POINT-OF-CARE ULTRASOUND (POCUS) FUNDING LANDSCAPE IN KENYA

CENTER FOR PUBLIC HEALTH & DEVELOPMENT
Saving Lives Through Innovation

HECTA CONSULTING

AN EVIDENCE BRIEF FOR GOVERNMENT AND DEVELOPMENT PARTNERS

Policy asks

- **Ministry of Health:** Issue EOI/tender for POCUS OEMs and publish minimum device standards.
- **Treasury:** Expedite disbursement of capital allocation for program lines on RMNCAH innovations within the FY 2026/27 budgets to ensure timely procurement.
- **Ministry of Health & Council of Governors:** Finalise and disseminate a costed implementation plan to accompany the POCUS Guidelines, and thereafter commit to a phased, prioritized rollout with county co-financing arrangements.

EXECUTIVE SUMMARY

Kenya's progress on reducing maternal mortality has stalled and the country is unlikely to meet SDG 3.1. Strengthening primary-level screening and clinical decision-making through Point-of-Care Ultrasound (POCUS), supported by telemedicine mentorship, offers a high-impact, scalable intervention to identify high-risk pregnancies early and reduce delays in referral and care. To realize this potential at scale, the national government must secure timely capital disbursements for MNCH innovations, issue a centralized procurement process to ensure standards and economies of scale, and provide counties with an implementation guide and costing framework to support budgetary planning.

THE PROBLEM: STALLED MATERNAL HEALTH GAINS

Kenya's maternal mortality statistics remain highly uncertain. The most recent Kenya Population Census (2019)[1] estimated a Maternal Mortality Ratio at 355 deaths per 100,000 live births, and the countdown to 2030 collaboration in Kenya provided a tentative estimate[2] in 2022 of 175—324 per 100,000 live births. Despite the uncertainty in estimation, Figure 1 below shows that there is a retardation in the rate of decline in maternal mortality over the past two decades. At the current rate, it is unlikely that the country can attain the SDG 3.1 target of less than 70 deaths per 100,000 live births by 2030. A more recent analysis[3] by the Ministry of Health, of institutional maternal mortality ratio (iMMR) reported through Kenya's Health Information System (KHIS) showed an 11% annual decline between 2011 and 2018, followed by a stagnation at 99 maternal deaths per 100,000 facility based live births between 2019 and 2022.

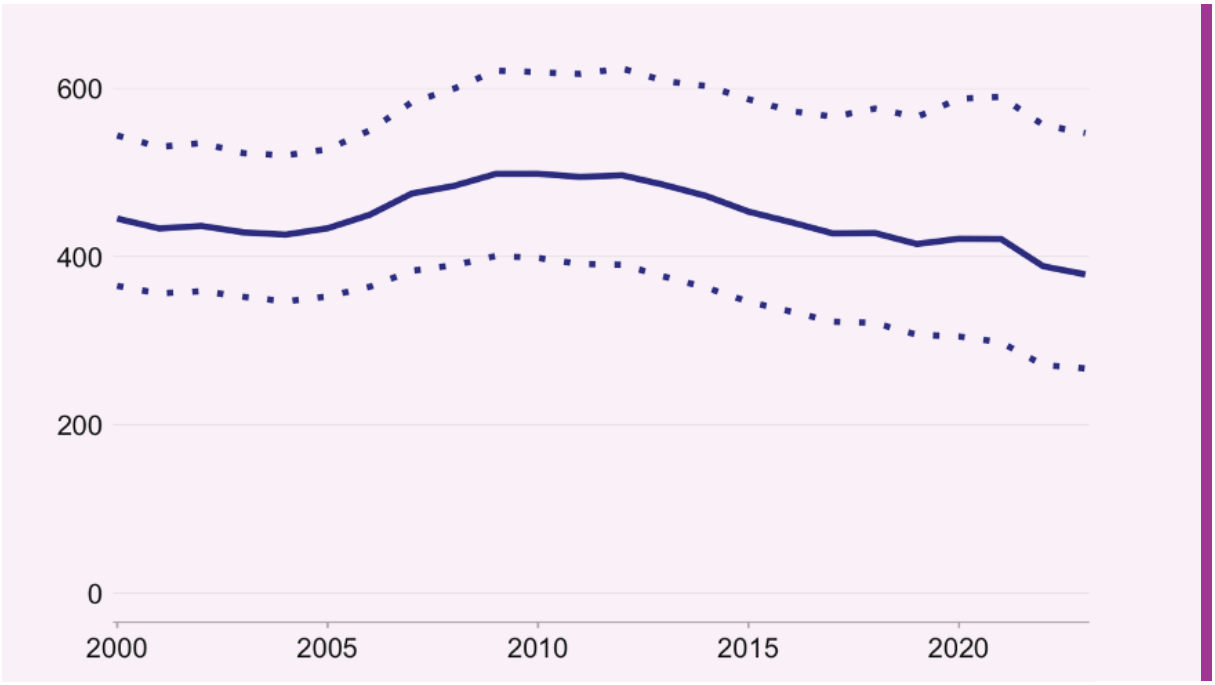

Figure 1: Modelled trend in maternal mortality ratio, Kenya. Source: WHO Global Health Observatory estimates Apr 2025

Many of these deaths stem from systematic failure to recognize danger signs in good time during pregnancy. The confidential enquiry into maternal deaths in Kenya (2017)[4] identified the leading causes of direct maternal deaths in Kenya as obstetric haemorrhage (51.1%), maternal hypertensive disorders (19.7%) and maternal sepsis (12.5%), risk factors of which are easily identifiable at antenatal clinic. Both at facility and community level therefore, the health system's failure to recognize high risk pregnancies and act appropriately in a timely manner, continues to contribute to the increased risk of maternal deaths and other adverse pregnancy outcomes.

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1 Kenya National Bureau of Statistics. 2019 Population and Housing Census (Vol 2).

2 Countdown to 2030 Data Uptake Series, Kenya, 2023. https://www.countdown2030.org/wp-content/uploads/2023/02/Data_Uptake_Kenya_Feb2023-2.pdf

3 Muthee, R., Mutua, M., Kiarie, H., Kagiri, H., Serem, E., Muchemi, S., Wabwire, S., & Boerma, T. (2025). Trends in maternal mortality and stillbirths by county in health facility data, Kenya, 2011-2022. BMC Pregnancy and Childbirth, 25(1), 932. https://doi.org/10.1186/s12884-025-07726-6

4 Ministry of Health. 2017. Confidential Enquiry into Maternal Deaths in Kenya. https://familyhealth.go.ke/wp-content/uploads/2018/02/CEMD-Summary-of-findings-Sept-3-FINAL.pdf

THE OPPORTUNITY: OBSTETRIC POCUS

The roll-out of Point-of-Care Ultrasound (POCUS) with AI-enabled screening capabilities is positioned to play a pivotal role in reducing maternal and neonatal mortality rates in Kenya. By enhancing the efficiency of screening for pregnancy-related abnormalities, POCUS can serve as an early warning system by:

- Enabling the early detection of high risk pregnancies at primary care level. Features such as the accurate determination of fetal gestational age and weight, presence of twins, fetal viability, and abnormalities in fetal and placental position are standardized and made objective.
- Promoting the real time decision making by frontline health workers at primary care level. This includes supporting documentation for timely referral of identified high risk pregnancies.
- Reduction in delays in access to higher level health facilities for appropriate care.

At the facility level, introducing POCUS can contribute to better maternal survival outcomes by building the community's trust in available health services. This increased confidence encourages more women to attend antenatal care visits and choose facility-based deliveries, thereby improving the overall use of maternal health services. At the same time, integrating telemedicine-based mentorship and training into such an approach helps strengthen the skills and confidence of frontline health workers. These support mechanisms enable providers to deliver higher-quality and more timely care, creating a reinforcing cycle of improved service delivery and greater community demand.

While the Division of Family Health (DFH) has developed a national guideline on the use of POCUS for obstetric care and endorsed an accompanying curriculum for use in training front line workers on POCUS, the absence of a detailed implementation guide and standardized costing framework presents a challenge for counties seeking to negotiate for more allocations towards their health budgets thus leaving some counties disconnected from the intricacies of implementing national policy and planning priorities.

THE CHALLENGE: CONSTRAINTS IN CURRENT FUNDING

Kenya has made progress in operationalizing the UHC related legislations of 2023 (namely the Facility Improvement Act, Primary Health Care Act, the Social Health Insurance Act and the Digital Health Act). In line with the recommendations of the 2015-2024 country RMNCAH investment case[5] , the country has recently increased the program budget allocations towards the national RMNCAH subprogram from KES 2.4 billion in FY 2024/25, to KES 4.8 in the third supplementary allocation of FY 2024/25, and to KES 6.8 billion in the FY 2025/26 budget[6] .

However, the entirety of the sub program's budget for capital investments and adoption of innovative technologies is dependent on external grants. This dependency creates vulnerability as it is not entirely assured that the funding will be available over the medium term. Furthermore, at the national level, recurrent exchequer delays and partial execution of approved health budgets have created uncertainty in resource flows, which in turn limits implementation and scale-up of life saving innovations. For example, the exchequer issue of KES 0.5 billion that was to be spent in FY 2024/25 for the procurement of specialized materials and supplies was delayed by administrative processes and has been rolled over to FY 2025/26. This resulted in a poor budget absorption index (63% for FY 2024/25) for the RMNCAH sub program[7] , which may make it difficult for the program argue for more domestic resources. At the county level, the budgetary space for primary health remains narrow, with only marginal appropriations directed towards primary healthcare (PHC) services. This leaves little room for counties to invest in new technologies such as POCUS, even when national policy signals their importance.

[5] Ministry of Health [Kenya]. (2015). Reproductive, Maternal, Neonatal, Child and Adolescent Health (RMNCAH) Investment Case. Nairobi: Ministry of Health

[6] Government of Kenya. 2025. The Program Based Budget of the National Government of Kenya for the year ending 30th June 2026. June 2025.

[7] Office of the Controller of Budget. 2025. National Government Budget Implementation Review Report FY2024/25. August 2025.

COUNTY LEVEL PRIORITIZATION AND EQUITABLE DISTRIBUTION

As at the end of 2024, a number of implementing partners have piloted obstetric POCUS in a number of counties in Kenya. These partnerships have provided support not only to training but also towards the allocation of POCUS devices, provision of associated commodities and provision of post training mentorship and quality assurance activities. As Figure 2 below shows, there is evidence of a mismatch between these pilot locations and counties with the highest institutional MMR. This misalignment is likely to contribute to overall reduced impact and further can exacerbate the inequity in county level maternal health outcomes if not corrected as part of the national rollout plan.

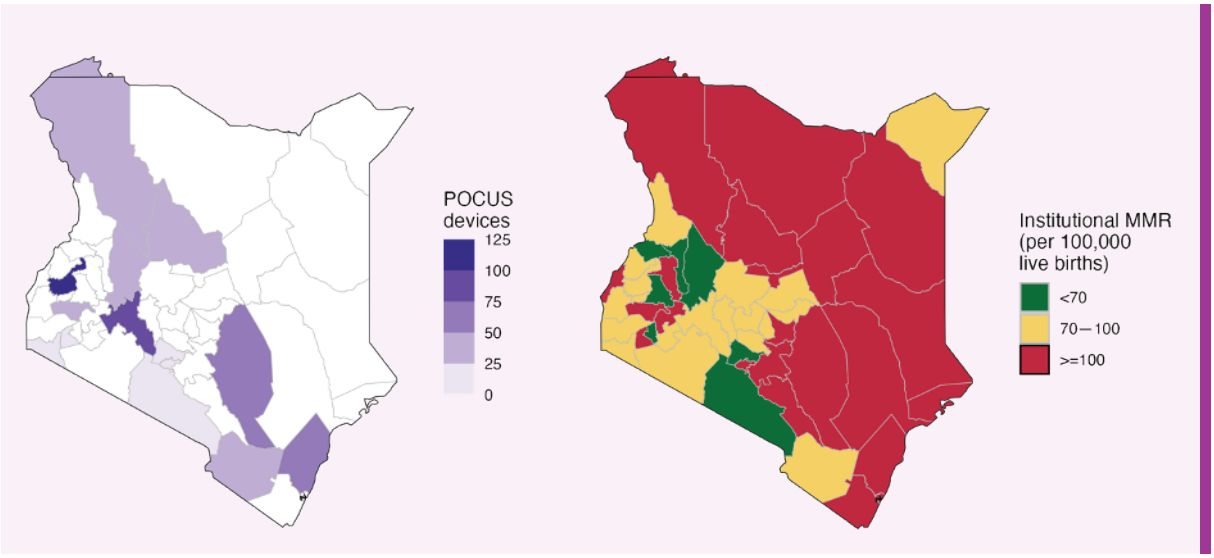

Figure 2: Geographic distribution of pilot POCUS devices in 2024[8] , versus county burden of institutional maternal mortality rates (2019-21 estimates)[9] .

[8] Landscape assessment of the funding and implementation of Obstetric Point of Care Ultrasound and other MNCNH innovations in Kenya, December 2024

[9] Muthee, R., Mutua, M., Kiarie, H., Kagiri, H., Serem, E., Muchemi, S., Wabwire, S., & Boerma, T. (2025). Trends in maternal mortality and stillbirths by county in health facility data, Kenya, 2011-2022. BMC Pregnancy and Childbirth, 25(1), 932. https://doi.org/10.1186/s12884-025-07726-6

STRATEGIC RECOMMENDATIONS FOR NATIONAL GOVERNMENT

To enable the effective adoption of POCUS across Kenya's health system, national-level budget advocacy should prioritize timely disbursement of capital allocations for essential maternal, newborn, and child health (MNCH) equipment and innovations. By safeguarding budget lines for the RMNCAH program's capital allocation, the national government can enhance budget predictability and create an enabling environment for the rollout of innovations such as POCUS, as well as facilitating more competitive market pricing for these innovations.

An immediate activity that the Ministry of Health could undertake is to expedite a national tender or Expression of Interest (EOI) to engage the Original Equipment Manufacturers (OEMs). Through volume-based bidding, Kenya can secure better prices while ensuring adherence to minimum technical standards for POCUS devices. Centralized procurement frameworks would not only reduce the cost burden on individual counties but also shorten order cycles, allowing facilities to access these essential devices in a more efficient and standardized manner.

The Ministry of Health, through the Directorate of Family Health, should finalize and disseminate a national implementation guide for obstetric POCUS. This guide would provide unit cost estimates and practical tools for planning device placement, consumables, maintenance, training, and coordination. Such a guide would better equip counties to estimate budget implications and make evidence-based budget proposals and allocations.

The initial phase of rollout should be strategically prioritized to areas of greatest need, targeting facilities within high-burden counties and established primary care networks (PCNs). To ensure fairness and impact, the selection of facilities should be based on objective and transparent criteria. These may include current levels of institutional delivery and comprehensive ANC uptake, documented burden of maternal and perinatal mortality, functionality of maternal and perinatal death surveillance and response systems, and demonstrated capacity to support PCN in-reach and referrals. This approach would ensure that early investments yield the greatest improvements in maternal and newborn survival.

Finally, continuous engagement (including budget advocacy) at county level, together with the Council of Governors, is needed to ensure that the counties are adequately informed and on board throughout the planning, procurement, and rollout process. County health departments are the main implementers of RMNCAH services and the greatest determinants of the success of adoption of these MNCH innovations. Their involvement from the outset is critical not only for fiscal planning but also for smooth integration of these and other innovations into existing service delivery models for improved quality of maternal health services.

CONCLUSION

POCUS coupled technology such as AI enabled screening and telemedicine, provides a timely and affordable innovation that can strengthen early detection of high-risk pregnancies and reduce avoidable maternal deaths. With predictable capital flows, a centralized procurement approach, and clear operational guidance, Kenya can equitably and rapidly scale POCUS where it will save the most lives. Immediate action on the three policy asks above will unlock impact and set the country on course to accelerate declines in maternal mortality.

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