REPUBLIC OF KENYA

COUNTY GOVERNMENT OF NAKURU

DEPARTMENT OF HEALTH SERVICES

Family Planning Costed Implementation Plan

2016/17-2020/21

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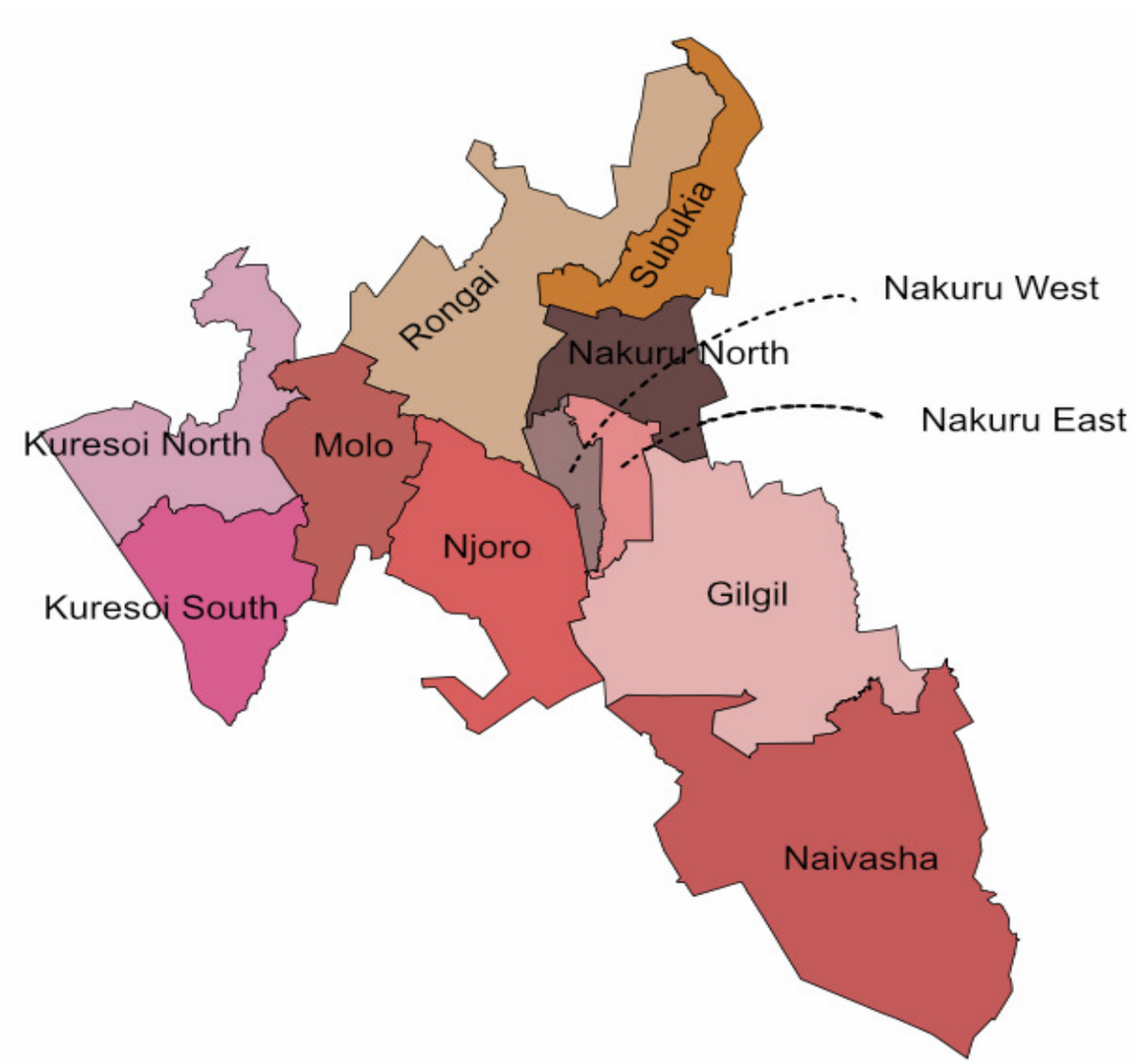


ABBREVIATIONS

AIDS	Acquired Immunodeficiency 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 Programme
CHVs	Community Health Volunteers	NCPD	National Council for Population and dev.
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 Kit
CPR	Contraceptive Prevalence Rate	PAI	Population Action International
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 Point
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 Communication Technology	TNA	Training Needs Assessment
IEC	Information Education & Communication	TOT	Trainer of Trainer's
IIBRC	Interim Independent Boundaries Review Commission	TWG	Technical Working Group
KDHS	Kenya Demographic Health Survey	UN	United Nations
KMYDO	Kenya Muslim Youth Development 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
MDG	Millennium Development Goals		

FOREWORD

Nakuru County has a total fertility rate of 3.7%, maternal mortality rates 362/100,000, and teenage pregnancy rates at 18.4% remain amongst the high. Clearly, we still have a tall and uphill task, as many women and families would like to delay, space, or limit their childbearing but are not using family planning (FP). Many women cite health concerns, including fear of side effects or opposition from their partner as reasons for not using contraception. We need to address these women's health concerns and fears, improve our counseling about side effects, and involve men as partners.

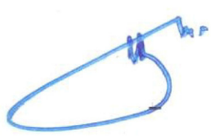
Our efforts to scale up use of modern family planning methods are motivated by the knowledge that family planning helps women achieve their human rights to health, education, autonomy, and personal decision making about the number and timing of their childbearing. More broadly, family planning improves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

The Ministry of Health (MOH), in collaboration with partners, developed the Nakuru Family Planning Costed Implementation Plan, 2016/17–2020/21 (FP-CIP) as an overarching document to provide county guidance for increased knowledge of and access to family planning interventions. In summary, the FP-CIP is aligned to several national frameworks, Kenya national Family planning implementation plan. The plan emphasizes the following key strategic priorities that will enhance the achievement of our objectives:

- Increasing efforts to reach all young people
- Developing a county social and behavior change communication strategy with harmonised programme efforts
- Implementing task sharing amongst health care workers to increase access to rural and underserved populations so as to scale up service delivery.
- Mainstreaming family planning in a multi-sectoral manner to improve policy, interventions, equity, and implementation
- Ensuring FP commodity security across the public and private service delivery points

We believe that our joint efforts will lead to a decline in the unmet need for family planning and an increase in the modern contraceptive prevalence rate (mCPR) to a level of impact by 2020.
This, therefore, is the plan of action that government, partners, and civil society must follow to achieve our desired goals of carrying forward the County Government of Nakuru's commitments to family planning.

The MOH pledges to bolster all coordination efforts and calls on development and implementing partners to work with us to support and implement the FP-CIP to ensure the success of the county FP programme intended to improve the quality of life and well-being of our people.



H.E Kinuthia Mbugua
Governor, Nakuru County

PREFACE

The County Government of Nakuru is committed to improving access to family planning, as it is a low cost, high dividend investment for addressing Nakuru's high maternal mortality ratio and improving the health and welfare of women, men, and ultimately, the nation. Family planning is an essential component in our county development agenda to become a middle-income country in the next 30 years.

Increased access to, and use of, family planning has far-reaching benefits for families and the county. As Nakuru's fertility rates have begun to decline, Nakuru has the potential to benefit from the opportunity of the demographic dividend. The demographic dividend refers to faster economic growth due in part by changes in the population age structure that result in more working-age adults and fewer dependents. This population shift can contribute to both county development and improved well-being for families and communities. However, if we are to realize the demographic dividend, we must make substantial investments to improve health outcomes and meet the needs for family planning, while also educating and training workers, promoting new job opportunities for young people, and strengthening economic stability and governance.

Therefore, let us work together to ensure the health and wealth of our county. By committing ourselves to the full financing and implementation of the Nakuru County Family Planning Costed Implementation Plan, 2016/17–2020/21 (FP-CIP), we can realize our goals of reducing unmet need for family planning to 10 percent and increasing the modern contraceptive prevalence rate amongst married and women in union to 50 percent by 2020.

Full and successful implementation of the FP-CIP requires the concerted and coordinated efforts of the county government, the private sector, and civil society and development partners. We must all work together to ensure an enabling environment for policy, financing, service delivery, advocacy programmes, and the effective mobilization of communities and individuals to overcome socio-cultural barriers to accessing family planning services.

The County Government of Nakuru department of health services is committed to providing the required leadership to coordinate and implement the FP-CIP, so as to ensure that every Nakuru citizen has the right to health, education, autonomy, and personal decision making about the number and timing of their childbearing.

Dr. Mungai Kabii

County Executive Committee Member for Health Services,

Nakuru County

ACKNOWLEDGEMENTS

The Ministry of Health (MOH) Nakuru county department of health services would like to express its appreciation to the many partners and groups who supported the development of the Nakuru Family Planning Costed Implementation Plan, 2017–2020 (FP-CIP). This document is the result of extensive consultations with stakeholders working at all levels, including key sector ministries, implementing partners and not-for-profit organizations working in aligned areas.

The Nakuru County Department of Health Services is greatly indebted to individuals and organizations who contributed in one way or another to this very important process. Specifically, the Department would like to thank PAI under the Faith Fund Award through the Kenya Muslim Youth Development Organization (KMYDO) led by Mr. Fadhili Msuri and Francis Kamau who provided the financial and technical support to ensure that the whole process was successful. We also thank DSW Kenya through their representative Mr. Peter Ngure who facilitated the SCHMT dissemination forum and also supported the launch of the document.

Finally, I 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.

The department recognizes the Reproductive Health Maternal, New-born and Adolescent Health Technical Working Group members led by Dr. O. Agere, N. Chelule, J. Mung'au, and B. Bowen who worked tirelessly to ensure success at each stage of the process.

We cannot forget the immense contribution from the National Council for Population and Development regional coordinator Ms. J. Lunayo who provided the literature and information that gave the background information for the framework. The Department of Health also wishes to specifically acknowledge the contributions of the various stakeholders; non-governmental agencies, government ministries and departments that led to the production of the Nakuru County Family Planning Costed Implementation plan 2016/17-2020/21.

Last but not list I acknowledge the important role that the County Health Management Team played in endorsement and launch of the Nakuru County family planning costed implementation plan 2016/17 -2020/21.

Dr. Samuel Mwaura

Chief Officer, Health Services

Nakuru County

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 their effective 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 her strategic framework towards HIV control, promotion of maternal, new born and child health in Kenya. Through this initiative Her Excellency hopes to give a mobile clinic to all the 47 counties. Nakuru County has already received the mobile clinic.

Contraception 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 1 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 an HIV-positive woman to her child during pregnancy, labour, delivery 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 body;

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 methods include female sterilization, male sterilization, oral hormonal pills, the intrauterine device (IUD), injectables, implants, male condoms, female condoms, lactational amenorrhea method (LAM), and standard days method (SDM). Methods such as rhythm and withdrawal are defined as traditional.

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

Policy: are 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: refer 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 programmes.

CHAPTER 1 – 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. The UN estimates, released in July 2016 indicate that it reached 47,251,449.

Nakuru County is one of the 47 Counties in the Republic of Kenya. It has 11 Sub-counties (Constituencies) namely; Nakuru East, Nakuru West, Nakuru North, Subukia, Naivasha, Gilgil, Molo, Njoro, Kuresoi North, Kuresoi South, and Rongai. It has an estimated population of 1,896,198 people as at the year 2016; with males and females accounting for approximately 50.6% and 49.4% of the total population respectively.

It is a predominantly young population with about 62.7% of the population aged 25 years or younger. A further 38.2% of the population is aged between 25 and 59 years of age. It has an estimated population of 457,431 women of reproductive age, 75,000 expected number of pregnancies and 73,000 deliveries in 2016. The current life expectancy is 57 years with a population growth rate of 3.05 and a total fertility rate of 3.7 children per woman. Population density is 2,139 per square kilometre, and covers an area of 7,496.5 km. About 2.43% of the population lives below poverty line. It is served by a total of 419 Health facilities, of which 16 are hospitals, 286 primary care facilities and 111 community units.

1.2 Rationale for and Use of the FP-CIP

The Nakuru County FP-CIP is the guide for all FP programming for the county government across all sectors, development partners, and implementing partners. Nakuru's 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 from partners. The plan gives critical direction to Nakuru's FP programme, ensuring that all components of a successful programme are addressed and budgeted for in 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 Nakuru's consensus-driven priorities for family planning—derived through a consultative process—and thus becomes 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 programmes. 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 sectoral ministries should work in tandem with the MOH to implement the FP-CIP and coordinate efforts.
• 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 county'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 costs and programme activity costs associated with the entire FP programme. It provides concrete activity and budget information to inform the MOH budget requests for FP programmes. It also provides guidance to the MOH and partners to prioritise the funding and implementation of strategic priorities.
• Mobilise resources: The FP-CIP should also be used by the County Government Of Nakuru (CGN) and partners to mobilize needed resources. The plan details the activities and budget required to implement a comprehensive FP programme, and as such, the MOH and partners can systematically track the currently available resources against those required as stipulated in the FP-CIP and conduct advocacy to mobilise funds from development partners to support any remaining 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 is meeting its objectives, ensuring coordination, and guiding any necessary course 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 CGN and are inclusive of relevant groups and representatives from key populations in the implementation and monitoring of the plan.

1.3 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 a country, it is estimated that one quarter to one 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 unwanted teenage pregnancies, and lowering infant deaths. Additionally, 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 limit pregnancies; however, they lack access to FP options. Amongst women of reproductive age in developing countries, 57 percent (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.

1.3.1 FP2020

The UK government, 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 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.11 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 countries need to reach their goals
• Fostering innovative approaches to family planning challenges
• Promoting accountability through improved monitoring and evaluation

1.3.2 Sustainable Development Goals

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. Proposed Goals 3 and 5 give include direct and indirect outcomes related to family planning. Proposed 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, proposed 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.

1.4 The County context

The Constitution of Kenya 2010 provides the overarching framework to ensure a comprehensive rights-based approach to health services delivery. Article 43 of the constitution of Kenya provides that every person has a right to the highest attainable standard of health, which includes reproductive health rights. The one (1) National Government and forty-seven (47) County Governments are distinct and interdependent, and are expected to undertake their relations through consultation and cooperation. The distinctiveness of the governments under the devolved system is determined by the fourth schedule of the Constitution, which has assigned different functions to the two levels of government. Health is one of the functions that have been devolved to the County government. Each County, to put in place county responsive health policies, strategies and plans that respond to the needs of the County, while aligning to national policies.

The Nakuru County MMR estimates stands at 375 per 100,000 live births according to NCPD and UNFPA-Kenyan Population Situation Analysis 2013 as compared to the National MMR of 362 per 100,000 live births estimated by KDHS in 2014 is still high and the recent estimates of WHO, UNICEF, UNFPA, the World Bank Group and UN Population Division also highlight insufficient progress. Coverage/utilization indicators also show some improvements but much more needs to be done to address inequities and to reach UHC. The contraceptive prevalence rate (CPR, any method) for Nakuru County among married women has increased to 56.8% in 2014 from 42.4% in 2008/9 (in Rift Valley Region) with a decline in unmet need for FP from 31.1% to 20.8%.About 96% of pregnant women received at least one antenatal care (ANC) by a skilled attendant, while 69.7% births were delivered in health facilities in 2014. Postnatal check up in the first two days after birth in Rift valley region increased from 44.5 percent in 2009 to 45.9 percent in 2014.

The total fertility rate (TFR) for Nakuru county stands at 3.7 compared to the National rate of 3.9 in 2014; however, teen pregnancy is high (18.4%) in comparison to the National rate of 18 percent adolescents in the 15-19 years age group having started child bearing due to early marriage, high unmet need for contraception and poor access to FP services. The Nakuru 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:

Logistical barriers, including distance and costs of services
Social, cultural and religious beliefs and practices
Behavioral restrictions, including a 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. Nakuru 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 56.8 percent (KDHS, 2014) to 70 percent by 2020. For this target to be realized, access to family planning services must be improved, especially among less educated, rural and poorer 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 Nakuru County Integrated Development Plan 2013, The Nakuru County Health Strategic and Investment Plan (2013-2017), The Nakuru Reproductive Health Policy and The Nakuru County Health Sector Strategic and Investment Plan Monitoring and Evaluation Framework.

Figure 1: Disparities in family planning uptake between Sub-counties in Nakuru County

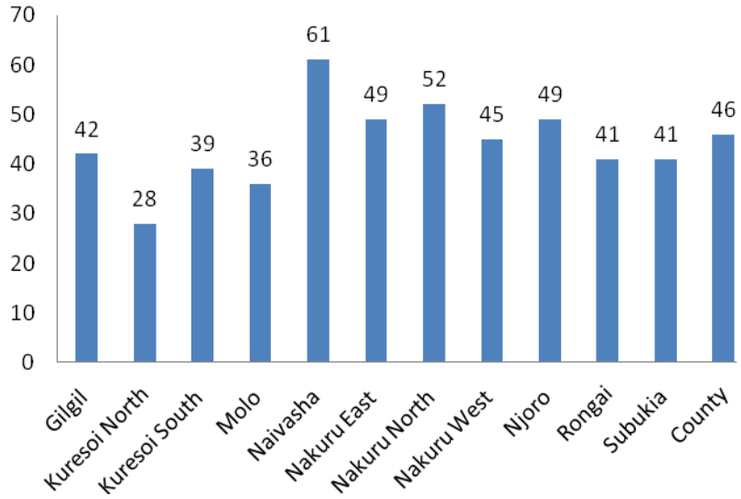


Figure 1 shows levels of family planning uptake among sub-counties in Nakuru County. Family planning uptake was highest in Naivasha at 61 percent and lowest witnessed with Kuresoi North at 28 percent. Therefore there is need to improve uptake of family planning in most of the sub-counties in Nakuru County.

1.4.1 Key Considerations Embedded in the Strategy

- Prioritization of family planning
- Alignment to National and County policies and guidelines
- Sustainability
- Considerations of special target populations (adolescents, youth, PLHIV, Drug users and sex workers)
- Accountability
- Ownership by the County Health Department with partners playing a supportive role
- Devolution

1.4.2 High Impact Interventions

FP is an essential and integral part of improving RMNAH outcomes. It reduces high risk pregnancies, facilitates birth spacing, and prevents unintended pregnancies and related unsafe abortions especially among adolescents. Despite overall increases in CPR, there is limited access to voluntary FP services especially among adolescents and particularly in counties with high maternal, new-born and child mortality. Access to quality modern contraceptive methods, including long acting and permanent methods (LAPM), is limited because of supply side gaps. Strategies for FP will ensure access to a secure choice of quality modern contraceptive methods with the necessary information, education and support structures in place that can inform this choice. Use of FP/contraceptive services will remain voluntary—with no coercion.

1.4.3 Key immediate actions:

- Address supply side barriers for contraceptives method mix, including LAPM, efficient distribution systems, and competency-based training and updates using WHO medical eligibility for contraceptive use for nurses, clinical officers and doctors in LAPM, FP/contraception counselling and follow-up.
- Scale up youth friendly health services3 and use non-governmental organizations (NGOs), CBOs and social media to more effectively reach youth.
- Ensure contraceptive commodity security and adequate financing for contraceptives
- Involve a wide range of stakeholders such as private sector, schools, universities, and uniformed forces to increase availability and quality of voluntary FP/contraceptive services.
- Train pharmacy staff to provide FP methods.
- Increase/expand community-based distribution of FP commodities and services through initiatives which will include task sharing.
- Initiate the output based aid (OBA) voucher program of FP services focusing on underserved groups and youth.
- Increase the coverage of postpartum FP planning services in facilities.
- Build the capacity of facilities to offer long term and permanent FP methods
- Encourage long acting and reversible methods among underserved groups such as adolescents/youth.
- Increase the availability of facilities providing integrated voluntary FP into other services including HIV & AIDS and the non-health sector and promote dual method use for HIV prevention.

1.5 The Development Process

Nakuru County began developing its Family Planning Costed Implementation Plan, 2017–2020 (FP-CIP) in late 2016, with support initiated by Kenya Muslim Youth Development Organization (KMYDO) supported by a consultant.
A group of high-level experts from the MOH, development partners, implementing partners, civil society were also involved.

The plan and activity matrix was presented in various forms to expert groups throughout the process, including the CIP Task Force; groups of various partner experts across technical areas; and the Family Planning/Reproductive Health Commodity Security Working Group.

The costing was developed based on international best practices and customized to the Kenyan and county context. Finally, the MOH circulated multiple draft versions of the complete FP-CIP to its partners and stakeholders before the plan was finalized.

During CIP execution, further refinement of the technical strategy will become necessary as information is generated from performance monitoring of the FP-CIP.

CHAPTER 2- SITUATIONAL ANALYSIS

2.1 General Healthcare situation in Nakuru County

Medical facilities in Nakuru County are inadequate in terms of the number of health centres and the services provided to the local population. The current life expectancy is 57 years with a population growth rate of 3.05 and a total fertility rate of 3.7 children per woman. Population density is 2,139 per square kilometer, and covers an area of 7,496.5 km. About 2.43% of the population live below poverty line. It is served by a total of 419 Health facilities, of which 16 are hospitals, 286 primary care facilities and 111 community units. People travel long distances for treatment. The poor road network further complicates access to the health services, which makes some residents skip FP services. The doctor population ratio is 1:10,000 while the nurse population 6:10,000. 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 2 breaks down the National health work force staffing needs and also gives the current number of staff in Nakuru County health facilities.

Table 1: No. of Health Facilities in Nakuru County (2016) and Percentage Coverage of FP as per DHIS 2015/16

SUB COUNTY	PUBLIC	FBO	PRIVATE	TOTAL	FP COVERAGE %
Gilgil	18	1	21	40	42%
Kuresoi North	17	2	2	21	28%
Kuresoi South	22	1	5	28	39%
Molo	13	5	7	25	36%
Naivasha	32	4	39	75	60%
Nakuru East	21	7	39	67	48%
Nakuru North	9	4	32	45	52%
Nakuru West	23	8	12	43	45%
Njoro	31	4	11	46	49%
Rongai	34	4	7	45	41%
Subukia	16	2	6	24	40%
COUNTY TOTAL	**236**	**41**	**182**	**459**	**45%**

The number of women of reproductive age (15-49 years) is estimated at457,431 with 75,000 expected number of pregnancies and 73,000 deliveries in 2016..The total fertility rate in the county stands at 3.7 against a national rate of 3.9. The percentage use of any FP method in Nakuru County stands at 56.8%, with 38% reported as using modern contraceptives, which is below the National average of 58%. The overall unmet need for FP in the county is at 35% against a National percentage of 18%. These statistics according to the last Kenya Demographic Health Survey KDHS (2014) indicate that the County of Nakuru is not doing very well in her FP indicators and there is need for improvement. The Nakuru CIDP recognizes that there is need to embark on vigorous campaigns in family planning methods, maternal health care as population control measures.

2.2 Factors affecting family planning in Nakuru County

The County of Nakuru 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 Nakuru County are discussed below.

2.2.1. 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 a 2012 rapid assessment of drugs and substance use in Kenya, about 18 percent of adolescents aged 15-17 reported ever using any drug or substance, including tobacco, Khat (Miraa), narcotics and inhalants.31 Despite the need for services to address substance abuse, very few drug rehabilitation programs and counseling centers are available for adolescents in Kenya and these tend to be urban-based. When under the influence of these substances, adherence to the use of family planning methods is affected, and they are exposed to unintended pregnancies and HIV infection.

2.2.2. Low Literacy

Low literacy caused by poor education, inadequate human resource for education, and negative attitude towards education by communities, has affected Nakuru 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 a secondary or higher level of education. Married women with no education have the highest unmet need for family planning (28%), compared with 12% among women with secondary or higher education.

2.2.3. Unemployment

Based on the forgoing information, of the total labour force of 968,745 in the year 2012 in Nakuru County, the employed are 740,608 while the unemployed are 228,137 representing 24 per cent of the total labour force. The female accounts for 46 per cent of the unemployed population. In order to enhance the growth of the economy in the county, there is need to enhance measures aimed at creating employment activities both in the formal and informal sectors to absorb the unemployed.
Teenagers from poorer households are more likely to have begun childbearing (26 percent) than are teenagers from wealthier households (10 percent). Family planning contributes to economic growth and poverty reduction at the family, community, and national levels, and hence the need to reposition family planning higher on national and local policy agendas in sub-Saharan Africa.24 UNFPA states that access to safe, voluntary family planning is a human right and is central to gender equality and women's empowerment, and it is a key factor in reducing poverty.

2.2.4 Facility Readiness to Provide Quality Services

It is evident that family planning programmes lacking adequate infrastructure, supplies, and trained personnel may not provide good 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.

2.2.5 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.

2.2.6 Culture and Religion

Women empowerment is still a serious issue in Nakuru 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.

2.3 Populations with Special Needs for Family Planning

2.3.1. 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 among younger adolescents (15-19 years) compared to 190 per 100,000 among older youth (20-24 years).34 They 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.35 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 percent to 80 percent 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 infant mortality, preterm birth, low birth weight and malformations among adolescent mothers.

Socio-economic consequences of this 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 percent 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 percent of all women seeking post-abortion care services and about 45 percent of all severe abortion-related admissions in Kenyan hospitals in 2012. Estimates from developing countries indicate that pregnancy and delivery complications.

2.3.2 People Living with Disability

Disability affects 3% 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 the persons with disability can access them with ease.

2.3.3 HIV Positive Women

The HIV prevalence among women in Nakuru County is higher (7.5%) than that of men (4.5%). There were about 2,438 HIV-positive pregnant women in Nakuru County in 2011.This number has since increased. Linkages between the sexual and reproductive health and HIV fields can maximize the opportunities to address four distinct reproductive possibilities.

2.3.4 Female Sex workers

Due to 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 for sex workers who are either HIV negative or of unknown status, and targeted education to increase knowledge of and demand for family planning and reproductive health as a whole.

2.4 Strengths, Weaknesses, Opportunities and Threats (SWOT) Analysis

A SWOT analysis was carried out to identify the current situation in Nakuru 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.

Strengths

1. Strong political goodwill by the county Government Of Nakuru.
2. Focused and dedicated CHMT and county health administration team
3. Improved infrastructure, linkages and referral system
4. Increased trained health personnel on RH targeting FP
5. Existence of the Beyond Zero Mobile Clinic for outreach health services
6. Availability of other working documents including County Policies such as the Nakuru CIDP, County Annual Work plan.
7. Presence of an FP TWG
8. Presence of FP investment Consortium.
9. Existing functional community health units
10. Availability of health information tools and systems for FP within LMIS and DHIS
11. Presence of Quality Improvement Teams for health
12. Availability of FP products in the SDPs
13. Existence of commodities management committee in the County.

Weaknesses

1. Inadequate number of health personnel
2. inadequate number CHVs trained in community RH/FP issues
3. Inadequate allocation of funds for FP services to SDPs
4. Erratic supply of FP commodities and inadequate storage space
5. Inadequate FP equipment e.g. implants removal kits, IUCD sets
6. Low utilization of health information management system
7. Incomplete, inaccurate and untimely reporting
8. Inadequate reporting tools to capture, document and report non-routine data
9. Weak linkages with private health sector on data management system
10. Inadequate skills in data analysis, interpretation and use. (M&E)
11. In adequate logistical support e.g. transport for supportive supervision
12. Lack of FP specific budget line from the county government
13. Lack of information on the resource package from the partners
14. low dissemination of FP related policies to the SDPs
15. Low number of partners involved in family planning programming.

Opportunities

1. Existence of Community health strategy; policy on CHVs providing DMPAs and oral contraceptives and ASRH policy with wider scope of services to youths and adolescence.
2. Existence of the TWG, County First Lady, county communication office and media partners for FP advocacy
3. Availability of health learning institutions within the County and existences of a national curriculum for FP

4. Existence of National policy guidelines for Integration of FP into other health services and programs
5. Supportive FP partners
6. Media advocacy for dispelling myths and misconceptions
7. Existence of health committees at county and Council of governors levels
8. Utilization of digital technology for data collection, analysis, interpretation and use.
9. Availability of County training needs assessment report
10. Data collection from the Private facilities that are currently not reporting
11. Public Private partnership
12. Availability of results- based financing (RBF)

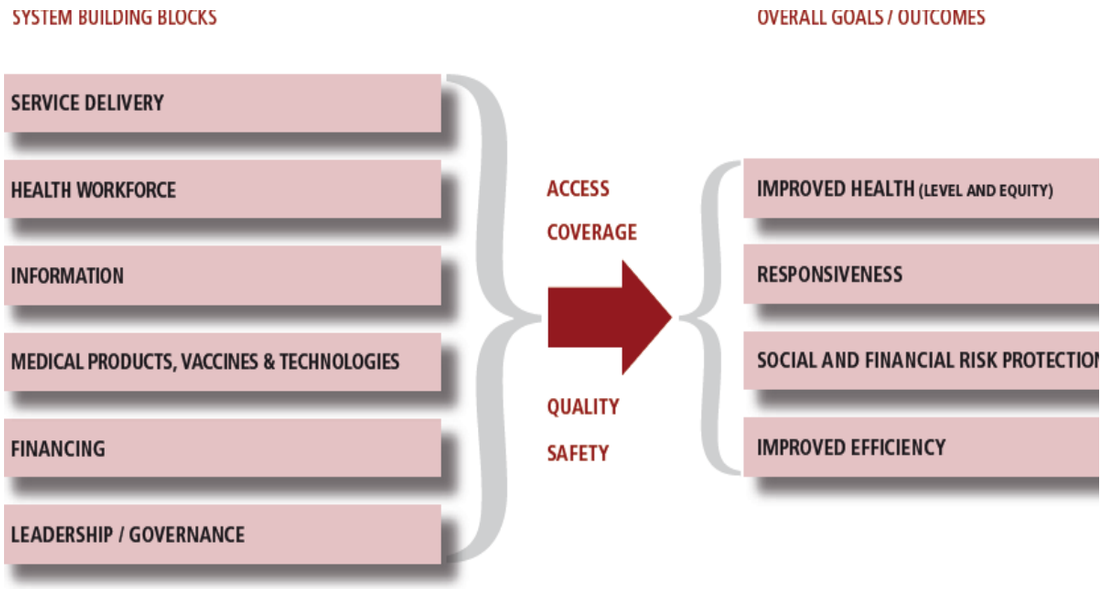
Threats

1. Political Interference with the concept of FP (i.e. viewing population as votes)
2. Political transition post general elections
3. Myths and misconceptions (Religious, social and cultural beliefs) surrounding FP
4. Regular medical personnel strikes

CHAPTER 3: STRENGTHENING HEALTH SYSTEMS FOR IMPROVED FAMILY PLANNING INTERVENTIONS

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. 2: 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 avoid demoralized staff that could lead to a high turnover.

Pillar 3: Information systems:

These include 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 included resource mobilization for funds to enable the smooth running of the health services. The systems should raise and secure and 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.

CHAPTER 4: FAMILY PLANNING IMPLEMENTATION PLAN

The vision, mission and strategy goal specifically bring out the expectations of this strategy in regards 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: A healthy and productive population

Mission: To promote sustainable development in Nakuru County through advocacy and provision of comprehensive and integrated quality FP services that are accessible, acceptable, affordable and responsive.

Strategy Goal: to reduce unmet family planning needs to 18% and increase the modern contraceptive prevalence rate (mCPR) to 56% among women of reproductive age in Nakuru County by 2020.

Strategic Objectives:

1. To increase utilization of FP services by 10% by 2021 in Nakuru County.
2. To increase the capacity of the Health care work force in FP by 50% by 2021.
3. To improve availability, quality and use of data for decision making by 2021.
4. To have a specific budget line for FP by 2019
5. To eliminate stock out of FP commodities in all health facilities in Nakuru County by 2019.

IMPLEMENTATION PLAN

PILLAR 1: Service delivery						
Aim: 1. To increase access and utilization of quality family planning services.						
STRATEGIES	OUTCOMES	KEY ACTIVITIES	INDICATORS	RESOURCES REQUIRED	TIMEFRAME	DATA SOURCE
Male involvement.	Increased male participation in RH/FP interventions.	1. Identify, engage and train 60 male FP champions. 2. Hold dialogue meetings. 3. carry out community outreaches in the wards targeting young boys	1. # of male champions identified, engaged and trained 2. # of dialogue meetings held 3. # of community outreaches held	Personnel, financial resources, M&E tools, guidelines.	Monthly, Quarterly Bi-monthly	Registers, Reporting tools, DHIS Checklist Inventories
Service integration	Increased access to FP services at all service provision points	1. Conduct comprehensive integrated outreaches by facilities per month. 2. Integrate FP services into CCC, TB, PAC Kit, PNC, FP toolkit, SOPs, outpatient and inpatient. 3. Ensure access of FP for populations with special needs e.g. adolescents, youth, the PWDs, young mothers, teenagers, street families, sex workers etc. 4. Strengthen capacity of existing institutions and structures in the provision of integrated age appropriate reproductive health care	1. # of comprehensive integrated outreaches conducted by facility. 2. # of facilities offering integrated FP services. 3. # of facilities reporting FP data for populations with special needs 4. # of health facilities integrating appropriate reproductive health care	Personnel, financial resources, M&E tools, guidelines, transport, EMMS. Personnel, financial resources, M&E tools, guidelines. Personnel, financial resources, M&E tools, guidelines. Personnel, financial resources, M&E tools, guidelines.	Monthly Monthly Monthly Monthly	Reporting tools and DHIS. Reports and registers. Reports and registers. Reports and registers.

Enhancing service delivery systems and structures	Increased access to age appropriate reproductive health care	1. Establish 11 Functional youth-friendly centers that offer age appropriate reproductive health care	# of resource centers offering age appropriate reproductive health care.	Personnel, financial resources, M&E tools, guidelines.	Quarterly	Reports and registers.
Community mobilization, education and empowerment	Increased community awareness on AYSRH	1. Establish youth friendly drop in centres that provide information and basic RH services in the community. 2. Support community education and outreaches on AYSRH. 3. Support community health units for improved AYSRH. 4. Support peer education initiatives on RH in the community. 5. Develop and implement strong mentorship programs for in and out of school youth. 6. Support parent education on adolescent sexual reproductive issues.	1. # of youth friendly drop in centres established. 2. # of community education and outreaches on AYSRH carried out. 3. # of family units supported for improved AYSRH 4. # of Peer educators trained. 5. # of mentorship programs for in and out of school youth. 6. # of parent education sessions held.	Personnel, financial resources, M&E tools, guidelines.	Bi-annually Monthly Monthly Monthly Quarterly Quarterly	Reports
		2. Train community health workers on FP.	2. # of community health workers trained on FP.	2. Personnel, financial resources, M&E tools, guidelines, transport, Curriculum	Quarterly	Training report.

		3. Conduct health talks in the facility.	3. # of health talks conducted.	3. Personnel.	Monthly.	Monthly reports.
Commodity Structure	Reduced stock outs.	1. Train 500 health workers on FP LMIS. 2. Mentor 500 health workers on LMIS. 3. Forecasting, quantification and procurement of FP commodities.	1.Proportional of health workers trained on FP LMI 2. Proportion of health workers mentored on LMIS. 3. Amount of commodities procured.	Personnel, financial resources, M&E tools, Curriculum. Personnel, financial resources, M&E tools. Financial resources.	Quarterly Quarterly Quarterly	Training reports. Training reports. Delivery notes, requisition notes.
Improved Structures	High quality services provided at all levels.	1. Equip the facilities with the minimum required standard of equipment. 2. Renovate and equip new facilities in hard to reach areas. 3. Establish 10 youth friendly centers.	1. Proportion of facilities with minimum standard equipment. 2. Number of facilities renovated. 3. # of youth friendly centers.	Financial resources. Personnel	Quarterly.	Facility inventories DHIS reports.
	Strengthen service delivery for RH for PWDs	1. Improve accessibility for PWDs by putting ramps, walkways, sanitation facilities	1. # of facilities with ramps, walkways, sanitation facilities	Financial resources. Personnel	Annually	Facility inventories DHIS reports.

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	RESOURCES REQUIRED	TIMEFRAME	DATA SOURCE
1. Human resource management	Increased/adequate number of service providers.	1. Identifying staff gaps/needs. 2. Recruit/deploy based on the needs assessment. 3. Inducting the new staff recruited. 4. Bi-annual staff appraisal. 5. Performance review meetings 6. Motivating best performers	1. Needs assessment report? 2. # of staff recruited and deployed. 3. # of staff inducted. 4. # of staff appraised. 5. # of facilities with targets and number of performance review meetings.	Financial resources, personnel	Quarterly Bi-annually	Training reports and inventories. Performance review reports Staff return reports
2. Capacity Building	Increased human resources for AYSRH initiatives	1. Train medical personnel in delivery of non-discriminatory AYSRH education and services. 2. Strengthen the capacity of CHVs to provide AYSRH education and basic SRH services.	1. # of providers trained on AYSRH issues. 2. # of CHVs offering integrated AYSRH education and services.	Financial resources, personnel, training material	Quarterly	Training reports
	Improved provider competency in offering FP services.	1. Train 400 staff on FP	1. Proportion of staff trained on FP.	Financial resources, personnel, training material	Quarterly	Training reports

		2. Train at least 2 service providers per sub-county on sign language. 3. A competency as assessment for FP developed	2. # of service providers trained in sign language. 3. # of health care workers mentored.			
		4. Mentor 500 healthcare workers. 5. Conduct 150 whole site facility orientations. 6. Conduct on job training. 7. Capacity building of health promotion officers (CHAs, PHOs and CHEWs)	4. # of whole site orientations. 5. of OJTs Conducted. 6. # of health promotion officers capacity built	Financial resources, Transport, Human resource Checklists Training manuals	Quarterly	Training reports OJT activity and supervision reports.

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	RESOURCES REQUIRED	TIMEFRAME	DATA SOURCE
1. Dissemination of tools	Increased availability of all reporting tools	Quantity requirements Procure and distribute	1. % facility with reporting tools 2. # and types of reporting tools to capture integration.	Skilled personnel, finances, Transport	Annually annually and as required	Tools distribution checklist
2. Supportive supervision	Increased availability of quality data	Gap analysis OJT/mentorship DQA	1. % of complete reports 2. % of timely reports 3. %# of DQAs done	Skilled personnel, money, Transport, Supervision tools	Annually Quarterly Quarterly	DHIS Summary tool
3. Data review meeting	Increased use of data for decision	Data analysis Root cause analysis Action plan Feedback	1. # of action plans derived from data 2. # of action plans implemented 3. # of review meetings	Skilled personnel, money	Monthly Monthly Monthly Monthly	Minutes of TWG Data review summary reports
4. Capacity building	Increased number of skilled personnel	Conduct CMEs OJT Training/ sensitization	# of health workers trained	Skilled personnel, money, Transport, training materials	Monthly Quarterly Biannually & as necessary	Training inventory, Training report
5. Operational research	Structured operational research to support the decision-making process	1. Exit point interviews 2. FP utilization research 3. FP quality service research	# of research reports # Of partnerships with institutions of higher learning. # of learning and knowledge sharing forums such as conferences held.	Skilled personnel, money, Tools	Biannually	Research reports

		4. Strengthen partnerships with higher institutions of learning for research on ASRH.				
6. Information and technology	Increased use of IT systems and structures for information sharing	1. Develop and utilize digital platforms for sharing SRH information. 2. Support production and dissemination of IEC materials at all levels.	1. # and types of digital platforms developed and utilized. 2. # of young people reached through technology. 3. # and types of youth friendly IEC material produced and disseminated.	Information and technology	Annually	Reports

PILLAR: 4. Medical products, vaccines and technologies						
Aim: Increase availability of quality FP commodities						
STRATEGIES	OUTCOMES	KEY ACTIVITIES	INDICATORS	RESOURCES REQUIRED	TIMEFRAME	DATA SOURCE
1. Supply chain management	Increased availability of contraceptives	Forecasting and quantification	% of facilities with stock out	Skilled personnel, money, Transport, stores/warehouses	Annually, biannual review	FP Dashboard
		Ordering			Monthly	
		Storage & distribution/redistribution			Continuous	
2. Resource mobilization	Increased resources for FP initiatives	Stakeholder mapping	% Budget fill rate	Skilled personnel, money (meetings), Advocacy tools	annually	County Budget Estimates
		Budgeting			annually	
		stakeholder engagement			quarterly	
3. Quality control	Increased availability of quality FP products	Sensitize SDPs on GDP and Good storage practices	1. % of obsolete products (value) 2. # meetings held	Mini-lab, skilled personnel, Money	Biannually &as necessary	F58
		Institutionalize FP products specifications				
		Products inspection			Annually	
		Pharmacovigilance (Monitoring on drugs procurement)				
		Hold quarterly drug, medicine and therapeutic committee meeting			Continuous	

PILLAR: 5 Health financing &Partnership						
Aim: Increase allocation & timely disbursement of FP funds						
STRATEGIES	OUTCOMES	KEY ACTIVITIES	INDICATORS	RESOURCES REQUIRED	TIMEFRAME	DATA SOURCE
Advocate for itemized budget on FP	Inclusion of FP budget line in the county health budget.	1. Joint AWP meeting between the CHMT & the Health Executive & The County Treasury	# of meetings held Availability of FP funds	Funds, Policy briefs,	Quarterly	County Treasury-Approved budget AWP Reports Signed MOUs. Reports
	2. Joint work-planning between the County Health Executive, CHMT & County Assembly Health Committee	# of meetings held	Quarterly	Funds, personnel	Annually	Reports
	Increased resources for FP	Stakeholder meeting [MCAs & County Assembly Health committee, MOE, Health Executive, CHMT, Youth & Gender]	# of meetings held # of Stakeholders who attended # of funding pledges given	Funds, personnel, policies	Biannually	Reports
	Increased partnerships for FP funding.	1. Sign an MOU between the Dept. of Health and the Partners	# Of signed MOU.	Funds	At the beginning of the year, As need arises,	
		2. A meeting of CHMT & Partners to share the approved health budget & AWP	# of meetings held	Funds	Annually (in quarter 1)	

PILLAR: 6. Leadership and governance						
Aim: Increase number of County & Sub County level FP Champions						
STRATEGIES	OUTCOMES	KEY ACTIVITIES	INDICATORS	RESOURCES REQUIRED	TIMEFRAME	DATA SOURCE
Leadership and governance for FP	Increased policy formulation and adaptation	Develop/ domesticate relevant RH/FP policies, guidelines and strategies Enforcement of RH/FP policies	# of RH/FP policies, guidelines and strategies developed # of RH/FP policies enforced	Funds, FP/RH policies	Ongoing	Reports
	Increased leadership and coordination for FP strategies in the County	1. Support dissemination of relevant policies, guidelines and laws on AYSRH. 2. Advocate for elimination barriers that hinder young people's access to RH information and services.	# and types of guidelines and policies on AYSRH disseminated. # of leaders speaking in support for ASYRH.	Funds, FP/RH policies	Ongoing	Reports
Capacity building of leaders as FP champions	FP champions in place	Identification of FP champions	# of FP/RH champions identified	Funds	Annually	Meeting reports
		Orientation of FP champions	# of FP champions orientated	Funds, advocacy materials, Fact sheets brochures	Quarterly	Meeting reports

PILLAR: 7. Advocacy						
Aim: Strengthen stakeholder involvement, political commitment and investment in advocacy for FP						
STRATEGIES	OUTCOMES	KEY ACTIVITIES	INDICATORS	RESOURCES REQUIRED	TIMEFRAME	DATA SOURCE
1. Build capacity of FP stakeholders	Strengthened inter-sectoral coordination and networking, partnership and community partnerships	Training [TWG)	#of TWG members trained	Funds, training material,	Annually	Reports
		Stakeholder mapping	# of stakeholders mapped	Funds, personnel	Annually	Reports
		Stakeholder meetings (FBOs, CORPs, Media, Admin, MOE, Youth & Gender, CHMT	# of meetings held # of Stakeholders who attended	Funds, personnel	Biannually	Reports
2.FP Awareness	Increased FP awareness among stakeholders	Dissemination of FP/RH related policies to stakeholders	# of policies disseminated # of stakeholders reached with the information	Funds, Personnel	Biannually	Reports
		Designing & development, of FP/RH related IEC materials.	# of IEC materials developed	Funds, Personnel	Periodically	Reports
		Pretesting of the developed IEC materials	# of IEC materials Pretested	Funds, Personnel	Annually	Reports
		Dissemination & distribution of the IEC materials.	# of IEC materials distributed	Funds, Personnel	Annually	Reports
2. Media advocacy	Increased media coverage	Pre-recorded media programs and talk shows	No. of programs aired.	Funds, Media package	Quarterly	Media Clips

CHAPTER 5: RESEARCH, MONITORING & EVALUATION

Research, monitoring and evaluation are critical elements for gathering evidence and measuring of the achievement of this four-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 at the end of every year. Data management tools will be enhanced to ensure that all the necessary data is collected, analyzed and used for 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

A mid-term evaluation of this CIP will be carried out in 2018, and an end-term evaluation in 2020. This will be soon after the release of the results of the National Population and Housing Census and the Kenya Demographic Health Survey, that are both expected in 2019. This will be compared to 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 2: Key Performance Indicators and Targets for the Strategy

PILLAR	Key Performance Indicators (KPIs)	Baseline 2016	Mid-term 2018/19	End-term 2020
1. Service Delivery	% of women of reproductive age receiving any family planning methods	46	49	56
	Total Fertility rate (TFR)	3.7	3.3	3
	% of women with unmet need of FP	20.8	19.	17.7
	# of facilities offering LARCs	274	294	315
	Percentage of facilities offering Youth friendly services	6	9	12
	% of adolescent accessing FP services (10-14 yrs)	1.07	2.5	6
	% of adolescent accessing FP services (15-19 yrs)	6.47	10	20
	% of HIV clients accessing modern FP services.	1.6	5	20
	% of clients with special needs (PWDS, PWUDs) accessing modern FP services.	0.2	2.6	5
	% of teenage pregnancies	18.4	15.9	13.4
	% of women of	1.4	2.9	4.4

	reproductive age receiving permanent methods of FP.			
	% of men receiving permanent methods of FP	0.2	0.7	1.2
	% of contraceptive Prevalence Rate, Modern Methods (mCPR)	53.5	58.5	63.5
	% of health facilities offering Adolescent friendly services	ND	50	80
2. Health workforce	# of health care providers with sign language skills	ND	15	30
	# of nurses recruited	0	50	130
	# of doctors recruited	0	10	15
	#. of clinical officer recruited	0	145	180
	% of clinical staffs trained on LARC	50	110	170
	% of clinical staffs trained on LAPM	ND	10	20
	% of CHVs, CHEWs and public health officers/technicians trained on FP	0	825	1650
	# mentorship and follow up visits on FP by CHMT	11	66	132
	# of mentorship and follow up visits on FP by SCHMT	0	880	1760
3. Information (Research, Monitoring & Evaluation)	% of facilities reporting FP data	92	100	100
	No. 0f health care workers trained on data for decision making	0	630	1260
	# of surveys conducted among special groups on FP.	0	1	2
	# of facilities using revised FP M&E tools.	346	382	419
	% of facilities submitting timely	90.2	95	100

	FP reports.			
	% of facilities submitting FP reports monthly	92	100	100
	No. of facilities with active QI teams.	8	19	29
	% of facilities visited by the CHMT during support supervision	25	100	100
	# of CHVs trained in community based information system management	0	3098	4130
	# of county Data review meetings with the sub counties	1	8	16
	No. of data review meetings with the facilities	0	264	528
	# of operational researches carried out	1	2	4
4. Medical Products, vaccines and technologies	% of facilities reporting no stock out of FP commodities	ND	10	0
	% of health workers trained on commodity management.	ND		1
	% of facilities with LHMIS tools	60	100	100
	% of primary SDPs that have at least 3 modern methods of contraception available on day of assessment	ND	50	80
	% of secondary/tertiary SDPs with at least 3 modern methods of contraception available on day of assessment	ND	30	80
5. Health Financing	Availability of a costed FP plan	0	1	1

	% financial allocation for implementation of the costed FP plan	0	50	80
	% of FP budget utilization on FP (Burn rate)	0%	80%	100 %
6. Leadership and governance	# of FP specific stakeholder committee forums held	0	8	16
	#. of MOUs done with FP current implementing partners	0	2	5
	# of FP TWG meetings held	0	6	12
7. Advocacy	#. of champions advocating for FP	0	5	20
	#. of policy formulated or /and adapted	0	1	2
	#. of FP advocacy messages developed and disseminated by media	0	5	10
	An FP communication strategy developed and disseminated	0	1	2

5.2 Data Collection

The methods of data collection will be a combination of quantitative and qualitative methods. 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 where possible. The data collected from National processes such as the DHS and the Population Census both expected to be done 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 3: 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 Quality

The data quality to be observed includes:

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.

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.

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.

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

Integrity: Integrity is when data generated by a program's information systems 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 CHMT 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 the 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 National is one of collaboration.

CHAPTER 6: PARTNERSHIP AND FINANCING

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 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. The costing helps to guide the allocation of this 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 Sector among others. Each of the groups mentioned in one way or another, engage with the Nakuru 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 in consultative processes through thematic interest groups. The table below gives a stakeholder analysis of Nakuru County.
Table 4: Stakeholders in Nakuru County

ORGANIZATION TYPE	SECTOR/ DEPARTMENT /ORGANIZATION NAME	ROLE IN FP
Government	Department of Health	Technical guidance/support, service delivery: Policy and guidelines, infrastructure, procurement, staffing, financing, Advocacy , Partner coordination
	National Government[(i.e. DRH,NASCOP) Ministry of Devolution and Planning County Government. Ministry of Education. Ministry of Public Service, Youth and Gender Affairs. Ministry of Culture, Sports and Talent Development Office of First Lady	Policy formulation, Resource allocation. Educate, sensitize and advocacy with a focus on youth and adolescent FP/HIV integration Capacity Building
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

	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
	DSW Kenya	FP Budget analysis and advocacy
	PIMA	Monitoring and Evaluation support
	FHI 360	Capacity building of FP partners Technical support
Private sector	Private facilities	Partnerships and service delivery
FBOs	PCEA Nakuru west health centre	Service delivery
	AIC Bethsaida health centre	Service delivery
Others	Media	Awareness creation and community mobilization
	Community	Mobilization, Consumers.

6.2 COSTING OF NAKURU COUNTY FAMILY PLANNING STRATEGY

This strategy costing is a reflection of what it will cost to deliver the strategies outlined in the implementation plan, in the most ideal and efficient way.

	Key Strategy	Activities	Cost Item	Total in year 1	Total in year 2	Total in year 3	Total in year 4	TOTAL COST
1. SERVICE DELIVERY	SERVICE INTEGRATION	Conduct comprehensive integrated outreaches by the facilities per month.	# of outreaches done	405,000	433,350	463,685	496,142	1,798,177
		Integrate FP services into CCC, TB, PAC, PNC Outpatient and inpatient.	# of health facilities with integrated FP services	2,500,000		2,500,000		5,000,000
	COMMUNITY INVOLVEMENT	Conduct quarterly Community dialogues during action days.	Proportion of community dialogues Conducted.	1,300,000	1,391,000	1,488,370	1,592,556	5,771,926
		Train 3580 from 248 CUs) community health volunteers on FP.	# of CHV's trained	2,500,000	2,605,000	2,717,350	2,837,565	12,659,915
		1. Identify and recruit 60 male FP champions.	Meeting	10,000	10,700	11,449	12,250	44,399
		2 Trainings of the 60 champions.	Training	320,000	342,400	366,368	392,014	1,420,782
		3. Quarterly dialogue meetings.	Meeting	55,000	58,850	62,969	67,377	244,196
	INFRASTRUCTURE	Equip the facilities with the minimum required standard of equipment.	Portable electric lamp	5,050,000		-	-	5,050,070
			Weighing scales		2,500,000		2,500,000	5,000,000
			IUCD Insertion kits	2,000,000	2,000,000	-	-	4,000,000
			BP machines	1,500,000	1,500,000	-	-	3,000,000
			Stethoscopes	1,000,000	1,000,000	-	-	2,000,000

			IUCD removal kits	1,500,000	1,5000,000	-	-	3,000,000
			Implant removal kits		1,500,000		1,500,000	3,000,000
		Furnish and equip existing facilities	Assorted medical Equipment	15,000,000				15,000,000
		Establish 11 youth friendly centers	Furniture	2,000,000				2,000,000
			Recreational Equipment	4,500,000				4,500,000
			ICT equipment		3,000,000			3,000,000
		Establish integrated 11 drop-in centers for Key populations	Furniture		300,000	321,000	343,470	964,470
		Support peer education and mentorship initiatives for adolescents on RH in the community	# of peer education trainings done		990,000			990,000
			# of mentorship forums carried out		165,000	176,550	188,909	530,459
	Sub- Total			**16,615,000**	**9,848,800**	**4,607,741**	**4,930,283**	**37,756,594**

2. HEALTH WORKFORCE	STAFFING	Needs assessment survey	# of surveys	200,000				200,000
		HCW training on LARC	# of HCW's trained	1,600,500	1,600,500	1,600,500	1,600,500	6,402,000
		HCW training on LAPM	# of HCW's trained	1,600,500	1,600,500	1,600,500	1,600,500	6,402,000
		Train medical personnel in delivery of non-discriminatory AYSRH education and services	# of service providers trained		1,746,000	1,746,000		3,492,000
		Train at least 4 service providers per sub-county on sign language	# of service providers trained	220,000	235,400	251,878	269,509	976,787
	Sub-Total			3,621,000	5,182,400	5,198,878	3,470,509	17,472,787

3. HEALTH INFORMATION RESEARCH AND M&E	RESEARCH AND M&E	Quantify requirements	Drug					
		Procure & Distribute Tools	Procurement		6,000,000	6,420,000	6,869,400	19,289,400
			Transport		440,000	470,800	503,756	1,414,556
		Gap analysis	Meeting		143,000	153,010	163,720	459,730
		OJT/Mentorship and coaching	Lunch		2,420,000	2,589,400	2,770,658	7,780,058
		DQA	Transport & Lunch		2,420,000	2,589,400	2,770,658	7,780,058
		Data analysis & review stakeholders meeting(county)	Meeting (quartely)		1,000,000	1,000,000	1,000,000	3,000,000
		Conduct CMEs	Meeting		1,000,000	1,000,000	1000,000	3,000,000
		Training/Sensitization	Meeting		1,500,000	1,500,000	1,500,000	4,500,000
		CBHIS support (tools review meetings reporting)	Meeting		1,000,000		1,000,000	2,000,000
		Support supervision SCHMT,	# support supervision visits		1,200,000		1,200,000	2,400,000
		Review meetings with the HF I/C and SCHMT	# Review meetings	1,000,000		1,000,000		2,000,000
	Sub-Total				11,956,000	12,792,920	13,688,424	38,437,344

4. MEDICAL PRODUCTS, VACCINES AND TECHNOLOGIES	PROCUREMENT, STORAGE AND DISTRIBUTION	Quantification	Meeting		240,000	256,800	274,776	771,576
		Products Cost	Meeting		51,843,842	55,472,911	59,356,015	166,672,768
		Consumables & accessories	Products e.g. Gloves, syringes		2,592,192	2,592,192	2,664,775	10,700,467
		Storage & distribution/redistribution	Warehouse			250,000	267,500	803,725
		Stakeholder mapping	Meeting	10,000	10,700	11,449	12,250	47,507
		Budgeting	Meeting	200,000	214,000	228,980	245,009	887,989
		stakeholder engagement	Meeting	120,000	128,400	137,388	147,005	532,793
		Sensitize SDPs on GDP and Good storage practices	Meeting	715,000	765,050	818,604	875,906	3,174,560
	Sub-Total			330,000	29,872,263	30,943,158	32,648,116	183,591,385

5. HEALTH FINANCING FINANCING		AWP FP Development		500,000	500,000	500,000	500,000	2,000,000
		Joint AWP meeting between the CHMT & the Health Executive & The County Treasury	Meeting (ONCE)	550,000	550,000	550,000	550,000	2,200,000
		AWP stakeholders meeting	Meeting (ONCE)	360,000	385,200	412,164	441,015	1,710,266
		Sign an MOU between the Dept of Health and the Partners	Meeting (ONCE)	-	-	-	-	-
	Sub-Total			570,000	609,900	652,593	698,275	2,767,921

6. LEADERSHIP & GOVERNANCE	FORUMS AND COMMUNICATION	Stakeholders meeting	Meeting (TWICE)	1,100,000	1,100,000	1,100,000	1,100,000	4,400,000
		Sensitization meetings (11 sub-counties)	Sensitization meetings (four sub-counties)	720,000	770,400	824,328	882,031	4,140,532
		Dissemination of FP/RH	Meeting (ONCE)		1,000,000			1,000,000
		Pre-recorded media programs and talk shows	PROGRAM (QUARTERLY)	200,000	[illegible]	200,000	[illegible]	[illegible]
	M & E	Support and supervision (County and sub- county)	Quarterly	4,251,000	4,251,000	4,251,000	4,251,000	17,004,000
	Sub-Total			1,100,000	1,177,000	1,259,390	1,347,547	5,375,665

7. ADVOCACY	ADVOCACY	Training [TWG)	Training (ONCE)		1,400,000			1,400,000
		Stakeholder mapping	Meeting (ONCE)	180,000	192,600	206,082	206,082	784,764
		Stakeholder meetings(FBOs, CORPs, Media, Admin, MOE, Youth & Gender, CHMT}	Meeting (quarterly)	2,0000,000	2,000,000	2,000,000	2,000,000	8,000,000
		Stakeholder meeting, County Assembly Health committee, MOE, Health Executive, CHMT, Youth & Gender]	Meeting (TWICE)	840,000	898,800	961,716	1,029,036	4,830,621
		Dissemination of FP/RH related policies to stakeholders.	Meeting (once)	180,000	192,600	206,082	206,082	784,764
	Sub-Total			1,380,000	2,876,600	1,579,962	1,647,282	8,584,913
	Grand Total			34,357,000	46,587,923	48,756,664	48,218,650	377,635,097

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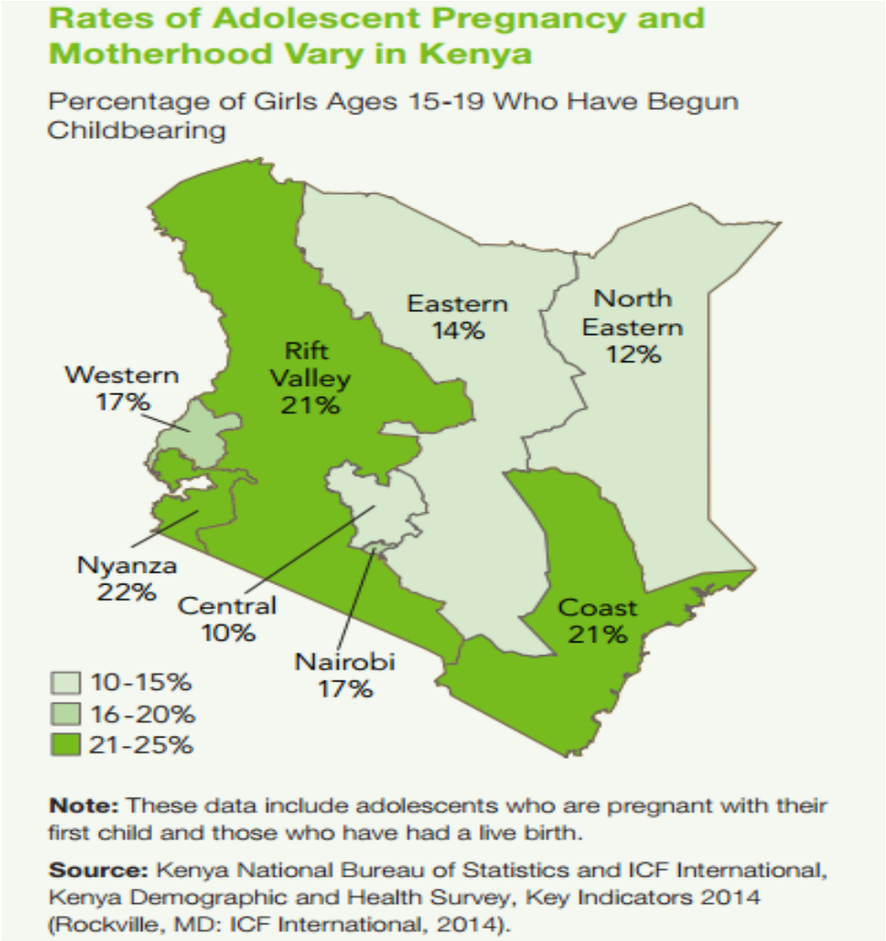
ANNEXES

ANNEX 1: NATIONAL HEALTH WORK FORCE STAFFING NEEDS

STAFF CATEGORy	Sub categories	Total staff needs	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 staff	Radiology assistant	1,505	0.6	0.3
	X-ray technician	0		-
	Radiographer	753		0.2
	Radiologist	576		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	1.2	0.9
	Health Records and Information Technician	0		-
	Medical engineering technologist	413		0.1
	Medical engineering technician	825		0.2

Administrative staff	Drivers	7,252	12.6	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		1.0
	Cooks	6,503		1.5
	Secretaries	3,362		0.8
General support staff	Casuals	2,593	2.5	0.6
	Mortuary attendants	749		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	CPR
Pills POPs	16.6	16.5	10.92
Pills COCs			
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	6.0	3.97
All others FP	5.0		
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.

ANNEXE 6: LIST OF FP-CIP DEVELOPMENT TEAM

NAME	ORGANIZATION/DEPARTMENT
Dr. Sirma	Department of Health
Dr. Wainaina D.N	Department of Health
Janet Lunayo	NCPD
Pauline Siror	PIMA
Jessica Musisi	Department of Health
Nancy Chelule	Department of Health
Jessica Mungau	Department of Health
Fadhili Msuri	KMYDO
Francis Maina	KMYDO
Martin Lunalo	RHYFE
Zeitun Khalif	KMYDO
Christine Omao	Dandelion Kenya
Caren Cherotich	Department of Gender
Judith Abongo	MOH
Bernard Bowen	MOH
Luke Kiptoon	MOH
Alex Omari	MSK
Eliza Wachuka	Afya Uzazi
Selina Nkatha	Department of Gender
Mustafa Musa	NYF
Jamila Ramadhan	KMYDO
Nassir Juma	NYF
Caroline Chepkorir	KMYDO
Videris Mwangi	Nurse
Ahmed Lole	NYF
Cosmas Mutua	Lead Consultant