



SMART ADVOCACY PLAN FOR MNCAH+N+FP EXAMPLES

**By OMMI partnership led by Women Engaged in
Development**

SMART Advocacy is an evidence-based, prioritized, results-oriented approach that seeks to influence decision-making, mobilize resources, having an enabling normative environment and accountability for improved health outcomes

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FOREWORD



In Makueni County, we recognize that health is a fundamental human right and a cornerstone of sustainable development. Guided by our County Integrated Development Plan, Universal Health Coverage framework, and community-led health policies, we remain committed to ensuring that every mother, newborn, child, and adolescent has access to quality, affordable, and responsive health services.

The situational analysis conducted in Makueni on Maternal, Newborn, Child, and Adolescent Health plus Nutrition and Family Planning (MNCAH+N+FP) has revealed both progress and persistent gaps. These must be addressed urgently if we are to accelerate survival, enable our people to thrive, and achieve true transformation. To this end, we are embracing Smart Advocacy as a strategic tool to mobilize resources, safeguard health investments through ring-fencing, and strengthen accountability to our citizens' needs.

This Smart Advocacy toolkit provides a practical roadmap. It encompasses strategic objectives anchored on the Every Woman Every Newborn Everywhere (EWENE) framework, prioritization using the Nominal Group Technique; the investment case and return on investment with related examples; an implementation and risk mitigation matrix, MEAL tools, gender transformation in the delivery of EWENE, tailored training workshops, and segmented knowledge products. It further outlines specifications for knowledge products, a visual content production matrix, community engagement approaches, partnership mapping, and a sample SMART advocacy budget.

With regular training cycles, multisector engagement, and improved data-driven messaging, this framework will enable us to mobilize dedicated resources, enhance accountability, and deliver transformative outcomes in MNCAH+N+FP. We envision healthier families, stronger communities, and a more prosperous Makueni County where no one is left behind.

H.E. Mutula Kilonzo Jnr, CBS
Governor, Makueni County

PREFACE



The health and well-being of Makueni’s people remain central to our vision of sustainable development. Building on the Governor’s call, this document underscores the importance of a stronger health ecosystem—one that delivers quality care and addresses the broader social determinants of health. Our success depends on engaging multiple line ministries, tackling harmful sociocultural practices, and overcoming the three delays that hinder timely access to maternal, newborn, child, and adolescent health plus nutrition and family planning (MNCAH+N+FP) services. Adequate financial and human resources are critical to this agenda, as are multi-sectoral collaborations that ensure the county fully reaps the benefits of its youthful population.

Smart Advocacy, grounded in local data, provides the context for priority-setting, examining both primary health care and universal health coverage. It highlights inequities, gender disparities, and the urgent need for home-grown solutions and innovations. By amplifying voice and agency, Smart Advocacy compels a call to action, demanding accountability from duty bearers and responsiveness from service providers.

Our collective responsibility is to be responsive to every patient and client, for therein lies the surest roadmap to health, wealth generation, and development. This document offers a pathway towards transformative outcomes for Makueni County.

Ms. Joyce Mutua

CECM Health, Makueni County

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ABSTRACT

SMART Advocacy is an evidence-based, results-oriented approach that seeks to influence decision-making and mobilize resources for improved health outcomes. In Makueni County, Kenya, the application of Smart Advocacy within the domains of Maternal, Newborn, Child, and Adolescent Health plus Nutrition and Family Planning (MNCAH+N+FP) has proven instrumental in advancing policy priorities and fostering sustainable interventions. The approach emphasizes strategic stakeholder engagement, including county leadership, health managers, civil society, community gatekeepers, and youth representatives, to build consensus on critical health issues.

Through situational analysis and data-driven messaging, SMART Advocacy initiatives in Makueni have targeted gaps in the health ecosystem, service delivery, financing, and accountability. Advocacy coalitions have successfully positioned MNCAH+N+FP as a county priority by aligning with existing legislation and policy frameworks, such as the County Integrated Development Plan, Primary Health Coverage, and the Universal Health Coverage agenda. Notable achievements include increased county budget allocations for reproductive, maternal, and child health services; integration of nutrition and family planning into community health strategies; and strengthening of adolescent health programs, gender empowerment, and entrepreneurship. Furthermore, multi-sectoral partnerships have expanded access to essential commodities, enhanced health worker capacity, and promoted community awareness and demand for services.

Despite resource limitations, SMART Advocacy has demonstrated that strategic, coordinated actions can yield measurable improvements in health system responsiveness. The Makueni experience underscores the value of tailoring advocacy to local contexts, leveraging champions, and maintaining continuous engagement with decision-makers. This model offers practical lessons for other countries and low-resource settings striving to improve MNCAH+N+FP outcomes through evidence-informed advocacy.

1. SMART ADVOCACY PLAN FOR MNCAH+N+FP IN MAKUENI COUNTY

Key factors that drive SMART advocacy include initiating, communicating, educating, advocating, and collaborating. It is related to EWENE as follows:

Initiate: Potential issues can arise from the media, government agencies, current events, or from members directly. **Research the problem** before you initiate a conversation among association leaders or members. Determine if the situation warrants more discussion. If there is an actual threat to the public, the profession, the industry, or the association, bring it forward in a debate. In EWENE, we are addressing the high mortality rate of mothers, stillbirths, neonates, children, and adolescents using their performance indicators. Research into the underlying factors can be obtained through associated factors or qualitative research.

Communicate: Use communication vehicles that ensure reach. Present the issue and propose several options on how/if to move forward. In EWENE, relating current performance indicators to the set targets, milestones, and SDGs.

Educate: Education is two-fold: internally, for members on the issue, and externally, for legislators to learn about the industry or profession. Both are necessary to engage stakeholders appropriately on an issue. Create standard speaking points based on data. Creating awareness among the duty bearers, the health care providers, other stakeholders, and the public so that they are called to action.

Advocate: Use a combination of strategies. It is critical to get the issue and data cascaded to policy makers and duty bearers responsible for the normative environment. Desk reviews, evidence-based practices, participatory action research, and innovations can give rise to solution pathways that can be exerted to reduce mortality, e.g., E-MOTIVE in the care bundle, reducing PPH by 60%

Collaborate: Health is influenced by public, private, and philanthropic relationships; the level of service delivery; coverage with public or private insurance schemes; access and coverage; the health system; and the quality of care to help patients thrive. However, health alone cannot yield optimal outcomes without a systems approach that addresses social and commercial

determinants, communicable and non-communicable diseases, and other line ministries such as education, gender, youth, social services, finance, culture, agriculture, climate change, road networks, and entrepreneurship with SMEs. This provides a holistic approach to patients through collaborative partnerships that transform and enhance health, wealth creation, and development.

Advocacy can cascade from the grassroots to duty bearers and vice versa. It becomes SMART advocacy when data-driven in real time for decision-making, context understanding, identifying evidence gaps and priorities, and informing policy. The call to action should be focused on defining strategic Objectives (SMART).



Strategic SMART Advocacy Objectives

1. Reduce teenage pregnancy by 20% in Makueni County by 2027 through advocacy for school re-entry policies, youth-friendly services, and comprehensive sexuality education.
2. Increase contraceptive uptake by 25% by 2027 by advocating stronger supply chains, demand-generation, and reducing sociocultural barriers.
3. Increase male engagement in advocacy for men in maternity care MNCAH+N+FP programs by 30% by 2027.

4. Improve nutrition outcomes (stunting, anemia, wasting) by 15% by 2027 through integration of nutrition-sensitive agriculture, social protection, and school feeding programs.
5. Advocate for the integration of climate resilience and MNCAH+N+FP in county development policies by 2026.
6. Reduce perinatal mortality by 20% by 2027 by advocating for quality maternal and newborn services, emergency transport, and digital referral systems.
7. Promote multi-sector partnerships (health, education, agriculture, social protection, youth, women's groups, private sector) for holistic service delivery and financing.

2. PRIORITIZATION TECHNIQUES

Several techniques can be used to prioritize and support policy development and decision-making through ordered ranking. They are briefly elaborated below:

1. Stack ranking and top ranking

2. Impact versus effort matrix

3. The Eisenhower matrix addresses urgency and importance:

- i. List of tasks
- ii. Sort them
- iii. Act: do it, schedule, delegate, dump.

4. RICE method (reach, impact, confidence, effort)

Best for many projects, but there is uncertainty about which to start with. It takes the following steps:

- i. Calculate the rice score = $(R \times I \times C) / E$
- ii. The score, then rank, and prioritize.
- iii. Take action.

5. The MoSCoW method

Sorts into must-have, should-have, could-have, and not-have.

6. Kano Model

Popular in the realms of product management, marketing, and customer experience design.

The model categorizes customer preferences into five groups based on need: basic, performance, excitement, indifference, and reverse.

- i. **Identify the Features or Tasks:** List all the possible features, improvements, or tasks that are under consideration.

- ii. **Survey and Analyze:** Use customer surveys or team brainstorming to classify each feature or task into one of the Kano categories.
- iii. **Prioritize based on the need.**
- iv. **Implement and Review:** Implement the features based on the set priorities and continuously review customer feedback or performance metrics to update your understanding.

7. Weighted scoring

- i. **Identify Criteria:** First, list the product strategy criteria critically for evaluating tasks or projects. These could include factors such as cost, impact, time-to-market, and technical feasibility.
- ii. **Assign Weights:** Give each criterion a weight based on its importance. Make sure all the weights add up to 100%. For instance, if cost is super important, you might give it a weight of 40%, and if time-to-market is less so, it may get a 20% weight.
- iii. **List Tasks or Projects:** Create a list of tasks or projects you're considering.
- iv. **Score Each Task:** For each task or project, give it a score between 1 and 10 for how well it meets each criterion. Often, a simple spreadsheet scorecard is useful for weighted scoring.
- v. **Calculate Weighted Scores**
- vi. **Rank and prioritize.**
- vii. **Review and adjust.**

8. Nominal Group Technique (NGT)

- A structured, participatory approach where stakeholders generate ideas, discuss them, and then individually rank or vote.
- Reduces the dominance of powerful voices, ensuring inclusivity, and is well-suited to community-driven policy prioritization.
- In health, it allows diverse actors such as health workers, policymakers, and citizens to collectively decide on urgent needs, such as strengthening referral systems or improving maternal health coverage.

9. Delphi Technique

- A structured, iterative process using rounds of anonymous questionnaires with experts and stakeholders.
- Help build consensus on priority issues without group pressure, ensuring diverse expert input.
- Useful in sensitive contexts where confrontation may limit honest contributions.

1. Multi-Criteria Decision Analysis (MCDA)

- Weighs multiple factors such as urgency, equity, feasibility, cost-effectiveness, and impact on health outcomes.
- Provides a scoring system to rank priorities objectively, blending both qualitative and quantitative inputs.

2. Pareto Analysis (80/20 Rule)

- Identifies the “vital few” interventions or issues that will contribute to the majority of health gains.
- Particularly useful in resource-constrained settings, helping to focus advocacy on high-impact interventions.

3. SWOT Analysis (Strengths, Weaknesses, Opportunities, Threats)

- Maps of internal and external factors influencing MNCAH+N+FP priorities.
- Help stakeholders balance opportunities with risks while aligning with county and national strategies.

4. Force Field Analysis

- Examines **driving vs restraining forces** affecting potential advocacy areas.
- Help stakeholders visualize feasibility and anticipate resistance in policy or sociocultural contexts.

5. Health Equity Impact Assessment

- Prioritizes interventions by assessing their **impact on marginalized groups** (adolescents, rural women, low-income households).
- Ensures advocacy objectives address inequities and gender disparities.

6. Participatory Budgeting

- Communities directly participate in ranking priorities based on resource allocation preferences.
- Strengthens community ownership and accountability.

Prioritization in SMART Advocacy for MNCAH+N+FP in Makueni County follows a structured, participatory methodology to ensure evidence-driven, inclusive, and context-specific decision-making. The process began with a situational analysis, drawing on routine health data, national surveys, and community consultations to identify gaps in maternal, newborn, child, adolescent health, nutrition, and family planning outcomes. To move from broad needs to actionable priorities, the Nominal Group Technique (NGT) was applied. This facilitated structured dialogue among diverse stakeholders—including county health officials, frontline health workers, civil society, youth, and community representatives—who independently ranked critical issues before engaging in consensus building. This transparent approach minimizes bias, elevates marginalized voices, and ensures alignment with both community demand and global frameworks, such as Every Woman, Every Newborn, Everywhere (EWENE) targets.

Once consensus was achieved, the prioritized issues were mapped against feasibility, resource availability, and potential impact using a scoring matrix. This step ensured that selected advocacy objectives were not only urgent but also achievable within existing policy frameworks, health financing structures, and Universal Health Coverage (UHC) commitments. The final priorities informed the SMART Advocacy objectives, providing a clear roadmap for targeted resource mobilization, accountability mechanisms, and multi-sectoral engagement towards sustainable health gains.

2.1 Nominal Group Technique (NGT) for EWENE Prioritization in Makueni County

A. Purpose

To systematically identify, rank, and prioritize the most urgent MNCAH+N+FP challenges and interventions in Makueni, ensuring voices from policy, health system, community, and youth are represented.

B. Steps in the NGT Process

1. Preparation & Group Selection

- Assemble 12–20 diverse participants: county health leadership, CHVs, adolescents, teachers, women’s groups, male champions, CSOs, agricultural reps, and faith leaders.
- Define the focus question (e.g., What should be the top priorities to accelerate progress on MNCAH+N+FP in Makueni County by 2030?).

2. Silent Idea Generation

- Each participant writes down their own ideas (5–10 minutes).
- Example ideas: improving FP uptake, reducing teenage pregnancies, addressing malnutrition, strengthening referral systems, tackling harmful practices.

3. Round-Robin Sharing

- Facilitator asks participants one at a time to share one idea, recorded on a flipchart/projector without discussion.
- Continue until all ideas are listed.

4. Clarification & Grouping

- Discuss briefly to clarify meaning (no debating).
- Similar ideas are grouped into themes (e.g., Health System Strengthening, Adolescent Health, Nutrition, Social Determinants).

5. Preliminary Voting/Ranking

- Each participant votes or ranks their top 5 ideas (e.g., 5 points = highest, 1 point = lowest).

- Votes are tallied for each theme.

6. Discussion & Final Ranking

- Review results and allow discussion on the top-ranked priorities.
- A final round of voting may be done to confirm the consensus priorities.

C. Expected Output

A ranked list of 5–7 EWENE priorities for Makueni County, e.g.:

1. Reduce teenage pregnancies & school dropout.
2. Expand FP access and reduce unmet need.
3. Strengthen maternal and newborn referral systems.
4. Improve nutrition (link agriculture–health–climate).
5. Engage men and community leaders against harmful practices.
6. Integrate digital health and data for decision-making.

D. Advantages of NGT in the Makueni Context

- Inclusive → balances voices (youth, women, policymakers, CHVs).
- Efficient → structured, avoids dominance by elites.
- Consensus-driven → transparent and democratic decision-making.
- Action-oriented → produces clear, ranked priorities aligned to EWENE targets.

3. INVESTMENT CASE PRORITY SELECTION

The investment advocacy tool shows decision-makers why specific investments matter, their impact, and their alignment with both local realities and global targets.

3.1 What Informs the Investment Case of Priority Selection?

A combination of evidence, feasibility, and equity considerations guides the investment case in health policy prioritization. First, epidemiological, and demographic data form the backbone—burden of disease, mortality and morbidity trends, fertility rates, and nutrition indicators help identify where interventions will yield the most significant health impact. For example, high maternal mortality or stunting prevalence directs investment towards emergency obstetric care or nutrition programs.

Second, economic analysis is critical. Cost-effectiveness studies, return-on-investment modeling, and fiscal space analysis highlight interventions that deliver maximum value per shilling spent. Governments and partners prefer priorities that both save lives and strengthen long-term economic productivity—such as family planning, which reduces healthcare costs and harnesses the demographic dividend.

Third, equity and human rights considerations shape investment choices. Programs that address marginalized groups—adolescents, rural populations, or low-income households—are prioritized to close health gaps and uphold the right to health.

Fourth, policy alignment and political feasibility are key. Priorities must align with national frameworks (e.g., Kenya’s UHC roadmap, PHC strategy, and FP2030 commitments) and county development plans, ensuring government ownership and sustainability.

Fifth, community voice and demand play a vital role. Responsiveness to citizen expectations builds legitimacy and increases service uptake.

Finally, systems strengthening potential—such as improving workforce capacity, supply chains, and digital health—ensures that selected priorities not only deliver immediate results but also transform health ecosystems sustainably.

3.2 Investment Case Mapping for Priority Selection in Makueni County (MNCAH+N+FP)

Criteria	Example Priority in Makueni	Justification
Epidemiological & Demographic Burden	Scale-up Emergency Obstetric and Newborn Care (EmONC) at sub-county hospitals	Makueni records maternal mortality higher than national targets, with delays in access to life-saving care; strengthening EmONC directly reduces preventable maternal and newborn deaths.
Economic Value & Cost-Effectiveness	Expanding Family Planning services, including postpartum FP	Family planning is one of the most cost-effective interventions—every KES 1 invested saves up to KES 4 in health and development costs; aligns with Kenya’s FP2030 commitments and reduces long-term service burden.
Equity & Human Rights	Strengthening adolescent SRHR and nutrition programs in rural wards	Adolescents and rural populations face higher unmet need, malnutrition, and early pregnancy; focusing here closes gaps, upholds the right to health, and advances gender equity.
Policy Alignment & Feasibility	Integrate MNCAH+N into the County Integrated Development Plan (CIDP) and the UHC roll-out.	Ensures county government ownership, alignment with PHC, the Kenya UHC roadmap, and EWENE targets; leverages existing governance and planning structures to assess feasibility.
Community Voice & Demand	Establish structured community dialogues on harmful	Responds to citizen-expressed concerns during situational analysis; builds social accountability,

	sociocultural practices (FGM, early marriage, home deliveries)	improves service uptake, and fosters trust in the health system.
System Strengthening Potential	Invest in digital health for real-time MNCAH+N data collection and referral linkages.	Improves decision-making and accountability, reduces the “three delays,” and strengthens workforce responsiveness and supply chain systems beyond the MNCAH+N scope.

3.3 Investment Case Mapping for Priority Selection in Makueni County (MNCAH+N+FP including Child Health)

Criteria	Example Priority in Makueni	Justification
Epidemiological & Demographic Burden	Expand access to integrated child survival services (immunization, IMCI, pneumonia/diarrhea treatment) at community and primary facilities.	Child mortality remains above the SDG target in Makueni; pneumonia, diarrhea, and malaria still contribute significantly to under-five deaths; scaling up immunization and case management addresses preventable child deaths.
Economic Value & Cost-Effectiveness	Increase investment in nutrition-sensitive interventions (school feeding, Vitamin A, fortified foods)	Malnutrition contributes to ~45% of under-five deaths; stunting undermines education and economic potential; every \$1 invested in nutrition yields up to \$16 in economic returns.
Equity & Human Rights	Address geographic and socioeconomic barriers by scaling up mobile outreach clinics for immunization and child health services in	Rural and poor households have lower access to essential health services; prioritizing outreach reduces inequities and ensures every child has the right to survive and thrive.

	remote wards (e.g., Kilungu, Mukaa)	
Policy Alignment & Feasibility	Integrate child health indicators and interventions into County Integrated Development Plan (CIDP), EWENE dashboards, and PHC/UHC frameworks	Strengthens accountability; aligns child health targets with Kenya’s UHC and global Every Woman Every Child (EWEC) agenda; ensures resources are allocated to child health in annual work plans.
Community Voice & Demand	Establish community health volunteer (CHV) engagement and dialogue platforms to promote immunization, breastfeeding, and early care-seeking	Parents and caregivers’ express concerns over service quality and costs; engaging them improves demand, trust, and uptake of lifesaving child interventions.
System Strengthening Potential	Introduce digital health and supply chain tracking for vaccines, essential medicines, and nutrition commodities	Prevents stock-outs, improves accountability, strengthens referral linkages, and allows real-time monitoring of child health services for evidence-based advocacy.

3.4 Investment Case for Addressing Stillbirths in Makueni County (MNCAH+N+FP)

Criteria	Example Priority / Intervention	Justification (Makueni Context)
Epidemiological Burden	Strengthen antenatal care (ANC) and intrapartum monitoring (e.g., fetal	High rates of stillbirths are linked to poor-quality ANC and gaps in intrapartum

	heart monitoring, partograph use)	surveillance; reducing stillbirths prevents avoidable maternal-newborn deaths.
Economic & Social Justification	Equip maternity units with fetal dopplers and train providers in perinatal monitoring.	Preventing stillbirth reduces psychosocial and economic trauma to families, preserves productivity, and strengthens trust in health services—critical for local development.
Feasibility & Policy Alignment	Integrate stillbirth prevention into UHC/PHC platforms; scale up skilled birth attendance.	Low-cost, high-impact interventions are feasible within existing infrastructure and align with the RMNCAH+N Investment Framework, FP2030, EPMM, and Every Newborn Action Plan.
Equity & Gender Sensitivity	Engage CHVs for early ANC registration and maternal-perinatal audits; address harmful sociocultural practices.	Ensures access for rural, poor, and marginalized women; reduces gendered inequities in access to maternal care. Men as active participants and allies in maternal health care
SMART Advocacy & Accountability	Use local data to drive county resource allocation for emergency obstetric care, referral systems, and human resources.	Data-driven advocacy builds political will, strengthens accountability, and compels allocation of financial and human resources for maternal-newborn survival.
Innovation & Home-grown Solutions	Digitized ANC registers, CHV-led pregnancy tracking, maternal-perinatal death audits	Enhances real-time data, supports early risk detection, and fosters community participation in reducing stillbirths.

3.5 Investment Case for Community Health Promoters in Makueni County

Criteria	Example CHP Role	Justification for Investment
Epidemiological Burden	Early identification of danger signs in pregnancy, newborns, and children; prompt referral	Reduces maternal and neonatal mortality, prevents stillbirths, and addresses preventable childhood illnesses.
Economic & Social Value	Promote family planning, immunization, and nutrition counseling; reduce delays in care.	Prevents costly complications, reduces out-of-pocket expenditures, and improves household productivity and resilience.
Feasibility & Policy Alignment	Link households to PHC, track pregnancies, support UHC enrollment	Aligns with Kenya’s Community Health Strategy (2021–2025), FP2030, and EWENE dashboards; feasible under devolution.
Equity & Gender Sensitivity	Reach remote households, adolescents, and marginalized women	Reduces health inequities, combats harmful sociocultural practices, and ensures gender-responsive services.
SMART Advocacy & Accountability	Mobilize communities for dialogue, track service gaps, and demand accountability.	Strengthens patient voice and agency, compels duty bearers to act, and enhances transparency in MNCAH+N+FP delivery.
Innovation & Home-grown Solutions	Use of digitized registers, mobile follow-up, and nutrition surveillance	Builds on Makueni’s community health insurance, leveraging digital health for sustainability and efficiency.

The ROI demonstrates that strategic investments in MNCAH+N+FP are not just lifesaving but also wealth-generating. By leveraging local data and aligning with PHC, UHC, and EWENE dashboards, Makueni can advocate for sustained funding, stronger partnerships, and accountability.

Investing in an integrated MNCAH+N+FP package could deliver a 12–15-fold return, strengthen UHC and PHC, and accelerate the achievement of EWENE and FP2030 targets. This ROI is especially critical in Makueni, given its youthful population, ongoing investments in community health promoters, and county leadership’s push for sustainable financing.

3.6 Investment Case and Return on Investment (ROI) in Makueni County (MNCAH+N+FP)

Priority Area	Investment Focus	Expected ROI
Child Health	Scale-up of immunization, nutrition, IMNCI (Integrated Management of Newborn & Childhood Illness)	Every \$1 invested in child health yields up to \$10 in economic returns through improved survival, productivity, and reduced treatment costs. Strengthens human capital for Makueni’s youthful population.
Stillbirth Reduction	Strengthening ANC, skilled birth attendance, emergency obstetric & newborn care, respectful maternity care	Preventing stillbirths reduces hospital costs of complications and psychological/social burden. WHO estimates a \$3 return for every \$1 invested through healthier mothers, reduced neonatal deaths, and improved workforce participation.
Community Health Promoters	Training, equipping, and digitizing CHPs for household-level	For every \$1 invested in CHPs , returns of \$9–10 is achieved through reduced maternal and child mortality, improved FP uptake, and reduced long-

	health promotion, referrals, and UHC enrollment	term costs of untreated conditions. Strengthens UHC and PHC foundations.
Family Planning	Scaling up contraceptive access, postpartum FP, adolescent-friendly services	Globally, every \$1 in FP yields \$4 in savings on health, education, and social costs. In Kenya, FP also reduces unintended pregnancies, maternal deaths, and pressure on limited county health budgets.
Nutrition (SUN targets)	Addressing stunting, anemia, exclusive breastfeeding, and school feeding integration	For every \$1 in nutrition , there is a \$16 return through better school performance, higher adult earnings, and reduced disease burden (World Bank/SUN Movement evidence).
MNCAH+N+FP		<ul style="list-style-type: none"> • Delivery in an integrated package, the ROI is higher than each standalone program, estimated at \$1 → \$12–15 return (Lancet Global Health Commission on Investing in Health, 2020). • Integration also reduces system inefficiencies by up to 30% cost savings compared to parallel programming (WHO, UNICEF, UNFPA).

3.7 Advocacy Implementation Plan based on prioritized priorities.

Objective	Advocacy Actions	Key Stakeholders	Timeline
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Reduce teenage pregnancies	Push for county by-laws on CSE, strengthen school re-entry, and community dialogues on harmful practices	MoE, MoH, youth groups, faith leaders, County Assembly	2025–2027
Increase contraceptive uptake	Advocate for budget allocation to FP commodities, strengthen last-mile delivery, and engage men & boys.	MoH, NGOs, CHVs, County Treasury	2025–2027
Improve nutrition	Advocate for integration of nutrition-sensitive agriculture (climate-smart), school meals, and mother support groups	MoA, MoH, WFP, farmers, CSOs	2025–2027
Climate change & health	Push for inclusion of climate-health nexus in CIDP & County Climate Action Plans.	County Climate Unit, MoH, NGOs, research institutions	2025–2026
Reduce perinatal mortality	Advocate for skilled birth attendance, functional ambulances, digital referrals, and EmONC scale-up	MoH, ICT sector, private facilities, NGOs	2025–2027
Strengthen partnerships	Multi-sector advocacy platform (health, education, agriculture, social services, youth councils)	Governor’s office, partners, civil society, private sector	2025–2027

3.8 Risk Mitigation Matrix

Risk	Mitigation Strategy
Cultural resistance to FP & CSE	Engage religious/traditional leaders, use culturally sensitive messaging.

Stock-outs of FP & nutrition supplies	Advocate for county ring-fenced health budgets, strengthen supply chain accountability.
Climate shocks (drought, floods) are disrupting services	Advocate for emergency preparedness financing and resilient service delivery, agroecology policy
Political shifts post-election	Build cross-party advocacy alliances, institutionalize MNCAH+N+FP policies.
Weak data systems	Advocate for DHIS2 strengthening and integrate real-time dashboards.

3.9 MEAL Framework

Domain	MEAL Tools & Indicators
Monitoring	Routine tracking of county FP uptake, teenage pregnancy rates, nutrition outcomes, perinatal mortality; DHIS2 data dashboards
Evaluation	Annual advocacy scorecards, policy adoption & budget allocation reviews
Accountability	Citizen scorecards, youth/women forums, public budget hearings
Learning	County learning workshops, cross-county exchange forums, and documentation of success stories

3.10 Example of MEAL (Monitoring, Evaluation, Accountability & Learning) Tools for Makueni County

MEAL Dimension	Specific Tools	Purpose	Application in Makueni
Monitoring	DHIS2 dashboards, RMNCAH scorecards,	Track service delivery, teenage pregnancy,	Real-time data at the county/sub-county level

	facility-based maternal & perinatal audits	perinatal loss, and FP uptake	
Evaluation	Mid-term & end-information impact surveys, Lot Quality Assurance Sampling (LQAS), Nutrition SMART surveys	Assess the effectiveness of interventions	Evidence on malnutrition, contraceptive unmet need, and school dropout
Accountability	Community scorecards, citizen feedback forums, digital reporting apps (Ushahidi, SMS hotlines)	Ensure citizen voices influence health planning	Engage women, adolescents, youth, and marginalized households
Learning	Policy briefs, data-to-action workshops, quarterly stakeholder reflection meetings	Share insights & adapt programs	Build political and community will for EWENE targets

4. GENDER IN EWENE: ADVANCING GENDER EQUITY ACROSS THE MATERNAL AND NEWBORN CONTINUUM OF CARE

4.1 Background and Rationale

Gender disparities remain a significant barrier to achieving equitable maternal and newborn health outcomes globally. Women, especially in low-resource and marginalized settings, face complex socio-anthropological, cultural, economic, and systemic challenges that compromise their health before, during, and after pregnancy. These disparities manifest in limited autonomy, restricted decision-making power, harmful cultural practices, poor access to essential services, and inadequate policy support.

To accelerate equitable women's health outcomes, advocacy must adopt a continuum-of-care lens, addressing disparities from preconception through pregnancy, childbirth, and the postpartum period, while integrating both clinical interventions and socio-cultural determinants.

4.2 Preconception Phase

Gender disparities:

- Women often lack the autonomy to decide on the timing of marriage, sexual debut, and childbearing.
- Cultural practices such as child marriage, teenage pregnancies, female genital mutilation/cutting (FGM/C), and gender-based violence (GBV) compromise reproductive and psychosocial health.
- Limited access to family planning (FP), especially for unmarried women or adolescents.
- Poor health literacy and inadequate nutrition before conception.

Advocacy priorities:

- Promote policies and community dialogue to eliminate early marriage, FGM/C, and GBV.

- Ensure universal access to modern contraceptives, adolescent-friendly reproductive health services, and education on pregnancy spacing and planned pregnancies.
- Address social determinants—education, economic empowerment, and legal protections for women.
- Integrate preconception counseling within PHC/UHC frameworks, including nutrition, anemia control, and screening for communicable and non-communicable diseases (NCDs).

4.2 Antenatal / Prenatal Period

Gender disparities:

- Limited decision-making power restricts women’s ability to seek timely antenatal care (ANC).
- Unequal access and coverage of quality ANC, especially in rural areas.
- Discrimination in service delivery (provider bias, lack of respectful care).
- Poor risk stratification and inequities in access to advanced prenatal diagnostics.

Advocacy priorities:

- Strengthen universal ANC coverage—at least 8 WHO-recommended contacts.
- Integrate precision risk profiling for early detection of high-risk pregnancies.
- Promote maternal immunization programs (tetanus, influenza, pertussis, etc.).
- Advocate for ANC services to include nutrition, WASH interventions, HIV/NCD management, mental health screening, and individualized birth preparedness plans.
- Address the three delays: (1) delay in decision-making, (2) delay in reaching care, (3) delay in receiving quality care.
- Advance health literacy for shared decision-making and strengthen male involvement in maternal health without undermining women’s autonomy.

4.3 Intrapartum Period (Labor and Delivery)

Gender disparities:

- Limited access to skilled birth attendance and emergency obstetric services.
- Weak blood and blood product delivery systems lead to preventable maternal deaths.
- Socio-cultural restrictions are delaying timely facility-based delivery.
- Disrespect and abuse in maternity care settings.

Advocacy priorities:

- Ensure adequate coverage of intrapartum services through PHC/UHC.
- Strengthen emergency obstetric and newborn care (EmONC) systems, including functional referral pathways.
- Advocate for safe blood banking and distribution systems.
- Promote respectful maternity care (RMC) standards to reduce mistreatment.
- Push for infrastructure, human resources, and financing to guarantee 24/7 skilled attendance.

4.4 Postpartum / Postnatal Period

Gender disparities:

- Early resumption of sexual activity due to socio-cultural pressures.
- Selective or restrictive nutritional practices for new mothers.
- Postpartum isolation in some communities, limiting social and healthcare support.
- Lack of maternity leave and workplace protections.
- Inadequate follow-up care for mother and newborn, particularly in the first 6 weeks.

Advocacy priorities:

- Ensure continuity of care through structured postnatal follow-up visits for both mother and newborn.
- Integrate family planning counseling and immediate postpartum FP options.
- Promote exclusive breastfeeding through community support programs and enforcement of maternity protection legislation.
- Address harmful socio-anthropological practices through community-based gender-transformative interventions.
- Advocate for maternity leave policies, workplace flexibility, and gender-sensitive labor laws.
- Strengthen postnatal care packages: maternal mental health, NCD management, newborn immunization, growth monitoring, oral rehydration for child illnesses, and ongoing management of chronic or acquired conditions.

4.5 Cross-Cutting Dimensions

- Gender-transformative community engagement: Empower women while shifting harmful gender norms and involving men and community leaders.
- Policy and financing advocacy: Ensure maternal health services are fully integrated into UHC benefit packages.
- Digital health innovations: Improve health literacy, decision-making, and service access through mobile platforms.
- Monitoring and accountability: Disaggregated data (by gender, geography, socioeconomic status) to track inequities across the continuum.

4.6 Conclusion

Addressing gender disparities in maternal and newborn health requires a holistic continuum-of-care approach—from preconception through postpartum. Advocacy must not only ensure access to essential and emergency health services but also dismantle socio-anthropological barriers, discriminatory practices, and systemic inequities that prevent women from achieving

optimal health outcomes. By integrating gender equity into maternal health policies, programs, and community norms, we can accelerate progress toward safe, dignified, and equitable care for all women and their newborns.

This can be put into a SMART Advocacy Framework.

A. SMART Advocacy Framework

i. Background

Gender disparities remain a critical barrier to achieving maternal and newborn health targets under the EWENE agenda. From preconception to the postpartum period, women face limitations in decision-making, harmful cultural practices, unequal access to services, and systemic inequities in health financing and policy.

Accelerating progress requires a gender-transformative continuum-of-care approach that addresses socio-anthropological barriers, strengthens health systems, and ensures universal access to quality, respect, and equitable services.

ii. Objectives

1. **Policy and Financing:** Advocate for integration of comprehensive maternal and newborn services into Universal Health Coverage (UHC) benefit packages, with gender equity at the core.
2. **Prevention and Empowerment:** Promote policies and programs that eliminate harmful practices (early marriage, FGM/C, GBV) and enhance women's autonomy in family planning and reproductive choices.
3. **Quality of Care:** Strengthen antenatal, intrapartum, and postnatal services with gender-responsive, respectful, and patient-centered approaches.
4. **Continuity of Care:** Ensure structured, integrated follow-up for mothers and newborns, addressing both health and socio-economic needs.
5. **Accountability and Equity:** Improve gender-disaggregated data collection and community participation in decision-making to track and reduce inequities.

iii. Key Messages

- **Preconception:**
Planned pregnancies, safe family planning, and elimination of harmful practices (early marriages, FGM/C, GBV) are foundational to healthy motherhood and child survival.
- **Antenatal:**
Universal coverage with precision risk profiling, nutrition, immunization, and WASH integration reduces preventable maternal and newborn complications.
- **Intrapartum:**
Access to skilled birth attendance, blood and emergency obstetric care, and respectful maternity care saves lives and upholds dignity.
- **Postpartum:**
Immediate postpartum family planning, breastfeeding support, maternity leave protections, and structured postnatal care are critical to maternal recovery and newborn survival.
- **Cross-cutting:**
Gender-transformative interventions, stronger community engagement, and digital innovations improve literacy, decision-making, and accountability for women's health.

iv. Advocacy Entry Points & Stakeholder Engagement Strategies

A. Policymakers & Government

Entry points are through National UHC reforms, maternal health policies, PHC strengthening agendas.

Strategies:

- Advocate for inclusion of maternal and newborn services as essential and emergency care within UHC packages.
- Push for legislation against child marriage, FGM/C, and GBV.
- Promote enforcement of maternity leave and workplace protections.

- Integrate maternal mental health, NCD management, and immunization in maternal health policies.

B. Donors & Development Partners

Entry points are through Global health financing windows (GFF, Gavi, Global Fund), the climate-health nexus, and gender equality agendas.

Strategies:

- Position investment in maternal and newborn health as a high-ROI investment (e.g., reduced maternal deaths, healthier children, demographic dividends).
- Advocate for financing models that prioritize marginalized women and underserved geographies.
- Highlight linkages with climate resilience, adolescent health, and gender equality frameworks (SDG 3, 5, 10).

C. Community Leaders & Civil Society

Entry points are through Faith-based organizations, cultural elders, women's groups, and youth networks.

Strategies:

- Use community dialogues and education to address harmful practices and strengthen social accountability.
- Promote male engagement without undermining women's autonomy in reproductive decision-making.
- Build the capacity of local CSOs for advocacy and service delivery monitoring.

D. Health Professionals & Institutions

Entry points are through professional associations (ObGyn, midwives, nurses), training institutions, and hospital boards.

Strategies:

- Advocate for respectful maternity care standards and elimination of mistreatment in facilities.
- Push for blood system strengthening and referral pathways.
- Promote training on precision antenatal risk assessment, maternal immunization, and gender-sensitive service delivery.

v. Accountability Mechanisms

- Establish gender-disaggregated indicators in maternal and newborn health monitoring systems.
- Institutionalize community scorecards and public health dialogues to strengthen accountability.
- Leverage digital health tools for real-time monitoring, health literacy, and emergency preparedness.

vi. Call to Action

To accelerate EWENE, stakeholders must:

- Invest in gender-responsive maternal and newborn health interventions across the continuum of care.
- Transform harmful gender norms through community and policy action.
- Guarantee every woman's right to respectful, equitable, and quality care—before, during, and after pregnancy.

5. ENGAGING MEN AS PARTNERS IN MATERNAL AND NEWBORN HEALTH ACROSS THE CONTINUUM OF CARE

5.1 Background and Rationale

While maternal and newborn health interventions primarily target women, men hold major influence over health-seeking behaviors, resource allocation, and decision-making within households and communities. Gender disparities in health are perpetuated when men are excluded from maternity care, reinforcing stereotypes that caregiving is solely a woman's role.

Evidence shows that when men are engaged as supportive partners—not gatekeepers—maternal health outcomes improve, skilled birth attendance increases, contraceptive uptake rises, postpartum depression declines, and newborn survival is enhanced. Yet, in many contexts, men are inadequately informed, excluded from care, or adhere to harmful masculinities that limit women's autonomy and compromise family health.

i. Preconception Phase

Disparities:

- Men often make unilateral decisions about marriage, timing of pregnancies, and contraceptive use.
- Low male participation in family planning counseling.
- Cultural norms perpetuate early marriage, early sexual debut, and gender-based violence.

Engagement priorities:

- Promote male-inclusive family planning counseling and awareness on the benefits of pregnancy spacing.
- Encourage men to share responsibility for contraceptive decision-making and use.
- Integrate male-focused health literacy programs addressing GBV, FGM/C, and early marriage.

- Position men as advocates for girls' education and women's empowerment.

ii. Antenatal / Prenatal Period

Disparities:

- Men may prevent women from attending ANC due to costs, cultural beliefs, or low awareness.
- Lack of male involvement in maternal nutrition, immunization, and birth preparedness.
- Low understanding of complications and risk factors during pregnancy.

Engagement priorities:

- Promote male partner attendance in ANC visits (with emphasis on HIV testing, nutrition, maternal immunization, and precision risk assessment).
- Encourage men to support household budgeting for maternal care, nutrition, and transport for emergencies.
- Build community programs where men are trained as birth companions and champions of respectful maternity care.
- Engage men in developing joint birth preparedness and complication readiness plans.

iii. Intrapartum (Labor and Delivery)

Disparities:

- Men are often absent during childbirth due to restrictive norms or facility policies.
- Lack of male awareness of emergency obstetric care delays timely decision-making.
- Blood shortages often worsen because men are not mobilized as blood donors.

Engagement priorities:

- Promote policies that allow male presence during labor and delivery where culturally and clinically appropriate.
- Involve men in recognition of danger signs and decision-making during obstetric emergencies.
- Mobilize men as blood donors and community advocates for strengthening blood and blood product delivery systems.
- Encourage men to advocate for respectful maternity care and accountability in facilities.

iv. Postpartum / Postnatal Period

Disparities:

- Men often disengage after childbirth, perceiving newborn and maternal care as “women’s work.”
- Low support for breastfeeding and postpartum contraception.
- Early resumption of sexual activity may be imposed, compromising maternal recovery.
- Limited male participation in infant immunization, nutrition, and growth monitoring.

Engagement priorities:

- Promote joint postpartum family planning counseling and informed choice.
- Encourage men to support exclusive breastfeeding practices by helping with childcare, household tasks, and advocacy at the community level.
- Engage men in maternity leave advocacy, promoting shared parental leave and workplace protections.
- Address harmful cultural practices (forced early sex, postpartum isolation) through male-targeted community dialogues.

- Involve men in newborn care—immunization visits, oral rehydration practices, chronic illness management, and growth monitoring.

5.2 Cross-Cutting Dimensions

- **Redefining masculinities:** Promote positive masculinity frameworks that position men as supportive, nurturing partners rather than gatekeepers.
- **Community transformation:** Train male champions, religious leaders, and cultural elders to drive gender-equitable norms.
- **Health system reforms:** Equip providers with training on how to involve men without compromising women’s autonomy.
- **Policy engagement:** Advocate for inclusion of male engagement in national maternal and newborn health strategies, guidelines, and UHC benefits.
- **Accountability:** Use gender-disaggregated data to track male participation in ANC, FP, and newborn care.

5.3 Conclusion

Engaging men in maternal and newborn health is not optional—it is central to dismantling gender disparities and accelerating EWENE. Men’s participation from preconception to postpartum strengthens women’s autonomy, improves health outcomes, and nurtures stronger, healthier families. Advocacy must reframe men not as decision-makers over women, but as partners in care, allies in dismantling harmful norms, and champions of respectful, equitable maternity care.

A. The SMART Advocacy Framework for Men's Engagement In EWENE

Advocacy Brief: Engaging Men as Partners in Maternal and Newborn Health

(Advancing Gender Equity Across the Continuum of Care)

A1. Background

Men play a decisive role in maternal and newborn health outcomes. Their influence over household decision-making, financial resources, and cultural practices can either accelerate or

hinder progress in achieving EWENE targets. Yet men are often excluded from maternity services and underinformed about their roles in supporting women and newborns.

Excluding men reinforces harmful gender norms, perpetuates delays in seeking care, and undermines women’s autonomy. Conversely, engaging men as supportive partners—not gatekeepers—enhances maternal and newborn survival, improves care-seeking, increases family planning uptake, and fosters respectful family dynamics.

A2. Objectives

1. **Empowerment and Equity:** Reframe men’s role in maternity care from authority figures to supportive partners who share responsibility for maternal and newborn health.
2. **Service Integration:** Advocate for male-inclusive policies and health services across the continuum of care.
3. **Behavioral and Norm Change:** Challenge harmful masculinities and cultural practices that negatively affect women’s health and autonomy.
4. **System Strengthening:** Build provider and community capacity to engage men while safeguarding women’s rights and decision-making.
5. **Accountability:** Track male involvement through disaggregated data to ensure meaningful participation that supports—not undermines—gender equity.

A3. Key Messages

- **Preconception:**
Men’s active involvement in family planning, prevention of early marriage, and ending GBV is foundational to healthier families and stronger communities.
- **Antenatal:**
When men accompany women to ANC, support nutrition, and immunization, and co-develop birth plans, pregnancy outcomes significantly improve.

- **Intrapartum:**
Men’s support during childbirth—including advocating for skilled attendance, donating blood, and recognizing emergencies—saves lives.
- **Postpartum:**
Fathers’ involvement in postpartum family planning, newborn care, breastfeeding support, and shared childcare responsibilities strengthens recovery and child survival.
- **Cross-cutting:**
Redefining masculinities and engaging men as partners in care foster respectful maternity care, accelerate EWENE goals, and benefit entire communities.

A4. Advocacy Entry Points & Stakeholder Engagement Strategies

i. Policymakers & Government

Entries are through national maternal health strategies, UHC reforms, and gender policy frameworks.

Strategies:

- Include male engagement components in national maternal and newborn health guidelines.
- Promote shared parental leave policies to normalize men’s caregiving roles.
- Enforce laws against early marriage, FGM/C, and GBV with male leadership in community enforcement.
- Integrate male-focused health education in PHC/UHC platforms.

ii. Donors & Development Partners

Entry points are through global gender equality, SRHR, and health financing agendas.

Strategies:

- Position male engagement as a high-impact, cost-effective intervention to improve maternal and newborn outcomes.

- Fund programs that test innovative male-inclusive approaches (digital literacy campaigns, peer champions, workplace interventions).
- Align male engagement funding with SDG 3 (health), SDG 5 (gender equality), and SDG 10 (reduced inequalities).

iii. **Community Leaders & Civil Society**

Entry points are through religious and cultural institutions, youth movements, men’s networks.

Strategies:

- Use male champions (elders, faith leaders, male peers) to model equitable behaviors.
- Facilitate community dialogues targeting harmful practices (early sex resumption, postpartum isolation, restrictive feeding practices).
- Develop education and storytelling approaches to redefine masculinity and caregiving.

iv. **Health Professionals & Institutions**

Entry points are through hospital boards, midwifery programs, and medical curricula.

Strategies:

- Train providers on how to engage men constructively while prioritizing women’s autonomy.
- Institutionalize male-friendly policies (allowing presence during labor, joint ANC visits, and couple counseling).
- Mobilize men as blood donors, health volunteers, and advocates for respectful maternity care.

A5. Accountability Mechanisms

- Develop indicators for male participation in ANC, FP, delivery, and postnatal care.
- Institutionalize community scorecards that assess both male and female involvement in care.

- Leverage digital platforms (SMS, apps, WhatsApp groups) to track men’s participation and deliver tailored health literacy content.

A6. Call to Action

To achieve EWENE, men must be redefined as allies, caregivers, and partners in the maternal-newborn health journey. Policymakers, donors, communities, and health systems must:

- Invest in male engagement strategies across the continuum of care.
- Transform cultural norms that reinforce harmful masculinities.
- Guarantee that men’s participation enhances—not undermines—women’s autonomy and dignity in maternity care.

I. Gender-Transformative MEAL Framework Inclusive of Social Determinants of Health (SDH)

Domain	Outcomes	Core Indicators	Data Source	Frequency	Responsible Actor
Preconception & Empowerment	Women and men equally engaged in planning healthy pregnancies and preventing harmful practices.	1. % of woman (15–49) with demand for FP satisfied with modern methods 2. % of men reporting joint decision-making on fertility/contraceptive use 3. % of adolescents with comprehensive SRHR knowledge 4. % of communities with bylaws against early marriage, FGM/C, GBV 5. % of girls completing lower secondary education 6. Household	DHS, MoE statistics, community surveys, HMIS, KAP surveys	DHS (every 3–5 yrs), annual community/facility	MoH, MoE, Social Services, CSOs, Community leaders

		poverty rate (female-headed vs male-headed)			
Antenatal / Prenatal Care	Women receive equitable, comprehens ive, and respectful care with supportive male participation	1. % of pregnant woman with ≥8 ANC contacts 2. % of ANC visits with male partner present (voluntary) 3. % of couples with birth preparedness plans 4. % of men able to identify ≥3 maternal danger signs 5. % of women reporting respectful, autonomous ANC 6. % of women covered by health insurance/social protection schemes	ANC registers, HMIS, household surveys, insurance coverage databases	Quarterly (facility HMIS), annually (insurance/social protection)	MoH, County Health Teams, Insurance Agencies, and Facility managers

<p>Intrapartum (Labor & Delivery)</p>	<p>Women have access to skilled, timely, and respectful childbirth services with male support.</p>	<p>1. % of births attended by skilled personnel 2. % of men participating in birth preparedness (funds, transport, blood donation) 3. % of women reporting freedom from mistreatment/abuse during childbirth 4. % reduction in the three delays 5. % of facilities with reliable electricity/water supply 6. % of women reporting transport affordability to facilities</p>	<p>Facility registers, infrastructure assessment, transport cost surveys</p>	<p>Monthly (facility), annual reviews</p>	<p>MoH, Ministry of Transport, Energy, Facility managers, CSOs</p>
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Postpartum / Postnatal Care	Women and newborns receive comprehensive follow-up care with equitable male involvement	1. % of woman with ≥ 2 PNC visits within 6 weeks 2. % of newborns with PNC checkups within 48 hrs 3. % of couples counseled on postpartum FP and uptake 4. % of fathers supporting exclusive breastfeeding 5% % of men are taking paternity leave 6. % of households reporting shared caregiving 7% % of women with access to adequate nutrition during lactation 8. % of	PNC registers, household surveys, nutrition surveys, IPV prevalence surveys	Quarterly (facility), biannual (nutrition/GBV surveys)	MoH, Employers' Associations, CHWs, Ministry of Gender, Nutrition Councils
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		postpartum women experiencing IPV			
Cross-cutting: Gender Norms, Systems & Accountability	Harmful gender norms are shifted, and systems are accountable for equity in care.	<p>1. % of facilities implementing respectful maternity care standards</p> <p>2. % of facilities with male-inclusive policies</p> <p>3. Existence of national policies on maternity & paternity leave</p> <p>4. % of community dialogues engaging men & women on MNH</p> <p>5. % of data systems with sex- & age-disaggregated indicators</p> <p>6. # of scorecard sessions held annually</p> <p>7. % of</p>	Facility assessment, labor force surveys, policy reviews, community reports	Annual national/community reporting	MoH, Ministry of Gender, MoL&E (Labor & Employment), National Statistics Bureau, CSOs

		<p>communities with safe public spaces and digital access for women/men</p> <p>8. Employment rate gap (men vs women) in reproductive age</p>			
<p>Social Determinants of Gender Parity (Cross-sectoral integration)</p>	<p>Structural barriers were reduced, enabling women and men to thrive equally across the MNH continuum.</p>	<p>1. Gender gap in educational attainment (secondary, tertiary)</p> <p>2. Employment gap (formal/informal sector participation)</p> <p>3. % of households with food insecurity (sex-disaggregated)</p> <p>4. % of women/men with access to social safety nets (cash transfers,</p>	<p>Education records, labor statistics, household surveys, nutrition/food security surveys, ICT access surveys, GBV service records</p>	<p>Annual – national & community-level</p>	<p>MoE, MoL&E, MoH, Ministry of ICT, Ministry of Gender, Social Protection Agencies, CSOs</p>

		health subsidies) 5. % of communities with functioning GBV prevention & response services 6. % of households with digital device ownership & internet access (by sex) 7. Housing adequacy for pregnant/postpar tum women (safe, sanitary, secure)			
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II. Training & Workshop Delivery by Target Population

Target Group	Mode of Delivery	Approach & Rationale
Policy makers (Governor, County Assembly, MoH)	High-level policy dialogues, evidence-based workshops, and executive breakfast meetings	Short, data-driven, time-efficient sessions with briefs, dashboards, and investment cases to influence budget and policy.
Health workers (Doctors, Nurses, Midwives)	In-person clinical workshops, simulation training, CME (Continuing Medical Education) sessions, advocacy and policy training, storytelling, opinion pieces, splash articles, and scientific publications	Hands-on skills in PPH prevention, neonatal resuscitation, and FP counseling; reinforced via CME credits,
Community Health Volunteers (CHVs)	Cascade training model, peer- to-peer mentorship, digital refresher courses via WhatsApp or SMS, Zoom trainings, cultural events	Practical community-based training, regular refreshers, job aids for door-to- door services, reporting positive deviants in the community, and an opportunity for homegrown innovations.
Adolescents & Youth	Peer-led workshops, youth clubs, edutainment events (drama, music, art), digital learning modules	Engaging, participatory approaches that foster ownership and address SRHR, FP, and life skills.

Women of Reproductive Age	Community barazas, women's support groups, ANC clinic group sessions	Safe spaces to discuss ANC, nutrition, FP, and breastfeeding; integrate with livelihood support (e.g., CHAMAS, CBO groups).
Men & Community Leaders	Male engagement forums, faith-based dialogues, cultural leaders' roundtables, boda boda, and sand collector SACCO	Gender-transformative dialogues to address harmful norms, support FP, and strengthen male involvement.
Civil Society & Media	Media sensitization workshops, journalist bootcamps, CSO advocacy capacity-building	Tailored training on storytelling, data interpretation, and advocacy framing for MNCAH+N+FP.
Agriculture & Education Sectors	Multi-sectoral joint planning workshops, cross-training seminars	Focus on linking agriculture–nutrition–health and school retention–SRHR, aligned with county development plans.

Key Cross-Cutting Features

1. Participatory methods → Use role plays, case studies, simulations, storytelling.
2. Digital integration → Zoom/Teams for policy and CSO, WhatsApp/SMS for CHVs and youth.
3. Localization → Translate into the Kamba language, use culturally relevant visuals.
4. Follow-up → post-training mentorship, supervision, and refresher courses to sustain impact.

III. Knowledge Products for Segmented Audiences in Makueni

Audience	Knowledge Product	Content Focus	Delivery Mode
Policy makers (Governor, County Assembly, MoH)	County MNCAH+N+FP scorecard; Policy briefs	EWENE progress, costed investment case, UHC alignment	High-level briefs, infographics, dashboards
Health workers & CHVs	Clinical guidelines; job aids; WhatsApp micro-learning modules	PPH prevention, nutrition counseling, and FP counseling	Printed guides, mobile training, CME sessions
Adolescents & Youth	Youth-friendly FP information packs; peer-led videos; edutainment campaigns	Teenage pregnancy prevention, SRHR rights, healthy lifestyles	Social media, radio dramas, school clubs, mobile apps, help lines, hotlines
Women of reproductive age	Illustrated brochures, SMS reminders, and radio talk shows	ANC visits, safe delivery, FP methods, nutrition	Radio, mobile platforms, CHV distribution
Men & community leaders	Dialogue kits; cultural adaptation briefs	Role in FP, gender norms, climate change resilience	Barazas, religious gatherings, and male champion forums
Civil society & media	Advocacy toolkits, press releases, evidence digests	MNCAH+N+FP advocacy priorities	Media roundtables, CSO coalitions
Agriculture & education sectors	Cross-sector briefs	Nutrition-sensitive agriculture, school retention	County multi-sectoral working groups

MEAL Tracks Knowledge Products

1. Reach – Track number of products disseminated (e.g., youth reached via WhatsApp campaigns, briefs presented to policymakers).
2. Uptake – Assess how knowledge influences policy and practice (e.g., budget allocations, new guidelines adopted).
3. Engagement – Use feedback loops (surveys, focus groups, community scorecards) to refine messaging.
4. Impact – Link dissemination to EWENE outcomes (e.g., reduction in teenage pregnancies, improved FP uptake, lower perinatal losses).

This ensures that knowledge products are not only produced and shared but also measured for dissemination and effectiveness in shifting behaviors, policies, and system performance in Makueni.

IV. Outline of Knowledge Products for MNCAH+N+FP Advocacy

1. Policy Brief

- Target audience: Policymakers, parliamentarians, county assemblies, and MoH.
- Content:
 - Problem statement (e.g., maternal mortality from PPH, teenage pregnancy).
 - Evidence/data (EWENE targets, county-specific challenges).
 - Recommended policy options.
 - Clear advocacy asks (budget allocation, FP integration, nutrition investment).
- Format: 2–4 pages, concise, infographics, easy-to-digest.

2. Training Toolkit

- Target audience: Health workers, CHVs, teachers, local leaders.
- Content:
 - Modules on MNCAH+N+FP, gender sensitivity, respectful maternity care, and adolescent SRHR.
 - Case studies & role plays.
 - Monitoring checklists & job aids.
- Format: Step-by-step training manual with slides, handouts, and visual aids.

3. Workshop Outline

- Target audience: Multi-sector stakeholders, community forums, youth groups, health care workers (define the targeted audience).
- Content:
 - Objectives & agenda.

- Ice-breakers & participatory sessions.
- Group work & discussions.
- Action planning.
- Format: Agenda + facilitator guide.

4. Advocacy Report

- Target audience: Donors, NGOs, MoH, and advocacy coalitions.
- Content:
 - Situation analysis.
 - Progress against EWENE indicators.
 - Best practices & success stories.
 - Funding/resource gaps.
 - Advocacy recommendations.
- Format: Formal report with annexes & evidence tables.

5. Scientific Publication

- Target audience: Academics, researchers, and medical professionals.
- Content:
 - Peer-reviewed articles on PPH, adolescent SRHR, nutrition, and FP.
 - Data analysis & modeling.
 - Implementation of research findings.
- Format: Journal submission (structured abstract, methods, results, discussion).

6. Dashboard

- Target audience: Policymakers, technical officers, NGOs, CSOs.

- Content:
 - Real-time MNCAH+N+FP data (maternal deaths, contraceptive uptake, perinatal outcomes).
 - Geographic heat maps.
 - Trend lines & comparisons to EWENE targets.
- Format: Digital, interactive, county-level disaggregation.

7. Citizen Report Card

- Target audience: Communities, local leaders, CSOs.
- Content:
 - Scorecard on MNCAH+N+FP services.
 - Service availability, affordability, and quality.
 - Voices from users & CHVs.
- Format: Simple, pictorial, local language versions.

8. Newsletter

- Target audience: Stakeholders, development partners, media, CSOs.
- Content:
 - Updates on MNCAH+N+FP interventions.
 - Human-interest stories.
 - Policy developments.
- Format: Quarterly, 4–6 pages, digital & print.

9. Media Opinion Piece

- Target audience: General public, policymakers (via media influence).

- Content:
 - Commentary on urgent issues (teenage pregnancy, PPH, FP gaps).
 - Evidence-based, persuasive call to action.
- Format: Newspaper op-ed, 600–800 words.

10. Video Outline

- Target audience: Communities, policymakers, donors, and youth.
- Content:
 - Storytelling (e.g., survivor of PPH, youth advocating for SRHR).
 - Expert interviews.
 - Infographic animations.
- Format: 3–7 minutes, subtitled, shareable via TV/social media.

11. Podcast Outline

- Target audience: Youth, professionals, civil society, diaspora.
- Content:
 - Panel discussions (MNH, FP, nutrition).
 - Voices from frontline workers.
 - Advocacy messages tied to EWENE.
- Format: 20–30 minutes per episode.

12. Gender Toolkit

- Target audience: Health managers, CSOs, policymakers.
- Content:
 - Frameworks for gender mainstreaming in MNCAH+N+FP.

- Checklists for service design & delivery.
- Case examples of gender-responsive programming.
- Format: Guidebook with practical tools & exercises.

V. Outline for Development of Visual Content for Targeted Audiences

1. Policymakers (County Assembly, MoH, Parliamentarians, Donors)

- Purpose: Influence policy and budget allocation.
- Key Features:
 - High-level infographics (budget gaps, health impact, return on investment).
 - Policy dashboards with trend lines & target tracking.
 - Short, animated videos summarizing advocacy asks.
- Formats:
 - Infographics: Budget vs. allocation, MNH outcomes, FP unmet need.
 - Policy data visuals: Heat maps, bar charts, dashboards.
 - Explainer animations: 2–3 min with subtitles.

2. Health Workers & Technical Teams (CHVs, Nurses, Facility Managers)

- Purpose: Build capacity, reinforce technical guidelines.
- Key Features:
 - Process flow diagrams (PPH management, referral pathways).
 - Job-aid posters & laminated checklists.
 - Training videos (role plays, simulation clips).
- Formats:
 - Visual protocols: Flow charts on MNH & FP guidelines.

- Interactive e-modules: Step-by-step training slides.
- Illustrated posters: Respectful maternity care, FP counseling.

3. Adolescents & Youth (In-school & Out-of-school)

- Purpose: Increase awareness, challenge harmful norms, promote FP & SRHR.
- Key Features:
 - Colorful, engaging, peer-led content.
 - TikTok/Reel-style short videos.
 - Comics/illustrations with relatable characters.
- Formats:
 - Comics/storyboards: Teenage pregnancy prevention, consent.
 - Youth-friendly animations: Myths vs. facts about contraception.
 - Social media visuals: Memes, infographics, GIFs.

4. Communities & Households (Parents, Caregivers, Community Leaders)

- Purpose: Mobilize behavior change, strengthen demand for services.
- Key Features:
 - Local language translation & cultural adaptation.
 - Storytelling & real-life testimonies.
 - Community dialogue posters.
- Formats:
 - Flip charts: Nutrition, danger signs in pregnancy.
 - Testimonial videos: “Mama’s story” on accessing safe delivery.
 - Pictorial IEC posters: Exclusive breastfeeding, family planning.

5. Media & Opinion Leaders (Journalists, Bloggers, Influencers)

- Purpose: Shape narratives, amplify advocacy messages.
- Key Features:
 - Data-driven yet human-centered visuals.
 - Ready-to-use graphics for coverage.
 - Story angles highlighting urgency.
- Formats:
 - Press kits: Data snapshots, infographics, policy highlights.
 - Short explainer videos: “Why Makeni must invest in FP/Nutrition now.”
 - Interactive dashboards: Quick access to facts & quotes.

6. General Public (Wider Community, National Audience)

- Purpose: Raise awareness, shift social norms, build accountability.
- Key Features:
 - Emotionally compelling visuals.
 - Simplified data with strong storytelling.
 - Call-to-action messaging.
- Formats:
 - Billboards/posters: MNH+FP campaigns.
 - Community theatre videos: Skits on harmful practices.
 - Radio/TV visual spots: 30–60 sec PSAs.

7. Academia & Researchers

- Purpose: Inform evidence generation & scholarly debate.

- Key Features:
 - Rigorous data visualization.
 - Comparative analytics.
 - Infographics linked to research papers.
- Formats:
 - Data dashboards: Maternal mortality trends, FP uptake.
 - Conference posters: Visual abstracts.
 - Publication-ready figures: Clean charts & graphs.

Cross-Cutting Visual Design Principles

- Use local imagery, languages, and context (e.g., Kamba culture in Makueni).
- Prioritize mobile-friendly designs (many users access via phones).
- Ensure gender sensitivity (balanced portrayal of women, men, youth).
- Include accessibility features (subtitles, pictorials, voice-overs).
- Embed action messages: “What you can do” at the individual, community, and policy levels.

VI. Visual Content Production Matrix – Makueni County (MNCAH+N+FP)

Audience	Content Format	Delivery Channel	Frequency
<p>Polycymakers (County Assembly, MoH, Donors)</p>	<p>Policy briefs, infographics, dashboards, short explainer videos</p>	<p>Policy roundtables, email distribution, county assembly sittings, donor meetings, WhatsApp policy groups</p>	<p>Quarterly (with mid-year & end-year updates)</p>
<p>Health Workers & Technical Teams (CHVs, Nurses, Facility Managers)</p>	<p>Job-aid posters, flowcharts, laminated checklists, simulation training videos, interactive e-learning slides</p>	<p>Facility notices boards, WhatsApp professional groups, CME sessions, health summits, DHIS2 dashboards</p>	<p>Monthly updates; refresher training every 6 months</p>
<p>Adolescents & Youth (in/out of school)</p>	<p>Comics/storyboards, TikTok/Reel-style videos, animations, memes, youth podcasts</p>	<p>Social media (TikTok, Instagram, YouTube), school clubs, youth forums, radio shows</p>	<p>Weekly social media posts; quarterly youth forums</p>
<p>Communities & Households (Parents, Caregivers, Leaders)</p>	<p>Flipcharts, testimonial videos, IEC posters, pictorial guides</p>	<p>Community barazas, local FM radio, churches/mosques, health outreach caravans, chief’s meetings</p>	<p>Monthly community dialogues; quarterly campaigns</p>
<p>Media & Opinion Leaders (Journalists, Bloggers, Influencers)</p>	<p>Press kits, infographics, explainer videos, fact sheets</p>	<p>Media briefings, WhatsApp journalist groups, press conferences, blogs</p>	<p>Biannually (before budget cycle & health reporting weeks)</p>

General Public (Wider Community & National Audience)	Billboards, posters, short PSA videos, community theatre skits	Billboards, radio/TV stations, markets, boda boda stages, public rallies	Continuous radio/TV PSAs; billboard updates every 6 months
Academia & Researchers	Data dashboards, conference posters, visual abstracts, publication- ready graphs	University seminars, academic conferences, journals, and digital repositories	Annual publications; quarterly dashboards

Key Notes for Implementation

- **Localization:** Translate visuals into the Kamba language where needed for community reach.
- **Digital-first:** Optimize for mobile phones since most youth & CHVs access content via WhatsApp/TikTok.
- **Equity:** Include gender and disability-sensitive visuals (sign language interpretation, pictorials).
- **Feedback loop:** Collect input from audiences (via MEAL tools such as surveys, citizen scorecards, and WhatsApp polls) to refine visual products.

6. COMMUNITY ENGAGEMENT APPROACHES UNDER MNCAH+N+FP SMART ADVOCACY IN MAKUENI COUNTY

Each one is tailored to strengthen policy dialogue, social mobilization, and community norm change.

6.1 Dialogue Forum (Policy & Technical Dialogue)

Objective:

- To engage policymakers, health leaders, CSOs, and community representatives in evidence-based discussions to accelerate progress on MNCAH+N+FP and EWENE targets.

Outline:

- Opening Session: Welcome, objectives, framing of EWENE in the Makueni context.
- Evidence Presentation: Dashboard on MNCAH+N+FP indicators (teenage pregnancy, malnutrition, contraceptive uptake).
- Panel Discussion: Policymakers, CHVs, youth reps, and technical experts discuss gaps and opportunities.
- Breakout Groups: Prioritization of actions (using Nominal Group Technique).
- Consensus Building: Present group priorities and align with county health and development plans.
- Way Forward: Commitments, timelines, accountability matrix.

Outputs:

- Policy commitments, action plans, advocacy communique, media coverage.

6.2 Edutainment Event (Youth & Community Engagement)

Objective:

- To use creative, interactive, and fun methods (music, drama, sports, storytelling) to raise awareness and transform social norms around MNCAH+N+FP issues (teenage pregnancy, nutrition, contraception, gender equity).

Outline:

- Opening Act: Local youth band or spoken word on maternal and child health.
- Drama/Skits: Role-play on harmful practices vs. positive behaviors (e.g., early marriage, family planning myths).
- Interactive Games/Competitions: Quiz on MNCAH+N+FP facts, with small prizes.
- Celebrity/Influencer Appearance: Local artist or radio host championing FP/Nutrition messages.
- Testimonial Sharing: Adolescent mother, CHV, or peer educator story.
- Resource Booths: Health check-ups, FP counseling, nutrition demonstration stalls.
- Closing: Collective pledge and referral linkages to services.

Outputs:

- Increased awareness, youth engagement, FP/N uptake, media/social media buzz.

6.3 Cultural Event (Traditional & Community Leadership Engagement)

Objective:

- To integrate MNCAH+N+FP advocacy into cultural traditions, community rituals, and local governance spaces to shift norms and practices.

Outline:

- Opening Blessing/Invocation: By elders or religious leaders.
- Traditional Performances: Songs, dances, proverbs with embedded MNCAH+N+FP messages.

- Dialogue Circle: Elders, chiefs, women’s groups, and youth reflect on harmful practices (FGM, early marriage, gender inequities).
- Intergenerational Exchange: Youth vs. elders discuss health, rights, and culture.
- Community Declaration: Public commitments against harmful practices and in support of health-seeking behaviors.
- Cultural Exhibition: Local foods (nutrition), crafts (economic empowerment), climate-smart farming demos.
- Closing: Joint signing/endorsement of a community pledge.

Outputs:

- Community buy-in, reduced resistance to FP, strengthened role of cultural gatekeepers, local ownership.

6.4 Mapping partnership in MNCAH+N+FP in Makueni County

i. Purpose & Scope

- Goal: Identify who does what, where, with which resources, and how aligned they are to county priorities (EWENE, PHC, UHC).
- Coverage: County, subcounty, ward, and facility levels; MNCAH+N+FP service tiers (community → referral).

2) Taxonomy of Partners

- Government/Parastatals: County DoH units, other line ministries (Education, Water, Agriculture, Gender/Youth, Social Services), referral/ambulance, supply chains.
- Health Service Providers: Public, FBO/mission, private facilities; CHPs; professional associations.
- Civil Society/Community: CBOs, youth/women’s groups, faith leaders, media, advocacy networks.

- Development & Financing: Donors, foundations, multilaterals, micro-insurance/SHI intermediaries.
- Academic/Research/Training: Universities, TVETs, research consortia.
- Private Sector & Social Enterprise: Pharmacies, distributors, digital health firms, transport, telcos.

3) Data Model (what to collect)

- Identity & Reach: Org name, legal status, years active, geography (subcounties/wards/facilities).
- Programmatic Role: MNCAH+N+FP focus, service tier, target groups, equity lens (adolescents, hard-to-reach).
- Resources: Annual budget (KES), in-kind support, HR cadres & counts, commodities, assets, information systems.
- Influence & Alignment: Power/interest, alignment to county priorities, community trust, risk/conflicts.
- Governance/Agreements: MoUs, contracts, reporting & data-sharing clauses, ring-fencing/accountability.
- Coordination: Platforms (TWGs, stakeholder forums), frequency, secretariat, ToR.
- MEAL & Indicators: Baselines/targets, disaggregation, reporting cadence, responsible parties.

4) Methodology

1. Desk Review: CIDP, AWP, TWG minutes, DHIS2/LMIS snapshots, previous partner lists.
2. Stakeholder Universe: Seed list from County DoH; snowball via KIIs and TWGs.
3. Key Informant Interviews: Standard tool capturing roles, resources, geography, gaps, dependencies.

4. Geocoding: Link partners to facilities/wards; overlay with burden/coverage maps for equity targeting.
5. Scoring & Prioritization: Influence–Alignment–Resources–Risk (1–5); compute overall partner score.
6. Validation Workshop: Nominal Group Technique to confirm roles, resolve overlaps, set engagement priorities.
7. RACI & Engagement Plans: Define Responsible/Accountable/Consulted/Informed; set quarterly touchpoints.
8. Publication & Feedback: Share partner registry + map; invite updates via TWGs.
9. Maintenance Cadence: Quarterly refresh, annual deep dive; change log.

5) Analytical Lenses

- Gaps & Overlaps: By subcounty/ward, service tier, commodity stream, and target population.
- Equity & Gender: Who serves adolescents, low-income, remote wards; gender-responsive programming.
- Systems Dependencies: Supply chain, referral, data systems, community linkages.
- Risk Register: Funding cliff risks, duplication, conflicts of interest, data governance issues.

6) Decision Tools

- Power–Interest Grid (to tailor engagement).
- IRA Scorecard (Influence, Resource capacity, Alignment; with risk adjustment).
- Partnership Heatmap (coverage vs. need).
- MEAL Tracker for knowledge products and joint action outputs.

7) Outputs

- County Partner Registry (Excel—template provided).
- Coverage Maps & Dashboards (ward/facility overlays).
- Quarterly Coordination Briefs (who/where/impact).
- Annual Partnership Review (performance & re-alignment to EWENE/PHC/UHC).

6.5 Sample Summarized 2-Year Budget (USD)

Budget Line	Cost Estimate (USD)
Policy & advocacy dialogues (youth, community, religious leaders, county assembly)	150,000
Knowledge products (policy briefs, IEC, infographics, data dashboards)	80,000
Media & communications (radio, social media, campaigns)	100,000
Capacity building (advocacy, leadership, youth & women champions)	120,000
Monitoring, evaluation, learning & documentation	70,000
Partnership platforms (multi-sector forums, public-private partnerships)	80,000
Contingency (climate/disaster-related advocacy needs)	50,000
Total (2 years)	650,000

References

1. Every Woman Every Child. *The Global Strategy for Women's, Children's, and Adolescents' Health (2016–2030): Survive, Thrive, Transform*. New York: United Nations; 2015.
2. World Health Organization (WHO). *Ending preventable maternal mortality (EPMM): a renewed focus for improving maternal and newborn health and well-being*. Geneva: WHO; 2021.
3. World Health Organization (WHO). *Every Newborn Action Plan: An update on progress and lessons learned*. Geneva: WHO; 2022.
4. Development Initiatives. *2022 Global Nutrition Report: Stronger commitments for greater action*. Bristol: Development Initiatives; 2022.
5. World Health Organization; United Nations Children's Fund; World Bank. *Levels and trends in child malnutrition: UNICEF/WHO/World Bank Group Joint Child Malnutrition Estimates, 2023 edition*. Geneva: WHO; 2023.
6. Countdown to 2030 Collaboration. *Countdown to 2030 country profiles*. New York: UNICEF; 2023. Available from: <https://countdown2030.org/country-profiles>
7. Every Woman Every Child. *Global Strategy for Women's, Children's, and Adolescents' Health (2016–2030) dashboards*. New York: United Nations; 2023. Available from: <https://www.everywomaneverychild.org>
8. World Health Organization. *Every Newborn Action Plan (ENAP) and Ending Preventable Maternal Mortality (EPMM) progress dashboard*. Geneva: WHO; 2023. Available from: <https://www.who.int/data/maternal-newborn-child-adolescent>
9. FP2030. *FP2030 Measurement Report 2023: A world of possibilities*. Washington (DC): FP2030; 2023.
10. FP2030; Ministry of Health, Kenya. *Kenya FP2030 Commitment Brief*. Nairobi: FP2030; 2021. Available from: <https://commitments.fp2030.org/commitments/kenya>
11. National Council for Population and Development (NCPD), Government of Kenya. *Review of modern family planning uptake: NCPD update, including adolescent pregnancy trends and policy progress in Kenya*. Nairobi: NCPD; 2023.

12. World Health Organization. Investment case for ending preventable maternal mortality and improving maternal and newborn health. Geneva: WHO; 2020.
13. World Bank. Investing in health: World Development Report 2019. Washington, DC: World Bank; 2019.
14. Shekar M, Kakietek J, D'Alimonte M, Rogers HE, Eberwein JD, Akuoku JK, et al. Investing in nutrition: the foundation for development. Washington, DC: World Bank; 2016.
15. Guttmacher Institute. Adding it up: Investing in sexual and reproductive health 2019. New York: Guttmacher Institute; 2020.
16. UNFPA, UNICEF, WHO, World Bank Group. Strategies toward ending preventable maternal mortality (EPMM). Geneva: WHO; 2015.
17. Horton S, Levin C. Cost-effectiveness of interventions for reproductive, maternal, neonatal, and child health. In: Black RE, Laxminarayan R, Temmerman M, Walker N, editors. Disease control priorities, third edition (Volume 2): Reproductive, maternal, newborn, and child health. Washington, DC: World Bank; 2016. p. 319–34.
18. Stenberg K, Hanssen O, Edejer TT, Bertram M, Brindley C, Meshreky A, et al. Financing transformative health systems towards achievement of the health Sustainable Development Goals: a model for projected resource needs in 67 low-income and middle-income countries. *Lancet Glob Health*. 2017;5(9): e875–e887.
19. Jamison DT, Summers LH, Alleyne G, Arrow KJ, Berkley S, Binagwaho A, et al. Global health 2035: a world converging within a generation. *Lancet*. 2013;382(9908):1898–955.
20. Countdown to 2030 Collaboration. Countdown to 2030: tracking progress towards universal coverage for reproductive, maternal, newborn, and child health. *Lancet*. 2018;391(10129):1538–48.
21. SMART Advocacy: Achieving Policy and Funding Change User's Guide. Gates Institute for Population and Reproductive Health; 2021. This user's guide lays out the structured nine-step SMART Advocacy process—including tools for planning, implementation, and evaluation—which remains a foundational resource for preparing evidence-driven advocacy strategies.

22. Ngaira D. Driving impact in Kenya's health sector through strategic advocacy. African Institute for Development Policy (AFIDEP); 2025 Jan 8. This blog captures how SMART Advocacy training under the Advance Domestic Health Financing project strengthened engagement with policymakers, particularly on health financing and Universal Health Coverage reforms in Kenya.
23. Pumbwa G, Malema M. SMART Advocacy capacity building results in meaningful engagement with the Minister of Finance on the health budget in Malawi. AFIDEP Blog; 2025 May 16. This report demonstrates how SMART Advocacy capacity building by AFIDEP and PPD-ARO enabled civil society organizations to influence the national health budget, particularly for MNCAH and primary health care.
24. Ministry of Health, Kenya. *Kenya Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCAH) Investment Framework 2016–2030*. Nairobi: MoH; 2016.
25. Ministry of Health, Kenya. *Kenya Primary Health Care Strategic Framework 2019–2024*. Nairobi: MoH; 2019.
26. Government of Makueni County. *County Integrated Development Plan (CIDP) 2023–2027*. Wote: Department of Finance, Planning, and Economic Development; 2023.
27. National Council for Population and Development (NCPD). *Kenya Demographic Dividend Roadmap*. Nairobi: NCPD; 2018.
28. United Nations Population Fund (UNFPA). *Kenya: Adolescent and Youth Demographics Factsheet*. Nairobi: UNFPA; 2022.
29. Ministry of Health, Kenya. *Universal Health Coverage Policy 2020–2030*. Nairobi: MoH; 2020.
30. Kuruvilla S, Bustreo F, Kuo T, Mishra CK, Taylor K, Fogstad H, et al. The Global Strategy for Women's, Children's, and Adolescents' Health (2016–2030): a roadmap based on evidence and country experience. *BMJ*. 2016;354: i4607.
31. World Health Organization (WHO). *Smart Advocacy for Health: A guide to policy influence and resource mobilization*. Geneva: WHO; 2020.
32. Nzei M. *Enhancing Health Program Effectiveness through Strategic Partnerships in Makueni County*. Maarifa Centre; 8 February 2023. This report discusses the mapping of

79 health-sector partners and the establishment of a strategic partnerships directorate in Makueni County.

33. Financing Alliance for Health. *Kenya's Makueni County to strengthen its partnerships with the private sector and faith-based organizations in the provision of community health services*. 19 October 2022. This article highlights the engagement of private and FBO partners in expanding community health platforms.
34. Government of Makueni County. *Makueni partners with key institutions to boost healthcare services*. 2025. This notice outlines MoUs with the Open University of Kenya, CHAK, and North Star Alliance, focusing on research, capacity-building, and service delivery.
35. Brush BL, Israel BA, Coombe CM, Lee SYD, Jensen M, Wilson-Powers E, et al. The Measurement Approaches to Partnership Success (MAPS) Questionnaire and Facilitation Guide: A validated measure of CBPR partnership success. *Progress in Community Health Partnerships: Research, Education, and Action*. 2024;13(3):225-35. Provides tools for evaluating collaborative partnerships.
36. Roussos ST, Fawcett SB. A review of collaborative partnerships as a strategy for improving community health. *Annual Review of Public Health*. 2000; 21:369-402. This classic review outlines the theoretical bases for health partnerships.
37. Sandoval JA, Lucero JE, Oetzel JG, Avila M, Belone L, Mau M, et al. Process and outcome constructs for evaluating community-based participatory research projects: A matrix of existing measures. *Health Education Research*. 2012;27(4):680-90. Guides MEAL and evaluation approaches for community partnerships.
38. Mutiso VN, Musyimi CW, Gitonga I, Tele A, Pervez R, Rebello TJ, et al. Using the WHO-AIMS to inform development of mental health systems: the case study of Makueni County, Kenya. *BMC Health Services Research*. 2020; 20:51. Demonstrates resource and systems mapping in Makueni using WHO-AIMS.
39. Thuku MK, Muriuki J, Adano U, Oyucho L, Nelson D. Coordinating health workforce management in a devolved context: lessons from Kenya. *Human Resources for Health*.

2020; 18:26. Highlights stakeholder coordination and mapping in a devolved Kenyan health system

7. SMART ADVOCACY EXAMPLES

7.1 Background

Advocacy is the deliberate process of influencing decisions within political, economic, and social systems and institutions. It takes several forms, each tailored to specific goals and audiences. **Individual advocacy** focuses on helping a person access information, services, or assert rights, often through legal or institutional channels. It usually provides the driver for socio-behavioral change. **Community advocacy** mobilizes local voices to address collective issues, often through grassroots campaigns and with a focus on accountability. **Policy advocacy** engages decision-makers to reform or introduce legislation or policies, usually spearheaded by NGOs or think tanks. **Media advocacy**, on the other hand, uses mass communication tools to shape public opinion and push issues onto political agendas.

In recent years, the emphasis on evidence-based advocacy (EBA) has grown, driven by the need to support arguments with credible data rather than ideology or anecdote. EBA ensures that advocacy is rooted in factual analysis, leading to more effective, accountable, and persuasive interventions. Policymakers are more likely to be responsive when presented with robust evidence demonstrating the extent of a problem, potential solutions, and expected outcomes. For instance, in global health, EBA has underpinned successful campaigns for vaccine funding by demonstrating cost-effectiveness and the number of lives saved.

This underscores the growing importance of data science in advocacy. As issues become increasingly complex, data science enables advocates to analyze vast datasets, identify trends,

and present findings in compelling formats such as dashboards and infographics. Tools such as machine learning, predictive modeling, and natural language processing provide strategic advantages in mapping public sentiment, forecasting policy impact, and tailoring campaigns. For example, during the COVID-19 pandemic, data science was instrumental in communicating health risks and driving compliance with safety protocols (Abbas et al., 2021). Increasing attempts to introduce the same are being undertaken in maternal and newborn health.

Effective advocacy must consider audience segmentation. Policymakers respond to clear, concise policy briefs and empirical evidence. The general public may be more influenced by emotionally resonant stories, social media content, and visual media. Grassroots communities prefer culturally relevant, face-to-face engagement. Private sector stakeholders often seek an economic rationale that addresses their value proposition and investment and risk analysis.

Accordingly, communication strategies must be audience-specific and multi-channeled. For policymakers, white papers, stakeholder meetings, and policy roundtables are effective. For the public, social media platforms (WhatsApp, Twitter/X, Instagram, TikTok) offer viral potential and reach. Community outreach may utilize town halls, radio/ TV programs, or local influencers. Crucially, message framing must align with each group's values and interests, whether appealing to human rights, economic growth, or moral obligation.

An effective communication strategy also requires feedback loops, adaptability, and consistent monitoring. This includes tracking media engagement, audience sentiment, and policy shifts, all of which can be measured through data analytics. Strategic timing—aligning messages with news cycles or policy windows—also enhances impact.

Knowledge products in advocacy are evidence-informed materials designed to influence decision-making, raise awareness, build support, and stimulate action around specific issues. They translate complex data, experiences, and insights into accessible, persuasive, and contextually relevant formats tailored for different audiences, including policymakers, civil society, funders, media, and communities.

Below is a categorization of **everyday knowledge products used in advocacy**, along with their purpose and typical target audiences:

1. Policy Briefs

- Purpose: Provide concise summaries of issues backed by evidence, with actionable recommendations.
- Audience: Policymakers, government officials, legislative bodies, and donors.
- Format: 2–4 pages, with executive summaries, problem statements, evidence, and recommendations.
- Example: "Investing in Midwives to Reduce Maternal Mortality in Kenya."

2. Advocacy Toolkits/Guides

- Purpose: Offer practical, step-by-step guidance for advocates to mobilize, campaign, or lobby.
- Audience: Civil society organizations, youth groups, health workers, and grassroots networks.
- Format: Manuals or digital guides with templates, checklists, and messaging tools.
- Example: UNICEF Advocacy Toolkit for Children's Rights

3. Fact Sheets

- Purpose: Present key statistics and messages in a quick, digestible format.
- Audience: General public, media, policymakers.
- Format: 1–2 pages with bullet points, graphs, and visuals.
- Example: "Key Facts on Postpartum Hemorrhage in Sub-Saharan Africa."

4. Infographics

- Purpose: Use visuals to communicate complex information persuasively.
- Audience: General public, online users, social media audiences, journalists.
- Format: Poster-style graphics, digital images, or dashboard snapshots.
- Example: Infographic on gender disparities in access to maternal health services.

5. Case Studies and Human-Interest Stories

- Purpose: Illustrate the real-life impact of issues or interventions through storytelling.
- Audience: Donors, media, decision-makers, communities.
- Format: Narrative write-ups, videos, blogs, or photo essays.
- Example: "A Midwife's Story: Saving Lives in Rural Uganda."

6. Research Summaries/Briefs

- Purpose: Distill academic or scientific findings into policy-relevant insights.
- Audience: Technical partners, donors, academics, and government agencies.
- Format: 3–5-page summaries with implications for policy or programming.
- Example: "Summary of Evidence on the Economic Cost of Gender-Based Violence."

7. Scorecards and Dashboards

- Purpose: Compare and track progress across regions, indicators, or institutions.
- Audience: Government stakeholders, development partners, public health actors.
- Format: Interactive dashboards or static scorecards using data visualization tools.
- Example: PMNCH Accountability Scorecard for Women's, Children's, and Adolescents' Health

8. Position Papers

- Purpose: Present an organization or coalition's stance on an issue or proposed policy.
- Audience: Legislators, UN agencies, donors, and advocacy coalitions.
- Format: Formal papers with rationale, position, and calls to action.
- Example: "Civil Society Position on Climate-Resilient Health Systems."

9. Press Releases and Media Kits

- Purpose: Announce new findings, events, or campaigns and secure media coverage.
- Audience: Journalists, editors, and the public.
- Format: One-page news releases, backgrounders, speaker bios, FAQs.
- Example: Press release on the launch of the maternal mortality reduction campaign.

10. Videos and Digital Stories

- Purpose: Evoke emotional connection and share lived experiences.
- Audience: General public, online users, donors, and advocacy events.
- Format: Short documentaries, animations, testimonial clips.
- Example: "Voices from the Field: Young Mothers Speak on Reproductive Health Rights."

11. Social Media Content (Micro-advocacy products)

- Purpose: Drive awareness, mobilize action, and influence public opinion.

- Audience: Broad online audiences, youth, and influencers.
- Format: Tweets, reels, carousels, memes, livestreams.
- Example: Campaign hashtags like #EndMaternalDeaths or #Youth4SRHR

7.2 Monitoring, Evaluation, Accountability, and Learning (MEAL)

It is an integral framework for assessing the effectiveness, quality, and impact of advocacy efforts. Unlike traditional service delivery programs, advocacy is about influencing people, policies, institutions, and systems—which can be complex and non-linear. Therefore, MEAL in advocacy must be adaptive, iterative, and designed to track both intended and unintended outcomes.

i. Monitoring in Advocacy

Monitoring advocacy involves systematically tracking activities, outputs, and outcomes in real time. This may include:

- **Tracking engagement** with key stakeholders (e.g., number of meetings with policymakers, public statements made, or partnerships formed).
- **Measuring reach** (e.g., number of people reached through social media or campaigns).
- **Recording policy changes or commitments**, such as draft bills tabled or funding allocated.

Real-time dashboards and advocacy logs (often maintained using tools like DevResults or custom Excel sheets) help capture both qualitative and quantitative data. Monitoring also helps identify shifts in the political landscape or public opinion that may influence strategy.

ii. Evaluation of Advocacy

Evaluation assesses the effectiveness and impact of the advocacy initiative. It looks at:

- **Contribution to policy or systems change** (rather than attribution since advocacy outcomes are rarely the result of one actor alone).
- **Progress against the Theory of Change (ToC)** and logical frameworks, which outline desired pathways from activity to outcome.
- **Behavioral or perceptual changes** among decision-makers or target audiences.

Evaluation methods often include:

- **Outcome harvesting** – capturing evidence of change and working backward to determine contribution.
- **Most Significant Change** technique – collecting stories from stakeholders to understand what changed and why.
- **Process tracing** – identifying causal links between advocacy actions and outcomes.
- **Case studies and policy analysis** – demonstrating shifts in legislation, discourse, or funding.

iii. **Accountability in Advocacy**

Advocacy actors must be accountable to both:

- **Communities and stakeholders, they represent** (ensuring legitimacy, transparency, and ethical representation), and
- **Donors or partners** who expect results based on the use of financial and technical resources.

Mechanisms include stakeholder consultations, periodic reports, and inclusive feedback loops. Participatory MEAL approaches ensure communities are involved in defining success and evaluating results.

iv. **Learning from Advocacy**

Learning is embedded throughout the advocacy cycle. It involves:

- **Using MEAL data** to reflect on what's working or not.
- **Documenting best practices, failures, and adaptations.**
- **Iterative planning**, ensuring strategies evolve with shifting contexts.

Learning is shared through after-action reviews, knowledge products (like briefs or blogs), and learning sessions.

v. MEAL and Impact Assessment Tools in Advocacy

Key frameworks and tools include:

- **The Advocacy Strategy Framework (Harvard)**
- **Oxfam’s “Compass” Monitoring Tool**
- **CARE’s Advocacy Impact Evaluation Toolkit**
- **Better Evaluation’s Rainbow Framework**
- **OECD-DAC Criteria** (relevance, effectiveness, efficiency, impact, sustainability)

Advocacy is not only about raising voices and agency but also about leveraging data, evidence, and tailored effective communication to bring about change. Data science has transformed advocacy into a more analytical, responsive, and strategic process that can better navigate complex sociopolitical landscapes. The international, regional and advocacy calendar days such as May 28th the International Women’s Health Day October 11th International day of the girl child; November 25th to December 10th the 16 days of activism against gender violence providing strategic time for spreading collective advocacy messages. We have successfully achieved in having the WHO World PPH day on 5th of October to commemorate mothers who have lost their lives and advocate that indeed every woman, every newborn, everywhere must survive, thrive, and transform.

In the **Global Strategy for Women’s, Children’s, and Adolescents’ Health (2016–2030)**, launched by the United Nations under Every **Woman Every Child** initiative, the terms "**Survive, Thrive, and Transform.**"

Survive – Ending preventable deaths.

This refers to ensuring that women, newborns, children, and adolescents **do not die from causes that are avoidable** with access to timely, quality health services. Key aspects include:

- **Reducing maternal mortality** from complications like hemorrhage, hypertensive disease in pregnancy, infection, and unsafe abortion.

- **Ending preventable newborn and child deaths**, such as those from prematurity, birth asphyxia, pneumonia, diarrhea, malaria, and malnutrition.
- **Addressing adolescent mortality** due to causes like road accidents, suicide, and violence.
- Improving access to **basic health care**, especially in low-resource settings.
- Focusing on **universal health coverage** and skilled birth attendance.

Goal: No one should die due to a lack of access to essential health services.

Thrive – Ensuring health and well-being.

- **Good nutrition** and growth (especially in early childhood).
- **Mental health support** and emotional well-being.
- Access to **quality education** and supportive environments.
- **Sexual and reproductive health services** for adolescents and women.
- Tackling **gender inequality**, domestic violence, and child marriage.
- Ensuring **developmental milestones** are reached through nurturing care.

Goal: Enable every woman, child, and adolescent to achieve their full potential.

Transform – Expanding enabling environments.

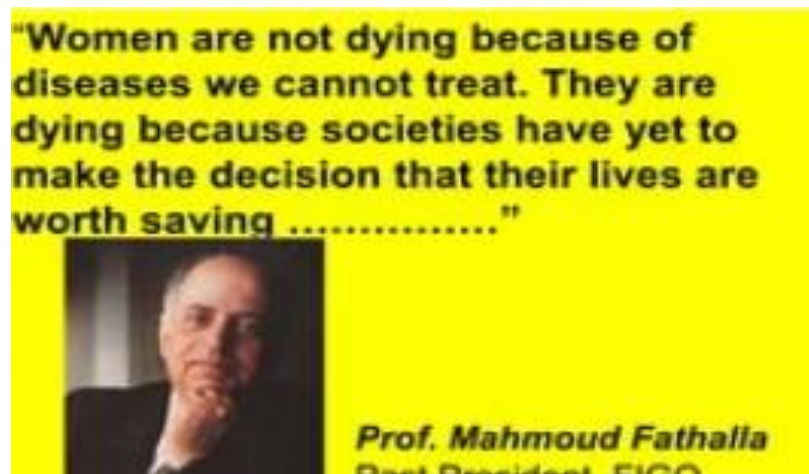
This pillar focuses on creating **sustainable systemic changes** that address the root causes of poor health outcomes and promote **equity and rights**. It involves:

- **Strengthening health systems** and policies.
- Creating **accountable governance** and financing structures.
- Fostering **community engagement** and multisectoral partnerships (health, education, sanitation, etc.).
- **Innovation and research** to drive evidence-based solutions.

- Addressing **social, economic, and environmental determinants** of health (poverty, climate, conflict, etc.).
- Promoting **resilience** and preparedness for pandemics or humanitarian crises.

Goal: Transform societies so that they uphold and sustain health and rights for future generations.

One of the most excellent advocacy quotes from the Late Prof Mahmoud Fathalla, Past President of FIGO



References

1. Abbas AH, Naser M, Ali D, et al. The role of data science and artificial intelligence during pandemics: COVID-19 case study. *Comput Biol Med.* 2021; 132:104328.
Parkhurst J. *The politics of evidence: from evidence-based policy to the good governance of evidence.* Routledge; 2017.
2. UNICEF. Advocacy toolkit: a guide to influencing decisions that improve children's lives. 2020. Available from: <https://www.unicef.org/media/99686/file/Advocacy-Toolkit.pdf>
3. WHO. *Strategic communications framework for effective communications.* Geneva: World Health Organization; 2017.
4. Oxfam. *Measuring advocacy impact: Methodologies and tools.* Oxfam International; 2014. Available from: <https://policy-practice.oxfam.org/resources/measuring-advocacy-impact-methodologies-and-tools-3027>
5. BetterEvaluation. *Develop and use knowledge products.* 2022. Available from: <https://www.betterevaluation.org/en/themes/knowledge-products>
6. Coffman J. *Strategic Communications Audits.* Harvard Family Research Project; 2004. Available from: <https://www.hfrp.org/publications-resources/browse-our-publications/strategic-communications-audits>
7. Jones H. *A guide to monitoring and evaluating policy influence.* ODI; 2011. Available from: <https://odi.org/en/publications/a-guide-to-monitoring-and-evaluating-policy-influence/>
8. Vogel, I. *Review of the use of 'Theory of Change' in international development.* UK Department for International Development (DFID); 2012.
9. Cox M, Scruton J, Baur E. *Advocacy impact evaluation: Review and options.* AusAID; 2011.
10. Oxfam. *Measuring Advocacy Impact: Methodologies and Tools.* Oxfam International; 2014. Available from: <https://policy-practice.oxfam.org/resources/measuring-advocacy-impact-methodologies-and-tools-302709/>

7.3 Advocacy and Knowledge Products Developed from April to November 2025 in Every Woman, Every Newborn, Everywhere- OMMI Initiative

1. World Health Assembly (WHA) blog addressing the PPH roadmap on April 7th, 2025. Following April 7th, there is a one-year advocacy campaign termed Healthy Beginnings: Hopeful Futures



2. Prof Kihara Anne- FIGO President with the DG Amoth, MoH, KENYA, addressing Every Woman Every Newborn Everywhere (EWENE) advocacy drive within the Ministry of Health (MoH) – DRMNCAH call center, Kenya. The EWENE program focuses on reducing maternal and newborn mortality and morbidity on 12th May 2025. There were 1,782 views.



3. Keynote speaker at KOGS Central symposium. The theme of the congress held in Meru County is " Empowering motherhood: innovations and collaborations in obstetrics and gynecology. Provided the Keynote address on 31st May 2025 and a follow-up Newsletter article on: Every woman, every newborn, everywhere (ENAP – EPMM) for a healthy future: The role of KOGS Central branch. Appendix: Find the link to the recording with the related PPT presentation. The newsletter article submitted (Appendix 1).



4. External Reviewer of the WHO draft consolidated guidelines for prevention, diagnosis, and treatment of PPH. This is in keeping with the PPH Roadmap 2023, which includes an undertaking to consolidate the existing PPH guidelines into one document. (17th June 2025)
5. Manuscript reference number: THE LANCET-D-25-03847
https://papers.ssrn.com/sol3/papers.cfm?abstract_id=5290994

Title: Prognostic accuracy of clinical markers of postpartum bleeding in predicting maternal mortality or severe morbidity: A WHO individual participant data meta-analysis

Reviewed: Fast Track Article conducted on 18th June 2025

Dear Prof Kihara,

Thank you for your review of this manuscript.

The review is now in your "Completed Assignments" folder in The Lancet's Editorial Manager system (EM). Using EM, you can track the progress of this manuscript through to the Editor's decision. You will also be able to view other

reviewers' anonymized comments by clicking 'View Reviewer Comments' in the 'Action' column.

6. End PPH training of medical students and midwives on PPH and their role in the build-up to end PPH run in collaboration with the OMMI consortium held at UON Natili House. Topic addressed <https://endpph.com/>



7. Year One postgraduate End-of-Year exam coordinated for the Master of Medicine students. One of the structured essay questions (SAQ1) addressed EWENE and PPH. There were 42 candidates with marks ranging from 36% to 92%, with a mean of 63.3% and a median of 60%. However, critical gaps were noted in their understanding of the mechanisms of action of the updated drugs, namely Heat Stable Carbetocin and Tranexamic acid, and the causes of PPH were not uniformly described. A decision was made to undertake a seminar training session for the students.
8. We recognized that the students are not able to orchestrate code blue for management of maternal shock, the most typical cause being hypovolaemic shock from PPH. Developed a concept note, shared this with my co-coordinator of postgraduates to see if this can be funded and taught using a team-based approach, engaging both the Obs/Gyn registrar and midwives in the maternity unit, and employing the use of simulation training. There is a need to normalize emergency Obstetric drills.
9. FIGO board and council meeting held in Frankfurt, Germany, discussed the EWENE acceleration effort in Kenya, contributing towards accelerated reduction of maternal and

neonatal mortality and SDG 3 in SSA. Additionally, asked FIGO to endorse and support the end PPH run in Kenya and the adjacent regional nations.



Members of BoT and Council at MEETING IN Frankfurt, Germany

10. On the global stage, efforts are being orchestrated through the PMNCH strategic plan 2026-2030 thematic pillars: unfinished SRHR agenda, adolescent health and well-being, and maternal and neonatal mortality, including ending preventable maternal deaths from PPH. Currently addressing the workplan for 2026 -2027 and provision of an enabling environment for HRH

11. Scientific Publication

JOGECA publication policy brief: *Kihara Anne – Beatrice^{1,2,3,5}, Musila P^{4,5}, Mwatha S^{4,5}, Mutula Kilonzo^{4,5}, Wanjiku Elizabeth^{1,5}. Nzioka Fredrick^{1,5} **Strengthening MNCAH Resilience in Makueni County Amid Climate Change** <https://www.jogeca.com/index.php/jogeca>

Policy Briefs

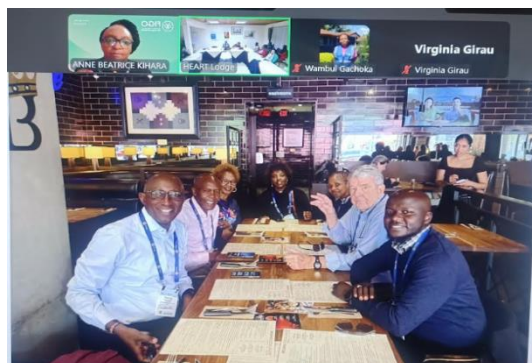
Strengthening maternal, newborn, child, and adolescent health (MNCAH) resilience in Makueni County amid climate change: A policy brief

Prof. Anne-Beatrice Kihara, P Musila, S Mwatha, Mutula Kilonzo, Elizabeth Wanjiku, Fredrick Nzioka, Dr. Paul Koigi

94-96



12. End PPH run shared on 10th July 2025 with Rotarians of Nairobi Muthaiga North with International Rotarian partners from Canada – Phoenix Club. The club has been actively engaged locally, equipping MNH facilities in various Counties. It has been training in emergency obstetric and neonatal care since 2016, in collaboration with the University of Nairobi. Made a presentation titled EWENE: moving stronger and further with the Rotary Nairobi Muthaiga North held on 10th July 2025.



13. FOGSI President Dr Sunita Devineni and FIGO President podcast addressing the topic: How distant is the dream of gender equality based on the UN Report on GENDER SDG 5 and all other SDGs, 2024, and the World Economic Forum 50 50 gender parity sprint report 2024.

The conversation focused on maternal and neonatal mortality. The importance of rights and quality of human capital, climate change and environment, poverty, hunger, prosperity and empowerment, social determinants, ownership of assets, decision making, and rights and participation in politics. Recognizing what affects women today affects her tomorrow and carries an inter-generational ripple effect. Specific to India, strides have been made in legislation, policy, and programming; however, drawbacks include ring-fencing funding, monitoring expenditure data with disaggregation by age cohort, geolocation, intersectionality, and data science to inform further evidence-based practices, policy review/formulation, advocacy, and accountability. Reduction of maternal mortality through gender equality in India, pre-recorded on 17th July 2025, podcast and aired by FOGSI on 27th July 2025



In line with the FOGSI President, preparing for the podcast

14. Makueni County is addressing developing a training package for community health promoters, the first line attending to patients at Level one, and providing linkage/referral into health institutions, and from health institutions, reverse referral back into communities. Currently, 3000 CHP have been recruited since the catalytic engagement by the current government. There is a need to have a master of trainers group (CHA) given the skill set to mentor the others in EWENE targets and milestones; identification of pregnant women in the community; provide health literacy related to prenatal, intrapartum, and postpartum care; recognize and refer those at high risk or develop danger signs in the postpartum period, e.g. bleeding after childbirth. Currently using the nominal method to prioritize their priority topic areas. Communication with Dr S. Mwatha, training of master trainers, has been undertaken with CHA in EWENE.
15. Commencement of the EWENE acceleration plan based on situation analysis in Makueni County to be undertaken collaboratively with the CHMT, medical personnel, and partners. This exercise has been on hold as the national guidance has yet to be released.
16. World Health Organization (WHO) granted Prof Kihara Anne B stewardship for the editorial addressing WHO World PPH day, a critical pillar in the EWENE reduction of the significant cause of maternal mortality advocacy. This was in addition to the launch of the WHO PPH consolidated guidelines and implementation tools at the XXV FIGO Congress 22025 held between October 5-9, 2025, in Cape Town – Convention Centre



17. Ongoing preparations with Kenya Obstetrical and Gynecological Society (KOGS) and “Okoa mama na mtoto” (OMMI) consortium partner had the end PPH run advanced and on 28th September 2025.



**PPH Insights, Issue 001 -
October 2025**



Africa leads Global Momentum to End Preventable Maternal Deaths

18. FIGO Congress that featured the President's flagship PPH.
- ✓ At the XXV FIGO Congress, at the opening ceremony, Prof. Kihara Anne's speech used on EWENE. The keynote speech by Prof. Obimbo Moses featured on ending PPH: beyond the guidelines for impact in advancing women's health.
 - ✓ The presidential plenary session featured distinct aspects related to PPH, namely: the normative environment, financing, women's rights, and the role of professional

societies in PPH. The lessons learnt from Makueni County, presented by the Governor HE Mutula Kilonzo Jnr, CBS, and one of the EWENE County sites.

- ✓ The launch of the WHO Consolidated PPH guidelines and implementation tools, and several scientific paper publications appended below.
- ✓ WATOG, under the leadership of the President, Dr Bernard Ubonr of Nigeria, dramatizing Code blue at the XXV FIGO Congress 2025, and the Kenyan Contingent had a march through the Exhibition Hall on zero rate PPH.

19. IJGO Special supplement on PPH

Topics

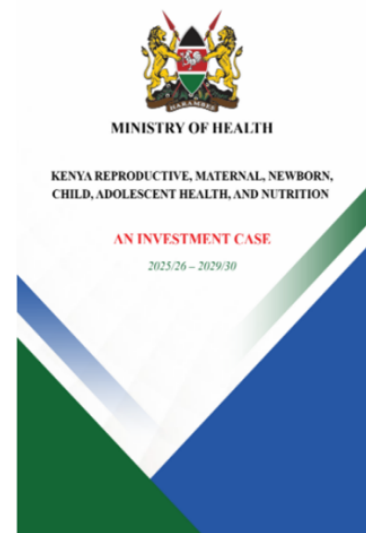
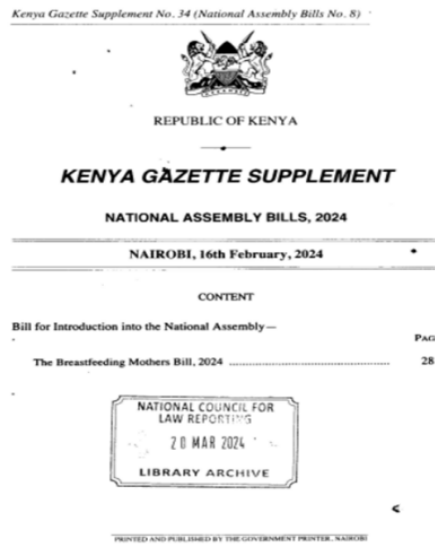
Articles



- [Open Access](#)
FIGO good practice recommendations on anemia in pregnancy, to reduce the incidence and impact of postpartum hemorrhage (PPH)
- [Open Access](#)
FIGO recommendations on objective measurement of blood loss after birth for early detection of postpartum hemorrhage
- [Open Access](#)
Gender inequity in postpartum hemorrhage: A public health issue
- [Open Access](#)
FIGO good practice recommendations: Assisted vaginal birth and the second stage of labor
- [Open Access](#)
Postpartum hemorrhage: Findings of a global survey by the World Association of Trainees in Obstetrics and Gynecology (WATOG)
- [Open Access](#)
FIGO call to action: Multisectoral approach to postpartum hemorrhage
- [Open Access](#)
FIGO good practice recommendations for vaginal birth after cesarean section
- [Open Access](#)
Complex cesarean section: Surgical approach to reduce the risks of intraoperative complications and postpartum hemorrhage

World PPH Day Articles


20. World postpartum hemorrhage day: Renewing the global call to end deaths from postpartum hemorrhage (PPH) Roadmap Advocacy Working Group. First published: 03 October 2025 <https://doi.org/10.1002/ijgo.70550>

21. Cadee F, Jacobs JL, Kihara AB, Atchoumi AH, Forna F, Igbokwe U, Af Ugglas A. Prevention first, preparedness always: a holistic approach for managing postpartum haemorrhage. *Lancet Glob Health*. 2025 Nov;13(11): e1799-e1800. doi: 10.1016/S2214-109X (25)00400-0. Epub 2025 Oct 3. PMID: 41052517.
22. Legislating to save lives: Strengthening the legal framework for maternal, newborn and child health in Kenya, 20th November, Fairmont The Norfolk Hotel with KEWOPA and the Chairperson of the Health Committee.



Collaborative Action Plan (CAAP)  **Hennet** 

Accelerating Reproductive, Maternal, Newborn, Child and Adolescent Health & Nutrition



Investing in reproductive, maternal newborn, child and adolescent health and nutrition is not only a moral imperative — it is a strategic economic investment in Kenya's future.

Based on findings from the BMNCAN-N Investment Case 2025/2026 – 2029/30, every shilling invested in BMNCAN-N returns more than 12 shillings in social and economic gains by 2030. This is due to fewer health emergencies, improved employment of parents and young people and overall contribution to national growth.

- Kenya has made encouraging progress in reducing maternal, newborn, and child deaths, expanding modern contraceptive use, and improving nutrition. Yet progress remains too slow to meet Sustainable Development Goal targets.
- Persistent gaps in financing, equitable access, quality of care, human resources, and accountability continue to undermine sustained gains — leaving women, children, and adolescents behind.

Maternal health

Every day, approximately 14 Kenyan women die from preventable pregnancy-related complications, many of which could be prevented through well-known interventions and quality health services.

Progress has largely stagnated over the past decade, and Kenya's maternal mortality ratio remains among the highest in East Africa—exceeding that of Ethiopia, Uganda, and Tanzania.



- Maternal mortality in Kenya remains high at 253 deaths per 100,000 live births in 2019—only a modest decline from 262 in 2014 and far above the SDG target of 70 by 2030. Despite slight improvements, the slow pace of reduction underscores the urgent need for sustained technical and financial investment to strengthen maternal health services and prevent avoidable deaths.
- Access to quality postpartum haemorrhage (PPH) commodities has improved—with heat-stable carbocystein now available in national medical stores; however, PPH remains the leading cause of maternal death in Kenya.

Newborn and Child health

Infant mortality has stagnated, and under-five mortality is improving too slowly. Limited management of sepsis and complications and weak comprehensive emergency obstetric and newborn care (CEmONC) hinder survival.

Children remain vulnerable to pneumonia, diarrhoea, malaria, and malnutrition, while inequities and low immunisation coverage slow progress.

© 2025 by the President John Mahi of the Republic of Kenya. Collaborative Action Plan (CAAP) on maternal, newborn, child and adolescent health and nutrition is a strategic economic investment in Kenya's future. It is a moral imperative — it is a strategic economic investment in Kenya's future.

Collaborative Action Plan (CAAP)  **Hennet** 

- Neonatal mortality has declined only marginally in past decade, from 22 deaths per 1,000 live births in 2014 to 21 in 2022. Stillbirth rates fell from 25 per 1,000 total births in 2014 to 15 per 1,000 in 2022, yet remain above the Global Strategy target of 12 or below.
- Under-five mortalities have fallen from 52 deaths per 1,000 live births in 2014 to 45 in 2022, however the rate of reduction is too slow to reach SDG target of at least 25 per 1,000 live births.
- While 38% of babies are breastfed, only 52% of infants aged 0-5 months are exclusively breastfed, despite the WHO recommendation of exclusive breastfeeding in the first six months.

Adolescent health

Individuals under 25 make up 30% of Kenya's population, with adolescents aged 10-19 accounting for 12% in 2024.

Despite supportive legislation guaranteeing the right to health and protection from harm, high rates of teenage pregnancy, child marriage, FGM, and increasing mental health challenges continue to slow social and economic progress and undermine adolescent well-being.

- Adolescents face persistent health risks, with 12% of girls aged 15-19 having experienced pregnancy in 2022, despite target to reduce to below 5%. When this average, there are stark regional disparities, with rates ranging from 50% in Samburu, 30% in West Pokot, compared to 5% in Nyeri and Nairobi counties.
- Pregnancy & childbirth complications are the leading cause of death among 15-19-year-old girls globally.
- Limited access to youth-friendly health services, inconsistent delivery of comprehensive sexuality education, and stigma undermine adolescent health & futures.

Reproductive health

Access to reproductive health services bolsters gender equality, strengthens families and communities, and drives national development.

Yet social, cultural, and religious norms—coupled with gaps in quality care and limited domestic financing—continue to slow progress. As a result, the right to the highest attainable standard of health, including reproductive health care as guaranteed under Article 43(1)(a) of the Constitution, is not yet fully realized for many.

- Kenya has made progress in improving access and coverage of family planning services, with 52% of married women in 2022 having access to modern contraception, compared to 53% in 2014.
- Despite this progress, 18% of married women still lack access to contraception — with significant regional variations, and some counties being upwards of 1 in 4 women without access to the family planning they need. Stockouts, suboptimal domestic financing, and stigma hinder access—especially for young people and marginalised groups.

Prioritising reproductive, maternal, newborn, child, and adolescent health in legislation is not just a health imperative—it is central to fulfilling Kenya's constitutional commitments and unlocking long-term social and economic development.

With sustained policy attention, predictable financing, and strengthened accountability, Parliament can drive the transformative progress needed for women, children, and adolescents. The decisions made now will shape a healthier, more resilient generation and deliver lasting social and economic dividends for the country.

© 2025 by the President John Mahi of the Republic of Kenya. Collaborative Action Plan (CAAP) on maternal, newborn, child and adolescent health and nutrition is a strategic economic investment in Kenya's future. It is a moral imperative — it is a strategic economic investment in Kenya's future.

"Parliament has the responsibility to deliver strong rights-based legislation that ensures coordinated, well-financed, and high-quality services."

Hon Dr James Nyikal, Chair of the Parliamentary Health Committee.



Hon Dr James Nyikal, Chair of the Parliamentary Health Committee.



Legislating to Save Lives: Strengthening the Legal Framework for Maternal, Newborn, and Child Health in Kenya
 20th November, 2025 | Fairmont the Norfolk Hotel | 7:30 AM – 11:00 AM

Background & Rationale

With only four years remaining to the Sustainable Development Goals (SDG 2030), the window to secure meaningful change for women and children is closing fast. This moment demands political will and the voice of women legislators who can reframe RMNCAHN as a national priority, ensure budgets match commitments, and hold systems accountable for results. The forum will further spotlight emerging **RMNCAHN Legislative Bills** designed to strengthen Kenya's legal framework for women's and newborns' health. It offers KEWOPA Members an opportunity to shape progressive laws and policies that ensure access to quality maternal care, adolescent sexual and reproductive health, newborn survival, and nutrition building a gender-responsive legislative agenda that delivers lasting change for Kenyan families.

To address these gaps and accelerate progress towards Universal Health Coverage (UHC), Parliament has prioritized key legislation including:

- **Maternal, Newborn and Child Health (MNCH) Bill, 2023** – to strengthen coordination, financing, and accountability for MNCH services.
- **Assisted Reproductive Health Bill, 2022** to establish a clear legal framework for comprehensive reproductive health services, including maternal, youth-friendly, and emergency obstetric care.
- **Breastfeeding Mothers Bill, 2024** – to safeguard the rights of working mothers and enhance early childhood nutrition.

These Bills collectively provide a rights-based, life-course approach to advancing Kenya's health agenda for women and children, aligned with the Constitution of Kenya 2010, SDG 3, AU Agenda 2063, and WHA commitments on maternal and newborn survival.

This **Parliamentary Dialogue** seeks to accelerate legislative momentum, foster cross-party collaboration, and build consensus for the timely passage and implementation of these priority Bills.

Meeting Objectives

1. To ensure the protection of women, newborns, and children through timely legislative reforms.
2. To strengthen Kenya's MNCH legal framework for improved maternal, newborn, and child health outcomes.

Expected Outcomes

- A unified commitment to fast-track and pass the priority MNCH and Reproductive Health laws needed to protect women, newborns, and children.
- A clear, time-bound parliamentary pathway to deliver these reforms and strengthen Kenya's MNCH legal framework.