County Government of Kilifi

Department of Health Services

FAMILY PLANNING

Costed Implementation Plan

(2017-2021)

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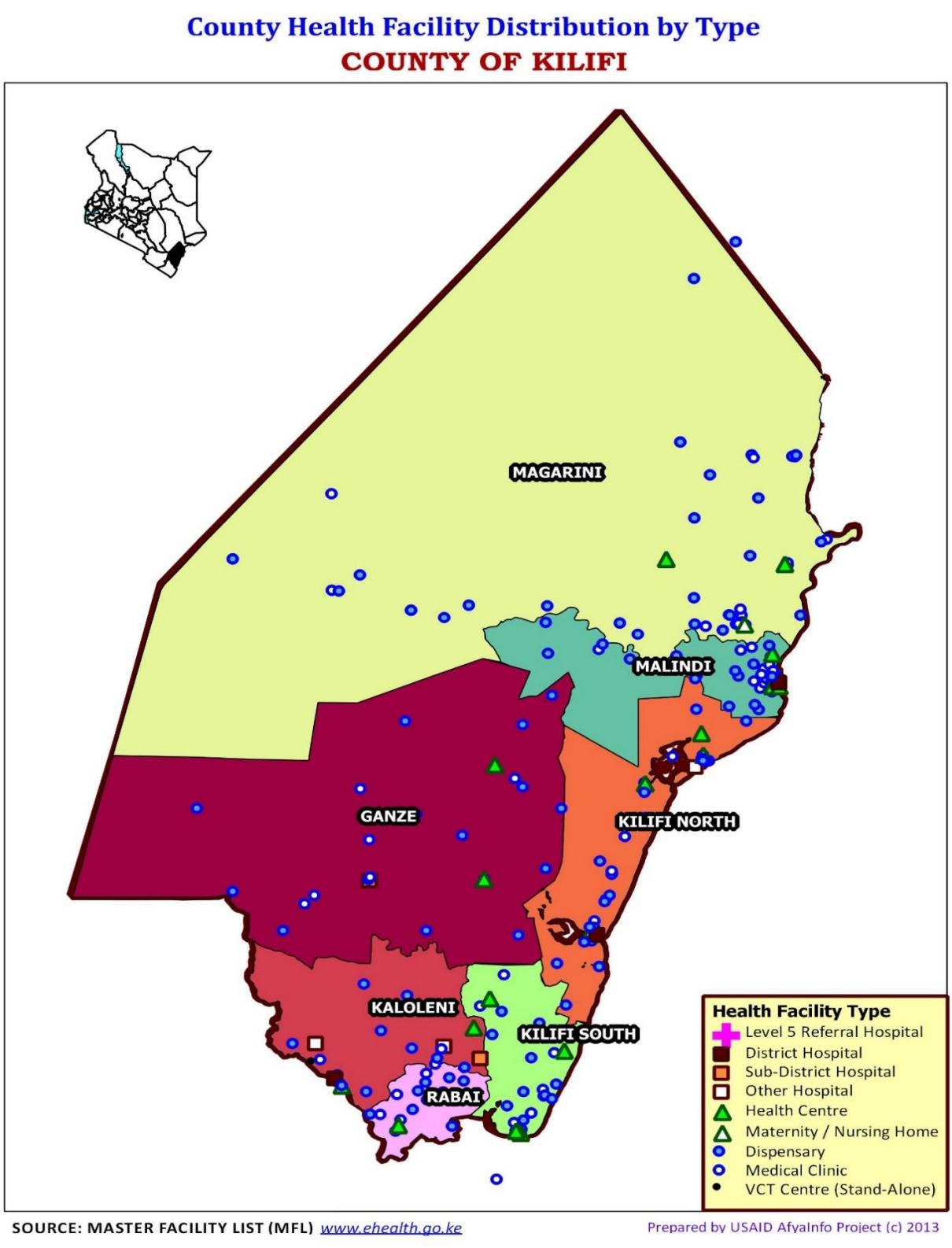


ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome	M&E	Monitoring & Evaluation
AWP	Annual Work Plan	MMR	Maternal Mortality Ratio
AYSRH	Adolescent and Youth Sexual and Reproductive Health	MOH	Ministry of Health
CHEWs	Community Health Extension Workers	MOU	Memorandum of Understanding
CHMT	County Health Management Team	NASCOP	National AIDS and STI Control Programm
CHVs	Community Health Volunteers	NCPD	National Council for Population and
CIDP	County Integrated Development Plan	NGO	Non-Governmental Organizations
CIP	Costed Implementation Plan	OJT	On Job Training
CME	Continuous Medical Education	PAC	Post Abortion Care
CPR	Contraceptive Prevalence Rate	JTF	John Templeton Foundation
CYP	Couple Year Protection	PHC	Population and Housing Census
DHIS	District Heath Information System	PHOs	Public Health Officers
DMPAs	Depot Medroxyprogesterone Acetate	PSK	Population Service Kenya
DQA	Data Quality Assurance	PWD	People with Disability
DRH	Division of Reproductive Health	PWUD	People Who Use Drugs
DSW	Deutsche Stiftung Weltbevölkerung	QI	Quality Improvement
eMTCT	Elimination of Mother to Child Transmission	SDG	Sustainable Development Goals
FBO	Faith Based Organization	SDPs	Service Delivery Points
FP	Family Planning	SOPs	Standard Operating Procedures
GDP	Good Dispensing Practice	STI	Sexually Transmitted Infection
HIS	Health Information Systems	SW	Sex Workers
HIV	Human Immunodeficiency Virus	WRA	Women of Reproductive Age
HRH	Human Resource for Health	TB	Tuberculosis
HSS	Health Systems Strengthening	TFR	Total Fertility Rate
ICT	Information and Communication Technology	TNA	Training Needs Assessment
IEC	Information Education & Communication	TOT	Trainer of Trainers/Training of Trainers
IIBRC	Interim Independent Boundaries Review Commission	TWG	Technical Working Group
KDHS	Kenya Demographic and Health Survey	UN	United Nations
KMYDO	Kenya Muslim Youth Dev Organization	UNFPA	United Nations Population Fund
LAPMs	Long Acting and Permanent Methods	URC	University Research Company
mCPR	Modern Contraceptive Prevalence Rate	WHO	World Health Organization
KNBS	Kenya National Burea of Statistics	UNICEF	United Nations Children's Fund
CCC	Comprehensive care centre	ANC	Anti Natal Care
GBV	Gender Based Violence	PNC	Post Natal Care
PAC	Post Abortion Care		

OPERATIONAL DEFINITIONS OF TERMS

Adolescent: An adolescent is any person between the age of 10 and 19 years. Adolescence is a period marked by significant growth, remarkable development and changes in the life course for boys and girls, filled with vulnerabilities and risks, as well as incredible opportunities and potential. (WHO)

Adolescent-Friendly Services: These are sexual and reproductive health services delivered in ways that are responsive to specific needs, vulnerabilities and desires of adolescents. These services should be offered in a non-judgmental and confidential way that fully respects human dignity.

Age Appropriate: This is suitability of information and services for people of a particular age, and in the case of the document, particularly in relation to adolescent development.

Advocacy: is the process of informing and/or influencing decision makers in order to change policies and/or financial allocations, and to ensure effective policy implementation. Advocacy plays a critical role in ensuring that national commitments translate into concrete action.

Beyond zero: is an initiative spearheaded by The First Lady of the Republic of Kenya, Her Excellency Margaret Kenyatta. It is part of the initiatives outlined in a strategic framework towards HIV control, promotion of maternal, newborn and child health in Kenya. Through this initiative Her Excellency has fundraised to ensure all the 47 counties have a mobile clinic (equivalent of a Level Four hospital). Kilifi County has already received the mobile clinic.

Contraceptive Prevalence Rate (CPR): the percentage of currently married women and sexually active unmarried women who are currently using a method of contraception or whose sexual partners are practicing any form of contraception.

Community strategy: recognition and introduction of Level One services, which are aimed at empowering Kenyan households and communities to take charge of improving their own health.

Elimination of Mother-To-Child Transmission (eMTCT): refers to the elimination of transmission of HIV from a HIV-positive woman to her child during pregnancy, labour, delivery and/or breastfeeding.

Family planning: refers to a conscious effort by a couple to limit or space the number of children they have through the use of contraceptive methods.

Health: Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. (WHO definition)

Health care professional: includes any person who has obtained health professional qualifications and licensed by the relevant regulatory bodies.

Integration: refers to delivering multiple services or interventions to the same patient by an individual health care worker or by a team of health care workers and, possibly, workers from other fields.

Life Skills Education: This is a structured program of needs and outcomes-based participatory learning that aims to increase positive and adaptive behavior by assisting individuals to develop and practice psycho-social skills that minimize risk factors and maximize protective factors. Life skills education programs are theory and evidence based, learner-focused, delivered by competent facilitators and are appropriately evaluated to ensure continuous improvement of documented results.

Linkage: refers to a relationship between different parties such as, between community to health facility, Sub-county and County hospitals or between two departments within a facility.

Methods of Contraception: (family planning) are classified as modern or traditional methods.

Modern Contraceptive Methods: include female sterilization, male sterilization, oral hormonal pills, the intrauterine device (IUD), injectable, implants, male condoms, female condoms, Lactational Amenorrhea Method (LAM.

Traditional Methods: include rhythm and withdrawal.

Missed Opportunity: for family planning is defined as an opportunity for family planning counseling, education or service that was missed at the health center or outreach.

Policy: Refers to those actions, customs, laws or regulations by governments or other social/civic groups that directly or indirectly, explicitly or implicitly affect people, communities, programs, or institutions. It can also be defined as a framework which guides decision making.

Reproductive Rights: include the right of all individuals to attain the highest standard of sexual and reproductive health and to make informed decisions regarding their reproductive lives free from discrimination, coercion or violence.

Special target populations: refers to populations that require special attention due to vulnerability. These groups vary according to the topic in discussion and the geographic area in discussion. For the purpose of this strategy, the following are the special target groups referred to: adolescents and youth, people living with disability, women living with HIV, drug users and female sex workers.

The Sustainable Development Goals (SDGs), officially known as Transforming our world: the 2030 Agenda for Sustainable Development is a set of seventeen aspirational "Global Goals" with 169 targets between them, spearheaded by the United Nations. See annex 6 for all the SDGs.

SDG Goal 3: Ensure healthy lives and promote well-being for all at all ages.

3.1: By 2030 reduce the global maternal mortality ratio to less than 70 per 100,000 live births

3.7: By 2030 ensure universal access to sexual and reproductive health care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programs.

Unmet need; Women with unmet need are those who are fecund and sexually active but are not using any method of contraception, and report not wanting any more children or wanting to delay the next child.

FOREWORD

Kilifi County has a projected total population of 1,447,670 [1]people with an estimated annual growth rate of 2.9 per cent. The Total Fertility Rate is at 5.1 births per woman, Maternal Mortality Ratio of 290/100,000 live births, an unmet family planning need of 34 per cent, teenage pregnancy rate of 22 per cent, and a Contraceptive Prevalence Rate of 34.1 per cent.

Contraceptive use has a wide range of benefits for the health of women, children, and the socioeconomic development of a population. As a County through the FP-CIP, we are dedicated to increasing access to contraceptive choices and decision making for clients. .

Full and successful implementation of the FP-CIP requires concerted and coordinated efforts of the community, County government, the private sector, and civil society and development partners. By committing ourselves to the full financing and implementation of the Kilifi County Family Planning Costed Implementation Plan 2017–2021, we can; (i) realize our goals of reducing unmet need for family planning to 10 per cent from the current 34.1 per cent; (ii) increase the modern contraceptive prevalence rate among married and women in union to 70 per cent by promoting the "By Choice not Accident" family planning agenda that encourages planned and wanted pregnancies; (iii) increase the chance that the birth of infants will not exceed the family's ability to care for the child; and (iv) reduce maternal and infant morbidity and mortality.

We believe that our joint efforts will lead to the realization of the FP 2020 goals as well as the Sustainable Development Goals.

H.E Amason Jeffa Kingi

Governor

KILIFI COUNTY GOVERNMENT

[1] KNBS 2017 projected population

PREFACE

Embracing a comprehensive strategy to address the family planning needs is paramount for the Department of Health. The Department is committed to providing the required leadership to coordinate and implement the Family Planning Costed Implementation Plan (FP-CIP). This document ensures that every Kilifi citizen's right to health is upheld and issues such as education, autonomy, and personal decision making about the number and spacing of their children are promoted.

Our efforts to scale up use of modern contraceptive methods are motivated by the knowledge that family planning helps women achieve their human rights to health, education and empowers families at large to make decisions about the number and spacing of their children. More broadly, family planning improves maternal and child health, facilitates educational advances, empowers women and families, reduces poverty and is a foundational element to the economic development of the county and nation at large.

The County's Family Planning Costed Implementation Plan gives emphasis to:

a) Increasing the efforts to reach all young people, women of reproductive age, families and communities with family planning information and services;

b) Developing a county social and behavior change communication strategy with harmonized programmes sensitive to individual needs, cultural and religious practices;

c) Implementing task sharing amongst health care workers to increase access to rural and underserved populations;

d) Promoting a multi-sectoral approach to family planning;

e) Ensuring family planning commodity security across the service delivery points.

f) Supporting advocacy to increase resources through programme based budgetary allocation towards family planning.

The Department of Health pledges to support all coordinated efforts and calls upon development, implementing partners and the community to work with us to support the implementation of activities in the Costed Implementation Plan.

Through this we shall safeguard the quality of life and well-being of our people.

Hon. Rachel Musyoki
County Executive Committee Member for Health Services
Kilifi County Government

ACKNOWLEDGEMENT

The Kilifi County Department of Health Services wishes to express our appreciation to partners and groups who supported the development of the Kilifi County Family Planning Costed Implementation Plan, 2017–2021. This document is the result of extensive consultations with stakeholders working at all levels, including key sector ministries, implementing partners, for-profit organizations, and the community.

The Department is greatly indebted to Kenya Muslim Youth Development Organization (KMYDO) under the leadership of Mr. Fadhili Msuri through funding from John Templeton foundation.

Sincere gratitude to JHPIEGO and DSW Kenya through their representatives, Emmah Kariuki and Peter Ngure respectively for their technical and financial support to ensure that the whole process was successful, UNFPA Kenya for their sincere contribution toward the CIP finalization, reprinting and disseminating up to sub county level . We cannot forget the immense contribution from the National Council for Population and Development Regional Coordinator Margaret Mwaila who provided the background information for the development of this plan and editorial review.

The department appreciates the tireless efforts of the Reproductive Maternal, New-born and Adolescent Health Technical Working Group members led by Mrs. Esther Mwema that ensured each stage of the process was accomplished successfully.

I would also like to acknowledge the efforts and dedication by the lead consultant Mr. Cosmas Mutua who ensured that the final document was delivered in the right time and in the best possible manner.

Finally, I recognize the important role that the County Health Management Team played in endorsing, validating, and in the launch of the Kilifi County FP-CIP 2017 -2021.

Dr. Timothy Malingi
Chief Officer, Health Services
Kilifi County Government

CHAPTER ONE: INTRODUCTION

1.1 BACKGROUND

Kenya was confirmed to have a population of 38,610,097 people according to the last official census that took place in 2009. According to the UN estimates released in July 2016 Kenya's population hit 47,251,449.

Kilifi County lies between latitudes 2' 20" and 4'0" South and between longitudes 39' 05" and 40' 14" East. The County borders Kwale County to the South West, Taita Taveta to the West, Tana River County to the North, Mombasa County to the South and Indian Ocean to the East. The county covers an area of 12,658km^2. According to the Kenya National Bureau of Statistics 2016, Kilifi County has a population of 1,447,670 people. The ratio of female to male is 1:1 according to the KNBS 2017 projected population

Kilifi County has an urban population of 25.73 per cent with main urban centers being Malindi 11%, kilifi town 4%, mtwapa 4% mariakani 2% watamu 1% majengo 1% mazeras 1% magarini 1%, Njiabini 1%, Marereni 1% and Kaloleni 1%[2]

The county comprises 7 sub counties namely: Kilifi North, Kilifi South, Ganze, Malindi, Magarini, Kaloleni and Rabai.

1.2 RATIONALE FOR AND USE OF THE FP-CIP

The Kilifi County FP-CIP is the guide for all FP programming for the county government across all sectors, development partners, and implementing partners. FP-CIP details the necessary programme activities and costs associated with achieving county goals, providing clear programme-level information on the resources the county must raise domestically and through partnerships. The plan gives critical direction to Kilifi FP programme, ensuring that all components of a successful programme are addressed and budgeted for in the county government and partner programming.

More specifically, the FP-CIP will be used to:

• **Ensure one unified county strategy for family planning is followed**: The FP-CIP articulates Kilifi consensus-driven priorities for family planning derived through a consultative process thus making it a social contract for donors and implementing partners. The plan will help ensure that all FP activities are aligned with the county's needs, prevent fragmentation of efforts, and guide current and new partners in their family planning investments and programs. All stakeholders must align their FP programming to the strategy detailed in this document. In addition, the Ministry of Health (MOH) must hold development and implementing partners to account for their planned activities and to realign funding to the county's needs identified as priorities. At the same time, the FP-CIP details commitments, targets, actions, and indicators to make the MOH ultimately accountable for their achievement. All other sectorial ministries should work in tandem with the MOH to implement the FP-CIP in a coordinated way.

[2] Kilifi county secondary data review as at feb 2014 - www.humanitarianresponse.info/.

• **Define key activities and an implementation roadmap**: The FP-CIP includes all necessary activities, with defined targets appropriately sequenced to deliver the outcomes needed to reach the country's committed FP goals by 2020.

• **Determine impact**: The FP-CIP includes estimates of the demographic, health, and economic impacts of the FP programme, providing clear evidence for advocates to use to mobilize resources.

• **Define a county budget**: The FP-CIP determines detailed commodity and programme activity costs associated with the entire FP programme. It provides concrete activity and budget information to guide the MOH and partners to prioritize funding and implementation of strategic priorities as outlined in the FP-CIP.

• **Mobilize resources**: The FP-CIP should also be used by the County Government of Kilifi (CGK) and partners to mobilize needed resources. The plan details the activities and budget required to implement a comprehensive FP programme. In so doing, the MOH and partners can systematically track the currently available resources against those required as stipulated in the FP-CIP. In addition, the FP-CIP can be used to conduct advocacy and mobilize funds from various sources to support any funding gaps.

• **Monitor progress**: The FP-CIP's performance management mechanisms measure the extent of activity implementation and help ensure that the county's FP programme objectives are met. Again, the FP-CIP ensures coordination and guidance on any necessary reviews and corrections.

• **Provide a framework for inclusive participation**: The FP-CIP and its monitoring system provide a clear framework for broad-based participation of stakeholders within and outside of the CGK and are inclusive of relevant groups and representatives from key populations in the implementation and monitoring of the plan.

1.3 THE DEVELOPMENT PROCESS

Kilifi County began developing its Family Planning Costed Implementation Plan, 2017–2021 (FP-CIP) in the first quarter of 2017, with support initiated by Kenya Muslim Youth Development Organization (KMYDO) supported by a consultant.

A group of high-level experts from the MOH, implementing partners and civil society were also involved through a technical working group.

The plan and activity matrix was presented in various forums to expert groups throughout the process, including the CIP Task Force; groups of various partners and MOH experts across technical areas.

The costing was developed based on international best practices and customized to the Kenyan and county context. The MOH circulated multiple draft versions of the FP-CIP to its partners and stakeholders before the plan was finalized. This was followed by a stakeholder's forum that called for inputs and critique. Finally the FP-CIP was validated then launched.

During the CIP execution, further refinement of the technical strategy will become necessary as information will be generated from performance indicators.

1.4 THE GLOBAL CONTEXT

Scaling up FP services is one of the most cost-effective interventions to prevent maternal, infant, and child deaths globally. Family planning interventions aid in lowering maternal, infant and child mortality, contributing to the Millennium Development Goals (MDGs) and the newly established Sustainable Development Goals (SDGs). Through a reduction in the number of unintended pregnancies in the country, it is estimated that a quarter to a third of all maternal deaths could be prevented. Family planning is linked indirectly as a contributor to positive health outcomes. For example, FP interventions contribute to reducing poverty, increasing gender equity, preventing the spread of HIV, reducing unintended teenage pregnancies, and lowering infant deaths. In addition, each dollar spent on FP initiatives on average results in a six dollar savings on health, housing, water, and other public services.

Lack of access by adolescent girls to family planning, including contraceptive information, education, and services, is a major factor contributing to unwanted teenage pregnancy and maternal death. In low and middle income countries, complications of pregnancy and childbirth are the leading causes of death amongst adolescent girls ages 15–19.Currently, more than 200 million women in developing countries desire to space or limiting pregnancies; however, they lack access to FP options. Amongst women of reproductive age in developing countries, 57 per cent (867 million women) need access to contraceptive methods because they are sexually active but do not want a child in the next two years. Of these women, 645 million (74%) are using modern methods of contraception; the remaining 222 million are not, resulting in significant unmet need for modern FP methods[3].

FP 2020

The government of the United Kingdom, through the Department for International Development (DFID), and the Bill & Melinda Gates Foundation partnered with the United Nations Population Fund (UNFPA) to host a gathering of leaders from national governments, donors, civil society, the private sector, the research and development community, and other interest groups. The purpose was to renew and revitalize global commitment to ensuring the world's women and girls, particularly those living in low-resource settings, have access to contraceptive information, services and supplies. The resulting event was the London Summit on Family Planning, held on 11 July 2012.

At the summit, implementers, governments and FP stakeholders united to determine priorities and set forth commitments.

The summit aimed to ***"mobilize global policy, financing, commodity and service delivery commitments to support the rights of an additional 120 million women and girls in the world's poorest countries to use contraceptive information, services and supplies, without coercion or discrimination, by 2020."***

Achieving this ambitious target would prevent a staggering 100 million unintended pregnancies, 50 million abortions, 200,000 child birth-related and maternal deaths, and 3 million infant deaths.

The London Summit on Family Planning called on all stakeholders to work together on various areas, including;

- Increasing the demand and support for family planning
- Improving supply chains, systems, and service delivery models
- Procuring the additional commodities.

2001 ABUJA DECLARATION

In April 2001, the African Union countries met and pledged to set a target of allocating at least 15% of their annual budget to improve the health sector and urged donor countries to scale up support

[3] www.guttmacher.org/adding-it-costs-and-benefits-contraceptive-services-estimates

• Fostering innovative approaches to family planning challenges

• Promoting accountability through improved monitoring and evaluation

Sustainable Development Goals (SDGs)

Building on the commitments of the Millennium Development Goals, the global SDGs are newly proposed by the United Nations to address domestic and global inequalities by 2030. Goals 3 and 5 give direct and indirect outcomes related to family planning. Goal 3 specifies to "ensure healthy lives and promote well-being for all at all ages." Further, the sub-activity states;

• 3.1- By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births

• 3.7- By 2030, ensure universal access to sexual and reproductive health care services, including family Planning, information and education and the integration of reproductive health into national strategies and programmes.

Further, Goal 5, "achieve gender equality and empower all women and girls," includes sub-activity

5.6: To ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development (ICPD) and the Beijing Platform for Action and the outcome documents of their review conferences. Given the focus areas in family planning and equitable access, if the necessary resources, political will, advocacy, and in country priorities are provided, the SDGs are set to achieve substantial impact outcomes.

1.5 NATIONAL CONTEXT

The constitution of Kenya mandates state and non-state organs to observe, respect, protect, promote and fulfil health rights and take legislative policy and other measures to achieve the said rights. Table 1 below summarizes some of the main constitutional provisions that impact on human health.

Table 1: Main constitutional provisions and impact on Health

ARTICLE	CONTENT
43	(1) Every person has the right - a) To the highest attainable standard of health, which includes the right to health care services including reproductive health care; b) To accessible and adequate housing, and to reasonable standards of sanitation; c) To be free from hunger and have adequate food of acceptable quality; d) To clean and safe water in adequate quantities. (2) A person shall not be denied emergency medical treatment.
53-57	Rights of special groups: - Children have the right to basic nutrition and health care. - People with disability have the right to reasonable access to health facilities, access to materials and devices. - Youth have the right to relevant education and protection from harmful cultural practices and exploitation. - Minority and marginalized groups have the right to affirmative action programs of the state that ensure they have reasonable health services.
174,235 and the Fourth Schedule	Objectives of devolution versus the fourth schedule on roles: National: Health policy, National referral facilities; and capacity building and technical assistance to counties; County Health services: County health facilities and pharmacies; Ambulance services; Promotion of primary health care; licensing and control of undertakings that sell food to the public; veterinary services; cemeteries; funeral parlours and crematoria; Refuse removal, refuse dumps and solid waste disposal. Staffing of county Governments: Within a framework of uniform norms and standards prescribed by an Act of Parliament for establishing and abolishing offices, appointment and confirmation of appointments and disciplining staff except for teachers.
176	Every County Government shall decentralize its functions and the provision of its services to the extent that it is efficient and practicable to do so.
187	Transfer of functions and powers between levels of Government

County departments of health services are mandated by law to carry out various health functions as outlined in the health sector functions, assignments and transfer policy paper of 2013. These functions include:

1. Provide leadership and management of the county health teams, planning, development and monitoring of County health services in compliance with the national standards.
2. County level prioritization of health investments, setting and reporting on relevant targets and coordination of all actors in the county health systems.
3. Provide guidance on health facilities within the county in implementing health service tariffs and benefits.
4. Development and management of referral services within the county health systems and other referral health facilities.
5. Conduct County studies including operational research to inform decision making in health service delivery at all levels.
6. Provision of emergency medical and ambulance services in the County.
7. Provision of County pharmacy services and county health facility services.
8. Provision of preventive, promotive and rehabilitative services to the County.
9. Strengthen inter County and national health services collaboration.
10. Facilitate and coordinate the role of non-state actors in the county health system focusing on county priorities and ensure their compliance with the national policy and regulatory requirements; and
11. To facilitate capacity building for health care workers and the community in the county.

1.6 KEY PRINCIPLES OF THE FP-CIP

I. A rights-based approach- Recognizing and respecting human and reproductive health rights as envisioned in article 43 of Kenya constitution, this CIP will seek to ensure inclusion of all residents of the county, including populations with special needs such as the adolescents and the people living with disability.

II. Devolution- Embracing a devolved system of government, the plan recognizes the power of the County to make decisions that are focused and targeted for the benefit of the residents of Kilifi County.

III. A multi-sectoral approach- Recognizing that health is not just a health issue, but a larger development issue, a response coordinated by the county department of health will engage the different stakeholders including the different ministries of the county Government, private sectors, religious leaders, traditional leaders, youth leadership, civil society and the community at large, in initiatives to support FP services in the county.

IV. Integration- Described in this strategy, will ensure that FP information and services are provided within the same health facilities where all other health services are provided, and will make use of the community units, with effective referrals made for services that need more specialized skills from other health facilities in the county.

V. Evidence-based interventions- This CIP will seek to address the real issues identified by the stakeholders, and brought out by the data from different sources in the county.

CHAPTER TWO: SITUATIONAL ANALYSIS

2.1 GLOBAL FAMILY PLANNING TRENDS

In 2012, an estimated 645 million women in the developing world were using modern methods - 42 million more than in 2008. About half of this increase was due to population growth. The proportion of married women using modern contraceptives in the developing world as a whole barely changed between 2008 (56%) and 2012 (57%). Larger than average increases were seen in Eastern Africa and South East Asia, but there was no increase in Western and Middle Africa.

The number of women who had an unmet need for modern contraception in 2012 was estimated at 222 million[4]. The number declined slightly between 2008 and 2012 in the developing world overall, but increased in some Sub-Saharan regions, as well as in the 69 poorest countries. Serving all women in developing countries that currently have an unmet need for modern methods would prevent an additional 54 million unintended pregnancies, including 21 million unplanned births, 26 million abortions (of which 16 million would be unsafe) and 7 million miscarriages; this would also prevent 79,000 maternal deaths and 1.1 million infant deaths[5].

Special attention is needed to ensure that the contraceptive needs of vulnerable groups such as unmarried young women, poor women and rural women are met and that inequities in knowledge and access are reduced. Improving services for current users and adequately meeting the needs of all women who currently need but are not using modern contraceptives will require increased commitment from governments and other stakeholders, as well as changes to a range of law, policies and factors related to service provision and practices that significantly impede access to and use of contraceptive services.

2.2 FAMILY PLANNING TRENDS IN KENYA

According to the Kenya Demographic and Health Survey (KDHS) 2014, 58 per cent of currently married women are using a contraceptive method. The most popular modern contraceptive methods used by married women are: injectable (26%), implants (10%), and the pills (8%). The use of modern methods has increased over the last decade from 32 per cent to 53 per cent.

However 18 per cent of currently married women have an unmet need for family planning services, with 9 per cent in need of spacing and 8 per cent in need of limiting. Women are more familiar with modern methods of contraception (98%) than with traditional methods (84%).

The public sector is the major source of contraceptive methods in Kenya, providing contraception to 60 per cent of current users. Within the public sector, 24 per cent of users obtain their methods from government dispensaries, 20 per cent from government hospitals, and 16 per cent from government

[4] Kenya reproductive transition unmet need for family planning

[5] Adding it up : cost and benefit of contraceptive services : estimates for 2012.

health centers. 34per cent of modern contraceptive users obtain their methods from the private medical sectors, mainly from private hospitals/clinics (21%) and pharmacies (10%).

Except for the pill and male condoms, the public sector is the primary provider of most types of contraception used in Kenya. The majority of women who use the pill obtain it from the private sector (57%), and nearly half of women who use male condoms obtain them from other sources, largely from shops (39%).

These findings point to the continued reliance on government facilities as a major source of contraceptives. However, 31 per cent of family planning users discontinue the use of a method within 12 months of starting its use. Side effects and health concerns (11%) are the main reasons for discontinuation.

2.3 UNMET NEED FOR FAMILY PLANNING

According to KDHS 2014 Kenya has Eighteen per cent (18%) of currently married women have an unmet need for family planning, with 9 per cent having an unmet need for spacing and 8 per cent having an unmet need for limiting. Only 15 per cent of women have a met need for family planning. If all currently married women who say they want to space or limit births were to use a family planning method, the contraceptive prevalence rate would rise to 76 per cent. Currently, 75 per cent of the family planning needs of married women are being met.

Unmet need is higher in rural areas (20%) than in urban areas (13%). Unmet need decreases with increasing education. Married women with no education have a higher unmet need for family planning (28%) than their educated counterparts (23% or less). Unmet need declines steadily as households' wealth increases from 29 per cent in the lowest wealth quintile to 11 per cent in the highest quintile[6].

Total demand for family planning is higher among women aged 35-39 (81.7%), However, it is lower among younger women (15-19) and those older (45-49) (each 61.4%). Demand for family planning does not vary much by urban-rural residence; however, there are wide variations by region. North Eastern has the lowest demand (33.3%) and Eastern the highest (82.9%). Women with no education (46.9%) and women in the lowest wealth quintile (59.8%) have a lower demand than their more educated or wealthier counterparts[7].

2.4 THE COUNTY CONTEXT

The County of Kilifi has an estimated Maternal Mortality Ratio of 290 per 100,000 live births according to the KNBS social economic atlas 2014 compared to the national MMR of 362 per 100,000 live births estimated by KDHS in 2014. This is still high. Indeed, the recent estimates by WHO, UNICEF, UNFPA, the World Bank Group and UN Population Division highlight insufficient

[6] www.prb.org/pdf14/kenya-unmet-need-contraception.pdf

[7] KDHS 2014 table 3.11

progress. Coverage/utilization indicators also show some improvements but much more needs to be done to address inequities and to reach Universal Health Care (UHC).

Use of contraception among Kilifi's married women decreased from 47 per cent in 2009 to 34.1 per cent in 2014. This is way below the national proportion of 58 per cent. Even lower is the use of modern contraceptives which stands at 32.8 per cent in Kilifi compared to the national average of 53 per cent,

The county realized a decline in unmet need for family planning from 25.4 per cent to 23.3 per cent in 2009 and 2014, respectively[8]. 2016 Kilifi Fact Sheet, 59% compared to 23% nationally

About 98.2 per cent of pregnant women received at least one antenatal care (ANC) by a skilled attendant, while 52.3 per cent births were delivered in health facilities by skilled service providers in 2014. Postnatal check up in the first two days after birth in Coast Region decreased from 42.9 per cent in 2009 to 39 per cent in 2014.

The Total Fertility Rate (TFR) for Kilifi county stands at 5.1 compared to the National rate of 3.9 in 2014. However, teen pregnancy is high 22 % KDHS 2014 Coast region in comparison to the national average of 18 per cent. Early childbearing among adolescents (15-19 years) has been occasioned by early marriages, high unmet need for contraception among adolescents of 59 per cent and poor access to FP services[9].

The Kilifi County department of Health and its development partners are committed to promoting and providing adequate FP health services. Nevertheless, a number of factors limit the demand for and use of FP health services in many parts of the county. These are:

- Logistical barriers, including distance and costs of services
- Social, cultural and religious beliefs and practices
- Behavioral restrictions, including lack of women's empowerment and male involvement
- Inadequate health-management systems
- Legal and medical regulations
- Poverty and increases in out-of-pocket expenses to access reproductive health services.

The overall trends in FP indicators point to challenges ahead. Kilifi County Health department is committed to decreasing the unmet need for family planning and to increasing the contraceptive prevalence rates for all methods from the current 34.1 per cent (KDHS, 2014) to 50 per cent by 2021. For this target to be realized, access to family planning services must be improved, especially among adolescent and youth, less educated, rural, and poor women.

This document will facilitate the preparation and implementation of the annual work plans on family planning within the health services agenda in the County. It is directly aligned to the Kilifi County Integrated Development Plan 2013, the Kilifi Reproductive Health Policy and the Kilifi County Health Sector Strategic and Investment Plan Monitoring and Evaluation Framework.

[8] (Refers to KDHS 2014 Coast Region)

[9] KDHS 2014

Table 2: No. of Health Facilities in Kilifi County and Percentage Coverage of FP as per DHIS 2016

SUB COUNTY	PUBLIC	FBO	PRIVATE	NO. OF CUs	FP Coverage
Ganze	17	1	6	**19**	**25.7%**
Kilifi North	22	1	26	**10**	**72.5%**
Kilifi South	10	2	15	**11**	**56.0%**
Magarini	31	0	10	**10**	**56.0%**
Malindi	12	7	66	**6**	**70.0%**
Kaloleni	13	2	10	**16**	**38.1%**
Rabai	8	1	6	**9**	**38.3%**
COUNTY TOTAL	**113**	**15**	**138**	**81**	**53.3%**

2.5 GENERAL HEALTHCARE SITUATION IN KILIFI COUNTY

Medical facilities in Kilifi County are inadequate in terms of the number of health centers and the services provided to the local population. The current life expectancy is 56 years with an annual population growth rate of 2.9 and a Total Fertility Rate of 5.1 births per woman.

Kilifi County covers an area of 12,658km^2 excluding water bodies[10]) and has a population density of 87 persons per square kilometer. According to the KNBS data, the county has an urban population of approximately 25.73 per cent. Therefore, most of its population is rural based. About 67.7 per cent of the population lives below the poverty line while the wealth inequality stands at 57.

It is served by a total of 113 Health facilities, of which 5 are hospitals, 108 primary care facilities and 81 community units. People travel long distances for treatment. The poor road network further complicates access to the health services, which forces some residents to skip FP services. The doctor population ratio is 1:10,000 while the nurse population is 5:10,000. This is way below the minimum threshold of 23 doctors per 10,000 population that was established by WHO as necessary to deliver essential maternal and child health services. Annex 1 breaks down the National health work force staffing needs and also gives the current number of staff in Kilifi County health facilities.

[10] KNBS social economic atlas 2014

2.6 FAMILY PLANNING INDICATORS

The development of this strategic plan is informed by data from Kenya Demographic and Health Survey (KDHS) 2014. The knowledge of at least one contraceptive method is universal in Kenya with more than half (58%) of currently married women using a contraceptive method. The survey shows that in Kenya the most popular modern contraceptive methods used by married women are: injectables (26%); implants (10%) and the pill (8%).

The use of modern methods has increased over the last decade from 32 per cent to 53 per cent with the public sector remaining the major provider of contraceptive methods. Sixty per cent of modern contraceptive users obtain their contraception from a government source.

Kilifi County has a modern Contraceptive Prevalence Rate (mCPR) of 32.8 per cent. Currently, the commonly used contraceptive method is injectables at (65%), followed by implants (13%) and male condoms at 9 per cent. This information is summarized in the figure below;

Fig 1. Family planning uptake in Kilifi County according DHIS 2016.

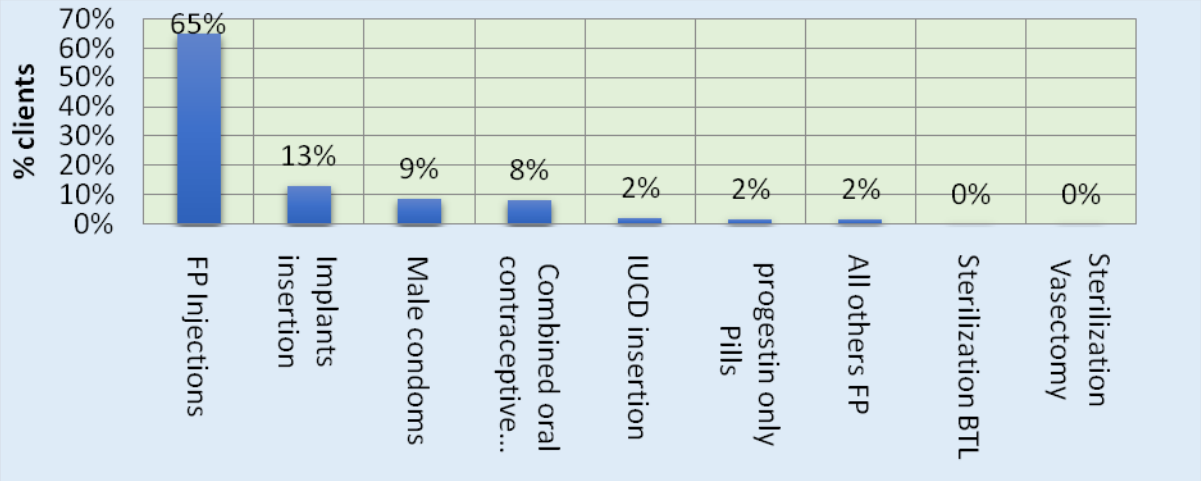


Table 3: Proportion of Women of Reproductive Age (WRA) receiving Family Planning (FP) commodities (DHIS 2010- JUNE2017)

Period / Data	Women of reproductive age (WRA) receiving family planning (FP) commodities	No. of Women of reproductive age (WRA)	% Coverage
Jul 2010 to Jun 2011	85137	268766	32%
Jul 2011 to Jun 2012	137632	276560	50%
Jul 2012 to Jun 2013	129691	284581	46%
Jul 2013 to Jun 2014	138254	292834	47%
Jul 2014 to Jun 2015	153448	301326	51%
Jul 2015 to Jun 2016	163637	310064	53%
Jul 2016 to Jun 2017	87486	319056	27%

KDHS 2014: Current use of any modern method of family planning (% of currently married women age 15-49) Kilifi 32.8% compared to 53%

2.7 FACTORS AFFECTING FAMILY PLANNING IN KILIFI COUNTY

The County of Kilifi Health Department recognizes that family planning is a development issue and that the great health and economic benefits of family planning extend beyond individuals, communities and countries. Women and girls who are using modern methods of contraception are better able to ensure the security, education, and well-being of their families, which are essential to sustainable development. A multi-sectoral approach to family planning is therefore required, and is based on the recognition that health cannot be improved by focusing on interventions relating to health services alone. A focus on other related sectors is equally important in attaining the overall health goals. These sectors include education, agriculture (food security); Roads (focusing on improving access amongst hard to reach populations); Housing and Environmental factors. Some specific issues affecting family planning in Kilifi County are discussed below.

2.7.1 Inadequate resources for FP activities

There is generally very low funding on health which in turn affects the family planning budget. This often leads to commodity stock outs, poor or no targeted outreaches for family planning and lack of the necessary family planning equipment not to mention continuous skills improvement.

2.7.2 Inadequate CHV involvement and Community health strategy coverage

Community Health Volunteers (CHV) play a very critical role in family planning since they are in direct touch with the community and they act as link persons between the community and primary

healthcare facilities/providers. The CHV coverage is still very low at 30% [11]. Needless to say, their logistical facilitation remains a challenge and their capacity building needs outstanding.

2.7.3. Drug and Substance Abuse

Drug and substance abuse particularly among the youth is very high. For adolescents, substance use and abuse is associated with increased risk for early sexual debut, multiple sexual partners and early childbearing. According to NACADA 2012 rapid assessment of drugs and substance use in Kenya[12], about 18 per cent of adolescents aged 15-17 reported ever using any drug or substance, including tobacco, Khat (Miraa), narcotics and inhalants. Despite the need for services to address substance abuse, very few drug rehabilitation programs and counseling centers are available for adolescents in Kenya while they tend to be urban-based. When under the influence of these substances, adherence to the use of family planning methods is affected leading to young people's exposure to unintended pregnancies and HIV infection.

2.7.4. Low Literacy

Kilifi's literacy rate was estimated at 53.5 per cent (KNBS, 2010). Low literacy caused by poor education, inadequate human resource for education, and negative attitude towards education by communities, has affected Kilifi County. Education remains the most critical component for economic development and social progression in any society. The KDHS, 2014 shows a clear link between education and health outcomes. The KDHS states that women with no education have a TFR more than twice that of women with secondary or higher level of education. Married women with no education have the highest unmet need for family planning (28%), compared with only 12 per cent among women with secondary or higher education.

Secondary school gross enrolment rate in Kilifi is very low at only 37.8%

(*Basic Statistic Booklet 2014)*

2.7.5. Poverty

Teenagers from poorer households are more likely to have begun childbearing (26%) than are teenagers from wealthier households (10%). Family planning contributes to economic growth and poverty reduction at the family, community, and national levels hence the need to reposition family planning higher on the national and local policy agendas in sub-Saharan Africa. UNFPA states that access to safe, voluntary family planning is a human right and is central to gender equality and women's empowerment. And that it is a key factor to reducing poverty.

[11]

[12] National Authority for the Campaign against Alcohol and Drug Abuse (NACADA), Rapid Situation Assessment of the Status of Drug and Substance Abuse in Kenya (2012)

2.7.6 Facility Capacity to Provide Quality Services

It is evident that family planning programs are lacking adequate infrastructure, supplies, and trained personnel. This in turn affects the quality of care. Factors influencing facility readiness may range from system-wide targeted interventions, such as public and private investments in family planning service delivery; management and training of the required personnel, health system laws and regulations including standards and guidelines.

2.7.7 Provider Ability to Foster Informed Contraceptive Choice

Providers of reproductive health information and services are critical conduits through which clients obtain family planning information and counseling, upon which basis clients may make informed decisions about contraceptive use. However, provider behaviour may also be influenced by facility readiness, knowledge gaps, community myths, and insufficient skills. Further, medical barriers and practices may limit provider interaction with the client, thus limiting the provider's ability to provide appropriate services.

2.7.8 Culture and Religion

Women empowerment is still a serious issue in Kilifi County. Many women still have to seek the consent of their spouses before making any decisions concerning family planning and child spacing. Religion also plays a critical role in this as some religions like the Catholic Church prohibits the use of modern contraceptives as a family control method. This makes many of their staunch followers get a high number of children beyond their capacity to offer quality care and provision. Islam allows birth spacing and use of contraception as long as it does not bring harm to the parties concerned. However, any contraception for purposes of limiting births is totally prohibited in Islamic teachings.

2.7.9 Inadequate Youth Friendly Services

Youth friendly services in Kilifi County are inadequate. Currently there are only 3 functional youth friendly centers. Capacity of health care workers to offer effective youth friendly services is also wanting.

2.7.10 Poor Dissemination of the 2015 ASRH Policy

The ASRH policy was revised in 2015. In Kilifi, the policy was disseminated in 2016. However, many service providers are either not aware of its existence or its contents. This then becomes an impediment to provision of quality services to the targeted population. There is also a conflict between constitutional provisions and the policy on the appropriate age of contraceptive provision.

2.8 POPULATIONS WITH SPECIAL NEEDS FOR FAMILY PLANNING

2.8.1. Adolescent Girls

Adolescent girls are most at risk of unplanned pregnancy, unsafe abortion, STIs, and HIV and AIDS. According to KDHS 2008-2009, nearly half (47%) of pregnancies among adolescents were unintended and less than half of girls aged below 20 reported that they delivered in a public or private health facility or with the help of a skilled birth attendant. Adolescent girls aged 15-19 years are twice as likely to die of pregnancy-related causes as women aged 20-24 years. There is higher maternal mortality rates at 260 per 100,000 live birth among adolescents (15-19 years) compared to 190 per 100,000 live births among older youth (20-24 years).Adolescent girls face greater adverse complications during pregnancy because they are not fully physiologically and biologically prepared

for pregnancy due to among other factors gynecological immaturity and incomplete pelvic growth. Socio-economic factors such as poverty, lack of education and limited economic opportunities among girls may contribute to the adolescent pregnancy rates. In addition to physiological immaturity, delay in receiving medical attention or emergency obstetric care at a health facility contributes to high rates of obstetric fistula among adolescents. An assessment by UNFPA on obstetric fistula showed there was a lack of accurate prevalence data in Kenya. However, studies in Africa indicate that 58 per cent to 80 per cent of women with obstetric fistula are under the age of 20. There is also evidence of association between adolescence and adverse neonatal outcomes such as mortality, preterm birth, low birth weight and malformations.

Socio-economic consequences of unintended pregnancy among girls in Kenya include dropping out of school. Evidence shows that among adolescent girls who had started childbearing by age 18 in Kenya, 98 per cent were out of school, indicating that early pregnancy means the end of education for almost all adolescent girls. About 13,000 girls drop out of school annually in Kenya due to early and unintended pregnancy. Unsafe abortion is another consequence of teenage pregnancy. A study conducted on the incidence and magnitude of abortions showed that girls below the age of 19 accounted for 17 per cent of all women seeking post-abortion care services and about 45 per cent of all severe abortion-related admissions in Kenyan hospitals in 2012.

2.8.2 Persons With Disability

Disability affects 3 per cent of the Kenyan population, according to the population census of 2009. Persons with Disability (PWD) face challenges accessing health care services and especially HIV and reproductive health services. These barriers also include inability to communicate with health providers and the misconception by providers on the lack of sexuality and needs of the people with disability. The County's investment and Development Plan recognizes the need to ensure that all buildings are disability friendly, so that PWDs can access them with ease.

2.8.3 HIV Positive Women

The HIV prevalence among women in Kilifi County is higher (6.4%) than that of men (2.7%). There were about 1,502 HIV-positive pregnant women in Kilifi County in 2015.This number has since increased.

2.8.4 Female Sex Workers

Given the practice of having multiple sex partners, sex workers are exposed to many reproductive health challenges, including the risk of HIV and STIs, unwanted pregnancies and abortions. The National Guidelines for HIV/STI Programs for Sex Workers (2010) has laid emphasis on using dual protection for family planning. Quarterly HIV tests are recommended for sex workers who are either HIV negative or of unknown status. Another intervention is targeted education to increase knowledge of and demand for family planning and reproductive health as a whole.

2.9 STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS (SWOT) ANALYSIS

A SWOT analysis was carried out to identify the current situation in Kilifi County in light of family planning, as viewed by the stakeholders. This coupled with the concerns raised in the previous section will guide the development of the implementation plan.

Fig. 2: SWOT Analysis

STRENGTHS	WEAKNESSES
❖ Political goodwill ❖ Dedicated CHMT and county health administration team ❖ Improved infrastructure, linkages and referral system ❖ Increased trained health personnel on RH targeting FP ❖ Existence of the Beyond Zero Mobile Clinic for outreach health services ❖ Availability of other working documents including County Policies such as CIDP, County Annual Work plan. ❖ Presence of advocacy partners ❖ Presence of a RH TWG ❖ Existing functional community health units ❖ Availability of health information tools and systems for FP within LMIS and DHIS ❖ Presence of Quality Improvement Teams for health ❖ Availability of FP products in the SDPs ❖ Existence of commodities management committee in the County ❖ County Government budgetary commitment for FP	❖ Inadequate number of health personnel ❖ Some CHVs not trained in community RH/FP issues ❖ Inadequate allocation of funds for FP services to SDPs ❖ Inadequate FP equipment e.g. implants removal kits, IUCD sets ❖ Low utilization of health information management system ❖ Uneven geographical distribution of health facilities ❖ Incomplete, inaccurate and untimely reporting ❖ Inadequate reporting tools to capture, document and report non-routine data ❖ Weak linkages with private health secto on data management system ❖ Inadequate skills in data analysis, interpretation and use.(M&E) ❖ In adequate logistical support e.g. transport for supportive supervision ❖ Lack of research on FP to inform on Decision and evidence-based interventions ❖ Inadequate integration of FP into other Health services. ❖ Inadequate number of HCWs trained on F.P (LAPM) ❖ Inadequate commodity management ski
OPPORTUNITIES	**THREATS**
❖ Partner support ❖ Availability of commodities ❖ Functional health systems ❖ Integrated outreach services ❖ Informed religious leaders ❖ Upcoming new health facilities	❖ High staff turnover ❖ Socio-cultural beliefs ❖ Religious beliefs ❖ Limited funding ❖ Vastness of the county ❖ Low literacy level

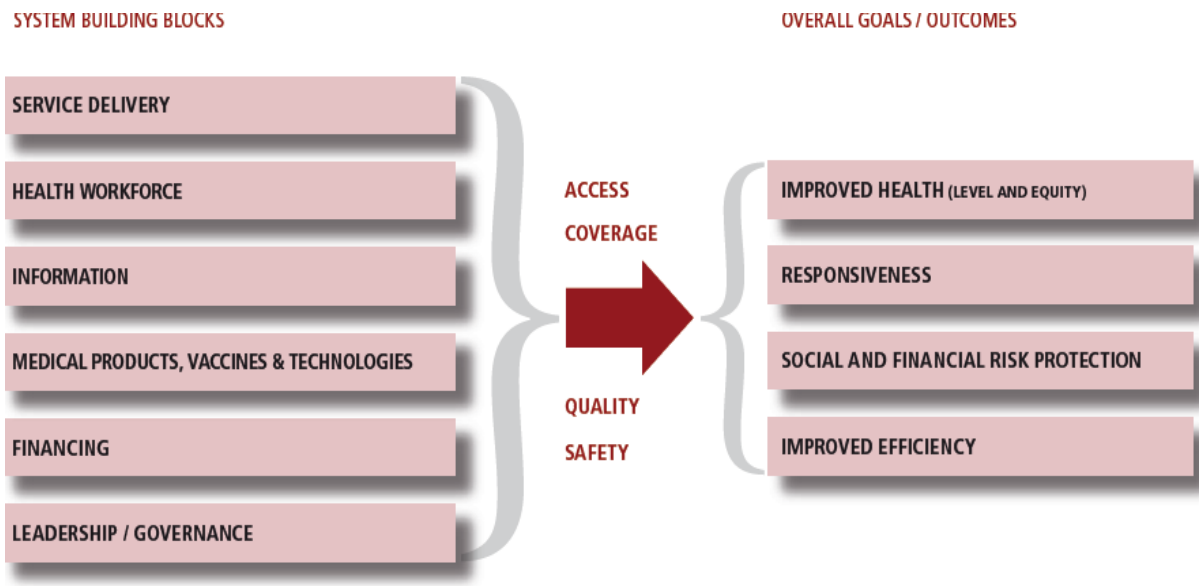
- ❖ Devolution of health services
- ❖ Male involvement in RH services
- ❖ High levels of teenage pregnancy

CHAPTER 3: STRENGTHENING HEALTH SYSTEMS FOR IMPROVED FAMILY PLANNING INTERVENTIONS

3.0 STRENGTHENING HEALTH SYSTEMS

The provision of family planning services can only be effectively achieved when the health systems are strengthened. The World Health Organization (WHO) defines a health system as *"the sum total of all the organizations, people and actions whose primary intent is to promote, restore or maintain health*". Health-system strengthening is also defined as improving the six building blocks and managing their interactions in ways that achieve more equitable and sustained improvements across health services and health outcomes. Due to the importance of FP advocacy, this CIP will handle it as a seventh block that needs strengthening.

Fig. 3: Health Systems Strengthening Blocks, Desired Attributes and Outcomes



Pillar 1: Service delivery:

Service delivery requires infrastructure and logistics, including physical space, equipment, utilities, waste management, transport, and communications. It also considers the need for privacy and confidentiality, safe water, sanitation and hygiene, and infection control.

Pillar 2: Health workforce:

Health workforce includes having trained service providers working with the right attitude, knowledge and skills. The staff should have the necessary commodities (such as medicines, disposables, and reagents), equipment, and adequate financing, to perform their jobs. Recognition and support for the vital roles played by community champions, community organizations and lay

workers, thus strengthening the community systems is critical to avoiding demoralized staff that could lead to a high turnover.

Pillar 3: Information systems:

A well-functioning health information system is one that ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health system performance and health status. Research, monitoring and evaluation are activities that support this function.

Pillar 4: Supply of medical and health products:

A well-functioning health system should ensure equitable access to essential medical products, vaccines and technologies of assured quality, safety, efficacy and cost-effectiveness. Systems should be put in place to avoid stock out of the essential medical and health products.

Pillar 5: Financing

Health financing includes resource mobilization for funds to enable the smooth running of the health services. The systems should raise and secure adequate funds for health in order to ensure people can use services they need.

Pillar 6: Leadership and governance:

This entails providing strategic direction to the family planning response. The County Health Department is responsible for providing leadership to the various actors in health in the County. The team should take up the ownership and commitment, and offer leadership and guidance to other interested partners in the provision of FP within the County.

Pillar 7: Advocacy:

This pillar is important for informing and/or influencing decision makers in order to change policies and/or financial allocations, and to ensure their effective implementation. Although it has not been discussed as a separate pillar in the WHO HSS pillars, advocacy plays a critical role in ensuring there is ownership and buy-in from the relevant stakeholders. Family planning in the County can only be effective if there is commitment by the County leadership, in order for the strategy on FP to translate into concrete action. [13]

[13] World Health Organization (2007). Everybody's business: Strengthening health systems to improve health outcomes. WHO's framework for action. Geneva, Switzerland

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CHAPTER 4: FAMILY PLANNING IMPLEMENTATION PLAN

4.0 FAMILY PLANNING IMPLEMENTATION PLAN

The vision, mission and strategy goal specifically bring out the expectations of this strategy in regard to FP. The strategies and key activities are suggestions that have been refined from the consultative meetings held with the different stakeholders and aligned to the existing County guidelines, policy and operational documents. These strategies and key activities have been divided into the agreed health systems pillars.

Vision: To have an efficient and high quality health care system that is accessible, equitable and affordable for every Kilifi resident.

Mission: To promote and participate in the provision of integrated and high quality promotive, preventive, curative and rehabilitative health care services to all Kilifi residents.

Strategy Goal: To reduce unmet need for family planning to 20 per cent and increase the modern contraceptive prevalence rate (mCPR) to 50 per cent among women of reproductive age in Kilifi County by 2021.

Core Values

- Right to Health and well being
- Equity
- Client Oriented
- Professionalism

Strategic Objectives:

1. To increase utilization of FP services by 80% by 2021 in Kilifi County.
2. To increase the capacity of the Health care work force in FP by 2021.
3. To improve availability, quality and use of data for decision making by 2021.
4. To increase FP budget by 50 per cent by 2021
5. To ensure sufficient and consistent supply of FP commodities in all health facilities in Kilifi County by 2021.

4.1 IMPLEMENTATION PLAN

PILLAR 1: Service delivery						
Aim: 1. To increase access and utilization of quality family planning services.						
STRATEGIES	**OUTCOMES**	**KEY ACTIVITIES**	**INDICATORS**	**INPUTS**	**FREQUENCY**	**DATA SOURCE**
Male involvement.	Increased male participation in RH/FP interventions.	1. Identify, engage and train 210 male FP champions (30 per sub-county) **2.** Hold 84 dialogue meetings in the sub-counties (3 meetings per quarter per sub-county) 3. Recognition of male partners	1. No of male FP champions trained. 2. No of dialogue meetings held in each sub-county 3. No of female clients accompanied by male partners	- Funds - Human resource - Venues - Training manuals - IEC materials	- Quarterly - Quarterly - Daily	- Activity reports - Activity reports - Activity reports
Service integration	Increased access to FP services at all service provision points	1.Integrate FP services in the CCC, ANC,CHUs, GBV Clinics, PNC, PAC, Maternity , Youth friendly clinic, inpatient, maternity, outpatient and cervical Cancer screening.	1. No of FP clients attended in CCC, ANC,CHUs, GBV Clinics, PNC, PAC, Maternity ,	- HIS registers - Personnel - Funds - Venues	- Daily	- Registers

		2. Scale up uptake of long term family planning methods 3. Conduct 252 integrated outreaches in all sub counties especially hard to reach areas (9 integrated outreaches per sub-county per quarter) 4. Provision of FP services for populations with special needs e.g. people with disabilities and key populations (FSWs, MSWs, Truck drivers, fish mongers, PWD) 5. Train community health volunteers on FP. 6. Conduct health talks in all the	Youth friendly clinic, inpatient, maternity, outpatient 2.No of clients using long term family planning methods. 3.No of integrated outreaches conducted 4 a. No of populations with special needs e.g. people with disabilities and key populations attended b. No of targeted outreaches conducted to populations with special	- FP commodities	- Monthly - Monthly - Monthly - Monthly	- Register - Activity reports - Registers - Activity reports

		facilities.	needs 5.No. of CHVs trained on FP. 6.No. of health talks conducted in all facilities			
Enhancing service delivery systems, structures and infrastructure	Improved access to Family planning services to; • Adolescent and Youth. • Persons with disabilities • Women	1. Establish 3 Functional youth-friendly centers that offer age appropriate reproductive health care (one per sub-county) 2. Train teachers, parents and guardians on Adolescent youth sexual reproductive health. 3.strengthen school health clubs	1. No of Youth friendly service centers established 2.No. of existing youth friendly centers strengthened to offer age appropriate reproductive health care (one per sub-county) 3.No. of teachers, parents and guardians trained on Adolescent youth sexual reproductive health	- Funds - HIS - Training manuals - Space	- Bi-annually - Quarterly	- Activity reports - Activity reports

			No. of functional school health clubs			
	High quality services provided at all levels.	1. Renovate and equip facilities in hard to reach areas. Equip the health facilities with infection prevention and control facilities (incinerators, waste bins and liners, IPC buckets)	1. No. of operational facilities in the hard to reach areas.	- Funds - Human resource	- Annually	- DHIS
	Strengthen service delivery for RH for PWDs	1. Conduct assessment to establish health facilities that are not disability friendly in the county. 2. Construct ramps, railed walkways and sanitation facilities, and other disability friendly structures where none exist within the health facilities in the county.	No. of facilities that are disability friendly	- Funds -	- Annually	- Facility reports
Community mobilization, education and empowerment	Increased community awareness on AYSRH	1. Conduct 84 community education and outreaches on AYSRH in the county (3 per quarter per Sub County).	1. No of community education and outreaches on AYSRH in the county per	- Funds - HIS - Training manuals	- Monthly	- Activity reports - HIS

			quarter.			
		2. Establish 7 community health units per sub county per year to improve AYSRH in the CUs	2. No of community health units established per sub county per quarter		- Annually	- Activity reports
		3. Train 100 peer educators on AYSRH. (25 participants per quarter in the County)	3. No of peer educators and CHVs trained on AYSRH.		- Quarterly	- Activity reports
		4. Sensitize 300 CHVs on AYSRH.	4. No. of CHVs sensitized on AYSRH.		-Bi-annually	- Activity reports
		5. Develop and implement AYSRH mentorship programs for CHVs and peer educators.	5. Availability of a mentorship program for CHVs and peer educators.		- One off.	

Commodity Security	Reduced stock outs.	1. Train 100 health care providers on forecasting and quantification of the RH/FP Commodities annually (25 participants per quarter). 2. Conduct routine forecasting and quantification of the RH/FP Commodities annually. 3.Scale up the commodity management system to all health facilities in the county to improve reporting for the RH/FP commodities 4. Equitable distribution/redistribution of the RH/FP commodities 5. Strengthen storage facilities for RH/FP and other commodities in the major health facilities in the County.	1. No. of health care providers trained on forecasting and quantification of the RH/FP Commodities. 2. No. of FNQ conducted per quarter. 3. Availability of commodity management system in all health facilities at the county b. Availability of timely and accurate reports. 4. Availability of RH/FP commodities all year through.	- Funds - HIS - Training manuals - Venue - Space	- Once - Annually - Quarterly - Quarterly - annually - annually	-Activity reports

			5. Availability of proper commodity storage facilities in the major health facilities in the County			
PILLAR: 2. Health workforce						
Aim: To improve the capacity of healthcare workforce to provide family planning services and information at all levels.						
STRATEGIES	**OUTCOMES**	**KEY ACTIVITIES**	**INDICATORS**	**INPUTS**	**FREQUENCY**	**DATA SOURCE**
1. Strengthening of Human resource management	Increased/adequate number of skilled service providers.	1. Conduct annual FP staff capacity gaps and needs assessment at the County. 2. Recruit/deploy RH/FP service providers based on the needs assessment. 3. Train 100 health care providers on FP (25HCW per quarter). 4. Conduct OJT and mentorship to 140 service	1. No of service providers with knowledge gap on FP 2. No of staff recruited and deployed. 3. No of HCW trained on FP. 4. No of HCW	Funds Personnel Data collection tools Training manuals	Annually Annually Quarterly Quarterly annualy Annually	Activity reports IHRIS Staff returns Activity reports Activity

		providers on FP (20 per sub county). 5. Motivation of best facilities and service provider regarding RH/FP service. 6. Strengthen in-service training and mentorship approaches for RH/FP service providers based on HRH norms and standard. 7. Disseminate updates on RH/FP policies, guidelines, registers, manuals regularly. 8. Engage existing training institutions for capacity building and training workshops on RH/ FP.	mentored on FP 5. No of facilities and HCW rewarded. 6. No of specialized RH/FP service providers in the different levels of care. 7. No of RH/FP update meetings conducted. b. Availability of the updated documents in all levels of care 8. No of staff from training institutions incorporated in		Annually On need basis Quarterly Annual Quarterly Quarterly	reports Activity reports Activity reports Staff returns Activity reports Activity reports Appraisal report

		9. Conduct annual staff appraisal.	the RH/FP trainings. 9. No. of staff appraised. 10. No of performance review meetings conducted.			Activity reports
2. Capacity Building	Increased human resources capacity for SRH initiatives	1. Train 100 service providers in delivery of non-discriminatory SRH education and services (25 participants per quarter).	1. No of health care workers trained.	Funds Training manuals Human resource Venue	Quarterly	Activity report
	Improved provider competency in offering FP services.	1. Train 3 service providers per sub-county on sign language. 2. Train 100 health promotion officers, PHOs & CHAs on FP advocacy (25 per quarter).	1. No of health care workers trained on sign language. 2. No of health promotion officers, PHOs & CHAs on FP	Funds Training manuals Human resource Venue	Quarterly Quarterly	Activity reports Activity reports Activity reports

		3. Train 300 CHVs on FP bi-annually	advocacy 3. No. of CHVs trained.		Bi-annually	
PILLAR: 3. Information (Research, Monitoring & Evaluation)						
Aim: Enhance availability of quality FP data and use at all levels of healthcare for decision making						
STRATEGIES	**OUTCOMES**	**KEY ACTIVITIES**	**INDICATORS**	**INPUTS**	**FREQUENCY**	**DATA SOURCE**
1. Distribution of tools	Increased availability of all reporting tools	1. Quantify data reporting tools required 2. Procure health data reporting tools. 3. Distribute data reporting tools to all levels of care	No. of facilities with all the health reporting tools.	Funds Personnel Data collection tools	Annually Annually On need basis	Distribution checklist.
2. Supportive supervision	Improved data quality	1. Provide data collection and reporting tools across all levels of care. 2. Train 100 Service providers and health managers on Data management (25 per	1. No. of facilities with all the health data collection and reporting tools. 2. No of service providers trained on data	Funds Human resource Venue HIS	On need basis Quarterly	Distribution checklist Activity report

		quarter). 3. Conduct 28 data Review meetings/ DQAs. 4. Conduct 84 data support supervision at the County level annually (7 visits per month). 5. Conduct 336 data support supervision at the Sub-county level annually (28 visits per month). 6. Develop quarterly FP score cards/ fact sheets 7. Conduct 948 FP data review meetings at CU level annually (79 per month).	management. 3. No of data review meetings and DQAs conducted. 4. No of major hospitals and dispensaries with functional electronic medical record system. 5. No of support supervision conducte 6. No of support supervision conducted 7. No of bulleting published 8. No of data review meetings conducted		Quarterly Bi-annual Annually Annually Quarterly Quarterly	Activity report Installation checklist Activity report Activity report Activity report

3. Strengthen Data and use	Increased use of data for decision making	1. Train 100 Service providers and health managers on Data demand and use (25 per quarter). 2. Conduct RH/FP data analysis in each Sub County. 3. Develop and review implementation of action plans in the county. 4. Conduct 4 RH/FP performance review meetings.	1. No. of service providers trained on DDU. 2. No of data analysis meetings held in each sub county. 3. No of activities implemented as per the action plans.	Funds Venue Personnel HIS Action plan	Quarterly Quarterly Quarterly	Activity report Activity report Activity report
4. Capacity building	Increased number of skilled personnel on data management	1. Conduct 84 Continuous Medical Education in the seven sub-counties.	1. No. of CMEs conducted 2. No. of research needs issues identified	Venue Funds Personnel Manuals	Monthly	CME report /register
5. Strengthen Operational research	Increased uptake of operational research to support the decision-making process	1. Set up 7 research teams in the County (1 per Sub County). 2. Identify areas of research (research needs) within RH/FP component.	1. No. of functional research teams. 2. Defined RH/FP research agenda within the	TOR Funds Data collection tools Venue	One off Annual	Activity report HIS registers Activity

		3. Disseminate to stakeholders the County RH research agenda 4. Identify health care workers research needs and skills gaps. 5. Capacity builds health care workers on basic research methods. 6. Budget for operational researches on the areas of RH/FP. 7. Conduct ASRH health research partner's forum. 8. Conduct 2 RH/FP service evaluations per facility annually.	County. 3. No of health care workers with research needs and gaps. 4. No of health care workers trained. 5. Budgeted RH/FP research agenda in the County and Sub County. 6. No of forums held. 7. No. of service evaluations conducted.	Personnel	Annual Annual Quarterly Quarterly Bi-annually	report Activity report PBB Activity report Evaluation report

6. Information and technology	Increased use of IT systems and structures for information sharing	1. Develop a website for the department of health 2. Develop and utilize digital platforms for sharing SRH information. 3. Support production and dissemination of RH/FP IEC materials at all levels. 4. Set up m-health platform for FP services at the community level. 5. Deploy electronic medical record system in the major hospitals and dispensaries in the County. 6. Conduct system reviews (EMR and m-health) quarterly	1. Availability of an operational website for the department. 2. No of digital platforms for sharing SRH information available. 3. No. and type of RH/FP IEC material produced and disseminated. 4. Functional mhealth platform for FP services at the community level. 5. No. of system reviews conducted.	Manuals Funds Personnel	One off One off/ Daily On need basis One off Quarterly	Website operation manuals Digital platform Distribution checklist Registers Activity report.

PILLAR: 4. Medical products, vaccines and technologies						
Aim: Increase availability of quality FP commodities						
STRATEGIES	**OUTCOMES**	**KEY ACTIVITIES**	**INDICATORS**	**INPUTS**	**FREQUENCY**	**DATA SOURCE**
1. Supply chain management	Increased availability of contraceptives	1. Participating in the National Forecasting and Quantification exercise. 2. Conduct F&Q activity in the county 3. Ordering & distribution/ redistribution of RH/FP commodities	1.No of participants 2.No of F&Q activity conducted 3.Order fill rate	Funds Venue	Annually Bi annually Bi annually	Consumption reports Bin cards and registers FCDRR & AMC

2. Quality control and Assurance	Increased availability of quality FP products	1. Sensitize SDPs on Good storage practices 2. Products inspection Pharmacovigilance (Monitoring on drugs procurement) 3. Hold quarterly drug, medicine and therapeutic committee meeting 4. Establish 7 appropriate commodity storage areas in each sub county annually (each facility needs a proper commodity storage area) 5. Conduct regular RH/FP commodities redistribution activities in the county	1. No of sensitized SDPs. 2. No of SDPs inspected. 3.No of therapeutic committee meetings held 4. No of appropriate commodity storage areas established 5.No of redistribution activities conducted	Funds Venue Inspection checklist Transport Fuel funds	Quarterly Quarterly Quarterly Annually quarterly	Activity reports Activity reports Activity reports Activity reports FCDRR

PILLAR: 5 Health financing &Partnership						
Aim: Increase allocation & timely disbursement of FP funds						
STRATEGIES	**OUTCOMES**	**KEY ACTIVITIES**	**INDICATORS**	**INPUTS**	**FREQUENCY**	**DATA SOURCE**
Advocate for itemized budget on FP	Inclusion of FP budget line in the county health budget.	1.Conduct 1 meeting of 70 county & sub county officers to develop a program based budget 2.Conduct 4 joint AWP meetings of 70 CHMT members, Health Executive & The County Treasury 3.Conduct 4 meetings to advocate for inclusion of FP budget line of 50 MCAs & CHMT	Availability of the program based budget No of meetings held No of advocacy meetings	Funds, personnel Policy documents Funds Funds, policy documents, documentary	Annually quarterly quarterly	County approved budgets AWP Progress reports Reports Signed MoU
	Increased resources for FP	1. Conduct Family planning Stakeholder mapping 2. Conduct 4 Stakeholder meetings of 50 (County Assembly Health committee, MOH, CSOs).	No of meetings held Attendance list Funds pledges given	Funds, policy documents, personnel, documentary	Quarterly	Reports
Resource mobilization	Increased partnerships for FP funding.	1. Conduct Family planning Stakeholder mapping 2. Conduct 4 stakeholders forums of 30 members to	No of proposals submitted No. of meetings held	Funds, policy documents, personnel, documentary	Quarterly Annual quarter)	Reports

		develop proposals and solicit for FP funding 3. Conduct 1 meeting of 50 CHMT & Partners to share the approved health budget & AWP 4. Conduct 1 meeting to sign an MOU between the Dept. of Health and the Partners	No. of meetings held No of MoUs signed		Annual	Reports MoUs
	Increase financing for AYSRH initiatives	1. Solicit for AYSRH funding from partners through the stakeholders forums 2. Conduct 1 meeting of CHMT & Partners to share the approved health budget & AWP 3. Sign an MOU between the Dept. of Health and the Partners 4. Conduct 4 stakeholder meeting (County Assembly Health committee, MOH, CSOs).	Funds allocated for AYSRH initiatives No of proposals submitted No. of meetings held No. of meetings held No of MoUs signed No. of development partners and stakeholders supporting AYSRH initiatives	Funds, policy documents, personnel, documentary	Quarterly Annual (1st quarter) Annual Quarterly	Reports reports MoUs Reports

PILLAR 6: Leadership and governance						
Aim: Increase number of County & Sub County level FP Champions						
STRATEGIES	**OUTCOMES**	**KEY ACTIVITIES**	**INDICATORS**	**INPUTS**	**FREQUENCY**	**DATA SOURCE**
Leadership and governance for FP	Increased policy formulation and adaptation	1. Conduct workshop to develop/ domesticate relevant RH/FP and ASRH policies, guidelines and strategies. 2. launch RH/FP and ASRH policies, guidelines and strategies 3. Conduct meetings to disseminate RH/FP and ASRH policies, guidelines and strategies 4. Operationalized RH/FP and ASRH policies	No. of policies/ guidelines developed/ domesticated No of meetings held No of copies disseminated No of RH/FP and ASRH policies operationalized	Funds, policies Funds, Policies Funds, personnel	Annually	National policies reports

	Increased leadership and coordination for FP strategies in the County	1. Conduct RH/FP and AYSRH support supervision in the county 2. Mainstream FP strategy in the CIDP 3. Conduct meetings to sensitize community structures (county health board, hospital boards, facility health committees and community health committees) on FP	No. of support supervisions done No of meetings held No of sensitization meetings held	Funds Funds Personnel funds	Quarterly Annual Annually	Reports Reports reports

PILLAR: 7. Advocacy and Communication						
Aim: Strengthen stakeholder involvement, political commitment and investment in advocacy for FP						
1. Build capacity of FP stakeholders	Strengthened multi-sectoral coordination and networking, partnership and community partnerships	1. Conduct Stakeholder mapping	No of partners identified	Funds personnel	annually	Database/matrix
		2. Identify, map out and meet leaders and decision-makers to inform and engage them on the need to support FP/RH activities	No of meetings held No of pledges given	Funds Policy documents AWP	quarterly	reports
		3. Establish &Train FP TWG	No of TWG members trained No of TWG meetings held	Funds Personnel Training materials	Annually	report
		4. Conduct Stakeholder meetings (FBOs, CORPs, Media, Admin, MOE, Youth & Gender, CHMT	No of meetings held	funds	quarterly	reports
2.FP Awareness	Increased FP awareness among stakeholders	1. Conduct meetings to sensitize stakeholders on FP/RH and ASRH related policies and guidelines	No of meetings held	Funds Personnel policies	quarterly	reports

		2. Conduct workshop to design & develop FP/RH and ASRH related IEC materials and documentary.	No of FP/RH and ASRH IEC materials developed	Funds Personnel consultant	Annually	IEC materials
		3. Pretest the developed IEC materials	No of materials pretested	Funds personnel	Annually	IEC materials
		4. Production of IEC materials	No. of materials printed	Funds	Annually	IEC materials
		5. Conduct meetings to disseminate & distribute the IEC materials.	No of dissemination meetings No of IEC materials distributed	Funds IEC materials	continuous	reports
		6. Erect billboards in 7 major sub county towns	No of billboards erected	funds	Annually	billboards
		7. Conduct road shows to create awareness on FP	No of road shows conducted	Funds IEC materials	Bi-annually	reports
		8. Commemoration of World Contraceptive Day 26th sept	No of people sensitized No of clients accessing RH/FP services No of IEC materials distributed	Funds IEC materials FP/RH commodities	Annually	Activity report

		9. Commemoration of World Condom Day 13th Feb	No of people sensitized No of clients accessing RH/FP services No of IEC materials distributed	Funds IEC materials FP/RH commodities	Annually	Activity report
		10. Commemoration of Intl Youth Day 12th Aug	No of people sensitized No of clients accessing RH/FP services No of IEC materials distributed	Funds IEC materials FP/RH commodities	Annually	Activity report
		11. Commemoration of World Population Day 11th July	No of people sensitized No of clients accessing RH/FP services No of IEC materials distributed	Funds IEC materials FP/RH commodities	Annually	Activity report
		12. Commemoration of Intl Women's Day 8th March	No of people sensitized No of clients accessing RH/FP services No of IEC materials distributed	Funds IEC materials FP/RH commodities	Annually	Activity report
		13. Commemoration of 16 Days of Activism	No of people sensitized No of clients accessing	Funds IEC materials	Annually	Activity report

			RH/FP services No of IEC materials distributed	FP/RH commodities		
		14. Strengthen integration of family planning awareness into other programmes/services	No of programmes/services integrating FP services	FP commodities IEC materials Trained personnel	continuous	reports
		15. Mainstreaming of family planning awareness into other sectors	No of sectors integrating FP services	FP commodities IEC materials FP policy	continuous	reports
		15. Identification of FP champions 16.Orientation of FP champions	FP champions in place	Funds Personnel IEC materials	continuous	Reports
	Advocate for elimination of barriers that hinder young people's access to RH information and services	1. Conduct an assessment to identify barriers 2. Develop targeted FP messages to demystify myths and misconceptions on FP 3. Conduct dialogue	No of young people, facilities and CUs reached No of FP messages developed No of dialogue sessions	Funds Tools Personnel consultant	Annual	Gap analysis report Targeted FP messages Report

		sessions and focused group discussions 4. Develop/customize FP e-platform for the youth	conducted e-platform developed		Annually	e-platform
FP advocacy for hard to reach population	Increased FP awareness and uptake among hard to reach population	1. Develop targeted FP messages to demystify myths and misconceptions on FP 2. Conduct dialogue sessions with religious leaders (catholic, Muslim, miracle church)	No of FP messages developed No of dialogue sessions conducted	Funds Personnel Funds Personnel IEC materials	Annually quarterly	IEC materials Report
2. Media advocacy	Increased media coverage	1. Conduct media assessment to identify popular media houses 2. Conduct sensitization meetings with popular media stations in FP/RH and ASRH programmes 3. Conduct meetings to develop FP/RH and ASRH messages	No. of popular media houses identified No of meetings held Availability of FP/RH and ASRH messages No of meetings held	Funds Personnel Tools Funds Personnel IEC materials Funds Personnel Funds	Annually Annually	Report FP/RH messages Reports

		4. Conduct meetings to develop Pre-recorded media programs, talk shows and radio spots	Availability of FP/RH and ASRH pre-recorded media programme	Personnel Funds	Annually	Reports FP/RH and ASRH Media programmes
		5. Airing the recorded messages	No. of media sessions aired	Funds	Quarterly	Reports
		6. Conduct feedback meetings	No of meetings held List of participants	personnel	quarterly	Reports

CHAPTER 5: RESEARCH, MONITORING & EVALUATION

5.0 INTRODUCTION

Research, monitoring and evaluation are critical elements for gathering evidence and measuring of the achievement of this five-year CIP. Every year, annual plans will be developed to ensure the CIP is operational. The annual work plans will outline indicators that will be used to track the progress. Data management tools will be enhanced to ensure that all the necessary data is collected, analyzed and used for programming and decision making. Routine data will be collected using the tools on the ground and operational research carried out as need arises. The County will partner with academic and research institutions, implementing partners, as well as the National government.

A mid-term evaluation of this CIP will be carried out in 2019, and an end-term evaluation in 2021. This will be soon after the release of the results of the National Population and Housing Census and the Kenya Demographic and Health Survey, that are both expected in 2019. The results will be compared with the baseline data used in this strategy that has primarily been drawn from the KDHS, 2014 and the estimates from the PHC. The targets for both the mid-term and end-term evaluations are provided in the table below.

5.1 EXPECTED RESULTS

Table 4: Key Performance Indicators and Targets for the Strategy

PILLAR	Key Performance Indicators (KPIs)	Baseline 2017	Mid-term 2019	End-term 2021	Data source
1. Service Delivery	% of women of reproductive age receiving any family planning methods	53.3%	60%	70%	DHIS 2
	Total Fertility rate (TFR)	5.1	4	3	KDHS2014
	% of women with unmet need of FP	23.3%	22%	20%	KDHS2014
	# of facilities offering LARCs	170	200	250	DHIS
	No. of facilities offering Youth	0	1	2	DHIS

	friendly services				
	% of adolescents accessing FP services (10-14 yrs)	0.6%	2.5%	5%	DHIS
	% of adolescents accessing FP services (15-19 yrs)	3.9%	10%	15%	DHIS
	% of HIV +ve clients accessing modern FP services.	0	10%	30%	DHIS
	% of clients with special needs (PWDS, PWUDs) accessing modern FP services.	0	10%	30%	DHIS
	% of teenage (10-14yrs) pregnancies				
	% of teenage (15-19yrs) pregnancies	22%	18%	16%	KDHS2014
	% of women of reproductive age receiving permanent methods of FP.	0.14%	10%	15%	DHIS
	% of men receiving permanent methods of FP	0.0045%	0.05%	1%	DHIS
	% of contraceptive Prevalence Rate, Modern Methods (mCPR)	32.8%	40%	50%	KDHS2014
	% of health facilities offering	59%	60%	70%	DHIS

	Adolescent friendly services				
2. Health workforce	# of health care providers with sign language skills	0.2%	0.5%	2%	Staff returns
	# of nurses recruited	71	150	200	Staff returns
	# of doctors recruited	22	10	10	Staff returns
	#. of clinical officer recruited	26	50	50	Staff returns
	% of clinical staffs trained on LARC	40%	60%	80%	Training database
	% of clinical staffs trained on LAPM	2.2%	10%	25%	Training database
	% of CHVs, CHEWs and public health officers/technicians trained on FP	0%	5%	30%	Training database
	# mentorship and follow up visits on FP by CHMT	14	104	104	Supervision report
	# of mentorship and follow up visits on FP by SCHMT	52	156	156	Supervision report
3. Information (Research, Monitoring & Evaluation)	% of facilities reporting FP data	91.3%	100%	100%	DHIS
	No. 0f health care workers trained on data for decision making	35	280	400	Training database
	# of surveys conducted among special groups on	0	2	4	Survey report

	FP.				
	# of facilities using revised FP M&E tools.	192	200	250	DHIS
	% of facilities submitting timely FP reports.	77.1%	85%	95%	DHIS
	% of facilities submitting FP reports monthly	91.3%	95%	100%	DHIS
	# of facilities with active QI teams.	3	5	18	Reports
	# of facilities visited by the CHMT during support supervision	14	30	50	Supervision report
	# of CHVs trained in community based information system management	70	200	500	Training database
	# of county Data review meetings with the sub counties	2	8	8	Report
	No. of data review meetings with the facilities	12	12	12	Report
	# of operational researches carried out	0	3	5	Research database
4. Medical Products, vaccines and technologies	% of facilities reporting no stock out of FP commodities	98%	100%	100%	DHIS

	% of health workers trained on commodity management.	10%	60%	80%	Training database
	% of facilities with LHMIS tools	60%	80%	100%	DHIS
	% of primary SDPs that have at least 3 modern methods of contraception available on day of assessment	100%	100%	100%	DHIS
	% of secondary/tertiary SDPs with at least 3 modern methods of contraception available on day of assessment	100%	100%	100%	DHIS
5. Health Financing	Availability of a costed FP plan	0	1	1	CIP
	% financial allocation for implementation of the costed FP plan	1%	5%	10%	CIP
	% of FP budget utilization on FP (Burn rate)	0%	80%	100%	CIP
6. Leadership and governance	# of FP specific stakeholder committee forums held	0	4	4	Report
	#. of MOUs done with FP current implementing partners	1	8	12	Signed MoU
	# of FP TWG	1	4	4	Minutes

	meetings held				
7. Advocacy	#. of champions advocating for FP	0	18	60	Report
	#. of policy formulated or /and adapted	0	1	1	FP Policy
	#. of FP advocacy messages developed and disseminated by media	0	2	5	Report
	A FP communication strategy developed and disseminated	0	1	1	Strategy

5.2 DATA COLLECTION

The methods of data collection will be a combination of quantitative and qualitative. Standardized data collection tools and techniques will be used. Most data in respect of some indicators will be collected monthly, quarterly or annually. The survey-based indicators will be collected at baseline, mid-term and end-term. The data collected from National processes such as the KDHS and the Population Census both expected in 2019, will also be used in the end line evaluation. The main data collection tools and techniques will include the DHIS. Listed in the table below are tools that are currently in use and of importance to FP.

Table 5: Current Reporting Tools and Registers Used for FP

TOOL	PURPOSE
MOH 105	AWP indicators
MOH 406	Post-natal register
MOH 511	CDRR for FP services(contraceptive date reporting and requisition form
MOH 512	DAR (Daily Activity Register) FP Register
MOH 514	CHW Daily Activity Register
MOH 515	CHEW summary
MOH 711 (A)	MOH integrated summary tool Deliveries/FP uptake/Cervical screening(integrated)
MOH 717	Service delivery summary for workload
MOH 731	HIV monthly summary
DHIS 2	District Health Information System version 2
FP Dashboard	National Family Planning Dashboard for monitoring FP commodity data on monthly basis
FO 58	Report on damaged products and products of poor quality

5.3 DATA QUALITIES

The data quality to be observed includes:

1. **Reliability:** The data generated by a program's information system, based on set protocols and procedures and does not change according to who is collecting or using it, and when or how often they are used. The data is measured and collected consistently.

2. **Accuracy (validity):** Accuracy refers to how correctly information is derived from the database or registry and it reflects the reality it was designated to measure. The data should be concise.

3. **Timeliness:** Timeliness refers primarily to how current or up-to-date the data is, at the time of release, by measuring the gap between the end of the reference period to which the data is obtained and the date on which the data becomes available to users. The data should come in consistently from the health facilities.

4. **Completeness:** Completeness means that an information system from which the results are derived is appropriately inclusive.

5. **Integrity:** Integrity is when data generated by a program's information system are protected from deliberate bias or manipulation for political or personal reasons.

5.4 DATA FLOW

Routine data will be generated from the community units and taken up to the facility level. The facilities will submit their data to the SCHMT through the MOH offices in the County. This will be consolidated and entered in the HMIS which is a system used nationally. There exists a feedback mechanism in form of reports, supervision and such forums from the CHMT downwards to the facilities and community units, and these shall be utilized. All relevant information received from the National level will be channeled down to the County mainly through the CHMT. The flow of data will include data for services as well as for commodities, and will be utilized for decision making. The communication between CHMT and MoH is one of collaboration.

CHAPTER 6: PARTNERSHIP AND FINANCING

6.0 INTRODUCTION

The delivery of this CIP is the responsibility of the County Health Team. This however does not mean that the other partners do not have a role. This chapter seeks to identify some of the key players in FP in the county, and their current contribution. These include partners in various sectors in Government, the private sector, faith based sector, NGOs and CBOs.

This chapter further seeks to cost the CIP, with the hope that it will be included as a stand-alone budget line within the county health budget in 2017/18FY. The costing helps to guide the allocation of these funds. With a clear budget, the partners can also identify areas that they can offer support, aligned to their core business. The successful implementation of this strategy will therefore be dependent upon the collaborative efforts and synergies of all the stakeholders and actors, led by the County Health Team.

6.1 STAKEHOLDERS ANALYSIS

The stakeholders in the FP response broadly include National and County Government Ministries, Development Partners, Private Sector, NGOs and the Faith based Sector among others. Each of the groups mentioned in one way or another, engage with the Kilifi County Health Department in providing financial and technical capacity support for successful FP services and programme interventions. The County Health Department engages the various groups, in consultative processes through thematic interest groups. The table below gives a stakeholder analysis of Kilifi County **Table 6: Stakeholders in Kilifi County**

ORGANIZATION TYPE	SECTOR/ DEPARTMENT /ORGANIZATION NAME	ROLE IN FP
Government	County Government. Economic and budgeting	Technical guidance/support, service delivery: Policy and guidelines, infrastructure, procurement, staffing, financing, Advocacy , Partner coordination
	National Government[(i.e. Reproductive Maternal Health Service Unit, NASCOP) Ministry of Devolution and Planning (NCPD) Ministry of Education.	Policy formulation, Resource mobilization and allocation. Educate, sensitize and advocacy with a focus on youth and adolescent

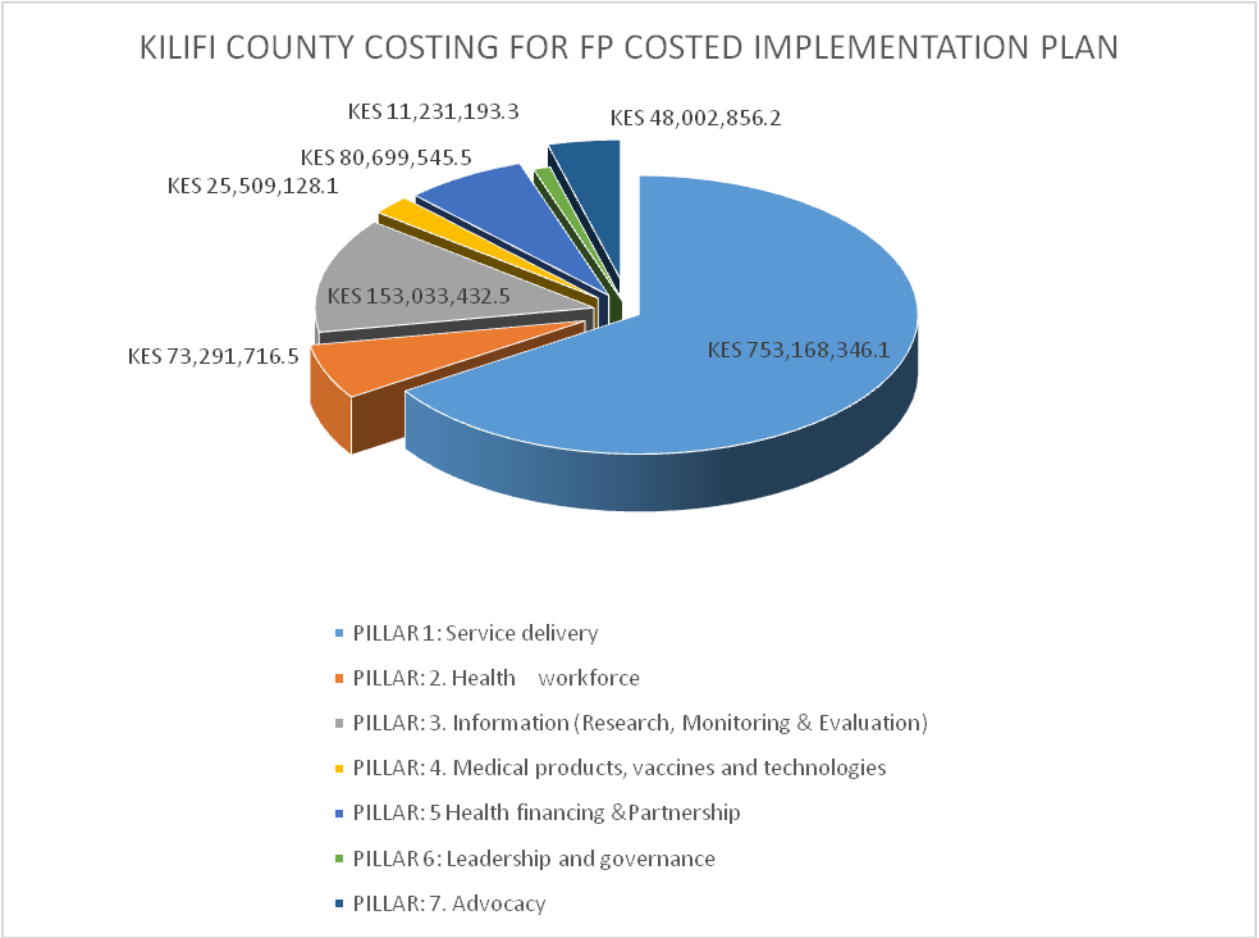
	Department of Health Ministry of Public Service, Youth and Gender Affairs. Ministry of interior and coordination Ministry of Culture, Sports and Talent Development Office of First Lady	FP/HIV integration Capacity Building FP advocacy.
NGOs	FAMILY HEALTH OPTIONS KENYA	Service provision FP advocacy Social marketing
	MARIE STOPES KENYA	Support service provision, Community mobilization FP Advocacy Support capacity building Private Public Partnership Social Marketing
	UNFPA	Support service provision, Community mobilization FP Advocacy Support capacity building Social Marketing
	FUNZO Kenya	Health workers capacity building
	JHPIEGO	Capacity building Health Systems strengthening Advocacy on FP FP Strategic Policy on Development
	KMYDO	FP advocacy Capacity building of FP

		partners Faith community mobilization Adolescents Youth and Women Engagement.
	DSW Kenya	FP Budget analysis and advocacy
	PIMA	Monitoring and Evaluation support
	FHI 360	Capacity building of FP partners Technical support
	PATH FINDER	Improving maternal, new born, child health and Sanitation
	MTG	Provision of contraceptives to youth in the communities within MTG's working area.
	AGAKHAN FOUNDATION	Capacity building Health system strengthening Technical support
	PLAN INTERNATIONAL	FP commodity and service provision
	ESHE	Technical support Supportive supervision Community mobilization Capacity building to private practitioners Social Marketing PPP
	AFYA PWANI	FP advocacy

		Capacity building Health system strengthening Technical support Service Provision Staffing
Private sector	PRIVATE FACILITIES	Partnerships and service delivery
FBOs	MISSION FACILITIES	Service delivery
	CIPK, SUPKEM, NCCK	FP awareness
Others	MEDIA	Awareness creation and community mobilization
	COMMUNITY	Mobilization, Consumers.
	MAENDELEO YA WANAWAKE	FP awareness

SUMMARY BUDGET

PILLAR	STRATEGIES	Year 1	Year 2	Year 3	Year 4	Year 5	TOTAL	% Distribution
PILLAR 1: Service delivery	Male involvement.	KES 7,352,400.00	KES 7,867,068.00	KES 8,417,762.76	KES 9,007,006.15	KES 9,637,496.58	KES 42,281,733.50	3.69%
	Scaling Up of FP services	KES 18,063,000.00	KES 19,327,410.00	KES 20,680,328.70	KES 22,127,951.71	KES 23,676,908.33	KES 103,875,598.74	9.07%
	Enhancing service delivery systems and structures	KES 25,899,885.71	KES 229,285.71	KES 245,335.71	KES 245,335.71	KES 280,884.86	KES 26,900,727.72	2.35%
	Community mobilization, education and empowerment	KES 113,284,871.43	KES 7,280,601.00	KES 7,790,243.07	KES 8,335,560.08	KES 8,919,049.29	KES 145,610,324.87	12.72%
	Commodity Structure	KES 49,140,000.00	KES 52,579,800.00	KES 56,260,386.00	KES 60,198,613.02	KES 64,412,515.93	KES 282,591,314.95	24.68%
	Improve Structure	KES 26,415,500.00	KES 28,264,585.00	KES 30,243,105.95	KES 32,360,123.37	KES 34,625,332.00	KES 151,908,646.32	13.27%
SUB TOTAL		KES 240,155,657.14	KES 115,548,749.71	KES 123,637,162.19	KES 132,274,590.05	KES 141,552,187.00	**KES 753,168,346.10**	65.78%
PILLAR: 2. Health workforce	Human resource management	KES 9,754,900.00	KES 4,726,083.00	KES 5,056,908.81	KES 5,410,892.43	KES 5,789,654.90	KES 30,738,439.13	2.68%
	Capacity Building	KES 15,056,000.00	KES 6,193,160.00	KES 6,626,681.20	KES 7,090,548.88	KES 7,586,887.31	KES 42,553,277.39	3.72%
SUB TOTAL		KES 24,810,900.00	KES 10,919,243.00	KES 11,683,590.01	KES 12,501,441.31	KES 13,376,542.20	**KES 73,291,716.52**	6.40%
PILLAR: 3. Information (Research, Monitoring & Evaluation)	Dissemination of tools	KES 455,000.00	KES 486,850.00	KES 520,929.50	KES 557,394.57	KES 596,412.18	KES 2,616,586.25	0.23%
	Supportive supervision	KES 15,430,000.00	KES 16,510,100.00	KES 17,665,807.00	KES 18,902,413.49	KES 20,225,582.43	KES 88,733,902.92	7.75%
	Data review meeting	KES 8,194,000.00	KES 3,986,820.00	KES 4,265,897.40	KES 4,564,510.22	KES 4,884,025.93	KES 25,895,253.55	2.26%
	Capacity building	KES 8,903,600.00	KES 2,103,192.00	KES 2,250,415.44	KES 2,407,944.52	KES 2,576,500.64	KES 18,241,652.60	1.59%
	Operational Research	KES 8,091,800.00	KES 1,893,686.00	KES 2,026,244.02	KES 2,168,081.10	KES 2,319,846.78	KES 16,499,657.90	1.44%
	Information and technology	KES 215,000.00	KES 187,250.00	KES 200,357.50	KES 214,382.53	KES 229,389.30	KES 1,046,379.33	0.09%
SUB TOTAL		KES 41,289,400.00	KES 25,167,898.00	KES 26,929,650.86	KES 28,814,726.42	KES 30,831,757.27	**KES 153,033,432.55**	13.37%
PILLAR: 4. Medical products, vaccines and technologies	Supply chain management	KES 372,800.00	KES 398,896.00	KES 426,818.72	KES 456,696.03	KES 488,664.75	KES 2,143,875.50	0.19%
	Quality control	KES 4,063,000.00	KES 4,347,410.00	KES 4,651,728.70	KES 4,977,349.71	KES 5,325,764.19	KES 23,365,252.60	2.04%
SUB TOTAL		KES 4,435,800.00	KES 4,746,306.00	KES 5,078,547.42	KES 5,434,045.74	KES 5,814,428.94	KES 25,509,128.10	2.23%
PILLAR: 5 Health financing &Partnership	Advocate for itemized budget on FP	KES 14,032,900.00	KES 15,015,203.00	KES 16,066,267.21	KES 17,190,905.91	KES 18,394,269.33	KES 80,699,545.45	7.05%
SUB TOTAL		KES 14,032,900.00	KES 15,015,203.00	KES 16,066,267.21	KES 17,190,905.91	KES 18,394,269.33	KES 80,699,545.45	7.05%
PILLAR 6: Leadership and governance	Leadership and governance for FP	KES 1,953,000.00	KES 2,089,710.00	KES 2,235,989.70	KES 2,392,508.98	KES 2,559,984.61	KES 11,231,193.29	0.98%
SUB TOTAL		KES 1,953,000.00	KES 2,089,710.00	KES 2,235,989.70	KES 2,392,508.98	KES 2,559,984.61	KES 11,231,193.29	0.98%
PILLAR: 7. Advocacy	Build capacity of FP stakeholders	KES 1,605,000.00	KES 1,717,350.00	KES 1,837,564.50	KES 1,966,194.02	KES 2,103,827.60	KES 9,229,936.11	0.81%
	Increased FP awareness among stakeholders	KES 3,982,250.00	KES 4,261,007.50	KES 4,559,278.03	KES 4,878,427.49	KES 5,219,917.41	KES 22,900,880.42	2.00%
	FP advocacy for hard to reach population	KES 1,120,000.00	KES 1,198,400.00	KES 1,282,288.00	KES 1,372,048.16	KES 1,468,091.53	KES 6,440,827.69	0.56%
	Media Advocacy	KES 1,640,000.00	KES 1,754,800.00	KES 1,877,636.00	KES 2,009,070.52	KES 2,149,705.46	KES 9,431,211.98	0.82%
SUB TOTAL		KES 8,347,250.00	KES 8,931,557.50	KES 9,556,766.53	KES 10,225,740.18	KES 10,941,541.99	KES 48,002,856.20	4.19%
GRAND TOTAL							**KES 1,144,936,218.21**	100.00%


KILIFI COUNTY COSTING FOR FP COSTED IMPLEMENTATION PLAN
KES 11,231,193.3
KES 48,002,856.2
KES 80,699,545.5
KES 25,509,128.1
KES 153,033,432.5
KES 73,291,716.5
KES 753,168,346.1
PILLAR 1: Service delivery
PILLAR: 2. Health workforce
PILLAR: 3. Information (Research, Monitoring & Evaluation)
PILLAR: 4. Medical products, vaccines and technologies
PILLAR: 5 Health financing &Partnership
PILLAR 6: Leadership and governance
PILLAR: 7. Advocacy

REFFERENCES

A. LEGISLATIVE FRAMEWORKS

- Republic of Kenya (2010). The Constitution of Kenya. 2010
- County Governments Act No. 17 of 2012

B. KILIFI COUNTY DOCUMENTS

- Kilifi County Integrated Development Plan (CIDP) 2013-2017.
- Kilifi County Health Sector Strategic and Investment Plan (2013 - 2017).
- Kilifi County Monitoring and Evaluation Framework (2014-2018).
- Kilifi County Reproductive Health Policy 2016.

C. NATIONAL DOCUMENTS

- Republic of Kenya. (2014). Human Resources For Health Norms and Standards Guidelines For The Health Sector: Towards Universal Health Coverage: The Kenya Health Strategic and Investment Plan, 2014 – 2018
- Republic of Kenya (2008). Kenya Vision 2030: Sector Plan for Health 2008-2012.
- Republic of Kenya (2012). Kenya Health Policy 2012 - 2030.
- Republic of Kenya (2012). Kenya Health Sector Strategic and Investment Plan 2012-2018.
- Republic of Kenya. (2014). Human Resources For Health Norms and Standards Guidelines For The Health Sector: Towards Universal Health Coverage: The Kenya Health Strategic and Investment Plan
- Republic of Kenya (2013-2017). Second Medium Term Plan: Transforming Kenya: Pathway to Devolution Socio-economic Development, Equity and National Unity.
- Republic of Kenya (2009). National Family Planning Guidelines for Service Providers.
- Republic of Kenya (2009). National Reproductive Health Strategy 2009-2015.
- Republic of Kenya (2011). Implementation Guidelines for the Kenya Quality Model for Health.
- Republic of Kenya (2012) The Independent Electoral and Boundaries Commission: Preliminary report on the Delimitation of Boundaries of Constituencies and Wards
- Kenya National Bureau of Statistics (KNBS) et al. (2014). Kenya Demographic Health Survey 2014
- Kenya National Bureau of Statistics (2009). Population and Housing Census.
- Kenya National Bureau of Statistics, ICF International. 2015. 2014 KDHS Key Findings. Rockville, Maryland, USA: KNBS and ICF International
- Kenya National Bureau of Statistics & Society for International Development. (2013) Exploring Kenya's Inequality: Pulling Apart or pooling Together
- National Authority for the Campaign against Alcohol and Drug Abuse (NACADA), Rapid Situation Assessment of the Status of Drug and Substance Abuse in Kenya (2012)
- National AIDS Control Council (2014). Kenya HIV County Profiles
- National Council for Population and Development (2013) Kenya Population Situation Analysis.

- Ministry of Devolution and Planning, Kenya. (2013). Millennium Development Goals: Status Report for Kenya
- Ministry of Health, Kenya. Family Planning Commodities Quantification and Supply Plan, Technical Report July 2016
- Ministry of Devolution and Planning. (2013). Millennium Development Goals: Status Report for Kenya – 2013.

D. OTHER DOCUMENTS

- African Population and Health Research Center (APHRC), Ministry of Health (MOH), Ipas, Guttmacher Institute, Incidence and Complications of Unsafe Abortions in Kenya: Key Findings of a National Study. Nairobi (2013)
- Cates W. Use of contraception by HIV-infected women. IPPF Med Bull 2001; 35: 1-2. Quoted in http://www.who.int/bulletin/volumes/87/11/08-059360/en/
- FP2020. Accelerating Progress: Strategy for 2016-2020.
- FP2020. Commitment to Action: Measurement Annex. November 2015
- Muganda-Onyando Rosemarie and Omondi M, Down the Drain: Counting the Cost of Teenage Pregnancy and School Dropout in Kenya. Center for the Study of Adolescents (2008)
- Population Council, The Adolescent Experience In-depth: Using Data to Identify and Reach the Most Vulnerable Young People (2010)
- Senate Economic Planning Office. (2009) Promoting Reproductive Health: A Unified Strategy to Achieve the MDGs. Policy Brief. Jul, 2009.
- United Nations Population Fund (UNFPA), Needs Assessment of Obstetric Fistula in Kenya (2004).
- World Health Organization (2007). Everybody's business: Strengthening health systems to improve health outcomes. WHO's framework for action. Geneva, Switzerland
- World Health Organization (2009). Priority Interventions: HIV/AIDS prevention, treatment and care in the health sector. Geneva, Switzerland.
- World Health Organization, Risk and Protection Factors Affecting Adolescent Reproductive Health in Development Countries. Summary (2004)

E. WEBSITES

- Beyond Zero - http://www.beyondzero.or.ke/commons/security/login.action;jsessionid=4688B1AECB92D56A144890E92024FE53. Accessed on September 26,
- County Statistics from KNBS: http://www.knbs.or.ke/index.php?option=com_ content view= article&id= 176&Itemid=645 Accessed 17th Aug 2016.
- Health work force - http://www.who.int/hrh/workforce_mdgs/en/ accessed September 26, 2016.
- Kenya Population (2016) - Worldometers. www.worldometers.info/world-population/kenya-population/. Accessed on 18th August 2016
- Kenya Health Information System. https://hiskenya.org/dhis-web-commons/security/login.action;jsessionid= 98D323654E5821F3E4FC05FD32C15CAA

- Population Reference Bureau: Family Planning: Pathway to Poverty Reduction. Accessed on October 13, 2016. http://www.prb.org/Multimedia/Video/2012/family-planning-poverty-reduction.aspx
- Promoting Reproductive Health: A Unified Strategy to Achieve the MDGs. Policy Brief: Senate Economic Planning Office. Jul, 2009. https://www.senate.gov.ph/.../PB%202009-03%20-%20Promoting%20Reproductive%. Accessed on 25th August 2016
- Sustainable Development Goals. http://www.un.org/sustainabledevelopment/sustainable-development-goals/ Accessed September 26, 2016.
- UNFPA. Family Planning. http://www.unfpa.org/family-planning. Accessed on October 13, 2016.
- UNFPA, 2014. http://kenya.unfpa.org/news/counties-highest-burden-maternal-mortality. Accessed October 9, 2016.
- WHO, achieving the health-related MDGs, http://www.who.int/hrh/workforce_mdgs/en/ accessed September 26, 2016.

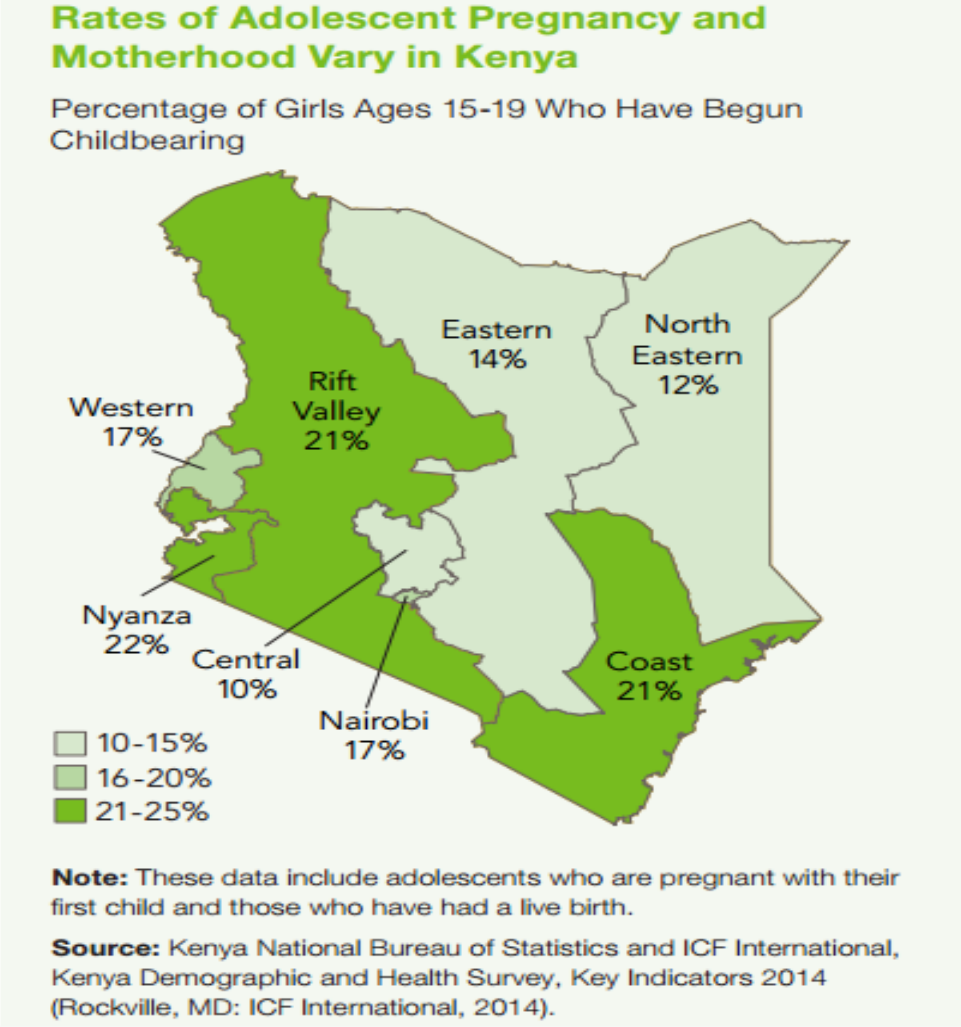
ANNEXES

Annex 1: National Health Work Force Staffing Needs

STAFF CATEGORY	Sub categories	Total staff	Norms/ 10,000 persons	
			By staff	By sub
Dental staff	Community Oral Health Officers	1,604	1.1	0.4
	Dental assistant	1,924		0.4
	Dental general practitioner	962		0.2
	Dental specialist	359		0.1
Laboratory staff	Laboratory assistant	11,137	4.1	2.5
	Laboratory technician / scientists	5,569		1.3
	Laboratory technologist	1,471		0.3
Medical practitioners	Nutritionist	2,335	7.2	0.5
	Clinical Officer	16,278		3.7
	Medical Officer	13,141		3.0
Midwives	Enrolled Midwife	0	3.0	-
	Registered Midwife	13,308		3.0
Non-surgical specialists	Emergency / trauma specialist	572	0.6	0.1
	Physician / internal medicine	1,544		0.4
	Psychiatrists	461		0.1
Surgical specialists	ENT	452	1.1	0.1
	General surgeon	947		0.2
	Obstetrics / Gynaecology	585		0.1
	Ophthalmologist	552		0.1
	Orthopedician	495		0.1
	Pediatrician	506		0.1
	Orthopedic technician	831		0.2
	Orthopedic technologist	416		0.1
Nurses	Plaster technician	0	8.7	-
	Nurse assistant	0		-
	Enrolled nurse	23,574		5.4
	Registered nurse	11,335		2.6
	BSN nurse	467		0.1
	specialized nurse	2,939		0.7
Pharmacy staff	Dispenser	0	0.9	-
	Pharmacy technologist	3,106		0.7
	Pharmacist	724		0.2
Radiology	Radiology assistant	1,505		0.3

staff	X-ray technician	0		-
	Radiographer	753		0.2
	Radiologist	576	0.6	0.1
Environmental health staff	Public Health Officers	4,229	1.6	1.0
	Public Health Technicians	2,662		0.6
Community staff	Trained Community Health Worker	120,886	28.3	27.5
	Social Health Worker	3,528		0.8
Rehabilitation specialists	Occupational Therapists	704	0.6	0.2
	Physiotherapists	1,768		0.4
Management staff	Health Records and Information Officer	4,071		0.9
	Health Records and Information Technician	0		-
	Medical engineering technologist	413		0.1
	Medical engineering technician	825	1.2	0.2
Administrative staff	Drivers	7,252		1.6
	Clerks	8,661		2.0
	Cleaners	11,890		2.7
	Security	9,718		2.2
	Accountants	3,846		0.9
	Administrators	4,330	12.6	1.0
	Cooks	6,503		1.5
	Secretaries	3,362		0.8
General support staff	Casuals	2,593		0.6
	Mortuary attendants	749	2.5	0.2
	Patient attendants	7,858		1.8

ANNEX 2: Rates of adolescent pregnancy and motherhood in Kenya per region



ANNEX 3: Commodity Prices

Product	Unit Size	Unit Price (USD)
DMPA	Vials	0.955
POPs	Cycles	0.34
COCs	Cycles	0.21
Male Condoms	Pieces	0.029
Implants – Jadelle	Sets	8.885
Implants – Implanon	Sets	10.542

IUCDs	Sets	0.54
Female Condoms	Pieces	0.72
Cycle Beads	Sets	2.256
Emergency Pills	Doses	0.25

Dollar exchange rate Ksh.100/dollar

ANNEX 4: Family Planning Method Mix Dynamics

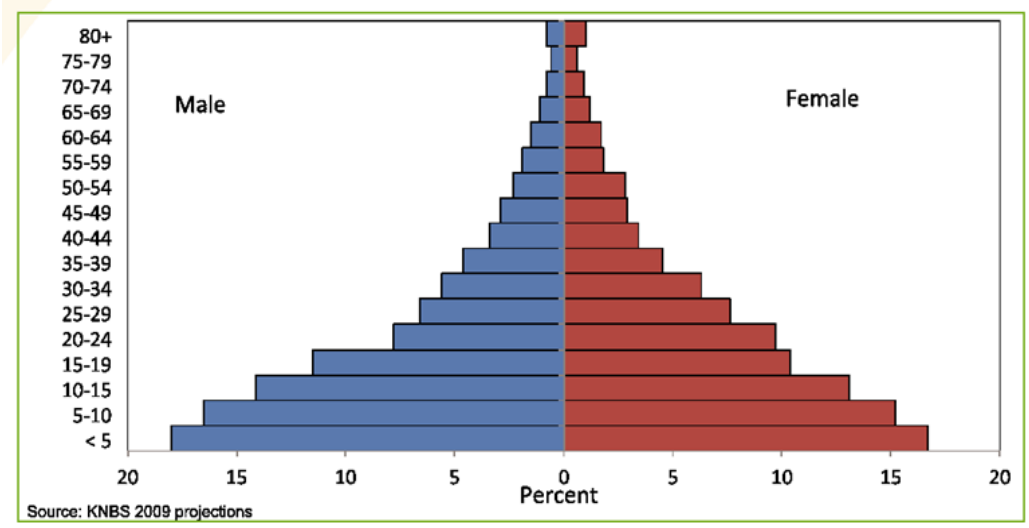
Method mix is not expected to change significantly between 2011 and 2017. However, female condoms are expected to contribute 0.5% of methods used in 2017 up from 0% in 2011. Pills are expected to decline by 0.1% from 16.6% in 2011 to 16.5% in 2017 and Vasectomy by 0.3% to 0% in 2017.

	Method Mix 2011	Method Mix 2017	
Data element	% of Total	% of Total	
Pills POPs			
Pills COCs	16.6	16.5	10.92
FP Injections	53.2	53.2	35.21
IUCD insertion	5.0	5.0	3.31
Implants insertion	10.0	10.0	6.62
Sterilization BTL	1.8	1.8	1.19
Sterilization Vasectomy	0.3	0.0	0.0
Client receiving condoms	7.0	7.0	4.63
Female Condoms	0.0	0.5	0.33
Natural Family Planning	1.0		
All others FP	5.0	6.0	3.97
Totals	100	100	66.19

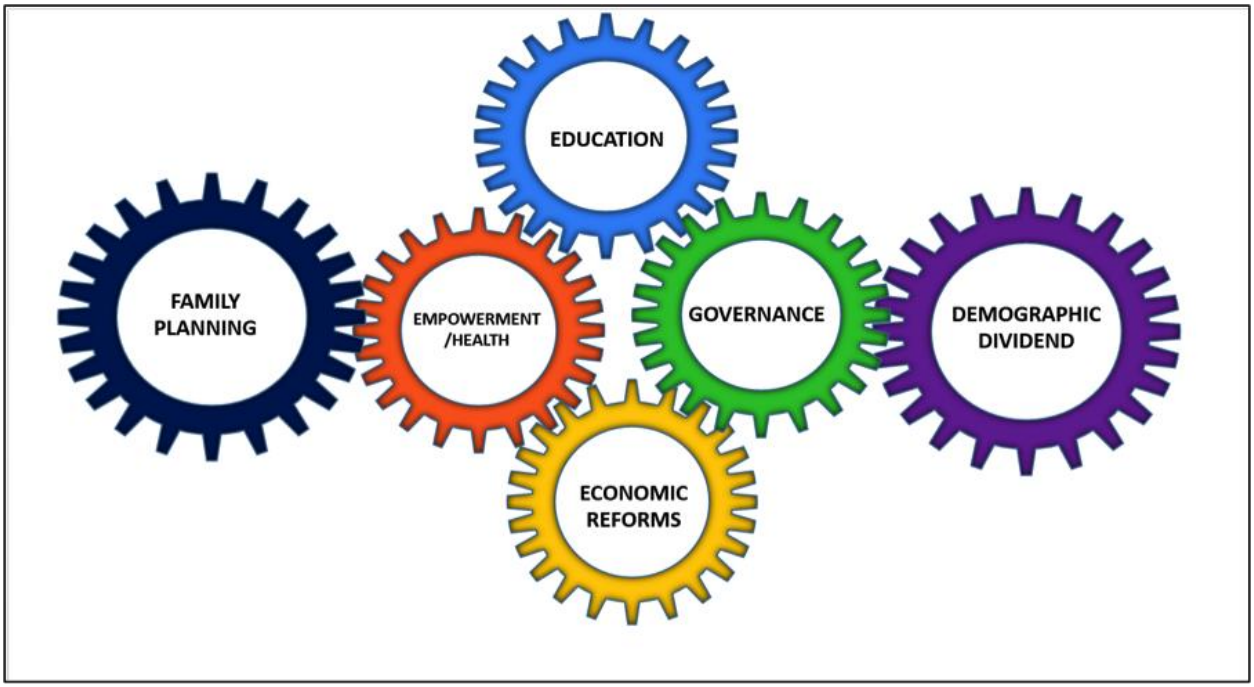
ANNEX 5: Sustainable Development Goals

The Sustainable Development Goals (SDGs), officially known as transforming our world: the 2030 Agenda for Sustainable Development is a set of seventeen aspirational "Global Goals" with 169 targets between them. Spearheaded by the United Nations, through a deliberative process involving its 193 Member States, as well as global civil society. The goals are contained in paragraph 54 United Nations Resolution A/RES/70/1 of 25 September 2015.

ANNEX 6: Population Pyramid by Age and Gender



ANNEX 7: Demographic Dividend Investment Wheels


EDUCATION
FAMILY PLANNING
EMPOWERMENT /HEALTH
GOVERNANCE
DEMOGRAPHIC DIVIDEND
ECONOMIC REFORMS

ANNEX 8: List of FP-CIP Development Team

NAME	ORGANIZATION/DEPARTMENT
ESTHER MWEMA	CRHC/CNO KILIFI COUNTY
SOPHIA K ONSARE	SNO/DOH COUNTY
JOB OGUTTU	SCPHN- RABAI COUNTY
MARGARET MWAILA	CPC – NCPD
JOSEPH KHONDE	CNO/DOH COUNTY
SHEKHA SULUBU	COMMUNICATION DEPT KILIFI COUNTY
EVALINE LANGAT	RESEARCH COORDINATOR KILIFI COUNTY
EMILY KARISA	SCPHN KILIFI COUNTY
WILFRED KAZUNGU	DCHRIO
REBECCA WACHIRA	KRCS P.O
JULIET KIMATU	ICRH- KP OFFICER
DANIEL YAWA	SCCHS FP
PAMELA CHONI MWATUA	DOH KILIFI NORTH
PHELOMENA M. MWAIDZA	SCNO/DOH KILIFI COUNTY
CELESTINE GONGOLO	CRN/DOH
DR. BENSON KITHI	PHARMACIST
SARAH BONAYA	SCRHCO/DOH
JESSIE MUGAMBI	DSW
M.REGINA WAMBUI	KMYDO
EMMAH KARIUKI	JHPIEGO
CATHERINE MUNYOKI	CCHSC/DOH KILIFI COUNTY
SULTAN A HUBESS	CP- DOH KILIFI COUNTY
VERONICAH KUBAMBANYA	SCRHC- KILIFI COUNTY
MOHAMMED MWINYI	KMYDO
MUSTAFA ASMAN	RPC- KMYDO
COSMAS MUTUA	LEAD CONSULTANT

Partners


KMYDO
KENYA MUSLIM YOUTH DEVELOPMENT ORGANISATION
UNFPA
innovating to save lives
Jhpiego
an affiliate of Johns Hopkins University
NCPD
DSW
ps
Kenya