Meru County

Family Planning Costed Implementation Plan

2017/2018 – 2021/2022

Every effort has been made to verify the accuracy of the information contained in this document. All information was believed to be correct as of August 2018.

Table of contents

List of Figures

List of Tables

Acronyms

CHAI	Clinton Health Access Initiative
CHV	Community Health Volunteers
CIP	Costed Implementation Plan
CPR	Contraceptive Prevalence Rate
CSO	Civil Society Organizations
CYP	Couple Years of Protection
DSW	Deutsche StiftungWeltbevoelkerung
EMMS	Essential Medicines and Medical Supplies
FP	Family Planning
HCP	Health Care Providers
HCW	Health Care Workers
IEC	Information Education Communication
KDHS	Kenya Demographic Health Survey
KHMFL	Kenya Health Master Facility List
KOGs	Kenya Obstetric Gynaecologists
LA(P)M	Long Acting (Permanent) Methods
LMIS	Logistics Management Information System
TFR	Total Fertility Rate
TWGs	Technical Working Groups
YFS	Youth Friendly Services

Executive Summary

The projected population of Meru County in 2017 was at 1,486,025 people composing of males being 745,134 (50.14%) and females 740,891 (48.86%)with an annual growth rate of 2.1%.The proportion of women of child bearing age (WCBA) is 371,506 women (25%). The proportions of women who are sexually active are 265,627 (71.5 %) in 2017. Adolescents and youths comprise 2.3% and 35% of the total population. The total fertility rate in Meru County is 3.1 live births per woman from beginning of child bearing age to end of fertility period compared to Kenyan TFR which is 3.9 and counties with highest TFR such as Wajir at 7.8 (KDHS 2014). The CPR is at 78.2% with injectable being the most common modern method of contraception at 44.8%.

The Meru County FP-CIP will be used as a guide for all FP programming for the county government, development and implementing partners. The FP-CIP provides details that are necessary for programme activities and costs associated with achieving county goals. The CIP defines key activities and an implementation roadmap that defines targets appropriately sequenced to deliver the outcomes needed to reach the county's committed FP goals by 2021. The FP CIP is a resource mobilization tool for the county on FP program. In addition the FP-CIP determines detailed commodity costs and programme activity costs associated with the entire FP programme.

The plan will particularly aim to improve the FP services of the people of Meru County by expanding access to family planning services to attain a modern contraceptive prevalence rate (mCPR) of 83% and a contraceptive prevalence rate (CPR) of 85% by the year 2021.

The development process was highly consultative and involved various stakeholders at different levels.A standard national family planning CIP format was used to compile an elaborate plan by the county-planning team which helped highlight the different sections and a structuring of information as required in each sub section. The Costed Implementation Plan for Meru County will be important in strengthening foundation of FP programming and service delivery and prioritize strategies on FP to be adopted over the next five years according to objectives laid down.

In the last five years, some of the key achievements for family planning services have been Training of HCWs on LAM, Routine service delivery of FP were offered across the facilities, integrated outreach services with Beyond Zero clinic and Marie Stopes and Supervision and re-distribution of FP commodities among others. It was important to note that a number of drawbacks were experienced in the same implementation period such as Delivery of FP commodities dependent on the EMMS, No funds allocations for FP services, Frequent industrial unrests by HCWs, Erratic supply of FP commodities, Non-functional youth friendly centres and Inadequate collection and reporting tools among others all of which affected access, demand and quality of family planning services. This CIP will concentrate its efforts on areas that have well achieved the current CPR 78.2% and propel it to 85% in 2021 by having new innovative activities like Involvement of CHVs, Establish YFS committees and

focal persons to coordinate RH-FP services and Development of family planning health education messages to mobilise the community using the local media for demand creation.

The Health Department identified six Thematic Areas and their priority activities with costs determined. These thematic groups are service delivery, human resource for health, infrastructure, health products and commodities, health information, governance and leadership and monitoring and evaluation.
The CIP development team underwent a rigorous exercise of coming up with activities that will accelerate CPR to 85%. A total of approximately KS 396,758,000.00 is estimated to be the amount of money that is required to enable the FP program to attain the desired goal CPR of 85% by 2021-2022.

Dr. Eunice Nkirote Kobia,
County Executive Committee Member, Health Services.

Foreword

The Meru County Family Planning Costed Implementation Plan (CIP) 2017-2021 was developed to address Family Planning services in Reproductive Maternal Neonatal Child and Adolescent Health programme. The need for this CIP 2017-2021is to guide implementation of the Family Planning 2020 activities at county level, ownership by the health department which leads to action, accountability and advocacy, greater stakeholder involvement, monitoring which ensures strategic implementation and inform policy change which can lead to expanded FP approaches.

Meru County on average has a high Contraceptive Prevalence Rate (CPR) of78.2% higher than the Country CPR of 58%. This is as a result of among other factors high number of FP acceptance rate, high literacy level, availability of FP commodities, a high number of facilities and human resource providing services. However, drawbacks to provision and access to FP has been as a result of limited funding of health services, skewed distribution of health facilities and qualified skills mix for FP service provision, lack of awareness and intensified advocacy on FP commodities and a large population of the youth debuting to sexual practices.

The health department desires to have an increased CPR of 85% in 2021 from the current 78.2% by addressing the access, quality and demand for FP services in the following six thematic areas: Service Delivery; Human Resource for Health; Infrastructure, FP products and technologies; Governance and Leadership; Health Information; and Financing for Family Planning services. The CIP is also aligned to the County Health Strategic and Investment Plan 2017/18-2021/22.

This plan consists of key activities that have been costed to that will lead to achieve the desired goal. The plan outlines the various resource mobilisation strategies, the implementation arrangements as well as monitoring and evaluation of the activities and targets.

We would like to extend our appreciation to all stakeholders who worked tirelessly in the development of this plan. Our expectation is not only to achieve the CPR of 85% but also achieve the broader goals of Sustainable Development Goals and Vision 2030.

Dr Kanana Kimonye,
Chief Officer, Health Services.

Acknowledgements

Development of the Family Planning Costed Implemetation Plan is as a result of concerted efforts from various individuals and partners. The process involved an inclusive consultative process that utilized experts from the RH programme, CHMT, partners and youth representation. The Health Department of Meru County would like to thank all those who participated in the process in one way or another.

Special thanks go to the County Chief Officer of Health for their support.

Sincere gratitude is extended to the following FP-CIP task force members for their tireless efforts to guide the process of development of this plan through its various consultative forums and review of successive draft versions: Robert Kinoti (CHRIMO) Team Leader, Dr James Katoloki (Pharmacist, Meru TRH),Dr Simon Munyoki (RH, Meru TRH), Santa Kagendo (Youth rep, Meru County), Benedict Muchai(Youth rep, Meru County), Andrew Muguna (CHPO), Simon Rukwaru (CHSC), MururuNguku (County Logistician), Hellen G Ringera (CNC), Agnes Makandi (CMCC), James Nyaga (DSW-Kenya Office) and Michael Muthamia (JHPIEGO-Kenya).

A special word of thanks goes to Robert KinotiMbajo, CHRIMO Meru County, who was the technical lead enabler for undertaking background desk review, facilitating the various consultative forums, collating contributions from all reviewers and producing the final draft of the strategy.

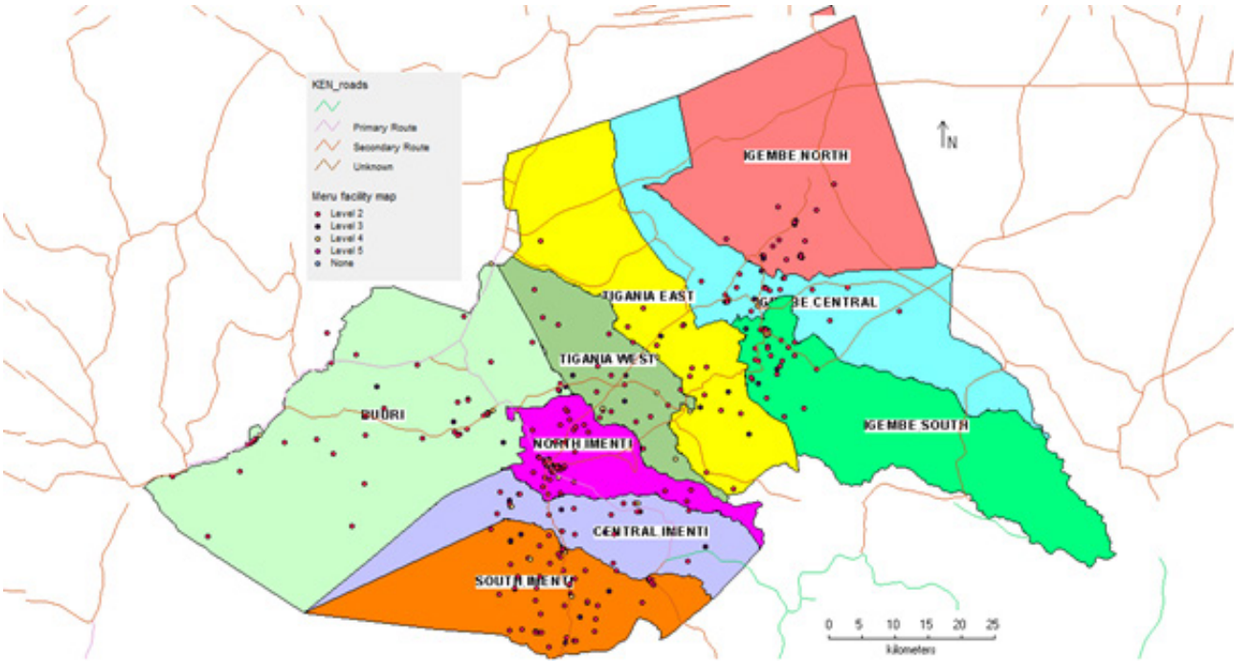
The Health Department also wishes to appreciate DSW Kenya and JHPIEGO for the technical, financial and logistical support towards development of this plan.

Dr Lilian Karoki,
Ag. Director of Medical Services

I. Introductions

Background information

This chapter presents a descriptive overview of Meru County in relation to this Costed Implementation Plan on family planning services in Meru (CIP Meru, 2017- 2021). The chapter captures the current FP situation, Rationale, goals and targets, development process and purpose or aim of the CIP. Position and size



The county lies to the east of Mt. Kenya whose peak cuts through the southern border. It shares borders with Laikipia County to the west, Nyeri to the south west, and Tharaka/Nithi to the east and Isiolo to the North. It straddles the equator lying within 00 6' North and about 00 1' South, and latitudes 370 West and 380 East. The county has a total area of 6,936.2 km2 out of which 1,776.1 Km2 is gazetted forest.Meru is an agricultural county but also a business and educational hub for Eastern and North Eastern parts of Kenya.

Population size and trends

The projected population of Meru County in 2017 was at 1,486,025 people composing of males being 745,134 (50.14%) and females 740,891 (48.86%). It is projected that by 2020 the population will increased 1,530, 043 people composing of males 771, 267 and females 758,776. The projected population of Meru County is estimated to be 1,530,043 people by 2020 with an annual growth rate of 2.1%.The proportion of women of child bearing age (WCBA) is 25% and is expected to increase from 371,506 women to 382,511 from 2017 to 2020. Of this, the proportions of women who are sexually active are 265,627 (71.5 %) in 2017. Adolescents and youths comprise 2.3% and 35% of the total population.

Political and administrative units

Table 1: Administrative Units

S/N	Sub- County Name	Number of Wards	Ward Names
1	Igembe South	5	Maua, Kiegoi/ Antubochiu, Kanuni, Akachiu, Athirugaiti
2	Igembe Central	5	Akirang'ondu, AthiruRuujine, Igembe East, Njia, Kangeta, Antuambui
3	Igembe North	5	Ntunene, AntubetweKiongo, Naathu, Amwathi.
4	Tigania West	5	Athwana, Akithi, Kianjai, Nkomo, Mbeu
5	Tigania East	5	Thangatha, Mikinduri, Kiguchwa, Muthaara, Karama
6	Imenti North	5	Municipality, Ntima East, Ntima west, Nyaki East, Nyaki West
7	Buuri	5	Timau, Kisima, Kiirua/ Naari, Ruiri/Rwarera, Kibirichia.
8	Meru central	4	Mwanganthia, Abothuguchi west, Abothuguchi central, Kiagu.
9	South Imenti	6	Abogeta east, Nkuene, Mitunguu, Igoji East, Igoji West, Abogeta west.

Health services

Number of facilities by ownership and levels of care

Table 2: Health Facilities by Level and Ownership

Level of care	Ownership				Total
	Public	Private	FBO	NGO	
Level 5	1	0	0	0	1
Level 4	13	3	7	0	23
Level 3	23	9	7	0	39
Level 2	130	251	48	6	435
Total	**167**	**263**	**62**	**6**	**498**

[Source: KHMFL V2]

Table 3: Distribution of FP Facilities

Sub County	No. of FP HFs	Proportion of HFs
Buuri	24	10.21%
Igembe Central	26	11.06%
Igembe North	19	8.09%
Igembe South	31	13.19%
Imenti Central	17	7.23%
Imenti North	34	14.47%
Imenti South	38	16.17%
Tigania East	22	9.36%
Tigania West	24	10.21%
Grand Total	**235**	**100.00%**

The number of health facilities offering FP services are 235 (53%) of all health facilities in the KHMFL. The highest number of health facilities offering FP services are found in Imenti South 38 (16.17%), followed by Imenti North 34 (14.47%) and the least number of health facilities are found in Imenti Central 17 (7.23%). The above table shows that distribution.

Current Family Planning Situations

Worldwide the CPR is at 64%, that is, 64% of married and women in reproductive age in stable relationship worldwide used modern or traditional methods contraception (UN Department of Economic and Social Affairs 2015).This is a significant rise from 36% in 1970.The CPR however varies within regions and countries with Africa with the lowest CPR at 33.4 % (UN Department of economic and social affairs 2015) despite this some African countries have made the biggest leaps in contraception use over the past 40 years and are projected to make the greatest gains in the next 15 years.

Kenya's population has risen tremendously from 10.9 million in 1969 to 38.6 million in 2009; at current growth the population will double to 71.5 million in 2030.Can available resources sustain this population? Contraceptive prevalence rate in Kenya has increased over the last decade from 46 %(KDHS 2008/9) to 58% (KDHS2014). The unmet need for family planning among married women has declined from 26% (KDHS 2008/9) to 18% (KDHS 2014). Total fertility rate has decreased from 4.6(KDHS2008/9) to 3.9 (KDHS2014).

Despite this tremendous achievement there is significant unmet need among women in Kenya 2 years after birth. According to KDHS analysis, 86.4% of unmarried, sexually active adolescent girls report not wanting a child in next 2 years, yet only 42.9% are currently using any method to prevent pregnancy.

The total fertility rate in Meru County is 3.1 live births per woman from beginning of child bearing age to end of fertility period compared to Kenyan TFR which is 3.9 and counties with highest TFR such as Wajir at 7.8(KDHS 2014). TheCPR is at 78.2% with injectable being the most common method of contraception at 44.8%.

Rationale

It is estimated that globally at least 200 million women lack access to FP information and services or support from their partners and community. Every year more than 190 million women become pregnant, out of these more than 50 million of these procure abortion which is concealed and performed under unsafe conditions.

There is unmet need for family planning which continues to rise every year, globally funding for FP has been declining due to other competing programs like HIV and TB. As result funding is decreasing the gap between the need and available resources is widening.

The Meru County FP-CIP will be used as a guide for all FP programming for the county government, development and implementing partners. The FP-CIP provides details that are necessary for programme activities and costs associated with achieving county goals. The CIP defines key activities and an implementation roadmap that defines targets appropriately sequenced to deliver the outcomes needed to reach the county's committed FP goals by 2021. The FP CIP is a resource mobilization tool for the county on FP program. In addition the FP-CIP determines detailed commodity costs and programme activity costs associated with the entire FP programme.

The CIP provides a vision with clearly defined and costed activities and targets, which are to be implemented at different governmental levels by different organizations and institutions over a specified period of time, all under the leadership of MOH, in order to make quality FP services more accessible and equitable. In addition, the CIP for FP will serve as a guide for development and implementing partners on areas of the FP Program that need support. More specifically the CIP for FP will:Update policy dialogue, planning, and budgeting at the national and county levels; Provide an opportunity for County Government of Meru, in general, to understand the budgetary needs for implementing the National FP program in an effective manner;Provide Reproductive Health programmatic services with a reliable source of financial information for the FP Programming; Mobilize and sustain quality essential for achieving cost-effective and scaled-up family planning services; and,Develop benchmarks that will be used by the Government and development partners to monitor and support the family planning program..

The annual population growth for Meru county sis estimated at 2.1% while the women of child bearing age is 364076 (24.5%). Though the contraceptive prevalence is high 78.2% the unmet need for FP is 12.4% for the region (KDHS 2014). The reported abortion outpatient cases for the county were 1661, 1187 and 1311 in 2015, 2016 and 2017 respectively. The CIP will be used to address these factors if well executed.

Goals and targets

Goal

The overall goal of this Family Planning strategic plan is to improve the quality of life of the people of Meru by providing a road map and guide for the realization of and institutionalization of adequate policy, legal and institutional framework for family planning services. The plan will particularly aim to improve the FP services of the people of Meru County by expanding access to family planning services to attain a modern contraceptive prevalence rate (mCPR) of 83% and a contraceptive prevalence rate (CPR) of 85% by the year 2021.

Objectives

The main objective of the strategic plan is to increase uptake of family planning options from 78.2% to 85% by 2021 in Meru County.

Strategic objectives are:

- To provideintegratedquality family planning services to all individuals who are sexually active in the health facilities
- To build capacity the human resources for family planning health services
- To establish adequate infrastructure, products and commodities for efficient access of FP services
- To strengthen collaboration and coordination mechanisms for all family planning stakeholders
- To carry out quality health information management for better decision making
- To mobilize adequate health financing resources for family planning services Targets
- Increase the contraceptive rate (CPR) from 78% to 85% by the year 2021.
- Increased modern contraceptive prevalence rate (mCPR) from 73% to 83% by the year 2021
- Increase CPR for any contraceptive method among adolescent women (15-19 years) by 10% by 2021.
- Reduce teenage pregnancy among adolescent women 15-19 years from 20% to 15% by 2021.
- Reduce unmet need for family planning to 10% by 2022

Development process

The development process was highly consultative and involved various stakeholders at different levels. The process was led by the county health records and information officer with the involvement of other county health management team (CHMT) members, representatives from Youth, JHPIEGO and DSW to obtain their inputs on what the family planning CIP 2017-2022 ought to address. The development process was started with identification of partners' resource and technical team from CHMT who formed the planning committee. The partner, JHPIEGO and DSW, together with the CHMT held a consultative meeting which agreed on family planning CIP.

For the process and timelines the team formed a core working group in which various responsibilities

were given during the retreat.A 5 day retreat was carried out for full planning. Work was carried out in groups representing CHMT, MeruTRH, representatives from youth and programme coordinators. A standard national family planning CIP format was used to compile an elaborate plan by the county-planning team which helped highlight the different sections and a structuring of information as required in each sub section. In each section, the format provided a space to capture narrative information, tables and figures to summarize the required information. Additional information was provided where necessary according to county's need.

A one day health stakeholder forum was held to validate this FP CIP 2017-2021 which was approved with very minimal amendments.

Purpose/Aim of the CIP

The Costed Implementation Plan for Meru County is important due to following reasons:-

1. Strengthen foundation of FP programming and service delivery and prioritize strategies on FP to be adopted over the next five years according to objectives laid down.
2. Generate cost estimates for each of the thematic areas over the five year implementation period as well as advocate resources needed for implementing the plan.
3. Inform policy dialogue, planning and budgeting to strengthen FP as a priority area.
4. Support government and key partners to understand financial and technical support needed for scaling up FP at the county level.
5. Set benchmarks to be used by the MoH and external developmental partners to monitor and support FP programme.
6. Serve as a roadmap for implementation and achievement of objectives.
7. Provides a framework for broad participation of stakeholders and inclusive of all relevant groups' representation from key population in the implementation and monitoring of the

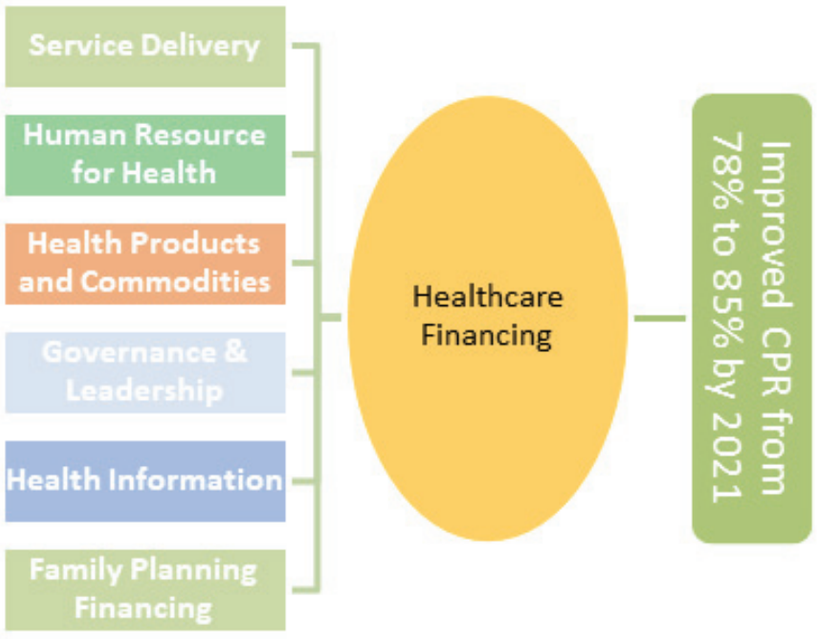


Figure 2: Results framework for FP-CIP

II. Analytical Approach

This section identifies the various population subsets that constitute the total population, associated FP programmes and activities (or causes) that contribute to the current achievements and determine what achievements are to be sustained, scaled up or replicated (priorities).

Populations' Subsets

The projected population of Meru County in 2017 is estimated at 1486025 people composing of males being 745134 (50.14%) and females 740891 (48.86%). The total population structure characterises an Expansive population as shown in Figure 1 below on Population Pyramid.

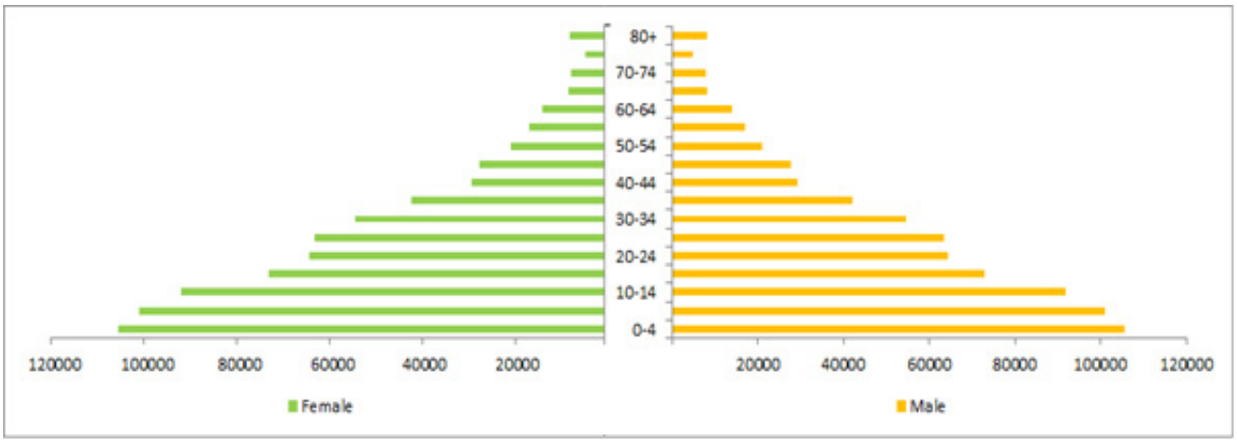


Figure 3: Population pyramid (DHIS2Kenya)

Population trends

Table 4: Population trends

	Description	Population estimates	Target population			
			2017	2018	2019	2020
1	Total population	100%	1486025	1501411	1517077	1530043
2	Male population	50.14%	745134	754097	763169	771267
3	Female population	48.86%	740891	747314	753908	758776
4	Total Number of Households	5	297205	300282	303415	306009
5	Children under 1 year (12 months)	2.70%	40123	40538	40961	41311
6	Children under 5 years (59 months)	14.10%	209530	211699	213908	215736
7	Under 15 year population	39.90%	592924	599063	605314	610487
8	Women of child bearing age (15 – 49 Years)	25%	371506	375353	379269	382511

	Description	Population estimates	Target population			
			2017	2018	2019	2020
9	Estimated Number of Pregnant Women	3.00%	44581	45042	45512	45901
10	Estimated Number of Deliveries	3.00%	44581	45042	45512	45901
11	Estimated Live Births	2.96%	43986	44442	44905	45289
12	Total number of Adolescent (15-24)	2.30%	34179	34532	34893	35191
13	Youths (15-35)	35%	525088	525494	530977	535515
14	Adults (25-59)	34.50%	512679	517987	523392	527865
15	Working population (15-64)	56%	826736	840790	849563	856824
16	Elderly (60+)	6.20%	92134	93087	94059	94863

The projected population of Meru County is estimated to be 1530043 people by 2020 with an annual growth rate of 2.1%. The proportion of women of child bearing age (WCBA) is 25% and is expected to increase from 371506 women to 382511 from 2017 to 2020. Of this, the proportions of women who are sexually active are 265627 (71.5 %) in 2017. Adolescents and youths comprise 2.3% and 35% of the total population. Table 2 above shows the population estimates and trends of various sub-populations.

FP programmes, activities (or other causes)

Thematic areas	Challenges (hindrances to attaining desired outcomes)		Priority Investment areas to address challenges
	Improving access (Where applicable)	Improving quality of care (Where applicable)	
Service delivery	• Limited health facilities offering LAM (<30%) • Illiteracy levels of the community (to access FP information) • Myths, misconceptions, beliefs on FP • Lack of information of FP services for general HCWs, and community on LAM • Low male involvement on FP services • Charges of FP services	• Limited knowledge and skills of HCPs (HCWs & CHVs) • Long waiting time for service provision by clients • Intergeneration gap of service providers and youthful clients • High defaulter rate of FP clients due to lack of tracking mechanisms	• Scale up no. of facilities offering LAM services • Use Multi-sector approaches (media, CSO, schools, organized groups, CHVs) • Demystify myths, misconceptions through trained providers (HCWs, CHVs), local media, IEC materials) • Sensitization of HCWs and community on LAM • Prioritize male involvement

Thematic areas	Challenges (hindrances to attaining desired outcomes)		Priority Investment areas to address challenges
	Improving access (Where applicable)	Improving quality of care (Where applicable)	
	(Meru TRH)	• Poor awareness on current FP guidelines • Inadequate pre- and post-counselling of FP services for youth	in service delivery • Implement policy of FP policy on charges • Training HCWs & CHVs on FP services • Exit satisfaction surveys, PDQs, suggestion boxes, health open days, service charter, performance appraisals • Train HCWs on YFS • Deploy HCWs with varied age-groups in YFS • Introduce tracking mechanisms for FP defaulters (FP cards, telephone, electronic alerts, CHVs, referral forms) • Dissemination of current guidelines and updates • Re-branding of MCH service points to Family Care clinics
Human Resources for Health	• Inadequate numbers of FP HCWs • No sign language specialist for FP clients with disabilities	• Poor attitude of HCWs • Inadequate skill mix (cadres) of FP service providers	• Recruitment and proper deployment of HCWs • Train or recruit HCW with skills on sign languages • Train HCW on soft skills (attitude change) • Train/deploy various cadres on FP

Thematic areas	Challenges (hindrances to attaining desired outcomes)		Priority Investment areas to address challenges
	Improving access (Where applicable)	**Improving quality of care (Where applicable)**	
Health infrastructure, Products and Commodities	• Shortage, stock outs and lack of FP commodities • Inconsistent delivery of FP commodities	• Difficulty in tracking, documenting commodity users due to stigma	• Proper documentation, quantification and reporting of FP commodities • Policy change on FP
	• Inadequate equipment for FP • Inadequate space to provide FP services • Inadequate disability friendly infrastructure • Inadequate YFS • Unavailability of FP commodities specifically to the youth	• Knowledge gap on LMIS for FP	delivery (not pegged on other EMMS) • Procure FP equipment • Modify existing structures to be disability friendly • Reactivate and establish integrated YFS at sub-county level
Governance and Leadership	• Lack of TWGs • Lack of stakeholder forums • Lack of management meeting for RH-FP	• Low quality of services due to lack of supervision • Little linkage mechanism between national policy makers and implementation levels • Lack of coordination of Youth friendly services • Lack of various stakeholders coordination of FP CHV activities	• Provide regular support supervision • Strengthen the communication linkage between policy making levels at national and county • Identify focal person for health on youth agendas • Establish a youth RH committee • Establish an inventory of partners with FP CHV activities • Establish RH-FP TWGs • Regular stakeholder forums • Regular management meetings

Thematic areas	Challenges (hindrances to attaining desired outcomes)		Priority Investment areas to address challenges
	Improving access (Where applicable)	**Improving quality of care (Where applicable)**	
Governance and Leadership Health Information	• Inadequate data collection and reporting tools for FP • Minimal dissemination for FP data	• Low data management practices • Low data use for decision making by service providers and managers • Low reporting rates for FP commodities than routine data	• Printing and distribution of FP tools • Regular dissemination of FP data • Training of HCWs on data management • Data quality audits • Regular support supervision
Health financing	• Inadequate financing for FP services • Lack of dedicated budget lines for FP • Lack of involvement of key RH coordinators and other stakeholders in planning and budgeting development process • Lack of policy to inform budgetary allocations on health programmes • Late/delay disbursement of health funds (RH)	• Poor utilization of funds • Poor accountability of funds • Lack of transparency of allocated funds	• Advocacy for financing of FP services • Prepare budget lines for FP services • Involvement of RH coordinators and stakeholders in planning and budgeting • Establish a Health Act to among other things guide on budgetary allocations • Ensure timely disbursement of health funds • Ensure 100% accountability and utilization of allocated funds • Increase transparency of funds

III. Demographic Determinants of Resource Requirements

This section reflects the achievements and drawbacks in the last five years, innovations for the next five years, the expected overall change of CPR and its possible causes, effects of service integration, effects of demographic determinants and the current method preferences of modern contraceptives in the county.

- **Achievements and drawbacks**

What worked well (5 years back)	What did not work well (5 years back)
• Training of HCWs on LAM by Division RH & CHAI	• Delivery of FP commodities dependent on the EMMS
• Training of RH managers on FP dashboards at county-sub county levels by CHAI	• No funds allocations for FP services
• Integrated outreach services with Beyond Zero clinic and Marie Stopes	• Frequent industrial unrests by HCWs
• Integrated outreach services with Beyond Zero clinic and Marie Stopes	• Erratic supply of FP commodities
• Piloting of post-partum intrauterine device in Meru TRH by KOGs	• Non-functional youth friendly centres
• Uninterrupted training of HCWs on comprehensive RH at Meru DTC	• Inadequate collection and reporting tools (F-CDRR, D-CDRR)
• Supervision and re-distribution of FP commodities by CHAI and APHIA Plus Kamili	• Minimal involvement of community health units

- **Innovations, new ideas for the next five years**
  - o Roll out of partner defined quality to improve the quality of services offered and understand from the demand side their challenges
  - o Involvement of CHVs has been low, expand the range of family planning services and or commodities they can distribute
  - o Develop family planning health education messages to mobilise the community using the local media for demand creation
  - o Use of e-mobile, e-health services to improve on the uptake and adherence to FP services
  - o Revive and establish the youth centres at sub-county levels
  - o Establish YFS committees and focal persons to coordinate RH-FP services
  - o Health promotion activities for FP services e.g. Road shows, integrated outreaches

- **Overall Change in CPR and the Possible Causes**
  - o Increased knowledge and skills through training of HCWs
  - o Increased awareness among the FP eligible population through dissemination of IEC materials and information from the media
  - o Enhanced supplemented services from partners' collaboration with Ministry of Health
  - o Integrated outreaches through the Beyond Zero clinic

- **Effects of Service Integration**
  - o Reduced stigma as clients are not segregated
  - o Cost-effectiveness and efficiency of service delivery
  - o Long waiting time

- **Effects of Women's Age, Education, Marital and Wealth status and number of children.**
  - o Preventsunwanted pregnancies
  - o Improved health of women due to child spacing and planned number of children desired
  - o Reduced incidences and prevalence of sexually transmitted infections
  - o Enhances family cohesion due to physiologically related conditions
  - o Improved the entire family socio-economic status
  - Method Preferences (CHARTS)

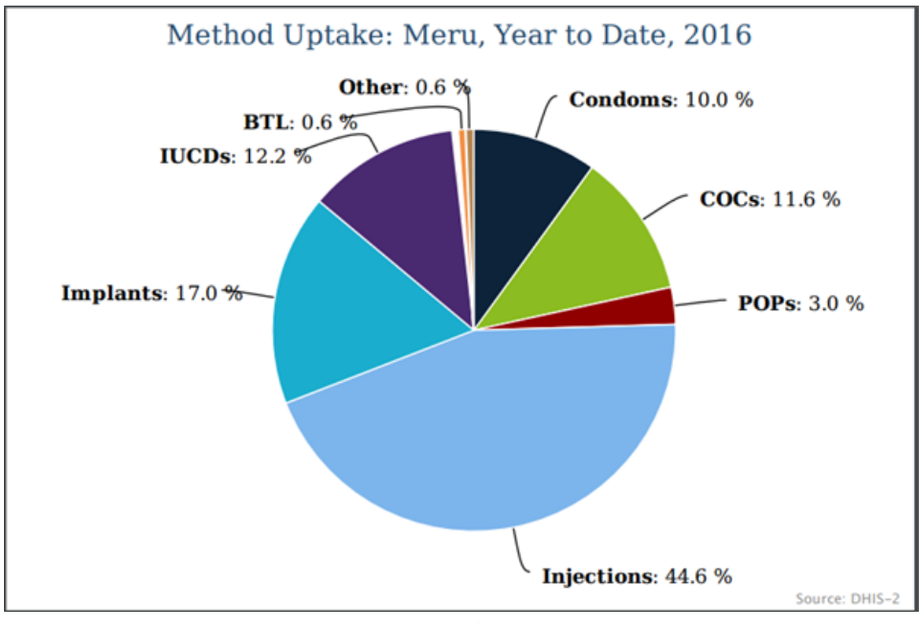


Figure 4: FP Method mix, 2016

Injectable are the most preferred methods of FP (44.6%) due to conveniences followed by implants (17.0%). Sterilizations (Vasectomy and BTL) are the least preferred methods of FP is very low (<1%) for both men and women due to perceptions or medical conditions.

IV. County Family Planning Costed Implemented Plan

Estimated resource requirement summary

Table 5: Resource requirement

	Estimated Cost (KS)					
Thematic Areas	**2017/18**	**2018/19**	**2019/20**	**2020/21**	**2021/22**	**Total**
Service Delivery	4,654,000	12,854,000	14,854,000	14,854,000	12,854,000	60,070,000
Human Resource for Health	14,220,500	13,415,000	13,255,000	6,811,000	6,295,000	53,996,500
Health Infrastructure, Products and Commodities	29,436,500	51,850,500	65,123,500	62,003,500	52,003,500	260,417,500
Governance and Leadership	1,721,000	1,797,000	1,797,000	1,797,000	1,797,000	7,909,000
Health Information	900,000	1,900,000	900,000	900,000	900,000	5,500,000
Family Planning Financing	945,000	1,980,000	1,980,000	1,980,000	1,980,000	8,865,000
Total	**51,877,000**	**83,796,500**	**97,909,500**	**88,345,500**	**75,829,500**	**396,758,000**

Matrix of CIP priority activities

Table 6: CIP priority activities

Thematic Areas	Activities	Estimated Cost (Kshs)					
		2017/18	2018/19	2019/20	2020/21	2021/22	5-Year Cost
Service Delivery	Introduce the LAPMs from 62 (30%) to 203 (80%) health facilities						-
	Conduct 2800 quarterly dialogue days by CHVs at community level	600,000	1,800,000	2,100,000	2,100,000	1,800,000	8,400,000
	Conduct 11200 monthly action days target communities	2,400,000	7,200,000	8,400,000	8,400,000	7,200,000	33,600,000
	Develop 5 different types of FP media contents for public engagement	600,000	1,000,000	1,200,000	1,200,000	1,000,000	5,000,000
	Hold 220 stakeholder media engagement through print, Radio and TV stations on FP information	400,000	1,000,000	1,000,000	1,000,000	1,000,000	4,400,000
	Develop and disseminate 95000 posters and teaching/ instruction aid materials to demystify myths	54,000	54,000	54,000	54,000	54,000	270,000
	Conduct 2800 targeted community dialogue days on male involvement	600,000	1,800,000	2,100,000	2,100,000	1,800,000	8,400,000
	Sub Total	**4,654,000**	**12,854,000**	**14,854,000**	**14,854,000**	**12,854,000**	**60,070,000**

Thematic Areas	Activities	Estimated Cost (Kshs)					
		2017/18	2018/19	2019/20	2020/21	2021/22	5-Year Cost
Human Resource for Health	Identify and induct 9 male FP champions at sub-county level	100,000	100,000	100,000	100,000	100,000	500,000
	Hold annual dissemination meeting with 50 Hospitals management on FP user fee	100,000	100,000	100,000	100,000	100,000	500,000
	Domesticate CHS for 2595 CHVs	3,892,500					3,892,500
	Train 3000 CHVs on FP services	2,000,000	4,000,000	6,000,000	-	-	12,000,000
	Provide monthly stipend to 2595 CHVs	1,188,000	2,595,000	2,595,000	2,595,000	2,595,000	11,568,000
	Domesticate the ASRH policy to 200 SCHMT members	800,000					800,000
	Domesticate national youth friendly service provision guidelines to 200 SCHMT members	800,000					800,000
	Train 250 HCWs on comprehensive RH 6 weeks programme	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	7,500,000
	Train 250 HCWs on LAPM a 5 day training	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	5,000,000
	Train 250 HCW on YFS a 5 day training	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	5,000,000
	Train 203 HCWs on PDQ for 3 days	240,000	720,000	960,000	516,000	-	2,436,000
	Train 250 HCWs on infection prevention for 4 days	1,600,000	2,400,000	-	-	-	4,000,000
	Sub Total	**14,220,500**	**13,415,000**	**13,255,000**	**6,811,000**	**6,295,000**	**53,996,500**

Thematic Areas	Activities	Estimated Cost (Kshs)					
		2017/18	2018/19	2019/20	2020/21	2021/22	5-Year Cost
Health Infrastructure, Products and Commodities	Conduct biannual client exit surveys in 254 HFs duration of 5 days	6,350,000	12,700,000	12,700,000	12,700,000	12,700,000	57,150,000
	Roll out PDQs in 203 HFs 5 people per facility	1,015,000	1,015,000	1,015,000	1,015,000	1,015,000	5,075,000
	Hold annual open days in 9 sub counties with 15 participants	202,500	202,500	202,500	202,500	202,500	1,012,500
	Develop and display 203 FP service charters	1,015,000					1,015,000
	Conduct quarterly facility performance appraisal on FP indicators at sub county level						-
	Identify and deploy 9 HCWs for YFS						-
	Follow up of FP clients using bulk mobile messages in 203 HFs	1,218,000	1,218,000	1,218,000	1,218,000	1,218,000	6,090,000
	Use of computer/ phone alert messages for HCWs on 5075 clients						-
	Print and disseminate IPC guidelines for 254 HFs	127,000					127,000
	Print and Disseminate 254 FP service provision guidelines	127,000					127,000
	Develop and install new branded signage for FP in 254 HFs	1,778,000					1,778,000

Thematic Areas	Activities	Estimated Cost (Kshs)					
		2017/18	2018/19	2019/20	2020/21	2021/22	5-Year Cost
	Recruit 200 HCWs to provide RH-FP and other health related services	14,400,000	21,600,000	36,000,000	36,000,000	36,000,000	144,000,000
	Train 203 HCWs with skills on basic sign languages	270,000	270,000	270,000	270,000	270,000	1,350,000
	Conduct quarterly FP data quality audits in HFs with a team of 4	160,000	160,000	160,000	160,000	160,000	800,000
	Conduct quarterly support supervision	160,000	160,000	160,000	160,000	160,000	800,000
	Conduct monthly sub county FP review meetings	54,000	108,000	108,000	108,000	108,000	486,000
	Conduct quarterly county FP review meetings	120,000	120,000	120,000	120,000	120,000	600,000
	Support supplementary emergency restocking of FP commodities at county level	50,000	50,000	50,000	50,000	50,000	250,000
	Procure FP equipment (815 IUCD sets)	600,000	645,000	1,200,000	-	-	2,445,000
	Procure FP equipment (815 implant sets)	560,000	602,000	1,120,000	-	-	2,282,000
	Construct disability friendly rumps in 203 HFs	230,000	1,000,000	800,000	-	-	2,030,000

Thematic Areas	Activities	Estimated Cost (Kshs)					
		2017/18	2018/19	2019/20	2020/21	2021/22	5-Year Cost
	Reactivate (equip, refurbish) 3 YF Centres at sub-county level	1,000,000	2,000,000	-	-	-	3,000,000
	Establish and equip 6 integrated YFS at sub-county level	-	10,000,000	10,000,000	10,000,000	-	30,000,000
	Sub Total	29,436,500	51,850,500	65,123,500	62,003,500	52,003,500	260,417,500
Governance and Leadership	Conduct quarterly support supervisions at 9 sub county level	36,000	72,000	72,000	72,000	72,000	324,000
	Conduct quarterly support supervision 15 facilities per sub county						
	Hold annual consultative meetings between County and Div. of RH-FP	165,000	165,000	165,000	165,000	165,000	825,000
	Assigning 10 Adolescent and Youth focal persons for RH-FP services	-					-

Thematic Areas	Activities	Estimated Cost (Kshs)					
		2017/18	2018/19	2019/20	2020/21	2021/22	5-Year Cost
	Hold youth multi-stakeholder meeting at sub county for RHFP	540,000					540,000
	Hold quarterly review meetings for RH stakeholder activities	540,000	1,080,000	1,080,000	1,080,000	1,080,000	4,860,000
	Conduct annual stakeholder consultation meeting on harmonizing CHV activities engagements	120,000	120,000	120,000	120,000	120,000	600,000
	Hold a meeting to establish RH-FP TWGs	40,000					40,000
	Engage women community leaders annually for FP advocacy	200,000	200,000	200,000	200,000	200,000	-
	Conduct quarterly TWG meetings for RHFP	80,000	160,000	160,000	160,000	160,000	720,000
	Sub Total	1,721,000	1,797,000	1,797,000	1,797,000	1,797,000	7,909,000
Family Planning Financing	Hold annual meetings with County Budget Committee on FP financing	60,000	60,000	60,000	60,000	60,000	300,000
	Hold sensitization workshop with Health Committee on FP financing	50,000	50,000	50,000	50,000	50,000	250,000
	Form inter-political parties' caucus to champion for FP activities	100,000					100,000

Thematic Areas	Activities	Estimated Cost (Kshs)					
		2017/18	2018/19	2019/20	2020/21	2021/22	5-Year Cost
	Support biannual inter-political parties' caucus meetings on FP activities	100,000	200,000	200,000	200,000	200,000	900,000
	Hold quarterly review meetings with 3MCA champions for FP	15,000	30,000	30,000	30,000	30,000	135,000
	Holding tri-annual meetings with the department of planning and budgeting on FP matters	40,000	60,000	60,000	60,000	60,000	280,000
	Active engagement of RH coordinators in the budget making process						-
	Hold stakeholder meetings on FP budgets	40,000	40,000	40,000	40,000	40,000	200,000
	Develop a County Reproductive Health policy	500,000	1,500,000	1,500,000	1,500,000	1,500,000	6,500,000
	Hold FP budget briefing meeting allocations	40,000	40,000	40,000	40,000	40,000	200,000
	Sub Total	945,000	1,980,000	1,980,000	1,980,000	1,980,000	8,865,000
	Grand Total	**51,877,000**	**83,796,500**	**97,909,500**	**88,345,500**	**5,829,500**	**396,758,000**

V. Institutional Arrangements for Implementation

National Level

The overall responsibility of the Ministry of Health in the National Government is strategic coordination and oversight, which include responsibility for developing or updating policies that affect implementation, for resource mobilization, and for monitoring and evaluation. For management and operational aspects, the DRH, with support from RH/FP TWG, will ensure that the right activities are carried out in the right way and to scale.

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

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

County level

The responsibility of the Department of Health is county health services, county planning and development, pre-primary education, village polytechnics, home craft centres and childcare facilities, disaster management and control of drugs and pornography.

The CIP will be implemented under the leadership and management of Department of Health, Meru County. Given the CIP partnership nature, the ministry of Department of Health will coordinate and mobilise actions and resources from a wide range of partners and stakeholders at all levels.

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

To support the MOH, the Meru FP TWG, County Government and development partners' representatives will continue to monitor its implementation, lobby for financial and technical support and advice on various courses of action.

Sub County Level

The sub county should be facilitated to ensure that the CIP is part of their key agendas and included Annual Work plans. The support is by the County of Government and partners.

Facility Level

The responsibility of the facilities is to develop a work plan for the facility and implement the FP CIP. This forms the bulk of the users of the FP program including the community linkage.

VI. Resource Mobilization

The sustained availability of adequate financial resources is essential for the successfulimplementation of the FP CIP. This cost analysis provides estimates ofthe resource requirements for the implementation of the FP CIP by allstakeholders. The estimates indicate resource needs for the period 2017-2022 that will guidemobilization of resources from different levels of government, development partners andother stakeholders.

To address the limited financial commitment to family planning commensurate to need, the county health department and its partners will advocate for increased funding within health budgets, in addition to funding secured from development partners and NGOs. The county health department will also cultivate FP advocates within the County department of Trade, Investment, Industrialization, Tourism and Cooperatives and in particular the Finance and budgeting committee as well as within County assembly particularly the County assembly health committee, to ensure that the County Health budget includes a line item for family planning programming, which is increased over time to meet the growing demand for FP services as SBCC and FP access activities are rolled out over the next five years. Advocacy for the creation of budget lines for family planning at the county level will support the prioritisation and integration of family planning into county planning and budgeting processes.

Champions will be selected from the sub county level to the county level to act as good will ambassadors of family planning with an aim of increased budget allocation for family planning. Efforts will be made to establish and build the capacity of a county assembly family planning caucus to increases advocacy for increased financing for family planning. Advocate for NHIF increased coverage to include services not currently covered and particularly those targeted to youths.

The total estimated budget for the period 2017-2021 is KS 396,758,000.00. The source of funding will be mainly from the county health budget, development partner and partners NGOs.

VII. Monitoring and Evaluation

The CIP currently has sets of interventions and activities intended to increase contraceptive use (CPR) from the current 78.2% to 85% by 2021. The measurement of CPR will be undertaken in the next DHS in 2018. Before the DHS, the CIP needs to be monitored so that Meru County Health Department can demonstratewhether the target can be realistically achieved. This continuous monitoring is expected to utilize lower level results and indicators from the AWPs.

The CIP itself has outlined a number of M&E related activities as found in the document plan. A good plan will ensure that roles played by various CIP actors are adequately covered. It will also ensure plans for final CIP evaluation will include secondary data from surveys (e.g. DHS) in addition to the use of routine data from the DHIS2.

VIII. Appendix

Appendix I: List of members of CIP Task force

1.	Robert Kinoti	CHRIMO	Meru County
2.	Dr James Katoloki	Pharmacist	Meru County
3.	Dr Simon Munyoki	RH	Meru TRH
4.	Santa Kagendo	Youth rep	Meru County
5.	Benedict Muchai	Youth rep	Meru County
6.	Andrew Muguna	CHPO	Meru County
7.	Simon Rukwaru	CHS	Meru County
8.	MururuNguku	EPI Logistician	Meru County
9.	Hellen G Ringera	CNC	Meru County
10.	Agnes Makandi	CMCC	Meru County
11.	James Nyaga	DSW Kenya	Kenya Office
12.	Michael Muthamia	JHPIEGO	Kenya

Appendix II: Reference documents

1. Costed implementation Plan: Guidance and lessons learned 2012
2. Kenya National Family Planning Costed Implementation Plan 2012-2016
3. Meru County Annual Work Plan 2017/18
4. Meru County Health Sector and Investment Plan 2017/18-2021/22