MOH for 50 pax requiring conference, teas and lunch 3. Finalization workshops for 30 pax for 5 days who require conference, transport and DSA Internal 4. External validation. Meeting at MOH and at county level for 50 pax requiring conference, transport and DSA 5. Professional editing 6. Print 100 copies 7. Undertake national and county cluster dissemination for 1 day.	Yr 1, 2, 3, 4, 5	Development workshops for 30 pax for 5 days who require conference, transport and DSA	Hold workshops for 30 pax for 5 days who require conference, transport and DSA	1	2,535,000	1	2,535,000	2,535,000	2,535,000	2,535,000	2,535,000	2,535,000	12,675,000
					2. Internal validation. Meeting at MOH for 50 pax requiring conference, teas and lunch		50	3,500	1	175,000	175,000					175,000
					3. Finalization workshops for 30 pax for 5 days who require conference, transport and DSA Internal		1	2,535,000	1	2,535,000	2,535,000	2,535,000	2,535,000	2,535,000	2,535,000	12,675,000
					4. External validation. Meeting at MOH and at county level for 50 pax requiring conference, transport and DSA		50	3,500	1	175,000	175,000	175,000	175,000	175,000	175,000	875,000
					5. Professional editing		1	80,000	1	80,000	80,000	80,000	80,000	80,000	80,000	400,000
					6. Print 100 copies		100	1,500	1	150,000	150,000	150,000	150,000	150,000	150,000	750,000
					7. Undertake national and county cluster dissemination for 1 day.	Assumed to be 50 pax 1 day involving 20 pax from counties	1	551,000	1	551,000	551,000	551,000	551,000	551,000	551,000	2,755,000
Advocate for strengthening financial accountability and control of NCH programmes	Monitoring and tracking of resources allocated for NCH	Annual Budget and expenditure analysis.	Annual Budget and expenditure analysis. 20 consultancy days. Meeting for 20 pax to finalize the report. Dissemination meeting	Yr 1, 2, 3, 4, 5	Consultancy to undertake annual Budget and expenditure analysis. 20 consultancy days.		20	40,000	1	800,000	800,000	800,000	800,000	800,000	800,000	4,000,000

		Hold a Meeting to finalize the budget and expenditure report	Hold meeting for 20 pax to finalize the budget and expenditure report.	Yr 1, 2, 3, 4, 6	Meeting for 20 pax to finalize the report.	Assumed 3 days non residential at the national level	20	3,500	1	70,000	9,400,000	9,400,000	9,400,000	9,400,000	9,400,000	47,000,000
		Hold Dissemination meeting	Hold Dissemination meeting with the counties	Yr 1, 2, 3, 4, 7	Dissemination meeting	Assumed to be 50 pax 1 day involving 20 pax from counties	1	551,000	1	551,000	55,948,800	55,948,800	55,948,800	55,948,800	55,948,800	279,744,000
	Capacity building on health budgeting at national and county level including sensitizing the county assembly on health priorities	Hold annual meeting with County Assembly for prioritization	Hold one sensitization meeting yearly for each - National, Senate and county level.	Yr 1, 2, 3, 4, 8	Hold 3 (for National, Senate and County) 1 day meeting, Cost: pax (20) DSA (20), Conference package, Transport reimbursement, Airtime(1) for 49 entities (National assembly, Senate and County assemblies		49	760,000	1	37,240,000	37,240,000	37,240,000	37,240,000	37,240,000	37,240,000	186,200,000
Total											**171,711,080**	**171,536,080**	**171,536,080**	**171,536,080**	**171,536,080**	**857,855,400**

Strategy 5.7 Health commodities and supplies - Strengthen systems including for procurement, supply and management to ensure availability of essential medicines, commodities, equipment and technologies for provision of newborn and child health services.																
Key actions	Detailed activities	Task Description	Quantities and unit costs	Year of implementation	Item Description	Assumptions	Quantity	Unit Cost	Frequency	Amount	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Build capacity of county and sub-county health management teams in procurement, supply and management of essential newborn and child health services	Capacity build CHMT/ health care providers (HCP) at all levels on child health services (including. commodities, guidelines, policies, etc.)	8 regional meetings one day meeting	8 regional meetings, 1 day meetings DSA for National 3 officers - @ KSH10500 for 2 days DSA for Driver @ 4900 for 2 days, DSA for 2 County Officers(CEC & CDH) @ 8, 400 for 94 pax, County Drivers 4900 for 2 days @ for 37 pax, Air tickets for 20 Officers Dissemination 1 day Conference package 3500 per pax Transport@ 2000, Airtime for coordination 1000.	Year 2, 3, 4	8 regional meetings, 1 day meetings DSA for National 3 officers - @ KSH10500 for 2 days DSA for Driver @ 4900 for 2 days, DSA for 2 County Officers(CEC & CDH) @ 8, 400 for 94 pax, County Drivers 4900 for 2 days @ for 37 pax, Air tickets for 20 Officers Dissemination 1 day Conference package 3500 per pax Transport@ 2000, Airtime for coordination 1000.		1	3,582,200	1	3,582,200	3,582,200	3,582,200	3,582,200	3,582,200	3,582,200	17,911,000

Advocate for Procurement and distribution of essential medicines, commodities and equipment for delivery of quality newborn and child health services	Advocate Forecasting and quantification of essential NCH medicines, commodities and equipment at national and county levels	8 regional meetings one day meeting with the national level HPT	8 regional meetings, 1 day meetings DSA for National 3 officers - @ KSH10500 for 2 days DSA for Driver @ 4900 for 2 days, DSA for 3 County Officers(CEC & CDH) @ 8, 400 for 94 pax, County Drivers 4900 for 2 days @ for 37 pax, Air tickets for 20 Officers Dissemination 1 day Conference package 3500 per pax Transport@ 2000, Airtime for coordination 1000. Tea and lunch @ 20,00	Year 2, 4	8 regional meetings, 1 day meetings DSA for National 3 officers - @ KSH10500 for 2 days DSA for Driver @ 4900 for 2 days, DSA for 2 County Officers(CEC & CDH) @ 8, 400 for 94 pax, County Drivers 4900 for 2 days @ for 37 pax, Air tickets for 20 Officers Dissemination 1 day Conference package 3500 per pax Transport@ 2000, Airtime for coordination 1000.		1	3,582,200	1	3,582,200		3,582,200		3,582,200		7,164,400
	Regular facility based deworming during CWCs, OPD	Targets about 8 million children twice a year@Ksh.5 per tablet	Annual	Year 1, 2, 3, 4, 5	Albendazole for deworming of children	Deworming done twice a year	8,000,000	5	2	83,328,000	16,665,600	16,665,600	16,665,600	16,665,600	16,665,600	83,328,000

	Advocate for inclusion of NCH essential medicines and equipment into the county procurement list as per Kenya essential medicine list (KEML) ; including oxygen	8 regional meetings one day meeting with CHMT	8 regional meetings, 1 day meetings DSA for National 3 officers - @ KSH10500 for 2 days DSA for Driver @ 4900 for 2 days, DSA for 2 County Officers(CEC & CDH) @ 8, 400 for 94 pax, County Drivers 4900 for 2 days @ for 37 pax, Air tickets for 20 Officers Dissemination 1 day Conference package 3500 per pax Transport@ 2000, Airtime for coordination 1000.	Year 2, 4	8 regional meetings, 1 day meetings DSA for National 3 officers - @ KSH10500 for 2 days DSA for Driver @ 4900 for 2 days, DSA for 2 County Officers(CEC & CDH) @ 8, 400 for 94 pax, County Drivers 4900 for 2 days @ for 37 pax, Air tickets for 20 Officers Dissemination 1 day Conference package 3500 per pax Transport@ 2000, Airtime for coordination 1000.		1	3,582,200	1	3,582,200		3,582,200		3,582,200		7,164,400
	Generate evidence on CHX use at community level	Conduct a study -DNCH and consultant	30 days' consultancy	Year 2	30 days' consultancy		30	40,000	1	1,200,000		1,200,000				1,200,000
	Advocate for proper utilisation and accountability of all procured and donated equipment and commodities at all levels.	Print and distribute tools for tracking and reporting of equipment	20000 copies per year about Ksh.200 per copy To be distributed for tracking and reporting	Year 1, 2, 3, 4, 5	Printing of tracking and reporting tools 20000 copies per year about Ksh.200 per copy To be distributed for tracking and reporting		20,000	200	1	4,000,000	4,000,000	4,000,000	4,000,000	4,000,000	4,000,000	20,000,000

	Advocate for purchase of paedi-atric-size equipment, medicine and supplies, as per national guidelines	8 regional meetings one day meeting	8 regional meetings, 1 day meetings DSA for National 3 officers - @ KSH10500 for 2 days DSA for Driver @ 4900 for 2 days, DSA for 3 County Officers) @ 8, 400 for 94 pax, County Drivers 4900 for 2 days @ for 37 pax, Air tickets for 20 Officers Dissemination 1 day Conference package 3500 per pax Transport@ 2000, Airtime for coordination 1000.	Year 1, 2, 3, 4, 5	8 regional meetings, 1 day meetings DSA for National 3 officers - @ KSH10500 for 2 days DSA for Driver @ 4900 for 2 days, DSA for 3 County Officers) @ 8, 400 for 94 pax, County Drivers 4900 for 2 days @ for 37 pax, Air tickets for 20 Officers Dissemination 1 day Conference package 3500 per pax Transport@ 2000, Airtime for coordination 1000.		1	3,582,200	1	3,582,200	3,582,200	3,582,200	3,582,200	3,582,200	3,582,200	17,911,000
Promote all time availability of blood and laboratory services for provision of emergency high impact interventions for newborns and children	Advocate and lobby for establishment of county blood banks	Advocacy meeting with NBTS	Conference package @ 3500 per person DSA 10500 @ 30 pax Transport 2000 @ 30 2 days Airtime coordi-nation @ 1000	Year 1, 2, 3, 4, 5	3-day workshop at the national level		1	1,695,000	1	1,695,000	214,368,000	214,368,000	214,368,000	214,368,000	214,368,000	1,071,840,000

	Advocate for integrated lab services and give priority to NCH samples	8 regional meetings one day meeting	8 regional meetings, 1 day meetings DSA for National 3 officers - @ KSH10500 for 2 days DSA for Driver @ 4900 for 2 days, DSA for 3 County Officers) @ 8, 400 for 94 pax, County Drivers 4900 for 2 days @ for 37 pax, Air tickets for 20 Officers Dissemination 1 day Conference package 3500 per pax Transport@ 2000, Airtime for coordination 1000.	Year 1, 2, 3, 4, 5	8 regional meetings, 1 day meetings DSA for National 3 officers - @ KSH10500 for 2 days DSA for Driver @ 4900 for 2 days, DSA for 3 County Officers) @ 8, 400 for 94 pax, County Drivers 4900 for 2 days @ for 37 pax, Air tickets for 20 Officers Dissemination 1 day Conference package 3500 per pax Transport@ 2000, Airtime for coordination 1000.		1	3,582,200	1	3,582,200	3,582,200	3,582,200	3,582,200	3,582,200	3,582,200	3,582,200	17,911,000
	Advocate for paediatric-size packaging of blood and blood products, and testing equipment.								-							-
	Advocate for the increase in the number of health facilities offering accredited laboratory services								-							-
	Advocate for steady supply of laboratory supplies and commodities through timely ordering and supply								-							-
Strengthen equipment maintenance and repair in health facilities for delivery of quality newborn and child health services	Advocate for inclusion of pediatric specific items into essential equipment list.	8 regional meetings one day meeting	8 regional meetings, 1 day meetings DSA for National 3 officers - @ KSH10500 for 2 days DSA for Driver @ 4900 for 2 days, DSA for 3 County Officers) @ 8, 400 for 94 pax, County Drivers 4900 for 2 days @ for 37 pax, Air tickets for 20 Officers Dissemination 1 day Conference package 3500 per pax Transport@ 2000, Airtime for coordination 1000.	Year 1, 2, 3, 4, 5	8 regional meetings, 1 day meetings DSA for National 3 officers - @ KSH10500 for 2 days DSA for Driver @ 4900 for 2 days, DSA for 3 County Officers) @ 8, 400 for 94 pax, County Drivers 4900 for 2 days @ for 37 pax, Air tickets for 20 Officers Dissemination 1 day Conference package 3500 per pax Transport@ 2000, Airtime for coordination 1000.		1	3,582,200	1	3,582,200	3,582,200	3,582,200	3,582,200	3,582,200	3,582,200	3,582,200	17,911,000
									-							-
	Advocate for establishment of paediatric equipment maintenance plan								-							-

	Timely procurement, ordering and distribution of essential commodities , equipment and technologies (antimalarials, antibiotics, ORS, zinc, pulse oximeters, etc.)	ORS and Zinc-Diarrhea prevalence-11% of under-fives Pulse oximeters-No of health facilities-Each facility 1-Disp and health center Level 4&5-2 oximeters To confirm the procurement cost-Pulse oximeter-5000	Amoxicillin DT- 10 tablets per treatment episode-9% of under fives Pneumonia-3 episodes per year Diarrhoea-4 episodes per year ARI timers-for counting breaths- To be used by CHPs-	Year 1, 2, 3, 4, 5	Amoxicillin DT	Assumed that 9% of under-fives will develop URTIs-3 episodes/year	540,000	38	3	61,236,000	12,247,200	12,247,200	12,247,200	12,247,200	12,247,200	61,236,000
					Procurement of ORS & Zinc	Assumed that 11% of under-fives will develop diarrhea-4 episodes/ year	660,000	81	4	214,368,000	42,873,600	42,873,600	42,873,600	42,873,600	42,873,600	214,368,000
					Procurement of pulse oximeters for dispensaries and health centres	One pulse oximeter per facility per year	5,862	5,000	1	29,310,000	5,862,000	5,862,000	5,862,000	5,862,000	5,862,000	29,310,000
					Procurement of pulse oximeters for Level 4 and 5 hospitals	Two pulse oximeters per facility per year	374	5,000	2	3,740,000	748,000	748,000	748,000	748,000	748,000	3,740,000
					ARI Timers for CHPs	That each CHP would have one timer-Year 1 &4	86,000	473	1	40,695,200	8,139,040	8,139,040	8,139,040	8,139,040	8,139,040	40,695,200
Total											**319,232,240**	**327,596,640**	**319,232,240**	**326,396,640**	**319,232,240**	**1,611,690,000**

Strategy 5.8 Health information systems, monitoring and evaluation, research and Learning - Strengthen health information systems to ensure collection, reporting, quality management and use of disaggregated data at the various levels of health service delivery to inform newborn and , child and adolescent health programming.																
Key actions	Detailed activities	Task Description	Quantities and unit costs	Year of implementation	Item Description	Assumptions	Quantity	Unit Cost	Frequency	Amount	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Strengthen data quality and use in routine monitoring and evaluation for decision-making	Advocate for availability and utilization of newborn and child health collection/ reporting tools	Printing NCH tool (MoH204A / 705A/ MOH373/ MOH374/ MOH283/ MOH711	13000 copies for MOH204A/705A/ MOH283/ MOH711 and 5000 copies for MOH373/ MOH374/	Yr 1, 2, 3, 4, 5	Printing of 5000 copies for MOH373/ MOH374	Print 5000 copies for MOH373/ MOH374	5,000	2,000	2	20,000,000	20,000,000	20,000,000	20,000,000	20,000,000	20,000,000	100,000,000
					Printing of 13000 copies for MOH204A/705A/ MOH283/ MOH711	Print 13000 copies for MOH204A / 705A / MOH283 / MOH711	13,000	2,000	4	104,000,000	20,800,000	20,800,000	20,800,000	20,800,000	20,800,000	104,000,000
	Periodically review new born and child health data collection/ reporting tools as per HIS guidelines	Hold 4 review workshop at the national level for 5 days-30 participants -20 national and 10 counties) in 2023 and 2026	4 workshops of (30 pax-20 national and 10 counties) for 5 days in 2023 and 2026(DSA national and county,Transport reimbursement, conference package	Yr 2,5	Workshop to review data reporting tools-30 pax-4 workshops-5 days	Hold 4 Workshops to review data reporting tools-30 pax conference,DSA,Transport reimbursement for 5 days each	1	2,535,000	4	10,140,000	9,073,120			9,073,120		18,146,240
	Advocate and conduct quarterly routine data quality audits (DQAs) for newborn and child health at service delivery units in collaboration with counties	Hold annual data quality audits in 20 sampled counties. 20 teams composed of 2national officers and 4 county officers per team	Field activity (DSA 40pax, fuel 20 vehicles, DSA drivers, lunch county pax 80 & air time	Yr 1, 2, 3, 4, 5	Annual data quality audits in 20 counties	Field activity for teams (DSA 40pax, fuel 20 vehicles, DSA drivers, lunch county pax 80 & air time	20	297,600	1	5,952,000	1,130,400	1,130,400	1,130,400	1,130,400	1,130,400	5,652,000

	Regional county annual data review meetings and develop action plans	Hold 8 regional workshops- for 40pax for 5 days.-3 facilitators from the national-40 ppts at the county(4pple per county (DSA 40PAX, Conference for 40pax, Transport reimburse-ment, Air fare and airport transfers for 16 national facilitators, airtime for coordination)	8 workshops 40pax=320. DSA for 320 county pax and 24 national facilitators and transport reim-bursement, con-ference 320pax, transport reim-bursements16 national officers, air fare and transfers for 16facilitators	Yr 1, 2, 3, 4, 5	Regional workshop of 40 pax for 5 days-3 national facilitators	Hold Regional workshops of 40 pax for 5 days-3 nation-al facilitators	1	13,692,000	1	13,692,000	55,671,500	55,671,500	55,671,500	55,671,500	55,671,500	278,357,500
	Ensure all data collec-tion/reporting tools and indicators are updated and embended in the national EMR system for newborn & child health to improve data demand and use for decision making at Na-tional, County and commu-nity levels. Support counties to adopt and update the data in the EMR system	Conduct a Pilot study(ies) on newborn and child health data col-lection and reporting	6.5 million + 6.5 million	Yr 1, 2, 3, 4, 5	Conduct study(ies) on NCH	Conduct study(ies) on NCH & ICCM	2	6,500,000	1	13,000,000	13,000,000	13,000,000	13,000,000	13,000,000	13,000,000	65,000,000

	Analysis and use of NCH available routine health information to inform decision making	Hold annual workshop at the national level for 5 days-40 participants	DSA, Conference , travel reimbursement, for 5 days per year for 30pax	Yr 1, 2, 3, 4, 5	Annual workshop at the national level-30 pax for 5 days	Hold Annual workshop at the national level-30 pax for 5 days	1	2,535,000	1	2,535,000	2,535,000	2,535,000	2,535,000	2,535,000	2,535,000	12,675,000
	To establish and operationalize NCH dashboard and strengthen the utilization of the RMNCAH scorecard in all levels	Hold 4 workshops to develop NCH dashboard and disseminate	DSA 20national officers & 10 county. Conference 30pax, travel reimbursement for 30pax, for five days year 2024	Yr 2	Four workshops at the national level-30 pax for 5 days	Hold 4 workshops at the national level-30 pax for 5 days	4	2,535,000	1	10,140,000		10,140,000				10,140,000
		Hold 3 workshops to review the RMNCAH scorecard indicators-National &County level- 40 participants for 5 days	Conference 40pax,DSA 40pax by 5 days,transport refund,	Yr4	Workshop at the national level to review RMNCAH scorecard indicators-40 participants for 5 days	Hold a Workshop at the national level together with the county to review RMNCAH scorecard indicators-40 participants for 5 days	1	3,327,500	3	9,982,500				9,982,500		9,982,500
	Performance tracking of the child health indicators in the RMNCAH scorecard	County regional performance review meetings-4 pax per county for 5 days per annum 4 from national	8regions,4pax by 47(188),number of days 5,DSA 188pax by 12,Transport reimbursement,4National facilitators by 8(32) by 12,Facilitation fee for 32pax	Yr 1, 2, 3, 4, 5	County regional performance review meetings-4 pax per county for 5 days per annum 3 persons from national	Hold County -regional performance review meetings-4 pax per county for 5 days per annum 3 persons from national	8	2,001,000	1	16,008,000	16,008,000	16,008,000	16,008,000	16,008,000	16,008,000	80,040,000
	Training of healthcare workers at all levels on newborn and child health data collection and reporting tools	47 county meetings of 50 pax per county per year	DSA for 100 national facilitators, lunch 50 county officers per county, Conference package, transport reimbursement for 5days	Yr 1, 2, 3, 4, 5	County level workshop-50pax for 5 days/ county-100 facilitators,47 meetings	Hold county-level meetings with DSA for 100 national facilitators and lunch for 50 county officers per county, Conference, travel reimbursement for 5 days		8,718,500	1		8,718,500	8,718,500	8,718,500	8,718,500	8,718,500	43,592,500

	Monitoring of the AWP/ High impact interventions performance for NCH targets	Hold bi-annual meeting with stakeholders 40paxs	DSA for 40 national officers , Conference for 50pax including stakeholders , travel reimbursement for 40pax	Yr 1, 2, 3, 4, 5	Hold bi-annual stakeholder meetings with 40paxs national and 50 stakeholders (DSA, Transport reimbursement, conference package) for 3days	Hold bi-annual stakeholder meetings with 40paxs national and 50 stakeholders (DSA, Transport reimbursement, conference package) for 3days	2	1485000	2	3915000		3915000		3,915,000		7,830,000
	Monitoring and evaluation of the implementation of the strategic plan 2022-2026	Midterm and end-term evaluation-Consultancy for 30 days	Local consultant for 30 days @ Ksh. 30000 per day. DSA for 10 national level officers for 30days, fuel and coordination air time	Yr 3,5	Consultancy for 30 days	Engage a Local consultant for 30 days @ Ksh. 40000 per day. DSA for 10 national level officers for 30days, fuel and coordination air time,8 drivers DSA, targeting 15 counties	30	40,000	1	1,200,000			1,200,000		1,200,000	2,400,000
Strengthen birth and death registration for newborns and children	Strengthen collaboration with civil registration department at community level to promote timely registration of children as soon as they are born and notification of deaths	Strengthen civil registrations by holding 8 regional meetings to discuss on enhancing the registration of all births and deaths that occur outside the health facilities.	8 regional meetings-3pax per county for 3 days 16 facilitators (DSA, Transport reimbursement, airtime)	Yr 1, 2, 3, 4, 5	Regional workshop of 25 pax for 3 days	Hold 8 regional meetings-3pax per county for 3 days(DSA,transport reimbursement,conference package) 16 facilitators (DSA, Transport reimbursement, airtime)	8	1,326,000	1	10,608,000	2,121,600	2,121,600	2,121,600	2,121,600	2,121,600	10,608,000

Support interventions to build capacity of national and county governments to conduct newborn and child health research.	Carry out situation analysis on newborns and child health to identify research gaps that will inform the research priority agenda	Local Consultancy for 45 days to conduct situation analysis to identify gaps in collaboration NCH in 15 counties	Engage a consultant -(Local) for 45 days at 40,000, DSA for 10 national supervisors for 30days & lunch allowance for 50 research assistants for 20days	Yr 2,5	Local consultancy for 45 days	Conduct situation analysis in 15 counties in each region to include DSA for 10 national supervisors for 30days & lunch allowance for 50 research assistants for 20days,field for fuel	45	40,000	1	1,800,000		1,800,000			1,800,000	3,600,000
	Support identification of research agenda, implementation research, evaluation and dissemination of emerging best practices and evidence.	Hold 2 workshops per year to develop research agenda	2 workshops to develop research agenda for born and child health (40 ppts-20 national and 20 counties) for 5 days	Yr 1, 2, 3, 4, 5	2 workshops per year to develop research agenda	Hold 2 workshops to develop research agenda for born and child health (40 pax-20 national and 20 counties) for 5 days in 15 counties	2	3,380,000	1	3,380,000	3,380,000	3,380,000	3,380,000	3,380,000	3,380,000	16,900,000
	Hold quarterly M&E and research Committee of Experts for NCH	Hold TWG meeting- 1 day per annum at the National level	TWG meeting- 1 day for 30paxs/quarter per annum/Tea and snacks.	Yr 1, 2, 3, 4, 5	Quarterly M&E research committee meeting	Hold TWG meetings- 1 day for 30ppts/ quarter per annum, Tea, and snacks.	30	3,500	4	420,000	84,000	84,000	84,000	84,000	84,000	420,000
	Establish a joint working framework and linkages between the national, counties, academic, and research institutions to harmonize research for Newborn and child health agenda	Hold annual a meeting of 50pax with counties, academic and research institutions	1 Annual meeting of 50pax for 5 days. Conference facilities, DSA & transport reimbursement	Yr 1, 2, 3, 4, 5	1 Annual meeting of 50pax for 5 days. Conference facilities, DSA & transport reimbursement	Hold Annual meeting of 50pax for 5 days(Conference facilities, DSA & transport reimbursement)	30	1,815,000	1	54,450,000	10,890,000	10,890,000	10,890,000	10,890,000	10,890,000	54,450,000

	Dissemination of research findings	Hold 8 regional workshops- for 50pax for 5 days.-3 facilitators from the national-40 ppts at the county(4pple per county (DSA 40PAX, Conference for 40pax, Transport reimburse-ment, Air fare and airport transfers for 16 national facilitators, airtime for coordination)	8 workshops 50pax=400. DSA for 400 county pax and 24 national facilitators and transport reim-bursement, con-ference 400pax, transport reim-bursements16 national officers, air fare and transfers for 16facilitators	Yr 1, 2, 3, 4, 5	Regional work-shops of 400 pax for 5 days	Hold 8 Regional workshops of 400 pax for 5 days(DSA,24 national facil-itators and transport re-imbursement, conference package, transport reimburse-ments16 national officers	1	16,756,000	1	16,756,000	16,756,000	16,756,000	16,756,000	16,756,000	16,756,000	83,780,000
	Utilize the research findings to generate poli-cy brief(s)	Hold 1 workshop per research to develop-ment policy briefs	1 workshops to develop policy briefs for new-born and child health (20 ppts-10 national, 5 stakeholders and 5 counties for 5 days	Yr 1, 2, 3, 4, 5	Workshop to develop policy brief-20 pax for 5 days	Hold work-shops to develop pol-icy briefs for newborn and child health (20 paxs-10 national, 5 stakehold-ers and 5 counties for 5 days	1	1,690,000	1		1,690,000	1,690,000	1,690,000	1,690,000	1,690,000	8,450,000

	Hold learning exchange / benchmarking visits and share best practices	Hold 8 regional workshops- for 50pax for 5 days.-3 facilitators from the national-40 ppts at the county(4pple per county (DSA 40PAX, Conference for 40pax, Transport reimburse-ment, Air fare and airport transfers for 16 national facilitators, airtime for coordination)	8 workshops 50pax=400. DSA for 400 county pax and 24 national facilitators and transport reim-bursement, con-ference 400pax, transport reim-bursements16 national officers, air fare and transfers for 16facilitators	Yr 1,2,3, 4,5	Regional work-shops of 400 pax for 5 days	8 workshops 50pax=400. DSA for 400 county pax and 24 national facilitators and transport reimburse-ment, confer-ence 400pax, transport reimburse-ments16 na-tional officers, air fare and transfers for 16facilitators	1	16,756,000	1	16,756,000	3,351,200	3,351,200	3,351,200	3,351,200	3,351,200	16,756,000
Strengthen support supervision in the in delivery of newborn and child health services	Conduct inte-grated quar-terly support supervision	Quarterly integrated supervisory visits to facilities in the 47 counties in collaboration with national level	Quarterly supervision-national level 4*10500*5*47, National driver(20), county team 2*8400*5*47 & field fuel	Yr 1,2,3, 4,5	Quarterly inte-grated support-ive supervision	Hold Quarterly supervisions with national level team (4*10500*5 *47, National driver(20), county team 2*8400*5*47 & field fuel	47	398,400	4	74,899,200	14,979,840	14,979,840	14,979,840	14,979,840	14,979,840	74,899,200
	Develop/re-view,validate and launch support supervision tools for NCH	Hold 4 Work-shops-5days to develop, review and validate integrated support supervision tools	5 days, 30 ppts,4 work-shops (confer-ence package, DSA, Transport reimbursement)	Yr 1,2	4 workshops to develop, review and validate integrated sup-port supervision tools		1	2,535,000	4	10,140,000	5,070,000	5,070,000				10,140,000
	Mobilize resources and advocate for availability of a budget for technical working group meet-ings	Hold M&E quarterly county TWG meeting, 30 pax conference package	Quarterly meet-ing for TWG for 30 pax. required, lunch and conference	Yr 1,2,3, 4,5	Quarterly M&E TWG meeting	Hold Quar-terly TWG meeting (4*10500*5 *47, National driver(20), county team 2*8400*5*47 & field fuel	30	398,400	4	47,808,000	9,561,600	9,561,600	9,561,600	9,561,600	9,561,600	47,808,000

	Establishment of NCH mentorship program at county/ sub-county level	Conduct situation analysis to identify the gaps that will inform on the areas requiring mentorship	Engage a consultant -(Local) for 45 days at 40,000, DSA for 10 national supervisors for 30days & lunch allowance for 50 research assistants for 20days	Yr 2,5	Local consultancy for 45 days	Conduct situation analysis in 15 counties in each region to include DSA for 10 national supervisors for 30days & lunch allowance for 50 research assistants for 20days,field for fuel	45	40,000	1	1,800,000		900,000			900,000	1,800,000
		Train national and county NCH mentors	Train 20 pax national and 3paxs per county mentors on NCH for 5 days (DSA, conference package, transport reimbursement)	Yr 1,2,3, 4,5	Training at the county level 47*3 pax and 20 pax at the national for 5 days	Training at the county level 47*3 pax and 20 pax at the national for 5 days(DSA,-conference package,transport reimbursement)	47	1,568,000	1	73,696,000	73,696,000	73,696,000	73,696,000	73,696,000	73,696,000	368,480,000
		Quarterly mentorship for county teams-7 people for 5 days per quarter per county;16 national facilitators for the 5 years(DSA, transport-2 drivers, 300km per county)	Quarterly mentorship,-7paxs/county/ quarter/year,-5days;5 days mentorship by 16 national facilitators /quarter/ years for all counties	Yr 1,2,3, 4,5	Quarterly mentorship for county teams-7 people for 5 days per quarter per county;16 national facilitators for the 5 years(DSA, transport-2 drivers, 300km per county)	Conduct Quarterly mentorship for county teams-7 people for 5 days per quarter per county;16 national facilitators for the 5 years(DSA, transport-2 drivers, 300km per county)	47	684,000	4	128,592,000	128,592,000	128,592,000	128,592,000	128,592,000	128,592,000	642,960,000

Monitoring and evaluation of IPC & M measures and practices in newborn and child health.	Advocate for the tracking and assessing the performance of IPC & M measures and practices including: Routine monitoring and regular evaluation of IPC program implementation at national and county levels; Updating tools for IPC audits and assessments, AND; Developing IPC M&E reporting frameworks that include indicators for IPC														
Promote research on emerging social determinants of newborn and child health and develop strategies to engage in strategic partnerships to address these determinants.	Coordinate research to identify social determinants to newborn and child health morbidity and mortality including socioeconomic conditions, education, housing and environmental conditions	Research activity on social determinants of newborn and child health													

Strategy 5.9 Infection Prevention Control and Management (IPC & M) measures and practices and other social determinants of health – Identify social determinants to child health including socioeconomic conditions, education, housing and environmental conditions and develop strategies to engage in strategic partnerships to address these determinants.																
Key actions	Detailed activities	Task Description	Quantities and unit costs	Year of implementation	Item Description	Assumptions	Quantity	Unit Cost	Frequency	Amount	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Promote access to evidence based interventions for effective infection prevention control and management (IPC & M) measures and practices in newborn and child health.	Establish a DNCH IPC TWG to enhance Infection Prevention Control and management (IPC & M) guidelines in newborn and child health at all levels															
	Participate in the development/ review of Infection Prevention Control and management (IPC & M) guidelines.															
	Advocate for the provision of hand hygiene facilities at all newborn and child health service delivery points as part of IPC & M standards compliance															
	Sensitize on the need for early identification and treatment of infections using existing newborn and childhealth protocols															

	Advocate for strengthening of clinical and nonclinical health facility based committees to include the newborn and child health agenda (IPC committees, quality of care committees etc.)														
	Capacity building of health care workers on IPC & M measures and practices at all newborn and child health service delivery points (to be included in other training)														
	Advocate on the need for maintenance of acceptable standards of IPC & M measures and practices at all newborn and child health service delivery points in all health facilities														

Strengthen IPC & M measures and practices as an element of quality of care and patient safety in newborn and child health service delivery	Advocate for safe injection practices through the implementation of injection safety policy, guidelines, and SOPs to guide the necessity of injections vs. other treatment options; Safe administration of injections and needle disposal; Safe blood collection practices; Use of safety engineered injection devices; Sterilization and disinfection practices for newborn and child care areas and equipment.															
	Advocate for prevention of HAIs, including: Catheter-associated urinary tract infection (CAUTI); Surgical site infection (SSI); Central line-associated bloodstream infection (CLABSI); Ventilator-associated pneumonia (VAP) etc.															

	Strengthen the interruption of infection transmission (breaking the chain of infection) through: Use of specific care bundles; Patient isolation and quarantine within health care settings; Aseptic techniques during medical procedures, AND; Implementation of IPC standard precautions during delivery of care in newborn and child health.															
	Advocate for blood safety practices through: Standard operating procedures (SOPs) to guide necessity of transfusions; Appropriate screening practices for blood and blood products for transfusion-transmissible infections, AND; Transfusion, clinical practice, and hemovigilance in newborn and child health.															

Strategy 5.10 Special needs and disabilities - Strengthen strategies for prevention and early identification of special needs and disabilities																
Key actions	Detailed activities	Task Description	Quantities and unit costs	Year of implementation	Item Description	Assumptions/ Comments from James	Quantity	Unit Cost	Frequency	Amount	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Early identification(,assessment,screening)and referral of children with developmental delays,-disabilities and special needs.	Training/ Sensitization of healthcare providers on identification and referral of children with disabilities and special needs at all levels of care (Including specialized therapists)	National workshop for 30 people for 5 days	Workshop of 30 pax . 6 nights DSA of 10500 and transport of 4000, conference-3500, 1 driver @4000x2	yr 1, 2, 3, 4 & 5	National workshop for 30 people for 5 days		1	2,535,000	1	2,535,000	2,535,000	2,535,000	2,535,000	2,535,000	2,535,000	12,675,000
		Regional meetings-3 ppts per county and 4 national facilitators	8 regional meetings with 3 participants per county for 3 days-3 national pax, (DSA-10500, conference package 2500, airtime 1000, transport -3 @ 14000 air travel, airport transfers 2000x2, road), County participants lunch allowance @2000, transport allowance @2000	yr 2, 3 & 4	8 regional meetings of 25 participants for 3 days		8	1,326,000	1	10,608,000		3,536,000	3,536,000	3,536,000		10,608,000
	Harmonising/ development of uniform tools and, a system of referral	5 days workshop for 30 pax to develop a situation analysis tool	5 day conference package for 30 pax, 6 Nights DSA 10500, Transport 2000x2, 1 Driver 4000x2	yr 1 & 2	National workshop for 30 people for 5 days		1	2,535,000	1	2,535,000	2,535,000	2,535,000				5,070,000

	Review existing guidelines for service providers and caregivers on early identification and referrals of children with developmental delays or disabilities.	30 days consultancy for situation analysis	Consultancy fees @30000 per day	yr 2	30 days consultancy situation analysis		30	40,000	1	1,200,000		1,200,000				1,200,000
	Development of community based rehabilitation policy	National workshop for 30 people for 5 days	Workshop of 30 pax . 6 nights DSA of 10500 for 20px and transport of 4000, conference-3500, 1 driver @4000x2	yr2	National workshop for 30 people for 5 days		1	2,535,000		2,535,000		2,535,000				2,535,000
		Regional meetings-3 ppts per county and 4 national facilitators	8 regional meetings with 3 participants per county for 3 days-3 national pax, (DSA-10500, conference package 2500, airtime 1000, transport -3 @ 14000 air travel, airport transfers 2000x2, road), County participants lunch allowance @2000, transport allowance @2000	yr2,	8 regional meetings of 25 participants for 3 days		8	1,326,000	1	10,608,000		10,608,000				10,608,000
	Develop guidelines on children with special needs and disabilities that incorporates waiver of medical fees.	5 days workshop for 30 pax for feedback and outcome analysis/way forward	5 day conference package for, 6 Nights DSA 10500	yr 2	5 days workshop for feedback and outcome analysis/way forward		1	2,535,000	1	2,535,000		2,535,000				2,535,000

	Advocate for creating awareness at all levels of community and the health service on prevention, identification, intervention ,referral and eliminate stigma in the community	3 National workshops for 30 people for 5 days per workshop to Harmonise and develop uniform tools and system of referral	5 day conference package for 30 pax, 6 Nights DSA 10500	yr 1, 2, 3, 4 & 5	3 National workshop of 30 participants for 5 days		1	2,535,000	3	7,605,000	7,605,000	7,605,000	7,605,000	7,605,000	7,605,000	38,025,000
	Review of the existing child policies and programs to identify any existing gaps	1 workshop of 30 ppts for 5 days	Workshop of 30 pax . 6 nights DSA of 10500 and transport of 4000, conference-3500	yr 1 & 2	1 workshop of 30 ppts for 5 days		1	2,535,000	1	2,535,000	2,535,000	2,535,000				5,070,000
	Advocate or create awareness for child health rights and seeking of health services appropriately	1 workshop of 30 ppts for 5 days	Workshop of 30 pax . 6 nights DSA of 10500 and transport of 4000, conference-3500	yr 1, 2, 3, 4 & 5	1 workshop of 30 ppts for 5 days		1	2,535,000	1	2,535,000	2,535,000	2,535,000	2,535,000	2,535,000	2,535,000	12,675,000
Promote mainstreaming of special needs and disabilities into all child policies and programs	Review of the existing child policies and programs to identify and fill any existing gaps	Consultancy for 30 days	Consultancy fee @40000	yr 1	Consultancy for 30 days		30	40,000	1	1,200,000	1,200,000					1,200,000
Total																
Strategy 5.11 Public private partnerships - Develop strategies and approaches to strengthen resource mobilization for newborn and child health services and programs through public private partnerships.																
Key actions	Detailed activities	Task Description	Quantities and unit costs	Year of implementation	Item Description	Assumptions/ Comments from James	Quantity	Unit Cost	Frequency	Amount	Year 1	Year 2	Year 3	Year 4	Year 5	Total

Establish functional multi-sectoral fora at national and county levels for enhanced provision of newborn and child health high impact interventions	Strengthen role in high level multi sectoral PPP stakeholders forum for newborn and child health	Hold bi annual stakeholder meetings	Conference package @ 4000 pax 30	yr 1, 2, 3, 4 & 5	Stakeholder meeting		30	600,000	5	3,000,000	600,000	600,000	600,000	600,000	600,000	3,000,000
	Advocate and promote reporting by private sector into the DHIS2	Regional meetings-5 pax per county and 4 national facilitators	8 regional meetings with 5 participants per county for 3 days-3 national pax, (DSA-10500, conference package 2500, airtime 1000, transport -3 @ 14000 air travel, airport transfers 2000x2, road), County participants lunch allowance @2000, transport allowance @2000	yr 1, 2, 3, 4 & 5	Regional meetings		1	2,535,000	5	12,675,000	2,535,000	2,535,000	2,535,000	2,535,000	2,535,000	12,675,000
Strengthen capacity of the private sector in implementing high impact newborn and child health interventions	Distribute guidelines and monitoring tools to private facilities	2 days meeting per year-30ppts-Conference package for 2 days Similar meeting in each county	Workshop of 30 pax . 3 nights DSA of 10500 and transport of 4000, conference-3500	yr 1 & 2	2-days' annual meeting at the national and county level-30 participants per meeting		1	1,275,000	2	2,550,000	1,275,000	1,275,000				2,550,000
	Advocate for provision of essential drugs and commodities/ supplies to private facilities as per MoH guidelines(timely forecasting and quantification)	Regional Sensitization meeting	Hold 8 regional workshops- for 50pax for 2 days.-3 facilitators from the national-40 ppts at the county(4pple per county (DSA 40PAX, Conference for 40pax, Transport reimbursement, Air fare and airport transfers for 16 national facilitators, airtime for coordination)	yr 1, 2, 3, 4 & 5	8 regional meetings of 50 pax for 2 days		1	2,535,000	5		2,535,000	2,535,000	2,535,000	2,535,000	2,535,000	12,675,000

	Establish and implement mechanisms for continued quality improvement focused on private facilities	Sensitization meetings	Hold 8 regional workshops- for 50pax for 2 days.-3 facilitators from the national-40 participants at the county(4pple per county (DSA 40PAX, Conference for 40pax, Transport reimbursement, Air fare and airport transfers for 16 national facilitators, airtime for coordination)	yr 1, 2, 3, 4 & 5	8 regional meetings of 50 pax for 2 days		1	2,535,000	5			2,535,000	2,535,000			5,070,000
Total											**6,345,000**	**8,880,000**	**7,605,000**	**5,070,000**	**5,070,000**	**32,970,000**
5:12 Newborn and Child health in Emergencies - Support effective preparedness response to Newborn and child health in humanitarian situations																
Key actions	Detailed activities	Task Description	Quantities and unit costs	Year of implementation	Item Description	Assumptions/ Comments from James	Quantity	Unit Cost	Frequency	Amount	Year 1	Year 2	Year 3	Year 4	Year 5	Total
PHASE 1 : Strengthen coordination, partnership, advocacy, quality & standards for effective newborn and child health emergency preparedness and response at the national and county levels	Advocate for stakeholders meeting to review/ include Newborn and Child Health interventions in emergencies through capacity building at all levels	Bi-annual two-day stakeholders meeting	Conference package @ 3500 per person DSA 10500 @ 30 pax Transport 2000 @ 30 2 days Airtime coordination @ 1000	Yr 1, 2, 3, 4 & 5	Conference package @ 3500 per person DSA 10500 @ 30 pax Transport 2000 @ 30 2 days Airtime coordination @ 1000/ twice a year	Hold Bi-annual two-day stakeholders meeting Conference package @ 3500 per person DSA 10500 @ 30 pax Transport 2000 @ 30 2 days Airtime coordination	30	541000	2	1082000	1082000	1082000	1082000	1082000	1082000	5410000

	Training of national officers on management and coordination of newborn and child health emergencies and disasters	Train national officers on coordination and management of newborn and child health emergencies and disasters on a		Yr1, Y3	Conference package @ (3500*1*7*2 DSA 14000* 2*7days Transport @ 2000*2*2)*2	Train DNCH focal persons on coordination and management of newborn and child health emergencies and disasters on a Conference package @ 3500*1 DSA 14000* 2*7days Transport @ 2000*2*2 and a refresher training at mid term of the strategic plan	2	253000	2	506000	506000		506000			1012000
	Establish an Emergency Rapid Response Committee (ERRC) at DNCH incorporating DNCH stakeholders (NB: The ERRC will also liaise with National Health ERRC and County NCH ERRM committees).	Appointing the disaster and emergency focal person by head of department to support optimal provision of Newborn and Child health services during the disaster/ emergencies, including the provision of essential medicines,- capacity in manging the leading causes of child hood illness.	1-day meeting at National level per quarter-30 participants	Yr 1		Hold national level meetings per quarter for 30 pax requiring a conference package,transport,DSA	30	200000	1	200000	200000					200000

	Advocate for the establishment of ERRC in the county level	Hold a 2 days regional advocacy meetings	8 five day regional workshop, each county having 3 pax= total of 141paxs *8400*5 nite DSA, transport 3000/=, conference package 2500*141 pax Facilitators-4 from national level (DSA-10500, transport reimbursement-3000)	yr 1, 2.	Hold 2 days advocacy meetings			2535000	2	5070000	235000	2535000				5070000
	Advocate for representation of newborn and child health officers in the health sector emergency committee.	Promote inclusion of appropriate Newborn and Child health services and related indicators in Emergency preparedness and response assessments	Transport 2000 @ 20	Yr1, Yr3, Yr5	Hold 3 consultative workshop meetings of 25 pax(DSA 10500/ Pax,transport 4000 reinbursement,conference package 3500/pax	Hold 3 consultative workshop meetings of 25 pax requiring DSA,transport reimbursement,-conference package	25	450000	3	1350000	1350000	1350000		1350000		4050000

		Advocate for inclusion of Newborn and Child Health emergency response kits at all levels.	Conference package @ (3500 per person DSA 10500 @ 30 pax Transport 2000 @ 30 2 days Airtime co-ordination @ 1000)*2	Yr1, Y2, Yr3, Y4, Yr5	2 days meeting	Hold Bi-annual two-day stakeholders meeting Conference package @ 3500 per person DSA 10500 @ 30 pax Transport 2000 @ 30 2 days Airtime coordination	30	1170000	2	2340000	2340000	2340000	2340000	2340000	2340000	11700000
		Participation in national and County Emergency preparedness and response assessment teams	Airtime coordination @ 1000	Yr1, Y2, Yr3, Y4, Yr5	Conference package @ (3500 pax DSA 10500 @ 30 pax Transport 2000 @ 30 2 days Airtime co-ordination @ 1000)*4*4	Hold quarterly three day workshops for RRT assessments with a Conference package @ (3500 pax DSA 10500 @ 30 pax Transport 2000 @ 30 2 days Airtime co-ordination @ 1000)*4*4	30	1384000	4	184000	1384000	1384000	1384000	1384000	1384000	5536000
	Advocate for inclusion of County Child Health focal persons into the County Emergency Rapid Response Committee (CERRC)	Coordinate Child Health National and County stakeholders fora based on priority areas and resources to ensure unified, comprehensive emergency preparedness and response to Newborn and Child Health needs	Hold Bi-annual 2 day meetings of 50paxs to update on the priority areas and resources to ensure unified, comprehensive emergency preparedness and response to Newborn and Child Health needs	Yr1, Y2, Yr3, Y4, Yr5	DSA for 50 national &county staff,transport reimbursement 2000*50 for 3days/biannual/ each year	Hold biannual meetings to update on priorities for comprehensive emergency preparedness considering DSA10500 *50 national &county staff,transport reimbursement 2000*50 *2, conference 3500*50 for 3days/ biannual/ each year	50	2300000	2	4600000	4600000	4600000	4600000	4600000	4600000	18400000

	Review Emergency Response Kit for Kenya on Child Health in Emergencies (With reference to existing MOH Policies and Guidelines)	Review Health Emergency Response Kit	Hold 3 workshops to review health emergency response kits for newborn and child health (25paxs, conference package, DSA,transport reimbursement)	Yr2, Yr3	Hold 3 workshops 5days meetings of 25 pax(DSA 10500/ Pax,transport 4000 reimbursement,conference package 3500/pax	Hold 3 workshops 5days meetings in Y2&3 of 25 paxs(DSA 10500/ Pax,transport 4000 reimbursement,conference package 3500/pax	25	799500	3	799500		2398500	1599000			2398500
		Sensitize KEMSA on the requirements for regional pre-positioning of medical countermeasures commodities,-supplies and equipment during public health emergencies and disasters	Hold annual meetings of 30paxs to update on the regional emerging prepositioning requirements depending on situation analysis(3day conference package,DSA,transport reimbursement)	Yr1, Y2, Yr3, Y4, Yr5	Hold annual meetings of 30paxs to update on the regional emerging prepositioning requirements depending on situation analysis (3500*30*3day conference package, DSA 10500* 30* 4, transport reimbursement 4000 *30 *2	Hold annual meetings of 30paxs to update on the regional emerging prepositioning requirements depending on situation analysis (3day conference package, DSA, transport reimbursement)	30	1920000	5	1920000	1920000	1920000	1920000	1920000	1920000	7680000
	Develop action plan on emergency preparedness and response to newborn and child health in humanitarian situations	Support counties to develop Context specific Annual Action Plans	Hold 5 day annual workshops with county representatives and draft newborn and child PHE & disaster AP	Y2,	Hold 5 day annual workshops with county representatives and draft newborn and child PHE & disaster AP (3500*60* 5day conference package, DSA 10500* 60* 5, transport reimbursement 4000 *60 *2)	Hold 5 day annual workshops with county representatives and draft newborn and child PHE & disaster AP catering for 60paxs conference package, DSA, transport reimbursement	60	2000000	4	8000000		8000000				8000000

	Strengthen surveillance of Newborn and Child Health indicators in emergency settings (With reference to existing MOH Policies and Guidelines)	Establish a surveillance system to capture Newborn and Child Health elements in emergencies (Via a Consultant)	Engage Local consultancy to design and establish newborn and child health surveillance system in emergency and disasters	Yr2	Engage consultant (fee 40000*30, hold workshops (3500*25* 5day conference package, DSA 10500*25*5, transport reimbursement 4000*25*2)*6, airtime 1000*6)	30 day consultancy at 40,000/day, six workshops 5 days/ workshop (25 pax conference,DSA, transport,airtime-coordination)	25	1956000	1	3186000	3186000					3186000
	Monitoring and Evaluation of the surveillance system on Newborn and Child Health in Emergencies	Conduct monitoring and evaluation on newborn and child health emergency and disaster surveillance system.	Conduct a 30 day annual emergency and disaster surveillance system	Yr1, Yr2, Yr3, Yr3, Yr4, Yr5	Conduct surveillance system evaluation (consultant fee 40000*30, DSA 14000*15*30, fuel 40000*8, airtime 8000) air ticket for 6 officers*30000, airport transfers 7000*6	Conduct emergency and disaster surveillance system evaluation (consultant fee 40000* 30, DSA 14000* 15 *30, fuel 40000*8, airtime 8000) air ticket for 6 officers* 30000, airport transfers 7000* 7	15	7870000	5	7870000	7870000	7870000	7870000	7870000	7870000	39350000

	Establishment and operationalization of the Monitoring, Evaluation, and Accountability and Learning System (MEAL) system for the newborn and child health in emergency and disasters	Carry out technical support supervision, monitoring and evaluation of the interventional package under the DNCH emergency and disasters in the selected counties	Conduct 7 day bi annual technical assistance on the interventional package under the DNCH emergency and disasters in the 8 regions in select counties by 15 officers	Yr1, Yr2, Yr3, Yr4, Y5	Conference package @ (3500 per person DSA 10500 @ 15 pax for 7days Transport 2000 @ 30 2 days Airtime co-ordination @ 1000)*2	Conduct 7 day bi annual technical assistance on the interventional package under the DNCH emergency and disasters in the 8 regions in select counties by 15 officers	15	1592000	2	3184000	3184000	3184000	3184000	3184000	3184000	15920000
			Conduct 30days M&E (Mid & end term) on the interventional package under the DNCH emergency and disasters in the 8 regions selected counties	Yr2, Yr5	Local consultant for 30 days @ Ksh. 40000 per day DSA for 10 national level officers for 30days, fuel and coordination air time	Engage a Local consultant for 30 days @ Ksh. 40000 per day. DSA for 10 national level officers for 30days, fuel and coordination air time,8 drivers DSA, targeting 15 counties	30			1	1	7,180,000		7,180,000		
	Foster/ Integrate multisectorial response to child emergencies with other sectors (e.g. WASH, Education, Protection and Community Engagement for Behaviour & Social Change etc.)	Hold planning and budgeting meetings for implementation of response	Hold planning and budgeting meetings for implementation of response	Yr1, Y2, Yr3, Y4, Yr5	Hold annual planning and budgeting meetings of 30paxs for implementation of response (3500*30* 3day conference package, DSA 10500*30*4, transport reimbursement 4000*30*2	Hold annual planning and budgeting meetings of 30paxs for implementation of response with conference package,DSA,transport reimbursement)	30	1920000	5	1920000	1920000	1920000	1920000	1920000	1920000	9600000

PHASE 2: Enhance newborn and child health emergency preparedness and response	Train ToTs on newborn and child health emergencies and disasters	Training of ToTs on newborn and child health emergencies and disasters	Hold 5 day training two sessions for 25 TOTs on newborn and child health emergencies and disasters	Y2,Y4	At national level, 2 training workshops each 5 days of 25 pax for TOTs(D-SA-10500 for 6 nights,Trans-port-200x2,-conference pax @3500,1 driver-4000x2)	Hold 5 day training two sessions for 25 TOTs on newborn and child health emergencies and disasters	25	2,085,500	2	2,085,500		2,085,500		2,085,500	-	4,181,000
	Support im-plementation of priority interventions on emergency and disasters by training of healthcare providers on high impact interventions	Conduct training for healthcare providers on high impact interventions	8 five day regional workshop, each county having 3 pax= total of 141paxs *8400*5 nite DSA, transport 3000/=, confer-ence package 2500*141 pax Facilitators-4 from national level (DSA-10500, trans-port reimburse-ment-3000)	Y1,Y4	8 regional workshops of 25 participants each	Hold 8 regional five day work-shops, each county having 3 pax= total of 141paxs *8400*5 nite DSA, trans-port 3000/=, conference package 2500*141 pax Facilita-tors-4 from national level (DSA-10500, transport reimburse-ment-3000)	6	2,001,000	1	12,006,000	12,006,000			12,006,000		24,012,000
	Collaborate with EOC to ensure that data on critical Neonatal and Child health interventions is up to date, strength-en and/or establish pre-emergen-cy tracking system	1 Workshop for DRRC TWG every year 1 training meeting every year 5 day train-ing once a year	Hold annual consultative meeting with EOC on neonatal and child health data tracking 30paxs (3day conference package,D-SA,transport reimbursement)	Yr 1, 2, 3, 4, 5	Hold annual consultative meeting with EOC on neo-natal and child health data tracking de-pending on sit-uation analysis (3500*30*3day conference package, DSA 10500*30*4, transport reimbursement 4000*30*2	Hold annual consultative meeting with EOC on neonatal and child health data tracking 30paxs (3day conference package,D-SA,transport reimburse-ment)	30	1920000	5	1920000	1920000	1920000	1920000	1920000	1920000	7680000

	Develop appropriate health education and promotion messages for all levels for implementing behavior change activities.	Development of communication and advocacy tool kit on neonatal and child emergency and disaster	Local consultancy for 30 days plus 5 day workshop (5 workshops) DSA,Transport conference package 25 pax	Yr2	30 day consultancy at 40,000/day, six workshops 5 days/workshop (25 pax conference,DSA, transport,air-time-coordination)	Local consultancy for 30 days plus 5 day workshop (5 workshops) DSA,Transport conference package 25 pax	25	1956000	6	3186000		3186000				3186000
			Printing of child and newborn emergency IEC Materials(10,000 assorted copies/ yr)	Yr2, 3, 4, 5	Design and development of IEC materials *200000,assorted posters 3000copies*200,brochures/ leaflets6000copies*15,small banners50copies*10000	Printing of 10,000 copies of IEC materials will be done	10,000	1,390,000	1	1,390,000						1,390,000
			Distribution and dissemination of IEC Materials	Yr 2, 3, 4, 5	DSA for 2 national & 1 driver/county,-fuel 40000/day *3 days	Distribution and dissemination of IEC	47	4,284,000	4	4,284,000		4,284,000	4,284,000	4,284,000	4,284,000	12,852,000
	Strengthen coordination mechanisms within the health sector at national and county levels to ensure strategic, coherent and effective implementation of NCH and nutrition responses to emergencies	Hold regional meetings with counties for Emergency Response team	8 Regional meetings- 20 national team pax for5 days, (DSA,transport(air with airport transfers,conference package)47 county staff DSA (8400/pax)air ticket for 6 officers*30000,airport transfers 7000*6	Yr1, 2, 3, 4, 5	8 Regional meetings- 20 national team pax for5 days, (DSA,transport(air with airport transfers,conference package)47 county staff DSA (8400/pax)air ticket for 6 officers*30000,airport transfers 7000*6	8Regional meetings will be held	8	4,560,000	1	4,560,000	4,560,000	4,560,000	4,560,000	4,560,000	4,560,000	22,800,000
	In collaboration with the emergency committee develop NCH response plan- life saving interventions	Hold one workshop to develop a child health emergency plan	Hold 1 workshops 5days meetings of 25 pax(DSA 10500/ Pax,transport 4000 reimbursement,conference package 3500/pax	Yr1, 2, 3, 4, 5	Hold 1 workshops 5days meetings of 25 pax(DSA 10500/ Pax,transport 4000 reimbursement,conference package 3500/pax	Hold 1 workshops 5days meetings of 25 pax(DSA 10500/ Pax,transport 4000 reimbursement,conference package 3500/pax	25	159900	1	159900	159900	159900	159900	159900	159900	799500

	Ensure the re-establishment of disrupted essential care services for NCH, including reassessment of the newborn and child health kits;	In collaboration with county disaster response team, support meetings with financial and technical support	8 regional training 3 national officers, 3 county participants, conference package and transport	Yr1, 3, 5	Quarterly Meetings of 20 pax for 5 days	Hold quarterly three day regional workshops for DNCH emergency kit reassessments with a Conference package @ (3500 pax DSA 10500 @ 30 pax Transport 2000 @ 30 2 days Airtime coordination @ 1000)*4*4	1	1384000	4	1384000	1384000	1384000	1384000	1384000	1384000	6,920,000
	Clinical and psychosocial services for victims of sexual violence and/or child abuse.	Develop training material for Psychological First Aid (PFA) and disseminate	Hold workshops 5days meetings of 25 pax(DSA 10500/ Pax,transport 4000 reimbursement,conference package 3500/pax	Yr 2	Hold 2 workshops 5days meetings of 25 pax(DSA 10500/ Pax,transport 4000 reimbursement,conference package 3500/pax	Hold 2 workshops 5days meetings of 25 pax(DSA 10500/ Pax,transport 4000 reimbursement,conference package 3500/pax	25	159900	2	319800		319800				319800
			Train psychosocial health care workers on how to provide psychosocial services to the children survivors	Y2	8 Regional training meetings- 20 national team pax for5 days, (DSA,transport(air with airport transfers,conference package)47 county staff DSA (8400/pax)air ticket for 6 officers*30000,airport transfers 7000*6	Eight regional training meetings will be held	8	4,560,000	1	4,560,000	4,560,000	4,560,000	4,560,000	4,560,000	4,560,000	18,240,000
	Ensure continues monitoring and evaluation of available supplies	Develop a checklist/ balance score card for monitoring the supply,adapt electronic version, and disseminate	Hold 3 workshops 5days meetings of 25 pax(DSA 10500/ Pax,transport 4000 reimbursement,conference package 3500/pax	Yr2	Hold 3 workshops 5days meetings of 25 pax(DSA 10500/ Pax,transport 4000 reimbursement,conference package 3500/pax	Hold 3 workshops 5days meetings of 25 pax(DSA 10500/ Pax,transport 4000 reimbursement,conference package 3500/pax	25	1599000	3	3198000		9,594,000				9,594,000

	Ensure continued health coordination and action links to recovery and long-term development	Hold annual stakeholder post recovery meetings to Mainstream Emergency Response in Health Coordination in the county	Conference package @ 3500 per person DSA 10500 @ 30 pax Transport 2000 @ 30 2 days Airtime coordination @ 1000	Yr 1, 2, 3, 4 & 5	Conference package @ 3500 per person DSA 10500 @ 30 pax Transport 2000 @ 30 2 days Airtime coordination @ 1000/ twice a year	Hold annual two-day stakeholders meeting Conference package @ 3500 per person DSA 10500 @ 30 pax Transport 2000 @ 30 2 days Airtime coordination	30	541000	1	541000	541000	541000	541000	541000	541000	2705000
	Conduct a gap analysis of local and national capacities in Newborn and Child health ensuring integration of capacity strengthening in early recovery and transition plans, with a focus on risk reduction.	Hold Planning gap analysis and redistribution scheduling meetings of Newborn and Child Health supplies to emergency affected regions	Conference package @ 3500 per person DSA 10500 @ 30 pax Transport 2000 @ 30 2 days Airtime coordination @ 1000	Yr 1, 2, 3, 4 & 5	Conference package @ 3500 per person DSA 10500 @ 30 pax Transport 2000 @ 30 2 days Airtime coordination @ 1000/ twice a year	Hold annual two-day stakeholders meeting Conference package @ 3500 per person DSA 10500 @ 30 pax Transport 2000 @ 30 2 days Airtime coordination	30	541000	10	1082000	1082000	1082000	1082000	1082000	1082000	4328000
PHASE 3: Facilitate newborn and child health recovery and rehabilitation services following emergencies	Hold review meetings on the use of the emergency response as a platform for sustainable scale-up of critical Newborn and Child health interventions at all levels.	5days review meeting (at county and sub county level)	8 Regional review post recovery meetings- 20 national team pax for5 days, (DSA,transport(air with airport transfers,conference package)47 county staff DSA (8400/pax)air ticket for 6 officers*30000,airport transfers 7000*6	Yr1, 2, 3, 4, 5	8 Regional review post recovery meetings- 20 national team pax for5 days, (DSA,transport(air with airport transfers,conference package)47 county staff DSA (8400/pax)air ticket for 6 officers*30000,airport transfers 7000*6	Eight regional training meetings will be held	8	4,560,000	1	4,560,000	4,560,000	4,560,000	4,560,000	4,560,000	4,560,000	22,800,000

	National sharing on newborn and child health in emergency and disaster situations	Hold annual 5day knowledge exchange forums on newborn and child health in emergency and disaster situations	Hold annual 5day knowledge exchange forums on newborn and child health in emergency and disaster situations for 70 pax(DSA14000,transport reimbursement 4000*55(air with airport transfers,conference package))air ticket for 15officers*30000,airport transfers 7000*15	Yr2, 3, 4, 5	Hold annual 5day knowledge exchange forums on newborn and child health in emergency and disaster situations for 50 pax (DSA14000, transport reimbursement 4000*50 (air with airport transfers, conference package 50*4500 air ticket for 15officers *30000, airport transfers 7000*15)	Hold annual 5day knowledge exchange forums on newborn and child health in emergency and disaster situations with facilitation	70	4,480,000	1	4,480,000	4,480,000	4,480,000	4,480,000	4,480,000	4,480,000	22,400,000
Total											**23,246,900**	**42,716,200**	**27,530,900**	**41,622,400**	**27,530,900**	**59,721,400**

Strategy 5.13 - Advocacy, communication and social mobilisation (ACSM) - Support development and implementation of newborn and child advocacy and communication strategic framework at national and county levels.																
Key actions	Detailed activities	Task Description	Quantities and unit costs	Year of implementation	Item Description	Assumptions/ Comments from James	Quantity	Unit Cost	Frequency	Amount	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Develop advocacy strategies for buy in and support for implementation of neonatal and child health high impact Interventions at national and county level	Develop and disseminate NCH Advocacy communication and SBCC	Hold 3 workshops for the development of the strategy	3 workshops of 30 pax at a DSA of 10500 and transport of 4000, conference-4000	yr 1	3 workshops		1	2,000,000	3	6,000,000		6,000,000				6,000,000
		County consultative meeting for the NCH ACSM Strategy	8 Regional county meetings with 6 counties per meeting, 5 pax per county	yr 3	Consultative meeting		8	2,000,000	1	16,000,000			16,000,000			16,000,000
		Conduct NCH ACSM Strategy validation meeting	1 half day meeting for validation	yr 4	Validation meeting		1	800,000	1	800,000				800,000		800,000
		Conduct county regional dissemination meetings	8 regional meetings to disseminate NCH communication SBCC and advocacy strategy	yr 4	Dissemination meeting		8	2,000,000	1	16,000,000				16,000,000		16,000,000
		Workshop, regional meetings, design, print and dissemination	3 workshops of 25 pax at a DSA of 10500 and transport of 4000, conference-3500		Consultative meeting		1	2,000,000	3	6,000,000						6,000,000
	Develop advocacy toolkits for Newborn health	Hold 4 workshops to develop design, pretest launch and disseminate newborn advocacy toolkit	4 workshops, 30 pax, 4000 conference package, DSA 10500 and transport 4000	yr 2	Workshop and launch		1	2,535,000	4	10,140,000		10,140,000				10,140,000
	Develop advocacy toolkit for Children 2months up-to 10 years	Hold 4 workshops to develop design, pretest launch and disseminate children 2-9 years advocacy toolkit	4 workshops, 30 pax, 4000 conference package, DSA 10500 and transport 4000	yr 2	4 workshops		1	2,535,000	4	10,140,000		10,140,000				10,140,000

	Develop advocacy toolkit for nurturing care	Hold 4 workshops to develop design, pretest launch and disseminate nurturing care advocacy toolkit	4 workshops, 30 pax, 4000 conference package, DSA 10500 and transport 4000	yr 2	4 workshops		1	2,535,000	4	10,140,000		6,000,000				
	Develop advocacy toolkit for iCCM	Hold 4 workshops to develop design, pretest launch and disseminate iCCM advocacy toolkit	4 workshops, 30 pax, 4000 conference package, DSA 10500 and transport 4000		4 workshops		1	2,535,000	4	10,140,000						
	Develop an advocacy plan for all NCH program interventions	Hold advocacy meetings with stakeholders (Parliamentary health committee, media,inter religious leaders, media, partners and counties)	3 workshops, 30 pax, 4000 conference package, DSA 10500 and transport 4000	yr 2	3 workshops		1	2,535,000	3	7605000		7605000				7605000
	Advocate for support for commemoration of world child health days	commemorate world pneumonia and prematurity days at national an county level	Participants and event organization	yr 1, 2, 3, 4, 5	Commemoration meetings		2	4,000,000	2	16,000,000	800,000	800,000	800,000	800,000	19,200,000	

Develop Communication strategies to support creating awareness on NCH high impact interventions	Develop IEC materials with key messages on newborn high impact intervention	3 workshops, 30 pax, 4000 conference package, DSA 10500 and transport 4000	3 workshops, 30 pax, 4000 conference package, DSA 10500 and transport 4000	yr 2	3 workshops		1	2535000	3	7605000		5070000	2535000			7605000
	Develop IEC materials with key messages on children 2 up to 10 year old high impact intervention	2 workshops, 30 pax, 4000 conference package, DSA 10500 and transport 4000	2 workshops, 30 pax, 4000 conference package, DSA 10500 and transport 4000	yr2	2 workshops		1	2535000	2	5070000	5070000					5070000
	Develop IEC materials with key messages on nurturing care high impact intervention	4 workshops, 30 pax, 4000 conference package, DSA 10500 and transport 4000	4 workshops, 30 pax, 4000 conference package, DSA 10500 and transport 4000	yr2	4 workshops		1	2535000	4	10140000		6000000				
	Develop IEC materials with key messages on iCCM high impact intervention	5 workshops, 30 pax, 4000 conference package, DSA 10500 and transport 4000	5 workshops, 30 pax, 4000 conference package, DSA 10500 and transport 4000		5 workshops		1	2535000	5	12675000						
	Develop a communication plan to disseminate IEC Materials with key messages through media engagement(print, electronic and social media)	Hold TV and radio talk shows, air radio and TV spots, air documentaries	TV and radio talk shows aird quarterly at 4000000	yr 1, 2, 3, 4, 5	TV and radio talks		5	4000000	1	20000000	4000000	4000000	4000000	4000000	4000000	280000000
	Disseminate IEC materials with key messages on NCH high impact interventions through interpersonal communication	Holding meetings with inter religious leaders, communities and community child health champions	8 regional meetings to disseminate materials with key messages	yr 4	Dissemination meeting		1	2000000	8	16000000				16000000		16000000

Research for NCH ACSM Activities	Conduct caregiver KAP survey on newborn and Child health high impact interventions	Development of research protocol, data collection tool, training the research assistants,data collection, data analysis and dissemination of KAP study Finding		yr2, 3, 5	Consultancy for 60 days, 40000 per day 3 workshops of 30 pax, DSA 10500. conference package @ 40000		4935000	3	3	14805000		4935000	4935000		4935000	
Coordination and Partnerships for ACSM	Hold one quarterly ACSM TWG meetings for coordination of stakeholders	1 meeting every quarter conference package for 30 participants	1 meeting every quarter conference package for 30 participants	yr1, 2, 3, 4, 5	Quarterly ACSM TWG-30 pax at national and county levels			800000	5	4000000	800000	800000	800000	800000	7200000	
Develop Social Mobilization strategies for Community engagement for NCH high impact interventions	Nominate newborn and child health community champions	sensitize on NCH interventions	1 workshop for the champion sensitization	yr2	Sensitization meeting			2350000	1			2350000				2350000
Total											**9,870,000**	**23,155,000**	**12,270,000**	**20,800,000**	**16,135,000**	#REF!

ANNEX 6: LIST OF CONTRIBUTORS

Contributors - MOH	
Dr. Isaak Bashir	Head, Department of Family Health
Dr. Laura Oyiengo	Head, DNCH
Dr. Caroline Mwangi	Deputy Head and Program Manager, DNCH
Dr. Silas Agutu	Program Manager, DNCH
Dr. Deborah Okumu	Program Manager, DNCH
Dr. Richard Muthoka	Program Manager, DNCH
Andolo Miheso	MOH - DNCH
Martin Matingi	MOH - DNCH
Allan Govoga	MOH - DNCH
Elsa Odira	MOH - DNCH
Benard Wambu	MOH - DNCH
Lydia Karimurio	MOH - DNCH
Jedida Obure	MOH - DNCH
Charles Matanda	MOH - DNCH
Grace Wasike	MOH - DNCH
Josephine Ayaga	MOH - DNCH
Alex Mutua	MOH - DNCH
Evans Munuve	MOH - DNCH
Dennis Mutua	MOH - DNCH
Hellen Mutsi	MOH - DRMHS
Dr. Betty Samburu	MOH - DND
Esther T. Papa	MOH - NASCOP
Stella Mbugua	T.A DNCH
Bridget Wesonga	MOH - DNCH
Dorcas Mutisya	MOH - DNCH
Enock Kipkosgei	DNCH
Akoth Daisy Beryl	DNCH
Nelius Nderitu	DNCH
Richard Kimenye	MOH - DNCH
Jackson Cheruiyot	MOH - NAKURU

Technical Assistance	
Prof. Larry Gelmon	Lead Consultant
Mr. James Odhiambo Oguta	Consultant - Costing
Stephen Macharia	MOH Planning
David Njuguna	Economist - MOH Planning
Jael Wachia	Graphics Designer
Charity Murugu	MOH -DFH

Partners	
Dr. Martin Chabi	WHO
Dr. Ben Odera	WHO
Dr. Shiroya Makeba	WHO
Dr. Peter Okoth	UNICEF
Judith Raburu	UNICEF
Fidelis Wanjiru	PATH
Wanjiku Manguyu,	PATH
Pauline Irungu,	PATH
Josphine Kinyanjui,	PATH
Oscar Kadenge,	PATH
Christine Mugambi,	PATH
Melissa Wanda	PATH
Janet Shauri	PATH
Dr. Linda Misiko	SAVE THE CHILDREN
Teresa Akun	SAVE THE CHILDREN
Dr. Paul Odila	USAID MCGL
Silah Kimanzi	USAID
Peter Kaimenyi	USAID
Dr. Wangui Muthigani	USAID
Zipporah Moraa	LIVING GOODS
Rosemary Kihoto	CHAI
Betty Wariari	CHAI
Dr. Supa Tunje	Kenya Pediatric Association

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