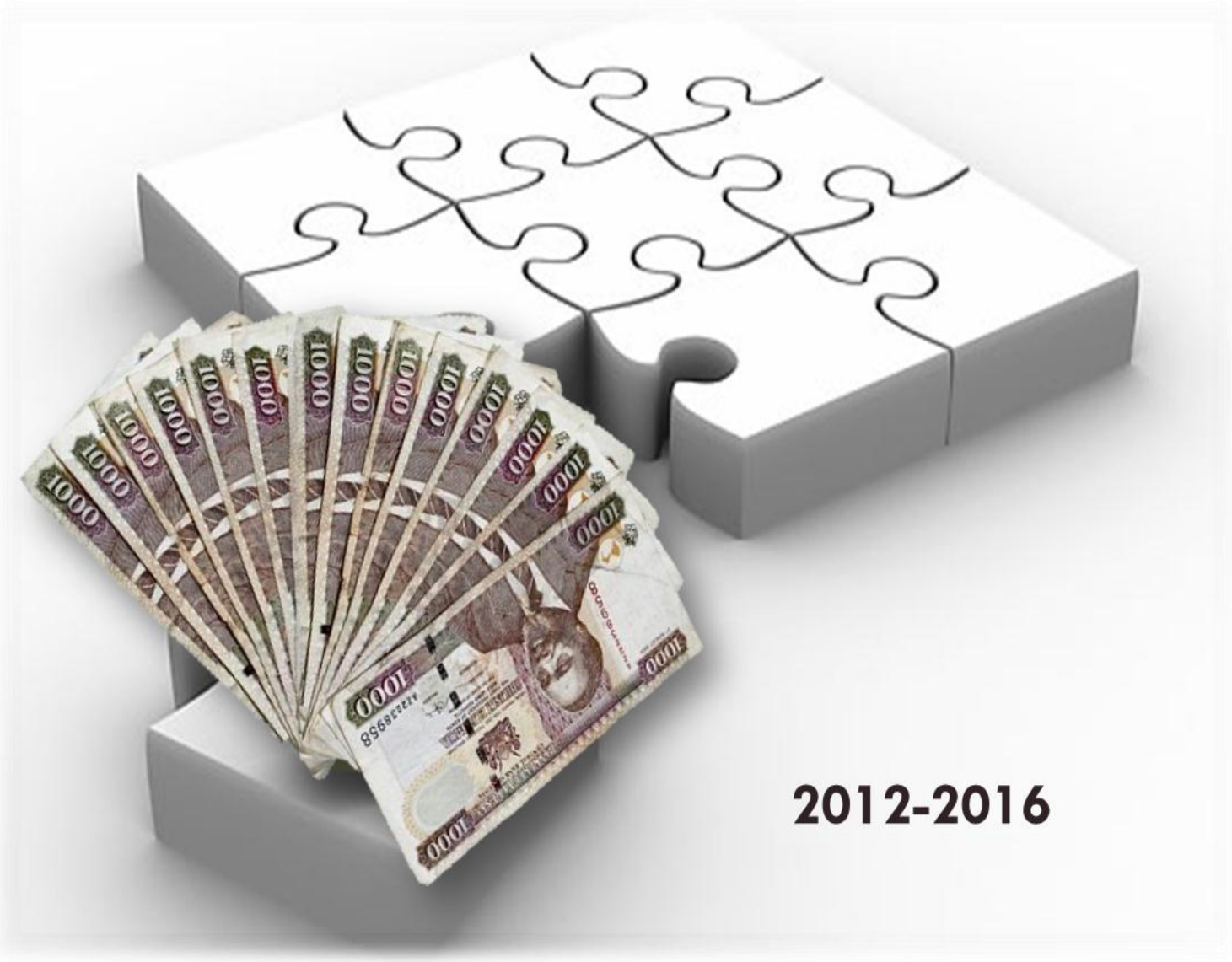
Ministry of Health

National Family Planning

Costed Implementation Plan



2012-2016

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Acronyms

AMKENI:	USAID/Kenya's Reproductive Health Project
AMUA:	GIZ's Output-Based Approach
ANC:	Antenatal Care
APHIA II:	USAID/Kenya Health and Population Program
ARH:	Adolescent Reproductive Health
ARHP:	Adolescent Reproductive Health Policy
BCC:	Behaviour Change Communication
CBD:	Community-Based Distribution
CCCs:	Comprehensive HIV/AIDS Care Centres
CFO:	Community-Facility Orientation Guide
CFPF:	County Family Planning Fund
CHEW:	Community Health Extension Worker
CHU:	Community Health Units
CHW:	Community Health Worker
CIP:	National Family Planning Costed Implementation Plan
CMO:	Community Mobilization Officer
CPR:	Contraceptive Prevalence Rate
CRHCs:	County Reproductive Health Coordinators
CSR:	Corporate Social Responsibility
CTU:	Contraceptive Technology Update
CWC:	Child Welfare Clinic
CYP:	Couple Years of Protection
DHMT:	District Health Management Team
DRH:	Division of Reproductive Health
DTC:	Decentralized Training Centres
FHOK:	Family Health Options of Kenya
FP:	Family Planning
GIZ:	German Development Cooperation
GLUK:	Great Lakes University of Kisumu
GOK:	Government of Kenya
HMO:	Health Maintenance Organization
IEC:	Information, Education & Communication
IUCD:	Intrauterine Contraceptive Device
KDHS:	Kenya Demographic and Health Survey
KEMSA:	Kenya Medical Supplies Agency
KSPA:	Kenya Service Provision Assessment Survey
LAPM:	Long-Acting and Permanent Family Planning Methods
MDGs:	Millennium Development Goals
MEDS:	Catholic Board's Medical Drugs Supply System
MOE:	Ministry of Education
MOF:	Ministry of Finance
MOH:	Ministry of Health
MOMS:	Ministry of Medical Services
MOPHS:	Ministry of Public Health and Sanitation
MOYAS:	Ministry of Youth and Sport Affairs
MSI:	Marie Stopes International
NCPD:	National Council for Population and Development
NFPSM:	National FP Social Mobilization Strategy
NGO:	Non-Governmental Organization
NYP:	National Youth Policy
OBA:	Output-Based Approach
OJT:	On-Job-Training
PAC:	Post Abortion Care
PPIUCD:	Post-Partum IUCD
PPP:	Public Private Partnerships
RH:	Reproductive Health
RRIs:	Rapid Results Initiatives
SMS:	Short Messaging Service
TL:	Tubal Ligation
TOT:	Training of Trainers
TUNZA:	Population Services International's Output-Based Approach
TWG:	Technical Working Group
UNFPA:	United Nations Population Fund
USAID:	United States Agency for International Development
YEC:	Youth Empowerment Centre
YFS:	Youth-Friendly Services

EXECUTIVE SUMMARY

The population of Kenya increased by about one million each year between 2000 through 2010 and is now one of the largest countries in Africa at more than 40 million. The population grew at a faster rate than economic indicators. Such a pattern threatens the reproductive and maternal newborn health gains that have been realized in the past and poses a big obstacle to achievement of Millennium Development Goals (MDGs) and Vision 2030. For Kenya to realize a more manageable population growth rate there is need to improve the Contraceptive Prevalence Rate (CPR) that currently stands at 45.5%. As part of interventions that will accelerate achievement of MDGs and Vision 2030, the Ministries of Health through the Division of Reproductive Health aim to raise CPR by at least 2% every year for the next five years so as to reach 56% or more by the year 2015. Interventions and activities required to achieve this increased CPR as well as the resources needed to support them are reflected in the following National Family Planning Costed Implementation Plan (CIP).

As part of efforts to reposition contraceptive services in Kenya, the Ministry of Public Health and Sanitation (MOPHS) and Ministry of Medical Services (MOMS), in collaboration with development partners and other stakeholders, have developed the following CIP for FP. This process was informed by the National Reproductive Health Policy 2007, the National RH Strategy 2009-2015, and other relevant RH/FP guidelines and policy documents. The CIP for FP presents a coherent set of actions organized by thematic areas that are expected to contribute to the national targets and are consistent with stated national policies, vision, and mission. The CIP provides a vision with clearly defined and costed activities and targets to be implemented at different levels by different organizations and institutions over a specified period of time and under the leadership of MOPHS and MOMS in order to make quality FP services more accessible and equitable. In addition, the CIP for FP will serve as a guide for development and implementing partners on areas of the National FP Program that need support.

A key focus of this CIP is youth. For all women, 15-24years old, the recent five years' change in CPR was among the highest but the rate is still too low (14.1%). Given that youth comprise 41% of all women, the continued increase in CPR by this group will have significant effects on overall CPR.

The CIP defines as five key thematic groups, and each had major priority actions with costs determined. These thematic groups were: human resources, integration, commodity security, youth, and advocacy and demand creation.

Each group underwent a systematic way of distilling out the key priority areas that kept the CPR at 46% and those that will help to accelerate it to reach 56%. These priority interventions were then costed. A total of approximately KShs. 26.6 billion is calculated to be the amount of money that is required to enable the FP program to attain the goal of reaching the CPR of 56 % by 2015/2016.

FOREWORD

Kenya had a very strong and successful family planning (FP) programme in the 80's and 90's. But at the beginning of 2000, programme funding for FP shifted to emerging epidemics such as HIV/AIDS. However, a renewed interest globally and locally has occurred around Reproductive Health due to the Millennium Development Goals, rapid population growth, and other factors. The opportunity to do much more now exists.

There is an inverse relationship between contraceptive prevalence rate (CPR) and maternal and child mortality rates; readily accessible contraceptive methods can significantly reduce maternal and neonatal mortality rates, as well as improve child survival. Use of modern contraception is also associated with reduction in rates of induced abortion. FP is efficient in preventing HIV transmission from mother to child; it is the second prong in WHO's package for the prevention of mother-to-child transmission of HIV (PMTCT). Indeed FP has been dubbed the 'social vaccine'; it is to maternal health what immunization is to child health.

The FP program in Kenya spearheaded by the MOPHS and MOMS through the DRH aims to increase access and improve quality, efficiency, and effectiveness of the FP services offered at all levels and to respond appropriately to client needs.

There have been achievements on the FP front; the KDHS results of 2009 for example show that the CPR increased from 39% to 46 %; however, the unmet FP need remained high at 25 %. Some other achievements include: a positive policy environment, an established budget line for contraceptives, a three-year quantification plan for contraceptive commodities to ensure contraceptive security, and continuing advocacy efforts working in collaboration with the National Council on Population Development (NCPD) to enhance the functions of the parliamentary Network on Population and Development. In addition, more focus has been paid to scale up of FP/HIV integration services as well as strengthening long acting and permanent methods (LAPM) and also the strengthening of the community based FP services in line with the new community strategy.

In order to accelerate the efforts to attain a CPR of 56% by 2015, the MOH with stakeholders developed the Costed Implementation Plan for FP. This plan comprises key priorities that are costed and will lead towards the attainment of the goal. In this respect, the plan will do the following: act as a powerful advocacy tool for FP, act as a guide to stakeholders on where they could direct their support, and finally, be used as a monitoring tool for the FP program.

We would like to extend our appreciation to all the stakeholders who worked tirelessly in the development of this plan. Our expectation is that this plan when implemented will not only act as a strategy to achieve the CPR goal of 56 % by 2015 but also achieve the broader MDGs and Vision 2030

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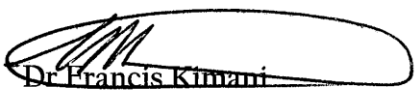

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ACKNOWLEDGEMENTS

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- Division of Reproductive Health (DRH)
- World Health Organization (WHO)
- FHI 360/Kenya and USA
- FHI 360/C-Change
- JHPIEGO
- MSK (Marie Stopes Kenya)
- I Choose Life (ICL)
- Population Council
- Management Sciences for Health/SPS
- University of Nairobi (UON)
- National Nursing Association of Kenya (NNAK)
- Aga Khan University
- IntraHealth International
- GTZ/GIZ
- United Nations Population Fund (UNFPA)
- National Council for Population and Development (NCPD)
- National Aids and STD Control Programme (NASCOP)
- Ministry of Medical Services (MOMS)
- Kenya Medical Supplies Agency (KEMSA)
- Ministry Of Youth Affairs (MOYA)
- Kenya Midwives Chapter

We would like to acknowledge the invaluable contribution of Dr. Marsden Solomon and Dr. Rose Otieno-Masaba of FHI 360, who spearheaded the development of the CIP Plan for FP, and Dr. Rick Homan, Health Economist of FHI 360, who costed the plan. Mr. Crispus Kamanga is owed a special word of thanks for being the technical team leader and for ably reviewing the background literature, collating all reviewer contributions, and producing the final draft of the implementation plan, as is Mathews Ogutu for providing the item costs. The MOPHS would like to thank the team of internal reviewers from FHI 360: Dr. Marsden Solomon, Dr. Rose Otieno-Masaba, Dr. Baker Maggwa, Bill Finger, Gwyneth Vance and Ruth Gathu.

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I. INTRODUCTION

Kenya increased in population by about one million new people each year from 2000 to 2010 and is now one of the largest countries in Africa at more than 40 million. The population grew at a faster rate than did the socioeconomic indicators. Such a pattern of development threatens the reproductive and maternal newborn health gains that have been realized in the past and is a big obstacle to achievement of the Millennium Development Goals (MDGs) and Vision 2030. For Kenya to realize a more manageable population growth rate, the Contraceptive Prevalence Rate (CPR) that currently stands at 45.5% needs to improve. As part of interventions that will accelerate achievement of MDGs and Vision 2030, the Ministries of Health through the Division of Reproductive Health aim to raise CPR by at least 2% every year for the next five years to reach 56% or more by the year 2015. Interventions and activities required to achieve this increased CPR as well as the resources required to support them are reflected in the following National Family Planning Costed Implementation Plan (CIP).

As part of efforts to reposition contraceptive services in Kenya, the Ministry of Public Health and Sanitation (MOPHS) and Ministry of Medical Services (MOMS), in collaboration with development partners and other stakeholders, have developed the following Costed Implementation Plan (CIP) for FP. This process was informed by the National Reproductive Health Policy 2007, the National RH Strategy 2009-2015, and other relevant RH/FP guidelines and policy documents. The CIP for FP presents a coherent set of actions organized by thematic areas that are expected to contribute to the national targets and are consistent with stated national policies, vision, and mission. The CIP provides a vision with clearly defined and costed activities and targets, which are to be implemented at different governmental levels by different organizations and institutions over a specified period of time, all under the leadership of MOPHS and MOMS, in order to make quality FP services more accessible and equitable. In addition, the CIP for FP will serve as a guide for development and implementing partners on areas of the National FP Program that need support. More specifically the CIP for FP will:

i. Inform policy dialogue, planning, and budgeting at the national, regional, and county (district) levels to strengthen the case for family planning within the national development agenda.

ii. Provide an opportunity for MOPHS, and the Government of Kenya, in general, to understand the budgetary needs for implementing the National FP program in an effective manner, which will achieve projected targets and make projections for the future FP needs of the country based on an increasing demand for services.

iii. Provide MOPHS/Division of Reproductive Health (DRH) with a reliable source of financial information for the FP Program, act as a basis upon which the annual operation plan for FP will be based, and be a useful guide for contraceptive commodity planning to ensure sustained commodity security.

iv. Mobilize and sustain quality resources (human, financial, technical, commodities, and equipment) that are essential for achieving cost-effective and scaled-up family planning services.

v. Develop benchmarks that will be used by the Government and development partners to monitor and support the family planning program.

A series of multi-country meetings in the region have discussed issues related to the structure and contents of a CIP approach. After exchange of ideas and experiences, stakeholders in Kenya identified five thematic areas on which to base the CIP. These thematic areas are: *Human Resources*, *Commodity Security*, *Youth*, *Demand Creation*, and *Integration and Cross Cutting Activities*.

The aim of the CIP is therefore to identify and develop, within each of the five thematic areas, priority activities that are likely to be major contributors to achieving the target of 56% CPR by 2015. The CIP emphasizes a number of issues that cut across the five thematic areas. In addition, youth, though a thematic area on its own, is cross-cutting and is thus considered in all the other thematic areas as well as during implementation. The MOH's Community Strategy also provides a point of emphasis to all the thematic areas. Integration should go beyond the health sector. The increased CPR is expected to contribute to achieving health-related MDGs and Vision 2030. These priority interventions are further disaggregated into specific activities that the Task Force consider as essential to implement of the plan. A subsequent step in developing the CIP was to estimate the resource requirements and the associated costs needed to fully implement the activities. The Task Force also envisions the CIP serving as a stimulus for partners and donors to supplement the Kenyan Government resources.

The Task Force noted as anticipated obstacles to achieving a CPR of 56% by 2015 as: limited financial resources, commodity security, political scenario (2012 elections), and geographical access such as expansiveness of the area with difficult terrains. While the DRH can attempt to address some of these obstacles in the course of implementation, most of these are outside DRH's sphere of influence. While DRH may not directly address all the obstacles it will nonetheless keep them in mind.

II. ANALYTICAL APPROACH

The development of this costed implementation plan for family planning started with the recognition by DRH that some factors led to a higher contraceptive use in the most recent five years compared to the previous periods. DRH then wished to identify these factors with a view of replicating or scaling them up. The broad steps in the CIP development process include:

1. Analyze what segments of the population had the largest changes in CPR in the past five years (age-groups, provinces, etc.).
2. Analyze the associated FP programmes and activities (or other causes) that may have led to the achievements identified in (1) above.
3. Draw lessons for the next five years with respect to how these achievements can be sustained, replicated, and scaled up.

In order to take the process forward, DRH formed a Task Force with key family planning actors/organizations, including DRH, NCPD, USAID, UNFPA, TUNZA, GIZ, and Marie Stopes (see Appendix for the members of the task force). The DRH requested that FHI 360 coordinate the work of the task force. FHI 360 hired a consultant to work with the Task Force to engage RH stakeholders in the CIP development around the five thematic areas. Specifically, the CIP development process involved the following:

1. Analyzing the CPR change of 6.2% reported in the Kenya Demographic and Health Survey (KDHS) from 2003-2008/9to identify the population segments that contributed most to the change.
2. Identifying the population segments that had a substantial change (positive or negative) in CPR and the key events associated with that change, i.e. events include potential causal factors such as policies, strategies, activities, and behaviour change.
3. Isolating the potential causal factors in (2) above that can be replicated or scaled up in the next five years (2012-2016) to lead to even larger changes in CPR. The population segments that had negative or stagnant changes in CPR were also identified in order to tailor activities to address these problem areas.
4. Given the changing landscape, identifying other complimentary factors, in addition to those identified in (3) that DRH can invest in order to gain increases in CPR.

III. DEMOGRAPHIC DETERMINANTS OF RESOURCE REQUIREMENTS

In order to lay the basis for the isolation of policies, strategies, and activities that need to be implemented, analyses of what worked well and what did not work well in the past is necessary. In particular, factors that led to increased CPR are important so that they may be replicated or scaled up. The population segments that did not register positive and significant changes also ought to be identified and addressed. In this regard, two broad objectives were set as follows:

(1) Identifying interventions that were likely responsible for past successes (possible causes for the 6.2% CPR increase between 2003 and 2008/9). Some of these activities could be selected for replication or scale up in 2012-2016 in order to maintain the current CPR of 45.5%. On the other hand, areas that did not perform well in the last five years were also examined since these would need to be addressed in order to maintain the current CPR in the midst of a growing population or to obtain an increase in CPR to 56%.

(2) Identifying new/innovative interventions that have potential to increase CPR significantly in the next five years (2012-2016). These interventions/activities are necessary as the main drivers for increasing CPR to 56%.

Based on the past successes, the aim of DRH is to raise the CPR to 56% by 2015 by maintaining the current users and add additional users to maintain the CPR of 45.5%, and by adding more new clients so that there is an additional 2% points increase in CPR each year (for five years) to reach 56% or more by 2015.

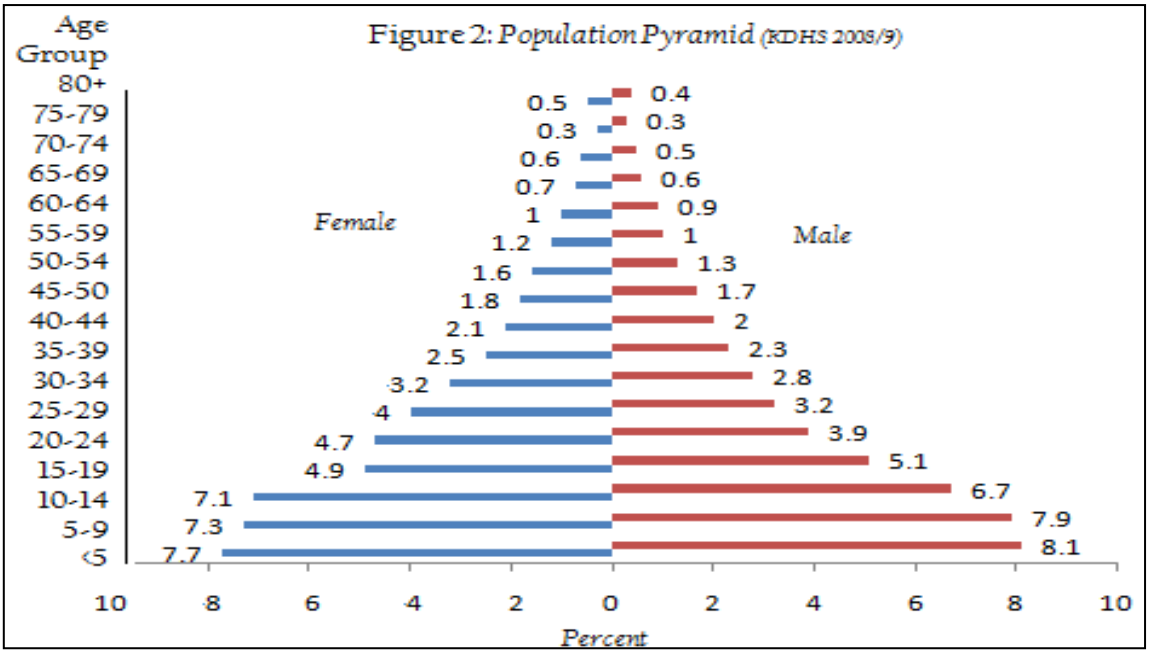
This section deals with secondary analysis of data from the Kenya Demographic and Health Survey (KDHS), the Kenya Service Provision Assessment Survey (KSPA), and various programme data to meet the two objectives above.

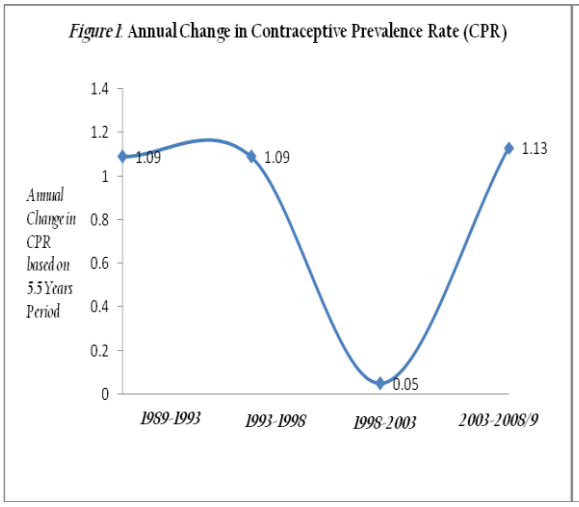
(A) Overall Change in CPR and the Possible Causes

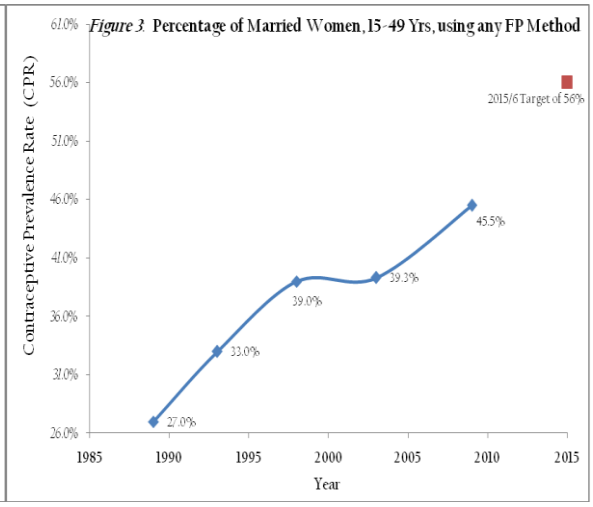
Between the 2003 KDHS to the 2008/9 KDHS there was an average annual increase of 1.13% in CPR while the annual increase between 1998 and 2003 was 0.05%. The actual change in CPR between 1998 and 2003 was only 0.3% and that of the period 2003 to 2008/9 was 6.2%, i.e., more than 20 greater than the prior five-year period!

The rate of change in CPR (Figure 1) points to some major causes for the increase in the last five years period -- causes that may have been absent or minimal in the previous five year periods. Even before an analysis of what caused the increase is done, it is important to first reflect on the overall recent population dynamics in Kenya.

Figure 2 illustrates the age-sex structure (2008 KDHS) of the Kenyan population in a population pyramid. As was the case in 2003, the household population age-sex structure is still wide at its base, as depicted by the population pyramid. The share of the Kenyan population under 15 years of age is 45%. The results of previous censuses indicate that the annual population growth rate was 2.9% per year during the 1989-1999 period, down from 3.4% reported for the 1979-1989 period. Given the age structure where 45% is made up of youth, and at a population growth rate of 2.9%, the fastest growing segment is the youth; therefore even maintaining CPR at 46% requires an increase in the total number of FP users since there is an ever increasing denominator. Based on the population growth, a target of 56% CPR (Figure 3) will be an uphill task because of the increase in youth population.







Some of the possible causes for the overall change in CPR in the past five years include:

- Increased support for family planning due to increased health sector funding after 2002 watershed general election. For instance, the actual expenditures on drugs and medical consumables were reduced by 20% from 2000/1 to 2002/3 financial year when the trend changed and there was a 40% increase by 2006/7 financial year (see Figure 6b).

- The change from an MOH-led but donor-managed procurement and distribution system to one led by Kenya Medical Supplies Agency (KEMSA)in 2006 was a major step since KEMSA had the capacity to distribute more commodities. Figures 4 and 5 show a major increase in commodity consumption as reported by facilities to KEMSA between non-KEMSA period (2004-2005) and KEMSA period (2006 onwards).

- Repositioning family planning in 2006 after a decade of focus on HIV/AIDS meant that more resources went to FP; the budget line for FP commodities increased from KShs. 200 million in 2005 to KShs. 572 million in 2010/11. Further, massive use of community mobilization for FP demand creation occurred, compared to earlier years, including use of peer educators. This focus on community mobilization was coupled with updated training for FP providers; training had previously had focused on HIV/AIDS.

- Integration of services also helped since programmes went beyond HIV/AIDS, with FP benefiting from prevention education and condoms that were provided through HIV/AIDS resources. There was more use of integrated outreach service delivery in the community where FP was one of the services.

- USAID's APHIA II program had a possible positive influence, since it put more resources in Western, Coast, Nyanza, and Rift Valley provinces, together recording an annual increase of about 400,000 Couple Years of Protection (CYP) between 2006 and 2009. There was some reduction in 2010 due to intermittent stock-outs and reduced activities of the project since it was coming to an end (see Figure 6).

Figure 4: Quantities of Commodities Consumed as Reported to KEMSA

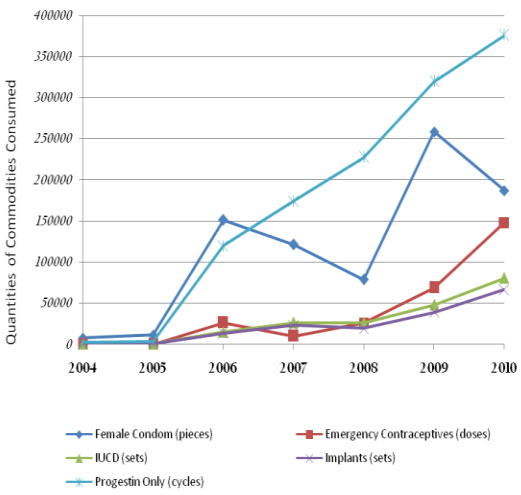


Figure 5: Quantities of Commodities Consumed as Reported to KEMSA

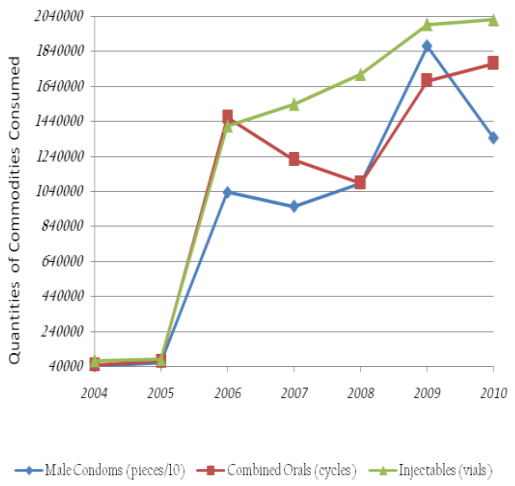


Figure 6: USAID's APHIA II Contribution to National CYPs

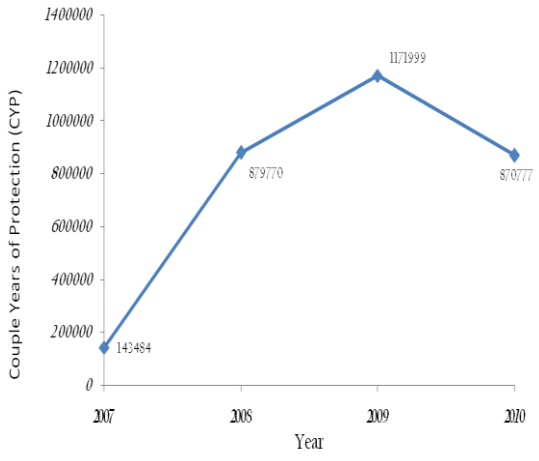
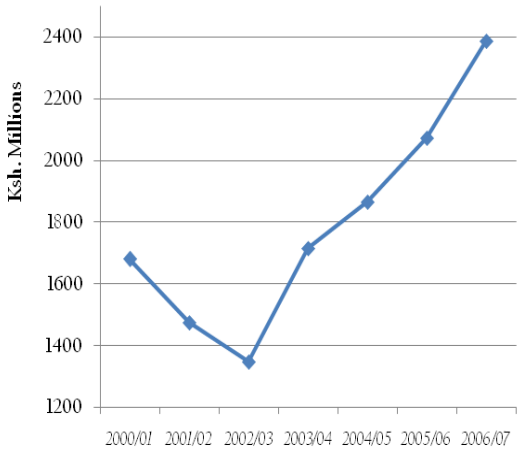


Figure 6b: Actual Expenditureon Drugs and Medical Consumables in millions



(B) Effects of Service Integration

- *Repositioning of family planning in 2006 after a decade of focus on HIV/AIDS.*

MoH and partner programs became more integrated and family planning benefited greatly from HIV/AIDS resources through improved health facility infrastructure, prevention information/education, demand creation through integrated outreaches (e.g., peer educators), and the supply of condoms. Between 2003 and 2008 DHS, there was a 3.9% increase in condom use.

- *Possible positive effects of USAID's integrated APHIA II programmes.*

The provinces that had the most significant APHIA II investments (Western, Coast, Nyanza, and Rift Valley) recorded an annual increase of 400,000 Couple Years of Protection (CYP) between 2006 and 2009. APHIA II programs were fully integrated and therefore leveraged HIV/AIDS resources for appropriate family planning activities.

(C) Effects of Women's Age, Education, Marital and Wealth status.

Age Effects

- *There has been a steady rise in Contraceptive Prevalence Rate (CPR), especially among the younger age groups.*

Apart from minimal reductions in some age groups in some years, over the last 20 years the contraceptive use by married women in Kenya has been increasing steadily (Figure 7). Although this trend has been generally similar for all age groups, the younger groups (15-34 years) have shown a sharper rise within the last five years (i.e., 2003-2008/9) with the most notable change being observed among the 30-34 year olds (9.9 percentage point increase in Figure 8), followed by 20-24 year olds (7.9 percentage points), and 15-19 year olds (6.1 percentage points).

- *Although the older age groups are the largest contributors to the current CPR, the younger age groups have shown faster increases which make them the future large contributors.*

The rate of change in CPR has been higher for the younger groups while the actual level of use is higher among the older age groups. The 30-34 years age group is particularly important in that it has both the highest rate of CPR change as well as the highest CPR. Although the 15-24 years group has the lowest CPR, its rate of change is among the highest. Given that this is also the fastest growing part of the population pyramid within reproductive age, it is critical that Kenya assures easy access to FP and creates demand for FP among the young. Younger people need youth-friendly services, and their preferred family planning methods may differ from that of the older age groups.

Although the actual CPR among the 35-39 years is relatively very high, the group has among the slowest rate of change, which may signify that the unmet need is lowest among this group and that those that wish to use FP have found a way to do so by this time. Overall, the target CPR of 56% is not found in any of the age groups, which may mean that to meet this target is a serious challenge.

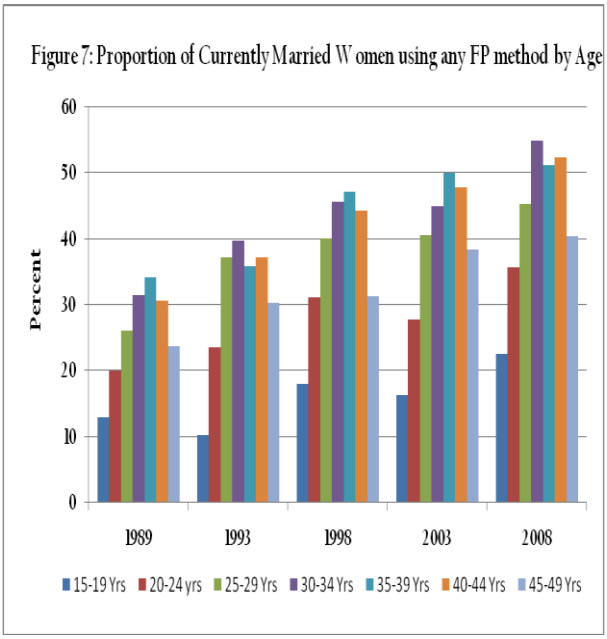


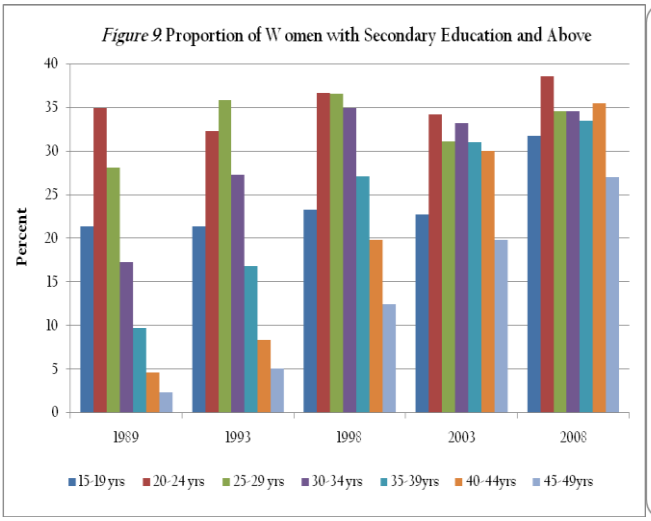
Figure 8: CPR & CPR Change 2003 – 2008 against Woman's Age

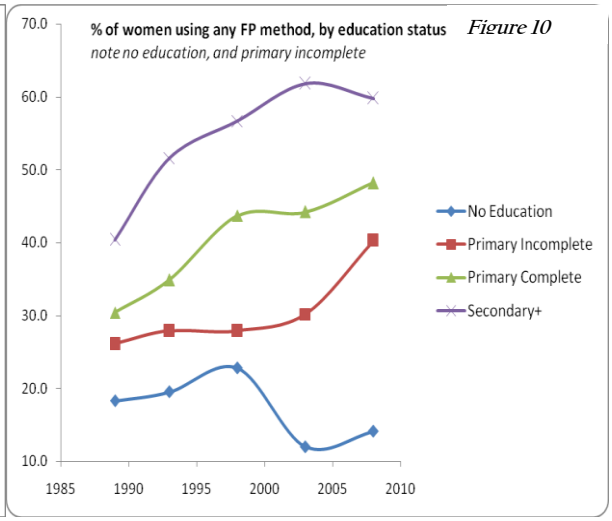
Year/Age	15-19	20-24	25-29	30-34	35-39	40-44	45-49
1989	13	20.1	26.1	31.5	34.2	30.6	23.7
1993	10.3	23.6	37.2	39.7	35.9	37.3	30.4
1998	18	31.2	40.1	45.6	47.2	44.3	31.1
2003	16.4	27.8	40.7	45	50.1	47.9	38.4
2008	22.5	35.7	45.3	54.9	51.2	52.5	40.4
Rank of 2008/9 CPR	7	6	4	1	3	2	5
CPR Change 2003 - 2008	6.1	7.9	4.6	9.9	1.1	4.6	2
Rank 2003 - 2008CPR Change	3	2	4	1	6	4	5

Effects of Level of Education and Exposure to family planning Information

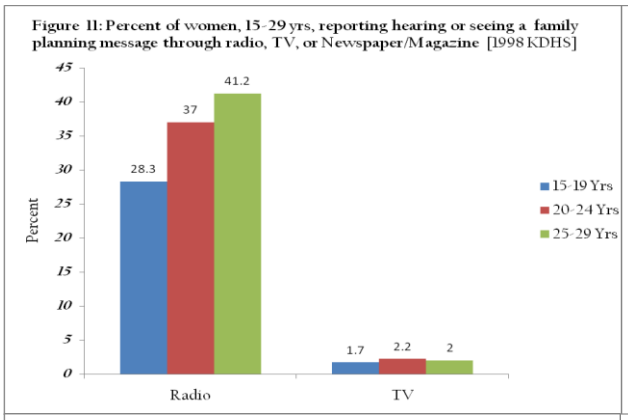
- *More involvement in secondary education (and higher) could partly explain the recent increase in contraceptive use by the youth.*

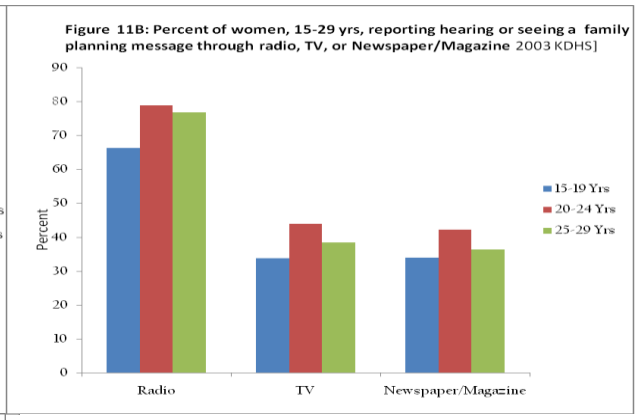
Education is a known determinant of family planning use. Attainment of higher education levels is related to CPR in two ways: a delay in childbearing to allow for education, and an increased awareness and use of family planning. In the last 20years, the proportion of Kenyan women who have attained secondary education and above has been increasing steadily. In the last five years (last two sets of bars in Figure 9), the most notable change in the proportion with secondary+ education occurred within two age groups, 15-19 years and 20-24 years. This observation points out that the current cohort of younger women is more engaged in educational activities than their past colleagues. It is important to note that only those with secondary+ have a CPR of 56% and above and that those with no education are being left behind (Figure 10). However, there has also been a general improvement in contraceptive use by those with no education and those with incomplete primary, but until the CPR gap can be closed, the CPR goal of 2015 will remain unrealized. The gain in CPR among the less educated is perhaps due to benefits from repositioning family planning efforts as well as education and condoms from the scaled up HIV/AIDS programs.

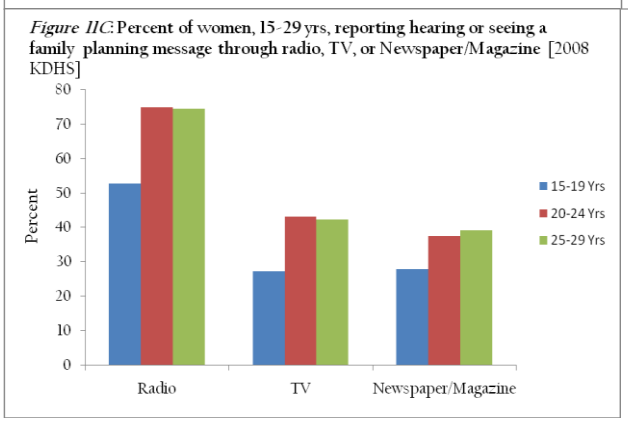




- *Most youth are getting their family planning information from the radio but over time an increasing number are also accessing information from TV and newspapers.*







For some time, DRH together with various stakeholders has been using electronic media to inform the population about family planning issues. While there is significant evidence of the effects of these interventions in the period 1998-2003, the last five years have shown a slight decline in the proportion of women (15-29yrs) reporting hearing or seeing a family planning method. The DHS data also shows that the most common source of messages is the radio and that older youth are more likely to access information compared with the younger ones.

Effect of Marital Status

There are a number of important differences in contraceptive use among married and unmarried women, and these differences also have interactions with a woman's age.

- *As expected, for all age groups, married women have generally lower contraceptive use rates than the unmarried since the marriage situation may mean desire to have children.*

According to KDHS 2008/9, there is widespread desire among Kenyans to control the timing and number of births they have. Among all currently married women, almost half do not want to have another child (49%), and an additional 5% are already sterilised. Over a quarter (27%) of married women would like to wait two years or more for their next birth, and14% would like to have a child soon (within two years). The remainder are uncertain about their fertility desires or say they are unable to get pregnant (infecund). Proportions are similar among currently married men, though men tend to be slightly more pro-natalist than women

- *There is a notable difference between contraceptive use in unmarried women between 15-19years and those between 20-24years.*

While the contraceptive use for the unmarried (aged 20-29years) is very high and rising (10%) over time, the trend is opposite for the unmarried 15-19years. This group has a much lower (by about 2.5 times) contraceptive use rate, and it has dropped sharply (22.6%) over the last five years (see Figure 12). Although unmarried adolescents may have a lower contraceptive use rate due to the fact that they have lower rates of sexual encounters, Figure 13 shows that this may not fully explain the drop since the proportion (among those who had sex one month) currently using a modern method has reduced by about 15% from 2003 to 2008 (according to the DHS).

Figure 12: Proportion of sexually active women using any FP method by marital status and age

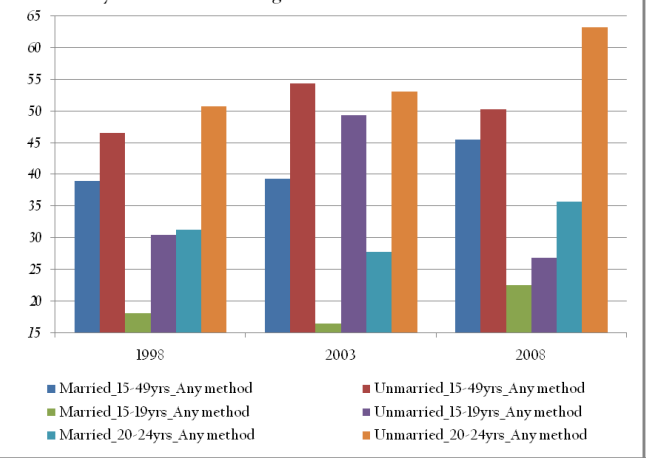
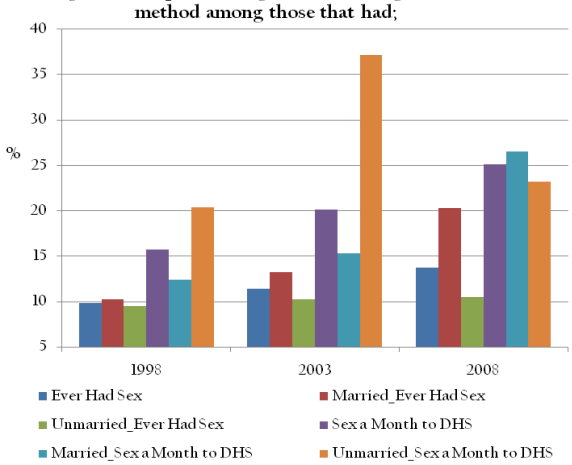


Figure 13: Proportion of girls, 15-19, using a modern FP method among those that had;



- *Nearly a quarter (21.3%) of the unmarried women, 20-24years, have ever used an emergency contraceptive.*

Over the years the percentage of all women who have ever used an emergency contraceptive never reached 3.5% up until 2008/9 DHS. However, the percentage of sexually active *unmarried* women that have ever used an emergency contraception method is very high (21.3% for 20-24years, 9.2% for 25 years+, and 5.8% for 15-19 years). Some of these differences may be explained by the possibility that the 20-24years are more empowered as they may have jobs and are staying away from parents. Since these youth are more worried about getting pregnant than sexually transmitted diseases, there is need for targeted mobilization to shift to a more regular contraceptive method to protect against unintended pregnancies. Interventions should also focus on condom use for dual protection of pregnancy and STIs, including HIV.

- *For all women, 15-24years, the recent five years' change in CPR was among the highest but the rate is still too low (14.1%).*

Given that this group comprise 41% of all women, the continued increase in CPR by this group will have significant effects on overall CPR.

- *Overall, the contraceptive rate for all unmarried women, 15-49years, has dropped by about 4% points in the last five years, which is perhaps due to the drop in contraceptive use by the 15-19years age group.*

Among girls, 15-19years, nearly a third (26.7%) has ever had sex. Among these, only about 10% are currently using a modern method -- a very low rate that has not changed over the last 10 years. Since 1993, when the unmet need for all women (15-19 years) was over 40%, there was only one period of significant reduction (1998) to about 27%. Since then the unmet need for this group has been rising by about 2% every five years and now stands at about 30%. Further, these users have over time shifted from using pills to the use of injectables and condoms.

- *The proportion of married adolescents (15-19yrs) who have ever had sex and are currently using a modern method is 20.3% which is almost twice that of the unmarried (10.3%).*

The urban adolescents who have ever had sex and currently using a modern (24.8%) method is more than twice that of the rural (10.8%).The contraceptive use (modern method) by unmarried adolescents (15-19years) with recent sexual activity (30 days prior to survey) has reduced drastically (37.1% in 2003 and 23.2% in 2008/9).Overall, the highest rate of use of modern method by adolescent girls who have ever had sex is 28.5%, which is in Nairobi Province. It is important that DRH further investigate the causes for these findings.

- *While the majority of women access their family planning methods from public facilities, adolescent girls tend to use private pharmacies.*(Source: *Levels, trends and determinants of contraceptive use among adolescent girls in Kenya*, Population Council, February 2011).

The data suggests that adolescents are looking for a quick fix at the pharmacies since public facilities may be perceived as bureaucratic and costly. So they go to private sector to buy pills and injectables and also buy condoms at Ks.10 per condom rather than getting them for free from public facilities. Adolescents may also face more provider bias at the public sector, another factor supporting use of pharmacies for adolescents. Also, a major project with pharmacies several years ago worked to establish youth-friendly points of service for youth.

Effect of Wealth Status: The DHS reveals that demand for FP is increasing across all wealth quintiles from 2003 – 2008/9, but unmet need is rising only in the lowest wealth quintile. This suggests some success in demand creation, but less success in expanding access to FP services and especially to the poorest groups.

Effect of Number of Children: As expected the various DHS reports indicate that the probability of FP use increases with parity. This CIP will continue to advocate for the sustainable family sizes through advocacy for implementation of the current population policies.

(D) Regional Variations in CPR

- Table 14 shows that there is increasing demand for FP across Kenya (except NE), plateauing in Central, and rapid increases in Western, Nyanza& Coast. Table 15 shows regional and age interactions in CPR.

Table 14: Regional Variations in CPR

Province	CPR 2008/9 (%)	CPR Change from 2003 to 2008/9 (percentage points)	Rank of 2008/9 CPR	Rank of 2003 to 2008/9 CPR Change
Nairobi	55.3	4.6	2	5
Central	66.7	0.3	1	8
Coast	34.3	10.2	7	3
Eastern	52.0	1.4	3	7
North Eastern	3.5	3.3	8	6
Nyanza	37.3	12.6	6	2
Rift Valley	42.4	8	5	4
Western	46.5	19.2	4	1

Table 15: Regional and Age Interactions in CPR				
Province *(ranking of overall CPR change for married women 15-49 years from 2003 to 2008/9)*	% of girls, 15-19yrs., currently using a modern method among those who have ever had sex			CPR *(change among 15-19 yrs., from 2003 to 2008/9)*
	1998	2003	2008/9	
Nairobi *(5)*	20.4%	15.6%	28.5%	12.9% *(1)*
Central *(8)*	13.9%	14.4%	25.6%	11.2% *(2)*
Coast *(3)*	4.8%	11.4%	22.0%	10.6% *(3)*
Eastern *(7)*	15.5%	21.2%	10.2%	-11.0% *(7)*
Nyanza *(2)*	7.1%	9.3%	15.0%	5.7% *(4)*
Rift Valley *(4)*	7.6%	11.4%	7.3%	-4.1% *(6)*
Western *(1)*	2.8%	9.6%	11.9%	2.3% *(5)*

- In Nairobi and Central, where the overall CPR change (15-49 yrs) was minimal, the CPR change for 15-19 years was relatively higher than in other provinces. Since the population of younger women is currently higher than before, and as older women age out of contraceptive use, this dynamic could explain the greater change in use by the younger group. In Western, CPR change (15-49 years) was the highest among the provinces but its younger women (15-19 years) had among the lowest relative CPR change, which may indicate that recent scale up of services in the province were largely taken up by older women whose unmet need was higher.

- There are big problems with Eastern and Rift Valley Provinces, where the percent of those 15-19 years using a modern method decreased in the past five years. DRH, through this CIP, needs to work with partners to investigate the causes and address the problem.

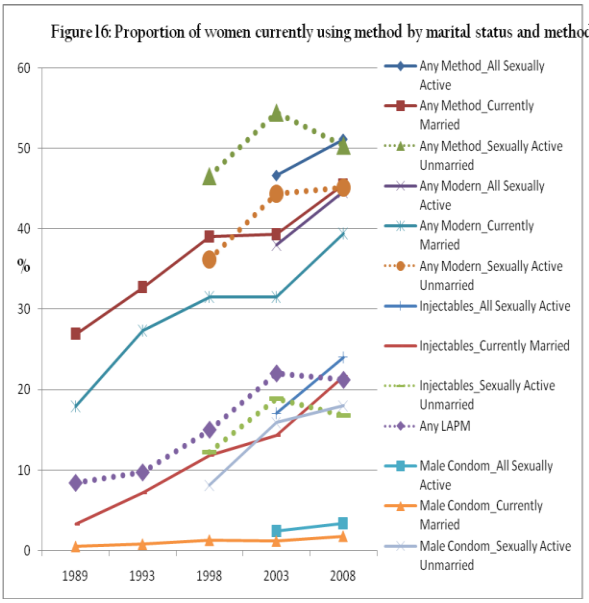
(E) Method Preferences

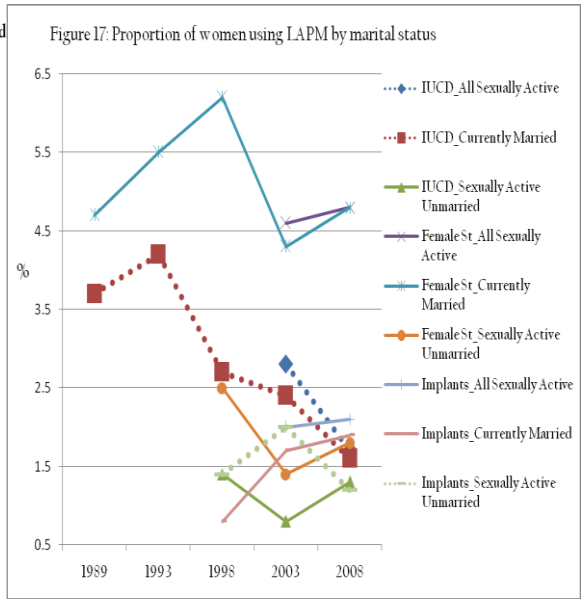
- Figures 16 and 17 show that the use of injectables continues to be the method of choice by most women, and that its use has been raising sharply over the last 20 years. Meanwhile, the use of the pill has stagnated over the 10 years. The use of male condom, though much lower than the injectables and the pill, continue to rise steadily largely due to use by youth. Although data is not presented in this CIP, the DHS 2008/9 shows that while overall use of emergency contraceptives is low, but its use by the unmarried women 15-29years is high.

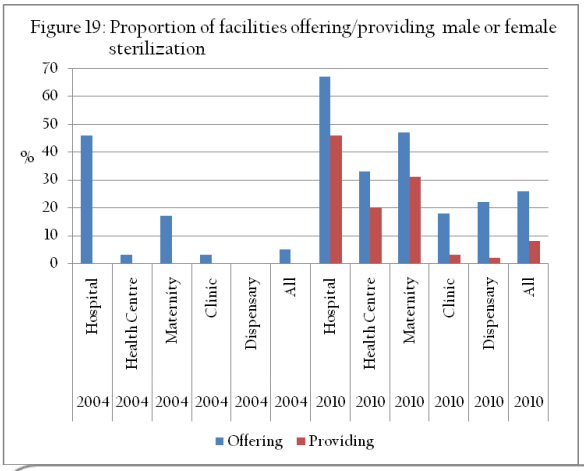
- The DHS 2008 shows a declining use of permanent and long-acting methods over the last five years. This could be due to provider bias which has resulted in reduced knowledge of these methods. Another possible reason is that it is not being offered by a majority of health facilities due to stock-outs. Further, the proportion of women 15-49 years who are aware of long-term and/or permanent methods (LAPM) has been declining except for knowledge of implants, which has remained steady or increased slightly.

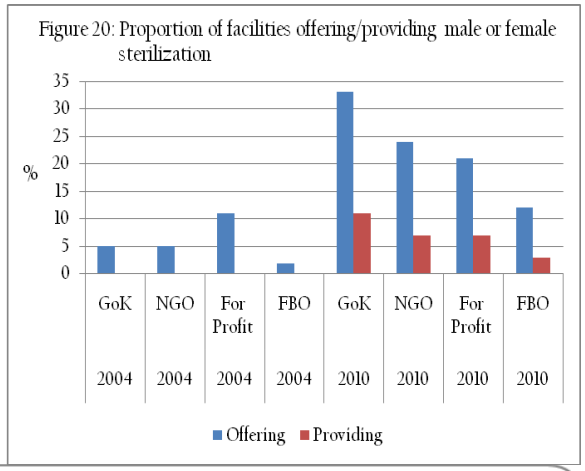
- The Kenya Service Provision Assessment Survey (KSPA) shows that although the proportion of facilities offering female or male sterilization has increased significantly from 5% in 2004 to 26% in 2010, only 8% of health facilities were actually providing the service in 2010. There are also regional and other variations in the proportion offering or providing male or female sterilization.

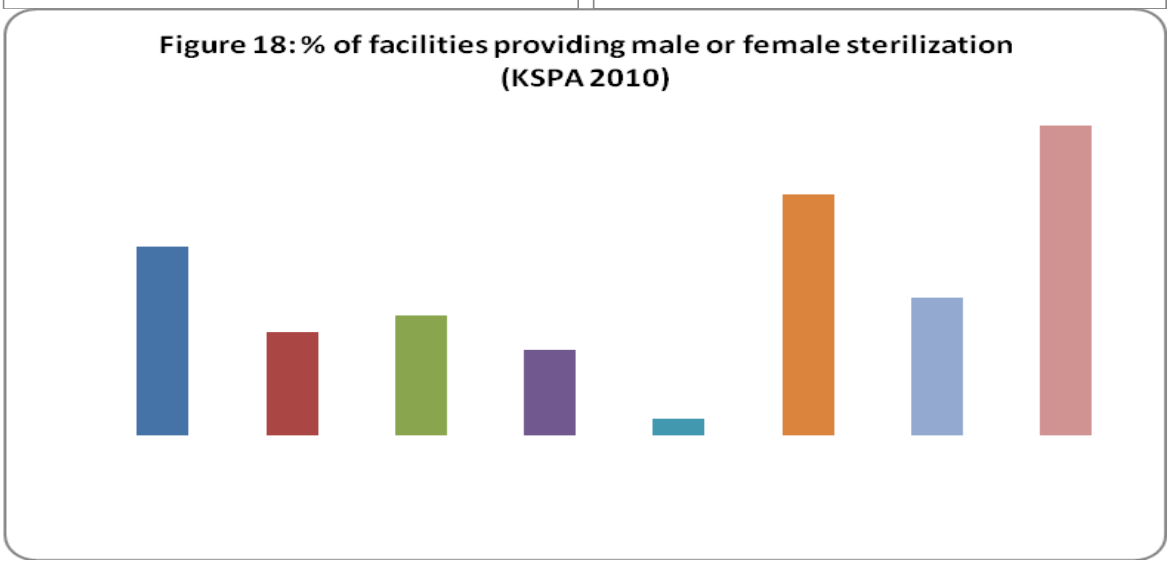
- KSPA 2010 has shown that Western and Nyanza had the highest proportion of health facilities offering female sterilization. These regions of high LAPM use coincides with AMUA intervention regions which had been selected on the basis of 2003 DHS findings that showed that these regions had low LAPM utilization. One may conclude that AMUA had significant effects as shown by the higher proportions of health facilities offering Bilateral Tubal Ligation(BTL) in Western, Nyanza, and Coast (Figures 18 and 19).











IV. NATIONAL FAMILY PLANNING COSTED IMPLEMENTATION PLAN

This section outlines the proposed key activities that need to be implemented in order to maintain the current contraceptive use of 46% as well as accelerate it to 56% or more by 2015. The activities have been grouped into five thematic areas: *Human Resources*, *Commodity Security*, *Youth*, *Demand Creation*, *and Integration and Cross-Cutting Issues*. For each theme, a few possible key causes of change in CPR in the past five years are provided to lay the basis for selection of some activities.

After consultations, document reviews, stakeholder meetings, and analysis of secondary data (determinants of resource requirements), a number of interventions and activities were agreed upon for each theme. Table 16 below outlines the estimated resource requirements to support the priority interventions summarized by thematic area and fiscal year. Resource requirements for specific interventions are presented by thematic area below; a complete summary table by thematic area, intervention, and activities is at the end of the document (Table 22). For each theme, the interventions (and related activities) have been grouped into two categories as stated earlier. First are those interventions/activities required for maintaining the CPR of 46%; these relate to past activities that need to be continued (or scaled up due to population increase) and costed. The ones for raising CPR to 56% are those new or innovative activities, or the same activities but different approaches that need to be implemented so that there can be additional increase in CPR.

Table 16: Estimated Resource Requirements by Thematic Area and Fiscal Year

	Estimated Cost (KShs.)			
Thematic Area	**2012/13**	**2013/14**	**2014/15**	**2015/16**
Human Resources	7,500,594,000	2,674,991,000	1,684,458,000	1,660,000,000
Commodity Security	1,157,826,000	1,286,703,000	1,469,863,000	1,662,453,000
Youth	1,500,154,000	1,434,403,000	1,419,213,000	1,419,967,000
Demand Creation	461,589,000	346,094,000	357,838,000	354,880,000
Integration & Cross-Cutting Issues	165,849,000	35,323,000	20,636,000	18,242,000
Total	***10,786,012,000***	***5,777,514,000***	***4,952,008,000***	***5,115,542,000***

The total amount needed to attain the goal of 56% CPR by 2015 is 26,631,076,000Kshs, or about 26.6 Billion KShs.

1. Human Resources

Possible causes of CPR change in the past five years

- Significant capacity building efforts were undertaken in the last five years. DRH conducted comprehensive RH training in 2006 with nine focal areas-- this replaced the earlier six-weeks training approach. APHIA II also conducted various trainings. There was also EHS training supported by DFID. In addition, DRH with support from partners conducted on-job-training (OJT) that started with AMKENI and was later taken up by APHIA II and AMUA in its Social Franchising program.

- Since the types of contraceptive methods offered change over time, continual training for providers is important. Training aims to improve the quality of counselling, management of complications or side effects, and providers' judgment and skills in assessing which contraceptive methods are most suitable for individual clients. However, among the interviewed family planning service providers, only about one-quarter reported receiving any family planning-related training during the 12 months preceding the KSPA 2010 survey (same as in 2004). There is little difference in the proportions of providers who report receiving training in various topics in the preceding 12 months, ranging from 14% receiving training in IUCD insertion/removal to 20% receiving training in family planning counselling.

- Supervision of family planning providers in Kenya is common. Supervision of individual staff members helps to promote adherence to standards and to identify problems that contribute to poor services. If at least half of the interviewed family planning service providers at a facility reported having been personally supervised during the six months preceding the survey, the facility is considered to have routine staff supervision. Supervision of family planning providers is common; 81% of family planning facilities met the criteria for routine staff supervision (a slight decline from 87% in 2004); health centres (94%) are more likely to meet the criteria for routine staff supervision than other types of facilities. Government facilities (92%) and facilities in Eastern and Nyanza provinces (93% and 92%, respectively) are among the most likely to have routine staff supervision activities.

Activities to maintain 46% CPR, based on what worked well and by addressing past gaps

Human resource is the most significant factor in the health system. The RH stakeholders meeting determined that six human resource areas need to be addressed in this CIP in order to maintain the CPR momentum created in the past five years. Although KSPA data showed that staff supervision is common in health facilities, there was a slight decline in proportion of facilities supervised. This finding, and the need to address other management gaps that may exist, require that this CIP continue to address leadership, management, and coordination of FP/RH programmes. Based on the knowledge of participating stakeholders, the stakeholders agreed that the priority areas that need to be addressed are:(1) Improve leadership, management, and coordination of FP/RH programmes, (2) Build technical capacity of service providers to offer quality services, (3) Increase staff productivity through facility staff development and support supervision, (4) Improve effectiveness of training by streamlining, rationalization, consolidating, and coordination of existing training systems, (5) Increase technical capacity of service providers to offer quality services by addressing poor performing areas, and (6) Increase institutional and human capacity to develop and implement effective monitoring and evaluation/management information (M&E/MI) systems. The estimated resource requirements for these interventions are shown below.

Table 17a: Human Resources: Interventions to Maintain 46% CPR

	Estimated Cost (KSh.)			
Intervention	**2012/13**	**2013/14**	**2014/15**	**2015/16**
1.1. Improve leadership, management, and coordination of FP/RH programmes	1,186,000	228,000	228,000	25,000
1.2. Build technical capacity of service providers to offer quality services	7,323,220,000	2,531,772,000	1,533,093,000	1,526,400,000
1.3. Increase staff productivity through facility staff development and support supervision	98,925,000	97,449,000	97,449,000	97,449,000
1.4. Improve effectiveness of training by streamlining, rationalization, consolidating, and coordination of existing training systems	15,929,000	6,908,000	6,908,000	6,908,000
1.5. Increase technical capacity of service providers to offer quality services by addressing poor performing areas	7,817,000	9,304,000	9,234,000	1,884,000
1.6. Increase institutional and human capacity to develop and implement effective Monitoring &Evaluation/Management Information (M&E/MI) systems	12,673,000	1,596,000		1,596,000
Total Resources Required to Maintain 46% CPR	***7,459,750,000***	***2,647,256,000***	***1,646,911,000***	***1,634,262,000***

New/Innovative activities to accelerate CPR to 56%

The following list of human resource activities are based on gaps in the program and clear opportunities that exist to further increase CPR. This CIP recommends increased support for family planning through use of champions to complement the efforts of DRH senior managers, increased capacity of service providers for delivery of quality services by improving pre-service curriculum, increased utilization of LAPM services (through pre-service training, continuing medical education, and on-job training), and increased capacity of service providers and facilities to offer natural family planning methods for clients attended in religious institutions and as an entry point to other methods of FP. The resources required to support these interventions as well as the total resources required to support human resource interventions are shown in Table 17b.

Table 17b: Human Resources: New/Innovative Activities to Accelerate CPR to 56%

	Estimated Cost (KSh.)			
Intervention	2012/13	2013/14	2014/15	2015/16
1.7. Increase support for family planning through use of champions to complement the efforts of DRH senior managers	*1,850,000*	*880,000*	*880,000*	*880,000*
1.8. Increase capacity of service providers for delivery of quality services by improving pre-service curriculum	*2,855,250*	*1,997,250*	*528,750*	-
1.9. Increase utilization of LAPM services through pre-service training, continuing medical education, and on-the-job training	*24,858,333*	*24,858,333*	*24,858,333*	*24,858,333*
1.10. Increase capacity of service providers and facilities to offer natural family planning methods to religious clients and as an entry method	*11,280,000*	-	*11,280,000*	-
Total Resources Required to Accelerate CPR to 56%	*40,844,000*	*27,736,000*	*37,547,000*	*25,738,000*
Total Human Resources Required	*7,500,594,000*	*2,674,991,000*	*1,684,458,000*	*1,660,000,000*

2. Commodity Security

Possible causes of CPR change in the past five years

- Establishment of a commodities' budget line item in 2006 ensured ring-fencing of a commodities' budget.

- Change from MOH-led but donor-managed procurement and distribution system to KEMSA. The procurement system under KEMSA had a higher distributional capacity. The transition to KEMSA resulted in annual commodity volume distribution increases (from the 2005 baseline) that ranged from 25% to 113% depending on the commodity.

- Increased availability of male condoms from the HIV/AIDS programmes. Prevention messages through media, billboards, and other angles resulted in very strong promotion.

- Availability of female sterilization in Western, Nyanza, and Coast provinces due to AMUA programme. KSPA has shown that Western and Nyanza had the highest proportion of health facilities offering female sterilization. These provinces were targeted by AMUA based on 2003 DHS findings, which revealed that these provinces had much lower LAPM utilization compared to other provinces.

- The establishment and functioning of Multi-Partners Logistics Working Group in 2008 helped to monitor continuous contraceptive quantification exercises by DRH and KEMSA leading to the development of the 2009-2012 Contraceptive Procurement Plan. The revitalization of the Family Planning Technical Working Group may also have contributed.

- Some donors extended technical assistance to DRH and KEMSA in form of resident experts.

Activities to maintain 46% CPR-based on what worked well and by addressing past gaps

Given the rising population especially among the youth and the actual rising contraceptive use by the younger women, increasing the availability of contraceptives is very important. This CIP plans to lobby the Ministry of Finance for increased financial allocation based on the commodity requirement projections annexed in the CIP.

One of the challenges that still persist in the health sector is the weak capacity of facilities to forecast, request, and report on commodities use. This CIP has included activities aimed at building the facilities' capacity in this regard.

KEMSA is a critical cog in the commodities' supply chain. The CIP includes activities to further build the capacity of KEMSA as well as explore other complementary commodity distribution channels including private sector or non-governmental organizations.

Further, the DHS 2008/9 has revealed that the proportion of commodities distributed through the Community-Based Distribution (CBD) system has been declining over the last five years. The CIP will revitalize the CBD as an integral level in the FP commodity supply chain.

The resources required to support theses interventions are estimated below.

Table 18a: Commodity Security: Interventions to Maintain 46% CPR

	Estimated Cost (KShs.)			
Intervention	2012/13	2013/14	2014/15	2015/16
2.1. Lobby for increased allocation for family planning in the national budget	*1,097,165,000*	*1,252,490,000*	*1,429,665,000*	*1,633,525,000*
2.2. Increase access to family planning commodities by improving the efficiency of commodity requests &distribution systems	*28,201,000*	*15,525,000*	*21,785,000*	*10,505,000*
Total Commodity Resources Required to Maintain 46% CPR	*1,125,366,000*	*1,268,015,000*	*1,451,450,000*	*1,644,040,000*

New/Innovative activities- to accelerate CPR to 56%

Past output-based approaches (OBA) such as AMUA, TUNZA, and others have demonstrated that these approaches can successfully reach disadvantaged groups such as poor women with maternal and child health services. DRH plans to work with partners implementing OBA activities to ensure that these become avenues for commodity access to targeted population segments.

DHS further analysis carried out by Population Council revealed that nearly all sexually active uneducated adolescent girls (15-19 years) and about a third of all the other adolescents access their contraceptives from private pharmacies. Further, while the percentage of all women who have ever used an emergency contraceptive never reached 3.5% by 2008/9 DHS, the percentage of sexually active unmarried women that have ever used an emergency contraception method is very high (21.3% for 20-24years, 9.2% for 25+, and 5.8% for 15-19 years). These findings generally point to the need to have some interventions at private pharmacies where the youth are increasingly accessing emergency contraceptives. This CIP plans to build the capacity of all registered private pharmacies to provide short-term methods.

In order to expand the access to family planning services, DRH will advocate for the inclusion of family planning services as part of standard medical packages offered by Health Maintenance Organizations (HMOs) and insurance companies. The CIP also plans to lobby and advocate for direct funding or advocacy for funding for FP commodities by various corporate bodies through their Corporate Social Responsibility (CSR).DRH will advocate for an expanded methods mix which will endeavour to provide a wide range of choices to meet the needs of the clients

The resources required to support these interventions as well as the total resources required to support commodity security interventions are shown in the table below.

Table 18b: Commodity Security: New/Innovative Activities to Accelerate CPR to 56%

	Estimated Cost (KShs.)			
Intervention	**2012/13**	**2013/14**	**2014/15**	**2015/16**
2.3. Increase the use of innovative and/or non-standard approaches for effective access to, and utilization of, commodities	32,460,000	18,689,000	18,413,000	18,413,000
Total Resources Required to Accelerate CPR to 56%	***32,460,000***	***18,689,000***	***18,413,000***	***18,413,000***
Total Resources Required for Commodity Security	***1,157,826,000***	***1,286,703,000***	***1,469,863,000***	***1,662,453,000***

3. The Youth

Possible causes of CPR change in the past five years

- Between 2003 and 2008/9, female youth (15-24years) had among the highest rate of CPR change (15-19, 6.1%; 20-24, 7.9%), although the actual use is still low (14.1%). These changes contributed to overall CPR and were perhaps due to benefits from HIV/AIDS programme promoting condoms and education, increased secondary school enrolment, and media-based FP messages especially through the radio.

Activities to maintain 46% CPR-based on what worked well and by addressing past gaps

In order to maintain the CPR of 46%, the CIP recognises that the rapidly increasing youth population will require serious attention. Advocates will need to utilize the CIP to lobby the Government to provide resources to fully implement the Adolescent Reproductive Health and Development Policy (ARH&D). These efforts need to include strengthening the community component of youth reproductive health programme. According to DHS, condom use among the youth has increased over the last five years, but the use of emergency contraceptives in the same age group has also increased. The CIP plans to increase the availability and promotion of condoms as providing dual protection against pregnancy and STIs, including HIV.

Although not strictly specific to family planning, the Kenya Service Provision Assessment Survey (KSPA 2010) revealed that only 7% of health facilities with an HIV testing system offered youth-friendly services (YFS). There is therefore a need to increase the availability of YFS (for family planning), and the CIP has planned some activities in this area.

The resources required to support these interventions are shown below.

Table 19a: The Youth: Interventions to Maintain 46% CPR

	Estimated Cost (KShs.)			
Intervention	**2012/13**	**2013/14**	**2014/15**	**2015/16**
3.1. Fully implement the GOK Adolescent Reproductive Health and Development Policy (ARH&D)	1,451,236,000	1,422,770,000	1,414,330,000	1,415,220,000
3.2. Strengthen the community component of youth reproductive health programme	26,824,000	11,497,000	4,747,000	4,747,000
3.3. Increase availability of condoms as a dual protection against pregnancy and STIs, including , HIV	3,055,000	-	-	-
3.4. Increase availability of youth-friendly services (YFS)	4,524,000	-	-	-
Total Resources Required to Maintain 46% CPR	***1,485,638,000***	***1,434,267,000***	***1,419,077,000***	***1,419,967,000***

New/Innovative activities- to accelerate CPR to 56%

As stated elsewhere, the contraceptive use (any method) among women 15-24 years is still relatively very low (below 15%) but increasing. Given the large contribution (about 41%) of the youth to the total population, it will be an uphill task to raise CPR to 56% by 2015. To address this challenge, this CIP has planned a number of new/innovative activities.

In line with the current trends in the use of information technology (internet, TV, mobile etc) by the youth, this CIP proposes partnering with a mobile service provider to design and implement a Short Messaging Service (SMS)-based family planning information activity where the youth and adolescents can send and receive information on pregnancy, HIV/AIDS, and STI prevention. In addition, DRH will work with a youth-led private company or NGO to establish a social media network (riding on Facebook, Twitter, etc.) that facilitates exchange of relevant information and experiences about life skills, including contraceptive use and abuse. Further, DRH will work with a private company or NGO, or media house to develop a behaviour change communication strategy that is branded so that the youth can own and use it.

Given the important role that private pharmacies play as a source of contraceptives for the youth, DRH will build the capacity of these pharmacies so that they can have referral systems for long-acting methods, as well as availability of subsidised emergency contraceptives and condoms. This activity will start with private pharmacies targeted for OBA and envisions expansion to others over time.

Since family planning is not a disease and factors affecting reproductive health among the youth occur outside the health system, services for youth need to extend beyond the health sector. The CIP proposes that DRH holds meetings with Ministry of Youth and Sport Affairs (MOYAS) to incorporate family planning component during the establishment of youth empowerment centres (YEC) in constituencies. In addition, DRH plans to lobby for incorporation of RH/FP training in non-health training institutions/colleges for faculty and students.

The resources required to support these interventions as well as the total resources required to support youth focused interventions are shown below.

Table 19b: The Youth: New/Innovative activities to accelerate CPR to 56%

	Estimated Cost (KShs.)			
Intervention	**2012/13**	**2013/14**	**2014/15**	**2015/16**
3.5. Increase access to youth prevention services through public/private partnerships (PPP)	10,909,000	136,000	136,000	-
3.6. Entrench youth reproductive health activities into other youth empowerment initiatives, including training	3,608,000	-	-	-
Total Resources Required to Accelerate CPR to 56%	***14,516,000***	***136,000***	***136,000***	***-***
Total Resources Required for Youth Interventions	***1,500,154,000***	***1,434,403,000***	***1,419,213,000***	***1,419,967,000***

4. Demand Creation

Possible causes of CPR change in the past five years

- DHS findings reveal that more than half of the adolescent girls would like to delay childbearing and about half desire three or fewer children. This shows that past advocacy activities by all actors may have resulted in increased demand for family planning.

- Demand creation activities by all partners and especially USAID's APHIA II programme have yielded results in the past five years because unmet need has significantly declined, especially in Nyanza, Western, Rift Valley, Eastern, North Eastern, and Coast (in that order, according to degree of decline).

- Family planning outreach efforts by MOH, GLUK, MST, APHIA II., and FHOK increased in the last five years. There were innovative outreach approaches for hard- to- reach communities such as the use of Health Wagons in Eastern Province. Also, community health workers made a contribution in advocacy, referral linkages to facilities, and distribution of pills.

- Although the percentage of women reporting having heard or seen a family planning message reduced slightly from 2003 to 2008/9, the rate is high due to increased media communication (radio, newspapers, other IEC).

- Men involvement was high, especially in Western Province under AMUA.

Activities to maintain 46% CPR - based on what worked well and by addressing past gaps

In order to maintain the CPR momentum created through demand creation, this CIP proposes a number of activities to sustain contraceptive use.

Currently no rational outreach program exists that is based on what has worked well for different population segments. Different implementing partners have a wealth of experience on their own outreach approaches but these lessons are not shared. The CIP proposes the design and implementation of a rational and targeted outreach program to reach areas with low CPR, especially among the poor in the rural and urban slum areas, among other groups.

One of the traditional barriers to family planning uptake has been the low male involvement. The CIP plans to review existing strategies and to develop a comprehensive strategy for male FP involvement.

As part of the RH Communication Strategy, the CIP plans to design, implement, and monitor an ambitious media communication FP strategy tailored to reach those with increasing unmet need.

The last three DHS surveys have shown that there has been a general decline in the uptake of long-term and permanent family planning methods (LAPM). The CIP has planned for the design of a method-specific marketing activity that uses mass media to reach potential LAPM clients more effectively than broader information campaigns. This will be coupled with the building of the capacity of community health workers to effectively refer clients for LAPM.

The resources required to support these interventions are shown below.

Table 20a: Demand Creation: Interventions to Maintain 46% CPR

	Estimated Cost (KShs.)			
Intervention	***2012/13***	***2013/14***	***2014/15***	***2015/16***
4.1: Sustain contraceptive use in areas that performed well	705,000	705,000	705,000	705,000
4.2. Increase contraceptive use in areas that did not perform well in the past	2,422,000	-	-	-
4.3. Increase male involvement in FP	3,663,000	-	-	-
4.4. Increase utilization of family planning services through targeted and effective advocacy and communication strategies	18,029,000	16,138,000	16,138,000	16,138,000
4.5. Increase awareness and voluntary utilization of long-acting and permanent methods (LAPM)	16,616,000	7,118,000	4,482,000	3,120,000
Demand Creation Resources Required to Maintain 46% CPR	***41,435,000***	***23,961,000***	***21,325,000***	***19,963,000***

New/Innovative activities- to accelerate CPR to 56%

To exploit areas that were previously not utilized, the CIP proposes a number of interventions and activities. For instance, the CIP plans to enhance the organizational capacity of communities to effectively participate in family planning activities through building the capacity of community health units (CHUs) to support and expand the functionality of family planning activities. There will also be activities to facilitate the formation and operational functioning of community groups, increase youth participation in advocacy for adoption of life skills including FP uptake, and build capacity of Youth Empowerment Centres to provide appropriate FP services.

In line with the new Constitution that has established some form of semi-autonomous sub-national units (Counties); the CIP proposes lobbying for the establishment of a County Family Planning Fund (CFPF) to support family planning programmes that are led by county governments.

In the past, and especially in the last 10 years, debates on national resource allocations to regions have tended to focus on misconceptions about family planning and the size of allocations to ethnic regions. The CIP plans to address these challenges by increased advocacy, including increased engagement with opinion leaders.

The DHS has shown that contraceptive use among unmarried women reduced in the past five years. The CIP plans to operationalize the FP component of the RH communication to reach unmarried women.

To further increase demand for family planning, the CIP plans to improve activity/resource targeting through outreaches and OBA programmes. There are planned activities to facilitate the design and implementation of effective outreaches in order to meet FP demand through contacts with clients accessing other services. The DHS reveals that the unmet need among the poorest is rising but the demand satisfied has reduced in the past five years. DRH will work with the existing Output-Based Aid (OBA) programs to allow targeting of the poor with services.

The resources required to support these interventions as well as the total resources required to support demand creation interventions are shown below.

Table 20b. Demand Creation: New/Innovative Activities to Accelerate CPR to 56%

	Estimated Cost (KShs.)			
Intervention	***2012/13***	***2013/14***	***2014/15***	***2015/16***
4.6. Enhance the organizational capacity of communities to effectively participate in family planning activities	120,300,000	51,090,000	63,874,000	63,874,000
4.7. Increase demand for FP by improving advocacy	47,413,000	23,143,000	24,739,000	23,143,000
4.8. Improve activity/resource targeting through outreaches and OBA programmes	252,441,000	247,900,000	247,900,000	247,900,000
Demand Creation Resources Required to Accelerate CPR to 56%	***420,154,000***	***322,133,000***	***336,513,000***	***334,917,000***
Total Demand Creation Resources Required	***461,589,000***	***346,094,000***	***357,838,000***	***354,880,000***

5. Integration and Cross-Cutting Issues

Possible causes of CPR change in the past five years

- Increased support for family planning due to increased health sector funding after 2002 watershed general elections. The budget line for FP commodities was raised from 200million in 2005 to 520million in 2010.

- The change from donor-managed (but MOH-led) procurement and distribution system to KEMSA was a major step since KEMSA had capacity to distribute more commodities. In addition, technical assistants (resident experts) provided by the development partners to KEMSA and DRH helped to streamline logistics system.

- Repositioning of family planning in 2006 after a decade of focus on HIV/AIDS. Many programs were integrated where family planning benefited greatly from HIV/AIDS resources through improved health facility infrastructure, prevention information/education, demand creation through integrated outreaches/ peer educators, and the supply of condoms (there was a 3.9% increase in condom use between 2003 and 2008/9). FP was more integrated into HIV/AIDS programs.

- Possible positive effects of USAID's APHIA II programmes. The provinces that had the most significant APHIA II investments (Western, Coast, Nyanza, and Rift Valley) recorded an annual increase of 400,000 Couple Years of Protection (CYP) between 2006 and 2009.

Activities to maintain 46% CPR - based on what worked well &by addressing past gaps

Service integration within the health system creates synergies and leveraging of resources. Integration of family planning into non-health sectors is essential since population dynamics, of which family planning is a key determinant, is an important planning factor for all sectors of development. Further, many important factors that influence family planning uptake also reside outside the health sector. Given these internal and external (to health sector) relationships, this CIP has identified a number of activities necessary to maintain the current CPR.

The CIP plans to revise/update the minimum package for RH/ FP/HIV integration to reflect current service delivery settings including the effects of task-shifting. Since the health system gets weaker towards the lower level facilities, the CIP plans to disseminate and sensitize on key integration policies and guidelines especially at lower KEPH levels.

Most of the adolescent reproductive health issues are best addressed in schools where pupils spend most of the time. The CIP has activities for revitalizing, professionalizing, and monitoring role of school guidance counsellors.

Some of the most neglected areas, or areas of lost opportunity, are family planning within the PAC, ANC, and post-partum settings. The CIP plans to train service providers to provide FP services in these settings.

With regard to private sector, the CIP has activities aimed at developing/strengthening mechanisms that allow private pharmacies and clinics to access commodities from the KEMSA district stores. There will also be activities aimed at training private sector service providers for quality FP services. Other activities include developing and implementing mechanisms for institutionalizing private sector participation in support supervision, reaches/outreaches, and in Rapid Results Initiatives (RRIs).

The resources required to support these interventions are shown below.

Table 21a: Integration and Cross-Cutting Issues: Interventions to Maintain 46% CPR

	Estimated Cost (KShs.)			
Intervention	**2012/13**	**2013/14**	**2014/15**	**2015/16**
5.1. Revitalize overall FP integration into other services (policies, guidelines, and other materials)	33,162,000	5,873,000	-	-
5.2 Re-activate and scale up the role of family planning champions	1,828,000	1,475,000	1,475,000	1,475,000
5.3. Revitalize and professionalize the role of school guidance counsellors	14,943,000	2,911,000	4,108,000	2,911,000
5.4. Strengthen FP counselling during ANC and provide FP during post-partum period	32,693,000	-	-	-
5.5. Leverage HIV/AIDS resources to support family planning	7,173,000	8,790,000	1,550,000	353,000
5.6. Strengthen Post-Abortion Care (comprehensive PAC) by integrating FP into PAC	43,849,000	-	-	-
5.7 Enhance Public Private Partnership (PPP)	23,352,000	9,262,000	6,491,000	6,491,000
Resources Required for Integration & Cross-Cutting Issues Interventions to Maintain 46% CPR	***157,000,000***	***28,310,000***	***13,623,000***	***11,229,000***

New/Innovative activities to accelerate CPR to 56%

Currently, no comprehensive strategy exists for embedding family planning in the non-health sectors. Whatever integration (outside health) is happening is ad hoc or opportunistic. This CIP proposes an activity for the development of such a strategy based on a desk review of the key opportunities and gaps for integration of family planning into non-health sectors. The resources required to support this intervention as well as the total resources required to support integration and cross-cutting issues are shown below.

Table 21b: Integration and Cross-Cutting Issues: New/Innovative Activities to Accelerate CPR to 56%

	Estimated Cost (KShs.)			
Intervention	**2012/13**	**2013/14**	**2014/15**	**2015/16**
5.8. Influence the development and implementation of a multi-sectoral family planning strategy based on the new population policy	8,849,000	7,013,000	7,013,000	7,013,000
Resources Required for Integration & Cross-Cutting Issues Interventions to Accelerate CPR to 56%	***8,849,000***	***7,013,000***	***7,013,000***	***7,013,000***
Total Resources Required for Integration & Cross-Cutting Issues	***165,849,000***	***35,323,000***	***20,636,000***	***18,242,000***

Table 22: Matrix of CIP Priority Activities

Theme 1a. Human Resources: Activities to maintain 46% CPR

		Estimated Cost (KShs.)			
Intervention	**Activities**	**2012/13**	**2013/14**	**2014/15**	**2015/16**
1.1. Improve leadership, management and coordination of FP/RH programmes.	1.1.1. Build leadership and management capacity of DRH and County RH senior managers.				
	• Identify and hire an appropriate human and organizational development specialist to conduct a two-day orientation for up to ten senior DRH Technical staff and up to 20 Provincial/ District/ County Reproductive Health Coordinators. The orientation should focus on; public/ social policy, management (including good governance and human resources), strategic planning, programme design, business and financial management.	731,300			
	1.1.2. Define, restructure, and institutionalize the role of County RH Coordinators (CRHCs).				
	• As part of her/his work, the human and organizational development specialist to convene meetings to write new terms of reference for CRHCs and to lobby inclusion of CRHCs in DHMT. (4 in 2012, 2 in 2013 & 2014).	405,000	202,500	202,500	
	1.1.3. Map out FP partner activities to reduce duplication.				

		Estimated Cost (KShs.)			
Intervention	**Activities**	**2012/13**	**2013/14**	**2014/15**	**2015/16**
	• Convene stakeholders' meetings to map out and negotiate/rationalize activity targeting (two in 2012 and annually thereafter).	50,000	25,000	25,000	25,000
1.2. Build technical capacity of service providers to offer quality services.	1.2.1. Improve FP service provider skills at the lower levels.				
	• Identify DRH and external trainers (a total of 47) who should conduct the training at level III facilities.				
	• Identify three level III facilities in each of the 47 Counties and conduct facility-based trainings to about 30 service providers on expanded FP methods. The service providers to be trained should include those working in the facility and those in the catchment (CHWs including home-based caregivers, pharmacists, and drug shopkeepers, and community midwives). By 2015, a total of about 5000 should have been trained, which includes 500 midwifes.	6,692,800	6,692,800	6,692,800	
	1.2.2. Facilitate the work of CHWs and CHEWS.				
	• Conduct eight regional training workshops to train CHWs (100,000 in 2012 and 126,000 in 2013). During the training, distribute training materials to the CHWs.	742,500,000	935,550,000		

		Estimated Cost (KShs.)			
Intervention	Activities	2012/13	2013/14	2014/15	2015/16
	• Conduct eight regional training workshops to train CHEWs (7,000 in 2012 and 8,400 in 2013). During the training, distribute training materials to the CHEWs.	52,237,500	62,685,000		
	• Procure CHW kits, bicycles, or camels for each of the 120,000 CHWs in 2012. Further, procure CHW kits, motorcycles, and badges for the 6,000 CHW leaders/supervisors.	4,992,492,000			
	• Mobilize funds from GOK to pay monthly allowances of KSH2000 for each of the 120,000 CHWs and 2400 for each of the 6000 CHW supervisors. Assumes CHWs devote 50% of their time on FP activities and the other half on other health activities. This CIP should therefore raise only half of the allowances.	1,526,400,000	1,526,400,000	1,526,400,000	1,526,400,000
	1.2.3. Improve the appeal of IEC materials for family planning through branding and distribution				
	• Hire a communications consultant to revise, translate, and brand the FP IEC materials and distribute to all health facilities (public and private).	1,566,000			
	1.2.4. Increase media personnel's awareness, analytical and reporting capacity for FP.				

		Estimated Cost (KShs.)			
Intervention	Activities	2012/13	2013/14	2014/15	2015/16
	• Hold a national and eight regional media training/awareness workshops and target to bring on board about 500 media personnel by 2013. The communications consultant (in 1.2.3) should be utilized for this activity.	1,331,400	443,800		
1.3. Increase staff productivity through facility staff development and support supervision	1.3.1. Build the capacity of facilities to offer routine staff development.				
	• Hire a training consultant to conduct a rapid inventory of all health workers and report on the names of workers who have not received any training in their area of service in the past 12 months. The report should also recommend a schedule of trainings to ensure that at least 50% of family planning service providers in a given health care facility have received a structured training in family planning in the following 12 months after the assessment. Training includes both pre-service and in-service training but excludes individual instruction received during routine supervision.	897,750			
	• DRH to implement the training plan produced by the consultant (assume that a quarter of about 10,000 workers have not received training in the past 12 months).	81,250,000	81,250,000	81,250,000	81,250,000

		Estimated Cost (KShs.)			
Intervention	Activities	2012/13	2013/14	2014/15	2015/16
	1.3.2. Facilitate DHMTs for effective support supervision				
	• Convene meetings to advocate for the revision or development of a monitoring tool to be used by teams conducting supportive supervision; the tool should collect facility performance data such as % of facilities without stock-out of FP commodities etc. (two in 2012 and then one annually thereafter).	1,157,667	578,833	578,833	578,833
	• KSh are mobilized to support logistical costs of support supervision (four support visits for each of the 650 facilities in a year).	8,320,000	8,320,000	8,320,000	8,320,000
	1.3.3. Improve staff productivity.				
	• FP champions to hold one meeting (per quarter) with MOH Human Resources Division to lobby for implementation of the consultant's recommendations.	7,300,000	7,300,000	7,300,000	7,300,000
1.4. Improve effectiveness of training by streamlining, rationalization, consolidating, and coordination of existing training systems.	1.4.1. Improve the coordination of training.				
	• Stakeholder workshops held to orient implementing partners and training institutions on the standard RH/FP curriculum and how other curriculi such as Board Exams of regulatory authorities can be rationalized and made complimentary of the standard curriculum (two in 2012 one annually thereafter).	3,675,000	1,837,500	1,837,500	1,837,500

		Estimated Cost (KShs.)			
Intervention	Activities	2012/13	2013/14	2014/15	2015/16
	• Follow-up advocacy meetings (quarterly each year) held including those with Board of Examiners.	5,070,000	5,070,000	5,070,000	5,070,000
	1.4.2. Strengthen existing Decentralized Training Centres (DTCs) at the districts and establish new ones at Counties.				
	• Hire consultant to conduct a rapid assessment of the status of the DTCs in relation to the expected minimum standards.	399,000			
	• TWG to draw terms of reference for the development/revision of the minimum requirements of a DTC.	2,085,333			
	• Mobilize funds to finance the institutionalization of minimum features for effective functioning of the DTCs.	4,700,000			
1.5. Increase technical capacity of service providers to offer quality services by addressing poor performing areas	1.5.1. Scale up the LAPM training using the new manual.				
	• Hold one national and eight regional training workshops for 30 national and 20 service providers per County.	5,118,000	7,350,000	7,350,000	
	1.5.2. Disseminate all FP/RH related policies, standards and guidelines to all facilities.				

		Estimated Cost (KShs.)			
Intervention	Activities	2012/13	2013/14	2014/15	2015/16
	• Utilize the IT Assistant hired under the Integration Section to install key FP/RH related policies to all facilities' computers OR simply have the IT Assistant compile an email list and send the documents via email to facilities that have email addresses.	2,090,000			
	1.5.3. Strengthen pre-service training through (1) working with a national university to develop and establish a short course/s in RH/FP and(2) updating pre-service lecturers on emerging RH/FP issues and developments.				
	• Meetings held to dialogue on the need and contents of a short RH/FP course.	210,000	70,000		
	• Hire a training consultant to produce a training manual for updating lecturers on the current RH/FP issues/practices.	399,000			
	• Each year, use consultant to train 30 lecturers.		1,884,250	1,884,250	1,884,250
1.6. Increase institutional and human capacity to develop and implement effective Monitoring &Evaluation/Management Information (M&E/MI) systems	1.6.1. Revise the Division of Reproductive Health Monitoring and Evaluation Framework and System to reflect the imperatives of this Costed Implementation Plan.				
	• Hold a national workshop to discuss challenges, issues, and priorities relating to FP M&E and logistics information systems.	790,000			

		Estimated Cost (KShs.)			
Intervention	Activities	2012/13	2013/14	2014/15	2015/16
	• Hire a consultant to revise the DRH M&E System including indicator, baselines, and targets for the CIP.	798,000			
	1.6.2. Build capacity for logistics information management system by revising or developing appropriate training materials and training, or by retraining of the relevant persons.				
	• Hire a consultant to revise the FP commodities' logistics information management system and produce an operations manual. The consultant should also sensitize HMIS management in RH logistics reporting, develop feedback tools for all levels, and sensitize on its importance.	798,000			
	• Hold a national training workshop targeting three data personnel per county for M&E and logistics information system training.	10,286,625			
	• Hire an M&E firm/consultant to conduct data quality assessment for selected indicators every two years.		1,596,000		1,596,000
	Total to Maintain CPR at 46%	***7,459,750,000***	***2,647,256,000***	***1,646,910,883***	***1,634,261,583***

Theme 1b.Human Resources: New/Innovative Activities to accelerate CPR to 56%

		Estimated Cost (KShs.)			
Intervention	**Activities**	**2012/13**	**2013/14**	**2014/2015**	**2015/16**
1.7. Increase support for family planning through use champions to compliment the efforts of DRH senior managers	1.7.1. Identify and enlist high impact champions to advocate changes in key FP/RH policies, strategies, and issues.				
	• Convene a stakeholder's workshop in 2012 to identify issues and champions. Some of the issues may include lobbying political parties to include certain FP issues in their 2012 election manifestos.	970,000			
	• KShs mobilized to facilitate the work of champions (assume 4 meetings per champion in a year).	880,000	880,000	880,000	880,000
1.8. Increase capacity of service providers for delivery of quality services by improving pre-service curriculum.	1.8.1. Identify and revise an existing or new pre-service curriculum that need strengthening in order to equip future service providers with RH/FP skills that meet emerging needs. (So far, focus has been in-service, yet FP is a long-term theme that needs pre-service training.)				
	• Hold DRHTWG meetings to brainstorm on the issues (three per year 2012-2014).	528,750	528,750	528,750	
	• Expanded DRHTWG/Champions/key trainers meetings held to identify the course and the training institution (two in 2012).	352,500			
	• Convene meetings between DRH and selected training institution where a Memorandum of Understanding is signed among key players to firm up the course and training institution.	705,000			
	• Convene workshops to discuss, enrich, and endorse the curriculum.	1,269,000	1,269,000		

		Estimated Cost (KShs.)			
Intervention	**Activities**	**2012/13**	**2013/14**	**2014/2015**	**2015/16**
	• Training institution facilitated to draft the Course Curriculum (consultant with 10 person-days LOE).		199,500		
1.9. Increase utilization of LAPM services through pre-service training, continuing medical education, and on-job training.	1.9.1. Advocate for health professionals signing off after pre-service to incorporate compulsory LAPM skills.				
	• Convene meetings(one per quarter) to lobby professional registration bodies (Medical Practitioners and Dentists Board, Nursing Council of Kenya, and Clinical Officers Council) to institute LAPM-related registration requirements, e.g., for initial registration, a health professional will have inserted 10 IUCDs/50 implants and for Medical Officers, 30 BTL every year	9,943,333	9,943,333	9,943,333	9,943,333
	• DRH and FP champions to schedule and hold one meeting per quarter with the registration bodies to lobby for implementation of the requirements.	4,971,667	4,971,667	4,971,667	4,971,667
	1.9.2. Train or deploy staff to ensure that there two dedicated service provider for LAPM at each of the level II facilities.				
	• DRH and FP champions to schedule and hold one meeting per quarter with the MOH Human Resources Division to ensure increased human resources for LAMP.	9,943,333	9,943,333	9,943,333	9,943,333
1.10. Increase capacity of service providers and	1.10.1. Strengthen natural FP to capture religious segments (Catholics, Muslims) through training.				

		Estimated Cost (KShs.)			
Intervention	**Activities**	**2012/13**	**2013/14**	**2014/2015**	**2015/16**
facilities to offer natural family planning methods to cater for the religious clients.	• DRH staff to hold eight regional training workshops every two years to train service providers from the religious sectors on natural family planning methods. The training is to focus largely on the lower level facilities' (Level II and below) service providers targeting 30 service providers per County.	11,280,000		11,280,000	
	Total to Accelerate CPR to 56%	***40,843,583***	***27,735,583***	***37,547,083***	***25,738,333***
	Grand Total Human Resource Interventions	***7,500,594,000***	***2,674,991,000***	***1,684,457,967***	***1,659,999,917***

Theme 2a. Commodity Security: Activities to maintain 46% CPR

		Estimated Cost (KShs.)			
Intervention	**Activities**	**2012/13**	**2013/14**	**2014/2015**	**2015/16**
2.1. Lobby for increased allocation for family planning in the national budget	2.1.1. Based on the commodity requirement projections made in this CIP and other costs, lobby Ministry of Finance for increased financial allocation.				
	• Quarterly DRH Head and FP Champions meetings with Ministry of Finance	8,560,000	8,560,000	8,560,000	8,560,000
	• KShs allocated from national budget for FP commodities	976,423,000	1,125,229,000	1,295,540,000	1,492,022,000
	• Procure IUCDs, Implants, and BTL kits.	112,182,000	118,701,000	125,565,000	132,953,000
2.2. Increase access to family planning commodities by improving the efficiency of commodity requests &distribution systems	2.2.1. Build capacity of health facilities to forecast, request, & report on commodities use				
	• Conduct eight regional training workshops (every two years) for health facility managers (DRHCs, DHRIOs, DPHNs) on essentials of pull system (estimations of commodity requirements, and reporting formats). Target to train 30 per county.	11,280,000	-	11,280,000	-
	• Facilitate DRHCs, DHRIOs, and DPHNs to conduct cascade training in RH commodity management to facilities. , support KEMSA in report analysis and derivation of re-order quantities (KSH200,000 per county),	9,400,000	9,400,000	9,400,000	9,400,000

		Estimated Cost (KShs.)			
Intervention	Activities	2012/13	2013/14	2014/2015	2015/16
	• Designate a DRH focal point to monitor availability of commodities in specific critical areas especially MCH/FP clinics, Gynae wards, CCCs, and other.	-	-	-	-
	2.2.2. Build capacity of KEMSA and explore other distribution channels				
	• Hold quarterly meetings with KEMSA to address any existing commodity leakages and or time/transport inefficiencies	1,105,000	1,105,000	1,105,000	1,105,000
	• Hire a supply chain consultant to conduct a rapid study of complimentary commodities distribution channels (e.g. MEDS) which should be capable of moving 100million worth of the commodities.	798,000	-	-	-
	• Hold two workshops bringing together stakeholders to guide consultant, discuss and endorse findings (one in 2012 & one in 2013)	2,042,917	2,042,917	-	-
	2.2.3. Revitalize the Community-Based Distribution (CBD) as an integral level in the FP commodity supply chain				
	• Hire a consultant to conduct a mapping of all existing CBDs and an assessment of their functionality. This assessment should ensure that it identifies areas, within the National Community Strategy , that need strengthening such as data collection and management tools	598,500	-	-	-

		Estimated Cost (KShs.)			
Intervention	Activities	2012/13	2013/14	2014/2015	2015/16
	• Hold two national workshops to guide consultant and discuss/endorse final assessment findings	2,976,667	2,976,667	-	-
	Total Maintain CPR at 46%	***1,125,366,083***	***1,268,014,583***	***1,451,450,000***	***1,644,040,000***

Theme 2b. Commodity Security New/Innovative Activities- to accelerate CPR to 56%

		Estimated Cost (KShs.)			
Intervention	**Activities**	**2012/13**	**2013/14**	**2014/2015**	**2015/16**
2.3. Increase the use of innovative and/or non-standard approaches for effective access to, and utilization of, commodities	2.3.1. Ensure that the Output-Based Approach (OBA) program is an avenue for commodity access to targeted population segments such as the poor, youth, adolescents, uneducated adolescents etc.				
	• Hold a national workshop of all partners implementing any form of OBA to discuss and agree on an action plan that ensures a comprehensive national OBA strategy that has clear and rational population targeting	2,976,667	-	-	-
	2.3.2. Build the capacity of all registered private pharmacies to provide short-term methods.				
	• Hold eight regional training workshops to train 30 private pharmacies per county on the essentials of short-term FP methods (pills and DMPA) and the benefits of offering these methods. This should also include linking the private pharmacies to KEMSA.	4,012,000	-	-	-
	2.3.3. Advocate (using champions and other approaches) for the inclusion of Family Planning services as part of standard medical packages offered by Health Maintenance Organizations (HMOs) and insurance companies with medical covers.				

		Estimated Cost (KShs.)			
Intervention	Activities	2012/13	2013/14	2014/2015	2015/16
	• Convene series of FP TWG meetings to decide on the minimum FP package to lobby for inclusion (4 in 2012, 2 in 2013, 1 in 2014 & 2015)	1,105,000	552,500	276,250	276,250
	• Convene workshops to lobby HMOS and Insurance companies to include FP in covered services (2 in 2012, 1 in following years)	552,500	276,250	276,250	276,250
	2.3.4. Lobby/advocate (using champions and other approaches) for direct funding or advocacy for funding for FP commodities by various corporate bodies through their Corporate Social Responsibility (CSR)				
	• FP Champions to hold meetings (quarterly) with corporate firms and target to raise 200 million worth of commodities as a security in case GOK funds do not become available to cover community FP related budgets.	11,906,667	11,906,667	11,906,667	11,906,667
	2.3.5. Lobby GOK to include all contraceptives registered by the Drugs & poison board of Kenya in the National method mix instead of limiting to a certain set of contraceptives.				
	• DRH and FP Champions to hold meetings with GOK /KEMSA to seek inclusion in the national method mix of all registered contraceptives in Kenya	11,906,667	5,953,333	5,953,333	5,953,333
	Total Accelerate CPR to 56%	***32,459,500***	***18,688,750***	***18,412,500***	***18,412,500***
	Grand Total Commodity Security Interventions	***1,157,825,583***	***1,286,703,330***	***1,469,862,500***	***1,662,452,500***

Theme 3a: The Youth: Activities to maintain 46% CPR

		Estimated Cost (KShs.)			
Intervention	**Activities**	**2012/13**	**2013/14**	**2014/2015**	**2015/16**
3.1. Fully implement the GOK Adolescent Reproductive Health and Development Policy (ARH&D, 2005)	3.1.1. Lobby for increased resources (human, financial, material and technical) to fully implement the GOK's ARH&D Policy.				
	• Form a multi-sectoral coordination committee (that includes MOH, MOYAS, MOE, MOF, NCPD, and Donors) for youth reproductive health	110,500	-	-	-
	• Hold quarterly multi-sectoral coordination committee meetings to identify youth RH priority activities	8,560,000	8,560,000	8,560,000	8,560,000
	• Hold four workshops to develop, track implement, and review an adolescent reproductive health (ARH) action plan	1,780,000	890,000	-	890,000
	• Use Champions and the multi-sectoral committee to hold meetings with Ministry of Finance, and private sector to mobilize funds to implement ARH annual action plan	58,750,000	58,750,000	58,750,000	58,750,000
	• Hold one national and eight regional workshops to train (on ARH) up to 30 youthful service providers from each county	9,437,500	7,550,000	-	-
	3.1.2. Operationalize the ASRH component of the (RH) reproductive health communication strategy.				
	• Conduct community outreaches to reach out-of-school youth with prevention messages (in each county, conduct one outreach every quarter through churches, mosques, and other avenues)	317,720,000	317,720,000	317,720,000	317,720,000

		Estimated Cost (KShs.)			
Intervention	Activities	2012/13	2013/14	2014/2015	2015/16
	• Revise, print, and distribute adolescent RH communication guidelines to all wards (target 20 copies for each of about 25 wards in each of the 47 counties, total = 23,500)	18,800,000	-	-	-
	3.1.3. Design a sharp radio/TV/Billboard pregnancy and HIV/AIDS prevention communication activity specifically targeting the unmarried adolescents, especially those with no education who also happens to be poor and in rural areas. (The activity should focus more on abstinence, and delay in sexual debut and marriage rather than family planning.				
	• Hire a Communications NGO or Firm to work with the TWG to design and implement the radio/TV activity plus 3 radio spots per day in each county	1,033,290,000	1,029,300,000	1,029,300,000	1,029,300,000
	3.1.4. Work with partners to study and act on adolescent reproductive health practices in Eastern, Western, and Rift Valley Provinces which showed reduced contraceptive among the adolescents in the DHS 2008/9.				
	• Hire a consultant to conduct a rapid assessment of the factors responsible for reduced contraceptive use and recommend options to partners working in these regions (US$20k)	997,500	-	-	-

		Estimated Cost (KShs.)			
Intervention	Activities	2012/13	2013/14	2014/2015	2015/16
	• Hold a partners' meeting/workshop bringing together implementers from Eastern, Western, and Rift Valley to discuss consultant's findings and develop an action plan to address the findings (2 participants each from about 5 implementers from each province)	1,790,000	-	-	-
3.2. Strengthen the community component of youth reproductive health programme.	3.2.1. Build the capacity of community health workers to offer community-based contraceptive services (education, condoms, and pills)				
	• Hold one national and eight regional workshops to train community health youth workers to offer community based contraceptive services (4 TOTs/peer educators per county which includes one coordinator= a total of about 200, i.e. 100 in year 1 and 100 in year 2)	8,437,500	6,750,000	-	-
	• Mobilize funds to support operations of community health youth workers (allowances of KShs 2000 per month and 2500 for County Coordinator. Assume CIP work constitutes half of their engagement and that other Divisions to pay the other half)	1,198,500	2,397,000	2,397,000	2,397,000
	• Purchase cell-phones to support communications for the 200 youth workers	400,000	-	-	-
	• Bicycles purchased to support transport for the 150 community youth workers (n=150)	1,500,000	-	-	-

		Estimated Cost (KShs.)			
Intervention	Activities	2012/13	2013/14	2014/2015	2015/16
	• Purchase motor cycles to ensure effective supervision by the 47 County Youth Coordinators.	7,050,000	-	-	-
	3.2.2. Assist the community health workers focusing on the youth to design and carry out a mapping of households that have youth in each County. (The mapping should ensure disaggregation of households by whether their youth are in-school or out-of-school. Further, assume a ward is the lowest enumeration unit and that there are about 25 wards per County)				
	• Mobilize funds to conduct the mapping (assume KShs 3000 miscellaneous mapping costs per ward).	3,525,000	-	-	-
	3.2.3. Work with the community health youth workers to develop and implement a Community-Clinic/Facility Orientation Guide (CFO) where community members interact with health facility staff to facilitate clinic-community linkage.				
	• Consultant contracted and funded in 2012 to help come up with CFO Guide in line with the Community Strategy	798,000	-	-	-
	• Workshop held in 2012 with community health youth workers and consultant to develop CFO Strategy	1,565,000	-	-	-
	• KSH needed for annual transport costs of youth community members to visit facilities	2,350,000	2,350,000	2,350,000	2,350,000

		Estimated Cost (KShs.)			
Intervention	**Activities**	**2012/13**	**2013/14**	**2014/2015**	**2015/16**
3.3. Increase availability of condoms as a dual protection against pregnancy, HIV/AIDS and STIs.	3.3.1. Operationalize the revised Condom Policy & strategy by conducting a rapid assessment (desk reviews & interviews) of innovative approaches for increased condom access.				
	• Hire a consultant to conduct an assessment of innovative approaches for increased condom access(US$20k)	798,000	-	-	-
	• Hold a workshop comprising of major/key condom distributors to share the consultant's findings and develop and agree on an action plan	2,256,667			
3.4. Increase availability of youth friendly services (YFS)	3.4.1. Build capacity of health facilities to offer youth friendly services (YFS).				
	• Hold a national stakeholders forum to appraise implementing partners on what they need to do in order institute youth friendly services in the facilities they work with. The workshop should consider the national guidelines, and map out which facilities each partner would assist. The workshop should also look at KSPA data to determine the geographical areas of priority	2,256,667			
	3.4.2. Increase capacity of service providers to offer youth friendly services.				

		Estimated Cost (KShs.)			
Intervention	**Activities**	**2012/13**	**2013/14**	**2014/2015**	**2015/16**
	• Conduct one national and eight regional workshops to equip service providers with the necessary skills and materials needed to establish and maintain youth friendly services.(In each County, plan to identify and train five young doctors, nurses, or social workers to serve as TOTs, i.e. 235)	2,267,100			
	Total Maintain CPR at 46%	***1,485,637,933***	***1,434,267,000***	***1,419,077,000***	***1,419,967,000***

Theme 3b: The Youth: New/Innovative Activities to accelerate CPR to 56%

		Estimated Cost (KShs.)			
Intervention	**Activities**	**2012/13**	**2013/14**	**2014/2015**	**2015/16**
3.5. Increase access to youth prevention services through public/private partnerships (PPP)	3.5.1. Partner with a mobile service provider to design and implement a Short Messaging Service (SMS)- based family planning information activity where the youth and adolescents can send and receive information on pregnancy, HIV/AIDS, and STI prevention (plan to reach 0.25, 0.75, 1, and 1 million adolescents in year 1, 2, 3, 4 respectively)				
	• Hire a consultant to work with FP champions and TWG to hold meetings with Mobile Phone Service Providers to agree on the options available. Consultant also to work with TWG to design the messages /contents.	1,197,000	-	-	-
	3.5.2. Work with a private company or NGO, or Media House to come up with a behavior change communication strategy that is branded so that the youth can own and use it (to support the activity, identify and develop Youth Champions and Role Models as part of the strategy. The Strategy should ensure that interventions/activities are piggy-backed on any available opportunities e.g. vijanatugutuke)				
	• KShs mobilized to fund a competitively bided contractor	5,985,000	-	-	-

		Estimated Cost (KShs.)			
Intervention	**Activities**	**2012/13**	**2013/14**	**2014/2015**	**2015/16**
	3.5.3. Work with a youth-led private company or NGO to establish a social media network (riding on Facebook, Twitter etc) that facilitates exchange of relevant information and experiences about life skills including contraceptive use and abuse.				
	• KShs mobilized to fund a competitively bided contractor	3,591,000	-	-	-
	3.5.4. For all the private pharmacies targeted for OBA, build-in an activity that ensures the following standards; a referral system for long-acting methods, adequate availability of subsidized emergency contraceptives and condoms.				
	• Hold three workshops comprising of representatives from private pharmacies, KEMSA, DRH, large private sector actors to exchange ideas on the benefits and opportunities available for private pharmacies to meet certain FP standards. The first workshop should come up with an action plan while the second workshop would be a review forum where any challenges would be addressed. Third workshop for mid-term review of performance.	135,500	135,500	135,500	-
3.6. Entrench youth	3.6.1. Establish youth empowerment centres (YEC) in constituencies				

		Estimated Cost (KShs.)			
Intervention	**Activities**	**2012/13**	**2013/14**	**2014/2015**	**2015/16**
reproductive health activities into other youth empowerment initiatives, including training.	• In 2012, TWG hold three meetings with MOYAS to incorporate family planning component during the establishment of youth empowerment centres (YEC) in constituencies (i.e. operationalize the eight thematic areas of the National Youth Policy (NYP) in the YECs to include FP).	903,750	-	-	-
	• Consultant hired to assist MOYAs integrate FP into a few youth empowerment centres so that MOYAs can work on the rest.	399,000	-	-	-
	3.6.2. Lobby for incorporation of RH/FP training in non-health training institutions/colleges for faculty and students.				
	• Hire a training consultant to develop a basic/relevant FP curriculum for the non-health training institutions' faculty and students	798,000	-	-	-
	• Use Champions and TWG to hold meetings with non-health institutions so that they can adopt the basic FP curriculum	1,507,083	-	-	-
	Total Accelerate CPR to 56%	***14,516,333***	***135,500***	***135,500***	***-***
	Grand Total Youth Interventions	***1,500,154,267***	***1,434,402,500***	***1,419,212,500***	***1,419,967,000***

Theme 4a: Demand Creation: Activities to maintain 46% CPR

		Estimated Cost (KShs.)			
Intervention	**Activities**	**2012/13**	**2013/14**	**2014/2015**	**2015/16**
4.1: Contraceptive use in areas that performed well, sustained	4.1.1. Sustain contraceptive use in areas that registered positive change in the past				
	• Hold quarterly TWG meetings with APHIA Plus and other partners to review partner work plans and activities to ensure continuous focus on the priorities	705,000	705,000	705,000	705,000
4.2. Increase contraceptive use in areas that did not perform well in the past	4.2.1. Design and implement a rational and targeted outreach program to reach areas with low CPR especially among the poor in the rural areas and urban slum areas.				
	• Three TWG meetings in 2012 to write terms of reference for development of National RH/FP Outreach Strategy	444,000	-	-	-
	• Hire a consultant in 2012 to lead in the design of National RH/FP Outreach Strategy	798,000	-	-	-
	• Hold two workshops in 2012 to design a national and targeted outreach program	1,180,000	-	-	-
4.3. Increase male involvement in FP	4.3.1. Review existing strategies, develop a comprehensive strategy for male FP involvement				
	• Hold 2 TWG meetings to write terms of reference	141,000	-	-	-
	• Hire a Consultant to lead design of strategy for male involvement (40 days LOE)	798,000	-	-	-
	• Hold two workshops to design male involvement strategy	2,724,000	-	-	-

		Estimated Cost (KShs.)			
Intervention	**Activities**	**2012/13**	**2013/14**	**2014/2015**	**2015/16**
4.4. Increase utilization of family planning services through targeted and effective advocacy and communication strategies	4.4.1. in line with the RH Communication Strategy, design, implement, and monitor an ambitious media family planning communication strategy tailored to reach different population segments, and especially those that have an increasing level of unmet need				
	• Hold series of TWG meetings to write terms of reference for design of media communication strategy and monitor implementation (4 in 2012, annually thereafter)	705,000	176,250	176,250	176,250
	• Firm contracted/funded to develop and implement strategy, and funds mobilized to support the Strategy implementation (assumes equivalent of 2 radio spots per day every day)	14,600,000	14,600,000	14,600,000	14,600,000
	• Series of workshops held to set priorities for, and review of, the Strategy (2 in 2012, 1 annually thereafter)	2,724,000	1,362,000	1,362,000	1,362,000
4.5. Increase awareness and voluntary utilization of long-acting and permanent methods (LAPM)	4.5.1. Design a method-specific marketing activity that uses mass media to reach potential clients more effectively (than broader information campaigns) on the benefits of LAPM				
	• TWG to hold two meetings in 2012 to draft terms of reference for the review and development of a socio-marketing strategy for LAPM.	141,000	-	-	-

		Estimated Cost (KShs.)			
Intervention	Activities	2012/13	2013/14	2014/2015	2015/16
	• Hire a communications NGO or firm to design and implement a socio-marketing strategy for LAPM (assumes equivalent of 3 radio spots per week every week).	3,120,000	3,120,000	3,120,000	3,120,000
	• Hold two national workshops to set priorities for the LAPM Strategy, and for review of the performance of the new strategy.	1,362,000	-	1,362,000	-
	4.5.2. Build capacity of community health workers to effectively refer clients for LAPM.				
	• Conduct eight regional workshops to train community health workers on identification and counseling (and especially referral) of potential clients for LAPM (plan to train 4 workers per ward in all 47 counties, i.e. 4 X 25 wards X 47 counties, = 4700)	11,992,500	3,997,500	-	-
	Total Maintain CPR at 46%	***41,434,500***	***23,960,750***	***21,325,250***	***19,963,250***

Theme 4b. Demand Creation: New/Innovative Activities- to accelerate CPR to 56%

		Estimated Cost (KShs.)			
Intervention	Activities	2012/13	2013/14	2014/2015	2015/16
4.6. Enhance the organizational capacity of communities to effectively participate in family planning activities	4.6.1. Build capacity of community health units (CHUs) to support family planning activities by expanding their number and functionality.				
	• Hire a consultant to work with TWG to extract, from the Community Strategy, the aspects that are relevant to family planning and how these can be easily implemented by utilizing the FP partners working in the community (20 days LOE).	399,000	-	-	-
	• Hold a national workshop to examine and enrich the consultant's reporting by taking into account the required standards for CHUs to be deemed as having capacity to carry out family planning activities at their level (i.e. MOH's minimum FP functions of a CHU)	3,842,500	-	-	-
	• Hold 47 county workshops to cater for the 4,200 CHUs in the country. The workshops should involve all FP implementing partners (within a county) meeting up with the representatives of CHUs to seek ways of implementing the consultant's findings and coming up with an action plan.	30,432,500	-	-	-
	4.6.2. Facilitate the formation and operational functioning of community groups				

		Estimated Cost (KShs.)			
Intervention	Activities	2012/13	2013/14	2014/2015	2015/16
	• TWG to draft terms of reference and facilitate hiring of a Community Mobilization Officer (CMO) whose salary will be sourced from an appropriate donor	3,800,000	3,800,000	3,800,000	3,800,000
	• CMO to work with Head of DRH to come up with a work plan of activities covering the relevant community-based activities as contained in this CIP. One such activity is to develop criteria for inclusion of community groups to be facilitated through this CIP to conduct FP advocacy activities.	-	-	-	-
	• CMO and Community Health Workers to convene eight regional meetings/workshops where different community groups are invited to be appraised on the role the groups can play in family planning advocacy. Using the criteria previously developed, these forums should also serve as an initial screening opportunity for those groups that are viable and with capacity to carry out the relevant FP activities. Community Groups would be given application forms to fill so that their eligibility could be assessed and communicated to them after a certain period (these may be large meetings since there be up to 15 groups invited from each of about six Counties in a region/province. If each group brings two members, there could be as many as 180 individuals per regional meeting).	41,040,000	-	-	-

		Estimated Cost (KShs.)			
Intervention	Activities	2012/13	2013/14	2014/2015	2015/16
	• Each year, the CMO and one Community Health Worker per County to meet for three weeks in Nairobi to screen Community Groups Applications with the aim of progressively selecting up to 1000 groups by 2015. The selected groups need to be representative of those led by or belonging to women, men, youth, and those with special needs, etc with youth taking 60% of the slots	11,765,667	11,765,667	11,765,667	11,765,667
	• The selected Community Groups should each conduct at least four FP events in a year (sensitization events or meetings through: Chief's barazas, dialogue days, youth-specific activities, etc). This CIP should mobilize funds as modest financial support to cover community groups meetings' transport, basic stationery/flip charts, and teas- plan to engage 300 (180), 700 (420), 1000 (600), and 1000 (600) community groups in year 1, 2, 3, and 4 respectively where those in brackets are youth groups. A group could consist of 13-20 members. Plan for 4 meetings in a year per group. Activities for youth groups are to be costed separately in section 4.6.3 below)	6,760,000	6,760,000	6,760,000	6,760,000
	4.6.3. Increase youth participation in advocacy for adoption of life skills including FP uptake.				

		Estimated Cost (KShs.)			
Intervention	Activities	2012/13	2013/14	2014/2015	2015/16
	• Youth activities within the communities (rural): With estimated 180,420, 600, and 600 youth groups supported in year 1, 2, 3, and 4 respectively, each County is expected to have about 4, 9, 13, and 13 youth groups over the four years. Each youth group is expected to perform various activities including skits on FP, Road-shows within the communities in the County. The CIP need to mobilize funds to facilitate groups to conduct 4 skits/road-shows in a year within each county	5,264,000	11,844,000	17,108,000	17,108,000
	• Youth activities at the County headquarters (urban): With estimated 180,420, 600, and 600 youth groups supported in year 1, 2, 3, and 4 respectively, each County is expected to have about 4, 9, 13, and 13 youth groups over the four years. Each youth group is expected to perform various activities including skits on FP, Road-shows within the County headquarters towns/cities. The CIP need to mobilize funds to facilitate groups to conduct 4 skits/road-shows in a year.	7,520,000	16,920,000	24,440,000	24,440,000
	4.6.4. Build capacity of Youth Empowerment Centres for provision of basic FP services (i.e. one per constituency).				

		Estimated Cost (KShs.)			
Intervention	**Activities**	**2012/13**	**2013/14**	**2014/2015**	**2015/16**
	• As part of his/her duties the Community Mobilization Officer should work with MOYAs to distribute relevant FP materials as part of the package for Youth Empowerment Centres	9,476,800	-	-	-
4.7. Increased demand for FP by improving advocacy	4.7.1. Lobby for establishment of a County Family Planning Fund to support County Governments-led family planning programmes				
	• TWG to hold three meetings to come up with guidelines on how a County FP Fund should be utilized and accounted for.	211,500	-	-	-
	• DRH to work with FP champions who will hold one meeting per quarter to lobby Ministry of Finance, and donors to raise funds for each county for priority FP demand creation and FP utilization activities in the county.	14,343,333	14,343,333	14,343,333	14,343,333

		Estimated Cost (KShs.)			
Intervention	**Activities**	**2012/13**	**2013/14**	**2014/2015**	**2015/16**
	4.7.2. Increased engagement with opinion leaders for family planning activities (some of the issues for engagement include; (1) Advocate for implementation of Adolescent Reproductive Health Policy of 2005, and the New Population Policy, 2011. (2) Develop an intervention that uses Champions to reach out to politicians with the aim of removing the misconceptions about family planning such as those asking constituents to reproduce in order to get a higher share of national resources, (3). Work with Champions to rapidly design and implement activities that seek to include critical FP issues or imperatives into the political parties' manifestos in time for 2012 General Elections' campaigns. Target inclusion of FP issues into the manifestos of the three leading political parties between Dec. 2011 and March 2012. (4) Lobby Members of Parliament for increased financial allocation for FP commodities and services. (5) Mobilize national and donor funds to purchase sanitary pads for all the lowest quintile girls 15-19 yrs, or simply target all the 15-19 yrs girls in schools within the 20 poorest Counties, (6) Advocate for inclusion of the DCHS in the FP TWG				

		Estimated Cost (KShs.)			
Intervention	Activities	2012/13	2013/14	2014/2015	2015/16
	• Convene series of advocacy meetings disaggregated by nature of leaders (Councils of Elders= 42, County Assemblies=47, Senate=1, Media Houses=10, FP champions=20, Relevant Committees of the National Assembly=3) (n=100 in 2012, 200 per yr thereafter)	4,400,000	8,800,000	8,800,000	8,800,000
	4.7.3. Operationalise the FP component of the RH communication strategy (Advocacy and Communicate) to reach unmarried women				
	• Work with TWG to develop terms of reference for task force to guide development of the National FP Social Mobilization Strategy (NFPSM). Hold two meetings for this purpose	360,000			
	• Contract a consultant to develop the NFPSM Strategy (40 days LOE)	798,000			
	• Hold two national and eight regional mobilization workshops to roll-out the Strategy to all Counties. The cost of this activity involves financing the workshops, buying radio and TV spots (10 radio/TV stations airing 2 times per week for 6 months in a year.	27,300,000			
	• Evaluate the effectiveness of the NFPSM Strategy by hiring an NGO, firm, or consultant to evaluate the effectiveness of the NFPSM Strategy (80 person days LOE)			1,596,000	

		Estimated Cost (KShs.)			
Intervention	**Activities**	**2012/13**	**2013/14**	**2014/2015**	**2015/16**
4.8. Improved activity/resource targeting through outreaches and OBA programmes.	4.8.1. Facilitate the design and implementation of effective outreaches in order to meet FP demand through contacts with clients accessing other services				
	• Hire a consultant to conduct a rapid assessment of existing outreaches and opportunities for integrated outreaches (60 days LOE)	1,197,000	-	-	-
	• Convene a national implementing partners meeting to exchange experiences on the nature and coverage of outreaches with a view of identifying options for integrated outreaches. The workshop should also come up with an action plan for integrated outreaches	2,815,000	-	-	-
	• Monitor to ensure partners have conducted at least two integrated outreaches per county per year	158,860,000	158,860,000	158,860,000	158,860,000
	• DRH to conduct two camel FP outreaches (that serve nomadic populations) per month in each of the seven nomadic constituencies	89,040,000	89,040,000	89,040,000	89,040,000
	4.8.2. Work within the Output-Based Aid (OBA) program to allow targeting of the poor with services.				
	• Hold three meetings with an appropriate OBA partner to agree on modalities for ensuring that 200,000 poor women are identified and provided with vouchers to access family planning services by the end of the year	528,750	-	-	-

		Estimated Cost (KShs.)			
Intervention	Activities	2012/13	2013/14	2014/2015	2015/16
	Total Accelerate CPR to 56%	*420,154,050*	*322,133,000*	*336,513,000*	*334,917,000*
	Grand Total Demand Creation Interventions	*461,588,550*	*346,093,750*	*357,838,250*	*354,880,250*

Theme 5a: Integration and cross-cutting- Activities to Maintain 46%

		Estimated Cost (KShs.)			
Intervention	**Activities**	**2012/13**	**2013/14**	**2014/2015**	**2015/16**
5.1. Revitalize overall FP integration into other services (policies, guidelines, and other materials).	5.1.1. Revise/update the minimum package for RH/ FP/HIV integration. Further, disseminate and sensitize on key integration policies and guidelines especially at lower KEPH levels				
	• Convene workshops to revise/update minimum package for RH/ FP/HIV (2 in 2012)	4,165,833	-	-	-
	• Distribute RH/FP/Other Services Integration Policies and Guidelines to all health facilities	9,476,800	-	-	-
	• Convene workshops to sensitize health care providers in levels 5 and 6 on integration polices and guidelines (8 in 2012)	4,537,500	-	-	-
	• Hold eight regional training workshops for lower level service providers on RH/FP/Other Services' Integration Policies and Guidelines (one workshop in each of the eight provinces to train about 50 TOTs, private sector, NGOs, and CHWs from each County)	9,787,500	5,872,500	-	-
	• Print and distribute 10 copies of visual aids for STI and HIV prevention education to each facility offering temporary family planning methods	4,000,000	-	-	-
	• Hire an IT Assistant and facilitate his/her movement to all facilities to install key integration documents to all facilities' computers OR simply have the IT Assistant compile an email list and send the documents via email to facilities that have email addresses.	1,194,750	-	-	-

		Estimated Cost (KShs.)			
Intervention	**Activities**	**2012/13**	**2013/14**	**2014/2015**	**2015/16**
5.2 Re-activate and scale up the role of family planning champions.	5.2.1 Conduct quarterly Family Planning Technical Working Group (TWG) meetings to identify and review the performance of five and 47 high impact family planning champions at national, and one for each county respectively. (Each year 21012-2015).	705,000	705,000	705,000	705,000
	5.2.2. TWG to hold two meetings to develop terms of reference and simple activity plan outlining key messages and scheduled forums where family planning issues will be addressed or represented	352,500	-	-	-
	5.2.3. Mobilize financial resources to support the operations of family planning champions.				
	• Amount of Kenya Shillings mobilized (KSH60,000-i.e. 15000 per quarter- for each of the five national champions, and KSH.10,000-i.e. 2500 per quarter- for each of the 47 County Champions)	770,000	770,000	770,000	770,000
5.3. Revitalize and professionalize the role of school guidance counselors	5.3.1. Lobby, hold workshops, form committees, and develop strategy and guidelines for revitalizing, professionalizing, and monitoring the role of school guidance counselors.				
	• Hire an NGO/firm/consultant to conduct a secondary schools' sexuality study, i.e. Knowledge Practice and Attitude (KAP) Study whose data is to be used to revise the Life Skills Curriculum (80 person-days LOE)	1,596,000	-	-	-
	• Convene workshops (20 participants) (2 in 2012, 1 each subsequent year)	1,111,000	555,500	555,500	555,500

		Estimated Cost (KShs.)			
Intervention	Activities	2012/13	2013/14	2014/2015	2015/16
	• TWG to hold three meetings with MOE to form a Joint National MOH/MOE Guidance Counseling Committee	528,750	-	-	-
	• Convene annual Joint MOH/MOE committee meetings to develop guidance and counseling strategy and operational manual (each year so that monitoring/review can also be done)	2,355,000	2,355,000	2,355,000	2,355,000
	5.3.2. Operationalize the Strategy and Operational Manual				
	• Hold eight regional/provincial workshops to train about 145 teachers (a male and a female teacher from two schools in each of the 290 constituencies) as TOT Guidance and Counselors in each of the eight workshops	9,352,000	-	-	-
	5.3.3. Evaluate the performance of the new guidance counseling program.				
	• Contract a health/education NGO or consultant to conduct a mid-term review of the Guidance and Counseling program (60 person-days LOE)	-	-	1,197,000	-
5.4. Strengthen FP counseling during ANC and provide FP during post-partum period	5.4.1. Build capacity of service providers to provide FP services in ANC and in post-partum settings				
	• Hold eight regional workshops to train 400 Service providers on Post-partum FP including PPIUCD.	18,400,000	-	-	-
	• Hold two national workshops to train 400 Service providers in the Child Welfare Clinic on FP	14,293,333	-	-	-

		Estimated Cost (KShs.)			
Intervention	**Activities**	**2012/13**	**2013/14**	**2014/2015**	**2015/16**
5.5. Leverage HIV/AIDS resources to support family planning	5.5.1. Support the RH/HIV Integration Committee co-chaired by NASCOP and DRH				
	• RH/HIV Integration Committee to sit quarterly in order to pursue their agenda	282,000	282,000	282,000	282,000
	5.5.2. Update integration training materials				
	• Hold workshops to continually update integration training materials (2 in 2012, annually thereafter)	141,000	70,500	70,500	70,500
	5.5.3. Build capacity of health care workers on RH/HIV integration				
	• Conduct one national and eight regional workshops to train health care workers on RH/FP/HIV integration (4 in year 1, 5 in year 2 with about 40 participants nationally and 20 from each of the 47 Counties)	6,750,000	8,437,500	-	-
	5.5.4. Evaluate the performance of revitalized FP/HIV integration strategy				
	• Contract an NGO or consultant to conduct a mid-term review of the performance of the revitalized FP/HIV integration (60 person-days LOE)	-	-	1,197,000	-
5.6. Strengthening of Post-Abortion Care (comprehensive PAC) by integrating FP into PAC	5.6.1 Build technical capacity of all PAC service providers on FP/PAC integration guidelines				
	• Hire a consultant to help revise the comprehensive PAC guidelines (which includes FP) and develop PAC/FP IEC/BCC materials (60 person-days LOE)	1,197,000	-	-	-

		Estimated Cost (KShs.)			
Intervention	**Activities**	**2012/13**	**2013/14**	**2014/2015**	**2015/16**
	• Convene a national workshop to develop guide the revision of comprehensive PAC (which includes FP) guidelines and IEC/BCC materials	1,565,000	-	-	-
	• Hold one national and eight regional training workshops to train about 500 PAC service providers, i.e. 30 national and 10 in each of the 47 Counties. The same workshops should also cover sensitization of service providers on comprehensive PAC IEC/BCC materials	20,700,000	-	-	-
	• Print and distribute the comprehensive PAC IEC/BCC materials to all eligible health facilities by either emails or physical delivery.	12,000,000	-	-	-
	5.6.2 Develop and disseminate task-sharing guidelines				
	• Hire a consultant to assist develop task-sharing guidelines (30 person-days LOE)	598,500	-	-	-
	• Hold one national workshop to develop task-sharing guidelines	1,700,000	-	-	-
	• Hold one national and eight regional workshops to disseminate task-sharing guidelines to 30 national and 30 service providers from each of the 47 Counties	6,088,500	-	-	-
5.7 Enhance Public Private Partnership (PPP)	5.7.1. Develop/strengthen mechanisms to facilitate/allow private pharmacies and clinics to access commodities from district stores				

		Estimated Cost (KShs.)			
Intervention	Activities	2012/13	2013/14	2014/2015	2015/16
	• Hire a consultant to conduct a desk review of existing policies, guidelines, institutional structures, barriers, & incentives relevant for linking private pharmacies/clinics to KEMSA district stores (30 person-days LOE)	598,500	-	-	-
	• Hold meetings (Using TWG and FP Champions) to advocate/influence decisions necessary to allow private pharmacies/clinics to access commodities (as recommended by the desk review) (6 in 2012 & 4 in 2013)	1,597,500	1,065,000	-	-
	5.7.2. Build capacity of private sector service providers for quality FP service provision				
	• Hold one national and eight regional workshops train about 20 national and 20 private sector service providers from each of the 47 counties on CTU and LAPM	2,132,500	1,706,000	-	-
	• Print and distribute key FP/RH policies and guidelines to all private sector pharmacies and clinics in the country (assume 30 registered pharmacies and clinics in each county)	12,000,000	-	-	-
	5.7.3. Develop mechanisms for institutionalizing private sector participation in support supervision, reaches/ outreaches, Rapid Results Initiatives (RRIs)				

		Estimated Cost (KShs.)			
Intervention	Activities	2012/13	2013/14	2014/2015	2015/16
	• Hold one workshop (facilitated by TWG and FP Champions) to appraise a representative group of principal private sector service provider organizations (equivalent of MOH facility Level IV and above) on the purpose, benefits, and technical and operational aspects of joint support supervision visits, outreaches, and Rapid Results Initiatives (RRIs). The workshop outputs should include a schedule of joint activities.	532,500	-	-	-
	• Facilitate at least one joint support supervision, outreach, or RRI in each county per year. The private sector organizations should be expected to pay for their participation (Number of joint activities)	1,880,000	1,880,000	1,880,000	1,880,000
	• Hold one national workshop (per year) where selected joint teams would present their findings of support supervision, outreach, or RRI. (4 participants, 2 public & 2 private, from each of the 47 counties). MOH should pay for this workshop	4,610,533	4,610,533	4,610,533	4,610,533
	Total Maintain CPR at 46%	***156,999,500***	***28,309,533***	***13,622,533***	***11,228,533***

Theme 5b: Integration and Cross-cutting: New/Innovative Activities to accelerate CPR to 56%

		Estimated Cost (KSh.)			
Intervention	**Activities**	**2012/13**	**2013/14**	**2014/2015**	**2015/16**
5.8. Influence the development and implementation of a multi-sectoral family planning strategy based on the new population policy	5.8.1. Develop the strategy based on desk review of the key opportunities and gaps for integration of family planning into non-health sectors				
	• Hold TWG meetings to develop terms of reference for the concept note and make links with other sectors to constitute a multi-sectoral committee on FP	319,500	213,000	213,000	213,000
	• Hire a consultant to assist the multi-sectoral committee to draft the strategy, and to work with FP champions to lobby for the implementation of the strategy (60 person-days LOE). The consultant to also assist the multi-sectoral committee to develop and implement an action plan for implementation of the strategy	1,197,000	-	-	-
	• Convene two stakeholders workshops to conceptualize the policy elements which should include, as a minimum, (1) a requirement that for a sectoral strategy/ plan to be approved it should have demonstrated that the effects of population growth were rigorously considered, posting of a Reproductive Health Advisor/Desk Officer in each of the relevant ministries, (2) it has exhausted all available opportunities to include family planning messages in its contacts with communities	532,500	-	-	-

		Estimated Cost (KSh.)			
Intervention	**Activities**	**2012/13**	**2013/14**	**2014/2015**	**2015/16**
	• Convene quarterly multi-sectoral committee meetings, to help develop the strategy and lobby/monitor its implementation	6,800,000	6,800,000	6,800,000	6,800,000
	Total Accelerate CPR to 56%	***8,849,000***	***7,013,000***	***7,013,000***	***7,013,000***
	Grand Total Integration & Cross-Cutting Interventions	***165,848,500***	***35,322,533***	***20,635,533***	***18,241,533***

V. INSTITUTIONAL ARRANGEMENTS FOR IMPLEMENTATION

The CIP will be implemented under the leadership and management of the Division of Reproductive Health (DRH) of Kenya's Ministry of Public Health and Sanitation (MOPHS) in conjunction with the Ministry of Medical Services (MOMS). Given the CIP partnership nature, DRH will coordinate and mobilize actions and resources from a wide range of partners and stakeholders at all levels.

The CIP will be implemented in collaboration with relevant stakeholders, which include related ministries and agencies, development partners, the civil society, community-based organizations (CBOs), professional associations, FBOs, champions, voluntary agencies, and the private sector, among others.

To support DRH, the RH/FP Technical Working Group (TWG) consisting of Government and development partner representatives will continue to monitor its implementation, lobby for financial and technical support, and advise on various courses of action. The roles and responsibilities of the many different stakeholders are summarized below.

National Level

The two Ministries (MOPHS and MOMS) are responsible for overall strategic coordination and oversight, which include responsibility for developing or updating policies that affect implementation, for resource mobilization, and for monitoring and evaluation. For management and operational aspects, the DRH, with support from RH/FP TWG, will ensure that the right activities are carried out in the right way and to scale.

Coordination includes ensuring that the strategic actions and activities of the CIP are integrated and harmonized with, and supported by, other health-sector and relevant non-health sector programs. Resource mobilization includes the development of annual budgets in collaboration with the MOMS and Ministry of Finance. Coordination will also involve collaboration with development partners, including those who participated in the CIP development.

Key Government agencies will play crucial roles in implementing the CIP; the agencies include KEMSA, NCPD, Medical Training Institutions, and County Governments. KEMSA is particularly important for ensuring timely and effective procurement and distribution of contraceptive commodities. A large segment of the CIP is aimed at increasing contraceptive use or adoption of safer behaviours among the youth. Most of these youth spend much of the time in school systems. The role of Ministry of Education has been articulated in the CIP, and the DRH will need to work to ensure that this role is actualized.

Sub-National Level

It is also critical that the newly created County Governments are closely facilitated to ensure that the CIP imperatives are part of their key agenda.

There are a significant number of activities requiring the action of Community Health Units (CHU). The limited human capacity at CHUs and at lower level health facilities could pose a serious challenge to the achievement of the CIP objectives. The CIP has planned for a number of capacity building activities that will need to be fully implemented.

At the activity level, a host of implementing partners will need to provide technical assistance and expertise in support of the national FP program. Donor agencies will be called upon to increase their support and to augment the resources that will be required for the CIP.

VI. RESOURCE MOBILIZATION

This CIP has an estimated total of KShs. 26.6 billion required over the coming four years (2012/13 to 2015/16) Compare this with the total of KShs 4.3 billion that was allocated to the entire Ministry of Health's development budget line item on "*Use of Goods and Services*" over the three year period 2006/7 to 2008/9. Even with development partners' contribution, it will be an uphill task to raise the required resources. The endeavour should be to prioritize these activities so that results can be achieved.

The main sources of funding for the current program include the Government of Kenya through the national budget process. There already exists a budget line item on commodities, and the aim is to lobby for increased allocation for both commodities and other activities.

Other sources of funds include multilateral and bilateral donors, NGOs, and FBOs, as well as costs recovered through fees for service by private-sector providers.

Among the key mechanisms for funds mobilization is to share this CIP with stakeholders through open forums. This should be followed by presentations to higher level committees such as the Joint Financing Framework (JAF), the relevant Inter-Agency Coordinating Committees (ICC), and bilateral meetings with donors. Parallel meetings would be held with Ministry of Finance and the relevant Parliamentary Committees. There should also be purposeful meetings with potential private sector donors as articulated in other sections of this CIP. This CIP has recommended and planned for the use of FP champions in these engagements.

VII. MONITORING AND EVALUATION

The CIP currently has sets of interventions and activities intended to increase contraceptive use (CPR) from the current 46% to 56% by 2015. The measurement of CPR will be undertaken in the next DHS in 2013 or 2014. Before the DHS, the CIP needs to be monitored so that DRH can tell if the target can be realistically achieved. This continuous monitoring will utilize lower level results and indicators which are yet to be developed. Thus, and as a first step, DRH needs to initiate a revision of its current results framework and its associated monitoring and evaluation framework (M&E) to reflect the M&E imperatives of the CIP.

The CIP itself has outlined a number of M&E related activities among which the development of an M&E plan is one of them. A good M&E Plan will ensure that roles played by various CIP actors are adequately covered. It will also ensure plans for final CIP evaluation which will include using secondary data from surveys (e.g. DHS and KSPA) in addition to the use of routine data from the national HMIS.

Appendix

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