MINISTRY OF HEALTH

National Family Planning Costed Implemetation Plan 2017-2020

2017

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Acknowledgements

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It is the belief of RMHSU that all the effort that has gone into the development of this CIP will only be worthwhile when there is successful implementation of this CIP through a continued collaboration at all levels and by all stakeholders.

List of Acronyms and Abbreviations

ABR	Adolescent birth rate
AIDS	Acquired Immune Deficiency Syndrome
ASFR	Age-Specific Fertility Rate
ASRH	Adolescent Sexual Reproductive Health
BCR	Benefit-Cost Ratio
BTL	Bilateral Tubal Ligation
CBA	Cost-Benefit Analysis
CBD	Community Based Distributor
CDB	Curriculum Development Board
CHD	County Health Department
CHMT	County Health Management Team
CIP	Costed Implementation Plan
CAC	Comprehensive Abortion Care
CHD	County Health Department
CHMT	County Health Management Team
COC	Combined Oral Contraceptive
COG	Council of Governors
CHV	Community Health Volunteer
CIP	Costed Implementation Plan
CPR	Contraceptive Prevalence Rate
CSE	Comprehensive Sexuality Education
CTS	Clinical Training Skill
CYP	Couple Years of Protection
DFID	Department for International Development
DHS	Demographic and Health Survey
DMPA	Depot Medroxyprogesterone Acetate
DP	Development Partners
DSW	German Foundation for World Population
ECP	Emergency Contraceptive Pill
EDCD	Epidemiology and Disease Control Division
EPI	Expanded Program on Immunization
FBO	Faith Based Organisation
FHD	Family Health Division
FHI360	Family Health International
FP	Family Planning
FP-MCH	Family Planning, Maternal and Child Health
FP-RHCS	Family Planning, Reproductive Health Commodity Security
FSW	Female Sex Workers
GDP	Gross Domestic Product
GFF	Global Financing Facility
GBV	Gender Based Violence
GOK	Government of Kenya
HCW	Health Care worker
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HRH	Human Resources for Health
IGC	Inter-Governmental Coordination
IMR	Infant Mortality Rate
INGO	International Non- Governmental Organisation
Ipas	International Post-abortal Care Services
IUD	Intrauterine Device

KDHS	Kenya demographic Health Survey
KEMSA	Kenya Medical Supplies Agency
KHFA	Kenya Health Facility Assessment
KfW	German Development Bank
KHSP	Kenya Health Sector Program
KHSP IP	Kenya Health Sector Program Implementation Plan
KNBS	Kenya National Bureau of Statistics
LARC	Long-Acting Reversible Contraceptive
LAM	Lactational Amenorrhea Method
LIC	Low Income Country
LMIC	Lower Middle Income Country
LMIS	Logistics Management and Information System
mCPR	Modern Contraceptive Prevalence Rate
MDG	Millennium Development Goal
MICS	Multiple Indictor Cluster Survey
M&E	Monitoring and Evaluation
MNCH	Maternal, New-born, and Child Health
MNH	Maternal and Neonatal Health
MoE	Ministry of Education
MoF	Ministry of Finance
MoH	Ministry of Health
MSI	Marie Stopes International
mCPR	Modern Contraceptive Prevalence Rate
MOH	Ministry of Health
MOMS	Ministry of Medical Services
MOPHS	Ministry of Public Health and Sanitation
NASCOP	National AIDS and STI Control Program
NCPD	National Council for Population and Development
NGO	Non- Governmental Organisation
NPHL	National Public Health Laboratory
NSV	Non-Scalpel Vasectomy
NTLP	National Tuberculosis and Leprosy control program
ODA	Official Development Assistance
PBF	Performance Based financing
PLWD	People Living with Disability
PMTCT	Prevention of Mother-To-Child Transmission of HIV
PPIUCD	Post-Partum Intrauterine Contraceptive Device
PPP	Private Public Partnership
PSK	Population Services Kenya
PSI	Population Services International
QA	Quality Assurance
RH	Reproductive Health
RHCS	Reproductive Health Commodity Security
RMHSU	Reproductive and Maternal Health Services Unit
RMNCAH	Reproductive Maternal Neonatal Child and Adolescent Health
RMNCH	Reproductive Maternal Neonatal and Child Health
SAGA	Sub-autonomous Government Agencies
SBCC	Social and Behavioural Change Communication
SDG	Sustainable Development Goals
SCM	Supply Chain Management
SDP	Service Delivery Points
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TBL	Tubaligation
TFR	Total Fertility Rate

TMA	Total Market Approach
TWG	Technical Working Group
U5MR	Under-5 Mortality Rate
UHC	Universal Health Coverage
UKAID	United Kingdom AID
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USD	United States Dollar
USD	United States Government
VSC	Voluntary Surgical Contraception
WRA	Women of Reproductive age
WHO	World Health Organization
YFHS	Youth Friendly Health Services

Executive Summary

Kenya has made steady progress in improving reproductive health outcomes in the last decade. According to the Kenya Demographic Health Survey (KDHS) 2014, the country achieved a total fertility rate of 3.9 and modern contraceptive prevalence rate of 53%, all being significant progress from the rates in the KDHS 2008/9. The Government of Kenya (GoK) recognises family planning (FP) as an essential component of the Kenya national development agenda and has in place constitutional, policy and political commitments. The Reproductive and Maternal Health Services Unit (RMHSU) of the MOH has proposed thematic working groups to steer the process of developing key FP priorities. This will enable the country to increase access to and use of quality FP services by all- and especially by the poor, vulnerable and marginalized populations- and achieve a mCPR of 58% by 2020.

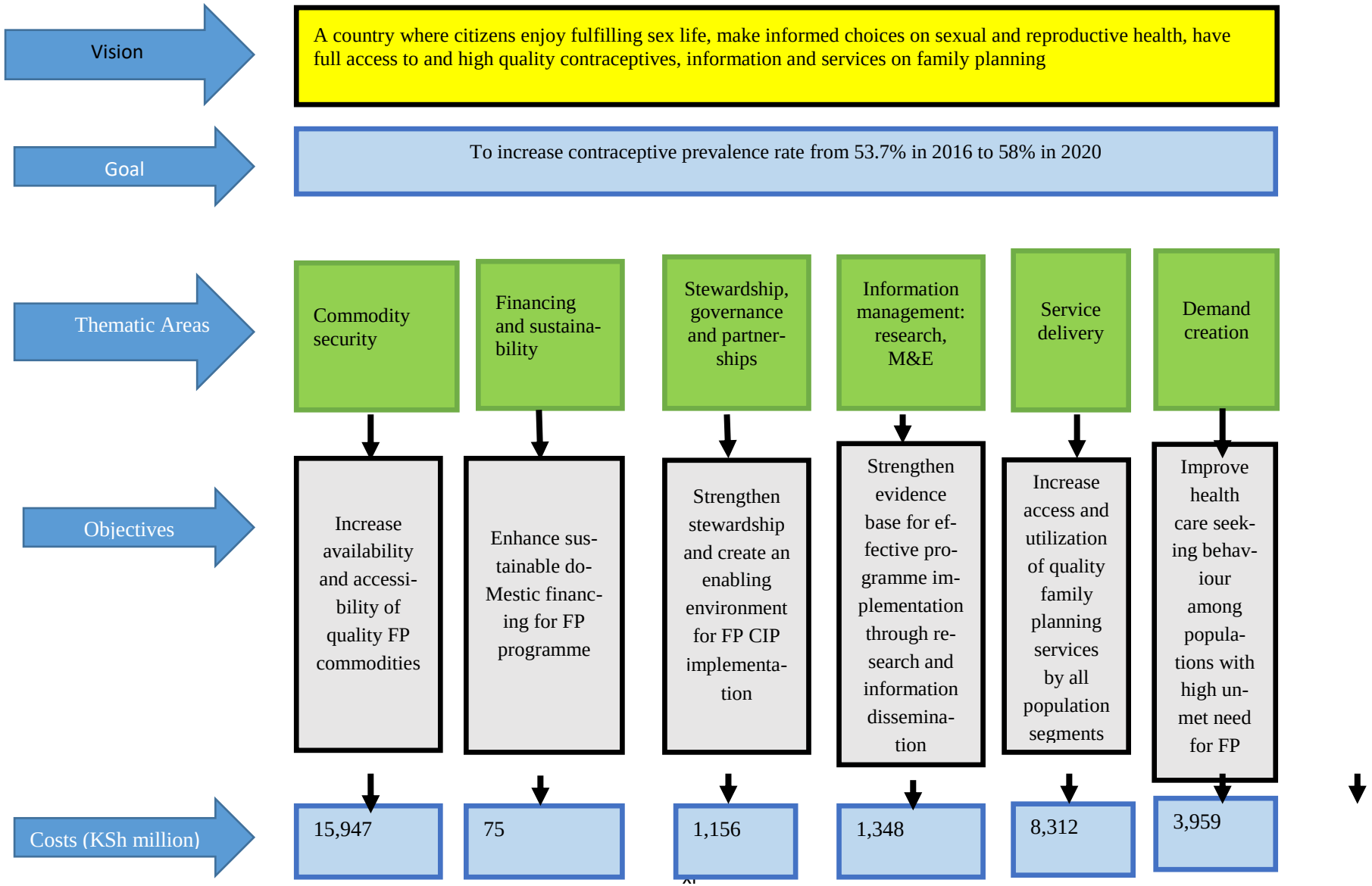
Among the various strategies the GoK has had in place is the 2012-2016 Costed Implementation Plan (CIP) for FP. This CIP aimed to accelerate efforts to attain a CPR of 56% by 2015. Owing to key aspects of the CIP and other interventions, Kenya has made progress in FP. However, the CIP 2012-2016 was not optimally utilised as had been envisioned at the time of its development mainly due to constitutional changes that saw devolution implemented. The MoH, with support of UNFPA has commissioned development of FP CIP 2017-2020. Under the leadership of the MoH/RMHSU, and building on the lessons learnt from CIP 2012-2016, a national FP CIP 2017-2020 has been developed in close consultation with all key stakeholders. The purpose of the CIP is to articulate national priorities for FP and to provide guidance at national and county levels on evidence-based programming for FP so as to achieve the expected results, as well as to identify the resources needed for CIP implementation. In addition, the CIP is intended to serve as a reference document for external development partners including donors and implementing agencies to understand and contribute to the national priorities on FP outlined in the plan to ensure coherence and harmonization of efforts in advancing FP in Kenya. The CIP 2017-2020 also takes cognizance of the devolved governance structures. It is aligned to FP2020 goals and will serve as a framework that will inform counties in development of their own county specific CIPs.

To address the existing challenges and opportunities for scaling up rights-based FP in the country, the FP CIP 2017-20 focuses on six thematic areas. They are; FP commodity security; FP financing and sustainability; stewardship, governance and partnerships; information management; demand creation and service delivery.

The total estimated funding requirements for the four years' CIP is is KSh 30.80 billion (US$ 305 million). These investments will result in enormous benefits which include about 2 million unplanned pregnancies averted, over one million unplanned births averted and over half a million unsafe abortions averted. Additionally, improved health outcomes will be realised through reduced maternal and child mortality. Assuming the recent level of funding is maintained, the funding gap is estimated at KSh 8.41 (US 83 million).

This CIP framework document recognizes that the counties will take the responsibility of financing FP services. However, inclusion of FP services in the essential services in social insurance under universal health coverage (UHC) that has been mooted by the country will ensure sustainability of FP.

Figure 1.0: KENYA NATIONAL FAMILY PLANNING COSTED IMPLEMENTATION PLAN 2017-2020



1 INTRODUCTION

1.1 General Overview

Voluntary, high-quality family planning (FP) can help curb rapid population growth and drive development. In recognition of these links, the Kenyan government has put in place various strategies and policies[1] to facilitate the use of FP services as a step towards reducing the fertility rates, increasing contraceptive prevalence rate (CPR) and reducing unmet FP needs. Based on the results of the 2014, Kenya National Demographic Health Survey (KDHS), Kenya has made significant progress on FP indicators putting the nation on track to surpass its 2020 target[2]. Regardless of the overall national progress in FP however, disparities in FP utilization rates are still visible among different regions and specific population groups[3]. Building on FP gains made so far, recognising existing disparities, and taking into consideration issues of national and global bearing on FP (see Annex C), the Reproductive and Maternal Health Services (RMHSU) of the Ministry of Health (MoH) begun a process of reviewing and revising the country's FP program.

The review of the country's FP programme is led by MOH in collaboration with partners through development of the Kenya National Family Planning Costed Implementation Plan (FP-CIP) 2017-2020. The CIP 2017-2020 is the second FP CIP to be developed in Kenya. This CIP takes cognisant of FP as an essential component in the Kenya national development agenda ring-fenced in various legal and policy frameworks. It also takes into account lessons learnt from the first CIP (2012-2016), builds on previous work done by stakeholders such as USG/USAID and UNFPA and takes cognisant of new innovative approaches for financing and sustainability (Figure 1.1).

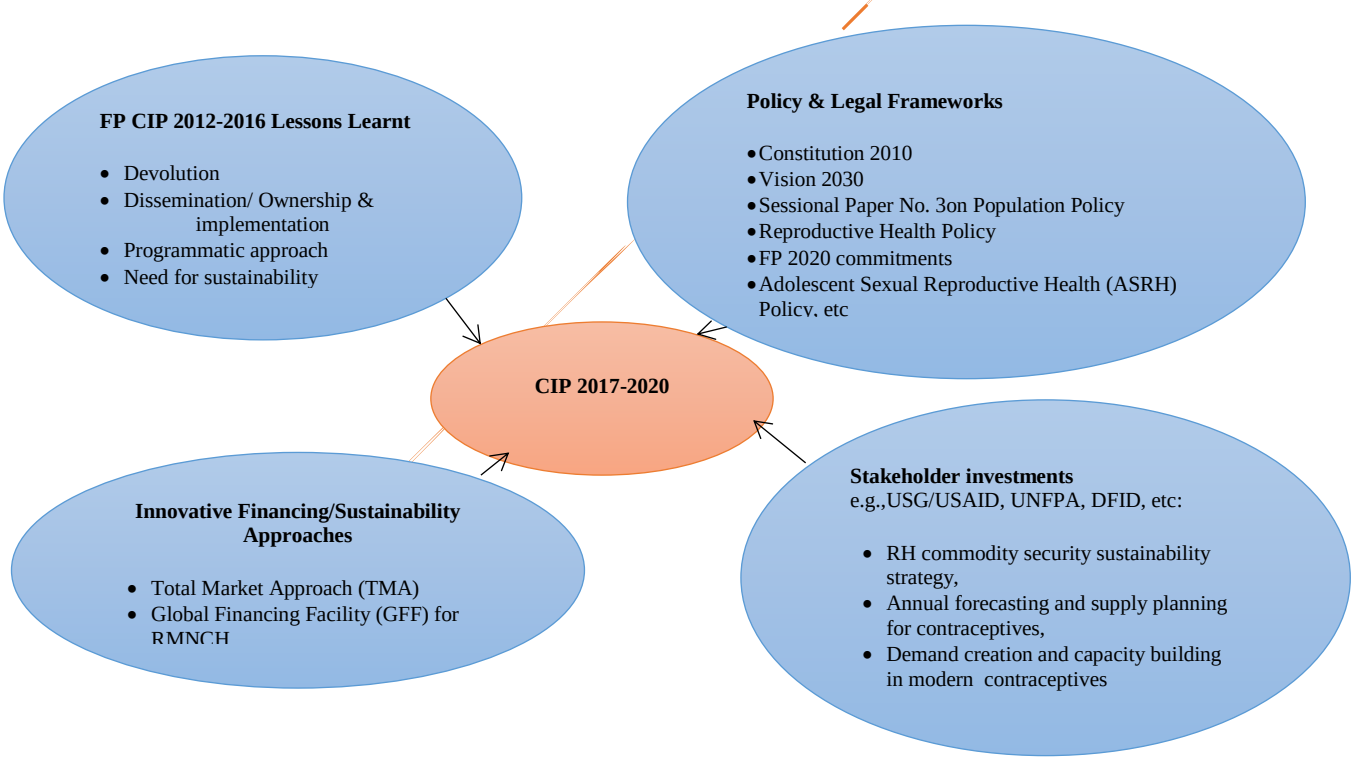


Figure 1.1. FP CIP 2017-2020 framework

[1] Key recent examples include the Kenyan Constitution 2010, the National Reproductive Health Policy 2007 implemented through the National Reproductive Health Strategy 2009-2015; Kenya's vision 2030 second pillar i.e. the social pillar commits to ensuring increased uptake of Reproductive Health services by poor and vulnerable women; the National Gender and Development Policy, the revised Adolescent Sexual Reproductive Health (ASRH) Policy of 2015, among others

2 Kenya National Bureau of Statistics and ICF International. 2015. Kenya Demographic and Health Survey 2014: Key Indicators. Nairobi and Rockville, MD: KNBS and ICF International

3 For example the CPR in some counties of central Kenya is 75% where as in some counties of Northern region it is as low as 1.9%; the percentage of women who have begun childbearing increases rapidly with age, from about 3% among women age 15 to 40% among women age 19 an unacceptably high fertility rate among the youth and adolescents.

1.2 Rationale for and Use of the National FP-CIP

The national FP-CIP 2017-20 details the country's plans to achieve its FP vision and goals to improve the health and well-being of its population and the nation through providing high-quality, right-based FP information and services. The plan provides critical direction to Kenya's FP programme, ensuring that all components are adequately addressed and budgeted for. More specifically, the FP-CIP will be used in the next four years to:

- Ensure a unified country strategy for family planning is followed
- Define key strategies, activities, inputs and an implementation roadmap
- Determine demographic, health, and economic impacts of the FP programme
- Define a national budget for FP
- Mobilize resources in order to secure donor, government and private sector commitments for the FP programming.
- Coordinate activities and monitor progress of activities implemented by multiple stakeholders
- Provide a framework for inclusive participation by providing a clear framework for broad-based participation of stakeholders within and outside of the MoH.

1.3 Status of Family Planning: A Global and Regional Overview

In 2015, two out of three women of reproductive age globally who are married or in a union, use some form of contraception, either modern or traditional, and another 12 per cent have an unmet need for contraception. Combining contraceptive use and unmet need shows that over eight out of ten women aged 15-49 who were married or in a union had their FP demand satisfied, but with substantial variation across regions and countries. However, in Africa, less than half of women who are married or in a union and needed contraception had their FP demand satisfied[4]. Worldwide, some 1.2 billion adolescents, aged 10-19, comprise more than 16 per cent of the total population. About 15 per cent of adolescent girls who are married or in a union are using modern contraception. In 2015, 12.7 million adolescent girls had an unmet need for FP. This number will increase to 15.1 million by 2035 if current trends continue[5].

Sub-Saharan Africa continues to lag behind the rest of the world, carrying a disproportionate burden of teenage pregnancy and maternal deaths. Variations and diversities are common within its two regions, with more significant progress seen in East and Southern Africa compared to West and Central Africa. As at 2015, Sub-Saharan Africa made the least progress in achieving the targets of the MDGs. In 2012, the region continued to show the highest adolescent birth rates (ABR) at 118 births per 1,000 girls, slightly lower than the rate in 1990 of 123 births. The total fertility rate (TFR) remains high for many of the countries in the region (3.9 in Kenya, 4.6 in Rwanda, 5.4 for Tanzania, 6.2 for Uganda, and 6.4 for Burundi). Modern contraceptive prevalence rate (mCPR) in the East African region is generally low and with a wide range of disparity (17.7% in Burundi to 45.1% in Rwanda)[6]. Levels of unmet need for FP are generally higher than contraceptive use in most countries in Eastern Africa. In most Demographic and Health Survey (DHS) reports, injectables and pills are the most popular methods, with low utilisation of condoms, implants, and intrauterine devices (IUDs). Major challenges with the provision of FP services in the Eastern Africa region include inadequate number of skilled providers and frequent stock-out of contraceptive commodities within many facilities (*ibid).* These factors need to be addressed in FP programing to ensure reduction in unmet need and increase mCPR.

[4] UNFPA. 2016. Universal Access to Reproductive Health: Progress and Challenges

[5] United Nations, Department of Economic and Social Affairs, Population Division. 2015. Trends in Contraceptive Use Worldwide 2015 (ST/ESA/SER.A/349

[6] Eastern Africa Reproductive Health Network Strategic Plan, 2012–2016. Retrieved 19 November 2016 from http://www.earhn.org/.

1.4 Overview of Population and Family Planning in Kenya

Kenya's population trends show a gradual increase in population size. In 2009, Kenya's population size was 38.6 million, with 2016 figures showing a population of 47.7 million, and 2020 projections indicating 52.2 million[7]. Kenya's largest population proportion is youthful, with over half (53.5%) ranging 0-24 years[8] (Figure 1.2).

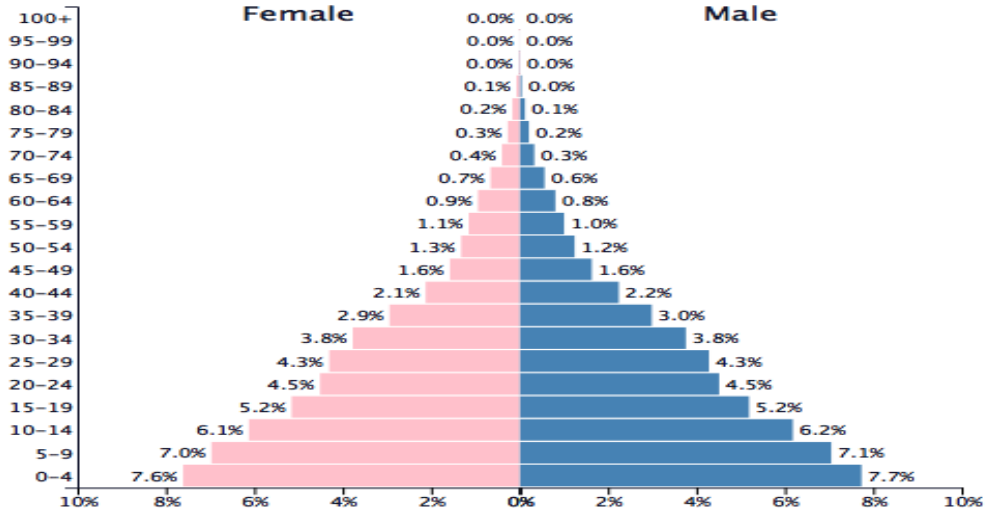


Figure 1.2: Kenya's population pyramid (2016)

Despite the gradual increase in population size, the country's Total Fertility Rates (TFR) have been improving since year 2003 as shown in Figure 1.3.

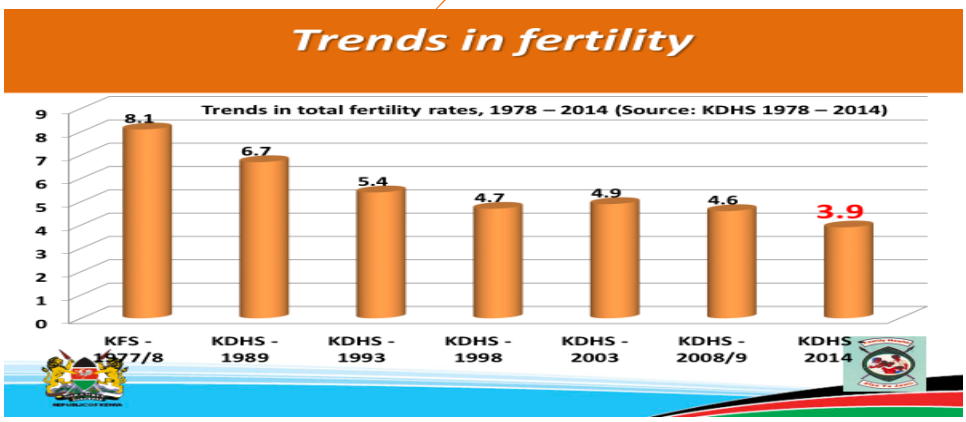
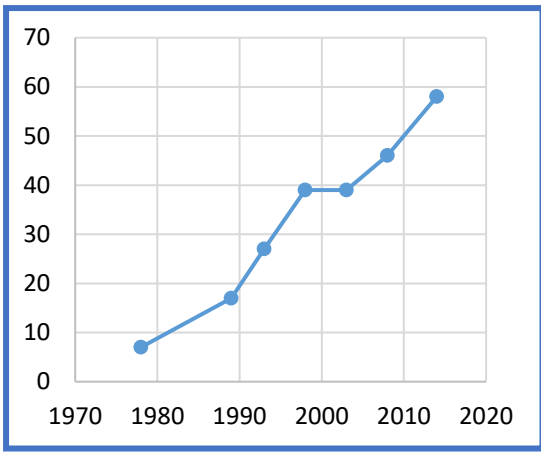


Figure 1.3: Trends in fertility in Kenya

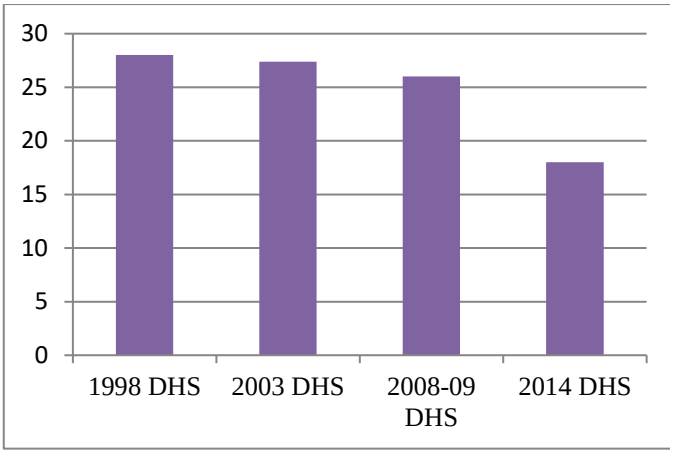
Kenya has made credible progress in improving its contraceptive prevalence rate (CPR) and reduction of unmet need for FP as shown in Figure 1.4, both major factors contributing to reduced TFR. There has also been an increase in uptake of long acting methods from 9% in 2008/9 to 25% in 2014.

[7] Kenya National Bureau of Statistics (KNBS). 2009

8 2016 population pyramid estimations



Trends in CPR



Trends in Unmet Need fro FP

Figure 1.4: Trends in CPR and unmet need for FP in Kenya

Despite the overall progress in TFR and CPR, there are disparities in exist among different counties, and specific population groups such as adolescents, and among women in poor backgrounds and hard to reach areas (see Annex C for details).

Kenya is among the countries that have pledged commitment to FP2020. Kenya has defined clear objectives and made commitments related to programme and service delivery and finance/budget allocation and at the policy and political level to achieve its pledge (see Annex C for Kenya's commitments and progress to FP2020).

2 ISSUES AND CHALLENGES FACING CURRENT FP PROGRAM IN KENYA

2.1 Operationalization of FP CIP 2012-16

In 2012, the then Ministry of Public Health and Sanitation (MOPHS) and Ministry of Medical Services (MOMS), in collaboration with various stakeholders developed the 2012-2016 FP- CIP. This CIP was aimed at accelerating the efforts to attain a CPR of 56% by 2015. However, the CIP, developed in the centralised context, was not fully utilized because devolution took effect immediately after its completion. Other challenges related to operationalization of the CIP are presented in Table 2.1.

Table 2.1: Challenges in operationalization of CIP 2012-2016.

Key issue	**Details**
Constitutional changes	Devolution of health immediately after development of CIP made its implementation largely inapplicable
Lack of dissemination	FP stakeholders unaware of the existence of the CIP
Lack of an M&E framework and plan	No indicators to guide monitoring and evaluation of CIP performance
Financial sustainability	Largely dependent on donors as source of funding

With lessons learned from the CIP 2012-2016, the current CIP addresses the challenge of devolution through providing a framework to be adapted by counties to ensure their FP programming aligns and contributes to the national FP goal of reaching the 58% CPR by 2020. Additionally, the CIP 2017-20 provides counties flexibility to adapt the national CIP to their specific circumstances by offering broad strategies that can be adapted to specific county situations, whilst ensuring these specific situations feed into the national goal.

2.2 Commodity Security

Reproductive health commodity security (RHCS) exists in the presence of supportive national policies, fully functional national and local logistics management systems and the supply chain being timely and adequately available to service providers9. The government of Kenya's commitment to ensuring that reproductive health services are accessible to all Kenyans is spelt out in the National Reproductive Health Policy, and outlined in the CIP 2012-16. However, challenges in RHCS exist in Kenya as follows:

Table 2.2: Challenges in commodity security

Key issue	Details
Limited availability and access to FP commodities and reproductive health medicines in health facilities	• Existence of supply chain bottle necks such as use of a decentralized supply chain design to serve a decentralized health system • Weak commodity management practices and inadequate commodity data for decision making due to low reporting rate and poor quality data • Inadequate capacity by counties in forecasting and supply planning • Stock-outs, e.g., only 14% of the service delivery points (SDPs) had no stock-out over the three-month period before

9 Definition adapted from K4Health Toolkits: https://www.k4health.org/toolkits/contraceptive-security-committees/what-commodity-security

	the survey. On the day of the survey, only 19 per cent of the facilities had no stock-out[10]
Private sector optimal involvement in FP	• Private sector data is not included in the forecasting and supply planning processes • Proper market segmentation has not been done thus, the existing market distortion (private providers getting free supplies and - those who can afford to pay- getting free commodities)
Mismatch between FP commodity stocking and FP strategies	• The push for long term methods is not aligned to resources availed by the government to procure the necessary methods
Fluctuation of FP budget line over the years & diminishing donor support	• Declining internal resourcing/ budgetary allocation for FP Commodities - steady drop in budget for FP, e.g., $6.6 million dollars (40% of commodities) in 2012-13 financial year, then dropping to 500,000USD (2.9%) in 2015
Loss of FP budget line post devolution	Led to dependence on donors for commodities

Recognising the need for ensuring commodity security and incorporating lessons learnt from diminishing donor support for FP commodities, this CIP addresses the above-mentioned issues by formulating and including a series of interventions that demand proper understanding of the national supply chain, compliance with national ordering and reporting process and skills in management of commodities at each level of the MoH system- national and county levels. This includes strategies and activities that improve the availability of quality modern FP methods in SDPs, through addressing the supply chain related issues -forecasting, procurement and distribution. Additionally, the CIP outlines approaches to improve skills in commodity management at national and county level.

2.3 Family Planning Financing and Sustainability

Family planning is a cost-effective investment which saves money. By the year 2015, every Ksh.85 (US$1) spent on FP saved Ksh 381 ($4.48) in direct healthcare costs in Kenya. If county governments accelerate progress in the uptake of modern FP methods, these savings would increase to Ksh 464 (US$5.46) per Ksh 85 (US$1) spent. This would save Kenya an additional Ksh 6.8 billion (US$80 million) in direct healthcare expenses by 2020[11]. Despite having an enabling and supportive policy environment on FP in the country, there still exists a disconnect between policies and budget allocations[12]. Other issues affecting FP financing are summarised in Table 2.3

Table 2.3: Key challenges of FP financing in Kenya

Key issue	Details
Devolution of health and budget line for FP	• Few counties have FP-specific budget lines within their Programme Based Budgets (PBB) • Lack of prioritization of RH and FP - funds not allocated and spent appropriately on FP-related supplies and personnel in recurrent budgets
Alignment of national policies to budgetary allocation	• Sub-optimal adaptation and implementation of national policies at the county level, including the Community Health Strategy

10 Kenya health facility Assessment Survey, 2015.

11 Health Policy Project (HPP), United States Agency for International Development (USAID), and Marie Stopes International (MSI). 2014. *ImpactNow Model: Estimating the Health and Economic Impacts of Family Planning Use*. Washington, DC: Futures Group, Health Policy Project

12 For example, the National Adolescent Sexual and Reproductive Strategy of 2015 did not have new resources attached to it. This applies to other strategies that are either under-funded or not costed

	• Limited financial support for scale up training and counselling for FP service providers on the provision of LAPM • Key FP strategies lacking a commensurate budgets
Capacity for comprehensive budgeting	• Limited capacity to track expenditure on FP commodities, in-service training, and facility improvement based on budget allocations • Weak annual performance reviews and annual workplans, limited understanding of PBB, and tracking of progress against plans
Diversity and amount of FP funding	• Contraction of donor financing for FP commodities • Multi-sectoral involvement in funding and provision of FP services is limited despite FP being a broad development issue • Private sector role in FP service delivery and financing not clearly defined • The position of FP within NHIF benefits packages not well understood by providers or clients • Novel funding streams such as the GFF are not well understood at county level and may not be optimized for FP (and its integration within RMNCAH)

This FP CIP seeks to address the key FP funding issues through diversifying funding sources; increasing funds allocation by the government and strengthening advocacy for funding from multiple sources including the county treasuries. In addition, it advocates for review of policy on "free" FP commodity allocation to private entities. The CIP also envisages other strategies such as risk pooling through expansion of insurance cover for full method mix. Additionally, the biggest new development in financing for FP (and maternal child and adolescent health) is the GFF. The MoH will use the CIP to build its investment strategy and put forth a projected budget for FP.

2.4 Stewardship, Governance and Partnerships

Effective governance and regulatory frameworks are the main vehicles through which targets set for the CIP can be achieved as it allows all stakeholders (health and non-health) to collaborate and coordinate their actions, recognizing each one's specific responsibilities. Governance obligations are outlined in the Country's legal framework. The governance of the health and other sectors have been guided by several legal frameworks including the 2010 constitution, Public Health Act Cap 242, the Pharmacy and Poisons Act Cap 244, Dangerous Drugs Act Cap 245, the Medical and Practitioners and Dentists Act Cap 253 and many others which continue to be enacted. As a result of the expansion of services and growth in the health sector, the numerous enacted legal frameworks in the sector have increasingly led to divergence and negative synergy. Additionally, Kenya faces a number of challenges with regard to operational leadership for FP programming at both the national and county level (Table 2.4):

Table 2.4: Key challenges of FP leadership

Key issue	Details
Political good-will	• Political goodwill has not entirely translated into conducive FP programme environment, nor led to effective facilitation of resources mobilization - key FP strategies lacking a commensurate budget • FP is not perceived as a broad development issue requiring sup-

	port of a significant proportion of non-health actors; Allocation of resources largely based on population parameters
Weak supportive supervision mechanisms and structures	• Facilities go without supervision for over 1 year especially in North Eastern, Central and Nairobi regions (KHFA, 2015) • Supervision visits not comprehensively inclusive of all RH/FP issues
Adequacy of FP coordination and governance mechanisms	• Coordination of FP at national level largely happens during FP technical working group meetings with government officials, partners, and in-country donors. Currently, such meetings happen in an ad hoc manner, making it difficult to track the results of action items developed during previous meetings • Lack of clear coordination mechanisms to track partner efforts at county level • Private-for-profit stakeholders reporting not mainstreaming in the county reporting system
Lobby for FP recognition as a development issue beyond health	• MOH and NCPD-led efforts are time consuming • Process requires policy alignment and/or change thus long-term in nature

Noting the above issues, the CIP outlines a number of strategies and activities to ensure effective leadership of FP programming. Some of these include establishment of a IGC mechanism including a broader detailed coordination of all stakeholders that outlines linkages and roles of various actors (see chapter 6).

2.5 Family Planning Information Management: Research, Monitoring and Evaluation

Successful FP programs use research, monitoring, and evaluation to guide design and implementation. By providing crucial information, these tools help program managers decide wisely how to take new directions, solve problems, assess effectiveness, and make adjustments[13] .

Table 2.5: Key challenges of FP information management

Key issue	Details
Research on FP ~~not cascaded to national level~~	• Partners' input address project priorities in a 'regionalised' manner thus do not inform national programming and policy formulation • National research agenda requires to be updated to guide FP research nationally
Persistent lack of information on FP budgets	• Information on amounts invested in FP is unavailable due to lumping together of the health budget with no clear designation of funds for FP programming
Weak M&E system	• National FP M&E plan is non-existent • Limited systematic use of data in formulation and implementation of national FP programme • Isolated donor-funded programmes are monitored and evaluated as standalone projects. Results of such evaluation not systematically fed into national programming

This CIP has a number of strategies to improve generation and utilization of information for FP programming. These include implementation of formative and operational research to inform program managers and planners, generating information to support policy advocacy, employment of strategies for reaching influential audiences with information generated, putting in place a performance man-

[13] John Hopkins Bloomberg School of Public Health (2008). Elements of Success in Family Planning Programming

agement systems and frequent M&E. The CIP has provided a number of outcomes and indicators that will be used to evaluate the FP programme.

Demand Creation

Data from FP programmes show that demand creation does drive uptake of long-term FP methods[14]. Kenya has made significant progress in increasing demand for FP services as a result strong leadership and political support at top levels. Despite the impressive progress in FP demand creation in Kenya, there are still challenges to address as shown in Table 2.6.

Table 2.6: Key challenges demand creation

Key issue	Details
Demand creation efforts are not met with commensurate availability of commodities	• Increased demand created not satisfied hence frustration at community level
Weak FP services seeking behaviour	• FP services not viewed as priority health needs/life-saving, hence not prioritised
Lack of accurate and consistence information among 15-19 year olds	• Lack of support and information-sharing by parents, teachers, religious bodies and incorrect information from peers.
Absence of support from critical stakeholders for incorporation of Comprehensie Sex Education (CSE)	• No backing for implementation of an age-appropriate, comprehensive sexuality education (CSE) due to cultural and religious sentiments
Myths and misconceptions on side effects	• High level of knowledge on contraceptive methods does not translate to complete accurate information on contraceptives • Cultural and/religious beliefs fuel myths and misconceptions
High cost of enganging Community Health Volunteers (CHVs) in demand creation	• CHVs are not part of the Kenyan health system human resources for health and operate as volunteers hence lack a budgetary allocation and pose a challenge to sustained engagement in demand creation activities, & their utiliation is low

The CIP has put in place various strategies to address the afore-identified challenges of FP demand creation, while incorporating best practices lessons learnt from the successful implementation in the country over the years.

2.6 Service Delivery

The overarching strategy of FP programmes is to offer clients easy access to a wide range of affordable contraceptive methods through multiple service delivery channels in good-quality, reliable and through a right-based approach[15]. Kenya has shown leadership in integration of health services, with substantial support from international partners and local civil society organizations (CSO)[16]. There are however challenges that need to be address to enhance FP service delivery in an equitable and more efficient as shown in Table 2.7

Table 2.7: Key challenges in FP service delivery

Key issue	Details

[14] PSKenya (2009-2013) and the Kenya Urban RH Initiative–Tupange

[15] John Hopkins Bloomberg School of Public Health (2008). Elements of Success in Family Planning Programming

[16] Centre for Strategic and International Studies. 2015. Family Planning and Women's Health in Kenya

Unequal deployment of health service providers and sufficiency of health care worker	• Government focus is equality rather than equity which continues to marginalize the already underserved areas • Inadequate health care workers compromises access to and quality of FP services provided by the existing personnel
Insufficient operationalization of FP guidelines on FP provision	• FP guides relating to provision of FP methods by different categories of service providers to ensure quality, equity in availability of investments needed for the services delivery not fully implemented • Healthcare providers often lack training to provide the full range of FP methods applicable to their cadre (especially the more effective and less expensive LARC
Public health facilities Inadequate supply of equioment and supplies	• Lack of adequate and steady supply of equipment, supplies and consumables for actual FP services provision
Insufficient strategies for provision of high quality youth friendly services (YFS)	• Support by critical stakeholders (parents, health care workers, religious leaders) and a multisectoral approach is not consolidated • Health care workers biases exists • Inadequate youth friendly service delivery points.
CHs engagement unsustainable	• CHVs are technically volunteers and thus not considered as part of the human resources for health therefore not included in the budgeting process. • Consequently, they do not have a steady income to enable them sustain providing services • Diminishing support from partners who initially supported CHVs activities • High numbers of CHVs (over 150,000) poses a challenge in their overall supervision and financing
Cultural factors	• Low male involvement in FP and RH services
Private facilities holistic integration in FP	• Data on the proportion of Kenyans seeking FP services from private sector including clinics, hospitals pharmacy outlets and health facilities is scanty - only 38% of registered private facilities reporting on FP service provision data

The CIP outlines strategies under service delivery centred around reduction of unmet FP needs for populations with special needs; strengthening human resources and skills to provide FP services and information; integration of FP services into other healthcare services; and establishment of partnerships for FP service provision.

3 NATIONAL COSTED IMPLEMENTATION PLAN FOR FAMILY PLANNING

3.1 Overall Vision Mission and Goal

The vision, mission and goal specifically bring out the expectations of this strategy with regard to family planning. It is designed to provide an overall framework into which FP priorities and actions are derived. Its strategic focus is as follows:

	Vision A country where citizens enjoy fulfilling sex life, make informed choices on sexual and reproductive health, have full access to and high quality contraceptives, information and services on family planning. ***Mission*** To ensure that all Kenyan people have access to high-quality, affordable reproductive health care, comprehensive sexual health education, and the right to manage their reproductive lives. ***Goal*** To increase contraceptive prevalence rate from 53.7% in 2016 to 58% in 2020.

3.2 Priority Action Areas

The priority action areas in the FP-CIP mirror key FP issues that should be addressed in order to reach the national FP goal. They represent key areas for financial resource allocation and implementation performance. The priorities are formulated to ensure that limited available resources are directed to interventions that have the highest potential to reduce the unmet need for FP. In case of a funding gap between resources required and those available, the strategic action areas should be prioritized to ensure the greatest impact and progress towards achieving the CIP objectives. Identifying the priority areas allows the MOH, through the RMHSU to focus resources and time on effectively coordinating and leading the national FP-CIP execution, and guides counties to align their FP priorities to the national ones.

Box 3.1: Seven strategic priority action areas

Priority # 1: Improve FP commodity procurement and distribution and ensure full financing of FP commodities in the public and private sectors to prevent stock-outs

Priority # 2: Increase the sustainability of FP commodities and services through government commitment, integration of the private sector, and diversification of funding sources

Priority # 3: Strengthen FP leadership at national and county levels; integrate FP policy, information, and services across sectors for holistic contribution to social and economic transformation

Priority #4: Strengthen evidence base for effective programme implementation through research and information dissemination to enhance relevant programming

Priority #5: Improve ability of individuals within the population as a whole, and special needs groups to achieve their fertility desires by providing tailored FP services, and information on SRH and linkage between fertility and general health and well-being

Priority # 6: Promote and nurture change in social and individual behaviour to address myths and misconceptions and improve acceptance and continued use of FP with a special focus on increasing age-appropriate information, access, and use of FP amongst young people, ages 10-24 years and populations living in ASAL areas

Priority #7: Enhance skills of new and existing health care workers through adequate practical training in the full FP method mix, and empower community health workers to provide counselling and referral services, and short-term methods

The seven strategic priorities above are addressed through various activities within the CIP's thematic areas (see Annex A).

3.3 Thematic Areas, Objectives and Interventions

The thematic areas, objectives and interventions were developed through a series of stakeholder consultative meetings that discussed issues related to the structure and contents of the FP CIP, and aligned to the existing country guidelines, policy and operational documents. The activities in the FP-CIP are structured around six thematic areas of a FP programme. Table 3.1 outlines the thematic areas and objectives of the CIP.

Table 3.1: CIP 2017-20 thematic areas and objectives

Thematic Area #	FP Thematic area	Objectives
1.	Commodity security	To increase availability of quality FP commodities
2.	Financing and sustainability	To increase allocation and diversify sources of FP funds
3.	Stewardship, governance and partnership	To strengthen stewardship and create an enabling environment for FP CIP implementation
4.	Information management: research, monitoring and evaluation	To strengthen evidence base for effective programme implementation
5.	Demand creation	To improve health care seeking behaviour among populations with high unmet need for modern contraception through a right-based approach[17]
6.	Service delivery	To increase access and utilization of quality FP services by all population segments in a right based manner

An Overarching concept of the CIP

An overarching concept of the FP CIP 2017-20 is the implementation of Family Planning Reproductive Health Commodity Security (FP-RHCS) Sustainability Strategy. This entails operationalization of the three FP-RHCS components namely financial equity, equitable access and sustainability through incorporating the nine modules[18] of the strategy across the proposed thematic areas.

3.3.1 Thematic Area 1: Commodity Security

Outcome: Increased access to quality FP commodities.

Strategy

The focus is reliability of supply of quality contraceptive commodities to meet clients' needs and prevention of stock-outs. In addition, it also addresses the sustainable supply of quality contraceptive commodities at all levels of the supply chain. This thematic area has four strategic activities discussed below.

Strategic activities:

CS1. Aligning FP supply chains to devolved governance structures. This will be done by implementing a system redesign of both National and County FP supply chains to ensure they are properly aligned to provide uninterrupted supply of FP commodities at all levels of the supply pipeline. The redesigning of the system will be informed by the needs of the devolved health function and will include aspects of private sector involvement. The new supply chain design will promote market segmentation based on the principles of Total Market Approach (TMA) and allow participation of the private sector in FP commodity security.

17 Right-based approach entails implementing programmes that aim to fulfill the rights of all individuals to choose whether, when , and how many children to have to act on those choices through high quality SRH services and information and education; and to access those services free from discrimination, coercion and violence

[18] 1. Contraceptive Repository & Revolving Fund, 2. Procurement & Forecasting Capacity Module, 3. Quality Contraceptive Supplies Module, 4. Supply Chain Management Module (including last mile), 5. Pooled risk Module (FP in health insurance), 6. Equitable Access Module (reaching underserved using TMA), 7. Social Norms Module (demand side FP), 8. Quality Contraceptive Services Module, 9. Communication and Dissemination Module (county focus & data)

CS2.Strengthening contraceptive forecasting and supply planning. This will entail: i)annual quantification (forecasting, supply planning) of FP commodities for the public, private for-profit and private not- for-profit sectors, pipeline monitoring to ensure uninterrupted supplies, ii) semi-annual reviews of forecasts and supply plans under the stewardship of FP CS TWG. iii) regular review of product specifications to ensure supply of quality products and auxiliary supplies, iv) review of current quantification guidelines to guide quantification of FP commodity requirements at all levels, v) training of FP managers and healthcare workers on forecasting and supply planning at national and county level to ensure they have the capacity to develop accurate forecasts for FP commodities and vi) strengthening and supporting the national FP logistics TWG and the County Commodity Security TWGs to undertake monthly pipeline monitoring and update the FP dashboards at national and county levels to ensure uninterrupted flow of FP commodities.

CS3. Enhancing skills and capacity for FP supply chain management at all levels. This will be informed by a skills audit to determine the capacity gap existing at all levels of the supply chain. The current FP commodity management training package will then be revised and used to build the capacity of program managers and health care workers on ordering, receiving, storage and distribution of FP commodities at all levels of care as determined by the skills audit. At the national level, the FP program in collaboration with the KEMSA will ensure commodities are available and distributed to last mile of the supply chain based on "pull/push" system as appropriate.
The national commodity security TWG and the County Commodity Security TWGs will be strengthened through training and mentorship to ensure they provide oversight, governance, leadership and accountability in FP commodity security at all levels of the healthcare systems.
FP focal persons/ RH coordinators and pharmacists within each County will coordinate to proactively manage contraceptives stocks in the facilities.

CS4. Establishing quality control system for FP commodities. At the national level, the FP program in collaboration with the procuring entities will ensure quality contraceptives are made available through development of quality assurance systems that will include quality control measures, appropriate product specifications and pre-qualification of suppliers. To ensure quality products at the last mile, HCWs at all levels will be sensitized on commodity management including guidelines for disposal of expired and damaged products. The intervention will also entail collection, detection, assessment, monitoring, and reporting of adverse effects related to family planning products.

3.3.2 Thematic Area 2: Financing and Sustainability

Outcome: Increased allocation of resources to FP programme by national Treasury, counties, donors, partners and private sector.

Strategy
Focus will be on consistent and reliable financing to procure contraceptives to ensure they are available when and where needed by health programs and clients. This will be achieved by increasing allocation and diversifying sources of funds for FP. Financial sustainability will also be supported by an enabling environment created through advocacy and policy reviews[19]. In the face of other competing demands for public sector resources, the FP program through MOH and partners will mobilize country and county resources to fill the financial gap left by donor phase-out.

Strategic activities
FS1. Establishment of a contraceptive repository. This will be achieved by establishing a contraceptives stock repository located at a central level such as KEMSA and stocked with donor and government procured contraceptives. In order to gain from economies of scale, KEMSA will be responsible for procurement, warehousing and distribution of the contraceptives to points of care based on

[19] For example, laws must allow cost recovery if that is the strategy chosen. Similarly, institutions must have the capability to collect and account for revenues so generated and demand should not be compromised.

orders received from the counties. Both the public and private sector will draw their requirements from the central repository.

FS2. Establishment of a contraceptive revolving fund. FP revolving fund will be established to ensure sustainability post-donor funding for procurement of contraceptives arising from the resizing of the Kenya economy to a lower middle income (LMIC) status. The funds charged to the clients accessing their contraceptives through the Contraceptive Repository will be placed in "Kenya FP Fund" account and used to finance replenishment of FP stocks.

FS3. Mobilization of resources for FP programme. This will entail advocacy for incorporating Reproductive Health Commodity Security (RHCS) in national budget and fostering partnerships for increased consolidation of FP resources. To address the limited financial commitment to FP commensurate to need, the RHMSU, County Health Departments and partners will advocate for increased funding within national and county budgets, starting with the inclusion of FP activities within county development plans and consequently budgets. GFF presents an opportunity for additional funds for FP programming. Kenya's investment case is approved and prioritizes FP.

FS4. Stewardship and implementation of a Total Market Approach (TMA)[20]. The steps in the TMA process include engaging stakeholders through advisory groups and network analysis, assembling evidence for decision-making, such as determining the needs of private providers to provide FP, identifying market segments, surveying commercial product availability, and modelling different financial resource scenarios, and building the total market plan. Given that most of these studies have been done, the FP CIP 2017-2020 will focus on the implementation of the recommendations arising from various research and modelling work.

FS5. Establishment of a risk pooling mechanisms. This will be realized through advocacy for inclusion of the full range of FP methods and contraceptives in health insurance schemes including National Health Insurance Fund (NHIF) and private insurance schemes in Kenya. MOH in collaboration with partners and insurance service providers will develop a business case and rationale for inclusion of full contraceptive method mix in health insurance scheme packages. Currently only tubal ligation and vasectomy procedures are covered by NHIF. Private insurance companies are yet to include FP in the package of insurance cover. Thus, the need to advocate for the same.

3.3.3 Thematic Area 3: Stewardship, Governance and Partnerships

Outcome: Enhanced coordination and stewardship of FP programming

Strategy

This thematic area entails several functions that will (under the leadership of MoH) rest on the RMHSU and the County Health Departments. These include stewardship of the provision of quality FP services through addressing policy issues related to access of FP services mechanisms and institutional arrangements for aligning FP strategies and goals. As the RMHSU supports implementation of the FP programme at national level, stakeholder coordination and management will be strengthened at both the national and county levels for efficient monitoring of FP-CIP activities.

Strategic activities

SGP1. Strengthening stewardship of the national FP agenda. Stewardship relates to the management function of the Government, through the Ministry of Health and is built around implementation of the mandate of the MoH. Key focus will be advocacy with the National Treasury for necessary budgetary allocations, building the capacities of national and county levels for FP programming, development of FP annual plans at both national and county levels and monitoring these plans.

[20] TMA is a whole, or total, market approach is "a coordinated approach that responds to the multiplicity of FP needs in a country or county and ensures that the entire market of clients—from those who require free supplies to those who can and will pay for commercial products—is covered

SGP2. Implementation of appropriate systems for FP governance. This will focus on the functioning of the institutions and departments by which the authority of the State is exercised. It will address the regulatory and legal functions that all actors in the FP sector have to adhere to, and are built around the health sector legal and regulatory framework. Activities will centre around strengthening the mainstreaming regulations, norms and standards, planning, needs of special populations such as the youth, and M&E in policies; and building capacity in social accountability approaches at county health facilities (both public and private).

SGP3. Consolidation of FP partnership arrangements. Partnership centres on the inter-relations and coordination of different actors working towards achievement of the FP goal. This will entail i) formation of a multi-sectoral inter-governmental coordinating (IGC) mechanism at both the national and county levels, ii) establishment and/or strengthening FP partnerships and coordination structures including coordination forum to enhance policy dialogue between various actors and iii) capacity building of stakeholders at national and county level for effective engagement.

3.3.4 Thematic Area 4: Information Management

Outcome: Strengthened evidence based decisions for effective programme implementation through research, M&E and information dissemination.

Strategy
The information management components of this CIP are geared towards strengthening evidence base for effective programme implementation through research, data collection, information dissemination, and M&E. The strategies and activities aim to i) improve demand for FP, ii) enhance service delivery to especially the underserved populations; iii) policy support for enhanced implementation and iv) operationalization of performance management system. Activities related to service delivery, demand creation will be implemented by counties, whereas operationalization of the performance management system for FP health care workers and national dissemination and cross-dissemination will be supported by RMHSU through FP2020 learning opportunities. A mid-term and end term review of the FP programme will conducted to inform implementation and measure progress.

Strategic activities
IM1. Implementation of evidence-based FP advocacy, programming and service delivery. The RMHSU will develop a national research agenda to provide a framework on relevant areas of research. Information to support FP policy advocacy will be led by RMHSU at national level. Key policy research will include implications for implementation of a TMA approach in delivery of FP (see thematic area #2 for more details), utilization of population for resources allocation by the revenue allocation authority, and the efficacy of expansion of utilization of community based distributors (CBD) to offer FP information including short term FP methods beyond the current focus on hard to reach areas. Counties will implement research on FP service uptake and delivery and social behaviour change (SBCC).

IM2. Utilization of data to track and inform progress. The RMHSU will collaborate with the CHD to monitor and supervise Track20 data for FP programme validation. Key components include review of FP supervision tools, support to counties to conduct quality assurance activities in sample facilities, implementation of social accountability mechanisms to provide feedback on the quality of FP services and collection of HMIS data on FP indicators. The CIP indicators will also be tracked and utilised to enhance FP programme implementation at both the national and county levels. Research findings on innovative approaches and technologies will be conducted by RMHSU and shared with counties and other stakeholders. The FP-CIP will be assessed periodically and at mid-term and end-of-plan to inform FP programming.

IM3. Strengthening the performance management systems to effectively monitor and support FP service providers. The capacity RMHSU and the CHD to implement the FP-CIP will be strength-

ened through the operationalizing of the performance management system. Facility managers will be trained on implementation. Regular monitoring of the system will ensure it is effective in improving implementation of the FP CIP programme.

3.3.5 Thematic Area 5: Demand Creation

Outcome: Improved demand among populations with high unmet need for modern contraception through a right-based approach.

Strategy
Demand generation strategy will focus on strengthening health service seeking behaviour with a special focus on populations with unique needs. The national level will provide the overall demand creation strategy and support its implementation, while the counties will be responsible for the design and actual implementation of the demand creation activities. This thematic area will have three strategic activities highlighted below and further elaborated in Annex A.

Strategic activities
DC1: Provision of accurate information and targeted services, on FP to all people
This will entail three aspects namely i) development of a national social behaviour change communications (SBCC) strategy to increases acceptability of FP. The strategy will provide room for counties and implementing partners to tailor messages to their specific situations and audiences, ii) addressing myths and misconceptions around modern contraceptives through creating and training a group of FP champions in each county , and iii) provision of FP information and services to special needs groups such as the youth and adolescents. This will focus on aspects such as training and supporting peer educators (TOT), development and dissemination of age-appropriate FP information.

DC2: Adaptation of a multi-sectoral approach in provision of accurate and consistent information on FP to communities. Multiple stakeholders will be used to promote FP in their communities. The MOH will engage leaders in other government sectors to support the promotion of FP as part of a broader development agenda, including using frontline workers in other sectors. The MoH through the FP TWG at national level will identify, train and engage prominent personalities such as musicians, artists, politicians, sports personalities, etc. to promote FP as champions. At community level, implementing partners will i) identify and engage couples who support the use of modern contraception , and ii) engage community, cultural/religious leaders promote FP in their communities.

DC 3: **Adaptation of a provider-led approach for integration of demand creation in service delivery.** Health care providers will be involved in creating demand for FP services within the course of their service provision activities. This will entail training health care workers on demand creation for groups with special needs such as the youth, PLHIV, PLWD and those in ASAL areas.

3.3.6 Thematic Area 6: Service Delivery

Outcome: Increased access and utilization of quality FP services by all population segments through a right based approach

Strategy
The aim of this thematic area is to increase accessibility, availability and acceptability of quality FP services in a right-based approach where rights of all individuals to choose whether, when , and how many children to have to act on those choices through high quality SRH services and information and education; and to access those services free from discrimination, coercion and violence. It will entail enhancing service delivery systems and structures, training healthcare workers and equitable distribution of FP services across the country. It also aims to ensure that special populations such as the youth and adolescent, people in emergency situations, those living in ASAL area, people living with disabilities and those living with HIV/AIDS have access to right-based FP services. Other focus include in-

tegration of FP services into all clinical areas; formation and maintenance of partnerships with the private sector.

Strategic activities

SD1. Provision of right-based high-quality FP services. Health care workers at facility level will be trained on the rights of clients. Quality assurance teams will be strengthened to conduct annual visits to each county to ensure high quality information and services are offered.

SD2. Reduce unmet FP needs for populations with special needs. Health care workers will be trained in providing services for these populations. A training of trainers will be conducted for county health personnel by the MOH. Supervision and monitoring tools on the delivery of services to these populations will be developed by the RMHSU in collaboration with representatives from these special populations and disseminated to counties in order to strengthen service delivery, supervision and monitoring at the county level. County FP coordinators will be trained by national level quality assurance (QA) specialists on the supervision and monitoring tools. Additionally, counties will make existing services accessible to people with disabilities by making necessary accommodations to for people with different types of disabilities. The RMHSU will put in place a plan for FP service delivery for emergency situation in readiness for response in case of emergency situations such as conflict or natural disasters that disrupt normal service delivery.

SD3. Increase equitable access to FP services in underserved areas. To ensure access to FP services for underserved communities is increased, the CHD in collaboration with implementing partners in each county will target mobile and outreach clinic visits to locations with long distances between clinics and low access to LARMs. This will entail collaboration between the CHD, implementing partners' and community gate-keepers to map location of FP services and areas with low access to FP services and map mobile outreach plans. The county FP coordinators will monitor and report on the impact of mobile outreach annually during county FP TWG meeting. The outcomes of the impact assessment will be used to re-assess frequency, locations, and services provided during the outreaches.

SD4. Train and increase number of health care providers to provide high quality FP services. The aim of this strategy is to strengthen human resources and skills to provide FP services and information. This will entail building the capacity of health care workers (HCWs) across all FP methods to provide all FP methods including short-term, LARCS and permanent methods, and strengthening pre-service training on FP to include increased requirements for the practical application of FP skills, YFS approaches, and internships to enhance the experience of graduates in providing FP services. Additionally, the MoH in collaboration with implementing partners and CHD will Train community workers on provision of information on the full method mix and to provide clients with the FP method of their choice, within the context of their service provision guidelines. To strengthen service availability, the MoH will review the feasibility of task shifting to allow CBDs to provide injectables.

SD 5. Integrate FP services into other health services. This will entail integration of FP in all service delivery points in a health facility. The MoH will lead development of protocols to integrate FP services into cervical cancer screening; prenatal, postnatal care, postpartum care; childhood immunization programmes; prevention and treatment of sexually transmitted infections, including HIV prevention, care, and treatment; and infant and young child feeding and immunisation programmes.

SD6. Establish partnerships with the private sector for FP service. This will entail involvement of private-not- for profit sectors (NGO) and the private-for-profit sectors in provision of FP services. The CHD with support from the RMHSU will conduct a baseline assessment of private sector capacity to provide FP services and engage them in FP service provision based on the outcomes of the assessment. The CHD in collaboration with implementing partners and RMHSU will conduct training needs assessment of the private sector actors and training will be conducted based on identified training needs. The county FP coordinator will support the private sector in provision of information and services by conducting bi-annual field visits to their facilities.

4 RESOURCE REQUIREMENTS FOR CIP

4.1 Introduction to Costing of the Activities

This cost analysis provides estimates of the resource requirements for the implementation of the CIP by all stakeholders. The estimates indicate resource needs for the period 2017-2020 that will guide mobilization of resources from different levels of government, development partners and other stakeholders. The costing approach adopted in the plan was activity based, where the inputs used in undertaking a FP activity were quantified and the total cost of the input computed by multiplying the input quantity by its cost price. The cost of any activity was then derived by sum the costs of all the inputs used for that activity. The unit prices of the inputs were based on national average, though it is acknowledged that counties have different cost prices for some inputs. However, for the commodities and related supplies in the provision of FP methods, the costing using the following simple formula:

Cost per person per FP method = population in need of FP method x coverage target in percentage x unit cost.

The population in need of service is the total persons of reproductive age in the country who need the FP method. Coverage target is the target CPR for that method, where target rate for each year was derived based on the countries CPR target for 2020 and distributed among the different methods. The unit cost is the total cost of FP commodity and consumables required for the provision of the FP method. The CIP costing model developed by Health Policy Project (HPP) was used to cost the methods and the activities in each of the thematic areas. The unit costs of methods in terms of commodity and consumables, excluding other FP commodities are shown in Table 4.1.

Table 4.1: cost of FP commodity and consumables

	Unit cost (KSH)	Unit cost (US$)	
Male sterilisations	1,227	12.15	*per procedure*
Female sterilisations	1,227	12.15	*per procedure*
IUDs	101	1.00	*per insertion*
Implants	1,069	10.58	*per insertion*
Injectables	115	1.14	*per injection*
Pills	30	0.30	*monthly cycle*
Male condoms	3	0.03	*per piece*
Female condoms	59	0.58	*per piece*

4.2 Estimates of Funding Requirements

The estimated total finding requirements for the FP CIP during the period 2017 – 2020 are presented in Figure 4.1.

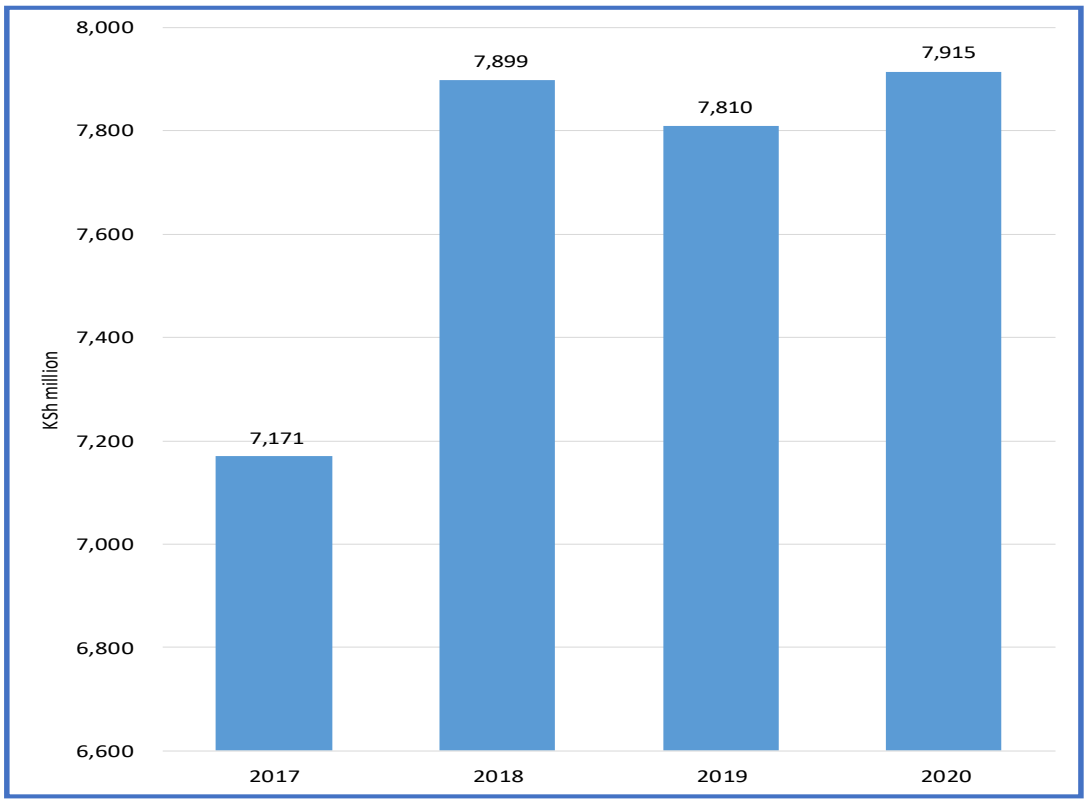


Figure 4.1: Total annual cost of CIP

Figure 4.1 shows that, on the average, annual funding requirements will be over about KES 7 billion annually. However, there are slight variations among the years. The estimated funding requirements for the CIP is KSh 7.17 billion (US$ 71 million) in 2017, KSh 7.90 billion (US$ 78) million in 2018, KSh 7.81billion (US$ 77 million) in 2019 and KSh 7.92 billion (US 78 million) in 2020. The total estimated cost for the entire period of four year is KSh 30.80 billion (US$ 305 million).

The distribution of the requirements per thematic[21] areas is given in Table 4.2, Table 4.3 and Figure 4.2.

Table 4.2: Total funding requirements (KSh million) by thematic area

	2017	2018	2019	2020	Total
Commodity Security	3,892	4,078	3,945	4,031	15,947
Family Planning Financing and Sustainability	38	19	10	9	75
Stewardship, Governance & Partnerships	468	226	227	235	1,156
Family Planning Information Management	338	353	283	373	1,348
Demand Creation	256	1,249	1,170	1,284	3,959
Service Delivery	2,179	1,974	2,175	1,983	8,312
Total	**7,171**	**7,899**	**7,810**	**7,915**	**30,796**

[21] Human resource costs captured mainly in service delivery.

Table 4.3: Total requirements (US$ million) by thematic area

	2017	2018	2019	2020	Total
Commodity Security	38.54	40.38	39.06	39.92	157.89
Family Planning financing and Sustainability	0.37	0.18	0.10	0.09	0.74
Stewardship, Governance & Partnerships	4.63	2.24	2.24	2.33	11.44
Family Planning Information Management	3.35	3.50	2.81	3.69	13.35
Service Delivery	21.57	19.55	21.54	19.63	82.29
Demand Creation	2.54	12.37	11.58	12.71	39.20
Total	**71.00**	**78.21**	**77.33**	**78.37**	**304.91**

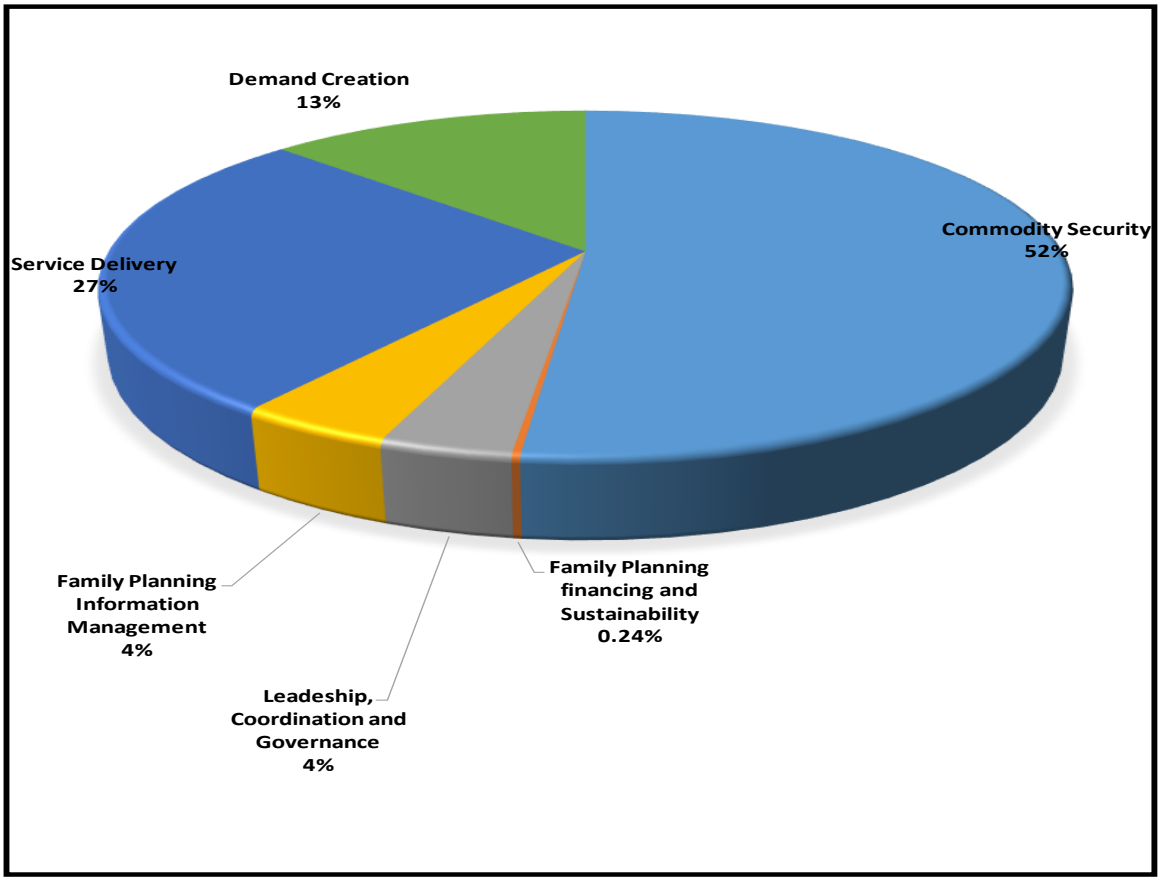


Figure 4.2: Relative shares of funding requirements by thematic area

Table 4.1 and Figure 4.2 show that two thematic areas, commodity security and service delivery will take the largest share of funding, accounting for 79% of the total requirements. The commodity security includes cost of FP commodities and consumables in addition to other activities. Financing and sustainability activities account for the least amount, taking for less than one percent of the total estimated funding requirements. The distributions of funding requirements within each thematic area are given Annex B.

The annual costs of the implementation of CIP were attributed to national and county level based on the activities in the CIP. The costs are shown in Table 4.4 and Figure 4.3.

Table 4.4: CIP annual cost (KSh million) by level of government

		2017	2018	2019	2020	Total
Commodity Security Actvities	National	42	30	31	34	137
	County	1,735	1,852	1,706	1,773	7,066
Commodities	National	-	-	-	-	-
	County	2,115	2,196	2,208	2,225	8,744
Commodity Security Total	National	42	30	31	34	137
	County	3,850	4,048	3,914	3,998	15,810
Family Planning financing and sustainability	National	38	19	10	9	75
	County	-	-	-	-	-
Stewardship, Governance & Partnerships	National	67	59	67	61	254
	County	401	167	160	174	902
Family Planning Information Management: Research, Monitoring and Evaluation	National	101	44	36	39	219
	County	237	309	248	334	1,129
Service Delivery	National	174	152	142	134	603
	County	2,005	1,822	2,033	1,849	7,709
Demand Creation	National	87	643	625	656	2,011
	County	169	606	545	628	1,948
Total	National	509	946	911	933	3,299
	County	6,662	6,953	6,899	6,983	27,497
Grand Total	**National and County**	**7,171**	**7,899**	**7,810**	**7,915**	**30,796**

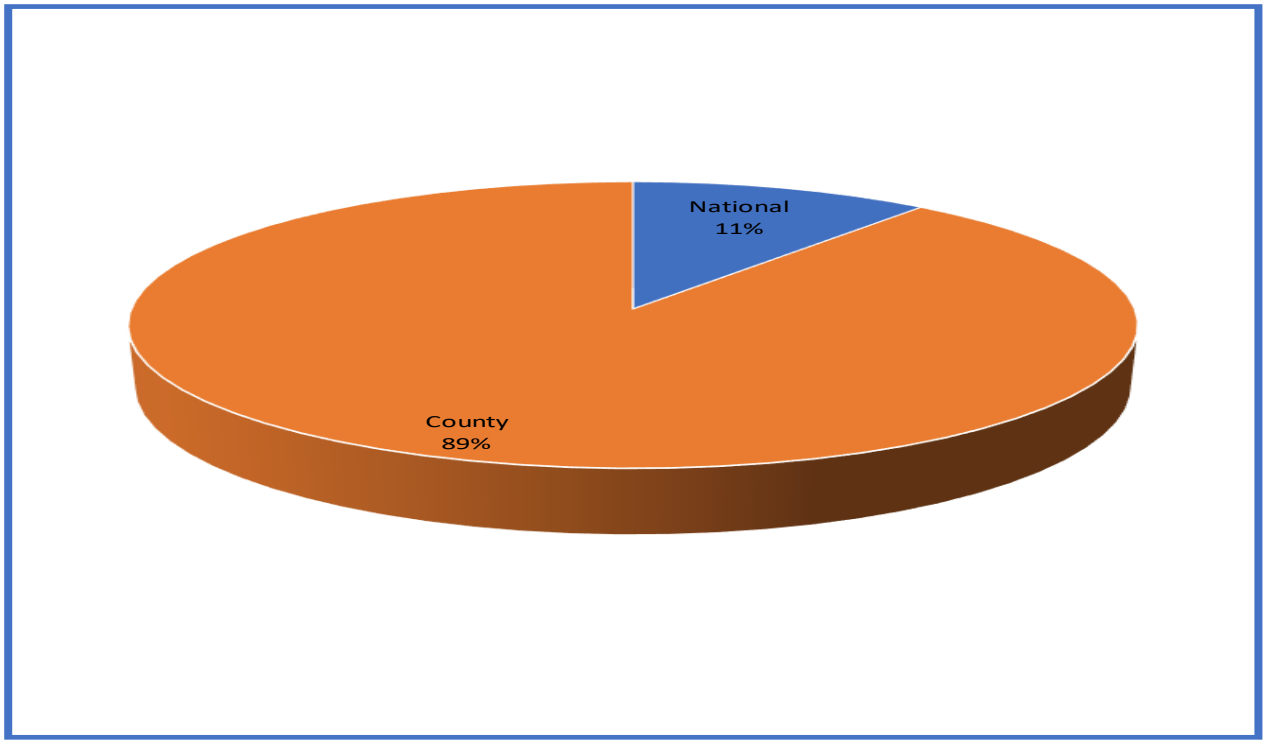


Figure 4.3: Distribution of costs by level of government 2017 -2020

Figure 4.3 show that county level will account 89% of the costs while the national level will take 11%. Further disaggregation of service delivery and FP commodities by public and private sector sows that the private sector will incur costs amount to KSh 832 million (US$ 8.24 million) in 2017, KSh 865 million (US$ 8.57 million) in 2018, KSh 834 million (US$ 8.26 million) in 2019, and KSh 847 million (KSH 8.39 million) in 2020. The estimated annual cost per county is given in Table 4.5.

Table 4.5: Estimated cost (KSh) of national CIP per county

	2017	2018	2019	2020
Baringo	55,559,093	58,509,150	58,564,402	60,935,463
Bomet	105,999,527	110,749,451	109,954,024	113,227,989
Bungoma	247,950,946	258,755,916	256,623,625	262,888,881
Busia	140,555,425	146,526,550	145,213,842	148,114,379
Elgeyo Marakwet	57,322,897	59,819,940	59,532,497	61,772,912
Embu	138,781,078	144,091,561	142,458,267	142,385,056
Garissa	13,097,410	14,998,469	16,151,157	12,829,380
Homa Bay	152,899,256	160,235,749	159,356,957	165,078,635
Isiolo	13,584,891	14,321,303	14,414,250	14,852,809
Kajiado	106,824,679	111,813,231	111,215,607	115,251,711
Kakamega	340,617,458	354,342,592	350,836,912	355,425,181
Kericho	147,930,180	154,316,642	152,919,828	155,878,647
Kiambu	395,160,062	410,635,291	405,944,389	405,342,813
Kilifi	122,936,767	129,313,782	129,470,139	134,678,780
Kirinyaga	138,262,362	143,926,208	142,091,873	139,511,888
Kisii	228,411,760	237,819,639	235,341,947	237,361,110
Kisumu	185,901,659	193,365,541	191,495,116	194,334,618
Kitui	158,883,220	165,448,476	164,030,845	167,717,245
Kwale	81,777,761	85,762,587	85,580,397	89,109,141
Laikipia	72,199,008	75,434,217	74,872,663	77,011,713
Lamu	13,531,540	14,157,813	14,114,667	14,686,531
Machakos	239,344,608	248,776,936	245,944,066	245,677,947
Makueni	153,874,503	160,245,857	158,502,523	159,171,008
Mandera	2,390,691	2,978,301	3,422,982	1,254,491
Marsabit	11,901,460	13,114,604	13,654,158	12,000,815
Meru	335,936,902	349,074,053	344,761,444	340,358,955
Migori	143,008,550	149,572,334	148,853,927	154,456,519
Mombasa	151,662,579	158,628,762	157,887,064	163,874,345
Murang'a	187,867,146	195,105,175	193,048,653	194,489,118
Nairobi	745,374,293	776,887,204	769,589,262	782,620,081
Nakuru	312,090,637	325,632,650	322,982,621	331,054,630

Nandi	149,671,051	155,984,039	154,486,174	156,860,570
Narok	104,994,645	110,429,688	110,200,171	114,746,594
Nyamira	110,125,947	114,402,489	113,171,441	113,780,040
Nyandarua	121,392,153	126,266,088	125,014,132	126,626,951
Nyeri	153,548,358	159,455,409	157,655,578	157,655,875
Samburu	14,755,463	15,879,215	16,105,687	16,187,810
Siaya	132,263,529	138,130,336	137,107,714	141,051,323
Taita Taveta	57,573,146	59,884,404	59,279,779	59,955,251
Tana River	18,173,940	19,466,224	19,754,672	19,813,146
Tharaka-Nithi	82,778,272	85,697,368	84,723,379	84,651,861
Trans-Nzoia	162,669,577	169,749,352	168,232,304	171,617,107
Turkana	41,940,871	46,236,358	48,201,870	42,023,620
Uasin Gishu	176,734,429	184,466,727	182,835,118	186,624,365
Vihiga	98,885,571	102,900,295	101,976,236	103,998,606
Wajir	9,318,118	11,287,812	12,676,832	6,572,739
West Pokot	25,904,656	28,263,607	29,129,483	27,148,087
Total	**6,662,368,074**	**6,952,859,393**	**6,899,380,673**	**6,982,666,733**

Table 4.6 shows the estimated cost of couple year protection of the different methods.

Table 4.6: Cost of couple year of protection (CYP)

	KSh	US$
Sterilisation	122.7	1.21
IUDs	28.9	0.29
Implants	388.4	3.85
Injectables	462.2	4.58
Pills	526.9	5.22
Male condoms	346.3	3.43
Female condoms	7026.0	69.56

As shown in Table 4.6, IUD is the cheapest and cost-effective method, followed by sterilisation and implants. Female condoms have the least cost benefit value.

4.3 Funding Gap

The funding gap analysis considered possible available resources from different sources against funding requirements given above. The available resources excluded administrative costs of the players since these costs were not included in the costing of the activities. Table 4.7 and Table 4.8 show the estimated financial resources from different.

Table 4.7: Estimated available resources (KSh million)

	2017	2018	2019	2020	Total
	KSh million	KSh million	KSh million	KSh million	KSh million
Government (National Level)	52	52	52	52	208
Government (Country Level)	1,314	1,314	1,314	1,314	5,254
USG	1,904	1,904	1,904	1,904	7,617
UK	796	796	796	796	3,186
UNFPA	342	342	342	342	1,368
World Bank (GFF commodities)	606	505	404	303	1,818
World Bank (GFF to counties)	63	139	152	152	505
Bill and Melinda Gates Foundation	404	403.58	4.00	4.00	815
Others	202	202	202	202	808
Total	5,683	5,658	5,170	5,069	21,580

Table 4.8: Estimated available resources (US$ million)

	2017	2018	2019	2020	Total
	US$ million	US$ million	US$ million	US$ million	US$ million
Government (National Level)	0.51	0.51	0.51	0.51	2
Government (Country Level)	13.01	13.01	13.01	13.01	52
USG	18.85	18.85	18.85	18.85	75
UK	7.89	7.89	7.89	7.89	32
UNFPA	3.39	3.39	3.39	3.39	14
World Bank (GFF commodities)	6.00	5.00	4.00	3.00	18
World Bank (GFF to counties)	0.63	1.38	1.50	1.50	5
Bill and Melinda Gates Foundation	4.00	4.00	4.00	4.00	16
Others	2.00	2.00	2.00	2.00	8
Total	56.27	56.02	55.14	54.14	222

The available funds were estimated based on recent expenditure by the different sources. The National Government captured only projected allocation for FP commodities while that of the county level included direct human for FP service delivery by both public and private sector. The available from United States Government (USG) was sources from OECD data base on FP disbursement to Kenya in 2015 as the data for 2016 were not available. The available funds were based on expenditure of DfID funded FP programme in Kenya for the year 2015/16. This programme will come to an end in 2018. The projected resources from the World Bank were provided by the Bank, for the period of the CIP. For the partner sources, 24% of the available funds were considered as programme administration costs and were excluded in the amounts in Table 4.6 and Table 4.7. The funding gap in each of the year is given in Table 4.9.

Table 4.9: Funding gap

		2017	2018	2019	2020	Total
Total Resourced requirements	KSh million	7,171	7,899	7,810	7,915	30,796
	US$ million	71	78	77	78	305
Available resources	KSh million	5,683	5,658	5,570	5,469	22,379
	US$ million	56	56	55	54	222
Funding gap	KSh million	1,488	2,241	2,241	2,447	8,417
	US$ million	15	22	22	24	83

5 METHOD MIX AND IMPACT

5.1 Method Mix Projections

The CIP costing and projection of needs were based mCPR for the country for the year 2016 as the base and the year 2020 as the final. The country has set the mCPR target of 58% by the year 2020. In the model, the country target mCPR of 56.4% in 2016 and 58% were used. The mCPR targets for 2017, 2018 and 2019 were interpolated using straight-line method with equal percentage increase each year. Figure 5.1 presents the trend in the target mCPR.

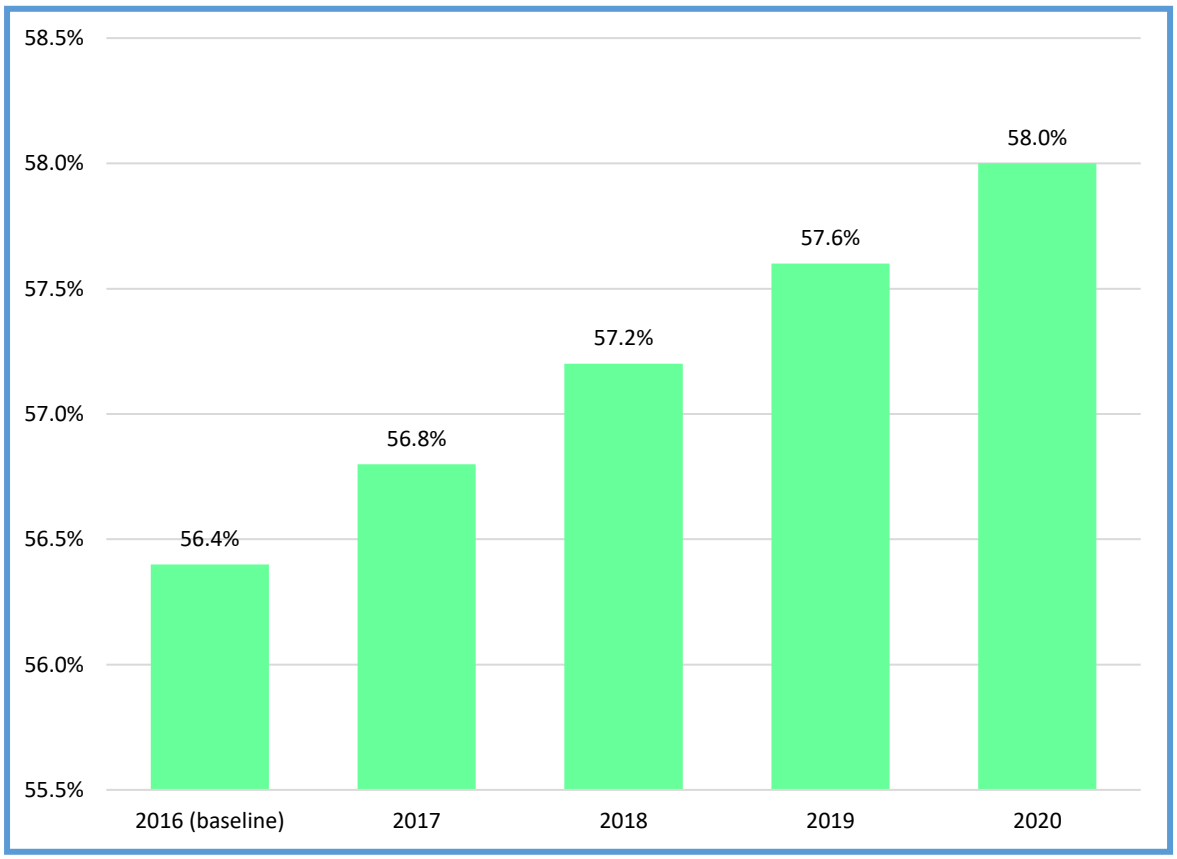


Figure 5.1: Trend in mCPR targets

Figure 5.1 depicts the trend in target mCPR over the period of CIP. Additionally, the mCPR target for each year was distributed to the different method mix, using information from Kenya Demographic and Health Survey 2014 and FP Quantification Review Technical Report of February 2017. Table 5.1 presents the distribution or the method mix. The condoms captured in the section are specifically for FP purpose and therefore those for HIV prevention were not included.

Table 5.1: mCPR method mix

Contraceptive Method	Method mix				
	2016 (baseline)	2017	2018	2019	2020
Male sterilisations	0.02%	0.03%	0.05%	0.06%	0.07%
Female sterilisations	2.03%	1.26%	0.47%	0.38%	0.23%
IUDs	4.72%	5.31%	5.92%	6.46%	7.00%
Implants	12.32%	13.33%	14.36%	15.25%	16.13%
Injectables	25.43%	24.35%	23.26%	21.83%	20.44%
Pills	9.25%	9.72%	10.18%	10.54%	10.90%
Male condoms	2.61%	2.78%	2.94%	3.06%	3.19%
Female condoms	0.01%	0.02%	0.02%	0.03%	0.03%
Total	56.4%	56.8%	57.2%	57.6%	58.0%

Table 5.1 shows that injectable will continue to dominate other contraceptive methods but will decline in the percentage of WRA using it. As shown, it is projected that use of IUDs and implants will continue to increase over the period of the plan.

5.2 Impact of CIP

The impact of the investment on ImpactNow Model was used to generate health impact of the CIP. The input into the model included the mCPR already given in this document.

Table 5.2: Impact of CIP

Indicator	2017	2018	2019	2020
Unintended pregnancies averted	1,902,938	1,949,697	2,024,513	2,105,392
Births averted	1,037,688	1,063,186	1,103,983	1,148,087
Abortions Averted	589,911	604,406	627,599	652,671
Unsafe Abortions Averted	564,900	578,781	600,990	624,999
Maternal deaths averted	4,955	4,856	4,813	4,767
Child deaths averted	29,887	30,621	31,796	33,067
DALYs averted	2,835,651	2,891,578	2,988,258	3,092,789
Unmet Need	14.60%	14.20%	13.80%	13.40%

As shown in Table 5.2, unintended pregnancies averted are significant, increasing from 1,902,938 in 2017 to 2,105,392 in 2020 because of CIP. These are the number of pregnancies that occurred at a time when women (and their partners) either did not want additional children or wanted to delay the next birth. They are usually measured with regard to last or recent pregnancies, including current pregnancies. Additionally, over one million births will be averted and over half a million unsafe abortions averted. The improved health outcomes will be realised through reduced mortality, where number of maternal deaths averted will be 4,955 in 2017 and declining to 4,767 in 2020. The number of child deaths averted will be increasing over the period of the CIP. The decline in mortality will be attributed to increase coverage of FP services in the country. Finally, implementation of CIP to reach the target for 2020 will result in decline in unmet need for FP.

6 INSTITUTIONAL FRAMEWORK FOR IMPLEMENTATION

6.1 CIP Management, Coordination and Accountability

This CIP realizes that effective governance and regulatory frameworks are the main vehicles through which targets set for the CIP can be achieved as it allows all health sector stakeholders to collaborate and coordinate their actions, recognizing each one's specific responsibilities. The governance of the health sector have been guided by several legal frameworks including the 2010 Constitution, Public Health Act Cap 242, the Pharmacy and Poisons Act Cap 244, Dangerous Drugs Act Cap 245, the Medical and Practitioners and Dentists Act Cap 253 and many others.

The framework for the operationalization of the CIP is largely derived from the RH policy and the Kenya Health Sector Strategic Plan, 2013-2017. The framework outlines how the CIP partnership, governance, and stewardship processes will work together to provide overall leadership in addressing FP programming in the country (Figure 6.1). The governance functions shall be coordinated through the National, and County governments, with their functions as defined in the Constitution. Governance and management structures that define ownership, selection and technical responsibility through boards/committees and the management team, respectively, are defined, strengthened and made functional (as part of devolution, in line with the constitutional 2010).

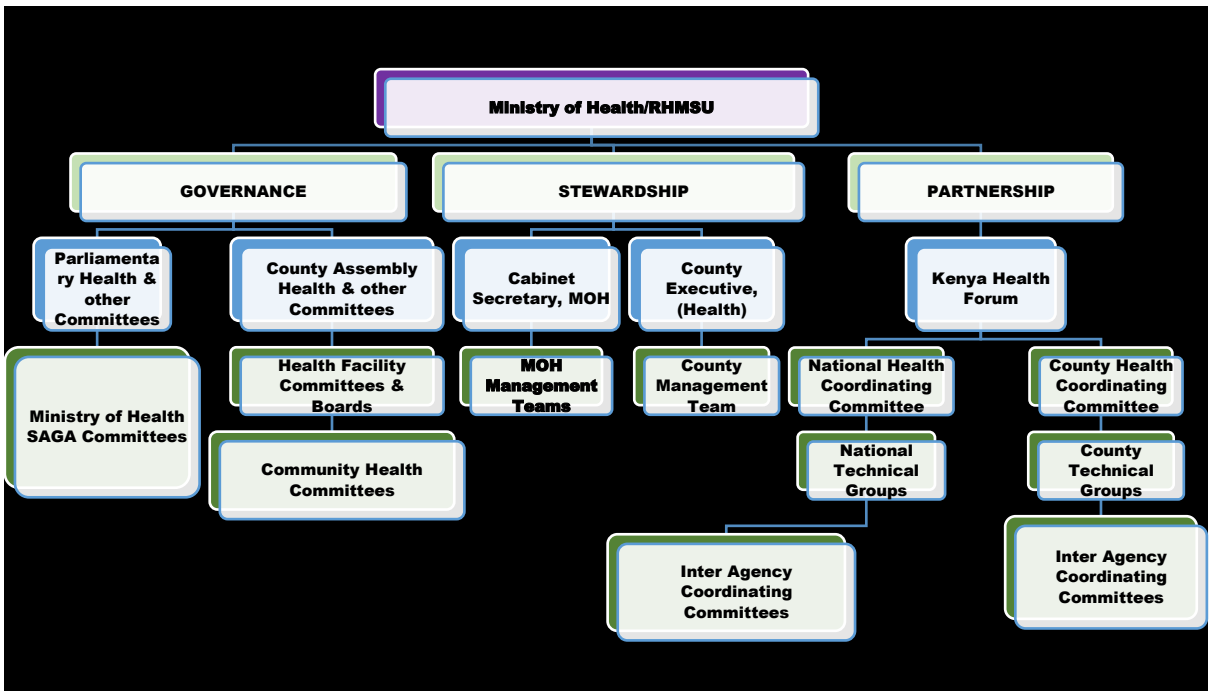


Figure 6.1. CIP Leadership Framework

Source: Adapted from the Health Sector Leadership Framework

6.1.2 Roles and Responsibilities of Key actors

The Government of Kenya (GoK) has the responsibility for ensuring universal access to FP services and meeting the national goals. From an operational perspective, implementation of the FP-CIP will require adoption of multi-sectoral and decentralized approaches in the coor-

dination and management of the national effort to create more opportunities for broad and diverse stakeholder involvement.

Based on stakeholders' consultations, a streamlined management coordination and accountability structure was proposed to steer the implementation of the CIP. This structure recognizes that the MOH, will be the steward to spearhead the planning, financing, implementation, and performance monitoring of the FP-CIP. The structure also recognizes FP as a key development intervention in harnessing the demographic dividend and accelerating socioeconomic progress towards the Vision 2030. Consequently, responsibility for implementing the FP-CIP surpasses the MOH to include other relevant ministries and institutions. Additionally, the CIP management, coordination and accountability structure recognizes that the FP-CIP will be implemented by a broad group of multi-sectoral stakeholders, including related ministries and agencies, development partners, civil society, community- based organizations/stakeholders, professional associations, faith-based organizations, voluntary agencies, and the private sector actors. Table 6.1 below outlines roles and responsibilities of various actors.

Table 6.1. Stakeholder, roles and responsibilities

Organization	Agency	Role
National Level	Government of Kenya	Governance and stewardship of the FP-CIP
	MoH, RMHSU	Lead the FP programming in the country by providing technical guidance/support in: • Formulation, review and implementation of policy and guidelines, • Stakeholders coordination • Leading review of progress of FP-CIP implementation against key indicators • Advocacy for financing of FP CIP
	Other government ministries & institutions:	
	Ministry of Planning and devolution/NCPD	• Policy formulation • Resource allocation • Identify mechanisms (through health Cabinet and Principal Secretaries) to engage with national treasury for allocation of funds for FP commodities • Lobby for inclusion of FP in the national and county budget and inclusion in supplementary budgeting process
	Ministry of Education	• Support on policy implementation on youth and adolescents SRH, • Foster an enabling environment in school systems to support implementation of comprehensive sexual education at all levels • Train teachers on implementation of life skills including FP
	Ministry of Public Service, Youth and Gender Affairs	• Policy support for addressing socio-cultural factors related reproductive health enhancement • Mainstreaming ASRH policy issues in policies and plans.
	Ministry of Culture, Sports and Talent Development	• Ensure primary investments for empowering youth to prevent unintended pregnancies
	Research and academia institutions	• Increase the use of FP services through technical guidance, research, and training of future professionals.
	Kenya Pharmacy and Poisons Board	• Ensure the quality, safety, and efficacy of contraceptive commodities by regulating their production, importation, distribution, and use. Post market surveillaince and quality checks; Pharmacovigillance
	The Kenyan Human Rights Commission (KHRC),	• Monitor government efforts to ensure universal access to rights-based family planning
	Ministry of Devolution and Planning	• Provide technical guidance to the government on medium- and long-term strategies for mainstreaming FP in relevant sectors. • Support institutionalization of FP as a key development intervention to harness the demographic dividend for achievement of vision 2030.
	Treasury	• Provide technical support to MOH in budgetary planning processes including disbursement of funds, and accounting for expenditures

		• National guarantor to FP national repository for FP commodities
	Ministry of Environment	• Support advocacy to strengthen population-health-environment programming e.g., educate the linkage between FP, population, resources and climate • Promote policies and programming to develop communities' appreciation of the linkages between informed natural resource management and their families' long term well-being.
	National Council for Population and Development	• Policy formulation and advocacy on FP
	Professionals associations	• Monitor compliance to the laws and set standards • Provide technical inputs for policies' formulation/review and implementation
	KEMSA	• Ensure an efficient procurement, distribution, and warehousing system for contraceptives and other reproductive health commodities • Support reliable RH commodity need projections
	KEBS	• Quality assurance pre-shipment and after entry
	National Health Insurance Fund (NHIF)	• Provide a risk pooling mechanism for FP
	National assembly and Senate	• Foster general awareness on population issues at all levels in the country • Lobby for inclusion of FP issues in government priority programmes • Advocate for an enabling environment, including promoting investments in FP projects.
	Development partners	• Support provision of technical assistance and expertise for FP programming • Support financing FP
	Implementing partners	Support service provision, capacity building and advocacy: • FP services provision • Social marketing • Training of health care workers • Health system strengthening
	Private sector	• Health services provision • FP commodity procurement and distribution • Financing FP through formation of FP public private partnerships agreements / (PPP contracts with the government)
	Suppliers	• Ensure product availability. • Provision of products Information. • Information on product safety and ADR. • Continuous product improvement (options, formulations, presentation). • Involvement in setting up of FP repository
County level	CHMT/ County RH department	• Lobby County assembly for inclusion of FP in the county budgets • Pay for the FP commodities and services • Track and monitor progress towards implementing the county-level activities

		• County level stewardship • Coordinating of cross-sectoral collaboration efforts • Supportive supervision and mentorship
	Council of Governors	• Escalate FP budget lines to national assembly
	Other government ministries and institutions	*See roles under national level*
	NGOs/FBOs/CSOs	• FP services provision • Community mobilization • Support of Community Units • Contribute service data for M&E of the CIP to assist the MoH in maintaining a comprehensive picture of national CIP implementation and for identifying needs and opportunities to expand services
	Private actors	
	Private facilities	• Form partnerships for service delivery • Provide data for decision making and M&E
	Media	• Awareness creation and community mobilization
	Community members	• Mobilization on FP services uptake • Consumers of FP services and products • Lobby for FP services

6.2 Resource Mobilization Framework

Two key foundational policies and strategies namely Kenya Health Policy 2014–2030 and Kenya Health Sector Strategic and Investment Plan III, 2014–2018 (KHSSP III), now guide Kenya's health sector and are being used to inform county health planning and budgeting. To ensure allocation of resources for FP, the MoH will continue working with other stakeholders to increase awareness and foster national dialogue domestic resource mobilization at both national and county levels. This will entail development of a communication strategy for the FP CIP by the Ministry of Planning/NCPD, and MoH to create a common understanding and conceptualization of the FP CIP by all stakeholders in order to build greater support and buy-in. The strategy will also ensure timely and accurate communication of carefully chosen messages to specific individuals and groups, by development of context specific tool kits, and their dissemination through appropriate and effective channels

The resource mobilization mechanisms and avenues for the CIP shall consist of:

- The MoH, in collaboration with partners will mobilise financial resources through appropriate and sustainable means to enable all the levels of health care and health sector to produce high quality health and social welfare data as well as for the development of staff skills and provide critical inputs to convert data into meaningful information readily available for decision making
- The National HIS Coordinating Committee (NHISCC) will also be used as a resource mobilization forum
- Budgetary allocation to FP programming of a specific proportion of the total health sector allocation

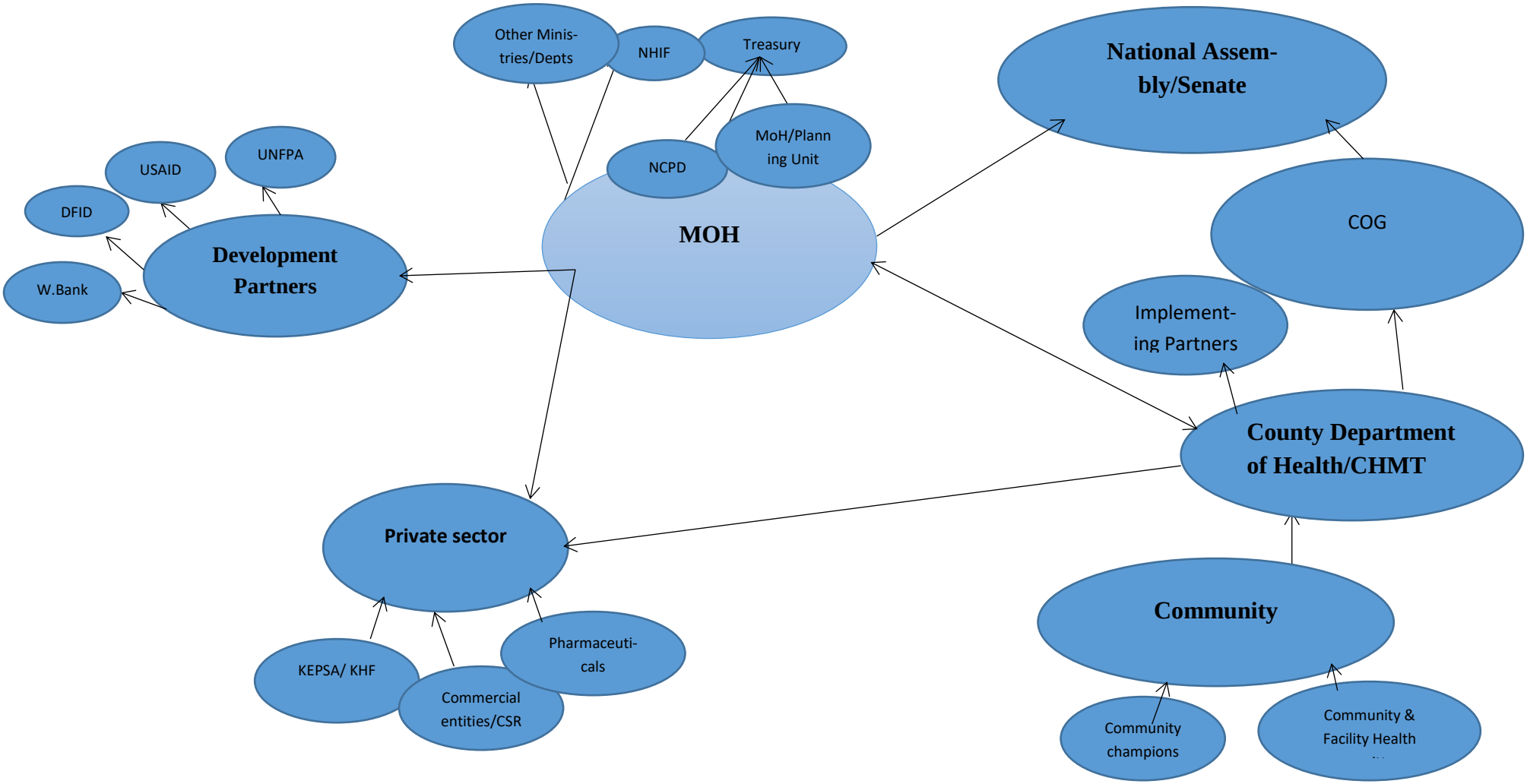
The implementation of the FP CIP shall be supported through a long term strategic plan complemented by annual action plans, which shall be developed to guide its implementation. Key actions include:

- Utilizing the Interagency Coordinating Committee for Healthcare Financing, which informs health financing strategies and decision making.
- Together with NCPD, allocate key personnel to set FP priorities before the budget cycle who will engage targeted treasury personnel in charge of budgeting. The MoH's planning unit/NCPD personnel will , for subsequent financial year explore opportunities of including a budget for the implementation of CIP in the supplementary budget
- Work with the Council of Governors and other partners in convening the annual national-county Health Sector Intergovernmental Forum (HSIF)—at which key financing and budgeting issues are raised and assigned action for resolution
- In collaboration with NCPD and other national partners, implement targeted advocacy campaign for full reinstatement of a line item for family planning commodities
- In collaboration with NCPD and partners, utilise developed advocacy models such as DemDiv10 and ImpactNow for county-level budget advocacy
- Build county level capacity to take ownership of their health systems and budgets. Support Counties to prepare work plan and discuss with the COG, upon which the

Governors escalates this with the national government, through advocacy to the senate, parliament.

- Use analysis such as Public Expenditure Tracking Surveys and the Kenya National Health Accounts to advocate for increased health budgeting by counties.
- Working with the Kenya School of Government on a training curriculum for county-level for program-based budgeting (PBB) using the existing health sector guidelines.
- Utilise costing data - summarized in various strategies such as RMNCH investment. case for Kenya to support successful negotiations with the development partners
- Meaningful engagement of the private sector by utilising their specific strengths such as through the Kenya Private sector Alliance (KEPSA, through the existing TWGs such as commodity security TWG, and TMA TWG.
- Advocacy for national- and county-level investments in FP and for the sustainable financing of FP services
- Strengthened communications and dialogue between national- and county-level actors on priority health programs and systems

Figure 6.2. CIP Resources Mobilization Framework



6.3 Monitoring and Evaluation

This FP CIP is oriented broadly to achieve Kenya's FP goal of attaining 58% mCPR by the year 2020. The CIP is on those elements in the strategy most likely to deliver the broad results sought and within the existing resource envelope. The revised Kenya national FP goal using spectrum modelling shows that the CIP will obtain increase in mCPR of 58%, by better selection of interventions and a more targeted approach to specific geographical areas. Only those interventions shown to have evidence of impact on mCPR have been chosen for the CIP. In addition, modelling from country survey and service statistics shows that prioritising certain geographical areas can produce the same result in national mCPR which means that there is better efficiency in resource use and greater equity in resource allocation.

Figure 1 describes the results framework for obtaining the increased mCPR of 58% by 2020 which is guided by investments in the six key intervention areas described in Chapter 3. Additionally, this is guided by interventions that have been identified and are aligned to high impact practices as stipulated by the Kenya FP goals model (Box 6.1).

Box 6.1 High Impact Interventions

Public Sector

- Post Partum Family Planning
- Post Abortion Family Planning
- Improve Public Sector provision
- Community Health Workers

Private sector

- Mobile Clinical Outreach
- Social Franchising
- Pharmacies and Drug Shops

System

- Reduce stock-outs
- Introduce a new method OR revitalize an under-used method

Demand generation

- Mass Media
- Community-centered SBVV
- Individual-based SBCC
- Adolescent-Focused interventions

Tables 1a and 1b describe the monitoring and evaluation plan for the CIP. They identify indicators that can track both at the output and outcomes level in the short and mid-term through routine service statistics and survey data respectively, while impact evaluation will be sourced through survey data.

Figure 6.3: CIP result frame work

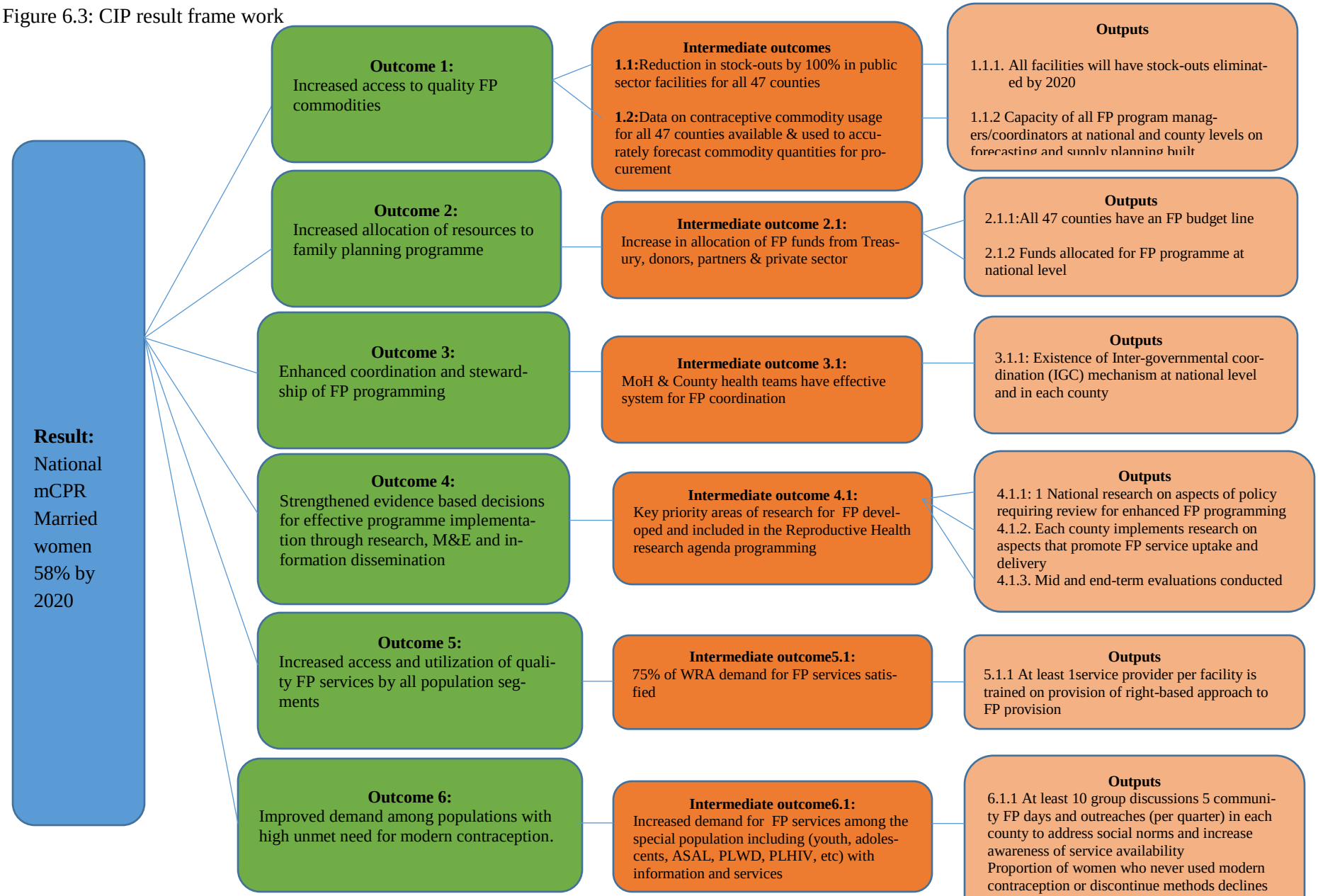


Table 6.2a: Monitoring Plan CIP, Outcome Level

Outcome	**Indicator**	**Source of data**	**Baseline levels (2017)**	**Target**
Stock-out of FP commodities in public sector eliminated by 2020	Percentage of public facilities stocked out by method, on the day of assessment, in all counties	LMIS/DHIS2 routine service statistics reports, Kenya Health Facility Assessment	76.4% stock out rate for in public facilities for each method in 2015*	0% stock out rate for public facilities
Increase in allocation of FP funds from Treasury, donors, partners & private sector	Proportion of counties with an FP budget line	National Health Accounts/ Health expenditure tracking reports	7** counties have an FP budget line	47 counties have an FP budget line
	General government expenditure on FP as % of the total government expenditure on health	NHA/ PETS	ND	10% of county health budget is spent on FP by 2020 5% Public Health Expenditures spent on FP
	% Public Health Expenditures (Govt, donor, private sector) spent on FP	HIS	ND	
MoH & County health teams have effective system for FP coordination	Percentage of Counties with functional County Health Management Teams	HIS	ND	At least 50% counties conducting bi-annual IGC meetings, national level hold bi-annual IGC meetings
	% of policies developed/revised on FP	MoH strategies		At least 3 FP policies developed/revised
Key priority areas of research for FP developed and included in the Reproductive Health research agenda programming	2007 FP research agenda updated	n/a	Outdate FP research agenda	Revised research agenda by 2018
	Each county generates data and reports on aspects that promote FP service uptake and delivery	Periodic, based on surveys and/or DHIS2, evaluation reports	ND	
	Data is used to inform programming		Baseline assessment of key indicators with missing in-	Mid and end-term evalua-

			formation to be generated	tions conducted
75% of WRA demand for FP services satisfied	%ge of facilities that have trained providers on all FP methods by counties Percentage of facilities with full stock on the day of assessment or last reporting period Proportion of new adopters of FP who discontinue within 12 months for reasons other than desire for pregnancy	DHIS2, LMIS, KHFA DHIS2, LMIS, KHFA Supervision review reports from registers at facility	% of facilities with providers currently offering all FP methods (KHFA) % of health facilities are stocked with LARC methods (KHFA) 31% (KDHS 2014)of family planning users discontinue use of a method within 12 months of starting its use due to poor outcomes	100% of facilities with at least one trained service provider by 2020 100% of facilities stocked adequately with all FP methods by 2020 10% reduction in FP methods discontinuation among new users
Targeted outreach to population with special needs (youth, adolescents, PLWD, PLHIV, emergency situations) with information and services	Proportion of women in special needs category who did not use contraception prior to demand creation interventions, who identify community mobilization events as source of referral for adopting FP use	Periodic, based on survey and/or DHIS2, KDHS 2019	% of WRA in selected special needs groups (national percentages unavailable- need for baseline assessment)	10%increase in new acceptors of modern methods by source of referral
Improved knowledge of modern methods of contraception among youth 15-19 who report that outreach as their main source of information	Proportion of working and in-school youth who can accurately report methods to prevent pregnancy, and have accurate knowledge of the fertile period by source of information % of youth who know where to obtain methods including emergency contraception by source of information	Periodic, based on survey measuring knowledge among sexually active and inactive youth. Behavioural surveys, KDHS 2019	% of working youth and in -school youth with accurate knowledge of methods to prevent pregnancy and knowledge of fertile period 0% of working and in school youth have accurate information on where to obtain methods of contraception	10 %increase in those who report accurate knowledge of methods to prevent pregnancy and knowledge of fertile period % accurate information on where to obtain methods of contraception
Increased use of modern methods of contraception among sexually active youth, 15-19 years	% of sexually active 15-19 married and unmarried who use modern methods of contraception	Periodic survey, KDHS 2019	36.8% married and 49.3% unmarried sexually active 15-19 year olds using a modern method of contraceptive (KDHIS 2014)	10% increase in sexually active 15-19 married and unmarried who use modern methods of contraception

ND = No data; *KHFA 2015; ** Information from County engagements in December 2016;

Table 6.2b. Monitoring Plan CIP, Output Level

Output	**Indicator**	**Source of data**	**Baseline levels**	**Target**
Procurement of adequate supply to support annual forecast requirements in all 47 counties	Quantification plan developed annually leading to zero gap in commodity requirements by 2020 for all counties	LMIS/DHIS2 routine service statistics reports, and/or UNFPA/KHFA survey	Annual quantification plan has 7gaps in commodity needs in 47 counties	0 Gap in commodity needs in 47 counties per quantification plan by 2020, with 50% in 2017, 25% in 2018, 12.5% in 2018, 7% in 2019 and 0% in 2020
Systems to maintain efficient inventory management in place by 2020	Proportion of facilities that report using standard inventory management practices	Logistics Master Plan annual report	0% of facilities are using standard inventory management	100% of facilities using standard inventory management practices
Capacity of all FP program and facility managers on forecasting and supply planning developed	Proportion of counties with FP and facility managers trained on FP commodity management	Skills gap report	0 number of program managers and facility in charges trained on FP commodity management	100% of managers trained on commodity management by 2020
Integrated County development Plans (ICDP) and Annual work plans include FP	All 47 counties have an FP budget line	County Budgets	7 counties have FP budget lines	47 counties have FP in the work and development plans
Funds allocated for FP programme in all counties level beginning 2018	%ge of total health budget dedicated to RH/FP programming	County budget reports/NHA	0 number of counties spend on FP budget	47 counties have FP expenditures reported
FP leadership structures in place at national and county levels	An Inter-governmental coordination (IGC) mechanism in place at national level and in each county by 2018	County reports	0 IGC structures for FP in place	48 stakeholder coordinating mechanisms -1 national, 47 counties

Technical working groups on FP areas on supported to undertake specific functions	FP Commodity Security TWG, FP logistics TWG, National and County TWG operationalized by mid-2018	County reports	FP TWGs at national level,	Each county has at least one TWG on commodity security and M&E by 2018
Evidenced-based FP programming implemented	A national research agenda on FP developed by 2018 County specific research on aspects that promote FP service uptake and delivery implemented Mid and end-term evaluations conducted	Report on national research agenda Research reports Evaluation reports	National research agenda outdated Baseline targets	A research agenda in place by 2018 At least 47 county-specific reports on FP research by 2019 Baseline and end line evaluations conducted
At least 1service provider per facility is trained and supervised on provision of right-based approach for FP provision	Proportion of facilities in each county that have trained health provider in place	DHIS2	0% of facilities with health care providers currently offering FP	100% of facilities in all counties with trained FP providers by 2020
	Number of health facilities and counties trained in provision of right-based approach of FP that have received a quarterly supervision visit to review quality and performance standards	Supervision reports by county	0 facilities and counties	All health facilities and 47 districts receive routine supervision by 2020
New community mobilisation including FP days conducted in all counties per schedule	Number of community events including FP days conducted with accurate information on modern methods of contraception, fertility period and return to fertility post-partum by county Number of non-users reached by community	Outreach – Community Health quarterly performance report by county	0 community events with targeted information 0 non users reached 0 non users who cite community mobilisation as source of referral for FP	At least 10 group discussions 5 community FP days and outreaches (per quarter) in each county to address social norms and increase awareness of service availability

	events Number of non-users who cite mobilization as source of referral at health facility Number of outreach events conducted by in-school and working youth per county	Attendance registers community outreach by county Family Planning register – periodic analysis Outreach coordinator reports	0 outreach events to working and in school youth on FP knowledge	Quarterly outreach events in county towns and villages and completed by 2020
Increased uptake of FP services by underserved populations	Proportion of women who never used modern contraception or discontinue methods declines by 10% in 10 lowest mCPR counties by 2020	KDHS	18 % unmet need	8% unmet need

Monitoring Success of the Implementation Plan

M&E of the process as well as the outcome of the implementation will inform MoH of the progress being made. It will identify gaps and suggest adaptation and remedial measures during the operational phase of the Implementation Plan.

The M&E Framework of the CIP is aligned to the M&E Plan of the Strategic Plan for RH. Core indicators including those that will measure long-term targets for monitoring and evaluating of the impact of the FP programmes and services have been developed. These include indicators identified by FP2020 (see Annex D). Indicators of success for the mplementation Plan are expressed in terms of outputs and outcomes to be achieved by each activity. Outcome indicators such as increases in contraceptive use will suggest how the programme is affecting health and well-being. Output indicators check whether intended improvements occurred in the products or services – for example, in accessibility and quality of care or service utilization. Ultimately, successful implementation of the Plan will be measured in terms of its effect on mCPR; and measures of other impact indicators (see chapter 5) which will be provided by the Demographic and Health Survey planned for 2019.

Monitoring of this Implementation Plan will rely greatly on routine data generated through the reporting systems of the LMIs, HMIS DHIS2. The annual RHCS review will also provide information on the availability and stock out of RH commodities, supply chain, staff training and supervision, availability of guidelines and protocols and user fees, among others. The KHFA will also provide data on stock outs, capacity of health providers and service provision.

Mid-term Review and Final Evaluation

A *Mid-term Review* (MTR) for the CIP is planned for 2018. For this review, data will be collected and analysed to assess programme, and management issues and budget expenditure. The findings and critical analysis will facilitate evidence-based decision-making with a view to inform the continued implementation for the remaining years.

The *Final Evaluation* will determine whether the interventions have had an impact and whether the implementation of the programme has been successful. The relevance, performance effectiveness and efficiency of the Strategic Plan for RH and Implementation Plan to meet FP2020 commitments will be established and areas for programme improvement identified. Information on impact indicators will also be obtained from national surveys e.g. the KDHS and KHFA. Impact and Outcome indicators will be reviewed again in 2020 to assess the realization of the commitments made and the objectives of the Implementation Plan.

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ANNEX A: IMPLEMENTATION FRAMEWORK WITH FULL ACTIVITY DETAIL

Thematic Area 1: Commodity Security						
Outcome: Increased access to quality FP commodities						
Objective: To increase availability of quality FP commodities						
Strategic Issue	**Expected Results**	**Key Activities**	**Sub Activities**	**Timeline**	**Output Indicator**	**Responsible**
CS 1. Aligning FP supply chains to devolved governance structures	National and County FP supply chains aligned to new governance structures to provide uninterrupted supply of FP commodities	CS1.1 Review FP Supply Chain system design	CS1.1.1. Review existing supply chain system and advise on system redesign (&develop an implementation plan)	2017	Recommendations for new FP supply chain system ; Implementation plan for FP supply chain system redesign	MOH, partners, CHMT
			CS1.1.2. Review contraceptive reporting system to incorporate data from the government, NGO, and private sectors and to ensure reporting requirements are streamlined	2017	Number of consultative meetings held	MOH, partners, CHMT
		CS1.2. Supply Chain system redesign	CS 1.2.1 Conduct FP supply chain system redesign (with an implementation plan) aligned to devolved governance structures	2017	Report of proposed new FP supply chain system	MOH, partners, CHMT
			CS 1.2.2 Roll-out of new system plan	2018	Roll-out plan and roll out report	MOH, partners, CHMT
		CS1.3. Coordinate FP stakeholders at national and county levels	CS.1.3.1. Hold meetings with FP stakeholders to discuss and agree on a coordinated FP supply chain	2017	Coordinated FP supply chain system defined and agreed upon.	MOH, partners,
			CS 1.3.2 Hold quarterly Inter Agency Coordination Committee (ICC) meetings	2017-2020	Minutes of ICC meetings	MOH, Partners
CS 2. Strengthening contraceptive forecasting and supply planning	Data are available on contraceptive commodity usage and used to accurately fore-	CS2.1. Audit FP stock status at all levels of supply chain **(**Both Public and Private sector stocks)	CS2.1.1. Undertake FP stocks Gap analysis at all levels of supply pipeline	2017	FP stocks Gap analysis report	MOH, Partners

	cast commodity quantities for procurement	CS2.2. Build capacity of FP program managers and County health managers on forecasting and supply planning	CS2.2.1. Train national and county level FP managers on quantification of FP commodities	Annually	Number of national and county level FP and health managers on quantification of FP commodities	MOH, Partners, CHMT
		CS2.3. Conduct annual forecast and semi-annual reviews of contraceptive forecast, supply plan and procurement plan	CS2.3.1. Conduct annual quantification for FP commodities	Annually	FP quantification report	MOH, partners, CHMT
			CS2.3.2. Review FP supply plans	semi annually	Updated supply plan report	MOH, partners, CHMT
		CS2.4. Procure, warehouse and distribute to last mile	CS2.4.1. Procure full range of contraceptives as per forecast, warehouse and distribute to points of use	Annually	% of FP commodities procured per supply plan	MOH, Partners; KEMSA
		CS2.5. Facilitate regular FP supply pipeline monitoring	CS2.5.1. Build capacity for pipeline monitoring at all levels of the supply chain	Annually	Number of target staff trained on FP pipeline monitoring	MOH, Partners, CHMT
CS3. Enhancing skills and capacity for FP supply chain management at all levels	Stock-outs are minimized	CS3.1Train and/or sensitize health care workers on FP commodity management and reporting	CS3.1.1. Conduct a skills gap analysis	2017	Skills gap report	MOH, partners, CHMT
			CS3.1.2. Train health workers FP commodity management and reporting based on identified gaps	2018	Number of identified health workers trained based on need	MOH
CS4. Establishing quality control system for FP commodities	Increased availability of quality FP products	CS4.1. Avail FP SOPs, guidelines and job aids	CS4.1.1. Review and avail FP commodity management SOPs, guidelines and job aids	2017(review) 2017-20	management SOPs, guidelines & job aids developed; Number of SOPs, guidelines and job aids printed and disseminated	MOH, partners, CHMT
		CS4.2. Products inspection	CS4.2.1. Conduct regular warehouse and facility visits	Quarterly	Report of warehouse and facility visits conducted	partners, CHMT
		CS4.3. Conduct pharmacovigilance	CS4.3.1. Conduct annual data review on adverse effects of FP products.	Annually	FP ADRs data review report	MOH
			CS4.3.2. Sensitize health facility in charges on tools and procedures for ADR reporting	2018	Number of health workers sensitized on FP ADR reporting	MOH, partners, CHMT

THEMATIC AREA 2: Financing and sustainability						
OUTCOME: Increased allocation of resources to FP programme by national Treasury, counties, donors, partners and private sector						
OBJECTIVE: To increase allocation and diversify sources of FP funds						
Strategic Activities	**Expected Results**	**Key Activities**	**Sub-Activities**	**Time-line**	**Output Indicator**	**Responsible**
FS 1. Establishment of a contraceptive repository	National FP stocks warehoused at a central point at upstream supply chain	FS1.1. Define type and scope of central repository	FS1.1.1. Mandate FP TWG to define scope of the FP contraceptives central repository	**2018**	Contraceptives repository established	MOH
			FS1.1.2. Disseminate recommendations to counties and other stakeholders	**2018**	Number of dissemination workshops held	MOH, Partners
		FS1.2 Advocate for use of the central contraceptives repository by all FP stakeholders & Operationalize central repository	FS1.2.1. Conduct meeting with key decision makers from MOH, KEMSA, Partners and CoG	**2018**	Number of advocacy workshops held	MOH, Partners
			FS1.2.Develop an operationalization plan consultatively	**2018**	Contraceptive repository operationalization plan	COG, KEMSA, MOH, Partners
		FS1.4. Monetize Contraceptives upon receipt by MOH	FS1.4.1. Revise order forms to include prices of FP commodities	**2019**	Order forms revised to include contraceptives prices	MOH, KEMSA
FS2. Establishment of a contraceptive revolving fund	Independent centralised FP funding mechanism in place	FS2.1. Advocate for establishment of FP fund	FS2.1.1. Conduct buy-in meetings with donors, partners and Council of Governors (CoGs) /counties for the establishment of FP revolving fund	**2017**	Number of meetings held	MOH
			FS2.1.2. Develop legal framework for FP revolving fund	**2018**	Legal framework developed	MOH
			FS2.1.3. Review FP policies in line with the legal frameworks	**2018**	Revised FP policies aligned to legal framework	MOH

			FS2.1.4. Establish the FP revolving fund	**2019**	FP revolving fund established	MOH
			FS2.1.5. Mobilize seed capital from government, donors, development partners and existing facilities such as GFF	**2019**	Proportion of FP commodity budget funded through the FP revolving fund	MOH
FS3. Mobilization of resources for FP programme	Increased resources for FP programming	FS3.1. Develop advocacy tools for increased FP funds from Treasury, donors and partners	FS3.1.1. Develop an advocacy strategy for FP programme financing	**2017**	Advocacy strategy developed	**MOH**
			FS3.1.2. Mobilize funds from donors, development partners and existing facilities such as GFF to fill funding gap	2017	Proportion of FP funds received from donors and development partners	MOH
FS4. Stewardship and implementation of a TMA	Enhanced equity in provision of FP commodities through market segmentation	FS4.1. Disseminate TMA studies on FP and ways of improving FP market	FS4.1.1. Disseminate FP market segmentation analysis	Annually	Market segmentation analysis adopted and used to inform decisions	MOH, partners
			FS4.1.2. Disseminate willingness to pay for FP studies	2017	willingness to pay for FP study report disseminated	MOH, partners
			FS 4.1.3 TMA modelling	2017	TMA Model for Kenya	MOH, partners
		FS4.2. Conduct a comprehensive review of policies, strategies, and actions that contribute to market distortions and inefficiencies	FS4.2.1. Review of policies, strategies and acts that contribute to market distortions and inefficiencies	2017	FP policy landscape analysis report	MOH, partners
			FS4.2.2. Hold meetings to disseminate briefs on strategies	2017	Policy briefs developed and disseminated	MOH, partners, CHMT
		FS4.3. Develop, implement and monitor policies and strategies that enhance TMA	FS4.4.1. Revise policy that allows private sector access free commodities	2017	Copy of revised FP policy	MOH
			FS4.4.2. Develop a transition plan from free supplies to for-pay products through a phased approach	2017	Copy of Transition plan developed	MOH

			FS 4.4.3 Pilot TMA in selected counties	2018	Numbers of subsidized products sold to richer women.	MOH, partners, CHMT
FS5. Establishment of a risk pooling mechanisms	Contraceptives included in health insurance schemes	FS5.1Build rationale for inclusion of full contraceptive method mix in insurance schemes packages	FS5.1.1. Develop an investment case for insurance companies to include full contraceptives method mix in the insurance schemes	2017	Investment case developed	MOH, partners
		FS5.2. Advocate for inclusion of FP services and contraceptives in private insurance schemes	FS5.2.1. Convene consultative meetings with NHIF and private sector insurance stakeholders to discuss and plan for inclusion of FP full method mix in the cover	2017	Number of FP methods included in NHIF and private insurance covers	MOH, Partners

THEMATI AREA 3: Stewardship, governance and partnership						
OUTCOME: Enhanced coordination and stewardship of FP programming						
OBJECTIVE: To strengthen stewardship and create an enabling environment for FP CIP implementations						
Strategic Activities	**Expected Results**	**Key Activities**	**Sub-Activities**	**Timefra me**	**Output indicator**	**Responsibility**
SGP1. Strengthening stewardship of the national FP agenda	Management capacity of MoH/CHD is built around implementation of its FP mandate	SGP 1.1 Conduct advocacy with National Treasury/County Assembly for a review of the GoK budget structure in order to facilitate evidence-based decision-making	SGP 1.1.1 Train MoH and county officials on the budgetary processes; FP budget lines allocation & host advocacy meetings with treasury officials	2017	National and county staff trained; Advocacy meetings held	MoH Planning unit/ RHMSU/CHD/NCPD
		SGP 1.2 Develop and institutionalize transparent and comprehensive FP resource tracking information system to provide timely information to national MOH, counties and stakeholders on financing requirements, expected inputs, funding gaps, and actual disbursements	SGP 1.2.1 Train MoH/RHMSU and county officials on FP resource tracking for evidence-based planning and budgeting, including for budget analysis and tracking studies	2017	Training conducted	MoH/RHMSU/CHD
			SGP 1.2.2 Develop (& monitor) annual work plans at county and national level guided by health sector strategic plans	2017-20	Annual workplans developed	MoH/RHMSU/CHD
		SGP 1.3 Orient and support CHDs on stewardship for FP	SGP 1.3.1 Train and supervise CHD officials on leadership of FP programme	2017-20	Number of counties with at least 80% of CHMT members supported on strategic leadership	MoH/ RHMSU/ CHD
SGP 2. Implementation of appropriate systems for FP governance	Regulatory and legal functions in place	SGP 2. 1 Lobby national and county assemblies for development of specific laws on FP	SGP 2.1.1 Hold bi-annual meetings with national and county assemblies	2017-2020	number of meetings held	RHMSU/NCPD/ CHD

			SGP 2.1.2 Draft FP specific bills e.g.,	2019	Drafts completed	RHMSU/NCPD/CHD
		SGP 2.2 Mainstreaming special needs population in policies, regulations, norms and standards, planning and M&E	SGP 2.2.1 Develop County RH/FP Strategic Plans with special needs groups analysis incorporated	2017	County RH/ FP Strategic Plans developed	RMHSU/ CHD
		SGP 2.3 Build capacity in social accountability approaches at CHDs, health facilities & community levels	SGP 2.3.1 Train/orient stakeholders (CHDs, facility staffs, community units) on Social Accountability guidelines	2017-20	Trainings conducted	MoH/RHMSU/CHD/partners
SGP3. Consolidation of FP partnership arrangements	An intergovernmental coordination (IGC) mechanism is strengthened	SGP 3.1 Establish and operationalize RH- IGC committee at national and county level	SGP 3.1.1. Create and structure partnerships	2017	Partnership structure created	RMHSU/CHD/CoG
			SGP 3.1.2. Constitute committees and sub-committees on a need basis to address inter-ministerial coordination and the private sector	2017-20	At least 2 committees and sub-committees constituted annually	RMHSU/CHD/CoG
			3.1.4. Undertake capacity building of stakeholders to improve capacity to engage in effective collaborations	2017	Stakeholders trained	RHMSU/CHD
			SGP 3.1.3 Form a coordination forum to enhance policy dialogue between the public and private sector stakeholders at national and county level	2017; 2019	Forum membership defined	RHMSU/CHD

THEMATIC AREA 4: Information Management						
OUTCOME: **Strengthened evidence-based decisions for effective programme implementation through research, M&E and information dissemination**						
OBJECTIVE: To strengthen evidence base for effective programme implementation through research and information dissemination						
Strategic Activities	**Expected Results**	**Key Activities**	**Sub-Activities**	**Output indicator**	**Timeline**	**Responsible**
IM1.Implementation of evidence-based FP advocacy, programming and service delivery	Evidence through operational research, to promote programming is generated	IM1.1 Develop and promote a national FP research agenda	IM1.1.1 Engage a consultant to develop the FP national research agenda	National research agenda is developed	2017	RMHSU
			IM 1.1.2 Disseminate the research agenda nationally	Number of counties aware of national research agenda (Target 47)	2017	RMHSU
		IM1.2 . Implement research on key FP issues	IM 1.2.1 Conduct research on aspects of policy that require review e.g., population policy for resources allocation; provision of FP by community health distributors (CBD); TMA, etc	Number of studies conducted	2017-2019	RHMSU/NCPD
			IM 1.2.2 Conduct research on aspects that promote FP service uptake and delivery e.g., formative on design of the SBCC strategy, contraceptive use among various populations; CSE	Number and type of studies on FP service delivery	2017-2018	RMHSU/CHD/partners
IM 2. Utilization of data to track and inform progress	Use of data to track progress in FP is strengthened at all levels	IM 2.1. Collect HMIS data on FP indicators	IM2.1.1. Conduct DHIS2 mentorship and refresher trainings for FP coordinators and HMIS officers	Number of FP coordinators trained (target: 47); number of HMIS officers trained (target: 47)	2017-20	RMHSU
			IM 2.1.2. Disseminate FP reports	Number of FP reports disseminated (target: 1 per year)	2017-20	RMHSU

		IM 2.2. Implement social accountability mechanisms, such as community scorecards, citizen report cards, and social audits to engage clients to provide feedback on the quality of FP services	IM 2.2.1 Conduct bi- annual national-level monitoring and data validation for FP, and develop FP-specific scorecards	FP- specific scorecards developed	2017	
		IM 2.3. Support FP2020 learning opportunities	IM 2.3.1 Disseminate FP best practices during national FP2020 meeting	National FP2020 meeting held	2018, 2020	RMHSU, CHD
			IM 2.3.2 Assess FP programme periodically and at mid-term and end-of-plan to inform future FP activities and programming.	Reviews conducted	2017-20	RHMSU/CHD
IM 3. Performance management systems effectively monitor and support FP service providers	The performance management system is operationalised	IM 3.1 Operationalise the performance management system for FP health care workers	IM 3.1.1 Evaluate current performance management system to identify gaps and challenges and the barriers to implementation	Current performance management system evaluated	2017	RHMSU/ CHD
			IM 3.1.2 Review current supervision and monitoring tools	Supervision and monitoring tools reviewed	2017	RMHSU/CHD
			IM 3.1.3 Train CHOs and health facility managers on supervision and monitoring	Number of CHOs and health facility managers trained on supervision and monitoring	2018; 2020	RMHSU/CHD

THEMATIC AREA 5: Demand creation						
OUTCOME: Improved demand among populations with high unmet need for modern contraception through a right-based approach						
OBJECTIVE: To improve health care seeking behaviour among populations with high unmet need for modern contraception						
Strategic Activity	**Expected Results**	**Key Activities**	**Sub-Activities**	**Output indicator**	**Timeline**	**Responsibility**
DC1: Develop and implement a strategy for provision of accurate information on FP to all people	FP communications strategy in place	DC 1.1. Develop, implement & monitor a communications strategy to increases acceptability of FP by all target populations	DC 1.1.1 National SBCC task force oversees design of a national SBCC strategy and FP communication messages	Communication strategy developed	2017	RHMSU/ partners/ county representatives
			DC 1.1.2 Produce standard communication materials for use by all stakeholders (soap episodes, mass mobile text messages, etc)	communication materials produced	2017-20	RMHSU
			DC 1.1.3. Monitor implementation of the SBCC strategy (bi-annually)	Guidance for redesign provided	2018-20	RMHSU
		DC 1.2. Address myths and misconceptions around modern contraceptives	DC 1.2.1 Train and deploy group of FP champions in each county to address myths and misconceptions	FP championed trained, no. of outreachs conducted	2018-20	RHMSU/ CHD/Partners
			DC 1.2.2 Evaluate the impact of messaging on myths and misconceptions	Evaluation conducted	2018, 2020	CHD/ RMHSU
DC 2. Adaptation of a multi-sectoral/stakeholder approach in provision of accurate and consistent information on FP to communities	Multiple stakeholders promote FP in their communities	2.1. Identify, engage and support diverse stakeholders to back use of modern contraception within communities	2.1.1 CHV identify and engage couples who support the use of modern contraception within villages	number of couples identified and supported	2017-20	CHD/partners
			2.1.2 FP coordinators engage cultural/religious leaders promote FP in their communities	Number of religious and cultural leaders sensitized	2017-20	RMHSU/CHD/ Partners
			DC 2.1.3. FP coordinators to support adolescents and youth to promote FP among peers	Number of ToTs trained	2017-20	CHD/ Partners

			DC 2.1.4. National FP TWG to identify and engage prominent personalities to promote FP as champions: (e.g., musicians, artists, politicians, sports personalitie)s.	Type and number of personalities identified and supported	2017	MoH/RMHSU/CHD
		DC 2.2 Enlist support of different sectors to promote FP	DC 2.2.1. Engage other Ministries'(e.g., Education, Agriculture, Environment) community workers/ frontline workers for FP promotion	Number of community workers engaged for FP promotion	2017	MoH/RMHSU/CHD
			DC 2.2.2. County FP coordinators to conduct bi-annual supportive supervision trips to the other Ministries' frontline workers	Number of support supervision trips conducted	2017-20	CHD

THEMATIC AREA 6: Service delivery						
OUTCOME: Increased access and utilization of quality FP services by all population segments through a right based approach						
OBJECTIVE: To increase access and utilization of quality family planning services by all population segments						
Strategic Activity	**Expected Results**	**Key Activities**	**Sub-Activities**	**Output indicator**	**Time-line**	**Responsibility**
SD1. Provision of high-quality right-based FP services to FP clients	Quality of FP services for clients are enhanced	SDA 1.1 Health care workers capacity is built around rights to FP information and services, including availability, accessibility, quality, equity, non-discrimination and informed choice	SDA 1.1.1 Train health care workers on the rights of clients	Number of HCWs trained and refreshed on clients rights	2017 & 2019	RMHSU/ CHD
			SD 1.1.2. Quality assurance teams (national & county) to conduct follow-up supervision visits	Number of quality assurance supervision trips conducted	2017-20	RMHSU
SD2. Reduction of unmet FP needs for populations with special needs	Increased access to quality FP services by populations with special needs	SD 2.1 Strengthen health care workers' (HCWs) capacity on provision of services to populations with special needs	SD 2.1.1. Train/ re-train HCWs on provision of services to: Youth; PLWD; emergency situations (Minimum Initial Service Package (MISP)} and in underserved areas	Report on training needs for HCWs on special needs population	2017	RHMSU/CHD
			SD 2.1.2. Train FP coordinators and county health department officers on supervision & monitoring of health care workers	Number of people trained	2017/18	RHMSU/CHD
			SD 2.1.3 FP coordinators and county health department officers to conduct quarterly supervision visits to facilities	Number of supervision visits	2017-20	RHMSU/CHD
		SD 2.2 Strenthen systems for provision of FP services for special needs populations	SD2.2.1. Develop a national plan for response to FP needs of special populations	Plan developed	2017	RHMSU/CHD/ Partners

			SD 2.2.2. Design and implement FP information materials and service delivery infrastructure for special populations (eg., YF centres, specialised equipments and facilities for PLWD and those in emergency situations; strategies for underserved areas e.g., mobile outreaches)	number and type of materials/infrastructure developed	2018	MoH/RMHSU/ partners
			SD 2.2.3. Train/recruit additional HCWs to provide FP services to people with special needs	Number of additional HCWs trained	2018-20	MoH/partners
SD3. Expand and adequately train health care providers to offer high quality FP services is	Human resources and skills to provide FP services and information are strengthened at all levels of providers	SD 3.1 Train and support different cadres of health workers on FP provision	SD 3.1.1. Review current guidelines to include expanded mandate of CBD in provision of expanded scope of FP services	New CBD guidelines	2017/18	
			SD 3.1.2 Train community volunteers on provision of information on the full method mix and to provide clients with the FP method of their choice, within the context of their service provision guidelines	Number of CBD trained	2017/8	RMHSU/CHD/ Partners
			SD 3.1.3. Nurses Association to train retired midwives (at least 1 for every 2 facilities) to provide FP information and services, including pills, condoms, implants, and injectables to the community	Number of retired nurses oriented on FP	2017-20	CHD/Nurses Association
			SD 3.1.4. County FP coordinators and representative from nurses association to provide quarterly support-ive supervision for mid-wives & monthly support for CBDs	number of supervisory visits conducted	2018-20	CHD
			3.1.5 Introduce FP pre-service practical skills for nurses	Internship mandate im-plemented		

SD 4. Integrate FP services into other health services	FP services are integrated into other services[22]:	SD4.1 Develop and roll out a national FP integration protocol	SD4.1.1 Conduct integration studies, and develop comprehensive integration protocol (by an integration task force)	Integration studies conducted and harmonised	2017	MoH/RMHSU
			SDA 4.1.2 Integration task force to develop integration protocol	Integration protocol developed	2017	RHMSU/Integration task force
			SD4.1.3 MoH/RHMSU to support integration of FP with other services	Integration support provided	2018	MoH/RHMSU
			SD4.1.4 Train CHD and FP coordinators on integration protocol	Number of FP coordinators trained per county	2018	RMHSU/CHD
SD5. 1. Establishment of partnerships with the private sector for FP service provision	Coverage of quality FP services through private sector stakeholders is increased	SDA 5.1 Enhance capacity of private sector actors in provision of quality FP services	5.1.1FP coordinators to identifysuitable private sector partners	Private sector actors mapped out	2017/18	RMHSU/CHD
			SD 5.1.2 Ttrain private sector stakeholders identified on providing quality FP information and services	Number of stakeholders trained	2017	CHD
			SD 5.1.3 CHD to conduct bi-annual supe visits to monitor private sector FP service provision	Number of field visits	2017-20	RHMSU/CHD

[22] STI screening, treatment, and care,• Immunisation, • Infant and young child feeding and malnutrition programmes• Routine childhood vaccination • Cancer screening Cervical cancer screening • Antenatal care (FP counselling only) • Postnatal care • Postpartum care

ANNEX B: COSTS OF CIP ACTIVITIES

Table B.1: Estimated cost FP commodities and consumables - commodity security

	2017	2017	2018	2018	2019		2020	2020	Total	
	KSh million	US$ million	KSh million	US$ million	KSh million	US$ million	KSh million	US$ million	KSh million	US$ million
Sterilisations	1.56	0.02	1.76	0.02	1.84	0.02	1.97	0.02	7.13	0.07
IUDs	15.78	0.16	17.67	0.17	18.31	0.18	19.58	0.19	71.34	0.71
Implants	492.88	4.88	542.02	5.37	561.68	5.56	592.92	5.87	2,189.49	21.68
Injectables	1,019.24	10.09	1,000.96	9.91	956.57	9.47	907.02	8.98	3,883.79	38.45
Pills	401.74	3.98	433.04	4.29	456.08	4.52	477.68	4.73	1,768.54	17.51
Male condoms	182.85	1.81	199.17	1.97	211.17	2.09	223.06	2.21	816.25	8.08
Female condoms	1.16	0.01	1.60	0.02	2.03	0.02	2.46	0.02	7.25	0.07
Total	2,115	21	2,196	22	2,208	22	2,225	22	8,744	87

Table B.2: Estimated cost other activities for commodity security

	2017		2018		2019		2020		Total	
	US$ million	KSh million	US$ million	KSh million	US$ million	KSh million	US$ million	KSh million	US$ million	KSh million
CS1.1 Review FP Supply Chain system design	8.25	833.29	8.53	861.43	8.88	896.69	9.24	933.05	34.90	3,524.45
CS1.2. Supply Chain system redesign	0.08	7.59	0.33	33.49	-	-	-	-	0.41	41.08
CS1.3. Coordinate FP stakeholders at national and county levels	0.01	1.07	0.01	0.65	0.01	0.68	0.01	0.71	0.03	3.11
CS2.1. Audit FP stock status at all levels of supply chain	0.03	2.89	-	-	-	-	-	-	0.03	2.89
CS2.2. Build capacity of FP program managers and County health managers on forecasting and supply planning	6.02	608.13	6.26	631.85	6.50	656.49	6.75	682.09	25.53	2,578.57
CS2.3. Conduct annual forecast and semi-annual reviews of contraceptive forecast, supply plan and procurement plan	0.03	3.50	0.02	2.22	0.04	3.78	0.04	3.93	0.13	13.44
CS2.4. Procure, warehouse and distribute to last mile	0.00	0.05	0.00	0.05	0.00	0.06	0.00	0.06	0.00	0.22
CS2.5. Facilitate regular FP supply pipeline monitoring	1.78	179.42	1.27	127.93	1.32	132.92	1.37	138.11	5.73	578.38
CS2.6. Review of FP quantification guidelines and SOPs	-	-	0.01	0.82	-	-	-	-	0.01	0.82
CS3.1Train and/or Sensitize health care workers on FP commodity management and reporting	1.23	123.87	1.26	126.80	0.32	31.95	0.33	33.19	3.13	315.82

CS4.1. Avail FP SOPs, guidelines and job aids	0.02	2.29	0.01	1.02	0.01	1.06	0.01	1.11	0.05	5.48
CS4.2. Products inspection	0.10	9.89	0.10	10.28	0.11	10.68	0.11	11.09	0.42	41.94
CS4.3. Conduct pharma-covigilance	0.03	3.08	0.84	85.19	0.03	3.32	0.03	3.45	0.94	95.05
CS4.4. Review guidelines for safe disposal of expired and/or damaged FP commodities	0.02	1.84	-	-	-	-	-	-	0.02	1.84
Total	17.59	1,776.91	18.63	1,881.76	17.20	1,737.64	17.89	1,806.79	71.32	7,203.10

Table B.3: Cost of activities for financing and sustainability

	2017		2018		2019		2020		Total	
	US$ million	KSh million	US$ million	KSh million	US$ million	KSh million	US$ million	KSh million	US$ million	KSh million
FS1.1. Define type and scope of central repository	-	-	0.03	3.32	-	-	-	-	0.03	3.32
FS1.2Advocate for use of KEMSA as the central contraceptives repository	-	-	0.00	0.11	-	-	-	-	0.00	0.11
FS1.3. Operationalize central repository	-	-	0.00	0.37	-	-	-	-	0.00	0.37
FS2.1. Advocate for establishment of the fund	0.01	1.32	0.07	6.67	0.01	1.28	-	-	0.09	9.27
FS1.4. Monetize Contraceptives upon receipt by MOH	-	-	-	-	0.00	0.03	-	-	0.00	0.03
FS3.1. Develop advocacy tools for increased FP funds from Treasury, donors and partners	0.07	7.04	-	-	-	-	-	-	0.07	7.04

FS4.1. Conduct and disseminate studies on TMA on FP and ways of improving FP market	0.11	11.09	0.03	2.91	0.03	3.02	0.03	3.14	0.20	20.15
0	-	-	-	-	-	-	-	-	-	-
FS4.2. Conduct a comprehensive review of policies, strategies, and actions that contribute to market distortions and inefficiencies	0.04	3.95	-	-	-	-	-	-	0.04	3.95
FS4.3. Advocate for revision of policies and practices that promote market distortion	0.05	4.77	0.05	4.96	0.05	5.15	0.05	5.35	0.20	20.22
FS4.4. Develop, implement and monitor policies and strategies that enhance TMA	0.05	5.38	0.00	0.33	0.00	0.34	0.00	0.35	0.06	6.40
FS5.1Build rationale for inclusion of full contraceptive method mix in insurance scheme package	0.04	4.18	-	-	-	-	-	-	0.04	4.18
Total	0.37	37.73	0.18	18.66	0.10	9.83	0.09	8.84	0.74	75.05

Table B.4: Cost of activities for leadership, coordination and governance

	2017		2018		2019		2020		Total	
	US$ million	KSh million	US$ million	KSh million	US$ million	KSh million	US$ million	KSh million	US$ million	KSh million
SGP 1.1 Conduct advocacy with National Treasury/County assembly for a review of the GoK budget structure in order to facilitate evidence-based decision-making	0.06	6.04	0.05	5.26	-	-	-	-	0.11	11.30
SGP 1.2 Develop and institutionalize transparent and comprehensive FP resource tracking information system to provide timely information to national MOH, counties and stakeholders on financing requirements, expected inputs, funding gaps, and actual disbursements	0.58	58.34	0.27	27.48	0.28	28.55	0.29	29.67	1.43	144.04
SGP 1.3 Orient and support CHDs on stewardship for FP	0.84	84.38	0.33	33.82	0.35	35.14	0.36	36.51	1.88	189.85
SGP 2. 1 Lobby national and county assemblies for development of specific laws on FP	0.13	13.05	0.13	13.56	0.14	14.55	0.14	14.64	0.55	55.81
SGP 2.2 Mainstreaming special needs population in policies, regulations, norms and standards, planning and M&E	0.19	19.27	-	-	-	-	-	-	0.19	19.27
SGP 2.3 Build capacity in social accountability approaches at CHDs and public and FBO facilities	0.75	76.20	0.61	61.88	0.61	61.23	0.63	63.62	2.60	262.92
2.4 Conduct annual client satisfaction and responsiveness survey	0.18	18.57	0.19	19.30	0.20	20.05	0.21	20.83	0.78	78.76

SGP 3.1 Establish and operationalize RH- IGC committee at national and county level	0.06	6.03	0.06	6.25	0.06	6.49	0.07	6.74	0.25	25.51
SGP 3.2 Establish a coordination forum to enhance policy dialogue between the public and private sector stakeholders at national and county level	0.71	72.16	0.49	49.98	0.51	51.93	0.53	53.95	2.26	228.02
SGP 3.3 Undertake capacity building of stakeholders to improve capacity to engage in effective collaborations	1.13	114.05	0.08	8.33	0.09	8.65	0.09	8.99	1.39	140.03
Total	4.71	475.43	2.28	230.22	2.40	242.46	2.37	239.67	11.76	1,187.78

Table B.5: Cost of activities for FP information

	2017		2018		2019		2020		Total	
	US$ million	KSh million	US$ million	KSh million	US$ million	KSh million	US$ million	KSh million	US$ million	KSh million
IM1.1 Develop and promote a national FP research agenda	0.22	22.56	0.15	15.46	0.14	13.80	0.14	14.34	0.66	66.16
IM2.1 implement research on aspects of policy that require review for enhanced FP programming	0.25	25.09	0.06	5.67	-	-	-	-	0.30	30.76
IM3.1. Implement research on aspects that promote FP service uptake and delivery	0.27	27.28	-	-	-	-	-	-	0.27	27.28

IM 4.1. Monitor and supervise Track20 data for FP programme validation	0.98	99.43	1.02	103.31	1.06	107.34	1.10	111.52	4.17	421.61
IM4.2. FP supervision tools are reviewed for quality	0.76	76.55	0.79	79.53	0.82	82.63	0.85	85.86	3.21	324.57
IM4.3. Support counties to conduct QI/QA activities in sample facilities	0.24	24.41	0.25	25.37	0.26	26.36	0.27	27.38	1.02	103.52
IM 4.4. Implement social accountability mechanisms, such as community scorecards, citizen report cards, and social audits to engage clients to provide feedback on the quality of FP services	0.00	0.16	0.00	0.16	0.00	0.17	0.00	0.18	0.01	0.67
IM 4.5. Collect HMIS data on FP indicators	0.23	22.94	0.24	23.84	0.16	16.25	0.25	25.73	0.88	88.76
IM 5.1 Disseminate FP best practices during national FP2020 meeting	-	-	0.02	1.88	-	-	0.02	2.02	0.04	3.90
IM 6.1 Operationalise the performance management system for FP health care workers	0.32	32.45	0.90	90.70	0.29	29.07	0.97	97.92	2.48	250.15
7.1 Conduct periodic reviews and evaluations of FP program components	0.07	7.20	0.07	7.49	0.08	7.78	0.08	8.08	0.30	30.55
Total	3.35	338.08	3.50	353.40	2.81	283.39	3.69	373.03	13.35	1,347.91

Table B.6: Cost of activities for service delivery

	2017		2018		2019		2020		Total	
	US$ million	KSh million	US$ million	KSh million	US$ million	KSh million	US$ million	KSh million	US$ million	KSh million
SDA 1.1 Health care workers are trained on rights to FP information and services, including availability, accessibility, quality, equity, non-discrimination and informed choice	2.64	266.83	-	-	1.78	180.23	-	-	4.43	447.07
SD 1.2 Reinforce quality assurance assessment from the central MOH	0.56	56.08	0.58	58.27	0.60	60.54	0.62	62.90	2.35	237.78
SD 2.1 Train health care workers on how to provide YFS	0.72	73.06	-	-	-	-	-	-	0.72	73.06
SD 2.2 Strengthen YFHS supervision and monitoring at the county level	0.90	91.29	0.65	65.92	0.68	68.49	0.70	71.16	2.94	296.87
SD2.3 Train HCW on service provision for PLWD & Design and implement FP information and service delivery for PLWD	-	-	1.30	131.01	0.67	68.15	0.70	70.81	2.67	269.97
SD 2.4 Prepare and implement a plan for FP service delivery for emergency situations at national level	1.33	134.12	1.43	144.53	1.74	175.30	1.28	129.66	5.78	583.60
SD 3.1 Target mobile and outreach clinic visits to locations with long distances between clinics and low access to LARMs	1.19	119.73	1.22	123.25	1.27	128.06	1.32	133.05	4.99	504.09
SD 4.1 Train community workers on provision of information on the full method mix and to provide clients with the FP method of their choice, within the context of their service provision guidelines	0.02	2.37	0.48	48.57	0.49	49.09	0.50	51.00	1.50	151.03
SD4.2 Expand the work of the Nurses Association to train retired nurses in the community to provide skilled FP services	0.20	20.47	0.21	21.27	0.22	22.10	0.23	22.96	0.86	86.79

4.3 FP pre-service practical skills strengthened	0.00	0.04	0.00	0.02	-	-	-	-	0.00	0.06
SD5.1 Develop and roll out a national FP integration protocol	0.00	0.37	0.24	24.24	-	-	-	-	0.24	24.61
SDA 6.1 Conduct a baseline assessment of private sector capacity to provide FP services and engage them in FP service provision	1.00	100.73	0.77	78.07	0.80	81.11	0.83	84.27	3.41	344.19
SDA 7.1 Human resource in actual FP service provision	13.01	1,313.57	12.67	1,279.29	13.29	1,342.32	13.44	1,357.25	52.40	5,292.44

TableB.7: Cost of activities for demand creation

	USD	KSh	USD	KSh	USD	KSh	USD	KSh	USD	KSh
DC 1.1 Conduct formative research to inform the design of the SBCC strategy	0.10	10.39	-	-	-	-	-	-	0.10	10.39
DC 1.2 Design a national SBCC strategy	0.04	4.32	-	-	-	-	-	-	0.04	4.32
DC 1.3 Develop and test FP communication messages	0.07	7.49	-	-	-	-	-	-	0.07	7.49
DC 1.4 Implement communications strategy and monitor impact of communications messages	0.06	6.24	3.23	326.63	3.32	335.70	3.45	348.79	10.07	1,017.37
DC 1.5 Produce and implement soap episodes to be played on the radio in all counties	-	-	5.20	525.46	5.41	545.96	5.62	567.25	16.22	1,638.67

DC 1.6 Develop targeted mass mobile text campaign to promote accurate information about FP services	-	-	0.22	21.95	0.01	1.09	0.01	1.13	0.24	24.17
DC1.7 Conduct evaluation of SBCC activities to inform re-design in next FP CIP	-	-	0.11	10.73	-	-	-	-	0.11	10.73
DC2.1 Create a group of FP champions in each county to address myths and misconceptions	0.78	78.91	0.81	82.02	0.84	85.19	0.88	88.51	3.31	334.63
DC 2.2 Evaluate the impact of messaging on myths and misconceptions	-	-	0.88	89.38	-	-	0.96	96.49	1.84	185.88
DC 3.1 Support youth to conduct peer-to-peer education on FP education on FP using evidence-based approaches	0.19	18.84	0.63	63.18	0.65	65.65	0.41	41.71	1.88	189.39
DC 3.2 Develop age-appropriate FP information to be distributed at youth clubs, schools, and health centres	0.08	7.64	0.05	5.45	0.06	5.66	0.06	5.89	0.24	24.64
DC 3.3 Engage parents to discussing FP with young people	0.50	50.40	0.52	52.34	0.54	54.38	0.56	56.50	2.11	213.60
4.1. Identify and engage couples who support the use of modern contraception within communities	0.28	27.82	0.29	28.90	0.30	30.03	0.31	31.20	1.17	117.95
4.2 Engage community/ cultural/religious leaders promote FP in their communities	0.37	36.87	0.38	38.31	0.39	39.80	0.41	41.35	1.55	156.33

DC 4.3 Identify and engage prominent personalities to promote FP as champions: •Musicians, artists, politicians, sports personalities.	0.03	3.07	0.01	0.87	0.03	2.57	0.01	0.94	0.07	7.45
DC 4.4 Enlist support of different sectors to promote FP	0.04	4.19	0.04	3.76	0.04	3.91	0.04	4.06	0.16	15.93
DC 5.1 Train and support health care providers on demand creation for FP	0.00	0.03	-	-	-	-	-	-	0.00	0.03
Total	2.54	256.22	12.37	1,248.99	11.58	1,169.94	12.71	1,283.83	39.20	3,958.97

ANNEX C: KENYA FP INFORMATION AND DATA

CI) Issues with a bearing on FP in Kenya

The FP-CIP 2017-2020, building on lessons learnt from its precursor (FP CIP 2012-16) serves as the country's blueprint to achieve its FP goal of attaining 58% mCPR by 2020. This is based on Kenya's commitment during the London Summit on Family Planning in July 2012. The CIP 2017-20 further incorporates the principles of a wider national development agenda of accelerating socioeconomic progress towards the Vision 2030 through recognizing FP as a key development intervention in harnessing the demographic dividend. The FP-CIP takes cognizant of the global development agenda by supporting the effective implementation of the Population Policy for National Development as key to the realization of Sustainable Development Goals (SDGs). The FP-CIP 2017-2020 is the second FP-CIP for Kenya. It builds on lessons learnt from the first FP CIP (2012-2016) and takes into account developments in the global and national arena that have direct implications for achievement of the national FP goal. To put into perspective key factors that have a bearing on this CIP, this section provides an outlines of the aforementioned issues. Further analysis of these issues is provided in the situation analysis section of this document.

- The first FP-CIP (2012-16) was largely underutilized to guide the implementation of FP programming in the country. A key contributing factor that hindered utilization of the FP-CIP was the constitutional changes that saw Kenya move from a centralized to devolved system of governance in the year 2013. This was immediately after the development of the first FP-CIP. Consequently, the FP-CIP, which was designed to operate under a centralized system, could not be effectively implemented. However, many FP programmes were implemented by various stakeholders, albeit largely un-guided by a national strategy. This saw Kenya receive the Excel Award in recognition of making great strides in implementation of the population and development policy including FP. A second challenge with the FP-CIP (2012-16) is that it was not widely disseminated[23] hence not utilized to guide FP implementation. This is despite the fact that some of the strategies contained therein could have been adapted by the counties and implementing partners even in the context of devolution.
- Related to devolution is the fact that the Central MoH and County Health Departments (CHD) have yet to fully comprehend a working relationship that ensures complementarity in its plans. For instance, as at December 2016, 10 counties[24] had developed their own FP CIPs. While this in itself is a positive step in devolving planning for FP, discussions with county health representatives during the CIP 2017-20 development consultative meetings revealed that they have not necessarily consulted with the central MoH to align their county FP goals with the national goal. Consequently, the CIP 2017-20 is designed to create a link and close the existing gaps between national and county level through ensuring that planning within the counties is linked to national plans, and vice versa, to safeguard integrated development planning.
- In 2015, Kenya was declared a lower middle income country (LMIC). This shift in status has a considerable impact on Kenya's situation on the international stage. Kenya's new standing as a LMIC threatens its income from official development assistance (ODA), which has been key in provision of FP commodities for the country. In recognition of this shift and its inevitable outcome on FP goals and especially FP commodities, UNFPA, in 2016, developed the FP Reproductive Health Commodity Security (FP- RHCS) Strategy to mitigate against these changes. The actualization of the FP-RHCS is integrated in the CIP.
- Now a LMIC, Kenya is also a front runner country for the new Global Financing Facility (GFF) for reproductive, maternal, neonatal, child and adolescent health (RMNCAH). This provides an opportunity for investment in FP. This CIP has outlined activities -such as capacity building across all areas of an FP programme and technical support - envisioned to be part of the GFF investment case.
- Additionally, related to shifts in international financing frameworks to include greater roles for private sector, stakeholders such as DfID and UNFPA have made efforts to develop a Total Market Approach (TMA) for FP. This is a relatively new concept for FP in the country and efforts to operationalize TMA are seen as one of the ways to mitigate against diminishing donor assistance for FP in the light of global and national changes in donor funding landscape. This CIP elaborates steps towards operationalization of a FP TMA approach.
- Although the government's commitment to ensuring FP access in Kenya, and making sure reproductive health services are available to all Kenyans is spelled out in the National Reproductive Health Policy, the availability and access of FP commodities and reproductive health medicines in health facilities remains limited in many areas. This was evident from findings of the Kenya Health Facility Assessment (KHFA) report on FP com-

[23] Qualitative analysis of stakeholder consultations reviewed that the FP-CIP (2012-15) was largely unknown by stakeholders. For instance, out of 101 participants of a consultative meeting held with 19 counties of Western, Nyanza and the Rift Valley, only 3 participants had heard and/or seen the first FP-CIP. Similarly, out of 88 participants from Lower Eastern, Central and North Eastern regions, only 3 participants were aware of the FP-CIP. For Coastal and upper Eastern counties 5 of the 75 participants and 6 of the 81 participants respectively indicated to have been aware of the CIP.

[24] Kwale, Makueni, Kakamega, Kitui, Siaya, Tharaka Nithi, Homabay, Nyeri and Busia.

modities and reproductive health medicines and services that was launched in 2016. These findings come at an opportune time for FP access in Kenya, as the challenges and bottlenecks identified are addressed in the CIP under the commodity security and service delivery thematic areas of this CIP.

In addition to the above-mentioned national issues, Kenya has made a commitment to the FP2020 goals and the sustainable development goals (SDGs) which recognize the critical role of FP as a human development issue. The CIP 2017-20 embody the principles of FP 2020 and SDGs.

CII) Kenya's FP2020 Commitments and Progress to Date

The GoK made its FP2020 commitment at the 2012 London Summit on Family Planning -including specific policy, financial and service delivery pledges. Commitment was made to enshrine the individual's rights to quality reproductive health care, including FP information, services and supplies, in the Constitution. The GoK also committed to scale up its Voucher System which provided reproductive health services, including FP, in an effort to address FP needs for the poor and hard to-reach segments of the population. Furthermore, Kenya committed to continue to work closely with development partners to secure increased financing for FP commodities and services. In addition to the above commitments some of which have seen significant changes, Kenya, committed to review barriers to some contraceptive methods at community level health facilities, especially in remote locations, and to reform the Kenya Medical Supply Agency (KEMSA) to end stock outs and improve the supply chain for all medical commodities including FP. Finally, Kenya committed to restructure the National Council for Population and Development Agency (NCPD), and facilitate additional resources to re-launch the national FP campaign.

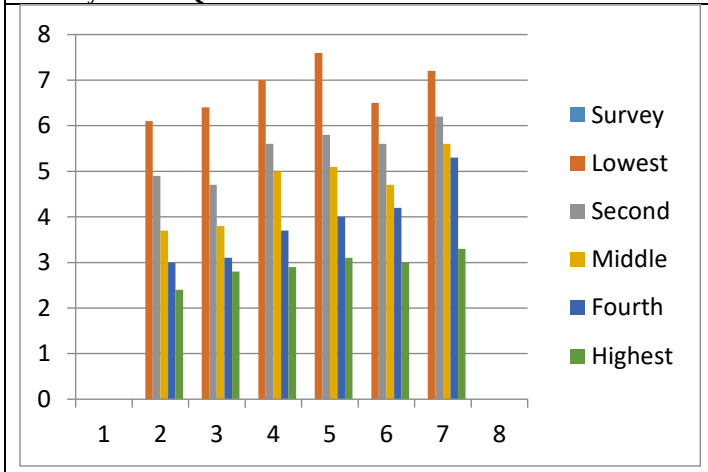
The situation regarding some of the above mentioned commitments has changed in the recent past as a result of global and national dynamics namely change of Kenya status to LMIC, policy change to free maternal services and devolution. Based on the 2016 FP2020 data and national updates[1], the GoK has made significant adjustments to reflect these changes.
Since 2012, the GoK has provided annual updates on the progress made and challenges faced in pursuing its commitment. For instance, the 2016 FP2020 updates indicated significant progress albeit with some challenges as follows[2]:

- The MOH secured funding amounting to US$7,846,027 for the procurement of contraceptive commodities from the GoK (US$ 448,595) and donors (US$ 7,397,432). However, a finding gap of US$ 2,461,052 remained.
- The MoH and the NCPD held a meeting with members of the Health and Budget Committees of the National Assembly to advocate for an increase in government allocation for FP. Meetings were also held with leaders at the county level for similar purposes. A few counties have provided budget-lines for FP commodities but the amounts are still very small and no county independently procured contraceptives for their use.
- The voucher system has been replaced by the free maternal health care which is provided in all public health facilities.
- No new youth empowerment centres have been established. Information and communications technology services have been scaled up in the existing 70 youth empowerment centres; however, provision of RH services is still weak due to the lack of youth-friendly services in these centres.
- With the change in governance structure, devolution has increased participation of local communities in decisions at the local level. Health services are devolved and county health managers are directly involved in formulating their priorities. Public participation is ensured through representation by the members of the county assemblies as well as in public hearings during budgeting process. The national government continued to provide resources to health facilities through the Health Sector Services Fund which is managed by local committees.
- Advocacy through the media, peer groups, mobilization for out-reach services and by observance of global days encouraged more women to use FP as well as to dispel myths and misconceptions.

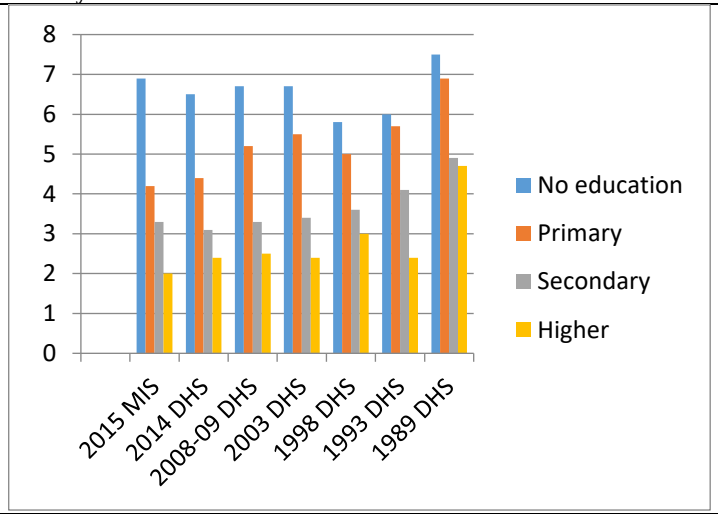
[1] Government of Kenya: 2016 Commitment updates. Available from http://www.familyplanning2020.org/entities/77
[2] http://www.familyplanning2020.org/entities/77/commitments

CIII) Disparities in FP Indicators among various groups

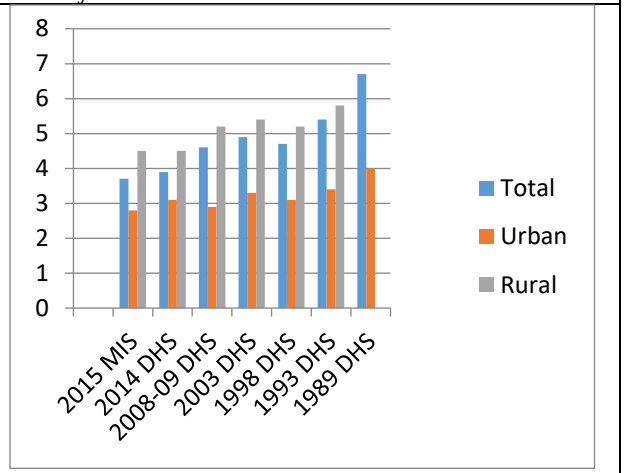
TFR by Wealth Quintile



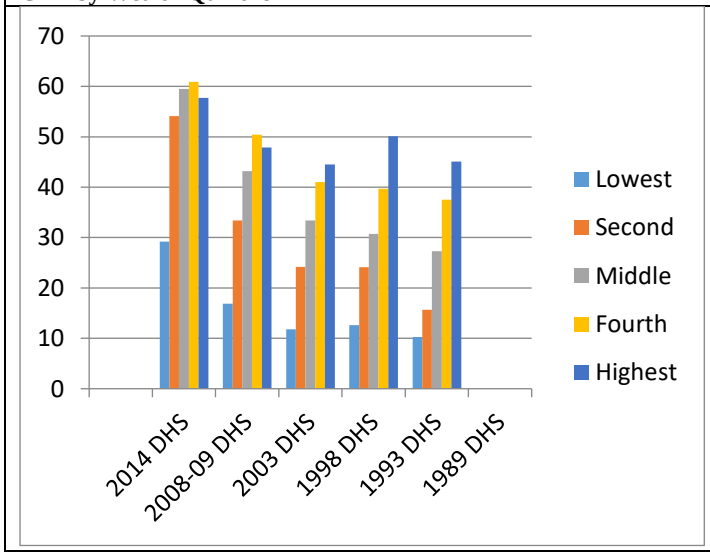
TFR by Education



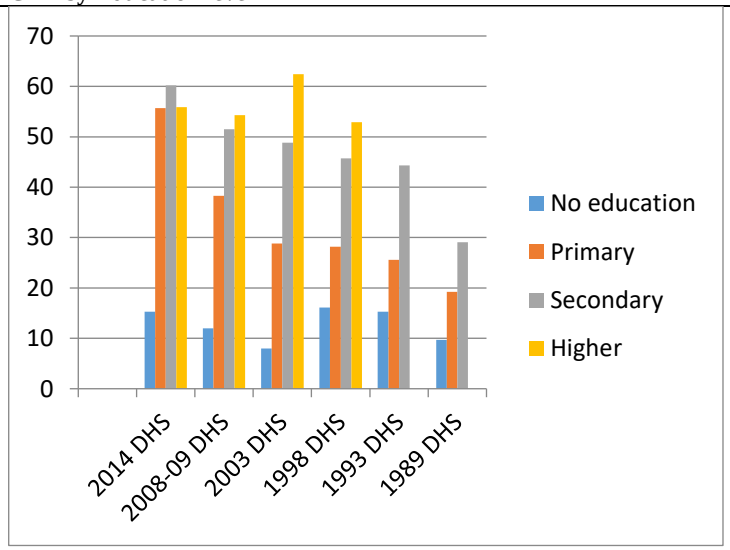
TFR by Residence



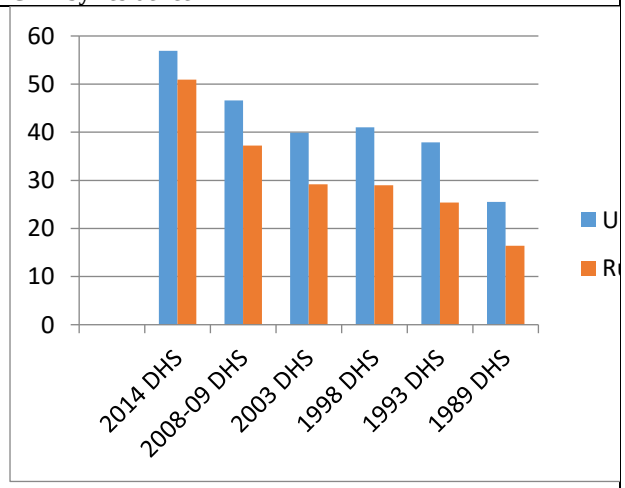
CPR by Wealth Quintile



CPR by Education level



CPR by residence



ANNEX D: FP CIP – ADDITIONAL INDICATORS

Type of Indicator	Indicator	Source
	Impact indicators	
National FP Goal	mCPR of 58%	KDHS 2019
FP2020 indictors	• Indicator 1a. Contraceptive prevalence rate, modern methods (mCPR), all women • Indicator 1b. % distribution of users by modern method of contraception • Indicator 2. Number of additional users of modern methods of contraception • Indicator 3. Percentage of women with an unmet need for modern methods of contraception • Indicator 4. Percentage of women whose demand is satisfied with a modern method of contraception • Indicator 5. Annual expenditure on family planning from government domestic budget • Indicator 6. Couple-years of protection (CYP) • Indicator 7: Number of unintended pregnancies • Indicator 8: Number of unintended pregnancies averted due to modern contraceptive use • Indicator 9: Number of maternal deaths averted due to modern contraceptive use • Indicator 10: Number of unsafe abortions averted due to modern contraceptive use	Track20, PMA2020, and the KDHS, National census, FP CIP end of programme evaluation
CIP Outcome indicators	• Availability of quality FP commodities • Allocation of FP funds and diversify sources of FP funds • Effectiveness of leadership in FP delivery • Evidence base for effective programme implementation through research and information dissemination • Access and utilization of quality family planning services • Health care seeking behaviour among populations with high unmet need for modern contraception	CIP monitoring F/work database and dash board FP CIP of programme mid-term evaluation
	Kenya Health Strategic & Investment Plan Indicators	
Services responsiveness	Client satisfaction index	Policy and planning
Provide essential health services	% of women of Reproductive age receiving family planning	HIS
Minimize exposure to health risk factors	Couple year protection due to condom use	HIS
	% Public Health Expenditures (Govt and donor) spent FP	HIS
Health Products	% of time out of stock for Essential Medicines and Medical Supplies (EMMS) – days per month	HIS
Health Products	% Public Health Expenditures (Govt and donor) spent on FP commodities and supplies	HIS/NHA
Health Infrastructure	% Public Health Expenditures (Govt and donor) spent on Infrastructure	HIS
Health Financing	General Government expenditure on FP as % of the total government Expenditure on health	NHA/ PETS
	Off budget resources for FP as % of total public health sector resources	NHA/ PETS
	% of health expenditure reaching the end users	NHA/ PETS
Health `	% of health facilities with functional committees	HIS
	% of Counties with functional County Health Management Teams	HIS
	% of Health sector Steering Committee meetings held at National level	HIS
	% of Health sector steering committees meeting held at county level	HIS
	% of facilities supervised	Unit R&D
	% of policies/document using evidence as per guidelines	Unit R&D
	# of Health research publications shared with decision makers	Unit R&D
Health Information	# of sector quarterly reports produced and disseminated	HIS
	% of planning units submitting timely, complete and accurate information	HIS
	% of facilities with submitting timely, complete and accurate information	HIS
	Public Health Expenditures (Govt and donor) spent on Health Information	HIS
Output indicators	See Activity Matrix in Annex A	Programme reports FP-CIP progress monitoring database/dashboard/ bi-annual reviews

Source: DFH M&E; Track 2020, Kenya Health Strategic & Investment Plan, RMNCH investment case